Oregon Prescription Drug Affordability Board

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Agenda

This is a regular meeting. *Date*: **November 19, 2025** | *Time*: **8 a.m.**

This is a draft agenda and subject to change

Board Members:
Chair Shelley Bailey
Vice Chair (vacant)
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
Discussion and vote	Election of vice chair	Chair Shelley Bailey
Informational	Board declarations of conflict of interest and meetings with entities or individuals related to board activities	Chair Shelley Bailey
Review	Board review of 10/15/2025 minutes	Chair Shelley Bailey
Informational	PDAB program update	Sarah Young
Informational	General public comment: limited to 3 minutes per speaker	Chair Shelley Bailey
Review and discussion	Board review and discussion of draft annual report	Cortnee Whitlock
Discussion and vote	Vote on 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

Purpose	Subject	Presenter
Review and discussion	**Continued prescription drug and insulin reviews: material packets**	Staff
Break	The board will take a break around 10:30	Chair Shelley Bailey
Informational	Announcements	Chair Shelley Bailey
Vote	Adjournment	Chair Shelley Bailey

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 Nov. 19 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.

Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board (PDAB) Regular Meeting
Wednesday, October 15, 2025
Draft Minutes

Web link to the meeting video: https://youtu.be/pWLLdMtLE0A
Web link to the meeting materials: https://dfr.oregon.gov/pdab/Documents/20251015-PDAB-document-package.pdf

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Call to order: Chair Shelley Bailey called the meeting to order at 8:03 a.m. and roll was called.
Board members present: Chair Shelley Bailey, Vice Chair Amy Burns, Dan Hartung, Lauri Hoagland, Dan Kennedy, Michele Koder, John Murray. Chris Laman arrived at 8:21 a.m.
Absent: None

The board provided American Sign Language during the meeting.

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 **00:01:36**.

Approval of board minutes: Chair Bailey asked for any corrections to the minutes of Aug. 20, 2025 and Sept. 17, 2025 on **Pages 3-7** and there were none. The chair approved the minutes by consensus, according to Robert's Rule of Order, which has been adopted by the board in **Policy 1**. View at video minute **00:03:54**.

Amendment to Oct. 15, 2025, board minutes from board member Lauri Hoagland: "I would like to amend my comments during the Oct. 15, 2025, board discussion. I did not articulate my concern regarding an audit of 340B pharmacies. I don't want to risk casting doubt on these programs at this time of health care austerity. From my experience working in a community clinic with a 340B pharmacy, many black and brown patients have access to medications that they would not otherwise as a result of 340B pricing. If we are going to consider equity, we need to understand the importance of this dispensing option for many vulnerable populations."

PDAB program update: Chair Bailey introduced Michele Koder, new board member, and Sarah Young, new executive director. Sarah Young provided a program update. View the video at minute **00:05:00**.

General public comment: Chair Bailey called on the people who signed up in advance to speak to the board: Jessica McBride, Oregon Coalition for Affordable Prescriptions; Dharia McGrew, PhRMA; Lorren Sandt, Caring Ambassadors Program; Auden Friedman, OSPIRG; and Dean Suhr, MLD Foundation. The board received 15 written comments, which are posted on the **PDAB website**. View the speakers at video minute **00:09:44**.

Board continued discussion about policy recommendations for inclusion in the 2025 annual legislative report: Cortnee Whitlock, senior policy analyst, led the board in a continued discussion about the policy recommendations. View the proposed policies on **Pages 8-19**. View the discussion at video minute **00:26:55**.

Board continued review of methodology for drug reviews and scoring rubric and worksheet: Cortnee Whitlock, senior policy analyst, led the board in a discussion about the rubric and worksheet. View the documents on **Pages 6-12**. View the discussion at video minute **01:32:19**.

Drug review: Insulin Glargine - Basaglar KwikPen, Insulin Glargine-yfgn, Lantus, Lantus SoloStar, Semglee, Toujeo Max SoloStar, and Toujeo SoloStar: The board began discussions about drug reviews for insulin products. View the insulin glargine report on **Pages 32-65** posted on the PDAB website. View the discussion at video minute **02:22:11**.

Drug review public comment periods: Chair Bailey announced the drug review public comment period and read the list of letters received regarding the insulin products under review. No one signed up to speak about insulin. See the table below for the list of public comment letters.

Announcements: Chair Bailey had to leave the meeting after the 10:30 am break and Vice Chair Amy Burns became acting chair. Vice Chair Amy Burns announced the next meeting will be Nov. 19, 2025, at 8 a.m. View at minute **03:21:02**.

Adjournment: Vice Chair Amy Burns adjourned the meeting at 11:28 a.m. with all board members in agreement. View at minute **03:21:09**.

Table of drug review public comment letters

Name of speaker	Association to drug under review	Drug	Format	Date	Exhibit website link
Carissa Kemp	Sanofi	Insulin glargine	Letter	6/17/25	**Exhibit A**
Cynthia Ransom	Eli Lilly	Basaglar	Letter	4/25/2025	**Exhibit B**
Carissa Kemp	Sanofi	Lantus	Letter	6/17/25	**Exhibit C**
Carissa Kemp	Sanofi	Toujeo	Letter	6/17/25	**Exhibit D**

Oregon Prescription Drug Affordability Board

2025 Draft Annual Report

Oregon Prescription Drug Affordability Board

Nov. 19, 2025

Table of contents

Abbreviations

PDAB background and activities: mission, membership, and milestones

The Prescription Drug Affordability Board (PDAB) was established by Oregon Senate Bill 844 (2021), and codified in Oregon Revised Statute (ORS) 646A.693 to 646A.697. The board's mission is to protect Oregonians, state and local governments, commercial health benefit plans, health care providers, pharmacies, and other Oregon stakeholders from the high costs of prescription drugs. PDAB is housed within the Department of Consumer and Business Services (DCBS) and operates as an independent, evidence-based body designed to analyze prescription drug cost trends, conduct drug reviews, and make policy recommendations to improve prescription drug affordability in the state.

Since its first meeting in June 2022, the board has continued to strengthen its governance structure, expand its capacity, and build transparent process for stakeholder engagement.

Board composition

The board is composed of eight members with expertise in health care economics, clinical medicine, pharmacy, and public health. Members represent a diverse range of professional backgrounds across Oregon. Read board member bios on the PDAB website.

Table 1 PDAB Members

Board Member	Title, Occupation	Term Dates
Shelley Bailey, MBA, Chair	CEO of Famlee Fertility Inc.	06/10/2022 to 12/31/2026
Dr. Amy Burns, PharmD, Vice chair	Vice President of Benefit Management and Pharmacy Service at AllCare Health	06/10/2022 to 12/31/2028
Dr. Daniel Hartung, PharmD, MPH	Tenured professor of pharmacy practice in the College of Pharmacy at Oregon State University	06/10/2022 to 12/31/2029
Lauri Hoagland, NP	Nurse practitioner for a school-based health center sponsored by La Clinica	10/01/2024 to 12/31/2026
Dan Kennedy, RPH	Retired pharmacist and outgoing president of the Oregon State Pharmacy Association	06/5/2024 to 12/31/2029
Dr. Michelle Koder, PharmD	Pharmacy director for the Multnomah County Health Department	10/1/2025 to 12/31/2026

Board Member	Title, Occupation	Term Dates
Dr. Christopher Laman, PharmD, MBA	Vice president of strategy, director of pharmacy and Cancer Center Services at Columbia Memorial Hospital	02/16/2024 to 12/31/2029
John Murray, RPH	Pharmacist and co-owner of Murray's Drugs	9/28/2022 to 12/31/2028

Governance and leadership

PDAB provides the foundation for transparent decision-making, statutory compliance, and strategic direction. The board has established a few key milestones in its organizational growth.

- ✓ **Board established**: 2021 through Senate Bill 844.
- ✓ **First meeting held**: June 2022.
- ✓ **53 total board meetings held to date**, establishing processes for transparency, public comment, decision-making, and prescription drug cost reviews.
- ✓ **Leadership transitions**: Shelley Baliey elected chair and Dr. Amy Burns elected vice chair in 2024 following the resignation of the initial chair.
- ✓ **Four new board members** appointed between 2024-2025, expanding the board's expertise: Dr. Chris Laman in February 2024, Dan Kennedy in June 2024, Lauri Hoagland in October 2024, and Dr. Michele Koder in October 2025.
- ✓ **The board also includes** Dr. Dan Hartung and John Murray.

Community engagement and public comment

The board encourages public involvement in its decision-making process. Public comment opportunities are provided at each board meeting, and additional comment periods are offered during each drug review session.

Table 2 2025 Outreach, public comments

Category	Letters	Speakers	Survey responses
Patients, caregivers, advocates	96	34	280
Scientific/medical professionals	11	0	29
Safety net clinics	1	0	11
Manufacturers	33	7	7
PBMs	2	2	0

Board activities and accomplishments

The work of PDAB is centered on advancing its mission through strategic actions, data-driven reviews, and meaningful stakeholder engagement. Since its inception the board has continued to meet its statutory responsibilities and strengthen its role as a trusted entity in promoting transparency and structured reviews for prescription drug costs impacting Oregon.

- ✓ **Annual Reports for the Legislature:** The board has provided an annual report with policy recommendations to the Oregon Legislature each year since 2022 as required by ORS 646A.696. The legislative reports can be found on the PDAB website.
- ✓ **Generic drug analysis:** Four reports produced on generic drug market dynamics to inform state policymakers.
- ✓ **Drug reviews**: The board conducted prescription drug reviews of 23 medications throughout the summer and fall of 2025. The board conducts the reviews based on criteria in Oregon Administrative Rule (OAR) 925-200-0010 and OAR 925-200-0020. The full drug review report will be submitted in March 2026.
- ✓ **Community outreach**: Conducted targeted outreach to stakeholders in 2025 with structured surveys, receiving over 300 responses.
- ✓ **New executive director**: Sarah Young, MPH, was named the next executive director of the Prescription Drug Affordability Board and the Drug Price Transparency Program (DPT) in October 2025.

Strengthening analytical infrastructure

PDAB continues to invest in strengthening its operations and analytical infrastructure to support consistent and transparent decision-making in drug reviews. This includes improving data workflows, enhancing the integration of DPT and the All Payer All Claims (APAC) data sources, and developing standardized tools to guide the review process.

- ✓ **Establishing** structured data analysis workflow.
- ✓ **Improving** analysis and increasing information from DPT and APAC data sets.
- ✓ **Enhancing** communication with stakeholders, including insurers, patient advocates, and manufacturers.
- ✓ **Implementing** scoring rubric as an optional decision-support tool to help standardize board member reviews and enhance transparency in the review process.

