OKLAHOMA
Health Care Authority

# Drug Utilization Review Board

## Wednesday,
## August 13, 2025

*No live meeting scheduled for August.*
*August 2025 will be a packet-only meeting.*

**Oklahoma Health Care Authority (OHCA)**
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

*The University of Oklahoma*
*Health Sciences Center*
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

MEMORANDUM

TO: Drug Utilization Review (DUR) Board Members

FROM: Michyla Adams, Pharm.D.

SUBJECT: Packet Contents for DUR Board Meeting – August 13, 2025

DATE: August 6, 2025

NOTE: **No live August meeting. August 2025 is a packet-only meeting.**

*Enclosed are the following items related to the August packet meeting. Material is arranged in order of the agenda.*

**DUR Board Meeting Minutes – Appendix A**

**Update on the Medication Coverage Authorization Unit – Appendix B**

**U.S. Food and Drug Administration (FDA) Safety Alerts – Appendix C**

**Annual Review of Iron Products – Appendix D**

**Annual Review of Miscellaneous Cancer Medications and 30-Day Notice to Prior Authorize Ryoncil® (Remestemcel-L-rknd) – Appendix E**

**Annual Review of Opioid Analgesics and Medication-Assisted Treatment (MAT) Medications and 30-Day Notice to Prior Authorize Tramadol 75mg Tablet – Appendix F**

**Annual Review of Topical Corticosteroids – Appendix G**

**Annual Review of Various Systemic Antibiotics and 30-Day Notice to Prior Authorize Blujepa (Gepotidacin), Emblaveo™ (Aztreonam/Avibactam), Likmez™ (Metronidazole Oral Suspension), and Metronidazole 125mg Tablet and 375mg Capsule – Appendix H**

**U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates – Appendix I**

## Future Business

# Oklahoma Health Care Authority

**Drug Utilization Review Board**
**(DUR Board)**
**Packet Meeting – August 13, 2025**

***NOTE:*** ***No live August meeting. August 2025 is a packet-only meeting.***

**AGENDA**

Review of the following items:

Items reviewed by Dr. Haymore, Chairman:

1. **DUR Board Meeting Minutes – See Appendix A**
   A. July 9, 2025 DUR Board Meeting Minutes
   B. July 9, 2025 DUR Board Recommendations Memorandum

Items reviewed by Dr. O'Halloran, Dr. Haymore, Chairman:

2. **Update on Medication Coverage Authorization Unit – See Appendix B**
   A. Pharmacy Help Desk Activity for July 2025
   B. Medication Coverage Activity for July 2025

Items reviewed by Dr. Moss, Dr. Haymore, Chairman:

3. **U.S. Food and Drug Administration (FDA) Safety Alerts – See Appendix C**
   A. Introduction
   B. FDA Safety Alerts

Items reviewed by Dr. Wilson, Dr. Haymore, Chairman:

4. **Annual Review of Iron Products – See Appendix D**
   A. Current Prior Authorization Criteria
   B. Utilization of Iron Products
   C. Prior Authorization of Iron Products
   D. Market News and Updates
   E. Cost Comparison: Intravenous (IV) Iron Products
   F. College of Pharmacy Recommendations
   G. Utilization Details of Iron Products

Items reviewed by Dr. Sinko, Dr. Haymore, Chairman:

5. **Annual Review of Miscellaneous Cancer Medications and 30-Day Notice to Prior Authorize Ryoncil® (Remestemcel-L-rknd) – See Appendix E**
   A. Current Prior Authorization Criteria
   B. Utilization of Miscellaneous Cancer Medications
   C. Prior Authorization of Miscellaneous Cancer Medications
   D. Market News and Updates
   E. Ryoncil® (Remestemcel-L-rknd) Product Summary
   F. College of Pharmacy Recommendations
   G. Utilization Details of Miscellaneous Cancer Medications

Items reviewed by Dr. Moss, Dr. Haymore, Chairman:

6. **Annual Review of Opioid Analgesics and Medication-Assisted Treatment (MAT) Medications and 30-Day Notice to Prior Authorize Tramadol 75mg Tablet – See Appendix F**
   A. Current Prior Authorization Criteria
   B. Utilization of Opioid Analgesics and MAT Medications
   C. Prior Authorization of Opioid Analgesics and MAT Medications
   D. Market News and Updates
   E. Cost Comparison: Tramadol
   F. College of Pharmacy Recommendations
   G. Utilization Details of Opioid Analgesics and MAT Medications

Items reviewed by Dr. O'Halloran, Dr. Haymore, Chairman:

7. **Annual Review of Topical Corticosteroids – See Appendix G**
   A. Current Prior Authorization Criteria
   B. Utilization of Topical Corticosteroids
   C. Prior Authorization of Topical Corticosteroids
   D. Market News and Updates
   E. College of Pharmacy Recommendations
   F. Utilization Details of Topical Corticosteroids

Items reviewed by Dr. DeRemer, Dr. Haymore, Chairman:

8. **Annual Review of Various Systemic Antibiotics and 30-Day Notice to Prior Authorize Blujepa (Gepotidacin), Emblaveo™ (Aztreonam/Avibactam), Likmez™ (Metronidazole Oral Suspension), and Metronidazole 125mg Tablet and 375mg Capsule – See Appendix H**
   A. Current Prior Authorization Criteria
   B. Utilization of Various Systemic Antibiotics
   C. Prior Authorization of Various Systemic Antibiotics
   D. Market News and Updates
   E. Product Summaries
   F. Cost Comparison: Metronidazole Products
   G. College of Pharmacy Recommendations
   H. Utilization Details of Various Systemic Antibiotics

Items reviewed by Dr. O'Halloran, Dr. Haymore, Chairman:

9. **U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates – See Appendix I**

Items reviewed by Dr. Adams, Dr. Haymore, Chairman:

10. **Future Business* (Upcoming Product and Class Reviews)**
    A. Amyloidosis Medications
    B. Breast Cancer Medications
    C. Camzyos® (Mavacamten)

D. Cystic Fibrosis (CF) Medications
E. Encelto (Revakinagene Taroretcel-lwey)
F. Jynarque® (Tolvaptan)
G. Photrexa® and Photrexa® Viscous (Riboflavin 5'-Phosphate)
H. Synagis® (Palivizumab)

*Future product and class reviews subject to change.

NOTE: An analysis of the atypical [Aged, Blind, and Disabled (ABD)] patient subgroup of the Oklahoma Medicaid population has been performed pertaining to all recommendations included in this DUR Board meeting packet to ensure fair and knowledgeable deliberation of the potential impact of the recommendations on this patient population.

NOTE: Oklahoma Medicaid transitioned from a fee-for-service (FFS) pharmacy benefit to a managed care pharmacy benefit for most members on April 1, 2024. At that time, the majority of SoonerCare members were transitioned to one of the three managed care SoonerSelect plans: Aetna, Humana, or Oklahoma Complete Health. SoonerSelect data has been provided to the College of Pharmacy and has been used in analyses throughout this DUR Board meeting packet. The data included in this DUR Board meeting packet combines FFS and managed care utilization data. The managed care utilization and prior authorization (PA) data reported in this packet is based solely on the data provided by the SoonerSelect plans.

# Appendix A

**OKLAHOMA HEALTH CARE AUTHORITY**
**DRUG UTILIZATION REVIEW (DUR) BOARD MEETING**
**MINUTES OF MEETING JULY 9, 2025**

| DUR BOARD MEMBERS: | PRESENT | ABSENT |
|---|---|---|
| Cassidy Blaiss, Pharm.D., BCOP | X | |
| Kenneth Foster, MHS, PA-C | X | |
| Bret Haymore, M.D.; Chairman | X | |
| Bethany Holderread, Pharm.D. | X | |
| T. Craig Kupiec II, M.D., MSPH | X | |
| Lee Muñoz, D.Ph. | X | |
| James Osborne, Pharm.D. | | X |
| Edna Patatanian, Pharm.D., FASHP; Vice Chairwoman | | X |
| Jennifer Weakley, M.D., DipABLM | X | |

| COLLEGE OF PHARMACY STAFF: | PRESENT | ABSENT |
|---|---|---|
| Michyla Adams, Pharm.D.; DUR Manager | X | |
| Michaela DeRemer, Pharm.D., MBA, BCPS; Clinical Pharmacist | X | |
| Darius Dorsey, Pharm.D.; Pharmacy Resident | X | |
| Erin Ford, Pharm.D.; Clinical Pharmacist | | X |
| Beth Galloway; Business Analyst | X | |
| Katrina Harris, Pharm.D.; Clinical Pharmacist | | X |
| Robert Klatt, Pharm.D.; Clinical Pharmacist | | X |
| Regan Moss, Pharm.D.; Clinical Pharmacist | X | |
| Brandy Nawaz, Pharm.D.; Clinical Pharmacist | | X |
| Alicia O'Halloran, Pharm.D.; Clinical Pharmacist | X | |
| Wynn Phung, Pharm.D.; Clinical Pharmacist | | X |
| Grant H. Skrepnek, Ph.D.; Associate Professor | X | |
| Peggy Snyder, Pharm.D.; Clinical Pharmacist | | X |
| Ashley Teel, Pharm.D.; Clinical Pharmacist | | X |
| Jacquelyn Travers, Pharm.D.; Practice Facilitating Pharmacist | X | |
| Devin Wilcox, D.Ph.; Pharmacy Director | X | |
| Justin Wilson, Pharm.D.; Clinical Pharmacist | X | |
| PA Oncology Pharmacists: Whitney Bueno, Pharm.D., BCOP | | X |
| Christine Hughes, Pharm.D., MBA, BCOP | | X |
| Lauren Sinko, Pharm.D., BCOP | X | |
| Graduate Students: Matthew Dickson, Pharm.D. | X | |
| Visiting Pharmacy Student(s): N/A | | |

| OKLAHOMA HEALTH CARE AUTHORITY STAFF: | PRESENT | ABSENT |
|---|---|---|
| Mark Brandenburg, M.D., MSC; Medical Director | | X |
| Ellen Buettner; Chief Executive Officer | | X |
| Terry Cothran, D.Ph.; Pharmacy Director | X | |
| Travis Dennis, J.D.: Deputy General Counsel | | X |
| Christina Foss, Chief of Staff; State Medicaid Director | | X |
| Conner Mulvaney, J.D.; Deputy General Counsel | | X |
| Jill Ratterman, D.Ph.; Clinical Pharmacist | X | |
| Paula Root, M.D.; Senior Medical Director, Chief Medical Officer | | X |

| | | |
|---|---|---|
| Shanna Simmons, Pharm.D.; Program Integrity Pharmacist | X | |
| Michelle Tahah, Pharm.D.; Clinical Pharmacist | X | |
| Sharon Smith, Pharm.D.; Clinical Pharmacist | X | |

| OTHERS PRESENT: | |
|---|---|
| Jennifer Lauper, Bristol Myers Squibb | JJ Roth, Mirum |
| Bobby White, Eisai | Kellie Vazzana, Alkermes |
| Thonda Clark, Indivior | Glenn Cornish, Alkermes |
| Bryan Steffan, Boehringer | Eardie Curry, Genentech |
| Kristen Winters, Centene | David Prather, Novo Nordisk |
| Brent Parker, Merck | Kenneth Berry, Alkermes |
| Rodney Brown, Genentech | Andi Stratton, Krystal Biotech |
| Lee Stout, Chiesi | David Large, Chiesi |
| Irene Chung, Aetna | Matt John, Otsuka |
| Patrick O'Neal, Millicent Pharma | David Mendoza, Otsuka |
| Andy Berg, Audaire Health | Christopher Fields, Abeona Therapeutics |
| Jenna Doerr, Artia Solutions | Marc Parker, VS Health Group |
| Rick Ludwico, Mayne Pharmaceuticals | Mark Kaiser, Otsuka |

**AGENDA ITEM NO. 1:** **CALL TO ORDER**
**1A: ROLL CALL**
Dr. Haymore called the meeting to order at 4:00pm. Roll call by Dr. Wilcox established the presence of a quorum.
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 2:** **PUBLIC COMMENT FORUM**
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 3:** **APPROVAL OF DUR BOARD MEETING MINUTES**
**3A: MAY 14, 2025 DUR MINUTES**
Materials included in agenda packet; presented by Dr. Haymore
Dr. Muñoz moved to approve; seconded by Mr. Foster
**ACTION: MOTION CARRIED**

**AGENDA ITEM NO. 4:** **UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT**
**4A: PHARMACY HELPDESK ACTIVITY FOR JUNE 2025**
**4B: MEDICATION COVERAGE ACTIVITY FOR JUNE 2025**
Non-presentation item; materials included in agenda packet by Dr. DeRemer
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 5:** **CHRONIC MEDICATION ADHERENCE (CMA) PROGRAM UPDATE**
**5A: INTRODUCTION**
**5B: CONCLUSIONS**
Materials included in agenda packet; presented by Dr. Travers
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 6:** **VOTE TO PRIOR AUTHORIZE COBENFY™ (XANOMELINE/TROSPIUM), ERZOFRI® [PALIPERIDONE PALMITATE EXTENDED-RELEASE (ER) INJECTION], AND OPIPZA™ (ARIPIPRAZOLE ORAL FILM) AND**

**UPDATE THE APPROVAL CRITERIA FOR THE ATYPICAL ANTIPSYCHOTIC MEDICATIONS**
**6A: MARKET NEWS AND UPDATES**
**6B: COBENFY™ (XANOMELINE/TROSPIUM) PRODUCT SUMMARY**
**6C: COST COMPARISONS**
**6D: COLLEGE OF PHARMACY RECOMMENDATIONS**
Materials included in agenda packet; presented by Dr. O'Halloran
Dr. Muñoz moved to approve; seconded by Dr. Blaiss
**ACTION: MOTION CARRIED**

**AGENDA ITEM NO. 7: VOTE TO PRIOR AUTHORIZE BUCAPSOL™ (BUSPIRONE CAPSULE), CARBAMAZEPINE 200MG CHEWABLE TABLET, FEMLYV™ [NORETHINDRONE ACETATE/ETHINYL ESTRADIOL ORALLY DISINTEGRATING TABLET (ODT)], FOCINVEZ™ (FOSAPREPITANT INJECTION), IMKELDI (IMATINIB ORAL SOLUTION), IVRA (MELPHALAN 90MG/ML INJECTION), MYHIBBIN™ (MYCOPHENOLATE MOFETIL ORAL SUSPENSION), ONDANSETRON 16MG ODT, TEZRULY™ (TERAZOSIN ORAL SOLUTION), TOPIRAMATE 50MG SPRINKLE CAPSULE, VELTASSA® (PATIROMER) 1G POWDER PACKET, AND VIGAFYDE™ (VIGABATRIN ORAL SOLUTION) AND UPDATE THE APPROVAL CRITERIA FOR THE VARIOUS SPECIAL FORMULATIONS**
**7A: INTRODUCTION**
**7B: PRODUCT SUMMARIES AND COLLEGE OF PHARMACY RECOMMENDATIONS**
**7C: COLLEGE OF PHARMACY ADDITIONAL RECOMMENDATIONS**
Materials included in agenda packet; presented by Dr. Moss
Dr. Muñoz moved to approve; seconded by Dr. Blaiss
**ACTION: MOTION CARRIED**

**AGENDA ITEM NO. 8: VOTE TO PRIOR AUTHORIZE AVMAPKI™ FAKZYNJA™ CO-PACK (AVUTOMETINIB AND DEFACTINIB) AND UPDATE THE APPROVAL CRITERIA FOR THE GENITOURINARY AND GYNECOLOGIC CANCER MEDICATIONS**
**8A: MARKET NEWS AND UPDATES**
**8B: AVMAPKI™ FAKZYNJA™ CO-PACK (AVUTOMETINIB AND DEFACTINIB) PRODUCT SUMMARY**
**8C: COLLEGE OF PHARMACY RECOMMENDATIONS**
Materials included in agenda packet; presented by Dr. Sinko
Dr. Muñoz moved to approve; seconded by Dr. Blaiss
**ACTION: MOTION CARRIED**

**AGENDA ITEM NO. 9: ANNUAL REVIEW OF COLORECTAL CANCER (CRC) MEDICATIONS**
**9A: CURRENT PRIOR AUTHORIZATION CRITERIA**
**9B: UTILIZATION OF CRC MEDICATIONS**
**9C: PRIOR AUTHORIZATION OF CRC MEDICATIONS**
**9D: MARKET NEWS AND UPDATES**
**9E: COLLEGE OF PHARMACY RECOMMENDATIONS**
**9F: UTILIZATION DETAILS OF CRC MEDICATIONS**
Non-presentation item; materials included in agenda packet by Dr. Sinko
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 10: ANNUAL REVIEW OF DEFENCATH® (TAUROLIDINE/HEPARIN)**
**10A: CURRENT PRIOR AUTHORIZATION CRITERIA**

**10B: UTILIZATION OF DEFENCATH® (TAUROLIDINE/HEPARIN)**
**10C: PRIOR AUTHORIZATION OF DEFENCATH® (TAUROLIDINE/HEPARIN)**
**10D: MARKET NEWS AND UPDATES**
**10E: COLLEGE OF PHARMACY RECOMMENDATIONS**
**10F: UTILIZATION DETAILS OF DEFENCATH® (TAUROLIDINE/HEPARIN)**
Materials included in agenda packet; presented by Dr. DeRemer
Dr. Muñoz moved to approve; seconded by Dr. Blaiss
**ACTION: MOTION CARRIED**

**AGENDA ITEM NO. 11: ANNUAL REVIEW OF CONSTIPATION AND DIARRHEA MEDICATIONS**
**11A: CURRENT PRIOR AUTHORIZATION CRITERIA**
**11B: UTILIZATION OF CONSTIPATION AND DIARRHEA MEDICATIONS**
**11C: PRIOR AUTHORIZATION OF CONSTIPATION AND DIARRHEA MEDICATIONS**
**11D: MARKET NEWS AND UPDATES**
**11E: COLLEGE OF PHARMACY RECOMMENDATIONS**
**11F: UTILIZATION DETAILS OF CONSTIPATION AND DIARRHEA MEDICATIONS**
Materials included in agenda packet; presented by Dr. DeRemer
Dr. Muñoz moved to approve; seconded by Dr. Holderread
**ACTION: MOTION CARRIED**

**AGENDA ITEM NO. 12: ANNUAL REVIEW OF TESTOSTERONE PRODUCTS AND 30-DAY NOTICE TO PRIOR AUTHORIZE AZMIRO™ (TESTOSTERONE CYPIONATE 200MG/ML SYRINGE) AND UNDECATREX™ (TESTOSTERONE UNDECANOATE CAPSULE)**
**12A: CURRENT PRIOR AUTHORIZATION CRITERIA**
**12B: UTILIZATION OF TESTOSTERONE PRODUCTS**
**12C: PRIOR AUTHORIZATION OF TESTOSTERONE PRODUCTS**
**12D: MARKET NEWS AND UPDATES**
**12E: COST COMPARISON**
**12F: COLLEGE OF PHARMACY RECOMMENDATIONS**
**12G: UTILIZATION DETAILS OF TESTOSTERONE PRODUCTS**
Materials included in agenda packet; presented by Dr. Wilson
**ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER**

**AGENDA ITEM NO. 13: ANNUAL REVIEW OF EPIDERMOLYSIS BULLOSA (EB) MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ZEVASKYN™ (PRADEMAGENE ZAMIKERACEL)**
**13A: CURRENT PRIOR AUTHORIZATION CRITERIA**
**13B: UTILIZATION OF EB MEDICATIONS**
**13C: PRIOR AUTHORIZATION OF EB MEDICATIONS**
**13D: MARKET NEWS AND UPDATES**
**13E: ZEVASKYN™ (PRADEMAGENE ZAMIKERACEL) PRODUCT SUMMARY**
**13F: COLLEGE OF PHARMACY RECOMMENDATIONS**
**13G: UTILIZATION DETAILS OF EB MEDICATIONS**
Materials included in agenda packet; presented by Dr. Moss
**ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER**

**AGENDA ITEM NO. 14: ANNUAL REVIEW OF ALZHEIMER'S DISEASE MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ZUNVEYL® (BENZGALANTAMINE)**
**14A: CURRENT PRIOR AUTHORIZATION CRITERIA**
**14B: UTILIZATION OF ALZHEIMER'S DISEASE MEDICATIONS**
**14C: PRIOR AUTHORIZATION OF ALZHEIMER'S DISEASE MEDICATIONS**

**14D: MARKET NEWS AND UPDATES**
**14E: ZUNVEYL® (BENZGALANTAMINE) PRODUCT SUMMARY**
**14F: COLLEGE OF PHARMACY RECOMMENDATIONS**
**14G: UTILIZATION DETAILS OF ALZHEIMER'S DISEASE MEDICATIONS**
Materials included in agenda packet; presented by Dr. O'Halloran
**ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER**

**AGENDA ITEM NO. 15: U.S. FOOD AND DRUG ADMINISTRATION (FDA) AND DRUG ENFORCEMENT ADMINISTATION (DEA) UPDATES**
Non-presentation item; materials included in agenda packet by Dr. DeRemer
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 16: FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)**
**16A: IRON PRODUCTS**
**16B: OPIOID ANALGESICS AND MEDICATION-ASSISTED TREATMENT (MAT) MEDICATIONS**
**16C: TOPICAL CORTICOSTEROIDS**
**16D: VARIOUS SYSTEMIC ANTIBITOICS**
*Future product and class reviews subject to change.
Non-presentation item; materials included in agenda packet by Dr. Adams
**ACTION: NONE REQUIRED**

**AGENDA ITEM NO. 17: ADJOURNMENT**
The meeting was adjourned at 4:30pm.

*The University of Oklahoma*
*Health Sciences Center*
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

**Memorandum**

**Date:** July 10, 2025

**To:** Terry Cothran, D.Ph.
Pharmacy Director
Oklahoma Health Care Authority

**From:** Michyla Adams, Pharm.D.
Drug Utilization Review (DUR) Manager
Pharmacy Management Consultants

**Subject:** DUR Board Recommendations from Meeting on July 9, 2025

**Recommendation 1: Update on Medication Coverage Authorization Unit**

NO ACTION REQUIRED.

**Recommendation 2: Chronic Medication Adherence (CMA) Program Update**

NO ACTION REQUIRED.

**Recommendation 3: Vote to Prior Authorize Cobenfy™ (Xanomeline/ Trospium), Erzofri® [Paliperidone Palmitate Extended-Release (ER) Injection], and Opipza™ (Aripiprazole Oral Film) and Update the Approval Criteria for the Atypical Antipsychotic Medications**

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the Atypical Antipsychotic Medications Product Based Prior Authorization (PBPA) category (changes noted in red in the following PBPA Tier chart and criteria):

1. Prior authorization of Cobenfy™ (xanomeline/trospium) and Erzofri® (paliperidone palmitate ER injection) and placement into Tier-3; and
2. Prior authorization of Opipza™ (aripiprazole oral film) and placement into Tier-3 with the following additional criteria; and

3. Removing the verbiage of clozapine not counting as a Tier-1 trial from the Tier-2 and Tier-3 criteria based on the removal of the Clozapine REMS program; and
4. Updating the Lybalvi® (olanzapine/samidorphan) approval criteria based on recent data from long-term extension trials and to be consistent with clinical practice.

| Atypical Antipsychotic Medications* | | |
|---|---|---|
| **Tier-1** | **Tier-2** | **Tier-3** |
| aripiprazole (Abilify®)¥ | asenapine (Saphris®) | aripiprazole tablets with sensor (Abilify MyCite®)~ |
| aripiprazole IM inj (Abilify Asimtufii®)^ | iloperidone (Fanapt®) | **aripiprazole oral film (Opipza™)+** |
| aripiprazole IM inj (Abilify Maintena®)^ | lurasidone (Latuda®) | asenapine transdermal system (Secuado®)+ |
| aripiprazole lauroxil IM inj (Aristada®)^ | paliperidone (Invega®) | brexpiprazole (Rexulti®) |
| aripiprazole lauroxil IM inj (Aristada Initio®)^ | | cariprazine (Vraylar®) |
| clozapine (Clozaril®)◆ | | clozapine (Fazaclo®)+ |
| olanzapine (Zyprexa®) | | clozapine oral susp (Versacloz®)+ |
| paliperidone palmitate IM inj (Invega Hafyera®)^ | | lumateperone (Caplyta®) |
| paliperidone palmitate IM inj (Invega Sustenna®)^ | | olanzapine/fluoxetine (Symbyax®)+ |
| paliperidone palmitate IM inj (Invega Trinza®)^ | | olanzapine/samidorphan (Lybalvi®)β |
| quetiapine (Seroquel®) | | **paliperidone palmitate ER inj (Erzofri®)^∞** |
| quetiapine ER (Seroquel XR®) | | quetiapine 150mg tablets+ |
| risperidone (Risperdal®) | | risperidone IM inj (Risperdal Consta®)^∞ |
| risperidone ER sub-Q inj (Perseris®)^ | | risperidone IM inj (Risvan®)^∞ |
| risperidone sub-Q inj (Uzedy®)^ | | risperidone IM inj (Rykindo®)^∞ |
| ziprasidone (Geodon®) | | |
| **Unique Mechanisms of Action** | | |
| | | **xanomeline/trospium (Cobenfy™)** |

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC). Placement of products shown in blue is based on net cost after federal and/or supplemental rebates,

and products may be moved to a higher tier if the net cost changes in comparison to other available products.
ER = extended-release; IM = intramuscular; inj = injection; sub-Q = subcutaneous; susp = suspension
¥Aripiprazole (Abilify®) orally disintegrating tablet (ODT) is considered a special formulation and requires a patient-specific, clinically significant reason why a special formulation product is needed in place of the regular tablet formulation.
*~~Clozapine does not count towards a Tier-1 trial.~~
^Use of a long-acting injectable product may require the member to have been adequately treated with another oral or injectable product prior to use and/or during initiation. The package labeling should be referenced for each individual product.
~Unique criteria applies to Abilify MyCite® (aripiprazole tablets with sensor).
+Unique criteria applies in addition to tier trial requirements.
ßUnique criteria applies to Lybalvi® (olanzapine/samidorphan).
∞Unique criteria applies to Tier-3 long-acting injectable (LAI) products.

Tier-1 products are available without prior authorization for members 5 years of age and older. Prior authorization requests for members younger than 5 years of age are reviewed by an Oklahoma Health Care Authority (OHCA)- or SoonerSelect health plan-contracted child psychiatrist.

**Atypical Antipsychotic Medications Tier-2 Approval Criteria:**

1. A Tier-1 trial at least 14 days in duration, titrated to recommended dose, which did not yield adequate response or resulted in intolerable adverse effects; and
    a. ~~Clozapine does not count towards a Tier-1 trial.~~
2. Members currently stable on a Tier-2 medication may be approved for continuation of therapy.

**Atypical Antipsychotic Medications Tier-3 Approval Criteria:**

1. A Tier-1 trial at least 14 days in duration, titrated to recommended dose, which did not yield adequate response or resulted in intolerable adverse effects; and
    a. ~~Clozapine does not count towards a Tier-1 trial; and~~
2. Trials of 2 oral Tier-2 medications, at least 14 days in duration each, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects; or
3. A manual prior authorization may be submitted for consideration of a Tier-3 medication when the member has had at least 4 trials of Tier-1 and Tier-2 medications (2 trials must be from Tier-1) that did not yield an adequate response or resulted in intolerable adverse effects; and
4. Members currently stable on a Tier-3 medication may be approved for continuation of therapy; and
5. Use of Fazaclo® (clozapine orally disintegrating tablet) or Versacloz® (clozapine oral suspension) or requires a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
6. Use of Opipza™ (aripiprazole oral film) will require a patient-specific, clinically significant reason why the member cannot use the oral tablet or oral disintegrating tablet formulation; and

7. Use of quetiapine 150mg tablet will require a patient-specific, clinically significant reason why the member cannot use the lower tiered quetiapine products, which are available without a prior authorization; and
8. Use of Secuado® (asenapine transdermal system) requires a patient-specific, clinically significant reason why the member cannot use the oral sublingual tablet formulation. Tier structure rules continue to apply; and
9. Use of Symbyax® (olanzapine/fluoxetine) requires a patient-specific, clinically significant reason why the member cannot use olanzapine and fluoxetine as individual components.

**Lybalvi® (Olanzapine/Samidorphan) Approval Criteria:**

1. An FDA approved diagnosis; and
2. Member must be 18 years of age or older; and
3. ~~Member must have a positive clinical response to olanzapine and gained ≥10% from baseline body weight after starting olanzapine (baseline and current weight must be provided); or~~
4. ~~A patient specific, clinically significant reason why the member cannot use a lower-tiered product with a lower weight gain profile must be provided; and~~
5. Member must meet 1 of the following:
    a. Member has a positive clinical response to olanzapine and experienced weight gain ≥7% from baseline body weight or other metabolic complications [e.g., increased waist circumference, increased metabolic parameters, worsening diabetes (i.e., increased A1c or glucose despite optimal adherent therapy for diabetes)] after starting olanzapine (baseline and current weight must be provided or documentation of metabolic complications); or
    b. Member has a trial of one Tier-1 and one Tier-2 medication with a lower weight gain or metabolic profile (e.g., aripiprazole, ziprasidone, lurasidone), at least 14 days in duration each, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects; and
6. Member must not be taking opioids or undergoing acute opioid withdrawal; and
7. Initial approvals will be for 3 months. For continuation consideration, documentation that the member is responding well to treatment and any increase in body weight is ~~<~~ ≤10% of baseline body weight (current weight must be provided) or has had no increase or worsening in metabolic complications (documentation must be provided) while on therapy must be provided.

**Recommendation 4: Vote to Prior Authorize Bucapsol™ (Buspirone Capsule), Carbamazepine 200mg Chewable Tablet, Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)], Focinvez™ (Fosaprepitant Injection), Imkeldi (Imatinib Oral Solution), IVRA (Melphalan 90mg/mL Injection), Myhibbin™ (Mycophenolate Mofetil Oral Suspension), Ondansetron 16mg ODT, Tezruly™ (Terazosin Oral Solution), Topiramate 50mg Sprinkle Capsule, Veltassa® (Patiromer) 1g Powder Packet, and Vigafyde™ (Vigabatrin Oral Solution) and Update the Approval Criteria for the Various Special Formulations**

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Bucapsol™ (buspirone capsules) with the following criteria (shown in red):

**Bucapsol™ (Buspirone Capsule) Approval Criteria:**

1. A patient-specific, clinically significant reason why the member cannot use buspirone tablets, even when the tablets are crushed, must be provided.

The College of Pharmacy recommends the prior authorization of carbamazepine 200mg chewable tablet with the following criteria (shown in red):

**Carbamazepine 200mg Chewable Tablet Approval Criteria:**

1. A patient-specific, clinically significant reason why the member cannot use all other forms of carbamazepine that are available without a prior authorization, including using 2 of the 100mg chewable tablets to achieve the 200mg dose, must be provided; and
2. A quantity limit of 720 chewable tablets per 90 days will apply.

The College of Pharmacy recommends the prior authorization of Femlyv™ (norethindrone acetate/ethinyl estradiol ODT) with criteria similar to Nextstellis® (drospirenone/estetrol tablet) and Slynd® (drospirenone tablet) with the following criteria (shown in red):

**Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)], Nextstellis® (Drospirenone/Estetrol Tablet), and Slynd® (Drospirenone Tablet) Approval Criteria:**

1. A patient-specific, clinically significant reason why the member cannot use all alternative formulations of hormonal contraceptives available without a prior authorization must be provided.

The College of Pharmacy recommends the prior authorization of Focinvez™ (fosaprepitant) with criteria similar to Anzemet® (dolasetron), Cinvanti® and Emend® (aprepitant), Emend® IV (fosaprepitant), and Kytril® and Sancuso®

(granisetron) with the following additional updates to be consistent with clinical practice and net costs (changes shown in red):

**Anzemet® (Dolasetron), Cinvanti® and Emend® (Aprepitant), Emend® IV (Fosaprepitant), Focinvez™ (Fosaprepitant), and Kytril® and Sancuso® (Granisetron) Approval Criteria:**

1. An FDA approved diagnosis; and
2. A recent trial of ondansetron (within the past 6 months) used for at least 3 days or 1 cycle that resulted in an inadequate response is required for authorization in members receiving moderately emetogenic chemotherapy; and
3. No ondansetron trial is required for authorization ~~of Emend® (aprepitant)~~ in members receiving highly emetogenic chemotherapy; and
4. For Emend® (aprepitant) oral suspension, an age restriction of 6 years and younger will apply. Members older than 6 years of age will require a patient-specific, clinically significant reason why the oral capsule formulation cannot be used; and
5. For Cinvanti® [aprepitant intravenous (IV) emulsion] and Focinvez™ (fosaprepitant), a previously failed trial of IV fosaprepitant (Emend® IV) that resulted in an inadequate response or a patient-specific, clinically significant reason why IV fosaprepitant (Emend® IV) cannot be used must be provided; and
6. Approval length will be based on duration of need.

The College of Pharmacy recommends the prior authorization of Imkeldi (imatinib oral solution) with the following criteria (shown in red):

**Imkeldi (Imatinib Oral Solution) Approval Criteria:**

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use imatinib tablets, which are available without a prior authorization, must be provided. Imatinib tablets may be dispersed in a glass of water or apple juice to form a suspension for members who cannot swallow the film-coated tablets.

The College of Pharmacy recommends the prior authorization of IVRA (melphalan 90mg/mL) with the following criteria (shown in red):

**IVRA (Melphalan 90mg/mL) Approval Criteria:**

1. An FDA approved diagnosis; and
2. A patient specific, clinically significant reason why the member cannot use generic melphalan 50mg/10mL vial which is available without a prior authorization.

The College of Pharmacy recommends the prior authorization of Myhibbin™ (mycophenolate mofetil oral suspension) with the following criteria (shown in red):

**Myhibbin™ (Mycophenolate Mofetil Oral Suspension) Approval Criteria:**

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use generic Cellcept® (mycophenolate mofetil for oral suspension), which is available without a prior authorization, must be provided.

The College of Pharmacy recommends the prior authorization of ondansetron 16mg ODT with the following criteria (shown in red):

**Ondansetron 16mg Orally Disintegrating Tablet (ODT) Approval Criteria:**

1. An FDA approved indication for the prevention of postoperative nausea and vomiting (PONV); and
2. A patient-specific, clinically significant reason why the member cannot use 2 of the 8mg ODTs to achieve the 16mg dose must be provided.

The College of Pharmacy also recommends the prior authorization of Tezruly™ (terazosin oral solution) with placement into the Special Prior Authorization (PA) Tier of the Benign Prostatic Hyperplasia (BPH) Medications Product Based Prior Authorization (PBPA) category with the following additional criteria (shown in red):

| Benign Prostatic Hyperplasia (BPH) Medications | | |
|---|---|---|
| **Tier-1** | **Tier-2** | **Tier-3** |
| alfuzosin (Uroxatral®) | doxazosin (Cardura XL®) | tadalafil 5mg (Cialis®) |
| doxazosin (Cardura®) | dutasteride/tamsulosin (Jalyn®) | finasteride/tadalafil 5mg/5mg (Entadfi®)* |
| dutasteride (Avodart®) | silodosin (Rapaflo®) | **terazosin oral solution (Tezruly™)*** |
| finasteride (Proscar®) | | |
| tamsulosin (Flomax®) | | |
| terazosin (Hytrin®) | | |

*Unique criteria applies

**Tezruly™ (Terazosin Oral Solution) Approval Criteria:**

1. An FDA approved diagnosis of benign prostatic hyperplasia (BPH) or hypertension (HTN); and
2. A patient specific, clinically significant reason why the member cannot use terazosin capsules must be provided; and
3. For a diagnosis of BPH, a patient specific, clinically significant reason why the member cannot use Rapaflo® (silodosin), which may be opened and sprinkled on applesauce for patients with difficulties swallowing, must be provided; and
4. A quantity limit of 600mL per 30 days will apply.

The College of Pharmacy recommends the prior authorization of topiramate 50mg sprinkle capsule with the following criteria (shown in red):

**Topiramate 50mg Sprinkle Capsule Approval Criteria:**

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use other available generic topiramate products, including using 2 topiramate 25mg sprinkle capsules to achieve the 50mg dose, must be provided; and
3. Members 12 years of age and older will require a patient-specific, clinically significant reason why a special formulation product is needed; and
4. A quantity limit of 240 capsules per 30 days will apply.

The College of Pharmacy recommends the prior authorization of Veltassa® (patiromer) 1 gram packet with criteria similar to the other Veltassa® strengths with the following additional criteria (changes shown in red):

**Veltassa® (Patiromer) Approval Criteria:**

1. An FDA approved diagnosis of hyperkalemia; and
2. Medications known to cause hyperkalemia [e.g., aldosterone antagonists, nonsteroidal anti-inflammatory drugs (NSAIDs)] have been discontinued or reduced to the lowest effective dose where clinically appropriate; and
3. A trial of a potassium-eliminating diuretic or documentation why a diuretic is not appropriate for the member; and
4. Documentation of a low potassium diet; and
5. For members 18 years of age and older, a patient-specific, clinically significant reason why the member cannot use Lokelma® (sodium zirconium cyclosilicate) must be provided; and
6. Quantity limits will apply as follows:
    a. 1g Packets: A quantity limit of 120 packets per 30 days will apply; or
    b. 8.4g, 16.8g, and 25.2g Packets: A quantity limit of 30 packets per month will apply.

The College of Pharmacy recommends the prior authorization of Vigafyde™ (vigabatrin oral solution) with the following criteria and updating the Sabril® (vigabatrin) criteria based on the Vigafyde™ FDA approval (changes shown in red):

**Vigafyde™ (Vigabatrin Oral Solution) Approval Criteria:**

1. An FDA approved diagnosis of infantile spasms in children 1 month to 2 years of age; and
2. A patient-specific, clinically significant reason why the member cannot use brand name Sabril® (vigabatrin) for oral solution must be provided; and
3. Prescription must be written by, or in consultation with, a neurologist; and
4. Member, prescriber, and pharmacy must all register in the Vigabatrin REMS program and maintain enrollment throughout therapy.

**Sabril® (Vigabatrin) Approval Criteria:**

1. An FDA approved diagnosis of refractory complex seizures in adults and pediatric patients 2 years of age or older, or infantile spasms in children 1 month to 2 years of age; and
2. Authorization of generic vigabatrin (in place of brand Sabril®) will require a patient-specific, clinically significant reason why the member cannot use the brand formulation (brand formulation is preferred); and
3. Members with refractory complex seizures must have previous trials of at least three other antiepileptic medications; or
4. Prescription must be written by, or in consultation with a neurologist; and
5. Member, prescriber, and pharmacy must all register in the Vigabatrin ~~SABRIL~~ REMS program and maintain enrollment throughout therapy.

The College of Pharmacy recommends updating the Jylamvo™ (methotrexate oral solution) based on the FDA label expansion to allow use of Jylamvo™ in pediatric patients for a diagnosis of acute lymphoblastic leukemia (ALL) or polyarticular juvenile idiopathic arthritis (pJIA) (changes shown in red):

**Jylamvo™ (Methotrexate Oral Solution) Approval Criteria:**

1. An FDA approved diagnosis of 1 of the following:
   a. Treatment of adults and pediatric members with acute lymphoblastic leukemia (ALL) as part of a combination chemotherapy maintenance regimen; or
   b. Treatment of adults with mycosis fungoides (cutaneous T-cell lymphoma) as a single agent or as part of a combination chemotherapy regimen; or
   c. Treatment of pediatric members with polyarticular juvenile idiopathic arthritis (pJIA); or
   d. Treatment of adults with relapsed or refractory non-Hodgkin lymphomas as part of a metronomic combination chemotherapy regimen; or
   e. Treatment of adults with rheumatoid arthritis; or
   f. Treatment of adults with severe psoriasis; and

~~2. Member must be 18 years of age or older; and~~

3. A patient-specific clinically significant reason why the oral tablets and the generic injectable formulation cannot be used must be provided.

Finally, the College of Pharmacy recommends removal of SoonerCare coverage and of the prior authorization criteria for Aspruzyo Sprinkle™ due to product discontinuation (shown in red):

~~**Aspruzyo Sprinkle™ [Ranolazine Extended-Release (ER) Granules] Approval Criteria:**~~

~~1. An FDA approved diagnosis of chronic angina; and~~

~~2. A patient-specific, clinically significant reason why the member cannot use ranolazine ER tablets must be provided.~~

**Recommendation 5: Vote to Prior Authorize Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib) and Update the Approval Criteria for the Genitourinary and Gynecologic Cancer Medications**

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Avmapki™ Fakzynja™ Co-Pack (avutometinib and defactinib) with the following criteria (shown in red):

**Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib) Approval Criteria [Ovarian Cancer Diagnosis]:**

1. Diagnosis of low-grade serous ovarian cancer; and
2. Disease is recurrent; and
3. Member has KRAS-mutation; and
4. Member has received prior systemic therapy; and
5. Member is 18 years of age or older.

Next, the College of Pharmacy recommends updating the approval criteria for Cabometyx® (cabozantinib), Jemperli (dostarlimab-gxly), Nubeqa® (darolutamide), Pluvicto® (lutetium Lu 177 vipivotide tetraxetan), and Welireg® (belzutifan) based on recent FDA approvals (changes and new criteria noted in red):

**Cabometyx® (Cabozantinib) Approval Criteria:**

1. For cabozantinib monotherapy:
    a. Diagnosis of advanced renal cell carcinoma (RCC); or
    b. Diagnosis of advanced hepatocellular carcinoma (HCC); and
        i. Member has previously received sorafenib; or
    c. Diagnosis of locally advanced or metastatic differentiated thyroid cancer (DTC) in adults and pediatric members 12 years of age and older; and
        i. Disease has progressed following prior vascular endothelial growth factor (VEGF)-targeted therapy; and
        ii. Disease is radioactive iodine-refractory or member is ineligible for radioactive iodine; or
    d. Diagnosis of locally advanced, unresectable or metastatic well-differentiated pancreatic neuroendocrine tumors (pNET) or extrapancreatic neuroendocrine tumors (epNET) in adults and pediatric members 12 years of age and older; and
        i. As second line or subsequent therapy; or
2. For cabozantinib in combination with nivolumab:
    a. Diagnosis of relapsed or surgically unresectable stage 4 disease in the initial treatment of members with advanced RCC; and

b. Nivolumab, when used in combination with cabozantinib for RCC, will be approved for a maximum duration of 2 years.

**Jemperli (Dostarlimab-gxly) Approval Criteria [Endometrial Cancer Diagnosis]:**

1. Used as a single agent; and
   a. Diagnosis of advanced, recurrent, or metastatic endometrial cancer; and
   b. Mismatch repair deficient (dMMR) disease; and
   c. Disease has progressed on or following prior treatment with a platinum-containing regimen; or
2. Used in combination with carboplatin and paclitaxel; and
   a. Diagnosis of primary advanced or recurrent endometrial cancer.~~; and~~
   b. ~~Mismatch repair deficient (dMMR) or microsatellite instability-high (MSI-H) disease.~~

**Nubeqa® (Darolutamide) Approval Criteria [Metastatic ~~Hormone~~ Castration-Sensitive Prostate Cancer (~~mHSPC~~ mCSPC) Diagnosis]:**

1. Diagnosis of ~~mHSPC~~ mCSPC; and
2. Concomitant treatment with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy; and
3. Used in combination with docetaxel or as a single agent.

**Pluvicto® (Lutetium Lu 177 Vipivotide Tetraxetan) Approval Criteria [Prostate Cancer Diagnosis]:**

1. Diagnosis of prostate-specific membrane antigen (PSMA)-positive metastatic castration-resistant prostate cancer (mCRPC); and
2. Member must have been treated with androgen receptor pathway inhibitor (ARPI) therapy ~~and taxane-based chemotherapy~~; and
3. Member must meet 1 of the following:
   a. Considered appropriate to delay taxane-based chemotherapy; or
   b. Has received prior taxane-based chemotherapy.

**Welireg® (Belzutifan) Approval Criteria [Pheochromocytoma or Paraganglioma (PPGL) Diagnosis]:**

1. Diagnosis of locally advanced, unresectable, or metastatic PPGL; and
2. Member must be 12 years of age or older; and
3. As a single agent.

**Welireg® (Belzutifan) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:**

1. Diagnosis of advanced RCC with a clear cell component; and
2. Member has received at least 2 lines of systemic therapy, including a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI); and

3. As a single agent.

Lastly, the College of Pharmacy recommends updating the approval criteria for Zytiga® (abiraterone) to be more consistent with the package labeling (changes shown in red):

**Zytiga® (Abiraterone) Approval Criteria [Castration-Sensitive Prostate Cancer (CSPC) Diagnosis]:**

1. Diagnosis of metastatic, high-risk, CSPC; and
2. Abiraterone must be used in combination with a corticosteroid; and
3. Concomitant treatment with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy; and
4. Use of the 500mg tablet will require a patient-specific, clinically significant reason why the member cannot use generic abiraterone 250mg tablets.

**Recommendation 6: Fiscal Year 2024 Annual Review of Colorectal Cancer (CRC) Medications**

NO ACTION REQUIRED.

**Recommendation 7: Fiscal Year 2024 Annual Review of Defencath® (Taurolidine/Heparin)**

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the Defencath® (taurolidine/heparin) approval criteria based on FDA approved updates to the package labeling (changes shown in red):

**Defencath® (Taurolidine/Heparin) Approval Criteria:**

1. An FDA approved indication of reducing the incidence of catheter-related bloodstream infections (CRBSIs) in adult members with kidney failure receiving chronic hemodialysis (HD) through a central venous catheter (CVC); and
2. Member must be 18 years of age or older; and
3. Must be used for prevention of CRBSIs; and
4. Prescriber must verify Defencath® is used only as a catheter lock solution (CLS) in CVCs and will not be administered systemically or used as a catheter lock flush product (i.e., it ~~must~~ should be aspirated from the catheter and discarded prior to the next utilization of the CVC); and
5. Member must not have a known history of heparin-induced thrombocytopenia (HIT) or known hypersensitivity to pork products, taurolidine, heparin, or other components of Defencath®; and
6. A quantity limit of 2 vials per HD session or 24 vials per 28 days will apply; and

a. For requests exceeding the quantity limit, supporting documentation (e.g., HD schedule, number of CVC lumens, CVC lumen volumes) must be provided for a quantity limit override; and

7. Approvals will be granted for 1 year.

**Recommendation 8: Fiscal Year 2024 Annual Review of Constipation and Diarrhea Medications**

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the current constipation medications approval criteria based on colorectal cancer screening guidelines published by the American College of Physicians (ACP), American Cancer Society (ACS), American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and the U.S. Preventative Services Task Force (USPSTF) (changes shown in red):

**Amitiza® (Lubiprostone) Approval Criteria [Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C) Diagnosis]:**

1. An FDA approved diagnosis of CIC in members 18 years of age or older, or IBS-C in female members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
4. Member must not have known or suspected gastrointestinal obstruction; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. A patient-specific, clinically significant reason why the member cannot use Linzess® (linaclotide) or Trulance® (plecanatide) must be provided; and
7. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents member is responding well to treatment; and

8. A quantity limit of 60 capsules per 30 days will apply.

**Amitiza® (Lubiprostone) Approval Criteria [Opioid-Induced Constipation (OIC) Diagnosis]:**

1. An FDA approved diagnosis of OIC in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy, except methadone, including members with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; and
2. Documentation of the underlying cause of chronic pain, or reason why member is on chronic opioid therapy; and
3. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
4. Member must not have known or suspected gastrointestinal obstruction; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents member is responding well to treatment; and
7. Amitiza® must be discontinued if treatment with the opioid pain medication is also discontinued; and
8. A quantity limit of 60 capsules per 30 days will apply.

**Ibsrela® (Tenapanor) Approval Criteria:**

1. An FDA approved diagnosis of irritable bowel syndrome with constipation (IBS-C) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~

~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~

4. Member must not have known or suspected gastrointestinal obstruction; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. A patient-specific, clinically significant reason why the member cannot use Amitiza® (lubiprostone), Linzess® (linaclotide), or Trulance® (plecanatide) must be provided; and
7. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents the member is responding well to treatment; and
8. A quantity limit of 60 tablets per 30 days will apply.

**Linzess® (Linaclotide) Approval Criteria:**

1. An FDA approved diagnosis of 1 of the following:
   a. Chronic idiopathic constipation (CIC) in members 18 years of age or older; or
   b. Irritable bowel syndrome with constipation (IBS-C) in members 18 years of age or older; or
   c. Functional constipation in members 6 to 17 years of age; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
4. Member must not have known or suspected gastrointestinal obstruction; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and

6. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents the member is responding well to treatment; and
7. A quantity limit of 30 capsules per 30 days will apply.

**Motegrity® (Prucalopride) Approval Criteria:**

1. An FDA approved diagnosis of chronic idiopathic constipation (CIC) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   a. ~~Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   b. ~~Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
4. Member must not have known or suspected gastrointestinal obstruction; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. A patient-specific, clinically significant reason why the member cannot use Amitiza® (lubiprostone), Linzess® (linaclotide), or Trulance® (plecanatide) must be provided; and
7. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents the member is responding well to treatment; and
8. A quantity limit of 30 tablets per 30 days will apply.

**Movantik® (Naloxegol) Approval Criteria:**

1. An FDA approved diagnosis of opioid-induced constipation (OIC) in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy including members with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; and
2. Member must not have known or suspected gastrointestinal obstruction; and
3. Documentation of the underlying cause of chronic pain, or reason why member is on chronic opioid therapy; and

4. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
5. depending on risk factors and/or previous screening results); and
6. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
7. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
8. Movantik® must be discontinued if treatment with the opioid pain medication is also discontinued; and
9. A quantity limit of 30 tablets per 30 days will apply.

**Pizensy™ (Lactitol) Approval Criteria:**

1. An FDA approved indication for treatment of chronic idiopathic constipation (CIC) in members 18 years of age or older; and
2. Member must not have a known contraindication to Pizensy™ (i.e., suspected gastrointestinal obstruction, galactosemia); and
3. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
4. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
5. Member must not have known or suspected gastrointestinal obstruction; and
6. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and

7. A patient-specific, clinically significant reason why the member cannot use Amitiza® (lubiprostone), Linzess® (linaclotide), or Trulance® (plecanatide) must be provided; and
8. Use of the unit-dose packets will require a patient-specific, clinically significant reason why the member cannot use the multi-dose bottle; and
9. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
10. A quantity limit of 560 grams per 28 days will apply.

**Relistor® (Methylnaltrexone) Injection Approval Criteria [Opioid-Induced Constipation (OIC) in Chronic Non-Cancer Pain Diagnosis]:**

1. An FDA approved diagnosis of OIC in members 18 years of age or older with chronic, non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; and
2. Documentation of the underlying cause of chronic pain, or reason why the member is on chronic opioid therapy; and
3. Member must have current use of opioid medications; and
4. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
5. Documentation of hydration attempts and trials of at least 3 different products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from trial requirements; and
6. Member must not have known or suspected gastrointestinal obstruction; and
7. A patient-specific, clinically significant reason why the member cannot use Amitiza® (lubiprostone), Movantik® (naloxegol), or Symproic® (naldemedine) must be provided; and
8. A patient-specific, clinically significant reason why the member cannot use the tablet formulation of Relistor® must be provided; and
9. The 12mg single-use vials, syringes, or kits will be the preferred products. Criteria for consideration of 8mg single-use syringes:
   a. Weight range of 38kg to 62kg; and/or
   b. Caregiver unable to draw up dose from vial; and

10. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
11. Relistor® must be discontinued if treatment with the opioid pain medication is also discontinued; and
12. A quantity limit of 30 units per month will apply.

**Relistor® (Methylnaltrexone) Tablets Approval Criteria:**

1. An FDA approved diagnosis of opioid-induced constipation (OIC) in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy, including members with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; and
2. Member must not have known or suspected gastrointestinal obstruction; and
3. Documentation of the underlying cause of chronic pain, or reason why the member is on chronic opioid therapy; and
4. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
5. Documentation of hydration attempts and trials of at least 3 different types of products that have failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from trial requirements; and
6. A patient-specific, clinically significant reason why the member cannot use Amitiza® (lubiprostone), Movantik® (naloxegol), or Symproic® (naldemedine) must be provided; and
7. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
8. Relistor® must be discontinued if treatment with the opioid pain medication is also discontinued; and
9. A quantity limit of 90 tablets per 30 days will apply.

**Symproic® (Naldemedine) Approval Criteria:**

1. An FDA approved diagnosis of opioid-induced constipation (OIC) in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy, including members with

chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; and
2. Member must not have known or suspected gastrointestinal obstruction; and
3. Documentation of the underlying cause of chronic pain, or reason why member is on chronic opioid therapy; and
4. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
7. Symproic® must be discontinued if treatment with the opioid pain medication is also discontinued; and
8. A quantity limit of 30 tablets per 30 days will apply.

**Trulance® (Plecanatide) Approval Criteria:**

1. An FDA approved diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members 45 years of age or older using an appropriate screening strategy ~~1 of the following methods~~ (results must be submitted)~~:~~; and
   ~~a. Recent colonoscopy (within the last 10 years or sooner depending on risk factors and/or previous screening results); or~~
   ~~b. Recent negative Cologuard® test (within the last 3 years or sooner depending on risk factors and/or previous screening results); and~~
4. Member must not have known or suspected gastrointestinal obstruction; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be

within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners; and
   a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
   b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. Approvals will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
7. A quantity limit of 30 tablets per 30 days will apply.

The College of Pharmacy also recommends the following changes to the Motofen® (difenoxin/atropine) criteria for clarity and to be consistent with FDA-approved package labeling (changes shown in red):

**Motofen® (Difenoxin/Atropine) Approval Criteria:**

1. An FDA approved diagnosis of acute nonspecific diarrhea or acute exacerbations of chronic functional diarrhea; and
2. Member must ~~not~~ be 2 years of age or ~~younger;~~ older. Use is contraindicated in pediatric patients younger than 2 years of age; and
3. Member must not have diarrhea associated with organisms that penetrate the intestinal mucosa (e.g., toxigenic *Escherichia coli*, *Salmonella* species, *Shigella*) or pseudomembranous colitis associated with broad spectrum antibiotics; and
4. A patient-specific, clinically significant reason why the member cannot use Lomotil® (diphenoxylate/atropine) and loperamide must be provided; and
5. A quantity limit of 16 tablets per 2 days will apply.

**Recommendation 9: Fiscal Year 2024 Annual Review of Testosterone Products and 30-Day Notice to Prior Authorize Azmiro™ (Testosterone Cypionate) and Undecatrex™ (Testosterone Undecanoate)**

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER 2025.

**Recommendation 10: Fiscal Year 2024 Annual Review of Epidermolysis Bullosa (EB) Medications and 30-Day Notice to Prior Authorize Zevaskyn™ (Prademagene Zamikeracel)**

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER 2025.

**Recommendation 11: Fiscal Year 2024 Annual Review of Alzheimer's Disease Medications and 30-Day Notice to Prior Authorize Zunveyl® (Benzgalantamine)**

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER 2025.

**Recommendation 12: U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates**

NO ACTION REQUIRED.

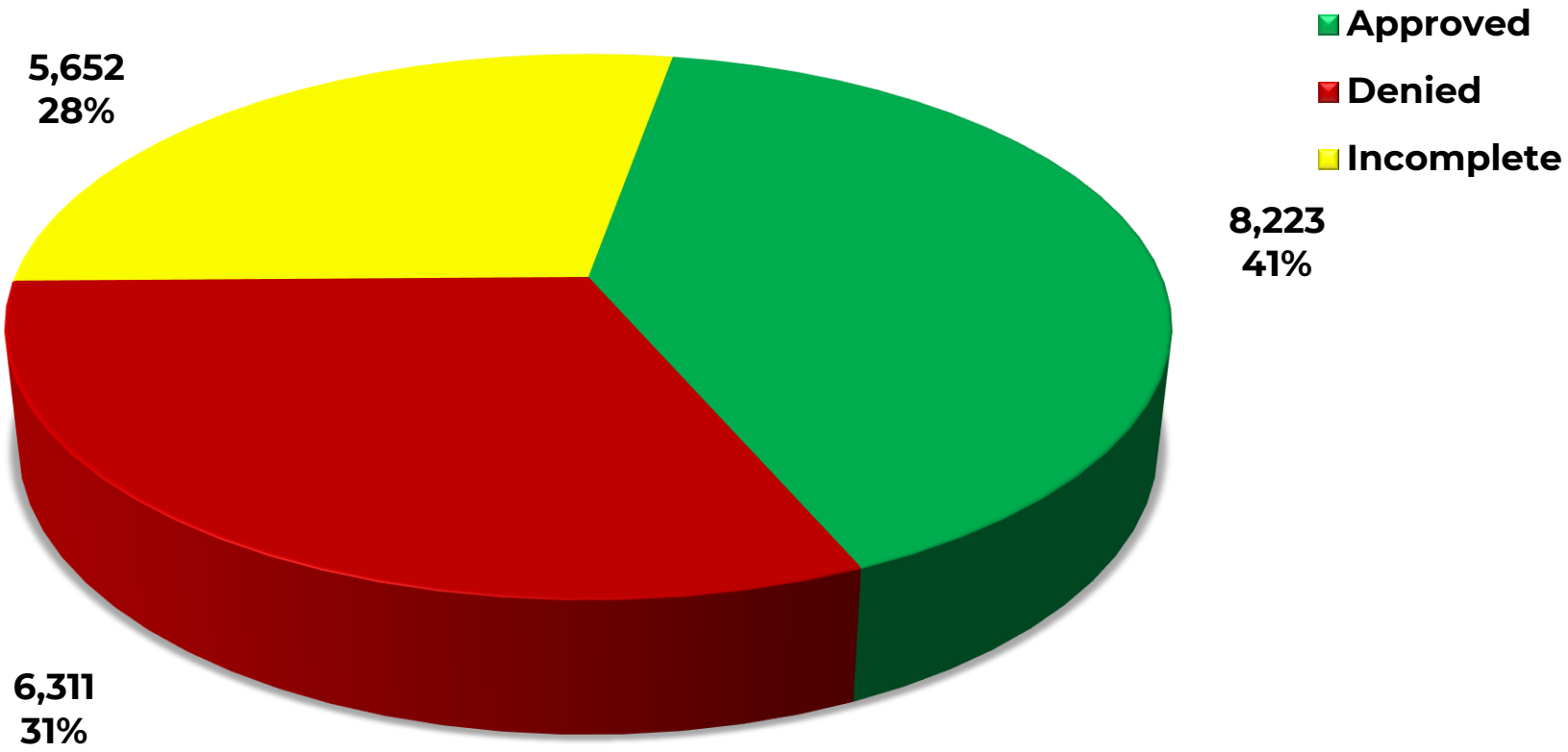
**Recommendation 13: Future Business**

No live DUR Board meeting is scheduled for August 2025. August 2025 will be a packet-only meeting.

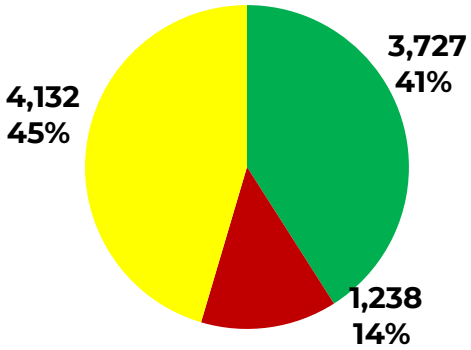
NO ACTION REQUIRED.

# Appendix B

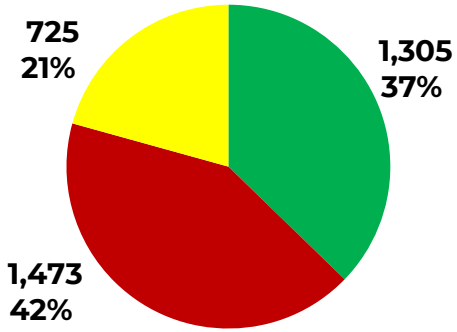
# PRIOR AUTHORIZATION (PA) ACTIVITY REPORT: JULY 2025



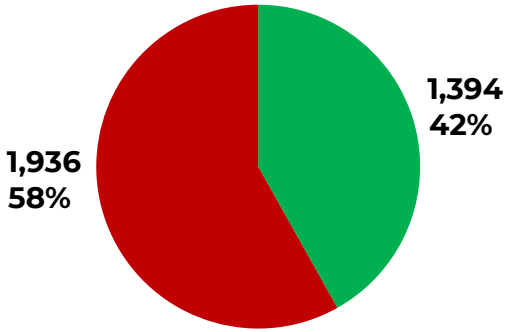

### SoonerCare FFS



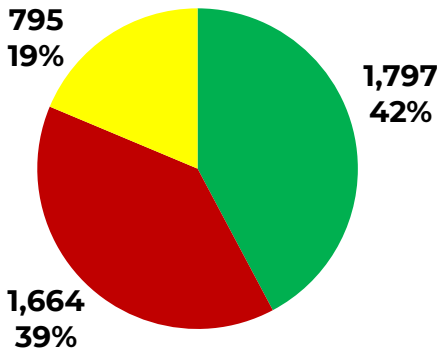

### SoonerSelect Aetna




### SoonerSelect Humana

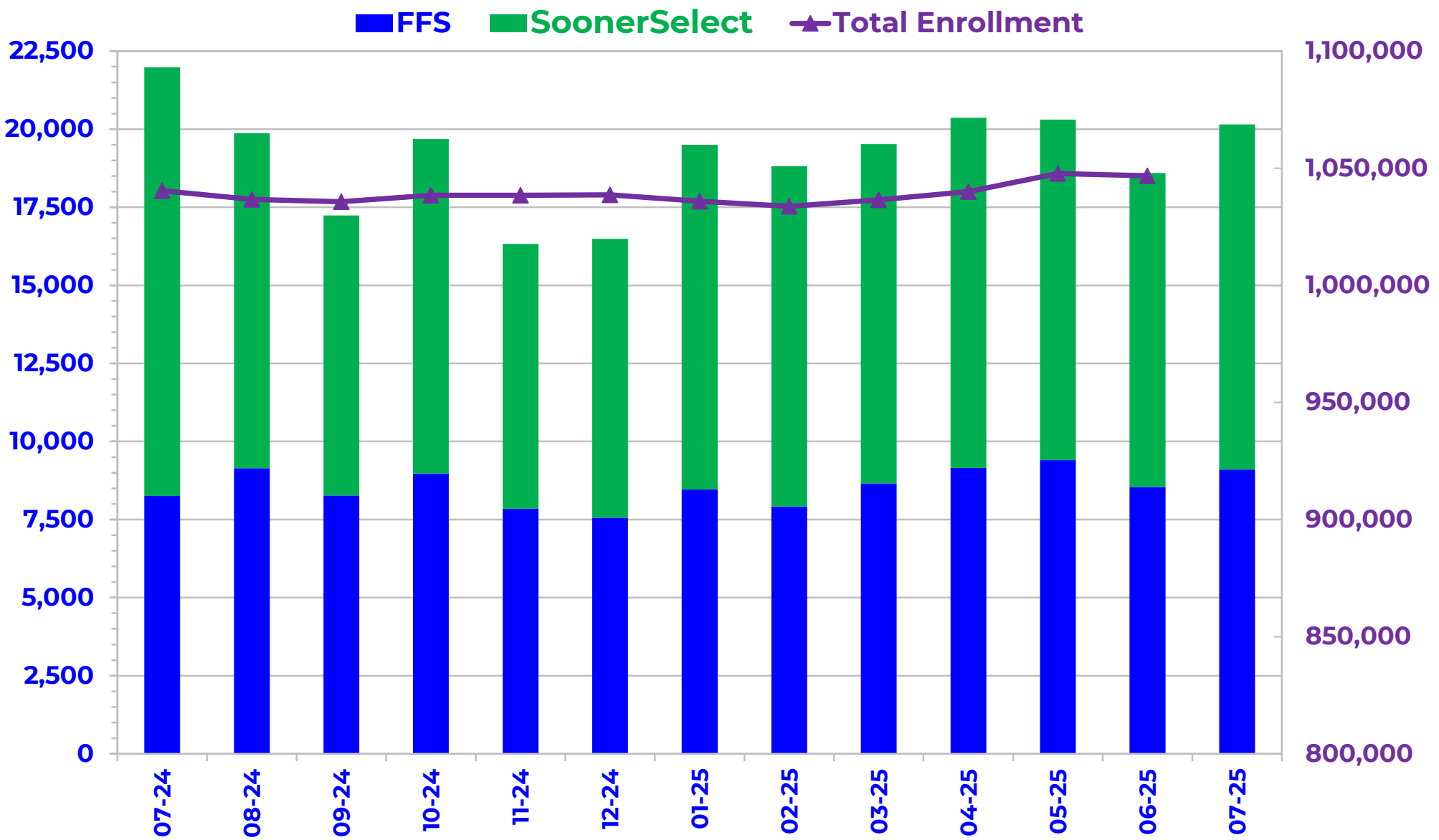



### SoonerSelect OK Complete Health



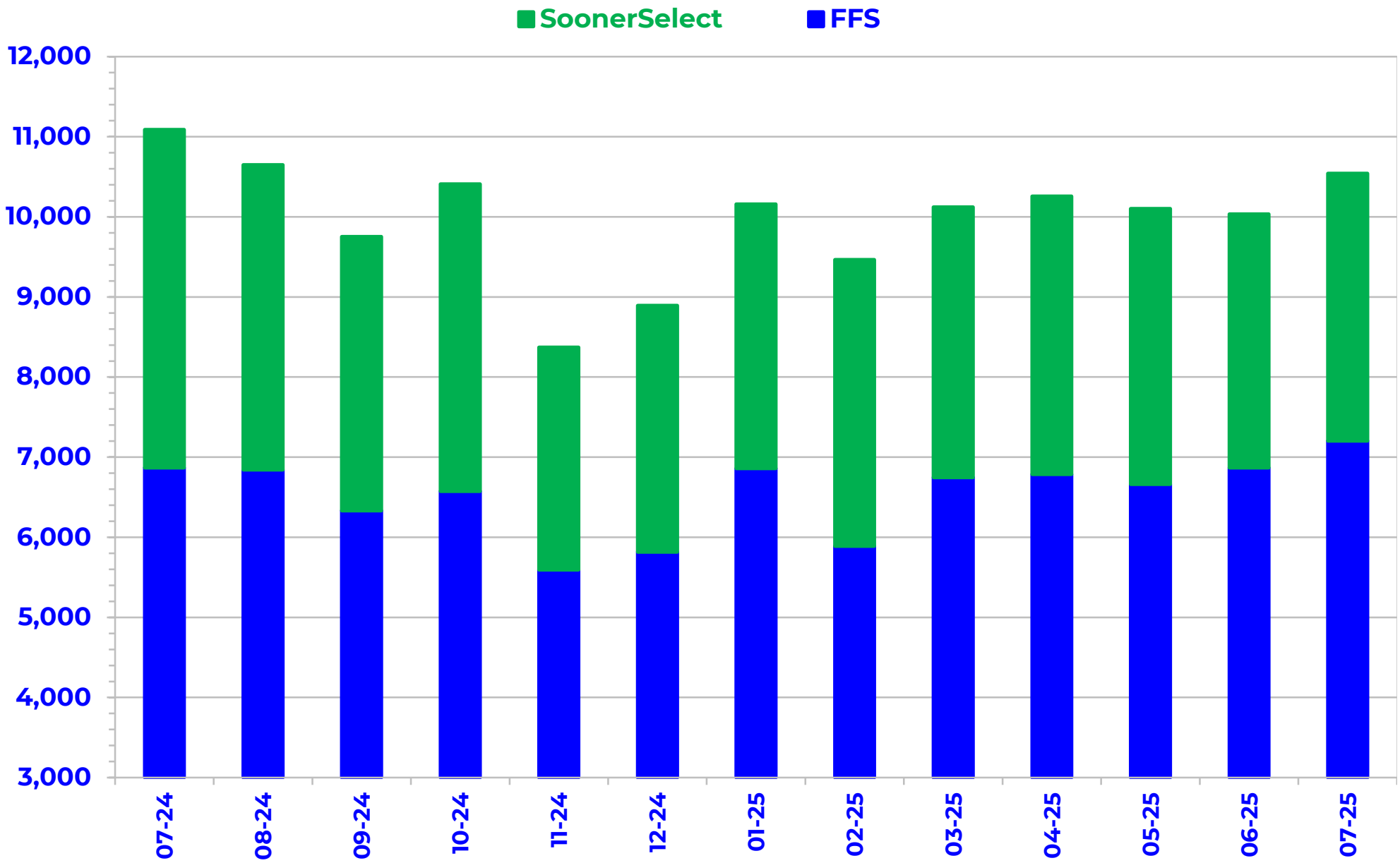

*PA totals include approved/denied/incomplete/overrides; SoonerSelect totals are based on data provided to the College of Pharmacy from the SoonerSelect plans.*

# PRIOR AUTHORIZATION (PA) REPORT: JULY 2024 – JULY 2025




*PA totals include approved/denied/incomplete/overrides*

# CALL VOLUME MONTHLY REPORT: JULY 2024 – JULY 2025



# SoonerCare FFS Prior Authorization Activity

## 7/1/2025 Through 7/31/2025

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Amebicides | 2 | 1 | 0 | 1 | 24 |
| Amphetamines | 793 | 580 | 9 | 204 | 354 |
| Analgesics - Anti-Inflammatory | 269 | 110 | 38 | 121 | 324 |
| Analgesics - Nonnarcotic | 13 | 1 | 0 | 12 | 187 |
| Analgesics - Opioid | 328 | 139 | 30 | 159 | 138 |
| Androgens - Anabolic | 67 | 20 | 14 | 33 | 347 |
| Anthelmintics | 8 | 2 | 0 | 6 | 14 |
| Anti-Infective Agents - Misc. | 20 | 6 | 4 | 10 | 302 |
| Anti-Obesity Agents | 102 | 7 | 68 | 27 | 134 |
| Antianginal Agents | 1 | 0 | 0 | 1 | 0 |
| Antianxiety Agents | 21 | 6 | 1 | 14 | 302 |
| Antiarrhythmics | 1 | 0 | 0 | 1 | 0 |
| Antiasthmatic and Bronchodilator Agents | 488 | 94 | 84 | 310 | 333 |
| Antibiotics | 27 | 9 | 4 | 14 | 204 |
| Anticoagulants | 19 | 2 | 1 | 16 | 358 |
| Anticonvulsants | 198 | 91 | 10 | 97 | 333 |
| Antidepressants | 238 | 68 | 29 | 141 | 312 |
| Antidiabetics | 1,306 | 355 | 249 | 702 | 353 |
| Antidotes and Specific Antagonists | 2 | 0 | 2 | 0 | 0 |
| Antiemetics | 7 | 3 | 0 | 4 | 198 |
| Antifungals | 5 | 2 | 2 | 1 | 128 |
| Antihistamines | 30 | 8 | 7 | 15 | 293 |
| Antihyperlipidemics | 62 | 14 | 13 | 35 | 296 |
| Antihypertensives | 15 | 4 | 1 | 10 | 359 |
| Antineoplastics and Adjunctive Therapies | 175 | 126 | 9 | 40 | 178 |
| Antiparkinson and Related Therapy Agents | 7 | 3 | 1 | 3 | 356 |
| Antipsychotics/Antimanic Agents | 335 | 135 | 27 | 173 | 351 |
| Antivirals | 21 | 6 | 5 | 10 | 43 |
| Attention-Deficit/Hyperactivity Disorder (ADHD) Agents | 220 | 148 | 15 | 57 | 337 |
| Beta Blockers | 9 | 3 | 0 | 6 | 360 |
| Calcium Channel Blockers | 13 | 4 | 1 | 8 | 221 |
| Cardiotonics | 1 | 1 | 0 | 0 | 362 |
| Cardiovascular Agents - Misc. | 73 | 39 | 3 | 31 | 303 |
| Contraceptives | 31 | 15 | 3 | 13 | 337 |
| Corticosteroids | 16 | 1 | 4 | 11 | 360 |
| Dermatologicals | 422 | 126 | 117 | 179 | 242 |
| Diagnostic Products | 72 | 26 | 6 | 40 | 181 |
| Dietary Products/Dietary Management Products | 2 | 0 | 2 | 0 | 0 |
| Digestive Aids | 3 | 3 | 0 | 0 | 359 |
| Diuretics | 23 | 12 | 0 | 11 | 162 |
| Dopamine and Norepinephrine Reuptake Inhibitors (DNRIs) | 4 | 0 | 2 | 2 | 0 |
| Emergency PA | 0 | 0 | 0 | 0 | 0 |
| Endocrine and Metabolic Agents - Misc. | 229 | 105 | 23 | 101 | 250 |
| Estrogens | 15 | 4 | 1 | 10 | 350 |
| Gastrointestinal Agents - Misc. | 302 | 74 | 73 | 155 | 242 |
| Genitourinary Agents - Misc. | 7 | 0 | 2 | 5 | 0 |
| Gout Agents | 5 | 3 | 0 | 2 | 300 |
| Hematological Agents - Misc. | 13 | 5 | 0 | 8 | 327 |

*Includes missing and invalid NDCs, unspecified HCPCS, and CPT codes.

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Hematopoietic Agents | 53 | 22 | 9 | 22 | 164 |
| Hypnotics/Sedatives/Sleep Disorder Agents | 73 | 7 | 13 | 53 | 211 |
| Laxatives | 20 | 8 | 2 | 10 | 103 |
| Medical Devices and Supplies | 295 | 53 | 62 | 180 | 261 |
| Migraine Products | 356 | 76 | 80 | 200 | 241 |
| Minerals and Electrolytes | 5 | 1 | 0 | 4 | 360 |
| Miscellaneous Therapeutic Classes | 89 | 37 | 10 | 42 | 337 |
| Multivitamins | 1 | 1 | 0 | 0 | 360 |
| Musculoskeletal Therapy Agents | 46 | 5 | 12 | 29 | 232 |
| Nasal Agents - Systemic and Topical | 19 | 6 | 3 | 10 | 359 |
| Neuromuscular Agents | 91 | 50 | 21 | 20 | 332 |
| Nutrients | 1 | 1 | 0 | 0 | 116 |
| Ophthalmic Agents | 64 | 16 | 10 | 38 | 213 |
| Other* | 60 | 17 | 2 | 41 | 215 |
| Otic Agents | 82 | 34 | 2 | 46 | 18 |
| Passive Immunizing and Treatment Agents | 3 | 0 | 0 | 3 | 0 |
| Progestins | 4 | 1 | 1 | 2 | 360 |
| Psychotherapeutic and Neurological Agents - Misc. | 275 | 104 | 36 | 135 | 217 |
| Respiratory Agents - Misc. | 35 | 22 | 2 | 11 | 309 |
| Stimulants - Misc. | 236 | 103 | 21 | 112 | 338 |
| Thyroid Agents | 17 | 6 | 1 | 10 | 358 |
| Ulcer Drugs/Antispasmodics/Anticholinergics | 78 | 17 | 10 | 51 | 267 |
| Urinary Antispasmodics | 35 | 7 | 12 | 16 | 318 |
| Vaginal and Related Products | 4 | 0 | 0 | 4 | 0 |
| Vasopressors | 2 | 0 | 0 | 2 | 0 |
| Vitamins | 19 | 1 | 11 | 7 | 72 |
| **Total** | **7,983** | **2,956** | **1,180** | **3,847** | |
| | | | | | |
| **Overrides** | | | | | |
| Brand | 16 | 11 | 1 | 4 | 335 |
| Compound | 24 | 18 | 0 | 6 | 30 |
| Diabetic Supplies | 3 | 3 | 0 | 0 | 78 |
| Dosage Change | 186 | 178 | 0 | 8 | 20 |
| High Dose | 4 | 2 | 0 | 2 | 189 |
| IHS-Brand | 1 | 1 | 0 | 0 | 360 |
| Lost/Broken Rx | 62 | 55 | 3 | 4 | 21 |
| MAT Override | 25 | 13 | 2 | 10 | 80 |
| NDC vs Age | 146 | 89 | 20 | 37 | 251 |
| NDC vs Sex | 23 | 18 | 2 | 3 | 280 |
| Nursing Home Issue | 73 | 64 | 0 | 9 | 16 |
| Opioid MME Limit | 67 | 22 | 4 | 41 | 153 |
| Opioid Quantity | 27 | 17 | 0 | 10 | 159 |
| Other | 57 | 40 | 8 | 9 | 25 |
| Quantity vs Days Supply | 331 | 211 | 17 | 103 | 277 |
| STBS/STBSM | 16 | 4 | 1 | 11 | 127 |
| Step Therapy Exception | 1 | 0 | 0 | 1 | 0 |
| Stolen | 7 | 3 | 0 | 4 | 20 |
| Third Brand Request | 45 | 22 | 0 | 23 | 21 |
| **Overrides Total** | **1,114** | **771** | **58** | **285** | |
| **Total Regular PAs + Overrides** | **9,097** | **3,727** | **1,238** | **4,132** | |

*Includes missing and invalid NDCs, unspecified HCPCS, and CPT codes.

| | |
|---|---|
| **Denial Reasons** | |
| Unable to verify required trials. | 3,639 |
| Does not meet established criteria. | 1,260 |
| Lack required information to process request. | 523 |
| **Other PA Activity** | |
| Duplicate Requests | 1,190 |
| Letters | 40,741 |
| No Process | 3 |
| Helpdesk Initiated Prior Authorizations | 371 |
| PAs Missing Information | 286 |
| Pharmacotherapy | 116 |
| Changes to Existing PAs | 632 |

*Includes missing and invalid NDCs, unspecified HCPCS, and CPT codes.

# SoonerSelect Aetna Prior Authorization Activity

## 7/1/2025 Through 7/31/2025

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Allergenic Extracts/Biologicals Misc. | 2 | 0 | 2 | 0 | 0 |
| Amphetamines | 232 | 183 | 28 | 21 | 361 |
| Analgesics - Anti-Inflammatory | 119 | 71 | 27 | 21 | 360 |
| Analgesics - Nonnarcotic | 3 | 0 | 3 | 0 | 0 |
| Analgesics - Opioid | 178 | 77 | 56 | 45 | 157 |
| Androgens - Anabolic | 55 | 13 | 41 | 1 | 365 |
| Anorectal and Related Products | 1 | 0 | 0 | 1 | 0 |
| Anthelmintics | 3 | 1 | 2 | 0 | 30 |
| Antianginal Agents | 4 | 0 | 0 | 4 | 0 |
| Antianxiety Agents | 27 | 9 | 8 | 10 | 326 |
| Antiasthmatic and Bronchodilator Agents | 150 | 26 | 102 | 22 | 313 |
| Antibiotics | 21 | 1 | 4 | 16 | 365 |
| Anticoagulants | 14 | 3 | 7 | 4 | 184 |
| Anticonvulsants | 64 | 17 | 25 | 22 | 363 |
| Antidepressants | 197 | 44 | 83 | 70 | 283 |
| Antidiabetics | 603 | 193 | 292 | 118 | 289 |
| Antidiarrheal/Probiotic Agents | 1 | 0 | 1 | 0 | 0 |
| Antiemetics | 5 | 0 | 2 | 3 | 0 |
| Antifungals | 3 | 1 | 2 | 0 | 365 |
| Antihistamines | 18 | 8 | 7 | 3 | 365 |
| Antihyperlipidemics | 32 | 4 | 17 | 11 | 206 |
| Antihypertensives | 21 | 3 | 1 | 17 | 365 |
| Anti-Infective Agents - Misc. | 8 | 6 | 1 | 1 | 292 |
| Antimyasthenic/Cholinergic Agents | 1 | 1 | 0 | 0 | 92 |
| Antineoplastics and Adjunctive Therapies | 23 | 8 | 3 | 12 | 276 |
| Anti-Obesity Agents | 66 | 3 | 59 | 4 | 30 |
| Antiparkinson and Related Therapy Agents | 3 | 0 | 0 | 3 | 0 |
| Antipsychotics/Antimanic Agents | 133 | 39 | 58 | 36 | 332 |
| Antivirals | 3 | 1 | 1 | 1 | 83 |
| Attention-Deficit/Hyperactivity Disorder (ADHD) Agents | 97 | 79 | 13 | 5 | 348 |
| Beta Blockers | 16 | 1 | 3 | 12 | 365 |
| Calcium Channel Blockers | 14 | 2 | 3 | 9 | 365 |
| Cardiovascular Agents - Misc. | 32 | 18 | 12 | 2 | 296 |
| Chemicals | 2 | 0 | 0 | 2 | 0 |
| Contraceptives | 14 | 2 | 8 | 4 | 365 |
| Corticosteroids | 43 | 29 | 12 | 2 | 127 |
| Dermatologicals | 256 | 105 | 112 | 39 | 218 |
| Diagnostic Products | 37 | 18 | 6 | 13 | 313 |
| Dietary Products/Dietary Management Products | 1 | 1 | 0 | 0 | 365 |
| Digestive Aids | 1 | 1 | 0 | 0 | 365 |
| Diuretics | 15 | 0 | 0 | 15 | 0 |
| Endocrine and Metabolic Agents - Misc. | 28 | 15 | 12 | 1 | 189 |
| Estrogens | 10 | 5 | 3 | 2 | 365 |
| Gastrointestinal Agents - Misc. | 87 | 34 | 47 | 6 | 262 |
| Genitourinary Agents - Misc. | 2 | 1 | 1 | 0 | 365 |
| Gout Agents | 5 | 2 | 0 | 3 | 365 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Hematological Agents - Misc. | 4 | 2 | 0 | 2 | 365 |
| Hematopoietic Agents | 34 | 32 | 2 | 0 | 189 |
| Histamine H3-Receptor Antagonist/Inverse Agonists | 1 | 0 | 1 | 0 | 0 |
| Hypnotics/Sedatives/Sleep Disorder Agents | 26 | 2 | 14 | 10 | 182 |
| Laxatives | 19 | 2 | 10 | 7 | 365 |
| Local Anesthetics-Parenteral | 4 | 4 | 0 | 0 | 180 |
| Medical Devices and Supplies | 67 | 28 | 23 | 16 | 333 |
| Migraine Products | 231 | 58 | 155 | 18 | 237 |
| Minerals and Electrolytes | 12 | 4 | 2 | 6 | 270 |
| Miscellaneous Therapeutic Classes | 20 | 17 | 2 | 1 | 365 |
| Multivitamins | 5 | 4 | 1 | 0 | 365 |
| Musculoskeletal Therapy Agents | 48 | 3 | 14 | 31 | 213 |
| Nasal Agents - Systemic and Topical | 21 | 1 | 6 | 14 | 184 |
| Neuromuscular Agents | 11 | 3 | 7 | 1 | 99 |
| Nutrients | 5 | 5 | 0 | 0 | 180 |
| Ophthalmic Agents | 35 | 15 | 13 | 7 | 267 |
| Other | 5 | 1 | 2 | 2 | 62 |
| Otic Agents | 26 | 1 | 22 | 3 | 30 |
| Pharmaceutical Adjuvants | 1 | 0 | 0 | 1 | 0 |
| Progestins | 4 | 3 | 0 | 1 | 365 |
| Psychotherapeutic and Neurological Agents - Misc. | 33 | 18 | 12 | 3 | 244 |
| Respiratory Agents - Misc. | 5 | 1 | 3 | 1 | 184 |
| Stimulants - Misc. | 96 | 56 | 37 | 3 | 350 |
| Thyroid Agents | 3 | 2 | 1 | 0 | 274 |
| Ulcer Drugs/Antispasmodics/Anticholinergics | 78 | 9 | 37 | 32 | 222 |
| Urinary Antispasmodics | 9 | 2 | 4 | 3 | 365 |
| Vaginal and Related Products | 7 | 1 | 4 | 2 | 365 |
| Vitamins | 43 | 6 | 37 | 0 | 274 |
| ****Total** | **3,503** | **1,305** | **1,473** | **725** | |

**PA overrides are also reported within the drug categories included in the PA Activity report.

| **Overrides** | | | | | |
|---|---|---|---|---|---|
| Brand | 1 | 1 | 0 | 0 | 92 |
| Quantity Level Limit | 24 | 24 | 0 | 0 | 293 |
| Step Therapy Met | 2 | 2 | 0 | 0 | 198 |
| **Overrides Total** | **27** | **27** | **0** | **0** | |

| **Denial Reason** | |
|---|---|
| Benefit | 82 |
| Experimental/Investigational | 181 |
| Medical Necessity | 1101 |
| Medical Necessity | 106 |
| Other | 728 |
| **Other PA Activity** | |
| Duplicate Requests | 12 |
| Letters | 4295 |
| Criteria used) | 281 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

| | |
|---|---|
| Changes to existing PAs | 0 |
| Helpdesk initiated PA | 2 |
| PAs missing info | 12 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

# SoonerSelect Humana Prior Authorization Activity

## 7/1/2025 Through 7/31/2025

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Amphetamines | 2 | 1 | 1 | 0 | 365 |
| Analgesics - Anti-Inflammatory | 61 | 41 | 20 | 0 | 325 |
| Analgesics - Nonnarcotic | 9 | 1 | 8 | 0 | 122 |
| Analgesics - Opioid | 78 | 48 | 30 | 0 | 264 |
| Androgens - Anabolic | 52 | 14 | 38 | 0 | 205 |
| Anthelmintics | 4 | 1 | 3 | 0 | 8 |
| Antianxiety Agents | 1 | 0 | 1 | 0 | 0 |
| Antiasthmatic and Bronchodilator Agents | 131 | 45 | 86 | 0 | 244 |
| Antibiotics | 9 | 4 | 5 | 0 | 365 |
| Anticonvulsants | 11 | 5 | 6 | 0 | 438 |
| Antidepressants | 54 | 23 | 31 | 0 | 308 |
| Antidiabetics | 308 | 131 | 177 | 0 | 244 |
| Antidotes and Specific Antagonists | 1 | 1 | 0 | 0 | 365 |
| Antiemetics | 2 | 0 | 2 | 0 | 0 |
| Antihyperlipidemics | 13 | 4 | 9 | 0 | 203 |
| Anti-Infective Agents - Misc. | 6 | 5 | 1 | 0 | 319 |
| Antineoplastics and Adjunctive Therapies | 37 | 34 | 3 | 0 | 246 |
| Anti-Obesity Agents | 74 | 4 | 70 | 0 | 42 |
| Antiparkinson and Related Therapy Agents | 2 | 2 | 0 | 0 | 274 |
| Antipsychotics/Antimanic Agents | 1 | 1 | 0 | 0 | 365 |
| Antivirals | 10 | 2 | 8 | 0 | 42 |
| Attention-Deficit/Hyperactivity Disorder (ADHD) Agents | 9 | 6 | 3 | 0 | 219 |
| Beta Blockers | 1 | 0 | 1 | 0 | 0 |
| Cardiovascular Agents - Misc. | 26 | 11 | 15 | 0 | 352 |
| Contraceptives | 21 | 18 | 3 | 0 | 301 |
| Corticosteroids | 3 | 1 | 2 | 0 | 122 |
| Dermatologicals | 158 | 58 | 100 | 0 | 228 |
| Diagnostic Products | 28 | 21 | 7 | 0 | 313 |
| Digestive Aids | 1 | 0 | 1 | 0 | 0 |
| Diuretics | 3 | 3 | 0 | 0 | 365 |
| Dopamine and Norepinephrine Reuptake Inhibitors (DNRIs) | 2 | 0 | 2 | 0 | 0 |
| Endocrine and Metabolic Agents - Misc. | 39 | 22 | 17 | 0 | 225 |
| Estrogens | 7 | 1 | 6 | 0 | 487 |
| Gastrointestinal Agents - Misc. | 87 | 39 | 48 | 0 | 178 |
| Genitourinary Agents - Misc. | 1 | 0 | 1 | 0 | 0 |
| Gout Agents | 1 | 0 | 1 | 0 | 0 |
| Hematological Agents - Misc. | 6 | 4 | 2 | 0 | 206 |
| Hematopoietic Agents | 9 | 4 | 5 | 0 | 256 |
| Hypnotics/Sedatives/Sleep Disorder Agents | 12 | 0 | 12 | 0 | 0 |
| Laxatives | 3 | 1 | 2 | 0 | 365 |
| Medical Devices and Supplies | 4 | 4 | 0 | 0 | 365 |
| Migraine Products | 116 | 54 | 62 | 0 | 216 |
| Miscellaneous Therapeutic Classes | 9 | 8 | 1 | 0 | 292 |
| Multivitamins | 5 | 4 | 1 | 0 | 319 |
| Musculoskeletal Therapy Agents | 32 | 15 | 17 | 0 | 296 |
| Nasal Agents - Systemic and Topical | 1 | 0 | 1 | 0 | 0 |
| Neuromuscular Agents | 24 | 18 | 6 | 0 | 275 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Ophthalmic Agents | 17 | 7 | 10 | 0 | 267 |
| Other | 1 | 0 | 1 | 0 | 0 |
| Otic Agents | 4 | 0 | 4 | 0 | 0 |
| Progestins | 1 | 1 | 0 | 0 | 365 |
| Psychotherapeutic and Neurological Agents - Misc. | 28 | 14 | 14 | 0 | 185 |
| Stimulants - Misc. | 11 | 6 | 5 | 0 | 324 |
| Thyroid Agents | 1 | 0 | 1 | 0 | 0 |
| Ulcer Drugs/Antispasmodics/Anticholinergics | 21 | 4 | 17 | 0 | 259 |
| Urinary Antispasmodics | 12 | 1 | 11 | 0 | 73 |
| Vaginal and Related Products | 3 | 0 | 3 | 0 | 0 |
| Vitamins | 56 | 1 | 55 | 0 | 11 |
| **Total** | **1,629** | **693** | **936** | **0** | |

| **Overrides** | | | | | |
|---|---|---|---|---|---|
| Ingredient Duplication | 142 | 72 | 70 | 0 | 203 |
| NDC vs Age | 399 | 251 | 148 | 0 | 231 |
| NDC vs Sex | 1 | 0 | 1 | 0 | 0 |
| Opioid MME Limit | 8 | 8 | 0 | 0 | 317 |
| Opioid Quantity | 18 | 15 | 3 | 0 | 314 |
| Other | 138 | 59 | 79 | 0 | 161 |
| Quantity vs Days Supply | 232 | 147 | 85 | 0 | 224 |
| STBS/STBSM | 464 | 27 | 437 | 0 | 25 |
| Step Therapy Exception | 299 | 122 | 177 | 0 | 153 |
| **Overrides Total** | **1,701** | **701** | **1,000** | **0** | |
| **Total Regular PAs + Overrides** | **3,330** | **1,394** | **1,936** | **0** | |

| **Denial Reasons** | |
|---|---|
| Benefit | 835 |
| Medical Necessity | 1,101 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

# SoonerSelect Oklahoma Complete Health Prior Authorization Activity

## 7/1/2025 Through 7/31/2025

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Allergenic Extracts/Biologicals Misc. | 2 | 0 | 1 | 1 | 0 |
| Alternative Medicines | 1 | 0 | 0 | 1 | 0 |
| Amphetamines | 285 | 177 | 44 | 64 | 264 |
| Analgesics - Anti-Inflammatory | 100 | 47 | 35 | 18 | 348 |
| Analgesics - Nonnarcotic | 5 | 0 | 4 | 1 | 0 |
| Analgesics - Opioid | 333 | 120 | 152 | 61 | 208 |
| Androgens - Anabolic | 61 | 11 | 42 | 8 | 318 |
| Anorectal and Related Products | 1 | 0 | 0 | 1 | 0 |
| Anorexiants Non-Amphetamine | 3 | 0 | 1 | 2 | 0 |
| Antacids | 1 | 1 | 0 | 0 | 365 |
| Anthelmintics | 18 | 5 | 9 | 4 | 197 |
| Antianginal Agents | 1 | 1 | 0 | 0 | 156 |
| Antianxiety Agents | 17 | 1 | 13 | 3 | 168 |
| Antiasthmatic and Bronchodilator Agents | 241 | 90 | 112 | 39 | 279 |
| Antibiotics | 19 | 3 | 11 | 5 | 297 |
| Anticoagulants | 3 | 2 | 1 | 0 | 167 |
| Anticonvulsants | 62 | 24 | 33 | 5 | 284 |
| Antidepressants | 164 | 54 | 86 | 24 | 299 |
| Antidiabetics | 690 | 349 | 239 | 102 | 331 |
| Antidiarrheal/Probiotic Agents | 1 | 0 | 0 | 1 | 0 |
| Antiemetics | 15 | 7 | 3 | 5 | 222 |
| Antifungals | 2 | 0 | 2 | 0 | 0 |
| Antihistamines | 14 | 5 | 8 | 1 | 365 |
| Antihyperlipidemics | 21 | 3 | 15 | 3 | 365 |
| Antihypertensives | 5 | 3 | 2 | 0 | 365 |
| Anti-Infective Agents - Misc. | 25 | 16 | 4 | 5 | 180 |
| Antineoplastics and Adjunctive Therapies | 82 | 41 | 12 | 29 | 252 |
| Anti-Obesity Agents | 101 | 3 | 47 | 51 | 112 |
| Antiparkinson and Related Therapy Agents | 1 | 1 | 0 | 0 | 365 |
| Antipsychotics/Antimanic Agents | 117 | 48 | 49 | 20 | 311 |
| Antivirals | 7 | 2 | 4 | 1 | 224 |
| Attention-Deficit/Hyperactivity Disorder (ADHD) Agents | 81 | 46 | 24 | 11 | 343 |
| Beta Blockers | 8 | 4 | 2 | 2 | 270 |
| Calcium Channel Blockers | 6 | 1 | 3 | 2 | 365 |
| Cardiovascular Agents - Misc. | 43 | 16 | 20 | 7 | 331 |
| Chemicals | 1 | 0 | 0 | 1 | 0 |
| Contraceptives | 12 | 4 | 5 | 3 | 173 |
| Corticosteroids | 5 | 1 | 3 | 1 | 31 |
| Cough/Cold/Allergy | 1 | 1 | 0 | 0 | 156 |
| Dermatologicals | 439 | 150 | 187 | 102 | 228 |
| Diagnostic Products | 31 | 17 | 9 | 5 | 281 |
| Digestive Aids | 3 | 2 | 0 | 1 | 365 |
| Diuretics | 6 | 1 | 3 | 2 | 365 |
| Dopamine and Norepinephrine Reuptake Inhibitors (DNRIs) | 1 | 0 | 1 | 0 | 0 |
| Endocrine and Metabolic Agents - Misc. | 47 | 21 | 22 | 4 | 242 |
| Estrogens | 11 | 4 | 5 | 2 | 303 |
| Gastrointestinal Agents - Misc. | 114 | 41 | 55 | 18 | 192 |
| Genitourinary Agents - Misc. | 1 | 0 | 1 | 0 | 0 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

| | Total | Approved | Denied | Incomplete | Average Length of Approvals in Days |
|---|---|---|---|---|---|
| Gout Agents | 2 | 0 | 2 | 0 | 0 |
| Hematological Agents - Misc. | 5 | 1 | 2 | 2 | 73 |
| Hematopoietic Agents | 24 | 7 | 13 | 4 | 261 |
| Histamine H3-Receptor Antagonist/Inverse Agonists | 3 | 0 | 1 | 2 | 0 |
| Hypnotics/Sedatives/Sleep Disorder Agents | 27 | 8 | 16 | 3 | 218 |
| Laxatives | 13 | 3 | 5 | 5 | 299 |
| Medical Devices and Supplies | 160 | 97 | 38 | 25 | 327 |
| Migraine Products | 200 | 72 | 115 | 13 | 292 |
| Minerals and Electrolytes | 1 | 0 | 0 | 1 | 0 |
| Miscellaneous Therapeutic Classes | 26 | 15 | 5 | 6 | 312 |
| Mouth/Throat/Dental Agents | 2 | 1 | 0 | 1 | 162 |
| Multivitamins | 10 | 2 | 6 | 2 | 365 |
| Musculoskeletal Therapy Agents | 23 | 10 | 12 | 1 | 193 |
| Nasal Agents - Systemic and Topical | 13 | 1 | 10 | 2 | 365 |
| Neuromuscular Agents | 30 | 16 | 5 | 9 | 298 |
| Nutrients | 2 | 0 | 1 | 1 | 0 |
| Ophthalmic Agents | 49 | 16 | 25 | 8 | 234 |
| Other | 51 | 15 | 5 | 31 | 288 |
| Otic Agents | 47 | 0 | 37 | 10 | 0 |
| Passive Immunizing and Treatment Agents | 1 | 1 | 0 | 0 | 365 |
| Progestins | 5 | 2 | 2 | 1 | 273 |
| Psychotherapeutic and Neurological Agents - Misc. | 35 | 12 | 15 | 8 | 277 |
| Respiratory Agents - Misc. | 11 | 6 | 3 | 2 | 290 |
| Stimulants - Misc. | 193 | 138 | 30 | 25 | 268 |
| Thyroid Agents | 36 | 26 | 3 | 7 | 250 |
| Ulcer Drugs/Antispasmodics/Anticholinergics | 47 | 12 | 30 | 5 | 263 |
| Urinary Antispasmodics | 29 | 13 | 13 | 3 | 299 |
| Vaccines | 1 | 0 | 1 | 0 | 0 |
| Vaginal and Related Products | 1 | 0 | 0 | 1 | 0 |
| Vitamins | 1 | 0 | 0 | 1 | 0 |
| ****Total** | **4,256** | **1,797** | **1,664** | **795** | |

**PA overrides are also reported within the drug categories included in the PA Activity report.

| **Denial Reasons** | |
|---|---|
| Medical Necessity | 1,664 |

*SoonerSelect totals are based on data provide to the College of Pharmacy from the SoonerSelect plans. Other includes missing and unmatched NDCs.

# Appendix C

# U.S. Food and Drug Administration (FDA) Safety Alerts*

***Additional information, including the full news release, on the following FDA Safety Communications can be found on the FDA website at: https://www.fda.gov/drugs/drug-safety-and-availability/drug-safety-communications.**

**Oklahoma Health Care Authority**
**August 2025**

## Introduction[1,2,3,4,5,6,7,8,9]

The following are recent FDA safety alerts included for the Drug Utilization Review (DUR) Board's consideration. SoonerCare specific data may be presented where applicable. The data included in this report combines fee-for-service (FFS) and managed care (SoonerSelect) utilization for fiscal year (FY) 2024 (07/01/2023 to 06/30/2024). Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans. The College of Pharmacy will make recommendations as well as take recommendations from the DUR Board.

| Date | Drug | Issue |
|---|---|---|
| **09/12/2024** | **Veozah® (Fezolinetant)** | **Serious Liver Injury** |
| **Issue Details:** The FDA is warning that Veozah® (fezolinetant) can cause rare but serious liver injury. If there are signs and symptoms suggesting liver injury, stopping the medication could prevent worsening liver injury and potentially return liver function to normal.<br>**FDA Recommendation(s):** The FDA added a warning about the risk of liver injury to the existing warning about elevated liver blood test values and required liver blood testing in the *Prescribing Information* for Veozah®. They made this update after reviewing a postmarketing report of a patient with elevated liver blood test values and signs and symptoms of liver injury after taking the medication for about 40 days. The FDA also added new recommendations for patients and health care professionals about increasing the frequency of liver blood testing, including adding monthly testing for the first 2 months after starting Veozah®, and then at months 3, 6, and 9 of treatment as already recommended. The updated *Prescribing Information* also instructs patients to stop the medication immediately and contact the health care professional who prescribed the medication if signs and symptoms of liver injury occur.<br>**Pharmacy Claims Evaluation:** During FY 2024, a total of 61 SoonerCare members had paid claims for Veozah®, accounting for 109 paid claims and an average of 1.79 claims per member.<br>**SoonerCare Action:** Currently, Veozah® requires a prior authorization (PA) for coverage consideration. The current criteria requires the prescriber to attest that they will monitor liver function tests, which aligns with the FDA | | |

recommendation. The College of Pharmacy will continue to monitor the FDA recommendations.

| Date | Drug | Issue |
|---|---|---|
| **12/12/2024** | **Ocaliva® (Obeticholic Acid)** | **Serious Liver Injury in Patients without Cirrhosis** |

**Issue Details:** The FDA identified cases of serious liver injury among patients being treated for primary biliary cholangitis (PBC) with Ocaliva® (obeticholic acid) who did not have cirrhosis of the liver. The FDA previously identified that patients with PBC and advanced cirrhosis were at risk of serious liver injury when taking Ocaliva® and updated the *Prescribing Information* to restrict its use in these patients. The FDA review of the required post-market clinical trial data for Ocaliva® found that some cases of liver injury in patients without cirrhosis resulted in liver transplant. This risk was notably higher for patients taking Ocaliva® compared with placebo. The FDA restricted the use of Ocaliva® in patients who have PBC with advanced cirrhosis of the liver in 2021 because it can cause serious harm in those patients, adding a new *Contraindication* to the Ocaliva® *Prescribing Information* and patient *Medication Guide*. However, the FDA's recent review of case reports submitted to the FDA found that some patients with PBC and advanced cirrhosis were still taking the medication despite these restrictions.
**FDA Recommendation(s):** The FDA is notifying health care professionals and patients of this new safety information, and that frequent liver test monitoring is necessary to identify worsening liver function and ensure appropriate discontinuation of Ocaliva®. The agency will continue to monitor the medication's safety and will follow up if additional information becomes available.
**Pharmacy Claims Evaluation:** During FY 2024, a total of 3 unique SoonerCare members had paid claims for Ocaliva®, accounting for 17 paid claims and an average of 5.67 claims per member.
**SoonerCare Action:** Currently, Ocaliva® requires a PA for coverage consideration. The approval criteria was updated at the April 2025 DUR Board Meeting to align with the FDA recommendations. Now for approval of Ocaliva®, the prescriber must agree to monitor liver tests frequently and to discontinue Ocaliva® if there is any evidence of liver disease progression while on treatment. The College of Pharmacy will continue to monitor the FDA recommendations.

| Date | Drug | Issue |
|---|---|---|
| **01/22/2025** | **Copaxone®, Glatopa® (Glatiramer Acetate)** | **Anaphylaxis** |

**Issue Details:** The FDA is warning about the risk of anaphylaxis with the medication glatiramer acetate (Copaxone®, Glatopa®), which is used to treat patients with multiple sclerosis (MS). Anaphylaxis can occur at any time

while on treatment, after the first dose or after doses administered months or years after starting the medication. For most patients who experienced anaphylaxis with glatiramer acetate use, the symptoms appeared within 1 hour of injection. In some cases, anaphylaxis resulted in hospitalization and death. The initial symptoms of anaphylaxis can overlap with those of a common reaction called immediate post-injection reaction that is temporary and can start soon after a shot is given. While immediate post-injection reaction is common, anaphylaxis is rare and its symptoms are typically more severe, worsen over time, and require treatment. Patients experiencing a reaction after the medication is administered should seek immediate medical attention if the symptoms are more than mild, get worse over time, or do not go away within a brief time.

**FDA Recommendation(s):** The FDA is adding a new *Boxed Warning* about the risk of anaphylaxis and to the *Warnings and Precautions* section of the glatiramer acetate *Prescribing Information*. These warnings include information that anaphylaxis can occur at any time, from as early as after the first dose or after doses administered years after starting the medicine. The FDA is also adding new recommendations for patients and health care professionals about the critical importance of quickly recognizing and treating symptoms of anaphylaxis. The updated *Prescribing Information* also instructs patients to stop taking the medicine and seek immediate medical attention by going to an emergency room or calling 911 if symptoms of anaphylaxis occur.

**Pharmacy Claims Evaluation:** During FY 2024, a total of 29 SoonerCare members had paid claims for glatiramer acetate, accounting for 192 paid claims and an average of 6.62 claims per member.

**SoonerCare Action:** Currently, glatiramer acetate requires a PA for coverage consideration. The approval criteria was updated at the May 2025 DUR Board Meeting to align with the FDA recommendations. Now for approval of glatiramer acetate, the prescriber must verify the member has no history of hypersensitivity reactions, including anaphylaxis, to glatiramer acetate and verify that the member has been counseled on the symptoms of anaphylaxis and instructed to seek immediate medical care should anaphylaxis symptoms occur. The College of Pharmacy will continue to monitor the FDA recommendations.

| Date | Drug | Issue |
|---|---|---|
| **01/31/2025** | **Fentanyl Transdermal System 25mcg/hr Patches** | **Defective Delivery System** |

**Issue Details:** There is a potential that the patches could be multi-stacked, meaning they could adhere one on top of the other, in a single product pouch resulting in serious, life threatening, or fatal respiratory depression. Groups at potential increased risk could include first-time recipients of such patches, children, and the elderly. This transdermal system is manufactured

by Kindeva Drug Delivery L.P., Northridge, CA and is distributed by Alvogen, Inc. as a private label distributor.
**FDA Recommendation(s):** Alvogen is voluntarily recalling 1 lot of fentanyl transdermal system 25mcg/hr transdermal patches at the consumer level with the knowledge of the FDA. Alvogen is notifying its distributors and direct customers by certified letter and is arranging for return and replacement of all recalled products. Pharmacies are requested not to dispense any product subject to this recall.
**Pharmacy Claims Evaluation:** During FY 2024, a total of 61 SoonerCare members had paid claims for the specific NDC in the recall, accounting for 171 paid claims and an average of 2.8 claims per member.
**SoonerCare Action:** In March 2025, a letter was sent by SoonerCare to prescribers of FFS members with a paid claim in the past 90 days for the specific NDC of fentanyl 25mcg/hr included in the recall. There were 14 prescribers notified for 14 FFS members.

| Date | Drug | Issue |
|---|---|---|
| **05/16/2025** | **Cetirizine (Zyrtec®) or Levocetirizine (Xyzal®)** | **Rare but Severe Pruritus After Stopping Long-Term Use of Cetirizine or Levocetirizine** |

**Issue Details:** The FDA is warning that patients stopping cetirizine (Zyrtec®) or levocetirizine (Xyzal®) after long-term use may experience rare but severe pruritus. These medications are available in prescription and over-the-counter (OTC) forms. The pruritus has been reported in patients who used these medications daily, typically for at least a few months and often for years. Patients did not experience pruritus before starting the medications. Reported cases were rare but sometimes serious, with patients experiencing widespread, severe pruritus that required medical intervention.
**FDA Recommendation(s):** The FDA is adding a warning about the risk of pruritus after stopping long-term use of prescription cetirizine or levocetirizine to the *Prescribing Information* to increase awareness about this rare but serious reaction. The updated *Prescribing Information* also states that pruritus symptoms may improve with restarting the medications. The FDA will also request that manufacturers add a warning about pruritus to the *Drug Facts Label* of OTC cetirizine and levocetirizine. The FDA will follow up when additional information becomes available.
**Pharmacy Claims Evaluation:** During FY 2024, a total of 81,903 SoonerCare members had paid claims for cetirizine or levocetirizine, accounting for 173,074 paid claims and an average of 2.11 claims per member.
**SoonerCare Action:** Currently, OTC cetirizine is covered without a PA and OTC levocetirizine is a Tier-2 medication. Both products are only covered for pediatric members 0 to 20 years of age. The College of Pharmacy will continue to monitor the FDA recommendations.

| Date | Drug | Issue |
|---|---|---|
| **06/18/2025** | **Transderm Scōp® (Scopolamine Transdermal System)** | **Risk of Heat-Related Complications** |

**Issue Details:** The FDA is warning that the antinausea patch Transderm Scōp® (scopolamine transdermal system) can increase body temperature and cause heat-related complications, resulting in hospitalization or even death in some cases. Most cases occurred in children 17 years of age and younger and in adults 60 years of age and older, who may be sensitive to body temperature control disturbances. As a result, the FDA required that the Transderm Scōp® *Prescribing Information* be revised to include a warning and other information about this risk. Most reports of hyperthermia that resulted in serious harm occurred when the Transderm Scōp® was used in children 17 years of age and younger. Transderm Scōp® is not FDA-approved for any use in children but is sometimes prescribed off-label to manage excessive drooling in children with cerebral palsy or other neurologic disorders. Hyperthermia occurred most often within 72 hours after the Transderm Scōp® patch was applied to patients' bodies for the first time. The Transderm Scōp® patch can affect the body's ability to maintain a stable internal temperature, leading to a rise in core body temperature. It can also reduce sweating, which may cause increases in body temperature. Severe cases may lead to heat-related complications, such as confusion, loss of consciousness, coma, or death. Hyperthermia may be exacerbated when patients are in warm environmental temperatures and when they are using external heat sources, such as a heated blanket.

**FDA Recommendation(s):** The FDA required the addition of a new warning and other information to the Transderm Scōp® *Prescribing Information* and patient information leaflet about the risk of hyperthermia resulting in serious harm. These revisions include information to help reduce this risk, particularly in children and older adult patients. It instructs patients to remove the Transderm Scōp® patch if their body temperature increases or if they are not sweating in warm environmental temperatures and to contact their health care professional if they are experiencing symptoms.

**Pharmacy Claims Evaluation:** During FY 2024, a total of 1,456 SoonerCare members had paid claims for scopolamine transdermal system, accounting for 3,259 paid claims and an average of 2.24 claims per member. Of the 1,456 members, 222 members were children 17 years of age and younger and 142 members were adults 60 years of age and older.

**SoonerCare Action:** Currently, Transderm Scōp® is covered by SoonerCare without a PA requirement; however, it does have a quantity limit of 10 patches for a 30-day supply. The College of Pharmacy will continue to monitor the FDA recommendations.

| Date | Drug | Issue |
|---|---|---|
| **06/30/2025** | **Extended-Release (ER) Stimulants** | **Risk of Weight Loss in Patients Younger Than 6 Years of Age Taking ER Stimulants for Attention-Deficit/Hyperactivity Disorder (ADHD)** |

**Issue Details:** The FDA is revising the labeling of all ER stimulants indicated to treat ADHD - including certain formulations of amphetamine and methylphenidate - to warn about the risk of weight loss and other adverse reactions in patients younger than 6 years of age taking these medications. Although ER stimulants are not approved for children younger than 6 years of age, health care professionals can prescribe them "off label" to treat ADHD. The FDA has found that patients younger than 6 years of age taking ER stimulants have a greater risk of weight loss and other side effects than older children taking the same medication at the same dosage. The FDA assessed data from clinical trials of ER formulations of amphetamine and methylphenidate for ADHD treatment. This analysis found that patients younger than 6 years of age had higher plasma exposures and higher rates of side effects than older children. In particular, clinically significant weight loss, defined by the Centers for Disease Control and Prevention (CDC) as at least 10% decrease in the weight percentile, was observed in both short- and long-term studies with ER stimulants. For these reasons, the benefits of ER stimulants may not outweigh the risks of these products in patients younger than 6 years of age with ADHD.

**FDA Recommendation(s):** The FDA is requiring a *Limitation of Use* section in the *Prescribing Information* of all ER stimulants that includes a statement about the higher plasma exposures and higher rates of adverse reactions in children younger than 6 years of age. Manufacturers of ER stimulants that do not have a *Limitation of Use* section in the labeling will be required to add one about this risk. Manufacturers of ER stimulants that already have a *Limitation of Use* section will be required to revise the labeling to ensure consistent messaging across the drug class. In the meantime, the FDA wanted to bring public attention to this risk.

**Pharmacy Claims Evaluation:** During FY 2024, a total of 31,974 SoonerCare members had paid claims for ER stimulants, accounting for 182,708 paid claims and an average of 5.71 claims per member. Of the 31,974 members, 308 members were children younger than 6 years of age.

**SoonerCare Action:** Currently, Tier-1 ER stimulants are available for members age 5 through 20 years without a PA requirement. All requests for members younger than 5 years of age must be reviewed by an OHCA- or SoonerSelect health plan-contracted psychiatrist. The College of Pharmacy will continue to monitor the FDA recommendations.

| Date | Drug | Issue |
|---|---|---|
| **07/31/2025** | **Opioid Pain Medications** | **Update Prescribing Information Regarding Long-Term Use** |

**Issue Details:** In May 2025, the FDA convened a joint meeting of the Drug Safety and Risk Management Advisory Committee and the Anesthetic and Analgesic Drug Products Advisory Committee to discuss 2 recently completed observational studies examining the risks of misuse, abuse, addiction, and fatal and non-fatal overdose in patients on long-term opioid pain medications. These studies [addressing postmarketing requirements (PMR) 3033-1 and 3033-2] provided new, quantitative data on risks of these serious adverse outcomes in patients prescribed opioid pain medications long term. After reviewing the study findings and the medical literature, as well as considering the committees' and public input, the FDA has determined that this new information should be included in the drug labeling to help health care professionals and patients better understand the benefit-risk profile of opioid pain medications when prescribed long term and to make more informed decisions. Separately, a prospective, randomized, controlled clinical trial will address a different PMR to examine the risks relative to the efficacy of long-term opioid use.

**FDA Recommendation(s):** The FDA is requiring safety labeling changes for opioid pain medications to further emphasize and characterize the risks associated with long-term use. Specifically, the FDA is notifying application holders the following labeling changes are needed:

- Remove the phrase "extended treatment period" in the *Indications* and *Usage* section to avoid misinterpretation that there are data to support safety and efficacy of opioid pain medications over an indefinitely long duration
- Further emphasize that higher doses are associated with increased risk of serious harm and that the risks of serious harm persist over the course of therapy
- Provide a brief description of the results of studies conducted to fulfill PMR 3033-1 and 3033-2, including new quantitative estimates of the risks of addiction, abuse, misuse, and fatal and non-fatal overdose in patients taking opioid pain medications long-term

The FDA is also requiring labeling updates to further clarify that ER opioid pain medications should only be used when alternative therapies, including immediate-release opioid pain medications, are inadequate to manage severe and persistent pain, and to emphasize the importance of avoiding rapid dose reduction or abrupt discontinuation in patients who may be physically dependent on opioid pain medications. Additionally, the FDA is requiring labeling updates regarding the availability of opioid overdose reversal agents, revising drug-drug interactions with central nervous system depressants to include gabapentinoids, adding information about toxic

leukoencephalopathy in the opioid overdose setting, and modifying warnings about gastrointestinal effects to include opioid-induced esophageal dysfunction.
**Pharmacy Claims Evaluation:** During FY 2024, a total of 99,975 SoonerCare members had paid claims for opioid pain medications, accounting for 29,865 paid claims and an average of 2.92 claims per member.
**SoonerCare Action:** Currently, Tier-1 opioid pain medications are available without a PA requirement. A PA is required for higher tiered medications and a chronic pain diagnosis is required for approval of long-acting/ER higher tiered opioid pain medications. Additionally, SoonerCare has an opioid morphine milligram equivalent (MME) limit of 90 MME per day. Members with a daily MME greater than 90 require a PA for opioid medication coverage and are reviewed on a case-by-case basis. The College of Pharmacy will continue to monitor the FDA recommendations.

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[1] U.S. Food and Drug Administration (FDA). Drug Safety Communications. Available online at: https://www.fda.gov/drugs/drug-safety-and-availability/drug-safety-communications. Last revised 06/18/2025. Last accessed 07/31/2025.
[2] U.S. FDA. FDA Adds Warning About Rare Occurrence of Serious Liver Injury with Use of Veozah® (Fezolinetant) for Hot Flashes Due to Menopause. Available online at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-adds-warning-about-rare-occurrence-serious-liver-injury-use-veozah-fezolinetant-hot-flashes-due. Issued 09/12/2024. Last accessed 06/27/2025.
[3] U.S. FDA. Serious Liver Injury Being Observed in Patients Without Cirrhosis Taking Ocaliva® (Obeticholic Acid) to Treat Primary Biliary Cholangitis. Available online at: https://www.fda.gov/drugs/drug-safety-and-availability/serious-liver-injury-being-observed-patients-without-cirrhosis-taking-ocaliva-obeticholic-acid-treat. Issued 12/30/2024. Last accessed 06/27/2025.
[4] U.S. FDA. FDA Adds Boxed About a Rare but Serious Allergic Reaction Called Anaphylaxis with the Multiple Sclerosis Medicine Glatiramer Acetate (Copaxone®, Glatopa®). Available online at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-adds-boxed-warning-about-rare-serious-allergic-reaction-called-anaphylaxis-multiple-sclerosis. Issued 01/30/2025. Last accessed 06/27/2025.
[5] U.S. FDA. Alvogen Issues Voluntary Nationwide Recall for One Lot of Fentanyl Transdermal System 25mcg/hr Due to Defective Delivery System. Available online at: https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/alvogen-issues-voluntary-nationwide-recall-one-lot-fentanyl-transdermal-system-25-mcgh-due-defective. Issued 01/31/2025. Last accessed 07/14/2025.
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[7] U.S. FDA. FDA Adds Warning About Serious Risk of Heat-Related Complications with Antinausea Patch Transderm Scōp® (Scopolamine Transdermal System). Available online at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-adds-warning-about-serious-risk-heat-related-complications-antinausea-patch-transderm-scop. Issued 06/18/2025. Last accessed 06/27/2025.
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# Appendix D

# Fiscal Year 2024 Annual Review of Iron Products

**Oklahoma Health Care Authority**
**August 2025**

## Current Prior Authorization Criteria

**Accrufer® (Ferric Maltol) Approval Criteria:**

1. Diagnosis of iron deficiency anemia (IDA); and
2. Lab results verifying IDA must be submitted; and
3. Member must be 18 years of age or older; and
4. Member must have a documented diagnosis of chronic kidney disease (CKD) or inflammatory bowel disease (IBD) (e.g., Crohn's disease, ulcerative colitis); and
5. Documentation of intolerance or inadequate response to over-the-counter (OTC) oral iron therapy after at least 3 months at recommended dosing; and
6. A recent, failed trial of Feraheme® (ferumoxytol), Infed® (iron dextran), or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Feraheme®, Infed®, and Venofer® must be provided; and
7. A patient-specific clinically significant reason why the member cannot utilize all other forms of intravenous (IV) iron must be provided; and
8. Initial approvals will be for the duration of 3 months of treatment. Subsequent approvals (for 3 months of treatment) will require updated recent laboratory results documenting continued IDA.

**Injectafer® (Ferric Carboxymaltose) Approval Criteria [Iron Deficiency Anemia (IDA) Diagnosis]:**

1. An FDA approved indication of 1 of the following:
   a. IDA; or
   b. IDA in members with non-dialysis dependent chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. A recent trial of Feraheme® (ferumoxytol), Infed® (iron dextran), or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Feraheme®, Infed®, and Venofer® must be provided.

**Injectafer® (Ferric Carboxymaltose) Approval Criteria [Iron Deficiency Diagnosis]:**

1. An FDA approved indication of iron deficiency in adult members with New York Heart Association (NYHA) class II-III heart failure (HF) to improve exercise capacity; and
2. Member must be 18 years of age or older; and
3. Documented lab results verifying iron deficiency; and
4. Prescriber must verify member is already receiving optimal background therapy for HF; and
5. Member must have left ventricular ejection fraction (LVEF) <45%; and
6. Member's current weight (kg) and hemoglobin (Hb) (g/dL) must be provided to ensure appropriate dosing according to package labeling; and
7. A recent trial of Feraheme® (ferumoxytol), Infed® (iron dextran), or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Feraheme®, Infed®, and Venofer® must be provided; and
8. Initial approvals will be for 1 or 2 doses only (depending on member's weight and Hb) according to package labeling; and
9. Subsequent requests for maintenance doses at weeks 12, 24, and 36 will require submission of updated lab results verifying continued iron deficiency for each dose and will be approved for (1) 500mg dose at a time.

**Monoferric® (Ferric Derisomaltose) Approval Criteria:**

1. An FDA approved indication of 1 of the following:
   a. Iron deficiency anemia (IDA); or
   b. IDA in members with non-dialysis dependent chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. A recent trial of Feraheme® (ferumoxytol), Infed® (iron dextran), or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Feraheme®, Infed®, and Venofer® must be provided; and
5. A patient-specific, clinically significant reason why the member cannot utilize all other forms of intravenous (IV) iron must be provided.

## Utilization of Iron Products: Fiscal Year 2024

Reimbursement of intravenous (IV) iron products for members with end stage renal disease (ESRD) receiving dialysis is included in the bundled dialysis payment and cannot be reimbursed separately. Utilization data for IV iron products reimbursed in the bundled dialysis payment is not included in this report.

### Comparison of Fiscal Years: Pharmacy Claims (All Plans)

| Plan Type | *Total Members | Total Claims | Total Cost | Cost/ Claim | Cost/ Day | Total Units | Total Days |
|---|---|---|---|---|---|---|---|
| **Fiscal Year 2024** | | | | | | | |
| **FFS** | 0 | 0 | $0.00 | $0.00 | $0.00 | 0 | 0 |
| **Aetna** | 4 | 4 | $1,933.77 | $483.44 | $16.11 | 210 | 120 |
| **Humana** | 7 | 8 | $3,659.19 | $457.40 | $17.34 | 317 | 211 |
| **OCH** | 0 | 0 | $0.00 | $0.00 | $0.00 | 0 | 0 |
| **2024 Total** | **11** | **12** | **$5,592.96** | **$466.08** | **$16.90** | **527** | **331** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.
Please note: There were no paid pharmacy claims for iron products during fiscal year 2023 to allow for a fiscal year comparison.

### Comparison of Fiscal Years: Medical Claims (All Plans)

| Plan Type | *Total Members | †Total Claims | Total Cost | Cost/ Claim | Claims/ Member |
|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | |
| **FFS** | 1,697 | 5,764 | $745,810.33 | $129.39 | 3.4 |
| **2023 Total** | **1,697** | **5,764** | **$745,810.33** | **$129.39** | **3.4** |
| **Fiscal Year 2024** | | | | | |
| **FFS** | 1,694 | 5,367 | $463,202.93 | $86.31 | 3.17 |
| **Aetna** | 18 | 34 | $6,319.20 | $185.86 | 1.89 |
| **Humana** | 40 | 63 | $7,331.60 | $116.37 | 1.58 |
| **OCH** | 64 | 137 | $10,775.86 | $78.66 | 2.14 |
| **2024 Total** | **1,787** | **5,601** | **$487,629.59** | **$87.06** | **3.13** |
| **% Change** | **5.30%** | **-2.83%** | **-34.62%** | **-32.72%** | **-7.94%** |
| **Change** | **90** | **-163** | **-$258,180.74** | **-$42.33** | **-0.27** |

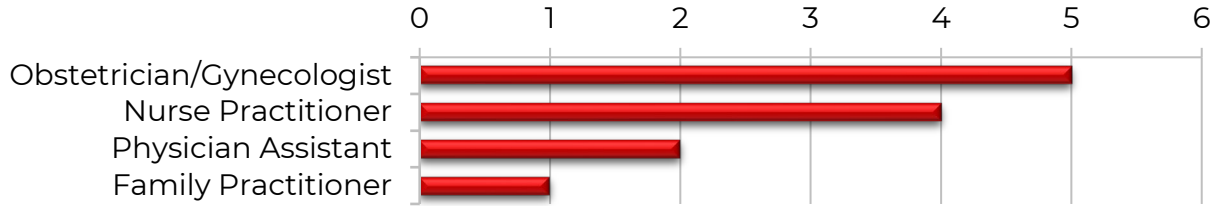
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

- Aggregate drug rebates collected during fiscal year 2024 for iron products totaled $297,624.79.[Δ] Rebates are collected after reimbursement for the medication and are not reflected in this report. The costs included in this report do not reflect net costs.

**Demographics of Members Utilizing Iron Products: Pharmacy Claims (All Plans)**

- Due to the limited number of members utilizing iron products during fiscal year 2024, detailed demographic information could not be provided.

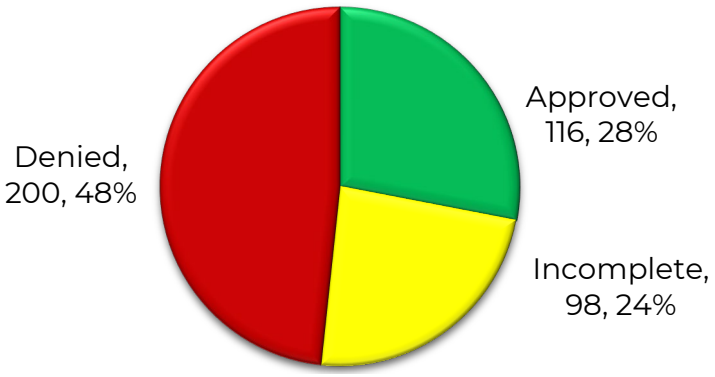
**Top Prescriber Specialties of Iron Products by Number of Claims: Pharmacy Claims (All Plans)**




## Prior Authorization of Iron Products

There were 414 prior authorization requests submitted for iron products during fiscal year 2024. The following chart shows the status of the submitted petitions for fiscal year 2024.

**Status of Petitions (All Plans)**




[Δ] Important considerations: Aggregate drug rebates are based on the date the claim is paid rather than the date dispensed. Claims data are based on the date dispensed.

### Status of Petitions by Plan Type

| Plan Type | Approved | | Incomplete | | Denied | | Total |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | |
| **FFS** | 105 | 29% | 95 | 26% | 159 | 44% | **359** |
| **Aetna** | 2 | 33% | 3 | 50% | 1 | 17% | **6** |
| **Humana** | 8 | 17% | 0 | 0% | 40 | 83% | **48** |
| **OCH** | 1 | 100% | 0 | 0% | 0 | 0% | **1** |
| **Total** | **116** | **28%** | **98** | **24%** | **200** | **48%** | **414** |

FFS = fee-for-service; OCH = OK Complete Health
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

## Market News and Updates[1]

### Anticipated Patent Expiration(s):

- Injectafer® (ferric carboxymaltose injection): February 2028
- Accrufer® (ferric maltol capsule): October 2035
- Monoferric® (ferric derisomaltose injection): June 2036

## Cost Comparison: Intravenous (IV) Iron Products

| Product | Cost Per mg | Cost Per Treatment Course* |
|---|---|---|
| Monoferric® (ferric derisomaltose) 1,000mg/10mL inj | $1.90 | $1,900.00 |
| Injectafer® (ferric carboxymaltose) 1,000mg/20mL inj | $1.14 | $1,140.00 |
| Infed® (iron dextran) 100mg/2mL inj | $0.36 | $360.00 |
| Feraheme® (ferumoxytol) 510mg/17mL inj | $0.31 | $316.20 |
| Venofer® (iron sucrose) 200mg/2mL inj | $0.22 | $220.00 |

Costs do not reflect rebated prices or net costs. Costs based on payment allowance limits subject to Average Sales Price (ASP) methodology as published by the Centers for Medicare and Medicaid Services (CMS), National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Cost per treatment course based on 1,000mg for Monoferric®, Injectafer®, and Infed®, (2) 510mg doses for Feraheme®, and (5) 200mg doses for Venofer®.
Please note: Infed®, Feraheme®, and Venofer® are available without a prior authorization.
inj = injection

## Recommendations

The College of Pharmacy does not recommend any changes to the current iron products prior authorization criteria at this time.

## Utilization Details of Iron Products: Fiscal Year 2024

### Pharmacy Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| ACCRUFER CAP 30MG | 11 | 10 | $4,712.41 | $428.40 | 1.1 | 84.26% |
| FERUMOXYTOL INJ 510MG/17ML[+] | 1 | 1 | $880.55 | $880.55 | 1 | 15.74% |
| **TOTAL** | **12** | **11*** | **$5,592.96** | **$466.08** | **1.09** | **100%** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
[+]This product is typically not covered as a pharmacy claim by SoonerCare; however, there was a paid claim in fiscal year 2024 through 1 of the SoonerSelect plans.
CAP = capsule; INJ = injection
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

### Medical Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS[+] | TOTAL MEMBERS* | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| J1756 IRON SUC INJ (VENOFER) | 4,820 | 1,259 | $182,064.68 | $37.77 | 3.83 | 37.34% |
| J1750 IRON DEX INJ (INFED) | 670 | 489 | $177,680.27 | $265.19 | 1.37 | 36.44% |
| J1437 FER DERIS INJ (MONOFERRIC) | 44 | 43 | $90,049.00 | $2,046.57 | 1.02 | 18.47% |
| J1439 FER CARB INJ (INJECTAFER) | 40 | 23 | $32,072.64 | $801.82 | 1.74 | 6.58% |
| Q0138 FERUMOXYTOL INJ (FERAHEME) | 24 | 12 | $5,763.00 | $240.13 | 2 | 1.18% |
| J2916 SOD FER GLUC INJ (FERRLECIT) | 3 | 3 | $0.00 | $0.00 | 1 | 0.00% |
| **TOTAL** | **5,601** | **1,787** | **$487,629.59** | **$87.06** | **3.13** | **100%** |

Costs do not reflect rebated prices or net costs.
[+]Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
CARB = carboxymaltose; DERIS = derisomaltose; DEX = dextran; FER = ferric; GLUC = gluconate; INJ = injection; SOD = sodium; SUC = sucrose
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 07/2025. Last accessed 07/11/2025.

# Appendix E

# Fiscal Year 2024 Annual Review of Miscellaneous Cancer Medications and 30-Day Notice to Prior Authorize Ryoncil® (Remestemcel-L-rknd)

**Oklahoma Health Care Authority**
**August 2025**

## Current Prior Authorization Criteria

**Bynfezia Pen™ (Octreotide) Approval Criteria [Acromegaly Diagnosis]:**

1. Diagnosis of acromegaly; and
2. Documentation of inadequate response to or inability to treat with surgical resection, pituitary irradiation, and bromocriptine mesylate or cabergoline at maximally tolerated doses; and
3. A patient-specific, clinically significant reason why the member cannot use other available short-acting injectable formulations of octreotide must be provided.

**Bynfezia Pen™ (Octreotide) Approval Criteria [Metastatic Carcinoid Tumor or Vasoactive Intestinal Peptide-Secreting Tumor (VIPoma) Diagnosis]:**

1. Diagnosis of advanced metastatic carcinoid tumor or VIPoma; and
2. Presence of severe diarrhea or flushing; and
3. A patient-specific, clinically significant reason why the member cannot use other available short-acting injectable formulations of octreotide must be provided.

**Danyelza® (Naxitamab-gqgk) Approval Criteria [Neuroblastoma Diagnosis]:**

1. Diagnosis of relapsed or refractory high-risk neuroblastoma in adult and pediatric members 1 year of age and older; and
2. Disease in the bone or bone marrow demonstrating a partial response, minor response, or stable disease to prior therapy (i.e., no progressive disease following most recent therapy); and
3. Must be given in combination with a granulocyte-macrophage colony-stimulating factor (GM-CSF) according to package labeling (GM-CSF dosed at 250mcg/$m^2$/day daily starting 5 days prior to Danyelza® therapy and 500mcg/$m^2$/day daily on days 1 to 5 of Danyelza® therapy); and
4. Prescriber must agree to provide the member appropriate premedication for pain management and neuropathic pain (e.g., oral opioids, gabapentin); and
5. Prescriber must agree to provide the member appropriate premedication for infusion-related reactions and nausea/vomiting

including an intravenous (IV) corticosteroid, a histamine 1 ($H_1$) antagonist, an $H_2$ antagonist, acetaminophen, and an antiemetic.

**Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension) Approval Criteria [Perivascular Epithelioid Cell Tumor (PEComa) Diagnosis]:**

1. Diagnosis of locally advanced unresectable or metastatic PEComa; and
2. Member must be 18 years of age or older.

**Iwilfin® (Eflornithine) Approval Criteria [Neuroblastoma Diagnosis]:**

1. Diagnosis of high-risk neuroblastoma (HRNB); and
2. Member has had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy; and
3. Used as a single agent to reduce the risk of relapse for a maximum of 2 years; and
4. Member's recent body surface area (BSA) must be provided.

**Kepivance® (Palifermin) Approval Criteria [Oral Mucositis Associated with Autologous Stem Cell Transplant Conditioning Diagnosis]:**

1. Diagnosis of hematologic malignancy; and
2. Undergoing autologous stem cell transplantation; and
3. Using a preparative regimen predicted to result in ≥Grade 3 mucositis in >50% of patients; and
4. The preparative regimen and a reference for the preparative regimen must be provided; and
    a. Single dose melphalan 200mg/$m^2$ is not included as an appropriate preparative regimen due to lack of efficacy of palifermin with this regimen.

**Loqtorzi® (Toripalimab-tpzi) Approval Criteria [Nasopharyngeal Carcinoma (NPC) Diagnosis]:**

1. Diagnosis of metastatic or recurrent, locally advanced NPC; and
    a. Used in the first-line setting; and
    b. Used in combination with cisplatin and gemcitabine; and
    c. Dose as follows:
        i. 240mg every 3 weeks; and
        ii. Maximum duration of 2 years; or
2. Diagnosis of previously treated recurrent unresectable or metastatic NPC; and
    a. Disease has progressed on or following a platinum-containing chemotherapy; and
    b. Used as a single agent; and
    c. Dose as follows:
        i. 3mg/kg every 2 weeks.

**Lutathera® (Lutetium Lu-177 Dotatate) Approval Criteria [Gastroenteropancreatic Neuroendocrine Tumor (GEP-NET) Diagnosis]:**

1. Diagnosis of progressive locoregional advanced disease or metastatic disease; and
2. Positive imaging of somatostatin receptor; and
3. Member must be 12 years of age or older; and
4. Used in 1 of the following settings:
    a. As second-line or subsequent therapy following progression on octreotide or lanreotide; or
    b. As first-line for treatment of pheochromocytoma/paraganglioma; or
    c. As alternative front-line therapy if surgical cytoreduction of metastases is not possible and there is clinically significant tumor burden following progression on octreotide or lanreotide.

**Niktimvo™ (Axatilimab-csfr) Approval Criteria [Chronic Graft Versus Host Disease (GVHD) Diagnosis]:**

1. Diagnosis of chronic GVHD; and
2. Has failed at least 2 prior lines of systemic therapy for chronic GVHD; and
3. Member's recent weight must be provided and must be ≥40kg.

**Ojemda™ (Tovorafenib) Approval Criteria [Low Grade Glioma (LGG) Diagnosis]:**

1. Diagnosis of relapsed or refractory pediatric LGG; and
2. Member must be 6 months to 25 years of age; and
3. Presence of BRAF fusion, BRAF rearrangement, or BRAF V600 mutation; and
4. Member's recent body surface area (BSA) must be provided; and
    a. For members with a BSA ≥0.90$m^2$, requests for the oral suspension formulation will require a patient-specific, clinically significant reason why the member cannot use the tablet formulation.

**Omisirge® (Omidubicel-onlv) Approval Criteria:**

1. Member is 12 years of age or older; and
2. Diagnosis of hematological malignancy; and
3. Allogeneic stem cell transplant using umbilical cord blood donor source is planned; and
    a. Documentation of the donor source must be provided; and
4. Myeloablative conditioning regimen will be used; and
    a. Documentation of the member's conditioning regimen must be provided; and
5. Will be used to reduce time to neutrophil recovery and incidence of infection.

**Pedmark® (Sodium Thiosulfate) Approval Criteria [Reduction in Ototoxicity Risk Associated with Cisplatin for Solid Tumor Diagnosis]:**

1. Pediatric members 1 month to 18 years of age with a diagnosis of localized, non-metastatic solid tumor; and
2. An FDA approved indication to reduce the risk of ototoxicity associated with cisplatin; and
    a. Member's cisplatin regimen must be provided (i.e., frequency of chemotherapy cycles, number of treatment days per cycle, number of chemotherapy cycles remaining); and
3. Pedmark® will be administered as follows:
    a. Starting 6 hours after completion of cisplatin infusion; or
    b. For multi-day cisplatin regimens, Pedmark® will be administered 6 hours after each cisplatin infusion but at least 10 hours before the next cisplatin infusion; and
4. Member has a baseline serum sodium <145mmol/L.

**Rezurock® (Belumosudil) Approval Criteria [Graft-Versus-Host Disease (GVHD) Diagnosis]:**

1. Diagnosis of chronic GVHD; and
2. Failure of at least 2 prior lines of systemic therapy; and
3. Member must be 12 years of age or older.

**Sylvant® (Siltuximab) Approval Criteria:**

1. An FDA approved diagnosis of multicentric Castleman's disease (MCD; also known as giant lymph node hyperplasia); and
2. Member must be human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8) negative; and
3. Member must be 18 years of age or older; and
4. The following FDA approved dosing restrictions will apply:
    a. 11mg/kg via intravenous (IV) infusion every 3 weeks until treatment failure (defined as disease progression based on increase in symptoms, radiologic progression, or deterioration in performance status); and
5. Sylvant® must be administered in a clinical setting able to provide resuscitation equipment, medications, and trained personnel; and
6. The prescriber must verify that a complete blood count (CBC) will be done prior to each dose for the first 12 months and for an additional 3 doses thereafter; and
7. Approvals will be for the duration of 6 months.

**Tecelra® (Afamitresgene Autoleucel) Approval Criteria [Synovial Sarcoma Diagnosis]:**

1. Diagnosis of unresectable or metastatic synovial sarcoma; and
2. Member must be 18 years of age or older; and

3. Has received previous anthracycline or ifosfamide-containing chemotherapy; and
4. HLA-A*02:01P, -A*02:02P, -A*02:03P, or -A*02:06P positive; and
5. Tumor expresses melanoma-associated antigen A4 (MAGE-A4) as detected by an FDA-approved test; and
6. Health care facilities must be able to administer cellular therapies and must be trained in the management of cytokine release syndrome (CRS) and neurologic toxicities; and
7. Approvals will be for 1 dose per member per lifetime.

**Vijoice® (Alpelisib) Approval Criteria [PIK3CA-Related Overgrowth Spectrum (PROS) Diagnosis]:**

1. Adult and pediatric members 2 years of age and older; and
2. Documented PIK3CA gene mutation; and
3. Severe or life-threatening clinical manifestations of PROS.

**Vitrakvi® (Larotrectinib) Approval Criteria [Solid Tumors with Neurotrophic Receptor Tyrosine Kinase (*NTRK*) Gene Fusion Diagnosis]:**

1. Diagnosis of a solid tumor with a *NTRK* gene fusion without a known acquired resistance mutation; and
2. Disease is metastatic or surgical resection (or radioactive iodine refractory if thyroid carcinoma) is contraindicated; and
3. Documentation of no satisfactory alternative treatments or progression following acceptable alternative treatments.

**Voranigo® (Vorasidenib) Approval Criteria [Astrocytoma or Oligodendroglioma Diagnosis]:**

1. Diagnosis of grade 2 astrocytoma or oligodendroglioma; and
2. Presence of susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation following surgery including biopsy, sub-total resection, or gross total resection.

**Oncology Medications Additional Criteria:**

1. Approvals for oncology medications will be for the duration of 6 months unless otherwise specified in a particular medication's approval criteria; and
    a. Unless otherwise specified in a medication's approval criteria, continuation requests will be approved for the duration of 6 months if there is no evidence of disease progression or adverse drug reactions; and
2. The following situations require the request to be reviewed by a board-certified oncology pharmacist (BCOP) or plan-contracted oncologist or other oncology physician:
    a. Any request for an oncology medication which does not meet approval criteria; or

b. Any continuation request if the member has evidence of disease progression or adverse drug reactions while on the requested medication; or
c. Any level-1 appeal request for an oncology medication; or
d. Any peer-to-peer request for an oncology medication.

## Utilization of Miscellaneous Cancer Medications: Fiscal Year 2024

### Comparison of Fiscal Years: Pharmacy Claims (All Plans)

| Plan Type | *Total Members | Total Claims | Total Cost | Cost/ Claim | Cost/ Day | Total Units | Total Days |
|---|---|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | | | |
| **FFS** | 7 | 52 | $1,457,811.69 | $28,034.84 | $971.87 | 3,030 | 1,500 |
| **2023 Total** | **7** | **52** | **$1,457,811.69** | **$28,034.84** | **$971.87** | **3,030** | **1,500** |
| **Fiscal Year 2024** | | | | | | | |
| **FFS** | 10 | 73 | $2,279,471.34 | $31,225.63 | $1,035.65 | 5,582 | 2,201 |
| **Aetna** | 2 | 3 | $52,561.06 | $17,520.35 | $536.34 | 230 | 98 |
| **Humana** | 0 | 0 | $0.00 | $0.00 | $0.00 | 0 | 0 |
| **OCH** | 2 | 3 | $104,033.55 | $34,677.85 | $1,182.20 | 148 | 88 |
| **2024 Total** | **11** | **79** | **$2,436,065.95** | **$30,836.28** | **$1,020.56** | **5,960** | **2,387** |
| **% Change** | **57.10%** | **51.90%** | **67.10%** | **10.00%** | **5.00%** | **96.70%** | **59.10%** |
| **Change** | **4** | **27** | **$978,254.26** | **$2,801.44** | **$48.69** | **2,930** | **887** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

### Fiscal Year 2024 Utilization: Medical Claims (All Plans)

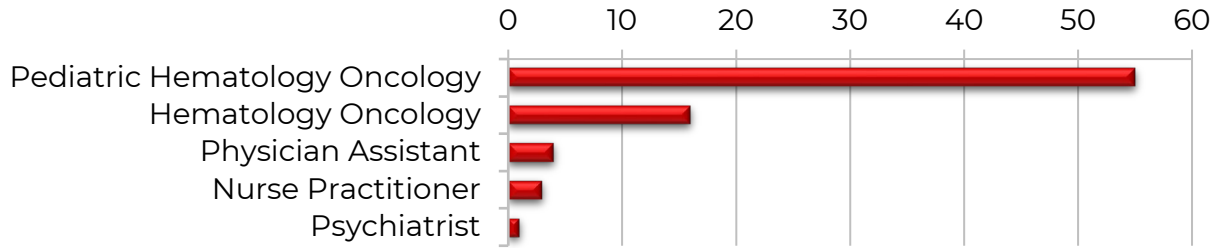
| Plan Type | *Total Members | †Total Claims | Total Cost | Cost/ Claim | Claims/ Member |
|---|---|---|---|---|---|
| **Fiscal Year 2024** | | | | | |
| **FFS** | 1 | 14 | $160,206.20 | $11,443.30 | 14 |
| **Aetna** | 0 | 0 | $0.00 | $0.00 | 0 |
| **Humana** | 0 | 0 | $0.00 | $0.00 | 0 |
| **OCH** | 0 | 0 | $0.00 | $0.00 | 0 |
| **2024 Total** | **1** | **14** | **$160,206.20** | **$11,443.30** | **14** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.
Please note: There were no paid medical claims for miscellaneous cancer medications during fiscal year 2023 to allow for a fiscal year comparison.

### Demographics of Members Utilizing Miscellaneous Cancer Medications: Pharmacy Claims (All Plans)

- Due to the limited number of members utilizing miscellaneous cancer medications during fiscal year 2024, detailed demographic information could not be provided.

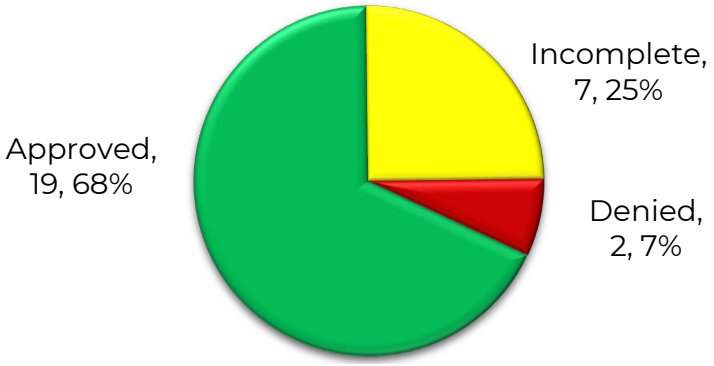
### Top Prescriber Specialties of Miscellaneous Cancer Medications by Number of Claims: Pharmacy Claims (All Plans)




## Prior Authorization of Miscellaneous Cancer Medications

There were 28 prior authorization requests submitted for miscellaneous cancer medications during fiscal year 2024. The following chart shows the status of the submitted petitions for fiscal year 2024.

### Status of Petitions (All Plans)




### Status of Petitions by Plan Type

| Plan Type | Approved | | Incomplete | | Denied | | Total |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | |
| **FFS** | 17 | 74% | 6 | 26% | 0 | 0% | **23** |
| **Aetna** | 1 | 50% | 1 | 50% | 0 | 0% | **2** |
| **Humana** | 0 | N/A | 0 | N/A | 0 | N/A | **0** |
| **OCH** | 1 | 33% | 0 | 0% | 2 | 67% | **3** |
| **Total** | **19** | **68%** | **7** | **25%** | **2** | **7%** | **28** |

FFS = fee-for-service; N/A = not applicable; OCH = OK Complete Health
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

## Market News and Updates[1,2,3,4,5,6]

**Anticipated Patent or Exclusivity Expiration(s):**

- Koselugo® (selumetinib): March 2029
- Vijoice® (alpelisib): April 2033
- Vitrakvi® (larotrectinib): May 2037
- Turalio® (pexidartinib): July 2038
- Lutathera® (lutetium Lu-177 dotatate): January 2039
- Pedmark® (sodium thiosulfate): July 2039
- Fyarro® (sirolimus): October 2040
- Bynfezia Pen™ (octreotide): November 2040
- Rezurock® (belumosudil): July 2042

**New U.S. Food and Drug Administration (FDA) Approval(s):**

- **December 2024:** The FDA approved Ryoncil® (remestemcel-l-rknd) for the treatment of steroid-refractory acute graft versus host disease (aGVHD) in pediatric patients 2 months of age and older.

**Guideline Update(s):**

- The National Comprehensive Cancer Network (NCCN) guidelines allow the use of toripalimab-tpzi (Loqtorzi®) for the treatment of locally unresectable or medically inoperable, advanced or metastatic anal carcinoma, colorectal cancer, or small bowel adenocarcinoma that is deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation positive with ultra-hypermutated phenotype.

## Ryoncil® (Remestemcel-L-rknd) Product Summary[7]

**Therapeutic Class:** Allogeneic bone marrow-derived mesenchymal stromal cell (MSC) therapy

**Indication(s):** Treatment of steroid-refractory aGVHD in pediatric patients 2 months of age and older

**How Supplied:**

- Cell suspension for intravenous (IV) infusion in a target concentration of 6.68 X $10^6$ MSCs per mL in 3.8mL contained in a 6mL cryovial
- Supplied as a customized kit containing a variable number of vials to meet dosing requirements for a single dose for each patient, based on the patient's weight

**Dosing and Administration:**

- The recommended dosage of Ryoncil® is 2 × $10^6$ MSCs/kg body weight per IV infusion given twice a week for 4 consecutive weeks for a total of 8 infusions.
- Infusions should be administered at least 3 days apart.

- Treatment response should be assessed 28 ± 2 days after the first dose, and further treatment may be administered based on day 28 response.
- For a partial or mixed response at day 28, Ryoncil® administration may be repeated once weekly for an additional 4 weeks (4 infusions total).
- For recurrence of GVHD after a complete response, Ryoncil® administration may be repeated twice weekly for an additional 4 consecutive weeks (8 infusions total).

**Cost:** The Wholesale Acquisition Cost (WAC) is $194,000 per infusion, regardless of weight. For the initial treatment course of 8 infusions, this would result in an estimated cost of $1,552,000. If a partial or mixed response is achieved after the initial treatment, the cost of 4 additional infusions would be $776,000, and the total cost for that member would be $2,328,000.

## Recommendations

The College of Pharmacy recommends the prior authorization of Ryoncil® (remestemcel-l-rknd) with the following criteria (shown in red):

**Ryoncil® (Remestemcel-L-rknd) Approval Criteria [Acute Graft Versus Host Disease (aGVHD) Diagnosis]:**

1. Diagnosis of aGVHD; and
2. Disease is steroid refractory; and
3. Member is 2 months of age to younger than 18 years of age; and
4. Member is an allogeneic hematopoietic stem cell transplant (HSCT) recipient; and
5. Initial approvals will be for a maximum of 8 infusions; and
6. Subsequent approvals for additional infusions will require repeat authorization and clinical documentation must be submitted to support the need for additional infusions; and
    a. All requests for subsequent approvals will require review by a board-certified oncology pharmacist (BCOP) or plan-contracted oncologist or other oncology physician.

Additionally, the College of Pharmacy recommends updating the Loqtorzi® (toripalimab-tpzi) approval criteria based on NCCN recommendations with the following changes (shown in red):

**Loqtorzi® (Toripalimab-tpzi) Approval Criteria [Anal Carcinoma, Colorectal Cancer (CRC), and Small Bowel Adenocarcinoma Diagnosis]:**

1. Diagnosis of anal carcinoma, CRC, or small bowel adenocarcinoma; and
2. Disease is locally unresectable, medically inoperable, advanced, or metastatic; and
3. Must meet 1 of the following:
    a. Deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H); or

b. Polymerase epsilon/delta (POLE/POLD1) mutation positive with ultra-hypermutated phenotype [e.g., tumor mutational burden (TMB) >50mut/Mb]; and

4. No prior treatment with a checkpoint inhibitor; and
5. Used as a single agent; and
6. Dose as follows:
   a. 3mg/kg every 2 weeks.

## Utilization Details of Miscellaneous Cancer Medications: Fiscal Year 2024

### Pharmacy Claims (All Plans)

| PRODUCT UTLIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **ALPELISIB PRODUCTS** | | | | | | |
| VIJOICE TAB 50MG | 35 | 4 | $1,137,899.35 | $32,511.41 | 8.75 | 46.71% |
| **SUBTOTAL** | **35** | **4** | **$1,137,899.35** | **$32,511.41** | **8.75** | **46.71%** |
| **LAROTRECTINIB PRODUCTS** | | | | | | |
| VITRAKVI SOL 20MG/ML | 24 | 2 | $659,487.84 | $27,478.66 | 12 | 27.07% |
| VITRAKVI CAP 100MG | 5 | 1 | $185,689.55 | $37,137.91 | 5 | 7.62% |
| **SUBTOTAL** | **29** | **3** | **$845,177.39** | **$29,144.05** | **9.67** | **34.69%** |
| **BELUMOSUDIL PRODUCTS** | | | | | | |
| REZUROCK TAB 200MG | 15 | 4 | $452,989.21 | $30,199.28 | 3.75 | 18.60% |
| **SUBTOTAL** | **15** | **4** | **$452,989.21** | **$30,199.28** | **3.75** | **18.60%** |
| **TOTAL** | **79** | **11*** | **$2,436,065.95** | **$30,836.28** | **7.18** | **100%** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; SOL = solution; TAB = tablet
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

### Medical Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS† | TOTAL MEMBERS* | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER |
|---|---|---|---|---|---|
| J2860 SILTUXIMAB INJ | 14 | 1 | $160,206.20 | $11,443.30 | 14 |
| **TOTAL** | **14** | **1** | **$160,206.20** | **$11,443.30** | **14** |

Costs do not reflect rebated prices or net costs.
†Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 07/2025. Last accessed 07/10/2025.
[2] U.S. FDA. FDA Approves Remestemcel-L-rknd for Steroid-Refractory Acute Graft Versus Host Disease in Pediatric Patients. Available online at: https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-remestemcel-l-rknd-steroid-refractory-acute-graft-versus-host-disease-pediatric. Issued 12/18/24. Last accessed 07/07/2025.
[3] National Comprehensive Cancer Network (NCCN). Anal Carcinoma Clinical Practice Guidelines in Oncology. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/anal.pdf. Last revised 05/30/2025. Last accessed 07/29/2025.
[4] National Comprehensive Cancer Network (NCCN). Colon Cancer Clinical Practice Guidelines in Oncology. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Last revised 06/27/2025. Last accessed 07/29/2025.
[5] National Comprehensive Cancer Network (NCCN). Rectal Cancer Clinical Practice Guidelines in Oncology. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf. Last revised 03/31/2025. Last accessed 07/29/2025.
[6] National Comprehensive Cancer Network (NCCN). Small Bowel Adenocarcinoma Clinical Practice Guidelines in Oncology. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/small_bowel.pdf. Last revised 03/31/2025. Last accessed 07/29/2025.
[7] Ryoncil® (Remestemcel-L-rknd) Prescribing Information. Mesoblast, Inc. Available online at: https://www.ryoncil.com/pdfs/prescribing-information.pdf. Last revised 01/2025. Last accessed 07/07/2025.

# Appendix F

# Fiscal Year 2024 Annual Review of Opioid Analgesics and Opioid Medication Assisted Treatment (MAT) Medications and 30-Day Notice to Prior Authorize Tramadol 75mg Tablet

**Oklahoma Health Care Authority**
**August 2025**

## Current Prior Authorization Criteria: Opioid Analgesics

| Opioid Analgesics* | | | |
|---|---|---|---|
| **Tier-1** | **Tier-2** | **Tier-3** | **Special PA** |
| ***Long-Acting*** | | | |
| buprenorphine patch (Butrans®) – **Brand Preferred** | fentanyl patch (Duragesic®) | buprenorphine ER buccal film (Belbuca®) | methadone soln (Dolophine®) |
| oxycodone ER tab 10mg, 15mg, 20mg only (OxyContin®) – **Brand Preferred** | Morphine ER tab (MS Contin®) | hydrocodone ER cap (Zohydro® ER) | oxymorphone ER tab |
| | oxycodone ER tab 30mg, 40mg, 60mg, 80mg (OxyContin®) – **Brand Preferred** | hydrocodone ER tab (Hysingla® ER) | tramadol ER cap (ConZip®) |
| | tramadol ER tab (Ultram® ER, Ryzolt®) | hydromorphone ER tab (Exalgo®) | |
| | | methadone tab (Dolophine®) | |
| | | morphine ER cap (Avinza®, Kadian®) | |
| ***Short-Acting*** | | | |
| APAP/butalbital/ caff/codeine cap 50/325/40/30mg (Fioricet® with Codeine) | hydrocodone/IBU tab 10/200mg (Ibudone®, Reprexain™) | dihydrocodeine/ APAP/caff cap (Trezix®) | APAP/butalbital/ caff/codeine cap 50/300/40/30mg (Fioricet® with Codeine) |
| ASA/butalbital/caff/ codeine cap (Fiorinal® with Codeine) | oxymorphone IR tab (Opana®) | oxycodone tab (RoxyBond™) | APAP/codeine elixir & soln |

| Opioid Analgesics* | | | |
|---|---|---|---|
| **Tier-1** | **Tier-2** | **Tier-3** | **Special PA** |
| codeine tab | | | hydrocodone/ APAP soln |
| codeine/APAP tab (Tylenol® with Codeine) | | | hydrocodone/APAP tab (Xodol®) |
| hydrocodone/ APAP tab (Norco®) | | | levorphanol tab |
| hydrocodone/IBU tab 5/200mg, 7.5/200mg only (Vicoprofen®, Ibudone®, Reprexain™) | | | oxycodone/APAP tab (Nalocet®) |
| hydromorphone tab & soln (Dilaudid®) | | | oxycodone/APAP tab & soln (Prolate®) |
| meperidine tab & soln (Demerol®) | | | Tramadol 25mg, 100mg tab |
| morphine IR tab & soln (MSIR®) | | | tramadol soln (Qdolo™) |
| oxycodone/APAP tab & soln (Percocet®) | | | |
| oxycodone/ASA tab (Percodan®) | | | |
| oxycodone IR cap (Oxy IR®) | | | |
| oxycodone IR tab & soln (Roxicodone®) | | | ***Oncology Only:*** |
| tramadol 50mg tab (Ultram®) | | | fentanyl buccal tab (Fentora®) |
| tramadol/APAP (Ultracet®) | | | fentanyl transmucosal lozenge (Actiq®) |

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
APAP = acetaminophen; ASA = aspirin; caff = caffeine; cap = capsule; ER = extended-release; IBU = ibuprofen; IR = immediate-release; PA = prior authorization; SL = sublingual; soln = solution; tab = tablet

- Tier-1 products are covered with no prior authorization necessary.
- Members with an oncology-related diagnosis are exempt from the prior authorization process and do not require a pain contract.
- Only 1 long-acting and 1 short-acting medication can be used concurrently.
- Short-acting, solid dosage formulation products are limited to a quantity of 4 units per day or a quantity of 120 units per 30 days. An exception applies to members with a current oncology-related diagnosis, sickle cell disease diagnosis, or hemophilia diagnosis.
- An age restriction applies on oral liquid narcotic analgesic products for all members 12 years of age or older and oral solid dosage forms for all members younger than 10 years of age.
- An age restriction applies for all tramadol and codeine products (both liquid and solid dosage formulations) for members younger than 12 years of age. Authorization consideration for members younger than 12 years of age requires a patient-specific, clinically significant reason for use of these products despite the medication being contraindicated for the member's age.

**Opioid Analgesics Tier-2 Approval Criteria:**

1. A documented 30-day trial/titration period with at least 1 Tier-1 medication within the last 90 days is required for a Tier-2 long-acting medication; and
2. A chronic pain diagnosis requiring time-released medication (for long-acting medications); or
3. A documented 30-day trial with at least 2 Tier-1 short-acting medications within the last 90 days is required for a Tier-2 short-acting medication; or
4. A documented allergy or contraindication(s) to all available Tier-1 medications.

**Opioid Analgesics Tier-3 Approval Criteria:**

1. A documented 30-day trial with at least 2 Tier-2 long-acting medications within the last 90 days is required for approval of a Tier-3 long-acting medication; or
2. A documented 30-day trial with at least 2 Tier-2 short-acting medications within the last 90 days is required for approval of a Tier-3 short-acting medication; or
3. A documented allergy or contraindication(s) to all available Tier-2 medications.

**Opioid Analgesics Special Prior Authorization (PA) Approval Criteria:**

1. Actiq® and Fentora® are approved for oncology-related diagnoses only.
2. ConZip® [Tramadol Extended-Release (ER) Capsule] Approval Criteria:

    a. A patient-specific, clinically significant reason why the member cannot use the ER tablet formulation must be provided. Tier structure rules apply.
3. Acetaminophen (APAP)/Codeine Elixir and Solution Approval Criteria:
    a. Authorization consideration for members younger than 12 years of age requires a patient-specific, clinically significant reason for use of these products despite the medication being contraindicated for the member's age; or
    b. For members 12 years of age or older, a patient-specific, clinically significant reason why the member cannot use the tablet formulation, which is available without a prior authorization, must be provided.
4. Fioricet® with Codeine (Butalbital/APAP/Caffeine/Codeine 50mg/300mg/40mg/30mg) Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot take the 325mg APAP formulation butalbital/APAP/ caffeine/codeine 50mg/325mg/40mg/30mg), which is available generically, must be provided.
5. Hydrocodone/APAP Unique Formulations and Strengths Approval Criteria:
    a. For hydrocodone/APAP 7.5mg-325mg/15mL oral solution (generic Hycet®) or Xodol® (hydrocodone/APAP 5mg/300mg, 7.5mg/300mg, and 10mg/300mg), a patient-specific, clinically significant reason why the member cannot use generic Norco® (hydrocodone/APAP 5/325mg, 7.5/325mg, or 10/325mg) tablets must be provided; or
    b. For hydrocodone/APAP 7.5mg-325mg/15mL oral solution (generic Hycet®), a prior authorization is not required for members 14 years of age or younger. For members older than 14 years of age, a prior authorization is required, unless the prescription is written by an otolaryngologist or a dentist; and
    c. For hydrocodone/APAP oral solution unit dose cups, a prior authorization is required for all members and a patient-specific, clinically significant reason why the member cannot use hydrocodone/APAP in bulk solution must be provided.
6. Levorphanol Tablet Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use alternative treatment options for pain (e.g., non-opioid analgesics, lower-tiered opioid analgesics) must be provided.
7. Methadone Oral Solution Approval Criteria:
    a. For the lower strengths of methadone (5mg/5mL or 10mg/5mL), a prior authorization is not required for members 1 year of age and younger; or

   b. For members older than 1 year of age, a patient specific clinically significant reason why the member cannot use methadone tablets and other lower-tiered opioid analgesics must be provided.
8. Oxycodone/APAP Unique Formulations and Strengths Approval Criteria:
   a. For Nalocet® (oxycodone/APAP 2.5mg/300mg) tablets and Prolate® (oxycodone/APAP 5mg/300mg, 7.5mg/300mg, and 10mg/300mg) tablets, a patient specific, clinically significant reason why the member cannot use generic Percocet® (oxycodone/APAP 2.5mg/325mg, 5mg/325mg, 7.5mg/325mg, or 10mg/325mg) tablets must be provided; and
   b. For Prolate® (10mg-300mg/5mL) oral solution, a patient specific, clinically significant reason why the member cannot use generic oxycodone/APAP tablets and generic oxycodone/APAP (5mg-325mg/5mL) oral solution must be provided.
9. Oxymorphone ER Tablet Approval Criteria:
   a. A patient specific, clinically significant reason why the member cannot use any other available extended-release opioid analgesic must be provided.
10. Qdolo™ (Tramadol 5mg/mL Oral Solution) Approval Criteria:
   a. A patient-specific, clinically significant reason why the member cannot use tramadol 50mg tablets, even when tablets are crushed, must be provided; and
   b. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the prescriber must provide patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age; and
   c. A quantity limit of 2,400mL per 30 days will apply.
11. Tramadol 25mg and 100mg Tablet Approval Criteria:
   a. A patient-specific, clinically significant reason why the member cannot use 2 tramadol 50mg tablets to achieve a 100mg dose or split a tramadol 50mg tablet to achieve a 25mg dose must be provided; and
   b. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the provider must submit patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age.

**Approval Criteria for Greater than 12 Claims Per Year of Hydrocodone Products:**

1. Members may be approved for greater than 12 claims per year of hydrocodone products if the member has a pain contract with a single

prescriber. A copy of the pain contract must be submitted with the prior authorization request. Requests outside of the plan outlined in the contract will not be approved.
2. Members with a current oncology-related diagnosis, hemophilia diagnosis, or sickle cell disease diagnosis do not require a pain contract for additional approvals.
3. Members in long-term care facilities do not require a pain contract for additional approvals.

**Approval Criteria for Greater than the Opioid Morphine Milligram Equivalent (MME) Limit:**

1. SoonerCare has an opioid MME limitation of 90 MME per day. Members with a daily MME >90 will require prior authorization. Each request for >90 MME per day will be evaluated on a case-by-case basis; and
2. Patient-specific, clinically significant reasoning for daily doses >90 MME must be provided; and
3. Reasoning why tapering to below the SoonerCare MME limit is not appropriate for the member must be provided; and
    a. A taper schedule, dates of an attempted taper with reason(s) for failure, or a patient-specific, clinically significant reason why a taper attempt is not appropriate for the member should be documented on the prior authorization request; and
4. For members unable to taper to below the SoonerCare MME limit or for whom tapering to below the SoonerCare MME limit is not appropriate, the prescriber must attest to all of the following:
    a. Other non-pharmacologic therapies have been ineffective (i.e., physical therapy); and
    b. Other non-opioid pharmacologic therapies have been ineffective [i.e., non-steroidal anti-inflammatory drugs (NSAIDs)]; and
    c. Risk factors for respiratory depression have been reviewed (i.e., concurrent benzodiazepine use, asthma); and
    d. Counseling on opioid overdose has been provided and a prescription for naloxone has been offered to the member; and
    e. Member has been evaluated for opioid use disorder; and
    f. Pain treatment plan has been established and includes realistic goals for pain and function; and
    g. Monitoring plan is established including random urine drug screens and review of the Oklahoma Prescription Monitoring Program (PMP); and
    h. Dose reduction has resulted in loss of pain control and/or function; and
    i. Further escalation in dose will not be allowed by provider. Authorization will only be granted at current MME; and

j. The benefits of high-dose opioid therapy for both pain and function in the member outweigh the risks to member safety; and

5. Requests for members exceeding the 90 MME limit per day can be approved when there is documentation of pain associated with end-of-life care, palliative care, or hospice; and
6. Members with oncology, sickle cell disease, or hemophilia diagnoses are excluded from the MME limit.

## Current Prior Authorization Criteria: MAT Medications

**Suboxone® [Buprenorphine/Naloxone Sublingual (SL) Tablet and Film], Subutex® (Buprenorphine SL Tablet), and Zubsolv® (Buprenorphine/ Naloxone SL Tablet) Approval Criteria:**

1. Generic buprenorphine/naloxone SL tablet is the preferred product. Authorization consideration of Zubsolv® and Suboxone® films (brand and generic) requires a patient-specific, clinically significant reason why generic buprenorphine/naloxone SL tablets are not appropriate.
2. Subutex® (buprenorphine) 2mg and 8mg SL tablets will only be approved if the member is pregnant or has a documented serious allergy or adverse reaction to naloxone; and
3. Member must have an FDA approved diagnosis of opioid abuse/ dependence; and
4. Concomitant treatment with opioid analgesics (including tramadol) will be denied; and
5. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
6. The following limitations will apply:
    a. Suboxone® 2mg/0.5mg and 4mg/1mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    b. Suboxone® 8mg/2mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    c. Suboxone® 12mg/3mg SL films: A quantity limit of 60 SL films per 30 days will apply.
    d. Subutex® 2mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    e. Subutex® 8mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    f. Zubsolv® 0.7mg/0.18mg, 1.4mg/0.36mg, and 2.9mg/0.71mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    g. Zubsolv® 5.7mg/1.4mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    h. Zubsolv® 8.6mg/2.1mg: A quantity limit of 60 SL tablets per 30 days will apply.

i. Zubsolv® 11.4mg/2.9mg SL tablets: A quantity limit of 30 SL tablets per 30 days will apply.

**High-Dose Buprenorphine Medication-Assisted Treatment (MAT) Products Approval Criteria:**

1. Each request for >24mg bioequivalent buprenorphine per day will be evaluated on a case-by-case basis; and
2. A taper schedule, dates of an attempted taper with reason(s) for failure, or a patient-specific, clinically significant reason why a taper attempt is not appropriate for the member should be documented on the prior authorization request; and
3. Opioid urine drug screens should be submitted with high-dose requests that plan to continue high-dose treatment longer than the duration of 1 month; and
    a. Urine drug screens must show the absence of opioid medications other than buprenorphine products for continued approval; or
    b. Prescriber must document a patient-specific reason the member should continue therapy, reason for opioid use, and document a plan for member to discontinue opioid use; and
4. Symptoms associated with withdrawal at lower doses or symptoms requiring high doses should be listed on the prior authorization request; and
5. Each approval will be for the duration of 1 month. If urine drug screen and other documentation are submitted indicating high-dose therapy is necessary, an approval can be granted for the duration of 3 months; and
6. Continued high-dose authorization after the 3-month approval will require a new (recent) urine drug screen; and
7. For Opioid Treatment Programs (OTPs), high-dose authorization will be approved for 1 year if urine drug screen and other documentation are submitted indicating high-dose therapy is necessary.

**Brixadi® [Buprenorphine Extended-Release (ER) Injection] and Sublocade® (Buprenorphine ER Injection) Approval Criteria:**

1. An FDA approved diagnosis of moderate-to-severe opioid use disorder (OUD); and
2. For Sublocade®, member must have initiated treatment with a transmucosal buprenorphine-containing product for a minimum of 7 days; or
3. For Brixadi®, member must have initiated treatment with a single dose of a transmucosal buprenorphine product or is currently treated with buprenorphine; and
4. Concomitant treatment with opioids (including tramadol) will be denied; and

5. Medication should only be prepared and administered by a health care provider; and
6. A patient-specific, clinically significant reason why the member cannot use the preferred buprenorphine product(s) (buprenorphine/naloxone sublingual tablets) must be provided; and
7. In general, concomitant treatment with transmucosal buprenorphine will not be approved long term; and
8. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
9. A quantity limit of 1 monthly dose per 28 days or 4 weekly doses per 28 days will apply.

**Lucemyra® (Lofexidine) Approval Criteria:**

1. An FDA approved indication for mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation in adults; and
2. Date of opioid discontinuation must be listed on the prior authorization request; and
3. Prescriber must verify member has been screened for hepatic and renal impairment and that dosing is appropriate for the member's degree of hepatic and renal function; and
4. Prescriber must verify member's vital signs have been monitored and that the member is capable of and has been instructed on self-monitoring for hypotension, orthostasis, bradycardia, and associated symptoms; and
5. Member must not have severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, chronic renal failure, or marked bradycardia; and
6. Member must not have congenital long QT syndrome; and
7. Prescriber must verify Lucemyra® will be used in conjunction with a comprehensive management program for the treatment of opioid use disorder; and
8. A patient-specific, clinically significant reason why clonidine tablets or patches cannot be used in place of Lucemyra® to mitigate opioid withdrawal symptoms must be provided; and
9. Approvals will be for a maximum duration of 14 days; and
10. A quantity limit of 12 tablets per day will apply.

## Utilization of Opioid Analgesics and MAT Medications: Fiscal Year 2024

### Comparison of Fiscal Years: Opioid Analgesics: Pharmacy Claims (All Plans)

| Plan Type | *Total Members | Total Claims | Total Cost | Cost/ Claim | Cost/ Day | Total Units | Total Days |
|---|---|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | | | |
| **FFS** | 112,507 | 324,396 | $10,888,307.82 | $33.56 | $1.92 | 20,112,490 | 5,679,699 |
| **2023 Total** | **112,507** | **324,396** | **$10,888,307.82** | **$33.56** | **$1.92** | **20,112,490** | **5,679,699** |
| **Fiscal Year 2024** | | | | | | | |
| **FFS** | 89,447 | 256,777 | $9,225,513.40 | $35.93 | $1.96 | 16,391,874 | 4,698,105 |
| **Aetna** | 6,383 | 10,723 | $338,573.56 | $31.57 | $1.88 | 623,310 | 180,135 |
| **Humana** | 7,572 | 14,129 | $453,972.66 | $32.13 | $2.18 | 759,146 | 208,084 |
| **OCH** | 6,384 | 10,236 | $275,145.09 | $26.88 | $1.67 | 568,634 | 164,955 |
| **2024 Total** | **99,975** | **291,865** | **$10,293,204.71** | **$35.27** | **$1.96** | **18,342,964** | **5,251,279** |
| **% Change** | **-11.10%** | **-10.00%** | **-5.50%** | **5.10%** | **2.10%** | **-8.80%** | **-7.50%** |
| **Change** | **-12,532** | **-32,531** | **-$595,103.11** | **$1.71** | **$0.04** | **-1,769,526** | **-428,420** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.
Please note: Butrans® and Belbuca® are included in the above opioid analgesics data as they are only indicated for chronic pain and are not indicated for the treatment of opioid dependence.

- Aggregate drug rebates collected during fiscal year 2024 for opioid analgesics totaled $5,735,723.84.[Δ] Rebates are collected after reimbursement for the medication and are not reflected in this report. The costs included in this report do not reflect net costs.

[Δ] Important considerations: Aggregate drug rebates are based on the date the claim is paid rather than the date dispensed. Claims data are based on the date dispensed.

## Comparison of Fiscal Years: MAT Medications: Pharmacy Claims (All Plans)

| Plan Type | *Total Members | Total Claims | Total Cost | Cost/ Claim | Cost/ Day | Total Units | Total Days |
|---|---|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | | | |
| **FFS** | 9,651 | 63,608 | $7,234,738.37 | $113.74 | $4.54 | 2,759,027 | 1,592,472 |
| **2023 Total** | **9,651** | **63,608** | **$7,234,738.37** | **$113.74** | **$4.54** | **2,759,027** | **1,592,472** |
| **Fiscal Year 2024** | | | | | | | |
| **FFS** | 9,905 | 53,378 | $7,615,955.13 | $142.68 | $5.60 | 2,308,387 | 1,360,172 |
| **Aetna** | 1,155 | 2,888 | $401,572.66 | $139.05 | $5.78 | 125,053 | 69,434 |
| **Humana** | 1,303 | 3,301 | $428,619.40 | $129.85 | $5.35 | 147,040 | 80,184 |
| **OCH** | 1,149 | 2,686 | $277,218.97 | $103.21 | $4.27 | 118,142 | 64,859 |
| **2024 Total** | **10,618** | **62,253** | **$8,723,366.16** | **$140.13** | **$5.54** | **2,698,622** | **1,574,649** |
| **% Change** | **10.00%** | **-2.10%** | **20.60%** | **23.20%** | **22.00%** | **-2.20%** | **-1.10%** |
| **Change** | **967** | **-1,355** | **$1,488,627.79** | **$26.39** | **$1.00** | **-60,405** | **-17,823** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.
Please note: The above MAT medications data does not include Butrans® or Belbuca® claims.

## Comparison of Fiscal Years: MAT Medications: Medical Claims (All Plans)

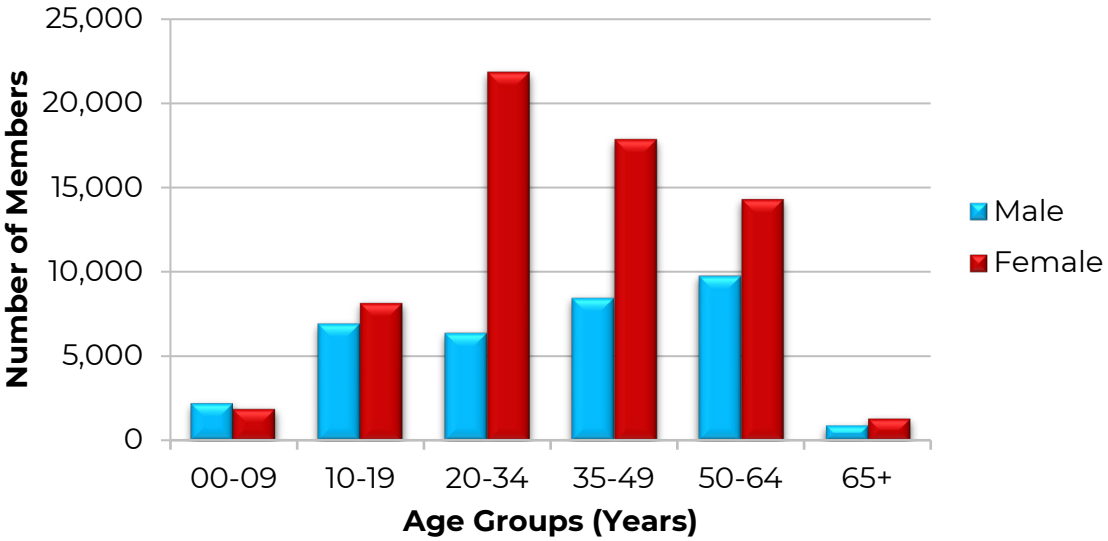
| Plan Type | *Total Members | †Total Claims | Total Cost | Cost/ Claim | Claims/ Member |
|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | |
| **FFS** | 3 | 11 | $2,860.97 | $260.09 | 3.67 |
| **2023 Total** | **3** | **11** | **$2,860.97** | **$260.09** | **3.67** |
| **Fiscal Year 2024** | | | | | |
| **FFS** | 9 | 19 | $9,058.09 | $476.74 | 2.11 |
| **Aetna** | 0 | 0 | $0.00 | $0.00 | 0 |
| **Humana** | 0 | 0 | $0.00 | $0.00 | 0 |
| **OCH** | 0 | 0 | $0.00 | $0.00 | 0 |
| **2024 Total** | **9** | **19** | **$9,058.09** | **$476.74** | **2.11** |
| **% Change** | **200.00%** | **72.73%** | **216.61%** | **83.30%** | **-42.51%** |
| **Change** | **6** | **8** | **$6,197.12** | **$216.65** | **-1.56** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members. †Total number of unduplicated claims.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

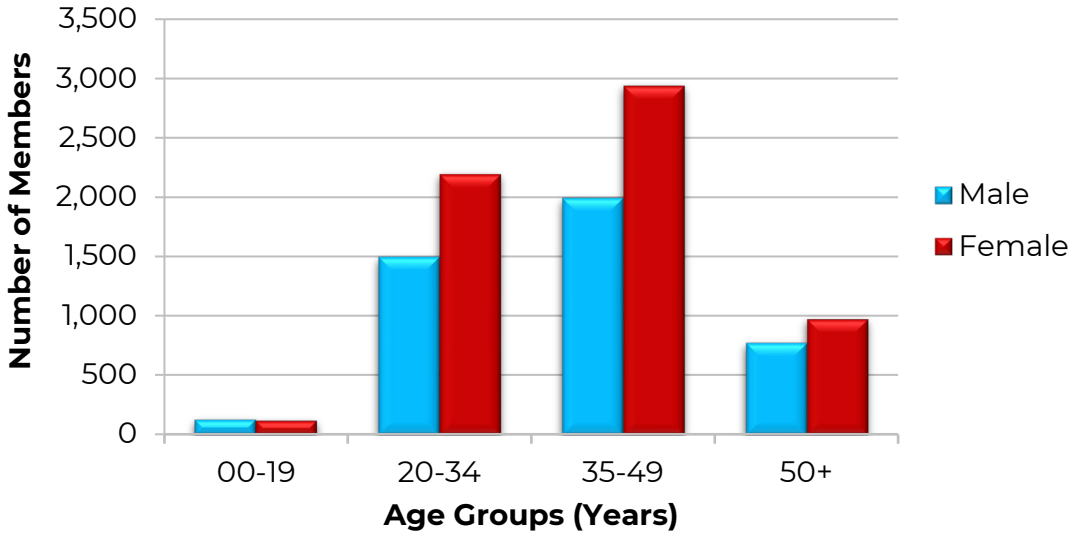
- Aggregate drug rebates collected during fiscal year 2024 for MAT medications totaled $2,076,719.56.[Δ] Rebates are collected after reimbursement for the medication and are not reflected in this report. The costs included in this report do not reflect net costs.

[Δ] Important considerations: Aggregate drug rebates are based on the date the claim is paid rather than the date dispensed. Claims data are based on the date dispensed.

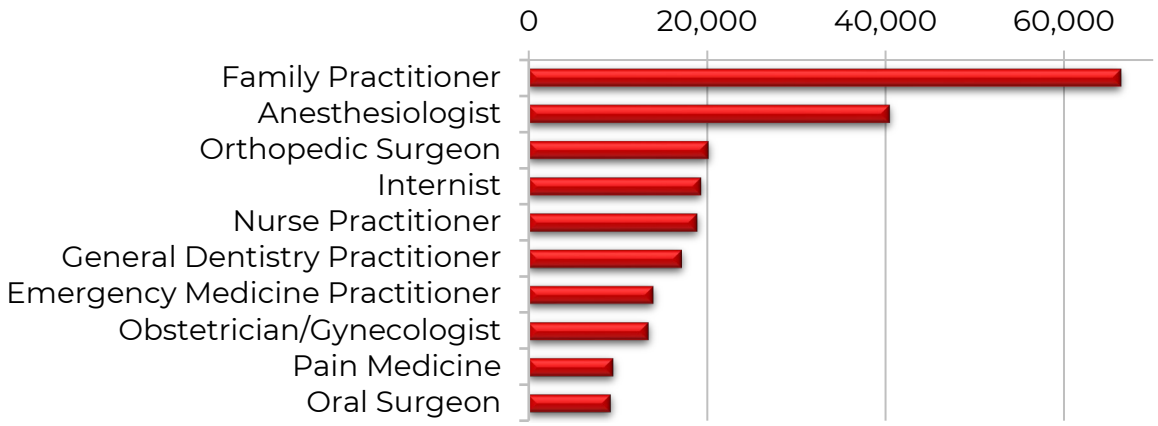
**Demographics of Members Utilizing Opioid Analgesics: Pharmacy Claims (All Plans)**



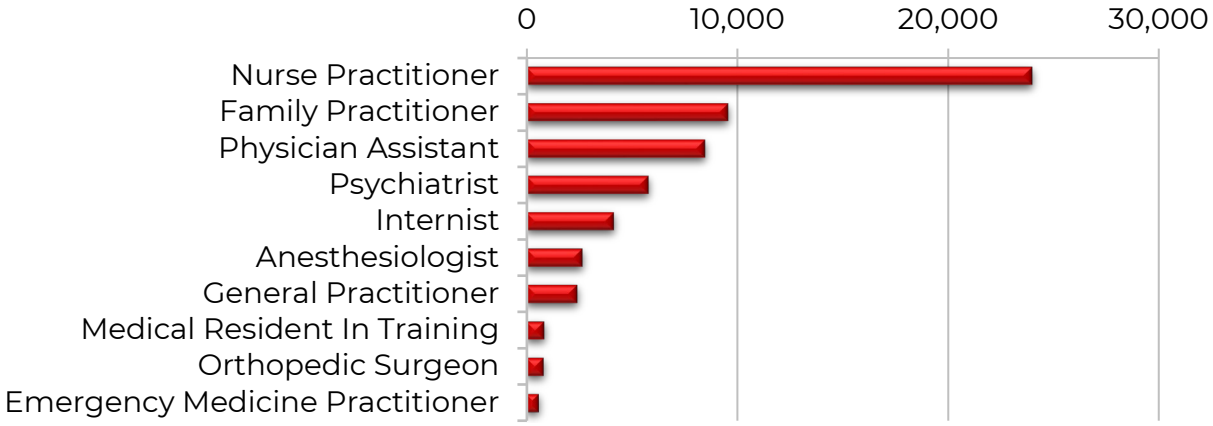

**Demographics of Members Utilizing MAT Medications: Pharmacy Claims (All Plans)**



**Top Prescriber Specialties of Opioid Analgesics by Number of Claims: Pharmacy Claims (All Plans)**



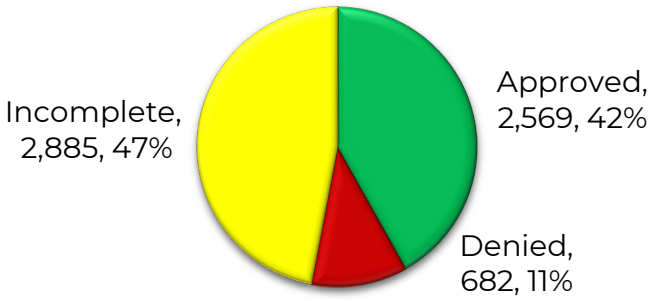

**Top Prescriber Specialties of MAT Medications by Number of Claims: Pharmacy Claims (All Plans)**




## Prior Authorization of Opioid Analgesics and MAT Medications

There were 6,136 prior authorization requests submitted for opioid analgesics during fiscal year 2024. The following chart shows the status of the submitted petitions for fiscal year 2024.

**Status of Petitions: Opioid Analgesics (All Plans)**



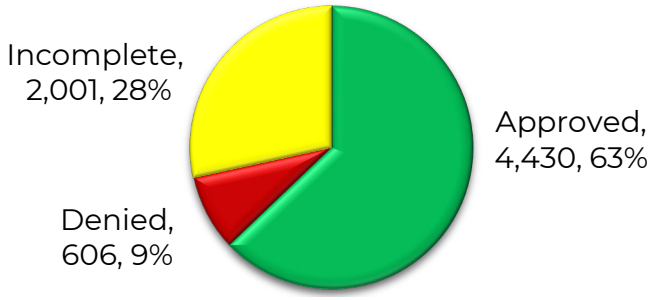
**Status of Petitions by Plan Type**

| Plan Type | Approved | | Incomplete | | Denied | | Total |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | |
| **FFS** | 2,127 | 40% | 2,773 | 52% | 418 | 8% | **5,318** |
| **Aetna** | 146 | 43% | 111 | 32% | 85 | 25% | **342** |
| **Humana** | 43 | 38% | 1 | 1% | 68 | 61% | **112** |
| **OCH** | 253 | 70% | 0 | 0% | 111 | 30% | **364** |
| **Total** | **2,569** | **42%** | **2,885** | **47%** | **682** | **11%** | **6,136** |

FFS = fee-for-service; OCH = OK Complete Health
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

There were 7,037 prior authorizations submitted for MAT medications during fiscal year 2024. The following chart shows the status of the submitted petitions for fiscal year 2024.

**Status of Petitions: MAT Medications (All Plans)**




**Status of Petitions by Plan Type**

| Plan Type | Approved | | Incomplete | | Denied | | Total |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | |
| **FFS** | 4,182 | 64% | 1,976 | 30% | 405 | 6% | **6,563** |
| **Aetna** | 124 | 53% | 25 | 11% | 87 | 37% | **236** |
| **Humana** | 43 | 54% | 0 | 0% | 36 | 46% | **79** |
| **OCH** | 81 | 51% | 0 | 0% | 78 | 49% | **159** |
| **Total** | **4,430** | **63%** | **2,001** | **28%** | **606** | **9%** | **7,037** |

FFS = fee-for-service; OCH = OK Complete Health
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

## Market News and Updates[1,2,3,4,5]

### Anticipated Patent Expiration(s):

- Fentora® (fentanyl buccal tablet): June 2028
- Brixadi® [buprenorphine extended-release (ER) injection]: July 2032
- Zubsolv® [buprenorphine/naloxone sublingual (SL) tablet]: September 2032
- Belbuca® (buprenorphine ER buccal film): December 2032
- Zohydro® ER (hydrocodone ER capsule): September 2034

- Sublocade® (buprenorphine ER injection): November 2035
- Qdolo™ (tramadol oral solution): September 2040

**New U.S. Food and Drug Administration (FDA) Approval(s):**

- **April 2024:** The FDA approved a new strength of tramadol in a 75mg tablet through an Abbreviated New Drug Application (ANDA).
- **February 2025:** The FDA approved a label change to allow a rapid initiation protocol for Sublocade® (buprenorphine ER injection) which can now be initiated after a single dose of transmucosal buprenorphine and a 1-hour observation period to confirm tolerability. The rapid initiation protocol was supported by a non-inferiority study of Sublocade® in 729 patients randomized at a 2:1 ratio to rapid initiation [receiving a single dose of 4mg transmucosal buprenorphine (TM-BUP), followed by a Sublocade® injection within 1 hour] or to the standard induction (daily TM-BUP for at least 7 days before receiving the first injection of Sublocade®). The results showed the rapid induction was effective with 66.4% of patients receiving the second injection in the rapid induction arm compared to 54.5% in the standard induction arm.
- **May 2025:** The Suboxone® (buprenorphine/naloxone SL tablet and film) and Zubsolv® (buprenorphine/naloxone SL tablet) labels were modified to clarify there is no maximum daily dosage. Both products' maintenance dosing states higher doses "may be appropriate for some patients". This update aligns with the American Society of Addiction Medicine's Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-Potency Synthetic Opioids, which was published in 2023. This document stated that some patients may need higher doses of buprenorphine (>24mg/day) if they are using high-potency synthetic opioids, such as fentanyl.

## Cost Comparison: Tramadol[6]

| Product | Cost Per Tablet | Cost Per 30 Days* |
|---|---|---|
| **tramadol 75mg tablet (generic)** | **$4.34** | **$520.80** |
| tramadol 50mg tablet (generic) | $0.02 | $3.60 |

Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Cost per 30 days based on the FDA approved dose of 75mg four times daily.

## Recommendations

The College of Pharmacy recommends the following changes to the Opioid Analgesics Product Based Prior Authorization (PBPA) category based on net costs (changes noted in red in the following Tier chart and approval criteria):

1. Adding tramadol 75mg tablet to the Special PA Tier with the following additional criteria; and

2. Moving oxycodone tablet (RoxyBond™) to the Special PA Tier with the following additional criteria; and
3. Making hydrocodone ER capsule (Hysingla® ER) brand preferred; and
4. Moving tramadol ER tablet (Ultram® ER) to Tier 1.

| Opioid Analgesics* | | | |
|---|---|---|---|
| **Tier-1** | **Tier-2** | **Tier-3** | **Special PA** |
| ***Long-Acting*** | | | |
| buprenorphine patch (Butrans®) – **Brand Preferred** | fentanyl patch (Duragesic®) | buprenorphine ER buccal film (Belbuca®) | methadone soln (Dolophine®) |
| oxycodone ER tab 10mg, 15mg, 20mg only (OxyContin®) – **Brand Preferred** | morphine ER tab (MS Contin®) | hydrocodone ER cap (Zohydro® ER) | oxymorphone ER tab |
| **tramadol ER tab (Ultram® ER)** | oxycodone ER tab 30mg, 40mg, 60mg, 80mg (OxyContin®) – **Brand Preferred** | hydrocodone ER tab (Hysingla® ER) – **Brand Preferred** | tramadol ER cap (ConZip®) |
| | tramadol ER tab (~~**Ultram® ER,**~~ Ryzolt®) | hydromorphone ER tab (Exalgo®) | |
| | | methadone tab (Dolophine®) | |
| | | morphine ER cap (Avinza®, Kadian®) | |
| | | oxycodone ER cap (Xtampza® ER) | |
| ***Short-Acting*** | | | |
| APAP/butalbital/ caff/codeine cap 50/325/40/30mg (Fioricet® with Codeine) | hydrocodone/IBU tab 10/200mg (Ibudone®, Reprexain™) | dihydrocodeine/ APAP/caff cap (Trezix®) | APAP/butalbital/ caff/codeine cap 50/300/40/30mg (Fioricet® with Codeine) |
| ASA/butalbital/caff/ codeine cap (Fiorinal® with Codeine) | oxymorphone IR tab (Opana®) | | APAP/codeine elixir & soln |
| codeine tab | | | hydrocodone/ APAP soln |

| Opioid Analgesics* | | | |
|---|---|---|---|
| **Tier-1** | **Tier-2** | **Tier-3** | **Special PA** |
| codeine/APAP tab (Tylenol® with Codeine) | | | hydrocodone/ APAP tab (Xodol®) |
| hydrocodone/ APAP tab (Norco®) | | | levorphanol tab |
| hydrocodone/IBU tab 5/200mg, 7.5/200mg only (Vicoprofen®, Ibudone®, Reprexain™) | | | **oxycodone tab (RoxyBond™)** |
| hydromorphone tab & soln (Dilaudid®) | | | oxycodone/APAP tab (Nalocet®) |
| meperidine tab & soln (Demerol®) | | | oxycodone/APAP tab & soln (Prolate®) |
| morphine IR tab & soln (MSIR®) | | | tramadol 25mg**, 75mg,** & 100mg tab |
| oxycodone/APAP tab & soln (Percocet®) | | | tramadol soln (Qdolo™) |
| oxycodone/ASA tab (Percodan®) | | | |
| oxycodone IR cap (Oxy IR®) | | | |
| oxycodone IR tab & soln (Roxicodone®) | | | ***Oncology Only:*** |
| tramadol 50mg tab (Ultram®) | | | fentanyl buccal tab (Fentora®) |
| tramadol/APAP (Ultracet®) | | | fentanyl transmucosal lozenge (Actiq®) |

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
APAP = acetaminophen; ASA = aspirin; caff = caffeine; cap = capsule; ER = extended-release; IBU = ibuprofen; IR = immediate-release; PA = prior authorization; SL = sublingual; soln = solution; tab = tablet

## Opioid Analgesics Special Prior Authorization (PA) Approval Criteria:

1. Actiq® and Fentora® are approved for oncology-related diagnoses only.
2. ConZip® [Tramadol Extended-Release (ER) Capsule] Approval Criteria:

    a. A patient-specific, clinically significant reason why the member cannot use the ER tablet formulation must be provided. Tier structure rules apply.
3. Acetaminophen (APAP)/Codeine Elixir and Solution Approval Criteria:
    a. Authorization consideration for members younger than 12 years of age requires a patient-specific, clinically significant reason for use of these products despite the medication being contraindicated for the member's age; or
    b. For members 12 years of age or older, a patient-specific, clinically significant reason why the member cannot use the tablet formulation, which is available without a prior authorization, must be provided.
4. Fioricet® with Codeine (Butalbital/APAP/Caffeine/Codeine 50mg/300mg/40mg/30mg) Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot take the 325mg APAP formulation butalbital/APAP/ caffeine/codeine 50mg/325mg/40mg/30mg), which is available generically, must be provided.
5. Hydrocodone/APAP Unique Formulations and Strengths Approval Criteria:
    a. For hydrocodone/APAP 7.5mg-325mg/15mL oral solution (generic Hycet®) or Xodol® (hydrocodone/APAP 5mg/300mg, 7.5mg/300mg, and 10mg/300mg), a patient-specific, clinically significant reason why the member cannot use generic Norco® (hydrocodone/APAP 5/325mg, 7.5/325mg, or 10/325mg) tablets must be provided; or
    b. For hydrocodone/APAP 7.5mg-325mg/15mL oral solution (generic Hycet®), a prior authorization is not required for members 14 years of age or younger. For members older than 14 years of age, a prior authorization is required, unless the prescription is written by an otolaryngologist or a dentist; and
    c. For hydrocodone/APAP oral solution unit dose cups, a prior authorization is required for all members and a patient-specific, clinically significant reason why the member cannot use hydrocodone/APAP in bulk solution must be provided.
6. Levorphanol Tablet Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use alternative treatment options for pain (e.g., non-opioid analgesics, lower-tiered opioid analgesics) must be provided.
7. Methadone Oral Solution Approval Criteria:
    a. For the lower strengths of methadone (5mg/5mL or 10mg/5mL), a prior authorization is not required for members 1 year of age and younger; or

b. For members older than 1 year of age, a patient specific clinically significant reason why the member cannot use methadone tablets and other lower-tiered opioid analgesics must be provided.

8. Oxycodone (RoxyBond™) Approval Criteria:
   a. A patient specific, clinically significant reason why the member cannot use any other available short-acting opioid analgesic must be provided.
9. Oxycodone/APAP Unique Formulations and Strengths Approval Criteria:
   a. For Nalocet® (oxycodone/APAP 2.5mg/300mg) tablet and Prolate® (oxycodone/APAP 5mg/300mg, 7.5mg/300mg, and 10mg/300mg) tablets, a patient specific, clinically significant reason why the member cannot use generic Percocet® (oxycodone/APAP 2.5mg/325mg, 5mg/325mg, 7.5mg/325mg, or 10mg/325mg) tablets must be provided; and
   b. For Prolate® (10mg-300mg/5mL) oral solution, a patient specific, clinically significant reason why the member cannot use generic oxycodone/APAP tablets and generic oxycodone/APAP (5mg-325mg/5mL) oral solution must be provided.
10. Oxymorphone ER Tablet Approval Criteria:
    a. A patient specific, clinically significant reason why the member cannot use any other available extended-release opioid analgesic must be provided.
11. Qdolo™ (Tramadol 5mg/mL Oral Solution) Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use tramadol 50mg tablets, even when tablets are crushed, must be provided; and
    b. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the prescriber must provide patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age; and
    c. A quantity limit of 2,400mL per 30 days will apply.
12. Tramadol 25mg, 75mg, and 100mg Tablet Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use 2 tramadol 50mg tablets to achieve a 100mg dose or split a tramadol 50mg tablet to achieve a 25mg or 75mg dose must be provided; and
    b. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the provider must submit patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age.

The College of Pharmacy also recommends the following changes to the MAT medications (changes shown in red):

1. Removing the prior authorization of Subutex® (buprenorphine SL tablet) based on net cost and to increase access and decrease barriers to opioid use disorder (OUD) treatment; and
2. Updating the Brixadi® (buprenorphine ER injection) and Sublocade® (buprenorphine ER injection) approval criteria based on the FDA label expansion of Sublocade®.

**Suboxone® [Buprenorphine/Naloxone Sublingual (SL) Tablet and Film]~~,~~ ~~Subutex® (Buprenorphine SL Tablet),~~ and Zubsolv® (Buprenorphine/ Naloxone SL Tablet) Approval Criteria:**

1. Generic buprenorphine/naloxone SL tablet and buprenorphine SL tablet ~~is~~ are the preferred product~~s~~. Authorization consideration of Zubsolv® and Suboxone® films (brand and generic) requires a patient-specific, clinically significant reason why ~~generic buprenorphine/naloxone SL tablets~~ the preferred SL tablets are not appropriate.
2. ~~Subutex® (buprenorphine) 2mg and 8mg SL tablets will only be approved if the member is pregnant or has a documented serious allergy or adverse reaction to naloxone; and~~
3. Member must have an FDA approved diagnosis of opioid abuse/ dependence [i.e., opioid use disorder (OUD)]; and
4. Concomitant treatment with opioid analgesics (including tramadol) will be denied; and
5. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
6. The following limitations will apply:
    a. Suboxone® 2mg/0.5mg and 4mg/1mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    b. Suboxone® 8mg/2mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    c. Suboxone® 12mg/3mg SL films: A quantity limit of 60 SL films per 30 days will apply.
    d. Subutex® 2mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    e. Subutex® 8mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    f. Zubsolv® 0.7mg/0.18mg, 1.4mg/0.36mg, and 2.9mg/0.71mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    g. Zubsolv® 5.7mg/1.4mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    h. Zubsolv® 8.6mg/2.1mg: A quantity limit of 60 SL tablets per 30 days will apply.

i. Zubsolv® 11.4mg/2.9mg SL tablets: A quantity limit of 30 SL tablets per 30 days will apply.

**Brixadi® [Buprenorphine Extended-Release (ER) Injection] and Sublocade® (Buprenorphine ER Injection) Approval Criteria:**

1. An FDA approved diagnosis of moderate-to-severe opioid use disorder (OUD); and
2. ~~For Sublocade®, member must have initiated treatment with a transmucosal buprenorphine-containing product for a minimum of 7 days; or~~
3. ~~For Brixadi®,~~ Member must have initiated treatment with a single dose of a transmucosal buprenorphine product or is currently treated with buprenorphine; and
4. Concomitant treatment with opioids (including tramadol) will be denied; and
5. Medication should only be prepared and administered by a health care provider; and
6. A patient-specific, clinically significant reason why the member cannot use the preferred buprenorphine product(s) (buprenorphine/naloxone sublingual (SL) tablets or buprenorphine SL tablets) must be provided; and
7. In general, concomitant treatment with transmucosal buprenorphine will not be approved long term; and
8. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
9. ~~A quantity limit of 1 monthly dose per 28 days or 4 weekly doses per 28 days will apply.~~
10. The following quantity limits will apply:
    a. Brixadi® 8mg/0.16mL, 16mg/0.32mL, 24mg/0.48mL, and 32mg/0.64mL: 4 weekly doses per 28 days
    b. Brixadi® 64mg/0.18mL, 96mg/0.27mL, and 128mg/0.36mL: 1 monthly dose per 28 days
    c. Sublocade® 100mg/0.5mL and 300mg/1.5mL: 1 monthly dose per 28 days
        i. A quantity limit override will be approved for initial dosing for members who need the second injection 1 week after the first injection when requested.

## Utilization Details of Opioid Analgesics: Fiscal Year 2024

### Pharmacy Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **SHORT-ACTING OPIOID ANALGESICS** | | | | | | |
| **IMMEDIATE-RELEASE HYDROCODONE PRODUCTS** | | | | | | |
| HYDROCO/APAP TAB 5/325MG | 50,270 | 35,119 | $646,042.99 | $12.85 | 1.43 | 6.28% |
| HYDROCO/APAP TAB 10/325MG | 43,632 | 8,500 | $908,080.46 | $20.81 | 5.13 | 8.82% |
| HYDROCO/APAP TAB 7.5/325MG | 41,936 | 18,987 | $689,087.21 | $16.43 | 2.21 | 6.69% |
| HYDROCO/APAP SOL 7.5/325MG | 3,881 | 3,596 | $83,958.94 | $21.63 | 1.08 | 0.82% |
| HYDROCO/IBU TAB 7.5/200MG | 59 | 21 | $1,768.09 | $29.97 | 2.81 | 0.02% |
| HYDROCO/IBU TAB 10/200MG | 28 | 6 | $10,665.27 | $380.90 | 4.67 | 0.10% |
| HYDROCO/IBU TAB 5/200MG | 11 | 3 | $545.59 | $49.60 | 3.67 | 0.01% |
| HYDROCO/APAP TAB 10/300MG | 9 | 5 | $312.54 | $34.73 | 1.8 | 0.00% |
| HYDROCO/APAP TAB 5/300MG | 3 | 3 | $35.38 | $11.79 | 1 | 0.00% |
| HYDROCO/APAP TAB 7.5/300MG | 1 | 1 | $13.39 | $13.39 | 1 | 0.00% |
| **SUBTOTAL** | **139,830** | **66,241** | **$2,340,509.86** | **$16.74** | **2.11** | **22.74%** |
| **IMMEDIATE-RELEASE OXYCODONE PRODUCTS** | | | | | | |
| OXYCOD/APAP TAB 5/325MG | 19,637 | 13,659 | $251,213.01 | $12.79 | 1.44 | 2.44% |
| OXYCOD/APAP TAB 10/325MG | 19,184 | 3,931 | $506,443.63 | $26.40 | 4.88 | 4.92% |
| OXYCOD/APAP TAB 7.5/325MG | 12,570 | 4,670 | $225,940.95 | $17.97 | 2.69 | 2.20% |
| OXYCODONE TAB 5MG | 10,404 | 7,631 | $126,551.28 | $12.16 | 1.36 | 1.23% |
| OXYCODONE TAB 10MG | 7,971 | 1,998 | $153,190.67 | $19.22 | 3.99 | 1.49% |
| OXYCODONE TAB 15MG | 5,521 | 909 | $120,125.45 | $21.76 | 6.07 | 1.17% |
| OXYCODONE SOL 5MG/5ML | 2,259 | 2,021 | $42,121.35 | $18.65 | 1.12 | 0.41% |
| OXYCODONE TAB 20MG | 1,372 | 276 | $36,588.08 | $26.67 | 4.97 | 0.36% |
| OXYCODONE TAB 30MG | 533 | 113 | $17,353.65 | $32.56 | 4.72 | 0.17% |
| OXYCODONE CAP 5MG | 215 | 177 | $5,125.87 | $23.84 | 1.21 | 0.05% |
| ENDOCET TAB 10/325MG | 87 | 53 | $2,279.66 | $26.20 | 1.64 | 0.02% |
| ENDOCET TAB 5/325MG | 70 | 64 | $896.44 | $12.81 | 1.09 | 0.01% |
| ENDOCET TAB 7.5/325MG | 14 | 9 | $226.55 | $16.18 | 1.56 | 0.00% |
| OXYCODONE CON 100MG/5ML | 11 | 9 | $828.59 | $75.33 | 1.22 | 0.01% |
| OXYCOD/APAP TAB 2.5/325MG | 4 | 4 | $110.68 | $27.67 | 1 | 0.00% |
| NALOCET TAB 2.5/300MG | 3 | 2 | $9,561.60 | $3,187.20 | 1.5 | 0.09% |
| PERCOCET TAB 7.5/325MG | 2 | 1 | $6,652.94 | $3,326.47 | 2 | 0.06% |
| **SUBTOTAL** | **79,857** | **35,527** | **$1,505,210.40** | **$18.85** | **2.25** | **14.62%** |
| **IMMEDIATE-RELEASE TRAMADOL PRODUCTS** | | | | | | |
| TRAMADOL HCL TAB 50MG | 33,669 | 13,296 | $390,693.01 | $11.60 | 2.53 | 3.80% |
| TRAMADOL/APAP TAB 37.5/325MG | 226 | 151 | $3,043.48 | $13.47 | 1.5 | 0.03% |
| TRAMADOL HCL TAB 100MG | 21 | 15 | $1,495.74 | $71.23 | 1.4 | 0.01% |
| TRAMADOL HCL TAB 25MG | 7 | 6 | $643.38 | $91.91 | 1.17 | 0.01% |
| **SUBTOTAL** | **33,923** | **13,468** | **$395,875.61** | **$11.67** | **2.52** | **3.85%** |
| **CODEINE PRODUCTS** | | | | | | |
| APAP/CODEINE TAB 300/30MG | 10,628 | 6,547 | $150,149.55 | $14.13 | 1.62 | 1.46% |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| APAP/CODEINE TAB 300/60MG | 6,980 | 1,928 | $189,616.88 | $27.17 | 3.62 | 1.84% |
| BUT/APAP/CAF/COD CAP 50/325/40/30MG | 313 | 91 | $17,145.73 | $54.78 | 3.44 | 0.17% |
| APAP/CODEINE TAB 300/15MG | 277 | 207 | $3,811.96 | $13.76 | 1.34 | 0.04% |
| BUT/ASA/CAF/COD CAP 50/325/40/30MG | 60 | 19 | $5,616.57 | $93.61 | 3.16 | 0.05% |
| CODEINE SULF TAB 30MG | 40 | 14 | $1,544.20 | $38.61 | 2.86 | 0.02% |
| APAP/CODEINE SOL 120-12MG/5ML | 21 | 10 | $418.38 | $19.92 | 2.1 | 0.00% |
| CODEINE SULF TAB 60MG | 7 | 4 | $682.70 | $97.53 | 1.75 | 0.01% |
| CODEINE SULF TAB 15MG | 7 | 3 | $346.46 | $49.49 | 2.33 | 0.00% |
| ASCOMP/COD CAP 30MG | 4 | 4 | $435.59 | $108.90 | 1 | 0.00% |
| BUT/APAP/CAF/COD CAP 50/300/40/30MG | 2 | 2 | $273.44 | $136.72 | 1 | 0.00% |
| **SUBTOTAL** | **18,339** | **8,829** | **$370,041.46** | **$20.18** | **2.08** | **3.60%** |
| **IMMEDIATE-RELEASE MORPHINE PRODUCTS** | | | | | | |
| MORPHINE SULF TAB 15MG | 1,229 | 350 | $35,204.13 | $28.64 | 3.51 | 0.34% |
| MORPHINE SULF TAB 30MG | 126 | 27 | $5,265.62 | $41.79 | 4.67 | 0.05% |
| MORPHINE SULF SOL 100MG/5ML | 83 | 49 | $2,057.47 | $24.79 | 1.69 | 0.02% |
| MORPHINE SULF SOL 10MG/5ML | 36 | 18 | $921.70 | $25.60 | 2 | 0.01% |
| MORPHINE SULF SOL 20MG/5ML | 12 | 7 | $176.84 | $14.74 | 1.71 | 0.00% |
| MORPHINE SULF SOL 20MG/ML | 4 | 4 | $93.18 | $23.30 | 1 | 0.00% |
| **SUBTOTAL** | **1,490** | **455** | **$43,718.94** | **$29.34** | **3.27** | **0.42%** |
| **IMMEDIATE-RELEASE HYDROMORPHONE PRODUCTS** | | | | | | |
| HYDROMORPHONE TAB 4MG | 733 | 198 | $12,515.33 | $17.07 | 3.7 | 0.12% |
| HYDROMORPHONE TAB 2MG | 573 | 302 | $7,701.82 | $13.44 | 1.9 | 0.07% |
| HYDROMORPHONE TAB 8MG | 87 | 26 | $3,583.17 | $41.19 | 3.35 | 0.03% |
| HYDROMORPHONE LIQ 1MG/ML | 17 | 5 | $3,662.34 | $215.43 | 3.4 | 0.04% |
| HYDROMORPHONE POW HCL | 3 | 1 | $888.15 | $296.05 | 3 | 0.01% |
| **SUBTOTAL** | **1,413** | **532** | **$28,350.81** | **$20.06** | **2.66** | **0.28%** |
| **MEPERIDINE PRODUCTS** | | | | | | |
| MEPERIDINE SOL 50MG/5ML | 190 | 162 | $1,989.27 | $10.47 | 1.17 | 0.02% |
| MEPERIDINE TAB 50MG | 7 | 4 | $559.61 | $79.94 | 1.75 | 0.01% |
| **SUBTOTAL** | **197** | **166** | **$2,548.88** | **$12.94** | **1.19** | **0.02%** |
| **PENTAZOCINE PRODUCTS** | | | | | | |
| PENTAZ/NALOX TAB 50/0.5MG | 79 | 16 | $14,056.74 | $177.93 | 4.94 | 0.14% |
| **SUBTOTAL** | **79** | **16** | **$14,056.74** | **$177.93** | **4.94** | **0.14%** |
| **IMMEDIATE-RELEASE TAPENTADOL PRODUCTS** | | | | | | |
| NUCYNTA TAB 50MG | 59 | 16 | $48,047.57 | $814.37 | 3.69 | 0.47% |
| NUCYNTA TAB 75MG | 3 | 2 | $2,726.45 | $908.82 | 1.5 | 0.03% |
| NUCYNTA TAB 100MG | 1 | 1 | $1,585.24 | $1,585.24 | 1 | 0.02% |
| **SUBTOTAL** | **63** | **19** | **$52,359.26** | **$831.10** | **3.32** | **0.51%** |
| **IMMEDIATE-RELEASE OXYMORPHONE PRODUCTS** | | | | | | |
| OXYMORPHONE TAB 10MG | 13 | 2 | $707.85 | $54.45 | 6.5 | 0.01% |
| **SUBTOTAL** | **13** | **2** | **$707.85** | **$54.45** | **6.5** | **0.01%** |
| **SHORT-ACTING SUBTOTAL** | **275,204** | **125,255** | **$4,753,379.81** | **$17.27** | **2.2** | **46.18%** |
| **LONG-ACTING OPIOID ANALGESICS** | | | | | | |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **BUPRENORPHINE PAIN PRODUCTS** | | | | | | |
| BUTRANS DIS 10MCG/HR | 1,572 | 673 | $655,745.22 | $417.14 | 2.34 | 6.37% |
| BUTRANS DIS 20MCG/HR | 1,543 | 317 | $1,123,336.52 | $728.02 | 4.87 | 10.91% |
| BUTRANS DIS 15MCG/HR | 1,343 | 390 | $843,252.26 | $627.89 | 3.44 | 8.19% |
| BUTRANS DIS 5MCG/HR | 676 | 396 | $189,844.99 | $280.84 | 1.71 | 1.84% |
| BUTRANS DIS 7.5MCG/HR | 484 | 222 | $182,485.72 | $377.04 | 2.18 | 1.77% |
| BELBUCA MIS 450MCG | 170 | 42 | $144,697.63 | $851.16 | 4.05 | 1.41% |
| BELBUCA MIS 900MCG | 119 | 18 | $116,660.48 | $980.34 | 6.61 | 1.13% |
| BELBUCA MIS 750MCG | 119 | 23 | $112,513.72 | $945.49 | 5.17 | 1.09% |
| BELBUCA MIS 600MCG | 119 | 32 | $107,202.53 | $900.86 | 3.72 | 1.04% |
| BELBUCA MIS 150MCG | 107 | 48 | $41,692.06 | $389.65 | 2.23 | 0.41% |
| BELBUCA MIS 300MCG | 99 | 48 | $61,302.29 | $619.22 | 2.06 | 0.60% |
| BELBUCA MIS 75MCG | 53 | 34 | $20,725.83 | $391.05 | 1.56 | 0.20% |
| BUPRENORPHINE DIS 10MCG/HR | 9 | 6 | $1,200.37 | $133.37 | 1.5 | 0.01% |
| BUPRENORPHINE DIS 15MCG/HR | 5 | 3 | $1,096.93 | $219.39 | 1.67 | 0.01% |
| BUPRENORPHINE DIS 7.5MCG/HR | 4 | 3 | $337.70 | $84.43 | 1.33 | 0.00% |
| BUPRENORPHINE DIS 20MCG/HR | 3 | 2 | $245.04 | $81.68 | 1.5 | 0.00% |
| BUPRENORPHINE DIS 5MCG/HR | 1 | 1 | $87.48 | $87.48 | 1 | 0.00% |
| **SUBTOTAL** | **6,426** | **2,258** | **$3,602,426.77** | **$560.60** | **2.85** | **35.00%** |
| **EXTENDED-RELEASE MORPHINE PRODUCTS** | | | | | | |
| MORPHINE SULF TAB 15MG ER | 2,519 | 467 | $50,300.36 | $19.97 | 5.39 | 0.49% |
| MORPHINE SULF TAB 30MG ER | 1,246 | 238 | $36,439.64 | $29.25 | 5.24 | 0.35% |
| MORPHINE SULF TAB 60MG ER | 143 | 41 | $6,153.13 | $43.03 | 3.49 | 0.06% |
| MORPHINE SULF CAP 10MG ER | 38 | 8 | $5,194.10 | $136.69 | 4.75 | 0.05% |
| MORPHINE SULF TAB 100MG ER | 31 | 8 | $2,513.94 | $81.09 | 3.88 | 0.02% |
| MORPHINE SULF CAP 30MG ER | 10 | 2 | $1,559.19 | $155.92 | 5 | 0.02% |
| MORPHINE SULF CAP 20MG ER | 8 | 2 | $1,396.17 | $174.52 | 4 | 0.01% |
| MORPHINE SULF CAP 60MG ER | 6 | 1 | $1,593.30 | $265.55 | 6 | 0.02% |
| MORPHINE SULF CAP 50MG ER | 2 | 1 | $205.72 | $102.86 | 2 | 0.00% |
| **SUBTOTAL** | **4,003** | **768** | **$105,355.55** | **$26.32** | **5.21** | **1.02%** |
| **EXTENDED-RELEASE OXYCODONE PRODUCTS** | | | | | | |
| OXYCONTIN TAB 10MG ER | 1,548 | 292 | $368,305.30 | $237.92 | 5.3 | 3.58% |
| OXYCONTIN TAB 15MG ER | 708 | 112 | $276,016.65 | $389.85 | 6.32 | 2.68% |
| OXYCONTIN TAB 20MG ER | 642 | 135 | $313,717.04 | $488.66 | 4.76 | 3.05% |
| OXYCONTIN TAB 30MG ER | 288 | 44 | $211,899.90 | $735.76 | 6.55 | 2.06% |
| OXYCONTIN TAB 40MG ER | 128 | 25 | $123,149.53 | $962.11 | 5.12 | 1.20% |
| XTAMPZA ER CAP 9MG | 115 | 29 | $38,295.65 | $333.01 | 3.97 | 0.37% |
| XTAMPZA ER CAP 13.5MG | 56 | 15 | $23,454.65 | $418.83 | 3.73 | 0.23% |
| XTAMPZA ER CAP 18MG | 46 | 7 | $26,989.19 | $586.72 | 6.57 | 0.26% |
| OXYCONTIN TAB 60MG ER | 44 | 10 | $57,503.38 | $1,306.90 | 4.4 | 0.56% |
| OXYCONTIN TAB 80MG ER | 38 | 5 | $68,367.04 | $1,799.13 | 7.6 | 0.66% |
| XTAMPZA ER CAP 36MG | 22 | 3 | $25,574.78 | $1,162.49 | 7.33 | 0.25% |
| XTAMPZA ER CAP 27MG | 22 | 4 | $17,104.28 | $777.47 | 5.5 | 0.17% |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **SUBTOTAL** | **3,657** | **681** | **$1,550,377.39** | **$423.95** | **5.37** | **15.06%** |
| **EXTENDED-RELEASE TRAMADOL PRODUCTS** | | | | | | |
| TRAMADOL TAB 200MG ER 24HR | 482 | 93 | $25,476.81 | $52.86 | 5.18 | 0.25% |
| TRAMADOL TAB 100MG ER 24HR | 462 | 114 | $17,439.01 | $37.75 | 4.05 | 0.17% |
| TRAMADOL TAB 300MG ER 24HR | 177 | 40 | $12,736.17 | $71.96 | 4.43 | 0.12% |
| TRAMADOL TAB 100MG BIPHASIC | 1 | 1 | $52.11 | $52.11 | 1 | 0.00% |
| **SUBTOTAL** | **1,122** | **248** | **$55,704.10** | **$49.65** | **4.52** | **0.54%** |
| **EXTENDED-RELEASE FENTANYL PRODUCTS** | | | | | | |
| FENTANYL DIS 25MCG/HR | 377 | 118 | $16,020.86 | $42.50 | 3.19 | 0.16% |
| FENTANYL DIS 12MCG/HR | 247 | 62 | $20,077.43 | $81.29 | 3.98 | 0.20% |
| FENTANYL DIS 50MCG/HR | 134 | 62 | $9,668.12 | $72.15 | 2.16 | 0.09% |
| FENTANYL DIS 75MCG/HR | 102 | 31 | $9,049.58 | $88.72 | 3.29 | 0.09% |
| FENTANYL DIS 37.5MCG/HR | 52 | 9 | $23,412.14 | $450.23 | 5.78 | 0.23% |
| FENTANYL DIS 100MCG/HR | 48 | 21 | $5,992.09 | $124.84 | 2.29 | 0.06% |
| **SUBTOTAL** | **960** | **303** | **$84,220.22** | **$87.73** | **3.17** | **0.82%** |
| **METHADONE PRODUCTS** | | | | | | |
| METHADONE TAB 10MG | 148 | 22 | $3,369.82 | $22.77 | 6.73 | 0.03% |
| METHADONE TAB 5MG | 55 | 19 | $1,001.33 | $18.21 | 2.89 | 0.01% |
| METHADONE SOL 5MG/5ML | 49 | 28 | $608.83 | $12.43 | 1.75 | 0.01% |
| METHADONE SOL 10MG/5ML | 1 | 1 | $11.63 | $11.63 | 1 | 0.00% |
| **SUBTOTAL** | **253** | **70** | **$4,991.61** | **$19.73** | **3.61** | **0.05%** |
| **EXTENDED-RELEASE HYDROCODONE PRODUCTS** | | | | | | |
| HYSINGLA ER TAB 40MG | 77 | 8 | $50,490.59 | $655.72 | 9.63 | 0.49% |
| HYSINGLA ER TAB 20MG | 45 | 5 | $14,935.43 | $331.90 | 9 | 0.15% |
| HYSINGLA ER TAB 60MG | 22 | 2 | $20,379.54 | $926.34 | 11 | 0.20% |
| HYSINGLA ER TAB 30MG | 18 | 3 | $8,085.20 | $449.18 | 6 | 0.08% |
| HYSINGLA ER TAB 80MG | 13 | 1 | $16,180.64 | $1,244.66 | 13 | 0.16% |
| HYDROCODONE CAP 30MG ER | 12 | 1 | $2,994.96 | $249.58 | 12 | 0.03% |
| HYDROCODONE TAB 40MG ER | 9 | 2 | $3,316.02 | $368.45 | 4.5 | 0.03% |
| HYDROCODONE CAP 10MG ER | 8 | 2 | $3,547.24 | $443.41 | 4 | 0.03% |
| HYDROCODONE TAB 30MG ER | 5 | 1 | $1,405.09 | $281.02 | 5 | 0.01% |
| HYDROCODONE TAB 20MG ER | 2 | 2 | $453.23 | $226.62 | 1 | 0.00% |
| HYDROCODONE CAP 15MG ER | 1 | 1 | $345.43 | $345.43 | 1 | 0.00% |
| **SUBTOTAL** | **212** | **28** | **$122,133.37** | **$576.10** | **7.57** | **1.19%** |
| **EXTENDED-RELEASE TAPENTADOL PRODUCTS** | | | | | | |
| NUCYNTA ER TAB 50MG | 21 | 6 | $11,305.37 | $538.35 | 3.5 | 0.11% |
| NUCYNTA ER TAB 100MG | 2 | 2 | $1,297.91 | $648.96 | 1 | 0.01% |
| **SUBTOTAL** | **23** | **8** | **$12,603.28** | **$547.97** | **2.88** | **0.12%** |
| **EXTENDED-RELEASE HYDROMORPHONE PRODUCTS** | | | | | | |
| HYDROMORPHONE TAB 12MG ER | 3 | 1 | $674.38 | $224.79 | 3 | 0.01% |
| **SUBTOTAL** | **3** | **1** | **$674.38** | **$224.79** | **3** | **0.01%** |
| **EXTENDED-RELEASE OXYMORPHONE PRODUCTS** | | | | | | |
| OXYMORPHONE TAB 20MG ER | 2 | 1 | $1,338.23 | $669.12 | 2 | 0.01% |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **SUBTOTAL** | **2** | **1** | **$1,338.23** | **$669.12** | **2** | **0.01%** |
| **LONG-ACTING SUBTOTAL** | **16,661** | **4,366** | **$5,539,824.90** | **$332.50** | **3.82** | **53.82%** |
| **OPIOID TOTAL** | **291,865** | **99,975*** | **$10,293,204.71** | **$35.27** | **2.92** | **100%** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
APAP = acetaminophen; ASA = aspirin; BUT = butalbital; CAF = caffeine; CAP = capsule; COD = codeine; CON = concentrate; DIS = patch; ER = extended-release; HCL = hydrochloride; HYDROCO = hydrocodone; IBU = ibuprofen; LIQ = liquid; MIS = film; NALOX = naloxone; OXYCOD = oxycodone; PENTAZ = pentazocine; POW = powder; SOL = solution; SULF = sulfate; TAB = tablet
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.
Please note: As of 1/1/2025, Nucynta®, Nucynta® ER, and Xtampza® ER are no longer covered by SoonerCare due to no federal drug rebate.

## Utilization Details of MAT Medications: Fiscal Year 2024

### Pharmacy Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **BUPRENORPHINE MAT PRODUCTS** | | | | | | |
| BUPREN/NALOX SUB 8-2MG | 37,346 | 5,474 | $1,966,967.79 | $52.67 | 6.82 | 22.55% |
| BUPRENORPHINE SUB 8MG | 6,466 | 967 | $334,699.18 | $51.76 | 6.69 | 3.84% |
| BUPREN/NALOX SUB 2-0.5MG | 2,752 | 674 | $97,291.56 | $35.35 | 4.08 | 1.12% |
| BUPREN/NALOX MIS 8-2MG | 1,702 | 274 | $293,405.06 | $172.39 | 6.21 | 3.36% |
| SUBLOCADE INJ 300MG/1.5ML | 1,059 | 342 | $2,093,435.83 | $1,976.80 | 3.1 | 24.00% |
| BUPRENORPHINE SUB 2MG | 990 | 274 | $30,577.37 | $30.89 | 3.61 | 0.35% |
| SUBLOCADE INJ 100MG/0.5ML | 722 | 197 | $1,417,074.93 | $1,962.71 | 3.66 | 16.24% |
| ZUBSOLV SUB 5.7-1.4MG | 162 | 18 | $69,017.77 | $426.04 | 9 | 0.79% |
| SUBOXONE MIS 8-2MG | 134 | 16 | $98,969.21 | $738.58 | 8.38 | 1.13% |
| BUPREN/NALOX MIS 2-0.5MG | 75 | 19 | $4,183.35 | $55.78 | 3.95 | 0.05% |
| BRIXADI SOL 128MG/0.36ML | 67 | 27 | $115,087.47 | $1,717.72 | 2.48 | 1.32% |
| BRIXADI SOL 96MG/0.27ML | 55 | 24 | $94,228.55 | $1,713.25 | 2.29 | 1.08% |
| BRIXADI SOL 64MG/0.18ML | 51 | 19 | $87,689.91 | $1,719.41 | 2.68 | 1.01% |
| BUPREN/NALOX MIS 12-3MG | 49 | 9 | $14,443.02 | $294.76 | 5.44 | 0.17% |
| ZUBSOLV SUB 8.6-2.1MG | 35 | 6 | $32,110.93 | $917.46 | 5.83 | 0.37% |
| BUPREN/NALOX MIS 4-1MG | 32 | 8 | $3,959.16 | $123.72 | 4 | 0.05% |
| BRIXADI SOL 8MG/0.16ML | 7 | 2 | $3,008.87 | $429.84 | 3.5 | 0.03% |
| BRIXADI SOL 16MG/0.32ML | 4 | 2 | $1,753.64 | $438.41 | 2 | 0.02% |
| BRIXADI SOL 24MG/0.48ML | 3 | 1 | $1,315.23 | $438.41 | 3 | 0.02% |
| ZUBSOLV SUB 2.9-0.71MG | 1 | 1 | $471.40 | $471.40 | 1 | 0.01% |
| **SUBTOTAL** | **51,712** | **8,354** | **$6,759,690.23** | **$130.72** | **6.19** | **77.49%** |
| **NALTREXONE PRODUCTS** | | | | | | |
| NALTREXONE TAB 50MG | 9,496 | 3,354 | $338,783.46 | $35.68 | 2.83 | 3.88% |
| VIVITROL INJ 380MG | 1,045 | 346 | $1,624,892.47 | $1,554.92 | 3.02 | 18.63% |
| **SUBTOTAL** | **10,541** | **3,700** | **$1,963,675.93** | **$186.29** | **2.85** | **22.51%** |
| **MAT TOTAL** | **62,253** | **10,618*** | **$8,723,366.16** | **$140.13** | **5.86** | **100%** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
BUPREN = buprenorphine; INJ = injection; MAT = medication-assisted treatment; MIS = film; NALOX = naloxone; SOL = solution; SUB = sublingual tablet; TAB = tablet
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

## Medical Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS+ | TOTAL MEMBERS* | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER |
|---|---|---|---|---|---|
| J2315 NALTREXONE INJ 1MG (VIVITROL) | 19 | 9 | $9,058.09 | $476.74 | 2.11 |
| **MAT TOTAL** | **19** | **9** | **$9,058.09** | **$476.74** | **2.11** |

Costs do not reflect rebated prices or net costs.
+Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

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[3] Indivior. Indivior Announces FDA Approval of Label Changes of Sublocade® (Buprenorphine Extended-Release) Injection. Available online at: https://www.indivior.com/en/media/press-releases/indivior-announces-fda-approval-of-label-changes-for-sublocade-injection. Issued 02/24/2025. Last accessed 07/14/2025.
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[5] American Society of Addiction Medicine (ASAM). New Buprenorphine OUD Labels Clarify Higher Doses Appropriate for Some Patients. Available online at: https://www.asam.org/news/detail/2025/06/09/new-buprenorphine-for-oud-labels-clarify-higher-doses-appropriate-for-some-patients. Issued 06/09/2025. Last accessed 07/14/2025.
[6] Tramadol Tablet Prescribing Information. U.S. National Library of Medicine: DailyMed. Available online at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=93b12089-3a0f-4b57-abb1-2429cf31995d. Last revised 09/06/2024. Last accessed 07/14/2025.

# Appendix G

# Fiscal Year 2024 Annual Review of Topical Corticosteroids

**Oklahoma Health Care Authority**
**August 2025**

## Current Prior Authorization Criteria

| Topical Corticosteroids | | | | | |
|---|---|---|---|---|---|
| **Tier-1** | | **Tier-2** | | **Tier-3** | |
| **Ultra-High to High Potency** | | | | | |
| augmented betamethasone dipropionate 0.05% (Diprolene®) Diprolene AF®) | C,O | amcinonide 0.1% | C | clobetasol propionate 0.025% (Impoyz®) | C |
| betamethasone dipropionate 0.05% (Diprosone®) | C,O | augmented betamethasone dipropionate 0.05% (Diprolene®) | G,L | clobetasol propionate 0.05% (Olux-E®, Tovet®) | F |
| clobetasol propionate 0.05% (Olux®) | F | clobetasol propionate 0.05% (Clobex®) | L,Sh,Spr | desoximetasone 0.25% (Topicort®) | Spr |
| clobetasol propionate 0.05% (Temovate®) | C,O,So | clobetasol propionate 0.05% (Temovate®) | G | diflorasone diacetate 0.05% (Apexicon®) | C,O |
| desoximetasone 0.25% (Topicort®) | C,O | desoximetasone 0.05% (Topicort®) | G | diflorasone diacetate 0.05% (Apexicon E®) | C |
| fluocinonide 0.05% | C,O,So | fluocinonide 0.05% | G | halcinonide 0.1% (Halog®) | C,So |
| fluocinonide 0.1% (Vanos®) | C | halobetasol propionate 0.05% (Ultravate®) | L | halobetasol propionate 0.01% (Bryhali®) | L |
| halobetasol propionate 0.05% (Ultravate®) | C,O | | | halobetasol propionate 0.05% | F |
| **Medium-High to Medium Potency** | | | | | |
| betamethasone dipropionate 0.05% | L | betamethasone valerate 0.12% (Luxiq®) | F | betamethasone dipropionate/ calcipotriene 0.064%/0.005% (Taclonex®) | O,Sus |

| Topical Corticosteroids | | | | | |
|---|---|---|---|---|---|
| **Tier-1** | | **Tier-2** | | **Tier-3** | |
| betamethasone valerate 0.1% (Beta-Val®) | C,O | betamethasone valerate 0.1% (Beta-Val®) | L | clocortolone pivalate 0.1% (Cloderm®) | C |
| fluticasone propionate 0.005% (Cutivate®) | O | calcipotriene/ betamethasone dipropionate 0.064%/0.005% (Enstilar®) | F | desoximetasone 0.05% (Topicort LP®) | C,O |
| fluticasone propionate 0.05% (Cutivate®) | C | fluocinolone acetonide 0.025% (Synalar®) | C,O | flurandrenolide 0.05% | L |
| hydrocortisone valerate 0.2% (Westcort®) | C | fluocinonide emollient 0.05% (Lidex E®) | C | fluticasone propionate 0.05% (Cutivate®) | L |
| mometasone furoate 0.1% (Elocon®) | C,L,O, So | hydrocortisone butyrate 0.1% | O, So | hydrocortisone butyrate 0.1% | C,L |
| triamcinolone acetonide 0.025% | O | hydrocortisone probutate 0.1% (Pandel®) | C | hydrocortisone valerate 0.2% (Westcort®) | O |
| triamcinolone acetonide 0.1% | C,L,O | triamcinolone acetonide 0.05% (Trianex®) | O | triamcinolone acetonide 0.147mg/g (Kenalog®) | Spr |
| triamcinolone acetonide 0.5% | C,O | | | | |
| **Low Potency** | | | | | |
| desonide emollient 0.05% | C,O | alclometasone dipropionate 0.05% (Aclovate®) | C,O | desonide 0.05% | L |
| fluocinolone acetonide 0.01% (Synalar®) | So | fluocinolone acetonide 0.01% (Derma-Smoothe®; Derma-Smoothe FS®) – **Brand Preferred** | Oil | desonide 0.05% (Desonate®) | G |
| hydrocortisone acetate 1% | C,O | fluocinolone acetonide 0.01% (Synalar®) | C | hydrocortisone 2.5% (Texacort®) | So |
| hydrocortisone acetate 2.5% | C,L,O | | | | |
| triamcinolone acetonide 0.025% | C,L | | | | |

Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
C = cream; F = foam; G = gel; L= lotion; O = ointment; Sh = shampoo; So = solution; Spr = spray; Sus = suspension

**Topical Corticosteroids Tier-2 Approval Criteria:**

1. Documented trials of all Tier-1 topical corticosteroids of similar potency in the past 30 days that did not yield adequate relief; and
2. If Tier-1 trials are completed and do not yield adequate relief, the member must also provide a patient-specific, clinically significant reason for requesting a Tier-2 medication in the same potency instead of trying a higher potency; and
3. When the same medication is available in Tier-1, a patient-specific, clinically significant reason must be provided for using a special dosage formulation of that medication in Tier-2 (e.g., foams, shampoos, sprays, kits); and
4. Topical corticosteroid kits require tier trials and a patient-specific, clinically significant reason for use of the kit over standard formulations.

**Topical Corticosteroids Tier-3 Approval Criteria:**

1. Documented trials of all Tier-1 and Tier-2 topical corticosteroids of similar potency in the past 90 days that did not yield adequate relief; and
2. If Tier-1 and Tier-2 trials are completed and do not yield adequate relief, the member must also provide a patient-specific, clinically significant reason for requesting a Tier-3 medication in the same potency instead of trying a higher potency; and
3. When the same medication is available in Tier-1 or Tier-2, a patient-specific, clinically significant reason must be provided for using a special dosage form of that medication in Tier-3 (e.g., foams, shampoos, sprays, kits); and
4. Topical corticosteroid kits require tier trials and a patient-specific, clinically significant reason for use of the kit over other standard formulations.

**Cortifoam® (Hydrocortisone Acetate 10% Rectal Foam) Approval Criteria:**

1. A patient-specific, clinically significant reason why the member cannot use other strengths and rectal formulations of hydrocortisone.

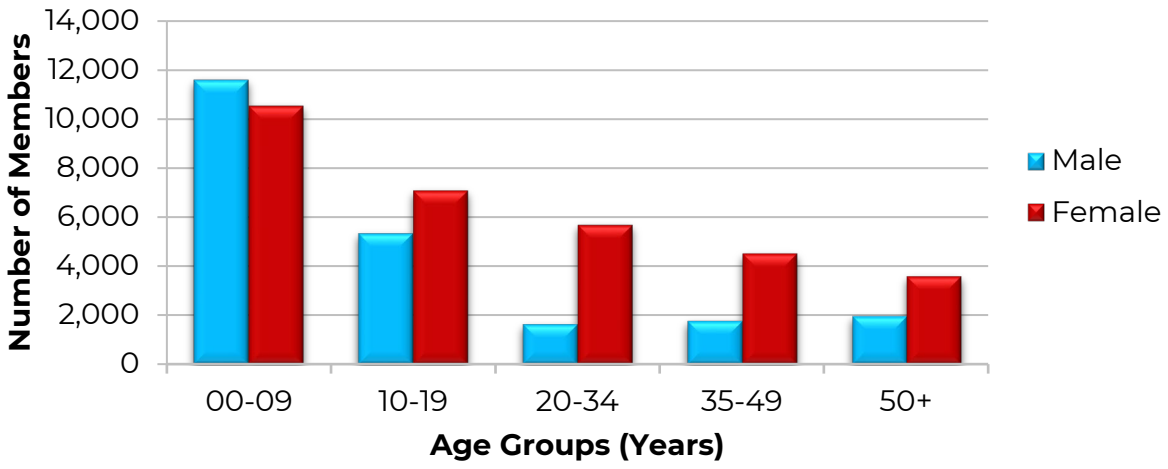
## Utilization of Topical Corticosteroids: Fiscal Year 2024

### Comparison of Fiscal Years: Pharmacy Claims (All Plans)

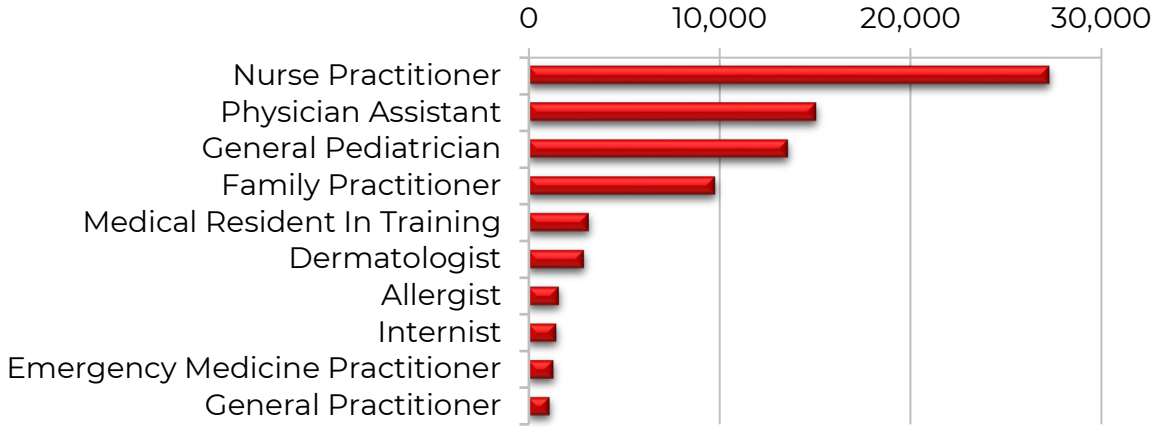
| Plan Type | *Total Members | Total Claims | Total Cost | Cost/ Claim | Cost/ Day | Total Units | Total Days |
|---|---|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | | | |
| **FFS** | 54,449 | 82,442 | $1,472,437.79 | $17.86 | $0.95 | 6,058,963 | 1,550,309 |
| **2023 Total** | **54,449** | **82,442** | **$1,472,437.79** | **$17.86** | **$0.95** | **6,058,963** | **1,550,309** |
| **Fiscal Year 2024** | | | | | | | |
| **FFS** | 44,806 | 65,853 | $1,174,058.65 | $17.83 | $0.93 | 4,905,347 | 1,265,456 |
| **Aetna** | 4,096 | 4,847 | $87,291.50 | $18.01 | $1.04 | 367,191 | 84,284 |
| **Humana** | 4,520 | 5,472 | $105,132.86 | $19.21 | $1.04 | 399,374 | 100,969 |
| **OCH** | 4,215 | 5,021 | $95,537.76 | $19.03 | $0.99 | 383,941 | 96,949 |
| **2024 Total** | **53,628** | **81,193** | **$1,462,020.77** | **$18.01** | **$0.94** | **6,055,853** | **1,547,658** |
| **% Change** | **-1.50%** | **-1.50%** | **-0.70%** | **0.80%** | **-1.10%** | **-0.10%** | **-0.20%** |
| **Change** | **-821** | **-1,249** | **-$10,417.02** | **$0.15** | **-$0.01** | **-3,110** | **-2,651** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

### Demographics of Members Utilizing Topical Corticosteroids: Pharmacy Claims (All Plans)



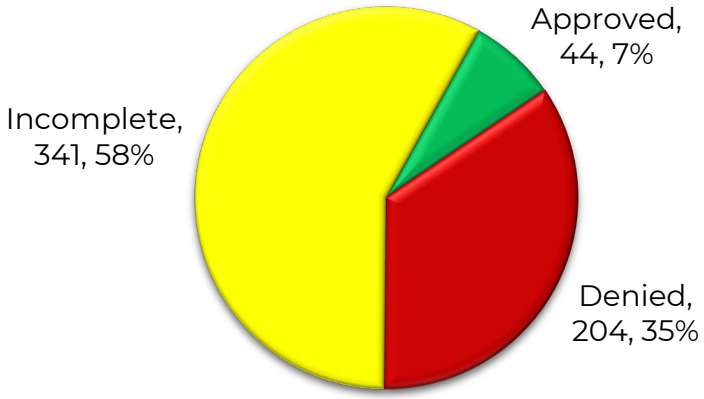
**Top Prescriber Specialties of Topical Corticosteroids by Number of Claims: Pharmacy Claims (All Plans)**




## Prior Authorization of Topical Corticosteroids

There were 589 prior authorization requests submitted for topical corticosteroids during fiscal year 2024. The following chart shows the status of the submitted petitions for fiscal year 2024.

**Status of Petitions (All Plans)**




**Status of Petitions by Plan Type**

| Plan Type | Approved | | Incomplete | | Denied | | Total |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | |
| **FFS** | 34 | 6% | 332 | 61% | 176 | 32% | **542** |
| **Aetna** | 4 | 14% | 9 | 32% | 15 | 54% | **28** |
| **Humana** | 2 | 22% | 0 | 0% | 7 | 78% | **9** |
| **OCH** | 4 | 40% | 0 | 0% | 6 | 60% | **10** |
| **Total** | **44** | **7%** | **341** | **58%** | **204** | **35%** | **589** |

FFS = fee-for-service; OCH = OK Complete Health
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

## Market News and Updates[1]

### Anticipated Patent Expiration(s):

- Topicort® (desoximetasone 0.25% spray): September 2028
- Bryhali® (halobetasol propionate 0.01% lotion): November 2031
- Enstilar® (calcipotriene/betamethasone dipropionate 0.064%/0.005% foam): December 2031
- Ultravate® (halobetasol 0.05% lotion): June 2033

## Recommendations

The College of Pharmacy recommends the following changes to the Topical Corticosteroids Product Based Prior Authorization (PBPA) Tier chart based on net costs (changes are shown in red in the following Tier chart):

1. Ultra-High to High Potency:
   a. Move amcinonide 0.1% cream from Tier-2 to Tier-3; and
   b. Move augmented betamethasone dipropionate 0.05% (Diprolene®) lotion from Tier-2 to Tier-1; and
2. Medium-High to Medium Potency:
   a. Move hydrocortisone valerate 0.2% (Westcort®) ointment from Tier-3 to Tier-2.

| Topical Corticosteroids | | | | | |
|---|---|---|---|---|---|
| **Tier-1** | | **Tier-2** | | **Tier-3** | |
| **Ultra-High to High Potency** | | | | | |
| augmented betamethasone dipropionate 0.05% (Diprolene®) Diprolene AF®) | C,**L,**O | ~~**amcinonide 0.1%**~~ | ~~**C**~~ | **amcinonide 0.1%** | **C** |
| betamethasone dipropionate 0.05% (Diprosone®) | C,O | augmented betamethasone dipropionate 0.05% (Diprolene®) | G~~,L~~ | clobetasol propionate 0.025% (Impoyz®) | C |
| clobetasol propionate 0.05% (Olux®) | F | clobetasol propionate 0.05% (Clobex®) | L,Sh,Spr | clobetasol propionate 0.05% (Olux-E®, Tovet®) | F |
| clobetasol propionate 0.05% (Temovate®) | C,O,So | clobetasol propionate 0.05% (Temovate®) | G | desoximetasone 0.25% (Topicort®) | Spr |
| desoximetasone 0.25% (Topicort®) | C,O | desoximetasone 0.05% (Topicort®) | G | diflorasone diacetate 0.05% (Apexicon®) | C,O |

| Topical Corticosteroids | | | | | |
|---|---|---|---|---|---|
| **Tier-1** | | **Tier-2** | | **Tier-3** | |
| fluocinonide 0.05% | C,O,So | fluocinonide 0.05% | G | diflorasone diacetate 0.05% (Apexicon E®) | C |
| fluocinonide 0.1% (Vanos®) | C | halobetasol propionate 0.05% (Ultravate®) | L | halcinonide 0.1% (Halog®) | C,So |
| halobetasol propionate 0.05% (Ultravate®) | C,O | | | halobetasol propionate 0.01% (Bryhali®) | L |
| | | | | halobetasol propionate 0.05% | F |
| **Medium-High to Medium Potency** | | | | | |
| betamethasone dipropionate 0.05% | L | betamethasone valerate 0.12% (Luxiq®) | F | betamethasone dipropionate/ calcipotriene 0.064%/0.005% (Taclonex®) | O,Sus |
| betamethasone valerate 0.1% (Beta-Val®) | C,O | betamethasone valerate 0.1% (Beta-Val®) | L | clocortolone pivalate 0.1% (Cloderm®) | C |
| fluticasone propionate 0.005% (Cutivate®) | O | calcipotriene/ betamethasone dipropionate 0.064%/0.005% (Enstilar®) | F | desoximetasone 0.05% (Topicort LP®) | C,O |
| fluticasone propionate 0.05% (Cutivate®) | C | fluocinolone acetonide 0.025% (Synalar®) | C,O | flurandrenolide 0.05% | L |
| hydrocortisone valerate 0.2% (Westcort®) | C | fluocinonide emollient 0.05% (Lidex E®) | C | fluticasone propionate 0.05% (Cutivate®) | L |
| mometasone furoate 0.1% (Elocon®) | C,L,O, So | hydrocortisone butyrate 0.1% | O, So | hydrocortisone butyrate 0.1% | C,L |
| triamcinolone acetonide 0.025% | O | hydrocortisone probutate 0.1% (Pandel®) | C | ~~**hydrocortisone valerate 0.2% (Westcort®)**~~ | ~~**O**~~ |
| triamcinolone acetonide 0.1% | C,L,O | **hydrocortisone valerate 0.2% (Westcort®)** | **O** | triamcinolone acetonide 0.147mg/g | Spr |

| Topical Corticosteroids | | | | | |
|---|---|---|---|---|---|
| **Tier-1** | | **Tier-2** | | **Tier-3** | |
| triamcinolone acetonide 0.5% | C,O | triamcinolone acetonide 0.05% (Trianex®) | O | | |
| **Low Potency** | | | | | |
| desonide emollient 0.05% | C,O | alclometasone dipropionate 0.05% (Aclovate®) | C,O | desonide 0.05% | L |
| fluocinolone acetonide 0.01% (Synalar®) | So | fluocinolone acetonide 0.01% (Derma-Smoothe®; Derma-Smoothe FS®) – **Brand Preferred** | Oil | desonide 0.05% (Desonate®) | G |
| hydrocortisone acetate 1% | C,O | fluocinolone acetonide 0.01% (Synalar®) | C | hydrocortisone 2.5% (Texacort®) | So |
| hydrocortisone acetate 2.5% | C,L,O | | | | |
| triamcinolone acetonide 0.025% | C,L | | | | |

Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
C = cream; F = foam; G = gel; L= lotion; O = ointment; Sh = shampoo; So = solution; Spr = spray; Sus = suspension

Additionally, the College of Pharmacy recommends removing the prior authorization of Cortifoam® (hydrocortisone acetate 10% rectal foam) and recommends the prior authorization of Proctofoam® HC (hydrocortisone/ pramoxine 1%/1% rectal foam) based on net costs (changes shown in red):

~~**Cortifoam® (Hydrocortisone Acetate 10% Rectal Foam) Approval Criteria:**~~

~~1. A patient-specific, clinically significant reason why the member cannot use other strengths and rectal formulations of hydrocortisone.~~

**Proctofoam® HC (Hydrocortisone/Pramoxine 1%/1% Rectal Foam) Approval Criteria:**

1. A patient-specific, clinically significant reason why the member cannot use Epifoam® (hydrocortisone/pramoxine 1%/1% rectal foam) or other rectal formulations of hydrocortisone available without a prior authorization must be provided.

## Utilization Details of Topical Corticosteroids: Fiscal Year 2024

### Pharmacy Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **TIER-1 UTILIZATION** | | | | | | |
| **LOW POTENCY PRODUCTS** | | | | | | |
| HYDROCORT CRE 2.5% | 6,162 | 4,914 | $77,484.84 | $12.57 | 1.25 | 5.30% |
| TRIAMCINOLONE CRE 0.025% | 3,989 | 3,224 | $52,762.78 | $13.23 | 1.24 | 3.61% |
| HYDROCORT OIN 2.5% | 3,982 | 2,877 | $67,547.04 | $16.96 | 1.38 | 4.62% |
| HYDROCORT CRE 1% | 1,109 | 951 | $12,002.05 | $10.82 | 1.17 | 0.82% |
| HYDROCORT CRE 2.5% | 767 | 661 | $13,897.27 | $18.12 | 1.16 | 0.95% |
| HYDROCORT OIN 1% | 664 | 581 | $8,850.66 | $13.33 | 1.14 | 0.61% |
| DESONIDE CRE 0.05% | 410 | 312 | $10,375.61 | $25.31 | 1.31 | 0.71% |
| HYDROCORT LOT 2.5% | 365 | 288 | $10,224.03 | $28.01 | 1.27 | 0.70% |
| DESONIDE OIN 0.05% | 165 | 122 | $4,601.04 | $27.89 | 1.35 | 0.31% |
| TRIAMCINOLONE LOT 0.025% | 142 | 116 | $4,823.79 | $33.97 | 1.22 | 0.33% |
| FLUOCINOLONE ACT SOL 0.01% | 133 | 91 | $3,127.14 | $23.51 | 1.46 | 0.21% |
| TRIAMCINOLONE ACT POW | 9 | 7 | $249.94 | $27.77 | 1.29 | 0.02% |
| HYDROCORT CRE 0.5% | 9 | 9 | $101.48 | $11.28 | 1 | 0.01% |
| FT ITCH RELF CRE 1% | 1 | 1 | $12.66 | $12.66 | 1 | 0.00% |
| FT ITCH RELF CRE /ALOE 1% | 1 | 1 | $12.38 | $12.38 | 1 | 0.00% |
| **SUBTOTAL** | **17,908** | **14,155** | **$266,072.71** | **$14.86** | **1.27** | **18.20%** |
| **MEDIUM-HIGH TO MEDIUM POTENCY PRODUCTS** | | | | | | |
| TRIAMCINOLONE CRE 0.1% | 25,482 | 19,852 | $348,938.61 | $13.69 | 1.28 | 23.87% |
| TRIAMCINOLONE OIN 0.1% | 15,315 | 11,682 | $241,277.82 | $15.75 | 1.31 | 16.50% |
| TRIAMCINOLONE CRE 0.5% | 2,842 | 2,132 | $42,785.47 | $15.05 | 1.33 | 2.93% |
| TRIAMCINOLONE OIN 0.025% | 2,678 | 2,218 | $40,176.04 | $15.00 | 1.21 | 2.75% |
| TRIAMCINOLONE OIN 0.5% | 1,296 | 1,024 | $24,191.32 | $18.67 | 1.27 | 1.65% |
| MOMETASONE CRE 0.1% | 768 | 543 | $18,044.06 | $23.49 | 1.41 | 1.23% |
| BETAMETH VAL CRE 0.1% | 467 | 356 | $13,294.76 | $28.47 | 1.31 | 0.91% |
| TRIAMCINOLONE LOT 0.1% | 419 | 359 | $11,794.55 | $28.15 | 1.17 | 0.81% |
| FLUTICASONE CRE 0.05% | 281 | 210 | $6,249.96 | $22.24 | 1.34 | 0.43% |
| MOMETASONE OIN 0.1% | 277 | 185 | $5,187.36 | $18.73 | 1.5 | 0.35% |
| BETAMETH VAL OIN 0.1% | 259 | 205 | $7,337.17 | $28.33 | 1.26 | 0.50% |
| MOMETASONE SOL 0.1% | 168 | 106 | $4,571.02 | $27.21 | 1.58 | 0.31% |
| BETAMETH DIP LOT 0.05% | 130 | 79 | $4,096.76 | $31.51 | 1.65 | 0.28% |
| FLUTICASONE OIN 0.005% | 75 | 54 | $2,086.42 | $27.82 | 1.39 | 0.14% |
| HYDROCORT VAL CRE 0.2% | 1 | 1 | $19.03 | $19.03 | 1 | 0.00% |
| **SUBTOTAL** | **50,458** | **39,006** | **$770,050.35** | **$15.26** | **1.29** | **52.67%** |
| **ULTRA-HIGH TO HIGH POTENCY PRODUCTS** | | | | | | |
| CLOBETASOL CRE 0.05% | 2,642 | 1,816 | $47,307.96 | $17.91 | 1.45 | 3.24% |
| CLOBETASOL SOL 0.05% | 2,510 | 1,446 | $54,062.77 | $21.54 | 1.74 | 3.70% |
| CLOBETASOL OIN 0.05% | 2,060 | 1,377 | $37,262.10 | $18.09 | 1.5 | 2.55% |
| BETAMETH DIP CRE 0.05% | 1,062 | 800 | $33,519.24 | $31.56 | 1.33 | 2.29% |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| FLUOCINONIDE SOL 0.05% | 760 | 475 | $17,412.66 | $22.91 | 1.6 | 1.19% |
| AUG BETAMETH DIP CRE 0.05% | 540 | 404 | $8,773.47 | $16.25 | 1.34 | 0.60% |
| BETAMETH DIP OIN 0.05% | 373 | 268 | $14,417.33 | $38.65 | 1.39 | 0.99% |
| FLUOCINONIDE OIN 0.05% | 276 | 168 | $7,154.60 | $25.92 | 1.64 | 0.49% |
| FLUOCINONIDE CRE 0.05% | 182 | 115 | $5,677.04 | $31.19 | 1.58 | 0.39% |
| AUG BETAMETH DIP OIN 0.05% | 110 | 87 | $3,946.67 | $35.88 | 1.26 | 0.27% |
| CLOBETASOL EMOL CRE 0.05% | 98 | 61 | $4,077.48 | $41.61 | 1.61 | 0.28% |
| CLOBETASOL FOAM 0.05% | 75 | 53 | $2,747.56 | $36.63 | 1.42 | 0.19% |
| HALOBETASOL CRE 0.05% | 61 | 41 | $1,841.56 | $30.19 | 1.49 | 0.13% |
| HALOBETASOL OIN 0.05% | 41 | 32 | $1,320.19 | $32.20 | 1.28 | 0.09% |
| DESOXIMETASONE CRE 0.25% | 19 | 14 | $500.60 | $26.35 | 1.36 | 0.03% |
| FLUOCINONIDE CRE 0.1% | 17 | 12 | $377.07 | $22.18 | 1.42 | 0.03% |
| DESOXIMETASONE OIN 0.25% | 5 | 4 | $129.03 | $25.81 | 1.25 | 0.01% |
| **SUBTOTAL** | **10,831** | **7,173** | **$240,527.33** | **$22.21** | **1.51** | **16.45%** |
| **TIER-1 TOTAL** | **79,197** | **60,334** | **$1,276,650.39** | **$16.12** | **1.31** | **87.32%** |
| **TIER-2 UTILIZATION** | | | | | | |
| **LOW POTENCY PRODUCTS** | | | | | | |
| FLUOCINOLONE ACT BODY OIL 0.01% | 18 | 16 | $589.91 | $32.77 | 1.13 | 0.04% |
| FLUOCINOLONE ACT SCALP OIL 0.01% | 15 | 9 | $481.28 | $32.09 | 1.67 | 0.03% |
| DERMA-SMOOTHE FS SCALP OIL 0.01% | 6 | 6 | $262.43 | $43.74 | 1 | 0.02% |
| DERMA-SMOOTHE FS BODY OIL 0.01% | 4 | 4 | $182.88 | $45.72 | 1 | 0.01% |
| FLUOCINOLONE ACT CRE 0.01% | 2 | 1 | $175.20 | $87.60 | 2 | 0.01% |
| ALCLOMETASONE OIN 0.05% | 1 | 1 | $34.61 | $34.61 | 1 | 0.00% |
| ALCLOMETASONE CRE 0.05% | 1 | 1 | $20.93 | $20.93 | 1 | 0.00% |
| **SUBTOTAL** | **47** | **38** | **$1,747.24** | **$37.18** | **1.24** | **0.12%** |
| **MEDIUM-HIGH TO MEDIUM POTENCY PRODUCTS** | | | | | | |
| TRIAMCINOLONE OIN 0.05% | 20 | 18 | $2,579.17 | $128.96 | 1.11 | 0.18% |
| BETAMETH VAL FOAM 0.12% | 5 | 5 | $288.08 | $57.62 | 1 | 0.02% |
| BETAMETH VAL LOT 0.1% | 4 | 4 | $152.29 | $38.07 | 1 | 0.01% |
| ENSTILAR FOAM 0.12% | 4 | 4 | $5,138.01 | $1,284.50 | 1 | 0.35% |
| FLUOCINONIDE EMOL CRE 0.05% | 2 | 2 | $95.10 | $47.55 | 1 | 0.01% |
| FLUOCINOLONE ACT OIN 0.025% | 1 | 1 | $42.88 | $42.88 | 1 | 0.00% |
| **SUBTOTAL** | **36** | **34** | **$8,295.53** | **$230.43** | **1.06** | **0.57%** |
| **ULTRA-HIGH TO HIGH POTENCY PRODUCTS** | | | | | | |
| CLOBETASOL SHA 0.05% | 42 | 33 | $1,778.38 | $42.34 | 1.27 | 0.12% |
| CLOBETASOL LOT 0.05% | 12 | 6 | $625.11 | $52.09 | 2 | 0.04% |
| CLOBETASOL GEL 0.05% | 5 | 5 | $162.01 | $32.40 | 1 | 0.01% |
| FLUOCINONIDE GEL 0.05% | 4 | 4 | $122.52 | $30.63 | 1 | 0.01% |
| CLOBETASOL SPR 0.05% | 3 | 2 | $137.32 | $45.77 | 1.5 | 0.01% |
| DESOXIMETASONE GEL 0.05% | 2 | 1 | $466.07 | $233.04 | 2 | 0.03% |
| AUG BETAMETH DIP LOT 0.05% | 1 | 1 | $30.26 | $30.26 | 1 | 0.00% |
| **SUBTOTAL** | **69** | **52** | **$3,321.67** | **$48.14** | **1.33** | **0.23%** |
| **TIER-2 TOTAL** | **152** | **124** | **$13,364.44** | **$87.92** | **1.23** | **0.91%** |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % COST |
|---|---|---|---|---|---|---|
| **TIER-3 UTILIZATION** | | | | | | |
| **LOW POTENCY PRODUCTS** | | | | | | |
| DESONIDE LOT 0.05% | 2 | 2 | $101.81 | $50.91 | 1 | 0.01% |
| **SUBTOTAL** | **2** | **2** | **$101.81** | **$50.91** | **1** | **0.01%** |
| **MEDIUM-HIGH TO MEDIUM POTENCY PRODUCTS** | | | | | | |
| HYDROCORT VAL OIN 0.2% | 7 | 6 | $610.76 | $87.25 | 1.17 | 0.04% |
| TRIAMCINOLONE SPR 0.147MG/G | 3 | 2 | $388.85 | $129.62 | 1.5 | 0.03% |
| CALCIP/BETAMETH SUS 0.005-0.064% | 2 | 2 | $439.56 | $219.78 | 1 | 0.03% |
| CALCIP/BETAMETH OIN 0.005-0.064% | 1 | 1 | $347.79 | $347.79 | 1 | 0.02% |
| HYDROCORT BUTYRATE CRE 0.1% | 1 | 1 | $108.77 | $108.77 | 1 | 0.01% |
| **SUBTOTAL** | **14** | **12** | **$1,895.73** | **$135.41** | **1.17** | **0.13%** |
| **ULTRA-HIGH TO HIGH POTENCY PRODUCTS** | | | | | | |
| CLOBETASOL EMOL FOAM 0.05% | 3 | 2 | $439.65 | $146.55 | 1.5 | 0.03% |
| **SUBTOTAL** | **3** | **2** | **$439.65** | **$146.55** | **1.5** | **0.03%** |
| **TIER-3 TOTAL** | **19** | **16** | **$2,437.19** | **$128.27** | **1.19** | **0.17%** |
| **TOPICAL RECTAL PRODUCTS** | | | | | | |
| PROCTOFOAM HC FOAM 1% | 739 | 591 | $141,808.00 | $191.89 | 1.25 | 9.70% |
| PROCTO-MED HC CRE 2.5% | 685 | 598 | $11,825.78 | $17.26 | 1.15 | 0.81% |
| HYDROCORT PERIANAL CRE 1% | 259 | 230 | $7,154.42 | $27.62 | 1.13 | 0.49% |
| LIDOCAINE/HYDROCORT CRE 3%/0.5% | 63 | 52 | $3,340.98 | $53.03 | 1.21 | 0.23% |
| PROCTOZONE HC CRE 2.5% | 37 | 37 | $637.67 | $17.23 | 1 | 0.04% |
| PROCTOSOL HC CRE 2.5% | 16 | 14 | $280.74 | $17.55 | 1.14 | 0.02% |
| HYDROCORT ENE 100MG | 13 | 12 | $2,872.89 | $220.99 | 1.08 | 0.20% |
| HYDROCORT AC SUP 25MG | 3 | 3 | $114.23 | $38.08 | 1 | 0.01% |
| HYDROCORT/PRAMOXINE CRE 2.5/1% | 2 | 2 | $104.94 | $52.47 | 1 | 0.01% |
| HYDROCORT/PRAMOXINE CRE 1/1% | 2 | 2 | $194.99 | $97.50 | 1 | 0.01% |
| CORTIFOAM 10% | 1 | 1 | $430.74 | $430.74 | 1 | 0.03% |
| LIDOCAINE/HYDROCORT KIT 2/2% | 1 | 1 | $232.61 | $232.61 | 1 | 0.02% |
| ANUSOL-HC CRE 2.5% | 1 | 1 | $175.93 | $175.93 | 1 | 0.01% |
| LIDOCAINE/HYDRCORT KIT 3/2.5% | 1 | 1 | $166.16 | $166.16 | 1 | 0.01% |
| LIDOCORT CRE 3/0.5% | 1 | 1 | $121.91 | $121.91 | 1 | 0.01% |
| EPIFOAM 1% | 1 | 1 | $106.76 | $106.76 | 1 | 0.01% |
| **RECTAL SUBTOTAL** | **1,825** | **1,547** | **$169,568.75** | **$92.91** | **1.18** | **11.60%** |
| **TOTAL** | **81,193** | **53,628** | **$1,462,020.77** | **$18.01** | **1.51** | **100%** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
AC = acetate; ACT = acetonide; AUG = augmented; BETAMETH = betamethasone; CALCIP = calcipotriene; CRE = cream; DIP = dipropionate; EMOL = emollient; ENE = enema; HYDROCORT = hydrocortisone; LOT = lotion; MICRO = micronized; OIN = ointment; POW = powder; SOL = solution; SHA = shampoo; SPR = spray; SUP = suppository; VAL = valerate
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 07/2025. Last accessed 07/18/2025.

# Appendix H

# Fiscal Year 2024 Annual Review of Various Systemic Antibiotics and 30-Day Notice to Prior Authorize Blujepa (Gepotidacin), Emblaveo™ (Aztreonam/ Avibactam), Likmez™ (Metronidazole Oral Suspension), and Metronidazole 125mg Tablet and 375mg Capsule

**Oklahoma Health Care Authority**
**August 2025**

## Current Prior Authorization Criteria

**Oral Antibiotic Special Formulation Approval Criteria:**

1. Member must have a patient-specific, clinically significant reason why the immediate-release formulation and/or other cost effective therapeutic equivalent medication(s) cannot be used.
2. The following oral antibiotics currently require prior authorization and the special formulation approval criteria will apply:
   - Amoxicillin/clavulanate potassium extended-release (ER) tablets (Augmentin XR®)
   - Cephalexin 250mg and 500mg tablets
   - Cephalexin 750mg capsules
   - Doxycycline hyclate 75mg and 150mg tablets (Acticlate®)
   - Doxycycline hyclate 50mg tablet (Targadox®)
   - Doxycycline hyclate delayed-release (DR) tablets (Doryx®, Doryx® MPC)
   - Doxycycline monohydrate 75mg capsules
   - Doxycycline monohydrate 150mg capsules and tablets
   - Doxycycline monohydrate DR 40mg capsules (Oracea®)
   - Minocycline ER tablets (Minolira™)
   - Minocycline ER tablets (Solodyn®)
   - Nitrofurantoin 50mg/5mL suspension

**Avycaz® (Ceftazidime/Avibactam) Approval Criteria:**

1. An FDA approved diagnosis of 1 of the following infections caused by designated susceptible microorganisms (culture/sensitivity results must be submitted):
   a. Complicated intra-abdominal infection (cIAI), used in combination with metronidazole; or
   b. Complicated urinary tract infection (cUTI), including pyelonephritis; or
   c. Hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia (HABP/VABP); and

2. Member must be at least 31 weeks gestational age or older; and
3. For the diagnosis of cIAI, Avycaz® must be used in combination with metronidazole; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime) in combination with metronidazole when indicated, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

**Baxdela® (Delafloxacin) Tablet and Vial Approval Criteria [Acute Bacterial Skin and Skin Structure Infection (ABSSSI) Diagnosis]:**

1. An FDA approved diagnosis of ABSSSI caused by designated susceptible bacteria; and
2. A patient-specific, clinically significant reason why the member cannot use vancomycin, linezolid, doxycycline, trimethoprim/sulfamethoxazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
3. Approval quantity will be based on package labeling and FDA approved dosing regimen(s); and
    a. For Baxdela® vials, an initial quantity limit of 6 vials for a 3-day supply will apply. Continued authorization will require a patient-specific, clinically significant reason why the member cannot switch to the oral tablets for the remainder of therapy.

**Baxdela® (Delafloxacin) Tablet and Vial Approval Criteria [Community-Acquired Bacterial Pneumonia (CABP) Diagnosis]:**

1. An FDA approved diagnosis of CABP caused by designated susceptible bacteria; and
2. A patient-specific, clinically significant reason why the member cannot use an appropriate beta lactam (e.g., ceftriaxone, cefotaxime, ceftaroline, ertapenem, ampicillin/sulbactam) in combination with a macrolide (e.g., azithromycin, clarithromycin) or doxycycline, monotherapy with a respiratory fluoroquinolone (e.g., levofloxacin, moxifloxacin, gemifloxacin), or other cost-effective therapeutic equivalent alternative(s) must be provided; and
3. Approval quantity will be based on package labeling and FDA approved dosing regimen(s); and
    a. For Baxdela® vials, an initial quantity limit of 6 vials for a 3-day supply will apply. Continued authorization will require a patient-

specific, clinically significant reason why the member cannot switch to the oral tablets for the remainder of therapy.

**Ciprofloxacin 100mg Tablet Approval Criteria:**

1. Approval requires a patient-specific, clinically significant reason why the member cannot use alternative strengths of ciprofloxacin tablets, levofloxacin tablets, moxifloxacin tablets, or other cost-effective therapeutic equivalent alternative(s).

**Ciprofloxacin 500mg and 1,000mg Extended-Release (ER) Tablet Approval Criteria:**

1. Approval requires a patient-specific, clinically significant reason why the member cannot use the immediate-release formulation of ciprofloxacin tablets, levofloxacin tablets, moxifloxacin tablets, or other cost-effective therapeutic equivalent alternative(s).

**Ciprofloxacin 250mg/mL and 500mg/mL Oral Suspension and Levofloxacin 25mg/mL Oral Solution Approval Criteria:**

1. Members older than 6 years of age require a patient-specific, clinically significant reason why the oral tablet formulations cannot be used.

**Dalvance® (Dalbavancin) Approval Criteria:**

1. An indicated diagnosis or infection known to be susceptible to requested agent and resistant to the cephalosporin-class of antibiotics and other antibiotics commonly used for diagnosis or infection; and
2. A patient-specific, clinically significant reason why the member cannot use vancomycin, linezolid, or other cost effective therapeutic equivalent medication(s) must be provided; and
3. A quantity limit of 3 vials per 7 days will apply.

**Fetroja® (Cefiderocol) Approval Criteria:**

1. An FDA approved diagnosis of 1 of the following infections caused by designated susceptible microorganisms (culture/sensitivity results must be submitted):
    a. Complicated urinary tract infection (cUTI), including pyelonephritis; or
    b. Hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia (HABP/VABP); and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime), or other cost-effective therapeutic equivalent alternative(s) must be provided; and

4. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

**Kimyrsa® (Oritavancin) Approval Criteria:**

1. An FDA approved indication for the treatment of acute bacterial skin and skin structure infection (ABSSSI) caused or suspected to be caused by susceptible isolates of designated gram-positive microorganisms; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use Orbactiv® (oritavancin) or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

**Meropenem 2 Gram Vial Approval Criteria:**

1. An FDA approved diagnosis of bacterial meningitis; and
2. Member must be 3 months of age or older; and
3. A patient-specific, clinically significant reason why the meropenem 1 gram or 500mg vials, which are available without a prior authorization, cannot be used must

**Minocycline (50mg, 75mg, and 100mg) Immediate-Release (IR) Tablet:**

1. Approval requires a patient-specific, clinically significant reason why the member requires the IR tablet formulation and cannot use the IR capsule formulation and/or other cost effective therapeutic equivalent medication(s).

**Nuzyra® (Omadacycline) Approval Criteria [Acute Bacterial Skin and Skin Structure Infection (ABSSSI) Diagnosis]:**

1. An FDA approved diagnosis of ABSSSI caused by designated susceptible microorganisms; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use vancomycin, linezolid, doxycycline, trimethoprim/sulfamethoxazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. Use of Nuzyra® vials will require a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
5. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

**Nuzyra® (Omadacycline) Approval Criteria [Community-Acquired Bacterial Pneumonia (CABP) Diagnosis]:**

1. An FDA approved diagnosis of CABP caused by designated susceptible microorganisms; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate beta-lactam (e.g., ceftriaxone, cefotaxime, ceftaroline, ertapenem, ampicillin/sulbactam) in combination with a macrolide (e.g., azithromycin, clarithromycin) or doxycycline, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).
    a. For Nuzyra® vials, an initial quantity limit of 4 vials for a 3-day supply will apply. Continued authorization will require a patient-specific, clinically significant reason why the member cannot switch to the oral tablet formulation for the remainder of therapy.

**Ofloxacin 300mg and 400mg Tablet Approval Criteria:**

1. Approval requires a patient-specific, clinically significant reason why the member cannot use ciprofloxacin tablets, levofloxacin tablets, moxifloxacin tablets, or other cost-effective therapeutic equivalent alternative(s).

**Recarbrio™ (Imipenem/Cilastatin/Relebactam) Approval Criteria:**

1. An FDA approved diagnosis of 1 of the following infections caused by designated susceptible microorganisms (culture/sensitivity results must be submitted):
    a. Complicated intra-abdominal infection (cIAI); or
    b. Complicated urinary tract infection (cUTI), including pyelonephritis; or
    c. Hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia (HABP/VABP); and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime) in combination with metronidazole when indicated, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. A quantity limit of 56 vials per 14 days will apply.

**Sivextro® (Tedizolid) Tablet and Vial Approval Criteria:**

1. An indicated diagnosis or infection known to be susceptible to requested agent and resistant to the cephalosporin class of antibiotics and other antibiotics commonly used for diagnosis or infection; and
2. A patient-specific, clinically significant reason why the member cannot use linezolid or other cost effective therapeutic equivalent medication(s) must be provided; and
3. A quantity limit of 6 tablets or vials per 6 days will apply.

**Solosec® (Secnidazole Oral Granules) Approval Criteria:**

1. An FDA approved diagnosis of bacterial vaginosis or trichomoniasis; and
2. A patient-specific, clinically significant reason why the member cannot use metronidazole, tinidazole, or other cost effective therapeutic equivalent alternative(s) must be provided; and
3. A quantity limit of 1 packet per 30 days will apply.

**Suprax® (Cefixime) Approval Criteria:**

1. An indicated diagnosis or infection known to be susceptible to requested agent; and
2. A patient-specific, clinically significant reason why member cannot use cephalexin, cefdinir, or other cost effective therapeutic equivalent medication(s) must be provided.

**Tetracycline 250mg and 500mg Capsule and Tablet Approval Criteria:**

1. Approval requires a patient-specific, clinically significant reason why the member requires tetracycline and cannot use doxycycline, minocycline capsules, and/or other cost effective therapeutic equivalent medication(s); and
2. For the tablet formulation, approval also requires a patient-specific, clinically significant reason why the member requires the tablet formulation and cannot use the capsule formulation.

**Vabomere® (Meropenem/Vaborbactam Injection) Approval Criteria:**

1. An FDA approved diagnosis of complicated urinary tract infection (cUTI) or pyelonephritis (culture/sensitivity results must be submitted); and
2. A patient-specific, clinically significant reason why the member cannot use piperacillin/tazobactam or other cost effective therapeutic equivalent alternative(s) must be provided; and
3. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

**Xerava® (Eravacycline) Approval Criteria:**

1. An FDA approved diagnosis of complicated intra-abdominal infection (cIAI) caused by designated susceptible microorganisms; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime) in combination with metronidazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

**Zemdri® (Plazomicin) Approval Criteria:**

1. An FDA approved diagnosis of complicated urinary tract infection (cUTI), including pyelonephritis, caused by designated susceptible microorganisms; and
2. A patient-specific, clinically significant reason why the member cannot use an appropriate alternative aminoglycoside (e.g., gentamicin, tobramycin) or other cost-effective therapeutic equivalent alternative(s) must be provided; and
3. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

**Zerbaxa® (Ceftolozane/Tazobactam) Approval Criteria:**

1. An FDA approved diagnosis of 1 of the following infections caused by designated susceptible microorganisms (culture/sensitivity results must be submitted):
    a. Complicated intra-abdominal infection (cIAI), used in combination with metronidazole; or
    b. Complicated urinary tract infection (cUTI), including pyelonephritis; or
    c. Hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia (HABP/VABP); and
2. For the diagnosis of HABP/VABP, member must be 18 years of age or older; and
3. For the diagnosis of cIAI, Zerbaxa® must be used in combination with metronidazole; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone,

ceftazidime) in combination with metronidazole when indicated, or other cost-effective therapeutic equivalent alternative(s) must be provided; and

5. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

## Utilization of Various Systemic Antibiotics: Fiscal Year 2024

### Comparison of Fiscal Years: Pharmacy Claims (All Plans)

| Plan Type | *Total Members | Total Claims | Total Cost | Cost/ Claim | Cost/ Day | Total Units | Total Days |
|---|---|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | | | |
| **FFS** | 462 | 632 | $781,080.23 | $1,235.89 | $97.95 | 54,663 | 7,974 |
| **2023 Total** | **462** | **632** | **$781,080.23** | **$1,235.89** | **$97.95** | **54,663** | **7,974** |
| **Fiscal Year 2024** | | | | | | | |
| **FFS** | 298 | 429 | $571,695.25 | $1,332.62 | $110.28 | 33,973 | 5,184 |
| **Aetna** | 83 | 86 | $6,529.00 | $75.92 | $6.44 | 3,342 | 1,014 |
| **Humana** | 131 | 144 | $120,727.85 | $838.39 | $69.95 | 5,204 | 1,726 |
| **OCH** | 119 | 130 | $32,627.42 | $250.98 | $20.52 | 4,741 | 1,590 |
| **2024 Total** | **624** | **789** | **$731,579.52** | **$927.22** | **$76.90** | **47,260** | **9,514** |
| **% Change** | **35.10%** | **24.80%** | **-6.30%** | **-25.00%** | **-21.50%** | **-13.50%** | **19.30%** |
| **Change** | **162** | **157** | **-$49,500.71** | **-$308.67** | **-$21.05** | **-7,403** | **1,540** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
FFS = fee-for-service; OCH = Oklahoma Complete Health
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

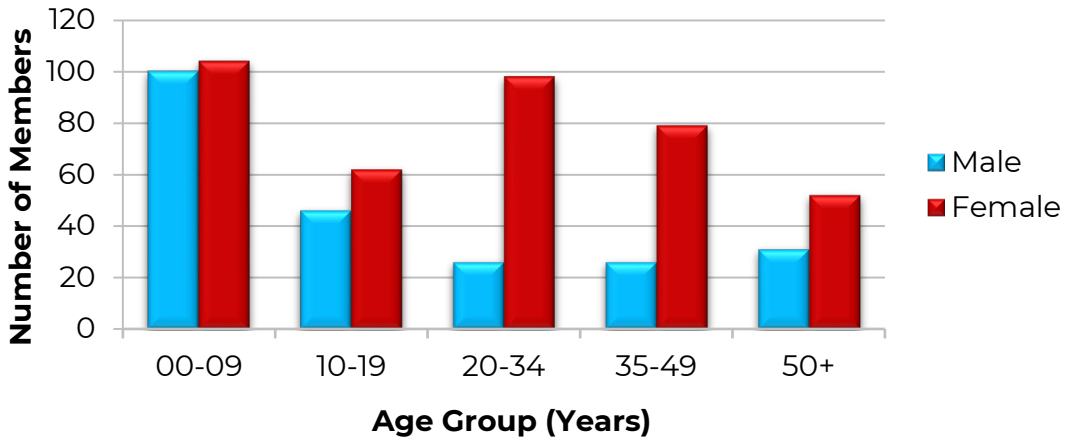
### Comparison of Fiscal Years: Medical Claims (All Plans)

| Plan Type | *Total Members | †Total Claims | Total Cost | Cost/ Claim | Claims/ Member |
|---|---|---|---|---|---|
| **Fiscal Year 2023** | | | | | |
| **FFS** | 21 | 28 | $110,591.40 | $3,949.69 | 1.33 |
| **2023 Total** | **21** | **28** | **$110,591.40** | **$3,949.69** | **1.33** |
| **Fiscal Year 2024** | | | | | |
| **FFS** | 12 | 92 | $106,677.00 | $1,159.53 | 7.67 |
| **Aetna** | 0 | 0 | $0.00 | $0.00 | 0 |
| **Humana** | 0 | 0 | $0.00 | $0.00 | 0 |
| **OCH** | 0 | 0 | $0.00 | $0.00 | 0 |
| **2024 Total** | **12** | **92** | **$106,677.00** | **$1,159.53** | **7.67** |
| **% Change** | **-42.86%** | **228.57%** | **-3.54%** | **-70.64%** | **476.69%** |
| **Change** | **-9** | **64** | **-$3,914.40** | **-$2,790.16** | **6.34** |

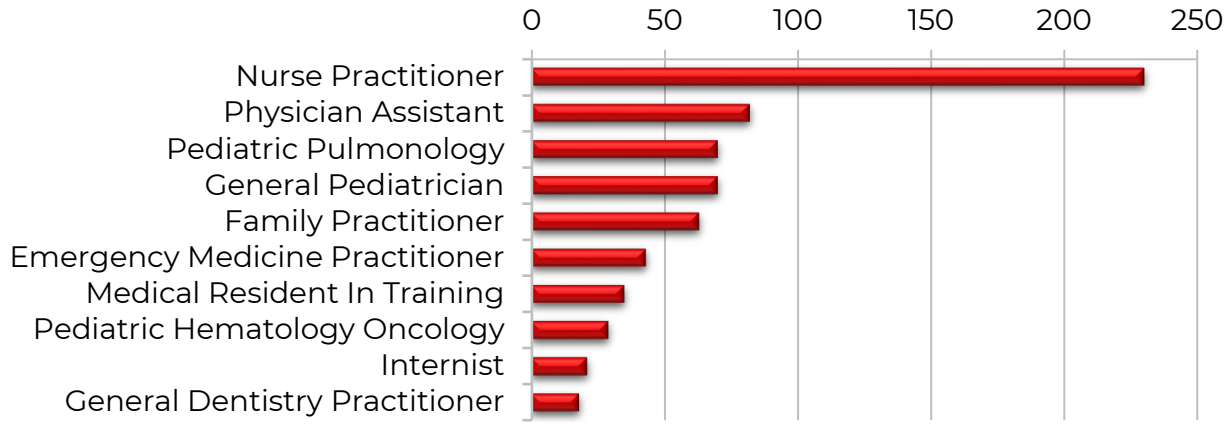
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for SoonerSelect plans.

- Aggregate drug rebates collected during fiscal year 2024 for the various systemic antibiotics totaled $245,269.01.[Δ] Rebates are collected after reimbursement for the medication and are not reflected in this report. The costs included in this report do not reflect net costs.

**Demographics of Members Utilizing Various Systemic Antibiotics: Pharmacy Claims (All Plans)**




**Top Prescriber Specialties of Various Systemic Antibiotics by Number of Claims: Pharmacy Claims (All Plans)**

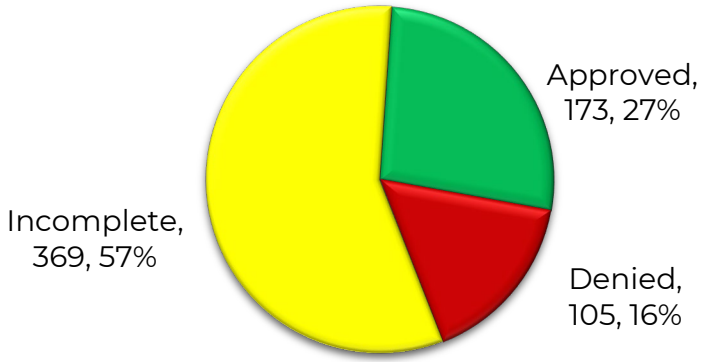



## Prior Authorization of Various Systemic Antibiotics

There were 647 prior authorization requests submitted for various systemic antibiotics during fiscal year 2024. The following chart shows the status of the submitted petitions for fiscal year 2024.

[Δ] Important considerations: Aggregate drug rebates are based on the date the claim is paid rather than the date dispensed. Claims data are based on the date dispensed.

**Status of Petitions (All Plans)**




**Status of Petitions by Plan Type**

| Plan Type | Approved | | Incomplete | | Denied | | Total |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | |
| **FFS** | 161 | 26% | 369 | 59% | 93 | 15% | **623** |
| **Aetna** | 7 | 50% | 0 | 0% | 7 | 50% | **14** |
| **Humana** | 3 | 38% | 0 | 0% | 5 | 63% | **8** |
| **OCH** | 2 | 100% | 0 | 0% | 0 | 0% | **2** |
| **Total** | **173** | **27%** | **369** | **57%** | **105** | **16%** | **647** |

FFS = fee-for-service; OCH = OK Complete Health
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

## Market News and Updates[1,2,3,4,5,6,7,8,9]

### Anticipated Patent Expiration(s):

- Doryx® [doxycycline hyclate delayed-release (DR) tablet]: February 2028
- Dalvance® [dalbavancin vial for intravenous (IV) infusion]: May 2028
- Suprax® (cefixime 500mg/5mL oral suspension): December 2028
- Recarbrio™ (imipenem/cilastatin/relebactam vial for IV infusion): November 2029
- Sivextro® (tedizolid tablet and vial for IV infusion): December 2030
- Baxdela® (delafloxacin tablet): June 2031
- Zemdri® (plazomicin vial for IV infusion): June 2031
- Solodyn® (minocycline ER tablet): November 2031
- Avycaz® (ceftazidime/avibactam vial for IV infusion): June 2032
- Emblaveo™ (aztreonam/avibactam): June 2032
- Baxdela® (delafloxacin vial for IV infusion): February 2033
- Doryx® MPC (doxycycline hyclate DR tablet): October 2034
- Bluejpa (gepotidacin tablet): March 2035
- Orbactiv® (oritavancin vial for IV infusion): July 2035
- Kimyrsa® (oritavancin vial for IV infusion): July 2035
- Zerbaxa® (ceftolozane/tazobactam vial for IV infusion): August 2035
- Fetroja® (cefiderocol vial for IV infusion): September 2035
- Solosec® (secnidazole 2g oral granules): September 2035

- Nuzyra® (omadacycline tablet and vial for IV infusion): October 2037
- Xerava® (eravacycline vial for IV infusion): October 2037
- Likmez™ (metronidazole oral suspension): January 2039
- Vabomere® (meropenem/vaborbactam vial for IV infusion): April 2039

**New U.S. Food and Drug Administration (FDA) Approval(s):**

- **September 2023:** The FDA approved Likmez™ (metronidazole oral suspension) for the indications of trichomoniasis in adults, amebiasis in adults and pediatric patients, and anaerobic bacterial infections in adults. Likmez™ is available as a 500mg/5mL oral suspension with a strawberry peppermint flavor.
- **February 2025:** The FDA approved the monobactam/beta-lactamase inhibitor combination antibiotic therapy, Emblaveo™ (aztreonam/avibactam). When used in combination with metronidazole, Emblaveo™ is indicated for the treatment of complicated intra-abdominal infections (cIAI), including those caused by susceptible gram-negative bacteria (e.g., *Klebsiella oxytoca, Enterobacter cloacae complex, Citrobacter freundii complex, Serratia marcescens*), in patients 18 years of age or older who have limited or no alternative treatment options. According to package labeling, the FDA approved this indication based on limited clinical safety and efficacy data.
- **March 2025:** The FDA approved Blujepa (gepotidacin) for the treatment of uncomplicated urinary tract infection (uUTI) caused by the following susceptible microorganisms: *Escherichia coli*, *Klebsiella pneumoniae*, *Citrobacter freundii* complex, *Staphylococcus saprophyticus* and *Enterococcus faecalis*. Blujepa is approved for female adult and pediatric patients 12 years of age and older and weighing at least 40kg. Blujepa is a first-in-class, bactericidal triazaacenaphthylene antibiotic that inhibits 2 different topoisomerase enzymes, thereby inhibiting bacterial deoxyribonucleic acid (DNA) replication.

**News:**

- **February 2024:** Generic metronidazole 375mg capsules were brought to market under an Abbreviated New Drug Application (ANDA).
- **January 2025:** Generic metronidazole 125mg tablets were brought to market under an ANDA.

**Guideline Update(s):**

- **American College of Gastroenterology (ACG) Guideline Update(s):** In September 2024, the ACG released an update to the 2017 guidelines for the treatment of *Helicobacter pylori* (*H. pylori)* infection. Changes to the recommended first-line regimens are based on data indicating increasing rates of *H. pylori* resistance to clarithromycin and levofloxacin in North America. The guidelines state that the rising

resistance rates greatly reduce the efficacy of clarithromycin- and levofloxacin-based regimens. First-line regimens for treatment-naïve patients include:

- Optimized bismuth quadruple therapy (BQT) for 14 days as the preferred option when the antibiotic susceptibility profile is unknown. BQT consists of a standards dose proton pump inhibitor (PPI), bismuth subcitrate or subsalicylate, tetracycline, and metronidazole.
- Rifabutin triple therapy or potassium channel acid blocker (PCAB) dual therapy for 14 days can be suitable alternatives in patients without a penicillin allergy. The rifabutin triple therapy regimen consists of omeprazole, amoxicillin, and rifabutin while the PCAB dual therapy regimen consists of vonoprazan and amoxicillin (available as Voquezna® DualPak®).
- In patients with unknown antibiotic susceptibility and no history of macrolide exposure or penicillin allergy, PCAB-clarithromycin triple therapy for 14 days is preferable to PPI-clarithromycin triple therapy when no other obvious first-line treatment option is available.

- **Infectious Disease Society of America (IDSA) Guideline Updates(s):** In July 2025, the IDSA released new guidelines for the management and treatment of complicated urinary tract infections (cUTIs). These guidelines serve as an update to the 2010 guidelines, which had only focused on uncomplicated cystitis and pyelonephritis in females. The 2025 updates include recommendations for UTIs in males, updated recommendations for antibiotic selections, new recommendations regarding the duration and timing of switching IV antibiotics to oral therapy, and new, simplified definitions of uUTIs and cUTIs, where the former is defined as an infection confined to the bladder and the latter is defined as an infection that extends beyond the bladder. These updated definitions apply to both female and male patients.

**Pipeline:**

- **Zaynich® (Zidebactam/Cefepime):** In January 2025, Wockhardt announced that its investigational antibiotic, Zaynich®, achieved over 97% efficacy in a clinical trial for serious infections cause by confirmed meropenem-resistant gram-negative pathogens. Zaynich® is a combination product of cefepime, a beta-lactam antibacterial, and zidebactam, a novel beta-lactam enhancer (BLE). Zidebactam is unique in that it has a high affinity for penicillin binding protein 2 (PBP2) as well as the ability to inhibit Ambler class A and C beta-lactamase enzymes. The clinical trial evaluated a range of severe infections, including hospital-acquired bacterial pneumonia (HABP), ventilator-associated bacterial pneumonia (VABP), bloodstream infection (BSI), cIAI, and cUTI. According to Wockhardt, Zaynich® is currently being

evaluated in a Phase 3 multinational trial that could support its registration and marketing authorization globally.

## Blujepa (Gepotidacin) Product Summary[10,11]

**Therapeutic Class:** Triazaacenaphthylene bacterial type II topoisomerase inhibitor

**Indication(s):** Treatment of female adult and pediatric patients 12 years of age and older and weighing at least 40kg with uUTI caused by the following susceptible microorganisms: *Escherichia coli*, *Klebsiella pneumoniae*, *Citrobacter freundii* complex, *Staphylococcus saprophyticus* and *Enterococcus faecalis*

**How Supplied:** 750mg film-coated tablet

**Dosing and Administration:** 1,500mg (2 tablets) orally twice daily after a meal for 5 days

**Efficacy:** The safety and efficacy of Blujepa was supported by 2 Phase 3 multicenter, double-blind, double-dummy, non-inferiority trials, designated as Trial 1 and Trial 2 in the *Prescribing Information*.

- Key Inclusion Criteria:
  - Female ≥12 years of age and weighing ≥40kg
  - At least 2 symptoms consistent with uUTI (e.g., dysuria, frequency, urgency, lower abdominal pain)
  - At least 1 baseline qualifying uropathogen [$\geq 10^5$ colony-forming units (CFU)/mL]
- Key Exclusion Criteria:
  - Medical condition or presentation suggestive of cUTI (e.g., pyelonephritis, urosepsis)
  - Baseline uropathogen not susceptible to nitrofurantoin
- Intervention(s):
  - Both trials compared Blujepa 1,500mg orally twice daily with food for 5 days vs. nitrofurantoin 100mg orally twice daily for 5 days
- Primary Endpoint(s):
  - Composite of clinical cure (resolution of all signs and symptoms) and microbiological response (reduction of baseline pathogen to $<10^3$ CFU/mL) at the Test-of-Cure (TOC) visit on day 10 to 13
  - -10% prespecified non-inferiority margin for the composite endpoint
- Results:
  - Both trials demonstrated non-inferiority of Blujepa to nitrofurantoin

- Trial 1: 51.8% (174/336) of participants who received Blujepa achieved the composite response vs. 47% (140/298) of participants who received nitrofurantoin [difference: 5.3; 95% confidence interval (CI): -2.4, 13.0)
- Trial 2: 58.9% (172/292) of participants who received Blujepa achieved the composite response vs. 44% (121/275) of participants who received nitrofurantoin (difference: 14.4; 95% CI: 6.4, 22.4)

**Cost:** The Wholesale Acquisition Cost (WAC) of Blujepa is not available at this time to allow for a cost analysis.

## Emblaveo™ (Aztreonam/Avibactam) Product Summary[3]

**Therapeutic Class:** Monobactam antibacterial and beta-lactamase inhibitor combination

**Indication(s):** Treatment of cIAI caused by designated susceptible gram-negative microorganisms in patients 18 years of age and older; used in combination with metronidazole

**How Supplied:** 2 gram single-dose vial (SDV) containing 1.5 grams of aztreonam and 0.5 grams of avibactam as a lyophilized powder for reconstitution and dilution

**Dosing and Administration:** The recommended dose of Emblaveo™ is a loading dose of 2.67 grams by IV infusion followed by a maintenance dose of 2 grams every 6 hours via IV infusion in adults with an estimated creatinine clearance (CrCl) >50mL/min.

- See package labeling for dose adjustments for adults with CrCl ≤50mL/min.
- The recommended treatment duration is 5 to 14 days.

**Efficacy:** According to the *Prescribing Information*, the safety and efficacy of Emblaveo™ were supported in part by previously published findings regarding the safety and efficacy of the aztreonam component for cIAI and, for the avibactam component, by established *in vitro* and animal models of infection. Emblaveo™ was studied in a randomized, active-controlled multicenter trial in patients with cIAI or hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia (HABP/VABP) (not an FDA-approved indication); this trial was not designed with any formal hypotheses for inferential testing against the active comparator.

**Cost:** The Wholesale Acquisition Cost (WAC) of Emblaveo™ is $327 per 2g SDV, resulting in a cost of $694 for the loading dose and $327 for each maintenance dose. The cost of a 14-day regimen, with a 2.67 gram loading

dose followed by maintenance dosing of 2 grams IV every 6 hours, would be $18,639.

## Cost Comparison: Metronidazole Products

| Product | Cost Per Unit | Cost Per Day* |
|---|---|---|
| **metronidazole 125mg tablet (generic)** | **$13.27** | **$159.24** |
| **metronidazole 375mg capsule (generic)** | **$6.56** | **$26.24** |
| **Likmez™ (metronidazole 500mg/5mL oral suspension)** | **$2.62** | **$39.30** |
| metronidazole 500mg tablet (generic) | $0.10 | $0.30 |
| metronidazole 250mg tablet (generic) | $0.09 | $0.54 |

Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Cost per day is based on a typical adult dose of 1,500mg per day.
Unit = capsule, milliliter, or tablet

## Recommendations

The College of Pharmacy recommends the prior authorization of Blujepa (gepotidacin), Emblaveo™ (aztreonam/avibactam) and Likmez™ (metronidazole oral suspension) with the following criteria (shown in red):

**Blujepa (Gepotidacin) Approval Criteria:**

1. An FDA approved diagnosis of uncomplicated urinary tract infection (uUTI) caused by designated microorganisms(culture/sensitivity results must be submitted); and
2. Member must be a female 12 years of age or older and weigh ≥40kg; and
3. Member must have an estimated glomerular filtration rate (eGFR) >30mL/min/1.73m$^2$) and must not be on dialysis; and
4. Member must not have severe hepatic impairment (Child Pugh C); and
5. Prior to and during treatment, the potential for drug interactions should be evaluated, including:
    a. Avoid concomitant administration with strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole) or inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort); and
    b. Avoid concomitant administration with CYP3A4 substrates with a narrow therapeutic index (e.g., quinidine, cyclosporine); and
    c. Monitor digoxin serum concentrations as clinically indicated; and
    d. Monitor for adverse effects with concomitant administration with acetylcholinesterase inhibitors, anticholinergic medications, or non-depolarizing neuromuscular blocking agents; and
6. Prescriber must verify that members with medical conditions that may be exacerbated by acetylcholinesterase inhibition will be monitored for adverse effects; and

7. If administration of Blujepa cannot be avoided in members with a history of QTc interval prolongation, taking antiarrhythmic medications, or taking other medications that may prolong the QTc interval, prescriber must verify that serum electrolyte abnormalities will be corrected and monitored and an ECG should be collected prior to administration and duration treatment, as clinically indicated; and
8. A patient-specific, clinically significant reason why the member cannot use an appropriate cost-effective, therapeutic alternative (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) must be provided; and
9. A quantity limit of 20 tablets per 5 days will apply.

**Emblaveo™ (Aztreonam/Avibactam) Approval Criteria:**

1. An FDA approved diagnosis of complicated intra-abdominal infections (cIAI) caused by susceptible gram-negative microorganisms (e.g., *Escherichia coli, Klebsiella pneumoniae, Klebsiella oxytoca*, *Enterobacter cloacae* complex, *Citrobacter freundii* complex, *Serratia marcescens*) in adults who have limited or no alternative treatment options (culture/sensitivity results must be submitted); and
2. Member must 18 years of age or older; and
3. Must be used in combination with metronidazole; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime) in combination with metronidazole, a fluoroquinolone (e.g., ciprofloxacin or levofloxacin) in combination with metronidazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. A quantity limit of 57 vials per 14 days will apply.

**Likmez™ (Metronidazole 500mg/5mL Suspension) Approval Criteria:**

1. A patient-specific clinically significant reason (beyond convenience) must be provided regarding why the member cannot use the 250mg and 500mg tablets, which are available without prior authorization, including but not limited to:
    a. Member is unable to swallow the oral tablet (i.e., has diagnosis characterized by difficulty or inability to swallow); or
    b. Clinically indicated dose cannot be achieved with available tablet formulations; or
    c. Treatment course was initiated inpatient; and
2. For members who require weight-based dosing, the member's recent weight (within the last 3 months) must be provided on the prior authorization request; and

3. A quantity limit of 200mL per 10 days will apply.

Additionally, the College of Pharmacy recommends the prior authorization of metronidazole 125mg tablets and 375mg capsules based on net costs within the Oral Antibiotic Special Formulation Approval Criteria (changes shown in red):

**Oral Antibiotic Special Formulation Approval Criteria:**

1. Member must have a patient-specific, clinically significant reason why the immediate-release formulation and/or other cost effective therapeutic equivalent medication(s) cannot be used.
2. The following oral antibiotics currently require prior authorization and the special formulation approval criteria will apply:
   - Amoxicillin/clavulanate potassium extended-release (ER) tablets (Augmentin XR®)
   - Cephalexin 250mg and 500mg tablets
   - Cephalexin 750mg capsules
   - Doxycycline hyclate 75mg and 150mg tablets (Acticlate®)
   - Doxycycline hyclate 50mg tablet (Targadox®)
   - Doxycycline hyclate delayed-release (DR) tablets (Doryx®, Doryx® MPC)
   - Doxycycline monohydrate 75mg capsules
   - Doxycycline monohydrate 150mg capsules and tablets
   - Doxycycline monohydrate DR 40mg capsules (Oracea®)
   - Metronidazole 125mg tablets
   - Metronidazole 375mg capsules
   - Minocycline ER tablets (Minolira™)
   - Minocycline ER tablets (Solodyn®)
   - Nitrofurantoin 50mg/5mL suspension

Lastly, based on the 2024 ACG guideline updates, the College of Pharmacy recommends updating the Tetracycline 250mg and 500mg Capsule and Tablet Approval Criteria to remove the prior authorization requirement from tetracycline 250mg and 500mg capsules for the diagnosis of *H. pylori* infection (changes shown in red):

**Tetracycline 250mg and 500mg Capsule and Tablet Approval Criteria:**

~~1. Approval requires a patient-specific, clinically significant reason why the member requires tetracycline and cannot use doxycycline, minocycline capsules, and/or other cost effective therapeutic equivalent medication(s).~~

2. For the capsule formulation, a quantity of 56 capsules for 14 days is available without a prior authorization for a diagnosis of *Helicobacter pylori* (*H. pylori*) infection; or

3. For the tablet formulation, approval ~~also~~ requires a patient-specific, clinically significant reason why the member requires the tablet formulation and cannot use the capsule formulation, which is available without prior authorization; and
4. A quantity limit of 56 capsules or tablets per 14 days will apply; and
    a. A quantity limit override for longer durations of therapy for indications other than for the eradication of *H. pylori* infection will require a patient specific, clinically significant reason why the member requires tetracycline and cannot use doxycycline, minocycline capsules, and/or other cost effective therapeutic equivalent medication(s).

## Utilization Details of Various Systemic Antibiotics: Fiscal Year 2024

### Pharmacy Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % Cost |
|---|---|---|---|---|---|---|
| **LEVOFLOXACIN PRODUCTS** | | | | | | |
| LEVOFLOXACIN SOL 25MG/ML | 155 | 105 | $22,456.63 | $144.88 | 1.48 | 3.07% |
| **SUBTOTAL** | **155** | **105** | **$22,456.63** | **$144.88** | **1.48** | **3.07%** |
| **CIPROFLOXACIN PRODUCTS** | | | | | | |
| CIPRO 10% SUS 500MG/5ML | 73 | 47 | $13,445.71 | $184.19 | 1.55 | 1.84% |
| CIPRO 5% SUS 250MG/5ML | 61 | 57 | $9,987.67 | $163.73 | 1.07 | 1.37% |
| CIPROFLOXACIN SUS 500MG/5ML | 1 | 1 | $239.73 | $239.73 | 1 | 0.03% |
| CIPROFLOXACIN SUS 250MG/5ML | 1 | 1 | $511.41 | $511.41 | 1 | 0.07% |
| **SUBTOTAL** | **136** | **106** | **$24,184.52** | **$177.83** | **1.28** | **3.31%** |
| **CEPHALEXIN PRODUCTS** | | | | | | |
| CEPHALEXIN TAB 500MG | 115 | 115 | $5,443.14 | $47.33 | 1 | 0.74% |
| CEPHALEXIN CAP 750MG | 11 | 10 | $1,603.82 | $145.80 | 1.1 | 0.22% |
| CEPHALEXIN TAB 250MG | 4 | 4 | $155.80 | $38.95 | 1 | 0.02% |
| **SUBTOTAL** | **130** | **129** | **$7,202.76** | **$55.41** | **1.01** | **0.98%** |
| **METRONIDAZOLE PRODUCTS** | | | | | | |
| METRONIDAZOLE CAP 375MG | 113 | 100 | $21,382.83 | $189.23 | 1.13 | 2.92% |
| FLAGYL CAP 375MG | 1 | 1 | $97.54 | $97.54 | 1 | 0.01% |
| **SUBTOTAL** | **114** | **101** | **$21,480.37** | **$188.42** | **1.13** | 2.94% |
| **TETRACYCLINE PRODUCTS** | | | | | | |
| TETRACYCLINE CAP 500MG | 63 | 60 | $3,050.96 | $48.43 | 1.05 | 0.42% |
| TETRACYCLINE CAP 250MG | 5 | 4 | $224.40 | $44.88 | 1.25 | 0.03% |
| **SUBTOTAL** | **68** | **64** | **$3,275.36** | **$48.17** | **1.06** | **0.45%** |
| **CEFIXIME PRODUCTS** | | | | | | |
| CEFIXIME CAP 400MG | 34 | 25 | $2,369.00 | $69.68 | 1.36 | 0.32% |
| CEFIXIME SUS 200MG/5ML | 8 | 8 | $1,048.20 | $131.03 | 1 | 0.14% |
| CEFIXIME SUS 100MG/5ML | 3 | 2 | $270.09 | $90.03 | 1.5 | 0.04% |
| **SUBTOTAL** | **45** | **35** | **$3,687.29** | **$81.94** | **1.29** | **0.50%** |
| **MINOCYCLINE PRODUCTS** | | | | | | |

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER | % Cost |
|---|---|---|---|---|---|---|
| MINOCYCLINE TAB 100MG | 20 | 17 | $714.47 | $35.72 | 1.18 | 0.10% |
| MINOCYCLINE TAB 90MG ER | 5 | 3 | $588.30 | $117.66 | 1.67 | 0.08% |
| MINOCYCLINE TAB 50MG | 5 | 4 | $131.47 | $26.29 | 1.25 | 0.02% |
| MINOCYCLINE TAB 75MG | 3 | 2 | $105.28 | $35.09 | 1.5 | 0.01% |
| MINOCYCLINE TAB 65MG ER | 2 | 2 | $277.68 | $138.84 | 1 | 0.04% |
| MINOCYCLINE TAB 135MG ER | 1 | 1 | $117.66 | $117.66 | 1 | 0.02% |
| MINOCYCLINE TAB 80MG ER | 1 | 1 | $192.66 | $192.66 | 1 | 0.03% |
| **SUBTOTAL** | **37** | **30** | **$2,127.52** | **$57.50** | **1.23** | **0.29%** |
| **OMADACYCLINE PRODUCTS** | | | | | | |
| NUZYRA TAB 150MG | 34 | 16 | $407,893.50 | $11,996.87 | 2.13 | 55.76% |
| **SUBTOTAL** | **34** | **16** | **$407,893.50** | **$11,996.87** | **2.13** | **55.76%** |
| **DOXYCYCLINE PRODUCTS** | | | | | | |
| DOXYCYCLINE HYC TAB 100MG DR | 12 | 11 | $705.10 | $58.76 | 1.09 | 0.10% |
| DOXYCYCLINE HYC TAB 50MG | 7 | 7 | $800.89 | $114.41 | 1 | 0.11% |
| DOXYCYCLINE HYC TAB 200MG DR | 2 | 2 | $784.60 | $392.30 | 1 | 0.11% |
| DOXYCYCLINE HYC TAB 150MG | 2 | 2 | $94.82 | $47.41 | 1 | 0.01% |
| DOXYCYCLINE HYC TAB 75MG | 2 | 2 | $56.82 | $28.41 | 1 | 0.01% |
| DOXYCYCLINE MONO TAB 150MG | 1 | 1 | $45.17 | $45.17 | 1 | 0.01% |
| DORYX MPC TAB 60MG | 1 | 1 | $1,211.41 | $1,211.41 | 1 | 0.17% |
| DOXYCYCLINE HYC TAB 50MG DR | 1 | 1 | $101.67 | $101.67 | 1 | 0.01% |
| **SUBTOTAL** | **28** | **27** | **$3,800.48** | **$135.73** | **1.04** | **0.52%** |
| **AMOXICILLIN/CLAVULANATE PRODUCTS** | | | | | | |
| AMOX/CLA TAB ER 1,000-62.5MG | 15 | 14 | $1,731.25 | $115.42 | 1.07 | 0.24% |
| **SUBTOTAL** | **15** | **14** | **$1,731.25** | **$115.42** | **1.07** | **0.24%** |
| **TEDIZOLID PRODUCTS** | | | | | | |
| SIVEXTRO TAB 200MG | 14 | 4 | $167,758.74 | $11,982.77 | 3.5 | 22.93% |
| **SUBTOTAL** | **14** | **4** | **$167,758.74** | **$11,982.77** | **3.5** | **22.93%** |
| **CEFTAZIDIME/AVIBACTAM PRODUCTS** | | | | | | |
| AVYCAZ INJ 2-0.5GM | 6 | 3 | $40,022.69 | $6,670.45 | 2 | 5.47% |
| **SUBTOTAL** | **6** | **3** | **$40,022.69** | **$6,670.45** | **2** | **5.47%** |
| **CEFTOLOZANE/TAZOBACTAM PRODUCTS** | | | | | | |
| ZERBAXA INJ 1.5GM | 3 | 3 | $19,081.75 | $6,360.58 | 1 | 2.61% |
| **SUBTOTAL** | **3** | **3** | **$19,081.75** | **$6,360.58** | **1** | **2.61%** |
| **NITROFURANTOIN PRODUCTS** | | | | | | |
| NITROFURANTOIN SUS 50MG/5ML | 2 | 2 | $5,224.75 | $2,612.38 | 1 | 0.71% |
| **SUBTOTAL** | **2** | **2** | **$5,224.75** | **$2,612.38** | **1** | **0.71%** |
| **DELAFLOXACIN PRODUCTS** | | | | | | |
| BAXDELA TAB 450MG | 1 | 1 | $1,605.41 | $1,605.41 | 1 | 0.22% |
| **SUBTOTAL** | **1** | **1** | **$1,605.41** | **$1,605.41** | **1** | **0.22%** |
| **OFLOXACIN PRODUCTS** | | | | | | |
| OFLOXACIN TAB 400MG | 1 | 1 | $46.50 | $46.50 | 1 | 0.01% |
| **SUBTOTAL** | **1** | **1** | **$46.50** | **$46.50** | **1** | **0.01%** |
| **TOTAL** | **789** | **624*** | **$731,579.52** | **$927.22** | **1.26** | **100%** |

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.
AMOX CLA = amoxicillin/clavulanate; CAP = capsule; DR = delayed release; ER = extended-release; HYC = hyclate; INJ = injection; MONO = monohydrate; SOL = solution; SUS = suspension; TAB = tablet
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans

## Medical Claims (All Plans)

| PRODUCT UTILIZED | TOTAL CLAIMS | TOTAL MEMBERS | TOTAL COST | COST/ CLAIM | CLAIMS/ MEMBER |
|---|---|---|---|---|---|
| CEFTOLOZANE-TAZO INJ (J0695) | 76 | 2 | $34,260.00 | $450.79 | 38 |
| DALBAVANCIN INJ (J0875) | 16 | 10 | $72,417.00 | $4,526.06 | 1.6 |
| **TOTAL** | **92⁺** | **12*** | **$106,677.00** | **$1,159.53** | **7.67** |

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
⁺Total number of unduplicated claims.
INJ = injection; TAZO = tazobactam
Fiscal Year 2024 = 07/01/2023 to 06/30/2024
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

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# Appendix I

# U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates*

***Additional information, including the full news release, on the following FDA and DEA updates can be found on the FDA website at: https://www.fda.gov/news-events/fda-newsroom/press-announcements.**

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**FDA NEWS RELEASE**

**For Immediate Release: July 31, 2025**

**FDA Requires Major Changes to Opioid Pain Medication Labeling to Emphasize Risks**

The FDA is requiring safety labeling changes to all opioid pain medications to better emphasize and explain the risks associated with their long-term use. These changes follow a public advisory committee meeting in May that reviewed data showing serious risks—such as misuse, addiction, and both fatal and non-fatal overdoses—for patients who use opioids over long periods.

Tragically, the new drug application for OxyContin® was initially approved without study data supporting its long-term use to treat pain in many patient populations for which it has been prescribed. The updated labeling change reflects robust data from 2 large FDA-required observational studies, called postmarketing requirements (PMR) 3033-1 and 3033-2, which recently provided new data on how long-term opioid use can lead to serious side effects. After reviewing those results, public comments, medical research and recognizing the absence of adequate and well-controlled studies on long-term opioid effectiveness, the FDA decided to require safety labeling changes to help health care professionals and patients make treatment decisions rooted in the latest evidence.

The FDA has required an additional prospective, randomized, controlled clinical trial to directly examine the benefits and risks of long-term opioid use. The Agency will be closely monitoring the progress of this clinical trial to ensure its timely completion. The labeling changes will include the following updates:

- Clearer Risk Information: A summary of study results showing the estimated risks of addiction, misuse, and overdose during long-term use.
- Dosing Warnings: Stronger warnings that higher doses come with greater risks, and that those risks remain over time.
- Clarified Use Limits: Removing language which could be misinterpreted to support using opioid pain medications over indefinitely long duration
- Treatment Guidance: Labels will reinforce that long-acting or extended-release opioids should only be considered when other treatments, including shorter-acting opioids, are inadequate.

- Safe Discontinuation: A reminder not to stop opioids suddenly in patients who may be physically dependent, as it can cause serious harm.
- Overdose Reversal Agents: Additional information on medicines that can reverse an opioid overdose.
- Drug Interactions: Enhanced warning about combining opioids with other drugs that slow down the nervous system—now including gabapentinoids.
- More Risks with Overdose: New information about toxic leukoencephalopathy—a serious brain condition that may occur after an overdose.
- Digestive Health: Updates about opioid-related problems with the esophagus.

The FDA sent letters to the relevant applicants outlining the required changes. The companies will have 30 days to submit their labeling updates to the FDA for review.

**FDA NEWS RELEASE**

**For Immediate Release: July 29, 2025**

**FDA Takes Steps to Restrict 7-OH Opioid Products Threatening American Consumers**

The FDA is taking a bold step to protect Americans from dangerous, illegal opioids by recommending a scheduling action to control certain 7-hydroxymitragynine (7-OH) products under the Controlled Substances Act (CSA). The FDA is specifically targeting 7-OH, a concentrated byproduct of the kratom plant; it is not focused on natural kratom leaf products. 7-OH is increasingly recognized as having potential for abuse because of its ability to bind to opioid receptors. The FDA is releasing a new report to educate the public about the health concerns of 7-OH and its distinction from the kratom plant leaf.

This recommendation follows a thorough medical and scientific analysis by the FDA and is one of several efforts to address the FDA's concerns around the growing availability and use of 7-OH opioid products. There are no FDA-approved 7-OH drugs, 7-OH is not lawful in dietary supplements, and 7-OH cannot be lawfully added to conventional foods.

The availability of 7-OH products is a major concern to the FDA, as consumers can easily purchase products with concentrated levels of 7-OH online and in gas stations, corner stores and vape shops. The FDA is particularly concerned with the growing market of 7-OH products that may be especially appealing to children and teenagers, such as fruit-flavored gummies and ice cream cones. These products may not be clearly or accurately labeled as to their 7-OH content and are sometimes disguised or marketed as kratom. The FDA has also published educational materials for consumers to be more informed about these harmful products.

In June, the FDA issued warning letters to 7 companies for illegally distributing products containing 7-OH, including tablets, gummies, drink mixes, and shots. The FDA is also issuing a letter to health care professionals and is warning consumers about the risks associated with 7-OH products.

Under the CSA, drugs, substances and certain chemicals are placed into one of five schedules based upon their medical use, potential for abuse and safety or dependence liability. The Drug Enforcement Administration is reviewing the recommendation and has the final authority on scheduling, which requires a rulemaking process that includes a period for the public to provide comments before any scheduling action is finalized.

**FDA NEWS RELEASE**

**For Immediate Release: July 28, 2025**

**FDA Recommends Removal of Voluntary Hold for Elevidys for Ambulatory Patients**

The FDA is recommending the removal of the voluntary hold for ambulatory patients who may now receive Elevidys, a Sarepta Therapeutics gene therapy for Duchenne muscular dystrophy (DMD). The FDA's investigation has concluded that the death of the 8-year-old boy is unrelated to the gene therapy product itself .

The FDA will continue to work with the sponsor regarding non-ambulatory patients, which remains subject to a voluntary hold, following 2 deaths. The patient community is an important voice, and the FDA will continue to listen to and respond to thoughts from the community impacted by DMD.

Elevidys is an adeno-associated virus vector-based gene therapy using Sarepta Therapeutics, Inc.'s AAVrh74 Platform Technology for the treatment of DMD. The product is administered as a single intravenous dose. DMD is a rare genetic condition characterized by progressive muscular weakness. The disease occurs due to a defective gene.

**FDA NEWS RELEASE**

**For Immediate Release: July 25, 2025**

**FDA Investigating Death of 8-Year-Old Boy Who Received Elevidys**

The FDA is investigating the death of an 8-year-old boy who received Elevidys, a Sarepta Therapeutics gene therapy for DMD. The death occurred on June 7, 2025. The FDA has requested and received voluntary suspension of product distribution as it investigates the safety concerns.

**FDA NEWS RELEASE**

**For Immediate Release: July 18, 2025**

# FDA Requests Sarepta Therapeutics Suspend Distribution of Elevidys and Places Clinical Trials on Hold for Multiple Gene Therapy Products Following 3 Deaths

The FDA announced it has placed Sarepta Therapeutics investigational gene therapy clinical trials for limb girdle muscular dystrophy (LGMD) on clinical hold following 3 deaths potentially related to these products and new safety concerns that the study participants are or would be exposed to an unreasonable and significant risk of illness or injury. The FDA has also revoked Sarepta's platform technology designation. The FDA leadership also met with Sarepta Therapeutics and requested it voluntarily stop all shipments of Elevidys today. The company refused to do so.

The 3 deaths appear to have been a result of acute liver failure in individuals treated with Elevidys or investigational gene therapy using the same AAVrh74 serotype that is used in Elevidys. One of the fatalities occurred during a clinical trial conducted under an investigational new drug application for the treatment of LGMD.

Elevidys is an adeno-associated virus vector-based gene therapy using Sarepta Therapeutics, Inc.'s AAVrh74 Platform Technology for the treatment of DMD. It is designed to deliver into the body a gene that leads to production of Elevidys micro-dystrophin, a shortened protein (138kDa, compared to the 427kDa dystrophin protein of normal muscle cells) that contains selected domains of the dystrophin protein present in normal muscle cells. The product is administered as a single intravenous dose.

DMD is a rare and serious genetic condition which worsens over time, leading to weakness and wasting away of the body's muscles. The disease occurs due to a defective gene that results in abnormalities in, or absence of, dystrophin.

The FDA revoked the platform technology designation for Sarepta's AAVrh74 Platform Technology because, among other things, given the new safety information, the preliminary evidence is insufficient to demonstrate that AAVrh74 Platform Technology has the potential to be incorporated in, or utilized by, more than 1 drug without an adverse effect on safety.

Elevidys received traditional approval for use in ambulatory DMD patients 4 years of age and older with a confirmed mutation in the *DMD* gene on June 20, 2024. It was approved for non-ambulatory patients on June 22, 2023 under the accelerated approval pathway. This pathway can allow earlier approval based on an effect on a surrogate endpoint or intermediate clinical endpoint that is reasonably likely to predict clinical benefit, while the company conducts confirmatory studies to verify the predicted clinical benefit. Continued approval for non-ambulatory patients is contingent upon verification and description of clinical benefit in a confirmatory trial. Given the new safety information, the FDA has

notified the company that the indication should be restricted to use in ambulatory patients. The FDA is committed to further investigating the safety of the product in ambulatory patients and will take additional steps to protect patients as needed.

The FDA is continuing to investigate the risk of acute liver failure with serious outcomes, including those such as hospitalization and death, following gene therapies using Sarepta's AAVrh74 Platform Technology, and the need for further regulatory actions.

**FDA NEWS RELEASE**

**For Immediate Release: July 10, 2025**

**FDA Embraces Radical Transparency by Publishing Complete Response Letters**

The FDA published more than 200 decision letters, known as complete response letters (CRLs). The CRLs were issued in response to applications submitted to the FDA for approval of drugs or biological products between 2020 and 2024, marking a significant step in the FDA's broader initiatives to modernize and increase transparency.

By making the CRLs available, the public now has significantly greater insight into the FDA's decision-making and the most common deficiencies cited that sponsors must address before their application is approved.

CRLs are issued directly to product sponsors when the FDA completes its review cycle and determines that it cannot grant approval of an application in its current form. The FDA issues CRLs for various reasons, most related to safety and efficacy concerns, manufacturing deficiencies, and bioequivalence issues. These deficiencies are detailed in the letter and may also include recommendations for addressing them.

Because the FDA has historically refrained from publishing CRLs for pending applications, sponsors often misrepresent the rationale behind FDA's decision to their stakeholders and the public. According to a 2015 analysis conducted by FDA researchers, sponsors avoided mentioning 85% of the FDA's concerns about safety and efficacy when announcing publicly that their application was not approved. Moreover, when FDA calls for a new clinical trial for safety or efficacy, that critical information is not disclosed approximately 40% of the time. Lessons learned from non-approvals are also not shared within the industry, leading companies to repeatedly make similar mistakes.

This initial batch of published decision letters associated with since-approved applications is now accessible to the public at openFDA (https://open.fda.gov/apis/other/approved_CRLs/). The CRLs were redacted for trade secrets and confidential commercial information. The FDA is in the process of publishing additional CRLs from its archives and is continuously exploring ways of providing the public with greater transparency into its decision-making process.

## Current Drug Shortages Index (as of July 30, 2025):

The information provided in this section is provided voluntarily to the FDA by manufacturers and is not specific to Oklahoma. Additional information regarding drug shortages can be found on the FDA website at: https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm.

| | |
|---|---|
| Albuterol Sulfate Solution | ***Currently in Shortage*** |
| Amino Acid Injection | ***Currently in Shortage*** |
| Amphetamine Aspartate Monohydrate, Amphetamine Sulfate, Dextroamphetamine Saccharate, Dextroamphetamine Sulfate Tablet | ***Currently in Shortage*** |
| Atropine Sulfate Injection | ***Currently in Shortage*** |
| Azacitidine Injection | ***Currently in Shortage*** |
| Bacitracin Ophthalmic Ointment | ***Currently in Shortage*** |
| Bumetanide Injection | ***Currently in Shortage*** |
| Bupivacaine Hydrochloride Injection | ***Currently in Shortage*** |
| Bupivacaine Hydrochloride, Epinephrine Bitartrate Injection | ***Currently in Shortage*** |
| Carboplatin Injection | ***Currently in Shortage*** |
| Cefotaxime Sodium Powder, for Solution | ***Currently in Shortage*** |
| Clindamycin Phosphate Injection | ***Currently in Shortage*** |
| Clonazepam Tablet | ***Currently in Shortage*** |
| Conivaptan Hydrochloride Injection | ***Currently in Shortage*** |
| Cromolyn Sodium Concentrate | ***Currently in Shortage*** |
| Desmopressin Acetate Spray | ***Currently in Shortage*** |
| Dexamethasone Sodium Phosphate Injection | ***Currently in Shortage*** |
| Dexmedetomidine Hydrochloride Injection | ***Currently in Shortage*** |
| Dextrose Monohydrate 10% Injection | ***Currently in Shortage*** |
| Dextrose Monohydrate 5% Injection | ***Currently in Shortage*** |
| Dextrose Monohydrate 50% Injection | ***Currently in Shortage*** |
| Dextrose Monohydrate 70% Injection | ***Currently in Shortage*** |
| Dextrose Monohydrate, Lidocaine Hydrochloride Anhydrous Injection | ***Currently in Shortage*** |
| Dobutamine Hydrochloride Injection | ***Currently in Shortage*** |
| Dopamine Hydrochloride Injection | ***Currently in Shortage*** |
| Echothiophate Iodide Ophthalmic Solution | ***Currently in Shortage*** |
| Epinephrine Bitartrate, Lidocaine Hydrochloride Injection | ***Currently in Shortage*** |
| Etomidate Injection | ***Currently in Shortage*** |
| Fentanyl Citrate Injection | ***Currently in Shortage*** |
| Flurazepam Hydrochloride Capsule | ***Currently in Shortage*** |
| Furosemide Injection | ***Currently in Shortage*** |

| | |
|---|---|
| Heparin Sodium Injection | ***Currently in Shortage*** |
| Hydrocortisone Sodium Succinate Injection | ***Currently in Shortage*** |
| Hydromorphone Hydrochloride Injection | ***Currently in Shortage*** |
| Hydroxocobalamin Injection | ***Currently in Shortage*** |
| Hydroxypropyl Cellulose (1600000 Wamw) Insert | ***Currently in Shortage*** |
| Indocyanine Green Injection | ***Currently in Shortage*** |
| Ketorolac Tromethamine Injection | ***Currently in Shortage*** |
| Lactated Ringers Injection | ***Currently in Shortage*** |
| Lidocaine Hydrochloride Injection | ***Currently in Shortage*** |
| Lidocaine Hydrochloride Solution | ***Currently in Shortage*** |
| Liraglutide Injection | ***Currently in Shortage*** |
| Lisdexamfetamine Dimesylate Capsule | ***Currently in Shortage*** |
| Lisdexamfetamine Dimesylate Tablet, Chewable | ***Currently in Shortage*** |
| Lorazepam Injection | ***Currently in Shortage*** |
| Mefloquine Hydrochloride Tablet | ***Currently in Shortage*** |
| Meperidine Hydrochloride Injection | ***Currently in Shortage*** |
| Methamphetamine Hydrochloride Tablet | ***Currently in Shortage*** |
| Methotrexate Sodium Injection | ***Currently in Shortage*** |
| Methylphenidate Film, Extended Release | ***Currently in Shortage*** |
| Methylphenidate Hydrochloride Tablet, Extended Release | ***Currently in Shortage*** |
| Methylprednisolone Acetate Injection | ***Currently in Shortage*** |
| Metronidazole Injection | ***Currently in Shortage*** |
| Midazolam Hydrochloride Injection | ***Currently in Shortage*** |
| Morphine Sulfate Injection | ***Currently in Shortage*** |
| Naltrexone Hydrochloride Tablet | ***Currently in Shortage*** |
| Nitroglycerin Injection | ***Currently in Shortage*** |
| Parathyroid Hormone Injection | ***Currently in Shortage*** |
| Peginterferon alfa-2a Injection | ***Currently in Shortage*** |
| Penicillin G Benzathine Injection | ***Currently in Shortage*** |
| Promethazine Hydrochloride Injection | ***Currently in Shortage*** |
| Propranolol Hydrochloride Injection | ***Currently in Shortage*** |
| Quinapril Hydrochloride Tablet | ***Currently in Shortage*** |
| Quinapril/Hydrochlorothiazide Tablet | ***Currently in Shortage*** |
| Remifentanil Hydrochloride Injection | ***Currently in Shortage*** |
| Rifampin Capsule | ***Currently in Shortage*** |
| Rifampin Injection | ***Currently in Shortage*** |
| Rifapentine Tablet, Film Coated | ***Currently in Shortage*** |
| Riluzole Oral Suspension | ***Currently in Shortage*** |
| Rocuronium Bromide Injection | ***Currently in Shortage*** |

| | |
|---|---|
| Ropivacaine Hydrochloride Injection | ***Currently in Shortage*** |
| Sodium Acetate Injection | ***Currently in Shortage*** |
| Sodium Bicarbonate Injection | ***Currently in Shortage*** |
| Sodium Chloride 0.9% Injection | ***Currently in Shortage*** |
| Somatropin Injection | ***Currently in Shortage*** |
| Sterile Water Injection | ***Currently in Shortage*** |
| Sterile Water Irrigant | ***Currently in Shortage*** |
| Streptozocin Powder, For Solution | ***Currently in Shortage*** |
| Sufentanil Citrate Injection | ***Currently in Shortage*** |
| Technetium TC-99M Pyrophosphate Kit Injection | ***Currently in Shortage*** |
| Triamcinolone Acetonide Injection | ***Currently in Shortage*** |
| Valproate Sodium Injection | ***Currently in Shortage*** |