Oregon Prescription Drug
Affordability Board

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Ozempic®

(*semaglutide*)[1]

Version 2.0

[1] Image source: https://www.ozempic.com/how-to-take/ozempic-dosing.html

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Document version history

Version	Date	Description
v1.0	6/9/2026	Original release
v2.0	6/15/2026	Updated health equity section with updated data.

Review summary

Therapeutic alternatives[2,3,4]

Ozempic (*semaglutide*) has the following therapeutic alternatives: **Byetta, Mounjaro, Rybelsus, Trulicity,** and **Victoza**.

Table 1 Subject drug and therapeutic alternative information

Proprietary name	Non-proprietary name	Manufacturer	Year approved	Number of patents	Patent date range	Exclusivity expiration	On the CMS drug Maximum Fair Price (MFP) list
Ozempic	*semaglutide*	Novo Nordisk Inc.	2017	19	2025-2028	2028	Yes (2027)[5]
Byetta[6]	*exenatide synthetic*	AstraZeneca Ab	2005	-	-	-	No
Mounjaro	*tirzepatide*	Eli Lilly and Co.	2022	4	2036-2041	2027	No
Rybelsus	*semaglutide*	Novo Nordisk Inc.	2017	13	2026-2039	2028	Yes (2027)[5]
Trulicity[7]	*dulaglutide*	Eli Lilly and Co.	2014	-	-	-	No
Victoza[8]	*liraglutide*	Novo Nordisk Inc.	2010	4	2025-2037	-	No

[2]Approved Drug Products with Therapeutic Equivalence Evaluations | Orange Book. U.S. Food & Drug Administration. https://www.fda.gov/drugs/drug-approvals-and-databases/approved-drug-products-therapeutic-equivalence-evaluations-orange-book.

[3] Frequently Asked Questions on Patents and Exclusivity, U.S. Food & Drug Administration, Feb. 5, 2020. https://www.fda.gov/drugs/development-approval-process-drugs/frequently-asked-questions-patents-and-exclusivity#What_is_the_difference_between_patents_a.

[4] Selected Drugs and Negotiated Prices. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-and-negotiated-prices.

[5] The year the Maximum Fair Price (MFP) becomes effective.

[6] Byetta was discontinued in 2025. Drug approvals and databases. U.S. Food & Drug Administration, Jun. 8, 2026. https://www.fda.gov/drugs/development-approval-process-drugs/drug-approvals-and-databases.

[7] No patent or exclusivity information was listed for Trulicity in the U.S. Food & Drug Administration Purple Book Database. https://www.fda.gov/drugs/drug-approvals-and-databases/approved-drug-products-therapeutic-equivalence-evaluations-orange-book.

[8] No exclusivity was listed for Victoza in the U.S. Food & Drug Administration Orange Book Database. https://www.fda.gov/drugs/drug-approvals-and-databases/approved-drug-products-therapeutic-equivalence-evaluations-orange-book.

Price history[9,10]

Ozempic® (*semaglutide*) rose at an **average annual rate of 2.2 percent** from 2023 to 2025.

- In the same time period, its therapeutic alternatives rose at these rates:
    - Byetta: 2.2 percent
    - Mounjaro: 2.6 percent
    - Rybelsus: 3.2 percent
    - Trulicity: 3.8 percent
    - Victoza: -1.0 percent

Additionally, the average annual rate of Ozempic exceeded inflation in **2024 and 2025**. Pharmacy acquisition costs for **Medicaid also increased by 3.8 percent** over the same period, reflecting broader trends in pricing escalation.

Price concessions [11]

Based on data received from healthcare carriers, Ozempic in 2024 had an **average gross spend of $1,091 per claim**, while the **average net spend after discount was $565 per claim**. Price concession per claim was reported to be **$526,** resulting in an **average price concession of 48.3 percent per claim**.

Cost to the payers[12]

Table 2 2024 APAC payer annual total expenditure, claims, and cost per enrollee[13]

Proprietary name	No. of enrollees[14]	No. of claims	Total payer paid	Cost per enrollee, mean	Cost per claim, median
Ozempic	36,575	229,743	$232,699,354	$6,362	$918
Byetta	60	266	$268,334	$4,472	$817
Mounjaro	9,658	55,891	$59,031,450	$6,112	$1,001

[9] Medi-Span. Wolters Kluwer, 2025. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.
[10] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.
[11] Based on data submitted to the Department of Consumer and Business Services (DCBS) by Oregon's commercial insurance carriers. The data call includes information about the cost of the drug before and after price concessions in the commercial market.
[12] Based on Oregon's 2024 All Payer All Claims (APAC) data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons. For more information regarding APAC data visit: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.
[13] The totals for amounts paid, costs, and claims are from both medical and pharmacy reporting.
[14] The number of enrollees is derived from unique individuals collected from APAC at the drug level. A single unique individual may occur across multiple lines of business, indicating that an enrollee can be counted for each claim line of business. As a result, this leads to the elevated enrollment numbers presented in Table 6, 9, and 10 as compared to other totals indicated in this report.

Proprietary name	No. of enrollees[14]	No. of claims	Total payer paid	Cost per enrollee, mean	Cost per claim, median
Rybelsus	3,177	13,188	$17,156,103	$5,400	$929
Trulicity	15,984	106,737	$108,809,464	$6,807	$935
Victoza	2,609	11,346	$8,079,397	$3,097	$736

Cost to enrollees[15]

Table 3 2024 gross APAC annual enrollee out-of-pocket (OOP) cost[16]

Proprietary name	Total paid by enrollee	OOP cost per enrollee, median	OOP cost per claim, mean	OOP cost per claim, median
Ozempic	$16,541,600	$132	$72	$11
Byetta	$11,887	$0	$45	$0
Mounjaro	$5,076,307	$135	$91	$30
Rybelsus	$1,487,143	$141	$113	$35
Trulicity	$5,945,895	$34	$56	$0
Victoza	$554,898	$0	$49	$0

Rubric considerations

Table 4 Rubric domains and scoring considerations

Domain	Consideration
Number of enrollees	36,575
Price evaluation	Average annual percent chang in WAC of 2.2 percent from 2023-2025
Price concessions	48.3% claims receive rebates or price concessions
System & payer costs	$232,699,354 payer paid
Enrollee burden	$452 mean of APAC enrollee OOP annual cost
Equity impact	TBD
Access restrictions	Yes
Therapeutic alternative	Yes
Stakeholder input	Yes
Patent expirations	Yes

[15] Based on Oregon's 2024 All Payer All Claims (APAC) data across commercial insurers and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons. For more information regarding APAC data visit: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.

[16] Total patient out-of-pocket costs is the sum of reported copayments, coinsurances, and deductibles.

Domain	Consideration
Excluded from CMS Maximum Fair Price List (MFP)	No

Review background

This review incorporates supporting information from Medi-Span, FDA databases (e.g., Orange Book, Purple Book), and other publicly available data where applicable.

Two primary data sources inform this review: the Oregon All Payers All Claims (APAC) Reporting Program database and the Oregon commercial carrier data call. APAC aggregates claims data across all payer types in Oregon, including Medicaid, Medicare, and commercial plans, and presents gross cost estimates. In contrast, the data call reflects submissions from 11 commercial health insurers and reports primarily net costs after manufacturer rebates, PBM discounts, and other price concessions. As a result, APAC generally reflects larger total claims and cost figures due to broader reporting for more enrollees, while the data call offers insight into actual expenditures from private payers in the commercial market.

In 2023, APAC included data for approximately 3.5 million Oregonians. Approximately 27% of people in APAC had Medicare coverage, 33% of people had Medicaid coverage, and 39% of people had commercial coverage. APAC cannot require submission of claims and enrollment data from entities regulated under the Employee Retirement Income Security Act of 1974 (ERISA), so data for many self-insured plans are not included.[17,18] For these drug reviews, APAC data on people with Medicare coverage are limited to Medicare Advantage and Part D only and do not include claims for Traditional Medicare Part A or Part B.

The 2026 Oregon commercial carrier data call included data from commercial health plans providing coverage for approximately 800,000 Oregonians based on claims in 2024.[19] The data call is limited to fully-insured plans that are regulated by the state and does not include coverage regulated under ERISA.

This review addresses the affordability review criteria to the extent practicable. Due to limitations in scope and resources, some criteria receive minimal or no consideration.

[17] Oregon All Payer All Claims Database (APAC) Data User Guide. Version 1.1 updated Nov 19, 2025. APAC-Data-User-Guide.pdf. The number of people represented in 2024 APAC data has not been published as of May 2026.
[18] For 2024, the DCBS Division of Financial Regulation reported that just under one million people in Oregon were enrolled in commercial health plans and slightly more than one million people in Oregon were enrolled in self-insured health plans. *2024 Quarterly enrollment report*, https://dfr.oregon.gov/business/reg/reports-data/annual-health-insurance-report/Pages/health-ins-enrollment.aspx, accessed June 1, 2026.
[19] The number of people covered by plans reporting to the commercial carrier data call was estimated using 2024 insurer data reported in 2025 to the Oregon Drug Price Transparency Program which receives reports on state-regulated health insurance plans.

In accordance with OAR 925-200-**0020**, PDAB conducted affordability reviews on prioritized prescription drugs selected under OAR 925-200-**0010**. The board selected ten drugs and two insulin products for affordability review in 2026. The selection process emphasized brand-name products with substantial cost impact and excluded antivirals, toxoids, vaccines, and products with available therapeutic equivalents or biosimilars as of February 2026. The board also removed from consideration products reviewed in 2025 and determined to possibly have potential system- or patient-level cost implications. To ensure broad relevance across Oregon's insured population, the board prioritized drugs reported by seven or more commercial health carriers.

For insulin products, the board focused on products with the highest end-of-year unit prices while excluding those with fewer than 100 covered enrollees. Insulin glargine products reviewed by the board in 2025 were also removed to maintain focus on products not yet evaluated. This approach ensured that the final selection aligned with statutory intent, reflected consistent application of rule-based selection factors, and supported a comprehensive assessment of products with meaningful affordability implications for Oregon's health care system and patients.

Visit the PDAB webpage for more information about purpose and statutory authority of the Oregon Prescription Drug Affordability Board (PDAB).

