Oregon Prescription Drug Affordability Board

# Patient, Caregiver, and Advocacy Group Survey Feedback

**Purpose and privacy note:** This document presents substantive feedback submitted through the 2026 patient, caregiver, and advocacy group survey for prescription drugs under review. Personally identifying and administrative information has been excluded, including respondent names, email addresses, timestamps, survey IDs, and demographic fields. Any apparent email address or telephone number found within narrative comments have also been removed. Responses are presented as submitted, with only minor spacing cleanup. The views expressed are those of individual respondents and have not been independently verified by PDAB.

## Jardiance (empagliflozin)

### Response 1

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|---|---|
| **Are you completing this form as:** | A patient |
| **Is the medication currently being taken?** | Yes |
| **How long has (or was) this medication taken?** | 1-3 years |
| **How often do you take this medication?** | Daily |
| **Do you have health insurance that covers this medication?** | Yes |
| **What is your typical out-of-pocket cost for a 30-day supply?** | More than $250 |
| **Has your out-of-pocket cost for this medication increased in the past 12 months?** | Yes |
| **If costs increased from last year, how significant was the increase?** | $25-50 |
| **How clear is the information you received about the cost of your medication?** | Somewhat clear |
| **Have you ever delayed filling a prescription for this medication due to cost?** | Yes |
| **Have you ever skipped doses or taken less than prescribed due to cost?** | Yes |

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| **Have you ever stopped taking this medication due to cost?** | No |
| **Have you had difficulty obtaining this medication due to insurance requirements (e.g., prior authorization, step therapy)?** | Yes |
| **Have you experienced any of the following barriers? Select all that apply** | None of the above; |
| **How much of a financial burden is paying for this medication?** | Significant burden |
| **Have you had to cut back on other essential expenses (e.g., food, housing, utilities) to afford this medication?** | Yes |
| **Do you use manufacturer coupons, discount cards, or patient assistance programs to afford this medication?** | Not sure |
| **Primary insurance type** | Individual/Marketplace |
| **Has your insurance ever denied coverage for this medication?** | No |
| **Has your insurance required you to switch to a different medication for cost reasons?** | Yes |
| **Has your copay or coinsurance for this medication changed in the past year?** | Increased |
| **Has difficulty affording this medication negatively affected your health?** | Yes |
| **Have you visited an emergency room or urgent care because you could not access this medication?** | No |
| **Is there anything else you would like PDAB to know about how medication costs or access affects you?** | No |
| **If you could change one thing about how this prescription drug is priced or accessed in Oregon, what would it be?** | Lower Prices |
| **Do you currently receive prescription medications in Oregon?** | Yes |

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## Response 2

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|---|---|
| **Are you completing this form as:** | A patient |
| **Is the medication currently being taken?** | Yes |
| **How long has (or was) this medication taken?** | Less than 3 months |
| **How often do you take this medication?** | Daily |
| **Do you have health insurance that covers this medication?** | Yes |
| **What is your typical out-of-pocket cost for a 30-day supply?** | $0–$25 |
| **Has your out-of-pocket cost for this medication increased in the past 12 months?** | No |
| **If costs increased from last year, how significant was the increase?** | Not applicable |
| **How clear is the information you received about the cost of your medication?** | I receive no cost information |
| **Have you ever delayed filling a prescription for this medication due to cost?** | No |
| **Have you ever skipped doses or taken less than prescribed due to cost?** | No |
| **Have you ever stopped taking this medication due to cost?** | No |
| **Have you had difficulty obtaining this medication due to insurance requirements (e.g., prior authorization, step therapy)?** | No |
| **Have you experienced any of the following barriers? Select all that apply** | None of the above; prescribed drug on the formulary....difficulty getting a prior authorization |
| **How much of a financial burden is paying for this medication?** | No burden |
| **Have you had to cut back on other essential expenses (e.g., food, housing, utilities) to afford this medication?** | No |
| **Do you use manufacturer coupons, discount cards, or patient assistance programs to afford this medication?** | No |

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| **Primary insurance type** | Medicare |
| **Has your insurance ever denied coverage for this medication?** | No |
| **Has your insurance required you to switch to a different medication for cost reasons?** | No |
| **Has your copay or coinsurance for this medication changed in the past year?** | Stayed the same |
| **Has difficulty affording this medication negatively affected your health?** | No |
| **Have you visited an emergency room or urgent care because you could not access this medication?** | No |
| **Is there anything else you would like PDAB to know about how medication costs or access affects you?** | |
| **If you could change one thing about how this prescription drug is priced or accessed in Oregon, what would it be?** | |
| **Do you currently receive prescription medications in Oregon?** | Yes |

