



Maximum Fair Price (MFP) Explanation for Eliquis

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 Eliquis for the agreed-upon MFP that resulted from the negotiations for initial price applicability year 2026 with Bristol Myers Squibb, the manufacturer of Eliquis (the “Primary Manufacturer”), provides information about the negotiations for Eliquis. 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 Eliquis.

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 Eliquis 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 \$231.00 for Eliquis 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:

- MFP Explanation Narrative for Eliquis
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- Redacted Negotiation Meeting Summaries for Eliquis
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MFP Explanation Narrative for Eliquis

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 Eliquis. 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 Eliquis 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 Eliquis in response to the Negotiation Program information collection request
- October 30, 2023: CMS met with the Primary Manufacturer regarding its response to the Negotiation Program information collection request
- October 30, 2023: CMS held a patient-focused listening session for Eliquis
- 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 1, 2024: CMS and the Primary Manufacturer met for the first negotiation meeting

- June 4, 2024: CMS and the Primary Manufacturer met for the second negotiation meeting
- June 24, 2024: CMS and the Primary Manufacturer met for the third negotiation meeting
- August 1, 2024: The negotiation period ended
- August 15, 2024: MFP of \$231.00 was published

Indications for Eliquis

Eliquis is an oral anticoagulant that blocks factor Xa, an enzyme involved in production of thrombin in the blood and in the formation of blood clots. In people who are at high risk for having a blood clot, such as patients with nonvalvular atrial fibrillation, or patients undergoing hip or knee surgery, anticoagulation treatment prevents blood clots that can cause a stroke, or blood clots that can develop in the legs or lungs.⁶

For Eliquis, 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 risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. 	NVAF
<ul style="list-style-type: none"> • For the prophylaxis of deep vein thrombosis (DVT) in patients who have undergone hip or knee replacement surgery. 	VTE prophylaxis following hip or knee surgery
<ul style="list-style-type: none"> • For the treatment of DVT. • For the treatment of pulmonary embolism (PE). • To reduce the risk of recurrent DVT and PE following initial therapy. 	The treatment of DVT and PE and the reduction of risk of recurrence of VTE, referred to as active and recurrent VTE

Table 1. NVAF = nonvalvular atrial fibrillation; VTE = venous thromboembolism. For purposes of CMS' consideration of indications for Eliquis, 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 Eliquis.

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:

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.

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

- Research and development (R&D) costs of the Primary Manufacturer for Eliquis and the extent to which the Primary Manufacturer has recouped R&D costs;
- Current unit costs of production and distribution of Eliquis;
- Prior Federal financial support for novel therapeutic discovery and development with respect to Eliquis;
- 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 Eliquis;⁹ and
- Market data and revenue and sales volume data for Eliquis in the United States (U.S.).

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

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

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 Eliquis.

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.

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 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 Eliquis, and other allowable direct costs. CMS also requested the global and U.S. total lifetime net revenue for Eliquis 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 Eliquis and current average unit costs of distribution for Eliquis 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 Eliquis 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 Eliquis. For example, CMS applied information on prices for Eliquis 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.

Evidence about Eliquis and Therapeutic Alternatives to Eliquis

CMS considered information related to the negotiation factors regarding evidence about Eliquis and therapeutic alternatives to Eliquis. 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

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](#).

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."

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 30, 2023.¹³ Patient input was important to CMS’ consideration of the evidence about Eliquis and therapeutic alternatives to Eliquis, including to help identify outcomes of interest for patients and to understand additional considerations such as treatment complexity. For example, some patients taking Eliquis described that they appreciated having an option that required minimal monitoring and minimal dietary restrictions. This was one consideration among the many that informed CMS’ understanding of the factors regarding evidence about Eliquis 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 Eliquis to therapeutic alternatives in its determination of offers and consideration of counteroffers for Eliquis.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 individual in place of Eliquis or that these are the only pharmaceutical treatments that might be used by a person with one of the indications treated by Eliquis. 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 Eliquis 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
NVAF	<ul style="list-style-type: none">• Dabigatran• Rivaroxaban

¹³ The redacted transcript for this patient-focused listening session is available at the following link: <https://www.cms.gov/files/document/eliquis-transcript-103023.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](#).

Indication	Therapeutic Alternatives
VTE prophylaxis following hip or knee surgery:	<ul style="list-style-type: none"> • Dabigatran • Rivaroxaban
Active and recurrent VTE	<ul style="list-style-type: none"> • Dabigatran • Rivaroxaban

Table 2. NVAf = nonvalvular atrial fibrillation; VTE = venous thromboembolism. 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 Eliquis or that these are the only pharmaceutical treatments that might be used by a person with one of the indications treated by Eliquis. 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 Eliquis 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 Eliquis and therapeutic alternatives to Eliquis, CMS identified clinically relevant and patient-centered outcomes of interest from the body of available literature to evaluate for each indication of Eliquis. CMS then identified evidence comparing Eliquis to 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 Eliquis:

Indication	Effectiveness Outcomes	Safety Outcomes
NVAf	<ul style="list-style-type: none"> • Prevention of stroke and systemic embolism 	<ul style="list-style-type: none"> • Bleeding
VTE prophylaxis following hip or knee surgery	<ul style="list-style-type: none"> • VTE 	<ul style="list-style-type: none"> • Bleeding
Active and recurrent VTE	<ul style="list-style-type: none"> • VTE 	<ul style="list-style-type: none"> • Bleeding

Table 3. NVAf = nonvalvular atrial fibrillation; VTE = venous thromboembolism. Outcomes identified in this table were of interest to CMS in its evaluation of Eliquis. 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, prevention of strokes, or blood clots in the legs or lungs, are key outcomes that are often used to evaluate the effectiveness of treatments for these indications. In addition, the risk of bleeding is an outcome that reflects important safety considerations when evaluating drugs for these indications.

Additionally, CMS considered the extent to which Eliquis represents a therapeutic advance as compared to existing therapeutic alternatives, and the extent to which Eliquis 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 Eliquis, CMS holistically considered the negotiation factors regarding evidence about Eliquis and its therapeutic alternatives, including consideration of the clinical benefit of Eliquis in the context of its therapeutic alternatives. For example, CMS applied its understanding of the comparative effectiveness of Eliquis and its therapeutic alternatives by assessing prevention of blood clots and rates of bleeding for each of the identified indications when negotiating with the Primary Manufacturer. CMS' holistic assessment was also informed by additional contextual considerations, such as use in patients with end-stage renal disease or on dialysis, patients with obesity, patients with cancer, and the elderly.

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 Eliquis 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 Eliquis

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.

1. Abbott T, Armijo N, Balmaceda C, Espinoza MA. Cost-Effectiveness of Dabigatran for Thromboembolic Events Prevention in Atrial Fibrillation Patients. ISPOR; 2022 Dec. Report No. EE492. Available from: <https://www.ispor.org/heor-resources/presentations-database/presentation/euro2022-3567/121265>.
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3. Ademi Z, Pasupathi K, Liew D. COST EFFECTIVENESS OF APIXABAN COMAPRED TO ASPIRIN IN PATIENTS WITH ATRIAL FIBRILLATION. ISPOR; 2014 May. Report No. PCV85. Available from: <https://www.ispor.org/heor-resources/presentations-database/presentation/ispor-19th-annual-international-meeting/cost-effectiveness-of-apixaban-comapred-to-aspirin-in-patients-with-atrial-fibrillation>.
4. Agnelli G, Becattini C, Meyer G, Munoz A, Huisman MV, Connors JM, et al. Apixaban for the Treatment of Venous Thromboembolism Associated with Cancer. *N Engl J Med*. 2020;382(17):1599-607. Epub 20200329. doi: 10.1056/NEJMoa1915103. PubMed PMID: 32223112.
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7. Agnelli G, Muñoz A, Franco L, Mahé I, Brenner B, Connors JM, et al. Apixaban and Dalteparin for the Treatment of Venous Thromboembolism in Patients with Different Sites of Cancer.

- Thromb Haemost. 2022;122(5):796-807. Epub 20210916. doi: 10.1055/s-0041-1735194. PubMed PMID: 34530482.
8. Al-Saffar H, Al-Zaidy M, Mohammed S, Al Yassin A, Haji G, Alghadhbani M, Shelbaia M, Basu S, Mohamed O. Cost-Effectiveness Analysis of Apixaban in Atrial Fibrillation Indication: Iraq (Private Sector). ISPOR; 2020 Dec. Report No. PCV56. Available from: <https://www.ispor.org/heor-resources/presentations-database/presentation/euro2020-3282/105871>.
 9. Alternatives to QALY-based cost-effectiveness analysis for determining the value of prescription drugs and other health interventions. National Council on Disability; 2022 Nov 28. Available from: <https://www.ncd.gov/report/alternatives-to-qaly-based-cost-effectiveness-analysis-for-determining-the-value-of-prescription-drugs-and-other-health-interventions/>.
 10. Altevers J, Seidel K, Stolskij A, Stross L. Major and Life-Threatening Bleeds Under Anticoagulation Therapy - Patient Numbers and Outcomes in Germany in 2017. ISPOR; 2020 Dec. Report No. PSY18. Available from: <https://www.ispor.org/heor-resources/presentations-database/presentation/euro2020-3282/105712>.
 11. American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2023;71(7):2052-81. Epub 20230504. doi: 10.1111/jgs.18372. PubMed PMID: 37139824.
 12. Amin A, Keshishian A, Hines DM, Dina O, Le H, Rosenblatt L, et al. Risk of stroke/systemic embolism, major bleeding, and associated costs in non-valvular atrial fibrillation patients who initiated apixaban, dabigatran, or rivaroxaban compared with warfarin in the United States medicare population: updated analysis. Curr Med Res Opin. 2022;38(12):2131-40. Epub 20220830. doi: 10.1080/03007995.2022.2115772. PubMed PMID: 35993487.
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Redacted Negotiation Meeting Summaries for Eliquis

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 Bristol Myers Squibb regarding Eliquis on May 1, 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. Bristol Myers Squibb (hereafter “the Primary Manufacturer”) chose to enter into an agreement to participate in the Negotiation Program for Eliquis (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 1, 2024 between 1:00 PM ET and 3:30 PM ET.

CMS Attendees:

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

Primary Manufacturer Attendees:

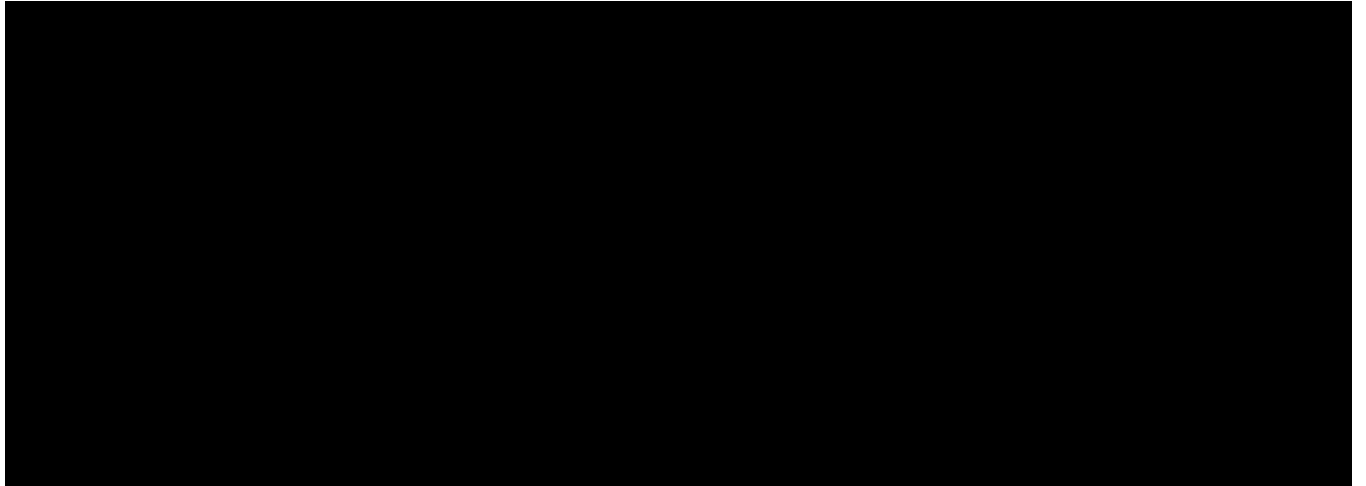
1. Anthony Barisano, Vice President, Global HEOR
2. Stephanie Dyson, Senior Vice President US Policy & Government Affairs
3. William Knott, VP and Assistant General Counsel
4. Xuemei Luo, Senior Director, HTA Value & Evidence Team Lead for Eliquis, Pfizer
5. Chris Mancill, Senior Vice President & Head, Global Market Access, Pricing & Value Demonstration
6. Katheryne Richardson, Vice President, Global Pricing & Health Systems Analytics

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 Bristol Myers Squibb regarding Eliquis on June 4, 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. Bristol Myers Squibb (hereafter “the Primary Manufacturer”) chose to enter into an agreement to participate in the Negotiation Program for Eliquis (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 1, 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 June 4, 2024 between 1:30 PM ET and 4:00 PM ET.

CMS Attendees:

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

Primary Manufacturer Attendees:

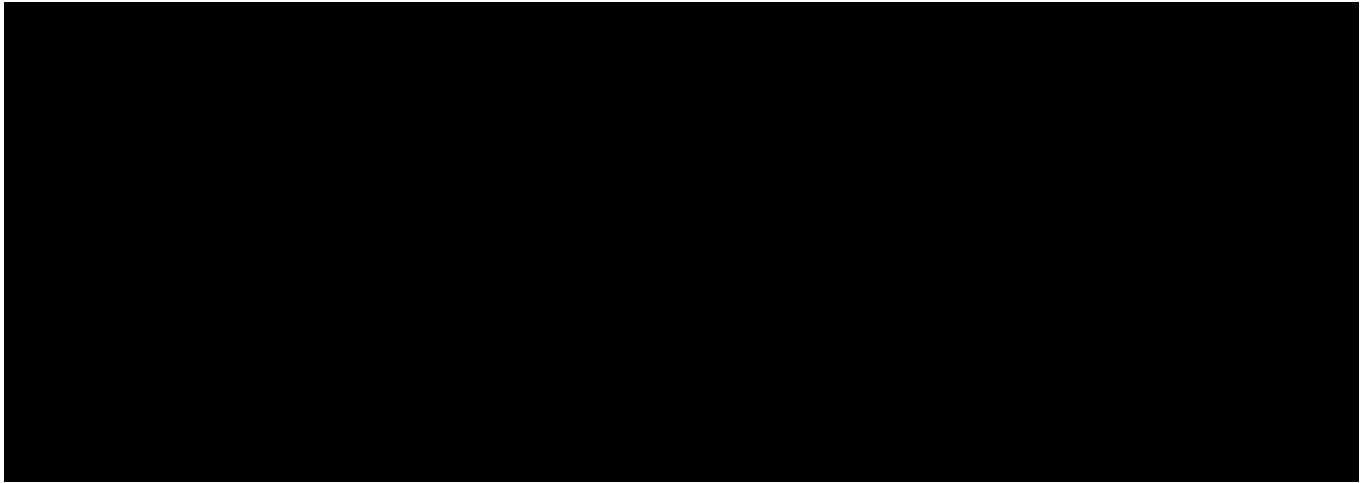
1. Anthony Barisano, Vice President, Global HEOR
2. Stephanie Dyson, Senior Vice President US Policy & Government Affairs
3. William Knott, VP and Assistant General Counsel
4. Xuemei Luo, Senior Director, HTA Value & Evidence Team Lead for Eliquis, Pfizer
5. Chris Mancill, Senior Vice President & Head, Global Market Access, Pricing & Value Demonstration
6. Kathyne Richardson, Vice President, Global Pricing & Health Systems Analytics

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

- Introductions and meeting reminders
- Any additional information from Primary Manufacturer on the impact of previously discussed access concerns
- Any additional information from Primary Manufacturer on comparative evidence related to subpopulations
- Offer/counteroffer price discussion
- 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 Bristol Myers Squibb regarding Eliquis on June 24, 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. Bristol Myers Squibb (hereafter “the Primary Manufacturer”) chose to enter into an agreement to participate in the Negotiation Program for Eliquis (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 June 4, 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 24, 2024 between 10:00 AM ET and 12:30 PM ET.

CMS Attendees:

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

Primary Manufacturer Attendees:

1. Stephanie Dyson, Senior Vice President US Policy & Government Affairs
2. William Knott, VP and Assistant General Counsel
3. Chris Mancill, Senior Vice President & Head, Global Market Access, Pricing & Value Demonstration
4. Rodrigo Puga, Senior Vice President, US Internal Medicine Lead, Pfizer
5. Alan Reba, Senior Vice President, U.S. Cardiovascular & Established Brands
6. Kathyne Richardson, Vice President, Global Pricing & Health Systems Analytics

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

- Introductions and meeting reminders
- Revised offer/counteroffer price discussion
 - Active, back and forth price negotiation, consistent with BMS’ standard business practices, with the goal of shared understanding of Eliquis’ value to Medicare and to patients and better alignment on that value.
- 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.

- Clear understanding of timelines and next steps

Offers/Counteroffers Exchanged:

