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May 6, 2026

Oregon Prescription Drug Affordability Board
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Re: Inappropriate Selection of Rituxan® (rituximab) as a Therapeutic Alternative to Ocrevus®

Dear Members of the Oregon Prescription Drug Affordability Board:

Genentech appreciates the opportunity to share timely feedback with you regarding the identification of Rituxan as a therapeutic alternative to Ocrevus as part of the 2026 drug selection and review process. Genentech objects to the inclusion of Rituxan and the manner in which it was added to the therapeutic alternatives listing. Immediately following the Board's March 18, 2026 meeting, the Board's website was updated to reflect a "subset list of prescription drugs 2026" with a hyperlink to a PDF file identifying the drugs selected during the meeting for 2026 affordability reviews. At a later date, the PDF file associated with this hyperlink was updated to reflect the schedule of affordability reviews and the list of therapeutic alternatives identified for each selected prescription drug. Genentech identified this change in file content on March 26, 2026 as there was no notification or indication that the PDF file content had been updated.

Between March 26, 2026 and April 10, 2026 when Genentech again accessed the "subset list of prescription drugs 2026" hyperlink via the Board's website, without notice, we became aware that the Board modified the initial list of therapeutic alternatives to be considered during the August 19, 2026 scheduled review of Ocrevus. By April 10, 2026, Rituxan (rituximab) was added to the list of therapeutic alternatives, establishing a list of five therapeutic alternatives when all prior data and content associated with Ocrevus only identified four therapeutic alternatives. **Genentech requests the Board immediately remove Rituxan as an inappropriate therapeutic alternative to Ocrevus.**

Under OAR 925-200-0010(5), the Board is tasked with considering the cost and availability of potential alternatives "where there are therapeutic alternatives".[1] The interpretation of what constitutes an "alternative" is provided in OAR 925-200-0020, which defines a therapeutic alternative as "a drug product containing a different therapeutic agent that is FDA-approved, compendia-recognized for the same indication, or recommended by professional guidelines as consistent with standard medical practice." Crucially, the rule requires that such an alternative

[1] Or. Admin. R. 925-200-0010 (2024).

must possess similar therapeutic effects, safety profiles, and expected outcomes when administered in a therapeutically equivalent dose.[2] The clinical data and the historical development of these molecules demonstrate that Rituxan fails to meet these criteria across every metric relevant to the treatment of multiple sclerosis (MS). By mistakenly benchmarking Ocrevus against a chimeric agent like Rituxan, which is not approved to treat MS, the Board's analysis is anchoring to an inappropriate reference point that ignores the distinct structural and clinical innovations that define Ocrevus' value proposition.

The following evidence demonstrates that the PDAB's inclusion of Rituxan as a therapeutic alternative for Ocrevus is both scientifically and clinically inappropriate and inconsistent with OAR 925-200-0010.

Biological Inconsistency: A chimeric antibody (Rituxan) with a high immunogenicity profile is not a biological or safety-equivalent to a humanized antibody (Ocrevus).
A nuanced understanding of the structural differences between Ocrevus and Rituxan is essential to recognize why they cannot be considered therapeutic alternatives. Although both are monoclonal antibodies that target CD20-expressing B cells, they interact with the human immune system in fundamentally distinct ways. Rituxan, developed in the 1990s and initially approved for non-Hodgkin's lymphoma, is a chimeric monoclonal antibody. This means the molecule contains a significant percentage of murine (mouse) protein sequence. In contrast, Ocrevus is a recombinant humanized monoclonal antibody, designed to be 90-95% human protein.[3]

The humanization of Ocrevus was a deliberate scientific response to the immunogenicity challenges observed with chimeric antibodies. When a patient is administered a chimeric drug like Rituxan, the presence of mouse-derived proteins increases the likelihood that the human immune system will develop anti-drug antibodies (ADAs).[4] In the HERMES Phase II study of Rituxan in patients with relapsing-remitting MS (RRMS), approximately 24.1% of patients developed anti-chimeric antibodies. These ADAs can neutralize the drug, rendering it ineffective, and increase the risk of adverse immune reactions. Ocrevus, by virtue of its humanized structure, significantly reduces this risk, as reflected in Phase III clinical trials where ADA formation was low and comparable to placebo groups.[5]

Further, a comparative study of the long-term safety profiles of ocrelizumab and rituximab in persons with MS published in January 2026 from the University of California health system found that Rituxan does not possess a safety profile similar to that of Ocrevus. In fact, patients treated with Rituxan experienced higher all-cause hospitalization rates and higher risk of developing hypogammaglobulinemia.[6]

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[2] Or. Admin. R. 925-200-0010 (2024).
[3] Hauser SL, Bar-Or A, Comi G, et al. Ocrelizumab versus Interferon Beta-1a in Relapsing Multiple Sclerosis [supplementary appendix appears online]. N Engl J Med 2017;376:221-234. https://www.ncbi.nlm.nih.gov/pubmed/28002679
[4] Moss B, Love T, Baldassari L, et al. Comparison of Tolerability Between Rituximab and Ocrelizumab. Presented at the American Academy of Neurology in Toronto, Canada; April 25 - May 1, 2020. AAN Abstract. https://index.mirasmart.com/AAN2020/SearchResults.php?cl
[5] Hauser SL, Waubant E, Arnold DL, et al. B-cell depletion with rituximab in relapsing-remitting multiple sclerosis. *N Engl J Med*. 2008;358(7):676-688.
[6] Cerono G, Cree BAC, Hauser SL, Baranzini SE. Comparative Safety Profiles of Ocrelizumab and Rituximab in Multiple Sclerosis

Clinical Inconsistency: Failure in primary-progressive MS (PPMS) trials does not support the idea that Rituxan has "similar expected outcomes".
Rituxan failed its primary efficacy outcome in the OLYMPUS study, the pivotal Phase II/III trial for Rituxan in PPMS.[7] The study showed no significant difference in the time to Confirmed Disease Progression (CDP) between patients receiving Rituxan and those receiving a placebo. Because Rituxan has no proven impact on slowing disability progression in PPMS, it is factually incorrect to categorize it as a therapeutic alternative to Ocrevus. Ocrevus remains the only medication with proven efficacy for this indication.

Further, the scientific community recognizes that Phase II results are insufficient to establish a drug as a standard therapeutic alternative, especially when Phase III evidence for a newer agent has demonstrated clear clinical superiority. The PDAB's reliance on Rituxan, which is not approved in MS, as a benchmark ignores the expected outcome requirement of OAR 925-200-0020, as the outcomes for Rituxan in MS have never been validated by the FDA.

Regulatory Inconsistency: Rituxan lacks the FDA-approved MS labeling that Ocrevus possesses, failing the primary criterion for a therapeutic alternative under OAR 925-200-0020.
OAR 925-200-0020 specifies that a therapeutic alternative must be FDA-approved or compendia-recognized for the same indication. Rituxan is not FDA-approved for MS. Its compendia-recognized status in MS is often restricted to specific refractory cases or second-line therapy, not as a general alternative to first-line agents like Ocrevus. Furthermore, most professional medical association guidelines, including the American Academy of Neurology, prioritize FDA-approved disease-modifying therapies with proven disability data over chimeric antibodies.[8]

For these reasons, Genentech requests the immediate removal of Rituxan as a therapeutic alternative to Ocrevus and urges the Board to suspend all data call efforts associated with Rituxan.

If you have any questions or want to discuss these data, please contact Tim Layton, Director of State Government Affairs at layton.timothy@gene.com or (206) 403-8224.

Sincerely,

Mary Wachter, RN
Executive Director, State & Local Government Affairs

Treatment Using Real-World Evidence. Ann Neurol. 2026 Jan;99(1):248-260. doi: 10.1002/ana.78033. Epub 2025 Sep 8. PMID: 40919837; PMCID: PMC12946588.
[7] Hawker K, O'Connor P, Freedman MS, et al. Rituximab in patients with primary progressive multiple sclerosis: results of a randomized double-blind placebo-controlled multicenter trial. *Annals of Neurology*. 2009;66(4):460-471.
[8] Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology*. 2018;90(17):777-788.

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For more information, contact Tim Layton, Government Affairs Director, laytont@gene.com, or (206) 403-8224

OCREVUS DATA SUBMISSION DOSSIER - ATTACHMENT TO OR PDAB FEEDBACK FORM RESPONSE - MAY 6, 2026

Genentech appreciates the opportunity to share additional information relevant to the Board's affordability review process and encourages the Board to fully review this submission in conjunction with Genentech's response to the manufacturer feedback form. The manufacturer feedback form focuses heavily on price concession and financial assistance provided by manufacturers neglecting to address key access metrics specified in OAR 925-200-020 that are essential to assessing a drug's affordability to Oregonians. Further, many of these important access metrics are not adequately incorporated across all stakeholder feedback forms or the carrier data call. In addition to better alignment with the Board's statutory obligations, inclusion of these metrics in the eventual affordability reviews, with input from varied stakeholders, would allow the Board to consider a more holistic, and accurate, view of a drug's value. For these reasons, **Genentech is submitting additional information on the value and affordability of Ocrevus as a supplemental response to Question 23 on the Board's manufacturer feedback form.**[1] In addition, immediately following the Board's March 18, 2026 meeting, the Board's website was updated to reflect a "subset list of prescription drugs 2026" with a hyperlink to a PDF file identifying the drugs selected during the meeting for 2026 affordability reviews. By April 10, 2026, Rituxan (rituximab) was added to the list of therapeutic alternatives, establishing a list of five therapeutic alternatives when all prior data and content associated with Ocrevus only identified four therapeutic alternatives. **Genentech disagrees with the board's assessment that Rituxan (rituximab) is an appropriate alternative for Ocrevus**. Genentech has submitted a separate letter to the Board addressing the addition of Rituxan and providing data and rationale for immediate removal of Rituxan as an alternative to Ocrevus.

Ocrevus, first approved in 2017, is the first and only approved disease-modifying therapy (DMT) for both the relapsing-remitting (RMS) and primary progressive (PPMS) forms of multiple sclerosis (MS), the latter of which is one of the most debilitating forms of multiple MS. **As demonstrated by the data included in our feedback form, this additional information submitted on May 6, 2026, plus prior comment letters as noted, Ocrevus is accessible and affordable for Oregonians, health systems and payers.**

The Board is directed by OAR 925-200-020 to consider the following criteria for affordability reviews. The criteria under OAR 925-200-020 listed below demonstrate the affordability of Ocrevus. Genentech urges the Board to ensure all of these elements are adequately incorporated in any future Board evaluation and discussion.

[1] This complete response supplements drug-specific data provided to the Board on Ocrevus in four prior comment letters in October 2023, November 2023, February 2024 and June 2024. Genentech incorporates these letters into its April 30, 2025 submissions to the Board.

1. ***"The relative financial impacts to health, medical or social services costs as can be quantified and compared to the costs of existing therapeutic alternatives."***

Based on the Board's carrier data for proposed 2024 affordability reviews, Ocrevus is the most affordable option within its therapeutic class.

- Ocrevus is priced lower than 15 other DMTs that represent treatment options for MS patients.[2]
- In the materials from the June 2024 Board meeting, Ocrevus was determined to have the lowest average health care spend per enrollee per year relative to Board-determined therapeutic alternatives per the Board's data analysis of Oregon all-payer claims data from 2022 (see table from the materials for June 2024 Board meeting below). While Ocrevus does have higher total annual health plan spend than therapeutic alternatives, it is more affordable to the health care system on a per patient basis. These data demonstrate the health care system in Oregon has recognized Ocrevus as among the most affordable options in its therapeutic class and data shows higher utilization as a result.
    - Importantly, out-of-pocket (OOP) costs captured in this table do not consider co-pay assistance programs intended to assist eligible patients in the cost sharing imposed by their health insurance. Genentech provided Oregon-specific Ocrevus co-pay assistance estimates and additional information in our response to Question 19 on the RFI form.

