

TABLE I. 2022 cost of most common combination inhalers: 1-month supply, United States vs Canada

Medication*	Local range (\$)†	Local average (\$)‡	Canada range (\$)†	Canada average (\$)‡	Savings (%)§
Advair 250/50	420-506	463	75-160 ¶***	125	73
Wixela 250/50	210-480	345	32-138 ¶††	85	75
Symbicort 160/4.5	400-489	445	80-115#**	98	78
Generic Symbicort 160/4.5	269-443	356	37-89#††	63	82
Breo 100/5	400-495	446	45-100 #	73	84
Trelegy 100/5	620-749	685	96-195 ¶	146	79
Breztri 160/4.5	620-861	741	269-305#††‡	287	61

*In mcg, Advair Diskus: fluticasone propionate/salmeterol; Wixela: fluticasone propionate/salmeterol; Symbicort: budesonide/formoterol; Generic Symbicort: budesonide/formoterol; Breo: fluticasone furoate/vilanterol; Trelegy: fluticasone furoate/umeclidinium/vilanterol; Breztri: budesonide/glycopyrrolate/formoterol.

†Cost range for 1-month supply at lowest price pharmacy – cost for 1-month supply at highest price pharmacy.

‡Average of lowest and highest medication cost.

§Local 1-month mean price – Canadian mean price/Local 1-month mean price.

||Turkey.

¶Canada.

#UK.

**New Zealand.

††India.

‡‡Australia.

for a 3-month supply from Canada could potentially save an additional 27%.

Sinaiko et al concerned themselves with population health. As prescribers, we are faced with individuals—1 patient at a time. On a granular level, the expectation of adherence cannot be adequately addressed if patients cannot afford their medication. In the life-threatening stream of rising health care costs, flow is regulated by the avarice of insurance companies, pharmacy benefit managers, and pharmacies.

If providers are to be “adherent” to the current Global Initiatives for Asthma guidelines, then daily combination controller inhalers are to be prescribed for moderate-to-severe asthmatics. The central question becomes then: how can we help guide patients to afford these expensive medication regimens? In the evaluation of an asthmatic, should we be asking patients how they afford their medications along with how many times they use a rescue inhaler? As part of a routine care plan, should we be offering patients a path to Canada to minimize OOP expenses and maximize compliance/adherence?

American prescribers often resist obtaining medications from across the border, but, in reality, should there be any anticipated differences from reputable pharmacies linked to major pharmaceutical manufacturing facilities outside the United States? The United States imported \$115 billion of finished pharmaceutical products in 2018.⁴ Thus, prescribers should not be deterred or patients impeded from accessing branded inhalers abroad. To date, there has been no legal case brought by the Food and Drug Administration against an individual importing medicines for personal use.⁵

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No funding was received for this work.

Conflicts of interest: The authors declare that they have no relevant conflicts of interest.

Received for publication January 20, 2022; accepted for publication February 26, 2022.
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<https://doi.org/10.1016/j.jaip.2022.02.045>

Reply to “When too much is too much”



To the Editor:

Wolf and Fortner¹ describe an individual patient's struggle to pay high out-of-pocket costs for asthma controller medications, a challenge faced by many patients with asthma. Cost-related nonadherence to medication is associated with complications and worse outcomes,²⁻⁴ thus helping patients afford their medications could improve health.

Wolf and Fortner also describe the substantial variation in retail drug prices in the United States and internationally to show that patients who pay retail price would pay different amounts for medication depending on where it is purchased. Retail price is paid by patients without insurance or when their insurance does not cover a medication. For patients with insurance coverage

for medications, choosing an in-network pharmacy, switching to 90-day supply of medications from 30 days, and switching medications within therapeutic class to one that is in a preferred tier on a patient's health plan formulary are other strategies to lower patient paid medication costs.⁵

We see this discussion of medication affordability challenges and of strategies to lower patient costs as a valuable addition to the findings of our paper on out-of-pocket spending. Whether medications are affordable for patients can affect adherence and is thus clinically meaningful. Discussing medication costs and helping patients access affordable medications can be part of efforts to maximize adherence and health outcomes.

Clinicians need resources to support patients through affordability challenges. Information about what a patient would pay for a prescription, which depends on the medication and on the patient's health plan formulary and benefit design, is needed. Only with the patient's cost information can clinicians and patients together think about the ideal care plan to maximize adherence and health outcomes.

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No funding was received for this work.

Conflicts of interest: A. C. Wu receives funding from GlaxoSmithKline for separate research. The rest of the authors declare that they have no relevant conflicts of interest.

Received for publication February 24, 2022; accepted for publication February 26, 2022.

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<https://doi.org/10.1016/j.jaip.2022.02.046>

Food allergy: One more book rather than one less pen



To The Editor:

We read with great interest the article by Shaker et al¹ on the analysis of the cost-effectiveness of risk stratification for prescription of the epinephrine autoinjector (EAI) for patients

with food allergies. The authors conclude that limiting the prescription of 2 EAIs to patients with a history of anaphylaxis would be significantly more cost-effective than the current strategy of routinely prescribing 2 EAIs to any patient with suspected anaphylaxis.

First, it is probably simplistic to extrapolate general results for food allergies from studies of peanut allergy alone. Moreover, it is likely that better knowledge of anaphylactic symptoms, and particularly gastrointestinal symptoms,² by patients would lead to an increase in the incidence of diagnosing acute anaphylaxis, and therefore in the costs inherent in their management and, ultimately, in the prescription of additional EAIs after the initial episode. Although this is not a financially profitable strategy in the short term, educating the population about this chronic condition through a national prevention program would very probably reduce its morbidity/mortality and thus the long-term costs. In the end, it is probably more cost-effective to educate patients by giving them a book rather than to take away a pen.

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No funding was received for this work.

Conflicts of interest: The authors declare that they have no relevant conflicts of interest. Received for publication January 19, 2022; accepted for publication March 2, 2022.

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<https://doi.org/10.1016/j.jaip.2022.03.011>

Reply to "Food allergy: One more book rather than one less pen"



To the Editor:

We appreciate the interest of Drs Cazes and Briquet¹ in cost-effective approaches to anaphylaxis management. The authors raise several important points.

In our evaluation of peanut allergy, universal prescription of 2 epinephrine autoinjectors for all allergic children was associated with an incremental cost of \$10,696,036/quality-adjusted life-year (QALY), compared with prescribing 2 devices for all children with a history of peanut anaphylaxis and only 1 device to those without a history of prior anaphylaxis.² Given a standard cost-effectiveness threshold of \$100,000/QALY, routine prescription of 2 devices for all patients with peanut allergy does not promote value-based care at current epinephrine device prices or costs of anaphylaxis care.^{3,4}

The model of childhood peanut allergy is an appropriate surrogate for any childhood food allergy.²⁻⁴ Peanut allergy is prevalent, frequently associated with anaphylaxis, and often