November 25, 2026

Chair Cullison and Members of the Board
Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

Re: Comments on the Draft Cost Review Study Dossier for Dupixent (dupilumab), Draft v.1.0 dated November 10, 2026

Dear Chair Cullison and Members of the Board:

Patients Rising is a national nonprofit that represents patients living with chronic and life-threatening conditions, including Marylanders living with atopic dermatitis, asthma, and other type 2 inflammatory conditions. We submitted comments on the design of this cost review in September, and we thank the Board and its staff for publishing the draft dossier and opening it to public comment before any preliminary determination.

We begin from what we take to be common ground. The Board's work is aimed at lowering what the State and local governments spend on prescription drugs, and we expect the State shares our view that those savings should not come at the cost of patients' access to treatment. Our comments focus on what it shows, and does not yet show, about the patients who would live with the result.

I. The dossier shows that patients already carry real costs, most heavily in the plans a payment limit would reach.

The draft dossier's out-of-pocket data are its most important contribution for patients, and we encourage the Board to give them weight. Commercially insured Marylanders paid an average of roughly $2,000 to $2,550 a year out of pocket in 2024, and the highest-cost tenth of patients paid between $7,195 and $8,904 (Table 7j). Those are substantial sums even against the State's median household income of $102,905, and heavier still in counties where per capita income is a third of the State's highest.

The figures are starker for the patients an upper payment limit would directly affect. In state and local government employee plans, the highest-cost tenth of patients paid between $7,092 and $11,086 a year, and average coinsurance per claim ranged from $1,318 to $3,538 depending on the dose (Tables 7h and 7j). These are State, county, and municipal employees and their families. The dossier shows that what drives their exposure is how their plans structure cost-sharing, particularly coinsurance, rather than the price their plans pay alone. The data bear out the distinction we raised in September. If the Board proceeds toward a payment limit, the dossier should state plainly whether, and how, any savings to these plans would reduce what these employees pay at the pharmacy counter.

II. The dossier documents an adherence gap but does not explain it.

By the dossier's own measure, the average patient in the analysis received about 69 percent of the doses expected over the year (Table 7c, mean normalized 30-day equivalent of 0.69). For a maintenance therapy, missed doses can mean flares, emergency visits, and systemic steroid use. The dossier does not discuss why the gap exists.

The dossier then concludes that while cost-sharing has a statistically significant relationship with use, "any impact is small" (page 68). We ask the Board not to rely on that conclusion without qualification, for three reasons. First, the model explains very little of the variation in use (R-squared of 0.023, Table 7e), which suggests that most of what drives the gap is not being measured. Second, the analysis can see only patients who filled prescriptions. A patient who was prescribed this therapy and never started because of cost, or who abandoned a prescription at the pharmacy, does not appear in the data at all, though they are the patients cost affects most. Third, the analysis excluded claims with no recorded cost-sharing and patients without nearly a full year of coverage, so it reflects only part of the population (Table 7a). The claims data also cannot show whether a manufacturer copay card paid part of a patient's bill, which the dossier acknowledges it could not quantify (pages 70 to 71).

The claims data cannot answer this question on their own. Patients and clinicians can, and we hope the Board will treat their comments in this period as evidence on this point.

III. Several figures need to be reconciled, and several gaps filled, before the dossier supports a determination.

We raise these as questions for staff rather than criticisms, because each affects how much weight the patient-facing sections of the dossier can bear.

Patient counts in the regression analysis. Table 7a reports 1,884 patients in the "final summary file for eligible claims," with more claims (24,348) than in the eligible population above it (9,663). The regression in Tables 7c through 7f, however, uses 3,397 patients, and the frequency analysis in Table 7b counts 19,663 claims. We ask staff to explain which population the regression describes and to correct the table if needed.

Average cost share. Table 7i reports that patients paid between roughly 0.002 percent and 0.5 percent of gross spending. Even allowing for the different data years, those figures are hard to square with the dossier's own data elsewhere: commercial gross spending for the most-used dose averaged about $29,000 per patient in 2024 (Table 4b), while average out-of-pocket cost for that dose was $2,211 (Table 7j), a share closer to 7.6 percent. A cost-share figure understated by that magnitude would give the Board a misleading picture of patient burden, and we ask staff to confirm how it was calculated.

Priority populations. Staff could not assess the impact on priority populations because the claims data lacked demographic information (page 76). Any determination should state plainly that this statutory factor was not assessed.

Copay assistance and Medicaid. The dossier could not determine the value of manufacturer assistance in Maryland, and the data contain no out-of-pocket information for Medicaid enrollees (pages 70 to 71 and 74).

Costs the therapy displaces. The incremental cost analysis relies on published national literature (page 59) rather than Maryland data on emergency visits, hospitalizations, and other care a working treatment can avoid. We renew our September request that the Board account for those offsets.

State and local government input. Staff received no input from the State and local government entities whose plans a payment limit would reach (page 81).

IV. Requests to the Board.

We respectfully ask the Board to:

1. **Correct or explain the patient-count and cost-share figures** in Tables 7a through 7i before the dossier is finalized.
2. **Present out-of-pocket costs by plan type and benefit design**, including coinsurance versus copay and the share of patients in each, with particular attention to State and local government employee plans.
3. **Treat the adherence finding as unresolved** rather than concluding that cost has only a small effect, and weigh patient and clinician comments on why patients miss doses or never start.
4. **State plainly which statutory factors could not be assessed**, including priority populations, copay assistance, and Medicaid out-of-pocket costs, in any determination that relies on this dossier.
5. **Account for displaced costs**, such as emergency care and hospitalization, using Maryland data where available.
6. **Explain how any savings would reach patients.** If the Board moves toward an upper payment limit, describe how savings to State and local plans would affect what their members pay, and commit to monitoring patient access after any limit takes effect, as we urged in our November 11 comments on the appeals regulation.

Our requests are meant to make sure the final record shows the Board not only what the State spends, but what Maryland patients pay and whether they can stay on treatment. We would be glad to help connect the Board with Maryland patients and clinicians as it completes this review. Please contact me at terry@patientsrising.org with any questions.

Yours in Advocacy,

Terry Wilcox

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