Oregon Prescription Drug Affordability Board

350 Winter Street NE, Salem, OR 97309-0405 | 971-374-3724 | pdab@dcbs.oregon.gov | dfr.oregon.gov/pdab

Agenda

This is a regular meeting. *Date*: **October 15, 2025** | *Time*: **8 a.m.**

This is a draft agenda and subject to change

Board Members:
Chair Shelley Bailey
Vice Chair Dr. Amy Burns
Dr. Daniel Hartung
Dr. Christopher Laman
John Murray
Dan Kennedy
Lauri Hoagland
Michele Koder

Meeting name	**Prescription Drug Affordability Board**
Meeting location	Virtual
Zoom link	Register for meeting

Staff: Sarah Young, executive director, Cortnee Whitlock, senior policy analyst; Stephen Kooyman, project manager, Heather Doyle, data analyst; Pei-Chen Choo, research analyst; Melissa Stiles, administrative specialist; Pramela Reddi, counsel

Purpose	Subject	Presenter
Informational and vote	Call to order and roll call	Chair Shelley Bailey
Informational	Board declarations of conflict of interest and meetings with entities or individuals related to board activities	Chair Shelley Bailey
Discussion and review	Board review of 8/20/2025 and 9/17/2025 minutes	Chair Shelley Bailey
Informational	PDAB program update	Chair Shelley Bailey, Sarah Young, executive director
Informational	General public comment: limited to 3 minutes	Chair Shelley Bailey
Review and discussion	Continued discussion about policy recommendations for inclusion in the 2025 annual legislative report	Cortnee Whitlock
Review and discussion	Continued discussion about methodology for drug reviews and scoring rubric and worksheet	Cortnee Whitlock

Review and discussion	**Drug review: Insulin Glargine - Basaglar KwikPen, Insulin Glargine-yfgn, Lantus, Lantus SoloStar, Semglee, Toujeo Max SoloStar, and Toujeo SoloStar** [1]	Staff
Break	The board will take a break around 10:20	Chair Shelley Bailey
Informational	Announcements	Vice Chair Amy Burns
Vote	Adjournment	Vice Chair Amy Burns

Accessibility

Anyone needing assistance due to a disability or language barrier can contact Melissa Stiles at least 48 hours ahead of the meeting at pdab@dcbs.oregon.gov or 971-374-3724. American sign language will be available during the October 15 board meeting.

How to provide testimony to the board

The Prescription Drug Affordability Board invites people to provide testimony. **Oral:** To speak to the board during the public comment portion of the agenda, please submit the **PDAB public comment form** no later than 24 hours before the PDAB meeting. **Written:** to provide written comments to the board, please submit the **PDAB public comment form** with attachments no later than 48 hours before the PDAB meeting. The board reviews all written comments. All written comments are posted on the website.

Open and closed sessions

All board meetings except executive sessions are open to the public. Pursuant to ORS 192.660, executive sessions are closed to everyone but board members, designated staff, and members of the news media. No action will be taken in executive session. Members of the media are directed not to report on or otherwise disclose anything said during executive session.

[1] The board is conducting drug reviews per ORS 646A.694 and OAR 925-200-0020. There will be a public comment period for the prescription drug selected for cost review. Each speaker will have 3 minutes. Board members may have follow-up questions for the speakers. The board chair has the discretion to extend a speaker's time. The board will hear from patients, caregivers, and individuals with scientific or medical background, per ORS 646A.694(3).

Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board (PDAB) Regular Meeting
Wednesday, September 17, 2025
Draft Minutes

Web link to the meeting video: https://youtu.be/euiMktuaQMw
Web link to the meeting materials: https://dfr.oregon.gov/pdab/Documents/20250917-PDAB-document-package.pdf

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Call to order: Chair Shelley Bailey called the meeting to order at 8:04 a.m. and roll was called.
Board members present: Chair Shelley Bailey, Vice Chair Amy Burns, Lauri Hoagland, Dan Kennedy, Chris Laman, John Murray
Absent: Dan Hartung

Chair Bailey announced the board would provide American Sign Language during the meeting. View at video minute 00:00:42.

Declaration of conflict of interest, meetings with entities or individuals related to board activities, or testifying before the Legislature: John Murray provided a statement. View at video minute 00:01:09.

Approval of board minutes: John Murray made a motion to approve the minutes as shown on Pages 3-5 of the agenda materials and Dan Kennedy provided a second. In the vote, two board members abstained because they did not attend the meeting so the motion failed. (Five votes are needed to pass a motion.) Chair Bailey asked staff to put the Sept. 17 minutes on the Oct. 15 agenda for approval next month. View at video minute 00:03:38.

MOTION to approve the Aug. 20, 2025, minutes
Board Vote:
Yes: Dan Kennedy, Chris Laman, John Murray, Chair Shelley Bailey
Abstain: Lauri Hoagland, Vice Chair Amy Burns
Absent: Dan Hartung
Motion failed 4-0

PDAB program update: Cortnee Whitlock, PDAB senior policy analyst, provided a program update. View at video minute 00:05:32.

General public comment: Chair Bailey called on the people who signed up in advance to speak to the board: Primo Castro, Biotechnology Innovation Organization (BIO), Lorren Sandt, Caring Ambassadors, Jessica McBride, Oregon Coalition for Affordable Prescriptions, Dharia McGrew, PhRMA, Vanessa Lathan, PIC, LuGina Mendez-Harper, Prime Therapeutics, and Derek Flowers, Value of Care Coalition. The board received 12 written comments, which are posted on the PDAB website. View at video minute 00:08:36.

Board discussion: volunteered trade secret information: Cortnee Whitlock, senior policy analyst, led the board in this discussion. View the slide presentation on **Pages 6-13**. View the discussion at video minute **00:32:45**.

Board discussion: policy recommendations for including in the 2025 annual legislative report: Cortnee Whitlock, senior policy analyst, led the board in this discussion. View the slide presentation on **Pages 14-23**. View the discussion at video minute **01:02:09**.

Board review of methodology for drug reviews and scoring rubric and worksheet: Cortnee Whitlock, senior policy analyst, led the board in the discussion about the drug review roadmap and the rubric and worksheet. View the slide presentation on **Pages 24-32**. View the discussion at video minute **01:33:23**.

Drug review for Jardiance - Antidiabetics: The board began discussions about drug reviews. View the Jardiance report on **Pages 33-65** posted on the PDAB website. View the discussion at video minute **01:47:34**.

Drug review for Mounjaro – Antidiabetics: The board continued the discussions about drug reviews. View the Mounjaro report on **Pages 66-98**. View the discussion at video minute **02:07:12**.

Drug review for Ozempic - Antidiabetics: The board continued the discussions about drug reviews. View the Ozempic report on **Pages 99-136** posted on the PDAB website. View the discussion at video minute **02:23:14**.

Drug review for Rybelsus –Antidiabetics: The board continued the discussions about drug reviews. View the Rybelsus report on **Pages 137-168** posted on the PDAB website. View the discussion at video minute **02:46:50**.

Drug review for Trulicity –Antidiabetics: The board continued the discussions about drug reviews. View the Trulicity report on **Pages 169-201** posted on the PDAB website. View the discussion at video minute **02:54:37**.

Drug review public comment periods: Chair Bailey read the list of letters about specific drugs under review. No one signed up to speak for the drug review public comment period of Sept. 17. See tables below for list of public comments.

Announcements: Chair Bailey announced the next meeting will be Oct. 15, 2025, at 8 a.m.

Adjournment: Chair Bailey adjourned the meeting at 11:30 a.m. with all board members in agreement. View at minute **03:24:08**.

Table of public comment speakers

Name of speaker	Association to drug under review	Drug	Format	Date	Exhibit website link
Stacie Phan	Boehringer Ingelheim	Jardiance	Letter	5/21/2025	Exhibit A
Dr. Harry Gewanter	Let My Doctors Decide Action Network	Jardiance	Letter	9/15/2025	Exhibit B
Jennifer Hazen	Patient	Jardiance	Letter	9/15/2025	Exhibit C
Suzanna Masartis	Community Liver Alliance	Mounjaro	Letter	5/12/2025	Exhibit D
Cynthia Ransom	Eli Lilly	Mounjaro	Letter	4/25/2025	Exhibit E
Carol Elkins	Retired, patient	Mounjaro	Letter	6/3/25	Exhibit F
Dr. Harry Gewanter	Let My Doctors Decide Action Network	Mounjaro	Letter	9/15/2025	Exhibit G
Mary Anne Cooper	Regence BlueCross BlueShield	Mounjaro	Letter	9/12/2025	Exhibit H
Jennifer Hazen	Patient	Mounjaro	Letter	9/15/2025	Exhibit I
Suzanna Masartis	Community Liver Alliance	Ozempic	Letter	5/12/2025	Exhibit J
Carol Elkins	Retired, patient	Ozempic	Letter	6/18/25	Exhibit K
Dr. Harry Gewanter	Let My Doctors Decide Action Network	Ozempic	Letter	5/15/2025	Exhibit L
Mary Anne Cooper	Regence BlueCross BlueShield	Ozempic	Letter	9/12/2025	Exhibit M
Suzanna Masartis	Community Liver Alliance	Rybelsus	Letter	5/12/2025	Exhibit N
Dr. Harry Gewanter	Let My Doctors Decide Action Network	Rybelsus	Letter	9/15/2025	Exhibit O
Mary Anne Cooper	Regence BlueCross BlueShield	Rybelsus	Letter	9/12/2025	Exhibit P
Suzanna Masartis	Community Liver Alliance	Trulicity	Letter	5/12/2025	Exhibit Q
Cynthia Ransom	Eli Lilly	Trulicity	Letter	4/25/2025	Exhibit R
Dr. Harry Gewanter	Let My Doctors Decide Action Network	Trulicity	Letter	5/15/2025	Exhibit S
Mary Anne Cooper	Regence BlueCross BlueShield	Trulicity	Letter	9/12/2025	Exhibit T

Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board (PDAB) Regular Meeting
Wednesday, August 20, 2025
Draft Minutes

Web link to the meeting video: https://youtu.be/wAl1u10eAM4
Web link to the meeting materials: https://dfr.oregon.gov/pdab/Documents/20250820-PDAB-document-package.pdf

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Call to order: Chair Shelley Bailey called the meeting to order at 9:00 a.m. and roll was called.
Board members present: Chair Shelley Bailey, Dan Hartung, Dan Kennedy, Chris Laman, John Murray
Absent: Vice Chair Amy Burns, Lauri Hoagland

Declaration of conflict of interest, meetings with entities or individuals related to board activities, or testifying before the Legislature: John Murray provided a statement. View at video minute **00:00:38**.

Approval of board minutes: Chair Bailey asked for a motion and second to approve the board minutes as shown on **Pages 3-8** of the agenda materials. Dan Kennedy made a motion to approve the minutes and John Murray provided a second. View the vote at video minute **00:01:44**.

MOTION to approve the July 16, 2025, minutes
Board Vote:
Yes: Dan Hartung, Dan Kennedy, Chris Laman, John Murray, Chair Shelley Bailey
No: None
Absent: Vice Chair Amy Burns, Lauri Hoagland
Motion passed 5-0

Executive session for legal advice pursuant to ORS 192.660(2)(f): The board adjourned to executive session. No decisions were made in closed session. View at video minute 00:02:48 The board returned to open session and called roll to confirm a board quorum. View at video minutes 00:03:45.

PDAB program update: Cortnee Whitlock, PDAB senior policy analyst, provided a program update. View the video at minute **00:04:12**.

General public comment: Chair Bailey called on the people who signed up in advance to speak to the board: Lorren Sandt, Caring Ambassadors, Ranier Simons, CANN, Tiffany Westrich-Robertson, EACH/PIC Coalition, Dharia McGrew, PhRMA, Derek Flowers, Value of Care Coalition, Silas Martin, Johnson and Johnson, Jessica McBride, OCAP.
The board received 12 written comments, which are posted on the **PDAB website**. View the speakers at video minute **00:06:00** and **00:30:14**.

Board review of methodology for drug reviews and scoring rubric and worksheet: Cortnee Whitlock, senior policy analyst, led the board in a discussion about the drug review process. View the slide presentation on **Pages 6-17**. View the discussion at video minute **00:23:43**.

Round 2 drug reviews: The board began discussions about drug reviews for Trelegy, Eliquis, Xarelto, Cosentyx, and Creon.

Drug review for Trelegy - Antiasthmatic and bronchodilator: View the Trelegy report on **Pages 18-46** posted on the PDAB website. View the discussion at video minute **01:27:34**. View the public comment for Trelegy at **01:27:47**.

Drug review for Eliquis – Anticoagulants: View the Eliquis report on **Page 48-79**. View the discussion at video minute **02:06:26**. View the public comment for Eliquis at **02:06:39**.

Drug review for Xarelto – Anticoagulants: View the Xarelto report on **Pages 80-110**. View the discussion at video minute **02:24:19**. View the public comment for Xarelto at **02:24:19**.

Drug review for Cosentyx - Dermatological: View the Cosentyx report on **Page 111-144**. View the discussion at video minute **02:43:33.** View the public comment for Cosentyx at video minute **02:55:14.**

Drug review for Creon –Digestive Aids: View the Creon report on **Pages 145 - 175**. View the discussion at video minute **02:58:51**. View the public comment for Creon at video minute **02:59:08**.

Drug review public comment periods: Chair Bailey announced public comment periods for people who signed up in advance to speak specifically about the drugs under review. The chair also read the list of letters received regarding the drugs under review. See table below for list of public comment speakers.

Announcements: Chair Bailey announced the next meeting will be Sept. 17, 2025, at 8 a.m. View at video minute **03:10:52**.

Adjournment: Chair Bailey adjourned the meeting at 11:30 a.m. with all board members in agreement. View at minute **03:11:01**.

Oregon Prescription Drug
Affordability Board

Prescription Drug Affordability Board

2025 policy recommendations

Oct. 15, 2025

2022 PDAB policy recommendations

PDAB recommendation	Legislative action
Implement upper payment limit (UPL).	Senate Bill 192 (2023): PDAB will develop a plan to implement UPL. Notes: PDAB submitted UPL report to the Oregon Legislature 12/2024. PDAB alternates became full members 9/2023.
Require pharmacy benefit managers (PBMs) and group purchasing organizations (GPOs) to report aggregated rebates and other payments from manufacturers annually to DPT.	Senate Bill 192 (2023): directs the state to begin collecting information from PBMs.
Require manufacturers to report to DPT annually on all patient assistance programs they maintain or fund.	Senate Bill 404 (2023) did not move out of committee.
Require all state regulated health insurance carriers in Oregon to report to the DPT program.	Senate Bill 404 (2023) did not move out of committee.
Require patient advocacy organizations to publicly disclose funding sources.	No action.

2023 PDAB policy recommendations

PDAB recommendation	Legislative action
Lower insulin co-pay limit to $35 and/or decouple from inflation index.	Senate Bill 1508 (2024): Legislature passed a bill that caps the cost of insulin at $35 a month and limits the cost to $105 for a 90-day supply.
Expand PBM report requirements for more transparency.	Senate Bill 192 (2023): directs the state to begin collecting information from PBMs. Notes: DCBS received its first batch of information in June 2024 from 59 companies operating in Oregon. The information included total rebates, fees, price protection payments, other payments from manufacturers related to managing benefits for insurance companies in Oregon, rebate amounts passed on to insurers, patients, and rebate amounts retained by PBMs.
Change Oregon's statute language regarding substitution requirements for biological products and biosimilars, updating ORS 689.522.	No action.

2024 PDAB policy recommendations

PDAB recommendation	Legislative action
Senate Bill 844 cleanup: • Language change from 9 drugs a year for affordability reviews to up to 9 drugs a year. • Remove requirement that DCBS provide PDAB with a list of prescription drugs each quarter. • Replace the generic drug report annual requirement with a new provision that relevant content would be incorporated into the affordability review report.	Senate Bill 289 (2025): Signed by the governor May 27, 2025, will implement three housekeeping changes for PDAB on behalf of DCBS, effective Jan. 1, 2026.
Expand patient assistance programs reporting to the Drug Price Transparency Program (DPT).	No action.
Require pharmacy benefit managers and insurers to report on copay accumulators and maximizers to the DPT Program Implement mandatory reporting on copay.	No action.
Require payers to provide a pharmacy dispensing fee equal to or greater than the dispending fee used in Oregon's medical assistance programs. • Require reimbursement of the dispensing fee.	No action.
Require Oregon Health Plan FFS and coordinated care organizations to purchase through a statewide purchasing group.	No action.
Extend Oregon Health Plan's preferred drug list for all classes of prescription drugs.	No action.

2025 policy concepts for discussion

From John Murray, RPh
1. Eliminate spread pricing in Medicaid and Managed care programs. All patients would benefit from this.
2. Base reimbursement drug cost figures on objective, verifiable data sources, not PBM owned and managed lists which can be manipulated for increased PBM profitability.
3. Work toward the ability to use NADAC cost basis in Oregon (this may require a constitutional change).
4. Delink PBM fees from the price of a drug or other fees/rebates and instead institute service fees for PBMs. This will remove an incentive for PBMs to prefer high-priced drugs, saving money for taxpayers and on insurance premiums.
5. Allow any willing pharmacy provider to participate, which would require plans to contract with any pharmacy that wants to join their network.

2025 policy concepts for discussion

From John Murray, RPh
6. Increase commercial PBM transparency.
7. Institute one PBM for all Medicaid and managed care patients in Oregon, to be selected through a bid process which emphasizes efficiency, reduced tax-payer costs, access for all Oregonians and maximum transparency.
8. Outlaw the PBM requirement that pharmacies must contractually dispense medications below their cost to dispense.
9. Base pharmacy reimbursement on an objective, verifiable cost figure plus percentage plus the OHA Medicaid dispensing fee schedule.
10. Institute and use upper payment limits ONLY if all other changes of drug delivery system and its economics fail. For two reasons, one, UPLs at the federal level are causing serious concerns about negative impacts to the already fragile system and, yet again, PBMs cannot be the only ones who come out whole should they be implemented.
11. Expand PDAB focus to allow PDAB to have authority to provide further review of the drug delivery system in Oregon. (suggested at Sept. board meeting)

2025 policy concepts for discussion

From Dr. Dan Hartung, PharmD, MPH
1. Medicaid single state-wide PBM and/or uniform preferred drug list (PDL) A single PBM or uniform PDL would reduce administrative burden for patients and providers through the advancement of uniform and consistent coverage policies across all 16 CCOs. A unform PDL/single PBM model would also improve opportunities for larger supplemental rebates. Finally, single PBM model could adopt the reimbursement arrangements (e.g. FFS reimbursement approach) that are sustainable for pharmacy providers in the state.
2. Audit of 340B entities Following up on the report from Minnesota, Oregon could benefit from greater transparency in its 340B program. The report could answer questions like these. What is the total economic impact of the 340B program to eligible entities in the state? What institutions are garnering the largest economic impact and what types of patients do they serve? What payer types are providing these revenue (e.g. Medicare, commercial, Medicaid)? To what extent does the state forego rebate dollars because of 340B discounts provided to Medicaid?

2025 policy concepts for discussion

From Board Chair Shelley Bailey, MBA
1. Cost Plus reimbursement for public employees: states with such programs include Montana, Colorado, New Mexico, Iowa, Arkansas, West Virginia, Kentucky, Tennessee, Alabama, Georgia, with legislation in Illinois, Ohio, and Pennsylvania.
~~**2.** Public sector benefit program for reverse auctions.~~
3. Vermont law S.30 (2025) – Pages 9-13 reference conflicts for health insurance brokers for contracts that involve rebates. Read S.30 (2025) text here: https://legislature.vermont.gov/Documents/2026/Docs/ACTS/ACT011/ACT011%20As%20Enacted.pdf.
4. Medicaid managed care Rx based pass through states with single managed Medicaid for pass through: Ohio, Kentucky, Louisiana, Mississippi. Fifteen states with MCO cost plus mandate: Nevada (2026), New Mexico (2024), Nebraska (2024), Kansas (2013), Oklahoma (2024), Minnesota (2027), Iowa (2016), Louisiana (2017), Mississippi (2017), Michigan (2021), Ohio (2022), Kentucky (2021), Georgia (2023), North Carolina (2022), Virginia (2026).

2025 policy concepts for discussion

From Board Chair Shelley Bailey, MBA
5. All drugs fee for service: Alaska, Idaho, Montana, Wyoming, Colorado, South Dakota, Wisconsin, Missouri, Arkansas, Tennessee, Alabama, Vermont, Maine.
6. Full drug carve out States that went “back” to FFS: California (2022), North Dakota (2019), West Virginia (2017), New York (2023).
7. Point of sale rebates – Like West Virginia referenced in the 2024/2025 report to the Oregon Legislature.
8. Previous suggestions from UPL report to legislature 2024/2025 pages 26-28. Read the suggestions here: https://dfr.oregon.gov/pdab/Documents/reports/PDAB-upper-payment-limit-report-2024.pdf#page-26

2025 policy concepts for discussion

From Dan Kennedy, RPh
1. Make a single pharmacy benefit manager (PBM) responsible for all state adjudication of claims and payments to pharmacies, with a mandated dispensing fee that would reimburse pharmacies appropriately. Include CCOs in this.

2025 policy concepts for discussion

Board members

Exemption under the Public Meetings Law (ORS 192.660(4)) from having media present at executive sessions so the board can review trade secret information in private.

