Exhibit 6-

Written Comments

(60-day COMAR 14.01.04.05C(2))

ENSURING ACCESS THROUGH COLLABORATIVE HEALTH

July 22, 2024

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

RE: Public Comments on Board Selected Drug for Cost Reviews

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

The Ensuring Access through Collaborative Health (EACH) Coalition is a network of national and state patient organizations and allied groups that advocate for treatment affordability policies that consider patient needs first.

Once diagnosed with a chronic condition, each patient starts an often life-long journey to identify the correct treatments to successfully manage their symptoms and improve their health. Many chronic disease patients will ultimately rely on multiple medications to their condition. Some will face multiple chronic conditions or even need additional medications to treat the side effects of either their condition or the medication that keeps their condition manageable. For these reasons, patients with chronic conditions often rely on a complicated and personalized course of treatment that is not easily altered.

We respectfully urge the board to consider the concerns of patient organizations outlined in this letter. We offer our organization as a resource to board members seeking to connect with patient organizations and patients.

Cost Reviews and UPLs Could Compromise Patient Access to Medications

While we applaud the board's commitment to supporting patients and lowering the costs of prescription medications, we are concerned that cost reviews and upper payment limits (UPLs) can further complicate an already complex healthcare marketplace and result in worse outcomes for patients.

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. Individual drug reviews unnecessarily create inequities between patient populations and can pit disease states against each other.

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. This eventuality was outlined by the Centers for Medicare and Medicaid Services in their May 3, 2024 Guidance on Medicare Drug Price Negotiation, "CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."

Additionally, many of the drugs under cost review are administered directly by physicians under a “buy and bill” model. Physician reimbursement rates are already being squeezed, and UPLs could additionally lower opportunities for treatment costs to be recouped. As a result, it is likely that physicians would adjust treatment recommendations to avoid facing financial deficits, leaving patients with fewer treatment options.

Finally, creating a unique pricing structure in Maryland will create state-specific conditions for coverage. We don’t know yet how either insurers or manufacturers will react to state-by-state exceptions, but this has potential to cause either of these stakeholders to limit availability in the state and could cause confusion for patients and providers in the state.

Upper Payment Limits Don’t Necessarily Translate to Patient Savings

Assuming that UPLs directly translate to lowered costs for patients ignores the complicated nature of our healthcare system. In our system, patients are not responsible for paying the full cost of their prescription medications nor are they allowed to freely select from the full range of treatments medically approved for their condition. Instead, these decisions are determined by their insurance company and pharmacy benefit manager (PBM). It is also these stakeholders that determine if cost-savings realized by the payer are subsequently shared with patients. Unfortunately, in most cases, they are not.

Payers in our health marketplace do not necessarily derive the most value from the lowest cost drugs. According to reporting on PBMs by the New York Times, “Even when an inexpensive generic version of a drug is available, P.B.M.s sometimes have a financial reason to push patients to take a brand-name product that will cost them much more. For example, Express Scripts typically urges employers to cover brand-name versions of several hepatitis C drugs and not the cheaper generic versions. The higher the original sticker price, the larger the discounts the P.B.M.s can finagle, the fatter their profits — even if the ultimate discounted price of the brand-name drug remains higher than the cost of the generic.”

Ultimately, this could mean insurers and PBMs place drugs subject to UPLs on higher tiers of the formulary. This could ultimately lead to higher out-of-pocket costs for patients who could face higher copay or coinsurance rates to retain access to that drug or alternatively be forced to switch to a more expensive drug that results in higher profits to their PBM. This is also supported by the concern raised by CMS above.

Additionally, non-medical switches in medication can cause unnecessary complications for patients. At a minimum, a switch in medication will require more doctor visits to monitor the efficacy of a new medication. Further, if the switch results in side effects or worsened outcomes, patients could face medical interventions or hospitalization and the additional costs borne out by both.

Patient Access Cannot Be Compromised

Ultimately, chronic conditions are incredibly complex to treat. Each patient will face a unique experience and should be able to work with their doctor to identify the treatment that works best for them. Substituting or requiring patients to change drugs based on cost considerations instead of medical needs can disrupt continuity of care and result in complications and higher overall medical costs.

We urge this board to seriously consider the unique circumstances faced by these patients and work diligently to ensure that access to all treatments is protected. We strongly urge the board and staff to utilize the authority of the board to fully explore with all healthcare stakeholders how UPLs will be implemented and identify in advance any adverse impact to patients.