Table 3 Average healthcare and average patient OoP costs for Ocrevus vs therapeutic alternatives

Drug	Average gross healthcare spend per enrollee per year[18]	Average patient out-of-pocket cost per year[19]
Subject drug Ocrevus	$45,133	$2,381
Kesimpta	$63,514	$1,625
Tysabri	$67,594	$2,795
Average	**$58,747**	**$2,267**

Ocrevus treatment is associated with improved work productivity versus other MS DMTs.

- As MS onset occurs during an individual's most productive years, a reduction in the ability to do routine activities, including being employed, results in a substantial economic burden.[3,4] In lieu of head-to-head direct comparisons across DMTs, a network meta-analysis was conducted to compare completed clinical trials and predict the impact of DMTs on work productivity. **The model predicted**

[2] Genentech (2025 April). *Ocrevus® (ocrelizumab) Multiple Sclerosis (MS) WAC Flash Card.*
[3] Nicholas JA, Electricwala B, Lee LK, Johnson KM. Burden of relapsing-remitting multiple sclerosis on workers in the US: a cross-sectional analysis of survey data. BMC Neurol. 2019;19(1):258.
[4] Chen, Jing, et al. "Effects of multiple sclerosis disease-modifying therapies on employment measures using patient-reported data." *Journal of Neurology, Neurosurgery & Psychiatry* 89.11 (2018): 1200-1207.

that over 10 years, productivity losses were lowest for Ocrevus compared with other DMTs.[5]

- In addition, the estimated percent employment among patients treated with Ocrevus was highest compared to other DMTs (53.3% versus 41.7%) in year 10.
    - **The economic benefit for patients treated with Ocrevus resulted from an improved ability to work due to delayed progression leading to productivity gains of up to $25 million over 10 years relative to other MS treatments.**

2. ***"The total cost of the disease and the drug price offset."***

Using Oregon-specific disease modeling and real world evidence, Ocrevus has helped save an estimated $19.8 million in Oregon by preserving mobility by slowing disability progression, and reducing healthcare spending, caregiver costs, and disability claims in the nearly 900 Oregonians treated with Ocrevus since 2018.

- The need for walking aids and wheelchairs highlights the critical stages of disease progression that are associated with not only a decreased quality of life, but also reduced work productivity, increased health care costs and caregiver burden.[6,7,8,9] By reducing disability for patients with MS in Oregon, Ocrevus reduces disability-related costs by an estimated $4.5 million, allows patients to stay in the workforce and engaged in their community/household saving an estimated $11.8 million, and reduces caregiver burden by an estimated $3.5 million.[10,11] These improved disability outcomes translate to an estimated savings of over $19 million to the state of Oregon due to reduced disability and increased productivity in those with MS and their caregivers.

Patients treated with Ocrevus are highly adherent and persistent with therapy, corresponding to an average savings of $16,000 over 24 months in non-drug medical cost offsets per patient, compared to those patients with MS who are non-adherent.

- Real-world research has shown that people with MS who were adherent and persistent with their DMT had substantially lower medical costs compared with those who were not.[12] Specifically, those who were persistent with medication for 24 months showed a reduction in mean total non-drug medical costs of

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[5] Geiger C, et al.Productivity Loss Among Persons With Multiple Sclerosis Treated With Ocrelizumab vs Other Disease-Modifying Therapies. Presented at the ISPOR Meeting. Atlanta, GA. May 5 - May 8 2024.
[6] Kwiatkowski A, et al. Social participation in patients with multiple sclerosis: correlations between disability and economic burden. BMC Neurology. 2014;14:1-8.
[7] Rezapour A, et al. The impact of disease characteristics on multiple sclerosis patients' quality of life. Epidemiology and Health. 2017:39.
[8] Geiger C, et al. Declines in Work Productivity in Persons With Multiple Sclerosis by PDDS Score. Presented at the American Academy of Neurology Annual Meeting. Boston, MA. 22-27 April, 2023. Poster #13-3.005.
[9] Simoens S. Societal economic burden of multiple sclerosis and cost-effectiveness of disease-modifying therapies. Frontiers in Neurology. 2022;13:1015256.
[10] Pineda E, et. al. National and State Population-Level Estimated Economic Impact of Ocrelizumab on Cumulative Disabilities Avoided and Work Productivity Under Different Access Scenarios in the United States. Presented at ISPOR Annual Meeting. Montreal, QC. May 2025.
[11] Genentech. Citations used to tailor disease modeling impacts to Oregonians treated with Ocrevus available at https://www.gene.com/assets/frontend/downloads/pdf/OCAr13plc.pdf.
[12] Pardo G et al. The Association Between Persistence and Adherence to Disease-Modifying Therapies and Healthcare Resource Utilization and Costs in Patients With Multiple Sclerosis. J Health Econ Outcomes Res. 2022 Apr 26;9(1):111-116.

approximately $19,000 compared with non-persistent patients. A similar pattern was observed for adherent versus non-adherent patients (reduction in costs at 24 months was about $16,000).

- Relatedly, when assessing Ocrevus compared with other MS DMTs (based on route of administration), one study found patients treated with Ocrevus had higher adherence than other therapeutic alternatives that were FDA-approved in or before 2019. Specifically, 80% of Ocrevus patients were adherent compared to 55%, 35%, and 54% for oral, injectable, and other intravenous (IV) treatments, respectively, over two years.[13] Similarly, at 24 months, 75% of patients initiating Ocrevus were persistent with therapy compared with 54%, 33%, and 55% on oral, injectable, and other IV treatments, respectively. In comparing Ocrevus to other therapies and in assessing its overall costs, the Board must consider the cost offsets enabled by Ocrevus's method of administration and its six-month dosing regimen, which results in improvements in adherence and persistence and significant associated cost savings.

Patients using Ocrevus as a first-line treatment had better clinical outcomes and lower health care resource use, including a lower probability of hospitalization, corresponding to payor savings of approximately $11,500 per year compared to those who were treated second-line or later.

- A recent retrospective claims study demonstrated that patients who initiated Ocrevus as a first-line treatment had better clinical outcomes and lower events often associated with relapse[14] than those who initiated it as a second-line or later treatment option.[15]
- Patients on first-line Ocrevus also had lower health care resource use, including a lower probability of hospitalization, and longer time to events often associated with relapse compared to those who used Ocrevus as second line treatment or later. Notably, these findings of first-line Ocrevus use correspond to an annual payor savings of approximately $11,500 per patient, compared to those who were treated second-line or later.

3. "***Patient copayment or other cost sharing data, across different health benefit plan designs, including copayment and coinsurance impacts from patient assistance programs and copay coupons; deductible; patient out-of-pocket costs; and any other cost sharing data***."

Ocrevus' cost to patients can vary due to a myriad of factors. Insurance type, benefit design, and site of care are a few of these factors outside of Wholesale Acquisition Cost (WAC) (or "list") price that can impact a patient's final out-of-pocket (OOP) costs, as well

[13] Pardo G et al. Adherence to and Persistence with Disease-Modifying Therapies for Multiple Sclerosis Over 24 Months: A Retrospective Claims Analysis. Neurol Ther. 2022 Mar;11(1):337-351. Note, this study was conducted using claims data from April 2016 through December 2019.
[14] Events often associated with relapse were defined as any inpatient stay with primary diagnosis of MS; or an outpatient visit with an MS diagnosis with evidence of high-dose steroids, IV corticosteroids, adrenocorticotropic hormone, or plasma exchange within 30 days of the outpatient visit. All patient characteristics, use of DMTs, and outcomes were identified using claims data.
[15] Geiger CK et al. Real-World Clinical and Economic Outcomes Among Persons With Multiple Sclerosis Initiating First- Versus Second- or Later-Line Treatment With Ocrelizumab. Neurol Ther. 2023 Oct;12(5):1709-1728.

as cost to the system. As a medicine traverses the delivery supply chain, it can be subject to a variety of factors across several intermediary stakeholders which impact costs, ranging from negotiated rebates and discounts to significant markup at the point of care.[16]

- While average patient copayment/cost sharing is requested in the carrier data call, it is not specifically assessed by health plan type or plan benefit designs. It is critical to assess the health plan type and benefit design impact on OOP costs as evident in the June 2024 Board materials from the previous Ocrevus carrier data call where OOP varied greatly by type of commercial health plan while the average drug cost to the plans remained similar across plan types. The table from that board meeting is reproduced below.