Price trends

Data sources, methodology and assumptions

This section outlines the data sources, reporting structure, and analytical assumptions that form the foundation of PDAB's price trend analysis. While ORS 646A.696 references the term price trends, the available data reported under ORS 743.025 to DPT reflect net insurer costs.[1] Analyzing the insurer-reported data from DPT for multiple years allows PDAB to examine actual financial impact on the health care system and patient costs, rather than list prices or wholesale acquisition costs (WAC).

Data for this analysis covers the 2023 and 2024 DPT reporting years. Earlier years were excluded due to reporting variances and inconsistencies that limited the ability to conduct a meaningful year-over-year comparison.

The state requires that commercial insurers submit top 25 lists to DPT every year for three categories—brand, generic, and specialty drugs. Insurers submit data for each market segment (e.g., small group, large group, individual)[2] separately. All submissions received for the data years of 2023 and 2024, from required reporting insurers were included in this analysis.

Three main reporting metrics are used:

- **Greatest Increase (GI)**: The top 25 drugs with the largest increase in total annual spending year-over-year.
- **Most Costly (MC)**: The top 25 drugs with the highest share of total annual spending.
- **Most Prescribed (MP)**: The top 25 drugs with the highest prescription counts.

Insurer submissions reflect net costs after all rebates, discounts, price concessions, and other reimbursement have been applied. Data rows with anomalies such as zero baselines or grouped reporting (e.g., COVID-19 vaccines) were filtered out to avoid artificial inflation. Medical devices and diagnostic products were also excluded.

Topline findings

Across three reporting metrics (GI, MC, and MP), the data reveal a clear and consistent trend: increased utilization is the primary driver of rising prescription drug spend in Oregon's commercial health insurance market. However, several drugs exhibited cost growth outpacing utilization, suggesting additional market dynamics such as rebate shifts, contract renegotiations, or expanded clinical use. While utilization remains the primary driver of total

[1] See Limitations and data considerations for more information on data used in this report.
[2] See the PDAB Data Dictionary for market definitions.

spending growth, affordability challenges arise when spending growth outpaces utilization, often due to price adjustments, rebate dynamics, or other market indications. These patterns highlight that affordability pressures are concentrated among higher cost drugs and therapeutic classes, not just the highest utilization.

Key topline observations include:

- Overall spending increased between 2023 and 2024, with growth concentrated among a small group of high-cost drugs.
- Skyrizi, Ozempic, Jardiance, and Cosentyx were among the top contributors to year-over-year cost increases, with Skyrizi recording the highest combined total spend across the two years.
- Cost versus utilization divergence was notable for Ozempic and Skyrizi, where spending increased faster than prescription volume.
- Therapeutic class trends show persistent cost growth in antidiabetic and dermatological categories, reflecting both increased utilization and price dynamics.
- Decreased utilization and spending were observed for drugs including Entyvio and Keytruda, suggesting market shifts or formulary changes.

These findings have helped identify therapeutic areas where cost pressures are most acute, which may inform future cost and access discussion.

Analysis: GI/MC/MP and therapeutic class findings

Greatest Increase (GI)

The GI metric identifies the top drugs contributing the largest year-over-year increases to total spending from 2023 to 2024. This measure highlights where market cost pressures are growing most rapidly, regardless of whether those drugs also represent the highest total spend. Increases may reflect combinations of utilization growth, changes in negotiated net prices, expanded indications, or formulary placement shifts.

Nationally, prescription drug costs have followed a trajectory. According to the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE)[3], gross costs for prescription retail drugs increased 39 percent between 2014

[3] Report to Congress: Prescription Drug Spending, Pricing Trends, and Premiums in Private Health Insurance Plans. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, November 2024. https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/2024-report-to-congress-prescription-drug-spending.pdf. Note: This study did not include physician administered drugs as dispensed in physician offices or hospitals.

and 2024, where per-person costs rose by 26 percent over the same period.[4] These trends provide important context for the Oregon commercial market, where year-over-year spending growth is concentrated among a small subset of high-impact drugs.

Figure 1 illustrates the top 15 prescription drugs, and Table 3 illustrates the top 25 prescription drugs with the greatest year-over-year increases in total annual spending from 2023 to 2024, based on submissions from insurers reporting to DPT. These figures and tables show aggregated data from all reporting insurers and all market segments to identify overall trends. The columns show the amount of the increase in annual spending from 2023 to 2024, while the line overlay indicates percentage change in utilization measured by prescription count across the period. This dual view captures both absolute cost growth and underlying demand trends.

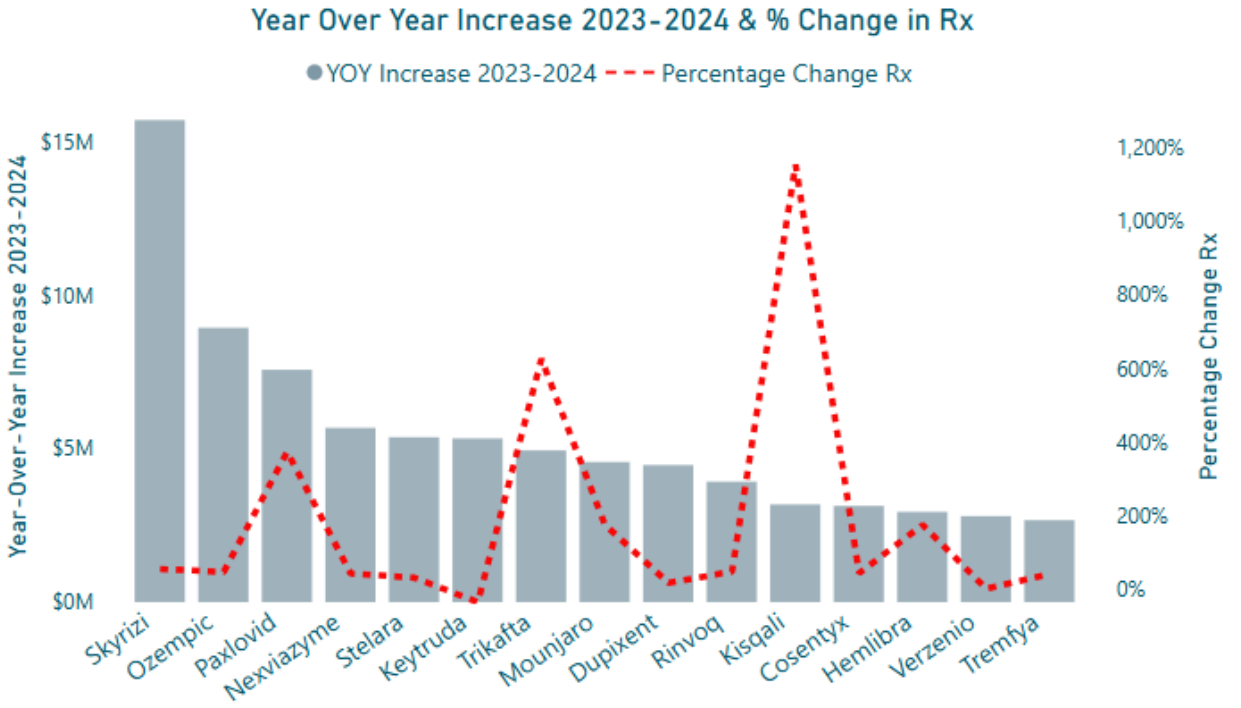

Figure 1 Year-over-year greatest increase in annual spending with percent change in utilization (2023-2024): Top 15 drugs by spending increase amount. Only drugs with a reported increase in both years are included.

Across the top 25 GI drugs, total spending increased between 2023 and 2024, with several products showing cost growth exceeding 40 percent. Leading contributors including Skyrizi,

[4] Report to Congress: Prescription Drug Spending, Pricing Trends, and Premiums in Private Health Insurance Plans. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, November 2024. https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/2024-report-to-congress-prescription-drug-spending.pdf. Note: This study did not include physician administered drugs as dispensed in physician offices or hospitals.

Ozempic, and Trikafta, which together accounted for a substantial share of total cost increases during the reporting period.

Key observations:

- Skyrizi recorded the largest increase, rising by approximately $15.7 million year-over-year, with utilization increasing by roughly 56 percent and a 63 percent increase in total annual spend.
- Ozempic showed a $8.9 million increase in annual spend, driven by a 48 percent rise in utilization and a 57 percent increase in total annual spend.
- Kisqali demonstrates a market where rapid uptake altered total system cost.

Table 3 further details the top 25 drugs ranked by year-over-year spending increase, including baseline and current spending levels, percentage change in prescriptions, and total utilization. This supports a more comprehensive review of whether spending increases were primarily driven by volume growth, net price changes, or both.

Table 3: Top 25 Year-over-year greatest increase in annual spend, 2023 through 2024, sorted by 2024 annual spend increase. Only drugs with a reported increase in both years are included.[5]

Proprietary Name	Annual spend YOY increase 2023 to 2024	% change Rx[6]	% change total annual spend	Total annual spend 2023	Total annual spend 2024	Total Rx 2023	Total Rx 2024
Skyrizi	$15,701,487	56%	63%	$22,794,581	$37,053,819	1,783	2,789
Ozempic	$8,934,850	48%	57%	$17,366,851	$27,326,718	30,760	45,591
Paxlovid	$7,566,764	374%	16,101%	$48,316	$7,827,817	1,592	7,553
Nexviazyme	$5,674,528	44%	63%	$4,087,654	$6,672,687	64	92
Stelara	$5,370,053	33%	30%	$17,393,531	$22,579,603	1,304	1,729
Keytruda	$5,332,555	-34%	-40%	$30,618,026	$18,406,718	1,540	1,021
Trikafta	$4,942,366	627%	614%	$3,338,422	$23,826,212	128	930
Mounjaro	$4,564,057	176%	189%	$2,568,722	$7,412,703	4,740	13,079
Dupixent	$4,463,941	19%	27%	$13,763,577	$17,424,333	4,490	5,328

[5] Due to reporting variances stemming from divergence in insurers who report a drug each year across different markets, the difference between the total annual spend from 2023 and 2024 does not equal the indicated increase amount. Each of these values is a separate field in the insurer submissions to DPT and not a direct calculation.
[6] Rx represents number of prescriptions

