



Maximum Fair Price (MFP) Explanation for Enbrel

Introduction

In August 2022, President Biden signed the Inflation Reduction Act of 2022 (IRA) (P.L. 117-169) into law. For the first time, the law provides Medicare with the ability to directly negotiate the prices of certain high expenditure, single source drugs without generic or biosimilar competition. On March 15, 2023, the Centers for Medicare & Medicaid Services (CMS) issued [initial guidance](#) for the Medicare Drug Price Negotiation Program (the “Negotiation Program”), including requests for public comment on key elements. On June 30, 2023, CMS issued [revised guidance](#) detailing the requirements and parameters of the Negotiation Program for the first cycle of negotiations.¹ CMS engaged in negotiations with participating manufacturers between October 1, 2023 and August 1, 2024. These negotiations resulted in agreements establishing prices (which the IRA refers to as “maximum fair prices” or “MFPs”) that will be effective beginning in 2026 (the first cycle of negotiations is referred to as negotiations for “initial price applicability year 2026” because any agreed-upon prices will be effective in 2026). CMS published the agreed-upon MFPs on August 15, 2024.

The MFP explanation for Enbrel for the agreed-upon MFP that resulted from the negotiations for initial price applicability year 2026 with Immunex Corporation, the manufacturer of Enbrel (the “Primary Manufacturer”), provides information about the negotiations for Enbrel. This information includes CMS’ perspective on the data considered that had the greatest impact in CMS’ determination of offers and consideration of counteroffers during the negotiation process through which the parties reached agreement on an MFP.² In some respects, the Primary Manufacturer had a different perspective on the relevant data. The parties to the negotiation had productive exchanges during the negotiation meetings described below in which they discussed their respective views, and these exchanges resulted in the exchange of offer(s) and counteroffer(s) among the parties and, ultimately, an agreed-upon MFP for Enbrel.

On the basis of the factors described below and the related considerations and evidence, CMS negotiated with the Primary Manufacturer in good faith and consistent with the requirements of the law on behalf of people with Medicare and the Medicare program. Throughout the negotiation process and in accordance with the IRA, CMS’ goal was to achieve agreement with the Primary Manufacturer on the lowest possible MFP for Enbrel that would be consistent with the process defined in the IRA for these price negotiations. CMS believes that the agreed-upon MFP achieves this aim. The negotiation process

¹ The [Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026](#), is referred to throughout this document as the revised guidance.

² Section 1195(a)(2) of the Social Security Act (the “Act”) requires CMS to publish an explanation for the MFP with respect to the factors as applied under section 1194(e) for each selected drug. The MFP explanation is discussed in section 60.6.1 of the [revised guidance](#).

ended in both parties agreeing to an MFP of \$2,355.00 for Enbrel by the conclusion of the negotiation period on August 1, 2024.³ The agreed-upon MFP is set to take effect on January 1, 2026.

The MFP explanation contains the following components:

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MFP Explanation Narrative for Enbrel

Summary of the Negotiation Process

CMS followed the negotiation process laid out in the IRA and in the revised guidance. On August 29, 2023, CMS announced the 10 selected drugs for the first cycle of negotiations, which included Enbrel. The Primary Manufacturers of the selected drugs signed agreements to participate in the Negotiation Program by the deadline in the IRA of October 1, 2023 and submitted information on the selected drugs by the deadline in the IRA of October 2, 2023.

CMS collected relevant data from numerous sources, such as written submissions from the Primary Manufacturers and other interested parties in response to an information collection request issued for the Negotiation Program (referred to as the “Negotiation Program information collection request” throughout this document), feedback from patient-focused listening sessions, meetings between CMS and the Primary Manufacturers to discuss the information submitted, and CMS’ literature review.⁴

Using the information collected, CMS then developed initial offers for the selected drugs, which were based on the factors outlined in the IRA for CMS’ determination of offers and which CMS developed in accordance with the process described in the revised guidance.⁵ As required by the IRA, CMS’ initial offers each included a concise justification on the range of evidence and other information within the negotiation factors that CMS found compelling during the development of the initial offer. The Primary Manufacturers each responded by declining CMS’ initial offer and providing a written counteroffer and justification for such offer, including considerations based on the negotiation factors.

³ The MFP is expressed as the price per 30-days equivalent supply. See section 60.1 of the [revised guidance](#) and the [Negotiated Prices for Initial Price Applicability Year 2026 Fact Sheet](#) for additional information.

⁴ The Negotiation Program information collection request is available on the Office of Management and Budget’s (OMB’s) website at the following link: https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202306-0938-013.

⁵ Section 1194(e) of the Act requires CMS to consider certain data as the basis for all offers and counteroffers in the negotiation. These data, which are referred to in this document as the “negotiation factors,” are discussed in more detail later in this document. More information on the negotiation factors is also available in sections 50, 60.3 and 60.4 of the [revised guidance](#). CMS’ process for developing the initial offers is described in section 60.3 of the revised guidance.

