PDAB July 15, meeting transcript

Mike Neuenschwander: So, Eileen, I'll let you take it away.

Eileen Cody: Well, thank you and I'll -- I'm going to apologize to everybody that I'm actually Chairing this meeting at the Omaha Airport, so if you start getting weird noises, let me know so then I'll make sure I mute myself. But anyhow, we've got some work to do today, and I don't -- I don't know that we have many introductions, but should we do a roll call so that we -- ? [Cross-talk] You want to go ahead, Mike, and do roll call?

Mike Neuenschwander: Yeah, sure. So we've got Eileen here, obviously. Greg, you on?

Greg Gipson: Hi. Good morning, everyone.

Mike Neuenschwander: Great. Thank you very much. Hung?

Hung Truong: Good morning. Hung Truong, Board Member.

Mike Neuenschwander: Awesome. And Doug, are you here?

Eileen Cody: He was.

Mike Neuenschwander: I was going to say I thought I saw him pop on for a minute.

Eileen Cody: He must have -- something must have happened. He dropped of, but he was here, so I'm sure he'll [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yeah. [cross-talk] but we'll circle back for him here.

Eileen Cody: Okay.

Mike Neuenschwander: And then from the HCA side of the house, Mike Neuenschwander, PDAB Director. We've got Simon over here, our Policy Analyst, Michael Tunick, our AG, Marina Suzuki, our Health Economist, Kelly Wu, our Data Guru, Jingping Xing, our other Data Guru, and I think that's most of the people from the immediate team [cross-talk] --

Eileen Cody: [Cross-talk] Okay.

Mike Neuenschwander: [Cross-talk] [indistinct].

Eileen Cody: Okay. So then do you want to give your report, Mike?

Mike Neuenschwander: Yeah, yeah. Let me pull up my little list here. So great to have everyone out here today. We are just kind of a thing of note, we are still missing our fifth Board Member; however, good news on that front. A new HCA Director has been found, and I believe he starts August 18th, if I'm not mistaken, so a little bit of time. And I think he's coming out of Maryland, so that will be good to get to know him and hopefully be able to introduce him to our work. And then we actually just had a chat with Marianne here this morning. She popped in before she had some meetings that she had to run up to, so working on keeping her seat warm for her and hopefully we'll see her back here in the not too distant future.

Eileen Cody: Amen.

Mike Neuenschwander: [Laugh]. Yeah. No, that'll be fun if she can come back. Just some general budget updates. Things have kind of calmed down here a little bit since the spring, and so we haven't had any big shakeups to our program or impacts to staffing. The data team has done some just like a reorg in terms of where they're located at, but they're still working with us and that, you know, the relationship there hasn't changed. We've had a small decrease to our budget but nothing significant that would impact current operations. So that's pretty good news with how everything fell out with that.

Colorado lawsuit. I know we talked about this last time, just the District Court dismissed that lawsuit, I guess, Amgen ruling that they didn't have any standing. No other updates on that that I'm aware of right now. Some other interesting state updates for other PDABs. So Colorado had their second rulemaking hearing, I want to say last week, about upper payment limits for Enbrel. So they're still working on that, and so, you know, be very interested to keep connecting with them and seeing how that's going. Oregon, they're currently taking public comment and going through some of the drug reviews that they've done. I want to say I was looking at their recent agenda that's coming out for tomorrow, and they were going to reviews -- go over six drug reviews in their meetings. And so just the initial view that I got of their reports looks interesting. I think that'd be something good, Simon, we can forward to the Board Members, so you can take a look at and see what other states are doing.

Maryland, I believe, also has a meeting coming up, I want to say in August -- I had to go back and double check where they're doing also two cost review studies that they're going to go over. Some other things of note, both the Oregon PDAB Director recently moved on to a different position, so they're looking to fill that. Colorado PDAB Director switched, and I think that we had a new one come in a couple of months back, so just some interesting stuff going on there. And then the New Hampshire PDAB, which was very relatively new as of last year, has been basically disbanded due to just the budget cuts that their state was going through and just some of the programs were

eliminated. So some interesting news of PDABs around the country, things that I've been trying to keep my eye on. And so if Board Members have any other questions, feel free to ping me.

We try and collaborate with the other PDABs regularly, just so we know what's going on and try and help each other out. And I think one of the last things on my report we did, we've gotten a few public comments. We forwarded those to the Board to take a look at. We really appreciate people taking the time to write and send us information. One of the public comments of note was a question about some physician-administered drugs being included on the list, and our legislation says the HCA must identify drug -- prescription drugs that are dispensed at a retail specialty or mail order pharmacy. Sorry, my throat is a little difficult today. So some of these physician-administered drugs are dispensed at these specialty pharmacies. So from how the law is written, they are not excluded from being on the drug price list. So we are going to -- we're working to set up a meeting with the group that sent us this comment to walk through some of those concerns specifically, but just kind of a putting that out there for the Board Members of things that we're hearing and just want to make sure that we're addressing the best we can with any of the public comments. Um, any questions, thoughts, concerns on any of that stuff that I shared?

Eileen Cody: Any questions? Don't see any hands. And I see Doug's back on now, so [cross-talk] --

Mike Neuenschwander: [Cross-talk] Great. And I do [cross-talk] think, Doug, do you have any great interesting news to -- you want to share with the Board?

Douglas Barthold: yeah. Hi, everybody. Um, it's good to see you all. Yeah, I just had a -- just had a daughter. She turned one month yesterday. So her name is Jo, and my wife and I are having some sleepless nights but, you know, it's been pretty wonderful so far. I don't have any pictures of Sandy, but I will show you all sometime, yep.

Eileen Cody: When she starts crying you can hold her up for us.

Douglas Barthold: Yeah, yeah.

Multiple Speakers: [Laughter].

Mike Neuenschwander: Congratulations, Doug.

Eileen Cody: Yes, congratulations.

Douglas Barthold: Thanks.

Eileen Cody: Okay. Well then, it looks like we move on to Kelly for the review of the dashboard updates.

Kelly Wu: Okay. Can you see my screen?

Mike Neuenschwander: Yep.

Kelly Wu: Okay. All right, so since last time, there were some updates to the dashboard that were requested, so I'm just going to go over the updates that I made and spare everyone from going over the dashboard for, like, the fifth time. So one of the updates that was requested was that that everybody be able to view both the specialty and non-specialty drugs in one tab. So before you can only aggregate by one type. So this is what it looks like, and we changed specialty to, like, biologics instead. So instead of saying, like, specialty or non-specialty, it's now, like, biologics or non-biologics because that was actually, like, how they were classified. So now when you go to the aggregated list and you filter, you can filter by All, and then for each rank. So this is just, like, top 25, not like their weighted rank, so by each rank you can see, like, each biologic and non-biologic drug in that rank. Yeah, that makes it, like, pretty easy to see, like, the top five for each category.

And then the main reason why the requested update was made was so you could see, like, all the visualizations together for the biologics and non-biologics so you could compare. And so this is what it looks like now. So they're color-coded. Orange are biologics and blue are non-biologics. And I know it's kind of hard to see the smaller bars because that's just like how big the range is for the data. And I decided not to add any annotations, so I didn't. It was just going to be too messy because there are so many small bars, but if you can't see the bar really well, you can just hover over it, and it has, like, a little pop up that shows the data for that. And yeah, those are the major changes for the dashboard. Any questions or comments?

Eileen Cody: I'll just say that I don't think we have to -- the small bars are not the ones we're worrying about because it's like we're more focused on the high costs, so that -- I don't think we have to worry about those. Any other comments guys? No. Okay.

Douglas Barthold: No, thanks.

Eileen Cody: Okay. Then we're going this -- and now we get into some meatier stuff and try and talk about how -- which drugs we're going to determine to have the reviews done on them. And I'm not quite sure how we want it. I guess everybody maybe just want to start out with your ideas and comments when you've looked at this because I'll say I went through and kind of starred what I thought were my top picks, and we'll find out what each one of you go through and we'll say, you know, what we've been thinking or where we're at, unless you have a better idea, Mike, of how we should do this.

Mike Neuenschwander: No, I think that's a great, a great idea because we've already had our Advisory Board share their thoughts and feelings on the ones that they thought were important. And so, yeah, if, you know, maybe go through Board Member by Board Member and see [cross-talk] what their thoughts are, and then we can coalesce around a grouping here and make some decisions.

Eileen Cody: Okay, so who will want -- Doug, should we have you go first since the baby is up crying right now?

Douglas Barthold: yeah, that sounds good. I just had a quick question. So why are there two drugs at each rank on this list?

Mike Neuenschwander: So that -- those are, for example, the list that we used to have that were specialty versus non-specialty now, it's like biologics versus traditional or nonbiologic. It's basically that those are the top #1s on each of the lists because you wanted to see both lists at the same time, so that way all of the numbers right there, so basically the two lists on top of each other, but then you can compare the numbers all on the same column and not back to back.

Douglas Barthold: I see. Okay, thanks.

Mike Neuenschwander: Yeah, because on that filter if we went to filter by biologics and selected Yes, then half of those would disappear. Then if we selected no, then the other [cross-talk] half would pop up.

Doug Barthold: Okay. So um, before I give any drug names, um, I just wanted to ask a quick question. Are we going to discuss -- I -- when I was emailing with you all, I had asked some question about the aggregation to the ingredient labeler level, and I wasn't sure if we were going to have a chance to discuss that issue today. Sorry, I should have brought this up before.

Mike Neuenschwander: [Cross-talk] Uh --

Eileen Cody: [Cross-talk] Uh -- go ahead, Mike. [cross-talk]

Mike Neuenschwander: [Cross-talk] I was going to say I remember -- I have had a lot of different conversations, so what were the specific questions again to help refresh my memory, and then maybe Kelly can answer some of those on the how and why everything was added the way it was.

Doug Barthold: Yeah. So basically, um, this was all in my, you know, on June 5th. And the -- there was -- I -- so, essentially the root of the issue was that before we did the ranking, we aggregated all

of the products to the level of the ingredient and labeler, and I was kind of -- I was just trying to figure out the justification for that and so I kind of outlined some questions for that in that June 5th email. And just sort of the -- more of the root question that I didn't understand was if we -- were to ever impose an upper payment limit, would it apply to all labelers or just one is kind of the -- just a factual question. So um, yeah, I'm sorry to derail our discussion of the drugs in the dashboard, I just did want to get some clarity on that or at least have a plan to discuss that in the future.

Mike Neuenschwander: [Cross-talk] Yeah.

Eileen Cody: [Cross-talk] Kelly, do you have --

Kelly Wu: I don't know if Ryan is on, but I thought our original justification for aggregating is we wanted to, like -- because, like, their original when we did not aggregate, like, a lot of the NDCs were kind of like from the same group, so then we wanted to aggregate so we can get, like, more different groups on the list. Um, and then as far as my understanding goes, and other people feel free to chime in, and when we do like the upper payment limit, it would affect, like, all of the NDCs on the labeler code and generic name, which are already on our list, but I know others think we're going to, like, grab other NDCs and the labeler code and generic not on our list.

Doug Barthold: So sorry, I should have clarified. Um, I understand why we aggregated to the ingredient level, but then the fact that we also require the same labeler at the level of aggregation. That's the part that I didn't understand. Um, I thought that it would -- I thought we would be just looking for all the drugs that -- all the products that had that ingredient.

Kelly Wu: Yeah. I think that would be a better question for Ryan, but I know, like, if we also aggregate by labeler code, like, the products are -- like, they're from the same manufacturer, so that would make more sense than, like, grabbing, like, the entire like generic name, like, -- entire group of drugs from that ingredient name, but, yeah, I'll let someone with more expertise chime in on that.

Eileen Cody: It doesn't, like [cross-talk] Ryan is on.

Mike Neuenschwander: Yeah, I know. He and Donna are on leave today, so our pharmacy experts are out right now. But I think in terms of, like, the UPL, you know, because just the way that the pricing, I think doing UPL across the entire ingredient would be a lot -- more difficult. So and we can have a little bit more because UPLs are kind of down the road here a little bit, so, you know, there's not, like, an immediate we need to resolve this right now, but, yeah, I think, we can dig into that discussion of exactly how -- I mean because creating the whole, you know, except for

Colorado is doing their rulemaking on UPLs, and they are taking a few months here to do that, so it's not a quick and easy thing that they are applying.

Douglas Barthold: Okay, um, yeah. And I think I agree that, you know, we -- I think we can still, you know, choose our -- making our selections for affordability review today, but I think -- um, I don't know if we can put this on the agenda for the next meeting, or -- I mean I'm happy to resolve it via emails, too. I think, like I said, that email on June 5th outlined my views fairly clearly. And yeah, basically, like, I just, you know, in my mind I can't really think of any justification for why the UPL would only apply to one manufacturer because it seems like that'd be -- cause up a couple other problems. It would, you know, just in terms of fairness, other manufacturers could then raise their prices through place that manufacturer would it subject to the UPL, this seems like it would be unfair to the manufactures of the UPL, and they just want to go through lawsuits. And then, also, in terms of gaming system and manufacturer bases the UPL that gain the system just by shifting their manufacturing to a partner or a subsidiary that is not subject to the UPL and then just keep -- charging the prices that are higher than the UPL. And so that is why it just didn't make any -- I still don't really understand why we would -- um, have this aggregation at the ingredient label or level.

To me, the labeler or manufacturer, I don't understand why that is relevant. So, um, you know, this is going to be -- I, again, I don't think it's that much of an issue, especially what we're doing right now. It's only going to be a problem if there are multiple manufacturers of a -- drug, so it would be for, you know, generics, um, but that said, this is an important part of our methods, and we have to justify the decisions that we made, and so I think it's important that we reach some clarity on what the justification for that decision was.

Mike Neuenschwander: Okay. Yeah, and we can [cross-talk] circle back in terms of UPLs and [cross-talk] --

Douglas Barthold: [Cross-talk] Yeah. And it's not necessarily just -- I mean, like I said, I don't think it's -- we can choose drugs for affordability review now, but it's not just an issue for UPL. It is initially for how we made this ranking, right? Because all of the data that defines each of the, you know, items on this list, so I'll just probably sticking to the drugs on this list, those are, if I understand correctly, those are for -- those are the -- each row is an ingredient labeler. It's not just that ingredient across all labelers, that's an ingredient labeler, and so it will affect this as well. Is that -- Kelly, is that right?

Kelly Wu: Yeah, that's right.

Marina Suzuki: Mike, I can maybe chime in here.

Mike Neuenschwander: Marina, go for it.

Marina Suzuki: Yeah. So the rulemaking for the UPL that's coming, so we don't have exact rule how it's going to be [indistinct] yet. But in terms of the affordability review for selecting drugs for that, they have to meet the statute criteria, which is the price cutoff and the price increase. And I remember either Ryan or Donna were saying that. Let's say we have, like, three generic manufactures, and there is one that is just pricing really high, and the other manufacturer's not meeting the threshold. If you just aggregate everything, then the manufacturer is putting a fair price, we'll have a good, you know, standing, saying that products didn't meet that threshold but still selected and have to submit all the information for affordability reviews. And I think that's why they at least try to do aggregation by the ingredient and the labeler level instead of the whole -- the entire ingredients in case that there are multiple manufacturers with generic companies or biosimilar companies.

Douglas Barthold: So that's a good point. So it's related to the [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. The threshold issue [cross-talk] --

Douglas Barthold: [Cross-talk] burden -- and the burden on the manufacturer that we propose [cross-talk] --

Marina Suzuki: [Cross-talk] Right.

Douglas Barthold: -- for the affordability review.

Marina Suzuki: Right.

Douglas Barthold: Okay. So yeah. I think that, you know, my previous feelings still hold with regard to the UPL, but I definitely think your point with regard to the affordability review. So, um, [cross-talk] --

Eileen Cody: [Cross-talk] I think you have a good point on the idea of that we might if we just had one that they might get somebody else to manufacture. So -- that's definitely something we should think about. So we want to go on -- go on about the review?

Douglas Barthold: Yeah, and I guess -- and we'll just have this similar mind [cross-talk] moving forward. Yeah.

Mike Neuenschwander: Yeah.

Douglas Barthold: Okay. And maybe I'll forward that email -- my June 5th email to the rest of the Board, because I was -- I was just emailing with the staff to try and figure out this kind of like -- these factual questions around the methods, but I will forward that to everybody else just so that everyone's clear. Essentially what I was do -- I was just -- I was working on the paper that we're all doing together, and I was trying to just -- I was writing the justification of our methods, and I couldn't really -- I couldn't grasp it, and so I was -- that's what I was trying to figure this out. Um, anyway, back to selecting drugs.

Simon Borumand: Can I just add [cross-talk] so please don't, like, reply all to that message. Just under the Open Public Meetings Act if you are communicating [cross-talk] by email, you run the risk of sort of having a quorum and taking actions. So, you know, just, passively accept and read it, that's fine, but please don't start a [cross-talk] --

Douglas Barthold: [Cross-talk] Okay.

Simon Borumand: -- conversation online.

Douglas Barthold: So I appreciate that, and I -- you're right that I had forgotten that point, so I will not email all of you. Okay. On a related note, if we're -- I mean, we're working on this paper together, if we're writing feedback to each other on the contents of the paper, do we need to be careful about that with regards to the Open Public Meetings Act?

Simon Borumand: I was aware that you were working on a paper, Doug. I wasn't aware that it was a [indistinct]. Is it the entire Board that is doing this?

Doug Barthold: Yeah. There are many other co-authors that are on the paper, and so those, um, that, you know, we will essentially the -- I think the entire Board was going to be co-authors. I'd have to look at the list of who responded when, but --

Simon Borumand: I will get back to you on that because my -- I don't want to, you know, force you on the spot to start doing things in the public forum, but my inclination is that if you're at least doing things that are as Members of the Board that, um, at least a sort of a conservative approach would be to try to do this [cross-talk] --

Doug Barthold: [Cross-talk] meetings.

Simon Borumand: Um, yeah. I don’t want to, you know, um -- I will get back to you if that's okay. Just it's yeah, it does concern me.

Doug Barthold: Okay, yeah. That's fair. I will be conservative on that until I hear anything else from you.

Simon Borumand: Okay, thank you.

Eileen Cody: Okay, but back to the idea -- discussion on the drugs for affordability review.

Doug Barthold: Okay, sorry. I, uh -- your [indistinct] there, but I just wanted to, you know, make sure that we had some discussion on that. Okay. And we -- and last time we met we decided it was going to be three? Is that the magic number?

Eileen Cody: No, we didn't make a [cross-talk] --

Doug Barthold: [Cross-talk] or was it five?

Eileen Cody: No, no. We have not made a decision on that, so [cross-talk] --

Doug Barthold: [Cross-talk] Okay.

Mike Neuenschwander: [Cross-talk] Yeah, I think the general [cross-talk] --

Eileen Cody: [Cross-talk] No. That's part of the discussion.

Mike Neuenschwander: [Cross-talk] Yeah.

Eileen Cody: [Cross-talk] Right? Mike will lobby for the lower number, and I push -- I will push him, so that gets -- we'll get to have this discussion.

Mike Neuenschwander: Yeah. I think that it was coming with a handful -- that we wanted to put on the list and then prioritizing them and doing [cross-talk] --

Eileen Cody: [Cross-talk] Yes.

Mike Neuenschwander: -- them a couple at a time. Um, [cross-talk] --

Doug Barthold: [Cross-talk] Okay.

Mike Neuenschwander: So I don't know [cross-talk] --

Doug Barthold: [Cross-talk] Right, right.

Mike Neuenschwander: [Cross-talk] or the six or something like that, and then we'll [cross-talk] --

Doug Barthold: [Cross-talk] Yes.

Mike Neuenschwander: [Cross-talk] see how we get through it -- through the first couple, you know, and how far we can get down the list.

Doug Barthold: Okay. Well, to me, I see two drugs that stand out above all else, and they are Enbrel and Cabometyx. Those are -- and I'm using the aggregated prioritized list visualization tab of the dashboard.

Eileen Cody: What was the second one?

Doug Barthold: Cabometyx. I don't know if I'm pronouncing that right. Hung, can you correct me? Or Greg?

Hung Truong: [Cross-talk] You're correct, Doug.

Doug Barthold: Yeah. Okay, great. [cross-talk] Yeah, I mean I'm -- I care a lot about out-of-pocket costs both in total and in average, and those are our leaders in those two categories, and so those are the two that I see as that sort of having a strong justification for affordability review.

Hung Truong: What's our capacity to do the review [cross-talk] --

Eileen Cody: [Cross-talk] Well, I -- I'll just say I thought that we could come up with a list of, like, five and then prioritize them, and they would then be able to, you know, after -- we don't know how long it's going to take and how much work it's going to be. So it doesn't mean that we would get through all five but just to have it -- ready. And I -- isn't that kind of the direction you were going -- thinking too, Mike.

Mike Neuenschwander: Yeah, yeah, something like that. And, Hung, to kind of answer your question, so part of the -- part of this in terms of, like, capacity is, you know, so we're -- so there's some internal data that we can collect on our own, but then we're also trying to submit and get data from manufacturers and, you know, do patient surveys and other things. So part of it is just how fast can we get information back? And then once we get that information then trying to go through it and then, you know, put it in a usable format to go into a report. And so as this will be kind of the first time that we're going out and trying to reach some of these patient groups that will be requesting information from manufacturers, a little bit of this is going to be, you know, an

experiment to seeing how, you know, how it all goes. So yeah, capacity, I think if we did start it with a couple, you know, that we're actually trying to gather that info for, and then we'll kind of see how the next few months go, and then once we've kind of got our processes refined and see, okay, this is this is how it's worked, then that'll help us refine down a lot more our future timelines.

Marina Suzuki: Yeah, this is Marina. I think if we have five drug lists with priority, then it's very likely we'll reach out to the top two first and see how it goes. If not, do we have to adjust some information section -- I mean information collection process or not. So we have to add it up like checkpoints to make as well. So I think we'll reach out to the -- we'll start with first or top two that you're going to select today, but if you can pick five -- four, five, six, maybe that's good. Then we can move on if something is up then. Yep. So that's the plan.

Eileen Cody: So if we think -- if life becomes positive and you get to move through then, but we will at least go for the top two.

Mike Neuenschwander: Mm-hmm, yeah. Yeah. And for example, if we hit huge roadblocks and, you know, people don't want to submit information, you know, then there's a whole other process of, you know, within the legislation of, you know, fines and things like that you're in appeals, I don't really want to go there but, again, you know, just the spectrum of what could happen is broad.

Marina Suzuki: Yeah. And also, yeah, if -- let's say a drug has, you know, expired exclusivity, and if biosimilar comes in or genetic drugs coming in and during our affordability review, would it change your mind? Now, that's another thing to think about.

Eileen Cody: [Cross-talk] just like to complicate things. So well, Doug, do you want to add anymore now or should we -- you want to think about it and we can come back.

Hung Truong: Um, yeah, come back to me. Thanks.

Eileen Cody: Okay. Greg or Hung, which one of you? Oh, okay. Go Hung. I see you had a --

Hung Truong: Oh, um, I feel like we just need to go with the data, and whatever is prioritized so we are not biased between picking any of them because some of the comments I have seen that they made a lot of good cases on, like, if there is an agreement already, and then would that be picking one -- would that, you know, incentivize the other one and so forth? Um, I think the safest bet is just to go with what was ranked. We already made a decision on the wait, and so we will just go with the data and pick the top two. And so I'm trying to look at the dashboard, and I'm a little still a little bit confused about the filters and everything but for sure like Enbrel is listed as one. I think

this is a filter whereas a nonbiologic extending, and that's why it's up there as a nonbiologic, but I think if you do it by all, I believe it would be Humira should be the second. Um --

Mike Neuenschwander: Yes, if you filter by just, like, put the S on the biologics, then it's Enbrel, Humira, Taltz, [cross-talk] --

Hung Truong: [Cross-talk] But this is all biologics.

