IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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August 8, 2024

Abby Cate, Pharm.D.
Pharmacy Consultant
Iowa Medicaid
1305 East Walnut
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Dear Abby:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 7, 2024. At this meeting, the DUR Commission members discussed updated prior authorization (PA) criteria for Antidiabetic Non-Insulin Agents; Biologicals for Axial Spondyloarthritis; and Biologics for Plaque Psoriasis. The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a May 3, 2024 letter that was sent to them detailing the updated PA criteria for Antidiabetic Non-Insulin Agents; Biologicals for Axial Spondyloarthritis; and Biologics for Plaque Psoriasis.

Anti-Diabetic Non-Insulin Agents

Current Clinical Prior Authorization

Prior authorization (PA) is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:

1. Patient has an FDA approved or compendia indicated diagnosis, and
2. Patient meets the FDA approved or compendia indicated age, and
3. For the treatment of Type 2 Diabetes Mellitus, the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose.
4. Requests for non-preferred anti-diabetic, non-insulin agents subject to clinical criteria, will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor Combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Requests for weight loss are not a covered diagnosis of use and will be denied.

Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
Prior authorization (PA) is required for *select* preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and* ~~Patient has an FDA approved or compendia indicated diagnosis, and~~
2. ~~Patient meets the FDA approved or compendia indicated age, and~~
3. For the treatment of Type 2 Diabetes Mellitus, *a current A1C is provided; and* ~~the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose.~~
4. Requests for non-preferred antidiabetic, non-insulin agents subject to clinical criteria, will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. *Additionally,* ~~R~~ *r*equests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with *at least 3 preferred agents from 3 different drug classes* ~~metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor Combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor~~ at maximally tolerated doses.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Requests for weight loss are not a covered diagnosis of use and will be denied.

~~Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).~~

Biologicals for Axial Spondyloarthritis

Current Clinical Prior Authorization
Prior authorization (PA) is required for biologicals used for axial spondyloarthritis conditions. Payment will be considered under the following conditions:

1. Patient has a diagnosis of:
    a. ankylosing spondylitis (AS) or
    b. nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and
2. The requested dose does not exceed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and
3. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and
4. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be

considered upon completion of TB treatment; and
5. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration; and
6. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and
7. Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.

In addition to the above:
Requests for TNF Inhibitors:
1. Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and
2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less.

Requests for Interleukins:
1. Medication will not be given concurrently with live vaccines.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
Prior authorization (PA) is required for biologicals used for axial spondyloarthritis conditions. *Request must adhere to all approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations.* Payment will be considered under the following conditions:
1. Patient has a diagnosis of:
    a. ankylosing spondylitis (AS) or
    b. nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and
~~2. The requested dose does not exceed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and~~
~~3. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and~~
~~4. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and~~
5. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration; and
6. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and

7. Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.

~~In addition to the above:~~
~~Requests for TNF Inhibitors:~~
1. ~~Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and~~
2. ~~Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less.~~

~~Requests for Interleukins:~~
1. ~~Medication will not be given concurrently with live vaccines.~~

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Biologicals for Plaque Psoriasis

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:
1. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and
2. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and
3. Patient has documentation of an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine; and

In addition to the above:
Requests for TNF Inhibitors:
1. Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and
2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less.

Requests for Interleukins:
1. Medication will not be given concurrently with live vaccines.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling *for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations*. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in

which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:

1. ~~Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and~~
2. ~~Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and~~
3. *Patient has a diagnosis of moderate to severe plaque psoriasis; and*
4. Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine~~; and~~

~~In addition to the above:~~

~~Requests for TNF Inhibitors:~~

1. ~~Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and~~
2. ~~Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less.~~

~~Requests for Interleukins:~~

1. ~~Medication will not be given concurrently with live vaccines.~~

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for Antidiabetic Non-Insulin Agents; Biologicals for Axial Spondyloarthritis; and Biologics for Plaque Psoriasis.

Sincerely,

Pamela Smith R.Ph.

Pamela Smith, R.Ph.
Drug Utilization Review Project Coordinator
Iowa Medicaid

Cc: Erin Halverson, R.Ph, Iowa Medicaid
Gina Kuebler, R.Ph, Iowa Medicaid

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Iowa Total Care Claims
Quarterly Statistics

REPORT_DATE	Mar 2024 through May 2024	Jun 2024 through Aug 2024	% CHANGE
TOTAL PAID AMOUNT	$77,055,076.39	$73,532,635.99	-4.57%
UNIQUE USERS	99,571	89,052	-10.56%
COST PER USER	$773.87	$825.73	6.70%
TOTAL PRESCRIPTIONS	712,184	663,331	-6.86%
AVERAGE PRESCRIPTION PER USER	7.15	7.45	4.14%
AVERAGE COST PER PRESCRIPTION	$108.20	$110.85	2.46%
# GENERIC PRESCRIPTIONS	641,237	596,352	-7.00%
% GENERIC	90.00%	90.00%	-0.15%
$ GENERIC	$10,941,204.47	$10,210,479.98	-6.68%
AVERAGE GENERIC PRESCRIPTION COST	$17.06	$17.12	0.35%
AVERAGE GENERIC DAYS SUPPLY	25	26	1.82%
# BRAND PRESCRIPTIONS	69,881	65,961	-5.61%
% BRAND	10.00%	10.00%	1.32%
$ BRAND	$66,091,167.46	$63,290,934.48	-4.24%
AVERAGE BRAND PRESCRIPTION COST	$945.77	$959.52	1.45%
AVERAGE BRAND DAYS SUPPLY	28	28	1.13%

UTILIZATION BY AGE

AGE		Mar 2024 through May 2024	Jun 2024 through Aug 2024
0-6		40,613	29,265
7-12		48,662	41,932
13-18		62,851	58,374
19-64		546,629	523,438
65+		9,030	9,215

UTILIZATION BY GENDER AND AGE

GENDER	AGE		Mar 2024 through May 2024	Jun 2024 through Aug 2024
F	0-6		17,766	12,643
	7-12		19,088	16,373
	13-18		33,682	31,310
	19-64		349,864	333,257
	65+		6,053	5,933
M	0-6		22,847	16,622
	7-12		29,574	25,559
	13-18		29,169	27,064
	19-64		196,765	190,181
	65+		2,977	3,282

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT

202406 - 202408

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	10,809	$6,376,092.12	$589.89	1
2	RIGHT DOSE PHARMACY	ANKENY	IA	6,131	$270,861.66	$44.18	3
3	WALGREENS #4405	COUNCIL BLUFFS	IA	5,914	$394,504.37	$66.71	2
4	WALGREENS #5042	CEDAR RAPIDS	IA	5,021	$342,788.70	$68.27	4
5	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,781	$262,770.56	$54.96	6
6	WALGREENS #5239	DAVENPORT	IA	4,419	$208,844.73	$47.26	5
7	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	4,164	$235,952.15	$56.66	7
8	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,072	$332,501.40	$81.66	8
9	DRILLING PHARMACY	SIOUX CITY	IA	3,833	$264,512.77	$69.01	9
10	WALGREENS #5721	DES MOINES	IA	3,705	$252,494.72	$68.15	10
11	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	3,687	$298,050.65	$80.84	14
12	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,668	$376,776.31	$102.72	13
13	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	3,665	$234,974.64	$64.11	12
14	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	3,661	$203,601.34	$55.61	30
15	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,527	$159,147.94	$45.12	11
16	WALGREENS #7455	WATERLOO	IA	3,508	$241,055.53	$68.72	16
17	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,321	$281,873.16	$84.88	20
18	WALGREENS #359	DES MOINES	IA	3,262	$211,308.26	$64.78	15
19	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,250	$226,114.39	$69.57	18
20	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,193	$252,452.34	$79.06	23
21	WALGREENS #7453	DES MOINES	IA	3,138	$221,529.11	$70.60	19
22	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,000	$253,678.43	$84.56	24
23	WALGREENS #15647	SIOUX CITY	IA	2,968	$233,702.57	$78.74	17
24	MAHASKA DRUGS INC	OSKALOOSA	IA	2,855	$238,302.38	$83.47	21
25	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	2,815	$274,033.78	$97.35	32
26	WALGREENS #4041	DAVENPORT	IA	2,756	$150,127.97	$54.47	34
27	WALGREENS #3700	COUNCIL BLUFFS	IA	2,756	$139,945.89	$50.78	22
28	CVS PHARMACY #08544	WATERLOO	IA	2,752	$213,715.36	$77.66	26
29	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,678	$208,347.24	$77.80	28
30	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	2,625	$93,877.52	$35.76	31
31	MEDICAP LTC	INDIANOLA	IA	2,621	$96,610.85	$36.86	27
32	NUCARA LTC PHARMACY #3	IOWA CITY	IA	2,612	$119,603.03	$45.79	33
33	CVS PHARMACY #10282	FORT DODGE	IA	2,605	$127,646.28	$49.00	25
34	SOUTH SIDE DRUG	OTTUMWA	IA	2,569	$177,014.69	$68.90	29
35	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,492	$207,333.06	$83.20	42

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT

202406 - 202408

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
36	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,478	$158,431.04	$63.94	37
37	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	2,467	$335,235.01	$135.89	40
38	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,463	$182,137.99	$73.95	48
39	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,444	$197,887.35	$80.97	38
40	WALMART PHARMACY 10-1509	MAQUOKETA	IA	2,418	$142,747.72	$59.04	39
41	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	2,357	$136,731.88	$58.01	35
42	WAGNER PHARMACY	CLINTON	IA	2,347	$221,418.83	$94.34	46
43	HY-VEE PHARMACY (1449)	NEWTON	IA	2,341	$197,762.87	$84.48	36
44	HY-VEE PHARMACY (1075)	CLINTON	IA	2,331	$148,902.77	$63.88	41
45	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,319	$197,083.09	$84.99	75
46	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,277	$138,800.58	$60.96	50
47	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,273	$135,094.11	$59.43	44
48	TOWNCREST LTC	IOWA CITY	IA	2,273	$125,947.06	$55.41	63
49	WALGREENS #10855	WATERLOO	IA	2,271	$144,432.28	$63.60	59
50	HY-VEE PHARMACY #6 (1155)	DES MOINES	IA	2,267	$132,274.68	$58.35	61
51	WALGREENS #5470	SIOUX CITY	IA	2,249	$147,339.19	$65.51	45
52	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	2,249	$140,606.24	$62.52	117
53	DANIEL PHARMACY	FT DODGE	IA	2,230	$205,687.50	$92.24	53
54	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,215	$177,440.07	$80.11	43
55	HY-VEE PHARMACY (1396)	MARION	IA	2,203	$213,029.73	$96.70	64
56	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,173	$149,194.24	$68.66	70
57	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,170	$259,259.78	$119.47	52
58	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,164	$153,505.69	$70.94	57
59	UNION PHARMACY	COUNCIL BLUFFS	IA	2,159	$163,403.34	$75.68	69
60	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,147	$111,356.30	$51.87	56
61	CVS PHARMACY #08658	DAVENPORT	IA	2,128	$134,676.05	$63.29	54
62	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,044	$365,305.79	$178.72	72
63	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,041	$172,228.26	$84.38	58
64	WALGREENS #7452	DES MOINES	IA	2,024	$117,410.46	$58.01	62
65	EXACTCARE	VALLEY VIEW	OH	2,010	$152,002.31	$75.62	51
66	WALGREENS #11942	DUBUQUE	IA	2,007	$100,594.48	$50.12	60
67	SCOTT PHARMACY	FAYETTE	IA	2,006	$126,211.70	$62.92	55
68	WALMART PHARMACY 10-1723	DES MOINES	IA	1,960	$138,368.21	$70.60	77
69	WALMART PHARMACY 10-0985	FAIRFIELD	IA	1,954	$154,908.77	$79.28	67
70	WALGREENS #4714	DES MOINES	IA	1,951	$103,728.35	$53.17	65

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT

202406 - 202408

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
71	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	1,940	$71,393.00	$36.80	85
72	WALGREENS #5044	BURLINGTON	IA	1,932	$136,254.47	$70.53	66
73	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	1,930	$70,556.50	$36.56	73
74	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,910	$169,597.32	$88.79	68
75	HY-VEE PHARMACY #1 (1281)	IOWA CITY	IA	1,902	$100,616.65	$52.90	71
76	WHITING FAMILY PHARMACY	WHITING	IA	1,899	$150,240.42	$79.12	383
77	WALMART PHARMACY 10-2889	CLINTON	IA	1,883	$107,300.75	$56.98	49
78	HERITAGE PARTNERS PHARMACY	WEST BURLINGTON	IA	1,875	$168,166.06	$89.69	125
79	WALGREENS #3875	CEDAR RAPIDS	IA	1,874	$95,396.90	$50.91	92
80	WALGREENS #3595	DAVENPORT	IA	1,837	$121,200.95	$65.98	93
81	WALGREENS #7454	ANKENY	IA	1,837	$107,940.32	$58.76	83
82	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	1,813	$128,957.37	$71.13	80
83	WALMART PHARMACY 10-0646	ANAMOSA	IA	1,809	$122,880.41	$67.93	95
84	HY-VEE DRUGSTORE #5 (7026)	CEDAR RAPIDS	IA	1,807	$144,609.53	$80.03	99
85	LAGRANGE PHARMACY	VINTON	IA	1,806	$124,483.53	$68.93	82
86	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,805	$372,219.09	$206.22	94
87	WALMART PHARMACY 10-1431	KEOKUK	IA	1,804	$104,207.17	$57.76	74
88	WALGREENS #5852	DES MOINES	IA	1,787	$132,119.00	$73.93	87
89	WALGREENS #9708	DUBUQUE	IA	1,773	$101,920.78	$57.48	76
90	HY-VEE PHARMACY (1011)	ALTOONA	IA	1,765	$135,497.56	$76.77	102
91	HY-VEE PHARMACY (1324)	KEOKUK	IA	1,764	$111,581.21	$63.25	88
92	WALGREENS #5886	KEOKUK	IA	1,756	$108,629.86	$61.86	79
93	WALMART PHARMACY 10-3394	ATLANTIC	IA	1,750	$126,062.29	$72.04	96
94	MEDICAP PHARMACY	CRESTON	IA	1,748	$130,875.98	$74.87	103
95	THOMPSON DEAN DRUG	SIOUX CITY	IA	1,705	$158,033.93	$92.69	91
96	HY-VEE PHARMACY (1544)	RED OAK	IA	1,700	$135,992.86	$80.00	104
97	HY-VEE PHARMACY (1095)	CRESTON	IA	1,690	$80,531.38	$47.65	97
98	NUCARA LTC PHARMACY #4	WATERLOO	IA	1,673	$79,214.59	$47.35	111
99	WALGREENS #3876	MARION	IA	1,661	$96,663.84	$58.20	86
100	PREFERRED CARE PHARMACY	CEDAR RAPIDS	IA	1,660	$101,849.45	$61.36	131

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TOP 100 PHARMACIES BY PAID AMOUNT
202406 - 202408

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	10,809	$6,376,092.12	$3,087.70	1
2	COMMUNITY, A WALGREENS PHARMACY #16528	DES MOINES	IA	564	$2,494,042.39	$12,989.80	3
3	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	307	$1,965,482.78	$13,555.05	2
4	UNITYPOINT AT HOME	URBANDALE	IA	457	$1,521,075.18	$9,688.38	4
5	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	141	$1,365,542.28	$20,381.23	6
6	ACARIAHEALTH PHARMACY #11	HOUSTON	TX	150	$1,168,688.82	$18,550.62	8
7	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,008	$1,098,057.90	$8,382.12	5
8	COMMUNITY, A WALGREENS PHARMACY #21250	IOWA CITY	IA	294	$956,857.29	$9,026.96	9
9	CVS PHARMACY #00102	AURORA	CO	101	$907,024.54	$22,675.61	7
10	AMBER PHARMACY	OMAHA	NE	147	$855,181.12	$16,135.49	11
11	CVS/SPECIALTY	MONROEVILLE	PA	121	$630,914.70	$15,021.78	12
12	PANTHERX SPECIALTY PHARMACY	CORAOPOLIS	PA	26	$591,363.01	$49,280.25	
13	OPTUM PHARMACY 705 LLC	BIRMINGHAM	AL	69	$513,844.69	$15,571.05	107
14	THE NEBRASKA MED CENTER CLINIC PHCY	OMAHA	NE	683	$458,753.28	$3,640.90	19
15	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	30	$426,208.33	$42,620.83	17
16	ANOVORX GROUP LLC	MEMPHIS	TN	65	$415,561.47	$20,778.07	14
17	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	878	$399,456.33	$2,377.72	22
18	WALGREENS #4405	COUNCIL BLUFFS	IA	5,914	$394,504.37	$356.37	16
19	GENESIS FIRSTMED PHARMACY	DAVENPORT	IA	523	$391,890.35	$2,595.30	18
20	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,668	$376,776.31	$734.46	20
21	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,805	$372,219.09	$2,514.99	13
22	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,044	$365,305.79	$1,707.04	28
23	WALGREENS #5042	CEDAR RAPIDS	IA	5,021	$342,788.70	$343.82	25
24	ALLEN CLINIC PHARMACY	WATERLOO	IA	876	$340,489.24	$1,182.25	26
25	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	2,467	$335,235.01	$2,483.22	27
26	PARAGON PARTNERS	OMAHA	NE	1,016	$333,668.09	$3,972.24	24
27	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,072	$332,501.40	$662.35	30
28	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	21	$308,172.84	$44,024.69	56
29	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,420	$304,888.51	$2,162.33	23
30	MISSION CANCER + BLOOD	DES MOINES	IA	43	$304,188.03	$20,279.20	51
31	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	3,687	$298,050.65	$598.50	40
32	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,321	$281,873.16	$690.87	34
33	KROGER SPECIALTY PHARMACY LA	HARVEY	LA	33	$275,723.42	$22,976.95	32
34	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	2,815	$274,033.78	$1,014.94	39

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TOP 100 PHARMACIES BY PAID AMOUNT
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RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
35	SOLEO HEALTH INC.	WOODRIDGE	IL	11	$273,897.15	$273,897.15	180
36	WALGREENS #16270	OMAHA	NE	38	$272,133.48	$16,007.85	44
37	RIGHT DOSE PHARMACY	ANKENY	IA	6,131	$270,861.66	$626.99	45
38	DRILLING PHARMACY	SIOUX CITY	IA	3,833	$264,512.77	$784.90	33
39	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,781	$262,770.56	$365.98	41
40	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,170	$259,259.78	$925.93	31
41	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,000	$253,678.43	$611.27	35
42	WALGREENS #5721	DES MOINES	IA	3,705	$252,494.72	$304.95	50
43	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,193	$252,452.34	$736.01	48
44	ALLIANCERX WALGREENS PHARMACY #16280	FRISCO	TX	12	$241,422.48	$40,237.08	36
45	WALGREENS #7455	WATERLOO	IA	3,508	$241,055.53	$296.87	49
46	MAHASKA DRUGS INC	OSKALOOSA	IA	2,855	$238,302.38	$611.03	54
47	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	65	$237,569.70	$8,484.63	80
48	ORSINI PHARMACEUTICAL SERVICES INC	ELK GROVE VILLAGE	IL	19	$236,464.10	$33,780.59	37
49	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	4,164	$235,952.15	$322.78	46
50	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	3,665	$234,974.64	$424.14	43
51	WALGREENS #15647	SIOUX CITY	IA	2,968	$233,702.57	$340.18	47
52	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	44	$232,869.01	$13,698.18	21
53	FOUNDATION CARE LLC	EARTH CITY	MO	16	$228,213.79	$38,035.63	62
54	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,250	$226,114.39	$516.24	52
55	WALGREENS #7453	DES MOINES	IA	3,138	$221,529.11	$337.18	70
56	WAGNER PHARMACY	CLINTON	IA	2,347	$221,418.83	$954.39	60
57	MAYO CLINIC PHARMACY	ROCHESTER	MN	24	$216,091.22	$21,609.12	61
58	CVS PHARMACY #08544	WATERLOO	IA	2,752	$213,715.36	$498.17	83
59	HY-VEE PHARMACY (1396)	MARION	IA	2,203	$213,029.73	$647.51	69
60	WALGREENS #359	DES MOINES	IA	3,262	$211,308.26	$304.92	53
61	SANFORD CANCER CENTER ONCOLOGY CLINIC PHARMACY	SIOUX FALLS	SD	30	$210,887.34	$19,171.58	42
62	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	4	$210,198.26	$52,549.57	10
63	WALGREENS #5239	DAVENPORT	IA	4,419	$208,844.73	$232.05	38
64	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,678	$208,347.24	$545.41	63
65	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,492	$207,333.06	$594.08	75
66	DANIEL PHARMACY	FT DODGE	IA	2,230	$205,687.50	$756.20	74
67	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	9	$204,367.44	$68,122.48	59
68	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	3,661	$203,601.34	$409.66	87

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RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
69	GENOA HEALTHCARE, LLC	MARSHALLTOWN	IA	955	$198,588.27	$1,946.94	57
70	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,444	$197,887.35	$727.53	65
71	HY-VEE PHARMACY (1449)	NEWTON	IA	2,341	$197,762.87	$513.67	67
72	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,319	$197,083.09	$613.97	78
73	ARJ INFUSION SERVICES, LLC	CEDAR RAPIDS	IA	30	$185,501.56	$37,100.31	104
74	SANFORD PHARMACY BROADWAY	FARGO	ND	18	$183,147.44	$36,629.49	114
75	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,463	$182,137.99	$529.47	72
76	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,215	$177,440.07	$534.46	79
77	SOUTH SIDE DRUG	OTTUMWA	IA	2,569	$177,014.69	$544.66	55
78	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,041	$172,228.26	$555.58	64
79	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,910	$169,597.32	$490.17	73
80	JUNE E. NYLEN CANCER CENTER	SIOUX CITY	IA	18	$168,938.58	$28,156.43	93
81	HERITAGE PARTNERS PHARMACY	WEST BURLINGTON	IA	1,875	$168,166.06	$1,449.71	119
82	BIOLOGICS BY MCKESSON	CARY	NC	10	$168,008.96	$28,001.49	29
83	MEDICAP PHARMACY	AMES	IA	1,228	$167,872.15	$1,459.76	95
84	UNION PHARMACY	COUNCIL BLUFFS	IA	2,159	$163,403.34	$955.58	86
85	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,527	$159,147.94	$307.24	77
86	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,478	$158,431.04	$460.56	99
87	THOMPSON DEAN DRUG	SIOUX CITY	IA	1,705	$158,033.93	$818.83	88
88	WALMART PHARMACY 10-0985	FAIRFIELD	IA	1,954	$154,908.77	$509.57	90
89	ALLIANCERX WALGREENS PHARMACY #16287	PITTSBURGH	PA	7	$153,721.12	$51,240.37	58
90	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,164	$153,505.69	$418.27	85
91	EXACTCARE	VALLEY VIEW	OH	2,010	$152,002.31	$1,688.91	68
92	WHITING FAMILY PHARMACY	WHITING	IA	1,899	$150,240.42	$830.06	372
93	WALGREENS #4041	DAVENPORT	IA	2,756	$150,127.97	$274.96	97
94	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,173	$149,194.24	$514.46	91
95	HY-VEE PHARMACY (1075)	CLINTON	IA	2,331	$148,902.77	$409.07	96
96	GENOA HEALTHCARE, LLC	MASON CITY	IA	860	$148,584.55	$1,375.78	135
97	ALL CARE HEALTH CENTER	COUNCIL BLUFFS	IA	1,204	$148,006.38	$1,333.39	89
98	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	1,323	$147,756.47	$547.25	100
99	WALGREENS #5470	SIOUX CITY	IA	2,249	$147,339.19	$371.13	98
100	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	1,581	$144,871.79	$658.51	129

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TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$71,363.92	1,314	13.14	1
2	1396289229	Jesse Becker	$79,499.73	1,306	8.11	2
3	1356359871	Rhea Hartley	$102,429.98	1,101	6.15	4
4	1659358620	Carlos Castillo	$47,196.84	972	7.04	3
5	1013115369	Bobbita Nag	$38,151.15	869	4.83	6
6	1770933046	Shelby Biller	$90,950.06	863	7.50	7
7	1457584740	Eric Meyer	$77,880.68	854	6.47	10
8	1801998372	Wendy Hansen-Penman	$34,353.48	836	10.58	13
9	1528365277	Mina Salib	$477,141.29	819	4.16	12
10	1538368170	Christopher Matson	$30,580.24	815	8.07	28
11	1821268335	Jacqueline Mcinnis	$107,089.56	814	10.71	19
12	1134854128	Dzevida Pandzic	$55,018.89	813	5.57	11
13	1316356496	Kimberly Roberts	$44,216.98	811	7.58	20
14	1205393386	Jessica Hudspeth	$76,273.73	810	8.62	16
15	1275763047	Rebecca Bowman	$98,680.00	804	8.55	17
16	1467502286	Charles Tilley	$136,856.46	803	6.48	8
17	1124006770	Wook Kim	$34,377.76	801	8.71	9
18	1902912538	Christian Jones	$40,975.30	771	6.48	18
19	1437238110	Genevieve Nelson	$46,728.48	762	9.07	15
20	1902478811	Joan Anderson	$215,849.44	753	8.76	27
21	1215125216	Rebecca Walding	$62,543.17	746	9.10	33
22	1992332563	Stacy Overman	$18,322.15	739	19.97	63
23	1184056822	Abby Kolthoff	$358,468.38	738	6.83	36
24	1619153137	Joada Best	$42,504.64	736	7.36	21
25	1902358443	Melissa Konken	$100,158.61	735	8.08	22
26	1184657603	Sara Rygol	$116,118.25	729	8.58	32
27	1992103386	Melissa Larsen	$69,623.79	729	7.52	24
28	1467907394	Cynthia Coenen	$81,276.78	723	10.04	26
29	1922455096	Dean Guerdet	$73,509.50	709	6.06	35
30	1356788616	Ted Bonebrake	$61,643.57	707	16.07	5
31	1982030946	Jacklyn Besch	$30,865.85	706	7.59	30
32	1164538674	Joseph Wanzek	$67,730.20	688	9.56	14
33	1457914657	Seema Antony	$65,644.13	685	6.28	41

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
34	1902596828	Lindsay Harms	$64,340.48	664	9.91	69
35	1609532373	Erin Fox-Hammel	$44,258.88	661	6.61	57
36	1417941188	Debra Neuharth	$44,424.42	660	6.06	58
37	1609218304	Amanda Garr	$119,858.04	656	7.05	31
38	1558770974	Marc Baumert	$43,046.51	655	5.50	61
39	1144900861	Lizabeth Sheets	$237,723.50	649	8.54	85
40	1528329398	Erin Rowan	$25,678.82	647	6.05	38
41	1649248378	Kathleen Wild	$21,013.52	647	6.88	37
42	1538149042	Eric Petersen	$24,188.46	646	7.69	29
43	1184395162	Danielle Van Oosbree	$118,522.57	638	15.19	70
44	1053630640	Jennifer Donovan	$97,827.94	636	7.23	43
45	1972758126	Rebecca Bollin	$31,181.69	632	6.65	59
46	1144214248	Kristi Walz	$92,681.49	628	8.37	45
47	1043434525	Robert Kent	$48,097.52	625	8.33	64
48	1629036546	Anita Simison	$36,687.42	623	4.98	25
49	1255823506	Nicole Delagardelle	$129,005.50	622	6.10	81
50	1619380680	Tara Brockman	$38,092.80	620	6.39	51
51	1477926434	Jackie Shipley	$32,256.02	617	5.77	47
52	1043211303	Ali Safdar	$52,726.32	613	5.68	23
53	1689077018	Stacy Roth	$38,209.51	606	6.12	62
54	1841220290	Kent Kunze	$24,267.63	605	7.76	46
55	1730849647	Melanie Rock	$20,530.01	604	5.54	71
56	1316471154	Nicole Woolley	$30,261.03	603	6.93	42
57	1942721584	Shawna Fury	$17,580.26	584	6.02	56
58	1538157383	David Wenger-Keller	$22,127.32	573	11.24	44
59	1417241621	Ashley Mathes	$21,397.77	573	6.30	53
60	1386044832	Mary Grieder	$46,488.03	566	10.29	40
61	1750845954	Stephanie Giesler	$78,945.98	562	7.11	75
62	1134191018	Dustin Smith	$18,149.06	558	6.13	39
63	1477534279	Edmund Piasecki	$15,285.14	555	7.03	48
64	1598183493	Jena Ellerhoff	$34,039.79	553	8.38	355
65	1326013426	Paul Peterson	$26,854.40	552	6.65	50
66	1154779460	Molly Eichenberger	$29,293.04	551	10.02	49

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
67	1023469798	Wei Shipeng	$21,689.92	551	17.22	315
68	1891707832	Lisa Klock	$26,564.06	550	6.04	76
69	1063827798	Jeffrey Guse	$33,327.61	546	7.80	96
70	1053963900	Nicole Mcclavy	$51,450.98	543	6.79	84
71	1245227099	Donna Dobson Tobin	$55,913.34	535	9.39	78
72	1477199198	Sajo Thomas	$96,333.27	533	5.86	65
73	1144588476	Rachel Filzer	$69,317.14	532	6.41	86
74	1043703887	Tenaea Jeppeson	$67,941.49	531	8.43	34
75	1336252097	Thomas Baer	$24,447.49	531	9.32	90
76	1538671961	Jamie Wright	$26,301.92	528	6.60	124
77	1467465716	Jeffrey Brady	$18,412.99	528	6.60	97
78	1154790517	Jamie Schumacher	$24,210.01	527	7.87	104
79	1992402655	Shane Eberhardt	$137,529.66	526	5.06	72
80	1942660204	Kimberly Rutledge	$69,193.38	526	5.91	105
81	1821333774	Brittni Benda	$41,548.45	525	5.20	74
82	1720698335	Danika Hansen	$63,948.80	524	6.47	73
83	1215184726	Babuji Gandra	$18,132.08	523	6.01	151
84	1356754337	Cyndi Mccormick	$124,811.17	520	7.43	68
85	1760455083	Thomas Schmadeke	$44,039.02	519	6.11	55
86	1871021543	Susan Wilson	$44,453.14	518	6.91	80
87	1598786097	Stephanie Gray	$114,886.11	510	9.11	54
88	1568532281	Ellen Natvig	$57,076.27	506	7.13	168
89	1982826905	Nilesh Mehta	$41,256.49	505	8.28	130
90	1699740159	Frank Marino	$21,012.51	502	4.25	118
91	1417549932	Amanda Mccormick	$52,540.38	501	6.96	110
92	1871105916	Lacie Theis	$37,042.35	501	5.83	66
93	1053398800	Steven Scurr	$30,945.42	499	5.25	52
94	1154815330	Bruce Pehl	$31,738.79	498	6.38	108
95	1891422606	Emily Clawson	$83,702.97	496	5.90	161
96	1881008704	Charity Carstensen	$26,311.09	496	12.40	149
97	1285841775	Sandra Worrell	$20,679.06	496	6.89	119
98	1033634407	Kristen Krakovec	$25,313.58	495	7.39	184
99	1437209434	Jon Thomas	$23,293.06	493	6.57	60

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
100	1124389697	Kevin Furness	$17,738.46	491	6.92	94

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
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RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
1	1295091510	Rebecca Weiner	331	$685,167.13	$2,069.99	1
2	1013126705	Janice Staber	71	$629,914.78	$8,872.04	6
3	1891146999	Becky Johnson	490	$577,660.46	$1,178.90	2
4	1316934318	Steven Lentz	48	$490,861.72	$10,226.29	4
5	1528365277	Mina Salib	819	$477,141.29	$582.59	3
6	1619382942	Eirene Alexandrou	120	$447,663.53	$3,730.53	5
7	1417443953	Rodney Clark	371	$440,500.25	$1,187.33	9
8	1942937388	Carly Trausch	405	$376,368.47	$929.30	7
9	1184056822	Abby Kolthoff	738	$358,468.38	$485.73	14
10	1326034984	Katherine Mathews	85	$332,639.71	$3,913.41	12
11	1326410499	Tara Eastvold	337	$297,834.10	$883.78	8
12	1285626390	Kathleen Gradoville	313	$297,238.57	$949.64	13
13	1467449579	Brian Wayson	74	$266,481.02	$3,601.09	69
14	1952539447	Anthony Fischer	47	$244,785.51	$5,208.20	32
15	1144900861	Lizabeth Sheets	649	$237,723.50	$366.29	52
16	1649419219	Heather Hunemuller	176	$226,765.34	$1,288.44	24
17	1477761328	Amy Calhoun	48	$224,188.06	$4,670.58	10
18	1588616171	Heather Thomas	106	$220,141.07	$2,076.80	25
19	1902478811	Joan Anderson	753	$215,849.44	$286.65	27
20	1437121407	Linda Cadaret	89	$206,968.96	$2,325.49	11
21	1538113337	Robert Smith	6	$206,331.50	$34,388.58	40
22	1174748180	Mohammad Alsharabati	133	$203,024.27	$1,526.50	26
23	1225263833	Lindsay Orris	118	$200,629.13	$1,700.25	18
24	1700417169	Courtney Reints	289	$198,681.25	$687.48	22
25	1841607900	Shayla Sanders	105	$195,454.49	$1,861.47	15
26	1659093292	Kathryn Foy	97	$194,578.94	$2,005.97	50
27	1700561826	Pedro Hsieh	44	$191,428.52	$4,350.65	16
28	1174970453	Daniel Hinds	184	$186,815.61	$1,015.30	34
29	1043565328	Sara Moeller	64	$183,484.68	$2,866.95	41
30	1306071915	Thomas Pietras	86	$181,869.14	$2,114.76	45
31	1740953439	Wilmar Garcia	106	$175,261.04	$1,653.41	53
32	1689646036	Robert Grant	126	$171,930.36	$1,364.53	35
33	1356752067	Kelly Delaney-Nelson	74	$171,566.12	$2,318.46	59

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
202406 - 202408

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
34	1487648705	Karen Hunke	139	$168,064.17	$1,209.09	39
35	1841673738	Rachel Person	47	$165,602.52	$3,523.46	42
36	1891955423	Leah Siegfried	331	$165,419.26	$499.76	33
37	1649943689	Jessica Coffey	149	$164,863.56	$1,106.47	51
38	1912208323	Lisa Meyer	440	$162,514.06	$369.35	37
39	1558808501	Jessica Braksiek	52	$157,065.21	$3,020.48	21
40	1134440886	Melissa Wells	99	$154,939.09	$1,565.04	43
41	1780788844	Tammy Wichman	25	$154,297.84	$6,171.91	225
42	1588288385	Jenifer Jones	117	$153,855.68	$1,315.01	29
43	1225143316	Susan Jacobi	109	$152,687.15	$1,400.80	31
44	1730406356	Christina Warren	181	$152,151.54	$840.62	61
45	1649826140	Taylor Boldt	194	$150,495.19	$775.75	60
46	1386902682	Melissa Willis	89	$150,418.57	$1,690.10	23
47	1578958542	Heidi Curtis	137	$145,369.48	$1,061.09	19
48	1265870950	Danita Velasco	3	$144,175.14	$48,058.38	48
49	1194945691	Anjali Sharathkumar	34	$142,698.93	$4,197.03	72
50	1326211889	James Friedlander	20	$141,982.36	$7,099.12	17
51	1386084747	Jennifer Condon	145	$140,713.70	$970.44	87
52	1992402655	Shane Eberhardt	526	$137,529.66	$261.46	68
53	1467502286	Charles Tilley	803	$136,856.46	$170.43	56
54	1912979261	David Visokey	146	$130,377.33	$893.00	76
55	1255823506	Nicole Delagardelle	622	$129,005.50	$207.40	114
56	1609131770	Sreenath Ganganna	232	$128,399.03	$553.44	30
57	1275836751	Holly Kramer	127	$126,537.15	$996.36	85
58	1114214541	Dimah Saade	53	$124,847.58	$2,355.61	83
59	1356754337	Cyndi Mccormick	520	$124,811.17	$240.02	64
60	1568097244	Elizabeth Dassow	51	$122,344.93	$2,398.92	55
61	1235518507	Adekunle Ajisebutu	13	$121,985.31	$9,383.49	343
62	1134249832	Steven Craig	83	$121,842.81	$1,467.99	88
63	1992810956	Christopher Ronkar	42	$121,606.05	$2,895.38	89
64	1609218304	Amanda Garr	656	$119,858.04	$182.71	47
65	1770091266	Jessie Baker	303	$119,247.09	$393.55	236
66	1720036353	Erik Swenson	48	$118,856.91	$2,476.19	96

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
202406 - 202408

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
67	1184395162	Danielle Van Oosbree	638	$118,522.57	$185.77	106
68	1861463275	Donald Wender	24	$117,437.45	$4,893.23	36
69	1093162075	Meghan Ryan	64	$116,848.16	$1,825.75	49
70	1093034266	Eric Boyum	455	$116,239.69	$255.47	108
71	1184657603	Sara Rygol	729	$116,118.25	$159.28	144
72	1679573893	Patty Hildreth	471	$115,490.01	$245.20	101
73	1275742090	Ashar Luqman	423	$115,166.08	$272.26	109
74	1598786097	Stephanie Gray	510	$114,886.11	$225.27	75
75	1245353242	Sandy Hong	114	$113,876.73	$998.92	92
76	1861876526	Nibash Budhathoki	19	$113,605.54	$5,979.24	77
77	1356753859	Katie Lutz	26	$112,676.86	$4,333.73	99
78	1669056123	Kama Ausborn	189	$110,974.69	$587.17	20
79	1780995506	Quanhathai Kaewpoowat	50	$110,609.42	$2,212.19	104
80	1497201610	Mohaddeseh Sharifzadeh	52	$108,352.52	$2,083.70	38
81	1144829300	Katie Shannon	36	$107,776.55	$2,993.79	198
82	1750913406	Carrissa Riggs	43	$107,670.13	$2,503.96	143
83	1871868984	Hana Niebur	43	$107,484.59	$2,499.64	157
84	1932153822	Christian Schultheis	16	$107,418.20	$6,713.64	116
85	1821268335	Jacqueline Mcinnis	814	$107,089.56	$131.56	113
86	1104012996	Venkatesh Rudrapatna	50	$105,015.94	$2,100.32	93
87	1366826109	Alyssa Mrsny	85	$104,980.27	$1,235.06	71
88	1285748004	Bruce Hughes	21	$104,925.33	$4,996.44	58
89	1376525196	Randolph Rough	81	$103,792.30	$1,281.39	66
90	1043418809	Michael Ciliberto	447	$103,699.90	$231.99	123
91	1386938447	Theresa Czech	145	$103,494.25	$713.75	67
92	1679521728	Jill Fliege	26	$103,405.96	$3,977.15	190
93	1811666118	Jessiann Dryden-Parish	154	$102,512.89	$665.67	155
94	1356359871	Rhea Hartley	1,101	$102,429.98	$93.03	119
95	1467616326	Benjamin Davis	63	$102,184.41	$1,621.97	122
96	1023108701	Ronald Zolty	21	$102,082.22	$4,861.06	78
97	1114521721	Tarrah Holliday	490	$101,847.60	$207.85	120
98	1487943908	Brittany Bettendorf	79	$101,488.82	$1,284.67	28
99	1013282953	David Terrero Salcedo	56	$101,020.85	$1,803.94	135

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
202406 - 202408

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
100	1477142289	Andrea Johnson	427	$100,743.10	$235.93	80

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TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

	202403 - 202405			202406 - 202408			
CATEGORY DESCRIPTION	PREVIOUS TOTAL COST	PREVIOUS RANK	PREVIOUS % BUDGET	CURRENT TOTAL COST	CURRENT RANK	CURRENT % BUDGET	% CHANGE
ANTIDIABETICS	$9,923,995.17	1	12.88 %	$10,159,367.89	1	13.82 %	0.94 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$8,821,206.88	2	11.45 %	$8,379,870.02	2	11.40 %	-0.05 %
ANALGESICS - ANTI-INFLAMMATORY	$7,024,390.50	3	9.12 %	$6,773,004.07	3	9.21 %	0.10 %
DERMATOLOGICALS	$6,766,150.55	4	8.78 %	$6,720,170.30	4	9.14 %	0.36 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$4,475,690.03	5	5.81 %	$4,184,687.34	5	5.69 %	-0.12 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$4,208,557.09	6	5.46 %	$3,766,666.35	6	5.12 %	-0.34 %
ANTIVIRALS	$3,531,434.28	7	4.58 %	$3,258,702.90	7	4.43 %	-0.15 %
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,287,943.01	8	4.27 %	$2,766,176.03	8	3.76 %	-0.51 %
RESPIRATORY AGENTS - MISC.	$2,796,850.99	9	3.63 %	$2,736,664.16	9	3.72 %	0.09 %
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC	$2,641,584.11	10	3.43 %	$2,558,194.57	10	3.48 %	0.05 %
ANTICONVULSANTS	$2,158,367.01	12	2.80 %	$2,023,183.41	11	2.75 %	-0.05 %
MIGRAINE PRODUCTS	$1,878,985.09	14	2.44 %	$1,921,120.15	12	2.61 %	0.18 %
HEMATOLOGICAL AGENTS - MISC.	$1,893,744.72	13	2.46 %	$1,890,185.99	13	2.57 %	0.11 %
ENDOCRINE AND METABOLIC AGENTS - MISC.	$2,162,111.47	11	2.81 %	$1,873,589.85	14	2.55 %	-0.26 %
ANTIDEPRESSANTS	$1,830,251.96	15	2.38 %	$1,717,446.48	15	2.34 %	-0.04 %
CARDIOVASCULAR AGENTS - MISC.	$1,503,632.87	16	1.95 %	$1,367,994.52	16	1.86 %	-0.09 %
ANTICOAGULANTS	$1,403,826.77	17	1.82 %	$1,367,582.16	17	1.86 %	0.04 %
GASTROINTESTINAL AGENTS - MISC.	$823,727.67	18	1.07 %	$767,290.07	18	1.04 %	-0.03 %
NEUROMUSCULAR AGENTS	$600,204.93	21	0.78 %	$641,349.03	19	0.87 %	0.09 %
PASSIVE IMMUNIZING AND TREATMENT AGENTS	$645,046.41	19	0.84 %	$603,278.46	20	0.82 %	-0.02 %

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TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

	202403 - 202405		202406 - 202408		
CURRENT CATEGORY DESCRIPTION	PREVIOUS CLAIMS	PREVIOUS RANK	CURRENT CLAIMS	CURRENT RANK	% CHANGE
ANTIDEPRESSANTS	93,354	1	88,378	1	-5.33 %
ANTICONVULSANTS	40,298	2	38,585	2	-4.25 %
ANTIHYPERTENSIVES	37,195	4	35,407	3	-4.81 %
ANTIDIABETICS	34,674	6	33,867	4	-2.33 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	37,348	3	33,834	5	-9.41 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	36,448	5	33,289	6	-8.67 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	32,081	7	30,577	7	-4.69 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	31,361	8	30,185	8	-3.75 %
ANTIANXIETY AGENTS	28,520	9	27,015	9	-5.28 %
ANTIHYPERLIPIDEMICS	24,698	10	23,765	10	-3.78 %
ANTIHISTAMINES	19,593	11	18,966	11	-3.20 %
DERMATOLOGICALS	18,146	13	18,664	12	2.85 %
BETA BLOCKERS	18,096	14	17,286	13	-4.48 %
ANALGESICS - ANTI-INFLAMMATORY	16,664	15	15,790	14	-5.24 %
ANALGESICS - OPIOID	15,750	16	14,795	15	-6.06 %
DIURETICS	13,841	17	13,433	16	-2.95 %
THYROID AGENTS	13,499	18	12,835	17	-4.92 %
PENICILLINS	19,243	12	11,514	18	-40.17 %
ANALGESICS - NonNarcotic	11,056	21	10,679	19	-3.41 %
MUSCULOSKELETAL THERAPY AGENTS	11,132	20	10,319	20	-7.30 %

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TOP 100 DRUGS BY PAID AMOUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Humira Pen	4161123.24	1	3876659.43	1	-6.84 %
Ozempic	3165418.12	2	3481248.78	2	9.98 %
Vraylar	2720215.41	3	2586137.89	3	-4.93 %
Trikafta	2356818.63	4	2414715.99	4	2.46 %
Dupixent	2134897.6	5	2103871.36	5	-1.45 %
Jardiance	1681107.57	6	1701549.75	6	1.22 %
Invega Sust	1634908.13	7	1617552.41	7	-1.06 %
Biktarvy	1578633.9	8	1504442.26	8	-4.70 %
Taltz	1417833.98	9	1292267.97	9	-8.86 %
Trulicity	1301479.05	11	1235877.14	10	-5.04 %
Stelara	1111038.44	12	1094072.17	11	-1.53 %
Vyvanse	1387915.77	10	967364.89	12	-30.30 %
Eliquis	976894.91	13	965115.75	13	-1.21 %
Rexulti	882904.22	14	901899.92	14	2.15 %
Skyrizi Pen	549982.51	23	802666.2	15	45.94 %
Aristada	869118.23	15	753778.45	16	-13.27 %
Ingrezza	720424.63	16	691965.73	17	-3.95 %
Mounjaro	510362.65	26	670571.76	18	31.39 %
Enbrel Srclk	626454.72	20	661401.71	19	5.58 %
Nurtec	657158.05	18	641593.8	20	-2.37 %
Farxiga	585808.98	21	560945.99	21	-4.24 %
Strensiq	693336.66	17	556046.28	22	-19.80 %
Invega Trinz	633772.49	19	551906.31	23	-12.92 %
Abilify Main	582157.85	22	530202.18	24	-8.92 %
Caplyta	499568.4	28	499811.94	25	0.05 %
Trintellix	511937.97	25	474013.78	26	-7.41 %
Trelegy	494337.03	29	467281.03	27	-5.47 %
Spiriva	534461.54	24	464622.34	28	-13.07 %

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TOP 100 DRUGS BY PAID AMOUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Symbicort	501073.39	27	461404.08	29	-7.92 %
Entresto	457918.06	32	442199.55	30	-3.43 %
Mavyret	474050.76	31	394863.6	31	-16.70 %
Albuterol	411513.26	33	389825.88	32	-5.27 %
Lybalvi	347711.89	36	383700.73	33	10.35 %
Xarelto	384277.17	34	364312.98	34	-5.20 %
Ajovy	361206.32	35	363065.38	35	0.51 %
Ilaris	482475.83	30	355798.39	36	-26.26 %
Januvia	339609.3	39	326110.94	37	-3.97 %
Lisdexamfeta	301384.53	44	325704.5	38	8.07 %
Wakix	202014.9	76	321351.96	39	59.07 %
Jornay Pm	324285.02	41	317707.01	40	-2.03 %
Cosentyx Pen	299712.4	45	303928.06	41	1.41 %
Xifaxan	324602.72	40	302310.42	42	-6.87 %
Concerta	323220.31	42	299241.92	43	-7.42 %
Rebinyn	155852.52	102	299240.16	44	92.00 %
Evrysdi	243615.83	59	296948.31	45	21.89 %
Rinvoq	223008.17	69	291865.59	46	30.88 %
Opsumit	240268.11	60	290850.87	47	21.05 %
Humira	320043.93	43	286474.12	48	-10.49 %
Norditropin	285766.74	48	284664.6	49	-0.39 %
Hizentra	284742.14	49	282162.08	50	-0.91 %
Ubrelvy	267809.2	52	277719.43	51	3.70 %
Creon	239668.16	61	276401.33	52	15.33 %
Adynovate	127605.62	128	273897.15	53	114.64 %
Xywav	191685.32	83	273366.84	54	42.61 %
Altuviiio	343476	38	273189.64	55	-20.46 %
Epidiolex	287826.67	47	265902.92	56	-7.62 %

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TOP 100 DRUGS BY PAID AMOUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Austedo	344459.6	37	263126.35	57	-23.61 %
Kesimpta	259831.32	53	256235.99	58	-1.38 %
Cabometyx	293444.35	46	250599.47	59	-14.60 %
Linzess	250606.03	55	244425.44	60	-2.47 %
Methylphenid	279326.8	50	239188.96	61	-14.37 %
Insulin Lisp	257551.97	54	238726.48	62	-7.31 %
Qelbree	247655.42	56	238160.5	63	-3.83 %
Advair Hfa	244300.73	57	232045.29	64	-5.02 %
Otezla	221092.88	70	230804.17	65	4.39 %
Tresiba Flex	267881.97	51	225533.88	66	-15.81 %
Lantus Solos	224756.28	68	222359.82	67	-1.07 %
Qulipta	168703.79	88	222154	68	31.68 %
Insulin Aspa	226282.23	67	221994.92	69	-1.89 %
Skyrizi	219225.78	71	207028.66	70	-5.56 %
Ravicti	182185.52	85	204963.9	71	12.50 %
Takhzyro	153542.16	105	204722.88	72	33.33 %
Epinephrine	159992.28	97	200538.65	73	25.34 %
Paxlovid	59393.23	229	192356.43	74	223.87 %
Amphet/dextr	194149.08	80	183931.53	75	-5.26 %
Aimovig	200090.95	77	180369.02	76	-9.86 %
Promacta	152515.16	107	176998.27	77	16.05 %
Quillichew	228065.02	65	176182.26	78	-22.75 %
Adempas	207684.96	75	175374.72	79	-15.56 %
Tremfya	189210.2	84	175319.22	80	-7.34 %
Austedo Xr	154355.97	104	173111.78	81	12.15 %
Ventolin Hfa	231211.08	63	171445.62	82	-25.85 %
Cosentyx Uno	237705.14	62	170634.44	83	-28.22 %
Daybue	159084.74	98	166228.72	84	4.49 %

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TOP 100 DRUGS BY PAID AMOUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Fintepla	226855.31	66	165799.19	85	-26.91 %
Fasenra Pen	157710.12	99	165104.57	86	4.69 %
Ibrance	229046.76	64	164401.14	87	-28.22 %
Descovy	194284.98	79	163191.03	88	-16.00 %
Atorvastatin	169665.56	87	163173.98	89	-3.83 %
Sertraline	168693.16	89	161344.44	90	-4.36 %
Azstarys	165406.87	92	158681.14	91	-4.07 %
Verzenio	178348.3	86	158337.09	92	-11.22 %
Actemra	161923.58	95	157659.78	93	-2.63 %
Eloctate	164339.52	93	157112.16	94	-4.40 %
Anoro Ellipt	163194.2	94	154037.74	95	-5.61 %
Toujeo Max	150313.29	109	151394.77	96	0.72 %
Omeprazole	157336.27	101	150613.23	97	-4.27 %
Breztri Aero	142929.75	115	150071.43	98	5.00 %
Orencia Clck	124160.81	131	147549.91	99	18.84 %
Dovato	143376.48	112	146987.85	100	2.52 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Atorvastatin	14,731	1	14,080	1	-4.42 %
Sertraline	14,657	2	13,932	2	-4.95 %
Omeprazole	14,395	3	13,747	3	-4.50 %
Levothyroxin	12,455	6	11,900	4	-4.46 %
Albuterol	12,923	5	11,725	5	-9.27 %
Trazodone	12,175	7	11,649	6	-4.32 %
Lisinopril	11,396	9	10,745	7	-5.71 %
Fluoxetine	11,575	8	10,736	8	-7.25 %
Escitalopram	11,354	10	10,630	9	-6.38 %
Metformin	10,915	12	10,502	10	-3.78 %
Cetirizine	11,051	11	10,458	11	-5.37 %
Bupropn Hcl	10,774	13	10,149	12	-5.80 %
Gabapentin	10,169	14	9,449	13	-7.08 %
Amphet/dextr	9,335	15	8,563	14	-8.27 %
Montelukast	8,364	16	7,947	15	-4.99 %
Hydroxyz Hcl	8,131	19	7,913	16	-2.68 %
Amlodipine	8,331	17	7,889	17	-5.31 %
Buspirone	8,170	18	7,704	18	-5.70 %
Duloxetine	7,929	21	7,569	19	-4.54 %
Pantoprazole	7,423	23	7,163	20	-3.50 %
Amoxicillin	13,059	4	7,132	21	-45.39 %
Methylphenid	7,967	20	7,066	22	-11.31 %
Quetiapine	7,375	24	7,057	23	-4.31 %
Clonidine	7,171	25	6,946	24	-3.14 %
Guanfacine	6,862	26	6,461	25	-5.84 %
Metoprol Suc	6,675	27	6,449	26	-3.39 %
Aripiprazole	6,631	28	6,251	27	-5.73 %
Venlafaxine	6,571	29	6,209	28	-5.51 %
Ondansetron	7,437	22	6,088	29	-18.14 %
Hydroco/apap	6,205	31	5,890	30	-5.08 %
Lamotrigine	6,040	32	5,827	31	-3.53 %
Losartan Pot	5,743	34	5,539	32	-3.55 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Prednisone	6,521	30	5,470	33	-16.12 %
Famotidine	5,746	33	5,438	34	-5.36 %
Loratadine	5,342	37	5,140	35	-3.78 %
Topiramate	5,263	39	5,025	36	-4.52 %
Fluticasone	5,543	35	4,953	37	-10.64 %
Cyclobenzapr	5,294	38	4,858	38	-8.24 %
Ibuprofen	5,237	40	4,829	39	-7.79 %
Aspirin Low	4,850	41	4,767	40	-1.71 %
Alprazolam	4,726	42	4,442	41	-6.01 %
Propranolol	4,613	43	4,416	42	-4.27 %
Rosuvastatin	4,375	46	4,402	43	0.62 %
Clonazepam	4,567	44	4,289	44	-6.09 %
Cephalexin	4,265	49	4,188	45	-1.81 %
Risperidone	4,324	48	4,168	46	-3.61 %
Ozempic	3,559	55	3,890	47	9.30 %
Meloxicam	4,015	50	3,836	48	-4.46 %
Amox/k Clav	5,465	36	3,805	49	-30.38 %
Hydrochlorot	3,955	52	3,753	50	-5.11 %
Furosemide	3,750	53	3,722	51	-0.75 %
Spironolact	3,682	54	3,632	52	-1.36 %
Triamcinolon	3,245	61	3,609	53	11.22 %
Prazosin Hcl	3,357	59	3,291	54	-1.97 %
Mirtazapine	3,401	58	3,275	55	-3.70 %
Lorazepam	3,404	57	3,237	56	-4.91 %
Jardiance	3,149	63	3,221	57	2.29 %
Levetiraceta	3,296	60	3,164	58	-4.00 %
Folic Acid	3,011	64	2,954	59	-1.89 %
Tramadol Hcl	3,157	62	2,887	60	-8.55 %
Vyvanse	4,007	51	2,843	61	-29.05 %
Acetamin	2,865	66	2,810	62	-1.92 %
Azithromycin	4,490	45	2,742	63	-38.93 %
Amitriptylin	2,873	65	2,699	64	-6.06 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Ferosul	2,773	68	2,693	65	-2.88 %
Ventolin Hfa	3,555	56	2,683	66	-24.53 %
Lisdexamfeta	1,900	95	2,663	67	40.16 %
Hydroxyz Pam	2,835	67	2,646	68	-6.67 %
Lantus Solos	2,725	70	2,618	69	-3.93 %
Fluconazole	2,694	71	2,601	70	-3.45 %
Pregabalin	2,559	74	2,591	71	1.25 %
Citalopram	2,729	69	2,550	72	-6.56 %
Oxycodone	2,546	75	2,521	73	-0.98 %
Metronidazol	2,503	78	2,510	74	0.28 %
Divalproex	2,533	77	2,494	75	-1.54 %
Cefdinir	4,361	47	2,440	76	-44.05 %
Metoprol Tar	2,461	79	2,396	77	-2.64 %
Olanzapine	2,543	76	2,392	78	-5.94 %
Doxycyc Mono	2,684	72	2,296	79	-14.46 %
Valacyclovir	2,398	81	2,272	80	-5.25 %
Pot Chloride	2,315	83	2,242	81	-3.15 %
Atomoxetine	2,442	80	2,202	82	-9.83 %
Tizanidine	2,397	82	2,159	83	-9.93 %
Baclofen	2,289	84	2,141	84	-6.47 %
Symbicort	2,265	85	2,118	85	-6.49 %
Tamsulosin	2,062	89	2,030	86	-1.55 %
Mupirocin	1,767	100	1,986	87	12.39 %
Vraylar	2,078	88	1,973	88	-5.05 %
Insulin Lisp	2,090	86	1,954	89	-6.51 %
Clindamycin	2,087	87	1,936	90	-7.24 %
Carvedilol	2,028	91	1,930	91	-4.83 %
Eliquis	1,915	94	1,903	92	-0.63 %
Naproxen	1,957	93	1,884	93	-3.73 %
Diclofenac	1,989	92	1,881	94	-5.43 %
Polyeth Glyc	2,045	90	1,804	95	-11.78 %
Oxcarbazepin	1,851	97	1,768	96	-4.48 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202403 - 202405		202406 - 202408		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Zolpidem	1,858	96	1,760	97	-5.27 %
Prednisolone	2,654	73	1,709	98	-35.61 %
Bupropion	1,651	102	1,668	99	1.03 %
Lisinop/hctz	1,846	98	1,661	100	-10.02 %

MOLINA HEALTHCARE OF IOWA CLAIMS QUARTERLY STATISTICS			
Category	March 2024 to May 2024	June 2024 to August 2024	% Change
Total paid Amount	$50,708,012.02	$53,028,906.45	4.58%
Unique users	80,257	76,044	-5.25%
Cost Per user	$631.82	$697.35	10.37%
Total prescriptions	512,644	503,230	-1.84%
Average Prescriptions per user	6.39	6.62	3.60%
Average cost per prescription	$98.91	$105.38	6.53%
# Generic Prescriptions	464,981	456,998	-1.72%
% Generic	90.7%	90.8%	0.12%
$ Generic	$7,704,238.67	$7,740,517.75	0.47%
Average Generic Prescription Cost	$16.57	$16.94	2.23%
Average Generic Days' Supply	24.84	25.24	1.61%
# Brand Prescriptions	47,664	47,144	-1.09%
% Brand	9.30%	9.37%	0.76%
$ Brand	$43,003,773	$45,288,389	5.31%
Average Brand Prescription cost	$902.23	$960.64	6.47%
Average Brand Days' Supply	27.89	27.86	-0.11%

UTILIZATION BY AGE		
Age	March 2024 to May 2024	June 2024 to August 2024
0 to 6	12,738	9,928
7 to 12	10,459	8,715
13 to 18	10,227	9,564
19 to 64	45,296	46,106
65+	1,979	2,163
Total	80,699	76,476

UTILIZATION BY GENDER AND AGE			
Gender	Age	March 2024 to May 2024	June 2024 to August 2024
F	0 to 6	5,964	4,597
	7 to 12	4,774	3,940
	13 to 18	5,816	5,529
	19 to 64	28,951	29,149
	65+	1,249	1,369
	Gender Total	46,754	44,584
M	0 to 6	6,770	5,329
	7 to 12	5,684	4,774
	13 to 18	4,409	4,035
	19 to 64	16,337	16,953
	65+	730	792
	Gender Total	33,930	31,883
Grand Total		80,684	76,467

Top 100 Pharmacies by Prescription Count June 2024 to August 2024							
RANK	Pharmacy NAME	Pharmacy City	State	Prescription Count	Paid Amount	Average Cost RX	Previous RANK
1	UIHC AMBULATORY CARE PHC	IOWA CITY	IA	7,198	$3,775,900.27	$524.58	1
2	WALGREENS 04405	COUNCIL BLUFFS	IA	5,465	$394,264.86	$72.14	2
3	BROADLAWNS MED CTR OP PH	DES MOINES	IA	4,760	$208,783.20	$43.86	4
4	WALGREENS 05042	CEDAR RAPIDS	IA	4,636	$248,009.69	$53.50	3
5	WALGREENS 05239	DAVENPORT	IA	3,740	$193,505.00	$51.74	5
6	HY-VEE PHARMACY 1403	MARSHALLTOWN	IA	3,721	$260,531.54	$70.02	6
7	RIGHT DOSE PHARMACY	ANKENY	IA	3,679	$202,491.96	$55.04	8
8	WALGREENS 05721	DES MOINES	IA	3,154	$205,133.30	$65.04	9
9	WALGREENS 07455	WATERLOO	IA	3,131	$171,148.78	$54.66	7
10	HY-VEE PHARMACY 1138	DES MOINES	IA	2,971	$216,397.04	$72.84	12
11	HY-VEE DRUGSTORE 7060	MUSCATINE	IA	2,863	$223,460.29	$78.05	14
12	HY-VEE PHARMACY 1092	COUNCIL BLUFFS	IA	2,794	$206,768.95	$74.00	17
13	WALGREENS 15647	SIOUX CITY	IA	2,754	$151,115.57	$54.87	11
14	WALGREENS 03700	COUNCIL BLUFFS	IA	2,742	$149,977.86	$54.70	15
15	HY-VEE PHARMACY 1109	DAVENPORT	IA	2,735	$215,134.98	$78.66	35
16	WALGREENS 07453	DES MOINES	IA	2,688	$132,836.16	$49.42	10
17	WALGREENS 00359	DES MOINES	IA	2,655	$154,074.30	$58.03	16
18	SIOUXLAND COMM HLTH CTR	SIOUX CITY	IA	2,601	$96,319.67	$37.03	13
19	DRILLING PHARMACY 67	SIOUX CITY	IA	2,508	$154,180.66	$61.48	22
20	NELSON FAMILY PHARMACY	FORT MADISON	IA	2,485	$165,623.15	$66.65	24
21	HY-VEE PHARMACY 1056	CEDAR RAPIDS	IA	2,449	$137,236.36	$56.04	23
22	HY-VEE DRUGSTORE 7020	CEDAR RAPIDS	IA	2,444	$137,732.12	$56.36	27
23	HY-VEE DRUGSTORE 7065	OTTUMWA	IA	2,383	$225,318.34	$94.55	21

24	WALGREENS 04041	DAVENPORT	IA	2,367	$128,232.75	$54.18	19
25	CVS PHARMACY 08544	WATERLOO	IA	2,364	$127,715.38	$54.03	20
26	HY-VEE PHARMACY 1044	BURLINGTON	IA	2,339	$142,122.81	$60.76	18
27	HY-VEE PHARMACY 1192	FORT DODGE	IA	2,273	$154,405.83	$67.93	32
28	HY-VEE PHARMACY 1151	DES MOINES	IA	2,264	$128,582.82	$56.79	25
29	COMMUNITY HEALTH CARE PH	DAVENPORT	IA	2,248	$66,158.04	$29.43	39
30	WALMART PHARMACY 10-2889	CLINTON	IA	2,215	$156,176.87	$70.51	28
31	GREENWOOD DRUG ON KIMBAL	WATERLOO	IA	2,207	$153,285.79	$69.45	31
32	HY-VEE PHARMACY 1075	CLINTON	IA	2,207	$173,974.21	$78.83	29
33	MAHASKA DRUGS	OSKALOOSA	IA	2,202	$130,735.22	$59.37	26
34	HY-VEE PHARMACY 1061	CEDAR RAPIDS	IA	2,198	$120,853.32	$54.98	57
35	CVS PHARMACY 10282	FORT DODGE	IA	2,025	$131,651.42	$65.01	30
36	OMNICARE OF URBANDA 48236	URBANDALE	IA	2,015	$76,259.63	$37.85	62
37	SOUTH SIDE DRUG, INC.	OTTUMWA	IA	1,821	$95,561.29	$52.48	34
38	HY-VEE PHARMACY 1142	DES MOINES	IA	1,814	$118,981.73	$65.59	37
39	HY-VEE PHARMACY 1866	WATERLOO	IA	1,789	$141,652.22	$79.18	61
40	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	1,765	$117,948.13	$66.83	47
41	HY-VEE PHARMACY 1074	CHARLES CITY	IA	1,753	$92,451.14	$52.74	33
42	WALGREENS 07452	DES MOINES	IA	1,742	$87,701.08	$50.35	44
43	HY-VEE PHARMACY 1504	OTTUMWA	IA	1,732	$101,877.04	$58.82	43
44	WALGREENS 05852	DES MOINES	IA	1,728	$107,987.88	$62.49	36
45	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	1,727	$189,564.19	$109.77	64
46	WALMART PHARMACY 10-5115	DAVENPORT	IA	1,721	$96,236.31	$55.92	50
47	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,716	$121,644.94	$70.89	45
48	WALGREENS 10855	WATERLOO	IA	1,698	$95,459.57	$56.22	93
49	WALMART PHARMACY 10-3394	ATLANTIC	IA	1,689	$91,406.86	$54.12	38
50	HY-VEE PHARMACY 1530	PLEASANT HILL	IA	1,687	$84,159.23	$49.89	72

51	WALGREENS 05470	SIOUX CITY	IA	1,643	$149,518.99	$91.00	42
52	HY-VEE PHARMACY 1615	SIOUX CITY	IA	1,643	$134,836.73	$82.07	66
53	HY-VEE PHARMACY 1058	CENTERVILLE	IA	1,609	$202,826.18	$126.06	49
54	WALMART PHARMACY 10-0646	ANAMOSA	IA	1,607	$111,526.21	$69.40	54
55	DANIEL PHARMACY	FORT DODGE	IA	1,597	$91,137.61	$57.07	41
56	WALGREENS 07454	ANKENY	IA	1,586	$67,770.25	$42.73	56
57	HY-VEE PHARMACY 1241	HARLAN	IA	1,578	$118,430.29	$75.05	59
58	WALMART PHARMACY 10-0559	MUSCATINE	IA	1,577	$149,616.36	$94.87	51
59	WALMART PHARMACY 10-1723	DES MOINES	IA	1,573	$144,981.01	$92.17	86
60	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	1,562	$120,036.00	$76.85	85
61	HY-VEE PHARMACY 1396	MARION	IA	1,557	$100,215.44	$64.36	70
62	WALMART PHARMACY 10-1496	WATERLOO	IA	1,536	$99,422.40	$64.73	74
63	HY-VEE DRUGSTORE 7056	MASON CITY	IA	1,530	$90,729.81	$59.30	81
64	HY-VEE PHARMACY 1281	IOWA CITY	IA	1,525	$68,428.94	$44.87	48
65	HY-VEE PHARMACY 1071	CLARINDA	IA	1,519	$92,023.21	$60.58	78
66	HY-VEE PHARMACY 1610	SIOUX CITY	IA	1,504	$124,325.26	$82.66	53
67	CVS PHARMACY 08658	DAVENPORT	IA	1,502	$85,559.54	$56.96	71
68	WALGREENS 03875	CEDAR RAPIDS	IA	1,500	$67,434.20	$44.96	88
69	HY-VEE PHARMACY 1522	PERRY	IA	1,490	$83,696.34	$56.17	55
70	UI HEALTHCARE	CORALVILLE	IA	1,487	$55,118.00	$37.07	67
71	WALGREENS 03595	DAVENPORT	IA	1,473	$78,156.15	$53.06	77
72	WALGREENS 05044	BURLINGTON	IA	1,472	$65,124.16	$44.24	46
73	WALMART PHARMACY 10-2716	CEDAR RAPIDS	IA	1,464	$72,885.83	$49.79	114
74	NUCARA LTC PHARMACY 3	IOWA CITY	IA	1,440	$33,637.27	$23.36	73
75	HY VEE PHARMACY 1459	OELWEIN	IA	1,435	$84,807.76	$59.10	58
76	HY-VEE PHARMACY 1148	DES MOINES	IA	1,434	$97,056.07	$67.68	94
77	WALMART PHARMACY 10-1621	CENTERVILLE	IA	1,427	$94,954.78	$66.54	84

78	WALGREENS 03876	MARION	IA	1,426	$71,543.90	$50.17	79
79	WALGREENS 05362	DES MOINES	IA	1,420	$93,494.53	$65.84	68
80	WALMART PHARMACY 10-0985	FAIRFIELD	IA	1,418	$60,319.38	$42.54	65
81	HY-VEE PHARMACY 1449	NEWTON	IA	1,418	$101,436.65	$71.54	69
82	HY-VEE PHARMACY 1042	BURLINGTON	IA	1,409	$109,870.20	$77.98	80
83	HY-VEE DRUGSTORE 7026	CEDAR RAPIDS	IA	1,406	$78,900.50	$56.12	76
84	ALL CARE HEALTH CENTER	COUNCIL BLUFFS	IA	1,405	$66,887.06	$47.61	83
85	SCOTT PHARMACY INC	FAYETTE	IA	1,404	$67,959.35	$48.40	96
86	COVENANT FAMILY PHARMACY	WATERLOO	IA	1,397	$124,374.91	$89.03	91
87	WALGREENS 05777	DES MOINES	IA	1,389	$79,809.40	$57.46	63
88	WALGREENS 05886	KEOKUK	IA	1,388	$91,859.48	$66.18	60
89	WALMART PHARMACY 10-0810	MASON CITY	IA	1,377	$109,933.46	$79.84	105
90	WAGNER PHARMACY	CLINTON	IA	1,367	$78,342.51	$57.31	82
91	LAGRANGE PHARMACY	VINTON	IA	1,363	$69,935.35	$51.31	108
92	WALMART PHARMACY 10-1393	OSKALOOSA	IA	1,357	$75,632.79	$55.74	102
93	FOREST PARK CLINIC PHCY	MASON CITY	IA	1,343	$80,476.97	$59.92	128
94	MEDICAP PHARMACY 8405	INDIANOLA	IA	1,341	$75,326.58	$56.17	52
95	WALMART PHARMACY 10-0797	WEST BURLINGTON	IA	1,338	$66,414.42	$49.64	90
96	HY-VEE PHARMACY 1895	WINDSOR HEIGHTS	IA	1,314	$85,682.04	$65.21	122
97	HY-VEE PHARMACY 1170	ESTHERVILLE	IA	1,303	$92,137.43	$70.71	95
98	HY-VEE PHARMACY 1065	CHARITON	IA	1,297	$54,212.70	$41.80	87
99	HY-VEE PHARMACY 1324	KEOKUK	IA	1,275	$104,590.17	$82.03	124
100	WALGREENS 05077	IOWA CITY	IA	1,274	$62,539.87	$49.09	101

Top 100 Pharmacies by Paid Amount June 2024 to August 2024							
RANK	Pharmacy NAME	Pharmacy City	State	Prescription Count	Paid Amount	Average Cost Member	Previous RANK
1	UIHC AMBULATORY CARE PHC	IOWA CITY	IA	7,198	$3,775,900.27	$524.58	1
2	CAREMARK SPECIALTY P 1702	LENEXA	KS	511	$3,453,886.34	$6,759.07	2
3	COMMUNITY, A WALGRE 16528	DES MOINES	IA	490	$2,080,866.10	$4,246.67	3
4	CVS SPECIALTY 02921	MONROEVILLE	PA	181	$1,452,580.87	$8,025.31	4
5	UNITYPOINT AT HOME	URBANDALE	IA	373	$1,262,934.27	$3,385.88	5
6	NUCARA SPECIALTY PHARMAC	PLEASANT HILL	IA	1,008	$1,021,011.49	$1,012.91	6
7	CAREMARK SPECIALTY 48031	MOUNT PROSPECT	IL	82	$731,557.68	$8,921.44	9
8	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	55	$649,806.84	$11,814.67	7
9	COMMUNITY A WALGREE 21250	IOWA CITY	IA	203	$632,447.60	$3,115.51	8
10	CARE PLUS CVS/PHARM 00102	AURORA	CO	52	$465,497.41	$8,951.87	10
11	CVS/SPECIALTY 1703	REDLANDS	CA	18	$435,485.06	$24,193.61	13
12	ACARIAHEALTH PHARMACY 11	HOUSTON	TX	37	$433,223.96	$11,708.76	11
13	WALGREENS 04405	COUNCIL BLUFFS	IA	5,465	$394,264.86	$72.14	12
14	AMBER PHARMACY	OMAHA	NE	90	$378,485.92	$4,205.40	14
15	MEDICAL ONCOLOGY & HEMAT	DES MOINES	IA	36	$350,443.74	$9,734.55	23
16	OPTUM PHARMACY	JEFFERSONVILLE	IN	36	$320,715.17	$8,908.75	15
17	ANOVORX GROUP LLC	MEMPHIS	TN	11	$314,186.52	$28,562.41	21
18	EXPRESS SCRIPTS SPECAILT	ST. LOUIS	MO	18	$281,796.46	$15,655.36	16
19	ARJ INFUSION SERVICES LL	CEDAR RAPIDS	IA	44	$269,429.94	$6,123.41	29
20	HY-VEE PHARMACY 1403	MARSHALLTOWN	IA	3,721	$260,531.54	$70.02	17
21	EVERSANA LIFE SCIENCE SE	CHESTERFIELD	MO	8	$252,256.04	$31,532.01	64
22	PRIMARY HEALTHCARE PHARM	DES MOINES	IA	907	$248,481.03	$273.96	19
23	WALGREENS 05042	CEDAR RAPIDS	IA	4,636	$248,009.69	$53.50	22

24	GENOA HEALTHCARE LL 20171	DAVENPORT	IA	989	$235,241.63	$237.86	18
25	HY-VEE DRUGSTORE 7065	OTTUMWA	IA	2,383	$225,318.34	$94.55	20
26	HY-VEE DRUGSTORE 7060	MUSCATINE	IA	2,863	$223,460.29	$78.05	28
27	HY-VEE PHARMACY 1138	DES MOINES	IA	2,971	$216,397.04	$72.84	26
28	HY-VEE PHARMACY 1109	DAVENPORT	IA	2,735	$215,134.98	$78.66	47
29	BROADLAWNS MED CTR OP PH	DES MOINES	IA	4,760	$208,783.20	$43.86	25
30	HY-VEE PHARMACY 1092	COUNCIL BLUFFS	IA	2,794	$206,768.95	$74.00	24
31	FOUNDATION CARE LLC	EARTH CITY	MO	12	$206,077.34	$17,173.11	55
32	WALGREENS 05721	DES MOINES	IA	3,154	$205,133.30	$65.04	36
33	CR CARE PHARMACY	CEDAR RAPIDS	IA	978	$203,970.60	$208.56	32
34	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	19	$203,446.47	$10,707.71	71
35	HY-VEE PHARMACY 1058	CENTERVILLE	IA	1,609	$202,826.18	$126.06	46
36	RIGHT DOSE PHARMACY	ANKENY	IA	3,679	$202,491.96	$55.04	51
37	SIOUXLAND REGIONAL CANCE	SIOUX CITY	IA	16	$197,017.62	$12,313.60	43
38	WALGREENS 05239	DAVENPORT	IA	3,740	$193,505.00	$51.74	27
39	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	1,727	$189,564.19	$109.77	37
40	FIRST MED EAST PHARMACY	DAVENPORT	IA	337	$182,328.94	$541.04	44
41	HY-VEE PHARMACY 1075	CLINTON	IA	2,207	$173,974.21	$78.83	41
42	WALGREENS 07455	WATERLOO	IA	3,131	$171,148.78	$54.66	30
43	GENOA HEALTHCARE LL 20304	SIOUX CITY	IA	1,041	$169,695.25	$163.01	49
44	GREENWOOD COMPLIANCE PHA	WATERLOO	IA	971	$167,391.07	$172.39	53
45	ALLEN CLINIC PHARMACY	WATERLOO	IA	774	$166,515.59	$215.14	31
46	NELSON FAMILY PHARMACY	FORT MADISON	IA	2,485	$165,623.15	$66.65	39
47	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	48	$158,942.13	$3,311.29	82
48	WALMART PHARMACY 10-2889	CLINTON	IA	2,215	$156,176.87	$70.51	45
49	HY-VEE PHARMACY 1192	FORT DODGE	IA	2,273	$154,405.83	$67.93	81
50	DRILLING PHARMACY 67	SIOUX CITY	IA	2,508	$154,180.66	$61.48	56

51	WALGREENS 00359	DES MOINES	IA	2,655	$154,074.30	$58.03	38
52	GREENWOOD DRUG ON KIMBAL	WATERLOO	IA	2,207	$153,285.79	$69.45	34
53	S-S PHARMACY	COUNCIL BLUFFS	IA	671	$151,387.65	$225.61	54
54	WALGREENS 15647	SIOUX CITY	IA	2,754	$151,115.57	$54.87	40
55	WALGREENS 03700	COUNCIL BLUFFS	IA	2,742	$149,977.86	$54.70	52
56	WALMART PHARMACY 10-0559	MUSCATINE	IA	1,577	$149,616.36	$94.87	66
57	WALGREENS 05470	SIOUX CITY	IA	1,643	$149,518.99	$91.00	42
58	WALMART PHARMACY 10-1723	DES MOINES	IA	1,573	$144,981.01	$92.17	175
59	HY-VEE PHARMACY 1044	BURLINGTON	IA	2,339	$142,122.81	$60.76	35
60	HY-VEE PHARMACY 1866	WATERLOO	IA	1,789	$141,652.22	$79.18	98
61	HY-VEE DRUGSTORE 7020	CEDAR RAPIDS	IA	2,444	$137,732.12	$56.36	69
62	HY-VEE PHARMACY 1056	CEDAR RAPIDS	IA	2,449	$137,236.36	$56.04	65
63	CHCSI PHARMACY	LEON	IA	972	$136,194.03	$140.12	126
64	HY-VEE PHARMACY 1615	SIOUX CITY	IA	1,643	$134,836.73	$82.07	136
65	WALGREENS 07453	DES MOINES	IA	2,688	$132,836.16	$49.42	50
66	PARAGON PARTNERS	OMAHA	NE	216	$132,798.54	$614.81	60
67	CHILDRENS HOSPITAL AND M	OMAHA	NE	166	$131,654.28	$793.10	141
68	CVS PHARMACY 10282	FORT DODGE	IA	2,025	$131,651.42	$65.01	73
69	NEBRASKA MED CTR CLINIC	OMAHA	NE	189	$130,856.07	$692.36	100
70	MAHASKA DRUGS	OSKALOOSA	IA	2,202	$130,735.22	$59.37	61
71	HY-VEE PHARMACY 1151	DES MOINES	IA	2,264	$128,582.82	$56.79	58
72	WALGREENS 04041	DAVENPORT	IA	2,367	$128,232.75	$54.18	62
73	CVS PHARMACY 08544	WATERLOO	IA	2,364	$127,715.38	$54.03	74
74	FAIRVIEW PHARMACY	MINNEAPOLIS	MN	36	$126,594.96	$3,516.53	57
75	WALMART PHARMACY 10-5315	ORLANDO	FL	10	$126,414.58	$12,641.46	110
76	GENOA HEALTHCARE LL 20459	MARSHALLTOWN	IA	610	$124,390.46	$203.92	174
77	COVENANT FAMILY PHARMACY	WATERLOO	IA	1,397	$124,374.91	$89.03	93

78	HY-VEE PHARMACY 1610	SIOUX CITY	IA	1,504	$124,325.26	$82.66	86
79	PANTHERX SPECIALTY PHARM	CORAOPOLIS	PA	6	$123,954.26	$20,659.04	#N/A
80	BIOLOGICS BY MCKESSON	CARY	NC	13	$123,318.58	$9,486.04	84
81	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,716	$121,644.94	$70.89	63
82	HY-VEE PHARMACY 1061	CEDAR RAPIDS	IA	2,198	$120,853.32	$54.98	151
83	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	1,562	$120,036.00	$76.85	80
84	HY-VEE PHARMACY 1142	DES MOINES	IA	1,814	$118,981.73	$65.59	76
85	HY-VEE PHARMACY 1241	HARLAN	IA	1,578	$118,430.29	$75.05	48
86	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	1,765	$117,948.13	$66.83	89
87	AON PHARMACY	FORT MYERS	FL	6	$116,825.73	$19,470.96	97
88	WALMART PHARMACY 10-0646	ANAMOSA	IA	1,607	$111,526.21	$69.40	91
89	WALMART PHARMACY 10-0810	MASON CITY	IA	1,377	$109,933.46	$79.84	153
90	HY-VEE PHARMACY 1042	BURLINGTON	IA	1,409	$109,870.20	$77.98	68
91	MEDICAP PHARMACY 8003	AMES	IA	565	$108,096.61	$191.32	247
92	WALGREENS 05852	DES MOINES	IA	1,728	$107,987.88	$62.49	102
93	HY-VEE PHARMACY 1324	KEOKUK	IA	1,275	$104,590.17	$82.03	117
94	GENOA HEALTHCARE LL 20523	SIOUX CITY	IA	342	$102,824.67	$300.66	167
95	HY-VEE PHARMACY 1504	OTTUMWA	IA	1,732	$101,877.04	$58.82	131
96	HY-VEE PHARMACY 1449	NEWTON	IA	1,418	$101,436.65	$71.54	92
97	STANGEL PHARMACY	ONAWA	IA	1,229	$101,158.33	$82.31	77
98	HY-VEE PHARMACY 1396	MARION	IA	1,557	$100,215.44	$64.36	94
99	WALMART PHARMACY 10-1496	WATERLOO	IA	1,536	$99,422.40	$64.73	106
100	JACKS CORNER DRUG	SIGOURNEY	IA	668	$99,393.57	$148.79	172

Top 100 Prescribing Providers by Prescription Count June 2024 to August 2024						
RANK	NPI Num	Prescriber Name	Paid Amount	Prescription Count	Average Scripts Member	Previous Rank
1	1356315311	DAVID NYSTROM	$33,058.25	1,106	10.34	2
2	1982605762	JEFFREY WILHARM	$42,339.38	957	13.11	1
3	1356359871	RHEA HARTLEY	$76,589.34	832	5.70	3
4	1982030946	JACKLYN BESCH	$32,027.24	777	7.54	5
5	1629036546	ANITA SIMISON	$31,054.75	691	5.81	4
6	1164538674	JOSEPH WANZEK	$33,524.98	674	8.32	8
7	1659358620	CARLOS CASTILLO	$28,027.60	659	5.83	7
8	1528365277	MINA SALIB	$294,900.32	656	4.93	9
9	1164823092	JAMEY GREGERSEN	$28,143.04	651	8.92	13
10	1477199198	SAJO THOMAS	$73,509.14	647	6.81	25
11	1619380680	TARA BROCKMAN	$29,369.47	634	6.10	18
12	1417941188	DEBRA NEUHARTH	$23,743.18	634	6.82	21
13	1013115369	BOBBITA NAG	$22,608.92	629	4.03	6
14	1902912538	CHRISTIAN JONES	$40,480.26	625	6.65	11
15	1043211303	ALI SAFDAR	$81,607.43	620	5.96	12
16	1134854128	DZEVIDA PANDZIC	$29,041.81	610	4.21	19
17	1467502286	CHARLES TILLEY	$117,028.58	570	6.55	14
18	1437238110	GENEVIEVE NELSON	$75,461.88	568	7.68	10
19	1477926434	JACKIE SHIPLEY	$28,976.81	566	5.34	16
20	1275763047	REBECCA BOWMAN	$97,928.34	550	7.86	30
21	1902596828	LINDSAY HARMS	$49,013.32	544	8.63	28
22	1508844465	MICHELE FRIEDMAN	$20,079.25	544	12.65	43
23	1467907394	CYNTHIA COENEN	$87,546.08	544	8.63	15
24	1184657603	SARA RYGOL	$76,549.30	532	6.65	31

25	1023469798	WEI SHIPENG	$39,583.21	521	13.03	24
26	1609218304	AMANDA GARR	$56,600.54	519	7.11	26
27	1891707832	LISA KLOCK	$18,124.19	518	6.32	68
28	1205393386	JESSICA HUDSPETH	$48,514.35	513	8.02	17
29	1437209434	JON THOMAS	$30,113.54	512	5.63	33
30	1144588476	RACHEL FILZER	$53,363.32	511	7.00	27
31	1770933046	SHELBY BILLER	$63,765.83	506	6.02	22
32	1942721584	SHAWNA FURY	$21,387.11	504	5.60	37
33	1932531316	BROOKE JOHNSON	$35,265.19	497	6.37	48
34	1922455096	DEAN GUERDET	$60,330.01	492	6.74	69
35	1598183493	JENA ELLERHOFF	$40,248.45	481	7.63	420
36	1275067696	OLAITAN IJITIMEHIN	$18,975.46	480	5.33	65
37	1689077018	STACY ROTH	$39,958.20	478	5.09	54
38	1972758126	REBECCA BOLLIN	$20,010.95	474	5.78	23
39	1356919658	SARAH CASTRO	$26,322.62	469	8.85	32
40	1538368170	CHRISTOPHER MATSON	$19,068.79	466	7.17	29
41	1316471154	NICOLE WOOLLEY	$11,982.56	462	5.25	74
42	1013355759	DYLAN GREENE	$15,726.60	452	5.72	34
43	1679986350	JENNIFER SPOERL	$85,411.11	449	6.41	20
44	1346621059	MARK ZACHARJASZ	$28,193.38	448	9.33	39
45	1043434525	ROBERT KENT	$24,922.40	448	8.15	49
46	1235514258	ASHLEY FULLER	$42,101.75	447	6.30	45
47	1053630640	JENNIFER DONOVAN	$46,578.88	447	7.33	52
48	1558770974	MARC BAUMERT	$18,181.76	445	5.30	46
49	1134191018	DUSTIN SMITH	$42,908.90	444	5.62	63
50	1053398800	STEVEN SCURR	$23,554.05	444	6.73	75
51	1477534279	EDMUND PIASECKI	$24,915.11	440	8.46	102

52	1902478811	JOAN ANDERSON	$65,812.15	435	7.63	38
53	1588746515	AMY BADBERG	$12,553.46	435	5.44	98
54	1780877878	CHRISTOPHER JACOBS	$24,071.08	434	6.68	96
55	1679573893	PATTY HILDRETH	$113,071.55	431	8.13	58
56	1255823506	NICOLE DELAGARDELLE	$51,526.10	431	5.53	41
57	1780979666	LINDSEY CHRISTIANSON	$27,984.31	429	4.77	95
58	1437692803	CASSANDRA DUNLAVY	$16,571.66	429	6.92	47
59	1841427564	MEL ROCA	$20,173.38	428	5.78	79
60	1124006770	WOOK KIM	$16,959.85	426	7.10	99
61	1720346232	CASSIE PARRISH	$40,418.97	423	10.58	42
62	1356987416	CHELSEA CHRISTENSEN	$20,044.35	414	4.70	88
63	1689139669	BENJAMIN BOLMEIER	$18,948.36	413	6.35	91
64	1992402655	SHANE EBERHARDT	$117,190.24	412	4.90	77
65	1891146999	BECKY JOHNSON	$431,290.05	412	5.64	36
66	1184056822	ABBY KOLTHOFF	$151,375.66	410	6.21	184
67	1467465716	JEFFREY BRADY	$16,177.67	408	6.69	64
68	1598786097	STEPHANIE GRAY	$77,958.85	407	7.98	70
69	1215184726	BABUJI GANDRA	$12,453.41	407	5.73	40
70	1699134072	JENNIFER ZIGRANG	$23,237.32	406	7.00	57
71	1457584740	ERIC MEYER	$31,059.68	405	5.70	62
72	1538157383	DAVID WENGER-KELLER	$34,694.97	404	10.10	53
73	1508846007	ANGELA TOWNSEND	$16,280.83	402	5.15	76
74	1811419815	GRETCHEN WENGER	$14,329.35	400	3.39	1,276
75	1831731298	HEATHER WILSON	$29,956.92	398	6.32	73
76	1407585623	COLETTE DEMOSS	$28,690.23	396	6.95	303
77	1306559786	ROY HENRY	$67,569.55	389	5.19	173
78	1992103386	MELISSA LARSEN	$37,590.42	388	6.36	89

79	1962418640	BARCLAY MONASTER	$23,504.30	388	5.17	174
80	1821333774	BRITTNI BENDA	$23,067.05	388	5.54	80
81	1417549932	AMANDA MCCORMICK	$27,226.98	385	5.75	147
82	1003053653	STANLEY MATHEW	$17,447.62	385	9.87	130
83	1114681889	KELSEY BAUER	$33,033.96	384	6.74	177
84	1780655100	JOHN BIRKETT	$19,789.40	383	10.08	114
85	1225140809	SUNDARA MUNAGALA VENKATA	$21,998.97	383	6.18	50
86	1568758746	DANIEL BINKOWSKI	$4,491.54	381	3.89	249
87	1154815330	BRUCE PEHL	$18,410.06	381	6.35	139
88	1740770726	KIMBERLY KRIEGER	$24,187.76	380	5.14	101
89	1619153137	JOADA BEST	$29,170.62	379	5.41	93
90	1528329398	ERIN ROWAN	$25,710.27	378	5.91	55
91	1649248378	KATHLEEN WILD	$19,733.52	377	5.54	66
92	1649469826	KATHERINE LUTYENS	$14,572.19	377	4.33	183
93	1821268335	JACQUELINE MCINNIS	$32,309.68	376	7.83	81
94	1730849647	MELANIE ROCK	$9,727.11	376	5.61	143
95	1063622637	HUSSAIN BANU	$13,019.59	376	9.64	56
96	1144240805	DANIEL ROWLEY	$23,758.64	374	12.47	71
97	1386044832	MARY GRIEDER	$18,577.45	372	10.05	72
98	1245227099	DONNA DOBSON TOBIN	$51,225.37	371	8.24	44
99	1033295308	TAKASHI KAWAMITSU	$22,920.90	371	6.63	179
100	1871105916	LACIE THEIS	$15,672.40	370	5.97	159

Top 100 Prescribing Providers by Paid Amount June 2024 to August 2024						
RANK	NPI Num	Prescriber Name	Paid Amount	Avg cost RX	Prescription Count	Previous Rank
1	1891146999	BECKY JOHNSON	$431,290.05	$1,046.82	412	2
2	1700561826	PEDRO HSIEH	$409,395.13	$29,242.51	14	4
3	1417443953	RODNEY CLARK	$371,570.98	$1,115.83	333	5
4	1295091510	REBECCA WEINER	$347,010.63	$1,304.55	266	3
5	1316934318	STEVEN LENTZ	$331,296.06	$15,776.00	21	6
6	1588616171	HEATHER THOMAS	$317,155.15	$2,857.25	111	7
7	1013126705	JANICE STABER	$309,376.97	$5,625.04	55	15
8	1528365277	MINA SALIB	$294,900.32	$449.54	656	1
9	1952423071	SAKEER HUSSAIN	$289,161.61	$6,724.69	43	23
10	1437121407	LINDA CADARET	$279,533.88	$3,937.10	71	8
11	1760562466	ARTHUR BEISANG	$259,767.38	$43,294.56	6	54
12	1073722112	RIAD RAHHAL	$240,419.78	$1,422.60	169	9
13	1194945691	ANJALI SHARATHKUMAR	$227,076.56	$5,046.15	45	11
14	1003315201	ABIGAIL BEHRENS	$220,534.37	$4,161.03	53	16
15	1952539447	ANTHONY FISCHER	$217,238.17	$4,525.80	48	64
16	1326410499	TARA EASTVOLD	$213,448.79	$751.58	284	50
17	1942937388	CARLY TRAUSCH	$212,249.86	$969.18	219	13
18	1700080538	EDUARDO CARLIN	$204,581.11	$2,802.48	73	18
19	1649943689	JESSICA COFFEY	$196,579.81	$1,414.24	139	27
20	1891955423	LEAH SIEGFRIED	$177,687.19	$533.60	333	20
21	1467449579	BRIAN WAYSON	$173,232.30	$3,149.68	55	33
22	1861876526	NIBASH BUDHATHOKI	$170,579.64	$6,823.19	25	26
23	1144455502	JENNIFER PETTS	$166,445.14	$1,300.35	128	19
24	1588618359	BARBARA BURKLE	$164,511.58	$2,317.06	71	32

25	1225263833	LINDSAY ORRIS	$164,442.37	$4,327.43	38	10
26	1245353242	SANDY HONG	$163,190.05	$2,331.29	70	39
27	1609820240	JAMES HARPER	$161,236.98	$53,745.66	3	68
28	1376525196	RANDOLPH ROUGH	$160,487.24	$2,865.84	56	12
29	1801405832	SARAH HIEMER	$155,652.88	$1,673.69	93	492
30	1487648705	KAREN HUNKE	$153,780.40	$1,747.50	88	21
31	1225266364	SARAH BLIGH	$153,488.61	$2,475.62	62	24
32	1184056822	ABBY KOLTHOFF	$151,375.66	$369.21	410	66
33	1245624626	BLAKE WILLIAMS	$145,121.21	$1,577.40	92	156
34	1780995506	QUANHATHAI KAEWPOOWAT	$142,728.68	$1,471.43	97	34
35	1730318205	DIANA BAYER-BOWSTEAD	$136,793.01	$2,630.63	52	1,154
36	1144214248	KRISTI WALZ	$134,063.42	$369.32	363	41
37	1750348496	VANESSA CURTIS	$133,167.86	$1,566.68	85	102
38	1275836751	HOLLY KRAMER	$131,872.58	$1,402.90	94	36
39	1437533130	KATIE BROSHUIS	$131,694.97	$1,254.24	105	17
40	1215333091	NADIA NAZ	$131,056.06	$5,040.62	26	270
41	1265420095	ELIZABETH COOPER	$127,363.97	$2,653.42	48	30
42	1699887133	DANIEL DIMEO	$126,718.41	$2,696.14	47	35
43	1871039917	ELIZABETH ALLEN	$124,881.32	$2,497.63	50	29
44	1902100746	AMI PATEL	$119,860.56	$2,724.10	44	45
45	1992402655	SHANE EBERHARDT	$117,190.24	$284.44	412	37
46	1467502286	CHARLES TILLEY	$117,028.58	$205.31	570	53
47	1700417169	COURTNEY REINTS	$113,318.96	$605.98	187	47
48	1679573893	PATTY HILDRETH	$113,071.55	$262.35	431	25
49	1245737097	ASHLEY PATRICK	$111,857.43	$2,485.72	45	85
50	1033347521	DREW THODESON	$111,759.75	$2,032.00	55	14
51	1841607900	SHAYLA SANDERS	$111,155.86	$1,792.84	62	63

52	1063792026	JILL MILLER	$110,634.39	$372.51	297	62
53	1669740957	COURTNEY KREMER	$104,757.60	$1,496.54	70	58
54	1558808501	JESSICA BRAKSIEK	$103,607.03	$5,453.00	19	61
55	1578958542	HEIDI CURTIS	$101,643.50	$1,168.32	87	142
56	1275763047	REBECCA BOWMAN	$97,928.34	$178.05	550	69
57	1306071915	THOMAS PIETRAS	$96,807.17	$3,122.81	31	55
58	1083102933	COLOMBIA PTACEK	$96,079.93	$1,281.07	75	110
59	1649238643	NAGENDRA MYNENI	$95,325.89	$4,766.29	20	92
60	1841254406	BRADLEY HIATT	$92,887.71	$2,444.41	38	167
61	1720430184	AMANDEEP RAKHRA	$92,583.34	$1,683.33	55	215
62	1770091266	JESSIE BAKER	$91,064.86	$659.89	138	65
63	1750648275	SARAH GROSS	$90,211.99	$1,582.67	57	73
64	1609003011	JOHN BERNAT	$89,726.85	$22,431.71	4	59
65	1982665337	THOMAS BUROKER	$89,273.17	$6,867.17	13	99
66	1356752067	KELLY DELANEY-NELSON	$88,799.87	$1,250.70	71	57
67	1669056123	KAMA AUSBORN	$88,510.98	$614.66	144	22
68	1710051222	JAMIE PROTASKEY	$88,084.51	$967.96	91	182
69	1215439708	ERNESTO RUIZ DUQUE	$88,012.31	$1,375.19	64	1,150
70	1972616316	JEFFREY BRANNEN	$87,982.07	$845.98	104	49
71	1467907394	CYNTHIA COENEN	$87,546.08	$160.93	544	84
72	1386084747	JENNIFER CONDON	$86,220.72	$805.80	107	40
73	1841548161	CRYSTAL MEYER	$85,967.20	$2,096.76	41	125
74	1679986350	JENNIFER SPOERL	$85,411.11	$190.23	449	48
75	1184395162	DANIELLE VAN OOSBREE	$85,029.83	$236.19	360	90
76	1730135070	JAMES WALLACE	$83,155.98	$3,615.48	23	43
77	1073811352	KYLE ROSE	$82,148.16	$8,214.82	10	138
78	1649826140	TAYLOR BOLDT	$81,850.78	$538.49	152	769

79	1043211303	ALI SAFDAR	$81,607.43	$131.62	620	51
80	1295217529	HEATHER STEHR	$81,227.51	$345.65	235	119
81	1336375369	SAMANTHA MALLORY	$81,176.47	$2,618.60	31	116
82	1619021144	CHRISTOPHER GIBBS	$80,815.90	$8,081.59	10	141
83	1962444349	MUKUND NADIPURAM	$79,258.28	$3,962.91	20	716
84	1174748180	MOHAMMAD ALSHARABATI	$79,142.22	$965.15	82	427
85	1093053142	RACHEAL MCMAHON	$77,987.71	$4,104.62	19	89
86	1598786097	STEPHANIE GRAY	$77,958.85	$191.55	407	96
87	1144829300	KATIE SHANNON	$77,634.63	$4,313.04	18	1,504
88	1598438095	LALAURA LOGAN	$77,289.47	$304.29	254	244
89	1144900861	LIZABETH SHEETS	$77,218.09	$292.49	264	83
90	1134249832	STEVEN CRAIG	$77,070.56	$963.38	80	76
91	1356359871	RHEA HARTLEY	$76,589.34	$92.05	832	88
92	1184657603	SARA RYGOL	$76,549.30	$143.89	532	94
93	1720698335	DANIKA HANSEN	$75,912.05	$225.26	337	107
94	1437238110	GENEVIEVE NELSON	$75,461.88	$132.86	568	38
95	1669137832	TIFFANY NAVRKAL	$75,085.31	$962.63	78	98
96	1841673738	RACHEL PERSON	$74,109.50	$2,964.38	25	174
97	1477199198	SAJO THOMAS	$73,509.14	$113.62	647	122
98	1588288385	JENIFER JONES	$73,237.05	$882.37	83	112
99	1720036353	ERIK SWENSON	$72,439.56	$1,420.38	51	101
100	1376893503	JESSICA HEIN	$71,500.34	$1,300.01	55	273

Top 20 Therapeutic Class by Paid Amount							
Category Description	March 2024 to May 2024 Total Cost	Previous Rank	Previous % Budget	June 2024 to August 2024 Total Cost	Current Rank	Current % Budget	% Change
ANTIDIABETICS	$6,661,710.81	1	13.14%	$7,176,543.46	1	13.50%	7.73%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$5,333,515.05	2	10.52%	$5,503,190.82	2	10.40%	3.18%
DERMATOLOGICALS	$4,912,340.50	3	9.69%	$5,448,514.89	3	10.30%	10.91%
ANALGESICS - ANTI-INFLAMMATORY	$4,414,381.76	4	8.71%	$4,630,499.67	4	8.70%	4.90%
ANTIVIRALS	$2,832,486.77	7	5.59%	$3,055,175.22	5	5.80%	7.86%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$2,994,771.83	5	5.91%	$2,897,955.30	6	5.50%	-3.23%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$2,911,498.73	6	5.74%	$2,738,690.99	7	5.20%	-5.94%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$1,666,683.91	10	3.29%	$2,150,204.51	8	4.10%	29.01%
HEMATOLOGICAL AGENTS - MISC.	$1,492,049.87	11	2.94%	$1,809,105.35	9	3.40%	21.25%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$1,750,137.17	9	3.45%	$1,714,787.74	10	3.20%	-2.02%
RESPIRATORY AGENTS - MISC.	$1,826,898.91	8	3.60%	$1,637,854.31	11	3.10%	-10.35%
MIGRAINE PRODUCTS	$1,213,187.11	13	2.39%	$1,219,437.31	12	2.30%	0.52%
ANTIDEPRESSANTS	$1,227,584.80	12	2.42%	$1,206,243.90	13	2.30%	-1.74%
ANTICOAGULANTS	$1,146,239.86	14	2.26%	$1,168,474.09	14	2.20%	1.94%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$1,090,735.95	15	2.15%	$1,068,483.21	15	2.00%	-2.04%
CARDIOVASCULAR AGENTS - MISC.	$956,290.11	17	1.89%	$1,052,689.47	16	2.00%	10.08%
ANTICONVULSANTS	$1,028,200.67	16	2.03%	$1,032,183.82	17	1.90%	0.39%
GASTROINTESTINAL AGENTS - MISC.	$709,505.40	18	1.40%	$883,450.72	18	1.70%	24.52%
ANTI-INFECTIVE AGENTS - MISC.	$356,156.93	20	0.70%	$411,503.17	19	0.80%	15.54%
MISCELLANEOUS THERAPEUTIC CLASSES	$286,497.33	25	0.56%	$404,605.34	20	0.80%	41.22%

Top 20 Therapeutic Class by Prescription Count					
Category Description	March 2024 to May 2024 Total Claims	Previous Rank	June 2024 to August 2024 Total Claims	Current Rank	% Change
ANTIDEPRESSANTS	68,053	1	67,914	1	-0.20%
ANTICONVULSANTS	27,020	4	27,378	2	1.32%
ANTIHYPERTENSIVES	27,137	3	27,224	3	0.32%
ANTIDIABETICS	25,707	5	26,764	4	4.11%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	27,425	2	25,525	5	-6.93%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	25,431	6	23,589	6	-7.24%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	22,718	7	22,756	7	0.17%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	21,286	8	21,431	8	0.68%
ANTIANXIETY AGENTS	20,921	9	20,869	9	-0.25%
ANTIHYPERLIPIDEMICS	17,910	10	18,512	10	3.36%
DERMATOLOGICALS	12,932	13	14,795	11	14.41%
BETA BLOCKERS	13,214	12	13,634	12	3.18%
ANALGESICS - ANTI-INFLAMMATORY	12,395	14	12,576	13	1.46%
ANALGESICS - OPIOID	11,946	15	12,433	14	4.08%
DIURETICS	10,856	17	11,226	15	3.41%
ANTIHISTAMINES	11,249	16	10,886	16	-3.23%
PENICILLINS	15,398	11	9,850	17	-36.03%
THYROID AGENTS	9,281	18	9,542	18	2.81%
CALCIUM CHANNEL BLOCKERS	7,984	20	8,256	19	3.41%
MUSCULOSKELETAL THERAPY AGENTS	7,693	21	7,887	20	2.52%

Top 100 Drugs by Paid Amount					
Drug Description	March 2024 to May 2024 Total Cost	Previous Rank	June 2024 to August 2024 Total cost	Current Rank	% Change
Ozempic	$2,145,908.89	2	$2,512,480.56	1	17.08%
Humira (2 Pen)	$2,340,293.12	1	$2,307,110.71	2	-1.42%
Dupixent	$1,572,052.73	5	$1,735,678.64	3	10.41%
Vraylar	$1,622,153.18	4	$1,701,934.63	4	4.92%
Biktarvy	$1,452,442.34	6	$1,462,941.75	5	0.72%
Trikafta	$1,653,980.07	3	$1,372,918.87	6	-16.99%
Jardiance	$1,208,013.38	7	$1,307,106.15	7	8.20%
Stelara	$1,173,054.42	8	$1,244,408.61	8	6.08%
Invega Sustenna	$1,047,523.21	10	$1,099,161.36	9	4.93%
Taltz	$833,658.89	12	$872,105.37	10	4.61%
Trulicity	$898,307.53	11	$832,728.51	11	-7.30%
Eliquis	$764,416.59	13	$797,557.67	12	4.34%
Vyvanse	$1,076,657.63	9	$767,484.81	13	-28.72%
Hemlibra	$446,593.28	17	$678,045.08	14	51.83%
Altuviiio	$273,745.72	34	$538,093.82	15	96.57%
Skyrizi Pen	$458,990.44	16	$502,909.62	16	9.57%
Aristada	$484,295.89	15	$472,914.28	17	-2.35%
Rexulti	$559,478.78	14	$469,738.95	18	-16.04%
Nurtec	$446,204.15	18	$450,490.88	19	0.96%
Ingrezza	$421,393.90	20	$436,952.22	20	3.69%
Mounjaro	$315,584.03	28	$422,668.42	21	33.93%
Farxiga	$401,397.51	21	$405,551.89	22	1.03%
Enbrel SureClick	$360,106.85	25	$402,806.02	23	11.86%

Mavyret	$305,450.18	30	$388,155.02	24	27.08%
Abilify Maintena	$376,910.34	22	$379,245.83	25	0.62%
Norditropin FlexPro	$291,758.98	32	$368,605.78	26	26.34%
Entresto	$361,498.55	24	$362,770.89	27	0.35%
Symbicort	$369,184.07	23	$355,526.07	28	-3.70%
Ilaris	$433,510.27	19	$341,427.45	29	-21.24%
Caplyta	$318,543.35	27	$333,952.46	30	4.84%
Xarelto	$333,602.20	26	$327,842.92	31	-1.73%
Invega Trinza	$314,207.35	29	$320,741.88	32	2.08%
Daybue	$241,891.89	37	$311,702.22	33	28.86%
Trintellix	$302,791.77	31	$298,194.08	34	-1.52%
Albuterol Sulfate HFA	$286,121.89	33	$278,669.51	35	-2.60%
Xifaxan	$225,877.33	41	$266,891.41	36	18.16%
Austedo	$221,193.97	42	$263,280.11	37	19.03%
Trelegy Ellipta	$247,079.74	36	$261,290.95	38	5.75%
Opsumit	$240,354.11	38	$252,924.18	39	5.23%
Concerta	$264,346.72	35	$250,297.20	40	-5.31%
Rinvoq	$186,729.82	51	$243,636.34	41	30.48%
Xywav	$235,634.94	40	$241,925.32	42	2.67%
Lybalvi	$208,621.67	43	$239,444.67	43	14.77%
Lisdexamfetamine Dimesylate	$151,399.79	68	$230,138.74	44	52.01%
Humira (2 Syringe)	$189,652.62	49	$225,967.59	45	19.15%
Livmarli	$128,201.52	76	$224,352.66	46	75.00%
Ajovy	$236,701.45	39	$221,507.41	47	-6.42%
Jakafi	$171,614.18	59	$215,035.66	48	25.30%
Humira-CD/UC/HS Starter	$20,207.19	330	$197,453.88	49	877.15%
Cosentyx UnoReady	$96,420.28	103	$192,705.42	50	99.86%

Promacta	$174,224.85	57	$187,215.30	51	7.46%
Januvia	$200,133.61	44	$186,126.41	52	-7.00%
Lantus SoloStar	$172,202.47	58	$184,161.73	53	6.94%
Wakix	$97,740.49	102	$183,483.24	54	87.72%
Sofosbuvir-Velpatasvir	$188,328.09	50	$181,109.98	55	-3.83%
Gattex	$179,720.46	52	$179,720.46	56	0.00%
Jornay PM	$177,489.74	53	$175,954.22	57	-0.87%
Tresiba FlexTouch	$199,112.54	45	$170,470.03	58	-14.39%
Spiriva Respimat	$176,029.82	55	$167,343.83	59	-4.93%
Advair HFA	$177,039.46	54	$166,816.91	60	-5.77%
Tremfya	$166,598.16	62	$166,598.16	61	0.00%
Paxlovid (300/100)	$23,668.76	306	$163,231.06	62	589.65%
EPINEPHrine	$130,451.57	74	$161,505.05	63	23.80%
Fasenra Pen	$197,128.32	46	$161,227.86	64	-18.21%
Skytrofa	$114,374.22	93	$159,824.14	65	39.74%
Creon	$126,357.07	78	$159,051.82	66	25.87%
Lenalidomide	$63,797.54	156	$156,641.82	67	145.53%
Spiriva HandiHaler	$170,963.62	60	$154,983.54	68	-9.35%
Linzess	$160,175.88	65	$152,727.99	69	-4.65%
Hizentra	$151,460.60	67	$152,657.54	70	0.79%
Qelbree	$158,916.76	66	$146,743.31	71	-7.66%
Remodulin	$114,671.46	92	$143,341.92	72	25.00%
Cosentyx Sensoready (300 MG)	$170,613.68	61	$141,854.01	73	-16.86%
Alprolix	$193,329.04	47	$139,754.10	74	-27.71%
Zenpep	$161,180.79	64	$139,348.25	75	-13.55%
Lynparza	$131,032.72	73	$139,142.47	76	6.19%
Insulin Lispro (1 Unit Dial)	$129,100.09	75	$133,812.33	77	3.65%

Emgality	$117,933.69	87	$132,746.32	78	12.56%
Actimmune	#N/A	#N/A	$130,294.44	79	#N/A
Pulmozyme	$90,623.01	108	$129,813.70	80	43.25%
Atorvastatin Calcium	$124,362.60	81	$129,274.77	81	3.95%
Kesimpta	$124,491.53	80	$128,984.93	82	3.61%
Sprycel	$109,393.46	96	$128,348.15	83	17.33%
Otezla	$193,220.30	48	$122,856.66	84	-36.42%
Abilify Asimtufii	$63,570.96	158	$121,690.97	85	91.43%
Ubrelvy	$121,156.75	83	$121,206.12	86	0.04%
Insulin Aspart FlexPen	$115,679.14	90	$121,075.72	87	4.67%
Ventolin HFA	$162,276.67	63	$121,019.24	88	-25.42%
Advate	$126,644.08	77	$120,058.26	89	-5.20%
Sertraline HCl	$120,254.56	85	$118,234.35	90	-1.68%
Anoro Ellipta	$120,729.24	84	$115,705.59	91	-4.16%
Tyvaso DPI Maintenance Kit	$138,092.70	70	$115,077.25	92	-16.67%
QuilliChew ER	$135,590.83	72	$113,943.00	93	-15.97%
Ibrance	$79,963.85	125	$112,653.17	94	40.88%
Epidiolex	$118,974.81	86	$111,969.40	95	-5.89%
Aimovig	$117,765.11	88	$111,908.44	96	-4.97%
Qulipta	$101,390.88	100	$111,728.03	97	10.20%
Omeprazole	$111,408.71	94	$109,399.44	98	-1.80%
Erleada	$69,836.72	138	$109,266.98	99	56.46%
buPROPion HCl ER (XL)	$106,424.36	98	$109,023.78	100	2.44%

Top 100 Drugs by Prescription Count					
Drug Description	March 2024 to May 2024 Total Claims	Previous Rank	June 2024 to August 2024 Total Claims	Current Rank	% Change
Atorvastatin Calcium	10,841	1	11,195	1	3.27%
Sertraline HCl	10,702	2	10,578	2	-1.16%
Omeprazole	10,333	4	10,198	3	-1.31%
Lisinopril	8,965	5	8,982	4	0.19%
Levothyroxine Sodium	8,617	7	8,847	5	2.67%
Escitalopram Oxalate	8,610	8	8,778	6	1.95%
traZODone HCl	8,638	6	8,554	7	-0.97%
FLUoxetine HCl	8,147	10	8,264	8	1.44%
buPROPion HCl ER (XL)	8,183	9	8,152	9	-0.38%
Albuterol Sulfate HFA	8,130	11	7,993	10	-1.69%
Gabapentin	7,467	12	7,645	11	2.38%
amLODIPine Besylate	6,450	13	6,650	12	3.10%
hydrOXYzine HCl	6,269	14	6,272	13	0.05%
Amoxicillin	10,645	3	6,098	14	-42.71%
busPIRone HCl	5,972	15	5,923	15	-0.82%
DULoxetine HCl	5,778	16	5,773	16	-0.09%
Pantoprazole Sodium	5,451	18	5,621	17	3.12%
Montelukast Sodium	5,666	17	5,316	18	-6.18%
QUEtiapine Fumarate	5,168	20	5,262	19	1.82%
Metoprolol Succinate ER	4,932	22	5,191	20	5.25%
Cetirizine HCl	5,240	19	5,164	21	-1.45%
HYDROcodone-Acetaminophen	4,661	25	4,803	22	3.05%
Losartan Potassium	4,512	28	4,765	23	5.61%

metFORMIN HCl	4,580	27	4,704	24	2.71%
predniSONE	5,028	21	4,678	25	-6.96%
ARIPiprazole	4,799	23	4,636	26	-3.40%
Venlafaxine HCl ER	4,713	24	4,629	27	-1.78%
cloNIDine HCl	4,587	26	4,614	28	0.59%
lamoTRIgine	3,999	31	3,987	29	-0.30%
Cyclobenzaprine HCl	3,914	34	3,922	30	0.20%
Famotidine	3,857	35	3,794	31	-1.63%
Ondansetron	4,303	29	3,749	32	-12.87%
metFORMIN HCl ER	3,447	38	3,709	33	7.60%
Amphetamine-Dextroamphet ER	3,968	32	3,692	34	-6.96%
Ibuprofen	3,494	37	3,681	35	5.35%
Cephalexin	3,544	36	3,656	36	3.16%
Fluticasone Propionate	3,944	33	3,482	37	-11.71%
Topiramate	3,315	39	3,348	38	1.00%
Rosuvastatin Calcium	3,208	45	3,340	39	4.11%
hydroCHLOROthiazide	3,259	42	3,340	40	2.49%
Amoxicillin-Pot Clavulanate	4,223	30	3,315	41	-21.50%
clonazePAM	3,306	40	3,253	42	-1.60%
ALPRAZolam	3,252	43	3,212	43	-1.23%
Furosemide	2,910	49	3,133	44	7.66%
Triamcinolone Acetonide	2,563	54	3,022	45	17.91%
Amphetamine-Dextroamphetamine	2,988	47	2,972	46	-0.54%
Meloxicam	2,961	48	2,944	47	-0.57%
Ozempic	2,460	56	2,879	48	17.03%
Spironolactone	2,757	51	2,768	49	0.40%
risperiDONE	2,615	53	2,631	50	0.61%

Aspirin Low Dose	2,493	55	2,595	51	4.09%
Methylphenidate HCl ER (OSM)	2,894	50	2,562	52	-11.47%
Jardiance	2,320	59	2,535	53	9.27%
Propranolol HCl	2,394	57	2,464	54	2.92%
Lantus SoloStar	2,317	60	2,443	55	5.44%
traMADol HCl	2,289	61	2,422	56	5.81%
Mirtazapine	2,286	62	2,347	57	2.67%
metroNIDAZOLE	2,269	64	2,327	58	2.56%
Prazosin HCl	2,337	58	2,307	59	-1.28%
LORazepam	2,264	65	2,287	60	1.02%
hydrOXYzine Pamoate	2,276	63	2,281	61	0.22%
oxyCODONE HCl	2,042	72	2,251	62	10.24%
Vyvanse	3,107	46	2,214	63	-28.74%
Azithromycin	3,239	44	2,193	64	-32.29%
Amitriptyline HCl	2,247	67	2,181	65	-2.94%
Doxycycline Monohydrate	2,251	66	2,172	66	-3.51%
Fluconazole	2,199	69	2,163	67	-1.64%
Loratadine	2,195	70	2,122	68	-3.33%
levETIRAcetam	2,029	75	2,100	69	3.50%
Metoprolol Tartrate	2,040	73	2,001	70	-1.91%
Ventolin HFA	2,628	52	1,995	71	-24.09%
Cefdinir	3,291	41	1,977	72	-39.93%
Sulfamethoxazole-Trimethoprim	1,775	80	1,937	73	9.13%
Folic Acid	1,817	78	1,899	74	4.51%
guanFACINE HCl	2,161	71	1,891	75	-12.49%
valACYclovir HCl	1,819	77	1,888	76	3.79%
Citalopram Hydrobromide	1,940	76	1,881	77	-3.04%

Lisdexamfetamine Dimesylate	1,172	106	1,836	78	56.66%
guanFACINE HCl ER	2,036	74	1,833	79	-9.97%
Pregabalin	1,797	79	1,831	80	1.89%
OLANZapine	1,758	82	1,777	81	1.08%
Eliquis	1,600	86	1,690	82	5.63%
tiZANidine HCl	1,603	85	1,665	83	3.87%
Symbicort	1,765	81	1,655	84	-6.23%
Tamsulosin HCl	1,556	89	1,642	85	5.53%
Albuterol Sulfate	2,207	68	1,624	86	-26.42%
FeroSul	1,627	84	1,613	87	-0.86%
Mupirocin	1,399	97	1,612	88	15.23%
Diclofenac Sodium	1,519	91	1,585	89	4.34%
Naproxen	1,563	88	1,549	90	-0.90%
Carvedilol	1,466	93	1,486	91	1.36%
Methylphenidate HCl	1,718	83	1,475	92	-14.14%
Atomoxetine HCl	1,552	90	1,449	93	-6.64%
Baclofen	1,402	96	1,444	94	3.00%
Ondansetron HCl	1,586	87	1,434	95	-9.58%
Lisinopril-hydroCHLOROthiazide	1,442	94	1,405	96	-2.57%
Zolpidem Tartrate	1,416	95	1,389	97	-1.91%
Clopidogrel Bisulfate	1,312	101	1,373	98	4.65%
Vraylar	1,242	104	1,304	99	4.99%
Acetaminophen Extra Strength	1,148	107	1,302	100	13.41%

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Quarterly Monthly Statistics

CATEGORY	March 2024 / May 2024	June 2024 / August 2024	% CHANGE
TOTAL PAID AMOUNT	$98,932,020	$97,248,376	-1.7%
UNIQUE USERS	108,090	98,025	-9.3%
COST PER USER	$915.27	$992.08	8.4%
TOTAL PRESCRIPTIONS	861,423	811,300	-5.8%
AVERAGE PRESCRIPTIONS PER USER	7.97	8.28	3.9%
AVERAGE COST PER PRESCRIPTION	$114.85	$119.87	4.4%
# GENERIC PRESCRIPTIONS	769,598	724,003	-5.9%
% GENERIC	89.34%	89.24%	-0.1%
$ GENERIC	$13,432,896	$12,905,161	-3.9%
AVERAGE GENERIC PRESCRIPTION COST	$17.45	$17.82	2.1%
AVERAGE GENERIC DAYS SUPPLY	25.74	26.12	1.5%
# BRAND PRESCRIPTIONS	91,825	87,297	-4.9%
% BRAND	10.66%	10.76%	0.9%
$ BRAND	$85,499,124	$84,343,215	-1.4%
AVERAGE BRAND PRESCRIPTION COST	$931.11	$966.16	3.8%
AVERAGE BRAND DAYS SUPPLY	27.52	27.56	0.1%

UTILIZATION BY AGE		
AGE	March 2024 / May 2024	June 2024 / August 2024
0-6	37,923	27,046
7-12	60,398	52,559
13-18	81,495	74,354
19-64	681,538	657,289
65+	8,501	8,271
TOTAL	869,855	819,519

UTILIZATION BY GENDER AND AGE			
GENDER	AGE	March 2024 / May 2024	June 2024 / August 2024
F			
	0-6	16,277	11,675
	7-12	23,710	20,645
	13-18	42,531	38,645
	19-64	454,161	437,846
	65+	5,488	5,343
	Gender Total	542,167	514,154
M			
	0-6	21,646	15,371
	7-12	36,688	31,914
	13-18	38,964	35,709
	19-64	227,377	219,443

M	65+	3,013	2,928
	Gender Total	327,688	305,365
Grand Total		869,855	819,519

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June 2024 / August 2024

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	12,152	$5,638,646.85	$464.01	1
2	WALGREENS #4405	COUNCIL BLUFFS	IA	7,533	$589,260.17	$78.22	2
3	WALGREENS #5239	DAVENPORT	IA	6,534	$347,501.34	$53.18	3
4	WALGREENS #5042	CEDAR RAPIDS	IA	6,493	$446,118.83	$68.71	4
5	RIGHT DOSE PHARMACY	ANKENY	IA	6,165	$239,940.23	$38.92	5
6	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	6,057	$434,756.93	$71.78	15
7	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	5,335	$475,128.38	$89.06	6
8	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,710	$324,834.77	$68.97	9
9	DRILLING PHARMACY	SIOUX CITY	IA	4,375	$336,473.31	$76.91	8
10	WALGREENS #5721	DES MOINES	IA	4,368	$283,597.14	$64.93	12
11	HY-VEE PHARMACY (1075)	CLINTON	IA	4,307	$332,095.69	$77.11	7
12	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	4,277	$304,395.05	$71.17	11
13	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,250	$306,181.51	$72.04	10
14	WALGREENS #359	DES MOINES	IA	4,166	$260,962.65	$62.64	16
15	HARTIG PHARMACY SERVICES	DUBUQUE	IA	4,161	$279,354.84	$67.14	17
16	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,101	$201,233.84	$49.07	20
17	WALGREENS #7453	DES MOINES	IA	4,057	$220,712.42	$54.40	19
18	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,025	$281,074.14	$69.83	13
19	WALGREENS #4041	DAVENPORT	IA	3,950	$219,568.39	$55.59	18
20	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	3,949	$251,927.84	$63.80	14

21	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,823	$316,792.79	$82.86	23
22	WALMART PHARMACY 10-1509	MAQUOKETA	IA	3,764	$285,928.47	$75.96	21
23	WALGREENS #15647	SIOUX CITY	IA	3,624	$228,528.35	$63.06	25
24	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,569	$232,950.23	$65.27	27
25	WALGREENS #7455	WATERLOO	IA	3,564	$198,264.39	$55.63	22
26	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	3,486	$308,643.06	$88.54	28
27	WALGREENS #3700	COUNCIL BLUFFS	IA	3,463	$244,146.87	$70.50	30
28	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,421	$373,130.50	$109.07	24
29	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	3,415	$247,685.90	$72.53	87
30	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,367	$251,747.65	$74.77	29
31	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,357	$265,575.56	$79.11	33
32	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	3,301	$122,423.08	$37.09	31
33	NUCARA LTC PHARMACY #3	IOWA CITY	IA	3,244	$104,707.37	$32.28	26
34	WAGNER PHARMACY	CLINTON	IA	3,233	$226,969.15	$70.20	38
35	WALGREENS #9708	DUBUQUE	IA	3,195	$223,775.31	$70.04	32
36	CVS PHARMACY #08658	DAVENPORT	IA	3,075	$228,770.34	$74.40	42
37	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,021	$239,458.40	$79.26	41
38	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,972	$200,850.19	$67.58	40
39	HY-VEE PHARMACY (1449)	NEWTON	IA	2,940	$178,424.28	$60.69	35
40	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	2,927	$231,347.21	$79.04	55
41	WALGREENS #11942	DUBUQUE	IA	2,919	$193,197.09	$66.19	36
42	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,887	$221,330.30	$76.66	46
43	HY-VEE PHARMACY (1396)	MARION	IA	2,870	$228,186.03	$79.51	37
44	MAHASKA DRUGS INC	OSKALOOSA	IA	2,860	$216,039.49	$75.54	43

45	WALGREENS #3875	CEDAR RAPIDS	IA	2,824	$184,734.36	$65.42	64
46	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	2,808	$84,809.01	$30.20	34
47	WALMART PHARMACY 10-5115	DAVENPORT	IA	2,785	$217,803.37	$78.21	49
48	CVS PHARMACY #10282	FORT DODGE	IA	2,767	$156,206.92	$56.45	39
49	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,735	$198,660.40	$72.64	50
50	LAGRANGE PHARMACY	VINTON	IA	2,712	$197,329.51	$72.76	52
51	WALMART PHARMACY 10-2889	CLINTON	IA	2,655	$158,589.53	$59.73	47
52	HY-VEE PHARMACY (1433)	MT PLEASANT	IA	2,633	$175,577.76	$66.68	45
53	CVS PHARMACY #08544	WATERLOO	IA	2,630	$154,829.51	$58.87	51
54	PREFERRED CARE PHARMACY	CEDAR RAPIDS	IA	2,606	$220,337.78	$84.55	108
55	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,596	$248,013.36	$95.54	48
56	UNION PHARMACY	COUNCIL BLUFFS	IA	2,519	$198,078.84	$78.63	53
57	MEDICAP PHARMACY	KNOXVILLE	IA	2,507	$243,560.90	$97.15	65
58	WALMART PHARMACY 10-0985	FAIRFIELD	IA	2,505	$173,676.54	$69.33	54
59	OSTERHAUS PHARMACY	MAQUOKETA	IA	2,461	$137,033.48	$55.68	56
60	SCOTT PHARMACY	FAYETTE	IA	2,448	$181,901.62	$74.31	57
61	SOUTH SIDE DRUG	OTTUMWA	IA	2,422	$200,537.34	$82.80	67
62	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,418	$163,884.55	$67.78	73
63	WALGREENS #3595	DAVENPORT	IA	2,416	$147,993.16	$61.26	74
64	HY-VEE PHARMACY (1065)	CHARITON	IA	2,412	$155,751.76	$64.57	68
65	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,356	$172,521.64	$73.23	60
66	MERCYONE FOREST PARK PHARMACY	MASON CITY	IA	2,335	$176,683.31	$75.67	61
67	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,326	$193,332.75	$83.12	62
68	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	2,320	$67,684.26	$29.17	71

69	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,313	$201,198.27	$86.99	122
70	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,308	$195,057.49	$84.51	58
71	WALGREENS #5470	SIOUX CITY	IA	2,285	$151,359.80	$66.24	79
72	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,284	$147,280.90	$64.48	59
73	HY-VEE PHARMACY (1895)	WINDSOR HEIGHTS	IA	2,283	$130,104.21	$56.99	78
74	DANIEL PHARMACY	FT DODGE	IA	2,256	$158,378.91	$70.20	77
75	HY-VEE DRUGSTORE #5 (7026)	CEDAR RAPIDS	IA	2,250	$162,866.75	$72.39	80
76	HY-VEE PHARMACY (1382)	LEMARS	IA	2,246	$145,269.67	$64.68	82
77	WALMART PHARMACY 10-3394	ATLANTIC	IA	2,244	$158,354.71	$70.57	75
78	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	2,240	$179,102.81	$79.96	89
79	WALGREENS #7454	ANKENY	IA	2,236	$121,619.66	$54.39	85
80	HY-VEE PHARMACY #6 (1155)	DES MOINES	IA	2,228	$190,394.23	$85.46	105
81	MEDICAP LTC	INDIANOLA	IA	2,217	$68,376.23	$30.84	63
82	WALMART PHARMACY 10-0646	ANAMOSA	IA	2,210	$154,706.47	$70.00	97
83	HY-VEE PHARMACY (1850)	WASHINGTON	IA	2,206	$156,837.40	$71.10	76
84	WALGREENS #7452	DES MOINES	IA	2,200	$143,768.05	$65.35	84
85	WALGREENS #3876	MARION	IA	2,191	$157,317.49	$71.80	102
86	WALGREENS #10855	WATERLOO	IA	2,165	$142,711.05	$65.92	116
87	CVS PHARMACY #10032	MARION	IA	2,126	$138,351.16	$65.08	92
88	HY-VEE PHARMACY (1241)	HARLAN	IA	2,124	$206,680.63	$97.31	86
89	MEDICAP PHARMACY	CRESTON	IA	2,124	$154,240.67	$72.62	98
90	HY-VEE PHARMACY #2 (1018)	AMES	IA	2,098	$192,109.26	$91.57	94
91	WALGREENS #12393	CEDAR RAPIDS	IA	2,089	$141,979.30	$67.97	91
92	PREFERRED CARE PHARMACY	BETTENDORF	IA	2,086	$162,701.82	$78.00	88

93	HY-VEE PHARMACY #3 (1107)	DAVENPORT	IA	2,080	$157,071.79	$75.52	104
94	MEDICAP PHARMACY	DES MOINES	IA	2,075	$218,604.21	$105.35	138
95	WALGREENS #5044	BURLINGTON	IA	2,062	$107,167.84	$51.97	69
96	HY-VEE PHARMACY (1271)	INDIANOLA	IA	2,053	$124,504.78	$60.65	99
97	WALMART PHARMACY 10-0784	MT PLEASANT	IA	2,050	$122,835.49	$59.92	66
98	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,049	$100,469.74	$49.03	100
99	WALGREENS #5852	DES MOINES	IA	2,048	$126,602.19	$61.82	72
100	STANGEL PHARMACY	ONAWA	IA	2,041	$159,357.26	$78.08	83

TOP 100 PHARMACIES BY PAID AMOUNT
June 2024 / August 2024

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	12,152	$5,638,646.85	$2,581.80	1
2	CVS/SPECIALTY	MONROEVILLE	PA	517	$4,377,081.54	$20,744.46	2
3	COMMUNITY, A WALGREENS PHARMACY #16528	DES MOINES	IA	794	$3,226,660.07	$13,116.50	4
4	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	407	$3,105,921.09	$18,710.37	3
5	UNITYPOINT AT HOME	URBANDALE	IA	808	$2,727,780.88	$10,411.38	5
6	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	274	$2,484,597.10	$27,606.63	6
7	COMMUNITY, A WALGREENS PHARMACY #21250	IOWA CITY	IA	554	$2,277,333.19	$12,178.25	7
8	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	67	$1,428,732.71	$59,530.53	11
9	AMBER SPECIALTY PHARMACY	OMAHA	NE	232	$1,210,216.91	$16,354.28	8
10	CVS PHARMACY #00102	AURORA	CO	132	$1,192,019.74	$24,326.93	9
11	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,185	$1,112,655.48	$9,045.98	10
12	ALLIANCERX WALGREENS PHARMACY #16280	FRISCO	TX	41	$955,644.41	$79,637.03	13
13	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	54	$824,094.52	$43,373.40	12
14	BIOPLUS SPECIALTY PHARMACY SERVICES, LLC	ALTAMONTE SPRINGS	FL	95	$650,133.99	$14,447.42	48
15	KROGER SPECIALTY PHARMACY LA	HARVEY	LA	68	$619,448.56	$18,771.17	16
16	ANOVORX GROUP LLC	MEMPHIS	TN	48	$613,588.06	$36,093.42	24
17	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	38	$589,923.98	$42,137.43	18
18	WALGREENS #4405	COUNCIL BLUFFS	IA	7,533	$589,260.17	$469.53	17
19	WALGREENS #16270	OMAHA	NE	100	$558,787.28	$23,282.80	14

20	ORSINI PHARMACEUTICAL SERVICES LLC	ELK GROVE VILLAGE	IL	35	$528,707.63	$40,669.82	15
21	SOLEO HEALTH INC.	WOODRIDGE	IL	6	$485,612.88	$485,612.88	65
22	BIOLOGICS BY MCKESSON	CARY	NC	27	$481,844.79	$48,184.48	20
23	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	5,335	$475,128.38	$917.24	22
24	EVERSANA LIFE SCIENCE SERVICES, LLC	CHESTERFIELD	MO	16	$468,214.14	$78,035.69	21
25	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,958	$452,639.71	$2,473.44	25
26	WALGREENS #5042	CEDAR RAPIDS	IA	6,493	$446,118.83	$362.40	23
27	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	6,057	$434,756.93	$645.04	62
28	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	1,993	$417,893.08	$2,154.09	33
29	THE NEBRASKA MEDICAL CENTER CLINIC PHARMACY	OMAHA	NE	662	$400,126.04	$3,226.82	35
30	MISSION CANCER + BLOOD	DES MOINES	IA	51	$389,419.76	$22,907.04	29
31	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	91	$382,838.82	$17,401.76	28
32	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,421	$373,130.50	$769.34	31
33	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,871	$369,615.36	$2,042.07	32
34	PANTHERX SPECIALTY PHARMACY	CORAOPOLIS	PA	34	$353,800.51	$20,811.79	0
35	WALGREENS #5239	DAVENPORT	IA	6,534	$347,501.34	$292.26	30
36	DRILLING PHARMACY	SIOUX CITY	IA	4,375	$336,473.31	$961.35	34
37	MAYO CLINIC PHARMACY	ROCHESTER	MN	70	$332,820.20	$22,188.01	26
38	HY-VEE PHARMACY (1075)	CLINTON	IA	4,307	$332,095.69	$653.73	36
39	ALLEN CLINIC PHARMACY	WATERLOO	IA	894	$326,390.14	$1,213.35	42
40	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,710	$324,834.77	$572.90	41
41	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,823	$316,792.79	$790.01	38
42	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	47	$311,941.70	$14,179.17	59
43	GENESIS FIRSTMED PHARMACY	DAVENPORT	IA	706	$309,122.14	$1,776.56	27

44	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	3,486	$308,643.06	$637.69	60
45	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,250	$306,181.51	$535.28	49
46	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	4,277	$304,395.05	$458.43	46
47	ACARIAHEALTH PHARMACY #11	HOUSTON	TX	22	$285,956.11	$25,996.01	37
48	WALMART PHARMACY 10-1509	MAQUOKETA	IA	3,764	$285,928.47	$569.58	40
49	WALGREENS #5721	DES MOINES	IA	4,368	$283,597.14	$298.21	47
50	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,025	$281,074.14	$542.61	45
51	HARTIG PHARMACY SERVICES	DUBUQUE	IA	4,161	$279,354.84	$928.09	39
52	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	1,642	$270,342.02	$2,703.42	43
53	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,357	$265,575.56	$649.33	44
54	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	7	$261,174.58	$43,529.10	19
55	WALGREENS #359	DES MOINES	IA	4,166	$260,962.65	$303.80	63
56	ALLIANCERX WALGREENS PHARMACY #15443	FRISCO	TX	18	$257,000.49	$36,714.36	99
57	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	3,949	$251,927.84	$525.95	55
58	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,367	$251,747.65	$584.10	58
59	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,596	$248,013.36	$858.18	54
60	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	3,415	$247,685.90	$513.87	128
61	INFOCUS PHARMACY SERVICES LLC	DUBUQUE	IA	1,956	$244,629.26	$1,027.85	50
62	WALGREENS #3700	COUNCIL BLUFFS	IA	3,463	$244,146.87	$383.28	67
63	MEDICAP PHARMACY	KNOXVILLE	IA	2,507	$243,560.90	$1,006.45	53
64	RIGHT DOSE PHARMACY	ANKENY	IA	6,165	$239,940.23	$771.51	66
65	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,021	$239,458.40	$817.26	57
66	SANFORD CANCER CENTER ONCOLOGY CLINIC PHARMACY	SIOUX FALLS	SD	58	$238,727.32	$14,920.46	115
67	PARAGON PARTNERS	OMAHA	NE	793	$233,642.46	$2,957.50	121

68	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,569	$232,950.23	$529.43	76
69	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	2,927	$231,347.21	$1,028.21	73
70	CVS PHARMACY #08658	DAVENPORT	IA	3,075	$228,770.34	$579.17	71
71	WALGREENS #15647	SIOUX CITY	IA	3,624	$228,528.35	$313.05	52
72	HY-VEE PHARMACY (1396)	MARION	IA	2,870	$228,186.03	$539.45	68
73	WAGNER PHARMACY	CLINTON	IA	3,233	$226,969.15	$665.60	69
74	WALGREENS #9708	DUBUQUE	IA	3,195	$223,775.31	$330.05	74
75	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,887	$221,330.30	$614.81	56
76	WALGREENS #7453	DES MOINES	IA	4,057	$220,712.42	$328.44	86
77	PREFERRED CARE PHARMACY	CEDAR RAPIDS	IA	2,606	$220,337.78	$1,449.59	104
78	ONCO360	LOUISVILLE	KY	23	$219,823.49	$27,477.94	64
79	WALGREENS #4041	DAVENPORT	IA	3,950	$219,568.39	$304.96	77
80	MEDICAP PHARMACY	DES MOINES	IA	2,075	$218,604.21	$1,917.58	83
81	WALMART PHARMACY 10-5115	DAVENPORT	IA	2,785	$217,803.37	$535.14	79
82	MAHASKA DRUGS INC	OSKALOOSA	IA	2,860	$216,039.49	$577.65	61
83	MERCYONE WATERLOO PHARMACY	WATERLOO	IA	1,550	$211,915.66	$632.58	146
84	MEDICAP PHARMACY	NEWTON	IA	2,031	$211,341.39	$1,072.80	78
85	HY-VEE PHARMACY (1241)	HARLAN	IA	2,124	$206,680.63	$633.99	93
86	FIFIELD PHARMACY	DES MOINES	IA	1,421	$205,898.28	$1,449.99	72
87	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,101	$201,233.84	$356.17	82
88	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,313	$201,198.27	$698.61	150
89	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,972	$200,850.19	$517.66	105
90	SOUTH SIDE DRUG	OTTUMWA	IA	2,422	$200,537.34	$646.89	84

91	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,735	$198,660.40	$462.00	102
92	WALGREENS #7455	WATERLOO	IA	3,564	$198,264.39	$252.24	80
93	UNION PHARMACY	COUNCIL BLUFFS	IA	2,519	$198,078.84	$952.30	75
94	LAGRANGE PHARMACY	VINTON	IA	2,712	$197,329.51	$685.17	70
95	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,308	$195,057.49	$530.05	87
96	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,326	$193,332.75	$642.30	89
97	WALGREENS #11942	DUBUQUE	IA	2,919	$193,197.09	$396.71	94
98	HY-VEE PHARMACY #2 (1018)	AMES	IA	2,098	$192,109.26	$655.66	112
99	HY-VEE PHARMACY #6 (1155)	DES MOINES	IA	2,228	$190,394.23	$869.38	117
100	HARTIG DRUG CO	DUBUQUE	IA	1,233	$188,212.61	$909.24	90

TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
June 2024 / August 2024

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$112,802.75	1,959	5.75	1
2	1215146055	Rebecca Wolfe	$77,795.77	1,582	2.76	3
3	1467502286	Charles Tilley	$145,394.31	1,521	3.61	4
4	1730434069	Larissa Biscoe	$87,464.80	1,467	3.33	5
5	1063491645	Allyson Wheaton	$107,942.44	1,377	2.53	9
6	1467907394	Cynthia Coenen	$153,068.83	1,348	4.20	6
7	1922455096	Dean Guerdet	$85,349.78	1,316	3.68	10
8	1316356496	Kimberly Roberts	$53,825.52	1,240	3.68	8
9	1437238110	Genevieve Nelson	$180,298.37	1,207	3.27	11
10	1659358620	Carlos Castillo	$35,299.14	1,170	3.03	12
11	1629036546	Anita Simison	$78,901.90	1,138	2.89	7
12	1902850845	Deborah Bahe	$85,026.85	1,126	4.04	26
13	1356359871	Rhea Hartley	$90,305.90	1,115	2.34	13
14	1770933046	Shelby Biller	$183,245.62	1,096	2.71	15
15	1457584740	Eric Meyer	$74,552.20	1,087	2.89	17
16	1356096572	Natasha Lash	$121,463.74	1,062	3.19	2
17	1164538674	Joseph Wanzek	$96,779.69	1,030	4.29	24
18	1902478811	Joan Anderson	$274,551.21	1,024	3.31	16
19	1790163848	Hesper Nowatzki	$151,127.97	1,018	3.26	18
20	1043418809	Michael Ciliberto	$511,985.62	1,010	2.94	20

21	1043434525	Robert Kent	$44,862.28	1,009	3.59	14
22	1043211303	Ali Safdar	$150,979.60	999	2.68	22
23	1902912538	Christian Jones	$67,109.46	972	2.95	23
24	1902358443	Melissa Konken	$174,477.80	971	3.36	27
25	1982030946	Jacklyn Besch	$47,236.29	966	3.24	21
26	1528365277	Mina Salib	$822,417.33	927	2.09	33
27	1609218304	Amanda Garr	$152,583.08	918	3.27	31
28	1215184726	Babuji Gandra	$36,172.20	905	2.64	25
29	1801998372	Wendy Hansen-Penman	$34,443.48	877	3.69	44
30	1316471154	Nicole Woolley	$49,296.17	873	2.77	30
31	1013115369	Bobbita Nag	$33,716.11	863	2.19	28
32	1992103386	Melissa Larsen	$69,352.80	863	3.11	43
33	1215125216	Rebecca Walding	$92,536.88	857	4.33	34
34	1275763047	Rebecca Bowman	$167,211.55	846	3.40	40
35	1417549932	Amanda McCormick	$87,953.59	843	3.39	35
36	1013639749	Robert Husemann	$76,509.68	838	3.48	37
37	1609532373	Erin Fox-Hammel	$78,325.46	833	3.34	51
38	1184657603	Sara Rygol	$93,475.22	832	3.37	56
39	1437209434	Jon Thomas	$38,462.71	825	2.93	32
40	1134191018	Dustin Smith	$53,619.41	824	3.47	36
41	1134854128	Dzevida Pandzic	$60,351.18	815	2.33	38
42	1558770974	Marc Baumert	$44,822.92	804	2.97	49
43	1730849647	Melanie Rock	$29,031.08	804	2.82	54
44	1528037082	Rodney Dean	$48,675.39	793	3.99	63

45	1689077018	Stacy Roth	$53,401.56	791	2.78	53
46	1528329398	Erin Rowan	$30,241.99	790	3.21	54
47	1013499029	Spencer Kissel	$133,270.09	789	2.61	19
48	1205393386	Jessica Hudspeth	$119,773.56	789	4.11	29
49	1477199198	Sajo Thomas	$116,194.09	779	3.14	75
50	1538368170	Christopher Matson	$20,444.57	766	3.03	45
51	1881008704	Charity Carstensen	$51,266.32	761	4.45	84
52	1053963900	Nicole Mcclavy	$121,054.32	752	3.07	58
53	1922144088	Thomas Hopkins	$30,493.33	750	2.29	41
54	1477926434	Jackie Shipley	$28,408.18	749	2.86	46
55	1649248378	Kathleen Wild	$34,558.98	748	2.89	39
56	1356315311	David Nystrom	$20,767.84	738	7.35	706
57	1457914657	Seema Antony	$68,360.19	738	2.77	42
58	1457007270	Lindsay Schock	$62,906.36	734	2.82	47
59	1639607757	Michael Gerber	$74,690.30	730	3.28	63
60	1679573893	Patty Hildreth	$211,311.93	730	3.22	61
61	1144588476	Rachel Filzer	$60,043.11	716	2.88	68
62	1255405338	Bryan Netolicky	$104,372.60	712	2.74	50
63	1588662050	Jason Davis	$40,002.16	709	2.78	111
64	1386044832	Mary Grieder	$41,075.98	706	5.22	59
65	1538149042	Eric Petersen	$23,618.99	703	3.79	67
66	1356724405	Beth Colon	$98,576.27	700	2.55	66
67	1275067696	Olaitan Ijitimehin	$29,312.00	695	2.85	60
68	1902596828	Lindsay Harms	$50,181.58	695	3.81	87

69	1396181012	Heather Kruse	$66,895.59	689	4.99	73
70	1609496033	Angela Dossett	$128,635.44	683	5.28	160
71	1316510324	Sandy Marcus	$35,869.88	680	3.17	47
72	1619153137	Joada Best	$52,584.36	680	3.15	62
73	1053630640	Jennifer Donovan	$63,430.43	679	3.07	97
74	1710941000	Laurie Warren	$95,365.95	677	3.65	69
75	1003470923	Earlene Angell	$81,484.77	669	3.04	248
76	1144214248	Kristi Walz	$72,741.12	668	3.82	83
77	1790013209	Tracy Tschudi	$111,811.75	668	3.20	82
78	1972758126	Rebecca Bollin	$33,348.34	667	3.09	112
79	1124006770	Wook Kim	$32,282.08	665	2.96	77
80	1609946243	Sina Linman	$37,857.27	663	2.34	52
81	1871105916	Lacie Theis	$33,907.51	660	2.73	80
82	1417214321	Leah Brandon	$24,896.60	659	4.33	96
83	1013978089	Jennifer Bradley	$167,749.02	657	4.93	110
84	1821268335	Jacqueline McInnis	$121,071.17	656	3.53	76
85	1003330036	Evan Peterson	$26,028.38	653	2.69	65
86	1114544681	Rachael Ploessl	$54,645.97	651	3.06	88
87	1245227099	Donna Dobson Tobin	$79,245.11	649	3.77	91
88	1942721584	Shawna Fury	$36,517.04	649	2.77	71
89	1891707832	Lisa Klock	$34,848.96	648	2.54	145
90	1306559786	Roy Henry	$22,862.40	644	2.63	309
91	1588838841	Leenu Mishra	$29,530.85	642	2.75	94
92	1568431880	Pomilla Kumar	$29,731.98	630	3.63	103

93	1255823506	Nicole Delagardelle	$115,395.77	622	2.73	120
94	1649438383	Qadnana Anwar	$29,567.52	619	3.24	102
95	1619380680	Tara Brockman	$28,309.85	618	2.48	92
96	1295967255	Mary Robinson	$40,967.72	617	3.86	106
97	1073945499	Jennifer Zalaznik	$41,697.17	613	3.93	128
98	1407585623	Colette Demoss	$102,676.45	607	3.46	334
99	1821333774	Brittni Benda	$49,318.34	604	2.03	85
100	1003053653	Stanley Mathew	$36,348.29	603	5.68	393

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June 2024 / August 2024

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
1	1326034984	Katherine Mathews	$1,011,260.56	$13,133.25	77	1
2	1528365277	Mina Salib	$822,417.33	$887.18	927	2
3	1326211889	James Friedlander	$756,671.16	$14,551.37	52	9
4	1477761328	Amy Calhoun	$655,473.40	$9,499.61	69	3
5	1437121407	Linda Cadaret	$654,152.28	$6,289.93	104	4
6	1316934318	Steven Lentz	$596,297.79	$16,563.83	36	7
7	1417443953	Rodney Clark	$591,703.42	$1,232.72	480	5
8	1841632965	Ahmad Al-Huniti	$586,532.38	$39,102.16	15	16
9	1295091510	Rebecca Weiner	$520,198.66	$1,667.30	312	12
10	1043418809	Michael Ciliberto	$511,985.62	$506.92	1010	6
11	1891146999	Becky Johnson	$388,913.63	$937.14	415	8
12	1023108701	Ronald Zolty	$381,212.06	$6,687.93	57	10
13	1285626390	Kathleen Gradoville	$372,756.58	$1,109.39	336	15
14	1942937388	Carly Trausch	$331,908.35	$1,021.26	325	22
15	1306071915	Thomas Pietras	$327,660.91	$2,100.39	156	11
16	1932153830	Michael Stephens	$281,331.70	$23,444.31	12	24
17	1992365894	Emily Weig	$281,159.30	$2,579.44	109	102
18	1700417169	Courtney Reints	$278,592.33	$814.60	342	13
19	1649943689	Jessica Coffey	$276,505.65	$1,348.81	205	45
20	1902478811	Joan Anderson	$274,551.21	$268.12	1024	18

21	1447373832	Joshua Wilson	$267,294.01	$6,364.14	42	23
22	1174748180	Mohammad Alsharabati	$267,281.90	$1,316.66	203	25
23	1013126705	Janice Staber	$261,537.33	$6,706.09	39	20
24	1174584072	Bradley Lair	$249,844.13	$4,383.23	57	19
25	1144455502	Jennifer Petts	$239,163.62	$988.28	242	192
26	1184056822	Abby Kolthoff	$238,494.48	$426.64	559	55
27	1952420705	Eric Rush	$229,985.52	$57,496.38	4	31
28	1386084747	Jennifer Condon	$229,350.59	$913.75	251	50
29	1043565328	Sara Moeller	$228,720.22	$2,178.29	105	33
30	1265064471	Lee Witt	$220,512.90	$14,700.86	15	8334
31	1821046087	Archana Verma	$217,335.80	$3,395.87	64	21
32	1871868984	Hana Niebur	$215,293.41	$3,312.21	65	34
33	1255658175	Ashley Deschamp	$215,054.14	$2,560.17	84	132
34	1932464971	Kari Ernst	$211,361.00	$1,975.34	107	36
35	1679573893	Patty Hildreth	$211,311.93	$289.47	730	44
36	1376525196	Randolph Rough	$208,741.41	$1,153.27	181	32
37	1427178284	Darcy Krueger	$208,493.66	$13,030.85	16	85
38	1649826140	Taylor Boldt	$207,093.69	$1,534.03	135	93
39	1609820240	James Harper	$206,645.13	$12,155.60	17	35
40	1144900861	Lizabeth Sheets	$202,697.75	$452.45	448	176
41	1508091109	Melissa Muff-Luett	$201,506.06	$6,297.06	32	41
42	1285748004	Bruce Hughes	$200,246.46	$2,781.20	72	26
43	1902191059	Amber Tierney	$196,053.50	$3,630.62	54	29
44	1720086523	Mark Cleveland	$193,629.57	$2,652.46	73	17

45	1285620583	Michael Tansey	$191,276.78	$1,494.35	128	70
46	1134249832	Steven Craig	$190,411.21	$2,294.11	83	40
47	1053520759	Alicia Gerke	$189,964.73	$4,522.97	42	105
48	1467449579	Brian Wayson	$189,869.02	$2,751.72	69	28
49	1144807876	Kathryn Kaufman	$189,093.09	$2,555.31	74	38
50	1326410499	Tara Eastvold	$188,956.88	$464.27	407	49
51	1841607900	Shayla Sanders	$188,149.75	$1,980.52	95	103
52	1770933046	Shelby Biller	$183,245.62	$167.19	1096	27
53	1659093292	Kathryn Foy	$180,436.96	$1,491.21	121	39
54	1437238110	Genevieve Nelson	$180,298.37	$149.38	1207	62
55	1225263833	Lindsay Orris	$178,183.73	$1,329.73	134	75
56	1194176586	Paul Fenton	$176,733.78	$1,785.19	99	201
57	1285710764	Jitendrakumar Gupta	$174,949.15	$609.58	287	78
58	1013026798	Stephen Grant	$174,596.40	$3,357.62	52	94
59	1902358443	Melissa Konken	$174,477.80	$179.69	971	60
60	1578958542	Heidi Curtis	$172,808.72	$1,183.62	146	90
61	1366858334	Alicia Duyvejonck	$169,643.11	$467.34	363	53
62	1013978089	Jennifer Bradley	$167,749.02	$255.33	657	67
63	1467561464	Timothy Feyma	$167,351.22	$4,648.65	36	122
64	1275763047	Rebecca Bowman	$167,211.55	$197.65	846	74
65	1730293705	Robert Jackson	$167,092.78	$2,088.66	80	43
66	1487648705	Karen Hunke	$164,046.28	$932.08	176	117
67	1730406356	Christina Warren	$161,076.14	$1,202.06	134	92
68	1073722112	Riad Rahhal	$160,627.75	$603.86	266	68

69	1801405832	Sarah Hiemer	$156,798.45	$1,081.37	145	89
70	1649419219	Heather Hunemuller	$154,754.59	$937.91	165	65
71	1487630489	Jason Wittmer	$153,230.31	$2,220.73	69	171
72	1154307114	Gena Ghearing	$153,113.37	$417.20	367	79
73	1467907394	Cynthia Coenen	$153,068.83	$113.55	1348	47
74	1609218304	Amanda Garr	$152,583.08	$166.21	918	81
75	1538676150	Megan Dietzel	$152,123.32	$2,535.39	60	64
76	1790163848	Hesper Nowatzki	$151,127.97	$148.46	1018	82
77	1043211303	Ali Safdar	$150,979.60	$151.13	999	80
78	1558887174	Melissa Halverson	$149,781.97	$1,576.65	95	180
79	1699765826	Joseph Merchant	$148,966.42	$1,839.09	81	51
80	1740953439	Wilmar Garcia	$145,997.86	$1,604.37	91	72
81	1124216676	Wendy Sanders	$145,975.37	$433.16	337	54
82	1467502286	Charles Tilley	$145,394.31	$95.59	1521	63
83	1104891704	Akshay Mahadevia	$144,758.52	$1,539.98	94	56
84	1588616171	Heather Thomas	$143,408.83	$2,048.70	70	30
85	1437533130	Katie Broshuis	$142,866.16	$1,373.71	104	154
86	1609003011	John Bernat	$141,015.34	$20,145.05	7	91
87	1366065047	Brittania Schoon	$140,445.79	$1,418.64	99	69
88	1184395162	Danielle Van Oosbree	$140,049.59	$242.72	577	84
89	1770716193	Aleksander Lenert	$139,410.49	$3,400.26	41	144
90	1932153822	Christian Schultheis	$138,170.95	$4,764.52	29	114
91	1255743928	Christine Gill	$137,646.13	$1,911.75	72	155
92	1104933878	David Mercer	$137,155.43	$4,286.11	32	187

93	1972869717	Fadi Alkhatib	$134,694.69	$312.52	431	99
94	1013499029	Spencer Kissel	$133,270.09	$168.91	789	46
95	1548611841	Adnan Kiani	$131,257.90	$2,524.19	52	59
96	1063792026	Jill Miller	$131,109.34	$254.58	515	106
97	1952539447	Anthony Fischer	$130,760.65	$1,614.33	81	14
98	1588288385	Jenifer Jones	$128,768.69	$1,384.61	93	57
99	1609496033	Angela Dossett	$128,635.44	$188.34	683	153
100	1245468768	Thomas Schmidt	$128,536.31	$2,178.58	59	126

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March 2024 / May 2024	RANK	% BUDGET	June 2024 / August 2024	RANK	% BUDGET	% CHANGE
ANTIDIABETICS	$12,060,590	1	12.2%	$12,261,715	1	12.6%	1.7%
DERMATOLOGICALS	$10,668,591	2	10.8%	$10,851,166	2	11.2%	1.7%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$10,513,488	3	10.6%	$10,305,141	3	10.6%	-2.0%
ANALGESICS - ANTI-INFLAMMATORY	$8,322,711	4	8.4%	$8,045,404	4	8.3%	-3.3%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$5,857,446	5	5.9%	$5,406,748	5	5.6%	-7.7%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$5,487,908	6	5.5%	$5,336,370	6	5.5%	-2.8%
ANTICONVULSANTS	$3,573,046	7	3.6%	$3,543,742	7	3.6%	-0.8%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$3,572,678	8	3.6%	$3,510,845	8	3.6%	-1.7%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,450,792	10	3.5%	$3,330,526	9	3.4%	-3.5%
ANTIVIRALS	$3,562,195	9	3.6%	$3,266,327	10	3.4%	-8.3%
HEMATOLOGICAL AGENTS - MISC.	$2,610,769	15	2.6%	$3,130,094	11	3.2%	19.9%
MIGRAINE PRODUCTS	$3,175,637	11	3.2%	$3,049,445	12	3.1%	-4.0%
RESPIRATORY AGENTS - MISC.	$2,720,393	13	2.7%	$2,646,374	13	2.7%	-2.7%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$2,973,400	12	3.0%	$2,623,726	14	2.7%	-11.8%
CARDIOVASCULAR AGENTS - MISC.	$2,657,459	14	2.7%	$2,394,090	15	2.5%	-9.9%
ANTIDEPRESSANTS	$2,326,839	16	2.4%	$2,203,042	16	2.3%	-5.3%
GASTROINTESTINAL AGENTS - MISC.	$1,483,924	18	1.5%	$1,698,436	17	1.7%	14.5%
ANTICOAGULANTS	$1,699,522	17	1.7%	$1,692,474	18	1.7%	-0.4%
NEUROMUSCULAR AGENTS	$1,073,264	19	1.1%	$1,078,981	19	1.1%	0.5%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$892,774	20	0.9%	$826,008	20	0.8%	-7.5%

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March 2024 / May 2024	PREV RANK	June 2024 / August 2024	CURR RANK	% CHANGE
ANTIDEPRESSANTS	114,060	1	108,516	1	-4.9%
ANTICONVULSANTS	50,639	2	49,315	2	-2.6%
ANTIHYPERTENSIVES	44,886	5	42,889	3	-4.4%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	46,145	3	42,497	4	-7.9%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	45,319	4	41,871	5	-7.6%
ANTIDIABETICS	40,768	7	39,740	6	-2.5%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	41,157	6	39,721	7	-3.5%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	39,649	8	38,051	8	-4.0%
ANTIANXIETY AGENTS	34,969	9	33,328	9	-4.7%
ANTIHYPERLIPIDEMICS	29,769	10	28,769	10	-3.4%
ANTIHISTAMINES	25,168	11	24,175	11	-3.9%
DERMATOLOGICALS	21,681	12	22,533	12	3.9%
BETA BLOCKERS	21,223	13	20,401	13	-3.9%
ANALGESICS - ANTI-INFLAMMATORY	19,858	14	18,794	14	-5.4%
ANALGESICS - OPIOID	18,084	16	17,244	15	-4.6%
DIURETICS	16,748	17	16,205	16	-3.2%
THYROID AGENTS	16,672	18	16,133	17	-3.2%
MUSCULOSKELETAL THERAPY AGENTS	13,498	19	13,153	18	-2.6%
PENICILLINS	19,638	15	11,773	19	-40.0%
CALCIUM CHANNEL BLOCKERS	11,695	21	11,249	20	-3.8%

Iowa Health Link
Iowa HHS

Wellpoint

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March 2024 / May 2024	RANK	June 2024 / August 2024	RANK	% CHANGE
OZEMPIC	$3,996,900	2	$4,345,559	1	8.7%
HUMIRA(CF) PEN	$4,637,851	1	$4,222,797	2	-8.9%
VRAYLAR	$3,410,862	3	$3,407,950	3	-0.1%
TRIKAFTA	$2,251,771	5	$2,247,337	4	-0.2%
STELARA	$2,501,882	4	$2,199,626	5	-12.1%
JARDIANCE	$1,987,238	7	$1,980,413	6	-0.3%
INVEGA SUSTENNA	$2,037,226	6	$1,957,852	7	-3.9%
DUPIXENT PEN	$1,789,131	9	$1,759,154	8	-1.7%
SKYRIZI PEN	$1,119,671	15	$1,468,523	9	31.2%
TALTZ AUTOINJECTOR	$1,269,800	12	$1,390,367	10	9.5%
TRULICITY	$1,544,497	10	$1,329,526	11	-13.9%
VYVANSE	$1,871,875	8	$1,303,229	12	-30.4%
BIKTARVY	$1,287,920	11	$1,212,936	13	-5.8%
ELIQUIS	$1,157,728	14	$1,175,423	14	1.5%
REXULTI	$1,210,434	13	$1,162,521	15	-4.0%
MOUNJARO	$814,660	18	$1,061,706	16	30.3%
NURTEC ODT	$1,016,136	16	$914,632	17	-10.0%
ALTUVIIIO	$538,866	34	$861,225	18	59.8%
DUPIXENT SYRINGE	$851,452	17	$842,351	19	-1.1%
ARISTADA	$792,935	19	$809,577	20	2.1%
INGREZZA	$781,621	20	$803,647	21	2.8%

WAKIX	$675,759	25	$765,168	22	13.2%
EVRYSDI	$742,927	22	$722,736	23	-2.7%
ABILIFY MAINTENA	$759,645	21	$706,948	24	-6.9%
COSENTYX SENSOREADY (2 PENS)	$481,737	42	$678,739	25	40.9%
TRINTELLIX	$705,492	24	$674,864	26	-4.3%
ENBREL SURECLICK	$618,618	28	$673,148	27	8.8%
TRELEGY ELLIPTA	$637,432	27	$665,165	28	4.4%
TREMFYA	$719,603	23	$642,406	29	-10.7%
FARXIGA	$590,104	29	$598,960	30	1.5%
CAPLYTA	$577,265	30	$594,733	31	3.0%
EPIDIOLEX	$658,706	26	$594,299	32	-9.8%
AJOVY AUTOINJECTOR	$571,380	31	$563,989	33	-1.3%
NORDITROPIN FLEXPRO	$535,314	35	$549,650	34	2.7%
INVEGA TRINZA	$533,618	36	$537,886	35	0.8%
UBRELVY	$484,324	41	$532,679	36	10.0%
COSENTYX UNOREADY PEN	$415,938	49	$486,727	37	17.0%
SYMBICORT	$497,935	38	$476,914	38	-4.2%
XARELTO	$494,016	39	$471,579	39	-4.5%
OPSUMIT	$480,536	44	$468,951	40	-2.4%
LYBALVI	$372,898	59	$457,802	41	22.8%
LINZESS	$415,437	51	$441,807	42	6.3%
OTEZLA	$492,196	40	$440,161	43	-10.6%
UPTRAVI	$508,760	37	$437,912	44	-13.9%
CONCERTA	$415,913	50	$431,466	45	3.7%

JORNAY PM	$480,833	43	$426,967	46	-11.2%
ENTRESTO	$437,881	47	$423,264	47	-3.3%
HEMLIBRA	$402,830	53	$421,706	48	4.7%
TAKHZYRO	$230,308	90	$409,456	49	77.8%
AUSTEDO	$547,660	33	$401,395	50	-26.7%
XIFAXAN	$392,603	54	$398,487	51	1.5%
LISDEXAMFETAMINE DIMESYLATE	$265,084	75	$398,049	52	50.2%
JANUVIA	$410,131	52	$387,504	53	-5.5%
RINVOQ	$366,815	60	$381,221	54	3.9%
FASENRA PEN	$390,478	55	$366,233	55	-6.2%
VERZENIO	$421,291	48	$359,346	56	-14.7%
RAVICTI	$461,094	45	$358,627	57	-22.2%
XYWAV	$389,609	56	$355,038	58	-8.9%
SKYRIZI ON-BODY	$188,816	113	$354,708	59	87.9%
FINTEPLA	$326,429	61	$350,456	60	7.4%
ALBUTEROL SULFATE HFA	$293,065	69	$335,285	61	14.4%
HAEGARDA	$387,389	57	$332,162	62	-14.3%
JYNARQUE	$288,152	70	$326,572	63	13.3%
VENTOLIN HFA	$459,588	46	$321,099	64	-30.1%
HIZENTRA	$323,186	63	$315,069	65	-2.5%
SPRYCEL	$261,936	76	$314,881	66	20.2%
AIMOVIG AUTOINJECTOR	$323,348	62	$308,603	67	-4.6%
PAXLOVID	$59,638	272	$306,891	68	414.6%
MAVYRET	$557,088	32	$298,400	69	-46.4%

QELBREE	$272,708	73	$297,394	70	9.1%
AUSTEDO XR	$244,504	84	$289,615	71	18.5%
SPIRIVA RESPIMAT	$294,410	68	$288,932	72	-1.9%
KESIMPTA PEN	$257,450	78	$279,174	73	8.4%
ORFADIN	$317,290	64	$278,068	74	-12.4%
CREON	$252,200	81	$276,353	75	9.6%
GATTEX	$227,686	93	$273,224	76	20.0%
QULIPTA	$255,833	80	$270,657	77	5.8%
BRIVIACT	$269,975	74	$268,421	78	-0.6%
ILARIS	$227,848	92	$259,338	79	13.8%
HUMIRA(CF)	$316,724	65	$256,865	80	-18.9%
EPINEPHRINE	$191,725	108	$252,001	81	31.4%
ORENITRAM ER	$235,992	88	$246,908	82	4.6%
LANTUS SOLOSTAR	$258,513	77	$243,466	83	-5.8%
SPIRIVA HANDIHALER	$285,001	71	$241,840	84	-15.1%
HUMIRA(CF) PEN CROHN'S-UC-HS	$167,918	124	$239,012	85	42.3%
BREZTRI AEROSPHERE	$248,355	82	$237,322	86	-4.4%
SODIUM OXYBATE	$156,591	130	$234,886	87	50.0%
STRENSIQ	$298,636	67	$229,986	88	-23.0%
ADVAIR HFA	$244,202	85	$225,491	89	-7.7%
OXERVATE		-	$220,037	90	0.0%
EMFLAZA	$379,183	58	$218,177	91	-42.5%
CRYSVITA	$280,535	72	$218,173	92	-22.2%
TRESIBA FLEXTOUCH U-200	$230,759	89	$216,067	93	-6.4%

ENBREL	$205,289	97	$212,705	94	3.6%
AZSTARYS	$226,089	94	$212,516	95	-6.0%
TYVASO DPI	$299,201	66	$207,129	96	-30.8%
REMODULIN	$205,285	98	$204,648	97	-0.3%
ACTIMMUNE	$195,442	107	$195,442	98	0.0%
METHYLPHENIDATE ER	$245,330	83	$195,091	99	-20.5%
HUMIRA PEN	$181,208	120	$194,720	100	7.5%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March 2024 / May 2024	PREVIOUS RANK	June 2024 / August 2024	RANK	% CHANGE
OMEPRAZOLE	18,244	1	17,561	1	-3.7%
ATORVASTATIN CALCIUM	17,226	3	16,570	2	-3.8%
SERTRALINE HCL	17,617	2	16,332	3	-7.3%
LEVOTHYROXINE SODIUM	15,334	4	14,898	4	-2.8%
ESCITALOPRAM OXALATE	13,523	5	12,970	5	-4.1%
TRAZODONE HCL	13,521	6	12,922	6	-4.4%
CETIRIZINE HCL	13,270	8	12,536	7	-5.5%
LISINOPRIL	13,325	7	12,492	8	-6.3%
FLUOXETINE HCL	11,300	11	11,979	9	6.0%
GABAPENTIN	11,857	10	11,537	10	-2.7%
MONTELUKAST SODIUM	10,899	12	10,335	11	-5.2%
HYDROXYZINE HCL	9,885	14	9,614	12	-2.7%
BUSPIRONE HCL	10,079	13	9,585	13	-4.9%
ALBUTEROL SULFATE HFA	8,394	19	9,456	14	12.7%
PANTOPRAZOLE SODIUM	9,470	15	9,244	15	-2.4%
DULOXETINE HCL	9,428	16	9,093	16	-3.6%
AMLODIPINE BESYLATE	9,242	17	8,804	17	-4.7%
CLONIDINE HCL	8,945	18	8,652	18	-3.3%
QUETIAPINE FUMARATE	8,251	21	7,974	19	-3.4%
ARIPIPRAZOLE	8,281	20	7,879	20	-4.9%

METOPROLOL SUCCINATE	7,882	22	7,592	21	-3.7%
LAMOTRIGINE	7,764	23	7,430	22	-4.3%
VENLAFAXINE HCL ER	7,730	24	7,387	23	-4.4%
AMOXICILLIN	13,046	9	7,200	24	-44.8%
FAMOTIDINE	7,191	27	6,927	25	-3.7%
BUPROPION XL	7,451	25	6,838	26	-8.2%
LOSARTAN POTASSIUM	7,006	30	6,830	27	-2.5%
HYDROCODONE-ACETAMINOPHEN	6,953	31	6,670	28	-4.1%
TOPIRAMATE	6,733	32	6,601	29	-2.0%
FLUTICASONE PROPIONATE	7,132	28	6,353	30	-10.9%
PREDNISONE	7,369	26	6,306	31	-14.4%
DEXTROAMPHETAMINE-AMPHET ER	6,365	33	5,918	32	-7.0%
CYCLOBENZAPRINE HCL	5,999	35	5,893	33	-1.8%
LORATADINE	6,126	34	5,873	34	-4.1%
METFORMIN HCL ER	5,847	38	5,757	35	-1.5%
BUPROPION HYDROCHLORIDE E	5,559	44	5,496	36	-1.1%
CLONAZEPAM	5,587	42	5,358	37	-4.1%
ALPRAZOLAM	5,736	39	5,347	38	-6.8%
RISPERIDONE	5,593	41	5,304	39	-5.2%
ROSUVASTATIN CALCIUM	5,391	46	5,298	40	-1.7%
VENTOLIN HFA	7,132	29	5,025	41	-29.5%
METFORMIN HCL	5,417	45	5,012	42	-7.5%
ONDANSETRON ODT	5,876	37	4,965	43	-15.5%
IBUPROFEN	4,999	48	4,868	44	-2.6%

METHYLPHENIDATE ER	5,648	40	4,845	45	-14.2%
OZEMPIC	4,459	55	4,838	46	8.5%
DEXTROAMPHETAMINE-AMPHETAMINE	4,894	51	4,708	47	-3.8%
MELOXICAM	4,941	49	4,698	48	-4.9%
CEPHALEXIN	4,835	52	4,655	49	-3.7%
HYDROCHLOROTHIAZIDE	4,901	50	4,624	50	-5.7%
FUROSEMIDE	4,576	53	4,524	51	-1.1%
ASPIRIN EC	4,571	54	4,342	52	-5.0%
SPIRONOLACTONE	4,394	58	4,329	53	-1.5%
GUANFACINE HCL	4,441	56	4,145	54	-6.7%
AMOXICILLIN-CLAVULANATE POTASS	5,979	36	4,072	55	-31.9%
PRAZOSIN HCL	4,202	59	4,048	56	-3.7%
PROPRANOLOL HCL	4,038	62	4,000	57	-0.9%
TRIAMCINOLONE ACETONIDE	3,585	70	3,982	58	11.1%
MIRTAZAPINE	4,107	60	3,955	59	-3.7%
VYVANSE	5,563	43	3,837	60	-31.0%
ACETAMINOPHEN	3,719	65	3,739	61	0.5%
LORAZEPAM	3,925	63	3,729	62	-5.0%
GUANFACINE HCL ER	4,073	61	3,695	63	-9.3%
POLYETHYLENE GLYCOL 3350	3,910	64	3,675	64	-6.0%
JARDIANCE	3,686	66	3,639	65	-1.3%
LEVETIRACETAM	3,681	67	3,624	66	-1.5%
HYDROXYZINE PAMOATE	3,642	69	3,444	67	-5.4%
FOLIC ACID	3,390	73	3,429	68	1.2%

TRAMADOL HCL	3,508	71	3,419	69	-2.5%
PREGABALIN	3,345	75	3,352	70	0.2%
LISDEXAMFETAMINE DIMESYLATE	2,152	104	3,262	71	51.6%
FEROSUL	3,208	78	3,187	72	-0.7%
AZITHROMYCIN	5,012	47	3,082	73	-38.5%
FLUCONAZOLE	3,355	74	3,070	74	-8.5%
CITALOPRAM HBR	3,211	77	3,028	75	-5.7%
POTASSIUM CHLORIDE	3,048	81	2,974	76	-2.4%
METHYLPHENIDATE HCL	3,333	76	2,971	77	-10.9%
LANTUS SOLOSTAR	3,129	79	2,959	78	-5.4%
BACLOFEN	3,006	83	2,935	79	-2.4%
METRONIDAZOLE	2,948	84	2,871	80	-2.6%
OLANZAPINE	2,917	86	2,868	81	-1.7%
DOXYCYCLINE MONOHYDRATE	3,423	72	2,863	82	-16.4%
VALACYCLOVIR	3,079	80	2,824	83	-8.3%
OXYCODONE HCL	2,947	85	2,797	84	-5.1%
ATOMOXETINE HCL	3,013	82	2,780	85	-7.7%
TIZANIDINE HCL	2,864	88	2,751	86	-3.9%
METOPROLOL TARTRATE	2,893	87	2,694	87	-6.9%
CEFDINIR	4,417	57	2,648	88	-40.0%
ALBUTEROL SULFATE	3,672	68	2,602	89	-29.1%
VRAYLAR	2,544	91	2,567	90	0.9%
SULFAMETHOXAZOLE-TRIMETHOPRIM	2,353	95	2,475	91	5.2%
ZOLPIDEM TARTRATE	2,545	90	2,461	92	-3.3%

DICLOFENAC SODIUM	2,477	92	2,382	93	-3.8%
AMITRIPTYLINE HCL	2,466	93	2,348	94	-4.8%
ELIQUIS	2,286	98	2,310	95	1.0%
SUMATRIPTAN SUCCINATE	2,321	97	2,245	96	-3.3%
MUPIROCIN	2,022	107	2,230	97	10.3%
SYMBICORT	2,351	96	2,218	98	-5.7%
NAPROXEN	2,263	100	2,178	99	-3.8%
ONDANSETRON HCL	2,283	99	2,154	100	-5.7%

IOWA | Health and Human Services

Fee for Service Claims
Quarterly Statistics

	March through May 2024	June through August 2024	% CHANGE
TOTAL PAID AMOUNT	$2,755,638	$2,624,682	-4.8%
UNIQUE USERS	3,812	3,760	-1.4%
COST PER USER	$722.89	$698.05	-3.4%
TOTAL PRESCRIPTIONS	23,747	23,798	0.2%
AVERAGE PRESCRIPTIONS PER USER	6.23	6.33	1.6%
AVERAGE COST PER PRESCRIPTION	$116.04	$110.29	-5.0%
# GENERIC PRESCRIPTIONS	21,455	21,514	0.3%
% GENERIC	90.3%	90.4%	0.1%
$ GENERIC	$1,097,385	$995,976	-9.2%
AVERAGE GENERIC PRESCRIPTION COST	$51.15	$46.29	-9.5%
AVERAGE GENERIC DAYS SUPPLY	25	25	0.0%
# BRAND PRESCRIPTIONS	2,292	2,284	-0.3%
% BRAND	9.7%	9.6%	-0.6%
$ BRAND	$1,658,252	$1,628,706	-1.8%
AVERAGE BRAND PRESCRIPTION COST	$723.50	$713.09	-1.4%
AVERAGE BRAND DAYS SUPPLY	28	28	0.0%

UTILIZATION BY AGE		
AGE	**March through May 2024**	**June through August 2024**
0-6	204	170
7-12	459	396
13-18	668	608
19-64	2,445	2,556
65+	36	30
	3,812	3,760

	UTILIZATION BY GENDER AND AGE		
GENDER	**AGE**	**March through May 2024**	**June through August 2024**
F			
	0-6	109	85
	7-12	200	173
	13-18	319	289
	19-64	1,542	1,619
	65+	16	14
		2,186	2,180
M			
	0-6	95	85
	7-12	259	223
	13-18	349	319
	19-64	903	937
	65+	20	16
		1,626	1,580

IOWA | Health and Human Services

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2024

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	958	$143,514.75	$149.81	1
2	MESKWAKI PHARMACY	TAMA	IA	754	$538,587.85	$714.31	2
3	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	677	$40,399.27	$59.67	4
4	SIOUXLAND COMMUNITY HEALTH CENTE	SIOUX CITY	IA	628	$23,761.75	$37.84	3
5	WALGREENS #15647	SIOUX CITY	IA	623	$28,232.85	$45.32	5
6	THOMPSON-DEAN DRUG	SIOUX CITY	IA	389	$29,612.16	$76.12	6
7	RIGHT DOSE PHARMACY	ANKENY	IA	285	$11,503.82	$40.36	10
8	GENOA HEALTHCARE LLC	SIOUX CITY	IA	269	$21,834.59	$81.17	8
9	WCHS PHARMACY	WINNEBAGO	NE	266	$189,112.33	$710.95	7
10	WALGREEN #04405	COUNCIL BLUFFS	IA	243	$8,063.24	$33.18	9
11	MAIN AT LOCUST PHARMACY	DAVENPORT	IA	192	$9,394.42	$48.93	23
12	COVENANT FAMILY PHARMACY	WATERLOO	IA	166	$6,736.67	$40.58	12
13	CVS PHARMACY #10282	FORT DODGE	IA	144	$3,625.44	$25.18	11
14	WALGREEN COMPANY #05470	SIOUX CITY	IA	140	$10,757.58	$76.84	26
15	MERCY MEDICAL CENTER NORTH IA DB	MASON CITY	IA	136	$3,268.93	$24.04	29
16	CVS PHARMACY #17554	CEDAR FALLS	IA	135	$15,011.00	$111.19	17
17	HY VEE PHARMACY #6 1155	DES MOINES	IA	130	$8,598.08	$66.14	25
18	UNITY POINT HEALTH PHARMACY	CEDAR RAPIDS	IA	127	$1,493.55	$11.76	42
19	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	126	$5,774.29	$45.83	53
20	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	121	$4,932.77	$40.77	13
21	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	119	$7,749.95	$65.13	19
22	DRUGTOWN PHARMACY #1 (7020)	CEDAR RAPIDS	IA	118	$6,431.98	$54.51	46
23	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	118	$7,345.48	$62.25	21
24	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	114	$3,722.19	$32.65	40
25	WALGREENS #03876	MARION	IA	108	$7,030.86	$65.10	62
26	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	106	$6,336.79	$59.78	30

IOWA | Health and Human Services

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2024

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
27	IOWA VETERANS HOME	MARSHALLTOWN	IA	106	$3,724.06	$35.13	15
28	HY-VEE STORE CLINIC 1023-039	GRIMES	IA	105	$3,556.48	$33.87	14
29	HY-VEE MAINSTREET PHARMACY #7070	SIOUX CITY	IA	104	$3,325.32	$31.97	55
30	HY-VEE PHARMACY (1052)	CEDAR FALLS	IA	103	$1,163.77	$11.30	57
31	WALGREEN #7452	DES MOINES	IA	103	$3,966.42	$38.51	45
32	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	101	$4,581.77	$45.36	131
33	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	100	$8,674.05	$86.74	39
34	MEDICAP PHARMACY	JEFFERSON	IA	98	$1,694.20	$17.29	20
35	ALL CARE HEALTH CENTER	COUNCIL BLUFFS	IA	98	$2,265.62	$23.12	41
36	HY-VEE PHARMACY (1065)	CHARITON	IA	97	$3,010.78	$31.04	123
37	MEDICAP PHARMACY	KNOXVILLE	IA	97	$8,952.04	$92.29	32
38	WAL-MART PHARMACY 10-2714	SPENCER	IA	97	$5,968.48	$61.53	112
39	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	96	$2,674.99	$27.86	37
40	DOTZLER PHARMACIES INC	HARLAN	IA	95	$9,953.28	$104.77	73
41	WAL MART PHARMACY 10 0559	MUSCATINE	IA	93	$3,494.63	$37.58	120
42	WALGREEN #05239	DAVENPORT	IA	92	$4,822.43	$52.42	36
43	WALGREEN #05721	DES MOINES	IA	92	$6,075.32	$66.04	43
44	ALLEN MEMORIAL HOSPITAL	WATERLOO	IA	89	$3,470.22	$38.99	193
45	COMMUNITY HEALTH CARE INC	DAVENPORT	IA	89	$4,493.97	$50.49	156
46	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	88	$10,712.84	$121.74	18
47	GREENWOOD DRUG ON KIMBALL AVENUE	WATERLOO	IA	87	$2,941.18	$33.81	91
48	MEDICAP PHARMACY	ANKENY	IA	87	$3,500.54	$40.24	47
49	CHC PHARMACY	WEST BURLINGTON	IA	87	$14,831.95	$170.48	316
50	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	86	$5,117.20	$59.50	50
51	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	86	$15,712.77	$182.71	58
52	GREENVILLE PHARMACY INC	SIOUX CITY	IA	86	$6,336.44	$73.68	66

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
53	NELSON FAMILY PHARMACY	FORT MADISON	IA	86	$4,686.32	$54.49	22
54	HY-VEE PHARMACY (1075)	CLINTON	IA	85	$5,466.69	$64.31	87
55	HERITAGE PARK PHARMACY	WEST BURLINGTON	IA	84	$2,103.91	$25.05	27
56	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	83	$2,680.47	$32.29	230
57	WALGREEN COMPANY 07455	WATERLOO	IA	82	$1,102.05	$13.44	56
58	HY-VEE PHARMACY 1068	CHEROKEE	IA	81	$1,265.22	$15.62	33
59	HY-VEE PHARMACY 1011	ALTOONA	IA	81	$4,189.84	$51.73	24
60	SUMMIT PHARMACY	FAIRFIELD	IA	81	$2,842.59	$35.09	135
61	UI HEALTHCARE RIVER LANDING PHAR	CORALVILLE	IA	79	$1,817.21	$23.00	85
62	HY VEE PHARMACY 7072	TOLEDO	IA	79	$4,401.89	$55.72	84
63	MEDICAP PHARMACY	GRIMES	IA	78	$3,329.87	$42.69	89
64	WALGREENS #07453	DES MOINES	IA	78	$1,805.09	$23.14	51
65	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	78	$4,489.98	$57.56	35
66	WAL-MART PHARMACY #10-0581	MARSHALLTOWN	IA	77	$1,150.25	$14.94	149
67	CVS PHARMACY #8544	WATERLOO	IA	77	$2,860.63	$37.15	52
68	WRIGHTWAY LTC PHARMACY	CLINTON	IA	77	$5,436.22	$70.60	69
69	WALGREEN CO DBA	ALTOONA	IA	76	$1,721.15	$22.65	80
70	ELIZABETHS PHARMACY ON MAIN	BRITT	IA	76	$6,346.23	$83.50	67
71	CHEROKEE MAIN STREET PHARMACY	CHEROKEE	IA	76	$3,318.85	$43.67	31
72	GENOA HEALTH LLC	MARSHALLTOWN	IA	76	$2,539.89	$33.42	28
73	NUCARA PHARMACY #27	PLEASANT HILL	IA	75	$6,343.42	$84.58	61
74	L & M PHARMACY CARE	LE MARS	IA	75	$739.11	$9.85	71
75	WALGREENS #12393	CEDAR RAPIDS	IA	75	$2,131.51	$28.42	77
76	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	74	$1,026.71	$13.87	76
77	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	73	$28,232.63	$386.75	38
78	CVS PHARMACY #08658	DAVENPORT	IA	72	$6,676.70	$92.73	108

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
79	WAL-MART PHARMACY #10-1625	LE MARS	IA	71	$2,384.42	$33.58	44
80	OSTERHAUS PHARMACY	MAQUOKETA	IA	71	$5,822.00	$82.00	54
81	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	70	$6,123.18	$87.47	88
82	HY-VEE PHARMACY #4 (1890)	WEST DES MOINES	IA	69	$2,108.15	$30.55	81
83	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	69	$11,337.84	$164.32	92
84	MEDICAP PHARMACY #7	GRINNELL	IA	69	$6,048.92	$87.67	221
85	CORNERSTONE APOTHECARY	BELLE PLAINE	IA	69	$4,698.31	$68.09	65
86	WALGREEN CO.# (03875)	CEDAR RAPIDS	IA	68	$1,276.49	$18.77	98
87	WAL-MART PHARMACY #10-3394	ATLANTIC	IA	68	$5,021.28	$73.84	159
88	SIOUXLAND COMMUNITY HEALTH CENTE	SOUTH SIOUX CITY	NE	68	$1,276.06	$18.77	170
89	HY-VEE DRUGSTORE # 1180	FAIRFIELD	IA	67	$3,015.16	$45.00	278
90	CARROLL APOTHECARY	CARROLL	IA	66	$562.63	$8.52	74
91	HY-VEE DRUGSTORE #7026	CEDAR RAPIDS	IA	66	$3,564.46	$54.01	70
92	HY-VEE PHARMACY #2 (1888)	WEST DES MOINES	IA	66	$847.52	$12.84	198
93	HY-VEE PHARMACY 1071	CLARINDA	IA	65	$7,498.58	$115.36	119
94	WAL-MART PHARMACY #10-0985	FAIRFIELD	IA	65	$1,616.52	$24.87	90
95	MERCY LONG TERM CARE PHARMACY	MASON CITY	IA	65	$680.67	$10.47	34
96	LEWIS FAMILY DRUG #52	SHELDON	IA	65	$1,970.67	$30.32	83
97	HY-VEE PHARMACY #2 (1101)	COUNCIL BLUFFS	IA	64	$3,178.17	$49.66	295
98	MERCY OUTPATIENT PHARMACY	DES MOINES	IA	64	$5,031.57	$78.62	97
99	MEDICAP PHARMACY	PANORA	IA	64	$4,567.86	$71.37	136
100	WAL-MART PHARMACY 10-1546	IOWA FALLS	IA	62	$6,442.95	$103.92	96

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	MESKWAKI PHARMACY	TAMA	IA	754	$538,587.85	$2,017.18	1
2	WCHS PHARMACY	WINNEBAGO	NE	266	$189,112.33	$1,734.98	2
3	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	958	$143,514.75	$820.08	3
4	CVS PHARMACY #00102	AURORA	CO	14	$112,583.81	$22,516.76	4
5	COMMUNITY A WALGREENS PHARMACY	IOWA CITY	IA	13	$92,137.62	$23,034.41	5
6	UNITY POINT AT HOME	URBANDALE	IA	29	$73,457.74	$5,650.60	7
7	CAREMARK KANSAS SPEC PHARMACY LL	LENEXA	KS	43	$53,279.48	$3,551.97	10
8	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	45	$41,764.98	$5,966.43	12
9	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	677	$40,399.27	$734.53	13
10	COMM A WALGREENS PHARMACY #16528	DES MOINES	IA	5	$40,304.48	$20,152.24	11
11	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	8	$30,531.34	$10,177.11	6
12	THOMPSON-DEAN DRUG	SIOUX CITY	IA	389	$29,612.16	$519.51	19
13	CR CARE PHARMACY	CEDAR RAPIDS	IA	61	$29,275.13	$3,252.79	17
14	WALGREENS #15647	SIOUX CITY	IA	623	$28,232.85	$186.97	16
15	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	73	$28,232.63	$742.96	21
16	CARL T CURTIS HEALTH EJ CENTER	MACY	NE	39	$28,041.00	$1,649.47	15
17	SIOUXLAND COMMUNITY HEALTH CENTE	SIOUX CITY	IA	628	$23,761.75	$203.09	9
18	FOUNDATION CARE LLC	EARTH CITY	MO	3	$22,591.71	$22,591.71	24
19	GENOA HEALTHCARE LLC	SIOUX CITY	IA	269	$21,834.59	$661.65	14
20	MT VERNON PHARMACY	MT VERNON	IA	36	$21,381.12	$7,127.04	18
21	FRED LEROY HEALTH & WELLNESS	OMAHA	NE	23	$16,537.00	$2,756.17	20
22	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	86	$15,712.77	$3,142.55	29
23	CVS PHARMACY #17554	CEDAR FALLS	IA	135	$15,011.00	$3,002.20	26
24	CHC PHARMACY	WEST BURLINGTON	IA	87	$14,831.95	$741.60	390
25	PARAGON PARTNERS	OMAHA	NE	57	$14,525.11	$7,262.56	30

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
26	RIGHT DOSE PHARMACY	ANKENY	IA	285	$11,503.82	$639.10	27
27	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	69	$11,337.84	$2,834.46	34
28	WHITE DRUG ENTERPRISES INC	SPENCER	IA	29	$11,113.52	$1,852.25	373
29	WALGREEN COMPANY #05470	SIOUX CITY	IA	140	$10,757.58	$290.75	72
30	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	88	$10,712.84	$396.77	36
31	HY-VEE PHARMACY 1382	LE MARS	IA	62	$10,385.02	$1,038.50	144
32	DOTZLER PHARMACIES INC	HARLAN	IA	95	$9,953.28	$3,317.76	54
33	KROGER SPECIALTY PHARMACY LA LLC	HARVEY	LA	2	$9,534.96	$9,534.96	38
34	MAIN AT LOCUST PHARMACY	DAVENPORT	IA	192	$9,394.42	$854.04	100
35	MEDICAP PHARMACY	KNOXVILLE	IA	97	$8,952.04	$1,790.41	53
36	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	100	$8,674.05	$867.41	32
37	HY VEE PHARMACY #6 1155	DES MOINES	IA	130	$8,598.08	$260.55	63
38	OPTUM PHARMACY 702 LLC	JEFFERSONVILLE	IN	9	$8,219.34	$4,109.67	42
39	HY-VEE PHARMACY (1522)	PERRY	IA	21	$8,092.41	$1,011.55	98
40	GENOA HEALTHCARE LLC	FORT DODGE	IA	51	$8,089.38	$2,696.46	61
41	WALGREEN #04405	COUNCIL BLUFFS	IA	243	$8,063.24	$196.66	22
42	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	119	$7,749.95	$407.89	108
43	THE NEBRASKA MED CENTER CLIN PHA	OMAHA	NE	39	$7,729.05	$1,288.18	116
44	CVS PHARMACY #10114	ANKENY	IA	27	$7,627.05	$1,089.58	306
45	HY-VEE PHARMACY 1071	CLARINDA	IA	65	$7,498.58	$624.88	95
46	KROGER SPECIALTY PHARMACY INC	LAKE MARY	FL	2	$7,372.86	$7,372.86	
47	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	118	$7,345.48	$432.09	77
48	WALGREENS #03876	MARION	IA	108	$7,030.86	$351.54	55
49	LEWIS FAMILY DRUG #69	ROCK VALLEY	IA	37	$6,889.14	$1,722.29	84
50	COVENANT FAMILY PHARMACY	WATERLOO	IA	166	$6,736.67	$140.35	74
51	FRESENIUS MEDICAL CARE RX LLC	FRANKLIN	TN	6	$6,677.93	$6,677.93	28

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
52	CVS PHARMACY #08658	DAVENPORT	IA	72	$6,676.70	$667.67	51
53	WAL-MART PHARMACY 10-1546	IOWA FALLS	IA	62	$6,442.95	$715.88	101
54	DRUGTOWN PHARMACY #1 (7020)	CEDAR RAPIDS	IA	118	$6,431.98	$378.35	67
55	HY-VEE PHARMACY (1009) DBA	ALBIA	IA	33	$6,365.09	$1,591.27	102
56	ELIZABETHS PHARMACY ON MAIN	BRITT	IA	76	$6,346.23	$1,269.25	58
57	NUCARA PHARMACY #27	PLEASANT HILL	IA	75	$6,343.42	$1,057.24	59
58	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	106	$6,336.79	$192.02	87
59	GREENVILLE PHARMACY INC	SIOUX CITY	IA	86	$6,336.44	$372.73	121
60	LEEDS PHARMACY INC	SIOUX CITY	IA	62	$6,303.29	$450.24	76
61	ANOVORX GROUP INC	MEMPHIS	TN	6	$6,198.28	$3,099.14	384
62	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	70	$6,123.18	$765.40	209
63	WALGREEN #05721	DES MOINES	IA	92	$6,075.32	$276.15	120
64	MEDICAP PHARMACY	CRESTON	IA	56	$6,049.24	$864.18	393
65	MEDICAP PHARMACY #7	GRINNELL	IA	69	$6,048.92	$1,209.78	179
66	HY VEE PHARMACY 1459	OELWEIN	IA	38	$6,004.97	$750.62	124
67	WALGREEN #06623	WEST DES MOINES	IA	24	$5,979.55	$996.59	340
68	WAL-MART PHARMACY 10-2714	SPENCER	IA	97	$5,968.48	$994.75	142
69	WAL-MART PHARMACY #10-0841	TIPTON	IA	21	$5,961.39	$2,980.70	371
70	OSTERHAUS PHARMACY	MAQUOKETA	IA	71	$5,822.00	$1,455.50	44
71	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	126	$5,774.29	$169.83	153
72	SERGEANT BLUFF PHARMACY	SERGEANT BLUFF	IA	45	$5,515.05	$612.78	115
73	HY-VEE PHARMACY (1075)	CLINTON	IA	85	$5,466.69	$455.56	86
74	CHI HEALTH PHARMACY 42ND AND L	OMAHA	NE	8	$5,448.68	$2,724.34	580
75	WRIGHTWAY LTC PHARMACY	CLINTON	IA	77	$5,436.22	$5,436.22	47
76	CVS PHARMACY #16254	MASON CITY	IA	54	$5,430.14	$678.77	65
77	WALGREEN #09708	DUBUQUE	IA	42	$5,292.51	$481.14	41

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
78	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	86	$5,117.20	$365.51	56
79	WAL-MART PHARMACY 10-1526	STORM LAKE	IA	18	$5,088.89	$2,544.45	90
80	MERCY OUTPATIENT PHARMACY	DES MOINES	IA	64	$5,031.57	$359.40	238
81	WAL-MART PHARMACY #10-3394	ATLANTIC	IA	68	$5,021.28	$313.83	297
82	HY-VEE PHARMACY (1080)	CORALVILLE	IA	21	$4,981.00	$830.17	173
83	WALGREENS #07833	DES MOINES	IA	52	$4,969.51	$451.77	91
84	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	121	$4,932.77	$117.45	52
85	WALGREEN #05239	DAVENPORT	IA	92	$4,822.43	$200.93	151
86	CORNERSTONE APOTHECARY	BELLE PLAINE	IA	69	$4,698.31	$2,349.16	80
87	NELSON FAMILY PHARMACY	FORT MADISON	IA	86	$4,686.32	$390.53	39
88	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	101	$4,581.77	$305.45	186
89	MEDICAP PHARMACY	PANORA	IA	64	$4,567.86	$652.55	106
90	MEDICAP PHARMACY	AUDUBON	IA	30	$4,567.59	$1,522.53	37
91	WALGREEN COMPANY #05512	BETTENDORF	IA	31	$4,564.08	$507.12	147
92	COMMUNITY HEALTH CARE INC	DAVENPORT	IA	89	$4,493.97	$449.40	138
93	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	78	$4,489.98	$236.31	49
94	HY-VEE DRUGSTORE #7065	OTTUMWA	IA	59	$4,448.64	$494.29	176
95	HY VEE PHARMACY 7072	TOLEDO	IA	79	$4,401.89	$258.93	148
96	HY-VEE PHARMACY (1037)	BETTENDORF	IA	49	$4,373.89	$874.78	82
97	WAL-MART PHARMACY #10-2935	KNOXVILLE	IA	61	$4,299.40	$614.20	268
98	HY VEE PHARMACY 1060	CEDAR RAPIDS	IA	27	$4,268.28	$533.54	31
99	CVS PHARMACY #16893	ANKENY	IA	33	$4,266.52	$1,422.17	50
100	WALGREENS CO DBA	BOONE	IA	17	$4,259.62	$4,259.62	89

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1053340661	LEIGHTON E FROST MD	$145,341.90	210	3.00	1
2	1043418809	MICHAEL CILIBERTO	$36,924.29	176	5.03	2
3	1902358443	MELISSA KONKEN ARNP	$4,553.34	141	7.83	7
4	1912991183	MOLLY EARLEYWINE PA	$4,713.39	121	7.56	5
5	1538671961	JAMIE WRIGHT ARNP	$7,817.29	116	8.29	4
6	1528037082	RODNEY J DEAN MD	$1,837.35	109	12.11	18
7	1194888024	ALICIA D WAGER NP	$59,211.89	105	2.06	3
8	1780877878	CHRISTOPHER JACOBS ARNP	$4,859.99	102	6.80	14
9	1164481362	MELISSA PEARSON ARNP	$68,375.73	100	1.52	6
10	1104251776	ANTHONY ERIK GLYDWELL	$68,316.62	96	1.75	9
11	1417214321	LEAH BRANDON DO	$5,291.43	95	7.92	19
12	1467502286	CHARLES R TILLEY	$5,125.91	90	15.00	20
13	1619153137	JOADA JEAN BEST ARNP	$6,082.22	90	8.18	10
14	1659358620	CARLOS CASTILLO MD	$2,978.76	89	7.42	8
15	1598733891	JERRY WILLE MD	$56,867.73	84	1.83	13
16	1558147868	JAMIE KARSTENS ARNP	$3,425.99	82	5.86	59
17	1396289229	JESSE N BECKER ARNP	$4,993.83	79	3.16	12
18	1215125216	REBECCA EVELYN WALDING	$5,798.33	73	4.87	11
19	1073235925	KRISTINA L BECK ARNP	$3,178.65	68	17.00	17
20	1013355759	DYLAN GREENE MD	$4,217.67	68	4.00	28
21	1144214248	KRISTI WALZ MD	$34,806.21	67	4.79	16
22	1356337273	LISA JAYNE MENZIES MD	$1,365.35	66	5.50	40
23	1891076386	SARA E FLEECS ARNP	$4,427.89	65	32.50	25
24	1407836513	NATHAN R NOBLE DO	$1,598.94	65	3.82	23
25	1003884107	RANDALL ALLEN KAVALIER DO	$621.10	64	6.40	36
26	1700356334	BRIANNA J SCHAFFER ARNP	$6,784.81	64	16.00	55

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27	1174583157	JOANNE STARR ARNP	$4,101.15	63	31.50	26
28	1578123915	BRIANNA BROWNLEE DO	$3,755.44	60	10.00	83
29	1457584740	ERIC DENNIS MEYER ARNP	$2,841.16	60	6.67	67
30	1407585623	COLETTE MARIE DEMOSS PA	$1,206.28	58	7.25	293
31	1841220290	KENT E KUNZE MD	$2,170.06	57	9.50	30
32	1609218304	AMANDA GARR ARNP	$26,126.90	54	7.71	32
33	1093272668	RICARDO OSARIO ARNP	$1,112.31	53	4.42	35
34	1164538674	JOSEPH MATTHEW WANZEK III DO	$2,311.92	52	13.00	31
35	1295217529	HEATHER STEHR ARNP	$18,770.36	52	5.20	29
36	1073249306	MELISSA WATCHORN ARNP	$8,592.47	51	7.29	15
37	1154929230	CHELSEA JONES ARNP	$32,360.33	47	2.35	38
38	1437506342	KYLE MERRILL MD	$482.97	47	7.83	39
39	1760965032	MELISSA MILLER ARNP	$1,618.47	47	3.13	27
40	1548987951	VIMALA VIJAYARAGHAVAN MD	$352.65	46	15.33	844
41	1356919658	SARAH CASTRO APRN	$1,585.96	46	23.00	115
42	1811493679	JUNE MYLER ARNP	$32,355.00	45	1.80	56
43	1609131770	SREENATH THATI GANGANNA MBBS	$11,095.78	43	8.60	70
44	1962418640	BARCLAY MONASTER MD	$5,069.61	43	10.75	76
45	1346557550	ROBERT BRYAN BOYLE ARNP	$5,361.74	43	6.14	79
46	1699740159	FRANK SAM MARINO JR DO	$1,082.18	43	3.91	33
47	1982030946	JACKLYN BESCH	$552.43	43	8.60	415
48	1649922410	CASSANDRA MARIE ZIMMERMAN ARNP	$1,787.46	43	43.00	21
49	1639134034	ELIZABETH PRATT ARNP	$333.53	43	1.79	44
50	1053600296	JESSICA MCCOOL MD	$4,210.85	42	21.00	77
51	1053376475	DANIEL GILLETTE MD	$1,914.72	42	14.00	53
52	1477950988	RIFALI VIMALKUMAR PATEL MD	$1,266.68	42	4.67	48

TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
June through August 2024

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
53	1760675177	LORI SWANSON ARNP	$28,782.11	42	2.47	84
54	1508946088	RICHARD NIGHTINGALE MD	$408.84	41	13.67	112
55	1801992532	KELLY BEAN ARNP	$475.57	41	8.20	162
56	1144240805	DANIEL ROWLEY MD	$4,295.22	41	20.50	72
57	1932582988	DIANNE HUMPHREY ARNP	$7,355.43	41	13.67	160
58	1619380680	TARA BROCKMAN DO	$2,020.40	41	10.25	75
59	1598117434	SOMMER KORTH ARNP	$1,528.66	40	4.00	176
60	1417679168	PAIGE REED ARNP	$2,509.49	40	20.00	95
61	1619649209	STEPHANIE HEALY ARNP	$555.36	40	8.00	66
62	1174640528	AMY JO PAYNE PA	$2,023.81	40	3.08	89
63	1932493749	NICHOLAS CHARLES BECHTOLD DO	$2,440.08	40	20.00	64
64	1922455096	DEAN L GUERDET ARNP	$8,060.85	39	6.50	99
65	1326036062	JON AHRENDSEN MD	$684.83	39	6.50	1840
66	1659420099	STEPHEN MANDLER	$147.29	38	38.00	22
67	1720698335	DANIKA LEIGH HANSEN ARNP	$5,223.26	38	4.22	58
68	1144455502	JENNIFER PETTS DO	$1,457.38	37	9.25	129
69	1588920151	AMANDA H CROXTON DO	$1,404.90	37	4.63	100
70	1043265176	SHARON K FEY PAC	$7,722.31	37	7.40	90
71	1427617471	SUSAN GRAVES PA	$3,623.90	36	9.00	166
72	1477652469	JILL JENSEN PA	$3,551.95	36	18.00	120
73	1508846007	ANGELA TOWNSEND MD	$613.74	36	6.00	54
74	1053398800	STEVEN T SCURR DO	$2,752.09	35	35.00	580
75	1427164789	MICHAEL JAMES OURADA MD	$650.85	35	17.50	81
76	1184056822	ABBY IRENE KOLTHOFF ARNP	$29,240.52	35	11.67	105
77	1093757999	MARY MCGOWAN ARNP	$279.14	34	5.67	827
78	1629265368	HANNAH LOKENVITZ PA	$452.80	34	17.00	42

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TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
June through August 2024

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
79	1932531316	BROOKE JOHNSON ARNP	$2,051.52	34	11.33	145
80	1124006770	WOOK KIM	$422.24	34	11.33	106
81	1982630703	JODI VANSICKLE MD	$522.77	34	4.25	284
82	1821268335	JACQUELINE MCINNIS PAC	$820.45	34	8.50	37
83	1477045797	CHANTAL J ROZMUS DO	$266.75	34	11.33	197
84	1457346231	DAWN RENAE EBACH MD	$1,437.80	34	3.78	62
85	1942896691	VIRIDIANA MUNOZ DE GONZALEZ ARNP	$2,426.43	34	3.09	24
86	1730609629	LAUREN MARIE THOMANN ARNP	$4,497.62	34	11.33	114
87	1336418425	DENA R NEIMAN ARNP	$393.94	34	5.67	41
88	1336599869	JOHN JOGHYUN LEE DO	$1,250.70	33	16.50	96
89	1164743357	ALISA M OLSON DO	$4,143.13	33	11.00	82
90	1548484165	CARRIE L GRADY MD	$2,131.29	33	16.50	50
91	1053099051	BAILIEY J ZARUBA ARNP	$447.34	33	5.50	88
92	1770077562	BRANDON JAMES HART MD	$485.71	33	33.00	264
93	1891422606	EMILY CLAWSON ARNP	$1,871.19	33	3.30	43
94	1972985232	TIFFANY MCEWAN ARNP	$487.54	33	11.00	841
95	1487908380	LISA ROCK ANRP	$1,867.50	33	5.50	311
96	1013115369	BOBBITA NAG MD	$1,090.26	33	4.71	69
97	1598750432	CHRISTOPHER OKIISHI MD	$896.84	33	6.60	127
98	1598166340	BRITTANY SANGER PA	$3,180.96	33	16.50	150
99	1326013426	PAUL DENNIS PETERSON DO	$524.69	33	3.67	172
100	1215184726	BABUJI REDDY GANDRA MD	$490.57	32	10.67	91

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2024

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
1	1053340661	LEIGHTON E FROST MD	$145,341.90	$692.10	210	1
2	1164481362	MELISSA PEARSON ARNP	$68,375.73	$683.76	100	2
3	1104251776	ANTHONY ERIK GLYDWELL	$68,316.62	$711.63	96	4
4	1194888024	ALICIA D WAGER NP	$59,211.89	$563.92	105	3
5	1598733891	JERRY WILLE MD	$56,867.73	$677.00	84	5
6	1316934318	STEVEN LENTZ MD	$46,662.76	$46,662.76	1	66
7	1447488325	ABDELAZIZ ELHADDAD MD	$42,476.01	$14,158.67	3	8
8	1952326530	LISA HEDRICK PA	$40,272.46	$13,424.15	3	11
9	1043418809	MICHAEL CILIBERTO	$36,924.29	$209.80	176	10
10	1144214248	KRISTI WALZ MD	$34,806.21	$519.50	67	7
11	1154929230	CHELSEA JONES ARNP	$32,360.33	$688.52	47	12
12	1811493679	JUNE MYLER ARNP	$32,355.00	$719.00	45	14
13	1790986925	TAHUANTY ANIBAL PENA MD	$30,275.97	$1,081.28	28	19
14	1891146999	BECKY L JOHNSON ARNP	$30,054.22	$1,252.26	24	27
15	1114214541	DIMAH NAYEF SAADE MD	$30,001.89	$3,333.54	9	70
16	1184056822	ABBY IRENE KOLTHOFF ARNP	$29,240.52	$835.44	35	25
17	1760675177	LORI SWANSON ARNP	$28,782.11	$685.29	42	17
18	1225263833	LINDSAY J ORRIS DO	$26,815.26	$4,469.21	6	35
19	1417307497	EMILY BOES DO	$26,500.58	$6,625.15	4	23
20	1639157373	CALVIN J HANSEN MD	$26,281.39	$4,380.23	6	16
21	1609218304	AMANDA GARR ARNP	$26,126.90	$483.83	54	20
22	1194990945	SANDEEP GUPTA MD	$24,948.98	$1,782.07	14	18
23	1255658175	ASHLEY R DESCHAMP MD	$22,657.79	$2,832.22	8	31
24	1730128653	KRISTI J ROBSON MD	$19,883.22	$6,627.74	3	24
25	1295217529	HEATHER STEHR ARNP	$18,770.36	$360.97	52	29
26	1649678582	LAURA STULKEN PA	$18,662.52	$1,166.41	16	40
27	1093141129	LARRY MARTIN NEWMAN ARNP	$18,024.48	$621.53	29	52

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
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RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
28	1073852059	AMBER HANSEN MD	$16,547.00	$689.46	24	13
29	1366402505	KUNAL KUMAR PATRA MD	$16,537.00	$719.00	23	22
30	1104012996	VENKATESH K RUDRAPATNA MD	$15,416.10	$15,416.10	1	30
31	1720086523	MARK GLENN CLEVELAND MD	$14,769.27	$2,461.55	6	132
32	1205504669	JENNIFER SWANSON ARNP	$14,410.92	$655.04	22	28
33	1255319422	DAVID STAUB MD	$13,436.32	$6,718.16	2	38
34	1538699806	JENNIFER HUTCHINSON ARNP	$12,983.80	$618.28	21	21
35	1356359871	RHEA ANNE HARTLEY MD	$11,755.16	$367.35	32	544
36	1992766299	PATRICK K CHAU MD	$11,569.01	$503.00	23	53
37	1609131770	SREENATH THATI GANGANNA MBBS	$11,095.78	$258.04	43	68
38	1508291717	JACOB J RIDDER PA	$11,056.99	$3,685.66	3	
39	1417251216	GRETCHEN ELIZABETH WHEELOCK APRN	$10,785.00	$719.00	15	56
40	1770933046	SHELBY BILLER	$10,686.07	$593.67	18	41
41	1306349956	KATIE LADEHOFF ARNP	$10,066.00	$719.00	14	42
42	1114521721	TARRAH HOLLIDAY ARNP	$9,872.25	$429.23	23	62
43	1104088202	PATRICK SAFO MD	$9,582.75	$1,916.55	5	47
44	1891955423	LEAH SIEGFRIED PA	$9,084.02	$567.75	16	44
45	1255538344	SARAH FEDDERSEN PA	$8,978.50	$2,244.63	4	37
46	1073249306	MELISSA WATCHORN ARNP	$8,592.47	$168.48	51	59
47	1326410499	TARA M EASTVOLD ARNP	$8,461.82	$604.42	14	129
48	1922455096	DEAN L GUERDET ARNP	$8,060.85	$206.69	39	75
49	1558347047	DANIEL L HAMILOS MD	$7,885.98	$657.17	12	
50	1538671961	JAMIE WRIGHT ARNP	$7,817.29	$67.39	116	142
51	1417931700	SUDHIR C KUMAR MD	$7,815.38	$3,907.69	2	126
52	1275836751	HOLLY M KRAMER ARNP	$7,766.20	$776.62	10	69
53	1043265176	SHARON K FEY PAC	$7,722.31	$208.71	37	33
54	1588618359	BARBARA BURKLE ARNP	$7,666.20	$3,833.10	2	

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
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RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
55	1366826109	ALYSSA D MRSNY PA-C	$7,606.54	$1,086.65	7	32
56	1902092091	SAHAYA KINSHUK MD	$7,552.02	$444.24	17	684
57	1932582988	DIANNE HUMPHREY ARNP	$7,355.43	$179.40	41	72
58	1104498039	BRENDA L CAIN ARNP	$7,002.62	$225.89	31	57
59	1114524378	ROSA M MARQUEZ PA-C	$6,926.61	$346.33	20	894
60	1558039495	SARAH HIETBRINK ARNP	$6,813.89	$219.80	31	99
61	1700356334	BRIANNA J SCHAFFER ARNP	$6,784.81	$106.01	64	101
62	1144588476	RACHEL D FILZER ARNP	$6,724.58	$611.33	11	77
63	1790772846	PETAR LENERT MD	$6,693.00	$3,346.50	2	61
64	1417435462	ALLISON R OWINGS NP-C	$6,527.24	$435.15	15	213
65	1679573893	PATTY HILDRETH ARNP	$6,368.20	$289.46	22	93
66	1245868751	RENATE GYENGE	$6,322.74	$2,107.58	3	3578
67	1528467859	WHITNEY A WEIS ARNP	$6,317.54	$1,263.51	5	3564
68	1225332463	MOLLY E SCHOOLEY PA-C	$6,091.21	$380.70	16	96
69	1619153137	JOADA JEAN BEST ARNP	$6,082.22	$67.58	90	76
70	1306559786	ROY E HENRY ARNP	$5,907.34	$268.52	22	108
71	1215125216	REBECCA EVELYN WALDING	$5,798.33	$79.43	73	55
72	1275025603	BROOKE YOSSI DDS	$5,752.00	$719.00	8	87
73	1497263008	TARA J SMITH PMHNP	$5,747.91	$638.66	9	73
74	1689077018	STACY ROTH ARNP	$5,596.85	$430.53	13	146
75	1477230936	ANDREA IMES FNP	$5,422.14	$417.09	13	2260
76	1205817061	VIJAY DEWAN MD	$5,383.34	$2,691.67	2	
77	1750348496	VANESSA ANN CURTIS MD	$5,378.91	$358.59	15	79
78	1346557550	ROBERT BRYAN BOYLE ARNP	$5,361.74	$124.69	43	65
79	1417214321	LEAH BRANDON DO	$5,291.43	$55.70	95	121
80	1720698335	DANIKA LEIGH HANSEN ARNP	$5,223.26	$137.45	38	67
81	1386174217	KITTIKA POONSOMBUDLERT MD	$5,148.82	$735.55	7	

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2024

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
82	1467502286	CHARLES R TILLEY	$5,125.91	$56.95	90	34
83	1962418640	BARCLAY MONASTER MD	$5,069.61	$117.90	43	90
84	1306226790	JACOB P FLINKMAN DO	$5,069.10	$422.43	12	233
85	1497356125	ASHLEEN BLACKBIRD NP	$5,048.96	$631.12	8	115
86	1316129786	ERIN ROLF DMD	$5,033.00	$719.00	7	88
87	1396289229	JESSE N BECKER ARNP	$4,993.83	$63.21	79	208
88	1114243052	OLGA TARASCHENKO MD	$4,918.73	$546.53	9	145
89	1831329630	SPYRIDON FORTIS MD	$4,917.16	$447.01	11	48
90	1780877878	CHRISTOPHER JACOBS ARNP	$4,859.99	$47.65	102	103
91	1942485560	TOD WALKER PA	$4,844.57	$4,844.57	1	
92	1811123318	AARON KAUER MD	$4,725.22	$225.01	21	81
93	1912991183	MOLLY EARLEYWINE PA	$4,713.39	$38.95	121	141
94	1821076753	IRENA MARIA CHARYSZ-BIRSKI MD	$4,622.42	$1,540.81	3	58
95	1912208323	LISA M MEYER ARNP	$4,620.44	$256.69	18	85
96	1902358443	MELISSA KONKEN ARNP	$4,553.34	$32.29	141	46
97	1730609629	LAUREN MARIE THOMANN ARNP	$4,497.62	$132.28	34	124
98	1275844649	KATIE MARIE CAMPBELL ARNP	$4,484.50	$194.98	23	104
99	1124549720	ZEINA HAJAR MD	$4,468.40	$1,117.10	4	105
100	1891076386	SARA E FLEECS ARNP	$4,427.89	$68.12	65	89

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TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March through May 2024	RANK	% BUDGET	June through August 2024	RANK	% BUDGET	% CHANGE
ANTIDIABETICS	$322,145	1	11.7%	$342,015	1	13.0%	6.2%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$225,347	2	8.2%	$195,923	2	7.5%	-13.1%
DERMATOLOGICALS	$199,524	3	7.2%	$187,753	3	7.2%	-5.9%
ANTIVIRALS	$121,863	8	4.4%	$180,170	4	6.9%	47.8%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$133,555	5	4.8%	$143,452	5	5.5%	7.4%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$157,167	4	5.7%	$135,564	6	5.2%	-13.7%
ANTICONVULSANTS	$132,563	6	4.8%	$130,546	7	5.0%	-1.5%
ANTIDEPRESSANTS	$119,907	10	4.4%	$115,084	8	4.4%	-4.0%
ANALGESICS - ANTI-INFLAMMATORY	$124,622	7	4.5%	$111,395	9	4.2%	-10.6%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$73,600	11	2.7%	$86,555	10	3.3%	17.6%
ANTIHYPERTENSIVES	$61,305	13	2.2%	$63,323	11	2.4%	3.3%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$120,871	9	4.4%	$61,411	12	2.3%	-49.2%
RESPIRATORY AGENTS - MISC.	$40,558	17	1.5%	$57,425	13	2.2%	41.6%
ANTICOAGULANTS	$44,163	16	1.6%	$50,386	14	1.9%	14.1%
HEMATOLOGICAL AGENTS - MISC.	$17,446	33	0.6%	$50,137	15	1.9%	187.4%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$49,372	15	1.8%	$46,418	16	1.8%	-6.0%
ANTIHYPERLIPIDEMICS	$53,311	14	1.9%	$44,724	17	1.7%	-16.1%
CONTRACEPTIVES	$39,113	19	1.4%	$41,417	18	1.6%	5.9%
ANALGESICS - OPIOID	$35,328	21	1.3%	$37,988	19	1.4%	7.5%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$39,223	18	1.4%	$34,634	20	1.3%	-11.7%

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March through May 2024	PREV RANK	June through August 2024	CURR RANK	PERC CHANGE
ANTIDEPRESSANTS	2,793	1	2,899	1	3.8%
ANTICONVULSANTS	1,746	2	1,673	2	-4.2%
ANTIHYPERTENSIVES	1,275	4	1,325	3	3.9%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	1,328	3	1,271	4	-4.3%
ANTIDIABETICS	1,128	7	1,206	5	6.9%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	1,195	5	1,148	6	-3.9%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	1,142	6	1,123	7	-1.7%
ANTIANXIETY AGENTS	960	9	1,055	8	9.9%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	1,060	8	1,023	9	-3.5%
ANTIHYPERLIPIDEMICS	691	10	703	10	1.7%
ANALGESICS - OPIOID	615	11	644	11	4.7%
DERMATOLOGICALS	523	15	614	12	17.4%
ANTIHISTAMINES	576	12	610	13	5.9%
ANALGESICS - ANTI-INFLAMMATORY	552	13	542	14	-1.8%
BETA BLOCKERS	514	16	504	15	-1.9%
DIURETICS	422	17	462	16	9.5%
MUSCULOSKELETAL THERAPY AGENTS	411	19	408	17	-0.7%
THYROID AGENTS	415	18	392	18	-5.5%
CORTICOSTEROIDS	368	20	368	19	0.0%
ANALGESICS - NONNARCOTIC	343	22	353	20	2.9%

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TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
OZEMPIC	$103,833.24	1	$124,068.38	1	19.49%
BIKTARVY	$79,412.93	2	$99,743.18	2	25.60%
TALTZ	$59,649.66	5	$72,894.76	3	22.20%
VRAYLAR	$74,138.48	3	$69,946.29	4	-5.65%
HUMIRA PEN	$71,792.29	4	$63,854.59	5	-11.06%
JARDIANCE	$56,683.95	6	$62,489.88	6	10.24%
DUPIXENT	$45,528.68	10	$55,798.07	7	22.56%
TRIKAFTA	$38,017.02	14	$52,996.31	8	39.40%
HEMLIBRA		999	$46,662.76	9	%
VYVANSE	$52,123.63	8	$44,738.62	10	-14.17%
KISQALI	$42,476.01	11	$42,476.01	11	0.00%
ELIQUIS	$32,349.29	16	$38,230.28	12	18.18%
ARISTADA	$18,453.78	32	$36,679.82	13	98.77%
ALBUTEROL SULFATE	$39,578.48	13	$34,831.09	14	-11.99%
TRULICITY	$32,048.42	17	$30,777.95	15	-3.96%
EVRYSDI	$9,646.14	71	$30,013.34	16	211.14%
KESIMPTA	$26,237.88	19	$26,237.88	17	0.00%
INGREZZA	$15,543.12	40	$24,796.14	18	59.53%
SERTRALINE HCL	$20,777.06	27	$23,985.60	19	15.44%
IBUPROFEN	$22,515.34	24	$23,190.29	20	3.00%
ESCITALOPRAM OXALATE	$21,538.66	26	$21,741.90	21	0.94%
LISINOPRIL	$23,709.54	22	$21,564.73	22	-9.05%
ATORVASTATIN CALCIUM	$23,136.83	23	$21,113.17	23	-8.75%
AUSTEDO	$13,941.76	46	$20,957.68	24	50.32%
INVEGA SUSTENNA	$35,640.79	15	$20,761.10	25	-41.75%
CETIRIZINE HCL	$24,516.24	21	$18,895.84	26	-22.93%
METFORMIN HCL	$19,234.55	29	$18,295.66	27	-4.88%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
ENTRESTO	$17,842.02	33	$17,797.92	28	-0.25%
JORNAY PM	$18,546.68	31	$17,767.09	29	-4.20%
REXULTI	$29,722.33	18	$15,906.24	30	-46.48%
LANTUS SOLOSTAR	$17,632.41	34	$15,610.98	31	-11.46%
VERZENIO	$46,248.30	9	$15,416.10	32	-66.67%
HYDROCODONE-ACETAMINOPHEN	$9,166.95	77	$14,810.36	33	61.56%
PANTOPRAZOLE SODIUM	$10,726.38	65	$14,449.84	34	34.71%
NORDITROPIN FLEXPRO	$8,422.35	81	$14,438.16	35	71.43%
AMLODIPINE BESYLATE	$12,511.21	54	$14,195.70	36	13.46%
SYMBICORT	$12,354.38	55	$14,089.85	37	14.05%
GENVOYA	$7,792.56	94	$14,043.15	38	80.21%
EPIDIOLEX	$13,038.33	50	$13,979.31	39	7.22%
ROSUVASTATIN CALCIUM	$19,113.47	30	$13,412.80	40	-29.83%
CEPHALEXIN	$16,682.22	36	$13,324.31	41	-20.13%
ACETAMINOPHEN	$24,555.86	20	$13,042.24	42	-46.89%
WESTAB PLUS	$7,054.54	104	$12,822.23	43	81.76%
AMOXICILLIN	$22,055.10	25	$12,366.64	44	-43.93%
PYRETHRINS-PIPERONYL BUTOXIDE	$1,438.00	291	$12,223.00	45	750.00%
OMEPRAZOLE	$16,925.32	35	$11,896.66	46	-29.71%
BANZEL	$11,535.17	60	$11,440.83	47	-0.82%
FARXIGA	$12,778.80	51	$11,345.83	48	-11.21%
CLONIDINE HCL	$8,363.16	83	$11,343.52	49	35.64%
NUCALA	$3,699.21	163	$11,097.63	50	200.00%
AMPHETAMINE-DEXTROAMPHETAMINE	$14,688.24	44	$10,878.82	51	-25.94%
DESCOVY	$10,884.77	63	$10,857.98	52	-0.25%
ODEFSEY	$2,186.49	225	$10,824.90	53	395.08%

IOWA | Health and Human Services

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
CONCERTA	$16,133.03	37	$10,772.33	54	-33.23%
FLUOXETINE HCL	$7,804.18	93	$10,541.37	55	35.07%
ONFI	$11,755.43	58	$10,520.60	56	-10.50%
PREDNISONE	$12,655.66	52	$10,036.05	57	-20.70%
INVEGA TRINZA	$10,045.26	69	$10,025.25	58	-0.20%
METHYLPHENIDATE HCL	$13,385.23	49	$10,007.31	59	-25.24%
TOUJEO SOLOSTAR	$6,240.58	114	$9,604.36	60	53.90%
OTEZLA	$9,405.14	72	$9,534.96	61	1.38%
SPIRIVA HANDIHALER	$9,015.84	79	$9,520.72	62	5.60%
LOSARTAN POTASSIUM	$11,566.36	59	$9,435.98	63	-18.42%
INSULIN ASPART	$6,458.52	110	$9,144.20	64	41.58%
DOVATO	$5,062.55	127	$8,998.90	65	77.75%
SAPROPTERIN DIHYDROCHLORIDE	$13,467.75	48	$8,978.50	66	-33.33%
MONTELUKAST SODIUM	$8,256.51	86	$8,894.53	67	7.73%
LEVONORGESTREL & ETH ESTRADIOL	$5,321.43	120	$8,885.51	68	66.98%
DROSPIRENONE-ETHINYL ESTRADIOL	$5,949.05	115	$8,807.67	69	48.05%
PAXLOVID		999	$8,804.53	70	%
AJOVY	$7,227.20	102	$8,645.54	71	19.63%
TRAZODONE HCL	$11,102.51	62	$8,645.03	72	-22.13%
NITROFURANTOIN MONOHYD MACRO	$2,995.60	183	$8,573.42	73	186.20%
KEPPRA	$11,919.02	57	$8,454.92	74	-29.06%
DULOXETINE HCL	$7,950.24	91	$8,374.93	75	5.34%
VELPHORO	$13,659.91	47	$8,306.08	76	-39.19%
LYBALVI	$10,755.22	64	$8,288.99	77	-22.93%
GABAPENTIN	$11,205.91	61	$8,207.83	78	-26.75%
CAPLYTA	$14,441.36	45	$8,097.74	79	-43.93%
XARELTO	$9,138.71	78	$7,778.77	80	-14.88%

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TOP 100 DRUGS BY PAID AMOUNT					
DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
TRINTELLIX	$14,754.44	43	$7,713.50	81	-47.72%
ONDANSETRON	$19,256.29	28	$7,696.67	82	-60.03%
SOFOSBUVIR-VELPATASVIR		999	$7,657.20	83	%
NURTEC	$15,895.79	38	$7,482.20	84	-52.93%
QUILLICHEW ER	$10,327.57	67	$7,447.10	85	-27.89%
BUPROPION HCL	$15,478.35	41	$7,434.56	86	-51.97%
NOVOLOG FLEXPEN	$6,951.78	107	$7,434.20	87	6.94%
AZITHROMYCIN	$12,535.99	53	$7,425.94	88	-40.76%
COSENTYX UNOREADY	$14,838.68	42	$7,419.34	89	-50.00%
TRIAMCINOLONE ACETONIDE (TOPICAL)	$4,683.80	134	$7,228.15	90	54.32%
XIFAXAN		999	$7,210.80	91	%
ASPIRIN	$7,740.75	95	$7,165.77	92	-7.43%
NORELGESTROMIN-ETHINYL ESTRADIOL	$6,446.57	111	$7,092.19	93	10.01%
TRESIBA FLEXTOUCH	$6,547.72	109	$6,944.63	94	6.06%
ADDERALL XR	$2,405.84	207	$6,901.43	95	186.86%
TRAMADOL HCL	$9,237.93	75	$6,883.66	96	-25.48%
HYDROXYZINE HCL	$5,507.34	116	$6,873.34	97	24.80%
LEVOTHYROXINE SODIUM	$7,868.89	92	$6,818.87	98	-13.34%
BENLYSTA	$10,001.52	70	$6,693.00	99	-33.08%
TIVICAY	$4,424.88	144	$6,654.92	100	50.40%

IOWA | Health and Human Services

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
SERTRALINE HCL	456	1	507	1	11.18%
TRAZODONE HCL	438	3	490	2	11.87%
ALBUTEROL SULFATE	445	2	450	3	1.12%
ATORVASTATIN CALCIUM	421	4	434	4	3.09%
OMEPRAZOLE	406	5	409	5	0.74%
CETIRIZINE HCL	384	7	398	6	3.65%
ESCITALOPRAM OXALATE	352	12	378	7	7.39%
CLONIDINE HCL	358	11	373	8	4.19%
GABAPENTIN	386	6	372	9	-3.63%
FLUOXETINE HCL	383	8	370	10	-3.39%
HYDROXYZINE HCL	303	15	364	11	20.13%
METFORMIN HCL	368	9	356	12	-3.26%
LEVOTHYROXINE SODIUM	367	10	338	13	-7.90%
LISINOPRIL	316	14	332	14	5.06%
AMPHETAMINE-DEXTROAMPHETAMINE	276	19	286	15	3.62%
METHYLPHENIDATE HCL	282	17	275	16	-2.48%
BUPROPION HCL	277	18	258	17	-6.86%
ARIPIPRAZOLE	248	22	253	18	2.02%
BUSPIRONE HCL	250	20	251	19	0.40%
QUETIAPINE FUMARATE	282	16	246	20	-12.77%
DULOXETINE HCL	245	23	242	21	-1.22%
MONTELUKAST SODIUM	248	21	242	22	-2.42%
HYDROCODONE-ACETAMINOPHEN	203	28	239	23	17.73%
IBUPROFEN	233	24	237	24	1.72%
AMLODIPINE BESYLATE	193	32	225	25	16.58%
PREDNISONE	211	27	221	26	4.74%

IOWA | Health and Human Services

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
PANTOPRAZOLE SODIUM	197	31	217	27	10.15%
FAMOTIDINE	226	25	197	28	-12.83%
RISPERIDONE	201	29	195	29	-2.99%
ASPIRIN	155	44	185	30	19.35%
LAMOTRIGINE	222	26	185	31	-16.67%
VENLAFAXINE HCL	183	34	181	32	-1.09%
LEVETIRACETAM	197	30	174	33	-11.68%
POLYETHYLENE GLYCOL 3350	166	38	174	34	4.82%
METOPROLOL SUCCINATE	162	41	174	35	7.41%
ONDANSETRON	184	33	172	36	-6.52%
TOPIRAMATE	162	42	168	37	3.70%
AMOXICILLIN	324	13	164	38	-49.38%
FLUTICASONE PROPIONATE (NASAL)	180	36	162	39	-10.00%
CYCLOBENZAPRINE HCL	156	43	161	40	3.21%
ACETAMINOPHEN	176	37	160	41	-9.09%
CEPHALEXIN	150	46	160	42	6.67%
AMOXICILLIN & POT CLAVULANATE	180	35	154	43	-14.44%
OZEMPIC	131	54	154	44	17.56%
LOSARTAN POTASSIUM	153	45	153	45	0.00%
GUANFACINE HCL	149	47	151	46	1.34%
CLONAZEPAM	136	52	148	47	8.82%
HYDROXYZINE PAMOATE	139	48	143	48	2.88%
FERROUS SULFATE	124	59	143	49	15.32%
VYVANSE	165	40	142	50	-13.94%
PROPRANOLOL HCL	136	51	140	51	2.94%
SPIRONOLACTONE	129	56	140	52	8.53%
GUANFACINE HCL (ADHD)	135	53	139	53	2.96%

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TOP 100 DRUGS BY PRESCRIPTION COUNT					
DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
OXYCODONE HCL	136	50	130	54	-4.41%
MIRTAZAPINE	128	57	128	55	0.00%
FUROSEMIDE	112	63	126	56	12.50%
JARDIANCE	107	65	125	57	16.82%
ROSUVASTATIN CALCIUM	127	58	123	58	-3.15%
LORATADINE	112	62	117	59	4.46%
TRIAMCINOLONE ACETONIDE (TOPICAL)	82	82	117	60	42.68%
ALPRAZOLAM	99	72	117	61	18.18%
LANTUS SOLOSTAR	113	61	116	62	2.65%
BACLOFEN	137	49	115	63	-16.06%
PRAZOSIN HCL	102	70	114	64	11.76%
TRAMADOL HCL	130	55	110	65	-15.38%
METRONIDAZOLE	118	60	110	66	-6.78%
HYDROCHLOROTHIAZIDE	91	78	110	67	20.88%
OLANZAPINE	104	67	109	68	4.81%
SULFAMETHOXAZOLE-TRIMETHOPRIM	105	66	100	69	-4.76%
MELOXICAM	100	71	98	70	-2.00%
LORAZEPAM	103	69	97	71	-5.83%
DOXYCYCLINE (MONOHYDRATE)	96	74	97	72	1.04%
AZITHROMYCIN	166	39	95	73	-42.77%
DIVALPROEX SODIUM	95	75	94	74	-1.05%
PREGABALIN	87	79	93	75	6.90%
ATOMOXETINE HCL	92	76	91	76	-1.09%
OXYBUTYNIN CHLORIDE	91	77	91	77	0.00%
FLUCONAZOLE	79	84	90	78	13.92%
ZOLPIDEM TARTRATE	76	86	84	79	10.53%

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TOP 100 DRUGS BY PRESCRIPTION COUNT					
DRUG DESCRIPTION	March through May 2024	PREVIOUS RANK	June through August 2024	RANK	PERCENT CHANGE
FOLIC ACID	84	80	84	80	0.00%
ONDANSETRON HCL	80	83	79	81	-1.25%
NALTREXONE HCL	69	94	78	82	13.04%
DEXMETHYLPHENIDATE HCL	98	73	78	83	-20.41%
VALACYCLOVIR HCL	69	93	78	84	13.04%
ELIQUIS	67	95	78	85	16.42%
AMITRIPTYLINE HCL	69	91	77	86	11.59%
METOPROLOL TARTRATE	75	87	76	87	1.33%
OXCARBAZEPINE	59	100	73	88	23.73%
SYMBICORT	70	90	73	89	4.29%
VENTOLIN HFA	111	64	72	90	-35.14%
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE	51	107	70	91	37.25%
TIZANIDINE HCL	66	96	69	92	4.55%
CARVEDILOL	82	81	68	93	-17.07%
CLOBAZAM	76	85	68	94	-10.53%
GLYCOPYRROLATE	71	89	67	95	-5.63%
NAPROXEN	73	88	66	96	-9.59%
WESTAB PLUS	57	102	65	97	14.04%
CEFDINIR	103	68	65	98	-36.89%
PAROXETINE HCL	58	101	64	99	10.34%
CITALOPRAM HYDROBROMIDE	69	92	64	100	-7.25%

Medicaid Statistics for Prescription Claims
June through August 2024

Tri-Monthly Statistics

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare	Total**
Total Dollars Paid	$2,624,682	$97,248,376	$73,532,636	$53,028,906	$226,434,600
Users	3,760	98,025	89,052	76,044	266,881
Cost Per User	$698.05	$992.08	$825.73	$697.35	
Total Prescriptions	23,798	811,300	663,331	503,230	2,001,659
Average Rx/User	6.33	8.28	7.45	6.62	
Average Cost/Rx	$110.29	$119.87	$110.85	$105.38	
# Generic Prescriptions	21,514	724,003	596,352	456,998	
% Generic	90.4%	89.2%	90.0%	90.8%	
$ Generic	$995,976	$12,905,161	$10,210,480	$7,740,518	
Average Generic Rx Cost	$46.29	$17.82	$17.12	$16.94	
Average Generic Days Supply	25	26.12	26	25.24	
# Brand Prescriptions	2,284	87,297	65,961	47,144	
% Brand	9.6%	10.8%	10.0%	9.4%	
$ Brand	$1,628,706	$84,343,215	$63,290,934	$45,288,389	
Average Brand Rx Cost	$713.09	$966.16	$959.52	$960.64	
Average Brand Days Supply	28	27.6	28	27.9	

**All reported dollars are pre-rebate

Top 20 Therapeutic Class by Paid Amount*

June through August 2024

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
1	ANTIDIABETICS	ANTIDIABETICS	ANTIDIABETICS	ANTIDIABETICS
2	ANTIPSYCHOTICS/ANTIMANIC AGENTS	DERMATOLOGICALS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS
3	DERMATOLOGICALS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANALGESICS - ANTI-INFLAMMATORY	DERMATOLOGICALS
4	ANTIVIRALS	ANALGESICS - ANTI-INFLAMMATORY	DERMATOLOGICALS	ANALGESICS - ANTI-INFLAMMATORY
5	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADHD/ANTI-NARCOLEPSY	ANTIASTHMATIC AND BROCHODILATOR AGENTS	ANTIVIRALS
6	ADHD/ANTI-NARCOLEPSY	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADHD/ANTI-NARCOLEPSY	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
7	ANTICONVULSANTS	ANTICONVULSANTS	ANTIVIRALS	ADHD/ANTI-NARCOLEPSY AGENTS
8	ANTIDEPRESSANTS	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
9	ANALGESICS - ANTI-INFLAMMATORY	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	RESPIRATORY AGENTS - MISC.	HEMATOLOGICAL AGENTS - MISC.
10	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ANTIVIRALS	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
11	ANTIHYPERTENSIVES	HEMATOLOGICAL AGENTS - MISC.	ANTICONVULSANTS	RESPIRATORY AGENTS - MISC.
12	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	MIGRAINE PRODUCTS	MIGRAINE PRODUCTS	MIGRAINE PRODUCTS
13	RESPIRATORY AGENTS - MISC.	RESPIRATORY AGENTS - MISC.	HEMATOLOGICAL AGENTS - MISC.	ANTIDEPRESSANTS
14	ANTICOAGULANTS	ENDOCRINE AND METABOLIC AGENTS - MISC.	ENDOCRINE AND METOBOLIC AGENTS - MISC.	ANTICOAGULANTS
15	HEMATOLOGICAL AGENTS - MISC.	CARDIOVASCULAR AGENTS - MISC.	ANTIDEPRESSANTS	ENDOCRINE AND METABOLIC AGENTS - MISC.
16	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	ANTIDEPRESSANTS	CARDIOVASCULAR AGENTS - MISC.	CARDIOVASCULAR AGENTS - MISC.
17	ANTIHYPERLIPIDEMICS	GASTROINTESTINAL AGENTS - MISC.	ANTICOAGULANTS	ANTICONVULSANTS
18	CONTRACEPTIVES	ANTICOAGULANTS	GASTROINTESTINAL AGENTS - MISC.	GASTROINTESTINAL AGENTS - MISC.
19	ANALGESICS - OPIOID	NEUROMUSCULAR AGENTS	NEUROMUSCULAR AGENTS	ANTI-INFECTIVE AGENTS - MISC.
20	ENDOCRINE AND METABOLIC AGENTS - MISC.	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	PASSIVE IMMUNIZING AND TREATMENT AGENTS	MISCELLANEOUS THERAPEUTIC CLASSES

* Pre-rebate

Top 20 Therapeutic Class by Prescription Count

June through August 2024

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
1	ANTIDEPRESSANTS	ANTIDEPRESSANTS	ANTIDEPRESSANTS	ANTIDEPRESSANTS
2	ANTICONVULSANTS	ANTICONVULSANTS	ANTICONVULSANTS	ANTICONVULSANTS
3	ANTIHYPERTENSIVES	ANTIHYPERTENSIVES	ANTIHYPERTENSIVES	ANTIHYPERTENSIVES
4	ADHD/ANTI-NARCOLEPSY	ADHD/ANTI-NARCOLEPSY	ANTIDIABETICS	ANTIDIABETICS
5	ANTIDIABETICS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
6	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIDIABETICS	ADHD/ANTI-NARCOLEPSY AGENTS	ADHD/ANTI-NARCOLEPSY
7	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS
8	ANTIANXIETY AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS
9	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	ANTIANXIETY AGENTS	ANTIANXIETY AGENTS	ANTIANXIETY AGENTS
10	ANTIHYPERLIPIDEMICS	ANTIHYPERLIPIDEMICS	ANTIHYPERLIPIDEMICS	ANTIHYPERLIPIDEMICS
11	ANALGESICS - OPIOID	ANTIHISTAMINES	ANTIHISTAMINES	DERMATOLOGICALS
12	DERMATOLOGICALS	DERMATOLOGICALS	DERMATOLOGICALS	BETA BLOCKERS
13	ANTIHISTAMINES	BETA BLOCKERS	BETA BLOCKERS	ANALGESICS - ANTI-INFLAMMATORY
14	ANALGESICS - ANTI-INFLAMMATORY	ANALGESICS - ANTI-INFLAMMATORY	ANALGESICS - ANTI-INFLAMMATORY	ANALGESICS - OPIOID
15	BETA BLOCKERS	ANALGESICS - OPIOID	ANALGESICS - OPIOID	DIURETICS
16	DIURETICS	DIURETICS	DIURETICS	ANTIHISTAMINES
17	MUSCULOSKELETAL THERAPY AGENTS	THYROID AGENTS	THYROID AGENTS	PENICILLINS
18	THYROID AGENTS	MUSCULOSKELETAL THERAPY AGENTS	PENICILLINS	THYROID AGENTS
19	CORTICOSTEROIDS	PENICILLINS	ANALGESICS - NONNARCOTIC	CALCIUM CANNEL BLOCKERS
20	ANALGESICS - NONNARCOTIC	CALCIUM CHANNEL BLOCKERS	MUSCULOSKELETAL THERAPY AGENTS	MUSCULOSKELETAL THERAPY AGENTS

Top 25 Drugs by Paid Amount**

June through August 2024

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
1	OZEMPIC	OZEMPIC	HUMIRA PEN	OZEMPIC
2	BIKTARVY	HUMIRA (CF) PEN	OZEMPIC	HUMIRA (2 PEN)
3	TALTZ	VRAYLAR	VRAYLAR	DUPIXENT
4	VRAYLAR	TRIKAFTA	TRIKAFTA	VRAYLAR
5	HUMIRA PEN	STELARA	DUPIXENT	BIKTARVY
6	JARDIANCE	JARDIANCE	JARDIANCE	TRIKAFTA
7	DUPIXENT	INVEGA SUSTENNA	INVEGA SUSTENNA	JARDIANCE
8	TRIKAFTA	DUPIXENT PEN	BIKTARVY	STELARA
9	HEMLIBRA	SKYRIZI PEN	TALTZ	INVEGA SUSTENNA
10	VYVANSE	TALTZ AUTOINJECTOR	TRULICITY	TALTZ
11	KISQALI	TRULICITY	STELARA	TRULICITY
12	ELIQUIS	VYVANSE	VYVANSE	ELIQUIS
13	ARISTADA	BIKTARVY	ELIQUIS	VYVANSE
14	ALBUTEROL HFA	ELIQUIS	REXULTI	HEMLIBRA
15	TRULICITY	REXULTI	SKYRIZI PEN	ALTUVIIIO
16	EVRYSDI	MOUNJARO	ARISTADA	SKYRIZI PEN
17	KESIMPTA	NURTEC ODT	INGREZZA	ARISTADA
18	INGREZZA	ALTUVIIIO	MOUNJARO	REXULTI
19	SERTRALINE	DUPIXEN SYRINGE	ENBREL SRCLK	NURTEC
20	IBUPROFEN	ARISTADA	NURTEC	INGREZZA
21	ESCITALOPRAM	INGREZZA	FARXIGA	MOUNJARO
22	LISINOPRIL	WAKIX	STRENSIQ	FARXIGA
23	ATORVASTATIN	EVRYSDI	INVEGA TRINZ	ENBREL SURECLICK
24	AUSTEDO	ABILIFY MAINTENA	ABILIFY MAINTENA	MAVYRET
25	INVEGA SUSTENNA	COSENTYX SENSOREADY (2 PENS)	CAPLYTA	ABILIFY MAINTENA

** Pre-rebate

Top 25 Drugs by Prescription Count

June through August 2024

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
1	SERTRALINE	OMEPRAZOLE	ATORVASTATIN	ATORVASTATIN
2	TRAZODONE	ATORVASTATIN	SERTRALINE	SERTRALINE
3	ALBUTEROL HFA	SERTRALINE	OMEPRAZOLE	OMEPRAZOLE
4	ATORVASTATIN	LEVOTHYROXINE	LEVOTHYROXINE	LISINOPRIL
5	OMEPRAZOLE	ESCITALOPRAM	ALBUTEROL	LEVOTHYROXINE
6	CETIRIZINE	TRAZODONE	TRAZODONE	ESCITALOPRAM
7	ESCITALOPRAM	CETIRIZINE	LISINOPRIL	TRAZODONE
8	CLONIDINE	LISINOPRIL	FLUOXETINE	FLUOXETINE
9	GABAPENTIN	FLUOXETINE	ESCITALOPRAM	BUPROPION ER
10	FLUOXETINE	GABAPENTIN	METFORMIN	ALBUTEROL HFA
11	HYDROXYZINE HCL	MONTELUKAST	CETIRIZINE	GABAPENTIN
12	METFORMIN	HYDROXYZINE HCL	BUPROPION	AMLODIPINE
13	LEVOTHYROXINE	BUSPIRONE	GABAPENTIN	HYDROXYZINE HCL
14	LISINOPRIL	ALBUTEROL HFA	AMPHET/DEXTROAMPHET	AMOXICILLIN
15	AMPHETAMINE/DEXTROAMPHET	PANTOPRAZOLE	MONTELUKAST	BUSPIRONE
16	METHYLPHENIDATE	DULOXETINE	HYDROXYZINE HCL	DULOXETINE
17	BUPROPION ER	AMLODIPINE	AMLODIPINE	PANTOPRAZOLE
18	ARIPIPRAZOLE	CLONIDINE	BUSPIRONE	MONTELUKAST
19	BUSPIRONE	QUETIAPINE	DULOXETINE	QUETIAPINE
20	QUETIAPINE	ARIPIPRAZOLE	PANTOPRAZOLE	METOPROLOL SUCCINATE
21	DULOXETINE	METOPROLOL SUCCINATE	AMOXICILLIN	CETIRIZINE
22	MONTELUKAST	LAMOTRIGINE	METHYLPHENIDATE	HYDROCODONE/APAP
23	HYDROCODONE-APAP	VENLAFAXINE ER	QUETIAPINE	LOSARTAN
24	IBUPROFEN	AMOXICILLIN	CLONIDINE	METFORMIN
25	AMLODIPINE	FAMOTIDINE	GUANFACINE	PREDNISONE

Stimulant Medication Utilization without Supporting Diagnosis RetroDUR Data

Purpose

- Identify members with claims for a stimulant indicated for the treatment of attention deficit hyperactivity disorder (ADHD) who do not have a supporting diagnosis in medical claims.

Background

- Prescription stimulant medication use has increased over the years. Based on prevalence reports from the MCOs and FFS, the ADHD/Narcolepsy agents are consistently in the top 20 therapeutic classes by paid amount and the top 20 therapeutic classes by prescription count.
- Preferred stimulant medications do not require prior authorization (PA) for members under 21 years of age, while PA is required for all members 21 years of age or older.
- Several stimulant medications FDA approved for the treatment of ADHD, have other FDA approved indications, including narcolepsy and binge eating disorder.

RDUR Criteria

- Pharmacy claim lookback: May 2024 through July 2024
- Members: < 21 years of age (broken out by age band) and ≥ 21 years of age
- Stimulants: amphetamine, amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate, serdexmethylphenidate-dexmethylphenidate
- Medical claim look back for diagnosis: 5 years (August 2019 through July 2024)
    - F90 Attention deficit hyperactivity disorders
    - G47 Sleep disorders including hypersomnia, circadian rhythm sleep disorders, sleep apnea narcolepsy and cataplexy, parasomnia, sleep related movement disorders, other sleep disorders, and unspecified sleep disorder (excludes insomnia)
    - F50.81 Binge eating disorder
    - R41.840 Attention and concentration deficit
    - F98.8X Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

Data

Iowa Total Care (ITC)

- Total unique members: 9,306
- Total unique prescribers: 2,201
- Total unique pharmacies: 661

ITC Members without Supporting Diagnosis – 2.4%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	0	2	15	50	34	15	108
Unique Providers	0	2	18	44	39	16	96

ITC Members with Supporting Diagnosis – 97.6%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	2	82	725	2,605	1,955	494	3,219
Unique Providers	4	85	445	1,002	876	446	1,319

Molina Healthcare (MHC)

- Total unique members: 7,673
- Total unique prescribers: 2,110
- Total unique pharmacies: 667

MHC Members without Supporting Diagnosis – 9.4%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	0	4	24	152	150	59	340
Unique Providers	0	4	22	140	143	62	284

MHC Members with Supporting Diagnosis – 90.6%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	3	93	625	2,082	1,361	343	2,573
Unique Providers	3	83	412	907	724	316	1,164

Wellpoint (WLP)

- Total unique members: 11,206
- Total unique prescribers: 2,362
- Total unique pharmacies: 668

Wellpoint Members without Supporting Diagnosis – 17%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	0	7	64	455	568	218	590
Unique Providers	0	7	71	372	409	206	385

Wellpoint Members with Supporting Diagnosis – 83%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	0	67	646	2,620	1,991	504	3,476
Unique Providers	0	61	397	949	817	408	1,400

Fee-for-Service (FFS)

- Total unique members: 379
- Total unique prescribers: 272
- Total unique pharmacies: 201

FFS Members without Supporting Diagnosis – 16.1%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	0	1	1	17	25	7	10
Unique Providers	0	1	1	16	25	8	11

FFS Members with Supporting Diagnosis – 83.9%							
Age Band	**0-3**	**4-5**	**6-7**	**8-12**	**13-17**	**18-20**	**21+**
Unique Members	0	1	16	81	115	28	77
Unique Providers	0	1	14	67	106	30	77

Next Steps

1. Send letters to prescribers of all members without a supporting diagnosis, inquiring about the rationale for prescribing the medication when a valid diagnosis is not present in medical claims.
2. Send letters to prescribers of members from specific age band(s) without a supporting diagnosis, inquiring about the rationale for prescribing the medication when a valid diagnosis is not present in medical claims.
3. Other?
4. None?

Monitoring Prescribing of Antipsychotic Medications in Adults
RetroDUR
Data

Purpose

- Identify adult members (18 years of age and older) who have three or more distinct antipsychotics in their pharmacy claims history.

Background

- H.R. 4366 – Consolidated Appropriations Act, 2024, Section 203 requires state Medicaid programs to monitor, through their DUR programs, the use of antipsychotic medications by adults who receive home- and community-based services or who are in institutional care settings.
- Questions regarding monitoring of adult antipsychotic use will be added to the DUR FFY 2024 DUR survey (to be released to States for completion on April 1, 2025).
- Need to determine how to "monitor" adults who are prescribed antipsychotics.
- Documentation of process and plan to monitor in DUR meeting minutes would be the first step. To date, CMS has not provided formal guidance.
- Effective October 1, 2022, a ProDUR duplicate therapy edit was put in place for members 18 years of age and older. The edit limits adults to two chemically distinct antipsychotics. Prior authorization is required to exceed this limit.

RDUR Criteria

- Pharmacy claims: May 2024 through July 2024
- Members: ≥ 18 years old
- Members with ≥ 3 chemically distinct antipsychotics for ≥ 60 days overlap
- Antipsychotics

First Generation	Second Generation
Chlorpromazine	Aripiprazole
Fluphenazine	Asenapine
Haloperidol	Brexpiprazole
Loxapine	Cariprazine
Perphenazine	Clozapine
Pimozide	Iloperidone
Prochlorperazine	Lumateperone
Thioridazine	Lurasidone
Thiothixene	Olanzapine
Trifluoperazine	Paliperidone
	Quetiapine
	Risperidone
	Ziprasidone

Data

	ITC # Members	**MHC** # Members	**WLP** # Members	**FFS** # Members
3 Distinct Antipsychotics	8	0	67	0
4 Distinct Antipsychotics	0	0	8	0
# Unique Prescribers	12	0	83	0

FFS = Fee-for-Service; ITC = Iowa Total Care; MHC = Molina Health Care; WLP = Wellpoint

Next Steps

1. Send letters to prescriber of all members taking 3 or more chemically distinct antipsychotics pointing out the lack of evidence for the safety and efficacy of using multiple antipsychotic medications and ask if the use of multiple antipsychotics outweighs the risks?
2. Develop retrospective reporting to monitor the prescribing of antipsychotic medications in adults?
3. Other?
4. DUR Digest?
5. None?

Triple Therapy
Opioid, Benzodiazepine, Muscle Relaxant
RetroDUR
Data

Purpose

- Identify members with concurrent therapy of at least 30 days for all three of the following medications: opioid, benzodiazepine, and muscle relaxant.

Background

- The combination of opioids with benzodiazepines and skeletal muscle relaxants has been reported to potentiate the high from the opioid. The combination of an opioid, benzodiazepine and carisoprodol is commonly referred to as the street name of “Holy Trinity”.
- When co-prescribed, this combination can cause euphoria, increased risk of respiratory depression, and increased risk of hospitalization.
- Current CDC guidelines state clinicians should use particular caution when prescribing opioids with benzodiazepines or other sedating medications (muscle relaxants, nonbenzodiazepine sedative hypnotics, and potentially sedating anticonvulsant medications such as gabapentin and pregabalin) and consider whether benefits outweigh the risks.
- Based on the Prescription Monitoring Program (PMP) data for 2022, Iowans received the following:
    - Opioid prescription – 499,153
    - Benzodiazepine prescription – 261,887
    - Opioid + benzodiazepine – 69,733 (PMP does not track muscle relaxant dispensations)

RDUR Criteria

- Pharmacy claims: May through July 2024
- Members: < 18 and ≥ 18 years of age
- Identify members with an opioid + benzodiazepine + muscle relaxant with at least a 30-day overlap with all 3 of the medications. Identify a subset of these members where the muscle relaxant is carisoprodol.
- Benzodiazepine: alprazolam, diazepam, lorazepam, clonazepam (excluding rectal or nasal benzodiazepine for seizure)

Data

Opioid + Benzodiazepine + Muscle Relaxant for ≥ 30 Days*

	ITC	MHC	WLP	FFS
# Members (18+ years old)	103	29	146	7
# Prescribers	210	52	285	17
# with Opioid + Benzo + Carisoprodol	2	0	2	0
# Prescribers	3	0	2	0

*Zero members 0 to 17 years of age identified

FFS = Fee-for-Service; ITC = Iowa Total Care; MHC = Molina Health Care; WLP = Wellpoint

Next Steps

1. Send letters to prescribers of members identified with an opioid + benzodiazepine + muscle relaxant for 30+ days and ask if the benefits outweigh the risks of triple therapy and if one or more drugs could be discontinued.
2. Send letters to prescribers of members identified with an opioid + benzodiazepine + carisoprodol and point out the risk of triple therapy, that it has been shown to have limited efficacy in the relief of acute pain associated with musculoskeletal conditions, and the effectiveness of carisoprodol has not been established for use longer than 2 to 3 weeks.
3. DUR Digest?
4. Other?
5. None?

72-Hour Emergency Override Utilization Review
RetroDUR
Proposal

Purpose

- To review the 72-Hour emergency override to ensure appropriate utilization of function and determine if any PDL changes or a pharmacy benefit build needs to be addressed due to consistent utilization of function.
- If inappropriate utilization is found, education to pharmacies may be needed on appropriate billing practices.

Background

- Per 42 U.S. Code § 1396r-8(d)(5)(B) state must make arrangements that permit pharmacist to dispense at least a 72-hour supply of any covered drug in an emergency situation.
- According to the Iowa Medicaid Prescribed Drugs Provider Manual, the provision for a 72-hour supply can be used in an emergency situation only one time per member, per drug. A 7-day override of the prior authorization requirement will be allowed while the prescriber is requesting prior authorization for certain mental health drugs. A 72-hour emergency supply may not be available for medications intended for a short duration of therapy.

Potential RDUR Criteria

- **Time Period:** November 1, 2023, to October 31, 2024
- **Data to include:**
  - Find all claims where the emergency 72-hour override (or 7-day override) process was used for a paid claim.
- **Report out:**
  - Total number of claims with the 72-hour emergency override code
  - Top 50 drugs where the 72-hour override code was used
  - Top 50 pharmacies that submitted a claim with the 72-hour override code
  - Total number of pharmacies that use the 72-hour override code
  - Number of non-preferred overrides vs preferred overrides
  - Common themes
- **Other items to consider**
  - Top 50 drugs too many? Not enough?
  - Other?

Concurrent Use of GLP-1 Receptor Agonist and DPP-4 Inhibitor
RetroDUR
Proposal

Purpose

- To identify members with concurrent use of a glucagon-like peptide receptor agonist (GLP-1 RA) and dipeptidyl peptidate-4 inhibitor (DPP-4i).

Background

- The American Diabetes Association (ADA) "Standards of Medical Care in Diabetes - 2024", Section 9, Pharmacologic Approaches to Glycemic Treatment provide recommendations in the overall approach to treating Type 2 Diabetes.
- Current recommendations do not recommend combined use of a GLP-1 RA and DPP-4i.
- GLP-1 RA and DPP-4i have overlapping mechanisms of action (MOA).
- Use of both agents concurrently does not offer additional significant lowering of A1C and adds to the patient's pill burden and increased medical costs.

RDUR Criteria

- Members with concurrent use of a GLP-1 RA and DPP-4i
- ≥ 60 days overlap
- Time period: July through September 2024
- Additional criteria?

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Acute Migraine Treatments *Use Acute Migraine Treatments PA form*	No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions: 1. A diagnosis of acute migraine; and 2. Patient meets the FDA approved age for requested agent; and 3. For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or 4. For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or 5. For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or 6. For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
ADD/ADHD/ NARCOLEPSY AGENTS *Use CNS Stimulants and Atomoxetine PA form*	*See CNS Stimulants and Atomoxetine Prior Authorization (PA) Criteria.*

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors *Use Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors PA form*	Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age; and 2. Documentation of adherence to prescribed lipid lowering medications (including a maximally tolerated statin), prior to ACL inhibitor therapy, for the previous 90 days is provided (further defined below, by diagnosis); and 3. Documentation is provided that medication will be used in combination with a maximally tolerated statin; and 4. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; and 5. Patient will continue to follow an appropriate low fat diet; and 6. Is prescribed by or in consultation with a lipidologist, cardiologist, or endocrinologist; and 7. If patient is taking in combination with: a. Simvastatin, dose does not exceed 20mg per day; or b. Pravastatin, dose does not exceed 40mg per day; and 8. Concurrent use with a PCSK9 inhibitor will not be considered; and 9. Goal is defined as a 50% reduction in untreated baseline LDL-C; and 10. Is prescribed for one of the following diagnoses: a. Heterozygous Familial Hypercholesterolemia (HeFH): i. Documentation is provided verifying diagnosis (attach documentation/results), as evidenced by: 1. Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) or: 2. Confirmation of diagnosis by gene or receptor testing; and ii. Documentation of untreated LDL-C ≥ 190 mg-dL; and iii. Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily; or b. Clinical Atherosclerotic Cardiovascular Disease (ASCVD): i. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and ii. Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily, If criteria for coverage are met, requests will be approved for 3 months. Additional authorizations will be considered at yearly intervals under the following conditions: a. Patient continues therapy with a maximally tolerated statin dose and remains at goal; and b. Patient continues to follow an appropriate low fat diet; and c. Documentation of LDL reduction is provided. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Age Edit Override – Codeine or Tramadol *Use Age Edit Override-Codeine or Tramadol PA form*	An age edit override for codeine or tramadol is required for patients under 18 years of age. Payment will be considered under the following conditions: 1. Member is 12 years of age or older; and 2. Medication is not being prescribed to treat pain after surgery following tonsil and/or adenoid procedure for members 12 to 18 years of age; and 3. If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m^2), does not have obstructive sleep apnea, or severe lung disease.
Alpelisib (Vijoice) *Use Alpelisib (Vijoice) PA form*	Prior authorization (PA) is required for alpelisib (Vijoice). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and *2.* Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing demonstrating a *PIK3CA* mutation; and 3. Patient's condition is severe or life-threatening requiring systemic therapy as determined by treating prescriber: and 4. Patient has at least one target lesion identified on imaging. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by a reduction in sum of measurable lesion volume across 1 to 3 target lesions.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Alpha$_1$-Proteinase Inhibitor Enzymes *Use Alpha$_1$-Proteinase Inhibitor Enzymes PA form*	Prior authorization (PA) is required for Alpha$_1$-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha$_1$-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following is met: 1. Patient has a diagnosis of congenital alpha$_1$-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or a. 80mg/dl if measured by radial immunodiffusion, or b. 50mg/dl if measured by nephelometry; and 2. Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and 3. Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV_1); and 4. Patient is 18 years of age or older; and 5. Patient is currently a non-smoker; and 6. Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and 7. Medication will be administered in the member's home by home health or in a long-term care facility. If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met: 1. Evidence of clinical efficacy, as documented by: a. An elevation of AAT levels (above protective threshold i.e., > 11µM/L); and b. A reduction in rate of deterioration of lung function as measured by a decrease in the FEV_1 rate of decline; and 2. Patient continues to be a non-smoker; and 3. Patient continues supportive therapy for obstructive lung disease.
Amylino Mimetic (Symlin) *Use Amylino Mimetic (Symlin) PA form*	Prior authorization (PA) is required for amylino mimetics (Symlin). Payment will be considered under the following conditions: 1. Diagnosis of Type 1 or Type 2 diabetes mellitus, 2. Concurrent use of insulin therapy, 3. Documentation of blood glucose monitoring three or more times daily, 4. Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments. Initial authorizations will be approved for six months; additional PAs will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial PA period.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Antidepressants *Aplenzin* *Auvelity* *Fetzima* *Use Antidepressants PA form*	Prior authorization (PA) is required for non-preferred antidepressants subject to clinical criteria. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and 3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant; and 5. Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and 6. Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and 7. Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and 8. If the request is for dextromethorphan and bupropion extended-release tablet (Auvelity), one of the trials must include a previous trial and inadequate response at a therapeutic dose with an extended-release bupropion agent; and 9. If the request is for an isomer, prodrug or metabolite of the requested medication, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Anti-Diabetics, Non-Insulin Agents *Use Anti-Diabetics, Non-Insulin PA form*	Prior authorization (PA) is required for select preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and 3. Requests for non-preferred antidiabetic, non-insulin agents subject to clinical criteria, will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Additionally, requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with at least 3 preferred agents from 3 different drug classes at maximally tolerated doses. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Requests for weight loss are not a covered diagnosis of use and will be denied.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents *Use Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents form*	Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. Payment for Antiemetic-5HT3 Receptor Agonists/ Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation. PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy. Aprepitant (N)/Emend (P): 4 – 125mg capsules 8 – 80mg capsules Dolasetron (N)/Anzemet (N): 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) Granisetron (N): 8 – 1mg tablets 8 vials (1mg/mL) 2 vials (4mg/mL) Akynzeo (N): 2 – 300/0.5mg capsules Ondansetron (P)/Zofran (N): 60 – 4mg tablets 60 – 8mg tablets 4 – 24mg tablets 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) Ondansetron ODT (P)/Zofran ODT (N): 60 – 4mg tablets 60 – 8mg tablets Ondansetron Oral Solution (N)/ Zofran Oral Solution (N) 50mL/month – oral solution (4mg/5mL)
Anti-Fungal- Oral / Injectable *Use Anti-Fungal PA form*	Prior authorization (PA) is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. PA will be required for all non-preferred antifungal therapy beginning the first day of therapy. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for any antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This PA requirement does not apply to nystatin.
Antihistamines *Use Antihistamine PA form*	Prior authorization (PA) is required for all non-preferred oral antihistamines. Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require PA, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine. Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Apremilast (Otezla) *Use Apremilast (Otezla) PA form*	Prior authorization (PA) is required for apremilast (Otezla). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 2. Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); with a. Documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 3. Patient has a diagnosis of plaque psoriasis; with a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; or 4. Patient has a diagnosis of Behçet disease; with a. Documentation of active oral ulcers associated with Behçet disease; and b. Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Aripiprazole Tablets with Sensor (Abilify MyCite) *Use Aripiprazole Tablets with Sensor (Abilify MyCite) PA form*	Prior authorization is required for aripiprazole tablets with sensor (Abilify MyCite). Payment will be considered under the following conditions: 1. Patient has a diagnosis of Schizophrenia, Bipolar I Disorder, or Major Depressive Disorder; and 2. Patient meets the FDA approved age for use of the Abilify MyCite device; and 3. Dosing follows the FDA approved dose for the submitted diagnosis; and 4. Documentation of patient adherence to generic aripiprazole tablets is less than 80% within the past 6 months (prescriber must provide documentation of the previous 6 months' worth of pharmacy claims for aripiprazole documenting non-adherence); and 5. Documentation all the following strategies to improve patient adherence have been tried without success: a. Utilization of a pill box b. Utilization of a reminder device (e.g. alarm, application, or text reminder) c. Involving family members or friends to assist d. Coordinating timing of dose with dosing of another daily medication; and 6. Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; and 7. Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite. Initial approvals will be given for one month. Prescriber must review member adherence in the web-based portal and document adherence for additional consideration. If non-adherence continues, prescriber must document a plan to improve adherence. If adherence is improved, consideration to switch member to generic aripiprazole tablets must be considered. Note, the ability of Abilify MyCite to improve patient compliance has not been established, 8. Requests will not be considered for patients in long-term care facilities. 9. A once per lifetime approval will be allowed. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Baclofen *Use Baclofen PA form*	Prior authorization (PA) is required for non-preferred baclofen dosage forms. Payment for a non-preferred agent will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient has a diagnosis of spasticity resulting from multiple sclerosis (relief of flexor spasms and concomitant pain, clonus, and muscular rigidity) or spinal cord injuries/diseases; and 2. Patient meets the FDA approved age; and 3. Documentation of a patient-specific, clinically significant reason (beyond convenience) why the member cannot use baclofen oral tablets, even when tablets are crushed and sprinkled on soft food or liquid. Presence of a nasogastric (NG) tube/J-tube alone are not reasons for approval; and 4. Request does not exceed the maximum dosage of 80mg daily.
Benzodiazepines *Use Benzodiazepine PA form*	Prior authorization (PA) is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member. PA will be approved for up to 12 months for documented: 1. Generalized anxiety disorder. 2. Panic attack with or without agoraphobia. 3. Seizure. 4. Non-progressive motor disorder. 5. Dystonia. PA requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines. For patients taking concurrent opioids, the prescriber must document the following: 1. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and 2. Documentation as to why concurrent use is medically necessary is provided; and 3. A plan to taper the opioid or benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Arthritis *Use Biologicals for Arthritis PA form*	Prior authorization (PA) is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1. Patient has a diagnosis of rheumatoid arthritis (RA); with a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxycholoroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated); or 2. Patient has a diagnosis of moderate to severe psoriatic arthritis; with a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 3. Patient has a diagnosis of juvenile idiopathic arthritis with oligoarthritis; with a. Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 4. Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (pJIA); with a. Documentation of a trial and inadequate response to methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 5. Patient has a diagnosis of systemic juvenile idiopathic arthritis (sJIA). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Axial Spondyloarthritis *Use Biologicals for Axial Spondyloarthritis PA form*	Prior authorization (PA) is required for biologicals used for axial spondyloarthritis conditions. Request must adhere to all approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment will be considered under the following conditions: 1. Patient has a diagnosis of: a. ankylosing spondylitis (AS) or b. nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and 2. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration; and 3. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and 4. Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Inflammatory Bowel Disease *Use Biologicals for Inflammatory Bowel Disease PA form*	Prior authorization (PA) is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and 3. Patient has a diagnosis of Crohn's Disease – Payment will be considered following an inadequate response to two preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; or 4. Patient has a diagnosis of Ulcerative Colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine; and In addition to the above: Requests for TNF Inhibitors: 1. Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less; and Requests for Interleukins: 1. Medication will not be given concurrently with live vaccines. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Hidradenitis Suppurativa *Use Biologicals for Hidradenitis Suppurativa PA form*	Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 3. Patient has at least three (3) abscesses or inflammatory nodules; and 4. Patient has documentation of adequate trials and therapy failures with the following: a. Daily treatment with topical clindamycin; b. Oral clindamycin plus rifampin; c. Maintenance therapy with a preferred tetracycline. If criteria for coverage are met, initial requests will be given for 4 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Biologicals for Plaque Psoriasis *Use Biologicals for Plaque Psoriasis PA form*	Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non- preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1. Patient has a diagnosis of moderate to severe plaque psoriasis; and Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Calcifediol (Rayaldee) *Use Calcifediol (Rayaldee) PA form*	Prior authorization (PA) is required for calcifediol (Rayaldee). Initial requests will be considered for patients when the following criteria are met: 1. Patient is 18 years of age or older; and 2. Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) as documented by a current glomerular filtration rate (GFR); and 3. Patient is not on dialysis; and 4. Patient has a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL within the past 3 months; and 5. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with a preferred vitamin D analog for a minimum of 3 months. 6. Initial requests will be considered for a dose of 30 mcg once daily for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) documented by a current glomerular filtration rate (GFR); and 2. Patient has a serum total 25-hydroxyvitamin D level between 30 and 100 ng/mL, a serum corrected total calcium below 9.8 mg/dL, and a serum phosphorus below 5.5 mg/dL.

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Updated 10/01/2024

Cholic Acid (Cholbam) *Use Cholic Acid (Cholbam) PA form*	Prior authorization (PA) is required for cholic acid (Cholbam). Payment will be considered under the following conditions: 1. Is prescribed by a hepatologist or pediatric gastroenterologist; and 2. Is prescribed for a diagnosis of bile acid synthesis disorder due to a single enzyme defect (SED) including: a. 3-beta-hydroxy-delta-5C27-steroid oxidoreductase deficiency (3β-HSD), b. aldo-keto reductase 1D1 (AKR1D1), c. alpha-methylacyl-CoA racemase deficiency (AMACR deficiency), d. sterol 27-hydroxylase deficiency (cerebrotendinous xanthomatosis [CTX]), e. cytochrome P450 7A1 (CYP7A1), f. 25-hydroxylation pathway (Smith-Lemli-Opitz); OR 3. Is prescribed as an adjunctive treatment of a peroxisomal disorder (PD) in patients who exhibit manifestations of liver disease, steatorrhea, or complications from fat soluble vitamin absorption. Peroxisomal disorders include Zellweger syndrome (ZWS), neonatal adrenoleukodystrophy (NALD), or infantile refsum disease (IRD); and 4. Diagnosis is confirmed by mass spectrometry or other biochemical testing or genetic testing (attach results); and 5. Baseline liver function tests are taken prior to initiation of therapy (AST, ALT, GGT, ALP, total bilirubin, INR) and provided with request; and 6. Patient must have elevated serum aminotransferases (AST and ALT) with normal serum gamma glutamyltransferase (GTT); and 7. Patient is at least 3 weeks old. When criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 12 months at a time requiring documentation of response to therapy by meeting two of the following criteria: 1. Body weight has increased by 10% or is stable at $\geq 50^{th}$ percentile, 2. Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) < 50 U/L or baseline levels reduced by 80%, 3. Total bilirubin level reduced to ≤1mg/dL.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

CNS Stimulants and Atomoxetine	Prior authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for CNS stimulants and atomoxetine will be considered when patient has an FDA approved or compendia indication for requested drug under the following conditions: 1. Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening, and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. Use of an amphetamine agent plus a methylphenidate agent will not be considered for a diagnosis of ADHD. 2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist. 4. Binge Eating Disorder (Vyvanse only) a. Patient is 18 to 55 years of age; and b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and c. Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and d. Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and e. Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and f. Patient has a BMI of 25 to 45; and g. Patient does not have a history of cardiovascular disease; and h. Patient has no history of substance abuse; and i. Is not being prescribed for the treatment of obesity or weight loss; and j. Doses above 70mg per day will not be considered. k. Initial requests will be approved for 12 weeks. l. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week. <u>DSM-5 Criteria</u> i. Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control overeating; and ii. The binge eating episodes are marked by at least three of the following:

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use CNS Stimulants and Atomoxetine or Binge Eating Disorder Agents PA form	1. Eating more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of embarrassment by the amount of food consumed 5. Feeling disgusted with oneself, depressed, or guilty after overeating; and iii. Episodes occur at least 1 day a week for at least 3 months; and iv. No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and v. Does not occur solely during the course of bulimia nervosa or anorexia nervosa. <u>Moderate to Severe BED</u> Based on the number of binge eating episodes per week: Moderate - 4 to 7 Severe – 8 to 13 Extreme – 14 or more Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Crisaborole (Eucrisa) *Use Crisaborole (Eucrisa) PA form*	Prior authorization (PA) is required for Eucrisa (crisaborole). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of mild to moderate atopic dermatitis; and 3. Patient has failed to respond to good skin care and regular use of emollients; and 4. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 5. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 6. Patient will continue with skin care regimen and regular use of emollients. 7. Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) *Use Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) PA form*	Prior authorization (PA) is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and 3. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and 4. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and 5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 6. Is not prescribed in combination with other ophthalmic cyclosporine products. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional authorizations will be considered upon documentation of clinical response to therapy.
Cystic Fibrosis Agents, Oral *Kalydeco* *Orkambi* *Symdeko* *Trikafta* *Use Cystic Fibrosis Agents, Oral PA form*	Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of cystic fibrosis; and 3. Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and 4. Prescriber is a CF specialist or pulmonologist; and 5. Baseline liver function tests (AST, ALT, and bilirubin) are provided; and 6. Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and 7. Will not be used with other CFTR modulator therapies. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Adherence to oral cystic fibrosis therapy is confirmed; and 2. Liver function tests (AST, ALT, and bilirubin) are assessed every 3 months during the first year of treatment and annually thereafter.
Dalfampridine (Ampyra) *Use Dalfampridine (Ampyra™) PA form*	Prior authorization (PA) is required for dalfampridine (Ampyra). Payment will be considered under the following conditions: 1. For patients that have a gait disorder associated with MS. 2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3. Additional PAs will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. PAs will not be considered for patients with a seizure diagnosis or in patients will moderate to severe renal impairment.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Deferasirox (Exjade) *Use Deferasirox (Exjade) PA form*	Prior authorization (PA) is required for deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions: 1. Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance <40mL/min; and 2. Patient does not have a poor performance status; and 3. Patient does not have a high-risk myelodysplastic syndrome; and 4. Patient does not have advanced malignancies; and 5. Patient does not have a platelet count < 50 x 10^9/L. **Transfusional Iron Overload** Initiation of Therapy 1. Patient is 2 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overlaod; and 4. Serum ferritin is consistently > 1000 mcg/L (attach lab results dates within the past month); and 5. Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6. Initial requests will be considered for up to 3 months. Continuation of Therapy 1. Serum ferritin has been measured within 30 days of continuation of therapy request (attach documentation); and 2. Ferritin levels are > 500mcg/L; and 3. Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day. **Non-Transfusional Iron Overload** Initiation of Therapy 1. Patient is 10 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4. Serum ferritin levels are > 300mcg/L; and 5. LIC are > 5mg Fe/g dw; and 6. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7. Initial authorization will be considered for up to 6 months. Continuation of Therapy 1. Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and 2. Serum ferritin levels are ≥ 300mcg/L; and 3. LIC is ≥ 3mg Fe/g dw; and 4. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw).

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Deucravacitinib (Sotyktu) *Use Deucravacitinib (Sotyktu) PA form*	Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis; and a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine is provided; and b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Dextromethorphan and Quinidine (Nuedexta) *Use Dextromethorphan and Quinidine (Nuedexta) PA form*	Prior authorization (PA) is required for Nuedexta. Payment will be considered under the following conditions: 1. Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition. 2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and 3. Patient has documentation of a current EKG (within the past 3 months) without QT prolongation. 4. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire. 5. Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Direct Oral Anticoagulants *Use Direct Oral Anticoagulants PA form*	Prior authorization (PA) is not required for preferred direct oral anticoagulants (DOACs). PA is required for non-preferred DOACs. Requests will be considered for FDA approved dosing and length of therapy for submitted diagnosis. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications for the requested drug under the following conditions: 1. Patient is within the FDA labeled age for indication; and 2. Patient does not have a mechanical heart valve; and 3. Patient does not have active bleeding; and 4. For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA_2DS_2-VASc score ≥1; and 5. A recent creatinine clearance (CrCl) is provided; and 6. A recent Child-Pugh score is provided; and 7. Patient's current body weight is provided; and 8. Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred DOACs; and. 9. For requests for edoxaban, when prescribed for the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE), documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin) is provided. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Dornase Alfa (Pulmozyme) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Pulmozyme. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.

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Updated 10/01/2024

Dupilumab (Dupixent)	Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient's current weight in kilograms (kg) is provided; and 3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and b. Patient has failed to respond to good skin care and regular use of emollients; and c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and e. Patient will continue with skin care regimen and regular use of emollients; and 4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and b. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta $_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and d. Patient must have one of the following, in addition to the regular maintenance medications defined above: i. One (1or more exacerbations in the previous year or ii. Require daily oral corticosteroids for at least 3 days; or 5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and a. Documentation dupilumab will be used as an add-on maintenance treatment; and b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid spray; and ii. Oral corticosteroid; or 6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Dupilumab (Dupixent) PA form	a. Is prescribed by, or in consultation with, an allergist, gastroenterologist, or immunologist; and b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and d. Documentation of previous trials and therapy failures with all of the following: i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and iii. Dietary therapy; or 7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and a. Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and b. Patient has experienced severe to very severe pruritits, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and c. Patient has ≥ 20 nodular lesions (attach documentation); and d. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and 8. Dose does not exceed the FDA approved dosing for indication. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Duplicate Therapy Edits **Antipsychotics** **NSAIDs** *Use Duplicate Therapy Edit Override PA form*	Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Eluxadoline (Viberzi) *Use Eluxadoline (Viberzi) PA form*	Prior authorization (PA) is required for eluxadoline. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age. 2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D). 3. Patient does not have any of the following contraindications to therapy: a. Patient is without a gallbladder. b. Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction. c. Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day. d. A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction). e. Severe hepatic impairment (Child-Pugh Class C). f. Severe constipation or sequelae from constipation. g. Known or suspected mechanical gastrointestinal obstruction. 4. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with both of the following: a. A preferred antispasmodic agent (dicyclomine or hyoscyamine). b. A preferred antidiarrheal agent (loperamide). If criteria for coverage are met, initial authorization will be given for 3 months to assess the response to treatment. Requests for continuation of therapy will require the following: 1. Patient has not developed any contraindications to therapy (defined above). 2. Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following: a. Improvement in abdominal cramping or pain. b. Improvement in stool frequency and consistency. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Eplerenone (Inspra) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Inspra. Payment will be authorized only in cases where there is documented trial and therapy failure on spironolactone or documented cases of gynecomastia from spironolactone therapy.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Erythropoiesis Stimulating Agents *Use Erythropoesis Stimulating Agent PA form*	Prior authorization (PA) is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Patients who meet all of the following criteria may receive PA for the use of erythropoiesis stimulating agents: 1. Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values must be dated within four weeks of the prior authorization request. 2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request. 3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy. 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
Extended Release Formulations *Use Extended Release Formulations PA form*	Payment for a non-preferred extended release formulation will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Prior authorization (PA) is required for the following extended release formulation(s): Adoxa, Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Coreg CR, Doryx, Elepsia XR, Envarsus XR, Glumetza, Gocovri, Gralise, Kapspargo, Keppra XR, Lamictal XR, Luvox CR, Memantine ER, Mirapex ER, Motpoly XR, Moxatag, Namenda XR, Oleptro, Osmolex ER, Oxtellar XR, Pramipexole ER, Pregabalin ER, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Solodyn ER, Topiramate ER, Trokendi XR, Ximino.
Fentanyl, Short Acting Products *Use Short Acting Fentanyl Products PA form*	Prior authorization (PA) is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a **Black Box Warning**. Short acting fentanyl products: 1. Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain. 2. Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Fifteen Day Initial Prescription Supply Limit *Use Fifteen Day Initial Prescription Supply Limit PA form*	Designated drugs are limited to a fifteen day initial supply. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Providers must submit a prior authorization (PA) request for override consideration. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.
Finerenone (Kerendia) *Use Finerenone (Kerendia) PA form*	Prior authorization (PA) is required for finerenone (Kerendia). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling, including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of chronic kidney disease (CKD) associated with Type 2 Diabetes (T2D); and 3. Patient is currently receiving a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB); and 4. Patient is currently receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease [i.e., dapagliflozin (Farxiga)]; and 5. Patient has the following baseline tests prior to initiation of treatment with finerenone: a. Serum potassium is ≤5.0 mEq/L; and b. Estimated glomerular filtration rate (eGFR) is ≥ 25 mL/min/1.73m^2; and c. Urine albumin to creatinine ration (UACR) is ≥ 30 mg/g. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional PAs will be considered with the following documentation: 1. Patient's serum potassium is < 5.5 mEq/L; and 2. Patient's eGFR is ≥ 25 mL/min/1.73m2; and 3. Patient remains on a maximally tolerated dose of an ACEi or ARB; and 4. Patient remains on a maximally tolerated dose of an SGLT2 inhibitor.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

GLP-1 Agonist/Basal Insulin Combinations *Use GLP-1 Agonist/Basal Insulin Combinations PA form*	Prior authorization (PA) is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met: 1. A diagnosis of type 2 diabetes mellitus; and 2. Patient is 18 years of age or older; and 3. The patient has not achieved HgbA1C goals after a minimum three-month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and 4. Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and 5. Will not be used concurrently with prandial insulin; and 6. Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and 7. Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of: a. Soliqua below 15 units or over 60 units, or b. Xultophy persistently below 16 units or over 50 units.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral *Use Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral PA form*	Prior authorization (PA) is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met: 1. Pregnancy has been ruled out; and 2. Patient does not have osteoporosis; and 3. Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 4. Requests for elagolix (Orilissa) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions: a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and c. Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist. d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms; and e. Requests will be considered based on drug, dose, and length of therapy: i. Orilissa- maximum duration of therapy of 24 months for the 150mg dose and six (6) months for the 200mg dose; or ii. Myfembree- maximum duration of therapy of 24 months; or 5. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions: a. Patient is premenopausal; and b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and d. Patient has documentation of a previous trial and therapy failure with tranexamic acid. e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement of symptoms. f. Requests will be considered for a maximum duration of therapy of 24 months. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Granulocyte Colony Stimulating Factor Agents *Use Granulocyte Colony Stimulating Factor PA form*	Prior authorization (PA) is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses: 1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy. 2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant. 3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy. 4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients. On current chemotherapy drug(s) that would cause severe neutropenia.
Growth Hormone	Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied: Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). Payment will be considered under the following conditions: Children with Growth Hormone Deficiency 1. Standard deviation of 2.0 or more below mean height for chronological age; and 2. No expanding intracranial lesion or tumor diagnosed by MRI; and 3. Growth rate below five centimeters per year; and 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and 5. Annual bone age testing is required. A Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. Pediatric Chronic Kidney Disease 1. Is prescribed by or in consultation with a nephrologist; and 2. Standard deviation of 2.0 or more below mean height for chronological age; and 3. No expanding intracranial lesion or tumor diagnosed by MRI; and 4. Growth rate below five centimeters per year; and 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. Turner's Syndrome 1. Chromosomal abnormality showing Turner's syndrome; and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. No expanding intracranial lesion or tumor diagnosed by MRI; and 5. Growth rate below five centimeters per year; and 6. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 7. Epiphyses open.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Growth Hormone PA form	Prader Willi Syndrome 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. Noonan Syndrome 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 5. Epiphyses open. SHOX (Short stature Homeobox) 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. Adults with Growth Hormone Deficiency 1. Patients who were growth hormone deficient during childhood (childhood onset) and who have a continued deficiency; or 2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g., panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and 3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of ≤ 5 mcg/L after stimulation. Adults with AIDS Wasting/Cachexia 1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and 2. Patient is currently being treated with antiviral agents; and 3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol). Short Bowel Syndrome If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel Syndrome. PA will be considered for a maximum of 4 weeks. If the criteria for coverage is met, initial requests will be given for 12-month periods, unless otherwise stated above. Additional PAs will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Hematopoietics/ Chronic ITP *Use Hematopoietics/Chronic ITP PA form*	Prior authorization (PA) is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions: 1. A diagnosis of thrombocytopenia with chronic immune thrombocytopenia (ITP) (Doptelet, Promacta, Nplate, Tavalisse) a. Patient has documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy. 2. A diagnosis of severe aplastic anemia (Promacta) a. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and b. Patient has a platelet count less than or equal 30 x 10^9/L. c. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration. 3. A diagnosis of thrombocytopenia with chronic liver disease in patients who are scheduled to undergo a procedure with the following documentation (Doptelet, Mulpleta): a. Pre-treatment platelet count; and b. Scheduled dosing prior to procedure; and c. Therapy completion prior to scheduled procedure; and d. Platelet count will be obtained before procedure.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Hepatitis C Treatments, Direct Acting Antivirals *Use Hepatitis C Treatments, Direct Acting Antivirals PA form*	Prior authorization (PA) is required for hepatitis C direct-acting antivirals (DAA). Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1. Patient has a diagnosis of chronic hepatitis C; and 2. Patient has had testing for hepatitis C virus (HCV) genotype; and 3. Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 4. Patient's prior HCV DAA treatment history is provided (treatment naïve or treatment experienced); and 5. DAAs approved for pediatric use will be considered for those under the age of 18 when used in accordance with current AASLD guidelines and patient's weight is provided; and 6. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. 7. If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on length of therapy for the particular treatment. 8. The 72-hour emergency supply rule does not apply to DAAs. Requests for treatment-experienced patients (with previous DAA) will be considered under the following conditions: 1. Patient must meet all criteria for treatment approval above; and 2. The requested therapy is FDA approved as therapy for treatment-experienced patients and follows current AASLD guidelines; and 3. HCV retreatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 4. Patient has not been previously treated with and failed the requested DAA therapy; and 5. Documentation is provided patient has a documented presence of detectable HCV RNA at least 12 weeks after completing previous DAA treatment.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

High Dose Opioids	Prior authorization (PA) is required for use of high-dose opioids ≥ 90 morphine milligram equivalents (MME) per day (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html). Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met: 1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and 2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and 3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants; and 5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and 6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and 7. Pain was inadequately controlled by 2 other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and 8. Chart notes from a recent office visit or telehealth visit for pain management are included documenting the following: a. Treatment plan – including all therapies to be used concurrently (pharmacologic and non-pharmacologic); and b. Treatment goals; and 9. Patient has been informed of the risks of high-dose opioid therapy; and 10. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and 11. The patient's risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and 12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and 13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and 14. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation] within the prior 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 15. Patient has been educated on opioid overdose prevention; and 16. Patient's household members have been educated on the signs of opioid overdose and how to administer an opioid reversal agent; and

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use High Dose Opioids PA form	17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and 18. A documented dose reduction is attempted at least annually. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of high-dose opioid therapy will be considered every 6 months with the following: 1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and 2. Patient has not experienced an overdose or other serious adverse event; and 3. Patient is not exhibiting warning signs of opioid use disorder; and 4. The benefits of opioids continue to outweigh the risks; and 5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and 6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and 7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests. 8. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP [attach documentation] within 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 9. Patient has been reeducated on opioid overdose prevention; and 10. Patient's household members have been reeducated on the signs of opioid overdose and how to administer an opioid reversal agent.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

IL-5 Antagonists *Fasenra* *Nucala*	Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and a. Patient has a pretreatment blood eosinophil count of ≥ 150 cells/mcL within the previous 6 weeks or blood eosinophils ≥ 300 cells/mcL within 12 months prior to initiation of therapy; and b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and d. A pretreatment forced expiratory volume in 1 second (FEV_1) < 80% predicted in adults and < 90% in adolescents; or 3. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and b. One of the following: i. Eosinophil count > 1000 cells/mcL; or ii. Eosinophil count > 10% of the total leukocyte count; and 4. Patient has a diagnosis of hypereosinophilic syndrome (HES); and a. Patient has been diagnosed with HES for ≥ 6 months prior to starting treatment; and b. Documentation that non-hematologic secondary causes of HES have been ruled out; and c. Documentation patient does not have FIP1L1-PDGFRα kinase-positive HES: and d. Documentation of ≥ 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and e. Patient has a blood eosinophil count ≥ 1,000 cells/mcL; and f. Medication will be used in combination with stable doses of at least one other HES therapy; and 5. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); and a. Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; and

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use IL-5 Antagonists PA form	b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid; and ii. Oral corticosteroid; and 6. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist. If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: Severe Asthma with an Eosinophilic Phenotype: 1. Patient continues to receive therapy with an ICS, LABA and LTRA; and 2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3. Patient has experienced a decrease in administration of rescue medication (albuterol); or 4. Patient has experienced a decrease in exacerbation frequency; or 5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline. Eosinophilic Granulomatosis with Polyangiitis 1. Patient has demonstrated a positive clinical response to therapy (increase in remission time). Hypereosinophilic Syndrome: 1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and 2. Medication continues to beused in combination with stable doses or at least one other HES therapy. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) 1. Patient has demonstrated positive clinical response to therapy (improvement in symptoms); and 2. Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Immunomodulators-Topical *Elidel* *Protopic* *Use Immunomodulators-Topical PA form*	Prior authorization (PA) is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel) or tacrolimus (Protopic) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with one preferred topical corticosteroid, except on the face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Initial Days' Supply Limit Override *Use Initial Days' Supply Limit Override PA form*	Requests for medications exceeding the initial days' supply limit require prior authorization. Payment will be considered under the following conditions: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Medical rationale for exceeding the initial days' supply limit is provided; and 4. Requests for opioids exceeding the 7 day initial supply limit will be considered: a. For patients with active cancer, patients experiencing acute sickle cell crises, end-of-life/palliative care, or on an individual case-by-case basis based on medical necessity documentation provided; and b. Request must meet all other opioid requirements (quantity limits, morphine milligram equivalents (MME), and the preferred drug list (PDL). If requests do not comply with these requirements, separate, additional, prior authorization is required. Please reference and use the following prior authorization (PA) forms at www.iowamedicaidpdl.com where appropriate: i. Quantity Limit Override Form (exceeds established quantity limit) ii. High Dose Opioid PA Form (exceeds established MME limit) iii. Short-Acting Opioids PA Form (non-preferred short-acting opioids) iv. Long-Acting Opioids PA Form (non-preferred long-acting opioids); or 5. Requests for benzodiazepines exceeding the 7 day initial supply limit will be considered: a. For patients with active cancer, end-of-life/palliative care, seizure disorder, or on an individual case-by-case basis based on medical necessity documentation provided; and b. For patients taking concurrent opioids, the prescriber must document the following: i. The risks of using an opioid and benzodiazepine concurrently have been discussed with the patient; and ii. Documentation is provided as to why concurrent use is medically necessary; and iii. A plan to taper the opioid is provided, if appropriate; and c. Request must meet all other benzodiazepine requirements (quantity limit, PDL, etc). If requests do not comply with these requirements, separate, additional prior authorization is required. Please use the following PA forms at www.iowamedicaidpdl.com where appropriate: i. Benzodiazepines (non-preferred benzodiazepine) ii. Quantity Limit Override (as posted at www.iowamedicaidpdl.com under Billing/Quantity Limits); and 6. Requests for drugs or drug classes subject to the initial days' supply limit not listed above, will be considered on an individual case-by-case basis, based on medical necessity documentation provided.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Isotretinoin (Oral) *Use Oral Isotretinoin PA form*	Prior authorization (PA) is required for oral isotretinoin therapy. Payment will be considered for preferred oral isotretinoin products for moderate to severe acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative (tretinoin or adapalene) therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative therapy are not required for approval for treatment of acne conglobata; and 2. Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE program. Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 24 weeks. A minimum of 8 weeks without therapy is required to consider subsequent authorizations. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Ivabradine (Corlanor) *Use Ivabradine (Corlanor) PA form*	Prior authorization (PA) is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and a. Patient is 18 years of age or older; and b. Patient has documentation of a left ventricular ejection fraction ≤35%; and c. Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and d. Patient has documentation of blood pressure ≥90/50 mmHg; or 2. Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class ll to lV) due to dilated cardiomyopathy, and a. Pediatric patient age 6 months and less than 18 years old; and b. Patient has documentation of a left ventricular ejection fraction ≤45%; and b. Patient is in sinus rhythm with a resting heart rate (HR) defined below; i. 6 to 12 months – HR ≥ 105 bpm ii. 1 to 3 years- HR ≥ 95 bpm iii. 3 to 5 years- HR ≥ 75 bpm iv. 5 to 18 years- HR ≥ 70 bpm; and 3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and 4. Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Janus Kinase Inhibitors	Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata, vitiligo, or other excluded medical use(s), as defined in Section 1927 (d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met: 1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Patient has a diagnosis of: a. Moderate to severe rheumatoid arthritis; with i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR b. Psoriatic arthritis; with i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR c. Moderately to severely active ulcerative colitis; with i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and ii. A documented trial and inadequate response with a preferred TNF inhibitor; and iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR d. Moderately to severely active Crohn's disease upadacitinib); with i. A documented trial and inadequate response to two preferred conventional therapies including aminosalicylates (sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; and ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR e. Polyarticular Course Juvenile Idiopathic Arthritis; with i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Use Janus Kinase Inhibitor PA form	iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR g. Atopic dermatitis; with i. Documentation patient has failed to respond to good skin care and regular use of emollients; and ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and iv. For mild to moderate atopic dermatitis: a. A documented trial and therapy failure with crisaborole; and b. Affected area is less than 20% of body surface area (BSA); and c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or v. For moderate to severe atopic dermatitis: a. A documented trial and therapy failure with cyclosporine or azathioprine; and b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Ketorolac *Use Ketorolac PA form*	Prior authorization (PA) is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a **Black Box Warning**. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions: 1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum intranasal dose is 126mg/day. Maximum combined duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred non-steroidal anti-inflammatory drugs at therapeutic doses.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Letermovir (Prevymis) *Use Letermovir (Prevymis) PA form*	Prior authorization (PA) is required for oral letermovir. Requests for intravenous letermovir should be directed to the member's medical benefit. Payment will be considered under the following conditions: 1. Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and 2. Patient or donor is CMV-seropositive R+ (attach documentation); and 3. Patient has received an allogeneic hematopoietic stem cell transplant (HSCT) within the last 28 days (provide date patient received HSCT); and 4. Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and 5. Patient is 18 years of age or older; and 6. Dose does not exceed: a. 240mg once daily when co-administered with cyclosporine; b. 480mg once daily; and 7. Patient must not be taking the following medications: a. Pimozide; or b. Ergot alkaloids (e.g., ergotamine, dihydroergotamine); or c. Rifampin; or d. Atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide when co-administered with cyclosporine; and 8. Patient does not have severe (Child-Pugh Class C) hepatic impairment (provide score); and 9. Therapy duration will not exceed 100 days post-transplantation.
Lidocaine Patch (Lidoderm) *Use Lidocaine Patch (Lidoderm) PA form*	Prior authorization (PA) is required for topical lidocaine patches. Payment will be considered only for cases in which there is a diagnosis of pain associated with post-herpetic neuralgia. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

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Linezolid (Zyvox) *Use linezolid (Zyvox) PA form*	Prior authorization (PA) is required for linezolid. Payment for linezolid will be authorized when there is documentation that: 1. The patient has an active infection and meets one of the following diagnostic criteria: a. Vancomycin-resistant Enterococcus (VRE); or b. Methicillin-resistant Staph aureus (MRSA); or c. Methicillin-resistant Staph epidermis (MRSE); or d. Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and 2. Patient meets ONE of the following criteria: a. Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or b. VRE in a part of the body other than lower urinary tract**, or c. Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed). 3. A current culture and sensitivity report is provided documenting sensitivity to linezolid. *Severe intolerance to vancomycin is defined as: 1. Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration 2. Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine) **VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

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Updated 10/01/2024

Long-Acting Opioids *Use Long-Acting Opioids PA form*	Prior authorization (PA) is required for all non-preferred long-acting opioids. PA is also required for members when the total daily opioid use (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1. Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment; and 2. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two nonopioid pharmacologic therapies (e.g., acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and 4. There is documentation of previous trial and therapy failure with one preferred long-acting opioid at maximally tolerated dose; and 5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization; and 6. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and. 7. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids. 8. Requests for long-acting opioids will only be considered for FDA approved dosing intervals. As-needed (PRN) dosing will not be considered; and 9. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP and has determined continued use of a long-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Mannitol Inhalation Powder (Bronchitol) *Use Mannitol Inhalation Powder (Bronchitol) PA form*	Prior authorization is required for mannitol inhalation powder (Bronchitol). Payment will be considered when the following criteria are met: 1. Patient has a diagnosis of cystic fibrosis; and 2. Patient meets the FDA approved age; and 3. Prescriber is a cystic fibrosis specialist or pulmonologist; and 4. Documentation is provided that patient has successfully completed the Bronchitol tolerance test (BTT); and 5. Patient will pre-medicate with a short-acting bronchodilator; and 6. Dose does not exceed the FDA approved dose. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Adherence to mannitol inhalation powder (Bronchitol) therapy is confirmed; and 2. Patient has demonstrated improvement or stability of disease symptoms, such as improvement in FEV_1, decrease in pulmonary exacerbations, decrease in hospitalizations, or improved quality of life.
Maralixibat (Livmarli) *Use Maralixibat (Livmarli) PA form*	Prior authorization (PA) is required for maralixibat (Livmarli). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a *JAG1* or *NOTCH2* mutation or deletion; and 3. Patient has cholestasis with moderate to severe pruritis; and 4. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS; and 5. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents: a. Ursodeoxycholic acid (ursodiol) b. Cholestyramine c. Rifampin; and 6. Patient's current weight in kilograms (kg) is provided. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, initial authorizations will be given for 6 months to assess the response to treatment. Request for continuation of therapy will required documentation of an improvement in pruritis symptoms and patient's current wright in kg.

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Mavacamten (Camzyos) *Use Mavacamten (Camzyos) PA form*	Prior authorization (PA) is required for mavacamten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and 3. Patient exhibits symptoms of New York Heart Association (NYHA) class ll or lll symptoms; and 4. Is prescribed by or in consultation with a cardiologist; and 5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and 6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and 7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following: a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.
Methotrexate Injection *Otrexup* *Rasuvo* *Use Methotrexate Injection PA form*	Prior authorization (PA) is required for non-preferred methotrexate injection. Payment will be considered under the following conditions: 1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA) and ALL of the following: a. Prescribed by a rheumatologist; and b. Patient has a documented trial and intolerance with oral methotrexate; and c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine); and d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and e. Patient does not reside in a long-term care facility. 2. Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: a. Patient is 18 years of age or older; and b. Prescribed by a dermatologist; and c. Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy). d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and e. Patient does not reside in a long-term care facility. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment *Use Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment PA form*	Prior Authorization (PA) is required for miconazole-zinc oxide-white petrolatum (Vusion) Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.
Mifepristone (Korlym) *Use Mifepristone (Korlym) PA form*	Prior authorization (PA) is required for mifepristone (Korlym). Payment will be considered for patients when the following is met: 1. The patient is 18 years of age or older: and 2. Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance: and 3. Patient must have failed surgery or is not a candidate for surgery: and 4. Prescriber is an endocrinologist: and 5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.
Modified Formulations *Use Modified Formulations PA form*	Payment for a non-preferred isomer, prodrug, or metabolite will be considered when the following criteria are met: 1. Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. The required trials may be overridden when documented evidence is provided that use of these preferred agent(s) would be medically contraindicated. Prior authorization is required for the following modified dosage forms: Abilify Discmelt, Adlarity, Alkindi, Aricept ODT, Aspruzyo, Binosto, Dartisla, Drizalma, Elyxyb, Eprontia, Exservan, Ezallor, FazaClo, Gimoti, Horizant, Lamotrigine ODT, Likmez, Metoclopramide ODT, Norliqva, Remeron SolTab, Risperidone ODT, Sertraline Caps, Sitavig, Spritam, Sympazan, Tramadol Oral Solution, Trilipix, Valsartan Oral Solution, Xopenex, Zyprexa Zydis.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Multiple Sclerosis Agents-Oral *Use Multiple Sclerosis Agents-Oral PA form*	For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided: 1. A diagnosis of relapsing forms of multiple sclerosis; and 2. Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and 3. Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Muscle Relaxants *Use Muscle Relaxant PA form*	Prior authorization (PA) is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.
Narcotic Agonist-Antagonist Nasal Sprays *Use Narcotic Agonist/Antagonist Nasal Spray PA form*	Prior authorization (PA) is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration. Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.
New to Market Drugs *Use New to Market Drugs PA form*	Prior authorization (PA) is required for newly marketed drugs. Payment will be considered for patients when the following criteria are met: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or 3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and 4. Request must adhere to all FDA approved labeling. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Once newly marketed drugs are reviewed by the Pharmaceutical & Therapeutics Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Nocturnal Polyuria Treatments *Use Nocturnal Polyuria Treatments PA form*	Prior authorization (PA) is required for nocturnal polyuria treatments. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24- hour urine productions occurring at night; and 3. Patient wakens at least 2 times at night to void; and 4. Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and 5. Patient is not taking a diuretic in the evening; and 6. Patient does not have any of the following contraindications: a) Current or previous history of hyponatremia; and b) Primary nocturnal enuresis; and c) Polydipsia; and d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and f) Estimated glomerular filtration rate < 50 mL/min.1.73m^2; and g) Illnesses that can cause fluid or electrolyte imbalance; and h) New York Heart Association (NYHA) Class ll-lV congestive heart failure; and i) Uncontrolled hypertension. Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following: 1. Patient continues to meet above criteria; and 2. Patient has experienced a decrease in nocturnal voiding; and 3. There is no evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).
Non-Biologic Agents for Ulcerative Colitis *Use Non-Biologic Agents for Ulcerative Colitis PA form*	Prior authorization is required for select non-biologicals for ulcerative colitis (UC). Payment for non-preferred select non-biologics for UC may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment will be considered under the following conditions: 1. Patient has a diagnosis of moderately to severely active ulcerative colitis (UC) and 2. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 3. A documented trial and inadequate response to two preferred conventional therapies (immunomodulators) including aminosalicylates and azathioprine/6-mercaptopurine; and 4. A documented trial and inadequate response with a preferred biological DMARD; and 5. Will not be taken concomitantly with immunomodulators or biologic therapies. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products *Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form*	Prior authorization (PA) is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus. 2. Hemophilia A. 3. Von Willebrand's disease. Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent. Please refer to the Selected Brand-Name Drugs prior authorization form is requesting a non-preferred brand-name product.
Non-Preferred Drug *Use Non-Preferred Drug PA form*	Prior authorization (PA) is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be considered for an FDA approved or compendia indicated diagnosis only for cases in which there is documentation of previous trial and therapy failure with the preferred agent(s), unless evidence is provided that use of these agents would be medically contraindicated. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.
Nonsteroidal Anti-inflammatory Drugs *Use Non-Steroidal Anti-inflammatory Drug PA form*	Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (NSAIDs). Payment for a non-preferred NSAID will be considered under the following conditions: 1. Documentation of previous trials and therapy failures with at least three preferred NSAIDs; and 2. Requests for a non-preferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred immediate release NSAID of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Odevixibat (Bylvay) *Use Odevixibat (Bylvay) Drug PA form*	Prior authorization (PA) is required for odevixibat (Bylvay) Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and a. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and b. Patient has moderate to severe pruritis associated with PFIC; or 3. Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAGI or NOTCH2 mutation or deletion; and a. Patient has cholestasis with moderate to severe pruritis; and b. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents: i. Ursodeoxycholic acid (ursodiol) ii. Cholesytramine iii. Rifampin; and 4. Patient's current weight in kg is provided; and

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	5. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in PFIC or ALGS Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met: 1. Patient's current weight in kg is provided; and 2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.
Omalizumab (Xolair)	Prior authorization (PA) is required for omalizumab (Xolair) prefilled syringe. Requests for omalizumab (Xolair) lyophilized powder for reconstitution will not be considered through the pharmacy benefit. Payment for omalizumab (Xolair) prefilled syringe will be considered for FDA approved and compendia indications under the following conditions: 1. Patient meets the FDA approved age; and 2. Therapy will be initiated in a healthcare setting, under the guidance of a healthcare provider, where the patient can be closely observed for anaphylaxis and safety of therapy has been established after a minimum of 3 doses of omalizumab; and 3. The healthcare provider has determined self-administration with omalizumab is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label; and 4. Dose follows the FDA approved dosing for indication; and 5. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and 6. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and 7. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced. <u>Moderate to Severe Persistent Asthma</u> 1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2. Pretreatment IgE level is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 700 IU/mL; or b. Pediatric patients 6 to less than 12 years of age - 30 IU/mL to 1300 IU/mL; and 3. Patient's weight is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; or b. Pediatric patients 6 to less than 12 years of age - 20 kg to 150 kg; and 4. History of positive skin or RAST test to a perennial aeroallergen; and 5. Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND a leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy; and 6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.

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The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Use Omalizumab (Xolair) PA form	If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist. <u>Chronic Idiopathic Urticaria</u> 1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and 2. Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and 3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and 4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and 5. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine. If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy. <u>Nasal Polyps</u> 1. Patient has a diagnosis of nasal polyps; and 2. Pretreatment IgE level is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 1500 IU/mL; and 3. Patient's weight is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; and 4. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and 5. Will be used concurrently with a nasal corticosteroid; and 6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances. If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Ophthalmic Agents for Presbyopia *Use Ophthalmic Agents for Presbyopia PA form*	Prior authorization (PA) is required for ophthalmic agents indicated for presbyopia. Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment for a non-preferred agent will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of presbyopia; and 3. Patient is aged 40-55 years old at start of therapy; and 4. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 5. Patient has documentation of a therapeutic failure with corrective lenses (eyeglasses or contact lenses), unless contraindicated or clinically significant intolerance. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions: 1. Patient has a documented improvement in presbyopia defined as the patient gained 3 lines or more is mesopic, high contrast, binocular distance corrected near vision acuity (DCNVA), without losing more than 1 line (5 letters) of corrected distance visual acuity (CDVA); and 2. Patient is not experiencing adverse effects from the drug.
Oral Constipation Agents	Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient must have documentation of adequate trials and therapy failures with the following: a. Member 18 years of age or older: i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); or b. Member 17 years of age or younger: i. Polyethylene glycol; and ii. One other preferred generic laxative, such as lactulose or senna; and 3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and 4. Patient has one of the following diagnoses: a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance) i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and ii. Patient has two or more of the following symptoms within the last 3 months: 1. Straining during at least 25% of bowel movements; 2. Lumpy or hard stools for at least 25% of bowel movements; and 3. Sensation of incomplete evacuation for at least 25% of bowel movements; and

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	iii. Documentation the patient is not currently taking constipation causing therapies; or b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, Ibsrela, Linzess, or Trulance) i. Patient is female (Amitiza only); and ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following: 1. Related to defecation; 2. Associated with a change in stool frequency; and/or 3. Associated with a change in stool form; or c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic) i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following: 1. Hard to very hard stool consistency; 2. Moderate to very severe straining; and/or 3. Having a sensation of incomplete evacuation; or d. A diagnosis of functional constipation (Linzess) i. Patient has less than 3 SBMs per week; and 1 or more of the following criteria at least once per week for at least 2 months: 1. History of stool withholding or excessive voluntary stool retention; 2. History of painful or hard bowel movements; 3. History of large diameter stools that may obstruct the toilet; 4. Presence of a large fecal mass in the rectum; 5. At least 1 episode of fecal incontinence per week.
Use Oral Constipation Agents PA form	If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment and patient continues to meet the age for indication.
Oral Glucocorticoids for Duchenne muscular dystrophy Agamree Deflazacort Emflaza *Use Oral Glucocorticoids for Duchenne muscular dystrophy PA form*	Prior authorization (PA) is required for oral glucocorticoids used for the treatment of Duchenne muscular dystrophy (DMD). Payment will be considered for patients when the following criteria are met: 1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and 2. Patient is within the FDA labeled age; and 3. Patient experienced onset of weakness before 5 years of age; and 4. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and 5. Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose; and 6. Is dosed based on FDA approved dosing. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Oral Immunotherapy *Grastek* *Oralair* *Ragwitek* *Use Oral Immunotherapy PA form*	Prior authorization (PA) is required for sublingual allergen immunotherapy. Payment will be considered when patient has an FDA or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Medication is prescribed by or in consultation with an allergist or immunologist; and 3. Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and 4. Patient has a documented intolerance to immunotherapy injections; and 5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration). 6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved. Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met: 1. Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; and and 2. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen. 3. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season. Grass Pollen (Grastek and Oralair) In addition to the above criteria being met: 1. Request is for Oralair; and a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and b. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass. c. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season. 2. Request is for Grastek; and a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and b. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop). c. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of grass pollen season as follows: ▪ Seasonally, through the end of the grass pollen season, or ▪ For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season. House Dust Mite (Odactra) In addition to the above criteria being met: 1. Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis; and 2. Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites; and 3. If criteria for coverage are met, authorization will be considered for 12 months.

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Ospemifene (Osphena) *Use Ospemifene (Osphena) PA form*	Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions: 1. Patient is a post-menopausal woman with a diagnosis is moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and 2. Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and 3. Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and 4. Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and 5. Patient does not have severe hepatic impairment (Child-Pugh Class C); and 6. Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and 7. Dose does not exceed the FDA approved dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy.

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Palivizumab (Synagis) *Use Palivizumab PA form*	Respiratory Syncytial Virus (RSV) surveillance is tracked by the national respiratory and enteric virus surveillance system (NREVSS) on the centers for disease control and prevention of the United States department of health and human services website. 1. Medicaid will use Iowa virology data reported to the NREVSS, as documented under RSV state trends. 2. Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the current American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection. 3. The RSV season in Iowa is predefined as November 1st through March 31st of each RSV season. Prescribers and dispensing pharmacies should monitor state specific virology data and hold administration of palivizumab if data indicates RSV is not prevalent at the beginning of the predefined Iowa RSV season. Consideration of use of palivizumab during interseasonal spread of RSV may be considered by Medicaid with widespread RSV circulation. Prior authorization (PA) is required for therapy with palivizumab. Pas will be approved for administration during the RSV season for a maximum of five doses per patient. No allowances will be made for a sixth dose. Patients who experience a breakthrough RSV hospitalization in the prior 5 months should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season. Payment for palivizumab will be considered for patients who meet one of the following criteria: <u>Chronic Lung Disease (CLD) of Prematurity</u> 1. Patient is less than 12 months of age at start of therapy and has CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth). 2. Requests for patients during their second year of life (12 months to < 24 months) will be considered for patients meeting the CLD of prematurity definition above and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season. <u>Prematurity (without CLD of Prematurity or Congenital Heart Disease)</u> 1. Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks. <u>Neuromuscular Disorders or Anatomic Pulmonary Abnormalities</u> 1. Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough. <u>Hemodynamically Significant Congenital Heart Disease (CHD)</u> 1. Patient is less than 12 months of age at start of therapy and has hemodynamically significant CHD further defined by any of the following: Acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgical procedures, moderate to severe pulmonary hypertension, or cyanotic heart defects with documentation of consultation with a pediatric cardiologist that recommends palivizumab prophylaxis. <u>Immunocompromised Children</u> 1. Patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

PCSK9 Inhibitors *Praluent* *Repatha*	Prior authorization (PA) is required for PCSK9 Inhibitors. Payment for a non-preferred PCSK9 Inhibitor will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age for indication; AND 2. Dosing follows the FDA approved dose for the submitted diagnosis; AND 3. Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); AND 4. Is to be prescribed as an adjunct to a low fat diet; AND 5. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; AND 6. Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program. 7. The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors. 8. Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced. 9. Lost or stolen medication replacement requests will not be authorized. 10. Goal is defined as a 50% reduction in untreated baseline LDL-C. 11. Is prescribed for one of the following diagnoses: <u>Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)</u> 1. Total cholesterol > 290mg/dL or LDL-C > 190mg/dL; AND a. Presence of tendon xanthomas; OR b. In first or second degree relative, one of the following: i. Documented tendon xanthomas; or ii. MI at age ≤60 years; or iii. Total cholesterol > 290mg/dL; OR c. Confirmation of diagnosis by gene or receptor testing (attach results); AND 2. Unable to reach goal LDL-C with a minimum of one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-

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Updated 10/01/2024

Use PCSK9 Inhibitors PA form	intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD) 1. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; AND 2. Unable to reach goal LDL-C with a minimum of one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. Diagnosis of Primary Hyperlipidemia (not associated with ASCVD or HeFH) 1. Baseline LDL-C ≥ 190 mg/dL; and 2. Unable to reach goal LDL-C < 100 mg/dL while on high-intensity statin therapy (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) 1. Total cholesterol and LDL-C > 600mg/dL and triglycerides within reference range; OR 2. Confirmation of diagnosis by gene or receptor testing (attach results); AND 3. Unable to reach goal LDL-C with a minimum one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional requests will be considered under the following conditions: 1. Documentation of positive clinical response to PCSK9 Inhibitor therapy (current LDL-C lab provided); and 2. Patient continues therapy with a maximally tolerated statin; and 3. Patient has continued compliance with a low-fat diet.

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Updated 10/01/2024

Peanut Allergen Powder-dnfp (Palforzia) *Use Peanut Allergen Powder-dnfp (Palforzia) PA form*	Prior authorization (PA) is required for Peanut (*Arachis hypogaea*) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions: 1. Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut ≥ 3 mm compared to control or a peanut-specific serum IgE ≥ 0.35 kUA/L (kilos of allergen-specific units per liter); and 2. Patient is 4 to 17 years of age at initiation of therapy or 4 years of age and older for continued up-dosing and maintenance therapy; and 3. Prescribed by or in consultation with an allergist or immunologist; and 4. Patient has access to injectable epinephrine; and 5. Will be used in conjunction with a peanut-avoidant diet; and 6. Patient does not have any of the following: a. Uncontrolled asthma; and/or b. A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease; and 8. The initial dose escalation and the first dose of each new up-dosing level is administered under the supervision of a health care professional in a health care setting with the ability to manage potentially severe allergic reactions, including anaphylaxis. Initial dose escalation and the first dose of all up-dosing levels is not to be billed to the Iowa Medicaid outpatient pharmacy program as the initial dose escalation is administered in the provider office and should be billed via the medical benefit and the first dose of all up-dosing levels is provided via the Office Dose Kit; and 9. Follows FDA approved dosing; and 10. PA is required for all up-dosing dose levels (dose 1 through 11); and 11. Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.

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Updated 10/01/2024

Pegcetacoplan (Empaveli) *Use Pegcetacoplan (Empaveli) PA form*	Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and 2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and 3. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and 4. History of at least one red blood cell transfusion in the previous 12 months; and 5. Documentation of hemoglobin < 10.5 g/dL; and 6. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross-titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and 7. Is prescribed by or in consultation with a hematologist; and 8. Medication will be administered in the member's home; and 9. Member or member's care giver has been properly trained in subcutaneous infusion and prescriber has determined home administration is appropriate. Initial authorizations will be approved for 4 weeks if within cross-titration period with eculizumab (Soliris) to verify eculizumab has been discontinued, or for 6 months otherwise. Additional authorizations will be considered when the following criteria are met: 1. Documentation of a positive clinical response to therapy (e.g., increased or stabilization or hemoglobin levels or reduction in transfusions); and 2. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris).
Pirfenidone (Esbriet) / Nintedanib (Ofev)	Prior authorization (PA) is required for pirfenidone (Esbriet) and nintedanib (Ofev). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Is prescribed by a pulmonologist; and 3. Patient does not have hepatic impairment as defined below: a. Nintedanib- Patient does not have moderate or severe hepatic impairment (Child Pugh B or C) or b. Pirfenidone- Patient does not have severe hepatic impairment (Child Pugh C); and 4. Patient does not have renal impairment as defined below: a. Nintedanib- Patient does not have severe renal impairment (CrCl <30ml/min) or end-stage renal disease or b. Pirfenidone- Patient does not have end-stage renal disease requiring dialysis; and 5. Patient does not utilize non-prescribed inhalants, such as vaping or other inhaled tobacco products, prior to initiating therapy and has been instructed to avoid tobacco products while using pirfenidone or nintedanib; and 6. Patient has a diagnosis of idiopathic pulmonary fibrosis (nintedanib or pirfenidone) as confirmed by one of the following (attach documentation): a. Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or b. A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and c. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational exposures, connective tissue disease, and drug toxicity; and

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Pirfenidone (Esbriet) / Nintedanib (Ofev) PA form	d. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥50% predicted; and e. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥30% predicted; or 7. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation): a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 40% predicted; and c. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥ 30-89% predicted; or 8. Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (nintedanib) as confirmed by the following (attach documentation): a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 45% predicted; and c. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥ 30-79% predicted; and d. Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months despite standard treatment with an agent other than nintedanib or pirfenidone: i. A relative decline in the FVC of at least 10% predicted; or ii. A relative decline in the FVC of 5-9% predicted combined with at least one of the following: 1. Worsening respiratory symptoms; or 2. Increased extent of fibrosis on HRCT; or iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only. If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met: 1. Adherence to pirfenidone (Esbriet) or nintedanib (Ofev) is confirmed; and 2. Documentation of a positive response to therapy, defined as meeting at least one of the following: a. Rate of lung function decline slowed; or b. Improved or no worsening of symptoms of cough, shortness of breath; and 3. Documentation is provided that the patient has remained tobacco-free; and 4. ALT, AST, and bilirubin are assessed periodically during therapy.
Proton Pump Inhibitors	Prior authorization (PA) is not required for preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day. Requests for PPIs exceeding one unit per day will be considered for the following diagnoses with additional documentation regarding the medical necessity: 1. Barrett's esophagus, Erosive esophagitis, or Peptic stricture (Please fax a copy of the scope results with the initial request); or 2. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas); or 3. Recurrent peptic ulcer disease; or

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Updated 10/01/2024

Use Proton Pump Inhibitor PA form	4. Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with the requested PPI at maximal dose within the established quantity limit of one per day. Requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a dose reduction to the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day; or 5. Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection. Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.
Pulmonary Arterial Hypertension Agents *Use Pulmonary Arterial Hypertension Agents PA form*	Prior Authorization (PA) is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions: 1. Diagnosis of pulmonary arterial hypertension
Quantity Limit Override *Use Quantity Limit Override PA form*	Designated drugs are limited to specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website www.iowamedicaidpdl.com under the Billing/Quantity Limits tab. Providers should submit a Prior Authorization (PA) request for override consideration.
Repository Corticotropin Injection (H.P. Acthar Gel) *Use Repository Corticotropin Injection (H.P. Acthar Gel) PA form*	Prior authorization (PA) is required for repository corticotropin injection. Payment will be considered under the following conditions: 1. Patient is under two years of age and 2. Patient has a diagnosis of infantile spasms. Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection. If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.

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Updated 10/01/2024

Rifaximin (Xifaxan) *Use Rifaximin (Xifaxan) PA form*	Prior authorization (PA) is required for rifaximin. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. A diagnosis of travelers' diarrhea: a. Patient is 12 years of age or older; and b. Patient has a diagnosis of travelers' diarrhea not complicated by fever or blood in the stool or diarrhea due to pathogens other than *Escherichia coli*; and c. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred generic fluoroquinolone or azithromycin. d. A maximum 3 day course of therapy (9 tablets) of the 200mg tablets per 30 days will be allowed. 2. A diagnosis of hepatic encephalopathy: a. Patient is 18 years of age or older; and b. Patient has a diagnosis of hepatic encephalopathy; and c. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with lactulose. 3. A diagnosis of irritable bowel syndrome with diarrhea: a. Patient is 18 years of age or older; and b. Patient has a diagnosis of irritable bowel syndrome with diarrhea; and c. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred antispasmotic agent (dicyclomine, hyoscyamine); and d. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with amitriptyline and loperamide. e. If criteria for coverage are met, a single 14-day course will be approved. f. Subsequent requests will require documentation of recurrence of IBS-D symptoms. A minimum 10 week treatment-free period between courses is required. g. A maximum of 3 treatment courses of rifaximin will be allowed per lifetime. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2024

Risdiplam (Evrysdi) *Use Risdiplam (Evrysdi) PA form*	Prior authorization (PA) is required for risdiplam (Evrysdi). Payment will be considered under the following conditions: 1. Patient has a diagnosis of spinal muscular atrophy (SMA); and 2. Patient meets the FDA approved age for diagnosis; and 3. Dosing follows FDA approved dose for age and weight; and 4. A negative pregnancy test for females of reproductive potential prior to initiating treatment; and 5. Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least one month after last dose and male patients of reproductive potential have been counseled on the potential effects on fertility; and 6. Patient does not have impaired liver function; and 7. Will not be prescribed concomitantly with other SMA treatments, such as Spinraza (nuninersen), Zolgensma (onasemnogene abeparvovec), or any other new products that are approved by the FDA and released; and 8. Documentation of previous SMA therapies and response to therapy is provided; and a. For patients currently on Spinraza, documentation Spinraza will be discontinued is provided, including date of last dose, and the appropriate interval based on the dosing frequency of the other drug has been met (i.e. 4 months from the last dose when on maintenance therapy); or b. For patients treated with Zolgensma, requests will not be considered; and 9. Is prescribed by or in consultation with a neurologist; and 10. Pharmacy will educate the member, or member's caregiver, on the storage and administration of Evrysdi, as replacements for improper storage or use will not be authorized. If the criteria for coverage are met, requests will be approved for 1 year. Requests for continuation of therapy will require documentation of a positive response to therapy including stabilization or improved function unless intercurrent event (fracture, illness, other) affects functional testing.
Roflumilast (Daliresp) *Use Roflumilast (Daliresp) PA form*	Prior authorization (PA) is required for roflumilast (Daliresp). Payment will be considered for patients 18 years of age or older when the following is met: 1. A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and 2. A smoking history of ≥ 20 pack-years, and 3. Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and 4. A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2024

Sapropterin (Kuvan) *Use Sapropterin (Kuvan) PA form*	Prior authorization (PA) is required for sapropterin (Kuvan). Requests for doses above the FDA approved dose will not be considered. Initial requests will be considered for patients when the following criteria are met: 1. Patient has a diagnosis of phenylketonuria (PKU); and 2. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and 3. Patient has a baseline blood Phe level ≥360 micromol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sapropterin therapy (attach lab results); and 4. Patient's current weight is provided; and 5. Request is for an FDA approved starting dose (10mg/kg/day for patients 1 month to 6 years and 10-20mg/kg/day for patients 7 years and older); and 6. Blood Phe levels will be measured after 1 week of therapy and at least one other time during the first month of therapy. Initial requests will be considered for 1 month to assess response to therapy. Continuation of therapy will be considered when the following criteria are met: 1. Patient's current weight is provided; and 2. Patient continues on a Phe restricted diet; and 3. For patients initiated at a dose of 10mg/kg/day and the blood Phe level did not decrease from baseline, dose may be increased to 20mg/kg/day. Approval will be given for 1 month to assess response to therapy. 4. For patients initiated at a dose of 20mg/kg/per day or those increased to this dose after 1 month of therapy at 10mg/kg/day, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction in blood Phe level. If blood Phe level does not decrease after 1 month at 20mg/kg/day, the patient is considered a non-responder and no further requests will be approved. 5. Maintenance dose requests will be considered for patients that have responded to therapy, based on the above criteria, at 6 month intervals. Documentation of compliance to diet and updated blood Phe levels documenting continued response to therapy are required for further consideration.
Satralizumab (Enspryng) *Use Satralizumab (Enspryng) PA form*	Prior authorization (PA) is required for satralizumab (Enspryng). Payment will be considered under the following conditions: 1. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD); and 2. Patient is anti-aquaporin 4 (AQP4) seropositive (attach documentation); and 3. Patient meets the FDA approved age and dosing; and 4. Patient has a history of at least 1 relapse in the previous 12 months prior to initiation of therapy; and 5. Patient has been tested for tuberculosis prior to the initiation of therapy and does not have active or untreated latent tuberculosis; and 6. Patient has been tested for hepatitis B virus (HBV) prior to the initiation of therapy and confirmed negative for active HBV; and 7. Prescribed by a neurologist. If criteria for coverage are met, initial requests will be given for 1 year. Additional authorizations will be considered upon documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse).

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Updated 10/01/2024

Sedative/Hypnotics-Non-Benzodiazepine *Use Sedative/Hypnotics-Non-Benzodiazepine PA form*	Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. A diagnosis of insomnia; and 3. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and 4. Enforcement of good sleep hygiene is documented; and 5. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses; and 6. Will not be used concurrently with a benzodiazepine sedative/hypnotic agent. 7. In addition to the above criteria, requests for an orexin receptor antagonist will require documentation of a trial and therapy failure with at least one non-preferred agent prior to consideration of coverage. 8. Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2024

Select Anticonvulsants *Diacomit* *Epidiolex* *Fintepla* *Ztalmy* *Use Select Anticonvulsants PA form*	Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations: and 2. Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, tuberous sclerosis complex, or cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and 3. Is prescribed by or in consultation with a neurologist; and 4. Patient's current weight is provided; and 5. The total daily dose does not exceed the following: a. Cannabidiol i. Lennox-Gastaut syndrome or Dravet syndrome: 20 mg/kg/day: or ii. Tuberous sclerosis complex: 25 mg/kg/day; or b. Fenfluramine i. With concomitant stiripentol (plus clobazam): 0.4 mg/kg/day with a maximum of 17 mg per day; or ii. Without concomitant stiripentol: 0.7 mg/kg/day with a maximum of 26 mg per day; or c. Stiripentol i. Prescribed concomitantly with clobazam; and ii. 50 mg/kg/day with a maximum of 3,000 mg/day; or d. Ganaxolone i. Weight ≤ 28 kg: 63mg/kg/day; or ii. Weight > 28 kg: 1800 mg/day. The required trials may be overridden when documented evidence is provided that use of these agents would medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Select Preventative Migraine Treatments	Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions: 1. Patient has one of the following diagnoses: a. Chronic Migraine, defined as: i. ≥ 15 headache days per month for a minimum of 3 months; and ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or b. Episodic Migraine, defined as: i. 4 to 14 migraine days per month for a minimum of 3 months; or c. Episodic Cluster Headache, defined as: i. Occurring with a frequency between one attack every other day and 8 attacks per day; and ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥3 months; and iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting <3 months, for at least 1 year); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and 3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and 4. Patient has been evaluated for and does not have medication overuse headache; and 5. For Episodic and Chronic Migraine, patient has documentation of two trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]); or 6. For Episodic Cluster Headache, patient has documentation of a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy. 7. Lost, stolen, or destroyed medication replacement requests will not be authorized. Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency). The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Select Oncology Agents *Use Select Oncology Agents PA form*	Prior authorization (PA) is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the PA request: copies of medical records (i.e. diagnostic evaluations and recent chart notes), location of treatment (provider office, facility, home health, etc.) if medication requested is not an oral agent, the original prescription, and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.
Select Topical Psoriasis Agents *Use Select Topical Psoriasis Agents PA form*	Prior authorization (PA) is required for select topical psoriasis agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and 3. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Selected Brand Name Drugs *Use Selected Brand Name PA forms*	Prior authorization (PA) is required for selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For PA to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with: 1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available. 2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval. Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

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Updated 10/01/2024

Short Acting Opioids *Use Short Acting Opioids PA form*	Prior authorization (PA) is required for all non-preferred short acting opioids. PA is also required for members when the total daily dose (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1. Patient has pain severe enough to require opioid treatment; and 2. Patient has tried and failed at least two non-pharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two non-opioid pharmacologic therapies (e.g. acetaminophen or NSAIDs); and 4. Patient has documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting opioids (based on opioid ingredient only) at therapeutic doses; and 5. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and has determined that use of a short-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and 6. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids; and 7. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and has determined continued use of a short-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: b. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and c. Documentation as to why concurrent use is medically necessary is provided; and d. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents and/or non-pharmacologic therapies would be medically contraindicated.

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Updated 10/01/2024

Sodium Oxybate Products *Xyrem* *Xywav* *Use Sodium Oxybate Products PA form*	Prior authorization (PA) is required for sodium oxybate (Xyrem). Payment will be considered under the following conditions: 1. A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trial and therapy failure with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline; or 2. A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant; and 3. Patient meets the FDA approved age; and 4. Is prescribed within the FDA approved dosing; and 5. Patient and prescriber are enrolled in the Xyrem® REMS Program; and 6. Patient has been instructed to not drink alcohol when using Xyrem; and 7. Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 8. Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered. 9. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting PA. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Step Therapy Requirements *Use Non-Preferred Drug PA form*	Designated therapeutic drug classes are subject to step therapy edits. For these therapeutic drug classes, drugs are assigned to numbered steps and appropriate trials must be made of the drugs assigned to each step before payment will be made for drugs assigned to a subsequent step. These therapeutic classes, as well as the specific step edit requirements, are identified on the Iowa Medicaid Preferred Drug List posted on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Providers should submit a Prior Authorization (PA) request for override consideration. Therapeutic Classes Included: Antipsychotics-Atypicals

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Updated 10/01/2024

Tasimelteon (Hetlioz) *Use Tasimelteon (Hetlioz) PA form*	Prior authorization (PA) is required for tasimelteon (Hetlioz). Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of: a. Non-24-Hour Sleep-Wake Disorder (Non-24); and i. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and ii. Patient has a documented trial and therapy failure with ramelteon (Rozerem®); or b. Sleep disturbances in Smith-Magenis Syndrome (SMS); and i. Documentation of confirmed deletion of 17p11.2 (cytogenic analysis or microarray) or RAI1 gene mutation is provided (attach results); and ii. Patient has a documented trial and therapy failure with at least one other medication used for sleep disturbances; and 3. Is prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders; and 4. Will not be used concomitantly with other sleep medications. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions: 1. Patient's use of tasimelteon (Hetlioz) has been continuous without gaps in treatment; and 2. Documentation patient has experienced a positive clinical response to therapy with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, significant decreases in daytime sleep, and/or nighttime sleep quality.
Testosterone Products	Prior authorization (PA) is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions: 1. Patient is male and 18 years of age or older (or 12 years of age or older for testosterone cypionate); and 2. Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (please attach lab results); and 3. Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below): a. Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:

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The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Testosterone Products PA form	• Cryptorchidism • Bilateral torsion • Orchitis • Vanishing testes syndrome • Orchiectomy • Klinefelter's syndrome • Chemotherapy • Toxic damage from alcohol or heavy metals b. Hypogonadotropic hypogonadism • Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency • Pituitary-hypothalamic injury from tumors, trauma, or radiation 4. Patient does not have: a. Breast or prostate cancer b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL c. Hematocrit > 50% d. Untreated severe obstructive sleep apnea e. Severe lower urinary tract symptoms f. Uncontrolled or poorly controlled heart failure If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following: 1. An updated testosterone level (Please attach lab result); and 2. Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months. The required trials may beoverridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Updated 10/01/2024

Tezepelumab-ekko (Tezspire) Prefilled Pen *Use Tezepelumab-ekko (Tezspire) Prefilled Pen PA form*	Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of severe asthma; and a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and b. Patient must have one of the following, in addition to the regular maintenance medications defined above: i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months, or ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and c. This medication will be used as an add-on maintenance treatment; and d. Patient/caregiver will administer medication in patient's home; and e. Is not prescribed in combination with other biologics indicated for asthma. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Updated 10/01/2024

Topical Acne and Rosacea Products *Use Topical Acne and Rosacea Products PA form*	Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Documentation of diagnosis; and 3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and 4. Payment for non-preferred topical antibiotic or topical retinoid acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and 5. Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and 6. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent; and 7. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and 8. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and 9. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Topical Antifungals for Onychomycosis *Use Topical Antifungals for Onychomycosis PA form*	Jublia (efinaconazole) and Kerydin (tavaborole) will be considered when the following criteria are met: 1. Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lunula (matrix) involvement; and 2. Patient is 18 years of age or older; and 3. Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and 4. Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and 5. Patient is diabetic or immunosuppressed/immunocompromised. If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection will not be considered. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Topical Corticosteroids *Use Topical Corticosteroids PA form*	Prior authorization (PA) is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2024

Tralokinumab-Idrm (Adbry) *Use Tralokinumab (Adbry) PA form*	Prior authorization (PA) is required for tralokinumab-Idrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe atopic dermatitis; and 3. Is prescribed by or in consultation with a dermatologist; and 4. Patient has failed to respond to good skin care and regular use of emollients; and 5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 6. Patient has documentation of a previous trial and therapy failure with a preferred topical immunomodulator for a minimum of 4 weeks; and 7. Patient has documentation of a previous trial and therapy failure with cyclosprorine or azathioprine; and 8. Patient will continue with skin care regimen and regular use of emollients. If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients. The required trials may be overridden when documented evidence if provided that the use of these agents would be medically contraindicated.
Triheptanoin (Dojolvi) *Use Triheptanoin (Dojolvi) PA form*	Prior authorization (PA) is required for triheptanoin (Dojolvi). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and 2. Patient has a diagnosis of long-chain fatty acid oxidation disorder (LC-FAOD), with supporting documentation of gene mutation(s) associated with LC-FAOD (LC-FOADs include: CPT1, CACT, CPT11, VLCAD, TFP, LCHAD); and 3. Patient will not be using another medium chain triglyceride (MCT) product; and 4. Documentation of a patient's daily caloric intake (DCI) is provided; and 5. Patient's target daily dose is provided as a percentage of the patient's total daily prescribed DCI, not to exceed 35%; and 6. Is prescribed by or in consultation with an endocrinologist, geneticist, or metabolic disease specialist. If the criteria for coverage are met, initial requests will be approved for four months. Additional authorizations will be considered upon documentation of a positive clinical response to therapy.

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Updated 10/01/2024

Vericiguat (Verquvo) *Use Vericiguat (Verquvo) PA form*	Prior authorization (PA) is required for vericiguat (Verquvo). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of symptomatic chronic heart failure (NYHF class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and 3. Patient meets one of the following: a. Recent hospitalization for heart failure (within the last 6 months); or b. Recent need for outpatient intravenous diuretics (within the last 3 months); and 4. Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least one month after the last dose; and 5. Will not be used concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or phosphodiesterase type 5 (PDE-5) inhibitors (e.g. sildenafil, tadalafil, vardenafil); and 6. Documentation of prior or current therapy, at a maximally tolerated dose, with one drug from each category below: a. Renin-angiotensin system inhibitor (angiotensin converting enzyme [ACEI], angiotensin receptor blocker [ARB], or angiotensin receptor-neprilysin inhibitor [ARNI]); and b. Evidence-based beta-blocker (carvedilol, metoprolol succinate, or bisoprolol); and c. Mineralocorticoid receptor antagonist (MRA); and d. Sodium-glucose cotransporter 2 inhibitor (SGLT2i) indicated for the treatment of heart failure (empagliflozin or dapagliflozin); and 7. Initial requests for vericiguat (Verquvo) 2.5 mg and 5 mg tablets will be limited to one 14-day supply for each strength. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Vesicular Monoamine Transporter (VMAT) 2 Inhibitors *Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form*	Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered when the patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Will not be used concurrently with other vesicular monoamine (VMAT) 2 inhibitors; and 3. Prescribed by or in consultation with a neurologist, psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and Tardive Dyskinesia (Ingrezza or Austedo) 1. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following: a. Involuntary athetoid or choreiform movements b. Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.) c. Symptoms lasting longer than 4-8 weeks; and 2. Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and 3. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS), If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS); or Chorea associated with Huntington's disease (Austedo, Ingrezza or tetrabenazine) 1. Patient has a diagnosis of Huntington's disease with chorea symptoms; and 2. Patient is not suicidal, or does not have untreated or inadequately treated depression; and 3. 4. For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in chorea symptoms is provided.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Viloxazine (Qelbree) *Use Viloxazine (Qelbree) PA form*	Prior authorization is required for viloxazine (Qelbree). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and 3. Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational) and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine or a preferred stimulant; and 5. Dose does not exceed 400 mg per day for pediatric patients (< 18 years of age) and 600 mg per day for adult patients; and 6. Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Vitamins, Minerals and Multiple Vitamins *Use Vitamin/Mineral PA form*	Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)
Voxelotor (Oxbryta) *Use Voxelotor (Oxbryta) PA form*	Prior authorization (PA) is required for Oxbryta (voxelotor). Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of sickle cell disease (SCD); and 3. Requested dose is within the FDA approved dosing; and 4. Patient has experienced at least two sickle cell-related vaso-occlusive crises within the past 12 months (documentation required); and 5. Patient has documentation of an adequate trial and therapy failure with hydroxyurea; and 6. Baseline hemoglobin (Hb) range is ≥5.5 to ≤10.5 g/dL; and 7. Is prescribed by or in consultation with a hematologist; and 8. Patient is not receiving concomitant blood transfusion therapy. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Documentation of an increase in hemoglobin by ≥1 g/dL from baseline; and 2. Documentation of a decrease in the number of sickle cell-related vaso-occlusive crises. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

Ensifentrine (Ohtuvayre)
Initial Review

Background
Ensifentrine (Ohtuvayre) is a phosphodiesterase-3 (PDE3) inhibitor and phosphodiesterase-4 (PDE4) inhibitor indicted for the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients.

See the attached new drug review for additional information.

The 2024 Global Initiative for Chronic Obstructive Lung Disease (GOLD) Report defines the diagnosis of COPD as any patient with a post-bronchodilator FEV1/FVC ratio of < 0.7, along with clinical indicators such as dyspnea, cough or sputum production, and/or history of exposure to risk factors (i.e. tobacco smoke, occupational contact, host factors). Assessment of the severity of airflow obstruction, based on the post-bronchodilator FEV1, is also recommended to guide therapy. The GOLD grades and severity of airflow obstruction in COPD are defined as below.

Grade	Severity	FEV1 % predicted
GOLD 1	Mild	≥ 80
GOLD 2	Moderate	50-79
GOLD 3	Severe	30-49
GOLD 4	Very Severe	< 30

In addition to spirometry and evaluating airflow obstruction, tools like the modified Medical Research Council (mMRC) dyspnea scale and the COPD Assessment Test (CAT) are used to assess COPD symptoms. These tools help determine disease severity and guide pharmacologic treatment. The mMRC scale measures the severity of breathlessness, while the CAT quantifies the overall impact of COPD symptoms on health. An mMRC score of 2 or higher, or a CAT score of 10 or higher, indicates more significant symptoms.

The GOLD ABE Assessment Tool categorizes COPD patients based on symptoms and exacerbation history into three groups: A, B, and E. Symptoms are evaluated using the mMRC dyspnea scale or the CAT. Severity groups are defined as follows:

- Group A: Less symptomatic, low risk of future exacerbations:
  - mMRC grade 0 to 1 or CAT score < 10
  - 0 to 1 exacerbations per year without hospitalization
- Group B: More symptomatic, low risk of future exacerbations:
  - mMRC grade ≥ 2 or CAT score ≥ 10
  - 0 to 1 exacerbations per year without hospitalization
- Group E: High risk of future exacerbations:
  - ≥ 2 exacerbations per year or ≥ 1 hospitalization for exacerbation

Based on the severity category, initial treatment for COPD includes a long-acting beta agonist (LABA) and/or a long-acting muscarinic agent (LAMA), with or without an inhaled corticosteroid (ICS). The guidelines emphasize the importance of blood eosinophil counts in managing COPD, as higher eosinophil counts predict a greater benefit from ICS in reducing exacerbations. If a patient's eosinophil count is ≥ 300, an ICS should be included in their treatment.

If initial treatment is effective, it should be continued. If not, factors like adherence, inhaler technique, and possible interfering comorbidities should be evaluated. Follow-up treatment is stepwise and depends on whether dyspnea or exacerbations are the predominate issue.

- For dyspnea: Start with either a LAMA or LABA, progress to LABA + LAMA.
- For exacerbations: Start with a LABA or LAMA, progressing to LABA + LAMA, and/or LABA + LAMA + ICS (if blood eosinophil is ≥ 100).

For patients treated with LABA + LAMA +/- ICS who continue to have exacerbations, adding roflumilast (if FEV1 < 50% and chronic bronchitis) or azithromycin (preferred in former smokers) may be considered. The GOLD guidelines have not yet been updated to include Ohtuvayre.

Cost

- WAC $2950 per month; $35,400 per year

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for ensifentrine (Ohtuvayre). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of moderate to severe COPD when all of the following are met:
    a. FEV1/FVC ratio < 0.7; and
    b. Post-bronchodilator FEV1 % predicted of 30% to 79%; and
    c. Modified Medical Research Council (mMRC) dyspnea score of ≥ 2 or a COPD Assessment Test (CAT) score ≥ 10; and
3. Patient is adherent with COPD treatments, meeting one of the following criteria:
    a. The patient has a blood eosinophil of ≥ 100 and has experienced an exacerbation while adherent to a current 60-day trial of a triple combination regimen consisting of a long-acting beta agonist (LABA), a long-acting muscarinic antagonist (LAMA), and an inhaled corticosteroid (ICS); or

   b. The patient has a blood eosinophil of < 100 and has experienced an exacerbation while adherent to a current 60-day trial of a dual combination regimen consisting of a LABA and LAMA; and
4. Dual or triple combination regimen will be continued in combination with ensifentrine (Ohtuvayre).

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If the criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Additional authorizations will be considered upon documentation of a response to treatment (e.g. improved dyspnea, decreased exacerbations) and patient continues their dual or triple combination regimen.

References

Ohtuvayre [Prescribing information]. Raleigh, NC: Verona Pharma. June 2024.

PDL DRUG REVIEW

Proprietary Name: Ohtuvayre®
Common Name: ensifentrine
PDL Category: Phosphodiesterase Inhibitors

Comparable Products	Preferred Drug List Status
Roflumilast	Preferred with Conditions

Pharmacology/Usage: Ensifentrine, the active ingredient of Ohtuvayre®, is an inhibitor of phosphodiesterase 3 and 4 (PDE3 and PDE4). It is a small molecule that is an inhibitor of the PDE3 and PDE4 enzymes. PDE3 mainly hydrolyzes the second-messenger molecule cyclic adenosine monophosphate (cAMP) but is also capable of hydrolyzing cyclic guanosine monophosphate (cGMP). PDE4 hydrolyzes cAMP only. Inhibition of PDE3 and PDE4 results in accumulation of intracellular levels of cAMP and/or cGMP, resulting in various downstream signaling effects.

Indication: For the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients.

There is no pregnancy category for this medication; however, the risk summary indicates that there are no available data on use in pregnant women to assess for a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. The safety and efficacy of use in the pediatric population have not been established.

Dosage Form: Inhalation suspension in low-density polyethylene unit-dose ampules: 3mg/2.5ml (1.2mg/ml). Shake ampule vigorously before administration.

Recommended Dosage: Using a standard jet nebulizer equipped with a mouthpiece, inhale 3mg (one unit-dose ampule) twice daily, once in the morning and once in the evening, via oral inhalation.

Compatibility of Ohtuvayre® mixed with other drugs has not been established. Ohtuvayre® should not be physically mixed with other drugs or added to solutions containing other drugs.

Dosage adjustments are not required in patients with mild or moderate renal impairment. Patients with severe renal impairment have not been evaluated. Ensifentrine systemic exposure increased by 2.3-fold in subjects with moderate or severe hepatic impairment compared with healthy subjects. Use Ohtuvayre® with caution in patients with hepatic impairment.

Drug Interactions: There are no drug interactions listed with this product.

Box Warning: There is no box warning listed with this product.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Ohtuvayre®) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included back pain (0.8%), hypertension (0.8%), urinary tract infection (0.3%), and diarrhea (0.3%).

Ohtuvayre® should not be used for the relief of acute symptoms (i.e., as rescue therapy for the treatment of acute episodes of bronchospasm). Ohtuvayre® has not been studied in the relief of acute symptoms

and extra doses should not be used for that purpose. The safety and efficacy of Ohtuvayre® for relief of acute symptoms have not been established. Acute symptoms should be treated with an inhaled, short-acting bronchodilator.

As with other inhaled medicines, Ohtuvayre® may produce paradoxical bronchospasm, which may be life threatening. If paradoxical bronchospasm occurs following dosing with Ohtuvayre®, it should be treated immediately with an inhaled, short-acting bronchodilator. Ohtuvayre® should be discontinued immediately and alternative therapy be started.

Treatment with Ohtuvayre® is associated with an increase in psychiatric adverse reactions. Psychiatric events including suicide-related adverse reactions were reported in clinical studies in patients who received Ohtuvayre®. Before starting treatment, healthcare providers should carefully weigh the risk and benefits of Ohtuvayre® treatment in patients with a history of depression and/or suicidal thoughts or behaviors. Healthcare providers should carefully assess the risks and benefits of continuing treatment with Ohtuvayre® if such events occur.

Contraindications: In patients with hypersensitivity to ensifentrine or any component of the product.

Manufacturer: Verona Pharma

Analysis: The efficacy of Ohtuvayre® was assessed in two 24-week randomized, double-blind, placebo-controlled, parallel-group clinical trials (ENHANCE-1 and ENHANCE-2) that enrolled adults (N=1553) with moderate to severe COPD.

ENHANCE-1 enrolled patients (N=763) randomized to receive 3mg Ohtuvayre® administered by oral inhalation via standard jet nebulizer such as PARI LC Sprint or placebo. Included participants had a mean age of 65 years (range 41 to 80), while 58% were male, 90% were white, 57% were current smokers, patients had a mean smoking history of 41 pack-years, and 25% reported exacerbations of COPD within the 15 months prior to the study. At screening, the mean post-bronchodilator percent predicted FEV1 was 52% and the mean post-bronchodilator FEV1/FVC ratio was 0.52. In addition, 68% were taking concurrent therapy: 30% taking concurrent LAMA, 18% taking concurrent LABA, and 20% taking concurrent LABA/ICS therapy throughout the trial.

ENHANCE-2 enrolled patients (N=790) randomized to receive 3mg Ohtuvayre® administered by oral inhalation via standard jet nebulizer such as PARI LC Sprint or placebo . Included participants had a mean age of 65 years (range 40 to 80), while 52% were female, 95% were white, 55% were current smokers, patients had a mean smoking history of 42 pack-years, and 21% of patients reported exacerbations of COPD within the 15 months prior to the study. At screening, the mean post-bronchodilator percent predicted FEV1 was 51%, and the mean post-bronchodilator FEV1/FVC ratio was 0.52. In addition, 55% of patients were taking concurrent therapy: 33% taking concurrent LAMA, 7% taking concurrent LABA, and 15% were taking concurrent LABA/ICS therapy throughout the trial.

The primary endpoint for both studies was the change from baseline in FEV1 AUC0-12h post dose at week 12. Results suggested that Ohtuvayre® demonstrated a statistically significant improvement in FEV1 AUC0-12h as compared to placebo in both studies. Results are presented in the table below, which was adapted from the prescribing information.

	ENHANCE-1		ENHANCE-2	
	Ohtuvayre® (N=479)	Placebo (N=284)	Ohtuvayre® (N=499)	Placebo (N=291)
n	477	282	498	291
Least Squares (LS) mean	61	-26	48	-46
LS mean difference from placebo	87	-	94	-

	ENHANCE-1		ENHANCE-2	
	Ohtuvayre® (N=479)	Placebo (N=284)	Ohtuvayre® (N=499)	Placebo (N=291)
p-value	<0.0001		<0.0001	

Trough FEV1 was defined as the last FEV1 value collected prior to the morning dose. The mean morning trough FEV1 improvement at week 12 relative to placebo was 35ml and 49ml in ENHANCE-1 and ENHANCE-2, respectively, which was statistically significant in ENHANCE-1 and not statistically significant in ENHANCE-2 due to failure higher in the testing hierarchy.

The St. George's Respiratory Questionnaire (SGRQ) was assessed in both studies. In ENHANCE-1, the SGRQ responder rate (defined as an improvement in score of 4 or more as threshold) for Ohtuvayre® at week 24 was 58.2% compared to 45.9% for placebo (OR 1.49). In ENHANCE-2, the SGRQ responder rate for Ohtuvayre® at week 24 was 45.4% compared to 50.3% for placebo (OR 0.92).

Place in Therapy: Ohtuvayre® is a phosphodiesterase 3 (PDE3) inhibitor and PDE4 inhibitor indicated for the maintenance treatment of COPD in adults that is to be administered by oral inhalation twice daily. The safety and efficacy of Ohtuvayre® were assessed in two randomized, double-blind, placebo-controlled trials that included adults with moderate to severe COPD. The primary endpoint for both studies was the change from baseline in FEV1 AUC0-12h post dose at week 12. In both trials, Ohtuvayre® demonstrated a statistically significant improvement in the primary endpoint as compared with placebo. Head-to-head active comparator trials were not currently found, but Ohtuvayre® offers providers and their patients with another treatment option.

Summary

There is no evidence at this time to support that Ohtuvayre® is safer or more effective than the other currently preferred, more cost-effective medications. It is therefore recommended that Ohtuvayre® remain non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications.

PDL Placement: ☐ **Preferred**
☒ **Non-Preferred**

References

[1] Ohtuvayre [package insert]. Raleigh, NC: Verona Pharma, Inc; 2024.

Select Preventative Migraine Treatments
Initial Review

Background

The American Headache Society (AHS) recently updated their position statement on calcitonin gene-related peptide (CGRP) targeting therapies for migraine prevention. The decision is based on evidence showing the efficacy, tolerability, and safety of these therapies for chronic and episodic migraine. Key updates include:

- CGRP targeting therapies are now considered a first-line option for migraine prevention. Initiation of these therapies should not require trial and failure of non-specific migraine preventative medication approaches.
- The update includes CGRP monoclonal antibodies such as erenumab (Aimovig), fremanezumab (Ajovy), and galcanezumab (Emgality), as well as CGRP receptor antagonists like rimegepant (Nurtec ODT) and atogepant (Qulipta), as first-line preventative treatments.

The prior authorization (PA) criteria are being updated to eliminate the requirement for trial and failure with non-specific migraine preventive medications, in accordance with the AHS position statement update.

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions:

1. Patient has one of the following diagnoses:
    a. Chronic Migraine, defined as:
        i. ≥ 15 headache days per month for a minimum of 3 months; and
        ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or
    b. Episodic Migraine, defined as:
        i. 4 to 14 migraine days per month for a minimum of 3 months; or
    c. Episodic Cluster Headache, defined as:
        i. Occurring with a frequency between one attack every other day and 8 attacks per day; and
        ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥3 months; and
        iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting <3 months, for at least 1 year); and
2. Request adheres to all FDA approved labeling for indication, including age,

dosing, contraindications, warnings and precautions; and
3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and
4. Patient has been evaluated for and does not have medication overuse headache; and
5. For Episodic and Chronic Migraine, patient has documentation of three trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]); or
6. For Episodic Cluster Headache, patient has documentation of
    a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and
    b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.
7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for 3 months. Additional PAs will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted and/or stricken)
Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions:

1. Patient has one of the following diagnoses:
    a. Chronic Migraine, defined as:
        i. ≥ 15 headache days per month for a minimum of 3 months; and
        ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or
    b. Episodic Migraine, defined as:
        i. 4 to 14 migraine days per month for a minimum of 3 months; or
    c. Episodic Cluster Headache, defined as:
        i. Occurring with a frequency between one attack every other day and 8 attacks per day; and
        ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥3 months; and
        iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting <3 months, for at least 1 year); and
2. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and
3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and
4. Patient has been evaluated for and does not have medication overuse headache; and
5. ~~For Episodic and Chronic Migraine, patient has documentation of three trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]); or~~
6. For Episodic Cluster Headache, patient has documentation of
    a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and
    b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.
7. Lost, stolen, or destroyed medication replacement requests will not be

authorized.

Initial requests will be approved for 3 months. Additional PAs will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Topical Roflumilast (Zoryve)
Initial Review

Background

Topical roflumilast (Zoryve) 0.3% cream was initially approved by the FDA for the treatment of plaque psoriasis in patients 12 years of age and older in July 2022. Since then, topical roflumilast has received two additional indications as well as a new strength and new dosage form. Topical roflumilast is available as and indicated for the following:

- Topical cream 0.3%: plaque psoriasis, including intertriginous areas, in adult and pediatric patients 6 years of age and older.
- Topical cream 0.15%: mild to moderate atopic dermatitis in adult and pediatric patients 6 years of age and older.
- Topical foam 0.3%: seborrheic dermatitis in adult and pediatric patients 9 years of age and older.

PA criteria are being updated to add new criteria for seborrheic dermatitis and mirroring established PA criteria of other topical agents indicated for atopic dermatitis.

Seborrheic dermatitis is a chronic relapsing condition involving sebaceous glands. Symptoms range from mild, such as dandruff, to severe involving widespread yellowish scales. Treatment is dependent on the severity and location of the condition. Topical antifungal agents (e.g., ketoconazole, other azoles, ciclopirox olamine) and topical anti-inflammatory agents (e.g., topical corticosteroids) are frequently used alone or in combination for the treatment of seborrheic dermatitis.

Clinical Trials

- Topical Foam 0.3%
  The efficacy of Zoryve foam was established in two randomized, double-blind, vehicle-controlled studies (STRATUM and Trial 203) in a total of 683 adult and pediatric patients with seborrheic dermatitis involving the scalp, face, and/or body. In each study, patients were randomized to receive Zoryve foam, 0.3%, or vehicle foam applied once daily for 8 weeks. The primary endpoint was the proportion of patients who achieved Investigator Global Assessment (IGA) treatment success at week 8. Success was defined as a score of “Clear” (0) or “Almost Clear” (1), plus a 2-grade improvement from baseline.
    - In STRATUM, 79.5% and 58.0% of patients achieved IGA success with Zoryve and vehicle foam, respectively (difference 20.6, 95% CI: 11.2, 30.0).
    - In Trial 203, 73.1% and 40.8% of patients achieved IGA success with Zoryve and vehicle foam, respectively (difference 33.8, 95% CI: 20.3, 47.4).

- Topical Cream 0.15%
  The approval of Zoryve 0.15% cream for the treatment of mild to moderate atopic dermatitis was based on two randomized, double-blind, vehicle-controlled studies (INTEGUMENT-1 and INTEGUMENT-2) in a total of 1,337 adult and pediatric patients 6 years of age and older. Patients were randomized to receive Zoryve 0.15% cream or vehicle cream for 4 weeks. The primary endpoint was the proportion of patients who achieved validated Investigator Global Assessment for Atopic Dermatitis (vIGA-AD) treatment success at week 4. Success was defined as a score of "Clear" (0) or "Almost Clear" (1), plus a 2-grade improvement from baseline.
    - In INTEGUMENT-1, vIGA-AD success was achieved in 32.0% of patients with Zoryve vs. 15.2% with vehicle cream (treatment difference 17.4, 95% CI: 11.09, 23.75).
    - In INTEGUMENT-2, vIGA-AD success was achieved in 28.9% of patients with Zoryve vs. 12.0% with vehicle cream (treatment difference 16.5, 95% CI: 10.61, 22.42).

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for select topical psoriasis agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and
3. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted and/or stricken)
Prior authorization (PA) is required for *topical roflumilast (Zoryve)* ~~select topical psoriasis agents~~. Payment ~~for a non-preferred agent~~ will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and
    a. *Request is for roflumilast 0.3% cream; and*
    b. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks*; or*
3. *Patient has a diagnosis of seborrheic dermatitis; and*
    a. *Request is for roflumilast 0.3% foam; and*
    b. *Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred topical corticosteroid (scalp - medium to high potency or nonscalp – low-potency) and preferred topical antifungal for a minimum of 4 consecutive weeks; or*
4. *Patient has a diagnosis of mild to moderate atopic dermatitis; and*
    a. *Request is for roflumilast 0.15% cream; and*
    b. *Patient has failed to respond to good skin care and regular use of emollients; and*
    c. *Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or*
    d. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks;

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

References

Zoryve cream [package insert]. Westlake Village, CA: Arcutis Biotherapeutics, Inc., July 2024
Zoryve foam [package insert]. Westlake Village, CA: Arcutis Biotherapeutics, Inc., December 2023

Vonoprazan (Voquezna)
Initial Review

Background

Vonoprazan (Voquezna) is a potassium-competitive acid blocker (PCAB) indicated:

- For healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults.
- To maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults.
- For the relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD) in adults.
- In combination with amoxicillin and clarithromycin for the treatment of *Helicobacter pylori* (*H. pylori*) infection in adults.
- In combination with amoxicillin for the treatment of *H. pylori* infection in adults.

Dosage and Administration*

Indication	Dosage	Length of Therapy
Healing of Erosive Esophagitis	20 mg once daily	8 weeks
Maintenance of Healed Erosive Esophagitis	10 mg once daily	Up to 6 months
Relief of Heartburn Associated with Non-Erosive GERD	10 mg once daily	4 weeks
Treatment of *H. pylori* Infection (Triple Therapy)	20 mg + amoxicillin 1,000 mg + clarithromycin 500mg, each given twice daily	14 days
Treatment of *H. pylori* Infection (Dual Therapy)	20 mg twice daily + amoxicillin 1,000 mg three times daily	14 days

*See full prescribing information for the recommended dosage by indication for patients with renal or hepatic impairment.

Dosage Forms and Strengths

- Tablets: 10 mg and 20 mg
- Triple pak (14-day administration packs for morning and evening dosing): vonoprazan 20 mg, amoxicillin 500 mg, clarithromycin 500 mg
- Dual pak (14-day administration packs for morning, mid-day, and evening dosing): vonoprazan 20 mg, clarithromycin 500mg

Warnings and Precautions

Gastric malignancy; acute tubulointerstitial nephritis; *Clostridioides difficile*-associated diarrhea; bone fracture; severe cutaneous adverse reactions; vitamin B12 deficiency; hypomagnesemia and mineral metabolism; interactions with diagnostic investigations for neuroendocrine tumors; and fundic gland polyps.

Adverse Reactions

- Healing of Erosive Esophagitis (≥2%): gastritis, diarrhea, abdominal distension, abdominal pain, and nausea.
- Maintenance of Healed Erosive Esophagitis (≥3%): gastritis, abdominal pain, dyspepsia, hypertension, and urinary tract infection.
- Relief of Heartburn Associated with Non-Erosive Gastroesophageal Reflux Disease(≥2%): abdominal pain, constipation, diarrhea, nausea, and urinary tract infection.
- Treatment of *H. pylori* Infection (≥2%): diarrhea, dysgeusia, vulvovaginal candidiasis, abdominal pain, headache, hypertension, and nasopharyngitis.

Clinical Trials

<u>Healing of Erosive Esophagitis and Relief of Heartburn</u>

- Efficacy of Voquezna was established in a randomized, active-controlled, double-blind study (U.S. and Europe) in 1,024 adult patients with erosive esophagitis. Patients were randomized to Voquezna 20 mg once daily or lansoprazole 30 mg once daily for 2 to 8 weeks. The primary endpoint was endoscopically confirmed complete healing of all grades of erosive esophagitis at week 2 or week 8. The percentage of 24-hour heartburn-free days through week 8 was evaluated as a secondary endpoint.
    - Voquezna demonstrated non-inferiority vs. lansoprazole for the rate of healing of erosive esophagitis at week 2 or 8. The healing rates were 93% and 85% with Voquezna and lansoprazole, respectively (difference 8, 95% CI: 4.5, 12.2).
        - A secondary endpoint of complete healing of erosive esophagitis at Week 2, superiority was demonstrated in the subgroup of patients with LA Grade C or D disease, 70% of 177 Voquezna-treated patients and 53% of 174 lansoprazole-treated patients achieved healing (18% treatment difference; 95% CI 7.4, 27.4).
        - Complete healing of erosive esophagitis at either Week 2 or Week 8 in the subgroup of patients with LA Grade C or D disease was 92% in patients treated with Voquezna and 72% in patients treated with lansoprazole. This endpoint was not statistically significant under the prespecified multiple testing procedure.
    - Voquezna demonstrated non-inferiority vs. lansoprazole for percentage of 24-hour heartburn-free days. The mean heartburn-free days were 67% and 64% for Voquezna and lansoprazole, respectively (difference 3, 95% CI: -1.6, 7.0).
- Two additional randomized, active-controlled, double-blind studies conducted outside of the U.S., of similar design to the U.S. trial, also demonstrated non-inferiority of vonoprazan 20 mg once daily compared to lansoprazole 30 mg once daily for the primary endpoint of healing of all grades of erosive esophagitis by week 8.

Maintenance of Healed Erosive Esophagitis and Relief of Heartburn

- Patients who completed the healing phase of the erosive esophagitis study and showed endoscopically confirmed healed erosive esophagitis at week 2 or week 8 were rerandomized in the maintenance phase to either Voquezna 10 mg once daily, a higher dosage of Voquezna, or lansoprazole 15 mg once daily. The primary endpoint was maintenance of healed erosive esophagitis (all grades) through week 24. The percentage of 24-hour heartburn-free days through week 24 was evaluated for non-inferiority as a secondary endpoint.
    - Voquezna 10 mg demonstrated non-inferiority and superiority vs. lansoprazole for the rate of maintenance healing at week 24. Maintenance healing rates were 79% and 72% for Voquezna and lansoprazole, respectively (difference 7, 95% CI: 0.2, 14.1).
    - Voquezna 10 mg demonstrated non-inferiority vs. lansoprazole for percentage of 24-hour heartburn-free days through week 24. The mean heartburn-free days were 81% and 79% for Voquezna and lansoprazole, respectively (difference 2, 95% CI: -2.3, 6.8).
    - The higher Voquezna dose group did not demonstrate additional treatment benefit compared to Voquezna 10 mg once daily.
- Two additional randomized, active-controlled, double-blind studies conducted outside of the U.S., of similar design to the U.S. trial, also demonstrated non-inferiority of vonoprazan 10 mg once daily compared to lansoprazole 15 mg once daily for the primary endpoint of maintenance of healed erosive esophagitis (all grades) through week 24.

Relief of Heartburn Associated with Non-Erosive GERD

- Approval was based on a randomized, placebo-controlled, double-blind study in 772 adult patients with a diagnosis of symptomatic non-erosive GERD. Patients were randomized to one of the following treatment groups in the 4-week placebo-controlled phase: Voquezna 10 mg once daily, a higher dosage of Voquezna, or placebo once daily. The primary endpoint was the percentage of 24-hour heartburn-free days, as assessed by daily diary over 4 weeks.
    - The least squares mean percentage of 24-hour heartburn-free days was 45% with Voquezna 10 mg vs. 28% with placebo (difference 17, 95% CI: 12, 22; $p < 0.001$).
    - The higher Voquezna dose group did not demonstrate additional treatment benefit compared to Voquezna 10 mg once daily through week 4.

Treatment of *H. pylori* Infection

- The efficacy of Voquezna Triple Pak and Dual Pak were established in a randomized, controlled, double-blind triple therapy/open-label dual therapy study in treatment-naïve *H. pylori*-positive adult patients. Patients were randomized to Voquezna Triple Pak, Voquezna Dual Pak, or lansoprazole 30 mg plus

amoxicillin 1,000 mg plus clarithromycin 500 mg (LAC), each dosed twice daily and administered for 14 consecutive days. The primary endpoint was eradication rates of *H. pylori* at test-of-cure (≥ 27 days post-therapy).

- Voquezna Triple Pak and Voquezna Dual Pak were shown to be noninferior to LAC in patients who did not have a clarithromycin or amoxicillin resistant strain of *H. pylori* at baseline (eradication rates: 85%, 79%, and 79%, respectively).
- Voquezna Triple Pak and Voquezna Dual Pak were shown to be superior to LAC in patients who had a clarithromycin resistant strain of *H. pylori* at baseline (eradication rates: 66%, 70%, and 32%, respectively) and in the overall population (eradication rates: 81%, 77%, and 69%, respectively).

Manufacturer

- Phathom Pharmaceuticals, Inc.

Cost

- Tablets: WAC $21.67 per tablet, $650.10 per 30 days
- Dual or Triple Pak: WAC $7.25 per unit; $812 per pak (14 days)

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for vonoprazan (Voquezna), Voquezna Dual Pak, and Voquezna Triple Pak. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including, age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of healing of erosive esophagitis (attach endoscopy results), maintenance of healed erosive esophagitis (attach endoscopy results), and relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD); and
    a. Documentation of an 8-week trial and therapy failure with three preferred PPIs, each twice-daily dosing; or
3. Patient has an active *Helicobacter pylori* (*H. pylori*) infection (attach documentation); and
    a. Patient has documentation of a recent trial and therapy failure with a preferred agent(s) for the treatment of *h. pylori* infection; and
    b. Request is for the triple pak or dual pak.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

If the criteria for coverage are met, requests will be evaluated for the dosage and duration of therapy according to the indications specified on the FDA approved label.

Other Items to Consider

- For treatment of moderate to severe erosive esophagitis (LA Grade C or D), require only one 8-week trial with a preferred PPI, at twice daily dosing?

References

Voquezna [package insert]. Buffalo Grove, IL: Phathom Pharmaceuticals, Inc; July 2024

Dupilumab (Dupixent)
Initial Review

Background
Dupilumab (Dupixent) received approval for a new indication of chronic obstructive pulmonary disease (COPD) as an add on maintenance treatment in adults with uncontrolled COPD and an eosinophilic phenotype. It is the first biologic approved for the treatment of COPD.

Prior authorization criteria are being updated to add criteria for the COPD indication. Refer to the Dupixent drug label for complete information.

The safety and efficacy of Dupixent as add-on maintenance treatment of adult patients with inadequately controlled COPD and an eosinophilic phenotype was evaluated in two randomized, double-blind, multicenter, parallel-group, placebo-controlled trials: BOREAS and NOTUS. Both trials enrolled 1,874 individuals with COPD with moderate to severe airflow limitation (post-bronchodilator FEV1/FVC ratio < 0.7 and post-bronchodilator FEV1 of 30% to 70% predicted) and a minimum blood eosinophil count of 300 cells/mcL at baseline. Enrollment in the trial required an exacerbation history of at least 2 moderate or 1 severe exacerbation(s) in the previous year despite receiving maintenance triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS), and symptoms of chronic productive cough for at least 3 months in the past year. Subjects were randomized to receive DUPIXENT 300 mg subcutaneously every two weeks or placebo in addition to their background maintenance therapy for 52 weeks. The primary endpoint was annualized rate of moderate to severe COPD exacerbations during the 52-week treatment period.

- In the BOREAS trial Dupixent-treated patients experienced 0.78 exacerbations/year vs 1.10 exacerbations/year with placebo; Rate ratio vs placebo 0.71 (95% CI 0.58 – 0.86); approximately 30% reduction.
- In the NOTUS trial Dupixent-treated patients experienced 0.86 exacerbations/year vs 1.30 exacerbations/year with placebo; Rate ratio vs placebo 0.66 (95% CI 0.5 – 0.82); approximately 34% reduction.

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and

3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and
    b. Patient has failed to respond to good skin care and regular use of emollients; and
    c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
    d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    f. Patient will continue with skin care regimen and regular use of emollients; and
4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and
    a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and
    b. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and
    c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta $_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
    d. Patient must have one of the following, in addition to the regular maintenance medications defined above:
        i. One (1) or more exacerbations in the previous year or
        ii. Require daily oral corticosteroids for at least 3 days; or
5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
    a. Documentation dupilumab will be used as an add-on maintenance treatment; and
    b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
        i. Nasal corticosteroid spray; and
        ii. Oral corticosteroid; or
6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and
    a. Is prescribed by, or in consultation with, an allergist, gastroenterologist, or immunologist; and
    b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and

c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and
d. Documentation of previous trials and therapy failures with all of the following:
    i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
    ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and
    iii. Dietary therapy; or

7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
    a. Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and
    b. Patient has experienced severe to very severe pruritits, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
    c. Patient has ≥ 20 nodular lesions (attach documentation); and
    d. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and
8. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changed italicized/highlighted and/or stricken)
Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and
    b. Patient has failed to respond to good skin care and regular use of emollients; and
    c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and

    d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    e. Patient will continue with skin care regimen and regular use of emollients; and
4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and
    a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and
    b. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and
    c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long-acting beta $_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
    d. Patient must have one of the following, in addition to the regular maintenance medications defined above:
        i. One (1) or more exacerbations in the previous year or
        ii. Require daily oral corticosteroids for at least 3 days; or
5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
    a. Documentation dupilumab will be used as an add-on maintenance treatment; and
    b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
        i. Nasal corticosteroid spray; and
        ii. Oral corticosteroid; or
6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and
    a. Is prescribed by, or in consultation with, an allergist, gastroenterologist, or immunologist; and
    b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
    c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and
    d. Documentation of previous trials and therapy failures with all of the following:
        i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
        ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and
        iii. Dietary therapy; or
7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and

a. Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and
b. Patient has experienced severe to very severe pruritits, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
c. Patient has ≥ 20 nodular lesions (attach documentation); and
d. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and

8. *Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and*
    a. *Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:*
        i. *FEV1/FVC ratio < 0.7, and*
        ii. *FEV1 % predicted between 30% to 70%; and*
    b. *Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and*
    c. *Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:*
        i. *Triple therapy with all of the following treatments:*
            1. *Long-acting muscarinic antagonist/anticholinergic (LAMA); and*
            2. *Long-acting beta agonist (LABA); and*
            3. *Inhaled corticosteroid (ICS); or*
        ii. *Double therapy with all of the following if ICS is contraindicated*
            1. *LABA; and*
            2. *LAMA; and*
    d. *Patient has history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and*
    e. *Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; and*
    f. *Prescribed by or in consultation with a pulmonologist; and*
9. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 6 months *for all the above indications, except for COPD, which will receive an initial authorization of 12 months* to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Biologicals for Inflammatory Bowel Disease
Second Review

Background

Prior authorization (PA) criteria are being updated to align with the recent recommended changes to other Biologicals PA criteria (Arthritis and Hidradenitis Suppurativa). PA criteria are being updated to remove many of the warning and precaution criteria that are covered by the statement "*Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations*." This update will decrease the need to update PA criteria when the label for a particular drug is updated or when a new drug is approved that would be subject to these clinical criteria. Additionally, treatment guidelines from the American Gastroenterological Association (AGA) for the medical management of adult patients with moderate to severe Crohn's disease and the AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis both suggest using biologic agents early rather than delaying their use until after failure of older conventional therapies.

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

1. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and
2. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and
3. Patient has a diagnosis of Crohn's Disease – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; or
4. Patient has a diagnosis of Ulcerative Colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine; and

In addition to the above:

Requests for TNF Inhibitors:

1. Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and
2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or IV and with an ejection fraction of 50% or less; and

Requests for Interleukins:

1. Medication will not be given concurrently with live vaccines.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)

Prior authorization (PA) is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling *for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations*. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

~~1. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and~~
~~2. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and~~
3. Patient has a diagnosis of *moderate to severe* Crohn's Disease*; or*
    a. ~~– Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; or~~
4. Patient has a diagnosis of *moderate to severe* Ulcerative Colitis ~~(moderate to severe)~~*; and*
    ~~a. Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine; and~~
5. *Medication will be administered in the patient's home by patient or patient's caregiver.*

~~In addition to the above:~~

~~Requests for TNF Inhibitors:~~

~~1. Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and~~
~~2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less; and~~

~~Requests for Interleukins:~~

~~1. Medication will not be given concurrently with live vaccines.~~

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Incretin Mimetics for Non-Diabetes Indications Second Review

Background

In March 2024, the FDA announced the approval of Wegovy (semaglutide), in combination with a reduced calorie diet and increased physical activity, to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease (CVD) and either obesity or overweight. This is the first FDA approved treatment to reduce the risk of MACE specifically for adults with obesity or overweight. Wegovy also carries an indication to reduce excess body weight and maintain weight reduction long term in adults and pediatric patients ages 12 years and older with obesity and adults with overweight in the presence of at least one weight-related comorbid condition. Currently, payment is not made for drugs used for weight loss.

Studies are currently underway to determine the effect of incretin hormones on different conditions, such as sleep apnea, Alzheimer's disease, substance use disorder, kidney disease, smoking cessation and more.

Clinical Study

The approval of Wegovy for the new indication was based on the SELECT cardiovascular outcomes trial, a randomized, double-blind, placebo-controlled study in 17,604 patients, 45 years of age or older, with an initial body mass index (BMI) of ≥ 27 kg/m^2 and established CVD (prior myocardial infarction, prior stroke, or peripheral arterial disease). Patients were randomized to Wegovy (2.4 mg once weekly) or placebo, added to current standard of care, which included management of cardiovascular risk factors and individualized healthy lifestyle counseling (including diet and physical activity). Standard of care treatments at baseline included lipid lowering therapy, platelet aggregation inhibitors, angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers, and beta-blockers. The primary endpoint, MACE, was the time to first occurrence of a three-part composite outcome which included cardiovascular death, non-fatal myocardial infarction, and non-fatal stroke.

- Wegovy significantly reduced the risk of MACE by 20% compared to placebo when added to standard of care. The treatment effect for the primary composite endpoint, its components, and other relevant endpoints are shown in the table below.

Endpoint	Patients with events n (%)		Hazard ratio (95% CI)
	Placebo	Wegovy	
Primary composite endpoint[1]	701 (8.0%)	569 (6.5%)	0.80 (0.72, 0.90)*
Key secondary endpoints			
Cardiovascular death[2]	262 (3.0%)	232 (2.5%)	0.85 (0.71, 1.01)
All-cause death[3]	458 (5.2%)	375 (4.3%)	0.81 (0.71, 0.93)
Other secondary endpoints			
Fatal or non-fatal myocardial infarction[4]	334 (3.8%)	243 (2.8%)	0.72 (0.61; 0.85)
Fatal or non-fatal stroke[4]	178 (2.0%)	160 (1.8%)	0.89 (0.72; 1.11)

* P-value < 0.001

[1] Composite of cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke

[2] Cardiovascular death was the first confirmatory secondary endpoint in testing hierarchy and superiority was not confirmed.

[3] Confirmatory secondary endpoint. Not statistically significant based on the prespecified testing hierarchy.

[4] Not included in the prespecified testing hierarchy.

Reference Semaglutide Effects on Heart Disease and Stroke in Patients With Overweight or Obesity (SELECT) at ClinitalTrials.gov for additional details.

Dosage and Administration

- Initiate at 0.25 mg subcutaneously once weekly. Follow dose escalation schedule (below) to minimize gastrointestinal adverse reactions.
- If patients do not tolerate a dose escalation, consider delaying dose escalation for 4 weeks.
- The maintenance dose in adults is 2.4 mg (recommended) or 1.7 mg once weekly. Consider treatment response and tolerability when selecting the maintenance dosage.
- Recommended dosage regimen for adults

Treatment	Weeks	Once Weekly SC Dose
Initiation	1 through 4	0.25 mg
Escalation	5 through 8	0.5 mg
	9 through 12	1 mg
	13 through 16	1.7 mg
Maintenance	17 and onward	1.7 mg or 2.4 mg

Dosage Forms and Strengths

- Injection: pre-filled, disposable, single-dose pen
  - 0.25 mg/0.5 mL
  - 0.5 mg/0.5 mL
  - 1 mg/0.5 mL
  - 1.7 mg/0.75 mL
  - 2.4 mg/0.75 mL

Adverse Reactions
Most common adverse reactions (incidence ≥ 5%) in adults or pediatric patients aged 12 years and older are: nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distension, eructation, hypoglycemia in patients with type 2 diabetes, flatulence, gastroenteritis, gastroesophageal reflux disease, and nasopharyngitis.

Manufacturer
- Novo Nordisk Inc.

Newly Proposed Clinical Prior Authorization Criteria
Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient is ≥ 45 years of age; and
3. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus (attach current lab results documenting an A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); and
4. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
    a. Patient has established CVD with history of one of the following (attach chart notes documenting diagnosis):
        i. Prior myocardial infarction (MI);
        ii. Prior stroke (ischemic or hemorrhagic);
        iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and
    b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2; and
    c. Patient is currently receiving cardiovascular standard of care treatment (e.g., lipid lowering therapy, platelet aggregation inhibitors, angiotensin converting enzyme [ACE] inhibitors or angiotensin II receptor blockers [ARBs], beta-blockers); and
    d. For Wegovy dosing:
        i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and

        ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; and
5. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose, will be considered when:

1. The requested drug will be used to reduce the risk of MACE; and
    a. Patient does not have type 1 or type 2 diabetes; and
    b. Patient continues to receive cardiovascular standard of care treatment, as defined above, and
    c. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; and
2. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
3. The requested agent will not be used in combination with other incretin mimetics.

References

Wegovy [package insert]. Plainsboro, NJ: Novo Nordisk Inc; March 2024

Janus Kinase Inhibitors
Second Review

Background
Opzelura (ruxolitinib), a topical JAK inhibitor, received FDA approval for the topical treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older in June 2022. At that time, vitiligo was not covered for this indication; the State has now determined vitiligo should be a covered medical condition. Prior authorization (PA) criteria are being updated to add criteria specific to vitiligo. Note, coverage of Opzelura for the diagnosis of vitiligo will not be considered before PA criteria are in place. Additionally, there are multiple oral JAK inhibitors in the pipeline being studied for the treatment of vitiligo. Opzelura is also indicated for short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adult and pediatric patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Vitiligo is a chronic autoimmune disease characterized by depigmentation of skin that results from the loss of melanocytes. The British Association of Dermatology Guidelines recommend first line therapy with potent or very potent topical corticosteroids once daily, avoiding the periocular area. Topical tacrolimus twice daily may be considered in patients with facial vitiligo or used in an intermittent regimen in combination with potent corticosteroids for patients with lesions in areas of thinner skin. Use of topical treatments should be reassessed every 3 to 6 months to check for improvement.

Additionally, criteria are being updated for:

- Polyarticular course juvenile idiopathic arthritis to align with current guidelines and recently proposed PA criteria for Biologicals for Arthritis.
- Moderately to severely active ulcerative colitis and moderately to severely active Chron's disease to align with current guidelines and recently proposed PA criteria for Biologicals for Inflammatory Bowel Disease.
- Moderate to severe atopic dermatitis to align with recently proposed PA criteria for Dupilumab.
- Mild to moderate atopic dermatitis and vitiligo at the request of the state. These changes were not discussed during the initial review of criteria, are positive in nature, and are highlighted in yellow to easily identify the new changes.

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata, vitiligo, or

other excluded medical use(s), as defined in Section 1927(d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Patient has a diagnosis of:
    a. Moderate to severe rheumatoid arthritis (baricitinib, tofacitinib, upadacitinib); with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
        ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
    b. Psoriatic arthritis (tofacitinib, upadacitinib); with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR
    c. Moderately to severely active ulcerative colitis (tofacitinib, upadacitinib); with
        i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and
        ii. A documented trial and inadequate response with a preferred TNF inhibitor; and
        iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR
    d. Moderately to severely active Crohn's disease (upadacitinib); with
        i. A documented trial and inadequate response to two preferred conventional therapies including aminosalicylates (sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; and
        ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
    e. Polyarticular Course Juvenile Idiopathic Arthritis (tofacitinib); with
        i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and
        ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR

f. Axial spondyloarthritis conditions (e.g., *a*nkylosing spondylitis or nonradiographic axial spondyloarthritis) (tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
    ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR
g. Atopic dermatitis; with
    i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
    ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
    iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    iv. For mild to moderate atopic dermatitis (ruxolitinib)
        a. A documented trial and therapy failure with crisaborole; and
        b. Affected area is less than 20% of body surface area (BSA); and
        c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
    v. For moderate to severe atopic dermatitis (abrocitinib, upadacitinib):
        a. A documented trial and therapy failure with cyclosporine or azathioprine; and
        b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization (changes highlighted/italicized and or stricken) Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata~~, vitiligo,~~ or other excluded medical use(s), as defined in Section 1927(d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Patient has a diagnosis of:

a. Moderate to severe rheumatoid arthritis (baricitinib, tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
    ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
b. Psoriatic arthritis (tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR
c. Moderately to severely active ulcerative colitis (tofacitinib, upadacitinib); with
    ~~i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and~~
    ii. A documented trial and inadequate response with a preferred TNF inhibitor; and
    iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR
d. Moderately to severely active Crohn's disease (upadacitinib); with
    ~~i. A documented trial and inadequate response to two preferred conventional therapies including aminosalicylates (sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; and~~
    ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
e. Polyarticular Course Juvenile Idiopathic Arthritis (tofacitinib); with
    ~~i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and~~
    ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
f. Axial spondyloarthritis conditions (e.g., *a*nkylosing spondylitis or nonradiographic axial spondyloarthritis) (tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
    ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR
g. Atopic dermatitis; with
    i. Documentation patient has failed to respond to good skin care and regular use of emollients; and

ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; *or* ~~and~~
iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
iv. For mild to moderate atopic dermatitis (ruxolitinib):
    ~~a. A documented trial and therapy failure with crisaborole; and~~
    b. Affected area is less than 20% of body surface area (BSA); and
    c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; OR
v. For moderate to severe atopic dermatitis (abrocitinib, upadacitinib):
    a. A documented trial and therapy failure with *a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics* ~~cyclosporine or azathioprine~~; and
    b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg~~.~~; *OR*

h. Nonsegmental vitiligo (ruxolitinib); with
i. *A documented trial and inadequate response with a potent topical corticosteroid; or*
ii. *A documented trial and inadequate response with a topical calcineurin inhibitor; and*
iii. *The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable.*

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Maralixibat (Livmarli)
Second Review

Background
Maralixibat (Livmarli) recently received a second indication for the treatment of cholestatic pruritus in patients 5 years of age and older with progressive familial intrahepatic cholestasis (PFIC). Livmarli is not recommended in a subgroup of PFIC type 2 patients with specific ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein. Livmarli is also approved for the treatment of cholestatic pruritus in individuals with Alagille syndrome (ALGS) who are aged 3 months and older. Odevixibat (Bylvay) was the first drug approved for PFIC. Bylvay was studied in patients with a confirmed molecular diagnosis of PFIC type 1 or type 2. Prior authorization (PA) criteria are being updated to include the new indication.

PFIC is a heterogenous disease caused by homozygous or compound heterozygous variants, with different PFIC subtypes occurring in the general population. PFIC1 is caused by variants in the aminophospholipid flippase (ATP8B1) gene, which encodes the Familial Intrahepatic Cholestasis 1 (FIC1) protein, while PFIC2 (most common subtype) results from variants in the ABCB11 gene, which encodes the Bile Salt Export Pump (BSEP) protein. PFIC2 is further categorized into BSEP subgroups based on specific variants. The BSEP-1 subgroup includes patients with at least one p.D482G (c.1445A>G) or p.E297G (c.890A>G) variant, BSEP-2 includes patients with at least one missense variant other than p.D482G or p.E297G (non BSEP-1), and BSEP-3 includes patients with variants that are predicted to encode a non-functional protein. PFIC3 is caused by variants in the ABCB4 gene, which encodes multidrug resistance protein 3 (MDR3). PFIC4 is caused by variants in the tight junction protein 2 gene (TJP2), which encodes TJP2. PFIC6 is caused by variants in myosin 5B (MYO5B), which encodes MYO5B. Patients can be clinically diagnosed with PFIC without a known pathogenic variant.

Dosage and Administration (PFIC indication)
- The recommended dosage of Livmarli for PFIC is 570 mcg/kg twice daily 30 minutes before a meal.
- The starting dose is 285 mcg/kg orally once daily in the morning, and should be increased to 285 mcg/kg twice daily, 428 mcg/kg twice daily, and then to 570 mcg/kg twice daily, as tolerated. The maximum daily dose should not exceed 38 mg (4 mL) per day.
- Refer to the drug label for complete dosing by weight guidelines for PFIC and for dosing for ALGS.

Adverse Reactions (PFIC indication; ≥ 5%)
- Diarrhea, fat soluble vitamin deficiency, abdominal pain, liver test abnormalities, hematochezia, and bone fractures.

Clinical Studies
The approval of Livmarli for the new indication was based on a randomized, placebo-controlled study in 64 patients with documented molecular diagnosis of PFIC. Patients were randomized to receive Livmarli or placebo. Given the patients' young age, a single-item observer-reported outcome was used to measure patients' pruritus symptoms as observed by their caregiver twice daily on the Itch Reported Outcome Instrument (ItchRO[Obs]). Pruritus symptoms were assessed on a 5-point ordinal response scale, with scores ranging from 0 (none observed or reported) to 4 (very severe).

- The change from baseline to weeks 15 to 26 in the average morning ItchRO(Obs) pruritus severity scores were -1.8 with Livmarli and -0.6 with placebo (mean difference -1.2, 95% CI: -1.7, -0.7; < 0.0001).

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for maralixibat (Livmarli). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a *JAG1* or *NOTCH2* mutation or deletion; and
3. Patient has cholestasis with moderate to severe pruritus; and
4. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS; and
5. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:
    a. Ursodeoxycholic acid (ursodiol)
    b. Cholestyramine
    c. Rifampin; and
6. Patient's current weight in kilograms (kg) is provided.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of an improvement in pruritus symptoms and patient's current weight in kg.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted and/or stricken)

Prior authorization (PA) is required for maralixibat (Livmarli). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. *Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS or PFIC; and*
3. Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a *JAG1* or *NOTCH2* mutation or deletion; and
    a. Patient has cholestasis with moderate to severe pruritus; and
    ~~b. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS; and~~
    c. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:
        i. Ursodeoxycholic acid (ursodiol)
        ii. Cholestyramine
        iii. Rifampin; *or*
2. *Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) demonstrating a gene mutation affiliated with PFIC (i.e., ATP8B1, ABCB11, ABCB4, TJP2, or MYO5B); and*
    a. Genetic testing does not indicate PFIC type 2 with ABCB11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and
    b. Patient has moderate to severe pruritis associated with PFIC; and
4. Patient's current weight in kilograms (kg) is provided.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of an improvement in pruritus symptoms and patient's current weight in kg.

References

Livmarli [package insert]. Foster City, CA; Mirum Pharmaceuticals, Inc.; March 2024.

Omalizumab (Xolair)
Second Review

Background

Omalizumab (Xolair) recently received FDA approval for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods in adult and pediatric patients aged 1 year and older with IgE-mediated food allergy. Xolair is to be used in conjunction with food allergen avoidance and is not indicated for the emergency treatment of allergic reactions, including anaphylaxis. Xolair is also approved for the treatment of asthma, chronic rhinosinusitis with nasal polyps, and chronic spontaneous urticaria.

Skin prick testing (SPT) or in vitro testing are used in patients with a convincing or suggestive history of an IgE-mediated food allergy. Several factors suggestive of an IgE-mediated reaction include the signs and symptoms of the reaction (urticaria, nausea/vomiting, wheezing), timing in relation to food ingestion (usually within minutes), and the food trigger suspected.

The approval of Xolair for the new indication was based on a randomized, double-blind, placebo-controlled study in patients who were allergic to peanut and at least two other foods, including milk, egg, wheat, cashew, hazelnut, or walnut (ie, studied foods). Patients were randomized to Xolair or placebo for 16 to 20 weeks. The efficacy analysis included 165 pediatric patients. The primary endpoint was the percentage of patients who were able to consume a single dose of ≥ 600 mg of peanut protein without dose-limiting symptoms (eg, moderate to severe skin, respiratory or gastrointestinal symptoms) during a double-blind placebo-controlled food challenge (DBPCFC). The secondary endpoints were the percentage of patients who were able to consume a single dose of ≥ 1000 mg of cashew, milk, or egg protein without dose-limiting symptoms during DBPCFC.

- Xolair treatment led to a statistically higher response rate than placebo for the primary and secondary endpoints (see table below).

Food, Challenge Dose	Response Rate		Treatment Difference (95% CI)
	Xolair	Placebo	
Peanut, ≥ 600 mg	68%	5%	63% (50, 73)
Peanut, ≥ 1000 mg	65%	0%	65% (56,74)
Cashew, ≥ 1000 mg	42%	3%	39% (20,53)
Milk, ≥ 1000 mg	66%	11%	55% (29,73)
Egg, ≥ 1000 mg	67%	0%	67% (49,80)

- The effectiveness of Xolair in adults is supported by the adequate and well-controlled trial of Xolair in pediatric patients, disease similarity in pediatric and adult patients, and pharmacokinetic similarity.
- While efficacy cannot be established from uncontrolled, open-label studies, for 38 pediatric patients who continued Xolair for 24 to 28 weeks in an open-label extension, the percentage of patients who were able to consume ≥ 600 mg of peanut protein and ≥ 1000 mg of egg, milk, and/or cashew protein without moderate to severe dose-limiting symptoms was maintained.

The recommended dose of Xolair for IgE-mediated food allergy is 75 mg to 600 mg by subcutaneous injection every 2 or 4 weeks based on serum total IgE level (IU/mL), measured before the start of treatment, and by body weight. Refer to the Xolair drug label for complete dosage recommendations.

- The appropriate duration of therapy for IgE-mediated food allergy has not been evaluated. The need for continued therapy should be periodically reassessed.
- Xolair therapy should be initiated in a healthcare setting and once therapy has been safely established, the healthcare provider may determine whether self-administration of Xolair prefilled syringe or autoinjector by the patient or caregiver is appropriate, based on careful assessment of risk for anaphylaxis and mitigation strategies.

Prior authorization (PA) criteria are being updated to incorporate criteria specific to the new indication.

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for omalizumab (Xolair) prefilled syringe. Requests for omalizumab (Xolair) lyophilized powder for reconstitution will not be considered through the pharmacy benefit. Payment for omalizumab (Xolair) prefilled syringe will be considered for FDA approved and compendia indications under the following conditions:

1. Patient meets the FDA approved age; and
2. Therapy will be initiated in a healthcare setting, under the guidance of a healthcare provider, where the patient can be closely observed for anaphylaxis and safety of therapy has been established after a minimum of 3 doses of omalizumab; and
3. The healthcare provider has determined self-administration with omalizumab is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label; and
4. Dose follows the FDA approved dosing for indication; and
5. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and
6. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and
7. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced.

Moderate to Severe Persistent Asthma

1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
2. Pretreatment IgE level is within the following range:
    a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 700 IU/mL; or
    b. Pediatric patients 6 to less than 12 years of age - 30 IU/mL to 1300 IU/mL; and
3. Patient's weight is within the following range:
    a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; or
    b. Pediatric patients 6 to less than 12 years of age - 20 kg to 150 kg; and
4. History of positive skin or RAST test to a perennial aeroallergen; and
5. Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND a leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy; and
6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist.

Chronic Idiopathic Urticaria

1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and
2. Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and
3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and
4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and
5. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine.

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be

granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.

Nasal Polyps

1. Patient has a diagnosis of nasal polyps; and
2. Pretreatment IgE level is within the following range:
    a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 1500 IU/mL; and
3. Patient's weight is within the following range:
    a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; and
4. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and
5. Will be used concurrently with a nasal corticosteroid; and
6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.

If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)

Prior authorization (PA) is required for omalizumab (Xolair) prefilled syringe. Requests for omalizumab (Xolair) lyophilized powder for reconstitution will not be considered through the pharmacy benefit. *Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations.* Payment for omalizumab (Xolair) prefilled syringe will be considered ~~for FDA approved and compendia indications~~ under the following conditions:

~~1. Patient meets the FDA approved age; and~~

2. Therapy will be initiated in a healthcare setting, under the guidance of a healthcare provider, where the patient can be closely observed for anaphylaxis and safety of therapy has been established after a minimum of 3 doses of omalizumab; and
3. The healthcare provider has determined self-administration with omalizumab is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label; and

4. ~~Dose follows the FDA approved dosing for indication; and~~
5. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and
6. *For a diagnosis of asthma, chronic rhinosinusitis with nasal polyps, IgE-mediated food allergy, and any other FDA approved diagnosis where dosing is dependent on serum IgE level and body weight, the pretreatment IgE level and body weight, in kilograms (kg), is provided. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances; and*
7. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab; and
8. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced.

Moderate to Severe Persistent Asthma

1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
2. ~~Pretreatment IgE level is within the following range:~~
    a. ~~Adults and adolescent patients 12 years of age or older - 30 IU/mL to 700 IU/mL; or~~
    b. ~~Pediatric patients 6 to less than 12 years of age - 30 IU/mL to 1300 IU/mL; and~~
3. ~~Patient's weight is within the following range:~~
    a. ~~Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; or~~
    b. ~~Pediatric patients 6 to less than 12 years of age - 20 kg to 150 kg; and~~
4. *Patient has a h*~~H~~istory of positive skin or RAST test to a perennial aeroallergen; and
5. Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND a leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy.~~; and~~
6. ~~Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.~~

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist.

Chronic Idiopathic Urticaria

1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and
2. Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and
3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and
4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and
5. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine.

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.

Nasal Polyps

1. Patient has a diagnosis of nasal polyps; and
2. ~~Pretreatment IgE level is within the following range:~~
    a. ~~Adults and adolescent patients 12 years of age or older - 30 IU/mL to 1500 IU/mL; and~~
3. ~~Patient's weight is within the following range:~~
    a. ~~Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; and~~
4. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and
5. ~~5.~~ Will be used concurrently with a nasal corticosteroid.~~; and~~
6. ~~Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.~~

If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid.

IgE Mediated Food Allergy

1. *Medication is being prescribed for the reduction of allergic reactions (Type 1) that may occur with accidental exposure to one or more foods in a patient that has an IgE-mediated food allergy; and*

2. *Diagnosis is confirmed by a skin prick test or in vitro test (attach results); and*
3. *Will be used in conjunction with food allergen avoidance.*

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

References

Xolair [package insert]. South San Francisco, CA; Genentech, Inc.: February 2024

Oral Glucocorticoids for Duchenne Muscular Dystrophy
Formerly Deflazacort (Emflaza)
Second Review

Background
Agamree (vamorolone) is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older. Emflaza (deflazacort), was the first glucocorticoid approved for the treatment of DMD. DMD is a rare, progressive X-linked disease resulting from mutation(s) of the dystrophin gene that result in absent or insufficient functional dystrophin. Glucocorticoids and physical therapy are the mainstays of DMD treatment. Glucocorticoid therapy should be initiated early, before significant physical decline, and continue after the patient loses ambulation. Benefits of long-term glucocorticoid therapy include loss of ambulation at a later age, preserved upper limb and respiratory function, and avoidance of scoliosis surgery. Agamree is not addressed in current guidelines. Prior authorization criteria are being updated to allow addition of Agamree to criteria and remove the requirement patient experience onset of weakness before 5 years of age.

See the attached new drug review for additional clinical information for Agamree.

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for Emflaza (deflazacort). Payment will be considered for patients when the following criteria are met:

1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and
2. Patient is within the FDA labeled age; and
3. Patient experienced onset of weakness before 5 years of age; and
4. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and
5. Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose; and
6. Is dosed based on FDA approved dosing.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized or stricken)
Prior authorization (PA) is required for *oral glucocorticoids for Duchenne muscular dystrophy* ~~Emflaza (deflazacort)~~. *Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with*

a preferred agent. Payment will be considered for patients when the following criteria are met:

1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and
2. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations* ~~Patient is within the FDA labeled age~~; and
3. ~~Patient experienced onset of weakness before 5 years of age; and~~
4. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and
5. Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose. ~~; and~~
6. ~~Is dosed based on FDA approved dosing.~~

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

References

Agamree oral suspension [prescribing information]. Coral Gables, FL: Catalyst; June 2024.

Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management. Lancet Neurol. 2018;17(3):251-267.

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PDL DRUG REVIEW

Proprietary Name: Agamree®
Common Name: vamorolone oral suspension
PDL Category: Glucocorticoids

Comparable Products	Preferred Drug List Status
Emflaza	Non-Preferred with Conditions
Prednisone	Preferred

Pharmacology/Usage: Vamorolone, the active ingredient of Agamree®, is a corticosteroid. It acts through the glucocorticoid receptor to exert anti-inflammatory and immunosuppressive effects. The exact mechanism by which vamorolone exerts its effect in patients with Duchenne muscular dystrophy is not known.

Indication: For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.

There is no pregnancy category for this medication; however, the risk summary indicates that Agamree® is indicated for use for the treatment of DMD, which is a disease of young male patients. However, corticosteroids in general should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Infants born to mothers who have received substantial doses of corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism. There are no data of use during pregnancy. The safety and efficacy of use in the pediatric population below the age of 2 years have not been established.

Dosage Form: Oral Suspension: 40mg/ml. Orange flavor.

Shake well for about 30 seconds prior to administration. Use only the oral syringe provided with the product. Discard any used suspension remaining after 3 months of first opening the bottle.

Recommended Dosage: Administer all immunizations per immunization guidelines prior to starting Agamree® treatment. Administer live-attenuated or live vaccines at least 4 to 6 weeks prior to starting treatment.

The recommended dosage is 6mg/kg PO QD preferably with a meal, up to a maximum daily dosage of 300mg for patients weighing more than 50kg. Some patients may respond to a dose of 2mg/kg daily. Doses may be titrated down to 2mg/kg/day as needed, based on individual tolerability.

Regarding discontinuation, the dosage of Agamree® must be decreased gradually if the drug has been administered for more than one week.

Moderate hepatic impairment increases vamorolone exposure. Reduce the Agamree® dosage in patients with mild to moderate hepatic impairment. The recommended dosage in patients with mild to moderate hepatic impairment is 2mg/kg PO QD preferably with a meal, up to a maximum daily dosage of 100mg for patients weighing more than 50kg. There is no clinical experience of use in patients with severe hepatic impairment, and a dosing recommendation cannot be provided for patients with severe hepatic impairment.

Patients can be switched from oral corticosteroid treatment (such as prednisone or deflazacort) to Agamree® without treatment interruption or period of prior corticosteroid dosage reduction to minimize the risk for adrenal insufficiency. Patients switching after long-term treatment with oral corticosteroids should start Agamree® at a dosage of 6mg/kg/day.

Drug Interactions: The co-administration of Agamree® with itraconazole, a strong CYP3A4 inhibitor, increases vamorolone exposure. Reduce the dosage of Agamree® in patients when strong CYP3A4 inhibitors are used concomitantly. The recommended dosage of Agamree® when administered with strong CYP3A4 inhibitors is 4mg/kg PO QD preferably with a meal, up to a maximum daily dosage of 200mg for patients weighing more than 50kg. Doses may be titrated down based on individual tolerability. Dosage adjustments are not required when Agamree® is administered concomitantly with moderate or weak CYP3A4 inhibitors.

Administer all immunizations per immunization guidelines prior to starting Agamree®. Administer live-attenuated or live vaccines at least 4 to 6 weeks prior to starting Agamree®. Patients on Agamree® may receive concurrent vaccinations, except for live-attenuated or live vaccines.

Box Warning: There is no box warning listed with this product.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Agamree® 2mg/kg/d) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included Cushingoid features (7%), psychiatric disorders (0%), vomiting (10%), weight increased (0%), vitamin D deficiency (7%), cough (7%), headache (4%), diarrhea (0%), increased appetite (0%), and rhinitis (0%).

Listed % incidence for adverse drug reactions= reported % incidence for drug (Agamree® 6mg/kg/d) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo. The most frequently reported adverse events included Cushingoid features (29%), psychiatric disorders (7%), vomiting (7%), weight increased (8%), vitamin D deficiency (11%), cough (4%), headache (4%), diarrhea (4%), increased appetite (4%), and rhinitis (4%).

Corticosteroids, such as Agamree® can cause serious and life-threatening alterations in endocrine function, especially with chronic use. Monitor for Cushing's syndrome, hyperglycemia, and adrenal insufficiency after Agamree® withdrawal. In addition, patients with hypopituitarism, primary adrenal insufficiency or congenital adrenal hyperplasia, altered thyroid function, or pheochromocytoma may be at increased risk for adverse endocrine events.

Corticosteroids, including Agamree®, suppress the immune system and increase the risk of infection with any pathogen, including viral, bacteria, fungal, protozoan, or helminthic pathogens. Monitor for the development of infection and consider Agamree® withdrawal or dosage reduction as needed. Hepatitis B virus reactivation can occur in patients who are hepatitis B carriers treated with immunosuppressive dosages of corticosteroids. Screen patients for hepatitis B infection before starting immunosuppressive treatment with Agamree®. In addition, corticosteroids may exacerbate systemic fungal infections, may activate latent amebiasis, and should be used with care in patients with known or suspected Strongyloides (threadworm) infestation. Varicella and measles can have a serious or even fatal course in non-immune patients taking corticosteroids.

Corticosteroids, including Agamree®, can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium and calcium. Monitor blood pressure and serum potassium levels.

Agamree® should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency. In addition, literature reports suggest an association between use of corticosteroids and left free wall rupture after a recent myocardial infarction; thus, therapy with Agamree® should be used with great caution in these patients.

There is an increased risk of GI perforation with use of corticosteroids in patients with certain GI disorders. Signs of GI perforation may be masked in patients receiving corticosteroids. Avoid Agamree® if there is a probability of impending perforation, abscess, or other pyogenic infections; diverticulitis; fresh intestinal anastomoses; or active or latent peptic ulcer.

Potentially severe psychiatric adverse reactions may occur with systemic corticosteroids, including Agamree®. Symptoms typically emerge within a few days or weeks of starting treatment and may be dose-related.

Corticosteroids, such as Agamree®, decrease bone formation and increase bone resorption both through their effect on calcium regulation and inhibition of osteoblast function. Bone loss can predispose patients to vertebral and long bone fractures. Consider a patient's risk of osteoporosis before starting corticosteroid treatment. Monitor bone mineral density in patients on long-term Agamree® treatment.

Corticosteroids may cause avascular necrosis.

The use of corticosteroids, such as Agamree®, may produce posterior subcapsular cataracts. Corticosteroids may also cause glaucoma with possible damage to the optic nerves, and may increase the risk of secondary ocular infections caused by bacteria, fungi, or viruses. Corticosteroids are not recommended for patients with active ocular herpes simplex. Intraocular pressure may become elevated in some patients taking corticosteroids. If treatment with Agamree® is continued for more than 6 weeks, monitor intraocular pressure.

Long-term use of corticosteroids, including Agamree®, can have negative effects on growth and development in children.

Patients receiving corticosteroids and concomitant therapy with neuromuscular blocking agents or patients with disorders of neuromuscular transmission may be at increased risk of developing acute myopathy.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions. Discontinuation of treatment may result in clinical improvement of Kaposi's sarcoma.

Observational studies have shown an increased risk of thromboembolism (including venous thromboembolism), especially with higher cumulative doses of corticosteroids. It is not clear if risk differs by daily dose or duration of dose. Use Agamree® with caution in patients who have or may be predisposed to thromboembolic disorders.

Contraindications: In patients with known hypersensitivity to vamorolone or to any of the inactive ingredients of the product.

Manufacturer: Catalyst Pharmaceuticals, Inc.

Analysis: The efficacy of Agamree® for the treatment of DMD was assessed in a multicenter, randomized, double-blind, parallel-group, placebo- and active-controlled study of 24 weeks in duration which included male patients (N=121) with DMD. Treatment groups included Agamree® 6mg/kg/day (N=30), Agamree® 2mg/kg/day (N=30), prednisone 0.75mg/kg/day (N=31) or placebo (N=30) for 24 weeks. After 24 weeks, patients on prednisone and placebo received either Agamree® 6mg/kg/day (N=29) or Agamree® 2mg/kg/day (N=29) for an additional 20 weeks. Note that information regarding the active prednisone comparator was not found in the prescribing information.

The study included males that were 4 to less than 7 years of age at the time of enrollment into the study who were corticosteroid naïve and ambulatory, with a confirmed diagnosis of DMD. At baseline, patients had a mean age of 5.4 years, while 83% were Caucasian.

The primary endpoint was the change from baseline to week 24 in the Time to Stand Test (TTSTAND) velocity for Agamree® 6mg/kg/day compared to placebo. TTSTAND velocity is a measure of muscle function that measures the time required for the patient to stand to an erect position from a supine position (floor). The key secondary endpoints consisted of change from baseline to week 24 in TTSTAND velocity

(Agamree® 2mg/kg/day vs placebo), 6 minute walk test (6MWT) distance (Agamree® 6mg/kg/day vs placebo and 2mg/kg/day vs placebo) and Time to Run/Walk 10 meters (TTRW) velocity (Agamree® 6mg/kg/day vs placebo and 2mg/kg/day vs placebo). The 6MWT measures the distance that a patient can walk on a flat, hard surface in a period of 6 minutes and TTRW measures the time that it takes a patient to run or walk 10 meters. The fixed sequential testing process was applied to the key secondary endpoints in the order listed above.

The primary endpoint and key secondary endpoints were met for the Agamree® 6mg/kg/day treatment group. The Agamree® 2mg/kg/day treatment group was statistically significant vs placebo for TTSTAND and 6MWT, but was not statistically significant vs placebo for TTRW. Results are presented in the table below, which was adapted from the prescribing information.

	Placebo	Agamree® 2mg/kg/d	Agamree® 6mg/kg/d
TTSTAND velocity (rises/sec) – primary endpoint with 6mg/kg/d dose			
Baseline	0.200	0.184	0.186
Mean change from baseline	-0.012	0.033	0.048
Difference from placebo	N/A	0.045	0.060
p-value	N/A	0.017	0.002
6MWT distance (meters)			
Baseline	355	316	313
Mean change from baseline	-14	27	29
Difference from placebo	NA	40	42
p-value	N/A	0.004	0.002
TTRW velocity (meters/sec)			
Baseline	1.735	1.563	1.600
Mean change from baseline	0.014	0.141	0.258
Difference from placebo	N/A	0.127	0.244
p-value	N/A	0.103	0.002

Place in Therapy: Agamree® is an oral corticosteroid suspension indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older. Administer all immunization per immunization guidelines prior to starting Agamree®. In addition, administer live-attenuated or live vaccines at least 4 to 6 weeks prior to starting Agamree®. The efficacy of Agamree® was assessed in a randomized, double-blind, parallel-group, placebo- and active-controlled study, with the primary endpoint being the change from baseline to week 24 in Time to Stand Test (TTSTAND) velocity for Agamree® 6mg/kg/day as compared to placebo. Statistically significant differences in favor of Agamree® 6mg/kg/day were observed as compared to placebo for the primary endpoint, as well as key secondary endpoints of 6MWT distance and TTRW velocity.

Per the full text by Guglieri et al[2], the total count of treatment emergent adverse events was lowest in the placebo group (n=77), highest in the prednisone group (N=121), and intermediate in the vamorolone groups (2mg/kg/d, n=97; 6mg/kg/d, n=91). One subject withdrew from the study that was receiving prednisone owing to an adverse event (personality change). Height percentile declined in those treated with prednisone but not in those treated with vamorolone (6mg/kg/day p=0.02). There was linear growth delay in the prednisone group but not in the vamorolone groups (6mg/kg/day p=0.02). Similar overall gain in body mass index was seen between the active treatments. Regarding efficacy, the relative efficacy of prednisone and vamorolone 6mg/kg per day were similar for all 5 motor outcomes per a post hoc analysis, including TTSTAND, TTCLIMB (time to climb 4 stairs), TTRW, 6MWT, and North Star Ambulatory Assessment (NSAA). However, vamorolone 2mg/kg/day demonstrated similar efficacy as prednisone for TTSTAND, 6MWT, and NSAA, but was less effective than prednisone for TTRW and TTCLIMB. The authors concluded that vamorolone was safe and effective for the treatment of boys with DMD over 24 weeks, and it may be a safer alternative than prednisone.

Summary

There is some evidence to suggest that Agamree® may be safer than prednisone when used as treatment for males with DMD in a phase 3 efficacy trial. It is recommended that Agamree® remain non-preferred in order to confirm the appropriate diagnosis and clinical parameters for use.

PDL Placement: ☐ **Preferred**
☒ **Non-Preferred**

References

[1] Agamree [package insert]. Coral Gables, FL: Catalyst Pharmaceuticals, Inc; 2023.
[2] Guglieri M, Clemens PR, Perlman SJ, et al. Efficacy and safety of vamorolone vs placebo and prednisone among boys with Duchenne Muscular Dystrophy: A randomized clinical trial. *JAMA Neurol*. 2022; 79(10): 1005-1014.

Tralokinumab-ldrm (Adbry)
Second Review

Background
Adbry (tralokinumab-ldrm) is indicated for the treatment of moderate to severe atopic dermatitis in adults and pediatric patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Prior authorization (PA) criteria are being updated to align with recent changes to PA criteria for dupilumab for the treatment of moderate to severe atopic dermatitis. Current clinical guidelines no longer support the use of immunosuppressants for the treatment of atopic dermatitis.

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for tralokinumab-ldrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of moderate to severe atopic dermatitis; and
3. Is prescribed by or in consultation with a dermatologist; and
4. Patient has failed to respond to good skin care and regular use of emollients; and
5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
6. Patient has documentation of a previous trial and therapy failure with a preferred topical immunomodulator for a minimum of 4 weeks; and
7. Patient has documentation of a previous trial and therapy failure with cyclosprorine or azathioprine; and
8. Patient will continue with skin care regimen and regular use of emollients.

If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted and/or stricken)

Prior authorization (PA) is required for tralokinumab-ldrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of moderate to severe atopic dermatitis; and
3. Is prescribed by or in consultation with a dermatologist; and
4. Patient has failed to respond to good skin care and regular use of emollients; and
5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
6. Patient has documentation of a previous trial and therapy failure with a preferred topical immunomodulator for a minimum of 4 weeks; and
7. ~~Patient has documentation of a previous trial and therapy failure with cyclosprorine or azathioprine; and~~
8. Patient will continue with skin care regimen and regular use of emollients.

If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

References

Adbry subcutaneous injection [prescribing information]. Madison, NJ: Leo Pharma Inc.; June 2024.

Zuranolone (Zurzuvae)
Second Review

Background
In 2023, the FDA approved Zurzuvae (zuranolone) for the treatment of postpartum depression (PPD) in adults. Zurzuvae is the first oral treatment approved for PPD. Also note, the FDA reviewed Zurzuvae for the treatment of adults with major depressive disorder (MDD). The manufacturer received an FDA Complete Response Letter (CRL) for the MDD indication stating that the application did not provide substantial evidence of effectiveness to support the approval of zuranolone for the treatment of MDD and that an additional study or studies would be needed. Zulresso (brexanolone), was approved by the FDA in 2019 for the treatment of PPD. Zulresso is administered as a continuous intravenous infusion over 60 hours and requires a healthcare provider be available on site to continuously monitor the patient for the duration of the infusion.

See attached new drug review for additional clinical information.

Postpartum depression (PPD) is a common perinatal condition that affects around 17% of women during pregnancy or up to 12 months postpartum. PPD is a leading cause of maternal mortality and can pose serious risks to infants. The American College of Obstetricians and Gynecologists (ACOG) practice guideline for the treatment and management of mental health conditions during pregnancy and postpartum provides recommendations for the pharmacologic management of perinatal depression. SSRIs are recommended as first-line pharmacotherapy for perinatal depression, with SNRIs recommended as reasonable alternatives. The guideline recommends that pharmacotherapy should be individualized based on prior response to therapy, and if no prior pharmacotherapy history exists, sertraline or escitalopram are reasonable first-line medications. An ACOG practice advisory provides recommendations for the use of zuranolone for the management of PPD. Zuranolone may be considered in the postpartum period (i.e., within 12 months postpartum) for depression that has an onset in the third trimester or within 4 weeks after childbirth. The drug's benefits (rapid symptom improvement) and risks (suicidal thoughts, sedation affecting daily activities, and limited efficacy data beyond 42 days) should be considered prior to initiating therapy.

Newly Proposed Prior Authorization Criteria
Prior authorization (PA) is required for zuranolone (Zurzuvae). Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of postpartum depression (PPD); and

3. Patient is 12 months or less postpartum on the date of request (state date of delivery); and
4. The onset of the current depressive episode was during the third trimester or within 4 weeks postpartum; and
5. Patient has not received brexanolone for the current PPD episode; and
6. Only one course of treatment (i.e., 14 days) per pregnancy will be considered. Extension of therapy beyond 14 days will not be authorized.

References

Zurzuvae [package insert], Cambridge, MA: Biogen, Inc.; November 2023

American College of Obstetricians and Gynecologists (ACOG). Treatment and management of mental health conditions during pregnancy and postpartum: ACOG Clinical Practice Guideline No. 5. Obstet Gynecol. 2023b;141(6):1262-1288.

IOWA | Health and Human Services

PDL DRUG REVIEW

Proprietary Name: Zurzuvae®
Common Name: zuranolone
PDL Category: Antidepressants

Comparable Products	Preferred Drug List Status
SSRIs	Preferred
Zulresso	Medical

Pharmacology/Usage: Zuranolone, the active ingredient of Zurzuvae®, is a neuroactive steroid gamma-aminobutyric acid (GABA) A receptor positive modulator. The mechanism of action of zuranolone in the treatment of postpartum depression is not fully understood, but is thought to be related to its positive allosteric modulation of GABA-A receptors.

Zurzuvae® is a Schedule IV controlled substance under the Controlled Substances Act. Zuranolone has abuse potential with associated risks of misuse, abuse, and substance use disorder including addiction. Zurzuvae® may produce physical dependence.

Indication: For the treatment of postpartum depression (PPD) in adults.

There is no pregnancy category for this medication; however, the risk summary indicates that based on findings from animal studies, Zurzuvae® may cause fetal harm. Advise pregnant women of the potential risk to a fetus. Available data on use in pregnant women from the clinical development program are not sufficient to assess for a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Advise female patients of reproductive potential to use effective contraception during treatment with Zurzuvae® and for one week after the final dose. There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to antidepressants, including Zurzuvae®, during pregnancy. Healthcare providers are encouraged to register patients by calling the National Pregnancy Registry for Antidepressants at 1-844-405-6185 or visiting online at https://womensmentalhealth.org/research/pregnancyregistry/antidepressants. The safety and efficacy of use in the pediatric population have not been established.

Dosage Form: Capsules: 20mg, 25mg, 30mg.

Recommended Dosage: Take 50mg PO QD in the evening for 14 days. Administer with fat-containing food (e.g., 400 to 1000 calories, 25% to 50% fat). If patients experience CNS depressant effects within the 14-day period, consider reducing the dosage to 40mg QD in the evening within the 14-day period. Zurzuvae® can be used alone or as an adjunct to oral antidepressant therapy. The safety and efficacy of use beyond 14 days in a single treatment course have not been established. If a Zurzuvae® evening dose is missed, take the next dose at the regular time the following evening. Do not take extra capsules on the same day to make up for the missed dose. Continue taking Zurzuvae® QD until the remainder of the 14-day treatment course is completed.

The recommended dosage in patients with mild or moderate hepatic impairment is the same as those in patients with normal hepatic function. The recommended dosage in patients with severe hepatic impairment is 30mg PO QD in the evening for 14 days. The recommended dosage in patients with mild renal impairment is the same as those in patients with normal renal function. The recommended dosage in patients with moderate or severe renal impairment is 30mg PO QD in the evening for 14 days.

Drug Interactions: If use with another CNS depressant is unavoidable, consider dosage reduction. Caution should be used when Zurzuvae® is administered in combination with other CNS drugs or alcohol.

Reduce the Zurzuvae® dosage when used with a strong CYP3A4 inhibitor. Reduce the Zurzuvae® dosage to 30mg PO QD in the evening for 14 days when used concomitantly with a strong CYP3A4 inhibitor. Dosage modification is not recommended when Zurzuvae® is concomitantly used with a moderate CYP3A4 inhibitor.

Avoid the concomitant use of Zurzuvae® with CYP3A4 inducers.

Box Warning: This product has a box warning regarding impaired ability to drive or engage in other potentially hazardous activities. Zurzuvae® causes driving impairment due to central nervous system (CNS) depressant effects. Advise patients not to drive or engage in other potentially hazardous activities until at least 12 hours after Zurzuvae® administration for the duration of the 14-day treatment course. Inform patients that they may not be able to assess their own driving competence, or the degree of driving impairment caused by Zurzuvae®.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Zurzuvae®) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included somnolence (30%), dizziness (4%), diarrhea (4%), fatigue (3%), urinary tract infection (1%), memory impairment (3%), abdominal pain (3%), tremor (2%), hypoesthesia (2%), muscle twitching (2%), myalgia (2%), COVID-19 (2%), anxiety (1%), and rash (1%).

Zurzuvae® can cause CNS depressant effects such as somnolence and confusion. Because Zurzuvae® can cause CNS depressant effects, patients may be at higher risk of falls. To reduce the risk of CNS depressant effects and/or mitigate CNS depressant effects that occurs with Zurzuvae® treatment:

- If patients develop CNS depressants effects, consider dosage reduction or discontinuation of treatment.
- If use with another CNS depressant is unavoidable, consider dosage reduction.
- Reduce the Zurzuvae® dosage in patients taking strong CYP3A4 inhibitors.

In pooled analyses of placebo-controlled trials of chronically administered antidepressant drugs that included about 77,000 adults and 4,500 pediatric patients, the incidence of suicidal thoughts and behaviors in antidepressant-treated patients aged 24 years and younger was greater than in placebo-treated patents. There was variation in risk of suicidal thoughts and behaviors among drugs, but there was an increased risk identified in young patients for most drugs studied. Zurzuvae® does not directly affect monoaminergic systems. Consider changing the therapeutic regimen, including discontinuing Zurzuvae®, in patients whose depression becomes worse or who experience emergent suicidal thoughts and behaviors.

Contraindications: There are no contraindications listed with this product.

Manufacturer: Biogen Inc.

Analysis: The efficacy of Zurzuvae® for the treatment of PPD in adults was demonstrated in two randomized, placebo-controlled, double-blind, multicenter studies (Study 1 and Study 2) that included women with PPD who met the DSM-5 criteria for a major depressive episode with onset of symptoms in the third trimester or within 4 weeks of delivery. In these studies, concomitant use of existing oral antidepressants was allowed for patients taking a stable dose of oral antidepressant for at least 30 days before baseline. These studies included patients with HAMD-17 scores ≥26 at baseline.

In Study 1, patients received Zurzuvae® 50mg (N=98) or placebo (N=97) QD in the evening with fat-containing food for 14 days, with the option to reduce the dosage based on tolerability to 40mg QD of Zurzuvae® or placebo. The patients were followed for a minimum of 4 weeks after the 14-day treatment course.

In Study 2, patients received another zuranolone capsule formulation (approximately equivalent to 40mg of Zurzuvae®; N=76) or placebo (N=74) QD in the evening with food for 14 days. The patients were followed for a minimum of 4 weeks after the 14-day treatment course.

Baseline demographics were similar between treatment groups in both studies. In Study 1, patients had a mean age of 30 years (range 19 to 44), while 70% were white and baseline use of stable oral antidepressants was reported in 15% of patients. In Study 2, patients had a mean age of 28 years (range 18 to 44), while 56% were white and baseline use of stable oral antidepressants was reported in 19% of patients.

The primary endpoint for both studies was the change from baseline in depressive symptoms as measured by the HAMD-17 total score at day 15. In these studies, patients in the Zurzuvae® groups experienced statistically significantly greater improvement on the primary endpoint compared to patients in the placebo group. Results are presented in the table below, which was adapted from the prescribing information.

Study number	Treatment group	N	Mean Baseline Score	LS mean change from baseline	Placebo-subtracted difference
1	50mg Zurzuvae®	98	28.6	-15.6	-4.0
	Placebo	97	28.8	-11.6	
2	Zuranolone * (another cap formulation)	76	28.4	-17.8	-4.2
	Placebo	74	28.8	-13.6	

*This capsule formulation of zuranolone is approximately equivalent to 40mg of Zurzuvae®.

Two randomized, double-blind, placebo- and active-controlled four-way crossover studies (Study 3 and Study 4) assessed the effects of nighttime Zurzuvae® administration on next-morning driving performance, 9 hours after dosing, using a computer-based driving simulation.

In Study 3, 50mg of Zurzuvae® was administered for six consecutive nights and on the seventh night a single dose of 50mg or 100mg (two times the recommended dose) was administered. The primary driving performance outcome measure was the change in Standard Deviation of Lateral Position (SDLP; a measure of driving impairment) in the Zurzuvae® group compared to the placebo group on days 2 and 8 (after a single dose and repeat doses, respectively).

This study included healthy participants (N=67), with a median age of 45 years (range from 22 to 81 years; 7 participants were ≥65 years of age). In addition, 38 were males and 88% were white. A single dose of Zurzuvae® 50mg caused statistically significant impairment in next-morning driving performance compared to placebo. Statistically significant effects on driving were also observed on day 8 following daily administration of 50mg Zurzuvae®. Administration of 100mg of Zurzuvae® on the final night increased impairment in driving ability. The exposure-response analysis for driving impairment in this study suggested that the projected mean placebo-adjusted SDLP at 12 hours post-dose would be less than the threshold associated with driving impairment.

In Study 4, 30mg of Zurzuvae® was administered for four consecutive nights and on the fifth night a single dose of 30mg or 60mg was administered. The primary driving performance outcome measure was the change in SDLP in the Zurzuvae® group compared to the placebo group on days 2 and 6 (after a single dose and repeat doses, respectively). This study included participants (N=60) with a median age of 41 years (range 22 to 62), while 60% were male and 90% were white.

A single 30mg dose of Zurzuvae® caused a statistically significant impairment in next-morning driving performance compared to placebo. The mean effect on driving performance was not statistically significantly different following 30mg of Zurzuvae® compared to placebo on day 6; however, driving ability was impaired in some participants taking Zurzuvae®. Administration of 60mg of Zurzuvae® on the final night caused statistically significant impairment in next-morning driving performance compared to placebo.

Place in Therapy: Zurzuvae® is a neuroactive steroid gamma-aminobutyric acid (GABA) A receptor positive modulator indicated for the treatment of postpartum depression (PPD) in adults. This once daily in the evening dosing for 14 days should be administered with fat-containing food and can be used alone or as an adjunct to oral antidepressant therapy. Zurzuvae® does have a box warning regarding the impaired ability to drive or engage in other potentially hazardous activities. It causes driving impairment due to CNS depressant effects, and thus patients should be advised not to drive or engage in other potentially hazardous activities until at least 12 hours after Zurzuvae® administration for the duration of the 14-day treatment course.

The safety and efficacy of Zurzuvae® were assessed in 2 randomized, double-blind, placebo-controlled trials that included women with PPD who met criteria for a major depressive episode with onset of symptoms in the third trimester or within 4 weeks of delivery. Note that in Study 2, patients received another zuranolone capsule formulation (about equivalent to 40mg Zurzuvae®). The primary efficacy endpoint for each study was the change from baseline in depressive symptoms as measured by the HAMD-17 total score at day 15. Results suggested that patients in the Zurzuvae® groups experienced statistically significantly greater improvement on the primary endpoint compared to patients in the placebo group. Zurzuvae® is the first oral medication FDA approved for the treatment of PPD in adults, taken for 14 days. Note that the safety and efficacy of Zurzuvae® use beyond 14 days in a single treatment course have not been established.

Summary

There is no evidence at this time to support that Zurzuvae® is safer or more effective than the other currently preferred, more cost-effective medications. It is therefore recommended that Zurzuvae® remain non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications.

PDL Placement: ☐ **Preferred**
☒ **Non-Preferred**

References

[1] Zurzuvae [package insert]. Cambridge, MA: Biogen Inc; 2023.

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DUR DIGEST

The Bulletin of Medicaid Drug Utilization Review in Iowa

Incoming Members of the DUR Commission

Caitlin Reinking, Pharm.D., CDCES

Dr. Reinking is currently a Staff Pharmacist and Certified Diabetes Care and Education Specialist at BCHC Oelwein Pharmacy in both the Oelwein, Iowa, and Independence, Iowa locations. Her previous experience includes working at Oelwein Family Pharmacy and NuCara Pharmacy. She received her Doctor of Pharmacy degree from the University of Iowa College of Pharmacy in 2013. Dr. Reinking was appointed to the DUR Commission in 2024; her first term will expire in June 2028.

Jennifer Johnson, PharmD

Dr. Johnson is currently a Pharmacist in Charge at Walgreens Pharmacy in Ankeny, Iowa, and previously worked at Hy-Vee, CVS, and Towncrest pharmacies, in addition to other Walgreens locations. She received her Doctor of Pharmacy degree from the University of Iowa College of Pharmacy in 2015. Dr. Johnson was appointed to the DUR Commission in 2024; her first term will expire in June 2028.

Opioid Prescribing for Acute Pain Management in Children and Adolescents in Outpatient Settings

The American Academy of Pediatrics (AAP) released a clinical practice guideline outlining evidence-based approaches to safely prescribe opioids for acute pain in outpatient settings. The goal is to aid clinicians in understanding when opioids may be indicated to treat acute pain in children and adolescents and how to minimize risks (including opioid use disorder, poisoning, and overdose).

Summary of Key Action Statements

- Pediatricians and other pediatric health care providers (PHCPs) should treat acute pain using a multimodal approach that includes the appropriate use of nonpharmacologic therapies, nonopioid medications, and when needed, opioid medications.
- Pediatricians and other PHCPs should not prescribe opioids as monotherapy for children and adolescents who have acute pain.
- When prescribing opioids for acute pain in children and adolescents, PHCPs should provide immediate-release opioid formulations, start with the lowest age- and weight-appropriate doses, and provide an initial supply of 5 days or fewer, unless the pain is related to trauma or surgery with an expected duration of pain of more than 5 days.
- When treating acute pain in children and adolescents younger than 12 years, pediatricians and other PHCPs should not prescribe codeine or tramadol.
- When treating acute pain in adolescents 12-18 years of age who have obesity, obstructive sleep apnea, or severe lung disease, pediatricians and other PHCPs should not prescribe codeine or tramadol.
- When treating postsurgical pain after tonsillectomy or adenoidectomy in children and adolescents younger than 18 years, pediatricians and other PHCPs should not prescribe codeine or tramadol.
- When treating acute pain in people of any age who are breastfeeding, pediatricians and other PHCPs should not prescribe codeine or tramadol.
- When treating acute pain in children or adolescents who are taking sedating medications, such as benzodiazepines, pediatricians and other PHCPs should use caution when prescribing opioids.
- When prescribing opioids, pediatricians and other PHCPs should provide naloxone and counsel patients and families on the signs of opioid overdose and how to respond to an overdose.
- When prescribing opioids, pediatricians and other PHCPs should educate caregivers about safe storage and directly observed administration of medications to children and adolescents.
- When prescribing opioids, pediatricians and other PHCPs should educate caregivers about safe disposal of unused mediations, help caregivers develop a plan to safely dispose of unused medications, and, if possible, offer safe disposal in their practice setting.
- When treating acute, worsened pain in children and adolescents with preexisting chronic pain, pediatricians and other PHCPs should prescribe opioids when indicated and partner with any other opioid-prescribing clinicians involved in the patient's care and with specialists in chronic pain, palliative cate, and/or other opioid stewardship programs to determine an appropriate treatment plan.

Medicaid Statistics for Prescription Claims
September through November 2024

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
Total $ Paid				
# Paid Claims				
Unique Users				
Avg Cost/Rx				
Top 5 Therapeutic Class by Prescription Count Therapeutic class taxonomy may differ among each plan				
Top 5 Therapeutic Class by Paid Amount (pre-rebate) Therapeutic class taxonomy may differ among each plan				
Top 5 Drugs by Prescription Count				
Top 5 Drugs by Paid Amount (pre-rebate)				