Identify and Resolve Patient-Reported Obstacles to Care

As we have outlined, while well-intentioned, UPLs fail to address many of the underlying causes and complicated factors that result in higher prescription drug costs for 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 patients and what will be the state or the broader healthcare system.

We acknowledge that this is a substantial undertaking in its own right, and urge the board to proceed with the care and humility that it requires. As recently as last month, the Oregon PDAB acknowledged the significance of their directive when they voted to halt drug reviews for 2024 to allow adequate time to improve their process, design, and definitions. We urge Maryland and other states to follow their lead in an effort to ensure patient benefit.

Sound Health Policy is Founded on Patient Perspectives

Finally, 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 as it evaluates the impact of its cost reviews and UPLs.

We urge the board to utilize this organization and its members as a direct conduit to understanding and incorporating patient and caregiver perspectives, as well as those of patient organizations who have an understanding of the life cycle of disease from the lens of prevention, diagnosis, and disease management.

We appreciate your laudable efforts to improve our health system and your steadfast commitment to protecting patients. We look forward to working together to achieve these goals.

Sincerely,

Ensuring Access through Collaborative Health (EACH) Coalition

July 22, 2024

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

RE: Board Selected Drugs (Skyrizi & Dupixent).

Dear Maryland Prescription Drug Affordability Members and Staff,

On behalf of the National Psoriasis Foundation, and the more than 8 million individuals living with psoriatic disease, we thank you for the opportunity to provide comment on the Cost Review Study Process for the Board Selected Drugs presented on May 20, 2024. We write to convey our concerns with the inclusion of Skyrizi (risankizumab) and Dupixent (dupilumab) on the referred list.

Psoriasis is an immune-mediated disease that causes inflammation in the body. There may be visible signs of inflammation such as raised plaques and scales on the skin, which may look different for different skin types. The symptoms associated with psoriasis, including itch, pain, and flaking skin, can directly impact patient wellbeing, patient sleep, and ability to complete activities of daily living. Psoriasis is also well known to have systemic medical associations including metabolic syndrome, cardiovascular disease, metal health conditions like depression and anxiety, and psoriatic arthritis (PsA), a potentially debilitating inflammatory arthritis. In fact, one in three people with psoriasis may develop psoriatic arthritis.[1] Signs of PsA include swelling, stiffness, and pain in the joints and areas surrounding the joints. Scientific research on PsA progression has demonstrated that it is important for patients with PsA to begin treatment for PsA shortly after the onset of symptoms to avoid (or at least minimize) permanent joint damage.

The National Psoriasis Foundation (NPF) is a non-profit, 501 (c)(3) organization that works to drive efforts to cure psoriatic disease and improve the lives of the over 8 million Americans affected by psoriatic disease. As part of that second mission the NPF advocates for access to care reforms that will benefit people living with psoriasis, and it's in this capacity that we reach out to the PDAB Board today with our concerns about the consequences of implementing a UPL on drugs used to treat psoriatic disease. Below we have outlined two priorities that we urge the Maryland PDAB to consider when assessing these medications:

Priority 1: Protecting a diverse range of treatment options for patients with psoriatic disease

The introduction of biologic products for the treatment of psoriasis and psoriatic arthritis has allowed many in our community to achieve a level of clearance never before possible. New systemic treatments, including biologics, have provided many patients with an effective therapy for the first time in their lives. Biologics have also opened a new world of combination therapies, being used alongside other systemic treatments, phototherapy, and/or topical treatments. Each patient is

[1] Mease PJ, Gladman DD, Papp KA, et al. Prevalence of rheumatologist-diagnosed psoriatic arthritis in patients with psoriasis in European/North American dermatology clinics. J Am Acad Dermatol. 2013;69(5):729-735. doi:10.1016/j.jaad.2013.07.023

unique in the way they respond to various therapies, however, and there is no 'one size fits all' approach to managing psoriasis.

Although recent research has shed some light on the underlying factors that determine whether or not any given drug will effectively treat a patient's specific presentation of psoriatic disease (for instance, psoriatic arthritis patients with enthesitis seem to do better with IL-23 inhibitors, while those with axial involvement seem to do better with IL-17 inhibitors),[2] there is still no universal heuristic for matching a patient to the most effective treatment for their psoriatic disease. Physicians often prescribe one or more ineffective treatments for patients with psoriatic disease before identifying an approach that works, and the immunological nature of psoriatic disease means that patients may even have to cycle off previously effective treatments if they build up immune tolerance.

