Washington State Prescription Drug Affordability Board
Meeting Transcription
July 15, 2026

MaryAnne Lindeblad: We can start? All right. Okay, let's go ahead and start. Um, good morning to all. The Prescription Drug Affordability Board Meeting, and we'll start with some introductions of the Board and then the staff. Eileen, do you want to start?

Eileen Cody: Eileen Cody.

MaryAnne Lindeblad: And then online, um, Doug.

Douglas Barthold: Hello. Douglas Barthold, Board Member.

MaryAnne Lindeblad: Greg.

Greg Gipson: Greg Gipson, Board Member.

MaryAnne Lindeblad: Hung.

Hung Truong: Hung Truong, Board Member.

MaryAnne Lindeblad: Welcome. And MaryAnne Lindeblad, Board Chair. And so let's go around the room here and then folks that want to introduce themselves that are online. So we want to start with Ryan.

Ryan Pistoresi: Okay. So I'm Ryan Pistoresi.

Mike Neuenschwander: HCA Mike Neuenschwander, uh, HCA Director for PDAB.

Michael Tunick: Assistant Attorney General, Michael Tunick, Legal Counsel.

Julie Colacurcio: Julie Colacurcio, DPTP.

MaryAnne Lindeblad: And then, um, HCA staff. Call out. Can't really I can't [cross-talk] --

Mike Neuenschwander: Marina, you want to go first?

Marina Suzuki: Sure. Um, hello. This is Marina Suzuki. I'm the head of Economics and Research Manager.

MaryAnne Lindeblad: Kelly.

Kelly Wu: I'm Kelly, and I'm the PDAB Data Analyst.

Mike Neuenschwander: Okay. And I think from the team that's all I'm seeing right now online.

MaryAnne Lindeblad: So, um, and so welcome to other attendees for the Board meeting today. Anyone else that would like to introduce themselves? All right. Well, why don't we just go ahead then and turn it over to Mike?

Mike Neuenschwander: Great. Well, thank you all for, uh, coming out here today. Uh, we're making some, uh, great progress. This is kind of a milestone here today for our Prescription Drug Affordability Board. Uh, we've been doing a lot of good work, uh, and I think, uh, it's been, uh, we're at a good spot here in terms of taking some, uh, big next steps and moving forward. Uh, so let's see. I guess first things here are, uh, I'll do a quick update. So as most of the internal staff know and the Board members know, Simon, uh, Borman has left. He's gone off to a great new job, uh, in the private sector. Uh, he will be sorely missed. Uh, we are currently hiring to backfill his position. Um, but for the meantime, we have Julie, who introduced herself and who's helping us out. She is, uh, in charge of the Drug Price Transparency Program and, uh, so she'll be lending her support as, uh, we are moving, uh, forward here for the next, uh, few months until we get that position backfilled. Um, let's see. Other things that are interesting that are going on here are, uh, with Colorado. I don't know for those of you who've been following, uh, some of the news, but they put in place a, uh, upper payment limit or UPL, uh, for one of their drugs that they reviewed, Enbrel, which is also a drug that we will be talking about today. Um, however, if you go to the Colorado Sun, uh, I think this was just last week or the week before, uh, they had an article that kind of summed up what's happened. Uh, so Colorado's upper payment limit has temporarily been blocked, uh, as the judge cited, "Their UPL likely runs a [indistinct] of legal precedent and federal patent law." Um, other background includes that their price cap was scheduled to go into 2027 at around $31,000 per year. Uh, which matches the, uh, Medicare maximum fair price. Uh, the price cap on, uh, Enbrel was the only one that Colorado has issued so far. Uh, but it was in the process of

studying UPLs for two other drugs, Stelara and Cosentyx. Um, so not sure exactly how that's going to affect that process yet, um, as this is all you know fairly recent and unrolling. Um, interestingly also a couple of weeks ago NASHP, uh, uh recently came out with new updated model legislation for PDABs, uh, which also was attempting to use, uh, the Medicare drug prices as you know upper payment limits for, uh, drugs. Um, so it'll be intriguing to kind of see with all this legal stuff, you know, how things shift and turn around. Uh, for Washington, just kind of a quick update on where we're at with the UPL's. Uh, so we were in the rulemaking process, uh, for our own upper payment limit, uh, parts of the program. Uh, we discussed, uh, some of the possible, uh, upper payment limit, uh, methodologies or ideas, uh, during our March meeting, uh, of this year. And so we've been working to put those into rule. We put some of those rules out to, uh, the public, and we've gotten a lot of external feedback -- considerable good feedback. So internally we're taking a look at some of that to see, uh, how, uh, we can incorporate that feedback with our rule making process. Uh, also been working with our AG's office here, uh, to, uh, take a look at what's happening in Colorado, what's happening with our process, and kind of, uh, try and figure out a strategy moving forward of what to do and the best way to move forward. Um, again, as this is all fairly recent, uh, I don't think we have answers to all of our questions yet, uh, but, uh, I think timing wise this is actually, uh, fairly good for us because we have the time to, uh, talk about this and potentially, uh, you know, modify things and pivot a little bit. So, uh, I think we're actually in a pretty good spot. We're also watching what some of the other states such as Maryland are doing as well as they are looking into upper payment limits. Um, so with that, I think those are some of my kind of general UPPL updates. Any questions on that for the Board before we move forward?

MaryAnne Lindeblad: I don't have any.

Mike Neuenschwander: No?

MaryAnne Lindeblad: No questions.

Mike Neuenschwander: Great. Okay. So then other things, uh, that we will be doing here is, uh, just general timeline updates. Uh, so we will, uh, we have our agenda here today, uh, which will look at our new, uh, list of eligible drugs for

review and a short list of kind of per our waiting and ranking categories, uh, you know, what drugs kind of came to the top of that list -- eligible list. Um, so goals are, you know, let's look about -- look at that today, talk about it, um, and then give the Board some time to think about it, ask questions between now and the next Board meeting, and then vote, uh, hopefully, potentially in our September meeting on selecting our new drugs. Uh, same thing with our affordability reviews. Uh, we're going to take a look at those here today, uh, go through the public, uh, with the public the public portions, and then we'll do an Executive Session for the confidential pieces of the report, uh, and, uh, give the Board some time to dig into those reports, uh, look at them for the next couple of months, and then we can, uh, vote on those as well during our September meeting. Um, and in terms of moving forward with that, I think, uh, again because we spent the work this year putting together our data collection forms, uh, getting, uh, a solid start for surveys and other, you know, all of the different mechanisms that we need to put together the reports and the outline and templates for the reports, um, once we vote in September, hopefully we should be able to, uh, jump into data collection and, um, starting to put together the reports, uh, fairly quickly this year. So, the first year is always the hardest, um, and, uh, but yeah. I think we're in a good spot. Additionally, we've done a lot of contracting work as well to get, uh, uh other sources of data, model data, uh, that we need to help fill out the drug reports, and those contracts are now, uh, done. So that also sets us up to be in a good position to, uh, really just get our hands in and start getting them dirty, uh, the second that, uh, we are able to vote on our next round of drugs. So those are kind of my general, uh, updates on UPLs and timelines and other states. Um, any other questions on timelines? Okay.

MaryAnne Lindeblad: Good.

Mike Neuenschwander: That's what I got.

MaryAnne Lindeblad: All right. So next item is the 2026 eligible bill -- eligible drug list for Kelly and Marina. I'll turn it over to them.

Mike Neuenschwander: Okay. Kelly, I'll let you, uh, take us -- take it away.

Kelly Wu: Sure. Um, do you want to go through the dashboard first and then stop at the drug list or go through the drug list first?

Mike Neuenschwander: Uh, let's go through the dashboard real quick and just, you know, kind of do a -- an update so, you know, a refresher. It's been a little while since the Board members have looked at the dashboard. Um, and then we can kind of dig into the specifics of the drug list. So, yeah, if we can just do a little orientation there, uh, and then we can let the let the Board, uh, chat about specific drugs and any questions that they have.

Kelly Wu: Okay, sounds good. So, this is um, our dashboard draft for this year, and it contains the same structure as our dashboard from last cycle. We just have some less tabs since we're not doing the NDC level list. So, I'll just, um, go through it really quickly and then we can go to the new list. So, um, we're still working on finalizing some of the language. So, um, just pretend you can't read. Um, so for this cycle we have 153 generic names that are eligible for affordability review. Um, and so everything is the same as before for our dashboard just different years of data. So this is our overview page. It contains, um, a brief overview of like what our dashboard contains and like some limitations. Um, and then and then our data sources. And then there's two shortcuts on the bottom where you can just go directly to the list. Um, and this is our dashboard information tab. So, um, you can just scroll through here to, um, get an overview of what each, um, tab in the dashboard contains. And then we have our Data Dictionary. And this contains, um, definitions of all the data fields that we're using in our dashboard. Um, and then this tab is a brief overview of some of our data. So it contains a summary of how many, um, drug ingredients are in each category for a list. Um, a breakdown of the different, um, cost groups for the eligible drug ingredients um, that met the course of treatment threshold. And then down here are interactive graphs where you can just filter by like top 20 or top 15 or top 100 -- um, I don't think we have 100 -- um, 100, um, drug ingredients by people -- number of people using the drug and um, then total paid amount.

Mike Neuenschwander: And then, Kelly, right there, uh, on that one page, can you just highlight how many drugs total we had for this year?

Kelly Wu: Yeah. 153.

Mike Neuenschwander: Okay.

Kelly Wu: And then we have the drug lookup tool which is, um, same as last year but we don't have NDC and label name anymore since we're aggregating by drug ingredient this year. And then, um, just a brief mention that we are censoring -- or, um, yeah -- we're censoring data with, um, number of people using the drug less than 10. So if that's the case, you'll see some, um, other corresponding missing data boxes so people can't back calculate the data. And then there are 13, I believe, drug ingredients that are on multiple lists. So they're all in this tab, and, um, contains information on like what different lists that the drug ingredients are on. And I remember, um, last cycle we did this. I think the most was like two, um -- some NDCs were on two lists, but this year we have some that are on three. So like this here is an example. All right. So um, going to the important part. Um, so there's like two lists in this dashboard. So one is the list that's broken down by biologics and non-biologics. And then another one that is the overall, so just like top 25 regardless of biologic status. And then in the last tab is a, um, crosswalk in case you want to look up which NDCs are in which drug ingredients. So I'll go back to, um, the aggregated prioritized list. So this is the list that's broken down by biologics and nonbiologics. So, if you don't filter by anything, you'll just see like, um, the ranks and then you'll see like two, um, drug ingredients per rank. That's because like one is for biologic and one is for non-biologic. So, this is just, um, all of them together. And then if you want to see any specifically, you can just, um, filter by biologics. So this would be the top 25 biologics and then top 25 non-biologics. And then what I showed before was the -- oh, sorry. It's early. Um, these are the top 25 biologics. And then what I showed before was the top 25 non-biologics. Um, and then I just want to point out that there are some, um, drug ingredients that had less than 10 people using the drug, so that's why you'll see like nulls for some of them in the data measures. And then this tab, it -- oh, go ahead.

Mike Neuenschwander: No.

MaryAnne Lindeblad: Okay.

Mike Neuenschwander: This is just a dashboard online. So we'll be posting this dashboard to the web here shortly.

Eileen Cody: So it's not on the web.

MaryAnne Lindeblad: So it's not on the web.

Eileen Cody: Yeah.

MaryAnne Lindeblad: That's what we were -- like, I didn't see this. Okay, great.

Mike Neuenschwander: No, no.

MaryAnne Lindeblad: Great. Thank you.

Ryan Pistoresi: Late breaking, uh, --

MaryAnne Lindeblad: Late breaking news.

Mike Neuenschwander: Yes.

MaryAnne Lindeblad: Perfect. Thank you.

Eileen Cody: We just want to know how far behind we are.

Multiple Speakers: [Laughter]

Mike Neuenschwander: You are on the ball.

Eileen Cody: Okay.

Kelly Wu: Um, oh, yeah. So, um, the last -- the second -- the last thing I'll mention is there's a tab that's associated with the aggregated prioritized list that just contains the data in like a visual form, so in case you want to compare anything visually. And the filters are connected. So if you filter by like this tab like for example to non-biologics, everything in the visualization tab also filters that. And then you can also compare like, um, specific generic names if you're interested. And then you can just compare them separately. All right. So, yeah, let me know if you just want to look at everything unfiltered or you want to filter by anything. I'll just manipulate the dashboard.

MaryAnne Lindeblad: I don't have anything. It'd be great once we have an opportunity to play with it. So I look forward to that.

Mike Neuenschwander: And so, uh, so last time, um, we -- when we were going through and looking at this, uh, we selected. So before we were calling it, uh, specialty versus non-specialty drugs. I think we've just switched to, uh, basically the [cross-talk] --

Ryan Pistoresi: [Cross-talk] Branded biologic. [Cross-talk] --

Mike Neuenschwander: [Cross-talk] Branded [cross-talk] biologic.

Ryan Pistoresi: Yep. So really splitting it between a BLA and an NDA on how they were approved by the FDA. So hoping to simplify it. [Cross-talk]

Eileen Cody: How many [indistinct] you got? [cross-talk] --

Ryan Pistoresi: Yeah. [Laugh] So, just trying to simplify it for purposes of doing the review.

Mike Neuenschwander: Yeah. And so I think last time we selected the top two from each of the lists. Um, and so, uh, you know, I -- we can do whatever we want this time but, you know, again, just going off of what we did last time versus now. Here -- here's the list. Um, and so we can take a look and, you know, I guess if the Board -- a couple of discussion points for today is, uh, you know, how many drugs do we think we would like to choose? Um, and then also, uh, you know, I guess, what is our kind of selection criteria? Do we want to do some from each of the list or just do the top, you know, whatever overall? Um, so, so yeah, I guess those would be two things that we should chat about a little bit here today. So as you dig into this list, you can kind of have to keep those data points in mind. Um, and Doug, I see you have your hand up.

Douglas Barthold: Yeah, thanks. Um, this is great. Um, I have a few questions about this. And so I don't I don't know if Kelly has anything else for her presentation or if I should just go through those my questions now.

MaryAnne Lindeblad: That would be, yeah, questions for Kelly. Yeah, great.

Douglas Barthold: Sure. Sure. So yeah, my first question is about the data year. Um, and so when we did this the first time the eligible drug list was calculated, uh, basically on, uh, using the measures from the 2022 All Payers Claims Database. My understanding is this is from the 2023. Is that right?

Kelly Wu: Yeah. So we were going to use 2024, which was available but, um, there is some data issues, and we didn't feel comfortable using it. So we're reverting to using the 2023 data.

Douglas Barthold: I see. Yeah. So I guess my question was, like, are we required by statute to do it for every data year? Or would it would we be better off using our resources of this of this review cycle to just do it on the most recent one if that's possible? Um, I don't know how if those data issues will be resolved soon. So, um, yeah, I don't know if Mike or Ryan, do you know anything about if the statute says we have to do it every year or what? How does that work?

Mike Neuenschwander: So, yeah. So, uh, it doesn't specify like we have to use XYZ year of drug data. Um, what we're trying to do is just use the most recent complete years worth of data that we have in order every June 30th to update our drug list, uh, for the Board [cross-talk] --

Douglas Barthold: [Cross-talk] Okay. So on June 30th of 2026, our best year of data is 2023?

Mike Neuenschwander: Correct.

Douglas Barthold: Okay. Sounds good. Um, okay. My next question is about the aggregation prior to the weighted ranking, and this is something that we discussed last year. Um, as you may recall, uh, in the -- in our first weighted ranking we, uh, aggregated by, I think it was -- where is my I lost it -- oh, yeah, uh, both by ingredient and labeler. And I think that this year we were going to do it just by ingredient. Right? And I just want to just -- is that what we did?

Kelly Wu: Yes, that's what we did this year.

Douglas Barthold: Fantastic. That's awesome. Thank you. Um, and then my other question is just about the results here. Um, so it's a lot fewer than the previous, uh, data year, uh, you know? We had 290 eligible drugs for the 2022 data cycle, 150 now. Um, obviously, once we uh, you know, once we get a chance to play around with the dashboard, maybe we can see um, which types of drugs dropped off. But I don't know on your first pass, do you

have any um, any thoughts about why there's so many fewer drugs eligible for this cycle?

Kelly Wu: So last time the 29-something was NDC level, and this time the 153 is, um, at the ingredient level. So if we were talking NDC level, I think there's like 490-something.

Douglas Barthold: Okay.

Kelly Wu: So there's more. Yeah.

Douglas Barthold: Interesting. Yeah. I could actually -- I mean, obviously, that I think it would make sense for more to be eligible as time goes on just because of inflation and, you know, because and the -- and the thresholds for eligibility don't increase with inflation. So um, okay. So it's 158 eligible ingredients this time in these 400-something NDCs. Is that right?

Kelly Wu: Yeah.

Douglas Barthold: Okay. Um, all right. Well, that's helpful. Um, yeah, and I'll look forward to, uh, playing with the dashboard once it's available. And that's it for me. So, thanks a lot.

MaryAnne Lindeblad: I have a question. My question. How much -- because one of the reasons why we only picked, you know, did a couple this first time was just because we didn't know how long it was going to take. Uh, so I guess that's my question. How did it go on the affordability review? How -- you know I don't know what -- I don't think that the legislature cut staff yet. I mean right? Last year? So we don't know what next year might bring, uh, but [laughter] [cross-talk] can't blame me anymore [laughter] [indistinct] but, uh -- so I'm just -- but how many do you think with the staff -- current staff level they could do? That's a -- now that they've done some.

Mike Neuenschwander: Yeah. So, uh, while the -- again, so while the legislature hasn't cut staff, we have lost Simon and [cross-talk] --

Eileen Cody: [Cross-talk] But he doesn't count. He's he decided to leave and we're replacing him. [laugh]

Mike Neuenschwander: We are replacing him. But yeah, that [cross-talk] --

Eileen Cody: [Cross-talk] I know, he's irreplaceable.

Mike Neuenschwander: That all -- well, it just takes time, right? You know, that the speed of, uh, bureaucracy, right, um, [cross-talk] [indistinct] with hiring. So, um [cross-talk] [indistinct]. Yeah [laugh] uh, so, uh, we are a little bit down just in terms of capacity. I think, uh, last year there were there were a decent number of struggles in terms of, um, gathering data, uh, especially, uh, some of the communications back and forth with manufacturers and trying to clarify what we were asking for, what they were, um, able and willing to give. Um, and so you know that took a I think a decent bit more time, uh, than was expected. Uh, again I think putting together -- putting together some of the data collection instruments took some time. Um, so I think some of that should be sped up. Uh, I think communications and gathering data from manufacturers still will take time. Um, [cross-talk] --

Eileen Cody: [Cross-talk] Because they drag their feet.

Mike Neuenschwander: And, uh, because there's -- yeah, there's a level of give and take in that communication. Um, and so, uh, so yeah, I think we can, we can speed up the process. However, that being said, uh, I kind of prefer to err on the more cautious side. So maybe we did -- we got two -we got two done last year. We did three or so this year, um, to kind of see how that goes. And then I think every year, if we can kind of keep ramping up a little bit, that would probably be, you know, a wise strategy just in terms of, uh, -- let's put it this way, I've seen other states get really ambitious sometimes in terms of their drug review goals, and they've had to completely stop and start over again.

MaryAnne Lindeblad: Do we take advantage or learn anything from them that we borrow?

Mike Neuenschwander: [Cross-talk] All the time. [Cross-talk] All the time.

MaryAnne Lindeblad: [Cross-talk] I'm assuming that we are [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yes.

MaryAnne Lindeblad: [Cross-talk] so that there's a lot [cross-talk] and collaboration.

Mike Neuenschwander: Yeah. No, we meet weekly with the other states in terms of, [cross-talk] uh, yeah. No, we chat with them all the time, uh, and we have a pretty close relationship, uh, with them. Uh, and so yeah, there's a lot of best practices being shared, uh, to the point of actually something to kind of toot our horn, some of the other states that have been ahead of us have actually stopped and asked us how we're doing our drug selection process. Uh, and they are wanting to mimic the work that we have done. Um, so I really think slow and steady has paid off for us and other states, uh, uh, have seen the success we've had and have been, uh, coming back to ask for thoughts as well.

Eileen Cody: So then backing up at the UPL , you're doing the rule making on UPL. Now, that will be done by the end of the year? Is that what you think?

Mike Neuenschwander: Yeah. So, the timeline for the UPL, so you know, uh, yeah, and that's a good question as well. So, uh, we're doing our drug reviews, vote on those here hopefully September is kind of the battle plan. UPL rulemaking process will be finished, uh, at the end of the year, end of the calendar year. However, those rules do not come into effect until 90 days after the next legislative session, which I believe ends April 26th of 2027. So, really, end of July 2027 the rules for UPL will come into effect. That being said, we also -- before we, uh, attend to, uh, vote on any UPLs, we need to -- for the legislation -- we need to post our intentions for 30 days, uh, give people a chance. Then they have 30 days to, uh, come back and object or, uh, you know request a review of our UPLs. then we have 60 days to respond to that request. So really voting a final vote on a UPL potentially could not take -- or could start taking place, uh, at like late fall of 2027.

Eileen Cody: And then we vote, but that does not go into effect until after the next legislative session.

Mike Neuenschwander: Not until again 90 days after the next legislative session.

Eileen Cody: I guess what my I'm trying to figure out is if the ones that we did this year and the ones that we're going to do this next year because of the rulemaking process of all of those, then we could do the UPL and have that go to the legislature in '28.

Mike Neuenschwander: Yeah. So, so yeah, so we would we would finish a second round of drug reviews by the summer of '27. And then those drugs, you know, by the time we actually got to voting on stuff at the end of '27 [cross-talk] --

Eileen Cody: [Cross-talk] Then we could [cross-talk] --

Mike Neuenschwander: Yeah. So, we could have two rounds of drug reviews [cross-talk] eligible to for UPLs at that time.

Eileen Cody: I'm just trying to get it laid out because I think the legislature is going to be asking some of those questions about "What the hell's going on?" Why does it take so long? I can tell them that it was because we made it.

Mike Neuenschwander: Oh, yeah. Yeah. No, no. Yeah. Again, especially with the UPL stuff. I mean, that is all legislative [cross-talk] language driven. So, um, so yeah, uh, that's, that's, that's as fast as we can go. [indistinct] However, I will also say again, just with the timing of these lawsuits in other states, timing wise, whether this was incredible foresight by the legislature [laugh] or --

Eileen Cody: [Laugh] You are a funny man.

Mike Neuenschwander: We'll just, we'll just say that it was, right? I think timing-wise, uh, it's actually working out fairly well again for us to kind of see what's happening in other states. And I think part of kind of the success that we've had so far is because of where we've been positioned in terms of our process compared to other states. We have been able to take a lot of lessons learned, uh, which have helped kind of move us forward. And now again, as I mentioned before, other states are coming back and saying, "Hey, uh, that actually [cross-talk]."

Eileen Cody: Sometimes it best not to be first.

Mike Neuenschwander: Yeah. Yeah. So, um, so yeah, I think we're actually sitting in a pretty good spot, um, all things considered. But those are those are fantastic questions.

Eileen Cody: Just trying to get it all straight.

Mike Neuenschwander: Okay. Um, so, any other questions on the dashboard?

Eileen Cody: So when will we actually -- when will we get it?

Mike Neuenschwander: Yeah. So, we should be able to post this here, uh, within a day or two after the meeting, I think. I think there's -- again, I think Kelly was mentioning there's just a few verbiage things that we need to clean up. Uh, but yeah, the -- previous years' is still posted on the website. You know, we'll just say that one was the 2025 dashboard. This will be the '26 dashboard. Um, and then, yeah. Board members, public, everyone can take a look at it. So and then, uh, so yeah, in terms of number of drugs, uh, any other that -- for review and consideration this next year, uh, and how we want to select those in terms of just taking the top three off of the list or, you know, some biologic, some brand? Uh, any other thoughts from the Board members online or in the room?

Eileen Cody: [Cross-talk] Gotta look at them first -- to really make that decision.

Mike Neuenschwander: Yep.

Eileen Cody: Yeah, what the guys say -- but yeah, I'm [cross-talk] --

Mike Neuenschwander: [Cross-talk] Greg?

Eileen Cody: -- anxious to hear what the -- but yeah -- just to hear what the pharmacist [cross-talk] --

Greg Gipson: [Cross-talk] Yeah. I think, I think -- personally, I think it would be more -- um, I don't know. I'd be more in favor of taking the most impactful drugs rather than just trying to choose from either the biologic and/or brand categories. But that's how I feel, um, just because I think it'll make the most difference. Um, but just another comment on this list, looking at this list, there are like a lot of these that are at the top have either a number of biosimilars available or generics that have come out recently or plan to come out soon. So I think we should just when we get to that point really be thoughtful about how the market might change because this data is a little old, and it'll take us a little while to again go through the legislative process to put upper payment limits on things, um, just to kind of have our own foresight about how impactful our choices will be. Excellent point.

MaryAnne Lindeblad: Very helpful.

Mike Neuenschwander: Doug?

Douglas Barthold: Yeah, I completely agree. I think the, uh, the existence of therapeutic alternatives is -- has to be a critical consideration, and so we -- we'll, uh, we'll want to look at that like Greg said. Um, and then obviously we wouldn't want to do a repeat, right? we wouldn't -- anything we've done. Like if it -- I mean I guess if we, depending on the number that we chose, we wouldn't want to do Enbrel again or --, you know, either -- or I wouldn't want to do that. So yeah.

MaryAnne Lindeblad: Thanks, Doug. Hung, anything.? Any comments?

Hung Truong: No. I concur with Doug and Greg.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: Well, uh, I think that's kind of what we have then for the drug list. So we'll post that, uh, we'll send, uh, links, uh, specifically to the Board members as well. Um, and, uh, yeah, if you have any questions, thoughts, comments, feel free to reach out. We can, you know, chat one-on-one, uh, about answering any of those questions that you have with the team.

MaryAnne Lindeblad: Thanks.

Mike Neuenschwander: Okay. We're on to the affordability report review draft. Great. Okay. So, uh, Marina, uh, we'll, uh, walk through here the public, uh, version of the report. Uh, there's a lot of, uh, you know, of course any of the confidential sensitive, uh, information has been redacted. Um, so we will, you know, we can explain. So really the goal for what I'm hoping to do here is just do a high-level walkthrough of the report. Um, so, you now, if someone wants to dig into, uh, you know, safety and efficacy and read all of the information about that. You know, we'll -- again, we'll post this online, the redacted version for the public. They can read to their heart's content. Um, so we don't want to get into too much of the details there, but just the -- here are the different sections, here is what is generally in each of the sections. Uh, maybe some general highlights from the sections, um, and then we'll walk through the redacted version here with the public. And then after that, we will do an Executive session to walk

through, uh, the other [cough] sections of the report [cough] and the confidential information. Um, so that's kind of the intent and goal. And again, we will post that shortly after the meeting. Uh, both the dashboard and this, uh, is meant to be kind of an introductory here is what it is, uh, here is how it looks, um, and then give people time to take a look at it. So, Marina, if you want to pull up, uh, do we -- let's start with maybe the Enbrel report. Does that sound okay?

Marina Suzuki: Yeah, let me -- yeah, let me do the screen share so that it comes up. Let's see. I'm just waiting for the screen to be shared. Is that coming up on your end?

Mike Neuenschwander: Yep, I can see it.

Marina Suzuki: All right, good. [Indistinct].

Mike Neuenschwander: Um, yeah. Go ahead. Okay. So, yeah, I'll -- both Marina and I will kind of walk through this and take turns talking about some of the different sections. Um, so really, we have here with our, uh, uh the beginning of the report for Enbrel, and we have our drug highlights. Uh, and this is just really a combination of key points of the report which, uh, we felt the Board members would find useful, uh, in getting a good -- overview of the drug, uh, to help make that affordability review decision. Uh, topics include net cost, negotiated price info, patient cost, uh, relevant, uh, information. ICER is the Institute for Clinical and Economic Review.

Eileen Cody: Can you make this any bigger?

Mike Neuenschwander: Uh, Marina, can we can we zoom in a little bit? [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah, I'm doing that. Okay. Is that coming?

Mike Neuenschwander: Maybe a smidge more. That okay? [cross-talk] There we go.

Eileen Cody: That's pretty good.

Marina Suzuki: Is this good?

Eileen Cody: Yeah.

Mike Neuenschwander: Yeah, awesome. Thank you so much, Marina. Um, and, uh, it talks about some of the therapeutical alternatives, key pricing info, R&D info, among other things. Um, so all of these sections are spelt out in a lot more detail later in the report. But again, I think when we were chatting with the Board, uh, at our last meeting, having that kind of I guess so what, uh, executive summary was, uh, one of the things that the Board was looking for. So um, this will this will kind of be your first stop, uh, for looking at stuff. And then you can dig into things more as you are, uh, have questions on specific topics or areas.

Eileen Cody: So this is the redacted step? I feel like we're [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. So this is the public part. Yeah. So we are using the redacted document, but you'll have the full access later in the closed session. So yeah.

Mike Neuenschwander: When I -- when I used to [cross-talk] --

Marina Suzuki: [Cross-talk] Sorry, I [indistinct] --

Mike Neuenschwander: When I used to work overseas, uh, you know, we had, you know, all sorts of, like, top secret documents and, you know, you couldn't read half of it. You know, you're like, "What the…" So, um, but if you look at some of the other states, they've done similar [cross-talk] things with theirs. So yeah. Uh, so then Section I, uh, just has like the background information. Um, and so a lot of this comes from, uh, the FDA, FDB Medi-Span and, uh, uh DynaMedex. Um, so this just goes over basic info, uh, brand, generic names, drug class, national drug codes, uh, various indications, orphan drug status, um, and if there is a orphan or a shortage, uh, for Enbrel, which there is not. Um, and then so in Section II, it goes into the, uh, drug efficacy and safety. Um, and so this section goes through, uh, the list of studies on safety for the various indications, uh, so you can take the time again to review specifics on drug efficacy and safety related to each indication and side effect. Um, uh, however, you know, generally speaking, uh, you know Enbrel, uh, is widely used for, I think, a good reason, uh, because, you know, it's been effective on a number of these indications. Um, so I think that is definitely something worthy of note. Um, then [cross-talk] --

Marina Suzuki: A hand from Doug.

Mike Neuenschwander: Well, Doug.

Douglas Barthold: Yeah, thanks. Um, so in the indication section, um, do you list, uh, therapeutic alternatives. And also do you list, uh, prevalence of that, uh, of that indication?

Marina Suzuki: [Indistinct] alternatives that will come to a later section.

Douglas Barthold: Okay. So that's, that's, that's shown later? Okay. Thanks.

Marina Suzuki: Yeah. And I just want to thank the manufacturer for putting all the information together for these structures. It they did a pretty comprehensive review for us, uh, which made, you know, our job really easy, um, just in validate and clean up the information, uh, for our purpose here. Uh, but the -- a lot of bases and that's done by the manufacturer. So I just want to acknowledge their effort here, um, about this section.

Mike Neuenschwander: Yeah, with the -- yeah, that I think that was a pretty, uh, extensive section as well. So yeah. No, I echo Marina's comments in terms of appreciation, uh, for the manufacturer on that. Uh, so Section III, uh, most of that is, uh, is confidential information. Um, and so, uh, this drug -- various drug price information comes from the manufacturer, FTB, Medi-Span, uh, SSR Health, um, and PBMs. Uh, and so, uh, it goes through, you know, wholesale acquisition cost or WAC average, uh, manufacturer price or AMP discounts, rebates, PBM payments. Um, so again, as you scroll through, uh, there's a lot of black on this section just again because of some of the sensitivity around, uh, that specific, uh, information. But we'll review that more in depth in executive session with the Board members [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. And the native information um, native information is published on the CMS website, so this is open to the public. Um, but any other pricing information, like Mike said, are coming from the manufacturers PBMS and also some proprietary database, uh, redacted. So that's why you see a lot of big black boxes. Uh, and for the Board members, you'll have the full access, uh, later in the closed session. I'm going to skip through these pages.

Mike Neuenschwander: So next, we come to manufacturing, delivery and administrative costs, uh, most of this came from the manufacturer as well. So it is also confidential, um, and so thus, uh, we have a few more black boxes, uh, uh on that section. So, um, Section V is Patient Costs. So these are pulled from the Washington All Payers Claims Database, uh, and payer submissions. Um, and so we'll see here, uh, there's a number of tables around, uh, patient co-pay. Um, and so just for general people's reference, copay refers to the, uh, specific financial, uh, information tracking the fixed out-of-pocket costs a patient pays for the covered healthcare service or prescription. Um, it also goes over patient co-insurance, uh, and co-insurance [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah.

Mike Neuenschwander: Go ahead.

Marina Suzuki: Yeah, that's a good point because I want to point out, you know, the co-pay and co-insurance are separated into two separate sections that you get the detailed information, not just ramped up as out of patient, you know, cost. Uh, so just pointing out this is only for the copay. And the next section is for the co-insurance only. So again these are two separate sections on the report.

Mike Neuenschwander: Yeah. Yeah. Thank you, Marina. So, yeah, the co-insurance is the percentage of the covered medical bill you must pay after you've met, uh, your annual insurance deductible.

MaryAnne Lindeblad: Not really being able to tell exactly what those are, but are those graphs -- is that like the range that you have?

Mike Neuenschwander: Yeah. So, uh, on the graphs -- so if we go up to -- uh, I guess the first one on [indistinct] the copay.

Marina Suzuki: The copay. Okay.

Mike Neuenschwander: Yeah.

Marina Suzuki: Um, yeah. So how it's organized is under each section the table gives you a detailed breakdown for the most recent year. And in this case, it's 2023 that's the most comprehensive data set we have in the APCD, uh, so you

get that years' data in the table. And to look at the trend, you get the graphs. Um, and also in the closed session we can go through dashboard as well if you have any specific thing you want to look it up. Um, but in the report, again, you get the table that's detailed data for the most recent year, and then in the graph you'll get the trend for the past five years.

Mike Neuenschwander: Yeah. So on each of the NDCs you can see, uh, the number of patients, units dispensed, uh, total co-pay amount for all Washington payments, and then the average co-pay for the 30-day supply. So you can kind of see, you know, generally speaking, you know, for example, uh, you know, some of the upward trends in terms of, you know, co-pay costs and, uh, uh, usage and things like that here, uh, in the various graphs.

Marina Suzuki: Yes. And we are showing for the top three NDCs by the Washington utilization, so on the X-axis you see data from 2019 to 2023, which is the most recent one. And this is the syringe, and this is the SureClick pen, and this is the mini cartridge. Uh, so, again, you see the price shift over the five years. And the first part is the total copay amount, and the bottom part is the dispensed units. So how many units are dispensed? um, and then the top you see how much they were. And exactly the same um, format for the co-insurance as well. In the table you see a detailed information for the most recent year, which is 2023, followed by the graph, uh, to see the trend for the past five years. So this is for the 30-day supply shift of the co-insurance amount for each patient. So this is per patient information. And in this big figure you see the total payment as just for the co-insurance amount. Um, and again copay is not counted into this amount. It's just the co-insurance. Um, the same format you see from 2019 to 2023 on the X-axis. And then you see the three the most common products used in the Washington, so the syringe, the SureClick, and mini cartilage. The top part is the dollar amount, and the bottom part is how many units are dispensed.

Mike Neuenschwander: Great. Thank you, Marina. Any other questions on the graphs?

MaryAnne Lindeblad: At this point, [cough] it's hard to see. Yeah.

Mike Neuenschwander: Okay. So next we have, uh, insurance premium deductible and patient out-of-pocket maximums. Uh, those, those are, uh, confidential. But the

following bullet is payment responsibility, or payment responsible by patient per claim. Um, so Marina [cross-talk] --

Marina Suzuki: [Cross-talk] I think -- yeah. Yeah. So this is more like the whole like patient out-of-pocket cost. So co-pay, co-insurance all combined. Um, how much was it? So again the same format in the table, um, you see the most you know recent data, uh, by the NDC. And again this is from 2023. And then you see a graph for the past five years for the 28-day supply. Um, and this is for the per patient amount. And then yeah I think those are the -- yeah this is the protection for the per patient cost.

Mike Neuenschwander: Yeah. And I think, uh, interesting parts, you know, are the average, uh, again payment for the 28-day supply. Uh, you know, then you have your minimum and then your maximum.

Eileen Cody: What's proprietary about premiums and the one that you have redacted right there?

Marina Suzuki: Uh, so the data source is different. So the section you saw, the co-pay, co-insurance, and out of patient -- out-of-pocket patient cost that comes from , but the premium, um, and then the deductible that information comes from the payers. Um, so that's why this is -- this part is redacted. It's just a different data source.

Eileen Cody: But they had to file that.

MaryAnne Lindeblad: Yeah.

Eileen Cody: It's public information, the rates. I'm surprised. I mean, it just doesn't [cross-talk] --

Mike Neuenschwander: Yeah, didn't it to do like with the number of payers that we were working with, Marina?

Marina Suzuki: I think it was in the legislation. Well, technically whatever the information the Board collected, it's considered confidential. Um, so it goes to the next criteria whether how easy it is for the public to find the information. So APCD, that's public information. FDA website, that's kind of public information, so that's open, um, in our report. But anything we are collecting, um, that's blacked out on this report.

Mike Neuenschwander: Okay. Any other questions?

Eileen Cody: We just think that was weird.

MaryAnne Lindeblad: Yeah.

Mike Neuenschwander: Okay.

Eileen Cody: [Laugh].

Marina Suzuki: Yeah. I know we just were reading and, like, what do we have to redact or not, and it was, yeah, very complicated.

Mike Neuenschwander: Well and just kind of as a point of note, we have spent a lot of time trying to make sure we are keeping the correct data in the correct buckets [cross-talk] --

Eileen Cody: [Cross-talk] You're going to error in the direction of protecting. I get it.

Mike Neuenschwander: Yeah. Yeah. So yeah, we've -- yeah. I can't even tell you how many meetings we've had of trying to, trying to make sure that, you know, everything is on, you know, the right spot and in the right place. And we're trying to put, you know, as many appropriate protections because I know that was a big concern the industry had. So, we really wanted to show that we were trying to be responsive to that.

Marina Suzuki: All right, moving on.

Mike Neuenschwander: Okay. So Section VI. Um, so yeah, price effect on consumer's access to the drug. Uh, so the first bullet, uh, there that was, uh, uh, redacted is, uh, around sales volume, uh, received from the manufacturer. So, you know, keeping that, uh, you know, confidential. However, uh, in the next one we go around recent utilization in the state so we can see the total number of patients, units dispensed, um, and payments, um, so the usage of, uh, the drug and the, uh, the units dispensed. Um, I think when we look at some of the graphs, uh, uh, it shows it's you know been holding relatively steady, I guess, over the last five years; however, payments, you know, do seem to be increasing. So then we go to, uh, Section VII. Uh, so here again, a lot of these parts are going to be, um, confidential, uh, because this is

around, you know, the patient assistance programs, um, and coupons. And so, you know, this goes over, you know, some of their availability and, you know, a wide number of pieces of information around discounts and all that other stuff. So, uh, we can kind of keep going. Uh, then Doug, kind of to your question here around therapeutically equivalent drugs. Um, and so we'll talk about some more of that, uh, in the confidential, uh, or executive session as well. Okay. And then Marina, do you want to chat about this section?

Marina Suzuki: Uh, yes. I think this is one of the key sections because the Board can make a decision based on the comparison with the therapeutic alternatives. And the, you know, one of the biggest questions is, what's considered a therapeutic alternative? And we collected information from the manufacturers, what they think, um, is the alternatives, and we reviewed the information, um, from the manufacturer and also the guidelines. Um, some information from the ISER, um, and then whatever is published in the medical literature in general. Um, and then the these are the lists that we have. We are limited to the TNF-inhibitors, and the indications slightly differ. Um, so the five indications for Enbrel, and not like all of the drugs indicated for all the indications, uh, with Enbrel. So, um, again this is just a quick reference table for you. Um, and after that we are reviewing for each indication. So the first one is a rheumatoid arthritis. Um, you have the potential alternatives listed here. Um, some information from the guidelines, how, you know clinicians can use one drug over the other. What are the recommendations based on the evidence? Um, and also we try to review multiple guidelines, not just the US one but more like a global, uh, or European, uh, guideline that's also reviewed. And just a head's up, they usually match pretty well. They align well. So, again, it's all summarized here. And then, uh, some place in therapy. So this is more a detailed comments regarding what's considered as first line, second line, etc. Um, so hopefully, this is helpful. And we do have some pricing comparisons among all these drugs, uh, but again, it's coming from the proprietary database. So this is redacted, and then, uh, you get a more detailed, um, efficacy and safety comparison in the following sections. And then I think if you get the just the punch point and what, what is the -- what is the punch line, then go to the summary table at the end of each indication, it will have a summary table comparing the therapeutic alternatives, the pricing information, efficacy and safety. So each, yeah, summary table are placed under each

indication. Uh, so yeah. So that's indication one, indication two [audio cuts out].

Mike Neuenschwander: Oh, Marina?

Marina Suzuki: Yeah?

Mike Neuenschwander: You there? Okay.

Marina Suzuki: Hello?

Mike Neuenschwander: Okay. Okay. We can hear you now.

Marina Suzuki: Oh, okay. Okay. Good. Yeah. Yeah. So, yeah, everything follows the same format. Um, I think what's, you know, most interesting or maybe helpful is to look at the guideline summaries and also the summary table under each section and then the pricing tables. Yeah. And that's going to be available to the Board members. And the last part under this [indistinct] section is the or some discussions regarding are there any same class drug that's not considered therapeutic alternative. Um, so this is sort of an exclusion criteria [indistinct] do not consider these therapeutic alternatives. And I agree with the comment from the manufacturer. Um, you know, we shouldn't, you know, include other drugs with different mechanism of action of alternative. Um, so that's just a brief description there.

Mike Neuenschwander: Doug, do you have a question?

Douglas Barthold: Yeah, thanks. Um, this is fantastic. Uh, the thing -- the question that I -- and I may have missed this, uh, but do we have any information about the prevalence of each of the indications in Washington State?

Marina Suzuki: Oh, that comes in a later section.

Douglas Barthold: Oh. That comes in the later section. Oh. Oh, okay. Yeah because that's what I -- when I -- when I'm looking at the, you know, the therapeutic alternatives, I want to -- I want to focus my attention on the most common indications. And, you know, and if some of the indications are super small, I probably will pay less attention. [cross-talk] --

Marina Suzuki: Yeah, and I should just point it's likely the rheumatoid arthritis and also the psoriasis indications, those are the two major ones here. And the -- okay, so let's move on to Section X. That's the ICER cost effectiveness analysis. Again, the ICER publish their report to the public, so anyone can access the whole report. Um, but here, I'm just including the most key -- important key tables, and they do not publish for every single indication. They look at usually the most impactful ones. So they have a report on the RA or rheumatoid arthritis and also the psoriasis. So these are the two I've included here in our report as well. Um, so you see the reviewed drug and belong on top, uh, followed by the therapeutic alternatives we reviewed on the section previously. And I want to point out that these, um, reports are not very recent. So the rheumatoid arthritis one, that's from the 2017, and the psoriasis one is 2018. So that's why, you know, you don't see a lot of like newer drugs listed here. Um, yeah, so just that's the caveat for us to be [audio cuts out] of. And in the closed session we can look at the interactive model available from the ICER, so we can play with that. Um, so this is Section X. Um, and for the Board members, if you go to the SharePoint website, um, I've placed, uh, the whole report as well as like a two-page quick summary from ICER regarding these reports um, in case you're interested in more details. Uh, so that's under the supplemental materials subfolder um, on the SharePoint. All right. Mike, do you want to move on to the next section?

Mike Neuenschwander: Yeah. So, uh, so yeah, we have Section XI, uh, additional information, which, uh, has a lot of the exclusivity and patent date, uh, and some of the revenue information, uh, related to that. So also confidential. Um, and Section XII, uh, off-label drug use. Um, so I think, uh, Doug, uh, maybe some of the -- I think other information you might be looking for, um, uh, around utilization will be, uh, in there. Um, and then Section XIII with pharmacy, uh, benefit manager policies, uh, that's also confidential. So then that takes us to our, uh, summary input, um, from the advisory groups. Uh, and so the we've posted already to the website, uh, the advisory group reports, uh, so people can go through and take a look, uh, at that. I appreciate our advisory group members and the time that they took to, um, talk about some of the different aspects of each of these drugs from their various, uh, clinical perspectives um, and their jobs and some of their professional thoughts and insights. So I'd encourage you to take time to read those reports as well. Um, and here we just have a highlight of some of that input, uh, which talks about, uh, you know, some of the limitations, uh, around the drugs, uh, a few of the patient

stories um, difficulties, uh, with maybe some of the patient, uh, assistance programs that they've experienced, um, and then some of the, you know, challenges with costs, um, or looking at, uh, you know, how people, uh, try and manage, uh, drugs with some of their other alternatives. So, uh, I think, again, I will I won't read through everything here, but I think this is a good summary report from the advisory group. Um, and then the full advisory group report again, uh, is here in your binders as well as posted online. So you can take a look at that.

Marina Suzuki: Yes. That advisory group report that's available to the public as well, and it's already posted on our website.

Mike Neuenschwander: Great. Um, and then the last part, uh, is around some of the summary info from patients. Uh, I think one of the difficulties that we had, and this has been a problem with all of the other states as they have tried to do patient outreach. It's just a limited number of responses and trying to get, uh, some of just getting out there and getting some of that information, uh, from some of these patient groups. I know, uh, multiple other states have done, um, you know, they've tried to do, you know, public community forums and meetings, um, of which you know attendance was always difficult. And, uh, in the meetings they did have, uh, they may have had, you know, uh, a couple of actual patients, but most of the people who showed up were usually various industry representatives. Um, and so, uh, getting patient feedback I know has been difficult. Uh, for Enbrel, we had nine responses to the patient survey, one response to the expert survey. Um, and so, uh, I think that's something that as all of the states where we've been talking about fairly regularly, you know, what's the best way to engage, um, and reach, uh, people to get their stories? Um, and so, uh, some of the respondents really focused throughout the surveys of, uh, discussing, you know, if they had the questions focused on discussing if they had troubles reporting, um, Enbrel, if they delayed picking up the medicine or took reduced amounts because of pricing, uh, their use of patient assistance programs, uh, insurance cost, and then shared personal stories about affordability. Um, and so I know with Enbrel, we got a number of horror stories of some people, you know, talking about some of the difficulties they had. Uh, and we also did get, uh, a couple positive responses saying, "Hey, Enbrel is a great drug that works for me." Um, so, uh, a little bit of variety there in terms of some of the feedback that we've gotten from the surveys. And that really kind of takes us to the end of our, uh, work for

Enbrel. So, again, we'll post this online so people can, you know, dig in and look at the sections that interest them most. Um, and, uh, and then yeah. Any questions on this before we move on to the Xtandi public?

Eileen Cody: All right. I [indistinct] on the advisory groups. I'm looking at this. I -- what happened that Dharia or Camille [audio cuts out] both have testimony?

Mike Neuenschwander: So I think, uh, Daria, uh, with, uh, her -- just her, uh, position representing, uh, PhRMA, uh, you know, I think reasonably declined to, to, uh, to comment on, uh, you know, these particular reports.

Eileen Cody: So like on a specific --

Mike Neuenschwander: Yeah.

Eileen Cody: Okay. Well, I'm kind of confused by that. So that why be on the Board? [Cross-talk] --

Mike Neuenschwander: [Cross-talk] I think [cross-talk] --

Eileen Cody: -- Advisory Board?