Drug information[20]

Table 5 Drug and FDA information

Drug proprietary name(s)	Ozempic®
Non-proprietary name (active ingredients)	*semaglutide*
Manufacturer	Novo Nordisk
Pharmacologic category	Glucagon-like Peptide 1 (GLP-1) Receptor Agonist
Treatment	Improve glycemic control in adults with type 2 diabetes mellitus as an adjunct to diet and exercise; reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease; reduce the risk of sustained eGFR decline, end-stage kidney disease, and cardiovascular death in adults with T2DM and chronic kidney disease (CKD).
Dosage strength	2 mg/3 mL (0.68 mg/mL) available in: Single-patient-use pen that delivers 0.25 mg or 0.5 mg per injection

[20] U.S. Food & Drug Administration. Ozempic *(semaglutide*) Prescribing information, May 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/209637s020s021lbl.pdf.

Drug proprietary name(s)	Ozempic®
	4 mg/3 mL (1.34 mg/mL) available in: Single-patient-use pen that delivers 1 mg per injection 8 mg/3 mL (2.68 mg/mL) available in: Single-patient-use pen that delivers 2 mg per injection
Form/Route	Subcutaneous Injection
Physician administered	No
NDCs reviewed	• 00169413001 • 00169413013 • 00169413212 • 00169418113 • 00169477212
First approved by the FDA	Dec. 5, 2017[21]
Expedited forms of approval by the FDA	None
Designations under the Orphan Drug Act	No

Health equity considerations

ORS 646A.694(1)(a) and OAR 925-200-0020 (1)(a) & (2)(a)(A-B). Limitations in scope and resources available for this statute requirement.

Claims data from APAC was evaluated for health equity considerations related to utilization in Oregon. The analysis included line of business (payer type), race, ethnicity, and gender where available and evaluated member counts, claims numbers, insurer paid amounts, and enrollee out-of-pocket costs. Equity data analysis using APAC is preliminary with additional data cleaning underway as of June 8, 2026. Claim counts and other metrics may change in future updates with improved data cleaning.

Ozempic claims were primarily **observed among Medicare and commercial enrollees**. Median and average claim costs were reviewed to understand typical and overall impacts. Median enrollee costs were generally similar across coverage categories, while average costs were higher in some groups, indicating a smaller number of higher-cost claims. Race, ethnicity, and gender information was included in the review; however, a substantial proportion of records were categorized as unknown, limiting interpretation of demographic differences.

[21] FDA approval date based on the earliest occurring approval dates in the FDA Orange/Purple Book. For drugs with multiple forms/applications, staff used the earliest approval date across all related FDA applications. https://www.fda.gov/drugs/drug-approvals-and-databases/approved-drug-products-therapeutic-equivalence-evaluations-orange-book.

Table 6 2024 APAC claim and enrollee count by line of business

Line of business	Claim count	Enrollee count[22]	Claims per enrollee
Commercial	109,488	17,141	6.4
Medicaid	36,195	5,518	6.6
Medicare	84,060	17,502	4.8
Total	**229,743**	**36,575**	**6.3**

Table 7 2024 APAC cost by line of business

Line of business	Total payer paid	Mean payer paid/claim	Median payer paid/claim	Total enrollee OOP[23]	Mean enrollee OOP/claim	Median enrollee OOP/claim
Commercial	$108,479,060	$991	$905	$7,635,205	$70	$30
Medicaid	$33,112,605	$915	$932	$0	$0	$0
Medicare	$90,335,404	$1,075	$906	$8,849,163	$105	$11

Table 8 2024 APAC mean and median insurer and enrollee out-of-pocket costs per claim, by race

Race	Claims	Mean payer paid	Median payer paid	Mean enrollee OOP[24]	Median enrollee OOP
White	82,935	$1,020	$930	$56	$0
Black/African American	3,382	$1,037	$940	$32	$0
American Indian/Alaska Native	2,272	$888	$918	$19	$0
Asian	2,077	$1,049	$930	$49	$0
Native Hawaiian/Pacific Islander	763	$933	$932	$24	$0
Mix race	5,203	$1,038	$930	$42	$0
Other	14,001	$920	$930	$30	$0
Refused to answer	599	$926	$927	$25	$0
Unknown	118,511	$1,014	$897	$92	$33

[22] The number of enrollees is derived from unique individuals collected from APAC at the drug level. A single unique individual may occur across multiple lines of business, meaning that an enrollee can be counted for each claim line of business. As a result, the difference in enrollment numbers may be different as compared to other totals indicated in this report.

[23] Total patient out-of-pocket costs is the sum of reported copayments, coinsurances, and deductibles for all enrollees in a line of business.

[24] The mean only includes claims paid from commercial and Medicare enrollees. Medicaid enrollees had $0 out-of-pocket costs.

Table 9 2024 APAC claim counts and enrollee counts, by ethnicity

Ethnicity	Claim count	Enrollee count
Hispanic	12,256	1,518
Non-Hispanic	100,856	15,332
Unknown	116,631	19,725

Table 10 2024 APAC claim counts and enrollee counts, by gender

Gender	Claim count	Enrollee count
Female	125,655	19,502
Male	86,622	14,171
Unknown	17,466	2,902

Residents prescribed

ORS 646A.694(1)(b) and OAR 925-200-0020(1)(b) & (2)(b). Data source from APAC.

Based on APAC, **36,575 enrollees filled prescriptions** for Ozempic with **229,743 claims paid by payers** in 2024.[25]

Price for the drug

ORS 646A.694(1)(c) and OAR 925-200-0020(1)(c) & (2)(e), (f), & (g). Data source from Medi-Span, APAC, and carrier data call.

This section examines the pricing dynamics of Ozempic, drawing on multiple data sources to characterize its historical price trends and implications for affordability. It includes an analysis of the drug's wholesale acquisition cost (WAC) and the Oregon Actual Average Acquisition Cost (AAAC), compared to its therapeutic alternatives. Together, the data provides a comprehensive view of Ozempic's list price trajectory and pharmacy acquisition costs, and the degree to which the list price impacts costs.

Price history

WAC per 30-day supply was calculated with package and unit WAC from Medi-Span based on the most utilized NDC in APAC in 2024 and was reviewed as an indication of historic price trends for the drug. However, WAC does not account for discounts, rebates, or other changes to the drug's cost throughout the supply chain.

[25] Number of 2024 enrollees in APAC database across commercial insurers, Medicaid, and Medicare. For more information regarding APAC data: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.

Table 11 30-day supply for review drug and its therapeutic alternatives

	Ozempic	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
30-day supply	1 package (1 pen of 3 ml)	1 package (1 pen of 2.4 ml)	1 package (4 pens of 0.5ml)	30 units (30 pills)	1 package (4 pens of 0.5 ml)	1 package (3 pens of 3 ml)
Reference NDC	00169418113	00310652401	00002149580	00169430730	00002143480	00169406013

Table 12 Drug vs therapeutic alternatives for 2019-2025 WAC per 30-day supply[26]

Year	Ozempic	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
2019	-	$730	-	-	$759	$922
2020	-	$716	-	-	$797	$968
2021	-	$778	-	$852	$844	$1,016
2022	-	$801	$974	$892	$887	$1,064
2023	$936	$825	$1,023	$936	$931	$1,116
2024	$969	$850	$1,069	$969	$977	$815
2025	$998	$850	$1,080	$998	$987	$815
Avg. Annual % Change	2.2%	2.2%	2.6%	3.2%	3.8%	-1.0%
% change 2019 between 2025	-	16.5%	-	-	30.0%	-11.6%

The WAC of Ozempic was approximately **$332.53 per unit** at the end of 2025.[27] Between 2023-2025, the unit WAC increased at an average annual rate of **2.2 percent**, exceeding the general consumer price index (CPI-U) inflation rate in 2023-2024 and 2024-2025 (See Figure 1 and Table 13).[28]

[26] Medi-Span. Wolters Kluwer, 2025. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.
[27] Ibid.
[28] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.

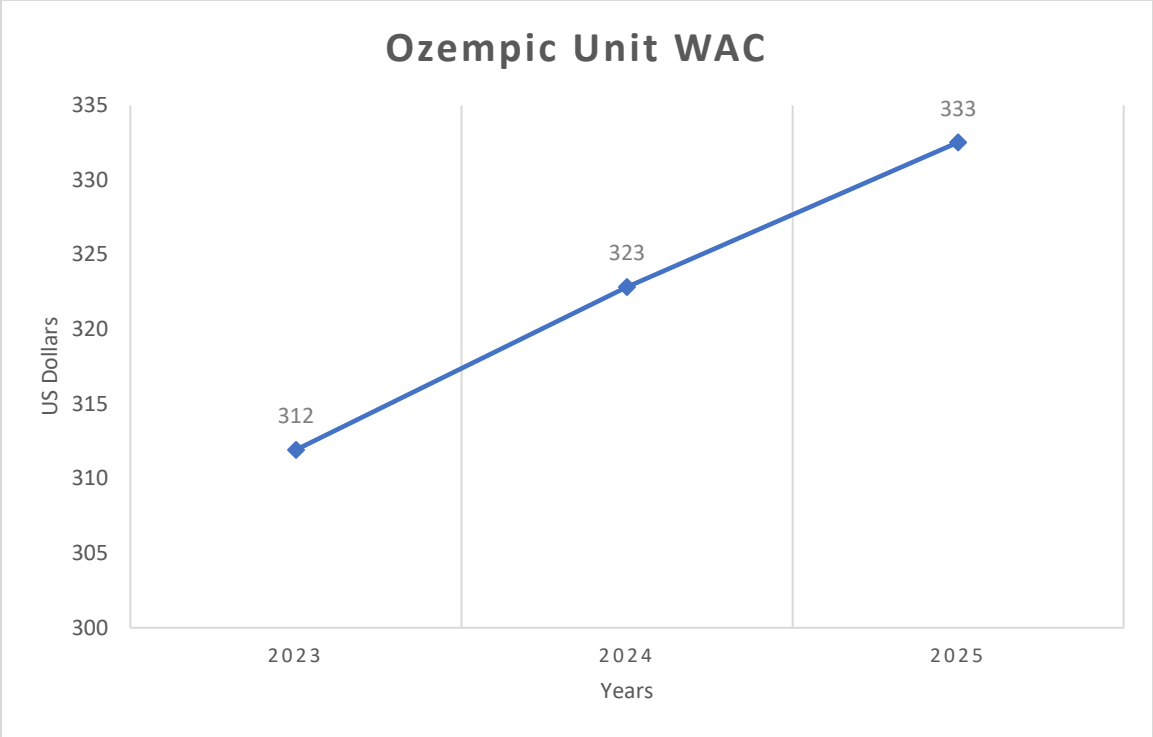

Figure 1 Unit WAC of most utilized NDC of Ozempic from 2023-2025

Table 13 Percent change of unit WAC of drug and therapeutic alternatives with CPI comparison[29]

Years	Ozempic	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza	CPI-U
2019-2020	-	3.0%	-	-	5.0%	5.0%	0.7%
2020-2021	-	3.5%	-	-	5.9%	5.0%	5.3%
2021-2022	-	3.0%	-	4.8%	5.0%	4.8%	9.0%
2022-2023	-	3.0%	5.0%	4.9%	5.0%	4.9%	3.1%
2023-2024	3.5%	3.0%	4.5%	3.5%	5.0%	-27.0%	3.0%
2024-2025	3.0%	3.0%	1.0%	3.0%	1.0%	0%	2.7%

[29] Percentages might differ from Table 12 as Table 13 percentages are based on unit WAC only.

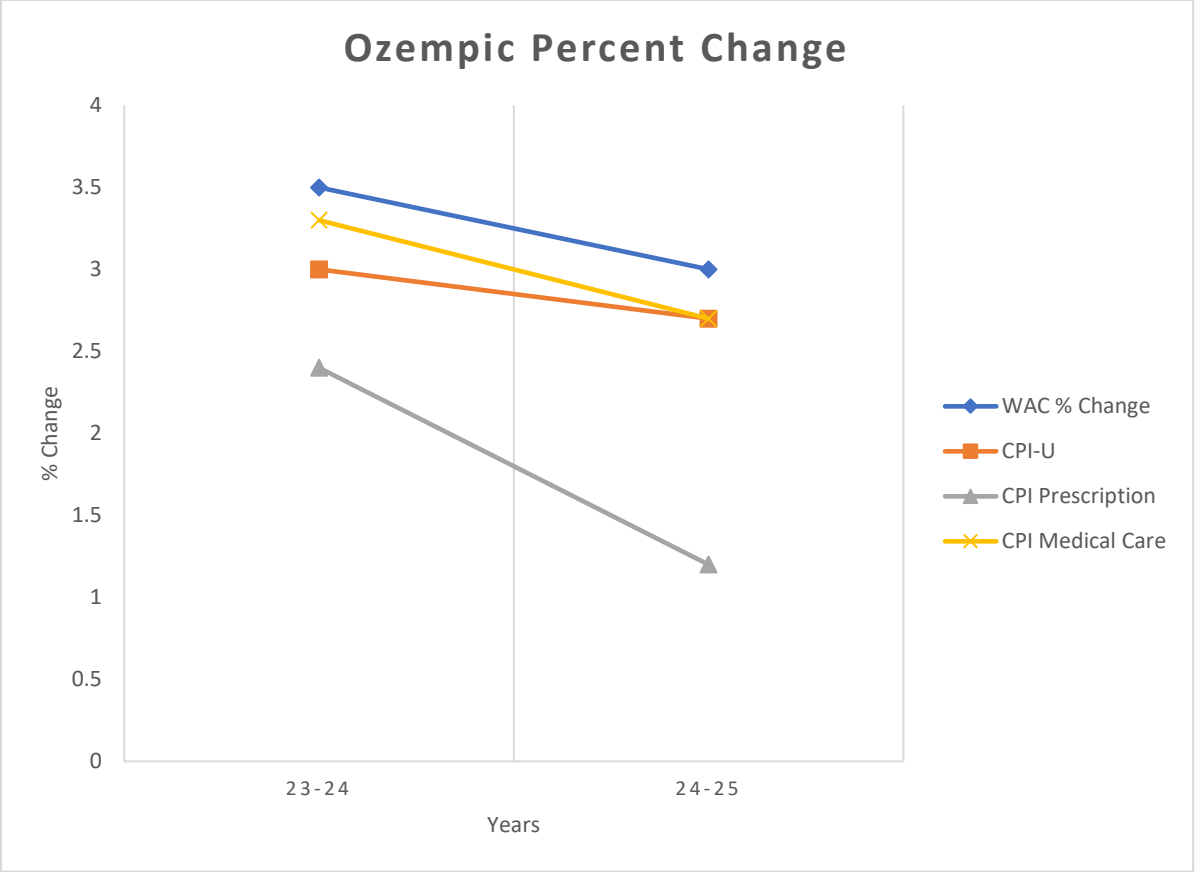

Figure 2 Year over year change in WAC compared to inflation rates[30]

Pharmacy acquisition costs

The AAAC, which reflects pharmacies' actual purchase prices for Medicaid fee-for-service claims, rose from **$386.65 per unit in Quarter 1 of 2020 to $401.51 per unit in Quarter 4 of 2025**, an approximate **3.8 percent increase** over the period (see Table 14).[31] Relative to the **$332.53** WAC in end-of-year 2025, the AAAC in end-of-year 2025 **is 20.7 percent higher**.

While WAC provides a standardized benchmark of list price, it does not account for negotiated price concessions. In contrast, the AAAC offers a more representative estimate of the point-of-sale price incurred by Medicaid payers in Oregon, derived from regular pharmacy surveys conducted by the Oregon Health Authority. Monitoring these trends over time contextualizes Ozempic's price trajectory relative to inflation and affordability for public and private payers.

[30] Consumer Price Index. U.S. Bureau of Labor Statistics. https://www.bls.gov/cpi/tables/supplemental-files/.
[31] This data was compiled using the first weekly AAAC chart of each month from January 2020 to December 2024, available at https://myersandstauffer.com/client-portal/oregon/.

Table 14 2020-2025 AAAC Medicaid FFS quarterly purchase prices for Ozempic

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual AAAC Average	Unit WAC
2020	$387	$389	$389	$390	$389	-
2021	$404	$408	$380	$363	$389	-
2022	$379	$381	$377	$357	$374	-
2023	$370	$371	$367	$357	$366	$312
2024	$372	$379	$388	$388	$382	$323
2025	$400	$401	$401	$402	$401	$333

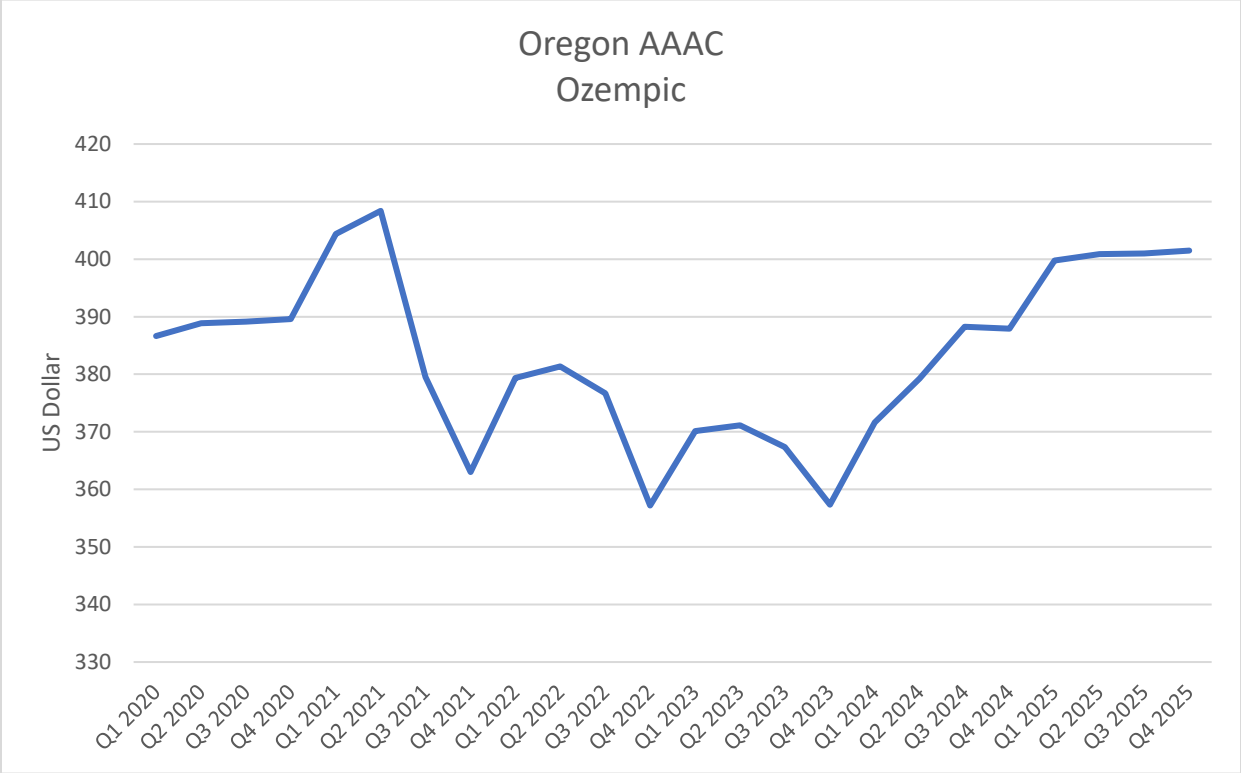

Figure 3 AAAC For Ozempic from Q1 2020 to Q4 2025

Maximum Fair Price

Ozempic and Rybelsus were selected by the Centers for Medicare & Medicaid Services (CMS) for inclusion in the Medicare Drug Price Negotiation Program (Cycle 2) and will be subject to a **Maximum Fair Price (MFP) beginning January 1, 2027**. CMS has established an **MFP of $274 per 30-day supply** for Ozempic and Rybelsus under Medicare Part D. The MFP reflects the maximum amount Medicare will pay for the drug and is intended to reduce beneficiary out-of-pocket costs and overall program spending.

Estimated average monetary price concession

ORS 646A.694(1)(d) and OAR 925-200-0020(1)(d) & (2)(d) & (2)(L)(A-B). Data source information provided from data call.

This section provides an analysis of the average monetary discounts, rebates, and other price concessions applied to Ozempic claims in the commercial market. Drawing on 2024 data submitted through the carrier data call, it evaluates the extent to which these concessions reduced gross drug costs and estimates the average net costs to payers after adjustments. The analysis includes claim-level data on the proportion of claims with applied discounts, and the breakdown of the total concession amounts by type, offering insight into the reduced costs provided through manufacturer, PBM, and other negotiated price reductions.

Based on carrier-submitted data for 2024, the **average gross annual cost of Ozempic per enrollee in the commercial market was approximately $4,324**. After accounting for manufacturer rebates, pharmacy benefit manager (PBM) discounts, and other price concessions, the **mean net cost per enrollee declined to approximately $2,238**, reflecting an **estimated mean discount of 48 percent** relative to gross costs.

Across all reporting carriers and market segments, the **total cost of Ozempic before concessions was $75,951,753**, with total reported **price concessions amounting to approximately $3,392,578**, as detailed in Table 15. Notably, **86 percent of claims benefited from some form of price concession,** leaving **14 percent at full gross cost**.

Table 15 Net cost price concessions estimate based on carrier submitted 2024 data

Total number of enrollees	17,565
Total number of claims	69,621
Total number of claims with price concessions applied	59,858
Percentage of claims with price concessions applied	86.0%
Percentage of cost remaining after concessions	51.7%
Percentage of discount	48.3%
Manufacturer price concessions for all market types	$33,162,788
PBM price concessions for all market types	$4,482,830
Other price reductions for all market types	$4,363
Cost before price concessions across all market types	$75,951,753
Total price concessions across all market types	$36,649,981

Cost after price concessions across all market types	$39,301,772

Mean cost per enrollee without price concessions	$4,324
Mean cost per enrollee with price concessions	$2,238

Including all market segments, the **gross average spend** of Ozempic **per claim for commercial carriers was $1,091 before any discounts, rebates, or other price concessions**. The **net cost per claim after** discounts, rebates, and other price concessions was **$565**, meaning that insurers reported a price concession of **$526** per claim on the initial drug cost as shown in Table 16.

Table 16 Mean price concessions across market types from data call[32]

	Mean	Individual market	Large group	Small group
Spend per claim, gross	$1,091	$1,068	$1,089	$1,115
Spend per claim, net	$565	$526	$581	$532
Price concessions per claim	$526	$542	$509	$582
Percent discount	48.3%	50.8%	46.7%	52.2%

Figure 4 shows manufacturer concessions comprised the largest share, supplemented by PBM discounted price arrangements and other adjustments across the payer types.

[32] Based on data submitted to the Department of Consumer and Business Services (DCBS) by Oregon's commercial insurance carriers.

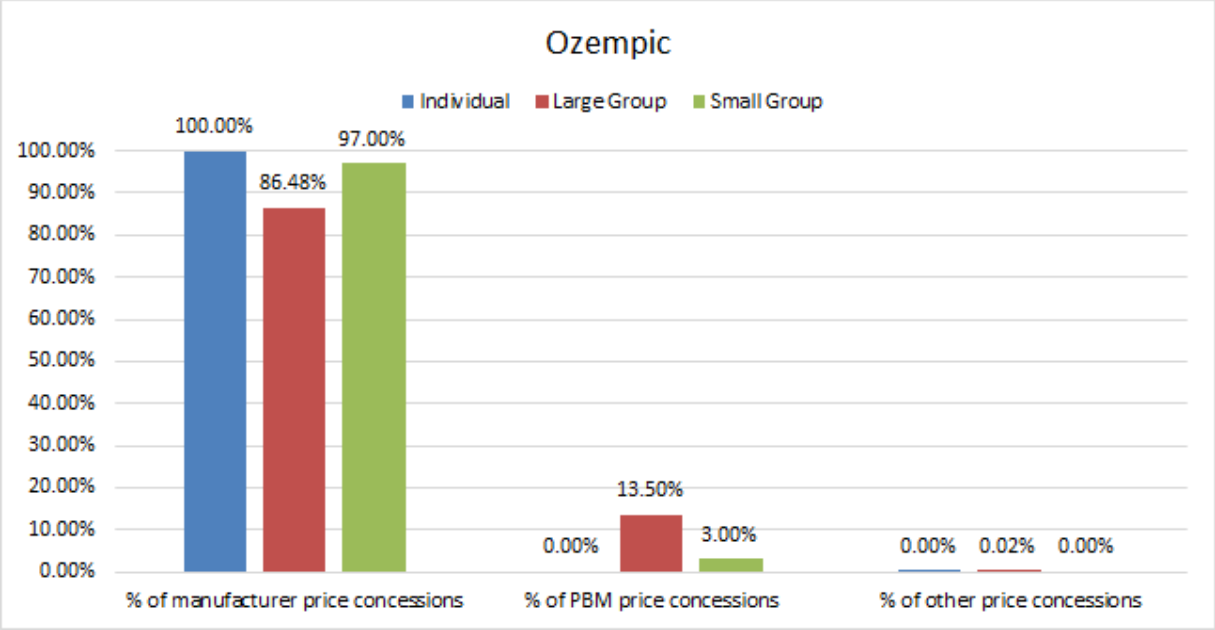

Figure 4 Percent of price concession in each market type[33, 34]

Estimated total amount of the price concession to PBMs

ORS 646A.694(1)(e) and OAR 925-200-0020(1)(e) & (2)(d) & (2)(L)(A-B). Limitations in scope and resources available for this statute requirement. Possible data source carrier data call.

This section is intended to quantify the total discounts, rebates, or other price concessions provided by the manufacturer of Ozempic to each pharmacy benefit manager, expressed as a percentage of the drug's price. At the time of this review, there was no specific data available to PDAB to determine the total amount of such price concessions in the Oregon market.

The statutory and regulatory criteria calls for consideration of such information to the extent practicable. However, due to limitations in available evidence and reporting, this analysis was not performed. Future reviews may incorporate this data as it becomes available through

[33] Price concession refers to any form of discount, directed or indirect subsidy, or rebate received by the carriers or its intermediary contracting organization from any source that serves to decrease the costs incurred under the health plan by the carriers. Examples of price concessions include but are not limited to: Discounts; chargebacks; rebates; cash discounts; free goods contingent on purchase agreement; coupons; free or reduced-price services; and goods in kind. Definition adapted from Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 423, Subpart C. See more at: CFR-2024-title42-vol3-sec423-100.pdf.

[34] Rebate refers to a discount that occurs after drugs are purchased from a pharmaceutical manufacturer and involves the manufacturer returning some of the purchase price of the purchaser. When drugs are purchased by a managed care organization, a rebate is based on volume, market share, and other factors. Academy of Managed Care Pharmacy. https://www.amcp.org/about/managed-care-pharmacy-101/managed-care-glossary.

improved reporting or additional disclosures from manufacturers, PBMs, and payers.

Estimated price for therapeutic alternatives[35]

ORS 646A.694(1)(f) and OAR 925-200-0020(1)(f), (2)(c) & (2)(m). Data source information provided from APAC.

This section presents information on the estimated spending associated with Ozempic and its therapeutic alternatives using 2024 data from APAC. APAC data reflects gross spending across Medicare, Medicaid, and commercial health plans in Oregon. The therapeutic alternatives are represented using APAC data, which does not reflect price concession or rebates.

Ozempic's gross total payer spend, based on APAC data, was nearly **$57.0 million**. Among its therapeutic alternatives, **Trulicity has the highest gross total payer spend at $108.8 million**. **Trulicity also has the greatest number of claims—106,737—compared with 69,261 claims for Ozempic**. **Victoza has the lowest payer-paid amount per claim at $712**, while **Rybelsus has the highest at $1,301**.

Although Ozempic has the highest total enrollee spend overall, **within its therapeutic class Trulicity has the highest total enrollee-paid amount at $59 million**, followed by Mounjaro at nearly $5.1 million. **Rybelsus has the highest enrollee-paid amount per claim at $116**, while **Byetta has the lowest at $45**.

Ozempic and Rybelsus have been designated by the FDA as being in shortage from March 31, 2022, to February 21, 2025. [36] Victoza is currently experiencing a drug shortage that began on July 19, 2024.[37] These shortages affect the availability of these medications for enrollees.

[35] The definition of therapeutic alternative is a drug product that contains a different therapeutic agent than the drug in question, but is FDA-approved, compendia-recognized as off-label use for the same indication, or has been recommended as consistent with standard medical practice by medical professional association guidelines to have similar therapeutic effects, safety profile, and expected outcome when administered to patients in a therapeutically equivalent dose. ORS 925-200-0020(2)(c).

[36] FDA Declaratory Order: Resolution of Shortages of Semaglutide Injection Products. https://www.fda.gov/media/185526/download?attachment

[37] Victoza shortage, FDA Drug shortage database. https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Liraglutide%20Injection&st=c

Table 17 APAC average healthcare and average enrollee OOP costs for Ozempic vs therapeutic alternatives[38]

Proprietary name	No. of enrollees	No. of claims	Total payer paid	Total enrollees paid[39]	Payer paid/ claim	Enrollee paid/ claim[40]
Subject Drug **Ozempic**	**17,565**	**69,261**	**$56,977,684**	**$6,452,114**	**$818**	**$93**
Byetta	60	266	$268,334	$11,887	$1,009	$45
Mounjaro	9,658	55,891	$59,031,450	$5,076,307	$1,056	$91
Rybelsus	3,177	13,188	$17,156,103	$1,487,143	$1,301	$113
Trulicity	15,984	106,737	$108,809,464	$5,945,895	$1,019	$56
Victoza	2,609	11,346	$8,079,397	$554,898	$712	$49

Estimated average price concession for therapeutic alternatives

ORS 646A.694(1)(g) and OAR 925-200-0020(1)(g) & (2)(d) & (2)(L)(A-B). Limitations in scope and resources available for this statute requirement.

This section provides an analysis of the average monetary discounts, rebates, and other price concessions applied to the therapeutic alternatives identified for Ozempic. Based on 2024 data submitted through the carrier data call, it evaluates the extent to which these concessions reduced gross drug costs and estimates the average net costs to payers after adjustments. The analysis includes claim-level data on the proportion of claims with applied discounts, and the breakdown of the total concession amounts by type, offering insight into the reduced costs provided through manufacturer, PBM, and other negotiated price reductions.

Table 18 shows the **average gross cost of the therapeutic alternatives per enrollee in the commercial market with Mounjaro having the highest cost at approximately $5,736 and Victoza at the lowest with $2,332**. After accounting for manufacturer rebates, pharmacy benefit manager (PBM) discounts, and other price concessions, the **average net spend per enrollee for Mounjaro was approximately $2,724** reflecting an **estimated mean discount of 52.5 percent** relative to gross costs.

[38] The therapeutic alternative information is based on 2024 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.asp.
[39] The cost includes all lines of business.
[40] Ibid.

Across all reporting carriers and market segments, the highest gross spend for a therapeutic alternative was **Mounjaro at around $20.2 million**, with total reported **price concessions amounting to approximately $10.6 million**. Notably, **92.5 percent of claims benefited from some form of price concession.**

Table 18 Table Net cost estimate for therapeutic alternatives based on carrier submitted 2024 data

	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
Total number of enrollees	4	3,519	915	3,164	508
Total number of claims	10	16,528	3,482	15,928	1,667
Total number of claims with price concessions applied	5	15,284	3,230	14,334	833
Percentage of claims with price concessions applied	50.0%	92.5%	92.8%	90.0%	50.0%
Percentage of cost remaining after concessions	69.6%	47.5%	45.0%	46.3%	84.8%
Percentage of discount	30.4%	52.5%	55.0%	53.7%	15.2%
Manufacturer price concessions for all market types	$0	$8,400,863	$2,345,929	$8,554,601	$166,238
PBM price concessions for all market types	$3,180	$2,197,885	$316,933	$962,513	$13,696
Other price reductions for all market types	$0	$678	$350	$438	$0
Cost before price concessions across all market types	$10,461	$20,184,264	$4,846,382	$17,716,679	$1,184,596
Total price concessions across all market types	$3,180	$10,599,426	$2,663,212	$9,517,551	$179,934
Cost after price concessions across all market types	$7,281	$9,631,234	$2,183,170	$8,199,129	$1,004,662

	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
Avg. payer spend per enrollee without price concessions	$2,615	$5,736	$5,297	$5,599	$2,332
Avg. payer spend per enrollee with price concessions	$1,820	$2,724	$2,386	$2,591	$1,978

Including all market segments, Rybelsus had the highest **gross average spend per claim at $1,392** before any discounts, rebates, or other price concessions. The net cost per enrollee after discounts, rebates, and other price concessions was **$627**, meaning that insurers reported a price concession of **$765** per claim on the initial drug cost as shown in Table 19.

Table 19 The average price concessions per claim across market types from data call for identified therapeutic alternatives[41]

Byetta	Average	Individual market	Large group	Small group
Spend per claim, gross	$1,046	$0	$1,046	$0
Spend per claim, net	$728	$0	$728	$0
Price concessions per claim	$318	$0	$318	$0
Percent discount	30.4%	0%	30.4%	0%

Mounjaro	Average	Individual market	Large group	Small group
Spend per claim, gross	$1,221	$1,199	$1,252	$1,167
Spend per claim, net	$580	$543	$609	$539
Price concessions per claim	$641	$565	$643	$628
Percent discount	52.5%	54.7%	51.4%	53.8%

Rybelsus	Average	Individual market	Large group	Small group
Spend per claim, gross	$1,392	$1,355	$1,374	$1,473
Spend per claim, net	$627	$605	$622	$658
Price concessions per claim	$765	$750	$752	$815
Percent discount	55.0%	55.3%	54.7%	55.3%

[41] Based on data submitted to the Department of Consumer and Business Services (DCBS) by Oregon's commercial insurance carriers.

Trulicity	Average	Individual market	Large group	Small group
Spend per claim, gross	$1,112	$1,111	$1,115	$1,104
Spend per claim, net	$515	$514	$516	$511
Price concessions per claim	$598	$597	$599	$594
Percent discount	53.7%	53.7%	53.7%	53.8%

Victoza	Average	Individual market	Large group	Small group
Spend per claim, gross	$711	$655	$742	$525
Spend per claim, net	$603	$542	$635	$416
Price concessions per claim	$108	$113	$107	$109
Percent discount	15.2%	17.2%	14.4%	20.7%

Estimated costs to health insurance plans

ORS 646A.694(1)(h) and OAR 925-200-0020(1)(h) & (2)(h) & (m). Data source information provided from APAC and data call.

This section quantifies the aggregate financial impact of Ozempic on health insurance plans in Oregon, based on claims and expenditure data from APAC and the 2024 carrier data call. Costs are delineated by payer type—including commercial plans, Medicaid, and Medicare—as well as by market segment within the commercial plans. These estimates highlight the distribution of expenditures across different types of health coverage and inform assessments of the drug's budgetary implications for public and private payers.

In 2024, the Oregon APAC database recorded **229,743 total claims for Ozempic among 36,575 total enrollees**, corresponding to a **total payer expenditure of nearly $232.7 million.**

Table 20 provides gross cost estimates by the total APAC payer spend across all lines of business:

- **Commercial** accounted for the **largest share of claims at 109,488 from** with a **total spend of $108.5 million**.
- **Medicare** had the **highest number of enrollees at 17, 502** with expenditures of approximately **$91.1 million**.

Table 20 Estimated 2024 APAC total annual gross payment, total enrollees and total claims [42]

Payer line of business	Total enrollees	Total claims	Total payer paid	Average cost per enrollee	Average cost per claim	Percent of total payer spend by LOB
Commercial	17,141	109,488	$108,507,109	$6,330	$991	46.6%
Medicaid	5,518	36,195	$33,112,605	$6,001	$915	14.2%
Medicare	17,502	84,060	$91,079,640	$5,204	$1,084	39.1%
Totals[43]	**36,575**	**229,743**	**$232,699,354**			

Table 21 provides claims information for the healthcare system for Ozempic and its therapeutic alternatives, distinguished by lines of business. **Ozempic has the most claims** among the drugs, with **229,743 claims**. Among its therapeutic alternatives, **Trulicity has higher total claims of 106,737, with Medicare showing to have the most claims at 40,558**.

Table 21 Estimated APAC payer 2024 claims of review drug and its therapeutic alternatives[44]

Proprietary name	Commercial claims	Medicaid claims	Medicare claims	Total claims[45]
Ozempic	109,488	36,195	84,060	229,743
Byetta	53	111	102	266
Mounjaro	27,202	3,973	24,716	55,891
Rybelsus	4,966	1,411	6,811	13,188
Trulicity	32,436	33,743	40,558	106,737
Victoza	3,066	4,291	3,989	11,346

Table 22 shows the overall payer expenditure of Ozempic and its therapeutic alternatives, distinguished by lines of business. Ozempic has a **total expenditure of $232,699,354** with **Commercial being the biggest portion at $91,079,640.** The therapeutic alternative with the **least expenditure is Byetta, at $268,334.**

[42] Based on 2024 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[43] The total number of enrollees is the summation of enrollees across all markets which differs from the unique enrollees at the drug level.
[44] Based on 2024 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[45] Total is the sum of all claims for the drug across all lines of business.

Table 22 Estimated 2024 APAC payer annual gross expenditures of the review drug and its therapeutic alternatives from all lines of business[46]

Proprietary name	Commercial expenditure	Medicaid expenditure	Medicare expenditure	Total[47]
Ozempic	$108,507,109	$33,112,605	$91,079,640	$232,699,354
Byetta	$51,974	$94,638	$121,722	$268,334
Mounjaro	$27,796,779	$3,703,163	$27,531,508	$59,031,450
Rybelsus	$6,522,310	$1,573,248	$9,060,545	$17,156,103
Trulicity	$31,472,374	$30,822,832	$46,514,257	$108,809,464
Victoza	$1,899,918	$2,885,706	$3,293,773	$8,079,397

Table 23 compares the overall payer cost per enrollee of Ozempic and its therapeutic alternatives, distinguished by lines of business. Among the therapeutic alternatives, **Trulicity has the highest mean cost per enrollee at $6,807,** compared to **Ozempic's** mean cost per enrollee **at $6,362.**

Table 23 Estimated 2024 APAC payer annual gross cost per enrollee of the review drug and its therapeutic alternatives[48]

Proprietary name	Ozempic	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
Commercial cost/enrollee	$6,330	$5,197	$6,778	$5,850	$5,999	$2,262
Medicaid cost/ enrollee	$5,204	$4,347	$5,390	$4,903	$5,878	$3,099
Medicare cost/ enrollee	$6,001	$3,640	$5,208	$5,579	$6,142	$2,638
Mean[49] cost/enrollee	$6,362	$4,472	$6,112	$5,400	$6,807	$3,097
Median, Cost/enrollee	$5,265	$2,461	$4,450	$4,337	$5,593	$2,327
Inter-quartile range (IQR)	$7,227	$5,666	$7,131	$6,379	$7,657	$3,266
Cost per enrollee, 75th percentile	$9,652	$6,651	$9,265	$8,369	$10,318	$4,305

[46] Based on 2024 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[47] Total is the sum of all expenditure for the drug across all lines of business.
[48] Based on 2024 Oregon APAC data across commercial insurers, Medicaid, and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[49] The overall mean cost per enrollee across commercial insurers, Medicaid, and Medicare.

Proprietary name	Ozempic	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
Cost per enrollee, 95th percentile	$14,975	$12,299	$15,432	$12,857	$15,962	$8,496

Table 24 Estimated 2024 APAC payer annual gross cost per claim of the review drugs

Proprietary name	Ozempic	Byetta	Mounjaro	Rybelsus	Trulicity	Victoza
Commercial cost/claim	$991	$981	$1,022	$1,313	$970	$620
Medicaid cost/claim	$915	$1,193	$1,114	$1,330	$1,147	$826
Medicare cost/claim	$1,084	$853	$932	$1,115	$913	$673
Cost per claim, mean	$1,013	$1,009	$1,056	$1,301	$1,019	$712
Cost per claim, median	$918	$817	$1,001	$929	$935	$736
IQR	$89	$68	$101	$1,136	$69	$263
Cost per claim, 75th percentile	$941	$875	$1,040	$2,857	$961	$783
Cost per claim, 95th percentile	$2,603	$2,316	$2,780	$2,700	$2,617	$1,636

Data for plan year 2024 submitted via the carrier data call further stratifies commercial expenditures by market segment. The collected **total net cost from reporting market types was around $63.4 million**, with payers paying **$57 million**, and **enrollees out-of-pocket estimated** to be **$6.4 million**.

Table 25 Estimated 2024 annual total net costs to the healthcare system, payers and OOP/enrollee[50]

Market	Number of claims	Number of enrollees	Total net annual spending	Total annual plan paid	Total annual enrollee out-of- pocket cost
Individual	9,738	2,473	$7,737,942	$6,331,081	$1,406,861
Large Group	47,577	11,978	$44,914,566	$40,855,517	$4,059,049
Small Group	12,306	3,114	$10,777,289	$9,791,086	$986,203
Total	**69,621**	**17,565**	**$63,429,798**	**$56,977,684**	**$6,452,114**

[50] Cost information from the data call is the cost of the drug after price concessions.

Table 26 includes the average plan costs per enrollee in the commercial market, ranging from **$3,750 (large group) to $3,129 (individual)** annually.

Table 26 Estimated 2024 annual total net costs to the healthcare system, payers and OOP/enrollee

Market	Avg. total paid/ claim	Avg. plan paid/ claim	Avg. enrollee paid/ claim	Avg. total paid/ enrollee	Avg. plan paid/ enrollee	Avg. enrollee OOP/ enrollee
Individual	$795	$650	$144	$3,129	$2,560	$569
Large Group	$944	$859	$85	$3,750	$3,411	$339
Small Group	$876	$796	$80	$3,461	$3,144	$317

As shown in Figure 5, the **large group market segment** represented the majority of commercial spending (71% of total), followed by individual markets and small group.

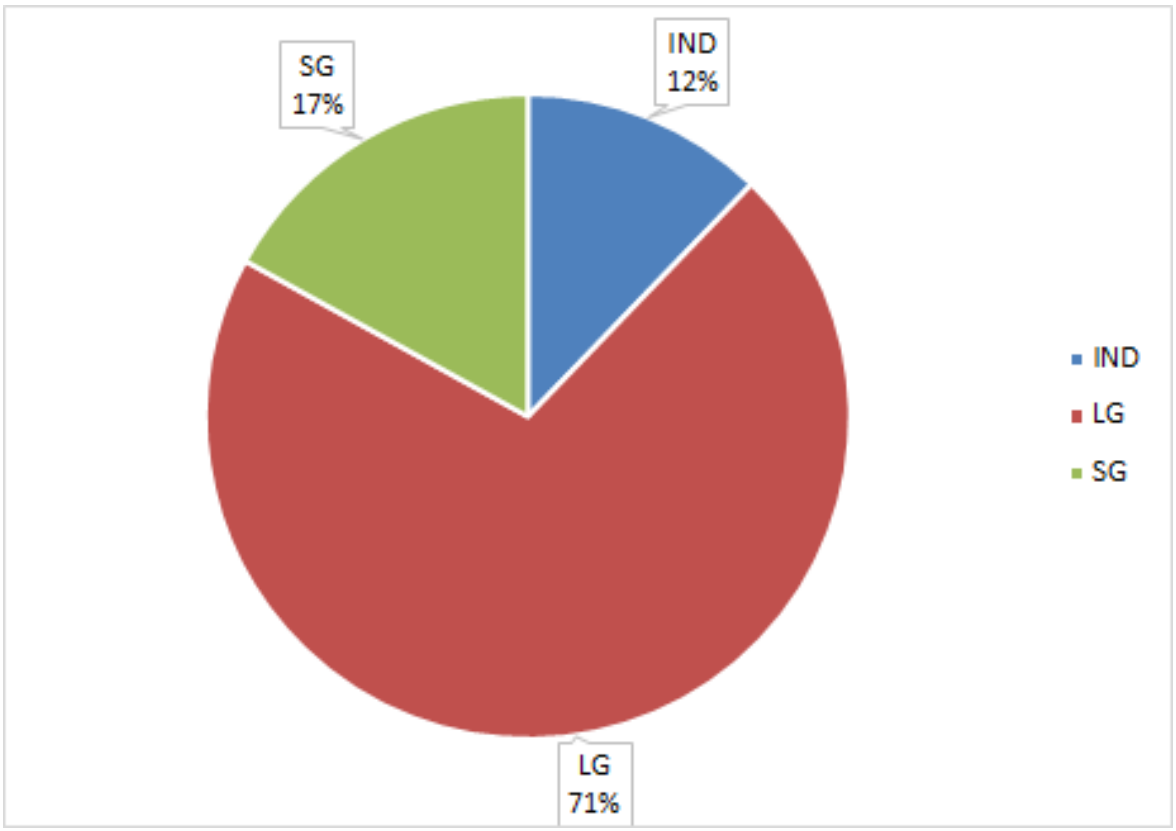

Figure 5 Data call total annual percent spend (payer paid) by market

Table 27 indicates CCOs reported Ozempic in their top 40 drugs by gross amount paid and the top 40 physical health drug by gross (FFS only) in multiple quarters throughout 2024.[51] In Q1 Ozempic was ranked number 14 on the physical health list with an average paid per claim at $556. By Q4 Ozempic was ranked number 5 with the average paid per claim at $578. The drug is identified as **not being on the preferred drug list**.

Table 27 Medicaid CCOs 2024 gross amount quarterly reports for Ozempic (rebates not included)[52]

Medicaid CCOs: Gross amount paid and Physical health drug by gross (FFS only)							
	FFS gross amount paid [53]	FFS physical health drugs[54]		Gross amount paid	Physical health drug		
Quarter	**Rank[55]**	**Rank**	**Amount paid**	**% Total FFS costs**	**% Total FFS costs**	**Claim count**	**Avg. paid per claim**
1	-	14	$135,782	-	1.2%	244	$556
2	37	6	$166,417	0.4%	1.8%	292	$570
3	37	6	$182,214	0.4%	1.9%	288	$633
4	38	5	$178,730	0.4%	2.0%	309	$578
Total	**37.3**	**7.8**	**$663,143**	**-**	**-**	**1133**	**$2,337**

Impact on enrollee access to the drug

ORS 646A.694(1)(i) and OAR 925-200-0020(1)(i). Data source information provided from carrier data call.

This section summarizes information reported by carriers regarding plan design features that relate to coverage of Ozempic, including prior authorization requirements, step therapy protocols, and formulary placement. The data describes how the drug is positioned within insurance benefit designs and the extent to which utilization management processes were applied during the reporting period.

Based on information reported through the carrier data call, the following plan design features were observed for Ozempic. In 2024, approximately **84 percent of reporting plans required**

[51] A physical health drug in DUR reporting is a regular outpatient prescription drug used for physical medical conditions, excluding mental-health medications and drugs administered by a provider.
[52] CCO Pharmacy spend provided by Oregon State University drug use research and management program. Oregon State University Drug Use and Research Management DUR claims reports 2024. College of Pharmacy, Oregon State University. https://pharmacy.oregonstate.edu/research/pharmacy-practice/drug-use-research-management/dur-reports.
[53] Top 40 drugs by gross amount paid (FFS Only) includes all FFS drug spending.
[54] Top 40 physical health drugs by gross amount paid (FFS Only) is the drug's gross amount of only physical health drugs and does not include mental health or physician administered drugs.
[55] Average rank in the 2024 DUR utilization quarterly reports for fee-for-service top 40 physical health drugs.

prior authorization (PA) for coverage of the drug, and **no plans required step therapy** before approving its use.

For formulary placement, **6.3 percent of plan types categorized Ozempic as a non-preferred drug**, and **all plans covered it**.

Table 28 Plan design analysis from 2024

Percentage of plans	
Required prior authorization	83.8%
Required step therapy	0.0%
On a non-preferred formulary	6.3%
Not covered	0.0%

Note: percentages can equal over 100 percent as some carrier and market combos may have multiple plans that fall under different designs. For example: Carrier A may have three plans in the small group market that require prior authorization but two other plans in the small group market that do not require prior authorization.

Relative financial impacts to health, medical, or social services costs

ORS 646A.694(1)(j) and OAR 925-200-0020(1)(j) & (2)(i)(A-B). Limitations in scope and resources available for this statute requirement.

This section addresses the extent to which the use of Ozempic may affect broader health, medical, or social service costs, as compared to alternative treatments or no treatment. At the time of this review, there was no quantifiable data available to PDAB to assess these relative financial impacts in the Oregon population.

The statutory and regulatory criteria calls for consideration of such information to the extent practicable. However, due to limitations in available evidence and reporting, this analysis was not performed. Future reviews may incorporate this data as it becomes available through carrier reporting, manufacturer disclosures, or other sources.

Future reviews may incorporate findings from real-world evidence, health technology assessments, or economic modeling as such data become available.

Estimated average patient copayment or other cost-sharing

ORS 646A.694(1)(k) and OAR 925-200-0020(1)(k) & (2)(j)(A-D). Data source information provided from APAC and carrier data call. Data limitations with patient assistance programs

This section summarizes the average annual enrollee out-of-pocket (OOP) costs for Ozempic in Oregon, as reported in 2024 by the Oregon All Payers All Claims (APAC).[56] These costs include enrollee copayments, coinsurance, and deductible contributions for the drug and are presented by insurance lines of business of Medicare and commercial heath care carriers.

Tables 29 and 30 presents the average annual enrollee OOP costs derived from APAC. The APAC data, which includes claims from commercial, and Medicare enrollees, showed average per-enrollee and per-claim and OOP gross costs. For example, **Medicare enrollees recorded higher average annual OOP costs**. Medicaid enrollees pay $0 OOP costs.

Table 29 Review drug vs. therapeutic alternatives: Annual out-of-pocket cost per enrollee by line of business (light green table header) and descriptive statistics for total market (dark green table header) [57]

Proprietary name	Commercial	Medicare	Medicaid	Mean[58]	Median[59]	IQR	75th percentile	95th percentile
Ozempic	$466	$509	$0	$452	$132	$480	$480	$2,101
Byetta	$106	$387	$0	$198	$0	$76	$767	$76
Mounjaro	$667	$458	$0	$526	$0	$496	$496	$2,597
Rybelsus	$492	$508	$0	$468	$141	$466	$477	$2,174
Trulicity	$402	$485	$0	$372	$34	$375	$375	$1,949
Victoza	$207	$358	$0	$213	$0	$185	$185	$1,154

[56] Gross costs from the APAC database are prior to any price concessions such as discounts or coupons. Net cost information from the data call is the cost of the drug after price concessions.
[57] Based on 2024 Oregon APAC data across commercial insurers and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[58] Includes summation of copay, coinsurance, and deductible across all from all markets across all claims.
[59] Median represents the middle value of the data set when arranged in ascending order.

Table 30 Review drug vs. therapeutic alternatives: Annual out-of-pocket cost per claim by line of business (light green table header) and descriptive statistics for total market (dark green table header) [60]

Proprietary name	Commercial	Medicare	Medicaid	Mean[61]	Median	IQR	75th percentile	95th percentile
Ozempic	$70	$106	$0	$72	$11	$50	$50	$375
Byetta	$20	$126	$0	$45	$0	$11	$11	$323
Mounjaro	$101	$95	$0	$91	$30	$60	$60	$465
Rybelsus	$110	$248	$0	$113	$35	$90	$90	$532
Trulicity	$65	$160	$0	$56	$0	$30	$30	$259
Victoza	$57	$152	$0	$49	$0	$30	$30	$268

Clinical information based on manufacturer material[62]

ORS 646A.694(1)(L) and OAR 925-200-0020(1)(L). Information provided from manufacturers and information with sources from contractor(s).

Drug indications

- FDA Approved:
  - As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (T2DM).
  - To reduce the risk of major adverse cardiovascular events in adults with T2DM and established cardiovascular disease.
  - To reduce the risk of sustained eGFR decline, end-stage kidney disease, and cardiovascular death in adults with T2DM and chronic kidney disease (CKD)
  - To reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease.
- Limitations of Use:
  - Includes warnings of pancreatitis and gallbladder events.
  - Evidence is insufficient to make recommendations in type 1 diabetes (T1DM), and it is currently not recommended in this population.
- Off Label Uses:
  - Type 1 diabetes mellitus (T1DM)
  - Chronic Weight Management

[60] Based on 2024 Oregon APAC data across commercial insurers and Medicare. APAC cost information is prior to any price concessions such as discounts or coupons.
[61] Includes summation of copay, coinsurance, and deductible across all from all markets across all claims.
[62] U.S. Food & Drug Administration. Ozempic *(semaglutide*) Prescribing information, May 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/209637s020s021lbl.pdf.

- GLP-1s have been used off label for both pediatric and adult Type 1 diabetes mellitus patients to manage their diseases. GLP-1s are used as adjunctive therapy to insulin therapy for these patients, though T1DM has not been approved by FDA as an indication for semaglutides, and have been reported to improve glycemic control with automated insulin delivery.[63, 64]
- Semaglutide is a glucose-dependent insulinotropic polypeptide (CIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist. GLP-1 agonists have effects such as decreased appetite because they enhance satiety and reduces hunger by stimulating insulin and inhibiting glucagon secretions. The decreased appetite leads to weight loss despite obesity not being part of the FDA indications. Similar to other semaglutide products, Ozempic is used for the off-label for weight loss.[65, 66, 67]

Clinical efficacy

- Injectable semaglutide (Ozempic) was FDA-approved based on three, phase 3, double-blind, placebo-controlled, randomized controlled trials (RCTs) in patients with T2DM both as monotherapy, as add-on therapy to background metformin with or without additional oral agents, and as add-on to basal insulin. These studies compared semaglutide subcutaneous (SC) 0.5 mg and 1.0 mg weekly to placebo. The primary outcome in all trials was changed in hemoglobin A1c (HbA1C) from baseline to week 30 or 52.[68]
- These initial studies provided moderate quality evidence that semaglutide SC 0.5 mg and 1.0 mg weekly reduces short term HbA1c from baseline in a dose-dependent manner,

[63] Pasqua, MR., et al. Subcutaneous weekly semaglutide with automated insulin delivery in type 1 diabetes: a double-blind, randomized, crossover trial. Nat Med 31, 1239–1245 (2025). https://www.nature.com/articles/s41591-024-03463-z.

[64]Gallagher, Mary Pat, et al. Understanding Off-Label Use of GLP-1 (Glucagon-Like Peptide-1 Receptor) Agonists among Providers Participating in the T1D Exchange Quality Improvement Collaborative (T1DX-QI). Diabetes 14 June 2024; 73 (Supplement_1): 804-P: Understanding Off-Label Use of GLP-1 (Glucagon-Like Peptide-1 Receptor) Agonists among Providers Participating in the T1D Exchange Quality Improvement Collaborative (T1DX-QI) | Diabetes | American Diabetes Association.

[65] Understanding Unapproved Use of Approved Drugs Off Label. U.S. Food & Drug Administration, Feb. 5, 2018. https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label.

[66] FDA's Concerns with Unapproved GLP-1 Drugs Used for Weight Loss. U.S. Food & Drug Administration, Aug. 8, 2025. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fdas-concerns-unapproved-glp-1-drugs-used-weight-loss.

[67] Blundell, J., et al. "Effects of once-weekly semaglutide on appetite, energy intake, control of eating, food preference and body weight in subjects with obesity." Diabetes, obesity & metabolism, 19(9), 1242–1251. https://dom-pubs.pericles-prod.literatumonline.com/doi/10.1111/dom.12932.

[68] FDA Center for Drug Evaluation and Research. Semaglutide Clinical Review. Application Number: 209637Prog1s000: https://www.accessdata.fda.gov/drugsatfda_docs/nda/2017/209637Orig1s000MedR.pdf.

ranging from -1.32% to -1.85% as monotherapy or as add-on therapy.[69] Semaglutide SC resulted in a dose-dependent weight loss of 3.5 to 6.5 kg in clinical trials.[70]

- In January 2020, the FDA labeling of semaglutide SC (Ozempic) was expanded to include the reduction of risk of major adverse CV events.[71] This indication was added based on data from the SUSTAIN-6 study, a double-blind, randomized, placebo-controlled trial comparing semaglutide SC to placebo in 3,297 adults with T2DM and CV disease, chronic heart failure, or chronic kidney disease on background therapy for glycemic control.[72] Over a median follow-up of 2 years, there was a reduction in the primary composite CV outcome (nonfatal myocardial infarction, nonfatal stroke, CV death) of 2.3% (6.6% in the semaglutide SC group and 8.9% in the placebo group; hazard ratio [HR] 0.74; 95% CI 0.58 to 0.95; p<0.02; number needed to treat [NNT] 44) and an absolute difference of 1.1% in the risk of stroke (HR 0.61; 0.38 to 0.99).[73] There was no significant difference in the individual outcomes of myocardial infarction, CV death, or all-cause death. There was a significant reduction in body weight with semaglutide SC 0.5 mg (-3.6 kg), semaglutide SC 1.0 mg (-4.9 kg) compared to placebo (-0.5 kg). [74]
- In January 2025, the FDA approved semaglutide SC (Ozempic) to reduce the risk of worsening kidney disease, kidney failure, and death from CVD in adults with T2DM and chronic kidney disease (CKD), the first GLP-1 agonist to be approved for renal benefits. Approval was based on data from the FLOW study, which resulted in a reduced risk of the composite of major kidney disease events, reduction in eGFR for baseline, and death from kidney related or CV causes with semaglutide 1.0 mg weekly compared to placebo (HR 0.71; 95%CI 0.56 to 0.89).

Clinical safety

- FDA safety warnings and precautions:
  - Risk of Thyroid C-Cell Tumors
  - Pancreatitis
  - Diabetic Retinopathy complications
  - Hypoglycemia in combination with insulin or an insulin secretagogue
  - Hypersensitivity
  - Acute kidney injury
  - Acute gallbladder disease
- Contraindications:

[69] Knop FK, Aroda VR, do Vale RD, et al. Oral semaglutide 50 mg taken once per day in adults with overweight or obesity (OASIS 1): a randomized, double-blind, placebo-controlled, phase 3 trial. Lancet. 2023 Aug 26;402(10403):705-719. https://pubmed.ncbi.nlm.nih.gov/37385278/.
[70] Ibid.
[71] Ozempic Prescribing Information. Novo Nordisk. Plainsboro, NJ 09/2023. https://www.novo-pi.com/ozempic.pdf.
[72] Marso SP, Bain SC, Consoli A, Eliaschewitz FG, et al. Semaglutide and Cardiovascular Outcomes in Patients with Type 2 Diabetes. N Engl J Med. 2016 Nov 10;375(19):1834-1844. https://pubmed.ncbi.nlm.nih.gov/27633186/.
[73] FDA Center for Drug Evaluation and Research. Semaglutide Clinical Review. Application Number: 209637Prog1s000. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2017/209637Orig1s000MedR.pdf.
[74] Ibid.

    - Personal or family history of medullary thyroid carcinoma or in patients with multiple endocrine neoplasia syndrome type 2.
    - Serious hypersensitivity reaction to semaglutide

- Common side effects:
    - Gastrointestinal effects (32 to 41%), including diarrhea (8 to 9%), nausea (15 to 20%), and vomiting (5 to 9%), abdominal pain (6 to 11%), and constipation (3 to 6%)

- Safety advantages or disadvantages:
    - The most common side effects associated with GLP-1 receptor agonists include gastrointestinal side effects. These are dose-related and likely due to delayed gastric emptying or activation of centers involved in appetite regulation, satiety, and nausea. These are most common soon after initiation and during dose escalation. Rapid titration is associated with higher risk of GI symptoms. There is no evidence that one GLP-1 is associated with higher rates of GI symptoms than others. This is likely to result in higher rates of discontinuation in real world use than in clinical trials.
    - Overall risk of hypoglycemia of GLP-1 agonists when used as monotherapy is low and there is no meaningful difference in risk between individual agents. The risk of hypoglycemia is increased when used in combination with insulin or sulfonylureas.
    - There is high quality evidence of an association with GLP-1 receptor agonists and an increased risk of a composite assessment of gallbladder or biliary diseases (including cholelithiasis, cholecystitis, and biliary disease) compared to active treatments or placebo (relative risk [RR] 1.37; 95% CI, 1.23 to 1.52).[75] The risk was increased with higher doses, longer durations and when used for weight loss. There was a statistically significant increase in risk with liraglutide and dulaglutide, a nonsignificant increased risk with exenatide and injectable semaglutide and no increased risk seen with oral semaglutide. Despite an increased risk compared to placebo, the absolute risk remains small (additional 27 cases per 10,000 persons treated per year).[76]

[75] He L, Wang J, Ping F, et al. Association of Glucagon-Like Peptide-1 Receptor Agonist Use With Risk of Gallbladder and Biliary Diseases: A Systematic Review and Meta-analysis of Randomized Clinical Trials. JAMA Intern Med. 2023;182(5):513–519. https://pubmed.ncbi.nlm.nih.gov/35344001/.
[76] Ibid.

Therapeutic alternatives[77,78,79,80,81]

Table 31 FDA-approved indications

Drug	Formulation	Dosing Frequency	Indications (per label)		
			T2DM	CV Risk Reduction	CKD
Semaglutide (Ozempic)	SubQ	Weekly	Yes	Yes	Yes
Semaglutide (Rybelsus)	Oral	Daily	Yes	No	No
Dulaglutide (Trulicity)	SubQ	Weekly	Yes	Yes	No
Liraglutide (Victoza)	SubQ	Daily	Yes	Yes	No
Exenatide (Byetta)	SubQ	Twice Daily	Yes	No	No
Tirzepatide (Mounjaro)	SubQ	Weekly	Yes	No	No
Abbreviations: CKD: chronic kidney disease; CV: cardiovascular; SubQ: subcutaneous; T2DM: type 2 diabetes mellitus					

Table 32 Efficacy: Comparative clinical efficacy (selected label trials)

Drug	~A1C Decrease	Short term weight loss	Rates of nausea	Cardiovascular Benefits
Semaglutide (Ozempic)	1.0%- 1.7%	4.0 – 6.0 kg	15% - 20%	↓ MACE (NNT 44)
Dulaglutide (Trulicity)	1.0% - 1.8 %	2.5 – 4.6 kg	12% - 20%	↓ MACE (NNT 71)
Exenatide (Byetta)	1.0%	2 kg	8% - 11%	-

[77] U.S. Food & Drug Administration. *Ozempic (semaglutide) Prescribing Information*. Teva Pharms., Action yr 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/209637s020s021lbl.pdf.
[78] U.S. Food & Drug Administration. *Byetta (exanatide) Prescribing Information*. Teva Pharms., Action year 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/021773s9s11s18s22s25lbl.pdf.
[79]U.S. Food & Drug Administration. *Rybelsus (semaglutide) Prescribing Information*. Teva Pharms., Action year 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/213051s012lbl.pdf.
[80] U.S. Food & Drug Administration. *Trulicity (dulaglutide) Prescribing Information*. Teva Pharms., Action year 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/125469s051lbl.pdf.
[81] U.S. Food & Drug Administration. *Victoza (liraglutide) Prescribing Information*. Teva Pharms., Action year 2022. Victoza https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/022341s037s038lbl.pdf.

Drug	~A1C Decrease	Short term weight loss	Rates of nausea	Cardiovascular Benefits
Liraglutide (Victoza)	1.0% - 1.3%	2.5 kg	18% - 20%	↓ MACE (NNT 53)
Semaglutide (Rybelsus)	1.0%	2.5 kg	11% - 20%	↓ MACE (NNT 56)
Tirzepatide (Mounjaro)	1.7%-2.5%	5.0-12.0 kg	12% - 29%	↓ MACE*
Abbreviations: CV: cardiovascular; ER: extended release; kg: kilogram; MACE: major adverse cardiovascular events; NNT: number needed to treat; SubQ: subcutaneous; T2DM: type 2 diabetes mellitus *Unpublished data. Pending publication of CV outcomes trial.				

Comparative clinical efficacy (selected labeled trials)

- Clinical guidelines recommend GLP-1 agonists as a first line option for patients with T2DM and compelling indications with evidence of benefit, including atherosclerotic cardiovascular disease (ASCVD) and those at high risk for ASCVD.[82] Agents with proven CV benefits are recommended, including dulaglutide (Trulicity), liraglutide (Victoza), and subcutaneous semaglutide (Ozempic). A large randomized, double-blind, phase 3 trial comparing tirzepatide to dulaglutide in adults with T2DM and CV disease evaluating CV outcomes found that tirzepatide was noninferior to dulaglutide when evaluating death due to cardiovascular causes.[83]
- Within the GLP-1 agonists, semaglutide is considered to have very high efficacy in lowering HgA1c and very high efficacy for weight loss. It is a long acting GLP-1 agonist and is available as weekly dosing which may be preferred by some patients. Tirzepatide is the only GLP-1/GIP agonist and has the highest efficacy for weight loss and similar HgA1c lowering ability to semaglutide
- Compared to dulaglutide, exenatide and liraglutide, semaglutide SC (Ozempic) was shown to be superior in reduction in HgA1C (-1.5% to -1.8%), and in reduction in body weight (-5.6 kg to -6.5 kg).
- Compared to liraglutide, oral semaglutide (Rybelsus) is noninferior in reduction in HgA1C (estimated treatment difference -0.2%; 95% CI -0.3 to -0.1) and superior in

[82] American Diabetes Association Professional Practice Committee. "9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2024." Diabetes Care, January 2024, 47 (Supplement_1): S158–S178. https://doi.org/10.2337/dc24-S009.

[83] Nicholls, Stephen J., et al. "Cardiovascular Outcomes with Tirzepatide versus Dulaglutide in Type 2 Diabetes." *New England Journal of Medicine*, vol. 393, no. 24, 18 Dec. 2025, pp. 2409–2420, https://doi.org/10.1056/nejmoa2505928.

reduction in body weight (-4.4 kg vs. -3.1 kg; p=0.003), with no known effects on CV outcomes.[84]

- In addition to the in-class (GLP-1 agonists) therapeutic alternatives included in above table, additional first line drug classes used for the treatment of T2DM include metformin, sodium-glucose cotransporter 2 inhibitors (SGLT2i), and inhibitors of dipeptidyl peptidase 4 (DPP-4).[85]

Table 33 Safety & therapeutic considerations (from warnings/precautions & highlights)

Drug	Boxed warning	Notable warnings/precautions (selected)
Semaglutide (Ozempic)	Thyroid C-cell tumors	Pancreatitis; diabetic retinopathy complications; AKI/dehydration; gallbladder disease; hypoglycemia with SU/insulin; delayed gastric emptying affecting oral meds.
Semaglutide (Rybelsus)	Thyroid C-cell tumors	Pancreatitis; diabetic retinopathy complications; AKI; severe GI effects; gallbladder disease; aspiration risk under anesthesia; oral-drug absorption interactions; strict empty-stomach dosing.
Dulaglutide (Trulicity)	Thyroid C-cell tumors	Pancreatitis; retinopathy complications (monitor if hx); AKI with severe GI events; severe GI disease caution; gallbladder disease; hypoglycemia with SU/insulin.
Liraglutide (Victoza)	Thyroid C-cell tumors	Pancreatitis; renal impairment cautions; hypersensitivity; gallbladder disease; daily injection/titration requirements.
Exenatide (Byetta)	No thyroid C-cell boxed warning on label.	Pancreatitis; avoid in severe renal impairment/ESRD; caution in moderate renal impairment; GI disease caution; immunogenicity; drug-induced thrombocytopenia warning added.

[84] Pratley R, Amod A, Hoff ST, Kadowaki T, et al. Oral semaglutide versus subcutaneous liraglutide and placebo in type 2 diabetes (PIONEER 4): a randomised, double-blind, phase 3a trial. Lancet. 2019 Jul 6;394(10192):39-50.
[85] American Diabetes Association Professional Practice Committee. "9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2024." Diabetes Care, January 2024, 47 (Supplement_1): S158–S178. https://doi.org/10.2337/dc24-S009.

Table 34 Strengths, dosing & route

Drug	Route & schedule	Starting & maintenance dose(s)	Marketed strengths / pens
Semaglutide (Ozempic)	SC, once weekly	Start 0.25 mg weekly ×4 wk to 0.5 mg; may increase to 1 mg then 2 mg (≥4 wk steps).	Pens delivering 0.25/0.5 mg (2 mg/3 mL), 1 mg (4 mg/3 mL), 2 mg (8 mg/3 mL).
Semaglutide (Rybelsus)	Oral, once daily (empty stomach with ≤4 oz water; wait ≥30 min)	R1: 3 mg to 7 mg to 14 mg; R2: 1.5 mg to 4 mg to 9 mg (formulations not mg-for-mg substitutable).	Tablets: R1 3/7/14 mg; R2 1.5/4/9 mg.
Dulaglutide (Trulicity)	SC, once weekly	Adults: start 0.75 mg to 1.5 mg; may increase in 1.5-mg steps to max 4.5 mg. Peds (≥10 y): start 0.75 mg; max 1.5 mg.	Single-dose pens: 0.75 mg/0.5 mL; 1.5 mg/0.5 mL; 3 mg/0.5 mL; 4.5 mg/0.5 mL.
Liraglutide (Victoza)	SC, once daily	Start 0.6 mg daily ×≥1 wk to 1.2 mg; may increase to 1.8 mg if needed; same titration in pediatrics (≥10 y).	6 mg/mL pen delivering 0.6, 1.2, or 1.8 mg doses.
Exenatide (Byetta)	SC, twice daily (≤60 min before morning & evening meals)	Start 5 mcg BID ×1 mo to 10 mcg BID as tolerated.	Prefilled pens: 5 mcg/dose (60 doses); 10 mcg/dose (60 doses).

Input from specified stakeholders

ORS 646A.694(3) and OAR 925-200-0020(2)(k)(A-D)

See Appendix for all stakeholder comment letters.

Survey-style feedback forms were posted on the PDAB website from April to August 2026, to collect voluntary information about drugs under review from stakeholders including patients, caregivers, and advocacy groups; individuals with scientific or medical training; safety net providers; pharmaceutical manufacturers; pharmacy benefit managers; and health insurers. This

section summarizes the input received for specific drugs. The 2026 community outreach report summarizes additional general input about drug prices and patient experiences.

Patients and caregivers:

Note: The information presented is based on self-reported survey responses from individuals prescribed certain medications. Participation in the survey was voluntary, and the responses reflect the individual's personal understanding and interpretation of the question asked. As such, the data may contain inconsistencies or inaccuracies due to varying levels of comprehension, recall bias, or misinterpretation of question intent. These limitations should be considered when interpreting the responses.

Ten patients and caregivers submitted feedback regarding Ozempic. Four respondents reported delaying prescription fills due to cost, four reported skipping doses or taking less medication than prescribed because of cost, and four reported stopping treatment due to cost. Five respondents reported experiencing difficulty obtaining the medication because of insurance requirements such as prior authorization or step therapy.

Four respondents reported paying more than $250 for a 30-day supply. Four respondents described the medication as a severe finical burden, while an additional three respondents reported moderate to significant financial burden. Three respondents reported cutting back on essential expenses to afford treatment. Four respondents reported that insurance has denied coverage, and five respondents indicated that difficulty affording the medication had negatively affected their health. Survey responses suggest that cost and coverage barriers may affect patient access to and continued use of Ozempic.

Individuals with scientific or medical training

Two individuals with scientific or medical training submitted feedback regarding Ozempic. Both respondents reported that Ozempic provides substantial additional clinical benefit compared with therapeutic alternatives and indicated that the supporting evidence is high quality and guideline supported. Both respondents also indicated that patients frequently delay or decline treatment due to cost and that patients' costs have a major negative impact on medications adherence.

The respondents reported that utilization management requirements, including prior authorization, step therapy, and quantity limits, frequently delay patient access and create a substantially higher administration burden than alternative therapies. One respondent reported that patient costs are significantly higher than available alternatives, while the second reported costs similar to alternatives. Both respondents indicated that Ozempic contributes to affordability concerns for patients. One respondent also noted that lower medication costs could improve access to treatment.

Safety net providers

No survey information has been received from safety net providers about this drug as of the last update of this document.

Manufacturers

No survey information has been received from manufacturers about this drug as of the last update of this document.

Pharmacy benefit managers

No survey information has been received from PBMs about this drug as of the last update of this document.

Health insurers

No survey information has been received from health insurers about this drug as of the last update of this document.

Appendix

Stakeholder feedback:

Table 35 Feedback

Name of speaker	Association to drug under review	Drug	Format	Date	Exhibit website link