Proprietary Name	Annual spend YOY increase 2023 to 2024	% change Rx[6]	% change total annual spend	Total annual spend 2023	Total annual spend 2024	Total Rx 2023	Total Rx 2024
Rinvoq	$3,923,914	49%	60%	$5,384,196	$8,604,876	1,177	1,756
Kisqali	$3,180,704	1,155%	1,241%	$290,197	$3,891,764	22	276
Cosentyx	$3,132,930	45%	54%	$11,887,783	$18,313,299	2,746	3,976
Hemlibra	$2,940,051	176%	92%	$2,697,247	$5,178,873	66	182
Verzenio	$2,802,231	3%	2%	$6,779,478	$6,906,042	547	561
Tremfya	$2,669,507	43%	47%	$5,628,840	$8,269,103	636	908
Jardiance	$2,397,936	26%	40%	$7,560,286	$10,614,335	19,701	24,790
Fluticasone	$2,176,609	471%	173%	$1,160,262	$3,169,997	4,081	23,304
Ocrevus	$1,937,823	-36%	-45%	$9,913,261	$5,462,631	319	203
Comirnaty	$1,915,898	48%	34%	$6,587,144	$8,794,039	69,367	102,980
Botox	$1,810,332	145%	108%	$4,171,280	$8,658,202	3,270	8,003
Entyvio	$1,787,648	-45%	-50%	$12,983,430	$6,485,863	1,293	712
Opdivo	$1,778,800	-31%	-6%	$4,393,311	$4,135,493	317	218
Biktarvy	$1,466,604	-45%	-43%	$18,214,289	$10,319,320	3,564	1,974
Gamunex-C	$1,454,095	513%	268%	$1,608,692	$5,919,037	283	1,734
Eliquis	$1,354,872	-3%	5%	$6,125,886	$6,404,148	11,911	11,570

In most cases utilization growth tracked closely with cost growth, indicating that demand remains the primary driver of increased spending in Oregon commercial health insurance market. However, a subset of drugs, including Keytruda, Biktarvy, and Ocrevus, showed declines in both utilization and spend, suggesting either market shifts or formulary and contracting changes, and the reporting market dynamics across the insurers from one year to the next.

Notably, a few drugs such as Paxlovid and Kisqali demonstrated disproportionate percentage increases, with utilization spikes exceeding 300 percent in some cases. These patterns may

indicate emerging market activity, newly covered indications, or shifts in coverage that could impact system costs. Paxlovid transitioned from federal distribution (no cost) to commercial distribution in mid-2023 and the increased reported spending in 2024 reflects this market shift.[7]

Figure 2 and Table 4 present the top prescription drugs by annual spend based on GI submissions, sorted by total annual spend in 2024 rather than by the size of their year-over-year increase. This alternative view illustrates which high-growth drugs now account for the largest share of overall spending in the commercial market. The columns in Figure 2 reflect the total annual spend by year, with color differentiation, while the lines represent utilization measured by prescription counts.

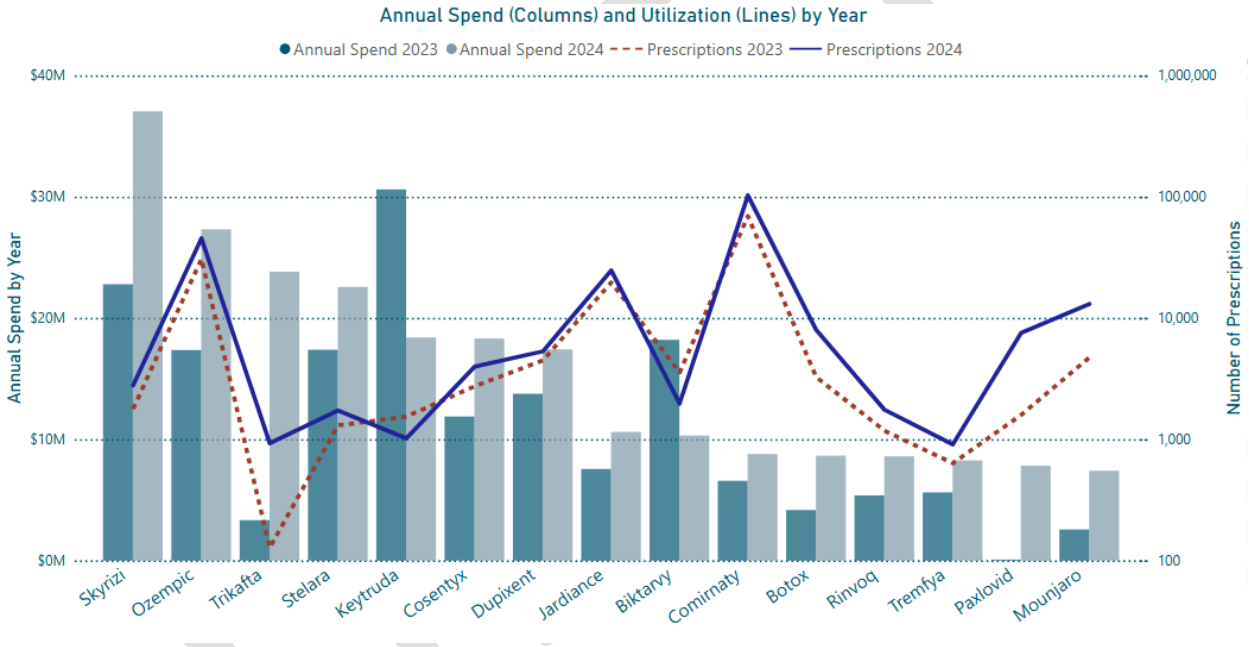

*Figure 2 Top 15 prescriptions drugs by annual spend and utilization based on **Greatest Increase** submissions, filtered and sorted by 2024 annual spend. Only drugs with a reported increase in both years are included.*

For many drugs, such as Skyrizi, Ozempic, and Trikafta, both total spending and utilization increased, demonstrating a strong correlation between rising demand and rising net costs. Other drugs, including Cosentyx, Dupixent, and Jardiance, follow the same trend of utilization-driven cost growth. In contrast, drugs such as Entyvio, Keytruda, Biktarvy, and Ocrevus show

[7] U.S. Department of HHS Press Release, October 13, 2023. https://web.archive.org/web/20240101142243/https://www.hhs.gov/about/news/2023/10/13/hhs-and-pfizer-reach-agreement-to-increase-patient-access-to-paxlovid.html

year-over-year declines in both utilization and spending, suggesting market shifts, contracting updates, or formulary adjustments.

The information reinforces the broader finding that utilization remains the primary driver of spending for most GI drugs. However, it also shows that some of the most expensive drugs in 2024 are not necessarily those with the highest growth, but are those with persistent high per-claim costs and continued utilization.

Table 4 Top 25 prescription drugs by annual spending and prescription utilization, 2023 through 2024, filtered and sorted by 2024 annual spend. Only drugs with a reported increase in both years are included.[8]

Proprietary name	Annual spend 2023	Annual spend 2024	Rx 2023	Rx 2024	Annual spend YOY increase 2023 to 2024
Skyrizi	$22,794,581	$37,053,819	1,783	2,789	$15,701,487
Ozempic	$17,366,851	$27,326,718	30,760	45,591	$8,934,850
Trikafta	$3,338,422	$23,826,212	128	930	$4,942,366
Stelara	$17,393,531	$22,579,603	1,304	1,729	$5,370,053
Keytruda	$30,618,026	$18,406,718	1,540	1,021	$5,332,555
Cosentyx	$11,887,783	$18,313,299	2,746	3,976	$3,132,930
Dupixent	$13,763,577	$17,424,333	4,490	5,328	$4,463,941
Jardiance	$7,560,286	$10,614,335	19,701	24,790	$2,397,936
Biktarvy	$18,214,289	$10,319,320	3,564	1,974	$1,466,604
Comirnaty	$6,587,144	$8,794,039	69,367	102,980	$1,915,898
Botox	$4,171,280	$8,658,202	3,270	8,003	$1,810,332
Rinvoq	$5,384,196	$8,604,876	1,177	1,756	$3,923,914
Tremfya	$5,628,840	$8,269,103	636	908	$2,669,507
Paxlovid	$48,316	$7,827,817	1,592	7,553	$7,566,764
Mounjaro	$2,568,722	$7,412,703	4,740	13,079	$4,564,057
Verzenio	$6,779,478	$6,906,042	547	561	$2,802,231
Nexviazyme	$4,087,654	$6,672,687	64	92	$5,674,528
Entyvio	$12,983,430	$6,485,863	1,293	712	$1,787,648
Amphetamine	$2,768,554	$6,463,405	48,469	182,572	$1,131,046
Eliquis	$6,125,886	$6,404,148	11,911	11,570	$1,354,872
Gamunex-C	$1,608,692	$5,919,037	283	1,734	$1,454,095
Ocrevus	$9,913,261	$5,462,631	319	203	$1,937,823
Ultomiris	$1,568,637	$5,194,205	24	47	$1,294,734
Hemlibra	$2,697,247	$5,178,873	66	182	$2,940,051
Opdivo	$4,393,311	$4,135,493	317	218	$1,778,800

[8] Due to reporting variances stemming from divergence in insurers who report a drug each year across different markets, the difference between the total annual spend from 2023 and 2024 does not equal the indicated increase amount. Each of these values is a separate field in the insurer submissions to DPT and not a direct calculation.

Most Costly (MC)

The MC metric identified drugs that account for the highest total annual spending in Oregon's commercial health insurance market, regardless of year-over-year change. While the GI metric highlights where spending is increasing most rapidly, the MC list shows where the largest share of financial burden is most concentrated. These drugs represent the highest overall system impact and key cost drivers for insurers and patients, even when utilization may not be the highest.

The MC submissions exhibit trends similar to those observed in the GI analysis. Several of the same high-cost drugs appear in both metrics, demonstrating both high current cost and continued cost growth. Figure 4 present the top 15 drugs by total annual spend based on MC submissions. As in the GI analysis, columns show total spend by year, while lines represent utilization measured by prescription counts.

Key observations:

- **Cost burden is highly concentrated**. Skyrizi, Keytruda, Stelar, Ozempic, and Trikafta are the top five drugs by total annual spend in 2024, each exceeding $35 million in annual insurer spending. Skyrizi alone accounted for more than $37 million in 2024.

- **High-cost drugs remain costly**. For example, Keytruda maintained one of the highest total spending amounts in 2024 ($36.4M), with total annual spending slightly decreasing while utilization increased by approximately 12 percent. This pattern of decreasing spending and increasing utilization suggests potential shifts in net pricing, rebate structure, or contracting strategies.

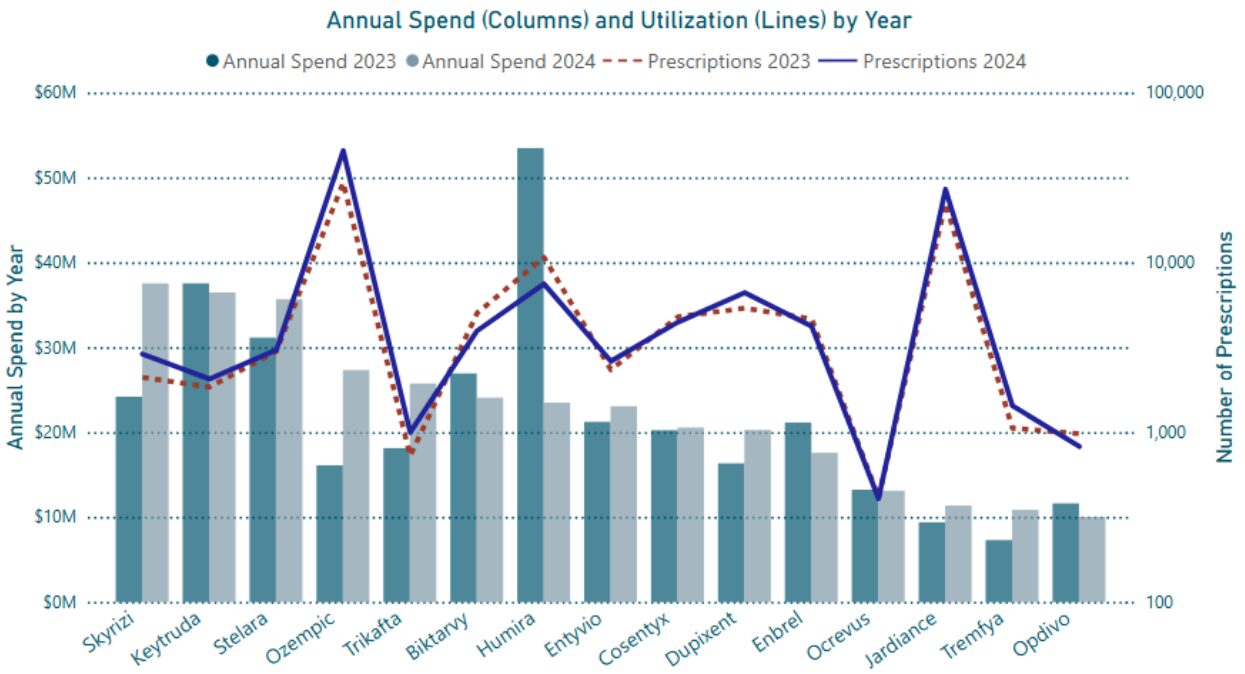

*Figure 3 Top 15 prescriptions drugs by total annual spend and utilization based on **Most Costly** submissions, filtered and sorted by 2024 annual spend*

Table 5 provides spending and utilization trends for the top 25 MC drugs. The list illustrates how high total spending can result from either sustained high prescription volume, high pre-prescription cost, or both. Several products show spending growth that outpaces utilization, while others demonstrate declining use but sustained high expenditure due to cost per claim.

Key observations:

- **Overlap between GI and MC metrics underscores sustained affordability pressure**. Skyrizi, Ozempic, and Trikafta appear near the top of both lists, signaling not only high total spending but also continued rapid growth year-over-year. These drugs reflect high impact drivers.

- **Some therapies are declining but remain costly**. Humira and Biktarvy decreased in utilization and spending but still rank among the costliest drugs overall, suggesting market competition from biosimilars or contracting changes.

*Table 5 Top 25 prescriptions drugs by total annual spend and utilization based on **Most Costly** submissions, filtered and sorted by 2024 annual spend*[9]

Proprietary name	Annual spend 2023	Annual spend 2024	Rx 2023	Rx 2024
Skyrizi	$24,194,057	$37,536,013	2,106	2,884
Keytruda	$37,544,942	$36,481,289	1,847	2,062
Stelara	$31,156,649	$35,685,330	2,995	3,056
Ozempic	$16,117,117	$27,326,718	29,555	45,591
Trikafta	$18,141,162	$25,747,283	726	999
Biktarvy	$26,933,839	$24,080,914	5,033	3,960
Humira	$53,490,178	$23,492,393	10,726	7,488
Entyvio	$21,234,668	$23,070,291	2,338	2,620
Cosentyx	$20,243,612	$20,562,420	4,788	4,455
Dupixent	$16,339,878	$20,274,398	5,387	6,647
Enbrel	$21,147,861	$17,589,300	4,648	4,216
Ocrevus	$13,234,514	$13,121,430	412	407
Jardiance	$9,396,589	$11,366,930	22,332	27,010
Tremfya	$7,300,157	$10,858,763	1,058	1,435
Opdivo	$11,622,429	$10,034,350	981	825
Verzenio	$6,983,502	$9,964,945	566	815
Eliquis	$9,604,024	$9,885,471	16,585	17,116
Comirnaty	$6,846,848	$9,581,042	71,272	108,210
Prevnar	$11,224,169	$9,286,997	41,998	29,298
Rinvoq	$3,246,818	$9,208,853	713	1,859
Botox	$5,097,465	$8,931,193	3,967	8,258
Inflectra	$10,596,057	$8,461,388	4,222	4,649
Amphetamine	$6,932,406	$8,439,699	161,293	227,615
Nexviazyme	$4,432,921	$7,854,642	67	136
Perjeta	$6,451,354	$7,817,473	555	713

[9] Due to reporting variances stemming from divergence in insurers who report a drug each year across different markets, the total annual spend in 2023 and 2024 reported in the MC submission does not equal the total annual spend reported in the GI submission. Each of these values is a separate field in the insurer submissions to DPT and not a direct calculation.

Twenty drugs overlap between MC and GI submissions, reflecting a concentrated cost burden among a relatively small number of high impact products, many of which are in therapeutic classes such as antidiabetics and dermatologicals. This concentration heightens the importance of monitoring net cost trends for these drugs, as even modest shifts in price or utilization can have disproportionate effects on total system spending.

Most Prescribed (MP)

The MP metric identifies the drugs with the highest prescription volume in Oregon's commercial health insurance market. While the metric offers insight into consumer demand and prescription trends, it does not necessarily indicate a cost or affordability impact. Many of the highest volume drugs are lower cost generics and common vaccines that contribute minimally to overall system spend. For this review of cost trends, MP data should be interpreted in conjunction with the GI and MC metrics, which more accurately identify affordability pressure points. Highlighting where MP overlaps with GI and MC helps distinguish drugs that are both widely used and high cost, versus those that are widely used and low cost. Information provided in this section focuses on the drugs with the greatest impact on the health care system and patient out-of-pocket costs.

As observed in the MC and GI analyses, fourteen drugs appear across all three metrics, indicating both widespread use and financial impacts. Figure 4 displays the top 15 drugs by prescription volume reported under the most prescribed metric. Columns represent annual spending, while the line trend shows total prescriptions in 2023 and 2024. This figure highlights high-volume drugs that also contribute to spending trends.

Key observations:

- **High volume and high-cost drugs**: Jardiance and Ozempic demonstrated a steady growth in both utilization and cost, reflecting their expanded role in diabetes management and treatment for obesity.
- **Cost growing faster than utilization**: Botox utilization grew by approximately 70 percent, while spending increased 55 percent, suggesting changes in dosing patterns or broader use across therapeutic indications.
- **High volume but low-cost impact**: Vaccine Comirnaty shows large prescription counts but relatively low total insurer costs.
- **Top cost but decline spending**: Humira prescription reporting declined about 31 percent but is still among the top costly drugs.

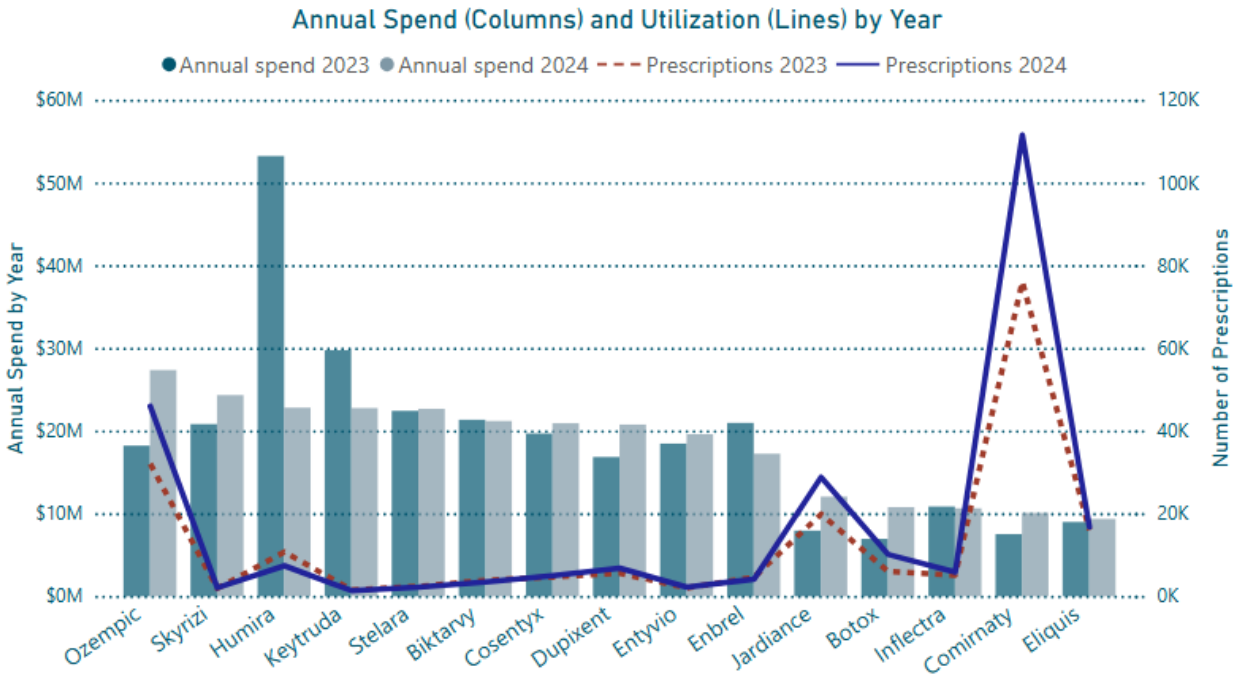

*Figure 4 Top 15 prescriptions drugs by annual spend and utilization based on **Most Prescribed** submissions, filtered and sorted by 2024 annual spend*

Table 6 expands the analysis to the top 25 drugs with the highest annual spend reported in the most prescribed submission, providing additional insight into prescription volume trends beyond the highest cost products. Unlike the GI and MC metrics, which emphasize financial impact, the MP metric collects information on medications with the highest utilization. The MP submission identifies drugs that are heavily used and often low cost, compared to the GI and MC submissions that highlight drugs which exert both cost and utilization pressure.