Mike Neuenschwander: Well, per the legislation we needed, uh, pharma industry representation on the Board. And I will say, uh -- and I think Dharia is on here today -- but I know a lot of the feedback that we've helped incorporate, uh, into, you know, our confidentiality and, uh, our drug selection process. And a few other things have been driven in large part by some of the comments that we've received from, uh, PhRMA and Dharia and some of her colleagues as well.

Eileen Cody: And then the Kaiser's Medical Director for [audio cuts out] Ronin.

Mike Neuenschwander: Uh, so I think she was more on -- she was our specialist more for Xtandi, if I'm not mistaken. So she was [cross-talk] --

Marina Suzuki: [Cross-talk] Yes. Yeah. She provided comments for the Xtandi review.

Mike Neuenschwander: Yeah. Yeah. Because we have our core advisory group, uh, who, you know, kind of comment on everything. And then we brought in specific

people, uh, relevant to the specific drugs that we reviewed. So she, uh -- Marina, she helped us with the, uh, safety and efficacy review.

Marina Suzuki: Yeah, we'll go over that next.

Mike Neuenschwander: Yeah, she did a ton of work in terms of, uh, helping us go through that. But yeah, her focus was more on Xtandi. Oh, Dharia.

Dharia McGrew: Yes, thank you. Um, can you hear me? Thanks for the, uh, question. Yeah, um, exactly what Mike said. Um, as a representative of the trade association, we are focusing our comments on, um, general, uh, processes, procedures, regulations, things that will apply to all drugs and won't be commenting on any specific, um, drug reviews. Thanks.

Mike Neuenschwander: Oh, thank you, Daria. Uh, and again, I will definitely want to give credit where credit was due. Uh, PhRMA has given us a lot of excellent comments and feedback that have helped, uh, shape some of our processes. Um, so I appreciate you taking the time to work with us, Dharia. Okay, so that is Enbrel, uh, the high-level overview. Um, and so we can close this one and then go to the Xtandi.

Marina Suzuki: Yeah, this is Xtandi report.

Mike Neuenschwander: Oh, this is? Okay, perfect.

Marina Suzuki: Uh-huh.

Mike Neuenschwander: You're, you're way ahead of me, Marina. You're awesome. Um, so, uh, this one we might go through a little bit faster because, again, uh, the general categories are going to be all the same. Uh, so unless you have some specific, uh, questions about a specific piece that -- there are a few differences. Um, but, uh, but yeah. So, uh, report highlights are going to be the same. Again, I think the highlights are really the I think the meat and potatoes that will help the Board focus in on some of the key pieces of information that are most important towards making the actual decision of this if this drug, uh, you know causes excess cost to Washington patients. Um, the Section I background information, again, uh, same just generic, uh, information about the names, drug class, national drug codes, um, if there's a drug shortage for Xtandi, which

there is not. Um, then Section II, uh, this one's a little bit different than, uh, our Enbrel section.

Marina Suzuki: Um, yeah, I want to point out here -- um, so extended report, we got a pretty extensive help from our advisory Board Members Camila and Steven. So we have a separate um, report. It's called Therapeutic Summary for PDAB Affordability Review. Uh, so this is, again, it's a totally separate document. Um, and we will be publishing this to the public as well because this is just a review of medical literature, the evidence. Um, nothing is confidential. So the whole report it's going to be available, uh, on our website later when we post with a redacted report. Um, yeah. And this goes to in drug efficacy safety. And also they did a quite detailed review of the guidelines, um, and therapeutic alternatives that's available as a separate document. So that -- so this is, this is going to be the biggest difference from the Enbrel. Enbrel is like all in one report. Um, but for Xtandi, we get a separate summary for the therapeutic use. And this is just a, you know, really brief -- a few paragraph descriptions of the prostate cancer.

Mike Neuenschwander: Great. Thank you. Yeah. And again, I really want to express appreciation to, uh, our advisory group members who helped extensively with that. So, uh, really, uh, yeah. Thank you so much.

Marina Suzuki: Yeah. And also the manufacturer, they did a lot of, you know, like leg work of collecting the evidence and summarizing them for us. So we appreciated that collaboration.

Mike Neuenschwander: Yes. Yeah, that's a thank you very much as well, Marina, with that. Um, Section III, again around the drug price information talking about the WAC, discounts, rebates, PBM, uh, payments, uh, so most of this is going to be confidential. Uh, so we'll see, uh, that manufacturing delivery costs again, uh, administrative cost same thing. Most of that will come from the manufacturer, so also confidential. Um, then we go to Section V, Patient Costs. So this is similar data to, uh, what we were talking about with Enbrel in terms of, you know, the top three NDCs, the number of patients um, related to co-pay, co-insurance, and then combining those. Uh, for the total cost, so you can see for 30-day supplies, uh, you know, how much it cost people and then the general, um, patterns. I will say if we can go to like the co-insurance and take a look at that graph there. There we go. Um, so we do see some variation with the graphs. With the other

one, you know, things were either kind of steady or generally increasing. Um, this one, you know, one of the questions I had is looking at this, uh, you know, we see some fairly uh, interesting deviations in price uh, going up and down. Um, and so I think with some of this as we were discussing, um, from the data sources that we have as things, uh, change from year to year. Uh, you know, the -- picture changes. And I don't know, Marina, if you want to talk a little bit about, uh, maybe some, some of the deviations in the graph or the way it looks why that may be with the data that we're using [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. Again, this is like separating out patients with copay versus co-insurance. Um, so it's not usually consistent year to year. We don't have exact same number of patients on the same insurance plan. So it just could be various reasons, you know, insurance, uh, plans. You know, the percentage coverage that might have changed or maybe availability of the alternatives. It could be different reasons. Uh, but yeah, the graph just shows you some trend how, you know, variable the up and down could be. Yes.

Mike Neuenschwander: Thank you, Marina. Um, yeah. And then at the end we have the, um, [cross-talk] --

Marina Suzuki: [Cross-talk] [indistinct] yeah. And then at the end we have the, uh, payment responsible by patient per payment responsible by patient per claim. Um, and so I think, again, interesting things to see how your averages, uh, your mins and your maxes of -- what those claims can look like. So uh, then we go on to Section VI. So these first two parts of Section VI are confidential because they talk about the prevalence of the indicated condition and sales volume, uh, which we got from, uh, some of that information from manufacturer. Uh, but in the next part it talks about recent utilization within Washington, um, so that's interesting. We can see the total number of patients, units dispensed, and payments. Um, and then we go on to Section VII. It is going to be again around our manufacturer, uh, patient assistance programs and coupons, which is confidential. Um, Section VIII, which is therapeutically equivalent drugs, is also confidential. And then Section IX, uh, we talk about price availability for therapeutic alternatives. Again, Marina, similar to what we talked about on Enbrel. Um, so [cross-talk] some of those key tables that we identified [cross-talk] --

Marina Suzuki: [Cross-talk] Yeah. We identified with three to be the therapeutic alternative based on the review of, um, evidence as well as submissions from the manufacturers. So this section looks much, much shorter compared to the Enbrel report because a lot of the information regarding the guideline, efficacy, safety, comparison, etc., that will be under this therapeutic summary document, so that's just separate. And this whole report just has the quick, you know, lookup table here and the pricing comparison. So that's why it just looks very, you know, much shorter compared to the Enbrel report because, yeah, a lot of information went to the therapeutic summary document. And then yeah, and the next section, again, is ICER cost effectiveness analysis. Um, the table is here. Um, again, this is a bit older report as well, and you have the whole a bit -- you have access to the whole report and also the summary [indistinct], um, to a one or two-page [indistinct] summary from ICER in -- under the supplemental, uh, materials subfolder for the Board members.

