August 31, 2026

Dear Oregon PDAB members,

The National Psoriasis Foundation (NPF) is the leading patient advocacy group representing roughly 8 million Americans living with psoriasis and psoriatic arthritis. Of the drugs selected for the current round of affordability reviews, three are indicated for the treatment of psoriasis and psoriatic arthritis: Xeljanz, Skyrizi and Tremfya. This comment letter will focus on the affordability concerns regarding the aforementioned drugs and their importance to the psoriatic disease community.

While the PDAB initially focused on out-of-pocket costs to patients, it seemingly has drifted toward a focus on affordability to the healthcare system as a whole – regardless of how it impacts patients at the pharmacy counter. This in itself has raised the question: affordable to whom? While the statute that created the PDAB requires savings to pass on to patients, there is no official guidance for how this is to be carried out (lower premiums, lower out-of-pocket costs, etc.) which is worrisome and not patient-centered.

At NPF, our priorities are affordable and accessible health care. We value efforts that work to lower out-of-pocket costs to patients, as well as efforts to reduce healthcare spending in the system as a whole. We want to commend Chair Shelly Bailey for her comments during the August 19 PDAB meeting regarding plan design and patient out of pocket costs. To achieve reductions in patient cost sharing, as well as cost to the healthcare system as a whole, price negotiations cannot happen in a silo. While PDABs can lower what payers pay for prescription drugs, the authority over how much patients pay for copays, coinsurance, deductibles and premiums lies with the Pharmacy Benefit Managers (PBMs).

We at NPF are urging the members of PDAB boards to look beyond a UPL. We encourage board members and lawmakers alike to look at healthcare spending through a holistic lens and evaluate all the expenses that cause financial burden to patients, beyond the drug list price. We also urge the board members to critically analyze the effects that setting a UPL will have on formulary design. This again would require lawmakers to address the power of PBMs and the role they play in patient access. If a drug is deemed un-affordable, but has kept a patient in remission, what protections will be in place to ensure that that patient is not non-medically switched to another drug, potentially disrupting their care? It is important to contain healthcare spending, but it is paramount to ensure continuity of care for patients with chronic conditions.

It is important to note that in the PDAB's subset list of prescription drugs, Xeljanz is listed as having 6 therapeutic alternatives and Skyrizi and Tremfya are each listed as having 11 therapeutic alternatives. The extreme heterogeneity of psoriatic disease makes physician and patient access to the full range of therapies particularly important given that a treatment that

may work for one may fail for another and because patients often cycle through a number of treatments during their lifetime. Therefore, for many individuals living with psoriatic disease, therapeutic alternatives may be limited, and may require access to pharmaceuticals that may otherwise be more rare in the community. Only when physicians are able to access all the tools in their treatment toolbox will they be able to provide individual patients with the care that will maximize their health outcomes.

It is important for patient communities to have access to a broad array of treatment options. Each patient is unique in the way they respond to therapy, and there is no 'one size fits all' approach. Stable patients should not be switched to different treatments, unless prescribed by their physician or where the alternative is a generic or biosimilar. Non-medical switching or payer-mandated switching can be dangerous because it exposes the patient to the risk of disease progression or return, and the patient may not be able to return to the treatment that was working for them without experiencing a loss of response. Switching patients may destabilize their health, and patients may develop immunogenicity to the treatment that was working for them. It is critical to ensure the treating physician and patient are informed of any switches with ample time to appeal as necessary. Stable patients should not be exposed to increased drug cost sharing because they were unwilling to switch treatments.

When we and other patient advocacy organizations have asked the PDAB how they plan to protect patients from non-medical switching as a result of a UPL, we have been met with comments from board members saying that is outside the jurisdiction of the PDAB and that our patient organizations must lobby to pass protections at the state level. While we at NPF as well as our peer organizations work tirelessly to pass such protections, we encourage the board to please use their own networks and resources, as a government appointed entity, to request such protections in board reports. The PDAB holds vast responsibility in its ability to impact patient costs and access to treatment. Please ensure that any decisions to set UPLs are paired with the appropriate safeguards for patients.

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National Psoriasis Foundation