Mike Neuenschwander: Yeah.

Hung Truong: Right?

Mike Neuenschwander: And then with the "nons" and the "nos" then Xtandi [cross-talk] --

Hung Truong: [Cross-talk] Oh, okay, but if you don't filter by any of it [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yeah, just put it all.

Hung Truong: But the two wouldn't be Xtandi.

Marina Suzuki: So this is not, like, an overall list. It's just the two side by side.

Hung Truong: Correct. Right. So what would be the overall list? I would assume it's Enbrel and Humira.

Mike Neuenschwander: Well then if you scroll to the right, then you can see the numbers on the columns side by side.

Doug Barthold: Yeah, you can see the weighted rank for each.

Greg Gipson: But is that weighted rank is not overall. Is it the weighted rank of the biologic list and the weighted rank of the nonbiologics? So are they directly comparable that weighted rank number?

Kelly Wu: No, they're not comparable. Like I said before, this is the side-by-side list, not the overall. And I just realized what is supposed to be the overall is for some reason a copy of the aggregated list, so I need to go back and fix that. But if -- I don't know if, like, our overall list is still on the website or you received it before, but that would be the overall list. I can try to find it and pull it up if you want to see it.

Mike Neuenschwander: Yeah, that would be great if you could.

Eileen Cody: But it does seem like Enbrel and Humira would be the -- are the top two expense-wise and weighted.

Hung Truong: I mean, my best guess would be the two of them, but we can verify it with the list and getting it because the two I can't imagine even a top five would be a nonbiologic.

Eileen Cody: Well, okay. So what -- but then would you go on -- is that -- you got your top two. Where would you go then after that to add to the list?

Hung Truong: We go by what is ranked and based on what was rated, right. And so I don't think we're here to choose one biologic or one nonbiologic. I think we just need to go down the list.

Douglas Barthold: I agree with Hung. And yeah, I didn't -- I noticed in looking at that weighted rank column I realize, yeah, those are not -- yeah, those are not directly comparable. So okay, great. So this is the [cross-talk] --

Marina Suzuki: [Cross-talk] Just to chime in here though. For the prioritized list, I remember you selected a few factors you want to consider, and these are the ranked list. But two things that are not in the rank is the availability of biosimilar or generic drugs and also the number of this list hold that met from the legislation. So that's not really considered into this ranked list, so when you go down the list, if you feel like one drug has a biosimilar already approved or generic drug already approved, you want to stick that. I think that's something the discussion you need to have because those are the two things previously mentioned that we want to consider, but it's not really in this ranking, just to give you a head's up.

Hung Truong: Yeah, I concur. I mean, Humira, there are at least 10 biosimilars if not more out there right now, and obviously, that's going to affect many of the other drugs and not just Humira, just because people would start using those over Enbrel and so forth. So it is a complex question -- complicated question. And then, you know, many of these drugs, too, will have biosimilars coming out soon. Um, and, you know, what is that timeline that we are willing to evaluate or take into consideration. Is it six months from now? Is it a year from now? And so if it's within a year, do we, you know, say yes, no? But yeah, that would be a significant variable.

Mike Neuenschwander: Well then, Kelly, this list doesn't have them grouped, correct?

Kelly Wu: So this was our original overall list of the Top 25.

Doug Barthold: But these are products, right?

Kelly Wu: Yeah, so this is at the NDC level.

Doug Barthold: Yeah.

Kelly Wu: So you wanted to see the Top 25 at the aggregated level?

Doug Barthold: Yeah.

Kelly Wu: Yeah, we don't have that, but I can work on that if you want.

Mike Neuenschwander: Well, I mean [cross-talk] --

Eileen Cody: So go ahead.

Hung Truong: Where is Humira on this?

Greg Gipson: You might have to scroll up. I think it's [indistinct].

Hung Truong: it's okay.

Doug Barthold: But that's just for one of -- whatever [cross-talk] --

Mike Neuenschwander: Yeah, this is the combined list.

Greg Gipson: One syringe size, yeah.

Mike Neuenschwander: But I mean if you look at this list versus if you, you know, go to the dashboard where we combined everything, you know, your Top 6 on that list are the Top 4 on the -- dashboard. So I think, you know, in terms of, you know, there is some consistency here whether you break it out or whether you combine it.

Douglas Barthold: I think you're right. I think you're probably right that we're going to, you know, we may end up with the same selection. But to Hung's point, we voted we have this ranking procedure. It seems, um -- it seems that if we doing anything other than the weighted rank as we said we're going to do, it may leave us -- it may seem arbitrary.

Eileen Cody: Well, I guess what I was looking at, it was the question of do we want to do, like, the Top 2 from the biologics and the Top 2 from the nonbiologics to put on the list. That, I mean, I think you can make a case that doesn't -- that just the rank -- the direct ranking doesn't -- you

could say that there are two lists, and then we're take -- you understand what I'm trying to say? I mean, I'll be --

Mike Neuenschwander: Yeah. Yeah. Well, because that's the way, you know, we originally, you know, back in the Spring wanted to [indistinct] wanted to break it out just to, you know, try and differentiate. But again, the Top 2 on the biologics versus nonbiologics, and then the Top 4 on the joint list are all the same.

Eileen Cody: Right.

Mike Neuenschwander: So basically, any way you slice it or dice it, the same things are coming to the top.

Hung Truong: Can we just -- can we do four?

Mike Neuenschwander: Yeah [cross-talk] and then we could -- we can select four and then just pick the top -- or pick the first two out of that that we want to do, and we can go from there.

Eileen Cody: Are we talking Enbrel, Humira, Xtandi, and Cabometyx, right? Because that's the Top 4.

Mike Neuenschwander: Yeah. And now take the Top 2 from each of the lists, and then there are also still the Top 4, and you throw everything together or break it out individually.

Eileen Cody: Greg, you should chime in here because you've been -- you're the newest one that haven't had to talk about their stuff much.

Greg Gipson: I've been quiet. I think I also agree that we should stick to our methodology, and I think if -- you know, I also agree that whether we merge the list or not, it's kind of a wash. It's very similar information. So I think I like the idea of taking the Top 4 and focusing on the Top 2 to start with. I do kind of, as Hung mentioned, the, like, plethora of biologic -- biosimilars to adalimumab there out. I do wonder about the utility of that. I don't know if we have any forecast or if anyone has a better idea. I know kind of, looking at some other utilization, it sort of dropped off over time, so I wonder if we're trying to solve a problem that in that regard is already being solved with time. And I think I looked up Enbrel. It looses their exclusivity in the United States in 2027, so I think there is probably some time, and there is probably going to be some litigation, and my guess drag that out because that still seems like a good target. So I think I like the idea of Top 4, focusing on the Top 2, and then, yeah, kind of, anyone has any input about Humira or thoughts about pursuing that or if it's a good use of our resources or not. It is a huge clue. It's a huge driver of [cross-talk]

costs. It's hard. I don't want to just say we shouldn't do it, but I want to make sure we think about it.

Mike Neuenschwander: And one thing, too, is, you know, this isn't our only crack at the at going through the drug reviews, so, you know, this year we can try one thing, next year, you know, we can focus on different drugs, right? So there is, you know, this is going to be an ongoing process where, you know, we can look at a lot of different things over the course of time.

Eileen Cody: That was -- I'll just say that personally since I have worked with MS patients that it's too far down the list, but I can't believe it's still on it is fingolimod, but it's up there because and then, you know, have to get me frustrated. So okay. So then I guess -- let me vocalize this and then we'll see if we have the agreement. That's Enbrel, Humira, Xtandi, and Cabometyx that we want to start with those four? Everybody seem to agree on that, or no?

Douglas Barthold: I think I have a couple of thoughts on that. First of all, it seems that Enbrel is the clear #1, so if we were going to prioritize, and we are prioritizing, maybe that should be the first one we do. Um, but then Humira, given that there are, you know, therapeutic alternatives, whatever, biosimilars, does that rule -- should we rule that out? And I'm trying to find the documentation of our -- how exactly when we're supposed to incorporate that information if it's now or if it's the affordability review. Does anyone happen to know that?

Mike Neuenschwander: So the way we were using that as a factor to help us select, um, so if you scroll all the way to the right on the -- or there we go. Yeah, keep going. There is a -- it talks about, you know, does it have an alternative or not?

Douglas Barthold: Yeah.

Mike Neuenschwander: There we go. Therapeutic equivalent and generic. Um, so that's something that can help us decide, you know, in terms of importance but not necessarily thou shalt type of consideration.

Eileen Cody: Well, I would say that we could since there is a therapeutic equivalent on that one that we drop it down in the priority list so it's not one of the Top 2 to start with. Since there -- if we have concerns that things are going to get -- are getting cheaper. Is that -- how you're -- what you were thinking, Doug?

Douglas Barthold: Something like that.

Hung Truong: Doug, I think we probably should keep it just to go through the exercise knowing that if we have four and it will prioritizing two, we can perhaps Humira would not be in the Top 2,

but I like the team to do some work on it and just to give us a good exercise to thinking about generics or, you know, alternative, availability, and so forth.

Douglas Barthold: Um, [cross-talk] --

Eileen Cody: Go ahead, Doug.

Douglas Barthold: Yeah, I agree, like, we obviously we don't have to, uh -- we can do the affordability review and [indistinct] we don't have to propose an upper payment limit or whatever, we [indistinct] -- we'll learn a lot from the affordability review regardless. And to your point, having it lower on the priority list I think would still align with our stated methodology, where we look at the weighted ranking, but then we also incorporate this information about whether or not there are therapeutic alternatives.

Eileen Cody: Okay. So then [cross-talk] --

Douglas Barthold: [Cross-talk] In short, I agree.

Eileen Cody: Okay.

Douglas Barthold: Yeah.

Eileen Cody: So then I'm going to try to see if it -- so we're thinking Enbrel then Xtandi, Cabometyx, Humira, is that in that order?

Greg Gipson: I like that.

Douglas Barthold: I like that, too.

Eileen Cody: It's okay, there's two. What about Hung?

Hung Truong: That's fine. I mean.

Eileen Cody: Okay.

Douglas Barthold: What about you, Eileen?

Eileen Cody: Oh no, I've been -- I have my little star. I had five stars, and you got four of the five.

Douglas Barthold: What was your fifth?

Greg Gipson: The last one.

Eileen Cody: My fifth was Cimzia, which I can't pronounce, but which I don't know where that's at now in the consolidated list. So yeah. So then, all right. Do we -- I guess we -- do we -- we probably need a formal vote. Does somebody want to take -- make that motion that those are the drugs in that order and that is --

Greg Gipson: Move to approve.

Eileen Cody: Okay, and a second.

Douglas Barthold: Second.

Hung Truong: yeah.

Eileen Cody: Oh, okay. All those in favor.

Greg Gipson: Aye.

Eileen Cody: Aye.

Douglas Barthold: Aye.

Hung Truong: Aye.

Eileen Cody: Okay, we got our first four drugs. [Cross-talk] Does that take --

Mike Neuenschwander: [Cross-talk] Woohoo!

Douglas Barthold: Way to go team!

Eileen Cody: Yeah, really. Does that make you happy, Mike?

Mike Neuenschwander: Yeah. We're moving up the road here.

Eileen Cody: So okay then. that -- I thought we -- I mean, we got plenty of time [indistinct] you want to have anymore discussion about if we wanted to think about the next steps or when we would -- oh, somebody wants to know the four drugs again. Enbrel, Humira -- it's not in that order. I said it wrong. Enbrel, Xtandi, Cabometyx, Humira.

Multiple Speakers: [Cross-talk] --

Simon Borumand: Can we -- would you agree to do that vote in a roll call because my recollection is that the procedures are for a roll call vote [cross-talk] [audio cuts out] [indistinct].

Eileen Cody: Okay. So all right then, you can -- we've got the motions on the floor. Mike, do you want to do the roll call?

Mike Neuenschwander: Okay. Eileen, yay or nay?

Eileen Cody: Aye.

Mike Neuenschwander: Okay. Greg?

Greg Gipson: Aye.

Mike Neuenschwander: Doug.

Douglas Barthold: Aye.

Mike Neuenschwander: Hung.

Hung Truong: Aye.

Mike Neuenschwander: Okay, there we go.

Eileen Cody: So moved and passed.

Mike Neuenschwander: Our AG is happy.

Eileen Cody: All right.

Mike Neuenschwander: It means [cross-talk] --

Eileen Cody: [Cross-talk] have the lawyers. Got to keep them happy.

Mike Neuenschwander: Great. Okay. Oh, Doug.

Douglas Barthold: Um, so I guess this is for Kelly. Should we expect the aggregated prioritized list on the dashboard to change to reflect the sort of the combined weighted ranks?

Kelly Wu: Um, no. I don't see any way to add it into our current dashboard because, like, they already reflect, like, both of the side by side, but I mean if you want to see it, I could make another tab or sent it out, but there won't be any new data there. It will just be like a handful of drugs from each list that make up the Top 25. If that makes sense.

Hung Truong: Kelly, can you find that, and then just do the Top 25 for us to see?

Kelly Wu: Yeah, I can generate it.

Hung Truong: Okay.

Eileen Cody: Don't sound so excited, Kelly. [laugh]

Hung Truong: She's like, "We've done this before. You guys had me change this."

Kelly Wu: I know. That's what we're here for.

Mike Neuenschwander: Kelly is a good sport, so --

Douglas Barthold: And then [indistinct] I think it's important to remember that we want to -- this isn't -- we're not done with this, right? We want to have -- this -- we'll use this prioritization again [cross-talk] um, you know, next year. We'll want it -- we'll this reference for, you know, for looking at it when we do the affordability reviews, and it's really good research for the public when the people want to go on here and see, okay, what's expensive in Washington State? And so we want it to -- and we want to get it right.

Mike Neuenschwander: Yeah. Well, and that's the thing, too, is because this is the first time we're going through all of this, you know, we've been honing and refining and tweaking and trying to figure out what we want. Next year, you know, this -- it's going to be a lot easier because now the dashboard is up. All we have to do is update the data with the latest stuff, and so, you know, it'll be a whole lot easier to go through this whole process because now everything's created. It's just a matter of inputting -- new data. So yeah, this will be a resource that we continue to use moving forward. So it's a good one to make sure we have it tweaked just right.

Hung Truong: So [cross-talk] --

Kelly Wu: [Cross-talk] So do you -- oh.

Hung Truong: I have just a quick question. So speaking of the data and refreshing it, when do we get new data? Is that database -- is that updated as new information comes in [cross-talk]. And so going back to the Humira [indistinct] with alternative, you would imagine that that number is going down, and so how do we stay updated on that information? Or is it -- so is it twice a year or once a year that database gets updated?

Mike Neuenschwander: Yeah, so the goal here is, again, once we get our process down and everything is kind of streamlined and refined, it's once a year every summer, basically update the data, then that starts a new, you know, okay, let's select our drugs for the year and, again, the dashboard and all of this should be new and easy to basically just update, and then we select the drugs, and then we start doing the drug reviews through the year and, you know, do our drug selections, you know, eventually with the UPLs -- do our, you know, any UPLs, and then the next summer start over again. So once we get through this first drug review cycle, then that will kind of be the new norm that we're trying to establish. It's just kind of going through, updating everything once a year, selecting the drugs, doing the drug reviews, doing the UPLs, and then starting over again in the summer.

Eileen Cody: So our years are more like fiscal years rather than calendar year.

Mike Neuenschwander: Yeah, yeah.

Eileen Cody: If that make -- it helps for you to think about it. Okay.

Marina Suzuki: Yes. And also just to add that, let's say if we are implementing UPLs, then we have to kind of review how it's performing as well at some point, so that's going to be part of the cycle too. Yeah. So whether we are going to select new drugs every year, I think we have to see what happens from here. And just to give you a more realistic expectation of the timelines -- so for the Colorado, you know, they took, like, 7-9 months just to do the very first drug. Now they are scaling up, but it can be a slow process depending on how the information collection will go. So just a heads up. Don't expect everything because we'll come back in one month because we need time to, you know, gather the data and also to analyze and to write up a report for you, so we'll see [cross-talk] how it goes, yeah.

Eileen Cody: So Hung put the list of the four drugs in the chat -- webinar chat, but it's not in the order that we said. So I just want to clarify so that we don't have different expectations. [Indistinct] the order was Enbrel, Xtandi, Cabometyx, then Humira. Right, so --

Mike Neuenschwander: Okay.

Eileen Cody: I'm correct, aren't I, what I just said.

Mike Neuenschwander: Yep. At least that's how I got it written down. [Cross-talk] --

Douglas Barthold: Yeah, okay. Okay.

Marina Suzuki: Thank you. Yeah, thank you for prioritizing that.

Douglas Barthold: Okay.

Eileen Cody: Okay. Just want to make sure that we get all of our Ts crossed. Okay then, Marina, we can move on to the next steps.

Marina Suzuki: Okay. Ah, let me see if I can share my screen. Let's see. Let's see if it's coming up on your end.

Eileen Cody: Yeah, we got a pretty picture.

Marina Suzuki: Okay, great. Is the document coming up, though?

Eileen Cody: Yeah, now it is.

Marina Suzuki: Okay, good. Okay, I don't know what -- this is in the way somehow out here. Okay. All right. So just a few updates for the next step, which is the affordability review. Um, the form has been updated for all stakeholders, but the one with a significant update is one for the manufacturer, so I just want to share what happened to this form. Let me see if I can do two pages side by side. Yes. Okay. Um, yeah, also I got some, like, numbering, so based on a recommendation from Michael. And then we got more, like, detailed instructions set up here what to do with this form for the stakeholder. And then if you look at this Table of Contents, one big change that happened is that we removed the pricing in the other in a foreign country, so that whole section is gone under the direct price information. And also, we don't have a section anymore for the advertising, marketing, and like [indistinct] costs, so that section is also removed.

And also, we changed the preference for the foreign HTA or Health Technology Assessment Information because ICER is the US organization. If we have a review from ICER, then it's optional for the other foreign HTA review information. So -- those are the new changes. Um, one thing, though, for the under the research cost, let's see -- yeah, for the cost of research and development we separated out the funding sources and other cost descriptions. Originally, we thought, well, the funding sources, this is going to be a required section, and R&D cost descriptions. This is going to be optional. However, after discussing with Michael, his recommendation was to keep this

required because this is information that we cannot look up, and also the data from the DPT Program, which is our sister/brother program, is not detailed and sometimes missing because it is optional information from -- ah, for the DPT, so that's there as a required section on this form. And we added language saying that if the manufacturers cannot provide it, then they can just put -- it's possible to omit certain sections if they cannot provide the information. So those are the changes on this form.

And one question we had was -- so to make some sections optional. Yeah, we are allowing the optional sections if we can look up information from the public facing platform. One thing that came up for the federal pricing and also the CMS pricing, we can look it up, but we don't have a good way to pull any historical pricing information. So all of the pricing information we have here we are doing, like, the last five years so that you can see the trend and whether it's increasing or has been stable. But the exception is going to be the federal pricing and the CMS pricing. So those are the ones that we are not likely to pull on our own. We can get the current pricing, but if you need any historical information on those to see any trends, then we have to make it required rather than optional, so I just want to hear from you. Do you think you'll need the historical data on the federal pricing or not?

Eileen Cody: That's a good question. What do -- the other members think?

Marina Suzuki: So that's usually under the Discounts. Let me go to see that portion. It's Page 9. Um, so it's currently -- I have it as, yeah. So it's under this Discount Section. So the information we're trying to get is the federal supply scheduled pricing the big 4, which is the VA pricing, DOD, Postcard, you know, PHS, so these are like the big 4 pricing. And also the VA National Contracts price. So these are the ones the federal pricing we can pull from the current one from their website, but if you need like a federal, you know, historical trends or past information, then it's something we are going to have to ask.

Eileen Cody: So the question really is, are we going to be needing historical trends?

Marina Suzuki: Yeah, and some [cross-talk] --

Eileen Cody: And when we get into upper payment limit discussions.

Marina Suzuki: Right.

Eileen Cody: So what [cross-talk] do you guys think?

Douglas Barthold: So just to be clear, when -- we should be thinking about this information as being useful for both determining on affordability and in our decision about, setting a UPL?

Marina Suzuki: Yes.

Eileen Cody: Yeah. Or do you think that historical -- I guess I would say I don't know whether that the historical information [cross-talk] is necessary.

Marina Suzuki: [Cross-talk] I think my advice is if you're not sure, then let's ask it for the first time and then see if it's going to help you or not, rather than like later saying [cross-talk] --

Eileen Cody: [Cross-talk] That's true. [cross-talk] --

Marina Suzuki: [Cross-talk] -- oh, we don't need this. We have, like in the past, data to see, you know, how it changed, then you don't have to go back to the manufacturer and ask again and wait for it for it -- for the data to come in.

Eileen Cody: So what do you guys think?

Multiple Speakers: [Cross-talk] --

Greg Gipson: Oh.

Douglas Barthold: [Cross-talk] Mike. Oh, go ahead, Greg.

Greg Gipson: I also don't know what I would do with it, I mean, if it were going up or down because we'd be picking kind of a point in time anyway. Um. [Cross-talk] --

Marina Suzuki: I think hearing like other state's PDAB, this is kind of unclear points for setting up upper payment limit because this tends to be the lowest pricing information that you might get.

Eileen Cody: [Cross-talk] Oh.

Marina Suzuki: [Cross-talk] So it is kind of important, you know, pricing information you might want to hear, so that that's why [cross-talk] I just --

Eileen Cody: [Cross-talk] Right.

Marina Suzuki: [cross-talk] double check with you. [cross-talk] --

Eileen Cody: [Cross-talk] I, uh -- I get it -- that. Now what -- so you're saying that when you would go to studying the upper payment limit and seeing how cheap that it actually had been delivered to the -- like to the VA. That's a good point.

Greg Gipson: Usually, it's like the Medicare price is, like, the lowest price that anyone pays the manufacturer for the drug, right?

Marina Suzuki: Right. Yeah, so you might want to know what the CMS pricing, you know, VA pricing in the past and how it's changing kind of might give you some insight then we saying that's corrected, even though it's available on the website for the current pricing. But again, you can -- if it's sometime helpful for you then we can make it optional and we can pull on our own, so just wanted to hear with you, like, how -- what your thoughts are.

Douglas Barthold: Yeah, I can see it being useful because, actually, yeah. You can imagine if the price has been going up, then you could say, you know, we -- and we're trying to set UPL, then we can see, oh, but for two years ago they were charging this, and, you know, and they charge this to CMS and so a lot at that level, then we might be able to -- you could -- we could use that as some type of benchmarking on our UPL decision.

Eileen Cody: Yeah. Hung, you haven’t said anything. No comment?

Hung Truong: Guess not. I'm trying to -- like Greg was thinking. I'm trying to how we make use of this, but maybe I'm getting too far ahead of myself. But just, you know, we're talking about there's a piece of it that there's the ceiling price for 340B. I mean, it varies between the drugs and I don't know how they determine, but some of these drugs are penny drugs, right? And so that's not the price, right? Um, yeah. I [laugh] it's --

Eileen Cody: Well, I think Marina's point about if we're not sure collecting it to start with, it may be a good idea, then if we don't use it, we can take it out.

Hung Truong: Yeah. I know, and is it proprietary information and so forth? Because it's negotiated and, um, [cross-talk] --

Marina Suzuki: Um, it's information [cross-talk] we publish on the website, so it's not [cross-talk] --

Eileen Cody: [Cross-talk] It's not --

Marina Suzuki: [Cross-talk] It's not the [cross-talk]

Eileen Cody: [Cross-talk] It's not --

Marina Suzuki: [Cross-talk] [indistinct] --

Eileen Cody: Yeah.

