Oregon Prescription Drug
Affordability Board

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Eliquis®
(*apixaban*)[1]

Version 3.0

[1] Image source: https://meds90.com/products/eliquis/

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Document version history

Version	Date	Description
v1.0	8/13/2025	Original Release
v1.5	9/24/2025	Updated table numbers and references
v2.0	10/9/2025	Added new patient survey information
v3.0	10/27/2025	30 day supply data added. 75th and 95th percentile data for cost per enrollee, and out of pocket costs added. Formatting changes.

Review summary

Therapeutic alternatives[2,3,4]

Eliquis® (apixaban) has the following therapeutic alternatives: **Pradaxa, Savaysa,** and **Xarelto**.

Proprietary name	Non-proprietary name	Manufacturer	Number of patents	Patent date range	Exclusivity expiration	On the CMS drug Maximum Fair Price (MFP) list
Eliquis	*apixaban*	Bristol-Myers Squibb Company	4	2026-2031	2028	Yes
Pradaxa[5]	*dabigatran etexilate*	Boehringer Ingelheim Pharmaceuticals, Inc.	4	2025-2031		No
Savaysa	*edoxaban*	Daiichi Sankyo, Co., LTD.	2	2027-2028	2026	No
Xarelto	*rivaroxaban*	Jenssen Pharmaceuticals, Inc.	4	2025-2039	2024-2025	Yes

Price history[6,7]

Eliquis rose at an **average annual rate of 6.0 percent** from 2018-2024.

- In the same time period, its therapeutic alternatives rose at these rates:
  - Pradaxa: **-9.6** percent
  - Savaysa: **3.1** percent
  - Xarelto: **5.2** percent

[2] Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations
[3] Definitions of patents and exclusivity based on the U.S. Food & Drug Administration. https://www.fda.gov/drugs/development-approval-process-drugs/frequently-asked-questions-patents-and-exclusivity#What_is_the_difference_between_patents_a
[4] https://www.cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-and-negotiated-prices
[5] No exclusivity information was listed for Pradaxa in the U.S. Food & Drug Administration Orange Book Database
[6] Medi-Span. Wolters Kluwer, 2025. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.
[7] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.

Additionally, the average annual rate of Eliquis exceeded inflation **in 2019, 2020, 2021, 2023, and 2024**. Pharmacy acquisition costs (AAAC) for **Medicaid also increased by 26.7 percent** over the same period, reflecting broader trends in pricing escalation.

Price concessions [8]

Based on data received from healthcare carriers, Eliquis in 2023 had the **gross spend of $872 per claim**, while the **spend net of discount was $601 per claim**. Price concession per claim was reported to be **$271**.

Cost to the payers[9]

Table 1 2023 APAC gross annual payer total expenditure, utilization, and cost per enrollee

Proprietary name	Total expenditure	Utilization	Cost per enrollee	Cost per enrollee, median
Eliquis	$258,815,637	335,401	$4,331	$606
Pradaxa	$4,620,535	21,487	$840	$277
Savaysa	$88,003	140	$2,839	$761
Xarelto	$60,140,359	73,766	$4,343	$1,101

Cost to enrollees[10]

Table 2 2023 APAC gross annual enrollee out-of-pocket (OOP) cost

Proprietary name	OOP cost per enrollee	OOP cost per enrollee median	OOP cost per claim	OOP cost per claim median
Eliquis	$602	$70	$114	$44
Pradaxa	$91	$20	$23	$20
Savaysa	$647	$94	$140	$75
Xarelto	$591	$90	$122	$47

[8] Based on data submitted to the Department of Consumer and Business Services (DCBS) by Oregon's commercial insurance carriers. Cost information from the data call is the cost of the drug after price concessions.
[9] Based on Oregon's 2023 All Payer All Claims (APAC) data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons. For more information regarding APAC data visit: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.
[10] Ibid.

Rubric considerations

Domain	Consideration
Utilization	59,757
Price evaluation	Avg percent change in WAC >5%, outpaced inflation for five years
Price concessions	93% of claims discounted
System & payer costs	Total gross spend >$50M, total net spend >$10M
Enrollee burden	Total APAC OOP $200-$700
Equity impact	Yes
Access restrictions	No
Therapeutic alternative fail to reduce system spending	Yes
Stakeholder input identify access or financial hardship?	Yes
Patent expirations more than 18 months from time of review?	Yes
Excluded from CMS Maximum Fair Price List (MFP)	No

Review background

This review incorporates supporting information from Medi-Span, FDA databases (e.g., Orange Book, Purple Book), and other publicly available data where applicable.

Two primary data sources inform this review: the Oregon All Payers All Claims (APAC) database and the commercial carrier data call. APAC aggregates utilization data across all payer types in Oregon, including Medicaid, Medicare, and commercial plans, and presents gross cost estimates. In contrast, the data call reflects submissions from 11 commercial health insurers and reports primarily net costs after manufacturer rebates, PBM discounts, and other price concessions. As a result, APAC generally reflects larger total utilization and cost figures due to broader reporting, while the data call offers insight into actual expenditures from private payers in the commercial market.

This review addresses the affordability review criteria to the extent practicable. Due to limitations in scope and resources, some criteria receive minimal or no consideration.

In accordance with OAR 925-200-0020, PDAB conducts affordability reviews on prioritized prescription drugs selected under OAR 925-200-0010 The 2023 drug affordability review selection included the following criteria: orphan-designated drugs were removed; drugs were reviewed based on payer-paid cost data from the data call submissions; and drugs reported to

the APAC program across Medicare, Medicaid, and commercial lines of business were included. To ensure broader public impact, drugs with fewer than 1,000 enrollees reported in APAC reports were excluded from consideration.

Senate Bill 844 (2021) created the Prescription Drug Affordability Board (PDAB) to evaluate the cost of prescription drugs and protect residents of this state, state and local governments, commercial health plans, health care providers, pharmacies licensed in Oregon and other stakeholders within the health care system from the high costs of prescription drugs.

Drug information[11]

Drug proprietary name	Eliquis®
Active ingredient	*apixaban*
Manufacturer	Bristol-Myers Squibb
Treatment: A factor Xa inhibitor indicated:	
	• To reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation.
	• For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in patients who have undergone hip or knee replacement surgery.
	• For the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy
Strength:	Tablets: 2.5 mg and 5 mg
Dosage	
	• 5 mg orally twice daily.
Reduction of risk of stroke and systemic embolism in nonvalvular atrial fibrillation:	• In patients with at least 2 of the following characteristics: age greater than or equal to 80 years, body weight less than or equal to 60 kg, or serum creatinine greater than or equal to 1.5 mg/dL, the recommended dose is 2.5 mg orally twice daily.
Prophylaxis of DVT following hip or knee replacement surgery	2.5 mg orally twice daily.
Treatment of DVT and PE	10 mg taken orally twice daily for 7 days, followed by 5 mg taken orally twice daily.
Reduction in the risk of recurrent DVT and PE following initial therapy	2.5 mg taken orally twice daily.

[11] U.S. Food & Drug Administration. *Eliquis (apixaban) Prescribing Information*. Bristol-Myers Squibb Company, Action yr 2021. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/202155s034lbl.pdf.

Route	Oral

FDA approval

Eliquis was first approved by the FDA on Dec. 28, 2012.[12]

The drug qualified for the following expedited forms of approval: Priority

At time of review, the drug had no approved designations under the Orphan Drug Act.

Health inequities

ORS 646A.694(1)(a) and OAR 925-200-0020 (1)(a) & (2)(a)(A-B). Limitations in scope and resources available for this statute requirement. Possible data source through APAC.

Disparities exist in the prescribing and utilization of direct oral anticoagulants (DOACs), including Eliquis (*apixaban*) and Xarelto (*rivaroxaban*), among racial and ethnic minority patients, individuals with limited socioeconomic means, and residents of areas with constrained access to care. Black patients, along with Hispanic and Americans Indian/Alaska Native groups, remain consistently less likely than white patients to receive DOAC therapy despite comparable clinical indications for stroke prevention in atrial fibrillation (AF) or treatment of venous thromboembolism.[13] Underrepresentation of these populations in major clinical trials limits generalizability and reinforces gaps in treatment equity, cost, and access.[14]

Provider bias, insurance formulary barriers, and structural social determinants contribute to these inequities. For instance, apixaban prescriptions are more frequently rejected for Medicaid-insured and Black patients than for others, potentially delaying access to care.[15] Geographic and socioeconomic disparities further influence prescribing patterns; a large Medicare cohort demonstrated that counties with higher proportions of Black residents have markedly higher untreated AF rates, frequently exceeding 50 percent, with reginal patterns particularly pronounced in the Southeast.[16]

According to the Journal of American College of Cardiology (JACC), most significant AF studies disproportionately involved white participants, leaving Black, Hispanic, Asian, and Indigenous

[12] FDA approval date based on the earliest occurring approval dates in the FDA Orange/Purple Book. For drugs with multiple forms/applications, the earliest approval date across all related FDA applications was used.
[13] Reynolds KR, Khosrow-Khavar F, Dave CV. Racial and Ethnic Disparities in Initiation of Direct Oral Anticoagulants Among Medicare Beneficiaries. JAMA Netw Open. 2024;7(5):e249465. doi:10.1001/jamanetworkopen.2024.9465.
[14] Norby, F. L., Benjamin, E. J., Alonso, A., & Chugh, S. S. (2021). Racial and Ethnic Considerations in Patients With Atrial Fibrillation: JACC Focus Seminar 5/9. Journal of the American College of Cardiology, *78*(25), 2563–2572. https://doi.org/10.1016/j.jacc.2021.04.110.
[15] Deitelzweig, S., Xie, L., Terasawa, E., Hood, D. W., Cato, M., Atreja, N., Kang, A., & Hines, D. M. (2023). Journey to anticoagulant access following payer rejection of apixaban. The American Journal of Managed Care, *29*(11), e330–e338. https://doi.org/10.37765/ajmc.2023.89459.
[16] Atwater, B.D., Singh, R., Parmar, S. *et al.* Geographic and Racial Variation in Oral Anticoagulant (OAC) Treatment Among Commercially Insured Patients with Non-valvular Atrial Fibrillation (NVAF) in the United States. American Journal of Cardiovascular Drugs (2025). https://doi.org/10.1007/s40256-025-00728-x.

groups underrepresented.[17] The authors emphasize that advancing equitable care requires integrating social determinants of health into AF risk prediction, prevention, and treatment strategies, including anticoagulation therapy.

The JACC review also highlights that racial and ethnic minority status is sometimes associated with adverse AF outcomes, such as higher stroke incidence, but that access to anticoagulant therapy may reduce these risks. Studies support the importance of equitable DOAC access (Eliquis and Xarelto) to mitigate stroke disparities, particularly among Black patients whose adjusted stroke risk may remain elevated without anticoagulants.

No definitive studies show differential efficacy or safety of Eliquis compared to Xarelto across ethnic groups. The primary inequity lies in access and utilization. Economically and socially marginalized patients are more likely to be managed with older therapies (e.g., warfarin) even when guidelines indicate that DOAC therapies could yield better outcomes.

Residents prescribed

ORS 646A.694(1)(b) and OAR 925-200-0020(1)(b) & (2)(b). Data source from APAC.

Based on APAC claims, **59,757** Oregonians filled a prescription for Eliquis in 2023.[18]

Price for the drug

ORS 646A.694(1)(c) and OAR 925-200-0020(1)(c) & (2)(e), (f), & (g). Data source from Medi-Span, APAC, and carrier data call.

This section examines the pricing dynamics of Eliquis, drawing on multiple data sources to characterize its historical price trends and implications for affordability. It includes an analysis of the drug's wholesale acquisition cost (WAC) and the Oregon Actual Average Acquisition Cost (AAAC), compared to its therapeutic alternatives. Together, the data provides a comprehensive view of Eliquis' list price trajectory and pharmacy acquisition costs, and the degree to which the list price impacts costs.

Price history

WAC per 30-day summary was calculated with unit WAC from Medi-Span and was reviewed as an indication of historic price trends for the drug. However, WAC does not account for discounts, rebates, or other changes to the drug's cost throughout the supply chain.

[17] Norby, F. L., Benjamin, E. J., Alonso, A., & Chugh, S. S. (2021). Racial and Ethnic Considerations in Patients With Atrial Fibrillation: JACC Focus Seminar 5/9. Journal of the American College of Cardiology, *78*(25), 2563–2572. https://doi.org/10.1016/j.jacc.2021.04.110.

[18] Number of 2023 enrollees in APAC database across commercial insurers, Medicaid, and Medicare. For more information regarding APAC data visit: : https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx..

Table 3 30-day supply for review drug and its therapeutic alternatives

	Eliquis	Pradaxa	Savaysa	Xarelto
30-day supply	60 units (60 pills)	60 units (60 pills)	30 units (30 pills)	30 units (30 pills)

Table 4 Drug vs therapeutic alternatives and 2018-2024 WAC per 30-day supply[19]

Year	Eliquis	Pradaxa	Savaysa	Xarelto
2018	$419	$401	$337	$419
2019	$444	$433	$364	$448
2020	$471	$459	$389	$470
2021	$499	$477	$389	$492
2022	$529	$496	$389	$517
2023	$561	$198	$397	$542
2024	$594	$159	$404	$570
Avg. Annual % Change	6.0%	-9.6%	3.1%	5.2%
% change 2018 between 2024	41.9%	-60.3%	20.0%	35.9%

The WAC of Eliquis, averaged across six NDCs reported, was approximately **$9.91 per unit** at the end of 2024.[20] Between 2018-2024, the unit WAC increased at an average annual rate of **6.0 percent**, exceeding the general consumer price index (CPI-U) inflation rate in 2018-2019, 2019-2020, 2020-2021, 2022-2023, and 2023-2024.[21]

[19] Medi-Span. Wolters Kluwer, 2025. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.
[20] Ibid.
[21] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.

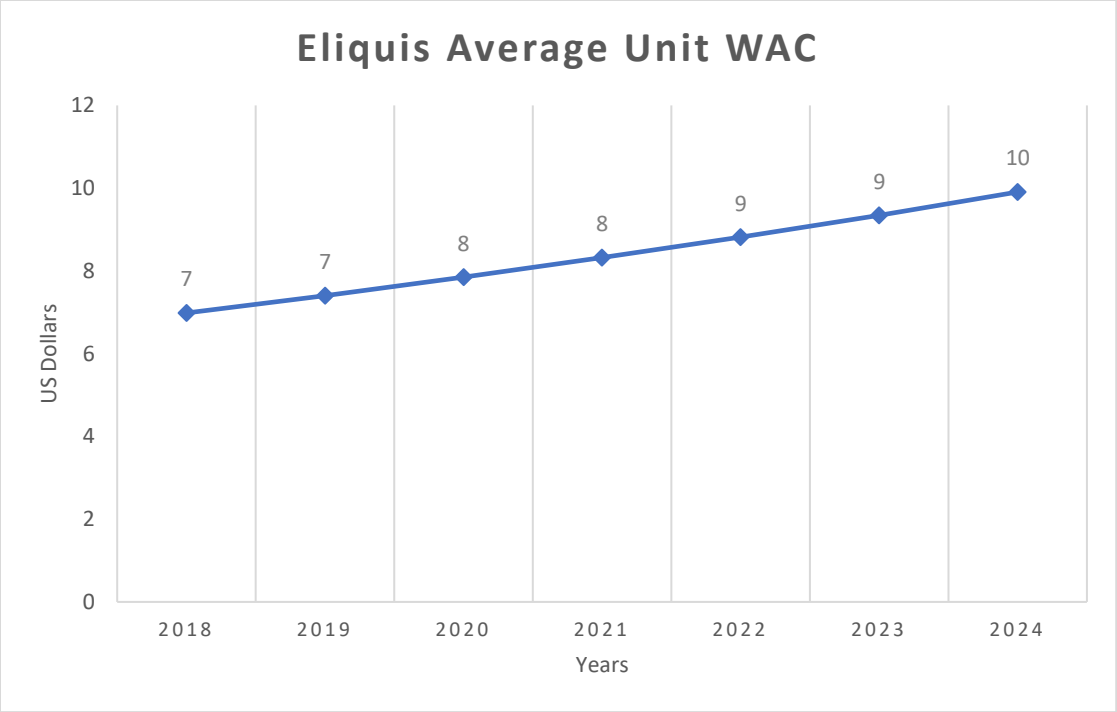

Figure 1 Eliquis average unit WAC from 2018-2024

Table 5 Percent change of WAC of drug and therapeutic alternatives with CPI comparison[22]

Year	Eliquis	Pradaxa	Savaysa	Xarelto	CPI-U
2018-2019	6.0%	8.0%	8.0%	6.7%	1.7%
2019-2020	6.0%	6.0%	7.0%	4.9%	0.7%
2020-2021	6.0%	4.0%	0.0%	4.8%	5.3%
2021-2022	6.0%	4.0%	0.0%	4.9%	9.0%
2022-2023	6.0%	-60.0%	2.0%	5.0%	3.1%
2023-2024	6.0%	-19.8%	1.7%	5.0%	3.0%

[22] Percentages might differ from Table 4 as Table 5 percentages are based on unit WAC only.

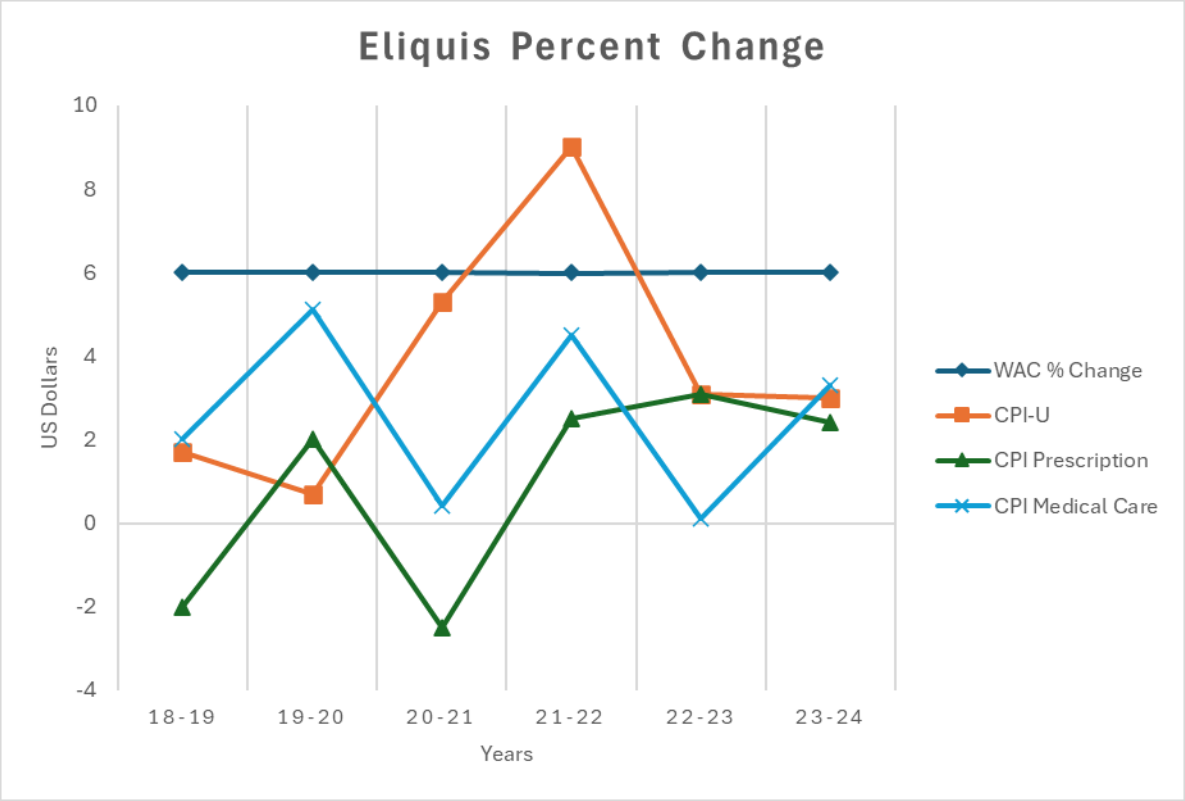

Figure 2 Year over year change in WAC compared to inflation rates[23]

Pharmacy acquisition costs

The AAAC, which reflects pharmacies' actual purchase prices for Medicaid fee-for-service claims, rose from **$7.51 per unit in Quarter 1 of 2020 to $9.53 per unit in Quarter 4 of 2024**, an approximate **26.7 percent increase** over the period (see Table 6).[24] Relative to the **$9.91** WAC in end-of-year 2024 an **AAAC discount of 3.8 percent** is indicated.

While WAC provides a standardized benchmark of list price, it does not account for negotiated price concessions. In contrast, the AAAC offers a more representative estimate of the net price incurred by Medicaid payers in Oregon, derived from regular pharmacy surveys conducted by the Oregon Health Authority. Monitoring these trends over time contextualizes Eliquis's price trajectory relative to inflation and affordability for public and private payers.

[23] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.
[24] Average Actual Acquisition Cost (AAAC) Rate Listing for Brand Drugs. Pharmacy Prescription Volume Survey, January 2020 to December 2024. AAAC Rate Review. Myers and Stauffer and Oregon Health Authority. https://myersandstauffer.com/client-portal/oregon/.

Table 6 2020-2024 AAAC Medicaid FFS quarterly purchase prices

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average AAAC	Average WAC
2020	$8	$8	$8	$8	$8	$8
2021	$8	$8	$8	$8	$8	$8
2022	$8	$8	$8	$8	$8	$9
2023	$9	$9	$9	$9	$9	$9
2024	$9	$9	$9	$10	$9	$10

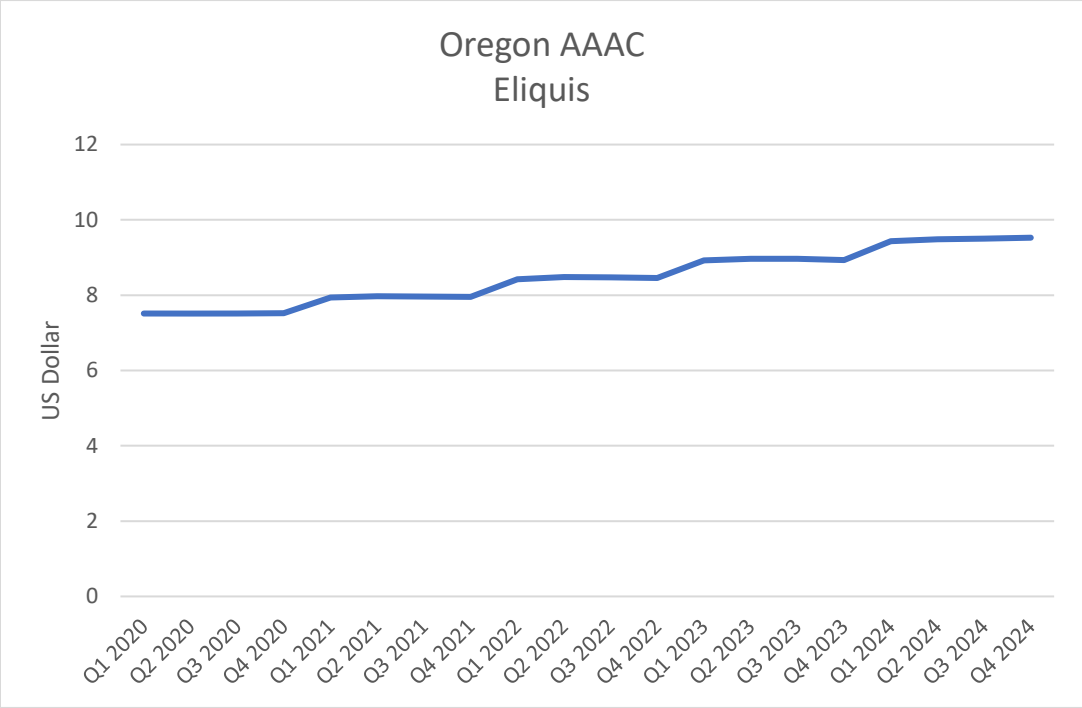

Figure 3 AAAC for Eliquis from Q1 2020 to Q4 2024

Estimated average monetary price concession

ORS 646A.694(1)(d) and OAR 925-200-0020(1)(d) & (2)(d) & (2)(L)(A-B). Data source information provided from data call.

This section provides an analysis of the average monetary discounts, rebates, and other price concessions applied to Eliquis claims in the commercial market. Drawing on data submitted through the 2023 carrier data call, it evaluates the extent to which these concessions reduced gross drug costs and estimates the average net costs to payers after adjustments. The analysis includes claim-level data on the proportion of claims with applied discounts, and the breakdown of the total concession amounts by type, offering insight into the reduced costs provided through manufacturer, PBM, and other negotiated price reductions.

Based on carrier-submitted data for 2023, the **average gross cost of Eliquis per enrollee in the commercial market was approximately $3,191**. After accounting for manufacturer rebates, pharmacy benefit manager (PBM) discounts, and other price concessions, the **average net cost per enrollee declined to approximately $2,198**, reflecting an **estimated mean discount of 31.1 percent** relative to gross costs.

Across all reporting carriers and market segments, the **total cost of Eliquis before concessions was $19,091,230**, with total reported **price concessions amounting to approximately $5,939,900**, as detailed in Table 7. Notably, **93.1 percent of claims benefited from some form of price concession,** leaving **6.9 percent at full gross cost**.

Table 7 Net cost estimate based on carrier submitted 2023 data

Total number of enrollees	5,982
Total number of claims	21,891
Total number of claims with price concessions applied	20,382

Percentage of claims with price concessions applied	93.1%
Percentage of cost remaining after concessions	68.9%
Percentage of discount	31.1%

Manufacturer price concessions for all market types	$5,015,041
PBM price concessions for all market types	$908,623
Other price reductions for all market types	$16,237

Cost before price concessions across all market types	$19,091,230
Total price concessions across all market types	$5,939,900
Cost of after price concessions across all market types	$13,151,330

Avg. payer spend per enrollee without price concessions	$3,191
Avg. payer spend per enrollee with price concessions	$2,198

Including all market segments, the **gross spend of Eliquis per claim for commercial carriers was $872** before any discounts, rebates, or other price concessions. The net cost per enrollee discounts, rebates, and other price concessions was **$601**, meaning that insurers reported a price concession of **$271** per claim on the initial drug cost as shown in Table 8.

Table 8 The average price concessions across market types from Data Call[25]

	Average	Individual market	Large market	Small market
Spend per claim, gross	$872	$892	$860	$894
Spend per claim, net	$601	$620	$584	$636
Price concessions per claim	$271	$272	$275	$257

Figure 4 shows manufacturer concessions comprised the largest share, supplemented by PBM discounted price arrangements and other adjustments across the payer types.

[25] Based on data submitted to the Department of Consumer and Business Services (DCBS) by Oregon's commercial insurance carriers.

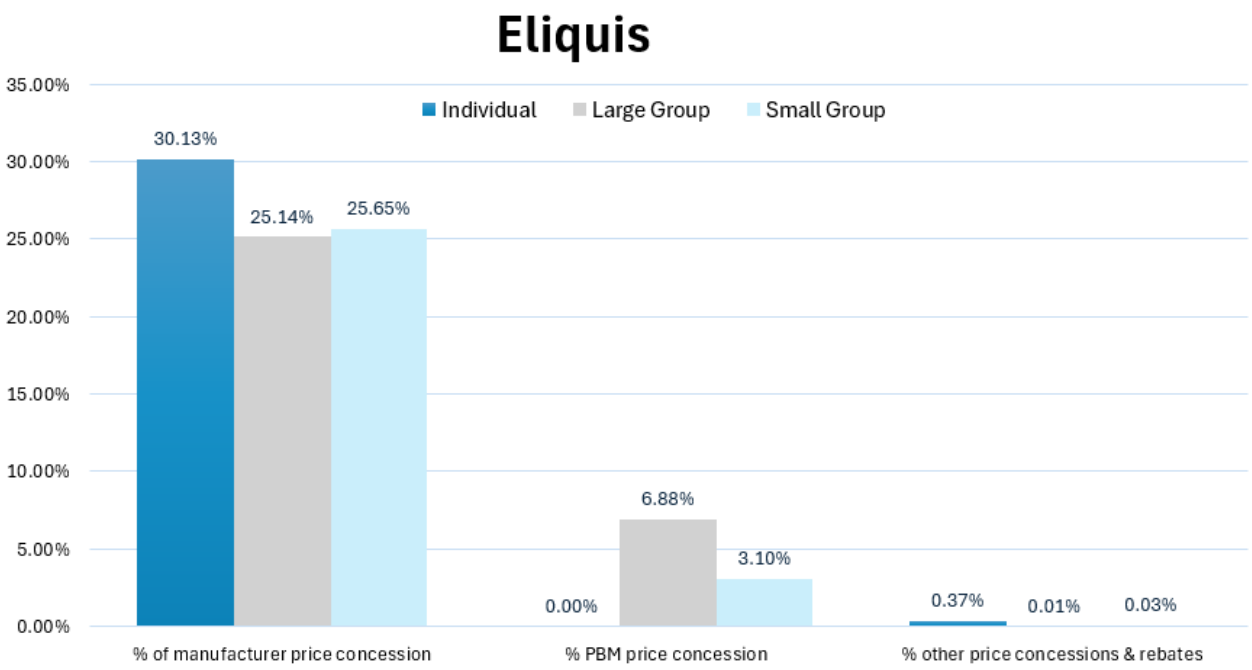

Figure 4 Percent of price concession in each market type[26, 27]

Estimated total amount of the price concession

ORS 646A.694(1)(e) and OAR 925-200-0020(1)(e) & (2)(d) & (2)(L)(A-B). Limitations in scope and resources available for this statute requirement. Possible data source carrier data call.

This section is intended to quantify the total discounts, rebates, or other price concessions provided by the manufacturer of Eliquis to each pharmacy benefit managers, expressed as a percentage of the drug's price. At the time of this review, there was no specific data available to PDAB to determine the total amount of such price concessions in the Oregon market.

The statutory and regulatory criteria call for consideration of such information to the extent practicable. However, due to limitations in available evidence and reporting, this analysis was not performed. Future reviews may incorporate this data as it becomes available through improved reporting or additional disclosures from manufacturers, PBMs, and payers.

[26] Price concession refers to any form of discount, directed or indirect subsidy, or rebate received by the carriers or its intermediary contracting organization from any source that serves to decrease the costs incurred under the health plan by the carriers. Examples of price concessions include but are not limited to: Discounts, chargebacks, rebates, cash discounts, free goods contingent on purchase agreement, coupons, free or reduced-price services, and goods in kind. Definition adapted from Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 423, Subpart C. See more at: CFR-2024-title42-vol3-sec423-100.pdf.

[27] Rebate refers to a discount that occurs after drugs are purchased from a pharmaceutical manufacturer and involves the manufacturer returning some of the purchase price of the purchaser. When drugs are purchased by a managed care organization, a rebate is based on volume, market share, and other factors. Academy of Managed Care Pharmacy. https://www.amcp.org/about/managed-care-pharmacy-101/managed-care-glossary.

Estimated price for therapeutic alternatives[28]

ORS 646A.694(1)(f) and OAR 925-200-0020(1)(f), (2)(c) & (2)(m). Data source information provided from APAC.

This section presents information on the estimated spending associated with Eliquis and its therapeutic alternatives using data from APAC and data call collection for 2023 information. APAC data reflects gross spending across Medicare, Medicaid, and commercial health plans in Oregon, while the data call includes net spending submitted by 11 commercial health insurers. All therapeutic alternatives are represented using APAC data, which does not reflect price concession or rebates.

Eliquis' gross total payer paid, based on APAC data, **was $258.8 million**, while total net payer paid received from the **carriers indicated a cost of $16.2 million. Eliquis has the highest gross total pay in consideration** with its therapeutic alternatives. The second highest is Xarelto, with $60.1 million. Notably, Eliquis has the **most utilization among the drugs, at 335,401 claims**, as compared to the second highest utilization of Xarelto, at 73,766 claims. Xarelto has a **higher payer paid per claim compared to Eliquis,** which are $815 and $772 respectively.

Eliquis also has the highest total enrollee paid at $33.3 million and Xarelto follows behind with $7.4 million. Savaysa has the highest patient paid per claim of $140, which is higher than both Xarelto at $122 and Eliquis at $99. The drug with the lowest patient paid per claim is Pradaxa, which is $23.

Neither the drug nor the therapeutic alternatives were reported by the FDA for drug shortage, thus availability is assumed to be unaffected.

[28] Therapeutic alternative to mean a drug product that contains a different therapeutic agent than the drug in question, but is FDA-approved, compendia-recognized as off-label use for the same indication, or has been recommended as consistent with standard medical practice by medical professional association guidelines to have similar therapeutic effects, safety profile, and expected outcome when administered to patients in a therapeutically equivalent dose. ORS 925-200-0020(2)(c).

Table 9 Average healthcare and average patient OOP costs vs therapeutic alternatives[29]

Proprietary name	No. of enrollees [30]	No. of claims	Total payer paid	Total enrollees paid[31]	Payer paid/ claim	Patient paid/ claim[32]
Subject Drug **Eliquis (Data call)**[33]	**5,982**	**21,891**	**$16,168,736**	**$2,518,263**	**$739**	**$115**
Subject Drug **Eliquis (APAC)**	**59,757**	**335,401**	**$258,815,637**	**$33,319,981**	**$772**	**$99**
Pradaxa	5,501	21,487	$4,620,535	$478,268	$215	$23
Xarelto	13,849	73,766	$60,140,359	$7,442,476	$815	$122
Savaysa	31	140	$88,003	$19,417	$629	$140

Estimated average price concession for therapeutic alternatives

ORS 646A.694(1)(g) and OAR 925-200-0020(1)(g) & (2)(d) & (2)(L)(A-B). Limitations in scope and resources available for this statute requirement.

This section addresses the estimated average of discounts, rebates, or other price concessions associated with therapeutic alternatives to Eliquis, as compared to the subject drug itself. At the time of this review, there was no quantifiable data available to PDAB to assess the average price concessions for the identified therapeutic alternatives in the Oregon market.

The statutory and regulatory criteria call for consideration of such information to the extent practicable. However, due to limitations in available evidence and reporting, this analysis was

[29] The therapeutic alternative information is based on 2023 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[30] The number of enrollees is derived from unique individuals collected from APAC at the drug level. A single unique individual may occur across multiple lines of business indicating, meaning that an enrollee can be counted for each claim line of business. As a result, this leads to the elevated enrollment numbers presented in Table 9, as compared to other totals indicated in this report.
[31] The cost includes all lines of business.
[32] Ibid.
[33] Information from the data call with the cost information after price concessions.

not performed. Future reviews may incorporate this information as additional data become available through carrier reporting, manufacturer disclosures, or other sources.

Estimated costs to health insurance plans

ORS 646A.694(1)(h) and OAR 925-200-0020(1)(h) & (2)(h) & (m). Data source information provided from APAC and data call.

This section quantifies the financial impact of Eliquis on health insurance plans in Oregon, based on claims and expenditure data from APAC and the carrier data call. Costs are delineated by payer type—including commercial, Medicaid, and Medicare—as well as by market segment within the commercial population. These estimates highlight the distribution of expenditures across different health coverage lines and inform assessments of the drug's budgetary implications for public and private payers.

In 2023, the Oregon APAC database recorded **335,401 total claims for Eliquis among 63,449 total enrollees**, corresponding to a **total payer expenditure of $258.8 million**.

Table 10 provides gross cost estimates by the total APAC payer spend across all lines of business:

- **Medicare** accounted for the largest share of utilization, with 246,059 claims from 46,525 enrollees and a total spend of **$205.6 million**.
- **Commercial** and **Medicaid** payers reported smaller but notable expenditures of approximately **$30.7 million** and **$22.5 million**, respectively.

Table 10 Estimated 2023 APAC total annual gross payers' expenditure for total enrollees and total claims [34]

Payer line of business	Total enrollees	Total claims	Total payer paid	Average cost amount per enrollee	Average cost amount per claim
Commercial	9,645	46,684	$30,683,588	$3,181	$657
Medicaid	7,279	42,658	$22,502,400	$3,091	$528
Medicare	46,525	246,059	$205,629,649	$4,420	$836
Totals[35]	**63,449**	**335,401**	**$258,815,637**		

Table 11 provides utilization for the healthcare system for Eliquis and its therapeutic alternatives, distinguished by lines of business. **Eliquis has the most utilization** among the

[34] Based on 2023 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.

[35] The total number of enrollees is the summation of enrollees across all markets which differs from the unique enrollees at the drug level.

drugs, with **335,401 claims**. In all lines of business, Eliquis is the most utilized. **Xarelto is the second most utilized at 73,766 claims**.

Table 11 Estimated APAC payer 2023 utilization of review drug and its therapeutic alternatives [36]

Proprietary name	Commercial utilization	Medicaid utilization	Medicare utilization	Total claims[37]
Eliquis	46,684	42,658	246,059	335,401
Pradaxa	5,971	962	14,554	21,487
Savaysa	25	1	114	140
Xarelto	12,570	12,532	48,664	73,766

Table 12 shows the overall payer expenditure of Eliquis and its therapeutic alternatives, distinguished by lines of business. Eliquis has a **total expenditure of $258.8 million** with **Medicare being the biggest portion at $205.6 million**. The therapeutic alternative with the **least expenditure is Savaysa, at $88,003**.

Table 12 Estimated APAC payer 2023 annual gross expenditure of the review drug and its therapeutic alternatives from all lines of business [38]

Proprietary name	Commercial expenditure	Medicaid expenditure	Medicare expenditure	Total[39]
Eliquis	$30,683,588	$22,502,400	$205,629,649	$258,815,637
Pradaxa	$1,176,190	$210,748	$3,233,597	$4,620,535
Savaysa	$17,033	$176	$70,794	$88,003
Xarelto	$9,274,654	$6,479,274	$44,386,431	$60,140,359

Table 13 compares the overall payer cost per enrollee of Eliquis and its therapeutic alternatives, distinguished by lines of business. **Xarelto has the highest total cost per enrollee at $4,343**. Eliquis has the **highest cost per enrollee in Medicare at $4,420**, though the cost per enrollee of the commercial line of business is comparable to its therapeutic alternative, Xarelto. **The median cost per enrollee for Eliquis is $606**, which is less than the median cost per enrollee for both Savaysa and Xarelto.

[36] Based on 2023 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[37] Total is the sum of all utilization for the drug across all lines of business.
[38] Based on 2023 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[39] Total is the sum of all expenditure for the drug across all lines of business.

Table 13 Estimated 2023 APAC payer annual gross cost per enrollee of the review drug and its therapeutic alternatives[40]

Proprietary name	Commercial cost/ enrollee	Medicaid cost/ enrollee	Medicare cost/ enrollee	Total[41] cost per enrollee	Cost per enrollee, median	IQR	Cost per enrollee, 75th percentile	Cost per enrollee, 95th percentile
Eliquis	$3,181	$3,091	$4,420	$4,331	$606	$1,019	$1,494	$1,813
Pradaxa	$519	$747	$808	$840	$277	$202	$303	$323
Savaysa	$2,839	$176	$2,950	$2,839	$761	$667	$1,035	$1,229
Xarelto	$3,478	$3,510	$4,357	$4,343	$1,101	$997	$1,483	$1,748

Data submitted via the carrier data call further stratifies commercial expenditures by market segment. The collected **total net cost to the healthcare system was around $18.7 million**, with payer paying $16.2 million, and enrollees out-of-pocket estimating to be $2.5 million. Table 14 includes the average plan costs per enrollee in the commercial market, ranging from **$2,806 (large group)** to **$2,360 (individual)** annually.

Table 14.a Estimated 2023 data total net costs to the healthcare system, payers and OOP/enrollee[42]

Market	Number of claims	Number of enrollees	Total annual spending	Payer paid	Enrollee out-of- pocket cost
Individual	4,429	1,220	$3,946,404	$2,879,226	$1,067,179
Large Group	13,530	3,691	$11,461,137	$10,358,235	$1,102,902
Small Group	3,932	1,071	$3,279,458	$2,931,276	$348,182
Total	**21,891**	**5,982**	**$18,687,000**	**$16,168,736**	**$2,518,263**

[40] Based on 2023 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[41] The total is the overall cost per enrollee across commercial insurers, Medicaid, and Medicare.
[42] Cost information from the data call is the cost of the drug after price concessions.

Table 14.b Estimated 2023 data total net costs to the healthcare system, payers and OOP/enrollee

Market	Avg. plans spend/ claim	Avg. payer paid/ claim	Avg. enrollee paid/ claim	Avg. plans spend/ enrollee	Avg. payer paid/ enrollee	Avg. OOP/ enrollee
Individual	$891	$650	$241	$3,235	$2,360	$875
Large Group	$847	$766	$82	$3,105	$2,806	$299
Small Group	$834	$745	$89	$3,062	$2,737	$325

As shown in Figure 5, the **large group market segment** represented the majority of commercial spending (61% of total), followed by individual and small group markets.

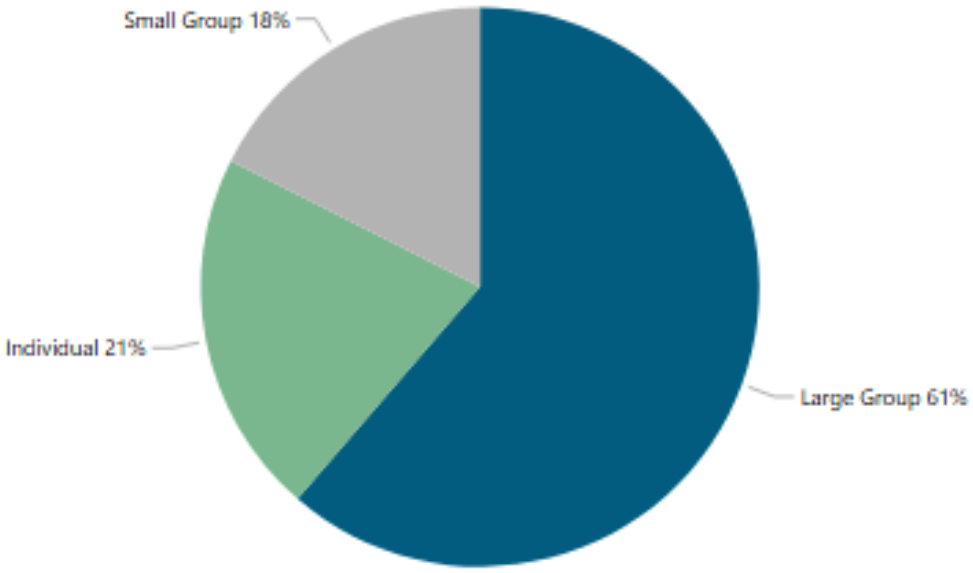

Figure 5 Data call percent of total annual spend (payer paid) by market

Table 15 indicates CCOs reported Eliquis as having an annual greatest increase from 2022-2023 (rebates not included) with a **$3,953,038 year-over-year increased cost growth**.

Table 15 Medicaid CCOs greatest increase in share to total cost from 2022-2023 (rebates not included)[43]

Medicaid CCOs			
2022	**2023**	**YoY change in spending**	**Percent of total CCO cost 2023**
$16,971,070	$20,924,108	$3,953,038	0.32%

Impact on enrollee access to the drug

ORS 646A.694(1)(i) and OAR 925-200-0020(1)(i). Data source information provided from carrier data call.

Review of rejected claims and drug benefit designs

This section summarizes information reported by carriers regarding plan design features that relate to coverage of Eliquis, including prior authorization requirements, step therapy protocols, and formulary placement. The data describes how the drug is positioned within insurance benefit designs and the extent to which utilization management processes were applied during the reporting period.

Based on information reported through the carrier data call, the following plan design features were observed for Eliquis. In 2023, approximately **36.5 percent of reporting plans required prior authorization (PA)** for coverage of the drug, and **0.0 percent of plans required step therapy** before approving its use.

For formulary placement, **34.3 percent of plans categorized Eliquis as a non-preferred drug**, and **no plans excluded it entirely from the formulary**.

Table 16 Plan design analysis from 2023 data

Percentage of plans	
Required prior authorization	36.5%
Required step therapy	0.0%
On a non-preferred formulary	34.3%
Not covered	0.0%

Note: percentages can equal over 100 percent as some carrier and market combos may have multiple plans that fall under different designs. For example: Carrier A may have three plans in the small group market that require prior authorization but two other plans in the small group market that do not require prior authorization.

[43] CCO Pharmacy spend provided by Oregon State University drug use research and management program. Oregon State University Drug Use and Research Management DUR utilization reports 2023. College of Pharmacy, Oregon State University. https://pharmacy.oregonstate.edu/research/pharmacy-practice/drug-use-research-management/dur-reports.

Relative financial impacts to health, medical or social services costs

ORS 646A.694(1)(j) and OAR 925-200-0020(1)(j) & (2)(i)(A-B). Limitations in scope and resources available for this statute requirement.

This section addresses the extent to which the use of Eliquis may affect broader health, medical, or social service costs, as compared to alternative treatments or no treatment. At the time of this review, there was no quantifiable data available to PDAB to assess these relative financial impacts in the Oregon population.

The statutory and regulatory criteria contemplate consideration of such information to the extent practicable. However, due to limitations in available evidence and reporting, this analysis was not performed. Future reviews may incorporate this data as it becomes available through carrier reporting, manufacturer disclosures, or other sources.
Future reviews may incorporate findings from real-world evidence, health technology assessments, or economic modeling as such data become available.

Estimated average enrollee copayment or other cost-sharing

ORS 646A.694(1)(k) and OAR 925-200-0020(1)(k) & (2)(j)(A-D). Data source information provided from APAC and carrier data call. Data limitations with patient assistance programs

This section summarizes the average annual enrollee out-of-pocket (OOP) costs for Eliquis in Oregon, as reported in 2023 by the Oregon All Payers All Claims (APAC).[44] These costs include enrollee copayments, coinsurance, and deductible contributions for the drug and are presented by insurance type.

Table 17 and 18 presents the average annual enrollee cost-sharing amounts derived from APAC. The APAC data, which includes claims from commercial, and Medicare enrollees, showed average per-claim and per-enrollee OOP gross costs. For example, **Medicare enrollees recorded higher average annual OOP costs**. Due to the absence of Medicaid OOP costs, the insurance type has been omitted entirely from the following tables.

[44] Gross costs from the APAC database are prior to any price concessions such as discounts or coupons. Net cost information from the data call is the cost of the drug after price concessions.

Table 17 Review drug vs. therapeutic alternatives and annual out-of-pocket cost per enrollee [45]

Proprietary name	Annual Medicare OOP cost/ enrollee	Annual commercial OOP cost/ enrollee	Total[46]	Median	IQR	75th percentile	95th percentile
Eliquis	$640	$368	$602	$70	$241	$245	$973
Pradaxa	$83	$64	$91	$20	$15	$25	$67
Savaysa	$626	$734	$647	$94	$272	$282	$823
Xarelto	$630	$385	$591	$90	$263	$267	$894

Table 18 Review drug vs. therapeutic alternatives and out-of-pocket cost per claim[47]

Proprietary name	Medicare OOP cost/ claim	Commercial OOP cost/ claim	Total[48]	Median	IQR	75th percentile	95th percentile
Eliquis	$121	$76	$114	$44	$135	$135	$471
Pradaxa	$23	$24	$23	$20	$10	$20	$45
Savaysa	$132	$176	$140	$75	$191	$195	$529
Xarelto	$132	$82	$122	$47	$141	$141	$515

Clinical information based on manufacturer material[49]

ORS 646A.694(1)(L) and OAR 925-200-0020(1)(L). Information provided from manufacturers and information with sources from contractor(s).

Drug indications

- FDA Approved: apixaban (Eliquis) is a factor Xa inhibitor indicated:
  - To reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation.

[45] Based on 2023 Oregon APAC data across commercial insurers and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[46] The total is the overall cost per enrollee across commercial insurers and Medicare.
[47] Based on 2023 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[48] The total is the overall cost per claim across commercial insurers and Medicare.
[49] U.S. Food & Drug Administration. *Eliquis (apixaban) Prescribing Information*. Bristol-Myers Squibb Company, Action yr 2021. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/202155s034lbl.pdf.

    - For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in patients who have undergone hip or knee replacement surgery.
- For the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy.
- Off Label Uses:
    - Heparin induced thrombocytopenia
    - Left ventricular thrombus

Clinical efficacy

The efficacy of *apixaban* (Eliquis), an oral factor Xa inhibitor, was demonstrated in six pivotal randomized, double-blind clinical trials across its approved indications, including stroke prevention in nonvalvular atrial fibrillation (NVAF), treatment and prevention of venous thromboembolism (VTE), and prophylaxis of deep vein thrombosis (DVT)following hip or knee replacement surgery.

Table 19 Clinical Efficacy Table – Eliquis vs Comparator

Indication (Study)	Comparator	Primary endpoint	Eliquis result	Comparator result	Effect	Bleeding
NVAF (ARISTOTLE)	Warfarin	Stroke or systemic embolism	1.27%/ year	1.60%/ year	HR 0.79; p=0.01 (superior)	Fewer major bleeds
DVT/PE (AMPLIFY)	Enoxaparin/ Warfarin	Recurrent VTE or VTE-related death	2.3%	2.7%	Non-inferior	Fewer major bleeds
Extended VTE Prophylaxis (AMPLIFY-EXT)	Placebo	Recurrent VTE or death	3.8% (2.5 mg), 4.2% (5 mg)	11.6%	7.4% - 7.8% ARR reduction (p<0.001)	Low rates of major bleeding similar to placebo
VTE Prophylaxis post TKA (ADVANCE 1)	Enoxaparin 30 mg twice daily	Composite of DVT, PE, and death	9%	8.8%	Did not meet non-inferiority	Less major bleeding
DVT Prophylaxis post TKA (ADVANCE 2)	Enoxaparin 40 mg daily	Composite of DVT, PE, and death	15%	24%	p<0.001	Similar bleeding rates

Indication (Study)	Comparator	Primary endpoint	Eliquis result	Comparator result	Effect	Bleeding
DVT Prophylaxis post THA (ADVANCE 3)	Enoxaparin 40 mg daily	Composite of DVT, PE, and death	1.4%	3.9%	2.5% ARR p<0.001	Similar bleeding rates
Abbreviations: ARR: absolute risk reduction; DVT: deep vein thrombosis; HR: hazard ratio; PE: pulmonary embolism: TKA: total knee arthroplasty; THA: total hip arthroplasty; VTE: venous thromboembolism						

Clinical safety

- FDA safety warnings and precautions:
  - May cause serious, potentially fatal, bleeding.
  - Valvular disease: Not recommended with mechanical prosthetic heart valves, severe mitral stenosis, or significant rheumatic heart disease
  - Antiphospholipid syndrome: Not recommended in patients with triple positive antiphospholipid syndrome, may increase risk of thrombosis.
  - Spinal or epidural hematoma

- Contraindications:
  - Active pathological bleeding
  - Severe hypersensitivity to Eliquis

- Common side effects:
  - Skin rash or severe allergic reactions
  - Bleeding-related events
  - Nausea

Therapeutic alternatives[50,51,52,53]

Table 20 FDA approved indications

Drug	Orthopedic VTE prophylaxis	DVT/PE treatment	Stroke prevention in NVAF	VTE prevention in acute medical illness	CAD and PAD
Xarelto (Rivaroxaban)	YES	YES	YES	YES	YES
Eliquis (apixaban)	YES	YES	YES	____	_____
Pradaxa (dabigatran)	YES	YES	YES	____	_____
Savaysa (edoxaban)	____	YES	YES	____	_____
Terms: CAD = coronary artery disease; DVT = deep vein thrombosis; NVAF: nonvalvular atrial fibrillation; PAD = peripheral artery disease; PE = pulmonary embolism; VTE = venous thromboembolism					

Comparative clinical efficacy

Direct oral anticoagulants (DOACs) have become standard of care and first line treatment for the treatment of stroke prevention in NVAF, and for the treatment and prevention of VTE. They are not recommended in patients with mechanical heart valves, in high-risk antiphospholipid syndrome, and in pregnant or breastfeeding. DOACs should be avoided in severe hepatic impairment and used cautiously with dose reduction in severe renal impairment. DOACs have been shown to be non-inferior or superior to warfarin in NVAF and non-inferior to low molecular weight heparin for the prevention and treatment of VTE.

There are no head-to-head randomized controlled trials directly comparing one DOAC to another and insufficient evidence that one is more effective or safer than another.

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[50] U.S. Food & Drug Administration. *Eliquis (apixaban) Prescribing Information*. Bristol-Myers Squibb Company, Action yr 2021. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/202155s034lbl.pdf.

[51] U.S. Food & Drug Administration. *Pradaxa (dabigatran etexilate) Prescribing Information*. Boehringer Ingelheim Pharmaceuticals, Inc., Action yr 2021. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/022512s041lbl.pdf.

[52] U.S. Food & Drug Administration. *Savaysa (edoxaban) Prescribing Information*. Daiichi Sankyo, Co., LTD., Action yr 2021. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/206316s017lbl.pdf.

[53] U.S. Food & Drug Administration. *Xarelto (rivaroxaban) Prescribing Information*. Jenssen Pharmaceuticals, Inc., Action yr 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/022406Orig1s039,202439Orig1s038correctedlbl.pdf

Observational data and network meta-analysis suggests similar effectiveness between DOACs and a possible lower risk of major and gastrointestinal bleeding with apixaban compared to rivaroxaban and dabigatran. Choice of therapy is typically based on dosing, side effects, cost, drug-drug interactions, and indications.

Table 21 Safety and therapeutic considerations

Drug	Safety considerations	Therapeutic considerations
***rivaroxaban* (Xarelto)**	• Avoid for VTE if CrCl < 15 ml/min • Avoid with strong inducers and inhibitors of both P-gp and CYP3A4	• Short half-life of 5-9 hour • Administer doses > 10 mg with food • Only DOAC approved for CV Risk reduction in CAD/PAD (with aspirin)
***apixaban* (Eliquis)**	• Lowest risk of major and GI bleeding • Avoid with strong inducers of both P-gp and CYP3A4	• Preferred DOAC in renal impairment • Preferred DOAC if other risk factors for GI bleed present • Requires twice daily dosing
***dabigatran* (Pradaxa)**	• GI symptoms (dyspepsia) and gastritis-like symptoms (10%) • Caution if 75 years or older, poor kidney function, or underweight • Avoid if CrCl < 15 ml/min and < 30 ml/min for VTE	• More renally cleared • Dispense in original package and use within 4 months of opening • Requires twice daily dosing
***edoxaban* (Savaysa)**	• anemia, rash, abnormal liver function tests • Not recommended if CrCl < 15 ml/min • Avoid if CrCl > 95 ml/min	• Not approved for VTE prophylaxis
Abbreviations: CAD: coronary artery disease; CrCl: creatinine clearance; DOAC: direct oral anticoagulants; GI: gastrointestinal; PAD: peripheral artery disease; VTE: venous thromboembolism		

Table 22 Dosing and route

Drug	Route	Strength & dose		
		NVAF	**VTE Treatment**	**VTE Prevention**
***rivaroxaban* (Xarelto)**	Oral	20 mg daily	15 mg twice daily x21d then 20 mg daily	10 mg once daily

Drug	Route	Strength & dose		
***apixaban* (Eliquis)**	Oral	5 mg twice daily *	10 mg twice daily ×7 days, then 5 mg twice daily	2.5 mg twice daily
***dabigatran* (Pradaxa)**	Oral	150 mg twice daily	150 mg twice daily after ≥ 5 days of parenteral therapy	220 mg once daily
***edoxaban* (Savaysa)**	Oral	60 mg daily	60 mg daily after ≥ 5 days of parenteral therapy	N/A
* SCr ≥1.5 mg/dL and either ≥80 years of age or body weight ≤60 kg: 2.5 mg twice daily.				

Input from specified stakeholders

ORS 646A.694(3) and OAR 925-200-0020(2)(k)(A-D)

See appendix page for all stakeholder feedback.

Patients and caregivers

Note: The information presented is based on self-reported survey responses from individuals prescribed certain medications. Participation in the survey was voluntary, and the responses reflect each individual's personal understanding and interpretation of the question asked. As such, the data may contain inconsistencies or inaccuracies due to varying levels of comprehension, recall bias, or misinterpretation of question intent. These limitations should be considered when interpreting the responses.

Survey information was **received from 81 individuals** either currently taking or associated with the use of Eliquis. According to the survey results, seven respondents indicated that Eliquis was not covered by their insurance. Three respondents were enrolled in Medicaid, 59 were on Medicare, and 20 had private health insurance.

One Medicaid participants reported the drug was covered by their plan but was receiving assistance through a patient assistance program (PAP). Among the Medicare respondents, 50 patients had the drug covered with three being enrolled in a PAP. Of the private insurance participants, 18 had the drug covered, one was on a PAP.

In terms of out-of-pocket (OOP) costs, 21 respondents paid less than $49, six reported paying between $50 and $99, 20 were paying between $100-$199, 19 paid between $200-399, three were paying between $400-599, one was paying between $600-799, two were paying between $800-999, and nine respondents did not indicate if they had OOP cost.

Below are written answers from Oregon patients who responded to the PDAB survey in April 2025. Survey responses have been edited for readability, length and to protect patient privacy.

” Eliquis ”

- This is a lifesaving drug that I will need for the rest of my life. I fear losing my insurance or them deciding not to cover it, in which case it would cost me around $900 a month. This would bankrupt me.
- I have applied to the Eliquis foundation and was refused due to my financial records as supplied by tax records, which I would agree to explain further.
- In 2024, my co-pay for the first two prescription fills/refills (90-day supply) was $135; by the end of 2024 it had gone up to just over $500, and this past March increased to $551 for same refill.
- High deductible made initial copay $310 for 30-day supply.
- This drug was $40 a month until 2025; now it’s $123 a month.
- The drug out of pocket was too expensive, so my doctor suggested I purchase it from Canada. I did and the price was less than half.
- This drug has helped me stay alive. Price would be prohibitive if not covered. Please do not allow this drug to be charged full price.
- I currently order this medication from Canada, after I paid $600 for the first month here. I can’t afford that amount on an ongoing basis. With the planned tariffs, I’m sure the price will go up.
- This drug is the most expensive one that I take, under my current Medicare Part D plan. I am hopeful that it will decrease in price as the drug becomes generic and Medicare limits on its cost go into effect.
- When my father had his first stroke in 2023 the hospitalist prescribed Eliquis and told us it was the newest and best anticoagulant available and was on the cutting edge. After being hospitalized for three months, we found the cost for Eliquis was too high to continue taking it once discharged and worked with the doctor to find a cheaper but similar medication. They noted that changing off Eliquis to Pradaxa (current medication) would work almost as well and was cheaper. It is frustrating that the cost of the best available medication was too high and we had to switch to something less effective.
- Now obtaining drug from mail-order Canadian pharmacy at far less cost than from Optum Rx domestic pharmacy.

Here is a compilation of consumers stories included in the Drug Price Transparency program's 2023 legislative report, lightly edited for readability and length. The term donut hole refers to a coverage gap in Medicare drug plans created by drug plan limitations.

- For 2024, my current Plan D with Cigna increased the annual deduction from $100 to $145, increased monthly premium from $54.70 to $65.20, and changed my Eliquis charge from a $47 monthly co-pay to 20 percent of total monthly cost. The current 3-month cost is $1,797. It is like being in the donut hole all year.
- Being new to Medicare this last year has been a real eye opener! Previously, while working and having commercial insurance, for the most expensive meds (i.e., Humira) you can use the company's $5 coupon, but not so on Medicare. Even with Part D, it is an astronomical cost. Same with Eliquis and many other drugs. We continue to let drug companies dictate and the government joins right in with them.
- My husband is on Medicare and a private insurance plan and he pays out of pocket $460 every 3 months for Jardiance and $400 for Eliquis. These are required to keep him alive per our primary doctor and not due to the ridiculous advertising we're subjected to non-stop while watching TV. We are both on a fixed income and cannot afford this. One step we should take as a nation is to ban prescription advertising to the public as is done in most countries except for the US and New Zealand. Only doctors should be made aware of their fabulous drugs. These ads must be very costly as they air in prime time and include an elaborate cast of actors with dancing and singing. Tell the drug companies to pass the cash savings on to those who really need these drugs. The Jardiance "little pill with the big story to tell" is particularly heinous given its cost to us.

Individuals with scientific or medical training

Surveys were posted on the PDAB website to collect drug information from individuals with scientific and medical training. There were no reports for Eliquis to determine the impact of the disease, benefits or disadvantages, drug utilization, or input regarding off label usage.

Safety net providers

The information reported by safety net providers describes their experience dispensing Eliquis, particularly in relation to the federal 340B Drug Pricing Program. The survey collected information on utilization, if the drug was eligible for 340B discounts, dispensing arrangements, and payment and reimbursement levels.

A total of **11 safety net clinics** responded to the survey. Among respondents, **11 clinics indicated that Eliquis was covered as a 340B-eligible prescription** within their programs. Most clinics (91%) reported operating an internal pharmacy for dispensing 340B-eligible medications, and 64 percent reported using one or more contract pharmacies for this purpose.