### Response 3

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|---|---|
| **Are you completing this form as:** | A patient |
| **Is the medication currently being taken?** | Previously taken but no longer on |
| **How long has (or was) this medication taken?** | More than 3 years |
| **How often do you take this medication?** | Daily |
| **Do you have health insurance that covers this medication?** | Yes |
| **What is your typical out-of-pocket cost for a 30-day supply?** | $51-100 |
| **Has your out-of-pocket cost for this medication increased in the past 12 months?** | No |
| **If costs increased from last year, how significant was the increase?** | Not applicable |

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| **How clear is the information you received about the cost of your medication?** | Very clear |
| **Have you ever delayed filling a prescription for this medication due to cost?** | No |
| **Have you ever skipped doses or taken less than prescribed due to cost?** | No |
| **Have you ever stopped taking this medication due to cost?** | No |
| **Have you had difficulty obtaining this medication due to insurance requirements (e.g., prior authorization, step therapy)?** | No |
| **Have you experienced any of the following barriers? Select all that apply** | None of the above; |
| **How much of a financial burden is paying for this medication?** | Minor burden |
| **Have you had to cut back on other essential expenses (e.g., food, housing, utilities) to afford this medication?** | No |
| **Do you use manufacturer coupons, discount cards, or patient assistance programs to afford this medication?** | No |
| **Primary insurance type** | Employer-sponsored |
| **Has your insurance ever denied coverage for this medication?** | No |
| **Has your insurance required you to switch to a different medication for cost reasons?** | Yes |
| **Has your copay or coinsurance for this medication changed in the past year?** | Stayed the same |
| **Has difficulty affording this medication negatively affected your health?** | No |
| **Have you visited an emergency room or urgent care because you could not access this medication?** | No |
| **Is there anything else you would like PDAB to know about how medication costs or access affects you?** | Providence stopped covering this medication; changed to another. |

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| **If you could change one thing about how this prescription drug is priced or accessed in Oregon, what would it be?** | no suggestions |
| **Do you currently receive prescription medications in Oregon?** | Yes |

### Response 4

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|---|---|
| **Are you completing this form as:** | A patient |
| **Is the medication currently being taken?** | No |
| **How long has (or was) this medication taken?** | Less than 3 months |
| **How often do you take this medication?** | No longer taking |
| **Do you have health insurance that covers this medication?** | Yes |
| **What is your typical out-of-pocket cost for a 30-day supply?** | More than $250 |
| **Has your out-of-pocket cost for this medication increased in the past 12 months?** | No |
| **If costs increased from last year, how significant was the increase?** | Not applicable |
| **How clear is the information you received about the cost of your medication?** | Very clear |
| **Have you ever delayed filling a prescription for this medication due to cost?** | Yes |
| **Have you ever skipped doses or taken less than prescribed due to cost?** | Yes |
| **Have you ever stopped taking this medication due to cost?** | Yes |
| **Have you had difficulty obtaining this medication due to insurance requirements (e.g., prior authorization, step therapy)?** | Yes |
| **Have you experienced any of the following barriers? Select all that apply** | Pharmacy closures or limited hours; |
| **How much of a financial burden is paying for this medication?** | Moderate burden |

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| **Have you had to cut back on other essential expenses (e.g., food, housing, utilities) to afford this medication?** | No |
| **Do you use manufacturer coupons, discount cards, or patient assistance programs to afford this medication?** | No |
| **Primary insurance type** | Federal drug program |
| **Has your insurance ever denied coverage for this medication?** | Yes |
| **Has your insurance required you to switch to a different medication for cost reasons?** | Yes |
| **Has your copay or coinsurance for this medication changed in the past year?** | Stayed the same |
| **Has difficulty affording this medication negatively affected your health?** | Not sure |
| **Have you visited an emergency room or urgent care because you could not access this medication?** | No |
| **Is there anything else you would like PDAB to know about how medication costs or access affects you?** | I ended up not filling my prescription after insurance denied coverage and out of pocket cost is approximately $500/month |
| **If you could change one thing about how this prescription drug is priced or accessed in Oregon, what would it be?** | My doctor thought this was an important drug for me to try but insurance denial made it unaffordable. Should insurance make these decisions? |
| **Do you currently receive prescription medications in Oregon?** | Yes |

### Response 5

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|---|---|
| **Are you completing this form as:** | A patient |
| **Is the medication currently being taken?** | No |
| **How long has (or was) this medication taken?** | Less than 3 months |
| **How often do you take this medication?** | No longer taking |
| **Do you have health insurance that covers this medication?** | No |

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|---|---|
| **What is your typical out-of-pocket cost for a 30-day supply?** | More than $250 |
| **Has your out-of-pocket cost for this medication increased in the past 12 months?** | No |
| **If costs increased from last year, how significant was the increase?** | Not applicable |
| **How clear is the information you received about the cost of your medication?** | Very clear |
| **Have you ever delayed filling a prescription for this medication due to cost?** | Yes |
| **Have you ever skipped doses or taken less than prescribed due to cost?** | No |
| **Have you ever stopped taking this medication due to cost?** | Yes |
| **Have you had difficulty obtaining this medication due to insurance requirements (e.g., prior authorization, step therapy)?** | No |
| **Have you experienced any of the following barriers? Select all that apply** | None of the above; |
| **How much of a financial burden is paying for this medication?** | Significant burden |
| **Have you had to cut back on other essential expenses (e.g., food, housing, utilities) to afford this medication?** | Yes |
| **Do you use manufacturer coupons, discount cards, or patient assistance programs to afford this medication?** | Yes |
| **Primary insurance type** | Medicare |
| **Has your insurance ever denied coverage for this medication?** | Not sure |
| **Has your insurance required you to switch to a different medication for cost reasons?** | No |
| **Has your copay or coinsurance for this medication changed in the past year?** | Stayed the same |

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|---|---|
| **Has difficulty affording this medication negatively affected your health?** | Not sure |
| **Have you visited an emergency room or urgent care because you could not access this medication?** | No |
| **Is there anything else you would like PDAB to know about how medication costs or access affects you?** | Cost was quoted at $2K for a 3 month supply, so $8K per year. That isn't affordable for someone on a fixed income from Social Security. |
| **If you could change one thing about how this prescription drug is priced or accessed in Oregon, what would it be?** | make generics available sooner |
| **Do you currently receive prescription medications in Oregon?** | Yes |

### Response 6

| | |
|---|---|
| **Are you completing this form as:** | A patient |
| **Is the medication currently being taken?** | Yes |
| **How long has (or was) this medication taken?** | 1-3 years |
| **How often do you take this medication?** | Daily |
| **Do you have health insurance that covers this medication?** | No |
| **What is your typical out-of-pocket cost for a 30-day supply?** | $26-$50 |
| **Has your out-of-pocket cost for this medication increased in the past 12 months?** | No |
| **If costs increased from last year, how significant was the increase?** | Not applicable |
| **How clear is the information you received about the cost of your medication?** | Somewhat clear |
| **Have you ever delayed filling a prescription for this medication due to cost?** | No |
| **Have you ever skipped doses or taken less than prescribed due to cost?** | No |

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|---|---|
| **Have you ever stopped taking this medication due to cost?** | No |
| **Have you had difficulty obtaining this medication due to insurance requirements (e.g., prior authorization, step therapy)?** | No |
| **Have you experienced any of the following barriers? Select all that apply** | Medication backordered or shortages; |
| **How much of a financial burden is paying for this medication?** | Minor burden |
| **Have you had to cut back on other essential expenses (e.g., food, housing, utilities) to afford this medication?** | No |
| **Do you use manufacturer coupons, discount cards, or patient assistance programs to afford this medication?** | No |
| **Primary insurance type** | Uninsured |
| **Has your insurance ever denied coverage for this medication?** | No |
| **Has your insurance required you to switch to a different medication for cost reasons?** | No |
| **Has your copay or coinsurance for this medication changed in the past year?** | Stayed the same |
| **Has difficulty affording this medication negatively affected your health?** | No |
| **Have you visited an emergency room or urgent care because you could not access this medication?** | No |
| **Is there anything else you would like PDAB to know about how medication costs or access affects you?** | Very expensive if purchased from US pharmacies. I order from Canada at great cost savings. |
| **If you could change one thing about how this prescription drug is priced or accessed in Oregon, what would it be?** | Make price same as rest of world. |
| **Do you currently receive prescription medications in Oregon?** | Yes |