Table 5 2022 data call reported costs to Oregon payers and enrollees

Market	Total enrollees	Total claims	Total of paid claims	Total payer cost	Average paid claim	Average paid per enrollee	Total annual out-of-pocket cost for enrollees	Out-of-pocket cost per enrollee
Individual	58	174	112	$3,728,561	$33,291	$64,286	$352,289	$6,074
Small Group	57	143	111	$3,630,011	$32,703	$63,684	$306,568	$5,378
Large Group	75	190	166	$5,104,892	$30,752	$68,065	$262,607	$3,501
OEBB	44	246	91	$2,426,422	$26,664	$55,146	$93,586	$2,127
PEBB	54	170	106	$3,705,192	$34,955	$68,615	$40,386	$748
TOTAL	**288**	**923**	**586**	**$18,595,078**			**$1,055,436**	

- From the table, Public Employees' Benefit Board (PEBB) that has the highest annual spend noted for the plan, has the lowest OOP cost per enrollee of all data collected. Further, the percentage of the average cost plans paid for Ocrevus per enrollee that was passed along as OOP costs to patients varied from 9.4% to 1% across commercial plan types. This highlights that other factors outside of drug price (list or net) are driving patient OOP spending.
- An independent analysis of Oregon APAC data from 2021 to 2023 found that a large number of patients treated with Ocrevus paid $0 out-of-pocket and patient cost sharing burden varied substantially by payer type, further highlighting that plan specific benefit design may be impacting patient liability.[17]
- Another such factor that can drive variations in drug cost is site of care (i.e., where a patient receives their medication).
    - For example, the setting in which the patient receives their infusion of Ocrevus may create significant variation in their OOP cost and overall cost to the health care system. Research published by a health insurer shows a 93% variation in the cost of MS treatments, depending on where the patient received their care.[18]

[16] https://www.gene.com/stories/the-science-of-pricing. Accessed 22 April 2025.
[17] Data on File: Ongoing analysis of OR all payer claims data. Results to be submitted for peer-review in May 2026.
[18] https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Administered-Specialty-Drugs.pdf. Accessed on 22 April 2025.

- Finally, Genentech provided Oregon-specific Ocrevus co-pay assistance estimates and additional information in our response to Question 17 on the RFI form.

4. **"*Patient treatment preferences*" and patient and caregiver "*perspective on benefits and disadvantages of using the prescription drug*."**
   In a study of patient preferences of those taking Ocrevus, 82% of patients preferred Ocrevus to the other DMTs taken prior to starting Ocrevus when surveyed after 48 weeks of treatment.[19]
   - In this same study, 98% of patients were either satisfied or very satisfied with Ocrevus as a treatment for their MS symptoms.

5. **Input on "*the availability of therapeutic alternatives on the formulary.*"**
   Because the Board did not request the formulary status of therapeutic alternatives via the carrier data call or the PBM RFI, estimates of national commercial and government payer coverage of therapeutic alternatives using Managed Markets Insight & Technology (MMIT) data are below.[20]

   In its June 2024 meeting materials, the Board included a draft affordability report for the potential review of Ocrevus which included the following drugs identified by the Board as therapeutic alternatives: ublituximab, ofatumumab, alemtuzumab, and natalizumab.

Status	Ocrelizumab	Ublituximab	Ofatumumab	Alemtuzumab	Natalizumab
Covered	17%	11.33%	17.58%	15.16%	14.82%
Covered (PA/ST)	77.39%	75.23%	67.83%	71.91%	77.81%
Not Covered	4.8%	11.81%	11.11%	11.86%	6.52%
Unknown	0.81%	1.63%	3.48%	1.08%	0.85%

   - Per the table above, Ocrevus has the lowest "not covered" proportion among its therapeutic alternatives, highlighting that payers recognize the value of Ocrevus to their health plans and enrollees.