Background: Oregon Public Meetings Law allows media members to attend executive sessions. Media members are allowed to attend but are restricted from reporting on information in executive session. During the September board meeting, members discussed the risks of receiving trade secret information in executive sessions when media members are present. Board members discussed a legislative policy recommendation to amend ORS 192.660(4) so that media are not permitted at executive sessions of PDAB meetings where trade secret information is reviewed.

ORS 192.660(4) *Representatives of the news media shall be allowed to attend executive sessions other than those held under subsection (2)(d) of this section relating to labor negotiations or executive session held pursuant to ORS 332.061 (2) [which concerns students] but the governing body may require that specified information be undisclosed.*

2025 policy concepts for discussion

From Vice Chair Amy Burns, PharmD
1. Disband the Oregon PDAB and suggest the Legislature consider alternative initiatives to address prescription drug affordability.
2. Expand PDAB scope to study the drug delivery system in Oregon. (suggested at Sept. board meeting)

Oregon Prescription Drug Affordability Board

Table of public comment letters and speakers for Group 2 drugs

Name of speaker	Association to drug under review	Drug	Format	Date	Exhibit website link
Harmeet Dhillon	GSK	Trelegy	Letter	5/21/2025	Exhibit A
Linda Nelson	Oregon Coalition for Affordability Prescriptions	Trelegy	Letter	5/21/2025	Exhibit B
Molly Burich	GSK	Trelegy	Letter	8/15/2025	Exhibit C
Tom Corbridge	GSK	Trelegy	Speaker	8/20/2025	Exhibit D
Anne Murray	Bristol Myers Squibb	Eliquis	Letter Speaker Letter Letter	5/21/2025 5/21/2025 7/13/2025 8/18/2025	Exhibit E Exhibit F Exhibit G Exhibit H
Sarah Hoffman	Partnership to Advance Cardiovascular Health	Eliquis	Letter	5/21/2025	Exhibit I
Sue Koob	Preventive Cardiovascular Nurses Association	Eliquis	Letter	7/14/2025	Exhibit J
John Mullin and board members	Oregon Coalition for Affordable Prescriptions	Eliquis	Letter	8/15/2025	Exhibit K
Sarah Hoffman	Partnership to Advance Cardiovascular Health	Xarelto	Letter	5/21/25	Exhibit L
Silas Martin	Johnson & Johnson	Xarelto	Speaker	5/21/25	Exhibit M
Michael Valenta	Johnson & Johnson	Xarelto	Letters	3/30/25 6/16/25 8/14/25	Exhibit N Exhibit O Exhibit P
Sue Koob	Preventive Cardiovascular Nurses Association	Xarelto	Letter	7/14/25	Exhibit Q
Lisa Pulver	Johnson & Johnson	Xarelto	Speaker	8/20/25	Exhibit R
Courtney Piron	Novartis	Cosentyx	Letters	5/1/2025 8/12/2025	Exhibit S Exhibit T
Gabrielle Draper	Derma Care Access Network	Cosentyx	Letter	8/17/2025	Exhibit U
Kim Sanders	OHSU	Cosentyx	Letter	8/17/2025	Exhibit V
Tiffany Westrich-Robertson	Patient living with arthritis and on Cosentyx for four years	Cosentyx	Speaker	8/20/2025	Exhibit W
Albert Faro et al	Cystic Fibrosis Foundation	Creon	Letter	5/21/2025	Exhibit X
Lindsay Silva	Mother/primary care giver to someone living with Cystic Fibrosis	Creon	Speaker	5/21/2025	Exhibit Y

Note: See 'Glossary & Definitions' and 'Methodology & Version Control' tabs for standard terminology, data sources, and scoring rationale (updated October 2025).

Domain	Score 0 (Low Impact)	Score 1 (Moderate Impac	Score 2 (High Impact)	Score 3 (Severe Impact)
Equity impact & considerations	No disparities; widely preferred	Minor disparities; May affect underserved populations	Clearly identified disparities; significant impact on marginalized groups	Strong evidence of disparities; interventions to reduce inequities are lacking or nonexistent.
Access	Minimal access barriers	Modest impact on access 25%-49% plans listed drug as non-preferred; prior auth for <25% plans	50%-74% plans listed drug as non-preferred; prior auth/step therapy >25%	75%-100% plans listed drug as non-preferred; majority of plans require prior auth/step therapy or over 50% denied prior-auth
Utilization	25,000 or more patients on drug reported in APAC	10,000 to 24,999 patients on drug reported in APAC	3,000 to 9,999 patients on drug reported in APAC	Less than 2,999 patients on drug reported in APAC
Price evaluation	Stable WAC changes or rising below inflation for five years; minimal divergence from net spend	Average percent change in WAC between 0% to 3.99% for four years; out paces inflation four years	Average percent change in WAC between 4% to 4.99% for three years; out paced inflation for three year	Average percent change in WAC between >5%; Outpaced inflation for four or more years
Price concessions (PC)	High percent of rebate or PC; net spend substantially reduced	50-75% of discounted; net spend modestly reduced	25-50% claims discounted; moderate payer relief	<25% of claims receive concessions; negligible payer relief
System & payer spend	Low total gross spend (<$10M); costs evenly spread across payers	Total gross spend $10M-$15M and total net spend <$3M	Total gross spend $15M-$50M and total net spend $3M-$10M	Total gross spend >$50M and total net spend >$10M

Domain	Score 0 (Low Impact)	Score 1 (Moderate Impac	Score 2 (High Impact)	Score 3 (Severe Impact)
Enrollee burden	Total APAC OOP annual cost of < $200	Total APAC OOP annual cost $200-$700	Total APAC OOP $700-$1,200	Total APAC OOP >$1,200; drug excluded
Therapeutic alternatives	Alternatives available; has a large number of TA/TE/Biosim	Somewhat more costly/effective; similar access; subject Rx has six or more TA/TE/Biosim	More expensive alternatives; subject Rx has 2-6 TA/TE/Biosim	No effective/affordable alternatives; subject drug has one or no TA/TE/Biosim
Specified stakeholder input	No concerns raised; positive feedback or minimal stakeholder input	Mixed views; moderate financial concerns noted	Significant concerns from providers/patients re: cost/affordability	Broad concern or consistent reports of high burden from multiple groups
Patent expirations	Patent expired or generic/biosimilars is available and accessible; Multiple competitors in the market or therapeutic class.	Patent expired but market entry of generic/biosimilars were delayed (e.g. die to regulatory hurdles, legal tactics, or market barriers; Limited cost relief observed.	Patent is expiring in 18 months but manufacturer is actively seeking exclusivity extensions (e.g. patent evergreening, pediatric extensions, or chemical/device tweaks)	Patent expired; manufacturer has taken legal or structural steps to prevent competition. Sustained high pricing.
Maximum Fair Price (MFP)	Drug has an established CMS MFP and the current market price aligns withing 5%. Evidence the manufacturer is adopting the fair price across all markets	Drug has an MFP but current pricing is modestly above the MFP 5-20%.	The drug has an MFP and currently pricing is 20-40% about fair price estimates	No MFP or current market price is more than 40% above available fair price benchmarks.

Term	Definition	Source / Rationale
Minor	Quantitative change <10% from baseline or qualitative impact affecting <25% of patient population.	PDAB / Based on APAC and Data Call utilization data trends.
Moderate	10–25% change or impact on 25–50% of population.	PDAB / Based on APAC and Data Call utilization data trends.
Significant	>25% change or affecting >50% of population.	PDAB / Based on APAC and Data Call utilization data trends.
Equity disparity	Quantified difference in utilization or adherence across race/ethnicity or socioeconomic strata.	PDAB rule 925-200-0200(1)(a).
Gross spend	The total cost of the drug before price concessions, rebates, or discounts as reported in the data call by carriers to the Drug Price Transparency program	PDAB
Net cost	Cost after manufacturer rebates, PBM discounts, and price concessions.	PDAB
Median OOP	Median enrollee out-of-pocket cost, representing typical patient burden.	PDAB / Preferred over mean to avoid bias from outliers.
IQR	Interquartile Range — measure of how spread out the data is; it is equal to the difference between the 75th and 25th percentiles	Math.net / Standard statistical measure for data distribution.
Payer Relief	Reduction in total payer cost due to rebates, discounts, or concessions.	PDAB / Economic interpretation aligning with CMS cost frameworks.

Category	Details
Version	v3.0 – Updated based on public comment feedback.
Date Revised	October 2025
Prepared By	PDAB Staff – Data & Policy Team
Purpose	To improve consistency, clarity, and transparency of affordability scoring rubric.
Key Updates	1. Added Glossary & Definitions. 2. Separated Access and Equity domains. 3. Added rationale and data source columns to all domains. 4. Shifted from average to median for enrollee burden. 5. Included IQR definition and standardization. 6. Added methodology documentation section. 7. Created formal version control for audit tracking.
Disclaimer	Scoring rubric is a decision support tool and not determinative of affordability outcomes.

Domain	Statutory* and Rule** References	Packet section	Key questions
Impact & equity considerations	*(2)(a) **(1)(a)-(b)	Health inequities; Residents prescribed; Relative financial impacts to health, medical or social services costs	• Are specific populations disproportionately affected (e.g. racial disparities, Medicaid reliance)? • How many Oregonians are using this drug, and through which payer line?
Access		Impact on patient access to the drug;	• Is the drug non-preferred or subject to access barriers (e.g., prior authorization, step therapy)?
Price evaluation	*(2)(e) **(1)(c)	Price for the drug	• Has the WAC increased above inflation? • Are pharmacy acquisition costs or net costs diverging from WAC?
Price concessions[1]	*(2)(d) & (L) **(1)(d), (e) & (g)	Estimated average monetary price concessions; Estimated total amount of the price concessions; Estimated average price concession for therapeutic alternatives	• What percentage of claims receive discounts? • How do concessions affect net payer costs? • Are concessions for alternatives better or worse?
System & payer costs	**(1)(h)	Estimated costs to health insurance plans; Relative financial impacts to health, medical or social services costs	• What is the annual cost burden on Medicaid, Medicare, and commercial insurers? • How concentrated is use in one line of business?
Enrollee burdens	*(2)(g) & (j) **(1)(i) & (k)	~~Impact on patient access to the drug;~~ Estimated average enrollee copayment or other cost-sharing; ~~Access and equity considerations~~	• Are enrollees facing high OOP costs with the drug? • ~~Is the drug non-preferred or subject to access barriers (e.g., prior authorization, step therapy)?~~
Therapeutic alternatives	*(2)(c) & (i) **(1)(f), (g), (j)	Estimated price for therapeutic alternatives; clinical information based on mfr material.	• Are there more affordable alternative that are equally or more effective? • Do those alternatives have fewer access restrictions?
Specified stakeholder input	*(3) **(2)(k)	Input from stakeholders	• What do patients and providers report about the affordability or access of the drug? • Are there unique cost burdens or value perceptions?
Patent expirations			• Are there expected date for loss of exclusivity? • Have generics or biosimilars launched? Are they meaningfully priced lower? • Is manufacturer seeking patent extensions?

Domain	Statutory* and Rule** References	Packet section	Key questions
			• Any active lawsuits or FDA delays that stall generic entry? • Is the market monopolized due to lack of competition?
Maximum Fair Price (MFP)			• Is an MFP currently established for the drug? • How does the current market price compare to the MFP?

* All references are to ORS 646A.694.

**All references are to OAR 925-200-0020.

~~1.~~ Scoring Framework Overview

Drug is assigned a **0–3 scale** for each domain, where:

Score	Interpretation
0	Minimal impact
1	Moderate impact
2	High impact
3	Severe impact

Apply 0-3 scale to each statutory domain (e.g., cost to payers, OOP burden, price trends) based on predefined criteria drawn from materials.

Total score of ~~21~~30

Suggested interpretations: ~~0-6~~0-9 minimal impact; ~~7-13~~10-19: moderate impact; ~~14-21~~20-30 high impact

~~2. Sample Metrics:~~

[1] Discounts: upfront reduction from the list price of a drug at the time of sale. Rebates: a retroactive payment from the manufacturer to a purchaser or payer (PBM or payer) after the drug is purchased and dispensed. Price concession: Encompasses any form of price reduction or adjustment provided by manufacturer, which may include discounts, rebates, chargebacks, and other negotiated reductions.

If a drug has total APAC cost of $38M, with 4.6% chang in the average price of WAC for three or more years, had 85% of reporting healthcare plans listing as non-preferred, 42% of claims discounted, two TAs, with enrollee OOP cost between APAC reported commercial and Medicare being $1,182, and patient surveys indicating a moderate financial concern, the scoring would look as followed:

Domain	Based on	Score
Access and equity considerations	85% of reporting healthcare plans listing as non-preferred	3
Price evaluation	WAC raised at an average annual rate of 4.6 percent	2
Price concessions	42% of claims included some form of price concessions	2
System & payer costs	Total cost: $38M	2
Enrollee burden	OOP reported APAC costs per enrollee for commercial $800 and $382 for Medicare	3
Therapeutic alternative	Has 2 TA/TE/Biosim	2
Specified stakeholder input	Moderate financial concerns	2
TOTAL		**16**

With a score of 16 the example drug reviewed would indicate a high impact to the healthcare system or patient OOP costs.

Oregon Prescription Drug
Affordability Board

Prescription Drug Affordability Board

2025 drug review roadmap

Oct. 15, 2025

2025-2026 drug review (DR) & annual report calendar

	Sept 17 PDAB Mtg	Oct 15 PDAB Mtg	Nov 19 PDAB Mtg	Dec 17 PDAB Mtg	Jan 21, '26 PDAB Mtg	Feb 17, '26 PDAB Mtg	Mar 17, '26 PDAB Mtg
Rx Subset list **Insulin Subset list**	DR Group 3	DR Group 4	Board Rx discussion	Board Rx discussion	Board Rx decision		
Drug Review Report					Draft DR report	**Final DR report**	
Stakeholder RFI (Request for Information)	Survey open for drugs under review						
Recommendation	Board discussion	Board discussion			Board discussion	Board discussion	
Annual Report **Price trends, drug subset list, policy recommendations, progress report**			Draft annual report	**Final annual report**			

Review grouping number	Therapy class	Drug name	Non-proprietary name
1	Antipsychotics & Antimanic agents	Vraylar	Cariprazine HCl
1	Cardiovascular agents – misc.	Entresto	Sacubitril; Valsartan
1	Migraine product	Ajovy	Fremanezumab-vfrm
1	Migraine product	Emgality	Galcanezumab-gnlm
1	Migraine product	Nurtec	Rimegepant/rimegepant sulfate
1	Migraine product	Ubrelvy	Ubrogepant
2	Antiasthmatic and bronchodilator	Trelegy	Fluticasone furoate; Umeclidinum bromide; Vilanterol trifenatate
2	Anticoagulants	Eliquis	Apixaban
2	Anticoagulants	Xarelto	Rivaroxaban
2	Dermatological	Cosentyx	Secukinumab
2	Digestive Aids	Creon	Pancrelipase (Amylase; Lipase; Protease)

3

Review grouping number	Therapy class	Drug name	Non-proprietary name
3	Antidiabetics	Jardiance	Empagliflozin
3	Antidiabetics	Mounjaro	Tirzepatide
3	Antidiabetics	Ozempic	Semaglutide
3	Antidiabetics	Rybelsus	Semaglutide
3	Antidiabetics	Trulicity	Dulaglutide
4	Insulin product	Basaglar KwikPen	Insulin Glargine
4	Insulin product	Insulin Glargine-yfgn	Insulin Glargine
4	Insulin product	Lantus	Insulin Glargine
4	Insulin product	Lantus SoloStar	Insulin Glargine
4	Insulin product	Semglee	Insulin Glargine
4	Insulin product	Toujeo Max SoloStar	Insulin Glargine
4	Insulin product	Toujeo SoloStar	Insulin Glargine

Oregon Prescription Drug
Affordability Board

Email: pdab@dcbs.oregon.gov Phone: 971-374-3724 Website: dfr.oregon.gov/pdab

Insulin Glargine

Version 1.5

[1]

[1] Image source: insulin-glargine-injection-1676098733-6758309.jpg (146×304)

Table of contents

Document version history

Version	Date	Description
v1.0	10/07/2025	Original Release
v1.5	10/14/2025	Added new public comment to the appendix table.

Review summary

Review drugs

Proprietary name	Non-proprietary name	Manufacturer	On the CMS Drug Price Negotiation List
Basaglar Kwikpen	*Insulin Glargine*	Eli Lilly and Co.	No
Insulin Glargine-yfgn	*Insulin Glargine*		No
Lantus	*Insulin Glargine*	Sanofi Aventis US	No
Lantus SoloStar	*Insulin Glargine*	Sanofi Aventis US	No
Semglee	*Insulin Glargine*	Mylan Pharms Inc	No
Toujeo Max SoloStar	*Insulin Glargine*	Sanofi US Services	No
Toujeo SoloStar	*Insulin Glargine*	Sanofi US Services	No

Price history[2,3]

From 2018-2024, insulin glargine drugs rose at an **average annual rate** of:

- Basaglar Kwikpen: 0.0 percent
- Insulin Glargine-yfgn: -12.3 percent
- Lantus: -11.6 percent
- Lantus SoloStar: -11.6 percent
- Semglee: 28.8 percent
- Toujeo Max SoloStar: 2.4 percent
- Toujeo SoloStar: 2.4 percent

Price concessions [4]

Based on data received from healthcare carriers, the **highest gross spend for insulin glargine products per claim for commercial carriers was $1,086 for Toujeo Max SoloStar.** For the same

[2] Medi-Span. Wolters Kluwer, 2025. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.
[3] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.
[4] 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.

product, the net spend per enrollee was $796, resulting in the highest price concession reported by insurers of $290 per claim.

Cost to the payers[5]

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

Drug	Total Expenditure	Utilization	Cost per Enrollee	Cost per Enrollee, median
Basaglar Kwikpen	$31,978,029	87,066	$2,397	$315
Insulin Glargine-yfgn	$6,286,384	41,523	$616	$132
Lantus	$11,879,620	20,128	$2,391	$309
Lantus SoloStar	$44,425,416	77,732	$2,538	$429
Semglee	$7,231,623	14,678	$1,975	$380
Toujeo Max SoloStar	$10,209,919	8,844	$6,169	$1,040
Toujeo SoloStar	$8,469,424	11,559	$3,607	$513

Cost to enrollees[6]

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

Drug	OOP cost per enrollee	OOP cost per enrollee median	OOP cost per claim	OOP cost per claim median
Basaglar Kwikpen	$101	$0	$19	$0
Insulin Glargine-yfgn	$90	$21	$35	$4
Lantus	$191	$35	$46	$20
Lantus SoloStar	$208	$30	$46	$10
Semglee	$154	$2	$39	$0
Toujeo Max SoloStar	$280	$30	$56	$4
Toujeo SoloStar	$262	$35	$55	$22

[5] 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.

[6] Based on Oregon's 2023 All Payer All Claims (APAC) data across commercial insurers, 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.

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[7]

Drug proprietary name(s) (Manufacturer)	**Basaglar (Eli Lilly & Co.), Lantus (Sanofi Aventis), Toujeo (Sanofi), Semglee (Mylan pharms)**
Non-proprietary name	*Insulin glargine, insulin glargine-yfgn**
Treatment:	Insulin glargine is a long-acting recombinant insulin analog indicated to improve glycemic control in: • Type 1 diabetes • Type 2 diabetes
Dosage and strength	• Individualized dosage based on metabolic needs, blood glucose monitoring, glycemic control, type of diabetes, prior insulin use. • 100 units/ml or 300 units/ml±
Form/Route	Subcutaneous injection
*Approved as interchangeable biosimilars to Lantus ± Basaglar and Lantus are provided as 100 units/ml; Toujeo is provided as 300 units/ml	

FDA approval

	FDA Approval Date[8]	Expedited Forms of Approval?	Orphan Drug Act[9]
Basaglar Kwikpen	12/16/2015	No	No
Insulin Glargine-yfgn			
Lantus	04/20/2000	No	No
Lantus SoloStar	04/20/2000	No	No
Semglee	07/28/2021	No	No
Toujeo Max SoloStar	02/25/2015	No	No
Toujeo SoloStar	02/25/2015	No	No

[7] 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.

[8] 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.

[9] At time of review, the drug had approved designations or not 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.

Insulin glargine products are essential for diabetes patients, yet data shows that access to insulin is a persisting issue. Affordability, complicated insurance claims, and availability issues due to formulary changes have been associated with the problem, which disproportionately impacts lower-income patients.[10] Furthermore, minorities historically have less access to long term care needed for chronic disease management despite the higher prevalence of diabetes in these communities, especially American Indians and Alaskan Natives, Black, and Hispanic patients.[11] Obstacles like cost and lack of care further exacerbates issues of access for diabetes patients.

Residents prescribed

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

Based on APAC claims, here are the number of Oregonians who filled a prescription for the review drugs in 2023:[12]

Insulin	Oregonians
Basaglar Kwikpen	13,343
Insulin Glargine-yfgn	10,198
Lantus	4,968
Lantus SoloStar	17,503
Semglee	3,661
Toujeo Max SoloStar	1,655
Toujeo SoloStar	2,348

[10] William T. Cefalu, Daniel E. Dawes, Gina Gavlak, Dana Goldman, William H. Herman, Karen Van Nuys, Alvin C. Powers, Simeon I. Taylor, Alan L. Yatvin, on behalf of the Insulin Access and Affordability Working Group; Insulin Access and Affordability Working Group: Conclusions and Recommendations. Diabetes Care 1 June 2018; 41 (6): 1299–1311. https://doi.org/10.2337/dci18-0019. *See also* McEwan P, Evans M. The health economics of insulin therapy: How do we address the rising demands, costs, inequalities and barriers to achieving optimal outcomes. Diabetes Obes Metab. 2025; 27(Suppl. 5): 24-35. doi:10.1111/dom.16488.