CMS considered each counteroffer proposed by the Primary Manufacturers and declined each counteroffer. CMS and each Primary Manufacturer then held three negotiation meetings. These meetings included extensive discussion of the negotiation factors, including any new information consistent with the factors that may have become available about the selected drugs or therapeutic alternatives, CMS' initial offer and the Primary Manufacturer's written counteroffer, and, in some cases, additional proposals for an MFP.

Across the first cycle of negotiations for all ten selected drugs, more than 50 revised offers or counteroffers were proposed by CMS or a Primary Manufacturer, not including the ten initial offers CMS made and the ten written counteroffers provided by Primary Manufacturers. During the negotiation meetings, CMS revised its initial offer for each selected drug upwards at least once in response to the discussions with the Primary Manufacturer. While many of the details of the negotiations are confidential between CMS and each Primary Manufacturer, the frequency of revised offers and counteroffers in the first cycle of negotiations indicates the robustness of the negotiations that occurred for each of the ten drugs. CMS' approach to its negotiations with each Primary Manufacturer turned on the particular details relevant to each selected drug and was sensitive to the issues raised during the course of CMS' conversations with the Primary Manufacturer. CMS anticipates this drug-specific approach will continue to inform CMS' negotiations with participating manufacturers in future cycles of negotiation.

Overall, in six of ten negotiations CMS moved more than the Primary Manufacturer during the meetings and for the final offer (if applicable) prior to reaching agreement, and in four of ten negotiations the Primary Manufacturer moved more than CMS prior to reaching agreement. For five of the selected drugs, this process of exchanging revised offers and counteroffers resulted in CMS and the Primary Manufacturer reaching an agreement on a negotiated price for the selected drug in association with a negotiation meeting. In four of these cases, CMS accepted a revised counteroffer proposed by the Primary Manufacturer. For the remaining five selected drugs, CMS sent a written final offer to the Primary Manufacturer, consistent with the process described in the revised guidance, and in each instance, the Primary Manufacturer accepted CMS' offer on or before the statutory deadline. Throughout the negotiation process, CMS and the Primary Manufacturers exchanged perspectives about a range of topics related to the negotiation factors, and while the parties did not always agree, CMS appreciated the Primary Manufacturers' engagement.

A detailed timeline of the negotiation process for Enbrel is below.

- August 29, 2023: CMS announced the 10 selected drugs for initial price applicability year 2026
- October 1, 2023: Deadline for the Primary Manufacturer to sign an agreement to participate in the Negotiation Program
- October 2, 2023: Deadline for the Primary Manufacturer and the public to submit information related to Enbrel in response to the Negotiation Program information collection request
- October 27, 2023: CMS met with the Primary Manufacturer regarding its response to the Negotiation Program information collection request
- October 31, 2023: CMS held a patient-focused listening session for Enbrel
- February 1, 2024: CMS provided the Primary Manufacturer with CMS' initial offer
- March 1, 2024: The Primary Manufacturer rejected CMS' initial offer and provided CMS with a counteroffer
- March 29, 2024: CMS rejected the Primary Manufacturer's counteroffer and invited the Primary Manufacturer to a negotiation meeting
- May 2, 2024: CMS and the Primary Manufacturer met for the first negotiation meeting

- May 23, 2024: CMS and the Primary Manufacturer met for the second negotiation meeting
- June 20, 2024: CMS and the Primary Manufacturer met for the third negotiation meeting
- August 1, 2024: The negotiation period ended
- August 15, 2024: MFP of \$2,355.00 was published

Indications for Enbrel

Enbrel is a drug that works by blocking the action of tumor necrosis factor, a protein in the body that causes inflammation. In people with certain autoimmune disorders, such as rheumatoid arthritis (RA), psoriatic arthritis, plaque psoriasis, and ankylosing spondylitis (AS), the body's immune system may be overactive and mistakenly attack healthy joints, skin, and/or other body systems leading to excess inflammation that can cause pain and damage to these systems.⁶

For Enbrel, CMS included the following indications in its assessment⁷:

Description of indication	Terminology used in this document
<ul style="list-style-type: none"> • To reduce the signs and symptoms, induce major clinical response, inhibit the progression of structural damage, and improve physical function in patients with moderately to severely active rheumatoid arthritis. 	RA
<ul style="list-style-type: none"> • To reduce the signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in patients 2 years of age and older. 	pJIA
<ul style="list-style-type: none"> • To reduce the signs and symptoms, inhibit the progression of structural damage of active arthritis, and improve physical function in adult patients with psoriatic arthritis. • For the treatment of active juvenile psoriatic arthritis in pediatric patients 2 years of age and older. 	Psoriatic arthritis
<ul style="list-style-type: none"> • To reduce the signs and symptoms in patients with active ankylosing spondylitis. 	AS

⁶ To compose this brief description, CMS used various sources, including MedlinePlus, a free online health information resource for patients and the general public. MedlinePlus is a service of the National Library of Medicine (NLM), a part of the U.S. National Institutes of Health (NIH). For more information about any drugs or conditions mentioned in this document, MedlinePlus can be accessed at: <https://medlineplus.gov/>.

⁷ CMS' process for identifying indications for a selected drug was to identify the FDA-approved indication(s) not otherwise excluded from coverage or otherwise restricted under section 1860D-2(e)(2) of the Act, using prescribing information approved by the FDA for the selected drug, in accordance with section 1194(e)(2)(B) of the Act. CMS considered off-label use when identifying indications if such use was included in nationally recognized, evidence-based guidelines and recognized in CMS-approved Part D compendia. CMS included indications that met these criteria during the negotiation period. Indications newly approved by FDA or included in nationally recognized, evidence-based guidelines and recognized in CMS-approved Part D compendia after the end of the negotiation period were not included.

Description of indication	Terminology used in this document
<ul style="list-style-type: none"> For the treatment of patients 4 years or older with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. 	Plaque psoriasis

Table 1. AS = ankylosing spondylitis; pJIA = polyarticular juvenile idiopathic arthritis; RA = rheumatoid arthritis. For purposes of CMS' consideration of indications for Enbrel, CMS grouped certain indications using the terminology as shown in this table. CMS' use of the terms listed here does not alter the FDA-approved indications for Enbrel.

Factors Applied

Consistent with the IRA, CMS considered certain negotiation factors as the basis for determining all offers and counteroffers during the negotiation process.

The following negotiation factors are referred to in this document as “manufacturer-specific data”⁸:

- Research and development (R&D) costs of the Primary Manufacturer for Enbrel and the extent to which the Primary Manufacturer has recouped R&D costs;
- Current unit costs of production and distribution of Enbrel;
- Prior Federal financial support for novel therapeutic discovery and development with respect to Enbrel;
- Data on pending and approved patent applications, exclusivities recognized by the FDA, and applications and approvals for New Drug Applications and Biologics License Applications for Enbrel;⁹ and
- Market data and revenue and sales volume data for Enbrel in the United States (U.S.).

The following negotiation factors are referred to in this document as “evidence about Enbrel and therapeutic alternatives to Enbrel”¹⁰:

- The extent to which Enbrel represents a therapeutic advance as compared to existing therapeutic alternatives and the costs of such existing therapeutic alternatives;
- Prescribing information approved by the FDA for Enbrel and therapeutic alternatives to Enbrel;
- Comparative effectiveness of Enbrel and therapeutic alternatives to Enbrel, taking into consideration the effects of Enbrel and therapeutic alternatives to Enbrel on specific populations, such as individuals with disabilities, the elderly, the terminally ill, children, and other patient populations; and
- The extent to which Enbrel and therapeutic alternatives to Enbrel address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy.

⁸ These factors are listed at section 1194(e)(1) of the Act.

⁹ New Drug Applications are approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act and Biologics License Applications are approved under section 351(a) of the Public Health Service Act.

¹⁰ These factors are listed at section 1194(e)(2) of the Act. In accordance with section 1194(e)(2) and section 1182(e) of Title XI of the Act, CMS did not use evidence from comparative clinical effectiveness research in a manner that treats extending the life of an individual who is elderly, disabled, or terminally ill as of lower value than extending the life of an individual who is younger, non-disabled, or not terminally ill, and, consistent with section 1182(e) of Title XI of the Act, did not use quality adjusted life years (QALYs).

The below sections describe how CMS considered and applied these factors during the negotiation process. CMS considered these factors, taking into account all data in totality during the negotiation process.

CMS and the Primary Manufacturer did not always agree on the information presented below, and the Primary Manufacturer was not restricted to consideration of these factors during the negotiation process but was free to discuss any topics with CMS it deemed relevant to its consideration of offer(s) and counteroffer(s) for Enbrel.

Manufacturer-Specific Data

CMS considered the information submitted by the Primary Manufacturer related to the manufacturer-specific data factors. These factors include R&D costs and the extent to which the Primary Manufacturer has recouped R&D costs, current unit costs of production and distribution, prior Federal financial support, data on pending and approved patents and exclusivities recognized by the FDA, and market data, including revenue and sales volume data for the drug in the United States. CMS considered these factors in totality, as part of its application of the negotiation factors during the negotiation process.

The Primary Manufacturer provided CMS with information for each of these factors in response to the Negotiation Program information collection request.¹¹ For R&D costs, CMS requested information separated into various categories of costs related to R&D, including acquisition costs, pre-clinical research costs, post-Investigational New Drug costs, costs of failed or abandoned products related to Enbrel, and other allowable direct costs. CMS also requested the global and U.S. total lifetime net revenue for Enbrel to provide insight into the extent to which the Primary Manufacturer has recouped R&D costs. CMS requested current average unit costs of production for Enbrel and current average unit costs of distribution for Enbrel separately, as well as a description of the methodology the Primary Manufacturer used to estimate such costs. For information related to prior Federal financial support, CMS requested the total amount of Federal financial support received, as well as a breakdown by various types of financial support, like tax credits and National Institutes of Health funding. CMS requested information on patents, both expired and unexpired, issued by the U.S. Patent and Trademark Office, patent applications, regulatory exclusivity periods, and active and pending FDA applications and approvals. For market data, CMS requested information about the prices for Enbrel and volume dispensed for other payers in the U.S. market, including commercial payers (e.g., the U.S. commercial average net price), Medicaid (Medicaid Best Price), and other Federal payers (the Federal supply schedule price and the Big Four price).

Throughout the negotiation process, CMS holistically considered the information submitted by the Primary Manufacturer related to the manufacturer-specific data negotiation factors for the purpose of negotiating an MFP for Enbrel. For example, CMS applied information on prices for Enbrel available to other payers in the U.S. market and how they compared to any offers or counteroffers when considering whether a potential price was consistent with CMS' aim to arrive at an agreement on the lowest possible MFP. The totality of CMS' application of these factors, in conjunction with application of the factors described below, informed CMS' negotiation of the MFP with the Primary Manufacturer.

¹¹ In accordance with the revised guidance, CMS treats R&D costs and the extent to which they are recouped, unit costs of production and distribution, pending patent applications, and market, revenue, and sales volume data as proprietary, unless the information that is provided to CMS is already publicly available. For more information, see section 40.2.1 of the [revised guidance](#).

Evidence about Enbrel and Therapeutic Alternatives to Enbrel

CMS considered information related to the negotiation factors regarding evidence about Enbrel and therapeutic alternatives to Enbrel. CMS' holistic consideration of clinical benefit included evidence from sources such as: pivotal clinical trials, pre-specified subgroup analyses, clinical practice guidelines, expert consensus statements, comparative clinical evidence, published literature reviews, real-world evidence, and FDA prescription drug labeling, among others. CMS evaluated the evidence based on a variety of considerations, including relevance and credibility, giving priority to well-designed and well-conducted studies, as stated in the revised guidance.¹² In general, CMS prioritized direct comparative evidence (e.g., head-to-head randomized controlled trials) when available. CMS also reviewed mixed and/or indirect treatment comparisons (e.g., network meta-analyses) when available and real-world evidence (e.g., observational studies) when available as part of its holistic assessment of comparative evidence.

In addition to information from the Primary Manufacturer, CMS received information from the public, including from patients during the patient-focused listening session held by CMS on October 31, 2023.¹³ Patient input was important to CMS' consideration of the evidence about Enbrel and therapeutic alternatives to Enbrel, including to help identify outcomes of interest for patients and to understand additional considerations such as patients' preferences with regard to potential treatments. For example, speakers at the patient-focused listening session shared that patients may respond differently to Enbrel and other treatments for autoimmune disorders, noting that an effective treatment for one patient may not be effective for another patient. This was one consideration among the many that informed CMS' understanding of the factors regarding evidence about Enbrel and its therapeutic alternatives. Throughout all of the patient-focused listening sessions for the first cycle of negotiations, speakers provided insight on the importance of affordability and access, which provided CMS helpful context for the speakers' described experiences.

Therapeutic Alternatives

The IRA directs CMS to compare Enbrel to therapeutic alternatives in its determination of offers and consideration of counteroffers for Enbrel.¹⁴ In the revised guidance, CMS defines a therapeutic alternative for the first cycle of negotiations as a pharmaceutical product that is clinically comparable to the selected drug.¹⁵

Importantly, use of the term "therapeutic alternative" in this MFP explanation is limited to the purposes and definition outlined in the IRA and the revised guidance. Use of this term does not suggest that CMS believes such drugs are interchangeable or otherwise universally appropriate to prescribe for an

¹² In section 50.2 of the [revised guidance](#), CMS stated, "When reviewing the literature from the public and manufacturer submissions as well as literature from CMS' review, CMS will consider the source, rigor of the study methodology, current relevance to the selected drug and its therapeutic alternative(s), whether the study has been through peer review, study limitations, degree of certainty of conclusions, risk of bias, study time horizons, generalizability, study population, and relevance to the negotiation factors listed in section 1194(e)(2) of the Act to ensure the integrity of the contributing data within the negotiation process. CMS will prioritize research, including both observational research and research based on randomized samples, that is methodologically rigorous, appropriately powered (i.e., has sufficient sample size) to answer the primary question of the research, and structured to avoid potential false positive findings due to multiple subgroup analyses."

¹³ The redacted transcript for this patient-focused listening session is available at the following link: <https://www.cms.gov/files/document/enbrel-transcript-103123.pdf>.

¹⁴ See section 1194(e)(2) of the Act and sections 50, 60.3 and 60.4 of the [revised guidance](#) for additional information.

¹⁵ This definition appears in Appendix C of the [revised guidance](#).

individual in place of Enbrel or that these are the only pharmaceutical treatments that might be used by a person with one of the indications treated by Enbrel. CMS trusts that patients and health care providers will continue to choose the therapy that best suits a given patient’s needs based on the patient’s health, history, experience, and preferences, the provider’s expertise, FDA-approved prescribing information, and relevant clinical guidelines, as applicable.

During the negotiation process, CMS identified therapeutic alternatives to Enbrel based on a holistic consideration of the available evidence from a range of sources. In addition to the sources listed above, such as data submitted by the Primary Manufacturer and the public and widely accepted clinical guidelines, other examples of data sources used include the following: drug classification systems commonly used in the public and commercial sector for formulary development, indications included in CMS-approved Part D compendia, and drug or drug class reviews.

The following table lists the therapeutic alternatives, among all clinically comparable alternatives that CMS reviewed, which were particularly relevant to CMS’ consideration, due to guideline recommendations, utilization in the Medicare population, and other considerations.

Indication	Therapeutic Alternatives
RA	<ul style="list-style-type: none"> • Adalimumab • Infliximab
pJIA	<ul style="list-style-type: none"> • Adalimumab
Psoriatic Arthritis	<ul style="list-style-type: none"> • Adalimumab • Infliximab • Risankizumab • Secukinumab • Ustekinumab
AS	<ul style="list-style-type: none"> • Adalimumab • Infliximab
Plaque psoriasis	<ul style="list-style-type: none"> • Adalimumab • Infliximab • Risankizumab • Secukinumab • Ustekinumab

Table 2. AS = ankylosing spondylitis; pJIA = polyarticular juvenile idiopathic arthritis; RA = rheumatoid arthritis. Use of the term “therapeutic alternative” in this MFP explanation is limited to the purposes and definition outlined in the IRA and the revised guidance. Use of this term does not suggest that CMS believes such drugs are interchangeable or otherwise universally appropriate to prescribe for an individual in place of Enbrel or that these are the only pharmaceutical treatments that might be used by a person with one of the indications treated by Enbrel. CMS trusts that patients and health care providers will continue to choose the therapy that best suits a given patient’s needs based on the patient’s health, history, experience, and preferences, the provider’s expertise, FDA-approved prescribing information, and relevant clinical guidelines, as applicable.

CMS considered utilization for Enbrel and its therapeutic alternatives by indication as one part of its application of the negotiation factors.

Outcomes and Additional Considerations

Outcomes are measurable effects or impacts of a treatment or intervention. Outcomes can be used to measure differences in the safety or effectiveness of different treatments. Patient-centered outcomes are outcomes identified by patients that are important to how they feel, function, or survive. To consider comparative effectiveness between Enbrel and therapeutic alternatives to Enbrel, CMS

identified clinically relevant and patient-centered outcomes of interest from the body of available literature to evaluate for each indication of Enbrel. CMS then identified evidence comparing Enbrel and its therapeutic alternatives based on these outcomes. The following table includes a non-exhaustive list of outcomes that were of interest to CMS in its consideration of Enbrel:

Indication	Effectiveness Outcomes	Safety Outcomes
RA	<ul style="list-style-type: none"> • Clinical response (e.g., ACR 20) • Disease activity (e.g., DAS 28) • Structural damage (e.g., radiographic non-progression) • Physical function (e.g., HAQ-DI) • HRQoL (e.g., SF-36) 	<ul style="list-style-type: none"> • Serious adverse events • Tolerability (e.g., discontinuation due to adverse events)
pJIA	<ul style="list-style-type: none"> • Clinical response (e.g., pediatric core set of ACR response) • Disease activity (e.g., juvenile arthritis disease activity score) • Pain (e.g., VAS) • HRQoL (e.g., Child Health Questionnaire) 	<ul style="list-style-type: none"> • Serious adverse events • Tolerability (e.g., discontinuation due to adverse events)
Psoriatic Arthritis	<ul style="list-style-type: none"> • Disease signs and symptoms (e.g., ACR 20; PASI 75) • Structural damage (e.g., radiographic non-progression) • Physical function (e.g., HAQ-DI) • HRQoL (e.g., Psoriatic Arthritis QOL) 	<ul style="list-style-type: none"> • Serious adverse events • Tolerability (e.g., discontinuation due to adverse events)
AS	<ul style="list-style-type: none"> • Clinical response (e.g., ASAS 20) • Inflammation (e.g., CRP) • HRQoL (e.g., SF-36) 	<ul style="list-style-type: none"> • Serious adverse events • Tolerability (e.g., discontinuation due to adverse events)
Plaque psoriasis	<ul style="list-style-type: none"> • Disease extent and severity (e.g., PASI 75) • HRQoL (e.g., DLQI) 	<ul style="list-style-type: none"> • Serious adverse events • Tolerability (e.g., discontinuation due to adverse events)

Table 3. ACR = American College of Rheumatology; AS = ankylosing spondylitis; CDAI = Clinical Disease Activity Index; CRP = C-reactive protein; DAS = Disease Activity Score; DLQI = Dermatology Life Quality Index Questionnaire; HAQ-DI = Health Assessment Questionnaire - Disability Index; HRQoL = Health-related quality of life; PASI = Psoriasis Area and Severity Index; pJIA = polyarticular juvenile idiopathic arthritis; QoL = Quality of Life; RA = rheumatoid arthritis; SF-36 = 36-Item Short Form Survey. Outcomes identified in this table were of interest to CMS in its evaluation of Enbrel. Evidence to support an assessment may not have been available for every outcome of interest.

Outcomes, like those listed above, were identified as being of interest to CMS based on their importance to patients and their ability to measure how effective and safe a drug is when used to treat these indications. For example, for RA, certain signs and symptoms of the disease, structural damage to joints, and impact on patients' physical functioning are key outcomes that are often used to evaluate the effectiveness of treatments. In addition, across indications, the risk of serious adverse events and

tolerability, or the degree to which patients can tolerate adverse events associated with taking a drug, are outcomes that reflect important safety considerations when evaluating drugs for these indications.

Additionally, CMS considered the extent to which Enbrel represents a therapeutic advance as compared to existing therapeutic alternatives, and the extent to which Enbrel and its therapeutic alternatives address an unmet medical need. CMS also evaluated access, equity, and health outcomes for specific populations (including individuals with disabilities, the elderly, individuals who are terminally ill, children, and other patient populations).

For the purpose of negotiating the MFP for Enbrel, CMS holistically considered the negotiation factors regarding evidence about Enbrel and its therapeutic alternatives, including consideration of the clinical benefit of Enbrel in the context of its therapeutic alternatives. For example, CMS applied its understanding of the comparative effectiveness of Enbrel and its therapeutic alternatives for each of the identified indications, as well as additional contextual considerations, when negotiating with the Primary Manufacturer. Examples of additional contextual considerations for Enbrel and its therapeutic alternatives include the treatment complexity of these drugs (e.g., route of administration and frequency), use in related co-occurring conditions (e.g., inflammatory bowel disease), and specific disease manifestations (such as scalp or nail involvement in patients with plaque psoriasis).

Throughout the negotiation process, including the development of the initial offer and in the consideration of any offers and counteroffers, CMS applied these and other factors regarding evidence about Enbrel and therapeutic alternatives. The totality of CMS' application of these factors, in conjunction with application of the manufacturer-submitted data negotiation factors described above, informed CMS' negotiation of the MFP with the Primary Manufacturer.

Citations to Data Reviewed during the Negotiation Process for Enbrel

CMS provides below a list of citations representative of evidence that CMS reviewed during the negotiation process, including citations provided by the Primary Manufacturer and the public in response to the Negotiation Program information collection request, those included in CMS' initial offer concise justification, and other citations which were considered during the evaluation of the Primary Manufacturer's counteroffer and during negotiation meetings.

Consistent with the IRA and section 1182(e) of Title XI of the Act, CMS did not use evidence from comparative clinical effectiveness research in a manner that treats extending the life of an individual who is elderly, disabled, or terminally ill as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill, and, consistent with section 1182(e) of Title XI of the Act, did not use quality adjusted life years (QALYs). Inclusion on this list of a citation that contains such evidence does not mean that CMS used such evidence in the course of the negotiation.

This list is intended to provide insight into the range of evidence that various parties, including CMS and the Primary Manufacturer, identified as being relevant to the negotiation. This list does not represent the totality of evidence that CMS reviewed and considered as part of its holistic consideration of the negotiation factors in the determination of any offers and consideration of any counteroffers.

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2. AbbVie Inc. Rinvoq (upadacitinib) [package insert]. U.S. Food and Drug Administration. Revised 2023 Jun. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/211675s017lbl.pdf.
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7. Amgen, Inc. Enbrel (etanercept) [package insert]. U.S. Food and Drug Administration. Revised 2023 Oct. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/103795s5595lbl.pdf.
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Redacted Negotiation Meeting Summaries for Enbrel

Below are summaries of the negotiation meetings between CMS and the Primary Manufacturer, which include redacted information regarding the negotiation meetings and exchange of offers and counteroffers in the meetings.



SUBJECT: Meeting Summary from Negotiation Meeting between the Centers for Medicare & Medicaid Services (CMS) and Immunex Corporation regarding Enbrel on May 2, 2024

Background: Sections 11001 and 11002 of the Inflation Reduction Act of 2022 (IRA) (P.L. 117-169), signed into law on August 16, 2022, established the Medicare Drug Price Negotiation Program (hereafter the “Negotiation Program”) to enable the Centers for Medicare & Medicaid Services (CMS) to negotiate maximum fair prices (MFPs) with willing manufacturers for certain high expenditure, single source drugs and biological products. Immunex Corporation (hereafter “the Primary Manufacturer”) chose to enter into an agreement to participate in the Negotiation Program for Enbrel (hereafter “the Selected Drug”).

In accordance with revised guidance and in the course of negotiation for the Selected Drug, CMS invited the Primary Manufacturer to a negotiation meeting when rejecting the Primary Manufacturer’s counteroffer, and the Primary Manufacturer accepted CMS’ invitation. CMS shared a proposed meeting agenda with the Primary Manufacturer approximately two weeks before the meeting. The Primary Manufacturer had the opportunity to request additions or edits to the agenda at least one week ahead of the meeting. This document includes a summary prepared by CMS of the first negotiation meeting, which was held on May 2, 2024 between 1:00 PM ET and 3:30 PM ET.

CMS Attendees:

1. Kristie Gurley, Representative from the Office of the General Counsel
2. Dan Heider, Director, Division of Rebate Agreements and Drug Price Negotiation
3. Min Kwon, Division of Rebate Agreements and Drug Price Negotiation
4. Tina Li, Medicare Drug Rebate and Negotiations Group
5. Corey Rosenberg, Deputy Director, Division of Rebate Agreements and Drug Price Negotiation
6. Lara Strawbridge, Deputy Director of Policy, Medicare Drug Rebate and Negotiations Group

Primary Manufacturer Attendees:

1. William Connelly, Associate General Counsel
2. Gary Fanjiang, Vice President, U.S. Medical
3. Yola Gawlik, Executive Director, U.S. Health Policy and Reimbursement
4. Susan Logan, Vice President, General Manager Inflammation
5. Pallavi Rane, Senior Director Health Economics
6. David Zimmer, Vice President, U.S. Value & Access

Topics: The discussion focused on topics outlined in the final agenda for the meeting, which was as follows:¹

- Introductions and meeting reminders
- Discussion of initial offer and any questions from the Primary Manufacturer
- Discussion of counteroffer and any questions from CMS
- Any other considerations that CMS and the Primary Manufacturer would like to discuss
- Next steps

¹ Note: This agenda may be inclusive of topics proposed by the Primary Manufacturer.

Offers/Counteroffers Exchanged:





SUBJECT: Meeting Summary from Negotiation Meeting between the Centers for Medicare & Medicaid Services (CMS) and Immunex Corporation regarding Enbrel on May 23, 2024

Background: Sections 11001 and 11002 of the Inflation Reduction Act of 2022 (IRA) (P.L. 117-169), signed into law on August 16, 2022, established the Medicare Drug Price Negotiation Program (hereafter the “Negotiation Program”) to enable the Centers for Medicare & Medicaid Services (CMS) to negotiate maximum fair prices (MFPs) with willing manufacturers for certain high expenditure, single source drugs and biological products. Immunex Corporation (hereafter “the Primary Manufacturer”) chose to enter into an agreement to participate in the Negotiation Program for Enbrel (hereafter “the Selected Drug”).

In accordance with revised guidance and in the course of negotiation for the Selected Drug, because CMS and the Primary Manufacturer did not reach agreement on an MFP in the first negotiation meeting held on May 2, 2024, each party had the opportunity to request one additional negotiation meeting, resulting in a maximum of three meetings. CMS requested a second negotiation meeting and the Primary Manufacturer accepted the invitation. CMS shared a proposed meeting agenda with the Primary Manufacturer approximately two weeks before the meeting. The Primary Manufacturer had the opportunity to request additions or edits to the agenda at least one week ahead of the meeting. This document includes a summary prepared by CMS of the second negotiation meeting, which was held on May 23, 2024 between 10:00 AM ET and 12:30 PM ET.

CMS Attendees:

1. Kristie Gurley, Representative from the Office of the General Counsel
2. Dan Heider, Director, Division of Rebate Agreements and Drug Price Negotiation
3. Kaitlin Hunter, Division of Rebate Agreements and Drug Price Negotiation
4. Min Kwon, Division of Rebate Agreements and Drug Price Negotiation
5. Tina Li, Medicare Drug Rebate and Negotiations Group
6. Lara Strawbridge, Deputy Director of Policy, Medicare Drug Rebate and Negotiations Group

Primary Manufacturer Attendees:

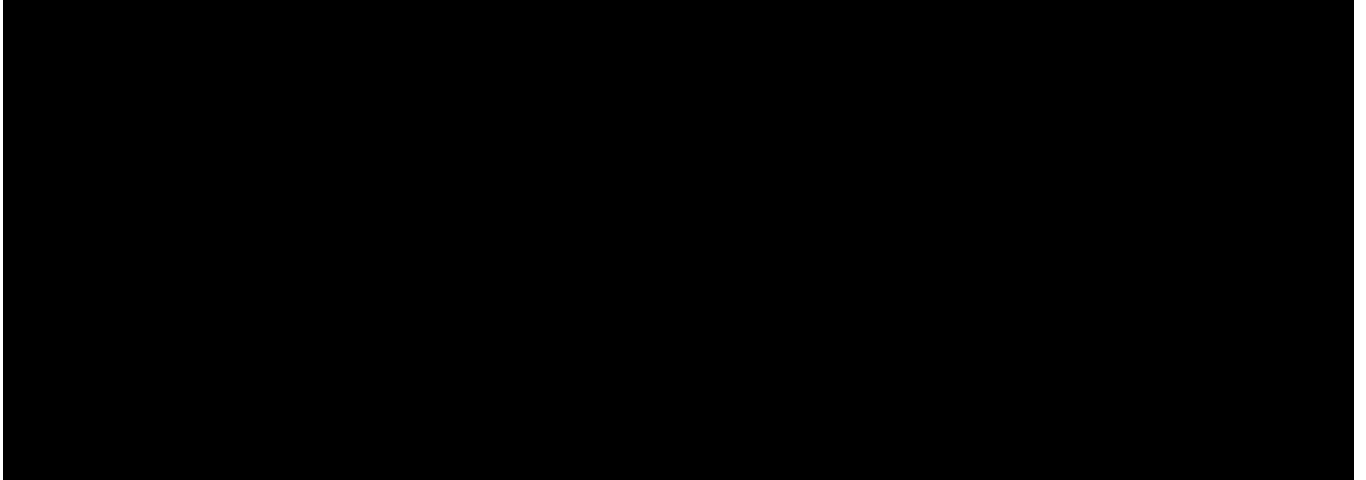
1. William Connelly, Associate General Counsel (virtual attendance)
2. Gary Fanjiang, Vice President, U.S. Medical (virtual attendance)
3. Kelsey Lang, Executive Director, U.S. Health Policy and Reimbursement (virtual attendance)
4. Susan Logan, Vice President, General Manager Inflammation (virtual attendance)
5. Pallavi Rane, Senior Director Health Economics (virtual attendance)
6. David Zimmer, Vice President, U.S. Value & Access (virtual attendance)

Topics: The discussion focused on topics outlined in the final agenda for the meeting, which was as follows:¹

- Introductions and meeting reminders
- Further discussion of real-world comparative evidence relative to therapeutic alternatives
- Any additional information from Primary Manufacturer on the impact of previously discussed access concerns
- Any other considerations that CMS or the Primary Manufacturer would like to discuss
- Next steps

¹ Note: This agenda may be inclusive of topics proposed by the Primary Manufacturer.

Offers/Counteroffers Exchanged:





SUBJECT: Meeting Summary from Negotiation Meeting between the Centers for Medicare & Medicaid Services (CMS) and Immunex Corporation regarding Enbrel on June 20, 2024

Background: Sections 11001 and 11002 of the Inflation Reduction Act of 2022 (IRA) (P.L. 117-169), signed into law on August 16, 2022, established the Medicare Drug Price Negotiation Program (hereafter the “Negotiation Program”) to enable the Centers for Medicare & Medicaid Services (CMS) to negotiate maximum fair prices (MFPs) with willing manufacturers for certain high expenditure, single source drugs and biological products. Immunex Corporation (hereafter “the Primary Manufacturer”) chose to enter into an agreement to participate in the Negotiation Program for Enbrel (hereafter “the Selected Drug”).

In accordance with revised guidance and in the course of negotiation for the Selected Drug, because CMS and the Primary Manufacturer did not reach agreement on an MFP in the second negotiation meeting, which was requested by CMS and held on May 23, 2024, the Primary Manufacturer had the opportunity to request one additional negotiation meeting, resulting in a maximum of three meetings. The Primary Manufacturer requested a third negotiation meeting and CMS accepted the invitation. CMS shared a proposed meeting agenda with the Primary Manufacturer approximately two weeks before the meeting. The Primary Manufacturer had the opportunity to request additions or edits to the agenda at least one week ahead of the meeting. This document includes a summary prepared by CMS of the third negotiation meeting, which was held on June 20, 2024 between 10:00 AM ET and 12:30 PM ET.

CMS Attendees:

1. Kristie Gurley, Representative from the Office of the General Counsel (virtual attendance)
2. Dan Heider, Director, Division of Rebate Agreements and Drug Price Negotiation
3. Min Kwon, Division of Rebate Agreements and Drug Price Negotiation
4. Tina Li, Medicare Drug Rebate and Negotiations Group
5. Corey Rosenberg, Deputy Director, Division of Rebate Agreements and Drug Price Negotiation
6. Lara Strawbridge, Deputy Director of Policy, Medicare Drug Rebate and Negotiations Group

Primary Manufacturer Attendees:

1. William Connelly, Associate General Counsel (virtual attendance)
2. Gary Fanjiang, Vice President, U.S. Medical (virtual attendance)
3. Yola Gawlik, Executive Director, U.S. Health Policy and Reimbursement
4. Susan Logan, Vice President, General Manager Inflammation (virtual attendance)
5. Pallavi Rane, Senior Director Health Economics (virtual attendance)
6. David Zimmer, Vice President, U.S. Value & Access (virtual attendance)

Topics: The discussion focused on topics outlined in the final agenda for the meeting, which was as follows:¹

- Introductions and meeting reminders
- Continued discussion of formulary access considerations
- Revised offer/counteroffer price discussion
- Any other considerations that CMS or the Primary Manufacturer would like to discuss
- Next steps

¹ Note: This agenda may be inclusive of topics proposed by the Primary Manufacturer.

Offers/Counteroffers Exchanged:

