IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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August 2, 2023

Susan L. Parker, R.Ph, Pharm.D.
Pharmacy Director
Iowa Medicaid
1305 East Walnut
Des Moines, Iowa 50309

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 2, 2023. At this meeting, the DUR Commission members discussed new or updated PA criteria for Palivizumab (Synagis); IL-5 Antagonists; Select Anticonvulsants; Cyclosporine Ophthalmic Emulsion (Verkazia); Topical Acne and Rosacea Products; and removal of PA criteria and quantity limit for Naloxone Nasal Spray. In addition, the DUR Commission discussed ProDUR quantity limits for Verkazia and Winlevi. The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a May 5, 2023 letter that was sent to them detailing the new or updated PA criteria for Palivizumab (Synagis); IL-5 Antagonists; Select Anticonvulsants; Cyclosporine Ophthalmic Emulsion (Verkazia); Topical Acne and Rosacea Products; removal of PA criteria and quantity limit for Naloxone Nasal Spray, as well as recommended ProDUR quantity limits for Verkazia and Winlevi.

Palivizumab (Synagis)

Current Clinical Prior Authorization Criteria

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.

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:

Chronic Lung Disease (CLD) of Prematurity

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.

Prematurity (without CLD of Prematurity or Congenital Heart Disease)

1. Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks.

Neuromuscular Disorders or Anatomic Pulmonary Abnormalities

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.

Hemodynamically Significant Congenital Heart Disease (CHD)

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.

Immunocompromised Children

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).

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

Respiratory Syncytial Virus (RSV) *surveillance is tracked* ~~Season is defined~~ by *the national respiratory and enteric virus surveillance system (NREVSS) on* the centers for disease control and prevention of the United States department of health and human services *website.* ~~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.~~

1. Medicaid will use *Iowa* virology data *reported to the NREVSS, as documented under RSV state trends.* ~~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 RSV season in Iowa is predefined as November 1st through March 31st of each RSV season. Prescribers and dispensing pharmacies should monitor state specific virology data and hold administration of palivizumab if data indicates RSV is not prevalent at the beginning of the predefined Iowa RSV season. Consideration of use of palivizumab during interseasonal spread of RSV may be considered by Medicaid with widespread RSV circulation.* ~~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 *in the prior 5 months* should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season. Payment for palivizumab will be considered for patients who meet one of the following criteria:

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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.

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1. Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks.

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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.

Hemodynamically Significant Congenital Heart Disease (CHD)

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.

Immunocompromised Children

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).

IL-5 Antagonists

Current Clinical Prior Authorization Criteria

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 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.

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

Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug* under the following conditions:

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

6. *Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); and*
    a. *Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; and*
    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*
7. Prescribed by or in consultation with an allergist, hematologist, immunologist, *otolaryngologist,* pulmonologist, or rheumatologist.

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

If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome *or CRSwNP* to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met:
Severe Asthma with an Eosinophilic Phenotype:

1. Patient continues to receive therapy with an ICS, LABA and LTRA; and
2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or
3. Patient has experienced a decrease in administration of rescue medication (albuterol); or
4. Patient has experienced a decrease in exacerbation frequency; or
5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline.

Eosinophilic Granulomatosis with Polyangiitis

1. Patient has demonstrated a positive clinical response to therapy (increase in remission time).

Hypereosinophilic Syndrome:

1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and
2. Medication continues to be used in combination with stable doses or at least one other HES therapy.

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

1. *Patient has demonstrated positive clinical response to therapy (improvement in symptoms.); and*
2. *Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray.*

Select Anticonvulsants

Current Clinical Prior Authorization Criteria
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 be medically contraindicated.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized/stricken)
Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations;* ~~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, *or cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder* with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and
3. Is prescribed by or in consultation with a neurologist; and
4. Patient's current weight is provided; and
5. ~~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*; or*
    d. Ganaxolone
        i. Weight ≤ 28 kg: 63 mg/kg/day; or
        ii. Weight > 28 kg: 1800 mg/day.

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

Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia)

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and
3. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and
4. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and
5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and
6. Is not prescribed in combination with other ophthalmic cyclosporine products.

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

Initial requests will be approved for 6 months. Additional authorizations will be considered upon documentation of clinical response to therapy.

Topical Acne and Rosacea Products

Current Prior Authorization Criteria

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.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized/stricken)
Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered *when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when* ~~under~~ the following conditions *are met*:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and*
2. Documentation of diagnosis; and
3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and
4. Payment for non-preferred topical *antibiotic or topical retinoid* acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and
5. *Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and*
6. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent; and
7. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and
8. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and
9. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.

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

Naloxone Nasal Spray

Naloxone nasal spray PA criteria and the number of naloxone doses allowed per year was reviewed by the DUR Commssion due to provider confusion regarding coverage and reqirements. After discussion, in order to remove barriers to access of naloxone, the DUR Commssion made a recommendation to remove current PA criteria and current quantity limits and monitor for appropriate utilization post-payment.

Current Clinical Prior Authorization (*recommendation to remove PA criteria*)
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.

Proposed ProDUR Quantity Limits

Drug Product	Quantity	Days Supply
Verkazia (cyclosporine ophthalmic emulsion 0.1%)	1 box (120 single-dose vials)	30
Winlevi (clascoterone cream 1%)	60 gm (1 tube)	30

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for Palivizumab (Synagis); IL-5 Antagonists; Select Anticonvulsants; Cyclosporine Ophthalmic Emulsion (Verkazia); Topical Acne and Rosacea Products; removal of PA criteria and quantity limit for Naloxone Nasal Spray, as well as recommended ProDUR quantity limits for Verkazia and Winlevi.

Sincerely,

Pamela Smith R.Ph.

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

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

Iowa Total Care Claims
Quarterly Statistics

REPORT_DATE	Mar 2023 through May 2023	Jun 2023 through Aug 2023	% CHANGE
TOTAL PAID AMOUNT	$104,701,457.80	$85,325,411.42	-18.51%
UNIQUE USERS	152,346	124,164	-18.50%
COST PER USER	$687.26	$687.20	-0.01%
TOTAL PRESCRIPTIONS	909,181	785,573	-13.60%
AVERAGE PRESCRIPTION PER USER	5.97	6.33	6.01%
AVERAGE COST PER PRESCRIPTION	$115.16	$108.62	-5.68%
# GENERIC PRESCRIPTIONS	803,712	699,383	-12.98%
% GENERIC	88.00%	89.00%	0.71%
$ GENERIC	$14,466,889.42	$11,898,911.28	-17.75%
AVERAGE GENERIC PRESCRIPTION COST	$18.00	$17.01	-5.48%
AVERAGE GENERIC DAYS SUPPLY	30	26	-13.19%
# BRAND PRESCRIPTIONS	105,469	86,190	-18.28%
% BRAND	12.00%	11.00%	-5.24%
$ BRAND	$90,234,568.38	$73,426,500.14	-18.63%
AVERAGE BRAND PRESCRIPTION COST	$855.56	$851.91	-0.43%
AVERAGE BRAND DAYS SUPPLY	31	29	-7.13%

UTILIZATION BY AGE

AGE		Mar 2023 through May 2023	Jun 2023 through Aug 2023
0-6		52,902	32,227
7-12		53,930	40,114
13-18		68,899	55,277
19-64		719,829	645,963
65+		13,621	11,992

UTILIZATION BY GENDER AND AGE

GENDER	AGE		Mar 2023 through May 2023	Jun 2023 through Aug 2023
F	0-6		23,088	14,083
	7-12		21,107	15,593
	13-18		38,078	29,745
	19-64		466,916	415,142
	65+		8,908	7,854
M	0-6		29,814	18,144
	7-12		32,823	24,521
	13-18		30,821	25,532
	19-64		252,913	230,821
	65+		4,713	4,138

TOP 100 PHARMACIES BY PRESCRIPTION COUNT

202306 - 202308

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	12,069	$6,220,458.81	$515.41	1
2	WALGREENS #4405	COUNCIL BLUFFS	IA	7,191	$492,392.21	$68.47	2
3	WALGREENS #5239	DAVENPORT	IA	6,798	$383,570.60	$56.42	3
4	WALGREENS #5042	CEDAR RAPIDS	IA	6,010	$427,803.73	$71.18	5
5	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	5,878	$280,345.10	$47.69	4
6	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	5,412	$363,437.96	$67.15	6
7	WALGREENS #7455	WATERLOO	IA	5,035	$350,012.37	$69.52	7
8	DRILLING PHARMACY	SIOUX CITY	IA	4,976	$317,298.86	$63.77	8
9	RIGHT DOSE PHARMACY	ANKENY	IA	4,959	$283,326.94	$57.13	12
10	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	4,560	$234,626.71	$51.45	11
11	WALGREENS #359	DES MOINES	IA	4,426	$274,816.11	$62.09	10
12	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,323	$294,372.76	$68.09	15
13	WALGREENS #15647	SIOUX CITY	IA	4,301	$285,265.57	$66.33	13
14	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,260	$326,095.42	$76.55	18
15	WALGREENS #5721	DES MOINES	IA	4,259	$256,032.14	$60.12	9
16	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,126	$323,620.92	$78.43	17
17	WALGREENS #7453	DES MOINES	IA	4,089	$235,504.45	$57.59	14
18	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,973	$466,268.21	$117.36	19
19	MAHASKA DRUGS INC	OSKALOOSA	IA	3,840	$266,163.83	$69.31	20
20	WALGREENS #3700	COUNCIL BLUFFS	IA	3,723	$218,716.51	$58.75	16
21	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,559	$281,359.15	$79.06	29
22	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,505	$287,171.55	$81.93	25
23	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,470	$240,343.15	$69.26	21
24	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,440	$271,358.64	$78.88	28
25	WALGREENS #4041	DAVENPORT	IA	3,403	$208,821.65	$61.36	22
26	WALGREENS #5044	BURLINGTON	IA	3,107	$216,460.50	$69.67	23
27	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	3,096	$367,756.67	$118.78	30
28	SOUTH SIDE DRUG	OTTUMWA	IA	3,059	$242,935.29	$79.42	32
29	HY-VEE PHARMACY (1449)	NEWTON	IA	3,003	$232,693.00	$77.49	27
30	MEDICAP LTC	INDIANOLA	IA	2,984	$139,652.48	$46.80	36
31	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	2,942	$94,511.17	$32.12	44
32	WALGREENS #7452	DES MOINES	IA	2,912	$221,130.96	$75.94	31
33	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,843	$180,603.17	$63.53	33
34	STANGEL PHARMACY	ONAWA	IA	2,834	$279,789.55	$98.73	26
35	CVS PHARMACY #10282	FORT DODGE	IA	2,796	$166,809.20	$59.66	54
36	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,791	$229,944.18	$82.39	46
37	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,772	$193,644.09	$69.86	43
38	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	2,766	$270,227.78	$97.70	24
39	REUTZEL PHARMACY	CEDAR RAPIDS	IA	2,756	$248,299.78	$90.09	40
40	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,750	$213,806.65	$77.75	48
41	NUCARA LTC PHARMACY #3	IOWA CITY	IA	2,714	$118,119.79	$43.52	34
42	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,702	$152,325.96	$56.38	42
43	DANIEL PHARMACY	FT DODGE	IA	2,701	$204,282.09	$75.63	38
44	HY-VEE PHARMACY #1 (1281)	IOWA CITY	IA	2,696	$158,361.52	$58.74	35
45	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,682	$220,023.17	$82.04	47
46	WALGREENS #5886	KEOKUK	IA	2,663	$132,239.09	$49.66	41
47	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,656	$217,635.49	$81.94	49

TOP 100 PHARMACIES BY PRESCRIPTION COUNT

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RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
48	HY-VEE PHARMACY (1396)	MARION	IA	2,622	$217,076.94	$82.79	57
49	WALGREENS #5470	SIOUX CITY	IA	2,614	$155,365.32	$59.44	37
50	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	2,609	$163,405.99	$62.63	50
51	HY-VEE PHARMACY #4 (1060)	CEDAR RAPIDS	IA	2,584	$158,854.05	$61.48	66
52	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	2,571	$153,615.65	$59.75	52
53	CVS PHARMACY #08546	WATERLOO	IA	2,556	$200,503.19	$78.44	62
54	HY-VEE PHARMACY (1075)	CLINTON	IA	2,541	$218,095.76	$85.83	39
55	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,484	$195,671.86	$78.77	51
56	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,475	$186,805.06	$75.48	59
57	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	2,471	$72,026.72	$29.15	60
58	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,451	$184,299.51	$75.19	55
59	WALGREENS #3875	CEDAR RAPIDS	IA	2,449	$166,381.97	$67.94	71
60	WALMART PHARMACY 10-1509	MAQUOKETA	IA	2,378	$139,115.21	$58.50	88
61	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	2,377	$190,181.99	$80.01	58
62	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,323	$233,917.91	$100.70	67
63	WAGNER PHARMACY	CLINTON	IA	2,312	$185,109.28	$80.06	72
64	WALGREENS #5852	DES MOINES	IA	2,298	$165,400.84	$71.98	56
65	PRAIRIE PARKWAY PHARMACY	CEDAR FALLS	IA	2,297	$154,222.15	$67.14	90
66	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,296	$311,938.95	$135.86	64
67	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,280	$295,536.87	$129.62	63
68	WALMART PHARMACY 10-1496	WATERLOO	IA	2,275	$153,173.88	$67.33	82
69	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	2,272	$114,221.10	$50.27	68
70	WALMART PHARMACY 10-2889	CLINTON	IA	2,265	$124,414.39	$54.93	45
71	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	2,260	$164,459.65	$72.77	74
72	WALMART PHARMACY 10-1723	DES MOINES	IA	2,244	$131,483.26	$58.59	76
73	WALGREENS #4714	DES MOINES	IA	2,243	$121,534.94	$54.18	81
74	EXACTCARE	VALLEY VIEW	OH	2,226	$207,453.05	$93.20	107
75	SCOTT PHARMACY	FAYETTE	IA	2,204	$141,386.19	$64.15	123
76	WALMART PHARMACY 10-3590	SIOUX CITY	IA	2,202	$162,084.08	$73.61	69
77	HY-VEE PHARMACY (1095)	CRESTON	IA	2,196	$144,436.66	$65.77	83
78	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,188	$98,680.14	$45.10	53
79	HY-VEE PHARMACY (1522)	PERRY	IA	2,184	$125,220.60	$57.34	65
80	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,179	$227,739.28	$104.52	78
81	WALMART PHARMACY 10-3394	ATLANTIC	IA	2,167	$128,000.23	$59.07	73
82	HY-VEE PHARMACY #6 (1155)	DES MOINES	IA	2,134	$137,117.99	$64.25	106
83	WALMART PHARMACY 10-2716	CEDAR RAPIDS	IA	2,119	$130,649.51	$61.66	108
84	WALGREENS #7454	ANKENY	IA	2,117	$118,660.28	$56.05	61
85	LAGRANGE PHARMACY	VINTON	IA	2,083	$131,400.06	$63.08	101
86	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,082	$184,491.12	$88.61	93
87	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,078	$200,786.80	$96.63	92
88	WALMART PHARMACY 10-1285	OTTUMWA	IA	2,073	$120,001.06	$57.89	86
89	MEDICAP PHARMACY	ELDORA	IA	2,060	$144,577.19	$70.18	77
90	WALMART PHARMACY 10-1683	SHENANDOAH	IA	2,052	$116,106.41	$56.58	98
91	WALGREENS #9708	DUBUQUE	IA	2,044	$139,604.67	$68.30	75
92	WALMART PHARMACY 10-1393	OSKALOOSA	IA	2,018	$153,934.63	$76.28	85
93	WALMART PHARMACY 10-0646	ANAMOSA	IA	2,008	$136,936.21	$68.20	91
94	WALGREENS #5777	DES MOINES	IA	2,004	$137,920.68	$68.82	70

TOP 100 PHARMACIES BY PRESCRIPTION COUNT

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RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
95	WALMART PHARMACY 10-1732	DENISON	IA	2,001	$162,064.88	$80.99	102
96	UNION PHARMACY	COUNCIL BLUFFS	IA	1,987	$211,973.88	$106.68	128
97	WALMART PHARMACY 10-0985	FAIRFIELD	IA	1,981	$131,756.11	$66.51	79
98	HY-VEE PHARMACY #1 (1105)	DAVENPORT	IA	1,969	$111,359.64	$56.56	111
99	WALGREENS #11942	DUBUQUE	IA	1,960	$127,153.98	$64.87	89
100	WALMART PHARMACY 10-5115	DAVENPORT	IA	1,951	$136,816.94	$70.13	132

TOP 100 PHARMACIES BY PAID AMOUNT
202306 - 202308

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	12,069	$6,220,458.81	$2,513.32	1
2	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	469	$2,701,912.78	$11,400.48	2
3	COMMUNITY, A WALGREENS PHARMACY #16528	DES MOINES	IA	461	$1,971,814.47	$11,140.19	3
4	UNITYPOINT AT HOME	URBANDALE	IA	604	$1,947,522.99	$7,884.71	4
5	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,483	$1,469,992.60	$6,901.37	5
6	ACARIAHEALTH PHARMACY #11	HOUSTON	TX	159	$1,271,579.10	$16,954.39	6
7	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	111	$1,154,327.90	$22,198.61	8
8	CVS PHARMACY #00102	AURORA	CO	127	$1,108,777.81	$18,792.84	7
9	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	23	$1,095,697.83	$109,569.78	10
10	HY-VEE PHARMACY SOLUTIONS	OMAHA	NE	178	$984,879.85	$15,388.75	9
11	COMMUNITY, A WALGREENS PHARMACY #21250	IOWA CITY	IA	283	$818,902.55	$6,657.74	11
12	CVS/SPECIALTY	MONROEVILLE	PA	131	$708,455.21	$10,899.31	15
13	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	82	$640,113.76	$20,648.83	14
14	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	79	$561,140.49	$12,198.71	12
15	WALGREENS #4405	COUNCIL BLUFFS	IA	7,191	$492,392.21	$331.58	13
16	ALLEN CLINIC PHARMACY	WATERLOO	IA	1,142	$471,920.95	$1,206.96	18
17	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,973	$466,268.21	$699.05	22
18	WALGREENS #5042	CEDAR RAPIDS	IA	6,010	$427,803.73	$310.90	16
19	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,805	$427,029.66	$2,412.60	19
20	KROGER SPECIALTY PHARMACY LA	HARVEY	LA	46	$411,004.20	$20,550.21	35
21	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	35	$392,583.19	$30,198.71	17
22	WALGREENS #5239	DAVENPORT	IA	6,798	$383,570.60	$249.07	24
23	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	3,096	$367,756.67	$2,113.54	37
24	THE NEBRASKA MED CENTER CLINIC PHCY	OMAHA	NE	583	$365,282.63	$3,044.02	23
25	OPTUM INFUSION SERVICES 305, LLC	LENEXA	KS	13	$363,740.62	$90,935.16	57
26	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	5,412	$363,437.96	$330.10	25
27	WALGREENS #16270	OMAHA	NE	52	$351,062.43	$14,042.50	21
28	WALGREENS #7455	WATERLOO	IA	5,035	$350,012.37	$286.43	26
29	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,335	$330,307.67	$2,144.86	46
30	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	1,497	$330,283.59	$1,032.14	27
31	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,260	$326,095.42	$480.26	31
32	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,126	$323,620.92	$514.50	29
33	DRILLING PHARMACY	SIOUX CITY	IA	4,976	$317,298.86	$661.04	39
34	PARAGON PARTNERS	OMAHA	NE	1,012	$314,294.75	$3,571.53	48
35	GENESIS FIRSTMED PHARMACY	DAVENPORT	IA	614	$314,040.60	$1,661.59	75
36	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,296	$311,938.95	$1,155.33	33
37	ANOVORX GROUP LLC	MEMPHIS	TN	43	$299,466.26	$17,615.66	252
38	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,280	$295,536.87	$869.23	36
39	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,323	$294,372.76	$373.10	30
40	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,505	$287,171.55	$526.92	49
41	WALGREENS #15647	SIOUX CITY	IA	4,301	$285,265.57	$270.91	34
42	RIGHT DOSE PHARMACY	ANKENY	IA	4,959	$283,326.94	$610.62	69
43	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,559	$281,359.15	$591.09	38
44	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	5,878	$280,345.10	$292.94	32
45	STANGEL PHARMACY	ONAWA	IA	2,834	$279,789.55	$813.34	40
46	ACCREDO HEALTH GROUP INC	ORLANDO	FL	14	$276,221.15	$69,055.29	43

TOP 100 PHARMACIES BY PAID AMOUNT
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RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
47	WALGREENS #359	DES MOINES	IA	4,426	$274,816.11	$255.17	28
48	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,440	$271,358.64	$570.08	53
49	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	2,766	$270,227.78	$718.69	41
50	MAHASKA DRUGS INC	OSKALOOSA	IA	3,840	$266,163.83	$485.70	56
51	WALGREENS #5721	DES MOINES	IA	4,259	$256,032.14	$228.80	42
52	ARJ INFUSION SERVICES, LLC	CEDAR RAPIDS	IA	59	$248,706.32	$35,529.47	68
53	REUTZEL PHARMACY	CEDAR RAPIDS	IA	2,756	$248,299.78	$1,144.24	85
54	SOUTH SIDE DRUG	OTTUMWA	IA	3,059	$242,935.29	$554.65	44
55	INFOCUS PHARMACY SERVICES LLC	DUBUQUE	IA	1,891	$242,801.21	$941.09	54
56	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,470	$240,343.15	$556.35	64
57	JUNE E. NYLEN CANCER CENTER	SIOUX CITY	IA	31	$236,640.79	$23,664.08	149
58	WALGREENS #7453	DES MOINES	IA	4,089	$235,504.45	$253.78	47
59	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	4,560	$234,626.71	$263.33	60
60	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,323	$233,917.91	$647.97	70
61	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	20	$233,025.90	$25,891.77	66
62	HY-VEE PHARMACY (1449)	NEWTON	IA	3,003	$232,693.00	$464.46	59
63	MISSION CANCER + BLOOD	DES MOINES	IA	35	$230,897.77	$20,990.71	51
64	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	18	$230,436.84	$32,919.55	50
65	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,791	$229,944.18	$513.27	80
66	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,179	$227,739.28	$831.17	87
67	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	1,761	$226,834.56	$596.93	104
68	ALLIANCERX WALGREENS PHARMACY #16280	FRISCO	TX	14	$222,934.01	$44,586.80	188
69	WALGREENS #7452	DES MOINES	IA	2,912	$221,130.96	$348.24	79
70	AMBER PHARMACY	OMAHA	NE	46	$220,769.74	$16,982.29	58
71	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,682	$220,023.17	$488.94	84
72	WALGREENS #3700	COUNCIL BLUFFS	IA	3,723	$218,716.51	$273.05	62
73	HY-VEE PHARMACY (1075)	CLINTON	IA	2,541	$218,095.76	$497.94	55
74	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,656	$217,635.49	$455.30	67
75	HY-VEE PHARMACY (1396)	MARION	IA	2,622	$217,076.94	$481.32	71
76	WALGREENS #5044	BURLINGTON	IA	3,107	$216,460.50	$316.00	88
77	SANFORD CANCER CENTER ONCOLOGY CLINIC PHARMACY	SIOUX FALLS	SD	37	$214,312.44	$13,394.53	92
78	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	7	$213,972.70	$53,493.18	45
79	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,750	$213,806.65	$551.05	61
80	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	62	$213,802.15	$8,223.16	52
81	FOUNDATION CARE LLC	EARTH CITY	MO	24	$213,178.19	$17,764.85	63
82	UNION PHARMACY	COUNCIL BLUFFS	IA	1,987	$211,973.88	$1,308.48	89
83	WALGREENS #4041	DAVENPORT	IA	3,403	$208,821.65	$272.97	77
84	EXACTCARE	VALLEY VIEW	OH	2,226	$207,453.05	$2,053.99	117
85	DANIEL PHARMACY	FT DODGE	IA	2,701	$204,282.09	$468.54	73
86	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,078	$200,786.80	$587.10	65
87	CVS PHARMACY #08546	WATERLOO	IA	2,556	$200,503.19	$374.77	74
88	ORSINI PHARMACEUTICAL SERVICES INC	ELK GROVE VILLAGE	IL	20	$199,606.81	$24,950.85	171
89	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,484	$195,671.86	$448.79	93
90	BIOLOGICS BY MCKESSON	CARY	NC	17	$194,298.80	$27,756.97	186
91	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,772	$193,644.09	$406.82	72
92	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	2,377	$190,181.99	$592.47	78

TOP 100 PHARMACIES BY PAID AMOUNT
202306 - 202308

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
93	MEDICAP PHARMACY	DES MOINES	IA	1,625	$189,842.60	$1,043.09	120
94	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,475	$186,805.06	$369.91	86
95	WAGNER PHARMACY	CLINTON	IA	2,312	$185,109.28	$685.59	101
96	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,082	$184,491.12	$602.91	99
97	FAIRVIEW SPECIALTY SERVICES PHARMACY	MINNEAPOLIS	MN	25	$184,321.17	$23,040.15	116
98	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,451	$184,299.51	$376.89	96
99	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,843	$180,603.17	$364.85	83
100	ALLIANCERX WALGREENS PHARMACY #15438	CANTON	MI	23	$175,646.46	$19,516.27	223

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

202306 - 202308

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$109,106.91	1,596	12.18	1
2	1396289229	Jesse Becker	$83,366.95	1,326	6.56	11
3	1043211303	Ali Safdar	$138,402.25	1,293	4.00	2
4	1659358620	Carlos Castillo	$62,211.32	1,119	6.02	6
5	1275763047	Rebecca Bowman	$194,165.78	1,097	5.96	13
6	1770933046	Shelby Biller	$129,981.20	1,001	5.21	17
7	1467502286	Charles Tilley	$182,668.34	993	6.25	9
8	1437238110	Genevieve Nelson	$95,768.19	958	6.99	10
9	1538368170	Christopher Matson	$38,874.21	950	6.88	14
10	1902358443	Melissa Konken	$141,114.09	947	8.09	34
11	1215125216	Rebecca Walding	$70,421.51	946	7.63	7
12	1124006770	Wook Kim	$38,890.62	942	7.03	15
13	1902912538	Christian Jones	$39,385.17	938	5.75	8
14	1609218304	Amanda Garr	$142,934.04	935	6.15	3
15	1467907394	Cynthia Coenen	$102,587.03	923	8.10	12
16	1801998372	Wendy Hansen-Penman	$25,336.20	918	7.40	5
17	1902478811	Joan Anderson	$178,249.10	890	7.36	4
18	1558770974	Marc Baumert	$54,832.21	886	4.82	30
19	1043434525	Robert Kent	$53,079.64	884	6.96	21
20	1821268335	Jacqueline Mcinnis	$82,589.03	880	9.89	18
21	1053630640	Jennifer Donovan	$120,201.72	852	5.33	20
22	1528329398	Erin Rowan	$33,485.03	850	5.70	67
23	1982030946	Jacklyn Besch	$38,202.62	839	5.67	23
24	1316356496	Kimberly Roberts	$60,372.67	817	6.33	26
25	1891146999	Becky Johnson	$625,917.68	813	6.07	22
26	1013115369	Bobbita Nag	$42,325.68	809	3.95	16
27	1164538674	Joseph Wanzek	$57,003.63	798	7.53	24
28	1538157383	David Wenger-Keller	$93,135.80	797	8.39	28
29	1841220290	Kent Kunze	$35,948.63	785	6.60	59
30	1144214248	Kristi Walz	$113,767.53	775	7.24	37
31	1275844649	Katie Campbell	$89,230.52	774	6.73	39
32	1477926434	Jackie Shipley	$43,551.46	774	5.13	38
33	1669056123	Kama Ausborn	$372,614.71	767	6.73	19
34	1427619170	Kristen Armstrong	$68,103.30	767	4.06	78
35	1992103386	Melissa Larsen	$53,101.05	765	5.98	41
36	1437209434	Jon Thomas	$51,655.51	764	5.13	33
37	1477534279	Edmund Piasecki	$31,012.11	762	6.00	36
38	1598183493	Jena Ellerhoff	$72,011.33	747	7.40	96
39	1417241621	Ashley Mathes	$34,520.67	741	4.94	25
40	1972758126	Rebecca Bollin	$24,746.99	736	5.37	40
41	1134191018	Dustin Smith	$28,294.95	735	5.00	46
42	1437552304	Anita Sharma	$54,785.60	734	4.24	301
43	1457584740	Eric Meyer	$68,180.64	731	5.54	42
44	1922455096	Dean Guerdet	$64,571.54	731	6.71	43
45	1356754337	Cyndi Mccormick	$141,451.16	727	6.01	54
46	1184395162	Danielle Van Oosbree	$140,364.53	719	10.57	48

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

202306 - 202308

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
47	1255823506	Nicole Delagardelle	$117,813.88	719	6.42	31
48	1003539784	Julia Sass	$111,225.63	719	5.25	124
49	1033295308	Takashi Kawamitsu	$52,862.89	718	6.59	51
50	1316471154	Nicole Woolley	$35,963.66	717	4.72	106
51	1043703887	Tenaea Jeppeson	$95,602.58	716	6.34	29
52	1356359871	Rhea Hartley	$65,758.82	713	5.44	47
53	1477199198	Sajo Thomas	$94,820.65	712	5.20	27
54	1932582988	Dianne Humphrey	$56,319.60	711	7.33	81
55	1699740159	Frank Marino	$33,251.86	708	4.88	45
56	1326013426	Paul Peterson	$35,229.61	705	5.42	55
57	1467465716	Jeffrey Brady	$35,671.29	692	5.41	58
58	1245227099	Donna Dobson Tobin	$141,460.23	690	7.11	32
59	1568431880	Pomilla Kumar	$49,706.09	690	7.84	50
60	1689077018	Stacy Roth	$38,959.92	678	5.42	35
61	1124389697	Kevin Furness	$35,865.04	678	6.05	61
62	1720698335	Danika Hansen	$90,048.30	675	6.31	49
63	1972989721	Jayson Gesulga	$208,055.77	673	7.92	93
64	1689979460	Timothy Doyle	$27,322.69	673	7.56	88
65	1275742090	Ashar Luqman	$126,473.04	672	6.11	138
66	1184657603	Sara Rygol	$84,211.80	671	5.74	101
67	1336252097	Thomas Baer	$31,473.42	669	8.58	73
68	1861452633	John Brownell	$44,275.23	668	9.41	170
69	1417941188	Debra Neuharth	$21,972.81	666	3.94	83
70	1457914657	Seema Antony	$53,667.69	662	5.86	75
71	1619380680	Tara Brockman	$31,323.27	654	4.92	79
72	1356788129	Rachael Parker	$55,980.71	646	7.02	66
73	1891707832	Lisa Klock	$30,533.34	646	3.96	80
74	1295830115	Alan Bollinger	$18,294.14	646	7.88	52
75	1184056822	Abby Kolthoff	$182,837.08	642	6.11	85
76	1568532281	Ellen Natvig	$56,619.82	641	5.53	108
77	1619153137	Joada Best	$33,030.53	637	5.06	74
78	1053398800	Steven Scurr	$22,632.81	637	4.72	60
79	1831710987	Margaret Fuller	$38,046.99	629	4.88	65
80	1912991183	Molly Earleywine	$37,191.58	624	6.43	113
81	1205393386	Jessica Hudspeth	$73,629.04	619	6.52	64
82	1649248378	Kathleen Wild	$36,027.88	619	5.34	87
83	1922305143	Olivia Woita	$37,993.71	617	7.81	72
84	1831731298	Heather Wilson	$35,115.44	615	6.34	99
85	1609532373	Erin Fox-Hammel	$41,808.47	609	7.52	70
86	1942721584	Shawna Fury	$18,733.90	609	4.87	94
87	1649438383	Qadnana Anwar	$35,181.50	608	5.96	141
88	1750845954	Stephanie Giesler	$80,295.65	601	6.75	77
89	1699109595	Tonya Flaugh	$19,248.72	598	4.75	107
90	1518567056	Katie Mogensen	$64,084.29	592	5.29	82
91	1285841775	Sandra Worrell	$27,820.82	592	5.38	224
92	1225414576	Sara Kuhn	$77,485.38	590	7.56	91

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

202306 - 202308

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
93	1679573893	Patty Hildreth	$139,085.87	589	5.03	97
94	1609445733	Michelle Houghton	$70,809.90	584	5.90	105
95	1942314604	Syed Sattar	$33,670.09	582	6.47	68
96	1962418640	Barclay Monaster	$33,547.75	579	4.02	139
97	1356724405	Beth Colon	$67,747.19	577	4.44	187
98	1215581251	Anna Throckmorton	$33,041.67	577	7.21	84
99	1134854128	Dzevida Pandzic	$38,454.94	573	4.12	326
100	1740770726	Kimberly Krieger	$49,057.80	572	5.25	148

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202306 - 202308

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
1	1376777524	Alladdin Abosaida	172	$681,874.24	$3,964.39	1
2	1316934318	Steven Lentz	61	$678,805.38	$11,127.96	3
3	1295091510	Rebecca Weiner	326	$633,173.40	$1,942.25	9
4	1891146999	Becky Johnson	813	$625,917.68	$769.89	2
5	1326034984	Katherine Mathews	72	$555,132.95	$7,710.18	5
6	1417443953	Rodney Clark	381	$477,902.48	$1,254.34	6
7	1619382942	Eirene Alexandrou	112	$463,589.73	$4,139.19	7
8	1760596357	Amal Shibli-Rahhal	9	$412,215.65	$45,801.74	8
9	1013126705	Janice Staber	35	$380,836.18	$10,881.03	10
10	1669056123	Kama Ausborn	767	$372,614.71	$485.81	15
11	1841607900	Shayla Sanders	102	$286,082.81	$2,804.73	12
12	1467449579	Brian Wayson	106	$282,228.65	$2,662.53	51
13	1376525196	Randolph Rough	126	$279,860.39	$2,221.11	18
14	1437121407	Linda Cadaret	147	$277,325.68	$1,886.57	14
15	1942937388	Carly Trausch	366	$276,259.82	$754.81	13
16	1558808501	Jessica Braksiek	45	$271,208.59	$6,026.86	55
17	1649419219	Heather Hunemuller	253	$270,694.43	$1,069.94	11
18	1700417169	Courtney Reints	278	$262,057.06	$942.65	17
19	1043312432	Charles Love	136	$260,231.88	$1,913.47	73
20	1043565328	Sara Moeller	99	$243,473.27	$2,459.33	20
21	1902191059	Amber Tierney	44	$235,098.87	$5,343.16	21
22	1578958542	Heidi Curtis	174	$232,412.61	$1,335.70	48
23	1558357806	Robin Hayward	137	$232,284.64	$1,695.51	16
24	1043418809	Michael Ciliberto	444	$227,511.75	$512.41	46
25	1497060776	Usha Perepu	23	$223,122.78	$9,700.99	4
26	1891955423	Leah Siegfried	365	$220,330.24	$603.64	19
27	1972989721	Jayson Gesulga	673	$208,055.77	$309.15	38
28	1477761328	Amy Calhoun	36	$197,145.06	$5,476.25	42
29	1275763047	Rebecca Bowman	1,097	$194,165.78	$177.00	23
30	1952539447	Anthony Fischer	65	$188,413.82	$2,898.67	70
31	1356752067	Kelly Delaney-Nelson	78	$183,864.97	$2,357.24	74
32	1184056822	Abby Kolthoff	642	$182,837.08	$284.79	53
33	1467502286	Charles Tilley	993	$182,668.34	$183.96	43
34	1972560597	Bernard Leman	41	$181,887.38	$4,436.28	68
35	1902478811	Joan Anderson	890	$178,249.10	$200.28	30
36	1730406356	Christina Warren	161	$175,475.12	$1,089.91	33
37	1861463275	Donald Wender	35	$174,516.11	$4,986.17	523
38	1245468768	Thomas Schmidt	110	$174,366.44	$1,585.15	26
39	1225143316	Susan Jacobi	96	$172,985.73	$1,801.93	25
40	1225266364	Sarah Bligh	179	$167,752.14	$937.16	67
41	1245353242	Sandy Hong	183	$164,806.18	$900.58	34
42	1265420095	Elizabeth Cooper	122	$160,688.86	$1,317.12	37
43	1104012996	Venkatesh Rudrapatna	85	$159,271.19	$1,873.78	248
44	1588616171	Heather Thomas	104	$157,543.09	$1,514.84	24
45	1487648705	Karen Hunke	111	$156,476.39	$1,409.70	60
46	1720475403	Shanker Kundumadam	35	$151,965.28	$4,341.87	224

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202306 - 202308

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
47	1679688626	Lawrence Rettenmaier	95	$150,197.11	$1,581.02	41
48	1326333220	Joel Van De Graaff	9	$150,046.52	$16,671.84	337
49	1780995506	Quanhathai Kaewpoowat	70	$144,044.23	$2,057.77	65
50	1386902682	Melissa Willis	92	$143,964.10	$1,564.83	58
51	1114521721	Tarrah Holliday	548	$143,445.73	$261.76	61
52	1609218304	Amanda Garr	935	$142,934.04	$152.87	35
53	1225263833	Lindsay Orris	108	$142,057.51	$1,315.35	28
54	1568097244	Elizabeth Dassow	118	$141,532.34	$1,199.43	232
55	1194945691	Anjali Sharathkumar	41	$141,512.23	$3,451.52	139
56	1245227099	Donna Dobson Tobin	690	$141,460.23	$205.01	52
57	1356754337	Cyndi Mccormick	727	$141,451.16	$194.57	102
58	1902358443	Melissa Konken	947	$141,114.09	$149.01	77
59	1184395162	Danielle Van Oosbree	719	$140,364.53	$195.22	44
60	1679573893	Patty Hildreth	589	$139,085.87	$236.14	112
61	1043211303	Ali Safdar	1,293	$138,402.25	$107.04	49
62	1932153822	Christian Schultheis	50	$138,039.73	$2,760.79	274
63	1295078533	Christopher Strouse	15	$134,368.62	$8,957.91	59
64	1134249832	Steven Craig	75	$130,499.24	$1,739.99	79
65	1285710764	Jitendrakumar Gupta	218	$130,252.79	$597.49	136
66	1770933046	Shelby Biller	1,001	$129,981.20	$129.85	31
67	1649943689	Jessica Coffey	139	$129,804.60	$933.85	36
68	1306071915	Thomas Pietras	98	$129,558.42	$1,322.02	71
69	1508291717	Jacob Ridder	57	$129,146.38	$2,265.73	156
70	1598786097	Stephanie Gray	489	$129,089.79	$263.99	113
71	1457346231	Dawn Ebach	158	$127,827.90	$809.04	99
72	1033221916	Adrian Letz	87	$127,737.23	$1,468.24	45
73	1275742090	Ashar Luqman	672	$126,473.04	$188.20	75
74	1366858334	Alicia Duyvejonck	285	$125,057.84	$438.80	83
75	1285626390	Kathleen Gradoville	203	$124,772.41	$614.64	178
76	1326410499	Tara Eastvold	220	$124,106.05	$564.12	284
77	1528247368	Mishelle Paullus	47	$123,877.92	$2,635.70	86
78	1528365277	Mina Salib	532	$123,597.94	$232.33	254
79	1215964796	Donner Dewdney	547	$122,691.48	$224.30	88
80	1386084747	Jennifer Condon	186	$121,210.64	$651.67	87
81	1053630640	Jennifer Donovan	852	$120,201.72	$141.08	107
82	1376512244	Raymond Kuwahara	137	$119,498.11	$872.25	262
83	1255823506	Nicole Delagardelle	719	$117,813.88	$163.86	78
84	1174748180	Mohammad Alsharabati	180	$117,172.22	$650.96	106
85	1013311778	Melissa Batt	292	$114,936.76	$393.62	69
86	1093382632	Gail Dooley	127	$114,501.62	$901.59	72
87	1144214248	Kristi Walz	775	$113,767.53	$146.80	76
88	1720086523	Mark Cleveland	93	$113,172.83	$1,216.91	133
89	1134440886	Melissa Wells	91	$113,128.52	$1,243.17	27
90	1386938447	Theresa Czech	222	$112,794.28	$508.08	347
91	1053520759	Alicia Gerke	29	$112,442.18	$3,877.32	100
92	1366826109	Alyssa Mrsny	99	$111,502.13	$1,126.28	63

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202306 - 202308

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
93	1003539784	Julia Sass	719	$111,225.63	$154.69	146
94	1730161050	Jason Barker	104	$110,503.17	$1,062.53	114
95	1033554498	Matthew Landherr	52	$110,250.98	$2,120.21	105
96	1689942518	Patria Alba Aponte	186	$110,191.01	$592.42	57
97	1982605762	Jeffrey Wilharm	1,596	$109,106.91	$68.36	97
98	1750913406	Carrissa Riggs	41	$107,178.64	$2,614.11	95
99	1366014698	Debbie Ohrt	330	$107,162.61	$324.74	207
100	1245349182	Mark Burdt	90	$106,946.89	$1,188.30	162

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

	202303 - 202305			202306 - 202308			
CATEGORY DESCRIPTION	**PREVIOUS TOTAL COST**	**PREVIOUS RANK**	**PREVIOUS % BUDGET**	**CURRENT TOTAL COST**	**CURRENT RANK**	**CURRENT % BUDGET**	**% CHANGE**
ANTIDIABETICS	$15,481,287.08	1	14.79 %	$12,623,571.18	1	14.79 %	0.01 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$10,998,170.30	2	10.50 %	$8,971,858.86	2	10.51 %	0.01 %
ANALGESICS - ANTI-INFLAMMATORY	$10,437,753.87	3	9.97 %	$8,259,605.82	3	9.68 %	-0.29 %
DERMATOLOGICALS	$8,281,047.38	4	7.91 %	$7,036,977.07	4	8.25 %	0.34 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$7,455,081.74	5	7.12 %	$5,815,255.15	5	6.82 %	-0.31 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$5,972,518.85	6	5.70 %	$4,913,502.68	6	5.76 %	0.06 %
ANTIVIRALS	$5,864,832.68	7	5.60 %	$4,124,741.74	7	4.83 %	-0.77 %
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,144,756.14	8	3.00 %	$3,095,622.23	8	3.63 %	0.62 %
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC	$3,114,772.71	9	2.97 %	$2,680,197.70	9	3.14 %	0.17 %
RESPIRATORY AGENTS - MISC.	$2,754,783.15	11	2.63 %	$2,511,481.87	10	2.94 %	0.31 %
ENDOCRINE AND METABOLIC AGENTS - MISC.	$3,037,330.30	10	2.90 %	$2,304,235.19	11	2.70 %	-0.20 %
ANTICONVULSANTS	$2,318,334.98	15	2.21 %	$2,244,157.16	12	2.63 %	0.42 %
MIGRAINE PRODUCTS	$2,430,259.98	13	2.32 %	$2,071,694.62	13	2.43 %	0.11 %
HEMATOLOGICAL AGENTS - MISC.	$2,693,197.38	12	2.57 %	$2,054,829.01	14	2.41 %	-0.16 %
ANTIDEPRESSANTS	$2,420,166.80	14	2.31 %	$1,999,101.85	15	2.34 %	0.03 %
ANTICOAGULANTS	$1,943,714.15	16	1.86 %	$1,514,280.90	16	1.77 %	-0.08 %
CARDIOVASCULAR AGENTS - MISC.	$1,870,475.39	17	1.79 %	$1,489,005.72	17	1.75 %	-0.04 %
GASTROINTESTINAL AGENTS - MISC.	$1,015,996.97	19	0.97 %	$900,552.70	18	1.06 %	0.09 %
ANTI-INFECTIVE AGENTS - MISC.	$745,667.31	21	0.71 %	$668,457.38	19	0.78 %	0.07 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$773,543.59	20	0.74 %	$663,815.67	20	0.78 %	0.04 %

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

	202303 - 202305		202306 - 202308		
CURRENT CATEGORY DESCRIPTION	PREVIOUS CLAIMS	PREVIOUS RANK	CURRENT CLAIMS	CURRENT RANK	% CHANGE
ANTIDEPRESSANTS	116,760	1	104,906	1	-10.15 %
ANTICONVULSANTS	51,583	2	45,343	2	-12.10 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	50,547	3	41,108	3	-18.67 %
ANTIHYPERTENSIVES	39,933	6	40,054	4	0.30 %
ANTIDIABETICS	40,208	5	39,396	5	-2.02 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	45,338	4	35,457	6	-21.79 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	36,027	9	34,967	7	-2.94 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	39,266	8	34,465	8	-12.23 %
ANTIANXIETY AGENTS	39,515	7	33,377	9	-15.53 %
ANTIHYPERLIPIDEMICS	23,795	14	26,582	10	11.71 %
DERMATOLOGICALS	26,160	12	21,729	11	-16.94 %
ANALGESICS - ANTI-INFLAMMATORY	24,929	13	20,675	12	-17.06 %
ANALGESICS - OPIOID	26,824	11	20,611	13	-23.16 %
BETA BLOCKERS	19,803	16	19,968	14	0.83 %
ANTIHISTAMINES	22,342	15	19,893	15	-10.96 %
DIURETICS	15,809	19	16,154	16	2.18 %
THYROID AGENTS	14,087	20	14,999	17	6.47 %
PENICILLINS	29,145	10	13,825	18	-52.56 %
MUSCULOSKELETAL THERAPY AGENTS	16,330	18	13,407	19	-17.90 %
ANALGESICS - NonNarcotic	13,564	21	12,172	20	-10.26 %

TOP 100 DRUGS BY PAID AMOUNT

	202303 - 202305		202306 - 202308		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Humira Pen	$6,616,759.74	1	$5,300,849.71	1	-19.89 %
Vraylar	$3,213,521.36	3	$2,779,628.73	2	-13.50 %
Ozempic	$2,497,694.62	5	$2,621,559.59	3	4.96 %
Trulicity	$3,287,855.12	2	$2,476,033.84	4	-24.69 %
Trikafta	$1,968,554.27	11	$2,201,088.78	5	11.81 %
Vyvanse	$2,707,643.34	4	$2,126,998.26	6	-21.44 %
Dupixent	$2,115,916.22	8	$1,868,089.98	7	-11.71 %
Biktarvy	$2,346,618.06	6	$1,715,221.76	8	-26.91 %
Invega Sust	$2,088,948.74	9	$1,696,926.29	9	-18.77 %
Stelara	$2,217,447.86	7	$1,632,271.47	10	-26.39 %
Jardiance	$2,027,932.81	10	$1,596,612.08	11	-21.27 %
Taltz	$1,532,032.22	12	$1,480,249.99	12	-3.38 %
Eliquis	$1,257,576.01	14	$1,009,407.40	13	-19.73 %
Lantus Solos	$1,369,045.41	13	$1,007,743.48	14	-26.39 %
Aristada	$1,093,030.65	17	$994,583.21	15	-9.01 %
Rexulti	$1,084,248.84	19	$929,824.18	16	-14.24 %
Symbicort	$1,132,004.12	15	$896,754.04	17	-20.78 %
Strensiq	$823,742.28	22	$871,800.66	18	5.83 %
Concerta	$802,998.35	23	$732,280.69	19	-8.81 %
Enbrel Srclk	$870,044.10	21	$699,481.43	20	-19.60 %
Spiriva	$903,465.07	20	$687,945.35	21	-23.85 %
Nurtec	$769,930.43	25	$680,564.42	22	-11.61 %
Mavyret	$1,091,609.15	18	$666,747.15	23	-38.92 %
Abilify Main	$788,164.35	24	$650,461.08	24	-17.47 %
Trintellix	$727,256.74	28	$567,154.74	25	-22.01 %
Ventolin Hfa	$1,119,720.48	16	$564,232.08	26	-49.61 %
Farxiga	$671,446.17	29	$561,278.85	27	-16.41 %
Skyrizi Pen	$525,900.01	42	$559,813.12	28	6.45 %
Invega Trinz	$738,205.03	27	$539,136.36	29	-26.97 %
Ingrezza	$753,492.93	26	$537,875.51	30	-28.62 %
Insulin Aspa	$629,370.87	30	$502,869.68	31	-20.10 %
Humira	$550,665.89	38	$499,382.99	32	-9.31 %
Trelegy	$535,376.92	41	$455,830.83	33	-14.86 %
Xarelto	$597,241.35	33	$442,514.46	34	-25.91 %
Adynovate	$545,241.40	39	$441,040.21	35	-19.11 %
Austedo	$443,500.59	50	$431,772.05	36	-2.64 %
Evrysdi	$456,085.61	48	$431,419.99	37	-5.41 %
Mounjaro	$379,549.31	58	$428,784.47	38	12.97 %

TOP 100 DRUGS BY PAID AMOUNT

	202303 - 202305		202306 - 202308		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Xifaxan	$475,835.06	43	$421,387.17	39	-11.44 %
Entresto	$561,097.56	36	$417,070.06	40	-25.67 %
Flovent Hfa	$575,317.51	35	$415,951.22	41	-27.70 %
Cosentyx Pen	$603,556.10	32	$410,994.07	42	-31.90 %
Advair Disku	$605,692.60	31	$409,952.86	43	-32.32 %
Januvia	$538,439.14	40	$394,832.16	44	-26.67 %
Ajovy	$441,694.96	51	$385,053.32	45	-12.82 %
Caplyta	$408,553.48	57	$369,190.16	46	-9.63 %
Victoza	$556,758.27	37	$362,425.57	47	-34.90 %
Levemir	$435,049.12	53	$353,892.65	48	-18.65 %
Hemlibra	$435,846.88	52	$346,179.56	49	-20.57 %
Cabometyx	$338,434.26	64	$342,693.15	50	1.26 %
Lybalvi	$352,580.58	62	$334,972.03	51	-4.99 %
Tresiba Flex	$472,995.48	44	$329,487.56	52	-30.34 %
Ubrelvy	$344,188.54	63	$307,909.18	53	-10.54 %
Advair Hfa	$377,111.68	59	$303,460.69	54	-19.53 %
Eloctate	$179,025.42	110	$300,299.72	55	67.74 %
Wakix	$226,465.14	88	$294,424.00	56	30.01 %
Opsumit	$314,330.40	66	$290,160.72	57	-7.69 %
Verzenio	$279,396.00	73	$268,748.02	58	-3.81 %
Sofos/velpat	$414,878.35	56	$265,304.60	59	-36.05 %
Albuterol	$122,926.12	169	$264,938.83	60	115.53 %
Insulin Lisp	$445,125.89	49	$259,178.04	61	-41.77 %
Jynarque	$463,624.64	45	$257,703.94	62	-44.42 %
Kesimpta	$169,367.92	118	$255,938.67	63	51.11 %
Otezla	$264,762.29	76	$249,060.04	64	-5.93 %
Ilaris	$457,501.17	47	$248,732.44	65	-45.63 %
Linzess	$354,842.18	61	$244,639.88	66	-31.06 %
Aimovig	$317,407.11	65	$240,934.08	67	-24.09 %
Jornay Pm	$266,190.38	75	$238,084.86	68	-10.56 %
Lantus	$313,370.20	67	$234,963.19	69	-25.02 %
Epinephrine	$230,058.86	85	$232,969.41	70	1.27 %
Ibrance	$202,109.23	99	$232,802.03	71	15.19 %
Descovy	$283,943.35	70	$232,745.11	72	-18.03 %
Lenalidomide	$121,048.06	170	$231,955.16	73	91.62 %
Rebinyn	$165,150.62	123	$228,445.38	74	38.33 %
Methylphenid	$358,086.10	60	$225,595.79	75	-37.00 %
Takhzyro	$223,622.01	91	$223,622.01	76	0.00 %

TOP 100 DRUGS BY PAID AMOUNT

	202303 - 202305		202306 - 202308		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Latuda	$591,423.72	34	$218,950.52	77	-62.98 %
Pulmozyme	$270,774.17	74	$216,078.40	78	-20.20 %
Epidiolex	$183,866.97	108	$215,611.99	79	17.27 %
Varenicline	$300,817.24	68	$211,790.11	80	-29.60 %
Genvoya	$285,627.13	69	$211,740.75	81	-25.87 %
Hizentra	$150,572.98	140	$210,292.55	82	39.66 %
Adderall Xr	$258,416.46	78	$199,098.44	83	-22.95 %
Sprycel	$232,081.46	83	$190,936.15	84	-17.73 %
Cimzia Prefl	$169,273.92	119	$189,371.81	85	11.87 %
Xywav	$262,086.84	77	$189,295.32	86	-27.77 %
Skyrizi	$226,166.97	89	$188,321.02	87	-16.73 %
Fasenra Pen	$226,551.06	87	$186,918.35	88	-17.49 %
Inlyta	$189,153.95	106	$186,190.99	89	-1.57 %
Atorvastatin	$174,558.94	114	$184,906.40	90	5.93 %
Sertraline	$209,269.20	96	$184,546.59	91	-11.81 %
Anoro Ellipt	$227,247.97	86	$184,195.57	92	-18.95 %
Quillichew	$238,337.40	81	$181,341.15	93	-23.91 %
Tremfya	$183,626.94	109	$179,254.21	94	-2.38 %
Creon	$219,497.29	92	$176,472.26	95	-19.60 %
Omeprazole	$191,223.66	105	$174,983.53	96	-8.49 %
Emflaza	$157,739.60	131	$174,690.02	97	10.75 %
Gabapentin	$200,630.63	100	$174,279.81	98	-13.13 %
Enbrel Mini	$206,536.87	98	$171,604.12	99	-16.91 %
Fintepla	$77,994.15	223	$171,027.66	100	119.28 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	202303 - 202305 PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	202306 - 202308 CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Sertraline	17,951	2	16,350	1	-8.92 %
Omeprazole	16,380	4	16,217	2	-1.00 %
Atorvastatin	14,201	7	16,090	3	13.30 %
Levothyroxin	12,785	11	13,764	4	7.66 %
Lisinopril	12,570	12	13,447	5	6.98 %
Trazodone	14,880	5	13,121	6	-11.82 %
Escitalopram	14,568	6	12,873	7	-11.64 %
Metformin	12,075	13	12,443	8	3.05 %
Bupropn Hcl	13,414	10	12,312	9	-8.22 %
Fluoxetine	13,919	8	12,288	10	-11.72 %
Gabapentin	13,602	9	12,008	11	-11.72 %
Amlodipine	8,675	26	9,425	12	8.65 %
Buspirone	10,550	18	9,268	13	-12.15 %
Hydroxyz Hcl	10,717	15	8,974	14	-16.26 %
Duloxetine	9,621	21	8,851	15	-8.00 %
Montelukast	9,124	23	8,835	16	-3.17 %
Albuterol	6,244	42	8,736	17	39.91 %
Ventolin Hfa	16,856	3	8,735	18	-48.18 %
Amphet/dextr	10,805	14	8,484	19	-21.48 %
Amoxicillin	19,436	1	8,404	20	-56.76 %
Quetiapine	9,807	20	8,348	21	-14.88 %
Cetirizine	9,272	22	8,299	22	-10.49 %
Pantoprazole	8,236	30	8,261	23	0.30 %
Hydroco/apap	10,683	16	8,168	24	-23.54 %
Venlafaxine	8,786	25	7,913	25	-9.94 %
Prednisone	10,249	19	7,538	26	-26.45 %
Aripiprazole	8,501	28	7,460	27	-12.25 %
Ondansetron	10,613	17	7,399	28	-30.28 %
Metoprol Suc	6,680	40	7,177	29	7.44 %
Lamotrigine	8,233	31	7,006	30	-14.90 %
Clonidine	7,825	34	6,993	31	-10.63 %
Vyvanse	8,640	27	6,799	32	-21.31 %
Cyclobenzapr	8,211	32	6,691	33	-18.51 %
Losartan Pot	5,606	46	6,190	34	10.42 %
Methylphenid	8,859	24	6,141	35	-30.68 %
Ibuprofen	8,171	33	6,120	36	-25.10 %
Alprazolam	7,341	36	6,082	37	-17.15 %
Guanfacine	6,934	38	6,076	38	-12.37 %
Fluticasone	7,814	35	5,900	39	-24.49 %
Famotidine	6,208	43	5,712	40	-7.99 %
Topiramate	6,023	44	5,710	41	-5.20 %
Clonazepam	6,602	41	5,469	42	-17.16 %
Aspirin Low	5,430	50	5,258	43	-3.17 %
Cephalexin	6,713	39	5,184	44	-22.78 %
Hydrochlorot	4,652	54	5,034	45	8.21 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	202303 - 202305 PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	202306 - 202308 CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Propranolol	5,504	49	5,002	46	-9.12 %
Meloxicam	5,557	48	4,982	47	-10.35 %
Amox/k Clav	8,495	29	4,607	48	-45.77 %
Furosemide	4,650	55	4,500	49	-3.23 %
Loratadine	5,231	51	4,469	50	-14.57 %
Rosuvastatin	3,901	65	4,401	51	12.82 %
Risperidone	4,942	53	4,377	52	-11.43 %
Tramadol Hcl	5,592	47	4,330	53	-22.57 %
Lorazepam	5,100	52	4,315	54	-15.39 %
Triamcinolon	4,639	56	4,218	55	-9.08 %
Mirtazapine	4,499	57	3,876	56	-13.85 %
Spironolact	3,742	68	3,865	57	3.29 %
Levetiraceta	4,185	61	3,597	58	-14.05 %
Prazosin Hcl	4,120	62	3,555	59	-13.71 %
Folic Acid	3,470	73	3,462	60	-0.23 %
Fluconazole	4,258	59	3,458	61	-18.79 %
Azithromycin	7,340	37	3,332	62	-54.60 %
Metronidazol	4,385	58	3,331	63	-24.04 %
Amitriptylin	3,714	69	3,329	64	-10.37 %
Hydroxyz Pam	4,027	63	3,260	65	-19.05 %
Citalopram	3,443	74	3,229	66	-6.22 %
Ozempic	2,930	88	3,169	67	8.16 %
Metoprol Tar	3,017	85	3,116	68	3.28 %
Acetamin	3,775	67	3,111	69	-17.59 %
Jardiance	2,823	90	3,047	70	7.93 %
Diclofenac	3,858	66	3,043	71	-21.12 %
Doxycyc Mono	4,206	60	2,992	72	-28.86 %
Ferosul	3,152	80	2,939	73	-6.76 %
Pregabalin	3,354	76	2,918	74	-13.00 %
Valacyclovir	3,473	72	2,885	75	-16.93 %
Trulicity	3,521	71	2,871	76	-18.46 %
Oxycodone	3,961	64	2,870	77	-27.54 %
Tizanidine	3,394	75	2,768	78	-18.44 %
Olanzapine	3,074	82	2,722	79	-11.45 %
Divalproex	3,060	83	2,699	80	-11.80 %
Allergy Reli	2,584	92	2,689	81	4.06 %
Cefdinir	5,717	45	2,652	82	-53.61 %
Lantus Solos	3,054	84	2,633	83	-13.79 %
Symbicort	3,172	79	2,607	84	-17.81 %
Naproxen	3,233	78	2,604	85	-19.46 %
Baclofen	3,015	86	2,585	86	-14.26 %
Polyeth Glyc	2,945	87	2,416	87	-17.96 %
Clindamycin	3,264	77	2,408	88	-26.23 %
Zolpidem	3,093	81	2,397	89	-22.50 %
Atomoxetine	2,903	89	2,368	90	-18.43 %

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	202303 - 202305 PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	202306 - 202308 CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Vraylar	2,507	95	2,274	91	-9.29 %
Pot Chloride	2,279	99	2,264	92	-0.66 %
Insulin Lisp	2,410	96	2,234	93	-7.30 %
Carvedilol	2,173	104	2,201	94	1.29 %
Sumatriptan	2,819	91	2,200	95	-21.96 %
Lisinop/hctz	2,071	109	2,195	96	5.99 %
Tamsulosin	2,214	103	2,177	97	-1.67 %
Mupirocin	2,581	93	2,174	98	-15.77 %
Nystatin	2,549	94	2,148	99	-15.73 %
Eliquis	2,160	105	2,073	100	-4.03 %

Quarterly Monthly Statistics

CATEGORY	March 2023 / May 2023	June 2023 / August 2023	% CHANGE
TOTAL PAID AMOUNT	$143,514,158	$110,618,579	-22.9%
UNIQUE USERS	183,615	147,387	-19.7%
COST PER USER	$781.60	$750.53	-4.0%
TOTAL PRESCRIPTIONS	1,160,177	958,675	-17.4%
AVERAGE PRESCRIPTIONS PER USER	6.32	6.50	2.9%
AVERAGE COST PER PRESCRIPTION	$123.70	$115.39	-6.7%
# GENERIC PRESCRIPTIONS	1,015,082	841,385	-17.1%
% GENERIC	87.49%	87.77%	0.3%
$ GENERIC	$18,464,285	$14,182,191	-23.2%
AVERAGE GENERIC PRESCRIPTION COST	$18.19	$16.86	-7.3%
AVERAGE GENERIC DAYS SUPPLY	30.42	25.81	-15.2%
# BRAND PRESCRIPTIONS	145,095	117,290	-19.2%
% BRAND	12.51%	12.23%	-2.2%
$ BRAND	$125,049,872	$96,436,388	-22.9%
AVERAGE BRAND PRESCRIPTION COST	$861.85	$822.20	-4.6%
AVERAGE BRAND DAYS SUPPLY	30.06	27.07	-9.9%

UTILIZATION BY AGE		
AGE	March 2023 / May 2023	June 2023 / August 2023
0-6	61,869	35,479
7-12	83,714	60,407
13-18	113,682	87,452
19-64	900,795	775,247
65+	10,372	9,181
TOTAL	1,170,432	967,766

	UTILIZATION BY GENDER AND AGE		
GENDER	AGE	March 2023 / May 2023	June 2023 / August 2023
F	0-6	27,033	15,267
	7-12	32,644	23,251
	13-18	60,798	46,258
	19-64	606,422	518,027
	65+	6,158	5,701
	Gender Total	733,055	608,504
M	0-6	34,836	20,212
	7-12	51,070	37,156
	13-18	52,884	41,194
	19-64	294,373	257,220
	65+	4,214	3,480
	Gender Total	437,377	359,262
Grand Total		1,170,432	967,766

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June 2023 / August 2023

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	13,148	$7,094,880.71	$539.62	1
2	WALGREENS #4405	COUNCIL BLUFFS	IA	9,820	$814,244.01	$82.92	2
3	WALGREENS #5239	DAVENPORT	IA	9,343	$609,598.90	$65.25	3
4	WALGREENS #5042	CEDAR RAPIDS	IA	7,451	$521,453.95	$69.98	4
5	DRILLING PHARMACY	SIOUX CITY	IA	5,804	$449,021.71	$77.36	10
6	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	5,753	$413,147.81	$71.81	7
7	WALGREENS #5721	DES MOINES	IA	5,319	$369,327.32	$69.44	6
8	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	5,303	$264,139.03	$49.81	9
9	WALGREENS #7455	WATERLOO	IA	5,150	$348,932.05	$67.75	5
10	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	5,110	$451,162.45	$88.29	16
11	WALGREENS #359	DES MOINES	IA	5,070	$366,630.16	$72.31	8
12	WALGREENS #4041	DAVENPORT	IA	4,964	$285,249.97	$57.46	13
13	WALGREENS #3700	COUNCIL BLUFFS	IA	4,776	$323,646.89	$67.77	11
14	WALGREENS #15647	SIOUX CITY	IA	4,771	$291,968.91	$61.20	14
15	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,769	$310,969.67	$65.21	12
16	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,674	$334,660.92	$71.60	22
17	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	4,631	$322,897.82	$69.73	19
18	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,618	$355,487.38	$76.98	18
19	WALGREENS #7453	DES MOINES	IA	4,586	$275,745.37	$60.13	15
20	HY-VEE PHARMACY (1075)	CLINTON	IA	4,435	$400,136.60	$90.22	20
21	WALMART PHARMACY 10-1509	MAQUOKETA	IA	4,409	$347,100.13	$78.73	26
22	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	4,364	$310,610.41	$71.18	25

23	RIGHT DOSE PHARMACY	ANKENY	IA	4,334	$210,521.21	$48.57	24
24	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	4,067	$422,987.18	$104.00	17
25	MAHASKA DRUGS INC	OSKALOOSA	IA	3,935	$306,529.90	$77.90	21
26	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,931	$304,008.74	$77.34	23
27	HARTIG PHARMACY SERVICES	DUBUQUE	IA	3,921	$282,774.85	$72.12	33
28	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,901	$145,733.47	$37.36	27
29	WALGREENS #9708	DUBUQUE	IA	3,897	$255,777.76	$65.63	29
30	HY-VEE PHARMACY (1396)	MARION	IA	3,692	$311,403.24	$84.35	42
31	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,658	$399,246.27	$109.14	43
32	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	3,657	$257,161.30	$70.32	36
33	HY-VEE PHARMACY (1433)	MT PLEASANT	IA	3,622	$258,197.20	$71.29	40
34	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,611	$241,699.64	$66.93	35
35	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	3,607	$253,003.34	$70.14	32
36	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,598	$238,488.08	$66.28	31
37	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	3,587	$123,060.19	$34.31	47
38	NUCARA LTC PHARMACY #3	IOWA CITY	IA	3,557	$117,968.73	$33.17	39
39	HY-VEE PHARMACY (1449)	NEWTON	IA	3,539	$247,279.64	$69.87	30
40	WALGREENS #5044	BURLINGTON	IA	3,515	$193,102.83	$54.94	28
41	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	3,501	$230,913.98	$65.96	37
42	WALGREENS #3875	CEDAR RAPIDS	IA	3,455	$228,361.52	$66.10	38
43	CVS PHARMACY #10282	FORT DODGE	IA	3,313	$180,228.68	$54.40	44
44	MEDICAP LTC	INDIANOLA	IA	3,247	$102,441.66	$31.55	56
45	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	3,244	$222,068.72	$68.46	57
46	WALGREENS #11942	DUBUQUE	IA	3,163	$208,437.10	$65.90	55
47	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,132	$240,949.60	$76.93	41
48	HY-VEE PHARMACY #1 (1105)	DAVENPORT	IA	3,132	$215,873.60	$68.93	53

49	WAGNER PHARMACY	CLINTON	IA	3,086	$249,033.23	$80.70	54
50	SOUTH SIDE DRUG	OTTUMWA	IA	3,083	$283,523.61	$91.96	46
51	WALMART PHARMACY 10-0985	FAIRFIELD	IA	3,054	$229,237.15	$75.06	52
52	WALMART PHARMACY 10-0559	MUSCATINE	IA	3,046	$210,961.79	$69.26	82
53	WALMART PHARMACY 10-2889	CLINTON	IA	3,021	$201,793.50	$66.80	62
54	WALMART PHARMACY 10-5115	DAVENPORT	IA	3,018	$247,240.22	$81.92	88
55	DANIEL PHARMACY	FT DODGE	IA	3,014	$238,325.31	$79.07	77
56	REUTZEL PHARMACY	CEDAR RAPIDS	IA	2,990	$274,437.00	$91.78	49
57	SCOTT PHARMACY	FAYETTE	IA	2,984	$215,007.48	$72.05	51
58	WALGREENS #7452	DES MOINES	IA	2,932	$210,712.01	$71.87	59
59	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	2,926	$279,221.51	$95.43	58
60	CVS PHARMACY #08546	WATERLOO	IA	2,925	$195,650.17	$66.89	64
61	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,924	$286,348.59	$97.93	66
62	HY-VEE PHARMACY (1850)	WASHINGTON	IA	2,920	$187,124.08	$64.08	60
63	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,900	$267,646.66	$92.29	50
64	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,883	$189,376.89	$65.69	45
65	WALMART PHARMACY 10-3394	ATLANTIC	IA	2,847	$206,302.47	$72.46	73
66	WALGREENS #5886	KEOKUK	IA	2,844	$178,230.85	$62.67	63
67	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	2,829	$249,715.76	$88.27	72
68	HY-VEE PHARMACY #4 (1060)	CEDAR RAPIDS	IA	2,828	$187,548.99	$66.32	70
69	WALGREENS #5470	SIOUX CITY	IA	2,800	$193,893.67	$69.25	48
70	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	2,793	$135,550.54	$48.53	65
71	LAGRANGE PHARMACY	VINTON	IA	2,790	$264,325.03	$94.74	76
72	WALMART PHARMACY 10-0646	ANAMOSA	IA	2,763	$196,055.91	$70.96	86
73	MERCYONE FOREST PARK PHARMACY	MASON CITY	IA	2,750	$196,180.26	$71.34	75
74	WALGREENS #7454	ANKENY	IA	2,746	$163,149.37	$59.41	68

75	STANGEL PHARMACY	ONAWA	IA	2,745	$212,946.44	$77.58	61
76	WALMART PHARMACY 10-0784	MT PLEASANT	IA	2,727	$166,616.89	$61.10	84
77	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,639	$128,770.74	$48.80	80
78	WALGREENS #3876	MARION	IA	2,618	$189,767.42	$72.49	87
79	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	2,615	$210,236.24	$80.40	94
80	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,610	$179,997.98	$68.96	115
81	WALGREENS #3595	DAVENPORT	IA	2,602	$159,711.12	$61.38	79
82	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	2,575	$61,103.35	$23.73	96
83	HY-VEE PHARMACY (1895)	WINDSOR HEIGHTS	IA	2,564	$175,354.91	$68.39	92
84	HY-VEE PHARMACY (1065)	CHARITON	IA	2,554	$175,799.46	$68.83	83
85	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	2,550	$209,150.00	$82.02	89
86	HY-VEE DRUGSTORE #5 (7026)	CEDAR RAPIDS	IA	2,550	$162,338.66	$63.66	101
87	HY-VEE PHARMACY (1382)	LEMARS	IA	2,506	$171,437.70	$68.41	74
88	WALMART PHARMACY 10-1723	DES MOINES	IA	2,503	$149,881.00	$59.88	90
89	HY-VEE PHARMACY (1522)	PERRY	IA	2,467	$225,886.29	$91.56	78
90	WALGREENS #5119	CLINTON	IA	2,467	$180,659.95	$73.23	67
91	WALMART PHARMACY 10-1683	SHENANDOAH	IA	2,459	$157,453.19	$64.03	126
92	WALGREENS #4714	DES MOINES	IA	2,449	$152,989.23	$62.47	71
93	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	2,422	$210,078.18	$86.74	91
94	MERCYONE DUBUQUE EAST PHARMACY	DUBUQUE	IA	2,392	$144,823.78	$60.55	258
95	CVS PHARMACY #08658	DAVENPORT	IA	2,373	$159,503.03	$67.22	120
96	MEDICAP PHARMACY	KNOXVILLE	IA	2,367	$204,215.34	$86.28	81
97	WALGREENS #12393	CEDAR RAPIDS	IA	2,362	$163,297.74	$69.14	128
98	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,360	$127,522.86	$54.04	69
99	HY-VEE PHARMACY #3 (1107)	DAVENPORT	IA	2,349	$144,566.85	$61.54	122
100	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,332	$229,733.87	$98.51	99

TOP 100 PHARMACIES BY PAID AMOUNT
June 2023 / August 2023

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	UNIVERSITY OF IOWA HEALTH CARE	IOWA CITY	IA	13,148	$7,094,880.71	$2,571.54	1
2	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	691	$4,907,993.68	$15,580.93	2
3	CVS/SPECIALTY	MONROEVILLE	PA	449	$3,521,958.41	$16,613.01	4
4	UNITYPOINT AT HOME	URBANDALE	IA	954	$2,930,666.52	$8,445.72	5
5	COMMUNITY, A WALGREENS PHARMACY #16528	DES MOINES	IA	698	$2,607,639.55	$10,472.45	3
6	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	273	$2,520,028.94	$24,466.30	6
7	COMMUNITY, A WALGREENS PHARMACY #21250	IOWA CITY	IA	562	$1,696,596.68	$7,747.02	7
8	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,565	$1,495,178.61	$7,475.89	9
9	HY-VEE PHARMACY SOLUTIONS	OMAHA	NE	261	$1,436,846.03	$12,494.31	8
10	CVS PHARMACY #00102	AURORA	CO	155	$1,313,481.87	$17,513.09	10
11	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	86	$1,286,551.74	$38,986.42	14
12	WALGREENS #4405	COUNCIL BLUFFS	IA	9,820	$814,244.01	$396.23	12
13	ALLIANCERX WALGREENS PHARMACY #16280	FRISCO	TX	37	$753,673.92	$57,974.92	18
14	ANOVORX GROUP LLC	MEMPHIS	TN	41	$738,388.86	$43,434.64	44
15	EVERSANA LIFE SCIENCE SERVICES, LLC	CHESTERFIELD	MO	20	$722,864.81	$120,477.47	23
16	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	48	$704,870.98	$32,039.59	17
17	KROGER SPECIALTY PHARMACY LA	HARVEY	LA	82	$691,559.55	$17,288.99	16
18	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	51	$637,274.09	$22,759.79	13
19	WALGREENS #5239	DAVENPORT	IA	9,343	$609,598.90	$292.37	15
20	AMBER SPECIALTY PHARMACY	OMAHA	NE	87	$595,049.26	$15,659.19	19
21	MISSION CANCER + BLOOD	DES MOINES	IA	62	$585,238.22	$27,868.49	39
22	WALGREENS #5042	CEDAR RAPIDS	IA	7,451	$521,453.95	$309.47	20

23	WALGREENS #16270	OMAHA	NE	124	$488,747.37	$13,576.32	25
24	BIOLOGICS BY MCKESSON	CARY	NC	13	$485,087.31	$80,847.89	79
25	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	5,110	$451,162.45	$633.66	22
26	ALLEN CLINIC PHARMACY	WATERLOO	IA	1,109	$449,672.14	$1,202.33	37
27	DRILLING PHARMACY	SIOUX CITY	IA	5,804	$449,021.71	$856.91	31
28	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,000	$448,666.92	$1,854.00	38
29	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,775	$445,676.07	$2,297.30	30
30	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,824	$435,333.48	$1,978.79	35
31	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	4,067	$422,987.18	$538.15	28
32	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	5,753	$413,147.81	$354.94	33
33	HY-VEE PHARMACY (1075)	CLINTON	IA	4,435	$400,136.60	$609.96	40
34	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,658	$399,246.27	$697.98	47
35	ORSINI PHARMACEUTICAL SERVICES LLC	ELK GROVE VILLAGE	IL	28	$382,158.34	$47,769.79	26
36	GENESIS FIRSTMED PHARMACY	DAVENPORT	IA	670	$372,509.97	$1,641.01	43
37	WALGREENS #5721	DES MOINES	IA	5,319	$369,327.32	$264.75	32
38	WALGREENS #359	DES MOINES	IA	5,070	$366,630.16	$307.83	34
39	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	4,618	$355,487.38	$505.67	52
40	MAYO CLINIC PHARMACY	ROCHESTER	MN	54	$354,018.19	$22,126.14	11
41	WALGREENS #7455	WATERLOO	IA	5,150	$348,932.05	$266.56	42
42	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	114	$348,772.23	$9,688.12	60
43	WALMART PHARMACY 10-1509	MAQUOKETA	IA	4,409	$347,100.13	$511.95	49
44	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,674	$334,660.92	$440.34	50
45	WALGREENS #3700	COUNCIL BLUFFS	IA	4,776	$323,646.89	$316.37	36
46	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	4,631	$322,897.82	$493.73	51
47	HY-VEE PHARMACY (1396)	MARION	IA	3,692	$311,403.24	$523.37	54
48	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	4,769	$310,969.67	$348.62	48

49	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	4,364	$310,610.41	$429.02	55
50	MAHASKA DRUGS INC	OSKALOOSA	IA	3,935	$306,529.90	$492.02	45
51	THE NEBRASKA MEDICAL CENTER CLINIC PHARMACY	OMAHA	NE	761	$305,303.75	$2,021.88	41
52	NELSON FAMILY PHARMACY	FORT MADISON	IA	3,931	$304,008.74	$603.19	66
53	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	1,671	$296,002.87	$2,529.94	72
54	WALGREENS #15647	SIOUX CITY	IA	4,771	$291,968.91	$263.99	57
55	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	19	$291,615.16	$32,401.68	21
56	INFOCUS PHARMACY SERVICES LLC	DUBUQUE	IA	2,085	$286,706.63	$1,009.53	64
57	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,924	$286,348.59	$669.04	71
58	WALGREENS #4041	DAVENPORT	IA	4,964	$285,249.97	$279.93	56
59	SOUTH SIDE DRUG	OTTUMWA	IA	3,083	$283,523.61	$598.15	59
60	HARTIG PHARMACY SERVICES	DUBUQUE	IA	3,921	$282,774.85	$859.50	73
61	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	2,926	$279,221.51	$742.61	77
62	WALGREENS #7453	DES MOINES	IA	4,586	$275,745.37	$266.68	63
63	PANTHERX SPECIALTY PHARMACY	PITTSBURGH	PA	26	$274,477.92	$24,952.54	118
64	REUTZEL PHARMACY	CEDAR RAPIDS	IA	2,990	$274,437.00	$1,059.60	81
65	ALLIANCERX WALGREENS PHARMACY #15443	FRISCO	TX	23	$267,922.61	$22,326.88	53
66	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,900	$267,646.66	$533.16	78
67	LAGRANGE PHARMACY	VINTON	IA	2,790	$264,325.03	$691.95	86
68	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	5,303	$264,139.03	$337.77	76
69	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	36	$260,848.03	$10,868.67	27
70	HY-VEE PHARMACY (1433)	MT PLEASANT	IA	3,622	$258,197.20	$452.18	83
71	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	3,657	$257,161.30	$431.48	74
72	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	1,087	$257,024.37	$1,163.01	58
73	WALGREENS #9708	DUBUQUE	IA	3,897	$255,777.76	$274.73	87
74	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	3,607	$253,003.34	$363.51	65

75	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	2,829	$249,715.76	$964.15	75
76	WAGNER PHARMACY	CLINTON	IA	3,086	$249,033.23	$676.72	82
77	HY-VEE PHARMACY (1449)	NEWTON	IA	3,539	$247,279.64	$445.55	68
78	WALMART PHARMACY 10-5115	DAVENPORT	IA	3,018	$247,240.22	$511.88	101
79	MEDICAP PHARMACY	DES MOINES	IA	2,306	$245,833.94	$1,148.76	67
80	OPTUM INFUSION SERVICES 302, LLC	LA VISTA	NE	27	$243,910.94	$27,101.22	104
81	UNION PHARMACY	COUNCIL BLUFFS	IA	2,161	$242,259.95	$1,170.34	103
82	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	3,611	$241,699.64	$412.46	84
83	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,132	$240,949.60	$680.65	69
84	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,598	$238,488.08	$439.20	61
85	DANIEL PHARMACY	FT DODGE	IA	3,014	$238,325.31	$568.80	91
86	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	3,501	$230,913.98	$322.06	70
87	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,332	$229,733.87	$806.08	90
88	WALMART PHARMACY 10-0985	FAIRFIELD	IA	3,054	$229,237.15	$497.26	106
89	WALGREENS #3875	CEDAR RAPIDS	IA	3,455	$228,361.52	$332.89	80
90	HY-VEE PHARMACY (1522)	PERRY	IA	2,467	$225,886.29	$446.42	102
91	ACARIAHEALTH PHARMACY #11	HOUSTON	TX	24	$225,561.23	$22,556.12	132
92	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	3,244	$222,068.72	$441.49	110
93	HY-VEE PHARMACY #2 (1614)	SIOUX CITY	IA	1,992	$217,511.16	$634.14	134
94	HY-VEE PHARMACY #1 (1105)	DAVENPORT	IA	3,132	$215,873.60	$539.68	113
95	SCOTT PHARMACY	FAYETTE	IA	2,984	$215,007.48	$590.68	89
96	STANGEL PHARMACY	ONAWA	IA	2,745	$212,946.44	$570.90	93
97	ARJ INFUSION SERVICES, LLC	CEDAR RAPIDS	IA	49	$212,558.45	$26,569.81	409
98	PARAGON PARTNERS	OMAHA	NE	640	$212,068.83	$2,945.40	194
99	WALMART PHARMACY 10-0559	MUSCATINE	IA	3,046	$210,961.79	$356.96	116
100	WALGREENS #7452	DES MOINES	IA	2,932	$210,712.01	$332.35	92

TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
June 2023 / August 2023

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$115,411.00	2,338	6.20	1
2	1356096572	Natasha Lash	$209,109.42	1,970	4.00	2
3	1215146055	Rebecca Wolfe	$114,592.15	1,586	2.60	3
4	1730434069	Larissa Biscoe	$104,709.18	1,579	2.81	6
5	1437238110	Genevieve Nelson	$174,369.29	1,531	3.00	4
6	1659358620	Carlos Castillo	$69,897.42	1,508	2.97	8
7	1922455096	Dean Guerdet	$119,800.87	1,440	3.50	7
8	1467502286	Charles Tilley	$139,668.53	1,418	3.61	5
9	1043211303	Ali Safdar	$223,405.26	1,414	2.19	13
10	1043434525	Robert Kent	$76,085.67	1,405	3.20	12
11	1467907394	Cynthia Coenen	$157,249.60	1,362	3.59	18
12	1063491645	Allyson Wheaton	$105,273.76	1,361	2.34	14
13	1316356496	Kimberly Roberts	$72,610.20	1,353	3.29	22
14	1770933046	Shelby Biller	$278,955.90	1,303	2.38	23
15	1982030946	Jacklyn Besch	$56,493.76	1,266	3.18	10
16	1215125216	Rebecca Walding	$173,805.70	1,259	3.68	11
17	1275763047	Rebecca Bowman	$195,079.48	1,254	2.93	26
18	1902912538	Christian Jones	$85,668.61	1,243	2.87	17
19	1902478811	Joan Anderson	$296,536.33	1,227	3.35	20
20	1457584740	Eric Meyer	$118,723.46	1,219	2.71	24
21	1013115369	Bobbita Nag	$61,849.88	1,213	2.12	9
22	1164538674	Joseph Wanzek	$107,442.34	1,213	3.95	16
23	1609218304	Amanda Garr	$184,580.10	1,167	3.19	19

24	1902850845	Deborah Bahe	$100,847.73	1,110	4.00	25
25	1437209434	Jon Thomas	$56,094.01	1,089	2.56	32
26	1003539784	Julia Sass	$122,714.22	1,088	2.46	34
27	1316471154	Nicole Woolley	$57,139.81	1,078	2.53	48
28	1538157383	David Wenger-Keller	$46,053.07	1,059	4.65	30
29	1538368170	Christopher Matson	$30,939.70	1,057	3.25	36
30	1902358443	Melissa Konken	$233,816.26	1,051	3.33	29
31	1053630640	Jennifer Donovan	$120,477.46	1,023	3.07	61
32	1013499029	Spencer Kissel	$157,070.73	1,022	3.12	54
33	1790163848	Hesper Nowatzki	$127,299.48	1,017	3.12	60
34	1649248378	Kathleen Wild	$51,932.80	1,011	2.90	35
35	1043418809	Michael Ciliberto	$426,167.02	1,006	2.58	39
36	1215184726	Babuji Gandra	$37,418.72	1,003	2.36	28
37	1558770974	Marc Baumert	$41,736.37	995	2.53	37
38	1790013209	Tracy Tschudi	$125,626.70	982	2.96	27
39	1134191018	Dustin Smith	$52,925.14	980	3.26	33
40	1477199198	Sajo Thomas	$120,063.70	969	2.85	21
41	1619153137	Joada Best	$63,068.94	956	2.99	42
42	1568431880	Pomilla Kumar	$68,041.91	955	3.69	31
43	1205393386	Jessica Hudspeth	$98,805.77	951	3.79	45
44	1801998372	Wendy Hansen-Penman	$31,545.61	930	4.04	47
45	1205571155	Dina Lentz	$141,752.93	925	3.07	69
46	1689077018	Stacy Roth	$60,841.26	916	2.75	43
47	1255405338	Bryan Netolicky	$127,259.95	909	2.38	46
48	1528329398	Erin Rowan	$39,685.68	889	2.62	73
49	1679573893	Patty Hildreth	$178,365.67	889	2.78	56

50	1669056123	Kama Ausborn	$283,021.75	881	3.51	40
51	1447680848	Mindy Roberts	$85,236.49	869	2.33	50
52	1144214248	Kristi Walz	$131,790.08	856	3.72	49
53	1932531316	Brooke Johnson	$60,073.74	852	2.68	122
54	1124006770	Wook Kim	$45,166.74	849	2.87	41
55	1275844649	Katie Campbell	$125,764.77	849	2.60	38
56	1003330036	Evan Peterson	$34,209.02	831	2.63	157
57	1477926434	Jackie Shipley	$37,070.60	828	2.73	67
58	1871105916	Lacie Theis	$69,501.03	826	2.82	55
59	1417549932	Amanda McCormick	$49,530.06	820	3.12	63
60	1437692803	Cassandra Dunlavy	$58,247.54	815	3.77	63
61	1609946243	Sina Linman	$50,063.17	813	2.39	75
62	1720698335	Danika Hansen	$92,083.52	803	3.57	61
63	1396083531	Joni Hanshaw	$45,737.37	799	3.72	73
64	1295967255	Mary Robinson	$49,026.12	798	3.89	107
65	1912991340	Ghada Hamdan-Allen	$49,449.69	775	2.76	56
66	1891146999	Becky Johnson	$682,517.29	774	3.02	52
67	1356754337	Cyndi McCormick	$126,908.92	772	3.24	77
68	1972758126	Rebecca Bollin	$28,363.47	772	2.81	123
69	1073945499	Jennifer Zalaznik	$50,494.90	765	2.90	15
70	1689139669	Benjamin Bolmeier	$44,227.09	765	2.73	81
71	1598183493	Jena Ellerhoff	$36,603.76	763	3.58	70
72	1356724405	Beth Colon	$85,328.66	762	2.26	164
73	1639607757	Michael Gerber	$87,468.96	761	3.31	109
74	1992103386	Melissa Larsen	$54,699.21	761	2.65	59
75	1245227099	Donna Dobson Tobin	$139,086.58	759	3.63	87

76	1710941000	Laurie Warren	$79,648.78	757	3.68	51
77	1356760011	Charissa Elliott	$58,960.06	755	3.44	93
78	1588746515	Amy Badberg	$30,251.78	751	2.57	107
79	1922144088	Thomas Hopkins	$45,708.80	751	2.42	180
80	1255823506	Nicole Delagardelle	$139,454.56	750	2.49	53
81	1841220290	Kent Kunze	$54,880.16	749	2.61	80
82	1164823092	Jamey Gregersen	$48,088.74	747	2.87	68
83	1437552304	Anita Sharma	$51,708.26	747	2.40	383
84	1134232481	Abbie White	$42,901.14	740	2.83	76
85	1063497840	Kaye Cleveland	$124,953.42	736	3.58	78
86	1538219530	Kevin Sheppard	$94,059.96	736	3.24	155
87	1780877878	Christopher Jacobs	$32,349.66	731	3.56	159
88	1346621059	Mark Zacharjasz	$64,449.17	729	3.22	116
89	1932582988	Dianne Humphrey	$46,990.44	728	3.38	95
90	1992332563	Stacy Overman	$21,149.96	726	6.26	189
91	1821268335	Jacqueline McInnis	$90,632.29	722	3.60	72
92	1831751908	Kelsey Frame	$55,680.55	716	3.03	90
93	1053398800	Steven Scurr	$32,039.62	715	3.52	118
94	1891707832	Lisa Klock	$42,999.94	713	2.34	120
95	1356359871	Rhea Hartley	$53,553.03	704	2.37	98
96	1154779460	Molly Eichenberger	$35,001.08	702	3.82	103
97	1912971425	Sherry Adams	$72,499.09	702	2.68	93
98	1093180440	Jennifer Griffith	$79,993.94	701	2.44	191
99	1184657603	Sara Rygol	$93,752.71	701	2.46	132
100	1609445733	Michelle Houghton	$72,968.43	701	2.81	121