Key observations:

- **High utilization plus high costs**: When sorting by total annual spend, Ozempic and Jardiance appear across GI, MC, and MP, signaling major cost and utilization impact.
- **High utilization with moderate cost**: Amphetamine and Comirnaty have high volume and low cost per claim showing the impact of high consumer demand.
- **Declined utilization but still costly**: Humira and Biktarvy have utilization declines but continue to show high annual spend.
- **Moderate prescriptions numbers with high costs**: Skyrizi and Keytruda do not show high utilization but have high spending.

*Table 6 Top 25 prescriptions drugs by annual spend and utilization based on **Most Prescribed** submissions, filtered and sorted by 2024 annual spend*[10]

Proprietary name	Annual spend 2023	Annual spend 2024	Rx 2023	Rx 2024
Ozempic	$18,214,810	$27,349,232	32,035	45,934
Skyrizi	$20,813,688	$24,323,366	1,893	2,068
Humira	$53,236,669	$22,804,372	10,708	7,385
Keytruda	$29,753,794	$22,757,638	1,532	1,355
Stelara	$22,420,351	$22,664,306	2,387	2,166
Biktarvy	$21,341,233	$21,193,338	3,879	3,453
Cosentyx	$19,686,046	$20,924,427	4,629	4,967
Dupixent	$16,839,254	$20,761,642	5,532	6,785
Entyvio	$18,457,454	$19,604,107	2,000	2,187
Enbrel	$20,963,031	$17,237,243	4,606	4,137
Jardiance	$7,932,779	$12,047,536	19,845	28,789
Botox	$6,936,282	$10,778,124	5,957	10,104
Inflectra	$10,850,632	$10,636,642	5,123	5,860
Comirnaty	$7,510,991	$10,091,184	76,125	111,570
Eliquis	$8,982,636	$9,351,860	15,976	16,747
Prevnar	$10,704,470	$9,286,133	40,067	29,295
Rinvoq	$3,402,180	$8,038,781	760	1,627
Paxlovid	$123,571	$7,966,709	5,662	7,673
Amphetamine	$6,431,142	$7,730,196	151,913	213,586
Mounjaro	$2,046,043	$7,364,416	3,978	13,017
Gamunex-C	$4,565,021	$6,623,404	1,367	1,884
Amjevita	$6,288,723	$6,615,558	3,019	4,354
Shingrix	$7,571,933	$6,373,573	36,092	28,874
Gardasil	$5,610,114	$6,348,452	17,229	18,251
Eylea	$6,377,235	$6,016,032	1,914	1,875

Overall, MP trends reinforce that utilization remains a primary driver of system-wide prescription drug spending, but not all heavily prescribed drugs are the most expansive. Some drugs with high prescription volume exert relatively modest cost impact, while others with moderate utilization contribute disproportionately to total spending.

[10] Due to reporting variances stemming from divergence in insurers who report a drug each year across different markets, the total annual spend in 2023 and 2024 reported in the MP submission does not equal the total annual spend reported in the GI or MC submissions. Each of these values is a separate field in the insurer submissions to DPT and not a direct calculation.

Therapeutic class trends

This section provides a broader view of cost drivers in Oregon's commercial health insurance market by examining aggregate spending and utilization with drug categories. While GI, MC, and MP metrics highlight individual products, this section helps identify systemic cost pressures and utilization patterns across therapeutic areas that shape overall spending trends.

Therapeutic class[11] analysis is especially useful for identifying clusters of drugs that collectively contribute to significant cost growth, even when no single product dominates. This perspective supports the understanding of market dynamics beyond individual brand names.

Across the top therapeutic classes, several key patterns emerged:

1. Antidiabetic and dermatological drugs remain the most consistently high impact classes, appearing both in the top 10 by total annual spend and by greatest year-over-year increase in spending. These classes reflect growing clinical demand combined with sustained high net costs. The growth in the market can also be attributed to increased demand due to the rising prevalence of diabetes and increased usage of antidiabetic drugs to treat obesity. The result is an overall upswing in costs.[12]

2. Antineoplastics/adjective cancer therapies have the highest overall spending in 2024, and the single largest dollar increase year-over-year, despite a 20% decline in utilization. This indicates rising per-claim costs and expanded use of high-cost oncology biologics.

3. Respiratory agents showed extreme cost growth and appeared among the top spenders overall in 2024. Utilization increased sharply (over 500%), indicating rapid patient uptake of high-cost therapies.

Figure 5 provides additional insight showing year-over-year greatest increase in cost at the therapeutic class level and percentage change in utilization. These data reinforce earlier product-level findings but highlight broader systemic cost pressures occurring across multiple drug classes.

[11] We reference therapeutic class information extracted from the Medi-Span drug database: Medi-Span, Copyright 2025, Wolters Kluwer Clinical Drug Information, Inc. The attribution to Wolters Kluwer Clinical Drug Information, Inc. (WKCDI) of the data from Medi-Span does not constitute WKCDI's endorsement of the data, views, opinions, or findings expressed, shared, or otherwise published or displayed in this report.

[12] Rogers, John, and Dewey, Barbara. Understanding the cost dynamics of antidiabetic medications: A trend analysis (2016-2024). Milliman, Dec. 19, 2024. https://www.milliman.com/en/insight/cost-antidiabetic-medications-trend-analysis.

Figure 5 Top 10 therapeutic classes by year over year greatest increase in annual spending and percentage change in utilization (2023-2024), filtered and sorted by spending increase amount. Only those classes that had increases in both 2023 and 2024 are included.

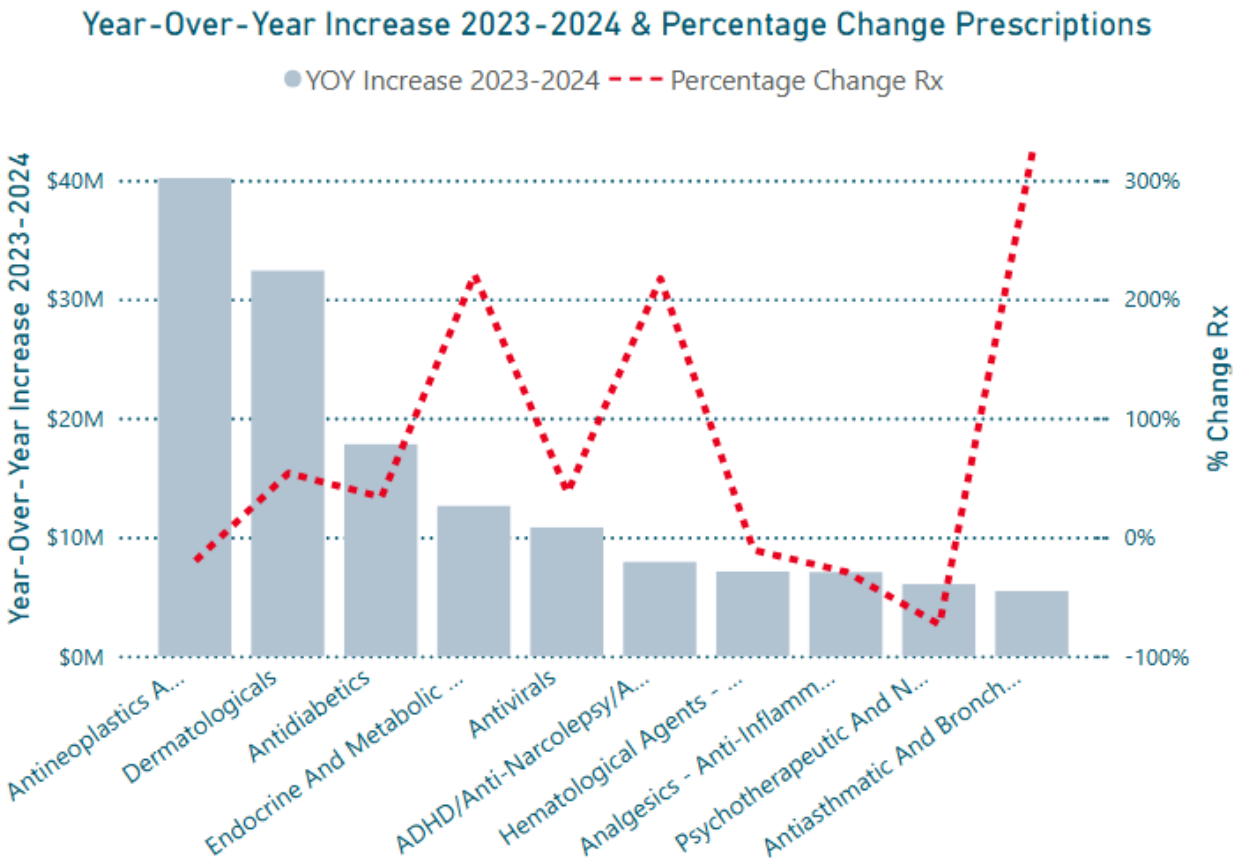

Table 7 continues to show the cost challenges are increasingly concentrated among a small number of therapeutic classes, particularly oncology, dermatologicals, and antidiabetics. In several of these classes, spending growth outpaces or diverges from utilization trends, indicating the influence of high-cost biologics, new indications, or market exclusivity.

Table 7 Top 25 therapeutic classes based on the amount of increase in annual spend from 2023 to 2024, filtered and sorted by the amount of reported increase. Only those classes that had increases in both 2023 and 2024 are included.[13]

Therapeutic class	Annual spend YOY increase 2023 to 2024	% Change Rx	% Change Total Annual Spend	Total Annual Spend 2023	Total Annual Spend 2024	Rx 2023	Rx 2024
Antineoplastics And Adjunctive Therapies	$40,184,671	-20%	-1%	$77,750,476	$76,715,330	8,795	7,052
Dermatologicals	$32,394,183	54%	49%	$72,140,323	$107,145,139	14,913	22,932
Antidiabetics	$17,806,221	34%	30%	$38,633,428	$50,101,933	99,153	132,536
Endocrine And Metabolic Agents - Misc.	$12,624,860	221%	106%	$10,522,717	$21,693,482	539	1,729
Antivirals	$10,816,296	37%	-4%	$23,198,422	$22,286,196	27,611	37,896
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	$7,913,962	217%	30%	$13,391,610	$17,440,478	93,852	297,772
Hematological Agents - Misc.	$7,107,226	-11%	-16%	$19,818,992	$16,618,207	938	836
Analgesics - Anti-Inflammatory	$7,057,161	-29%	26%	$14,051,410	$17,653,689	5,805	4,103
Psychotherapeutic And Neurological Agents - Misc.	$6,051,518	-74%	-7%	$16,729,773	$15,572,465	6,584	1,742
Antiasthmatic And Bronchodilator Agents	$5,465,161	324%	158%	$4,867,111	$12,560,062	40,533	171,693

Figure 6 illustrates the top 10 therapeutic classes ranked on total annual spending in 2024, as reported in the GI submissions. Unlike Figure 5, which focuses on year-over-year growth, Figure 6 highlights where overall financial burden is most concentrated regardless of utilization change. The class with the highest total spending is dermatologicals, totaling $107.1 million in 2024, driven by increased use of biologics such as Skyrizi, Stelara, Dupixent, and Cosentyx.

