

Drug Utilization Review Board



OKLAHOMA
Health Care Authority

**Wednesday,
January 8, 2025**

*No live meeting scheduled for January.
January 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 – January 8, 2025
DATE: January 1, 2025
NOTE: **No live January meeting. January 2025 is a packet-only meeting.**

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

DUR Board Meeting Minutes – Appendix A

Prenatal Vitamin (PNV) Utilization Update – Appendix B

Annual Review of Antihyperlipidemics and 30-Day Notice to Prior Authorize Tryngolza™ (Olezarsen) – Appendix C

Annual Review of Adrenocorticotrophic Hormone (ATCH) Products and 30-Day Notice to Prior Authorize Acthar® SelfJect™ (Corticotropin Auto-Injector) and Purified Cortrophin® Gel (Repository Corticotropin Injection) – Appendix D

Annual Review of Xgeva® (Denosumab) and 30-Day Notice to Prior Authorize Wyost® (Denosumab-bbdz) – Appendix E

Annual Review of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and 30-Day Notice to Prior Authorize Diflunisal 500mg Tablet, Dolobid™ (Diflunisal) 250mg and 375mg Tablet, and Indomethacin 50mg Suppository – Appendix F

Annual Review of Ophthalmic Antibiotic Medications – Appendix G

Annual Review of Gastrointestinal (GI) Cancer Medications and 30-Day Notice to Prior Authorize Tevimbra® (Tislelizumab-jsgr), Vyloy® (Zolbetuximab-clzb), and Ziihera® (Zanidatamab) – Appendix H

Annual Review of Miscellaneous Cancer Medications and 30-Day Notice to Prior Authorize Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension), Niktimvo™ (Axatilimab-csfr), Ojemda™ (Tovorafenib), Tecelra® (Afamitresgene Autoleucel), and Voranigo® (Vorasidenib) – Appendix I

Annual Review of Non-Malignant Solid Tumor Medications – Appendix J

Annual Review of Antihypertensive Medications and 30-Day Notice to Prior Authorize Labetalol Hydrochloride 400mg Tablet, Nexiclon™ XR [Clonidine Extended-Release (ER)], and Tryvio™ (Aprocitentan) – Appendix K

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

Future Business

Oklahoma Health Care Authority

Drug Utilization Review Board

(DUR Board)

Packet Meeting – January 8, 2025

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

AGENDA

Discussion and action on the following items:

Items to be presented by Dr. Haymore, Chairman:

1. DUR Board Meeting Minutes – See Appendix A

- A. December 11, 2024 DUR Board Meeting Minutes
- B. December 11, 2024 DUR Board Recommendations Memorandum
- C. Correspondence

Items to be presented by Dr. Moss, Dr. Haymore, Chairman:

2. Prenatal Vitamin (PNV) Utilization Update – See Appendix B

- A. Introduction
- B. Utilization of PNV
- C. College of Pharmacy Recommendations

Items to be presented by Dr. O'Halloran, Dr. Haymore, Chairman:

3. Annual Review of Antihyperlipidemics and 30-Day Notice to Prior Authorize Tryngolza™ (Olezarsen) – See Appendix C

- A. Current Prior Authorization Criteria
- B. Utilization of Antihyperlipidemics
- C. Prior Authorization of Antihyperlipidemics
- D. Market News and Updates
- E. Tryngolza™ (Olezarsen) Product Summary
- F. College of Pharmacy Recommendations
- G. Utilization Details of Antihyperlipidemics

Items to be presented by Dr. O'Halloran, Dr. Haymore, Chairman:

4. Annual Review of Adrenocorticotrophic Hormone (ACTH) Products and 30-Day Notice to Prior Authorize Acthar® SelfJect™ (Corticotropin Auto-Injector) and Purified Cortrophin® Gel (Repository Corticotropin Injection) – See Appendix D

- A. Current Prior Authorization Criteria
- B. Utilization of ACTH Products
- C. Prior Authorization of ACTH Products
- D. Market News and Updates
- E. College of Pharmacy Recommendations
- F. Utilization Details of ACTH Products

Items to be presented by Dr. Moss, Dr. Haymore, Chairman:

5. Annual Review of Xgeva® (Denosumab) and 30-Day Notice to Prior Authorize Wyost® (Denosumab-bbdz) – See Appendix E

- A. Current Prior Authorization Criteria
- B. Utilization of Xgeva® (Denosumab)
- C. Prior Authorization of Xgeva® (Denosumab)
- D. Market News and Updates
- E. College of Pharmacy Recommendations
- F. Utilization Details of Xgeva® (Denosumab)

Items to be presented by Dr. Wilson, Dr. Haymore, Chairman:

6. Annual Review of Systemic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and 30-Day Notice to Prior Authorize Diflunisal 500mg Tablet, Dolobid™ (Diflunisal) 250mg and 375mg Tablet, and Indomethacin 50mg Suppository – See Appendix F

- A. Current Prior Authorization Criteria
- B. Utilization of NSAIDs
- C. Prior Authorization of NSAIDs
- D. Market News and Updates
- E. Dolobid™ (Diflunisal) Product Summary
- F. Cost Comparison: Indomethacin Products
- G. College of Pharmacy Recommendations
- H. Utilization Details of NSAIDs

Items to be presented by Dr. Wilson, Dr. Haymore, Chairman:

7. Annual Review of Ophthalmic Antibiotic Medications – See Appendix G

- A. Current Prior Authorization Criteria
- B. Utilization of Ophthalmic Antibiotic Medications
- C. Prior Authorization of Ophthalmic Antibiotic Medications
- D. Market News and Updates
- E. College of Pharmacy Recommendations
- F. Utilization Details of Ophthalmic Antibiotic Medications

Items to be presented by Dr. Daugherty, Dr. Haymore, Chairman:

8. Annual Review of Gastrointestinal (GI) Cancer Medications and 30-Day Notice to Prior Authorize Tevimbra® (Tislelizumab-jsgr), Vyloy® (Zolbetuximab-clzb), and Ziihera® (Zanidatamab) – See Appendix H

- A. Current Prior Authorization Criteria
- B. Utilization of GI Cancer Medications
- C. Prior Authorization of GI Cancer Medications
- D. Market News and Updates
- E. Product Summaries
- F. College of Pharmacy Recommendations
- G. Utilization Details of GI Cancer Medications

Items to be presented by Dr. Daugherty, Dr. Haymore, Chairman:

9. Annual Review of Miscellaneous Cancer Medications and 30-Day Notice to Prior Authorize Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension), Niktimvo™ (Axatilimab-csfr), Ojemda™ (Tovorafenib), Tecelra® (Afamitresgene Autoleucel), and Voranigo® (Vorasidenib) – See Appendix I

- A. Current Prior Authorization Criteria
- B. Utilization of Miscellaneous Cancer Medications
- C. Prior Authorization of Miscellaneous Cancer Medications
- D. Market News and Updates
- E. Product Summaries
- F. College of Pharmacy Recommendations
- G. Utilization Details of Miscellaneous Cancer Medications

Items to be presented by Dr. Daugherty, Dr. Haymore, Chairman:

10. Annual Review of Non-Malignant Solid Tumor Medications – See Appendix J

- A. Current Prior Authorization Criteria
- B. Utilization of Non-Malignant Solid Tumor Medications
- C. Prior Authorization of Non-Malignant Solid Tumor Medications
- D. Market News and Updates
- E. College of Pharmacy Recommendations
- F. Utilization Details of Non-Malignant Solid Tumor Medications

Items to be presented by Dr. Metts, Dr. Haymore, Chairman:

11. Annual Review of Antihypertensive Medications and 30-Day Notice to Prior Authorize Labetalol Hydrochloride 400mg Tablet, Nexiclon™ XR [Clonidine Extended-Release (ER)], and Tryvio™ (Aprocitentan) – See Appendix K

- A. Current Prior Authorization Criteria
- B. Utilization of Antihypertensive Medications
- C. Prior Authorization of Antihypertensive Medications
- D. Market News and Updates
- E. Tryvio™ (Aprocitentan) Product Summary
- F. Cost Comparisons
- G. College of Pharmacy Recommendations
- H. Utilization Details of Antihypertensive Medications

Items to be presented by Dr. Metts, Dr. Haymore, Chairman:

12. U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates – See Appendix L

Items to be presented by Dr. Adams, Dr. Haymore, Chairman:

13. Future Business* (Upcoming Product and Class Reviews)

- A. Anti-Migraine Medications
- B. Cholestatic Liver Disease Medications

C. Heart Failure Medications

D. Thrombocytopenia Medications

*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. SoonerSelect PA data only includes medications billed as pharmacy claims (NDC) and does not include those billed as medical claims (HCPCS), where applicable.



**OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
MINUTES OF MEETING DECEMBER 11, 2024**

DUR BOARD MEMBERS:	PRESENT	ABSENT
Kenneth Foster, MHS, PA-C		X
Megan A. Hanner, D.O.		X
Bret Haymore, M.D.	X	
John Muchmore, M.D.; Ph.D.; Chairman	X	
Lee Muñoz, D.Ph.	X	
James Osborne, Pharm.D.	X	
Edna Patatanian, Pharm.D., FASHP; Interim Vice Chairwoman	X	
Vineetha Thomas, Pharm.D., BCOP	X	
Beth Walton, Pharm.D.	X	

COLLEGE OF PHARMACY STAFF:	PRESENT	ABSENT
Michyla Adams, Pharm.D.; DUR Manager	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
Michaela Metts, Pharm.D., MBA, BCPS; 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	
Chinemerem Opara, Pharm.D.; Pharmacy Resident	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: Tad Autry Pharm.D., BCPS, BCOP		X
Brooke Daugherty, Pharm. D., 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	
Conner Mulvaney, J.D.; Deputy General Counsel	X	
Traylor Rains; State Medicaid Director		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
Toney Welborn, M.D., MPH, MS; Medical Director	X	

OTHERS PRESENT:	
Brielle Dozier, Artia Solutions	Phil Lohec, Viatris
Matt John, Otsuka	Tina Hartmann, Arcutis
Gary Parenteau, Dexcom	Erik Schindler, Sanofi
Paul Ford, Johnson & Johnson	Matt Grewe, Leo Pharmaceuticals
Alison Davis, Galderma	John Suelzer, Leo Pharmaceuticals
Dana Mennen, Apellis	Mike Sullivan, Amgen
Janelle Raymond, Intra Bio	Craig Kupiec, Integris
Kimberly Burlison, Orchard Therapeutics	Julia Compton, Novartis
Michele Rayes, HypoPARAthyroidism Association	Patty Keating, HypoPARAthyroidism Association
Ron Abraham, Cencora	Sheleatha Taylor-Bristow
Vincent Lawler, Sanofi	Kristen Winters, Centene
Lindsey Walter	Tracey Maravilla, Ascendis Pharma
Heather Menken	Cherokee Menken
Drew Sligar, Novartis	JJ Roth, Mirum Pharma
Ronnie DePue, Axsome	Dan O'Donnell, Axsome
Patty Laster, BeiGene	Dana Bates, BeiGene
Chrystal Mayes, Sanofi	Jody White, Sanofi
Lauren Vermillion, Regeneron	David Prather, Novo Nordisk
Irene Chung, Aetna	Maya Gharfeh, Oklahoma Allergy and Asthma Society
Kathy Huynh, Southside Dermatology	

PRESENT FOR PUBLIC COMMENT:	
Maya Gharfeh, Oklahoma Allergy and Asthma Society	Kathy Huynh, Southside Dermatology
Ronnie DePue, Axsome Therapeutics	Drew Sligar, Novartis
Tracey Maravilla, Ascendis Pharma	

AGENDA ITEM NO. 1: CALL TO ORDER

1A: ROLL CALL

Dr. Muchmore called the meeting to order at 4:00pm. Roll call by Dr. Wilcox established the presence of a quorum. Following the roll call, Dr. Cothran and Ms. Buettner recognized Dr. Muchmore for his years of service as DUR Board chair.

ACTION: NONE REQUIRED

AGENDA ITEM NO. 2:

2A: AGENDA ITEM NO. 6

2B: AGENDA ITEM NO. 6

2C: AGENDA ITEM NO. 10

2D: AGENDA ITEM NO. 11

2E: AGENDA ITEM NO. 13

ACTION: NONE REQUIRED

PUBLIC COMMENT FORUM

DR. MAYA GHARFEH, MD, MPH

KATHY HUYNH, PA-C

RONNIE DEPUE

DREW SLIGAR

TRACEY MARAVILLA

AGENDA ITEM NO. 3:

APPROVAL OF DUR BOARD MEETING MINUTES

3A: NOVEMBER 13, 2024 DUR MINUTES – VOTE

Materials included in agenda packet; presented by Dr. Muchmore

Dr. Patatanian moved to approve; seconded by Dr. Muñoz

ACTION: MOTION CARRIED

**AGENDA ITEM NO. 4: UPDATE ON MEDICATION COVERAGE
AUTHORIZATION UNIT/ACADEMIC DETAILING (AD) PROGRAM UPDATE**

4A: PHARMACY HELPDESK ACTIVITY FOR OCTOBER 2024

4B: MEDICATION COVERAGE ACTIVITY FOR OCTOBER 2024

4C: AD PROGRAM UPDATE

Materials included in agenda packet; presented by Dr. Metts, Dr. Snyder

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: SOONERCARE MAINTENANCE DRUG LIST

5A: INTRODUCTION

5B: MAINTENANCE DRUG LIST

5C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Moss

ACTION: NONE REQUIRED

**AGENDA ITEM NO. 6: VOTE TO PRIOR AUTHORIZE EBGLYSS™
(LEBRIKIZUMAB) AND UPDATE THE APPROVAL CRITERIA FOR THE ATOPIC
DERMATITIS MEDICATIONS**

6A: MARKET NEWS AND UPDATES

6B: EBGLYSS™ (LEBRIKIZUMAB) PRODUCT SUMMARY

6C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Wilson

Dr. Patatanian moved to approve; seconded by Dr. Muñoz

ACTION: MOTION CARRIED

**AGENDA ITEM NO. 7: VOTE TO PRIOR AUTHORIZE OHTUVAYRE™
(ENSIFENTRINE) AND UPDATE THE APPROVAL CRITERIA FOR THE ASTHMA AND
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) MAINTENANCE
MEDICATIONS**

7A: MARKET NEWS AND UPDATES

7B: OHTUVAYRE™ (ENSIFENTRINE) PRODUCT SUMMARY

7C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. O'Halloran

Dr. Muñoz moved to approve; seconded by Dr. Patatanian

ACTION: MOTION CARRIED

**AGENDA ITEM NO. 8: VOTE TO PRIOR AUTHORIZE NEMLUVIO®
(NEMOLIZUMAB-ILTO)**

8A: MARKET NEWS AND UPDATES

8B: NEMLUVIO® (NEMOLIZUMAB-ILTO) PRODUCT SUMMARY

8C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Wilson

Dr. Patatanian moved to approve; seconded by Dr. Haymore

ACTION: MOTION CARRIED

**AGENDA ITEM NO. 9: ANNUAL REVIEW OF SKIN CANCER
MEDICATIONS**

9A: CURRENT PRIOR AUTHORIZATION CRITERIA

9B: UTILIZATION OF SKIN CANCER MEDICATIONS

9C: PRIOR AUTHORIZATION OF SKIN CANCER MEDICATIONS

9D: MARKET NEWS AND UPDATES

9E: COLLEGE OF PHARMACY RECOMMENDATIONS

9F: UTILIZATION DETAILS OF SKIN CANCER MEDICATIONS

Materials included in agenda packet; presented by Dr. Sinko
Dr. Thomas moved to approve; seconded by Dr. Patatanian

ACTION: MOTION CARRIED

AGENDA ITEM NO. 10: ANNUAL REVIEW OF ANTIDEPRESSANTS

10A: CURRENT PRIOR AUTHORIZATION CRITERIA

10B: UTILIZATION OF ANTIDEPRESSANTS

10C: PRIOR AUTHORIZATION OF ANTIDEPRESSANTS

10D: MARKET NEWS AND UPDATES

10E: COLLEGE OF PHARMACY RECOMMENDATIONS

10F: UTILIZATION DETAILS OF ANTIDEPRESSANTS

Materials included in agenda packet; presented by Dr. O'Halloran
Dr. Muñoz moved to approve; seconded by Dr. Patatanian

ACTION: MOTION CARRIED

AGENDA ITEM NO. 11: ANNUAL REVIEW OF COMPLEMENT INHIBITORS AND MISCELLANEOUS IMMUNOMODULATORY AGENTS AND 30-DAY NOTICE TO PRIOR AUTHORIZE BKEMV™ (ECULIZUMAB-AEEB), EPYSQLI® (ECULIZUMAB-AAGH), FABHALTA® (IPTACOPAN), PIASKY® (CROVALIMAB-AKKZ), AND VOYDEYA™ (DANICOPAN)

11A: CURRENT PRIOR AUTHORIZATION CRITERIA

11B: UTILIZATION OF COMPLEMENT INHIBITORS AND MISCELLANEOUS IMMUNOMODULATORY AGENTS

11C: PRIOR AUTHORIZATION OF COMPLEMENT INHIBITORS AND MISCELLANEOUS IMMUNOMODULATORY AGENTS

11D: MARKET NEWS AND UPDATES

11E: PRODUCT SUMMARIES

11F: COLLEGE OF PHARMACY RECOMMENDATIONS

11G: UTILIZATION DETAILS OF COMPLEMENT INHIBITORS AND MISCELLANEOUS IMMUNOMODULATORY AGENTS

Materials included in agenda packet; presented by Dr. Moss

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY

AGENDA ITEM NO. 12: ANNUAL REVIEW OF LYSOSOMAL STORAGE DISEASE MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE AQNEURSA™ (LEVACETYLLUCINE), LENMELDY™ (ATIDARSAGENE AUTOTEMCEL), AND MIPLYFFA™ (ARIMOCLOMOL)

12A: CURRENT PRIOR AUTHORIZATION CRITERIA

12B: UTILIZATION OF LYSOSOMAL STORAGE DISEASE MEDICATIONS

12C: PRIOR AUTHORIZATION OF LYSOSOMAL STORAGE DISEASE MEDICATIONS

12D: MARKET NEWS AND UPDATES

12E: PRODUCT SUMMARIES

12F: COLLEGE OF PHARMACY RECOMMENDATIONS

12G: UTILIZATION DETAILS OF LYSOSOMAL STORAGE DISEASE MEDICATIONS

Materials included in agenda packet; presented by Dr. Wilson

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY

AGENDA ITEM NO. 13: ANNUAL REVIEW OF PARATHYROID MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE YORVIPATH® (PALOPEGTERIPARATIDE)

13A: CURRENT PRIOR AUTHORIZATION CRITERIA

13B: UTILIZATION OF PARATHYROID MEDICATIONS

13C: PRIOR AUTHORIZATION OF PARATHYROID MEDICATIONS

13D: MARKET NEWS AND UPDATES

13E: YORVIPATH® (PALOPEGTERIPARATIDE) PRODUCT SUMMARY

13F: COLLEGE OF PHARMACY RECOMMENDATIONS

13G: UTILIZATION DETAILS OF PARATHYROID MEDICATIONS

Materials included in agenda packet; presented by Dr. O'Halloran

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY

AGENDA ITEM NO. 14: ANNUAL REVIEW OF OSTEOPOROSIS MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE JUBBONTI® (DENOSUMAB-BBDZ)

14A: CURRENT PRIOR AUTHORIZATION CRITERIA

14B: UTILIZATION OF OSTEOPOROSIS MEDICATIONS

14C: PRIOR AUTHORIZATION OF OSTEOPOROSIS MEDICATIONS

14D: MARKET NEWS AND UPDATES

14E: JUBBONTI® (DENOSUMAB-BBDZ) PRODUCT SUMMARY

14F: COLLEGE OF PHARMACY RECOMMENDATIONS

14G: UTILIZATION DETAILS OF OSTEOPOROSIS MEDICATIONS

Materials included in agenda packet; presented by Dr. Metts

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY

AGENDA ITEM NO. 15: U.S. FOOD AND DRUG ADMINISTRATION (FDA) AND DRUG ENFORCEMENT ADMINISTRATION (DEA) UPDATES

Materials included in agenda packet; presented by Dr. Metts

ACTION: NONE REQUIRED

AGENDA ITEM NO. 16: FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)

16A: ANTIHYPERLIPIDEMICS

16B: ANTIHYPERTENSIVE MEDICATIONS

16C: MISCELLANEOUS CANCER MEDICATIONS

16D: NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

*Future product and class reviews subject to change.

Materials included in agenda packet; presented by Dr. Adams

ACTION: NONE REQUIRED

AGENDA ITEM NO. 17: NOMINATION OF DUR BOARD OFFICERS

17A: NOMINATIONS AND APPROVAL OF DUR BOARD CHAIR AND VICE CHAIR

Dr. Haymore was nominated for DUR Board Chair by Dr. Patatanian; seconded by Dr. Muñoz

Dr. Patatanian was nominated for DUR Board Vice Chair by Dr. Muñoz; seconded by Dr. Walton

ACTION(S): MOTIONS CARRIED

AGENDA ITEM NO. 18: ADJOURNMENT

The meeting was adjourned at 6:11pm.



The University of Oklahoma

Health Sciences Center

COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

Memorandum

Date: December 13, 2024

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 December 11, 2024

Recommendation 1: Update on Medication Coverage Authorization Unit/Academic Detailing (AD) Program Update

NO ACTION REQUIRED.

Recommendation 2: SoonerCare Maintenance Drug List

NO ACTION REQUIRED.

Recommendation 3: Vote to Prior Authorize Ebglyss™ (Lebrikizumab) and Update the Approval Criteria for the Atopic Dermatitis Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Ebglyss™ (lebrikizumab-lbkz) with the following criteria (shown in red):

Ebglyss™ (Lebrikizumab-lbkz) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies or when those therapies are not advisable; and
2. Member must be 12 years of age or older and weigh ≥ 40 kg; and
3. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following

topical therapies (or have a contraindication or documented intolerance):

- a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
 - b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Member's body surface area (BSA) of atopic dermatitis involvement must be provided and the member must have a documented BSA involvement of $\geq 10\%$ (can apply to member's current BSA or a historical value prior to treatment); and
 5. A patient-specific, clinically significant reason the member cannot use Adbry® (tralokinumab-ldrm) and Dupixent® (dupilumab) must be provided; and
 6. Must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
 7. Requests for concurrent use of Ebglyss™ with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Ebglyss™ has not been studied in combination with other biologic therapies); and
 8. Initial approvals will be for a quantity limit override for the initial dosing for the duration of 16 weeks; and
 9. Reauthorization may be granted for the maintenance dosing of 250mg every 4 weeks for a duration of 1 year if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

The College of Pharmacy also recommends updating the Adbry® (tralokinumab-ldrm), Cibinqo® (abrocitinib), Dupixent® (dupilumab), and Rinvoq® (upadacitinib) approval criteria based on the recent FDA approvals and age expansion for Adbry®, as well as net costs and to be consistent with clinical practice (changes shown in red):

Adbry® (Tralokinumab-ldrm Injection) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies or when those therapies are not advisable; and
2. Member must be:
 - a. 12 ~~18~~ years of age or older for use of the prefilled syringe; ~~and~~ or
 - b. 18 years of age or older for use of the autoinjector; and
3. Member must have a documented trial within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following topical therapies (or have a contraindication or documented intolerance):

- a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
 - b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Member's body surface area (BSA) of atopic dermatitis involvement must be provided and the member must have a documented BSA involvement of $\geq 10\%$ (can apply to member's current BSA or a historical value prior to treatment); and
 5. Adbry® must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
 6. Requests for concurrent use of Adbry® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Adbry® has not been studied in combination with other biologic therapies); and
 7. Initial approvals will be for the duration of 16 weeks. Reauthorization may be granted for the duration of 1 year if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Cibinqo® (Abrocitinib) and Rinvoq® (Upadacitinib) Approval Criteria [Atopic Dermatitis (AD) Diagnosis]:

1. An FDA approved diagnosis of moderate-to-severe AD not adequately controlled with other systemic drug products, including biologics, or when those therapies are not advisable; and
2. For Cibinqo®, member must be 12 years of age or older; and
3. For Rinvoq®, member must be 12 years of age or older; and
4. Member must have a documented trial within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following topical therapies (or have a contraindication or documented intolerance):
 - a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
 - b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
5. Member must have a documented 16-week trial with Adbry® (tralokinumab-ldrm), ~~or~~ Dupixent® (dupilumab), or Ebglyss™ (lebrikizumab-lbkz) that resulted in inadequate response (or have a contraindication or documented intolerance); and
6. Member's body surface area (BSA) of atopic dermatitis involvement must be provided and the member must have a documented BSA involvement of $\geq 10\%$ (can apply to member's current BSA or a historical value prior to treatment); and

7. Requested medication must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
8. For Cibinqo[®], prescriber must verify the member will not use antiplatelet therapies (e.g., clopidogrel, prasugrel, ticagrelor) concurrently with Cibinqo[®], except for low-dose aspirin, during the first 3 months of treatment; and
9. Cibinqo[®] and Rinvoq[®] will not be approved for use in combination with other Janus kinas (JAK) inhibitors, biologic immunomodulators, or with other immunosuppressant medications; and
10. For Rinvoq[®], a patient-specific, clinically significant reason why the member cannot use Cibinqo[®] must be provided; and
11. Initial approvals will be for the duration of 3 months. Reauthorization may be granted for the duration of 1 year if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval; and
12. For Rinvoq[®], the maximum approvable dose for AD is 30mg once daily.

Dupixent[®] (Dupilumab Injection) Approval Criteria [Atopic Dermatitis Diagnosis]:

1. An FDA approved diagnosis of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies; and
2. Member must be 6 months of age or older; and
3. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):
 - a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
 - b. 1 topical calcineurin inhibitor [e.g., Elidel[®] (pimecrolimus), Protopic[®] (tacrolimus)]; and
4. Member's body surface area (BSA) of atopic dermatitis involvement must be provided and the member must have a documented BSA involvement of $\geq 10\%$ (can apply to member's current BSA or a historical value prior to treatment); and
5. A patient-specific, clinically significant reason the member cannot use Adbry[®] (tralokinumab-ldrm) must be provided; and
6. Dupixent[®] must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
7. Requests for concurrent use of Dupixent[®] with other biologic medications will be reviewed on a case-by-case basis and will require

- patient-specific information to support the concurrent use (Dupixent® has not been studied in combination with other biologic therapies); and
8. Initial approvals will be for the duration of 16 weeks. Reauthorization may be granted **for the duration of 1 year** if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Recommendation 4: Vote to Prior Authorize Ohtuvayre™ (Ensifentrine) and Update the Approval Criteria for the Asthma and Chronic Obstructive Pulmonary Disease (COPD) Maintenance Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Ohtuvayre™ (ensifentrine) with the following criteria (shown in red):

Ohtuvayre™ (Ensifentrine) Approval Criteria:

1. An FDA approved diagnosis of chronic obstructive pulmonary disease (COPD); and
2. Member must be 18 years of age or older; and
3. Member has moderate to severe disease [i.e., GOLD 2 or GOLD 3 airflow obstruction as demonstrated by forced expiratory volume in 1 second (FEV₁) ≥30% and <80% predicted] and is symptomatic [i.e., modified Medical Research Council (mMRC) dyspnea scale grade ≥2]; and
4. Member is inadequately controlled on dual or triple combination long-acting bronchodilator therapy (must have ≥3 claims for long-acting bronchodilators in the previous 6 months); and
5. Member must not be taking Daliresp® (roflumilast) concurrently with Ohtuvayre™; and
6. A quantity limit of 60 ampules (150mL) per 30 days will apply.

Next, the College of Pharmacy recommends the following changes to the Dupixent® (dupilumab) criteria based on the new FDA approval, age expansion, and to be consistent with clinical practice (changes shown in red):

Dupixent® (Dupilumab injection) Approval Criteria [Chronic Obstructive Pulmonary Disease (COPD) Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment of members with inadequately controlled COPD; and
2. Member must be 18 years of age or older; and
3. Member has moderate to severe disease [i.e., GOLD 2 or GOLD 3 airflow obstruction as demonstrated by forced expiratory volume in 1 second (FEV₁) ≥30% and <80% predicted] and is symptomatic [i.e., modified Medical Research Council (mMRC) dyspnea scale grade ≥2]; and
4. Member must have a blood eosinophil count of ≥300 cells/mcL (can apply to either a recent level or a historical level prior to treatment); and

5. Member must have experienced ≥ 2 moderate exacerbations (e.g., required treatment with systemic corticosteroids and/or antibiotics) or ≥ 1 severe exacerbation (e.g., required hospitalization or 24-hour observation in emergency department) in the last 12 months; and
6. Member is inadequately controlled on triple therapy combination [long-acting beta₂ agonist/long-acting muscarinic agonist/inhaled corticosteroid (LABA/LAMA/ICS)] used compliantly within the last 3-6 consecutive months, unless contraindicated; and
7. Prescriber must verify the member has been counseled on proper administration and storage of Dupixent®; and
8. Dupixent® must be prescribed by a pulmonologist or pulmonary specialist or the member must have been evaluated by a pulmonologist or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is a pulmonologist or pulmonary specialist); and
9. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval; and
10. Quantities approved must not exceed FDA recommended dosing requirements.

Dupixent® (Dupilumab Injection) Approval Criteria [Eosinophilic Phenotype Asthma or Oral Corticosteroid-Dependent Asthma Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment of members with moderate-to-severe eosinophilic phenotype asthma or oral corticosteroid-dependent asthma; and
2. Member must be 6 years of age or older; and
3. Member must meet 1 of the following:
 - a. Member must have a blood eosinophil count of ≥ 150 cells/mcL (can apply to either a recent level or in history prior to oral corticosteroid use); ~~and~~ or
 - b. Member must have had at least 2 asthma exacerbations requiring systemic corticosteroids within the last 12 months or require daily systemic corticosteroids despite compliant use of medium-to-high dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication; and
4. Member must have failed a medium-to-high dose ICS used compliantly within the last 3-6 consecutive months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
5. Member must have failed at least 1 other asthma controller medication used in addition to the medium-to-high dose ICS compliantly for at least the past 3 months; and
6. Prescriber must verify the member has been counseled on proper administration and storage of Dupixent®; and
7. Dupixent® must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an

- allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
8. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval; and
 9. Quantities approved must not exceed FDA recommended dosing requirements.

Dupixent® (Dupilumab Injection) Approval Criteria [Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP) Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment in adult members with inadequately controlled CRSwNP; and
2. Member must be ~~12~~ 18 years of age or older; and
3. Member must have a documented trial with an intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance); and
4. Member must meet 1 of the following:
 - a. Member has required prior sino-nasal surgery; or
 - b. Member has previously been treated with systemic corticosteroids in the past 2 years (or has a contraindication or documented intolerance); and
5. Dupixent® must be prescribed by an otolaryngologist, allergist, immunologist, or pulmonologist or the member must have been evaluated by an otolaryngologist, allergist, immunologist, or pulmonologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an otolaryngologist, allergist, immunologist, or pulmonologist); and
6. Member has symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management; and
7. Member has evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy; and
8. Member will continue to receive intranasal corticosteroid therapy, unless contraindicated; and
9. Prescriber must verify the member has been counseled on proper administration and storage of Dupixent®; and
10. Requests for concurrent use of Dupixent® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use; and
11. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval; and
12. A quantity limit of 2 syringes every 28 days will apply.

Dupixent® (Dupilumab injection) Approval Criteria [Eosinophilic Esophagitis (EoE) Diagnosis]:

1. An FDA approved diagnosis of eosinophilic esophagitis (EoE) defined as:
 - a. ~~The presence of clinical symptoms of EoE 2 or more episodes of dysphagia ≥ 2 times per week (i.e., dysphagia, emesis, epigastric pain); and~~
 - b. ~~Intraepithelial eosinophilia [≥ 15 eosinophils per high-power field (eos/hpf) in the esophagus] Member must have ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf); and~~
2. Member must be ~~17~~ 12 years of age or older and weigh ≥ 15 ~~40~~ kg; and
3. Dupixent® must be prescribed by a gastroenterologist, allergist, or immunologist, or the member must have been evaluated by a gastroenterologist, allergist, or immunologist within the last 12 months (or be an advanced care practitioner with a supervising physician who is a gastroenterologist, allergist, or immunologist); and
- ~~4. Member must have 2 or more episodes of dysphagia per week; and~~
- ~~5. Member must have ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf); and~~
6. Member must have documented trials for a minimum of 8 weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):
 - a. One high-dose proton pump inhibitor; and
 - b. One swallowed respiratory corticosteroid (e.g., budesonide); and
7. Requests for concurrent use of Dupixent® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use; and
8. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval; and
9. A quantity limit of 8mL (4 syringes) every 28 days will apply.

Dupixent® (Dupilumab) Approval Criteria [Prurigo Nodularis (PN) Diagnosis]:

1. An FDA approved diagnosis of PN for at least 3 months; and
2. Member must have a Worst-Itch Numeric Rating Scale (WI-NRS) score of ≥ 7 ; and
3. Member must have ≥ 20 PN lesions; and
4. Member must be 18 years of age or older; and
5. Dupixent® must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist for PN within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and

6. Prescriber must verify that all other causes of pruritus have been ruled out; and
7. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):
 - a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
 - b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
8. Requests for concurrent use of Dupixent® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Dupixent® has not been studied in combination with other biologic therapies); and
9. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Next, the College of Pharmacy recommends the following changes to the Fasenra® (benralizumab) criteria based on the new FDA approval, age expansion, and to be consistent with the FDA approved label and clinical practice and recommends the following changes to the approval criteria for Nucala (mepolizumab) based on net costs and to be consistent with clinical practice (changes shown in red):

Fasenra® (Benralizumab injection) Approval Criteria [Eosinophilic Granulomatosis with Polyangiitis (EGPA) Diagnosis]:

1. An FDA approved indication for the treatment of EGPA; and
2. Member must be 18 years of age or older; and
3. Member meets 1 of the following:
 - a. Member must have a past history of at least 1 confirmed EGPA relapse [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the past 12 months; or
 - b. Member must have refractory disease within the last 6 months following induction of standard treatment regimen administered compliantly for at least 3 months; and
4. Diagnosis of granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) will not be approved; and
5. Failure to achieve remission despite corticosteroid therapy (oral prednisone equivalent equal to or greater than 7.5mg/day) for a minimum of 4 weeks duration; and
6. Fasenra® must be prescribed by an allergist, pulmonologist, pulmonary specialist, or rheumatologist or the member must have been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist for EGPA within the last 12 months (or an advanced care practitioner

- with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist); and
7. For authorization of Fasentra[®] in a health care facility, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
 8. For authorization of Fasentra[®] prefilled autoinjector pen for self-administration, prescriber must verify the member or caregiver has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Fasentra[®]; and
 9. A quantity limit of 1 prefilled syringe or prefilled autoinjector pen per 28 days will apply.
 10. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval. For continued approval, member must be compliant, and prescriber must verify the member is responding to Fasentra[®] as demonstrated by a Birmingham Vasculitis Activity Score (BVAS) of 0 (zero), fewer EGPA relapses from baseline, or a decrease in daily OCS dose regimen from baseline.

Fasentra[®] (Benralizumab injection) Approval Criteria [Eosinophilic Phenotype Asthma Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment of members with severe eosinophilic phenotype asthma; and
2. Member must be ~~6~~ 12 years of age or older; and
3. Member must have a blood eosinophil count of ≥ 150 cells/mcL (can apply to either a recent level or in history prior to oral corticosteroid use); and
4. Member must have had at least 2 asthma exacerbations requiring systemic corticosteroids within the last 12 months or require daily systemic corticosteroids despite compliant use of medium-to-high dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication; and
5. Member must have failed a medium-to-high dose ICS used compliantly within the last 3-6 consecutive months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
6. Member must have failed at least 1 other asthma controller medication used in addition to the medium-to-high dose ICS compliantly for at least the past 3 months; and
7. For authorization of Fasentra[®] **in a health care facility** ~~prefilled syringe~~, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
8. For authorization of Fasentra[®] prefilled autoinjector pen **for self-administration**, prescriber must verify the member or caregiver has been trained by a health care professional on subcutaneous

administration, monitoring for any allergic reactions, and storage of Fasentra[®]; and

9. Fasentra must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
10. For members who require weight-based dosing, the member's recent weight, taken within the last 3 weeks, must be provided on the prior authorization request in order to authorize the appropriate dose according to package labeling; and
11. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval; and
12. A quantity limit of 1 prefilled syringe or prefilled autoinjector pen per 56 days will apply.

Nucala (Mepolizumab Injection) Approval Criteria [Eosinophilic Granulomatosis with Polyangiitis (EGPA) Diagnosis]:

1. An FDA approved diagnosis of EGPA; and
2. Member must be 18 years of age or older; and
3. Member meets 1 of the following:
 - a. Member must have a past history of at least 1 confirmed EGPA relapse [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the past 12 months; or
 - b. Member must have refractory disease within the last 6 months following induction of a standard treatment regimen administered compliantly for at least 3 months; and
4. Diagnosis of granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) will not be approved; and
5. Failure to achieve remission despite corticosteroid therapy (oral prednisone equivalent $\geq 7.5\text{mg/day}$) for a minimum of 4 weeks duration; and
6. Nucala must be prescribed by an allergist, pulmonologist, pulmonary specialist, or rheumatologist or the member must have been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist for EGPA within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist); and
7. For authorization of Nucala in a health care facility via, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
8. For authorization of Nucala prefilled autoinjector or prefilled syringe for self-administration, prescriber must verify the member or caregiver has been trained by a health care professional on subcutaneous

administration, monitoring for any allergic reactions, and storage of Nucala; and

9. A patient-specific, clinically significant reason why the member cannot use Fasenra® (benralizumab injection) must be provided; and
10. A quantity limit of 3 vials, prefilled autoinjectors, or prefilled syringes per 28 days will apply; and
11. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval. For continued approval, member must be compliant and prescriber must verify the member is responding to Nucala as demonstrated by a Birmingham Vasculitis Activity Score (BVAS) of 0 (zero), fewer EGPA relapses from baseline, or a decrease in daily OCS dosing from baseline.

Nucala (Mepolizumab Injection) Approval Criteria [Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP) Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment in adult members with inadequately controlled CRSwNP; and
2. Member must be 18 years of age or older; and
3. Member must have a documented trial with an intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance); and
4. Member must meet 1 of the following:
 - a. Member has required prior sino-nasal surgery; or
 - b. Member has previously been treated with systemic corticosteroids in the past 2 years (or has a contraindication or documented intolerance); and
5. Nucala must be prescribed by an otolaryngologist, allergist, immunologist, or pulmonologist or the member must have been evaluated by an otolaryngologist, allergist, immunologist, or pulmonologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an otolaryngologist, allergist, immunologist, or pulmonologist); and
6. Member has symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management; and
7. Member has evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy; and
8. Member will continue to receive intranasal corticosteroid therapy, unless contraindicated; and
9. For authorization of Nucala **in a health care facility via**, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
10. For authorization of Nucala prefilled autoinjector or prefilled syringe **for self-administration**, prescriber must verify the member or caregiver has been trained by a health care professional on subcutaneous

administration, monitoring for any allergic reactions, and storage of Nucala; and

11. Requests for concurrent use of Nucala with other biologic medications will be reviewed on a case-by-case basis and will require patient specific information to support the concurrent use; and
12. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval; and
13. A quantity limit of 1 vial, prefilled autoinjector, or prefilled syringe per 28 days will apply.

Nucala (Mepolizumab Injection) Approval Criteria [Eosinophilic Phenotype Asthma Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment of members with severe eosinophilic phenotype asthma; and
2. Member must be 6 years of age or older; and
3. Member must have a blood eosinophil count of ≥ 150 cells/mcL (can apply to either a recent level or in history prior to oral corticosteroid use); and
4. Member must have had at least 2 asthma exacerbations requiring systemic corticosteroids within the last 12 months or require daily systemic corticosteroids despite compliant use of medium-to-high dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication; and
5. Member must have failed a medium-to-high dose ICS used compliantly within the last 3-6 consecutive months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
6. Member must have failed at least 1 other asthma controller medication used in addition to the medium-to-high dose ICS compliantly for at least the past 3 months; and
7. For authorization of Nucala **in a health care facility via**, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
8. For authorization of Nucala prefilled autoinjector or prefilled syringe **for self-administration**, prescriber must verify the member or caregiver has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Nucala; and
9. Nucala must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and

10. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval; and
11. A quantity limit of 1 vial, prefilled autoinjector, or prefilled syringe per 28 days will apply.

Nucala (Mepolizumab Injection) Approval Criteria [Hypereosinophilic Syndrome (HES) Diagnosis]:

1. An FDA approved diagnosis of HES for ≥ 6 months without an identifiable non-hematologic secondary cause; and
2. Member must be 12 years of age or older; and
3. Member must have a past history of at least 2 confirmed HES flares [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of cytotoxic or immunosuppressive therapy, or hospitalization] within the past 12 months; and
4. Member must have a baseline blood eosinophil count of $\geq 1,000$ cells/mcL in the last 4 weeks prior to initiating Nucala; and
5. Diagnosis of FIP1L1-PDGFR α kinase-positive HES will not be approved; and
6. Failure to achieve remission despite corticosteroid therapy (oral prednisone equivalent ≥ 10 mg/day) for a minimum of 4 weeks duration or member is unable to tolerate corticosteroid therapy due to significant side effects from corticosteroid therapy; and
7. Nucala must be prescribed by a hematologist or a specialist with expertise in treatment of HES (or an advanced care practitioner with a supervising physician who is a hematologist or a specialist with expertise in treatment of HES); and
8. For authorization of Nucala **in a health care facility via**, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
9. For authorization of Nucala prefilled autoinjector or prefilled syringe **for self-administration**, prescriber must verify the member or caregiver has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Nucala; and
10. A quantity limit of 3 vials, prefilled autoinjectors, or prefilled syringes per 28 days will apply; and
11. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval. For continued approval, member must be compliant and prescriber must verify the member is responding to Nucala as demonstrated by fewer HES flares from baseline or a decrease in daily OCS dosing from baseline.

Additionally, the College of Pharmacy recommends the following changes to the Xolair® (omalizumab) criteria based on the new FDA approval and to be consistent with clinical practice and recommends the following changes to

the Tezspire® (tezepelumab-ekko) approval criteria to be consistent with clinical practice (changes shown in red):

Xolair® (Omalizumab) Approval Criteria [Immunoglobulin E (IgE)-Mediated Food Allergy Diagnosis]:

1. An FDA approved diagnosis of IgE-mediated food allergy for the reduction of allergic reactions; and
2. Member must be 1 year of age or older; and
3. Member must have a diagnosis of peanut, milk, egg, wheat, cashew, hazelnut, or walnut allergy confirmed by a positive skin test, positive in vitro test for food-specific IgE, or positive clinician-supervised oral food challenge (documentation of allergy testing results must be submitted); and
4. Prescriber must confirm member will use Xolair® with an allergen-avoidant diet; and
5. Member must have a pretreatment serum IgE level between 30 and 1,850 IU/mL; and
6. Member's weight must be between 10kg and 150kg; and
7. Member or family member must be trained in the use of an auto-injectable epinephrine device and have such a device available for immediate use at all times; and
8. Prescribed Xolair® dose must be an FDA approved regimen per package labeling; and
9. For authorization of Xolair® in a health care facility, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; or
10. For authorization of Xolair® prefilled autoinjector or prefilled syringe for self-administration, prescriber must verify the following:
 - a. Member has no prior history of anaphylaxis; and
 - b. Member must have had at least 3 doses of Xolair® under the guidance of a health care provider with no hypersensitivity reactions; and
 - c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Xolair®; and
11. Xolair® must be prescribed by an allergist or immunologist or the member must have been evaluated by an allergist or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist or immunologist); and
12. Approvals will be for the duration of 1 year. Reauthorization may be granted if the prescriber documents the member is responding well to therapy. Additionally, compliance will be evaluated for continued approval.

Xolair® (Omalizumab Injection) Approval Criteria [Asthma Diagnosis]:

1. Diagnosis of severe persistent asthma [as per National Asthma Education and Prevention Program (NAEPP) guidelines]; and
2. Member must be between 6 and 75 years of age; and
3. Member must have a positive skin test to at least 1 perennial aeroallergen (positive perennial aeroallergens must be listed on the prior authorization request); and
4. Member must have a pretreatment serum IgE level between 30 and 1,300 IU/mL (depending on member age); and
5. Member's weight must be between 20kg and 150kg; and
6. Member must have failed a medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
7. Prescribed Xolair® dose must be an FDA approved regimen per package labeling; and
8. For authorization of Xolair® ~~vial~~ **in a health care facility**, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; ~~or and~~
9. For authorization of Xolair® prefilled autoinjector or prefilled syringe **for self-administration**, prescriber must verify the following:
 - a. Member has no prior history of anaphylaxis; and
 - b. Member must have had at least 3 doses of Xolair® under the guidance of a health care provider with no hypersensitivity reactions; and
 - c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Xolair®; and
10. Xolair® must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
11. Member must have been in the emergency room (ER) or hospitalized, due to an asthma exacerbation, twice in the past 12 months (date of visits must be listed on the prior authorization request), or member must have been determined to be dependent on systemic corticosteroids to prevent serious exacerbations; and
12. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval.

Xolair® (Omalizumab Injection) Approval Criteria [Chronic Idiopathic Urticaria (CIU) Diagnosis]:

1. An FDA approved diagnosis of CIU; and
2. Member must be 12 years of age or older; and
3. Other forms of urticaria must be ruled out; and

4. Other potential causes of urticaria must be ruled out; and
5. Member must have an Urticaria Activity Score (UAS) ≥ 16 ; and
6. For authorization of Xolair® ~~vial~~ **in a health care facility**, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; ~~or and~~
7. For authorization of Xolair® prefilled autoinjector or prefilled syringe **for self-administration**, prescriber must verify the following:
 - a. Member has no prior history of anaphylaxis; and
 - b. Member must have had at least 3 doses of Xolair® under the guidance of a health care provider with no hypersensitivity reactions; and
 - c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Xolair®; and
8. Prescriber must be an allergist, immunologist, or dermatologist (or an advanced care practitioner with a supervising physician that is an allergist, immunologist, or dermatologist); and
9. A trial of a second-generation antihistamine dosed at 4 times the maximum FDA dose within the last 3 months for at least 4 weeks (or less if symptoms are intolerable); and
10. Initial dosing will only be approved for 150mg every 4 weeks. If the member has inadequate results at this dose, then the dose may be increased to 300mg every 4 weeks; and
11. Initial approvals will be for the duration of 3 months at which time compliance will be evaluated for continued approval.

Xolair® (Omalizumab Injection) Approval Criteria [Nasal Polyps Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment of nasal polyps in adult members with inadequate response to nasal corticosteroids; and
2. Member must be 18 years of age or older; and
3. Member must have a trial of intranasal corticosteroids for at minimum the past 4 weeks; and
4. Prescriber must verify member will continue to receive intranasal corticosteroid therapy, unless contraindicated; and
5. Member has symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management; and
6. Member has evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy; and
7. Member must have a pretreatment serum IgE level between 30 and 1,500 IU/mL; and
8. Member's weight must be between 31kg and 150kg; and
9. Prescribed Xolair® dose must be an FDA approved regimen per package labeling; and

10. For authorization of Xolair® ~~vial~~ **in a health care facility**, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; ~~or and~~
11. For authorization of Xolair® prefilled autoinjector or prefilled syringe **for self-administration**, prescriber must verify the following:
 - a. Member has no prior history of anaphylaxis; and
 - b. Member must have had at least 3 doses of Xolair® under the guidance of a health care provider with no hypersensitivity reactions; and
 - c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Xolair®; and
12. Xolair® must be prescribed by an otolaryngologist, allergist, immunologist, or pulmonologist or the member must have been evaluated by an otolaryngologist, allergist, immunologist, or pulmonologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an otolaryngologist, allergist, immunologist, or pulmonologist); and
13. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Tezspire® (Tezepelumab-ekko) Approval Criteria:

1. An FDA approved diagnosis of add-on maintenance treatment for severe asthma; and
2. Member must be 12 years of age or older; and
3. Member must have experienced ≥ 2 asthma exacerbations requiring oral or injectable corticosteroids or that resulted in hospitalization in the last 12 months; and
4. Member must have failed a medium-to-high dose inhaled corticosteroid (ICS) used compliantly within the last 3-6 consecutive months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
5. Member must have failed at least 1 other asthma controller medication used in addition to the medium-to-high dose ICS compliantly for at least the past 3 months; and
6. For authorization of Tezspire® **in a health care facility ~~vial~~ or pre-filled syringe**, prescriber must verify that the injection will be administered by a health care provider prepared to manage anaphylaxis; ~~or and~~
7. For authorization of Tezspire® pre-filled pen **for self-administration**, prescriber must verify that the injection will be administered by a health care provider prepared to manage anaphylaxis or the member or caregiver has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Tezspire®; and

8. Tezspire® must be prescribed by a pulmonologist or pulmonary specialist, or the member must have been evaluated by a pulmonologist or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is a pulmonologist or pulmonary specialist); and
9. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval; and
10. A quantity limit of 1.91mL (1 single-dose glass vial or single-dose pre-filled syringe) per 28 days will apply.

Finally, the College of Pharmacy recommends the following changes to the Asthma and COPD Maintenance Medications Product Based Prior Authorization (PBPA) category (changes noted in red in the following PBPA Tier charts and criteria):

1. Creation of Tier-1 approval criteria based on the member's age; and
2. Removing the prior authorization of Wixela Inhub® (fluticasone/salmeterol inhalation powder) based on net costs; and
3. Moving Alvesco® (ciclesonide) and fluticasone propionate (generic Flovent®) from Tier-1 to Tier-2 based on net costs; and
4. Moving QVAR® RediHaler® (beclomethasone dipropionate) from Tier-2 to Tier-1 based on net costs; and
5. Removal of ArmonAir® Digihaler® (fluticasone propionate) and AirDuo® Digihaler® (fluticasone propionate/salmeterol) due to product discontinuations; and
6. The prior authorization of formoterol fumarate nebulizer solution kit and placement into Tier-2 of the long-acting beta₂ agonists (LABA) and long-acting muscarinic antagonists (LAMA) category.

Inhaled Corticosteroids (ICS) and Combination Products	
Tier-1	Tier-2*
beclomethasone dipropionate (QVAR® RediHaler®)	beclomethasone dipropionate (QVAR® RediHaler®)
budesonide (Pulmicort Flexhaler®)	budesonide/formoterol (Symbicort Aerosphere®)
budesonide/formoterol (Symbicort®) ^β – Brand Preferred	ciclesonide (Alvesco®)
ciclesonide (Alvesco®)	fluticasone propionate (Flovent®)
fluticasone furoate (Arnuity® Ellipta®)	fluticasone furoate/vilanterol (Breo® Ellipta®) – Brand Preferred
fluticasone propionate (Flovent®)	fluticasone propionate (ArmonAir® Digihaler®)
fluticasone propionate/salmeterol (Advair®) ^α	fluticasone propionate/salmeterol (AirDuo® Digihaler®)
mometasone furoate (Asmanex®)	fluticasone propionate/salmeterol (AirDuo RespiClick®)
mometasone furoate/formoterol (Dulera®) ^δ	mometasone furoate/formoterol 50mcg/5mcg (Dulera®)

Tier 1 products indicated for the member's age are covered with no prior authorization required.

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).

*Unique criteria apply to each Tier-2 product.

^β Does not include Breyne[®]; authorization of Breyne[®] requires a reason why the member cannot use the brand formulation (Symbicort[®]).

~~^α Does not include Wixela Inhub[®]; authorization of Wixela Inhub[®] requires a reason why the member cannot use the brand formulation (Advair[®]) or other generic formulations of fluticasone propionate/salmeterol.~~

[°] Includes all strengths other than Dulera[®] 50mcg/5mcg.

Inhaled Corticosteroids (ICS) and Combination Products Tier-1 Approval Criteria:

1. Tier-1 products indicated for the member's age are covered with no prior authorization required; or
2. Tier-1 products will be approved for members younger than the FDA approved age range if prescribed by a pulmonologist, immunologist, or an allergist (or a mid-level practitioner supervised by a pulmonologist, immunologist, or an allergist).

AirDuo[®] Digihaler[®] (Fluticasone Propionate/Salmeterol Inhalation Powder) Approval Criteria:

- ~~1. An FDA approved diagnosis of asthma; and~~
- ~~2. Member must be 12 years of age or older; and~~
- ~~3. A patient specific, clinically significant reason why the member requires AirDuo[®] Digihaler[®] over AirDuo RespiClick[®] and all preferred Tier 1 inhaled corticosteroid (ICS) and long acting beta₂ agonist (ICS/LABA) products (Advair[®], Dulera[®], and Symbicort[®]) must be provided; and~~
- ~~4. Failure of Advair[®], Dulera[®], and Symbicort[®] or a reason why Advair[®], Dulera[®], and Symbicort[®] are not appropriate for the member must be provided; and~~
- ~~5. Member must have used an ICS for at least 1 month immediately prior; and~~
- ~~6. Member must be considered uncontrolled by provider [required rescue medication >2 days a week (not for prevention of exercise induced bronchospasms) and/or needed oral systemic corticosteroids]; or~~
- ~~7. A clinical situation warranting initiation with combination therapy due to severity of asthma; and~~
- ~~8. Prescriber agrees to closely monitor member adherence; and~~
- ~~9. Member should be capable and willing to use the Companion Mobile App and to follow the Instructions for Use, and member must ensure the Digihaler[®] Companion Mobile App is compatible with their specific smartphone; and~~
- ~~10. Member's phone camera must be functional and able to scan the inhaler QR code and register the AirDuo[®] Digihaler[®] inhaler; and~~
- ~~11. Approvals will be for the duration of 3 months. For continuation consideration, documentation demonstrating positive clinical response and member compliance >80% with prescribed maintenance therapy must be provided. In addition, a patient specific, clinically significant~~

reason why the member cannot transition to Tier-1 medications must be provided. Tier structure rules continue to apply.

ArmonAir® Digihaler® (Fluticasone Propionate Inhalation Powder)

Approval Criteria:

1. An FDA approved diagnosis of asthma; and
2. Member must be 12 years of age or older; and
3. A patient specific, clinically significant reason why Flovent® (fluticasone propionate) and other preferred monotherapy inhaled corticosteroids (ICS) are not appropriate for the member must be provided; and
4. The prescriber agrees to closely monitor member adherence; and
5. The member should be capable and willing to use the Companion Mobile App and to follow the Instructions for Use, and member must ensure the Digihaler® Companion Mobile App is compatible with their specific smartphone; and
6. The member's phone camera must be functional and able to scan the inhaler QR code and register the ArmonAir® Digihaler® inhaler; and
7. Approvals will be for the duration of 3 months. For continuation consideration, documentation demonstrating positive clinical response and member compliance >80% with prescribed maintenance therapy must be provided. In addition, a patient specific, clinically significant reason why the member cannot transition to Tier-1 medications must be provided. Tier structure rules continue to apply.

Alvesco® (Ciclesonide) and Fluticasone Propionate (Generic Flovent®)

QVAR® RediHaler® (Beclomethasone Dipropionate) Approval Criteria:

1. An FDA approved diagnosis of asthma; and
2. Member must be at the age indicated for the requested product:
 - a. QVAR® RediHaler®: Member must be 4 years of age or older; and
3. A trial of all available Tier-1 inhaled corticosteroids appropriate to the members' age or a patient-specific, clinically significant reason why they are not appropriate for the member must be provided.

Wixela Inhub® (Fluticasone/Salmeterol Inhalation Powder) Approval Criteria:

1. A patient specific, clinically significant reason why the member cannot use the brand formulation (Advair® Diskus®), or other generic formulations (fluticasone/salmeterol) must be provided (brand formulation and other generics are preferred and do not require prior authorization).

Long-Acting Beta ₂ Agonists (LABA) and Long-Acting Muscarinic Antagonists (LAMA)	
Tier-1	Tier-2
Long-Acting Beta₂ Agonists* (LABA)	
salmeterol inhalation powder (Serevent®)	arformoterol nebulizer solution (Brovana®)

Long-Acting Beta ₂ Agonists (LABA) and Long-Acting Muscarinic Antagonists (LAMA)	
Tier-1	Tier-2
	formoterol nebulizer solution (Perforomist®)
	formoterol nebulizer solution kit
	olodaterol inhalation spray (Striverdi® Respimat®)
Long-Acting Muscarinic Antagonists (LAMA)	
aclidinium inhalation powder (Tudorza® PressAir®)	revefenacin inhalation solution (Yupelri®)
tiotropium inhalation powder (Spiriva® HandiHaler®) – Brand Preferred	
tiotropium soft mist inhaler (Spiriva® Respimat®)	
umeclidinium inhalation powder (Incruse® Ellipta®)	

*Tier-1 combination products that contain a long-acting beta₂ agonist (LABA) qualify for the LABA trial requirement.

Tier-1 medications do not require prior authorization.

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).

Recommendation 5: Vote to Prior Authorize Nemluvio® (Nemolizumab-ilto)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Nemluvio® (nemolizumab-ilto) with the following criteria (shown in red):

Nemluvio® (Nemolizumab-ilto) Approval Criteria [Prurigo Nodularis (PN) Diagnosis]:

1. An FDA approved diagnosis of PN for at least 3 months; and
2. Member must have severe pruritus as defined by a Peak Pruritus Numeric Rating Scale (PP-NRS) score of ≥ 7 ; and
3. Member must have ≥ 20 PN lesions; and
4. Member must be 18 years of age or older; and
5. Must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist for PN within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
6. Prescriber must verify that all other causes of pruritus have been ruled out; and
7. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):

- a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
- b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
- 8. A patient-specific, clinically significant reason why the member cannot use Dupixent® (dupilumab) must be provided; and
- 9. Requests for concurrent use of Nemluvio® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Nemluvio® has not been studied in combination with other biologic therapies); and
- 10. The member's recent weight must be provided, and approval quantities will be based on the FDA approved dosing regimen; and
- 11. Initial approvals will be for the duration of 16 weeks. Reauthorization (for a duration of 1 year) may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Recommendation 6: Annual Review of Skin Cancer Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends updating the approval criteria for Keytruda® (pembrolizumab) and Opdivo® (nivolumab) based on recent FDA approvals (new criteria and changes shown in red):

Keytruda® (Pembrolizumab) Approval Criteria [Endometrial Cancer Diagnosis]:

- 1. Member has not previously failed other PD-1 inhibitors [e.g., Opdivo (nivolumab)]; and
- 2. Disease progression following prior systemic therapy; and
 - a. Member is not a candidate for curative surgery or radiation; and
 - b. Used in 1 of the following settings:
 - i. In combination with lenvatinib for advanced endometrial cancer that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); or
 - ii. As a single agent for advanced endometrial cancer that is MSI-H or dMMR; or
- 3. Primary advanced (newly diagnosed stage III/IVA or stage IVB) or recurrent endometrial cancer; and
 - a. Used in combination with carboplatin and paclitaxel followed by single-agent maintenance pembrolizumab.