6. **"*Changes in the prescription drug's net cost over time*."**
   - Genentech has a long-standing pricing philosophy that is designed to strike a balance between ensuring patients have rapid, broad and sustainable access to our medicines, while at the same time preserving our ability to invest in future scientific innovations that drive the important medical breakthroughs that patients depend on us for. Since its launch in 2017, the WAC price of Ocrevus remained at $65,000 and was not increased until 2021.
   - Genentech provided information on price concessions in our response on the RFI to Questions 13-15.

[19] SD Newsome et. al. Presented at the ACTRIMS Forum 2025; February 27–March 1, 2025; West Palm Beach, FL, USA, and virtual.
[20] MMIT Coverage Data and DRG Payer Lives. Data as of April 2026.

- Ocrevus is priced lower than 15 other DMTs that represent treatment options for MS patients,[21] and has been consistently priced approximately 30% less than the average annual WAC for MS medications.
- In its nine years on the market, Ocrevus pricing has not triggered price increase advance notice nor reporting requirements under Oregon's price transparency reporting laws.

Beyond the additional criteria the Board must consider per OAR 925-200-020, Genentech has chosen to provide additional clinical information that we believe the Board should review and include in any affordability review to holistically consider the full value of Ocrevus.

1. **Ocrevus has established long-term benefits in slowing disease progression.**
    - The recent publication of 10-year milestone data from the Ocrevus open-label extensions of the Phase III RMS and PPMS studies demonstrated benefits in slowing long-term disability progression.[22] In a 10 year study of Ocrevus, 77% of patients with RMS were free from disability progression, and 92% were still walking unassisted.
    - In patients with PPMS, 36% were free from disability progression, and 80% of those patients treated with Ocrevus over 10 years could still walk unassisted. Importantly, the 10-year pooled safety data across a number of studies from over 6,000 patients continues to reinforce the consistent long-term safety profile of Ocrevus.[23]

2. **Ocrevus is a critical option for Oregonians with MS who are family planning based on recent real-world evidence.**
    - Although historically women with MS have been discouraged from pregnancy, a recent review works to educate the MS community on evidence-based considerations before, during, and after pregnancy.[24]
    - An analysis from the Roche safety database found that maternal exposure to Ocrevus (ie., *in utero* exposure to Ocrevus) was not associated with increases in the risk of adverse pregnancy or infant outcomes compared with the general population.[25]
    - Recent evidence shows that among women with MS with a live birth, Ocrevus (25%) was the most commonly prescribed DMT in the preconception and postpartum period versus other DMTs in its therapeutic class (5%). This evidence suggests growing confidence in the MS community in Ocrevus, with limited

[21] Genentech (2026 April). *Ocrevus® (ocrelizumab) Multiple Sclerosis (MS) WAC Flash Card.*
[22] Weber M, et al. The Patient Impact of 10 Years of Ocrelizumab Treatment in Multiple Sclerosis: Long-Term Data from the Phase III OPERA
and ORATORIO Studies.Presented at the 9th Joint ECTRIMS-ACTRIMS Meeting. Milan, Italy. 11–13 October 2023.
[23] Hauser et al. Safety of Ocrelizumab in Multiple Sclerosis: Updated Analysis in Patients with Relapsing and Progressive Multiple Sclerosis Presented at the 9th Joint ECTRIMS-ACTRIMS Meeting. Milan, Italy. 11–13 October 2023.
[24] Graham EL, et al. "Practical Considerations for Managing Pregnancy in Patients With Multiple Sclerosis: Dispelling the Myths." Neurol Clin Pract. 2024;14(2):e200253.
[25] Hellwig, Kerstin, et al. "Pregnancy and Infant Outcomes in Women Receiving Ocrelizumab for the Treatment of Multiple Sclerosis: Analysis of the Largest Available Outcomes Database." Multiple Sclerosis and Related Disorders 80 (2023): 105306.

administration during pregnancy due to its extended dosing schedule (every 6 months), as a suitable DMT strategy for those who are family planning.[26]

[26] Houtchens MK, et. al. Real-world patterns of ocrelizumab and other disease-modifying therapy utilization before, during and after pregnancy in women with multiple sclerosis: a retrospective claims-based cohort study." To be presented at ECTRIMS September 2025.