The extreme heterogeneity of both psoriatic disease and treatments for psoriatic disease make physician and patient access to the full range of therapies particularly important. Because of this unique set of considerations, we caution the PDAB to be on guard against creating scenarios in which UPLs incentivize insurers to re-tier, restrict access to, or even eliminate certain drugs from their formularies. Given the diversity of drugs that could plausibly treat one patient's psoriatic disease but not another's, any incentive structure that makes it more difficult for psoriatic disease patients to access a full range of treatment options through Maryland's state-regulated plans would create major access barriers for people living with the condition.

UPLs are a new enough policy tool that our team has struggled to predict or model the potential impacts of a UPL on insurers, PBMs, hospitals, pharmacies, and providers. That said, we have seen some analyses of the likely impacts of a UPL that echo our concerns of increased utilization management. For instance, a recent Avalere report summarized their findings into a March 2024 report that warned "All payers interviewed noted that UPL drugs and competitors in the therapeutic class are likely to see increased utilization management (e.g., step therapy, prior authorization) should the UPL restructure new benefit designs. Additionally, five of six payers cited in their interviews that UPL implementation would result in changes to formulary designs, such as movement up or down tiers for UPL drugs."[3] We urge the Maryland PDAB to think seriously about these effects and consult outside stakeholders with expertise in healthcare economics before making decisions which could create unintended consequences that ultimately restrict access.

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[2] Kamata M, Tada Y. Efficacy and Safety of Biologics for Psoriasis and Psoriatic Arthritis and Their Impact on Comorbidities: A Literature Review. Int J Mol Sci. 2020;21(5):1690. Published 2020 Mar 1. doi:10.3390/ijms21051690

[3] Avalere, Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs, https://www.fightchronicdisease.org/sites/default/files/FINAL%20PFCD%20Avalere%20PDAB%20Insurer%20Research.pdf.

Priority 2: Distinguish between affordability to the patient and affordability to the state

In the Maryland Legislature's instruction to the PDAB for conducting a cost review found in HB 768, the legislature instructs the Board to consider whether "use of the prescription drug product that is fully consistent with the labeling approved by the united states food and drug administration or standard medical practice has led or will lead to affordability challenges for the state health care system or high out–of–pocket costs for patients."[4]

As an organization focused squarely on advancing patient access, NPF wants to reiterate and emphasize the already-noted distinction between "affordability challenges for the state health care system" and "high out-of-pocket costs for patients." Under current law the Maryland PDAB can only create UPLs for state and local government plans, and this limitation dramatically constrains the possibilities for reducing out-of-pocket costs for patients via an UPL. Maryland PDAB Executive Director Dr. York noted these shortcomings to the current system in his testimony to the Maryland Senate Finance Committee on SB 3088, a bill that would (among other things) task the PDAB with writing a report on whether their power to implement UPLs should be expanded, when he said that "most of the savings [created under the current law] will be to the state and local government, because Medicaid has a nominal copayment and then our employee health plan has a very generous copay as well."[5]

Although the PDAB's own website states that the Board has been "tasked with protecting Marylanders and the Maryland health care system from the high costs of prescription drug products," Dr. York's comments indicate that this current version of the PDAB has very little power to reduce out of pocket costs for patients. Given these facts, NPF is concerned that any UPLs implemented under the current law would do very little to reduce costs for HealthChoice users or Maryland state employees while simultaneously creating potential unintended consequences that restrict available treatment diversity for all the reasons laid out in Priority 1. Avalere once again agrees with our analysis in their study on UPLs, writing that of the health plan representatives they interviewed "Most payers (five of six) did not anticipate that UPL-related savings would be passed on to patients in the form of lower premiums, deductibles, or cost sharing."[6]

Reducing the state's expenditure on prescription drug use is obviously an important policy goal in its own right, but we believe that any cost review report examining whether a drug's use creates "affordability challenges for the state health care system or high out–of–pocket costs for patients" should clarify that these high out-of-pocket costs are likely to remain unchanged *unless* the report also contains clear guidance on how the state can implement a UPL that ensures savings will be passed on to patients using these drugs. Absent this sort of guarantee, our fear is that the cost review process will overstate the need for a UPL by considering patient affordability issues that the

[4] https://mgaleg.maryland.gov/2019RS/Chapters_noln/CH_692_hb0768e.pdf.
[5] https://mgaleg.maryland.gov/mgawebsite/Committees/Media/false?cmte=fin&ys=2024RS&clip=FIN_2_7_2024_meeting_1&billNumber=sb0388, timestamp 21:53.
[6] Avalere, Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs.

PDAB is not actually equipped to meaningfully address with its current toolkit. Implementing a UPL that saves the state money without doing the same for patients would practically be a cost-cutting measure like state Medicaid cuts, something that drives down state budgets while potentially reducing access for end healthcare users. For these reasons, NPF urges the PDAB Board to remain cautious in its cost-benefit analysis of UPLs for Skyrizi (risankizumab) and Dupixent (dupilumab).

On behalf of National Psoriasis Foundation, thank you for your consideration of these comments which we hope will positively inform this review. We again invite you to call upon us, our Medical Board, and our patient community as you move forward. Please contact Will Hubbert, State Government Relations Manager, East at whubbert@psoriasis.org with any questions.

Sincerely,

Jason Harris Vice President, Government Relations and Advocacy

July 22, 2024

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

RE: SIX DRUGS CHOSEN FOR COST REVIEW
(FARXIGA, JARDIANCE, OZEMPIC, TRULICITY, DUPIXENT, SKYRIZI)

Dear Members of the Board,

As a broad coalition of advocacy organizations representing patients, caregivers and health care providers, we write concerning the value of the six drugs chosen by the Prescription Drug Affordability Board for cost review and consideration of affordability. The Coalition has previously submitted comments expressing concern that methods available to the Board to lower health care spending – the setting of upper payment limits, in particular – may restrict patients' access to needed treatments. Therefore, we are hopeful that the Board will consider the value of access to these drugs when considering affordability.

The Value of Care Coalition believes that value is best determined by those who know – providers who prescribe medicines and patients who rely on the medicine to keep their medical conditions stable. Just as the term "affordability" has many different definitions and could be determined by a multitude of criteria, so does "value". Cost and value are not the same thing, but cost, or affordability, cannot be fully considered without accounting for value.

DIABETES TREATMENTS

At the May 20 meeting of the Prescription Drug Affordability Board, the Board voted to review four drugs with an indication for type 2 diabetes as a "class". It is not clear what this grouping means for how reviews are conducted, or the drugs are compared to each other or other treatments, and it is not clear if such a grouping is appropriate considering the different types of treatments within the group.

FARXIGA, JARDIANCE, OZEMPIC, TRULICITY

Two of these treatments, Farxiga and Jardiance, are SGLT-2 inhibitors. Two others, Ozempic and Trulicity, are GLP1 agonists. While each drug is used to treat type 2 diabetes, they are not all the same and physicians value each for their unique role in their toolbox of treatments.

For example, Farxiga and Jardiance both treat chronic kidney disease and heart failure independent of diabetes, but are commonly used for patients with both heart failure or chronic kidney disease and diabetes. Farxiga has also been shown to reduce cardiovascular death with certain kinds of heart failure, while Jardiance may be prescribed for people with diabetes and established cardiovascular disease or stroke. These two drugs are taken orally.

Ozempic and Trulicity are commonly prescribed for type 2 diabetes and weight loss. Ozempic has also been shown to reduce risk of cardiovascular hospitalizations and death. These two drugs are injected.

There is a well-established connection between diabetes and cardiovascular disease. People with diabetes are at a greater risk of heart failure.[1] In fact, according to the Partnership to Advance Cardiovascular Health, "people with type 2 diabetes are twice as likely to develop heart disease and if they struggle with obesity their risk is even higher."[2]

Cardiovascular disease was the cause of death for over 900,000 Americans in 2020 – more than all forms of cancer and Chronic Lower Respiratory Disease combined. Meanwhile, in 2020, heart attacks occurred approximately every 40 seconds, and someone died of stroke every 3 minutes 17 seconds in the United States. As of 2018, the prevalence of adult obesity stood at 43% of males and 41.9% of females in America with an upward trend over the previous twenty years.[3]

In the face of these statistics, physicians value treatments tailored to patients' unique needs and comorbidities. Additionally, loss of access to these medications could force doctors to veer from evidence-based guidelines.

At the same time, the value patients find in these treatments is immense. Without access to a treatment that works for them, that they're comfortable with and that keeps their condition stable, their diabetes may be less well controlled. This can lead to weight gain and higher risk for other complications such as eye disease, neuropathy, foot complications and limb loss, gum disease, hearing loss, and cardiovascular disease, chronic kidney disease, and stroke.[4] These comorbidities are each debilitating in their own way, causing patients pain, suffering and an inability to go about their day to day lives as they otherwise would.

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[1] CDC, *Your Heart and Diabetes,* https://www.cdc.gov/diabetes/diabetes-complications/diabetes-and-your-heart.html

[2] Partnership to Advance Cardiovascular Health, *The Diabetes-Cardiovascular Connection, https://www.youtube.com/watch?v=RshYNrftKwo*

[3] American Heart Association, *2023 Heart Disease and Stroke Statistics Updated Fact Sheet, https://professional.heart.org/en/science-news/-/media/453448D7D79948B39D5851D1FF2A0CFE.ashx*

[4] American Diabetes Association, *Diabetes Complications, https://diabetes.org/about-diabetes/complications*

Left untreated, the progression of chronic kidney disease can lead to cardiovascular complications, hospitalizations, dialysis and kidney transplant.

Likewise, the benefits of these treatments related to cardiovascular diseases are profound. Consider a patient who suffers a stroke. Lucky to be alive, they may face paralysis causing them to lose mobility, have speech and language problems, vision problems, trouble thinking and memory issues. They can no longer work or even hold their child or grandchild. The value of treatment proven to reduce stroke risk is extraordinary to this patient.

In addition to the value found in quality-of-life aspects provided by these treatments, a forced switch to another medication may result disease progression, symptoms re-emerge or new side effects surfacing, more doctor visits, hospitalizations, additional treatments, and lost economic output in terms of missed work. In fact, the American Heart Association estimates the indirect cost of cardiovascular disease alone to be "$155.9 billion in lost productivity/mortality" from 2018-2019.[5]

DUPIXENT

Dupixent is a biologic approved for several conditions, including eczema, asthma, nasal polyps and eosinophilic esophagitis, including approval for young children for many of those indications. Prescribers value Dupixent for its versatility as asthma and nasal polyps often coexist, as do asthma and eczema. Like other treatments being assessed, Dupixent treats multiple debilitating conditions at the same time.

From the patient perspective, consider a patient with severe asthma and nasal polyps. Symptoms of polyps can include runny nose or congestion, postnasal drip, loss of smell and taste, pain in the face and teeth, headache and snoring.[6] With proper treatment, polyps shrink. The patient no longer needs surgery to remove polyps. Their nose stops running and they can breathe again. They can smell again and taste food. And they may feel better than they have in decades.

In the short term, asthma patients can have trouble breathing, suffer from wheezing, coughing and tightness or pain in the chest. Symptoms can be exacerbated by simple changes in the weather, seasonal cycles, and many other common triggers. [7]

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[5] American Heart Association, *2023 Heart Disease and Stroke Statistics Updated Fact Sheet, https://professional.heart.org/en/science-news/-/media/453448D7D79948B39D5851D1FF2A0CFE.ashx*

[6] Mayo Clinic, *Nasal Polyps, https://www.mayoclinic.org/diseases-conditions/nasal-polyps/symptoms-causes/syc-20351888#:*

[7] Asthma and Allergy Foundation of America, *Asthma Facts, https://aafa.org/asthma/asthma-facts/*

Like many chronic conditions, uncontrolled asthma can lead to further complications. Damage to airways and lungs can occur, sleep can be disrupted, pregnancy complications can arise, patients face an increased risk of infection, gastroesophageal reflux disease and obesity.[8] On average, 10 Americans die from asthma each day and nearly all deaths are avoidable with proper treatment and care.[9]

Conversely, when not facing common asthma symptoms or reducing the impact of common triggers, patients value the ability to live their daily lives, missing fewer days of work, exercising, playing outdoors with their friends or their children.

For a patient with eczema, the impact of proper treatment can be equally valuable. According to the National Eczema Association (NEA), 10% of Americans have some form of eczema. Unbearable itching can occur, lasting 12 or more hours per day. Some patients have severe pain. About a third of patients face insomnia, shorter sleep time, daytime sleepiness and fatigue. NEA states that hospitalizations due to flares of atopic dermatitis "and related infections is associated with an 8.3-year reduction in lifespan compared to the general population."[10]

Without their condition controlled, sores emerge requiring regular antibiotics. Lifestyle impacts emerge. Patients report feeling angry or embarrassed about their appearance due to their disease, causing them to limit interactions with others. They turn down job or educational opportunities. Children and teens are bullied because of their disease. Mental health can suffer as feelings of isolation, frustration, helplessness and sadness set in. Economically speaking, NEA reports "nearly 5.9 million work days annually are lost due to eczema."[11]

SKYRIZI

Plaque psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis are all treated with Skyrizi. The inflammatory bowel diseases can be life-threatening, while psoriatic arthritis can be debilitating, and plaque psoriasis can be associated with severe complications. Like other treatments chosen for assessment, prescribers value Skyrizi in their toolbox because of its versatility. It is not uncommon for psoriatic arthritis and inflammatory bowel disease to occur simultaneously, and Skyrizi is one of only two drugs in its class that are approved to treat the joint, skin and bowel conditions.