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June 2023 / August 2023

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
1	1326034984	Katherine Mathews	$891,691.11	$11,580.40	77	6
2	1376777524	Alladdin Abosaida	$876,686.06	$3,563.76	246	2
3	1316934318	Steven Lentz	$855,518.38	$13,161.82	65	9
4	1477761328	Amy Calhoun	$799,120.16	$10,115.45	79	8
5	1891146999	Becky Johnson	$682,517.29	$881.81	774	3
6	1437121407	Linda Cadaret	$591,368.23	$5,797.73	102	10
7	1417443953	Rodney Clark	$524,696.61	$1,095.40	479	5
8	1285748004	Bruce Hughes	$490,759.66	$4,267.48	115	4
9	1326211889	James Friedlander	$475,672.10	$6,606.56	72	13
10	1295091510	Rebecca Weiner	$472,609.77	$1,305.55	362	7
11	1043418809	Michael Ciliberto	$426,167.02	$423.63	1006	12
12	1174748180	Mohammad Alsharabati	$399,072.23	$1,435.51	278	31
13	1003103383	Grerk Sutamtewagul	$393,980.34	$9,849.51	40	705
14	1093382632	Gail Dooley	$378,474.37	$1,406.97	269	14
15	1841632965	Ahmad Al-Huniti	$372,171.81	$20,676.21	18	1
16	1043565328	Sara Moeller	$368,889.33	$2,653.88	139	41
17	1497060776	Usha Perepu	$327,306.01	$13,637.75	24	19
18	1013126705	Janice Staber	$323,983.13	$8,099.58	40	11
19	1306071915	Thomas Pietras	$302,944.28	$2,046.92	148	21
20	1225263833	Lindsay Orris	$300,561.67	$1,810.61	166	27
21	1902478811	Joan Anderson	$296,536.33	$241.68	1227	22
22	1376525196	Randolph Rough	$283,306.17	$2,162.64	131	29
23	1669056123	Kama Ausborn	$283,021.75	$321.25	881	23

24	1770933046	Shelby Biller	$278,955.90	$214.09	1303	28
25	1386084747	Jennifer Condon	$278,377.03	$1,015.97	274	32
26	1285626390	Kathleen Gradoville	$266,803.08	$984.51	271	552
27	1649419219	Heather Hunemuller	$261,882.42	$1,100.35	238	15
28	1558357806	Robin Hayward	$255,831.29	$2,149.84	119	37
29	1942937388	Carly Trausch	$247,798.45	$576.28	430	30
30	1306495296	Amber Burns	$245,595.83	$6,297.33	39	1053
31	1467449579	Brian Wayson	$239,951.04	$3,242.58	74	36
32	1588616171	Heather Thomas	$237,237.57	$2,062.94	115	40
33	1366858334	Alicia Duyvejonck	$236,486.65	$479.69	493	33
34	1902358443	Melissa Konken	$233,816.26	$222.47	1051	35
35	1013026798	Stephen Grant	$233,667.42	$4,868.07	48	39
36	1356445886	Megan Eisel	$223,996.82	$1,197.84	187	66
37	1043211303	Ali Safdar	$223,405.26	$158.00	1414	18
38	1508091109	Melissa Muff-Luett	$219,865.67	$7,328.86	30	121
39	1841607900	Shayla Sanders	$218,602.21	$1,852.56	118	46
40	1720086523	Mark Cleveland	$217,572.49	$1,163.49	187	25
41	1578958542	Heidi Curtis	$216,602.81	$1,134.05	191	20
42	1023108701	Ronald Zolty	$215,061.83	$4,887.77	44	85
43	1386902682	Melissa Willis	$214,960.61	$1,335.16	161	100
44	1447373832	Joshua Wilson	$214,796.65	$3,977.72	54	81
45	1871868984	Hana Niebur	$211,237.24	$2,200.39	96	67
46	1386938447	Theresa Czech	$210,750.28	$486.72	433	86
47	1285710764	Jitendrakumar Gupta	$210,640.78	$640.25	329	71
48	1356096572	Natasha Lash	$209,109.42	$106.15	1970	63
49	1962497438	Sheryl Mulder	$209,025.04	$2,679.81	78	105

50	1427178284	Darcy Krueger	$206,926.31	$15,917.41	13	0
51	1033554498	Matthew Landherr	$204,036.46	$1,221.78	167	62
52	1700417169	Courtney Reints	$203,957.57	$515.04	396	43
53	1124216676	Wendy Sanders	$202,260.13	$475.91	425	53
54	1366826109	Alyssa Mrsny	$201,917.03	$1,160.44	174	104
55	1174970453	Daniel Hinds	$201,737.71	$1,024.05	197	57
56	1972989721	Jayson Gesulga	$200,320.13	$355.81	563	48
57	1538676150	Megan Dietzel	$200,318.57	$3,179.66	63	89
58	1447519038	Erin Richardson	$199,098.15	$711.06	280	101
59	1821046087	Archana Verma	$197,788.65	$2,081.99	95	68
60	1134402373	Julie Schuck	$197,449.72	$3,085.15	64	103
61	1275763047	Rebecca Bowman	$195,079.48	$155.57	1254	42
62	1619186368	Mathew Wehbe	$191,992.13	$4,682.73	41	115
63	1730293705	Robert Jackson	$187,962.50	$1,724.43	109	49
64	1467561464	Timothy Feyma	$187,106.58	$8,909.84	21	3042
65	1528365277	Mina Salib	$186,293.15	$285.29	653	271
66	1073722112	Riad Rahhal	$184,982.45	$572.70	323	163
67	1609218304	Amanda Garr	$184,580.10	$158.17	1167	51
68	1356834113	Susan Deo	$183,364.72	$1,608.46	114	95
69	1134249832	Steven Craig	$182,043.62	$1,529.78	119	26
70	1679573893	Patty Hildreth	$178,365.67	$200.64	889	70
71	1609003011	John Bernat	$177,345.96	$25,335.14	7	34
72	1649943689	Jessica Coffey	$176,770.94	$1,178.47	150	72
73	1437238110	Genevieve Nelson	$174,369.29	$113.89	1531	69
74	1275836751	Holly Kramer	$173,829.97	$1,198.83	145	126
75	1215125216	Rebecca Walding	$173,805.70	$138.05	1259	59

76	1184395162	Danielle Van Oosbree	$173,099.56	$260.69	664	87
77	1104891704	Akshay Mahadevia	$171,717.89	$1,129.72	152	147
78	1487648705	Karen Hunke	$168,616.02	$1,179.13	143	47
79	1902191059	Amber Tierney	$167,278.52	$3,097.75	54	127
80	1689942518	Patria Alba Aponte	$165,476.97	$683.79	242	80
81	1588618359	Barbara Burkle	$162,377.87	$1,021.24	159	56
82	1366014698	Debbie Ohrt	$161,493.89	$342.87	471	106
83	1699765826	Joseph Merchant	$160,877.12	$1,675.80	96	142
84	1932464971	Kari Ernst	$160,780.51	$1,914.05	84	91
85	1467907394	Cynthia Coenen	$157,249.60	$115.45	1362	79
86	1013499029	Spencer Kissel	$157,070.73	$153.69	1022	109
87	1790708451	Michael McCubbin	$154,676.35	$1,154.30	134	122
88	1043703887	Tenaea Jeppeson	$154,518.81	$240.68	642	82
89	1265420095	Elizabeth Cooper	$153,102.59	$927.89	165	102
90	1114521721	Tarrah Holliday	$146,803.82	$215.89	680	156
91	1356337273	Lisa Menzies	$146,486.57	$290.65	504	17
92	1437262086	Amy Hughes	$144,888.30	$2,733.74	53	203
93	1740700632	Jessica Dunne	$142,241.01	$277.27	513	75
94	1154307114	Gena Ghearing	$141,913.47	$326.24	435	112
95	1205571155	Dina Lentz	$141,752.93	$153.25	925	151
96	1245353242	Sandy Hong	$141,724.80	$869.48	163	55
97	1003315201	Abigail Behrens	$140,134.24	$1,819.93	77	50
98	1437533130	Katie Broshuis	$139,997.16	$1,196.56	117	61
99	1467502286	Charles Tilley	$139,668.53	$98.50	1418	58
100	1255823506	Nicole Delagardelle	$139,454.56	$185.94	750	78

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March 2023 / May 2023	RANK	% BUDGET	June 2023 / August 2023	RANK	% BUDGET	% CHANGE
ANTIDIABETICS	$18,871,097	1	13.1%	$14,630,165	1	13.2%	-22.5%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$15,382,323	2	10.7%	$11,399,310	2	10.3%	-25.9%
DERMATOLOGICALS	$12,626,459	4	8.8%	$10,098,905	3	9.1%	-20.0%
ANALGESICS - ANTI-INFLAMMATORY	$12,763,803	3	8.9%	$9,911,929	4	9.0%	-22.3%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$10,190,556	5	7.1%	$7,690,518	5	7.0%	-24.5%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$9,610,513	6	6.7%	$7,269,056	6	6.6%	-24.4%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$5,690,369	8	4.0%	$4,076,333	7	3.7%	-28.4%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$4,614,352	10	3.2%	$4,002,023	8	3.6%	-13.3%
ANTIVIRALS	$5,520,001	9	3.8%	$3,922,582	9	3.5%	-28.9%
ANTICONVULSANTS	$4,334,305	11	3.0%	$3,749,188	10	3.4%	-13.5%
HEMATOLOGICAL AGENTS - MISC.	$5,718,186	7	4.0%	$3,411,890	11	3.1%	-40.3%
MIGRAINE PRODUCTS	$4,051,122	13	2.8%	$3,297,728	12	3.0%	-18.6%
RESPIRATORY AGENTS - MISC.	$4,163,679	12	2.9%	$3,111,952	13	2.8%	-25.3%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$3,725,314	14	2.6%	$2,740,978	14	2.5%	-26.4%
ANTIDEPRESSANTS	$3,376,985	15	2.4%	$2,618,642	15	2.4%	-22.5%
CARDIOVASCULAR AGENTS - MISC.	$2,351,910	16	1.6%	$2,237,213	16	2.0%	-4.9%
ANTICOAGULANTS	$2,339,246	17	1.6%	$1,770,217	17	1.6%	-24.3%
GASTROINTESTINAL AGENTS - MISC.	$1,544,826	18	1.1%	$1,268,381	18	1.1%	-17.9%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$1,163,364	19	0.8%	$927,500	19	0.8%	-20.3%
NEUROMUSCULAR AGENTS	$542,004	29	0.4%	$875,880	20	0.8%	61.6%

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March 2023 / May 2023	PREV RANK	June 2023 / August 2023	CURR RANK	% CHANGE
ANTIDEPRESSANTS	152,816	1	130,605	1	-14.5%
ANTICONVULSANTS	67,991	3	56,836	2	-16.4%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	65,459	4	51,818	3	-20.8%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	68,483	2	50,450	4	-26.3%
ANTIHYPERTENSIVES	50,991	7	48,023	5	-5.8%
ANTIDIABETICS	47,812	8	45,268	6	-5.3%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	47,118	9	44,111	7	-6.4%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	53,985	5	43,691	8	-19.1%
ANTIANXIETY AGENTS	51,273	6	40,393	9	-21.2%
ANTIHYPERLIPIDEMICS	29,268	15	31,104	10	6.3%
DERMATOLOGICALS	33,381	11	26,951	11	-19.3%
ANTIHISTAMINES	30,554	13	26,894	12	-12.0%
ANALGESICS - ANTI-INFLAMMATORY	30,110	14	24,383	13	-19.0%
ANALGESICS - OPIOID	31,242	12	23,396	14	-25.1%
BETA BLOCKERS	23,825	16	22,949	15	-3.7%
DIURETICS	18,891	19	18,579	16	-1.7%
THYROID AGENTS	17,551	20	18,147	17	3.4%
PENICILLINS	35,656	10	16,283	18	-54.3%
MUSCULOSKELETAL THERAPY AGENTS	20,659	18	16,142	19	-21.9%
CORTICOSTEROIDS	20,866	17	13,620	20	-34.7%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March 2023 / May 2023	RANK	June 2023 / August 2023	RANK	% CHANGE
HUMIRA(CF) PEN	$7,221,445	1	$5,800,944	1	-19.7%
VRAYLAR	$4,341,625	3	$3,363,385	2	-22.5%
VYVANSE	$4,553,208	2	$3,334,538	3	-26.8%
OZEMPIC	$3,221,086	5	$3,043,247	4	-5.5%
TRULICITY	$4,105,310	4	$2,993,457	5	-27.1%
STELARA	$2,951,862	7	$2,566,084	6	-13.1%
TRIKAFTA	$3,138,211	6	$2,553,413	7	-18.6%
INVEGA SUSTENNA	$2,742,588	8	$2,066,015	8	-24.7%
JARDIANCE	$2,505,189	9	$1,879,119	9	-25.0%
BIKTARVY	$2,249,284	10	$1,564,969	10	-30.4%
DUPIXENT PEN	$1,858,987	11	$1,554,774	11	-16.4%
REXULTI	$1,694,082	13	$1,301,018	12	-23.2%
TALTZ AUTOINJECTOR	$1,751,680	12	$1,140,107	13	-34.9%
ELIQUIS	$1,516,530	16	$1,130,516	14	-25.5%
LANTUS SOLOSTAR	$1,561,285	15	$1,102,338	15	-29.4%
SYMBICORT	$1,356,573	19	$1,072,617	16	-20.9%
CONCERTA	$1,231,781	21	$1,058,578	17	-14.1%
VENTOLIN HFA	$1,460,831	18	$1,053,552	18	-27.9%
SKYRIZI PEN	$1,240,953	20	$1,007,792	19	-18.8%
ARISTADA	$1,223,878	22	$1,007,339	20	-17.7%
NURTEC ODT	$1,101,106	23	$930,523	21	-15.5%
DUPIXENT SYRINGE	$1,039,526	26	$925,804	22	-10.9%
ABILIFY MAINTENA	$1,035,133	27	$849,468	23	-17.9%
ENBREL SURECLICK	$960,341	28	$846,108	24	-11.9%

INGREZZA	$1,075,752	25	$845,828	25	-21.4%
TRINTELLIX	$1,077,892	24	$819,612	26	-24.0%
MOUNJARO	$783,019	32	$723,757	27	-7.6%
AJOVY AUTOINJECTOR	$853,466	31	$654,205	28	-23.3%
EVRYSDI	$541,158	53	$638,443	29	18.0%
INVEGA TRINZA	$750,423	34	$634,792	30	-15.4%
AUSTEDO	$688,570	40	$629,328	31	-8.6%
TREMFYA	$652,186	44	$627,403	32	-3.8%
ELOCTATE	$411,252	70	$600,605	33	46.0%
LATUDA	$1,654,874	14	$577,271	34	-65.1%
XARELTO	$735,441	37	$572,901	35	-22.1%
NORDITROPIN FLEXPRO	$635,519	45	$565,781	36	-11.0%
FARXIGA	$702,561	38	$560,423	37	-20.2%
MAVYRET	$854,459	30	$556,364	38	-34.9%
EPIDIOLEX	$668,072	43	$556,278	39	-16.7%
FLOVENT HFA	$752,821	33	$551,550	40	-26.7%
COSENTYX PEN (2 PENS)	$936,373	29	$548,892	41	-41.4%
TRELEGY ELLIPTA	$685,740	41	$542,261	42	-20.9%
WAKIX	$500,865	61	$516,438	43	3.1%
ORFADIN	$401,612	76	$509,734	44	26.9%
ADDERALL XR	$737,696	36	$509,580	45	-30.9%
XYWAV	$742,569	35	$506,693	46	-31.8%
CAPLYTA	$633,273	46	$501,703	47	-20.8%
UBRELVY	$539,465	54	$499,196	48	-7.5%
OTEZLA	$511,877	58	$483,466	49	-5.6%
ADVATE	$611,250	47	$482,124	50	-21.1%

XIFAXAN	$507,328	59	$481,428	51	-5.1%
HEMLIBRA	$681,997	42	$463,374	52	-32.1%
JANUVIA	$693,837	39	$459,809	53	-33.7%
FASENRA PEN	$506,461	60	$436,271	54	-13.9%
JORNAY PM	$493,591	62	$414,558	55	-16.0%
VERZENIO	$323,009	91	$412,984	56	27.9%
ENTRESTO	$515,843	57	$411,894	57	-20.2%
LYBALVI	$530,552	55	$404,599	58	-23.7%
OPSUMIT	$423,151	68	$401,800	59	-5.0%
AIMOVIG AUTOINJECTOR	$487,864	63	$392,304	60	-19.6%
INSULIN ASPART FLEXPEN	$519,327	56	$390,959	61	-24.7%
SPIRIVA HANDIHALER	$584,878	48	$390,877	62	-33.2%
LINZESS	$577,793	50	$386,476	63	-33.1%
ALPROLIX	$431,978	66	$372,239	64	-13.8%
HUMIRA(CF)	$556,822	52	$370,633	65	-33.4%
ADVAIR DISKUS	$580,900	49	$353,734	66	-39.1%
SPIRIVA RESPIMAT	$481,164	64	$350,456	67	-27.2%
UPTRAVI	$309,656	98	$340,061	68	9.8%
HUMIRA PEN	$377,047	81	$338,974	69	-10.1%
EMFLAZA	$252,290	119	$338,253	70	34.1%
SPRYCEL	$440,458	65	$335,456	71	-23.8%
AYVAKIT	$37,121	429	$334,030	72	799.8%
FINTEPLA	$267,127	109	$313,381	73	17.3%
ADVAIR HFA	$424,906	67	$310,964	74	-26.8%
ORENITRAM ER	$204,983	141	$310,446	75	51.4%
LENVIMA	$307,337	99	$308,442	76	0.4%

RINVOQ	$367,530	84	$305,123	77	-17.0%
HAEGARDA	$253,965	118	$304,758	78	20.0%
TRESIBA FLEXTOUCH U-200	$416,176	69	$303,909	79	-27.0%
EPINEPHRINE	$310,875	97	$295,559	80	-4.9%
ENBREL MINI	$401,151	77	$287,384	81	-28.4%
RAVICTI	$328,757	89	$279,422	82	-15.0%
ENBREL	$280,992	106	$275,569	83	-1.9%
KESIMPTA PEN	$393,393	78	$273,767	84	-30.4%
TAKHZYRO	$323,003	92	$273,312	85	-15.4%
PULMOZYME	$386,581	80	$270,420	86	-30.0%
LEVEMIR FLEXPEN	$338,783	86	$269,740	87	-20.4%
DESCOVY	$337,566	87	$264,055	88	-21.8%
LYNPARZA	$262,352	112	$262,373	89	0.0%
VICTOZA 3-PAK	$406,033	75	$260,896	90	-35.7%
CREON	$336,588	88	$259,740	91	-22.8%
LANTUS	$410,119	71	$257,936	92	-37.1%
TALTZ AUTOINJECTOR (2 PACK)	$209,261	139	$256,244	93	22.5%
HIZENTRA	$213,186	135	$241,572	94	13.3%
DAYBUE		-	$237,437	95	0.0%
QUILLICHEW ER	$343,401	85	$231,112	96	-32.7%
METHYLPHENIDATE ER	$389,727	79	$224,849	97	-42.3%
MYRBETRIQ	$291,990	105	$220,229	98	-24.6%
BRIVIACT	$240,805	123	$219,025	99	-9.0%
SERTRALINE HCL	$261,308	113	$218,660	100	-16.3%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March 2023 / May 2023	PREVIOUS RANK	June 2023 / August 2023	RANK	% CHANGE
OMEPRAZOLE	20,960	4	20,078	1	-4.2%
SERTRALINE HCL	23,084	2	19,851	2	-14.0%
ATORVASTATIN CALCIUM	16,979	7	18,187	3	7.1%
TRAZODONE HCL	20,042	5	16,794	4	-16.2%
LEVOTHYROXINE SODIUM	15,864	9	16,624	5	4.8%
VENTOLIN HFA	21,943	3	16,156	6	-26.4%
ESCITALOPRAM OXALATE	18,332	6	15,860	7	-13.5%
LISINOPRIL	14,557	11	14,910	8	2.4%
GABAPENTIN	16,079	8	13,846	9	-13.9%
FLUOXETINE HCL	15,329	10	12,815	10	-16.4%
MONTELUKAST SODIUM	13,298	15	12,295	11	-7.5%
BUSPIRONE HCL	13,723	14	11,422	12	-16.8%
HYDROXYZINE HCL	14,100	13	11,251	13	-20.2%
DULOXETINE HCL	12,357	18	10,845	14	-12.2%
VYVANSE	14,168	12	10,522	15	-25.7%
AMOXICILLIN	23,941	1	10,102	16	-57.8%
AMLODIPINE BESYLATE	9,851	29	10,074	17	2.3%
PANTOPRAZOLE SODIUM	10,142	28	9,919	18	-2.2%
CETIRIZINE HCL	10,636	26	9,654	19	-9.2%
QUETIAPINE FUMARATE	11,811	19	9,603	20	-18.7%
HYDROCODONE-ACETAMINOPHEN	12,388	17	9,242	21	-25.4%
ARIPIPRAZOLE	11,541	20	9,217	22	-20.1%
CLONIDINE HCL	10,804	25	9,213	23	-14.7%

VENLAFAXINE HCL ER	10,875	23	9,204	24	-15.4%
LAMOTRIGINE	10,820	24	8,837	25	-18.3%
PREDNISONE	12,416	16	8,499	26	-31.5%
BUPROPION XL	11,191	21	8,370	27	-25.2%
FLUTICASONE PROPIONATE	11,021	22	8,143	28	-26.1%
METFORMIN HCL	8,467	37	7,872	29	-7.0%
TOPIRAMATE	8,473	36	7,535	30	-11.1%
FAMOTIDINE	8,118	39	7,343	31	-9.5%
CYCLOBENZAPRINE HCL	9,449	30	7,187	32	-23.9%
LOSARTAN POTASSIUM	6,593	46	7,071	33	7.3%
METOPROLOL SUCCINATE	6,977	44	7,018	34	0.6%
ALPRAZOLAM	9,438	31	7,003	35	-25.8%
CLONAZEPAM	8,735	34	6,593	36	-24.5%
BUPROPION HYDROCHLORIDE E	5,998	50	6,563	37	9.4%
IBUPROFEN	8,182	38	6,241	38	-23.7%
MELOXICAM	7,114	42	6,229	39	-12.4%
CEPHALEXIN	8,512	35	6,203	40	-27.1%
ONDANSETRON ODT	9,156	33	6,130	41	-33.0%
ALLERGY RELIEF	5,785	53	6,097	42	5.4%
RISPERIDONE	7,529	40	6,038	43	-19.8%
METFORMIN HCL ER	5,882	51	5,949	44	1.1%
HYDROCHLOROTHIAZIDE	5,573	56	5,667	45	1.7%
DEXTROAMPHETAMINE-AMPHETAMINE	7,307	41	5,598	46	-23.4%
FUROSEMIDE	5,412	59	5,353	47	-1.1%
AMOXICILLIN-CLAVULANATE POTASS	10,218	27	5,325	48	-47.9%
ROSUVASTATIN CALCIUM	4,752	67	5,224	49	9.9%

LORATADINE	6,070	49	5,133	50	-15.4%
TRIAMCINOLONE ACETONIDE	5,868	52	5,074	51	-13.5%
ASPIRIN EC	5,384	60	5,002	52	-7.1%
MIRTAZAPINE	5,772	54	4,837	53	-16.2%
LORAZEPAM	6,263	47	4,704	54	-24.9%
TRAMADOL HCL	6,151	48	4,677	55	-24.0%
SPIRONOLACTONE	4,550	71	4,400	56	-3.3%
METHYLPHENIDATE ER	7,047	43	4,399	57	-37.6%
DEXTROAMPHETAMINE-AMPHET ER	5,730	55	4,315	58	-24.7%
AZITHROMYCIN	9,417	32	4,251	59	-54.9%
PRAZOSIN HCL	5,084	64	4,237	60	-16.7%
FLUCONAZOLE	5,485	57	4,128	61	-24.7%
LEVETIRACETAM	4,868	66	4,081	62	-16.2%
HYDROXYZINE PAMOATE	5,231	62	4,044	63	-22.7%
CITALOPRAM HBR	4,509	72	4,013	64	-11.0%
POLYETHYLENE GLYCOL 3350	5,031	65	3,947	65	-21.5%
ACETAMINOPHEN	4,581	69	3,904	66	-14.8%
FOLIC ACID	3,942	87	3,826	67	-2.9%
METRONIDAZOLE	5,111	63	3,702	68	-27.6%
VALACYCLOVIR	4,408	74	3,693	69	-16.2%
OZEMPIC	3,685	94	3,690	70	0.1%
POTASSIUM CHLORIDE	3,942	88	3,682	71	-6.6%
JARDIANCE	3,865	91	3,619	72	-6.4%
DICLOFENAC SODIUM	4,638	68	3,520	73	-24.1%
PREGABALIN	4,158	81	3,500	74	-15.8%
TRULICITY	4,368	76	3,491	75	-20.1%

DOXYCYCLINE MONOHYDRATE	5,368	61	3,479	76	-35.2%
TIZANIDINE HCL	4,351	78	3,456	77	-20.6%
BACLOFEN	4,189	79	3,422	78	-18.3%
SULFAMETHOXAZOLE-TRIMETHOPRIM	4,147	82	3,417	79	-17.6%
METOPROLOL TARTRATE	3,536	96	3,393	80	-4.0%
ALBUTEROL SULFATE	5,423	58	3,385	81	-37.6%
ATOMOXETINE HCL	4,356	77	3,359	82	-22.9%
PROPRANOLOL HCL	3,905	90	3,353	83	-14.1%
FEROSUL	3,605	95	3,291	84	-8.7%
OXYCODONE HCL	4,434	73	3,271	85	-26.2%
GUANFACINE HCL	4,181	80	3,239	86	-22.5%
GUANFACINE HCL ER	4,002	84	3,202	87	-20.0%
SYMBICORT	3,944	86	3,142	88	-20.3%
CEFDINIR	6,929	45	3,138	89	-54.7%
METHYLPHENIDATE HCL	4,572	70	3,132	90	-31.5%
LANTUS SOLOSTAR	3,422	98	3,121	91	-8.8%
OLANZAPINE	3,859	92	3,118	92	-19.2%
ZOLPIDEM TARTRATE	4,017	83	3,101	93	-22.8%
DEXMETHYLPHENIDATE HCL ER	4,402	75	3,081	94	-30.0%
SUMATRIPTAN SUCCINATE	3,920	89	3,019	95	-23.0%
NAPROXEN	3,972	85	2,958	96	-25.5%
FLUOXETINE HYDROCHLORIDE	3,326	99	2,944	97	-11.5%
VRAYLAR	3,320	100	2,716	98	-18.2%
CONCERTA	3,092	104	2,660	99	-14.0%
ONDANSETRON HCL	3,731	93	2,645	100	-29.1%

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Fee for Service Claims
Quarterly Statistics

	March through May 2023	June through August 2023	% CHANGE
TOTAL PAID AMOUNT	$2,916,195	$2,925,207	0.3%
UNIQUE USERS	3,755	3,654	-2.7%
COST PER USER	$776.62	$800.55	3.1%
TOTAL PRESCRIPTIONS	22,482	21,959	-2.3%
AVERAGE PRESCRIPTIONS PER USER	5.99	6.01	0.4%
AVERAGE COST PER PRESCRIPTION	$129.71	$133.21	2.7%
# GENERIC PRESCRIPTIONS	19,802	19,389	-2.1%
% GENERIC	88.1%	88.3%	0.2%
$ GENERIC	$966,652	$876,470	-9.3%
AVERAGE GENERIC PRESCRIPTION COST	$48.82	$45.20	-7.4%
AVERAGE GENERIC DAYS SUPPLY	28	26	-7.1%
# BRAND PRESCRIPTIONS	2,680	2,570	-4.1%
% BRAND	11.9%	11.7%	-1.8%
$ BRAND	$1,949,543	$2,048,737	5.1%
AVERAGE BRAND PRESCRIPTION COST	$727.44	$797.17	9.6%
AVERAGE BRAND DAYS SUPPLY	29	28	-3.4%

UTILIZATION BY AGE		
AGE	March through May 2023	June through August 2023
0-6	226	214
7-12	529	470
13-18	808	717
19-64	2,166	2,228
65+	26	25
	3,755	3,654

	UTILIZATION BY GENDER AND AGE		
GENDER	AGE	March through May 2023	June through August 2023
F			
	0-6	103	99
	7-12	237	205
	13-18	399	360
	19-64	1,353	1,363
	65+	15	16
		2,107	2,043
M			
	0-6	123	115
	7-12	292	265
	13-18	409	357
	19-64	813	865
	65+	11	9
		1,648	1,611

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2023

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	SIOUXLAND COMM HEALTH CTR PHARMA	SIOUX CITY	IA	971	$68,876.09	$70.93	1
2	MESKWAKI PHARMACY	TAMA	IA	714	$466,956.00	$654.00	2
3	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	688	$26,615.07	$38.68	4
4	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	638	$134,846.27	$211.36	3
5	WALGREENS #15647	SIOUX CITY	IA	554	$38,330.74	$69.19	5
6	THOMPSON-DEAN DRUG	SIOUX CITY	IA	504	$32,180.45	$63.85	6
7	GENOA HEALTHCARE LLC	SIOUX CITY	IA	309	$40,123.09	$129.85	8
8	WALGREEN #04405	COUNCIL BLUFFS	IA	280	$19,772.40	$70.62	9
9	WCHS PHARMACY	WINNEBAGO	NE	273	$178,542.00	$654.00	7
10	RIGHT DOSE PHARMACY	ANKENY	IA	163	$6,705.00	$41.13	30
11	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	162	$25,748.45	$158.94	25
12	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	150	$11,861.26	$79.08	10
13	GENOA HEALTH LLC	MARSHALLTOWN	IA	146	$16,636.28	$113.95	34
14	WALGREEN #05239	DAVENPORT	IA	138	$14,161.27	$102.62	16
15	HY-VEE MAINSTREET PHARMACY #7070	SIOUX CITY	IA	128	$5,891.67	$46.03	27
16	NUCARA PHARMACY #27	PLEASANT HILL	IA	122	$5,534.21	$45.36	22
17	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	122	$12,819.63	$105.08	18
18	HY VEE PHARMACY #6 1155	DES MOINES	IA	122	$7,105.22	$58.24	29
19	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	120	$6,282.52	$52.35	11
20	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	114	$6,825.06	$59.87	13
21	MEDICAP PHARMACY	KNOXVILLE	IA	114	$8,862.40	$77.74	31
22	ALL CARE HEALTH CENTER PHARMACY	COUNCIL BLUFFS	IA	114	$6,491.42	$56.94	12
23	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	109	$51,383.57	$471.41	23
24	WALGREEN COMPANY #05470	SIOUX CITY	IA	107	$6,409.24	$59.90	19
25	MEDICAP PHARMACY	GRIMES	IA	106	$1,299.20	$12.26	60

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2023

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
26	WALGREEN #04041	DAVENPORT	IA	106	$8,796.02	$82.98	14
27	MEDICAP PHARMACY	JEFFERSON	IA	104	$1,769.47	$17.01	17
28	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	102	$5,219.48	$51.17	20
29	WAL-MART PHARMACY #10-0985	FAIRFIELD	IA	97	$42,874.07	$442.00	36
30	HY-VEE DRUGSTORE #7026	CEDAR RAPIDS	IA	97	$3,318.68	$34.21	32
31	COVENANT FAMILY PHARMACY	WATERLOO	IA	96	$2,795.46	$29.12	53
32	UNITY POINT HEALTH PHARMACY	CEDAR RAPIDS	IA	95	$473.18	$4.98	87
33	IOWA VETERANS HOME	MARSHALLTOWN	IA	95	$5,358.46	$56.40	21
34	MEDICAP PHARMACY	RED OAK	IA	94	$2,348.33	$24.98	37
35	HY VEE PHARMACY 1060	CEDAR RAPIDS	IA	92	$10,120.71	$110.01	46
36	HY-VEE PHARMACY 1382	LE MARS	IA	92	$4,651.69	$50.56	90
37	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	90	$5,980.38	$66.45	62
38	MEDICAP PHARMACY	ANKENY	IA	88	$3,133.13	$35.60	28
39	TIPTON PHARMACY	TIPTON	IA	88	$4,582.54	$52.07	177
40	BOOTH PHARMACY	HAWARDEN	IA	85	$5,805.63	$68.30	24
41	CVS PHARMACY #17554	CEDAR FALLS	IA	84	$3,283.49	$39.09	50
42	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	82	$3,748.03	$45.71	41
43	MERCY MEDICAL CENTER NORTH IA DB	MASON CITY	IA	82	$4,056.18	$49.47	48
44	HY-VEE PHARMACY (1634)	STORM LAKE	IA	80	$15,305.73	$191.32	54
45	HERITAGE PARK PHARMACY	WEST BURLINGTON	IA	77	$1,424.52	$18.50	103
46	HY-VEE PHARMACY (1065)	CHARITON	IA	76	$1,952.74	$25.69	64
47	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	76	$2,037.57	$26.81	130
48	WALGREEN #05721	DES MOINES	IA	76	$6,576.07	$86.53	78
49	HY-VEE PHARMACY (1075)	CLINTON	IA	75	$5,972.51	$79.63	106
50	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	74	$78,074.33	$1,055.06	146
51	HY-VEE PHARMACY (1052)	CEDAR FALLS	IA	73	$2,175.33	$29.80	86

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2023

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
52	COMMUNITY HEALTH CARE INC	DAVENPORT	IA	72	$3,785.73	$52.58	89
53	GREENWOOD DRUG ON KIMBALL AVENUE	WATERLOO	IA	72	$3,578.69	$49.70	45
54	WAL-MART PHARMACIES #10-0753	CEDAR FALLS	IA	71	$6,551.76	$92.28	47
55	HY-VEE PHARMACY 1068	CHEROKEE	IA	69	$637.71	$9.24	70
56	WAL MART PHARMACY 10 0559	MUSCATINE	IA	69	$2,507.51	$36.34	61
57	CVS PHARMACY #08659	DAVENPORT	IA	69	$4,240.70	$61.46	68
58	HY VEE PHARMACY 7072	TOLEDO	IA	68	$4,308.75	$63.36	55
59	HARTIG PHARMACY SERVICES	DUBUQUE	IA	68	$8,789.30	$129.25	40
60	HY-VEE PHARMACY 1071	CLARINDA	IA	68	$7,741.20	$113.84	74
61	NELSON FAMILY PHARMACY	FORT MADISON	IA	68	$6,978.40	$102.62	15
62	ALLEN MEMORIAL HOSPITAL	WATERLOO	IA	67	$2,563.35	$38.26	88
63	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	67	$10,026.31	$149.65	209
64	SERGEANT BLUFF PHARMACY	SERGEANT BLUFF	IA	67	$2,253.14	$33.63	126
65	MEDICAP PHARMACY	WAUKEE	IA	66	$2,582.16	$39.12	49
66	WALGREEN #06678	WEST DES MOINES	IA	66	$5,186.34	$78.58	72
67	UI HEALTHCARE RIVER LANDING PHAR	CORALVILLE	IA	66	$3,292.37	$49.88	33
68	HY-VEE PHARMACY (1759)	URBANDALE	IA	66	$965.43	$14.63	148
69	WALGREENS #07453	DES MOINES	IA	65	$1,136.27	$17.48	43
70	PHARMACY MATTERS LTC	IOWA CITY	IA	64	$730.85	$11.42	152
71	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	63	$2,568.83	$40.78	51
72	HY-VEE PHARMACY #3 (1889)	WEST DES MOINES	IA	62	$1,874.85	$30.24	42
73	KOERNER WHIPPLE PHARMACY	HAMPTON	IA	62	$2,731.03	$44.05	123
74	SMART PHARMACY	OSAGE	IA	62	$4,668.13	$75.29	109
75	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	62	$2,706.79	$43.66	82
76	CORNERSTONE APOTHECARY	BELLE PLAINE	IA	62	$4,865.09	$78.47	58
77	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	62	$6,450.37	$104.04	71

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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
78	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	61	$7,229.35	$118.51	184
79	HY-VEE PHARMACY #4 (1890)	WEST DES MOINES	IA	61	$1,911.84	$31.34	114
80	HY-VEE PHARMACY (1124)	DENISON	IA	61	$2,352.71	$38.57	100
81	WAL-MART PHARMACY #10-0810	MASON CITY	IA	61	$1,079.02	$17.69	296
82	CVS PHARMACY #17056	ALTOONA	IA	61	$1,549.78	$25.41	110
83	WALGREEN #7452	DES MOINES	IA	60	$4,781.72	$79.70	77
84	WALGREEN #03196	MARSHALLTOWN	IA	60	$1,123.35	$18.72	91
85	REDLERS LONG TERM CARE PHARMACY	DAKOTA DUNES	SD	60	$1,102.90	$18.38	303
86	WALGREEN COMPANY #07967	CLIVE	IA	59	$809.13	$13.71	56
87	DANIEL PHARMACY INC	FORT DODGE	IA	59	$1,834.44	$31.09	44
88	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	58	$2,306.38	$39.77	204
89	HY-VEE PHARMACY #2 (1101)	COUNCIL BLUFFS	IA	58	$1,768.10	$30.48	111
90	PELLA REGIONAL HEALTH CENTER PHA	PELLA	IA	58	$3,954.17	$68.18	97
91	HY-VEE PHARMACY #1 (1136)	DES MOINES	IA	57	$1,740.52	$30.54	128
92	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	57	$4,664.40	$81.83	139
93	WALGREEN COMPANY 07455	WATERLOO	IA	57	$1,727.69	$30.31	57
94	WRIGHTWAY LTC PHARMACY	CLINTON	IA	57	$5,705.31	$100.09	132
95	HY-VEE PHARMACY (1271)	INDIANOLA	IA	57	$2,518.90	$44.19	80
96	MEDICAP PHARMACY	INDIANOLA	IA	56	$261.62	$4.67	69
97	PRAIRIE PARKWAY PHARMACY	CEDAR FALLS	IA	56	$5,289.56	$94.46	63
98	NUCARA PHARMACY #100	GREENFIELD	IA	55	$9,498.44	$172.70	178
99	CARROLL APOTHECARY	CARROLL	IA	54	$1,247.59	$23.10	116
100	HY-VEE PHARMACY #2 (1160)	DUBUQUE	IA	54	$1,704.30	$31.56	59

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	MESKWAKI PHARMACY	TAMA	IA	714	$466,956.00	$1,838.41	1
2	WCHS PHARMACY	WINNEBAGO	NE	273	$178,542.00	$1,821.86	2
3	UNITY POINT AT HOME	URBANDALE	IA	25	$170,498.41	$14,208.20	3
4	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	638	$134,846.27	$1,114.43	4
5	CVS PHARMACY #00102	AURORA	CO	12	$112,305.37	$28,076.34	6
6	CAREMARK KANSAS SPEC PHARMACY LL	LENEXA	KS	29	$107,506.27	$10,750.63	19
7	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	18	$104,596.24	$13,074.53	5
8	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	74	$78,074.33	$6,005.72	11
9	SIOUXLAND COMM HEALTH CTR PHARMA	SIOUX CITY	IA	971	$68,876.09	$346.11	8
10	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	109	$51,383.57	$1,605.74	10
11	COMM A WALGREENS PHARMACY #16528	DES MOINES	IA	6	$42,906.18	$21,453.09	7
12	WAL-MART PHARMACY #10-0985	FAIRFIELD	IA	97	$42,874.07	$3,298.01	13
13	COMMUNITY A WALGREENS PHARMACY	IOWA CITY	IA	6	$42,868.00	$14,289.33	22
14	GENOA HEALTHCARE LLC	SIOUX CITY	IA	309	$40,123.09	$1,253.85	9
15	WALGREENS #15647	SIOUX CITY	IA	554	$38,330.74	$255.54	12
16	THOMPSON-DEAN DRUG	SIOUX CITY	IA	504	$32,180.45	$595.93	14
17	THE NEBRASKA MED CENTER CLIN PHA	OMAHA	NE	18	$27,536.95	$6,884.24	17
18	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	688	$26,615.07	$409.46	21
19	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	162	$25,748.45	$436.41	29
20	OSTERHAUS PHARMACY	MAQUOKETA	IA	37	$22,188.65	$7,396.22	18
21	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	3	$20,167.41	$20,167.41	25
22	WALGREEN #04405	COUNCIL BLUFFS	IA	280	$19,772.40	$329.54	26
23	CR CARE PHARMACY	CEDAR RAPIDS	IA	17	$17,285.04	$5,761.68	35
24	FRED LEROY HEALTH & WELLNESS	OMAHA	NE	26	$17,004.00	$2,125.50	27
25	GENOA HEALTH LLC	MARSHALLTOWN	IA	146	$16,636.28	$2,376.61	16

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26	MEYER HEALTHMART PHARMACY	WAVERLY	IA	54	$16,388.46	$3,277.69	23
27	SANFORD CANCER CTR ONC CLINIC PH	SIOUX FALLS	SD	1	$15,778.41	$15,778.41	
28	HY-VEE PHARMACY (1634)	STORM LAKE	IA	80	$15,305.73	$3,061.15	28
29	L & M PHARMACY CARE	LE MARS	IA	23	$14,252.79	$14,252.79	38
30	WALGREEN #05239	DAVENPORT	IA	138	$14,161.27	$566.45	70
31	WALGREENS #16270	OMAHA	NE	4	$13,988.87	$6,994.44	24
32	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	122	$12,819.63	$610.46	36
33	MAYO CLINIC PHARMACY	ROCHESTER	MN	5	$12,576.04	$6,288.02	20
34	PARAGON PARTNERS	OMAHA	NE	40	$12,524.11	$4,174.70	44
35	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	150	$11,861.26	$741.33	31
36	HERITAGE PARK PHARMACY INC D/B/A	WEST BURLINGTON	IA	35	$10,663.11	$2,132.62	263
37	HY VEE PHARMACY 1060	CEDAR RAPIDS	IA	92	$10,120.71	$1,124.52	48
38	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	67	$10,026.31	$1,253.29	84
39	GENOA HEALTHCARE LLC	FORT DODGE	IA	44	$10,012.34	$5,006.17	32
40	NUCARA PHARMACY #100	GREENFIELD	IA	55	$9,498.44	$2,374.61	59
41	HY-VEE PHARMACY (1437)	MUSCATINE	IA	20	$9,496.01	$1,582.67	312
42	KROGER SPECIALTY PHARMACY LA LLC	HARVEY	LA	2	$8,943.61	$8,943.61	94
43	MEDICAP PHARMACY	KNOXVILLE	IA	114	$8,862.40	$1,266.06	34
44	WALGREEN #04041	DAVENPORT	IA	106	$8,796.02	$799.64	43
45	HARTIG PHARMACY SERVICES	DUBUQUE	IA	68	$8,789.30	$1,757.86	30
46	FRESENIUS MEDICAL CARE RX LLC	FRANKLIN	TN	5	$7,967.31	$7,967.31	229
47	HY-VEE PHARMACY (1522)	PERRY	IA	20	$7,885.41	$985.68	104
48	HY-VEE PHARMACY 1071	CLARINDA	IA	68	$7,741.20	$774.12	55
49	ANOVORX GROUP INC	MEMPHIS	TN	6	$7,628.51	$2,542.84	73
50	LEWIS FAMILY DRUG #69	ROCK VALLEY	IA	48	$7,476.94	$1,068.13	62
51	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	61	$7,229.35	$556.10	149

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52	CASH SAVER	DES MOINES	IA	29	$7,212.41	$7,212.41	51
53	HY VEE PHARMACY #6 1155	DES MOINES	IA	122	$7,105.22	$373.96	53
54	NELSON FAMILY PHARMACY	FORT MADISON	IA	68	$6,978.40	$775.38	56
55	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	114	$6,825.06	$262.50	33
56	RIGHT DOSE PHARMACY	ANKENY	IA	163	$6,705.00	$515.77	89
57	WALGREEN #05721	DES MOINES	IA	76	$6,576.07	$365.34	85
58	WAL-MART PHARMACIES #10-0753	CEDAR FALLS	IA	71	$6,551.76	$935.97	147
59	ALL CARE HEALTH CENTER PHARMACY	COUNCIL BLUFFS	IA	114	$6,491.42	$405.71	45
60	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	62	$6,450.37	$645.04	67
61	WALGREEN COMPANY #05470	SIOUX CITY	IA	107	$6,409.24	$188.51	75
62	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	120	$6,282.52	$232.69	41
63	WALGREEN #07454	ANKENY	IA	51	$6,122.45	$612.25	69
64	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	90	$5,980.38	$249.18	158
65	HY-VEE PHARMACY (1075)	CLINTON	IA	75	$5,972.51	$746.56	63
66	CVS PHARMACY #16893	ANKENY	IA	34	$5,919.35	$1,973.12	61
67	HY-VEE MAINSTREET PHARMACY #7070	SIOUX CITY	IA	128	$5,891.67	$168.33	91
68	BETTER HEALTH INC DBA	MISSOURI VALLEY	IA	33	$5,850.48	$1,462.62	90
69	BOOTH PHARMACY	HAWARDEN	IA	85	$5,805.63	$322.54	107
70	HY-VEE PHARMACY (1037)	BETTENDORF	IA	43	$5,708.54	$951.42	97
71	WRIGHTWAY LTC PHARMACY	CLINTON	IA	57	$5,705.31	$5,705.31	106
72	NUCARA PHARMACY #27	PLEASANT HILL	IA	122	$5,534.21	$395.30	88
73	MERCY FAMILY PHARMACY-CASCADE	CASCADE	IA	20	$5,514.06	$5,514.06	211
74	GREENVILLE PHARMACY INC	SIOUX CITY	IA	40	$5,414.00	$601.56	125
75	HY-VEE PHARMACY 1241	HARLAN	IA	32	$5,406.50	$1,081.30	209
76	IOWA VETERANS HOME	MARSHALLTOWN	IA	95	$5,358.46	$1,339.62	79
77	GENOA HEALTHCARE	SIOUX CITY	IA	17	$5,352.96	$2,676.48	

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78	HY-VEE DRUGSTORE #7065	OTTUMWA	IA	19	$5,330.05	$1,066.01	47
79	PRAIRIE PARKWAY PHARMACY	CEDAR FALLS	IA	56	$5,289.56	$755.65	115
80	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	102	$5,219.48	$179.98	66
81	GENOA HEALTHCARE LLC	MASON CITY	IA	21	$5,190.01	$1,297.50	68
82	WALGREEN #06678	WEST DES MOINES	IA	66	$5,186.34	$345.76	76
83	WAL-MART PHARMACY 10-2714	SPENCER	IA	20	$5,073.38	$5,073.38	135
84	CLARKS MEDICINE SHOP	CEDAR RAPIDS	IA	48	$5,057.20	$1,011.44	298
85	GENESIS FIRST MED PHARMACY	DAVENPORT	IA	25	$4,984.93	$712.13	204
86	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	15	$4,974.78	$4,974.78	40
87	WALGREEN CO.# (03875)	CEDAR RAPIDS	IA	36	$4,942.91	$617.86	46
88	CORNERSTONE APOTHECARY	BELLE PLAINE	IA	62	$4,865.09	$2,432.55	87
89	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	44	$4,860.53	$607.57	179
90	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	38	$4,819.17	$438.11	99
91	WALGREEN #7452	DES MOINES	IA	60	$4,781.72	$434.70	202
92	HYVEE PHARMACY SOLUTIONS	OMAHA	NE	4	$4,675.73	$2,337.87	474
93	SMART PHARMACY	OSAGE	IA	62	$4,668.13	$778.02	52
94	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	57	$4,664.40	$777.40	100
95	HY-VEE PHARMACY 1382	LE MARS	IA	92	$4,651.69	$244.83	187
96	TIPTON PHARMACY	TIPTON	IA	88	$4,582.54	$1,145.64	188
97	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	46	$4,555.87	$569.48	54
98	WALGREEN #05886	KEOKUK	IA	42	$4,471.57	$558.95	81
99	AMBER SPECIALTY PHARMACY	OMAHA	NE	1	$4,449.33	$4,449.33	174
100	HY VEE PHARMACY 7072	TOLEDO	IA	68	$4,308.75	$269.30	103

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1053340661	LEIGHTON E FROST MD	$107,339.96	171	2.55	2
2	1396289229	JESSE BECKER ARNP	$3,975.66	150	6.00	15
3	1043418809	MICHAEL CILIBERTO	$21,305.23	145	4.83	1
4	1619153137	JOADA JEAN BEST ARNP	$10,210.01	132	8.25	4
5	1902358443	MELISSA KONKEN ARNP	$13,180.38	131	10.08	3
6	1780877878	CHRISTOPHER JACOBS ARNP	$5,036.60	112	7.47	13
7	1912991183	MOLLY EARLEYWINE PA	$5,872.34	111	6.17	18
8	1699109595	TONYA K FLAUGH ARNP	$2,528.70	109	5.74	23
9	1194888024	ALICIA D WAGER NP	$57,121.51	106	1.96	5
10	1417214321	LEAH BRANDON DO	$4,704.36	95	7.31	27
11	1538671961	JAMIE WRIGHT ARNP	$2,635.16	94	5.22	12
12	1164481362	MELISSA PEARSON ARNP	$60,838.21	94	1.54	6
13	1194722413	AIMEE LORENZ MD	$8,128.80	93	5.81	19
14	1457584740	ERIC D MEYER ARNP	$2,724.86	92	5.75	16
15	1215125216	REBECCA E WALDING	$7,674.23	92	5.75	7
16	1144214248	KRISTI WALZ MD	$36,655.62	88	4.89	28
17	1093141129	LARRY MARTIN NEWMAN ARNP	$51,119.49	87	2.72	14
18	1003884107	RANDALL ALLEN KAVALIER DO	$3,578.52	83	5.93	8
19	1104251776	ANTHONY GLYDWELL DNP	$52,717.86	82	1.67	9
20	1407836513	NATHAN R NOBLE DO	$2,657.66	79	3.95	22
21	1316389497	SHANNON STEWART ARNP	$22,036.46	78	7.09	21
22	1598117434	SOMMER KORTH ARNP	$2,573.00	76	5.85	20
23	1639134034	ELIZABETH PRATT ARNP	$1,002.94	76	1.81	50
24	1982605762	JEFFREY DEAN WILHARM MD	$1,432.77	71	11.83	10
25	1841220290	KENT E KUNZE MD	$3,833.30	70	7.78	11
26	1851795033	PETER ROSEN ARNP	$1,762.17	65	65.00	84

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
27	1295217529	HEATHER STEHR ARNP	$19,850.03	65	4.06	34
28	1992766299	PATRICK KIN-YEE CHAU MD	$6,801.94	64	12.80	179
29	1720698335	DANIKA LEIGH HANSEN ARNP	$2,889.54	63	5.25	190
30	1821268335	JACQUELINE J MCINNIS	$11,773.21	60	12.00	35
31	1013355759	DYLAN GREENE MD	$3,898.42	59	3.28	77
32	1053376475	DANIEL GILLETTE MD	$14,609.60	59	14.75	32
33	1942562129	MELISSA AUSTREIMMD	$2,297.40	59	19.67	40
34	1154929230	CHELSEA JONES ARNP	$37,294.97	58	2.90	24
35	1619380680	TARA BROCKMAN DO	$5,509.63	57	14.25	78
36	1700356334	BRIANNA SCHAFFER ARNP	$5,429.48	57	11.40	49
37	1336418425	DENA NEIMAN ARNP	$764.29	56	4.31	29
38	1033157557	BRAHMANANDA PRASADARAO MAKKAPATI	$294.90	56	28.00	224
39	1073235925	KRISTINA L BECK ARNP	$4,761.58	55	18.33	36
40	1609218304	AMANDA GARR ARNP	$6,736.73	55	6.88	26
41	1811123318	AARON KAUER MD	$2,754.84	51	10.20	31
42	1528365277	MINA SALIB MD	$2,422.11	51	5.10	108
43	1093272668	RICARDO OSARIO ARNP	$2,073.86	50	6.25	39
44	1114681889	KELSEY BAUER ARNP	$715.09	49	4.08	66
45	1598733891	JERRY WILLE MD	$30,783.89	49	1.44	25
46	1881691517	GEORGE FOTIADIS MD	$1,837.65	49	12.25	140
47	1881972412	RACHEL JEAN WURTH ARNP	$1,076.54	49	3.77	17
48	1184056822	ABBY KOLTHOFF ARNP	$6,495.12	47	11.75	68
49	1760821680	TYLER WENDEL DO	$2,486.07	47	4.70	125
50	1174780944	GERRY SERTLE ARNP	$15,685.65	47	47.00	199
51	1376117036	THOMAS H VOLBERDING MD	$965.35	46	15.33	
52	1275742090	ASHAR LUQMAN MD	$529.88	44	8.80	43

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53	1144240805	DANIEL ROWLEY MD	$4,170.15	44	22.00	61
54	1285047951	BRIAN VOLD ARNP	$1,919.65	44	7.33	65
55	1649922410	CASSANDRA MARIE ZIMMERMAN ARNP	$2,836.78	44	22.00	118
56	1285602649	DAVID WELCH PA	$4,628.12	44	8.80	57
57	1164538674	JOSEPH MATTHEW WANZEK III DO	$5,337.12	43	14.33	69
58	1699740159	FRANK SAM MARINO JR DO	$1,158.41	42	3.23	37
59	1174583157	JOANNE STARR ARNP	$2,210.20	42	14.00	58
60	1205393386	JESSICA HUDSPETH ARNP	$246.83	42	10.50	87
61	1356337273	LISA JAYNE MENZIES MD	$478.09	42	3.82	56
62	1922305143	OLIVIA WOITAARNP	$479.60	42	6.00	47
63	1952955692	TRINA SMITH ARNP	$1,801.22	41	41.00	3190
64	1013516566	ERIN A HODGSON ARNP	$3,242.97	41	5.86	80
65	1659358620	CARLOS CASTILLO MD	$2,322.00	40	5.71	33
66	1255823506	NICOLE MARIE DELAGARDELLE	$1,811.46	40	6.67	52
67	1144715954	TIFFINI COLLETTE TOLIVER ARNP	$419.02	40	6.67	146
68	1790755395	CYNTHIA A GUTHMILLER ARNP	$6,170.00	40	6.67	107
69	1427766559	KORIE JORDAN EISCHEID ARNP	$3,784.17	40	20.00	196
70	1316356496	KIMBERLY N ROBERTS ARNP	$632.98	39	4.33	44
71	1053600296	JESSICA MCCOOL MD	$4,448.43	39	39.00	120
72	1457346231	DAWN RENAE EBACH MD	$1,218.25	39	3.25	60
73	1356919658	SARAH CASTRO ARNP	$593.37	39	6.50	54
74	1811493679	JUNE MYLER ARNP	$25,506.00	39	2.29	53
75	1871052472	CASSIDY ALANA CARR ARNP	$1,920.13	38	5.43	38
76	1083240865	JACOB MACDOWELL PA	$1,626.35	37	12.33	277
77	1730609629	LAUREN MARIE THOMANN ARNP	$6,137.42	37	9.25	98
78	1679669832	ERIN HATCHER ARNP	$10,780.89	37	7.40	72

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79	1649248378	KATHLEEN L WILD ARNP	$2,152.45	37	6.17	48
80	1578123915	BRIANNA BROWNLEE DO	$1,050.32	36	9.00	110
81	1750900809	LOGAN TAYLOR CHIRI ARNP	$1,346.89	36	6.00	216
82	1013115369	BOBBITA NAG MD	$844.50	35	5.83	73
83	1477652469	JILL JENSEN PA	$3,813.57	35	35.00	143
84	1609243013	CRISELLA TORRES MD	$1,711.12	35	5.83	126
85	1326036062	JON AHRENDSEN MD	$554.15	35	8.75	46
86	1730197476	MICHAEL BLAESS DO	$7,277.81	35	17.50	106
87	1831308576	JILL K SHIVAPOUR MD	$1,138.61	35	8.75	105
88	1346349388	THOMAS BRENT HOEHNS MD	$4,218.92	35	35.00	82
89	1548484165	CARRIE L GRADY MD	$5,801.77	35	17.50	94
90	1588838841	LEENU MISHRA MD	$392.39	35	5.00	30
91	1134533599	NICOLE THOMAS ARNP	$2,395.26	34	6.80	104
92	1073600755	THOMAS MORGAN MD	$1,430.38	34	4.86	139
93	1891955423	LEAH SIEGFRIED PA	$18,400.89	34	4.86	172
94	1164416269	ANN PICK ARNP	$3,086.43	33	5.50	124
95	1942896691	VIRIDIANA MUNOZ DE GONZALEZ ARNP	$919.38	33	3.30	271
96	1205249562	KELLY RYDER MD	$1,274.67	33	3.00	55
97	1598166340	BRITTANY SANGER PA	$3,099.54	32	10.67	83
98	1043265176	SHARON K FEY PAC	$8,355.91	32	8.00	151
99	1033569223	AUDRA POTERUCHA DO	$1,287.75	32	16.00	144
100	1225022809	FRANCES M JACKSON MD	$2,483.79	32	4.00	161

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1	1053340661	LEIGHTON E FROST MD	$107,339.96	$627.72	171	1
2	1326034984	KATHERINE MATHEWS MD	$99,246.63	$3,969.87	25	2
3	1902191059	AMBER R TIERNEY MD	$80,378.90	$26,792.97	3	19
4	1508281619	KELLY MARINE ARNP	$71,457.21	$14,291.44	5	
5	1164481362	MELISSA PEARSON ARNP	$60,838.21	$647.22	94	4
6	1194888024	ALICIA D WAGER NP	$57,121.51	$538.88	106	7
7	1730477407	SALIM HOMMEIDA MD	$53,899.31	$2,155.97	25	13
8	1104251776	ANTHONY GLYDWELL DNP	$52,717.86	$642.90	82	5
9	1093141129	LARRY MARTIN NEWMAN ARNP	$51,119.49	$587.58	87	6
10	1003079997	SARAH ANNE TOFILON MD	$43,797.35	$2,737.33	16	16
11	1841607900	SHAYLA SANDERS ARNP	$40,387.04	$5,048.38	8	18
12	1053387522	AMY L DIETRICH PAC	$40,307.39	$13,435.80	3	40
13	1952326530	LISA HEDRICK PA	$40,136.70	$13,378.90	3	8
14	1447488325	ABDELAZIZ ELHADDAD MD	$39,370.53	$6,561.76	6	14
15	1154929230	CHELSEA JONES ARNP	$37,294.97	$643.02	58	10
16	1144214248	KRISTI WALZ MD	$36,655.62	$416.54	88	20
17	1174584072	BRADLEY SCOTT LAIR MD	$35,144.82	$4,393.10	8	2952
18	1134402373	JULIE A SCHUCK ARNP	$35,063.59	$5,009.08	7	
19	1598733891	JERRY WILLE MD	$30,783.89	$628.24	49	11
20	1225266364	SARAH M BLIGH MD	$29,167.12	$1,944.47	15	230
21	1891146999	BECKY L JOHNSON ARNP	$26,504.29	$1,019.40	26	58
22	1811493679	JUNE MYLER ARNP	$25,506.00	$654.00	39	15
23	1639157373	CALVIN J HANSEN MD	$24,523.41	$8,174.47	3	12
24	1316389497	SHANNON STEWART ARNP	$22,036.46	$282.52	78	23
25	1043418809	MICHAEL CILIBERTO	$21,305.23	$146.93	145	28
26	1962899088	KELSEY A HOLKESVIK MD	$20,185.86	$5,046.47	4	29
27	1295217529	HEATHER STEHR ARNP	$19,850.03	$305.39	65	55

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2023

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
28	1225263833	LINDSAY JO ORRIS DO	$19,230.03	$3,846.01	5	30
29	1417307497	EMILY BOES DO	$19,222.02	$6,407.34	3	31
30	1073852059	AMBER HANSEN MD	$18,966.00	$654.00	29	17
31	1891955423	LEAH SIEGFRIED PA	$18,400.89	$541.20	34	62
32	1760675177	LORI SWANSON ARNP	$18,330.42	$632.08	29	35
33	1760612113	VIJAYA, BHATT	$17,773.22	$3,554.64	5	32
34	1447694617	BRIANNA MURPHY DO	$15,778.41	$15,778.41	1	885
35	1174780944	GERRY SERTLE ARNP	$15,685.65	$333.74	47	43
36	1861629578	HEIDI M CURRIER MD	$15,208.00	$3,802.00	4	25
37	1780178723	EMMA MARTZ DO	$14,716.77	$566.03	26	234
38	1053376475	DANIEL GILLETTE MD	$14,609.60	$247.62	59	66
39	1891204871	ANN B ROGERS APRN	$13,755.30	$1,719.41	8	26
40	1528467859	WHITNEY A WEIS ARNP	$13,691.50	$3,422.88	4	27
41	1710941000	LAURIE N WARREN	$13,251.83	$414.12	32	50
42	1902358443	MELISSA KONKEN ARNP	$13,180.38	$100.61	131	24
43	1417251216	GRETCHEN ELIZABETH WHEELOCK APRN	$13,080.00	$654.00	20	44
44	1093388639	REBECCA OLSON PA	$12,507.05	$12,507.05	1	
45	1114521721	TARRAH HOLLIDAY ARNP	$12,195.29	$813.02	15	57
46	1609003433	DANIEL PAUL FULTON MD	$11,892.84	$1,698.98	7	46
47	1821268335	JACQUELINE J MCINNIS	$11,773.21	$196.22	60	60
48	1366402505	KUNAL K PATRA MD	$11,118.00	$654.00	17	39
49	1497060776	USHA PEREPU MBBS	$10,867.40	$2,716.85	4	2202
50	1144588476	RACHEL D FILZER ARNP	$10,812.10	$720.81	15	48
51	1679669832	ERIN HATCHER ARNP	$10,780.89	$291.38	37	34
52	1770933046	SHELBY BILLER	$10,592.55	$1,176.95	9	37
53	1205504669	JENNIFER SWANSON ARNP	$10,464.00	$654.00	16	154
54	1043573025	NEVERMAN, ERIC M DO	$10,450.04	$3,483.35	3	49

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2023

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
55	1497201610	MOHADDESEH SHARIFZADEH MD	$10,435.60	$5,217.80	2	
56	1821254863	AMY JOANN JOHN PA	$10,422.48	$2,084.50	5	64
57	1619153137	JOADA JEAN BEST ARNP	$10,210.01	$77.35	132	73
58	1295091510	REBECCA WEINER MD	$10,199.37	$463.61	22	182
59	1427491778	JENNIFER L MEDLIN MD	$9,836.38	$702.60	14	71
60	1922455096	DEAN L GUERDET ARNP	$9,718.03	$373.77	26	51
61	1104088202	PATRICK SAFO MD	$9,031.52	$1,128.94	8	109
62	1154604536	ANNA C PRUESS DO	$8,387.29	$335.49	25	126
63	1043265176	SHARON K FEY PAC	$8,355.91	$261.12	32	188
64	1881905768	HANNAH HECKART MD	$8,355.01	$596.79	14	
65	1770685604	JOHN CHARLES KEECH MD	$8,235.14	$514.70	16	45
66	1194722413	AIMEE LORENZ MD	$8,128.80	$87.41	93	78
67	1215125216	REBECCA E WALDING	$7,674.23	$83.42	92	53
68	1194990945	SANDEEP GUPTA MD	$7,557.85	$251.93	30	81
69	1417931700	SUDHIR C KUMAR MD	$7,477.86	$3,738.93	2	129
70	1649678582	LAURA STULKEN PA	$7,469.24	$3,734.62	2	
71	1750348496	VANESSA ANN CURTIS MD	$7,454.83	$392.36	19	612
72	1730197476	MICHAEL BLAESS DO	$7,277.81	$207.94	35	85
73	1417435462	ALLISON OWINGS ARNP	$7,139.71	$254.99	28	130
74	1558346015	DELWYN LASSEN MD	$7,020.07	$270.00	26	83
75	1972879625	LAUREN KANNER MD	$6,970.55	$995.79	7	114
76	1588185631	CATHERINE M MARTY ARNP	$6,865.35	$3,432.68	2	
77	1992766299	PATRICK KIN-YEE CHAU MD	$6,801.94	$106.28	64	796
78	1609218304	AMANDA GARR ARNP	$6,736.73	$122.49	55	52
79	1184056822	ABBY KOLTHOFF ARNP	$6,495.12	$138.19	47	86
80	1013911692	JEFFREY SCOTT SARTIN MD	$6,384.69	$2,128.23	3	74
81	1790755395	CYNTHIA A GUTHMILLER ARNP	$6,170.00	$154.25	40	63

Iowa Medicaid
IOWA HHS

CHANGE HEALTHCARE

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2023

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
82	1730609629	LAUREN MARIE THOMANN ARNP	$6,137.42	$165.88	37	149
83	1912208323	LISA MARIE MEYER ARNP	$5,914.34	$184.82	32	75
84	1902336548	CAMERON W OVERCASH MD	$5,909.66	$537.24	11	512
85	1710973029	JOHN HALLGREN	$5,897.67	$589.77	10	250
86	1912991183	MOLLY EARLEYWINE PA	$5,872.34	$52.90	111	99
87	1831329630	SPYRIDON FORTIS MD	$5,830.54	$364.41	16	54
88	1548484165	CARRIE L GRADY MD	$5,801.77	$165.76	35	100
89	1609131770	SREENATH THATI GANGANNA MBBS	$5,637.20	$187.91	30	87
90	1275844649	KATIE MARIE CAMPBELL ARNP	$5,541.30	$263.87	21	280
91	1619380680	TARA BROCKMAN DO	$5,509.63	$96.66	57	105
92	1366858334	ALICIA L DUYVEJONCK ARNP	$5,486.96	$457.25	12	295
93	1700356334	BRIANNA SCHAFFER ARNP	$5,429.48	$95.25	57	141
94	1023555638	CYNTHIA JEAN JOHNSON ARNP	$5,355.22	$191.26	28	70
95	1164538674	JOSEPH MATTHEW WANZEK III DO	$5,337.12	$124.12	43	98
96	1932531316	BROOKE JOHNSONARNP	$5,274.76	$219.78	24	131
97	1326567660	MARIA DOUTHETT APRN	$5,232.00	$654.00	8	89
98	1275763047	REBECCA ELIZABETH BOWMAN ARNP	$5,155.30	$468.66	11	59
99	1013978089	JENNIFER BRADLEY ARNP	$5,130.38	$190.01	27	69
100	1972583573	SHERRY LYNN KOLACIA-TIGHE MD	$5,073.38	$253.67	20	181

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March through May 2023	RANK	% BUDGET	June through August 2023	RANK	% BUDGET	% CHANGE
ANALGESICS - ANTI-INFLAMMATORY	$344,694	1	11.8%	$365,994	1	12.5%	6.2%
ANTIDIABETICS	$292,011	2	10.0%	$291,582	2	10.0%	-0.1%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$277,611	3	9.5%	$225,471	3	7.7%	-18.8%
ANTIVIRALS	$151,164	6	5.2%	$213,608	4	7.3%	41.3%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$187,991	4	6.4%	$178,558	5	6.1%	-5.0%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$180,322	5	6.2%	$172,338	6	5.9%	-4.4%
MISCELLANEOUS THERAPEUTIC CLASSES	$89,074	11	3.1%	$154,728	7	5.3%	73.7%
ANTICONVULSANTS	$149,158	7	5.1%	$127,179	8	4.3%	-14.7%
ANTIDEPRESSANTS	$106,356	8	3.6%	$106,720	9	3.6%	0.3%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$87,588	12	3.0%	$105,355	10	3.6%	20.3%
DERMATOLOGICALS	$90,281	10	3.1%	$103,052	11	3.5%	14.1%
NEUROMUSCULAR AGENTS	$103,771	9	3.6%	$101,140	12	3.5%	-2.5%
ANTIHYPERTENSIVES	$68,796	13	2.4%	$57,182	13	2.0%	-16.9%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$55,026	14	1.9%	$48,535	14	1.7%	-11.8%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$35,423	17	1.2%	$42,090	15	1.4%	18.8%
CONTRACEPTIVES	$38,695	16	1.3%	$38,692	16	1.3%	0.0%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$31,199	20	1.1%	$37,174	17	1.3%	19.2%
ANTICOAGULANTS	$23,361	26	0.8%	$33,002	18	1.1%	41.3%
ANALGESICS - OPIOID	$30,416	21	1.0%	$32,740	19	1.1%	7.6%
ANTIANXIETY AGENTS	$32,783	19	1.1%	$29,166	20	1.0%	-11.0%

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March through May 2023	PREV RANK	June through August 2023	CURR RANK	PERC CHANGE
ANTIDEPRESSANTS	2,582	1	2,594	1	0.5%
ANTICONVULSANTS	1,808	2	1,660	2	-8.2%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	1,509	3	1,348	3	-10.7%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	1,265	4	1,281	4	1.3%
ANTIHYPERTENSIVES	1,188	6	1,251	5	5.3%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	1,207	5	1,119	6	-7.3%
ANTIDIABETICS	898	7	1,019	7	13.5%
ANTIANXIETY AGENTS	877	8	877	8	0.0%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	834	9	872	9	4.6%
ANALGESICS - OPIOID	592	12	602	10	1.7%
ANALGESICS - ANTI-INFLAMMATORY	578	14	590	11	2.1%
ANTIHISTAMINES	592	11	577	12	-2.5%
DERMATOLOGICALS	579	13	555	13	-4.1%
ANTIHYPERLIPIDEMICS	448	15	487	14	8.7%
BETA BLOCKERS	394	16	421	15	6.9%
DIURETICS	331	20	366	16	10.6%
ANTI-INFECTIVE AGENTS - MISC.	372	19	359	17	-3.5%
PENICILLINS	597	10	356	18	-40.4%
THYROID AGENTS	330	21	352	19	6.7%
MUSCULOSKELETAL THERAPY AGENTS	373	18	352	20	-5.6%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
HUMIRA PEN	$253,899.43	1	$274,930.00	1	8.28%
BIKTARVY	$73,800.42	4	$133,639.51	2	81.08%
EVRYSDI	$103,770.58	2	$98,840.20	3	-4.75%
VIJOICE	$79,575.32	3	$71,440.32	4	-10.22%
REVLIMID		999	$70,032.41	5	%
INVEGA SUSTENNA	$70,869.93	5	$61,680.63	6	-12.97%
TRULICITY	$56,026.12	6	$57,778.18	7	3.13%
VYVANSE	$51,810.17	7	$54,463.25	8	5.12%
OZEMPIC	$51,565.39	8	$53,176.53	9	3.12%
VERZENIO	$43,632.18	11	$43,632.18	10	0.00%
MAVYRET	$39,631.14	12	$39,631.14	11	0.00%
KISQALI	$39,331.95	14	$39,331.95	12	0.00%
CONCERTA	$39,135.86	15	$39,128.58	13	-0.02%
TALTZ	$39,580.68	13	$38,159.88	14	-3.59%
JARDIANCE	$38,640.71	16	$36,246.52	15	-6.20%
VRAYLAR	$44,307.54	10	$35,724.33	16	-19.37%
ALBUTEROL SULFATE	$35,119.59	17	$34,567.62	17	-1.57%
REXULTI	$27,172.42	24	$34,550.79	18	27.15%
LANTUS SOLOSTAR	$27,545.65	23	$32,208.04	19	16.93%
ARISTADA	$31,473.05	19	$27,466.22	20	-12.73%
ENBREL SURECLICK	$47,889.31	9	$27,345.79	21	-42.90%
KESIMPTA	$32,677.12	18	$24,523.41	22	-24.95%
LISINOPRIL	$31,307.31	20	$23,616.30	23	-24.57%
SYMBICORT	$29,602.48	22	$23,192.61	24	-21.65%
ELIQUIS	$15,302.20	38	$22,905.51	25	49.69%
EPIDIOLEX	$14,356.41	43	$20,870.14	26	45.37%
IBUPROFEN	$20,787.80	29	$20,824.41	27	0.18%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
ESCITALOPRAM OXALATE	$16,255.55	36	$20,157.03	28	24.00%
ADDERALL XR	$14,650.76	40	$18,836.00	29	28.57%
INSULIN ASPART	$13,579.31	47	$18,086.95	30	33.19%
PROMACTA	$19,198.38	32	$17,719.26	31	-7.70%
SERTRALINE HCL	$13,672.18	46	$17,179.17	32	25.65%
METFORMIN HCL	$18,003.48	34	$16,868.75	33	-6.30%
RISPERDAL CONSTA	$15,121.87	39	$16,358.77	34	8.18%
VENTOLIN HFA	$24,581.80	27	$16,143.43	35	-34.33%
NORDITROPIN FLEXPRO	$10,948.23	57	$15,830.51	36	44.59%
KOSELUGO		999	$15,778.41	37	%
CETIRIZINE HCL	$25,394.41	26	$15,030.04	38	-40.81%
LAMICTAL CHEWABLE DISPERS	$19,919.82	31	$14,912.19	39	-25.14%
FLOVENT HFA	$11,180.28	55	$14,487.04	40	29.58%
TRINTELLIX	$16,689.71	35	$14,118.47	41	-15.41%
AMLODIPINE BESYLATE	$13,274.92	49	$13,642.35	42	2.77%
ACETAMINOPHEN	$15,919.55	37	$13,473.92	43	-15.36%
ADVAIR HFA	$7,444.01	86	$13,461.80	44	80.84%
JORNAY PM	$13,548.82	48	$12,689.49	45	-6.34%
OFEV	$24,524.04	28	$12,507.05	46	-49.00%
ENTRESTO	$13,911.43	44	$12,258.09	47	-11.88%
CEPHALEXIN	$13,856.12	45	$11,552.43	48	-16.63%
DUPIXENT	$8,547.18	75	$11,312.38	49	32.35%
GENVOYA	$7,429.50	87	$11,144.25	50	50.00%
CREON	$1,200.42	290	$11,020.81	51	818.08%
ADVAIR DISKUS	$11,932.25	51	$10,983.31	52	-7.95%
HUMATE-P		999	$10,801.08	53	%
FARXIGA	$14,370.27	42	$10,506.79	54	-26.89%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
ORENCIA CLICKJECT		999	$10,435.60	55	%
LUPRON DEPOT-PED (3-MONTH	$10,370.08	60	$10,370.08	56	0.00%
OMEPRAZOLE	$10,816.45	58	$10,129.32	57	-6.35%
VIMPAT	$11,483.54	52	$9,720.37	58	-15.35%
BENLYSTA	$6,526.72	98	$9,659.30	59	48.00%
PREDNISONE	$9,164.95	65	$9,628.59	60	5.06%
INVEGA TRINZA	$14,493.72	41	$9,611.18	61	-33.69%
TRESIBA FLEXTOUCH	$11,208.51	54	$9,448.52	62	-15.70%
SPIRIVA HANDIHALER	$8,972.97	71	$9,006.14	63	0.37%
OTEZLA	$4,452.15	146	$8,943.61	64	100.88%
AUSTEDO	$2,243.43	211	$8,898.66	65	296.65%
METHYLPHENIDATE HCL	$19,933.04	30	$8,841.25	66	-55.65%
POLYETHYLENE GLYCOL 3350	$8,554.14	74	$8,745.18	67	2.23%
ERGOCALCIFEROL	$6,600.92	96	$8,644.12	68	30.95%
HYDROCODONE-ACETAMINOPHEN	$6,700.84	95	$8,587.16	69	28.15%
DESCOVY	$8,404.63	76	$8,513.07	70	1.29%
XARELTO	$5,124.47	126	$8,464.46	71	65.18%
BUPROPION HCL	$8,822.32	72	$8,366.69	72	-5.16%
ODEFSEY	$4,394.47	149	$8,191.09	73	86.40%
LAMOTRIGINE	$8,068.21	78	$8,190.40	74	1.51%
GABAPENTIN	$7,629.27	83	$8,164.51	75	7.02%
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE	$3,989.44	159	$8,094.87	76	102.91%
FLUOXETINE HCL	$8,729.75	73	$8,044.20	77	-7.85%
ROSUVASTATIN CALCIUM	$9,795.88	62	$7,959.12	78	-18.75%
LEVEMIR FLEXPEN	$4,375.02	150	$7,958.11	79	81.90%
SULFAMETHOXAZOLE-TRIMETHOPRIM	$7,230.89	90	$7,907.97	80	9.36%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
BUSPIRONE HCL	$5,134.74	125	$7,906.29	81	53.98%
CRESEMBA	$11,250.76	53	$7,901.22	82	-29.77%
SPIRIVA RESPIMAT	$5,265.45	121	$7,555.86	83	43.50%
EPINEPHRINE (ANAPHYLAXIS)	$5,251.55	122	$7,478.67	84	42.41%
ATORVASTATIN CALCIUM	$8,997.18	69	$7,302.11	85	-18.84%
AMOXICILLIN	$30,456.70	21	$7,211.90	86	-76.32%
ABILIFY MAINTENA	$25,503.93	25	$7,124.33	87	-72.07%
TRAZODONE HCL	$7,785.71	82	$7,118.01	88	-8.58%
CLONIDINE HCL	$7,226.78	91	$7,112.45	89	-1.58%
QELBREE	$7,494.03	84	$7,089.84	90	-5.39%
KEPPRA	$9,030.28	67	$7,035.74	91	-22.09%
PREDNISOLONE SODIUM PHOSPHATE	$2,185.76	214	$6,995.27	92	220.04%
NAYZILAM	$6,445.14	101	$6,951.54	93	7.86%
TRIAMCINOLONE ACETONIDE (TOPICAL)	$5,981.55	107	$6,932.40	94	15.90%
ENBREL		999	$6,851.18	95	%
TRELEGY ELLIPTA	$5,190.15	124	$6,845.54	96	31.89%
FAMOTIDINE	$3,496.72	169	$6,825.17	97	95.19%
SYNTHROID	$9,027.41	68	$6,810.05	98	-24.56%
QUETIAPINE FUMARATE	$7,181.78	93	$6,745.09	99	-6.08%
DULOXETINE HCL	$5,810.45	111	$6,735.49	100	15.92%

Iowa Medicaid
IOWA HHS

CHANGE HEALTHCARE

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
SERTRALINE HCL	421	2	452	1	7.36%
CLONIDINE HCL	422	1	428	2	1.42%
TRAZODONE HCL	407	3	415	3	1.97%
ESCITALOPRAM OXALATE	385	5	390	4	1.30%
CETIRIZINE HCL	380	6	375	5	-1.32%
GABAPENTIN	372	8	374	6	0.54%
FLUOXETINE HCL	390	4	370	7	-5.13%
OMEPRAZOLE	335	10	360	8	7.46%
ALBUTEROL SULFATE	185	35	328	9	77.30%
METFORMIN HCL	284	14	325	10	14.44%
LEVOTHYROXINE SODIUM	283	15	308	11	8.83%
ATORVASTATIN CALCIUM	266	18	298	12	12.03%
HYDROXYZINE HCL	314	12	289	13	-7.96%
LISINOPRIL	279	16	289	14	3.58%
QUETIAPINE FUMARATE	290	13	275	15	-5.17%
MONTELUKAST SODIUM	268	17	267	16	-0.37%
VENTOLIN HFA	372	9	262	17	-29.57%
LAMOTRIGINE	242	22	260	18	7.44%
IBUPROFEN	246	21	244	19	-0.81%
BUSPIRONE HCL	220	27	243	20	10.45%
METHYLPHENIDATE HCL	330	11	241	21	-26.97%
VYVANSE	239	23	236	22	-1.26%
ARIPIPRAZOLE	255	19	233	23	-8.63%
HYDROCODONE-ACETAMINOPHEN	213	28	221	24	3.76%
AMLODIPINE BESYLATE	177	38	211	25	19.21%
AMPHETAMINE-DEXTROAMPHETAMINE	254	20	208	26	-18.11%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
BUPROPION HCL	222	24	200	27	-9.91%
PREDNISONE	204	30	198	28	-2.94%
AMOXICILLIN	372	7	190	29	-48.92%
DULOXETINE HCL	170	40	189	30	11.18%
LEVETIRACETAM	203	31	185	31	-8.87%
RISPERIDONE	222	26	182	32	-18.02%
FLUTICASONE PROPIONATE (NASAL)	222	25	181	33	-18.47%
PANTOPRAZOLE SODIUM	167	41	177	34	5.99%
POLYETHYLENE GLYCOL 3350	194	32	175	35	-9.79%
VENLAFAXINE HCL	179	36	168	36	-6.15%
FAMOTIDINE	158	42	166	37	5.06%
CEPHALEXIN	185	34	156	38	-15.68%
FERROUS SULFATE	129	49	150	39	16.28%
ASPIRIN	103	65	141	40	36.89%
PROPRANOLOL HCL	129	50	140	41	8.53%
CYCLOBENZAPRINE HCL	145	45	133	42	-8.28%
GUANFACINE HCL	149	43	133	43	-10.74%
TRAMADOL HCL	140	46	130	44	-7.14%
BACLOFEN	132	48	129	45	-2.27%
AMOXICILLIN & POT CLAVULANATE	188	33	128	46	-31.91%
DEXMETHYLPHENIDATE HCL	177	37	127	47	-28.25%
AZITHROMYCIN	210	29	127	48	-39.52%
SULFAMETHOXAZOLE-TRIMETHOPRIM	127	52	126	49	-0.79%
CLONAZEPAM	148	44	125	50	-15.54%
HYDROXYZINE PAMOATE	128	51	124	51	-3.13%
PRAZOSIN HCL	107	63	124	52	15.89%
ACETAMINOPHEN	120	55	123	53	2.50%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
ONDANSETRON	173	39	122	54	-29.48%
MIRTAZAPINE	127	53	122	55	-3.94%
LORATADINE	113	60	114	56	0.88%
DIVALPROEX SODIUM	138	47	113	57	-18.12%
FUROSEMIDE	108	62	112	58	3.70%
TOPIRAMATE	124	54	110	59	-11.29%
GUANFACINE HCL (ADHD)	103	66	110	60	6.80%
METOPROLOL SUCCINATE	114	59	108	61	-5.26%
OLANZAPINE	95	70	108	62	13.68%
ATOMOXETINE HCL	112	61	107	63	-4.46%
MELOXICAM	99	67	107	64	8.08%
CONCERTA	93	72	105	65	12.90%
SPIRONOLACTONE	80	78	102	66	27.50%
LOSARTAN POTASSIUM	78	79	101	67	29.49%
HYDROCHLOROTHIAZIDE	88	73	100	68	13.64%
LANTUS SOLOSTAR	69	87	98	69	42.03%
NAPROXEN	82	76	96	70	17.07%
METRONIDAZOLE	104	64	96	71	-7.69%
OXYBUTYNIN CHLORIDE	86	74	95	72	10.47%
TRIAMCINOLONE ACETONIDE (TOPICAL)	114	58	94	73	-17.54%
FLUCONAZOLE	69	86	90	74	30.43%
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE	60	95	88	75	46.67%
ALPRAZOLAM	76	80	87	76	14.47%
TRULICITY	74	82	82	77	10.81%
SYMBICORT	96	69	81	78	-15.63%
ADDERALL XR	70	84	81	79	15.71%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2023	PREVIOUS RANK	June through August 2023	RANK	PERCENT CHANGE
OXYCODONE HCL	116	57	77	80	-33.62%
OZEMPIC	75	81	75	81	0.00%
DOXYCYCLINE (MONOHYDRATE)	99	68	75	82	-24.24%
JARDIANCE	62	93	75	83	20.97%
AMITRIPTYLINE HCL	70	85	75	84	7.14%
ROSUVASTATIN CALCIUM	64	90	74	85	15.63%
PREGABALIN	82	77	73	86	-10.98%
ONDANSETRON HCL	60	97	73	87	21.67%
OXCARBAZEPINE	86	75	71	88	-17.44%
LORAZEPAM	72	83	70	89	-2.78%
CLOBAZAM	94	71	68	90	-27.66%
MUPIROCIN	58	99	67	91	15.52%
CARVEDILOL	59	98	66	92	11.86%
METOPROLOL TARTRATE	65	88	66	93	1.54%
FLOVENT HFA	54	103	64	94	18.52%
FOLIC ACID	54	102	58	95	7.41%
TIZANIDINE HCL	65	89	58	96	-10.77%
CEFDINIR	119	56	57	97	-52.10%
INSULIN ASPART	33	135	56	98	69.70%
DIAZEPAM	56	100	55	99	-1.79%
ZOLPIDEM TARTRATE	63	91	55	100	-12.70%

MOLINA HEALTHCARE OF IOWA CLAIMS QUARTERLY STATISTICS			
CATEGORY	MARCH 2023 THROUGH MAY 2023*	JUNE THROUGH AUGUST 2023*	% CHANGE
Total paid Amount	NA	$35,826,892.18	NA
Unique users	NA	65,914	NA
Cost Per user	NA	$543.54	NA
Total prescriptions	NA	333,313	NA
Average Prescriptions per user	NA	5.06	NA
Average cost per prescription	NA	$107.49	NA
# Generic Prescriptions	NA	296,858	NA
% Generic	NA	89.1%	NA
$ Generic	NA	$5,059,595.68	NA
Average Generic Prescription Cost	NA	$17.04	NA
Average Generic Days' Supply	NA	25.45	NA
# Brand Prescriptions	NA	36,455	NA
% Brand	NA	10.94%	NA
$ Brand	NA	$30,767,296.50	NA
Average Brand Prescription cost	NA	$843.98	NA
Average Brand Days' Supply	NA	27.34	NA

**No data prior to July 1, 2023*

UTILIZATION BY AGE		
AGE	MARCH 2023 THROUGH MAY 2023	JUNE 2023 THROUGH AUGUST 2023
0 to 6	NA	6,474
7 to 12	NA	7,196
13 to 18	NA	8,023
19 to 64	NA	43,354
65+	NA	944
TOTAL	NA	65,991

UTILIZATION BY GENDER AND AGE			
GENDER	AGE	MARCH 2023 THROUGH MAY 2023	JUNE 2023 THROUGH AUGUST 2023
	0 to 6	NA	3,014
	7 to 12	NA	3,114
	13 to 18	NA	4,624
	19 to 64	NA	28,417
	65+	NA	585
F	**GENDER TOTAL**	NA	**39,754**
	0 to 6	NA	3,460
	7 to 12	NA	4,082
	13 to 18	NA	3,399
	19 to 64	NA	14,937
	65+	NA	359
M	**GENDER TOTAL**	NA	**26,237**
GRAND TOTAL		NA	**65,991**

Top 100 Pharmacies by Prescription Count June 2023 through August 2023 (no data prior to July 1, 2023)							
RANK	Pharmacy NAME	Pharmacy City	State	Prescription Count	Paid Amount	Average Cost RX	Previous RANK
1	UIHC AMBULATORY CARE PHC	IOWA CITY	IA	4518	$2,415,529.37	$534.65	NA
2	WALGREENS 04405	COUNCIL BLUFFS	IA	4098	$383,248.29	$93.52	NA
3	WALGREENS 05239	DAVENPORT	IA	3445	$194,760.83	$56.53	NA
4	WALGREENS 05042	CEDAR RAPIDS	IA	3103	$196,555.16	$63.34	NA
5	HY-VEE PHARMACY 1403	MARSHALLTOWN	IA	2536	$189,724.64	$74.81	NA
6	BROADLAWNS MED CTR OP PH	DES MOINES	IA	2528	$103,718.14	$41.03	NA
7	WALGREENS 07455	WATERLOO	IA	2377	$148,050.74	$62.28	NA
8	WALGREENS 05721	DES MOINES	IA	2298	$125,516.54	$54.62	NA
9	WALGREENS 00359	DES MOINES	IA	2119	$130,942.85	$61.79	NA
10	WALGREENS 07453	DES MOINES	IA	2014	$110,908.24	$55.07	NA
11	DRILLING PHARMACY 67	SIOUX CITY	IA	1950	$118,594.57	$60.82	NA
12	HY-VEE DRUGSTORE 7060	MUSCATINE	IA	1941	$152,701.11	$78.67	NA
13	HY-VEE PHARMACY 1092	COUNCIL BLUFFS	IA	1897	$141,272.36	$74.47	NA
14	WALGREENS 03700	COUNCIL BLUFFS	IA	1869	$132,310.94	$70.79	NA
15	WALGREENS 15647	SIOUX CITY	IA	1759	$111,346.11	$63.30	NA
16	WALGREENS 04041	DAVENPORT	IA	1697	$116,681.81	$68.76	NA
17	MAHASKA DRUGS	OSKALOOSA	IA	1696	$154,693.76	$91.21	NA
18	HY-VEE DRUGSTORE 7065	OTTUMWA	IA	1645	$169,647.16	$103.13	NA
19	SIOUXLAND COMM HLTH CTR	SIOUX CITY	IA	1637	$63,529.91	$38.81	NA
20	HY-VEE PHARMACY 1138	DES MOINES	IA	1595	$129,241.74	$81.03	NA
21	WALGREENS 05470	SIOUX CITY	IA	1476	$111,404.31	$75.48	NA
22	HY-VEE PHARMACY 1151	DES MOINES	IA	1420	$90,605.05	$63.81	NA

23	WALGREENS 05044	BURLINGTON	IA	1414	$65,073.01	$46.02	NA
24	NELSON FAMILY PHARMACY	FORT MADISON	IA	1410	$101,594.02	$72.05	NA
25	HY-VEE DRUGSTORE 7020	CEDAR RAPIDS	IA	1398	$99,454.82	$71.14	NA
26	RIGHT DOSE PHARMACY	ANKENY	IA	1383	$84,458.86	$61.07	NA
27	HY-VEE PHARMACY 1449	NEWTON	IA	1364	$106,633.17	$78.18	NA
28	WALMART PHARMACY 10-2889	CLINTON	IA	1346	$86,910.60	$64.57	NA
29	HY-VEE PHARMACY 1075	CLINTON	IA	1341	$128,380.48	$95.73	NA
30	HY-VEE PHARMACY 1056	CEDAR RAPIDS	IA	1319	$91,811.58	$69.61	NA
31	HY-VEE PHARMACY 1044	BURLINGTON	IA	1317	$117,748.43	$89.41	NA
32	CVS PHARMACY 10282	FORT DODGE	IA	1316	$87,437.20	$66.44	NA
33	GREENWOOD DRUG ON KIMBAL	WATERLOO	IA	1313	$144,253.66	$109.87	NA
34	HY-VEE PHARMACY 1142	DES MOINES	IA	1312	$82,175.02	$62.63	NA
35	HY-VEE PHARMACY 1074	CHARLES CITY	IA	1304	$71,043.81	$54.48	NA
36	WALGREENS 05852	DES MOINES	IA	1294	$82,914.52	$64.08	NA
37	WALGREENS 07452	DES MOINES	IA	1242	$93,180.91	$75.02	NA
38	CVS PHARMACY 08546	WATERLOO	IA	1230	$82,509.23	$67.08	NA
39	HY-VEE PHARMACY 1192	FORT DODGE	IA	1229	$91,810.41	$74.70	NA
40	HY-VEE PHARMACY 1504	OTTUMWA	IA	1212	$77,879.41	$64.26	NA
41	HY-VEE PHARMACY 1109	DAVENPORT	IA	1206	$79,948.51	$66.29	NA
42	REUTZEL PHARMACY	CEDAR RAPIDS	IA	1199	$83,357.28	$69.52	NA
43	WALMART PHARMACY 10-0559	MUSCATINE	IA	1182	$70,748.21	$59.85	NA
44	WALMART PHARMACY 10-0646	ANAMOSA	IA	1156	$74,734.28	$64.65	NA
45	UI HEALTHCARE	CORALVILLE	IA	1143	$44,281.47	$38.74	NA
46	HY-VEE DRUGSTORE 7056	MASON CITY	IA	1119	$68,107.11	$60.86	NA
47	WALMART PHARMACY 10-3394	ATLANTIC	IA	1117	$78,684.95	$70.44	NA
48	WALGREENS 03875	CEDAR RAPIDS	IA	1102	$74,970.24	$68.03	NA
49	HY-VEE PHARMACY 1281	IOWA CITY	IA	1096	$58,292.01	$53.19	NA

50	WALGREENS 05886	KEOKUK	IA	1089	$68,971.78	$63.33	NA
51	HY VEE PHARMACY 1459	OELWEIN	IA	1086	$66,947.82	$61.65	NA
52	HY-VEE PHARMACY 1042	BURLINGTON	IA	1084	$78,472.97	$72.39	NA
53	WALMART PHARMACY 10-1509	MAQUOKETA	IA	1067	$58,097.38	$54.45	NA
54	COMMUNITY HEALTH CARE PH	DAVENPORT	IA	1060	$34,622.46	$32.66	NA
55	STANGEL PHARMACY	ONAWA	IA	1055	$93,710.83	$88.83	NA
56	HY-VEE PHARMACY 1530	PLEASANT HILL	IA	1046	$50,998.67	$48.76	NA
57	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1041	$71,212.89	$68.41	NA
58	WALMART PHARMACY 10-1723	DES MOINES	IA	1029	$66,203.55	$64.34	NA
59	HY-VEE PHARMACY 1060	CEDAR RAPIDS	IA	1024	$71,751.98	$70.07	NA
60	HY-VEE PHARMACY 1058	CENTERVILLE	IA	1017	$103,823.74	$102.09	NA
61	WALMART PHARMACY 10-1621	CENTERVILLE	IA	1010	$85,700.08	$84.85	NA
62	HY-VEE PHARMACY 1170	ESTHERVILLE	IA	1009	$72,874.79	$72.22	NA
63	HY-VEE PHARMACY 1396	MARION	IA	1008	$80,573.18	$79.93	NA
64	WALMART PHARMACY 10-1683	SHENANDOAH	IA	994	$71,775.26	$72.21	NA
65	WALMART PHARMACY 10-0985	FAIRFIELD	IA	993	$49,608.20	$49.96	NA
66	HY-VEE PHARMACY 1615	SIOUX CITY	IA	986	$62,188.94	$63.07	NA
67	WAGNER PHARMACY	CLINTON	IA	973	$60,463.00	$62.14	NA
68	WALMART PHARMACY 10-5115	DAVENPORT	IA	973	$54,984.37	$56.51	NA
69	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	964	$55,555.46	$57.63	NA
70	HY-VEE PHARMACY 1061	CEDAR RAPIDS	IA	961	$63,683.05	$66.27	NA
71	SOUTH SIDE DRUG, INC.	OTTUMWA	IA	953	$82,620.15	$86.69	NA
72	WALGREENS 03595	DAVENPORT	IA	952	$47,849.28	$50.26	NA
73	HY-VEE PHARMACY 1065	CHARITON	IA	952	$56,993.44	$59.87	NA
74	WALGREENS 05362	DES MOINES	IA	947	$57,618.94	$60.84	NA
75	HY-VEE PHARMACY 1009	ALBIA	IA	945	$57,906.53	$61.28	NA
76	HY-VEE PHARMACY 1522	PERRY	IA	939	$66,414.45	$70.73	NA

77	MEDICAP PHARMACY 8043	KNOXVILLE	IA	938	$91,939.71	$98.02	NA
78	MEDICAP PHARMACY 8405	INDIANOLA	IA	938	$41,831.55	$44.60	NA
79	WALGREENS 11759	FORT MADISON	IA	934	$51,506.29	$55.15	NA
80	DANIEL PHARMACY	FORT DODGE	IA	934	$69,665.43	$74.59	NA
81	SCOTT PHARMACY INC	FAYETTE	IA	928	$61,447.89	$66.22	NA
82	MEDICAP PHARMACY 8282	RED OAK	IA	928	$71,536.61	$77.09	NA
83	WALGREENS 07454	ANKENY	IA	927	$46,489.76	$50.15	NA
84	CVS PHARMACY 08544	WATERLOO	IA	927	$46,169.09	$49.80	NA
85	HY-VEE PHARMACY 1136	DES MOINES	IA	917	$60,305.75	$65.76	NA
86	HY-VEE PHARMACY 1895	WINDSOR HEIGHTS	IA	902	$72,446.36	$80.32	NA
87	WALMART PHARMACY 10-1496	WATERLOO	IA	897	$54,801.16	$61.09	NA
88	HY-VEE PHARMACY 1180	FAIRFIELD	IA	892	$72,796.38	$81.61	NA
89	WALGREENS 05119	CLINTON	IA	890	$63,842.76	$71.73	NA
90	HY-VEE DRUGSTORE 7026	CEDAR RAPIDS	IA	889	$53,448.77	$60.12	NA
91	PRAIRIE PARKWAY PHARMACY	CEDAR FALLS	IA	886	$51,884.79	$58.56	NA
92	WALGREENS 07968	DES MOINES	IA	884	$63,590.94	$71.94	NA
93	WALMART PHARMACY 10-1393	OSKALOOSA	IA	884	$64,605.20	$73.08	NA
94	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	882	$92,839.84	$105.26	NA
95	WALGREENS 03876	MARION	IA	882	$57,620.74	$65.33	NA
96	HY-VEE PHARMACY 1610	SIOUX CITY	IA	877	$64,344.57	$73.37	NA
97	WALGREENS 05777	DES MOINES	IA	869	$78,097.58	$89.87	NA
98	WALMART PHARMACY 10-0810	MASON CITY	IA	866	$65,452.52	$75.58	NA
99	HY-VEE PHARMACY 1875	WEBSTER CITY	IA	866	$55,054.65	$63.57	NA
100	REX PHARMACY INC	ATLANTIC	IA	857	$54,039.00	$63.06	NA

Top 100 Pharmacies by Paid Amount June 2023 through August 2023 (no data prior to July 1, 2023)							
RANK	Pharmacy NAME	Pharmacy City	State	Prescription Count	Paid Amount	Average Cost Member	Previous RANK
1	UIHC AMBULATORY CARE PHC	IOWA CITY	IA	4518	$2,415,529.37	$534.65	NA
2	CAREMARK SPECIALTY P 1702	LENEXA	KS	185	$1,280,408.31	$6,921.13	NA
3	COMMUNITY, A WALGRE 16528	DES MOINES	IA	213	$928,959.80	$4,361.31	NA
4	UNITYPOINT AT HOME	URBANDALE	IA	244	$775,797.85	$3,179.50	NA
5	NUCARA SPECIALTY PHARMAC	PLEASANT HILL	IA	723	$739,951.11	$1,023.45	NA
6	CVS SPECIALTY 02921	MONROEVILLE	PA	101	$677,458.23	$6,707.51	NA
7	COMMUNITY A WALGREE 21250	IOWA CITY	IA	145	$509,396.05	$3,513.08	NA
8	CARE PLUS CVS/PHARM 00102	AURORA	CO	50	$414,629.89	$8,292.60	NA
9	HY-VEE PHARMACY SOL	OMAHA	NE	80	$392,638.62	$4,907.98	NA
10	WALGREENS 04405	COUNCIL BLUFFS	IA	4098	$383,248.29	$93.52	NA
11	OPTUM PHARMACY	JEFFERSONVILLE	IN	34	$315,618.56	$9,282.90	NA
12	CAREMARK SPECIALTY 48031	MOUNT PROSPECT	IL	41	$308,696.37	$7,529.18	NA
13	EXPRESS SCRIPTS SPECAILT	ST. LOUIS	MO	18	$284,531.84	$15,807.32	NA
14	MAYO CLINIC PHARMACY	ROCHESTER	MN	84	$264,367.66	$3,147.23	NA
15	CVS/SPECIALTY 1703	REDLANDS	CA	14	$253,132.66	$18,080.90	NA
16	ACARIAHEALTH PHARMACY 11	HOUSTON	TX	26	$228,258.85	$8,779.19	NA
17	WALGREENS 05042	CEDAR RAPIDS	IA	3103	$196,555.16	$63.34	NA
18	WALGREENS 05239	DAVENPORT	IA	3445	$194,760.83	$56.53	NA
19	ANOVORX GROUP LLC	MEMPHIS	TN	8	$191,533.47	$23,941.68	NA
20	HY-VEE PHARMACY 1403	MARSHALLTOWN	IA	2536	$189,724.64	$74.81	NA
21	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	15	$184,266.47	$12,284.43	NA
22	NEBRASKA MED CTR CLINIC	OMAHA	NE	286	$175,009.41	$611.92	NA
23	HY-VEE DRUGSTORE 7065	OTTUMWA	IA	1645	$169,647.16	$103.13	NA
24	ALLIANCERX WALGREEN 16280	FRISCO	TX	8	$157,993.97	$19,749.25	NA

25	WALGREENS SPECIALTY 15438	CANTON	MI	18	$155,800.73	$8,655.60	NA
26	MAHASKA DRUGS	OSKALOOSA	IA	1696	$154,693.76	$91.21	NA
27	PANTHERX SPECIALTY PHARM	PITTSBURGH	PA	6	$153,738.50	$25,623.08	NA
28	HY-VEE DRUGSTORE 7060	MUSCATINE	IA	1941	$152,701.11	$78.67	NA
29	WALGREENS 07455	WATERLOO	IA	2377	$148,050.74	$62.28	NA
30	GREENWOOD DRUG ON KIMBAL	WATERLOO	IA	1313	$144,253.66	$109.87	NA
31	SIOUXLAND REGIONAL CANCE	SIOUX CITY	IA	14	$142,610.65	$10,186.48	NA
32	HY-VEE PHARMACY 1092	COUNCIL BLUFFS	IA	1897	$141,272.36	$74.47	NA
33	PRIMARY HEALTHCARE PHARM	DES MOINES	IA	588	$136,322.09	$231.84	NA
34	CR CARE PHARMACY	CEDAR RAPIDS	IA	577	$135,579.18	$234.97	NA
35	GENOA HEALTHCARE LL 20304	SIOUX CITY	IA	643	$133,728.14	$207.98	NA
36	WALGREENS 03700	COUNCIL BLUFFS	IA	1869	$132,310.94	$70.79	NA
37	WALGREENS 00359	DES MOINES	IA	2119	$130,942.85	$61.79	NA
38	HY-VEE PHARMACY 1138	DES MOINES	IA	1595	$129,241.74	$81.03	NA
39	HY-VEE PHARMACY 1075	CLINTON	IA	1341	$128,380.48	$95.73	NA
40	FOUNDATION CARE LLC	EARTH CITY	MO	11	$127,227.01	$11,566.09	NA
41	WALGREENS 05721	DES MOINES	IA	2298	$125,516.54	$54.62	NA
42	S-S PHARMACY	COUNCIL BLUFFS	IA	462	$124,727.82	$269.97	NA
43	DRILLING PHARMACY 67	SIOUX CITY	IA	1950	$118,594.57	$60.82	NA
44	HY-VEE PHARMACY 1044	BURLINGTON	IA	1317	$117,748.43	$89.41	NA
45	WALGREENS 04041	DAVENPORT	IA	1697	$116,681.81	$68.76	NA
46	GENOA HEALTHCARE LL 20171	DAVENPORT	IA	665	$113,119.17	$170.10	NA
47	WALGREENS 05470	SIOUX CITY	IA	1476	$111,404.31	$75.48	NA
48	WALGREENS 15647	SIOUX CITY	IA	1759	$111,346.11	$63.30	NA
49	AMBER PHARMACY	OMAHA	NE	15	$111,046.48	$7,403.10	NA
50	WALGREENS 07453	DES MOINES	IA	2014	$110,908.24	$55.07	NA
51	WALGREENS 16270	OMAHA	NE	37	$110,872.72	$2,996.56	NA

52	KROGER SPECIALTY PHARMAC	HARVEY	LA	17	$108,021.79	$6,354.22	NA
53	WALGREENS SPECIALTY 13625	FRISCO	TX	7	$107,713.66	$15,387.67	NA
54	ORSINI PHARMACEUTICAL SE	ELK GROVE VILLAGE	IL	5	$107,495.97	$21,499.19	NA
55	HY-VEE PHARMACY 1449	NEWTON	IA	1364	$106,633.17	$78.18	NA
56	HY-VEE PHARMACY 1058	CENTERVILLE	IA	1017	$103,823.74	$102.09	NA
57	BROADLAWNS MED CTR OP PH	DES MOINES	IA	2528	$103,718.14	$41.03	NA
58	NELSON FAMILY PHARMACY	FORT MADISON	IA	1410	$101,594.02	$72.05	NA
59	HY-VEE DRUGSTORE 7020	CEDAR RAPIDS	IA	1398	$99,454.82	$71.14	NA
60	ALLEN CLINIC PHARMACY	WATERLOO	IA	462	$94,628.99	$204.82	NA
61	STANGEL PHARMACY	ONAWA	IA	1055	$93,710.83	$88.83	NA
62	WALGREENS 07452	DES MOINES	IA	1242	$93,180.91	$75.02	NA
63	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	882	$92,839.84	$105.26	NA
64	MEDICAP PHARMACY 8043	KNOXVILLE	IA	938	$91,939.71	$98.02	NA
65	HY-VEE PHARMACY 1056	CEDAR RAPIDS	IA	1319	$91,811.58	$69.61	NA
66	HY-VEE PHARMACY 1192	FORT DODGE	IA	1229	$91,810.41	$74.70	NA
67	HY-VEE PHARMACY 1151	DES MOINES	IA	1420	$90,605.05	$63.81	NA
68	GREENWOOD COMPLIANCE PHA	WATERLOO	IA	641	$89,113.42	$139.02	NA
69	MEDICAP PHARMACY 8052	DES MOINES	IA	738	$88,069.88	$119.34	NA
70	CVS PHARMACY 10282	FORT DODGE	IA	1316	$87,437.20	$66.44	NA
71	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	25	$87,268.64	$3,490.75	NA
72	WALMART PHARMACY 10-2889	CLINTON	IA	1346	$86,910.60	$64.57	NA
73	WALMART PHARMACY 10-1621	CENTERVILLE	IA	1010	$85,700.08	$84.85	NA
74	HY-VEE DRUGSTORE 7025	CEDAR RAPIDS	IA	815	$84,697.49	$103.92	NA
75	RIGHT DOSE PHARMACY	ANKENY	IA	1383	$84,458.86	$61.07	NA
76	ARJ INFUSION SERVICES LL	CEDAR RAPIDS	IA	14	$83,830.28	$5,987.88	NA
77	REUTZEL PHARMACY	CEDAR RAPIDS	IA	1199	$83,357.28	$69.52	NA
78	WALGREENS 05852	DES MOINES	IA	1294	$82,914.52	$64.08	NA

79	WALMART PHARMACY 4606	OSCEOLA	IA	765	$82,752.20	$108.17	NA
80	SOUTH SIDE DRUG, INC.	OTTUMWA	IA	953	$82,620.15	$86.69	NA
81	CVS PHARMACY 08546	WATERLOO	IA	1230	$82,509.23	$67.08	NA
82	HY-VEE PHARMACY 1142	DES MOINES	IA	1312	$82,175.02	$62.63	NA
83	MEDICAL ONCOLOGY & HEMAT	DES MOINES	IA	7	$81,994.04	$11,713.43	NA
84	AON PHARMACY	FORT MYERS	FL	4	$81,843.93	$20,460.98	NA
85	HY-VEE PHARMACY 1396	MARION	IA	1008	$80,573.18	$79.93	NA
86	HY-VEE PHARMACY 1109	DAVENPORT	IA	1206	$79,948.51	$66.29	NA
87	INFOCUS PHARMACY SERVICE	DUBUQUE	IA	668	$79,898.25	$119.61	NA
88	WALMART PHARMACY 10-3394	ATLANTIC	IA	1117	$78,684.95	$70.44	NA
89	HY-VEE PHARMACY 1042	BURLINGTON	IA	1084	$78,472.97	$72.39	NA
90	WALGREENS 05777	DES MOINES	IA	869	$78,097.58	$89.87	NA
91	HY-VEE PHARMACY 1504	OTTUMWA	IA	1212	$77,879.41	$64.26	NA
92	HY-VEE PHARMACY 1013	AMES	IA	799	$77,281.41	$96.72	NA
93	OPTIME CARE INC	EARTH CITY	MO	2	$75,677.84	$37,838.92	NA
94	WALGREENS 03875	CEDAR RAPIDS	IA	1102	$74,970.24	$68.03	NA
95	WALMART PHARMACY 10-0646	ANAMOSA	IA	1156	$74,734.28	$64.65	NA
96	PARAGON PARTNERS	OMAHA	NE	130	$74,356.38	$571.97	NA
97	WALMART PHARMACY 10-5315	ORLANDO	FL	6	$74,338.53	$12,389.76	NA
98	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	658	$73,567.93	$111.81	NA
99	MAIN AT LOCUST PHARMACY	DAVENPORT	IA	748	$73,094.46	$97.72	NA
100	HY-VEE PHARMACY 1170	ESTHERVILLE	IA	1009	$72,874.79	$72.22	NA

Top 100 Prescribing Providers by Prescription Count June 2023 through August 2023 (no data prior to July 1, 2023)						
RANK	NPI Num	Prescriber Name	Paid Amount	Prescription Count	Average Scripts Member	Previous Rank
1	1043211303	ALI SAFDAR	$105,657.79	173	3.18	NA
2	1013115369	BOBBITA NAG	$20,654.12	146	3.25	NA
3	1770933046	SHELBY BILLER	$101,808.03	119	3.77	NA
4	1982030946	JACKLYN BESCH	$29,161.71	112	5.18	NA
5	1659358620	CARLOS CASTILLO	$22,138.43	108	3.81	NA
6	1003539784	JULIA SASS	$43,868.19	103	3.22	NA
7	1164538674	JOSEPH WANZEK	$39,686.32	99	5.98	NA
8	1427619170	KRISTEN ARMSTRONG	$50,337.83	97	4.00	NA
9	1316471154	NICOLE WOOLLEY	$13,250.80	97	3.74	NA
10	1558770974	MARC BAUMERT	$22,219.75	95	4.41	NA
11	1477926434	JACKIE SHIPLEY	$17,454.89	95	3.92	NA
12	1902912538	CHRISTIAN JONES	$27,709.67	91	4.71	NA
13	1437209434	JON THOMAS	$24,378.99	90	4.09	NA
14	1437238110	GENEVIEVE NELSON	$36,345.57	88	5.24	NA
15	1275763047	REBECCA BOWMAN	$72,986.96	87	4.14	NA
16	1619380680	TARA BROCKMAN	$13,327.12	87	3.78	NA
17	1972758126	REBECCA BOLLIN	$17,395.53	85	4.24	NA
18	1528365277	MINA SALIB	$183,755.03	85	3.61	NA
19	1467502286	CHARLES TILLEY	$61,653.51	84	4.65	NA
20	1962418640	BARCLAY MONASTER	$19,208.40	82	3.29	NA
21	1699740159	FRANK MARINO	$12,766.10	80	4.00	NA
22	1134191018	DUSTIN SMITH	$22,395.43	77	3.65	NA
23	1982605762	JEFFREY WILHARM	$29,801.11	76	9.38	NA
24	1043434525	ROBERT KENT	$27,471.47	76	5.93	NA

25	1255823506	NICOLE DELAGARDELLE	$28,267.99	76	4.80	NA
26	1457584740	ERIC MEYER	$30,139.83	76	4.78	NA
27	1356096572	NATASHA LASH	$45,198.84	74	6.20	NA
28	1609218304	AMANDA GARR	$60,008.43	73	5.77	NA
29	1316356496	KIMBERLY ROBERTS	$24,449.72	73	4.73	NA
30	1679573893	PATTY HILDRETH	$60,912.95	73	4.25	NA
31	1356359871	RHEA HARTLEY	$24,916.82	73	4.19	NA
32	1184666539	PENUMETSA RAJU	$16,849.41	73	3.60	NA
33	1891146999	BECKY JOHNSON	$308,399.18	72	4.76	NA
34	1215184726	BABUJI GANDRA	$16,578.98	72	4.42	NA
35	1932531316	BROOKE JOHNSON	$24,580.92	71	4.23	NA
36	1417241621	ASHLEY MATHES	$5,934.69	71	4.06	NA
37	1467907394	CYNTHIA COENEN	$49,166.09	70	5.87	NA
38	1477112688	FELICIA HOERNER	$30,291.58	70	4.69	NA
39	1891707832	LISA KLOCK	$13,177.29	70	4.49	NA
40	1538368170	CHRISTOPHER MATSON	$9,774.19	69	5.42	NA
41	1184657603	SARA RYGOL	$30,451.95	69	4.99	NA
42	1053630640	JENNIFER DONOVAN	$39,878.79	68	5.07	NA
43	1922455096	DEAN GUERDET	$34,623.85	68	5.01	NA
44	1649248378	KATHLEEN WILD	$22,246.04	68	4.18	NA
45	1689077018	STACY ROTH	$28,658.40	67	5.06	NA
46	1477199198	SAJO THOMAS	$44,984.12	67	4.73	NA
47	1942721584	SHAWNA FURY	$14,760.70	67	3.87	NA
48	1902478811	JOAN ANDERSON	$70,176.69	66	5.62	NA
49	1679986350	JENNIFER SPOERL	$21,435.76	66	4.44	NA
50	1144588476	RACHEL FILZER	$18,948.84	66	4.35	NA
51	1205571155	DINA LENTZ	$29,159.74	65	5.29	NA

52	1003330036	EVAN PETERSON	$17,842.92	65	4.29	NA
53	1629036546	ANITA SIMISON	$16,700.56	65	4.12	NA
54	1871021543	SUSAN WILSON	$39,138.10	64	5.89	NA
55	1235514258	ASHLEY FULLER	$37,498.12	64	5.09	NA
56	1417941188	DEBRA NEUHARTH	$13,295.94	64	4.72	NA
57	1164823092	JAMEY GREGERSEN	$29,175.43	63	5.71	NA
58	1215125216	REBECCA WALDING	$27,122.88	63	4.68	NA
59	1952993354	ELIZEBETH BRAKE	$19,879.29	63	4.37	NA
60	1902358443	MELISSA KONKEN	$63,666.36	63	4.17	NA
61	1720698335	DANIKA HANSEN	$35,578.15	62	4.58	NA
62	1275844649	KATIE CAMPBELL	$27,797.15	62	4.39	NA
63	1982826905	NILESH MEHTA	$19,556.09	61	4.97	NA
64	1467465716	JEFFREY BRADY	$18,067.98	60	4.95	NA
65	1780877878	CHRISTOPHER JACOBS	$9,191.12	60	4.33	NA
66	1598183493	JENA ELLERHOFF	$26,850.36	59	5.08	NA
67	1669056123	KAMA AUSBORN	$89,109.13	59	4.86	NA
68	1073037115	BRIANNA DUERKSEN	$24,631.69	58	5.36	NA
69	1871934851	BENJAMIN KOLNER	$20,743.37	58	5.24	NA
70	1831731298	HEATHER WILSON	$29,548.44	58	4.95	NA
71	1780979666	LINDSEY CHRISTIANSON	$10,748.09	58	4.53	NA
72	1013499029	SPENCER KISSEL	$60,240.56	57	4.74	NA
73	1477534279	EDMUND PIASECKI	$14,686.65	55	5.56	NA
74	1992103386	MELISSA LARSEN	$24,228.81	55	5.18	NA
75	1649438383	QADNANA ANWAR	$18,458.79	55	5.18	NA
76	1699134072	JENNIFER ZIGRANG	$25,440.73	54	5.94	NA
77	1396289229	JESSE BECKER	$18,073.99	54	5.06	NA
78	1790163848	HESPER NOWATZKI	$28,625.77	53	5.49	NA

79	1528329398	ERIN ROWAN	$14,997.69	53	4.96	NA
80	1437692803	CASSANDRA DUNLAVY	$16,028.11	52	5.27	NA
81	1043703887	TENAEA JEPPESON	$40,563.02	51	5.63	NA
82	1801998372	WENDY HANSEN-PENMAN	$5,646.39	51	5.29	NA
83	1144214248	KRISTI WALZ	$47,108.88	51	5.24	NA
84	1881691517	GEORGE FOTIADIS	$17,318.07	51	5.20	NA
85	1538157383	DAVID WENGER-KELLER	$25,932.68	50	7.52	NA
86	1932582988	DIANNE HUMPHREY	$22,580.60	50	5.30	NA
87	1063622637	HUSSAIN BANU	$15,515.33	49	6.00	NA
88	1356788129	RACHAEL PARKER	$15,155.96	49	5.47	NA
89	1346621059	MARK ZACHARJASZ	$20,853.26	48	6.35	NA
90	1396083531	JONI HANSHAW	$17,673.17	47	5.66	NA
91	1760965032	MELISSA MILLER	$7,484.17	46	6.50	NA
92	1245227099	DONNA DOBSON TOBIN	$53,720.63	45	7.76	NA
93	1215581251	ANNA THROCKMORTON	$7,025.47	45	5.91	NA
94	1780655100	JOHN BIRKETT	$11,293.18	44	6.00	NA
95	1922305143	OLIVIA WOITA	$11,772.79	43	6.21	NA
96	1104435791	STACY MURPHY	$59,542.58	40	6.53	NA
97	1720346232	CASSIE PARRISH	$15,733.68	37	7.38	NA
98	1144240805	DANIEL ROWLEY	$15,458.75	33	8.18	NA
99	1568506988	LORRAINE TANGEN	$16,585.70	28	9.61	NA
100	1447363700	ROBERT CONNER	$21,660.07	26	12.54	NA

Top 100 Prescribing Providers by Paid Amount June 2023 through August 2023 (no data prior to July 1, 2023)						
RANK	NPI Num	Prescriber Name	Paid Amount	Avg cost RX	Prescription Count	Previous Rank
1	1316934318	STEVEN LENTZ	$400,764.07	$30,828.01	13	NA
2	1295091510	REBECCA WEINER	$357,463.31	$2,127.76	168	NA
3	1891146999	BECKY JOHNSON	$308,399.18	$899.12	343	NA
4	1376777524	ALLADDIN ABOSAIDA	$272,983.86	$4,074.39	67	NA
5	1417443953	RODNEY CLARK	$202,764.38	$1,096.02	185	NA
6	1528365277	MINA SALIB	$183,755.03	$598.55	307	NA
7	1841632965	AHMAD AL-HUNITI	$181,486.02	$20,165.11	9	NA
8	1588616171	HEATHER THOMAS	$170,059.31	$2,237.62	76	NA
9	1245353242	SANDY HONG	$142,798.83	$2,462.05	58	NA
10	1225263833	LINDSAY ORRIS	$134,782.28	$3,063.23	44	NA
11	1487648705	KAREN HUNKE	$133,687.22	$4,609.90	29	NA
12	1326211889	JAMES FRIEDLANDER	$117,549.27	$6,530.52	18	NA
13	1649419219	HEATHER HUNEMULLER	$115,946.04	$1,017.07	114	NA
14	1013026798	STEPHEN GRANT	$112,290.61	$5,910.03	19	NA
15	1356337273	LISA MENZIES	$109,926.26	$1,324.41	83	NA
16	1477968303	JOSEPH LARSON	$106,736.51	$1,593.08	67	NA
17	1043211303	ALI SAFDAR	$105,657.79	$192.11	550	NA
18	1942937388	CARLY TRAUSCH	$105,172.76	$626.03	168	NA
19	1467449579	BRIAN WAYSON	$102,449.77	$3,304.83	31	NA
20	1770933046	SHELBY BILLER	$101,808.03	$226.74	449	NA
21	1174748180	MOHAMMAD ALSHARABATI	$100,421.05	$2,282.30	44	NA
22	1134402373	JULIE SCHUCK	$96,751.77	$1,974.53	49	NA
23	1437121407	LINDA CADARET	$95,581.77	$3,982.57	24	NA
24	1225266364	SARAH BLIGH	$94,913.31	$1,725.70	55	NA

25	1730406356	CHRISTINA WARREN	$93,969.66	$1,999.35	47	NA
26	1700561826	PEDRO HSIEH	$93,827.11	$46,913.56	2	NA
27	1376525196	RANDOLPH ROUGH	$93,318.07	$2,592.17	36	NA
28	1669740957	COURTNEY KREMER	$90,572.45	$2,744.62	33	NA
29	1700080538	EDUARDO CARLIN	$90,331.44	$1,505.52	60	NA
30	1669056123	KAMA AUSBORN	$89,109.13	$310.48	287	NA
31	1871039917	ELIZABETH ALLEN	$88,591.11	$1,703.68	52	NA
32	1265420095	ELIZABETH COOPER	$88,453.62	$2,764.18	32	NA
33	1003315201	ABIGAIL BEHRENS	$87,696.27	$3,132.01	28	NA
34	1689942518	PATRIA ALBA APONTE	$86,879.24	$860.19	101	NA
35	1467561464	TIMOTHY FEYMA	$85,626.21	$10,703.28	8	NA
36	1841607900	SHAYLA SANDERS	$84,691.17	$2,823.04	30	NA
37	1457986671	PAITON CALVERT	$83,883.40	$1,823.55	46	NA
38	1952423071	SAKEER HUSSAIN	$83,211.34	$3,081.90	27	NA
39	1437533130	KATIE BROSHUIS	$82,512.67	$1,178.75	70	NA
40	1033554498	MATTHEW LANDHERR	$81,752.32	$1,703.17	48	NA
41	1861876526	NIBASH BUDHATHOKI	$79,451.84	$3,783.42	21	NA
42	1093382632	GAIL DOOLEY	$77,805.89	$1,318.74	59	NA
43	1669137832	TIFFANY NAVRKAL	$77,186.84	$3,675.56	21	NA
44	1093053142	RACHEAL MCMAHON	$76,572.47	$3,190.52	24	NA
45	1386084747	JENNIFER CONDON	$75,431.09	$857.17	88	NA
46	1558357806	ROBIN HAYWARD	$75,252.45	$1,881.31	40	NA
47	1972989721	JAYSON GESULGA	$73,557.11	$353.64	208	NA
48	1275763047	REBECCA BOWMAN	$72,986.96	$202.74	360	NA
49	1891955423	LEAH SIEGFRIED	$70,476.49	$329.33	214	NA
50	1902478811	JOAN ANDERSON	$70,176.69	$189.16	371	NA
51	1952539447	ANTHONY FISCHER	$67,063.94	$1,426.89	47	NA

52	1700417169	COURTNEY REINTS	$66,426.24	$464.52	143	NA
53	1780995506	QUANHATHAI KAEWPOOWAT	$65,994.03	$1,099.90	60	NA
54	1275836751	HOLLY KRAMER	$65,205.11	$1,863.00	35	NA
55	1902358443	MELISSA KONKEN	$63,666.36	$242.08	263	NA
56	1861463275	DONALD WENDER	$63,441.87	$5,767.44	11	NA
57	1679521728	JIL, FLIEGE	$62,834.53	$4,833.43	13	NA
58	1467502286	CHARLES TILLEY	$61,653.51	$157.68	391	NA
59	1578958542	HEIDI CURTIS	$61,364.14	$807.42	76	NA
60	1902100746	AMI PATEL	$61,338.33	$3,407.69	18	NA
61	1679573893	PATTY HILDRETH	$60,912.95	$196.49	310	NA
62	1891055612	ZEESHAN JAWA	$60,482.97	$1,374.61	44	NA
63	1013499029	SPENCER KISSEL	$60,240.56	$223.11	270	NA
64	1609218304	AMANDA GARR	$60,008.43	$142.54	421	NA
65	1245468768	THOMAS SCHMIDT	$59,854.24	$1,301.18	46	NA
66	1134440886	MELISSA WELLS	$59,570.38	$839.02	71	NA
67	1104435791	STACY MURPHY	$59,542.58	$228.13	261	NA
68	1528000940	SHELBY DAMES	$59,340.02	$2,967.00	20	NA
69	1013126705	JANICE STABER	$59,305.46	$2,471.06	24	NA
70	1710051222	JAMIE PROTASKEY	$57,153.54	$1,504.04	38	NA
71	1194797449	DIANNA PROKUPEK	$56,629.99	$1,769.69	32	NA
72	1649943689	JESSICA COFFEY	$56,314.72	$782.15	72	NA
73	1285765354	CORY PITTMAN	$55,465.25	$1,066.64	52	NA
74	1467743039	SAMYUKTHA RAMAVARAM	$54,044.59	$1,256.85	43	NA
75	1720416563	CRYSTAL OBERLE	$53,996.49	$1,199.92	45	NA
76	1285999797	AMY WENTLAND	$53,816.00	$6,727.00	8	NA
77	1245227099	DONNA DOBSON TOBIN	$53,720.63	$153.93	349	NA
78	1912053364	BHARAT JENIGIRI	$53,460.54	$2,970.03	18	NA

79	1720039126	RODRIGO ERLICH	$53,150.67	$6,643.83	8	NA
80	1588618359	BARBARA BURKLE	$52,439.57	$971.10	54	NA
81	1710972823	LYNN RANKIN	$52,185.54	$322.13	162	NA
82	1144455502	JENNIFER PETTS	$52,175.29	$1,134.25	46	NA
83	1386902682	MELISSA WILLIS	$52,052.87	$1,626.65	32	NA
84	1225143316	SUSAN JACOBI	$51,777.18	$750.39	69	NA
85	1730135070	JAMES WALLACE	$51,666.45	$5,740.72	9	NA
86	1063522266	JAY KENIK	$51,498.40	$1,287.46	40	NA
87	1780889485	JOHN DICKINSON	$51,167.86	$2,558.39	20	NA
88	1558808501	JESSICA BRAKSIEK	$50,588.52	$3,613.47	14	NA
89	1427619170	KRISTEN ARMSTRONG	$50,337.83	$129.74	388	NA
90	1790708451	MICHAEL MCCUBBIN	$50,325.74	$1,324.36	38	NA
91	1194945691	ANJALI SHARATHKUMAR	$50,298.04	$5,588.67	9	NA
92	1962444349	MUKUND NADIPURAM	$50,213.00	$5,021.30	10	NA
93	1407065469	CHRISTOPH RANDAK	$50,049.42	$1,787.48	28	NA
94	1295253557	ABBEY MODLIN	$49,977.13	$324.53	154	NA
95	1831485077	SANGGYU BAE	$49,950.43	$4,995.04	10	NA
96	1063792026	JILL MILLER	$49,772.47	$253.94	196	NA
97	1992790778	MYRL HOLIDA	$49,683.18	$9,936.64	5	NA
98	1003203779	CRAIG BAKER	$49,500.57	$9,900.11	5	NA
99	1467907394	CYNTHIA COENEN	$49,166.09	$119.63	411	NA
100	1215964796	DONNER DEWDNEY	$48,991.16	$204.13	240	NA

Top 20 Therapeutic Class By Paid Amount (no data prior to July 1, 2023)							
Category Description	Prior Quarter Total Cost	Previous Rank	Previous % Budget	June 2023 through August 2023 Total Cost	Current Rank	Current % Budget	% Change
ANTIPSYCHOTICS	NA	NA	NA	$3,903,495.87	1	10.9%	NA
ANTIRHEUMATIC	NA	NA	NA	$3,166,612.36	2	8.8%	NA
INCRETIN MIMETI	NA	NA	NA	$2,501,354.80	3	7.0%	NA
SKIN AND MUCOUS	NA	NA	NA	$2,349,905.42	4	6.6%	NA
AMPHETAMINES	NA	NA	NA	$1,414,443.66	5	3.9%	NA
ANTIRETROVIRALS	NA	NA	NA	$1,376,938.77	6	3.8%	NA
INSULINS	NA	NA	NA	$1,350,796.28	7	3.8%	NA
CF REG CORRECT	NA	NA	NA	$1,161,133.97	8	3.2%	NA
ANTINEOPLASTIC	NA	NA	NA	$1,149,454.32	9	3.2%	NA
ANTIDIABETIC	NA	NA	NA	$1,004,690.32	10	2.8%	NA
ADRENALS	NA	NA	NA	$988,242.01	11	2.8%	NA
CALCITONIN GENE	NA	NA	NA	$917,691.63	12	2.6%	NA
ANTIDEPRESSANTS	NA	NA	NA	$881,603.26	13	2.5%	NA
RESP AND CNS	NA	NA	NA	$813,017.63	14	2.3%	NA
HEMOSTATICS	NA	NA	NA	$786,907.91	15	2.2%	NA
B-ADREN AGON	NA	NA	NA	$748,235.07	16	2.1%	NA
MISC ANTICONVUL	NA	NA	NA	$648,571.25	17	1.8%	NA
ANTICOAGULANTS	NA	NA	NA	$646,942.87	18	1.8%	NA
NERVOUS SYS AGT	NA	NA	NA	$544,679.44	19	1.5%	NA
ANTIMUSCARINICS	NA	NA	NA	$460,860.19	20	1.3%	NA

Top 20 Therapeutic Class By Prescription Count (no data prior to July 1, 2023)					
Category Description	Prior Quarter Total Claims	Previous Rank	June 2023 through August 2023 Total Claims	Current Rank	% Change
ANTIDEPRESSANTS	NA	NA	46157	1	NA
MISC ANTICONVUL	NA	NA	15237	2	NA
ANTIPSYCHOTICS	NA	NA	13357	3	NA
PPI	NA	NA	11947	4	NA
ANXIOLYTICS, SE	NA	NA	10882	5	NA
NONSTEROIDAL AN	NA	NA	10628	6	NA
HMG-COA RED INH	NA	NA	10084	7	NA
B-ADREN AGON	NA	NA	9767	8	NA
BETA BLOCKERS	NA	NA	8676	9	NA
AMPHETAMINES	NA	NA	8343	10	NA
OPIATE AGONISTS	NA	NA	7845	11	NA
ADRENALS	NA	NA	7842	12	NA
BENZODIAZEPINES	NA	NA	7507	13	NA
ACEI	NA	NA	7233	14	NA
CORTICOSTEROIDS	NA	NA	6978	15	NA
2ND GEN ANTIHIS	NA	NA	6787	16	NA
THYROID AGENTS	NA	NA	6198	17	NA
PENICILLINS	NA	NA	6069	18	NA
RESP AND CNS	NA	NA	5769	19	NA
BIGUANIDES	NA	NA	5338	20	NA

Top 100 Drugs by Paid Amount (no data prior to July 1, 2023)					
Drug Description	Prior Quarter Total Cost	Previous Rank	June 2023 through August 2023 Total cost	Current Rank	% Change
Humira Pen	NA	NA	$1,753,552.45	1	NA
Vraylar	NA	NA	$1,168,939.59	2	NA
Trikafta	NA	NA	$1,117,224.67	3	NA
Vyvanse	NA	NA	$1,113,035.74	4	NA
Trulicity	NA	NA	$1,008,371.38	5	NA
Biktarvy	NA	NA	$818,020.44	6	NA
Dupixent	NA	NA	$784,548.05	7	NA
Invega Sustenna	NA	NA	$741,231.57	8	NA
Jardiance	NA	NA	$692,243.05	9	NA
Taltz	NA	NA	$600,480.28	10	NA
Stelara	NA	NA	$579,537.55	11	NA
Ozempic (0.25 or 0.5 MG/DOSE)	NA	NA	$494,690.05	12	NA
Rexulti	NA	NA	$453,607.77	13	NA
Eliquis	NA	NA	$407,573.61	14	NA
Ozempic (1 MG/DOSE)	NA	NA	$386,325.18	15	NA
Lantus SoloStar	NA	NA	$385,568.03	16	NA
Aristada	NA	NA	$359,883.00	17	NA
Concerta	NA	NA	$342,503.48	18	NA
Advate	NA	NA	$299,236.56	19	NA
Nurtec	NA	NA	$285,873.90	20	NA
Symbicort	NA	NA	$281,510.10	21	NA
Ilaris	NA	NA	$264,094.00	22	NA

Ingrezza	NA	NA	$262,711.86	23	NA
Mounjaro	NA	NA	$257,962.17	24	NA
Trintellix	NA	NA	$254,897.83	25	NA
Abilify Maintena	NA	NA	$249,280.62	26	NA
Hemlibra	NA	NA	$243,448.84	27	NA
Ventolin HFA	NA	NA	$238,417.03	28	NA
Humira	NA	NA	$237,877.13	29	NA
Skyrizi Pen	NA	NA	$236,350.45	30	NA
Farxiga	NA	NA	$229,393.88	31	NA
Enbrel SureClick	NA	NA	$223,763.96	32	NA
Invega Trinza	NA	NA	$215,798.00	33	NA
Xarelto	NA	NA	$212,934.13	34	NA
Xywav	NA	NA	$212,564.94	35	NA
Adynovate	NA	NA	$200,973.60	36	NA
Mavyret	NA	NA	$193,712.44	37	NA
Trelegy Ellipta	NA	NA	$185,811.47	38	NA
Cosentyx Sensoready (300 MG)	NA	NA	$183,518.62	39	NA
Entresto	NA	NA	$176,927.96	40	NA
Ajovy	NA	NA	$175,339.08	41	NA
Flovent HFA	NA	NA	$171,457.25	42	NA
Ozempic (2 MG/DOSE)	NA	NA	$156,561.69	43	NA
Januvia	NA	NA	$154,816.94	44	NA
Caplyta	NA	NA	$154,421.92	45	NA
Tresiba FlexTouch	NA	NA	$152,824.98	46	NA
Opsumit	NA	NA	$145,080.36	47	NA
Lybalvi	NA	NA	$144,614.19	48	NA
Aimovig	NA	NA	$142,435.65	49	NA

Spiriva HandiHaler	NA	NA	$139,601.51	50	NA
Norditropin FlexPro	NA	NA	$137,967.24	51	NA
Adderall XR	NA	NA	$133,424.32	52	NA
Austedo	NA	NA	$133,266.57	53	NA
Xtandi	NA	NA	$133,201.40	54	NA
Daybue	NA	NA	$132,961.14	55	NA
Ubrelvy	NA	NA	$132,724.52	56	NA
Wakix	NA	NA	$131,208.70	57	NA
Linzess	NA	NA	$127,943.65	58	NA
Latuda	NA	NA	$127,712.29	59	NA
Advair Diskus	NA	NA	$125,619.53	60	NA
Spiriva Respimat	NA	NA	$125,317.79	61	NA
Promacta	NA	NA	$122,777.48	62	NA
Tremfya	NA	NA	$119,003.13	63	NA
Rinvoq	NA	NA	$118,988.85	64	NA
Victoza	NA	NA	$118,821.66	65	NA
Xifaxan	NA	NA	$116,739.69	66	NA
Ruconest	NA	NA	$116,330.38	67	NA
EPINEPHrine	NA	NA	$115,942.35	68	NA
Albuterol Sulfate HFA	NA	NA	$115,508.31	69	NA
Jornay PM	NA	NA	$114,800.95	70	NA
Advair HFA	NA	NA	$114,619.10	71	NA
Insulin Aspart FlexPen	NA	NA	$114,444.88	72	NA
Jynarque	NA	NA	$109,879.80	73	NA
Naglazyme	NA	NA	$107,444.76	74	NA
Levemir FlexPen	NA	NA	$105,998.93	75	NA
Takhzyro	NA	NA	$99,380.64	76	NA

Fasenra Pen	NA	NA	$98,342.61	77	NA
Kesimpta	NA	NA	$97,835.61	78	NA
Genvoya	NA	NA	$96,583.50	79	NA
Pulmozyme	NA	NA	$95,219.36	80	NA
Lantus	NA	NA	$94,253.93	81	NA
Epidiolex	NA	NA	$94,219.87	82	NA
Emgality	NA	NA	$92,751.78	83	NA
Varenicline Tartrate	NA	NA	$89,101.95	84	NA
QuilliChew ER	NA	NA	$88,523.51	85	NA
Creon	NA	NA	$87,242.37	86	NA
Sprycel	NA	NA	$86,906.96	87	NA
Sofosbuvir-Velpatasvir	NA	NA	$85,690.56	88	NA
Sertraline HCl	NA	NA	$79,544.08	89	NA
Qulipta	NA	NA	$79,251.12	90	NA
Atorvastatin Calcium	NA	NA	$78,816.12	91	NA
Descovy	NA	NA	$78,795.32	92	NA
Omeprazole	NA	NA	$78,587.28	93	NA
Imbruvica	NA	NA	$76,180.40	94	NA
Orladeyo	NA	NA	$75,677.84	95	NA
Ibrance	NA	NA	$75,440.55	96	NA
Enbrel Mini	NA	NA	$75,280.92	97	NA
Anoro Ellipta	NA	NA	$72,779.81	98	NA
Lupron Depot-Ped (3-Month)	NA	NA	$72,702.32	99	NA
Otezla	NA	NA	$71,885.26	100	NA

Top 100 Drugs by Prescription Count (no data prior to July 1, 2023)					
Drug Description	Prior Quarter Total Claims	Previous Rank	June 2023 through August 2023 Total Claims	Current Rank	% Change
Omeprazole	NA	NA	7223	1	NA
Sertraline HCl	NA	NA	7048	2	NA
Atorvastatin Calcium	NA	NA	6840	3	NA
Escitalopram Oxalate	NA	NA	5883	4	NA
Lisinopril	NA	NA	5842	5	NA
Levothyroxine Sodium	NA	NA	5829	6	NA
traZODone HCl	NA	NA	5480	7	NA
buPROPion HCl ER (XL)	NA	NA	5455	8	NA
FLUoxetine HCl	NA	NA	5348	9	NA
Gabapentin	NA	NA	4885	10	NA
Montelukast Sodium	NA	NA	4029	11	NA
busPIRone HCl	NA	NA	3972	12	NA
hydrOXYzine HCl	NA	NA	3929	13	NA
amLODIPine Besylate	NA	NA	3899	14	NA
DULoxetine HCl	NA	NA	3890	15	NA
Amoxicillin	NA	NA	3825	16	NA
Pantoprazole Sodium	NA	NA	3758	17	NA
Ventolin HFA	NA	NA	3698	18	NA
Venlafaxine HCl ER	NA	NA	3573	19	NA
HYDROcodone-Acetaminophen	NA	NA	3561	20	NA
Vyvanse	NA	NA	3376	21	NA
Metoprolol Succinate ER	NA	NA	3305	22	NA

metFORMIN HCl	NA	NA	3175	23	NA
QUEtiapine Fumarate	NA	NA	3144	24	NA
Albuterol Sulfate HFA	NA	NA	3127	25	NA
predniSONE	NA	NA	3126	26	NA
ARIPiprazole	NA	NA	3017	27	NA
Cetirizine HCl	NA	NA	2953	28	NA
lamoTRIgine	NA	NA	2784	29	NA
cloNIDine HCl	NA	NA	2731	30	NA
Cyclobenzaprine HCl	NA	NA	2721	31	NA
Losartan Potassium	NA	NA	2702	32	NA
ALPRAZolam	NA	NA	2611	33	NA
Fluticasone Propionate	NA	NA	2597	34	NA
Famotidine	NA	NA	2394	35	NA
Cephalexin	NA	NA	2388	36	NA
Ondansetron	NA	NA	2288	37	NA
Ibuprofen	NA	NA	2275	38	NA
clonazePAM	NA	NA	2236	39	NA
hydroCHLOROthiazide	NA	NA	2223	40	NA
Amphetamine-Dextroamphetamine	NA	NA	2207	41	NA
Topiramate	NA	NA	2196	42	NA
Meloxicam	NA	NA	2149	43	NA
metFORMIN HCl ER	NA	NA	2133	44	NA
Rosuvastatin Calcium	NA	NA	1948	45	NA
Amoxicillin-Pot Clavulanate	NA	NA	1897	46	NA
Furosemide	NA	NA	1840	47	NA
Amphetamine-Dextroamphet ER	NA	NA	1834	48	NA
traMADol HCl	NA	NA	1804	49	NA

risperiDONE	NA	NA	1776	50	NA
Triamcinolone Acetonide	NA	NA	1765	51	NA
Spironolactone	NA	NA	1622	52	NA
Aspirin Low Dose	NA	NA	1619	53	NA
Amitriptyline HCl	NA	NA	1590	54	NA
LORazepam	NA	NA	1561	55	NA
Mirtazapine	NA	NA	1549	56	NA
metroNIDAZOLE	NA	NA	1502	57	NA
hydrOXYzine Pamoate	NA	NA	1500	58	NA
Citalopram Hydrobromide	NA	NA	1454	59	NA
Fluconazole	NA	NA	1441	60	NA
Propranolol HCl	NA	NA	1438	61	NA
Prazosin HCl	NA	NA	1438	62	NA
Azithromycin	NA	NA	1420	63	NA
Metoprolol Tartrate	NA	NA	1381	64	NA
guanFACINE HCl	NA	NA	1374	65	NA
Jardiance	NA	NA	1316	66	NA
levETIRAcetam	NA	NA	1302	67	NA
Loratadine	NA	NA	1284	68	NA
guanFACINE HCl ER	NA	NA	1279	69	NA
oxyCODONE HCl	NA	NA	1265	70	NA
valACYclovir HCl	NA	NA	1259	71	NA
Sulfamethoxazole-Trimethoprim	NA	NA	1243	72	NA
Diclofenac Sodium	NA	NA	1242	73	NA
tiZANidine HCl	NA	NA	1217	74	NA
Naproxen	NA	NA	1216	75	NA
Trulicity	NA	NA	1172	76	NA

Folic Acid	NA	NA	1160	77	NA
Cefdinir	NA	NA	1152	78	NA
Doxycycline Monohydrate	NA	NA	1143	79	NA
Lantus SoloStar	NA	NA	1142	80	NA
Allergy Relief Cetirizine	NA	NA	1139	81	NA
Atomoxetine HCl	NA	NA	1118	82	NA
Pregabalin	NA	NA	1115	83	NA
Methylphenidate HCl ER (OSM)	NA	NA	1080	84	NA
Albuterol Sulfate	NA	NA	1073	85	NA
Baclofen	NA	NA	1027	86	NA
FeroSul	NA	NA	1021	87	NA
Methylphenidate HCl	NA	NA	1017	88	NA
Zolpidem Tartrate	NA	NA	992	89	NA
Dexmethylphenidate HCl ER	NA	NA	987	90	NA
SUMAtriptan Succinate	NA	NA	982	91	NA
Lisinopril-hydroCHLOROthiazide	NA	NA	982	92	NA
Mupirocin	NA	NA	979	93	NA
OLANZapine	NA	NA	973	94	NA
Ondansetron HCl	NA	NA	954	95	NA
Tamsulosin HCl	NA	NA	945	96	NA
Vraylar	NA	NA	909	97	NA
Carvedilol	NA	NA	892	98	NA
PARoxetine HCl	NA	NA	870	99	NA
Concerta	NA	NA	862	100	NA

Medicaid Statistics for Prescription Claims
June through August 2023

Tri-Monthly Statistics

	FFS	Amerigroup	Iowa Total Care	Molina Healthcare[1]	Total**
Total Dollars Paid	$2,925,207	$110,618,579	$85,325,411	$35,826,892	$234,696,090
Users[2]	3,654	147,387	124,164	65,914	N/A
Cost Per User	$800.55	$750.53	$687.20	$543.54	
Total Prescriptions	21,959	958,675	785,573	333,313	2,099,520
Average Rx/User	6.01	6.50	6.33	5.06	
Average Cost/Rx	$133.21	$115.39	$108.62	$107.49	
# Generic Prescriptions	19,389	841,385	699,383	296,858	
% Generic	88.3%	87.8%	89.0%	89.1%	
$ Generic	$876,470	$14,182,191	$11,898,911	$5,059,596	
Average Generic Rx Cost	$45.20	$16.86	$17.01	$17.04	
Average Generic Days Supply	26	25.81	26	25.45	
# Brand Prescriptions	2,570	117,290	86,190	36,455	
% Brand	11.7%	12.2%	11.0%	10.9%	
$ Brand	$2,048,737	$96,436,388	$73,426,500	$30,767,297	
Average Brand Rx Cost	$797.17	$822.20	$851.91	$843.98	
Average Brand Days Supply	28	27.07	29	27.34	

**All reported dollars are pre-rebate

[1] July 2023 data only; Molina Healthcare start July 1, 2023

[2] Not Unique; Includes members from Amerigroup and/or Iowa Total Care due to reassignment of members to Molina Healthcare

Top 20 Therapeutic Class by Paid Amount*

June through August 2023

	FFS	Amerigroup	Iowa Total Care	Molina Healthcare
1	ANALGESICS - ANTI-INFLAMMATORY	ANTIDIABETICS	ANTIDIABETICS	ANTIPSYCHOTICS
2	ANTIDIABETICS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIRHEUMATIC
3	ANTIPSYCHOTICS/ANTIMANIC AGENTS	DERMATOLOGICALS	ANALGESICS - ANTI-INFLAMMATORY	INCRETIN MIMETIC
4	ANTIVIRALS	ANALGESICS - ANTI-INFLAMMATORY	DERMATOLOGICALS	SKIN AND MUCOUS
5	ADHD/ANTI-NARCOLEPSY	ADHD/ANTI-NARCOLEPSY	ANTIASTHMATIC AND BROCHODILATOR AGENTS	AMPHETAMINES
6	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADHD/ANTI-NARCOLEPSY	ANTIRETROVIRALS
7	MISCELLANEOUS THERAPEUTIC CLASSES	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ANTIVIRALS	INSULINS
8	ANTICONVULSANTS	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	CF REG CORRECT
9	ANTIDEPRESSANTS	ANTIVIRALS	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ANTINEOPLASTIC
10	ANTINEOPLASTIVS AND ADJUNCTIVE THERAPIES	ANTICONVULSANTS	RESPIRATORY AGENTS - MISC.	ANTIDIABETIC
11	DERMATOLOGICALS	HEMATOLOGICAL AGENTS - MISC.	ENDOCRINE AND METOBOLIC AGENTS - MISC.	ADRENALS
12	NEUROMUSCULAR AGENTS	MIGRAINE PRODUCTS	ANTICONVULSANTS	CALCITONIN GENE
13	ANTIHYPERTENSIVES	RESPIRATORY AGENTS - MISC.	MIGRAINE PRODUCTS	ANTIDEPRESSANTS
14	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ENDOCRINE AND METABOLIC AGENTS - MISC.	HEMATOLOGICAL AGENTS - MISC.	RESP AND CNS
15	ULCER DRUGS/ ANTISPASMODICS/ANTICHOLINERGICS	ANTIDEPRESSANTS	ANTIDEPRESSANTS	HEMOSTATICS
16	CONTRACEPTIVES	CARDIOVASCULAR AGENTS - MISC.	ANTICOAGULANTS	B-ADREN AGON
17	ENDOCRINE AND METABOLIC AGENTS - MISC.	ANTICOAGULANTS	CARDIOVASCULAR AGENTS - MISC.	MISC ANTICONVUL
18	ANTICOAGULANTS	GASTROINTESTINAL AGENTS - MISC.	GASTROINTESTINAL AGENTS - MISC.	ANTICOAGULANTS
19	ANALGESICS - OPIOIDS	ULCER DRUGS/ ANTISPASMODICS/ANTICHOLINERGICS	ANTI-INFECTIVE AGENTS - MISC.	NERVOUS SYSTEM AGT
20	ANTIANXIETY AGENTS	NEUROMUSCULAR AGENTS	ULCER DRUGS/ ANTISPASMODICS/ANTICHOLINERGICS	ANTIMUSCARINICS

* Pre-rebate

Top 20 Therapeutic Class by Prescription Count

June through August 2023

	FFS	Amerigroup	Iowa Total Care	Molina Healthcare
1	ANTIDEPRESSANTS	ANTIDEPRESSANTS	ANTIDEPRESSANTS	ANTIDEPRESSANTS
2	ANTICONVULSANTS	ANTICONVULSANTS	ANTICONVULSANTS	MISC ANTICONVUL
3	ADHD/ANTI-NARCOLEPSY	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ANTIPSYCHOTICS
4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADHD/ANTI-NARCOLEPSY	ANTIHYPERTENSIVES	PPI
5	ANTIHYPERTENSIVES	ANTIHYPERTENSIVES	ANTIDIABETICS	ANXIOLYTICS, SE
6	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIDIABETICS	ADHD/ANTI-NARCOLEPSY AGENTS	NONSTEROIDAL AN
7	ANTIDIABETICS	ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	HMG-COA RED INH
8	ANTIANXIETY AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	ANTIPSYCHOTICS/ANTIMANIC AGENTS	B-ADREN AGON
9	ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS	ANTIANXIETY AGENTS	ANTIANXIETY AGENTS	BETA BLOCKERS
10	ANALGESICS - OPIOIDS	ANTIHYPERLIPIDEMICS	ANTIHYPERLIPIDEMICS	AMPHETAMINES
11	ANALGESICS - ANTI-INFLAMMATORY	DERMATOLOGICALS	DERMATOLOGICALS	OPIATE AGONISTS
12	ANTIHISTAMINES	ANTIHISTAMINES	ANALGESICS - ANTI-INFLAMMATORY	ADRENALS
13	DERMATOLOGICALS	ANALGESICS - ANTI-INFLAMMATORY	ANALGESICS - OPIOID	BENZODIAZEPINES
14	ANTIHYPERLIPIDEMICS	ANALGESICS - OPIOID	BETA BLOCKERS	ACEI
15	BETA BLOCKERS	BETA BLOCKERS	ANTIHISTAMINES	CORTICOSTEROIDS
16	DIURETICS	DIURETICS	DIURETICS	2ND GEN ANTIHIS
17	ANTI-INFECTIVE AGENTS - MISC.	THYROID AGENTS	THYROID AGENTS	THYROID AGENTS
18	PENICILLINS	PENICILLINS	PENICILLINS	PENICILLINS
19	THYROID AGENTS	MUSCULOSKELETAL THERAPY AGENTS	MUSCULOSKELETAL THERAPY AGENTS	RESP AND CNS
20	MUSCULOSKELETAL THERAPY AGENTS	CORTICOSTEROIDS	ANALGESICS - NONNARCOTIC	BIGUANIDES

Top 25 Drugs by Paid Amount**

June through August 2023

	FFS	Amerigroup	Iowa Total Care	Molina Healthcare
1	HUMIRA PEN	HUMIRA (CF) PEN	HUMIRA PEN	HUMIRA PEN
2	BIKTARVY	VRAYLAR	VRAYLAR	VRAYLAR
3	EVRYSDI	VYVANSE	OZEMPIC	TRIKAFTA
4	VIJOICE	OZEMPIC	TRULICITY	VYVANSE
5	REVLIMID	TRULICITY	TRIKAFTA	TRULICITY
6	INVEGA SUSTENNA	STELARA	VYVANSE	BIKTARVY
7	TRULICITY	TRIKAFTA	DUPIXENT	DUPIXENT
8	VYVANSE	INVEGA SUSTENNA	BIKTARVY	INVEGA SUSTENNA
9	OZEMPIC	JARDIANCE	INVEGA SUSTENNA	JARDIANCE
10	VERZENIO	BIKTARVY	STELARA	TALTZ
11	MAVYRET	DUPIXENT PEN	JARDIANCE	STELARA
12	KISQALI	REXULTI	TALTZ	OZEMPIC 0.25 OR 0.5MG/DOSE
13	CONCERTA	TALTZ AUTOINJECTOR	ELIQUIS	REXULTI
14	TALTZ	ELIQUIS	LANTUS SOLOSTAR	ELIQUIS
15	JARDIANCE	LANTUS SOLOSTAR	ARISTADA	OZEMPIC 1MG/DOSE
16	VRAYLAR	SYMBICORT	REXULTI	LANTUS SOLOSTAR
17	ALBUTEROL SULFATE	CONCERTA	SYMBICORT	ARISTADA
18	REXULTI	VENTOLIN HFA	STRENSIQ	CONCERTA
19	LANTUS SOLOSTAR	SKYRIZI PEN	CONCERTA	ADVATE
20	ARISTADA	ARISTADA	ENBREL SURECLICK	NURTEC
21	ENBREL SURECLICK	NURTEC ODT	SPIRIVA	SYMBICORT
22	KESIMPTA	DUPIXENT SYRINGE	NURTEC	ILARIS
23	LISINOPRIL	ABILIFY MAINTENA	MAVYRET	INGREZZA
24	SYMBICORT	ENBREL SURECLICK	ABILIFY MAINTENA	MOUNJARO
25	ELIQUIS	INGREZZA	TRINTELLIX	TRINTELLIX

** Pre-rebate

Top 25 Drugs by Prescription Count

June through August 2023

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

Antidepressants in Children
RetroDUR
Data

Purpose

- Identify members in the pediatric population with a claim for an antidepressant where:
  - The member is below the FDA approved minimum age,
  - The member is identified as having duplicate therapy, and
  - The member is on low dose trazodone.

Background

- The annual federal Drug Utilization Review (DUR) report (Sec. 1927. [42 U.S.C. 1396r–8]) issued by the Centers for Medicare and Medicaid Services (CMS) contains various survey questions relative to drug utilization and practice topics. The most recent survey includes the following questions:
  - "Does your state have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? If "yes", does your state either manage or monitor only children in foster care, all children, or other?"
  - "Does your state have edits in place to monitor child's age, dosage, indication, polypharmacy, other?"
- After reviewing data during the August 2023 meeting regarding members taking an antidepressant below the FDA approved age (Table 1), the Commission requested additional information to determine next steps.
  - Utilization by age band (Table 2)
  - Duplicate therapy (Table 3)
  - Daily trazodone dose (Table 4)
- Molina Healthcare began providing coverage for IA Health Link members starting July 1, 2023.

Original RDUR Criteria and Data

- Members: < FDA approved minimum age for antidepressant (age defined in table below)
- Time period: 3 months of pharmacy claims; February through April 2023

Table 1.

Drug	FDA Approved Minimum Age	AGP		ITC		FFS	
		Mbrs	Drs	Mbrs	Drs	Mbrs	Drs
Imipramine	6	0	0	0	0	0	0
Sertraline	6	16	18	11	8	0	0
Duloxetine	7	0	0	0	0	0	0
Fluoxetine	7	56	61	28	28	2	2
Fluvoxamine	8	0	0	0	0	0	0
Clomipramine	10	1	1	1	1	0	0
Amitriptyline	12	49	51	38	31	1	1
Doxepin	12	8	7	3	2	0	0
Escitalopram	12	320	272	174	132	8	8
Nortriptyline	13	22	24	16	11	0	0
Protriptyline	13	0	0	0	0	0	0
Trimipramine	13	0	0	0	0	0	0
Isocarboxazid	16	0	0	0	0	0	0
Amoxapine	18	0	0	0	0	0	0
Bupropion HCl	18	721	460	381	272	10	9
Citalopram	18	263	180	136	124	6	6
Desipramine	18	2	3	0	0	0	0
Desvenlafaxine	18	87	65	34	33	3	2
Levomilnacipran	18	0	0	0	0	0	0
Mirtazapine	18	597	240	315	183	19	20
Nefazodone	18	0	0	0	0	0	0
Paroxetine	18	78	68	61	62	2	2
Phenelzine	18	0	0	0	0	0	0
Tranylcypromine	18	0	0	0	0	0	0
Trazodone	18	2026	496	1122	482	60	56
Venlafaxine	18	309	194	199	147	5	7
Vilazodone	18	10	11	11	10	0	0
Vortioxetine	18	15	12	10	9	0	0
# Unique Mbrs (per plan)		4580	2163	2540	1535	103	93

Drs = prescribers; Mbrs = members AGP = Amerigroup; ITC = Iowa Total Care; MHC = Molina Healthcare; FFS = Fee-for-Service

Additional RDUR Data (Time period: May through July 2023)

Utilization by Age Band[1] Total number of members across all plans (Amerigroup [AGP], Iowa Total Care [ITC], Molina Healthcare [MHC] and Fee-for-Service [FFS])

Table 2.

May - July 2023[1]	0-3	4-5	6-7	8-12	13-17
Drug (FDA Age)	**TOTAL[2]**	**TOTAL[2]**	**TOTAL[2]**	**TOTAL[2]**	**TOTAL[2]**
Imipramine (6)	0	1			
Sertraline (6)	0	28			
Duloxetine (7)	0	0	1		
Escitalopram (7)	1	8	33		
Fluoxetine (7)	2	26	101		
Fluvoxamine (8)	0	0	3		
Clomipramine (10)	0	0	1	1	
Amitriptyline (12)	0	2	12	90	
Doxepin (12)	0	2	1	13	
Nortriptyline (13)	0	0	5	31	
Protriptyline (13)	0	0	0	0	
Trimipramine (13)	0	0	0	0	
Isocarboxazid (16)	0	0	0	0	0
Amoxapine (18)	0	0	0	0	0
Bupropion HCl (18) [3]	0	0	3	94	860
Citalopram (18) [3]	1	5	28	316	1,173
Desipramine (18)	0	0	0	0	0
Desvenlafaxine (18)	0	0	0	14	131
Levomilnacipran (18)	0	0	0	0	0
Mirtazapine (18)	1	5	34	358	539
Nefazodone (18)	0	0	0	0	0
Paroxetine (18)	0	0	1	23	119
Phenelzine (18)	0	0	0	0	0
Tranylcypromine (18)	0	0	0	0	0
Trazodone (18)	8	46	128	1,098	2,156
Venlafaxine (18) [3]	0	0	1	37	517
Vilazodone (18)	0	0	0	2	23
Vortioxetine (18)	0	0	0	0	24

[1] Includes Molina Healthcare data for July 2023 only.

[2] Count may include members from ITC and/or AGP due to reassignment of members to MHC, effective July 1, 2023.

[3] Compendia supported age is 6 years and older.

Duplicate therapy > 1 chemically distinct agent ≥ 60 days (Excludes Molina Healthcare data)

Table 3.

Plan	Members	Prescribers
AGP	2,292	1,356
ITC	107	97
FFS	8	9

Trazodone Dose

Table 4.

Daily Dose	AGP		ITC		MHC[1]		FFS	
	Member	Prescriber	Member	Prescriber	Member	Prescriber	Member	Prescriber
0-25mg	231	186	0	0	46	44	3	3
26-50mg	938	540	701	148	169	133	18	17
51-100mg	807	556	221	148	144	109	23	22
101-149mg	15	15	0	0	4	4	2	2
≥ 150mg	399	355	68	55	61	48	8	8

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

[1] July 2023 data only.

[2] Count may include members from AGP and/or ITC due to reassignment of members to MHC effective July 1, 2023.

Next Steps

1. Make a recommendation to implement age edits on all above antidepressants based on FDA approved minimum age?
2. Make a recommendation to implement age edits on select antidepressants based on FDA approved minimum age? Identify which antidepressant(s).
3. Make recommendation to implement age edits on all above antidepressants based on FDA approved minimum age and compendia supported age, where applicable? Bupropion, citalopram, and venlafaxine all have compendia indications down to 6 years of age.
4. Send letters to prescribers of members using an antidepressant below the FDA approved minimum age and/or compendia supported age?
5. Implement duplicate therapy edit for antidepressants. Would be brought to a future meeting for further discussion.
6. Other?
7. None?

Antianxiety/Sedatives in Children
RetroDUR
Data

Purpose

- Identify members in the pediatric population (less than 18 years old) with a claim for an antianxiety/sedative drug where:
    - The member is below the FDA approved minimum age, and
    - The member is identified as having duplicate therapy.

Background

- The annual federal Drug Utilization Review (DUR) report (Sec. 1927. [42 U.S.C. 1396r–8]) issued by the Centers for Medicare and Medicaid Services (CMS) contains various survey questions relative to drug utilization and practice topics. The most recent survey includes the following questions:
    - "Does your state have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children? If "yes", does your state either manage or monitor only children in foster care, all children, or other?"
    - "Does your state have edits in place to monitor child's age, dosage, indication, polypharmacy, other?"
    - CMS does not define antianxiety/sedative drugs.
- Molina Healthcare began providing coverage for IA Health Link members starting July 1, 2023.

RDUR Criteria

- Time period: 3 months of pharmacy claims; May through July 2023
- FDA approved age
    - Members: < age listed below
- Duplicate therapy
    - Members < 18 years old
    - > 1 chemically distinct medication for ≥ 60 days overlap

Data

FDA Approved Age

Number of members identified under FDA approved age[1]

Drug (FDA Age)	AGP	ITC	MHC[1]	FFS
Alprazolam (18)	20	14	11	1
Buspirone (18)	693	406	352	0
Estazolam (18)	0	1	0	0
Eszopiclone (18)	4	2	5	1
Temazepam (18)	1	1	0	1
Trazodone (18)	1836	963	574	44
Triazolam (18)	1	1	2	0
Zaleplon (18)	3	0	0	0
Zolpidem (18)	14	4	1	0
Lorazepam (12)	30	17	8	0
Clorazepate (9)[3]	0	0	0	0
Chlordiazepoxide (6)[3]	0	0	0	0
Hydroxyzine (6)	127	106	82	1
Oxazepam (6)	0	0	0	0

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

[1] Includes members from AGP and/or ITC due to reassignment of members to MHC effective July 1st.

[2]July 2023 data only

[3] Current age edit for FDA approved age

Duplicate Therapy > 1 chemically distinct agent ≥ 60 days (Excludes Molina Healthcare data)

	# Unique Members	# Unique Prescribers
AGP	561	500
ITC	8	11
FFS	1	1

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

Next Steps

1. Make recommendation to implement age edits on above antianxiety/sedatives based on FDA approved minimum age?
2. Make a recommendation to implement age edits on select antianxiety/sedatives based on FDA approved minimum age? Identify which antianxiety/sedatives.
3. Send letters to prescribers of members using an antianxiety/sedative below the FDA approved minimum age?
4. Implement duplicate therapy edit for antianxiety/sedative agents. Would be brought to a future meeting for further discussion.
5. Other?
6. None?

Mood Stabilizers in Children
RetroDUR
Proposal

Purpose

- Review mood stabilizers in Iowa Medicaid children to determine if additional management of this drug class is warranted.

Background

- The annual federal Drug Utilization Review (DUR) report (Sec. 1927. [42 U.S.C. 1396r–8]) issued by the Centers for Medicare and Medicaid Services (CMS) contains various survey questions relative to drug utilization and practice topics. The most recent survey includes the following questions:
    - "Does your state have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children? If "yes", does your state either manage or monitor only children in foster care, all children, or other?"
    - "Does your state have edits in place to monitor child's age, dosage, indication, polypharmacy, other?"
- CMS does not define mood stabilizers.

Next Steps

- How can the state review the use of mood stabilizers in children that will be meaningful, yet not disruptive to use for other indications (e.g., seizure)?
- Define "mood stabilizers" and potential ideas for review:
    - NIH - Mood stabilizers are typically used to treat bipolar disorder and mood changes associated with other mental disorders.
    - Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health – carbamazepine, divalproex sodium, lithium, lamotrigine, oxcarbazepine. Criteria indicating need for further review:
        - Mood stabilizer: Three or more concomitant mood stabilizers
        - Mood stabilizer: Less than four years of age
        - Four or more psychotropic medications prescribed concomitantly.
    - MassHealth Pediatric Behavioral Health Medication Initiative – carbamazepine, divalproex, eslicarbazepine, gabapentin, lamotrigine, lithium, oxcarbazepine, pregabalin, topiramate, valproic acid.
        - Mood stabilizer polypharmacy – overlapping pharmacy claims for three or more mood stabilizers (agents considered to be used only for seizure diagnoses are not included) for at least 60 days within a 90-day period for members less than 18 years of age.
        - Behavioral health medication polypharmacy – any combination of four or more behavioral health medications (i.e., alpha2 agonists, antidepressants,

antipsychotics, armodafinil, atomoxetine, benzodiazepines buspirone, cerebral stimulants, donepezil, hypnotic agents, memantine, modafinil, mood stabilizers [agents considered to be used only for seizure diagnoses are not included], naltrexone, and viloxazine) within a 45-day period for members less than 18 years of age.

- What MCOs are doing in other states?
    - Iowa Total Care – how this is managed in other states where Centene has a presence.
        - New Jersey, Nevada, Mississippi, Kentucky: no edits or restrictions on these at all; intent is to have barriers removed.
        - Washington: Extensive requirement called the Second Opinion Network which requires edits on specific drug combinations, and age/dose edits (all mental health medications). If members are over a specific threshold, the regimen must be reviewed by an outside organization (Seattle Children's psychiatric department) prior to approval in CVS. There must be a consultation between the prescriber and a psychiatrist at Seattle Childrens.
        - New Hampshire, New Mexico, Texas: These states follow the Texas PMUR criteria and have added POS edits when possible: Psychotropic Medication Utilization Parameters for Children and Youth in Behavioral Health (texas.gov)
        - Illinois: Children in Foster Care have any behavioral health medications reviewed by University of Illinois at Chicago mental health specialists as part of the consent for treatment process. Children not in Foster Care are not subject to this program, but starting in 2024, there is a retro DUR program from Express Scripts that is to be put in place and is intended to cover the CMS DUR Survey questions.
        - Nebraska: Mental Health Medications are subject to state-defined quantity and age limits which are taken from the Texas guidelines. A state licensed child and adolescent psychiatrist must sign off on any PAs for psychotropic meds in youth. There is also a Centene corporate led Behavioral Health Medication Review program, and the Nebraska plan has adopted it.
- Determine appropriate use. What to look for?
    - Three or more chemically distinct mood stabilizers?
    - Utilization for patients less than 4 years of age?
    - Exclude seizure diagnosis?
- No need to review.
- Other suggestions

Low-Dose Quetiapine
RetroDUR
Proposal

Purpose

- Identify members with a quetiapine total daily dose less than 150 mg per day.

Background

- Quetiapine is FDA approved in adults for acute manic and mixed episodes of bipolar disorder, acute depressive episodes associated with bipolar disorder, maintenance therapy of bipolar disorder when used adjunctively with lithium or divalproex, major depressive disorder when used as adjunctive therapy to antidepressants (extended-release formulation only), and schizophrenia.
    - Adult dosage recommendations for FDA approved indications range from 300 mg to 800 mg per day.
- Quetiapine is FDA approved for acute mania in bipolar disorder in pediatric patients 10-17 years of age, and acute management of schizophrenia in adolescents 13-17 years of age.
    - FDA approved indication dosing - 600 mg to 800 mg per day.
    - Literature based dosing:
        - Bipolar disorder
            - 5 to 9 years – 400 mg per day maximum
            - 10 to 17 years – 800 mg per day maximum
        - Acute schizophrenia
            - 13 to 17 years – 400 to 800 mg per day
- Currently there are no FDA approved indications for low-dose quetiapine (< 150 mg per day) in adults or pediatric/adolescents. Additionally, there is no compendia indication for the use of quetiapine in the pediatric/adolescent population and evidence is inconclusive for adults.
- Quetiapine doses less than 150 mg per day may be used for the off-label treatment of insomnia.

Potential RDUR Criteria

- Identify members with low-dose quetiapine in pharmacy claims for ≥ 60 days.
- Time period: 3 months (August through October 2023)
- Break out by age: ≥ 18 and < 18 years of age.
- Other?

Seizure Rescue Treatment – Nasal Spray
ProDUR Quantity Limits
Second Review

Background

Retrospective review of paid pharmacy claims can identify patterns of incorrect utilization, inappropriate or medically unnecessary care, gross overuse, abuse, or fraud. Recent review of monthly paid pharmacy claims found an instance where Valtoco (diazepam nasal spray) was being dispensed in large quantities to one member (receiving a quantity greater than the maximum dosage and treatment frequency, as stated in the FDA approved label, in a 30-day period). Valtoco is preferred on the Preferred Drug List (PDL) with no current quantity limit. After further review of preferred rescue medications indicated for the acute treatment of seizures, quantity limits are being recommended for Valtoco and Nayzilam (midazolam nasal spray) to ensure appropriate use. Diazepam (anticonvulsant) gel is currently preferred on the PDL and subject to a quantity limit.

Nayzilam (midazolam nasal spray)

- Initial dose: Administer one spray (5 mg dose) into one nostril.
- Second dose: One additional spray (5 mg dose) into the opposite nostril may be administered after 10 minutes if the patient has not responded to the initial dose.
- Maximum dosage and treatment frequency: Do not use more than 2 doses of Nayzilam to treat a seizure cluster. It is recommended that Nayzilam be used to treat no more than one episode every three days and treat no more than five episodes per month.
- How Supplied
    - 5 mg box – 2 nasal spray units, each contained within an individual blister pack

Valtoco (diazepam nasal spray)

- Initial dose: 5 mg and 10 mg doses are administered as a single spray into one nostril. Administration of 15 mg and 20 mg doses requires two nasal spray devices, one spray into each nostril.
- Second dose: When required may be administered at least 4 hours after the initial dose. If administered use a new blister pack.
- Maximum dosage and treatment frequency: Do not use more than 2 doses to treat a single episode. It is recommended that Valtoco be used to treat no more than one episode every five days and no more than five episodes per month.
- How Supplied
    - 5 mg carton – 2 individual blister packs, each containing one 5 mg nasal spray device
    - 10 mg carton – 2 individual blister packs, each containing one 10 mg nasal spray device
    - 15 mg carton – 2 individual blister packs, each containing two 7.5 mg nasal spray devices

- 20 mg carton – 2 individual blister packs, each containing two 10 mg nasal spray devices

Proposed Quantity Limits

Medication Name & Strength	**Quantity Limit Per 30 Days**
Nayzilam (midazolam) 5 mg	5 boxes (10 nasal spray units)
Valtoco (diazepam) 5 mg, 10 mg	5 cartons (10 blister packs)
Valtoco (diazepam) 15 mg, 20 mg	10 cartons (20 blister packs)

References

Nayzilam [prescribing information]. UCB, Inc., Smyrna, GA. January 2023
Valtoco [prescribing information]. Neurelis, Inc. San Diego, CA. January 2023

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 10/01/2023

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 10/01/2023

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 $\geq$ 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,

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 10/01/2023

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

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 10/01/2023

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.

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 10/01/2023

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.
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.

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 10/01/2023

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. Requests for weight loss are not a covered diagnosis of use and will be denied. Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).

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 10/01/2023

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.

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 10/01/2023

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 10/01/2023

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 10/01/2023

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.

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 10/01/2023

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

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Updated 10/01/2023

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.

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 10/01/2023

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.

Biologicals for Hidradenitis Suppurativa *Adalimumab (Humira)* *Use Biologicals for Hidradenitis Suppurativa PA form*	Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent. 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.

Iowa Medicaid Drug Prior Authorization Criteria

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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.

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

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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 10/01/2023

CNS Stimulants and Atomoxetine	Prior authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for CNS stimulants and atomoxetine will be considered when patient has an FDA approved or compendia indication for requested drug under the following conditions: 1. Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening, and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. Use of an amphetamine agent plus a methylphenidate agent will not be considered for a diagnosis of ADHD. 2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist. 4. Binge Eating Disorder (Vyvanse only) a. Patient is 18 to 55 years of age; and b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and c. Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and d. Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and e. Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and f. Patient has a BMI of 25 to 45; and g. Patient does not have a history of cardiovascular disease; and

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 10/01/2023

Use CNS Stimulants and Atomoxetine or Binge Eating Disorder Agents PA form	h. Patient has no history of substance abuse; and i. Is not being prescribed for the treatment of obesity or weight loss; and j. Doses above 70mg per day will not be considered. k. Initial requests will be approved for 12 weeks. l. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week. <u>DSM-5 Criteria</u> i. Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control 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. <u>Moderate to Severe BED</u> Based on the number of binge eating episodes per week: Moderate - 4 to 7 Severe – 8 to 13 Extreme – 14 or more Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2023

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.
Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) *Use Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) PA form*	Prior authorization (PA) is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and 3. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and 4. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and 5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 6. Is not prescribed in combination with other ophthalmic cyclosporine products. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional authorizations will be considered upon documentation of clinical response to therapy.

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 10/01/2023

Cystic Fibrosis Agents, Oral *Kalydeco* *Orkambi* *Symdeko* *Trikafta* *Use Cystic Fibrosis Agents, Oral PA form*	Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of cystic fibrosis; and 3. Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and 4. Prescriber is a CF specialist or pulmonologist; and 5. Baseline liver function tests (AST, ALT, and bilirubin) are provided; and 6. Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and 7. Will not be used with other CFTR modulator therapies. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Adherence to oral cystic fibrosis therapy is confirmed; and 2. Liver function tests (AST, ALT, and bilirubin) are assessed every 3 months during the first year of treatment and annually thereafter.
Dalfampridine (Ampyra) *Use Dalfampridine (Ampyra™) PA form*	Prior authorization (PA) is required for dalfampridine (Ampyra). Payment will be considered under the following conditions: 1. For patients that have a gait disorder associated with MS. 2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3. Additional PAs will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. PAs will not be considered for patients with a seizure diagnosis or in patients will moderate to severe renal impairment.
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

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 Deferasirox (Exjade) PA form	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. <u>Continuation of Therapy</u> 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** <u>Initiation of Therapy</u> 1. Patient is 10 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4. Serum ferritin levels are > 300mcg/L; and 5. LIC are > 5mg Fe/g dw; and 6. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7. Initial authorization will be considered for up to 6 months. <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).

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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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.

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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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.

Updated 10/01/2023

Dupilumab (Dupixent)	Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient's current weight in kilograms (kg) is provided; and 3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and b. Patient has failed to respond to good skin care and regular use of emollients; and c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and e. Patient 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 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; or 5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and a. Documentation dupilumab will be used as an add-on maintenance treatment; and b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid spray; and ii. Oral corticosteroid; or

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 10/01/2023

Use Dupilumab (Dupixent) PA form	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. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and a. Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and b. Patient has experienced severe to very severe pruritits, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and c. Patient has ≥ 20 nodular lesions (attach documentation); and d. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and 8. Dose does not exceed the FDA approved dosing for indication. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Duplicate Therapy Edits **Antipsychotics** **NSAIDs** *Use Duplicate Therapy Edit Override PA form*	Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.

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

Updated 10/01/2023

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.

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 10/01/2023

Eplerenone (Inspra) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Inspra. Payment will be authorized only in cases where there is documented trial and therapy failure on spironolactone or documented cases of gynecomastia from spironolactone therapy.
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.

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 10/01/2023

Extended Release Formulations *Use Extended Release Formulations PA form*	Payment for a non-preferred extended release formulation will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Prior authorization (PA) is required for the following extended release formulation(s): Adoxa, Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Coreg CR, Doryx, Elepsia XR, Envarsus XR, Glumetza, Gocovri, Gralise, Kapspargo, Keppra XR, Lamictal XR, Luvox CR, Memantine ER, Mirapex ER, 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.
Fentanyl, Short Acting Products *Use Short Acting Fentanyl Products PA form*	Prior authorization (PA) is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a **Black Box Warning**. Short acting fentanyl products: 1. Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain. 2. Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.

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

Updated 10/01/2023

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

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

Updated 10/01/2023

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

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

Updated 10/01/2023

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

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

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 10/01/2023

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

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Updated 10/01/2023

	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 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.

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 10/01/2023

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

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

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

Updated 10/01/2023

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 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

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 10/01/2023

Use Hepatitis C Treatments, Direct Acting Antivirals PA form	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.

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 10/01/2023

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

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 10/01/2023

Use High Dose Opioids PA form	14. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation] within the prior 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 15. Patient has been educated on opioid overdose prevention; and 16. Patient's household members have been educated on the signs of opioid overdose and how to administer an opioid reversal agent; and 17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and 18. A documented dose reduction is attempted at least annually. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of high-dose opioid therapy will be considered every 6 months with the following: 1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and 2. Patient has not experienced an overdose or other serious adverse event; and 3. Patient is not exhibiting warning signs of opioid use disorder; and 4. The benefits of opioids continue to outweigh the risks; and 5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and 6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and 7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests. 8. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP [attach documentation] within 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 9. Patient has been reeducated on opioid overdose prevention; and 10. Patient's household members have been reeducated on the signs of opioid overdose and how to administer an opioid reversal agent.

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

Updated 10/01/2023

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

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 10/01/2023

Use IL-5 Antagonists PA form	a. Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; 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; and ii. Oral corticosteroid; and 6. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist. If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: Severe Asthma with an Eosinophilic Phenotype: 1. Patient continues to receive therapy with an ICS, LABA and LTRA; and 2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3. Patient has experienced a decrease in administration of rescue medication (albuterol); or 4. Patient has experienced a decrease in exacerbation frequency; or 5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline. Eosinophilic Granulomatosis with Polyangiitis 1. Patient has demonstrated a positive clinical response to therapy (increase in remission time). Hypereosinophilic Syndrome: 1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and 2. Medication continues to be used in combination with stable doses or at least one other HES therapy. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) 1. Patient has demonstrated positive clinical response to therapy (improvement in symptoms); and 2. Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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 10/01/2023

Immunomodulators-Topical *Elidel* *Protopic* *Use Immunomodulators-Topical PA form*	Prior authorization (PA) is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel) or tacrolimus (Protopic) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with one preferred topical corticosteroid, except on the face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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

Updated 10/01/2023

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

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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	ii. Quantity Limit Override (as posted at www.iowamedicaidpdl.com under Billing/Quantity Limits); and 6. Requests for drugs or drug classes subject to the initial days' supply limit not listed above, will be considered on an individual case-by-case basis, based on medical necessity documentation provided.
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.

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 10/01/2023

Ivabradine (Corlanor) *Use Ivabradine (Corlanor) PA form*	Prior authorization (PA) is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and a. Patient is 18 years of age or older; and b. Patient has documentation of a left ventricular ejection fraction ≤35%; and c. Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and d. Patient has documentation of blood pressure ≥90/50 mmHg; or 2. Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class ll to lV) due to dilated cardiomyopathy, and a. Pediatric patient age 6 months and less than 18 years old; and b. Patient has documentation of a left ventricular ejection fraction ≤45%; and b. Patient is in sinus rhythm with a resting heart rate (HR) defined below; i. 6 to 12 months – HR ≥ 105 bpm ii. 1 to 3 years- HR ≥ 95 bpm iii. 3 to 5 years- HR ≥ 75 bpm iv. 5 to 18 years- HR ≥ 70 bpm; and 3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and 4. Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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

Updated 10/01/2023

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

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 10/01/2023

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

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

Updated 10/01/2023

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.

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 10/01/2023

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.

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 10/01/2023

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

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 10/01/2023

Use Long-Acting Opioids PA form	b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
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 10/01/2023

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 10/01/2023

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

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 10/01/2023

Mavacamten (Camzyos)	Prior authorization (PA) is required for mavacamten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and 3. Patient exhibits symptoms of New York Heart Association (NYHA) class ll or lll symptoms; and 4. Is prescribed by or in consultation with a cardiologist; and 5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and 6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and 7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following: a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker.
Use Mavacamten (Camzyos) PA form	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.

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 10/01/2023

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.
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.

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 10/01/2023

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.
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.

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2023

Muscle Relaxants *Use Muscle Relaxant PA form*	Prior authorization (PA) is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.
Narcotic Agonist-Antagonist Nasal Sprays *Use Narcotic Agonist/Antagonist Nasal Spray PA form*	Prior authorization (PA) is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration. Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.
New to Market Drugs *Use New to Market Drugs PA form*	Prior authorization (PA) is required for newly marketed drugs. Payment will be considered for patients when the following criteria are met: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or 3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and 4. Request must adhere to all FDA approved labeling. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Once newly marketed drugs are reviewed by the Pharmaceutical & Therapeutics Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

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

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

Updated 10/01/2023

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 10/01/2023

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.

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 10/01/2023

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 10/01/2023

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

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	6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances. If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist. <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

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 10/01/2023

Use Omalizumab (Xolair) PA form	6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances. If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
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.

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Updated 10/01/2023

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.

Updated 10/01/2023

	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.

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 10/01/2023

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

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 10/01/2023

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

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 10/01/2023

Use Palivizumab PA form	Immunocompromised Children 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).
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: Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) 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

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

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 10/01/2023

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

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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Pegcetacoplan (Empaveli) *Use Pegcetacoplan (Empaveli) PA form*	Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and 2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and 3. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and 4. History of at least one red blood cell transfusion in the previous 12 months; and 5. Documentation of hemoglobin < 10.5 g/dL; and 6. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross-titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and 7. Is prescribed by or in consultation with a hematologist; and 8. Medication will be administered in the member's home; and 9. Member or member's care giver has been properly trained in subcutaneous infusion and prescriber has determined home administration is appropriate. Initial authorizations will be approved for 4 weeks if within cross-titration period with eculizumab (Soliris) to verify eculizumab has been discontinued, or for 6 months otherwise. Additional authorizations will be considered when the following criteria are met: 1. Documentation of a positive clinical response to therapy (e.g., increased or stabilization or hemoglobin levels or reduction in transfusions); and 2. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris).
Pirfenidone (Esbriet) / Nintedanib (Ofev)	Prior authorization (PA) is required for pirfenidone (Esbriet) and nintedanib (Ofev). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Is prescribed by a pulmonologist; and 3. Patient does not have hepatic impairment as defined below: a. Nintedanib- Patient does not have moderate or severe hepatic impairment (Child Pugh B or C) or b. Pirfenidone- Patient does not have severe hepatic impairment (Child Pugh C); and

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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	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 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:

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Updated 10/01/2023

Use Pirfenidone (Esbriet) / Nintedanib (Ofev) PA form	1. Worsening respiratory symptoms; or 2. Increased extent of fibrosis on HRCT; or iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only. If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met: 1. Adherence to pirfenidone (Esbriet) or nintedanib (Ofev) is confirmed; and 2. Documentation of a positive response to therapy, defined as meeting at least one of the following: a. Rate of lung function decline slowed; or b. Improved or no worsening of symptoms of cough, shortness of breath; and 3. Documentation is provided that the patient has remained tobacco-free; and 4. ALT, AST, and bilirubin are assessed periodically during therapy.
Proton Pump Inhibitors *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.

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Updated 10/01/2023

Pulmonary Arterial Hypertension Agents *Use Pulmonary Arterial Hypertension Agents PA form*	Prior Authorization (PA) is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions: 1. Diagnosis of pulmonary arterial hypertension
Quantity Limit Override *Use Quantity Limit Override PA form*	Designated drugs are limited to specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website www.iowamedicaidpdl.com under the Billing/Quantity Limits tab. Providers should submit a Prior Authorization (PA) request for override consideration.
Repository Corticotropin Injection (H.P. Acthar Gel) *Use Repository Corticotropin Injection (H.P. Acthar Gel) PA form*	Prior authorization (PA) is required for repository corticotropin injection. Payment will be considered under the following conditions: 1. Patient is under two years of age and 2. Patient has a diagnosis of infantile spasms. Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection. If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.

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Updated 10/01/2023

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

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Updated 10/01/2023

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

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 10/01/2023

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.

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Updated 10/01/2023

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. PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. A diagnosis of insomnia; and 3. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and 4. Enforcement of good sleep hygiene is documented; and 5. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses; and 6. Will not be used concurrently with a benzodiazepine sedative/hypnotic agent. 7. In addition to the above criteria, requests for an orexin receptor antagonist will require documentation of a trial and therapy failure with at least one non-preferred agent prior to consideration of coverage. 8. Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2023

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

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 10/01/2023

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,

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Updated 10/01/2023

	triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy. 7. Lost, stolen, or destroyed medication replacement requests will not be authorized. Initial requests will be approved for 3 months. Additional PAs will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency). The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Select Oncology Agents *Use Select Oncology Agents PA form*	Prior authorization (PA) is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the PA request: copies of medical records (i.e. diagnostic evaluations and recent chart notes), location of treatment (provider office, facility, home health, etc.) if medication requested is not an oral agent, the original prescription, and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.
Select Topical Psoriasis Agents *Use Select Topical Psoriasis Agents PA form*	Prior authorization (PA) is required for select topical psoriasis agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and 3. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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 10/01/2023

Selected Brand Name Drugs *Use Selected Brand Name PA forms*	Prior authorization (PA) is required for selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For PA to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with: 1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available. 2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval. Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

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Updated 10/01/2023

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

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 10/01/2023

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

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 10/01/2023

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):

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 10/01/2023

Use Testosterone Products PA form	a. Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following: • 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.

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 10/01/2023

Topical Acne and Rosacea Products *Use Topical Acne and Rosacea Products PA form*	Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Documentation of diagnosis; and 3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and 4. Payment for non-preferred topical antibiotic or topical retinoid acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and 5. Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and 6. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent; and 7. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and 8. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and 9. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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 10/01/2023

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 10/01/2023

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 10/01/2023

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

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

Updated 10/01/2023

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:

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 10/01/2023

Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form	1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS). <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 10/01/2023

Viloxazine (Qelbree) *Use Viloxazine (Qelbree) PA form*	Prior authorization is required for viloxazine (Qelbree). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and 3. Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational) and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine or a preferred stimulant; and 5. Dose does not exceed 400 mg per day for pediatric patients (< 18 years of age) and 600 mg per day for adult patients; and 6. Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Vitamins, Minerals and Multiple Vitamins *Use Vitamin/Mineral PA form*	Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)
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 10/01/2023

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.

Odevixibat (Bylvay)
Initial Review

Background

Odevixibat (Bylvay) recently received U.S. Food and Drug Administration (FDA) approval for the treatment of cholestatic pruritus in patients 12 months of age and older with Alagille syndrome (ALGS). Bylvay is the second drug to receive this indication. Maralixibat (Livmarli) received FDA approval for ALGS in 2021. Bylvay is also indicated for the treatment of pruritus in patients 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC). Dosing for Bylvay varies by indication, age, and weight.

Prior authorization (PA) criteria are being updated to add the new indication, mirroring the criteria for maralixibat.

Clinical Trials

The efficacy of Bylvay was evaluated in a 24-week, randomized, double-blind, placebo-controlled trial in 52 pediatric patients, aged 6 months to 15 years, with a confirmed diagnosis of ALGS and presence of pruritus at baseline. Patients were randomized to placebo or Bylvay. A single-item observer-reported outcome (ObsRO) was used to measure patients' scratching severity as observed by their caregiver twice daily (once in the morning and once in the evening). Scratching severity was assessed on a 5-point ordinal response scale, with scores ranging from 0 (no scratching) to 4 (worst possible scratching).

- The mean change from baseline in scratching score at month 6 was -0.8 with placebo vs. -1.7 with Bylvay (treatment difference -0.9, 95% CI: -1.4, -0.3; p = 0.002).

Current Clinical Prior Authorization

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.

Proposed Clinical Prior Authorization (changes highlighted, italicized and/or stricken)
Prior authorization (PA) is required for odevixibat (Bylvay). Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and
2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and
    a. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and
    b. Patient has moderate to severe pruritis associated with PFIC; ~~and~~ *or*
3. *Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAG1 or NOTCH2 mutation or deletion; and*
    a. *Patient has cholestasis with moderate to severe pruritis; and*
    b. *Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:*
        i. *Ursodeoxycholic acid (ursodiol)*
        ii. *Cholestyramine*
        iii. *Rifampin; and*
4. Patient's current weight in kg is provided; and
5. Is prescribed by or in consultation with a hepatologist*,* ~~or~~ gastroenterologist*, or a prescriber who specializes in PFIC or ALGS*.

Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met:

1. Patient's current weight in kg is provided; and
2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.

References

Bylvay [package insert]. Boston, MA: Albireo Pharma, Inc; June 2023

Oral Constipation Agents
Initial Review

Background

Linaclotide (Linzess) recently received U.S. Food and Drug Administration (FDA) approval for the treatment of functional constipation (FC) in pediatric patients 6 to 17 years of age. The recommended dose for the treatment of FC in pediatric patients is 72 mcg orally once daily.

Clinical trials for treatment of functional constipation used Rome III diagnostic criteria. Criteria for a child with a developmental age ≥4 years with insufficient criteria for irritable bowel syndrome include:

1. ≤ 2 defecations in the toilet per week
2. At least one episode of fecal incontinence per week
3. History of retentive posturing or excessive volitional stool retention
4. History of painful or hard bowl movements
5. Presence of a large fecal mass in the rectum
6. History of large-diameter stools that may obstruct the toilet.

Diagnosis is confirmed when criteria occur at least once per week for at least 2 months.

Polyethylene glycol (PEG) 3350 is first-line treatment for functional constipation in children. Lactulose can be used as a first-line treatment if PEG is not available. Use of milk of magnesia, mineral oil, and stimulant laxatives may be considered as an additional or second-line treatment.

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

Clinical Trials

The efficacy of Linzess in FC was evaluated in a randomized, double-blind, placebo-controlled study in 328 pediatric patients 6 to 17 years of age with FC. For trial enrollment, Rome III criteria for child/adolescent FC were modified to require patients have less than 3 spontaneous bowel movements (SBMs) per week (defined as a BM that occurred in the absence of laxative, enema, or suppository use on the calendar day of or before the BM) and 1 or more of the following criteria at least once per week for at least 2 months before the screening visit:

- History of stool withholding or excessive voluntary stool retention
- History of painful or hard bowel movements
- History of large diameter stools that may obstruct the toilet
- Presence of a large fecal mass in the rectum
- At least 1 episode of fecal incontinence per week

Patients were allowed to continue previously stable dose of bulk laxatives, fiber, stool softeners, or probiotics. During the trial, patients could use bisacodyl or senna as needed, but were not allowed to take other laxatives, bismuth, prokinetic agents, or other drugs to treat FC.

Patients received Linzess or placebo. The primary endpoint was the 12-week change from baseline in SBM frequency rate.

- The least squares 12-week mean change from baseline in SBM frequency rate was 2.6 with Linzess and 1.3 with placebo (treatment difference 1.3, 95% CI: 0.7, 1.8).

Current Clinical Prior Authorization

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
    c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic)
        i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
        ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
            1. Hard to very hard stool consistency;

2. Moderate to very severe straining; and/or
3. Having a sensation of incomplete evacuation

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.

Proposed Clinical Prior Authorization (changes highlighted, italicized and/or stricken)
Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met* ~~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 meets the FDA approved age~~; and
2. Patient must have documentation of adequate trials and therapy failures with ~~both of~~ the following:
    a. *Members 18 years of age or older:*
        i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
        ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); *or* ~~and~~
    b. *Members 17 years of age or younger:*
        i. *Polyethylene glycol; and*
        ii. *One other preferred generic laxative, such as lactulose or senna; and*
3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
4. Patient has one of the following diagnoses:
    a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance)
        i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and
        ii. Patient has two or more of the following symptoms within the last 3 months:
            1. Straining during at least 25% of bowel movements; ~~and~~
            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; or
    b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, Ibsrela, Linzess, or Trulance)
        i. Patient is female (Amitiza only); and
        ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following:
            1. Related to defecation;
            2. Associated with a change in stool frequency; ~~and/or~~

3. Associated with a change in stool form; *or*

c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic)
    i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
    ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
        1. Hard to very hard stool consistency;
        2. Moderate to very severe straining; ~~and/or~~
        3. Having a sensation of incomplete evacuation; *or*

d. *A diagnosis of functional constipation (Linzess)*
    i. *Patient has less than 3 SBMs per week; and 1 or more of the following criteria at least once per week for at least 2 months:*
        1. *History of stool withholding or excessive voluntary stool retention;*
        2. *History of painful or hard bowel movements;*
        3. *History of large diameter stools that may obstruct the toilet;*
        4. *Presence of a large fecal mass in the rectum;*
        5. *At least 1 episode of fecal incontinence per week.*

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment *and patient continues to meet the age for indication*.

References

Linzess [package insert]. North Chicago, Il, AbbVie, Inc; June 2023

Tabbers MM, DiLorenzo C, Berger MY, et al: Evaluation and treatment of functional constipation in infants and children: evidence-based recommendations from ESPGHAN and NASPGHAN. J Pediatr Gastroenterol Nutr 2014; 58(2):258-274.
https://www.naspghan.org/files/documents/pdfs/cme/jpgn/Evaluation_and_Treatment_of_Functional.24.pdf

Oral Immunotherapy
Initial Review

Background

Odactra is an allergen extract indicated as immunotherapy for the treatment of house dust mite (HDM) induced allergic rhinitis, with or without conjunctivitis, confirmed by positive *in vitro* testing for IgE antibodies to *Dematophagoides* farina or *Dermatophagoides pteronyssinus* house dust mites or by positive skin testing to licensed house dust mite allergen extracts. Odactra was initially approved by the U.S. Food and Drug Administration (FDA) in 2017 but the manufacturer did not participate in the federal Medicaid Drug Rebate Program (MDRP) until mid-2023.

See attached drug review for additional clinical information.

Since the development of prior authorization (PA) criteria for sublingual allergen immunotherapy (SLIT), there have been several updates to the labels of several drugs, including age and dosing. Grastek and Ragwitek, manufactured by the same company as Odactra, have not been payable due to the manufacturer not participating in the MDRP program, therefore, criteria have not been updated in the interim. Grastek dosing has been updated to allow for daily dosing for three consecutive years (including the interval between the grass pollen seasons). Additionally, the FDA approved age for use has changed. Grastek, Oralair, and Ragwitek are now approved for use in persons 5 through 65 years of age.

PA criteria are being updated to add criteria specific to Odactra and modify criteria for the other agents based on changes to the FDA approved label.

Cost

- WAC $11.57 per tablet; $347.10 per month; 44,165.20 per 12 months

Current Clinical Prior Authorization

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:

1. Medication is prescribed by 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.

Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:

- Patient is 18 through 65 years of age; and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.
- If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

Grass Pollen (Grastek® and Oralair®) In addition to the above criteria being met:

- Patient is 10 through 65 years of age (Oralair®); and
- 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.
- 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; or
- Patient is 5 through 65 years of age (Grastek®); and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).
- If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of each grass pollen season.

Proposed Clinical Prior Authorization (changes italicized/highlighted and/or stricken)
Prior authorization is required for sublingual allergen immunotherapy. 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 & precautions, drug interactions, and use in specific populations; and*
2. Medication is prescribed by *or in consultation with* an allergist *or immunologist*; and
3. ~~Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and~~
4. *Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and* ~~Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and~~
5. Patient has a documented intolerance to immunotherapy injections; and
6. 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).

7. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.

Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:

~~1. Patient is 18 through 65 years of age; and~~

2. *Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; and*
3. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to short ragweed pollen.
4. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

Grass Pollen (Grastek® and Oralair®) In addition to the above criteria being met:

1. *Request is for* ~~Patient is 10 through 65 years of age (~~Oralair®~~)~~; and
    a. *Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and*
    b. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.
    c. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season; or
2. *Request is for* ~~Patient is 5 through 65 year of age (~~Grastek®~~)~~; and
    a. *Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and*
    a. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).
    b. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ~~each~~ grass pollen season *as follows:*
        - *Seasonally, through the end of the grass pollen season or*
        - *For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season .*

House Dust Mite (Odactra®)

1. *Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, and*
2. *Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farina or Dermatophagoids pteronyssinus house dust mites; and*
3. *If criteria for coverage are met, authorization will be considered for 12 months.*

References

Grastek [package insert]. Hørsholm, Denmark: ALK-Abelló A/S: December 2019.
Odactra [package insert]. Hørsholm, Denmark: ALK-Abelló A/S: January 2023.
Ragwitek [package insert]. Hørsholm, Denmark: ALK-Abelló A/S: April 2021.

Iowa Medicaid
IOWA HHS

PDL DRUG REVIEW

Proprietary Name: Odactra®
Common Name: dermatophagoides pteronyssinus & dermatophagoides farinae
PDL Category: Allergenic Extracts

Summary

Pharmacology/Usage: Odactra® tablets contain house dust mite allergen extract from *Dermatophagoides farinae* and *Dermatophagoides pteronyssinus*. The precise mechanisms of action of allergen immunotherapy have not been fully established.

Indication: An allergen extract indicated as immunotherapy for the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive *in vitro* testing for IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites, or by positive skin testing to licensed house dust mite allergen extracts. Odactra® is approved for use in persons 12 through 65 years of age. Note that Odactra® is not indicated for the immediate relief of allergic symptoms.

There is no pregnancy category for this medication; however, the risk summary indicates that available data on Odactra® administered to pregnant women are not sufficient to inform associated risks in pregnancy. In an embryo/fetal developmental toxicity study in mice, administration of Odactra® during gestation did not reveal adverse developmental outcomes in fetuses. The safety and efficacy of use have not been established in the pediatric population younger than 12 years of age. The safety and efficacy have not been established in persons older than 65 years of age.

Dosage Form: Tablets of 12 SQ-HDM (6 SQ-HDM *D. farinae* and 6 SQ-HDM *D. pteronyssinus*). Each tablet contains a 1:1:1:1 potency ratio of *D. farinae* group 1 allergen, *D. farinae* group 2 allergen, *D. pteronyssinus* group 1 allergen, and *D. pteronyssinus* group 2 allergen.

SQ-HDM is the dose unit for Odactra®. SQ is a method of standardization of biological potency, major allergen content and complexity of the allergen extract. HDM is an abbreviation for house dust mite.

Recommended Dosage: For sublingual (SL) use only. One tablet daily.

Administer the first dose of Odactra® in a healthcare setting under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. After receiving the first dose of Odactra®, observe the patient for at least 30 minutes to monitor for signs or symptoms of a severe systemic or a severe local allergic reaction. If the patient tolerates the first dose, the patient may take subsequent doses at home. The patient should administer Odactra® as follows:

- Take the tablet from the blister unit after carefully removing the foil with dry hands.
- Place the tablet immediately under the tongue where it will dissolve within 10 seconds. Do not swallow for at least 1 minute.
- Wash hands after handling the tablet.

- Do not take the tablet with food or beverage. Food or beverage should not be taken for 5 minutes after taking the tablet.

Data regarding the safety of restarting treatment after missing a dose are limited. In the clinical studies, treatment interruptions for up to 7 days were allowed.

Prescribe auto-injectable epinephrine to patients prescribed Odactra® and instruct patients (or their parents/guardians) in the proper use of auto-injectable epinephrine.

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

Box Warning: Odactra® has a box warning regarding severe allergic reactions. Odactra® can cause life-threatening allergic reactions such as anaphylaxis and severe laryngopharyngeal restriction. Do not administer Odactra® to patients with severe, unstable or uncontrolled asthma. Observe patients in the office for at least 30 minutes following the initial dose. Prescribe auto-injectable epinephrine, instruct and train patients or parents/guardians on its appropriate use, and instruct patients or parents/guardians to seek immediate medical care upon its use. Odactra® may not be suitable for patients with certain underlying medical conditions that may reduce their ability to survive a serious allergic reaction. Odactra® may not be suitable for patients who may be unresponsive to epinephrine or inhaled bronchodilators, such as those taking beta-blockers.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Odactra®) minus reported % incidence for placebo of any intensity for adults. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included itching in the ear (40%), itching in the mouth (47.2%), swelling of the uvula/back of the mouth (17.4%), swelling of the lips (15.3%), swelling of the tongue (13.7%), nausea (7.1%), tongue pain (11.2%), tongue ulcer/sore on the tongue (9.5%), stomach pain (6.1%), mouth ulcer/sore in the mouth (7.4%), diarrhea (3.3%), vomiting (1.1%), taste alteration/food tastes different (6.4%), throat irritation/tickle (46.2%), and throat swelling (11.2%).

Listed % incidence for adverse drug reactions= reported % incidence for drug (Odactra®) minus reported % incidence for placebo for adolescents 12 through 17 years of age. Please note that an incidence of 0% means the incidence was the same as or less than placebo. The most frequently reported adverse events included itching in the ear (38.4%), itching in the mouth (58.7%), tongue pain (20.3%), stomach pain (7.6%), swelling of the uvula/back of the mouth (17%), swelling of the lips (19.1%), swelling of the tongue (15.9%), nausea (7.5%), tongue ulcer/sore on the tongue (8.6%), mouth ulcer/sore in the mouth (7.4%), diarrhea (5.6%), vomiting (4.3%), taste alteration/food tastes different (0.1%), throat irritation/tickle (37.6%), and throat swelling (9.7%).

Odactra® can cause systemic allergic reactions including anaphylaxis which may be life-threatening. In addition, Odactra® can cause severe local reactions, including laryngopharyngeal swelling, which can compromise breathing and be life-threatening. Refer to the box warning for additional information.

Odactra® can cause local reactions in the mouth or throat that could compromise the upper airway. Consider discontinuation in patients who experience persistent and escalating adverse reactions in the mouth or throat.

Eosinophilic esophagitis has been reported in association with sublingual tablet immunotherapy. Discontinue Odactra® and consider a diagnosis of eosinophilic esophagitis in patients who experienced severe or persistent gastroesophageal symptoms including dysphagia or chest pain.

Withhold immunotherapy with Odactra® if the patient is experiencing an acute asthma exacerbation. Re-evaluate patients who have recurrent asthma exacerbations and consider discontinuation of Odactra®.

Odactra® has not been studied in subjects who are receiving concomitant allergen immunotherapy. Concomitant dosing with other allergen immunotherapy may increase the chance of local or systemic adverse reactions to either subcutaneous or sublingual allergen immunotherapy.

Stop treatment with Odactra® to allow complete healing of the oral cavity in patients with oral inflammation (e.g., oral lichen planus, mouth ulcers, or thrush) or oral wounds, such as those following oral surgery or dental extraction.

Contraindications: In patients with:

- Severe, unstable or uncontrolled asthma
- A history of any severe systemic allergic reaction
- A history of any severe local reaction after taking any sublingual allergen immunotherapy
- A history of eosinophilic esophagitis
- Hypersensitivity to any of the inactive ingredients contained in this product.

Manufacturer: ALK-Abello A/S.

Analysis: The efficacy of Odactra® for the treatment of HDM-induced allergic rhinitis was investigated in two double-blind, placebo-controlled, randomized, clinical field efficacy studies (Studies 1 and 2) and one environmental exposure chamber (EEC) study.

Study 1 (North American Field Efficacy Study) was a double-blind, placebo-controlled, randomized field efficacy study conducted in the US and Canada for a duration of up to 12 months that compared the efficacy of Odactra® (N=741) with placebo (N=741) in the treatment of HDM-induced allergic rhinitis in adults and adolescents. Subjects aged 12 through 85 years of age were enrolled if they had a history of symptomatic allergic rhinitis (AR) and were sensitized to *D. farinae* and/or *D. pteronyssinus* as determined by house dust mite specific IgE. Subjects were required to be symptomatic and were not taking symptom-relieving allergy medications at enrollment. In addition, subjects with mild to moderate asthma, defined as asthma of a severity that required, at most, a daily medium dose of an inhaled corticosteroid, were enrolled in the study. In the study, 31% of subjects had asthma, 48% had conjunctivitis, and 76% were polysensitized to other allergens in addition to HDM, including trees, grasses, weed, animal danders, and molds. Furthermore, 76% were white, 59% were female, and the mean age of subjects was 35 years.

The efficacy of Odactra® was assessed through self-reporting of symptoms and medication use. Based on these self-assessments, the Total Combined Rhinitis Score (TCRS), daily symptom scores (DSS), and daily medication scores (DMS) for rhinoconjunctivitis were calculated. Daily symptoms included 4 nasal symptoms (runny nose, stuffy nose, sneezing, and itchy nose) and two ocular symptoms (gritty/itchy eyes and watery eyes). Each of these rhinoconjunctivitis symptoms was individually graded by subjects daily on a scale of 0 (none) to 3 (severe) and then summed. Subjects were allowed to take symptom-relieving allergy medications (including oral and ocular antihistamines and nasal corticosteroids) during the study as needed. The DMS measured the use of these standard symptom-relieving allergy medications. Predefined daily maximum scores were assigned to each class of rhinitis and conjunctivitis medication as 0=none, 6=oral antihistamine, 6=ocular antihistamine, and 8=nasal corticosteroid.

The primary efficacy endpoint was the difference between the treatment and placebo groups in the average TCRS during approximately the last 8 weeks of treatment. The TCRS represents the sum of the daily rhinitis DSS and the rhinitis DMS. Other secondary endpoints in this study included the average rhinitis DSS, the average rhinitis DMS, and the Total Combined Score (TCS). The TCS represents the sum of the rhinoconjunctivitis DSS and the rhinoconjunctivitis DMS, which was then averaged during about the last 8 weeks of treatment.

Subjects were required to stop taking symptom-relieving allergy medication during the baseline period. The mean rhinitis DSS at baseline was 7.94 out of 12 total points in both the treatment arm and placebo arm. Results of this study are presented in the table below, which was adapted from the prescribing information. Note that consistent results across age groups were observed, supporting a similar treatment effect in adolescent and adult subgroups.

Endpoint	Odactra® score (N=566)	Placebo score (N=620)	Treatment difference	Difference relative to placebo, estimate
Primary Endpoint				
TCRS *	4.10	4.95	-0.80	-17.2%
Secondary Endpoints				
Rhinitis DSS	3.55	4.20	-0.60	-15.5%

Endpoint	Odactra® score (N=566)	Placebo score (N=620)	Treatment difference	Difference relative to placebo, estimate
Rhinitis DMS	0.65	0.79	-0.15	-18.4%
TCS *	5.50	6.60	-1.10	-16.7%

*TCRS=Total Combined Rhinitis Score (rhinitis DSS + rhinitis DMS); TCS-Total Combined Score (rhinoconjunctivitis DSS + rhinoconjunctivitis DMS)

Study 2 (European Field Efficacy Study) was a double-blind, placebo-controlled, randomized field efficacy study that assessed adult subjects 18 through 66 years of age who were randomized to Odactra® (N=318) or placebo (N=338) for a duration of about 12 months. Subjects in this study had a history of symptomatic allergic rhinitis when exposed to house dust and were sensitized to *D. farinae* and/or *D. pteronyssinus* as determined by house dust mite specific IgE testing. At study entry, subjects were required to be symptomatic despite taking symptom-relieving allergy medications during the baseline period. In this study, 46% of subjects had asthma, 97% had conjunctivitis, and 67% were polysensitized to other allergens in addition to HDM, including trees, grass, weeds, animal danders, and molds. The study population was mainly white (98%), 50% were female, and the mean age of subjects was 32 years.

The primary efficacy endpoint was the difference relative to placebo in the average TCRS during the last 8 weeks of treatment. The mean Rhinitis DSS at baseline was 7.95 out of 12 for the treatment arm and 8.00 out of 12 total points for the placebo arm. Results are presented in the table below, which was adapted from the prescribing information.

Endpoint	Odactra® score (n)	Placebo score (n)	Treatment difference	Difference relative to placebo, estimate
Primary Endpoint				
TCRS	(318) 5.71	(338) 6.81	-1.09	-16.1%
Secondary Endpoints				
Rhinitis DSS	(318) 2.84	(338) 3.31	-0.47	-14.1%
Rhinitis DMS	(318) 2.32	(338) 2.86	-0.54	-18.9%
TCS	(241) 7.91	(257) 9.12	-1.21	-13.2%

Note that subjects from Serbia and Croatia were excluded from the analysis of TCS because the preferred formulations of antihistamine eyedrops were not available in these countries at the time the study was conducted. The TCS analysis is based on the full analysis set (FAS). All available data used to its full extent (i.e. subjects who provided data during the efficacy assessment period).

Study 3 (EEC Study) was a double-blind, placebo-controlled, randomized EEC study that included adult subjects 18 through 58 years of age who were randomized to Odactra® (N=42) or placebo (N=41) for about 24 weeks. Subjects had a history of symptomatic allergic rhinitis and were sensitized to *D. farinae* and/or *D. pteronyssinus* as determined by HDM specific IgE. In this study, 23% of subjects had asthma, 87% had conjunctivitis, and 84% were polysensitized to other allergens in addition to HDM, including tree, grass, weed, animal danders, and molds. The subject population was 90% White, while 43% were female, and the mean age of subjects was 27 years.

The primary endpoint was the difference relative to placebo in the average TNSS at week 24. The Total Nasal Symptom Score (TNSS) represents the sum of 4 nasal symptoms (runny nose, stuffy nose, sneezing, and itchy nose). Secondary endpoints were the differences relative to placebo in the average TNSS at weeks 8 and 16 and average Total Symptom Score (TSS) at week 24, which represents the sum of TNSS plus 2 ocular symptoms (gritty/itchy eyes and watery eyes). Baseline TNSS following house dust mite EEC challenge prior to treatment was 7.74 out of

12 total points for Odactra® and 7.32 out of 12 total points for placebo. Results are presented in the table below, which was adapted from the prescribing information.

Endpoint	Odactra® score (n)	Placebo score (n)	Treatment difference	Difference relative to placebo, estimate
Primary Endpoint				
TNSS- week 24	(36) 3.83	(34) 7.45	-3.62	-48.6%
Secondary Endpoints				
TNSS- week 8	(40) 5.34	(39) 6.71	-1.37	-20.4%
TNSS- week 16	(39) 4.82	(38) 6.90	-2.08	-30.1%
TSS- week 24	(36) 4.43	(34) 9.27	-4.84	-52.2%

Place in Therapy: Odactra® is an allergen extract indicated as immunotherapy for the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive *in vitro* testing for IgE antibodies to *D. farinae* or *D. pteronyssinus* house dust mites, or by positive skin testing to licensed house dust mite allergen extracts. Odactra® is approved for use in persons 12 through 65 years of age. Note that Odactra® is not indicated for the immediate relief of allergic symptoms. It has a box warning regarding risk of severe allergic reactions. Patients must be observed in the office for at least 30 minutes following the initial dose and patients must be prescribed auto-injectable epinephrine.

The efficacy of Odactra® for the treatment of HDM-induced allergic rhinitis was assessed in two double-blind, placebo-controlled, randomized clinical field efficacy studies (Study 1 and 2) and one environmental exposure chamber (EEC) study. The primary efficacy endpoint for Study 1 and 2 was the difference between treatment and placebo groups in the average TCRS during about the last 8 weeks of treatment. The difference relative to placebo (estimate) was -17.2% in Study 1 and -16.1% in Study 2.The primary endpoint in Study 3 was the difference relative to placebo in the average TNSS at week 24; the difference relative to placebo (estimate) in this study was -48.6%. Per the full-text of study 1 by Nolte et al[2], there was a significantly lower average TCRS with 12 SQ-HDM as compared to placebo ($p<0.001$).

It is recommended that Odactra® should be non-preferred in order to confirm the appropriate diagnosis and clinical parameters for use.

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

References

[1] Odactra [package insert]. Horsholm, Denmark: ALK-Abello A/S; 2023.
[2] Nolte H, Bernstein DI, Nelson HS, et al. Efficacy of house dust mite sublingual immunotherapy tablet in North American adolescents and adults in a randomized, placebo-controlled trial. *J Allergy Clin Immunol*. 2016; 138(6): 1631-1638.

Vesicular Monoamine Transporter (VMAT) 2 Inhibitors
Initial Review

Background

Valbenazine (Ingrezza) recently received US Food and Drug Administration (FDA) approval for the treatment of adults with chorea associated with Huntington's disease. In addition to the new indication, the drug label for Ingrezza was updated to include a warning and precaution for depression and suicidal ideation and behavior in patients with Huntington's disease (boxed warning), and neuroleptic malignant syndrome. Additionally, a new formulation for Austedo was approved. Austedo XR, a once-daily, extended-release formulation approved for the same indications as the twice-daily formulation.

Prior authorization (PA) criteria are being updated to add Ingrezza to the current criteria for chorea associated with Huntington's disease and adding language regarding the FDA approved label, allowing removal of dosing and contraindications to the specific drug(s).

Clinical Trials

The approval of Ingrezza for the new indication was based on a randomized, double-blind, placebo-controlled study in 125 patients with Huntington's disease. The primary endpoint was the change from baseline to the end of the treatment period (average of week 10 and week 12) in the Total Maximal Chorea score of the Unified Huntington's Disease Rating Scale (UHDRS). The Total Maximal Chorea score is rated from 0 to 4 (with 0 representing no chorea) for 7 different parts of the body, with a total score ranging from 0 to 28.

- The mean change in Total Maximal Chorea scores for patients receiving Ingrezza improved by 4.6 units (least-squares mean) from baseline to the end of the treatment period (average of week 10 and week 12), compared to 1.4 units in the placebo group (placebo-subtracted difference 3.2, 95% CI: -4.4, -2.0; $p < 0.0001$).

Current Clinical Prior Authorization Criteria

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
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.

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

Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered *when the patient has an FDA approved or compendia indication for the requested drug* under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations; and*
2. *Will not be used concurrently with other vesicular monoamine transporter 2 (VMAT2) inhibitors; and*
3. Prescribed by or in consultation with a neurologist, ~~or~~ psychiatrist*, psychiatric nurse practitioner, or psychiatric physician assistant*; *and*

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
2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS)~~.~~*; or*

Chorea associated with Huntington's disease (Austedo*, Ingrezza* or tetrabenazine)

1. ~~Patient 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.

References

Austedo [package insert]. Parsippany, NJ: Teva Neuroscience, Inc; February 2023
Ingrezza [package insert]. San Diego, CA: Neurocrine Biosciences, Inc; August 2023

Antidepressants
Second Review

Background
Dextromethorphan and bupropion extended-release tablet (Auvelity) was approved by the U.S. Food and Drug Administration (FDA) for the treatment of major depressive disorder (MDD) in adults. Prior authorization (PA) criteria are being updated to add criteria specific to Auvelity and add additional preferred antidepressant trials now that several other agents are more cost-effective since PA criteria were initially developed.

See attached new drug review for additional clinical information.

Cost
- WAC $17.47/tablet; $1,048.20/ month; $12,578.70/year

Current Clinical Prior Authorization Criteria
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.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized or stricken)
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 *when patient has an FDA approved or compendia indication for the requested drug* ~~for patients~~ 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. ~~The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age~~

~~or older; and~~

3. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and
4. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and
5. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant*; and*
6. *Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and*
7. *Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and*
8. *Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and*
9. *If the request is for dextromethorphan and bupropion extended-release tablet (Auvelity), one of the trials must include a previous trial and inadequate response at a therapeutic dose with an extended-release bupropion agent; and*
10. If the request is for an isomer, prodrug or metabolite of ~~a~~ *the requested* 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.

Other Items to Consider

- Quantity limit – 60 tablets per 30 days
- Age edit (Auvelity) – 18 years old (should a recommendation be made to implement ProDUR age edits on antidepressants)

References

Auvelity [package insert]. New York, NY: Axsome Therapeutics, Inc; December 2022.

Iowa Medicaid
IOWA HHS

PDL DRUG REVIEW

Proprietary Name: Auvelity®
Common Name: dextromethorphan hydrobromide, bupropion HCl, multilayer, ER
PDL Category: Antidepressants

Comparable Products	Preferred Drug List Status
Buproprion	Preferred
SNRIs	Preferred
SSRIs	Preferred

Summary

Pharmacology/Usage: Auvelity® is a combination of dextromethorphan hydrobromide (an uncompetitive NMDA receptor antagonist and sigma 1 receptor agonist) and bupropion HCl (an aminoketone and CYP450 2D6 inhibitor).

The mechanism of dextromethorphan in the treatment of MDD is unclear. The mechanism of action of bupropion in the treatment of MDD is unclear; however, it may be related to noradrenergic and/or dopaminergic reuptake mechanisms. Bupropion increases plasma levels of dextromethorphan by competitively inhibiting CYP2D6, which catalyzes a major biotransformation pathway for dextromethorphan. Bupropion is a relatively weak inhibitor of the neuronal reuptake of norepinephrine and dopamine and does not inhibit monoamine oxidase or the reuptake of serotonin.

Indication: For the treatment of major depressive disorder (MDD) in adults.

There is no pregnancy category for this medication; however, the risk summary indicates that based on animal studies, Auvelity® may cause fetal harm when administered during pregnancy. Auvelity® is not recommended during pregnancy. If a female becomes pregnant while being treated with Auvelity®, discontinue treatment and counsel the patient about the potential risk to a fetus. There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to antidepressants, including Auvelity®, during pregnancy. Healthcare providers are encouraged to register patients by contacting the National Pregnancy Registry for Antidepressants at 1-866-961-2388 or online at https://womensmentalhealth.org/research/pregnancyregistry/antidepressants. There are risks to the mother associated with untreated depression in pregnancy. The safety and efficacy of use in the pediatric population have not been established.

Dosage Form: Extended-release Tablets: 45mg dextromethorphan hydrobromide & 105mg bupropion HCl. Swallow tablets whole, do not crush, divide, or chew.

Each tablet contains 45mg dextromethorphan in an immediate-release formulation and 105mg bupropion in an extended-release formulation.

Recommended Dosage: Prior to initiating and during treatment with Auvelity®:

- Assess blood pressure and monitor periodically during treatment.
- Screen patients for a personal or family history of bipolar disorder, mania, or hypomania.
- Screen patients to determine if they are receiving any other medications that contain bupropion or dextromethorphan.

The recommended starting dosage of Auvelity® is one tablet QAM. After 3 days, increase to the maximum recommended dosage of one tablet BID, given at least 8 hours apart. Do not exceed two doses within the same day. Administer with or without food.

The recommended dosage for patients known to be poor CYP2D6 metabolizers is one tablet QAM.

The recommended dosage in patients with moderate renal impairment (eGFR 30 to 59ml/min/1.73m^2) is one tablet QAM. Auvelity® is not recommended in patients with severe renal impairment. Dose adjustment is not recommended in patients with mild or moderate hepatic impairment; however, use is not recommended in patients with severe hepatic impairment.

Drug Interactions: Auvelity® is contraindicated in patients taking MAO inhibitors or in patients who have taken MAO inhibitors within the preceding 14 days. Allow at least 14 days after stopping Auvelity® before starting an MAO inhibitor.

Concomitant use of Auvelity® with other serotonergic drugs increases the risk of serotonin syndrome. Monitor for symptoms of serotonin syndrome when Auvelity® is used concomitantly with other drugs that may affect the serotonergic neurotransmitter systems.

Use caution when administering Auvelity® concomitantly with drugs that lower the seizure threshold. Discontinue Auvelity® and do not restart treatment if the patient experiences a seizure.

Dosage adjustment is necessary when Auvelity® is co-administered with strong inhibitors of CYP2D6. The recommended dosage of Auvelity® when co-administered with strong CYP2D6 inhibitors is one tablet QAM. Monitor patients for adverse reactions potentially attributable to dextromethorphan, such as somnolence or dizziness.

Avoid the co-administration of Auvelity® with strong inducers of CYP2B6. Consider alternatives to strong CYP2B6 inducers if needed.

When using Auvelity® concomitantly with CYP2D6 substrates, it may be necessary to decrease the dose of CYP2D6 substates, particularly for drugs with a narrow therapeutic index. Patients treated concomitantly with Auvelity® may require increased doses of drugs that require activation by CYP2D6 to be effective.

Monitor plasma digoxin levels in patients treated concomitantly with Auvelity® and digoxin.

Use caution when administering Auvelity® concomitantly with dopaminergic drugs.

Consumption of alcohol should be minimized or avoided during treatment with Auvelity®.

False-positive urine immunoassay screening tests for amphetamines have been reported in patients taking bupropion. This is due to the lack of specificity of some screening tests. False positive test results may result even following discontinuation of bupropion therapy. Confirmatory tests will distinguish bupropion from amphetamines.

Box Warning: Auvelity® has a box warning regarding suicidal thoughts and behaviors. Antidepressants increased the risk of suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and emergence of suicidal thoughts and behaviors. Auvelity® is not approved for use in pediatric patients.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Auvelity®) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included dizziness (10%), nausea (4%), headache (4%), diarrhea (4%), somnolence (4%), dry mouth (4%), sexual dysfunction (6%), hyperhidrosis (5%), anxiety (3%), constipation (2%), decreased appetite (3%), insomnia (2%), arthralgia (3%), fatigue (1%), paresthesia (3%), and blurred vision (3%).

Bupropion can cause seizures. The risk of seizure with bupropion is dose-related. Because the risk of seizure with bupropion is dose-related, screen patients for use of other bupropion-containing products prior to starting Auvelity®. If concomitant use of Auvelity® with other bupropion-containing products is clinically warranted, inform patients of the risk. Discontinue Auvelity® and do not restart treatment if the patient experiences a seizure.

Bupropion can cause elevated blood pressure and hypertension. The risk of hypertension is increased if Auvelity® is used concomitantly with MAO inhibitors or other drugs that increase dopaminergic or noradrenergic activity. Assess blood pressure prior to starting treatment, and periodically monitor blood pressure during treatment with Auvelity®.

Antidepressant treatment can precipitate a manic, mixed, or hypomanic manic episode. The risk appears to be increased in patients with bipolar disorder or who have risk factors for bipolar disorder. Screen patients for a history of bipolar disorder and the presence of risk factors for bipolar disorder prior to starting treatment. Auvelity® is not approved for use in treating bipolar depression.

Depressed patients treated with bupropion have had a variety of neuropsychiatric signs and symptoms. Some of these patients had a diagnosis of bipolar disorder. Dextromethorphan overdose can cause toxic psychosis, stupor, coma, and hyperexcitability. Because the risks of neuropsychiatric reactions are dose-related, screen patients for use of other bupropion- or dextromethorphan-containing products prior to starting Auvelity®.

The pupillary dilation that occurs after the use of many antidepressants, including bupropion, may trigger an angle closure attack in a patient with anatomically narrow angles who does not have a patent iridectomy. Avoid use of antidepressants, including Auvelity®, in patients with untreated anatomically narrow angles.

As Auvelity® may cause dizziness, take precautions to reduce the risks of falls, especially for patients with motor impairment affecting gait or those with a history of falls. Caution patients about operating hazardous machinery, including motor vehicles, until they are reasonably certain that Auvelity® therapy does not affect them adversely.

Concomitant use of Auvelity® with SSRIs or TCAs may cause serotonin syndrome. Prior to starting Auvelity®, screen patients for use of other dextromethorphan-containing products. If concomitant use of Auvelity® with other serotonergic drugs is clinically warranted, inform patients of the increased risk of serotonin syndrome and monitor for symptoms.

Contraindications: In patients:

- With a seizure disorder.
- With a current or prior diagnosis of bulimia or anorexia nervosa as a higher incidence of seizures was observed in such patients treated with the immediate-release formulation of bupropion.
- Undergoing abrupt discontinuation of alcohol, benzodiazepines, barbiturates, and antiepileptic drugs.
- Taking, or within 14 days of stopping, MAO inhibitors due to the risk of serious and possibly fatal drug interactions. Starting Auvelity® in a patient treated with reversible MAOIs such as linezolid and IV methylene blue is contraindicated.
- With known hypersensitivity to bupropion, dextromethorphan, or other components of the product.

Manufacturer: Axsome Therapeutics, Inc.

Analysis: The efficacy of Auvelity® for the treatment of MDD in adults was demonstrated in a placebo-controlled clinical study (Study 1) and confirmatory evidence included a second study comparing Auvelity® to bupropion HCl SR tablets (Study 2). In Study 1, adult patients (18 to 65 years of age) who met the DSM 5 criteria for MDD were randomized to Auvelity® (45mg of dextromethorphan and 105mg of bupropion) BID (N=156) or placebo BID (N=162) for 6 weeks. Patients in this study had a median age of 41 years, while 67% were female and 55% were Caucasian.

The primary outcome measure was the change from baseline to week 6 in the total score of the Montgomery-Asberg Depression Rating Scale (MADRS). The MADRS is a clinician-rated scale used to assess the severity of depressive symptoms. Patients are rated on 10 items to assess feelings of sadness, inner tension, reduced sleep or appetite, difficulty concentrating, lassitude, lack of interest, pessimism, and suicidality. Scores on the MADRS range from 0 to 60, with higher scores indicating more severe depression. Results suggested that Auvelity® was statistically significantly superior to placebo in improvement of depressive symptoms as measured by a decrease in MADRS total score at week 6. Results are presented in the table below, which was adapted from the prescribing information.

Study	Treatment	Mean Baseline Score	LS Mean Change from baseline	LS Mean difference
Study 1	Auvelity® (N=156)	33.6	-15.9	-3.9
	Placebo (N=162)	33.2	-12.1	

The change in MADRS total score from baseline to week 1 and from baseline to week 2 were pre-specified secondary efficacy endpoints. The difference between Auvelity® and placebo in change from baseline in MADRS total score was statistically significant at week 1 and week 2.

In Study 2, patients with MDD were randomized to receive Auvelity® or bupropion HCl SR tablets 105mg BID for 6 weeks. The primary outcome measure was calculated by assessing the change from baseline in total MADRS score at each on-site visit from week 1 to week 6 and then taking the average of those scores. The results of the study demonstrated that dextromethorphan contributes to the antidepressant properties of Auvelity®.

Place in Therapy: Auvelity® is a fixed-dose combination tablet consisting of dextromethorphan and bupropion indicated for the treatment of major depressive disorder (MDD) in adults. In a 6-week, placebo-controlled study that compared Auvelity® with placebo, Auvelity® was statistically significantly superior to placebo in improvement of depressive symptoms as measured by a decrease in MADRS total score at week 6. Per the manufacturer's website, "it's the first and only rapid-acting oral antidepressant labeled to start working at 1 week." In study 1, the difference between Auvelity® and placebo in change from baseline in MADRS total score was statistically significant at week 1 and at week 2. In addition, in a second study comparing Auvelity® with bupropion SR tablets, the results of the study demonstrated that dextromethorphan contributes to the antidepressant properties of Auvelity®. Per the full-text of study 2 by Tabuteau et al[3], the mean change from baseline in MADRS score over weeks 1-6 was significantly greater with dextromethorphan-bupropion 45mg/105mg BID than with bupropion 105mg BID (-13.7 points vs -8.8 points). In addition, the MADRS score change with dextromethorphan-bupropion was significantly greater than with bupropion at week 2 and every time point thereafter. Bupropion, the active comparator in study 2, dose is noted to have been administered in the low therapeutic range.

There is currently some evidence to suggest that Auvelity® may be more effective than bupropion monotherapy for the primary endpoint of mean change from baseline in MADRS score for weeks 1-6; however, there is no evidence at this time to support that Auvelity® is safer or more effective than the other currently preferred, more cost-effective medications, including using the combination of the individual components. The individual components of Auvelity® have been generically available for many years. There are no studies identified which directly compare Auvelity® to any other antidepressant, or that demonstrate the superiority of this agent over any other antidepressant. It is therefore recommended that Auvelity® 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 with Conditions**

References

[1] Auvelity [package insert]. New York, NY: Axsome Therapeutics, Inc; 2022.
[2] Auvelity. Website: https://www.auvelity.com/how-auvelity-may-help. Accessed February 2023.
[3] Tabuteau H, Jones A, Anderson A, et al. Effect of AXS-05 (dextromethorphan-bupropion) in major depressive disorder: A randomized, double-blind controlled trial. *Am J Psychiatry*. 2022; 179(9): 490-99.

Deucravacitinib (Sotyktu)
Second Review

Background

Deucravacitinib (Sotyktu) was approved by the U.S. Food and Drug Administration (FDA) for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. Deucravacitinib is also being studied for the treatment of psoriatic arthritis, systemic lupus erythematosus, alopecia areata, Crohn's disease, ulcerative colitis, and discoid lupus erythematosus.

Guidelines have not been updated to address deucravacitinib. Joint guidelines from the American Academy of Dermatology and National Psoriasis Foundation for the management and treatment of psoriasis with biologics were published in 2019. These guidelines list the biologics approved at the time of publication as agents that may be used as monotherapy for adults with moderate to severe plaque psoriasis. See attached new drug review for additional clinical information.

Cost - WAC $205.48/tablet; $ 6,164.40/30 days; $73,972.80/12 months

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of plaque psoriasis; and
    a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine is provided; and
    b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and
    c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant.

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

Other Items to Consider

- Quantity limit: 6 mg tablet – 30 tablets per 30 days

References

Sotyktu [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; 2022.

Iowa Medicaid
IOWA HHS

PDL DRUG REVIEW

Proprietary Name: Sotyktu®
Common Name: deucravacitinib
PDL Category: Anti-Psoriatics

Comparable Products	Preferred Drug List Status
Otezla	Preferred with Conditions
Taltz	Preferred with Conditions

Summary

Pharmacology/Usage: Deucravacitinib, the active ingredient of Sotyktu®, is a tyrosine kinase 2 (TYK2) inhibitor. TYK2 is a member of the Janus kinase (JAK) family. Deucravacitinib binds to the regulatory domain of TYK2, stabilizing an inhibitory interaction between the regulatory and the catalytic domains of the enzyme. This results in allosteric inhibition of receptor-mediated activation of TYK2 and its downstream activation of Signal Transducers and Activators of Transcription (STATs) as shown in cell-based assays. JAK kinases, including TYK2, function as pairs of homo- or heterodimers in the JAK-STAT pathways. TYK2 pairs with JAK1 to mediate multiple cytokine pathways and also pairs with JAK2 to transmit signals as shown in cell-based assays. The precise mechanism linking inhibition of TYK2 enzyme to therapeutic effectiveness for its approved indication is not currently known.

Indication: For the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. It is not recommended for use in combination with other potent immunosuppressants.

There is no pregnancy category for this medication; however, the risk summary indicates that available data from case reports on use during pregnancy are not sufficient to assess a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Report pregnancies to the Bristol-Myers Squibb Company's Adverse Event reporting line at 1-800-721-5072. The safety and efficacy of use in the pediatric population have not been established.

Dosage Form: Tablets: 6mg. Do not crush, cut, or chew.

Recommended Dosage: Assess patients for active and latent tuberculosis (TB) infection prior to starting treatment with Sotyktu®. If positive, start treatment for TB prior to Sotyktu® use. In addition, update immunizations according to current immunization guidelines.

Take 6mg PO QD, with or without food.

Dosage adjustments are not required with mild to moderate hepatic impairment; however, use is not recommended in patients with severe hepatic impairment. Dose adjustments are not required with renal impairment, including patients with end stage renal disease on dialysis.

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 (Sotyktu®) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included upper respiratory infections (4.4%), blood creatine phosphokinase increased (1.5%), herpes simplex (1.8%), mouth ulcers (1.9%), folliculitis (1.7%), and acne (1.2%).

Hypersensitivity reactions have been reported in subjects receiving Sotyktu®. If a clinically significant hypersensitivity reaction occurs, start appropriate therapy and discontinue Sotyktu®.

Sotyktu® may increase the risk of infections. Serious infections have been reported in subjects with psoriasis who received Sotyktu®. Avoid use of Sotyktu® in patients with active or serious infection. Consider the risks and benefits of treatment prior to starting Sotyktu® in patients with chronic or recurrent infection; who have been exposed to tuberculosis; with a history of a serious or an opportunistic infection; or with underlying conditions that may predispose them to infection. Closely monitor patients for the development of signs and symptoms of infection during and after treatment with Sotyktu®. A patient who develops a new infection during treatment with Sotyktu® should undergo prompt diagnostic testing, appropriate antimicrobial therapy should be started, and the patient should be closely monitored. Interrupt Sotyktu® if a serious infection develops and do not restart treatment until the infection resolves or is adequately treated.

Assess patients for latent and active TB infection prior to starting treatment and do no administer Sotyktu® to patients with active TB. Start treatment of latent TB prior to administering Sotyktu®. Consider anti-TB therapy prior to initiation of Sotyktu® in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Monitor patients receiving Sotyktu® for signs and symptoms of active TB during treatment.

Malignancies, including lymphomas, were observed in clinical trials with Sotyktu®. Consider the benefits and risks for the individual patient prior to starting or continuing therapy with Sotyktu®, especially in patients with a known malignancy (other than a successfully treated non-melanoma skin cancer) and patients who develop a malignancy when on treatment with Sotyktu®.

Cases of rhabdomyolysis were reported in subjects treated with Sotyktu® resulting in interruption or discontinuation of Sotyktu® dosing. Treatment with Sotyktu® was also associated with an increased incidence of asymptomatic creatine phosphokinase (CPK) elevation and rhabdomyolysis compared to treatment with placebo. Discontinue Sotyktu® if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Instruct patients to promptly report any unexplained muscle pain, tenderness or weakness, especially if accompanied by malaise or fever.

Treatment with Sotyktu® was associated with increases in triglyceride levels. The effect of this elevated parameter on cardiovascular morbidity and mortality has not been determined. Periodically assess serum triglycerides per clinical guidelines for hyperlipidemia while patients are receiving Sotyktu® treatment. Manage patients per clinical guidelines for the management of hyperlipidemia.

Treatment with Sotyktu® was associated with an increase in the incidence of liver enzyme elevation compared to placebo. Liver serum transaminase elevations ≥3 times the upper limit of normal (ULN) were reported in subjects treated with Sotyktu®. Evaluate liver enzymes at baseline and thereafter in patients with known or suspected liver disease per routine patient management. If treatment-related increases in liver enzymes occur and drug-induced liver injury is suspected, interrupt Sotyktu® until a diagnosis of liver injury is excluded.

Prior to starting Sotyktu®, consider completion of all age-appropriate immunizations per current immunization guidelines including prophylactic herpes zoster vaccination. Avoid the use of live vaccines in patients treated with Sotyktu®. The response to live or non-live vaccines has not been evaluated.

It is not known whether TYK2 inhibition may be associated with the observed or potential adverse reactions of JAK inhibition. In a large randomized, post marketing safety trial of a JAK inhibitor in rheumatoid arthritis (RA), patients 50 years of age and older with at least one cardiovascular risk factor, higher rates of all-cause mortality, including

sudden cardiovascular death, major adverse cardiovascular events, overall thrombosis, deep vein thrombosis, pulmonary embolism, and malignancies (excluding non-melanoma skin cancer) were observed in patients treated with a JAK inhibitor compared to those treated with TNF blockers. Sotyktu® is not approved for use in RA.

Contraindications: In patients with a history of hypersensitivity reaction to deucravacitinib or to any of the excipients of the product.

Manufacturer: Bristol Myers Squibb.

Analysis: The safety and efficacy of Sotyktu® were assessed in 2 multicenter, randomized, double-blind, placebo- and active-controlled trials (PSO-1 and PSO-2) that included adults 18 years of age and older with moderate-to-severe plaque psoriasis who were eligible for systemic therapy or phototherapy. Subjects had a body surface area (BSA) involvement of ≥10%, a Psoriasis Area and Severity Index (PASI) score ≥12, and a static Physician's Global Assessment (sPGA) ≥3 (moderate or severe).

In PSO-1 and PSO-2, efficacy was assessed in subjects (N=1684) randomized to either Sotyktu® 6mg PO QD, placebo, or apremilast 30mg PO BID. In both trials, the mean age was 47 years, the mean weight was 91kg, 67% were male, and 87% were white. At baseline, subjects had a median affected BSA of 20% and a median PASI score of 19. The proportion of subjects with sPGA score of 3 (moderate) and 4 (severe) at baseline were 80% and 20%, respectively. In addition, about 18% had a history of psoriatic arthritis. Across both trials, 40% of subjects had received prior phototherapy, 42% were naïve to any systemic therapy (including biologic and/or non-biologic treatment), 41% received prior non-biologic systemic treatment, and 35% had received prior biologic therapy.

Both trials assessed the responses at week 16 compared to placebo for the 2 co-primary endpoints:

- The proportion of subjects who achieved a sPGA score of 0 (clear) or 1 (almost clear) with at least a 2-grade improvement from baseline;
- The proportion of subjects who achieved at least a 75% improvement in PASI scores from baseline (PASI 75).

Other comparisons between Sotyktu® and placebo that were secondary endpoints at week 16 included:

- The proportion of subjects who achieved PASI 90, PASI 100, sPGA 0, scalp severity PGA (ssPGA) score of 0 (clear) or 1 (almost clear) with at least 2-grade improvement, and Psoriasis Symptoms and Signs Diary (PSSD) Symptom Score of 0 (symptom-free).

Comparisons between Sotyktu® and apremilast were made for the following secondary endpoints at these time points:

- At week 16 and week 24 (PSO-1 and PSO-2), the proportion of subjects who achieved PASI 75, PASI 90, and sPGA 0/1 with at least a 2-grade improvement from baseline.
- At week 16 (PSO-1 and PSO-2), the proportion of subjects who achieved sPGA 0 and ssPGA 0/1 with at least a 2-grade improvement from baseline (scalp).

Results for PSO-1 are presented in the table below, which was adapted from the prescribing information.

Endpoints in PSO-1	Sotyktu® (N=330)	Placebo (N=166)	Apremilast (N=168)	Difference from placebo	Difference from apremilast
sPGA response of 0/1 (clear or almost clear)					
Week 16 [1]	178 (54%)	12 (7%)	54 (32%)	47%	22%

Endpoints in PSO-1	Sotyktu® (N=330)	Placebo (N=166)	Apremilast (N=168)	Difference from placebo	Difference from apremilast
NNT *calculated per CHC* (Sotyktu® vs placebo)	3				
NNT *calculated per CHC* (Sotyktu® vs apremilast)	5				
Week 24	194 (59%)	-	52 (31%)	-	27%
sPGA response of 0					
Week 16	58 (18%)	1 (1%)	8 (5%)	17%	13%
PASI 75 response					
Week 16 [1]	193 (58%)	21 (13%)	59 (35%)	46%	23%
NNT *calculated per CHC* (Sotyktu® vs placebo)	3				
NNT *calculated per CHC* (Sotyktu® vs apremilast)	5				
Week 24	228 (69%)	-	64 (38%)	-	31%
PASI 90 response					
Week 16	118 (36%)	7 (4%)	33 (20%)	32%	16%
Week 24	140 (42%)	-	37 (22%)	-	20%
PASI 100 response					
Week 16	47 (14%)	1 (1%)	-	14%	-
ssPGA response of 0/1 (scalp)					
N	209	121	110		
Week 16	147 (70%)	21 (17%)	43 (39%)	53%	30%

[1] Co-primary endpoints comparing Sotyktu® to placebo

Results for PSO-2 are presented in the table below, which was adapted from the prescribing information.

Endpoints in PSO-2	Sotyktu® (N=511)	Placebo (N=255)	Apremilast (N=254)	Difference from placebo	Difference from apremilast
sPGA response of 0/1 (clear or almost clear)					
Week 16 [1]	253 (50%)	22 (9%)	86 (34%)	41%	16%
NNT *calculated per CHC* (Sotyktu® vs placebo)	3				
NNT *calculated per CHC* (Sotyktu® vs apremilast)	7				
Week 24	251 (49%)	-	75 (30%)	-	20%

Endpoints in PSO-2	Sotyktu® (N=511)	Placebo (N=255)	Apremilast (N=254)	Difference from placebo	Difference from apremilast
sPGA response of 0					
Week 16	80 (16%)	3 (1%)	16 (6%)	14%	9%
PASI 75 response					
Week 16 [1]	271 (53%)	24 (9%)	101 (40%)	44%	13%
NNT *calculated per CHC* (Sotyktu® vs placebo)	3				
NNT *calculated per CHC* (Sotyktu® vs apremilast)	8				
Week 24	296 (58%)	-	96 (38%)	-	20%
PASI 90 response					
Week 16	138 (27%)	7 (3%)	46 (18%)	24%	9%
Week 24	164 (32%)	-	50 (20%)	-	13%
PASI 100 response					
Week 16	52 (10%)	3 (1%)	-	9%	-
ssPGA response of 0/1 (scalp)					
N	305	173	166		
Week 16	182 (60%)	30 (17%)	61 (37%)	42%	23%

[1] Co-primary endpoints comparing Sotyktu® to placebo

In PSO-1, among subjects who received Sotyktu® and had sPGA 0/1 response at week 24, the sPGA 0/1 response at week 52 was 78% (151/194). Among subjects who received Sotyktu® and had PASI 75 response at week 24, the PASI 75 response at week 52 was 82% (187/228). Among subjects who received Sotyktu® and had PASI 90 response at week 24, the PASI 90 response at week 52 was 74% (103/140).

In PSO-2, to assess maintenance and durability of response, subjects who were originally randomized to Sotyktu® and were PASI 75 responders at week 24 were re-randomized to either continue treatment on Sotyktu® or be withdrawn from therapy (i.e., receive placebo).

For subjects who were re-randomized and also had a sPGA score of 0 or 1 at week 24, 70% of subjects (83/118) who continued on Sotyktu® maintained this response (sPGA 0 or 1) at week 52 compared to 24% of subjects (28/119) who were re-randomized to placebo. In addition, at week 52, 80% of subjects (119/148) who continued on Sotyktu® maintained PASI 75 compared to 31% of subjects (47/150) who were withdrawn from Sotyktu®.

For sPGA 0 or 1 responders at week 24 who were re-randomized to treatment withdrawal (i.e., placebo), the median time to loss of sPGA score of 0 or 1 was about 8 weeks. For PASI-75 responders at week 24 who were re-randomized to treatment withdrawal (i.e., placebo), the median time to loss of PASI 75 was about 12 weeks.

Regarding patient reported outcomes, a greater proportion of subjects treated with Sotyktu® compared to placebo achieved Psoriasis Symptoms and Signs Diary (PSSD) symptom score of 0 (absence of itch, pain, burning, stinging, and skin tightness) at week 16 (8% Sotyktu® vs 1% placebo; calculated NNT=15) in both trials.

Place in Therapy: Sotyktu® is a tyrosine kinase 2 (TYK2) inhibitor indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. Its use is not recommended in combination with other potent immunosuppressants. Avoid use of Sotyktu® in patients with an active or serious infection. Assess patients for active and latent TB infection prior to starting treatment with Sotyktu®. The safety and efficacy of Sotyktu® were assessed in 2 multicenter, double-blind, placebo- and active-controlled trials. Per the full-text study of PSO-1 by Armstrong et al[2], the authors noted that response rates at week 16 were significantly higher with deucravacitinib versus placebo or apremilast for PASI 75 ($p<0.0001$) and sPGA 0/1 ($p<0.0001$). In addition, efficacy improved beyond week 16 and was maintained through week 52. Per the full-text study of PSO-2 by Strober et al[3], the authors noted that significantly more subjects treated with deucravacitinib versus placebo and apremilast at week 16 achieved PASI 75 ($p<0.0001$ vs placebo, $p=0.0004$ vs apremilast) and sPGA 0/1 ($p<0.0001$ for both). Efficacy was maintained through week 52 with continuous deucravacitinib. The authors concluded in both studies that deucravacitinib demonstrated superiority to placebo and apremilast across efficacy endpoints, while being well tolerated.

There is some evidence in two phase-3 studies to suggest that Sotyktu® may be more effective than apremilast for the endpoints of sPGA response of 0/1 with at least a 2-grade improvement from baseline and PASI 75 response; however, there is no other head-to-head evidence at this time to support that Sotyktu® is safer or more effective than the other currently preferred, more cost-effective medications. It is therefore recommended that Sotyktu® 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 with Conditions**

References

[1] Sotyktu [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; 2022.
[2] Armstrong AW, Gooderham M, Warren RB, et al. Deucravacitinib versus placebo and apremilast in moderate to severe plaque psoriasis: efficacy and safety results from the 52-week, randomized, double-blind, placebo-controlled phase 3 POETKY PSO-1 trial. *J Am Acad Dermatol*. 2023; 88(1): 29-39.
[3] Strober B, Thaci D, Sofen H, et al. Deucravacitinib versus placebo and apremilast in moderate to severe plaque psoriasis: efficacy and safety results from the 52-week, randomized, double-blind, phase 3 Program fOr Evaluation of TYK2 inhibitor psoriasis second trial. *J Am Acad Dermatol*. 2023; 88(1): 40-51.

Tezepelumab-ekko (Tezspire) Prefilled Pen
Second Review

Background

The U.S. Food and Drug Administration (FDA) recently approved tezepelumab-ekko (Tezspire) indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma. Several other biologics indicated for asthma (e.g., Fasenra, Nucala, Xolair, Dupixent) are currently on the Preferred Drug List requiring prior authorization (PA). According to the AstraZeneca website, tezepelumab-ekko is being studied for several other respiratory and immunology indications including chronic obstructive pulmonary disease, eosinophilic esophagitis, and nasal polyps.

See attached new drug review for additional clinical information.

Cost

- WAC $2,155.50/month; $28,021.50/year (13 fills in a 12-month period)

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of severe asthma; and
    a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
    b. Patient must have of one of the following, in addition to the regular maintenance medications defined above:
        i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months, or
        ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and
    c. This medication will be used as an add-on maintenance treatment; and
    d. Patient/caregiver will administer medication in patient's home; and
    e. Is not prescribed in combination with other biologics indicated for asthma.

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

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

Proposed Quantity Limit

- 210 mg/1.91 mL (110 mg/mL) prefilled pen – 1 prefilled pen per 28 days

References

Tezspire [prescribing information]. Thousand Oakes, CA: Amgen, Inc.; May 2023

Iowa Medicaid
IOWA HHS

PDL DRUG REVIEW

Proprietary Name: Tezspire®
Common Name: tezepelumab-ekko
PDL Category: Antiasthmatic- Anti-Inflammatory Agents

Comparable Products	Preferred Drug List Status
Dupixent	Non-Preferred with Conditions
Fasenra	Preferred with Conditions
Nucala	Non-Preferred with Conditions

Summary

Pharmacology/Usage: Tezepelumab-ekko, the active ingredient of Tezspire®, is a thymic stromal lymphopoietin (TSLP) blocker, a human monoclonal antibody immunoglobulin G2λ (IgG2λ) that binds to human TSLP with a dissociation constant of 15.8pM and blocks its interaction with the heterodimeric TSLP receptor. TSLP is a cytokine mainly derived from epithelial cells and occupies an upstream position in the asthma inflammatory cascade. Blocking TSLP with tezepelumab-ekko reduces biomarkers and cytokines associated with inflammation including blood eosinophils, airway submucosal eosinophils, IgE, FeNO, IL-5, and IL-13; however, the mechanism of action in asthma has not been definitely established.

Indication: For the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma. Tezspire® is not indicated for the relief of acute bronchospasm or status asthmaticus.

There is no pregnancy category for this medication; however, the risk summary indicates that there are no available data with use in pregnant women to assess for any drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Placental transfer of monoclonal antibodies such as tezepelumab-ekko is greater during the third trimester of pregnancy; thus, potential effects on a fetus are likely to be greater during the third trimester of pregnancy. Clinical considerations include that in women with poorly or moderately controlled asthma, evidence demonstrates that there is an increased risk of preeclampsia in the mother and prematurity, low birth weight, and small for gestational age in neonates. The level of asthma control should be closely monitored in pregnant women and treatment adjusted as necessary to maintain optimal control. The safety and efficacy of use in the pediatric population younger than 12 years of age have not been established.

Dosage Form: Solution for injection, available as:

- 210mg/1.91ml (110mg/ml) solution in a single-dose glass vial
- 210mg/1.91ml (110mg/ml) solution in a single-dose prefilled syringe
- 210mg/1.91ml (110mg/ml) solution in a single-dose prefilled pen.

Prior to administration, remove from the refrigerator and allow to reach room temperature, which generally takes 60 minutes.

Recommended Dosage: Tezspire® vial and prefilled syringe are intended for administration by a healthcare provider. Tezspire® prefilled pen can be administered by patients/caregivers or healthcare providers. Patients/caregivers may administer Tezspire® prefilled pen after proper training in SC injection technique and after the healthcare provider determines it is appropriate.

The recommended dosage is 210mg administered SC once every 4 weeks. If a dose is missed, administer the dose as soon as possible. Thereafter, the patient can continue (resume) dosing on the usual day of administration. If the next dose is already due, then administer as planned. To be injected into the upper arm (if a healthcare provider or caregiver administers the injection), thigh, or abdomen, except for the 2 inches around the navel. Rotate the injection site with each injection.

No formal clinical studies have been conducted to assess the effect of renal or hepatic impairment on tezepelumab-ekko. Changes in hepatic function are not expected to influence tezepelumab-ekko clearance. In an analysis that included subjects with mild and moderate renal impairment, tezepelumab-ekko clearance was similar in patients with mild or moderate renal impairment and those with normal renal function. Use has not been studied in patients with severe renal impairment.

Drug Interactions: No formal drug interaction studies have been performed with Tezspire®.

The concomitant use of Tezspire® and live attenuated vaccines has not been evaluated. The use of live attenuated vaccines should be avoided in patients receiving Tezspire®.

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 (Tezspire®) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included pharyngitis (1%), arthralgia (1%), and back pain (1%).

In the pooled safety population, in which Tezspire® or placebo was administered using the vial by a healthcare provider, injection site reactions (e.g. injection site erythema, injection site swelling, injection site pain) occurred at a rate of 3.3% in patients treated with Tezspire® compared with 2.7% in patients treated with placebo.

In an open-label study of patients with asthma (N=216) in which Tezspire® was administered by healthcare providers and patients or caregivers using either the prefilled pen or prefilled syringe, injection site reactions were observed in 5.7% of patients using the prefilled pen and 0% using the prefilled syringe. However, the trial was not designed to compare injection site reactions between patients who received Tezspire® by the prefilled pen versus prefilled syringe.

Hypersensitivity reactions were observed in the clinical trials following the administration of Tezspire®. These reactions can occur within hours of administration, but in some instances have a delayed onset (i.e., days). In the event of a hypersensitivity reaction, consider the benefits and risks for the individual patient to determine whether to continue or discontinue treatment with Tezspire®.

Tezspire® should not be used to treat acute asthma symptoms or acute exacerbations. Do not use Tezspire® to treat acute bronchospasm or status asthmaticus. Patients should seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with Tezspire®.

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with Tezspire®. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

Thymic stromal lymphopoietin (TSLP) may be involved in the immunological response to some helminth infections. Patients with known helminth infections were excluded from participation in clinical trials. It is not known if Tezspire® will influence a patient's response against helminth infections. Treat patients with pre-existing helminth

infections before starting Tezspire®. If patients become infected while receiving treatment with Tezspire® and do not respond to anti-helminth treatment, discontinue treatment with Tezspire® until infection resolves.

Contraindications: In patients who have known hypersensitivity to tezepelumab-ekko or any of its excipients.

Manufacturer: Amgen, Inc.

Analysis: The safety and efficacy of Tezspire® were assessed in two randomized, double-blind, parallel group, placebo-controlled studies of 52 weeks duration that included patients 12 years of age and older (N=1609) with severe asthma.

Study 1 (PATHWAY) was a dose-ranging exacerbation trial that included 550 adults with severe asthma who received treatment with tezepelumab-ekko 70mg SC Q4W, Tezspire® 210mg SQ Q4W, tezepelumab-ekko 280mg SC Q2W, or SC placebo. Patients were required to have a history of ≥2 asthma exacerbations requiring oral or injectable corticosteroid treatment or 1 asthma exacerbation resulting in hospitalization in the past 12 months. The mean age of patients in this study was 52 years, while 66% were female, 92% were white, 81% never smoked, 49% had high-dose inhaled corticosteroid (ICS) use, 9% had oral corticosteroid (OCS) use, the mean duration of asthma was 17 years, the mean number of exacerbation in previous year was 2.4, the mean baseline % predicted FEV1 was 60, and the mean baseline blood eosinophil (EOS) count (cells/μL) was 371.

Study 2 (NAVIGATOR) was a 52-week exacerbation trial that enrolled 1061 patients (adults and pediatric patients 12 years of age and older) with severe asthma who received Tezspire® 210mg SQ Q4W or SC placebo Q4W. Patients were required to have a history of ≥2 asthma exacerbations requiring oral or injectable corticosteroid treatment or resulting in hospitalization in the past 12 months. The mean age of patients in this study was 50 years, while 64% were female, 62% were white, 80% never smoked, 75% had high-dose inhaled corticosteroid (ICS) use, 9% had oral corticosteroid (OCS) use, the mean duration of asthma was 22 years, the mean number of exacerbation in previous year was 2.8, the mean baseline % predicted FEV1 was 63, and the mean baseline blood EOS count (cells/μL) was 340.

In both studies, patients were required to have an Asthma Control Questionnaire 6 (ACQ-6) score of 1.5 or more at screening and reduced lung function at baseline (pre-bronchodilator FEV1 below 80% predicted in adults and below 90% predicted in adolescents). Patients were required to have been on regular treatment with medium or high-dose ICS and at least one additional asthma controller, with or without oral corticosteroids (OCS). Patients continued background asthma therapy throughout the duration of the trials. In both trials, patients were enrolled without requiring a minimum baseline level of blood eosinophils or fractional exhaled nitric oxide (FeNO).

The results summarized below are for the recommended Tezspire® 210mg SC Q4W dosing regimen.

The primary endpoint for both studies was the rate of clinically significant asthma exacerbations measured over 52 weeks. Clinically significant asthma exacerbations were defined as worsening of asthma requiring the use of or an increase in oral or injectable corticosteroids for at least 3 days, or a single depo-injection of corticosteroids, and/or emergency department visits requiring use of oral or injectable corticosteroids and/or hospitalization. Results suggested that in both studies, patients in the Tezspire® group had significant reductions in the annualized rate of asthma exacerbations as compared to placebo. There were also fewer exacerbations requiring emergency room visits and/or hospitalization in patients treated with Tezspire® as compared with placebo. Results are presented in the table below, which was adapted from the prescribing information.

Trial	Treatment	Exacerbations per year	
		Rate	Rate Ratio
Annualized Asthma Exacerbation Rate			
Pathway	Tezspire® (N=137)	0.20	0.29
	Placebo (N=138)	0.72	
Navigator	Tezspire® (N=528)	0.93	0.44

Trial	Treatment	Exacerbations per year	
		Rate	Rate Ratio
	Placebo (N=531)	2.10	
Exacerbations requiring emergency room visit/hospitalization			
Pathway	Tezspire® (N=137)	0.03	0.15
	Placebo (N=138)	0.18	
Navigator	Tezspire® (N=528)	0.06	0.21
	Placebo (N=531)	0.28	
Exacerbations requiring hospitalization			
Pathway	Tezspire® (N=137)	0.02	0.14
	Placebo (N=138)	0.14	
Navigator	Tezspire® (N=528)	0.03	0.15
	Placebo (N=531)	0.19	

In Navigator, patients receiving Tezspire® experienced fewer exacerbations than those receiving placebo regardless of baseline levels of blood eosinophils or FeNO. Similar results were observed in the Pathway study. The time to first exacerbation was longer for the patients receiving Tezspire® compared with placebo in the Navigator study. Similar findings were seen in the Pathway study.

The change from baseline in FEV1 was assessed as a secondary endpoint in Pathway and Navigator. Results suggested that compared with placebo, Tezspire® provided clinically meaningful improvements in the mean change from baseline in FEV1 in both trials. Results are presented in the table below, which was adapted from the prescribing information.

Trial	Treatment	LS mean change from baseline	Difference from placebo
PATHWAY	Tezspire® (N=133)	0.08	0.13
	Placebo (N=138)	-0.06	
NAVIGATOR	Tezspire® (N=527)	0.23	0.13
	Placebo (N=531)	0.10	

In the Navigator study, improvement in FEV1 was seen as early as 2 weeks after initiation of treatment and was sustained through week 52.

Changes from baseline in Asthma Control Questionnaire 6 (ACQ-6) and Standardized Asthma Quality of Life Questionnaire for ages 12 and older [AQLQ(S)+12] were also assessed as secondary endpoints in both studies. Results suggested that in both studies, more patients treated with Tezspire® compared to placebo had a clinically meaningful improvement in ACQ-6 and AQLQ(S)+12. Clinically meaningful improvement (responder rate) for both measures was defined as improvement in score of 0.5 or greater at the end of the trial. In Navigator, the ACQ-6 responder rate for Tezspire® was 86% compared with 77% for placebo (OR 1.99) (Calculated NNT = 12) and the AQLQ(S)+12 responder rate for Tezspire® was 78% compared with 72% for placebo (OR 1.36) (NNT = 17). Similar findings were also observed in Pathway.

An additional randomized, double-blind, parallel group, placebo-controlled trial was performed to assess the effect of Tezspire® 210mg SC Q4W on reducing the use of maintenance OCS. The trial enrolled adults (N=150) with severe asthma who required treatment with daily OCS (7.5mg to 30mg per day) in addition to regular use of high-

dose ICS and a long-acting beta agonist with or without additional controller(s). The primary endpoint was categorized percent reduction from baseline of the final OCS dose at week 48 (≥90 reduction, ≥75% to <90% reduction, ≥50% to <75% reduction, >0% to <50% reduction, and no change or no decrease in OCS), while maintaining asthma control. Results suggested that Tezspire® did not demonstrate a statistically significant reduction in maintenance OCS dose compared with placebo (cumulative OR 1.28).

Place in Therapy: Tezspire® is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma. Tezspire® is not indicated for the relief of acute bronchospasm or status asthmaticus. It is the first and only biologic indicated for severe asthma that does not have a phenotype or biomarker limitation within its approved indication. While the Tezspire® vial and prefilled syringe are intended for administration by a healthcare provider, the Tezspire® prefilled pen can be administered by patients/caregivers or healthcare providers.

The safety and efficacy of Tezspire® were assessed in two randomized, double-blind, placebo-controlled studies, and the primary endpoint of the two studies was the rate of clinically significant asthma exacerbations measured over 52 weeks. Results suggested that patients receiving Tezspire® had significant reductions in the annualized rate of asthma exacerbations compared to placebo in both studies. There were also fewer exacerbations requiring emergency room visits and/or hospitalization in patients treated with Tezspire® compared with placebo.

References

[1] Tezspire [package insert]. Thousand Oaks, CA: Amgen Inc; 2023.

Janus Kinase Inhibitors
Second Review

Background

Upadacitinib (Rinvoq) recently received a seventh indication for adults with moderately to severely active Crohn's disease who have had an inadequate response or intolerance to one or more TNF blockers. Limitation of use - Upadacitinib is not recommended for use in combination with other JAK inhibitors, biological DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine. Upadacitinib (Rinvoq) is the first oral drug FDA approved for moderately to severely active Crohn's disease.

Clinical Trials

The approval of Rinvoq for the new indication was based on two induction studies (CD-1 and CD-2) in 857 patients with moderately to severely active Crohn's disease. Patients were randomized to Rinvoq 45 mg or placebo for 12 weeks. The co-primary endpoints were the proportion of patients achieving clinical remission at week 12, and the proportion of patients achieving endoscopic response at week 12.

- In CD-1, clinical remission was achieved in 36% and 18% of patients with Rinvoq and placebo, respectively (treatment difference 17, 95% CI: 9, 25; $p < 0.001$). Endoscopic response was achieved in 34% and 3% of patients with Rinvoq and placebo, respectively (treatment difference 30, 95% CI: 24, 36; $p < 0.001$).
- In CD-2, clinical remission was achieved in 46% and 23% of patients with Rinvoq and placebo, respectively (treatment difference 24, 95% CI: 15, 32; $p < 0.001$). Endoscopic response was achieved in 46% and 13% of patients with Rinvoq and placebo, respectively (treatment difference 33, 95% CI: 26, 41; $p < 0.001$).

Rinvoq was also evaluated in a maintenance study (CD-3) in 343 patients who responded to 12 weeks of Rinvoq induction treatment. Patients were re-randomized to receive a maintenance regimen of either Rinvoq 15 mg or 30 mg once daily or placebo for 52 weeks, representing a total of at least 64 weeks of therapy. The co-primary endpoints of clinical remission and endoscopic response were assessed at week 52.

- Clinical remission was achieved in 42%, 55%, and 14% with Rinvoq 15 mg, Rinvoq 30 mg, and placebo, respectively. The treatment difference vs. placebo was 29% (95% CI: 18, 39; $p < 0.001$) and 40% (95% CI: 29, 51; $p < 0.001$) for Rinvoq 15 mg and 30 mg, respectively.
- Endoscopic response was achieved in 28%, 41%, and 7% with Rinvoq 15 mg, Rinvoq 30 mg, and placebo, respectively. The treatment difference vs. placebo was 22% (95% CI: 13, 32; $p < 0.001$) and 34% (95% CI: 25, 44; $p < 0.001$) for Rinvoq 15 mg and 30 mg, respectively.

Prior authorization (PA) criteria are being updated to add this new indication and mirror the Biologicals for Inflammatory Bowel Disease criteria specific to Crohn's disease.

Current Clinical Prior Authorization Criteria

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

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

i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR

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.

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

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

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

i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR

b. Psoriatic arthritis (tofacitinib, upadacitinib); with
i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR

c. Moderately to severely active ulcerative colitis (tofacitinib, upadacitinib); with
i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and
ii. A documented trial and inadequate response with a preferred TNF inhibitor; and
iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR

d. *Moderately to severely active Crohn's disease (upadacitinib); with*
i. *A documented trial and inadequate response to two preferred conventional therapies including aminosalicylates (sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; and*
ii. *A documented trial and inadequate response with a preferred TNF inhibitor; OR*

e. Polyarticular Course Juvenile Idiopathic Arthritis (tofacitinib); with
i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and
ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR

g. Axial spondyloarthritis conditions (e.g., *a*nkylosing spondylitis or nonradiographic axial spondyloarthritis) (tofacitinib, upadacitinib); with
i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR

h. 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.

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DUR DIGEST

The Bulletin of Medicaid Drug Utilization Review in Iowa

Outgoing Members of the DUR Commission

John Ellis, Pharm.D. completed over four years of service with the Iowa Drug Utilization Review Commission. Dr. Ellis served on the Commission from October 2019 through November 2023.

Susan Parker, Pharm.D., R.Ph. retired from the Department of Health and Human Services after almost 22 years as the Pharmacy Director.

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

New State Pharmacy Director

Abby Cate, Pharm.D. is the Pharmacy Consultant for Iowa Medicaid. Abby graduated with a Doctor of Pharmacy from the University of Iowa College of Pharmacy in 2015 as well as a Bachelor of Business Administration in Management and Organizations from Iowa's Tippie College of Business in 2011. She has a vast pharmacy experience with positions held in hospital, community, specialty and managed care pharmacy areas. Prior to her role in Iowa Medicaid, Abby served on the Iowa Medicaid Pharmaceuticals and Therapeutics Committee from 2021 to 2023. She is an active member of the Iowa Pharmacy Association and the City of Johnston, having served on committees for both.

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 during 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.

DUR Activities

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.

New GOLD Strategy for Initial COPD Pharmacologic Management

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2023 report identified key changes for patients with chronic obstructive pulmonary disease (COPD), specifically more aggressive initial bronchodilator therapy.

- Single-agent long-acting bronchodilator therapy for less severe symptoms and low exacerbation risk (Group A).
- Dual long-acting bronchodilator therapy for more severe symptoms and low exacerbation risk (Group B).
- Dual long-acting bronchodilator therapy for high exacerbation risk, regardless of symptoms (Group E).

A new classification for severity of exacerbations was also outlined. GOLD recommends the ABCD assessment tool be replaced with the ABE assessment tool, where the C and D groups are merged into a single group termed E to highlight the clinical relevance of exacerbations. Symptoms are assessed using the Modified British Medical Research Council (mMRC) or COPD assessment test (CAT) scale. The full GOLD ABE assessment tool can be found in the GOLD guidelines.

- Group A: low risk (zero to one exacerbation per year, not requiring hospitalization) and fewer symptoms (mMRC 0 to 1 or CAT < 10).
- Group B: low risk (zero to one exacerbation per year, not requiring hospitalization) and more symptoms (mMRC ≥ 2 or CAT ≥ 10).
- Group E: high risk (≥2 exacerbations per year, or ≥1 requiring hospitalization) and any level of symptoms.

Single-Agent Long-Acting Bronchodilators for COPD (Group A)

Drug	Brand Name	Dosing	Inhaler Device
Long-Acting Beta-Agonists (LABAs)			
Arformoterol	Brovana	Inhale contents of 1 vial twice daily	NEB
Formoterol	Perforomist	Inhale contents of 1 vial twice daily	NEB
Olodaterol	Striverdi Respimat	Use 2 inhalations once daily	SMI
Salmeterol	Serevent Diskus	Use 1 inhalation twice daily	DPI
Long-Acting Muscarinic Antagonists (LAMAs)			
Aclidinium	Tudorza Pressair	Use 1 inhalation twice daily	DPI
Glycopyrrolate	Lonhala Magnair*	Inhale contents of 1 vial twice daily	NEB
Tiotropium	Spiriva HandiHaler	Inhale contents of 1 capsule once daily	DPI
	Spiriva Respimat	Use 2 inhalations once daily	SMI
Umeclidinium	Incruse Ellipta	Use 1 inhalation once daily	DPI
Revefenacin	Yupelri	Inhale contents of 1 vial once daily	NEB

Dual Long-Acting Muscarinic Antagonist/Long-Acting Beta Agonist Inhalers for COPD (Group B & E)

Drug	Brand Name	Dosing	Delivery Type
Aclidinium/formoterol	Duaklir Pressair	Use 1 inhalation twice daily	DPI
Glycopyrrolate/formoterol	Bevespi Aerosphere	Use 2 inhalations twice daily	MDI
Tiotropium/olodaterol	Stiolto Respimat	Use 2 inhalations once daily	SMI
Umeclidinium/vilanterol	Anoro Ellipta	Use 1 inhalation once daily	DPI

DPI: dry powder inhaler; MDI metered dose inhaler; NEB: nebulizer; SMI: soft mist inhaler

* Requires specialized Magnair nebulizer device

Medicaid Statistics for Prescription Claims
September through November 2023

	FFS	Amerigroup	Iowa Total Care	Molina Healthcare
# 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)				