66 Hudson Boulevard East
New York, NY 10001-2192

VIA ELECTRONIC SUBMISSION

July 9, 2026

Oregon Prescription Drug Affordability Board
ATTN: Shelley Bailey, Chair
350 Winter St. NE
Room 410
Salem, OR 97309-0405

RE: Factors Impacting Affordability Review of XELJANZ® (tofacitinib)

Dear Chair Bailey and Members of the Oregon Prescription Drug Affordability Board:

Pfizer appreciates the opportunity to submit comments to the Oregon Prescription Drug Affordability Board (the "Board"). As noted in our previous correspondence on February 28, 2024, June 11, 2025, July 11, 2025, and April 27, 2026, Pfizer maintains significant concerns with ORS 646A.693 et seq., which we believe takes a narrow view of health care costs and lacks a mechanism to impact health insurance benefit design or pharmacy benefit manager (PBM) practices that control patient access and out-of-pocket costs for medicines. Pfizer submits these comments without waiver of, and expressly reserves, all legal objections to the statute and the Board's implementation of it.

Pfizer is a research-based, global biopharmaceutical company that applies science and our global resources to bring therapies to people that extend and significantly improve their lives through the discovery, development, and manufacture of medicines and vaccines.

We understand that the Board intends to conduct an affordability review of XELJANZ® (tofacitinib) on July 15, 2026. We wish to highlight two factors for the Board's consideration: 1) the preceding expiration of patent and data exclusivity for XELJANZ®, and 2) the selection of XELJANZ® for the federal Maximum Fair Price (MFP) process.

OAR 925-200-0010(6) requires the Board to consider, when selecting prescription drugs for a subset list for affordability review, whether a prescription drug has a patent expiration or data exclusivity expiration within 18 months.[1] Basic product patent expiration for XELJANZ® occurred in December 2025 and data exclusivity expired June 2026. **Thus, XELJANZ® basic patent and data exclusivity no longer exists.**

In the U.S. health care system, loss of exclusivity for brand prescription drugs serves as a built-in cost-control mechanism that does not exist for other health care services. Even as the FDA has approved more than 800 novel medicines since 2000[2], retail prescription drugs have remained a stable share of total health

[1] 925-200-0010 Selecting Prescription Drugs for Affordability Reviews. Available at: https://dfr.oregon.gov/pdab/Documents/OAR-925-200-0010.pdf
[2] U.S. Food & Drug Administration, Center for Drug Evaluation & Research, Compilation of CDER NME and New Biologic Approvals 1985–2025, https://www.fda.gov/drugs/drug-approvals-and-databases/compilation-cder-new-molecular-entity-nme-drug-and-

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care spending in the U.S., at approximately 9-10 percent.[3] When accounting for both retail and non-retail medicines, prescription drugs are estimated to represent 13-14 percent of total health care spending.[4] This reflects the exclusivity-to-competition cycle[5] functioning as intended: continued innovation adds to the body of available therapies while, over time, individual products lose exclusivity and typically face downward price pressure without external intervention.

Further, in January 2026, the Centers for Medicare and Medicaid Services (CMS) announced the selection of XELJANZ® for a Maximum Fair Price that will go into effect on January 1, 2028.[6] The Board has repeatedly discussed, and in 2023 voted to exclude,[7] prescription drugs subject to a federal MFP process in recognition that this materially changes a product's treatment within the supply chain.

For these reasons, we respectfully request that the Board conclude that XELJANZ® does not create affordability challenges for health care systems or high out-of-pocket costs for patients in Oregon.

Additionally, we fully appreciate the Board's ongoing contemplation of policy recommendations that seek to evaluate and address the role of other actors across the prescription drug supply chain. Patients' out-of-pocket costs are set by insurance benefit design—including deductibles, copayments, and coinsurance—determined by health plans and pharmacy benefit managers.[8] Along with determining patients' cost-sharing requirements, PBMs and health plans determine whether patients receive the discounts and rebates they negotiate with pharmaceutical manufacturers.