Clinicians also note that the medical benefits of this drug can be life-changing for patients, and switching to another drug on the PDAB's therapeutic alternative list may be inappropriate for

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[8] Asthma.com, *Uncontrolled Asthma's Effects Over Time,* https://www.asthma.com/treating-asthma/effects-of-asthma/

[9] Asthma and Allergy Foundation of America, *Asthma Facts, https://aafa.org/asthma/asthma-facts/*

[10] National Eczema Association, *Eczema Stats, https://nationaleczema.org/research/eczema-facts/*

[11] ibid

the patient's condition. Moreover, when talking about autoimmune diseases, it is important to understand that people sometimes have an initial response to a treatment followed by a change in their immune system which causes them to need a different treatment. Similarly, a patient switched to another drug followed by a return to the original drug may find that the original drug does not work anymore due to changes in the immune system. Therefore, prescribers value access to multiple treatments with a variety of mechanisms of action and the ability to maintain access to the treatment as long as it's working.

Among psoriasis patients, plaque psoriasis is the most common type of psoriasis and causes scaly, itchy, painful patches on skin.[12] If not controlled, this can lead to frequent complications such as infections, requiring additional doctor visits and treatments. Psoriatic skin disease can cause superinfections than can lead to life-threatening sepsis. Unfortunately, about one in three people with plaque psoriasis will develop psoriatic arthritis.[13]

For patients whose psoriatic arthritis is newly controlled by proper, effective treatment, the elimination of joint inflammation leads to incredible gains in quality of life. Where their disease can be deforming, debilitating and deadly due to an increased risk of early heart disease, and it had previously caused them to be unable to work or do hobbies, play with their kids or be active in their communities, effective treatment allows them to function, work, and go about their daily lives.

Meanwhile patients with inflammatory bowel disease face persistent diarrhea, abdominal pain, bleeding, weight loss and fatigue.[14] This disease puts patients at risk for gastrointestinal cancer and can lead to removal of portions of the gastrointestinal tract. If the disease is active, the patient may be bleeding and not absorbing food, which can be deadly. With proper treatment, symptoms can be managed, and disease progression can be slowed or stopped, preventing these outcomes.

Unfortunately, inflammation in the gut, skin and joints can flare relentlessly and simultaneously. Without proper treatment, this can lead to worse health outcomes and absorption of more medical resources, time and cost for the system and the patient.

CONCLUSION

Each treatment selected for review by the Maryland Prescription Drug Affordability Board provides unique value to prescribers and the patients they treat.

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[12] National Psoriasis Foundation, *Plaque Psoriasis,* https://www.psoriasis.org/plaque/
[13] National Psoriasis Foundation, *About Psoriasis,* https://www.psoriasis.org/about-psoriasis/
[14] CDC, *What is inflammatory bowel disease?,* https://www.cdc.gov/ibd/what-is-IBD.htm#

In each instance, prescribers value the ability to treat their patients more efficiently and holistically as the conditions the drugs treat often exist simultaneously (i.e. psoriatic arthritis and inflammatory bowel disease) or create greater risk for each other (i.e. diabetes and cardiovascular disease). To be able to effectively treat one condition while also lowering the risk of another with one medication is impactful to their practice of medicine. While there may be other treatments for each indication, each drug listed is a valuable tool in the toolbox for doctors as they assess the medical needs of each individual patient.

Patients value the ways these treatments change their lives for the better. What was once a deadly diagnosis is something that can now be managed. They now have the power to control their symptoms and do things many Americans may take for granted – work, play, interact with friends, family and colleagues in a meaningful, productive way, exercise, go outside, and even simply breathe normally.

While it may be difficult to properly quantify the value doctors find in these treatments or that patients receive in terms of quality of life, these benefits cannot be ignored when considering cost and affordability. The Value of Care Coalition asks that as the Board evaluates the affordability of the treatments its chosen, it considers the value these treatments provide to clinicians and patients in Maryland.

Sincerely,

Derek Flowers
Executive Director
Value of Care Coalition