June 17, 2025

Oregon Prescription Drug Affordability Board
c/o Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

TO: Members of Oregon Prescription Drug Affordability Board

I am writing to share my concerns regarding the Oregon Prescription Drug Affordability Board's process for selecting medications and conducting affordability reviews. As a physician, the well-being of my patients is my primary focus, and I am deeply troubled that the current approach to affordability reviews may jeopardize access to essential medications.

I am a board-certified pediatric rheumatologist and spent my career caring for young people with chronic or disabling conditions. Many of my patients, including those with juvenile idiopathic arthritis and lupus, rely on specialized, innovative, yet often expensive therapies.

The criteria used to identify therapeutic alternatives often fail to account for the complexities of individual patient care, such as cases where substitution is not clinically appropriate due to unique medical conditions or treatment needs. Unilaterally designating certain medications as "therapeutic alternatives" fundamentally disrupts the physician's ability to exercise their medical expertise in concert with their patient. Healthcare providers like myself consider therapeutic equivalents when considering medication substitutions as a matter of standard practice, but "therapeutic alternatives" do not constitute therapeutic equivalents. Patients who suffer from complex chronic conditions, such as rheumatoid arthritis and other rheumatologic diseases, require continuity of care to successfully manage their conditions. Policymakers have no business overriding their doctor's prescribing recommendations.

Additionally, the lack of clarity in how collected data is evaluated undermines confidence in the affordability review process. Without detailed methodologies or standards for assessing therapeutic alternatives and other critical factors, the Board risks decisions that do not adequately reflect real-world patient experiences or clinical realities. Establishing clear, consistent processes and ensuring transparency in decision-making are essential steps toward improving access to affordable medications for those who depend on them.

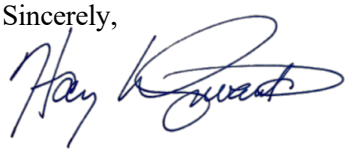
The proposed list of potential therapies for affordability review is extensive and could significantly impact Oregon patients across a wide range of disease states. I am deeply concerned about the potential unintended consequences of such evaluations, especially when conducted under tight timelines and without sufficient public input.

I share your goal to lower prescription drug costs, but the current process risks limiting access to essential medications. Physicians and patients are eager to collaborate with the Board to ensure affordability decisions reflect real-world patient needs on a more thoughtful, patient-centered approach. As it stands

now, the Board's actions could inadvertently restrict access to medications for those who need them most in Oregon.

Thank you for your attention to this critical issue.

Sincerely,



Harry L. Gewanter, MD, FAAP, MACR
President, Virginia Society of Rheumatology
Board Member, Let My Doctors Decide Action Network

TO: Oregon Prescription Drug Affordability Board
FROM: Robert Popovian, Pharm.D., MS
RE: PDAB public comment
DATE: 6/16/2025

It is important for the Oregon PDAB to consider the real-world results from the announced suppression of prices through the Inflation Reduction Act (IRA) on patient out-of-pocket (OOP) costs.
Please visit the Pioneer site: https://pioneerinstitute.org/the-inflation-reduction-act-ira-overview/

The information regarding the impact of the announced IRA price reductions on patient OOP costs is based on **actual** OOP data secured through IQVIA. This is **not** a modeling project.

Summary of Results:
All data compares OOP prices between 1Q2024 and 1Q2025.

- The average OOP cost increased overall for all MFP medicines included in the analysis.
- The average OOP cost across all nine MFP drugs rose by $23.91, from $74.51 to $98.42.
- This represents a 32% increase in average OOP cost across all nine MFP medicines.
- OOP costs increased specifically for seven of the nine medicines with a negotiated MFP.
- Cost increases ranged from $10.56 to $316.81.
- Of the two medicines that did not have OOP increases, one faced new biosimilar competition that only became available in 2025.
- All four of the largest PBMs increased OOP costs for six of the seven medicines with cost increases. One medication had OOP increases from three of the four PBMs.

Due to rebate contracting, higher-priced drugs offer more generous rebates. Thus, suppressing retail prices may reduce PBM revenue and profit margins. While this reduction in PBM profit may appear beneficial, an **unintended outcome** is that PBMs can recoup lost profits by increasing patient OOP costs. The Pioneer data clearly demonstrates this scenario for the medicines subjected to IRA price setting.

For example, despite a ~40% list price reduction for **Januvia**, patient OOP costs actually increased year-over-year.

It is also important to note that in the case of **Stelara**, multiple biosimilars are now on the market. Stelara biosimilars were priced at approximately ~80% or more discount. However, patient OOP costs dropped by only 27%. As such, patients did not recoup the full value of price reductions through biosimilar competition.

The consequences of price suppression may extend beyond higher OOP costs. PBMs may implement additional policies in response to lost profitability. For example, PBMs and their vertically integrated insurance companies may:

- Increase administrative barriers such as prior authorization and step therapy, limiting access to PDAB or non-PDAB medicines.
- Raise premiums.
- Increase OOP costs for drugs not evaluated by PDAB.
- Exclude certain drugs from formularies, restricting patient access.

The reason I am sharing this information with the PDAB Board is fivefold:

1. Any price suppression by Oregon PDAB may result in higher patient OOP costs.
2. Oregon PDAB must implement mechanisms to monitor and penalize PBMs that increase OOP costs for medicines under PDAB evaluation.
3. Oregon PDAB must implement mechanisms to monitor and penalize PBMs that increase OOP costs for medicines not under PDAB evaluation.
4. Oregon PDAB should develop a strategy to prevent PBMs from adopting policies that harm patients and Oregon taxpayers beyond higher OOP costs, such as formulary exclusions.
5. Unless the State of Oregon, in collaboration with PDAB, eliminates rebate contracting for any drug benefit program where patients incur OOP costs, suppressing retail prices will become another failed attempt to improve patient affordability.

June 17, 2025

Via Electronic Mail
Oregon Prescription Drug Affordability Board
PO Box 14480
Salem, OR 97309
pdab@dcbs.oregon.gov

Re: June 18, 2025 Board review and possible vote for updated data subset list of prescription drugs and insulin products pursuant to OAR 925-200-0010

Dear Members of the Oregon Prescription Drug Affordability Board:

Sanofi appreciates the opportunity to submit comments to the Oregon Prescription Drug Affordability Board ("OR PDAB") regarding the Board's potential selection of certain insulin products for affordability reviews, pursuant to OAR 925-200-0010. We understand that the OR PDAB is considering whether to include one or more of Sanofi's insulin glargine products, including Lantus®, Toujeo®, and unbranded products, Insulin Glargine U-100 and Insulin Glargine U-300, in the subset list of prescription drug and insulin products for review. For the reasons described below, OR PDAB's consideration of Sanofi's insulin products is inappropriate and inconsistent with the goal of ORS 646A.694, which is to identify products that currently create affordability challenges for the health care system or high out-of-pocket costs for patients.

1. **The 2023 data is outdated and does not reflect the significant reductions in list prices and other market trends, which reduce Oregon's cost and spending metrics for Sanofi's insulins.**

To further our commitment to support patients directly at the pharmacy counter and accelerate the transformation of the U.S. insulin market, in January 2024, Sanofi reduced the list price of Lantus®, our most widely prescribed insulin in the United States, by 78%.[1] Additionally, beginning January 1, 2024, all commercially-insured patients who fill their Lantus® prescriptions at participating pharmacies have their out-of-pocket responsibility capped at $35 for a monthly supply. At the same time, Sanofi launched Insulin Glargine Injection U-300, an unbranded version of Toujeo®, at a list price that was 60% less than Toujeo's® list price. For additional information

[1] In conjunction with this pricing action, Sanofi withdrew the lower priced, unbranded version of Lantus, Insulin Glargine U-100, from the market because the new list price for Lantus was below the list price of Insulin Glargine U-100. At that time, Sanofi also reduced the list price of our short-acting Apidra® (insulin glulisine injection) 100 Units/mL by 70%.

regarding the steps Sanofi took in 2024 to drive insulin affordability, please see our 2025 Pricing Principles Report.[2]

Although payers, including PBMs and government and private insurers, ultimately decide which medicines to cover, how much to reimburse dispensing pharmacies, and patients' out-of-pocket responsibility, Sanofi's pricing actions have reduced pharmacy reimbursement and out-of-pocket costs for these products. Unfortunately, although Sanofi continues to provide lower cost options to payers and PBMs, patients often do not realize the full cost savings because incentives within the health system drive health plans and middlemen to favor high list prices and larger rebates over lower priced options.

Taken together, the scope of these changes mean that the OR PDAB's 2023 data simply do not accurately reflect current costs, utilization, and spending. At a minimum, the OR PDAB should not consider including Sanofi's insulin products in an affordability review unless and until it can review current data that reflects these changes.

2. **Sanofi's insulin glargine products are highly utilized and affordable life-saving treatments for Oregon residents with diabetes.**

The inclusion of Sanofi's insulin products, like Lantus®, among the top gross spending products is presumably a result of the number of patients who rely on these insulin products – not their prices. As demonstrated by Oregon's own 2023 data,[3] Sanofi's insulin glargine products are not among the highest cost insulin products on a per prescription or per patient basis across multiple metrics, including overall costs, payer payments, and patient out-of-pocket costs. Indeed, healthcare providers and patients choose Sanofi's insulin glargine products because of their well-established clinical benefits and their affordability.

We are proud of the meaningful ways in which our products have transformed the standard of care for patients, from the introduction of Lantus®, which provided significant improvements in basal insulin levels, to the introduction of Toujeo®, a next generation basal insulin that more closely mimics the body's endogenous insulin secretions, among others. In addition to delivering meaningful innovation in the types of insulin available to patients, we are proud of the role we have played in transforming the patient experience through the development of devices to ease the daily burden of insulin administration, allowing for fewer injections and, in some cases, fewer refills and related patient copays.

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[2] Sanofi 2025 Pricing Principles Report: Action Driving Insulin Affordability, *available at* *https://www.sanofi.us/assets/dot-us/pages/images/our-company/Social-impact/responsible-business-values/pricing-principles/Sanofi-2025-Pricing-Principles-Report_Action-Driving-Insulin-Affordability.pdf*.

[3] *See* Insulin Preliminary Data, Oregon PDAB Data Dashboard, *available at* https://app.powerbigov.us/view?r=eyJrIjoiOGM2YjhlMWUtNzE2OC00MmU1LTk2MjktYWUzZGMyNTNmZmQ1IiwidCI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9.

We have coupled these clinical innovations with our progressive and industry-leading pricing principles, which reflect our commitment to sustainable pricing and transparency,[4] and a suite of innovative affordability programs to help people reduce their prescription medicine costs, regardless of their insurance status or income level. As a result, no Oregon patient has to pay more than $35 per month for their Sanofi insulin product.[5]

Given these utilization and cost trends – even using 2023 data, Sanofi's insulin glargine products are not an appropriate target for the OR PDAB.

3. **The data the OR PDAB is relying on does not appear to take into account the significant rebates and other price concessions that Sanofi provides to payers.**

The "list price" of a medicine often receives the most attention in public discussions, but it does not reflect the price patients pay at the pharmacy counter, nor does it reflect the amount health insurance companies pay (or that Sanofi receives).

Sanofi provides significant discounts, rebates, and fees to different stakeholders across the healthcare value chain, including to payers and their pharmacy benefit managers ("PBMs"), to ensure our medicines are accessible to patients. Sanofi pays these price concessions to insurers (or their PBMs) after a medicine is dispensed to a patient so it is not captured in the "payer paid" amount. As a result, the "payer paid" and "overall spend" data have no relation to the net amount payers actually pay for Sanofi's insulin products.

OR PDAB clearly recognizes the importance of understanding net spend to its analysis as it has collected this data for non-insulin products.[6] OR PDAB should consider payer spend net of rebates for insulin products as well.
For these reasons, Sanofi respectfully requests that the Board remove Lantus®, Toujeo®, Insulin Glargine U100, and Insulin Glargine U300 from consideration for the subset list of insulin products. Further, any consideration of these products should and at a minimum take into account updated data on insulin products before proceeding with any insulin product review.

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[4] *See* Sanofi 2025 Pricing Principles Report, *available at* https://www.sanofi.us/assets/dot-us/pages/images/our-company/Social-impact/responsible-business-values/pricing-principles/Sanofi-2025-Pricing-Principles-Report.pdf.
[5] Additional details regarding our programs are available at https://www.teamingupfordiabetes.com/sanofidiabetes-savings-program.
[6] *See* Carrier Preliminary Data, including Carrier Spend Net of Rebate and Carrier Spend Net of Rebate per Enrollee, Oregon PDAB Data Dashboard, *available at* https://app.powerbigov.us/view?r=eyJrIjoiOGM2YjhlMWUtNzE2OC00MmU1LTk2MjktYWUzZGMyNTNmZmQ1IiwidCI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9. The 2023 insulin data from the Oregon All Payer All Claims Database (APAC) is gross and not net of rebates. *See* Insulin Data Process, Oregon Prescription Drug Affordability Board (Jan 2025), *available at* https://dfr.oregon.gov/pdab/Documents/Insulin-Data-Process-Documentation.pdf.

Please feel free to contact me at with any questions at carissa.kemp@sanofi.com or (208) 954-6330.

Sincerely,

Carissa Kemp
Lead, State Government Relations, Sanofi

Enclosure:

2025 Sanofi Pricing Principles Report

sanofi

2025 Pricing Principles Report

Advancing Responsible Leadership

At Sanofi, we work passionately to help prevent, treat, and cure illness and disease, understand and solve healthcare needs of people across the world, and transform the practice of medicine.

We have a longstanding commitment to promoting healthcare systems that make our treatments accessible and affordable to those in need. In May 2017, Sanofi reinforced this commitment with the introduction of our Pricing Principles, which details how we price our medicines and advocates for policy solutions to make the system work better for patients.

Our goal—then and now—is to foster a culture of transparency that helps our stakeholders better understand our pricing decisions and facilitates a more informed discussion related to the pricing of medicines across the U.S. healthcare system.

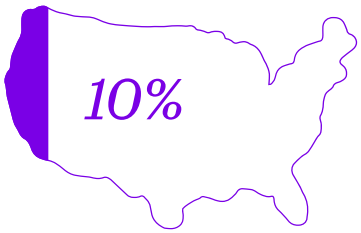
This report outlines our principles, 2024 pricing decisions, and our perspectives on advancing solutions to improve patient outcomes and affordability in the United States.

Our Pricing Principles *& Perspectives*

We share concerns about patients' affordability of medicines while recognizing that we are only one of many stakeholders involved in healthcare delivery.

At Sanofi, we price our medicines according to their value while advancing broader solutions that improve patient outcomes and support affordability within the U.S. healthcare system. Our pricing strategy underscores our commitment to patient access while minimizing our contribution to overall healthcare system spending. We remain transparent in how we price our prescription medicines and limit price increases in the United States.

As of September 2024, prescription medicines accounted for only



of U.S. healthcare spending, marking a reduction of approximately 4% compared to the previous year.[1]

The pricing principles we put forth focus on three pillars:

- **Clear Rationale for Pricing** at the time of launch of a new medicine
- **Reporting of U.S. Pricing Actions** on our medicines over time
- **Continued Transparency in the U.S.** around our pricing decisions

[1] Altarum. Health Sector Economic Indicators. November 2024.

Clear Rationale for Pricing

When we set the price of a new medicine, we follow a rigorous process that includes consultation with external stakeholders and consideration of the following factors:

A holistic value assessment using various internal and external methodologies to define or quantify value, incorporating patient perspectives and priorities. This includes:

- Clinical value and outcomes: the benefit the medicine delivers to patients and its effectiveness compared to the standard of care
- Economic value: how the medicine reduces the need for – and costs of – other healthcare interventions
- Social value: how the medicine contributes to quality of life and productivity

Similar current or future treatment options at launch to understand the landscape within the disease areas where our medicines or vaccines may be used.

System-wide affordability, including steps we must take to promote patient access and contribute to a more sustainable system for payors and healthcare systems.

Unique launch factors specific to a medicine or vaccine at its launch. For example, we may need to support ongoing clinical trials, implement regulatory commitments, or develop sophisticated patient support tools.

Reporting of U.S. Pricing Actions

We acknowledge our role in preserving the sustainability of our healthcare system and limiting our contribution to U.S. healthcare spending growth.

Our approach to pricing actions for existing medicines balances our ambition to chase the miracles of science, patients' access to the medicines they need, government policies, and evolving marketplace trends.

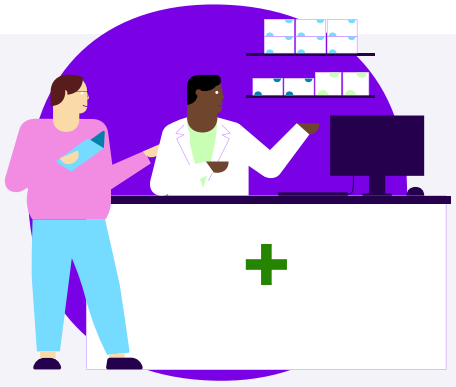
The guiding principle for any list price actions taken during the fiscal year 2024 was to adhere to a level consistent with our approach to responsible pricing.

Sanofi will annually disclose additional background if price actions trigger a prescription drug mandatory supplemental rebate under the Inflation Reduction Act (IRA) of 2022.

Continued Transparency in the U.S.

To maintain an open dialogue and recognize calls for continued transparency in our pricing actions, **we annually disclose our average aggregate U.S. list and net price changes from the prior calendar year**. We believe this information contributes to better-informed discussions to improve patient access and affordability.

It is important to note that patient cost-sharing and coverage decisions are made by public and private payors and employers, not manufacturers. It is most often the case that patients' out-of-pocket costs ultimately depend on how their health plan structures insurance coverage and to what extent it passes through negotiated discounts.



Although list prices often garner the most attention, they often do not represent the price patients pay.

Learn more about misaligned incentives in the drug supply chain impacting patient affordability.

Learn more →

A Look Back
2024 Pricing Actions

Our Pricing Principles reflect our unwavering dedication to providing patients with innovative and life-changing treatments while limiting costs and minimizing our contribution to healthcare spending growth.

Clear Rationale for Pricing

In 2024, Sanofi ushered in scientific breakthroughs by expanding the indications for five of our existing medicines, widening their FDA-authorized labels to treat additional conditions. This achievement was based on extensive and continued research and data, offering new treatment options to different patient populations with unmet needs.

Although post-approval research is less heralded than the investigation and launch of new medicines, continuing research into a medicine's potential to treat multiple different diseases can help unlock its full economic and societal value, allowing more people to benefit from treatments that may improve their conditions.

Specifically, post-approval research is critical for medicines targeting immune system disorders, an area with significant unmet need and severe symptoms, in which the body's immune system mistakenly attacks healthy cells or fails to respond to harmful invaders, causing inflammation and pain.

Our R&D approach, rooted in immunoscience, investigates the underlying causes of inflammation in the body and leverages our deep understanding of biological pathways, often linking seemingly unrelated conditions and broadening the populations of patients that can benefit from our medicines.

These "unsung heroes" of science highlight how fostering an innovative ecosystem that values post-approval research expands these medicines' value to patients and society – an ecosystem at risk due to new government price-setting policies.

Sanofi supports policy solutions that preserve drug discovery while ensuring affordable patient access to life-changing medicines.

Learn more about health care reforms we support.

Learn more →

Unlocking New Potential for Existing Medicines

Our 2024 Milestones in Pediatric, COPD, and Multiple Myeloma Treatments

January 2024

Dupixent® (dupilumab) was approved for pediatric patients aged 1 year and older weighing at least 15 kg with eosinophilic esophagitis, the first and only U.S.-approved medicine indicated for as young as 1 year old. The label was also updated to include efficacy and safety data for patients aged 12 and older with uncontrolled moderate to severe atopic dermatitis affecting the hands and/or feet.

May 2024

Altuviiio's® [Antihemophilic Factor (Recombinant), Fc-VWF-XTEN Fusion Protein-ehtl] label was updated with Phase 3 pediatric study results, showing effective bleed protection in children with hemophilia A with once-weekly dosing.

June 2024

Kevzara® (sarilumab) was approved for treating active polyarticular juvenile idiopathic arthritis in patients weighing 63 kg or more.

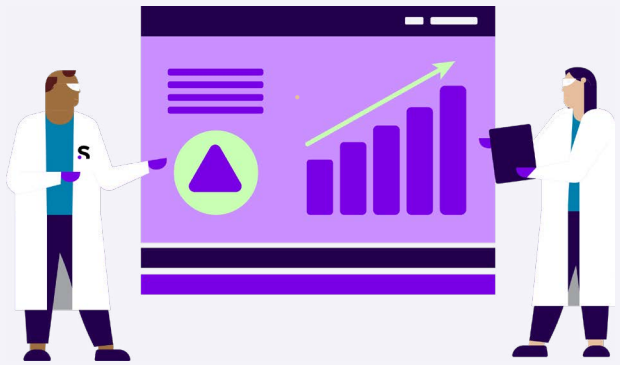
September 2024

Sarclisa® (isatuximab-irfc) was approved in combination with standard-of-care treatment for adults with newly diagnosed multiple myeloma who are not eligible for autologous stem cell transplant.

Dupixent was approved as an add-on maintenance treatment for adults with inadequately controlled COPD and an eosinophilic phenotype, making it the first-ever biologic for these patients in the U.S. Dupixent is not indicated for the relief of acute bronchospasm in this COPD population. It is also approved as the first and only add-on maintenance treatment for patients as young as 12 years of age with inadequately controlled chronic rhinosinusitis with nasal polyps, expanding on the 2019 approval for adults.

October 2024

The label of Flublok® (Influenza Vaccine) was updated with data from a safety study involving over 48,000 pregnant individuals aged 18 and older.



We keep delivering for patients with the continued momentum of Dupixent, our leading biologic medicine

Approved in

7

indications, driven in part by type 2 inflammation

Treating more than

1 million

patients worldwide[2]

[2]This worldwide number is largely comprised from 10 countries (Canada, China, France, Germany, Italy, Japan, the Netherlands, Spain, the UK, and the US), with the rest of the world comprising ≈10% of this number. This number is comprised of the following US approved indications: AD, asthma, CRSwNP, PN, and EoE. Data through August 2024.

Reporting of U.S. Pricing Actions

In 2024, Sanofi increased the price of *40* of its *80* prescription medicines in line with our Pricing Principles.

Effective January 1, 2024, Sanofi significantly reduced the list price for two insulin products in the U.S.

- The list price of Lantus® (insulin glargine injection) 100 Units/mL, our most prescribed insulin, was reduced by ▼*78%*
- Similarly, the list price of our short-acting insulin, Apidra® (insulin glulisine injection) 100 Units/mL, was lowered by ▼*70%*

Continued Transparency in the U.S.

U.S. Portfolio Annual Aggregate Price Change from Prior Year[3]

Year	Average Aggregate List Price	Average Aggregate Net Price
2016	4.0% Increase	2.1% Decrease
2017	1.6% Increase	8.4% Decrease
2018	4.6% Increase	8.0% Decrease
2019	2.9% Increase	11.1% Decrease
2020	0.2% Increase	7.8% Decrease
2021	1.5% Increase	1.3% Decrease
2022	2.6% Increase	0.4% Decrease
2023	4.3% Increase	15.7% Decrease
2024[4]	1.1% Increase	7.4% Increase

[4]Excluding the unique dynamics of the insulin market, Sanofi saw a 4.5% increase in aggregated gross price and a 3% decrease in net price. This demonstrates the increased demand for rebates and its overwhelming impact on the flow of revenue through the drug supply chain without directly impacting patients' out-of-pocket costs.

[3]As of December 31, 2024

Gross Sales Sanofi Paid as Rebates in 2024

36%
of our gross sales to payors as rebates

$4.3 billion
in mandatory rebates to government payors as required by federal law

$7.4 billion
in rebates negotiated with health plans and pharmacy benefit managers (PBMs) and their related fees

Sanofi's annual net price change is influenced by a number of factors, including the level of discounts, rebates, and fees paid to ensure access to our medicines; the makeup of our product portfolio; the type of health plan or program through which the medicine is dispensed (especially those with both negotiated and government-mandated rebates and discounts); and the extent of patient assistance we provide to improve the affordability of our medications.