Additionally, **82 percent of clinics reported having a prescription savings program**, and all respondents (100%) reported employing a staff member dedicated to 340B compliance.

Regarding expenditures under the 340B program, respondents reported a range of total amounts paid: 27 percent reported paying between **$0–$100,000**, 18 percent reported between **$100,001–$300,000**, while **55 percent declined to report, citing trade secret protections**.

Reported reimbursement for dispensing under 340B also varied: 18 percent of respondents reported reimbursement between **$0–$100,000**, 9 percent between **$100,001–$500,000**, and 18 percent between **$500,000–$10,000,000**.

Without additional detail on the volume of patients treated or the per-claim costs, it is difficult to interpret the figures in terms of clinic financial risk or access outcomes. The wide range may reflect differing clinic sizes, patient populations, or inventory management practices. Notably, the absence of full reporting by 55 percent of clinics makes it challenging to assess how 340B drug costs affect long-term affordability or sustainability for safety-net providers.

These results suggest that while Eliquis is incorporated into many safety-net programs, further data would be necessary to understand how reimbursement aligns with acquisition cost and whether 340B discounts adequately mitigate financial exposure for patients and the healthcare system.

Table 23 Safety net provider survey responses

Survey information	Response
Clinics responded	11
The drug is covered as a 340B eligible prescription in their program	11
Reported having an internal pharmacy they use to dispense 340B eligible prescriptions.	91%
Reported having one or more contract pharmacies from which 340b eligible prescriptions are dispensed.	64%
Reported having a prescription savings program to improve patient access to prescription medications	82%
Reported having a staff person dedicated to 340b compliance requirements	100%
Reported total amount paid for drug under 340B was between $0-$100,000	27%
Reported total amount paid for drug under 340B was between $100,001-$300-000	18%
Reported total amount paid for drug under 340B was between this was trade secret and did not provide an amount	55%
Reported total reimbursement for drugs dispensed under 340B was between $0-$100,000	18%
Reported total reimbursement for drugs dispensed under 340B was between $100-001-$500,000	9%
Reported total reimbursement for drugs dispensed under 340B was between $500,000-$10,000,000	18%

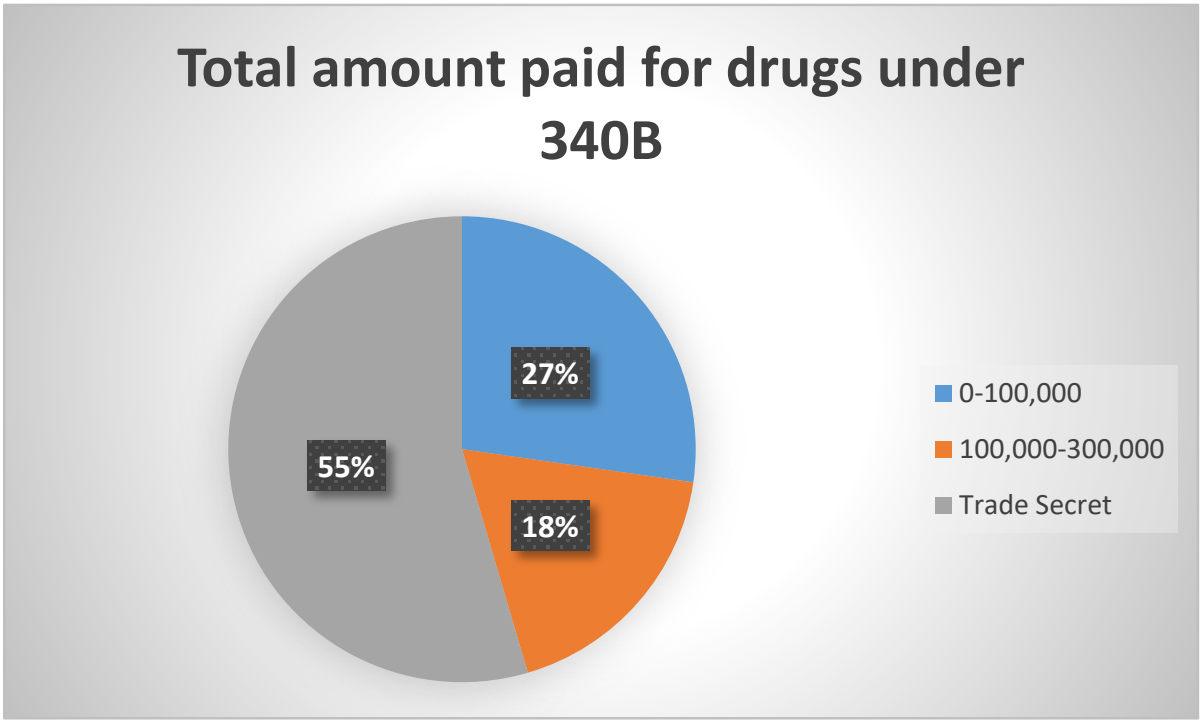

Figure 6 Amounts paid for drug under 340B discount program

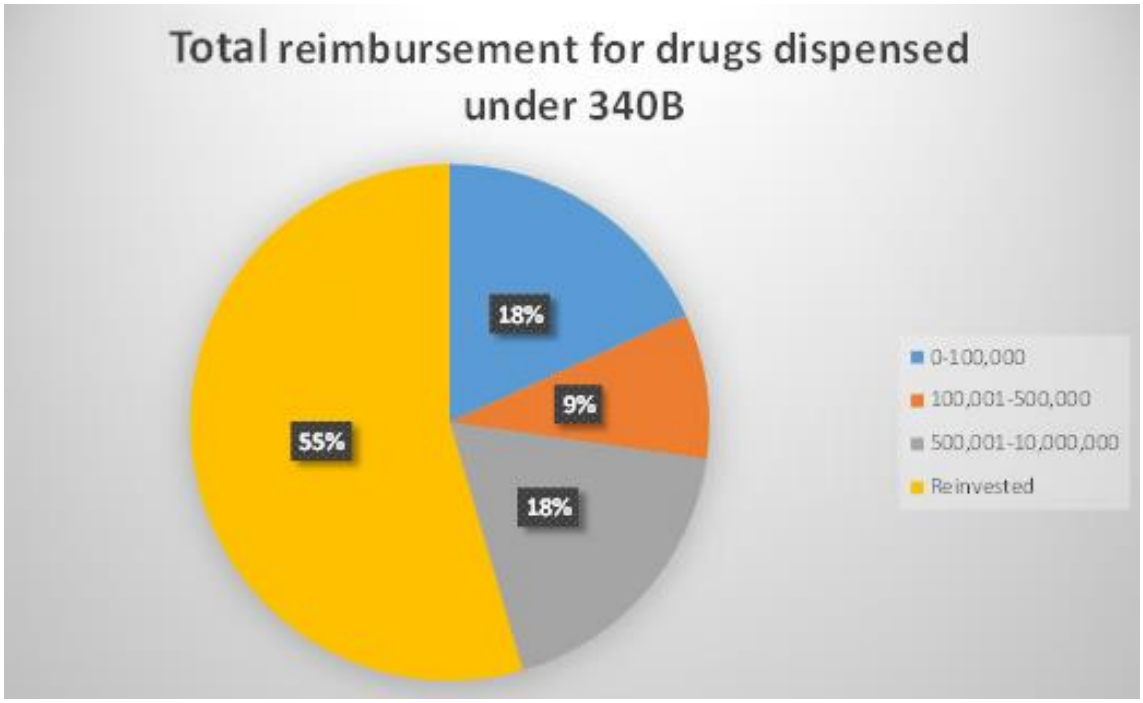

Figure 7 Estimated reimbursement ranges in dollars for potential reimbursement with drugs dispensed under 340B programs

Payers

Relevant information from payers is incorporated throughout the material packed based on the data submitted through the formal data call process. This includes details on the total cost of care for the disease, the cost and utilization of the prescription drug, the availability and formulary placement, therapeutic alternatives, as well as reported impacts to member costs.

The data provided through the carrier data call serves as a comprehensive source of payer input and reflects aggregate insights across participating organizations. No separate qualitative feedback or narrative statements were requested or received from individual payers for inclusion in the section.

Appendix

Stakeholder feedback:

Name of speaker	Association to drug under review	Drug	Format	Date	Exhibit website link
Anne Murray	Bristol Myers Squibb	Eliquis	Letter Speaker Letter Letter	5/21/2025 5/21/2025 7/13/2025 8/18/2025	Exhibit A Exhibit B Exhibit C Exhibit D
Sarah Hoffman	Partnership to Advance Cardiovascular Health	Eliquis	Letter	5/21/2025	Exhibit E
Sue Koob	Preventive Cardiovascular Nurses Association	Eliquis	Letter	7/14/2025	Exhibit F
John Mullin and board members	Oregon Coalition for Affordable Prescriptions	Eliquis	Letter	8/15/2025	Exhibit G