[13] Due to reporting variances stemming from divergence in insurers who report a drug each year across different markets, the difference between the total annual spend from 2023 to 2024 does not calculate to the indicated increase amount. Each of these values is a separate field in the insurer submissions to DPT and not a direct calculation.

Antineoplastics and adjunctive cancer therapies are the second highest, with $76 million in total spending. However, unlike dermatologicals, this class experienced a decline in utilization (20%), suggesting rising cost per treatment and continued reliance on high-cost specialty oncology drugs.

Antidiabetics rank third, with $50.1 million in 2024 spending, and show both rising utilization (34%) and spending (30%), reflecting ongoing uptake in GLP-1 therapies like Ozempic, Mounjaro, and Trulicity.

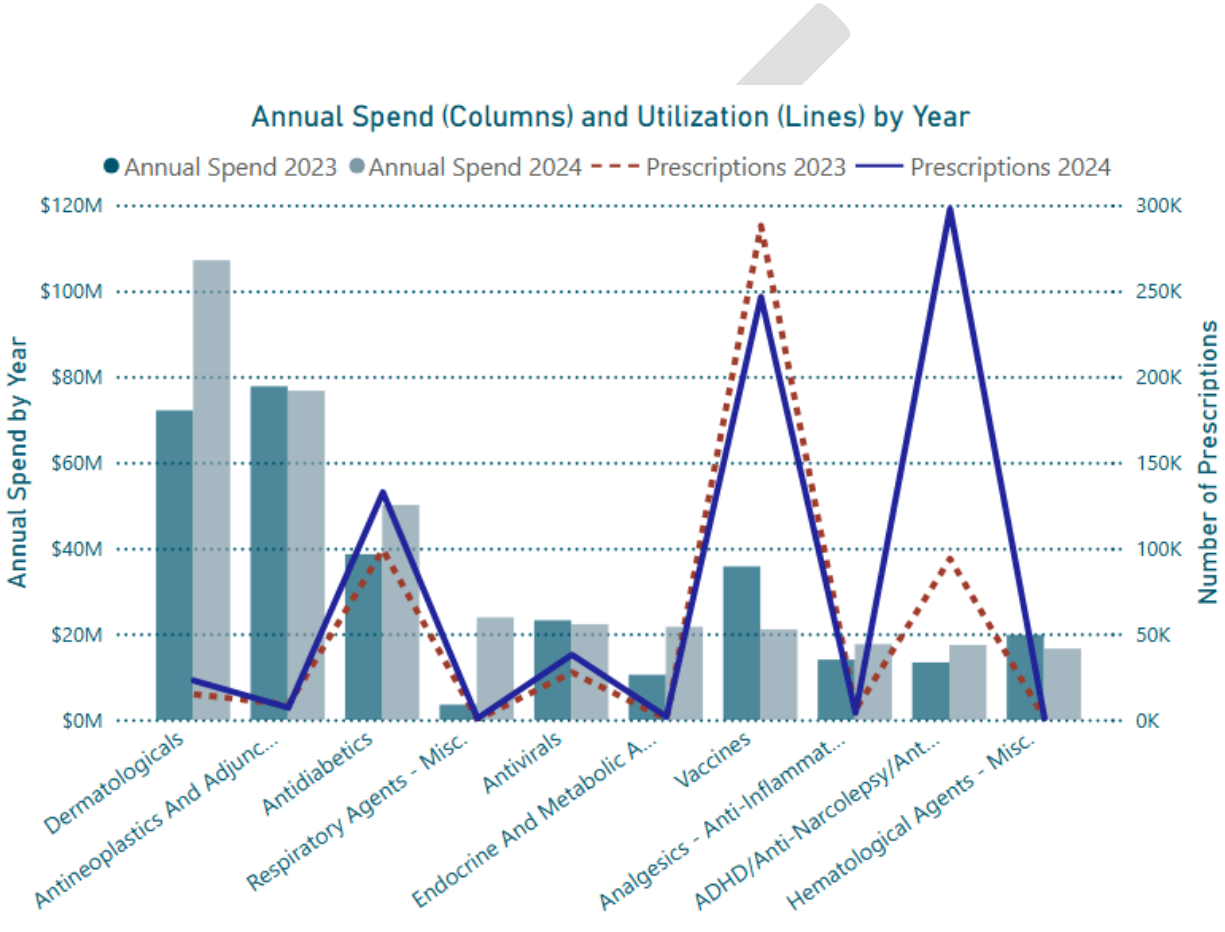

*Figure 6 Top 10 Therapeutic classes by **annual spend** as reported for **Greatest Increase** submissions, filtered and sorted by 2024 annual spend. Only those classes that had increases in both 2023 and 2024 are included.*

Table 8 provides a deeper comparison of how spending and utilization diverge across the top ten classes, sorted by 2024 annual spend. For example, dermatologicals and antidiabetics both show increases in spending that align with utilization growth, suggesting demand driven trends. In contrast, antineoplastics show high spending despite a 20 percent decline in prescriptions, indicating rising per-claim costs or shifting treatment intensity.

Vaccines and hematological agents remain among the top spend categories but show declining utilization and total costs, reflecting post-pandemic normalization or contracting demand rather than pricing pressure.

*Table 8 - Top 10 Therapeutic classes by **annual spend** as reported for **Greatest Increase** submissions, filtered and sorted by 2024 annual spend*[14]

Therapeutic class	Annual spend 2023	Annual spend 2024	Rx 2023	Rx 2024	Annual spend YOY increase 2023 to 2024
Dermatologicals	$72,140,323	$107,145,139	14,913	22,932	$32,394,183
Antineoplastics And Adjunctive Therapies	$77,750,476	$76,715,330	8,795	7,052	$40,184,671
Antidiabetics	$38,633,428	$50,101,933	99,153	132,536	$17,806,221
Respiratory Agents - Misc.	$3,542,190	$23,883,212	149	937	$4,953,294
Antivirals	$23,198,422	$22,286,196	27,611	37,896	$10,816,296
Endocrine And Metabolic Agents - Misc.	$10,522,717	$21,693,482	539	1,729	$12,624,860
Vaccines	$35,769,601	$21,083,385	287,898	246,528	$5,426,913
Analgesics - Anti-Inflammatory	$14,051,410	$17,653,689	5,805	4,103	$7,057,161
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	$13,391,610	$17,440,478	93,852	297,772	$7,913,962
Hematological Agents - Misc.	$19,818,992	$16,618,207	938	836	$7,107,226

These therapeutic classes represent areas where affordability challenges may be most pronounced and have patterns that align closely with individual drug level trends. Many of the high-cost or high-growth drugs identified in the GI and MC analyses are concentrated in a small number of therapeutic classes, amplifying their overall market impact as cost growth may exceed utilization trends. Monitoring class-level trends provides an early insight into emerging cost concerns.

Market dynamics

The trends observed across the GI, MC, MP and therapeutic-class analysis point to a complex interplay of utilization, pricing, and coverage dynamics rather than simply increases in

[14] See appendix for the list of drugs associated with the therapeutic classes shown

prescription volume alone. While rising utilization remains a principal driver of spending growth, market dynamics underscore that affordability is shaped by both clinical demand and financial structures such as rebates and formulary placements. Since the current data set represents approximately one-quarter of the insured population, results should be interpreted as directional indicators of affordability pressures, not exhaustive systemwide trends.

- **Rebate and negotiated price dynamics**. In many cases, spending increases exceed utilization growth, suggesting that net pricing changes and rebate structures are influencing cost trends. For example, rebates have grown substantially as a share of brand-drug spending in recent years, while net price inflation has lagged list price growth.[15]
- **Expanded indications and market uptake**. Drugs in major classes such as antidiabetics and dermatologicals are increasingly used, broadening patient populations and raising cost exposure even when utilization increments are currently moderate.[16]
- **Formulary placement, benefit design, and contracting.** Shifts in formulary tiering, prior-authorization policies, and negotiated contract terms with insurers and pharmacy benefit managers (PBMs) can affect both utilization and net cost.[17]
- **Launch of high-cost therapies and lifecycle transitions.** The introduction of novel agents (especially in specialty and biologic classes) and the transition of older therapies to generics or biosimilars affect market dynamics, often concentrating cost burdens among fewer products.[18]

Together, these dynamics help explain why some drugs show cost growth that outpaces utilization, and why therapeutic classes with a small number of high-cost products appear to drive a large share of spending.

Limitations and data considerations

The results presented in this report are subject to several important data considerations and limitations. While every effort was made to ensure data accuracy and consistency, certain

[15] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. (2024, November). Prescription drug spending, pricing trends, and premiums in private health insurance plans: Report to Congress. U.S. Department of Health & Human Services. https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/2024-report-to-congress-prescription-drug-spending.pdf.

[16] IQVIA institute. *Understanding the Use of Medicines in the U.S. 2025.* April 2025. Understanding the Use of Medicines in the U.S. 2025 - IQVIA.

[17] Report to Congressional Requesters: Medicare Part D: CMS Should Monitor Effects of Rebates. U.S. Government Accountability Office, September 2023. https://www.gao.gov/assets/gao-23-105270.pdf.

[18] Cowman, Craig. 2025 Advance Therapies Report. Cardinal Health. https://www.cardinalhealth.com/content/dam/corp/web/documents/Report/cardinal-health-advanced-therapies-report-25.pdf.

factors inherently affect the interpretation of the trends over time. These should be considered when evaluating across the GI, MC, MP, and therapeutic class analyses.

- **Price trends noted as cost trends** – The report is referred as "price trend", however the data supporting the analysis aligns with cost trending. House Bill 4005 defines price as "the wholesale acquisition cost as defined in 42 U.S.C. 1395w-3a(c)(6)(B)."[19] The data received from DPT is related to commercial health benefit plan reporting on net costs rather than WAC. Therefore, the analysis in this report is a review of the insurer costs and the trends therein.
- **Prescription drugs are reported at the drug level to DPT** - These drugs are entered by name into a text field. Manual text entry fosters multiple variations for drug names as entered by differing insurers. To better conduct this analysis, a summarized proprietary naming convention was adopted to associate all data lines at the prescription drug level.
- **Trends not indicative of Wholesale Acquisition Cost (WAC)** – Price trends as represented in the market by the data received are not necessarily indicative of WAC (see the bullet above "price trends noted as cost trends"). A WAC price may increase, decrease or remain the same from one period to the next and may not align with general market price and costs or trends seen in this report. The final cost for a drug can be influenced by many factors, including negotiations, rebates, fees, and supply chain variances.
- **The number of reporting insurers** – Eleven insurers are required to report data to DPT based on the above-mentioned statute. This is not inclusive of all insurers in the state or all markets. Roughly one quarter of the Oregon population is represented by these insurers.
- **Data submitted by insurers that are not required to report** – Not all insurers in the state are required to submit data to DPT. However, some who were not required to report still chose to submit data. Only data that is part of the required reporting is considered in this analysis.
- **Data values** - Net values are reported by the insurers representing spending after all rebates, discounts, price concessions, and any other forms of reimbursement have been applied.
- **Data rows where total annual spending equals the year-over-year increase** – For these values to be equal, the total annual spend for the previous year would be zero. This can either be due to a novel drug or a new addition to the insurer's formulary. These values were excluded during the analysis to prevent artificial escalation of the data. The data year for 2024 did not have any occurrences of these errors as they were identified by

[19] House Bill 4005 (2018). https://olis.oregonlegislature.gov/liz/2018R1/Downloads/MeasureDocument/HB4005/Enrolled.

improved validation processes. For the data year for 2023, there were 303 rows of data exhibiting this anomaly accounting for 5.95 percent of the data rows for that year and 3.00 percent of the data rows across both years.

- **Data rows where there are positive values for the number of enrollees and prescriptions and a zero amount for total annual spending** – These rows were validated with each insurer as they occurred and can result from an insurer receiving the total annual spend amount as a provider write-off. Represented rows were maintained in the data set as a zero value is a legitimate representation of total annual spend. This is represented by eleven rows and 0.01 percent of the data received from insurers for 2023 and 2024.
- For any given metric, **values must occur in all data years being analyzed for a trend to be identified**. Therefore, data rows for specific drugs that did not have values in both 2023 and 2024 for a given parameter were filtered out of the metric.
- **Grouping of multiple drugs for COVID-19 vaccines under one name, "COVID-19 Vaccines"** - Most insurers parsed out each vaccine; however, some provided the data as a group. Since these values cannot be attributed to a single drug by name, these values were filtered out when appearing for a given metric at the drug level. This accounted for 9 rows of data in the 2024 data with a cumulative total annual spend of $13.8 million. There were no occurrences of this type in the 2023 data.
- **Medical devices and diagnostic products reported by insurers** – Medical devices and diagnostic products can be reported in the top 25 lists. These items are beyond the scope of PDAB and are filtered out of all metrics.
- **Differing values for the same drug in analytics** – This report considers information from the three main lists submitted to DPT by insurers. A single drug may be represented on each of these lists; however, this does not mean that the values will be the same across each list. Therefore, when reviewing data across lists, these variances for individual drugs are expected.

Key takeaways

The findings of this analysis highlight several critical cost and utilization dynamics shaping Oregon's prescription drug market

- **Utilization remains the primary cost driver**. Across GI, MC, and MP metrics, spending growth closely tracks utilization trends. However, for a subset of high-impact drugs, cost growth exceeds utilization, pointing to pricing and rebates dynamics that warrant closer monitoring.

- **Cost pressures are concentrated in small number of drugs and classes**. Antidiabetic, dermatological, and anti-inflammatory drugs emerged consistently across metrics, accounting for a disproportionate share of total spending.
- **Net cost trends provide a more accurate view than list price**. Because the analysis is based on net insurer costs rather than WAC, the data better reflect real financial impacts on the health care system, although it does not capture all pricing or patient cost dynamics.
- **Market dynamics influence cost trajectories**. Factors such as formulary placement, rebate structures, expanded indications, and uptake of high-cost therapies contribute to observed trends, especially where spending increases outpace utilization.
- **Data limitations shape interpretation**. Trends are based on required insurer reporting, representing about one-quarter of the Oregon insured population. While this provides meaningful insight into commercial market dynamics, it does not represent the full payer landscape.

Together these findings point to growing financial pressure from a concentrated set of drugs and therapeutic classes. These pressures may have significant implications for patient affordability, payer sustainability, and systemwide spending. The analysis provides a data-driven foundation that PDAB can use in future work, including contributing to drug reviews and potential policy recommendations.

Drug review process and drugs under review

The Prescription Drug Affordability Board began its review cycle by examining 2023 cost and utilization data submitted through the Drug Price Transparency program (DPT). These data from plan year 2023, submitted to DPT in 2024, were the most recent data available at the beginning of calendar year 2025. These data included the top 25 most costly, greatest increase, and most prescribed drugs as reported by commercial health benefit plans.

Preliminary drug list development

The DPT data set was cleaned and standardized by the PDAB data analyst, with support from the data researcher, to ensure consistency across the sources. This process included:

- Standardizing drug identifiers and naming conventions.
- Removing duplicate entries and products outside PDAB's scope (e.g., medical devices, diagnostics).
- Aligning reporting formats across multiple insurers.

From this work, a preliminary drug list of 158 products was developed for board consideration.

Application of statutory and rule-based criteria

The board applied statutory and regulatory filters consistent with Oregon Senate Bill 844 (2021) and OAR 925-200-0010 to refine the list. This included removing:

- 62 orphan-designated drugs,
- 25 generic drugs,
- 13 vaccines,
- 2 toxoids,
- 1 diagnostic product,
- 8 drugs that have generics, and
- 20 drugs with fewer than six insurers reporting impacts.

This narrowed list of 27 drugs was submitted to insurers for further data collection through a targeted data call, along with seven long-active insulin products.

Supplemental data call collection and refinement

To supplement the DPT data set, PDAB staff conducted a data call to obtain additional 2023 net pricing information from commercial health benefit plans. Staff also incorporated data from the All Payor All Claims (APAC) database to assess gross cost impact across all payers. Using this additional information, the board removed:

- 4 orphan-designated drugs (early-stage vetting did not flag), and
- 7 drugs with fewer than 500 APAC enrollees.

This resulted in a final subset of 16 drugs and seven insulin products for formal cost review in 2025.

Scoring rubric and review tools

To support a structured and transparent review process, PDAB staff developed a drug scoring rubric in 2025 as an optional decision-support tool. While not adopted as a formal scoring methodology, the rubric provides board members with a consistent framework to consider factors such as:

- Cost impact and utilization trends
- Availability of therapeutic alternatives, and
- Health equity considerations

This tool enhances transparency and consistency in how information is interpreted, but board members retain full discretion in their review determinations.

Timeline and next steps

The final drug list for the 2025 review using 2023 data will be voted on by board members in January 2026 (extended from November 2025). By March of 2026, the board will present to the Legislature a final list of up to nine drugs and at least one insulin product determined to create affordability challenges based on the cost review process.

Prescription drugs and insulin products currently under review

The board's 2025 cost review cycle focuses on 16 prescription drugs and seven glargine insulin products identified through the DPT data set, supplemental data calls, and APAC analysis. These products were selected because they represented some of the highest cost drivers and utilization trends in Oregon's health care system and significant patient out-of-pocket costs.

These products fall across key therapeutic classes, including:

1. **Antidiabetic agents**: reflecting increased demand and market expansion for GLP-1 therapies and insulin products.
2. **Dermatological and anticoagulants**: representing high-cost specialty drugs with growing utilization.
3. **Cardiovascular therapies**: including ongoing use in chronic disease management.
4. **Neurological and migraine treatments**: showing moderate utilization with relatively high per-unit cost impacts.

The focused list allows the board to conduct a more in-depth and transparent review of products with the greatest potential affordability implications for both patients and payers. Final determination and recommendations will be based on multiple factors, including net cost trends, utilization, therapeutic alternatives, and equity impact.

Table 9 2023 Prescription drugs and insulin products reviewed by the board in 2025

Proprietary name	Non-proprietary name	Therapeutic class
Vraylar	Cariprazine HCl	Antipsychotic; Antimanic agents
Entresto	Sacubitril; Valsartan	Cardiovascular agents - misc.
Ajovy	Fremanezumab-vfrm	Migraine products
Emgality	Galcanezumab-gnlm	Migraine products
Nurtec	Rimegepant; Rimegepant sulfate	Migraine products
Ubrelvy	Ubrogepant	Migraine products
Trelegy	Fluticasone furoate; Umeclidinium bromide; Vilanterol trifenatate	Anti-asthmatic; bronchodilator
Eliquis	Apixaban	Anticoagulants
Xarelto	Rivaroxaban	Anticoagulants
Cosentyx	Secukinumab	Dermatological
Creon	Pancrelipase (Amylase; Lipase; Protease)	Digestive aids
Jardiance	Empagliflozin	Antidiabetics
Mounjaro	Tirzepatide	Antidiabetics
Ozempic	Semaglutide	Antidiabetics
Rybelsus	Semaglutide	Antidiabetics
Trulicity	Dulaglutide	Antidiabetics
Basaglar KwikPen	Insulin Glargine	Long-acting Insulin
Insulin Glargine-yfgn	Insulin Glargine	Long-acting Insulin
Lantus	Insulin Glargine	Long-acting Insulin
Lantus SoloStar	Insulin Glargine	Long-acting Insulin
Semglee (yfgn)	Insulin Glargine	Long-acting Insulin
Toujeo Max SoloStar	Insulin Glargine	Long-acting Insulin
Toujeo SoloStar	Insulin Glargine	Long-acting Insulin

Recommendations

Appendix

Therapeutic class	Drug
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	Amphetamine
	Atomoxetine
	Azstarys
	Dexmethylphenidate
	Jornay PM
	Lisdexamfetamine
	Methylphenidate
	Qelbree
	Vyvanse
	Wakix
	Wegovy
Analgesics - Anti-Inflammatory	Actemra
	Enbrel
	Humira
	Ilaris
	Orencia
	Otezla
	Rinvoq
	Simponi
	Xeljanz
Antiasthmatic And Bronchodilator Agents	Advair
	Albuterol
	Anoro Ellipta
	Breo Ellipta
	Breztri Aerosphere
	Cromolyn
	Fluticasone
	Nucala
	Qvar
	Spiriva
	Stiolto
	Symbicort
	Tiotropium Bromide
	Trelegy
	Xolair
Antidiabetics	Baqsimi
	Basaglar
	Farxiga
	Fiasp
	Glimepiride
	Humalog
	Humulin

	Insulin Aspart
	Insulin Degludec
	Insulin Glargine
	Insulin Lispro
	Janumet
	Januvia
	Jardiance
	Lantus
	Lyumjev
	Metformin
	Mounjaro
	Novolog
	Ozempic
	Rybelsus
	Semglee
	Toujeo
	Tresiba
	Trulicity
Antineoplastics And Adjunctive Therapies	Abraxane
	Adcetris
	Avastin
	Ayvakit
	Brukinsa
	Cabometyx
	Calquence
	Carboplatin
	Cyclophosphamide
	Docetaxel
	Enhertu
	Erbitux
	Exemestane
	Fluorouracil
	Gazyva
	Imfinzi
	Jakafi
	Kadcyla
	Keytruda
	Kisqali
	Kyprolis
	Lenvima
	Leucovorin
	Lonsurf
	Lorbrena
	Lynparza
	Mvasi
	Opdivo

	Opdualag
	Oxaliplatin
	Paclitaxel
	Perjeta
	Phesgo
	Piqray
	Pomalyst
	Riabni
	Rituxan
	Ruxience
	Sprycel
	Tagrisso
	Tasigna
	Tecentriq
	Temozolomide
	Tibsovo
	Trodelvy
	Truxima
	Vectibix
	Venclexta
	Verzenio
	Yervoy
	Zoladex
	Zynlonta
Antivirals	Biktarvy
	Cabenuva
	Descovy
	Dovato
	Emtricitabine-Tenofovir
	Entecavir
	Juluca
	Paxlovid
	Prezcobix
	Triumeq
	Valacyclovir
	Valganciclovir
Dermatologicals	Cosentyx
	Dupixent
	Isotretinoin
	Ivermectin
	Lidocaine
	Opzelura
	Skyrizi
	Stelara
	Tacrolimus
	Taltz

	Tremfya
	Tretinoin
Endocrine And Metabolic Agents - Misc.	Crysvita
	Fabrazyme
	Genotropin
	Jynarque
	Nexviazyme
	Norditropin Flexpro
	Orilissa
	Palynziq
	Ravicti
	Sandostatin
	Signifor LAR
	Somatuline Depot
	Tepezza
	Xgeva
Hematological Agents - Misc.	Altuviiio
	Brilinta
	Cathflo Activase
	Hemlibra
	Orladeyo
	Ultomiris
Psychotherapeutic And Neurological Agents - Misc.	Acamprosate Calcium
	Amvuttra
	Avonex
	Glatopa
	Kesimpta
	Ocrevus
	Sodium Oxybate
	Tysabri
	Varenicline
	Vumerity
	Xywav
Respiratory Agents - Misc.	Ofev
	Trikafta
Vaccines	Abrysvo
	Bexsero
	Comirnaty
	Engerix-B
	Flublok
	Fluzone
	Gardasil
	Heplisav-B
	Menquadfi
	Menveo
	Moderna Covid-19 Vaccine

	Novavax Covid-19 Vaccine
	Prevnar
	ProQuad
	Shingrix
	Spikevax Covid-19 Vaccine
	Twinrix

Oregon Prescription Drug
Affordability Board

Prescription Drug Affordability Board

2025 policy recommendations

November 19, 2025

2025 policy concepts for discussion

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

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.
- 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 uniform 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.
- 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.
- 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).

8) Outlaw the PBM requirement that pharmacies must contractually dispense medications below their cost to dispense.

2025 policy concepts for discussion

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)
12) 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

13) 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.
14) 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.
15) All drugs fee for service: Alaska, Idaho, Montana, Wyoming, Colorado, South Dakota, Wisconsin, Missouri, Arkansas, Tennessee, Alabama, Vermont, Maine.
16) Full drug carve out States that went “back” to FFS: California (2022), North Dakota (2019), West Virginia (2017), New York (2023).
17) Point of sale rebates – Like West Virginia referenced in the 2024/2025 report to the Oregon Legislature.

2025 policy concepts for discussion

18) 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
19) 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.
20) 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.
21) Disband the Oregon PDAB and suggest the Legislature consider alternative initiatives to address prescription drug affordability.

2025 policy concepts for vote

1. Pharmacy Benefit Manager (PBM) reform and pricing transparency

a) Enact reforms to improve transparency within PBM operations. Specifically, eliminate spread pricing in Medicaid and managed care programs, require PBMs reimbursement benchmarking to rely on objective and verifiable cost data, such as NADAC, and delink PBM services from drug prices.
b) Prohibit PBMs contract terms that require pharmacies to dispense medications below cost and increasing public reporting of PBM rebate pricing practices.
c) Evaluate potential conflicts of interest and rebate-linked incentives among insurance brokers and contracting intermediates, consistent with emerging national models such as Vermont's S.30 (2025).

Cross-references original recommendations numbers 1 through 6, 8, and 14

2. Pharmacy network access and fair reimbursement

Adopt an 'any-willing-provider' standard, allowing all qualified pharmacies to participate in insurance plan networks. Reimbursement should be based on verified acquisition costs, include a reasonable margin, and adhere to the Oregon Health Authority's Medicaid dispensing fee schedule to promote equitable and sustainable payments for pharmacy providers statewide.

Cross-references original recommendations numbers 5 and 9

2025 policy concepts for vote

3. Single statewide PBM and uniform preferred drug list (PDL)

a) Establish a single statewide PBM for administration of prescription benefits across Medicaid and managed-care programs and consider extending to commercial markets were feasible. The PDM should be selected through a competitive bid process that prioritized transparency, efficiency, and equitable access.

b) Establish a uniform PDL applicable to Medicaid, managed care, and where practical, commercial health programs.

Cross-references original recommendations numbers 7 and 19

4. Drug pricing oversight and affordability mechanisms

a) Consider implementing upper payment limits (UPLs) only after all other cost-containment reforms have been evaluated.

b) Explore cost-plus reimbursement models for public employee programs and implementation of point-of-sale rebate models that directly lower patient out-of-pocket costs.

Cross-references original recommendations numbers 10, 13, 15, 16, 17, and 18

2025 policy concepts for vote

5. Medicaid delivery and carve-out structure
Evaluate the feasibility of full drug carve-outs or fee-for-services (FFS) reimbursement models for Medicaid pharmacy benefits.

Cross-references original recommendations numbers 15 and 16

6. 340B program transparency
Require reporting of data about the 340B program to assess its financial impact, transparency, and equitable distribution of benefits. The report should evaluate which entities receive the largest economic gains, the patient populations served, payer types contributing to revenue, and any potential rebate losses to the state due to 340B discounts provided to Medicaid.

Cross-references original recommendation number 12

2025 policy concepts for vote

7. PDAB scope and governance

a) Expand PDABs authority to allow for broader review of Oregon's prescription drug delivery system.
b) Amend ORS 192.660 (4) to review trade-secret or proprietary information in executive session without media present.

Cross-references original recommendations numbers 11 and 20

8. Legislative review and strategic alternatives

a) Disband the Oregon PDAB.
b) Consider alternative initiatives to address prescription drug affordability.

Cross-references original recommendations number 21

Rubric

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

Domain *Statutory and **Rule References	Score 0 (low impact)	Score 1 (moderate impact	Score 2 (high impact)	Score 3 (severe impact)
Utilization *Sec. 2.(1)(b) **(1)(b) & (2)(b)	Less than 2,999 patients on drug reported in APAC	3,000 to 9,999 patients on drug reported in APAC	10,000 to 24,999 patients on drug reported in APAC	25,000 or more patients on drug reported in APAC
Price evaluation *Sec. 2.(1)(c), (f) **(1)(c), (f), & (2)(c)	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) *Sec. 2.(1)(d), (e), (g) **(1)(d), (e), (g), & (2)(d), (L)	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 *Sec. 2.(1)(h), (j) **(1)(h), (j) & (2)(h), (i)	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
Enrollee burden *Sec. 2(1)(k) **(1)(k), & (2)(j)	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
Domain ***Statutory and ****Rule References**	**No = Score 0**	**Yes = Score 1**		
Equity impact & considerations. **Does information show the drug disproportionately burdens or limits access for specific populations (e.g. cost, coverage)?** *Sec. 2.(1)(a), (j) **(1)(a), (j) & (2)(a), (i)				
Do access restrictions (e.g. prior authorizations, non-preferred formulary status, high patient OOP costs) contribute to increased system spending or patient financial burden? *Sec. 2.(1)(i) ** (1)(i), & (2)(g)				

Domain *Statutory and **Rule References	No = Score 0	Yes = Score 1	[redacted]	[redacted]
Do therapeutic alternatives fail to reduce total system spending or patient OOP burden for the drug under review? *Sec. 2.(1)(f), (g) & (j) **(1)(f), (g), (j), & (2)(c), (i), (m)			[redacted]	[redacted]
Did stakeholder input identify affordability access, or financial hardship concerns related to the drug under review? *Sec. 2.(1)(L), & (3)			[redacted]	[redacted]
Is the exclusivity expiration date more than 18 months in the future, based on available patent or exclusory information?			[redacted]	[redacted]
Is the drug excluded from CMS price negotiation drug Maximum Fair Price (MFP) list?			[redacted]	[redacted]

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.
OOP	Out of pocket: The sum of the out-of-pocket cost for enrollees.	PDAB
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.

Scoring rubric is a decision support tool and not

Version	Date Revised	Prepared By	Purpose	Key Updates
v3.0 – Updated based on public comment feedback.	October 2025	PDAB Staff – Data & Policy Team	To improve consistency, clarity, and transparency of affordability scoring rubric.	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.
v4.0 – Updated based on public comment feedback.	November 2025	PDAB Staff – Data & Policy Team	To improve consistency, clarity, and transparency of affordability scoring rubric.	1. Added statutory and rule references 2. Arranged five domains to be Yes or No.

Oregon Prescription Drug Affordability Board

Web links to final drug reports

Agenda item: Drug and insulin material packets. Board will continue reviewing subset list of prescription drugs and insulin products pursuant to OAR 925-200-0020.

In Table 1 below, click on the prescription drug name to read the final version of the drug review document. This table of information is also available on the **Prescription Drug Affordability Board drug review page**.

Table 1: 2025 Oregon PDAB drug review documents, videos, and minutes web links

Drug review documents	Review date	Meeting video	Meeting minutes
• Vraylar • Entresto • Ajovy • Emgality • Nurtec • Ubrelvy	July 16, 2025	July 16, 2025	July 16, 2025
• Trelegy • Eliquis • Xarelto • Cosentyx • Creon	Aug. 20, 2025	Aug. 20, 2025	Aug. 20, 2025
• Jardiance • Mounjaro • Ozempic • Rybelsus • Trulicity	Sept. 17, 2025	Sept. 17, 2025	Sept. 17, 2025
• Insulin products: **Basaglar KwikPen, Insulin Glargine-yfgn, Lantus, Lantus SoloStar, Semglee, Toujeo Max SoloStar Toujeo SoloStar**	Oct. 15, 2025	Oct. 15, 2025	Oct. 15, 2025