[11] Hasan Nassereldine, Zhuochen Li, Kelly Compton, Parkes Kendrick, Ethan Kahn, Yekaterina O. Kelly, Mathew M. Baumann, Chris A. Schmidt, Dillon O. Sylte, Kanyin Liane Ong, Wichada La Motte-Kerr, Farah Daoud, Susan A. McLaughlin, Simon I. Hay, Erik J. Rodriquez, Anna M. Nápoles, George A. Mensah, Eliseo J. Pérez-Stable, Ali H. Mokdad, Laura Dwyer-Lindgren; The Burden of Diabetes Mortality by County, Race, and Ethnicity in the U.S., 2000–2019. Diabetes Care 20 March 2025; 48 (4): 546–555. https://doi.org/10.2337/dc24-2259 . *See also* National Diabetes Statistics Report. CDC Diabetes, Public Health, May 15, 2024. https://www.cdc.gov/diabetes/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.

[12]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.

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 insulin glargine products, 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). Together, the data provides a comprehensive view of insulin glargine's list price trajectory and pharmacy acquisition costs, and the degree to which the list price impacts costs.

Price history

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

Table 3 30-day supply for Review Drugs

	Basaglar Kwikpen	Insulin Glargine-yfgn	Lantus	Lantus SoloStar	Semglee	Toujeo Max SoloStar	Toujeo SoloStar
30-day supply	600 units	600 units	600 units	600 units	600 units	600 units	600 units

Table 4 2018-2024 WAC for review drugs per 30-day supply[13]

Year	Basaglar Kwikpen	Insulin Glargine-yfgn	Lantus	Lantus SoloStar	Semglee	Toujeo Max SoloStar	Toujeo SoloStar
2018	$13,054		$16,172	$16,172		$49,646	$49,645
2019	$13,054		$17,014	$17,012		$51,830	$51,829
2020	$13,054		$17,014	$17,012	$5,919	$51,830	$51,829
2021	$13,054	$5,919	$17,014	$17,012	$12,748	$51,830	$51,829
2022	$13,054	$5,919	$17,014	$17,012	$12,748	$51,830	$51,829
2023	$13,054	$5,919	$17,524	$17,522	$12,748	$54,422	$54,421
2024	$13,054	$3,729	$3,856	$3,856	$12,748	$57,143	$57,143
Avg. Annual % Change	0.0%	-12.3%	-11.6%	-11.6%	28.8%	2.4%	2.4%
% change 2018	0.0%		-76.2%	-76.2%		15.1%	15.1%

[13] Medi-Span. Wolters Kluwer, 2025. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.

Year	Basaglar Kwikpen	Insulin Glargine-yfgn	Lantus	Lantus SoloStar	Semglee	Toujeo Max SoloStar	Toujeo SoloStar
between 2024							

The WAC of the insulin products was based off one reported NDC. The exceptions were Lantus SoloStar, Semglee, and insulin glargine-yfgn, which were averaged across, two, three, and four NDCs reported respectively. The number of NDC's used to calculate each insulin product was determined by the NDC's reported from the carriers to Drug Price Transparency program. The most expensive insulin products, Toujeo SoloStar and Toujeo Max SoloStar, were approximately **$95.24 per unit** at the end of 2024.[14] The generic version of insulin glargine-yfgn was the least expensive with the average of $6.22 per unit at the end of 2024.[15] For the same product, between 2021-2024, the unit WAC decreased at an average annual rate of **-12.3 percent**. Moving in the other direction, between 2020-2024, the unit WAC of Semglee increased at an average annual rate of **28.8 percent**. The most notable increases in unit WAC, when comparing to the general consumer price index (CPI-U) inflation rate, occurred in 2018-2019, 2020-2021, and 2023-2024 (see Table 5).[16] Lantus, Lantus SoloStar, Toujeo Max SoloStar, and Toujeo SoloStar all had significant price increases from 2018-2019 that far outpaced the CPI-U. Between 2020 and 2021, Semglee had a 115.4% increase of unit WAC price, which is a stark contrast to the 5.3% inflation rate. However, from 2023-2024, insulin glargine-yfgn, Lantus, and Lantus SoloStar all had large unit WAC decreases.

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

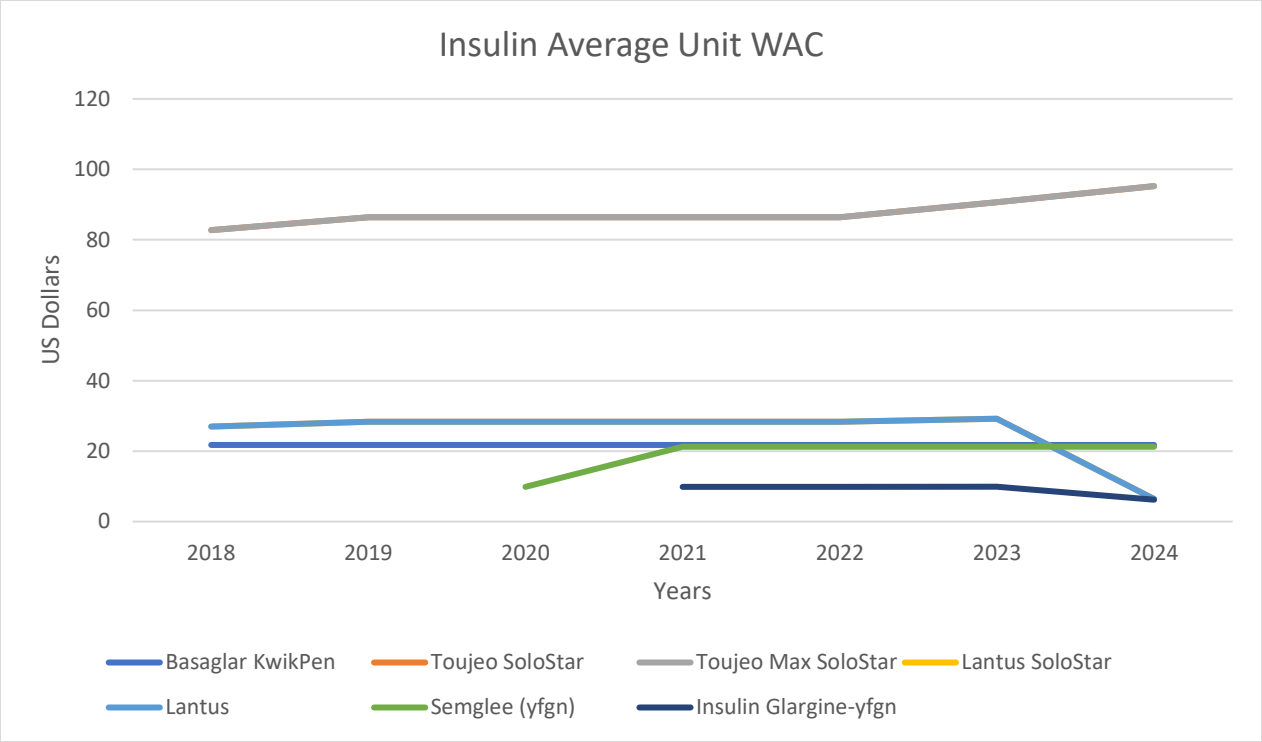

Figure 1 Insulin average unit WAC from 2018-2024[17]

Table 5 Percent change of WAC of review drugs with CPI comparison

Year	Basaglar Kwikpen	Insulin Glargine-yfgn	Lantus	Lantus SoloStar	Semglee	Toujeo Max SoloStar	Toujeo SoloStar	CPI-U
2018-2019	0.0%		5.2%	5.2%		4.4%	4.4%	1.7%
2019-2020	0.0%		0.0%	0.0%		0.0%	0.0%	0.7%
2020-2021	0.0%		0.0%	0.0%	115.4%	0.0%	0.0%	5.3%
2021-2022	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.0%
2022-2023	0.0%	0.0%	3.0%	3.0%	0.0%	5.0%	5.0%	3.1%
2023-2024	0.0%	-37.0%	-78.0%	-78.0%	0.0%	5.0%	5.0%	3.0%

[17] Toujeo SoloStar and Toujeo Max SoloStar have comparable numbers for average unit WAC; therefore, their lines are overlapping with Toujeo SoloStar residing behind Toujeo Max SoloStar.

Pharmacy acquisition costs

The AAAC, which reflects pharmacies' actual purchase prices for Medicaid fee-for-service claims, is consistently lower across insulin glargine products when compared to the unit WAC, except for Semglee. Four insulin glargine products were found in the AAAC data and are listed below in Table 6.

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 drug price trajectory relative to inflation and affordability for public and private payers.

Table 6 2020-2024 AAAC Medicaid FFS quarterly purchase prices for review drugs

Proprietary Name	Cost	2020	2021	2022	2023	2024
Lantus	Annual AAAC Avg	$27.16	$27.19	$27.23	$28.06	$6.17
	Avg Unit WAC	$28.36	$28.36	$28.36	$29.21	$6.43
Semglee	Annual AAAC Avg			$26.12	$26.03	$25.98
	Avg Unit WAC	$9.87	$21.25	$21.25	$21.25	$21.25
Toujeo Max SoloStar	Annual AAAC Avg	$83.03	$82.79	$82.82	$87.10	$91.45
	Avg Unit WAC	$86.38	$86.38	$86.38	$90.70	$95.24
Toujeo SoloStar	Annual AAAC Avg	$82.84	$82.77	$82.93	$87.11	$91.41
	Avg Unit WAC	$86.38	$86.38	$86.38	$90.70	$95.24

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 insulin glargine product claims in the commercial market. Drawing on data submitted through the 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 **highest average gross cost per enrollee in the commercial market was approximately $4,476 for Toujeo Max SoloStar**. The lowest average

gross cost per enrollee is $458 for insulin glargine-yfgn. After accounting for manufacturer rebates, pharmacy benefit manager (PBM) discounts, and other price concessions, the **average net cost per enrollee declined to approximately $1,194** for Toujeo Max SoloStar, reflecting an **estimated mean discount of 73.3 percent** relative to gross costs. Semglee was reported to be the highest mean discount while insulin glargine was reported to be the lowest, with 75.6 and 34.4 percent respectively.

Across all reporting carriers and market segments, the **total cost of Lantus SoloStar before concessions was $4,998,478**, with the highest total reported **price concessions amounting to approximately $3,490,855**, as detailed in Table 7. Notably, Toujeo SoloStar had the highest **percentage of claims that benefited from some form of price concessions,** with 95.6 percent.

Table 7 Net cost estimate based on carrier-submitted, 2023 data

	Basaglar Kwikpen	Insulin Glargine-yfgn	Lantus	Lantus SoloStar	Semglee	Toujeo Max SoloStar	Toujeo SoloStar
Total number of enrollees	267	2,853	1,106	2,549	1,271	430	626
Total number of claims	983	7,311	3,036	8,611	4,229	1,772	2,719
Total number of claims with price concessions applied	497	4,772	1,559	7,203	3,812	1,636	2,600
Percentage of claims with price concessions applied	50.6%	65.3%	51.4%	83.7%	90.1%	92.3%	95.6%
Percentage of cost remaining after concessions	64.9%	65.7%	44.9%	30.0%	24.4%	26.7%	29.6%
Percentage of discount	35.1%	34.3%	55.1%	70.0%	75.6%	73.3%	70.4%
Manufacturer price concessions for all market types	$57,121	$449,189	$630,016	$2,712,159	$1,702,087	$1,239,688	$1,283,929
PBM price concessions for all market types	$81,005	$0	$89,322	$778,541	$22,746	$171,535	$102,338
Other price reductions for all market types	$15	$0	$180	$155	$30	$0	$0
Cost before price concessions across all market types	$393,989	$1,307,504	$1,305,619	$4,998,478	$2,281,562	$1,924,725	$1,970,087
Total price concessions across all market types	$138,142	$449,189	$719,518	$3,490,855	$1,724,863	$1,411,223	$1,386,267
Cost of after price concessions across all market types	$255,847	$858,315	$586,101	$1,497,623	$556,698	$513,502	$583,820
Avg. payer spend per enrollee without price concessions	$1,476	$458	$1,180	$1,957	$1,795	$4,476	$3,147
Avg. payer spend per enrollee with price concessions	$958	$301	$530	$588	$438	$1,194	$933

Including all market segments, the **highest gross spend of insulin glargine products per claim for commercial carriers was $1,086 for Toujeo Max SoloStar** before any discounts, rebates, or other price concessions. For the same product, the net cost per enrollee with discounts, rebates, and other price concessions was $796. This resulted in the highest price concession reported by insurers of $290 per claim on the initial drug cost as shown in Table 8.

Table 8 The average price concessions across market types

Drug	Spend per Claim	Average	Individual Market	Large Market	Small Market
Basaglar Kwikpen	Spend per Claim, gross	$401	$512	$390	$536
	Spend per Claim, net	$260	$512	$237	$536
	Price Concessions per Claim	$141	$0	$153	$0
Insulin Glargine-yfgn	Spend per Claim, gross	$179	$179	$178	$182
	Spend per Claim, net	$117	$108	$122	$109
	Price Concessions per Claim	$61	$71	$57	$73
Lantus	Spend per Claim, gross	$430	$559	$384	$435
	Spend per Claim, net	$193	$209	$196	$155
	Price Concessions per Claim	$237	$349	$187	$280
Lantus SoloStar	Spend per Claim, gross	$579	$636	$566	$553
	Spend per Claim, net	$174	$199	$171	$152
	Price Concessions per Claim	$405	$437	$395	$401
Semglee	Spend per Claim, gross	$540	$578	$521	$568
	Spend per Claim, net	$132	$128	$134	$125
	Price Concessions per Claim	$408	$450	$386	$442
Toujeo Max SoloStar	Spend per Claim, gross	$1,086	$1,006	$1,055	$1,303
	Spend per Claim, net	$290	$254	$286	$345
	Price Concessions per Claim	$796	$752	$769	$958
Toujeo SoloStar	Spend per Claim, gross	$725	$737	$731	$678
	Spend per Claim, net	$215	$228	$222	$165
	Price Concessions per Claim	$510	$509	$509	$513

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 insulin glargine products to each pharmacy benefit manager, expressed as a percentage of the drug 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 calls 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.

Estimated price for therapeutic alternatives[18]

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 insulin glargine products and its therapeutic alternatives using data from APAC and the 2023 data call. 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 concessions, discounts or rebates.

Lantus SoloStar's gross total payer paid, based on APAC data, **was $44.4 million**, which is the highest of the insulin glargine products. Basaglar Kwikpen followed behind with $32.0 million of gross total payer paid. The lowest gross total payer paid is insulin glargine-yfgn with $6.3 million. **Basaglar Kwikpen had the most utilization among the insulin glargine products with 87,066 claims**. Conversely, Toujeo Max SoloStar has the least utilization with 8,844 claims and the **highest payer paid per claim at $1,154**.

Reflecting the gross total payer paid, Lantus SoloStar also has the highest total enrollee paid at $3.4 million and Basaglar Kwikpen is the second highest with $907,351. Lantus SoloStar, Toujeo Max SoloStar, and Toujeo SoloStar had the **highest patient paid per claim of $70**. The drug with the **lowest patient paid per claim is Basaglar Kwikpen, which is $10**.

[18] 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) PDAB 1-2023: Prescription Drug Affordability Review (oregon.gov).

The highest total net payer paid received from the **carriers indicated a cost of $3.0 million for Lantus SoloStar.** Semglee was the second highest at $2.2 million and **Basaglar Kwikpen had the lowest total net payer paid $355,470**. The carriers reported that Lantus SoloStar had the highest utilization among the insulin glargine products, and the generic insulin glargine-yfgn followed behind in utilization, with 8,611 and 7,311 claims respectively. Toujeo Max SoloStar had the **highest payer paid per claim at $835, as compared to insulin glargine-yfgn at $137 with the lowest payer paid per claim.**

Based on the carrier data, Lantus SoloStar also has the highest total enrollee paid at $417,965 and Basaglar Kwikpen had the lowest total enrollee paid at $60,276. Semglee and Toujeo SoloStar had the highest patient paid per claim of $65. The drug with the lowest patient paid per claim is insulin glargine-yfgn, which is $42.

None of the insulin glargine products were reported by the FDA for drug shortage, thus availability is assumed to be unaffected.

Table 9 Average healthcare and average patient OOP costs for review drugs based on APAC

Proprietary Name	No. of enrollees	No. of claims	Total payer paid	Total enrollees paid[19]	Payer paid/ claim	Patient paid/ claim[20]
Basaglar Kwikpen	13,343	87,066	$31,978,029	$907,351	$367	$10
Insulin Glargine-yfgn	10,198	41,523	$6,286,384	$416,738	$151	$10
Lantus	4,968	20,128	$11,879,620	$870,253	$590	$43
Lantus SoloStar	17,503	77,732	$44,425,416	$3,423,174	$572	$44
Semglee	3,661	14,678	$7,231,623	$552,076	$493	$38
Toujeo Max SoloStar	1,655	8,844	$10,209,919	$427,723	$1,154	$48
Toujeo SoloStar	2,348	11,559	$8,469,424	$583,479	$733	$50

[19] The cost includes all lines of business.
[20] Ibid.

Table 10 Average healthcare and average patient OOP costs for review drugs based on carrier data

Proprietary Name	No. of enrollees	No. of claims	Total payer paid	Total enrollees paid[21]	Payer paid/ claim	Patient paid/ claim[22]
Basaglar Kwikpen	267	983	$355,470	$60,276	$362	$61
Insulin Glargine-yfgn	2,853	7,311	$998,657	$309,211	$137	$42
Lantus	1,106	3,036	$927,202	$129,845	$305	$43
Lantus SoloStar	2,549	8,611	$2,966,945	$417,965	$345	$49
Semglee	1,271	4,229	$2,156,714	$276,978	$510	$65
Toujeo Max SoloStar	430	1,772	$1,480,263	$108,090	$835	$61
Toujeo SoloStar	626	2,719	$1,460,303	$175,761	$537	$65

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 insulin glargine products, 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 calls for consideration of such information to the extent practicable. However, due to limitations in available evidence and reporting, this analysis was

[21] The cost includes all lines of business.
[22] Ibid.

not performed. Future reviews may incorporate this data as it becomes 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 insulin glargine products 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.

Table 11 provides enrollee count across all lines of business. Basaglar Kwikpen had the most enrollees in the commercial and Medicaid market, while Lantus SoloStar had the most enrollees in the Medicare market. Overall, **Lantus SoloStar had the most enrollees across all lines of business with 18,031 enrollees**.

Table 11 Estimated APAC payer 2023 enrollees of review drugs

Proprietary name	Commercial Enrollees	Medicaid Enrollees	Medicare Enrollees	Total enrollees[23]
Basaglar Kwikpen	4,528	8,328	4,591	17,447
Insulin Glargine-yfgn	2,753	6,108	1,904	10,765
Lantus	1,252	489	3,432	5,173
Lantus SoloStar	3,774	1,398	12,859	18,031
Semglee	1,242	155	2,380	3,777
Toujeo Max SoloStar	539	166	1,003	1,708
Toujeo SoloStar	783	158	1,471	2,412

Table 12 provides utilization for the healthcare system for insulin glargine products, distinguished by lines of business. **Basaglar Kwikpen has the most utilization** among the drugs, with **87,066 claims** in the commercial and Medicaid markets. In the Medicare market, Lantus SoloStar is the most utilized with 57,577 claims, making it the **second most utilized insulin glargine with 77,732 claims**.

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

Table 12 Estimated APAC payer 2023 utilization of review drugs[24]

Proprietary name	Commercial Utilization	Medicaid Utilization	Medicare Utilization	Total claims[25]
Basaglar Kwikpen	21,372	40,428	25,266	87,066
Insulin Glargine-yfgn	7,798	29,588	4,137	41,523
Lantus	4,282	1,390	14,456	20,128
Lantus SoloStar	16,087	4,068	57,577	77,732
Semglee	4,329	361	9,988	14,678
Toujeo Max SoloStar	2,781	1,140	4,923	8,844
Toujeo SoloStar	3,918	987	6,654	11,559

Table 13 shows the overall payer expenditure for insulin glargine, distinguished by lines of business. Lantus SoloStar has a **total expenditure of $44.4 million** with **Medicare holding the largest portion at $34.2 million**. The insulin glargine product with the **lowest expenditure is insulin glargine-yfgn, at $6.3 million**.

Table 13 Estimated 2023 APAC payer annual gross expenditures of the review drugs from all lines of business[26]

Proprietary name	Commercial Expenditure	Medicaid Expenditure	Medicare Expenditure	Total[27]
Basaglar Kwikpen	$6,649,633	$15,206,910	$10,121,486	$31,978,029
Insulin Glargine-yfgn	$1,085,018	$4,748,734	$452,632	$6,286,384
Lantus	$1,940,281	$435,983	$9,503,355	$11,879,620
Lantus SoloStar	$8,720,783	$1,506,993	$34,197,640	$44,425,416
Semglee	$2,196,565	$84,086	$4,950,972	$7,231,623
Toujeo Max SoloStar	$2,962,928	$1,037,925	$6,209,066	$10,209,919
Toujeo SoloStar	$2,607,225	$636,035	$5,226,164	$8,469,424

[24] 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.
[25] Total is the sum of all utilization for the drug across all lines of business.
[26] 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.
[27] Total is the sum of all expenditure for the drug across all lines of business.