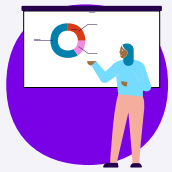
We experienced a 7.4% increase in 2024 in our average aggregated net price across our portfolio, the first increase reported since we began disclosing aggregate data. This increase was influenced by several factors, including dynamics within our insulin portfolio and the broader U.S. insulin market.

In 2024, Sanofi took a significant price reduction for Lantus, our most-prescribed insulin product. As a result of this price reduction within existing regulatory contracts, we saw an increase in net prices due to lower rebates across several channels. The portfolio impact of this net price increase was amplified by an increase in Sanofi market share for Lantus in 2024, which was due in part to a competitor product exiting the insulin market.

It is worth noting that the vast majority of Sanofi medicines still face heightened demand for rebates and fees from health plans and PBMs – which continue to assert control over drug pricing and patient out-of-pocket costs.

Living Out *Our Commitments*

Learn about our perspectives on significant policy issues impacting patient access and affordability and see how we are actively working to lower the out-of-pocket costs of prescription medications for all patients.



The Disconnect Between List Prices & Patient Costs

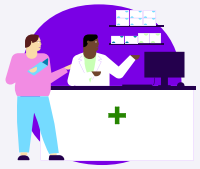
Learn more →

Prioritizing Patient Affordability: Our Patient Support Programs

Learn more →

A Closer Look at 340B

Learn more →



Action Driving Insulin Affordability

Learn more →

Navigating the Complexities of Accessing Specialty Medicine

Learn more →

Health Policy Solutions Protecting Innovation

Learn more →

June 18, 2025

My name is Melissa Horn and I am the State Legislative Affairs Director for the Arthritis Foundation. Thank you for the opportunity to comment on the list of drugs included in the affordability review process. While we have a broader set of principles on patient-centered value assessment that could be applicable to all drugs on the list, I'd like to focus my comments today on Humira's inclusion in the affordability review process.

The Arthritis Foundation supports efforts to improve drug affordability for patients, however, we are concerned that reviewing Humira may not be the best use of the Board's capacity. While Humira has historically been a high-cost drug, the market landscape is rapidly evolving. There are now over 10 FDA-approved Humira biosimilars.

Access to biosimilars has increased greatly over the past year, with major PBMs like CVS and Optum Rx preferring biosimilars over Humira on their formularies. CVS and Optum Rx removed Humira from their lowest net cost formularies in 2024 and 2025. These actions are beginning to lower prices and change market dynamics.

We think the state of OR would be better served by focusing on how to incentivize and ensure access to biosimilars to more people, rather than conducting an affordability review on their reference product. Thank you for your consideration and we look forward to opportunities to engage with the Board in the future.

Melissa Horn, MPA (she/her)
Arthritis Foundation
Director of State Legislative Affairs | Department of Advocacy and Access
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mhorn@arthritis.org
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PCMA

June 30, 2025

Shelley Bailey, MBA
Chair, Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

Dear Chair Bailey and members of the Oregon Prescription Drug Affordability Board:

I am writing to share our disappointment with the Oregon State Pharmacy Association's (OSPA) June 14th comment letter to the Oregon Prescription Drug Affordability Board (Board) calling for a ban on PBMs from operating in the state. Such hyperbole is a disservice to OSPA's members as well as all Oregonians. Ignoring the incongruity of calling for a ban while also asking the Board to adopt its legislative agenda, OPSA makes several inaccurate statements about PBMs and their role in the drug supply chain.

PBMs help manage the drug benefit for more than 3.5 million Oregonians and are projected to save them more than $13.6B over the next 10 years. Every single state employee plan in U.S. contracts with a PBM, including the Oregon Public Employees' Benefit Board (PEBB). Virtually every single state Medicaid program, including the Oregon Health Plan, contracts with a PBM. They do so because PBMs help lower the cost to the payer and patient. PBMs role is to exert downward pressure on drug prices set by drug manufacturers.

As you know, the statutory mission of the Board is to "protect Oregon residents and stakeholders from the financial burdens associated with exorbitant drug prices." OSPA's request to force the closure of certain pharmacies to protect their own interests contradicts this purpose. Further, eliminating PBMs in Oregon would remove a key mechanism in controlling prescription drug prices, leading to higher costs for consumers at the pharmacy counter. The Board is tasked with studying the entire prescription drug distribution and payment system to identify affordability challenges and recommend reforms. Banning PBMs would remove a critical component, limiting the Board's ability to assess and improve how drug costs are managed across the entire supply chain.

The recommendations made by OSPA fall far short of doing anything to help expand access or lower costs for patients, who should be at the center of any policy considerations, particularly from the PDAB. In light of the above, it is important to consider each of OSPA's recommendations.

Prohibiting vertical integration
OSPA states there has been a decrease in the number of pharmacies in the state. However, upon a deeper examination of these closures, there is little evidence that most closures are related to PBM business practices. Bi-Mart closed 13 pharmacies in Oregon attributing the closures to "rising medical costs and Oregon's corporate activity tax." Rite Aid is closing hundreds of pharmacies across the country due to a high debt load and continued lawsuits related to its role in the opioid

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crisis. Seeking legislation that would force the closure of additional pharmacies that offer greater access to Oregon health care consumers is counter to patient access and OSPA's stated concern.

Eliminating opaque reimbursement models
Spread pricing is not a reimbursement model. It is a contract between a health plan and a PBM, unrelated to pharmacy reimbursement. During stakeholder meetings leading up to the 2025 legislative session, it was made clear spread pricing is not a reimbursement model for pharmacies.

Of the handful of states that have enacted a ban on spread pricing, none have seen a reduction in prices for patients nor an increase in pharmacy reimbursement. They have, however, seen the elimination of a choice for payers and employers in how they manage their prescription drug benefit expenditures. Data from DCBS showed nearly all pharmacy reimbursements were above their acquisition costs. Of the 8.3% of claims that were reimbursed below acquisition cost, the high net profit reimbursement claims made up for these losses and resulted in a net pharmacy profit when looking at the totality of all prescription claims paid.

Requiring 100% rebate pass-through to payers and patients
PBMs already do this at a client's request. It is always up to the client how they choose to compensate PBMs, including if a PBM is contractually allowed to keep an agreed-upon percentage of rebates. Please refer to the DCBS Drug Price Transparency Program report which shows how all rebates are handled by Oregon-licensed PBMs. Dictating how health plans compensate PBMs will not lower costs for patients or increase reimbursement for pharmacies.

Restricting formulary practices that prioritize PBM profit over patient care
Nationally, 90% of all drugs dispensed are generic. If PBMs favored higher rebated brand drugs, the percentage of generic drugs dispensed would be significantly lower. Additionally, simply pursuing higher rebates for the sake of higher profits fails to make economic sense. Example:

- There are two therapeutically equivalent competing brand drugs that are safe and effective in treating a specific medical condition.
- A PBM negotiates a $100 rebate on a $1,000 drug and is contractually permitted to retain 5% or $5 as compensation for its services.
- The PBM negotiates a $200 rebate on a $2,000 competitor drug and is contractually permitted to retain 5% or $10 as compensation for their services.
- With the second drug, the PBM retains a higher rebate ($10 instead of $5)
- However, the cost to the health plan increases significantly from $905 to $1810

No one would hire a PBM if they pursued higher rebates instead of working to ensure payers get the lowest net cost possible.

In conclusion, not a single one of these recommendations passed in other states has resulted in lower costs for payers or consumers. Pharmacists are seeking increased reimbursements and dispensing fees which will result in higher overall costs. We encourage the OSPA to engage in constructive dialogue on this matter rather than advocating for extreme measures that may lead to higher costs and reduced access for payers and patients.

While we continue to stand ready to work with pharmacists, we reject the call for actions that would dramatically and unnecessarily disrupt Oregonians' ability to access safe and affordable

PCMA

medications. We hope the Board will reject OSPA's effort to turn the PDAB into a weapon in its legislative advocacy campaign.

Sincerely,

Bill Head
Assistant Vice President
State Affairs

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To the Prescription Drug Affordability Board,

My name is Katie Lukins, and I'm a public school teacher. I've lived with migraines since I was eight years old. Over the years, I've tried many treatments, but it wasn't until I was prescribed Nurtec that I found something that actually helped stop a migraine once it started. It has made a real difference in my ability to function during an attack.

As a teacher, I don't have the option of missing work easily. When I get a migraine and don't have access to an effective abortive medication, I either have to push through the pain—unable to give my students my best—or I have to miss school altogether, which puts a strain on my students, my colleagues, and myself.

I'm proud to do the work I do, but like many public servants, I'm on a limited income. The high cost of Nurtec makes it hard to consistently afford the medication I need to stay present in the classroom and maintain my quality of life. It shouldn't be this difficult for someone with a chronic condition to access a medication that works.

Please consider the real-world impact of drug pricing on working people like me. I urge you to take action to make Nurtec more affordable so that those of us who depend on it don't have to choose between our health and our paycheck.

Thank you for your time and for the work you're doing to make prescription drugs more affordable.

Sincerely,
Katie Lukins

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July 9, 2025

Shelley Bailey, MBA
Chair, Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

Subject: Rebuttal to Misleading PCMA Public Comments for July 2025 Meeting

Dear Chair Bailey and Members of the Oregon Prescription Drug Affordability Board,

I am writing to provide a direct rebuttal to the Pharmaceutical Care Management Association's (PCMA) public comments submitted for the July 2025 meeting. While PCMA attempts to defend the current Pharmacy Benefit Manager (PBM) model, their arguments consistently misrepresent the realities faced by Oregon patients and pharmacies, and fundamentally diverge from the PDAB's core mission to protect Oregonians from exorbitant drug prices.

The PDAB board consists of well-educated healthcare professionals who are knowledgeable about the abusive practices by PBMs. Unlike state legislators who are not industry professionals, you cannot be manipulated by the misleading narratives spread by PCMA and their insurance partner lobbyists. It's insulting that this organization attempts to undermine the discussion and doesn't even cite sources in their letter.

The Evidence Against PBM Claims
Recent testimony before the U.S. Senate Judiciary Committee by Dr. Neeraj Sood of USC's Schaeffer Institute provides damning evidence of PBM market manipulation that directly contradicts PCMA's assertions. Dr. Sood's research reveals that **more than 40% of prescription drug spending flows to intermediaries in the supply chain, including PBMs, rather than to manufacturers who actually develop medications**. Most significantly, vertically-integrated PBMs earn excess returns of 5.9% compared to 3.6% for the average S&P 500 company, demonstrating these are not competitive markets but oligopolies extracting economic rents from patients.

PCMA's letter asserts that PBMs save Oregonians billions and are essential to controlling drug costs. This narrative directly contradicts the lived experience of patients struggling with high out-of-pocket costs and pharmacies facing unsustainable operating conditions. My previous submission on June 14, 2025, on behalf of the Oregon State Pharmacy Association (OSPA), detailed how PBMs, through opaque, profit-driven models, restrict access, inflate costs, and undermine independent pharmacies.

Addressing PCMA's Misleading Claims

1. PCMA Claimed "$13.6 Billion in Savings" Costs Oregon Patients Real Money
PCMA suggests PBMs will save Oregonians $13.6 billion over the next 10 years. This figure is not only misleading, it's mathematically impossible to verify due to the very opacity PBMs create. Worse, this claimed

"savings" actually costs Oregon patients money at the pharmacy counter through a systematic scheme of list price inflation.

As Dr. Sood's research demonstrates, for every $1 increase in manufacturer rebates paid to PBMs, list prices rise by approximately $1.17. **This creates a perverse incentive system where PBMs profit from higher list prices while Oregon patients pay inflated costs when filling prescriptions**. Patients with high-deductible health plans or co-insurance pay based on these artificially inflated list prices, not the lower net price after rebates, meaning they're directly subsidizing PBM profits.

The insulin market provides a stark example of how PBMs extract money from patients: Between 2014 and 2018, while manufacturers' net prices decreased by 33%, **PBMs' share of insulin expenditures increased nearly three-fold, from $5.64 to $14.36 per $100 spent**. Oregon diabetes patients paid higher out-of-pocket costs while PBMs retained the savings negotiated on their behalf.

