IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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August 5, 2022

Susan L. Parker, R.Ph, Pharm.D.
Pharmacy Director
Iowa Medicaid
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Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 3, 2022. At this meeting, the DUR Commission members discussed the proposed prior authorization (PA) criteria for Tasimelteon (Hetlioz); Janus Kinase Inhibitors; Tralokinumab-Idrm (Adbry); Crisaborole (Eucrisa); Extended-Release Formulations; Non-Preferred Drug; Biologicals for Hidradenitis Suppurativa; and Ophthalmic Agents for Presbyopia. The DUR Commission members also discussed ProDUR edits for Initial Days' Supply Limit – Benzodiazepines; Benzodiazepine Cumulative Quantity Limit; and quantity limits for select drugs (as detailed below). The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a May 9, 2022 letter that was sent to them detailing the proposed criteria for Tasimelteon (Hetlioz); Janus Kinase Inhibitors; Tralokinumab-Idrm (Adbry); Crisaborole (Eucrisa); Extended-Release Formulations; Non-Preferred Drug; Biologicals for Hidradenitis Suppurativa; and Ophthalmic Agents for Presbyopia. Also included were details regarding proposed ProDUR edits for Initial Days' Supply Limit – Benzodiazepines; Benzodiazepine Cumulative Quantity Limit; and quantity limits for select drugs.

Tasimelteon (Hetlioz)

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for tasimelteon (Hetlioz®). Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions:

1. Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and
2. Patient is 18 years of age or older; and

3. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and
4. Patient has a documented trial and therapy failure with ramelteon (Rozerem®).

If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, and/or significant decreases in daytime sleep.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted and stricken)
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.* ~~Requests for doses above the manufacturer recommended dose will not be considered.~~
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)~~, as confirmed by a sleep specialist~~; and
        ~~i. Patient is 18 years of age or older; and~~
        ii. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and
        iii. 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 17p11.2 (cytogenetic 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 concurrently 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;* ~~when the patient has received 3 months of continuous therapy~~ and
2. *Documentation* patient has *experienced a positive clinical response to therapy* ~~achieved adequate results~~ with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, ~~and/or~~ significant decreases in daytime sleep*, and/or nighttime sleep quality*.

Janus Kinase Inhibitors

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 when the following conditions are met:

1. Patient meets the FDA approved age for indication; and
2. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
3. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and
4. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and
5. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and
6. Patient is not at an increased risk of gastrointestinal perforation; and
7. Patient does not have an active, serious infection, including localized infections; and
8. Medication will not be given concurrently with live vaccines; and
9. Follows FDA approved dosing based on indication; and
10. 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. 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
        iii. A documented trial and inadequate response with a preferred TNF inhibitor.

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

<u>Proposed Clinical Prior Authorization Criteria</u> (changes stricken/italicized and/or highlighted)
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* when the following conditions are met:

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

2. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, *biological therapies,* ~~biologic DMARDs~~ or potent immunosuppressants (azathioprine or cyclosporine); and
3. *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*

~~4. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and~~

~~5. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and~~

~~6. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and~~

~~7. Patient is not at an increased risk of gastrointestinal perforation; and~~

~~8. Patient does not have an active, serious infection, including localized infections; and~~

~~9. Medication will not be given concurrently with live vaccines; and~~

~~10. Follows FDA approved dosing based on indication; and~~

11. 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. 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*
    e. Ankylosing spondylitis (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

f. 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.

Tralokinumab (Adbry)

Newly Proposed 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 cyclosporine 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.

Crisaborole (Eucrisa)

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

1. Patient has a diagnosis of mild to moderate atopic dermatitis; and
2. Patient is within the FDA labeled age; 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 two preferred medium to high potency topical corticosteroids 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.

Proposed Prior Authorization Criteria (changes italicized/highlighted/stricken)
Prior authorization (PA) is required for Eucrisa (crisaborole). Payment will be considered ~~for patients~~ 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 is within the FDA labeled age; 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 *one* ~~two~~ preferred medium to high potency topical corticosteroid~~s~~ for a minimum of 2 consecutive weeks; and
6. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
7. Patient will continue with skin care regimen and regular use of emollients.
8. 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.

Extended Release Formulations

Current Prior Authorization Criteria
Payment for a non-preferred extended release formulation will be considered when the following criteria are met:

1. 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
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.

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

Proposed Prior Authorization Criteria (changes italicized/highlighted/stricken)
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 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. 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.

Non-Preferred Drug

Current Prior Authorization Criteria
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 authorized only for cases in which there is documentation of previous trial and therapy failure with the preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.

Proposed Prior Authorization Criteria (changes italicized/highlighted/stricken)
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* ~~authorized~~ 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.*

Biologicals for Hidradenitis Suppurativa

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for biologicals FDA approved for the treatment of Hidradenitis Suppurativa (HS). Patients initiating therapy with a biological agent must:

1. Be screened for hepatitis B and C. Patients with active hepatitis B will not be considered for coverage; and
2. Have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biologic agent; and
3. 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
4. Be 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.

Payment will be considered under the following conditions:

1. Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and
2. Patient is 18 years of age or older; 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 tetracyclines (doxycycline or minocycline).

If criteria for coverage are met, initial requests will be given for 3 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.

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

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.* Patients initiating therapy with a biological agent must:

1. Be screened for hepatitis B and C. Patients with active hepatitis B will not be considered for coverage; and
2. Have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biologic agent; and
3. 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

4. Be 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.

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 is 18 years of age or older; and~~
4. Patient has at least three (3) abscesses or inflammatory nodules; and
5. 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~~s (doxycycline or minocycline)~~.

If criteria for coverage are met, initial requests will be given for 3 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.

Ophthalmic Agents for Presbyopia

Newly Proposed Clinical Prior Authorization Criteria

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 to 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 in mesopic, high contrast, binocular distance corrected near visual 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.

Proposed ProDUR Quantity Limits

Drug	**Proposed Quantity Limit per 30 Days** (unless otherwise stated)
Cibinqo (abrocitinib) 50 mg, 100 mg, 200 mg	30
Olumiant (baricitinib) 1 mg, 2 mg	30
Opzelura (ruxolitinib) 1.5% cream	240 g (4 tubes)
Rinvoq (upadacitinib)15 mg, 30 mg	30
Rinvoq (upadacitinib) 45 mg	28 per 28 days
Xeljanz (tofacitinib) 5 mg, 10 mg	60
Xeljanz (tofacitinib) XR 11 mg, 22 mg	30
ProAir HFA 8.5 g (albuterol)	2 inhalers (17 grams)
ProAir Digihaler (albuterol)	2 inhalers
ProAir Respiclick (albuterol)	2 inhalers
Proventil HFA 6.7 g (albuterol)	2 inhalers (13.4 grams)
Ventolin HFA 18 g (albuterol)	2 inhalers (36 grams)
Xopenex HFA 15 g (levalbuterol)	2 inhalers (30 grams)
Halcion 0.125 mg (triazolam)	30
Halcion 0.25 mg (triazolam)	60
Vuity (Pilocarpine) 1.25% opth. soln.	2.5 mL

Proposed ProDUR Initial Days Supply Limit for Benzodiazepines

The DUR Commission made a recommendation to implement a 7-day initial limit on all benzodiazepines for new users. The ProDUR point-of-sale (POS) edit would limit to an initial 7 days' supply for a benzodiazepine if the requested benzodiazepine is not found in pharmacy claims in the preceding 90 days. Exceptions to this edit include nasal and rectal diazepam, nasal midazolam and clobazam. Prior authorization would be required for use beyond the 7-day allowance. The Commission will develop PA criteria for requests exceeding the initial limit at a future meeting and will be shared with interested parties for comment prior to implementation.

Proposed ProDUR Cumulative Quantity Limit for Oral Benzodiazepines

The DUR Commission made a recommendation to implement a cumulative quantity limit of 4 units per day across the benzodiazepine class for solid oral dosage forms. The quantity limit chart would include the following statement: Benzodiazepines are subject to a cumulative quantity limit of 4 units per day, unless otherwise indicated on the chart.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for Tasimelteon (Hetlioz); Janus Kinase Inhibitors; Tralokinumab-Idrm (Adbry); Crisaborole (Eucrisa); Extended-Release Formulations; Non-Preferred Drug; Biologicals for Hidradenitis Suppurativa; and Ophthalmic Agents for Presbyopia; and the Proposed ProDUR initiatives detailed above.

Sincerely,

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

Cc: Erin Halverson, R.Ph, IME
Gina Kuebler, R.Ph, IME

Iowa Total Care Claims
Quarterly Statistics

REPORT_DATE	RPT_PERIOD	Mar 2022 through May 2022	Jun 2022 through Aug 2022	% CHANGE
TOTAL PAID AMOUNT	TOTAL PAID AMOUNT	$87,551,184.09	$88,493,857.90	1.08%
UNIQUE USERS	UNIQUE USERS	131,269	128,701	-1.96%
COST PER USER	COST PER USER	$666.96	$687.59	3.09%
TOTAL PRESCRIPTIONS	TOTAL PRESCRIPTIONS	810,630	797,260	-1.65%
AVERAGE PRESCRIPTION PER USER	AVERAGE PRESCRIPTION PER USER	6.18	6.19	0.31%
AVERAGE COST PER PRESCRIPTION	AVERAGE COST PER PRESCRIPTION	$108.00	$111.00	2.77%
# GENERIC PRESCRIPTIONS	# GENERIC PRESCRITPIONS	718,421	704,608	-1.92%
% GENERIC	% GENERIC	88.63%	88.38%	-0.25%
$ GENERIC	$ GENERIC	$12,750,214.59	$12,708,073.18	-0.33%
AVERAGE GENERIC PRESCRIPTION COST	AVERAGE GENERIC PRESCRIPTION COST	$17.75	$18.04	1.62%
AVERAGE GENERIC DAYS SUPPLY	AVERAGE GENERIC DAYS SUPPLY	31	32	1.94%
# BRAND PRESCRIPTIONS	# BRAND PRESCRITPIONS	92,209	92,652	0.48%
% BRAND	% BRAND	11.37%	11.62%	0.25%
$ BRAND	$ BRAND	$74,800,969.50	$75,785,784.72	1.32%
AVERAGE BRAND PRESCRIPTION COST	AVERAGE BRAND PRESCRIPTION COST	$811.21	$817.96	0.83%
AVERAGE BRAND DAYS SUPPLY	AVERAGE BRAND DAYS SUPPLY	32	31	-0.41%

UTILIZATION BY AGE

AGE		Mar 2022 through May 2022	Jun 2022 through Aug 2022
0-6		43,112	35,916
7-12		47,449	42,576
13-18		62,220	58,867
19-64		646,785	648,253
65+		11,064	11,648

UTILIZATION BY GENDER AND AGE

GENDER	AGE	Age_Category	Mar 2022 through May 2022	Jun 2022 through Aug 2022
F	0-6	0-6	18,812	15,598
	7-12	7-12	18,123	16,372
	13-18	13-18	34,068	32,662
	19-64	19-64	419,832	421,207
	65+	65+	7,262	7,577
M	0-6	0-6	24,300	20,318
	7-12	7-12	29,326	26,204
	13-18	13-18	28,152	26,205
	19-64	19-64	226,953	227,046
	65+	65+	3,802	4,071

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
202206 - 202208

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	AMBULATORY CARE PHARMACY	IOWA CITY	IA	11,125	$5,681,184.50	$510.67	1
2	WALGREENS #4405	COUNCIL BLUFFS	IA	7,925	$573,066.12	$72.31	2
3	WALGREENS #5239	DAVENPORT	IA	7,154	$450,014.79	$62.90	3
4	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	6,776	$307,033.87	$45.31	4
5	WALGREENS #5042	CEDAR RAPIDS	IA	6,549	$512,275.01	$78.22	5
6	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	5,949	$481,312.74	$80.91	7
7	WALGREENS #7455	WATERLOO	IA	5,677	$397,970.75	$70.10	6
8	WALGREENS #359	DES MOINES	IA	5,607	$376,821.80	$67.21	8
9	WALGREENS #5721	DES MOINES	IA	5,569	$343,702.23	$61.72	9
10	DRILLING PHARMACY	SIOUX CITY	IA	4,863	$261,396.81	$53.75	11
11	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,761	$367,885.68	$77.27	10
12	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,685	$305,927.82	$65.30	13
13	WALGREENS #15647	SIOUX CITY	IA	4,407	$382,604.54	$86.82	12
14	RIGHT DOSE PHARMACY	ANKENY	IA	4,374	$231,375.77	$52.90	16
15	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,232	$367,510.50	$86.84	14
16	WALGREENS #3700	COUNCIL BLUFFS	IA	4,043	$261,691.89	$64.73	15
17	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,962	$179,661.39	$45.35	18
18	WALGREENS #7453	DES MOINES	IA	3,930	$246,391.70	$62.70	17
19	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,849	$459,266.51	$119.32	20
20	STANGEL PHARMACY	ONAWA	IA	3,777	$304,495.00	$80.62	22
21	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,565	$389,633.79	$109.29	19
22	MAHASKA DRUGS INC	OSKALOOSA	IA	3,549	$215,091.17	$60.61	21
23	HY-VEE PHARMACY (1449)	NEWTON	IA	3,418	$260,876.67	$76.32	23
24	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,358	$270,882.14	$80.67	25
25	SOUTH SIDE DRUG	OTTUMWA	IA	3,252	$306,026.26	$94.10	26
26	WALGREENS #5044	BURLINGTON	IA	3,240	$207,532.80	$64.05	27
27	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,199	$251,258.04	$78.54	28
28	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	3,188	$472,167.21	$148.11	24
29	WALGREENS #5470	SIOUX CITY	IA	3,164	$200,381.19	$63.33	29
30	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	3,126	$259,138.58	$82.90	34
31	WALGREENS #7452	DES MOINES	IA	3,062	$235,879.10	$77.03	39
32	HY-VEE PHARMACY (1075)	CLINTON	IA	2,973	$311,594.32	$104.81	35
33	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	2,972	$203,274.54	$68.40	31
34	REUTZEL PHARMACY	CEDAR RAPIDS	IA	2,964	$196,377.67	$66.25	30
35	WALGREENS #4041	DAVENPORT	IA	2,855	$183,705.31	$64.35	33

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
202206 - 202208

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
36	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,852	$238,313.46	$83.56	32
37	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	2,814	$214,663.61	$76.28	36
38	WALGREENS #5886	KEOKUK	IA	2,761	$184,048.11	$66.66	43
39	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,760	$202,486.64	$73.36	44
40	RASHID PHARMACY PLC	FORT MADISON	IA	2,743	$47,082.26	$17.16	38
41	HY-VEE PHARMACY #1 (1281)	IOWA CITY	IA	2,723	$173,375.68	$63.67	37
42	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,698	$255,425.02	$94.67	41
43	WALGREENS #3595	DAVENPORT	IA	2,696	$172,958.09	$64.15	51
44	WALGREENS #7454	ANKENY	IA	2,664	$190,447.13	$71.49	45
45	WALGREENS #5777	DES MOINES	IA	2,655	$237,539.64	$89.47	46
46	DANIEL PHARMACY	FT DODGE	IA	2,642	$210,099.77	$79.52	48
47	HY-VEE PHARMACY (1192)	FT DODGE	IA	2,630	$188,553.19	$71.69	49
48	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,570	$202,264.37	$78.70	50
49	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,558	$162,720.84	$63.61	58
50	HY-VEE PHARMACY #4 (1060)	CEDAR RAPIDS	IA	2,537	$213,110.92	$84.00	42
51	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	2,534	$78,731.47	$31.07	47
52	MARTIN HEALTH URBANDALE	URBANDALE	IA	2,480	$147,649.16	$59.54	53
53	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,477	$192,161.60	$77.58	56
54	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,441	$220,905.36	$90.50	52
55	WALMART PHARMACY 10-2889	CLINTON	IA	2,426	$148,750.93	$61.32	59
56	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,412	$202,987.35	$84.16	55
57	HY-VEE PHARMACY (1396)	MARION	IA	2,372	$236,136.62	$99.55	61
58	CVS PHARMACY #08546	WATERLOO	IA	2,363	$215,002.47	$90.99	68
59	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,352	$181,622.14	$77.22	66
60	HY-VEE PHARMACY (1522)	PERRY	IA	2,350	$163,385.44	$69.53	64
61	MEDICAP LTC	INDIANOLA	IA	2,338	$97,060.81	$41.51	40
62	HY-VEE PHARMACY (1095)	CRESTON	IA	2,316	$154,648.24	$66.77	63
63	WALMART PHARMACY 10-0985	FAIRFIELD	IA	2,311	$145,868.01	$63.12	60
64	NUCARA LTC PHARMACY #3	IOWA CITY	IA	2,305	$54,175.48	$23.50	76
65	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,286	$189,078.28	$82.71	73
66	EXACTCARE	VALLEY VIEW	OH	2,273	$202,198.45	$88.96	98
67	CVS PHARMACY #10282	FORT DODGE	IA	2,258	$174,949.69	$77.48	97
68	WALGREENS #3875	CEDAR RAPIDS	IA	2,254	$151,393.79	$67.17	78
69	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,237	$205,506.45	$91.87	57
70	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,233	$207,048.97	$92.72	65

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
202206 - 202208

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
71	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,224	$201,886.60	$90.78	72
72	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,217	$186,526.69	$84.13	54
73	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	2,204	$148,739.70	$67.49	114
74	WALGREENS #5852	DES MOINES	IA	2,185	$144,102.25	$65.95	62
75	LAGRANGE PHARMACY	VINTON	IA	2,160	$150,228.72	$69.55	89
76	WALMART PHARMACY 10-1496	WATERLOO	IA	2,151	$139,079.72	$64.66	77
77	WALGREENS #4714	DES MOINES	IA	2,137	$149,540.21	$69.98	71
78	WALMART PHARMACY 10-3394	ATLANTIC	IA	2,134	$117,733.13	$55.17	96
79	HY-VEE PHARMACY (1009)	ALBIA	IA	2,131	$123,388.00	$57.90	75
80	WALMART PHARMACY 10-0646	ANAMOSA	IA	2,099	$145,178.96	$69.17	90
81	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	2,095	$293,542.24	$140.12	109
82	WALGREENS #7968	DES MOINES	IA	2,095	$154,534.62	$73.76	70
83	WALMART PHARMACY 10-1509	MAQUOKETA	IA	2,075	$129,859.54	$62.58	88
84	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	2,070	$137,810.89	$66.58	69
85	WALMART PHARMACY 10-1723	DES MOINES	IA	2,067	$151,519.99	$73.30	94
86	WALMART PHARMACY 10-3590	SIOUX CITY	IA	2,062	$185,579.92	$90.00	80
87	WALMART PHARMACY 10-1285	OTTUMWA	IA	2,061	$130,506.50	$63.32	83
88	WALGREENS #5119	CLINTON	IA	2,058	$111,167.88	$54.02	67
89	WALGREENS #9708	DUBUQUE	IA	2,034	$144,803.66	$71.19	74
90	WALGREENS #11942	DUBUQUE	IA	2,030	$137,243.44	$67.61	79
91	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	2,028	$45,862.23	$22.61	119
92	WALMART PHARMACY 10-1621	CENTERVILLE	IA	2,027	$220,974.72	$109.02	92
93	WAGNER PHARMACY	CLINTON	IA	2,025	$149,628.50	$73.89	111
94	HY-VEE DRUGSTORE #5 (7026)	CEDAR RAPIDS	IA	2,012	$163,345.13	$81.19	100
95	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	2,007	$158,220.44	$78.83	110
96	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,003	$196,130.15	$97.92	95
97	HY-VEE PHARMACY (1180)	FAIRFIELD	IA	1,997	$150,859.49	$75.54	81
98	HY-VEE PHARMACY (1382)	LEMARS	IA	1,980	$197,821.28	$99.91	120
99	HY-VEE PHARMACY (1065)	CHARITON	IA	1,980	$148,697.78	$75.10	82
100	MEDICAP PHARMACY	ELDORA	IA	1,980	$104,382.65	$52.72	102

TOP 100 PHARMACIES BY PAID AMOUNT

202206 - 202208

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	AMBULATORY CARE PHARMACY	IOWA CITY	IA	11,125	$5,681,184.50	$2,436.19	1
2	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	353	$1,972,001.97	$12,481.03	3
3	UNITYPOINT AT HOME	URBANDALE	IA	574	$1,761,630.46	$8,388.72	2
4	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,677	$1,742,685.02	$8,670.07	4
5	COMMUNITY, A WALGREENS PHARMACY #16528	DES MOINES	IA	339	$1,739,489.79	$13,078.87	6
6	CVS PHARMACY #00102	AURORA	CO	177	$1,417,467.92	$19,417.37	5
7	ACARIAHEALTH PHARMACY #11	HOUSTON	TX	176	$1,375,058.30	$17,188.23	7
8	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	114	$1,316,891.79	$32,119.31	8
9	COMMUNITY, A WALGREENS PHARMACY #21250	IOWA CITY	IA	304	$1,017,639.89	$7,217.30	9
10	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	62	$765,557.02	$42,530.95	12
11	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	108	$714,924.09	$13,489.13	14
12	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	16	$712,299.34	$118,716.56	10
13	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	73	$626,182.94	$22,363.68	13
14	WALGREENS #4405	COUNCIL BLUFFS	IA	7,925	$573,066.12	$354.40	15
15	AMBER PHARMACY	OMAHA	NE	81	$560,369.99	$20,013.21	16
16	HY-VEE PHARMACY SOLUTIONS	OMAHA	NE	137	$549,651.23	$11,451.07	11
17	WALGREENS #5042	CEDAR RAPIDS	IA	6,549	$512,275.01	$321.18	18
18	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	5,949	$481,312.74	$395.82	23
19	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	3,188	$472,167.21	$2,524.96	17
20	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,849	$459,266.51	$665.60	26
21	WALGREENS #5239	DAVENPORT	IA	7,154	$450,014.79	$257.00	22
22	FOUNDATION CARE LLC	EARTH CITY	MO	43	$416,108.89	$37,828.08	31
23	WALGREENS #7455	WATERLOO	IA	5,677	$397,970.75	$280.66	28
24	HY-VEE PHARMACY SOLUTIONS	DES MOINES	IA	66	$392,052.34	$12,251.64	20
25	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,565	$389,633.79	$763.99	24
26	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,882	$387,663.36	$2,363.80	25
27	WALGREENS #15647	SIOUX CITY	IA	4,407	$382,604.54	$352.96	37
28	WALGREENS #359	DES MOINES	IA	5,607	$376,821.80	$288.75	27
29	THE NEBRASKA MED CENTER CLINIC PHCY	OMAHA	NE	589	$370,732.70	$2,746.17	21
30	CVS/SPECIALTY	MONROEVILLE	PA	61	$369,593.71	$12,319.79	29
31	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,761	$367,885.68	$410.13	33
32	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,232	$367,510.50	$592.76	32
33	WALGREENS #16270	OMAHA	NE	54	$352,208.35	$16,009.47	19
34	WALGREENS #5721	DES MOINES	IA	5,569	$343,702.23	$237.36	35

TOP 100 PHARMACIES BY PAID AMOUNT

202206 - 202208

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
35	KROGER SPECIALTY PHARMACY LA	HARVEY	LA	35	$336,046.49	$22,403.10	69
36	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	30	$329,101.68	$32,910.17	42
37	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	12	$326,363.63	$65,272.73	30
38	HY-VEE PHARMACY (1075)	CLINTON	IA	2,973	$311,594.32	$665.80	39
39	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	6,776	$307,033.87	$338.14	43
40	SOUTH SIDE DRUG	OTTUMWA	IA	3,252	$306,026.26	$675.55	34
41	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,685	$305,927.82	$464.94	38
42	STANGEL PHARMACY	ONAWA	IA	3,777	$304,495.00	$748.14	46
43	ALLEN CLINIC PHARMACY	WATERLOO	IA	1,137	$299,332.24	$870.15	116
44	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	2,095	$293,542.24	$855.81	58
45	ALLIANCERX WALGREENS PHARMACY #15443	FRISCO	TX	26	$285,145.51	$25,922.32	76
46	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	23	$271,542.98	$30,171.44	75
47	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,358	$270,882.14	$806.20	45
48	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	60	$270,258.56	$11,750.37	57
49	WALGREENS #3700	COUNCIL BLUFFS	IA	4,043	$261,691.89	$292.72	40
50	DRILLING PHARMACY	SIOUX CITY	IA	4,863	$261,396.81	$524.89	47
51	HY-VEE PHARMACY (1449)	NEWTON	IA	3,418	$260,876.67	$466.68	49
52	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	3,126	$259,138.58	$666.17	59
53	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,311	$258,004.16	$1,842.89	48
54	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,698	$255,425.02	$456.93	44
55	OPTUM INFUSION SERVICES 305, LLC	LENEXA	KS	5	$254,621.30	$127,310.65	36
56	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,199	$251,258.04	$534.59	55
57	WALGREENS #7453	DES MOINES	IA	3,930	$246,391.70	$262.68	51
58	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	1,808	$246,032.45	$1,382.20	54
59	ALLIANCERX WALGREENS PHARMACY #15438	CANTON	MI	15	$244,345.36	$24,434.54	266
60	OPTUM PHARMACY 701 LLC	FLINT	MI	24	$244,334.57	$13,574.14	107
61	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,852	$238,313.46	$480.47	61
62	WALGREENS #5777	DES MOINES	IA	2,655	$237,539.64	$393.93	52
63	HY-VEE PHARMACY (1396)	MARION	IA	2,372	$236,136.62	$484.88	62
64	WALGREENS #7452	DES MOINES	IA	3,062	$235,879.10	$337.94	50
65	RIGHT DOSE PHARMACY	ANKENY	IA	4,374	$231,375.77	$571.30	60
66	ARJ INFUSION SERVICES, LLC	CEDAR RAPIDS	IA	46	$223,020.67	$22,302.07	41
67	WALMART PHARMACY 10-1621	CENTERVILLE	IA	2,027	$220,974.72	$605.41	63
68	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,441	$220,905.36	$824.27	53

TOP 100 PHARMACIES BY PAID AMOUNT

202206 - 202208

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
69	MAHASKA DRUGS INC	OSKALOOSA	IA	3,549	$215,091.17	$398.32	66
70	CVS PHARMACY #08546	WATERLOO	IA	2,363	$215,002.47	$404.90	77
71	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	2,814	$214,663.61	$378.60	68
72	HY-VEE PHARMACY #4 (1060)	CEDAR RAPIDS	IA	2,537	$213,110.92	$429.66	80
73	DANIEL PHARMACY	FT DODGE	IA	2,642	$210,099.77	$503.84	65
74	ORSINI PHARMACEUTICAL SERVICES INC	ELK GROVE VILLAGE	IL	17	$207,565.96	$29,652.28	129
75	WALGREENS #5044	BURLINGTON	IA	3,240	$207,532.80	$270.23	85
76	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,233	$207,048.97	$553.61	78
77	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,237	$205,506.45	$471.35	72
78	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	2,972	$203,274.54	$320.62	70
79	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,412	$202,987.35	$472.06	83
80	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,760	$202,486.64	$429.91	81
81	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,570	$202,264.37	$483.89	84
82	EXACTCARE	VALLEY VIEW	OH	2,273	$202,198.45	$2,221.96	101
83	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,224	$201,886.60	$576.82	82
84	WALGREENS #5470	SIOUX CITY	IA	3,164	$200,381.19	$300.87	91
85	HY-VEE PHARMACY (1382)	LEMARS	IA	1,980	$197,821.28	$709.04	102
86	PARAGON PARTNERS	OMAHA	NE	600	$196,872.44	$3,860.24	125
87	REUTZEL PHARMACY	CEDAR RAPIDS	IA	2,964	$196,377.67	$909.16	67
88	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,003	$196,130.15	$568.49	90
89	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,477	$192,161.60	$423.26	71
90	WALGREENS #7454	ANKENY	IA	2,664	$190,447.13	$299.92	79
91	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,286	$189,078.28	$375.16	88
92	HY-VEE PHARMACY (1192)	FT DODGE	IA	2,630	$188,553.19	$412.59	109
93	WALMART PHARMACY 10-5315	ORLANDO	FL	20	$188,384.86	$18,838.49	183
94	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,217	$186,526.69	$379.12	74
95	WALMART PHARMACY 10-3590	SIOUX CITY	IA	2,062	$185,579.92	$394.01	103
96	WALGREENS #5886	KEOKUK	IA	2,761	$184,048.11	$409.00	99
97	WALGREENS #4041	DAVENPORT	IA	2,855	$183,705.31	$260.57	87
98	WALMART PHARMACY 10-1393	OSKALOOSA	IA	1,930	$182,620.65	$497.60	89
99	WALMART PHARMACY 10-1431	KEOKUK	IA	1,806	$182,191.31	$583.95	122
100	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,352	$181,622.14	$452.92	100

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

202206 - 202208

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$103,244.06	1,440	12.63	1
2	1013115369	Bobbita Nag	$74,328.80	1,318	5.03	2
3	1801998372	Wendy Hansen-Penman	$42,528.08	1,168	8.78	6
4	1609218304	Amanda Garr	$175,050.21	1,147	6.87	11
5	1124006770	Wook Kim	$65,641.08	1,117	6.73	8
6	1619380680	Tara Brockman	$52,793.69	1,098	5.78	4
7	1043211303	Ali Safdar	$150,508.86	1,087	5.06	3
8	1477199198	Sajo Thomas	$127,143.79	1,084	6.78	13
9	1467907394	Cynthia Coenen	$101,140.54	1,077	8.90	14
10	1558770974	Marc Baumert	$61,280.01	1,072	5.53	16
11	1356788616	Ted Bonebrake	$79,803.69	1,067	11.60	33
12	1053630640	Jennifer Donovan	$141,392.48	1,056	7.33	26
13	1215125216	Rebecca Walding	$70,666.48	1,050	7.61	9
14	1538368170	Christopher Matson	$47,372.91	1,039	7.64	12
15	1770933046	Shelby Biller	$169,003.67	1,029	6.05	17
16	1922455096	Dean Guerdet	$106,765.08	1,013	5.76	15
17	1467502286	Charles Tilley	$187,067.14	1,010	7.48	10
18	1538157383	David Wenger-Keller	$58,478.36	1,001	10.01	22
19	1902912538	Christian Jones	$56,490.84	1,001	5.47	25
20	1659358620	Carlos Castillo	$35,774.91	1,001	6.18	7
21	1902358443	Melissa Konken	$139,639.40	963	8.45	19
22	1437238110	Genevieve Nelson	$73,187.50	942	6.93	28
23	1437209434	Jon Thomas	$67,163.09	932	4.88	24
24	1275763047	Rebecca Bowman	$175,305.32	926	5.86	5
25	1902478811	Joan Anderson	$156,058.82	906	7.37	134
26	1144214248	Kristi Walz	$136,483.32	906	8.47	30
27	1821268335	Jacqueline Mcinnis	$106,676.54	891	10.48	31
28	1043434525	Robert Kent	$66,669.53	889	6.79	32
29	1417241621	Ashley Mathes	$34,811.89	889	5.77	20
30	1164538674	Joseph Wanzek	$62,999.99	876	8.59	45
31	1891146999	Becky Johnson	$767,429.01	871	6.65	38
32	1982030946	Jacklyn Besch	$42,789.69	866	5.89	35
33	1588193643	Kathleen Mcguire	$109,128.41	864	6.22	55
34	1255823506	Nicole Delagardelle	$121,772.48	861	5.98	50

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

202206 - 202208

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
35	1992103386	Melissa Larsen	$80,250.92	851	6.55	49
36	1285697722	Douglas Jones	$87,659.37	846	6.18	27
37	1114521721	Tarrah Holliday	$167,491.76	843	7.33	37
38	1073945499	Jennifer Zalaznik	$70,800.16	843	8.03	23
39	1245227099	Donna Dobson Tobin	$133,072.63	834	8.42	34
40	1780979666	Lindsey Christianson	$34,270.06	830	5.65	42
41	1316356496	Kimberly Roberts	$58,028.33	826	6.45	44
42	1689077018	Stacy Roth	$63,241.77	817	7.04	39
43	1972989721	Jayson Gesulga	$226,861.52	815	9.94	21
44	1073500690	Kathleen Adams	$30,607.25	815	5.78	29
45	1821423799	Dorothy Metz	$73,380.45	813	6.30	122
46	1932652757	Kelsie Swisher	$320,701.72	800	6.90	47
47	1972758126	Rebecca Bollin	$26,156.40	800	5.52	71
48	1477534279	Edmund Piasecki	$58,045.80	791	6.33	40
49	1457584740	Eric Meyer	$44,333.04	791	5.95	36
50	1669056123	Kama Ausborn	$179,533.26	788	6.41	79
51	1275844649	Katie Campbell	$87,813.11	786	7.02	54
52	1467465716	Jeffrey Brady	$45,740.19	766	6.13	51
53	1356788129	Rachael Parker	$82,539.50	753	6.38	41
54	1124389697	Kevin Furness	$37,127.05	745	6.65	74
55	1043703887	Tenaea Jeppeson	$135,654.19	743	7.66	43
56	1356359871	Rhea Hartley	$126,137.44	742	5.08	65
57	1518567056	Katie Mogensen	$70,811.91	739	6.97	52
58	1376579706	Tze Chan	$43,083.00	738	6.71	69
59	1477112688	Felicia Hoerner	$47,562.88	728	5.56	171
60	1114544681	Rachael Ploessl	$62,567.38	725	6.47	58
61	1831710987	Margaret Fuller	$58,943.16	718	5.40	75
62	1093034266	Eric Boyum	$76,212.22	715	5.77	82
63	1467437806	Georgia Lauer	$60,330.93	711	7.11	67
64	1205393386	Jessica Hudspeth	$80,080.60	710	7.55	91
65	1134191018	Dustin Smith	$32,369.67	710	5.59	62
66	1528329398	Erin Rowan	$31,888.18	710	4.80	105
67	1467449710	Michelle Malloy	$35,516.82	707	6.20	114
68	1205169273	Teresa Dowling	$52,940.02	702	7.47	61

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

202206 - 202208

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
69	1891707832	Lisa Klock	$49,335.20	692	4.33	118
70	1356754337	Cyndi Mccormick	$126,988.38	686	6.53	121
71	1932531316	Brooke Johnson	$56,308.90	678	5.79	64
72	1679573893	Patty Hildreth	$79,714.16	677	6.70	48
73	1841220290	Kent Kunze	$29,854.03	676	6.90	89
74	1295830115	Alan Bollinger	$15,288.19	676	8.56	90
75	1023555638	Cynthia Johnson	$89,208.76	675	6.37	57
76	1033295308	Takashi Kawamitsu	$44,383.64	673	6.41	93
77	1932582988	Dianne Humphrey	$56,164.87	671	6.78	120
78	1801430731	Harold Horn	$37,344.45	669	6.90	97
79	1184666539	Penumetsa Raju	$48,169.06	666	5.41	107
80	1871052472	Cassidy Carr	$60,385.10	657	5.43	72
81	1316471154	Nicole Woolley	$37,210.96	655	4.17	68
82	1699740159	Frank Marino	$29,265.85	654	4.39	84
83	1053963900	Nicole Mcclavy	$78,738.54	652	5.39	111
84	1326013426	Paul Peterson	$38,072.68	652	4.83	81
85	1336252097	Thomas Baer	$28,576.99	649	7.91	108
86	1962558957	Albert Okine	$73,919.25	646	7.78	78
87	1760445423	Shailesh Desai	$39,860.43	645	7.09	46
88	1720698335	Danika Hansen	$49,396.56	644	7.08	129
89	1841293354	Keith Guess	$30,853.32	644	4.95	88
90	1225414576	Sara Kuhn	$102,398.94	640	8.42	60
91	1477926434	Jackie Shipley	$45,578.92	639	4.26	100
92	1508844465	Michele Friedman	$40,412.38	639	11.21	130
93	1679536015	David Wolff	$42,479.94	637	10.80	92
94	1174176093	Carol Chukwuka	$52,470.16	636	4.61	56
95	1871598557	Christopher Vandelune	$29,111.00	634	4.40	66
96	1679669832	Erin Hatcher	$68,593.43	632	6.02	63
97	1235514258	Ashley Fuller	$52,093.62	631	6.07	103
98	1750845954	Stephanie Giesler	$70,471.26	628	6.75	109
99	1649438383	Qadnana Anwar	$48,554.83	626	4.85	112
100	1104976109	Isam Marar	$84,956.85	622	9.72	102

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202206 - 202208

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
1	1891146999	Becky Johnson	871	$767,429.01	$881.09	2
2	1376777524	Alladdin Abosaida	330	$683,351.64	$2,070.76	4
3	1497060776	Usha Perepu	68	$636,516.25	$9,360.53	1
4	1316934318	Steven Lentz	20	$510,350.82	$25,517.54	6
5	1295091510	Rebecca Weiner	298	$455,787.71	$1,529.49	8
6	1326034984	Katherine Mathews	88	$439,974.96	$4,999.72	7
7	1417443953	Rodney Clark	356	$382,484.43	$1,074.39	9
8	1760596357	Amal Shibli-Rahhal	10	$343,306.61	$34,330.66	13
9	1619382942	Eirene Alexandrou	168	$335,764.82	$1,998.60	5
10	1932652757	Kelsie Swisher	800	$320,701.72	$400.88	12
11	1013126705	Janice Staber	26	$315,908.71	$12,150.34	3
12	1558357806	Robin Hayward	166	$310,309.79	$1,869.34	15
13	1649419219	Heather Hunemuller	262	$279,673.04	$1,067.45	16
14	1225263833	Lindsay Orris	160	$275,727.65	$1,723.30	22
15	1447506217	Theodosia Thoma	232	$256,401.59	$1,105.18	38
16	1669740957	Courtney Kremer	147	$238,951.10	$1,625.52	28
17	1447242359	Daniel Sleiter	247	$235,365.02	$952.89	21
18	1972989721	Jayson Gesulga	815	$226,861.52	$278.36	17
19	1841607900	Shayla Sanders	135	$205,633.61	$1,523.21	18
20	1972560597	Bernard Leman	48	$204,483.75	$4,260.08	46
21	1679569495	Wendianne Wilson	9	$204,482.63	$22,720.29	4364
22	1437121407	Linda Cadaret	133	$203,675.92	$1,531.40	34
23	1891955423	Leah Siegfried	479	$197,363.46	$412.03	67
24	1588288385	Jenifer Jones	293	$192,573.99	$657.25	116
25	1245468768	Thomas Schmidt	106	$187,878.60	$1,772.44	35
26	1467502286	Charles Tilley	1,010	$187,067.14	$185.21	30
27	1679688626	Lawrence Rettenmaier	88	$186,342.24	$2,117.53	55
28	1437147386	Douglas Hornick	35	$185,014.29	$5,286.12	42
29	1477761328	Amy Calhoun	47	$180,638.66	$3,843.38	70
30	1588616171	Heather Thomas	98	$180,302.48	$1,839.82	10
31	1164408548	Maxwell Cosmic	73	$180,138.14	$2,467.65	61
32	1033554498	Matthew Landherr	126	$180,085.96	$1,429.25	54
33	1669056123	Kama Ausborn	788	$179,533.26	$227.83	93
34	1275763047	Rebecca Bowman	926	$175,305.32	$189.31	24

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202206 - 202208

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
35	1609218304	Amanda Garr	1,147	$175,050.21	$152.62	45
36	1043565328	Sara Moeller	108	$172,871.30	$1,600.66	23
37	1679521728	Jill Fliege	23	$172,117.48	$7,483.37	14
38	1376525196	Randolph Rough	100	$169,561.68	$1,695.62	11
39	1770933046	Shelby Biller	1,029	$169,003.67	$164.24	56
40	1114521721	Tarrah Holliday	843	$167,491.76	$198.69	36
41	1356387260	Samuel Wood	86	$167,303.73	$1,945.39	20
42	1871039917	Elizabeth Allen	78	$166,364.71	$2,132.88	49
43	1245353242	Sandy Hong	149	$165,622.27	$1,111.56	29
44	1689942518	Patria Alba Aponte	195	$164,829.95	$845.28	72
45	1285748004	Bruce Hughes	82	$160,869.40	$1,961.82	66
46	1972583573	Sherry Kolacia-Tighe	146	$160,802.07	$1,101.38	99
47	1043418809	Michael Ciliberto	458	$160,704.41	$350.88	26
48	1295078533	Christopher Strouse	22	$157,773.07	$7,171.50	51
49	1902478811	Joan Anderson	906	$156,058.82	$172.25	50
50	1376512244	Raymond Kuwahara	185	$155,558.95	$840.86	211
51	1952423071	Sakeer Hussain	49	$154,696.45	$3,157.07	27
52	1225266364	Sarah Bligh	221	$152,635.76	$690.66	58
53	1487648705	Karen Hunke	82	$151,396.88	$1,846.30	48
54	1043211303	Ali Safdar	1,087	$150,508.86	$138.46	32
55	1407180094	Tulsi Sharma	403	$148,264.59	$367.90	60
56	1972616316	Jeffrey Brannen	195	$145,866.37	$748.03	52
57	1922058148	Jill Poole	6	$144,781.87	$24,130.31	10491
58	1134402373	Julie Schuck	124	$144,513.04	$1,165.43	63
59	1386902682	Melissa Willis	79	$143,515.52	$1,816.65	62
60	1588618359	Barbara Burkle	113	$141,809.96	$1,254.96	37
61	1053630640	Jennifer Donovan	1,056	$141,392.48	$133.89	101
62	1134440886	Melissa Wells	98	$141,162.00	$1,440.43	105
63	1467449579	Brian Wayson	121	$140,649.42	$1,162.39	19
64	1902358443	Melissa Konken	963	$139,639.40	$145.00	43
65	1700417169	Courtney Reints	246	$139,149.90	$565.65	64
66	1144214248	Kristi Walz	906	$136,483.32	$150.64	57
67	1043703887	Tenaea Jeppeson	743	$135,654.19	$182.58	40
68	1225143316	Susan Jacobi	98	$134,455.21	$1,371.99	41

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202206 - 202208

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
69	1578958542	Heidi Curtis	133	$133,550.32	$1,004.14	214
70	1245227099	Donna Dobson Tobin	834	$133,072.63	$159.56	69
71	1134249832	Steven Craig	100	$132,519.47	$1,325.19	33
72	1720036353	Erik Swenson	121	$130,703.15	$1,080.19	76
73	1386084747	Jennifer Condon	190	$128,353.40	$675.54	114
74	1477199198	Sajo Thomas	1,084	$127,143.79	$117.29	86
75	1356754337	Cyndi Mccormick	686	$126,988.38	$185.11	80
76	1356359871	Rhea Hartley	742	$126,137.44	$170.00	307
77	1720086523	Mark Cleveland	149	$126,107.67	$846.36	47
78	1215964796	Donner Dewdney	593	$125,679.85	$211.94	79
79	1356752067	Kelly Delaney-Nelson	103	$125,257.45	$1,216.09	89
80	1255538344	Sarah Feddersen	24	$124,000.26	$5,166.68	53
81	1730406356	Christina Warren	166	$123,754.65	$745.51	44
82	1285844217	Mirac Ince	47	$123,073.39	$2,618.58	961
83	1255823506	Nicole Delagardelle	861	$121,772.48	$141.43	109
84	1144829300	Katie Shannon	41	$121,583.91	$2,965.46	256
85	1265420095	Elizabeth Cooper	115	$121,014.18	$1,052.30	31
86	1902191059	Amber Tierney	38	$120,119.86	$3,161.05	97
87	1124078100	Paul Sammut	33	$119,776.23	$3,629.58	131
88	1790986925	Tahuanty Pena	62	$119,679.74	$1,930.32	501
89	1356834113	Susan Deo	100	$119,591.06	$1,195.91	107
90	1790046548	Laurie Clair	504	$119,139.24	$236.39	126
91	1053387522	Amy Dietrich	127	$116,387.96	$916.44	59
92	1295253557	Abbey Modlin	300	$116,084.87	$386.95	102
93	1750648275	Sarah Gross	125	$115,899.64	$927.20	68
94	1245349182	Mark Burdt	115	$114,963.85	$999.69	111
95	1841673738	Rachel Person	58	$113,955.63	$1,964.75	268
96	1841783123	Jennifer Greimann	47	$112,664.06	$2,397.11	73
97	1508291717	Jacob Ridder	80	$112,658.32	$1,408.23	195
98	1124216676	Wendy Sanders	166	$112,224.57	$676.05	74
99	1528247368	Mishelle Paullus	74	$111,907.42	$1,512.26	85
100	1326211889	James Friedlander	41	$111,440.52	$2,718.06	95

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

	202203 - 202205			202206 - 202208			
CATEGORY DESCRIPTION	PREVIOUS TOTAL COST	PREVIOUS RANK	PREVIOUS % BUDGET	CURRENT TOTAL COST	CURRENT RANK	CURRENT % BUDGET	% CHANGE
ANTIDIABETICS	$12,274,782.93	1	14.02 %	$12,771,320.83	1	14.44 %	0.43 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$9,537,281.30	2	10.89 %	$9,909,523.10	2	11.21 %	0.32 %
ANALGESICS - ANTI-INFLAMMATORY	$8,273,439.84	3	9.45 %	$8,631,307.47	3	9.76 %	0.31 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$7,328,964.87	4	8.37 %	$7,413,493.40	4	8.38 %	0.01 %
DERMATOLOGICALS	$5,624,268.38	5	6.42 %	$6,270,569.50	5	7.09 %	0.67 %
ANTIVIRALS	$4,306,807.93	6	4.92 %	$4,599,669.90	6	5.20 %	0.28 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$3,900,767.51	7	4.46 %	$3,804,902.47	7	4.30 %	-0.15 %
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$2,914,606.24	8	3.33 %	$2,971,800.95	8	3.36 %	0.03 %
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC	$2,457,491.97	11	2.81 %	$2,670,431.87	9	3.02 %	0.21 %
RESPIRATORY AGENTS - MISC.	$2,718,144.53	9	3.10 %	$2,536,581.72	10	2.87 %	-0.24 %
ANTICONVULSANTS	$2,444,903.72	12	2.79 %	$2,411,303.10	11	2.73 %	-0.07 %
ANTIDEPRESSANTS	$2,364,488.74	13	2.70 %	$2,343,710.57	12	2.65 %	-0.05 %
ENDOCRINE AND METABOLIC AGENTS - MISC.	$2,254,812.31	14	2.58 %	$2,138,871.64	13	2.42 %	-0.16 %
HEMATOLOGICAL AGENTS - MISC.	$2,707,308.61	10	3.09 %	$2,100,145.44	14	2.38 %	-0.72 %
MIGRAINE PRODUCTS	$1,708,506.20	15	1.95 %	$1,896,361.97	15	2.14 %	0.19 %
ANTICOAGULANTS	$1,693,228.53	16	1.93 %	$1,731,134.60	16	1.96 %	0.02 %
CARDIOVASCULAR AGENTS - MISC.	$1,538,212.98	17	1.76 %	$1,437,341.47	17	1.63 %	-0.13 %
ANTI-INFECTIVE AGENTS - MISC.	$780,075.13	20	0.89 %	$790,378.55	18	0.89 %	0.00 %
GASTROINTESTINAL AGENTS - MISC.	$881,958.00	19	1.01 %	$787,174.99	19	0.89 %	-0.12 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$1,088,098.68	18	1.24 %	$758,077.95	20	0.86 %	-0.39 %
MISCELLANEOUS THERAPEUTIC CLASSES	$742,780.40	22	0.85 %	$720,756.92	21	0.82 %	-0.03 %
CONTRACEPTIVES	$566,580.71	24	0.65 %	$633,637.59	22	0.72 %	0.07 %
ANALGESICS - OPIOID	$641,792.41	23	0.73 %	$626,815.74	23	0.71 %	-0.02 %

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

	202203 - 202205		202206 - 202208		
CURRENT CATEGORY DESCRIPTION	PREVIOUS CLAIMS	PREVIOUS RANK	CURRENT CLAIMS	CURRENT RANK	% CHANGE
ANTIDEPRESSANTS	106,157	1	105,016	1	-1.07 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	46,867	2	45,687	2	-2.52 %
ANTICONVULSANTS	45,531	3	45,526	3	-0.01 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	38,213	4	36,476	4	-4.55 %
ANTIHYPERTENSIVES	36,984	5	36,236	5	-2.02 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	35,409	6	35,413	6	0.01 %
ANTIDIABETICS	35,133	7	35,363	7	0.65 %
ANTIANXIETY AGENTS	34,781	8	34,896	8	0.33 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	33,496	9	32,734	9	-2.27 %
ANALGESICS - OPIOID	25,127	10	24,888	10	-0.95 %
DERMATOLOGICALS	21,481	13	23,742	11	10.53 %
ANALGESICS - ANTI-INFLAMMATORY	22,922	11	22,915	12	-0.03 %
ANTIHYPERLIPIDEMICS	22,367	12	22,417	13	0.22 %
ANTIHISTAMINES	20,544	15	20,043	14	-2.44 %
BETA BLOCKERS	17,767	16	17,904	15	0.77 %
PENICILLINS	21,317	14	16,573	16	-22.25 %
DIURETICS	14,929	17	14,719	17	-1.41 %
MUSCULOSKELETAL THERAPY AGENTS	14,445	18	14,600	18	1.07 %
CORTICOSTEROIDS	14,316	19	13,817	19	-3.49 %
THYROID AGENTS	13,068	20	13,138	20	0.54 %

TOP 100 DRUGS BY PAID AMOUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Humira Pen	$5,355,019	1	$5,456,038	1	1.89 %
Trulicity	$2,442,418	2	$2,659,096	2	8.87 %
Vraylar	$2,324,411	3	$2,457,978	3	5.75 %
Vyvanse	$2,112,429	4	$2,002,546	4	-5.20 %
Biktarvy	$1,705,482	7	$1,889,728	5	10.80 %
Invega Sust	$1,822,641	6	$1,802,816	6	-1.09 %
Trikafta	$2,065,589	5	$1,785,141	7	-13.58 %
Jardiance	$1,449,291	10	$1,639,186	8	13.10 %
Stelara	$1,661,194	9	$1,627,937	9	-2.00 %
Latuda	$1,684,668	8	$1,593,130	10	-5.43 %
Taltz	$1,094,502	14	$1,399,730	11	27.89 %
Lantus Solos	$1,376,133	11	$1,393,497	12	1.26 %
Dupixent	$993,758	17	$1,242,899	13	25.07 %
Ozempic	$1,203,500	12	$1,214,595	14	0.92 %
Symbicort	$1,127,510	13	$1,146,563	15	1.69 %
Eliquis	$1,044,430	16	$1,056,059	16	1.11 %
Aristada	$937,076	19	$989,976	17	5.65 %
Spiriva	$1,045,715	15	$980,128	18	-6.27 %
Proair Hfa	$975,235	18	$969,372	19	-0.60 %
Advair Disku	$930,905	20	$927,378	20	-0.38 %
Rexulti	$684,750	24	$860,680	21	25.69 %
Enbrel Srclk	$711,043	22	$779,309	22	9.60 %
Mavyret	$593,373	30	$734,100	23	23.72 %
Trintellix	$684,811	23	$692,438	24	1.11 %
Cosentyx Pen	$612,784	27	$690,543	25	12.69 %
Ingrezza	$599,950	29	$633,039	26	5.52 %
Insulin Aspa	$620,033	26	$619,319	27	-0.12 %
Strensiq	$858,104	21	$617,833	28	-28.00 %
Adynovate	$631,573	25	$609,853	29	-3.44 %
Invega Trinz	$513,274	38	$603,037	30	17.49 %
Xarelto	$574,721	31	$599,813	31	4.37 %

TOP 100 DRUGS BY PAID AMOUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Abilify Main	$606,973	28	$599,446	32	-1.24 %
Victoza	$568,099	32	$582,276	33	2.50 %
Nurtec	$472,745	44	$575,425	34	21.72 %
Januvia	$548,388	34	$564,608	35	2.96 %
Xifaxan	$533,365	37	$531,300	36	-0.39 %
Tresiba Flex	$508,132	39	$522,974	37	2.92 %
Levemir	$535,510	36	$512,877	38	-4.23 %
Farxiga	$492,673	40	$499,909	39	1.47 %
Vimpat	$492,011	41	$496,444	40	0.90 %
Insulin Lisp	$483,182	43	$491,807	41	1.78 %
Flovent Hfa	$547,765	35	$480,934	42	-12.20 %
Humira	$489,208	42	$476,320	43	-2.63 %
Ilaris	$381,888	52	$462,774	44	21.18 %
Ajovy	$447,681	45	$425,003	45	-5.07 %
Lantus	$435,128	46	$422,006	46	-3.02 %
Entresto	$405,022	50	$414,905	47	2.44 %
Trelegy	$380,428	53	$407,911	48	7.22 %
Jynarque	$326,728	58	$361,121	49	10.53 %
Ventolin Hfa	$346,730	55	$352,845	50	1.76 %
Orkambi	$252,598	68	$345,314	51	36.70 %
Norditropin	$391,015	51	$336,396	52	-13.97 %
Revlimid	$413,539	48	$327,365	53	-20.84 %
Cabometyx	$334,320	56	$325,113	54	-2.75 %
Hemlibra	$416,902	47	$322,207	55	-22.71 %
Linzess	$300,074	61	$313,605	56	4.51 %
Austedo	$257,459	66	$310,998	57	20.80 %
Evrysdi	$364,696	54	$302,496	58	-17.06 %
Advair Hfa	$283,886	64	$297,013	59	4.62 %
Methylphenid	$321,421	59	$284,770	60	-11.40 %
Opsumit	$279,871	65	$279,871	61	0.00 %
Eloctate	$289,633	62	$277,011	62	-4.36 %

TOP 100 DRUGS BY PAID AMOUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Caplyta	$190,243	90	$273,906	63	43.98 %
Creon	$237,357	70	$266,146	64	12.13 %
Adempas	$230,032	72	$265,336	65	15.35 %
Pulmozyme	$253,043	67	$262,219	66	3.63 %
Aimovig	$212,429	79	$248,223	67	16.85 %
Genvoya	$285,065	63	$245,637	68	-13.83 %
Epinephrine	$204,042	85	$242,984	69	19.09 %
Takhzyro	$144,730	121	$241,227	70	66.67 %
Varenicline	$182,509	97	$240,533	71	31.79 %
Sofos/velpat	$215,954	75	$238,905	72	10.63 %
Verzenio	$182,888	96	$236,594	73	29.37 %
Wakix	$149,401	118	$230,707	74	54.42 %
Ubrelvy	$163,467	108	$230,413	75	40.95 %
Sprycel	$215,596	76	$230,168	76	6.76 %
Odefsey	$215,009	77	$224,462	77	4.40 %
Amphet/dextr	$214,914	78	$219,849	78	2.30 %
Fasenra Pen	$180,810	99	$209,526	79	15.88 %
Anoro Ellipt	$210,681	81	$209,449	80	-0.58 %
Lupr Dep-Ped	$178,994	100	$204,927	81	14.49 %
Tremfya	$203,554	86	$203,607	82	0.03 %
Oxervate			$203,539	83	
Xeljanz Xr	$183,074	95	$202,959	84	10.86 %
Xywav	$108,103	148	$202,355	85	87.19 %
Emflaza	$204,929	84	$199,718	86	-2.54 %
Gabapentin	$193,409	88	$195,031	87	0.84 %
Sertraline	$188,570	91	$193,803	88	2.78 %
Ibrance	$184,460	94	$193,039	89	4.65 %
Inlyta	$205,637	83	$187,905	90	-8.62 %
Invokana	$187,085	92	$187,166	91	0.04 %
Triumeq	$202,802	87	$185,415	92	-8.57 %
Skyrizi Pen	$219,860	74	$183,394	93	-16.59 %

TOP 100 DRUGS BY PAID AMOUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Tivicay	$167,570	107	$182,881	94	9.14 %
Kesimpta	$150,092	116	$182,076	95	21.31 %
Uptravi	$310,925	60	$181,144	96	-41.74 %
Omeprazole	$186,694	93	$180,768	97	-3.17 %
Advate	$208,701	82	$179,456	98	-14.01 %
Emgality	$190,625	89	$176,026	99	-7.66 %
Atorvastatin	$170,181	105	$174,872	100	2.76 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION	CURRENT RANK	% CHANGE
Sertraline	16,073	1	16,003	1	-0.44 %
Omeprazole	15,745	2	15,359	2	-2.45 %
Trazodone	13,858	3	13,524	3	-2.41 %
Atorvastatin	13,455	5	13,465	4	0.07 %
Gabapentin	12,896	7	12,744	5	-1.18 %
Escitalopram	13,020	6	12,730	6	-2.23 %
Fluoxetine	12,836	8	12,357	7	-3.73 %
Lisinopril	12,326	9	12,048	8	-2.26 %
Bupropn Hcl	11,359	11	11,613	9	2.24 %
Proair Hfa	11,643	10	11,409	10	-2.01 %
Metformin	11,222	12	11,005	11	-1.93 %
Levothyroxin	10,974	14	10,930	12	-0.40 %
Cetirizine	11,092	13	10,914	13	-1.60 %
Amphet/dextr	10,543	15	10,640	14	0.92 %
Amoxicillin	13,608	4	10,238	15	-24.76 %
Hydroco/apap	10,178	16	10,025	16	-1.50 %
Buspirone	8,951	20	9,237	17	3.20 %
Duloxetine	8,832	22	8,950	18	1.34 %
Quetiapine	8,978	19	8,949	19	-0.32 %
Montelukast	8,921	21	8,675	20	-2.76 %
Hydroxyz Hcl	8,672	24	8,646	21	-0.30 %
Prednisone	8,693	23	8,560	22	-1.53 %
Ondansetron	9,929	17	8,417	23	-15.23 %
Methylphenid	9,444	18	8,416	24	-10.89 %
Venlafaxine	8,370	25	8,165	25	-2.45 %
Amlodipine	8,036	26	7,957	26	-0.98 %
Aripiprazole	7,622	27	7,555	27	-0.88 %
Pantoprazole	7,415	29	7,540	28	1.69 %
Cyclobenzapr	7,379	30	7,454	29	1.02 %
Ibuprofen	7,432	28	7,377	30	-0.74 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION	CURRENT RANK	% CHANGE
Alprazolam	7,069	32	7,091	31	0.31 %
Clonidine	6,991	33	6,892	32	-1.42 %
Lamotrigine	6,687	35	6,872	33	2.77 %
Fluticasone	7,359	31	6,724	34	-8.63 %
Vyvanse	6,962	34	6,608	35	-5.08 %
Clonazepam	6,298	37	6,204	36	-1.49 %
Metoprol Suc	5,927	41	5,942	37	0.25 %
Cephalexin	5,145	47	5,908	38	14.83 %
Loratadine	5,971	40	5,878	39	-1.56 %
Guanfacine	6,003	39	5,772	40	-3.85 %
Tramadol Hcl	5,409	42	5,413	41	0.07 %
Meloxicam	5,338	44	5,329	42	-0.17 %
Topiramate	5,340	43	5,315	43	-0.47 %
Amox/k Clav	6,570	36	5,218	44	-20.58 %
Ventolin Hfa	5,209	46	5,180	45	-0.56 %
Famotidine	5,283	45	5,148	46	-2.56 %
Aspirin Low	4,687	52	4,958	47	5.78 %
Losartan Pot	4,861	49	4,750	48	-2.28 %
Propranolol	4,566	54	4,745	49	3.92 %
Lorazepam	4,808	50	4,711	50	-2.02 %
Triamcinolon	3,917	58	4,611	51	17.72 %
Hydrochlorot	4,699	51	4,509	52	-4.04 %
Furosemide	4,445	56	4,449	53	0.09 %
Risperidone	4,453	55	4,383	54	-1.57 %
Azithromycin	6,283	38	4,356	55	-30.67 %
Albuterol	4,968	48	4,231	56	-14.83 %
Mirtazapine	4,081	57	4,106	57	0.61 %
Metronidazol	3,818	59	3,921	58	2.70 %
Fluconazole	3,573	62	3,810	59	6.63 %
Hydroxyz Pam	3,652	61	3,610	60	-1.15 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION	CURRENT RANK	% CHANGE
Prazosin Hcl	3,572	63	3,591	61	0.53 %
Diclofenac	3,508	65	3,573	62	1.85 %
Amitriptylin	3,529	64	3,427	63	-2.89 %
Citalopram	3,487	66	3,417	64	-2.01 %
Oxycodone	3,286	67	3,318	65	0.97 %
Doxycyc Mono	3,784	60	3,309	66	-12.55 %
Rosuvastatin	3,170	70	3,300	67	4.10 %
Spironolact	3,270	68	3,283	68	0.40 %
Cefdinir	4,635	53	3,218	69	-30.57 %
Levetiraceta	3,151	71	3,182	70	0.98 %
Symbicort	3,125	73	3,172	71	1.50 %
Folic Acid	3,097	74	3,141	72	1.42 %
Naproxen	3,137	72	3,065	73	-2.30 %
Valacyclovir	3,029	76	3,007	74	-0.73 %
Tizanidine	2,960	78	2,985	75	0.84 %
Acetamin	2,825	82	2,982	76	5.56 %
Zolpidem	3,085	75	2,960	77	-4.05 %
Lantus Solos	2,950	79	2,954	78	0.14 %
Polyeth Glyc	3,256	69	2,953	79	-9.31 %
Metoprol Tar	3,008	77	2,943	80	-2.16 %
Trulicity	2,666	88	2,875	81	7.84 %
Ferosul	2,774	84	2,856	82	2.96 %
Clindamycin	2,836	81	2,819	83	-0.60 %
Pregabalin	2,693	87	2,760	84	2.49 %
Olanzapine	2,738	85	2,760	85	0.80 %
Divalproex	2,797	83	2,727	86	-2.50 %
Baclofen	2,736	86	2,717	87	-0.69 %
Sumatriptan	2,598	89	2,574	88	-0.92 %
Smz/tmp Ds	2,398	90	2,424	89	1.08 %
Insulin Lisp	2,353	91	2,405	90	2.21 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

	202203 - 202205		202206 - 202208		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION	CURRENT RANK	% CHANGE
Prednisolone	2,887	80	2,385	91	-17.39 %
Mupirocin	1,988	103	2,372	92	19.32 %
Nystatin	2,061	98	2,270	93	10.14 %
Atomoxetine	2,277	93	2,247	94	-1.32 %
Advair Disku	2,257	94	2,225	95	-1.42 %
Jardiance	1,945	105	2,185	96	12.34 %
Bupropion	2,326	92	2,175	97	-6.49 %
Paroxetine	2,120	96	2,119	98	-0.05 %
Pot Chloride	2,041	100	2,048	99	0.34 %
Tamsulosin	2,074	97	2,001	100	-3.52 %

Department of HUMAN SERVICES

CHANGE HEALTHCARE

Fee for Service Claims
Quarterly Statistics

	March through May 2022	June through August 2022	% CHANGE
TOTAL PAID AMOUNT	$2,375,352	$2,513,938	5.8%
UNIQUE USERS	3,712	3,532	-4.8%
COST PER USER	$639.91	$711.76	11.2%
TOTAL PRESCRIPTIONS	21,906	20,784	-5.1%
AVERAGE PRESCRIPTIONS PER USER	5.90	5.88	-0.4%
AVERAGE COST PER PRESCRIPTION	$108.43	$120.96	11.6%
# GENERIC PRESCRIPTIONS	19,333	18,333	-5.2%
% GENERIC	88.3%	88.2%	-0.1%
$ GENERIC	$816,140	$863,491	5.8%
AVERAGE GENERIC PRESCRIPTION COST	$42.21	$47.10	11.6%
AVERAGE GENERIC DAYS SUPPLY	29	29	0.0%
# BRAND PRESCRIPTIONS	2,573	2,451	-4.7%
% BRAND	11.7%	11.8%	0.4%
$ BRAND	$1,559,212	$1,650,447	5.9%
AVERAGE BRAND PRESCRIPTION COST	$605.99	$673.38	11.1%
AVERAGE BRAND DAYS SUPPLY	30	29	-3.3%

UTILIZATION BY AGE		
AGE	March through May 2022	June through August 2022
0-6	203	200
7-12	545	492
13-18	757	704
19-64	2,176	2,110
65+	31	26
	3,712	3,532

	UTILIZATION BY GENDER AND AGE		
GENDER	AGE	March through May 2022	June through August 2022
F			
	0-6	95	99
	7-12	226	199
	13-18	361	348
	19-64	1,350	1,311
	65+	18	15
		2,050	1,972
M			
	0-6	108	101
	7-12	319	293
	13-18	396	356
	19-64	826	799
	65+	13	11
		1,662	1,560

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2022

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	SIOUXLAND COMM HEALTH CTR PHARMA	SIOUX CITY	IA	781	$40,793.07	$52.23	2
2	MESKWAKI PHARMACY	TAMA	IA	696	$445,439.94	$640.00	1
3	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	547	$27,211.33	$49.75	4
4	WALGREENS #15647	SIOUX CITY	IA	537	$31,256.32	$58.21	5
5	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	498	$168,163.92	$337.68	3
6	THOMPSON-DEAN DRUG	SIOUX CITY	IA	382	$29,499.07	$77.22	6
7	WCHS PHARMACY	WINNEBAGO	NE	262	$167,680.00	$640.00	7
8	GENOA HEALTHCARE LLC	SIOUX CITY	IA	252	$20,601.48	$81.75	9
9	WALGREEN #04405	COUNCIL BLUFFS	IA	250	$15,401.04	$61.60	8
10	WALGREEN #910	SIOUX CITY	IA	181	$23,100.01	$127.62	10
11	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	177	$9,752.46	$55.10	13
12	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	164	$13,055.21	$79.60	27
13	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	160	$9,468.30	$59.18	12
14	WALGREEN COMPANY #05470	SIOUX CITY	IA	157	$7,256.70	$46.22	14
15	WALGREEN #05239	DAVENPORT	IA	148	$11,908.07	$80.46	11
16	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	142	$5,281.13	$37.19	16
17	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	138	$40,731.08	$295.15	19
18	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	137	$20,681.24	$150.96	23
19	WALGREEN COMPANY #05512	BETTENDORF	IA	129	$6,939.84	$53.80	32
20	CORNERSTONE APOTHECARY	BELLE PLAINE	IA	124	$8,522.99	$68.73	55
21	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	120	$3,348.41	$27.90	37
22	SMART SCRIPTS	WASHINGTON	IA	113	$5,393.16	$47.73	31
23	RIGHT DOSE PHARMACY	ANKENY	IA	111	$3,288.18	$29.62	20
24	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	107	$7,670.51	$71.69	15
25	MEDICAP PHARMACY	JEFFERSON	IA	107	$5,658.75	$52.89	28

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2022

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
26	IOWA VETERANS HOME	MARSHALLTOWN	IA	102	$5,905.88	$57.90	17
27	TOWNCREST PHARMACY	IOWA CITY	IA	101	$559.16	$5.54	75
28	WALGREEN #07454	ANKENY	IA	101	$4,490.26	$44.46	36
29	HY-VEE MAINSTREET PHARMACY #7070	SIOUX CITY	IA	101	$4,116.61	$40.76	33
30	NUCARA PHARMACY #27	PLEASANT HILL	IA	101	$5,743.80	$56.87	56
31	MEDICAP PHARMACY	KNOXVILLE	IA	100	$8,577.82	$85.78	18
32	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	98	$3,877.79	$39.57	103
33	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	98	$3,895.14	$39.75	25
34	UNITY POINT HEALTH PHARMACY	CEDAR RAPIDS	IA	93	$892.99	$9.60	46
35	ALL CARE HEALTH CENTER PHARMACY	COUNCIL BLUFFS	IA	88	$6,638.40	$75.44	22
36	COVENANT FAMILY PHARMACY	WATERLOO	IA	87	$1,524.92	$17.53	24
37	RASHID PHARMACY PLC	FORT MADISON	IA	86	$1,674.59	$19.47	29
38	HY-VEE PHARMACY (1271)	INDIANOLA	IA	84	$3,390.61	$40.36	43
39	ALYSSA VOSECKY	ANKENY	IA	83	$6,408.45	$77.21	67
40	MERCY MEDICAL CENTER NORTH IA DB	MASON CITY	IA	82	$5,261.16	$64.16	68
41	WALGREEN #05721	DES MOINES	IA	79	$9,017.21	$114.14	26
42	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	79	$2,378.59	$30.11	30
43	NUCARA PHARMACY #9	NEVADA	IA	79	$8,190.47	$103.68	40
44	GREENWOOD DRUG ON KIMBALL AVENUE	WATERLOO	IA	76	$10,786.91	$141.93	39
45	PHARMACY MATTERS LTC	IOWA CITY	IA	76	$602.53	$7.93	59
46	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	75	$4,773.85	$63.65	44
47	MEDICAP PHARMACY	WAUKEE	IA	73	$920.86	$12.61	86
48	HY VEE PHARMACY #1449	NEWTON	IA	73	$1,820.37	$24.94	54
49	HY-VEE PHARMACY #3 (1889)	WEST DES MOINES	IA	73	$977.15	$13.39	85
50	HY VEE PHARMACY 7072	TOLEDO	IA	71	$11,498.48	$161.95	52
51	COMMUNITY HEALTH CARE INC	DAVENPORT	IA	71	$1,203.62	$16.95	21

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
52	UI HEALTHCARE RIVER LANDING PHAR	CORALVILLE	IA	70	$2,672.59	$38.18	176
53	MEDICAP PHARMACY	GRIMES	IA	70	$1,750.16	$25.00	58
54	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	69	$2,496.74	$36.18	51
55	BOOTH PHARMACY	HAWARDEN	IA	68	$1,947.41	$28.64	63
56	WALGREEN COMPANYY #05060	CLIVE	IA	68	$1,156.34	$17.01	108
57	WALGREEN COMPANY 07455	WATERLOO	IA	67	$2,115.78	$31.58	60
58	VALUMED PHARMACY	CORALVILLE	IA	67	$7,679.74	$114.62	200
59	CVS PHARMACY #17554	CEDAR FALLS	IA	67	$6,422.67	$95.86	61
60	HY-VEE DRUGSTORE #7026	CEDAR RAPIDS	IA	67	$2,163.41	$32.29	49
61	STANGEL PHARMACY	ONAWA	IA	67	$3,134.85	$46.79	99
62	WALGREENS #07453	DES MOINES	IA	66	$8,148.56	$123.46	42
63	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	66	$2,532.17	$38.37	38
64	WALGREEN #03196	MARSHALLTOWN	IA	65	$2,138.66	$32.90	76
65	HARTIG PHARMACY SERVICES	DUBUQUE	IA	63	$10,208.88	$162.05	34
66	WALGREEN #03773	URBANDALE	IA	63	$3,449.40	$54.75	244
67	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	63	$5,147.94	$81.71	197
68	CASH SAVER	DES MOINES	IA	63	$7,208.00	$114.41	183
69	SUMMIT PHARMACY	FAIRFIELD	IA	62	$4,935.29	$79.60	113
70	MERCY OUTPATIENT PHARMACY	DES MOINES	IA	62	$1,699.44	$27.41	110
71	DRUGTOWN PHARMACY #1 (7020)	CEDAR RAPIDS	IA	62	$4,586.79	$73.98	53
72	WALGREEN #06678	WEST DES MOINES	IA	62	$2,514.43	$40.56	69
73	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	62	$2,765.96	$44.61	80
74	HY-VEE PHARMACY (1396)	MARION	IA	61	$996.90	$16.34	89
75	WAL-MART PHARMACY #10-1361	SIOUX CITY	IA	61	$3,684.94	$60.41	94
76	WALGREEN CO DBA	ALTOONA	IA	60	$1,649.79	$27.50	82
77	NUCARA PHARMACY #100	GREENFIELD	IA	59	$5,769.27	$97.78	128

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
78	WALGREEN #11709	DAVENPORT	IA	58	$6,947.12	$119.78	88
79	HY-VEE PHARMACY #2 (1160)	DUBUQUE	IA	58	$3,720.32	$64.14	169
80	MEDICAP PHARMACY	ANKENY	IA	58	$6,423.60	$110.75	64
81	HY-VEE STORE CLINIC 1023-039	GRIMES	IA	58	$872.57	$15.04	111
82	WALGREEN #04041	DAVENPORT	IA	57	$2,458.90	$43.14	133
83	WALGREEN #05361	FORT DODGE	IA	55	$3,896.38	$70.84	35
84	MEDICAP PHARMACY	INDIANOLA	IA	55	$1,301.07	$23.66	130
85	GREENVILLE PHARMACY INC	SIOUX CITY	IA	55	$3,965.88	$72.11	144
86	HY-VEE PHARMACY (1634)	STORM LAKE	IA	55	$8,620.98	$156.75	41
87	RASHID LONG TERM CARE PHARMACY	FORT MADISON	IA	55	$4,449.95	$80.91	115
88	HERITAGE PARK PHARMACY	WEST BURLINGTON	IA	55	$724.65	$13.18	74
89	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	54	$1,729.89	$32.04	155
90	WALGREEN #09708	DUBUQUE	IA	54	$3,040.63	$56.31	105
91	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	54	$1,081.90	$20.04	174
92	WRIGHTWAY LTC PHARMACY	CLINTON	IA	54	$3,978.53	$73.68	122
93	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	53	$8,214.16	$154.98	78
94	WAL-MART PHARMACY #10-0581	MARSHALLTOWN	IA	53	$2,485.49	$46.90	150
95	HY-VEE PHARMACY 1011	ALTOONA	IA	53	$850.08	$16.04	65
96	WALGREENS #07833	DES MOINES	IA	52	$1,130.31	$21.74	270
97	WALGREEN #7452	DES MOINES	IA	52	$1,395.05	$26.83	182
98	SERGEANT BLUFF PHARMACY	SERGEANT BLUFF	IA	52	$1,702.07	$32.73	109
99	MAHASKA DRUG INC	OSKALOOSA	IA	52	$1,054.78	$20.28	107
100	HY-VEE DRUGSTORE # 7042	IOWA CITY	IA	51	$1,954.79	$38.33	47

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	MESKWAKI PHARMACY	TAMA	IA	696	$445,439.94	$1,700.15	1
2	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	30	$169,344.08	$16,934.41	3
3	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	498	$168,163.92	$1,681.64	4
4	WCHS PHARMACY	WINNEBAGO	NE	262	$167,680.00	$1,711.02	2
5	CVS PHARMACY #00102	AURORA	CO	5	$68,672.13	$34,336.07	15
6	ACARIAHEALTH PHARMACY #11 INC	HOUSTON	TX	2	$51,299.52	$51,299.52	8
7	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	46	$41,926.53	$6,987.76	13
8	ANOVORX GROUP INC	MEMPHIS	TN	6	$41,385.77	$13,795.26	126
9	SIOUXLAND COMM HEALTH CTR PHARMA	SIOUX CITY	IA	781	$40,793.07	$283.29	10
10	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	138	$40,731.08	$1,071.87	6
11	CR CARE PHARMACY	CEDAR RAPIDS	IA	21	$35,003.88	$11,667.96	28
12	WALGREENS #15647	SIOUX CITY	IA	537	$31,256.32	$215.56	12
13	THOMPSON-DEAN DRUG	SIOUX CITY	IA	382	$29,499.07	$627.64	11
14	MEYER HEALTHMART PHARMACY	WAVERLY	IA	38	$28,176.06	$9,392.02	14
15	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	547	$27,211.33	$544.23	26
16	WALGREEN #910	SIOUX CITY	IA	181	$23,100.01	$537.21	25
17	COMMUNITY A WALGREENS PHARMACY	IOWA CITY	IA	9	$22,894.17	$11,447.09	17
18	OPTUM INFUSION SERVICES 550 LLC	URBANDALE	IA	3	$20,857.17	$20,857.17	18
19	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	137	$20,681.24	$544.24	38
20	GENOA HEALTHCARE LLC	SIOUX CITY	IA	252	$20,601.48	$664.56	22
21	OSTERHAUS PHARMACY	MAQUOKETA	IA	26	$20,074.88	$6,691.63	
22	COMM A WALGREENS PHARMACY #16528	DES MOINES	IA	10	$20,049.95	$5,012.49	318
23	WAL-MART PHARMACY #10-0985	FAIRFIELD	IA	46	$19,713.55	$2,464.19	16
24	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	9	$19,310.42	$6,436.81	9
25	OPTUM PHARMACY 705 LLC	FRANKLIN	TN	3	$17,975.42	$8,987.71	

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
26	FRED LEROY HEALTH & WELLNESS	OMAHA	NE	25	$16,000.00	$2,285.71	23
27	WALGREEN #04405	COUNCIL BLUFFS	IA	250	$15,401.04	$252.48	27
28	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	164	$13,055.21	$450.18	29
29	CAREMARK KANSAS SPEC PHARMACY LL	LENEXA	KS	32	$12,281.21	$1,228.12	21
30	WALGREEN #05239	DAVENPORT	IA	148	$11,908.07	$350.24	33
31	HY VEE PHARMACY 7072	TOLEDO	IA	71	$11,498.48	$638.80	40
32	GREENWOOD DRUG ON KIMBALL AVENUE	WATERLOO	IA	76	$10,786.91	$1,540.99	36
33	HARTIG PHARMACY SERVICES	DUBUQUE	IA	63	$10,208.88	$3,402.96	51
34	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	177	$9,752.46	$513.29	69
35	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	160	$9,468.30	$263.01	32
36	HY-VEE PHARMACY (1522)	PERRY	IA	18	$9,217.18	$1,843.44	50
37	WAL-MART PHARMACY #10-3394	ATLANTIC	IA	47	$9,061.43	$906.14	37
38	WALGREEN #05721	DES MOINES	IA	79	$9,017.21	$409.87	45
39	HY-VEE PHARMACY (1634)	STORM LAKE	IA	55	$8,620.98	$2,155.25	34
40	MEDICAP PHARMACY	KNOXVILLE	IA	100	$8,577.82	$1,225.40	46
41	CORNERSTONE APOTHECARY	BELLE PLAINE	IA	124	$8,522.99	$2,841.00	77
42	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	53	$8,214.16	$4,107.08	30
43	NUCARA PHARMACY #9	NEVADA	IA	79	$8,190.47	$1,365.08	57
44	WALGREENS #07453	DES MOINES	IA	66	$8,148.56	$543.24	44
45	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	47	$7,773.60	$1,554.72	47
46	CVS PHARMACY #17133	DES MOINES	IA	34	$7,749.60	$1,937.40	20
47	VALUMED PHARMACY	CORALVILLE	IA	67	$7,679.74	$1,535.95	338
48	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	107	$7,670.51	$284.09	41
49	PARAGON PARTNERS	OMAHA	NE	31	$7,443.83	$7,443.83	52
50	WALGREEN COMPANY #05470	SIOUX CITY	IA	157	$7,256.70	$168.76	58

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
51	CASH SAVER	DES MOINES	IA	63	$7,208.00	$1,802.00	91
52	CVS PHARMACY #10480	URBANDALE	IA	33	$7,201.13	$1,028.73	49
53	WALGREEN #11709	DAVENPORT	IA	58	$6,947.12	$771.90	81
54	WALGREEN COMPANY #05512	BETTENDORF	IA	129	$6,939.84	$462.66	111
55	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	48	$6,710.89	$2,236.96	48
56	ALL CARE HEALTH CENTER PHARMACY	COUNCIL BLUFFS	IA	88	$6,638.40	$442.56	68
57	DANIEL PHARMACY INC	FORT DODGE	IA	45	$6,511.27	$813.91	39
58	LEWIS FAMILY DRUG #59	SIOUX CENTER	IA	27	$6,426.68	$6,426.68	59
59	MEDICAP PHARMACY	ANKENY	IA	58	$6,423.60	$1,605.90	55
60	CVS PHARMACY #17554	CEDAR FALLS	IA	67	$6,422.67	$1,070.45	31
61	HY-VEE PHARMACY #2 (1023)	ANKENY	IA	83	$6,408.45	$640.85	96
62	THE NEBRASKA MED CENTER CLIN PHA	OMAHA	NE	40	$6,337.45	$792.18	56
63	HY VEE PHARMACY 1060	CEDAR RAPIDS	IA	47	$6,264.50	$569.50	66
64	HY-VEE PHARMACY 1297	JEFFERSON	IA	45	$6,226.56	$1,245.31	70
65	IOWA VETERANS HOME	MARSHALLTOWN	IA	102	$5,905.88	$1,181.18	42
66	NUCARA PHARMACY #100	GREENFIELD	IA	59	$5,769.27	$2,884.64	67
67	PELLA REGIONAL HEALTH CENTER PHA	PELLA	IA	26	$5,765.49	$960.92	87
68	NUCARA PHARMACY #27	PLEASANT HILL	IA	101	$5,743.80	$717.98	84
69	MEDICAP PHARMACY	JEFFERSON	IA	107	$5,658.75	$943.13	62
70	CHI HEALTH PHARMACY WEST BROADWA	COUNCIL BLUFFS	IA	16	$5,630.77	$1,876.92	85
71	PARKVIEW PHARMACY	NEVADA	IA	8	$5,601.79	$1,400.45	35
72	GENOA HEALTHCARE LLC	MASON CITY	IA	28	$5,477.67	$1,369.42	78
73	SMART SCRIPTS	WASHINGTON	IA	113	$5,393.16	$1,797.72	65
74	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	142	$5,281.13	$170.36	155
75	MERCY MEDICAL CENTER NORTH IA DB	MASON CITY	IA	82	$5,261.16	$876.86	89
76	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	63	$5,147.94	$643.49	157

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
77	HY-VEE PHARMACY #1 (1860)	WATERLOO	IA	43	$5,120.32	$1,024.06	97
78	WALGREENS #11759	FORT MADISON	IA	26	$5,015.34	$501.53	43
79	SUMMIT PHARMACY	FAIRFIELD	IA	62	$4,935.29	$2,467.65	75
80	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	75	$4,773.85	$397.82	98
81	FAIRVIEW SPECIALTY SERVICES PHAR	MINNEAPOLIS	MN	3	$4,650.61	$4,650.61	53
82	DRUGTOWN PHARMACY #1 (7020)	CEDAR RAPIDS	IA	62	$4,586.79	$352.83	60
83	CVS PHARMACY #16893	ANKENY	IA	46	$4,553.35	$1,517.78	54
84	WALGREEN #07454	ANKENY	IA	101	$4,490.26	$236.33	72
85	BETTER HEALTH INC DBA	MISSOURI VALLEY	IA	20	$4,450.37	$4,450.37	71
86	RASHID LONG TERM CARE PHARMACY	FORT MADISON	IA	55	$4,449.95	$4,449.95	103
87	WAL-MART PHARMACY #10-1389	BOONE	IA	35	$4,369.19	$728.20	74
88	MAYO CLINIC PHARMACY MARY BRIGH	ROCHESTER	MN	15	$4,339.41	$1,446.47	
89	WAL-MART PHARMACY #10-1241	DAVENPORT	IA	19	$4,289.16	$1,072.29	445
90	WAL-MART PHARMACY #10-0841	TIPTON	IA	35	$4,248.27	$606.90	118
91	WALGREENS #12580	CEDAR RAPIDS	IA	26	$4,185.31	$2,092.66	79
92	HY-VEE MAINSTREET PHARMACY #7070	SIOUX CITY	IA	101	$4,116.61	$147.02	92
93	WRIGHTWAY LTC PHARMACY	CLINTON	IA	54	$3,978.53	$3,978.53	99
94	MEDICAP PHARMACY	NORWALK	IA	36	$3,975.30	$795.06	104
95	GREENVILLE PHARMACY INC	SIOUX CITY	IA	55	$3,965.88	$360.53	95
96	WALGREEN #05361	FORT DODGE	IA	55	$3,896.38	$324.70	124
97	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	98	$3,895.14	$259.68	107
98	WALGREENS #11942	DUBUQUE	IA	32	$3,878.19	$646.37	191
99	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	98	$3,877.79	$143.62	166
100	HY-VEE PHARMACY #2 (1160)	DUBUQUE	IA	58	$3,720.32	$1,240.11	296

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1043418809	MICHAEL CILIBERTO	$56,538.50	215	5.81	1
2	1053340661	LEIGHTON E FROST MD	$116,619.84	190	2.47	2
3	1194888024	ALICIA D WAGER NP	$78,583.56	153	1.99	3
4	1902358443	MELISSA KONKEN ARNP	$10,784.36	139	9.27	4
5	1912991183	MOLLY EARLEYWINE PA	$3,633.77	123	5.59	6
6	1215125216	REBECCA E WALDING	$6,396.08	113	5.95	8
7	1780877878	CHRISTOPHER JACOBS ARNP	$4,579.36	103	5.42	21
8	1457584740	ERIC D MEYER ARNP	$2,279.68	92	6.13	10
9	1982605762	JEFFREY DEAN WILHARM MD	$689.14	92	13.14	9
10	1104251776	ANTHONY GLYDWELL DNP	$55,761.60	89	1.51	5
11	1871052472	CASSIDY ALANA CARR ARNP	$9,296.67	89	5.56	7
12	1619153137	JOADA JEAN BEST ARNP	$4,906.36	84	6.00	11
13	1699109595	TONYA K FLAUGH ARNP	$3,472.67	83	4.61	16
14	1003884107	RANDALL ALLEN KAVALIER DO	$995.92	82	5.47	24
15	1841220290	KENT E KUNZE MD	$2,397.78	82	9.11	13
16	1407836513	NATHAN R NOBLE DO	$1,163.34	78	3.55	12
17	1154929230	CHELSEA JONES ARNP	$46,730.39	74	2.96	25
18	1194722413	AIMEE LORENZ MD	$4,512.86	73	3.84	14
19	1073500690	KATHLEEN S ADAMS ARNP	$1,612.50	69	5.31	17
20	1447744362	EMMA JOHNSON PA-C	$5,817.80	69	17.25	56
21	1912208323	LISA MARIE MEYER ARNP	$13,111.77	67	4.79	30
22	1821568858	LEAH MARIE HAUBRICH ARNP	$993.73	64	16.00	15
23	1932547718	SEBASTIAN HARRIS MD	$4,952.87	64	32.00	31
24	1316389497	SHANNON STEWART ARNP	$14,218.60	63	5.73	19
25	1285602649	DAVID WELCH PA	$6,979.80	63	7.88	27
26	1336418425	DENA NEIMAN ARNP	$8,942.43	62	3.44	26

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
27	1538671961	JAMIE WRIGHT ARNP	$920.06	61	4.69	35
28	1609218304	AMANDA GARR ARNP	$5,505.86	61	10.17	23
29	1528037082	RODNEY JULIUS DEAN MD	$2,060.12	59	11.80	22
30	1093141129	LARRY MARTIN NEWMAN ARNP	$37,760.00	59	2.46	45
31	1164481362	MELISSA PEARSON ARNP	$37,120.00	58	1.14	790
32	1578174975	BRITTANY VONDRAK ARNP	$11,827.67	57	4.75	34
33	1275742090	ASHAR LUQMAN MD	$682.91	53	5.30	137
34	1144214248	KRISTI WALZ MD	$14,500.32	52	3.47	78
35	1326036062	JON AHRENDSEN MD	$1,608.45	52	8.67	62
36	1023641172	CHRISTA WIGGINS ARNP	$3,986.98	52	26.00	55
37	1023555638	CYNTHIA JEAN JOHNSON ARNP	$7,995.54	51	6.38	29
38	1013355759	DYLAN GREENE MD	$1,378.34	50	4.17	83
39	1013516566	ERIN HODGSON ARNP	$1,952.47	50	10.00	40
40	1821268335	JACQUELINE J MCINNIS	$1,373.36	50	8.33	39
41	1811123318	AARON KAUER MD	$4,745.47	49	8.17	53
42	1093272668	RICARDO OSARIO ARNP	$2,572.95	49	4.45	121
43	1649248378	KATHLEEN L WILD ARNP	$313.09	47	7.83	66
44	1659358620	CARLOS CASTILLO MD	$1,628.87	47	7.83	33
45	1447506217	THEODOSIA THOMA MD	$40,870.86	47	3.62	18
46	1619380680	TARA BROCKMAN DO	$3,981.86	47	7.83	50
47	1053376475	DANIEL GILLETTE MD	$1,681.33	47	15.67	42
48	1093034266	ERIC BOYUM MD	$2,038.16	46	9.20	58
49	1730173766	FRANK BABCOCK MD	$7,419.41	45	45.00	
50	1013191451	MICHELLE L VANDEBERG ARNP	$5,044.35	45	22.50	166
51	1699740159	FRANK SAM MARINO JR DO	$1,343.07	45	4.50	49
52	1891792206	ANN E REHAN MD	$2,462.21	45	2.25	72

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
53	1679669832	ERIN HATCHER ARNP	$3,078.21	44	6.29	64
54	1356337273	LISA JAYNE MENZIES MD	$600.19	43	3.91	116
55	1609131770	SREENATH THATI GANGANNA MBBS	$7,788.64	43	6.14	65
56	1144240805	DANIEL ROWLEY MD	$5,242.77	42	21.00	48
57	1225022809	FRANCES M JACKSON MD	$1,153.61	41	5.13	51
58	1851795033	PETER ROSEN ARNP	$651.75	40	20.00	52
59	1457346231	DAWN RENAE EBACH MD	$435.33	40	4.00	44
60	1831307701	KRISTIN MARSH	$643.61	40	13.33	172
61	1881088342	MEGAN LEHR DO	$746.02	40	8.00	71
62	1588838841	LEENU MISHRA MD	$487.82	40	5.71	54
63	1205249562	KELLY RYDER MD	$1,268.82	39	2.60	114
64	1285047951	BRIAN VOLD ARNP	$595.56	39	6.50	81
65	1811354483	RENEA LYNN KESTEL ARNP	$556.76	39	6.50	1492
66	1891076386	SARA E FLEECS ARNP	$708.89	39	39.00	127
67	1801145776	ANDREA LYNN HARRIS ARNP	$1,176.02	38	3.45	100
68	1164416269	ANN PICK ARNP	$483.90	37	4.11	59
69	1801998372	WENDY MICHELE HANSEN-PENMAN DO	$395.42	37	9.25	220
70	1073852059	AMBER HANSEN MD	$23,680.00	37	2.47	70
71	1639134034	ELIZABETH PRATT ARNP	$474.68	37	1.85	28
72	1700356334	BRIANNA SCHAFFER ARNP	$3,088.56	37	18.50	79
73	1861678997	ELIZABETH WESSLING PA	$542.48	37	1.95	207
74	1841293354	KEITH GUESS PA	$777.69	36	5.14	75
75	1891146999	BECKY L JOHNSON ARNP	$22,894.20	36	4.00	161
76	1396289229	JESSE BECKER ARNP	$2,063.46	36	3.60	216
77	1205169273	TERESA DOWLING ARNP	$345.07	36	12.00	43
78	1790135176	EMILY REITER PMH-NP	$6,757.01	35	8.75	125

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
June through August 2022

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
79	1811493679	JUNE MYLER ARNP	$22,400.00	35	1.94	84
80	1629430293	ALICE MENG MD	$1,158.81	35	1.84	32
81	1821423799	DOROTHY METZ ARNP	$4,419.82	35	17.50	191
82	1386044832	MARY GRIEDER ARNP	$511.14	35	7.00	147
83	1174583157	JOANNE STARR ARNP	$2,123.92	35	17.50	135
84	1164743357	ALISA M OLSON DO	$1,169.75	35	11.67	46
85	1619416013	HEATHER LYNN JACOBS NP-C	$383.35	34	6.80	47
86	1215996418	HILLARD SALAS MD	$2,012.55	34	34.00	77
87	1063497840	KAYE CLEVELAND ARNP	$753.07	33	8.25	60
88	1427164789	MICHAEL JAMES OURADA MD	$580.50	33	11.00	126
89	1073600755	THOMAS MORGAN MD	$452.67	33	6.60	68
90	1801430731	HAROLD HORN ARNP	$520.42	33	8.25	123
91	1730197476	MICHAEL BLAESS DO	$3,506.77	32	16.00	320
92	1780795393	JOHN LEE BOEDEKER DO	$442.89	32	16.00	107
93	1477950988	RIFALI VIMALKUMAR PATEL MD	$414.38	32	4.00	91
94	1609243013	CRISELLA TORRES MD	$4,291.89	32	6.40	38
95	1235124942	JULIE OSTERHAUS ARNP	$834.90	32	4.57	112
96	1528605367	JENNIFER MEETHER ARNP	$6,930.89	31	7.75	20
97	1508844465	MICHELE L FRIEDMAN ARNP	$379.17	31	15.50	893
98	1477652469	JILL JENSEN PA	$1,258.14	31	15.50	179
99	1023213030	REBECCA JOY TIMMER BENSON MD	$342.07	31	7.75	92
100	1891955423	LEAH SIEGFRIED PA	$1,519.57	31	6.20	151

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2022

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
1	1326034984	KATHERINE MATHEWS MD	$148,896.62	$5,514.69	27	1
2	1053340661	LEIGHTON E FROST MD	$116,619.84	$613.79	190	2
3	1194888024	ALICIA D WAGER NP	$78,583.56	$513.62	153	3
4	1043418809	MICHAEL CILIBERTO	$56,538.50	$262.97	215	19
5	1104251776	ANTHONY GLYDWELL DNP	$55,761.60	$626.53	89	4
6	1619021144	CHRISTOPHER M GIBBS MD	$51,299.52	$25,649.76	2	6
7	1194945691	ANJALI SHARATHKUMAR MBBS	$50,021.90	$10,004.38	5	2511
8	1154929230	CHELSEA JONES ARNP	$46,730.39	$631.49	74	7
9	1003079997	SARAH ANNE TOFILON MD	$41,414.38	$5,916.34	7	10
10	1447506217	THEODOSIA THOMA MD	$40,870.86	$869.59	47	149
11	1093141129	LARRY MARTIN NEWMAN ARNP	$37,760.00	$640.00	59	13
12	1366826109	ALYSSA D MRSNY PAC	$37,569.92	$3,415.45	11	14
13	1164481362	MELISSA PEARSON ARNP	$37,120.00	$640.00	58	1546
14	1861629578	HEIDI M CURRIER MD	$27,799.43	$2,779.94	10	11
15	1447488325	ABDELAZIZ ELHADDAD MD	$27,344.59	$5,468.92	5	1248
16	1831685023	JACLYN HULETT ARNP	$26,908.00	$6,727.00	4	1726
17	1073852059	AMBER HANSEN MD	$23,680.00	$640.00	37	18
18	1891146999	BECKY L JOHNSON ARNP	$22,894.20	$635.95	36	44
19	1770933046	SHELBY BILLER	$22,444.94	$1,246.94	18	97
20	1811493679	JUNE MYLER ARNP	$22,400.00	$640.00	35	24
21	1174817134	VUONG A NAYIMA DO	$22,196.69	$2,017.88	11	21
22	1255538344	SARAH FEDDERSEN PA	$19,447.86	$6,482.62	3	27
23	1952326530	LISA HEDRICK PA	$19,257.50	$9,628.75	2	1099
24	1275585259	MARK W NIEMER MD	$19,004.10	$3,167.35	6	25
25	1417307497	EMILY BOES DO	$18,881.41	$3,146.90	6	32
26	1841607900	SHAYLA SANDERS ARNP	$18,797.07	$2,685.30	7	16
27	1467441238	ANTONIO SANCHEZ	$17,291.68	$8,645.84	2	

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2022

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
28	1760675177	LORI SWANSON ARNP	$16,020.14	$616.16	26	20
29	1144214248	KRISTI WALZ MD	$14,500.32	$278.85	52	22
30	1316389497	SHANNON STEWART ARNP	$14,218.60	$225.69	63	29
31	1124518030	ANDREW JOSEPH SIMMS MD	$14,002.54	$3,500.64	4	36
32	1730473315	LYNDSAY ANNE HARSHMAN MD	$13,801.95	$492.93	28	48
33	1912208323	LISA MARIE MEYER ARNP	$13,111.77	$195.70	67	51
34	1356752067	KELLY L DELANEY-NELSON MD	$12,684.31	$1,585.54	8	1518
35	1578174975	BRITTANY VONDRAK ARNP	$11,827.67	$207.50	57	243
36	1609003433	DANIEL PAUL FULTON MD	$11,665.55	$1,296.17	9	116
37	1528485471	CHRISTINA GONZALEZ APRN	$11,503.69	$575.18	20	40
38	1780998559	JASON GILLESPIE ARNP	$10,880.00	$640.00	17	45
39	1902358443	MELISSA KONKEN ARNP	$10,784.36	$77.59	139	50
40	1255526430	ELAINE WIRRELL MD	$10,723.48	$369.78	29	100
41	1417931700	SUDHIR C KUMAR MD	$10,514.87	$3,504.96	3	55
42	1366402505	KUNAL K PATRA MD	$9,685.65	$484.28	20	33
43	1871052472	CASSIDY ALANA CARR ARNP	$9,296.67	$104.46	89	62
44	1205811940	NASSER ABU-ERREISH	$8,965.21	$8,965.21	1	8
45	1356357149	THOMAS FENNESSY MD	$8,960.00	$640.00	14	90
46	1336418425	DENA NEIMAN ARNP	$8,942.43	$144.23	62	47
47	1578777231	AMANDA LEIGH HECK ARNP	$8,708.03	$378.61	23	46
48	1619989605	JANELL SIMPKINS MD	$8,320.00	$640.00	13	98
49	1023555638	CYNTHIA JEAN JOHNSON ARNP	$7,995.54	$156.78	51	69
50	1558346015	DELWYN LASSEN MD	$7,918.01	$255.42	31	54
51	1013911692	JEFFREY SCOTT SARTIN MD	$7,887.11	$1,971.78	4	1624
52	1609131770	SREENATH THATI GANGANNA MBBS	$7,788.64	$181.13	43	37
53	1982124103	SABRINA MARTINEZ	$7,525.06	$250.84	30	65
54	1922455096	DEAN L GUERDET ARNP	$7,481.70	$311.74	24	42

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2022

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
55	1295217529	HEATHER STEHR ARNP	$7,442.56	$256.64	29	822
56	1730173766	FRANK BABCOCK MD	$7,419.41	$164.88	45	
57	1255319422	DAVID STAUB MD	$7,380.04	$1,476.01	5	38
58	1295091510	REBECCA WEINER MD	$7,221.89	$232.96	31	39
59	1538664149	LAURIE JORGENSEN ARNP	$7,005.29	$583.77	12	23
60	1285602649	DAVID WELCH PA	$6,979.80	$110.79	63	64
61	1114521721	TARRAH HOLLIDAY ARNP	$6,951.22	$408.90	17	58
62	1528605367	JENNIFER MEETHER ARNP	$6,930.89	$223.58	31	31
63	1629036546	ANITA T SIMINSON MD	$6,860.47	$236.57	29	61
64	1558357806	ROBIN HAYWARD PA	$6,820.53	$2,273.51	3	1443
65	1790135176	EMILY REITER PMH-NP	$6,757.01	$193.06	35	670
66	1952784662	MARIA V ROMERO ALVAREZ MD	$6,732.65	$1,122.11	6	60
67	1972879625	LAUREN KANNER MD	$6,417.34	$641.73	10	28
68	1215125216	REBECCA E WALDING	$6,396.08	$56.60	113	124
69	1689077018	STACY ROTH ARNP	$6,201.72	$295.32	21	111
70	1366634255	JULIE ESTELLE HANNA MD	$6,201.31	$1,550.33	4	71
71	1174512859	REBECCA SUE TUETEKEN	$6,001.88	$6,001.88	1	
72	1336150713	ZAID S AL-KADHIMI MD	$5,905.43	$656.16	9	70
73	1447744362	EMMA JOHNSON PA-C	$5,817.80	$84.32	69	95
74	1194990945	SANDEEP GUPTA MD	$5,667.55	$217.98	26	185
75	1790046548	LAURIE CLAIR PA	$5,592.33	$349.52	16	57
76	1245349182	MARK ANTHONY BURDT DO	$5,557.54	$1,111.51	5	35
77	1609218304	AMANDA GARR ARNP	$5,505.86	$90.26	61	43
78	1437185394	GALEN NATLEY BRENINGSTALL MD	$5,459.13	$454.93	12	79
79	1285844217	MIRAC INCE	$5,424.15	$2,712.08	2	2509
80	1144240805	DANIEL ROWLEY MD	$5,242.77	$124.83	42	81
81	1427464379	AKHILA RAMAKRISHNA MD	$5,166.30	$738.04	7	52

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2022

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
82	1104804822	MARY I HORN ARNP	$5,120.00	$640.00	8	9
83	1700808185	JENNIFER GOERBIG-CAMPBELL MD	$5,071.21	$362.23	14	82
84	1013191451	MICHELLE L VANDEBERG ARNP	$5,044.35	$112.10	45	304
85	1932547718	SEBASTIAN HARRIS MD	$4,952.87	$77.39	64	84
86	1619153137	JOADA JEAN BEST ARNP	$4,906.36	$58.41	84	63
87	1407170210	PEGGY A STRUEBING PA-C	$4,902.79	$377.14	13	133
88	1013978089	JENNIFER BRADLEY ARNP	$4,858.45	$186.86	26	67
89	1063837102	JODY LYNN ZOLONDEK ARNP	$4,841.78	$806.96	6	
90	1225414576	SARA E KUHN ARNP	$4,757.52	$226.55	21	87
91	1811123318	AARON KAUER MD	$4,745.47	$96.85	49	99
92	1639585359	ELIZABETH WOOSTER-PIERSON MD	$4,701.76	$940.35	5	122
93	1780877878	CHRISTOPHER JACOBS ARNP	$4,579.36	$44.46	103	127
94	1306470851	MICHELLE A RICHMOND ARNP	$4,570.12	$228.51	20	56
95	1952374811	ADRIAN PALAR MD	$4,545.76	$168.36	27	93
96	1053630640	JENNIFER A DONOVAN MD	$4,545.10	$909.02	5	106
97	1194722413	AIMEE LORENZ MD	$4,512.86	$61.82	73	76
98	1306349956	KATIE LADEHOFF ARNP	$4,480.00	$640.00	7	96
99	1932185543	JOSEPH LOZANO MD	$4,480.00	$640.00	7	128
100	1548484165	CARRIE L GRADY MD	$4,469.95	$212.85	21	80

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March through May 2022	RANK	% BUDGET	June through August 2022	RANK	% BUDGET	% CHANGE
ANTI-INFLAMMATORIES, NON-NSAID	$246,637	1	10.4%	$211,356	1	8.4%	-14.3%
ANTICONVULSANTS	$164,209	3	6.9%	$194,228	2	7.7%	18.3%
ANTIPSYCHOTICS - ATYPICALS	$171,124	2	7.2%	$183,721	3	7.3%	7.4%
ANTINEOPLASTICS - PROTEIN-TYROSINE KINASE INHIBITORS	$74,731	8	3.1%	$118,111	4	4.7%	58.0%
ANTIRETROVIRAL COMBINATIONS	$75,835	7	3.2%	$113,688	5	4.5%	49.9%
ANTIDEPRESSANTS - SELECTED SSRI'S	$89,126	5	3.8%	$102,211	6	4.1%	14.7%
MUSCULAR DYSTROPHY AGENTS	$98,068	4	4.1%	$92,924	7	3.7%	-5.2%
DIABETIC - INSULIN PENFILLS	$80,171	6	3.4%	$83,820	8	3.3%	4.6%
DIABETIC - NON-INSULIN INJECTABLES	$67,915	10	2.9%	$80,935	9	3.2%	19.2%
ANTIASTHMATIC - ADRENERGIC COMBOS	$68,449	9	2.9%	$78,198	10	3.1%	14.2%
GLUCOCORTICOIDS - MINERALOCORTICOIDS	$51,129	13	2.2%	$72,828	11	2.9%	42.4%
STIMULANTS - AMPHETAMINES - LONG ACTING	$64,108	11	2.7%	$61,884	12	2.5%	-3.5%
DIABETIC - OTHER	$52,976	12	2.2%	$57,395	13	2.3%	8.3%
ANTIASTHMATIC - BETA - ADRENERGICS	$45,450	14	1.9%	$52,620	14	2.1%	15.8%
ENDOCRINE METABOLIC AGENTS			%	$50,006	15	2.0%	%
CYSTIC FIBROSIS AGENTS	$43,520	15	1.8%	$41,911	16	1.7%	-3.7%
ANTIHISTAMINES - NON-SEDATING	$23,588	23	1.0%	$29,226	17	1.2%	23.9%
STIMULANTS - METHYLPHENIDATE - LONG ACTING	$27,767	19	1.2%	$26,770	18	1.1%	-3.6%
NSAIDS	$35,968	16	1.5%	$25,136	19	1.0%	-30.1%
ANTICOAGULANTS	$26,972	20	1.1%	$24,200	20	1.0%	-10.3%

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March through May 2022	PREV RANK	June through August 2022	CURR RANK	PERC CHANGE
ANTIDEPRESSANTS - SELECTED SSRI'S	2,517	1	2,377	1	-5.6%
ANTICONVULSANTS	1,739	2	1,667	2	-4.1%
ANTIPSYCHOTICS - ATYPICALS	983	3	963	3	-2.0%
ANTIHYPERTENSIVES - CENTRAL	798	4	755	4	-5.4%
GI - PROTON PUMP INHIBITOR	566	6	573	5	1.2%
ANTIASTHMATIC - BETA - ADRENERGICS	589	5	562	6	-4.6%
ANTIHISTAMINES - NON-SEDATING	542	7	522	7	-3.7%
STIMULANTS - AMPHETAMINES - LONG ACTING	491	8	442	8	-10.0%
ANTIHISTAMINES - OTHER	488	9	434	9	-11.1%
NARCOTICS - MISC.	478	10	432	10	-9.6%
CHOLESTEROL - HMG COA + ABSORB INHIBITORS	402	12	384	11	-4.5%
NSAIDS	382	14	370	12	-3.1%
BETA-LACTAMS / CLAVULANATE COMBO'S	475	11	369	13	-22.3%
MUSCLE RELAXANTS	339	17	362	14	6.8%
STIMULANTS - METHYLPHENIDATE - LONG ACTING	389	13	324	15	-16.7%
ACE INHIBITORS	342	16	320	16	-6.4%
GLUCOCORTICOIDS - MINERALOCORTICOIDS	365	15	318	17	-12.9%
DIABETIC - ORAL BIGUANIDES	304	21	304	18	0.0%
THYROID HORMONES	308	20	298	19	-3.2%
DIURETICS	337	18	295	20	-12.5%

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
HUMIRA PEN	$156,007.10	1	$122,553.89	1	-21.44%
EVRYSDI	$98,067.96	2	$92,923.72	2	-5.25%
BIKTARVY	$55,740.41	3	$80,284.94	3	44.03%
EMFLAZA	$39,953.49	8	$55,773.12	4	39.60%
TRULICITY	$39,401.53	9	$50,053.10	5	27.03%
VIJOICE		999	$50,005.76	6	%
INVEGA SUSTENNA	$35,617.57	11	$45,195.43	7	26.89%
VYVANSE	$53,883.01	4	$44,598.82	8	-17.23%
TRIKAFTA	$43,475.21	6	$41,775.56	9	-3.91%
VERZENIO	$27,572.76	15	$41,359.14	10	50.00%
FINTEPLA		999	$38,213.12	11	%
SUTENT	$35,860.84	10	$35,860.84	12	0.00%
PROAIR HFA	$35,289.21	12	$35,795.36	13	1.43%
ENBREL SURECLICK	$43,597.19	5	$31,565.64	14	-27.60%
SYMBICORT	$26,655.08	18	$30,799.54	15	15.55%
LANTUS SOLOSTAR	$26,261.11	21	$28,386.49	16	8.09%
LAMICTAL CHEWABLE DISPERS	$27,843.12	14	$27,664.29	17	-0.64%
KISQALI		999	$27,312.99	18	%
LATUDA	$40,916.89	7	$25,942.49	19	-36.60%
TALTZ	$18,849.54	26	$24,851.42	20	31.84%
OZEMPIC	$23,652.84	22	$24,612.59	21	4.06%
VRAYLAR	$26,285.33	20	$23,702.23	22	-9.83%
ESCITALOPRAM OXALATE TABLET	$16,314.69	30	$22,787.87	23	39.68%
GAMMAGARD LIQUID	$21,657.17	24	$22,057.17	24	1.85%
LISINOPRIL TABLET	$19,633.82	25	$21,771.02	25	10.89%
VIMPAT	$26,949.94	16	$21,479.66	26	-20.30%
JARDIANCE	$26,809.29	17	$20,891.56	27	-22.07%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
SAPROPTERIN DIHYDROCHLORIDE PACKET	$18,475.57	27	$19,447.86	28	5.26%
REXULTI	$13,805.70	35	$19,427.09	29	40.72%
ELIQUIS	$16,714.55	29	$19,354.15	30	15.79%
HUMIRA PEN-CD/UC/HS START		999	$19,239.95	31	%
MAVYRET	$26,420.76	19	$17,291.68	32	-34.55%
ARISTADA	$13,208.80	38	$16,960.85	33	28.41%
NORDITROPIN FLEXPRO	$29,538.79	13	$15,496.10	34	-47.54%
AMPHETAMINE-DEXTROAMPHETAMINE CAPSULE ER 24HR	$8,347.72	68	$15,487.41	35	85.53%
IBUPROFEN TABLET	$22,663.09	23	$15,386.09	36	-32.11%
ADVAIR DISKUS	$14,319.96	34	$15,050.73	37	5.10%
CETIRIZINE HCL TABLET	$13,690.67	36	$14,851.46	38	8.48%
SERTRALINE HCL TABLET	$11,764.40	42	$14,796.25	39	25.77%
FLOVENT HFA	$14,717.07	32	$13,970.08	40	-5.08%
LEVEMIR FLEXTOUCH	$12,042.72	41	$13,680.85	41	13.60%
TRESIBA FLEXTOUCH	$10,901.46	48	$13,646.81	42	25.18%
BANZEL	$8,821.11	63	$13,410.79	43	52.03%
AFINITOR	$10,953.02	47	$13,382.20	44	22.18%
FARXIGA	$9,565.25	57	$13,309.97	45	39.15%
INSULIN ASPART SOLN PEN-INJ	$9,058.68	61	$12,405.54	46	36.95%
SPIRIVA HANDIHALER	$13,195.47	39	$12,121.12	47	-8.14%
TRINTELLIX	$12,467.30	40	$12,030.00	48	-3.51%
ONFI	$16,034.22	31	$11,967.32	49	-25.36%
OMEPRAZOLE CAPSULE DR	$10,089.88	53	$11,395.84	50	12.94%
FLUTICASONE PROPIONATE (NASAL) SUSPENSION	$5,606.56	96	$11,039.35	51	96.90%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
AMLODIPINE BESYLATE TABLET	$17,671.35	28	$11,004.25	52	-37.73%
CHOLECALCIFEROL TABLET	$7,495.89	79	$10,926.73	53	45.77%
ATORVASTATIN CALCIUM TABLET	$9,240.89	58	$10,913.27	54	18.10%
GENVOYA	$10,525.14	49	$10,525.14	55	0.00%
JORNAY PM	$9,742.89	55	$10,464.44	56	7.41%
GUANFACINE HCL TABLET	$10,436.53	50	$10,334.01	57	-0.98%
RISPERDAL CONSTA	$11,058.02	44	$10,178.94	58	-7.95%
ABILIFY MAINTENA	$8,904.81	62	$10,006.79	59	12.38%
ODEFSEY	$7,273.17	80	$9,720.45	60	33.65%
PREDNISONE TABLET	$7,729.06	75	$9,639.50	61	24.72%
HYDROCODONE-ACETAMINOPHEN TABLET	$11,703.32	43	$9,457.24	62	-19.19%
ADVAIR HFA	$9,641.40	56	$9,381.41	63	-2.70%
SPIRIVA RESPIMAT	$8,809.52	64	$9,290.77	64	5.46%
INVEGA TRINZA		999	$8,919.26	65	%
METFORMIN HCL TABLET	$9,131.47	60	$8,914.91	66	-2.37%
METFORMIN HCL TABLET ER 24HR	$6,536.08	86	$8,847.68	67	35.37%
VENLAFAXINE HCL CAPSULE ER 24HR	$7,214.04	81	$8,821.28	68	22.28%
DESCOVY		999	$8,798.28	69	%
BUSPIRONE HCL TABLET	$6,624.84	84	$8,591.34	70	29.68%
ENTRESTO	$11,026.18	46	$8,335.75	71	-24.40%
PANTOPRAZOLE SODIUM TABLET DR	$6,630.60	83	$8,330.91	72	25.64%
LEVETIRACETAM TABLET	$4,173.16	125	$8,212.57	73	96.79%
CLONAZEPAM TABLET	$4,391.02	119	$8,173.13	74	86.13%
BUPROPION HCL TABLET ER 24HR	$5,404.73	101	$8,073.54	75	49.38%
LORATADINE TABLET	$5,855.12	92	$7,931.69	76	35.47%
PREZCOBIX	$6,654.57	82	$7,830.41	77	17.67%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
JANUVIA	$5,820.06	93	$7,823.37	78	34.42%
NAYZILAM	$8,488.09	67	$7,650.93	79	-9.86%
VENTOLIN HFA	$8,323.92	69	$7,480.56	80	-10.13%
SYNTHROID	$8,063.13	71	$7,394.86	81	-8.29%
LISINOPRIL & HYDROCHLOROTHIAZIDE TABLET	$6,064.09	90	$7,312.71	82	20.59%
SULFAMETHOXAZOLE-TRIMETHOPRIM TABLET	$7,736.73	74	$7,302.92	83	-5.61%
ONDANSETRON TABLET DISINT	$7,598.75	76	$7,186.63	84	-5.42%
LEVONORGESTREL-ETHINYL ESTRADIOL (91-DAY) TABLET	$4,560.87	114	$7,161.02	85	57.01%
METHYLPHENIDATE HCL TABLET ER	$10,149.34	52	$6,942.15	86	-31.60%
TRAZODONE HCL TABLET	$10,163.81	51	$6,934.91	87	-31.77%
FLUOXETINE HCL CAPSULE	$8,544.33	66	$6,845.81	88	-19.88%
KEPPRA	$2,573.73	185	$6,832.64	89	165.48%
AJOVY	$9,150.61	59	$6,764.34	90	-26.08%
INSULIN LISPRO SOLN PEN-INJ	$6,536.73	85	$6,705.42	91	2.58%
GABAPENTIN CAPSULE	$5,601.59	97	$6,438.44	92	14.94%
TRELEGY ELLIPTA	$6,302.48	88	$6,427.88	93	1.99%
VICTOZA	$4,860.80	110	$6,268.98	94	28.97%
EPIDIOLEX	$8,736.99	65	$6,205.77	95	-28.97%
EPINEPHRINE (ANAPHYLAXIS) SOLN AUTO-INJ	$3,651.80	141	$6,068.14	96	66.17%
HYDROXYZINE HCL TABLET	$5,738.47	94	$6,061.54	97	5.63%
FERROUS SULFATE TABLET	$3,997.25	128	$5,980.43	98	49.61%
DULOXETINE HCL CAPSULE DR PART	$4,214.08	124	$5,923.93	99	40.57%
QUILLICHEW ER	$7,567.36	77	$5,833.69	100	-22.91%

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
CLONIDINE HCL TABLET	407	3	393	1	-3.44%
TRAZODONE HCL TABLET	420	1	390	2	-7.14%
SERTRALINE HCL TABLET	410	2	369	3	-10.00%
ESCITALOPRAM OXALATE TABLET	358	4	361	4	0.84%
OMEPRAZOLE CAPSULE DR	349	5	351	5	0.57%
PROAIR HFA	305	7	305	6	0.00%
FLUOXETINE HCL CAPSULE	321	6	300	7	-6.54%
LISINOPRIL TABLET	298	8	285	8	-4.36%
ATORVASTATIN CALCIUM TABLET	282	9	273	9	-3.19%
LEVOTHYROXINE SODIUM TABLET	270	10	267	10	-1.11%
CETIRIZINE HCL TABLET	267	11	263	11	-1.50%
GABAPENTIN CAPSULE	246	16	250	12	1.63%
ARIPIPRAZOLE TABLET	259	14	249	13	-3.86%
QUETIAPINE FUMARATE TABLET	263	13	245	14	-6.84%
METHYLPHENIDATE HCL TABLET ER	266	12	228	15	-14.29%
AMPHETAMINE-DEXTROAMPHETAMINE CAPSULE ER 24HR	223	21	219	16	-1.79%
FLUTICASONE PROPIONATE (NASAL) SUSPENSION	204	26	217	17	6.37%
BUPROPION HCL TABLET ER 24HR	216	23	216	18	0.00%
HYDROXYZINE HCL TABLET	220	22	211	19	-4.09%
BUSPIRONE HCL TABLET	234	18	208	20	-11.11%
VYVANSE	250	15	208	21	-16.80%
POLYETHYLENE GLYCOL 3350 POWDER	225	20	204	22	-9.33%
PREDNISONE TABLET	227	19	200	23	-11.89%
LAMOTRIGINE TABLET	204	25	199	24	-2.45%

Department of HUMAN SERVICES

CHANGE HEALTHCARE

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
IBUPROFEN TABLET	214	24	196	25	-8.41%
GUANFACINE HCL TABLET	200	27	195	26	-2.50%
METFORMIN HCL TABLET	185	30	191	27	3.24%
HYDROCODONE-ACETAMINOPHEN TABLET	236	17	185	28	-21.61%
VENLAFAXINE HCL CAPSULE ER 24HR	158	36	180	29	13.92%
RISPERIDONE TABLET	191	29	179	30	-6.28%
PANTOPRAZOLE SODIUM TABLET DR	170	35	175	31	2.94%
DULOXETINE HCL CAPSULE DR PART	184	31	172	32	-6.52%
AMLODIPINE BESYLATE TABLET	199	28	159	33	-20.10%
MONTELUKAST SODIUM TABLET	181	32	158	34	-12.71%
CYCLOBENZAPRINE HCL TABLET	123	45	142	35	15.45%
HYDROXYZINE PAMOATE CAPSULE	170	34	132	36	-22.35%
CLONAZEPAM TABLET	120	47	131	37	9.17%
ONDANSETRON TABLET DISINT	171	33	129	38	-24.56%
PRAZOSIN HCL CAPSULE	148	37	127	39	-14.19%
FAMOTIDINE TABLET	111	55	124	40	11.71%
DEXMETHYLPHENIDATE HCL CAPSULE ER 24HR	143	38	124	41	-13.29%
TOPIRAMATE TABLET	125	43	117	42	-6.40%
BACLOFEN TABLET	135	40	117	43	-13.33%
CEPHALEXIN CAPSULE	120	46	115	44	-4.17%
VENTOLIN HFA	127	42	114	45	-10.24%
LEVETIRACETAM TABLET	118	50	113	46	-4.24%
LORATADINE TABLET	117	51	113	47	-3.42%
TRAMADOL HCL TABLET	96	61	113	48	17.71%
METFORMIN HCL TABLET ER 24HR	119	48	111	49	-6.72%
OXYCODONE HCL TABLET	89	66	110	50	23.60%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
FERROUS SULFATE TABLET	94	62	109	51	15.96%
FUROSEMIDE TABLET	115	52	105	52	-8.70%
CETIRIZINE HCL SOLUTION	118	49	104	53	-11.86%
MIRTAZAPINE TABLET	128	41	104	54	-18.75%
MELOXICAM TABLET	82	71	103	55	25.61%
AMOXICILLIN & POT CLAVULANATE TABLET	124	44	102	56	-17.74%
SULFAMETHOXAZOLE-TRIMETHOPRIM TABLET	102	59	99	57	-2.94%
METOPROLOL SUCCINATE TABLET ER 24HR	96	60	97	58	1.04%
MONTELUKAST SODIUM TABLET CHEWABLE	111	54	97	59	-12.61%
AMOXICILLIN FOR SUSPENSION	141	39	95	60	-32.62%
METRONIDAZOLE TABLET	83	70	93	61	12.05%
SYMBICORT	78	74	93	62	19.23%
AZITHROMYCIN TABLET	111	53	93	63	-16.22%
AMPHETAMINE-DEXTROAMPHETAMINE TABLET	110	56	90	64	-18.18%
ALBUTEROL SULFATE NEBULIZED SOLN	106	58	88	65	-16.98%
ATOMOXETINE HCL CAPSULE	107	57	85	66	-20.56%
OLANZAPINE TABLET	82	72	85	67	3.66%
ASPIRIN TABLET DR	82	73	84	68	2.44%
ONDANSETRON HCL TABLET	78	76	84	69	7.69%
NAPROXEN TABLET	73	79	83	70	13.70%
LANTUS SOLOSTAR	78	75	81	71	3.85%
ALPRAZOLAM TABLET	88	67	80	72	-9.09%
LORAZEPAM TABLET	73	80	79	73	8.22%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
TRIAMCINOLONE ACETONIDE (TOPICAL) CREAM	57	96	79	74	38.60%
LEVETIRACETAM SOLUTION	91	64	77	75	-15.38%
AMOXICILLIN CAPSULE	87	68	76	76	-12.64%
LOSARTAN POTASSIUM TABLET	68	83	75	77	10.29%
PROPRANOLOL HCL TABLET	73	78	74	78	1.37%
FOLIC ACID TABLET	61	91	72	79	18.03%
ACETAMINOPHEN TABLET	56	97	71	80	26.79%
DOXYCYCLINE (MONOHYDRATE) CAPSULE	92	63	71	81	-22.83%
METOPROLOL TARTRATE TABLET	58	94	70	82	20.69%
HYDROCHLOROTHIAZIDE TABLET	70	82	67	83	-4.29%
GUANFACINE HCL (ADHD) TABLET ER 24HR	91	65	66	84	-27.47%
TRULICITY	50	103	66	85	32.00%
FLOVENT HFA	85	69	65	86	-23.53%
CARVEDILOL TABLET	68	84	63	87	-7.35%
SPIRONOLACTONE TABLET	74	77	60	88	-18.92%
GABAPENTIN TABLET	62	87	59	89	-4.84%
FLUCONAZOLE TABLET	49	107	58	90	18.37%
NITROFURANTOIN MONOHYD MACRO CAPSULE	49	108	57	91	16.33%
MUPIROCIN OINTMENT	60	93	57	92	-5.00%
ROSUVASTATIN CALCIUM TABLET	52	102	56	93	7.69%
OXCARBAZEPINE TABLET	65	86	55	94	-15.38%
CITALOPRAM HYDROBROMIDE TABLET	70	81	54	95	-22.86%
VALACYCLOVIR HCL TABLET	49	104	53	96	8.16%
AMITRIPTYLINE HCL TABLET	62	88	52	97	-16.13%

TOP 100 DRUGS BY PRESCRIPTION COUNT					
DRUG DESCRIPTION	March through May 2022	PREVIOUS RANK	June through August 2022	RANK	PERCENT CHANGE
CHLORHEXIDINE GLUCONATE (MOUTH-THROAT) SOLUTION	42	119	51	98	21.43%
DIVALPROEX SODIUM TABLET ER 24HR	52	100	51	99	-1.92%
PREGABALIN CAPSULE	61	90	50	100	-18.03%

Quarterly Monthly Statistics

CATEGORY	March 2022 / May 2022	June 2022 / August 2022	% CHANGE
TOTAL PAID AMOUNT	$128,895,825	$129,596,815	0.5%
UNIQUE USERS	176,898	172,028	-2.8%
COST PER USER	$728.64	$753.35	3.4%
TOTAL PRESCRIPTIONS	1,158,155	1,134,449	-2.0%
AVERAGE PRESCRIPTIONS PER USER	6.55	6.59	0.7%
AVERAGE COST PER PRESCRIPTION	$111.29	$114.24	2.6%
# GENERIC PRESCRIPTIONS	1,032,844	1,011,635	-2.1%
% GENERIC	89.18%	89.17%	0.0%
$ GENERIC	$21,343,383	$21,524,246	0.8%
AVERAGE GENERIC PRESCRIPTION COST	$20.66	$21.28	3.0%
AVERAGE GENERIC DAYS SUPPLY	31.47	32.11	2.0%
# BRAND PRESCRIPTIONS	125,311	122,814	-2.0%
% BRAND	10.82%	10.83%	0.1%
$ BRAND	$107,552,441	$108,072,569	0.5%
AVERAGE BRAND PRESCRIPTION COST	$858.28	$879.97	2.5%
AVERAGE BRAND DAYS SUPPLY	31.34	31.20	-0.5%

UTILIZATION BY AGE		
AGE	March 2022 / May 2022	June 2022 / August 2022
0-6	57,972	47,933
7-12	80,003	73,265
13-18	109,677	104,371
19-64	910,329	908,730
65+	10,017	9,965
TOTAL	1,167,998	1,144,264

	UTILIZATION BY GENDER AND AGE		
GENDER	AGE	March 2022 / May 2022	June 2022 / August 2022
F	0-6	25,529	21,070
	7-12	30,646	27,922
	13-18	58,639	55,349
	19-64	608,003	607,607
	65+	6,447	6,314
	Gender Total	729,264	718,262
M	0-6	32,443	26,863
	7-12	49,357	45,343
	13-18	51,038	49,022
	19-64	302,326	301,123
	65+	3,570	3,651
	Gender Total	438,734	426,002
Grand Total		1,167,998	1,144,264

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June 2022 / August 2022

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	AMBULATORY CARE PHARMACY	IOWA CITY	IA	14,905	$6,740,659.51	$452.24	1
2	WALGREENS #4405	COUNCIL BLUFFS	IA	12,942	$1,114,722.78	$86.13	2
3	WALGREENS #5239	DAVENPORT	IA	12,134	$861,284.97	$70.98	3
4	WALGREENS #5042	CEDAR RAPIDS	IA	9,161	$647,979.41	$70.73	4
5	WALGREENS #359	DES MOINES	IA	7,540	$565,969.81	$75.06	7
6	WALGREENS #5721	DES MOINES	IA	7,232	$485,114.29	$67.08	6
7	WALGREENS #7455	WATERLOO	IA	7,101	$440,859.60	$62.08	5
8	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	6,946	$359,817.46	$51.80	10
9	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	6,825	$661,926.73	$96.99	8
10	WALGREENS #3700	COUNCIL BLUFFS	IA	6,611	$531,907.92	$80.46	11
11	DRILLING PHARMACY	SIOUX CITY	IA	6,291	$463,061.81	$73.61	13
12	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	6,234	$688,183.48	$110.39	9
13	WALGREENS #15647	SIOUX CITY	IA	5,996	$431,669.93	$71.99	12
14	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	5,914	$416,980.92	$70.51	14
15	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	5,537	$521,822.63	$94.24	15
16	WALGREENS #7453	DES MOINES	IA	5,303	$344,827.71	$65.03	16
17	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	5,226	$380,382.29	$72.79	17
18	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	5,024	$365,516.08	$72.75	24
19	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	4,918	$393,540.05	$80.02	18
20	WALGREENS #3595	DAVENPORT	IA	4,820	$294,687.00	$61.14	26
21	HY-VEE PHARMACY (1075)	CLINTON	IA	4,809	$407,496.23	$84.74	21
22	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	4,791	$370,262.05	$77.28	25

23	MERCYONE DUBUQUE ELM PHARMACY	DUBUQUE	IA	4,763	$347,181.19	$72.89	27
24	MAHASKA DRUGS INC	OSKALOOSA	IA	4,722	$351,086.99	$74.35	20
25	WALGREENS #4041	DAVENPORT	IA	4,713	$285,374.65	$60.55	19
26	WALMART PHARMACY 10-1509	MAQUOKETA	IA	4,623	$395,671.19	$85.59	22
27	WALGREENS #5044	BURLINGTON	IA	4,518	$282,465.83	$62.52	29
28	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	4,438	$200,952.20	$45.28	28
29	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	4,437	$343,263.30	$77.36	23
30	WALGREENS #9708	DUBUQUE	IA	4,391	$275,666.36	$62.78	30
31	HY-VEE PHARMACY (1449)	NEWTON	IA	4,276	$316,343.73	$73.98	31
32	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	4,211	$330,506.42	$78.49	33
33	HY-VEE PHARMACY (1850)	WASHINGTON	IA	4,199	$231,357.01	$55.10	34
34	HY-VEE PHARMACY (1396)	MARION	IA	4,150	$346,342.96	$83.46	32
35	REUTZEL PHARMACY	CEDAR RAPIDS	IA	4,104	$340,536.48	$82.98	41
36	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	4,053	$359,606.19	$88.73	37
37	RIGHT DOSE PHARMACY	ANKENY	IA	4,053	$295,153.96	$72.82	42
38	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	4,030	$313,509.62	$77.79	38
39	WALGREENS #11942	DUBUQUE	IA	3,977	$304,286.21	$76.51	35
40	SOUTH SIDE DRUG	OTTUMWA	IA	3,942	$382,617.58	$97.06	52
41	WALGREENS #7454	ANKENY	IA	3,940	$264,404.68	$67.11	36
42	HY-VEE PHARMACY (1459)	OELWEIN	IA	3,932	$273,162.73	$69.47	39
43	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,906	$393,203.15	$100.67	40
44	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,871	$273,578.39	$70.67	49
45	STANGEL PHARMACY	ONAWA	IA	3,827	$287,690.78	$75.17	43
46	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	3,786	$245,662.06	$64.89	46
47	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,784	$291,605.75	$77.06	53
48	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,781	$316,818.29	$83.79	58

49	WALGREENS #5470	SIOUX CITY	IA	3,773	$291,008.84	$77.13	47
50	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	3,722	$281,526.58	$75.64	44
51	HY-VEE PHARMACY (1433)	MT PLEASANT	IA	3,702	$255,988.91	$69.15	54
52	HARTIG PHARMACY SERVICES	DUBUQUE	IA	3,664	$276,720.90	$75.52	51
53	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	3,662	$355,521.01	$97.08	57
54	WALGREENS #3875	CEDAR RAPIDS	IA	3,638	$307,230.84	$84.45	55
55	WALGREENS #5119	CLINTON	IA	3,630	$236,353.04	$65.11	48
56	WALGREENS #5886	KEOKUK	IA	3,620	$260,435.83	$71.94	50
57	CVS PHARMACY #10282	FORT DODGE	IA	3,589	$247,603.76	$68.99	69
58	WALGREENS #7452	DES MOINES	IA	3,541	$261,994.10	$73.99	56
59	NUCARA LTC PHARMACY #3	IOWA CITY	IA	3,509	$118,014.01	$33.63	45
60	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	3,464	$279,114.70	$80.58	63
61	CVS PHARMACY #08546	WATERLOO	IA	3,457	$284,596.14	$82.32	61
62	RASHID PHARMACY PLC	FORT MADISON	IA	3,435	$59,996.40	$17.47	60
63	HY-VEE PHARMACY #4 (1060)	CEDAR RAPIDS	IA	3,412	$299,225.77	$87.70	59
64	WAGNER PHARMACY	CLINTON	IA	3,400	$231,935.83	$68.22	79
65	HY-VEE PHARMACY (1065)	CHARITON	IA	3,391	$260,117.87	$76.71	67
66	HY-VEE PHARMACY #1 (1105)	DAVENPORT	IA	3,360	$229,261.63	$68.23	65
67	WALMART PHARMACY 10-0985	FAIRFIELD	IA	3,356	$209,507.98	$62.43	64
68	WALMART PHARMACY 10-0784	MT PLEASANT	IA	3,350	$241,448.71	$72.07	71
69	DANIEL PHARMACY	FT DODGE	IA	3,333	$249,787.83	$74.94	73
70	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	3,322	$117,464.25	$35.36	62
71	SCOTT PHARMACY	FAYETTE	IA	3,321	$249,226.45	$75.05	68
72	WALMART PHARMACY 10-3394	ATLANTIC	IA	3,289	$233,241.15	$70.92	70
73	MERCYONE FOREST PARK PHARMACY	MASON CITY	IA	3,244	$243,472.28	$75.05	75
74	WALMART PHARMACY 10-2889	CLINTON	IA	3,219	$237,345.19	$73.73	78

75	LAGRANGE PHARMACY	VINTON	IA	3,216	$294,550.73	$91.59	74
76	WALMART PHARMACY 10-3590	SIOUX CITY	IA	3,195	$244,068.68	$76.39	81
77	HY-VEE PHARMACY (1180)	FAIRFIELD	IA	3,177	$264,474.83	$83.25	76
78	WALGREENS #5362	DES MOINES	IA	3,160	$192,367.17	$60.88	88
79	WALGREENS #5852	DES MOINES	IA	3,102	$246,133.07	$79.35	82
80	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	3,076	$191,646.48	$62.30	94
81	HY-VEE PHARMACY #1 (1281)	IOWA CITY	IA	3,058	$201,808.71	$65.99	66
82	WALGREENS #11709	DAVENPORT	IA	3,057	$257,420.79	$84.21	91
83	HY-VEE PHARMACY (1522)	PERRY	IA	3,052	$252,745.94	$82.81	80
84	WALMART PHARMACY 10-1723	DES MOINES	IA	3,030	$219,611.29	$72.48	83
85	MEDICAP PHARMACY	KNOXVILLE	IA	3,015	$294,930.66	$97.82	85
86	WALMART PHARMACY 10-0646	ANAMOSA	IA	3,009	$243,593.68	$80.96	86
87	HY-VEE PHARMACY (1071)	CLARINDA	IA	3,007	$279,873.42	$93.07	77
88	HY-VEE PHARMACY (1382)	LEMARS	IA	2,977	$280,907.93	$94.36	93
89	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,969	$193,712.61	$65.25	108
90	WALMART PHARMACY 10-5115	DAVENPORT	IA	2,968	$281,344.27	$94.79	89
91	WALGREENS #5777	DES MOINES	IA	2,964	$204,878.75	$69.12	72
92	MEDICAP PHARMACY	NEWTON	IA	2,874	$226,018.77	$78.64	109
93	HY-VEE PHARMACY #2 (1018)	AMES	IA	2,870	$222,888.71	$77.66	96
94	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,863	$259,403.34	$90.61	87
95	WALGREENS #4714	DES MOINES	IA	2,861	$225,312.49	$78.75	101
96	MEDICAP PHARMACY	RED OAK	IA	2,860	$227,915.35	$79.69	102
97	HY-VEE PHARMACY (1009)	ALBIA	IA	2,853	$156,904.77	$55.00	100
98	WALGREENS #5077	IOWA CITY	IA	2,842	$181,350.34	$63.81	90
99	HY-VEE PHARMACY (1481)	OSKALOOSA	IA	2,838	$248,909.91	$87.71	103
100	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	2,835	$293,466.59	$103.52	92

TOP 100 PHARMACIES BY PAID AMOUNT
June 2022 / August 2022

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	AMBULATORY CARE PHARMACY	IOWA CITY	IA	14,905	$6,740,659.51	$2,278.02	1
2	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	996	$6,229,092.38	$14,385.89	2
3	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	287	$2,911,995.10	$29,714.24	4
4	COMMUNITY, A WALGREENS PHARMACY #16528	DES MOINES	IA	603	$2,824,869.91	$12,228.87	3
5	UNITYPOINT AT HOME	URBANDALE	IA	907	$2,409,831.24	$8,859.67	5
6	CVS/SPECIALTY	MONROEVILLE	PA	277	$2,224,376.36	$20,596.08	6
7	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	2,249	$2,075,498.28	$9,063.31	7
8	CVS PHARMACY #00102	AURORA	CO	253	$2,060,408.83	$22,893.43	9
9	COMMUNITY, A WALGREENS PHARMACY #21250	IOWA CITY	IA	625	$1,780,148.05	$5,993.76	10
10	HY-VEE PHARMACY SOLUTIONS	OMAHA	NE	247	$1,600,520.62	$15,846.74	8
11	WALGREENS #4405	COUNCIL BLUFFS	IA	12,942	$1,114,722.78	$451.12	12
12	ALLIANCERX WALGREENS PHARMACY #16280	FRISCO	TX	61	$1,089,217.15	$83,785.93	11
13	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	82	$1,086,803.27	$33,962.60	13
14	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	89	$1,083,073.32	$38,681.19	14
15	KROGER SPECIALTY PHARMACY LA	HARVEY	LA	114	$983,670.75	$20,493.14	17
16	WALGREENS #5239	DAVENPORT	IA	12,134	$861,284.97	$330.50	15
17	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	27	$746,942.42	$82,993.60	22
18	AMBER SPECIALTY PHARMACY	OMAHA	NE	180	$707,997.46	$15,391.25	16
19	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	6,234	$688,183.48	$851.71	18
20	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	18	$677,198.16	$84,649.77	19
21	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	6,825	$661,926.73	$450.60	21
22	WALGREENS #5042	CEDAR RAPIDS	IA	9,161	$647,979.41	$292.41	20

23	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	83	$631,297.27	$15,397.49	24
24	WALGREENS #359	DES MOINES	IA	7,540	$565,969.81	$321.57	27
25	HY-VEE PHARMACY SOLUTIONS	DES MOINES	IA	109	$558,916.09	$12,702.64	23
26	WALGREENS #3700	COUNCIL BLUFFS	IA	6,611	$531,907.92	$430.35	28
27	ORSINI PHARMACEUTICAL SERVICES LLC	ELK GROVE VILLAGE	IL	28	$528,527.99	$75,504.00	25
28	WALGREENS #16270	OMAHA	NE	183	$523,768.97	$11,903.84	26
29	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	5,537	$521,822.63	$545.27	32
30	CR CARE PHARMACY	CEDAR RAPIDS	IA	2,162	$519,732.38	$2,547.71	33
31	WALGREENS #5721	DES MOINES	IA	7,232	$485,114.29	$255.05	29
32	DRILLING PHARMACY	SIOUX CITY	IA	6,291	$463,061.81	$783.52	37
33	EVERSANA LIFE SCIENCE SERVICES, LLC	CHESTERFIELD	MO	20	$446,614.79	$63,802.11	34
34	WALGREENS #7455	WATERLOO	IA	7,101	$440,859.60	$256.31	31
35	WALGREENS #15647	SIOUX CITY	IA	5,996	$431,669.93	$324.81	35
36	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,973	$426,648.72	$2,133.24	65
37	THE NEBRASKA MEDICAL CENTER CLINIC PHARMACY	OMAHA	NE	819	$421,721.71	$2,382.61	61
38	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	5,914	$416,980.92	$394.12	41
39	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	2,111	$413,704.93	$2,955.04	36
40	HY-VEE PHARMACY (1075)	CLINTON	IA	4,809	$407,496.23	$539.02	43
41	ANOVORX GROUP LLC	MEMPHIS	TN	39	$398,140.83	$33,178.40	98
42	WALMART PHARMACY 10-1509	MAQUOKETA	IA	4,623	$395,671.19	$502.12	40
43	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	4,918	$393,540.05	$454.96	38
44	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,906	$393,203.15	$612.47	46
45	SOUTH SIDE DRUG	OTTUMWA	IA	3,942	$382,617.58	$696.94	48
46	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	5,226	$380,382.29	$481.50	47
47	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	4,791	$370,262.05	$538.95	44
48	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	5,024	$365,516.08	$471.63	50

49	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	6,946	$359,817.46	$388.15	75
50	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	4,053	$359,606.19	$686.27	58
51	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	3,662	$355,521.01	$701.22	39
52	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	1,915	$353,448.85	$1,584.97	49
53	MAHASKA DRUGS INC	OSKALOOSA	IA	4,722	$351,086.99	$552.02	52
54	MERCYONE DUBUQUE ELM PHARMACY	DUBUQUE	IA	4,763	$347,181.19	$753.10	57
55	HY-VEE PHARMACY (1396)	MARION	IA	4,150	$346,342.96	$464.27	51
56	WALGREENS #7453	DES MOINES	IA	5,303	$344,827.71	$303.81	42
57	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	4,437	$343,263.30	$401.48	45
58	REUTZEL PHARMACY	CEDAR RAPIDS	IA	4,104	$340,536.48	$1,094.97	54
59	WALMART PHARMACY 10-1621	CENTERVILLE	IA	2,138	$334,116.39	$795.52	55
60	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	4,211	$330,506.42	$446.63	63
61	INFOCUS PHARMACY SERVICES	DUBUQUE	IA	2,251	$323,379.41	$1,341.82	101
62	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,781	$316,818.29	$542.50	91
63	HY-VEE PHARMACY (1449)	NEWTON	IA	4,276	$316,343.73	$467.27	59
64	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	4,030	$313,509.62	$364.12	53
65	WALGREENS #3875	CEDAR RAPIDS	IA	3,638	$307,230.84	$397.45	85
66	WALGREENS #11942	DUBUQUE	IA	3,977	$304,286.21	$376.13	56
67	ALLEN CLINIC PHARMACY	WATERLOO	IA	1,208	$304,148.45	$822.02	161
68	MEDICAP PHARMACY	DES MOINES	IA	2,491	$301,446.38	$1,389.15	87
69	HY-VEE PHARMACY #4 (1060)	CEDAR RAPIDS	IA	3,412	$299,225.77	$470.48	73
70	RIGHT DOSE PHARMACY	ANKENY	IA	4,053	$295,153.96	$1,021.29	72
71	MEDICAP PHARMACY	KNOXVILLE	IA	3,015	$294,930.66	$921.66	81
72	WALGREENS #3595	DAVENPORT	IA	4,820	$294,687.00	$274.38	84
73	LAGRANGE PHARMACY	VINTON	IA	3,216	$294,550.73	$645.94	64
74	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	2,835	$293,466.59	$598.91	69

75	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,784	$291,605.75	$501.04	71
76	WALGREENS #11759	FORT MADISON	IA	2,575	$291,277.21	$659.00	94
77	WALGREENS #5470	SIOUX CITY	IA	3,773	$291,008.84	$377.93	93
78	STANGEL PHARMACY	ONAWA	IA	3,827	$287,690.78	$628.15	79
79	WALGREENS #4041	DAVENPORT	IA	4,713	$285,374.65	$263.02	67
80	CVS PHARMACY #08546	WATERLOO	IA	3,457	$284,596.14	$454.63	80
81	WALGREENS #5044	BURLINGTON	IA	4,518	$282,465.83	$300.18	86
82	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	3,722	$281,526.58	$454.08	83
83	WALMART PHARMACY 10-5115	DAVENPORT	IA	2,968	$281,344.27	$491.00	90
84	HY-VEE PHARMACY (1382)	LEMARS	IA	2,977	$280,907.93	$605.41	78
85	HY-VEE PHARMACY (1071)	CLARINDA	IA	3,007	$279,873.42	$627.52	77
86	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	3,464	$279,114.70	$502.00	102
87	JUNE E. NYLEN CANCER CENTER	SIOUX CITY	IA	30	$276,748.27	$27,674.83	156
88	HARTIG PHARMACY SERVICES	DUBUQUE	IA	3,664	$276,720.90	$988.29	88
89	WALGREENS #9708	DUBUQUE	IA	4,391	$275,666.36	$259.08	92
90	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	111	$275,003.98	$9,482.90	66
91	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	1,683	$274,914.96	$938.28	109
92	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,871	$273,578.39	$687.38	95
93	HY-VEE PHARMACY (1459)	OELWEIN	IA	3,932	$273,162.73	$426.15	70
94	FIFIELD PHARMACY	DES MOINES	IA	2,163	$271,465.73	$1,317.79	74
95	BIOLOGICS BY MCKESSON	CARY	NC	17	$271,046.06	$45,174.34	68
96	HY-VEE PHARMACY (1180)	FAIRFIELD	IA	3,177	$264,474.83	$520.62	131
97	WALGREENS #7454	ANKENY	IA	3,940	$264,404.68	$302.18	76
98	GENOA HEALTHCARE, LLC	FORT DODGE	IA	1,581	$263,918.96	$2,399.26	133
99	WALGREENS #7452	DES MOINES	IA	3,541	$261,994.10	$329.55	112
100	WALGREENS #5886	KEOKUK	IA	3,620	$260,435.83	$451.36	100

TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
June 2022 / August 2022

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$164,047.25	2,951	6.12	1
2	1073945499	Jennifer Zalaznik	$160,500.87	2,144	4.01	4
3	1922455096	Dean Guerdet	$257,178.26	2,141	3.12	5
4	1467502286	Charles Tilley	$251,329.75	2,010	3.73	3
5	1215146055	Rebecca Wolfe	$123,314.94	1,968	2.61	8
6	1013115369	Bobbita Nag	$85,619.26	1,938	2.14	2
7	1790013209	Tracy Tschudi	$228,616.73	1,904	2.90	9
8	1215125216	Rebecca Walding	$215,284.45	1,841	3.78	6
9	1467907394	Cynthia Coenen	$196,769.47	1,840	3.38	10
10	1730434069	Larissa Biscoe	$116,278.68	1,726	2.70	19
11	1437238110	Genevieve Nelson	$165,576.76	1,711	3.04	7
12	1659358620	Carlos Castillo	$97,492.12	1,706	3.01	12
13	1902912538	Christian Jones	$96,559.19	1,652	2.61	15
14	1437209434	Jon Thomas	$91,518.23	1,629	2.46	29
15	1447680848	Mindy Roberts	$172,064.08	1,583	2.37	14
16	1982030946	Jacklyn Besch	$76,977.56	1,577	2.92	11
17	1609218304	Amanda Garr	$230,719.16	1,552	3.02	31
18	1316356496	Kimberly Roberts	$75,253.23	1,544	3.02	23
19	1043434525	Robert Kent	$93,632.81	1,542	3.04	26
20	1841293354	Keith Guess	$60,720.78	1,542	2.55	28
21	1457584740	Eric Meyer	$125,382.22	1,540	2.63	16
22	1063491645	Allyson Wheaton	$110,422.73	1,519	2.29	16
23	1164538674	Joseph Wanzek	$113,618.83	1,506	4.02	22

24	1902850845	Deborah Bahe	$159,424.19	1,501	3.97	21
25	1043211303	Ali Safdar	$275,559.90	1,478	2.29	18
26	1477199198	Sajo Thomas	$184,643.51	1,465	3.05	27
27	1770933046	Shelby Biller	$283,919.92	1,430	2.39	25
28	1902478811	Joan Anderson	$281,125.19	1,423	3.12	170
29	1821423799	Dorothy Metz	$101,601.86	1,410	2.71	96
30	1902358443	Melissa Konken	$260,980.05	1,394	3.41	30
31	1013499029	Spencer Kissel	$129,776.53	1,369	3.12	32
32	1275763047	Rebecca Bowman	$251,159.90	1,354	2.49	20
33	1538157383	David Wenger-Keller	$88,225.34	1,353	4.13	42
34	1801998372	Wendy Hansen-Penman	$47,133.43	1,325	3.75	34
35	1073500690	Kathleen Adams	$78,298.80	1,323	2.57	24
36	1558770974	Marc Baumert	$70,088.15	1,300	2.56	35
37	1124006770	Wook Kim	$95,186.78	1,268	2.89	36
38	1215184726	Babuji Gandra	$65,899.48	1,265	2.51	39
39	1285697722	Douglas Jones	$151,410.11	1,260	2.57	38
40	1134191018	Dustin Smith	$69,775.80	1,233	3.27	54
41	1538368170	Christopher Matson	$32,405.43	1,214	3.11	60
42	1619380680	Tara Brockman	$41,525.09	1,192	2.36	46
43	1588193643	Kathleen McGuire	$103,040.24	1,155	2.62	52
44	1063497840	Kaye Cleveland	$145,003.87	1,140	3.81	66
45	1720698335	Danika Hansen	$101,537.59	1,126	3.23	48
46	1043418809	Michael Ciliberto	$432,882.79	1,124	2.57	44
47	1174176093	Carol Chukwuka	$119,568.44	1,122	2.41	51
48	1568431880	Pomilla Kumar	$46,351.89	1,100	3.57	37
49	1205169273	Teresa Dowling	$67,607.19	1,096	4.32	45

50	1316471154	Nicole Woolley	$93,737.16	1,092	2.18	58
51	1619153137	Joada Best	$71,179.48	1,089	2.79	78
52	1649248378	Kathleen Wild	$50,607.87	1,087	2.76	47
53	1063408870	Paul McGee	$151,255.01	1,085	3.85	84
54	1689077018	Stacy Roth	$96,064.28	1,076	2.78	40
55	1932652757	Kelsie Swisher	$318,838.47	1,074	3.04	61
56	1356754337	Cyndi McCormick	$145,899.44	1,066	3.17	63
57	1164823092	Jamey Gregersen	$95,749.29	1,063	2.81	100
58	1710941000	Laurie Warren	$100,392.64	1,062	3.83	53
59	1205393386	Jessica Hudspeth	$97,974.12	1,057	3.28	71
60	1679669832	Erin Hatcher	$134,867.56	1,054	2.49	41
61	1730173766	Frank Babcock	$67,654.88	1,053	4.10	67
62	1891146999	Becky Johnson	$908,012.21	1,053	2.77	68
63	1740700632	Jessica Dunne	$215,628.84	1,050	3.24	33
64	1528329398	Erin Rowan	$50,961.50	1,043	2.37	93
65	1972812097	Michelle Schnack	$79,721.26	1,036	2.42	57
66	1255823506	Nicole Delagardelle	$174,940.70	1,035	2.64	59
67	1275844649	Katie Campbell	$166,435.93	1,024	2.74	80
68	1114521721	Tarrah Holliday	$259,845.03	1,018	3.10	70
69	1912991340	Ghada Hamdan-Allen	$61,756.88	1,017	2.58	43
70	1912971425	Sherry Adams	$130,799.06	1,012	2.70	75
71	1053845677	Shannon Jans	$94,061.17	1,010	2.58	94
72	1053630640	Jennifer Donovan	$155,124.95	1,007	3.12	81
73	1437692803	Cassandra Dunlavy	$52,269.42	1,006	3.37	89
74	1871105916	Lacie Theis	$79,522.30	1,004	3.08	102
75	1891342671	Nancy Childe	$79,612.56	1,003	3.48	69

76	1649209933	Richard Blunk	$64,175.37	1,002	2.26	79
77	1962558957	Albert Okine	$158,063.42	996	3.51	50
78	1255405338	Bryan Netolicky	$110,548.13	991	2.41	77
79	1609946243	Sina Linman	$55,513.44	991	2.32	61
80	1992103386	Melissa Larsen	$93,522.92	988	3.10	73
81	1831751908	Kelsey Frame	$92,198.20	983	2.91	163
82	1689139669	Benjamin Bolmeier	$67,467.84	973	2.58	82
83	1841220290	Kent Kunze	$53,017.59	965	2.68	82
84	1053963900	Nicole Mcclavy	$129,480.74	957	2.38	90
85	1144214248	Kristi Walz	$128,685.56	955	3.24	98
86	1669056123	Kama Ausborn	$187,622.90	951	2.94	121
87	1356724405	Beth Colon	$113,495.01	944	2.13	76
88	1871598557	Christopher Vandelune	$55,636.82	944	2.84	49
89	1356096572	Natasha Lash	$129,833.56	938	2.83	2781
90	1679573893	Patty Hildreth	$145,339.14	936	2.77	86
91	1396083531	Joni Hanshaw	$35,618.69	925	3.13	136
92	1790135176	Emily Reiter	$87,495.49	925	2.69	108
93	1932582988	Dianne Humphrey	$66,979.88	920	3.07	87
94	1417549932	Amanda McCormick	$68,469.94	915	2.39	56
95	1538149042	Eric Petersen	$18,532.45	912	4.39	65
96	1154779460	Molly Eichenberger	$39,503.07	909	3.31	64
97	1871934851	Benjamin Kolner	$83,824.78	908	2.82	120
98	1821268335	Jacqueline McInnis	$127,068.88	907	3.43	100
99	1477112688	Felicia Hoerner	$61,796.21	904	2.33	129
100	1821333774	Brittni Benda	$82,489.20	901	2.37	135

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June 2022 / August 2022

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
1	1376777524	Alladdin Abosaida	$1,315,559.73	$2,962.97	444	1
2	1891146999	Becky Johnson	$898,350.73	$857.20	1048	2
3	1326034984	Katherine Mathews	$783,892.88	$8,709.92	90	4
4	1477761328	Amy Calhoun	$690,025.35	$10,952.78	63	7
5	1417443953	Rodney Clark	$662,478.85	$1,166.34	568	6
6	1295091510	Rebecca Weiner	$547,731.66	$1,193.32	459	3
7	1285748004	Bruce Hughes	$508,343.44	$2,955.49	172	5
8	1841607900	Shayla Sanders	$453,169.88	$2,797.34	162	21
9	1326211889	James Friedlander	$443,832.38	$5,160.84	86	22
10	1013126705	Janice Staber	$439,088.49	$8,284.69	53	8
11	1497060776	Usha Perepu	$437,459.07	$7,953.80	55	9
12	1043418809	Michael Ciliberto	$433,892.57	$386.37	1123	16
13	1437121407	Linda Cadaret	$416,219.23	$3,177.25	131	11
14	1093382632	Gail Dooley	$393,384.94	$1,618.87	243	28
15	1386084747	Jennifer Condon	$373,926.03	$863.57	433	18
16	1356337273	Lisa Menzies	$367,892.68	$729.95	504	10
17	1467449579	Brian Wayson	$367,560.07	$4,176.82	88	12
18	1366826109	Alyssa Mrsny	$360,300.93	$1,233.91	292	17
19	1306071915	Thomas Pietras	$349,620.78	$1,520.09	230	15
20	1225263833	Lindsay Orris	$347,964.42	$1,420.26	245	19
21	1952420705	Eric Rush	$346,704.66	$43,338.08	8	51
22	1023108701	Ronald Zolty	$341,631.22	$5,255.86	65	42
23	1578958542	Heidi Curtis	$332,919.56	$1,513.27	220	13

24	1649419219	Heather Hunemuller	$327,149.57	$979.49	334	37
25	1932652757	Kelsie Swisher	$313,304.38	$294.18	1065	27
26	1447506217	Theodosia Thoma	$310,569.49	$867.51	358	130
27	1174748180	Mohammad Alsharabati	$309,497.98	$1,117.32	277	62
28	1366858334	Alicia Duyvejonck	$305,732.43	$536.37	570	35
29	1760480289	Michael Brooks	$300,448.66	$1,901.57	158	32
30	1134249832	Steven Craig	$295,827.20	$1,634.40	181	24
31	1194945691	Anjali Sharathkumar	$290,355.18	$2,962.81	98	65
32	1770933046	Shelby Biller	$282,471.19	$199.49	1416	33
33	1902478811	Joan Anderson	$281,011.53	$198.31	1417	64
34	1558357806	Robin Hayward	$277,547.82	$1,940.89	143	46
35	1043211303	Ali Safdar	$276,898.38	$187.47	1477	38
36	1104189323	Jad Sfeir	$274,580.76	$137,290.38	2	14
37	1447242359	Daniel Sleiter	$262,546.85	$846.93	310	31
38	1902358443	Melissa Konken	$260,954.20	$187.60	1391	39
39	1114521721	Tarrah Holliday	$258,646.89	$255.33	1013	48
40	1467502286	Charles Tilley	$251,196.18	$125.35	2004	43
41	1275763047	Rebecca Bowman	$251,084.27	$185.71	1352	30
42	1922455096	Dean Guerdet	$250,530.63	$118.01	2123	40
43	1720086523	Mark Cleveland	$249,453.66	$1,022.35	244	72
44	1841673738	Rachel Person	$243,543.95	$2,081.57	117	119
45	1942262688	Lori Schumann	$242,642.09	$411.26	590	36
46	1972989721	Jayson Gesulga	$242,495.04	$295.01	822	20
47	1700417169	Courtney Reints	$241,273.53	$648.58	372	58
48	1316934318	Steven Lentz	$241,102.99	$9,644.12	25	56
49	1124216676	Wendy Sanders	$233,535.54	$763.19	306	55

50	1790013209	Tracy Tschudi	$228,145.09	$120.08	1900	52
51	1104891704	Akshay Mahadevia	$226,086.55	$991.61	228	208
52	1609218304	Amanda Garr	$225,637.68	$145.85	1547	54
53	1013205657	Rhonda Dunn	$224,347.78	$1,419.92	158	50
54	1376512244	Raymond Kuwahara	$222,374.67	$642.70	346	161
55	1730406356	Christina Warren	$221,128.11	$1,176.21	188	26
56	1720039126	Rodrigo Erlich	$218,078.43	$2,506.65	87	198
57	1376525196	Randolph Rough	$217,292.28	$2,194.87	99	25
58	1740700632	Jessica Dunne	$214,222.60	$205.00	1045	34
59	1215125216	Rebecca Walding	$213,984.92	$116.93	1830	53
60	1033554498	Matthew Landherr	$212,613.77	$993.52	214	29
61	1447519038	Erin Richardson	$210,747.97	$795.28	265	98
62	1104804053	Winthrop Risk	$209,332.22	$398.73	525	44
63	1871039917	Elizabeth Allen	$208,954.01	$2,749.39	76	63
64	1699765826	Joseph Merchant	$208,068.61	$1,486.20	140	123
65	1447373832	Joshua Wilson	$207,852.33	$3,779.13	55	100
66	1386902682	Melissa Willis	$207,552.99	$997.85	208	69
67	1356834113	Susan Deo	$203,175.41	$1,651.83	123	49
68	1427178284	Darcy Krueger	$202,910.74	$22,545.64	9	133
69	1467907394	Cynthia Coenen	$195,165.45	$107.35	1818	61
70	1225266364	Sarah Bligh	$193,993.79	$593.25	327	188
71	1356445886	Megan Eisel	$193,877.16	$1,047.98	185	66
72	1316269160	Yen Liu	$193,657.15	$4,120.36	47	185
73	1588616171	Heather Thomas	$189,983.64	$1,696.28	112	68
74	1669056123	Kama Ausborn	$186,256.08	$196.47	948	160
75	1245353242	Sandy Hong	$185,250.45	$1,017.86	182	57

76	1477199198	Sajo Thomas	$184,681.75	$127.45	1449	60
77	1477765584	Sangeeta Shah	$183,948.45	$290.60	633	126
78	1457986671	Paiton Calvert	$183,656.02	$2,324.76	79	81
79	1275061459	Jason Cascio	$182,310.62	$5,697.21	32	152
80	1487226833	Lily Gullickson	$181,096.90	$30,182.82	6	162
81	1689942518	Patria Alba Aponte	$180,903.17	$779.76	232	91
82	1730135070	James Wallace	$179,052.91	$2,011.83	89	76
83	1174584072	Bradley Lair	$177,548.32	$2,731.51	65	99
84	1013978089	Jennifer Bradley	$176,924.60	$236.21	749	96
85	1952539447	Anthony Fischer	$176,325.43	$1,130.29	156	106
86	1285626390	Kathleen Gradoville	$175,399.28	$693.28	253	114
87	1285765354	Cory Pittman	$175,341.32	$1,594.01	110	156
88	1255823506	Nicole Delagardelle	$174,900.52	$169.48	1032	71
89	1841254406	Bradley Hiatt	$173,337.56	$2,708.40	64	90
90	1568423192	John Wollner	$172,992.48	$1,201.34	144	190
91	1447680848	Mindy Roberts	$171,370.61	$109.64	1563	70
92	1609820240	James Harper	$169,799.35	$5,477.40	31	179
93	1275844649	Katie Campbell	$166,211.48	$163.43	1017	118
94	1437238110	Genevieve Nelson	$165,532.20	$96.97	1707	67
95	1043565328	Sara Moeller	$164,855.15	$1,063.58	155	47
96	1982605762	Jeffrey Wilharm	$164,006.52	$55.48	2956	77
97	1790708451	Michael McCubbin	$163,556.24	$801.75	204	45
98	1720416563	Crystal Oberle	$162,436.33	$748.55	217	225
99	1437147386	Douglas Hornick	$161,653.69	$2,342.81	69	86
100	1104967090	John Southard	$161,143.61	$601.28	268	92

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March 2022 / May 2022	RANK	% BUDGET	June 2022 / August 2022	RANK	% BUDGET	% CHANGE
ANTIDIABETICS	$16,855,331	1	13.1%	$17,219,042	1	13.3%	2.2%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$14,323,439	2	11.1%	$14,880,875	2	11.5%	3.9%
ANALGESICS - ANTI-INFLAMMATORY	$11,721,229	3	9.1%	$11,660,840	3	9.0%	-0.5%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$10,462,696	4	8.1%	$10,238,638	4	7.9%	-2.1%
DERMATOLOGICALS	$9,332,139	5	7.2%	$10,157,215	5	7.9%	8.8%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$7,585,982	6	5.9%	$6,963,656	6	5.4%	-8.2%
ANTIVIRALS	$5,354,382	7	4.2%	$5,006,009	7	3.9%	-6.5%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$4,459,850	9	3.5%	$4,663,939	8	3.6%	4.6%
ANTICONVULSANTS	$4,599,365	8	3.6%	$4,529,818	9	3.5%	-1.5%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,772,077	12	2.9%	$4,290,097	10	3.3%	13.7%
RESPIRATORY AGENTS - MISC.	$3,846,601	10	3.0%	$4,028,281	11	3.1%	4.7%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$3,784,080	11	2.9%	$3,755,937	12	2.9%	-0.7%
ANTIDEPRESSANTS	$3,635,021	13	2.8%	$3,576,744	13	2.8%	-1.6%
MIGRAINE PRODUCTS	$3,349,467	14	2.6%	$3,549,962	14	2.8%	6.0%
HEMATOLOGICAL AGENTS - MISC.	$2,941,628	15	2.3%	$2,652,722	15	2.1%	-9.8%
ANTICOAGULANTS	$2,353,357	16	1.8%	$2,351,016	16	1.8%	-0.1%
CARDIOVASCULAR AGENTS - MISC.	$2,066,920	17	1.6%	$2,077,853	17	1.6%	0.5%
GASTROINTESTINAL AGENTS - MISC.	$1,550,567	19	1.2%	$1,470,068	18	1.1%	-5.2%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$1,752,982	18	1.4%	$1,251,744	19	1.0%	-28.6%
CONTRACEPTIVES	$879,483	21	0.7%	$890,444	20	0.7%	1.2%

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March 2022 / May 2022	PREV RANK	June 2022 / August 2022	CURR RANK	% CHANGE
ANTIDEPRESSANTS	154,986	1	151,992	1	-1.9%
ANTICONVULSANTS	68,511	2	67,772	2	-1.1%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	67,817	3	64,817	3	-4.4%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	64,861	4	61,109	4	-5.8%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	54,112	5	52,880	5	-2.3%
ANTIHYPERTENSIVES	54,039	6	52,412	6	-3.0%
ANTIANXIETY AGENTS	51,155	7	50,908	7	-0.5%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	47,974	8	46,955	8	-2.1%
ANTIDIABETICS	47,125	9	46,751	9	-0.8%
DERMATOLOGICALS	30,364	14	33,319	10	9.7%
ANALGESICS - OPIOID	32,851	10	32,337	11	-1.6%
ANALGESICS - ANTI-INFLAMMATORY	30,549	12	30,706	12	0.5%
ANTIHYPERLIPIDEMICS	30,839	11	30,534	13	-1.0%
ANTIHISTAMINES	30,522	13	29,717	14	-2.6%
BETA BLOCKERS	24,264	16	24,073	15	-0.8%
PENICILLINS	28,458	15	21,474	16	-24.5%
MUSCULOSKELETAL THERAPY AGENTS	20,893	17	20,903	17	0.0%
DIURETICS	20,315	18	19,975	18	-1.7%
THYROID AGENTS	18,502	20	18,444	19	-0.3%
CORTICOSTEROIDS	19,766	19	18,270	20	-7.6%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March 2022 / May 2022	RANK	June 2022 / August 2022	RANK	% CHANGE
HUMIRA(CF) PEN	$6,801,063	1	$6,801,992	1	0.0%
TRULICITY	$3,644,631	3	$3,978,778	2	9.2%
VYVANSE	$4,222,493	2	$3,868,763	3	-8.4%
VRAYLAR	$3,464,531	4	$3,622,540	4	4.6%
TRIKAFTA	$2,924,607	5	$3,016,285	5	3.1%
LATUDA	$2,898,996	6	$2,871,300	6	-1.0%
STELARA	$2,489,090	8	$2,688,365	7	8.0%
INVEGA SUSTENNA	$2,544,509	7	$2,514,403	8	-1.2%
JARDIANCE	$2,071,619	10	$2,164,765	9	4.5%
BIKTARVY	$2,104,971	9	$2,143,866	10	1.8%
LANTUS SOLOSTAR	$1,708,450	11	$1,677,600	11	-1.8%
OZEMPIC	$1,620,695	12	$1,640,709	12	1.2%
REXULTI	$1,396,126	15	$1,496,348	13	7.2%
ELIQUIS	$1,451,594	14	$1,478,761	14	1.9%
SYMBICORT	$1,475,609	13	$1,414,587	15	-4.1%
PROAIR HFA	$1,331,056	16	$1,310,788	16	-1.5%
ARISTADA	$1,181,197	17	$1,235,609	17	4.6%
TALTZ AUTOINJECTOR	$1,020,618	20	$1,201,361	18	17.7%
ADVAIR DISKUS	$1,124,107	18	$1,083,706	19	-3.6%
TRINTELLIX	$1,063,699	19	$1,071,641	20	0.7%
DUPIXENT PEN	$858,975	25	$977,403	21	13.8%
COSENTYX PEN (2 PENS)	$969,253	21	$965,809	22	-0.4%
NURTEC ODT	$844,241	28	$952,054	23	12.8%
SKYRIZI PEN	$824,352	30	$879,430	24	6.7%

ABILIFY MAINTENA	$790,728	32	$877,480	25	11.0%
ENBREL SURECLICK	$850,561	26	$860,274	26	1.1%
INGREZZA	$919,508	23	$855,051	27	-7.0%
NORDITROPIN FLEXPRO	$909,981	24	$816,665	28	-10.3%
DUPIXENT SYRINGE	$634,204	41	$772,806	29	21.9%
XARELTO	$790,156	33	$764,510	30	-3.2%
AJOVY AUTOINJECTOR	$745,462	37	$750,610	31	0.7%
FLOVENT HFA	$833,067	29	$749,479	32	-10.0%
JANUVIA	$751,739	36	$747,571	33	-0.6%
SPIRIVA	$850,096	27	$726,617	34	-14.5%
XYWAV	$629,454	42	$707,903	35	12.5%
INVEGA TRINZA	$599,929	45	$672,405	36	12.1%
VIMPAT	$789,935	34	$672,041	37	-14.9%
UPTRAVI	$645,119	40	$644,689	38	-0.1%
STRENSIQ	$645,309	39	$621,285	39	-3.7%
MAVYRET	$791,615	31	$620,181	40	-21.7%
EVRYSDI	$535,808	49	$604,430	41	12.8%
VICTOZA 3-PAK	$620,991	44	$591,856	42	-4.7%
TRELEGY ELLIPTA	$510,325	51	$590,767	43	15.8%
LANTUS	$646,162	38	$586,528	44	-9.2%
FARXIGA	$485,442	55	$572,914	45	18.0%
EPIDIOLEX	$532,306	50	$552,847	46	3.9%
INSULIN ASPART FLEXPEN	$547,156	47	$546,601	47	-0.1%
LINZESS	$536,827	48	$523,578	48	-2.5%
TREMFYA	$506,058	52	$523,028	49	3.4%
TRESIBA FLEXTOUCH U-200	$500,993	53	$510,280	50	1.9%

VENTOLIN HFA	$488,549	54	$489,715	51	0.2%
HUMIRA PEN	$621,142	43	$484,935	52	-21.9%
HEMLIBRA	$475,276	57	$477,288	53	0.4%
LEVEMIR FLEXTOUCH	$482,920	56	$475,449	54	-1.5%
UBRELVY	$431,634	60	$465,545	55	7.9%
ENTRESTO	$401,247	64	$446,939	56	11.4%
SPIRIVA RESPIMAT	$438,468	59	$444,333	57	1.3%
XIFAXAN	$411,861	61	$436,740	58	6.0%
HUMIRA(CF)	$408,029	62	$430,944	59	5.6%
HAEGARDA	$263,026	98	$419,195	60	59.4%
PULMOZYME	$344,182	72	$411,502	61	19.6%
ADVAIR HFA	$398,743	65	$410,560	62	3.0%
OTEZLA	$381,767	67	$409,509	63	7.3%
WAKIX	$583,466	46	$402,707	64	-31.0%
XYREM	$354,014	70	$378,900	65	7.0%
EPINEPHRINE	$294,484	81	$376,552	66	27.9%
AUSTEDO	$295,672	80	$368,224	67	24.5%
FASENRA PEN	$348,907	71	$365,220	68	4.7%
RAVICTI	$284,777	88	$363,865	69	27.8%
JORNAY PM	$363,981	69	$362,154	70	-0.5%
AIMOVIG AUTOINJECTOR	$320,468	74	$355,259	71	10.9%
METHYLPHENIDATE ER	$407,156	63	$354,823	72	-12.9%
ORFADIN	$340,434	73	$351,719	73	3.3%
NAGLAZYME	$468,691	58	$351,518	74	-25.0%
ILARIS	$260,746	102	$347,931	75	33.4%
CAPLYTA	$216,050	129	$342,014	76	58.3%

DEXILANT	$922,678	22	$341,352	77	-63.0%
GILENYA	$290,331	83	$339,572	78	17.0%
CREON	$307,879	79	$336,883	79	9.4%
IBRANCE	$274,024	91	$335,620	80	22.5%
INSULIN LISPRO	$310,371	76	$325,469	81	4.9%
KALYDECO	$269,349	93	$324,163	82	20.4%
ELOCTATE	$257,391	105	$313,083	83	21.6%
LUPRON DEPOT-PED	$235,406	111	$306,974	84	30.4%
SPRYCEL	$279,862	90	$303,846	85	8.6%
VERZENIO	$105,369	223	$301,718	86	186.3%
ENBREL	$309,217	77	$296,008	87	-4.3%
ACTHAR	$165,867	167	$290,244	88	75.0%
TAKHZYRO	$289,450	84	$289,460	89	0.0%
EMGALITY PEN	$283,519	89	$289,345	90	2.1%
MYRBETRIQ	$261,336	101	$284,385	91	8.8%
NUCALA	$287,675	86	$284,076	92	-1.3%
TASIGNA	$211,638	134	$284,062	93	34.2%
KESIMPTA PEN	$173,346	162	$281,979	94	62.7%
REVLIMID	$379,366	68	$280,150	95	-26.2%
OPSUMIT	$267,567	95	$279,125	96	4.3%
GENVOYA	$308,026	78	$277,660	97	-9.9%
QUILLICHEW ER	$319,827	75	$273,289	98	-14.6%
SERTRALINE HCL	$268,651	94	$270,217	99	0.6%
LYBALVI	$206,419	138	$269,624	100	30.6%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March 2022 / May 2022	PREVIOUS RANK	June 2022 / August 2022	RANK	% CHANGE
SERTRALINE HCL	23,003	1	22,542	1	-2.0%
OMEPRAZOLE	22,041	2	21,678	2	-1.6%
TRAZODONE HCL	20,729	3	20,170	3	-2.7%
ESCITALOPRAM OXALATE	18,543	4	18,146	4	-2.1%
ATORVASTATIN CALCIUM	18,057	7	17,836	5	-1.2%
FLUOXETINE HCL	18,485	5	17,776	6	-3.8%
GABAPENTIN	17,616	8	17,590	7	-0.1%
CETIRIZINE HCL	15,969	10	15,859	8	-0.7%
LISINOPRIL	16,316	9	15,687	9	-3.9%
LEVOTHYROXINE SODIUM	15,785	12	15,629	10	-1.0%
PROAIR HFA	15,876	11	15,363	11	-3.2%
MONTELUKAST SODIUM	14,381	13	13,912	12	-3.3%
BUSPIRONE HCL	13,160	16	13,318	13	1.2%
AMOXICILLIN	18,290	6	13,166	14	-28.0%
HYDROCODONE-ACETAMINOPHEN	12,931	18	12,949	15	0.1%
HYDROXYZINE HCL	12,728	20	12,792	16	0.5%
DULOXETINE HCL	12,948	17	12,635	17	-2.4%
VYVANSE	13,416	15	12,435	18	-7.3%
QUETIAPINE FUMARATE	12,806	19	12,330	19	-3.7%
VENLAFAXINE HCL ER	11,651	22	11,427	20	-1.9%
PREDNISONE	11,922	21	11,392	21	-4.4%
BUPROPION XL	14,090	14	11,254	22	-20.1%
ARIPIPRAZOLE	11,374	23	10,938	23	-3.8%

CLONIDINE HCL	10,885	25	10,638	24	-2.3%
FLUTICASONE PROPIONATE	11,142	24	10,444	25	-6.3%
PANTOPRAZOLE SODIUM	10,116	28	10,286	26	1.7%
AMLODIPINE BESYLATE	10,515	26	10,204	27	-3.0%
ALPRAZOLAM	10,190	27	10,055	28	-1.3%
LAMOTRIGINE	9,959	30	9,895	29	-0.6%
CLONAZEPAM	9,502	32	9,373	30	-1.4%
METFORMIN HCL	9,583	31	9,226	31	-3.7%
METHYLPHENIDATE ER	10,058	29	9,166	32	-8.9%
CYCLOBENZAPRINE HCL	9,023	34	9,031	33	0.1%
IBUPROFEN	8,510	39	8,639	34	1.5%
TOPIRAMATE	8,572	37	8,297	35	-3.2%
DEXTROAMPHETAMINE-AMPHET ER	8,563	38	8,170	36	-4.6%
CEPHALEXIN	7,201	46	8,066	37	12.0%
METOPROLOL SUCCINATE	8,014	40	7,878	38	-1.7%
ONDANSETRON ODT	9,231	33	7,741	39	-16.1%
FAMOTIDINE	7,781	41	7,658	40	-1.6%
LORATADINE	7,462	43	7,405	41	-0.8%
RISPERIDONE	7,628	42	7,300	42	-4.3%
MELOXICAM	7,188	47	7,154	43	-0.5%
VENTOLIN HFA	7,327	44	7,104	44	-3.0%
TRAMADOL HCL	7,279	45	6,991	45	-4.0%
AMOXICILLIN-CLAVULANATE POTASS	8,702	36	6,934	46	-20.3%
LORAZEPAM	6,986	49	6,833	47	-2.2%
LOSARTAN POTASSIUM	6,561	50	6,527	48	-0.5%
DEXTROAMPHETAMINE-AMPHETAMINE	7,184	48	6,467	49	-10.0%

TRIAMCINOLONE ACETONIDE	5,417	58	6,324	50	16.7%
AZITHROMYCIN	8,926	35	6,160	51	-31.0%
HYDROCHLOROTHIAZIDE	6,312	53	6,130	52	-2.9%
MIRTAZAPINE	6,067	54	6,041	53	-0.4%
FUROSEMIDE	5,962	55	6,001	54	0.7%
METFORMIN HCL ER	5,568	56	5,562	55	-0.1%
ASPIRIN EC	5,516	57	5,455	56	-1.1%
GUANFACINE HCL	6,459	51	5,401	57	-16.4%
HYDROXYZINE PAMOATE	5,300	60	5,282	58	-0.3%
FLUCONAZOLE	5,217	63	5,273	59	1.1%
BUPROPION HYDROCHLORIDE E	2,201	122	5,168	60	134.8%
METRONIDAZOLE	5,037	65	5,107	61	1.4%
CITALOPRAM HBR	5,284	61	4,968	62	-6.0%
DICLOFENAC SODIUM	4,583	70	4,718	63	2.9%
ROSUVASTATIN CALCIUM	4,612	68	4,678	64	1.4%
SULFAMETHOXAZOLE-TRIMETHOPRIM	4,604	69	4,658	65	1.2%
DOXYCYCLINE MONOHYDRATE	5,229	62	4,584	66	-12.3%
PRAZOSIN HCL	5,084	64	4,493	67	-11.6%
POLYETHYLENE GLYCOL 3350	4,779	66	4,473	68	-6.4%
CEFDINIR	6,389	52	4,454	69	-30.3%
AMITRIPTYLINE HCL	4,744	67	4,425	70	-6.7%
SPIRONOLACTONE	4,476	72	4,423	71	-1.2%
POTASSIUM CHLORIDE	4,385	74	4,354	72	-0.7%
TIZANIDINE HCL	4,295	77	4,341	73	1.1%
ALBUTEROL SULFATE	5,381	59	4,340	74	-19.3%
ACETAMINOPHEN	4,058	88	4,328	75	6.7%

ZOLPIDEM TARTRATE	4,351	75	4,272	76	-1.8%
NAPROXEN	4,285	78	4,249	77	-0.8%
LEVETIRACETAM	4,219	80	4,242	78	0.5%
BACLOFEN	4,399	73	4,238	79	-3.7%
TRULICITY	3,779	91	4,155	80	9.9%
SYMBICORT	4,340	76	4,150	81	-4.4%
VALACYCLOVIR	4,261	79	4,131	82	-3.1%
OXYCODONE HCL	4,094	84	4,081	83	-0.3%
FOLIC ACID	4,072	87	4,056	84	-0.4%
ATOMOXETINE HCL	4,099	82	3,964	85	-3.3%
PREGABALIN	3,991	89	3,928	86	-1.6%
GUANFACINE HCL ER	4,097	83	3,915	87	-4.4%
METOPROLOL TARTRATE	4,145	81	3,909	88	-5.7%
METHYLPHENIDATE HCL	4,529	71	3,840	89	-15.2%
SUMATRIPTAN SUCCINATE	4,092	85	3,750	90	-8.4%
OLANZAPINE	3,724	92	3,650	91	-2.0%
DEXMETHYLPHENIDATE HCL ER	4,088	86	3,611	92	-11.7%
ONDANSETRON HCL	3,865	90	3,604	93	-6.8%
LANTUS SOLOSTAR	3,698	93	3,501	94	-5.3%
FEROSUL	3,500	94	3,462	95	-1.1%
MUPIROCIN	2,816	102	3,360	96	19.3%
JARDIANCE	3,158	97	3,324	97	5.3%
NYSTATIN	2,757	104	3,022	98	9.6%
OXCARBAZEPINE	3,119	98	3,018	99	-3.2%
PROPRANOLOL HCL	3,267	95	3,002	100	-8.1%

Medicaid Statistics for Prescription Claims
June through August 2022

Tri-Monthly Statistics

	FFS	Amerigroup	Iowa Total Care	Total**
Total Dollars Paid	$2,513,938	$129,596,815	$88,493,858	$220,604,611
Unique Users	3,532	172,028	128,701	304,261
Cost Per User	$711.76	$753.35	$687.59	
Total Prescriptions	20,784	1,134,449	797,260	1,952,493
Average Rx/User	5.88	6.59	6.19	
Average Cost/Rx	$120.96	$114.24	$111.00	
# Generic Prescriptions	18,333	1,011,635	704,608	
% Generic	88.2%	89.2%	88.4%	
$ Generic	$863,491	$21,524,246	$12,708,073	
Average Generic Rx Cost	$47.10	$21.28	$18.04	
Average Generic Days Supply	29	32.11	32	
# Brand Prescriptions	2,451	122,814	92,652	
% Brand	11.8%	10.4%	11.6%	
$ Brand	$1,650,447	$108,072,569	$75,785,785	
Average Brand Rx Cost	$673.38	$879.97	$817.96	
Average Brand Days Supply	29	31.2	31	

**All reported dollars are pre-rebate

Top 20 Therapeutic Class by Paid Amount*

June through August 2022

	FFS	Amerigroup	Iowa Total Care
1	ANTI-INFLAMMATORIES, NON-NSAID	ANTIDIABETICS	ANTIDIABETICS
2	ANTICONVULSANTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS
3	ANTIPSYCHOTICS - ATYPICALS	ANALGESICS - ANTI-INFLAMMATORY	ANALGESICS - ANTI-INFLAMMATORY
4	ANTINEOPLASTICS - PROTEIN-TYROSINE KINASE INHIBITORS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTIASTHMATIC AND BROCHODILATOR AGENTS
5	ANTIRETROVIRAL COMBINATIONS	DERMATOLOGICALS	DERMATOLOGICALS
6	ANTIDEPRESSANTS - SELECTED SSRIs	ADHD/ANTI-NARCOLEPSY	ANTIVIRALS
7	MUSCULAR DYSTROPHY AGENTS	ANTIVIRALS	ADHD/ANTI-NARCOLEPSY
8	DIABETIC - INSULIN PENFILLS	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
9	DIABETIC - NON-INSULIN INJECTABLES	ANTICONVULSANTS	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
10	ANTIASTHMATIC - ADRENERGIC COMBOS	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	RESPIRATORY AGENTS - MISC.
11	GLUCOCORTICOIDS - MINERALOCORTICOIDS	RESPIRATORY AGENTS - MISC.	ANTICONVULSANTS
12	STIMULANTS - AMPHETAMINES - LONG ACTING	ENDOCRINE AND METABOLIC AGENTS - MISC.	ANTIDEPRESSANTS
13	DIABETIC - OTHER	ANTIDEPRESSANTS	ENDOCRINE AND METOBOLIC AGENTS - MISC.
14	ANTIASTHMATIC - BETA ADRENERGICS	MIGRAINE PRODUCTS	HEMATOLOGICAL AGENTS - MISC.
15	ENDOCRINE METABOLIC AGENTS	HEMATOLOGIC AGENTS - MISC.	MIGRAINE PRODUCTS
16	CYSTIC FIBROSIS AGENTS	ANTICOAGULANTS	ANTIGOAGULANTS
17	ANTIHISTAMINES - NON-SEDATING	CARDIOVASCULAR AGENTS - MISC.	CARDIOVASCULAR AGENTS - MISC.
18	STIMULANTS - METHYLPHENIDATE - LONG ACTING	GASTROINTESTINAL AGENTS - MISC.	ANTI-INFECTIVE AGENTS - MISC.
19	NSAIDS	ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS	GASTROINTESTINAL AGENTS - MISC.
20	ANTICOAGULANTS	CONTRACEPTIVES	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS

* Pre-rebate

Top 20 Therapeutic Class by Prescription Count

June through August 2022

	FFS	Amerigroup	Iowa Total Care
1	ANTIDEPRESSANTS - SELECTED SSRIs	ANTIDEPRESSANTS	ANTIDEPRESSANTS
2	ANTICONVULSANTS	ANTICONVULSANTS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
3	ANTIPSYCHOTICS - ATYPICALS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTICONVULSANTS
4	ANTIHYPERTENSIVES - CENTRAL	ADHD/ANTI-NARCOLEPSY	ADHD/ANTI-NARCOLEPSY
5	PPIs	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	ANTIHYPERTENSIVES
6	ANTIASTHMATIC - BETA-ADRENERGICS	ANTIHYPERTENSIVES	ANTIPSYCHOTICS/ ANTIMANIC AGENTS
7	ANTIHISTAMINES - NON-SEDATING	ANTIANXIETY AGENTS	ANTIDIABETICS
8	STIMULANTS - AMPHETAMINES - LONG-ACTING	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	ANTIANXIETY AGENTS
9	ANTIHISTAMINES - OTHER	ANTIDIABETICS	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
10	NARCOTICS-MISC.	DERMATOLOGICALS	ANALGESICS - OPIOID
11	CHOLESTEROL - HMG COA + ABSORB INHIBITORS	ANALGESICS - OPIOID	DERMATOLOGICALS
12	NSAIDS	ANALGESICS - ANTI-INFLAMMATORY	ANALGESICS - ANTI-INFLAMMATORY
13	BETA-LACTAMS/CLAVULANATE COMBOS	ANTIHYPERLIPIDEMICS	ANTIHYPERLIPIDEMICS
14	MUSCLE RELAXANTS	ANTIHISTAMINES	ANTIHISTAMINES
15	STIMULANTS - METHYLPHENIDATE - LONG-ACTING	BETA BLOCKERS	BETA BLOCKERS
16	ACE INHIBITORS	PENICILLINS	PENICILLINS
17	GLUCOCORTICOIDS - MINERALOCORTICOIDS	MUSCULOSKELETAL THERAPY AGENTS	DIURETICS
18	DIABETIC - ORAL BIGUANIDES	DIURETICS	MUSCULOSKELETAL THERAPY AGENTS
19	THYROID HORMONES	THYROID AGENTS	CORTICOSTEROIDS
20	DIURETICS	CORTICOSTEROIDS	THYROID AGENTS

Top 25 Drugs by Paid Amount**

June through August 2022

	FFS	Amerigroup	Iowa Total Care
1	HUMIRA PEN	HUMIRA (CF) PEN	HUMIRA PEN
2	EVRYSDI	TRULICITY	TRULICITY
3	BIKTARVY	VYVANSE	VRAYLAR
4	EMFLAZA	VRAYLAR	VYVANSE
5	TRULICITY	TRIKAFTA	BIKTARVY
6	VIJOICE	LATUDA	INVEGA SUSTENNA
7	INVEGA SUSTENNA	STELARA	TRIKAFTA
8	VYVANSE	INVEGA SUSTENNA	JARDIANCE
9	TRIKAFTA	JARDIANCE	STELARA
10	VERZENIO	BIKTARVY	LATUDA
11	FINTEPLA	LANTUS SOLOSTAR	TALTZ
12	SUTENT	OZEMPIC	LANTUS SOLOSTAR
13	PROAIR HFA	REXULTI	DUPIXENT
14	ENBREL SURECLICK	ELIQUIS	OZEMPIC
15	SYMBICORT	SYMBICORT	SYMBICORT
16	LANTUS SOLOSTAR	PROAIR HFA	ELIQUIS
17	LAMICTAL CHEWABLE	ARISTADA	ARISTADA
18	KISQALI	TALTZ AUTOINJECTOR	SPIRIVA
19	LATUDA	ADVAIR DISKUS	PROAIR HFA
20	TALTZ	TRINTELLIX	ADVAIR DISKUS
21	OZEMPIC	DUPIXENT PEN	REXULTI
22	VRAYLAR	COSENTYX PEN	ENBREL SRCLK
23	ESCITALOPRAM	NURTEC ODT	MAVYRET
24	GAMMAGARD LIQUID	SKYRIZI PEN	TRINTELLIX
25	LISINOPRIL	ABILIFY MAINTENA	COSENTYX PEN

** Pre-rebate

Top 25 Drugs by Prescription Count

June through August 2022

	FFS	Amerigroup	Iowa Total Care
1	CLONIDINE	SERTALINE	SERTRALINE
2	TRAZODONE	OMEPRAZOLE	OMEPRAZOLE
3	SERTRALINE	TRAZODONE	TRAZODONE
4	ESCITALOPRAM	ESCITALOPRAM	ATORVASTATIN
5	OMEPRAZOLE	ATORVASTATIN	GABAPENTIN
6	PROAIR HFA	FLUOXETINE	ESCITALOPRAM
7	FLUOXETINE	GABAPENTIN	FLUOXETINE
8	LISINOPRIL	CETIRIZINE	LISINOPRIL
9	ATORVASTATIN	LISINOPRIL	BUPROPION
10	LEVOTHYROXINE	LEVOTHYROXINE	PROAIR HFA
11	CETIRIZINE	PROAIR HFA	METFORMIN
12	GABAPENTIN	MONTELUKAST	LEVOTHYROXINE
13	ARIPIPRAZOLE	BUSPIRONE	CETIRIZINE
14	QUETIAPINE	AMOXIXILLIN	AMPHETAMINE/ DEXTRO
15	METHYLPHENIDATE ER	HYDROCODONE/APAP	AMOXICILLIN
16	AMPHETAMINE/DEXTROAMPHET ER	HYDROXYZINE HCL	HYDROCODONE/APAP
17	FLUTICASONE PROP (NASAL)	DULOXETINE	BUSPIRONE
18	BUPROPION ER	VYVANSE	DULOXETINE
19	HYDROXYZINE HCL	QUETIAPINE	QUETIAPINE
20	BUSPIRONE	VENLAFAXINE ER	MONTELUKAST
21	VYVANSE	PREDNISONE	HYDROXYZINE HCL
22	PEG 3350	BUPROPION XL	PREDNISONE
23	PREDNISONE	ARIPIPRAZOLE	ONDANSETRON
24	LAMOTRIGINE	CLONIDINE	METHYLPHENIDATE
25	IBUPROFEN	FLUTICASONE PROPIONATE	VENLAFAXINE

Top Prescribers by Prescription Count*

	Number of Rx Claims			
PRESCRIBER	**FFS**	**AGP**	**ITC**	**Total**
Jeffrey Wilharm	92	2,951	1,440	**4,483**
Bobbita Nag	0	1,938	1,318	**3,256**
Dean Guerdet	24	2,141	1,013	**3,178**
Charles Tilley	0	2,010	1,010	**3,020**
Rebecca Walding	113	1,841	1,050	**3,004**
Jennifer Zalaznik	0	2,144	843	**2,987**
Cynthia Coenen	0	1,840	1,077	**2,917**
Amanda Garr	61	1,547	1,147	**2,755**
Ali Safdar	0	1,478	1,087	**2,565**
Sajo Thomas	0	1,465	1,084	**2,549**
Wendy Hansen-Penman	37	1,325	1,168	**2,530**
Melissa Konken	139	1,394	963	**2,496**
Eric Meyer	92	1,540	791	**2,423**
Wook Kim	0	1,268	1,117	**2,385**
Marc Baumert	0	1,300	1,072	**2,372**
Tara Brockman	47	1,192	1,098	**2,337**
Rebecca Wolfe	0	1,968	0	**1,968**
Tracy Tschudi	0	1,904	0	**1,904**
Michael Ciliberto	215	1,124	458	**1,797**
Larissa Biscoe	0	1,726	0	**1,726**
Leighton Frost	190	0	0	**190**
Alicia Wager	153	0	0	**153**
Molly Earleywine	123	0	0	**123**
Christopher Jacobs	103	0	0	**103**
Anthony Glydwell	89	0	0	**89**

FFS = Fee-for-Service
AGP = Amerigroup
ITC = Iowa Total Care

*Based on the top 10 prescribers by prescription count from each entity (rx count taken from top 10 prescribers by rx count or paid amount)

Iowa Medicaid DUR September 2022

[redacted] MD

Iowa Kidney Physicians, Senior Nephrology Educator

I would like to write a brief letter in support of Bayer's Kerendia (finerenone) formular application.

For years I have been extremely interested in chronic kidney disease (CKD) and the factors which are responsible for the progressive loss f kidney function in my patients. It was 2001 when the definitive data that showed Angiotensin Receptor Inhibitors (RENNAL and IDNT Trials) could change the natural history of diabetic kidney disease. Now, twenty-one years later there is excellent evidence that SGLT-2 inhibitors (DAPA CKD and EMPA CKD Trials) and the selective mineralocorticoid receptor antagonist (MRA) finerenone (FIDELIO and FIGARO Trials) can also have a dramatically positive effect on preventing renal and cardiovascular complications in my patients by very separate presumed mechanisms of action.

The beneficial effect of this selective MRA agent has not been demonstrated for other drugs (spironolactone or eplerenone) in this class despite multiple studies over many years that these agents have been available for clinical use.

I have been a paid Speaker for Bayer, mostly because I believe that we can make patient's lives better by lowering their cardiovascular risk and preventing loss of kidney function.

I would be happy to answer any questions.

[redacted] MD

Clinical Professor, University of Iowa Carver College of Medicine and Senior Nephrology Education Iowa Kidney Physicians

LABA without ICS in Asthma
RetroDUR
Data

Purpose

- To identify members with asthma using a long-acting beta$_2$-adrenergic agonist (LABA) without an inhaled corticosteroid.

Background

- LABAs as monotherapy increase the risk of asthma-related death and should be prescribed only as additional therapy for patients with asthma who are currently taking but are inadequately controlled on an inhaled corticosteroid (ICS).
- Salmeterol xinafoate inhalation powder (Serevent Diskus) is the only single-ingredient LABA indicated for the treatment of asthma.
    - Indicated for the treatment of asthma and in the prevention of bronchospasm only as concomitant therapy with an ICS in patients aged 4 years and older with reversible obstructive airway disease, including patients with symptoms of nocturnal asthma.
    - Use only as additional therapy for patients with asthma who are currently taking but are inadequately controlled on an ICS. Do not use salmeterol for patients whose asthma is adequately controlled on low- or medium-dose ICS.
- Currently, Serevent Diskus is preferred on the Preferred Drug List (PDL), with an age edit requiring prior authorization (PA) for members under 4 years of age.

RDUR Criteria

- Members with an asthma diagnosis and a claim for Serevent Diskus in pharmacy claims that do not have a claim for an ICS in the same time period.
- Time period: May through July 2022

Data

	AGP	ITC	FFS
Members with Serevent Claim	38	45	0
Members with Serevent Claim with ICS	7	9	0
Members with Serevent Claim without ICS	31	36	0

AGP = Amerigroup; ITC = Iowa Total Care; FFS = Fee-for-Service

Next Steps

- Send letters to prescribers of members using Serevent Diskus without an ICS pointing out the increased risks associated of monotherapy use in the treatment of asthma and recommend the addition of an ICS to Serevent Diskus or switch to a combination LABA/ICS product.

- Develop PA criteria for Serevent Diskus, requiring documentation member is also receiving treatment with an ICS for the treatment of asthma.

Concurrent Use of Opioids and Sedatives
RetroDUR
Proposal – Additional Information

Purpose

- To identify members with concurrent use of sedatives and an opioid in pharmacy claims.

Background

- Opioids carry an FDA boxed warning of increased risk of respiratory and CNS depression with concurrent use of opioid and CNS depressants such as antipsychotics or sedatives.
    - In an August 2016 FDA Drug Safety Communication, the FDA warned about serious risks and death when combining opioid pain or cough medicines with benzodiazepines and required the addition of *Boxed Warnings* to prescription opioid pain and prescription opioid cough medicines, and benzodiazepines.
    - Within this Drug Safety Communication, the FDA listed other CNS depressants:
        - Other sleep drugs and tranquilizers
        - Muscle relaxants
        - Antipsychotics
- Questions related to this issue appeared in the FFY20 and FFY21 CMS DUR Survey. *Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and sedatives being used concurrently?*
    - Based on the FFS FFY20 CMS DUR Survey Report (most current data available):
        - 13 states (26%) have an automated retrospective claim review
        - 11 states (22%) have a POS edit
        - 10 states (20%) have a POS edit and an automated retrospective claims review
        - 16 states (32%) have neither
- Currently, there are no hard POS edits to stop this combination or an automated retrospective claims review process (i.e., retrospective review) for concurrent use of an opioid and sedative.
- In researching drug interactions in a drug data base, between opioids and the sedatives listed below, the interaction rating is considered major severity with a documentation level of possible. This indicates the interaction is potentially severe or life-threatening supported by primary literature that includes multiple case reports and/or controlled studies. Data supporting the interaction includes the following:
    - A cohort study found that the risk of opioid-related overdose death was 10-fold higher in patients who also received benzodiazepines (7.0 per 10,000 person-years) compared with patients who received opioids alone (0.7 per 10,000 person years).
    - In another analysis of opioid-treated patients in the Veterans Health Administration database, the risk of death from drug overdose was significantly

higher among those prescribed concomitant benzodiazepines compared with those receiving opioids alone (HR 3.86).
    - A cohort study of 4501 patients prescribed buprenorphine or methadone for treatment of opioid dependence reported an increased risk of both overdose-related deaths (adjusted HR 1.49 to 2.02) and all-cause mortality (adjusted HR 1.28 to 2.01) for patients receiving concurrent benzodiazepines, z-drugs (zopiclone, zolpidem, or zaleplon), or pregabalin. Not all of these increases were statistically significant, but the overall picture of a general increased risk with these combinations is consistent with other data.
    - The odds of opioid-related death was also significantly increased in opioid-treated patients who were exposed to gabapentin within 120 days (adjusted OR 1.5) as compared with those taking an opioid prescription alone, according to a case-control study of 1,256 cases (individuals who died of an opioid-related cause) and 4,619 matched controls (opioid users).
    - Similarly, another case-control study by the same group found that concomitant exposure to opioids and pregabalin within 120 days was associated with increased odds of opioid-related death compared to opioids alone (adjusted OR 1.7) in an analysis of 1,417 cases and 5,097 matched controls.
    - Additional analyses have concluded that other CNS depressants (e.g. antipsychotics, antidepressants, antiepileptics) and alcohol are often implicated in opioid-related overdose and death.

RDUR Criteria

- Members with claims for a sedative and an opioid with at least one day overlap
- Time period: August through October 2022
- Sedatives to include:
    - Chloral hydrate
    - Daridorexant
    - Eszopiclone
    - Lemborexant
    - Phenobarbital
    - Ramelteon
    - Suvorexant
    - Tasimelteon
    - Zaleplon
    - Zolpidem
    - Other recommendations? Muscle Relaxants?

Underutilization of Beta Blockers in Heart Failure
RetroDUR
Proposal

Purpose

- To Identify members with a diagnosis of heart failure (HF) that are not receiving guideline-directed medical therapy (GDMT) with a beta-blocker proven to reduce mortality.

Background

- Evidence based beta-blocker therapy in patients with HFrEF can reduce all-cause and cardiovascular mortality, sudden cardiac death, and heart failure hospitalizations.
- Use of a beta-blocker proven to reduce mortality in patients with chronic HFrEF is recommended for all adult patients with current or prior symptoms of HFrEF, unless contraindicated or not tolerated.
- Beta-blockers proven to reduce mortality in patients with HFrEF include bisoprolol, carvedilol, or sustained-release metoprolol succinate.

RDUR Criteria

- Identify adult members with a diagnosis of heart failure in the last 2 years that do not have a claim(s) for bisoprolol, carvedilol, or sustained-release metoprolol succinate in the previous 6 months (May 2022 through October 2022)
- Other?

References

Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation 2022; 145:e895.

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 10/01/2022

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

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 10/01/2022

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

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 10/01/2022

	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.
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.

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

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.

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

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 10/01/2022

Antidepressants *Aplenzin* *Fetzima* *Viibryd* *Use Antidepressants PA form*	Prior authorization (PA) is required for non-preferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met: 1. The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; 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 5. If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, 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 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. 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).

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 10/01/2022

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.

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

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.
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.

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

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.
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.

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

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 10/01/2022

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.

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

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 10/01/2022

Biologicals for Arthritis *Abatacept (Orencia)* *Adalimumab (Humira)* *Anakinra (Kineret)* *Certolizumab Pegol (Cimzia)* *Etanercept (Enbrel)* *Ixekizumab (Taltz)* *Golimumab (Simponi)* *Tocilizumab (Actemra)* *Ustekinumab (Stelara)* *Canakinumab (Ilaris)* *Sarilumab (Kevzara)* *Secukinumab (Cosentyx)* *Risankizumab (Skyrizi)* *Use Biologicals for Arthritis PA form*	Prior authorization (PA) is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling, including age, indication, dosing, and contraindications. 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 been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment; 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 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 4. 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 5. Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis; with 1. 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); 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.

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

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 10/01/2022

Biologicals for Axial Spondyloarthritis *Adalimumab (Humira)* *Certolizumab Pegol (Cimzia)* *Etanercept (Enbrel)* *Golimumab (Simponi)* *Ixekizumab (Taltz)* *Secukinumab (Cosentyx)* *Use Biologicals for Axial Spondyloarthritis PA form*	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.

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 10/01/2022

Biologicals for Inflammatory Bowel Disease *Adalimumab (Humira)* *Certolizumab Pegol (Cimzia)* *Golimumab (Simponi)* *Ustekinumab (Stelara)* *Risankizumab (Skyrizi)* *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.

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 10/01/2022

Biologicals for Hidradenitis Suppurativa *Adalimumab (Humira)*	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. Patients initiating therapy with a biological agent must: 1. Be screened for hepatitis B and C. Patients with active hepatitis B will not be considered for coverage; and 2. Have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biologic agent; and 3. 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 4. Be 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. 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 3 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.
Use Biologicals for Hidradenitis Suppurativa PA form	

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 10/01/2022

Biologicals for Plaque Psoriasis *Adalimumab (Humira)* *Etanercept (Enbrel)* *Secukinumab (Cosentyx)* *Ustekinumab (Stelara)* *Brodalumab (Siliq)* *Ixekizumab (Taltz)* *Guselkumab (Tremfya)* *Certolizumab (Cimzia)* *Risankizumab (Skyrizi)* *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. 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.

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 10/01/2022

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.

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 10/01/2022

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 10/01/2022

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. Requests will be considered for an FDA approved age for the submitted diagnosis. Payment for CNS stimulants and atomoxetine will be considered 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 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. 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.

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Updated 10/01/2022

Use CNS Stimulants and Atomoxetine or Binge Eating Disorder Agents PA form	l. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week. DSM-5 Criteria 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 over eating; and ii. The binge eating episodes are marked by at least three of the following: 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. Moderate to Severe BED 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.

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 10/01/2022

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.
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.

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Updated 10/01/2022

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.
Deferasirox (Exjade)	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

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Use Deferasirox (Exjade) PA form	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. <u>Continuation of Therapy</u> 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).
Deflazacort (Emflaza) *Use Deflazacort (Emflaza™) PA form*	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.
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.

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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.

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.

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Dupilumab (Dupixent) *Use Dupilumab (Dupixent) PA form*	Prior authorization (PA) is required for Dupixent (dupilumab). Payment will be considered under the following conditions: 1. Patient is within the FDA labeled age for indication; and 2. 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 has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and f. Patient will continue with skin care regimen and regular use of emollients; and 3. 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; 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. Two (2) or more exacerbations in the previous year or ii. Require daily oral corticosteroids for at least 3 days; and 4. 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; and 5. Dose does not exceed the FDA approved dosing for indication. 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. 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 10/01/2022

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.

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Updated 10/01/2022

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 spironolocatone or documented cases of gynecomastia from spironolactone therapy.

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

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 indicaed 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, 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.
Febuxostat (Uloric) *Use Febuxostat (Uloric) PA form*	Prior authorization (PA) is required for febuxostat (Uloric). Payment for febuxostat (Uloric) will only be considered for cases in which symptoms of gout still persist while currently using 300mg per day of a preferred allopurinol product unless documentation is provided that such a trial 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 10/01/2022

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.
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)	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:

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Use Finerenone (Kerendia) PA form	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.

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.
Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral	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) will be considered under the following conditions: a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and

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Use Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral PA form	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 e. Requests will be considered for a maximum of 24 months for the 150mg dose and six (6) months for the 200mg dose; 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 of 24 months of treatment. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
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:

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	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. 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

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Updated 10/01/2022

Use Growth Hormone PA form	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) 3. Diagnosis is confirmed by appropriate genetic testing (attach results); and 4. Prescribed by or in consultation with an endocrinologist; 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. 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.
Hematopoietics/ Chronic ITP	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

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Updated 10/01/2022

Use Hematopoietics/Chronic ITP PA form	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.
Hepatitis C Treatments, Direct Acting Antivirals	Prior authorization (PA) is required for hepatitis C direct-acting antivirals (DAA). 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's age and/or weight is within the FDA labeled age and/or weight; and 3. Patient has had testing for hepatitis C virus (HCV) genotype; and 4. Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 5. Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and 6. Patient's prior HCV DAA treatment history is provided (treatment naïve or treatment experienced); and 7. If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 8. Patient has been evaluated to determine the patient's readiness for HCV treatment with scales or assessment tools, such as SAMHSA-HRSA Center for Integrated Health Solutions – Drug & Alcohol Screening Tools and the Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C); and 9. Patient has been educated on the importance of abstinence from IV drug use and alcohol use, the importance of compliance with HCV treatment, and how to prevent HCV transmission. If patient is currently using IV drug and/or alcohol, recommend the patient participate in alcohol and/or substance abuse counseling; and 10. HCV treatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 11. DAAs approved for pediatric use will be considered for those under the age of 18 when used in accordance with current AASLD guidelines including for indication and age; and

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Use Hepatitis C Treatments, Direct Acting Antivirals PA form	12. For patients on a regimen containing ribavirin, the following must be documented on the PA form: a. Patient is not a pregnant female or male with a pregnant female partner; and b. Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and c. Monthly pregnancy tests will be performed during treatment; and 13. Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the DAA; and 14. Documentation is provided for patients who are ineligible to receive ribavirin; and 15. Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved; and 16. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. 17. 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. 18. Lost or stolen medication replacement requests will not be authorized. 19. 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. Patients who previously achieved SVR that have HCV recurrence due to IV drug use must have documentation that the patient has completed or is participating in a recovery program, receiving alcohol or substance abuse counseling services, or seeing an addiction specialist as part of HCV treatment, and can be managed as an initial infection; and 3. The requested therapy is FDA approved as therapy for treatment-experienced patients and follows current AASLD guidelines; 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.

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 10/01/2022

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/drugoverdose/prescribing/guideline.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 for pain management is 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 been provided a prescription for a preferred naloxone product 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 naloxone; and 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.

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 10/01/2022

Use High Dose Opioids PA form	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 been provided a prescription for a preferred naloxone product 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 naloxone.

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 10/01/2022

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 under the following conditions: 1. Is requested for an FDA approved or compendia indicated diagnosis; and 2. Patient meets the FDA approved or compendia indicated age and dose for submitted diagnosis; and 3. 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 4. 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 5. 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 6. Prescribed by or in consultation with an allergist, hematologist, immunologist, 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 to assess the need for

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Updated 10/01/2022

Use IL-5 Antagonists PA form	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 be used in combination with stable doses or at least one other HES therapy. 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.

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 10/01/2022

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. Diagnosis is provided; and 2. Medical rationale for exceeding the initial days' supply limit is provided; and 3. 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 4. Requests for non-opioid drugs subject to the initial days' supply limit will be considered on an individual case-by-case basis, based on medical necessity documentation provided.
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.

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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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.

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Updated 10/01/2022

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 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. 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 iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR e. Ankylosing spondylitis; 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 f. Atopic dermatitis; with

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Updated 10/01/2022

Use Janus Kinase Inhibitor PA form	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.

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Updated 10/01/2022

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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Updated 10/01/2022

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 10/01/2022

Long-Acting Opioids	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

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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Use Long-Acting Opioids PA form	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.
Lupron Depot – Adult *Use Lupron Depot-Adult PA form*	Prior authorization (PA) is required for Lupron Depot (leuprolide acetate). Payment will be considered for patients under the following conditions: 1. Patient meets the FDA approved age; and 2. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility; and 3. Patient has a diagnosis of endometriosis for which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of a hormonal contraceptive has failed; or 4. Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or 5. Patient has a diagnosis of advanced prostate cancer. Therapy will be limited as follows: 1. Endometriosis – initial 6 month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5 mg daily will be considered. Retreatment is not recommended for longer than one additional 6 month course. 2. Uterine leiomyomata – 3 month approval. 3. Advanced prostate cancer – initial 6 month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

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 10/01/2022

Lupron Depot – Pediatric *Use Lupron Depot-Pediatric PA form*	Prior authorization (PA) is required for Lupron Depot-Ped. Payment will be considered for patients when the following is met: 1. Patient has a diagnosis of central precocious puberty (CPP); and 2. Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; and 3. Patient is currently < 11 years of age for females or < 12 years of age for males; and 4. Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results); and 5. Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean); and 6. Baseline evaluations including the following have been conducted and/or evaluated: a. Height and weight measurements; and b. Sex steroid (testosterone or estradiol) levels have been obtained; and c. Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor; and d. Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors; and e. Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor; and f. Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia; and 7. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility. When criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted at 6 month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

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 10/01/2022

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.
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.

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 10/01/2022

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, Alkindi, Aricept ODT, Baqsimi, Binosto, Dartisla, Drizalma, Elyxyb, Eprontia, Exservan, Ezallor, FazaClo, Gimoti, Horizant, Invega, Lamotrigine ODT, Metoclopramide ODT, Norliqva, Remeron SolTab, Risperidone ODT, Sertraline Caps, Sitavig, Spritam, Sympazan, Tramadol Oral Solution, Trilipix, 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 10/01/2022

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.
Naloxone Nasal Spray *Use Naloxone Nasal Spray PA form*	Prior authorization (PA) is required for a patient requiring more than 2 doses of naloxone nasal spray per 365 days. Requests for quantities greater than 2 doses per 365 days will be considered under the following conditions: 1. Documentation is provided indicating why patient needs additional doses of naloxone nasal spray (accidental overdose, intentional overdose, other reason); and 2. Naloxone nasal spray is to be used solely for the patient it is prescribed for; and 3. The patient is receiving an opioid as verified in pharmacy claims; and 4. Patient has been reeducated on opioid overdose prevention; and 5. Documentation is provided on the steps taken to decrease the chance of opioid overdose again; and 6. A treatment plan is included documenting a plan to lower the opioid dose.

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 10/01/2022

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.
Nebivolol (Bystolic) *Use Nebivolol (Bystolic) PA form*	Prior authorization (PA) is required for Bystolic. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
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.

Updated 10/01/2022

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).

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 10/01/2022

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.
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.

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 10/01/2022

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 3. 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 4. Patient has moderate to severe pruritis associated with PFIC; and 5. Patient's current weight in kg is provided; and 6. Is prescribed by or in consultation with a hepatologist or gastroenterologist. 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.

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 10/01/2022

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.

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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	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.

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 10/01/2022

Use Omalizumab (Xolair) PA form	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.
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.

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 10/01/2022

Oral Constipation Agents *Use Oral Constipation Agents PA form*	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 under the following conditions: 1. Patient meets the FDA approved age; and 2. Patient must have documentation of adequate trials and therapy failures with both of the following: a. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and b. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); 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 iii. Documentation the patient is not currently taking constipation causing therapies 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 b. 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

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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	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.
Oral Immunotherapy *Oralair* *Use Oral Immunotherapy PA form*	Prior authorization (PA) is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions: 1. Medication is prescribed in consultation with an allergist; and 2. Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and 3. Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); 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. <u>Grass Pollen (Oralair) In addition to the above criteria being met:</u> Oralair 1. Patient is 10 through 65 years of age; and 2. 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. 3. 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.

Ospemifene (Osphena)	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:

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Use Ospemifene (Osphena) PA form	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.

Palivizumab (Synagis)	Respiratory Syncytial Virus (RSV) Season is defined by the centers for disease control and prevention of the United States department of health and human services and described in the RSV surveillance reports published annually in the Morbidity and Mortality Weekly Report (MMWR) and available at http://www.cdc.gov/surveillance/nrevss/rsv/reports.html.

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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Use Palivizumab PA form	1. Medicaid will use virology data provided by the Iowa department of public health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season. 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 start date will begin two weeks prior to the expected season start date for the state of Iowa. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. The expected season start date shall be derived from the median start date of the past 5 seasons using Iowa virological data. 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, 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.

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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-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. <u>Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD)</u>

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 PCSK9 Inhibitors PA form	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) – Repatha (evolocumab) only 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.
Peanut Allergen Powder-dnfp (Palforzia)	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

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 Peanut Allergen Powder-dnfp (Palforzia) PA form	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.

Pegcetacoplan (Empaveli)	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

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 Pegcetacoplan (Empaveli) PA form	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

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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.
Potassium Binders	Prior authorization (PA) is required for non-preferred potassium binders. Payment will be considered under the following conditions:

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Use Potassium Binders PA form	1. Patient is 18 years of age or older; and 2. Patient has a diagnosis of chronic hyperkalemia; and 3. Patient has documentation of a recent trial and therapy failure with sodium polystyrene sulfonate. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Proton Pump Inhibitors *Use Proton Pump Inhibitor PA form*	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 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.

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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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.

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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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.

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 10/01/2022

Risdiplam (Evrysdi)	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.
Use Risdiplam (Evrysdi) PA form	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)	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.
Use Roflumilast (Daliresp) PA form	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 10/01/2022

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.

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 10/01/2022

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).
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. Requests for doses above the manufacturer recommended dose will not be considered. PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics 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 non-preferred non-benzodiazepine sedative/hypnotics will be considered when the following criteria are met: 1. A diagnosis of insomnia; and 2. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and 3. Enforcement of good sleep hygiene is documented; and 4. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses. 5. In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage. 6. 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.

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 10/01/2022

Select Anticonvulsants *Diacomit* *Epidiolex* *Fintepla* *Use Select Anticonvulsants PA form*	Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age for submitted diagnosis and drug: and 2. Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex, 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. Follows FDA approved dosing for indication and drug. 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. The required trials may be overridden when documented evidence is provided that use of these agents would medically contraindicated.

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 10/01/2022

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 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

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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	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.
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.
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.

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 10/01/2022

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.

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

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Updated 10/01/2022

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 10/01/2022

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

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Updated 10/01/2022

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 under the following conditions: 1. Documentation of diagnosis; and 2. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and 3. Payment for non-preferred topical 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 4. 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 5. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and 6. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and 7. 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.

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 10/01/2022

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.

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 10/01/2022

Vericiguat (Verquvo) *Use Vericiguat (Verquvo) PA form*	Prior authorization (PA) is required for vericiguat (Verquvo). Payment will be considered under the following conditions: 6. Patient has a diagnosis of symptomatic chronic heart failure (NYHF class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and 7. 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 8. Patient is within the FDA labeled age for indication; and 9. 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 10. 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 11. 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 12. Is dosed based on FDA approved dosing; and 13. Initial requests for 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 10/01/2022

Vesicular Monoamine Transporter (VMAT) 2 Inhibitors	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 under the following conditions: Tardive Dyskinesia (Ingrezza or Austedo) 1. Patient meets the FDA approved age; and 2. 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 3. Prescribed by or in consultation with a neurologist or psychiatrist; and 4. 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 5. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS); and 6. For Ingrezza: a. Will not be used concurrently with MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.); and b. Will not be used concurrently with other vesicular monoamine transporter 2 (VMAT2) inhibitors; and c. Is prescribed within the FDA approved dosing; or 7. For Austedo: a. Patient does not have hepatic impairment; b. Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and c. Patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed 36mg per day (18mg twice daily); and d. Is prescribed within the FDA approved dosing. 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

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 10/01/2022

Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form	2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS). <u>Chorea associated with Huntington's disease</u> (Austedo or tetrabenazine) 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of Huntington's disease with chorea symptoms; and 3. Prescribed by or in consultation with a neurologist or psychiatrist; and 4. Is prescribed within the FDA approved dosing; and 5. Patient is not suicidal, or does not have untreated or inadequately treated depression; and 6. Patient does not have hepatic impairment; and 7. Patient does not have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and 8. 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 9. In patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed the following: a. Austedo - 36mg per day (18mg single dose) or b. Tetrabenazine – 50mg per day (25mg single dose) 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.

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 10/01/2022

Viloxazine (Qelbree) *Use Viloxazine (Qelbree) PA form*	Prior authorization is required for viloxazine (Qelbree). Payment will be considered under the following conditions: 1. 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 2. Patient is between 6 and 17 years of age; 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 at least one preferred amphetamine stimulant; and 5. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and 6. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine; and 7. Is dosed based on FDA approved dosing, and dose does not exceed 400 mg per day; and 8. 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.)
Vorapaxar (Zontivity) *Use Vorapaxar (Zontivity) PA form*	Prior authorization (PA) is required for vorapaxar (Zontivity). Payment will be considered under the following conditions: 1. Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and 2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and 3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and 4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel. 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 10/01/2022

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.

Nebivolol (Bystolic)
Removal of Criteria
Initial Review

Background

Currently, Bystolic and nebivolol are non-preferred on the Preferred Drug List (PDL). The P&T Committee will be reviewing a recommendation to make generic nebivolol preferred at the November 17, 2022 meeting. Removal of prior authorization (PA) criteria is being recommended with generic nebivolol becoming a cost effective option.

Current Prior Authorization Criteria

Prior authorization is required for Bystolic. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Other Items to Consider

- Proposed Quantity limit
    - 2.5 mg, 5 mg, 10 mg tablets – 30 tablets per 30 days
    - 20 mg tablet – 60 tablets per 30 days
        - Recommended starting dose for most patients is 5 mg once daily; dose can be increased at 2-week intervals up to 40 mg. A more frequent dosing regimen is unlikely to be beneficial.
        - Recommended starting dose in patients with severe renal impairment or moderate hepatic impairment is 2.5 mg once daily.

Potassium Binders
Removal of Criteria
Initial Review

Background

Current prior authorization (PA) criteria for the preferred potassium binders Lokelma (sodium zirconium cyclosilicate) and Veltassa (patiromer) requires a recent trial and therapy failure with sodium polystyrene sulfonate (SPS). There has been a history of reported adverse gastrointestinal events associated with SPS including bleeding, ischemic colitis, perforation, and intestinal necrosis. Additionally doses must be separated from other orally administered medications.

UpToDate currently indicates SPS should be used only in a patient who meets all the following:

- Potentially life-threatening hyperkalemia
- Dialysis not readily available
- New cation exchangers (patiromir, sodium zirconium cyclosilicate) are not available
- Other therapies to remove potassium (e.g., diuretics, rapid restoration of kidney function) have failed or are not possible

Due to the availability of safer, effective products, it is recommended the clinical PA criteria requiring SPS be used initially be removed to allow access to the preferred potassium binders.

Current Prior Authorization Criteria

Prior authorization (PA) is required for potassium binders subject to clinical criteria. Payment will be considered under the following conditions:

1. Patient is 18 years of age or older; and
2. Patient has a diagnosis of chronic hyperkalemia; and
3. Patient has documentation of a recent trial and therapy failure with sodium polystyrene sulfonate.

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

Other Items to Consider

- Proposed Age Edit – 18 years of age or older
- Proposed Quantity limit
    - Veltassa (patiromer) – 30 packets per 30 days
        - Recommended starting dose is 8.4 g once daily; monitor serum potassium and adjust dose, up to a maximum dose of 25.2 g once daily.
        - Available in 8.4 g, 16.8 g, or 25.2 g single use packets

    - Lokelma (sodium zirconium cyclosilicate) – 34 packets per 30 days (6 packets x 2 days plus 28 packets for 28 days)
        - Recommended initial treatment is 10 g three times a day for up to 48 hours. Recommended continued treatment dose is 10 g once daily; monitor serum potassium and adjust dose to recommended maintenance dose range of 5 g every other day to 15 g daily.
        - Available in 5 g or 10 g single use packets
- Make recommendation to P&T Committee to make sodium polystyrene sulfonate non-preferred on the Preferred Drug List (PDL) due to safety issues.

Select Topical Psoriasis Agents
Initial Review

Background

In May 2022, the U.S. Food and Drug Administration (FDA) approved Vtama (tapinarof) cream 1%, indicated for the topical treatment of plaque psoriasis in adults.

See attached new drug review for additional clinical information.

The mainstay of treatment of plaque psoriasis is topical therapy, including corticosteroids, vitamin D analogs, calcineurin inhibitors, keratolytics (e.g. tazarotene), and combination therapies (e.g., a corticosteroid with a vitamin D analog). Joint guidelines from the American Academy of Dermatology (AAD) and the Medical Board of the National Psoriasis Foundation (NPF) were released in 2021 for the management of psoriasis with topical therapies. Tapinarof is not addressed in the guidelines. Recommendations for treatment of plaque psoriasis not involving intertriginous areas include use of topical corticosteroids for up to 4 weeks (strength of recommendation, A). Topical vitamin D analogs can be used long-term, up to 52 weeks (strength of recommendation, A). Guidelines also address use of topical calcineurin inhibitors (strength of recommendation, B), topical tazarotene (strength of recommendation, B), and topical salicylic acid (strength of recommendation, B). The use of combination treatments with vitamin D analogues and potent topical corticosteroids from 3 to 52 weeks is more effective than either agent alone for the treatment of psoriasis (strength of recommendation, A).

Cost

- WAC $22.08/g; $1,325/60 g tube

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization 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.

Other Items to Consider

- Proposed Quantity limit – one 60 g tube per 30 days

References

Vtama cream [prescribing information]. Long Beach, CA: Dermavant; May 2022

Elmets C, Korman NJ, Farley Prater E, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol. 2021;84:432-470.

Iowa Medicaid
IOWA HHS

PDL DRUG REVIEW

Proprietary Name: Vtama®
Common Name: tapinarof cream
PDL Category: Antipsoriatic

Comparable Products	Preferred Drug List Status
Calcipotriene	Preferred
Tazarotene	Preferred with Conditions
Topical Corticosteroids	Preferred

Summary

Pharmacology/Usage: Tapinarof, the active ingredient of Vtama®, is an aryl hydrocarbon receptor (AhR) agonist. The specific mechanisms by which this cream exerts its therapeutic action in psoriasis patients are not known.

Indication: For the topical treatment of plaque psoriasis in adults.

There is no pregnancy category for this medication; however, the risk summary indicates that the available data on use in pregnant women are not sufficient 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: Cream, 1% (each gram of cream contains 10mg of tapinarof).

Recommended Dosage: Apply a thin layer of cream to affected areas once daily. Wash hands after application unless the cream is for treatment of the hands.

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 (Vtama® cream) minus reported % incidence for vehicle cream. Please note that an incidence of 0% means the incidence was the same as or less than vehicle.* The most frequently reported adverse events included folliculitis (19%), nasopharyngitis (2%), contact dermatitis (6%), headache (3%), pruritus (2%), and influenza (1%). Two subjects (0.3%) using Vtama® cream developed urticaria. Adverse reactions leading to treatment discontinuation in >1% of subjects who received Vtama® cream were contact dermatitis (2.9%) and folliculitis (2.8%).

Contraindications: There are no contraindications listed with this product.

Manufacturer: Dermavant Sciences, Inc.

Analysis: The safety and efficacy of Vtama® cream were assessed in two multicenter, randomized, double-blind, vehicle-controlled trials that included adults (N=1025) with plaque psoriasis (PSOARING 1 and PSOARING 2) who were randomized to Vtama® cream or vehicle cream once daily for 12 weeks to any lesion regardless of anatomic location.

Baseline disease severity was graded using the 5-point Physician's Global Assessment (PGA). Most included subjects had 'moderate' disease (82%), while 10% had 'mild' disease and 8% had 'severe' disease at baseline. The extent of disease involvement assessed by mean body surface area (BSA), excluding the scalp, palms, and soles, was 8% (range 3 to 20%). In addition, subjects included in the studies ranged in age from 18 to 75 years (with a median age of 51 years), while 57% of subjects were male and 85% were white.

The primary efficacy endpoint in both trials was the proportion of subjects who achieved treatment success, defined as a PGA score of "clear" (0) or "almost clear" (1) and at least a 2-grade improvement from baseline. Efficacy results are presented in the table below, which was adapted from the prescribing information.

	Study 1 (PSOARING 1)		Study 2 (PSOARING 2)	
	Vtama® cream (N=340)	Vehicle cream (N=170)	Vtama® cream (N=343)	Vehicle cream (N=172)
PGA Treatment Success	36%	6%	40%	6%
Difference	29%		34%	
NNT *calculated by CHC*	4		3	

Following 12 weeks of treatment, 73 subjects randomized to Vtama® achieved complete disease clearance (PGA 0) and had Vtama® withdrawn. These subjects were followed for up to 40 additional weeks with a median time to first worsening (PGA ≥2 ('mild') of 114 days.

Place in Therapy: Vtama® cream is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults. Its efficacy was assessed in two randomized, double-blind, vehicle-controlled studies that included adults with plaque psoriasis. The primary efficacy endpoint in both studies was the proportion of subjects who achieved treatment success, defined as a PGA score of 'clear' or 'almost clear' and at least a 2-grade improvement from baseline. Per the full-text study by Lebwohl et al[2], the differences between the tapinarof group and vehicle group were statistically significantly different ($p<0.001$ for both comparisons) and the authors concluded that tapinarof 1% cream was superior to vehicle in reducing the severity of plaque psoriasis over a period of 12 weeks. Vtama® cream was, however, associated with local adverse events and headache. Longer studies are needed. Vtama® cream is a first-in-class topical treatment that provides another treatment option for plaque psoriasis.

There is no evidence at this time to support that Vtama® is safer or more effective than the other currently preferred, more cost-effective medications. It is therefore recommended that Vtama® 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] Vtama [package insert]. Long Beach, CA: Dermavant Sciences Inc; 2022.
[2] Lebwohl MG, Gold LS, Strober B, et al. Phase 3 trials of tapinarof cream for plaque psoriasis. *NEJM*. 2021; 385(24): 2219-2229.

Initial Days' Supply Limit Override
Benzodiazepines
Initial Review

Background

At the August 2022 DUR meeting, the Commission made a recommendation to implement an initial seven (7) days' supply limit on all benzodiazepines for new users, with a 90 day lookback for the requested benzodiazepine. Excluded from the edit are nasal and rectal diazepam, nasal midazolam, and clobazam. Prior to the ProDUR edit going into place, prior authorization (PA) criteria are needed for allowances greater than an initial 7 day supply. Criteria is being added to the Initial Days' Supply Limit Override PA.

Current Prior Authorization Criteria

Requests for medications exceeding the initial days' supply limit require prior authorization. Payment will be considered under the following conditions:

1. Diagnosis is provided; and
2. Medical rationale for exceeding the initial days' supply limit is provided; and
3. 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
4. Requests for non-opioid drugs subject to the initial days' supply limit will be considered on an individual case-by-case basis, based on medical necessity documentation provided.

Proposed Prior Authorization Criteria

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* ~~Diagnosis is provided~~; 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 ~~non-opioid~~ 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.

High Dose Opioids
Initial Review

Background

Prior authorization (PA) criteria are being updated based on review of members on high dose opioids (≥ 90 MME per day) without an opioid reversal agent. Review of data during the August DUR meeting found almost half of the members identified as receiving high dose opioid therapy did not have an opioid reversal agent paid by Medicaid within 24 months of the opioid claim. Language is being updated to require documentation patient has received an opioid reversal agent versus patient receiving a prescription for an opioid reversal agent.

Current Prior Authorization Criteria

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/drugoverdose/prescribing/guideline.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 for pain management is 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 been provided a prescription for a preferred naloxone product 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 naloxone; and
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 been provided a prescription for a preferred naloxone product 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 naloxone.

Proposed Prior Authorization Criteria

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/drugoverdose/prescribing/guideline.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 for pain management *are* ~~is~~ 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* ~~been provided a prescription for a preferred~~ *opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation]) within 24 months of high dose opioid request* ~~naloxone product~~ 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* ~~naloxone~~; and
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* ~~been provided a prescription for a preferred~~ *opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation]) within 24 months of high dose opioid request* ~~naloxone product~~ 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* ~~naloxone~~.

Sedative/Hypnotics- Non-Benzodiazepine
Second Review

Background

- Utilization data for chronic use of controlled sedative/hypnotic agents was discussed at the February 2022 DUR meeting. Results found members are using these medications chronically versus short-term. Review of sedative/hypnotics, non-benzodiazepine prior authorization (PA) criteria was requested.
- Sedative/hypnotic, non-benzodiazepine PA criteria were discussed at the May 2022 meeting for next steps based on utilization data.
- After reviewing current criteria and previous criteria, the DUR recommended making modifications to current PA criteria.
- Medications subject to current PA criteria include:
    - Preferred agents – eszopiclone, zaleplon, and zolpidem
    - Non-preferred agents – Ambien, Ambien CR, Belsomra, Dayvigo, Edular, Intermezzo, Lunesta, Quviviq, ramelteon, Rozerem, Sonata, zolpidem ER, zolpidem SL, and Zolpimist

Current Clinical Prior Authorization Criteria

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.

PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics 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 non-preferred non-benzodiazepine sedative/hypnotics will be considered when the following criteria are met:

1. A diagnosis of insomnia; and
2. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and
3. Enforcement of good sleep hygiene is documented; and
4. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.
5. In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage.
6. 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.

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

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. ~~Requests for doses above the manufacturer recommended dose will not be considered.~~ PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for *a* non-preferred *agent* ~~non-benzodiazepine sedative/hypnotics~~ 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* ~~non-benzodiazepine sedative/hypnotics~~ 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* ~~suvorexant (Belsomra)~~ will require documentation of a trial and therapy failure with at least one non-preferred agent~~, other than suvorexant,~~ 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.

Vericiguat (Verquvo)
Second Review

Background

The 2022 AHH/ACC/HFSA Guideline for the Management of Heart Failure now includes four medication classes as part of guideline-directed medical therapy (GDMT) for heart failure (HF) with reduced ejection fraction (HFrEF), including the newly added sodium-glucose contransporter-2 inhibitors (SGLTi). Step 1 GDMT treatment recommendations for patient with HFrEF include:

- ARNi (angiotensin receptor-neprilysin inhibitor) in NYHA II – III or ACEi (angiotensing-converting enzyme inhibitor) or ARB (angiotensin receptor blocker) in NYHA II – IV
- Beta blocker (bisoprolol, metoprolol succinate, and carvedilol have been shown to be effective in reducing the risk of death in patients with HFrEF)
- MRA (mineralocorticoid receptor antagonist)
- SGLT2i
- Diuretics as needed

The above medications may be started simultaneously at initial (low) doses recommended for HFrEF. Alternatively, these medications may be started sequentially, with sequence guided by clinical or other factors, without need to achieve target dosing before initiating the next medication.

Additionally, in selected high-risk patients with HFrEF and recent worsening of HF despite GDMT, an oral soluble guanylyl cyclase stimulator (e.g. vericiguat) may be considered to reduce HF hospitalization and cardiovascular death.

Due to the updated guideline recommendations, prior authorization criteria are being updated to include trials with all four GDMT medication classes prior to the consideration of vericiguat.

Current Clinical Prior Authorization Criteria

Prior authorization is required for vericiguat (Verquvo). Payment will be considered under the following conditions:

1. Patient has a diagnosis of symptomatic chronic heart failure (NYHF class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and
2. 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
3. Patient is within the FDA labeled age for indication; 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
7. Is dosed based on FDA approved dosing; and
8. Initial requests for 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.

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

Prior authorization 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. ~~Patient is within the FDA labeled age for indication; and~~
5. 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
6. 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
7. 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*
8. ~~Is dosed based on FDA approved dosing; and~~

9. 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.

Maralixibat (Livmarli)
Second Review

Background

Maralixibat (Livmarli) received U.S. Food and Drug Administration (FDA) approval for the treatment of cholestatic pruritus in individuals with Alagille syndrome (ALGS) who are aged 1 year and older.

AGLS is a rare genetic disorder that can affect multiple organ systems of the body including the liver, heart, skeleton, eyes, and kidneys. Common symptoms include cholestasis, jaundice, poor weight gain and growth, and pruritus. ALGS is caused by deletion or mutation of the *JAG1* gene or the *NOTCH2* gene, with the *JAG1* gene mutation being the most common (88% of cases). These mutations are inherited in an autosomal dominant pattern, or in some cases, the mutations occur randomly due to a spontaneous genetic change. Progression of the disease can cause liver fibrosis, cirrhosis, or end stage liver disease and leads to death at an early age in life (infancy to adolescence). Treatment is directed toward the specific symptoms of each patient. Prior to the approval of maralixibat, medications used to treat pruritis included ursodeoxycholic acid (ursodiol), rifampin, and bile acid sequestrants.

See the attached new drug review for additional clinical information regarding maralixibat.

Cost

- WAC $1550.00/mL
    - 13 to 15 kg - $27,900/30 days; $334,800/12 months
    - 30 to 34 kg - $58,125/30 days; $$697,500/12 months
    - ≥ 70 kg (max dose) - $139,500/30 days; $1,674,000/12 months

Newly Proposed 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 Quantity Limit

- 90 mL per 30 days

References

Livmarli [package insert]. Foster City, CA; Mirum Pharmaceuticals, Inc.; September 2021.

National Organization for Rare Disorders (NORD). Alagille Syndrome. Available at https://rarediseases.org/rare-diseases/alagille-syndrome/. Accessed on: June 16, 2022.

PDL DRUG REVIEW

Proprietary Name: Livmarli®
Common Name: maralixibat
PDL Category: GI

Comparable Products	Preferred Drug List Status
Bylvay	Non-Preferred

Summary

Pharmacology/Usage: Maralixibat, the active ingredient of Livmarli®, is a reversible inhibitor of the ileal bile acid transporter (IBAT). It decreases the reabsorption of bile acids (primarily the salt forms) from the terminal ileum. Pruritus is a common symptom in patients with Alagille syndrome (ALGS) and the pathophysiology of pruritus in patients with ALGS is not completely understood. While the complete mechanism by which maralixibat improves pruritus in ALGS patients is not known, it may involve inhibition of the IBAT, which results in decreased reuptake of bile salts, as observed by a decrease in serum bile acids.

Indication: For the treatment of cholestatic pruritus in patients with ALGS 1 year of age and older.

There is no pregnancy category for this medication; however, the risk summary indicates that maternal use at the recommended clinical dose is not expected to result in measurable fetal exposure because systemic absorption following oral administration is low. Maralixibat may inhibit the absorption of fat-soluble vitamins. The safety and efficacy of use in the pediatric population under 1 year of age have not been established.

Dosage Form: Oral Solution: 9.5mg of maralixibat per ml.

A calibrated measuring device (0.5ml, 1ml, or 3ml oral dosing dispenser) will be provided by the pharmacy to measure and deliver the prescribed dose accurately.

Store between 68 and 77°F. Discard any remaining Livmarli® solution 45 days after first opening of bottle.

Recommended Dosage: The recommended dosage is 380mcg/kg PO QD, taken 30 minutes before the first meal of the day. Start dosing at 190mcg/kg PO QD; after one week, increase to 380mcg/kg QD, as tolerated. The maximum daily dose volume for patients above 70kg is 3ml or 28.5mg/day. Refer to the dosing table by weight guidelines in the prescribing information. If a dose is missed, it should be taken as soon as possible within 12 hours of the time it is usually taken, and the original dosing schedule should be resumed. If a dose is missed by more than 12 hours, the dose can be omitted and the original dosing schedule resumed.

Establish the baseline pattern of variability of liver tests prior to starting Livmarli®, so that potential signs of liver injury can be identified. Monitor liver tests (e.g. ALT, AST, total bilirubin, direct bilirubin) and INR during treatment with Livmarli®. Interrupt Livmarli® if new onset liver test abnormalities occur in the absence of other causes. Once the liver test abnormalities either return back to baseline values or stabilize at a new baseline value, consider restarting Livmarli® at 190mcg/kg, and increase to 380mcg/kg as tolerated. Consider discontinuing Livmarli® permanently if liver test abnormalities recur or symptoms consistent with clinical hepatitis are observed.

Livmarli® has not been studied in patients with hepatic decompensation. Discontinue Livmarli® permanently if a patient experiences a hepatic decompensation event (e.g. variceal hemorrhage, ascites, hepatic encephalopathy).

Drug Interactions: Bile acid binding resins may bind to maralixibat in the gut. Administer bile acid binding resins (e.g. cholestyramine, colesevelam, or colestipol) at least 4 hours before or 4 hours after administration of Livmarli®.

Maralixibat is an OATP2B1 inhibitor based on in vitro studies. A decrease in the oral absorption of OATP2B1 substrates (e.g. statins) due to OATP2B1 inhibition in the GI tract cannot be ruled out. Consider monitoring the drug effects of OATP2B1 substrates (e.g. statins) as needed.

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 (Livmarli®) for any grade. Please note that there was no placebo data to compare with in the prescribing information.* The most frequently reported adverse events included diarrhea (55.8%), abdominal pain (53.5%), vomiting (40.7%), nausea (8.1%), fat-soluble vitamin (FSV) deficiency (25.6%), transaminases increased (ALT, AST; 18.6%), gastrointestinal bleeding (10.4%), and bone fractures (9.3%).

Patients enrolled in Trial 1 had abnormal liver tests at baseline. During the study, treatment-emergent elevations of liver tests or worsening of liver tests, relative to baseline values, were observed. Most abnormalities included elevation in ALT, AST, or total/direct bilirubin. Obtain baseline liver tests and monitor during treatment. Dose reduction or treatment interruption may be considered if abnormalities occur in the absence of other causes. For persistent or recurrent liver test abnormalities, consider treatment discontinuation. Livmarli® was not assessed in ALGS patients with cirrhosis. Monitor patients during treatment with Livmarli® for elevations in liver tests and for the development of liver-related adverse reactions. Weigh the potential risks against the benefits of continuing Livmarli® in patients who have experienced persistent or recurrent liver test abnormalities. Discontinue Livmarli® permanently if a patient progresses to portal hypertension or experiences a hepatic decompensation event.

Diarrhea, abdominal pain, and vomiting were reported as the most common adverse reactions in patients treated with Livmarli®. Three patients (3%) experienced vomiting as a serious adverse event requiring hospitalization or IV fluid administration. If diarrhea, abdominal pain, and/or vomiting occur and no other etiologies are identified, consider reducing the dose of Livmarli® or interrupting Livmarli® dosing. For diarrhea or vomiting, monitor for dehydration and treat promptly. Consider interrupting Livmarli® dosing if a patient experiences persistent diarrhea or has diarrhea with accompanying signs and symptoms such as bloody stool, vomiting, dehydration requiring treatment, or fever. When diarrhea, abdominal pain, and/or vomiting resolve, restart Livmarli® at 190mcg/kg/day and increase the dose as tolerated. If they recur upon re-challenge with Livmarli®, then consider discontinuing Livmarli® treatment.

Fat-soluble vitamins (FSV) include vitamin A, D, E, and K (measured using INR levels). ALGS patients can have FSV deficiency at baseline. Livmarli® may affect absorption of fat-soluble vitamins. In Trial 1, treatment emergent FSV deficiency was reported in 3 patients (10%) during 48 weeks of treatment. Obtain serum FSV levels at baseline and monitor during treatment, along with any clinical manifestations. If FSV deficiency is diagnosed, supplement with FSV. Consider discontinuing Livmarli® if FSV deficiency persists or worsens despite adequate FSV supplementation.

Contraindications: There are no contraindications listed with this product.

Manufacturer: Mirum Pharmaceuticals, Inc.

Analysis: The safety and efficacy of Livmarli® were assessed in Trial 1, which consisted of an 18-week, open-label treatment period; a 4-week randomized, double-blind, placebo-controlled, drug-withdrawal period; a subsequent 26-week, open-label treatment period; and a long-term open-label extension period. Pediatric patients with ALGS (N=31) with cholestasis and pruritus were enrolled, with 90.3% of patients receiving at least one medication to treat pruritus at study entry. All patients had JAGGED1 mutation. Patients were administered open-label treatment with Livmarli® 380mcg/kg QD for 13 weeks after an initial 5-week dose escalation period; two patients discontinued

treatment during this first 18 weeks of open-label treatment. The 29 patients who completed the open-label treatment phase were then randomized to continue treatment with Livmarli® or receive matching placebo during the 4-week drug withdrawal period at weeks 19-22 (N=16 placebo, N=13 Livmarli®). All 29 patients completed the randomized, blinded drug withdrawal period; subsequently, patients received open-label Livmarli® at 380mcg/kg QD for an additional 26 weeks.

Randomized patients had a median age of 5 years (range 1 to 15 years), while 66% were male. The baseline mean of liver test parameters include serum bile acid levels of 280µmol/L, AST 158 U/L, ALT 179 U/L, gamma glutamyl transferase (GGT) 498 U/L, and total bilirubin 5.6mg/dL.

Given the patients young age, a single-item observer-reported outcome was used to measure patient's 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). Patients were included in this trial if their average pruritus score was greater than 2.0 (moderate) in the 2 weeks prior to baseline.

The average of the worst daily ItchRO(Obs) pruritus scores was computed for each week. For randomized patients, the mean at baseline (pre-treatment) was 3.1 and the mean at week 18 (pre-randomized withdrawal period) was 1.4. On average, patients administered Livmarli® for 22 weeks maintained pruritus reduction whereas those in the placebo group who were withdrawn from Livmarli® after week 18 returned to baseline pruritus scores by week 22.

Results from the placebo-controlled period can be seen in the table below, which was adapted from the prescribing information. After re-entering the open-label treatment phase, both randomized treatment groups had similar mean pruritus scores by week 28, the first week placebo patients received the full dosage of Livmarli® after withdrawal. These observer-rated pruritus results are supported by similar results on patient-rated pruritus in patients 5 years of age and older who were able to self-report their itching severity.

Weekly average of worst daily ItchRO(Obs) pruritus severity scores	Maralixibat (N=13)	Placebo (N=16)	Mean Difference
Week 22, mean	1.6	3.0	
Change from week 18 to week 22, mean	0.2	1.6	-1.4

Place in Therapy: Livmarli®, an oral reversible inhibitor of the ileal bile acid transporter (IBAT), is indicated for the treatment of cholestatic pruritus in patients with Alagille syndrome (ALGS) 1 year of age and older. Obtain baseline liver tests and monitor during treatment. In addition, obtain serum fat-soluble vitamin (FSV) levels at baseline and monitor during treatment, along with any clinical manifestations. If FSV deficiency is diagnosed, supplement with FSV. In one small study that included pediatric ALGS patients with cholestasis and pruritus, on average, patients administered Livmarli® for 22 weeks maintained pruritus reduction whereas those in the placebo group who were withdrawn from Livmarli® after 18 weeks returned to baseline pruritus scores by week 22.

There is no evidence at this time to support that Livmarli® is safer or more effective than other currently available medications. It is therefore recommended that Livmarli® remain non-preferred and require prior authorization to confirm the appropriate diagnosis and clinical parameters for use.

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

References

[1] Livmarli [package insert]. Foster City, CA: Mirum Pharmaceuticals, Inc; 2021.

PIK3CA-Related Overgrowth Spectrum (PROS) Treatments
Alpelisib (Vijoice)
Second Review

Background

Alpelisib (Piqray, Vijoice) is a phosphoinositide 3-kinase (PI3K) inhibitor. Piqray, approved in May 2019, is indicated in combination with fulvestrant for the treatment of postmenopausal women, and men, with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer as detected by an FDA-approved test following progression on or after an endocrine-based regimen. Vijoice was recently approved for the treatment of adult and pediatric patients 2 years of age and older with severe manifestations of *PIK3CA*-related overgrowth spectrum (PROS) who require systemic therapy. This indication is approved under accelerated approval based on response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

PROS is a group of rare disorders that cause overgrowth of parts of the body, due to mutations in the *PIK3CA* gene. There are different subtypes within PROS that include:

- CLAPO syndrome
- CLOVES syndrome
- Diffuse capillary malformation with overgrowth (DCMO)
- Dysplastic megalencephaly (DMEG)
- Fibroadipose hyperplasia (FAH)/fibroadipose overgrowth (FAO)/hemihyperplasia-multiple lipomatosis syndrome (HHML)
- Fibroadipose vascular anomaly (FAVA)
- Facial infiltrating lipomatosis (FIL)
- Hemimegalencephaly (HMEG)
- Klippel-Trenaunay syndrome (KTS)
- Lipomatosis of nerve (LON)
- Macrodactyly
- Megalencephaly-capillary malformation syndrome (MCAP syndrome)
- Muscular hemihyperplasia (HH)

Diagnosis is based on genetic testing for *PIK3CA* genetic variants. Clinical features that help doctors suspect PROS include:

- Overgrowth symptoms either at birth or during early childhood
- Tissue overgrowth that is patchy and irregular
- Overgrowth in fat, muscle, nerve or skeletal tissue
- Vascular malformations in capillaries, veins, arteries or lymphatic vessels
- Epidermal nevus
- Congenial neurological disorders

For patients with megalencephaly and neurological symptoms, brain imaging is a part of the diagnostic workup and used for monitoring structural changes. Vascular anomalies are detected with imaging of the affected regions to show vascular details.

Prior authorization (PA) criteria are being developed specifically for Vijoice. Piqray is subject to the Select Oncology Agents PA criteria.

Dosage and Administration

- Pediatric patients (2 to 17 years of age):
    - Initial: 50 mg orally once daily with food.
        - Pediatric patients ≥ 6 years old: Consider dose increase to 125 mg once daily for response optimization after 24 weeks at 50 mg dose.
            - Reduce dose to 50 mg if higher dose not tolerated.
        - Pediatric patients 2 to < 6 years old: No recommended dose increase.
            - Discontinue if 50 mg dose not tolerated.
- Adult patients: 250 mg orally once daily with food.
    - Dosage reduction recommendations (due to adverse reactions):
        - First-dose reduction – 125 mg once daily.
        - Second-dose reduction – 50 mg once daily.
        - Discontinue if 50 mg dose not tolerated.

Dosage Forms and Strengths

- Tablets: 50 mg, 125 mg, 200 mg

Contraindications

- Severe hypersensitivity to Vijoice or any of its ingredients

Warnings and Precautions

- Severe hypersensitivity: discontinue and promptly initiate appropriate therapy.
- Severe cutaneous adverse reactions (SCARs): including Stevens-Johnson syndrome, erythema multiforme, toxic epidermal necrolysis, and drug reaction with eosinophilia and systemic symptoms. Interrupt therapy for signs or symptoms of SCARs and permanently discontinue therapy if SCARs are confirmed.
- Hyperglycemia: can cause severe hypoglycemia, in some cases associated with hyperglycemic hyperosmolar non-ketotic syndrome or ketoacidosis.
    - Safety in patients with Type 1 or uncontrolled Type 2 diabetes has not been established. Test fasting plasma glucose, HbA1c, and optimize blood glucose prior to initiating therapy and monitor periodically after initiating treatment.
- Pneumonitis
- Diarrhea
- Embryo-Fetal Toxicity

Adverse Reactions

- Most common (Grades 1 to 4, incidence ≥ 10%): diarrhea, stomatitis, and hyperglycemia.

Clinical Studies

- The efficacy of Vijoice was established in EPIK-P1, a single-arm clinical study in 37 patients who were treated as part of an expanded access program for compassionate use which enrolled patients across seven sites in five countries (France, Spain, U.S., Ireland and Australia).
- Eligible patients 2 years of age and older with PROS who received Vijoice had clinical manifestations of PROS that were assessed by the treating physician as severe or life-threatening and necessitating systemic treatment and had documented evidence of mutation in the PIK3CA gene.
- The major efficacy outcome measure was the proportion of patients with radiological response at week 24, defined as a ≥ 20% reduction from baseline in the sum of measurable target lesion volume (1 to 3 lesions) confirmed by at least one subsequent imaging assessment, in the absence of a ≥ 20% increase from baseline in any target lesion, progression of non-target lesions, or appearance of a new lesion.
- The response rate at week 24 was 27% (95% CI: 14, 44).

Cost

- 50 mg & 125 mg: WAC $1160.74/tablet
- 250 mg dose (available in a blister pack containing 200 mg & 50 mg tablets): WAC $580.36/tablet or $1160.72/daily dose

Newly Proposed Clinical Prior Authorization Criteria

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 assessed across 1 to 3 target lesions.

Proposed Quantity Limits

- Based on daily dose blister packs (per 28 days)
    - 50 mg daily dose – One 28-day supply blister pack (28 tablets)
    - 125 mg daily dose – One 28-day supply blister pack (28 tablets)
    - 250 mg daily dose – One 28-day supply blister pack (56 tablets)

References

Vijoice [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corporation.; April 2022.

National Organization for Rare Disorders (NORD). NIH GARD Information: PIK3CA-related overgrowth spectrum. Available at https://rarediseases.org/gard-rare-disease/pik3ca-related-overgrowth-spectrum/. Accessed on: June 22, 2022.

Mavacamten (Camzyos)
Second Review

Indication

Mavacamten (Camzyos) is a cardiac myosin inhibitor indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II to III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.

Because mavacamten (Camzyos) can cause heart failure and could interact with many other drugs, it's only available through a Risk Evaluation and Mitigation Strategy (REMS) program.

Background

HCM is a common autosomal genetic disorder in which a mutation causes excessive crossbridge formation between myosin and actin proteins, preventing myocyte relaxation and causing thickening of the left ventricle. Many patients with HCM are asymptomatic, while others develop symptoms including exertional intolerance, dyspnea, chest pain, palpitations, and syncope.

The diagnosis of HCM may be suspected based on the following: family history of HCM, unexplained symptoms (i.e., dyspnea, chest pain, fatigue, palpitations), systolic ejection murmur, and abnormal 12-lead electrocardiogram or syncope (or presyncope). The presence of one or more of these clinical findings should prompt further testing with echocardiography and/or cardiac magnetic resonance imaging to confirm diagnosis. The presence of increased left ventricular (LV) wall thickening ≥15 mm anywhere in the LV wall in the absence of any other identifiable cause such as hypertension or valve disease is consistent with a diagnosis of HCM.

Treatment of obstructive HCM has been targeted at symptom management with use of negative inotropic drugs. Non-vasodilating beta-blockers are considered first line therapy. The non-dihydropyridine calcium channel blockers, verapamil and diltiazem, are alternatives to beta-blocker therapy when ineffective or not tolerated. For patients who do not respond to one or more of the first line beta-blockers or calcium channel blocker alternatives, disopyramide or septal reduction are often the next step in treatment. Note: the use of calcium channel blockers in combination with beta-blockers for treatment of HCM is unsupported by evidence (but may have a role in the management of concomitant hypertension). Disopyramide should be used in combination with a beta blocker, verapamil, or diltiazem.

Dosage and Administration

Dosage must be individualized based on clinical status and echocardiographic assessment of patient response.

- Initiation or up-titration in patients with left ventricular ejection fraction (LVEF) < 55% is not recommended.

- Recommended starting dose: 5 mg once daily and dose titrated up or down according to a treatment algorithm outlined in the package insert that is based on the Valsalva left ventricular outflow tract (LVOT) gradient and the LVEF. Subsequent doses with titration are 2.5, 5, 10, or 15 mg once daily.
- When initiating or titrating therapy, consider LVEF first then consider the Valsalva LVOT gradient and patient clinical status to guide appropriate dosing.
- Patients may develop heart failure while taking mavacamten. Regular Valsalva LVOT and LVEF assessment is required.
- Patients should be evaluated clinically and with an echocardiogram every 4 weeks for the first 12 weeks of treatment, at 4 and 12 weeks after any dosage adjustment, and every 12 weeks while on a stable maintenance dose.
- Treatment should be interrupted if the LVEF falls to < 50%. It can be restarted at a reduced dose (or in patients already taking 2.5mg/day, the same dose) after ≥ 4 weeks if the LVEF has risen to ≥ 50%

Dosage Forms and Strengths

- Capsule: 2.5, 5, 10, 15 mg

Contraindications

- Concomitant use of moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors
- Concomitant use with moderate to strong CYP2C19 inducers or moderate to strong CYP3A1 inducers

Warnings and Precautions

- Heart failure
- CYP450 drug interactions leading to heart failure or loss of effectiveness
- Embryo-fetal toxicity

Adverse Reactions

- Occurring in > 5%: dizziness and syncope

Clinical Studies

The efficacy of mavacamten (Camzyos) was established in EXPLORER-HCM, a double-blind, randomized, placebo-controlled study in 251 adults with symptomatic NYHA class II and III obstructive HCM. Patients were randomized to receive mavacamten or placebo once daily for 30 weeks. The primary composite functional endpoint, assessed at 30 weeks, was defined as the proportion of patients who achieved either improvement of mixed venous oxygen tension (pVO_2) by ≥ 1.5 mL/kg/min plus improvement in NYHA class by at least 1 or improvement of pVO_2 by ≥ 3.0 mL/kg/min plus no worsening in NYHA class.

- Overall, 37% of patients met the primary endpoint with mavacamten vs. 17% with placebo (treatment difference 19, 95% CI: 9, 30; p = 0.0005).

- Although the benefit of mavacamten was smaller in patients on background beta blocker therapy compared to those who were not, analyses of other secondary endpoints (symptoms, left ventricular outflow tract gradient) suggest that patients might benefit from mavacamten treatment regardless of beta blocker use.

Cost

- WAC, all strengths: $245.21/capsule; $7,356.30/month; $88,275.60/year

Newly Proposed Clinical Prior Authorization Criteria

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 II or III 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.

Proposed Quantity Limits

- Across all strengths: 30 capsules per 30 days

References

Camzyos [package insert]. Brisbane, CA; Bristol Myers Squibb.; May 2022.

Maron MS. Hypertrophic cardiomyopathy: Clinical manifestations, diagnosis and evaluation. In UpToDate, McKenna WJ (Ed), UpToDate, Waltham, MA. (Accessed June 28. 2022.)

SR Ommen et al. 2020 AHA/ACC guideline for the diagnosis and treatment of patients with hypertrophic cardiomyopathy: a report of the American College of Cardiology/American Heart Association Joint Committee on clinical practice guidelines. Circulation 2020; 142:e558.

Dupilumab (Dupixent)
Second Review

Background

In May 2022 dupilumab (Dupixent), an interleukin-4 (IL-4) receptor alpha antagonist, received a fourth indication for the treatment of adult and pediatric patients 12 years of age and older, weighing at least 40 kg, with eosinophilic esophagitis (EoE). Dupilumab is also indicated for atopic dermatitis, asthma, and chronic rhinosinusitis with nasal polyposis.

EoE is a chronic immune/antigen mediated disease characterized by clinical symptoms of esophageal dysfunction and eosinophil-predominant inflammation. The diagnosis of EoE requires all of the following:

- Symptoms related to esophageal dysfunction (dysphagia, food impaction, food refusal, abdominal pain, heartburn, regurgitation, chest pain, odynophagia).
- Eosinophil predominant inflammation on esophageal biopsy, consisting of a peak value of ≥ 15 eosinophils per high power field.
- Exclusion of other causes that may be responsible for or contributing to symptoms and esophageal eosinophilia.

The American Gastroenterological Association (AGA) and the Joint Task Force for Allergy-Immunology Practice Parameters, released in 2020, provide several recommendations, including the following:

- In patients with symptomatic esophageal eosinophilia, the AGA/JTF suggests using proton pump inhibition over no treatment. (Conditional recommendation, very low-quality evidence)
- In patients with EoE, the AGA/JTF recommends topical glucocorticosteroids over no treatment. (Strong recommendation, moderate quality evidence)
- In patients with EoE, the AGA/JTF suggests topical glucocorticosteroids rather than oral glucocorticosteroids. (Conditional recommendation, moderate quality evidence)
- In patients with EoE, the AGA/JTF suggests using elemental diet over no treatment. (Conditional recommendation, moderate quality evidence) Comment: Patients who put a higher value on avoiding the challenges of adherence to an elemental diet and the prolonged process of dietary reintroduction may reasonably decline this treatment option.
- In patient with EoE the AGA/JTF suggests using an empiric six-food elimination diet over no treatment. (Conditional recommendation, low quality evidence) Comment: Patients who put a higher value on avoiding the challenges of adherence to diet involving elimination of multiple common food staples and the prolonged process of dietary reintroduction may reasonably decline this treatment option.
- In patients with EoE, the AGA/JTF suggests allergy testing-based elimination diet over no treatment. (Conditional recommendation, very low quality evidence) Comment: Due to the potential limited accuracy of currently available, allergy-based testing for the identification of specific food triggers, patients may prefer alternative medical or dietary therapies to an exclusively testing-based elimination diet.

Guidelines have not been updated to include recommendations for use of dupilumab. It should be noted, the AGA/JFT guidelines did mention anti-IL-5 therapy, anti-IL-13, and anti-IL-4 receptor α therapy for EoE, with a recommendation to only be used in the context of a clinical trial.

Prior authorization criteria are being updated to include the new indication.

Clinical Trials

The efficacy and safety of dupilumab in EoE was studied in a randomized, double-blind, parallel-group, multicenter, placebo-controlled trial, including two 24-week treatment periods (Part A and Part B) that was conducted in adult and pediatric patients 12 to 17 years of age. In both parts, patients received either placebo or 300 mg of dupilumab every week. Eligible patients had ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) following a treatment course of a proton pump inhibitor (PPI) either prior to or during the screening period and symptoms of dysphagia as measured by the Dysphagia Symptom Questionnaire (DSQ). The coprimary efficacy endpoints were the proportion of patients achieving histological remission defined as a peak esophageal intraepithelial eosinophil count of ≤ 6 eos/hpf at week 24, and the change in the patient reported DSQ score from baseline to week 24. The DSQ is a questionnaire designed to measure difficulty swallowing associated with EoE, with total scores ranging from 0 to 84; higher DSQ scores indicate worse symptoms.

In Part A of the trial, 60% of the 42 patients who received dupilumab achieved histological remission compared to 5% of the 39 patients who received a placebo. Patients in Part A who received dupilumab experienced an average improvement of 22 points in their DSQ score compared to 10 points in patients who received placebo. In Part B, 59% of the 80 patients who received dupilumab achieved histological remission compared to 6% of the 79 patients who received a placebo. Patients in Part B who received dupilumab experienced an average improvement of 24 points in their DSQ score compared to 14 points in patients who received placebo. Assessments incorporating the perspectives from patients with EoE supported that the DSQ score improvement in patients who received dupilumab in the clinical trial was representative of clinically meaningful improvement in dysphagia.

Dosing

- EoE: 300 mg weekly

Cost

- AAC $825.95/mL; $6,607.56/4 weeks; $85,898.28/13 weeks

Current Clinical Prior Authorization Criteria

Prior authorization is required for Dupixent (dupilumab). Payment will be considered under the following conditions:

1. Patient is within the FDA labeled age for indication; and
2. 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 has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
   f. Patient will continue with skin care regimen and regular use of emollients; or
3. 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; 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. Two (2) or more exacerbations in the previous year or
      ii. Require daily oral corticosteroids for at least 3 days; ~~and~~ *or*
4. 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; and
5. Dose does not exceed the FDA approved dosing for indication.

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.

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 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* ~~Patient is within the FDA labeled age for indication~~; 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 has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
    f. Patient will continue with skin care regimen and regular use of emollients; or
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; 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. Two (2) or more exacerbations in the previous year or
        ii. Require daily oral corticosteroids for at least 3 days; ~~and~~ *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; ~~and~~ *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; and
7. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for *6 months* ~~16 weeks~~ 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.

References

Dupixent [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; June 2022

Bonis PA. Clinical manifestations and diagnosis of eosinophilic esophagitis (EoE). In UpToDate, Tally NJ (Ed), UpToDtae, Waltham, MA. (Accessed June 24. 2022.)

Viloxazine (Qelbree)
Second Review

Background

In April 2022, viloxazine (Qelbree) received an expanded indication for the treatment of attention deficit hyperactivity disorder (ADHD) in adults and pediatric patients 6 years and older. Previously, it was only approved for this indication in pediatric patients 6 to 17 years of age.

Prior authorization criteria are being updated to include treatment of adults for ADHD.

Dosage (expanded indication)

- Adults – 200 mg once daily, may titrate dose in increments of 200 mg weekly to the maximum recommended dosage of 600 mg once daily, depending on response and tolerability.

Clinical Studies

- Approval for the expanded indication was based on a randomized, double-blind, placebo-controlled monotherapy study in 374 adults 18 to 65 years of age with ADHD. The primary endpoint was the change from baseline to the end of study on the total score on the ADHD Investigator Symptom Rating Scale (AISRS), an 18-item scale corresponding to 18 symptoms of ADHD. Higher AISRS scores reflect more severe symptoms.
- The change from baseline in the AISRS total score was -15.5 with Qelbree vs. -11.7 with placebo (difference -3.7, 95% CI: -6.2, -1.2).

Cost

- AAC - 200 mg capsule: $10.12/capsule; $910.78/month; $10,925.71/12 months at maximum adult dose

Current Clinical Prior Authorization Criteria

Prior authorization is required for viloxazine (Qelbree). Payment will be considered under the following conditions:

1. 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
2. Patient is between 6 and 17 years of age; 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 at least one preferred amphetamine stimulant; and
5. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and
6. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine; and

7. Is dosed based on FDA approved dosing, and dose does not exceed 400 mg per day; and
8. 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.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
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. Patient is between 6 and 17 years of age; and~~
4. 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
~~5. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred amphetamine stimulant; and~~
~~6. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and~~
7. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine; and
8. ~~Is dosed based on FDA approved dosing, and~~ ~~d~~*D*ose does not exceed 400 mg per day *for pediatric patients (< 18 years of age) and 600 mg per day for adult patients*; and
9. 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.

Proposed Quantity Limit

- Update quantity limit for viloxazine (Qelbree) 200 mg capsule to accommodate adult dosing
    - Current – 60 capsules
    - Proposed – 90 capsules

References

Qelbree[package insert]. Rockville, MD; Supernus Pharmaceuticals, Inc.; April 2022.

CNS Stimulants and Atomoxetine
Second Review

Background

Data regarding members identified with more than one chemically distinct stimulant in their pharmacy claims was reviewed at the May 2022 DUR meeting. In addition to sending letters to providers regarding the therapeutic duplication, a recommendation was made to update prior authorization (PA) criteria to add a statement regarding use of an amphetamine-based stimulant concurrently with a methylphenidate-based stimulant.

PA criteria for ADHD are being updated. Criteria for other indications (narcolepsy, excessive sleepiness from obstructive sleep apnea/hypopnea, and binge eating disorder) are not included below.

Current Clinical Prior Authorization Criteria for ADHD

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. Requests will be considered for an FDA approved age for the submitted diagnosis. Payment for CNS stimulants and atomoxetine will be considered under the following conditions:

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.

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.

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

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. ~~Requests will be considered for an FDA approved age for the submitted diagnosis~~. *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 the requested drug* under the following conditions:

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.*

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.

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DUR DIGEST

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Benzodiazepine ProDUR Edits - Coming Soon

Initial Days' Supply Limit for Benzodiazepines
Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act requires State Medicaid Programs to have in place prospective safety edits (as specified by the state) and a claims review automated process (i.e., retrospective review) for concurrent use of opioids and benzodiazepines. Iowa Medicaid satisfies this requirement by having safety edits at the point of sale (POS), in the form of a soft edit, in place to notify the pharmacy of opioids and benzodiazepines prescribed concurrently as well as conducting a retrospective claims review for concurrent opioid plus benzodiazepines. The DUR Commission discussed the concurrent use of opioids and benzodiazepines over the course of several meetings and made a recommendation to implement a 7-day initial limit on all benzodiazepines for new users. The ProDUR point-of-sale (POS) edit would limit to an initial 7 days' supply for a benzodiazepine if the requested benzodiazepine is not found in the member's pharmacy claims in the preceding 90 days. Benzodiazepines excluded from this edit include nasal and rectal diazepam, nasal midazolam and clobazam. Prior authorization would be required for an initial days' supply greater than the 7-day allowance. The Commission will develop PA criteria for requests exceeding the initial limit.

ProDUR Cumulative Quantity Limit for Oral Benzodiazepines
In September 2020, the U.S. Food and Drug Administration (FDA) required a *Boxed Warning* to be added to the label for benzodiazepines, describing the potential for abuse, addiction, physical dependence, and withdrawal reactions. The DUR reviewed utilization data for select benzodiazepines (alprazolam, clonazepam, diazepam, and lorazepam) and also reviewed the Iowa Medicaid benzodiazepine quantity limits. The DUR Commission made a recommendation to implement a cumulative quantity limit of 4 units per day across the benzodiazepine class for solid oral dosage forms. The quantity limit chart will be updated to include the following statement: *Benzodiazepines are subject to a cumulative quantity limit of 4 units per day, unless otherwise indicated on the chart*. Quantity limits can be found at www.iowamediaidpdl.com under the Billing/Quantity Limits link.

Outgoing Members of the DUR Commission

Brett Faine, Pharm.D recently completed a twelve-year term of service with the Iowa Drug Utilization Review Commission. Dr. Faine served on the Commission from July 2010 through June of 2022.

Kellen Ludvigson, Pharm.D. recently completed ten years of service with the Iowa Drug Utilization Review Commission. Dr. Ludvigson served on the Commission from July 2012 through June 2022.

The Commission and the Department of Health and Human Services would like to thank Dr. Faine and Dr. Ludvigson for their contributions and dedication to the Commission and the members of Iowa Medicaid.

Incoming Members of the DUR Commission

The Iowa Medicaid Drug Utilization Review Commission recently welcomed two new members.

Rhea Hartley, M.D. is the Chief Medical Officer at Community Health Centers of Southeast Iowa in West Burlington, Iowa. She received her Doctor of Medicine degree from the University of Kansas School of Medicine in 2003 and has a Master of Science in Health Care Administration from Oklahoma State University. Dr. Hartley was appointed to the DUR Commission in July 2022; her first term will expire in June 2026.

Holly Randleman, Pharm.D. is currently an Emergency Medicine Clinical Staff Pharmacist at Iowa Methodist Medical Center in Des Moines, Iowa. She received her Doctor of Pharmacy degree from Drake University in 2007. She served on the Iowa Medicaid Pharmaceuticals and Therapeutics Committee from 2013 to 2020. Dr. Randleman was appointed to the DUR Commission in July 2022; her first term will expire in June 2026.

DUR Public Comment

Iowa Medicaid Drug Utilization Review Commission meetings are open to the public. To assure public input into the DUR process, the agenda and meeting materials are posted on the DUR website, www.iadur.org, prior to the meeting and public comment can be submitted in writing to info@iadur.org or presented at the meeting. Anyone wishing to provide public comment must complete a Conflict of Interest disclosure. The complete public comment policy can be found on the DUR website.

Parties interested in the activities of the Iowa Medicaid DUR Commission can request to receive notification emails regarding the posting of the agenda and meeting materials on the website. To receive notification emails, please send an email with your contact information to info@iadur.org with subscribe to DUR meeting notifications in the subject line.

Medicaid Statistics for Prescription Claims
September 2022 through November 2022

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