Drug Shortages in the United States 2026: Full Report

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Executive Summary

The United States entered the second half of 2026 with two, sometimes contradictory, official pictures of its drug supply. The **American Society of Health-System Pharmacists (ASHP)**, working with the University of Utah Drug Information Service (UUDIS), counted **227 active national drug shortages** in its second-quarter 2026 report, the third consecutive quarterly increase after a 2025 low (Source: ashp.org), a rise trade press attributed largely to reliance on lone suppliers (Source: endpoints.news). The **Food and Drug Administration (FDA)** reported **93 ongoing shortages** as of December 31, 2025 (Source: fda.gov). This is a historical year-end snapshot, not a figure comparable to ASHP's second-quarter 2026 count; FDA's live database changes as product statuses are updated. A third tracker, the **U.S. Pharmacopeia (USP)**, put the year-end 2025 count at just 75, down 23% from 98 in 2024 (Source: cidrap.umn.edu). FDA reported fewer *new* shortages, while ASHP and USP reported active-shortage counts using different methodologies. Those active-count snapshots should not be used to infer a shared trend in newly emerging shortages.

Beneath that improving top-line trend sits a more troubling structural finding: shortages that do occur are lasting far longer. USP calculated the average duration of an active US drug shortage at **over five years** by the end of 2025, up from roughly four years in 2024 and about three years in 2023 (Source: usp.org). More than 90% of all US shortages are now "persistent," lasting a year or longer, and 39% have lasted more than five years (Source: usp.org) (Source: cidrap.umn.edu). The five longest-running US shortages, all more than a decade old, are all injectable medicines: atropine sulfate, fentanyl citrate, leucovorin calcium, lidocaine hydrochloride, and epinephrine bitartrate (Source: usp.org).

Sterile injectable drugs, generic sterile injectables in particular, remain the epicenter of the crisis. They accounted for **71% of all active US shortages** at the end of 2025, the largest share of any dosage form (Source: usp.org), and 63% of drugs that entered shortage between 2013 and 2017 were administered by injection (Source: fda.gov), a pattern GAO confirmed remained unchanged as of its most recent 2025 review (Source: gao.gov). FDA's root-cause analysis identifies market concentration, GPO contracting practices, and reliance on overseas manufacturing as contributors. A later

ASPE analysis reported that 70% of drugs in this market do not achieve profitability by their third year (Source: ncbi.nlm.nih.gov). FDA found that 40% of generic drug markets had only one manufacturer (Source: fda.gov), that four GPOs accounted for about 90% of the medical-supply market by 2018 (Source: fda.gov), and that 88% of API sites and 63% of finished-dosage-form sites were outside the United States as of 2018 (Source: fda.gov).

The financial toll on hospitals is substantial and growing. A 2025 Vizient survey found US hospitals spent roughly 20 million labor hours managing shortages, translating to nearly $894 million in annual labor costs, up from $359 million in 2019 (Source: beckershospitalreview.com). Hospitals forced onto secondary or gray-market distributors pay roughly 214% more than through primary channels (Source: beckershospitalreview.com), and a separate 2023 ASHP member survey found that over 99% of hospital pharmacists were personally experiencing drug shortages at the time (Source: ashp.org).

Federal policy responses have multiplied since 2024: FDA's new PreCheck Program (launched February 1, 2026) aims to streamline domestic manufacturing reviews (Source: fda.gov); Executive Order 14336 (August 2025) directs Health and Human Services (HHS) to build a Strategic Active Pharmaceutical Ingredients Reserve covering roughly 26 critical drugs (Source: whitehouse.gov); Medicare now pays qualifying small hospitals to voluntarily hold six-month buffer stocks of essential medicines (Source: cms.gov); and USP's 2026 Vulnerable Medicines List separately flags 100 additional drugs at heightened risk of a future shortage (Source: usp.org). Real-world cases from 2024 through mid-2026, the intravenous saline shortage after Hurricane Helene, the resolution of GLP-1 shortages, the persistent carboplatin chemotherapy shortage, the unresolved Adderall shortage, and a new 2026 shortage of the chemotherapy drug ifosfamide, illustrate both the progress and the limits of these interventions. This report examines the data, the causes, the policy response, and the outlook for drug availability in the United States as of July 2026.

Introduction and Background

A drug shortage, under the Federal Food, Drug, and Cosmetic Act (FD&C Act), exists whenever "the demand or projected demand for a drug within the United States exceeds the supply of the drug" (Source: fda.gov). That single sentence, simple on its face, has produced years of confusion for patients, clinicians, and journalists trying to answer a seemingly basic question: how many drugs are actually short in the United States right now? As of July 2026, the honest answer is that it depends entirely on whose list is being consulted.

At year-end 2025, the FDA's Drug Shortages Database recorded 93 ongoing shortages tracked by the Center for Drug Evaluation and Research (CDER) and the Center for Biologics Evaluation and Research (CBER) (Source: fda.gov). ASHP's parallel list, compiled with the University of Utah, counted 216 active shortages at the same year-end point, then 223 by the end of the first quarter of 2026 and 227 by the end of the second quarter, the third straight quarterly increase (Source: endpoints.news). USP, a third organization that publishes an independent annual shortages report, counted 75 shortages active at the end of 2025 (Source: cidrap.umn.edu). The FDA and USP figures are year-end 2025 snapshots, whereas ASHP's 227 figure is from Q2 2026, and the organizations also use different inclusion rules.

What all three trackers agree on is the shape of the recent past. Active shortages climbed for years, reaching an all-time high of **323** on ASHP's count in the first quarter of 2024, the highest level since ASHP and the University of Utah began tracking data in 2001 (Source: statnews.com). New shortages identified by FDA fell sharply thereafter: "55 new drug shortages in CY 2023, 15 new drug shortages in CY 2024, and 4 new drug shortages in CY 2025," the fewest since a historic peak of 251 new shortages in CY2011 (Source: fda.gov) (Source: fda.gov). Yet even as new shortages became rarer, the shortages already on the books grew stubbornly persistent, and 2026 brought a renewed uptick in ASHP's active count alongside a wave of new federal policy activity aimed at the underlying manufacturing base.

This report synthesizes FDA, ASHP, USP, GAO, and HHS Assistant Secretary for Planning and Evaluation (ASPE) data, along with named 2024 to 2026 case studies, to answer the central question behind the 2026 search interest in this topic: what is actually short, why does it keep happening, how long do shortages last, and what is Washington doing about it. It covers the FDA Drug Shortages Database and the ASHP list, the root causes concentrated in generic sterile injectable manufacturing, the breakdown of shortages by therapeutic class, and the outlook for chemotherapy and other high-stakes drug categories heading into the second half of 2026.

For hospital pharmacy directors, oncology practices, and patients managing chronic conditions, the practical stakes of this methodological disagreement are not academic. A drug shortage forces clinicians to substitute therapeutically similar but not identical products, adjust dosing protocols, or in the worst cases delay treatment altogether, consequences that fall hardest on the sterile injectable and pediatric drug categories examined in detail below. Understanding which tracker to consult, and why its number differs from the one a colleague or a news article might cite, is therefore a practical prerequisite to interpreting any shortage-related guidance issued in 2026.

Tracking the Shortage Landscape: FDA and ASHP Methodology

Two organizations dominate US drug-shortage tracking, and understanding why their numbers diverge is essential to interpreting any statistic in this space. FDA's Drug Shortage Staff (DSS) within CDER maintains the government's official Drug Shortages Database, a live, searchable tool at accessdata.fda.gov that lists both current and resolved shortages (Source: accessdata.fda.gov). A shortage is marked resolved in that database "when the Drug Shortages Staff (DSS) determines that the market is covered," meaning at least one manufacturer can meet total national demand (Source: accessdata.fda.gov). FDA also separately tracks drug discontinuations, cases where a manufacturer stops making a product entirely rather than experiencing a temporary supply gap, in a separate, similarly structured list on the same database interface.

The ASHP list, compiled in partnership with the University of Utah Drug Information Service, applies a broader clinical-impact standard. UUDIS explained to the Senate Homeland Security and Governmental Affairs Committee in March 2023 that it "receive[s] voluntary reports from healthcare providers across the United States (US) and... confirm[s] directly with the manufacturer" before listing a shortage (Source: hsgac.senate.gov). ASHP's own comparison document explains that its list counts "all drug and biologic shortages reported and confirmed with manufacturer that are national in impact," and explicitly notes that "ASHP frequently lists more shortages than FDA" (Source: ashp.org). Critically, ASHP defines a shortage in terms of practical clinical impact, including situations that "affect[] how pharmacy prepares or dispenses a product, or... require[] use of alternative drugs, which may affect patient care" (Source: ashp.org), a lower bar than FDA's strict national supply-versus-demand calculation, and ASHP does not remove a shortage from its active list until every manufacturer and every formulation is fully restored.

FDA's tracking also depends heavily on mandatory manufacturer reporting under section 506C(a) of the FD&C Act. In CY2025 alone, FDA received 1,424 potential shortage notifications from 167 different manufacturers (Source: fda.gov), the raw intake that DSS staff triage into confirmed shortages, prevented disruptions, or false alarms. The annual-report requirement is in FD&C Act section 506C-1, which requires FDA to submit its report to Congress "not later than March 31 of each calendar year" (Source: fda.gov). Section 506C(a), by contrast, governs certain manufacturer notifications. This annual report anchors most of FDA's statistics cited throughout this article. A related but distinct FDA tool is the Essential Medicines, Medical Countermeasures, and Critical Inputs List, created in response to a 2020 executive order directing the agency to identify medicines "medically necessary to have available at all times," specifically "those that are most needed for patients in U.S. acute care medical facilities" (Source: fda.gov), and that list now feeds directly into several of the 2025 to 2026 policy initiatives discussed later in this report.

The Current Count: FDA and ASHP Numbers Through Mid-2026

Table 1 below assembles the parallel FDA and ASHP data series across the last several years, illustrating both the shared trend and the persistent numerical gap between the two trackers. Figures already established with a full citation in the surrounding text above are shown in the table without a repeated citation.

PERIOD	ASHP/UUDIS ACTIVE SHORTAGES	FDA NEW SHORTAGES (CALENDAR YEAR)	FDA ONGOING SHORTAGES (YEAR-END)	FDA SHORTAGES PREVENTED (CALENDAR YEAR)
CY2011 (historic peak, new shortages)	not directly comparable	**251** (historic peak)	n/a	n/a
Q2 2023	**309**, highest in nearly a decade at the time (Source: ashp.org)	55 (CY2023)	n/a	n/a
Q1 2024	**323**, all-time high since 2001 (Source: statnews.com)	n/a	n/a	n/a
Q2 2024	**300** (Source: statnews.com)	n/a	n/a	n/a
Year-end 2024	**271** (Source: ashp.org)	15 (CY2024)	n/a	283 (CY2024) (Source: fda.gov)
Year-end 2025	**216**	4 (CY2025); ASHP separately identified 89 new shortages, its lowest count since 2006 (Source: statnews.com)	**93**	330 (CY2025) (Source: fda.gov)
Q1 2026	**223** (Source: ashp.org)	n/a	n/a	n/a
Q2 2026	**227**, third straight quarterly increase (Source: ashp.org)	n/a	n/a	n/a

The table shows two important, and only apparently contradictory, patterns. First, the FDA's count of brand-new shortages has fallen almost every year since the CY2011 peak of 251, reaching a low of just 4 in CY2025, evidence that the agency's prevention tools, discussed later in this report, are increasingly effective at stopping shortages before they start. Second, ASHP's count of shortages already active on any given day rose for years, peaked at 323 in the first quarter of 2024, fell through most of 2025, and then began climbing again in early 2026, a renewed rise trade coverage tied to hospitals' growing dependence on single, sole-source manufacturers for many generic products (Source: endpoints.news). Both patterns are consistent with a shortage landscape where new problems are becoming rarer, but existing problems are proving very difficult to fully resolve, a dynamic examined quantitatively in the Data Analysis section below. ASHP's comparison document explains part of the gap: ASHP includes drug and biologic shortages that are nationally impactful and retains them until all manufacturers restore every formulation and dosage size, whereas FDA lists shortages confirmed as national supply shortfalls and considers them resolved once one or more manufacturers can meet full market demand (Source: ashp.org).

Why Generic Sterile Injectables Dominate the Shortage List

FDA's landmark 2019 (updated February 2020) report, "Drug Shortages: Root Causes and Potential Solutions," remains the most cited government analysis of why the United States cannot keep certain drugs consistently in stock, and its findings have been reaffirmed by subsequent Government Accountability Office (GAO) and ASPE work through 2025. The report's central empirical finding is that sterile injectable drugs are wildly overrepresented among shortages: of the drugs that entered shortage between 2013 and 2017, **63 percent (103) were drugs administered by injection** ("sterile injectables") (Source: fda.gov). That imbalance persists: USP's 2026 data show sterile injectables made up 71% of all active shortages at the end of 2025, up from 69% a year earlier (Source: usp.org) (Source: usp.org), and injectable products accounted for half of all

shortages recorded by ASPE between 2018 and 2023 (Source: aspe.hhs.gov). ASHP's own March 2022 survey of the sterile injectable crisis found more than 99% of the 345 hospital respondents affected in some way, and 7% reported at least one shortage-related medication safety event that caused at least temporary patient harm (Source: ashp.org), a direct clinical consequence of the structural causes described below.

FDA's report identifies several reinforcing structural causes. The first is economic: current GPO and hospital contracting practices, combined with a market where by 2018 the four largest GPOs accounted for about 90 percent of the market for medical supplies in the United States (Source: fda.gov), push generic prices toward unsustainably thin margins. FDA further found that "forty percent of generic drug markets were supplied by only one manufacturer" (Source: fda.gov), meaning a single quality failure or plant shutdown can eliminate national supply overnight. A 2024 ASPE brief updated this economic picture starkly: **70 percent of drugs in this market do not achieve profitability by their third year** after launch (Source: ncbi.nlm.nih.gov), a finding ASPE's earlier 2011 analysis had already anticipated when it concluded that "the current shortage of sterile injectable drugs is concentrated in the generics industry" (Source: aspe.hhs.gov). The generic injectable market is also, per ASPE, "composed of fewer manufacturers per molecule than the generic oral market" (Source: ncbi.nlm.nih.gov), compounding the concentration risk.

The second cause is manufacturing quality and capacity. FDA found that "drug manufacturing facilities typically operate above 80 percent capacity" (Source: fda.gov), leaving little slack to absorb a plant closure, a natural disaster, or a quality remediation. ASPE's original 2011 analysis had already flagged that "at these high levels of utilization, it may be difficult to maintain manufacturing quality levels" (Source: aspe.hhs.gov). GAO's 2016 review confirmed the consequence, finding that FDA "generally issued an increasing number of warning letters to sterile injectable drug establishments" and that "seven establishments that were linked to widespread shortages and received warning letters" had prior indications of manufacturing noncompliance before the warning letters were even issued (Source: gao.gov) (Source: gao.gov). GAO's earlier 2014 testimony had already connected the dots economically, concluding that "low profit margins have limited infrastructure investments or led some manufacturers to exit the market" entirely (Source: gao.gov).

The third structural cause is geographic concentration of manufacturing overseas. FDA's 2019/2020 report found that "63 percent of sites making finished dosage forms (FDFs) were located overseas" as of 2018, alongside an even higher 88 percent of API manufacturing sites (Source: fda.gov). That dependence has changed little in the years since: an August 2025 White House executive order states that "only about 10 percent of the APIs by volume for the finished drug products" consumed in the United States are made domestically (Source: whitehouse.gov). GAO's most recent (2025) review of the issue confirmed the pattern remains unresolved, finding that "shortages most commonly affect sterile injectable drugs that are critical to hospital care and cancer treatment" and that the agency "started developing an effort to encourage manufacturers to invest in more mature quality systems, as quality issues underlie many shortages" (Source: gao.gov) (Source: gao.gov).

Taken together, these root causes describe a self-reinforcing cycle rather than any single point of failure: thin margins discourage the capital investment needed to build redundant manufacturing lines, high capacity utilization leaves existing lines with little slack to absorb a disruption, and geographic concentration overseas means that a single regulatory or natural-disaster event abroad can simultaneously affect several US-bound suppliers at once. Breaking that cycle, rather than simply reacting to each individual shortage as it emerges, is the explicit goal of the manufacturing-resilience policies examined later in this report.

Shortages by Therapeutic Class and Dosage Form

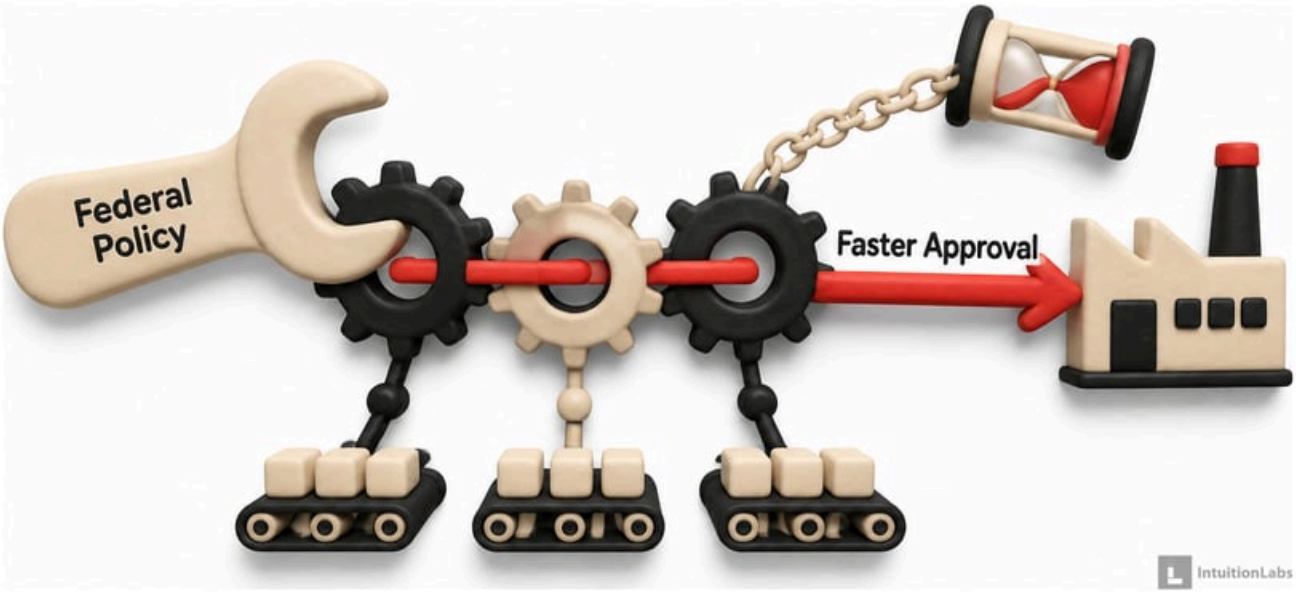
Table 2 compiles the most recent authoritative breakdowns of US drug shortages by therapeutic category and structural risk factor, drawing on USP's end-of-2025 data and ASHP's mid-2026 quarterly report. Because USP and ASHP use different classification schemes and measurement windows, the two data sets are presented side by side rather than merged.

CATEGORY OR RISK FACTOR	STATISTIC	AS OF	SOURCE
Pediatric medications	Most-affected therapeutic category, with 16 active shortages (Source: cidrap.umn.edu)	Dec. 31, 2025	USP
Gastroenterology	11 active shortages (Source: cidrap.umn.edu)	Dec. 31, 2025	USP
Anesthesia	10 active shortages (Source: cidrap.umn.edu)	Dec. 31, 2025	USP
Endocrinology / metabolism	10 active shortages (Source: cidrap.umn.edu)	Dec. 31, 2025	USP
Oncology (chemotherapy)	6 active shortages in USP's narrower count (Source: cidrap.umn.edu)	Dec. 31, 2025	USP
Sterile injectables (dosage form, all categories)	71% of all active shortages, largest of any dosage form (Source: usp.org)	Dec. 31, 2025	USP
Controlled substances	16% of active shortages (Source: ashp.org)	June 2026	ASHP
Sole-source (single manufacturer) products	48% of all new 2026 shortages (Source: ashp.org)	2026 year-to-date	ASHP
Generic vs. brand shortages	Twice as many generic drug shortages began (n = 1,391) as brand drug shortages (Source: aspe.hhs.gov)	2018 to 2023	ASPE
Single-country key starting material dependence	Nearly half of shortages have at least one key starting material (KSM) sourced from a single country (Source: usp.org)	Dec. 31, 2025	USP

The table underscores that "therapeutic class" is a less reliable predictor of shortage risk than dosage form and market structure. ASHP's own Q1 2024 top-five-classes chart had ranked central nervous system (CNS) drugs, antimicrobials, hormone agents, chemotherapy, and cardiology therapies as the most shortage-prone categories, according to trade-press coverage of that report (Source: pharmacytimes.com), while USP's end-of-2025 data instead ranks pediatric medications first. The discrepancy is best explained by measurement window and classification method rather than any real change in underlying risk: both data sets agree that injectable, sole-source, generic products, regardless of which therapeutic label is attached to them, are disproportionately likely to end up on a shortage list. That generic-injectable link is reinforced by USP's price data: in 2025, a generic injectable not currently in shortage averaged 8.5 times the unit price of one that was in shortage (Source: cidrap.umn.edu), a striking confirmation of FDA's original 2019 thesis that unsustainably low prices, not raw manufacturing difficulty, are the root economic driver of shortage risk.

Federal Policy Response: Executive Orders, Legislation, and FDA Programs

Federal drug-shortage policy accelerated markedly between 2024 and mid-2026, spanning executive action, new FDA operational programs, a proposed Medicare payment reform, and pending legislation. FDA's newest initiative, the **PreCheck Program**, launched February 1, 2026, and "represents a strategic initiative to strengthen America's pharmaceutical supply chain" by reducing regulatory friction for domestic manufacturing (Source: fda.gov). It builds on FDA's existing Quality Management Maturity (QMM) program, which encourages manufacturers to "implement quality management practices that go beyond current good manufacturing practice" standards and announced a third pilot cohort in February 2026 (Source: fda.gov).



At the White House level, Executive Order 14293 (May 2025) directs FDA to streamline reviews of new domestic manufacturing facilities, citing findings that building a new plant "may take as long as 5 to 10 years" under current rules, and requires FDA to "publicly disclose the annual number of inspections" it conducts of foreign facilities (Source: whitehouse.gov) (Source: whitehouse.gov). Three months later, Executive Order 14336 (August 2025) directed the Administration for Strategic Preparedness and Response (ASPR) to build a **Strategic Active Pharmaceutical Ingredients Reserve (SAPIR)** covering "approximately 26 drugs that are especially critical to the health and security interests of the Nation" (Source: whitehouse.gov).

On the payment-policy side, the Centers for Medicare and Medicaid Services (CMS) finalized a rule allowing small, independent hospitals of 100 beds or fewer to "voluntarily establish and maintain a 6-month buffer stock of one or more" essential medicines and receive separate Medicare payment for the added inventory cost, effective for cost-reporting periods on or after October 1, 2024 (Source: cms.gov). Notably, CMS built in a guardrail against gaming the system: "Medicare will not pay for a newly established buffer stock of an essential medicine" if that medicine is already in active shortage (Source: cms.gov), meaning the incentive rewards proactive stockpiling rather than after-the-fact hoarding.

A more ambitious, and still unenacted, proposal is HHS's **Manufacturer/Manufacturing Resiliency Assessment Program (MRAP)**, outlined in a January 2024 ASPE white paper. MRAP "would assign resilience scores to manufacturers of generic drugs" (Source: aspe.hhs.gov), giving hospitals and GPOs a data-driven way to reward manufacturers that invest in redundancy and quality over those that simply offer the lowest price. As of the white paper's publication, HHS acknowledged it would need to "work with Congress to create new authorities and provide additional funding" before MRAP could operate (Source: aspe.hhs.gov), and estimated "our initial estimate is that such a program would cost between" roughly $3.26 billion and $5.11 billion over ten years, combined with a companion hospital-side resiliency program (Source: aspe.hhs.gov). MRAP has not been enacted as of mid-2026 and remains a proposal awaiting congressional action, a distinction worth stressing given how often it is discussed in industry commentary as though it were already operating.

Congress has also acted directly: Senators Klobuchar, Lee, Durbin, and Grassley introduced the bipartisan **Short on Competition Act** (S. 2345) in July 2025, which would authorize "expedited approval of generic prescription drugs and temporary importation of prescription drugs" for shortage-prone or thinly competitive drug markets (Source: govinfo.gov). FDA has already used similar emergency tools without waiting for that bill to pass: in its CY2024 report to Congress, the agency described how it "exercised enforcement discretion for temporary importation to provide treatment options for patients" after Hurricane Helene knocked out a major IV-fluid plant in September 2024 (Source: fda.gov), and separately "requested an increase in lisdexamfetamine quota, which DEA subsequently granted" to ease an ADHD stimulant shortage (Source: fda.gov).

Beyond federal action, USP's April 2026 Vulnerable Medicines List flags a forward-looking risk category: it "identifies 100 unique drug products across acute and chronic care settings" that face heightened future supply risk even though none is currently short (Source: usp.org), effectively an early-warning list meant to guide manufacturer and purchaser attention before a crisis, not after. The Healthcare Supply Chain Association, which

represents major GPOs, told federal regulators in 2024 that its members "work tirelessly to prevent and mitigate shortages of drugs and other products" through diversified sourcing contracts (Source: supplychainassociation.org), a claim that sits in some tension with FDA's own finding, described above, that GPO contracting concentration is itself a contributor to shortage risk.

Data Analysis and Evidence

The single most important quantitative finding in the 2025 to 2026 shortage data is that duration, not incidence, is now the dominant problem. USP calculated that the **average duration of an active US drug shortage grew to over 5 years** by the end of 2025 (Source: usp.org), up from an average exceeding four years at the end of 2024, which was itself up from roughly three years in the 2023 data (Source: usp.org). HHS's own ASPE analysis of 2018 to 2023 FDA data found that duration varies sharply by dosage form and clinical necessity: injectable-product shortages last "roughly twice as long for injectable products (median = 4.6 years)" as other forms, and shortages of medicines on FDA's essential-medicines list run a median of 4.0 years compared to 2.3 years for non-essential products (Source: aspe.hhs.gov) (Source: aspe.hhs.gov). USP's 2025 data show that "persistent shortages account for more than 90% of all drug shortages in the United States" (Source: usp.org), with 64% of currently short medicines unavailable for more than three years and 39% for more than five years (Source: cidrap.umn.edu). Consistent with the manufacturing-economics findings above, USP identifies the five most persistent US shortages, all lasting more than a decade, as "the five most persistent shortages all are injectable medicines": atropine sulfate, fentanyl citrate, leucovorin calcium, lidocaine hydrochloride, and epinephrine bitartrate (Source: usp.org).

At the same time, USP's headline count of total year-end active shortages "declined by 23% in 2025, from 98 in 2024 to 75" (Source: cidrap.umn.edu), a figure roughly a third of ASHP's parallel count of 216 to 271 active shortages across the same period, itself illustrating again how methodology, not underlying reality, drives most of the disagreement between trackers cited in this report. The scale of that three-way discrepancy, FDA's 93, ASHP's 216, and USP's 75 for the same year-end 2025 snapshot, is itself instructive: it demonstrates that any single statistic describing "the" number of US drug shortages should be treated as one data point within a defined methodology rather than an objective fact, and that policymakers, journalists, and hospital administrators comparing figures across sources need to first confirm which tracker, and which inclusion criteria, produced the number in question. USP's data also flag a worrying leading indicator: **product discontinuations**, where a manufacturer exits a market entirely rather than experiencing a temporary gap, "reached their highest level since 2019, with an acute 60 percent increase" from 2024 to 2025 (Source: usp.org), and nearly half of currently short "drugs in shortage have at least one KSM solely manufactured in a single country" (Source: usp.org), a supply-chain fragility measure that discontinuation counts alone do not capture.

Economically, Vizient's 2025 hospital survey put a concrete dollar figure on the burden: US hospitals collectively spent roughly "20 million hours managing a range of drug shortages" (Source: vizientinc.com), which translated into an annualized labor cost rising "from $359 million in 2019 to $894 million in 2024" (Source: beckershospitalreview.com). That figure captures only staff time, not the higher unit prices hospitals pay once forced off primary distribution channels: Vizient found that "relying on secondary distributors for essential medicines costs about 214% more than primary distributors" (Source: beckershospitalreview.com), and USP's 2025 price-gap data show a generic injectable not currently in shortage averaged 8.5 times the price of an equivalent drug that was in shortage (Source: cidrap.umn.edu). ASHP's own 2023 member survey, drawing on 1,123 pharmacist respondents, quantified the operational burden directly: over 99% reported experiencing drug shortages (Source: ashp.org), 57% specifically flagged chemotherapy shortages as critically impactful (Source: ashp.org), and 73% estimated a 6 to 20 percent increase in their overall drug budget attributable to shortage-driven substitutions (Source: ashp.org). Taken together, the data support a consistent narrative across every credible source consulted for this report: the drugs most likely to enter shortage, and to stay in shortage the longest, are precisely the low-priced, sole-source, injectable generics that offer manufacturers the thinnest financial incentive to invest in redundant capacity.

Case Studies and Real-World Examples

The aggregate statistics above describe a system-wide pattern, but individual shortage events illustrate how that pattern plays out for a specific drug, manufacturer, and patient population. The five cases below, spanning a hurricane-driven sterile fluid disruption, two demand-driven GLP-1 shortages, a persistent oncology crisis, a controlled-substance shortage shaped by federal quota policy, and a seasonal pediatric antibiotic shortfall, were selected to represent the range of causes and resolution timelines documented in FDA, ASHP, and USP data since 2022.

The IV Saline Shortage After Hurricane Helene (2024 to 2025)

In late September 2024, Hurricane Helene flooded Baxter International's North Cove, North Carolina manufacturing plant, a facility that, according to trade coverage, "produced roughly 60% of the IV bags used in the U.S." before the storm struck (Source: healthexec.com). A subsequent ASHP survey of 401 health systems in October 2024 found that 84% of respondents reported a moderate or critical clinical impact from the resulting sterile

fluid shortage (ashp.org. FDA responded by exercising enforcement discretion to allow temporary importation of IV solutions from international facilities, an action documented in the agency's own CY2024 report to Congress (Source: fda.gov). Baxter itself confirmed on May 13, 2025 that "our inventory levels are restored and therefore allocations have been removed" (Source: baxter.com), though FDA "did not declare resolved until August 2025" (Source: healthexec.com). FDA Commissioner Marty Makary announced formally that the shortage "has officially ended. This marks a significant milestone for public health" (Source: fda.gov), nearly eleven months after the storm, illustrating how even a well-resourced, single-manufacturer disruption with a clear cause can take the better part of a year to fully resolve.

The GLP-1 Drug Shortages: Semaglutide and Tirzepatide (2022 to 2025)

The multi-year shortage of GLP-1 (glucagon-like peptide-1) diabetes and weight-loss drugs offers a case study in how demand-driven shortages resolve differently from supply-shock shortages. FDA declared Novo Nordisk's semaglutide products (Ozempic and Wegovy) no longer in shortage on February 21, 2025, with Reuters reporting that "Novo says supply now meets or exceeds current and projected demand" (Source: reuters.com), a determination CNN confirmed the same day (Source: cnn.com). Eli Lilly's tirzepatide products (Mounjaro and Zepbound) had already been declared resolved by FDA on October 2, 2024, after the agency "stated product availability and manufacturing capacity can meet the present and projected national demand" (Source: foley.com). That determination was challenged and reaffirmed in December 2024, when FDA drug-office head Patrizia Cavazzoni wrote in a declaratory order that "Lilly's supply is currently meeting or exceeding demand" for tirzepatide, confirming Mounjaro and Zepbound "are no longer in shortage" (Source: biopharmadive.com) (Source: biopharmadive.com). Unlike the saline case, the GLP-1 shortages resolved primarily through manufacturer capacity expansion rather than emergency importation, but both cases underscore that FDA's resolution declarations are contested and litigated events, not purely technical determinations.

Chemotherapy Shortages: Carboplatin, Cisplatin, and 2026's Ifosfamide (2023 to 2026)

The 2023 shortage of the platinum-based chemotherapy agents carboplatin and cisplatin became, in the words of American Society of Clinical Oncology (ASCO) chief medical officer Julie Gralow, "the worst I have seen in my 30-year career" (Source: cancertherapyadvisor.com). A survey of National Comprehensive Cancer Network (NCCN) member cancer centers that summer found "carboplatin was in short supply at 93% of the cancer centers surveyed" (Source: cancertherapyadvisor.com). In December 2023 Senate testimony, oncologist Jason Westin, MD, described the human stakes bluntly: "We have drugs that are lifesaving and shortages that are life threatening" (asco.org. An analysis of FDA's shortage database found that "the related cisplatin shortage was declared resolved in June 2024" while the carboplatin shortage, which the same analysis found "was first posted on April 28, 2023," remained active far longer (Source: pharmadossier.com) (Source: pharmadossier.com). The chemotherapy category has not stabilized heading into the second half of 2026: ASHP's Q2 2026 report specifically flags ifosfamide, another injectable chemotherapy agent, as "a particularly severe new shortage this quarter," attributing it to manufacturing quality problems at a key supplier (Source: ashp.org), confirming that oncology, though a comparatively small share of total shortages by USP's count, remains a category where new disruptions still emerge and carry outsized clinical consequences.

The ADHD Stimulant (Adderall) Shortage (2022 to Present)

Unlike the saline and GLP-1 cases, the shortage of amphetamine mixed salts (Adderall and its generics) has not resolved. Trade coverage in mid-2026 noted that "the Adderall shortage that began in October 2022 remains unresolved" (Source: issup.net), and as of July 28, 2026 Adderall was still "currently listed on the FDA drug shortage list (since August 2023)" with limited pharmacy availability nationally (Source: medfinder.com). Regulators have used production-quota tools similar to those FDA applied for lisdexamfetamine, described above: the Drug Enforcement Administration (DEA) raised its 2025 aggregate production quota for d-amphetamine substances effective October 2, 2025, "from 21.2 million grams to 26.5 million grams," a roughly 25% increase intended to ease the underlying raw-material constraint (Source: issup.net). The Adderall case illustrates that stimulant shortages, unlike most sterile injectable shortages, are shaped as much by DEA-controlled production quotas for a Schedule II controlled substance as by conventional manufacturing economics, which helps explain why 16% of all active shortages tracked by ASHP in mid-2026 involved controlled substances specifically.

Pediatric Amoxicillin Shortage (2022 to 2025)

The 2022 to 2023 shortage of liquid amoxicillin, the most commonly prescribed pediatric antibiotic, illustrated how seasonal demand spikes intersect with generic-market fragility. As the 2023 respiratory illness season approached, University of Utah drug-shortage researcher Erin Fox warned the country was "heading into the season without good supplies of oral liquid" amoxicillin (Source: cnn.com), while another researcher cautioned "it is a

problem. Respiratory illness season is coming up" (Source: cnn.com). FDA eventually resolved the amoxicillin powder-for-oral-suspension shortage on May 2, 2025 (Source: medfinder.com), though follow-on reporting the following month noted that even after the formal resolution, "the FDA has marked several strengths of Amoxicillin powder for suspension as available again," implying distributor-level inconsistency persisted for some time after the database status changed (Source: republicpharma.com).

Implications and Future Directions

The 2026 data point to a bifurcated outlook. On one hand, FDA's prevention machinery is demonstrably working at the margin, having helped prevent hundreds of shortages a year through expedited reviews, temporary importation, and DEA quota coordination, described in the Policy Response section above, while producing the fewest brand-new shortages in nearly two decades. On the other hand, the shortages that persist are getting harder, not easier, to resolve, with average duration now exceeding five years (Source: usp.org) and discontinuations, a leading indicator of future shortage risk, up 60% year over year (Source: usp.org). The policy architecture assembled since 2024, FDA's PreCheck and QMM programs, the two 2025 executive orders on domestic API production and inspection transparency, the CMS buffer-stock payment rule, and the pending MRAP resiliency-scoring proposal and Short on Competition Act, targets exactly the structural weaknesses FDA, GAO, and ASPE identified as far back as 2011 and 2014: thin generic margins, extreme manufacturer concentration, and overseas API dependence (Source: gao.gov). Whether these measures durably shorten shortage duration, rather than merely reducing the count of new shortages, will not be answerable with confidence until at least the 2027 and 2028 reporting cycles, and USP's own forward-looking Vulnerable Medicines List, which already flags 100 additional at-risk drugs, suggests the underlying fragility has not been resolved even where the current shortage count looks favorable (Source: usp.org).

For hospital pharmacy leadership specifically, the duration data indicate that shortage mitigation planning should consider persistence as well as incidence. USP’s figure is an average among shortages active at year-end 2025, not a probability that a newly reported shortage will last multiple years; ASPE separately found a 4.6-year median duration for injectable-product shortages in its 2018–2023 analysis. CMS's new buffer-stock payment rule and the proposed MRAP resilience-scoring program both reflect a shift in federal thinking from reacting to individual shortages toward building structural redundancy into the generic sterile injectable supply chain before the next disruption occurs.

A parallel, less regulatory trend is the growing use of supply-chain analytics and forecasting tools by hospitals and manufacturers seeking to anticipate shortages rather than react to them; commercial products such as Bluesight's ShortageCheck platform explicitly market "predictive analytics, up-to-date inventory data, and collaborative planning tools" to health systems for exactly this purpose (Source: bluesight.com). This reflects a broader pattern across regulated life-science operations, where artificial intelligence (AI) and data-engineering capabilities are increasingly applied to regulatory and supply-chain visibility problems that were previously handled manually. Life-science consultancies operating adjacent to this space, including IntuitionLabs, an official Veeva Vault CRM X-Pages partner that advises pharmaceutical and life-science organizations, describe their advisory and analytics work as "built for regulated life-science environments" with "built-in compliance with FDA, EMA, and global regulations" (Source: intuitionlabs.ai), and identify themselves as an "Official Veeva Vault CRM X-Pages Partner" (Source: intuitionlabs.ai). Such firms do not sell shortage-monitoring software directly, but their broader data-engineering, business-intelligence, and regulatory-compliance advisory practices illustrate how the analytics and AI capabilities increasingly demanded across pharmaceutical commercial and regulatory operations are also being brought to bear, by a range of vendors and consultancies, on the underlying supply-chain visibility problem that this report's data show remains only partially solved.

Longer term, three open questions will likely shape the 2027 shortage landscape: whether HHS secures congressional authority and funding to operationalize MRAP's manufacturer resilience scoring, whether the SAPIR stockpile reaches meaningful coverage of its roughly 26 target drugs, and whether FDA’s PreCheck Program measurably shortens the 5-to-10-year domestic facility build timeline that EO 14293 identified as a core barrier to reshoring generic sterile injectable production.

Frequently Asked Questions (FAQs)

What is the current FDA drug shortage list? FDA's Drug Shortages Database is the current public list of shortages and resolved shortages; it changes continuously as FDA updates product statuses. The 93 figure is historical: FDA reported 93 ongoing CDER- and CBER-tracked shortages as of December 31, 2025 (Source: fda.gov).

What is the FDA Drug Shortage Database, and how does it define "resolved"? It is a live, public tool at accessdata.fda.gov that lists both current and resolved drugs by active ingredient; the Methodology section above details how it marks a shortage resolved only once at least one manufacturer's full national supply covers the market.

Why are there so many drug shortages in the United States? FDA's root-cause analysis identifies manufacturer concentration and reliance on overseas API and finished-dosage manufacturing capacity as contributing factors. An ASPE analysis found that 70 percent of drugs in this market do not achieve profitability by their third year (Source: ncbi.nlm.nih.gov); FDA found that 40 percent of generic drug markets were served by a single supplier (Source: fda.gov).

What is the ASHP drug shortages list? It is a shortage tracker compiled by ASHP together with the University of Utah Drug Information Service, based on voluntary provider reports confirmed directly with manufacturers, using a clinical-impact standard rather than FDA's strict national-supply calculation (Source: ashp.org); it reported 227 active shortages as of the second quarter of 2026 (Source: ashp.org).

How long do drug shortages typically last? USP's most recent data put the average duration of an active US shortage at over five years as of the end of 2025 (Source: usp.org), with more than 90 percent of shortages classified as persistent (lasting a year or more) (Source: usp.org); injectable products in particular have a median duration of 4.6 years (Source: aspe.hhs.gov).

Which drug shortages are worst by therapeutic class? By USP's end-2025 count, pediatric medications topped the list with 16 active shortages, followed by gastroenterology (11), anesthesia (10), endocrinology and metabolism (10), and oncology (6) (Source: cidrap.umn.edu); ASHP's separate Q1 2024 ranking had placed CNS drugs, antimicrobials, hormone agents, chemotherapy, and cardiology drugs at the top (Source: pharmacytimes.com).

Why are generic sterile injectable shortages so common? Sterile injectables made up 71 percent of all active US shortages at the end of 2025, the largest share of any dosage form (Source: usp.org), because they combine thin generic margins, high manufacturing-capacity utilization above 80 percent (Source: fda.gov), and heavy dependence on a small number of specialized sterile-fill facilities.

Is there a chemotherapy drug shortage in 2026? Yes. ASHP's second-quarter 2026 report flags ifosfamide as "a particularly severe new shortage" tied to manufacturing quality problems at a key supplier (Source: ashp.org), and the carboplatin shortage that began in April 2023 has, per available database analysis, remained active far longer than the related cisplatin shortage, which FDA declared resolved in June 2024 (Source: pharmadossier.com).

Conclusion

The United States enters the second half of 2026 with a drug shortage landscape that is simultaneously improving and worsening, depending on which metric is examined. New shortages have become rare by historical standards, and the agency credits its expanding toolkit, expedited reviews, temporary importation, DEA quota coordination, and the new PreCheck Program, with preventing hundreds of additional shortages a year. Yet the shortages that remain are lasting longer than ever, with average duration surpassing five years and more than 90 percent of active shortages now classified as persistent. The figures require date context as well as methodological context: the FDA and USP figures are year-end 2025 snapshots, while ASHP's 227 figure is from Q2 2026. Across their respective analyses, FDA, ASHP, and USP identify generic sterile injectable drugs, sold into markets with limited manufacturing redundancy, as a central shortage vulnerability.

The federal response assembled since 2024, spanning two executive orders, a new CMS payment rule, FDA's PreCheck and Quality Management Maturity programs, a proposed manufacturer resiliency scoring system, and bipartisan legislation still pending in Congress, addresses each of the structural causes FDA identified more than six years ago. Real-world cases from Hurricane Helene's saline disruption to the still-unresolved Adderall shortage and 2026's new ifosfamide chemotherapy shortage demonstrate that some disruptions resolve within a year through aggressive regulatory intervention, while others, tied to controlled-substance quotas, chronic underinvestment, or single-country raw-material dependence, persist for years despite that same intervention. None of the individual interventions catalogued in this report, whether a single executive order, a Medicare payment rule, or a hospital's own buffer-stock policy, is likely to fully resolve a problem rooted in decades of generic-drug pricing economics. FDA reports a falling count of brand-new shortages alongside its prevention and mitigation work, but the available figures do not isolate the effect of those interventions; the deeper structural work of shortening shortage duration remains unfinished. For hospitals, prescribers, and patients, the practical takeaway is that shortage risk in 2026 concentrates overwhelmingly in generic injectable drugs, and that the duration of a shortage, once it begins, has become a more urgent policy problem than the frequency with which new shortages emerge.

Tags: drug shortages, fda drug shortage database, ashp drug shortages, sterile injectable shortages, chemotherapy drug shortage, generic drug shortages, drug supply chain, pharmaceutical manufacturing, 2026

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