Table 14 compares the overall payer cost per enrollee of insulin glargine products, distinguished by lines of business. **Toujeo Max SoloStar has the highest total cost per enrollee at $6,169,** across all lines of business. The highest median cost per enrollee is also Toujeo Max SoloStar at $1,040. **Insulin glargine-yfgn has the lowest total cost per enrollee at $616 and the lowest median cost per enrollee at $132**.

Table 14 Estimated 2023 APAC payer annual gross cost per enrollee of the review drugs[28]

Proprietary name	Commercial Cost/ Enrollee	Medicaid Cost/ Enrollee	Medicare Cost/ Enrollee	Total[29] Cost per Enrollee	Cost per Enrollee, Median	IQR	Cost per Enrollee, 75th percentile	Cost per Enrollee, 95th percentile
Basaglar Kwikpen	$1,469	$1,826	$2,205	$2,397	$315	$151	$380	$1,152
Insulin Glargine-yfgn	$394	$777	$238	$616	$132	$70	$150	$416
Lantus	$1,550	$892	$2,769	$2,391	$309	$597	$831	$2,138
Lantus SoloStar	$2,311	$1,078	$2,659	$2,538	$429	$541	$839	$1,872
Semglee	$1,769	$542	$2,080	$1,975	$380	$456	$716	$1,575
Toujeo Max SoloStar	$5,497	$6,253	$6,190	$6,169	$1,040	$1,312	$1,815	$3,895
Toujeo SoloStar	$3,330	$4,026	$3,553	$3,607	$513	$802	$1,145	$2,468

Table 15 compares the overall payer cost per claim of insulin glargine products, distinguished by lines of business. **Toujeo Max SoloStar has the highest total cost per claim at $1,154,** across all lines of business. The highest median cost per claim is also Toujeo Max SoloStar at $894. **Insulin glargine-yfgn has the lowest total cost per claim at $151 and the lowest median cost per claim at $139**.

[28] 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.
[29] The total is the overall cost per enrollee across commercial insurers, Medicaid, and Medicare.

Table 15 Estimated 2023 APAC payer annual gross cost per claim of the review drugs

Proprietary name	Commercial Cost/ Claim	Medicaid Cost/ Claim	Medicare Cost/ Claim	Total[30] Cost/ Claim	Cost per Claim, Median	IQR	Cost per Claim, 75th percentile	Cost per Claim, 95th percentile
Basaglar Kwikpen	$311	$376	$401	$367	$316	$91	$345	$949
Insulin Glargine-yfgn	$139	$160	$109	$151	$139	$54	$149	$373
Lantus	$453	$314	$657	$590	$312	$532	$800	$1,825
Lantus SoloStar	$542	$370	$594	$572	$427	$435	$732	$1,582
Semglee	$507	$233	$496	$493	$373	$330	$592	$1,347
Toujeo Max SoloStar	$1,065	$910	$1,261	$1,154	$894	$1,043	$1,559	$3,017
Toujeo SoloStar	$665	$644	$785	$733	$430	$525	$878	$2,069

Data submitted via the carrier data call further stratifies commercial expenditures by market segment. Tables 16 through 20 examine the financial impacts of insulin glargine products through different metrics.

Table 16 provides utilization by the healthcare system for insulin glargine products, distinguished by market. **Lantus SoloStar has the most utilization** among the drugs, with **8,611 claims** and in all market segments. **The second most utilized insulin glargine is 7,311 claims for insulin glargine-yfgn.**

Table 16 Estimated data call 2023 claims utilization of review drugs [31]

Proprietary name	Individual Market Claims	Large Group Market Claims	Small Group Market Claims	Total claims
Basaglar Kwikpen	21	904	58	983
Insulin Glargine-yfgn	1,387	4,964	960	7,311
Lantus	671	1,912	453	3,036
Lantus SoloStar	1,927	5,241	1,443	8,611
Semglee	795	2,716	718	4,229

[30] The total is the overall cost per enrollee across commercial insurers, Medicaid, and Medicare.
[31] Cost information from the data call is the cost of the drug after price concessions.

Proprietary name	Individual Market Claims	Large Group Market Claims	Small Group Market Claims	Total claims
Toujeo Max SoloStar	304	1,186	282	1,772
Toujeo SoloStar	649	1,657	413	2,719

Table 17 provides enrollee count across all market segments. **Insulin glargine-yfgn has the most enrollees in the large group market, at 1,996 enrollees, and the most total enrollees at 2,853.** Lantus SoloStar had the most enrollees in the individual and small group market. Lantus SoloStar has the second highest number of enrollees overall at 2,549.

Table 17 Estimated data call 2023 enrollees of review drugs

Proprietary name	Individual Market Enrollees	Large Group Market Enrollees	Small Group Market Enrollees	Total enrollees
Basaglar Kwikpen	9	245	13	267
Insulin Glargine-yfgn	512	1,996	345	2,853
Lantus	203	765	138	1,106
Lantus SoloStar	570	1,550	429	2,549
Semglee	234	817	220	1,271
Toujeo Max SoloStar	83	278	69	430
Toujeo SoloStar	149	387	90	626

Table 18 shows the overall annual spending of insulin glargine products, distinguished by market segments. Lantus SoloStar has a **total annual spending of $3.4 million** with the **large group market being the biggest portion at $1.7 million**. **Basaglar Kwikpen has the least annual spending at $415,746**.

Table 18 Estimated 2023 data call annual net spending of the review drugs from all markets

Proprietary name	Individual Market Annual Spending	Large Group Market Annual Spending	Small Group Market Annual Spending	Total Annual Spending
Basaglar Kwikpen	$6,954	$337,673	$31,119	$415,746
Insulin Glargine-yfgn	$247,798	$884,778	$175,292	$1,307,868

Proprietary name	Individual Market Annual Spending	Large Group Market Annual Spending	Small Group Market Annual Spending	Total Annual Spending
Lantus	$333,109	$553,043	$170,895	$1,057,047
Lantus SoloStar	$1,061,577	$1,709,929	$613,405	$3,384,911
Semglee	$459,500	$1,565,785	$408,409	$2,433,693
Toujeo Max SoloStar	$296,258	$995,987	$296,107	$1,588,352
Toujeo SoloStar	$418,115	$992,149	$225,800	$1,636,064

Table 19 shows the overall payer expenditure of insulin glargine, distinguished by market segments. Lantus SoloStar has the highest **total payer expenditure of $3.0 million** with **the large group market being the biggest portion at $1.5 million**. Basaglar Kwikpen has the **least expenditure at $355,470**.

Table 19 Estimated 2023 data call payer net gross expenditures of the review drugs from all markets

Proprietary name	Individual Market Payer Paid	Large Group Market Payer Paid	Small Group Market Payer Paid	Total payer paid
Basaglar Kwikpen	$4,513	$326,281	$24,677	$355,470
Insulin Glargine-yfgn	$179,765	$703,727	$115,166	$998,657
Lantus	$300,536	$479,470	$147,195	$927,202
Lantus SoloStar	$923,576	$1,523,664	$519,705	$2,966,945
Semglee	$397,883	$1,405,717	$353,114	$2,156,714
Toujeo Max SoloStar	$271,137	$933,320	$275,806	$1,480,263
Toujeo SoloStar	$365,396	$896,923	$197,985	$1,460,303

Table 20 shows the enrollee out-of-pocket of insulin glargine, distinguished by market segments. Lantus SoloStar has the highest **enrollee OOP cost of $417,965** with **the large group market being the biggest portion at $186,266**. Basaglar Kwikpen has the **least enrollee OOP cost of $60,276**.

Table 20 Estimated 2023 data call annual enrollee out-of-pocket cost of the review drugs from all markets

Proprietary name	Individual Market Enrollee OOP cost	Large Group Market Enrollee OOP Cost	Small Group Market Enrollee OOP Cost	Total Enrollee OOP Cost
Basaglar Kwikpen	$2,441	$51,392	$6,443	$60,276
Insulin Glargine-yfgn	$68,034	$181,051	$60,126	$309,211
Lantus	$32,573	$73,573	$23,699	$129,845
Lantus SoloStar	$138,000	$186,266	$93,700	$417,965
Semglee	$61,616	$160,067	$55,295	$276,978
Toujeo Max SoloStar	$25,121	$62,668	$20,301	$108,090
Toujeo SoloStar	$52,720	$95,226	$27,815	$175,761

Table 21 details the average spend per claim and per enrollee for different parties (plan, payer, and enrollee) in the healthcare system across all market segments. The net average spend for each of the insulin glargine products is broken down below.

Table 21 Estimated 2023 data call net average plan, payer, and enrollee spending per claim and per enrollee in all markets

Proprietary name	Market	Avg. plan spend/ claim	Avg. payer paid/ claim	Avg. enrollee paid/ claim	Avg. plan spend/ enrollee	Avg. payer paid/ enrollee	Avg. OOP/ enrollee
Basaglar Kwikpen	Individual	$331	$215	$116	$773	$501	$271
	Large Group	$418	$361	$57	$1,542	$1,332	$210
	Small Group	$537	$425	$111	$2,394	$1,898	$496
Insulin Glargine-yfgn	Individual	$179	$130	$49	$484	$351	$133
	Large Group	$178	$142	$36	$443	$353	$91
	Small Group	$183	$120	$63	$508	$334	$174
Lantus	Individual	$496	$448	$49	$1,641	$1,480	$160
	Large Group	$289	$251	$38	$723	$627	$96

Proprietary name	Market	Avg. plan spend/ claim	Avg. payer paid/ claim	Avg. enrollee paid/ claim	Avg. plan spend/ enrollee	Avg. payer paid/ enrollee	Avg. OOP/ enrollee
	Small Group	$377	$325	$52	$1,238	$1,067	$172
Lantus SoloStar	Individual	$551	$479	$72	$1,862	$1,620	$242
	Large Group	$326	$291	$36	$1,103	$983	$120
	Small Group	$425	$360	$65	$1,430	$1,211	$218
Semglee	Individual	$578	$500	$78	$1,964	$1,700	$263
	Large Group	$577	$518	$59	$1,917	$1,721	$196
	Small Group	$569	$492	$77	$1,856	$1,605	$251
Toujeo Max SoloStar	Individual	$975	$892	$83	$3,569	$3,267	$303
	Large Group	$840	$787	$53	$3,583	$3,357	$225
	Small Group	$1,050	$978	$72	$4,291	$3,997	$294
Toujeo SoloStar	Individual	$644	$563	$81	$2,806	$2,452	$354
	Large Group	$599	$541	$57	$2,564	$2,318	$246
	Small Group	$547	$479	$67	$2,509	$2,200	$309

Table 22 indicates CCOs reported insulin glargine-yfgn having an annual greatest increase from 2022-2023 (rebates not included) with a **$1.2 million year-over-year increased cost growth**.

Table 22 Medicaid CCOs greatest increase in share to total cost from 2022-2023 (rebates not included)

Medicaid CCOs				
Proprietary Name	2022	2023	YoY change in spending	Percent of total CCO cost 2023
Insulin Glargine-yfgn	$3,224,199	$4,462,220	$1,238,021	0.1%

CCO Pharmacy spend provided by Oregon State University drug use research and management program.

Impact on patient 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 insulin glargine products, 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 insulin glargine products. For Basaglar Kwikpen, approximately **73.3 percent of reporting plans required prior authorization (PA)** for coverage of the drug, and **54.8 percent of plans required step therapy** before approving its use, which are the highest percentages for both categories.

For formulary placement, Basaglar Kwikpen has **96.2 percent of plans that categorized the drug as a non-preferred drug**, the highest of the insulin glargine products. For Semglee, however, **3.5 percent of plans excluded it entirely from the formulary**.

Table 23 Plan design analysis from 2023 data call

Proprietary Name	Required Prior Authorization	Required Step Therapy	On a non-preferred formulary	Not covered
Basaglar Kwikpen	73.3%	54.8%	96.2%	2.4%
Insulin Glargine-yfgn	6.0%	0.0%	6.3%	3.1%
Lantus	60.7%	22.3%	82.3%	1.3%
Lantus SoloStar	58.3%	21.3%	79.3%	0.8%
Semglee	48.2%	0.0%	46.5%	3.5%
Toujeo Max SoloStar	40.9%	0.4%	41.6%	0.4%
Toujeo SoloStar	41.2%	0.4%	41.8%	0.4%

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.

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 insulin glargine products 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 calls 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 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 patient 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 insulin glargine products in Oregon, as reported in 2023 by the Oregon All Payers All Claims (APAC). These costs include enrollee copayments, coinsurance, and deductible contributions for the drug and are presented by insurance type.

Tables 24 and 25 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.

Table 24 Annual out-of-pocket cost per enrollee for review drugs[32]

Proprietary name	Annual Medicare OOP Cost/ Enrollee	Annual Commercial OOP Cost/ Enrollee	Total[33]	Median	IQR	75th percentile	95th percentile
Basaglar Kwikpen	$167	$32	$101	$0	$20	$20	$225
Insulin Glargine-yfgn	$90	$89	$90	$21	$74	$74	$141
Lantus	$201	$144	$191	$35	$84	$84	$305
Lantus SoloStar	$204	$213	$208	$30	$94	$94	$337
Semglee	$133	$190	$154	$2	$75	$75	$220
Toujeo Max SoloStar	$260	$310	$280	$30	$100	$100	$379
Toujeo SoloStar	$246	$284	$262	$35	$100	$100	$355

Table 25 Annual out-of-pocket cost per claim for review drugs

Proprietary name	Medicare OOP Cost/Claim	Commercial OOP Cost/Claim	Total[34]	Median	IQR	75th percentile	95th percentile
Basaglar Kwikpen	$30	$7	$19	$0	$10	$10	$105
Insulin Glargine-yfgn	$41	$31	$35	$4	$60	$60	$120
Lantus	$48	$42	$46	$20	$65	$65	$150
Lantus SoloStar	$45	$50	$46	$10	$70	$70	$150
Semglee	$32	$54	$39	$0	$60	$60	$150
Toujeo Max SoloStar	$53	$60	$56	$4	$70	$70	$180
Toujeo SoloStar	$54	$57	$55	$22	$70	$70	$195

[32] 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.
[33] The total is the overall cost per enrollee across commercial insurers and Medicare.
[34] The total is the overall cost per claim across commercial insurersand Medicare.

Information from manufacturers

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: Insulin glargine is a long-acting recombinant insulin indicated to improve glycemic control in:
    - Type 1 diabetes (T1DM)
    - Type 2 diabetes (T2DM)
- Limitations of use: Not recommended for treatment diabetic ketoacidosis (DKA)
- Off label uses:
    - Hyperglycemia in hospitalized patients with non-critical illness

Clinical efficacy

Insulin glargine is a long-acting insulin analogue with a duration of approximately 24 hours recommended for the treatment of T1DM and T2DM. Insulin is essential in the treatment of T1DM due to a lack of ß-cell function. Insulin replacement should include a basal insulin, mealtime insulin, and correction insulin. Basal insulin includes NPH insulin or long-acting analogues, including insulin glargine. Recommendations do not give preference to one long-acting analogue over another. A 2021 Cochrane review found no clear differences in all-cause mortality, health-related quality of life, severe hypoglycemia, severe adverse events, and hemoglobin A1c (HgA1c) between long-acting and ultra-long-acting insulin analogues in the treatment of T1DM.

In the treatment of T2DM, insulin is recommended for consideration with background glucose-lowering therapy if symptoms of hyperglycemia are present or when HgA1C or blood glucose levels are very high (A1C > 10% or blood glucose ≥ 300 mg/dl). Basal insulin with NPH or a long-acting insulin analogue is often used as initial insulin treatment in T2DM. Guideline recommend that choice of basal insulin should be based on patient-specific considerations, including cost. A Cochrane review found that insulin glargine had a reduced risk of hypoglycemia and nocturnal hypoglycemia when compared to NPH insulin.

Insulin glargine U-300 (Toujeo) has a longer duration of action than U-100 and may have a lower risk of nocturnal hypoglycemia risk than U-100 glargine. Multiple studies have demonstrated no difference in HgA1C between U-300 glarine and U-100 glarine in both T1DM and T2DM. with similar effects on HgA1C. Studies in both T1DM and T2DM demonstrated no difference in severe hypoglycemia or severe adverse events. Three studies provided evidence that rates of nocturnal hypoglycemia were lower with U-300 than U-100 in T2DM (38% vs. 51%).

Clinical safety

- FDA safety warnings and precautions:
    - Hyperglycemia or hypoglycemia with changes in insulin regimen
    - Hypoglycemia
    - Hypersensitivity reactions
    - Hypokalemia
    - Fluid retention and heart failure with concomitant use of PPAR-gamma agonists, including thiazolidinediones
    - Diabetic ketoacidosis: should not be used as monotherapy
- Contraindications:
    - During episodes of hypoglycemia
    - Hypersensitivity to insulin glargine
- Common side effects:
    - Severe hypoglycemia
    - Hypertension
    - Peripheral edema
    - Diarrhea
    - Urinary tract infection
    - Antibody development
    - Nasopharyngitis and upper respiratory tract infection

Therapeutic Alternatives[35,36,37,38]

Table 26 Dosing and route

Drug	Duration	Frequency	• Formulations	Biosimilars Available
Insulin degludec (Tresiba)	≥ 42 hours	Once daily (flexible timing)	• U-100 vial • U-100 pen U-200 pen	No
Insulin glargine (Lantus)	~24 hours (10.8-24)	Once daily at the same time	• U-100 vial U-100 pen	• Semglee Rezvoglar
Insulin glargine (Basaglar)	~24 hours	Once daily at the same time	• U-100 vial • U-100 pen	• No
Insulin glargine-yfgn (Semglee)	~24 hours	Once daily at the same time	• U-100 vial • U-100 pen	• Interchangeable biosimilar to Lantus
Insulin glargine-aglr (Rezvoglar)	~24 hours	Once daily at the same time	• U-100 pen	• Interchangeable biosimilar to Lantus
Insulin glargine (Toujeo)	>24 hours	Once daily at the same time	• U-300 pen	• No

Comparative clinical efficacy

- Clinical guidelines do not give preference to one long-acting insulin over another.
- There is consistent evidence that long-acting insulin analogues have less hypoglycemia than intermediate insulin analogues (NPH). There is low quality evidence that long-acting insulins have a greater HbA1c reductions compared to intermediate insulins.
- One randomized, double-blind, multicenter, cardiovascular outcomes trial compared insulin degludec to insulin glargine in patients with T2DM at high risk of cardiovascular events (n=7637). Overall, insulin degludec was non-inferior to insulin glargine in the primary outcome of major cardiovascular events (8.5% vs. 9.3%; hazard ratio [HR] 0.91;

[35] 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.
[36] 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.
[37] 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.
[38] 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

95% CI 0.78 to 1.06; p<0.001 for noninferiority). There was a higher rate of severe hypoglycemic events in the insulin glargine group (6.25 events per 100 patient-years) compared to the insulin degludec group (3.70 events per 100 patient-years) (rate ratio [RR] 0.60; 95% CI 0.48 to 0.76; p<0.001). There was also a lower rate of nocturnal severe hypoglycemia in the degludec group compared to glargine (0.65 vs. 1.40 events per 100 patient-years).

- A systematic review of adult patients with T1DM and T2DM found no difference in HbA1c, hypoglycemia, nocturnal hypoglycemia, or severe hypoglycemia between insulin degludec and insulin glargine 300 units/ml.
- Insulin glargine -yfgn (Semglee) was approved as the first biosimilar to Lantus and was later FDA approved as an *interchangeable* biosimilar to Lantus. Based on evidence of a similar clinical effect with insulin glargine (Lantus), including HgA1C lowering and rates of hypoglcemia, it was approved as interchangeable that can be automatically substituted.
- Insulin glargine 300 units/ml has been shown to have similar reductions in HbA1c as insulin glargine 100 units/ ml with possibly lower rates of nocturnal hypoglycemia.

Input from specified stakeholders

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

Input from individual stockholder groups, including patient and caregivers, scientific and medical professions, and safety net providers, was not collected for the insulin glargine products included in this review. However, the board received public comments about insulin glargine. The comments are posted on the PDAB website and listed in the table in the appendix.

Appendix

Stakeholder feedback:

Name of speaker	Association to drug under review	Drug	Format	Date	Exhibit website link
Carissa Kemp	Sanofi	Insulin glargine	Letter	6/17/2025	Exhibit A
Cynthia Ransom	Eli Lilly	Basaglar	Letter	4/25/2025	Exhibit B
Carissa Kemp	Sanofi	Lantus	Letter	6/17/2025	Exhibit C
Carissa Kemp	Sanofi	Toujeo	Letter	6/17/2025	Exhibit D
Erin Callahan	Diabetes Patient Advocacy Coalition	Insuline glargine	Letter	10/13/2024	Exhibit E

Oregon Prescription Drug Affordability Board

2026 Board Calendar: Click on date to register for Zoom meeting.

Wednesday, Jan. 21

Wednesday, Feb. 18

Wednesday, March 18

Wednesday, April 15

Wednesday, May 20

Wednesday June 17

Wednesday July 15

Wednesday, Aug. 19

Wednesday, Sept. 16

Wednesday, Oct. 21

Wednesday, Nov. 18

Wednesday, Dec. 16