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POLICY BRIEF · FISCAL ANALYSIS
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# 10-Year CMS Cost Impact of Negotiated First-Line Suzetrigine Access

A 10-year Medicare and Medicaid fiscal-impact model of a negotiated first-line access deal for suzetrigine.

Moving suzetrigine from restricted, high-cost access to low-barrier first-line coverage saves CMS an estimated $13–$18 billion over ten years, incremental to a continued managed-access status quo.

Companion analysis to CASPR Policy Brief 003

AUTHOR
Nicholas Reville
Executive Director, CASPR

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# Executive Summary

– Suzetrigine is a non-addictive, non-opioid painkiller from Vertex that was approved in 2025. Suzetrigine can replace approximately 50% of acute pain prescriptions in CMS, in mild-to-moderate pain use cases.

– Negotiating with Vertex to lower the price and move suzetrigine in CMS from a high-cost restricted treatment to low-barrier first-line access will save Medicaid and Medicare approximately $13B–$18B over 10 years, incremental to a continued managed-access status quo.

– Roughly three-quarters of that fiscal benefit accrues to federal Medicare Part D, the rest to Medicaid (split federal/state via FMAP); states share the Medicaid line plus most of the avoided criminal-justice cost. A stakeholder breakdown is included in the report.

– Cost savings are driven primarily by reduced incidence of new opioid use disorder (OUD) cases and the associated incremental CMS medical cost (about $5,900 per year per OUD beneficiary, above a comparable non-OUD beneficiary).

– Over 10 years, negotiated first-line access prevents roughly 664,000 additional new OUD cases and avoids about 26,000 additional OUD-attributable deaths in CMS beneficiaries beyond what the status-quo trajectory would deliver on its own.

– Under negotiated lower pricing, Vertex receives access to a dramatically larger patient population in exchange for reduced per-pill pricing. A range of prices are explored.

– Suzetrigine also reduces direct drug costs by decreasing the number of prescriptions relative to opioid standard of care, as fewer patients seek refills versus habit-forming opioid treatments.

– If Vertex is successful in expanding suzetrigine labeling to include chronic pain, CMS fiscal benefits roughly double (the primary $2/pill scenario grows from approximately $14B to about $29B in 10-year savings) due to the higher incidence of OUD driven by chronic pain prescribing.

– Large additional social benefits, fiscal benefits to other agencies (VA, DoD, IHS), and positive impact in the commercial market are likely as well.

# Model Overview

– A 10-year CMS fiscal impact model (2027–2036) of a negotiated suzetrigine access deal under five pricing scenarios, with explicit assumptions on reach, production cost, and Vertex CMS-channel revenue.

– Core fiscal line = avoided generic opioid drug cost (index Rx + refills + escalation outside opioid use disorder) + avoided CMS-paid opioid use disorder (OUD) medical care – CMS suzetrigine drug spend. Societal impact (productivity, criminal justice,

value of a statistical life) is reported separately and NOT added to the core line.

– In the modeled StatusQuo current-access comparator, suzetrigine remains a non-preferred, utilization-managed brand and reaches <3% of eligible patients over the first modeled year.

– In the negotiated first-line access scenarios, suzetrigine receives standardized first-line placement, opioid-like patient cost sharing, no routine step therapy, and no routine prior authorization.

## Net Cost Savings from Negotiated First-Line Access to Suzetrigine

Negotiating a lower price for suzetrigine in exchange for first-line access without patient or prescriber barriers generates large savings for CMS over the next ten years.

Incremental 10-Year CMS Fiscal Impact vs StatusQuo: Price2 at $2/pill, Acute-Pain Label Only

| Metric | 10-Year Value |
|---|---|
| **Additional avoided OUD medical care** | -$13.0B |
| **Additional avoided opioid drug cost (index + refills)** | -$2.9B |
| **Additional CMS savings** | -$16.0B |
| **Additional CMS suzetrigine drug spend** | +$1.1B |
| **Incremental net CMS savings vs StatusQuo** | -$14.9B |
| **Additional new OUD cases prevented in CMS beneficiaries** | 664K |

Acute-pain label only, 2027-2036. Rows are incremental versus the modeled StatusQuo current-access comparator. Negative values = money CMS does not spend; positive = money CMS does spend. OUD medical savings use the incremental cost attributable to an OUD diagnosis ($5,900/yr = Medicare OUD PBPY $15,464 minus non-OUD PBPY $9,558, Drug & Alcohol Dependence 2023).

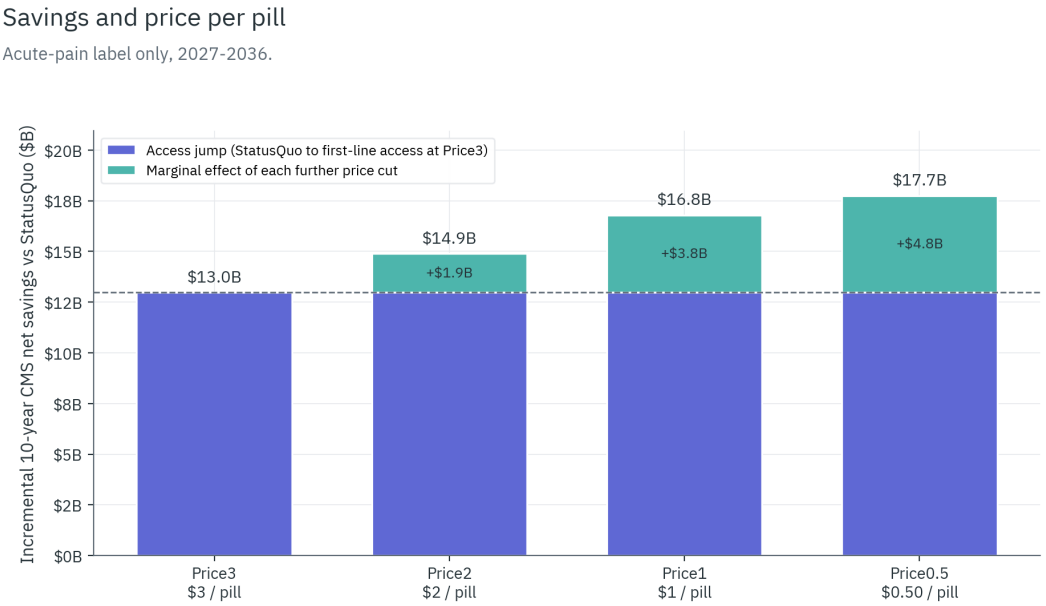



*Figure 1. Incremental 10-year CMS savings versus StatusQuo, decomposed into the one-time access jump (StatusQuo to first-line deal) and the marginal effect of each further price step down to Price0.5 (acute-pain label only, 2027–2036).*

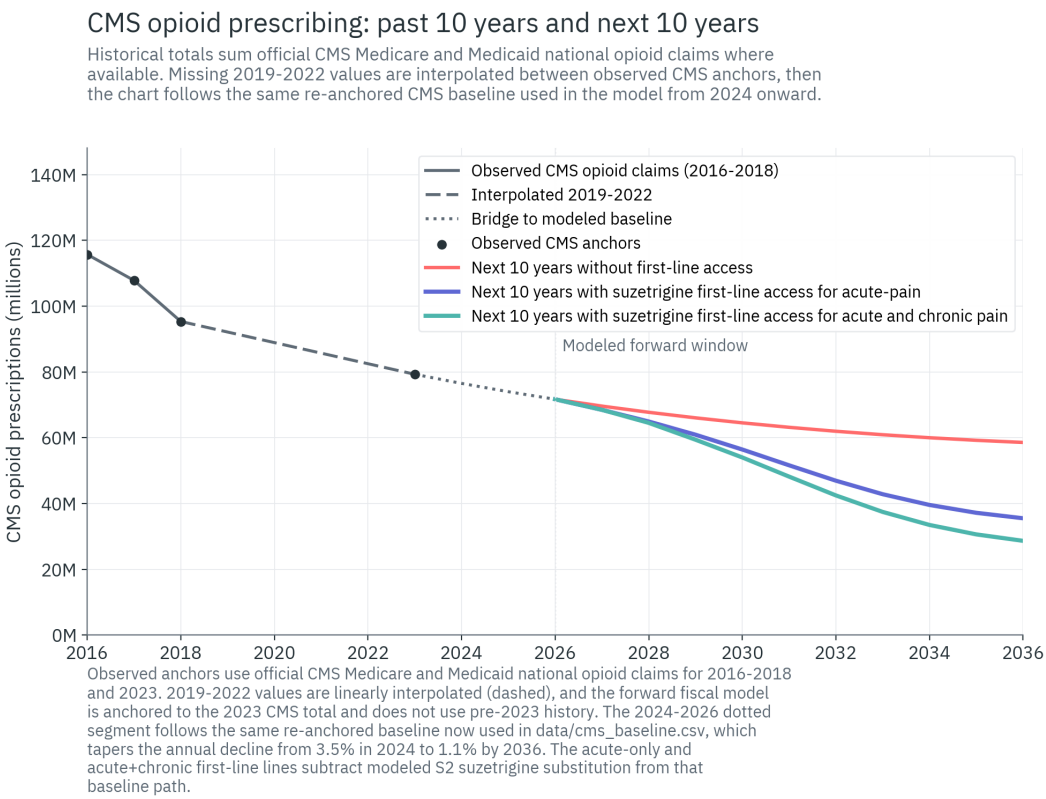
**Key inputs / vs StatusQuo:** deal Bass terminal peak 85% vs StatusQuo 25%; ~50.4% addressable acute share; net CMS savings = avoided OUD medical ($5.9K/yr × 5-yr) + avoided opioid drug spend ($17.5/Rx × 1.5 refill) minus suzetrigine drug spend.

# Increased Suzetrigine Adoption and Patient Impact

Avoided opioid prescriptions reduce the probability that a CMS beneficiary develops opioid use disorder.

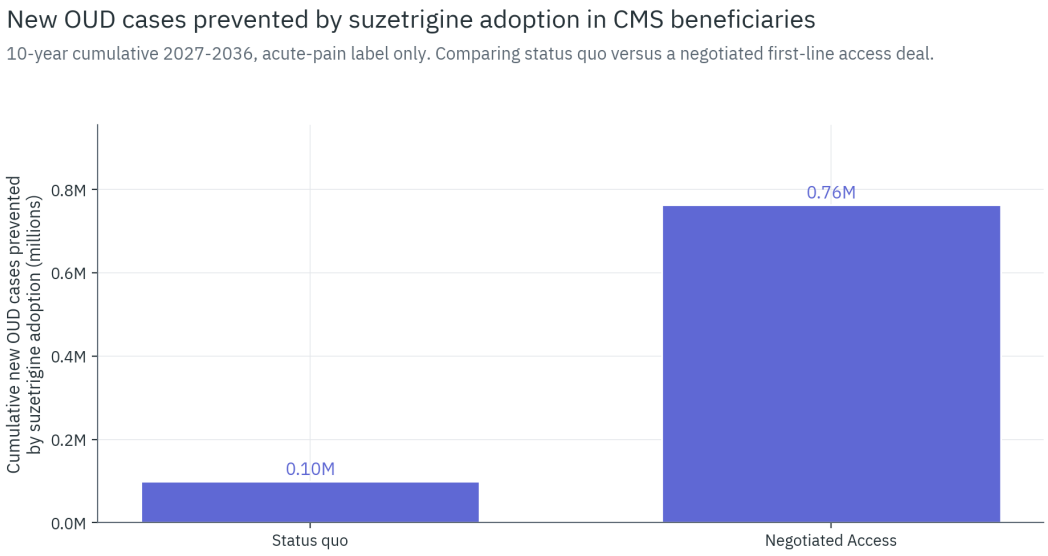
**Scope note:** "acute" here means the FDA-approved moderate-to-severe acute pain label, so severe acute pain is already inside the base case. There is no separate severity axis in this model. The only label expansion modeled separately is the chronic-pain scenario, shown in Figure 12.

Total opioid prescriptions in CMS are projected to be reduced by 39.4%–51.1% at year ten, from 58.6 million to 35.5 million with first-line access for acute pain and from 58.6 million to 28.7 million if chronic pain is added to the label as expected in 2027–2028.




*Historical CMS opioid claims and modeled future opioid prescribing with and without first-line suzetrigine access.*

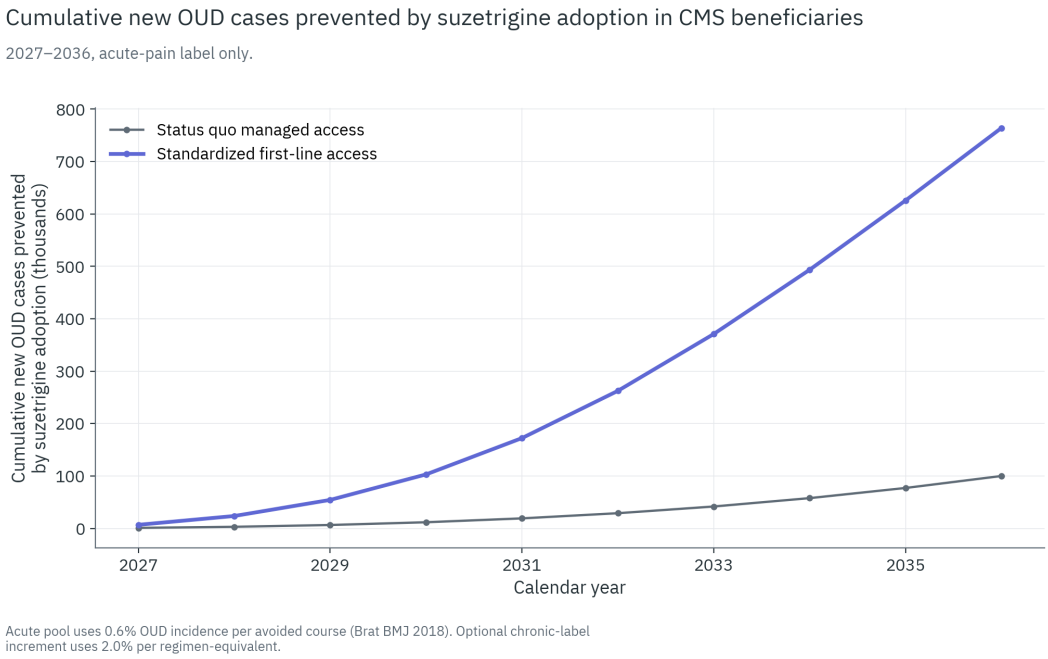
*Figure 2. CMS opioid prescribing: past 10 years and next 10 years.*




*Total new OUD cases prevented by suzetrigine adoption in CMS beneficiaries over the 10-year window, comparing status quo versus negotiated access.*

*Figure 3. Cumulative new OUD cases prevented by suzetrigine adoption in CMS beneficiaries: status quo versus negotiated first-line access.*

**Key inputs / vs StatusQuo:** 0.6% acute OUD incidence per avoided Rx (Brat BMJ 2018); ~50.4% addressable acute share; deal Bass terminal peak 85% vs StatusQuo 25%.

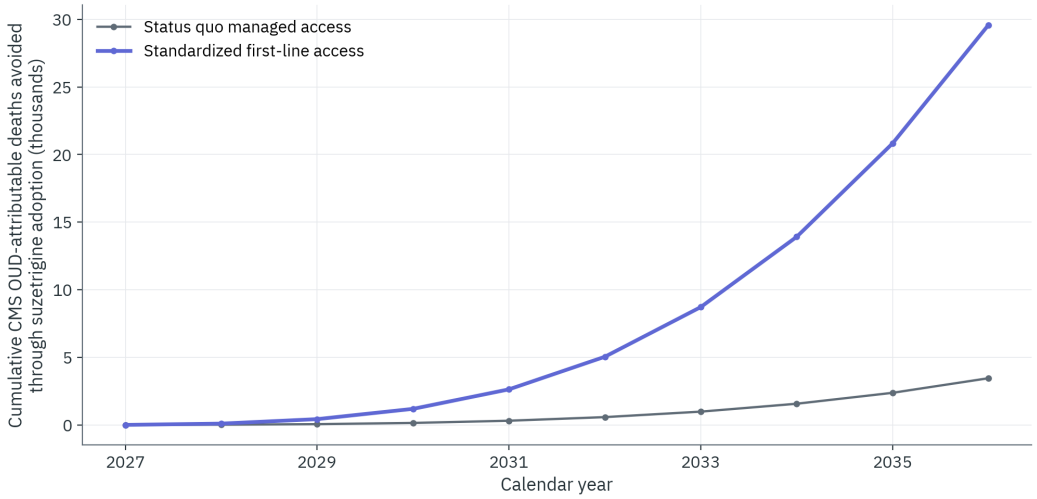



*Cumulative new OUD cases prevented by suzetrigine adoption in CMS beneficiaries, 2027–2036.*

*Figure 4A. Cumulative new OUD cases prevented by suzetrigine adoption in CMS beneficiaries, 2027–2036.*

Cumulative OUD-attributable deaths avoided through suzetrigine adoption in CMS beneficiaries

2027–2036, acute-pain label only.




Mortality applies a 1.4%/yr OUD-attributable excess all-cause rate to prevented OUD cohorts.
Low/high sensitivity: 0.7% overdose-only excess to 2.0% observed OUD-associated all-cause upper bound.

*Cumulative OUD-attributable deaths avoided through suzetrigine adoption in CMS beneficiaries, 2027–2036.*

*Figure 4B. Cumulative OUD-attributable deaths avoided through suzetrigine adoption in CMS beneficiaries, 2027–2036.*

# Current Obstacles for Suzetrigine Adoption in CMS

Suzetrigine received FDA approval in January 2025 for moderate-to-severe acute pain. In its January and February 2026 public updates, Vertex said JOURNAVX had more than 550,000 prescriptions written and filled through year-end 2025. The main obstacles to adoption are:

## Non-preferred coverage and cost sharing

In CMS, suzetrigine is currently treated as a non-preferred branded option that often carries materially higher patient cost sharing than a generic opioid. The model uses that gap as one of the reasons first-line uptake remains slow under current access conditions.

## Prior authorization and launch-phase utilization management

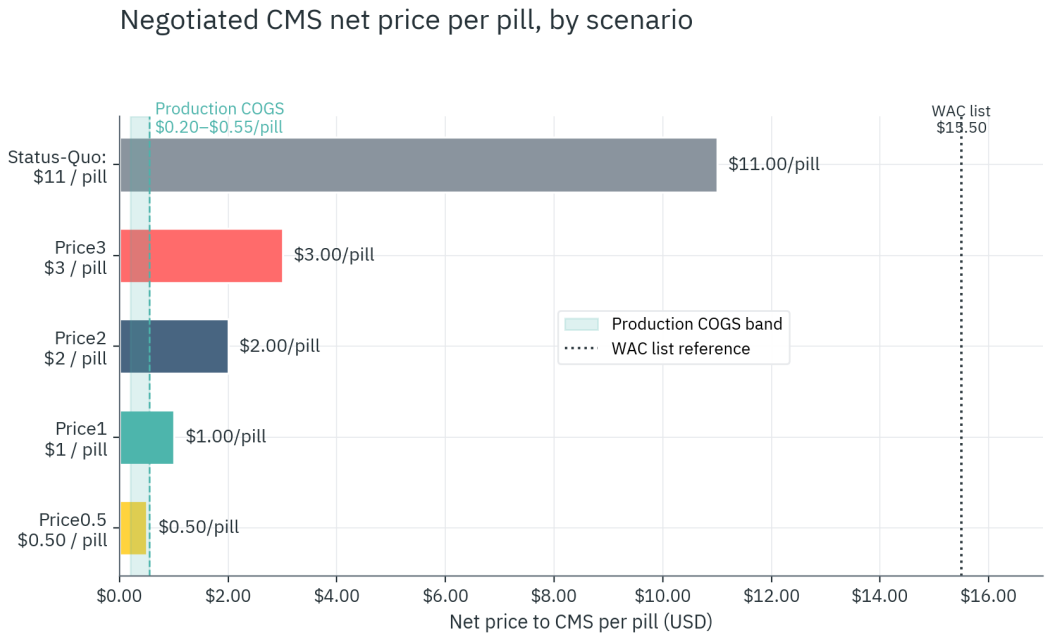
Prescribers often face approval friction before dispensing suzetrigine in high-volume acute-pain settings.

### Fail-first pressure toward cheaper analgesics

Opioids are cheap, already on every formulary, and sit as the default option in most acute-pain workflows. That makes them the path of least resistance over suzetrigine unless CMS explicitly removes the friction and encourages prescribing.

## First-line access will dramatically increase adoption of suzetrigine

Our model is conservative about how quickly providers will switch from opioids to suzetrigine once first-line access is established. In practice, the transition could happen materially faster than modeled if prescriber workflows, formulary defaults, and patient demand all shift in the same direction.

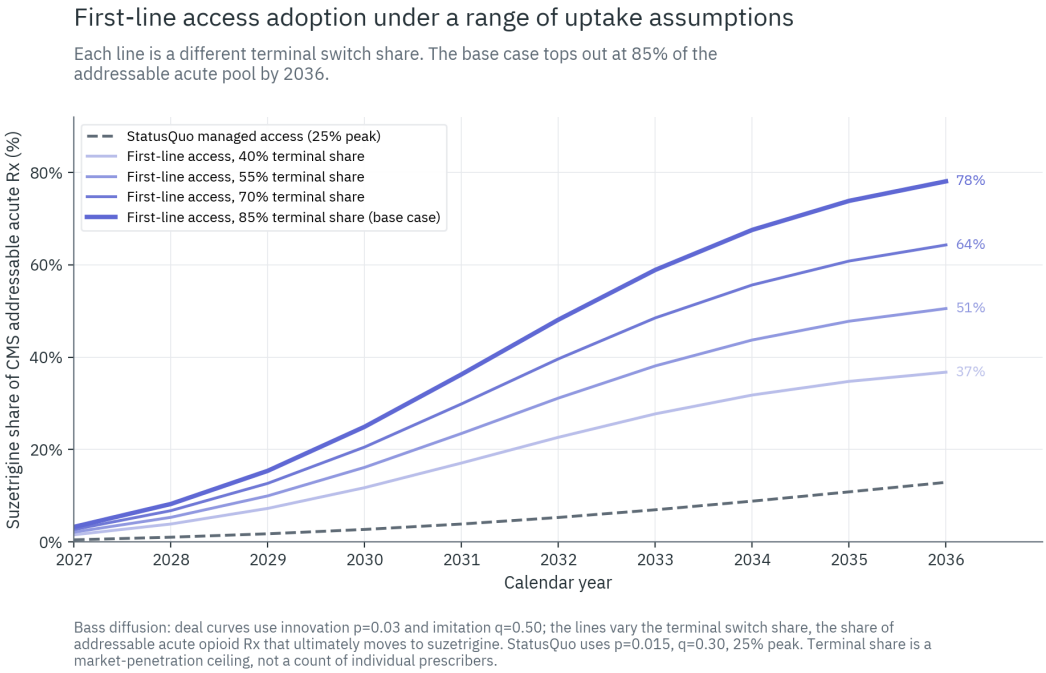



*Negotiated CMS net price per pill for each scenario, shown against the industry production COGS band ($0.20–$0.55/pill) and the $15.50 WAC (Wholesale Acquisition Cost) list reference.*