For Oregon's state budget, PBM opacity means taxpayers cannot verify whether they're receiving value for money. An audit by the Oregon Secretary of State found PBM transactions in Medicaid too complex and opaque to ensure accountability, making any claimed "savings" impossible to verify. True affordability means lower costs at the pharmacy counter for patients and verifiable savings for taxpayers, not hidden profits for PBMs.

2. PBMs Are Directly Responsible for Higher Patient Costs Through Pharmacy Closures
PCMA's attempt to dismiss PBM culpability in pharmacy closures by citing Bi-Mart and Rite Aid ignores how this crisis directly increases costs for Oregon patients. When pharmacies close due to PBM predatory pricing, patients must travel farther and pay higher prices at remaining chain pharmacies in "pharmacy deserts."

A 3-Axis Advisors analysis in Oregon found that **75% of Medicaid reimbursements to independent pharmacies don't even cover basic labor and drug costs**. These predatory reimbursement tactics force pharmacies to operate at a loss, creating a vicious cycle where Oregon patients lose access to affordable, convenient pharmacy services.

The data demonstrates how PBM practices directly harm Oregon patients:

- Over 200 pharmacy closures since 2008, forcing patients to travel farther for prescriptions
- A 56% increase in pharmacy deserts in just four years, reducing competition and increasing prices
- Oregon ranking last in pharmacy access among contiguous U.S. states, limiting patient choice

When pharmacies close, Oregon patients face higher costs through:

- Increased transportation costs and time off work to reach remaining pharmacies
- Loss of personalized pharmacy services that help patients manage medications effectively
- Reduced access to pharmacy-based healthcare services like immunizations and health screenings

When three PBMs control (at least) 80% of the prescription market, as documented by USC researchers, and systematically engage in below-cost reimbursements, the causal relationship to both pharmacy closures and higher patient costs becomes undeniable. Every pharmacy closure represents a direct cost increase for Oregon patients who lose convenient, competitive pharmacy access.

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3. Spread Pricing Directly Increases Patient Costs and Wastes Oregon Tax Dollars
PCMA's claim that "spread pricing is not a reimbursement model" is semantic misdirection that obscures how this practice directly increases costs for both patients and Oregon taxpayers. Spread pricing works as a hidden tax on every prescription: PBMs charge health plans (including Oregon's Medicaid program) one price while reimbursing pharmacies a lower amount, pocketing the difference as pure profit.

For Oregon patients, spread pricing means higher costs at the pharmacy counter in multiple ways:

- Higher insurance premiums: When PBMs overcharge health plans through spread pricing, these inflated costs are passed directly to patients through higher premiums and deductibles
- Increased co-pays: Many patients pay co-insurance based on the inflated amount PBMs charge health plans, not the actual pharmacy cost
- Pharmacy access fees: When pharmacies can't survive on below-cost reimbursements, patients must travel farther and pay higher prices at remaining chain pharmacies in "pharmacy deserts"

For Oregon taxpayers, spread pricing represents a direct waste of public funds. Every dollar of spread pricing profit extracted from Oregon's Medicaid program is a dollar that could have purchased additional healthcare services or reduced taxpayer burden. Even DCBS data, which PCMA selectively quotes, acknowledges that 8.3% of claims were reimbursed below acquisition cost, meaning taxpayers paid PBMs more than the actual drug cost while pharmacies lost money filling prescriptions.

PCMA's assertion that states banning spread pricing haven't seen cost reductions is demonstrably false. **Ohio's Medicaid program saved $140 million by removing large PBMs and eliminating spread pricing; savings that went directly back to taxpayers and the healthcare system.** Similarly, Dr. Sood's research shows Medicare could have saved $2.6 billion in 2018 on just 184 common generic drugs if purchased at transparent prices instead of through PBM-manipulated pricing schemes.

Eliminating spread pricing would deliver immediate savings to Oregon patients and taxpayers by:

- Reducing insurance premiums through lower administrative costs
- Decreasing co-pays by eliminating artificial price inflation
- Preserving pharmacy access by ensuring sustainable reimbursement rates
- Returning millions in taxpayer dollars to Oregon's Medicaid program for actual healthcare services

4. The 100% Rebate Pass-Through Would Put Money Back in Patients' Pockets
PCMA's suggestion that PBMs already pass through 100% of rebates "at a client's request" reveals the fundamental problem: the system is designed to obscure rather than deliver savings to Oregon patients. The issue isn't whether clients *can* request it; it's that the current system allows PBMs to profit from higher list prices and larger rebates while patients pay inflated costs.

Oregon patients are directly subsidizing PBM profits through higher out-of-pocket costs. Dr. Sood's research proves this point: PBMs have driven systematic increases in list prices to generate higher rebates for themselves. When Oregon patients with high-deductible plans or co-insurance fill prescriptions, they pay based on these artificially inflated list prices, not the lower net price after rebates that never reach the pharmacy counter.

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A mandatory 100% rebate pass-through would deliver immediate savings to Oregon patients by:

- Reducing out-of-pocket costs for patients with high-deductible plans who currently pay inflated list prices
- Lowering insurance premiums by eliminating PBM rebate retention as a profit center
- Reducing co-pays by basing patient costs on actual drug prices rather than inflated list prices
- Saving Oregon's Medicaid program millions in taxpayer dollars by ensuring all negotiated discounts benefit the state rather than PBM shareholders

OSPA's recommendation for *required* 100% rebate pass-through aims to eliminate the perverse incentive that drives up costs for Oregon patients while ensuring genuine savings reach those who need them most, patients at the pharmacy counter and taxpayers funding Oregon's healthcare programs!

5. Formulary Manipulation Favors PBM Profits Over Patients

PCMA's argument that high generic utilization proves PBMs don't favor higher-rebated drugs is a false equivalency. While generics are widely used where no alternatives exist, PBMs systematically restrict access to lower-cost alternatives within therapeutic classes in favor of drugs yielding higher rebates.

USC research found that **the share of drugs restricted in non-protected classes in Medicare Part D rose from 31.9% in 2011 to 44.4% in 2020**. By 2020, Medicare plan formularies excluded an average of 44.7% of brand-name-only drugs. These restrictions compromise patient care through non-medical switching, prior authorization delays, and step therapy requirements, all designed to maximize PBM rebate revenue rather than optimize patient outcomes.

The Broader Context of PBM Market Manipulation

Dr. Sood's testimony reveals the full scope of PBM market manipulation:

- **Market Concentration**: Just three PBMs control 80% of the prescription market, with the top five controlling 93.6% of Medicare Part D, far exceeding Department of Justice thresholds for "highly concentrated" markets.
- **Vertical Integration Conflicts**: PBMs increasingly own pharmacies and insurers, creating systematic conflicts of interest that harm independent pharmacies and competing health plans.
- **Patient Cost Exposure**: The share of Medicare Part D plans using coinsurance for preferred branded drugs increased from 9.9% in 2020 to 71.9% in 2024, meaning patients increasingly pay full list prices inflated by PBM rebate demands.

The Path Forward

PCMA's letter represents a poor attempt to protect an opaque and profitable business model at the expense of Oregonians' health and financial well-being. Their arguments fail to acknowledge the widespread harm documented by independent researchers and government audits.

The Prescription Drug Affordability Board was established to "protect Oregon residents and stakeholders from the financial burdens associated with exorbitant drug prices." To fulfill this critical mission, the Board must look beyond the PBM industry self-serving claims and recognize that incremental reforms have failed.

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I urge the Board to reject PCMA's misleading assertions and instead recommend comprehensive legislative action to ban harmful PBM operational models, as outlined in OSPA's June 14, 2025 submission:

- **Prohibit vertical integration and PBM ownership of pharmacies**
- **Eliminate spread pricing and opaque reimbursement models**
- **Require 100% rebate pass-through to payers and patients**
- **Establish fiduciary responsibility for PBMs to act in clients' best interests**
- **Implement price transparency benchmarks for key transactions**
- **Restrict formulary practices that prioritize PBM profit over patient care**

Oregonians cannot afford to wait for federal reform while PBMs continue extracting billions in economic rents from our healthcare system. The time for bold, state-level action to create a truly patient-centered drug supply chain is now.

Sincerely,

Brian Mayo
Executive Director

Novartis Services, Inc.
801 Pennsylvania Avenue NW
Suite 700
Washington, DC 20004

Courtney Piron
US Country President
Head, US Public Affairs
Telephone +1 202-253-1803

July 11, 2025

VIA ELECTRONIC DELIVERY
Oregon Prescription Drug Affordability Review Board
Labor & Industry Building
350 Winter Street NE
Salem, OR 97309-0405

Care of: pdab@dcbs.oregon.gov

Re: Entresto® Affordability Review

Dear Oregon Prescription Drug Affordability Board ("Board"):

Novartis Services, Inc. submits this letter on behalf of Novartis Pharmaceuticals Corporation and its affiliates referred to collectively herein as "Novartis." We appreciate the opportunity to comment on the Board's affordability review of Entresto® (sacubitril/valsartan) for affordability review pursuant to *OR. Rev. Stat. § 646A.693 - 646A.697*.[1]

Novartis is an innovative medicines company concentrated on the core therapeutic areas of cardiovascular, immunology, neuroscience, and oncology. At Novartis, we are united by a single purpose to reimagine medicine to improve and extend lives. We believe everyone should have access to the medicines they need. When we determine the prices for our medicines, we consider the value that these medicines provide to patients as well as health care systems and society at large.

Entresto is a proven medicine backed by robust clinical evidence. Patients in Oregon have broad affordable access to Entresto:

- Eligible patients with commercial health coverage can access Entresto at a cost as low as zero dollars with the Novartis co-pay support program.
- Eligible patients who are uninsured or underinsured pay nothing for Entresto via the Novartis Patient Assistance Foundation.
- When adjusted for inflation, the average net price of Entresto has declined between January 2018 and December 2023.

[1] By making this submission, Novartis does not waive its rights with regard to any legal challenge to ORS § 646A.694 and OAR 925-200-0020 and the Board's implementing regulations.

- Entresto provides value to the broader health care system. This is particularly clear for Entresto when compared to the former standard of care, enalapril, since Entresto is a first-in-class heart failure therapy without a current therapeutic alternative.[2]

Additionally, for forecasting purposes, Novartis currently assumes Entresto loss of exclusivity in mid-2025.[3]

Entresto is a Proven Medicine Backed by Robust Evidence.

Entresto is the first and only angiotensin receptor-neprilysin inhibitor (ARNi) approved for the treatment of heart failure in the United States that helps patients stay alive longer and out of the hospital.[4] Entresto is the #1 heart failure brand prescribed by cardiologists and has helped over 2 million people with heart failure.[5]

Entresto targets two complementary pathways to help the heart's ability to pump blood to the body. [6] It has a Class I recommendation by the American Heart Association / American College of Cardiology / Heart Failure Society of America (AHA/ACC/HFSA) treatment guidelines for people with heart failure with reduced ejection fraction (HFrEF).[7]

Entresto is Affordable for Oregonians and the Health Care System

At its core, the question of whether Entresto is "affordable" for Oregonians has a simple answer: it is affordable because eligible Oregon patients with commercial health coverage can access it at a cost as low as zero dollars with the assistance of the Entresto Co-pay Card Program.[8] Additionally, pursuant to state and federal

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[2] McMurray JJ et al. (2014). Angiotensin–Neprilysin Inhibition versus Enalapril in Heart Failure. NEJM**.** https://www.nejm.org/doi/full/10.1056/nejmoa1409077; Solomon SD et al. (2019). Angiotensin–Neprilysin Inhibition in Heart Failure with Preserved Ejection Fraction. NEJM. https://www.nejm.org/doi/full/10.1056/NEJMoa1908655

[3] Novartis Q4 2024 Results Investor Presentation, Slide 6. https//www.novartis.com/sites/novartis_com/files/q4-2024-investor-presentation.pdf

[4] McMurray JJ et al. (2014). Angiotensin–Neprilysin Inhibition versus Enalapril in Heart Failure. NEJM. https://www.nejm.org/doi/full/10.1056/nejmoa1409077

[5] Entresto Webpage. Accessed April 10, 2025. https://www.entresto.com/

[6] ENTRESTO NDA Approval Letter, https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2015/207620orig1s000ltr.pdf

[7] Heidenreich PA, et al. on behalf of the American Heart Association Advocacy Coordinating Committee; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular Radiology and Intervention; Council on Clinical Cardiology; Council on Epidemiology and Prevention; Stroke Council (2013). Forecasting the impact of heart failure in the United States: a policy statement from the American Heart Association. Circ Heart Fail. https://pubmed.ncbi.nlm.nih.gov/23616602/

[8] Entresto.com, Savings and Support. https://www.entresto.com/financial-support

regulations, patients who access prescription drugs through Oregon's Medicaid program do not pay anything out-of-pocket for covered drugs.[9]

Furthermore, the health plans that pay a portion of the cost of Entresto benefit from heavily discounted prices. The complicated interplay of drug pricing and rebates throughout the supply chain and the selective use of pricing data can misleadingly complicate what should be a straight-forward analysis of affordability.

Chief among these complicating factors is a reliance on "list" prices as a proxy for patient costs and affordability. A patient or health plan rarely if ever pays the list price of a drug. In Oregon, as in the rest of the United States, where third-party payers and government health care programs negotiate the price of drugs they buy, Novartis works with third parties to negotiate significant rebates and other price concessions on our medicines. When adjusted for inflation, the average net price of Entresto has declined between January 2018 and December 2023.

Entresto is Affordable for Oregon Patients.

For patients, the most significant hallmark of "affordability" is the price they pay out-of-pocket. Patients judge the cost of a medicine not by reference to complicated gross or net price formulas, but by how much they must pay out-of-pocket to access their medication.

Novartis negotiates with third-party payers for affordable coverage for patients and provides programs to help address residual affordability challenges once coverage is determined by payers. Over 70% of commercial lives in Oregon have coverage for Entresto on the preferred brand tier or lowest branded copay tier.[10] Further, through our Patient Assistance website[11], we inform patients about programs that may provide savings or resources that can help them access Entresto or any other Novartis prescription medication. We do this because Novartis believes that medicines should be available to all who need them.

Novartis has a co-pay assistance program in the US that helps thousands of patients with commercial health coverage access our medicines for as little as zero cost to them. Manufacturer co-pay card programs play a critical role in helping eligible commercially-insured patients satisfy the cost-sharing requirements dictated by their health insurance coverage. Alarmingly, insurers

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[9] Oregon Health Plan, What to Do If You Are Asked to Pay for a Prescription, https://www.oregon.gov/oha/hsd/ohp/pages/prescriptions.aspx#:~:text=The%20Oregon%20Health%20Plan%20(OHP,they%20give%20them%20to%20you.., Accessed February 25, 2024.
[10] Internal Analysis of MMIT Data. February 2025.
[11] Novartis.com. Patient Assistance. https://www.novartis.com/us-en/patients-and-caregivers/patient-assistance. Accessed April 10, 2025.

and pharmacy benefit managers are increasingly subjecting this assistance to accumulator adjustment programs, which prevent co-pay card amounts from counting toward a patient's deductible and out-of-pocket maximum. This can lead to surprise increases in out-of-pocket costs for patients once the pharmacy benefit manager has exhausted the total value of the co-pay card.

Twenty-five states, the District of Columbia, and Puerto Rico have enacted laws banning accumulator adjustment programs in state-regulated commercial plans.[12] We commend Oregon for taking similar action to protect patients in 2024.[13] However, payers are still using other tactics, such as copay maximizers[14] and alternative funding programs[15], that disrupt the value of copay cards for patients. Any affordability determination by the Oregon PDAB must consider these health insurer tactics that result in Oregonians paying more out-of-pocket for a necessary medication than they should.

Patients who cannot afford the cost of their Novartis medication, do not have private insurance, and meet income guidelines and other relevant criteria may be eligible to receive the medication at no cost from the Novartis Patient Assistance Foundation (NPAF), an independent, 501(c)(3) non-profit, non-commercial entity. Income and affordability guidelines vary by drug but are generally well above federal poverty levels.[16]

In 2024, NPAF provided approximately $6.0 billion in free medicines to approximately 146,000 patients, covering 42 medicines from our portfolio. Over the last five years, medication has been made available to over 300,000 patients valued at more than $23.0 billion.[17]

We caution the Board against relying on data from third-party sources, including the state's All Payer All Claims Reporting program, that purports to indicate a patient out-of-pocket cost for Entresto. That cost may well have been borne by Novartis or the NPAF for the benefit of patients through the mechanisms described above.

Oregon Payers Benefit from Significant Discounts on Entresto.

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[12] All Copays Count Coalition. State Legislation Against Copay Accumulators. Accessed July 7, 2025. https://allcopayscount.org/state-legislation-against-copay-accumulators/

[13] Oregon House Bill 4113. https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4113

[14] Copay maximizers allow plans to "maximize" the value extracted from copay assistance programs by adjusting a patient's cost-sharing to the maximum amount of available assistance and not allowing the funds to count toward the patient's deductible or out-of-pocket maximum.

[15] Alternative funding programs are strategies used by employer-sponsored health plans to exclude certain medications from coverage, redirecting patients to external assistance programs which can be result in significant burden and delays for patients trying to obtain the medications they need.

[16] Novartis Patient Assistance Foundation. https://pap.novartis.com/ Accessed April 29, 2025.

[17] Novartis Internal Data Analysis. April 10, 2025.

Payers such as commercial insurers routinely negotiate rebates and other price concessions from the Novartis list price. These rebates and price concessions lower the final “net” price of the drug significantly below the initial list price. Payers and employers in turn can pass these rebates and price concessions on to patients by reducing their out-of-pocket costs, or use them in other ways, such as lowering premiums, applying the discount to administrative costs, or other uses.

The continuing gap between list and net prices generated by this practice fuels increasing confusion and misperceptions about the real price paid for drugs by the health care system. While industry critics focus on the rise in wholesale acquisition cost (WAC), also known as the list or gross price, the reality is that price increases are often outpaced by rebates and price concessions to third-party payers and other channel intermediaries (e.g., wholesalers, pharmacies). Oregon, unlike some states, does not require payers and intermediaries to share these rebates and price concessions with patients.

Novartis rebates and price concessions to payers are important not just to understanding why Entresto is *currently* affordable to patients, but also why Entresto’s net price has declined when adjusted for inflation, despite WAC price increases over the same period. It is critical that the Board base its affordability determination on the net price. The Board must take account of these rebates and price concessions, which are a significant component of the affordability of Entresto.

Notably, between January 2018 and January 2023, inflation, measured by the CPI, was 22.9%. By our estimate, this means Entresto’s net price declined over this timeframe when adjusted for inflation.

Entresto Provides Value for the Broader Health Care System.

In evaluating a drug’s affordability, the Board must take account of its “relative financial effects on health, medical, or social services costs.”[18] Entresto is recognized as the standard of care for treatment of heart failure.[19] It treats a condition, chronic heart failure, that would otherwise significantly limit patient health and impose major costs on the state. We strongly urge the Board to consider the value Entresto provides in reducing the direct and indirect costs of these diseases to the workforce, communities, and overall health care system as described below.

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[18] OAR 925-200-0020-(1)-(j)

[19] Novartis. The 2024 ACC Expert Consensus Decision Pathway for the treatment of HFrEF recommends ARNi as the only first-line RASi. Accessed April 2025. https://www.entrestohcp.com/sites/entrestohcp_com/files/documents/entresto-acc-ecdp-digital-flashcard.pdf

Chronic Heart Failure

Almost 7 million Americans are currently living with chronic heart failure, a progressive chronic condition that can lead to hospitalization or shortened life expectancy.[20] Heart failure prevalence is on the rise and is expected to increase by 46% by 2030.[21,22,23] It is projected that the total costs of heart failure will reach nearly $70 billion by 2030.[24]

According to benchmarks adopted by the AHA/ACC/HFSA, the heart failure guidelines determined that Entresto delivers a high economic value when compared to ACE inhibitors for patients with chronic symptomatic HFrEF. Entresto delivers value for patients, reducing risk of hospitalization, emergency visits, and premature death[25,26,27] and this is backed up by real-world data.[28,29] It was estimated in a model that use of Entresto compared with enalapril in HFrEF patients was associated with averting over 50,000 hospitalizations in the US, saving $92.3 million annually.[30] As a result, Entresto has set a new standard of

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[20] Centers for Disease Control and Prevention and National Center for Health Statistics. National Health and Nutrition Examination Survey (NHANES) public use data files. https://www.cdc.gov/nchs/nhanes/
[21] Oktay AA, Rich JD and Shah SJ (2013). The emerging epidemic of heart failure with preserved ejection fraction. Curr Heart Fail Rep. https://pubmed.ncbi.nlm.nih.gov/24078336/
[22] Heidenreich PA, et al. on behalf of the American Heart Association Advocacy Coordinating Committee; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular Radiology and Intervention; Council on Clinical Cardiology; Council on Epidemiology and Prevention; Stroke Council (2013). Forecasting the impact of heart failure in the United States: a policy statement from the American Heart Association. Circ Heart Fail. https://pubmed.ncbi.nlm.nih.gov/23616602/
[23] CMS Office of Minority Health (2020). Heart Failure Disparities In Medicare Fee-For-Service Beneficiaries. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-snapshot-heart-failure.pdf
[24] Heidenreich PA, et al. on behalf of the American Heart Association Advocacy Coordinating Committee; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular Radiology and Intervention; Council on Clinical Cardiology; Council on Epidemiology and Prevention; Stroke Council (2013). Forecasting the impact of heart failure in the United States: a policy statement from the American Heart Association. Circ Heart Fail. https://pubmed.ncbi.nlm.nih.gov/23616602/
[25] McMurray JJ et al. (2014). Angiotensin–Neprilysin Inhibition versus Enalapril in Heart Failure. NEJM. https://www.nejm.org/doi/full/10.1056/nejmoa1409077
[26] Solomon SD et al. (2019). Angiotensin–Neprilysin Inhibition in Heart Failure with Preserved Ejection Fraction. NEJM. https://www.nejm.org/doi/full/10.1056/NEJMoa1908655
[27] Packer M et al. (2015). Angiotensin receptor neprilysin inhibition compared with enalapril on the risk of clinical progression in surviving patients with heart failure. Circulation: https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.114.013748?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed
[28] Albert NM et al. (2019). Lower Hospitalization and Healthcare Costs With Sacubitril/Valsartan Versus Angiotensin-Converting Enzyme Inhibitor or Angiotensin-Receptor Blocker in a Retrospective Analysis of Patients With Heart Failure
JAHA:
https://www.ahajournals.org/doi/full/10.1161/JAHA.118.011089?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org
[29] Tan NY et al. (2020). Comparative Effectiveness of Sacubitril-Valsartan Versus ACE/ARB Therapy in Heart Failure With Reduced Ejection Fraction. JACC**:**
https://www.sciencedirect.com/science/article/pii/S2213177919306766?via%3Dihub
[30] Gaziano TA et al (2020). Cost-effectiveness of Sacubitril-Valsartan in Hospitalized Patients Who Have Heart Failure With Reduced Ejection Fraction. JAMA Cardiol:
https://jamanetwork.com/journals/jamacardiology/fullarticle/2769180

care for the treatment of chronic heart failure patients per the 2022 AHA/ACC/HFSA guidelines, and its clinical value was reiterated in the 2024 ACC Expert Consensus Decision Pathway guidelines.[31]

The Board Should Address the Methodological and Implementation Issues with its Processes.

When the Board voted to postpone its affordability reviews during its June 26, 2024, meeting, it did so to, "review, assess and possibly improve both the criteria and methods used to assess and select drugs for potential affordability reviews in 2025".[32] Board members acknowledged data errors, a lack of a clear definition for when a drug "may create affordability challenges for health care systems or high out-of-pocket costs for patients in Oregon," and an incomplete picture of the drug pricing environment as key factors in their decision to postpone affordability reviews.

Unfortunately, the Board's second attempt at selecting drugs for affordability reviews has so far been hampered by many of the same issues. In particular, Novartis would like to bring the Board's attention to the following gaps:

The Board Selected Entresto for Review Based on Incorrect Information.

As explained above, for forecasting purposes, Novartis currently assumes Entresto loss of exclusivity in mid-2025.[33] This is important because the availability of generic alternatives was a key factor in the Board's selection of drugs for affordability reviews. The Board should reconsider its selection of Entresto.

The Board Has Not Defined What Constitutes "Affordability Challenges to the Health Care System" or "High Out-of-Pocket Costs for Patients."

The Board is required in its affordability analysis to determine if a drug "may create affordability challenges for health care systems or high out-of-pocket costs for patients in Oregon." When the Board elected to postpone its affordability reviews during its meeting on June 26, 2024, one of the key reasons was the Board's desire to better define what "affordability challenges to the health care

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[31] Novartis. The 2024 ACC Expert Consensus Decision Pathway for the treatment of HFrEF recommends ARNi as the only first-line RASi. Accessed April 2025. https://www.entrestohcp.com/sites/entrestohcp_com/files/documents/entresto-acc-ecdp-digital-flashcard.pdf
[32] Oregon Prescription Drug Affordability Board. June 26, 2024 Meeting Minutes. Minutes approved by the Board on July 24, 2024. https://dfr.oregon.gov/pdab/Documents/20240626-PDAB-approved-minutes.pdf
[33] Novartis Q4 2024 Results Investor Presentation, slide 4. https//www.novartis.com/sites/novartis_com/files/q4-2024-investor-presentation.pdf

system" or "high out-of-pocket costs for patients" mean, but this has still not been done.

The Board still has not defined what it means for a drug to present "affordability challenges to the health care system" or "high out-of-pocket costs for patients" nor has it developed thresholds that would guide the Board in making such a determination. This striking gap leaves Novartis and the public with no understanding of what principles the Board is applying to reach its ultimate conclusions, and no means of verifying that the Board's analysis has been conducted correctly.

While the Board has released additional documentation about the affordability review process and factors that it will consider during the affordability reviews, the relative importance of these factors in determining whether a drug may present "affordability challenges to the health care system" or "high out-of-pocket costs for patients" is unclear. This negatively impacts the ability of Novartis and the public to provide meaningful input.

Ultimately, the Board appears to be making an *ad hoc* determination of whether a drug may create affordability challenges for health care systems or high out-of-pocket costs for patients in Oregon without clearly articulating what those thresholds would look like.

The Board has not instituted protections for commercially sensitive data, limiting its ability to understand the drug pricing environment.

Despite repeated requests by stakeholders, the Board's efforts to gather information for affordability reviews continue to be hamstrung by the lack of a mechanism for manufacturers to submit commercially sensitive information. The Board has not developed a process or provided guidance in its Public Comment Policy on how manufacturers can confidentially submit such data. This refusal by the Board makes it impossible for manufacturers to provide data on net pricing of their products. Several Board members acknowledged net pricing data to be a crucial, but missing, component of affordability reviews during the June 26, 2024, meeting when the Board elected to postpone its affordability reviews. Additionally, there is not an opportunity for the Board to discuss commercially sensitive data or meet with manufacturers in executive session, which could have been another opportunity for manufacturers to provide important data for affordability reviews.

Conclusion

For the reasons detailed above, Entresto is affordable to patients and the health care system. We welcome the opportunity to answer any questions you may

have about the information provided above. Please contact me at courtney.piron@novartis.com.

Sincerely,

Courtney Piron
US Country President
Head, US Public Affairs

Via electronic submission

July 11, 2025

Oregon Prescription Drug Affordability Board
ATTN: Shelley Bailey, Chair
350 Winter St. NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

RE: Affordability Review for NURTEC® ODT (rimegepant)

Dear Members of the Oregon Prescription Drug Affordability Board:

Pfizer appreciates the opportunity to submit comments to the Oregon Prescription Drug Affordability Board (the "Board"). As noted in our letters dated February 28, 2024 and June 11, 2025, Pfizer has significant concerns with ORS 646A.693-697 which we believe takes a narrow view of controlling health care costs and lacks a mechanism to improve insurance plan design, a key driver of high out-of-pocket cost for patients. **For this reason and others outlined below, we request that the Board determine that Nurtec® ODT (rimegepant) does not pose affordability challenges.**

Pfizer Inc. ("Pfizer") is a research-based global pharmaceutical company dedicated to the discovery and development of innovative medicines and vaccines that improve the quality of life for people around the world. A top priority for Pfizer is ensuring that patients can access and afford our medicines and vaccines. We negotiate with insurers and pharmacy benefit managers (PBMs) to help ensure robust coverage for our medicines. We also provide financial assistance for many of our products to help both eligible insured patients for whom high insurance cost-sharing requirements may jeopardize affordability and uninsured patients who lack drug coverage altogether.[1]

We continue to have significant concerns regarding the affordability review process, and we would like to reiterate the concerns expressed in our letter dated June 11, 2025. ORS 646A.693-697 fails to address determinants of patient affordability including insurance plan design, access to insurer and PBM negotiated discounts, and the role of patient assistance programs. Moreover, the potential unintended consequences of affordability reviews may limit patient access to medicines. For these reasons, we request that the Board find that NURTEC® does not pose an affordability challenge.

[1] Pfizer assistance programs can be found at PfizerForAll™, https://www.pfizerforall.com/prescription-assistance#select-medication-section.

Patient affordability depends on insurance plan design.
What patients pay for their medicines is determined by their insurance company or pharmacy benefit manager (PBM). Insurers and PBMs develop formularies, which are lists of drugs that will be covered under different insurance plans. Formularies not only determine if a drug will be covered, but they also determine how much patients must pay out-of-pocket for medicines and if there are any administrative actions required to obtaining coverage (e.g., prior authorizations, fail first policies). The federal government recognized that patient affordability depends on robust insurance coverage and capped Medicare Part D enrollees' annual out-of-pocket cost at $2,000.[2] Similarly, several states have enacted laws or promulgated regulations directly addressing cost-sharing requirements set by insurers or PBMs.[3] However, the affordability review process under ORS 646A.693-697 contains no mechanism for the Board to lower patient cost-sharing requirements set by an insurer or PBM to improve patient affordability for prescription drugs.

Patients should benefit from negotiated discounts.
Along with determining patients' cost-sharing requirements, PBMs and insurers determine whether patients receive the discounts and rebates they negotiate with pharmaceutical manufacturers. Three PBMs control nearly 80 percent of U.S. prescriptions and medication access for about 270 million Americans.[4] As the PBM market has consolidated, their negotiating leverage with manufacturers has increased. For example, in 2023, manufacturers paid an estimated $334 billion in discounts and rebates.[5] However, unlike other medical services where the patient pays *less* when their insurer negotiates a better price, very few, if any, patients pay less at the pharmacy counter despite billions of dollars in discounts and rebates paid to PBMs and insurers by manufacturers. [6] Instead, most manufacturer discounts and rebates are retained by PBMs as profit or are passed to an insurer, rather than the patient obtaining the medicine.[7]

Oregon law requires PBMs to report how much they collect in rebates and the proportion that is passed to patients in Oregon health benefit plans. The first report, published in 2024, found that, of the over $287 million collected by PBMs, less than $2.3 million went to

[2] Kaiser Family Foundation, A Current Snapshot of the Medicare Part D Prescription Drug Benefit. Available at: https://www.kff.org/medicare/issue-brief/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/
[3] California Chapter 619 of 2015; Maryland Chapter 422 of 2014; New Jersey AB 2431 (2019).
[4] U.S. Federal Trade Commission, Office of Policy Planning, Interim Staff Report, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, Page 7. July 2024. Available at: https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
[5] Drug Channels, PBM Power: The Gross-to-Net Bubble Reached $334 Billion in 2023—But Will Soon Start Deflating. July 7, 2024. Available at: https://www.drugchannels.net/2024/07/pbm-power-gross-to-net-bubble-reached.html
[6] Petersen-KFF Health System Tracker, Price transparency and variation in U.S. health services. January 13 ,2021. https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/.

patients, or less than 1 percent (0.78%) of rebates collected.[7] In addition to investigating the impact of insurance design on patient affordability, we encourage the Board to examine the role that rebates play in what patients pay at the pharmacy counter.

Pfizer's assistance programs support patient access and affordability for Nurtec® ODT.
Pfizer recognizes the growing burden of rising insurance deductibles, copayments, and co-insurance on patient access and affordability of medicines, and supports policies that reform insurance benefit design and patient access to negotiated discounts.[8] However, we also recognize that many patients continue to face high cost-sharing requirements under their insurance plans. To help such patients, Pfizer offers copay assistance programs to eligible commercially insured patients for a range of products, including Nurtec® ODT. In addition, some government insured patients struggle to afford their cost-sharing requirements. We therefore provide eligible financially insecure, government insured patients access to our therapies for free.[9] Lastly, we also recognize that an estimated 26 million people in the United States lack health insurance.[10] Therefore, we also offer patient assistance programs that offer free medicines to qualified individuals who lack insurance.[11]

Additional considerations.
Pursuant to OAR 925-200-0010, the Board must take into consideration various factors when selecting the subset of prescription drugs to prioritize for an affordability review, including, but not limited to, whether the drug appears on insurer-reported top 25 lists.[12] According to the original Oregon PDAB Data Dashboard, *Aggregated Carrier Data*, Nurtec® ODT is not included on the top 25 drug lists and ranked well below for the lists on which it was included. Nurtec® ODT was included on only two lists ranked at #63 and #73.[13] Thus, the methodology used to prioritize Nurtec® ODT on the initial subset list for affordability review remains unclear.

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[7]Oregon Department of Consumer and Business Services, Division of Financial Regulation, Drug Price Transparency Program, Pharmacy Benefit Managers 2024 Data. https://dfr.oregon.gov/drugtransparency/Pages/DPT-pbm-data-2024.aspx

[8]Kaiser Family Foundation, 2024 Employer Heath Benefit Survey. https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/.

[9]PfizerForAll Prescription Assistance. https://www.pfizerforall.com/prescription-assistance.

[10]The Commonwealth Fund, The State of Health Insurance Coverage in the U.S., Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey.
https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey.

[11]Pfizer RxPathways. https://www.pfizerrxpathways.com/. The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

[12]OAR 925-200-0010 Selecting Prescription Drugs for Affordability Reviews. Available at:
https://dfr.oregon.gov/pdab/Documents/OAR-925-200-0010.pdf

[13]Oregon PDAB Data Dashboard. Available at:
https://app.powerbigov.us/view?r=eyJrIjoiOGM2YjhlMWUtNzE2OC00MmU1LTk2MjktYWUzZGMyNTNmZmQ1Iiwid
CI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9

Further, the Board has listed affordability reviews for prescription drugs, including Nurtec® ODT, on the July 16, 2025 meeting agenda[14]. Immediately preceding affordability reviews, the Board has also listed discussion with no vote regarding "*a process for measuring affordability to determine drug review cost impact.*" Pfizer is concerned that the Board plans to conduct an affordability review for Nurtec® ODT without a final, Board-approved process for measuring affordability.

***

Once again, Pfizer appreciates the opportunity to provide comments to the Board. We support efforts to help ensure that patients can access life-saving medicines and look forward to working with Oregon policymakers to find solutions that help patients. If you have any questions, please contact Brandy Flores, Director of Government Relations, at Brandy.Flores@Pfizer.com.

Sincerely,

Tom Brownlie

Vice President
State Policy and Government Relations

[14] Oregon Prescription Drug Affordability Board. July 16, 2025 Draft Agenda. Available at: https://dfr.oregon.gov/pdab/Documents/20250716-PDAB-agenda_DRAFT.pdf

OCAP OREGON COALITION FOR AFFORDABLE PRESCRIPTIONS

July 11, 2025

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Dear Chair Bailey, Vice Chair Burns, and PDAB Board Members,

Thank you for the time and effort you dedicate to the important work of this board.

We represent a coalition of **Oregonians, including health care providers, nonprofit organizations, and community advocates**, united by the belief that **prescription medications should be affordable and accessible to all who need them**. Since 2017, we have worked to curb skyrocketing prescription drug prices and hold the pharmaceutical industry accountable for practices that have disproportionately harmed Oregon seniors, adults, children with chronic conditions, and their families. Our goal is to amplify the voices of Oregonians impacted by out-of-control drug pricing, and support efforts aimed at greater transparency, accountability, and lowering prescription drug costs.

We are glad that the PDAB is beginning affordability reviews. **These reviews are an essential step toward reining in the high prescription drug costs that strain every day Oregonians**, many of whom are forced to choose between paying rent, buying groceries, or affording their medications.

We'd like to address the question PDAB often hears in reference to affordability reviews, ***"Affordable for whom?"*** The affordability criteria, as defined in *ORS 646A.694*, centers on Oregon health care stakeholders, and highlights populations most affected by high costs: people of color, under-resourced communities, and regions with limited pharmacy access. To answer the question, **prescription drugs should be affordable for the Oregonians most burdened by high prices: those living in poverty, rural, and under-resourced areas, as well as communities of color.**

No one, regardless of race, income, ability, or geography, should ever feel forced to ration their medication by cutting pills, skipping doses, or not filling prescriptions. Yet, as we've previously shared, **1 in 4 Oregonians reported doing exactly that** in 2024[1]. The burden is not evenly felt: **low-income residents and those living in Central and Eastern**

[1] 2024 Poll of Oregon Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey.https://healthcarevaluehub.org/chess-state-survey/oregon/2024/oregon-survey-respondents-worry-about-high-drug-costs-support-a-range-of-government-solutions/

Oregon reported higher rates of rationing, and **Oregonians of color reported doing so at nearly twice the rate of white residents**[2].

As the PDAB moves forward with affordability reviews, we urge you to keep these communities at the forefront of your decision-making. Declaring a drug unaffordable **does not set a price limit**; it simply initiates a legislative conversation about whether regulation is needed.

With that in mind, we also encourage you to **critically evaluate the feedback you receive** during this process. Are the critiques coming from Oregonians and Oregon-based health care stakeholders, or from out-of-state corporations and organizations with little connection to the lived realities of Oregon families? Too often, these outside groups submit nearly identical comments to PDABs and state legislatures across the country. **These comments are rooted not in the specifics of Oregon law, but in vague, misleading definitions of PDAB authority that conveniently align with the narrative pushed by industry interests**, including the false claim that the Oregon PDAB sets price caps.

Please prioritize Oregon voices, particularly those from historically marginalized communities. With recent federal funding cuts, your work is more important than ever to Oregonians from every corner of our state.

Thank you for the opportunity to submit these comments. Our board is available to support your work in any way we can. You can reach us at info@affordablerxnow.org or through BethAnne Darby at Strategies 360 Oregon.

Sincerely,
The Oregon Coalition for Affordable Prescriptions Board

John Mullin, Board Chair (Seanduine, and health and human service advocate)
Inga Deckert, (Kaiser Permanente)
Richard Blackwell, Board Treasurer (Pacific Source)
Marcus Mundy, (Coalition of Communities of Color)
Odalis Aguilar, (AFSCME Council 75)
Christi Marcotte, (Oregon Community Registered Nurse)

[2] 2024 Poll of Oregon Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey, Table 1
https://healthcarevaluehub.org/chess-state-survey/oregon/2024/oregon-survey-respondents-worry-about-high-drug-costs-support-a-range-of-government-solutions/

COMMUNITY ACCESS NATIONAL NETWORK

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July 14, 2025

Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

RE: Affordability Review Process

Dear Honorable Members of the Oregon Prescription Drug Affordability Board,

The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

Concern regarding staff interaction with actors outside of the Oregon

During the July 11, 2025, Colorado PDAB meeting, Colorado staff disclosed that the Executive Director from the Oregon PDAB has been asked to represent analytical actions and processes of this Board at a future meeting.

Specifically, the Colorado PDAB's suggestion of having Oregon PDAB staff present information is the result of CANN staff referencing the Oregon PDAB's Stauffer-Meyer report on impacts and considerations related to public health funding mechanisms and policy considerations the Oregon PDAB had engaged in. Notably, the Colorado PDAB has refused similar requests from the public for the same manner of assessments as they relate to Colorado. For the Oregon PDAB's laudable undertaking of the impact analysis, you should be commended for seeking to sufficiently understand potential adverse and unintended consequences due to the complexity of public health funding mechanisms.

Subsequent to CANN's verbal suggestion to the Colorado PDAB, applauding the Oregon PDAB's consideration of policy issues such as pharmacy benefit manager reform, plan design concerns, and impacts on public health providers (to name a few), Colorado PDAB staff disclosed "close coordination" with Oregon PDAB staff and falsely suggested that CANN had misrepresented the Oregon PDAB's report. Despite CANN's attachment of Oregon PDAB report materials to emphasize these conclusions, the conflicting message brings us great concern as to how the Oregon PDAB is being represented **and** even greater concern as to what appears to be multi-state coordination of specific actors to achieve a policy end that does not reflect the needs of each individual state.

To that end, **CANN urges the Oregon PDAB Board to clarify this issue by suggesting that Chair Bailey, as an actual Board member, offer to clarify the ideas and processes the Oregon PDAB has engaged upon** - though not necessarily conclusions as those similar conclusions are specific to each state's consideration. Given Colorado's staff's disclosure that multi-state PDAB staff are engaging in "collaboration" with one another, the natural conclusion, and perhaps misappropriation of appropriated dollars and staff time, to influence another state's policy actions based upon staff conclusions, rather than Board conclusions, **is of significant public interest and must be appropriately addressed, up to and including any ethics investigation as to current or former staff behavior and any appropriate referral for disciplinary action as a result thereof.**

Drug selection process rationale is a bit confusing

We are pleased that, as of the June 2025 meeting, Odefsey and Tremfya have been excluded from the list of medications selected for the 2025 affordability review. We also thank Chair Bailey for reiterating the mechanisms of affordability for HIV antiretrovirals, including but not limited to the state AIDS Drug Assistance Program (ADAP). Although Tremfya has been removed from the list, it is unclear why it was initially included. The regulatory requirement for drug selection appeared to be based on metrics such as the most expensive, most costly, most prescribed, and gross percentage increase. However, Tremfya didn't seem to fit into the "top 25" medications, but was still selected as the "most costly" and "gross increase" medications, ranking 46 and 47, respectively. When drugs are chosen that do not align with the regulatory metrics, it is challenging to follow the rationale behind the selection.

We are also concerned that Eliquis remains on the official list of medications to be selected for affordability review. A large portion of the patient survey respondents indicated that they were users of Eliquis; however, this does not necessarily translate into it being considered an affordability challenge. Eliquis' Patient Assistance Program (PAP) brings the out-of-pocket medication cost to $10/mo. It is readily accessible by a simple online form with no requirement for provider engagement. The requested information seeks verification of a medical indication and identification of patient information to validate the associated claim application at the pharmacy counter. The only spaces in which the PAP is not applicable are in Medicaid and Medicare, areas where the PDAB would not have influence. Eligible patients who could benefit from the PAP but are not using it may be unaware of its existence and how it works. Remedies for issues of affordability include promoting patient and provider education.

Affordability goals remain in question

There was thoughtful discourse during the June 2025 meeting on the still nebulous concept of affordability. Discourse highlighted that there is still no clear understanding of what "affordability" means in relation to the Board's decision-making process. What is considered to be too high of an out-of-pocket cost for patients based on the medication in question? What net expenditures are too high for the health system based on the medication in question? Moreover, without an understanding or consensus of benchmark questions like these, it is not possible to effectively describe the landscape or suggest solutions. It is not prudent to operate on the premise that there is no definition of affordability but only concepts of costs. While patient affordability is partially a function of system cost, patient affordability and system affordability are two distinct concepts. As the Board is tasked with evaluating patient affordability and system impact, it is presently unclear how all of the data collected, including patient surveys, will be used to make assessments.

Concern about the speed and quality of review

The Board agenda states that the July meeting will conduct an affordability review and discussion of six drugs. It does not seem possible to conduct thorough inquiries and analyses of affordability for six drugs in one meeting. It is understood that the Board feels pressure to complete a statutorily described number of reviews by a specified timeline. However, as expressed during the June meeting, it would be more beneficial and impactful to conduct thorough examinations of a smaller number of drugs. An exercise in quality analysis of a smaller number of drugs would establish a process that would provide the public and legislature greater confidence in the utility of the affordability review outcomes. Additionally, establishing an effective evidence-based process on a smaller number of drugs would result in a replicable format that could be used for efficient reviews of larger groups of drugs in the future.

Similarly, the Board has delayed determinations due to complexity more than once in the past. For decisions by the Board to be of sufficient quality, sufficient time to assess data and receive public input must be given. **Absent adequate time, sufficient data, and quality of debate on the merits, any decision made by the Board solely on the basis of experiences risks both damaging the public trust and courting unnecessary legal obligations due to being arbitrary and capricious.**

We fully appreciate the daunting task with which the Board has a mandate to assess patient affordability and system impact. The careful and deliberate discussions the Board have been having exemplify how dedicated you are to effecting positive change. As you halted deliberations in the past to regroup, we encourage you to be very precise and focused on this stage of your process going forward.

Respectfully submitted,

Ranier Simons
Director of State Policy, PDABs
Community Access National Network (CANN)

~On behalf of
Jen Laws
President & CEO
Community Access National Network

Bristol Myers Squibb™

July 13, 2025

VIA ELECTRONIC SUBMISSION

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Re: Prescription Drug Subset List

Dear Members of the Oregon Prescription Drug Affordability Board:

Bristol Myers Squibb ("BMS") appreciates the opportunity to submit written comments to the Oregon Prescription Drug Affordability Board (the "Board") on its subset of prescription drugs to prioritize for affordability review. **For the following reasons, we respectfully ask that ELIQUIS® (apixaban) be removed from the prioritized subset and not subject to the affordability review process:**

- ELIQUIS has already been selected for and completed the process for the Medicare Drug Price "Negotiation" Program, with its Maximum Fair Price (MFP) set to begin on January 1, 2026;
- The Board's own data sources, including patient-reported data from the Board's survey, demonstrates that ELIQUIS is affordable for Oregonians; and
- ELIQUIS will soon face generic competition.

We offer the following background and rationale in support of this request.

The Board Should Remove Drugs from the Subset List that Have Already Been Subject to the Medicare Drug Price "Negotiation" Program.

As part of the discussion to reduce the number of prescription drugs on the subset list during the Board's most recent meeting in June, several Board members expressed a desire to remove drugs subject to the Medicare "negotiation" process under the IRA as they have been addressed in a separate process by the Centers for Medicare and Medicaid Services (CMS). **ELIQUIS was included as one of the first ten prescription drugs selected for the Medicare program, with Maximum Fair Prices (MFPs) for these products set to take effect on January 1, 2026.** Given that the vast majority (71%) of ELIQUIS patients in Oregon who responded to the Board's survey cited Medicare as their primary payer, focusing on ELIQUIS for review at the state level is redundant. The Board's limited resources should instead be directed to drugs with greater impacts to Medicaid or commercially-insured patients, which are more closely aligned with the Board's scope.

While most Board members present at the June meeting indicated a preference for removing IRA drugs from the subset list, the discussion was abandoned after one member commented that the Medicare Drug Price Negotiation Program had yet to be implemented. While a valid concern at the outset of the change in presidential administrations, there have been several developments since that time which confirm the program will be moving forward as planned:

- On January 29, 2025, CMS stated that it "remains committed to achieving value for beneficiaries and taxpayers" through the program.[1]
- Dr. Mehmet Oz, newly confirmed CMS Administrator, has said of the program: *"It's the law. I'm going to defend it and use it."*[2]
- CMS is hosting a series of public engagement events in April 2025 to "provide an opportunity for patients, beneficiaries, caregivers, consumer and patient organizations, and other interested parties, such as clinicians and researchers, to share input relevant to prescription drugs selected for the second cycle of negotiations."[3]
- CMS has communicated a timeline beginning in June 2025 to pharmacies and other drug dispensing entities to help them prepare for implementation of the program.[4]

These public comments confirm the federal government's intent to continue implementing the Medicare Drug Price Negotiation Program and impose MFPs on selected prescription drugs, which, in the case of ELIQUIS, will take place mere months after the Board completes the affordability review process for 2025. Of note, since the IRA's inception, we have expressed serious concerns about the impact government price-setting will have on the development of future medicines that can help patients prevail over serious disease.

The PDAB's Own Data Suggests ELIQUIS Is Affordable.

BMS supports public policies that promote patient access to new and effective medical treatments and help ensure patients benefit from the innovation that defines the U.S. health care system, and we have long supported efforts in Oregon to meaningfully enhance patient access and improve affordability by lowering out-of-pocket costs for patients. Currently, ELIQUIS is widely available to patients, with over 90% open access among commercial plans and low out-of-pocket costs. This is confirmed by the Board's own data sources, including both the DC and APAC datasets and patient-reported surveys, which clearly demonstrate that ELIQUIS is one of the most widely prescribed and covered drugs in the state. Further, the data shows that ELIQUIS is affordable for commercially-insured patients. In the patient survey, the largest group of patients reported paying between $0-$49 per month for ELIQUIS. This closely matches nationwide data, which shows that, on average, non-valvular atrial fibrillation

[1] Centers for Medicare & Medicaid Services. (2025, January 29). *CMS statement on lowering the cost of prescription drugs*. https://www.cms.gov/newsroom/press-releases/cms-statement-lowering-cost-prescription-prescription drugs
[2] Senate Committee on Finance. (2025, March 14). *Hearing to consider the nomination of Mehmet Oz, of Pennsylvania, to be Administrator of the Centers for Medicare and Medicaid Services, vice Chiquita Brooks-LaSure, resigned*. https://www.finance.senate.gov/hearings/hearing-to-consider-the-nomination-of-mehmet-oz-of-pennsylvania-to-be-administrator-of-the-centers-for-medicare-and-medicaid-services-vice-chiquita-brooks-lasure-resigned
[3] Centers for Medicare & Medicaid Services. (2025). 2027 public engagement events. Retrieved from https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation/2027-public-engagement-events
[4] Centers for Medicare & Medicaid Services. *Resources for pharmacies and dispensing entities*. Retrieved from https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation/resources-pharmacies-and-dispensing-entities

patients with commercial insurance pay only $38 per month, and 5 out of 10 pay $20 per month or less.[5]

Driven by our patient-focused mission, we disagree with the potential application of an "affordability review" process to ELIQUIS. Oregon law states that the Board shall identify prescription drugs "that the [B]oard determines may create affordability challenges for health care systems or high out-of-pocket costs for patients in this state" and instructs the Board to consider multiple factors in determining which prescription drugs to prioritize for affordability review.[6] Notably, the data sources most relied upon by the Board are derived from hospital-reported measures, and the Oregon Health Authority recently released a report showing that the payments hospitals receive from commercial insurance companies have largely increased in recent years.[7] This data does not provide the Board with reliable and unbiased information from which it can reasonably determine which drugs, if any, pose patient affordability challenges. We believe that ELIQUIS should be removed from the prioritized subset of prescription drugs as its continued inclusion is inappropriately anchored in volume and payer cost rather than genuine patient affordability issues.

ELIQUIS's Limited Remaining Market Exclusivity

ELIQUIS's patent exclusivity is estimated to expire on April 1, 2028, after which generic competitors are expected to enter the market. This creates a narrow window between the implementation of Medicare's Maximum Fair Price and the arrival of generic alternatives. This substantially limits any potential impacts of the affordability review process, even assuming affordability review was appropriate and could result in positive impacts, which we do not believe to be true.

Conclusion

BMS is committed to promoting policies that protect Oregonian patients and enable them to better afford their medicines. Considering the preceding arguments, **we strongly urge the Board to remove ELIQUIS from the prioritized subset of prescription drugs, as its inclusion is unnecessary and misaligned with the intended focus of the Board's efforts.**

Thank you for the opportunity to provide comments and for considering our concerns. Should you have any questions or concerns, please contact Richard Meyers, Director, State & Federal Policy at richard.meyers@bms.com and Anne Murray, Director, State & Local Government Affairs, U.S. Policy & Government Affairs at anne.murray@bms.com.

Sincerely,

/s/ Anne Murray

Director, State & Local Government Affairs
Bristol Myers Squibb

[5] Pricing information. AFib Pricing Information for Rx ELIQUIS® (apixaban) | Safety Info (December 2024). https://www.eliquis.bmscustomerconnect.com/afib/price.
[6] Or. Rev. Stat. Ann. § 646A.694(1); Or. Admin. R. 925-200-0010.
[7] Oregon Health Authority. (n.d.). *Hospital payment reform*. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Payment.aspx

EACH PIC COALITION

July 14, 2025

Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

RE: Public Comments on Affordability Review Meeting on July 16

Dear Members and Staff of the Oregon Prescription Drug Affordability Board:

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) is a two-part coalition that unites patient organizations and allied groups (EACH), as well as patients and caregivers (PIC), to advocate for drug affordability policies that benefit patients.

We appreciate your continued efforts to strengthen Oregon's drug affordability review process. This letter provides input on the ongoing cost review process and deliberations on Vraylar, Entresto, Ajovy, Emgality, Nurtec, and Ubrelvy.

Ensure a Thorough and Deliberative Process

We urge the board to slow their cost review process to ensure that the actions taken by the board are the result of methodical, evidence-based decision making. The lengthy list of drugs coupled with the board's need to complete reviews by year-end have resulted so far in a hurried and unclear process.

While we are pleased that the board heeded input from stakeholders that the original subset list was too lengthy and set out to shorten the list, the deliberations during the June meeting made clear that there is little concrete criteria being utilized by the board to determine which and how many drugs to examine. Drugs were removed and added back to the list in a haphazard manner, leaving advocates and even board members unclear on the reasoning employed.

Further, several drugs were removed from the provisional list due to their orphan drug status. Since this is a statutory requirement, we were perplexed that these drugs made it onto the initial subset list in the first place. Furthermore, this mistake is reminiscent of issues the board faced during last year's cost review, which prompted the board to halt its process and ensure appropriate care and methodology were applied. It is disheartening to find ourselves a year later and still encountering the same issues.

Finally, according to the agenda for the July meeting, the board purports to deliberate on the process for measuring affordability and apply that methodology to the review of six drugs in the same meeting.

Let us be clear, the actions of the board will have a direct impact on the health of Oregonians and cannot be rushed.

EACH PIC COALITION

Therefore, once again we assert that Oregon's proposal to review 23 drugs and insulin products over only four months poses obvious challenges for both the board and the community. We urge the board, at a minimum, to shorten the list of drugs under affordability review for 2025 to ensure a thorough and deliberative process.

Protect Vulnerable Populations

Additionally, we urge the board to evaluate the impact the review process will have on the populations of patients that rely on the drug. The initial subset list of drugs for review in 2025 includes multiple medications used to treat the same condition. For the drugs under review in the July hearing, four of the six treat migraines, almost assuring that patients who seek treatment for this condition will have a treatment on the board's final list. The same will be true for antidiabetics in the September hearing and insulins in the October hearing.

If the board includes in its final list multiple medications that treat the same condition, the board risks creating increased hardship for specific patients should there be unintended consequences from the affordability review. These consequences could include increased utilization management, non-medical switching, or restricted access to these medications should health industry stakeholders in Oregon or other states react by changing formularies or altering preferred treatments.

We urge the board to consider the risks to the patients who rely on the medications selected for affordability review as it refines the subset list for 2025. In future years, it is essential to diversify the types of drugs selected for affordability review and to include safeguards that protect vulnerable populations.

Integrate Public Input and Address Patient Needs

As we continue to note in our outreach to the board, meaningful participation from patients, caregivers, and patient advocacy organizations is critical to ensuring that board actions appropriately address patient needs.

While we are encouraged to hear the board may leave the patient survey open for additional responses, it is unclear how this data will be incorporated into reviews that may already be underway. This raises questions about the weight given to public input and the transparency of the process.

We remain concerned that reported response rates to the patient survey were insufficient for drawing meaningful conclusions about patient experiences and should prompt further outreach and engagement efforts. We also continue to encourage the board to go beyond three-minute public testimony by creating more robust avenues for patient participation. Patient roundtables or extended listening sessions could provide more substantive insights and help the board better understand the burdens individuals face.

Center the Process on Affordability and Patient Burden

The board's work must be centered on the real-world challenges patients face in affording and accessing their prescribed medications. A narrow focus on systemic or payer-level costs

overlooks the most meaningful measure of affordability: whether individuals can obtain and adhere to the medications they need.

We invite the board to partner directly with our coalition and its EACH and PIC members. Our organizations represent patients across disease areas and have a deep understanding of the life cycle of disease—from prevention to diagnosis to long-term management. We offer ourselves as a resource to ensure patient perspectives remain at the forefront of this work.

Thank you for your continued commitment to improving drug affordability in Oregon. We appreciate the opportunity to provide this feedback and look forward to continuing our engagement with the board.

Sincerely,

Tiffany Westrich-Robertson
tiffany@aiarthritis.org
Ensuring Access through Collaborative Health (EACH) Coalition Lead

Vanessa Lathan
vanessa@aiarthritis.org
Patient Inclusion Council (PIC) Coalition Lead

July 13, 2025

Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

Dear Chair Bailey and board members,

Thank you to you and the Board for your hard work to address cost structures within our healthcare system. It is concerning that the question of process is not a dedicated meeting. To add this fundamental question before reviewing six drugs in the same meeting seems impossible, given your past track record. I am, however, thrilled to see it on the agenda and look forward to hearing your discussion.

While I appreciate that you received some feedback from patients and providers on the drugs under review today, it is not enough to rely on when making these critical decisions. Providers' feedback appears not to relate PBM and formulary issues to prior authorization, step-therapy, quantity limits, and patient out-of-pocket costs. The manufacturers do not set these limitations; PBMs and insurance formularies do.

> *"A survey of healthcare professionals with scientific or medical training identified key barriers for patients in accessing medications. A main obstacle reported was the need for prior authorization for insurance approval before prescriptions can be provided. Other challenges include step therapy protocols, quantity limits, and medication costs.* ***Few respondents viewed PBM or formulary issues as a barrier to accessing drugs."*** *[page 211, Jul 16 Meeting packet]*

I don't know if this was just a function of the survey. Still, it seems misleading to continue to perpetuate this false narrative, especially given the feedback from patients that affordability and access were all up to their insurance plan.

The staff could not analyze many data points in your report due to insufficient data. Once again, I encourage you to consider all stakeholders' concerns and collaborate with everyone to develop a more effective process. Asking patients and manufacturers to provide personal or proprietary information through non-secure means is not an effective way to garner the critical data points you need to make decisions. Was there another outreach to gather more input from patients and providers, informing them that these drugs made the list for the first meeting?

Regarding the drugs under review today, I lived with migraines most of my teenage and young adult life. Every attack was 2-3 days of lost school or work. I would have paid anything to have the options that are available today. Please consider the nuances of each of these drugs carefully, as each one will benefit a different subset of people living with debilitating pain.

As to Vraylar, it is my experience that the Oregon Health Plan does not choose an expensive drug unless it **works** and is saving money in the system. The fact that so many Medicaid patients are on this drug speaks volumes. Living with schizophrenia is difficult enough; do you want to create any potential barriers and intervene in a patient-provider decision? Mental health drugs have a carve-out in our system for a reason.

The Board has a lot of work ahead to meet the deadlines in your agenda, but deadlines can be broken, and the legislature will understand.

Sincerely,

Lorren Sandt, Executive Director

To the Prescription Drug Affordability Board,

My name is Katie Lukins, and I'm a public school teacher. I've lived with migraines since I was eight years old. Over the years, I've tried many treatments, but it wasn't until I was prescribed Nurtec that I found something that actually helped stop a migraine once it started. It has made a real difference in my ability to function during an attack.

As a teacher, I don't have the option of missing work easily. When I get a migraine and don't have access to an effective abortive medication, I either have to push through the pain—unable to give my students my best—or I have to miss school altogether, which puts a strain on my students, my colleagues, and myself.

I'm proud to do the work I do, but like many public servants, I'm on a limited income. The high cost of Nurtec makes it hard to consistently afford the medication I need to stay present in the classroom and maintain my quality of life. It shouldn't be this difficult for someone with a chronic condition to access a medication that works.

Please consider the real-world impact of drug pricing on working people like me. I urge you to take action to make Nurtec more affordable so that those of us who depend on it don't have to choose between our health and our paycheck.

Thank you for your time and for the work you're doing to make prescription drugs more affordable.

Sincerely,
Katie Lukins

July 8, 2025

To: Oregon Prescription Drug Affordability Board
From: Ms. Dresden Skees-Gregory, PhD Candidate, Principal & CEO, Sustainable Environmental Services Corp.
Re: Nurtec

As someone who experiences frequent migraines I would certainly appreciate the PDAB lowering the out-of-pocket costs for Nurtec. Thank you.