Marina Suzuki: Information.

Hung Truong: Yeah, okay.

Eileen Cody: So, like, do we have agreement just [indistinct] again?

Douglas Barthold: Yeah, how many -- oh, it's almost five -- last five years is what these are. Is there a date range?

Marina Suzuki: Yeah, because everything we are selecting are like seven years old. Yeah. So I think five is a [cross-talk] enough to see the trend. And this you need the full pricing information. Okay. All right, I'll change the form on this aspect. I think that's it for the form update, and I also changed a few, you know, like, wording where stakeholder some clarifications, um, and again, for some information that they can -- cannot making -- to make it optional, we put the -- have a box that they can check the box and they don't need to submit the information, and we'll do our own data pull, so some changes on the form. But, yeah, we'll have this reviewed by the agency and we'll -- this will be posted on the website later. Okay, so that's one update.

Another one I want to discuss today is the patient and expert surveys. Let me pull up a document here. Okay. All right. Um, so I did get a few requests on what type of questions you want to include, but the majority of them -- something that I screened from surveys available from other states PDABs as well as in different organizations out there, and I didn't include everything because, you know, a lot of the surveys are pretty lengthy, I just pulled whatever seems relevant and rephrase it for our purposes here. Um, so we are going to go one by one, but the two big questions I have for this survey is which questions what you want to mandate. Some information is a bit sensitive, like, asking for their income level kind of stuff, and that could be optional, but any key or essential questions you want to get input on, I think we'll make a mandate. So that is one question of which questions you will now make it mandate. And another question is, do you want to target only the Washington residents or make this survey available to anyone? And we ask if you are a Washington resident or not, yes or no, and we can do a subgroup analysis.

So those are the two major questions, but as we go through, feel free to add any questions that you want to ask, or did it -- if you think this question is not necessary. One notice, though we haven't -- we don't know what kind of formatting is possible in the service now -- survey questionnaire, so

that's a plot form we have to use for any surveys going outside of our agencies, like a patient or medical experts, and, you know, I traditionally do, like, a multiple choice questions, fill in the blank, but we are not sure if we can do any like scales or kind of complex matrix questions. We can build some logics. I know that. So, like, let's say if patients answered Yes to this question, then we are going to ask these two more questions if the answer is Yes to the previous one, so we can do that type of logics. So don't get hung up too much on the exact wording because we may have to adjust what kind of formatting is possible on the questionnaire. But I mean just focus on the big idea for now, like what information you need from patients and medical experts, and you get to review the exact survey later once it's built into our system. Yeah. So just focus on the big idea for now, like what type of questions you want to ask. Okay?

So for the patient survey, a few different sections just to point out. So it will be some demographic questions, and then there will be some medication question of what is your medication you've been using? That kind of thing? And then the meat is here affordability questions, and then there will be some specific questions for patients not using the drug that's like being reviewed but using something like therapeutic alternatives for comparisons. And then we have questions on the coupon news, questions for the patient assistance program, and then the last one is the free comments. So those are the big sections we have currently. And I just want to go one by one from the top. So let's say it's going to -- sorry -- well, for the patient's demographic questions, we'll be asking their name, the e-mail to make sure we don't have any duplicated submissions from one person, and then you'll be asking, let's see, are you taking this particular medication that's being reviewed? Yes/No. And then are you a Washington resident currently living in Washington? Yes/No.

Douglas Barthold: Marina?

Marina Suzuki: Yup!

Douglas Barthold: So and -- so you just want us to tell you which of these questions you think needs to be mandatory?

Marina Suzuki: Ah, yes. Yeah, you can do that later. I just want to go through the questions [cross-talk] --

Douglas Barthold: [Cross-talk] Okay, got it.

Marina Suzuki: [Cross-talk] so that you'll hear, so, yeah, so thank you for asking that. Yeah, but feel free to try me if you have any, like, burning saying that you want to add or remove. Yeah, so this is just the demographic, you know, asking name, e-mail, are you Washington resident or not? Where do you live in terms of the ZIP code so that we can figure out whether it's in the rural area,

the underserved area, or not, and then just household size and income so that we can kind of tie into their affordability, and then insurance premiums, and whether they have an insurance that's covering prescription drugs, and what type of insurance they have. Is it Medicare, Medicaid, commercial, or what they just purchasing for their self-coverage? So those are the questions for the patient demographic.

And then for the medication utilization questions, we have one. You know, again, are you using the reviewed drug? Do you have any experience with other medications that's treating the same condition? And then see what is the most current one you're using and how long you're using it. So this is just to get some kind of baseline information of their medication use. And I think this is the meat of the questions regarding affordability. So Yes/No question regarding if they have any difficulty affording the medication. So that's the first one. And then more detailed questions are following: So one is, gave you ever not picked up the drug because of the concern of the cost? And have you ever delayed picking up or refilling the drug because, again, the concern for the cost? Yes/No. And then have you skipped a dose so that, you know, they can prolong the usage of the medication that they have at hand? So that's another question.

And kind of similar idea have been -- have you ever taken a reduced dose or amount of the drug than recommended by the doctor because, you know, they cannot afford it if they are trying to follow the instructions. And then, what is your monthly out-of-pocket cost before and after meeting the deductible if they have insurance. And if they don't have insurance, it's just asking what is your monthly cost for the drug? And then the last question is, like, what is your affordable monthly budget for whatever the drug we are going to be selecting or asking about? So those are the affordability questions. And same questions for people who say, I'm not taking the exact drug that's being reviewed but the therapeutic alternatives." I'm wondering if they have a similar experience here or not, so it's pretty much a duplicated question from the sections above.

And then questions on the coupon use: Have you used the coupons to, you know, get the medication? Yes/No. And have you had any trouble obtaining or using the coupon? Yes/No. and then, what is a difficulty using the coupon? Sometimes coupons have a limitation, so it's just asking for that. And another -- so this is the section for the patient assistance program. Again, have you applied, and have you approved? Yes/No type of questions here for the drugs that we are selecting and also for the therapeutic alternatives. And then asking what type of programs they applied for and got approved for.

So these are going to be follow-up questions if they answered Yes on the previous one: And then, let's see, have you had any difficulty using the patient assistance program? Yes/No. And if they say Yes, we can ask, was it the paperwork? Was it the income threshold? Or was it something that just took too much time? Some of those are the questions that we are asking. And then also concerns on the future because eligibility could change, or the, you know, whoever the organization offering

the PAP program, they can remove the program. So have you had any concerns on it? Yes/No. And then the last one is the free comment. They can do more details on the free text, so this is going to be the last question that we have on the survey.

So this is the current draft, and before the agency starts -- I actually start building the question into our system, I just want to hear from you. Do you think this -- am I hitting the information that you wanted to ask? Or you know, let's say you don't need any of these sections entirely, then I have to remove it. Then I just want to hear before I do more work on this. So what are your thoughts on this?

Hung Truong: I can start, Marina. Uh [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah.

Hung Truong: Many of the questions are great. This is a very long survey. Uh -- [laugh] Okay, more like [cross-talk] --

Marina Suzuki: [Cross-talk] Ah, yes. I think that you say no because you're seeing the entire list. This will cut off based on, you know, the Yes/No from the earlier question. [cross-talk] --

Hung Truong: [Cross-talk] Okay.

Marina Suzuki: [Cross-talk] So they are not going to have, like, the whole thing here, yeah, especially, you know, depending on which drug that they gain, if they're not using any drug that is under the review, then I think it's like a quarter of the length. [laugh]

Hung Truong: [Cross-talk] Okay.

Marina Suzuki: [Cross-talk] Yeah.

Hung Truong: I'm just thinking, even if it gets shown by because they pick yes or no, I mean it's still long when you think about a survey, I mean it's usually like 10 questions, and anything more people are just like, "I'm not going to finish this." I mean, that's how I am. Maybe people are more [laugh] patient. Um, the other piece, too, is a lot of these questions they may not know to answer to because, like, patient assistant program and so forth, a lot of time is being done by the provider office or by the pharmacy that they're getting at, especially if it's a specialty pharmacy, it does many of that work for them, or the drug manufacturer would have a hub, and so many of the question they may not know. So that's just a comment. I think we'll need time [cross-talk] review this. I would -- have a lot of comments for this because we do this a lot where I'm at, and so [cross-talk] --

Marina Suzuki: [Cross-talk] Yes, I appreciate that comment, and, yeah, keeping it short is usually better based on my past experience as well with different surveys. And for the PAP, we are asking kind of similar questions in the expert survey that is September from this, and we are going to go through it next, but yeah. I am thinking making the exceptions also optional. They can just skip through. They don't need to answer. I think we have to make the -- again, the name, email, that kind of questions mandate. And the key question, you know, like this one -- Have you had any difficulty affording it? I think this is the meat of the survey, so making it -- this mandate but other, you know, coupon use, PAP, is kind of good to know so having these questions optional, and they can skip through. If they don't want to answer, that is totally fine. So yeah, we can set it up that way as well. [Cross-talk] --

Hung Truong: [Cross-talk] And we should probably [cross-talk] -- okay, go ahead.

Marina Suzuki: Oh yeah, yeah, go ahead, go ahead.

Hung Truong: No, and you probably want to run this through some type of readability score [cross-talk] --

Marina Suzuki: [Cross-talk] Yes, yeah. So we have, like, a communication thing full work on the wording, phrasing, that kind of stuff --

Hung Truong: Okay.

Marina Suzuki: And they use, like, a survey team who is kind of an expert building this into the logics and into that system, so we'll be getting their help as well. I just want to make sure before, you know, getting their help, I want to make sure that we are capturing whatever you would ask into our draft so that they can work on it.

Hung Truong: And you're saying there is another survey for providers?

Marina Suzuki: Yes.

Hung Truong: Okay, okay, so this is just for [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. Yeah, so this is just for the patient caregiver survey.

Hung Truong: Okay.

Eileen Cody: Well, I'll just throw in that I definitely think we want to know if they are Washington residents because that's who we -- that's what we're working for is Washington residents.

Marina Suzuki: Okay, yeah. So we'll make this mandated as well.

Eileen Cody: But then the other I thought, which maybe it's the readability people that it will take care of this is, like, you shouldn't just say Medicaid because we call it Apple Health, and some of the patients don't know they are on Medicaid. They think it's just [cross-talk] Apple Health.

Marina Suzuki: Oh, that's a good idea.

Eileen Cody: And well, and then Medicare, you know, it's a -- they don't know the difference between that. Half of the Legislature doesn't know the difference between Medicare and Medicaid, so -- I'm kidding, I'm kidding. But still, you -- I think we need to, like, put some describers in there so that they know what you're looking for.

Marina Suzuki: Okay. Okay, um [cross-talk] --

Eileen Cody: Doug or Greg? Yeah. Any other comments?

Douglas Barthold: Um, yeah. I just wanted to ask, how are we, like, targeting respondents for this [cross-talk] survey.

Eileen Cody: [Cross-talk] That's a good question.

Douglas Barthold: Is it just going to be on our website and we'll say if you have used or used on of these drugs, fill out our survey.

Marina Suzuki: I think other states did just post on the website, and they didn't get a good response. So but I think Oregon, they used like an external company or consultant to reach out and gather the data. Um, that's one. Um, and I think I remember right, I mentioned there is a mailing list that we can use to actively reach out, so I think we'll do that as well instead of, you know, because we'll post it on our website, but I think we have to do some type of active reach out to get some good response. What type of name [cross-talk] it is that we're going to use is still a question, but yes, [cross-talk] we'll get into that.

Douglas Barthold: [Cross-talk] Um, okay. Okay, yeah, then that sounds good. I'm just reading in the RCW about where this input is supposed to come from, and it says patients affected by the condition or disease treated by the drug as well as individuals with mythical -- medical or scientific expertise. And so given that it says, "patients affected by the condition or disease," I do

think we need to make whatever questions about have you used this drug, or do you use this drug, those need to be mandatory.

Marina Suzuki: Oh. Okay, yes. That's true.

Douglas Barthold: So um -- and -- relatedly, I'm not sure. I guess we could consider input from caregivers,

Eileen Cody: [indistinct] Right.

Douglas Barthold: -- but the RCW doesn't mention that. But I suppose, you know, it says, "we shall consider patients," but [cross-talk] --

Marina Suzuki: [Cross-talk] I think that's usually for, like, any pediatric medication. I mean the drugs we selected, it's not really that, but in case that later if there's any pediatric medication, they might be the parents filling in the survey, I think that's why Colorado name it as patient and caregiver survey, I think.

Douglas Barthold: And then so -- um, thanks. Yeah, that's good. In terms of the -- have you ever used? Do we -- ask them when they used it because this will also be relevant to [cross-talk] the --

Marina Suzuki: [Cross-talk] that's, yeah, that's -- a good question. I think we asked what's the [cross-talk] current one.

Douglas Barthold: Rather than how -- long have you used it, it might be better [cross-talk] to say, you know, check the years during which you used this drug or something like that [cross-talk] --

Marina Suzuki: [Cross-talk] Ah, okay.

Douglas Barthold: [Cross-talk] maybe. Is a year granular enough? Probably. Um, yeah.

Marina Suzuki: All right. Okay, I'll do that.

Hung Truong: Um, could we go over each question? I'm just worried it's going to -- it's going to keep going because I think [cross-talk] we have a lot to talk about with some of these questions so probably give us a chance to kind of think through it and then just provide comments back to you guys on it. Doug has a good question in the targeting. So are we targeting just for those drugs that we have picked to do an evaluation on, or is it open to everyone?

Marina Suzuki: I think the recommendation is to make it open to everyone who's being treated for the same condition because if you think about it, if we are just targeting the patients using the reviewed drug, then they can find a way, you know, to make -- to make it affordable to them, right? So it's possible that some patients not using it because of the affordability concern, and we want to hear from them. So I think we need to be more inclusive just asking [audio cuts out] patients being treated for the same condition in general.

Eileen Cody: So if there's, like, any patient support groups for the disease, then you'll target them.

Marina Suzuki: Yeah. That will be a good way to, um, if we can get some help from, like, patient advocacy group having, like, a meeting [indistinct], then that might be a good way to reach out to them as well.

Hung Truong: And many of these drugs have many, many indications, so it's [cross-talk] --

Marina Suzuki: Yeah.

Hung Truong: -- it's going to be.

Marina Suzuki: Yeah, I'll have to kind of dip [cross-talk] --

Hung Truong: [Cross-talk] -- I don't know, think about how will you -- would [cross-talk] --

Marina Suzuki: [Cross-talk] Well, that's a good question, yes. Yeah, like which -- for which indication are you being treated for when they have to, yeah, select, yeah.

Hung Truong: With the target, yeah. Advocacy group. I mean if you have a list of what the hospitals or providers, I mean, they can forward this to their patients if they're willing to help and so forth.

Marina Suzuki: Okay. I'm just typing in some notes here so that I can add that later in. Okay. Okay. All right. any other, like, major, major input before, you know, we start building this into a system for you to do more, like, a detailed commenting?

Eileen Cody: Greg, do you have? You didn't say anything. You have any comments?

Greg Gipson: I mean I just thought, I was wondering if we could use like the HCA's kind of [cross-talk] data to target these patients if we had contact information for them or people in disease states, if we could do some data mining internally, but maybe that's too much. Maybe just advocacy groups make more sense in that it would kind of ensure that we are reaching those patients if they have these disease states around these medications, um, and sort of get around

maybe asking some of these other questions, but perhaps it's not appropriate. Um, and then, yeah, I had to think, yeah, cutting it -- down would be the big thing I would also agree that [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. Um, do -- let's say they answer no to whether, you know, their a Washington resident or not, do you still want to hear from them? Should we keep asking? I mean should we include them or -- think.

Greg Gipson: I don't think so, but [cross-talk] --

Eileen Cody: [Cross-talk] I don't think so either.

Marina Suzuki: Okay. I guess if you're asking help from patient advocacy group, then they may have a mailing list with all of the members, but they may not have like a Washington-specific list, so I'm assuming -- they may just email it and then for some patients they say no, I'm not a Washington resident, and we can just end the survey there or, you know, keep asking questions, and we can screen out on our end later if you want to look up Washington-specific response. Either way is fine. Just, you know, giving you a head's up that if we are asking how from, yeah, from external groups, then [cross-talk] some patients may not be a Washington resident exactly, so.

Mike Neuenschwander: I think one thing we want to be careful of is not collecting data that we want or can use. So we've got enough data already, and this is going to be a lot, so anything to sort out data that we are not looking for, I think, would be important. So, you know, if we're not looking for, you know, outside of Washington, like, you know, I don't know -- I don't know if we want to waste other people's time having them fill out a survey that we're not [cross-talk] --

Hung Truong: [Cross-talk] So that's, like, a good point, Mike, because [cross-talk] what's the purpose of the survey? And because, you know, deciding on what drug we're reviewing and what to put an upper payment limit, how would this help with it? Is it -- is this going to be a fact in determining what that amount would be, or is this to see how successful the program is? And if that's the case, then I'm thinking a whole different set of questions.

Douglas Barthold: My understanding is that it's part of our affordability review, and so it will help us determine whether or not the drug is unaffordable.

Hung Truong: Okay, okay, [cross-talk], okay. That -- so that makes sense and [cross-talk] --

Douglas Barthold: So one thing I would say about nonresidence is, you know, you could have situations were someone, you know, they moved last year. They lived here for 20 years. They

moved last year. Um, they -- or someone who, like ,lives in Portland but gets their care in Vancouver, something like that, but -- I don't -- I'm not -- these are obviously extenuating circumstances.

Eileen Cody: Well, the reason I think it's just Washington residents is the upper payment limit is only going to be good for Washington residents.

Douglas Barthold: Is that true? Like if you live in Portland and then you buy a drug in Washington it doesn't apply?

Eileen Cody: Well, that's [cross-talk] I -- maybe if you're filling it over here.

Douglas Barthold: I don't know.

Multiple Speakers: [Cross-talk] [indistinct].

Greg Gipson: They wouldn't have coverage, right? Because this is for -- through the HCA, you have to be a Washington resident? Is that right?

Eileen Cody: [Cross-talk] Well, no, it's not just -- I mean, it's -- the upper payment level would be for those that aren't -- don't have to be insured by the state necessarily.

Hung Truong: This is for all drugs, Greg, I think --

Eileen Cody: Oh yeah.

Greg Gipson: Oh, okay.

Hung Truong: -- and would affect commercial [cross-talk] --

Eileen Cody: Yeah.

Hung Truong: -- um, and everything because you're affecting -- you're affecting the drug cost, acquisition cost. Right? And so it doesn't matter what insurance, that's the cost going to be in Washington if [cross-talk] --

Douglas Barthold: [Cross-talk] But does that -- or there are some insured. It's a -- there's a set of insurers that it applies for and a set that it doesn't. I think we decided it's about half of insured people or something like that.

Hung Truong: Yeah. I think if someone wants to give their input, it's hard to say no. I mean, if they are prepared to do the survey and then you cut them off, I'm not sure, but yeah, it's --

Eileen Cody: Well.

Marina Suzuki: I think the [indistinct] tradition asking or getting information from out of Washington is, you know, just the pricing kind of information just to have a bigger pool rather than asking Washington residents specifically. You might get just a bigger, I guess, sample size to see the average or extreme numbers. I think that would be the only [cross-talk] --

Douglas Barthold: [Cross-talk] To [cross-talk] Mike's point benefit [cross-talk] we have great data on costs, on out-of-pocket spending, and on total spending. We're, like, that's not the information that we're going to be using from these surveys, so getting a big sample to get representative data on costs, I don't see that as the goal here. I see the, you know, the sort of questions about I did -- for people who didn't use the drug because it was too affordable, what did they use instead [cross-talk] --

Eileen Cody: [Cross-talk] Yes.

Douglas Barthold: -- anecdotes about unaffordability, that's what I want to see.

Marina Suzuki: Yeah.

Douglas Barthold: So and I think that will do it like because I think people are probably, you know, if you're going to go in and fill out a survey, that's probably a story that maybe you have on your mind and you're likely to tell, I think we'll do okay listening to that information, but I don't think we really need to worry too much about, like, getting [cross-talk] data.

Marina Suzuki: [Cross-talk] Yeah. I think one thing I just want to point out is that out-of-pocket costs calculation, that's all coming from our Washington State all payer data [cross-talk], so that's coming from payers, [cross-talk] not patients. So one critique, you know, we had from manufacturers is that those out-of-pocket costs are actually -- well, could be an overestimate because they are offering patient assistance programs, they can use coupons, that kind of things. So if you -- I think getting the out of pocket cost from the patients, I think that might be a more actual representative numbers, so I think that that's -- I think that's the only thing that [cross-talk] --

Douglas Barthold: Yeah [cross-talk] yeah. Well, certainly asking about coupons -- is a great point.

Eileen Cody: [Cross-talk] Oh yeah.

Douglas Barthold: [Cross-talk] I agree with that, yeah.

Eileen Cody: So do we have -- Marina, do we have -- have we all given you enough information for this time?

Marina Suzuki: Yes, yes. I have an idea which questions to mandate based on your input. And, oh, and further whether to collect information from -- no, only Washington only or not. So the survey will be available for distribution, but we can cut it once they select 'No, I'm not a resident'. So I can -- I can make that structure into the questionnaire. Okay, so that's good. Thank you for the input. But yeah, if you have any additional questions you want to add or any feedback, just feel free to e-mail me, and earlier is better.

Douglas Barthold: Sorry.

Eileen Cody: Doug's got something.

Douglas Barthold: When I'm done and asking if you're a Washington resident we asked, "Do you receive care in Washington State?"

Marina Suzuki: Oh yeah, we can do that, [cross-talk] but if they say -- if they say, No, do you or not [cross-talk] participants? Or how --

Douglas Barthold: Yeah. If no, then I don't think we, we'll, want to hear from them.

Marina Suzuki: Okay, okay, we can ask that question. All right, so let's switch to the expert survey here. Let me put it up here. Yeah, okay. Um, hopefully it is coming up on your screen [cross-talk] -- so it's kind of a similar flow [cross-talk] the demographic questions here. [Cross-talk] I'm hearing a lot of, like, background noise somehow right now. I don't know where it's coming from, though.

Hung Truong: It might be you, Eileen, yep. [laugh]

Marina Suzuki: Okay. All right. Okay, so again, it's a kind of similar to the patient survey, but this is targeting the medical experts, asking the demographic questions first, kind of similar questions: What's your name, email. Do you practice in Washington? Do you provide care to patients living in Washington? Yes/No. Um, oh, Doug, yeah, you have a hand up.

Douglas Barthold: Yeah, so just to start us off, is this -- can anyone just click a link on our website and fill out this survey?

Marina Suzuki: Um, yes. I think this survey will be posted on our website, but we [cross-talk] --

Douglas Barthold: [Cross-talk] Okay.

Marina Suzuki: [Cross-talk] -- we may have to do some active reach out, like getting some mailing lists from, I don't know, like, border [cross-talk] --

Douglas Barthold: [Cross-talk] Yeah.

Marina Suzuki: [Cross-talk] I was saying border pharmacies, a lot you can -- yeah.

Douglas Barthold: Well, I wonder, like, if we -- can anyone just say, like, you can just fill out this survey and say, "Oh, I'm a physician. I treat this disease." I guess we don't have any way of knowing if there's -- verifying any of the information.

Mike Neuenschwander: Yeah, I mean there is a level of trust, you know, involved in some of this stuff. I know some of the other states have done surveys and, you know, some of their responses were, you know, from targeted groups, and so -- I mean there is a level of, you know, things that as you're putting out information and gathering stuff back, um, you know, there could be -- not everything is maybe exactly the people that you were hoping to reach for [cross-talk] --

Douglas Barthold: [Cross-talk] I think that's -- I think it's fine that, I mean, we can fill it out and, you know, maybe we'll probably get some good information from that, but I think the real key is that we do target those, I guess, like there's a professional society of providers in this disease area, or something like that, because that -- I think that those are the ones that we ha -- that have credibility, where we would really be curious of what the responses are so, um, having -- reaching out to them, I think, is important.

Marina Suzuki: Yeah, we'll find a way to reach out somehow to the experts. Um, yeah, and we'll have to remember other states as well. But, um, yeah, I just want to make sure we have the questions ready for that. And okay, so yeah, the demographics just asking their profession medical specialty and, yes, do they provide care for the patients with the certain condition that we are interested in and then how many patients in a typical month. How many patients with a specific medication we are selecting for affordability review? So these are the demographic question. And some [indistinct] set of questions here as well, like what kind of setting are they practicing? And what is the patient population in terms of the insurance coverage and whether they are considered as a [indistinct] covered entity or not, so just the -- this is the basic, you know, demographic information, and the meat of the question is here for the affordability review. Have you ever recommended drug X to your patient? Yes/No. I think it just kind of goes through their

specialty as well. And then have you ever had any hesitancy recommending the drug due to concern on the affordability? Yes/No.

What is the percentage of patients who do not immediately initiate the drug because of a concern on the cost or the insurance coverage? What is the percentage of patients initiating the drug? And I guess the other portion is the patient not initiating the drug that they are recommending? And issues with adherence? Yes/No. Or the percentage we're asking actually here. And what is the percentage of patients who discontinue the drug or needs to switch when the affordability is a concern. And also, what is the administrative burden of the drug? So yes, it's possible the patients can afford it because they have these patient assistance programs or coupons, etc. But for the clinician standpoint, do they have any administrative burdens that they have to file the paperwork or have to do some steps set up for the insurance approval? So that's a question we are adding here.

And kind of similar questions here on the coupon and patient assistance programs. The coupons typically available for the patients or not? Um, any issues with it? Similar with patient assistance programs? Is the program available for the concern -- for the patients with affordability concerns? What is usually the percentage of the patients using it? Um, any difficulty with approval? Yes/No.

How timely approval is for the initiation of the drug? And if there are any delays, how long it usually takes. Yeah. The eligibility concern for the patient assistance programs. And the last one is the free comment. So these are the questions that we have for experts. I just want to hear from you if you think these are the -- kind of hitting the points that you wanted to ask or you have other questions to experts.

Douglas Barthold: Um, one thing that came into my mind was, like, some of the questions refer to the condition.

Marina Suzuki: Uh-huh.

Douglas Barthold: Um, and as Hung noted, you know, a lot of these will have multiple indications, and so [cross-talk] is it [cross-talk] --

Marina Suzuki: I [cross-talk] okay, yeah, that's right.

Douglas Barthold: [Cross-talk] need to be phrased in a way, like, uh [cross-talk] --

Marina Suzuki: [Cross-talk] Okay, yeah. I have to [cross-talk] --

Douglas Barthold: [Cross-talk] How many patients do you take care of who might be candidates for this drug?

Marina Suzuki: Okay.

Douglas Barthold: Yeah.

Marina Suzuki: [Indistinct] different [cross-talk] --

Hung Truong: There will be more drug-specific, Doug, what your thinking?

Douglas Barthold: Yeah.

Hung Truong: Same here.

Douglas Barthold: I don't mean additional questions. I mean the questions you already [cross-talk] --

Marina Suzuki: [Cross-talk] Oh, I see.

Douglas Barthold: -- asked. They should be referring to basically, you know, patients who are candidates for the drug rather than mentioning any specific condition, right?

Marina Suzuki: Ah, okay, okay, okay. Yeah, I got it. Yeah, I'll look through the wording to make it, yeah, more drug-specific rather than the condition where it is applicable. Okay, thank you for the comment.

Douglas Barthold: Mm-hmm.

Eileen Cody: I just have to throw in depending on who it filling this out, like, a lot of the docs are not going to have a clue about the percentages or it's the [cross-talk] office staff did it.

Marina Suzuki: [Cross-talk] Yeah. I [cross-talk] Right. It may be different to estimate. Um, do you have any, I don't know, suggestion on [cross-talk] --

Eileen Cody: [Cross-talk] Well, I think it may be when you're doing the outreach that we somehow you can be coming from the prac -- as the question to the practice, and then the doc will had it off to the nurse to fill out or whoever is doing -- because I can just tell you that my role is to do all of this outreach on trying to get drugs approved or getting the money, and the docs didn't know what happened until so --

Marina Suzuki: I see.

Eileen Cody: And I'm sure it's that way in a lot of the practices so, and a pharmacist. I mean, I know that you have pharmacists on the list, but they're doing a lot of this, too. So I'm just trying to think of how to phrase it so that it gets filled out [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah.

Eileen Cody: -- the doc, it's not all doctor totally oriented, I guess.

Marina Suzuki: I -- hmm. That's a good question.

Eileen Cody: So, well, I'll think it and try and see if I can [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah, [indistinct] down [indistinct] we need like a good wording [cross-talk] to talk about, that would be -- that would be great.

Eileen Cody: And Hung, you're probably -- I mean the pharmacists, so you guys tell me that it's the same kind of thing that you're -- you do a lot of the work. It's not the doc's side. They're not going to know some of the stuff that you've done, too.

Hung Truong: Yeah. So it's [cross-talk] both on the clinic side a lot of their support staff does to prior auth and patient assistant, so that's a piece, and you're right. Usually the provider wouldn't be involved with that. Um, but they -- you know, and the drug selection is interesting, too. Some times it's not the provider. They leave it to a support staff to help select based on formulary and so forth. Um, so especially saying they will have a pharmacist that has, like, a protocol on hand to help select a drug and so forth. So that's one on the clinic side of it. The pharmacy that fills for these prescriptions also has a lot of information, but those pharmacies can be -- they're huge, and we're probably unlikely to get any information say Optum, Accredo, you know, the CVS. Those sites will have information, but I'm not sure if we're going to be able to get anyone to fill out that information just because they are national and they are so big.

Marina Suzuki: Right.

Hung Truong: But many of their systems do have their own specialty pharmacies. I know, you know, here at Virginia Mason, UW, MultiCare, and so those questionnaires can be -- these questionnaires can be answered from those sites as well.

Marina Suzuki: I wonder if we should put the phrasing on the cover page, you know, if you have a support staff helping you with any programs or, I don't know, supply, then feel free to forward the link to them. I think that might be one way to do it as well.

Greg Gipson: And also, just ask the other Board Members, like, how important is kind of getting an idea of how much prior auth on step therapy these drugs require in setting affordability like upper payment limits and things like that.

Douglas Barthold: [Cross-talk] It does not seem -- it does not seem important to me.

Greg Gipson: Sort of what I was driving towards, like, I'm not sure, like, if everyone has to do it. I mean a lot of these -- everyone is going to require prior authorizations for all these biologics. Everything that's expensive is going to be a yes [cross-talk] --

Hung Truong: [Cross-talk] It's because it's 100%.

Greg Gipson: Yeah. So, like, why are we asking it? You know? Like, why? Why do we need to dive and get that information? Maybe further down the list perhaps, but perhaps it's rel-, unrel-, not relevant now.

Marina Suzuki: Do you want to remove this question then or --?

Greg Gipson: I mean, we got to cut this. If providers are going to do it, this has to be short, like, really easy to do. This has got to be quick, and we got to ask, like, really, really focused questions to get our answers, and it's got to be something they can do in, like, 5 minutes or less.

Hung Truong: Yeah. The administrative burden will be 1000 out of 1000 because that's the biggest complaint that's on national news. It's everything, right? So I think a lot of -- these questions, it's very -- it's redundant, and we know the answer to.

Marina Suzuki: Oh no, we can remove this one. And you think [cross-talk] --

Douglas Barthold: [Cross-talk] I guess. What are we really trying to learn here? We want to learn our -- again, the same things I said before. Are patients who are candidates for the drug not using it because of the cost? And what are they using instead if anything?

Eileen Cody: Yep.

Douglas Barthold: Um, so are we capturing that somewhere?

Marina Suzuki: Okay, so we can ask that question somewhere. Yeah, here. Like, it's [cross-talk] --

Douglas Barthold: It can be a free form question that [cross-talk] --

Eileen Cody: [Cross-talk] yeah, we're trying to say is that we don't think we need most of this question -- or a lot of this questionnaire and to just boil it down to some basic questions. Right guys? Isn't that what [cross-talk] --

Douglas Barthold: Yeah, or at least put, I mean, with the one I just mentioned I think should be, like, at the very top, right? Because maybe they are going to work on this for 5 minutes and say, "that's enough," and X out of it. Um, and so what I'll -- like, aside from that, what else are we trying to learn here?

Greg Gipson: I mean, yeah, I think [cross-talk] like the number of patients that can -- that are adherent to therapy or not adherent to therapy due to cost, that might be kind of a driver, like, "This is too expensive for my patients to get on appropriate therapy."

Douglas Barthold: Right. And yeah, exactly. Like, have you seen it once or have you seen it 100 times?

Greg Gipson: Yeah.

Hung Truong: Or the alternative therapy, are we going to a second line because the first line is too expensive? Right? Because then you're not picking what's recommended due to cost or affordability. Sorry.

Marina Suzuki: Okay. Ah, let's see. So if you think of any additional questions, can you send it to me? Let's say by the end of this week? Or is that a good timeline or you need more time?

Hung Truong: Anymore time, Marina? I'm actually out of the country for a couple weeks. [laugh]

Marina Suzuki: Oh. [laugh]

Hung Truong: Yeah. So I mean, it's up to you. I'll try to give feedback, but it's not going to get done today. I mean this week.

Greg Gipson: Can we do another and maybe slightly different exercise, like, try to figure out what exactly we need out of this survey and maybe -- I don't know -- and then we can kind of boil these down?

Marina Suzuki: you mean like during the next Board meeting or sometime sooner or -- ?

Hung Truong: I concur with Greg that we need to try to understand what information we're trying, what we're trying to do with the survey. Yeah. So I don't know, Mike, if we -- is this a discussion that needs to be on the agenda? Or is it something that we can do on our one-on-one?

Mike Neuenschwander: Yeah, I think let's try just for expediency's sake, um, if we can, maybe do some one-on-ones today and discuss some of this stuff a little bit more, um, and kind of take it from there and see how everyone's feeling about that. So, um, and maybe Marina, what we can try and do is kind of at the beginning of the survey, like, you know, maybe some bullet points if this is -- this is, and this is kind of for internal use. This is what we're hoping to get, that, you know, this is the type of information we're hoping to get and how we think it's going to fit into the drug review. Um, and then we can kind of look through, you know, see if the Board Members kind of agree with that and look through and see, you know, do these questions meet this intent of what we want? And if not, you know, we can get rid of them. And if we feel like they're, you know, we need some more questions, we can talk about some of those. And then we can take the feedback from the Board Members, kind of compile it into a new survey, and then send that out to give them, you know, a second round for you or [indistinct]. Does that sound okay?

Douglas Barthold: [Cross-talk] I like that, um --

Marina Suzuki: [Cross-talk] Yeah, yeah, yeah. I think I don't want to wait until the -- yeah, next Board meeting, so having one-on-one then having time to hear from individually, that would be great if they're available. Um, and is it helpful if I email this to the Board Members for you to take a look at [indistinct] ?

Eileen Cody: Yes, I think that's a good idea.

Marina Suzuki: Okay. All right. Great. Okay, I'll e-mail this out so that you can kind of comment on it, and I can compile sort of the consensus among them. Maybe we can discuss at the next Board meeting, and that's going to be more complete in instead of, yeah, going one by one, I think that'd be great.

Douglas Barthold: And I would just echo what Greg said about if we want people to fill this out, it's got to be 5 minutes, 10 minutes max, and so we have to be really stringent about it. It only gets -- like a question only gets included if it has to be on there. We should just -- we should drop everything else. I mean, these are -- these are great questions. It would be great information to have, but it just doesn't seem like it's going to be feasible to get the people to fill this out.

Greg Gipson: Yeah. I think [indistinct] get good provider response, you have to pay them to do it. I mean it's hard.

Eileen Cody: Yeah, reality is really tough for us here in dealing with all the providers.

Douglas Barthold: We'll just pay them with all the extra money we have in the state budget.

Eileen Cody: Yeah, right.

Douglas Barthold: So we could increase the cost of the drugs, and [cross-talk] [laugh] --

Eileen Cody: Sarcasm. Now, now. All right, is that it, Marina?

Marina Suzuki: Yeah, thank you. Thank you for your input.

Eileen Cody: Okay. I'm sorry, it's getting louder here, too, so I'm sure you're having a hard time [cross-talk]. Um, okay. So it's public comment time. Mike, I'll let you call on people since I don't know what's -- what we got here.

Mike Neuenschwander: Well, I think, um, we -- were going to do just a quick update on Advisory Boards.

Eileen Cody: Sorry.

Mike Neuenschwander: Oh, no worries. So maybe we can take just like a quick, like, 5-minute break. I know we've been at this for, like, two hours, and then we can -- do the advisory Boards. It shouldn't take too long to do the public comment and wrap up. Does that sound okay, Eileen? Okay.

Eileen Cody: Sure, let's go.

Mike Neuenschwander: All right, great. Do -- 5 minutes. We'll be back here at, like, 10:40.

[break]

Mike Neuenschwander: Hey. I think we all made it back. Um, so I think we can -- hop here, Simon, to chat about advisory groups next, and then we'll do public comment afterwards.

Simon Borumand: Yeah. Hey, everyone. Um, my part can be pretty -- short, um, so we can move to the -- public comment. If you'll remember when we had set up the advisory group, which is kind of

part of, you know, a body that will provide feedback as we go through the affordability reviews. We had set up the core advisory group and with the expectation that we would add on a supplementary advisory group once drugs were selected for affordability review, and so I just want to give a preview of where we'll go in terms of recruiting and staffing at supplemental advisory group, how they'll contribute, and that work will take place over the next few months as we actually kick off the affordability reviews, so what new experts have to add.

When we had written the policies we had spoken of adding up to five supplemental advisors from the patient community as well as provider community, and we're thinking, you know, we could also add in patient advocates, maybe not those directly receiving cares but those advocating for them, and then any academics that are specifically focused within that drug category, or that drug or the indications treated by the drug, where to find them, so similar to the survey process looking at the list serves that we have within HCA's GovDelivery list serves and sending it out. Getting any nominations from the PDAB or the existing advisory group numbers, asking portal in other states and who is on the advisory groups show us they have any experts that they are aware of reaching out to patient advocacy groups, both ones that reach out to us and then can source them ourselves and then reaching out and trying to [indistinct] recruiting anyone if there are folks at UW that we know of that are experts in a certain drug or certain condition, then we're reaching out to them.

And then lastly, how they'll contribute. So the core advisory group, responding to any ad hoc requests from PDAB or the existing core advisory group, and then ideally, we were thinking having them join in the regular advisory group meetings and then whatever the outcome of the advisory groups meetings is if it's a drafted report then having these supplemental advisors' kind of draft different sections according to their specific perspectives. So that's just a kind of a high-level -- overview, but any thoughts or questions?

Eileen Cody: [Cross-talk] So I have a question on it. So this is just to patients, providers. These are those experts that you're adding. It's one group. It's not a group of each one of those. Right?

Mike Neuenschwander: Yeah, just [cross-talk] one group. You know, one patient [cross-talk], one provider, one patient advocate.

Eileen Cody: Just wanted to clarify because I was going to -- I thought you're getting too many groups going. [laugh] Any other questions or comments? Okay. Looks good.

Mike Neuenschwander: Awesome. Thanks, everyone. Okay. Well, I think that then takes us to public -- well, actually, here real quick before I go into that. So just kind of a -- some general kind of next steps overview. Um, so yeah. So we'll be -- Board Members will be reaching out doing some more one-on-ones and -- talking about the patient surveys. We have our list of drugs. One of the things that we, you know, for the statute we're required to do is post -- those publicly before we

start doing the actual drug review, so we'll need to do that on our website. And then over the next couple of months, the big things that we're going to be working on then are getting these forms finalized so we can start doing data collection on our first two drugs and sending those out, and so we'll kind of keep you posted on how that's going as well as getting these surveys finalized so then we can look at how to do them. Simon talked about also in getting our advisory boards flushed out now that we have our drugs selected and then working on getting feedback from those.

So the next few months, there's going to be a lot of basically data collection and trying to put those pieces of the puzzle together and gathering feedback from various sources, so we'll -- kind of keep you posted on how that goes. Depending on where we're at come September, I'll -- reach out and chat with the Board Members. Maybe not having the September meeting, if we still just really haven't gotten any financial data back, or we're in the middle of that, or maybe a short one virtually to, you know, if we're just doing updates on how our data collection is going. So again, I'll -- chat with you, kind of more on our one-on-ones to get a feel of, you know, how things are going and where we're at and what we want to do. So that's just kind of my general where we're at, kind of our next steps over the next couple of months. So any questions, comments on that?

Kelly Wu: I have a question about the overall list that the Board Members wanted to see. So do you all want that, like, on the dashboard or do you want it as an Excel file?

Douglas Barthold: I think it should be on the dashboard, right? What do you guys think?

Mike Neuenschwander: In a separate tab?

Douglas Barthold: Well, the way the current tab is where -- when you toggle the All option for biologic, that just basically appends the two lists but doesn't re-rank them. That list, when you filter by all -- for all, it should be a re-ranking, I think is what we're saying, right?

Kelly Wu: Well, no because last time there was a comment that someone wanted to see, like, both of them at the same time for the visualization, so you could, like, compare the graphs -- the information in the graphs. So if I made it overall, then you wouldn't be able to do that. But is that something that you all now want to change to overall?

Douglas Barthold: Wouldn't the information in the graph still be the same? It would just be the order of the drugs on the ranking that would change. Is that -- is that accurate?

Kelly Wu: Right, but before, um, I think you all wanted to see both of the lists together, so you could compare both of them on the graphs, so you can, like, see all 50 bars or whatever.

Douglas Barthold: I see.

Kelly Wu: So if you still want that, then we can do a separate tab. Or if you just want it to change to the overall, we can do that too.

Douglas Barthold: [Cross-talk] I guess there is.

Mike Neuenschwander: I mean maybe just because to keep with what we've asked for previously, maybe keep that and then just add another tab, um, might be the easiest just kind of from a operational standpoint.

Douglas Barthold: Yeah, I agree with that. And I also think -- I think the point that there is still value in having the appended list that we have now because that way it does allow us to have to see all of them side-by-side, so I agree that just an additional tab would be good.

Eileen Cody: [Cross-talk] I'm okay with [cross-talk]. I think that's a good idea to do it that way. Greg or Hung, any comments?

Hung Truong: No, that's, yeah, that's fine. I mean just add on to it.

Greg Gipson: Yeah. I'm okay with that, too.

Mike Neuenschwander: Okay, great. [cross-talk] So let it be written, so let it be done.

Eileen Cody: Yes.

Mike Neuenschwander: Okay, any other question [cross-talk] --

Eileen Cody: [Cross-talk] Public comment. Right?

Mike Neuenschwander: Okay. Okay. [cross-talk] --

Eileen Cody: [Cross-talk] Then we have our public --

Mike Neuenschwander: We have Dharia right here. She can be our first, public comment, and then we can go to the people on the web if there's anyone else.

Dharia McGrew: Thank you so much. Happy to be here in the room today. Okay. Dharia McGrew on behalf of PhRMA for the record. Appreciate the good conversation today of the Board Members. Always thoughtful in your deliberations. We ask that the updated new manufacturer data call template be posted to the website so that we can review and comment before it's finalized and

official. Same for the new materials, the provider survey, and the patient survey, those have not been publicly posted at all yet. I really think that they should be posted for public comment officially, with the notice and comment period for patients and providers to respond. You know, haven't reviewed them yet, but just by way of example in Oregon, there was comments from patient groups saying that their original survey didn't allow for patient groups to respond, so your survey.

You know, it suggests that your survey should allow for both. You will have patient groups that are national groups that represent patients all over the country that do have important information that they will want to provide, particularly when you're talking about a rare disease or an infrequent disease. You know, there might not be that many people in Washington tuned in willing to spend the time to submit the survey, but you will have patient advocacy groups that are very well informed on the issues that will want to respond, so I suggest that you allow for both of those. But really, I think the groups themselves will want to comment. I just remember that being a comment in Oregon that came up recently. Um, that's everything from me. Thank you very much.

Mike Neuenschwander: Great. Thank you so much, and that's a really great point and comment on that, so thank you very much. Okay. Simon, anyone else online? [Indistinct] oh, Seth Greiner. Here, let me unmute. Those are the top [indistinct]. There we go.

Seth Greiner: Good morning.

Mike Neuenschwander: Good morning.

Seth Greiner: Good morning. This is Seth Greiner. I'm with the National Multiple Sclerosis Society. Thank you so much for the public comment period of this meeting and for a robust conversation. I would just like to second Dharia's remarks about the importance of including the patient advocacy community in public comments. As referenced, the Oregon Prescription Drug Affordability Board had a couple of hiccups involved with their public commenting from patient advocacy groups. It is an important voice for all Washingtonians, and we thank the Board for this robust conversation and look forward to commenting from the patient advocacy perspective. Thank you very much.

Mike Neuenschwander: Great. Duly noted. I had received an e-mail, from another commenter, but I'm not seeing her hand raised. Okay. Vanessa Lathan. There we go.

Vanessa Lathan: Hello. My name is Vanessa Lathan, and I'm speaking on behalf of the EACH Coalition and Patient Inclusion Council, a novel coalition that brings together patient organizations, caregivers, and people living with chronic conditions to advocate for patient-centered drug affordability policies. Throughout the affordability review and UPL process, it is essential that the Board includes strong input from patients and advocacy groups. Hearing directly

from those who rely on these treatments will help the Board understand the real life impact of its decisions and ensure the Board is addressing the true patient issues. At the end of the day, affordability should be about whether people can get and stay on the medications they need, not just what insurers or states pay.

To that end, we encourage the Board to establish a clear, thorough, and patient-friendly process for gathering public input on the drugs selected for the affordability review. We have participated in the patient input process put in place by PDABs in multiple states. While we applaud their efforts, we also observe their flaws and their approaches that limit their ability to adequately engage patients and caregivers. We have included many recommendations to the Board in our written comments that we encourage the Board to review in full. In addition, we offer our coalition, its network of patient organizations, and patients, themselves, as a resource to the Board on the development of patient-facing materials, and establishment of patient outreach best practices to hopefully mitigate some of the obstacles encountered by other PDABs.

Finally, as the Board continues the affordability review process, we encourage the Board to establish clear affordability framework that centers on patient calls and the value of medications to individual patients. We encourage the Board to take the complexity of each individual into account when deliberating on affordability reviews and not treat therapeutic alternatives as interchangeable. Thank you for your continued commitment to improving drug affordability in the State of Washington. We appreciate the opportunity to provide this feedback and look forward to continuing our engagement with this Board.

Mike Neuenschwander: Great. Thank you very much. Yeah, we'll make sure we -- take a look at, all of your comments that you sent. Okay, anyone else? Okay. Well, thank you very much. And yeah. Now, we've got a lot of stuff and work to do ahead of us in the next couple of months, but thank you, Board Members, for your time and, we'll -- be in touch soon.

Eileen Cody: All right. Well, thanks, everybody.

Hung Truong: Thank you.

Douglas Barthold: Thank you, everyone.

Eileen Cody: We're good.

Greg Gipson: Yeah, bye.

Eileen Cody: Take care.

Mike Neuenschwander: Bye.

[end of audio]