Mike Neuenschwander: Great. Uh, additional information from the manufacturer talks again about patent dates and revenue information, uh, which is confidential. Um, Section XII talks about off-label drug usage, uh, which is not applicable, uh, in this case. And Section XIII, uh, again, talks about, uh, PBM, uh, policies. And then with Section XIV, again, we come to, uh, the summary input from the advisory groups. Uh, again, we have the full report, uh, here in this folder and also posted online so you can dig into that. Um, and this covers, uh, a same a lot of the same topics in terms of, uh, you know, their perspective, uh, from their professions of, uh, the drug. And then finally, survey again. Uh, we had -- for Xtandi, we had, uh, six patients, uh, survey responses and 12 expert survey responses. So, uh, that was kind of an interesting change up from the previous one. Um, and again, discussing, uh, how if they had troubles affording Xtandi, if they delayed picking up the medicine, patient assistance programs, insurance costs, uh, shared personal stories about affordability. On this one, we didn't have, uh, nearly as many, uh, personal, uh, specific, uh, stories or um, experiences that were shared. So um, but, uh, yeah so that's these are the public, uh, sections of, uh, the report which we'll be posting. And any other questions on that?

MaryAnne Lindeblad: It doesn't look like it. I don't see any.

Mike Neuenschwander: Okay. So, with that, um, I think that ends this piece of the meeting. Um, and I don't know if the Board wants to take a short break, and then we can come back to the executive session?

MaryAnne Lindeblad: So, just on the agenda, so we've got public comment later or at all.

Mike Neuenschwander: Hmm.

MaryAnne Lindeblad: I mean, I guess thinking -- guessing, should we do public comment and then do the executive session?

Mike Neuenschwander: See, this is why you're the Chair.

Multiple Speakers: [Laughter]

Mike Neuenschwander: So, uh, yeah. That, that might be a good idea, [cross-talk] uh, just so we can, uh, uh -- so we can, uh, just get that done [cross-talk] so that way people aren't hanging [cross-talk] out waiting [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Right, exactly. [Cross-talk] --

Eileen Cody: [Cross-talk] and won't know when to come back, so --

MaryAnne Lindeblad: Yeah.

Mike Neuenschwander: Okay.

Michael Tunick: And then sort of the break for -- before executive session could be that the technological whatever to move us, we could just be like, "Okay, we're gonna come back in five minutes," and [cross-talk] --

Eileen Cody: [Cross-talk] Yeah. Yeah. [cross-talk] That makes sense. [Cross-talk] --

Michael Tunick: [Cross-talk] -- we set up.

Eileen Cody: [Cross-talk] Should we go ahead and do public comment?

Michael Tunick: [Cross-talk] Julie may also need a break.

Mike Neuenschwander: Yeah.

Michael Tunick: I shouldn't prevent you from [indistinct]. Sorry about that suggestion.

Julie Colacurcio: Oh, no.

MaryAnne Lindeblad: Then do we have anybody signed up?

Mike Neuenschwander: Uh, so I think, uh, we do have one question here, uh, that maybe I can answer really quickly, um, and, uh, then we can open it up to anyone who has a comment, if they can raise their hand and then we can open the floor to them. Uh, so the first question was that we noticed that, uh, Cabometyx and Humera are still on the PDA website. Are these drugs going to be reviewed in addition to the 2026 dashboard list? Um, and so I think -- of course, I'm open to whatever the Board would like to do. [cross-talk] --

Eileen Cody: [Cross-talk] [indistinct].

MaryAnne Lindeblad: [Laugh]We appreciate your thoughts.

Mike Neuenschwander: But, uh, I think I thought when we were discussing during our last meeting, we mentioned, uh, just looking at the new list and just starting -- or just using the drugs off of the new list. So that way -- I think Doug mentioned just using the drugs that have the most recent impactful data for our next reviews. Um, so [cross-talk] --

MaryAnne Lindeblad: And that makes sense.

Eileen Cody: So in other words, -- those two might end up there but might not.

Mike Neuenschwander: Yeah. So yeah. If they are reselected, I think, with the new drug list, and I, and I believe they both are still at the top of the 2026 list. Um, so that's a possibility but not necessarily that they guaranteed.

MaryAnne Lindeblad: So is there any other comments from any Board members on that one? [Audio cuts out] like it.

Mike Neuenschwander: Okay, cool deal. Um, any other comments? Is there any other hands who would like to speak? [Indistinct] Dharia, you don't have anything to share at this time?

Dharia McGrew: Well, since you asked.

Multiple Speakers: [Laughter]

Mike Neuenschwander: Well, I mean, you've just been like a really solid staple. So, you know, I hate to break a, you know, a tradition.

Dharia McGrew: Uh, thanks. Thanks so much. Dharia McGrew. Uh, hold on, let me -- one second here -- and fix my microphone situation. Sorry. Uh, Dharia McGrew on behalf of PhRMA. Thank you so much. Um, really looking forward to seeing the dashboard and the reviews when they're public. Uh, my only question is can you please confirm when you expect to have these posted publicly?

Mike Neuenschwander: Uh, by the beginning of next week, uh, I think at the latest. So sooner rather than later, most definitely.

Dharia McGrew: Okay. Thanks.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Anything else? Anyone else? So, it looks like we can go ahead and close this part of the meeting and for the Board members to take a break and staff, and we'll be [cross-talk] return in like 5 minutes.

Michael Tunick: Yeah. So I just want to kind of read here from the Open Public Meetings [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Oh, okay. [cross-talk] Thank you.

Michael Tunick [Cross-talk] -- Act [cross-talk] before convening an executive session. A presiding officer shall publicly announce the purpose of the meeting and the time when the executive session will begin. So we've got a PDAB specific reason for executive session that you can quote from here.

MaryAnne Lindeblad: Well that's good. I'm glad that's [cross-talk] --

Michael Tunick: -- that's been highlighted [cross-talk] --

MaryAnne Lindeblad: All right. Consider moving into an executive session to consider proprietary or confidential data collected or analyzed pursuant to Chapter 70.405 RCW.

Michael Tunick: And then, um, I don't know if we're running ahead and suggest that we, uh, don't want to even though the public portion of the meeting is done, we will be gaveling back in after the executive session to officially close the meeting.

MaryAnne Lindeblad: So we do need out and then come back.

Michael Tunick: Yeah. Or we do need to like -- yeah. Like tell the public instead of when we will be coming back. So if we're running ahead, we don't need to say that we're going to come back at noon. We could say that we're going to come back at [cross-talk] --

MaryAnne Lindeblad: Well, it's unclear when we're going to come [cross-talk] --

Michael Tunick: [Cross-talk] Yes.

MaryAnne Lindeblad: -- back would be my guess.

Mike Neuenschwander: So --

Michael Tunick: Yeah. So if we needed additional time, [cross-talk] we come back in and we gavel back into the public meeting, "Hey, we need an additional 15 minutes. We'll be back at 11:15." [Cross-talk] --

Mike Neuenschwander: Maybe if we take a little break, uh, start our executive session at 10:00, go to 11:00, [cross-talk] and then if we need to gavel back in for a little more time, we can tell them. Uh, so I think -- I think we'll -- we can close this public meeting. We'll just come back in at 11:00 [cross-talk] whether we're going to close the meeting out or ask for a little more time. We'll reopen this team's link at 11:00.

MaryAnne Lindeblad: Okay, That sounds good.

Michael Tunick: So that's -- so like the robot in me is like can the presiding officer say that we're going to convene at 11:00? [laugh]

MaryAnne Lindeblad: I can see that. [laugh] Yes.

Eileen Cody: [Cross-talk] in charge.

MaryAnne Lindeblad: [Cross-talk] Yeah. So we're going to close this out for now, and we will be reconvening -- excuse me -- reconvening the meeting at 11:00.

Michael Tunick: Thank you for saying public.

MaryAnne Lindeblad: Public at 11:00. All right.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: So 5-minute break.

Michael Tunick: Okay.

Mike Neuenschwander: Okay. All right. And we will close this team's link until 11:00 when we come back.

MaryAnne Lindeblad: Come back. Yes.

Greg Gipson: And then we'll join you back on the other link. Is that correct?

Eileen Cody: Executive.

Mike Neuenschwander: So there's a separate executive link, uh, that we sent to the Board. So you guys will join on that one. If you have any problems, shoot me an email and then we can maybe do a tech phone call to adjust.

Greg Gipson: Perfect. Thank you.

Eileen Cody: Seeing this cracks me up because [indistinct] the Board [indistinct] [audio cuts out] quality. Yeah.

[end of audio]