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<https://doi.org/10.1016/j.mayocp.2020.06.025>

Editor's Note: When publishing a letter that comments on an article published previously in *Mayo Clinic Proceedings*, it is the journal's policy to invite the author(s) of the referenced article to publish a response. Drs Choo and Rajkumar were fully supportive of the letter by Guharoy and did not feel any response from them was necessary.

Impactful Policy Action to Reduce Drug Costs in Managing Critically Ill Patients with COVID-19



To the Editor: We read the recent commentary *Medication Shortages During the COVID-19 Crisis* by Drs Choo and Rajkumar with great interest.¹ As supply chain management leaders at Mayo Clinic, we appreciate the attention these authors draw towards the issue of drug shortages and drug costs. One of the interesting observations we have made from the supply chain perspective while navigating the coronavirus disease 2019 (COVID-19) pandemic is that the impacts on drug cost from COVID-19 have been minimal in the retail segment and are more significant in the hospital sector. This phenomenon is a result of costly inpatient care for COVID-19 and there are currently no effective commercially available drug therapies that are being routinely used in the ambulatory setting.²

Due to the high cost of COVID-19 inpatient care within health care,

we project that the cost containment recommendations of Medicare price negotiations and controls of deductibles/rebates suggested by Drs Choo and Kumar will have minimal impact on drug costs at this time (there could be a benefit if new therapeutic agents emerge in the future or if brand name drugs are used for COVID-19 patients). One potentially highly impactful and easy to implement public policy solution we call attention to is the need to remedy unintended effects of the Drug Efficacy Study Implementation and Unapproved Drugs Initiative programs. These programs were implemented to provide review of drugs that have been available for decades and that had not completed formal Food and Drug Administration review. Because of these programs and abuses by manufacturers, dramatic escalation of cost and expense for certain older drugs that were once generic continue to occur.^{3,4}

The most egregious example in the hospital sector over the past decade is the dramatic rise in the cost of vasopressin, a drug that has been around for over 80 years and that is now among the top 25 drugs expenditures in hospitals as of 2019 and has patent protection until 2032.⁵ Because of the high use of vasopressin in critically ill COVID-19 patients and the greater than 6000% price increase that has occurred after completing the Unapproved Drugs Initiative process, vasopressin will likely become a top 10 drug expense within the hospital sector by the end of 2020. Inflation for vasopressin since undergoing approval through the Unapproved Drugs Initiative has been and continues to be dramatic. As result of COVID-19, the manufacturer Parr Pharmaceuticals will experience further massive windfall profits and inflict billions of dollars of

unreasonable costs for managing critically ill patients over the next decade.

Policy adjustments that address unintended consequences of the Drug Efficacy Study Implementation and Unapproved Drugs Initiative programs could prevent further economic harm related to vasopressin pricing and avoid similar abuses in the future.

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Potential Competing Interests: The authors report no competing interests.

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<https://doi.org/10.1016/j.mayocp.2020.06.042>

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however, they were fully supportive of the letter by Tichy and Francis and did not feel a response was necessary.

CORRECTION



Correction to ‘Cardiovascular Outcomes and Rehospitalization Rates in Homeless Patients Admitted With Acute Myocardial Infarction’ [*Mayo Clinic Proceedings* 95 (2020) 660–668/2745]

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In the Original Article titled “Cardiovascular Outcomes and Rehospitalization Rates in Homeless Patients Admitted With Acute Myocardial Infarction,” published

in the April issue of *Mayo Clinic Proceedings* (*Mayo Clin Proc* 2020;95(4):660-668), an error was made. “Homeless” should be corrected to “non-homeless” in the following corrected sentence: “Our study did not show an increase in adjusted in-hospital mortality compared with that in *non-homeless* patients, despite their different risk profile and the fewer referrals for invasive angiography and revascularization among them.”

<https://doi.org/10.1016/j.mayocp.2020.06.017>