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Oregon Prescription Drug Affordability Board (PDAB)
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Re: Concerns with Affordability Review of KEYTRUDA® (pembrolizumab) for July Meeting

Members of the Oregon Prescription Drug Affordability Board,

Merck appreciates the opportunity to provide further comments regarding the Board's decision to include KEYTRUDA in the 2026 affordability review process. At the outset, Merck maintains that KEYTRUDA should not be reviewed at all. ORS 646A.694(2) provides that a drug designated by FDA under 21 U.S.C. 360bb as a drug for a rare disease or condition "is not subject to review," and Oregon's affordability-review rule OAR 925-200-0020(1)(m) likewise states that a prescription drug with such an FDA rare-disease designation is not subject to an affordability review. We refer the Board to our prior comments (March 13, 2026, April 10, 2026, & May 15, 2026) on the orphan drug exemption in ORS 646A.694(2) issue and other process concerns.

Not only is the Board proceeding in direct violation of the statute but also is using a methodology that will produce an incomplete and fundamentally flawed result. To support this conclusion, we will discuss:

- **Why KEYTRUDA cannot be evaluated as a single product,**
- **Why other PD-1/PD-L1 inhibitors are not therapeutic alternatives,**
- **Why a credible review requires disease-specific clinical expertise, and**
- **Why the time allotted for review is insufficient.**

Nothing in these comments should be read as agreeing that the review is lawful or appropriate.

KEYTRUDA cannot be evaluated as a single product.

Since its approval in 2014, KEYTRUDA has transformed the treatment paradigm for some of the world's deadliest forms of cancer. A review of KEYTRUDA is different from a typical drug review because it is not used in one disease area, one treatment setting, or one patient population. Unlike a typical drug review, a review of KEYTRUDA involves evaluating a drug that is used in more than one disease area, setting, and patient population.

The current prescribing information lists 46 indications across many cancers types, including certain indications within the following tumor types: melanoma, non-small cell lung cancer, mesothelioma, head and neck cancer, classical Hodgkin lymphoma, primary mediastinal large B-cell lymphoma, urothelial cancer, gastric cancer, esophageal cancer, cervical cancer, hepatocellular carcinoma, biliary tract cancer, Merkel cell carcinoma, renal cell carcinoma, endometrial carcinoma, cutaneous squamous cell carcinoma, triple-negative breast cancer, and ovarian cancer, microsatellite instability-high or mismatch repair deficient cancers and tumor mutational burden-high cancers[1] In addition to the drug's substantial breadth of approved uses, KEYTRUDA has demonstrated improved survival outcomes in 14 tumor types. Importantly, improved survival outcomes have been demonstrated in certain patients with early-stage non-small cell lung cancer, intermediate-high or high-risk resectable renal cell carcinoma, and early-stage high-risk triple-negative breast cancer – cancers that have been difficult to treat. The label also reflects multiple dosing schedules, adult and pediatric uses for certain indications, biomarker-defined populations, as well as monotherapy and combination regimens. Overall spend therefore reflects KEYTRUDA's broad utilization across its 46 approved indications, rather than use in a single disease area or treatment setting.

An affordability conclusion generalized at the product level would obscure clinically material differences across uses. KEYTRUDA may be used in first line, neoadjuvant, adjuvant, recurrent, metastatic, locally advanced, and post-surgical settings, depending on the indication. Some uses require PD-L1 expression, MSI-H/dMMR status, or TMB-H status; others do not. Some uses involve use in combination with chemotherapy, other targeted therapies, surgery or radiation. The relevant comparators, treatment duration, stopping rules, survival endpoints, toxicity profile, administration burden, and patient need differ materially by tumor type and setting. A single affordability determination for "KEYTRUDA" therefore risks treating unlike clinical circumstances as though they were the same.

Other PD-1/PD-L1 inhibitors are not therapeutic alternatives.

The Board should not treat other available PD-1 or PD-L1 inhibitors as therapeutic alternatives to KEYTRUDA merely because they share an immuno-oncology mechanism. Oregon's rule requires more than a shared pharmacologic class; a therapeutic alternative must be FDA-approved, compendia-recognized for the same indication, or guideline-supported as consistent with standard medical practice, and must have similar therapeutic effects, safety profile, and expected outcome at a therapeutically equivalent dose.[2]

Merck has identified 38 instances (see Appendix A) in which other PD-1/PD-L1 agents, or PD-1/PD-L1-based regimens, were studied in settings relevant to approved uses of KEYTRUDA but failed to meet primary or co-primary endpoints, were stopped for futility, or otherwise did not demonstrate the expected clinical benefit. These failures are clinically meaningful and demonstrate that KEYTRUDA has no therapeutic alternative. Evidence should not be extrapolated across the PD-1/PD-L1 class, as shared mechanisms of action alone do not demonstrate comparable therapeutic effect, safety, or expected clinical outcomes.

A credible review requires disease-specific clinical expertise.

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[1] KEYTRUDA® (pembrolizumab) injection. Prescribing information. Merck & Co., Inc.; revised 2026. U.S. Food and Drug Administration. Accessed July 2026.

[2] OAR 925-200-0010 (2)(c)

KEYTRUDA cannot be meaningfully assessed by a general affordability review alone. Its 46 approved indications span 19 tumor types and two tumor-agnostic indications, including cancers that differ substantially in prognosis, treatment goals, available alternatives, biomarker requirements, and patient needs. Prior comments have emphasized that these uses include both common and rare cancers, advanced and earlier-stage disease, and settings where treatment may be intended to extend life or prevent recurrence. For that reason, the Board would need in depth disease-specific oncology expertise before drawing conclusions about utilization, value, alternatives, or affordability.

The time allotted for review is insufficient.

Even if the Board was conducting a narrow, high-level review using public materials alone, a 6-to-8-week timeline would be inadequate for a therapy with 46 indications covering 19 tumor types and two tumor-agnostic indications that is used across multiple treatment settings. Based on our extensive experience with payer value reviews across the globe, a full indication-by-indication review of KEYTRUDA would take at least 9 to 12 months. KEYTRUDA is currently scheduled for review by the Board on July 15, 2026. When presented, the report should make clear what analyses were completed, what analyses were not possible, and what assumptions were used in place of data.

For these reasons, Merck renews its request that the Board withdraw KEYTRUDA from review. If the Board proceeds notwithstanding that objection, it should pause before making any affordability determination; publish a transparent indication-specific methodology; disclose assumptions, and data limitations; and allow adequate time and disease-specific stakeholder input. The clinical and data complexity of KEYTRUDA makes a compressed, product-level review unsuitable and risks conclusions that could be misunderstood or misapplied in ways that affect patient access.

Thank you for considering these comments.

Sincerely,

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Christin O' Neill
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Appendix A. References supporting identified PD-1/PD-L1 trial failures in settings relevant to KEYTRUDA-approved uses

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