*Figure 5. Net CMS price per pill by scenario, with industry production COGS band and WAC list reference.*

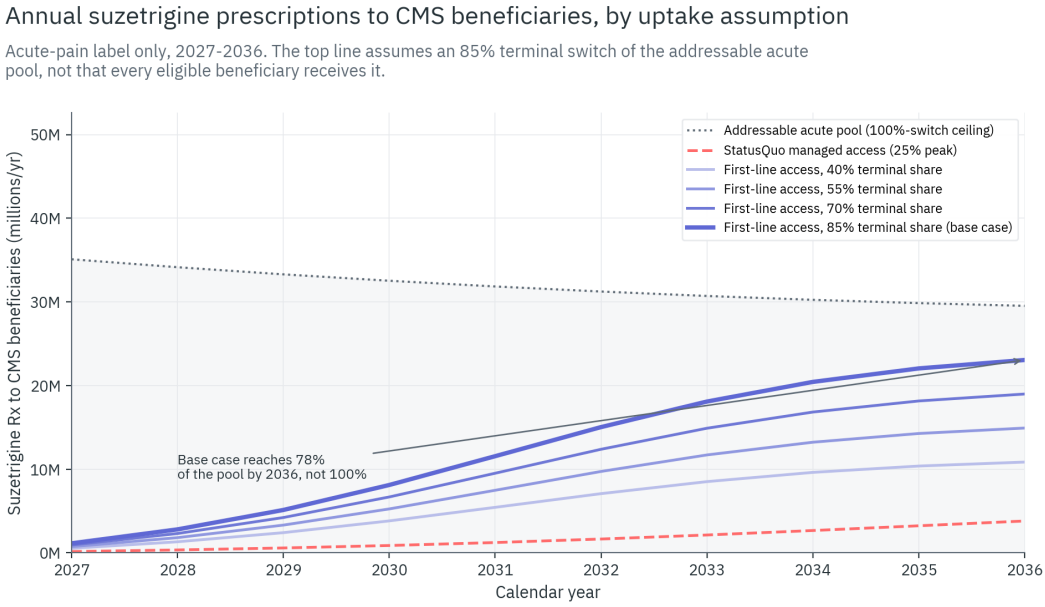
**Price selection:** StatusQuo $11 is a modeled pre-deal net proxy (~30% off the $15.50 WAC). The negotiated prices ($3 / $2 / $1 / $0.50) bracket the policy-relevant range: a mild discount (Price3), the primary recommendation (Price2, ~90% off list), and the production-cost floor (Price0.5).

**Abbreviations:** WAC = Wholesale Acquisition Cost (manufacturer list price); OUD = opioid use disorder; COGS = cost of goods sold (production cost per pill); FMAP = Federal Medical Assistance Percentage (the federal share of Medicaid spending).




*Share of CMS addressable opioid Rx receiving suzetrigine by year, shown across a range of terminal switch shares.*

*Figure 6. Bass-diffusion penetration curves, 2027–2036. Deal curves use p=0.03, q=0.50; the StatusQuo curve uses p=0.015, q=0.30. The array of lines brackets different provider-uptake assumptions (terminal switch of roughly 25% / 50% / 65% / 85% of the addressable acute pool).*




*Annual suzetrigine prescriptions to CMS beneficiaries, 2027–2036, across the same array of terminal switch shares.*

*Figure 7. Annual suzetrigine prescriptions to CMS beneficiaries. The top line assumes an 85% terminal switch of the addressable acute pool, which is a ceiling on provider uptake, not an assumption that every eligible beneficiary receives suzetrigine.*

# What CMS spends on opioids today

CMS pays for the opioid prescriptions themselves (cheap per-Rx but large volume), and opioids drive refills and a non-OUD persistence tail that suzetrigine does not have, because it is non-addictive.

– CMS would spend approximately $8.4B on generic opioid prescriptions (index Rx + refills + non-OUD escalation) for the addressable acute-pain pool over 2027–2036 if no substitution occurred.

– Using CASPR's projected by-drug substitution mix for the acute addressable market, the weighted opioid index-Rx comparator is $17.5/Rx, used directly in the core model.

– Applying a 1.5× refill-and-escalation multiplier captures the empirical reality that about 30% of acute opioid prescriptions get at least one refill (Shah MMWR 2017) and about 6% of opioid-naive patients develop persistent non-OUD opioid use beyond 90 days (Brummett JAMA Surgery 2017).

| Opioid class | Addressable Rx (2025) | Share of pool | DEA | OUD-risk (0–10) | Substitutability | Index Rx cost |
|---|---|---|---|---|---|---|
| **Hydrocodone/APAP (short-acting)** | 35.3M | 60.3% | II | 6 / 10 | 0.80 | $15 |
| **Oxycodone (short-acting)** | 8.1M | 13.8% | II | 7 / 10 | 0.60 | $25 |
| **Tramadol** | 7.2M | 12.3% | IV | 5 / 10 | 0.50 | $13 |
| **Codeine combinations** | 4.7M | 8.0% | III | 3 / 10 | 0.70 | $18 |
| **Morphine/Hydromorphone** | 2.3M | 3.9% | II | 6 / 10 | 0.30 | $30 |
| **Long-acting opioids** | 1.0M | 1.6% | II | 9 / 10 | 0.10 | $50 |
| **Acute substitutable pool** | **58.5M** | **100.0%** | **—** | **5.82 / 10** | **0.70** | **$17.5** |
| **Substitution-weighted average (of substituted Rx)** | **—** | **—** | **—** | **5.80 / 10** | **—** | **—** |

OUD-risk scores are directional 0–10 composites of DEA schedule, persistent-use rate vs. hydrocodone, per-drug OUD-progression literature, and abuse-liability data. Sources per drug in data/opioid_mix_costs.csv (column `oud_risk_basis`).

**Bottom-up by drug class.** Summing the substitutable acute prescriptions across the six opioid classes in the table above gives 58.5M prescriptions, 50.1% of the 116.6M projected 2025 U.S. opioid prescriptions.

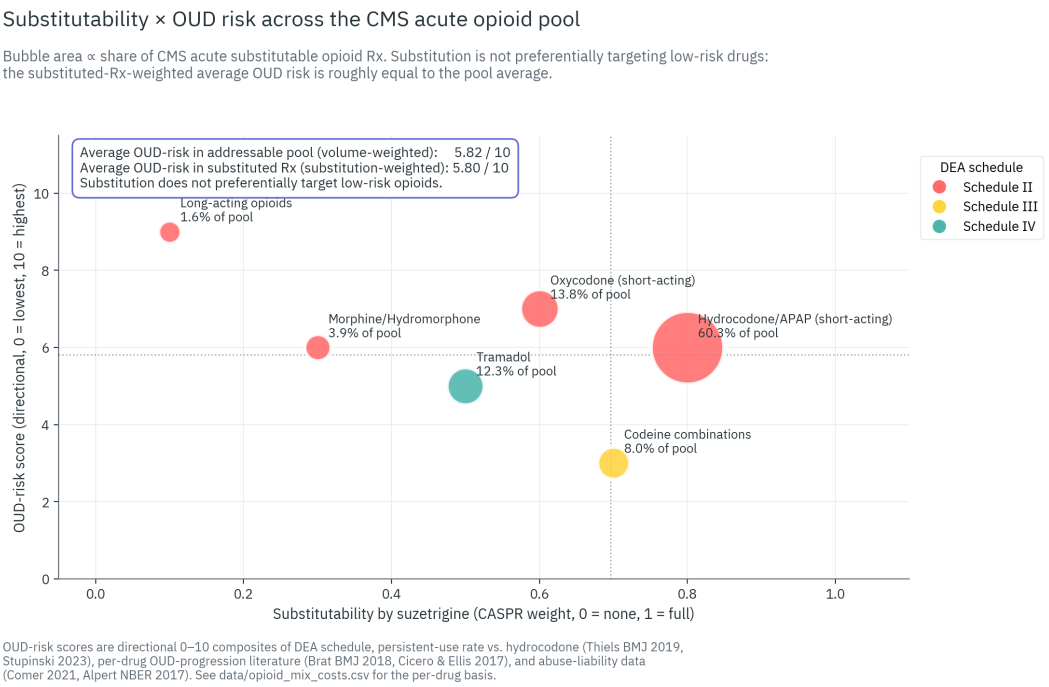
**Top-down by indication.** Weighting each clinical indication's share of opioid prescribing by the fraction where a non-opioid is a reasonable first-line choice (acute post-surgical, dental, musculoskeletal, minor procedural) gives 50.4%, derived from CDC dispensing data and the acute/chronic indication split.

The model uses 50.4%; the by-drug roll-up is the cross-check. A chronic-pain label would add about 15 points (chronic neuropathic, roughly 12% of opioid Rx at 60% eligible; chronic back and musculoskeletal pain, roughly 26% at 30%), the basis for the 65.4% sensitivity.

## Does substitutability track inversely with addiction potential?

A reasonable concern is that the most substitutable opioids in the addressable pool might also be the least addictive, which would mute the OUD-prevention benefit of substitution. However, the average OUD-risk score across the entire addressable pool is 5.82 / 10, and the average OUD-risk score across the prescriptions that would actually be substituted (each drug weighted by its share × substitutability) is 5.80 / 10. The two averages are essentially identical, which means substitution is not preferentially targeting the low-risk corner of the pool.

The intuition: hydrocodone/APAP is roughly 60% of the addressable acute pool by itself, is Schedule II, sits in the upper band of the OUD-risk score, and is highly substitutable. Oxycodone IR adds another 14% at higher OUD-risk and moderate substitutability. The lower-risk corner (codeine combinations, tramadol) is meaningful but not dominant, and the highest-risk corner (long-acting Schedule II) is barely substitutable but is also a small share of the acute pool. The distribution shown in the figure below reflects this directly.




*Bubble area is proportional to each drug's share of the CMS acute substitutable pool. Substitution is not preferentially targeting low-risk drugs: the substitution-weighted average OUD risk is roughly equal to the pool average, so the OUD prevention from substitution is real, not an artifact of swapping low-risk drugs for low-risk drugs.*

*Figure 17. Substitutability × OUD-risk across the CMS acute opioid pool. Pool-weighted vs. substitution-weighted average OUD-risk scores shown in callout box.*

## Where is suzetrigine being prescribed today?

JOURNAVX has been on the market since January 2025 and Vertex's public disclosures sketch a real-world prescribing footprint that maps closely to the high-volume, opioid-naive acute pool the model targets. As of mid-October 2025, more than 300,000 prescriptions had been filled, including roughly 170,000 in Q3 2025 alone, on the way to more than 550,000 prescriptions by year-end 2025. Vertex has described the prescriber base as including orthopedic surgeons, plastic surgeons, anesthesiologists, pain specialists, and dentists, and the use settings as joint replacement and repair, shoulder surgeries, fractures and sprains, and dental procedures, across hospital and retail pharmacy channels. The clinical-trial program that supports the label is concentrated in the same setting (about 87% orthopedic-surgery patients in the open-label safety study, with the remainder in plastic, otorhinolaryngologic, general, and urologic surgery). Acute opioid initiation in opioid-naive adults in exactly these settings is the population the headline OUD-prevention rate (Brat BMJ 2018, ~0.6% per acute course) is calibrated on, so the live-market prescribing pattern matches the population the model targets rather than diluting the modeled benefit.

Sources: Vertex Q3 2025 results, Vertex full-year 2025 results, VA Pharmacy Benefits Management monograph (May 2025), and the JOURNAVX prescribing information.

Setting-level prescribing volumes are described qualitatively in Vertex disclosures; granular per-setting Rx counts are not publicly broken out yet.

## Pricing Scenarios

A range of potential negotiated prices from a CMS-Vertex access deal, with first-line positioning exchanged for lower per-pill economics.

**Implementation framing:** This analysis models a voluntary price-for-access framework, not immediate ordinary IRA negotiation. In this framework, Vertex would accept lower net pricing in exchange for broader, lower-friction access across participating CMS channels. Near-term implementation would likely require voluntary contracting with Part D sponsors/PBMs, Medicaid supplemental rebate arrangements, or a CMS Innovation Center-style model that standardizes terms for participating plans or states.

Relevant precedents include CMS Innovation Center voluntary drug models such as the Part D Senior Savings Model for insulin, the Cell and Gene Therapy Access Model for state Medicaid agencies and manufacturers, and CMS's BALANCE Model announcement for GLP-1 access terms.

**StatusQuo**
Net Price
**$11.00/pill**
$165.00 / 7-day Rx
10-Year Net Impact
**$-0.5B**
CMS spend: **$2.7B**
*Incremental net vs StatusQuo:* ***baseline***
Vertex revenue: **$2.7B**
Current pricing status quo

**Price3**
Net Price
**$3.00/pill**
$45.00 / 7-day Rx
10-Year Net Impact
**$12.5B**
CMS spend: **$5.7B**
*Incremental net vs StatusQuo:* ***+$13.0B***
Vertex revenue: **$5.7B**

**Price2**
Net Price
**$2.00/pill**
$30.00 / 7-day Rx
10-Year Net Impact
**$14.4B**
CMS spend: **$3.8B**
*Incremental net vs StatusQuo:* ***+$14.9B***
Vertex revenue: **$3.8B**

**Price1**
Net Price
**$1.00/pill**
$15.00 / 7-day Rx
10-Year Net Impact
**$16.3B**
CMS spend: **$1.9B**
*Incremental net vs StatusQuo:* ***+$16.8B***
Vertex revenue: **$1.9B**

**Price0.5**
Net Price
**$0.50/pill**
$7.50 / 7-day Rx
10-Year Net Impact
**$17.2B**
CMS spend: **$1.0B**
*Incremental net vs StatusQuo:* ***+$17.7B***
Vertex revenue: **$1.0B**

The matrix below compares all five scenarios on one grid. Read column-wise, it is also the granular CMS-spend table: the avoided-index versus avoided-refill split and the Vertex revenue line appear as their own rows. Price2 (the primary recommendation) is shaded. All figures are 10-year cumulative, acute-pain label only, 2027–2036.

| Metric | StatusQuo | Price3 | Price2 | Price1 | Price0.5 |
|---|---|---|---|---|---|
| **Pricing** | | | | | |
| **Net price / pill** | $11.00 | $3.00 | $2.00 | $1.00 | $0.50 |

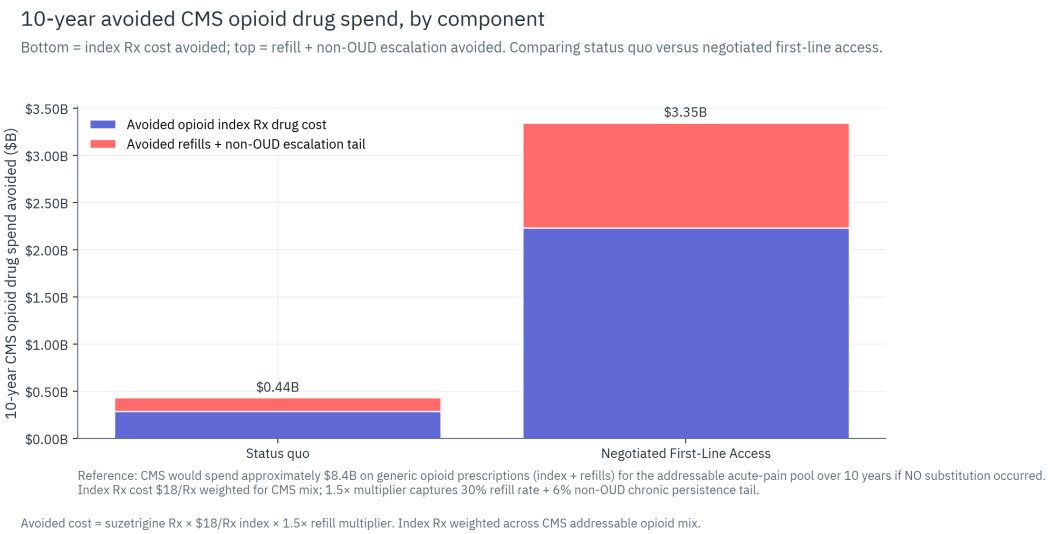
| Metric | StatusQuo | Price3 | Price2 | Price1 | Price0.5 |
|---|---|---|---|---|---|
| **Cost / 7-day course** | $165.00 | $45.00 | $30.00 | $15.00 | $7.50 |
| **% off WAC list ($15.50)** | 29% | 81% | 87% | 94% | 97% |
| **Terminal Bass peak** | 25% | 85% | 85% | 85% | 85% |
| **CMS spend & savings (10-yr)** | | | | | |
| **CMS suzetrigine drug spend** | $2.7B | $5.7B | $3.8B | $1.9B | $1.0B |
| **Avoided OUD medical care** | $1.8B | $14.8B | $14.8B | $14.8B | $14.8B |
| **Avoided opioid index Rx** | $0.3B | $2.2B | $2.2B | $2.2B | $2.2B |
| **Avoided opioid refill / escalation** | $0.1B | $1.1B | $1.1B | $1.1B | $1.1B |
| **Gross CMS savings (before drug spend)** | $2.2B | $18.2B | $18.2B | $18.2B | $18.2B |
| **Net vs StatusQuo** | baseline | +$13.0B | +$14.9B | +$16.8B | +$17.7B |
| **Outcomes & manufacturer** | | | | | |
| **OUD cases prevented** | 100K | 764K | 764K | 764K | 764K |
| **Vertex CMS revenue** | $2.7B | $5.7B | $3.8B | $1.9B | $1.0B |

Net vs StatusQuo = each scenario's net CMS impact minus the StatusQuo (S0) net impact. Total CMS savings and OUD cases prevented are identical across the negotiated scenarios (S1–S4) because they share the same first-line access policy and adoption curve; only price (and therefore CMS drug spend, net impact, and Vertex revenue) varies.

**Basis for the StatusQuo price ($11/pill):** Suzetrigine launched in January 2025 with a $15.50 WAC (Wholesale Acquisition Cost). The $11/pill StatusQuo figure is a *modeling proxy* for a current-access net price after typical launch-phase concessions and rebates; it is not a directly observed blended CMS net price. Actual Medicaid rebate mechanics and Medicare Part D net prices vary materially by state, plan, and contract.

## Fiscal Impact of First-Line Suzetrigine Access

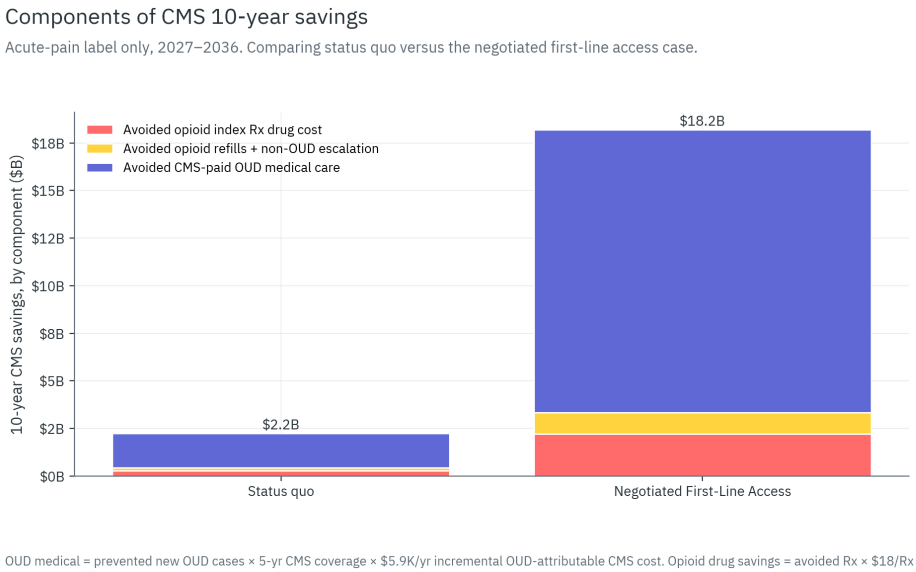
CMS savings come from two distinct sources. The smaller source is avoided opioid drug spend: the index Rx plus the refills and non-OUD escalation tail that suzetrigine does not have (suzetrigine is non-addictive, so refills are unnecessary). The much larger source is avoided CMS-paid OUD medical care.




*10-year avoided CMS opioid drug spend comparing status quo versus negotiated first-line access, decomposed into index Rx cost (bottom, indigo) and refills plus non-OUD escalation (top, coral).*

*Figure 8. Avoided CMS opioid drug spend over 10 years for status quo versus negotiated first-line access, decomposed into index-Rx cost (bottom, indigo) and refill + non-OUD escalation savings (top, coral).*

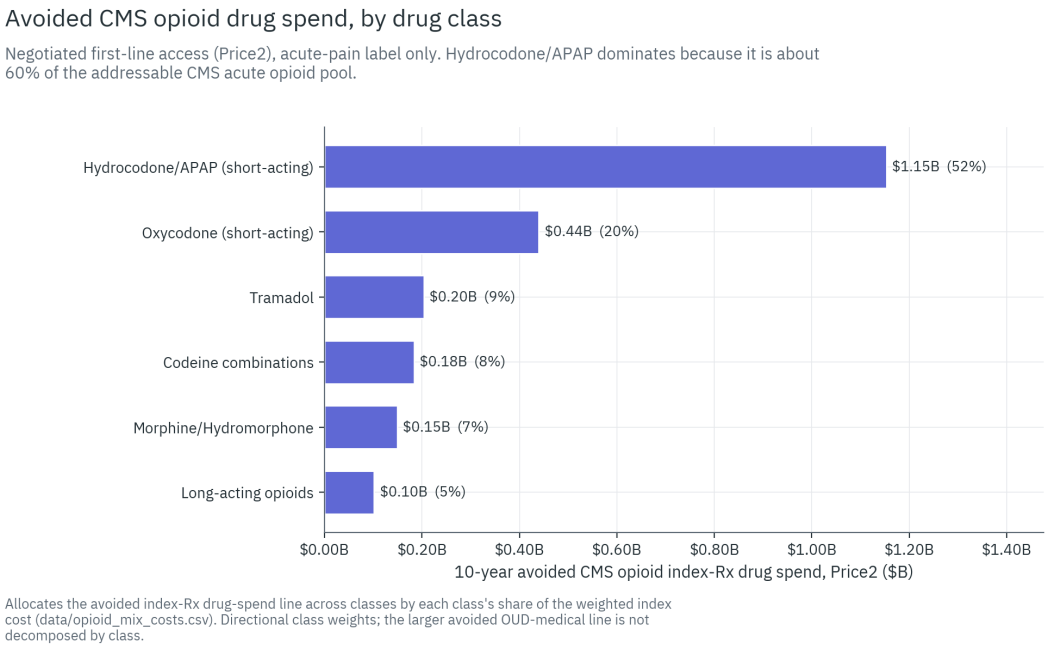
**Key inputs / vs StatusQuo:** $17.5/Rx index cost × 1.5 refill-and-escalation multiplier; ~50.4% addressable acute share; deal Bass terminal peak 85% vs StatusQuo 25%.




*Gross CMS 10-year savings (before subtracting suzetrigine drug spend) comparing status quo versus negotiated first-line access.*

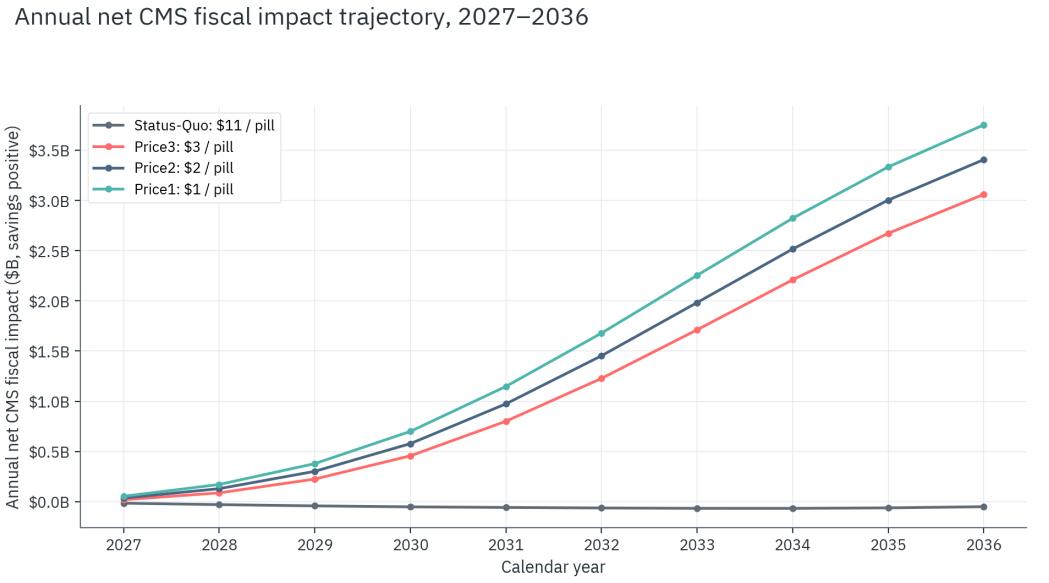
*Figure 9. Gross components of CMS 10-year savings for status quo versus negotiated first-line access, acute-pain label only. Savings side only, suzetrigine drug spend not netted here.*

**Key inputs / vs StatusQuo:** avoided OUD medical = $5.9K/yr × 5-yr coverage per prevented case; avoided opioid drug = $17.5/Rx index × 1.5 refill; deal Bass terminal peak 85% vs StatusQuo 25%.




*Avoided opioid index-Rx drug spend, decomposed across the six CMS opioid classes. Hydrocodone/APAP dominates at roughly 60% of the addressable pool, with oxycodone IR a distant second.*

*Figure 19. Avoided opioid index-Rx drug spend by opioid class. This decomposes only the class-attributable avoided drug-spend line, using the directional CASPR class weights; it does not decompose the much larger avoided OUD-medical line.*

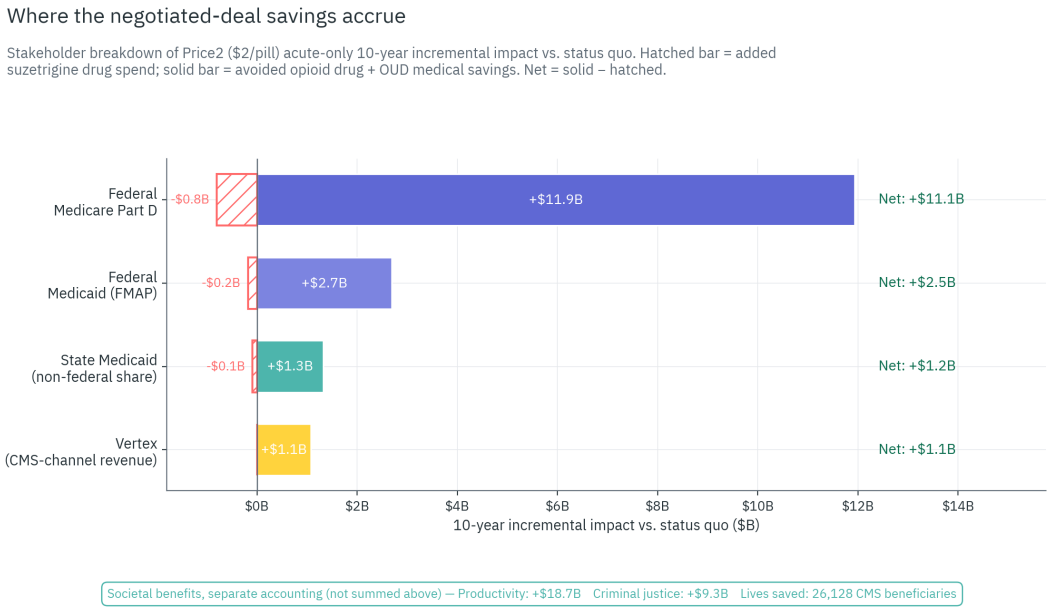



*Annual CMS net fiscal impact (savings minus spend) by scenario, 2027–2036.*

*Figure 10. Annual CMS net fiscal impact trajectory.*

# Where the savings accrue

The headline net-impact line is "CMS combined." That number is internally consistent for federal budget scoring, but the question of *which* stakeholder writes the smaller drug-spend check and pockets the much larger OUD medical-care savings matters. Medicare Part D drug spend and Part D / Medicare Parts A and B medical savings sit on the federal balance sheet. Medicaid drug spend and Medicaid medical savings flow through the federal/state shared FMAP, so the gain accrues to two different appropriators. Vertex captures the suzetrigine net-price line. Society captures avoided productivity loss, criminal-justice cost, and lives saved on a separate accounting from the fiscal line.




*Stakeholder breakdown of the Price2 ($2/pill) acute-only 10-year incremental impact vs. status quo. Federal Medicare Part D captures roughly 75% of the CMS net fiscal gain; federal Medicaid (FMAP share) captures another 17%; state Medicaid (non-federal share) captures the remaining 8%. Vertex captures incremental CMS-channel revenue. Societal benefits are shown separately and are not summed with the fiscal lines.*

*Figure 16. Savings accrual by stakeholder, Price2 acute-only, 2027–2036.*

**For the negotiated Price2 deal vs. status quo (10-year, acute-only):**

– Federal Medicare Part D: ~$11.1B net fiscal benefit (about 75% of the CMS line).

– Federal Medicaid (FMAP share): ~$2.5B net fiscal benefit.

– State Medicaid (non-federal share): ~$1.2B net fiscal benefit, distributed across all 50 states roughly in proportion to Medicaid opioid-claims volume. Large-Medicaid states (California, New York, Texas, Florida) carry a meaningful share of this line.

– Vertex CMS-channel revenue: ~$1.1B incremental over the conservative status-quo baseline modeled here.

– Society (separate accounting): $18.7B productivity savings, $9.3B criminal-justice cost avoided, and 26,000 OUD-attributable deaths avoided in CMS beneficiaries.

Volume split: observed 2023 CMS opioid claims (Medicare 59.3M / Medicaid 20.0M / Total 79.3M). Medicaid federal/state allocation uses a blended 67% / 33% FMAP weighted across regular and ACA-expansion populations; per-state splits and Medicaid Drug Rebate Program flows shift this directionally and are not modeled here.

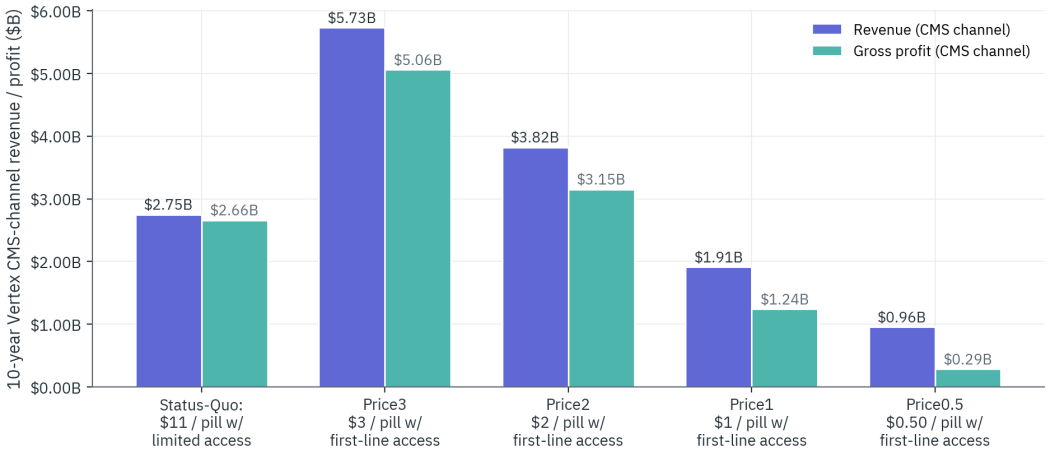
The federal government captures the bulk of the fiscal upside (Medicare Part D + federal Medicaid ≈ 92% of the CMS line), while states share roughly 8% of the CMS upside on top of essentially the entire criminal-justice avoided cost (which is borne primarily by state and local governments). A blue state acting unilaterally on a Medi-Cal-only or CalPERS-only pathway can capture only its slice of the state-Medicaid line plus the criminal-justice and productivity benefits in its population. The federal Medicare/Medicaid lines are unavailable to a state-only deal. This stakeholder split is a major reason the federal pathway is the preferred channel where it is feasible; the state pathway is the right backstop and is analyzed in the companion California State Pathway Analysis.

## Vertex Expected Revenue

In its January 11, 2026 and February 12, 2026 releases, Vertex said JOURNAVX had more than 550,000 prescriptions written and filled through year-end 2025, and prescription volume expected to more than triple in 2026 versus 2025. The company also guided to $500 million or more of combined 2026 non-CF product revenue across CASGEVY and JOURNAVX. Vertex did not, in those official materials, publish a JOURNAVX-only 2026

revenue target or a JOURNAVX-specific patent-life revenue forecast.

Vertex CMS-channel revenue and gross profit by scenario




Gross profit = revenue − COGS ($0.35/pill central estimate). Excludes R&D recoup, SG&A, and tax.

*10-year Vertex CMS-channel revenue (indigo) and gross profit (teal) by pricing scenario, against this model's conservative status-quo baseline.*

*Figure 11. Vertex 10-year CMS-channel revenue and gross profit by scenario. Gross profit = revenue − COGS at $0.35/pill central estimate.*

## Potential Impact in Commercial Market

The core fiscal model is CMS-only, but the same policy could have meaningful spillover effects in the commercial market. If first-line use becomes routine in Medicare and Medicaid, that can reshape prescriber behavior, formulary expectations, and employer demand well beyond the public programs directly modeled here.

Commercial payers do not capture the full lifetime value of OUD prevention the way CMS does, because members often churn between plans and employers. Even so, lower opioid exposure can still matter financially through fewer refill cascades, lower short-run acute-care utilization, less disability, and less workplace disruption. The commercial opportunity should therefore be viewed both as a direct market opportunity for JOURNAVX and as a broader practice-pattern effect that could widen national adoption.

– **Prescriber normalization matters.** If CMS makes suzetrigine first-line in common acute-pain settings, clinicians gain familiarity using it in surgery, emergency care, dentistry, and primary care. Commercial prescribing could rise even without

identical private-payer rules simply because the drug becomes part of routine care pathways.

– **Employer economics differ from CMS economics.** Commercial plans capture less of the long-tail OUD-prevention value because of churn, but employers still face meaningful near-term costs from opioid-related disability, absenteeism, and avoidable complications. That can still make opioid-sparing acute-pain treatment economically attractive.

– **CMS can anchor private-market expectations.** A large public deal could establish a reference point for price, access, and clinical expectations that commercial payers may partially follow. Even partial imitation in private formularies could materially expand total treated volume beyond the CMS-only numbers shown in this report.

## Further Acceleration Strategies for Suzetrigine Adoption

CMS can do more than negotiate price and preferred placement. If the agency also uses implementation levers to make non-opioid prescribing routine at the point of care, the rate of adoption could increase materially, which would greatly expand both fiscal savings and societal benefits.

– **Explicit first-line prescribing guidance.** CMS could issue sub-regulatory guidance, preferred-drug recommendations, and quality-oriented communications that frame suzetrigine as the default first-line pharmacologic option for short-term acute pain in opioid-naive patients when clinically appropriate.

– **Combination-therapy protocols with APAP.** CMS could encourage standardized acute-pain pathways that pair suzetrigine with acetaminophen (APAP) before escalating to opioids, especially in common outpatient, dental, surgical, and emergency-department pain scenarios where multimodal analgesia is already familiar to prescribers.

– **Opioid justification requirements for short-term acute pain.** CMS or CMS-aligned plans could require prescribers to document why an opioid is being selected instead of suzetrigine for routine short-duration acute-pain use cases, creating a clear administrative nudge away from default opioid prescribing.

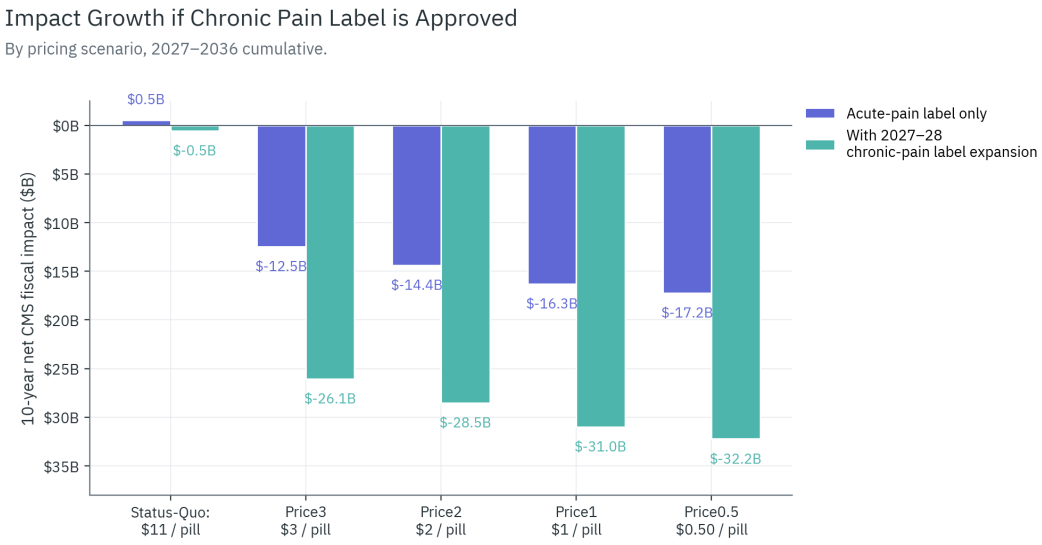
– **Clinical decision-support and EHR defaults.** CMS could work with health systems, Part D sponsors, Medicaid managed-care plans, and major EHR vendors to place suzetrigine-based acute-pain order sets higher in prescribing workflows and make opioid alternatives easier to choose in real time.

– **Plan-performance incentives tied to opioid avoidance.** CMS could build opioid-exposure reduction, non-opioid first-line use, or post-procedural opioid-sparing metrics into plan oversight and quality-improvement efforts so payers have operational reason to drive uptake instead of merely allowing it.

– **Targeted provider education in high-volume acute-pain settings.** Focused education for emergency medicine, primary care, dentistry, orthopedics, and ambulatory surgery could reduce launch-phase inertia and accelerate comfort with suzetrigine in exactly the settings that generate a large share of avoidable first opioid exposure.

# Additional Fiscal Benefits from Likely Chronic-pain Label Expansion

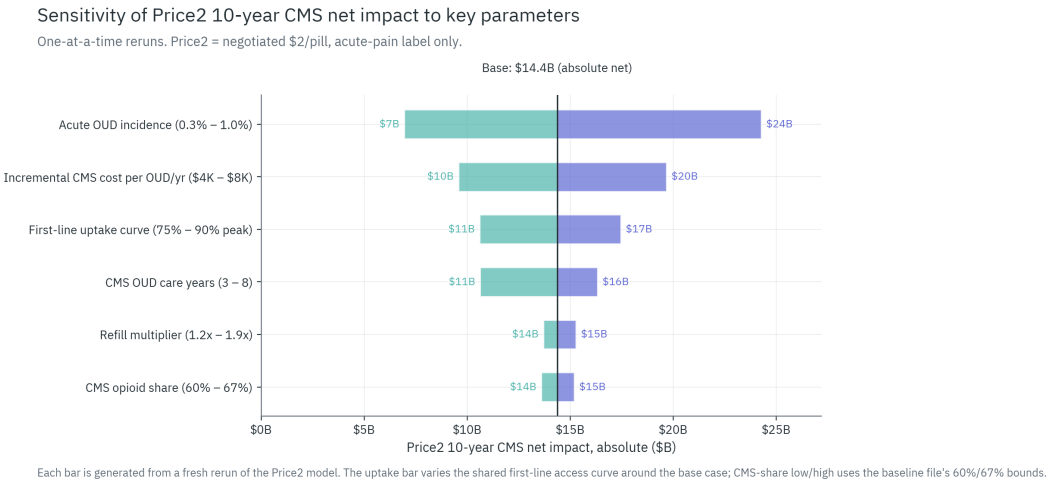
Vertex is currently running two Phase 3 suzetrigine studies in painful diabetic peripheral neuropathy. In its August 4, 2025 results, Vertex said it would not advance painful lumbosacral radiculopathy into Phase 3 and would instead prioritize a second DPN Phase 3 study; in its January 11, 2026 pipeline update, Vertex said it expects to complete enrollment in both DPN studies by the end of 2026.




*Illustrative upside comparison only: acute-pain label only (the base case) versus a future chronic-label scenario under the same simplified regimen structure.*

*Figure 12. Acute-only base case versus an illustrative future chronic-label scenario. Chronic addressable adds ~15pp to substitutable share, phased in Y2–Y3.*

# Sensitivity



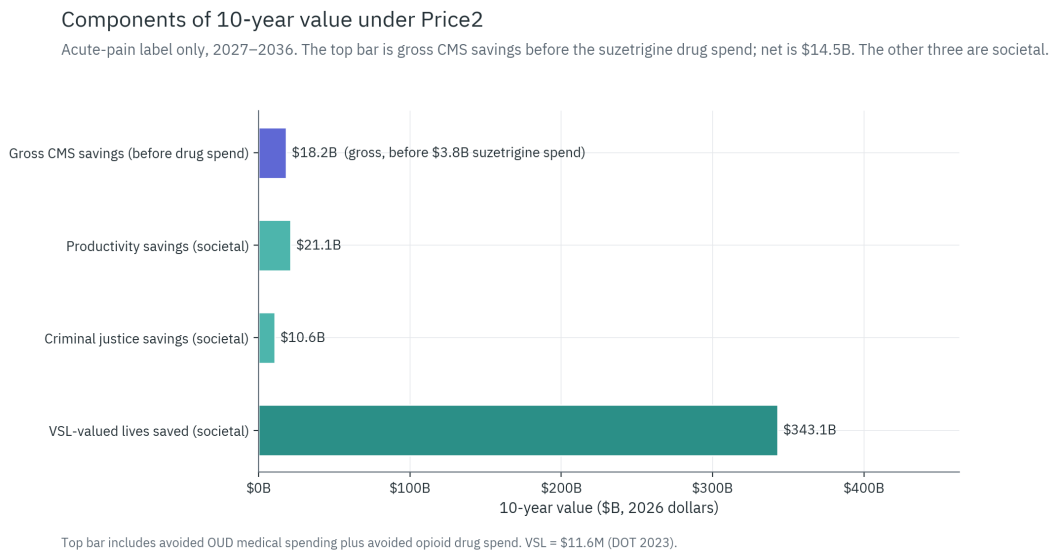

*One-at-a-time sensitivity analysis on Price2 10-year CMS net impact. Each bar shows the result of a fresh Price2 model rerun with one assumption moved to its low or high setting.*

*Figure 13. Tornado sensitivity on Price2 10-year net CMS impact. Bars are generated from full reruns.*

Each row below is a fresh full-model rerun with one assumption moved to its low or high setting; the other assumptions are held at base. The base case is Price2 at $14.4B incremental 10-year net CMS savings.

| Parameter | Low-case 10-yr net | High-case 10-yr net |
|---|---|---|
| **Acute OUD incidence (0.3% – 1.0%)** | $7.0B | $24.3B |
| **Incremental CMS cost per OUD/yr ($4K – $8K)** | $9.6B | $19.7B |
| **First-line uptake curve (75% – 90% peak)** | $10.6B | $17.5B |
| **CMS OUD care years (3 – 8)** | $10.6B | $16.3B |
| **Refill multiplier (1.2x – 1.9x)** | $13.7B | $15.3B |
| **CMS opioid share (60% – 67%)** | $13.6B | $15.2B |
| **Base case** | $14.4B | |

# Appendix 1: Societal impact of CMS action, separate from the CMS fiscal line




*Components of 10-year value under Price2. The top bar is gross CMS savings, before the suzetrigine drug spend is netted out; the headline net is $14.4B absolute ($14.9B versus StatusQuo). The other three are societal externalities.*

*Figure 14. Gross CMS savings (before drug spend) and societal externalities for Price2 ($2/pill), on an absolute basis. Net CMS impact after subtracting suzetrigine spend is $14.4B absolute / $14.9B incremental.*

# Appendix 2: Other Federal Channels

This section is supplemental. The core report is CMS-only. The VA, DoD/TRICARE, and IHS together fill millions of additional opioid prescriptions per year and could potentially benefit from similar pricing, but the estimates below are stylized directional extensions of the CMS framework rather than channel-specific actuarial forecasts.

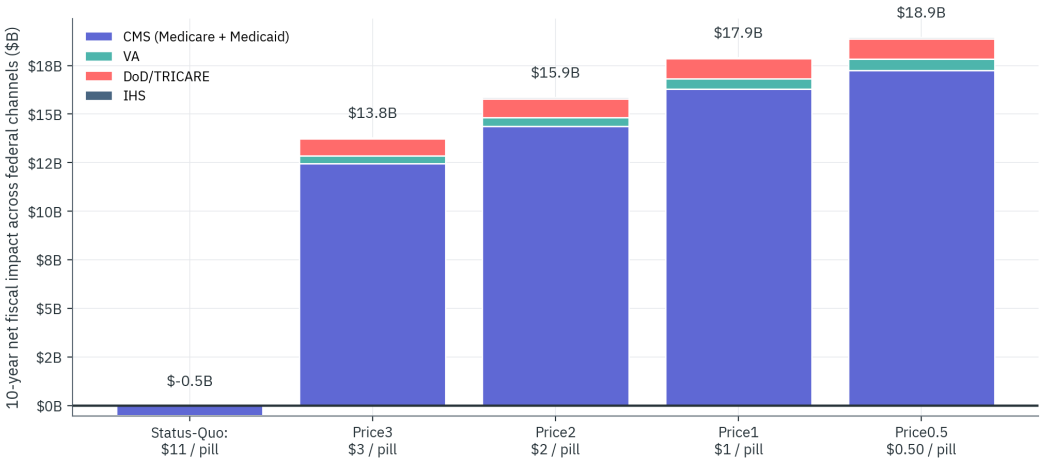
| Channel | Annual opioid Rx | Population | $/opioid Rx (eff.) | Effective modeled $/OUD-yr | Price2 net 10-yr fiscal savings |
|---|---|---|---|---|---|
| **VA (Veterans Health Administration)** | 4.5M | 9.1M | $11.20 | $3,404 | $0.5B |
| **DoD (DoD/TRICARE Military Health System)** | 2.5M | 9.5M | $22.50 | $8,091 | $1.0B |
| **IHS (Indian Health Service)** | 0.3M | 2.8M | $8.40 | $5,033 | $0.1B |

**Source basis for effective modeled $/OUD-yr column:** Displayed values are effective modeled averages over the 10-year window, not raw annual source assumptions. VA = VA opioid stewardship reporting and VHA OUD utilization trends (VA News, 2023; JAMA Network Open, 2024). DoD/TRICARE = DHA/TRICARE enrollment and Military Health System pain-care framework synthesis (DHA TRICARE Numbers; Pain Medicine, 2023).

IHS = IHS profile and opioid stewardship reporting (IHS Profile, Oct. 2024; IHS Opioid Stewardship Data).

Appendix: stylized total federal-channel 10-year net fiscal impact

CMS + VA + DoD/TRICARE + IHS combined; supplemental directional extension of the CMS memo, acute-pain label only, 2027-2036




This appendix reuses the CMS modeling structure with channel-specific opioid volume and cost inputs. It is a directional comparison, not a channel-specific actuarial forecast.

*Stylized appendix estimate: 10-year net fiscal impact across all four federal payers (CMS + VA + DoD + IHS) for each pricing scenario. Under these simplifying assumptions, federal channels beyond CMS add roughly 10% to the CMS-only fiscal line under the negotiated deal.*

*Figure 15. Appendix figure: stylized total federal-channel 10-year net fiscal impact, by pricing scenario.*

– Stylized directional estimate only: under Price2, the four federal payers together net approximately $15.9B in 10-year fiscal savings ($14.4B CMS plus $1.5B VA/DoD/IHS combined) and prevent approximately 824K new OUD cases in their combined beneficiary populations.

– VA's marginal opportunity is smaller than naive scaling would suggest because the Opioid Safety Initiative has already cut VA opioid prescribing 67% from its 2012 peak.

– IHS direct-care volume is small but each prevented case has disproportionate weight given the AI/AN overdose burden.

# Appendix 3: Limitations in Typical CMS Drug Management Levers

These are important obstacles to consider when implementing this policy if maximum efficacy is the goal.

– Medicare Part D drug coverage is delivered through private PDP and MA-PD plans, not a single national formulary. Source: Medicare Part D; Medicare health plans.

– Under the current Medicare Drug Price Negotiation Program, CMS can negotiate a Maximum Fair Price for eligible selected drugs, require formulary inclusion, and use formulary review to scrutinize non-preferred placement or more restrictive step therapy / prior authorization than comparable drugs. Source: CMS final negotiation guidance for initial price applicability year 2027.

– CMS has said it is not currently imposing uniform national tier-placement or utilization-management rules for selected drugs, and ordinary small-molecule negotiation is not a near-term tool for a product first approved in January 2025 like suzetrigine. Source: CMS final negotiation guidance for initial price applicability year 2027.

– A true “first-line everywhere, opioid-like copay, no PA, no step therapy” policy would likely require a stronger mechanism than ordinary IRA negotiation alone, such as a CMMI model, tighter bid and formulary conditions, or legislation. Source: CMS Medicare $2 Drug List Model page; CMS final negotiation guidance for initial price applicability year 2027.

# Appendix 4: Diversion-Seeded OUD Sensitivity

The core fiscal line counts only OUD developed by the index patient who receives an opioid prescription. It does not count OUD that develops in a non-recipient who later uses pills diverted from that patient's leftover supply. Suzetrigine has no diversion tail because it is non-addictive, has no street value, and produces no withdrawal or craving, so substituting suzetrigine for an opioid Rx prevents both the index-patient OUD risk (already in the model) and the diversion-seeded OUD risk (currently excluded). This appendix quantifies what the headline would look like if the diversion pathway were added at three literature-bracketed rates.

**Why this is presented as an off-by-default sensitivity.** No peer-reviewed study reports a single direct conversion rate from "leftover opioid pill" to "new OUD case in a non-recipient." Any quantitative estimate must layer multiple inputs (unused-pill rate, diversion rate, exposure-to-use rate, use-to-OUD rate), each carrying its own uncertainty. Including a layered estimate in the headline would create an attack surface in peer review. Reporting it as a sensitivity preserves the conservative posture of the core fiscal line while making the upside visible to the reader.

## Two-step derivation

**Bottom-up (Bicket-anchored).** Start from Bicket et al., JAMA Surgery 2017: 42 to 71 percent of post-surgical opioid tablets are unused (use 60 percent central). Apply assumed downstream rates: roughly 15 percent of leftover pills reach a non-recipient (literature ranges; central estimate is conservative because most leftover pills go to disposal, hoarding by the patient, or take-back programs). Roughly 5 pills per first-exposure event (typical pattern from drug-use ethnography). Roughly 5 percent of first-exposure individuals progress to repeated nonmedical use, and roughly 7 to 10 percent of repeated nonmedical users develop OUD within several years (NSDUH cohort follow-ups; Florence et al. 2016). The resulting central estimate is approximately 0.20 percent per avoided Rx (sensitivity range 0.05 to 0.40 percent).

**Top-down (NSDUH cross-check).** The 2023 SAMHSA National Survey on Drug Use and Health reports approximately 8 to 9 million past-year nonmedical opioid users. The "source of misused pain reliever" question consistently shows that roughly half of those users obtained the drug from a friend or relative for free (the diversion pathway, as opposed to direct prescription, theft, or purchase). About 8 to 10 percent of past-year nonmedical users go on to develop OUD within several years. That implies roughly 360,000 to 450,000 new OUD cases per year with a diversion lineage. Dividing by the approximately 125 million annual U.S. opioid Rx gives an upper-bound rate of about 0.3 to 0.4 percent per Rx (this is an overestimate because not every diversion-lineage OUD case traces to a current-year prescription; some leftover pills date back many years). The two methods agree on the order of magnitude.

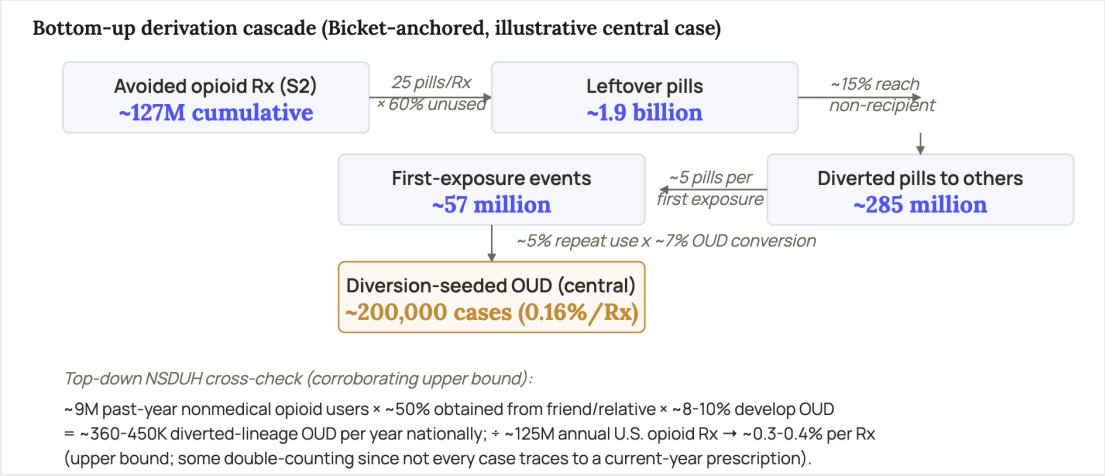
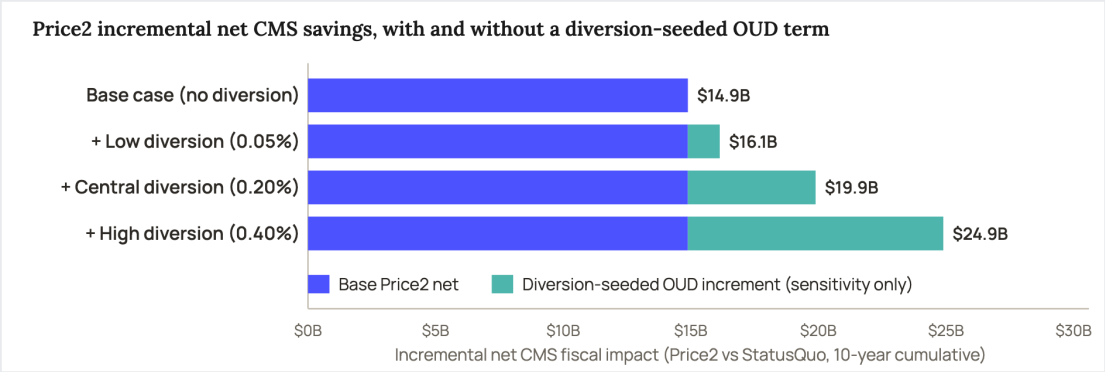



*Figure A4-1. Diversion-seeded OUD derivation cascade (illustrative central case). Sources: Bicket JAMA Surgery 2017; SAMHSA NSDUH 2023; Florence et al. 2016.*

## Sensitivity impact on Price2 headline

Adding the diversion-seeded OUD term at the three literature-bracketed rates lifts the Price2 incremental net CMS savings as follows. The base-case Price2 fiscal line is unchanged.

| Diversion rate | Per-Rx OUD risk | Additional OUD prevented | Additional deaths avoided | Additional CMS savings | New Price2 incr. net |
|---|---|---|---|---|---|
| **Base case (no diversion)** | 0.00% | +0K | +0 | +$0.0B | $14.9B |
| **Low** | 0.05% | +64K | +2,505 | +$1.3B | $16.1B |
| **Central** | 0.20% | +255K | +10,020 | +$5.0B | $19.9B |
| **High** | 0.40% | +509K | +20,039 | +$10.0B | $24.9B |




*Even at the conservative low rate, diversion adds roughly $1.3B to the Price2 headline; at the central rate, roughly $5.0B; at the high rate, roughly $10.0B. Suzetrigine's lack of a diversion tail is therefore a real upside that the core fiscal line excludes by design.*

*Figure A4-2. Price2 incremental net CMS savings under base case and three diversion-sensitivity rates. Indigo: base Price2 net (unchanged). Teal: diversion-seeded OUD increment (sensitivity only, not in headline).*

### Model notes

– This appendix is a sensitivity, not a base-case revision.

– The central 0.20 percent rate sits roughly one-third of the way between the bottom-up Bicket-anchored derivation and the top-down NSDUH cross-check. Both derivations carry layered uncertainty; the range bracket (0.05 to 0.40 percent) is wider than either method alone would imply.

– The fiscal-savings calculation uses the same effective per-prevented-OUD value the model produces for the Price2 cohort (about $19.6K cumulative within the 10-year window, reflecting partial-window cohorts in years 6 through 10). It does not assume a different OUD-care cost for diverted-lineage versus index-patient cases.

– The diversion contribution is monotonically positive across all parameter ranges. There is no sensitivity case in which diversion makes the deal worse, only cases in which the upside is larger or smaller.

# Assumptions

| Parameter | Base | Range | Units | Source |
|---|---|---|---|---|
| **OUD incidence per avoided ACUTE CMS opioid Rx** | 0.006 | 0.003 - 0.010 | fraction | Brat, BMJ 2018 |
| **OUD incidence per avoided CHRONIC-label regimen-equivalent** | 0.020 | 0.010 - 0.030 | fraction | Shah, MMWR 2017 |
| **Avg years of CMS coverage per new OUD case** | 5.0 | 3.0 - 8.0 | years | MACPAC, June 2025 |
| **Incremental annual CMS medical cost attributable to OUD** | 5900 | 4000 - 8000 | USD | Drug & Alcohol Dependence, 2023 |
| **Net CMS cost per avoided generic opioid INDEX Rx** | 17.52 | 12.00 - 30.00 | USD | CMS NADAC pricing |
| **Refill-and-escalation multiplier on opioid index cost** | 1.50 | 1.20 - 1.90 | ratio | Shah, MMWR 2017 |
| **CMS share of total US OUD medical cost** | 0.55 | 0.45 - 0.65 | fraction | MACPAC, June 2025 |
| **OUD-attributable excess all-cause mortality rate** | 0.014 | 0.007 - 0.020 | fraction | Bahji 2020 meta-analysis + 2026 matched MOUD cohort |
| **Value of a statistical life** | 11600000 | 6000000 - 15000000 | USD | US DOT, 2023 VSL guidance |
| **Suzetrigine production COGS per pill** | 0.35 | 0.20 - 0.55 | USD | Hill et al., small-molecule cost analogs |
| **Suzetrigine StatusQuo net price to CMS** | $11.00/pill | $9 – $13 | USD/pill | Modeling proxy around the $15.50 WAC launch price rather than a directly observed blended CMS net price. Actual Medicaid rebate mechanics and Medicare Part D net prices vary by state, plan, and contract. |
| **Observed CMS share of national opioid claims baseline** | ~63% | 60% – 67% | share of national opioid claims | Reference crosswalk implied by official 2023 CMS Medicare and Medicaid opioid claims versus the CDC national dispensing denominator. The model now runs on an anchored CMS claims baseline rather than deriving CMS volume from a fixed share assumption. The CMS share has risen from ~40% in 2010 (Jena 2012) to ~63% in 2023 because U.S. opioid prescribing fell ~50% from its 2012 peak while Medicare enrollment grew ~30%, and CMS now anchors a much larger share of a much smaller national pool (Medicare 59.3M + Medicaid 20.0M = 79.3M ÷ ~125M CDC dispensing total). |

| Parameter | Base | Range | Units | Source |
|---|---|---|---|---|
| **CMS opioid baseline decline path** | -3.5% in 2024, tapering to -1.1% by 2036 | - | annual change | Re-anchored CMS opioid-claims projection built from the same observed Medicare and Medicaid anchors, with national trend context from the CDC opioid dispensing series. It assumes the large mid-2010s decline has already occurred and the remaining decline gradually flattens over time. |
| **Addressable substitutable share** | 50.4% acute-only | +15pp with chronic label (phase-in Y2–Y3) | share of opioid Rx pool | Modeled share of opioid prescribing that suzetrigine could plausibly substitute under the acute-only case, with an incremental chronic-label expansion scenario. Built bottom-up from the acute opioid mix (six classes, 58.5M substitutable Rx, about 50% of U.S. opioid volume) and cross-checked against a per-indication eligibility estimate from CDC dispensing data. See the addressable-share derivation in the Substitutability section. Per-class substitutability weights are CASPR clinical judgment, shown in full in the by-drug table. |
| **Stakeholder allocation: Medicare / Medicaid volume split** | 74.8% / 25.2% | — | share of CMS opioid claims | Observed 2023 CMS national opioid-claim totals (Medicare 59.3M / Medicaid 20.0M, total 79.3M). Used only to allocate the combined CMS net-impact line into stakeholder buckets in Figure 16; does not affect the headline number. |
| **Stakeholder allocation: Medicaid federal / state FMAP blend** | 67% / 33% | 62% – 72% federal | share of Medicaid drug + medical spend | Blended FMAP across regular Medicaid (~62% federal national average) and ACA-expansion (90% federal). Used only for the stakeholder breakdown chart. Per-state splits, the Medicaid Drug Rebate Program, and supplemental rebates shift this directionally; this allocation is intentionally simplified and labeled directional. Source: KFF FMAP indicator. |
| **Per-drug OUD-risk score (figure 17 only)** | 0–10 directional composite | — | directional risk index | Constructed per drug class from DEA scheduling, persistent-use rate vs. hydrocodone (Thiels et al. BMJ 2019; Mayo Clinic), comparative OUD-progression studies (Stupinski et al. 2023), abuse-liability evidence (Comer 2021), and abuse-deterrent reformulation literature (Alpert et al. NBER 2017; Cicero & Ellis 2017). Per-drug basis stored in the `oud_risk_basis` column of data/opioid_mix_costs.csv. |

# Methodology

## Structure

For each of five pricing scenarios, the model computes 10 years of: (1) CMS suzetrigine drug spend = (addressable CMS opioid Rx) × (Bass-diffusion penetration) × 15 tablet-equivalents per modeled 7-day course (including the FDA loading dose) × net price per pill; (2) CMS savings = avoided generic opioid drug cost + avoided CMS-paid OUD medical cost. Net impact = savings − spend, reported both annually and as a 10-year cumulative total.

## Adoption model

Bass diffusion curves $N(t)/M = (1 - e^{-(p+q)t}) / (1 + (q/p) \times e^{-(p+q)t})$. Negotiated-access scenarios use a common first-line Bass curve (p=0.03, q=0.50, peak=85%) calibrated to the CASPR opioid-substitution analysis's Low-Cost parameter set.

StatusQuo uses a managed-access curve (p=0.015, q=0.30, peak=25%). The historical peak penetration of non-preferred branded analgesics launched against a cheap generic alternative (for example Celebrex in the COX-2/NSAID category and Lyrica in pain indications) typically plateaus at 15–25% of addressable volume even over 10-year windows under utilization management, prior authorization, and cost-sharing friction. Headline net impact in this memo is reported incremental to that status-quo trajectory.

## OUD-prevention accounting

Two distinct windows:

– **CMS medical savings** (in core net impact): 5-year rolling window matching average CMS coverage duration per OUD beneficiary. Each new-prevention cohort contributes $\$5.9K/yr \times 5\ yrs \approx \$29.5K$ per prevented case (incremental OUD-attributable CMS medical cost per beneficiary, from Drug & Alcohol Dependence 2023: Medicare PBPY $15,464 OUD − $9,558 non-OUD = $5,906 excess), spread across the window.

– **Societal impact** (separate box): lag-1 cumulative pool, applying annual OUD-attributable excess all-cause mortality / productivity / criminal-justice rates to all prior prevented cases. Deaths and social benefits accrue for the full OUD lifetime (~15–25 years untreated), not just the CMS-coverage window.

## Key methodology notes

– **OUD-attributable mortality**: 1.4%/yr base excess all-cause mortality per active OUD case. The construct is observed mortality among people with OUD minus expected mortality in a comparable non-OUD population, so it captures overdose plus non-overdose OUD-driven mortality without counting background deaths as caused by OUD. The sensitivity range is 0.7%/yr (overdose-only excess) to 2.0%/yr (observed OUD-associated all-cause mortality upper bound).

– **OUD incidence by pool**: the core acute-pain pool uses 0.6% per avoided course (Brat BMJ 2018). The optional chronic-label increment uses a separate 2.0% per regimen-equivalent proxy derived from higher-risk long-duration exposure literature.

– **Discounting**: headline totals are shown undiscounted in 2026 dollars; the model also computes a companion 3% discounted view in `output/results.json` for budget-style comparison.

– **Scope**: CMS-only (Medicare Part D + Medicaid).

## Known limitations

– **The forward CMS baseline is a projection**, not an observed post-2023 series. The model is anchored to official 2023 Medicare + Medicaid opioid claims and projected forward with a tapering decline path.

– **Diversion factor** is not counted in the core fiscal line. Unused post-surgical tablets (42–71% of dispensed) seed new-user OUD in non-recipients, but no peer-reviewed study quantifies the conversion rate.

– **Managed Medicaid drug-encounter reporting gaps** in T-MSIS (~10–15% in some states) may cause slight underestimation of Medicaid opioid Rx baseline.

– **Chronic-pain label** timing is uncertain. Vertex's January 2026 public update supports ongoing Phase 3 development, not a locked near-term label date. The acute-only view is therefore the primary policy baseline; the chronic section should be read only as an illustrative upside case.

– **Vertex status-quo revenue baseline** in this model is $2.7B of CMS-channel revenue over 10 years and is intentionally conservative.

## Acknowledgements

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# Data Access

CASPR is happy to share the underlying data files, model code, and source citations with anyone interested in inspecting, reusing, or extending this analysis. Please reach out via caspr.org.

# Sources

All external sources cited in this analysis, grouped by type.

### CASPR companion analysis

– CASPR Policy Brief 003: Negotiating First-Line Access to Non-Addictive Painkillers for All Americans

### Suzetrigine and Vertex disclosures

– FDA: JOURNAVX (suzetrigine) prescribing information

– Vertex: FDA approval announcement for JOURNAVX, January 2025 — includes the $15.50 WAC launch price.

– Vertex: Q3 2025 financial results

– Vertex: Q4 and full-year 2025 financial results, February 12, 2026

– Vertex: pipeline and business update, January 11, 2026

– VA Pharmacy Benefits Management: suzetrigine (JOURNAVX) drug monograph, May 2025

### CMS, Medicare, and Medicaid program materials

– CMS: Medicare Drug Price Negotiation final guidance, initial price applicability year 2027

– CMS Innovation Center: Part D Senior Savings Model

– CMS Innovation Center: Cell and Gene Therapy Access Model

– CMS: BALANCE Model announcement

– CMS Innovation Center: Medicare $2 Drug List Model

– Medicare.gov: Medicare drug coverage (Part D)

– Medicare.gov: Medicare health and drug plans

– Medicaid.gov: NADAC pharmacy pricing

– KFF: federal matching rate (FMAP) state indicator

– MACPAC: June 2025 report to Congress, Chapter 3

## Claims and dispensing data

– CMS: Medicare opioid claims dataset (data.cms.gov)

– CMS: Medicaid opioid claims dataset (data.cms.gov)

– CDC: U.S. opioid dispensing rate maps

– SAMHSA: 2023 National Survey on Drug Use and Health

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– Pain Medicine, 2023 — Military Health System pain-care framework.

– Shah et al., MMWR, 2017 — likelihood of long-term opioid use by initial prescription episode; refill and escalation multiplier.

– Stupinski et al., 2023 — comparative OUD-progression evidence.

– Thiels et al., BMJ, 2019 — persistent opioid use by drug class.

## Other federal channels and valuation


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- Defense Health Agency: TRICARE beneficiary numbers
- IHS: agency profile fact sheet, October 2024
- IHS: opioid stewardship data
- U.S. Department of Transportation: value of a statistical life guidance, 2023