Keytruda® (Pembrolizumab) Approval Criteria [Mesothelioma Diagnosis]:

- 1. Diagnosis of unresectable advanced or metastatic malignant pleural mesothelioma; and
- 2. Used as first-line therapy in adult members; and
- 3. Used in combination with pemetrexed and platinum chemotherapy.

Opdivo® (Nivolumab) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of NSCLC; and
2. For first-line therapy for recurrent, advanced, or metastatic disease, meeting the following:
 - a. Used in combination with Yervoy® (ipilimumab) and 2 cycles of platinum-doublet chemotherapy; and
 - b. No epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations; and
 - c. Expresses programmed death ligand 1 (PD-L1) $\geq 1\%$; or
3. For first-line therapy for resectable disease ($>4\text{cm}$ or node positive), meeting the following:
 - a. Used in the neoadjuvant setting in combination with platinum-doublet chemotherapy for up to 3 treatment cycles; or
4. For resectable disease (tumors $\geq 4\text{cm}$ or node positive), meeting the following:
 - a. Used in the neoadjuvant setting in combination with platinum-doublet chemotherapy, followed by single-agent nivolumab as adjuvant treatment after surgery; and
 - b. No known EGFR mutations or ALK rearrangements; or
5. For second-line therapy for metastatic disease, meeting the following:
 - a. Tumor histology is 1 of the following:
 - i. Adenocarcinoma; or
 - ii. Squamous cell; or
 - iii. Large cell; and
 - b. Disease progression on or after platinum-containing chemotherapy (e.g., cisplatin, carboplatin); and
 - c. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; and
 - d. Used as a single agent; and
 - e. Dose as follows: 240mg every 2 weeks or 480mg every 4 weeks.

Opdivo® (Nivolumab) Approval Criteria [Urothelial Bladder Cancer Diagnosis]:

1. Diagnosis of urothelial carcinoma; and
 - a. Member has undergone radical resection; and
 - b. Disease is at high risk of recurrence; or
2. Diagnosis of metastatic or unresectable locally advanced disease; and
 - a. Used as second-line or greater therapy; and
 - b. Previous failure of a platinum-containing regimen; and
 - c. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; or
3. Diagnosis of metastatic or unresectable urothelial carcinoma; and
 - a. Used as first-line therapy; and
 - b. In combination with cisplatin and gemcitabine.

Lastly, the College of Pharmacy recommends updating the Keytruda® (pembrolizumab), Libtayo® (cemiplimab-rwlc), Opdivo® (nivolumab), Yervoy® (ipilimumab), and Zelboraf® (vemurafenib) approval criteria based on National Comprehensive Cancer Network (NCCN) recommendations (changes and new criteria shown in red):

Keytruda® (Pembrolizumab) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of locally recurrent unresectable or metastatic triple-negative breast cancer; and
 - a. Tumors express programmed death ligand 1 (PD-L1) with a combined positive score (CPS) ≥ 10 ; and
 - b. Used in combination with chemotherapy; or
2. Diagnosis of early stage triple-negative breast cancer; and
 - a. Disease is considered high-risk; and
 - b. Used in combination with chemotherapy as neoadjuvant therapy **and may be continued as a single agent as adjuvant treatment after surgery.**

Keytruda® (Pembrolizumab) Approval Criteria [Cervical Cancer Diagnosis]:

1. Diagnosis of recurrent or metastatic cervical cancer; and
 - a. Tumor must express programmed death ligand 1 (PD-L1) [combined positive score (CPS) ≥ 1]; and
 - b. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
 - i. Disease progression on or after chemotherapy; or
 - ii. As first-line therapy in combination with chemotherapy, with or without bevacizumab; or
 - iii. **As second line or subsequent therapy as a single agent; or**
2. Diagnosis of FIGO Stage III-IV cervical cancer; and
 - a. Used in combination with concomitant chemotherapy and radiation.

Keytruda® (Pembrolizumab) Approval Criteria [Classical Hodgkin Lymphoma (cHL) Diagnosis]:

1. Member has not previously failed other programmed death 1 (PD-1) inhibitors [i.e., Opdivo® (nivolumab)]; and
2. For adult members:
 - a. Diagnosis of relapsed or refractory cHL; and
 - i. Used as a single agent; or
 - ii. Exception: lymphocyte-predominant Hodgkin lymphoma; or
 - iii. Used in Second-line or subsequent systemic therapy in combination with gemcitabine, vinorelbine, and liposomal doxorubicin **(GVD) or ifosfamide, carboplatin, and etoposide (ICE); or**
3. For pediatric members:
 - a. Used as a single agent; and
 - b. Diagnosis of refractory cHL; or

- c. Relapsed disease after ≥ 2 therapies; or
- d. Decrease in cardiac function is observed.

Keytruda® (Pembrolizumab) Approval Criteria [Urothelial Carcinoma Diagnosis]:

1. Member must have 1 of the following:
 - a. As a single agent for locally advanced or metastatic urothelial carcinoma with disease progression during or following platinum-containing chemotherapy; or
 - b. As a single agent within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy; or
 - c. As a single agent frontline for members with locally advanced or metastatic urothelial carcinoma who are ineligible for cisplatin-containing chemotherapy or any platinum-containing chemotherapy; and
 - i. Cisplatin ineligibility is defined as:
 1. Baseline creatinine clearance of < 60 mL/min; or
 2. ECOG performance status of 2; or
 3. Class III heart failure; or
 4. Grade 2 or greater peripheral neuropathy; or
 5. Grade 2 or greater hearing loss; or
 - d. In combination with enfortumab vedotin-ejfv for locally advanced or metastatic urothelial carcinoma; and
2. Member has not previously failed other programmed death 1 (PD-1) inhibitors [i.e., Opdivo® (nivolumab)].

Libtayo® (Cemiplimab-rwlc) Approval Criteria [Cervical, Vaginal, or Vulvar Cancer Diagnosis]:

1. Diagnosis of recurrent or metastatic cervical, vaginal, or vulvar cancer; and
2. Used as second-line or subsequent therapy; and
3. Used as a single agent; and
4. Member has not received prior immunotherapy agent(s) [e.g., Keytruda® (pembrolizumab), Opdivo® (nivolumab), Yervoy® (ipilimumab)].

Opdivo® (Nivolumab) Approval Criteria [Hodgkin Lymphoma Diagnosis]:

1. Diagnosis of relapsed or refractory classical Hodgkin lymphoma; and
 - a. Exception: lymphocyte-predominant HL
2. Nivolumab must be used in 1 of the following settings:
 - a. As a single-agent; or
 - b. In combination with doxorubicin, vinblastine, and dacarbazine (AVD) for primary systemic therapy in stage III-IV disease; or
 - c. In combination with brentuximab vedotin as second line or subsequent therapy after failure of autologous stem cell transplant (SCT), allogeneic SCT, or those who are transplant-ineligible; and

3. Member has not previously failed other PD-1 inhibitors [e.g., Keytruda® (pembrolizumab)].

Opdivo® (Nivolumab) Approval Criteria [Small Cell Lung Cancer (SCLC) Diagnosis]:

1. Must meet 1 of the following criteria:
 - a. Disease relapsed within 6 months of initial chemotherapy; or
 - b. Disease is progressive on initial chemotherapy; and
2. Used as a single agent ~~or in combination with ipilimumab~~; and
3. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)].

~~**Yervoy® (Ipilimumab) Approval Criteria [Small Cell Lung Cancer (SCLC) Diagnosis]:**~~

- ~~1. Diagnosis of SCLC; and~~
- ~~2. Must meet 1 of the following criteria:~~
 - ~~a. Disease relapsed within 6 months of initial chemotherapy; or~~
 - ~~b. Disease is progressive on initial chemotherapy; and~~
- ~~3. Used in combination with nivolumab.~~

Zelboraf® (Vemurafenib) Approval Criteria [Hairy-Cell Leukemia Diagnosis]:

1. Diagnosis of hairy-cell leukemia; and
 - a. Used as a single agent; and
 - i. Disease progression following failure of purine analog therapy (i.e., pentostatin, cladribine); ~~or~~
 - b. ~~Used in combination with rituximab or obinutuzumab for patients who are not candidates for purine analogs.~~

Recommendation 7: Annual Review of Antidepressants

MOTION CARRIED by unanimous approval.

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

1. Moving Aplenzin® (bupropion ER) from Special PA Tier to Tier-1 based on net costs; and
2. Removal of the general Special PA approval criteria and updating with specific criteria for each product for clarity.

Antidepressants			
Tier-1	Tier-2	Tier-3	Special PA*
Selective Serotonin Reuptake Inhibitors (SSRIs)			
citalopram tabs & soln (Celexa®)			citalopram 30mg caps
escitalopram tabs & soln (Lexapro®)			fluoxetine tabs

Antidepressants			
Tier-1	Tier-2	Tier-3	Special PA*
fluoxetine caps & soln (Prozac®)			fluoxetine DR (Prozac® Weekly™)
fluvoxamine (Luvox®)			fluvoxamine CR (Luvox CR®)
paroxetine (Paxil®)			paroxetine CR (Paxil CR®)
sertraline tabs & soln (Zoloft®)			sertraline 150mg & 200mg caps
Dual-Acting Antidepressants			
bupropion (Wellbutrin®, Wellbutrin SR®, XL®)	desvenlafaxine (Pristiq®)	desvenlafaxine (Khedezla®)	bupropion ER (Aplenzin®)
bupropion ER (Aplenzin®)		levomilnacipran (Fetzima®)	bupropion ER (Forfivo XL®)
duloxetine (Cymbalta®)		nefazodone (Serzone®)	duloxetine (Drizalma Sprinkle™)
mirtazapine (Remeron®, Remeron SolTab®)		vilazodone (Viibryd®)	duloxetine 40mg (Irenka™)
trazodone 50mg, 100mg, & 150mg tabs (Desyrel®)			trazodone 300mg tabs (Desyrel®)
venlafaxine tabs & ER caps (Effexor®, Effexor XR®)			venlafaxine besylate ER 112.5mg tablets
venlafaxine 75mg & 150mg ER tabs (Effexor XR®)			venlafaxine ER 225mg tabs (Effexor XR®)
Monoamine Oxidase Inhibitors (MAOIs)			
		phenelzine (Nardil®)	isocarboxazid (Marplan®)
		selegiline (Emsam®)	
		tranylcypromine (Parnate®)	
Unique Mechanisms of Action			
		vortioxetine (Trintellix®)	dextromethorphan/bupropion (Auvelity®)
			esketamine nasal spray (Spravato®)
			gepirone (Exxua™)
			zuranolone (Zurzuvae™)

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).

*Unique criteria applies.

caps = capsules; CR = controlled-release; DR = delayed-release; ER = extended-release; PA = prior authorization; soln = solution; tabs = tablets

~~Antidepressants Special Prior Authorization (PA) Approval Criteria:~~

- ~~1. Use of any Special PA medication will require a patient-specific, clinically significant reason why the member cannot use other available generic Tier-1 medications; or~~
- ~~2. A petition may be submitted for consideration whenever a unique patient-specific situation exists; and~~
- ~~3. Tier structure rules still apply.~~

Forfivo XL® [Bupropion Extended-Release (ER)] Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use other available generic Tier-1 products, including using 3 bupropion 150mg XL tablets to achieve the 450mg dose, must be provided.

Luvox CR® (Fluvoxamine CR) and Paxil CR® (Paroxetine CR) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Tier-1 immediate-release products that are available without prior authorization must be provided.

Venlafaxine Extended-Release (ER) 225mg Tablet Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use other available generic Tier-1 products, including using 3 venlafaxine ER 75mg capsules or tablets to achieve the 225mg dose, must be provided.

Recommendation 8: Annual Review of Complement Inhibitors and Miscellaneous Immunomodulatory Agents and 30-Day Notice to Prior Authorize Bkempv™ (Eculizumab-aeeb), Epysqli® (Eculizumab-aagh), Fabhalta® (Iptacopan), Piasky® (Crovalimab-akkz), and Voydeya™ (Danicopan)

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

Recommendation 9: Annual Review of Lysosomal Storage Disease Medications and 30-Day Notice to Prior Authorize Aqneursa™ (Levacetylleucine), Lenmeldy™ (Atidarsagene Autotemcel), and Miplyffa™ (Arimocloamol)

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

Recommendation 10: Annual Review of Parathyroid Medications and 30-Day Notice to Prior Authorize Yorvipath® (Palopegteriparatide)

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

Recommendation 11: Annual Review of Osteoporosis Medications and 30-Day Notice to Prior Authorize Jubbonti® (Denosumab-bbdz)

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

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

NO ACTION REQUIRED.

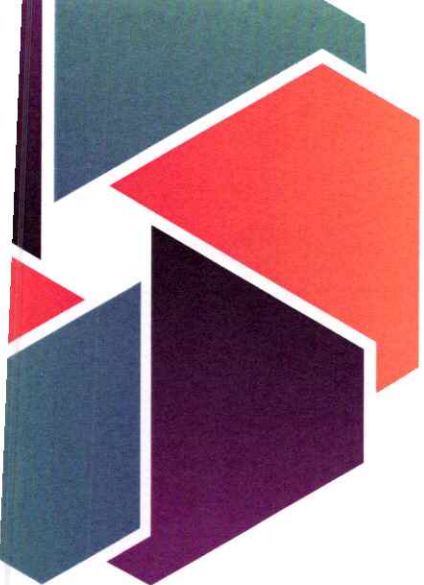
Recommendation 13: Future Business

NO ACTION REQUIRED.

Recommendation 14: Nomination of DUR Board Officers

MOTION(S) CARRIED by unanimous approval.

- Dr. Haymore nominated and confirmed as chair.
- Dr. Patatanian nominated and confirmed as vice chair.



December 10, 2024

To whom it may concern,

My name is Whitney Mashburn and I have been a physician associate for 12 years. For the last 10 years I have worked alongside Dr. Hillary Lawrence, the only board-certified Pediatric Dermatologist in Oklahoma. Our patient population includes a large volume of Medicaid patients from across the state ranging in age from newborn to adults. It is a privilege to take care of these patients and give them the best quality care that is available. I ask that you consider our opinions in the discussion for formulary changes for the biologic treatments for atopic dermatitis.

SPECTRUM
DERMATOLOGY

Tel: 405.285.8823

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www.spectrumdermokc.com

Edmond Clinic

1354 E. 15th St.
Edmond, OK 73013

Northwest OKC Clinic

Coming Soon!

Hillary Lawrence, M.D., FAAD
Pediatric/Adult

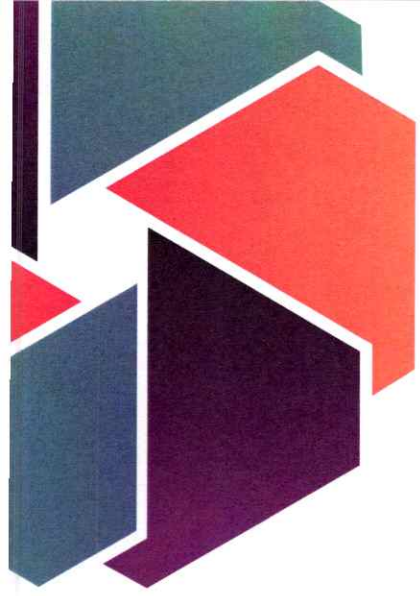
Pranathi Lingam, M.D., FAAD
Adult/Adolescent

Whitney Mashburn, MHS, PA-C
Pediatric/Adult

According to the National Eczema Association, atopic dermatitis is a chronic condition that affects approximately 9.6 million U.S children under the age of 18 and one-third have moderate to severe disease. The American Academy of Dermatology has recently updated the Atopic Dermatitis Guidelines in 2024 and can be referenced in the Journal of the American Academy of Dermatology (Guidelines of care for the management of atopic dermatitis in adults with phototherapy and systemic therapies, JAAD Vol 90, Issue 2, E43-56, February 2024). The guidelines state “We make strong recommendations for the use of dupilumab, tralokinumab, abrocitinib, baricitinib, and upadacitinib. We make conditional recommendations in favor of using phototherapy, azathioprine, cyclosporine, methotrexate, and mycophenolate, and against the use of systemic corticosteroids.”

Since 2014 our treatment options for AD have broadened allowing these patients to finally get control over their chronic disease. Dupilumab is the only current biologic treatment that is approved for the ages of 6 months and older. The other treatment options are FDA approved twelve years and older.

Families with a child with moderate to severe AD come to our office exhausted from consistent application of moisturizers, steroids, recurrent infections, sleepless nights due to itching and bleeding. These families and children think about atopic dermatitis



every single day. Dupilumab has given these parents and their children the chance to think about atopic dermatitis only every 2 weeks or 4 weeks, depending on their dosing. Our patients who previously were seen in office every 1-2 weeks have now been able to come every 3-6 months. They are no longer being evaluated for frequent skin infections and needing oral antibiotics. They are not visiting urgent cares or emergency departments for flares and infections. Dupilumab has been life changing for these children and their parents.

In conclusion, the inclusion of dupilumab on the formulary is not just a matter of medical efficacy but one of profound impact on the quality of life for our pediatric patients. It stands as the only biologic treatment available for children starting from six months of age, offering a significant reduction in the frequency of medical interventions and greatly enhancing daily living for both children and their families. Removing dupilumab would not only revert these patients to more frequent, less effective treatments but would also place an unnecessary burden on both the healthcare system and the families involved. We strongly urge the board to maintain dupilumab in the formulary to continue providing the best possible care for our young patients with atopic dermatitis.

Sincerely,



Whitney Mashburn PA-C
Spectrum Dermatology

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DERMATOLOGY

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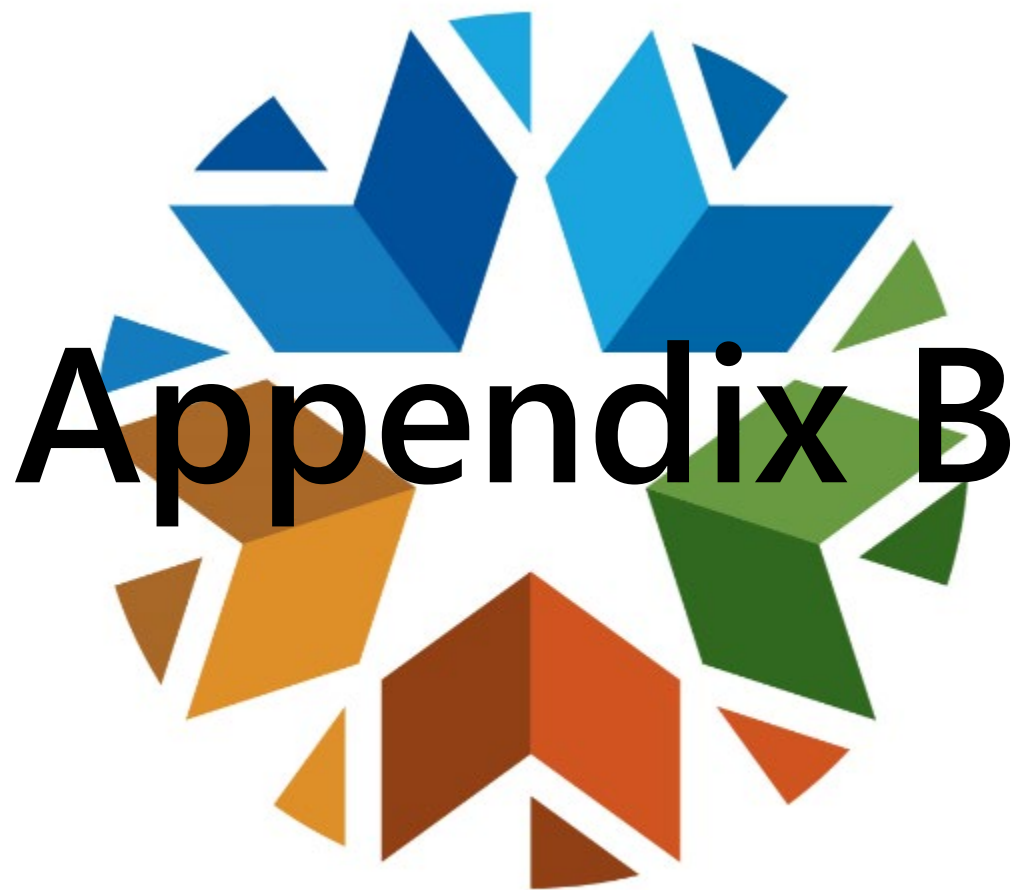
Northwest OKC Clinic

Coming Soon!

Hillary Lawrence, M.D., FAAD
Pediatric/Adult

Pranathi Lingam, M.D., FAAD
Adult/Adolescent

Whitney Mashburn, MHS, PA-C
Pediatric/Adult



Appendix B

Prenatal Vitamin Utilization Update

Oklahoma Health Care Authority
January 2025

Introduction^{1,2,3,4}

The use of prenatal vitamins (PNVs) plays a major role in optimal pregnancy outcomes. Deficiencies in folic acid, iron, calcium, and vitamin D can lead to an array of adverse outcomes that can affect both the mother and baby. The increased risk of neural tube defects due to folic acid deficiency has been well documented in the literature. Iron deficiency is the second most common cause of anemia in pregnancy, and several large studies have found correlations between maternal anemia and the risk of preterm birth and low birth weight. Insufficient calcium has been linked to the development of maternal hypertension, which can lead to maternal mortality, fetal growth restriction, and preterm birth. Vitamin D deficiency can lead to pre-eclampsia and increase the risk of babies being born prematurely and small-for-gestational age. The role of PNVs in reducing these possible outcomes cannot be understated.

The College of Pharmacy and the Oklahoma Health Care Authority (OHCA) are engaged in an ongoing effort to increase PNV utilization among pregnant SoonerCare members. PNVs currently have a \$0 copay and do not count toward the monthly prescription limit. Prescribers also have the option to select from dozens of PNVs that are covered without prior authorization (PA). In June 2020, prescribers and pharmacies received an educational outreach addressing the concerning decrease in PNV utilization in pregnant SoonerCare members. The educational outreach highlighted SoonerCare's preferred PNVs and included NDC numbers to encourage increased prescribing of PNVs. Additionally, in May 2023, 43 providers received Academic Detailing (AD) to increase PNV utilization. The AD program is an educational initiative combining standards of care with the most current peer-reviewed studies and presenting them in an unbiased, independent, evidence-based manner to prescribers.

The College of Pharmacy also incorporates PNV education into its workflow to increase PNV utilization. When a PA request for any pregnancy-related medication is received, as well as any medication for a member in the Soon-to-be-Sooners (STBS) program, the member's pharmacy claims history is reviewed for PNV paid claims. If the member does not have a recent paid claim for a PNV, a reminder is included in the PA response to the prescriber and the pharmacy. The STBS program began in April 2008 and provides health care benefits for pregnancy-related medical services for pregnant

women who would not otherwise qualify for SoonerCare benefits due to their citizenship status. There is a similar program, the STBS-Maintenance (STBS-M) program, which began in 2014 to provide health care benefits for pregnancy-related medical services for pregnant women who do not otherwise qualify for SoonerCare; PAs for a member in the STBS-M program are evaluated in a similar manner to review for PNV utilization.

Utilization of PNV: Fiscal Year 2024 (FY24)

In FY24 (07/01/2023-06/30/2024), there were a total of 27,797 SoonerCare members with an outcome of delivery, based on the mother's paid claims with delivery ICD-10 diagnosis codes, which may include non-live births. Mothers with multiple delivery ICD-10 diagnosis codes occurring on multiple dates were only included once. In FY24, only 15% of these members had at least 1 paid claim for a PNV. Of the 4,036 pregnant members who received a PNV in FY24, 70% of these members had only 1 to 2 fills of a PNV. Although preferred PNVs may be filled for greater than a 30-day supply, this number is very concerning since the maximum benefits of PNVs requires continued use throughout pregnancy. However, it is important to note that PNV utilization may be falsely low due to the large number of over-the-counter (OTC) products available. Data for the use of OTC products in SoonerCare members is not obtainable and, therefore, cannot be included in this analysis. Additionally, the analysis does not include whether the member is receiving their PNVs through a non-SoonerCare source (i.e., office samples, Indian Health Services, private insurance, free clinics).

Recommendations

Based on the low percentage of pregnant members utilizing PNV in FY24, further education efforts are warranted. The College of Pharmacy will continue to promote PNV use in pregnant members by continuing educational outreach initiatives through prescriber letters, pharmacy fax blasts, provider and member newsletters, and other platforms as appropriate.

¹ Oh C, Keats EC, Bhutta ZA. Vitamin and Mineral Supplementation During Pregnancy on Maternal, Birth, Child Health and Development Outcomes in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. *Nutrients* 2020; 12(2):491. doi: 10.3390/nu12020491.

² Garner C. Nutrition in Pregnancy. *UpToDate*. Available online at: <https://www.uptodate.com/contents/nutrition-in-pregnancy>. Last revised 10/24/2024. Last accessed 12/16/2024.

³ Auerbach M, Landy HJ. Anemia in Pregnancy. *UpToDate*. Available online at: <https://www.uptodate.com/contents/anemia-in-pregnancy>. Last revised 11/14/2024. Last accessed 12/16/2024.

⁴ Yeh JS, Van Hoof TJ, Fischer MA. Key Features of Academic Detailing: Development of an Expert Consensus Using the Delphi Method. *Am Health Drug Benefits* 2016; 9(1):42-50.



Appendix C

Fiscal Year 2024 Annual Review of Antihyperlipidemics 30-Day Notice to Prior Authorize Tryngolza™ (Olezarsen)

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

Evkeeza® (Evinacumab-dgnb) Approval Criteria:

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
 - a. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - b. An untreated LDL >500mg/dL and at least 1 of the following:
 - i. Documented evidence of definite HeFH in both parents; or
 - ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; and
2. Member must be 5 years of age or older; and
3. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
4. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Documented trial of a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®) at least 12 weeks in duration; and
6. Member requires additional lowering of LDL-cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
7. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation. Female members of

- reproductive potential must be willing to use effective contraception while on therapy and for 5 months after discontinuation of therapy; and
8. Initial approvals will be for the duration of 6 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Fibric Acid Derivative Medications	
Tier-1	Tier-2
choline fenofibrate DR cap 45mg (Trilipix®)	choline fenofibrate DR cap 135mg (Trilipix®)
fenofibrate micronized cap 67mg, 134mg (Lofibra®)	fenofibrate cap 50mg, 150mg (Lipofen®)
fenofibrate tab 160mg (Triglide®)	fenofibrate micronized cap 200mg (Lofibra®)
fenofibrate tab 48mg, 145mg (Tricor®)	fenofibrate micronized cap 30mg, 43mg, 90mg, 130mg (Antara®)
fenofibrate tab 54mg, 160mg (Lofibra®)	fenofibrate tab 40mg, 120mg (Fenoglide®)
fenofibric acid tab 35mg (Fibricor®)	fenofibric acid tab (Fibricor®) 105mg
gemfibrozil tab 600mg (Lopid®)	

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).
cap = capsule; DR = delayed release; tab = tablet

Fibric Acid Derivative Medications Tier-2 Approval Criteria:

1. Laboratory documented failure with a Tier-1 medication after a 6-month trial; or
2. Documented adverse drug effect, drug interaction, or contraindication to all Tier-1 medication(s); or
3. Prior stabilization on the Tier-2 medication documented within the last 100 days.

Juxtapid® (Lomitapide) Approval Criteria:

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following criteria:
 - a. A documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - b. An untreated LDL >500mg/dL and triglycerides <300mg/dL and at least 1 of the following:
 - i. Documented evidence of definite HeFH in both parents; or

- ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; and
- 2. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
- 3. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
- 4. Documented trial of a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®) at least 12 weeks in duration; and
- 5. Member requires additional lowering of LDL-cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
- 6. Prescriber must be certified with Juxtapid® Risk Evaluation and Mitigation Strategy (REMS) program.

Leqvio® (Inclisiran) Approval Criteria:

- 1. An FDA approved indication as an adjunct to diet and statin therapy for the treatment of 1 of the following:
 - a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. Both of the following:
 - 1. Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL; and
 - 2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
 - iii. Dutch Lipid Clinic Network Criteria score of >8; or
 - b. Established atherosclerotic cardiovascular disease (ASCVD); and
 - i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; or
 - c. Primary hyperlipidemia; and
 - i. Member's untreated LDL-C level must be ≥190mg/dL; and
 - ii. Current LDL-C level is ≥100mg/dL; and
- 2. Member must be 18 years of age or older; and

3. Documented trial of all of the following for at least 12 weeks in duration each:
 - a. High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy; and
 - b. Ezetimibe; and
 - c. Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent[®], Repatha[®]); and
4. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C must be provided); and
6. Leqvio[®] must be administered by a health care professional. Approvals will not be granted for self-administration; and
 - a. Prior authorization requests must indicate how Leqvio[®] will be administered (e.g., prescriber, pharmacist, home health care provider); and
 - i. Leqvio[®] must be shipped to the facility where the member is scheduled to receive treatment; or
 - ii. Prescriber must verify the member has been counseled on the proper storage of Leqvio[®]; and
7. Initial approvals will be for the duration of 6 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

**Nexletol[®] (Bempedoic Acid) and Nexlizet[®] (Bempedoic Acid/Ezetimibe)
Approval Criteria:**

1. An FDA approved indication as an adjunct to diet and statin therapy for the treatment of 1 of the following:
 - a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. Both of the following:

1. Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL; and
2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
- iii. Dutch Lipid Clinic Network Criteria score of >8; or
- b. Established atherosclerotic cardiovascular disease (ASCVD); and
 - i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; or
- c. Primary hyperlipidemia; and
 - i. Member's untreated LDL-C level must be \geq 190mg/dL; and
 - ii. Current LDL-C level is \geq 100mg/dL; and
2. Member must be 18 years of age or older; and
3. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 - a. LDL-C levels should be included following at least 4 weeks of treatment; and
 - b. Member must not be taking simvastatin at doses >20mg or pravastatin at doses >40mg due to drug interactions with Nexletol[®] and Nexlizet[®]; and
4. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different lower dose statins (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
6. A quantity limit of 30 tablets per 30 days will apply; and
7. Initial approvals will be for the duration of 3 months, after which time compliance and recent LDL-C levels to demonstrate the effectiveness of this medication will be required for continued approval. Subsequent approvals will be for the duration of 1 year.

Omega-3 Fatty Acids [Epanova[®] (Omega-3-Carboxylic Acids) and Vascepa[®] (Icosapent Ethyl)] Approval Criteria:

1. An FDA approved indication of 1 of the following:
 - a. Severe hypertriglyceridemia; and
 - i. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides \geq 500mg/dL) and controlled diabetes

- (fasting glucose <150mg/dL at the time of triglycerides measurement and HgA1c <7.5%); and
- ii. Previous failure with fibric acid medications; and
 - iii. Use of Vascepa® (icosapent ethyl) or Epanova® (omega-3-carboxylic acids) requires a previous failure of or a patient-specific, clinically significant reason why the member cannot use omega-3-acid ethyl esters (generic Lovaza®), which is available without prior authorization; or
- b. For the use of Vascepa® (icosapent ethyl) as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult members with elevated triglyceride levels; and
- i. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 - ii. Laboratory documentation of fasting triglycerides \geq 150mg/dL; and
 - iii. Member must have 1 of the following:
 - 1. Established cardiovascular disease; or
 - 2. Diabetes mellitus and \geq 2 additional risk factors for cardiovascular disease; and
2. Use of Vascepa® 0.5 gram requires a patient-specific, clinically significant reason why the member cannot use Vascepa® 1 gram.

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors [Praluent® (Alirocumab) and Repatha® (Evolocumab)] Approval Criteria:

- 1. An FDA approved indication of 1 of the following:
 - a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. Both of the following:
 - 1. Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL; and
 - 2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
 - iii. Dutch Lipid Clinic Network Criteria score of >8; or
 - b. Homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:

- i. Documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. An untreated LDL >500mg/dL and at least 1 of the following:
 1. Documented evidence of definite HeFH in both parents; or
 2. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or
 - c. As an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD); and
 - i. Documentation of established CVD; and
 - ii. Supporting diagnoses/conditions and date of occurrence signifying established CVD; or
 - d. Primary hyperlipidemia; and
 - i. Member's untreated LDL-C level must be ≥ 190 mg/dL; and
 - ii. Current LDL-C level is ≥ 100 mg/dL; and
 2. For the use of Repatha® in members with HeFH or HoFH, member must be 10 years of age or older; and
 3. For the use of Repatha® for FDA approved indications other than HeFH or HoFH or for the use of Praluent® for all FDA approved indications, the member must be 18 years of age or older; and
 4. Member must be on high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or on maximally tolerated statin therapy; and
 - a. Statin trials must be at least 12 weeks in duration (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 - b. LDL-C levels should be included following at least 12 weeks of treatment; and
 5. Members with statin intolerance must meet 1 of the following:
 - a. Creatinine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different lower dose statins (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 6. Member must have a recent trial with a statin with ezetimibe, or a recent trial of ezetimibe without a statin for members with a documented statin intolerance, or a patient-specific, clinically

significant reason why ezetimibe is not appropriate must be provided; and

7. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
8. Prescriber must verify that member has been counseled on appropriate use, storage of the medication, and administration technique; and
9. A quantity limit of 2 syringes or pens per 28 days will apply for Praluent®. A quantity limit of 2 syringes or auto-injectors per 28 days will apply for Repatha® 140mg and a quantity limit of 1 auto-injector per 28 days will apply for Repatha® 420mg. Requests for the Repatha® 420mg dose will not be approved for multiple 140mg syringes or auto-injectors, but instead members need to use (1) 420mg auto-injector; and
10. Initial approvals will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Statin Medications and Ezetimibe	
Tier-1	Special PA
atorvastatin (Lipitor®)	atorvastatin suspension (Atorvaliq®)
ezetimibe (Zetia®)	fluvastatin (Lescol® & Lescol® XL)
lovastatin (Mevacor®)	lovastatin ER (Altoprev®)
pravastatin (Pravachol®)	pitavastatin (Livalo®)
rosuvastatin (Crestor®)	pitavastatin magnesium (Zypitamag®)
simvastatin (Zocor®)	rosuvastatin capsule (Ezallor Sprinkle™)
	simvastatin suspension (FloLipid®)
	simvastatin/ezetimibe (Vytorin®)

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).
ER = extended-release; PA = prior authorization

Statin Medications Special Prior Authorization (PA) Approval Criteria:

1. Use of any Special PA medication will require a patient-specific, clinically significant reason why lower tiered medications with similar or higher low-density lipoprotein-cholesterol (LDL-C) reduction cannot be used; and
2. Use of Atorvaliq® (atorvastatin oral suspension) will require:
 - a. An FDA approved indication; and
 - b. Member must be 10 years of age or older; and
 - c. A patient specific, clinically significant reason why the member cannot use atorvastatin oral tablets, even when the tablets are crushed; and

3. Use of FloLipid® (simvastatin oral suspension) will require a patient specific, clinically significant reason why the member cannot use simvastatin oral tablets, even when the tablets are crushed; and
4. Use of Ezallor Sprinkle™ (rosuvastatin capsule) will require a patient-specific, clinically significant reason why the member cannot use rosuvastatin oral tablets, even when the tablets are crushed.

Welchol® (Colesevelam) Packets for Oral Suspension Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use the oral tablet formulation of colesevelam, which is available without prior authorization, must be provided; and
3. The following quantity limits will apply:
 - a. 30 packets for oral suspension per 30 days.

Utilization of Antihyperlipidemics: 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	46,760	151,015	\$2,371,699.03	\$15.71	\$0.24	10,193,825	9,818,904
2023 Total	46,760	151,015	\$2,371,699.03	\$15.71	\$0.24	10,193,825	9,818,904
Fiscal Year 2024							
FFS	44,488	126,255	\$2,105,653.32	\$16.68	\$0.25	8,673,539	8,382,468
Aetna	4,426	5,692	\$114,402.21	\$20.10	\$0.29	405,192	392,738
Humana	5,993	8,643	\$169,780.74	\$19.64	\$0.33	535,631	514,598
OCH	4,449	5,894	\$118,909.37	\$20.17	\$0.33	370,783	357,279
2024 Total	47,647	146,484	\$2,508,745.64	\$17.13	\$0.26	9,985,144	9,647,083
% Change	1.90%	-3.00%	5.80%	9.00%	8.30%	-2.00%	-1.70%
Change	887	-4,531	\$137,046.61	\$1.42	\$0.02	-208,681	-171,821

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.

- Aggregate drug rebates collected during fiscal year 2024 for antihyperlipidemics totaled \$334,611.23.^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: Medical Claims (All Plans)

Plan Type	*Total Members	*Total Claims	Total Cost	Cost/Claim	Claims/Member
Fiscal Year 2023					
FFS	3	3	\$10,201.28	\$3,400.43	1
2023 Total	3	3	\$10,201.28	\$3,400.43	1
Fiscal Year 2024					
FFS	4	6	\$20,564.44	\$3,427.41	1.5
Aetna	0	0	\$0.00	\$0.00	0.00
Humana	0	0	\$0.00	\$0.00	\$0.00
OCH	0	0	\$0.00	\$0.00	\$0.00
2024 Total	4	6	\$20,564.44	\$3,427.41	1.5
% Change	33.33%	100.00%	101.59%	0.79%	50.00%
Change	1	3	\$10,363.16	\$26.98	0.50

Costs do not reflect rebated prices or net costs.

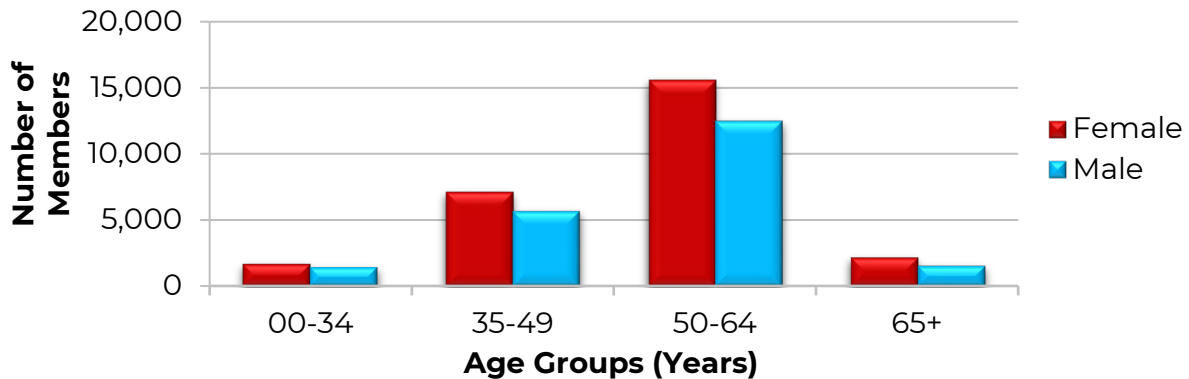
*Total number of unduplicated utilizing members.

FFS = fee-for-service; OCH = Oklahoma Complete Health

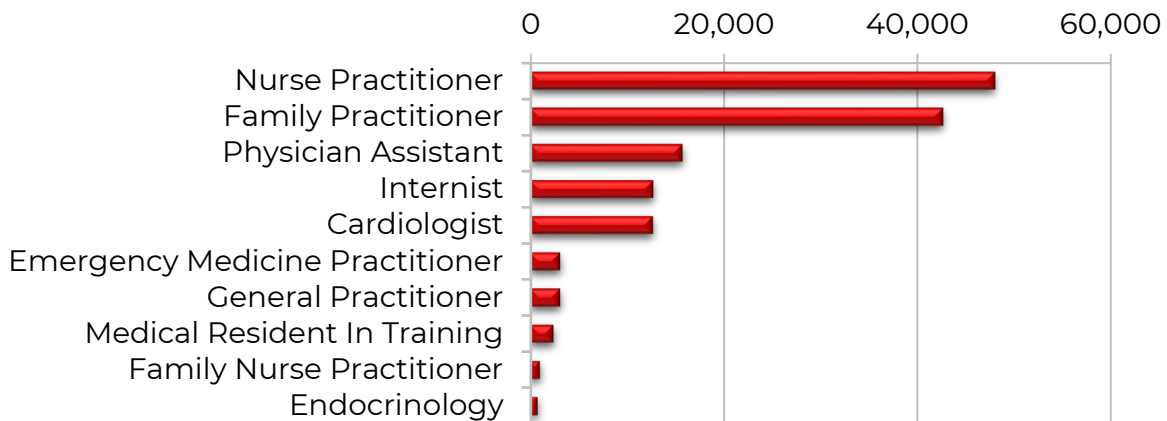
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Demographics of Members Utilizing Antihyperlipidemics: Pharmacy Claims (All Plans)



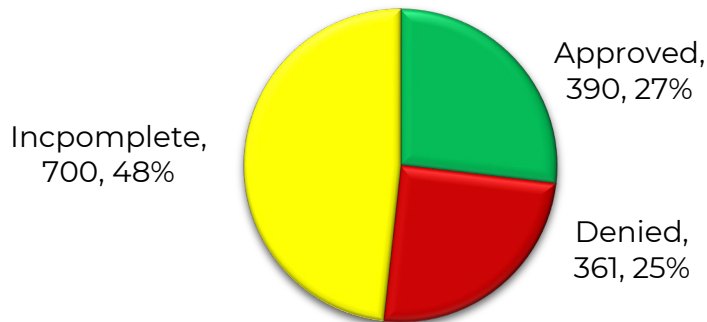
Top Prescriber Specialties of Antihyperlipidemics by Number of Claims: Pharmacy Claims (All Plans)



Prior Authorization of Antihyperlipidemics

There were 1,451 prior authorization requests submitted for antihyperlipidemics 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	362	28%	643	49%	298	23%	1,303
Aetna	6	7%	57	63%	27	30%	90
Humana	5	26%	0	0%	14	74%	19
OCH	17	44%	0	0%	22	56%	39
Total	390	27%	700	48%	361	25%	1,451

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^{1,2,3,4,5,6,7,8,9,10,11,12}

Anticipated Patent Expiration(s):

- Juxtapid® (lomitapide capsule): August 2027
- FloLipid® (simvastatin oral suspension): February 2030
- Zypitamag® (pitavastatin magnesium tablet): January 2031
- Epanova® (omega-3-carboxylic acids capsule): January 2033
- Vascepa® (icosapent ethyl capsule): June 2033
- Ezallor™ Sprinkle (rosuvastatin capsule): February 2036
- Leqvio® (inclisiran solution): August 2036
- Atorvaliq® (atorvastatin oral suspension): June 2037
- Nexletol® (bempedoic acid tablet): June 2040
- Nexlizet® (bempedoic acid/ezetimibe tablet): June 2040

New U.S. Food and Drug Administration (FDA) Approval, Expansion, and Label Update(s):

- **March 2024:** Praluent® (alirocumab) received FDA approval for an age expansion for those 8 years of age or older with heterozygous familial

hypercholesterolemia (HeFH) to reduce low-density lipoprotein cholesterol (LDL-C). Previously, Praluent® was only approved for HeFH in patients 18 years of age or older.

- **March 2024:** The FDA approved a label expansion for Nexletol® (bempedoic acid) and Nexlizet® (bempedoic acid/ezetimibe) to include indications for cardiovascular (CV) risk reduction for both primary and secondary prevention in adults who are unable to take recommended statin therapy. The label expansion also includes the use of Nexletol® or Nexlizet® alone or in combination with statins or other LDL-C lowering therapies for primary hyperlipidemia, including HeFH. This label expansion will make Nexletol® and Nexlizet® the only LDL-C lowering non-statin medications indicated for primary prevention. The label expansion is based on the results from the CLEAR outcomes trial that assessed the effect of Nexletol® on CV outcomes in almost 14,000 patients who had established CV disease (CVD) or were at high risk of CVD. The primary composite endpoint, time to first occurrence of CV death, nonfatal myocardial infarction (MI), nonfatal stroke, or coronary revascularization, showed a 13% lower risk of occurrence vs. placebo [hazard ratio: 0.87; 95% confidence interval (CI): 0.79, 0.96; P=0.004]. Additionally, a reduction of LDL-C by 20% was seen in the bempedoic acid group when compared to placebo.
- **December 2024:** The FDA approved Tryngolza™ (olezarsen) as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS). FCS, also known as hyperlipoproteinemia type 1, is a rare autosomal recessive disorder caused by impaired function in the lipoprotein lipase (LPL) enzyme leading to disruptions in the normal breakdown of fats in the body causing severe hypertriglyceridemia, triglycerides >880mg/dL, due to the accumulation of chylomicrons. FCS has an estimated prevalence of 1 in 300,000 people in the United States and Europe and is expected to impact approximately 3,000 people in the United States. Patients with FCS will also have recurrent episodes of pancreatitis, fatty deposits in the skin, abdominal pain, nausea, fatigue, hepatosplenomegaly, eruptive xanthomas, lipemia retinalis, and failure to thrive. Prior to the approval of Tryngolza™, there have been no FDA approved treatment options for FCS. The mainstay of treatment is a fat restricted diet of ≤20g/day in combination with weight maintenance, exercise, and avoidance of processed foods, alcohol, and smoking. Standard lipid-lowering medications and plasmapheresis have been shown to be ineffective for FCS, and treatment has relied on diet, management of triglyceride levels, and keeping acute pancreatitis controlled.

News:

- **April 2024:** Amgen announced that the Repatha® Pushtronex® (evolocumab) on-body infusor system would be discontinued on June 30, 2024. The Repatha® SureClick® autoinjector and prefilled syringes will still be available, and patients were instructed to reach out to their health care providers about transitioning to a different product.
- **December 2024:** As of December 2024, the FDA Orange Book lists Epanova® (omega-3-carboxylic acids) as a discontinued product. There are no generic equivalents for this product.

Pipeline:

- **Lerodalcibep:** Lerodalcibep is an investigational once-monthly third-generation proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor being studied to reduce LDL-C in patients with CVD or who are at high or very high risk of CVD, and for primary hyperlipidemia, including HeFH and homozygous familial hypercholesterolemia (HoFH). A Biologics License Application (BLA) was submitted to the FDA in December 2024. The BLA submission includes data from the LIBerate program that included more than 2,300 patients on maximally tolerated statin therapy who required additional LDL-C reduction. The LIBerate-CVD trial showed LDL-C reductions of 62% over 52 weeks versus placebo.
- **Plozasiran:** Plozasiran is an investigational RNA interference (RNAi) therapeutic designed to reduce production of apolipoprotein C-III (APOC3) and thereby reduce triglycerides and restore lipids to more normal levels. Plozasiran is being studied for FCS, severe hypertriglyceridemia, and mixed hyperlipidemia. In the Phase 3 PALISADE trial, results showed a reduction of >90% in APOC3 levels and approximately 80% reduction in triglycerides compared to placebo. A New Drug Application (NDA) was submitted to the FDA for FCS in November 2024.

Tryngolza™ (Olezarsen) Product Summary^{13,14}

Therapeutic Class: APOC3 directed antisense oligonucleotide (ASO)

Indication(s): Adjunct to diet to reduce triglycerides in adults with FCS

How Supplied: 80mg/0.8mL single-dose autoinjector

Dosing and Administration:

- The recommended dose is 80mg subcutaneously (sub-Q) once monthly.
- Tryngolza™ should be administered in the abdomen or the front of the thigh. The back of the upper arm can also be used if administered by a health care provider or caregiver.

Mechanism of Action: Olezarsen binds to APOC3 mRNA leading to mRNA degradation and a reduction of serum APOC3. The reduction of APOC3 protein leads to an increased clearance of plasma triglycerides and very-low-density lipoprotein (VLDL).

Efficacy: The efficacy of Tryngolza™ was studied in a randomized, placebo-controlled, double-blind, Phase 3 trial in 66 patients with genetically identified FCS and fasting triglyceride levels ≥ 880 mg/dL.

- Key Inclusion Criteria:
 - Genetically confirmed diagnosis of FCS
 - Fasting triglycerides ≥ 880 mg/dL
 - Stable low-fat diet with ≤ 20 g of fat per day
 - Stable doses of statins, omega-3 fatty acids, or other lipid-lowering medications were allowed
- Intervention(s):
 - Randomized 1:1 to Tryngolza™ 80mg once every 4 weeks or placebo
- Primary Endpoint(s) and Results:
 - Percent change in fasting triglycerides from baseline to month 6
 - 30% reduction in the Tryngolza™ group vs. 12% increase in the placebo group (treatment difference: -42.5%; 95% CI: -74.1%, -10.9%; P=0.0084)
 - Key secondary endpoints showed a consistent fasting triglyceride lowering effect and a lower incidence of acute pancreatitis (5% in Tryngolza™ group vs. 30% in placebo group) during the 12-month treatment period.

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

Recommendations

The College of Pharmacy recommends the prior authorization of Tryngolza™ (olezarsen) with the following criteria (shown in red):

Tryngolza™ (Olezarsen) Approval Criteria:

1. An FDA approved indication to reduce triglyceride levels in adults with familial chylomicronemia syndrome (FCS); and
2. Diagnosis of FCS must be confirmed by the following:
 - a. Genetic testing identifying biallelic pathogenic variants in the *LPL*, *GPIIBP1*, *APOA5*, *APOC2*, or *LMF1* genes (results of genetic testing must be submitted); and
 - b. Fasting triglyceride levels ≥ 880 mg/dL; and
3. Member must be 18 years of age or older; and

4. Prescriber must verify the member is on a low-fat diet of ≤ 20 g of fat per day and will continue the low-fat diet while on treatment with Tryngolza™; and
5. Member or caregiver has been trained by a health care professional on the subcutaneous (sub-Q) administration and proper storage of Tryngolza™; and
6. Initial approvals will be for 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment, as indicated by a reduction in fasting triglyceride levels, decreased episodes of acute pancreatitis, and/or other documentation of a positive clinical response to therapy. Subsequent approvals will be for the duration of 1 year.

Additionally, the College of Pharmacy recommends the following changes to the Nexletol® (bempedoic acid) and Nexlizet® (bempedoic acid/ezetimibe) approval criteria based on the new FDA approved label expansion and to be consistent with clinical practice (changes shown in red):

Nexletol® (Bempedoic Acid) and Nexlizet® (Bempedoic Acid/Ezetimibe) Approval Criteria:

1. An FDA approved indication ~~as an adjunct to diet and statin therapy for the treatment~~ of 1 of the following:
 - a. ~~As an adjunct to diet and other low-density lipoprotein cholesterol (LDL-C) lowering therapies or alone when concomitant LDL-C lowering therapies are not possible to reduce LDL-C in those with heterozygous familial hypercholesterolemia (HeFH). HeFH must be~~ **as** confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. Both of the following:
 1. Pre-treatment total cholesterol >290 mg/dL or LDL-cholesterol (LDL-C) >190 mg/dL; and
 2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
 - iii. Dutch Lipid Clinic Network Criteria score of >8 ; or
 - ~~b. Established atherosclerotic cardiovascular disease (ASCVD); and~~
 - ~~i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; or~~
 - c. ~~As an adjunct to diet and other LDL-C lowering therapies or alone when concomitant LDL-C lowering therapies are not possible to reduce LDL-C in those with~~ primary hyperlipidemia; and
 - i. Member's untreated LDL-C level must be ≥ 190 mg/dL; and

- ii. Current LDL-C level is ≥ 100 mg/dL; and
- d. To reduce the risk of myocardial infarction and coronary revascularization in those unable to take recommended statin therapy with 1 of the following:
 - i. High risk for a cardiovascular disease (CVD) event without established atherosclerotic CVD (ASCVD); or
 - ii. Established ASCVD; and
 - iii. Supporting diagnoses/conditions/risk factors and dates of occurrences must be submitted; and
- 2. Member must be 18 years of age or older; and
- 3. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 - a. LDL-C levels should be included following at least 4 weeks of treatment; and
 - b. Member must not be taking simvastatin at doses >20 mg or pravastatin at doses >40 mg due to drug interactions with Nexletol[®] and Nexlizet[®]; and
- 4. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different lower dose statins (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
- 5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
- 6. A quantity limit of 30 tablets per 30 days will apply; and
- ~~7. Initial approvals will be for the duration of 3 months, after which time compliance and recent LDL-C levels to demonstrate the effectiveness of this medication will be required for continued approval. Subsequent approvals will be for the duration of 1 year.~~
- 8. Initial approvals will be for the duration of 6 months (subsequent approvals for 1 year). Continued authorization will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication. Additionally, compliance will be checked for continued approval.

Next, the College of Pharmacy recommends the following changes to the PCSK9 inhibitors criteria based on the new FDA approved age expansion, discontinuation, and to be consistent with clinical practice (changes shown in red):

**Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors
[Praluent® (Alirocumab) and Repatha® (Evolocumab)] Approval Criteria:**

1. An FDA approved indication of 1 of the following:
 - a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. Both of the following:
 1. Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL; and
 2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
 - iii. Dutch Lipid Clinic Network Criteria score of >8; or
 - b. Homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
 - i. Documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. An untreated LDL >500mg/dL and at least 1 of the following:
 1. Documented evidence of definite HeFH in both parents; or
 2. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or
 - c. As an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD); and
 - i. Documentation of established CVD; and
 - ii. Supporting diagnoses/conditions and date of occurrence signifying established CVD; or
 - d. Primary hyperlipidemia; and
 - i. Member's untreated LDL-C level must be \geq 190mg/dL; and
 - ii. Current LDL-C level is \geq 100mg/dL; and
2. For the use of Repatha® in members with HeFH or HoFH, member must be 10 years of age or older; and
3. For the use of Praluent® in members with HeFH, member must be 8 years of age or older; and
4. For the use of Repatha® for FDA approved indications other than HeFH or HoFH or for the use of Praluent® for **all** FDA approved indications **other than HeFH**, the member must be 18 years of age or older; and

5. Member must be on high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or on maximally tolerated statin therapy; and
 - a. Statin trials must be at least 12 weeks in duration (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 - b. LDL-C levels should be included following at least 12 weeks of treatment; and
6. Members with statin intolerance must meet 1 of the following:
 - a. Creatinine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different lower dose statins (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
7. Member must have a recent trial with a statin with ezetimibe, or a recent trial of ezetimibe without a statin for members with a documented statin intolerance, or a patient-specific, clinically significant reason why ezetimibe is not appropriate must be provided; and
8. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
9. Prescriber must verify that member has been counseled on appropriate use, storage of the medication, and administration technique; and
10. A quantity limit of 2 syringes or pens per 28 days will apply for Praluent®. A quantity limit of 2 syringes or auto-injectors per 28 days will apply for Repatha® 140mg ~~and a quantity limit of 1 auto-injector per 28 days will apply for Repatha® 420mg. Requests for the Repatha® 420mg dose will not be approved for multiple 140mg syringes or auto-injectors, but instead members need to use (1) 420mg auto-injector;~~ and
11. Initial approvals will be for the duration of ~~6~~ 3 months (subsequent approvals for 1 year). Continued authorization ~~at that time~~ will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication. ~~and Additionally, compliance will be checked for continued approval. at that time and every 6 months thereafter for continued approval.~~

Next, the College of Pharmacy recommends the following changes to the Evkeeza® (evinacumab-dgnb) and Leqvio® (inclisiran) criteria to be consistent with clinical practice and the other antihyperlipidemic medications (changes shown in red):

Evkeeza® (Evinacumab-dgnb) Approval Criteria:

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
 - a. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - b. An untreated LDL >500mg/dL and at least 1 of the following:
 - i. Documented evidence of definite HeFH in both parents; or
 - ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; and
2. Member must be 5 years of age or older; and
3. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
4. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Documented trial of a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®) at least 12 weeks in duration; and
6. Member requires additional lowering of LDL-cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
7. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation. Female members of reproductive potential must be willing to use effective contraception while on therapy and for 5 months after discontinuation of therapy; and
8. Initial approvals will be for the duration of 6-months (**subsequent approvals for 1 year**). Continued authorization ~~at that time~~ will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication. ~~and Additionally, compliance will be checked for continued approval. at that time and every 6 months thereafter for continued approval.~~

Leqvio® (Inclisiran) Approval Criteria:

1. An FDA approved indication as an adjunct to diet and statin therapy for the treatment of 1 of the following:

- a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (results of genetic testing must be submitted); or
 - ii. Both of the following:
 1. Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL; and
 2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
 - iii. Dutch Lipid Clinic Network Criteria score of >8; or
 - b. Established atherosclerotic cardiovascular disease (ASCVD); and
 - i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; or
 - c. Primary hyperlipidemia; and
 - i. Member's untreated LDL-C level must be ≥ 190 mg/dL; and
 - ii. Current LDL-C level is ≥ 100 mg/dL; and
2. Member must be 18 years of age or older; and
 3. Documented trial of all of the following for at least 12 weeks in duration each:
 - a. High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy; and
 - b. Ezetimibe; and
 - c. Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent[®], Repatha[®]); and
 4. Members with statin intolerance must meet 1 of the following:
 - a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C must be provided); and
 6. Leqvio[®] must be administered by a health care professional. Approvals will not be granted for self-administration; and
 - a. Prior authorization requests must indicate how Leqvio[®] will be administered (e.g., prescriber, pharmacist, home health care provider); and
 - i. Leqvio[®] must be shipped to the facility where the member is scheduled to receive treatment; or

- ii. Prescriber must verify the member has been counseled on the proper storage of Leqvio®; and
- 7. Initial approvals will be for the duration of 6 months (~~subsequent approvals for 1 year~~). Continued authorization ~~at that time~~ will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication. ~~and Additionally, compliance will be checked for continued approval. at that time and every 6 months thereafter for continued approval.~~

Next, the College of Pharmacy recommends the removal of Epanova® (omega-3-carboxylic acids) from the omega-3 fatty acids approval criteria based on product discontinuation (changes shown in red):

~~Omega-3 Fatty Acids [Epanova® (Omega-3-Carboxylic Acids) and Vascepa® (Icosapent Ethyl)] Approval Criteria:~~

1. An FDA approved indication of 1 of the following:
 - a. Severe hypertriglyceridemia; and
 - i. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides ≥ 500 mg/dL) and controlled diabetes (fasting glucose < 150 mg/dL at the time of triglycerides measurement and HgA1c $< 7.5\%$); and
 - ii. Previous failure with fibric acid medications; and
 - iii. ~~Use of Vascepa® (icosapent ethyl) or Epanova® (omega-3-carboxylic acids) requires a~~ Previous failure of or a patient-specific, clinically significant reason why the member cannot use omega-3-acid ethyl esters (generic Lovaza®), which is available without prior authorization; or
 - b. ~~For the use of Vascepa® (icosapent ethyl)~~ As an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult members with elevated triglyceride levels; and
 - i. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
 - ii. Laboratory documentation of fasting triglycerides ≥ 150 mg/dL; and
 - iii. Member must have 1 of the following:
 1. Established cardiovascular disease; or
 2. Diabetes mellitus and ≥ 2 additional risk factors for cardiovascular disease; and
2. Use of Vascepa® 0.5 gram requires a patient-specific, clinically significant reason why the member cannot use Vascepa® 1 gram.

Finally, the College of Pharmacy recommends moving Lofibra® (fenofibrate micronized) 200mg capsules from Tier-2 to Tier-1 based on net cost (changes shown in red):

Fibric Acid Derivative Medications	
Tier-1	Tier-2
choline fenofibrate DR cap 45mg (Trilipix®)	choline fenofibrate DR cap 135mg (Trilipix®)
fenofibrate micronized cap 67mg, 134mg (Lofibra®)	fenofibrate cap 50mg, 150mg (Lipofen®)
fenofibrate tab 160mg (Triglide®)	fenofibrate micronized cap 200mg (Lofibra®)
fenofibrate tab 48mg, 145mg (Tricor®)	fenofibrate micronized cap 30mg, 43mg, 90mg, 130mg (Antara®)
fenofibrate tab 54mg, 160mg (Lofibra®)	fenofibrate tab 40mg, 120mg (Fenoglide®)
fenofibrate micronized cap 200mg (Lofibra®)	fenofibric acid tab (Fibricor®) 105mg
fenofibric acid tab 35mg (Fibricor®)	
gemfibrozil tab 600mg (Lopid®)	

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).
cap = capsule; DR = delayed release; tab = tablet

Utilization Details of Antihyperlipidemics: Fiscal Year 2024

Fee-For-Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
STATIN PRODUCTS AND EZETIMIBE						
TIER-1 UTILIZATION						
ATORVASTATIN TAB 40MG	29,790	11,968	\$379,946.13	\$12.75	2.49	18.04%
ATORVASTATIN TAB 20MG	22,846	9,660	\$289,401.72	\$12.67	2.37	13.74%
ATORVASTATIN TAB 10MG	12,868	5,235	\$157,971.99	\$12.28	2.46	7.50%
ATORVASTATIN TAB 80MG	10,186	3,968	\$151,774.53	\$14.90	2.57	7.21%
ROSUVASTATIN TAB 20MG	6,399	2,754	\$90,122.59	\$14.08	2.32	4.28%
ROSUVASTATIN TAB 10MG	6,209	2,750	\$77,435.88	\$12.47	2.26	3.68%
EZETIMIBE TAB 10MG	4,576	1,901	\$67,664.91	\$14.79	2.41	3.21%
ROSUVASTATIN TAB 40MG	4,073	1,706	\$67,567.18	\$16.59	2.39	3.21%
SIMVASTATIN TAB 20MG	3,345	1,244	\$36,431.80	\$10.89	2.69	1.73%
PRAVASTATIN TAB 40MG	2,679	1,009	\$40,599.67	\$15.15	2.66	1.93%
ROSUVASTATIN TAB 5MG	2,659	1,195	\$34,419.21	\$12.94	2.23	1.63%
SIMVASTATIN TAB 40MG	2,450	837	\$28,915.51	\$11.80	2.93	1.37%
PRAVASTATIN TAB 20MG	1,901	746	\$25,029.71	\$13.17	2.55	1.19%
SIMVASTATIN TAB 10MG	1,580	575	\$18,215.89	\$11.53	2.75	0.87%
LOVASTATIN TAB 20MG	1,001	409	\$12,549.70	\$12.54	2.45	0.60%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
PRAVASTATIN TAB 10MG	895	342	\$12,160.86	\$13.59	2.62	0.58%
LOVASTATIN TAB 40MG	597	222	\$7,465.04	\$12.50	2.69	0.35%
PRAVASTATIN TAB 80MG	529	207	\$10,126.15	\$19.14	2.56	0.48%
SIMVASTATIN TAB 80MG	262	90	\$3,756.03	\$14.34	2.91	0.18%
LOVASTATIN TAB 10MG	222	105	\$2,505.91	\$11.29	2.11	0.12%
SIMVASTATIN TAB 5MG	127	45	\$1,408.81	\$11.09	2.82	0.07%
SUBTOTAL	115,194	46,968	\$1,515,469.22	\$13.16	2.45	71.97%
SPECIAL PA UTILIZATION						
LIVALO TAB 4MG	18	4	\$7,117.00	\$395.39	4.5	0.34%
VYTORIN TAB 10-80MG	5	1	\$5,145.12	\$1,029.02	5	0.24%
LIVALO TAB 2MG	4	3	\$3,207.83	\$801.96	1.33	0.15%
EZETIM/SIMVA TAB 10-40MG	4	1	\$214.40	\$53.60	4	0.01%
PITAVASTATIN TAB 4MG	2	1	\$561.46	\$280.73	2	0.03%
PITAVASTATIN TAB 2MG	2	2	\$411.93	\$205.97	1	0.02%
LIVALO TAB 1MG	1	1	\$317.76	\$317.76	1	0.02%
FLUVASTATIN CAP 20MG	1	1	\$313.99	\$313.99	1	0.01%
SUBTOTAL	37	14	\$17,289.49	\$467.28	2.64	0.82%
STATINS AND EZETIMIBE TOTAL	115,231	46,982	\$1,532,758.71	\$13.30	2.45	72.79%
FIBRIC ACID DERIVATIVE PRODUCTS						
TIER-1 UTILIZATION						
FENOFIBRATE TAB 145MG	2,925	1,039	\$50,005.30	\$17.10	2.82	2.37%
FENOFIBRATE TAB 160MG	1,612	634	\$30,109.09	\$18.68	2.54	1.43%
GEMFIBROZIL TAB 600MG	1,357	464	\$23,571.42	\$17.37	2.92	1.12%
FENOFIBRATE TAB 48MG	783	307	\$12,291.25	\$15.70	2.55	0.58%
FENOFIBRATE TAB 54MG	659	249	\$10,165.17	\$15.43	2.65	0.48%
FENOFIBRATE CAP 134MG	456	177	\$8,297.68	\$18.20	2.58	0.39%
FENOFIBRIC CAP 45MG DR	180	30	\$2,914.60	\$16.19	6	0.14%
FENOFIBRATE CAP 67MG	87	35	\$1,369.49	\$15.74	2.49	0.07%
SUBTOTAL	8,059	2,935	\$138,724.00	\$17.21	2.75	6.59%
TIER-2 UTILIZATION						
FENOFIBRIC CAP 135MG DR	64	17	\$2,201.69	\$34.40	3.76	0.10%
FENOFIBRATE CAP 200MG	59	16	\$1,189.89	\$20.17	3.69	0.06%
FENOFIBRATE TAB 120MG	18	12	\$13,784.74	\$765.82	1.5	0.65%
FENOFIBRATE TAB 40MG	11	4	\$3,515.42	\$319.58	2.75	0.17%
FENOFIBRATE CAP 150MG	10	3	\$3,364.32	\$336.43	3.33	0.16%
FENOFIBRATE CAP 130MG	6	2	\$315.64	\$52.61	3	0.01%
FENOFIBRATE CAP 43MG	2	1	\$79.12	\$39.56	2	0.00%
FENOFIBRATE CAP 50MG	2	2	\$500.92	\$250.46	1	0.02%
SUBTOTAL	172	57	\$24,951.74	\$145.07	3.02	1.18%
FIBRIC ACID DERIVATIVE TOTAL	8,231	2,992	\$163,675.74	\$19.89	2.75	7.77%
OMEGA-3 FATTY ACID PRODUCTS						
OMEGA-3-ACID CAP 1GM	1,600	630	\$56,920.55	\$35.58	2.54	2.70%
ICOSAPENT CAP 1GM	209	45	\$32,665.38	\$156.29	4.64	1.55%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
VASCEPA CAP 1GM	41	16	\$11,938.58	\$291.18	2.56	0.57%
OMEGA-3 FATTY ACIDS TOTAL	1,850	691	\$101,524.51	\$54.88	2.68	4.82%
PCSK9 INHIBITORS						
REPATHA SURE INJ 140MG/ML	332	69	\$181,330.34	\$546.18	4.81	8.61%
REPATHA INJ 140MG/ML	75	13	\$37,311.71	\$497.49	5.77	1.77%
PRALUENT INJ 150MG/ML	52	7	\$25,531.18	\$490.98	7.43	1.21%
REPATHA PUSH INJ 420MG/3.5ML	39	8	\$22,994.70	\$589.61	4.88	1.09%
PRALUENT INJ 75MG/ML	32	7	\$15,675.96	\$489.87	4.57	0.74%
PCSK9 INHIBITORS TOTAL	530	104	\$282,843.89	\$533.67	5.1	13.43%
COLESEVELAM PRODUCTS						
COLESEVELAM TAB 625MG	389	118	\$15,764.01	\$40.52	3.3	0.75%
COLESEVELAM PRODUCTS TOTAL	389	118	\$15,764.01	\$40.52	3.3	0.75%
BEMPEDOIC ACID AND EZETIMIBE PRODUCTS						
NEXLIZET TAB 180/10MG	19	8	\$7,513.07	\$395.42	2.38	0.36%
BEMPEDOIC ACID/EZETIMIBE TOTAL	19	8	\$7,513.07	\$395.42	2.38	0.36%
BEMPEDOIC ACID PRODUCTS						
NEXLETOL TAB 180MG	5	4	\$1,573.39	\$314.68	1.25	0.07%
BEMPEDOIC ACID TOTAL	5	4	\$1,573.39	\$314.68	1.25	0.07%
TOTAL	126,255	44,488*	\$2,105,653.32	\$16.68	2.84	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DR = delayed-release; EZETIM/SIMVA = ezetimibe/simvastatin; INJ = injection; PA = prior authorization; PUSH = Pushtronex®; SURE = SureClick®; TAB = tablet

Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Aetna Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
STATIN PRODUCTS AND EZETIMIBE						
TIER-1 UTILIZATION						
ATORVASTATIN TAB 40MG	1,213	1,055	\$18,303.38	\$15.09	1.15	16.00%
ATORVASTATIN TAB 20MG	1,067	925	\$14,940.76	\$14.00	1.15	13.06%
ATORVASTATIN TAB 10MG	603	516	\$8,003.79	\$13.27	1.17	7.00%
ATORVASTATIN TAB 80MG	382	334	\$6,130.08	\$16.05	1.14	5.36%
ROSUVASTATIN TAB 20MG	330	285	\$5,195.97	\$15.75	1.16	4.54%
ROSUVASTATIN TAB 10MG	323	256	\$4,541.61	\$14.06	1.26	3.97%
EZETIMIBE TAB 10MG	225	194	\$3,910.26	\$17.38	1.16	3.42%
ROSUVASTATIN TAB 40MG	195	170	\$3,473.25	\$17.81	1.15	3.04%
ROSUVASTATIN TAB 5MG	146	112	\$2,035.56	\$13.94	1.3	1.78%
SIMVASTATIN TAB 20MG	107	93	\$1,396.79	\$13.05	1.15	1.22%
SIMVASTATIN TAB 40MG	95	82	\$1,318.60	\$13.88	1.16	1.15%
PRAVASTATIN TAB 40MG	95	84	\$1,644.23	\$17.31	1.13	1.44%
PRAVASTATIN TAB 20MG	84	72	\$1,290.12	\$15.36	1.17	1.13%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
SIMVASTATIN TAB 10MG	67	49	\$858.31	\$12.81	1.37	0.75%
LOVASTATIN TAB 20MG	60	49	\$858.78	\$14.31	1.22	0.75%
PRAVASTATIN TAB 10MG	52	41	\$784.32	\$15.08	1.27	0.69%
PRAVASTATIN TAB 80MG	20	18	\$445.92	\$22.30	1.11	0.39%
LOVASTATIN TAB 40MG	14	12	\$207.50	\$14.82	1.17	0.18%
SIMVASTATIN TAB 80MG	11	7	\$150.45	\$13.68	1.57	0.13%
LOVASTATIN TAB 10MG	9	9	\$132.15	\$14.68	1	0.12%
SIMVASTATIN TAB 5MG	7	4	\$84.63	\$12.09	1.75	0.07%
STATIN AND EZETIMIBE TOTAL	5,105	4,367	\$75,706.46	\$14.83	1.17	66.18%
FIBRIC ACID DERIVATIVE PRODUCTS						
TIER-1 UTILIZATION						
FENOFIBRATE TAB 145MG	180	112	\$2,313.00	\$12.85	1.61	2.02%
FENOFIBRATE TAB 160MG	96	65	\$1,408.37	\$14.67	1.48	1.23%
GEMFIBROZIL TAB 600MG	45	37	\$827.47	\$18.39	1.22	0.72%
FENOFIBRATE TAB 48MG	41	26	\$579.94	\$14.14	1.58	0.51%
FENOFIBRATE CAP 134MG	36	21	\$533.67	\$14.82	1.71	0.47%
FENOFIBRATE TAB 54MG	30	18	\$406.90	\$13.56	1.67	0.36%
FENOFIBRATE CAP 67MG	6	4	\$83.02	\$13.84	1.5	0.07%
FENOFIBRIC CAP 45MG DR	4	2	\$65.89	\$16.47	2	0.06%
SUBTOTAL	438	285	\$6,218.26	\$14.20	1.54	5.44%
TIER-2 UTILIZATION						
FENOFIBRATE CAP 200MG	2	2	\$31.82	\$15.91	1	0.03%
FENOFIBRATE CAP 43MG	1	1	\$21.32	\$21.32	1	0.02%
FENOFIBRATE CAP 130MG	1	1	\$32.17	\$32.17	1	0.03%
FENOFIBRATE TAB 120MG	1	1	\$450.66	\$450.66	1	0.39%
SUBTOTAL	5	5	\$535.97	\$107.19	1	0.47%
FIBRIC ACID DERIVATIVE TOTAL	443	290	\$6,754.23	\$15.25	1.53	5.90%
OMEGA-3 FATTY ACID PRODUCTS						
OMEGA-3-ACID CAP 1GM	74	56	\$3,121.47	\$42.18	1.32	2.73%
ICOSAPENT CAP 1GM	6	5	\$756.81	\$126.14	1.2	0.66%
OMEGA-3 FATTY ACIDS TOTAL	80	61	\$3,878.28	\$48.48	1.31	3.39%
PCSK9 INHIBITORS						
REPATHA SURE INJ 140MG/ML	39	18	\$21,640.50	\$554.88	2.17	18.92%
PRALUENT INJ 150MG/ML	4	3	\$2,006.86	\$501.72	1.33	1.75%
PRALUENT INJ 75MG/ML	3	1	\$1,503.25	\$501.08	3	1.31%
REPATHA INJ 140MG/ML	2	2	\$1,107.75	\$553.88	1	0.97%
PCSK9 INHIBITORS TOTAL	48	24	\$26,258.36	\$547.05	2	22.95%
COLESEVELAM PRODUCTS						
COLESEVELAM TAB 625MG	13	11	\$596.94	\$45.92	1.18	0.52%
COLESEVELAM PRODUCTS TOTAL	13	11	\$596.94	\$45.92	1.18	0.52%
BEMPEDOIC ACID PRODUCTS						
NEXLETOL TAB 180MG	2	1	\$805.26	\$402.63	2	0.70%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
BEMPEDOIC ACID TOTAL	2	1	\$805.26	\$402.63	2	0.70%
BEMPEDOIC ACID AND EZETIMIBE PRODUCTS						
NEXLIZET TAB 180/10MG	1	1	\$402.68	\$402.68	1	0.35%
BEMPEDOIC ACID/EZETIMIBE TOTAL	1	1	\$402.68	\$402.68	1	0.35%
TOTAL	5,692	4,426*	\$114,402.21	\$20.10	1.29	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DR = delayed-release; INJ = injection; PA = prior authorization; SURE = SureClick®; 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.

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
STATIN PRODUCTS AND EZETIMIBE						
TIER-1 UTILIZATION						
ATORVASTATIN TAB 40MG	1,721	1,429	\$25,866.98	\$15.03	1.2	15.24%
ATORVASTATIN TAB 20MG	1,511	1,253	\$20,999.50	\$13.90	1.21	12.37%
ATORVASTATIN TAB 10MG	1,209	703	\$14,852.50	\$12.28	1.72	8.75%
ATORVASTATIN TAB 80MG	557	477	\$8,940.38	\$16.05	1.17	5.27%
EZETIMIBE TAB 10MG	481	259	\$6,714.76	\$13.96	1.86	3.95%
ROSUVASTATIN TAB 10MG	456	387	\$6,512.42	\$14.28	1.18	3.84%
ROSUVASTATIN TAB 20MG	433	372	\$6,824.72	\$15.76	1.16	4.02%
ROSUVASTATIN TAB 40MG	263	224	\$4,742.65	\$18.03	1.17	2.79%
ROSUVASTATIN TAB 5MG	214	169	\$3,020.12	\$14.11	1.27	1.78%
SIMVASTATIN TAB 20MG	191	157	\$2,438.97	\$12.77	1.22	1.44%
SIMVASTATIN TAB 40MG	121	101	\$1,719.10	\$14.21	1.2	1.01%
PRAVASTATIN TAB 40MG	117	102	\$2,003.97	\$17.13	1.15	1.18%
PRAVASTATIN TAB 20MG	98	82	\$1,478.51	\$15.09	1.2	0.87%
SIMVASTATIN TAB 10MG	96	74	\$1,208.22	\$12.59	1.3	0.71%
PRAVASTATIN TAB 10MG	60	45	\$884.53	\$14.74	1.33	0.52%
LOVASTATIN TAB 20MG	55	48	\$795.58	\$14.47	1.15	0.47%
PRAVASTATIN TAB 80MG	29	28	\$678.39	\$23.39	1.04	0.40%
LOVASTATIN TAB 40MG	26	23	\$409.16	\$15.74	1.13	0.24%
LOVASTATIN TAB 10MG	16	15	\$225.80	\$14.11	1.07	0.13%
SIMVASTATIN TAB 80MG	10	7	\$136.98	\$13.70	1.43	0.08%
SIMVASTATIN TAB 5MG	7	5	\$84.72	\$12.10	1.4	0.05%
SUBTOTAL	7,671	5,960	\$110,537.96	\$14.41	1.29	65.11%
SPECIAL PA UTILIZATION						
PITAVASTATIN TAB 1MG	3	3	\$145.29	\$48.43	1	0.09%
LIVALO TAB 2MG	3	2	\$954.01	\$318.00	1.5	0.56%
LESCOL XL TAB 80MG	2	1	\$809.14	\$404.57	2	0.48%
EZETIM/SIMVA TAB 10-10MG	2	1	\$47.55	\$23.78	2	0.03%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
EZETIM/SIMVA TAB 10-20MG	1	1	\$21.21	\$21.21	1	0.01%
EZETIM/SIMVA TAB 10-40MG	1	1	\$21.02	\$21.02	1	0.01%
PITAVASTATIN TAB 4MG	1	1	\$64.05	\$64.05	1	0.04%
PITAVASTATIN TAB 2MG	1	1	\$66.86	\$66.86	1	0.04%
SUBTOTAL	14	11	\$2,129.13	\$152.08	1.27	1.25%
STATIN AND EZETIMIBE TOTAL	7,685	5,971	\$112,667.09	\$14.66	1.29	66.36%
FIBRIC ACID DERIVATIVE PRODUCTS						
TIER-1 UTILIZATION						
FENOFIBRATE TAB 145MG	256	145	\$3,195.87	\$12.48	1.77	1.88%
FENOFIBRATE TAB 160MG	142	74	\$2,079.75	\$14.65	1.92	1.22%
GEMFIBROZIL TAB 600MG	83	52	\$1,218.03	\$14.68	1.6	0.72%
FENOFIBRATE TAB 48MG	80	46	\$1,140.43	\$14.26	1.74	0.67%
FENOFIBRATE TAB 54MG	52	29	\$711.23	\$13.68	1.79	0.42%
FENOFIBRATE CAP 134MG	46	28	\$686.53	\$14.92	1.64	0.40%
FENOFIBRIC CAP 45MG DR	14	5	\$228.31	\$16.31	2.8	0.13%
FENOFIBRATE CAP 67MG	13	7	\$178.34	\$13.72	1.86	0.11%
TRICOR TAB 48MG	1	1	\$28.40	\$28.40	1	0.02%
SUBTOTAL	687	387	\$9,466.89	\$13.78	1.78	5.58%
TIER-2 UTILIZATION						
FENOFIBRATE TAB 120MG	8	4	\$3,841.82	\$480.23	2	2.26%
FENOFIBRATE CAP 50MG	5	3	\$434.26	\$86.85	1.67	0.26%
FENOFIBRATE CAP 200MG	5	3	\$79.55	\$15.91	1.67	0.05%
FENOFIBRATE CAP 43MG	4	2	\$83.34	\$20.84	2	0.05%
FENOFIBRATE CAP 150MG	3	1	\$517.52	\$172.51	3	0.30%
FENOFIBRATE TAB 40MG	3	1	\$637.84	\$212.61	3	0.38%
FENOFIBRATE CAP 130MG	2	2	\$66.75	\$33.38	1	0.04%
FENOFIBRIC CAP 135MG DR	2	1	\$42.14	\$21.07	2	0.02%
SUBTOTAL	32	17	\$5,703.22	\$178.23	1.88	3.36%
FIBRIC ACID DERIVATIVE TOTAL	719	404	\$15,170.11	\$21.10	1.78	8.94%
OMEGA-3 FATTY ACID PRODUCTS						
OMEGA-3-ACID CAP 1GM	119	80	\$4,955.29	\$41.64	1.49	2.92%
ICOSAPENT CAP 1GM	29	17	\$3,450.66	\$118.99	1.71	2.03%
VASCEPA CAP 1GM	6	3	\$1,599.60	\$266.60	2	0.94%
OMEGA-3 FATTY ACIDS TOTAL	154	100	\$10,005.55	\$64.97	1.54	5.89%
PCSK9 INHIBITORS						
REPATHA SURE INJ 140MG/ML	33	18	\$18,303.08	\$554.64	1.83	10.78%
REPATHA INJ 140MG/ML	16	6	\$8,861.84	\$553.87	2.67	5.22%
REPATHA PUSH INJ 420MG/3.5ML	1	1	\$599.63	\$599.63	1	0.35%
PCSK9 INHIBITOR TOTAL	50	25	\$27,764.55	\$555.29	2	16.35%
COLESEVELAM PRODUCTS						
COLESEVELAM TAB 625MG	27	14	\$948.96	\$35.15	1.93	0.56%
COLESEVELAM PRODUCTS TOTAL	27	14	\$948.96	\$35.15	1.93	0.56%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
BEMPEDOIC ACID AND EZETIMIBE PRODUCTS						
NEXLIZET TAB 180/10MG	7	3	\$2,821.85	\$403.12	2.33	1.66%
BEMPEDOIC ACID/EZETIMIBE TOTAL	7	3	\$2,821.85	\$403.12	2.33	1.66%
BEMPEDOIC ACID PRODUCTS						
NEXLETOL TAB 180MG	1	1	\$402.63	\$402.63	1	0.24%
BEMPEDOIC ACID TOTAL	1	1	\$402.63	\$402.63	1	0.24%
TOTAL	8,643	5,993*	\$169,780.74	\$19.64	1.44	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DR = delayed-release; EZETIM/SIMVA = ezetimibe/simvastatin; INJ = injection; PA = prior authorization; PUSH = Pushtronex®; SURE = SureClick®; 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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
STATIN PRODUCTS AND EZETIMIBE						
TIER-1 UTILIZATION						
ATORVASTATIN TAB 40MG	1,150	1,039	\$16,860.56	\$14.66	1.11	14.18%
ATORVASTATIN TAB 20MG	1,068	928	\$14,837.76	\$13.89	1.15	12.48%
ATORVASTATIN TAB 10MG	774	502	\$9,448.19	\$12.21	1.54	7.95%
ATORVASTATIN TAB 80MG	354	311	\$5,973.38	\$16.87	1.14	5.02%
ROSUVASTATIN TAB 10MG	349	306	\$4,957.36	\$14.20	1.14	4.17%
ROSUVASTATIN TAB 20MG	333	288	\$5,224.76	\$15.69	1.16	4.39%
EZETIMIBE TAB 10MG	330	209	\$4,555.57	\$13.80	1.58	3.83%
ROSUVASTATIN TAB 40MG	189	160	\$3,359.78	\$17.78	1.18	2.83%
ROSUVASTATIN TAB 5MG	152	131	\$2,148.88	\$14.14	1.16	1.81%
SIMVASTATIN TAB 20MG	141	123	\$1,828.11	\$12.97	1.15	1.54%
PRAVASTATIN TAB 40MG	94	81	\$1,604.97	\$17.07	1.16	1.35%
SIMVASTATIN TAB 40MG	73	63	\$1,027.74	\$14.08	1.16	0.86%
PRAVASTATIN TAB 20MG	67	61	\$1,027.53	\$15.34	1.1	0.86%
SIMVASTATIN TAB 10MG	65	58	\$833.21	\$12.82	1.12	0.70%
LOVASTATIN TAB 20MG	32	29	\$464.83	\$14.53	1.1	0.39%
PRAVASTATIN TAB 10MG	28	26	\$438.29	\$15.65	1.08	0.37%
PRAVASTATIN TAB 80MG	22	21	\$485.49	\$22.07	1.05	0.41%
LOVASTATIN TAB 40MG	20	19	\$321.53	\$16.08	1.05	0.27%
SIMVASTATIN TAB 5MG	11	5	\$132.99	\$12.09	2.2	0.11%
LOVASTATIN TAB 10MG	7	7	\$94.82	\$13.55	1	0.08%
SIMVASTATIN TAB 80MG	4	4	\$54.56	\$13.64	1	0.05%
SUBTOTAL	5,263	4,371	\$75,680.31	\$14.38	1.2	63.65%
SPECIAL PA UTILIZATION						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS / MEMBER	% COST
PITAVASTATIN TAB 2MG	4	2	\$261.22	\$65.31	2	0.22%
LIVALO TAB 2MG	3	1	\$954.56	\$318.19	3	0.80%
PITAVASTATIN TAB 4MG	1	1	\$63.33	\$63.33	1	0.05%
PITAVASTATIN TAB 1MG	1	1	\$37.90	\$37.90	1	0.03%
FLUVASTATIN CAP 40MG	1	1	\$108.67	\$108.67	1	0.09%
SUBTOTAL	10	6	\$1,425.68	\$142.57	1.67	1.20%
STATIN AND EZETIMIBE TOTAL	5,273	4,377	\$77,105.99	\$14.62	1.2	64.84%
FIBRIC ACID DERIVATIVE PRODUCTS						
TIER-1 UTILIZATION						
FENOFIBRATE TAB 145MG	171	110	\$2,231.81	\$13.05	1.55	1.88%
FENOFIBRATE TAB 160MG	89	55	\$1,306.36	\$14.68	1.62	1.10%
GEMFIBROZIL TAB 600MG	72	41	\$988.06	\$13.72	1.76	0.83%
FENOFIBRATE TAB 48MG	34	24	\$483.29	\$14.21	1.42	0.41%
FENOFIBRATE CAP 134MG	32	22	\$483.34	\$15.10	1.45	0.41%
FENOFIBRATE TAB 54MG	23	18	\$315.28	\$13.71	1.28	0.27%
FENOFIBRATE CAP 67MG	8	4	\$110.90	\$13.86	2	0.09%
FENOFIBRIC CAP 45MG DR	6	3	\$109.46	\$18.24	2	0.09%
SUBTOTAL	435	277	\$6,028.50	\$13.86	1.57	5.07%
TIER-2 UTILIZATION						
FENOFIBRATE TAB 120MG	8	4	\$2,609.28	\$326.16	2	2.19%
FENOFIBRATE CAP 50MG	7	5	\$577.58	\$82.51	1.4	0.49%
FENOFIBRATE CAP 200MG	3	2	\$48.99	\$16.33	1.5	0.04%
FENOFIBRATE CAP 150MG	2	1	\$374.90	\$187.45	2	0.32%
FENOFIBRATE CAP 130MG	2	1	\$69.16	\$34.58	2	0.06%
FENOFIBRIC CAP 135MG DR	1	1	\$21.07	\$21.07	1	0.02%
FENOFIBRATE CAP 43MG	1	1	\$20.35	\$20.35	1	0.02%
FENOFIBRATE TAB 40MG	1	1	\$223.69	\$223.69	1	0.19%
SUBTOTAL	25	16	\$3,945.02	\$157.80	1.56	3.32%
FIBRIC ACID DERIVATIVE TOTAL	460	293	\$9,973.52	\$21.68	1.57	8.39%
OMEGA-3 FATTY ACID PRODUCTS						
OMEGA-3-ACID CAP 1GM	74	61	\$3,200.42	\$43.25	1.21	2.69%
ICOSAPENT CAP 1GM	23	13	\$2,549.54	\$110.85	1.77	2.14%
VASCEPA CAP 1GM	6	3	\$1,939.86	\$323.31	2	1.63%
ICOSAPENT CAP 0.5GM	1	1	\$110.04	\$110.04	1	0.09%
OMEGA-3 FATTY ACIDS TOTAL	104	78	\$7,799.86	\$75.00	1.33	6.56%
PCSK9 INHIBITORS						
REPATHA SURE INJ 140MG/ML	27	14	\$14,979.30	\$554.79	1.93	12.60%
PRALUENT INJ 75MG/ML	7	3	\$3,508.27	\$501.18	2.33	2.95%
REPATHA PUSH INJ 420MG/3.5ML	3	2	\$1,794.54	\$598.18	1.5	1.51%
REPATHA INJ 140MG/ML	3	2	\$1,661.39	\$553.80	1.5	1.40%
PCSK9 INHIBITOR TOTAL	40	21	\$21,943.50	\$548.59	1.9	18.45%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS / MEMBER	% COST
COLESEVELAM PRODUCTS						
COLESEVELAM TAB 625MG	13	8	\$472.90	\$36.38	1.63	0.40%
COLESEVELAM PRODUCTS TOTAL	13	8	\$472.90	\$36.38	1.63	0.40%
BEMPEDOIC ACID PRODUCTS						
NEXLETOL TAB 180MG	3	2	\$1,210.92	\$403.64	1.5	1.02%
BEMPEDOIC ACID TOTAL	3	2	\$1,210.92	\$403.64	1.5	1.02%
BEMPEDOIC ACID AND EZETIMIBE PRODUCTS						
NEXLIZET TAB 180/10MG	1	1	\$402.68	\$402.68	1	0.34%
BEMPEDOIC ACID/EZETIMIBE TOTAL	1	1	\$402.68	\$402.68	1	0.34%
TOTAL	5,894	4,449*	\$118,909.37	\$20.17	1.32	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DR = delayed-release; INJ = injection; PA = prior authorization; PUSH = Pushtronex®; SURE = SureClick®; 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.

Fee-For-Service Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS*	TOTAL MEMBERS*	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER
INCLISIRAN INJ (J1306)	6	4	\$20,564.44	\$3,427.41	1.50
TOTAL	6	4	\$20,564.44	\$3,427.41	1.50

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

*Total number of unduplicated claims.

INJ = injection

Fiscal Year 2024 = 07/01/2023 to 06/30/2024

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 12/2024. Last accessed 12/18/2024.

² Praluent® (Alirocumab) – Expanded indication. *OptumRx*. Available online at: https://professionals.optumrx.com/content/dam/optum3/professional-optumrx/news/rxnews/clinical-updates/clinicalupdate_praluent_2024-0312.pdf. Issued 03/11/2024. Last accessed 12/18/2024.

³ Esperion Therapeutics. U.S. FDA Approves Broad New Labels for Nexletol® and Nexlizet® to Prevent Heart Attacks and Cardiovascular Procedures in Both Primary and Secondary Prevention Patients, Regardless of Statin Use. *Globe Newswire*. Available online at: <https://www.globenewswire.com/news-release/2024/03/22/2851118/0/en/U-S-FDA-Approves-Broad-New-Labels-for-NEXLETOL-and-NEXLIZET-to-Prevent-Heart-Attacks-and-Cardiovascular-Procedures-in-Both-Primary-and-Secondary-Prevention-Patients-Regardless-of-S.html>. Issued 03/22/2024. Last accessed 12/18/2024.

⁴ Nexletol® (Bempedoic Acid) Prescribing Information. Esperion Therapeutics. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/211616s012s013lbl.pdf. Last revised 03/2024. Last accessed 12/18/2024.

⁵ Ionis Pharmaceuticals. Tryngolza™ (Olezarsen) Approved in U.S. As First-Ever Treatment for Adults Living with Familial Chylomicronemia Syndrome as an Adjunct to Diet. *PR Newswire*. Available online at: <https://www.prnewswire.com/news-releases/tryngolza-olezarsen-approved-in-us-as-first-ever-treatment-for-adults-living-with-familial-chylomicronemia-syndrome-as-an-adjunct-to-diet-302336747.html>. Issued 12/19/2024. Last accessed 12/20/2024.

⁶ Orphanet. Familial Chylomicronemia Syndrome. Available online at: <https://www.orpha.net/en/disease/detail/444490>. Last updated 03/2023. Last accessed 12/20/2024.

⁷ U.S. FDA. FDA Drug Shortages: Discontinuations. Available online at: <https://dps.fda.gov/drugshortages/discontinuations/evolocumab-injection>. Issued 04/12/2024. Last accessed 12/18/2024.

⁸ Amgen. Important Notice for Patients: Discontinuation of Repatha® (Evolocumab) Pushtronex® System (Single-dose On-body Infusor with Prefilled Cartridge). Available online at: <https://www.repatha.com/pushtronexsystemupdate>. Last accessed 12/18/2024.

⁹ LIB Therapeutics. LIB Therapeutics Submits a Biologics License Application to FDA for Lerodalcibep for the Treatment of Adults with Elevated LDL-Cholesterol. *Businesswire*. Available online at: <https://www.businesswire.com/news/home/20241216448140/en/LIB-Therapeutics-Submits-a-Biologic-License-Application-to-FDA-for-Lerodalcibep-for-the-Treatment-of-Adults-with-Elevated-LDL-Cholesterol>. Issued 12/16/2024. Last accessed 12/18/2024.

¹⁰ LIB Therapeutics. LIB Therapeutics Announces Positive Lerodalcibep Results from Two Phase 3 LIBerate Studies at the 92nd European Atherosclerosis Society Congress. *Businesswire*. Available online at: <https://www.businesswire.com/news/home/20240529904905/en/LIB-Therapeutics-Announces-Positive-Lerodalcibep-Results-from-Two-Phase-3-LIBerate-Studies-at-the-92nd-European-Atherosclerosis-Society-Congress/>. Issued 05/29/2024. Last accessed 12/18/2024.

¹¹ Arrowhead Pharmaceuticals. Arrowhead Pharmaceuticals Submits New Drug Application to U.S. FDA for Plozasiran for the Treatment of Familial Chylomicronemia Syndrome. Available online at: <https://arrowheadpharma.com/news-press/arrowhead-pharmaceuticals-submits-new-drug-application-to-u-s-fda-for-plozasiran-for-the-treatment-of-familial-chylomicronemia-syndrome/>. Issued 11/18/2024. Last accessed 12/18/2024.

¹² Arrowhead Pharmaceuticals. Arrowhead Pharmaceuticals Presents New Data at AHA24 from PALISADE Phase 3 Study and Open-Label Extension from MUIR and SHASTA-2 Studies of Plozasiran. Available online at: <https://arrowheadpharma.com/news-press/arrowhead-pharmaceuticals-presents-new-data-at-aha24-from-palisade-phase-3-study-and-open-label-extension-from-muir-and-shasta-2-studies-of-plozasiran/>. Issued 11/18/2024. Last accessed 12/18/2024.

¹³ Tryngolza™ (Olezarsen) Prescribing Information. Ionis Pharmaceuticals. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/218614s000lbl.pdf. Last revised 12/2024. Last accessed 12/20/2024.

¹⁴ Stroes E, Alexander V, Karwatowska-Prokopczuk E, et al. Olezarsen, Acute Pancreatitis, and Familial Chylomicronemia Syndrome. *N Engl J Med* 2024; 390:1781-1792. doi: 10.1056/NEJMoa2400201.



Appendix D

Fiscal Year 2024 Annual Review of Adrenocorticotrophic Hormone (ACTH) Products and 30-Day Notice to Prior Authorize Acthar® Gel SelfJect™ (Repository Corticotropin Auto-Injector) and Purified Cortrophin® Gel (Repository Corticotropin Injection)

**Oklahoma Health Care Authority
January 2025**

Current Prior Authorization Criteria

H.P. Acthar® Gel (Repository Corticotropin Injection) Approval Criteria:

1. An FDA approved diagnosis of infantile spasms; and
 - a. Member must be 2 years of age or younger; and
 - b. Must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); or
2. An FDA approved diagnosis of multiple sclerosis (MS); and
 - a. Member is experiencing an acute exacerbation; and
 - b. Must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist) or a prescriber who specializes in MS; and
 - c. Prescriber must rule out pseudo-exacerbation from precipitating factors (e.g., pain, stress, infection, premenstrual syndrome); and
 - d. Symptoms of acute exacerbation last at least 24 hours; and
 - e. Member must be currently stable within the last 30 days on an immunomodulator agent, unless contraindicated; and
 - f. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy [e.g., intravenous (IV) methylprednisolone, IV dexamethasone, oral prednisone] must be provided; and
 - g. A quantity limit of daily doses of up to 120 units for up to 3 weeks for acute exacerbation will apply; or
3. An FDA approved diagnosis of nephrotic syndrome without uremia of the idiopathic type or that is due to lupus erythematosus to induce diuresis or remission of proteinuria; and
 - a. Must be prescribed by, or in consultation with, a nephrologist (or an advanced care practitioner with a supervising physician who is a nephrologist); and
 - b. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g., prednisone) must be provided; or

4. An FDA approved diagnosis of the following disorders or diseases: rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; or edematous states; and
 - a. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy must be provided.

Utilization of ACTH Products: 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	12	35	\$2,415,360.01	\$69,010.29	\$2,766.74	325	873
2023 Total	12	35	\$2,415,360.01	\$69,010.29	\$2,766.74	325	873
Fiscal Year 2024							
FFS	8	19	\$1,804,839.01	\$94,991.53	\$2,319.84	250	778
Aetna	0	0	\$0.00	\$0.00	\$0.00	0	0
Humana	2	4	\$573,011.43	\$143,252.86	\$5,457.25	85	105
OCH	1	1	\$76,395.60	\$76,395.60	\$7,639.56	10	10
2024 Total	11	24	\$2,454,246.04	\$102,260.25	\$2,748.32	345	893
% Change	-8.30%	-31.40%	1.60%	48.20%	-0.70%	6.20%	2.30%
Change	-1	-11	\$38,886.03	\$33,249.96	-\$18.42	20	20

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

FFS = fee-for-service; OCH = Oklahoma Complete Health

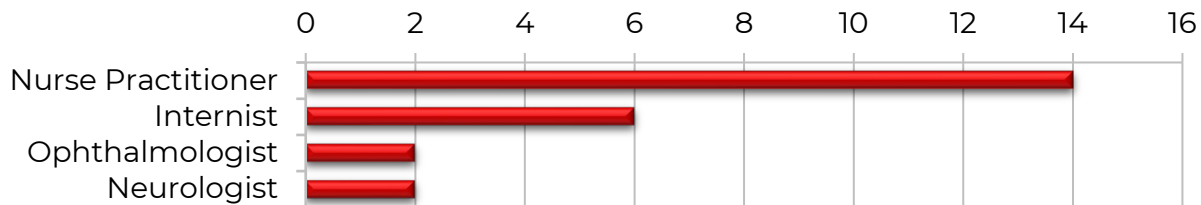
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Demographics of Members Utilizing ACTH Products (All Plans)

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

Top Prescriber Specialties of ACTH Products by Number of Claims (All Plans)



Prior Authorization of ACTH Products

There were 37 prior authorization requests submitted for ACTH products 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	8	24%	18	55%	7	21%	33
Aetna	0	N/A	0	N/A	0	N/A	0
Humana	2	100%	0	0%	0	0%	2
OCH	1	50%	0	0%	1	50%	2
Total	11	30%	18	49%	8	21%	37

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 Expiration(s):

- Acthar® Gel (repository corticotropin injection): February 2041
- Acthar® Gel SelfJect™ (repository corticotropin auto-injector): February 2041
- Purified Cortrophin® Gel (repository corticotropin injection): October 2043

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

- November 2021:** The FDA approved a supplemental New Drug Application (sNDA) for Purified Cortrophin® Gel (repository corticotropin injection) for all indications of Acthar® Gel except infantile spasms. Purified Cortrophin® Gel is supplied as 1mL and 5mL multi-dose vials (80units/mL) for subcutaneous or intramuscular injection.

- **March 2024:** Mallinckrodt announced the FDA approval of an sNDA for Acthar® Gel SelfJect™ (repository corticotropin injection) in February 2024 for use in all indications of Acthar® Gel except infantile spasms due to the need for specific dosing based on body surface area (BSA). Acthar® Gel SelfJect™ comes as single-dose, pre-filled auto-injectors in 80units/mL or 40units/0.5mL strengths for subcutaneous injection. In August 2024, Mallinckrodt also announced that Acthar® Gel SelfJect™ is available in the U.S.

Recommendations

The College of Pharmacy recommends the prior authorization of Purified Cortrophin® Gel (repository corticotropin injection) and Acthar® Gel SelfJect™ (repository corticotropin auto-injector) and recommends the following changes to the ACTH products prior authorization criteria based on the new FDA approvals, net costs, and to be consistent with clinical practice (changes shown in red):

H.P. Acthar® Gel (Repository Corticotropin Injection) Approval Criteria:

1. An FDA approved diagnosis of infantile spasms; and
 - a. Member must be 2 years of age or younger; and
 - b. Must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); ~~or and~~
 - c. Only the multi-dose vial will be approved. Acthar® Gel SelfJect™ auto-injector will not be approved for this indication; or
2. An FDA approved diagnosis of multiple sclerosis (MS); and
 - a. Member is experiencing an acute exacerbation; and
 - b. Must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist) or a prescriber who specializes in MS; and
 - c. Prescriber must rule out pseudo-exacerbation from precipitating factors (e.g., pain, stress, infection, premenstrual syndrome); and
 - d. Symptoms of acute exacerbation last at least 24 hours; and
 - e. Member must be currently stable within the last 30 days on an immunomodulator agent, unless contraindicated; and
 - f. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy [e.g., intravenous (IV) methylprednisolone, IV dexamethasone, oral prednisone] must be provided; and
 - g. A quantity limit of daily doses of up to 120 units for up to 3 weeks for acute exacerbation will apply; or
3. An FDA approved diagnosis of nephrotic syndrome without uremia of the idiopathic type or that is due to lupus erythematosus to induce diuresis or remission of proteinuria; and

- a. Must be prescribed by, or in consultation with, a nephrologist (or an advanced care practitioner with a supervising physician who is a nephrologist); and
- b. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g., prednisone) must be provided; or
- 4. An FDA approved diagnosis of the following disorders or diseases: rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; or edematous states; and
 - a. Must be prescribed by or in consultation with a specialist appropriate to the member's disease state (or an advanced care practitioner with a supervising physician who is a specialist appropriate to the member's disease state); and
 - b. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy must be provided; and
- 5. Requests for Purified Cortrophin® Gel (repository corticotropin injection) will require a patient-specific, clinically significant reason why Acthar® Gel (repository corticotropin injection) or Acthar® Gel SelfJect™ (repository corticotropin auto-injector) cannot be used.

Utilization Details of ACTH Products: Fiscal Year 2024

Fee-For-Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
CORTROPHIN GEL 80UNIT	12	5	\$899,179.14	\$74,931.60	2.4	49.82%
ACTHAR INJ 80UNIT	7	3	\$905,659.87	\$129,379.98	2.33	50.18%
TOTAL	19	8*	\$1,804,839.01	\$94,991.53	2.38	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

INJ = injection

Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
CORTROPHIN GEL 80UNIT	3	1	\$505,592.28	\$168,530.76	3	88.23%
ACTHAR INJ 80UNIT	1	1	\$67,419.15	\$67,419.15	1	11.77%
TOTAL	4	2*	\$573,011.43	\$143,252.86	2	100%

Costs do not reflect rebated prices or net costs.

*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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
CORTROPHIN GEL 80UNIT	1	1	\$76,395.60	\$76,395.60	1	100%
TOTAL	1	1*	\$76,395.60	\$76,395.60	1	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

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: <http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm>. Last revised 12/2024. Last accessed 12/18/2024.

² ANI Pharmaceuticals. ANI Pharmaceuticals Announces FDA Approval of Purified Cortrophin® Gel for Multiple Indications Including Multiple Sclerosis, Rheumatoid Arthritis and Nephrotic Syndrome. *Business Wire*. Available online at: <https://www.businesswire.com/news/home/20211101005292/en/ANI-Pharmaceuticals-Announces-FDA-Approval-of-Purified-Cortrophin%E2%84%A2-Gel-for-Multiple-Indications-Including-Multiple-Sclerosis-Rheumatoid-Arthritis-and-Nephrotic-Syndrome>. Issued 11/01/2021. Last accessed 12/26/2024.

³ Purified Cortrophin® Gel (Repository Corticotrophin Injection) Prescribing Information. ANI Pharmaceuticals, Inc. Available online at: <https://cortrophin.com/pdfs/purified-cortrophin-gel-prescribing-information.pdf>. Last revised 10/2023. Last accessed 12/18/2024.

⁴ Mallinckrodt. Mallinckrodt Announces U.S. FDA Approval of Supplemental New Drug Application for Acthar® Gel (Repository Corticotropin Injection) Single-Dose Pre-filled SelfJect™ Injector. *PR Newswire*. Available online at: <https://www.prnewswire.com/news-releases/mallinckrodt-announces-us-fda-approval-of-supplemental-new-drug-application-for-acthar-gel-repository-corticotropin-injection-single-dose-pre-filled-selfject-injector-302077212.html>. Issued 03/01/2024. Last accessed 12/18/2024.

⁵ Mallinckrodt. Mallinckrodt Announces Availability of Acthar® Gel (Repository Corticotropin Injection) Single-Dose Pre-filled SelfJect™ Injector in the U.S. *PR Newswire*. Available online at: <https://www.prnewswire.com/news-releases/mallinckrodt-announces-availability-of-acthar-gel-repository-corticotropin-injection-single-dose-pre-filled-selfject-injector-in-the-us-302214582.html>. Issued 08/06/2024. Last accessed 12/18/2024.

⁶ Acthar® Gel (Repository Corticotropin Injection) Prescribing Information. Mallinckrodt. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/008372s074lbl.pdf. Last revised 02/2024. Last accessed 12/18/2024.



Appendix E

Fiscal Year 2024 Annual Review of Xgeva® (Denosumab) and 30-Day Notice to Prior Authorize Wyost® (Denosumab-bbdz)

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

Xgeva® (Denosumab) Approval Criteria:

1. An FDA approved indication of 1 of the following:
 - a. Prevention of skeletal-related events in members with multiple myeloma and in members with bone metastases from solid tumors; or
 - b. Treatment of adults and skeletally mature adolescents with giant cell tumor of the bone (GCTB) that is unresectable or where surgical resection is likely to result in severe morbidity; and
 - i. Prescriber must document that tumor is unresectable or that surgical resection is likely to result in severe morbidity; or
 - c. Treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy; and
 - i. Member must have albumin-corrected calcium of >12.5mg/dL (3.1mmol/L) despite treatment with intravenous bisphosphonate therapy in the last 30 days prior to initiation of Xgeva® therapy.

Utilization of Xgeva® (Denosumab): Fiscal Year 2024

Comparison of Fiscal Years: Medical Claims (All Plans)

Plan Type	*Total Members	*Total Claims	Total Cost	Cost/Claim	Claims/Member
Fiscal Year 2023					
FFS	91	409	\$1,111,464.00	\$2,717.52	4.49
2023 Total	91	409	\$1,111,464.00	\$2,717.52	4.49
Fiscal Year 2024					
FFS	79	294	\$865,099.20	\$2,942.51	3.72
Aetna	1	1	\$3,022.80	\$3,022.80	1
Humana	1	1	\$3,024.00	\$3,024.00	1
OCH	2	2	\$6,046.80	\$3,023.40	1
2024 Total	78	298	\$877,192.80	\$2,943.60	3.82
% Change	-14.29%	-27.14%	-21.08%	8.32%	-14.92%
Change	-13	-111	-\$234,271.20	\$226.08	-0.67

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

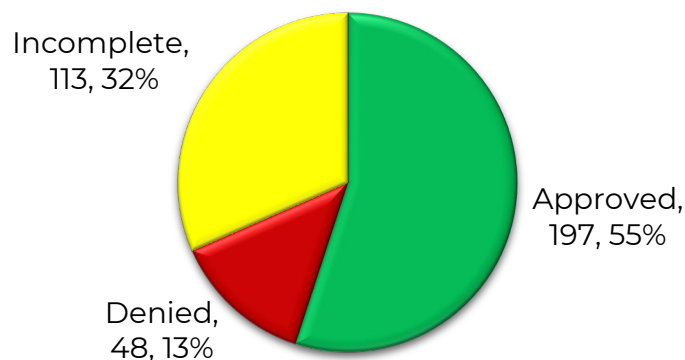
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Prior Authorization of Xgeva® (Denosumab)

There were 358 prior authorization requests submitted for denosumab during fiscal year 2024. Xgeva® (denosumab) and Prolia® (denosumab) are billed using the same procedure code; therefore, the status of petitions includes prior authorization requests for both Xgeva® and Prolia®. Prolia® is reviewed annually with the osteoporosis medications. The Fiscal Year 2024 Annual Review of Osteoporosis Medications is included in the December 2024 Drug Utilization Review (DUR) Board Packet. The following chart shows the status of the submitted petitions for all denosumab products 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	185	53%	113	33%	48	14%	346
Aetna	0	N/A	0	N/A	0	N/A	0
Humana	12	100%	0	0%	0	0%	12
OCH	0	N/A	0	N/A	0	N/A	0
Total	197	55%	113	32%	48	13%	358

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}

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

- March 2024:** The FDA approved Wyost® (denosumab-bbdz) as an interchangeable biosimilar to Xgeva® (denosumab) for all the currently approved indications for Xgeva®. The cost for Wyost® (denosumab-bbdz) is not available at this time.

Pipeline:

- **HLX14:** In October 2024, Organon announced that the FDA accepted the Biologic License Application (BLA) for HLX14, an investigational biosimilar to Xgeva® (denosumab).

Recommendations

The College of Pharmacy recommends the prior authorization of Wyost® (denosumab-bbdz) with criteria similar to Xgeva® (denosumab) with the following additional criteria (changes shown in red):

Wyost® (Denosumab-bbdz) and Xgeva® (Denosumab) Approval Criteria:

1. An FDA approved indication of 1 of the following:
 - a. Prevention of skeletal-related events in members with multiple myeloma and in members with bone metastases from solid tumors; or
 - b. Treatment of adults and skeletally mature adolescents with giant cell tumor of the bone (GCTB) that is unresectable or where surgical resection is likely to result in severe morbidity; and
 - ii. Prescriber must document that tumor is unresectable or that surgical resection is likely to result in severe morbidity; or
 - d. Treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy; and
 - i. Member must have albumin-corrected calcium of >12.5mg/dL (3.1mmol/L) despite treatment with intravenous bisphosphonate therapy in the last 30 days prior to initiation of Xgeva® therapy; and
2. For Wyost® (denosumab-bbdz), a patient-specific, clinically significant reason why the member cannot use Xgeva® (denosumab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Utilization Details of Xgeva® (Denosumab): Fiscal Year 2024

Fee-For-Service Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS*	TOTAL MEMBERS*	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER
J0897 DENOSUMAB INJ (XGEVA)	294	79	\$865,099.20	\$2,942.51	3.72
TOTAL	294	79	\$865,099.20	\$2,942.51	3.72

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

Aetna Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS ⁺	TOTAL MEMBERS*	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER
J0897 DENOSUMAB INJ (XGEVA)	1	1	\$3,022.80	\$3,022.80	1
TOTAL	1	1	\$3,022.80	\$3,022.80	1

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.

Humana Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS ⁺	TOTAL MEMBERS*	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER
J0897 DENOSUMAB INJ (XGEVA)	1	1	\$3,024.00	\$3,024.00	1
TOTAL	1	1	\$3,024.00	\$3,024.00	1

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.

OK Complete Health Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS ⁺	TOTAL MEMBERS*	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER
J0897 DENOSUMAB INJ (XGEVA)	2	2	\$6,046.80	\$3,023.40	1
TOTAL	2	2	\$6,046.80	\$3,023.40	1

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.

¹U.S. Food and Drug Administration (FDA). FDA Approves First Interchangeable Biosimilars to Prolia[®] and Xgeva[®] to Treat Certain Types of Osteoporosis and Prevent Bone Events in Cancer. Available online at: <https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-first-interchangeable-biosimilars-prolia-and-xgeva-treat-certain-types-osteoporosis-and>. Issued 03/05/2024. Last accessed 12/18/2024.

² Organon. U.S. FDA Accepts Biologics License Application (BLA) for HLX14, Biosimilar Candidate of Prolia[®]/Xgeva[®] (Denosumab). Available online at: <https://www.organon.com/news/us-fda-accepts-biologics-license-application-bla-for-hlx14-biosimilar-candidate-of-prolia-xgeva-denosumab/>. Issued 10/30/2024. Last accessed 12/18/2024.



Appendix F

Fiscal Year 2024 Annual Review of Systemic Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) and 30-Day Notice to Prior Authorize Diflunisal 500mg Tablet, Dolobid™ (Diflunisal) 250mg and 375mg Tablet, and Indomethacin 50mg Suppository

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)		
Tier-1	Tier-2	Special PA
celecoxib (Celebrex®) 50mg, 100mg, & 200mg caps	diclofenac ER (Voltaren® XR)	celecoxib (Celebrex®) 400mg caps
diclofenac epolamine (Flector® Patch) – Brand Preferred	diclofenac potassium (Cataflam®)	celecoxib (Elyxyb®) oral solution
diclofenac sodium (Voltaren®) 50mg & 75mg tabs	diclofenac sodium/ misoprostol (Arthrotec®)	diclofenac (Zorvolex®)
diclofenac sodium 1% (Voltaren® Gel)	diclofenac sodium (Voltaren®) 25mg tabs	diclofenac epolamine (Licart®) topical system
etodolac (Lodine®) 400mg & 500mg tabs	etodolac (Lodine®) 200mg & 300mg caps	diclofenac potassium (Cambia®) powder pack
flurbiprofen (Ansaid®)	etodolac ER (Lodine® XL)	diclofenac potassium (Lofena™) tabs
ibuprofen (Motrin®)	naproxen sodium (Anaprox®) 275mg & 550mg tabs	diclofenac potassium (Zipsor®) caps
indomethacin (Indocin®) caps	oxaprozin (Daypro®)	diclofenac sodium (Dyloject™) inj
meloxicam (Mobic®)	piroxicam (Feldene®)	diclofenac sodium (Pennsaid®) topical drops
nabumetone (Relafen®)	tolmetin (Tolectin®)	fenoprofen (Nalfon®)
naproxen* (Naprosyn®)		ibuprofen (Caldolor®) inj
naproxen DR (EC- Naprosyn®)		ibuprofen/acetaminophen (Combogesic® IV) inj ⁺
sulindac (Clinoril®)		ibuprofen/famotidine (Duexis®)
		indomethacin (Indocin®) susp & ER caps
		indomethacin (Tivorbex®)

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)		
Tier-1	Tier-2	Special PA
		ketoprofen (Orudis [®]) caps
		ketoprofen ER (Oruvail [®])
		ketorolac tromethamine (Sprix [®]) nasal spray
		meclofenamate (Meclomen [®])
		mefenamic acid (Ponstel [®])
		meloxicam (Anjeso [®]) inj ⁺
		meloxicam (Vivlodex [®]) caps
		meloxicam ODT (Qmiiz ODT [™])
		nabumetone 1,000mg (Relafen DS [®])
		naproxen sodium ER (Naprelan [®])
		naproxen/esomeprazole (Vimovo [®])

Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), or Wholesale Acquisition Costs (WAC) if NADAC unavailable.

*Naproxen oral suspension is available without prior authorization for members 12 years of age and younger. Members older than 12 years of age require a reason why a special formulation product is needed in place of the regular tablet formulation.

*Unique criteria applies.

caps = capsules; DR = delayed-release; ER = extended-release; EC = enteric-coated; inj = injection; ODT = orally disintegrating tablet; PA = prior authorization; susp = suspension; tabs = tablets

NSAIDs Tier-2 Approval Criteria:

1. Previous use of at least 2 Tier-1 NSAID products (from different product lines) plus a proton pump inhibitor (PPI) within the last 120 days.

NSAIDs Special Prior Authorization (PA) Approval Criteria:

1. A unique indication for which a Tier-1 or Tier-2 medication is not appropriate; or
2. Previous use of at least 2 Tier-1 NSAID products (from different product lines); and
3. A patient-specific, clinically significant reason why a special formulation is needed over a Tier-1 product; and
4. Additionally, use of Celebrex[®] (celecoxib) 400mg capsules will require a diagnosis of Familial Adenomatous Polyposis (FAP) and a patient-specific, clinically significant reason why the member cannot use 2 celecoxib 200mg capsules to achieve a 400mg dose; and
5. Additionally, use of Elyxyb[®] (celecoxib oral solution) will require a diagnosis of acute migraine treatment in adults 18 years of age and older and a patient-specific, clinically significant reason why the member cannot use Cambia[®] (diclofenac potassium powder); and

6. Additionally, use of Lofena™ (diclofenac potassium) will require a patient-specific, clinically significant reason why the member cannot use all other available generic diclofenac products; and
7. Additionally, use of Tivorbex® will require a patient-specific, clinically significant reason why the member cannot use all other available generic indomethacin products.

Anjeso® (Meloxicam Injection) Approval Criteria:

1. An FDA approved diagnosis of management of moderate-to-severe pain, alone or in combination with non-NSAID analgesics; and
2. Member must be 18 years of age or older; and
3. Member must be well hydrated before Anjeso® administration to reduce the risk of renal toxicity; and
4. Anjeso® should be used for the shortest duration consistent with individual patient treatment goals; and
5. A patient-specific, clinically significant reason the member cannot use oral meloxicam tablets or other Tier-1 NSAID products must be provided; and
6. A quantity limit of 3 vials per 3 days will apply; and
7. For consideration of a longer duration of use, a patient-specific, clinically significant reason why the member cannot transition to an oral Tier-1 NSAID product must be provided, along with the anticipated duration of treatment.

Combogesic® IV (Ibuprofen/Acetaminophen Injection) Approval Criteria:

1. An FDA approved indication in members where an intravenous (IV) route of administration is considered clinically necessary for 1 of the following:
 - a. Relief of mild-to-moderate pain; or
 - b. Management of moderate-to-severe pain as an adjunct to opioid analgesics; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member requires IV administration and cannot use Tier-1 oral and/or topical alternatives must be provided; and
4. A quantity limit of 2,000mL (20 vials) per 5 days will apply; and
5. A maximum approval duration of 5 days will apply, as Combogesic® IV is only indicated for short-term use of 5 days or less.

Utilization of NSAIDs: 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	138,180	271,648	\$3,663,290.28	\$13.49	\$0.58	13,339,834	6,359,507
2023 Total	138,180	271,648	\$3,663,290.28	\$13.49	\$0.58	13,339,834	6,359,507
Fiscal Year 2024							
FFS	112,127	207,591	\$2,809,802.49	\$13.54	\$0.57	10,033,291	4,972,984
Aetna	8,712	11,602	\$169,534.63	\$14.61	\$0.71	492,887	238,116
Humana	10,259	14,589	\$215,689.03	\$14.78	\$0.70	642,348	309,407
OCH	8,926	11,611	\$167,526.13	\$14.43	\$0.71	495,165	235,026
2024 Total	126,470	245,393	\$3,362,552.28	\$13.70	\$0.58	11,663,691	5,755,533
% Change	-8.50%	-9.70%	-8.20%	1.60%	0.00%	-12.60%	-9.50%
Change	-11,710	-26,255	-\$300,738.00	\$0.21	\$0.00	-1,676,143	-603,974

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

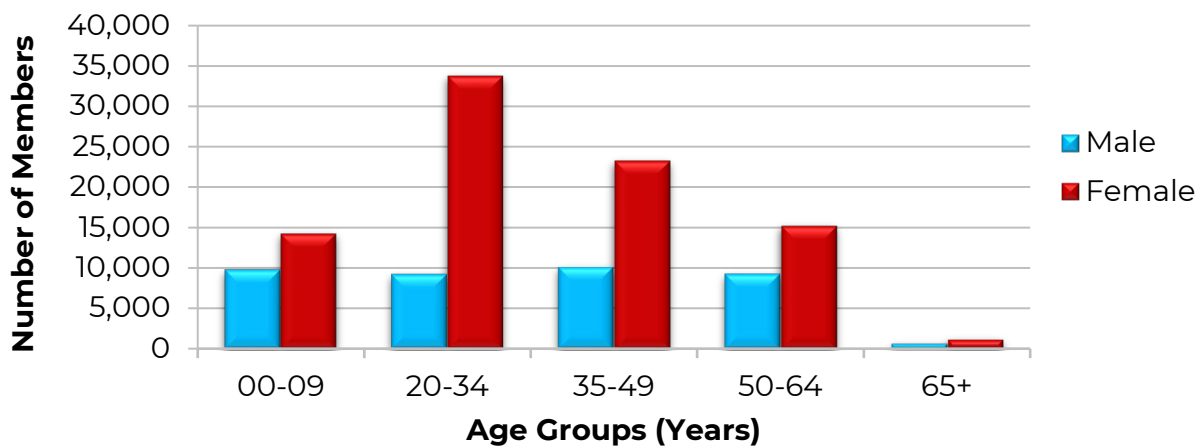
FFS = fee-for-service; OCH = Oklahoma Complete Health

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.

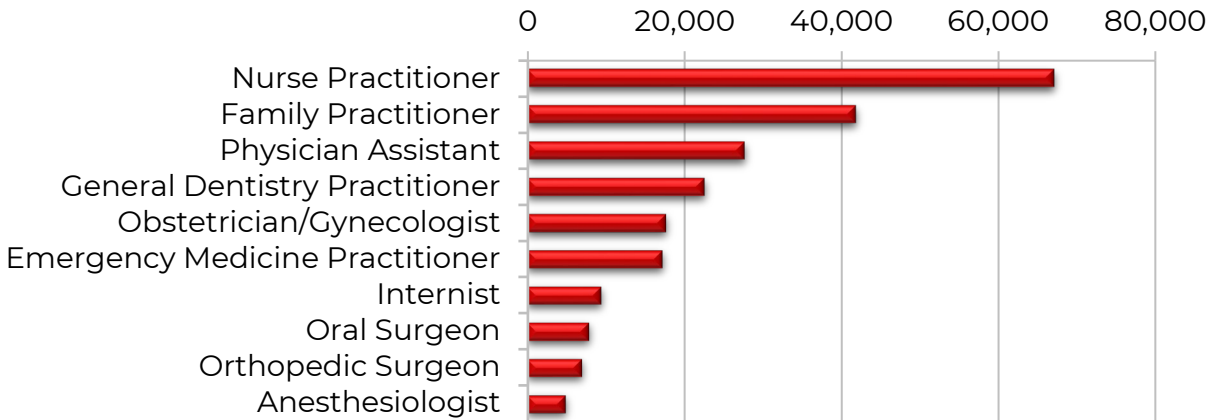
- Aggregate drug rebates collected during fiscal year 2024 for NSAIDs totaled \$116,264.93.^Δ Rebates are collected after reimbursement for the medication and are not reflected in this report. The costs included in this report do not reflect net costs.

Demographics of Members Utilizing NSAIDs (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.

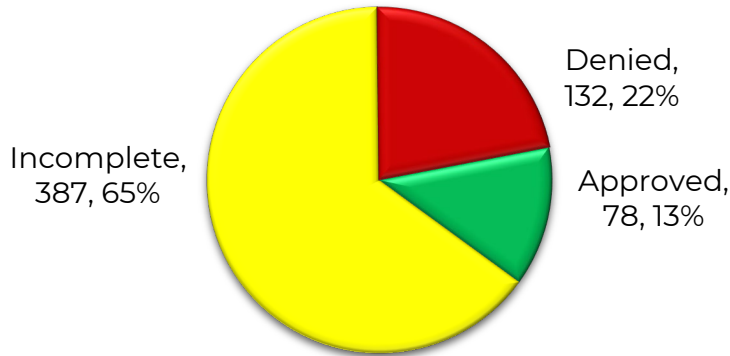
Top Prescriber Specialties of NSAIDs by Number of Claims (All Plans)



Prior Authorization of NSAIDs

There were 597 prior authorization requests submitted for NSAIDs 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	69	13%	352	67%	107	20%	528
Aetna	3	5%	35	58%	22	37%	60
Humana	0	N/A	0	N/A	0	N/A	0
OCH	6	67%	0	0%	3	33%	9
Total	78	13%	387	65%	132	22%	597

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}

Anticipated Patent Expiration(s):

- Caldolor[®] (ibuprofen injection): March 2032
- Combogesic[®] IV (ibuprofen/acetaminophen injection): January 2036
- Elyxyb[®] (celecoxib oral solution): May 2036

News:

- **June 2012:** The U.S. Food and Drug Administration (FDA) withdrew their previous approval for Celebrex[®] (celecoxib) for the indication to reduce the number of adenomatous colorectal polyps in familial adenomatous polyposis (FAP), as an adjunct to usual care.
- **August 2024:** New formulations of Dolobid[™] (diflunisal), available as 250mg and 375mg tablets, are being marketed by INA Pharmaceuticals; however, only the 250mg strength is available at this time. Diflunisal is also available generically as 500mg tablets.
- **October 2024:** IBSA Pharma, the manufacturer of Flector[®] (diclofenac epolamine patch) and Licart[®] (diclofenac epolamine patch) voluntarily ended their Federal Drug Rebate Agreement with the Centers for Medicare and Medicaid Services (CMS). As a result, SoonerCare no longer covers any of the IBSA Pharma products per regulatory requirements. There are authorized generics available for Flector[®] that remain on the market, but there are no generic equivalents for Licart[®].
- **December 2024:** As of December 2024, the FDA Orange Book lists Anjeso[®] (meloxicam injection), Dyloject[™] (diclofenac sodium injection), Qmiiz ODT[™] [meloxicam orally disintegrating tablet (ODT)], Tivorbex[®] (indomethacin), and Zorvolex[®] (diclofenac) as discontinued products. Additionally, there are no generic equivalents for these products.

Dolobid[™] (Diflunisal) Product Summary⁴

Therapeutic Class: NSAID

Indication(s): Acute or long-term use for symptomatic treatment of mild to moderate pain, osteoarthritis, or rheumatoid arthritis

How Supplied: 250mg and 375mg oral tablets

Dosing and Administration:

- For mild to moderate pain, an initial dose of 1,000mg followed by 500mg every 12 hours is recommended for most patients. Following the initial dose, some patients may require 500mg every 8 hours.
- A lower dosage may be appropriate depending on such factors as pain severity, patient response, weight, or advanced age; for example, 500mg initially followed by 250mg every 8 to 12 hours.

- For osteoporosis and rheumatoid arthritis, the suggested dosage range is 500mg to 1,000mg daily in 2 divided doses. The dosage may be increased or decreased according to patient response. Maintenance doses higher than 1,500mg per day are not recommended.
- The tablets should be swallowed whole, not crushed or chewed.

Cost Comparison:

Product	Cost Per Unit	Cost Per 30 Days	Cost Per Year
Dolobid™ (diflunisal) 250mg tablet	\$41.75	\$5,010.00*	\$60,120.00
diflunisal 500mg tablet (generic)	\$0.85	\$51.00*	\$612.00
celecoxib 200mg capsule (generic)	\$0.08	\$4.80 ⁺	\$57.60
diclofenac sodium 75mg tablet (generic)	\$0.07	\$4.20 ^Δ	\$50.40
ibuprofen 800mg tablet (generic)	\$0.05	\$4.50 [§]	\$54.00
meloxicam 15mg tablet (generic)	\$0.02	\$0.60 [‡]	\$7.20

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 based on use of 500mg twice daily

⁺Cost based on use of 200mg twice daily

^ΔCost based on use of 75mg twice daily

[§]Cost based on use of 800mg 3 times daily

[‡]Cost based on use of 15mg once daily

Unit = Each capsule or tablet

Please note: Cost is not yet available for the Dolobid™ 375mg tablet.

Cost Comparison: Indomethacin Products

Product	Cost Per Unit	Cost Per Day*	Cost Per Month
indomethacin 50mg suppository (generic)	\$343.81	\$1,031.43	\$30,942.90
indomethacin 25mg/5mL suspension (generic)	\$7.99	\$239.70	\$7,191.00
indomethacin 50mg capsule (generic)	\$0.11	\$0.33	\$9.90

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 based on a total daily dose of 150mg

Unit = Each capsule, mL, or suppository

Recommendations

The College of Pharmacy recommends the following changes to the NSAIDs Product Based Prior Authorization (PBPA) category based on net cost and the additional factors noted below (changes noted in red in the following PBPA Tier chart and approval criteria):

1. Prior authorization and placement of Dolobid™ (diflunisal) 250mg tablet and 375mg tablet into the Special PA Tier with the additional criteria listed below; and
2. Prior authorization and placement of diflunisal 500mg tablet into Tier-2; and

3. Prior authorization and placement of Indocin® (indomethacin) suppository into the Special PA Tier; and
4. Removing the brand preferred status for Flector® (diclofenac epolamine patch) and moving the authorized generics to the Special PA Tier; and
5. Moving Ansaid® (flurbiprofen) and EC-Naprosyn® (naproxen) 500mg tablet from Tier-1 to Tier-2; and
6. Moving Tolectin® (tolmetin) from Tier-2 to the Special PA Tier; and
7. Moving Cataflam® (diclofenac potassium) and Lodine® (etodolac) 200mg capsule and 300mg capsule from Tier-2 to Tier-1; and
8. Moving Indocin® SR (indomethacin extended-release capsule) and Ponstel® (mefenamic acid) from the Special PA Tier to Tier-2; and
9. Moving Celebrex® (celecoxib) 400mg capsule from the Special PA Tier to Tier-1 and removing the unique approval criteria for the 400mg strength based on the FDA's withdrawal of the FAP indication and net cost; and
10. Removing Anjeso® (meloxicam injection), Dyloject™ (diclofenac sodium injection), Licart® (diclofenac epolamine patch), Qmiiz ODT™ [meloxicam orally disintegrating tablet (ODT)], Tivorbex® (indomethacin), and Zorvolex® (diclofenac) based on product discontinuations or lack of manufacturer rebate participation.

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)		
Tier-1	Tier-2	Special PA
celecoxib (Celebrex®) 50mg, 100mg, & 200mg caps	diclofenac ER (Voltaren® XR)	celecoxib (Celebrex®) 400mg caps
diclofenac epolamine (Flector® Patch) — Brand Preferred	diclofenac potassium (Cataflam®)	celecoxib (Elyxyb®) oral solution
diclofenac potassium (Cataflam®)	diclofenac sodium/ misoprostol (Arthrotec®)	diclofenac (Zorvolex®)
diclofenac sodium (Voltaren®) 50mg & 75mg tabs	diclofenac sodium (Voltaren®) 25mg tabs	diclofenac epolamine (generic Flector® Patch)
diclofenac sodium 1% (Voltaren® Gel)	diflunisal 500mg tabs	diclofenac epolamine (Licart®) topical system
etodolac (Lodine®) 400mg & 500mg tabs	etodolac (Lodine®) 200mg & 300mg caps	diclofenac potassium (Cambia®) powder pack
flurbiprofen (Ansaid®)	etodolac ER (Lodine® XL)	diclofenac potassium (Lofena™) tabs
ibuprofen (Motrin®)	flurbiprofen (Ansaid®)	diclofenac potassium (Zipsor®) caps
indomethacin (Indocin®) caps	indomethacin (Indocin®) ER caps	diclofenac sodium (Dyloject™) inj
meloxicam (Mobic®)	mefenamic acid (Ponstel®)	diclofenac sodium (Pennsaid®) topical drops

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)		
Tier-1	Tier-2	Special PA
nabumetone (Relafen®)	naproxen DR (EC-Naprosyn®) 500mg tab	diflunisal (Dolobid™) 250mg and 375mg tabs
naproxen* (Naprosyn®)	naproxen sodium (Anaprox®) 275mg & 550mg tabs	fenoprofen (Nalfon®)
naproxen DR (EC-Naprosyn®) 375mg tab	oxaprozin (Daypro®)	ibuprofen (Caldolor®) inj
sulindac (Clinoril®)	piroxicam (Feldene®)	ibuprofen/acetaminophen (Combogesic® IV) inj ⁺
	tolmetin (Tolectin®)	ibuprofen/famotidine (Duexis®)
		indomethacin (Indocin®) supp & susp & ER-caps
		indomethacin (Tivorbex®)
		ketoprofen (Orudis®) caps
		ketoprofen ER (Oruvail®)
		ketorolac tromethamine (Sprix®) nasal spray
		meclofenamate (Meclomen®)
		mefenamic acid (Ponstel®)
		meloxicam (Anjese®) inj⁺
		meloxicam (Vivlodex®) caps
		meloxicam ODT (Qmiiz ODT™)
		nabumetone 1,000mg (Relafen DS®)
		naproxen sodium ER (Naprelan®)
		naproxen/esomeprazole (Vimovo®)
		tolmetin (Tolectin®)

Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), or Wholesale Acquisition Costs (WAC) if NADAC unavailable.

*Naproxen oral suspension is available without prior authorization for members 12 years of age and younger. Members older than 12 years of age require a reason why a special formulation product is needed in place of the regular tablet formulation.

⁺Unique criteria applies.

caps = capsules; DR = delayed-release; ER = extended-release; EC = enteric-coated; inj = injection; ODT = orally disintegrating tablet; PA = prior authorization; **supp = suppository**; susp = suspension; tabs = tablets

NSAIDs Special Prior Authorization (PA) Approval Criteria:

1. A unique indication for which a Tier-1 or Tier-2 medication is not appropriate; or
2. Previous use of at least 2 Tier-1 NSAID products (from different product lines); and

3. A patient-specific, clinically significant reason why a special formulation is needed over a Tier-1 product; and
4. ~~Additionally, use of Celebrex® (celecoxib) 400mg capsules will require a diagnosis of Familial Adenomatous Polyposis (FAP) and a patient-specific, clinically significant reason why the member cannot use 2 celecoxib 200mg capsules to achieve a 400mg dose; and~~
5. ~~Additionally, use of Dolobid™ (diflunisal) 250mg or 375mg tablet will require a patient-specific, clinically significant reason why the member cannot use generic diflunisal 500mg tablets; and~~
6. Additionally, use of Elyxyb® (celecoxib oral solution) will require a diagnosis of acute migraine treatment in adults 18 years of age and older and a patient-specific, clinically significant reason why the member cannot use Cambia® (diclofenac potassium powder); and
7. Additionally, use of Lofena™ (diclofenac potassium) will require a patient-specific, clinically significant reason why the member cannot use all other available generic diclofenac products. ;and
8. ~~Additionally, use of Tivorbex® will require a patient-specific, clinically significant reason why the member cannot use all other available generic indomethacin products.~~

Anjeso® (Meloxicam Injection) Approval Criteria:

1. ~~An FDA approved diagnosis of management of moderate to severe pain, alone or in combination with non-NSAID analgesics; and~~
2. ~~Member must be 18 years of age or older; and~~
3. ~~Member must be well hydrated before Anjeso® administration to reduce the risk of renal toxicity; and~~
4. ~~Anjeso® should be used for the shortest duration consistent with individual patient treatment goals; and~~
5. ~~A patient-specific, clinically significant reason the member cannot use oral meloxicam tablets or other Tier 1 NSAID products must be provided; and~~
6. ~~A quantity limit of 3 vials per 3 days will apply; and~~
7. ~~For consideration of a longer duration of use, a patient-specific, clinically significant reason why the member cannot transition to an oral Tier 1 NSAID product must be provided, along with the anticipated duration of treatment.~~

Utilization Details of NSAIDs: Fiscal Year 2024

Fee-For-Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-1 UTILIZATION						
IBUPROFEN PRODUCTS						
IBUPROFEN TAB 800MG	67,554	46,819	\$807,597.79	\$11.95	1.44	28.74%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
IBUPROFEN TAB 600MG	15,057	13,097	\$165,757.22	\$11.01	1.15	5.90%
IBUPROFEN TAB 400MG	2,154	1,727	\$25,312.34	\$11.75	1.25	0.90%
IBU TAB 800MG	977	703	\$13,555.46	\$13.87	1.39	0.48%
IBU TAB 600MG	227	199	\$2,881.93	\$12.70	1.14	0.10%
IBU TAB 400MG	24	24	\$294.98	\$12.29	1	0.01%
IBUPROFEN POW	4	4	\$46.48	\$11.62	1	0.00%
SUBTOTAL	85,997	62,573	\$1,015,446.20	\$11.81	1.37	36.14%
MELOXICAM PRODUCTS						
MELOXICAM TAB 15MG	30,282	15,682	\$314,008.97	\$10.37	1.93	11.18%
MELOXICAM TAB 7.5MG	12,784	7,065	\$132,133.27	\$10.34	1.81	4.70%
SUBTOTAL	43,066	22,747	\$446,142.24	\$10.36	1.89	15.88%
NAPROXEN PRODUCTS						
NAPROXEN TAB 500MG	23,038	16,047	\$261,622.05	\$11.36	1.44	9.31%
NAPROXEN TAB 375MG	1,727	1,244	\$22,002.52	\$12.74	1.39	0.78%
NAPROXEN TAB 250MG	1,367	908	\$17,357.90	\$12.70	1.51	0.62%
NAPROXEN DR TAB 500MG	593	454	\$71,507.50	\$120.59	1.31	2.54%
NAPROXEN SUS 125MG/5ML	424	255	\$56,909.14	\$134.22	1.66	2.03%
EC-NAPROXEN TAB 500MG	212	158	\$22,034.21	\$103.93	1.34	0.78%
NAPROXEN DR TAB 375MG	78	52	\$1,583.70	\$20.30	1.5	0.06%
SUBTOTAL	27,439	19,118	\$453,017.02	\$16.51	1.44	16.12%
DICLOFENAC PRODUCTS						
DICLOFENAC TAB 75MG DR	10,013	4,623	\$144,063.36	\$14.39	2.17	5.13%
DICLOFENAC GEL 1%	5,146	3,362	\$107,439.05	\$20.88	1.53	3.82%
DICLOFENAC TAB 50MG DR	3,233	1,719	\$46,855.75	\$14.49	1.88	1.67%
FLECTOR DIS 1.3%	107	40	\$33,352.68	\$311.71	2.68	1.19%
SUBTOTAL	18,499	9,744	\$331,710.84	\$17.93	1.9	11.81%
CELECOXIB PRODUCTS						
CELECOXIB CAP 200MG	12,035	4,791	\$187,041.90	\$15.54	2.51	6.66%
CELECOXIB CAP 100MG	5,173	2,246	\$79,873.62	\$15.44	2.3	2.84%
CELECOXIB CAP 50MG	200	96	\$2,976.25	\$14.88	2.08	0.11%
SUBTOTAL	17,408	7,133	\$269,891.77	\$15.50	2.44	9.61%
KETOROLAC PRODUCTS						
KETOROLAC TAB 10MG	7,525	6,766	\$135,921.18	\$18.06	1.11	4.84%
KETOROLAC INJ 60MG/2ML	21	12	\$303.03	\$14.43	1.75	0.01%
KETOROLAC INJ 30MG/ML	4	3	\$53.80	\$13.45	1.33	0.00%
SUBTOTAL	7,550	6,781	\$136,278.01	\$18.05	1.11	4.85%
NABUMETONE PRODUCTS						
NABUMETONE TAB 750MG	1,587	594	\$26,360.38	\$16.61	2.67	0.94%
NABUMETONE TAB 500MG	1,004	429	\$16,026.50	\$15.96	2.34	0.57%
SUBTOTAL	2,591	1,023	\$42,386.88	\$16.36	2.53	1.51%
ETODOLAC PRODUCTS						
ETODOLAC TAB 400MG	1,543	910	\$34,720.41	\$22.50	1.7	1.24%
ETODOLAC TAB 500MG	634	436	\$13,556.34	\$21.38	1.45	0.48%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
SUBTOTAL	2,177	1,346	\$48,276.75	\$22.18	1.62	1.72%
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 50MG	904	574	\$12,652.12	\$14.00	1.57	0.45%
INDOMETHACIN CAP 25MG	443	289	\$5,971.15	\$13.48	1.53	0.21%
SUBTOTAL	1,347	863	\$18,623.27	\$13.83	1.56	0.66%
SULINDAC PRODUCTS						
SULINDAC TAB 200MG	221	101	\$4,828.51	\$21.85	2.19	0.17%
SULINDAC TAB 150MG	94	41	\$1,673.02	\$17.80	2.29	0.06%
SUBTOTAL	315	142	\$6,501.53	\$20.64	2.22	0.23%
FLURBIPROFEN PRODUCTS						
FLURBIPROFEN TAB 100MG	57	11	\$1,615.45	\$28.34	5.18	0.06%
SUBTOTAL	57	11	\$1,615.45	\$28.34	5.18	0.06%
DIFLUNISAL PRODUCTS						
DIFLUNISAL TAB 500MG	10	7	\$563.39	\$56.34	1.43	0.02%
SUBTOTAL	10	7	\$563.39	\$56.34	1.43	0.02%
TIER-1 SUBTOTAL	206,456	112,008*	\$2,770,453.35	\$13.42	1.84	98.60%
TIER-2 UTILIZATION						
DICLOFENAC PRODUCTS						
DICLOFENAC POT TAB 50MG	419	176	\$8,439.12	\$20.14	2.38	0.30%
DICLOFENAC TAB 100MG ER	207	87	\$10,439.42	\$50.43	2.38	0.37%
DICLOFENAC TAB 25MG DR	35	20	\$1,719.50	\$49.13	1.75	0.06%
SUBTOTAL	661	283	\$20,598.04	\$31.16	2.34	0.73%
ETODOLAC PRODUCTS						
ETODOLAC CAP 300MG	118	106	\$2,627.28	\$22.27	1.11	0.09%
ETODOLAC CAP 200MG	87	68	\$2,199.62	\$25.28	1.28	0.08%
ETODOLAC ER TAB 600MG	4	3	\$536.80	\$134.20	1.33	0.02%
ETODOLAC ER TAB 400MG	4	2	\$102.22	\$25.56	2	0.00%
ETODOLAC ER TAB 500MG	1	1	\$39.86	\$39.86	1	0.00%
SUBTOTAL	214	180	\$5,505.78	\$25.73	1.19	0.20%
NAPROXEN PRODUCTS						
NAPROXEN SOD TAB 550MG	118	67	\$2,561.05	\$21.70	1.76	0.09%
NAPROXEN SOD TAB 275MG	3	2	\$82.59	\$27.53	1.5	0.00%
SUBTOTAL	121	69	\$2,643.64	\$21.85	1.75	0.09%
DICLOFENAC/MISOPROSTOL PRODUCTS						
DICLO/MISOPR TAB 75/0.2MG	60	15	\$4,458.57	\$74.31	4	0.16%
DICLO/MISOPR TAB 50/0.2MG	12	6	\$755.07	\$62.92	2	0.03%
SUBTOTAL	72	21	\$5,213.64	\$72.41	3.43	0.19%
PIROXICAM PRODUCTS						
PIROXICAM CAP 20MG	23	8	\$682.06	\$29.65	2.88	0.02%
SUBTOTAL	23	8	\$682.06	\$29.65	2.88	0.02%
OXAPROZIN PRODUCTS						
OXAPROZIN TAB 600MG	20	8	\$1,021.56	\$51.08	2.5	0.04%
SUBTOTAL	20	8	\$1,021.56	\$51.08	2.5	0.04%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-2 SUBTOTAL	1,111	567*	\$35,664.72	\$32.10	1.96	1.27%
SPECIAL PRIOR AUTHORIZATION (PA) UTILIZATION						
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 75MG ER	8	1	\$178.49	\$22.31	8	0.01%
SUBTOTAL	8	1	\$178.49	\$22.31	8	0.01%
FENOPROFEN PRODUCTS						
FENOPROFEN TAB 600MG	5	1	\$877.85	\$175.57	5	0.03%
FENOPROFEN CAP 400MG	1	1	\$461.41	\$461.41	1	0.02%
SUBTOTAL	6	2	\$1,339.26	\$223.21	3	0.05%
IBUPROFEN/FAMOTIDINE PRODUCTS						
IBU/FAMOT TAB 800/26.6MG	6	2	\$1,277.86	\$212.98	3	0.05%
SUBTOTAL	6	2	\$1,277.86	\$212.98	3	0.05%
DICLOFENAC PRODUCTS						
DICLOFENAC POW 50MG	3	1	\$840.85	\$280.28	3	0.03%
SUBTOTAL	3	1	\$840.85	\$280.28	3	0.03%
MEFENAMIC ACID PRODUCTS						
MEFENAMIC ACID CAP 250MG	1	1	\$47.96	\$47.96	1	0.00%
SUBTOTAL	1	1	\$47.96	\$47.96	1	0.00%
SPECIAL PA SUBTOTAL	24	6*	\$3,684.42	\$153.52	4	0.13%
TOTAL	207,591	112,127*	\$2,809,802.49	\$13.54	1.85	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DICLO/MISOPR = diclofenac/misoprostol; DIS = patch; DR = delayed-release; EC = enteric-coated; ER = extended-release; IBU/FAMOT = ibuprofen/famotidine; INJ = injection; POT = potassium; POW = powder; SOD = sodium; SOL = solution; SUS = suspension; TAB = tablet
Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Aetna Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-1 UTILIZATION						
IBUPROFEN PRODUCTS						
IBUPROFEN TAB 800MG	3,885	3,434	\$50,540.78	\$13.01	1.13	29.81%
IBUPROFEN TAB 600MG	772	741	\$9,176.59	\$11.89	1.04	5.41%
IBUPROFEN TAB 400MG	80	79	\$840.51	\$10.51	1.01	0.50%
IBU TAB 800MG	65	57	\$956.09	\$14.71	1.14	0.56%
IBU TAB 600MG	19	18	\$239.46	\$12.60	1.06	0.14%
IBUPROFEN SUS 100MG/5ML	5	5	\$57.02	\$11.40	1	0.03%
SUBTOTAL	4,826	4,334	\$61,810.45	\$12.81	1.11	36.46%
MELOXICAM PRODUCTS						
MELOXICAM TAB 15MG	1,855	1,270	\$21,602.95	\$11.65	1.46	12.74%
MELOXICAM TAB 7.5MG	596	447	\$6,889.46	\$11.56	1.33	4.06%
SUBTOTAL	2,451	1,717	\$28,492.41	\$11.62	1.43	16.81%
NAPROXEN PRODUCTS						
NAPROXEN TAB 500MG	1,236	1,006	\$15,669.03	\$12.68	1.23	9.24%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
NAPROXEN TAB 375MG	96	82	\$1,179.99	\$12.29	1.17	0.70%
NAPROXEN TAB 250MG	82	60	\$1,052.72	\$12.84	1.37	0.62%
NAPROXEN DR TAB 500MG	43	33	\$4,566.97	\$106.21	1.3	2.69%
NAPROXEN SUS 125MG/5ML	14	10	\$1,653.34	\$118.10	1.4	0.98%
EC-NAPROXEN TAB 500MG	8	8	\$702.47	\$87.81	1	0.41%
NAPROXEN DR TAB 375MG	5	4	\$89.56	\$17.91	1.25	0.05%
SUBTOTAL	1,484	1,203	\$24,914.08	\$16.79	1.23	14.70%
CELECOXIB PRODUCTS						
CELECOXIB CAP 200MG	835	520	\$13,155.21	\$15.75	1.61	7.76%
CELECOXIB CAP 100MG	315	211	\$4,877.65	\$15.48	1.49	2.88%
CELECOXIB CAP 50MG	13	8	\$191.87	\$14.76	1.63	0.11%
SUBTOTAL	1,163	739	\$18,224.73	\$15.67	1.57	10.75%
DICLOFENAC PRODUCTS						
DICLOFENAC TAB 75MG DR	453	328	\$7,040.48	\$15.54	1.38	4.15%
DICLOFENAC TAB 50MG DR	165	125	\$2,611.72	\$15.83	1.32	1.54%
DICLOFENAC GEL 1%	152	131	\$3,295.33	\$21.68	1.16	1.94%
FLECTOR DIS 1.3%	7	6	\$2,228.92	\$318.42	1.17	1.31%
SUBTOTAL	777	590	\$15,176.45	\$19.53	1.32	8.95%
KETOROLAC PRODUCTS						
KETOROLAC TAB 10MG	436	417	\$7,658.78	\$17.57	1.05	4.52%
SUBTOTAL	436	417	\$7,658.78	\$17.57	1.05	4.52%
ETODOLAC PRODUCTS						
ETODOLAC TAB 400MG	90	65	\$2,180.58	\$24.23	1.38	1.29%
ETODOLAC TAB 500MG	41	33	\$924.36	\$22.55	1.24	0.55%
SUBTOTAL	131	98	\$3,104.94	\$23.70	1.34	1.83%
NABUMETONE PRODUCTS						
NABUMETONE TAB 750MG	72	47	\$1,322.32	\$18.37	1.53	0.78%
NABUMETONE TAB 500MG	52	32	\$891.29	\$17.14	1.63	0.53%
SUBTOTAL	124	79	\$2,213.61	\$17.85	1.57	1.31%
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 50MG	57	46	\$911.07	\$15.98	1.24	0.54%
INDOMETHACIN CAP 25MG	24	19	\$353.46	\$14.73	1.26	0.21%
SUBTOTAL	81	65	\$1,264.53	\$15.61	1.25	0.75%
SULINDAC PRODUCTS						
SULINDAC TAB 200MG	11	8	\$240.65	\$21.88	1.38	0.14%
SULINDAC TAB 150MG	3	2	\$61.64	\$20.55	1.5	0.04%
SUBTOTAL	14	10	\$302.29	\$21.59	1.4	0.18%
TIER-1 SUBTOTAL	11,487	8,629*	\$163,162.27	\$14.20	1.33	96.24%
TIER-2 UTILIZATION						
DICLOFENAC PRODUCTS						
DICLOFENAC POT TAB 50MG	34	32	\$668.71	\$19.67	1.06	0.39%
DICLOFENAC TAB 100MG ER	8	7	\$254.86	\$31.86	1.14	0.15%
DICLOFENAC TAB 25MG DR	6	4	\$274.53	\$45.76	1.5	0.16%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
SUBTOTAL	48	43	\$1,198.10	\$24.96	1.12	0.71%
ETODOLAC PRODUCTS						
ETODOLAC CAP 300MG	30	30	\$614.06	\$20.47	1	0.36%
ETODOLAC CAP 200MG	11	11	\$253.79	\$23.07	1	0.15%
ETODOLAC ER TAB 600MG	1	1	\$52.81	\$52.81	1	0.03%
SUBTOTAL	42	42	\$920.66	\$21.92	1	0.54%
NAPROXEN PRODUCTS						
NAPROXEN SOD TAB 550MG	9	9	\$169.02	\$18.78	1	0.10%
NAPROXEN SOD TAB 275MG	1	1	\$16.32	\$16.32	1	0.01%
SUBTOTAL	10	10	\$185.34	\$18.53	1	0.11%
PIROXICAM PRODUCTS						
PIROXICAM CAP 20MG	2	1	\$41.40	\$20.70	2	0.02%
SUBTOTAL	2	1	\$41.40	\$20.70	2	0.02%
TIER-2 SUBTOTAL	102	96*	\$2,345.50	\$23.00	1.06	1.38%
SPECIAL PRIOR AUTHORIZATION (PA) UTILIZATION						
DICLOFENAC PRODUCTS						
DICLOFENAC TAB 25MG	2	2	\$2,296.90	\$1,148.45	1	1.35%
DICLOFENAC POW 50MG	2	2	\$581.46	\$290.73	1	0.34%
DICLOFENAC SOL 2%	1	1	\$158.91	\$158.91	1	0.09%
DICLOFENAC CAP 25MG	1	1	\$87.04	\$87.04	1	0.05%
SUBTOTAL	6	6	\$3,124.31	\$520.72	1	1.84%
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 75MG ER	3	3	\$65.15	\$21.72	1	0.04%
SUBTOTAL	3	3	\$65.15	\$21.72	1	0.04%
CELECOXIB PRODUCTS						
CELECOXIB CAP 400MG	2	2	\$32.79	\$16.40	1	0.02%
SUBTOTAL	2	2	\$32.79	\$16.40	1	0.02%
MELOXICAM PRODUCTS						
MELOXICAM CAP 5MG	1	1	\$756.65	\$756.65	1	0.45%
SUBTOTAL	1	1	\$756.65	\$756.65	1	0.45%
MEFENAMIC ACID PRODUCTS						
MEFENAMIC ACID CAP 250MG	1	1	\$47.96	\$47.96	1	0.03%
SUBTOTAL	1	1	\$47.96	\$47.96	1	0.03%
SPECIAL PA SUBTOTAL	13	13*	\$4,026.86	\$309.76	1	2.38%
TOTAL	11,602	8,712*	\$169,534.63	\$14.61	1.33	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DIS = patch; DR = delayed-release; EC = enteric-coated; ER = extended-release; POT = potassium; POW = powder; SOD = sodium; 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.

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-1 UTILIZATION						
IBUPROFEN PRODUCTS						
IBUPROFEN TAB 800MG	4,515	3,839	\$59,358.71	\$13.15	1.18	27.52%
IBUPROFEN TAB 600MG	848	798	\$10,229.24	\$12.06	1.06	4.74%
IBUPROFEN TAB 400MG	112	103	\$1,273.56	\$11.37	1.09	0.59%
IBU TAB 800MG	77	68	\$1,159.98	\$15.06	1.13	0.54%
IBUPROFEN SUS 100MG/5ML	41	40	\$614.90	\$15.00	1.03	0.29%
IBU TAB 600MG	9	9	\$118.33	\$13.15	1	0.05%
IBUPROFEN POW	1	1	\$20.16	\$20.16	1	0.01%
FT IBU CHILD SUS 100MG/5ML	1	1	\$16.17	\$16.17	1	0.01%
IBUPROFEN IB CHW 100MG	1	1	\$12.15	\$12.15	1	0.01%
SUBTOTAL	5,605	4,860	\$72,803.20	\$12.99	1.15	33.75%
MELOXICAM PRODUCTS						
MELOXICAM TAB 15MG	2,437	1,568	\$28,600.37	\$11.74	1.55	13.26%
MELOXICAM TAB 7.5MG	908	630	\$10,548.09	\$11.62	1.44	4.89%
SUBTOTAL	3,345	2,198	\$39,148.46	\$11.70	1.52	18.15%
NAPROXEN PRODUCTS						
NAPROXEN TAB 500MG	1,518	1,238	\$19,063.07	\$12.56	1.23	8.84%
NAPROXEN TAB 375MG	101	81	\$1,368.68	\$13.55	1.25	0.63%
NAPROXEN DR TAB 500MG	56	46	\$5,878.72	\$104.98	1.22	2.73%
NAPROXEN TAB 250MG	55	49	\$716.69	\$13.03	1.12	0.33%
NAPROXEN SUS 125MG/5ML	14	11	\$1,238.24	\$88.45	1.27	0.57%
EC-NAPROXEN TAB 500MG	5	4	\$442.21	\$88.44	1.25	0.21%
NAPROXEN DR TAB 375MG	4	4	\$65.61	\$16.40	1	0.03%
SUBTOTAL	1,753	1,433	\$28,773.22	\$16.41	1.22	13.34%
CELECOXIB PRODUCTS						
CELECOXIB CAP 200MG	1,093	637	\$17,064.03	\$15.61	1.72	7.91%
CELECOXIB CAP 100MG	414	260	\$6,455.48	\$15.59	1.59	2.99%
CELECOXIB CAP 50MG	11	11	\$174.16	\$15.83	1	0.08%
CELEBREX CAP 200MG	1	1	\$953.82	\$953.82	1	0.44%
SUBTOTAL	1,519	909	\$24,647.49	\$16.23	1.67	11.43%
DICLOFENAC PRODUCTS						
DICLOFENAC TAB 75MG DR	746	461	\$11,826.15	\$15.85	1.62	5.48%
DICLOFENAC GEL 1%	264	210	\$5,743.79	\$21.76	1.26	2.66%
DICLOFENAC TAB 50MG DR	220	156	\$3,408.59	\$15.49	1.41	1.58%
GOODSENSE GEL ART PAIN	13	9	\$257.82	\$19.83	1.44	0.12%
FLECTOR DIS 1.3%	3	3	\$953.34	\$317.78	1	0.44%
ARTHRITIS PAIN GEL 1%	2	2	\$45.25	\$22.63	1	0.02%
GNP DICLOFENAC GEL 1%	1	1	\$20.08	\$20.08	1	0.01%
FT ARTHRITIS GEL 1%	1	1	\$18.06	\$18.06	1	0.01%
SUBTOTAL	1,250	843	\$22,273.08	\$17.82	1.48	10.33%
KETOROLAC PRODUCTS						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
KETOROLAC TAB 10MG	496	462	\$8,810.30	\$17.76	1.07	4.08%
SUBTOTAL	496	462	\$8,810.30	\$17.76	1.07	4.08%
NABUMETONE PRODUCTS						
NABUMETONE TAB 750MG	113	60	\$2,082.06	\$18.43	1.88	0.97%
NABUMETONE TAB 500MG	50	32	\$862.87	\$17.26	1.56	0.40%
SUBTOTAL	163	92	\$2,944.93	\$18.07	1.77	1.37%
ETODOLAC PRODUCTS						
ETODOLAC TAB 400MG	79	59	\$1,830.50	\$23.17	1.34	0.85%
ETODOLAC TAB 500MG	45	32	\$1,078.48	\$23.97	1.41	0.50%
SUBTOTAL	124	91	\$2,908.98	\$23.46	1.36	1.35%
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 50MG	63	49	\$931.67	\$14.79	1.29	0.43%
INDOMETHACIN CAP 25MG	24	20	\$361.53	\$15.06	1.2	0.17%
SUBTOTAL	87	69	\$1,293.20	\$14.86	1.26	0.60%
SULINDAC PRODUCTS						
SULINDAC TAB 200MG	7	6	\$151.54	\$21.65	1.17	0.07%
SULINDAC TAB 150MG	5	3	\$93.98	\$18.80	1.67	0.04%
SUBTOTAL	12	9	\$245.52	\$20.46	1.33	0.11%
FLURBIPROFEN PRODUCTS						
FLURBIPROFEN TAB 100MG	8	3	\$275.76	\$34.47	2.67	0.13%
SUBTOTAL	8	3	\$275.76	\$34.47	2.67	0.13%
TIER-1 SUBTOTAL	14,362	10,120*	\$204,124.14	\$14.21	1.42	94.64%
TIER-2 UTILIZATION						
DICLOFENAC PRODUCTS						
DICLOFENAC POT TAB 50MG	70	47	\$1,387.27	\$19.82	1.49	0.64%
DICLOFENAC TAB 100MG ER	21	17	\$678.09	\$32.29	1.24	0.31%
DICLOFENAC TAB 25MG DR	5	5	\$275.43	\$55.09	1	0.13%
SUBTOTAL	96	69	\$2,340.79	\$24.38	1.39	1.09%
ETODOLAC PRODUCTS						
ETODOLAC CAP 300MG	47	44	\$935.43	\$19.90	1.07	0.43%
ETODOLAC CAP 200MG	26	22	\$548.89	\$21.11	1.18	0.25%
SUBTOTAL	73	66	\$1,484.32	\$20.33	1.11	0.69%
NAPROXEN PRODUCTS						
NAPROXEN SOD TAB 550MG	27	26	\$496.34	\$18.38	1.04	0.23%
ALL DAY RELIEF TAB 220MG	2	1	\$25.64	\$12.82	2	0.01%
NAPROXEN SOD TAB 220MG	1	1	\$14.49	\$14.49	1	0.01%
SUBTOTAL	30	28	\$536.47	\$17.88	1.07	0.25%
OXAPROZIN PRODUCTS						
OXAPROZIN TAB 600MG	4	3	\$169.79	\$42.45	1.33	0.08%
SUBTOTAL	4	3	\$169.79	\$42.45	1.33	0.08%
DICLOFENAC/MISOPROSTOL PRODUCTS						
DICLO/MISOPR TAB 75/0.2MG	2	2	\$163.48	\$81.74	1	0.08%
DICLO/MISOPR TAB 50/0.2MG	1	1	\$68.71	\$68.71	1	0.03%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SUBTOTAL	3	3	\$232.19	\$77.40	1	0.11%
PIROXICAM PRODUCTS						
PIROXICAM CAP 20MG	1	1	\$21.39	\$21.39	1	0.01%
SUBTOTAL	1	1	\$21.39	\$21.39	1	0.01%
TIER-2 SUBTOTAL	207	168*	\$4,784.95	\$23.12	1.23	2.22%
SPECIAL PRIOR AUTHORIZATION (PA) UTILIZATION						
DICLOFENAC PRODUCTS						
DICLOFENAC TAB 25MG	3	1	\$4,945.31	\$1,648.44	3	2.29%
DICLOFENAC POW 50MG	2	2	\$703.73	\$351.87	1	0.33%
DICLOFENAC SOL 1.5%	1	1	\$27.02	\$27.02	1	0.01%
DICLOFENAC SOL 2%	1	1	\$158.91	\$158.91	1	0.07%
SUBTOTAL	7	5	\$5,834.97	\$833.57	1.4	2.71%
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 75MG ER	7	6	\$135.90	\$19.41	1.17	0.06%
SUBTOTAL	7	6	\$135.90	\$19.41	1.17	0.06%
MELOXICAM PRODUCTS						
MELOXICAM CAP 5MG	2	2	\$605.52	\$302.76	1	0.28%
SUBTOTAL	2	2	\$605.52	\$302.76	1	0.28%
CELECOXIB PRODUCTS						
CELECOXIB CAP 400MG	2	2	\$43.90	\$21.95	1	0.02%
SUBTOTAL	2	2	\$43.90	\$21.95	1	0.02%
NAPROXEN PRODUCTS						
NAPROXEN SOD TAB 500MG ER	1	1	\$124.74	\$124.74	1	0.06%
SUBTOTAL	1	1	\$124.74	\$124.74	1	0.06%
MEFENAMIC ACID PRODUCTS						
MEFENAMIC ACID CAP 250MG	1	1	\$34.91	\$34.91	1	0.02%
SUBTOTAL	1	1	\$34.91	\$34.91	1	0.02%
SPECIAL PA SUBTOTAL	20	17*	\$6,779.94	\$339.00	1.18	3.14%
TOTAL	14,589	10,259*	\$215,689.03	\$14.78	1.42	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

ART = arthritis; CAP = capsule; CHW = chewable; DICLO/MISOPR = diclofenac/misoprostol; DIS = patch; DR = delayed-release; EC = enteric-coated; ER = extended-release; POT = potassium; POW = powder; SOD = sodium; 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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-1 UTILIZATION						
IBUPROFEN PRODUCTS						
IBUPROFEN TAB 800MG	3,842	3,393	\$50,268.31	\$13.08	1.13	30.01%
IBUPROFEN TAB 600MG	835	793	\$10,073.87	\$12.06	1.05	6.01%
IBU TAB 800MG	75	66	\$1,117.83	\$14.90	1.14	0.67%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
IBUPROFEN TAB 400MG	72	66	\$857.89	\$11.92	1.09	0.51%
IBU TAB 600MG	20	20	\$246.44	\$12.32	1	0.15%
IBUPROFEN SUS 100MG/5ML	6	5	\$84.29	\$14.05	1.2	0.05%
SUBTOTAL	4,850	4,343	\$62,648.63	\$12.92	1.12	37.40%
MELOXICAM PRODUCTS						
MELOXICAM TAB 15MG	1,823	1,292	\$21,246.97	\$11.65	1.41	12.68%
MELOXICAM TAB 7.5MG	679	520	\$7,873.64	\$11.60	1.31	4.70%
SUBTOTAL	2,502	1,812	\$29,120.61	\$11.64	1.38	17.38%
NAPROXEN PRODUCTS						
NAPROXEN TAB 500MG	1,209	1,035	\$14,997.78	\$12.41	1.17	8.95%
NAPROXEN TAB 375MG	107	93	\$1,324.30	\$12.38	1.15	0.79%
NAPROXEN TAB 250MG	87	72	\$1,095.76	\$12.59	1.21	0.65%
NAPROXEN DR TAB 500MG	47	41	\$5,028.94	\$107.00	1.15	3.00%
NAPROXEN SUS 125MG/5ML	29	21	\$2,686.41	\$92.63	1.38	1.60%
EC-NAPROXEN TAB 500MG	11	10	\$813.58	\$73.96	1.1	0.49%
NAPROXEN DR TAB 375MG	6	6	\$83.85	\$13.98	1	0.05%
SUBTOTAL	1,496	1,278	\$26,030.62	\$17.40	1.17	15.54%
CELECOXIB PRODUCTS						
CELECOXIB CAP 200MG	696	465	\$10,978.17	\$15.77	1.5	6.55%
CELECOXIB CAP 100MG	326	222	\$4,984.07	\$15.29	1.47	2.98%
CELECOXIB CAP 50MG	9	8	\$145.21	\$16.13	1.13	0.09%
SUBTOTAL	1,031	695	\$16,107.45	\$15.62	1.48	9.61%
DICLOFENAC PRODUCTS						
DICLOFENAC TAB 75MG DR	492	334	\$7,657.96	\$15.56	1.47	4.57%
DICLOFENAC GEL 1%	172	143	\$3,782.41	\$21.99	1.2	2.26%
DICLOFENAC TAB 50MG DR	158	126	\$2,363.97	\$14.96	1.25	1.41%
FLECTOR DIS 1.3%	3	2	\$698.05	\$232.68	1.5	0.42%
DICLOFENAC DIS 1.3%	3	3	\$770.00	\$256.67	1	0.46%
SUBTOTAL	828	608	\$15,272.39	\$18.44	1.36	9.12%
KETOROLAC PRODUCTS						
KETOROLAC TAB 10MG	431	414	\$7,635.13	\$17.71	1.04	4.56%
KETOROLAC INJ 30MG/ML	1	1	\$8.40	\$8.40	1	0.01%
KETOROLAC INJ 60MG/2ML	1	1	\$4.22	\$4.22	1	0.00%
SUBTOTAL	433	416	\$7,647.75	\$17.66	1.04	4.57%
NABUMETONE PRODUCTS						
NABUMETONE TAB 750MG	74	45	\$1,373.56	\$18.56	1.64	0.82%
NABUMETONE TAB 500MG	43	34	\$752.60	\$17.50	1.26	0.45%
SUBTOTAL	117	79	\$2,126.16	\$18.17	1.48	1.27%
ETODOLAC PRODUCTS						
ETODOLAC TAB 400MG	69	58	\$1,617.12	\$23.44	1.19	0.97%
ETODOLAC TAB 500MG	38	31	\$840.88	\$22.13	1.23	0.50%
SUBTOTAL	107	89	\$2,458.00	\$22.97	1.2	1.47%
INDOMETHACIN PRODUCTS						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
INDOMETHACIN CAP 50MG	45	38	\$745.38	\$16.56	1.18	0.44%
INDOMETHACIN CAP 25MG	32	24	\$476.89	\$14.90	1.33	0.28%
SUBTOTAL	77	62	\$1,222.27	\$15.87	1.24	0.73%
SULINDAC PRODUCTS						
SULINDAC TAB 200MG	8	5	\$171.66	\$21.46	1.6	0.10%
SULINDAC TAB 150MG	2	2	\$34.66	\$17.33	1	0.02%
SUBTOTAL	10	7	\$206.32	\$20.63	1.43	0.12%
DIFLUNISAL PRODUCTS						
DIFLUNISAL TAB 500MG	4	3	\$210.86	\$52.72	1.33	0.13%
SUBTOTAL	4	3	\$210.86	\$52.72	1.33	0.13%
TIER-1 SUBTOTAL	11,455	8,814*	\$163,051.06	\$14.23	1.3	97.33%
TIER-2 UTILIZATION						
ETODOLAC PRODUCTS						
ETODOLAC CAP 300MG	38	36	\$775.91	\$20.42	1.06	0.46%
ETODOLAC CAP 200MG	19	18	\$406.05	\$21.37	1.06	0.24%
ETODOLAC ER TAB 400MG	1	1	\$43.27	\$43.27	1	0.03%
SUBTOTAL	58	55	\$1,225.23	\$21.12	1.05	0.73%
DICLOFENAC PRODUCTS						
DICLOFENAC POT TAB 50MG	43	34	\$866.76	\$20.16	1.26	0.52%
DICLOFENAC TAB 100MG ER	11	6	\$326.49	\$29.68	1.83	0.19%
DICLOFENAC TAB 25MG DR	2	2	\$101.46	\$50.73	1	0.06%
SUBTOTAL	56	42	\$1,294.71	\$23.12	1.33	0.77%
NAPROXEN PRODUCTS						
NAPROXEN SOD TAB 550MG	23	23	\$414.31	\$18.01	1	0.25%
SUBTOTAL	23	23	\$414.31	\$18.01	1	0.25%
DICLOFENAC/MISOPROSTOL PRODUCTS						
DICLO/MISOPR TAB 75/0.2MG	6	3	\$472.48	\$78.75	2	0.28%
SUBTOTAL	6	3	\$472.48	\$78.75	2	0.28%
PIROXICAM PRODUCTS						
PIROXICAM CAP 20MG	1	1	\$18.41	\$18.41	1	0.01%
SUBTOTAL	1	1	\$18.41	\$18.41	1	0.01%
OXAPROZIN PRODUCTS						
OXAPROZIN TAB 600MG	1	1	\$13.79	\$13.79	1	0.01%
SUBTOTAL	1	1	\$13.79	\$13.79	1	0.01%
TIER-2 SUBTOTAL	145	124*	\$3,438.93	\$23.72	1.17	2.05%
SPECIAL PRIOR AUTHORIZATION (PA) UTILIZATION						
INDOMETHACIN PRODUCTS						
INDOMETHACIN CAP 75MG ER	4	4	\$71.28	\$17.82	1	0.04%
SUBTOTAL	4	4	\$71.28	\$17.82	1	0.04%
DICLOFENAC PRODUCTS						
DICLOFENAC SOL 2%	1	1	\$257.85	\$257.85	1	0.15%
DICLOFENAC POW 50MG	1	1	\$245.20	\$245.20	1	0.15%
DICLOFENAC CAP 25MG	1	1	\$122.77	\$122.77	1	0.07%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SUBTOTAL	3	3	\$625.82	\$208.61	1	0.37%
CELECOXIB PRODUCTS						
CELECOXIB CAP 400MG	2	2	\$43.01	\$21.51	1	0.03%
SUBTOTAL	2	2	\$43.01	\$21.51	1	0.03%
MELOXICAM PRODUCTS						
MELOXICAM CAP 5MG	1	1	\$258.46	\$258.46	1	0.15%
SUBTOTAL	1	1	\$258.46	\$258.46	1	0.15%
MEFENAMIC ACID PRODUCTS						
MEFENAMIC ACID CAP 250MG	1	1	\$37.57	\$37.57	1	0.02%
SUBTOTAL	1	1	\$37.57	\$37.57	1	0.02%
SPECIAL PA SUBTOTAL	11	11*	\$1,036.14	\$94.19	1	0.62%
TOTAL	11,611	8,926*	\$167,526.13	\$14.43	1.3	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; DICLO/MISOPR = diclofenac/misoprostol; DIS = patch; DR = delayed-release; EC = enteric-coated; ER = extended-release; INJ = injection; POT = potassium; POW = powder; SOD = sodium; 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.

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 12/2024 Last accessed 12/19/2024.

² Federal Register. Pfizer, Inc.; Withdrawal of Approval of Familial Adenomatous Polyposis Indication for Celebrex[®]. Available online at: <https://www.federalregister.gov/documents/2012/06/08/2012-13900/pfizer-inc-withdrawal-of-approval-of-familial-adenomatous-polyposis-indication-for-celebrex>. Issued 06/08/2012. Last accessed 12/19/2024.

³ U.S. FDA. National Drug Code Directory. Available online at: <https://dps.fda.gov/ndc>. Last accessed 12/19/2024.

⁴ Dolobid[™] (Diflunisal) Prescribing Information. INA Pharmaceuticals, Inc. Available online at: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=725234b2-0e23-45c3-a42d-eb4e62273f9b>. Last revised 08/2024. Last accessed 12/20/2024.



Appendix G

Fiscal Year 2024 Annual Review of Ophthalmic Antibiotic Medications

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

Ophthalmic Antibiotic Medications: Liquids		
Tier-1	Tier-2	Tier-3
ciprofloxacin (Ciloxan®)	levofloxacin (Quixin®)	azithromycin (Azasite®)
gentamicin (Gentak®)		besifloxacin (Besivance®)
neomycin/polymyxin B/gramicidin (Neosporin®)		gatifloxacin (Zymaxid®)
ofloxacin (Ocuflax®)		moxifloxacin (Vigamox®, Moxeza®)
polymyxin B/trimethoprim (Polytrim®)		
sulfacetamide sodium (Bleph-10®)		
tobramycin (Tobrex®)		
Ophthalmic Antibiotic Medications: Ointments		
Tier-1	Tier-2	
bacitracin/polymyxin B (AK-Poly-Bac®, Polycin®)	bacitracin (AK-Tracin®)	
erythromycin (Ilotycin™, Romycin®)	ciprofloxacin (Ciloxan®)	
gentamicin (Gentak®)	sodium sulfacetamide (Bleph-10®)	
neomycin/polymyxin B/bacitracin (Neosporin®)		
tobramycin (Tobrex®)		
Ophthalmic Antibiotic/Steroid Combination Products		
Tier-1	Tier-2	
neomycin/polymyxin B/dexamethasone (Maxitrol®) oint & susp	bacitracin/polymyxin B/neomycin/hydrocortisone (Neo-Polycin® HC) oint	
sulfacetamide/prednisolone 10%/0.23% solution	gentamicin/prednisolone (Pred-C®) oint & susp	
tobramycin/dexamethasone 0.3%/0.1% (Tobradex®) susp – Brand Preferred	neomycin/polymyxin B/hydrocortisone (Cortisporin®) susp	
tobramycin/dexamethasone 0.3%/0.05% (Tobradex® ST) susp	sulfacetamide/prednisolone (Blephamide®) oint & susp	
	tobramycin/dexamethasone (Tobradex®) oint	
	tobramycin/loteprednol (Zylet®) susp	

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).

HC= hydrocortisone; oint= ointment; susp= suspension

Ophthalmic Antibiotic Medications Tier-2 Approval Criteria:

1. An FDA approved indication/suspected infection by an organism not known to be covered by Tier-1 products, or failure of a Tier-1 product; or
2. Known contraindication to all indicated Tier-1 medications; or
3. Prescription written by an optometrist or ophthalmologist; or
4. When requested medication is being used for pre/post-operative prophylaxis.

Ophthalmic Antibiotic Medications Tier-3 Approval Criteria:

1. An FDA approved indication/suspected infection by an organism not known to be covered by Tier-2 products, or failure of a Tier-2 product; or
2. Known contraindication to all indicated Tier-2 medications; or
3. Prescription written by an optometrist or ophthalmologist; or
4. When requested medication is being used for pre/post-operative prophylaxis.

Ophthalmic Antibiotic/Steroid Combination Products Tier-2 Approval Criteria:

1. Prescription written by an optometrist or ophthalmologist; or
2. When requested medication is being used for pre/post-operative prophylaxis.

Utilization of Ophthalmic Antibiotic 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	60,887	72,123	\$1,408,474.71	\$19.53	\$1.42	454,133	994,834
2023 Total	60,887	72,123	\$1,408,474.71	\$19.53	\$1.42	454,133	994,834
Fiscal Year 2024							
FFS	41,650	48,674	\$936,035.41	\$19.23	\$1.41	302,861	662,095
Aetna	2,700	2,924	\$58,119.10	\$19.88	\$2.20	18,331	26,449
Humana	2,805	3,105	\$64,395.25	\$20.74	\$1.55	19,409	41,633
OCH	2,738	2,958	\$57,476.20	\$19.43	\$1.48	18,429	38,814
2024 Total	48,734	57,661	\$1,116,025.96	\$19.35	\$1.45	359,030	768,991
% Change	-20.00%	-20.10%	-20.80%	-0.90%	2.10%	-20.90%	-22.70%
Change	-12,153	-14,462	-\$292,448.75	-\$0.18	\$0.03	-95,103	-225,843

Costs do not reflect rebated prices or net costs.

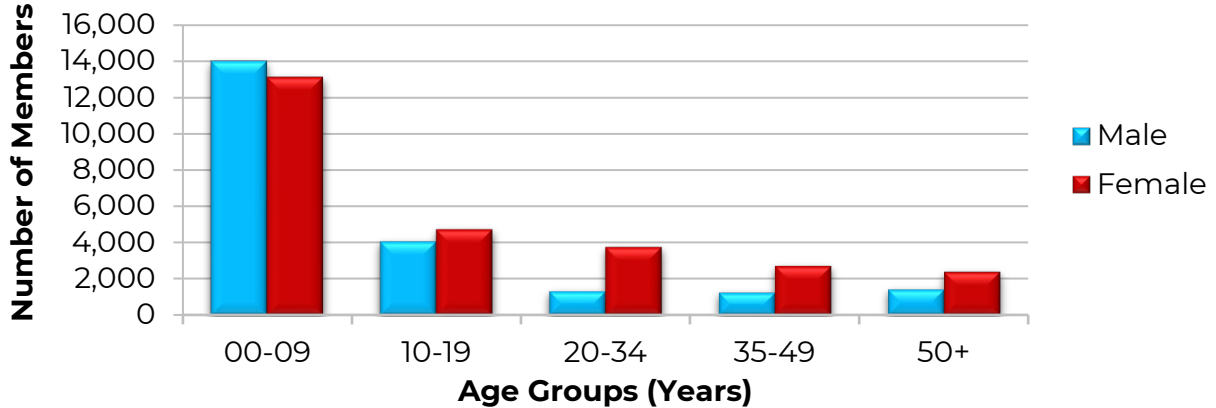
*Total number of unduplicated utilizing members.

FFS = fee-for-service; OCH = Oklahoma Complete Health

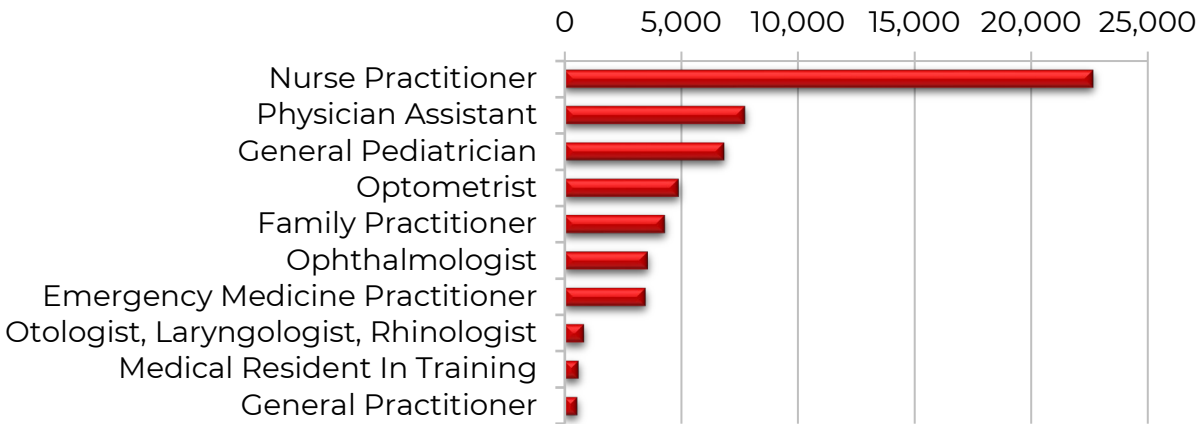
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Demographics of Members Utilizing Ophthalmic Antibiotic Medications (All Plans)



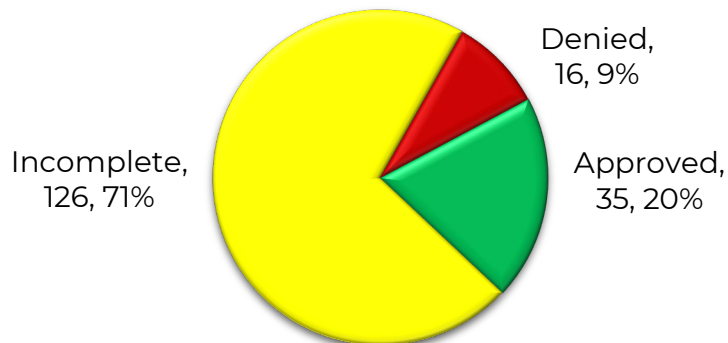
Top Prescriber Specialties of Ophthalmic Antibiotic Medications by Number of Claims (All Plans)



Prior Authorization of Ophthalmic Antibiotic Medications

There were 177 prior authorization requests submitted for ophthalmic antibiotic 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	30	18%	122	75%	11	7%	163
Aetna	4	40%	4	40%	2	20%	10
Humana	1	33%	0	0%	2	67%	3
OCH	0	0%	0	0%	1	100%	1
Total	35	20%	126	71%	16	9%	177

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 Updates¹

Anticipated Patent Expiration(s):

- Tobradex[®] ST (tobramycin/dexamethasone ophthalmic suspension): August 2028
- Besivance[®] (besifloxacin ophthalmic suspension): January 2031

News:

- **December 2024:** As of December 2024, the U.S. Food and Drug Administration (FDA) Orange Book lists Blephamide[®] (sulfacetamide/prednisolone) ointment and suspension, Gentak[®] (gentamicin) ointment, Moxeza[®] (moxifloxacin) solution, Pred-G[®] (gentamicin/prednisolone) ointment and suspension, and Quixin[®] (levofloxacin) solution as discontinued products. Additionally, there are no generic equivalents available for these products.

Recommendations

The College of Pharmacy recommends the following changes to the Ophthalmic Antibiotic Medications Product Based Prior Authorization (PBPA) category based on net cost and product discontinuations (changes noted in red in the following PBPA Tier chart and approval criteria):

1. Removing the brand preferred status for Tobradex[®] (tobramycin/dexamethasone) suspension; and
2. Moving Bleph-10[®] (sulfacetamide sodium) solution and Neosporin[®] (neomycin/polymyxin B/gramicidin) solution from Tier-1 to Tier-2; and
3. Moving Ciloxan[®] (ciprofloxacin) ointment, Neo-Polycin[®] HC (bacitracin/polymyxin B/neomycin/hydrocortisone) ointment, Tobradex[®] (tobramycin/dexamethasone) ointment, and Zylet[®] (tobramycin/loteprednol) suspension from Tier-2 to Tier-1; and
4. Moving Azasite[®] (azithromycin), Besivance[®] (besifloxacin), and Vigamox[®] (moxifloxacin) from Tier-3 to Tier-1; and
5. Moving Zymaxid[®] (gatifloxacin) from Tier-3 to Tier-2; and

6. Removing Blephamide® (sulfacetamide/prednisolone) ointment and suspension, Gentak® (gentamicin) ointment, Moxeza® (moxifloxacin) solution, Pred-G® (gentamicin/prednisolone) ointment and suspension, and Quixin® (levofloxacin) solution based on product discontinuations.

Ophthalmic Antibiotic Medications: Liquids		
Tier-1	Tier-2	Tier-3
azithromycin (Azasite®)	levofloxacin (Quixin®)	azithromycin (Azasite®)
besifloxacin (Besivance®)	gatifloxacin (Zymaxid®)	besifloxacin (Besivance®)
ciprofloxacin (Ciloxan®)	neomycin/polymyxin B/gramicidin (Neosporin®)	gatifloxacin (Zymaxid®)
gentamicin (Gentak®)	sulfacetamide sodium (Bleph-10®)	moxifloxacin (Vigamox®; Moxeza®)
moxifloxacin (Vigamox®)		
neomycin/polymyxin B/gramicidin (Neosporin®)		
ofloxacin (Ocuflox®)		
polymyxin B/trimethoprim (Polytrim®)		
sulfacetamide sodium (Bleph-10®)		
tobramycin (Tobrex®)		
Ophthalmic Antibiotic Medications: Ointments		
Tier-1	Tier-2	
bacitracin/polymyxin B (AK-Poly-Bac®, Polycin®)	bacitracin (AK-Tracin®)	
ciprofloxacin (Ciloxan®)	ciprofloxacin (Ciloxan®)	
erythromycin (Ilotycin™, Romycin®)	sodium sulfacetamide (Bleph-10®)	
gentamicin (Gentak®)		
neomycin/polymyxin B/bacitracin (Neosporin®)		
tobramycin (Tobrex®)		
Ophthalmic Antibiotic/Steroid Combination Products		
Tier-1	Tier-2	
bacitracin/polymyxin B/neomycin/hydrocortisone (Neo-Polycin® HC) oint	bacitracin/polymyxin B/neomycin/hydrocortisone (Neo-Polycin® HC) oint	
neomycin/polymyxin B/dexamethasone (Maxitrol®) oint & susp	gentamicin/prednisolone (Pred-G®) oint & susp	
sulfacetamide/prednisolone 10%/0.23% solution	neomycin/polymyxin B/hydrocortisone (Cortisporin®) susp	
tobramycin/dexamethasone 0.3%/0.1% (Tobradex®) ointment & susp –Brand Preferred	sulfacetamide/prednisolone (Blephamide®) oint & susp	
tobramycin/dexamethasone 0.3%/0.05% (Tobradex® ST) susp	tobramycin/dexamethasone (Tobradex®) oint	
tobramycin/loteprednol (Zylet®) susp	tobramycin/loteprednol (Zylet®) susp	

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). HC= hydrocortisone; oint= ointment; susp= suspension

Utilization Details of Ophthalmic Antibiotic Medications: Fiscal Year 2024

Fee-For-Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
OPHTHALMIC ANTIBIOTIC LIQUIDS						
TIER-1 PRODUCTS						
OFLOXACIN DRO 0.3% OP	12,812	11,694	\$263,718.88	\$20.58	1.1	28.17%
POLYMYXIN B/TRIMETH SOL	11,067	10,695	\$157,906.36	\$14.27	1.03	16.87%
TOBRAMYCIN SOL 0.3% OP	3,239	3,057	\$44,917.51	\$13.87	1.06	4.80%
CIPROFLOXACIN SOL 0.3% OP	2,707	2,515	\$49,474.95	\$18.28	1.08	5.29%
GENTAMICIN SOL 0.3% OP	1,864	1,762	\$26,761.09	\$14.36	1.06	2.86%
SULFACET SOD SOL 10% OP	359	345	\$14,143.12	\$39.40	1.04	1.51%
NEO/POLY/GRAM SOL OP	27	27	\$1,361.98	\$50.44	1	0.15%
TRIMETH/POLYMYXN SOL	1	1	\$16.44	\$16.44	1	0.00%
SUBTOTAL	32,076	30,096	\$558,300.33	\$17.41	1.07	59.65%
TIER-3 PRODUCTS						
MOXIFLOXACIN SOL HCL 0.5%	1,057	768	\$19,497.22	\$18.45	1.38	2.08%
BESIVANCE SUS 0.6%	60	51	\$12,977.11	\$216.29	1.18	1.39%
GATIFLOXACIN SOL 0.5%	37	31	\$1,208.47	\$32.66	1.19	0.13%
MOXIFLOXACIN SOL 0.5%	9	7	\$170.18	\$18.91	1.29	0.02%
AZASITE SOL 1%	3	3	\$479.17	\$159.72	1	0.05%
MOXIFLOXACIN SOL 0.5% BID	1	1	\$102.87	\$102.87	1	0.01%
SUBTOTAL	1,167	861	\$34,435.02	\$29.51	1.36	3.68%
LIQUID SUBTOTAL	33,243	29,707*	\$592,735.35	\$17.83	1.12	63.32%
OPHTHALMIC ANTIBIOTIC OINTMENTS						
TIER-1 PRODUCTS						
ERYTHROMYCIN OIN 5MG/GM	10,952	10,026	\$193,403.17	\$17.66	1.09	20.66%
BACITRACIN/POLY OIN OP	112	108	\$2,275.52	\$20.32	1.04	0.24%
TOBREX OIN 0.3% OP	35	28	\$8,783.75	\$250.96	1.25	0.94%
NEO/BAC/POLY OIN OP	34	34	\$977.03	\$28.74	1	0.10%
SUBTOTAL	11,133	10,196	\$205,439.47	\$18.45	1.09	21.95%
TIER-2 PRODUCTS						
BACITRACIN OIN OP	10	10	\$1,136.51	\$113.65	1	0.12%
SUBTOTAL	10	10	\$1,136.51	\$113.65	1	0.12%
OINTMENT SUBTOTAL	11,143	10,182*	\$206,575.98	\$18.54	1.09	22.07%
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATION PRODUCTS						
TIER-1 PRODUCTS						
NEO/POLY/DEX SUS 0.1% OP	3,322	3,115	\$67,018.37	\$20.17	1.07	7.16%
NEO/POLY/DEX OIN 0.1% OP	693	614	\$13,526.17	\$19.52	1.13	1.45%
TOBRADEX SUS 0.3-0.1%	164	153	\$30,584.98	\$186.49	1.07	3.27%
TOBRADEX ST SUS 0.3-0.05%	56	53	\$13,320.08	\$237.86	1.06	1.42%
SULFACET/PRED NA SOL 10-0.23% OP	4	4	\$90.96	\$22.74	1	0.01%
TOBRAMYCIN/DEX SUS 0.3-0.1%	3	3	\$117.35	\$39.12	1	0.01%
SUBTOTAL	4,242	3,942	\$124,657.91	\$29.39	1.08	13.32%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-2 PRODUCTS						
TOBRADEX OIN 0.3-0.1%	37	35	\$9,710.01	\$262.43	1.06	1.04%
ZYLET SUS 0.5-0.3%	7	7	\$2,191.44	\$313.06	1	0.23%
NEO/POLY/BAC/HC OIN 1% OP	1	1	\$31.60	\$31.60	1	0.00%
NEO/POLY/HC SUS OP	1	1	\$133.12	\$133.12	1	0.01%
SUBTOTAL	46	44	\$12,066.17	\$262.31	1.05	1.29%
COMBINATION SUBTOTAL	4,288	3,882*	\$136,724.08	\$31.89	1.1	14.61%
TOTAL	48,674	41,650*	\$936,035.41	\$19.23	1.17	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

BAC = bacitracin; BID = twice daily formulation; DEX = dexamethasone; DRO = drops; GRAM = gramicidin; HC = hydrocortisone; HCL = hydrochloride; NA = sodium; NEO = neomycin; OIN = ointment; OP = ophthalmic; POLY = polymyxin; PRED = prednisolone; SOD = sodium; SOL = solution; ST = suspension technology; SULFACET = sulfacetamide; SUS = suspension; TRIMETH = trimethoprim
Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Aetna Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
OPHTHALMIC ANTIBIOTIC LIQUIDS						
TIER-1 PRODUCTS						
OFLOXACIN DRO 0.3% OP	845	806	\$18,397.22	\$21.77	1.05	31.65%
POLYMYXIN B/TRIMETH SOL	663	651	\$9,182.52	\$13.85	1.02	15.80%
CIPROFLOXACIN SOL 0.3% OP	198	193	\$3,794.76	\$19.17	1.03	6.53%
TOBRAMYCIN SOL 0.3% OP	187	185	\$2,153.73	\$11.52	1.01	3.71%
GENTAMICIN SOL 0.3% OP	88	87	\$1,431.88	\$16.27	1.01	2.46%
SULFACET SOD SOL 10% OP	19	19	\$802.45	\$42.23	1	1.38%
NEO/POLY/GRAM SOL OP	2	2	\$109.70	\$54.85	1	0.19%
SUBTOTAL	2,002	1,943	\$35,872.26	\$17.92	1.03	61.72%
TIER-3 PRODUCTS						
MOXIFLOXACIN SOL HCL 0.5%	55	50	\$1,040.05	\$18.91	1.1	1.79%
BESIVANCE SUS 0.6%	4	4	\$914.68	\$228.67	1	1.57%
GATIFLOXACIN SOL 0.5%	1	1	\$30.72	\$30.72	1	0.05%
MOXIFLOXACIN SOL 0.5%	1	1	\$18.26	\$18.26	1	0.03%
SUBTOTAL	61	56	\$2,003.71	\$32.85	1.09	3.45%
LIQUID SUBTOTAL	2,063	1,952*	\$37,875.97	\$18.36	1.06	65.17%
OPHTHALMIC ANTIBIOTIC OINTMENTS						
TIER-1 PRODUCTS						
ERYTHROMYCIN OIN 5MG/GM	583	559	\$10,370.94	\$17.79	1.04	17.84%
TOBREX OIN 0.3% OP	7	7	\$1,796.03	\$256.58	1	3.09%
BACITRACIN/POLY OIN OP	6	6	\$115.66	\$19.28	1	0.20%
NEO/BAC/POLY OIN OP	2	1	\$73.36	\$36.68	2	0.13%
SUBTOTAL	598	573	\$12,355.99	\$20.66	1.04	21.26%
TIER-2 PRODUCTS						
BACITRACIN OIN OP	1	1	\$104.09	\$104.09	1	0.18%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
SUBTOTAL	1	1	\$104.09	\$104.09	1	0.18%
OINTMENT SUBTOTAL	599	574*	\$12,460.08	\$20.80	1.04	21.44%
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATION PRODUCTS						
TIER-1 PRODUCTS						
NEO/POLY/DEX SUS 0.1% OP	180	178	\$3,559.28	\$19.77	1.01	6.12%
NEO/POLY/DEX OIN 0.1% OP	37	35	\$735.50	\$19.88	1.06	1.27%
TOBRAMYCIN/DEX SUS 0.3-0.1%	33	32	\$1,072.28	\$32.49	1.03	1.84%
TOBRADEX ST SUS 0.3-0.05%	5	5	\$1,190.33	\$238.07	1	2.05%
SUBTOTAL	255	250	\$6,557.39	\$25.72	1.02	11.28%
TIER-2 PRODUCTS						
TOBRADEX OIN 0.3-0.1%	3	3	\$814.27	\$271.42	1	1.40%
NEO/POLY/HC SUS OP	3	3	\$381.57	\$127.19	1	0.66%
NEO/POLY/BAC/HC OIN 1% OP	1	1	\$29.82	\$29.82	1	0.05%
SUBTOTAL	7	7	\$1,225.66	\$175.09	1	2.11%
COMBINATION SUBTOTAL	262	254*	\$7,783.05	\$29.71	1.03	13.39%
TOTAL	2,924	2,700*	\$58,119.10	\$19.88	1.08	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

BAC = bacitracin; DEX = dexamethasone; DRO = drops; GRAM = gramicidin; HC = hydrocortisone; HCL = hydrochloride; NA = sodium; NEO = neomycin; OIN = ointment; OP = ophthalmic; POLY = polymyxin; PRED = prednisolone; SOD = sodium; SOL = solution; ST = suspension technology; SULFACET = sulfacetamide; SUS = suspension; TRIMETH = trimethoprim

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.

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
OPHTHALMIC ANTIBIOTIC LIQUIDS						
TIER-1 PRODUCTS						
OFLOXACIN DRO 0.3% OP	816	779	\$17,963.81	\$22.01	1.05	27.90%
POLYMYXIN B/TRIMETH SOL	709	697	\$9,977.86	\$14.07	1.02	15.49%
TOBRAMYCIN SOL 0.3% OP	176	169	\$2,237.00	\$12.71	1.04	3.47%
CIPROFLOXACIN SOL 0.3% OP	159	149	\$3,061.68	\$19.26	1.07	4.75%
GENTAMICIN SOL 0.3% OP	102	101	\$1,710.78	\$16.77	1.01	2.66%
SULFACET SOD SOL 10% OP	16	16	\$635.11	\$39.69	1	0.99%
NEO/POLY/GRAM SOL OP	1	1	\$48.99	\$48.99	1	0.08%
SUBTOTAL	1,979	1,912	\$35,635.23	\$18.01	1.04	55.34%
TIER-3 PRODUCTS						
MOXIFLOXACIN SOL HCL 0.5%	116	95	\$2,212.86	\$19.08	1.22	3.44%
BESIVANCE SUS 0.6%	7	6	\$1,603.13	\$229.02	1.17	2.49%
GATIFLOXACIN SOL 0.5%	3	3	\$95.93	\$31.98	1	0.15%
AZASITE SOL 1%	1	1	\$258.00	\$258.00	1	0.40%
SUBTOTAL	127	105	\$4,169.92	\$32.83	1.21	6.48%
LIQUID SUBTOTAL	2,106	1,970*	\$39,805.15	\$18.90	1.07	61.81%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
OPHTHALMIC ANTIBIOTIC OINTMENTS						
TIER-1 PRODUCTS						
ERYTHROMYCIN OIN 5MG/GM	655	621	\$12,156.53	\$18.56	1.05	18.88%
TOBREX OIN 0.3% OP	3	3	\$769.59	\$256.53	1	1.20%
NEO/BAC/POLY OIN OP	3	3	\$160.58	\$53.53	1	0.25%
BACITRACIN/POL OIN OP	3	3	\$59.08	\$19.69	1	0.09%
SUBTOTAL	664	630	\$13,145.78	\$19.80	1.05	20.41%
TIER-2 PRODUCTS						
BACITRACIN OIN OP	2	2	\$208.17	\$104.09	1	0.32%
CILOXAN OIN 0.3% OP	1	1	\$270.80	\$270.80	1	0.42%
SUBTOTAL	3	3	\$478.97	\$159.66	1	0.74%
OINTMENT SUBTOTAL	667	633*	\$13,624.75	\$20.43	1.05	21.16%
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATION PRODUCTS						
TIER-1 PRODUCTS						
NEO/POLY/DEX SUS 0.1% OP	202	198	\$4,163.13	\$20.61	1.02	6.46%
TOBRAMYCIN/DEX SUS 0.3-0.1%	62	57	\$2,140.21	\$34.52	1.09	3.32%
NEO/POLY/DEX OIN 0.1% OP	51	44	\$1,008.50	\$19.77	1.16	1.57%
TOBRADEX ST SUS 0.3-0.05%	4	4	\$952.26	\$238.07	1	1.48%
SUBTOTAL	319	303	\$8,264.10	\$25.91	1.05	12.83%
TIER-2 PRODUCTS						
TOBRADEX OIN 0.3-0.1%	5	5	\$1,357.48	\$271.50	1	2.11%
NEO/POLY/HC SUS OP	5	5	\$655.53	\$131.11	1	1.02%
ZYLET SUS 0.5-0.3%	2	2	\$659.96	\$329.98	1	1.02%
NEO/POLY/BAC/HC OIN 1% OP	1	1	\$28.28	\$28.28	1	0.04%
SUBTOTAL	13	13	\$2,701.25	\$207.79	1	4.19%
COMBINATION SUBTOTAL	332	306*	\$10,965.35	\$33.03	1.08	17.03%
TOTAL	3,105	2,805*	\$64,395.25	\$20.74	1.11	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

BAC = bacitracin; DEX = dexamethasone; DRO = drops; GRAM = gramicidin; HC = hydrocortisone; HCL = hydrochloride; NA = sodium; NEO = neomycin; OIN = ointment; OP = ophthalmic; POLY = polymyxin; PRED = prednisolone; SOD = sodium; SOL = solution; ST = suspension technology; SULFACET = sulfacetamide; SUS = suspension; TRIMETH = trimethoprim

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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
OPHTHALMIC ANTIBIOTIC LIQUIDS						
TIER-1 PRODUCTS						
OFLOXACIN DRO 0.3% OP	842	805	\$17,079.01	\$20.28	1.05	29.71%
POLYMYXIN B/TRIMETH SOL	670	664	\$9,294.31	\$13.87	1.01	16.17%
TOBRAMYCIN SOL 0.3% OP	181	178	\$2,463.07	\$13.61	1.02	4.29%
CIPROFLOXACIN SOL 0.3% OP	149	141	\$2,749.50	\$18.45	1.06	4.78%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
GENTAMICIN SOL 0.3% OP	111	107	\$1,656.84	\$14.93	1.04	2.88%
SULFACET SOD SOL 10% OP	18	18	\$659.76	\$36.65	1	1.15%
NEO/POLY/GRAM SOL OP	1	1	\$48.99	\$48.99	1	0.09%
SUBTOTAL	1,972	1,914	\$33,951.48	\$17.22	1.03	59.07%
TIER-3 PRODUCTS						
MOXIFLOXACIN SOL HCL 0.5%	76	71	\$1,431.93	\$18.84	1.07	2.49%
AZASITE SOL 1%	6	5	\$1,472.60	\$245.43	1.2	2.56%
BESIVANCE SUS 0.6%	5	5	\$1,146.79	\$229.36	1	2.00%
GATIFLOXACIN SOL 0.5%	2	2	\$65.21	\$32.61	1	0.11%
SUBTOTAL	89	83	\$4,116.53	\$46.25	1.07	7.16%
LIQUID SUBTOTAL	2,061	1,966*	\$38,068.01	\$18.47	1.05	66.23%
OPHTHALMIC ANTIBIOTIC OINTMENTS						
TIER-1 PRODUCTS						
ERYTHROMYCIN OIN 5MG/GM	606	590	\$10,914.06	\$18.01	1.03	18.99%
BACITRACIN/POLY OIN OP	4	4	\$80.85	\$20.21	1	0.14%
TOBREX OIN 0.3% OP	1	1	\$256.61	\$256.61	1	0.45%
SUBTOTAL	611	595	\$11,251.52	\$18.41	1.03	19.58%
TIER-2 PRODUCTS						
BACITRACIN OIN OP	2	2	\$173.66	\$86.83	1	0.30%
SUBTOTAL	2	2	\$173.66	\$86.83	1	0.30%
OINTMENT SUBTOTAL	613	597*	\$11,425.18	\$18.64	1.03	19.88%
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATION PRODUCTS						
TIER-1 PRODUCTS						
NEO/POLY/DEX SUS 0.1% OP	175	171	\$3,566.67	\$20.38	1.02	6.21%
NEO/POLY/DEX OIN 0.1% OP	56	54	\$1,110.85	\$19.84	1.04	1.93%
TOBRAMYCIN/DEX SUS 0.3-0.1%	44	43	\$1,394.97	\$31.70	1.02	2.43%
TOBRADEX ST SUS 0.3-0.05%	3	3	\$714.68	\$238.23	1	1.24%
SUBTOTAL	278	271	\$6,787.17	\$24.41	1.03	11.81%
TIER-2 PRODUCTS						
TOBRADEX OIN 0.3-0.1%	3	3	\$814.27	\$271.42	1	1.42%
NEO/POLY/HC SUS OP	3	3	\$381.57	\$127.19	1	0.66%
SUBTOTAL	6	6	\$1,195.84	\$199.31	1	2.08%
COMBINATION SUBTOTAL	284	273*	\$7,983.01	\$28.11	1.04	13.89%
TOTAL	2,958	2,738*	\$57,476.20	\$19.43	1.08	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

BAC = bacitracin; DEX = dexamethasone; DRO = drops; GRAM = gramicidin; HC = hydrocortisone; HCL = hydrochloride; NA = sodium; NEO = neomycin; OIN = ointment; OP = ophthalmic; POLY = polymyxin; PRED = prednisolone; SOD = sodium; SOL = solution; ST = suspension technology; SULFACET = sulfacetamide; SUS = suspension; TRIMETH = trimethoprim

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 12/2024. Last Accessed 12/20/2024.



Appendix H

Fiscal Year 2024 Annual Review of Gastrointestinal (GI) Cancer Medications and 30-Day Notice to Prior Authorize Tevimbra® (Tislelizumab-jsgr), Vyloy® (Zolbetuximab-clzb), and Ziihera® (Zanidatamab-hrii)

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

Utilization data for Enhertu® (fam-trastuzumab deruxtecan-nxki), Herceptin® (trastuzumab), Hercessi™ (trastuzumab-strf), Herzuma® (trastuzumab-pkrb), Kanjinti® (trastuzumab-anns), Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), and Trazimera® (trastuzumab-qyyp) and approval criteria for indications other than GI cancer can be found in the September 2024 Drug Utilization Review (DUR) Board packet. These medications and criteria are reviewed annually with the breast cancer medications. Utilization data for Imfinzi® (durvalumab) and approval criteria for indications other than GI cancer can be found in the April 2024 DUR Board packet. This medication and criteria are reviewed annually with the lung cancer medications. Utilization data for Keytruda® (pembrolizumab), Opdivo® (nivolumab), and Yervoy® (ipilimumab) and approval criteria for indications other than GI cancer can be found in the December 2024 DUR Board packet. These medications and criteria are reviewed annually with the skin cancer medications. Utilization data for Lonsurf® (trifluridine/tipiracil) and Stivarga® (regorafenib) and approval criteria for indications other than GI cancer can be found in the July 2024 DUR Board packet. These medications and criteria are reviewed annually with the colorectal cancer medications. Utilization data for Sprycel® (dasatinib) and Tassigna® (nilotinib) and approval criteria for indications other than GI cancer can be found in the February 2024 DUR Board packet. These medications and criteria are reviewed annually with the leukemia medications.

Ayvakit® (Avapritinib) Approval Criteria [Advanced Systemic Mastocytosis (AdvSM) Diagnosis]:

1. Diagnosis of AdvSM, including members with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematologic neoplasm, or mast cell leukemia; and
2. Member must be 18 years of age or older; and
3. Platelet count $\geq 50 \times 10^9/L$.

Ayvakit® (Avapritinib) Approval Criteria [Gastrointestinal Stromal Tumor (GIST) Diagnosis]:

1. Diagnosis of unresectable or metastatic GIST; and
2. Member must be 18 years of age or older; and
3. Member has a PDGFRA exon 18 mutation (including PDGFRA D842V mutations).

Ayvakit® (Avapritinib) Approval Criteria [Indolent Systemic Mastocytosis (ISM) Diagnosis]:

1. Diagnosis of ISM; and
2. Member must be 18 years of age or older; and
3. Platelet count $\geq 50 \times 10^9/L$.

Cyramza® (Ramucirumab) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of CRC; and
2. Subsequent therapy for metastatic disease after progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine; and
3. In combination with an irinotecan-based regimen.

Cyramza® (Ramucirumab) Approval Criteria [Esophageal Cancer Diagnosis]:

1. Diagnosis of esophageal or esophagogastric junction adenocarcinoma; and
2. Member has unresectable, locally advanced, recurrent, or metastatic disease; and
3. Karnofsky performance score $\geq 60\%$; and
4. As a single agent or in combination with paclitaxel.

Cyramza® (Ramucirumab) Approval Criteria [Gastric Cancer Diagnosis]:

1. Diagnosis of gastric cancer; and
2. Member is not a surgical candidate or has unresectable, locally advanced, recurrent, or metastatic disease; and
3. Karnofsky performance score $\geq 60\%$; and
4. As a single agent or in combination with paclitaxel.

Cyramza® (Ramucirumab) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of HCC; and
2. Second-line or greater therapy; and
3. Previously failed sorafenib; and
4. Alpha-fetoprotein concentration $\geq 400\text{ng/mL}$; and
5. As a single agent.

Cyramza® (Ramucirumab) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of metastatic NSCLC; and
2. First-line in combination with erlotinib; and
 - a. Epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R mutation; or
3. Subsequent therapy for metastatic disease; and
 - a. In combination with docetaxel.

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of locally advanced or metastatic gastric or GEJ adenocarcinoma; and
2. Human epidermal growth factor receptor 2 (HER2)-positive disease; and
3. Member has received at least 1 prior trastuzumab-based regimen.

Herceptin® (Trastuzumab), Hercessi™ (Trastuzumab-strf), Herzuma® (Trastuzumab-pkrb), Kanjinti® (Trastuzumab-anns), Ogivri® (Trastuzumab-dkst), Ontruzant® (Trastuzumab-dttb), and Trazimera® (Trastuzumab-qyyp) Approval Criteria [Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic gastric or gastroesophageal junction adenocarcinoma; and
2. Preferred trastuzumab products include Kanjinti® (trastuzumab-anns) and Trazimera® (trastuzumab-qyyp). Authorization of non-preferred trastuzumab products [Herceptin® (trastuzumab), Hercessi™ (trastuzumab-strf), Herzuma® (trastuzumab-pkrb), Ogivri® (trastuzumab-dkst), or Ontruzant® (trastuzumab-dttb)] will also require a patient-specific, clinically significant reason why the member cannot use the preferred trastuzumab products [Kanjinti® (trastuzumab-anns) or Trazimera® (trastuzumab-qyyp)]. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Imfinzi® (Durvalumab) Approval Criteria [Biliary Tract Cancer (BTC) Diagnosis]:

1. Diagnosis of locally advanced or metastatic BTC; and
2. Used in combination with gemcitabine and cisplatin.

Keytruda® (Pembrolizumab) Approval Criteria [Biliary Tract Cancer (BTC) Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic BTC; and

2. Used in combination with gemcitabine and cisplatin.

Keytruda® (Pembrolizumab) Approval Criteria [Esophageal or Gastroesophageal Junction (GEJ) Carcinoma Diagnosis]:

1. Diagnosis of locally advanced, recurrent, or metastatic esophageal or GEJ carcinoma; and
2. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
3. For first-line therapy:
 - a. In combination with platinum- and fluoropyrimidine-based chemotherapy; or
4. For second-line or greater therapy:
 - a. Following disease progression after 1 or more prior lines of systemic therapy; and
 - b. Tumor must be squamous cell histology; and
 - c. Used as a single agent; and
 - d. Tumor expresses programmed death ligand 1 (PD-L1) [combined positive score (CPS) ≥ 10].

Keytruda® (Pembrolizumab) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of locally advanced, unresectable, or metastatic gastric or GEJ adenocarcinoma; and
2. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
3. For first-line therapy:
 - a. Human epidermal receptor 2 (HER2)-positive disease; and
 - i. Used in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy; and
 - ii. Tumor is positive for expression of programmed death ligand 1 (PD-L1) with a combined positive score (CPS) ≥ 1 ; or
 - b. HER2-negative disease; and
 - i. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy.

Lonsurf® (Trifluridine/Tipiracil) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of metastatic gastric or GEJ adenocarcinoma; and
2. Previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, paclitaxel, docetaxel, or irinotecan; and
3. If human epidermal receptor type 2 (HER2)-positive disease, prior treatment should have included HER2 targeted therapy.

Lytgobi® (Futibatinib) Approval Criteria [Intrahepatic Cholangiocarcinoma Diagnosis]:

1. Diagnosis of unresectable, locally advanced, or metastatic intrahepatic cholangiocarcinoma; and
2. Member was previously treated with at least 1 prior therapy; and
3. Tumor is positive for fibroblast growth factor receptor 2 (FGFR2) gene fusion or rearrangement.

Opdivo® (Nivolumab) Approval Criteria [Esophageal Squamous Cell Carcinoma (ESCC) or Esophageal or Gastroesophageal Junction (GEJ) Cancer Diagnosis]:

1. Diagnosis of unresectable advanced or metastatic ESCC; and
 - a. Used in the first-line setting; and
 - b. Used in combination with 1 of the following:
 - i. Fluoropyrimidine- and platinum-based chemotherapy; or
 - ii. Ipilimumab; or
2. Diagnosis of esophageal or GEJ cancer; and
 - a. Member has received preoperative chemoradiation; and
 - b. Member underwent R0 (complete) resection and has residual disease; and
 - c. As a single agent; or
3. Palliative therapy for members who are not surgical candidates or have unresectable locally advanced, recurrent, or metastatic disease; and
 - a. Human epidermal receptor 2 (HER2)-negative disease; and
 - i. Used in first-line setting; and
 1. Used in combination with oxaliplatin and fluorouracil or capecitabine; and
 2. Adenocarcinoma pathology; or
 - ii. Used in the second-line or greater setting; and
 1. As a single agent; and
 2. Squamous cell pathology.

Opdivo® (Nivolumab) Approval Criteria [Gastric Cancer Diagnosis]:

1. Diagnosis of advanced or metastatic disease; and
2. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy.

Pemazyre® (Pemigatinib) Approval Criteria [Cholangiocarcinoma Diagnosis]:

1. Diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma; and
2. Must have failed 1 or more prior therapies; and
3. Disease is positive for a fibroblast growth factor receptor 2 (FGFR2) gene fusion or other FGFR rearrangement.

Pemazyre® (Pemigatinib) Approval Criteria [Myeloid/Lymphoid Neoplasms (MLNs) Diagnosis]:

1. Diagnosis of relapsed or refractory MLNs; and
2. Disease is positive for a fibroblast growth factor receptor 1 (FGFR1) rearrangement.

Qinlock® (Ripretinib) Approval Criteria [Gastrointestinal Stromal Tumor (GIST) Diagnosis]:

1. Diagnosis of advanced GIST; and
2. Previously received ≥ 3 kinase inhibitors, including imatinib; and
3. As a single agent.

Sprycel® (Dasatinib) Approval Criteria [Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST) Diagnosis]:

1. Member must have all of the following:
 - a. Progressive disease and failed imatinib, sunitinib, or regorafenib; and
 - b. PDGFRA D842V mutation.

Stivarga® (Regorafenib) Approval Criteria [Gastrointestinal Stromal Tumor (GIST) Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic GIST; and
2. Previously treated with imatinib and sunitinib.

Tasigna® (Nilotinib) Approval Criteria [Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST) Diagnosis]:

1. Member must have progressive disease and failed imatinib, sunitinib, or regorafenib.

Truseltiq® (Infigratinib) Approval Criteria [Cholangiocarcinoma Diagnosis]:

1. Diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma; and
2. Presence of fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement; and
3. Disease has progressed on at least 1 prior systemic therapy; and
4. As a single agent; and
5. Members who are new to treatment with Truseltiq® will generally not be approved.

Yervoy® (Ipilimumab) Approval Criteria [Esophageal Squamous Cell Carcinoma (ESCC) Diagnosis]:

1. Diagnosis of unresectable advanced or metastatic ESCC; and
 - a. Used in the first-line setting; and
 - b. Used in combination with nivolumab.

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 GI Cancer Medications: Fiscal Year 2024

The following utilization data includes medications indicated for GI cancer; however, the data does not differentiate between GI cancer diagnoses and other diagnoses, for which use may be appropriate.

Fiscal Years 2024 Utilization: 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	0	0	\$0.00	\$0.00	\$0.00	0	0
Humana	1	2	\$48,686.74	\$24,343.37	\$869.41	280	56
OCH	0	0	\$0.00	\$0.00	\$0.00	0	0
2024 Total	1	2	\$48,686.74	\$24,343.37	\$869.41	280	56

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: There were no paid pharmacy claims for GI cancer medications during fiscal year 2023 to allow for a fiscal year comparison.

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the 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	23	78	\$609,810.75	\$7,818.09	3.39
2023 Total	23	78	\$609,810.75	\$7,818.09	3.39
Fiscal Year 2024					
FFS	23	177	\$864,286.95	\$4,882.98	7.7
Aetna	0	0	\$0.00	\$0.00	0
Humana	0	0	\$0.00	\$0.00	0
OCH	1	3	\$20,954.00	\$6,984.67	3
2024 Total	23	180	\$885,240.95	\$4,918.01	7.83
% Change	0.00%	130.77%	45.17%	-37.09%	130.97%
Change	0	102	\$275,430.20	-\$2,900.08	4.44

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.

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

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

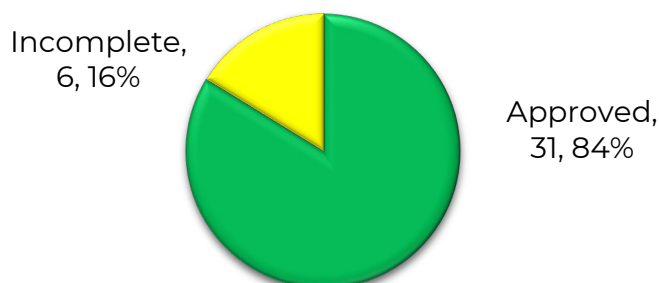
Top Prescriber Specialties of GI Cancer Medications by Number of Claims: Pharmacy Claims (All Plans)

- The only prescriber specialty listed on paid pharmacy claims for GI cancer medications during fiscal year 2024 was oncologist.

Prior Authorization of GI Cancer Medications

There were 37 prior authorization requests submitted for GI 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	30	83%	6	17%	0	0%	36
Aetna	0	N/A	0	N/A	0	N/A	0
Humana	1	100%	0	0%	0	0%	1
OCH	0	N/A	0	N/A	0	N/A	0
Total	31	84%	6	16%	0	0%	37

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^{1,2,3,4,5,6,7}

Anticipated Patent or Exclusivity Expiration(s):

- Lytgobi[®] (futibatinib): November 2039
- Pemazyre[®] (pemigatinib): August 2040
- Ayvakit[®] (avapritinib): March 2042
- Qinlock[®] (ripretinib): October 2042

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

- **March 2024:** The FDA approved Tevimbra[®] (tislelizumab-jsgr) for the treatment of adult patients with unresectable or metastatic esophageal squamous cell carcinoma (ESCC) after prior systemic chemotherapy that did not include a programmed death ligand 1 (PD-L1) inhibitor.
- **October 2024:** The FDA approved Vyloy[®] (zolbetuximab-clzb), in combination with fluoropyrimidine- and platinum-containing chemotherapy, for the first-line treatment of adults with locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma whose tumors are claudin (CLDN) 18.2 positive as determined by an FDA-approved test.
- **November 2024:** The FDA granted accelerated approval to Ziihera[®] (zanidatamab-hrii) for the treatment of adults with previously treated, unresectable or metastatic HER2-positive immunohistochemistry (IHC) 3+ biliary tract cancer (BTC), as detected by an FDA-approved test.

News:

- **May 2024:** The FDA announced the final withdrawal of its previous accelerated approval for Truseltiq[®] (infigratinib) for previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. This was a voluntary withdrawal of accelerated approval that was requested by the manufacturer, Helsinn Therapeutics, due to difficulty enrolling patients into the required confirmatory trial for the medication.

Guideline Update(s):

- The National Comprehensive Cancer Network (NCCN) guidelines for esophageal cancer, esophagogastric junction cancers, and gastric cancer allow for the use of Cyramza® (ramucirumab) for patients who are not surgical candidates or have unresectable locally advanced, recurrent, or metastatic adenocarcinoma and Karnofsky performance score $\geq 60\%$ or ECOG performance score ≤ 2 as second-line or subsequent therapy.

Tevimbra® (Tislelizumab-jsgr) Product Summary⁸

Therapeutic Class: Programmed death receptor-1 (PD-1) blocking antibody

Indication(s): Treatment of adult patients with unresectable or metastatic ESCC after prior systemic chemotherapy that did not include a PD-L1 inhibitor

How Supplied: 100mg/10mL solution in a single-dose vial (SDV)

Dosing and Administration: Recommended dose is 200mg as an intravenous (IV) infusion once every 3 weeks until disease progression or unacceptable toxicity

Cost: The Wholesale Acquisition Cost (WAC) is \$546.40 per mL, resulting in a cost of \$10,928 per dose or \$185,776 per year based on the recommended dosing.

Vyloy® (Zolbetuximab-clzb) Product Summary⁹

Therapeutic Class: CLDN 18.2-directed cytolytic antibody

Indication(s): First-line treatment, in combination with fluoropyrimidine- and platinum-containing chemotherapy, of adults with locally advanced unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma whose tumors are CLDN 18.2 positive as determined by an FDA-approved test

How Supplied: 100mg lyophilized powder in a SDV for IV infusion

Dosing and Administration:

- Initial dose: 800mg/m² IV
- Subsequent doses:
 - 600mg/m² IV every 3 weeks; or
 - 400mg/m² IV every 2 weeks
- Should be continued until disease progression or unacceptable toxicity
- Should be administered in combination with fluoropyrimidine- and platinum-containing chemotherapy

Cost: The WAC is \$1,600 per SDV. For a member with a body surface area (BSA) of 1.73m², this would result in a cost of \$22,400 for the initial dose. If the member receives a dose of 400mg/m² every 2 weeks for subsequent doses, this would result in a cost of \$22,400 per 28 days or \$291,200 per year based on recommended dosing.

Ziihera® (Zanidatamab-hrii) Product Summary¹⁰

Therapeutic Class: Bispecific HER2-directed antibody

Indication(s): Treatment of adults with previously treated, unresectable or metastatic HER2-positive IHC 3+ BTC, as detected by an FDA-approved test.

- This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

How Supplied: 300mg lyophilized powder in a SDV

Dosing and Administration: Recommended dose is 20mg/kg as an IV infusion every 2 weeks until disease progression or unacceptable toxicity

Cost: The WAC is \$3,555 per SDV. For a member weighing 80kg, this would result in a cost of \$42,660 per 28 days or \$554,580 per year based on recommended dosing.

Recommendations

The College of Pharmacy recommends the prior authorization of Tevimbra® (tislelizumab-jsgr), Vyloy® (zolbetuximab-clzb), and Ziihera® (zanidatamab-hrii) with the following criteria (shown in red):

Tevimbra® (Tislelizumab-jsgr) Approval Criteria [Esophageal Squamous Cell Carcinoma (ESCC) Diagnosis]:

1. Diagnosis of unresectable or metastatic ESCC; and
2. Used after disease progression on prior systemic chemotherapy; and
3. Member has not previously failed other programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitors.

Vyloy® (Zolbetuximab-clzb) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic gastric or GEJ adenocarcinoma; and
2. Human epidermal growth factor receptor 2 (HER2)-negative; and
3. Claudin (CLDN) 18.2 positive (defined as ≥75% of tumor cells demonstrating moderate to strong membranous CLDN18 immunohistochemical staining); and

4. Used for first-line treatment; and
5. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy; and
6. Member's recent body surface area (BSA) must be provided in order to authorize the appropriate amount of drug required according to package labeling.

Ziihera® (Zanidatamab-hrii) Approval Criteria [Biliary Tract Cancer (BTC) Diagnosis]:

1. Diagnosis of unresectable or metastatic BTC; and
2. Human epidermal growth factor receptor 2 (HER2)-positive immunohistochemistry (IHC) 3+; and
3. Used for subsequent-line therapy; and
4. As a single agent.

Additionally, the College of Pharmacy recommends updating the Cyramza® (ramucirumab) approval criteria based on NCCN recommendations (changes and new criteria shown in red):

Cyramza® (Ramucirumab) Approval Criteria [Esophageal Cancer Diagnosis]:

1. Diagnosis of esophageal or esophagogastric junction adenocarcinoma; and
2. Member **is not a surgical candidate or** has unresectable, locally advanced, recurrent, or metastatic disease; and
3. Karnofsky performance score $\geq 60\%$ **or ECOG performance score ≤ 2** ; and
4. **Used as second-line or subsequent therapy; and**
5. As a single agent or in combination with paclitaxel.

Cyramza® (Ramucirumab) Approval Criteria [Gastric Cancer Diagnosis]:

1. Diagnosis of gastric cancer; and
2. Member is not a surgical candidate or has unresectable, locally advanced, recurrent, or metastatic disease; and
3. Karnofsky performance score $\geq 60\%$ **or ECOG performance score ≤ 2** ; and
4. **Used as second-line or subsequent therapy; and**
5. As a single agent or in combination with paclitaxel.

Lastly, the College of Pharmacy recommends removal of SoonerCare coverage and of the approval criteria for Truseltiq® (infigratinib) based on the withdrawal of FDA approval for the medication (changes shown in red):

~~Truseltiq® (Infigratinib) Approval Criteria [Cholangiocarcinoma Diagnosis]:~~

- ~~1.—Diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma; and~~
- ~~2.—Presence of fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement; and~~

- 3. Disease has progressed on at least 1 prior systemic therapy; and
- 4. As a single agent; and
- 5. Members who are new to treatment with Truseltiq® will generally not be approved.

Utilization Details of GI Cancer Medications: Fiscal Year 2024

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
LYTGOBI TAB 4MG	2	1	\$48,686.74	\$24,343.37	2	100%
TOTAL	2	1*	\$48,686.74	\$24,343.37	2	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

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.

Fee-For-Service Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS*	TOTAL MEMBERS*	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
J9308 RAMUCIRUMAB INJ	177	23	\$864,286.95	\$4,882.98	7.7
TOTAL	177	23	\$864,286.95	\$4,882.98	7.7

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

OK Complete Health Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS*	TOTAL MEMBERS*	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
J9308 RAMUCIRUMAB INJ	3	1	\$20,954.00	\$6,984.67	3
TOTAL	3	1	\$20,954.00	\$6,984.67	3

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 12/2024. Last accessed 12/16/2024.

² BeiGene, Ltd. BeiGene Receives FDA Approval for Tevimbra® for the Treatment of Advanced or Metastatic Esophageal Squamous Cell Carcinoma After Prior Chemotherapy. Available online at: <https://ir.beigene.com/news/beigene-receives-fda-approval-for-tevimbra-for-the-treatment-of-advanced-or-metastatic-esophageal-squamous/20eb032c-15ce-456a-a852-39c88a28d811/>. Issued 03/14/2024. Last accessed 12/16/2024.

³ U.S. FDA. FDA Approves Zolbetuximab-clzb with Chemotherapy for Gastric or Gastroesophageal Junction Adenocarcinoma. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-zolbetuximab-clzb-chemotherapy-gastric-or-gastroesophageal-junction-adenocarcinoma>. Issued 10/18/2024. Last accessed 12/16/2024.

⁴ U.S. FDA. FDA Grants Accelerated Approval to Zanidatamab-hrii for Previously Treated Unresectable or Metastatic HER2-Positive Biliary Tract Cancer. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-zanidatamab-hrii-previously-treated-unresectable-or-metastatic-her2>. Issued 11/20/2024. Last accessed 12/16/2024.

⁵ U.S. FDA. WITHDRAWN: FDA Grants Accelerated Approval to Infigratinib for Metastatic Cholangiocarcinoma. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/withdrawn-fda-grants-accelerated-approval-infigratinib-metastatic-cholangiocarcinoma>. Issued 05/16/2024. Last accessed 12/16/2024.

⁶ National Comprehensive Cancer Network (NCCN). Esophageal and Esophagogastric Junction Cancers Clinical Practice Guidelines in Oncology. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf. Last revised 12/20/2024. Last accessed 12/30/2024.

⁷ NCCN. Gastric Cancer Clinical Practice Guidelines in Oncology. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf. Last revised 12/20/2024. Last accessed 12/30/2024.

⁸ Tevimbra™ (Tislelizumab-jsgr) Prescribing Information. BeiGene USA, Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761232Orig1s000lbl.pdf. Last revised 03/2024. Last accessed 12/16/2024.

⁹ Vyloy® (Zolbetuximab-clzb) Prescribing Information. Astellas Pharma US, Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761365s000lbl.pdf. Last revised 10/2024. Last accessed 12/16/2024.

¹⁰ Ziihera® (Zanidatamab-hrii) Prescribing Information. Jazz Pharmaceuticals, Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761416s000lbl.pdf. Last revised 11/2024. Last accessed 12/16/2024.



Fiscal Year 2024 Annual Review of Miscellaneous Cancer Medications and 30-Day Notice to Prior Authorize Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension), Niktimvo™ (Axatilimab-csfr), Ojemda™ (Tovorafenib), Tecelra® (Afamitresgene Autoleucel), and Voranigo® (Vorasidenib)

**Oklahoma Health Care Authority
January 2025**

Current Prior Authorization Criteria

Azedra® (Iobenguane I-131) Approval Criteria [Pheochromocytoma or Paraganglioma (PPGL) Diagnosis]:

1. Adult and pediatric members 12 years of age and older; and
2. Iobenguane scan positive; and
3. Unresectable, locally advanced or metastatic pheochromocytoma or PPGL requiring systemic anticancer therapy.

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-gqqk) 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/m²/day daily starting 5 days prior to Danyelza[®] therapy and 500mcg/m²/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 (H₁) antagonist, an H₂ antagonist, acetaminophen, and an antiemetic.

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/m² 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. Used as second-line or subsequent therapy following progression on octreotide or lanreotide; or
4. May be used first-line for treatment of pheochromocytoma/ paraganglioma.

Omisirge® (Omidubicel-only) 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 (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.

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.

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 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

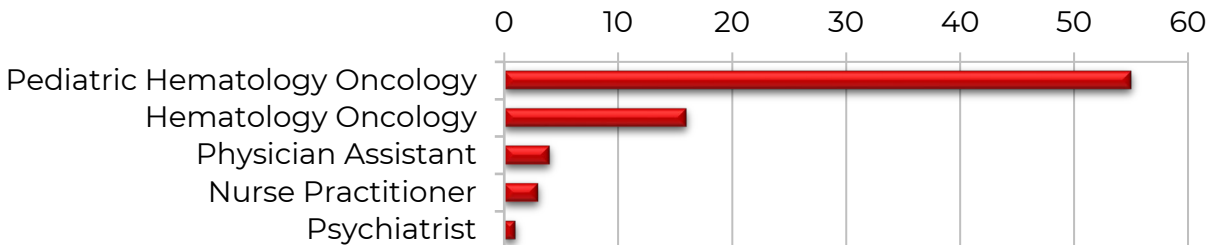
Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Please note: 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.

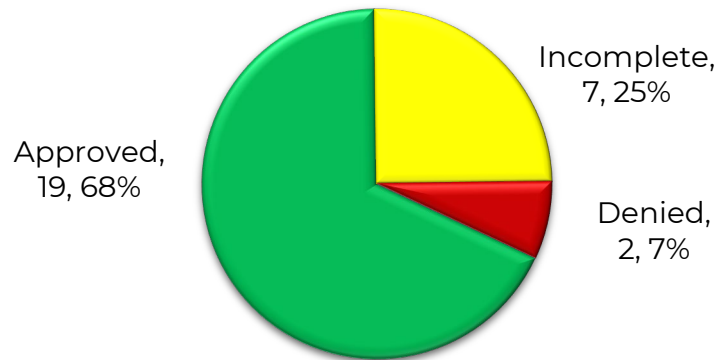
Top Prescriber Specialties of Miscellaneous Cancer Medications by Number of Claims: Pharmacy Claims (All Plans)



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^{1,2,3,4,5,6,7,8,9}

Anticipated Patent or Exclusivity Expiration(s):

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

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

- **November 2021:** The FDA approved Fyarro[®] (sirolimus protein-bound particles for injectable suspension) for the treatment of adult patients with locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa).
- **April 2024:** The FDA approved Lutathera[®] (lutetium Lu-177 dotatate) for an age expansion for the treatment of pediatric patients 12 years of age and older with somatostatin receptor (SSTR)-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including

foregut, midgut, and hindgut neuroendocrine tumors. Previously, Lutathera® was only FDA approved for the treatment of adults.

- **April 2024:** The FDA approved Ojemda™ (tovorafenib) for the treatment of patients 6 months of age and older with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation.
- **August 2024:** The FDA approved Tecelra® (afamitresgene autoleucel) for the treatment of adults with unresectable or metastatic synovial sarcoma who have received prior chemotherapy, are HLA-A*02:01P, -A*02:02P, -A*02:03P, or -A*02:06P positive and whose tumor expresses the melanoma-associated antigen A4 (MAGE-A4) antigen as determined by FDA-approved or cleared companion diagnostic devices.
- **August 2024:** The FDA approved Voranigo® (vorasidenib) for the treatment of adult and pediatric patients 12 years and older with grade 2 astrocytoma or oligodendroglioma with a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation following surgery including biopsy, sub-total resection, or gross total resection.
- **August 2024:** The FDA approved Niktimvo™ (axatilimab-csfr) for the treatment of chronic graft-versus-host disease (cGVHD) after failure of at least 2 prior lines of systemic therapy in adult and pediatric patients weighing at least 40kg.

News:

- **August 2023:** Progenics Pharmaceuticals, the manufacturer of Azedra® (iobenguane I-131) announced plans to cease production of Azedra® due to limited usage of the product and manufacturing costs. Azedra® manufacturing was continued into the first quarter of 2024 but has since been discontinued.

Guideline Update(s):

- The National Comprehensive Cancer Network (NCCN) guidelines for neuroendocrine and adrenal tumors allow for the use of Lutathera® (lutetium Lu-177 dotatate) as alternative front-line therapy if surgical cytoreduction of metastases is not possible and there is clinically significant tumor burden if somatostatin receptor positive and prior progression on octreotide long-acting release (LAR) or lanreotide.

Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension) Product Summary¹⁰

Therapeutic Class: Mammalian target of rapamycin (mTOR) inhibitor

Indication(s): Treatment of adult patients with locally advanced unresectable or metastatic malignant PEComa

How Supplied: Lyophilized powder containing 100mg of sirolimus formulated as albumin-bound particles in a single-dose vial (SDV)

Dosing and Administration: Recommended dosage is 100mg/m² administered as an intravenous (IV) infusion over 30 minutes on days 1 and 8 of each 21-day cycle, continued until disease progression or unacceptable toxicity

Cost: The Wholesale Acquisition Cost (WAC) is \$7,634.96 per SDV. For a member with a body surface area (BSA) of 1.73m², this would result in an estimated cost of \$15,269.92 per dose or \$30,539.84 per 21-day cycle. The estimated cost for a year of treatment would be \$519,177.28.

Niktimvo™ (Axatilimab-csfr) Product Summary¹¹

Therapeutic Class: Colony stimulating factor-1 receptor (CSF-1R)-blocking antibody

Indication(s): Treatment of cGVHD after failure of at least 2 prior lines of systemic therapy in adult and pediatric patients weighing at least 40kg

How Supplied: 50mg/mL solution in a SDV

Dosing and Administration: Recommended dose is 0.3mg/kg (up to a maximum dose of 35mg) administered as an IV infusion over 30 minutes every 2 weeks until disease progression or unacceptable toxicity

Cost: The cost of Niktimvo™ is not available at this time.

Ojemda™ (Tovorafenib) Product Summary¹²

Therapeutic Class: Kinase inhibitor

Indication(s): Treatment of patients 6 months of age and older with relapsed or refractory pediatric LGG harboring a BRAF fusion or rearrangement, or BRAF V600 mutation

How Supplied:

- 100mg oral tablets available in boxes containing 16, 20, or 24 tablets
- 300mg/12mL (25mg/mL) powder for oral suspension in a single-use bottle

Dosing and Administration: Administered orally once weekly with the dose based on BSA, and continued until disease progression or intolerable toxicity

▪ **Recommended Dosage for Tablets:**

Body Surface Area (m ²)	Recommended Dosage
0.30-0.89	Use oral suspension
0.90-1.12	400mg [using (4) 100mg tablets] once weekly
1.13-1.39	500mg [using (5) 100mg tablets] once weekly
≥1.40	600mg [using (6) 100mg tablets] once weekly

▪ **Recommended Dosage for Oral Suspension:**

Body Surface Area (m ²)	Recommended Dosage
0.30-0.35	125mg (5mL) once weekly
0.36-0.42	150mg (6mL) once weekly
0.43-0.48	175mg (7mL) once weekly
0.49-0.54	200mg (8mL) once weekly
0.55-0.63	225mg (9mL) once weekly
0.64-0.77	275mg (11mL) once weekly
0.78-0.83	300mg (12mL) once weekly
0.84-0.89	350mg (14mL) once weekly
0.90-1.05	375mg (15mL) once weekly
1.06-1.25	450mg (18mL) once weekly
1.26-1.39	525mg (21mL) once weekly
≥1.40	600mg (24mL) once weekly

Cost: The WAC of Ojemda™ tablets is \$33,916.00 per 28 days, regardless of the dosage required. The WAC of Ojemda™ oral suspension is \$706.58 per mL or \$8,478.96 per 300mg (12mL) single-use bottle. For a member using the oral suspension with a BSA ≥0.84m², requiring the use of 2 single-use bottles per dose, it would result in an estimated cost of \$67,831.68 per 28 days.

Tecelra® (Afamitresgene Autoleucel) Product Summary¹³

Therapeutic Class: MAGE-A4-directed genetically modified autologous T cell immunotherapy

Indication(s): Treatment of adults with unresectable or metastatic synovial sarcoma who have received prior chemotherapy, are HLA-A*02:01P, -A*02:02P, -A*02:03P, or -A*02:06P positive and whose tumor expresses the MAGE-A4 antigen as determined by FDA-approved or cleared companion diagnostic devices

How Supplied: Cell suspension for IV infusion provided in 1 or more infusion bags containing 2.68 x 10⁹ to 10 x 10⁹ MAGE-A4 T cell receptor (TCR) positive T cells

Dosing and Administration: Recommended dose is 2.68 x 10⁹ to 10 x 10⁹ MAGE-A4 TCR positive T cells administered as a single IV infusion

Cost: The WAC is \$727,000 per 1-time treatment.

Voranigo® (Vorasidenib) Product Summary¹⁴

Therapeutic Class: IDH1 and IDH2 inhibitor

Indication(s): Treatment of adult and pediatric patients 12 years of age and older with grade 2 astrocytoma or oligodendroglioma with a susceptible IDH1 or IDH2 mutation following surgery including biopsy, sub-total resection, or gross total resection

How Supplied: 10mg and 40mg oral tablets

Dosing and Administration:

- **Adults and Pediatric Patients Weighing ≥40kg:** 40mg orally once daily with or without food
- **Pediatric Patients Weighing <40kg:** 20mg orally once daily with or without food
- Should be continued until disease progression or unacceptable toxicity

Cost: The WAC is \$664.68 per 10mg tablet or \$1,329.37 per 40mg tablet. This would result in an estimated cost of approximately \$39,881 per month, regardless of the member's weight, based on recommended dosing.

Recommendations

The College of Pharmacy recommends the prior authorization of Fyarro® (sirolimus protein-bound particles for injectable suspension), Niktimvo™ (axatilimab-csfr), Ojemda™ (tovorafenib), Tecelra® (afamitresgene autoleucel), and Voranigo® (vorasidenib) with the following criteria (shown in red):

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.

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 $\geq 0.90\text{m}^2$, requests for the oral suspension formulation will require a patient-specific, clinically significant reason why the member cannot use the tablet formulation.

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.

Voranigo® (Vorasideinib) 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.

Additionally, the College of Pharmacy recommends updating the Lutathera® (lutetium Lu-177 dotatate) approval criteria based on the recent FDA approved age expansion and NCCN recommendations with the following changes (shown in red):

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.

Lastly, the College of Pharmacy recommends removal of SoonerCare coverage and of the approval criteria for Azedra® (iobenguane I-131) based on product discontinuation (changes shown in red):

Azedra® (Iobenguane I-131) Approval Criteria [Pheochromocytoma or Paraganglioma (PPGL) Diagnosis]:

- ~~1. Adult and pediatric members 12 years of age and older; and~~
- ~~2. Iobenguane scan positive; and~~
- ~~3. Unresectable, locally advanced or metastatic pheochromocytoma or PPGL requiring systemic anticancer therapy.~~

Utilization Details of Miscellaneous Cancer Medications: Fiscal Year 2024

Fee-For-Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
ALPELISIB PRODUCTS						
VIJOICE TAB 50MG	34	4	\$1,105,387.94	\$32,511.41	8.5	48.49%
SUBTOTAL	34	4	\$1,105,387.94	\$32,511.41	8.5	48.49%
LAROTRECTINIB PRODUCTS						
VITRAKVI SOL 20MG/ML	22	2	\$624,813.02	\$28,400.59	11	27.41%
VITRAKVI CAP 100MG	5	1	\$185,689.55	\$37,137.91	5	8.15%
SUBTOTAL	27	3	\$810,502.57	\$30,018.61	9	35.56%
BELUMOSUDIL PRODUCTS						
REZUROCK TAB 200MG	12	3	\$363,580.83	\$30,298.40	4	15.95%
SUBTOTAL	12	3	\$363,580.83	\$30,298.40	4	15.95%
TOTAL	73	10*	\$2,279,471.34	\$31,225.63	7.3	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

Aetna Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
LAROTRECTINIB PRODUCTS						
VITRAKVI SOL 20MG/ML	2	1	\$34,674.82	\$17,337.41	2	65.97%
SUBTOTAL	2	1	\$34,674.82	\$17,337.41	2	65.97%
BELUMOSUDIL PRODUCTS						
REZUROCK TAB 200MG	1	1	\$17,886.24	\$17,886.24	1	34.03%
SUBTOTAL	1	1	\$17,886.24	\$17,886.24	1	34.03%
TOTAL	3	2*	\$52,561.06	\$17,520.35	1.5	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
BELUMOSUDIL PRODUCTS						
REZUROCK TAB 200MG	2	1	\$71,522.14	\$35,761.07	2	68.75%
SUBTOTAL	2	1	\$71,522.14	\$35,761.07	2	68.75%
ALPELISIB PRODUCTS						
VIJOICE TAB 50MG	1	1	\$32,511.41	\$32,511.41	1	31.25%
SUBTOTAL	1	1	\$32,511.41	\$32,511.41	1	31.25%
TOTAL	3	2*	\$104,033.55	\$34,677.85	1.5	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

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.

Fee-For-Service Medical Claims

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

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- ² U.S. FDA. FDA Approves Sirolimus Protein-Bound Particles for Malignant Perivascular Epithelioid Cell Tumor. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-sirolimus-protein-bound-particles-malignant-perivascular-epithelioid-cell-tumor>. Issued 11/22/2021. Last accessed 12/17/2024.
- ³ U.S. FDA. FDA Approves Lutetium Lu 177 Dotatate for Pediatric Patients 12 Years and Older with GEP-NETS. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-lutetium-lu-177-dotatate-pediatric-patients-12-years-and-older-gep-nets>. Issued 04/23/2024. Last accessed 12/17/2024.
- ⁴ U.S. FDA. FDA Grants Accelerated Approval to Tovorafenib for Patients with Relapsed or Refractory BRAF-Altered Pediatric Low-Grade Glioma. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-tovorafenib-patients-relapsed-or-refractory-braf-altered-pediatric>. Issued 04/23/2024. Last accessed 12/17/2024.
- ⁵ U.S. FDA. FDA Grants Accelerated Approval to Afamitresgene Autoleucel for Unresectable or Metastatic Synovial Sarcoma. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-afamitresgene-autoleucel-unresectable-or-metastatic-synovial-sarcoma>. Issued 08/02/2024. Last accessed 12/17/2024.
- ⁶ U.S. FDA. FDA Approves Vorasidenib for Grade 2 Astrocytoma or Oligodendroglioma with a Susceptible IDH1 or IDH2 Mutation. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-vorasidenib-grade-2-astrocytoma-or-oligodendroglioma-susceptible-idh1-or-idh2-mutation>. Issued 08/06/2024. Last accessed 12/17/2024.
- ⁷ U.S. FDA. FDA Approves Axatilimab-csfr for Chronic Graft-Versus-Host Disease. Available online at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-axatilimab-csfr-chronic-graft-versus-host-disease>. Issued 08/14/2024. Last accessed 12/17/2024.
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- ¹⁰ Fyarro[®] (Sirolimus Protein-Bound Particles for Injectable Suspension) Prescribing Information. Aadi Bioscience, Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/213312Orig1s000Corrected_lbl.pdf. Last revised 11/2021. Last accessed 12/16/2024.
- ¹¹ Niktimvo[™] (Axatilimab-csfr) Prescribing Information. Incyte Corporation. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761411s000lbl.pdf. Last revised 08/2024. Last accessed 12/16/2024.
- ¹² Ojemda[™] (Tovorafenib) Prescribing Information. Day One Biopharmaceuticals, Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/217700s001.218033s001lbl.pdf. Last revised 06/2024. Last accessed 12/16/2024.
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- ¹⁴ Voranigo[®] (Vorasidenib) Prescribing Information. Servier Pharmaceuticals, LLC. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/218784s000lbl.pdf. Last revised 08/2024. Last accessed 12/16/2024.



Fiscal Year 2024 Annual Review of Non-Malignant Solid Tumor Medications

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

Hyftor® (Sirolimus Topical Gel) Approval Criteria [Facial Angiofibromas Associated with Tuberous Sclerosis Complex (TSC) Diagnosis]:

1. Documented diagnosis of TSC; and
2. Member has facial angiofibromas that are at least 2mm in diameter with redness in each; and
3. Member must be 6 to 20 years of age; or
 - a. For members older than 20 years of age, a clinical exception may apply for medical issues caused by facial angiofibromas (specific documentation of clinically significant medical issues must be provided; Hyftor® is not covered for cosmetic use); and
4. Initial approvals will be for a duration of 12 weeks, as the need for continuing Hyftor® should be reevaluated if symptoms do not improve within 12 weeks of treatment. Reauthorization may be granted if the prescriber documents the member is responding well to treatment and documents the anticipated duration of treatment.

Koselugo® (Selumetinib) Approval Criteria [Neurofibromatosis Type 1 (NF1) Diagnosis]:

1. Members must be 2 years of age or older; and
2. Diagnosis of NF1 with symptomatic, inoperable plexiform neurofibromas.

Ogsiveo® (Nirogacestat) Approval Criteria [Desmoid Tumor Diagnosis]:

1. Diagnosis of desmoid tumor; and
2. Tumor is progressing, requiring systemic treatment; and
3. As a single agent.

Turalio® (Pexidartinib) Approval Criteria [Soft Tissue Sarcoma – Pigmented Villonodular Synovitis (PVNS)/Tenosynovial Giant Cell Tumor (TGCT) Diagnosis]:

1. Member must not be a candidate for surgery; and
2. As a single agent.

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 Non-Malignant Solid Tumor 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	26	224	\$2,540,617.43	\$11,342.04	\$379.54	24,058	6,694
2023 Total	26	224	\$2,540,617.43	\$11,342.04	\$379.54	24,058	6,694
Fiscal Year 2024							
FFS	32	222	\$2,445,873.88	\$11,017.45	\$383.37	20,012	6,380
Aetna	4	9	\$119,945.84	\$13,327.32	\$487.58	1,138	246
Humana	1	2	\$19,728.66	\$9,864.33	\$328.81	120	60
OCH	9	26	\$322,199.98	\$12,392.31	\$453.80	2,570	710
2024 Total	34	259	\$2,907,748.36	\$11,226.83	\$393.15	23,840	7,396
% Change	30.80%	15.60%	14.50%	-1.00%	3.60%	-0.90%	10.50%
Change	8	35	\$367,130.93	-\$115.21	\$13.61	-218	702

Costs do not reflect rebated prices or net costs.

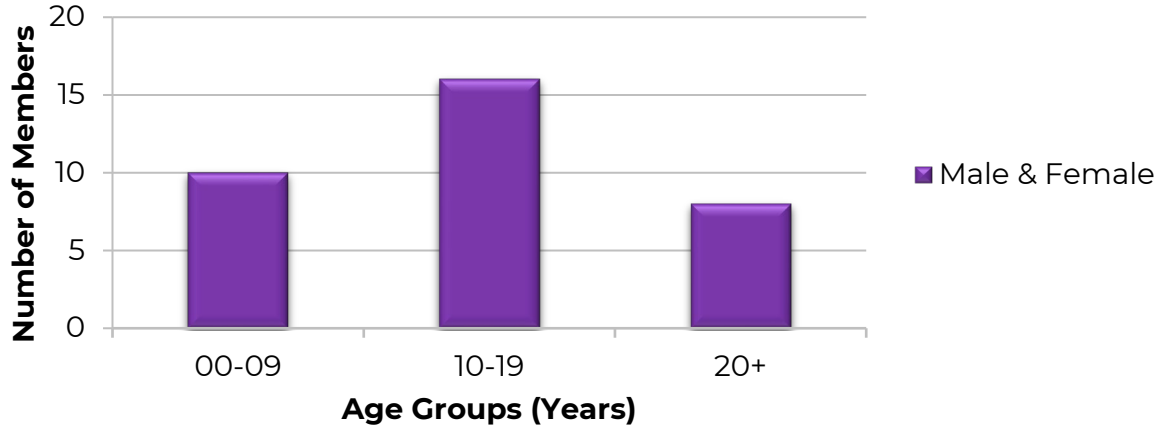
*Total number of unduplicated utilizing members.

FFS = fee-for-service; OCH = Oklahoma Complete Health

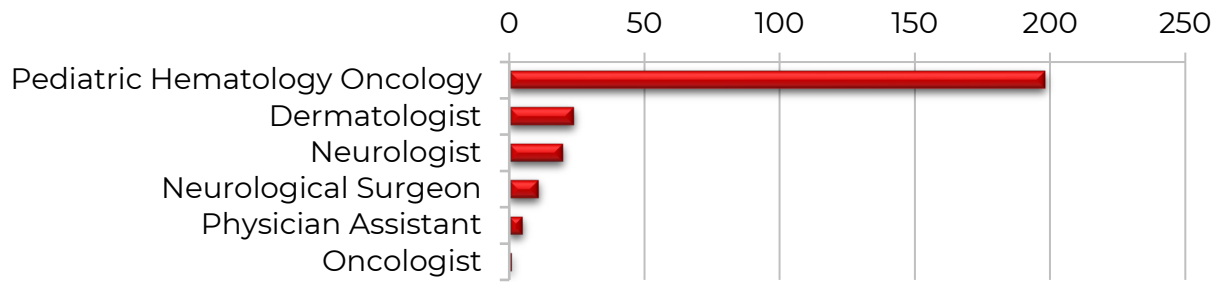
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Demographics of Members Utilizing Non-Malignant Solid Tumor Medications: Pharmacy Claims (All Plans)



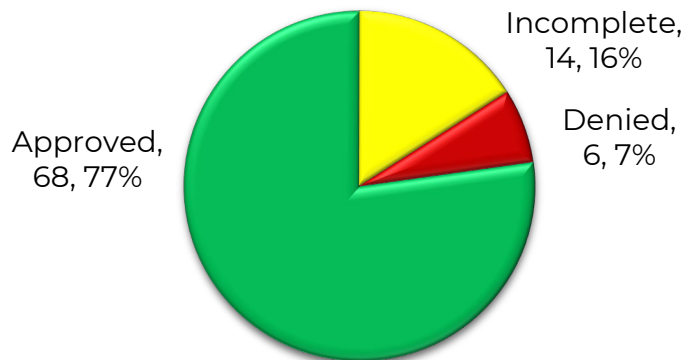
Top Prescriber Specialties of Non-Malignant Solid Tumor Medications by Number of Claims: Pharmacy Claims (All Plans)



Prior Authorization of Non-Malignant Solid Tumor Medications

There were 88 prior authorization requests submitted for non-malignant solid tumor 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	58	78%	14	19%	2	3%	74
Aetna	1	50%	0	0%	1	50%	2
Humana	0	0%	0	0%	2	100%	2
OCH	9	90%	0	0%	1	10%	10
Total	68	77%	14	16%	6	7%	88

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}

Anticipated Patent or Exclusivity Expiration(s):

- Hyftor[®] (sirolimus gel): March 2029
- Koselugo[®] (selumetinib): March 2029
- Turalio[®] (pexidartinib): July 2038
- Ogsiveo[®] (nirogacestat): May 2043

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

- **March 2024:** The FDA approved a supplemental New Drug Application (sNDA) for Ogsiveo[®] (nirogacestat) allowing for the addition of 2 new dosage strengths, 100mg and 150mg tablets. Previously, Ogsiveo[®] was only available as a 50mg tablet.

Recommendations

The College of Pharmacy does not recommend any changes to the current non-malignant solid tumor medications prior authorization criteria at this time.

Utilization Details of Non-Malignant Solid Tumor Medications: Fiscal Year 2024

Fee-For-Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SELUMETINIB PRODUCTS						
KOSELUGO CAP 10MG	114	18	\$1,209,378.69	\$10,608.59	6.33	49.45%
KOSELUGO CAP 25MG	74	12	\$1,146,102.88	\$15,487.88	6.17	46.86%
SUBTOTAL	188	30	\$2,355,481.57	\$12,529.16	6.27	96.30%
SIROLIMUS PRODUCTS						
HYFTOR GEL 0.2%	34	9	\$90,392.31	\$2,658.60	3.78	3.70%
SUBTOTAL	34	9	\$90,392.31	\$2,658.60	3.78	3.70%
TOTAL	222	32*	\$2,445,873.88	\$11,017.45	6.94	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule

Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Aetna Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SELUMETINIB PRODUCTS						
KOSELUGO CAP 10MG	7	2	\$89,038.02	\$12,719.72	3.5	74.23%
SUBTOTAL	7	2	\$89,038.02	\$12,719.72	3.5	74.23%
NIROGACESTAT PRODUCTS						
OGSIVEO TAB 50MG	1	1	\$29,011.41	\$29,011.41	1	24.19%
SUBTOTAL	1	1	\$29,011.41	\$29,011.41	1	24.19%
SIROLIMUS PRODUCTS						
HYFTOR GEL 0.2%	1	1	\$1,896.41	\$1,896.41	1	1.58%
SUBTOTAL	1	1	\$1,896.41	\$1,896.41	1	1.58%
TOTAL	9	4*	\$119,945.84	\$13,327.32	2.25	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule; 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.

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SELUMETINIB PRODUCTS						
KOSELUGO CAP 25MG	1	1	\$14,087.01	\$14,087.01	1	71.40%
KOSELUGO CAP 10MG	1	1	\$5,641.65	\$5,641.65	1	28.60%
TOTAL	2	1*	\$19,728.66	\$9,864.33	2	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule

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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SELUMETINIB PRODUCTS						
KOSELUGO CAP 10MG	12	5	\$185,934.84	\$15,494.57	2.4	57.71%
KOSELUGO CAP 25MG	9	4	\$126,783.09	\$14,087.01	2.25	39.35%
SUBTOTAL	21	9	\$312,717.93	\$14,891.33	2.33	97.06%
SIROLIMUS PRODUCTS						
HYFTOR GEL 0.2%	5	1	\$9,482.05	\$1,896.41	5	2.94%
SUBTOTAL	5	1	\$9,482.05	\$1,896.41	5	2.94%
TOTAL	26	9*	\$322,199.98	\$12,392.31	2.89	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

CAP = capsule

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 12/2024. Last accessed 12/16/2024.

² U.S. FDA. Ogsiveo® (Nirogacestat) Supplement Approval Letter. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/applletter/2024/217677Orig1s001ltr.pdf. Issued 04/04/2024. Last accessed 12/16/2024.



Appendix K

Fiscal Year 2024 Annual Review of Antihypertensive Medications and 30-Day Notice to Prior Authorize Labetalol Hydrochloride 400mg Tablet, Nexiclon™ XR [Clonidine Extended-Release (ER)], and Tryvio™ (Aprocitentan)

Oklahoma Health Care Authority
January 2025

Current Prior Authorization Criteria

There are 6 major subcategories of antihypertensive medications divided by drug class currently included in the Antihypertensive Medications Product Based Prior Authorization (PBPA) category:

1. Angiotensin I Converting Enzyme Inhibitors (ACEIs)
2. ACEI/Hydrochlorothiazide (HCTZ) Combination Products
3. Angiotensin II Receptor Blockers (ARBs) and ARB Combination Products
4. Calcium Channel Blockers (CCBs)
5. ACEI/CCB Combination Products
6. Direct Renin Inhibitors (DRIs) and DRI Combination Products

Angiotensin I Converting Enzyme Inhibitors (ACEIs)		
Tier-1	Tier-2	Special PA
benazepril (Lotensin®)	captopril (Capoten®)	enalapril oral solution (Epaned®)
enalapril (Vasotec®)		lisinopril oral solution (Qbrelis®)
enalaprilat (Vasotec® IV)		
fosinopril (Monopril®)		
lisinopril (Prinivil®, Zestril®)		
moexipril (Univasc®)		
perindopril (Aceon®)		
quinapril (Accupril®)		
ramipril (Altace®)		
trandolapril (Mavik®)		
ACEI/Hydrochlorothiazide (HCTZ) Combination Products		
Tier-1	Tier-2	Special PA
benazepril/HCTZ (Lotensin® HCT)	captopril/HCTZ (Capozide®)	fosinopril/HCTZ (Monopril-HCT®)
enalapril/HCTZ (Vaseretic®)		
lisinopril/HCTZ (Prinzide®, Zestoretic®)		

moexipril/HCTZ (Uniretic®)		
quinapril/HCTZ (Accuretic®)		
Angiotensin II Receptor Blockers (ARBs) and ARB Combination Products		
Tier-1	Tier-2	Special PA
candesartan (Atacand®)*	candesartan 32mg (Atacand®)	azilsartan (Edarbi®)
irbesartan (Avapro®)	olmesartan/amlodipine/HCTZ (Tribenzor®)	azilsartan/chlorthalidone (Edarbyclor®)
irbesartan/HCTZ (Avalide®)	telmisartan/HCTZ (Micardis® HCT)	candesartan/HCTZ (Atacand® HCT)
losartan (Cozaar®)		eprosartan (Teveten®)
losartan/HCTZ (Hyzaar®)		eprosartan/HCTZ (Teveten® HCT)
olmesartan (Benicar®)		telmisartan/amlodipine (Twynsta®)
olmesartan/amlodipine (Azor®)		valsartan 4mg/mL oral solution
olmesartan/HCTZ (Benicar HCT®)		
telmisartan (Micardis®)		
valsartan (Diovan®)		
valsartan/amlodipine (Exforge®)		
valsartan/amlodipine/HCTZ (Exforge® HCT)		
valsartan/HCTZ (Diovan HCT®)		
Calcium Channel Blockers (CCBs)		
Tier-1	Tier-2	Special PA
amlodipine (Norvasc®)	amlodipine/atorvastatin (Caduet®)	amlodipine oral solution (Norliqva®)
diltiazem (Cardizem®)	diltiazem LA (Cardizem® LA, Matzim® LA)	amlodipine oral suspension (Katerzia®)
diltiazem (Tiazac®, Taztia XT®)	diltiazem SR (Cardizem® SR)	amlodipine/celecoxib (Consensi®)
diltiazem CD (Cardizem® CD)*	isradipine (Dynacirc®, Dynacirc CR®)	diltiazem CD 360mg (Cardizem® CD)
diltiazem ER (Cartia XT®, Diltia XT®)	nicardipine (Cardene®)	levamlodipine (Conjupri®)
diltiazem XR (Dilacor® XR)	nicardipine (Cardene® SR)	
felodipine (Plendil®)	nisoldipine (Sular®)	
nifedipine (Adalat®, Procardia®)	verapamil (Covera-HS®)	

nifedipine ER (Adalat® CC)	verapamil ER (Verelan®, Verelan® PM)	
nifedipine XL (Nifedical XL®, Procardia XL®)		
nimodipine (Nimotop®)		
verapamil (Calan®, Isoptin®)		
verapamil SR (Calan® SR, Isoptin® SR)		
ACEI/CCB Combination Products		
Tier-1	Tier-2	Special PA
Tier-1 ACEI + Tier-1 CCB	trandolapril/verapamil (Tarka®)	perindopril/amlodipine (Prestalia®)
benazepril/amlodipine (Lotrel®)		

*All strengths other than 32mg.

*All strengths other than 360mg.

CD = controlled-delivery; ER, XR, XL = extended-release; LA = long-acting; SR = sustained-release

Antihypertensive Medications Tier-2 Approval Criteria:

(or Tier-3 approval criteria when no Tier-2 medications exist)

1. A documented inadequate response to 2 Tier-1 medications (trials must include medication(s) from all available classes where applicable); or
2. An adverse drug reaction to all Tier-1 classes of medications; or
3. Previous stabilization on the Tier-2 medication; or
4. A unique indication for which the Tier-1 antihypertensive medications lack.

Antihypertensive Medications Tier-3 Approval Criteria:

1. A documented inadequate response to 2 Tier-1 medications and documented inadequate response to all available Tier-2 medication(s); or
2. An adverse drug reaction to all Tier-1 and Tier-2 classes of medications; or
3. Previous stabilization on the Tier-3 medication; or
4. A unique indication which the lower tiered antihypertensive medications lack.

Antihypertensive Medications Special Prior Authorization (PA) Approval Criteria:

1. Angiotensin I Converting Enzyme Inhibitors (ACEIs):

a. Epaned® (Enalapril Solution) Approval Criteria:

- i. An age restriction of 7 years or older will apply with the following criteria:
 1. A patient-specific, clinically significant reason why the member cannot use the oral tablet formulation in place

of the oral solution formulation, even when the tablets are crushed, must be provided.

b. Qbrelis® (Lisinopril Oral Solution) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use lisinopril oral tablets in place of the oral solution formulation, even when the tablets are crushed, must be provided.

2. ACEI/Hydrochlorothiazide (HCTZ) Combination Products:

a. Monopril-HCT® (Fosinopril/HCTZ) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use the individual components separately must be provided.

3. Calcium Channel Blockers (CCBs):

a. Cardizem® CD (Diltiazem CD 360mg Capsules) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use (2) 180mg Cardizem® CD (diltiazem CD) capsules must be provided.

b. Conjupri® (Levamlodipine Tablets) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use amlodipine oral tablets, which are available without prior authorization, must be provided.

c. Consensi® (Amlodipine/Celecoxib Tablets) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use the individual components separately, which are available without prior authorization, must be provided; and
- ii. A quantity limit of 30 tablets per 30 days will apply.

d. Katerzia® (Amlodipine Oral Suspension) and Norliqva® (Amlodipine Oral Solution) Approval Criteria:

- i. An FDA approved diagnosis of 1 of the following:
 - 1. Hypertension in adults and pediatric members 6 years of age and older; or
 - 2. Coronary artery disease; or
 - 3. Chronic stable angina; or
 - 4. Vasospastic angina; and
- ii. A patient specific, clinically significant reason why the member cannot use amlodipine oral tablets, even when the tablets are crushed, must be provided; and
- iii. A quantity limit of 300mL per 30 days will apply.

4. ACEI/CCB Combination Products:

a. Prestalia® (Perindopril/Amlodipine) Approval Criteria:

- i. An FDA approved diagnosis; and

- ii. Documented trials of inadequate response to 2 Tier-1 angiotensin I converting enzyme inhibitors (ACEIs) in combination with amlodipine; and
- iii. A patient-specific, clinically significant reason why the member cannot use the individual components separately must be provided; and
- iv. A quantity limit of 30 tablets per 30 days will apply.

The following restrictions also apply for each individual product based on U.S. Food and Drug Administration (FDA) approval information, special formulations, or individualized Drug Utilization Review (DUR) Board recommended criteria:

CaroSpir® (Spironolactone Oral Suspension) Approval Criteria:

1. An FDA approved indication; and
2. A patient-specific, clinically significant reason why the member cannot use spironolactone oral tablets must be provided.

Hemangeol® (Propranolol Hydrochloride Oral Solution) Approval Criteria:

1. An FDA approved indication for the treatment of proliferating infantile hemangioma requiring systemic therapy; and
2. For the 50mL bottle of Hemangeol®, a patient-specific, clinically significant reason why the member cannot use the 120mL bottle, which is the preferred package size, must be provided.

Kapsargo™ Sprinkle [Metoprolol Succinate Extended-Release (ER) Capsules] Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use metoprolol succinate ER tablets, which are available without prior authorization, must be provided.

Nymalize® (Nimodipine Oral Solution) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use nimodipine liquid-filled capsules, which are available without prior authorization and can be opened for administration of the liquid contents via oral syringe for members unable to swallow the capsules whole, must be provided.

Sotylize® (Sotalol Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of life-threatening ventricular arrhythmias or for the maintenance of normal sinus rhythm in members with highly symptomatic atrial fibrillation/flutter; and
2. A patient-specific, clinically significant reason why the member cannot use sotalol oral tablets in place of the oral solution formulation must be provided; and
3. A quantity limit of 64mL per day or 1,920mL per 30 days will apply.

Tekturna® (Aliskiren Oral Pellets and Tablets) and Tekturna HCT® (Aliskiren/Hydrochlorothiazide) Approval Criteria:

1. An FDA approved diagnosis; and
2. Member must be 6 years of age or older; and
3. A recent trial, within the previous 6 months and at least 4 weeks in duration, of an angiotensin I converting enzyme inhibitor (ACEI) [or an angiotensin II receptor blocker (ARB) if previous trial of an ACEI] and a diuretic, used concomitantly at recommended doses, that did not yield adequate blood pressure control; and
4. May be used in either monotherapy or combination therapy; and
5. For Tekturna® oral pellets, a patient-specific, clinically significant reason why the member cannot use Tekturna® oral tablets must be provided.

Valsartan 4mg/mL Oral Solution Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
 - a. Hypertension in adults and pediatric members 6 years of age and older; or
 - b. Heart failure; or
 - c. Post-myocardial infarction; and
2. A patient specific, clinically significant, reason why the member cannot use valsartan tablets must be provided; and
3. A quantity limit of 360mL per 36 days will apply.

Vecamyl® (Mecamylamine) Approval Criteria:

1. An FDA approved diagnosis of moderately-severe-to-severe essential hypertension or uncomplicated malignant hypertension; and
2. Use of at least 6 classes of medications, in the past 12 months, that did not yield adequate blood pressure control. Treatment must have included combination therapy with a diuretic and therapy with at least a 4-drug regimen. Medications can be from, but not limited to, the following classes: angiotensin I converting enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), calcium channel blockers (CCBs), direct renin inhibitors (DRIs), beta blockers, alpha blockers, alpha agonists, or diuretics; and
3. Prescriber must verify member does not have any of the following contraindications:
 - a. Coronary insufficiency; or
 - b. Recent myocardial infarction; or
 - c. Rising or elevated blood urea nitrogen (BUN), or known renal insufficiency; or
 - d. Uremia; or
 - e. Glaucoma; or
 - f. Organic pyloric stenosis; or

- g. Currently receiving sulfonamides or antibiotics; or
- h. Known sensitivity to Vecamyl® (mecamylamine).

Utilization of Antihypertensive 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	98,649	449,450	\$6,269,397.10	\$13.95	\$0.25	29,636,775	24,706,651
2023 Total	98,649	449,450	\$6,269,397.10	\$13.95	\$0.25	29,636,775	24,706,651
Fiscal Year 2024							
FFS	93,322	359,927	\$5,144,383.05	\$14.29	\$0.25	24,584,081	20,307,431
Aetna	9,966	16,778	\$249,161.04	\$14.85	\$0.26	1,124,741	965,064
Humana	12,052	20,882	\$315,019.85	\$15.09	\$0.25	1,458,948	1,255,520
OCH	10,805	17,839	\$271,432.59	\$15.22	\$0.27	1,201,334	1,017,291
2024 Total	99,016	415,426	\$5,979,996.53	\$14.39	\$0.25	28,369,104	23,545,306
% Change	0.40%	-7.60%	-4.60%	3.20%	0.00%	-4.30%	-4.70%
Change	367	-34,024	-\$289,400.57	\$0.44	\$0.00	-1,267,671	-1,161,345

Costs do not reflect rebated prices or net costs.

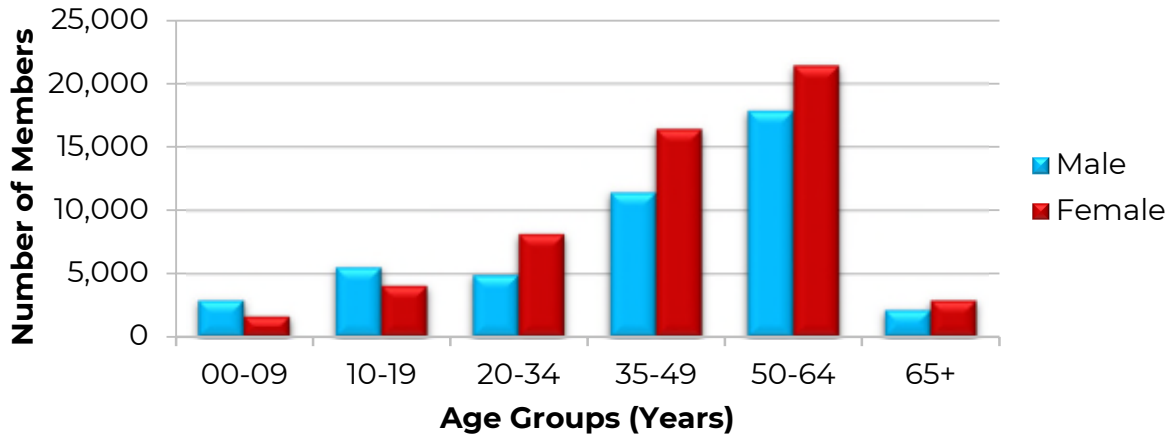
*Total number of unduplicated utilizing members.

FFS = fee-for-service; OCH = Oklahoma Complete Health

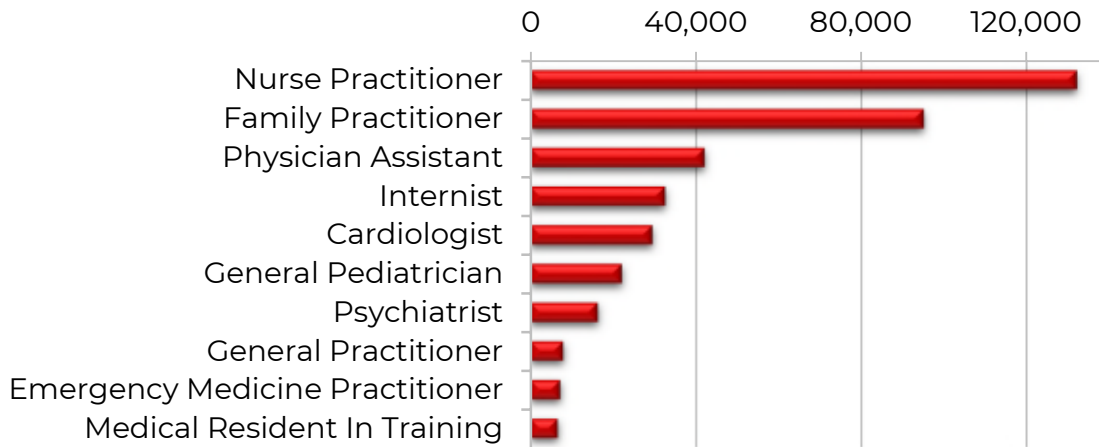
Fiscal Year 2023 = 07/01/2022 to 06/30/2023; Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Please note: Only data from 04/01/2024 to 06/30/2024 are available for the SoonerSelect plans.

Demographics of Members Utilizing Antihypertensive Medications (All Plans)



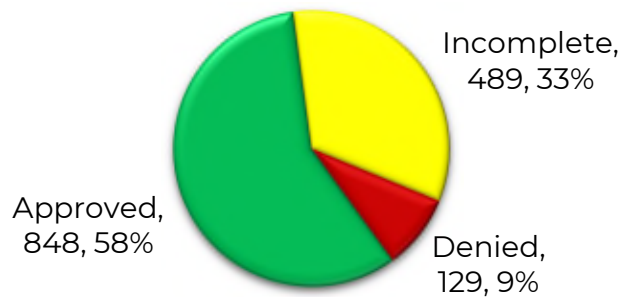
Top Prescriber Specialties of Antihypertensive Medications by Number of Claims (All Plans)



Prior Authorization of Antihypertensive Medications

There were 1,466 prior authorization requests submitted for antihypertensive 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	798	63%	378	30%	82	7%	1,258
Aetna	13	9%	111	73%	28	18%	152
Humana	5	83%	0	0%	1	17%	6
OCH	32	64%	0	0%	18	36%	50
Total	848	58%	489	33%	129	9%	1,466

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,,3,4,5,6}

Anticipated Patent Expiration(s):

- Tekturna[®] (aliskiren tablet): August 2026
- Edarbi[®] (azilsartan tablet): March 2028
- Hemangeol[®] (propranolol hydrochloride oral solution): October 2028
- Prestalia[®] (perindopril/amlodipine tablet): October 2029
- Edarbyclor[®] (azilsartan/chlorthalidone tablet): July 2031
- Kapspargo Sprinkle[™] [metoprolol succinate extended-release (ER) capsule]: July 2035
- Nexiclon[™] XR [clonidine ER tablet]: September 2031
- Sotylize[®] (sotalol oral solution): August 2035
- Qbreliis[®] (lisinopril oral solution): November 2035
- Epaned[®] (enalapril oral solution): March 2036
- CaroSpir[®] (spironolactone oral suspension): October 2036
- Nymalize[®] (nimodipine oral solution): April 2038
- Tryvio[™] (aprocitentan tablet): July 2038
- Katerzia[®] (amlodipine oral suspension): April 2039
- Norliqva[®] (amlodipine oral solution): February 2041

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

- **December 2009:** Nexiclon[™] XR (clonidine ER tablet) was approved for the treatment of hypertension. Per package labeling, the 0.17mg daily dose of Nexiclon[™] XR is equivalent to 0.1mg twice daily of immediate release (IR) clonidine hydrochloride.
- **March 2024:** Tryvio[™] (aprocitentan) tablet was approved by the FDA for the treatment of hypertension in combination with other antihypertensive drugs to lower blood pressure (BP) in patients who are not adequately controlled by other drugs.
- **November 2024:** A marketing start date of December 2, 2024, was published for labetalol hydrochloride 400mg film-coated tablets in an updated Abbreviated New Drug Application (ANDA) submitted by Appco Pharma, LLC.

Pipeline:

- **August 2024:** George Medicines filed a New Drug Application (NDA) with the FDA for their investigative product, GMRx2, for the treatment of hypertension. GMRx2 is a combination of low doses of telmisartan 20mg, amlodipine 2.5mg, and indapamide 1.25mg in a single tablet. GMRx2 was compared to two-component combinations of the active ingredients in GMRx2 in a clinical trial. After 12 weeks, the primary outcome of reduction in mean home BP was met by all individual treatment groups as compared to placebo (P<0.0001).

Tryvio™ (Aprocitentan) Product Summary^{7,8}

Therapeutic Class: Endothelin receptor antagonist (ERA)

Indication(s): Treatment of hypertension in combination with other antihypertensive drugs, to lower BP in adult patients who are not adequately controlled on other drugs

- **Boxed Warning:** Embryo-fetal toxicity
 - Tryvio™ can cause major birth defects if used by pregnant patients and is contraindicated in pregnancy.

How Supplied: 12.5mg tablet

Dosing and Administration: 12.5mg orally once daily, with or without food

Efficacy: The efficacy of Tryvio™ was supported by results from a multipart, multicenter, blinded, randomized, parallel-group Phase 3 clinical trial (PRECISION).

- Key Inclusion Criteria:
 - Uncontrolled BP despite use of ≥ 3 antihypertensive medications for ≥ 1 year (all from different pharmacologic classes for ≥ 4 weeks)
 - Sitting systolic blood pressure (SiSBP) ≥ 140 mmHg at screening
- Key Exclusion Criteria:
 - Confirmed severe hypertension (grade 3)
 - Major cardiovascular (CV), renal, or cerebrovascular medical complications within the previous 6 months
 - Heart failure [New York Heart Association (NYHA) Stage III-IV]
 - N-terminal Pro B-type Natriuretic Peptide (NT-proBNP) ≥ 500 pg/mL
 - Estimated glomerular filtration rate (eGFR) < 15 mL/min/1.73m²
- Intervention(s):
 - In Part 1 of the trial, patients were randomized 1:1:1 to receive aprocitentan 12.5mg daily, aprocitentan 25mg daily, or placebo
- Primary Endpoint(s):
 - Change in SiSBP from baseline to week 4 during Part 1
- Results:
 - The least squares (LS) mean difference of -3.8 [97.5% confidence limits (CL): -6.8, -0.8]; $P < 0.0043$] indicated that the 12.5mg dose of aprocitentan was statistically superior to placebo for the primary endpoint.
 - The 25mg dose of aprocitentan did not demonstrate any additional statistically or clinically meaningful improvement in SiBP as compared to the 12.5mg dose.

Cost: The Wholesale Acquisition Cost (WAC) of Tryvio™ is \$25.83 per tablet, resulting in a cost of \$774.90 per 30 days or a cost of \$9,298.80 per year based on recommended dosing.

Cost Comparison: Clonidine Products

Product	Cost Per Unit	Cost Per 28 Days
Nexiclon™ XR (clonidine ER) 0.17mg tablet	\$18.30	\$512.40*
Clonidine ER 0.17mg tablet (authorized generic)	\$12.89	\$360.92*
clonidine 0.1mg tablet (generic)	\$0.02	\$1.12 [†]
clonidine 0.1mg/24hr patch (generic)	\$5.80	\$23.20 [‡]

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).

ER = extended-release; hr = hour

Unit = tablet

*Cost per day based on FDA-approved initial dosing of 0.17mg once daily

[†]Cost per day based on the FDA-approved initial dosing of 0.1mg twice daily.

[‡]Cost per day based on the FDA-approved initial dosing of a 0.1mg/24hr patch applied once every 7 days

Cost Comparison: Labetalol Products

Product	Cost Per Unit	Cost Per 30 Days
labetalol 400mg tablet (authorized generic)	\$1.89	\$113.40*
labetalol 200mg tablet (generic)	\$0.14	\$16.80*

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).

ER = extended-release

Unit = tablet

*Cost per day based on an FDA-approved maintenance dosing regimen of 400mg twice daily.

Recommendations

The College of Pharmacy recommends the prior authorization of labetalol hydrochloride 400mg tablet, Nexiclon™ XR (clonidine ER tablet) and Tryvio™ (aprocitentan) with the following criteria (shown in red):

Labetalol Hydrochloride 400mg Tablet Approval Criteria:

1. An FDA-approved indication of the management of hypertension; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use labetalol hydrochloride 200mg tablets, which are available without prior authorization, to achieve a 400mg dose must be provided.

Nexiclon™ XR [Clonidine Extended-Release (ER) Tablet] Approval Criteria:

1. An FDA approved diagnosis of hypertension; and

2. A patient-specific, clinically significant reason why the member cannot utilize clonidine immediate-release tablet and clonidine transdermal patch, which are available without a prior authorization, must be provided; and
3. Request must be for an FDA-approved once-daily dosing regimen, according to package labeling.

Tryvio™ (Aprocitentan) Approval Criteria:

1. An FDA approved diagnosis of hypertension; and
2. Member has a reported systolic blood pressure of ≥ 140 mmHg confirmed on at least 2 separate blood pressure readings on 2 separate occasions within the last month (documentation of blood pressure readings with dates must be submitted); and
3. Prescriber must rule out other causes of elevated blood pressure including:
 - a. Inaccurate readings due to faulty or inappropriate equipment (i.e., cuff size) or improper technique; and
 - b. White coat hypertension; and
 - c. Prescription non-adherence. Compliance with antihypertensive medications will be evaluated prior to initiation of Tryvio™; and
4. Member must be currently on at least 3 antihypertensive medications at optimal (or maximally tolerated) doses for at least 4 weeks prior to systolic blood pressure reading of ≥ 140 mmHg; and
5. Member must have tried at least 6 different classes of medications, including a diuretic, in the past 12 months that did not yield adequate blood pressure control. Medications can include, but are not limited to, angiotensin I converting enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), calcium channel blockers (CCBs), direct renin inhibitors (DRIs), beta blockers, alpha blockers, alpha agonists, or diuretics; and
6. Female members of reproductive potential must not be pregnant or breastfeeding during treatment with aprocitentan and must be willing to use an effective method of contraception during treatment and for 1 month after discontinuing aprocitentan; and
7. Female members of reproductive potential must have a negative pregnancy test prior to initiation of aprocitentan and must agree to take pregnancy tests monthly during treatment and for 1 month after discontinuing aprocitentan; and
8. Member, pharmacy, and provider must be registered under the Tryvio™ Risk Evaluation and Mitigation Strategy (REMS) program; and
9. Member must not have elevated aminotransferases >3 times the upper limit of normal (ULN) or moderate to severe hepatic impairment (Child Pugh class B or C); and

10. Prescriber must attest that they will monitor liver transaminase levels during treatment and discontinue Tryvio™ if a sustained, unexplained, clinically relevant elevation occurs or if elevations occur with an increase in bilirubin that is >2 times the ULN; and
11. Member must not have severe anemia prior to initiation of aprocitentan; and
12. A quantity limit of 30 tablets per 30 days will apply; and
13. Initial approvals will be for the duration of 3 months. After 3 months, compliance with all antihypertensive medications, including aprocitentan, will be evaluated and the provider must provide documentation that the member has had a positive response to treatment, including a decrease in blood pressure. Inadequate compliance or a lack of positive response will result in denial of continuation. Subsequent approvals will be for 1 year.

Next, the College of Pharmacy recommends moving Atacand® (candesartan) 32mg from Tier 2 to Tier 1 within the Antihypertensive Medications Product Based Prior Authorization (PBPA) category based on net costs (changes noted in red in the following tier chart):

Angiotensin I Converting Enzyme Inhibitors (ACEIs)		
Tier-1	Tier-2	Special PA
benazepril (Lotensin®)	captopril (Capoten®)	enalapril oral solution (Epaned®)
enalapril (Vasotec®)		lisinopril oral solution (Qbrelis®)
enalaprilat (Vasotec® IV)		
fosinopril (Monopril®)		
lisinopril (Prinivil®, Zestril®)		
moexipril (Univasc®)		
perindopril (Aceon®)		
quinapril (Accupril®)		
ramipril (Altace®)		
trandolapril (Mavik®)		
ACEI/Hydrochlorothiazide (HCTZ) Combination Products		
Tier-1	Tier-2	Special PA
benazepril/HCTZ (Lotensin® HCT)	captopril/HCTZ (Capozide®)	fosinopril/HCTZ (Monopril-HCT®)
enalapril/HCTZ (Vaseretic®)		
lisinopril/HCTZ (Prinzide®, Zestoretic®)		
moexipril/HCTZ (Uniretic®)		
quinapril/HCTZ (Accuretic®)		
Angiotensin II Receptor Blockers (ARBs) and ARB Combination Products		

Tier-1	Tier-2	Special PA
candesartan (Atacand®)+	candesartan 32mg (Atacand®)	azilsartan (Edarbi®)
irbesartan (Avapro®)	olmesartan/amlodipine/HCTZ (Tribenzor®)	azilsartan/chlorthalidone (Edarbyclor®)
irbesartan/HCTZ (Avalide®)	telmisartan/HCTZ (Micardis® HCT)	candesartan/HCTZ (Atacand® HCT)
losartan (Cozaar®)		eprosartan (Teveten®)
losartan/HCTZ (Hyzaar®)		eprosartan/HCTZ (Teveten® HCT)
olmesartan (Benicar®)		telmisartan/amlodipine (Twynsta®)
olmesartan/amlodipine (Azor®)		valsartan 4mg/mL oral solution
olmesartan/HCTZ (Benicar HCT®)		
telmisartan (Micardis®)		
valsartan (Diovan®)		
valsartan/amlodipine (Exforge®)		
valsartan/amlodipine/HCTZ (Exforge® HCT)		
valsartan/HCTZ (Diovan HCT®)		
Calcium Channel Blockers (CCBs)		
Tier-1	Tier-2	Special PA
amlodipine (Norvasc®)	amlodipine/atorvastatin (Caduet®)	amlodipine oral solution (Norliqva®)
diltiazem (Cardizem®)	diltiazem LA (Cardizem® LA, Matzim® LA)	amlodipine oral suspension (Katerzia®)
diltiazem (Tiazac®, Taztia XT®)	diltiazem SR (Cardizem® SR)	amlodipine/celecoxib (Consensi®)
diltiazem CD (Cardizem® CD)*	isradipine (Dynacirc®, Dynacirc CR®)	diltiazem CD 360mg (Cardizem® CD)
diltiazem ER (Cartia XT®, Diltia XT®)	nicardipine (Cardene®)	levamlodipine (Conjupri®)
diltiazem XR (Dilacor® XR)	nicardipine (Cardene® SR)	
felodipine (Plendil®)	nisoldipine (Sular®)	
nifedipine (Adalat®, Procardia®)	verapamil (Covera-HS®)	
nifedipine ER (Adalat® CC)	verapamil ER (Verelan®, Verelan® PM)	
nifedipine XL (Nifedical XL®, Procardia XL®)		
nimodipine (Nimotop®)		
verapamil (Calan®, Isoptin®)		

verapamil SR (Calan [®] SR, Isoptin [®] SR)		
ACEI/CCB Combination Products		
Tier-1	Tier-2	Special PA
Tier-1 ACEI + Tier-1 CCB	trandolapril/verapamil (Tarka [®])	perindopril/amlodipine (Prestalia [®])
benazepril/amlodipine (Lotrel [®])		

***All strengths other than 32mg.**

*All strengths other than 360mg.

CD = controlled-delivery; ER, XR, XL = extended-release; LA = long-acting; SR = sustained-release

Lastly, the College of Pharmacy recommends the following additions and changes to the Antihypertensive Medications Special Prior Authorization (PA) Approval Criteria based on clinical practice and to clarify formulation and clinical exceptions for age restrictions in existing criteria (changes shown in red):

Antihypertensive Medications Special Prior Authorization (PA) Approval Criteria:

1. Angiotensin I Converting Enzyme Inhibitors (ACEIs):

a. Epaned[®] (Enalapril Solution) Approval Criteria:

- i. An age restriction of 7 years or older will apply with the following criteria:
 1. A patient-specific, clinically significant reason why the member cannot use the oral tablet formulation in place of the oral solution formulation, even when the tablets are crushed or used to prepare an oral suspension, must be provided (e.g., dose was stabilized inpatient, clinically indicated dose cannot be achieved by splitting available tablet formulations); and
 2. Clinical exceptions for the age restriction (younger than the FDA-approved age) may be considered; and
- ii. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request.

b. Qbrelis[®] (Lisinopril Oral Solution) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use lisinopril oral tablets in place of the oral solution formulation, even when the tablets are crushed, must be provided (e.g., dose was stabilized inpatient, clinically indicated dose cannot be achieved by splitting available tablet formulations); and

- ii. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request.

2. ACEI/Hydrochlorothiazide (HCTZ) Combination Products:

a. Monopril-HCT[®] (Fosinopril/HCTZ) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use the individual components separately must be provided.

3. Calcium Channel Blockers (CCBs):

a. Cardizem[®] CD (Diltiazem CD 360mg Capsules) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use (2) 180mg Cardizem[®] CD (diltiazem CD) capsules must be provided.

b. Conjugri[®] (Levamlodipine Tablets) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use amlodipine oral tablets, which are available without prior authorization, must be provided.

c. Consensi[®] (Amlodipine/Celecoxib Tablets) Approval Criteria:

- i. A patient-specific, clinically significant reason why the member cannot use the individual components separately, which are available without prior authorization, must be provided; and
- ii. A quantity limit of 30 tablets per 30 days will apply.

d. Katerzia[®] (Amlodipine Oral Suspension) and Norliqva[®] (Amlodipine Oral Solution) Approval Criteria:

- i. An FDA approved diagnosis of 1 of the following:
 - 1. Hypertension in adults and pediatric members 6 years of age and older; or
 - 2. Coronary artery disease; or
 - 3. Chronic stable angina; or
 - 4. Vasospastic angina; and
- ii. A patient specific, clinically significant reason why the member cannot use amlodipine oral tablets, even when the tablets are crushed, must be provided; and
- iii. Clinical exceptions for age restrictions may be considered for doses stabilized inpatient or for clinically indicated doses that cannot be achieved by splitting available tablet formulations; and
- iv. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
- v. A quantity limit of 300mL per 30 days will apply.

4. ACEI/CCB Combination Products:

a. Prestalia® (Perindopril/Amlodipine) Approval Criteria:

- i. An FDA approved diagnosis; and
- ii. Documented trials of inadequate response to 2 Tier-1 angiotensin I converting enzyme inhibitors (ACEIs) in combination with amlodipine; and
- iii. A patient-specific, clinically significant reason why the member cannot use the individual components separately must be provided; and
- iv. A quantity limit of 30 tablets per 30 days will apply.

CaroSpir® (Spironolactone Oral Suspension) Approval Criteria:

1. An FDA approved indication; and
2. A patient-specific, clinically significant reason why the member cannot use spironolactone oral tablets must be provided, **including, but not limited to the following:**
 - 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. Dose was stabilized inpatient; and
3. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request.

Sotylize® (Sotalol Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of life-threatening ventricular arrhythmias or for the maintenance of normal sinus rhythm in members with highly symptomatic atrial fibrillation/flutter; and
2. A patient-specific, clinically significant reason why the member cannot use sotalol oral tablets in place of the oral solution formulation must be provided (e.g., dose was stabilized inpatient, clinically indicated dose cannot be achieved by splitting available tablet formulations); and
3. For pediatric members, a recent weight or body surface area (BSA) must be provided on the prior authorization request; and
4. A quantity limit of 64mL per day or 1,920mL per 30 days will apply.

Valsartan 4mg/mL Oral Solution Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
 - a. Hypertension in adults and pediatric members 6 years of age and older; or
 - b. Heart failure; or
 - c. Post-myocardial infarction; and
2. A patient specific, clinically significant, reason why the member cannot use valsartan tablets **or the oral suspension prepared from the tablets** must be provided (i.e., dose was stabilized inpatient); and

3. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
4. A quantity limit of 360mL per 36 days will apply.

Utilization Details of Antihypertensive Medications: Fiscal Year 2024

Fee-For Service Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
CLONIDINE PRODUCTS						
NO PA REQUIRED						
CLONIDINE TAB 0.1MG	48,588	13,477	\$530,585.84	\$10.92	3.61	10.31%
CLONIDINE TAB 0.2MG	20,176	4,322	\$233,046.78	\$11.55	4.67	4.53%
CLONIDINE TAB 0.3MG	6,211	1,197	\$72,840.02	\$11.73	5.19	1.42%
CLONIDINE PATCH 0.3MG/24HR	515	122	\$34,477.22	\$66.95	4.22	0.67%
CLONIDINE PATCH 0.1MG/24HR	467	154	\$16,634.02	\$35.62	3.03	0.32%
CLONIDINE PATCH 0.2MG/24HR	457	155	\$23,371.29	\$51.14	2.95	0.45%
CLONIDINE POW	1	1	\$11.41	\$11.41	1	0.00%
NO PA SUBTOTAL	76,415	19,428	\$910,966.58	\$11.92	3.93	17.71%
SPECIAL PA UTILIZATION						
CLONIDINE ER TAB 0.17MG	1	1	\$959.03	\$959.03	1	0.02%
SPECIAL PA SUBTOTAL	1	1	\$959.03	\$959.03	1	0.02%
CLONIDINE TOTAL	76,416	19,429	\$911,925.61	\$11.93	3.93	17.73%
ANGIOTENSIN I CONVERTING ENZYME INHIBITORS (ACEIs)						
TIER-1 UTILIZATION						
LISINOPRIL TAB 20MG	22,595	9,676	\$232,434.47	\$10.29	2.34	4.52%
LISINOPRIL TAB 10MG	21,564	9,617	\$211,472.36	\$9.81	2.24	4.11%
LISINOPRIL TAB 40MG	12,594	5,086	\$167,036.46	\$13.26	2.48	3.25%
LISINOPRIL TAB 5MG	9,090	3,917	\$84,576.06	\$9.30	2.32	1.64%
LISINOPRIL TAB 2.5MG	3,970	1,669	\$37,698.01	\$9.50	2.38	0.73%
LISINOPRIL TAB 30MG	1,759	758	\$19,573.27	\$11.13	2.32	0.38%
ENALAPRIL TAB 20MG	630	230	\$12,171.95	\$19.32	2.74	0.24%
ENALAPRIL TAB 5MG	531	154	\$7,968.47	\$15.01	3.45	0.15%
ENALAPRIL TAB 2.5MG	527	132	\$8,129.53	\$15.43	3.99	0.16%
ENALAPRIL TAB 10MG	486	181	\$8,064.67	\$16.59	2.69	0.16%
BENAZEPRIL TAB 40MG	281	111	\$3,754.66	\$13.36	2.53	0.07%
BENAZEPRIL TAB 20MG	275	115	\$3,374.53	\$12.27	2.39	0.07%
RAMIPRIL CAP 10MG	195	85	\$2,314.89	\$11.87	2.29	0.04%
BENAZEPRIL TAB 10MG	187	69	\$2,523.92	\$13.50	2.71	0.05%
RAMIPRIL CAP 5MG	89	41	\$958.90	\$10.77	2.17	0.02%
RAMIPRIL CAP 2.5MG	62	26	\$737.35	\$11.89	2.38	0.01%
RAMIPRIL CAP 1.25MG	52	23	\$729.64	\$14.03	2.26	0.01%
BENAZEPRIL TAB 5MG	50	22	\$619.80	\$12.40	2.27	0.01%
FOSINOPRIL TAB 10MG	29	9	\$595.42	\$20.53	3.22	0.01%
FOSINOPRIL TAB 40MG	25	7	\$511.65	\$20.47	3.57	0.01%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
FOSINOPRIL TAB 20MG	21	7	\$414.56	\$19.74	3	0.01%
MOEXIPRIL TAB 15MG	7	2	\$463.35	\$66.19	3.5	0.01%
PERINDOPRIL TAB 4MG	4	1	\$196.48	\$49.12	4	0.00%
TRANDOLAPRIL TAB 4MG	4	2	\$102.28	\$25.57	2	0.00%
TRANDOLAPRIL TAB 2MG	1	1	\$16.00	\$16.00	1	0.00%
QUINAPRIL TAB 10MG	1	1	\$15.00	\$15.00	1	0.00%
TIER-1 SUBTOTAL	75,028	31,941	\$806,453.68	\$10.75	2.35	15.68%
TIER-2 UTILIZATION						
CAPTOPRIL TAB 50MG	40	7	\$1,314.67	\$32.87	5.71	0.03%
CAPTOPRIL TAB 25MG	25	4	\$741.73	\$29.67	6.25	0.02%
CAPTOPRIL TAB 12.5MG	4	1	\$340.88	\$85.22	4	0.01%
CAPTOPRIL TAB 100MG	3	1	\$67.14	\$22.38	3	0.00%
TIER-2 SUBTOTAL	72	13	\$2,464.42	\$34.23	5.54	0.05%
SPECIAL PRIOR AUTHORIZATION (PA) UTILIZATION						
ENALAPRIL SOL 1MG/ML	1,036	213	\$162,271.76	\$156.63	4.86	3.83%
EPANED SOL 1MG/ML	152	30	\$62,934.47	\$414.04	5.07	1.49%
QBRELIS SOL 1MG/ML	120	25	\$48,521.21	\$404.34	4.8	1.15%
SPECIAL PA SUBTOTAL	1,308	268	\$273,727.44	\$209.27	4.88	5.32%
ACEI TOTAL	76,409	32,223	\$1,082,645.54	\$14.17	2.37	21.05%
CALCIUM CHANNEL BLOCKERS (CCBs)						
TIER-1 UTILIZATION						
AMLODIPINE TAB 10MG	27,334	11,191	\$281,548.32	\$10.30	2.44	5.47%
AMLODIPINE TAB 5MG	22,254	9,700	\$228,565.40	\$10.27	2.29	4.44%
AMLODIPINE TAB 2.5MG	3,461	1,546	\$35,806.05	\$10.35	2.24	0.70%
NIFEDIPINE TAB 30MG ER	1,985	1,104	\$33,415.76	\$16.83	1.8	0.65%
NIFEDIPINE TAB 60MG ER	1,008	447	\$18,970.54	\$18.82	2.26	0.37%
NIFEDIPINE TAB 30MG ER	903	522	\$14,192.41	\$15.72	1.73	0.28%
DILTIAZEM CAP 120MG ER	809	386	\$15,011.10	\$18.56	2.1	0.29%
DILTIAZEM CAP 240MG ER	787	280	\$17,013.50	\$21.62	2.81	0.33%
DILTIAZEM CAP 180MG ER	670	274	\$14,412.86	\$21.51	2.45	0.28%
NIFEDIPINE TAB 60MG ER	655	318	\$11,696.09	\$17.86	2.06	0.23%
VERAPAMIL TAB 120MG ER	355	152	\$6,851.21	\$19.30	2.34	0.13%
NIFEDIPINE TAB 90MG ER	347	163	\$8,965.99	\$25.84	2.13	0.17%
NIFEDIPINE CAP 10MG	345	233	\$10,973.08	\$31.81	1.48	0.21%
VERAPAMIL TAB 240MG ER	327	111	\$6,081.48	\$18.60	2.95	0.12%
NIFEDIPINE TAB 90MG ER	273	120	\$6,954.29	\$25.47	2.28	0.14%
DILTIAZEM TAB 30MG	260	108	\$4,123.19	\$15.86	2.41	0.08%
VERAPAMIL TAB 180MG ER	212	88	\$4,341.87	\$20.48	2.41	0.08%
DILTIAZEM TAB 120MG	207	75	\$4,421.06	\$21.36	2.76	0.09%
DILTIAZEM TAB 60MG	177	72	\$3,691.16	\$20.85	2.46	0.07%
VERAPAMIL TAB 80MG	144	61	\$1,995.10	\$13.85	2.36	0.04%
VERAPAMIL TAB 40MG	134	57	\$2,883.10	\$21.52	2.35	0.06%
CARTIA XT CAP 120MG/24HR	132	66	\$2,277.92	\$17.26	2	0.04%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
VERAPAMIL TAB 120MG	130	45	\$2,248.17	\$17.29	2.89	0.04%
DILTIAZEM CAP 360MG ER	101	33	\$3,961.48	\$39.22	3.06	0.08%
DILTIAZEM CAP 300MG ER	101	33	\$2,578.74	\$25.53	3.06	0.05%
DILT-XR CAP 240MG	100	32	\$4,228.93	\$42.29	3.13	0.08%
DILTIAZEM TAB 90MG	94	26	\$2,012.36	\$21.41	3.62	0.04%
DILT-XR CAP 120MG	88	41	\$1,857.57	\$21.11	2.15	0.04%
DILTIAZEM CAP 120MG/24HR	85	45	\$1,917.87	\$22.56	1.89	0.04%
DILTIAZEM CAP 120MG ER	74	18	\$13,464.53	\$181.95	4.11	0.26%
NIFEDIPINE CAP 20MG	59	40	\$3,352.44	\$56.82	1.48	0.07%
DILTIAZEM CAP 60MG ER	57	11	\$6,074.54	\$106.57	5.18	0.12%
DILTIAZEM CAP 240MG/24HR	49	24	\$1,510.94	\$30.84	2.04	0.03%
DILT-XR CAP 180MG	49	21	\$1,874.14	\$38.25	2.33	0.04%
DILTIAZEM CAP 120MG ER	45	24	\$1,548.51	\$34.41	1.88	0.03%
DILTIAZEM CAP 180MG/24HR	42	25	\$1,031.58	\$24.56	1.68	0.02%
DILTIAZEM CAP 180MG ER	39	18	\$1,750.03	\$44.87	2.17	0.03%
FELODIPINE TAB 5MG ER	35	13	\$607.79	\$17.37	2.69	0.01%
DILTIAZEM CAP 300MG ER	30	10	\$1,108.43	\$36.95	3	0.02%
DILTIAZEM CAP 240MG ER	29	12	\$1,497.22	\$51.63	2.42	0.03%
DILTIAZEM CAP 90MG ER	27	5	\$3,134.77	\$116.10	5.4	0.06%
FELODIPINE TAB 10MG ER	27	14	\$567.26	\$21.01	1.93	0.01%
TIADYLT CAP 120MG/24HR	21	4	\$404.55	\$19.26	5.25	0.01%
CARTIA XT CAP 240MG/24HR	20	15	\$484.31	\$24.22	1.33	0.01%
TIADYLT CAP 360MG/24HR	17	5	\$702.01	\$41.29	3.4	0.01%
FELODIPINE TAB 2.5MG ER	16	5	\$283.81	\$17.74	3.2	0.01%
CARTIA XT CAP 300MG/24HR	14	5	\$357.43	\$25.53	2.8	0.01%
CARTIA XT CAP 180MG/24HR	10	7	\$191.35	\$19.14	1.43	0.00%
NIMODIPINE CAP 30MG	10	7	\$2,051.33	\$205.13	1.43	0.04%
TIADYLT CAP 240MG/24HR	10	6	\$381.95	\$38.20	1.67	0.01%
TAZTIA XT CAP 120MG/24HR	9	1	\$127.78	\$14.20	9	0.00%
DILTIAZEM TAB 240MG ER	7	4	\$817.02	\$116.72	1.75	0.02%
DILTIAZEM TAB 120MG ER	6	3	\$794.88	\$132.48	2	0.02%
DILTIAZEM CAP 420MG/24HR	5	2	\$488.19	\$97.64	2.5	0.01%
TIADYLT CAP 180MG/24HR	5	4	\$190.15	\$38.03	1.25	0.00%
TIADYLT CAP 420MG/24HR	4	2	\$324.00	\$81.00	2	0.01%
DILTIAZEM TAB 300MG ER	1	1	\$194.39	\$194.39	1	0.00%
TIER-1 SUBTOTAL	64,195	27,635	\$798,311.93	\$12.44	2.32	15.52%
TIER-2 UTILIZATION						
VERAPAMIL CAP 240MG SR	51	14	\$4,354.34	\$85.38	3.64	0.08%
DILTIAZEM ER TAB 180MG	36	9	\$3,581.14	\$99.48	4	0.07%
AMLOD/ATORVA TAB 10/40MG	34	10	\$3,613.23	\$106.27	3.4	0.07%
VERAPAMIL CAP 120MG SR	29	7	\$2,756.89	\$95.07	4.14	0.05%
VERAPAMIL CAP 180MG SR	28	15	\$2,445.93	\$87.35	1.87	0.05%
DILTIAZEM ER TAB 360MG	26	9	\$4,475.12	\$172.12	2.89	0.09%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
AMLOD/ATORVA TAB 10/10MG	25	7	\$1,817.05	\$72.68	3.57	0.04%
AMLOD/ATORVA TAB 10/20MG	23	4	\$1,525.92	\$66.34	5.75	0.03%
VERAPAMIL CAP 360MG SR	19	11	\$7,096.83	\$373.52	1.73	0.14%
DILTIAZEM ER TAB 240MG	17	11	\$1,830.01	\$107.65	1.55	0.04%
DILTIAZEM TAB 360MG ER	14	6	\$2,095.92	\$149.71	2.33	0.04%
ISRADIPINE CAP 2.5MG	14	6	\$1,067.22	\$76.23	2.33	0.02%
AMLOD/ATORVA TAB 5/10MG	13	3	\$858.88	\$66.07	4.33	0.02%
VERAPAMIL CAP 200MG ER	12	3	\$1,923.72	\$160.31	4	0.04%
AMLOD/ATORVA TAB 10/80MG	11	3	\$2,041.89	\$185.63	3.67	0.04%
MATZIM LA TAB 360MG/24HR	10	5	\$1,953.42	\$195.34	2	0.04%
ISRADIPINE CAP 5MG	10	6	\$903.54	\$90.35	1.67	0.02%
AMLOD/ATORVA TAB 5/20MG	9	3	\$853.57	\$94.84	3	0.02%
MATZIM LA TAB 240MG/24HR	9	4	\$1,713.12	\$190.35	2.25	0.03%
VERAPAMIL CAP 240MG ER	7	3	\$631.43	\$90.20	2.33	0.01%
VERAPAMIL CAP 100MG ER	7	2	\$2,657.40	\$379.63	3.5	0.05%
CARDIZEM LA TAB 120MG	6	1	\$1,381.26	\$230.21	6	0.03%
VERAPAMIL CAP 180MG ER	5	2	\$258.51	\$51.70	2.5	0.01%
VERAPAMIL CAP 300MG ER	5	4	\$2,901.95	\$580.39	1.25	0.06%
VERAPAMIL CAP 120MG ER	4	3	\$402.14	\$100.54	1.33	0.01%
AMLOD/ATORVA TAB 5/40MG	4	1	\$682.48	\$170.62	4	0.01%
AMLOD/ATORVA TAB 2.5/10MG	3	1	\$315.60	\$105.20	3	0.01%
MATZIM LA TAB 180MG/24HR	3	1	\$202.44	\$67.48	3	0.00%
MATZIM LA TAB 300MG/24HR	1	1	\$224.13	\$224.13	1	0.00%
TIER-2 SUBTOTAL	435	155	\$56,565.08	\$130.03	2.81	1.10%
SPECIAL PA UTILIZATION						
KATERZIA SUS 1MG/ML	177	37	\$69,514.44	\$392.74	4.78	1.35%
NORLIQVA SOL 1MG/ML	70	19	\$31,433.71	\$449.05	3.68	0.61%
DILTIAZEM CAP 360MG CD	13	9	\$321.19	\$24.71	1.44	0.01%
SPECIAL PA SUBTOTAL	260	65	\$101,269.34	\$389.50	4	1.97%
CCB TOTAL	64,890	27,855	\$956,146.35	\$14.73	2.33	18.59%
METOPROLOL PRODUCTS						
NO PA REQUIRED						
METOPROLOL SUC TAB 25MG ER	13,770	5,861	\$186,074.32	\$13.51	2.35	3.62%
METOPROLOL TAR TAB 25MG	11,625	4,526	\$115,983.05	\$9.98	2.57	2.25%
METOPROLOL SUC TAB 50MG ER	10,517	4,405	\$148,955.40	\$14.16	2.39	2.90%
METOPROLOL TAR TAB 50MG	7,144	2,741	\$73,674.32	\$10.31	2.61	1.43%
METOPROLOL SUC TAB 100MG ER	5,140	2,060	\$85,226.05	\$16.58	2.5	1.66%
METOPROLOL TAR TAB 100MG	2,505	934	\$25,844.31	\$10.32	2.68	0.50%
METOPROLOL SUC TAB 200MG ER	825	316	\$17,820.40	\$21.60	2.61	0.35%
METOPROLOL TAR TAB 75MG	253	102	\$6,493.82	\$25.67	2.48	0.13%
NO PA SUBTOTAL	51,779	20,945	\$660,071.67	\$12.75	2.47	12.83%
SPECIAL PA UTILIZATION						
KAPSPARGO CAP 50MG	7	1	\$444.94	\$63.56	7	0.01%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
SPECIAL PA SUBTOTAL	7	1	\$444.94	\$63.56	7	0.01%
METOPROLOL TOTAL	51,786	20,946	\$660,516.61	\$12.75	2.47	12.84%
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) AND ARB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LOSARTAN POT TAB 50MG	13,197	5,840	\$162,025.80	\$12.28	2.26	3.15%
LOSARTAN POT TAB 100MG	10,573	4,379	\$138,900.81	\$13.14	2.41	2.70%
LOSARTAN POT TAB 25MG	9,890	4,545	\$112,071.88	\$11.33	2.18	2.18%
LOSARTAN/HCTZ TAB 100-25MG	2,753	1,135	\$47,728.26	\$17.34	2.43	0.93%
LOSARTAN/HCTZ TAB 50-12.5MG	2,373	1,121	\$31,886.96	\$13.44	2.12	0.62%
LOSARTAN/HCTZ TAB 100-12.5MG	1,491	653	\$25,155.65	\$16.87	2.28	0.49%
OLMESARTAN TAB 40MG	1,122	439	\$18,398.13	\$16.40	2.56	0.36%
VALSARTAN TAB 80MG	1,071	450	\$19,866.38	\$18.55	2.38	0.39%
OLMESARTAN TAB 20MG	1,065	506	\$22,458.12	\$21.09	2.1	0.44%
VALSARTAN TAB 160MG	1,042	436	\$22,494.00	\$21.59	2.39	0.44%
VALSARTAN TAB 320MG	563	237	\$14,080.32	\$25.01	2.38	0.27%
VALSARTAN TAB 40MG	539	228	\$9,442.72	\$17.52	2.36	0.18%
TELMISARTAN TAB 40MG	459	215	\$12,515.56	\$27.27	2.13	0.24%
TELMISARTAN TAB 80MG	426	188	\$10,177.96	\$23.89	2.27	0.20%
CANDESARTAN TAB 16MG	392	144	\$17,699.87	\$45.15	2.72	0.34%
IRBESARTAN TAB 150MG	384	138	\$6,676.93	\$17.39	2.78	0.13%
IRBESARTAN TAB 300MG	352	145	\$7,367.76	\$20.93	2.43	0.14%
CANDESARTAN TAB 8MG	322	145	\$14,590.44	\$45.31	2.22	0.28%
VALSAR/HCTZ TAB 160-12.5MG	316	145	\$6,128.49	\$19.39	2.18	0.12%
VALSAR/HCTZ TAB 320-25MG	285	145	\$8,052.50	\$28.25	1.97	0.16%
OLMESARTAN TAB 5MG	275	114	\$3,675.99	\$13.37	2.41	0.07%
VALSAR/HCTZ TAB 160-25MG	275	117	\$5,808.85	\$21.12	2.35	0.11%
OLM/HCTZ TAB 40-25MG	267	116	\$6,761.67	\$25.32	2.3	0.13%
AMLOD/VALSAR TAB 10-320MG	256	94	\$12,155.94	\$47.48	2.72	0.24%
TELMISARTAN TAB 20MG	228	112	\$4,806.64	\$21.08	2.04	0.09%
AMLOD/VALSAR TAB 5-160MG	219	102	\$7,988.82	\$36.48	2.15	0.16%
OLM/HCTZ TAB 20-12.5MG	214	109	\$7,071.31	\$33.04	1.96	0.14%
CANDESARTAN TAB 4MG	206	103	\$9,407.39	\$45.67	2	0.18%
VALSAR/HCTZ TAB 80-12.5MG	194	67	\$3,463.94	\$17.86	2.9	0.07%
AMLOD/VALSAR TAB 10-160MG	176	78	\$6,813.63	\$38.71	2.26	0.13%
IRBESARTAN TAB 75MG	156	54	\$2,693.77	\$17.27	2.89	0.05%
OLM/HCTZ TAB 40-12.5MG	140	60	\$3,200.02	\$22.86	2.33	0.06%
AMLOD/OLM TAB 5-20MG	129	56	\$3,266.38	\$25.32	2.3	0.06%
VALSAR/HCTZ TAB 320-12.5MG	103	48	\$2,728.18	\$26.49	2.15	0.05%
AMLOD/VALSAR TAB 5-320MG	87	29	\$2,963.83	\$34.07	3	0.06%
AMLOD/OLM TAB 10-40MG	80	38	\$2,378.80	\$29.74	2.11	0.05%
IRBESAR/HCTZ TAB 300-12.5MG	74	33	\$1,804.17	\$24.38	2.24	0.04%
IRBESAR/HCTZ TAB 150-12.5MG	74	23	\$1,484.48	\$20.06	3.22	0.03%
AMLOD/VALSAR/HCTZ 10-320-25MG	55	21	\$4,513.48	\$82.06	2.62	0.09%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
AMLOD/OLM TAB 10-20MG	52	33	\$1,549.42	\$29.80	1.58	0.03%
AMLOD/OLM TAB 5-40MG	49	18	\$1,298.15	\$26.49	2.72	0.03%
AMLOD/VALSAR/HCTZ 10-160-12.5MG	26	9	\$2,511.73	\$96.61	2.89	0.05%
AMLOD/VALSAR /HCTZ 10-160-25MG	22	8	\$1,293.19	\$58.78	2.75	0.03%
AMLOD/VALSAR/HCTZ 5-160-12.5MG	14	8	\$1,339.49	\$95.68	1.75	0.03%
BENICAR TAB 20MG	4	1	\$3,306.40	\$826.60	4	0.06%
COZAAR TAB 50MG	3	1	\$1,491.46	\$497.15	3	0.03%
MICARDIS TAB 80MG	2	1	\$847.85	\$423.93	2	0.02%
TIER-1 SUBTOTAL	51,995	22,687	\$814,343.52	\$15.66	2.29	15.83%
TIER-2 UTILIZATION						
CANDESARTAN TAB 32MG	71	33	\$5,166.34	\$72.77	2.15	0.10%
TELMISA/HCTZ TAB 80-12.5MG	38	14	\$1,542.57	\$40.59	2.71	0.03%
TELMISA/HCTZ TAB 40-12.5MG	37	13	\$1,260.23	\$34.06	2.85	0.02%
OLM/AMLOD/HCTZ 40-10-25MG	27	11	\$2,318.29	\$85.86	2.45	0.05%
TELMISA/HCTZ TAB 80-25MG	18	10	\$1,031.44	\$57.30	1.8	0.02%
OLM/AMLOD/HCTZ 40-5-25MG	7	2	\$445.38	\$63.63	3.5	0.01%
OLM/AMLOD/HCTZ 20-5-12.5MG	7	4	\$712.71	\$101.82	1.75	0.01%
OLM/AMLOD/HCTZ 40-10-12.5MG	2	2	\$299.00	\$149.50	1	0.01%
OLM/AMLOD/HCTZ 40-5-12.5MG	2	2	\$124.90	\$62.45	1	0.00%
TIER-2 SUBTOTAL	209	91	\$12,900.86	\$61.73	2.30	0.25%
SPECIAL PA UTILIZATION						
EDARBYCLOR TAB 40-25MG	23	7	\$6,782.82	\$294.91	3.29	0.13%
EDARBYCLOR TAB 40-12.5MG	16	3	\$5,987.86	\$374.24	5.33	0.12%
CANDESAR/HCTZ TAB 16-12.5MG	9	2	\$399.57	\$44.40	4.5	0.01%
CANDESAR/HCTZ TAB 32-25MG	6	3	\$790.58	\$131.76	2	0.02%
TELMISAR/AMLOD TAB 80-5MG	5	1	\$808.87	\$161.77	5	0.02%
EDARBI TAB 40MG	3	1	\$717.96	\$239.32	3	0.01%
SPECIAL PA SUBTOTAL	62	17	\$15,487.66	\$249.80	3.65	0.30%
ARB TOTAL	52,266	22,795	\$842,732.04	\$16.12	2.29	16.38%
SPIRONOLACTONE PRODUCTS						
NO PA REQUIRED						
SPIRONOLACTONE TAB 25MG	10,498	4,150	\$121,754.89	\$11.60	2.53	2.37%
SPIRONOLACTONE TAB 50MG	6,250	2,454	\$95,093.88	\$15.22	2.55	1.85%
SPIRONOLACTONE TAB 100MG	4,058	1,562	\$81,866.53	\$20.17	2.6	1.59%
SPIRONOLACTONE POW	16	2	\$343.76	\$21.49	8	0.01%
NO PA SUBTOTAL	20,822	8,168	\$299,059.06	\$14.36	2.55	5.81%
SPECIAL PA UTILIZATION						
SPIRONOLACTONE SUS 25MG/5ML	5	5	\$2,798.93	\$559.79	1	0.05%
CAROSPIR SUS 25MG/5ML	129	40	\$51,536.00	\$399.50	3.23	1.00%
SPECIAL PA SUBTOTAL	134	45	\$54,334.93	\$405.48	2.98	1.06%
SPIRONOLACTONE TOTAL	20,956	8,213	\$353,393.99	\$16.86	2.55	6.87%
ACEI/HCTZ COMBINATION PRODUCTS						
TIER-1 UTILIZATION						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
LISINOP/HCTZ TAB 20-12.5MG	5,457	2,311	\$71,868.10	\$13.17	2.36	1.40%
LISINOP/HCTZ TAB 20-25MG	4,769	2,068	\$51,648.80	\$10.83	2.31	1.00%
LISINOP/HCTZ TAB 10-12.5MG	3,408	1,515	\$37,802.18	\$11.09	2.25	0.73%
ENALAP/HCTZ TAB 10-25MG	66	33	\$1,282.78	\$19.44	2	0.02%
BENAZEP/HCTZ TAB 20-12.5MG	47	19	\$1,713.49	\$36.46	2.47	0.03%
BENAZEP/HCTZ TAB 10-12.5MG	41	16	\$1,134.23	\$27.66	2.56	0.02%
ENALAP/HCTZ TAB 5-12.5MG	28	13	\$603.28	\$21.55	2.15	0.01%
BENAZEP/HCTZ TAB 20-25MG	26	10	\$1,008.66	\$38.79	2.6	0.02%
BENAZEP/HCTZ TAB 5-6.25MG	5	2	\$394.97	\$78.99	2.5	0.01%
TIER-1 SUBTOTAL	13,847	5,987	\$167,456.49	\$12.09	2.31	3.26%
ACEI/HCTZ TOTAL	13,847	5,987	\$167,456.49	\$12.09	2.31	3.26%
PROPRANOLOL SOL PRODUCTS						
NO PA REQUIRED						
PROPRANOLOL SOL 20MG/5ML	949	234	\$22,471.29	\$23.68	4.06	0.44%
PROPRANOLOL SOL 40MG/5ML	28	9	\$399.88	\$14.28	3.11	0.01%
NO PA SUBTOTAL	977	243	\$22,871.17	\$23.41	4.02	0.44%
SPECIAL PA UTILIZATION						
HEMANGEOL SOL 4.28/ML	53	18	\$39,378.29	\$742.99	2.94	0.77%
SPECIAL PA SUBTOTAL	53	18	\$39,378.29	\$742.99	2.94	0.77%
PROPRANOLOL SOL TOTAL	1,030	261	\$62,249.46	\$60.44	3.95	1.21%
ACEI/CCB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
AMLOD/BENAZEP CAP 10-40MG	338	131	\$6,215.73	\$18.39	2.58	0.12%
AMLOD/BENAZEP CAP 10-20MG	259	121	\$4,806.60	\$18.56	2.14	0.09%
AMLOD/BENAZEP CAP 5-20MG	165	72	\$2,738.61	\$16.60	2.29	0.05%
AMLOD/BENAZEP CAP 5-10MG	150	63	\$2,435.20	\$16.23	2.38	0.05%
AMLOD/BENAZEP CAP 5-40MG	46	19	\$844.90	\$18.37	2.42	0.02%
AMLOD/BENAZEP CAP 2.5-10MG	16	11	\$306.09	\$19.13	1.45	0.01%
TIER-1 SUBTOTAL	974	417	\$17,347.13	\$17.81	2.33	0.34%
ACEI/CCB TOTAL	974	417	\$17,347.13	\$17.81	2.33	0.34%
MISCELLANEOUS (MISC) COMBINATION PRODUCTS						
NO PA REQUIRED						
ATENOLOL/CHLOR TAB 50-25MG	193	75	\$5,710.17	\$29.59	2.57	0.11%
ATENOLOL/CHLOR TAB 100-25MG	70	34	\$2,953.98	\$42.20	2.06	0.06%
BISOPROLOL/HCTZ TAB 5-6.25MG	209	78	\$5,563.75	\$26.62	2.68	0.11%
BISOPROLOL/HCTZ TAB 10-6.25MG	168	69	\$4,619.20	\$27.50	2.43	0.09%
BISOPROLOL/HCTZ TAB 2.5-6.25MG	68	23	\$1,939.52	\$28.52	2.96	0.04%
METOPROLOL/HCTZ TAB 50-25MG	89	32	\$6,220.79	\$69.90	2.78	0.12%
METOPROLOL TAR TAB 37.5MG	60	21	\$1,069.08	\$17.82	2.86	0.02%
METOPROLOL/HCTZ TAB 100-25MG	24	9	\$2,849.87	\$118.74	2.67	0.06%
METOPROLOL/HCTZ TAB 100-50MG	5	1	\$308.60	\$61.72	5	0.01%
NO PA SUBTOTAL	886	342	\$31,234.96	\$35.25	2.59	0.61%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
MISC TOTAL	886	342	\$31,234.96	\$35.25	2.59	0.61%
SOTALOL PRODUCTS						
NO PA REQUIRED						
SOTALOL HCL TAB 80MG	248	68	\$4,225.08	\$17.04	3.65	0.08%
SOTALOL HCL TAB 120MG	91	27	\$1,549.89	\$17.03	3.37	0.03%
SOTALOL HCL TAB 160MG	27	6	\$594.51	\$22.02	4.5	0.01%
SOTALOL AF TAB 80MG	17	6	\$286.99	\$16.88	2.83	0.01%
SOTALOL AF TAB 120MG	3	2	\$50.17	\$16.72	1.5	0.00%
SOTALOL AF TAB 160MG	2	1	\$59.36	\$29.68	2	0.00%
NO PA SUBTOTAL	388	110	\$6,766	\$17.44	3.53	0.13%
SPECIAL PA UTILIZATION						
SOTYLIZE SOL 5MG/ML	78	13	\$51,194.35	\$656.34	6	1.00%
SPECIAL PA SUBTOTAL	78	13	\$51,194.35	\$656.34	6	1.00%
SOTALOL TOTAL	466	123	\$57,960.35	\$124.38	3.79	1.13%
ALISKIREN PRODUCTS						
SPECIAL PA UTILIZATION						
TEKTURNA TAB 300MG	1	1	\$774.52	\$774.52	1	0.02%
ALISKIREN TOTAL	1	1	\$774.52	\$774.52	1	0.02%
TOTAL	359,927	93,322*	\$5,144,383.05	\$14.29	3.86	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

AMLOD = amlodipine; ATORVA = atorvastatin; BENAZEP = benazepril; CANDESAR = candesartan; CAP = capsule; CD = controlled-delivery; CHLOR = chlorthalidone; ENALEP = enalapril; ER = extended-release; HCL = hydrochloride; HCTZ = hydrochlorothiazide; HR = hour; INJ = injection; IRBESAR = irbesartan; LA = long-acting; LISINOP = lisinopril; OLM = olmesartan; PA = prior authorization; POT = potassium; POW = powder; SOL = solution; SR = sustained-release; SUC = succinate; SUS = suspension; TAB = tablet; TAR = tartrate; TELMISAR = telmisartan; VAL = valsartan; VALSAR = valsartan; XR = extra-release; XT = extra-time
Fiscal Year 2024 = 07/01/2023 to 06/30/2024

Aetna Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
ANGIOTENSIN I CONVERTING ENZYME INHIBITORS (ACEIs)						
TIER-1 UTILIZATION						
LISINOPRIL TAB 20MG	1,082	899	\$12,866.68	\$11.89	1.2	5.16%
LISINOPRIL TAB 10MG	1,061	887	\$11,967.34	\$11.28	1.2	4.80%
LISINOPRIL TAB 40MG	589	499	\$8,406.90	\$14.27	1.18	3.37%
LISINOPRIL TAB 5MG	437	358	\$4,620.05	\$10.57	1.22	1.85%
LISINOPRIL TAB 2.5MG	145	131	\$1,555.13	\$10.73	1.11	0.62%
LISINOPRIL TAB 30MG	79	65	\$1,035.19	\$13.10	1.22	0.42%
ENALAPRIL TAB 20MG	33	22	\$567.00	\$17.18	1.5	0.23%
ENALAPRIL TAB 5MG	23	14	\$362.97	\$15.78	1.64	0.15%
ENALAPRIL TAB 2.5MG	18	14	\$282.63	\$15.70	1.29	0.11%
ENALAPRIL TAB 10MG	13	13	\$253.87	\$19.53	1	0.10%
RAMIPRIL CAP 10MG	11	9	\$135.59	\$12.33	1.22	0.05%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
BENAZEPRIL TAB 20MG	10	8	\$145.79	\$14.58	1.25	0.06%
BENAZEPRIL TAB 10MG	10	7	\$139.89	\$13.99	1.43	0.06%
BENAZEPRIL TAB 40MG	10	10	\$137.66	\$13.77	1	0.06%
RAMIPRIL CAP 5MG	7	5	\$75.25	\$10.75	1.4	0.03%
RAMIPRIL CAP 2.5MG	2	2	\$19.24	\$9.62	1	0.01%
RAMIPRIL CAP 1.25MG	1	1	\$19.83	\$19.83	1	0.01%
FOSINOPRIL TAB 20MG	1	1	\$16.01	\$16.01	1	0.01%
BENAZEPRIL TAB 5MG	1	1	\$14.42	\$14.42	1	0.01%
TIER-1 SUBTOTAL	3,533	2,946	\$42,621.44	\$12.06	1.20	17.11%
TIER-2 UTILIZATION						
CAPTOPRIL TAB 25MG	3	3	\$76.09	\$25.36	1	0.03%
CAPTOPRIL TAB 12.5MG	1	1	\$59.83	\$59.83	1	0.02%
CAPTOPRIL TAB 50MG	1	1	\$33.91	\$33.91	1	0.01%
TIER-2 SUBTOTAL	5	5	\$169.83	\$33.97	1	0.07%
SPECIAL PRIOR PA UTILIZATION						
ENALAPRIL SOL 1MG/ML	29	15	\$3,969.56	\$136.88	1.93	1.59%
QBRELIS SOL 1MG/ML	5	2	\$2,609.94	\$521.99	2.5	1.05%
SPECIAL PA SUBTOTAL	34	17	\$6,579.50	\$193.51	2	2.64%
ACEI TOTAL	3,572	2,968	\$49,370.77	\$13.82	1.2	19.81%
CALCIUM CHANNEL BLOCKERS (CCBs)						
TIER-1 UTILIZATION						
AMLODIPINE TAB 10MG	1,182	994	\$14,316.16	\$12.11	1.19	5.75%
AMLODIPINE TAB 5MG	1,083	882	\$12,779.68	\$11.80	1.23	5.13%
AMLODIPINE TAB 2.5MG	179	140	\$2,039.42	\$11.39	1.28	0.82%
NIFEDIPINE TAB 30MG ER	141	103	\$2,213.50	\$15.70	1.37	0.89%
NIFEDIPINE TAB 30MG ER	77	48	\$1,124.90	\$14.61	1.6	0.45%
NIFEDIPINE TAB 60MG ER	49	32	\$801.27	\$16.35	1.53	0.32%
NIFEDIPINE TAB 60MG ER	45	27	\$656.02	\$14.58	1.67	0.26%
DILTIAZEM CAP 120MG ER	39	36	\$804.90	\$20.64	1.08	0.32%
VERAPAMIL TAB 120MG ER	23	20	\$513.67	\$22.33	1.15	0.21%
DILTIAZEM CAP 240MG ER	21	17	\$493.21	\$23.49	1.24	0.20%
DILTIAZEM CAP 180MG ER	19	14	\$434.18	\$22.85	1.36	0.17%
NIFEDIPINE TAB 90MG ER	19	12	\$369.41	\$19.44	1.58	0.15%
DILTIAZEM TAB 30MG	15	11	\$289.98	\$19.33	1.36	0.12%
NIFEDIPINE CAP 10MG	12	11	\$274.31	\$22.86	1.09	0.11%
VERAPAMIL TAB 120MG	10	6	\$179.11	\$17.91	1.67	0.07%
DILTIAZEM TAB 60MG	9	5	\$196.38	\$21.82	1.8	0.08%
NIFEDIPINE TAB 90MG ER	9	6	\$150.94	\$16.77	1.5	0.06%
VERAPAMIL TAB 240MG ER	7	4	\$133.24	\$19.03	1.75	0.05%
VERAPAMIL TAB 80MG	7	5	\$124.32	\$17.76	1.4	0.05%
NIFEDIPINE CAP 20MG	5	4	\$331.94	\$66.39	1.25	0.13%
DILTIAZEM CAP 180MG ER	5	2	\$143.47	\$28.69	2.5	0.06%
DILT-XR CAP 240MG	5	2	\$128.98	\$25.80	2.5	0.05%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
DILTIAZEM CAP 60MG ER	4	2	\$480.28	\$120.07	2	0.19%
DILTIAZEM CAP 120MG ER	4	2	\$470.50	\$117.63	2	0.19%
NIMODIPINE CAP 30MG	4	1	\$199.19	\$49.80	4	0.08%
DILTIAZEM CAP 120MG/24HR	4	3	\$142.19	\$35.55	1.33	0.06%
FELODIPINE TAB 10MG ER	4	2	\$75.29	\$18.82	2	0.03%
DILT-XR CAP 120MG	4	4	\$72.59	\$18.15	1	0.03%
DILTIAZEM TAB 120MG	4	4	\$53.43	\$13.36	1	0.02%
DILT-XR CAP 180MG	3	3	\$166.12	\$55.37	1	0.07%
DILTIAZEM CAP 360MG ER	3	2	\$111.15	\$37.05	1.5	0.04%
DILTIAZEM CAP 240MG/24HR	3	3	\$60.65	\$20.22	1	0.02%
TAZTIA XT CAP 120MG/24HR	3	1	\$51.72	\$17.24	3	0.02%
FELODIPINE TAB 5MG ER	3	1	\$47.21	\$15.74	3	0.02%
VERAPAMIL TAB 40MG	3	2	\$36.66	\$12.22	1.5	0.01%
DILTIAZEM CAP 120MG ER	2	2	\$83.20	\$41.60	1	0.03%
VERAPAMIL TAB 180MG ER	2	2	\$50.27	\$25.14	1	0.02%
VERAPAMIL CAP 200MG ER	1	1	\$142.18	\$142.18	1	0.06%
DILTIAZEM CAP 240MG ER	1	1	\$52.36	\$52.36	1	0.02%
DILTIAZEM CAP 300MG ER	1	1	\$41.36	\$41.36	1	0.02%
CARTIA XT CAP 300MG/24HR	1	1	\$35.50	\$35.50	1	0.01%
DILTIAZEM CAP 180MG/24HR	1	1	\$27.61	\$27.61	1	0.01%
CARTIA XT CAP 120MG/24HR	1	1	\$22.77	\$22.77	1	0.01%
CARTIA XT CAP 180MG/24HR	1	1	\$16.25	\$16.25	1	0.01%
CARTIA XT CAP 240MG/24HR	1	1	\$15.79	\$15.79	1	0.01%
TIER-1 SUBTOTAL	3,019	2,423	\$40,953.26	\$13.57	1.25	16.44%
TIER-2 UTILIZATION						
VERAPAMIL CAP 360MG SR	5	2	\$580.95	\$116.19	2.5	0.23%
VERAPAMIL CAP 240MG SR	4	2	\$177.62	\$44.41	2	0.07%
DILTIAZEM TAB 360MG ER	3	2	\$220.58	\$73.53	1.5	0.09%
MATZIM LA TAB 360MG/24HR	3	1	\$220.58	\$73.53	3	0.09%
AMLOD/ATORVA TAB 10/40MG	3	3	\$165.67	\$55.22	1	0.07%
ISRADIPINE CAP 2.5MG	1	1	\$129.95	\$129.95	1	0.05%
ISRADIPINE CAP 5MG	1	1	\$84.48	\$84.48	1	0.03%
DILTIAZEM ER TAB 180MG	1	1	\$64.21	\$64.21	1	0.03%
MATZIM LA TAB 180MG/24HR	1	1	\$64.21	\$64.21	1	0.03%
VERAPAMIL CAP 120MG SR	1	1	\$41.13	\$41.13	1	0.02%
AMLOD/ATORVA TAB 5/20MG	1	1	\$37.93	\$37.93	1	0.02%
TIER-2 SUBTOTAL	24	16	\$1787.31	\$74.47	1.5	0.72%
SPECIAL PA UTILIZATION						
KATERZIA SUS 1MG/ML	14	5	\$3,477.43	\$248.39	2.8	1.40%
DILTIAZEM CAP 360MG ER	4	2	\$72.75	\$18.19	2	0.03%
SPECIAL SUBTOTAL	18	7	\$3,550.18	\$197.23	2.57	1.42%
CCB TOTAL	3,061	2,446	\$46,290.75	\$15.12	1.25	18.58%
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) AND ARB COMBINATION PRODUCTS						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
TIER-1 UTILIZATION						
LOSARTAN POT TAB 50MG	700	569	\$9,295.94	\$13.28	1.23	3.73%
LOSARTAN POT TAB 100MG	564	485	\$7,929.94	\$14.06	1.16	3.18%
LOSARTAN POT TAB 25MG	496	401	\$6,473.38	\$13.05	1.24	2.60%
LOSARTAN/HCTZ TAB 100-25MG	139	115	\$2,629.82	\$18.92	1.21	1.06%
LOSARTAN/HCTZ TAB 50-12.5MG	136	111	\$1,914.59	\$14.08	1.23	0.77%
LOSARTAN/HCTZ TAB 100-12.5MG	84	67	\$1,541.83	\$18.36	1.25	0.62%
OLMESARTAN TAB 20MG	80	67	\$1,374.21	\$17.18	1.19	0.55%
VALSARTAN TAB 80MG	75	46	\$1,256.88	\$16.76	1.63	0.50%
VALSARTAN TAB 160MG	71	39	\$1,248.39	\$17.58	1.82	0.50%
VALSARTAN TAB 320MG	68	37	\$1,272.86	\$18.72	1.84	0.51%
VALSAR/HCTZ TAB 160-12.5MG	40	25	\$676.83	\$16.92	1.6	0.27%
OLMESARTAN TAB 40MG	36	30	\$696.60	\$19.35	1.2	0.28%
TELMISARTAN TAB 80MG	34	31	\$813.20	\$23.92	1.1	0.33%
VALSAR/HCTZ TAB 320-25MG	29	19	\$582.19	\$20.08	1.53	0.23%
CANDESARTAN TAB 16MG	28	17	\$758.50	\$27.09	1.65	0.30%
TELMISARTAN TAB 40MG	27	20	\$664.32	\$24.60	1.35	0.27%
CANDESARTAN TAB 8MG	25	15	\$725.53	\$29.02	1.67	0.29%
IRBESARTAN TAB 300MG	23	14	\$298.21	\$12.97	1.64	0.12%
OLMESARTAN TAB 5MG	21	16	\$329.37	\$15.68	1.31	0.13%
VALSARTAN TAB 40MG	20	14	\$334.58	\$16.73	1.43	0.13%
AMLOD/VALSAR TAB 5-160MG	16	9	\$440.43	\$27.53	1.78	0.18%
OLM/HCTZ TAB 20-12.5MG	15	11	\$338.20	\$22.55	1.36	0.14%
AMLOD/VALSAR TAB 10-320MG	15	11	\$666.53	\$44.44	1.36	0.27%
OLM/HCTZ TAB 40-12.5MG	14	11	\$343.91	\$24.57	1.27	0.14%
OLM/HCTZ TAB 40-25MG	13	12	\$364.08	\$28.01	1.08	0.15%
AMLOD/VALSAR TAB 10-160MG	12	7	\$318.56	\$26.55	1.71	0.13%
VALSAR/HCTZ TAB 160-25MG	12	8	\$209.53	\$17.46	1.5	0.08%
AMLOD/OLM TAB 5-20MG	11	8	\$214.25	\$19.48	1.38	0.09%
AMLOD/OLM TAB 10-40MG	11	7	\$232.32	\$21.12	1.57	0.09%
TELMISARTAN TAB 20MG	11	11	\$244.28	\$22.21	1	0.10%
IRBESARTAN TAB 150MG	10	7	\$135.64	\$13.56	1.43	0.05%
IRBESAR/HCTZ TAB 150-12.5MG	10	5	\$183.77	\$18.38	2	0.07%
IRBESARTAN TAB 75MG	9	5	\$137.53	\$15.28	1.8	0.06%
AMLOD/OLM TAB 5-40MG	8	5	\$168.69	\$21.09	1.6	0.07%
VALSAR/HCTZ TAB 320-12.5MG	8	5	\$142.19	\$17.77	1.6	0.06%
AMLOD/VALSAR/HCTZ 10-320-25MG	7	3	\$1,352.47	\$193.21	2.33	0.54%
CANDESARTAN TAB 4MG	6	5	\$175.88	\$29.31	1.2	0.07%
AMLOD/VALSAR TAB 5-20MG	5	5	\$225.55	\$45.11	1	0.09%
VALSAR/HCTZ TAB 80-12.5MG	5	5	\$80.27	\$16.05	1	0.03%
AMLOD/OLM TAB 10-20MG	4	3	\$79.92	\$19.98	1.33	0.03%
AMLOD/VALSAR/HCTZ 10-160-25MG	3	1	\$440.13	\$146.71	3	0.18%
TIER-1 SUBTOTAL	2,901	2,282	\$47,311.30	\$16.31	1.27	18.99%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
TIER-2 UTILIZATION						
CANDESARTAN TAB 32MG	8	5	\$292.61	\$36.58	1.6	0.12%
TELMISAR/HCTZ TAB 80-25MG	7	4	\$195.16	\$27.88	1.75	0.08%
TELMISAR/HCTZ TAB 40-12.5MG	4	3	\$92.26	\$23.07	1.33	0.04%
TELMISAR/HCTZ TAB 80-12.5MG	1	1	\$27.37	\$27.37	1	0.01%
TIER-2 SUBTOTAL	20	13	\$607.40	\$30.37	1.54	0.24%
SPECIAL PA UTILIZATION						
TELMISAR/AMLOD TAB 40-5MG	1	1	\$90.27	\$90.27	1	0.04%
TELMISAR/AMLOD TAB 80-5MG	1	1	\$153.04	\$153.04	1	0.06%
CANDESAR/HCTZ TAB 32-12.5MG	2	1	\$91.35	\$45.68	2	0.04%
SPECIAL PA SUBTOTAL	4	3	\$334.66	\$83.67	1.33	0.13%
ARB AND COMBO	2,925	2,298	\$48,253.36	\$16.50	1.27	19.37%
CLONIDINE PRODUCTS						
NO PA REQUIRED						
CLONIDINE TAB 0.1MG	1,860	1,129	\$19,065.16	\$10.25	1.65	7.65%
CLONIDINE TAB 0.2MG	624	349	\$6,884.79	\$11.03	1.79	2.76%
CLONIDINE TAB 0.3MG	168	90	\$1,853.24	\$11.03	1.87	0.74%
CLONIDINE PATCH 0.1MG/24HR	17	7	\$579.32	\$34.08	2.43	0.23%
CLONIDINE PATCH 0.3MG/24HR	15	8	\$961.10	\$64.07	1.88	0.39%
CLONIDINE PATCH 0.2MG/24HR	15	9	\$799.22	\$53.28	1.67	0.32%
NO PA SUBTOTAL	2,699	1,592	\$30,142.83	\$11.17	1.70	12.10%
CLONIDINE TOTAL	2,699	1,592	\$30,142.83	\$11.17	1.70	12.10%
METOPROLOL PRODUCTS						
NO PA REQUIRED						
METOPROLOL SUC TAB 25MG ER	672	546	\$9,983.36	\$14.86	1.23	4.01%
METOPROLOL SUC TAB 50MG ER	526	439	\$8,175.58	\$15.54	1.2	3.28%
METOPROLOL TAR TAB 25MG	454	360	\$4,987.11	\$10.98	1.26	2.00%
METOPROLOL TAR TAB 50MG	264	210	\$3,024.91	\$11.46	1.26	1.21%
METOPROLOL SUC TAB 100MG ER	253	217	\$4,714.36	\$18.63	1.17	1.89%
METOPROLOL TAR TAB 100MG	104	80	\$1,247.51	\$12.00	1.3	0.50%
METOPROLOL SUC TAB 200MG ER	43	35	\$1,034.11	\$24.05	1.23	0.42%
METOPROLOL TAR TAB 75MG	11	7	\$266.64	\$24.24	1.57	0.11%
METOPROLOL TAR TAB 37.5MG	1	1	\$21.86	\$21.86	1	0.01%
NO PA SUBTOTAL	2,328	1,895	\$33,455.44	\$14.37	1.23	13.43%
SPECIAL PA UTILIZATION						
KAPSPARGO CAP 50MG	1	1	\$64.41	\$64.41	1	0.03%
SPECIAL PA SUBTOTAL	1	1	\$64.41	\$64.41	1	0.03%
METOPROLOL TOTAL	2,329	1,896	\$33,519.85	\$14.39	1.23	13.45%
SPIRONOLACTONE PRODUCTS						
NO PA REQUIRED						
SPIRONOLACTONE TAB 25MG	568	363	\$6,470.17	\$11.39	1.56	2.60%
SPIRONOLACTONE TAB 50MG	437	266	\$6,450.98	\$14.76	1.64	2.59%
SPIRONOLACTONE TAB 100MG	294	179	\$5,632.19	\$19.16	1.64	2.26%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
NO PA SUBTOTAL	1,299	808	\$18,553.34	\$14.28	1.61	7.45%
SPECIAL PA UTILIZATION						
SPIRONOLACTONE SUS 25MG/5ML	7	5	\$2,046.61	\$292.37	1.4	0.82%
SPECIAL PA SUBTOTAL	7	5	\$2,046.61	\$292.37	1.4	0.82%
SPIRONOLACTONE TOTAL	1,306	813	\$20,599.95	\$15.77	1.61	8.27%
ACEI/HCTZ COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LISINOP/HCTZ TAB 20-12.5MG	297	244	\$4,197.35	\$14.13	1.22	1.68%
LISINOP/HCTZ TAB 20-25MG	242	212	\$3,101.91	\$12.82	1.14	1.24%
LISINOP/HCTZ TAB 10-12.5MG	165	137	\$2,110.85	\$12.79	1.2	0.85%
BENAZEP/HCTZ TAB 10-12.5MG	5	2	\$100.17	\$20.03	2.5	0.04%
BENAZEP/HCTZ TAB 20-12.5MG	3	3	\$94.63	\$31.54	1	0.04%
ENALAP/HCTZ TAB 5-12.5MG	1	1	\$23.11	\$23.11	1	0.01%
TIER-1 SUBTOTAL	713	599	\$9,628.02	\$13.50	1.19	3.86%
ACEI/HCTZ TOTAL	713	599	\$9,628.02	\$13.50	1.19	3.86%
PROPRANOLOL SOLUTION PRODUCTS						
NO PA REQUIRED						
PROPRANOLOL SOL 20MG/5ML	56	29	\$1,231.59	\$21.99	1.93	0.49%
NO PA SUBTOTAL	56	29	\$1,231.59	\$21.99	1.93	0.49%
SPECIAL PA UTILIZATION						
HEMANGEOL SOL 4.28/ML	8	5	\$5,094.32	\$636.79	1.6	2.04%
SPECIAL PA SUBTOTAL	8	5	\$5,094.32	\$636.79	1.6	2.04%
PROPRANOLOL TOTAL	64	34	\$6,325.91	\$98.84	1.88	2.53%
MISCELLANEOUS (MISC) COMBINATION PRODUCTS						
NO PA REQUIRED						
ATENOLOL/CHLOR TAB 50-25MG	10	5	\$266.28	\$26.63	2	0.11%
BISOPROLOL/HCTZ TAB 5-6.25MG	22	17	\$500.49	\$22.75	1.29	0.20%
BISOPROLOL/HCTZ TAB 10-6.25MG	8	7	\$206.09	\$25.76	1.14	0.08%
METOPROLOL/HCTZ TAB 50-25MG	6	6	\$435.39	\$72.57	1	0.17%
METOPROLOL/HCTZ TAB 100-25MG	1	1	\$132.66	\$132.66	1	0.05%
NO PA SUBTOTAL	47	36	\$1,540.91	\$32.79	1.31	0.62%
MISC TOTAL	47	36	\$1,540.91	\$32.79	1.31	0.62%
ACEI/CCB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
AMLOD/BENAZP CAP 10-40MG	18	14	\$369.11	\$20.51	1.29	0.15%
AMLOD/BENAZP CAP 10-20MG	14	13	\$270.64	\$19.33	1.08	0.11%
AMLOD/BENAZP CAP 5-10MG	8	7	\$138.38	\$17.30	1.14	0.06%
AMLOD/BENAZP CAP 5-20MG	4	4	\$96.39	\$24.10	1	0.04%
AMLOD/BENAZP CAP 2.5-10MG	1	1	\$13.61	\$13.61	1	0.01%
AMLOD/BENAZP CAP 5-40MG	1	1	\$22.28	\$22.28	1	0.01%
TIER-1 SUBTOTAL	46	40	\$910.41	\$19.79	1.15	0.37%
ACEI/CCB TOTAL	46	40	\$910.41	\$19.79	1.15	0.37%
SOTALOL PRODUCTS						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
NO PA REQUIRED						
SOTALOL HCL TAB 80MG	9	6	\$129.84	\$14.43	1.5	0.05%
SOTALOL HCL TAB 120MG	3	2	\$42.47	\$14.16	1.5	0.02%
SOTALOL HCL TAB 160MG	2	2	\$52.51	\$26.26	1	0.02%
NO PA SUBTOTAL	14	10	\$224.82	\$16.06	1.4	0.90%
SPECIAL PA UTILIZATION						
SOTYLIZE SOL 5MG/ML	2	1	\$2,353.46	\$1,176.73	2	0.94%
SPECIAL PA SUBTOTAL	2	1	\$2,353.46	\$1,176.73	2	0.94%
SOTALOL TOTAL	16	11	\$2,578.28	\$161.14	1.45	1.03%
TOTAL	16,778	9,966*	\$249,161.04	\$14.85	1.68	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

AMLOD = amlodipine; ATORVA = atorvastatin; BENAZEP = benazepril; CANDESAR = candesartan; CAP = capsule; CHLOR = chlorthalidone; ENALEP = enalapril; ER = extended-release; HCL = hydrochloride; HCTZ = hydrochlorothiazide; HR = hour; INJ = injection; IRBESAR = irbesartan; LA = long-acting; LISINOP = lisinopril; OLM = olmesartan; PA = prior authorization; POT = potassium; SOL = solution; SR = sustained-release; SUC = succinate; SUS = suspension; TAB = tablet; TAR = tartrate; TELMISAR = telmisartan; VALSAR = valsartan; XR = extra-release; XT = extra-time

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.

Humana Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
ANGIOTENSIN I CONVERTING ENZYME INHIBITORS (ACEIs)						
TIER-1 UTILIZATION						
LISINOPRIL TAB 10MG	1,392	1,114	\$15,441.24	\$11.09	1.25	4.90%
LISINOPRIL TAB 20MG	1,361	1,126	\$15,947.66	\$11.72	1.21	5.06%
LISINOPRIL TAB 40MG	748	639	\$10,762.71	\$14.39	1.17	3.42%
LISINOPRIL TAB 5MG	522	427	\$5,520.57	\$10.58	1.22	1.75%
LISINOPRIL TAB 2.5MG	212	184	\$2,370.61	\$11.18	1.15	0.75%
LISINOPRIL TAB 30MG	106	87	\$1,335.79	\$12.60	1.22	0.42%
ENALAPRIL TAB 20MG	33	24	\$669.33	\$20.28	1.38	0.21%
ENALAPRIL TAB 10MG	21	17	\$398.79	\$18.99	1.24	0.13%
ENALAPRIL TAB 5MG	20	14	\$320.73	\$16.04	1.43	0.10%
ENALAPRIL TAB 2.5MG	17	10	\$273.16	\$16.07	1.7	0.09%
BENAZEPRIL TAB 40MG	28	23	\$418.53	\$14.95	1.22	0.13%
BENAZEPRIL TAB 20MG	21	15	\$284.00	\$13.52	1.4	0.09%
BENAZEPRIL TAB 10MG	11	9	\$170.49	\$15.50	1.22	0.05%
RAMIPRIL CAP 10MG	16	14	\$220.90	\$13.81	1.14	0.07%
RAMIPRIL CAP 5MG	8	6	\$109.31	\$13.66	1.33	0.03%
RAMIPRIL CAP 2.5MG	3	3	\$45.72	\$15.24	1	0.01%
RAMIPRIL CAP 1.25MG	2	2	\$38.44	\$19.22	1	0.01%
FOSINOPRIL TAB 20MG	3	2	\$66.40	\$22.13	1.5	0.02%
FOSINOPRIL TAB 10MG	1	1	\$23.74	\$23.74	1	0.01%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TRANDOLAPRIL TAB 4MG	1	1	\$26.36	\$26.36	1	0.01%
TIER-1 SUBTOTAL	4,526	3,718	\$54,444.48	\$12.03	1.22	17.28%
TIER-2 UTILIZATION						
CAPTOPRIL TAB 25MG	4	2	\$116.84	\$29.21	2	0.04%
TIER-2 SUBTOTAL	4	2	\$116.84	\$29.21	2	0.04%
SPECIAL PA UTILIZATION						
ENALAPRIL SOL 1MG/ML	31	18	\$4,014.02	\$129.48	1.72	1.27%
SPECIAL PA SUBTOTAL	31	18	\$4,014.02	\$129.48	1.72	1.27%
ACEI TOTAL	4,561	3,738	\$58,575.34	\$12.84	1.22	18.59%
CALCIUM CHANNEL BLOCKERS (CCBs)						
TIER-1 UTILIZATION						
AMLODIPINE TAB 10MG	1,534	1,291	\$18,654.44	\$12.16	1.19	5.92%
AMLODIPINE TAB 5MG	1,342	1,073	\$15,752.69	\$11.74	1.25	5.00%
AMLODIPINE TAB 2.5MG	224	176	\$2,611.85	\$11.66	1.27	0.83%
NIFEDIPINE TAB 30MG ER	134	94	\$2,299.68	\$17.16	1.43	0.73%
NIFEDIPINE TAB 30MG ER	96	66	\$1,394.87	\$14.53	1.45	0.44%
NIFEDIPINE TAB 60MG ER	54	40	\$1,120.73	\$20.75	1.35	0.36%
DILTIAZEM CAP 120MG ER	51	40	\$1,078.42	\$21.15	1.28	0.34%
NIFEDIPINE TAB 60MG ER	46	36	\$722.48	\$15.71	1.28	0.23%
VERAPAMIL TAB 120MG ER	32	22	\$699.35	\$21.85	1.45	0.22%
NIFEDIPINE TAB 90MG ER	28	26	\$751.58	\$26.84	1.08	0.24%
DILTIAZEM CAP 180MG ER	28	24	\$665.04	\$23.75	1.17	0.21%
DILTIAZEM CAP 240MG ER	26	21	\$665.13	\$25.58	1.24	0.21%
NIFEDIPINE CAP 10MG	24	18	\$806.61	\$33.61	1.33	0.26%
VERAPAMIL TAB 240MG ER	24	14	\$396.35	\$16.51	1.71	0.13%
NIFEDIPINE TAB 90MG ER	20	12	\$363.66	\$18.18	1.67	0.12%
DILTIAZEM TAB 30MG	14	9	\$219.96	\$15.71	1.56	0.07%
DILTIAZEM TAB 120MG	13	9	\$296.31	\$22.79	1.44	0.09%
DILTIAZEM CAP 120MG/24HR	13	10	\$289.76	\$22.29	1.3	0.09%
VERAPAMIL TAB 180MG ER	13	10	\$263.96	\$20.30	1.3	0.08%
VERAPAMIL TAB 40MG	10	8	\$194.62	\$19.46	1.25	0.06%
DILT-XR CAP 120MG	9	7	\$221.00	\$24.56	1.29	0.07%
DILTIAZEM TAB 60MG	9	7	\$186.35	\$20.71	1.29	0.06%
VERAPAMIL TAB 120MG	9	5	\$133.31	\$14.81	1.8	0.04%
VERAPAMIL TAB 80MG	7	6	\$120.01	\$17.14	1.17	0.04%
NIFEDIPINE CAP 20MG	6	3	\$426.56	\$71.09	2	0.14%
DILT-XR CAP 240MG	6	5	\$264.04	\$44.01	1.2	0.08%
DILTIAZEM CAP 300MG ER	6	6	\$176.31	\$29.39	1	0.06%
DILTIAZEM CAP 360MG ER	6	3	\$110.57	\$18.43	2	0.04%
DILTIAZEM CAP 120MG ER	5	3	\$481.81	\$96.36	1.67	0.15%
DILTIAZEM TAB 120MG ER	5	3	\$235.13	\$47.03	1.67	0.07%
DILTIAZEM CAP 120MG ER	4	3	\$130.88	\$32.72	1.33	0.04%
CARTIA XT CAP 120/24HR	4	4	\$80.66	\$20.17	1	0.03%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
DILTIAZEM TAB 90MG	3	2	\$66.13	\$22.04	1.5	0.02%
VERAPAMIL POW	3	1	\$57.06	\$19.02	3	0.02%
CARTIA XT CAP 240/24HR	3	1	\$52.98	\$17.66	3	0.02%
DILTIAZEM CAP 60MG ER	2	2	\$165.69	\$82.85	1	0.05%
DILT-XR CAP 180MG	2	2	\$83.11	\$41.56	1	0.03%
DILTIAZEM CAP 360MG ER	2	2	\$80.77	\$40.39	1	0.03%
DILTIAZEM CAP 240MG/24HR	2	2	\$75.08	\$37.54	1	0.02%
FELODIPINE TAB 10MG ER	2	2	\$52.48	\$26.24	1	0.02%
CARDIZEM CD CAP 240MG/24HR	1	1	\$4,385.46	\$4,385.46	1	1.39%
DILTIAZEM CAP 180MG/24HR	1	1	\$24.19	\$24.19	1	0.01%
FELODIPINE TAB 5MG ER	1	1	\$23.80	\$23.80	1	0.01%
TIER-1 SUBTOTAL	3,824	3,071	\$56,880.87	\$14.87	1.25	18.06%
TIER-2 UTILIZATION						
AMLOD/ATORVA TAB 10-40MG	6	3	\$313.74	\$52.29	2	0.10%
VERAPAMIL CAP 240MG ER	5	3	\$185.42	\$37.08	1.67	0.06%
VERAPAMIL CAP 360MG SR	4	2	\$532.26	\$133.07	2	0.17%
VERAPAMIL CAP 120MG SR	4	2	\$251.72	\$62.93	2	0.08%
VERAPAMIL CAP 300MG ER	3	1	\$630.91	\$210.30	3	0.20%
DILTIAZEM TAB 360MG ER	3	1	\$215.08	\$71.69	3	0.07%
MATZIM LA TAB 180MG/24HR	3	1	\$178.26	\$59.42	3	0.06%
DILTIAZEM ER TAB 180MG	3	3	\$162.49	\$54.16	1	0.05%
DILTIAZEM CAP 240MG ER	3	2	\$142.79	\$47.60	1.5	0.05%
VERAPAMIL CAP 180MG SR	3	3	\$112.83	\$37.61	1	0.04%
DILTIAZEM TAB 300MG ER	2	1	\$164.82	\$82.41	2	0.05%
DILTIAZEM ER TAB 240MG	2	1	\$123.86	\$61.93	2	0.04%
AMLOD/ATORVA TAB 10-10MG	2	2	\$87.68	\$43.84	1	0.03%
VERAPAMIL CAP 200MG ER	1	1	\$142.18	\$142.18	1	0.05%
CARDIZEM LA TAB 120MG	1	1	\$120.81	\$120.81	1	0.04%
MATZIM LA TAB 300MG/24HR	1	1	\$73.74	\$73.74	1	0.02%
AMLOD/ATORVA TAB 10-80MG	1	1	\$61.64	\$61.64	1	0.02%
AMLOD/ATORVA TAB 5-10MG	1	1	\$42.37	\$42.37	1	0.01%
VERAPAMIL CAP 180MG ER	1	1	\$40.22	\$40.22	1	0.01%
AMLOD/ATORVA TAB 10-20MG	1	1	\$39.69	\$39.69	1	0.01%
DILTIAZEM CAP 180MG ER	1	1	\$34.57	\$34.57	1	0.01%
VERAPAMIL CAP 240MG SR	1	1	\$19.69	\$19.69	1	0.01%
TIER-2 SUBTOTAL	52	34	\$3,676.77	\$70.71	1.53	1.17%
SPECIAL PA UTILIZATION						
NORLIQVA SOL 1MG/ML	6	4	\$1,760.51	\$293.42	1.5	0.56%
KATERZIA SUS 1MG/ML	2	2	\$471.70	\$235.85	1	0.15%
SPECIAL PA SUBTOTAL	8	6	\$2,232.21	\$279.03	1.33	0.71%
CCB TOTAL	3,884	3,111	\$62,789.85	\$16.17	1.25	19.93%
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) AND ARB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
LOSARTAN POT TAB 50MG	957	758	\$12,815.42	\$13.39	1.26	4.07%
LOSARTAN POT TAB 100MG	724	594	\$10,265.72	\$14.18	1.22	3.26%
LOSARTAN POT TAB 25MG	708	564	\$9,223.60	\$13.03	1.26	2.93%
LOSARTAN/HCTZ TAB 100-25MG	210	163	\$3,754.67	\$17.88	1.29	1.19%
LOSARTAN/HCTZ TAB 50-12.5MG	170	131	\$2,332.10	\$13.72	1.3	0.74%
LOSARTAN/HCTZ TAB 100-12.5MG	120	95	\$2,173.81	\$18.12	1.26	0.69%
OLMESARTAN TAB 20MG	91	74	\$1,535.20	\$16.87	1.23	0.49%
VALSARTAN TAB 160MG	83	69	\$1,964.18	\$23.66	1.2	0.62%
OLMESARTAN TAB 40MG	79	62	\$1,519.54	\$19.23	1.27	0.48%
VALSARTAN TAB 80MG	59	44	\$1,129.47	\$19.14	1.34	0.36%
TELMISARTAN TAB 80MG	48	32	\$1,019.70	\$21.24	1.5	0.32%
TELMISARTAN TAB 40MG	40	30	\$939.58	\$23.49	1.33	0.30%
VALSARTAN TAB 320MG	39	31	\$1,045.77	\$26.81	1.26	0.33%
VALSARTAN TAB 40MG	39	30	\$753.43	\$19.32	1.3	0.24%
CANDESARTAN TAB 8MG	36	22	\$961.81	\$26.72	1.64	0.31%
CANDESARTAN TAB 16MG	35	19	\$935.88	\$26.74	1.84	0.30%
OLM/HCTZ TAB 40-25MG	30	20	\$741.50	\$24.72	1.5	0.24%
IRBESARTAN TAB 300MG	27	19	\$523.98	\$19.41	1.42	0.17%
VALSAR/HCTZ TAB 320-25MG	25	23	\$735.21	\$29.41	1.09	0.23%
VALSAR/HCTZ TAB 160-25MG	23	19	\$523.20	\$22.75	1.21	0.17%
AMLOD/VALSAR TAB 10-320MG	18	14	\$800.24	\$44.46	1.29	0.25%
CANDESARTAN TAB 4MG	18	13	\$504.65	\$28.04	1.38	0.16%
VALSAR/HCTZ TAB 160-12.5MG	17	16	\$398.87	\$23.46	1.06	0.13%
IRBESARTAN TAB 150MG	15	14	\$313.38	\$20.89	1.07	0.10%
OLMESARTAN TAB 5MG	15	11	\$247.97	\$16.53	1.36	0.08%
AMLOD/VALSAR TAB 10-160MG	14	10	\$398.79	\$28.49	1.4	0.13%
AMLOD/OLMTAB 10-40MG	14	8	\$295.68	\$21.12	1.75	0.09%
AMLOD/VALSAR TAB 5-160MG	12	10	\$487.87	\$40.66	1.2	0.15%
TELMISARTAN TAB 20MG	12	11	\$248.19	\$20.68	1.09	0.08%
OLM/HCTZ TAB 20-12.5MG	11	10	\$282.55	\$25.69	1.1	0.09%
VALSAR/HCTZ TAB 80-12.5MG	10	8	\$187.62	\$18.76	1.25	0.06%
OLM/HCTZ TAB 40-12.5MG	9	7	\$240.89	\$26.77	1.29	0.08%
IRBESARTAN TAB 75MG	9	7	\$176.99	\$19.67	1.29	0.06%
AMLOD/VALSAR/HCTZ 10-320-25MG	7	5	\$1,988.77	\$284.11	1.4	0.63%
VALSAR/HCTZ TAB 320-12.5MG	7	5	\$149.06	\$21.29	1.4	0.05%
AMLOD/OLM TAB 10-20MG	7	5	\$139.86	\$19.98	1.4	0.04%
IRBESAR/HCTZ TAB 300-12.5MG	6	6	\$150.70	\$25.12	1	0.05%
AMLOD/VALSAR TAB 5-320MG	5	3	\$165.47	\$33.09	1.67	0.05%
AMLOD/OLMESA TAB 5-20MG	4	3	\$79.35	\$19.84	1.33	0.03%
AMLOD/VALSAR/HCTZ 10-160-25MG	3	1	\$440.13	\$146.71	3	0.14%
AMLOD/OLMESA TAB 5-40MG	3	2	\$65.61	\$21.87	1.5	0.02%
IRBESAR/HCTZ TAB 150-2.5MG	3	2	\$63.76	\$21.25	1.5	0.02%
AMLOD/VALSAR/HCTZ 5-160-25MG	1	1	\$574.67	\$574.67	1	0.18%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
COZAAR TAB 25MG	1	1	\$96.38	\$96.38	1	0.03%
AMLOD/VALSAR/HCTZ 5-160-12.5MG	1	1	\$44.17	\$44.17	1	0.01%
TIER-1 SUBTOTAL	3,765	2,973	\$63,435.39	\$16.85	1.27	20.14%
TIER-2 UTILIZATION						
CANDESARTAN TAB 32MG	19	12	\$686.61	\$36.14	1.58	0.22%
TELMISA/HCTZ TAB 80-12.5MG	8	6	\$210.80	\$26.35	1.33	0.07%
TELMISA/HCTZ TAB 80-25MG	4	3	\$111.89	\$27.97	1.33	0.04%
OLM/AMLO/HCTZ TAB 40-10-12.5MG	4	4	\$194.48	\$48.62	1	0.06%
OLM/AMLO/HCTZ TAB 40-5-12.5MG	1	1	\$48.91	\$48.91	1	0.02%
OLM/AMLO/HCTZ TAB 40-5-25MG	1	1	\$56.25	\$56.25	1	0.02%
TELMISAR/HCTZ TAB 40-12.5MG	1	1	\$30.24	\$30.24	1	0.01%
TIER-2 SUBTOTAL	38	28	\$1,339.18	\$35.24	1.36	0.43%
SPECIAL PA UTILIZATION						
EDARBYCLOR TAB 40-12.5MG	3	1	\$738.17	\$246.06	3	0.23%
TELMISAR/AMLOD TAB 40-5MG	3	1	\$253.03	\$84.34	3	0.08%
EDARBI TAB 80MG	1	1	\$259.31	\$259.31	1	0.08%
TELMISAR/AMLOD TAB 40-10MG	1	1	\$90.23	\$90.23	1	0.03%
CANDESAR/HCTZ TAB 32-25MG	1	1	\$45.61	\$45.61	1	0.01%
CANDESAR/HCTZ TAB 32-12.5MG	1	1	\$44.82	\$44.82	1	0.01%
SPECIAL PA SUBTOTAL	10	6	\$1,431.17	\$143.12	1.68	0.45%
ARB TOTAL	3,813	3,007	\$66,205.74	\$17.36	1.28	21.02%
METOPROLOL PRODUCTS						
NO PA REQUIRED						
METOPROLOL SUC TAB 25MG ER	846	680	\$12,523.08	\$14.80	1.24	3.98%
METOPROLOL SUC TAB 50MG ER	702	555	\$10,826.61	\$15.42	1.26	3.44%
METOPROLOL TAR TAB 25MG	584	439	\$6,358.85	\$10.89	1.33	2.02%
METOPROLOL TAR TAB 50MG	391	310	\$4,513.26	\$11.54	1.26	1.43%
METOPROLOL SUC TAB 100MG ER	339	278	\$6,282.32	\$18.53	1.22	1.99%
METOPROLOL TAR TAB 100MG	145	116	\$1,697.65	\$11.71	1.25	0.54%
METOPROLOL SUC TAB 200MG ER	60	45	\$1,474.57	\$24.58	1.33	0.47%
METOPROLOL TAR TAB 75MG	15	11	\$399.18	\$26.61	1.36	0.13%
NO PA SUBTOTAL	3,082	2,434	\$44,075.52	\$14.30	1.27	13.99%
SPECIAL PA UTILIZATION						
KAPSPARGO CAP 25MG	4	3	\$259.17	\$64.79	1.33	0.08%
KAPSPARGO CAP 100MG	4	3	\$298.70	\$74.68	1.33	0.09%
KAPSPARGO CAP 50MG	2	1	\$236.93	\$118.47	2	0.08%
SPECIAL PA SUBTOTAL	10	7	\$794.80	\$79.48	1.43	0.25%
METOPROLOL TOTAL	3,092	2,441	\$44,870.32	\$14.51	1.27	14.24%
CLONIDINE PRODUCTS						
NO PA REQUIRED						
CLONIDINE TAB 0.1MG	1,979	1,181	\$21,233.28	\$10.73	1.68	6.74%
CLONIDINE TAB 0.2MG	739	409	\$8,376.60	\$11.34	1.81	2.66%
CLONIDINE TAB 0.3MG	246	116	\$2,796.40	\$11.37	2.12	0.89%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
CLONIDINE PATCH 0.1MG/24HR	23	17	\$867.44	\$37.71	1.35	0.28%
CLONIDINE PATCH 0.2MG/24HR	21	13	\$1,275.43	\$60.73	1.62	0.40%
CLONIDINE PATCH 0.3MG/24HR	20	13	\$1,498.71	\$74.94	1.54	0.48%
CLONIDINE TOTAL	3,028	1,749	\$36,047.86	\$11.90	1.73	11.44%
SPIRONOLACTONE PRODUCTS						
NO PA REQUIRED						
SPIRONOLACTONE TAB 25MG	669	491	\$8,765.14	\$13.10	1.36	2.78%
SPIRONOLACTONE TAB 50MG	435	301	\$7,482.24	\$17.20	1.45	2.38%
SPIRONOLACTONE TAB 100MG	288	215	\$6,578.72	\$22.84	1.34	2.09%
NO PA SUBTOTAL	1,392	1,007	\$22,826.10	\$16.40	1.38	7.25%
SPECIAL PA UTILIZATION						
CAROSPIR SUS 25MG/5ML	1	1	\$176.15	\$176.15	1	0.06%
SPECIAL PA SUBTOTAL	1	1	\$176.15	\$176.15	1	0.06%
SPIRONOLACTONE TOTAL	1,393	1,008	\$23,002.25	\$16.51	1.38	7.30%
ACEI/HCTZ COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LISINOP/HCTZ TAB 20-12.5MG	354	301	\$5,118.24	\$14.46	1.18	1.62%
LISINOP/HCTZ TAB 20-25MG	314	262	\$4,015.51	\$12.79	1.2	1.27%
LISINOP/HCTZ TAB 10-12.5MG	213	175	\$2,736.50	\$12.85	1.22	0.87%
BENAZEP/HCTZ TAB 20/12.5MG	8	6	\$261.03	\$32.63	1.33	0.08%
ENALAP/HCTZ TAB 5-12.5MG	3	2	\$64.75	\$21.58	1.5	0.02%
BENAZEP/HCTZ TAB 10-12.5MG	2	2	\$57.53	\$28.77	1	0.02%
ENALAP/HCTZ TAB 10-25MG	2	2	\$51.02	\$25.51	1	0.02%
TIER-1 SUBTOTAL	896	750	\$12,304.58	\$13.73	1.19	3.91%
ACEI/HCTZ TOTAL	896	750	\$12,304.58	\$13.73	1.19	3.91%
ACEI/CCB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
AMLOD/BENAZP CAP 10/40MG	25	19	\$480.94	\$19.24	1.32	0.15%
AMLOD/BENAZP CAP 10/20MG	21	17	\$397.26	\$18.92	1.24	0.13%
AMLOD/BENAZP CAP 5/10MG	15	11	\$264.38	\$17.63	1.36	0.08%
AMLOD/BENAZP CAP 5/20MG	10	7	\$183.74	\$18.37	1.43	0.06%
AMLOD/BENAZP CAP 5/40MG	4	3	\$93.84	\$23.46	1.33	0.03%
AMLOD/BENAZP CAP 2.5/10MG	1	1	\$13.61	\$13.61	1	0.00%
TIER-1 SUBTOTAL	76	58	\$ 1,433.77	\$18.87	1.31	0.46%
ACEI/CCB TOTAL	76	58	\$ 1,433.77	\$18.87	1.31	0.46%
MISCELLANEOUS (MISC) COMBINATION PRODUCTS						
NO PA REQUIRED						
ATENOLOL/CHLOR TAB 50-25MG	21	15	\$591.83	\$28.18	1.4	0.19%
BISOPROLOL/HCTZ TAB 5-6.25MG	11	9	\$297.43	\$27.04	1.22	0.09%
BISOPROLOL/HCTZ TAB 10-6.25MG	10	9	\$305.07	\$30.51	1.11	0.10%
METOPROLOL/HCTZ TAB 50-25MG	9	7	\$525.97	\$58.44	1.29	0.17%
METOPROLOL TAR TAB 37.5MG	6	4	\$102.53	\$17.09	1.5	0.03%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
ATENOLOL/CHLOR TAB 100-25MG	5	4	\$167.40	\$33.48	1.25	0.05%
BISOPROLOL/HCTZ TAB 2.5-6.25MG	3	3	\$81.38	\$27.13	1	0.03%
METOPROLOL/HCTZ TAB 100-25MG	1	1	\$132.66	\$132.66	1	0.04%
NO PA SUBTOTAL	66	52	\$2,204.27	\$33.40	1.27	0.70%
MISC TOTAL	66	52	\$2,204.27	\$33.40	1.27	0.70%
PROPRANOLOL SOLUTION PRODUCTS						
NO PA REQUIRED						
PROPRANOLOL SOL 20MG/5ML	42	23	\$805.35	\$19.18	1.83	0.26%
PROPRANOLOL SOL 40MG/5ML	3	2	\$74.12	\$24.71	1.5	0.02%
NO PA SUBTOTAL	45	25	\$879.47	\$19.54	1.8	0.28%
SPECIAL PA UTILIZATION						
HEMANGEOL SOL 4.28/ML	5	4	\$3,183.95	\$636.79	1.25	1.01%
SPECIAL PA SUBTOTAL	5	4	\$3,183.95	\$636.79	1.25	1.01%
PROPRANOLOL SOL TOTAL	50	29	\$4,063.42	\$81.27	1.72	1.29%
SOTALOL PRODUCTS						
NO PA REQUIRED						
SOTALOL HCL TAB 120MG	9	6	\$161.33	\$17.93	1.5	0.05%
SOTALOL HCL TAB 80MG	6	5	\$145.68	\$24.28	1.2	0.05%
SOTALOL HCL TAB 160MG	2	1	\$36.56	\$18.28	2	0.01%
NO PA SUBTOTAL	17	12	\$343.57	\$20.21	1.42	0.11%
SPECIAL PA UTILIZATION						
SOTYLIZE SOL 5MG/ML	5	3	\$3,028.61	\$605.72	1.67	0.96%
SPECIAL PA SUBTOTAL	5	3	\$3,028.61	\$605.72	1.67	0.96%
SOTALOL TOTAL	22	15	\$3,372.18	\$153.28	1.47	1.07%
ALISKIREN PRODUCTS						
SPECIAL PA UTILIZATION						
ALISKIREN TAB 300MG	1	1	\$150.27	\$150.27	1	0.05%
ALISKIREN TOTAL	1	1	\$150.27	\$150.27	1	0.05%
TOTAL	20,882	12,052*	\$315,019.85	\$15.09	1.73	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

AMLOD = amlodipine; ATORVA = atorvastatin; BENAZEP = benazepril; CANDESAR = candesartan; CAP = capsule; CD = controlled-delivery; CHLOR = chlorthalidone; ENALEP = enalapril; ER = extended-release; HCL = hydrochloride; HCTZ = hydrochlorothiazide; HR = hour; IRBESAR = irbesartan; LA = long-acting; LISINOP = lisinopril; OLM = olmesartan; PA = prior authorization; POT = potassium; POW = powder; SOL = solution; SR = sustained-release; SUC = succinate; SUS = suspension; TAB = tablet; TAR = tartrate; TELMISAR = telmisartan; VAL = valsartan; VALSAR = valsartan; XR = extra-release; XT = extra-time

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.

OK Complete Health Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
CLONIDINE PRODUCTS						
NO PA REQUIRED						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
CLONIDINE TAB 0.1MG	3,027	1,719	\$32,025.39	\$10.58	1.76	11.80%
CLONIDINE TAB 0.2MG	1,061	582	\$11,792.76	\$11.11	1.82	4.34%
CLONIDINE TAB 0.3MG	297	157	\$3,444.30	\$11.60	1.89	1.27%
CLONIDINE PATCH 0.1MG/24HR	17	12	\$575.68	\$33.86	1.42	0.21%
CLONIDINE PATCH 0.3MG/24HR	16	9	\$1,009.30	\$63.08	1.78	0.37%
CLONIDINE PATCH 0.2MG/24HR	5	3	\$266.02	\$53.20	1.67	0.10%
NO PA SUBTOTAL	4,423	2,482	\$49,113.45	\$10.58	1.78	18.09%
SPECIAL PA UTILIZATION						
CLONIDINE ER TAB 0.17MG	1	1	\$476.41	476.41	1	0.18%
SPECIAL PA SUBTOTAL	1	1	\$476.41	\$476.41	1	0.18%
CLONIDINE SUBTOTAL	4,424	2,483	\$49,589.86	\$11.21	1.78	18.27%
ANGIOTENSIN I CONVERTING ENZYME INHIBITORS (ACEIs)						
TIER-1 UTILIZATION						
LISINOPRIL TAB 10MG	1,000	845	\$11,032.84	\$11.03	1.18	4.96%
LISINOPRIL TAB 20MG	964	819	\$11,352.20	\$11.78	1.18	5.11%
LISINOPRIL TAB 40MG	560	489	\$8,052.14	\$14.38	1.15	3.62%
LISINOPRIL TAB 5MG	427	358	\$4,614.87	\$10.81	1.19	2.08%
LISINOPRIL TAB 2.5MG	166	142	\$1,829.39	\$11.02	1.17	0.82%
LISINOPRIL TAB 30MG	80	68	\$1,036.98	\$12.96	1.18	0.47%
ENALAPRIL TAB 20MG	41	29	\$776.24	\$18.93	1.41	0.35%
ENALAPRIL TAB 10MG	21	17	\$345.52	\$16.45	1.24	0.16%
ENALAPRIL TAB 2.5MG	17	12	\$285.65	\$16.80	1.42	0.13%
ENALAPRIL TAB 5MG	17	12	\$244.07	\$14.36	1.42	0.11%
BENAZEPRIL TAB 40MG	9	9	\$151.23	\$16.80	1	0.07%
BENAZEPRIL TAB 20MG	9	9	\$113.27	\$12.59	1	0.05%
BENAZEPRIL TAB 10MG	8	6	\$122.77	\$15.35	1.33	0.06%
RAMIPRIL CAP 10MG	7	6	\$100.53	\$14.36	1.17	0.05%
BENAZEPRIL TAB 5MG	6	4	\$81.57	\$13.60	1.5	0.04%
RAMIPRIL CAP 5MG	6	4	\$53.21	\$8.87	1.5	0.02%
RAMIPRIL CAP 1.25MG	4	2	\$61.48	\$15.37	2	0.03%
MOEXIPRIL TAB 15MG	1	1	\$79.99	\$79.99	1	0.04%
FOSINOPRIL TAB 10MG	1	1	\$23.74	\$23.74	1	0.01%
RAMIPRIL CAP 2.5MG	1	1	\$10.00	\$10.00	1	0.00%
TIER-1 SUBTOTAL	3,345	2,835	\$40,367.69	\$12.07	1.18	14.87%
TIER-2 UTILIZATION						
CAPTOPRIL TAB 25MG	1	1	\$31.65	\$31.65	1	0.01%
CAPTOPRIL TAB 12.5MG	1	1	\$16.89	\$16.89	1	0.01%
TIER-2 SUBTOTAL	2	2	\$48.54	\$24.27	1	0.02%
SPECIAL PA UTILIZATION						
ENALAPRIL SOL 1MG/ML	39	22	\$4,880.57	\$125.14	1.77	2.20%
EPANED SOL 1MG/ML	3	1	\$1,820.09	\$606.70	3	0.82%
SPECIAL PA SUBTOTAL	42	23	\$6,700.66	\$159.54	1.83	2.47%
ACEI TOTAL	3,389	2,859	\$47,116.89	\$13.90	1.19	17.36%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
CALCIUM CHANNEL BLOCKERS (CCBs)						
TIER-1 UTILIZATION						
AMLODIPINE TAB 10MG	1,160	1,009	\$14,022.85	\$12.09	1.15	5.17%
AMLODIPINE TAB 5MG	1,029	849	\$12,111.73	\$11.77	1.21	4.46%
AMLODIPINE TAB 2.5MG	170	142	\$1,994.18	\$11.73	1.2	0.73%
NIFEDIPINE TAB 30MG ER	97	78	\$1,648.72	\$17.00	1.24	0.61%
NIFEDIPINE TAB 30MG ER	72	56	\$1,190.19	\$16.53	1.29	0.44%
NIFEDIPINE TAB 60MG ER	57	43	\$1,113.67	\$19.54	1.33	0.41%
DILTIAZEM CAP 120MG ER	50	36	\$935.90	\$18.72	1.39	0.34%
NIFEDIPINE TAB 60MG ER	33	29	\$599.35	\$18.16	1.14	0.22%
DILTIAZEM CAP 180MG ER	28	18	\$596.47	\$21.30	1.56	0.22%
VERAPAMIL TAB 120MG ER	24	20	\$581.38	\$24.22	1.2	0.21%
DILTIAZEM CAP 240MG ER	21	19	\$548.29	\$26.11	1.11	0.20%
NIFEDIPINE CAP 10MG	18	13	\$529.91	\$29.44	1.38	0.20%
NIFEDIPINE TAB 90MG ER	17	15	\$412.88	\$24.29	1.13	0.15%
VERAPAMIL TAB 240MG ER	14	9	\$184.74	\$13.20	1.56	0.07%
NIFEDIPINE TAB 90MG ER	13	12	\$302.86	\$23.30	1.08	0.11%
VERAPAMIL TAB 180MG ER	13	10	\$313.56	\$24.12	1.3	0.12%
DILTIAZEM TAB 120MG	8	7	\$152.37	\$19.05	1.14	0.06%
VERAPAMIL TAB 40MG	7	6	\$134.59	\$19.23	1.17	0.05%
DILTIAZEM TAB 30MG	6	5	\$90.19	\$15.03	1.2	0.03%
DILTIAZEM CAP 180MG/24HR	6	4	\$173.66	\$28.94	1.5	0.06%
VERAPAMIL TAB 80MG	6	5	\$94.26	\$15.71	1.2	0.03%
DILTIAZEM CAP 360MG ER	5	4	\$192.24	\$38.45	1.25	0.07%
CARTIA XT CAP 120MG/24HR	5	4	\$96.69	\$19.34	1.25	0.04%
NIFEDIPINE CAP 20MG	5	5	\$233.03	\$46.61	1	0.09%
DILTIAZEM CAP 120MG/24HR	4	4	\$128.69	\$32.17	1	0.05%
FELODIPINE TAB 2.5MG ER	4	2	\$63.62	\$15.91	2	0.02%
DILT-XR CAP 240MG	4	3	\$196.34	\$49.09	1.33	0.07%
DILT-XR CAP 120MG	4	4	\$81.24	\$20.31	1	0.03%
VERAPAMIL TAB 120MG	4	4	\$77.09	\$19.27	1	0.03%
DILTIAZEM TAB 60MG	3	3	\$72.31	\$24.10	1	0.03%
DILTIAZEM CAP 360MG ER	3	2	\$55.76	\$18.59	1.5	0.02%
DILTIAZEM CAP 60MG ER	3	1	\$193.86	\$64.62	3	0.07%
DILTIAZEM CAP 240MG/24HR	2	1	\$40.24	\$20.12	2	0.01%
DILTIAZEM CAP 300MG ER	2	2	\$56.74	\$28.37	1	0.02%
CARTIA XT CAP 240MG/24HR	2	2	\$60.34	\$30.17	1	0.02%
NICARDIPINE CAP 20MG	2	1	\$864.01	\$432.01	2	0.32%
DILTIAZEM TAB 90MG	1	1	\$23.18	\$23.18	1	0.01%
DILTIAZEM CAP 360MG CD	1	1	\$18.94	\$18.94	1	0.01%
DILTIAZEM CAP 240MG ER	1	1	\$25.06	\$25.06	1	0.01%
DILTIAZEM TAB 240MG ER	1	1	\$61.93	\$61.93	1	0.02%
FELODIPINE TAB 10MG ER	1	1	\$26.24	\$26.24	1	0.01%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
FELODIPINE TAB 5MG ER	1	1	\$23.80	\$23.80	1	0.01%
CARTIA XT CAP 300/24HR	1	1	\$35.50	\$35.50	1	0.01%
CARTIA XT CAP 180/24HR	1	1	\$25.23	\$25.23	1	0.01%
TIADYLT CAP 120MG/24HR	1	1	\$28.95	\$28.95	1	0.01%
TIADYLT CAP 240MG/24HR	1	1	\$19.83	\$19.83	1	0.01%
DILT-XR CAP 180MG	1	1	\$46.15	\$46.15	1	0.02%
TAZTIA XT CAP 240MG/24HR	1	1	\$40.97	\$40.97	1	0.02%
TIER-1 SUBTOTAL	2,913	2,438	\$40,519.73	\$13.91	1.19	14.93%
TIER-2 UTILIZATION						
DILTIAZEM ER TAB 180MG	7	4	\$384.97	\$55.00	1.75	0.14%
DILTIAZEM CAP 120MG ER	7	4	\$1,101.75	\$157.39	1.75	0.41%
VERAPAMIL CAP 240MG SR	6	5	\$297.32	\$49.55	1.2	0.11%
VERAPAMIL CAP 180MG SR	4	2	\$165.54	\$41.385	2	0.06%
VERAPAMIL CAP 360MG SR	4	2	\$540.16	\$135.04	2	0.20%
MATZIM LA TAB 180MG/24HR	3	2	\$153.90	\$51.30	1.5	0.06%
DILTIAZEM ER TAB 240MG	2	1	\$215.52	\$107.76	2	0.08%
MATZIM LA TAB 240MG/24HR	2	1	\$96.26	\$48.13	2	0.04%
AMLOD/ATORVA TAB 5-10MG	1	1	\$73.33	\$73.33	1	0.03%
DILTIAZEM TAB 360MG ER	1	1	\$69.86	\$69.86	1	0.03%
AMLOD/ATORVA TAB 10-40MG	1	1	\$57.01	\$57.01	1	0.02%
VERAPAMIL CAP 180MG ER	1	1	\$42.85	\$42.85	1	0.02%
VERAPAMIL CAP 120MG SR	1	1	\$40.48	\$40.48	1	0.01%
ISRADIPINE CAP 5MG	1	1	\$17.94	\$17.94	1	0.01%
TIER-2 SUBTOTAL	41	27	\$3,256.89	\$79.44	1.52	1.20%
SPECIAL PA UTILIZATION						
NORLIQVA SOL 1MG/ML	10	7	\$3,107.41	\$310.74	1.43	1.14%
SPECIAL PA SUBTOTAL	10	7	\$3,107.41	\$310.74	1.43	1.14%
CCB TOTAL	2,964	2,473	\$46,884.03	\$15.82	1.20	17.27%
METOPROLOL PRODUCTS						
NO PA REQUIRED						
METOPROLOL SUC TAB 25MG ER	690	568	\$10,205.10	\$14.79	1.21	4.59%
METOPROLOL SUC TAB 50MG ER	514	422	\$7,990.24	\$15.55	1.22	3.59%
METOPROLOL TAR TAB 25MG	476	388	\$5,117.04	\$10.75	1.23	2.30%
METOPROLOL TAR TAB 50MG	255	214	\$2,982.98	\$11.70	1.19	1.34%
METOPROLOL SUC TAB 100MG ER	250	213	\$4,606.61	\$18.43	1.17	2.07%
METOPROLOL TAR TAB 100MG	109	85	\$1,209.69	\$11.10	1.28	0.54%
METOPROLOL SUC TAB 200MG ER	29	25	\$731.40	\$25.22	1.16	0.33%
METOPROLOL TAR TAB 75MG	7	7	\$246.05	\$35.15	1	0.11%
METOPROLOL TAR TAB 37.5MG	2	2	\$43.72	\$21.86	1	0.02%
NO PA SUBTOTAL	2,332	1,924	\$33,132.83	\$14.21	1.21	12.21%
SPECIAL PA UTILIZATION						
KAPSPARGO CAP 25MG	3	2	\$194.25	\$64.75	1.5	0.09%
KAPSPARGO CAP 100MG	2	1	\$149.19	\$74.60	2	0.07%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
KAPSPARGO CAP 50MG	3	2	\$194.84	\$64.95	1.5	0.09%
SPECIAL PA SUBTOTAL	8	5	\$538.28	\$67.29	1.60	0.20%
METOPROLOL TOTAL	2,340	1,929	\$33,671.11	\$14.39	1.21	12.40%
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) AND ARB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LOSARTAN POT TAB 50MG	668	568	\$9,169.79	\$13.73	1.18	3.38%
LOSARTAN POT TAB 100MG	562	480	\$8,288.29	\$14.75	1.17	3.05%
LOSARTAN POT TAB 25MG	492	422	\$6,406.94	\$13.02	1.17	2.36%
LOSARTAN/HCTZ TAB 100-25MG	155	133	\$3,047.40	\$19.66	1.17	1.12%
LOSARTAN/HCTZ TAB 50-12.5MG	139	120	\$2,083.60	\$14.99	1.16	0.77%
LOSARTAN/HCTZ TAB 100-12.5MG	92	83	\$1,820.52	\$19.79	1.11	0.67%
VALSARTAN TAB 160MG	84	58	\$1,863.98	\$22.19	1.45	0.69%
OLMESARTAN TAB 20MG	67	53	\$1,108.11	\$16.54	1.26	0.41%
OLMESARTAN TAB 40MG	57	47	\$1,078.17	\$18.92	1.21	0.40%
VALSARTAN TAB 80MG	52	40	\$1,031.08	\$19.83	1.3	0.38%
CANDESARTAN TAB 16MG	42	21	\$1,267.44	\$30.18	2	0.47%
IRBESARTAN TAB 150MG	29	22	\$543.01	\$18.72	1.32	0.20%
VALSARTAN TAB 40MG	27	24	\$523.79	\$19.40	1.13	0.19%
VALSARTAN TAB 320MG	26	24	\$763.49	\$29.37	1.08	0.28%
TELMISARTAN TAB 80MG	25	21	\$546.12	\$21.84	1.19	0.20%
TELMISARTAN TAB 40MG	22	18	\$511.50	\$23.25	1.22	0.19%
OLMESARTAB TAB 5MG	19	14	\$298.88	\$15.73	1.36	0.11%
OLM/HCTZ TAB 40-25MG	17	15	\$460.45	\$27.09	1.13	0.17%
AMLOD/VALSAR TAB 10-320MG	17	10	\$589.42	\$34.67	1.7	0.22%
CANDESARTAN TAB 8MG	16	11	\$463.15	\$28.95	1.45	0.17%
CANDESARTAN TAB 4MG	16	9	\$444.94	\$27.81	1.78	0.16%
IRBESARTAN TAB 300MG	16	12	\$313.31	\$19.58	1.33	0.12%
VALSAR/HCTZ TAB 160-12.5MG	15	11	\$300.80	\$20.05	1.36	0.11%
VALSAR/HCTZ TAB 80-12.5MG	14	10	\$251.80	\$17.99	1.4	0.09%
AMLOD/VALSAR TAB 5-160MG	13	10	\$540.12	\$41.55	1.3	0.20%
VALSART/HCTZ TAB 320-25MG	12	8	\$285.31	\$23.78	1.5	0.11%
AMLOD/OLM TAB 10-40MG	11	7	\$232.32	\$21.12	1.57	0.09%
OLM/HCTZ TAB 20-12.5MG	9	8	\$226.12	\$25.12	1.13	0.08%
VALSAR/HCTZ TAB 160-25MG	9	6	\$164.78	\$18.31	1.5	0.06%
VALSAR/HCTZ TAB 320-12.5MG	9	8	\$230.43	\$25.60	1.13	0.08%
TELMISARTAN TAB 20MG	8	7	\$165.33	\$20.67	1.14	0.06%
AMLOD/OLM TAB 10-20MG	7	5	\$139.86	\$19.98	1.4	0.05%
OLM/HCTZ TAB 40-12.5MG	6	6	\$169.65	\$28.28	1	0.06%
AMLOD/VALSAR/HCTZ 10-320-25MG	6	3	\$442.30	\$73.72	2	0.16%
AMLOD/VALSAR TAB 10-160MG	6	6	\$280.20	\$46.70	1	0.10%
AMLOD/OLM TAB 5-20MG	5	4	\$111.84	\$22.37	1.25	0.04%
AMLOD/OLM TAB 5-40MG	5	2	\$105.17	\$21.03	2.5	0.04%
IRBESAR/HCTZ TAB 150-12.5MG	5	3	\$97.54	\$19.51	1.67	0.04%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
IRBESARTAN TAB 75MG	4	4	\$72.48	\$18.12	1	0.03%
AMLOD/VALSAR TAB 5-320MG	3	3	\$131.88	\$43.96	1	0.05%
AMLOD/VALSAR/HCTZ 10-320-25MG	2	2	\$275.24	\$137.62	1	0.10%
IRBESAR/HCTZ TAB 300-12.5MG	1	1	\$26.32	\$26.32	1	0.01%
TIER-1 SUBTOTAL	2,790	2,319	\$46,872.87	\$16.80	1.20	17.27%
TIER-2 UTILIZATION						
OLM/AMLOD/HCTZ 40-10-25 MG	5	2	\$243.10	\$48.62	2.5	0.09%
OLM/AMLOD/HCTZ 20-5-12.5 MG	4	2	\$175.68	\$43.92	2	0.06%
TELMISAR/HCTZ TAB 80-12.5MG	4	4	\$125.69	\$31.42	1	0.05%
OLM/AMLOD/HCTZ 40-5-12.5 MG	2	2	\$91.84	\$45.92	1	0.03%
CANDESARTAN TAB 32MG	2	1	\$70.99	\$35.50	2	0.03%
TELMISAR/HCTZ TAB 80-25MG	1	1	\$27.22	\$27.22	1	0.01%
TIER-2 SUBTOTAL	18	12	\$734.52	\$40.81	1.50	0.27%
SPECIAL PA UTILIZATION						
EDARBYCLOR TAB 40/12.5MG	3	1	\$736.66	\$245.55	3	0.27%
EDARBI TAB 80MG	3	2	\$717.96	\$239.32	1.5	0.26%
CANDESA/HCTZ TAB 16/12.5MG	1	1	\$34.66	\$34.66	1	0.01%
SPECIAL PA SUBTOTAL	7	4	\$1,489.28	\$212.75	1.75	0.55%
ARB TOTAL	2,813	2,335	\$49,096.67	\$17.44	1.21	18.09%
SPIRONOLACTONE PRODUCTS						
NO PA REQUIRED						
SPIRONOLACTONE TAB 25MG	449	352	\$5,999.74	\$13.36	1.28	2.70%
SPIRONOLACTONE TAB 50MG	351	248	\$5,931.94	\$16.90	1.42	2.67%
SPIRONOLACTONE TAB 100MG	198	144	\$4,335.45	\$21.90	1.38	1.95%
NO PA SUBTOTAL	998	744	\$16,267.13	\$16.30	1.34	5.99%
SPECIAL PA UTILIZATION						
SPIRONOLACTONE SUS 25MG/5ML	6	4	\$1,950.33	\$325.06	1.5	0.72%
CAROSPIR SUS 25MG/5ML	4	2	\$1,999.31	\$499.83	2	0.74%
SPECIAL PA SUBTOTAL	10	6	\$3,949.64	\$394.96	1.67	1.46%
SPIRONOLACTONE TOTAL	1,008	750	\$20,216.77	\$20.06	1	7.45%
ACEI/HCTZ COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LISINOP/HCTZ TAB 20-12.5MG	300	250	\$4,204.94	\$14.02	1.2	1.55%
LISINOP/HCTZ TAB 20-25MG	237	208	\$3,009.07	\$12.70	1.14	1.11%
LISINOP/HCTZ TAB 10-12.5MG	174	151	\$2,244.11	\$12.90	1.15	0.83%
BENAZEP/HCTZ TAB 20-25MG	3	3	\$95.00	\$31.67	1	0.02%
ENALAP/HCTZ TAB 10-25MG	3	2	\$57.73	\$19.24	1.5	0.03%
BENAZEP/HCTZ TAB 20-12.5MG	2	2	\$95.54	\$47.77	1	0.04%
BENAZEP/HCTZ TAB 10-12.5MG	2	2	\$58.19	\$29.10	1	0.02%
TIER-1 SUBTOTAL	721	618	\$9,764.58	\$13.54	1.17	3.60%
ACEI/HCTZ TOTAL	721	618	\$9,764.58	\$13.54	1.17	3.60%
ACEI/CCB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/CLAIM	CLAIMS/MEMBER	% COST
AMLOD/BENAZEP CAP 10-40MG	19	15	\$354.50	\$18.66	1.27	0.13%
AMLOD/BENAZEP CAP 10-20MG	16	15	\$316.28	\$19.77	1.07	0.12%
AMLOD/BENAZEP CAP 5-20MG	11	8	\$196.67	\$17.88	1.38	0.07%
AMLOD/BENAZEP CAP 5-10MG	5	3	\$82.82	\$16.56	1.67	0.03%
AMLOD/BENAZEP CAP 2.5-10MG	1	1	\$19.18	\$19.18	1	0.01%
TIER-1 SUBTOTAL	52	42	\$969.45	\$18.64	1.24	0.36%
ACEI/CCB TOTAL	52	42	\$969.45	\$18.64	1.24	0.36%
MISCELLANEOUS (MISC) COMBINATION PRODUCTS						
NO PA REQUIRED						
BISOPROLOL/HCTZ TAB 10-6.25MG	11	10	\$347.54	\$31.59	1.1	0.16%
ATENOLOL/CHLOR TAB 50-25MG	10	10	\$371.64	\$37.16	1	0.17%
BISOPROLOL/HCTZ TAB 5-6.25MG	8	6	\$204.62	\$25.58	1.33	0.09%
BISOPROLOL/HCTZ TAB 2.5-6.25MG	7	5	\$151.59	\$21.66	1.4	0.07%
METOPROLOL/HCTZ TAB 50-25MG	6	4	\$368.81	\$61.47	1.5	0.17%
ATENOLOL/CHLOR TAB 100-25MG	6	6	\$264.36	\$44.06	1	0.12%
METOPROLOL/HCTZ TAB 100-25MG	2	1	\$97.23	\$48.62	2	0.04%
NO PA SUBTOTAL	50	42	\$1,805.79	\$36.12	1.19	0.67%
MISC TOTAL	50	42	\$1,805.79	\$36.12	1.19	0.67%
PROPRANOLOL SOLUTION PRODUCTS						
NO PA REQUIRED						
PROPRANOLOL SOL 20MG/5ML	45	26	\$1,023.12	\$22.74	1.73	0.38%
PROPRANOLOL SOL 40MG/5ML	1	1	\$8.59	\$8.59	1	0.00%
NO PA SUBTOTAL	46	27	\$1,031.71	\$22.43	1.70	0.38%
SPECIAL PA UTILIZATION						
HEMANGEOL SOL 4.28/ML	12	7	\$8,266.86	\$688.91	1.71	3.05%
SPECIAL PA SUBTOTAL	12	7	\$8,266.86	\$688.91	1.71	3.05%
PROPRANOLOL SOL TOTAL	58	34	\$9,298.57	\$160.32	1.71	3.43%
SOTALOL PRODUCTS						
NO PA REQUIRED						
SOTALOL HCL TAB 80MG	10	6	\$170.45	\$17.05	1.67	0.06%
SOTALOL HCL TAB 120MG	2	2	\$52.25	\$26.13	1	0.02%
NO PA SUBTOTAL	12	8	\$222.70	\$18.56	1.50	0.08%
SPECIAL PA UTILIZATION						
SOTYLIZE SOL 5MG/ML	6	3	\$2,796.17	\$466.03	2	1.03%
SPECIAL PA SUBTOTAL	6	3	\$2,796.17	\$466.03	2	1.03%
SOTALOL TOTAL	18	11	\$3,018.87	\$167.72	1.64	1.11%
TOTAL	17,839	10,805*	\$271,432.59	\$15.22	1.65	100%

Costs do not reflect rebated prices or net costs.

*Total number of unduplicated utilizing members.

AMLOD = amlodipine; ATORVA = atorvastatin; BENAZEP = benazepril; CAP = capsule; CD = controlled-delivery; CHLOR = chlorthalidone; ENALEP = enalapril; ER = extended-release; HCL = hydrochloride; HCTZ = hydrochlorothiazide; HR = hour; INJ = injection; IRBESAR = irbesartan; LA = long-acting; LISINOP = lisinopril; OLM = olmesartan; PA = prior authorization; POT = potassium; SOL = solution; SR = sustained-release; SUC = succinate; SUS = suspension; TAB = tablet; TAR = tartrate; TELMISAR = telmisartan; VALSAR = valsartan; XR = extra-release; XT = extra-time

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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- 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 12/2024. Last accessed 12/18/2024.
- ² Nexiclon™ XR (Clonidine) Extended-Release Tablets Prescribing Information. Athena. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022500s001bl.pdf. Last revised 09/23/2010. Last accessed 12/18/2024.
- ³ Idorsia Pharmaceuticals U.S., Inc. U.S. FDA Approves Idorsia's Once-Daily Tryvio™ (Aprocitentan) - The First and Only Endothelin Receptor Antagonist for The Treatment of High Blood Pressure Not Adequately Controlled in Combination with Other Antihypertensives. *PRNewswire*. Available online at: <https://www.prnewswire.com/news-releases/us-fda-approves-idorsias-once-daily-tryvio-aprocitentan--the-first-and-only-endothelin-receptor-antagonist-for-the-treatment-of-high-blood-pressure-not-adequately-controlled-in-combination-with-other-antihypertensives-302094474.html>. Issued 03/20/2024. Last accessed 12/18/2024.
- ⁴ George Medicines. George Medicines Files New Drug Application with FDA for Novel Low Dose Triple Combination for Treatment of Hypertension Following Successful International Phase III Development Program. *GlobeNewswire*. Available online at: <https://www.globenewswire.com/news-release/2024/08/06/2924923/0/en/George-Medicines-files-New-Drug-Application-with-FDA-for-novel-low-dose-triple-combination-for-treatment-of-hypertension-following-successful-international-Phase-III-development-pr.html>. Issued 08/06/2024. Last accessed 12/18/2024.
- ⁵ Labetalol Hydrochloride Tablet, Film Coated Prescribing Information. U.S. National Library of Medicine: DailyMed. <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=27e4ab03-c17b-4268-912c-e45a5e8f8dd8>. Last revised 11/19/2024. Last accessed 12/26/2024.
- ⁶ Bavry AA. Efficacy and Safety of GMRx2 Compared to Dual Combinations for the Treatment of Hypertension - GMRx2_ACT. Available online at: <https://www.acc.org/latest-in-cardiology/clinical-trials/2024/11/12/19/38/gmrx2>. Issued 10/19/2024. Last accessed 12/18/2024.
- ⁷ Tryvio™ (Aprocitentan) Prescribing Information. Idorsia Pharmaceuticals U.S., Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/217686s000bl.pdf. Last revised 03/19/2024. Last accessed 12/18/2024.
- ⁸ Danaïetash P, Verweij, P, Wang J, et. al. Identifying and Treating Resistant Hypertension in PRECISION: A Randomized Long-Term Clinical Trial with Aprocitentan. *J Clin Hypertens*. 2022;24(7):804-813. doi: 0.1111/jch.14517.



Appendix L

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>.

FDA NEWS RELEASE

For Immediate Release: December 23, 2024

FDA Approves First Generic of Once-Daily GLP-1 Injection to Lower Blood Sugar in Patients with Type 2 Diabetes

The FDA approved the first generic referencing Victoza® (liraglutide injection) 18 mg/3mL, a glucagon-like peptide-1 (GLP-1) receptor agonist indicated to improve glycemic control in adults and pediatric patients aged 10 years and older with type 2 diabetes as an adjunct to diet and exercise. The FDA approved the first generic in this class of medications last month with the approval of a generic referencing Byetta® (exenatide). Liraglutide injection and certain other GLP-1 medications are currently in shortage. The FDA prioritizes assessment of generic drug applications for drugs in shortage to help improve patient access to these medications.

Liraglutide improves blood sugar levels by creating similar effects in the body as GLP-1 in the pancreas, which is often found in insufficient levels in type 2 diabetes patients. According to the Centers for Disease Control and Prevention (CDC), more than 38 million Americans have diabetes, and 90% to 95% of those individuals have type 2 diabetes.

The prescribing information for the generic liraglutide injection approved includes a *Boxed Warning* to advise health care professionals and patients about the increased risk of thyroid C-cell tumors. For this reason, patients who have had, or have family members who have ever had medullary thyroid carcinoma should not use liraglutide, nor should patients who have an endocrine system condition called multiple endocrine neoplasia syndrome type 2. In addition, people who have a prior serious hypersensitivity reaction to liraglutide or any of the product components should not use liraglutide. Liraglutide also carries warnings about pancreatitis, liraglutide pen sharing, hypoglycemia when used in conjunction with certain other drugs known to cause hypoglycemia including insulin and sulfonylurea, renal impairment or kidney failure, hypersensitivity and acute gallbladder disease. The most common side effects reported in the clinical trials for liraglutide injection include nausea, diarrhea, vomiting, decreased appetite, dyspepsia and constipation.

FDA NEWS RELEASE

For Immediate Release: December 20, 2024

FDA Approves First Medication for Obstructive Sleep Apnea

The FDA approved Zepbound® (tirzepatide) for the treatment of moderate to severe obstructive sleep apnea (OSA) in adults with obesity, to be used in combination with a reduced-calorie diet and increased physical activity.

OSA occurs when a person's upper airway becomes blocked, causing pauses in breathing during sleep. While OSA can affect anyone, it is more common in people who are overweight or have obesity. Zepbound® works by activating receptors of hormones secreted from the intestine [GLP-1 and glucose-dependent insulinotropic polypeptide (GIP)] to reduce appetite and food intake. By reducing body weight, studies show that Zepbound® also improves OSA.

Zepbound®'s approval for moderate to severe OSA in adults with obesity is based on two randomized, double-blind, placebo-controlled studies of 469 adults without type 2 diabetes. One study enrolled participants using positive airway pressure (PAP), the standard of care for moderate to severe OSA, and 1 study enrolled participants unable or unwilling to use PAP. In both studies, participants randomly received either 10mg or 15mg of Zepbound® or placebo once weekly for 52 weeks. The primary measure of efficacy was the change from baseline in the apnea hypopnea index (AHI), a measurement of how many times a person experiences apnea or hypopnea per hour during sleep, at week 52. After 52 weeks of treatment in both studies, participants who received Zepbound® experienced a statistically significant and clinically meaningful reduction in events of apnea or hypopnea as measured by AHI compared with placebo, and greater proportions of participants treated with Zepbound® achieved remission or mild OSA with resolution of symptoms compared to placebo. Participants treated with Zepbound® had a significant decrease in body weight compared with placebo at 52 weeks. The improvement in AHI in participants with OSA is likely related to body weight reduction with Zepbound®.

Zepbound® can cause side effects such as nausea, diarrhea, vomiting, constipation, abdominal discomfort and pain, injection site reactions, fatigue, hypersensitivity reactions (typically fever and rash), burping, hair loss, and gastroesophageal reflux disease. Zepbound® causes thyroid C-cell tumors in rats. It is unknown whether Zepbound® causes such tumors, including medullary thyroid cancer, in humans. Zepbound® should not be used in patients with a personal or family history of medullary thyroid cancer or in patients with Multiple Endocrine Neoplasia syndrome type 2. Zepbound® should not be used in patients with a history of severe allergic reaction to tirzepatide or to any of its other ingredients. Patients should stop Zepbound® immediately and seek medical help if a severe allergic reaction is suspected. Zepbound® also contains warnings for pancreatitis, gallbladder problems,

hypoglycemia, acute kidney injury, diabetic retinopathy in patients with type 2 diabetes mellitus, suicidal behavior or thinking, and pulmonary aspiration during general anesthesia or deep sedation.

FDA NEWS RELEASE

For Immediate Release: December 18, 2024

FDA Approves First Mesenchymal Stromal Cell Therapy to Treat Steroid-refractory Acute Graft-versus-host Disease

The FDA approved Ryoncil® (remestemcel-L-rknd), an allogeneic bone marrow-derived mesenchymal stromal cell (MSC) therapy indicated for the treatment of steroid-refractory acute graft-versus-host disease (SR-aGVHD) in pediatric patients 2 months of age and older. Ryoncil® is the first FDA-approved MSC therapy. It contains MSCs, which are a type of cell that can have various roles in the body and can differentiate into multiple other types of cells. These MSCs are isolated from the bone marrow of healthy adult human donors.

SR-aGVHD is a serious and life-threatening condition that can occur as a complication of allogeneic hematopoietic stem cell transplantation (allo-HSCT). In allo-HSCT, a patient receives hematopoietic stem cells from a healthy donor to replace their own stem cells and form new blood cells, a procedure often done as part of treatment for certain types of blood cancers, blood disorders, or immune system disorders.

The safety and effectiveness of Ryoncil® were evaluated in a multicenter, single-arm study in 54 pediatric study participants with SR-aGVHD after undergoing allo-HSCT. Study participants received intravenous infusion of Ryoncil® twice weekly for 4 consecutive weeks, for a total of 8 infusions. Each study participant's condition at baseline was analyzed using the International Blood and Marrow Transplantation Registry Severity Index Criteria (IBMTR) to evaluate which organs have been affected and the overall severity of the disease.

Ryoncil®'s effectiveness was based primarily on the rate and duration of response to treatment 28 days after initiating Ryoncil®. Study participants who had a partial or mixed response to treatment—meaning that there was improved condition in 1 organ with either no change (partial) or worsening condition (mixed) in another organ—received additional infusions once weekly for an additional 4 weeks. Sixteen study participants (30%) had a complete response to treatment 28 days after receiving Ryoncil®, while 22 study participants (41%) had a partial response.

Infusion of Ryoncil® should be monitored by the treating physician, and the infusion should be discontinued if there is any evidence of a reaction which may include dyspnea, hypotension, fever, tachypnea, cyanosis and hypoxia.

The most common adverse reactions in study participants who received Ryoncil® were infections, fever, hemorrhage, edema, abdominal pain

and hypertension. Complications such as hypersensitivity and acute infusion reactions, transmission of infectious disease or agents and ectopic tissue formation may occur following treatment with Ryoncil®.

Ryoncil® is contraindicated in patients with known hypersensitivity to dimethyl sulfoxide or porcine and bovine proteins. Patients should be premedicated with corticosteroids and antihistamines prior to infusion and monitored for hypersensitivity reactions during treatment with Ryoncil®.

FDA NEWS RELEASE

For Immediate Release: December 13, 2024

FDA Approves New Treatment for Congenital Adrenal Hyperplasia

The FDA approved Crenessity™ (crinecerfont) to be used together with glucocorticoids to control androgen levels in adults and pediatric patients 4 years of age and older with classic congenital adrenal hyperplasia (CAH).

Classic CAH is a rare genetic condition affecting the adrenal glands, which produce hormones such as cortisol and androgens. Patients with classic CAH do not produce enough cortisol and produce too many androgens. These patients require high doses of glucocorticoids, because the glucocorticoids also help to reduce the excess levels of androgens. Crenessity™ works by reducing excessive adrenal androgen production, which helps reduce the amount of glucocorticoid treatment needed.

Crenessity™'s approval is based on two randomized, double-blind, placebo-controlled trials in 182 adults and 103 children with classic CAH. In the first trial, 122 adults received Crenessity™ twice daily and 60 received placebo twice daily for 24 weeks. After the first 4 weeks of the trial, the glucocorticoid dose was reduced to replacement levels, then adjusted based on levels of androstenedione, an androgen hormone. The primary measure of efficacy was the change from baseline in the total glucocorticoid daily dose while maintaining androstenedione control at the end of the trial. The group that received Crenessity™ reduced their daily glucocorticoid dose by 27% while maintaining control of androstenedione levels, compared to a 10% daily glucocorticoid dose reduction in the group that received placebo.

In the second trial, 69 pediatric patients received Crenessity™ twice daily and 34 received placebo twice daily for 28 weeks. The primary measure of efficacy was the change from baseline in serum androstenedione at week 4. The group that received Crenessity™ experienced a statistically significant reduction from baseline in serum androstenedione, compared to an average increase from baseline in the placebo group. At the end of the trial, patients assigned to Crenessity™ were able to reduce their daily glucocorticoid dose by 18% while maintaining control of androstenedione levels compared to an almost 6% daily glucocorticoid dose increase in patients assigned to placebo.

Crenessity™ has a warning for acute adrenal insufficiency or adrenal crisis, which can occur if patients with underlying adrenal insufficiency who do not also receive adequate doses of glucocorticoid replacement therapy in

situations associated with increased cortisol need (i.e., “stress dose steroids”). Crenessity™ should not be taken by patients with hypersensitivity to Crenessity™’s active ingredient or any of its components. The most common side effects of Crenessity™ in adults include fatigue, dizziness, and arthralgia. For pediatric patients, the most common side effects are headache, abdominal pain, and fatigue.

Current Drug Shortages Index (as of December 31, 2024):

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
Amifostine Injection	Currently in Shortage
Amino Acid Injection	Currently in Shortage
Amoxapine Tablet	Currently in Shortage
Amoxicillin Powder, For Suspension	Currently in Shortage
Amphetamine Aspartate Monohydrate, Amphetamine Sulfate, Dextroamphetamine Saccharate, Dextroamphetamine Sulfate Tablet	Currently in Shortage
Atropa Belladonna, Opium Suppository	Currently in Shortage
Atropine Sulfate Injection	Currently in Shortage
Azacitidine Injection	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 Injection	Currently in Shortage
Chloroprocaine Hydrochloride Injection	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
Cyclopentolate Hydrochloride Ophthalmic Solution	Currently in Shortage
Dacarbazine Injection	Currently in Shortage
Desmopressin Acetate Spray	Currently in Shortage
Dexamethasone Sodium Phosphate Injection	Currently in Shortage
Dexmedetomidine Hydrochloride Injection	Currently in Shortage
Dextrose 50% 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
Dulaglutide 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
Isoniazid Tablet	Currently in Shortage
Ketamine Hydrochloride Injection	Currently in Shortage
Ketorolac Tromethamine Injection	Currently in Shortage
Lactated Ringers Injection	Currently in Shortage
Leucovorin Calcium 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
Methamphetamine Hydrochloride Tablet	Currently in Shortage
Methotrexate Sodium Injection	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
Oxazepam Capsule	Currently in Shortage
Parathyroid Hormone Injection	Currently in Shortage
Penicillin G Benzathine Injection	Currently in Shortage
Peritoneal Dialysis Solution	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
Semaglutide Injection	Currently in Shortage
Sodium Acetate Injection	Currently in Shortage
Sodium Bicarbonate Injection	Currently in Shortage
Sodium Chloride 0.9% Injection	Currently in Shortage
Sodium Chloride 0.9% Irrigation	Currently in Shortage
Sodium Chloride 14.6% Injection	Currently in Shortage
Sodium Chloride 23.4% 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
Triamcinolone Hexacetonide Injection	Currently in Shortage
Valproate Sodium Injection	Currently in Shortage
Vecuronium Bromide Injection	Currently in Shortage