Exhibit 4C-

Written Comments

(Request January 27, 2025)

EACH PIC COALITION

January 22, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Public Comments on Drugs Subject to Cost Review (Farxiga)

Dear Members and Staff of the Maryland Prescription Drug Affordability Board and Stakeholder Council:

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) is a two-part coalition that unites patient organizations and allied groups (EACH), as well as patients and caregivers (PIC), to advocate for drug affordability policies that benefit patients.

On behalf of our national network of coalition participants, we appreciate the opportunity to provide comments to the board on Farxiga. We continue to urge the board to carefully evaluate the impact implementing UPLs could have on patients in the state and to consider the concerns of patient organizations as they proceed with cost reviews and consideration of UPLs.

Ensure Patients Will Benefit from Cost Reviews

UPLs fail to address many of the underlying causes and complicated factors that result in higher prescription drug costs for patients. There are also no current mechanisms in place to guarantee that payers who benefit from UPLs will pass along savings to patients.

Therefore, we urge the board to focus its time on identifying and addressing patient-reported obstacles to drug affordability. Failing to resolve the underlying factors that lead to higher costs for patients can result in short-term relief and uneven benefits – aiding some but potentially leaving others with higher costs and drug accessibility challenges. Additionally, regulators should clearly define cost-saving targets, including what percentage will be for patients and what will be the state or the broader healthcare system.

Enact Patient Protections

At their core, cost reviews necessitate selecting individual drugs for review and implementing market interventions for the selected drugs. This alone puts PDABs in a position of picking winners and losers between drugs and within the broader population of Maryland patients.

While UPLs are intended to lower costs for patients, the reality is that they will create a new incentive structure for payers that could compromise patient access to the selected medications due to increased utilization management or reshuffling of formularies. We appreciate the board's recognition that this could be a consequence of UPL implementation; however, we are disappointed that the board only intends to monitor for these types of changes after the UPL has been implemented.

Instead, we urge the board to work with the state legislature to put in place safeguards for patients prior to moving forward with UPL policies to protect patients from increased utilization

management, compromised access to drugs under review, and other unintended consequences of the board's actions.

Focus on Patient Experiences and Perspectives

Finally, we continue to urge the board to ensure that patient experiences are a critical focus of the process to identify the appropriate policy remedy. Rather than immediately proceeding to a UPL, the board should instead take the opportunity to gather more in-depth input from patients to better understand the source and reasons for affordability challenges.

We invite the board to engage with our coalition participants who can serve as a direct conduit to understanding and incorporating patient and caregiver perspectives and who understand the life cycle of disease from the lens of prevention, diagnosis, and disease management.

While our health system and the policies that impact it are complicated, one principle is simple: every change that we make and policy we implement should ultimately benefit patients. We urge the board to keep this principle as a singular focus of the policy review process.

We look forward to continuing to engage with staff as cost reviews proceed. We invite any and all opportunities to speak directly with any board member who would be interested in more detailed perspectives from our national network of patient organizations and allied groups (EACH) and patients and caregivers (PIC).

Sincerely,

Tiffany Westrich-Robertson
Ensuring Access through Collaborative Health (EACH) Coalition and Patient Inclusion Council (PIC)

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Farxiga

Maryland is working to support affordability through its Prescription Drug Affordability Board, while advocates press for the expansion of this authority to help more residents. Among the drugs up for review by the PDAB is Farxiga (dapagliflozin). Farxiga is manufactured by AstraZeneca and is used to treat diabetes, heart failure, and chronic kidney disease.

Farxiga has brought in more than $20 billion in revenue for AstraZeneca. As AstraZeneca reaped huge profits by charging Americans ten times more than it charges comparable countries, the company spent billions on self-enriching activities like executive compensation and dividends (a way publicly traded companies return cash to investors).

AstraZeneca has generated over $20.9 billion in sales revenue from Farxiga since its launch in 2014.

- Revenues obtained by AstraZeneca through Farxiga sales are nearly **30 times** the median cost for research and development of a new drug estimated by experts.

AstraZeneca charges Americans the highest price in the world for Farxiga.

- Farxiga's list price is $582 for a 30-day supply — this is 10.8 times higher than the average price across comparable countries ($54), according to a recent analysis.

AstraZeneca ripping us off is even more egregious considering significant taxpayer contributions to research prior to the approval of Farxiga, including $437.3 million[1] in NIH funding for basic and applied research.[2]

AstraZeneca uses predatory patenting tactics to expand monopoly protections over Farxiga. This staves off generic competition — a proven way to lower prices — keeping prices higher, longer.

- According to Public Citizen research, the patent protection for some of the more recent indications of Farxiga related to heart failure expires as late as 2040 — almost 14 years after the patent covering the drug substance expires and 26 years after the drug's initial approval.

AstraZeneca spends huge sums on payouts to executives and shareholders, rather than R&D.

- In 2023 alone, AstraZeneca spent $4.5 billion paying dividends and maintaining its exorbitant executive compensation.

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[1] Zhou et al. identified PubMed publications related to the drug target or the drug and subsequently identified NIH grants associated with the publications. Basic research funding was totaled through the date of approval of a first-in-class product associated with that target (in the case of Farxiga and Jardiance (which both target SGLT2), the first-in-class drug approval was Invokana (canagliflozin) in 2013). Thus, the funding total applies to multiple drugs.
See, https://www.ineteconomics.org/uploads/papers/WP_219-Federal-spending-on-drugs-Ledley-et-al-final.pdf

[2] NIH support for biomedical research is largely focused on basic research (the foundational research on biological targets for drug action that drug development is based upon). A smaller proportion goes toward applied research (research associated with later-stage development of a drug). See, https://www.bmj.com/content/367/bmj.l5766