In 2024, manufacturers paid an estimated $356 billion in discounts and rebates.[9] However, unlike other medical services where the patient pays less when their health plan negotiates a better price, very few, if any, patients pay less at the pharmacy counter despite billions of dollars in discounts and rebates paid to PBMs and insurers by manufacturers.[10] Instead, most manufacturer discounts and rebates are retained by PBMs as profit or are passed to a health plan rather than the patient obtaining the medicine. Recent analyses confirm that, after accounting for rebates and discounts, net prices for brand-name prescription drugs have

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new-biologic-approvals (last updated May 12, 2026). Figure reflects a count of new molecular entity and new biologic approvals for calendar years 2000 through 2025 and does not include biologics reviewed by FDA's Center for Biologics Evaluation and Research.

[3] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Data: Historical, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

[4] Altarum, Projections of the Non-Retail Prescription Drug Share of National Health Expenditures (July 2022), https://drugchannelsinstitute.com/files/Projections-of-Non-Retail-Drug-Share-of-NHE-2022.pdf.

[5] Kolchinsky, P. (2020). The great American drug deal: A new prescription for innovative and affordable medicines. Evelexa Press.

[6] U.S. Centers for Medicare & Medicaid Services (CMS), CMS Announces Selection of Drugs for Third Cycle of Medicare Drug Price Negotiation Program, Including First-Ever Part B Drugs, Press Release (Jan. 27, 2026), https://www.cms.gov/newsroom/press-releases/cms-announces-selection-drugs-third-cycle-medicare-drug-price-negotiation-program-including-first.

[7] Oregon Prescription Drug Affordability Board, Public Meeting (Nov. 15, 2023), segment begins 1:34:45, YouTube (Oregon Division of Financial Regulation channel), https://www.youtube.com/watch?v=6Gk2182MFZw (accessed Apr. 13, 2026).

[8] Kaiser Family Foundation. (2025). Navigating the maze: Patient cost-sharing complexities and consumer protections. https://www.kff.org/private-insurance/navigating-the-maze-a-look-at-patient-cost-sharing-complexities-and-consumer-protections/

[9] Fein, A. (2025, March). The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. Drug Channels Institute. https://drugchannelsinstitute.com/files/2025-PharmacyPBM-DCI-Overview.pdf

[10] Peterson-KFF Health System Tracker. (2021, January 13). Price transparency and variation in U.S. health services. https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/

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declined[11] as other supply chain actors, who do not create or manufacture medicines, retain more than half of their cost.[12]

Within only two years, Oregon's PBM data collection underscored and localized the national trend: higher discounts from manufacturers are not translating into increased affordability for patients. Despite a fewer number of PBMs required to report to the state in 2025, reported manufacturer rebates increased by over 31 percent while the share of rebates reaching patients fell sharply. With over $377 million collected by PBMs in rebates from manufacturers, approximately **one-tenth of one percent was passed to enrollees**, down 80 percent from the prior year's report. The remaining 99.9 percent went to health insurance companies – often vertically integrated into ownership structures that include the PBM – or was directly retained by the PBM.[13]

Once again, Pfizer appreciates the opportunity to provide comments to the Board. We support efforts to help ensure that patients can access innovative medicines and look forward to working with Oregon policymakers to find solutions that directly help patients. If you have any questions, please contact Donna Kaylor, Director of Government Relations, at Donna.Kaylor@pfizer.com.

Sincerely,

Tom Brownlie
Vice President
State Policy and Government Relations

[11] Fein, A. J. (2026, January 7). U.S. brand-name drug prices fell in 2025 as the net pricing drug channel emerges. Drug Channels Institute. https://www.drugchannels.net/2026/01/us-brand-name-drug-prices-fell-in-2025.html
[12] Berkeley Research Group (BRG). New Analysis Finds More than Half of Brand Medicine Spending Goes to the Supply Chain, Middlemen and Other Stakeholders. January 7, 2022. https://www.thinkbrg.com/news/more-than-half-brand-medicine-spending-goes-to-supply-chain-middlemen-other-stakeholders/
[13] Oregon Department of Consumer and Business Services, Division of Financial Regulation, Pharmacy Benefit Manager Data – 2025 (Drug Price Transparency Report, 2025), https://dfr.oregon.gov/drugtransparency/Documents/DPT-pbm-data-2025.pdf.