May 15, 2026

Colorado Prescription Drug Affordability Board
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
Submitted via email to dora_insurance@state.co.us

Re: Proposed Upper Payment Limit (UPL) for Cosentyx

Dear Members of the Colorado Prescription Drug Affordability Board:

The Alliance for Safe Biologic Medicines appreciates the opportunity to provide comments as the Board continues its work related to Cosentyx and prescription drug affordability in Colorado. ASBM is a multi-stakeholder organization of physicians, pharmacists, patients, manufacturers, researchers, and others committed to maintaining patient access to safe, effective biologic medicines.

ASBM shares the Board's concern that patients must be able to afford the medicines their physicians prescribe. Patients should not be forced to choose between filling a prescription and paying for other necessities. But any policy adopted in the name of affordability should be judged by a simple standard:

Does it lower costs for patients while preserving access to the medicine their clinician believes is right for them?

By that standard, we remain concerned that an upper payment limit for Cosentyx does not solve the affordability problem patients actually experience and would instead benefit insurers and PBMs without guaranteeing any reduction in patient out-of-pocket costs.

The record before the Board shows why this distinction matters. In previous meetings, the Colorado Consumer Health Initiative cited 2022 APCD data showing Cosentyx cost $46,948 per patient, with average annual commercial patient out-of-pocket costs of $2,801. It also cited a 116% increase in wholesale acquisition cost from launch through 2024. Those figures may or may not accurately reflect broader health system spending, but **they do not answer the most important patient-centered questions**:

1) **What are patients actually paying at the pharmacy counter; and**
2) **Would the proposed UPL reduce that amount?**

Clinical stakeholders have provided a very different picture of real-world patient costs. The Coalition of State Rheumatology Organizations informed the Board that rheumatologists who frequently prescribe Cosentyx report that **patients typically pay between $0 and $25, with $5 being the most common amount**[i]. CSRO explained that copay assistance programs often cover most or all of the patient's cost-sharing responsibility at the point of sale.

Current patient-support information for Cosentyx is consistent with that account. The manufacturer states that eligible privately insured patients may pay as little as $0 per month, and that 84% of eligible patients who used the copay program in 2024 paid $0 out of pocket. The program also includes "Covered Until You're Covered," through which eligible privately insured patients whose prescription coverage is not initially approved may receive up to two years of Cosentyx for free while coverage is pursued.[ii]

This does not mean every patient has no affordability challenge. Medicare, Medicaid, TRICARE, VA, and other government-program patients generally are not eligible for manufacturer copay programs, and some patients may face deductibles, coinsurance, restrictive formularies, or other benefit-design barriers. But those barriers are precisely why a UPL is poorly targeted. If a patient already pays $0, a UPL cannot reduce that patient's out-of-pocket cost. If a patient faces a copay or coinsurance, a UPL does not require the insurer or PBM to pass savings through to that patient. And if a patient's problem is prior authorization, step therapy, adverse tiering, a copay accumulator/maximizer, or specialty-pharmacy restriction, a UPL does not fix that problem either.

A UPL would transfer savings only to the middlemen in Colorado's medication distribution system rather than to the state's patients. The Board may reduce what a payer or PBM pays for Cosentyx, but unless the policy includes enforceable pass-through requirements, there is no guarantee that a patient's cost-sharing will fall by even one dollar. Worse, plans and PBMs may respond by changing formularies, increasing utilization management, preferring different products, narrowing specialty pharmacy networks, or creating new administrative hurdles that disrupt stable patients.

In the absence of enforceable pass-through requirements, the record has shown PBMs have not only failed to pass along savings from discounted and rebated drugs to patients but have applied staggering markups upon these drugs. In January 2025, the Federal Trade Commission reported that the three largest PBMs marked up numerous specialty generic drugs dispensed through affiliated pharmacies by hundreds or even thousands of percent, generating more than $7.3 billion in revenue above estimated acquisition costs from 2017 to 2022.[iii] The FTC also found that plan sponsor and patient payments for these drugs *increased* over the same period, rather than falling.

If the Board's goal is indeed patient affordability, it should focus on shaping the utilization-management tools that health plans and PBMs use to determine what patients actually pay: cost-sharing design, rebate pass-through, copay accumulator and maximizer programs, formulary placement, prior authorization, step therapy, and continuity-of-care protections. A UPL that reduces reimbursement but leaves those mechanisms untouched would reduce spending and increase profitability for insurers or PBMs, while doing little or nothing for the patient.

This is especially important for biologic medicines such as Cosentyx. Patients prescribed biologics typically live with serious, chronic diseases, and treatment is highly individualized. Many patients arrive at an effective biologic only after many prior treatment failures. For these patients, administrative disruption is not a minor inconvenience. A forced or pressured change in therapy can mean disease flare, pain, missed work, worsening quality of life, and additional medical costs.

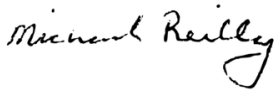
ASBM therefore urges the Board not to proceed with a Cosentyx UPL unless it can clearly demonstrate that the policy will directly reduce patient out-of-pocket costs and will not create new access barriers. At minimum, any affordability action should include the following safeguards:

- The Board should require evidence that any savings generated by a UPL are passed through to patients at the point of sale, not retained by insurers, PBMs, or plan sponsors.
- The Board should require monitoring of formulary placement, tiering, prior authorization, step therapy, specialty pharmacy restrictions, and non-medical switching before and after implementation.
- The Board should protect patients who are stable on Cosentyx from coverage disruption or forced switching driven by payer or PBM response to a UPL.
- The Board should specifically evaluate the impact of a UPL on Cosentyx IV, the first FDA-approved intravenous IL-17A inhibitor and apparently the only FDA-approved infusible IL-17 therapy, to ensure the payment limit covers acquisition, administration, storage, handling, and clinical overhead costs and does not put physicians or infusion centers underwater, limiting access.
- The Board should separately evaluate affordability for patients who are not eligible for manufacturer assistance, including Medicare and Medicaid patients, rather than assuming that a reimbursement cap for the payer will solve the out-of-pocket burden of beneficiaries.
- The Board should clearly communicate to patients how it will measure whether a UPL is reducing out-of-pocket costs and ensuring access is not adversely affected, including the specific metrics, data sources, and timelines it will use to demonstrate success.
- The Board should establish a clear process to suspend, revise, or repeal a UPL if patient access worsens or if savings are not demonstrably reaching patients.

ASBM supports efforts to make medicines more affordable. But affordability policy should not stop at reducing what the health plan pays. The patient- not the PBM, not the insurer or another intermediary - should be the primary beneficiary of any cost-control measure. In the case of Cosentyx, many commercially insured patients already pay little or nothing out of pocket through existing assistance programs. For those who do face out-of-pocket costs, a UPL does not guarantee relief unless the Board explicitly requires savings to reach them directly.

For these reasons, ASBM urges the Board to reject a UPL without the above patient protections, and to prioritize patient-centered reforms that lower out-of-pocket costs, preserve physician-directed treatment decisions, and prevent middlemen from capturing savings intended for patients.

Sincerely,



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Lupus and Allied Diseases Association, Inc.
National Hispanic Medical Association
National Psoriasis Foundation
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[i] https://csro.info/UserFiles/file/Memos/CSROMemoreCosentyxReview.pdf

[ii] https://www.cosentyx.com/all/treatment-cost

[iii] https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen