OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
March 25, 2026, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_h3wPpqn1S3Cat1L-I_GrWg
Telephone: 1-669-216-1590 Webinar ID: 160 201 4392

*Please note: Since the physical address for the OHCA Board Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA Board Meeting will not be suspended or reconvened because of this failure or technical issue.

1. Call to Order / Determination of Quorum……...Marc Nuttle, Chair

2. Discussion and Vote on the November 10, 2025, OHCA Board Meeting Minutes……..….Marc Nuttle, Chair

3. Chief Executive Officer Report……..…..……..Clay Bullard, Chief Executive Officer

    a) Member Moment

4. State Medicaid Director Update……...……..Melissa Miller, State Medicaid Director

5. Discussion of Report from the Pharmacy……..……Jeffrey Cruzan, MD
   Advisory Committee and Possible Action Regarding Chair, Pharmacy Advisory Committee
   Drug Utilization Review Board Recommendation:

    a) Discussion and Possible Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (Attachment “A”):

Item:	Drug Name:	Used For:
i.	Keytruda Qlex™ (Pembrolizumab/Berahyaluronidase Alfa-pmph) Opdivo Qvantig™ (Nivolumab/Hyaluronidase nyhy)	Multiple Cancer Diagnoses
ii.	Imaavy™ (Nipocalimab-aahu)	Myasthenia Gravis (MG)
iii.	Wayrilz™ (Rilzabrutinib)	Chronic Immune Thrombocytopenia (ITP)
iv.	Zepbound® (Tirzepatide)	Obstructive Sleep Apnea (OSA)
v.	Redemplo® (Plozasiran)	Familial Chylomicronemia Syndrome (FCS)
vi.	Polyethylene Glycol 3350 (PEG 3350/Sodium Sulfate/Sodium Chloride/Potassium Chloride/Sodium Ascorbate/Ascorbic Acid for Oral Solution (generic MoviPrep®)	Bowel Preparation before Colonoscopy
vii.	Gomekli® (Mirdametinib) Papzimeos™ (Zopapogene Imadenovec-drba) Romvimza™ (Vimseltinib)	Neurofibromatosis Type 1 (NF1) Recurrent Respiratory Papillomatosis (RRP) Tenosynovial Giant Cell Tumors (TGCT)

6. Discussion of Report from the……..……..……Phillip Kennedy
   Compliance Advisory Committee — Chair, Compliance Advisory Committee
   and Possible Action

   a) Discussion and Possible Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16. (Attachment "B")

      i. Non-Emergency Medical Transportation
      ii. Health Management Program

7. Discussion of Report from the……..……..…….Kevin Corbett
   Managed Care Oversight Committee — Chair, Managed Care Oversight Committee

8. Discussion of Report of Strategic……..Marc Nuttle, Chair
   Planning & Operational Advisory Committee — Chair, Strategic Planning & Operational Advisory Committee

9. Adjournment……..…….Marc Nuttle, Chair

NEXT BOARD MEETING
May 20, 2026, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 21, 2026
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 20, 2026, at 1:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of statutory public notice, the agency placed its agenda on its website on January 16, 2026, at 4:05 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:03 p.m.

BOARD MEMBERS PRESENT: Chairman Nuttle (2:05p.m.), Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE NOVEMBER 10, 2025, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Case moved for approval of the November 10, 2025, board meeting minutes, as published. The motion was seconded by Member Christ.

FOR THE MOTION: Vice-Chairman Yaffe, Member Case, Member Christ, Member Cruzan

BOARD MEMBERS ABSTAIN: Member Corbett, Member Kennedy

BOARD MEMBER ABSENT: Chairman Nuttle, Member Jolley, Member Leland

ITEM 3 / STATE MEDICAID DIRECTOR UPDATE
Melissa Miller, State Medicaid Director

Ms. Miller provided a State Medicaid Director update which included information on Rural Health Transformation (RHT), Oklahoma Award Amount, Oklahoma's RHT Initiatives, OHCA Managed Initiatives, Other Initiatives, Next Steps, RHT Related Policy Initiatives, HR 1 Policy Milestones for Eligibility and Finance, Other Federal Items, Transforming Maternal Health, Food is Medicine, and MAC Changes.

For more detailed information, see Attachment A of the committee packet.

ITEM 4 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE
Dr. Jeff Cruzan, Pharmacy Committee Member

a) Discussion and Possible Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 to Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (see attachment "B")

Item:	Drug Name:	Used For:
i.	Eliquis® (Apixaban) Tablet for Oral Suspension Eliquis® Sprinkle (Apixaban)	Venous Thromboembolism (VTE)
ii.	Boruzu® (Bortezomib) Lynozyfic™ (Linvoseltamab-gcpt)	Multiple Myeloma (MM)

iii.	Bilprevda® (Denosumab-nxxp) Bomyntra® (Denosumab-bnht) Osenvelt® (Denosumab-bmwo)	Prevention of Skeletal-related events in patients with bone metastases from solid tumors and patients with MM Giant Cell Tumor of the Bone (GCTB) Hypercalcemia of Malignancy (HoM)
iv.	Forzinity™ (Elamipretide)	Barth Syndrome (BS)
v.	Harliku™ (Nitisinone) Orfadin® (Nitisinone) Nityr® (Nitisinone) Sephience™ (Sepiapterin)	Alkaptonuria (AKU) AKU and Hereditary Tyrosinemia type I (HT-1) AKU and HT-1 Phenylketonuria (PKU)
vi.	Brinsupri™ (Brensocatib)	Non-Cystic Fibrosis Bronchiectasis (NCFB)
vii.	Anzupgo® (Delgocitinib 2% Cream)	Chronic Hand Eczema (CHE)
viii.	Rhapsido® (Remibrutinib)	Chronic Spontaneous Uticaria (CSU)
ix.	Omlyclo (omalizumab-igec)	Immuneglobulin E-Mediated Asthma (IgE-MA) CSU Immuneglobulin E-Medicated Food Allergy (IgE-MFA) Nasal Polyps

MOTION: Member Corbett moved for approval of item 5a.i-ix as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

For more detailed information, see Attachment "B" of the board packet.

ITEM 5 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phillip Kennedy, Compliance Committee Chair

Member Kennedy stated that during the January 14th Compliance Committee meeting, the Committee reviewed the SPARC item listed in item 5.a. After discussion, the Compliance Committee voted to recommend item 5.a.i to the Board for approval contingent upon advanced payment from the associated state agency.

a) Discussion and Possible Vote to Approve the State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006 (A)(2) under OAC 317:1-3-4 (Attachment "C")

i. Behavioral Health Transportation Rates – Vice-Chairman Yaffe asked what OHCA will do with that $15 million, should the legislature not approve the state share reimbursement. Mr. Richards stated that OHCA has a contingency line in the budget for that $15 million. Vice-Chairman Yaffe also asked how confident we are that DMH can pay their state share moving forward. Mr. Richards stated he is much more confident. He

also added that at the beginning of 2026, OHCA required DMH to pay one month in advance, and they've made that payment.

MOTION: Member Christ moved to approve item 5a.i as published. The motion was seconded by Member Corbett.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

For more detailed information, see Attached "C" of the board packet.

ITEM 6 / DISCUSSION OF REPORT OF THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION

Tanya Case, Chair, Administrative Rules Advisory Committee

Member Case presented the following emergency rules. Member Case stated that the Rules Committee did not approve a motion to recommend advancement of one item, WF # 25-11, listed as item 6.a.iii. With the Chairman's permission, Member Case presented the committee-recommended items first, and then returned to item 6.a.iii for further discussion and vote.

a) Discussion and Possible Vote on Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following PERMANENT and EMERGENCY Rules (see Attachment "D").

The following PERMANENT rules were not previously adopted and are new to the Board:

i. APA WF # 25-04A&B Hospice for HCBS
ii. APA WF # 25-07 Health Information Exchange Cleanup
iv. APA WF # 25-10 Residential Behavioral Management Services
v. APA WF # 25-13 Secure Behavioral Health Transportation
vi. APA WF # 25-17 Outpatient Behavioral Health Agency Services
vii. APA WF # 25-18 Inpatient Psychiatric Accrediting Bodies
viii. APA WF # 25-21 Pharmacists' Policy Revisions
ix. APA WF # 25-22 Elective Sterilization Clarification
x. APA WF # 25-19 Medically Fragile Change of Agency
xi. APA WF # 25-23 Sports Physical Clarification
xii. APA WF # 25-24 PACE Two-Way Agreement
xiii. APA WF # 25-25 Opioid Overdose Reversal Agent
xiv. APA WF # 25-26 Lactation Consultant Revisions
xv. APA WF # 25-27 Determination of Qualifying Categorical Relationships
xvi. APA WF # 25-28A&B Developmental Disabilities Services Revisions
xvii. Chapter 150: Employees Group Insurance Division

MOTION: Vice-Chairman Yaffe moved to approve the permanent rules listed in item 6.a.i-ii, iv-xvii as published. The motion was seconded by Member Corbett.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

The following PERMANENT rules were previously adopted by the Board under EMERGENCY rulemaking:

xviii. APA WF # 25-01 Functional Family Therapy
xix. APA WF # 25-02 ADvantage Waiver Revisions – Member Corbett asked if a portion of the originating site reimbursement will be covered by the grant that was just received? Ms. Miller stated that the rural health grants are limited, and things that are coverable services or direct provider payments are limited by the grant. The reimbursement originating site reimbursement is not something that would be covered under the grants. Member Corbett asked what fee will be used to pay them to host a service. Ms. Miller stated that OHCA is going to use the Medicare fee which is around $31 and will be paid per visit.

xx. APA WF # 25-03 SoonerSelect Auto-Assignment
xxi. APA WF # 25-05 Ancillary Services
xxii. APA WF # 25-06 Rapid Whole Genome Sequencing
xxiii. APA WF # 25-08 Birthing Centers and Licensed Midwives
xxiv. APA WF # 25-09 RHC and FQHC Policy Revisions
xxv. APA WF # 25-12 Four Walls Clinic Services
xxvi. APA WF # 25-14 Paid Family Caregiver Program
xxvii. APA WF # 25-15 340B Drug Discount Program

MOTION: Member Corbett moved to approve the permanent rules listed in item 6.a.xviii-xxvii as published. The motion was seconded by Member Christ.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

The following EMERGENCY and PERMANENT rules were not previously adopted and are new to the Board. The Agency is requesting emergency rules be effective upon the Governor's signature, with concurrent adoption of permanent rules.

xxviii. APA WF # 26-01 Removal of Physician Limit Caps
xxix. APA WF # 26-02 Telehealth Originating Site Reimbursement

MOTION: Vice-Chairman Yaffe moved to approve the declaration of compelling public interest for the promulgation of the emergency rules listed in item 6.a.xxviii-xxix. The motion was seconded by Member Corbett.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

MOTION: Member Cruzan moved to approve the emergency rules listed in item 6.a.xxviii-xxix, as published. The motion was seconded by Member Christ.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

MOTION: Member Christ moved to approve the permanent rules listed in item 6.a.xxviii-xxix, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy

BOARD MEMBER ABSENT: Member Jolley, Member Leland

The following PERMANENT rule was pulled out for separate discussion and vote:

iii. APA WF # 25-11 Dental Policy Revisions – Chairman Nuttle stated for the record that the OHCA Board may consider the work order and take whatever action it deems appropriate. The OHCA Board has received and reviewed public comments on the following rule. The Board should consider the public comments when determining the action to be taken on WF # 25-11. Chairman Nuttle called for a representative of the staff to inform the Board and direct the Board on their opinions, conclusions, and answering questions. Ms. Miller provided some history surrounding this rule. The issues were initially brought to OHCA by the MCEs, stating that there was overuse of surgical extraction codes. The Dental MCEs have implemented a very similar practice as what OHCA is proposing in this rule regarding the prior authorization for more than two surgical extractions in one day; they do it on a prepayment basis. OHCA, however, is looking to do it at a prior authorization basis, meaning that the provider would not have already rendered the service, so it puts them at less risk. OHCA has indication from one of the MCEs

that they have seen cost savings, and OHCA conservatively estimates about $500k in cost savings to implement this rule. OHCA did receive 70-80 comments online from the dental community and other commenters opposing this rule, citing concerns about access to care, and ER utilization. OHCA has talked with its Dental Director about these issues. Vice-Chairman Yaffe asked Ms. Miller to more about the potential issue this could be or the expansion population. Ms. Miller stated that OHCA does not think this is a potential expansion issue and asked Dr. Rhone to provide input. Dr. Rhone stated that the issues lie mostly with the adult population. For members under 21, this is not an issue. He added that on an emergency basis, or an initial appointment basis, it is not the norm for more than two teeth to be extracted surgically. Member Cruzan asked if there are any requirements, in emergent situations, to get a prior authorization it if more than two teeth need to be removed. Dr. Rhone stated that the provider would be instructed to perform the extractions necessary and ensure the provider understands how to document it properly, including photos x-rays, etc. Anything over two teeth may get denied and sent through the appeals process, which is where the provider will be able to address things that are outside of the norm. Member Cruzan asked if oral surgeons are required to submit prior authorization. Dr. Rhone stated that oral surgeons have different levels of specialty. Vice-Chaiman Yaffe asked for a comparison of reimbursement for simple extraction versus simple surgical extraction. Dr. Rhone stated that a simple extraction reimbursement is about $74 and for a simple surgical extraction it is about $134. Member Case asked whether the MCEs would be able to continue their current practice of prepayment should the Board not pass this rule. Ms. Miller stated that they would be able to continue with the prepayment process, as OHCA approved their process through a separate process to institute what they have already instituted.

MOTION:	Chairman Nuttle moved to approve the permanent rule listed in item 6.a.iii, as published. The motion was seconded by Member Corbett.
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy
AGAINST THE MOTION:	Vice-Chairman Yaffe
BOARD MEMBER ABSENT:	Member Jolley, Member Leland

ITEM 7 / CHIEF EXECUTIVE OFFICER REPORT
Clay Bullard, Chief Executive Officer

CEO Bullard asked Dr. Corey Finch to provide a brief testimony regarding the removal of physician limits cap.

CEO Bullard provided a brief update on some of the IT items that are going on at the moment. OHCA has about $21 million worth of IT spend and programs that are being built in those areas which will come out of the RHT funding. There are also some mandates that come in with H.R.1 which have been moving forward, as are OHCA's modernization plans. OHCA is also working on integrating AI into the call center program to help cut down on call center wait times. OHCA is also working on developing a database that can be shared with other HHS state agencies regarding eligibility. Estimates show about $4 to $5 million could be cut in duplicative services.

CEO Bullard also provided a brief update on the budget and upcoming budget hearings. The current changes affecting the budget are FMAP, utilization, and unfunded items. OHCA has two-line items specific to Rural Health Transformation. OHCA does not know what utilization will be like. By the time FY 27 is done, there will be an estimate of $300 to $400 million pushed into rural healthcare.

CEO Bullard stated that the Governor revised and reissued his executive order on abortion. A new attestation form will be sent out today.

Vice-Chairman Yaffe asked for a brief update on the recent SoonerSelect Town Halls scheduled over the last week and half. Ms. White stated that staff did a brief presentation, very similar to what Ms. Miller presented, and opened it up for questions. Representatives from both the medical and dental MCEs were present. Vice-Chairman Yaffe asked if Ms. White thinks the value-based programs of the CEs have delivered what was promised. Ms. White stated that she believes they are on track with the value-based program. Vice-Chairman Yaffe asked if the reimbursement payments are at the same level or above the levels as promised. CEO Bullard stated that that is on an individual basis.

Chairman Nuttle stated that he is going to establish a standing committee for oversight of MCOs, providers, and Oklahoma Health Care Authority for performance standards that reference the Oklahoma Managed Healthcare System.

Chairman Nuttle asked Members Case, Corbett, and Kennedy if they would be willing to serve on the committee, and asked that the committee get to the bottom of these issues by the March board meeting.

ITEM 8 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION:	Member Cruzan moved to adjourn. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy
BOARD MEMBER ABSENT:	Member Jolley, Member Leland

Meeting adjourned at 3:42 p.m., 1/21/2025.

NEXT BOARD MEETING
March 25, 2026
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

Attachment A

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – February 11, 2026

Vote Item	Drug	Used for	Cost*	Notes
1	Keytruda Qlex™ (Pembrolizumab/Berahyaluronidase Alfa-pmph)	• **Multiple Cancer Diagnoses:** Melanoma, Non-Small Cell Lung Cancer, Mesothelioma, Head and Neck Squamous Cell Carcinoma, Urothelial Cancer, Metastatic Microsatellite Instability-High Colorectal Cancer, Mismatch Repair Deficient Colorectal Cancer, Gastric Cancer, Esophageal Cancer, Cervical Cancer, Hepatocellular Carcinoma, Biliary Tract Cancer, Markel Cell Carcinoma, Renal Cell Carcinoma, Endometrial Carcinoma, Tumor Mutational Burden-High solid tumors, Cutaneous Squamous Cell Carcinoma, and Triple-Negative Breast Cancer. *297 members used Keytruda last year.*	• $216,564 per year Budget impact estimate: $2,165,640 per year	• Subcutaneous injection version of Keytruda which is given intravenously.
	Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy)	Renal Cell Carcinoma, Melanoma, Non-Small Cell Lung Cancer, Head and Neck Squamous Cell Carcinoma, Urothelial Carcinoma, Colorectal Cancer, Hepatocellular Carcinoma, Esophageal Cancer, Gastric Cancer, Gastroesophageal Junction Cancer, and Esophageal Adenocarcinoma. *76 members used Opdivo last year.*	• $210,650 per year *Budget impact estimate: $1,053,250 per year*	• Subcutaneous injection version of Opdivo which is given intravenously.

2	Imaavy™ (Nipocalimab-aahu)	• **Myasthenia Gravis (MG):** MG is a condition that happens when communication between nerves and muscles breaks down. This causes muscles to feel weak and get tired quickly. This condition may affect any of the muscles you control, called voluntary muscles. This may cause eyelids to droop, double vision, trouble speaking and eating, and trouble walking. *133 members with diagnosis*.	• $324,480 per year *Budget impact estimate: $324,480 per year*	• Approved in patients 12 years of age and older
3	Wayrilz™ (Rilzabrutinib)	• **Chronic Immune Thrombocytopenia (ITP):** ITP is a blood disorder. With this disease, patients have a lower amount of platelets than normal in their blood. Platelets are blood cell fragments that help with blood clotting. ITP becomes chronic when lasting for over 6 months. *320 members with diagnosis*.	• $210,002 per year *Budget impact estimate: $1,050,010 per year*	• Other cheaper therapies required first¥
4	Zepbound® (Tirzepatide)	• **Obstructive Sleep Apnea (OSA):** OSA is the most common sleep-related breathing disorder. People with obstructive sleep apnea repeatedly stop and start breathing while they sleep. *341 with diagnosis*.	• $13,673 per year *Budget impact estimate: $4,785,550 per year*	• Coverage only for OSA diagnosis
5	Redemplo® (Plozasiran)	• **Familial Chylomicronemia Syndrome (FCS):** FCS is a rare genetic disorder estimated to affect 1-2 individuals per million. It is a serious disease that prevents the body from breaking down fats	• $60,000 per year *Budget impact estimate: $60,000 per year*	• Only approved in adults

		(triglycerides) consumed through diet. *58 members with diagnosis*.		
6	Polyethylene Glycol 3350 (PEG 3350)/Sodium Sulfate/Sodium Chloride/ Potassium Chloride/Sodium Ascorbate/Ascorbic Acid for Oral Solution (generic MoviPrep®)	• **Bowel Preparation before Colonoscopy,** *22,864 members with a claim for colon screening last year*.	• $71 per cleanse *Budget impact estimate: $3,550 per year*	• Other cheaper therapies required first[¥]
7	Gomekli® (Mirdametinib)	• **Neurofibromatosis Type 1 (NF1):** NF1 is a rare genetic condition that causes changes in skin pigment and tumors on nerve tissue. Tumors can grow anywhere in the nervous system, including the brain, spinal cord and nerves. *206 members with diagnosis*.	• $486,486 per year *Budget impact estimate: $5,35441,346 per year*	• Approved in ages 2 years old and up
	Papzimeos™ (Zopapogene Imadenovec-drba)	• **Recurrent Respiratory Papillomatosis (RRP):** RRP is a disease in which noncancerous tumors called papillomas grow in the air passages leading from the nose and mouth into the lungs. Patients may experience hoarseness, chronic coughing, or breathing problems. *16 members with diagnosis*.	• $460,000 per 4-dose treatment course *Budget impact estimate: $1,380,000 per year*	• A gene therapy only approved in adults
	Romvimza™ (Vimseltinib)	• **Tenosynovial Giant Cell Tumors (TGCT):** TGCTs are a group of rare, typically non-life-threatening tumors that involve the synovium, bursae and tendon sheath. Synovium is the	• $360,048 per year *Budget impact estimate: $360,048 per year*	• Approved in adults

		thin layer of tissue or membrane that covers the inner surface of the joint spaces and the bursae and tendon sheaths. The tumors can grow and cause damage to the surrounding tissue and structures of the affected limb. *1 member with diagnosis.*		
8	Estradiol 0.06% Gel (Generic EstroGel®) Lynkuet™ (Elinzanetant)	• **Vasomotor Symptoms (VMS):** VMS is commonly known as hot flashes and night sweats for women in menopause. *5,094 members with diagnosis.*	• $1,579 per year *Budget impact estimate: none* • $7,502 per year *Budget impact estimate: $375,100 per year*	• Other cheaper therapies required first[¥]
9	Alyglo™ [Immune Globulin (IG)Intravenous (IV),Human-stwk] Asceniv™ (IGIV, Human-slra) Bivigam® (IGIV, Human) Cuvitru® [IG Subcutaneous (SC), Human]	• **Primary Humoral Immunodeficiency (PHI):** PHI means patients do not have an immune system which works correctly. This means patients with PHI are more likely to get and become very sick from infections. *493 members with immune deficiency diagnosis.*	• $178,329 per year *Budget impact estimate: $356,658 per year* • $695,088 per year *Budget impact estimate: $1,390,176 per year* • $114,688 per year *Budget impact estimate: $229,376 per year* • $89,762 per year *Budget impact*	• Other cheaper therapies required first[¥]

	Gammaplex® (IGIV, Human) Hizentra® (IGSC, Human) Octagam® (IGIV, Human) Panzyga® (IGIV, Human-ifas) Xembify® (IGSC, Human)		*estimate: $179,524 per year* • $92,059 per year *Budget impact estimate: $184,118 per year* • $75,623 per year *Budget impact estimate: $151,246 per year* • $68,234 per year *Budget impact estimate: $136,468 per year* • $102,564 per year *Budget impact estimate: $205,128 per year* • $102,648 per year *Budget impact estimate: $205,296 per year*	
10	Hereditary Angioedema (HAE) Medications Product Based Prior Authorization Categories	• **Hereditary Angdioedema (HAE):** HAE is a very rare and potentially life-threatening genetic condition involving swelling of various parts of	• Cost savings up to $227,458 per member per year by requiring lowest	• There are preventative treatments and

		the body, hands, feet, or face. *8 members used treatments in the last year.*	tiered medications first	treatments for acute attacks

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.
¥Other cheaper therapies required first: There are other treatment options available with or without a prior authorization (PA) which will be required for the member to try and fail before a PA would be issued for this new therapy.
±Not first line: The patient must have failed treatment with other therapy first per FDA approval.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Keytruda Qlex™ and Opdivo Qvantig™

The Drug Utilization Review Board recommends the prior authorization of Keytruda Qlex™ (Pembrolizumab/Berahyaluronidase Alfa-pmph) and Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) with the following criteria:

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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 or carboplatin (if ineligible for cisplatin).

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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 Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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 2014 Stage III-IVA cervical cancer; and
    a. Used in combination with concomitant chemotherapy and radiation.

Pharmacy Agenda Items

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 member does not have lymphocyte-predominant Hodgkin lymphoma; and
        i. Used as a single agent; or
        ii. 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 Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of unresectable or metastatic CRC; and
2. Metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Cutaneous Squamous Cell Carcinoma (cSCC) Diagnosis]:

1. Diagnosis of locally advanced, recurrent or metastatic disease; and
2. Not curable by radiation or surgery.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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 Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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 Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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; and

ii. Tumor is positive for expression of PD-L1 with a CPS ≥1.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Head and Neck Cancer Diagnosis]:

1. Diagnosis of head and neck cancer; and
2. Squamous cell histology; and
3. Used in first-line or recurrent setting for resectable locally advanced disease; and
    a. As neoadjuvant and adjuvant addition to standard care (surgery and adjuvant radiotherapy with or without concomitant chemotherapy); and
    b. Tumor expresses PD-L1 [Combined Positive Score (CPS) ≥1]; and
    c. Request must be for Keytruda®. Keytruda Qlex™ may not be used in the neoadjuvant/adjuvant addition setting; or
4. Used in metastatic or unresectable disease, as first-line or subsequent-line therapy, in combination with chemotherapy; and
    a. Pembrolizumab was not previously used; and
    b. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; or
5. As subsequent therapy as a single agent; and
    a. Disease is PD-L1 positive recurrent or metastatic disease; or
    b. Disease is tumor-mutational burden-high (TMB-H) tumors (≥10 mut/Mb); or
    c. Disease has progressed on or after prior platinum therapy.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of relapsed or progressive HCC; and
2. Member must have been previously treated with sorafenib; and
3. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)].

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Melanoma Diagnosis]:

1. Member meets 1 of the following:
    a. Adjuvant treatment of adult and pediatric members 12 years of age or older with stage 2B, 2C, or 3 melanoma following complete resection; or
    b. Diagnosis of unresectable or metastatic melanoma in adults; and
2. Used as a single agent; and

3. Member meets 1 of the following:
    a. Used as first-line therapy; or
    b. Used as second-line therapy or subsequent therapy for disease progression if not previously used; and
4. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
5. For adjuvant treatment of melanoma, approvals will be for a maximum duration of 1 year.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Merkel Cell Carcinoma (MCC) Diagnosis]:

1. Diagnosis of recurrent, locally advanced, or metastatic MCC; and
2. No history of prior systemic chemotherapy; and
3. Used as a single agent; and
4. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
5. Member must be 12 years of age or older; and
6. Member must weigh ≥40kg.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Metastatic Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of metastatic NSCLC; and
2. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
3. Tumor proportion scores for programmed death ligand 1 (PD-L1) expression as follows:
    a. As a single agent, first-line: ≥1%; or
    b. First-line in combination: No expression required; or
    c. As a single agent, second-line: ≥1%; and
4. Member meets 1 of the following:

a. Previously untreated, metastatic squamous NSCLC in combination with carboplatin and either paclitaxel or nab-paclitaxel; or
b. Previously untreated, metastatic non-squamous NSCLC in combination with pemetrexed and carboplatin; or
c. New diagnosis as first-line therapy (member has not received chemotherapy to treat disease) if:
    i. Tumor does not express sensitizing epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) translocations; or
d. Used as a single agent for disease progression on or after platinum-containing chemotherapy (i.e., cisplatin, carboplatin):
    i. Members with EGFR-mutation-positive tumors should have disease progression on FDA-approved therapy for these aberrations prior to receiving pembrolizumab. *This does not apply if tumors do not have these mutations* (*examples of drugs for EGFR-mutation-positive tumors: osimertinib, erlotinib, afatinib, or gefitinib);* and
    ii. Members with ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving pembrolizumab. *This does not apply if tumors do not have these mutations (examples of drugs for ALK-mutation-positive tumors: crizotinib, ceritinib, or alectinib).*

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Solid Tumor (Tissue/Site-Agnostic) Diagnosis]:

1. Member has not previously failed other programmed death 1 (PD-1) inhibitors [i.e., Opdivo® (nivolumab)]; and
2. MSI-H or dMMR solid tumors that have progressed following prior treatment with no satisfactory alternative treatment options; and
3. Member must be 12 years of age or older and weigh ≥40kg.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Nonmetastatic Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of stage 3 NSCLC; and
    a. Ineligible for surgery or definitive chemoradiation; and
    b. Tumor proportion scores for PD-L1 expression ≥1%; and
    c. Member has not previously failed other PD-1 inhibitors [e.g., Opdivo (nivolumab)]; or
2. Diagnosis of stage 1B (T2a ≥4cm), stage 2, or stage 3A NSCLC; and

   a. Used as adjuvant treatment following resection and platinum-based chemotherapy; or
3. Diagnosis of resectable (tumors ≥4cm or node positive) NSCLC; and
   a. Used as neoadjuvant treatment in combination with platinum-containing chemotherapy; and
   b. Continued as a single agent as adjuvant treatment after surgery.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Bladder Cancer Diagnosis]:

1. For non-muscle invasive bladder cancer (NMIBC):
   a. Diagnosis of high-risk NMIBC; and
   b. Member must have failed therapy with Bacillus Calmette-Guerin (BCG)-therapy; and
   c. Member must be ineligible for or has elected not to undergo cystectomy; or
2. For muscle invasive bladder cancer (MIBC):
   a. Used as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment; and
   b. Used in combination with enfortumab vedotin; and
   c. Member is ineligible for cisplatin-containing chemotherapy.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:

1. Diagnosis of new or recurrent stage 4 clear-cell RCC; and
   a. Member has not received previous systemic therapy for advanced disease; and
   b. Must be used in combination with axitinib or lenvatinib; and
   c. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; or
2. Diagnosis of RCC at intermediate-high or high risk of recurrence following nephrectomy or following nephrectomy and resection of metastatic lesions.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Small Cell Lung Cancer (SCLC) Diagnosis]:

1. Diagnosis of metastatic SCLC; and
2. Progressed on or following a platinum-based regimen and at least 1 other regimen; and
3. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)].

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) Approval Criteria [Tumor Mutational Burden-High (TMB-H) Solid Tumors Diagnosis]:

1. Diagnosis of unresectable or metastatic TMB-H [≥10 mutations/megabase (mut/Mb)] solid tumors; and
2. Used following disease progression after prior treatment; and
3. No satisfactory alternative treatment options; and
4. Member must be 12 years of age or older and weigh ≥40kg.

Keytruda Qlex™ (Pembrolizumab/ Berahyaluronidase Alfa-pmph) 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 <60mL/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)].

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of unresectable or metastatic CRC; and
2. Tumor is microsatellite-instability high (MSI-H), mismatch repair deficient (dMMR), or has polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype [e.g., tumor mutational burden (TMB) >50mut/Mb]; and
3. Used as a single agent; and

4. Member must be 12 years of age or older; and
    a. Member must weigh ≥30kg; and
5. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) Approval Criteria [Cutaneous Melanoma Diagnosis]:

1. Diagnosis of stage 2B, 2C, 3, or 4 melanoma following complete resection; and
    a. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; and
    b. Used as a single agent; and
    c. Maximum approval duration of 1 year; or
2. Diagnosis of stage 3 disease with clinically positive nodes; and
    a. Used as neoadjuvant therapy; and
    b. Used as a single agent; and
    c. Adjuvant nivolumab may be continued after therapeutic lymph node dissection (TLND) for 11 cycles; or
3. Diagnosis of unresectable or metastatic melanoma; and
    a. Used as a single agent:
        i. As first-line therapy for untreated melanoma; or
        ii. As second-line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy; and
        iii. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; and
4. Member must be 12 years of age or older; and
    a. Member must weigh ≥30kg; and
5. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) 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; and
    c. Tumor is positive for expression of programmed death ligand 1 (PD-L1) with a combined positive score (CPS) ≥1; or
2. Diagnosis of esophageal or GEJ cancer; and
    a. Used in 1 of the following settings:
        i. Member has received preoperative chemoradiation; and

1. Member underwent R0 (complete) resection and has residual disease; and
2. As a single agent; or

ii. As induction therapy in members who are medically fit and planned for esophagectomy; and

1. Squamous cell histology; and
2. Tumor is positive for expression of PD-L1 with a CPS ≥1 or tumor is microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR); and
3. Used in combination with fluoropyrimidine- and platinum-based chemotherapy; 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; and
         3. Tumor is positive for expression of PD-L1 with a CPS ≥1; or
      ii. Used in the second-line or greater setting; and
         1. As a single agent; and
         2. Squamous cell pathology; and
4. Member must be 18 years of age or older; and
5. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) Approval Criteria [Gastric Cancer Diagnosis]:

1. Diagnosis of locally advanced, recurrent, or metastatic human epidermal receptor 2 (HER2) negative disease; and
2. Tumor is positive for expression of programmed death ligand 1 (PD-L1) with a combined positive score (CPS) ≥1
3. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy; and
4. Member must be 18 years of age or older; and
5. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) Approval Criteria [Head and Neck Cancer Diagnosis]:

1. Diagnosis of recurrent or metastatic head and neck cancer; and
2. Squamous cell histology; and

3. Member has received prior platinum-containing regimen (i.e., cisplatin, carboplatin); and
4. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; and
5. Member must be 18 years of age or older; and
6. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of HCC; and
2. Member must have unresectable disease and is not a transplant candidate, metastatic disease, or extensive liver tumor burden; and
3. Must meet 1 of the following:
    a. Used as first-line systemic therapy if no previous anti-CTLA-4 combination therapy; or
    b. Used as subsequent therapy, as a single agent, if not previously treated with another checkpoint inhibitor as subsequent therapy; and
4. Member must be 18 years of age or older; and
5. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) 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. No epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations; or
3. For first-line therapy for resectable disease (>4cm 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 ≥4cm 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

6. Member must be 18 years of age or older; and
7. Must not be used in combination with ipilimumab.

Opdivo® (Nivolumab) and Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:

1. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; and
2. Used in 1 of the following settings:
   a. For nivolumab monotherapy:
      i. Diagnosis of relapsed or surgically unresectable stage 4 disease; and
      ii. Failed prior therapy with 1 of the following medications:
         1. Sunitinib; or
         2. Sorafenib; or
         3. Pazopanib; or
         4. Axitinib; or
   b. For nivolumab use in combination with cabozantinib:
      i. Diagnosis of relapsed or surgically unresectable stage 4 disease in the initial treatment of members with advanced RCC; and
      ii. Nivolumab, when used in combination with cabozantinib for RCC, will be approved for a maximum duration of 2 years; and
3. Member must be 18 years of age or older; and
4. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) 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; and
3. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)]; and

4. Member must be 18 years of age or older; and
5. Must not be used in combination with ipilimumab.

Opdivo Qvantig™ (Nivolumab/Hyaluronidase-nvhy) 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; and
   c. Followed by maintenance treatment with nivolumab for a maximum duration of 24 months of therapy; and
4. Member must be 18 years of age or older' and
5. Must not be used in combination with ipilimumab.

Recommendation 2: Vote to Prior Authorize Imaavy™

The Drug Utilization Review Board recommends the prior authorization Imaavy™ (Nipocalimab-aahu) with the following criteria:

Imaavy™ (Nipocalimab-aahu) Approval Criteria [Generalized Myasthenia Gravis (gMG) Diagnosis]:

1. An FDA approved diagnosis of gMG; and
2. Member must be 12 years of age or older; and
3. Member must have a positive serologic test for anti-acetylcholine receptor (AChR) antibodies or anti-muscle-specific tyrosine kinase (MuSK) antibodies; and
4. Member must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV; and
5. MG-Activities of Daily Living (MG-ADL) total score ≥6; and
6. Member must be on a stable dose of either an acetylcholinesterase (AChE) inhibitor or immunosuppressive therapies (ISTs) or a patient specific, clinically significant reason why the member cannot use an AChE inhibitor or an IST must be provided; and

7. Imaavy™ must be prescribed by, or in consultation with, a neurologist, or a specialist with expertise in the treatment of gMG; and
8. Member must not be receiving Imaavy in combination with a complement inhibitor or with another neonatal Fc receptor blocker used to treat gMG; and
9. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to the package labeling; and
10. Initial approvals will be for the duration of 6 months, at which time an updated MG-ADL score must be provided. Continued authorization requires improvement in the MG-ADL score from baseline. Subsequent approvals will be for the duration of 1 year.

Recommendation 3: Vote to Prior Wayrilz™

The Drug Utilization Review Board recommends the prior authorization of Wayrilz™ (Rilzabrutinib) with the following criteria:

Wayrilz™ (Rilzabrutinib) Approval Criteria:

1. An FDA approved diagnosis of persistent or chronic immune thrombocytopenia (ITP); and
2. Member must be 18 years of age or older; and
3. Must be prescribed by, or in consultation with, a hematologist or other specialist with expertise in the treatment of ITP; and
4. Previous insufficient response to at least 2 of the following treatments:
    a. Corticosteroids; or
    b. Immunoglobulins; or
    c. Splenectomy; or
    d. Thrombopoietin receptor agonists; or
    e. Fostamatinib; or
    f. Rituximab; and
5. Prescriber must attest that all other causes of thrombocytopenia, including malignancy and liver disease, have been ruled out; and
6. Prescriber must verify liver function tests (LFTs) (e.g., ALT, AST, bilirubin) will be monitored prior to initiation of Wayrilz™ and during treatment as clinically indicated; and
7. Prescriber must verify that the member will be monitored for signs and symptoms of infection while on Wayrilz™; and
8. Member must not be taking any of the following medications concomitantly with Wayrilz™:
    a. Moderate to strong CYP3A inhibitors (e.g., itraconazole, clarithromycin); and

   b. Moderate to strong CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin); and
   c. Proton pump inhibitors; and
9. Female members of reproductive potential must not be pregnant, must have a negative pregnancy test prior to initiation of therapy, and must agree to use effective contraception during therapy and for at least 1 week after the last dose; and
10. Female members must not be breastfeeding during treatment and for at least 1 week after discontinuation of treatment; and
11. A quantity limit of 60 tablets per 30 days will apply.

Recommendation 4: Vote to Prior Authorize Zepbound®

The Drug Utilization Review Board recommends the prior authorization of Zepbound® (Tirzepatide) with the following criteria:

Zepbound® (Tirzepatide) Approval Criteria [Obstructive Sleep Apnea (OSA) Indication Only]:

1. An FDA approved indication of moderate to severe OSA in members with obesity; and
   a. Zepbound® will not be approved for obese members in the absence of OSA; and
2. Member must be 18 years of age or older; and
3. Member must have moderate-to-severe OSA defined as an apnea-hypopnea index (AHI) ≥15 determined by a polysomnography (PSG) or home sleep apnea testing (HSAT) with a technically adequate device (AHI value must be provided); and
4. Member has a body mass index (BMI) ≥30kg/m^2; and
5. Member must not have central or mixed sleep apnea; and
6. Member does not have type 1 diabetes mellitus (T1DM) or type 2 diabetes mellitus (T2DM); and
7. Member has a hemoglobin A1C (HbA1c) <6.5%; and
8. Member will not be using Zepbound® in combination with other tirzepatide-containing products or any other glucagon-like peptide-1 (GLP-1) receptor agonist; and
9. Zepbound® must be used in conjunction with behavioral changes and/or a reduced calorie diet [clinical documentation (e.g., office notes) of ~~member's diet and exercise program~~ this discussion with the member must be included with the request]; and
10. For Zepbound® vials or KwikPen®, a patient-specific, clinically significant reason why the member cannot use the pen formulation must be provided (Zepbound® pens are preferred over the vials and KwikPen®); and

11. Initial approvals will be for the titration period to allow initial and escalation dosing. A separate prior authorization request must be submitted for each dose; and
    a. Approvals will be for ~~4~~ 8 weeks at a time to allow for proper dose escalation; and
    b. An additional ~~4~~ 8 weeks for each dose may be approved for those who experience intolerable adverse effects during dose escalation with proper documentation; and
    c. Members who cannot tolerate dose escalation to at least 5mg after an additional ~~4~~ 8-week approval will not be approved for continuation; and
12. Subsequent approvals for the maintenance dose (5mg to 15mg) will be approved for 1 year if the prescriber documents the following:
    a. Member is tolerating maintenance dosing and adherent to therapy; and
    b. Clinical improvement of OSA (e.g., patient-reported improvement in daytime sleepiness, partner-reported reduction of snoring episodes or pauses in breathing, reduction of AHI events); and
    c. Member has not developed T1DM or T2DM; and
    d. Member is continuing a reduced calorie diet and increased physical activity in conjunction with Zepbound®; and
13. A quantity limit of 4 pens or vials (2mL) per 28 days or 1 KwikPen® (2.4mL) per 28 days will apply; and
14. Zepbound® should be discontinued in members who cannot tolerate at least the 5mg once weekly maintenance dosing.

Recommendation 5: Vote to Prior Authorize Redemplo®

The Drug Utilization Review Board recommends the prior authorization Redemplo® (Plozasiran)with the following criteria:

Redemplo® (Plozasiran) 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. Fasting triglyceride levels ≥880mg/dL; and
    b. One of the following:
        i. Genetic testing identifying biallelic pathogenic variants in the *LPL, GPIHBP1, APOA5, APOC2*, or *LMF1* genes (results of genetic testing must be submitted); or
        ii. Familial chylomicronemia score ≥10; or
        iii. North American familial chylomicronemia syndrome score ≥45; or

iv. History of clinical signs and symptoms associated with FCS (i.e., pancreatitis and/or abdominal pain, eruptive xanthomas, lipemia retinalis, lipemic plasma) and a diagnosis of multifactorial chylomicronemia syndrome (MCS) has been ruled out; and

3. Member must be 18 years of age or older; and
4. Must be prescribed by, or in consultation with, a cardiologist, an endocrinologist, or a specialist with expertise in the treatment of disorders related to severe hypertriglyceridemia; and
5. Prescriber must verify the member is on a low-fat diet of ≤20g of fat per day and will continue the low-fat diet while on treatment with Redemplo®; and
6. Member or caregiver will be trained by a health care professional on the subcutaneous (sub-Q) administration and proper storage of Redemplo®; and
7. 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.

Recommendation 6: Vote to Prior Authorize Polyethylene Glycol 3350 (PEG 3350)/Sodium Sulfate/Sodium Chloride/ Potassium Chloride/Sodium Ascorbate/Ascorbic Acid for Oral Solution

The Drug Utilization Review Board recommends the prior authorization of Polyethylene Glycol 3350 (PEG 3350)/Sodium Sulfate/Sodium Chloride/Potassium Chloride/Sodium Ascorbate/Ascorbic Acid for Oral Solution with the following criteria:

Polyethylene Glycol 3350 (PEG 3350)/Sodium Sulfate/Sodium Chloride/ Potassium Chloride/Sodium Ascorbate/Ascorbic Acid for Oral Solution (Generic MoviPrep®) Approval Criteria:

1. An FDA approved indication for use in cleansing of the colon as a preparation for colonoscopy; and
2. A patient-specific, clinically significant reason, other than convenience, why the member cannot use other bowel preparation medications available without prior authorization must be provided; and

3. If the member requires a low volume product, brand name Suprep® is available without prior authorization. Other medications currently available without a prior authorization include: Gavilyte® and Golytely®.

Recommendation 7: Vote to Prior Authorize Gomekli® Papzimeos™, and Romvimza™ (Vimseltinib)

The Drug Utilization Review Board recommends the prior authorization of Gomekli® (Mirdametinib), Papzimeos™ (Zopapogene Imadenovec-drba), and Romvimza™ (Vimseltinib) with the following criteria:

Gomekli® (Mirdametinib) Approval Criteria [Neurofibromatosis Type 1 (NF1) Diagnosis]:

1. Diagnosis of NF1; and
2. Member must be 2 years of age or older; and
3. Member has symptomatic plexiform neurofibromas not amenable to complete resection; and
4. Member's recent body surface area (BSA) must be provided in order to authorize the appropriate amount of drug required according to package labeling.

Papzimeos™ (Zopapogene Imadenovec-drba) Approval Criteria [Recurrent Respiratory Papillomatosis Diagnosis]:

1. Diagnosis of recurrent respiratory papillomatosis; and
2. Member must be 18 years of age or older; and
3. Initial administration will follow surgical debulking of visible papilloma to maintain minimal residual disease; and
4. Visible papilloma will be removed, if present, prior to the third and fourth administration; and
5. Approvals will be for no more than 4 doses per member per lifetime.

Romvimza™ (Vimseltinib) Approval Criteria [Tenosynovial Giant Cell Tumor (TGCT) Diagnosis]:

1. Diagnosis of TGCT; and
2. Member is 18 years of age or older; and
3. Member is not a candidate for surgical resection.

Recommendation 8: Vote to Prior Authorize Estradiol 0.06% Gel and Lynkuet™

Pharmacy Agenda Items
The Drug Utilization Review Board recommends the prior authorization of Estradiol 0.06% Gel and Lynkuet™ (Elinzanetant) with the following criteria:

Estradiol 0.06% Gel (Generic EstroGel®) Approval Criteria:

1. An FDA approved indication of 1 of the following:
   a. Treatment of moderate to severe vasomotor symptoms due to menopause; or
   b. Treatment of moderate to severe symptoms of vulvar and vaginal atrophy due to menopause; and
2. Member must not have any contraindications for use of estradiol 0.06% gel; and
3. A patient-specific, clinically significant reason why other topical estradiol formulations (e.g., Divigel®) are not appropriate for the member must be provided; and
4. Members older than 65 years of age will generally not be approved without supporting information; and
5. Approvals will be for the duration of 6 months to ensure the need for continued therapy is reassessed periodically and the medication is being used for the shortest duration possible; and
6. Brand name EstroGel® is not a covered product; and
7. A quantity limit of 37.5 grams per 30 days will apply.

Lynkuet® (Elinzanetant) Approval Criteria:

1. An FDA approved indication for the treatment of moderate-to-severe vasomotor symptoms (VMS) due to menopause; and
2. Prescriber must verify the following:
   a. Member will not use strong CYP3A4 inhibitors (e.g., clarithromycin, grapefruit juice, itraconazole, ketoconazole) or moderate/strong CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort) concomitantly with Lynkuet®; and
   b. Liver function tests (LFTs) (e.g., ALT, AST, bilirubin) will be assessed prior to the initiation of Lynkuet®, and member will not start treatment with Lynkuet® if labs are ≥2 times the upper limit of normal; and
   c. Follow-up evaluations of LFTs will be done 3 months after initiation of therapy; and
3. A patient-specific, clinically significant reason why the member cannot use menopausal hormone therapy must be provided; and
4. A patient-specific, clinically significant reason why the member cannot use other guideline supported non-hormonal therapy for VMS (e.g., gabapentin, paroxetine, venlafaxine) must be provided; and
5. A quantity limit of 60 capsules per 30 days will apply.

Pharmacy Agenda Items

Recommendation 9: Vote to Prior Authorize Alyglo™, Asceniv™, Bivigam®, Cuvitru®, Gammaplex®, Hizentra®, Octagam®, Panzyga®, and Xembify®

The Drug Utilization Review Board recommends the prior authorization of Alyglo™ [Immune Globulin (IG)Intravenous (IV),Human-stwk], Asceniv™ (IGIV, Human-slra), Bivigam® (IGIV, Human), Cuvitru® [IG Subcutaneous (SC), Human], Gammaplex® (IGIV, Human), Hizentra® (IGSC, Human), Octagam® (IGIV, Human), Panzyga® (IGIV, Human-ifas), and Xembify®(IGSC, Human) with the following criteria:

Alyglo™ [Immune Globulin (IG) Intravenous (IV), Human-stwk], Asceniv™ (IGIV, Human-slra), Bivigam® (IGIV, Human), Cuvitru® [IG Subcutaneous (SC), Human], Gammaplex® (IGIV, Human), Hizentra® (IGSC, Human), Octagam® (IGIV, Human), Panzyga® (IGIV, Human-ifas) and Xembify® (IGSC, Human) Approval Criteria:

1. Documentation of prior stabilization on the requested product with documented benefit from therapy (i.e., recent office notes) must be submitted with the request; or
2. For Alyglo™ and Asceniv™, a patient-specific clinically significant reason why the member cannot use all other available immunoglobulin therapy products must be provided; or
3. A patient-specific, clinically significant reason why the member cannot use all of the following, which are available without prior authorization, as appropriate for the requested route of administration:
    a. For intravenous (IV) administration:
        i. Gammagard Liquid® (IG infusion, human); and
        ii. Gammagard S/D® (IGIV, human); and
        iii. Gammaked™ (IG injection, human); and
        iv. Gamunex®-C (IG injection, human); and
        v. Privigen® (IGIV, human); and
    b. For subcutaneous (SC) administration:
        i. Cutaquig® (IGSC, human); and
        ii. HyQvia® (IG infusion, human and recombinant human hyaluronidase); and
        iii. Gammagard Liquid® (IG infusion, human); and
        iv. Gammaked™ (IG injection, human); and
        v. Gamunex®-C (IG injection, human); and
4. Member's recent weight (taken within the last 3 months) utilized for dosing calculations (e.g., actual body weight, ideal body weight, adjusted body weight) and intended dosing frequency must be provided on the prior authorization request in order to authorize the appropriate amount of product; and

5. Initial approvals will be for up to 6 months. Subsequent approval will be for the duration of up to 1 year if there is documentation of clinical effectiveness.

The Drug Utilization Review Board recommends establishing a Product Based Prior Authorization categories for Hereditary Angioedema (HAE) Medications to ensure appropriate cost-effective utilization in accordance with current treatment guidelines. The DUR Board recommends the following tier list and criteria to the OHCA Board of Directors based on cost and clinical effectiveness for approval before referral to the Oklahoma Health Care Authority.

Hereditary Angioedema (HAE) Prophylaxis Products			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Orladeyo® (berotralstat)	Cinryze® (C1 esterase inhibitor)	Takhzyro® (lanadelumab-flyo)	Andembry® (garadacimab-gxii)
	Haegarda® (C1 esterase inhibitor)		Dawnzera™ (donidalorsen)

Initial Approval Criteria for All HAE Prophylaxis Products:

1. An FDA approved diagnosis of hereditary angioedema (HAE); and
2. Requested medication must be used for prophylaxis of HAE; and
3. Member must not currently be taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy; and
4. Based on HAE attack frequency, attack severity, comorbid conditions, and member's access to emergent treatment, the prescriber has determined long-term prophylaxis is appropriate for the member; or
5. Approval consideration will be given if the member has a recent hospitalization for a severe episode of angioedema; and
6. Prescriber must verify the member or caregiver has been trained by a health care professional on proper storage and administration of the prescribed product; and
7. For products requiring weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
8. Quantity limits will apply based on FDA-approved dosing.

HAE Prophylaxis Products Tier-2 Approval Criteria:

1. Initial Approval Criteria for All HAE Prophylaxis Products must be met; and
2. A patient specific, clinically significant reason why the member cannot use all Tier-1 products must be provided.

HAE Prophylaxis Products Tier-3 Approval Criteria:

1. Initial Approval Criteria for All HAE Prophylaxis Products must be met; and
2. A patient specific, clinically significant reason why the member cannot use all Tier-1 and Tier-2 products must be provided.

HAE Prophylaxis Products Special Prior Authorization (PA) Approval Criteria:

1. Initial Approval Criteria for All HAE Prophylaxis Products must be met; and
2. A patient specific, clinically significant reason why the member cannot use all other available lower-tiered HAE prophylaxis products must be provided.

Hereditary Angioedema (HAE) Treatment Products		
Tier-1	**Tier-2**	**Special PA**
Firazyr® (icatibant)	Berinert® (C1 esterase inhibitor)	Ekterly® (sebetralstat)
	Sajazir™ (icatibant)	Kalbitor® (ecallantide)
		Ruconest® (C1 esterase inhibitor)

Initial Approval Criteria for All HAE Treatment Products:

1. An FDA approved diagnosis of hereditary angioedema (HAE); and
2. Requested medication must be used for the treatment of acute attacks of HAE; and
3. Prior authorization requests for products administered via injection must indicate if the product is to be self-administered or to be administered by a health care provider; and
    a. For products approved for self-administration per FDA package labeling, the prescriber must verify the member or caregiver has

been trained by a health care professional on proper storage and administration of the prescribed product; or

b. For products not recommended for self-administration by FDA package labeling, the prescriber must verify the product will be administered by a health care provider; and

4. For products requiring weight-based dosing, the member's recent weight must be provided on the prior authorization request.

HAE Treatment Products Tier-2 Approval Criteria:

1. Initial Approval Criteria for All HAE Treatment Products must be met; and
2. A patient specific, clinically significant reason why the member cannot use all Tier-1 products must be provided.

HAE Treatment Products Special Prior Authorization (PA) Approval Criteria:

1. Initial Approval Criteria for All HAE Treatment Products must be met; and
2. A patient specific, clinically significant reason why the member cannot use all other available lower-tiered HAE treatment products must be provided.

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SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 25, 2026
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.

BACKGROUND

Services	Non-Emergency Medical Transportation – Contract Award
Purpose and Scope	The Authority seeks to extend the current contract for NEMT services to ensure safe, reliable, and efficient transportation for SoonerCare Traditional members to medical appointments and other medically necessary services, including accommodation for members with physical and intellectual disabilities. Transportation options may include van service, stretcher service, taxi, volunteer drivers, public transit, and mileage reimbursement, with statewide coverage required, including remote and underserved areas. The contractor will continue to operate an accessible reservation system available by phone, mobile application, and web. This extension is necessary while the Authority finalizes the award of the new NEMT RFP and manages the transition from the existing contract to the newly awarded contract, ensuring uninterrupted transportation services and operational stability for members and providers.
Mandate	N/A
Procurement Method	Request for Proposal- Contract Extension
External Approvals	N/A
Contract Term	Fiscal Year 2026 (Q4): April 1, 2026, through June 30, 2026. Anticipated Optional Renewals: OHCA staff expect to return to the Board to request an additional extension of the current NEMT contract for (Q1) of SFY27 once rates are released to ensure uninterrupted services during the transition to the newly procured contract.

BUDGET

Amount requested for Approval	$ 10,729,016.00 for (Q4) SFY26
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Cost Allocation Plan 66.62% $7,147,670.46 Federal Share Total $3,581,345.54 State Share Total

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for the total not to exceed amount of $10,729,016.00 from the period of April 1, 2026, to June 30, 2026, for an extension of the Non-Emergency Medical Transportation Services.

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SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 25, 2026
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.

BACKGROUND

Services	Health Management Program – Contract Extension
Purpose and Scope	The Authority seeks to extend the current contract, originally awarded under an existing RFP, to continue the Third Generation SoonerCare Health Management Program (HMP). HMP identifies SoonerCare Choice members who need health and care management, applies Medicaid best practices, standardizes processes, and supports primary care providers in delivering patient-centered care for members with complex or chronic conditions. The extension is needed to maintain uninterrupted services while the Authority completes the new Patient-Centered Medical Home (PCMH) Redesign procurement, which will replace both the Health Management Program (HMP) and the Health Access Networks (HAN). Extending the current contract ensures continuity of care, supports provider operations, and maintains compliance with state requirements until the redesigned PCMH model is implemented.
Mandate	Oklahoma Statute 56 O.S. §1011.6 Incorporated into the Oklahoma 1115 Waiver Demonstration
Procurement Method	Request for Proposal- Contract Extension
External Approvals	N/A
Contract Term	Fiscal Year 2027: July 1, 2026, through June 30, 2027. A subsequent extension covering Q1 and Q2 of State Fiscal Year 2028 is expected and will be brought forward for approval in the spring of FY28.

BUDGET

Amount requested for Approval	$11,304,022.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Cost Allocation Plan 66.01% $7,462,068.00 Federal Share Total $3,841,954.00 State Share Total

RECOMMENDATION

The Authority affirms its ability to support the procurement decision made by the CEO based on the proposed budget and available funds. Board approval is requested for a total not to exceed $11,304,022 for the period of July 1, 2026, through June 30, 2027, to continue Telligen Health Management Program services.

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OPERATIONAL METRICS

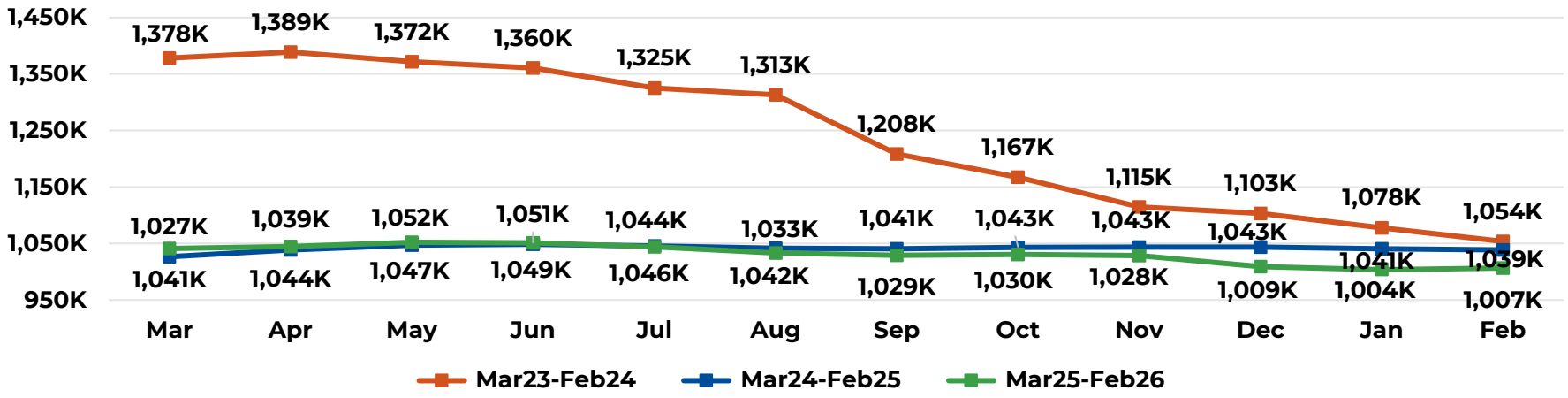
March 2026

OKLAHOMA HEALTH CARE AUTHORITY

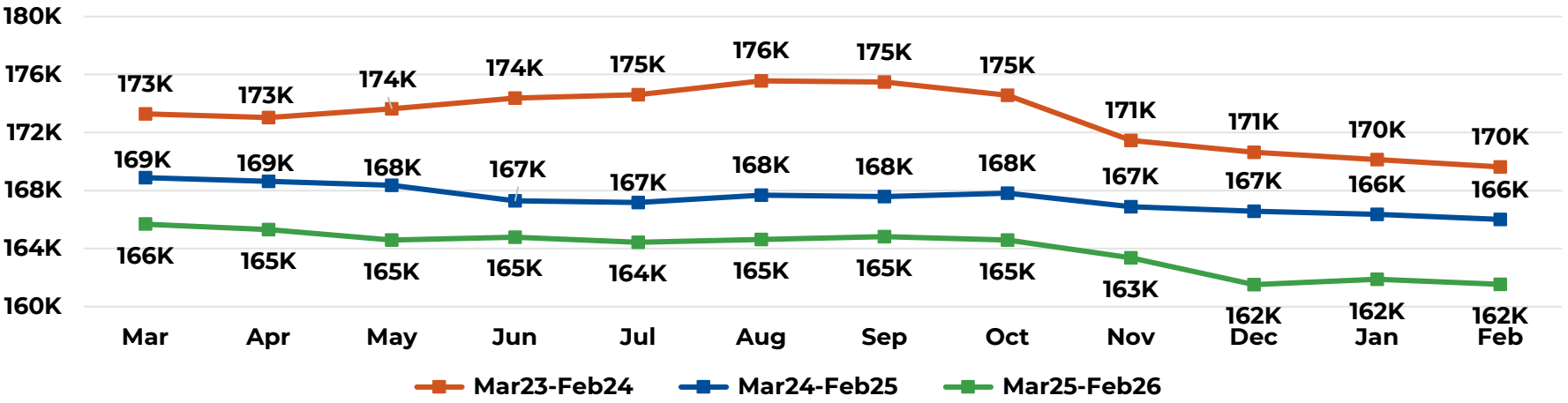
4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

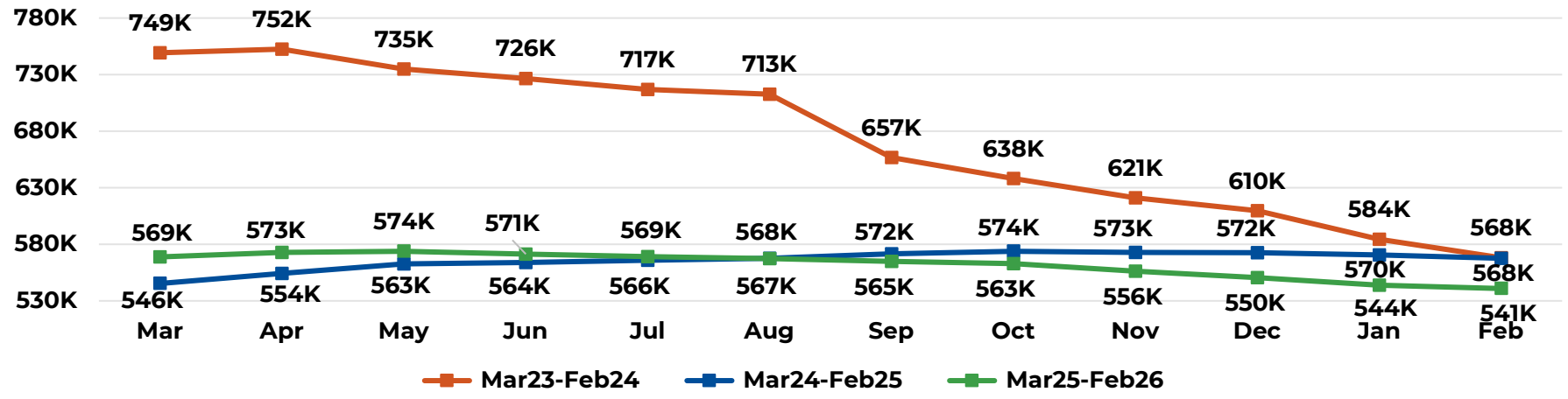


Aged/Blind/Disabled Enrolled Members

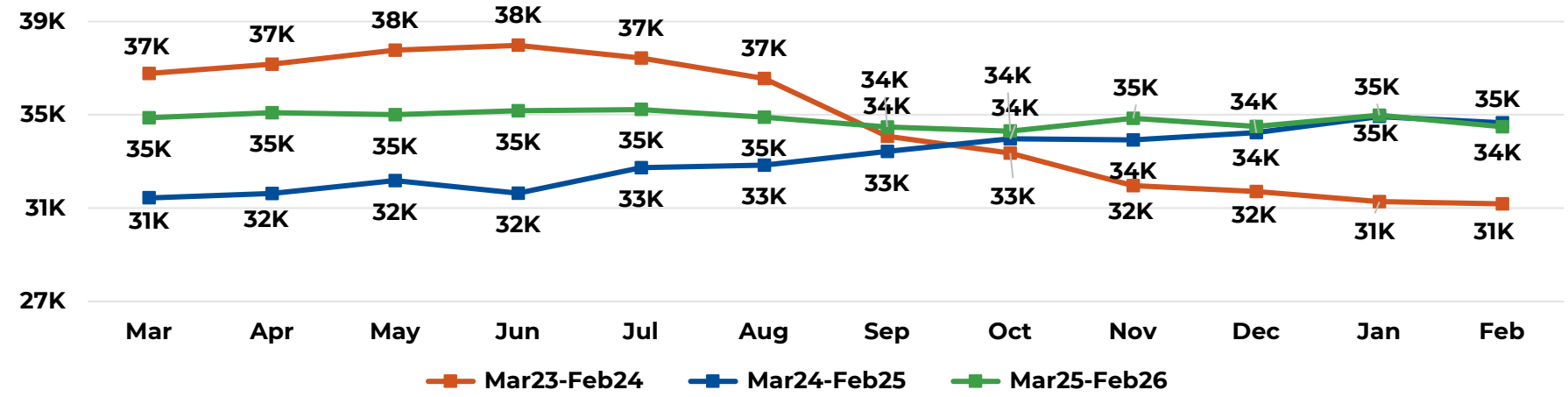


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled Members

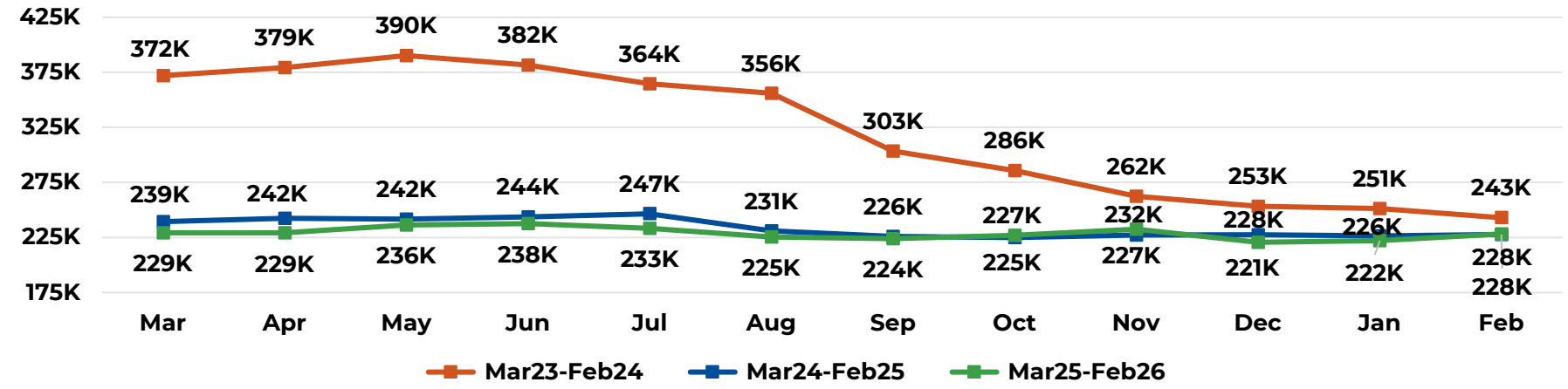


Pregnant (Full Scope) Enrolled Members

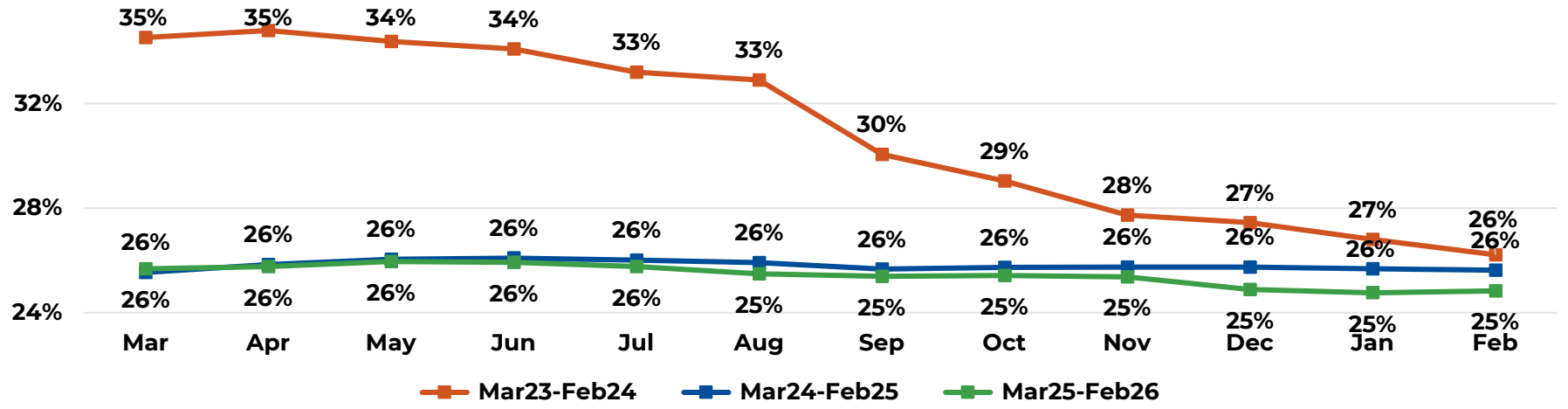


Enrollment & Utilization (Cont.)

Expansion Enrolled Members

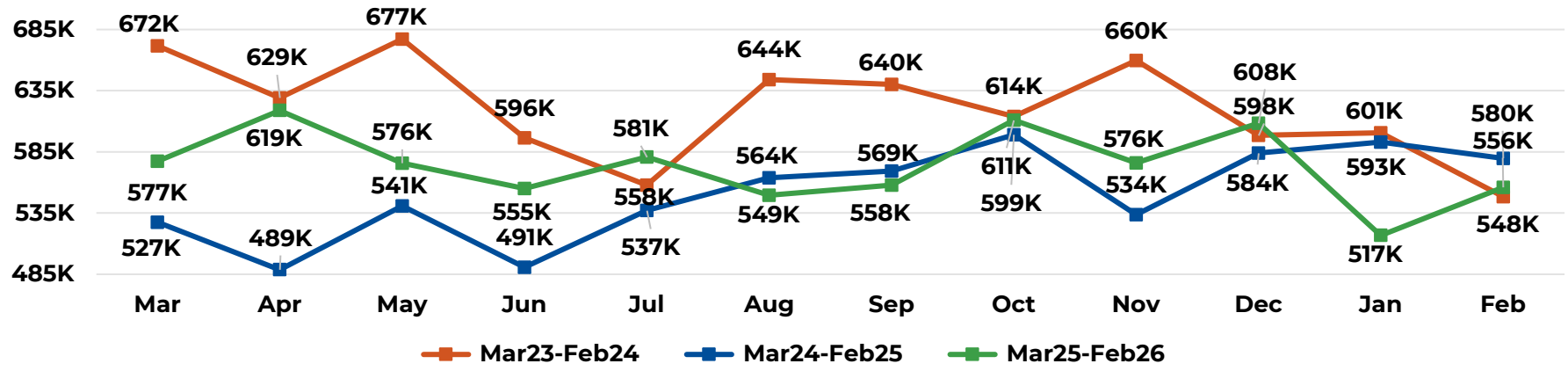


Percent of OK Population Enrolled Members

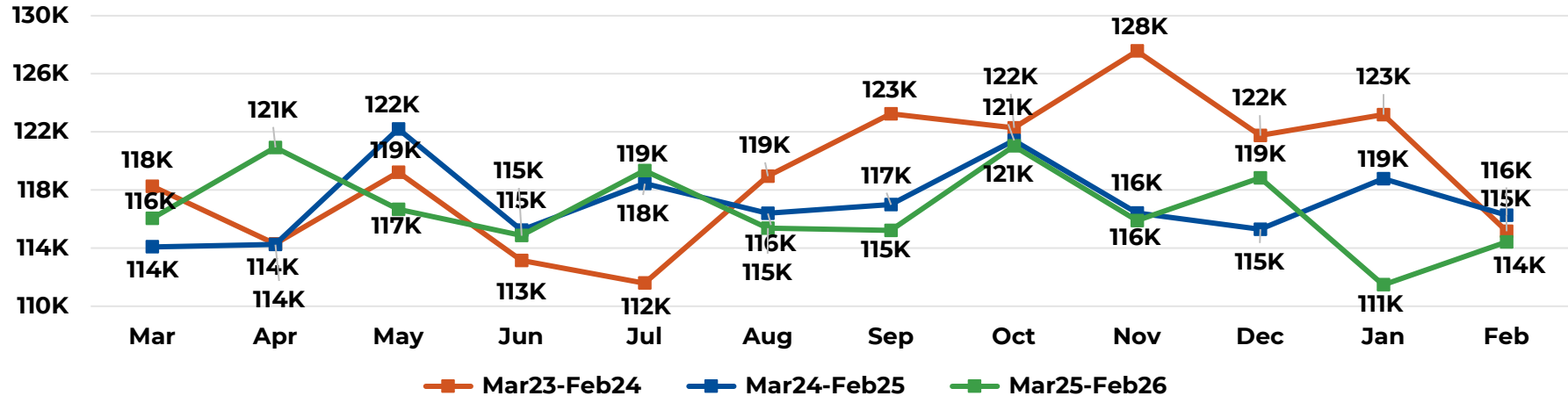


Enrollment & Utilization (Cont.)

Total Members Served

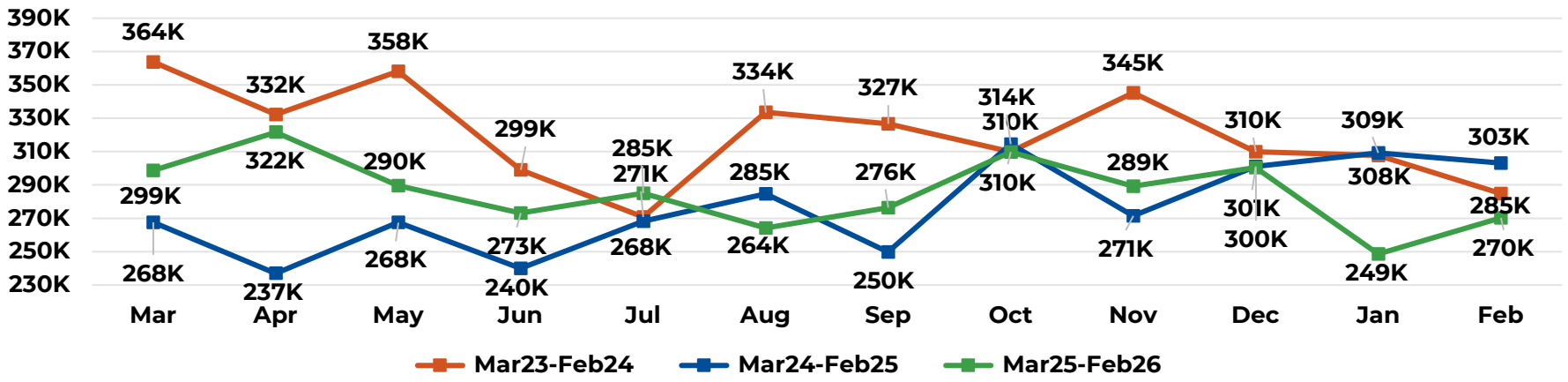


Aged/Blind/Disabled Members Served

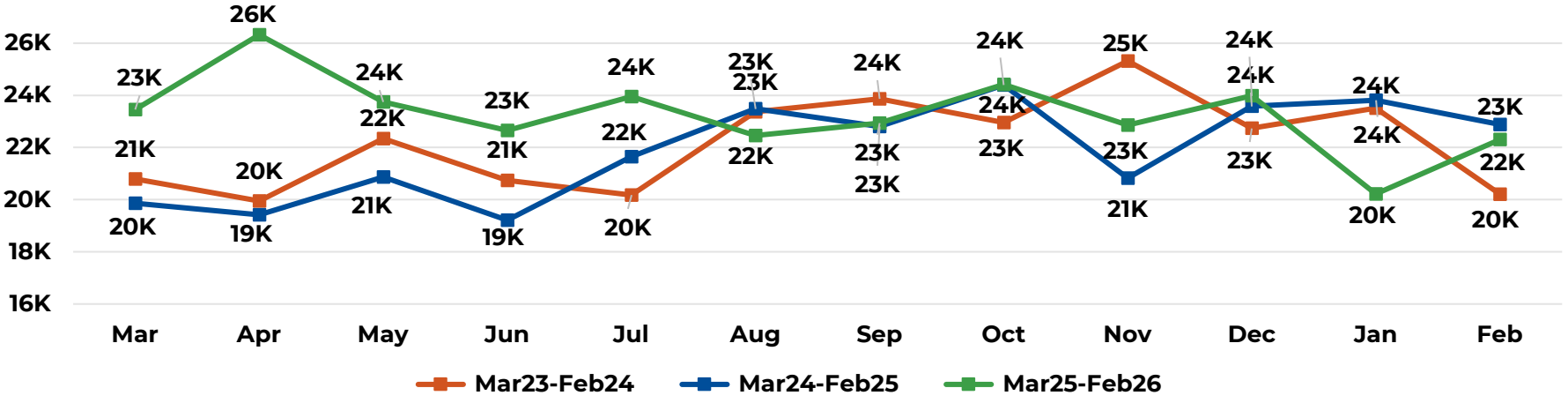


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Members Served

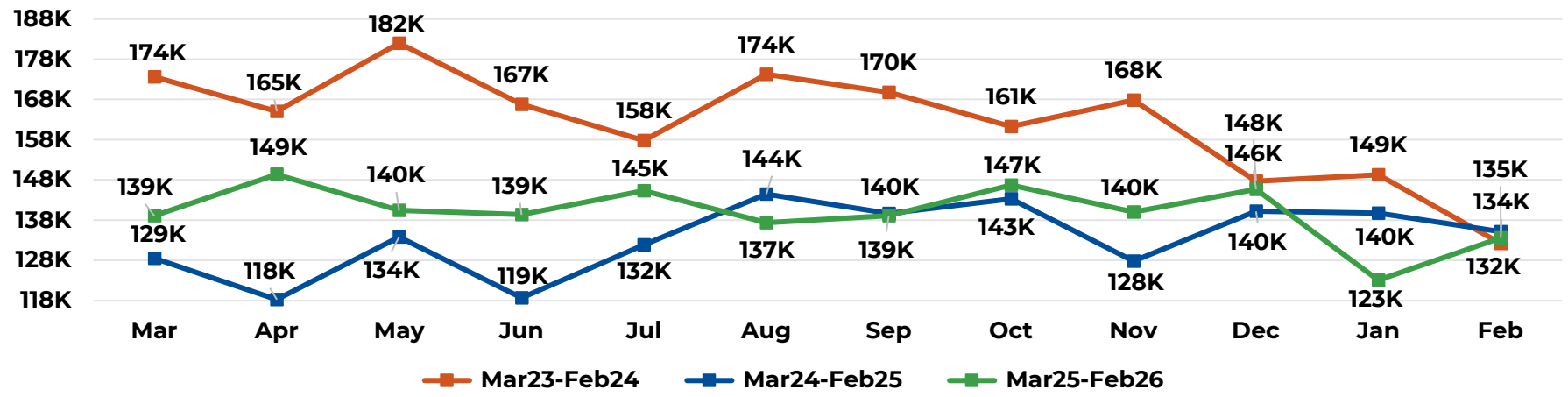


Pregnant (Full Scope) Members Served

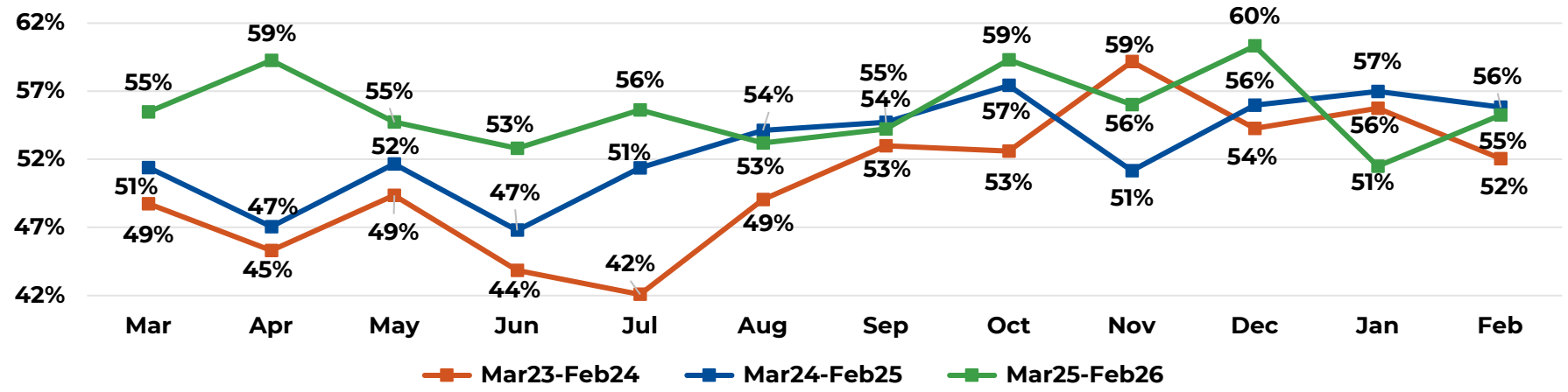


Enrollment & Utilization (Cont.)

Expansion Members Served

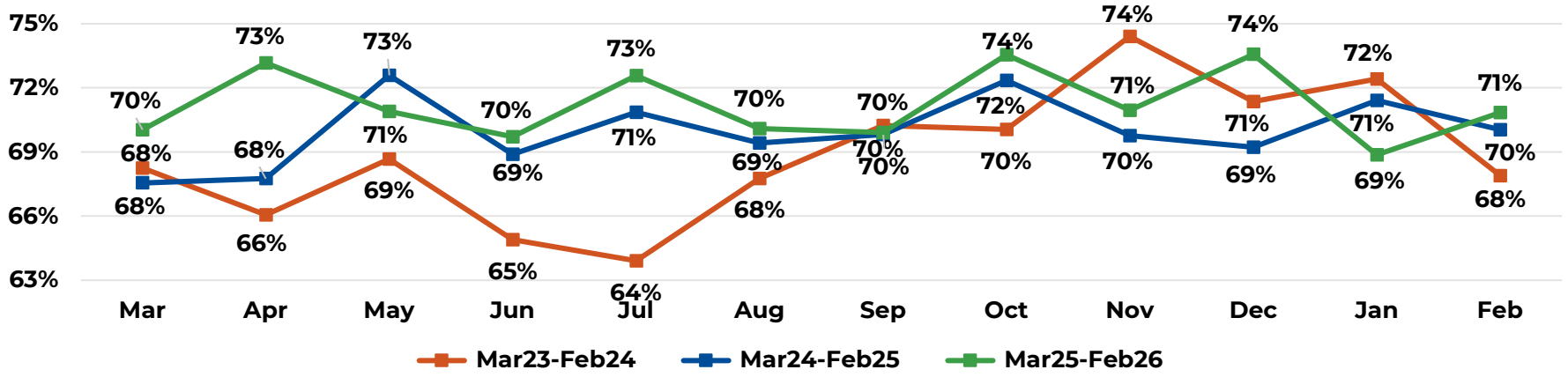


Percent of Total Enrolled Members Served

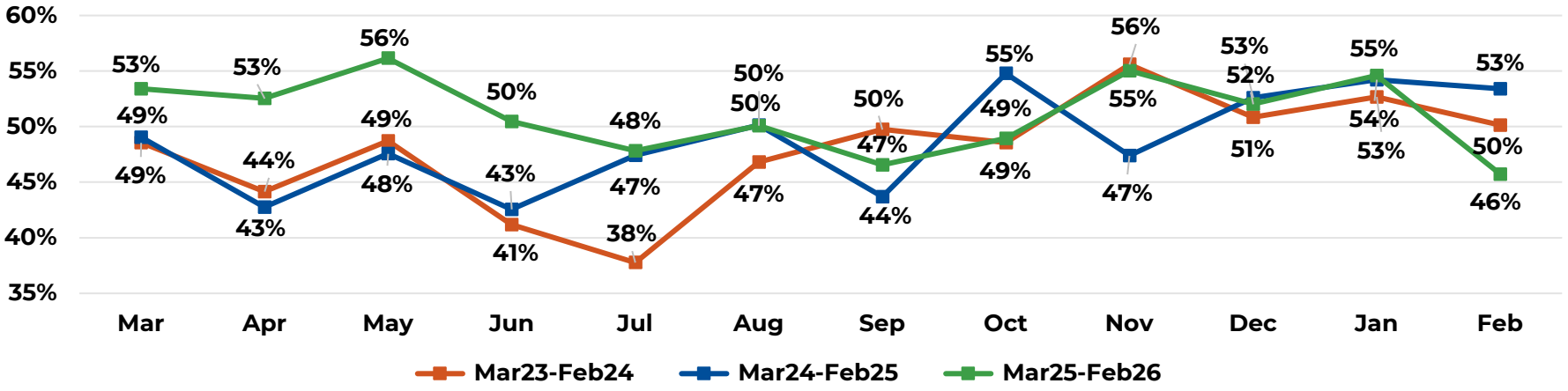


Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Served

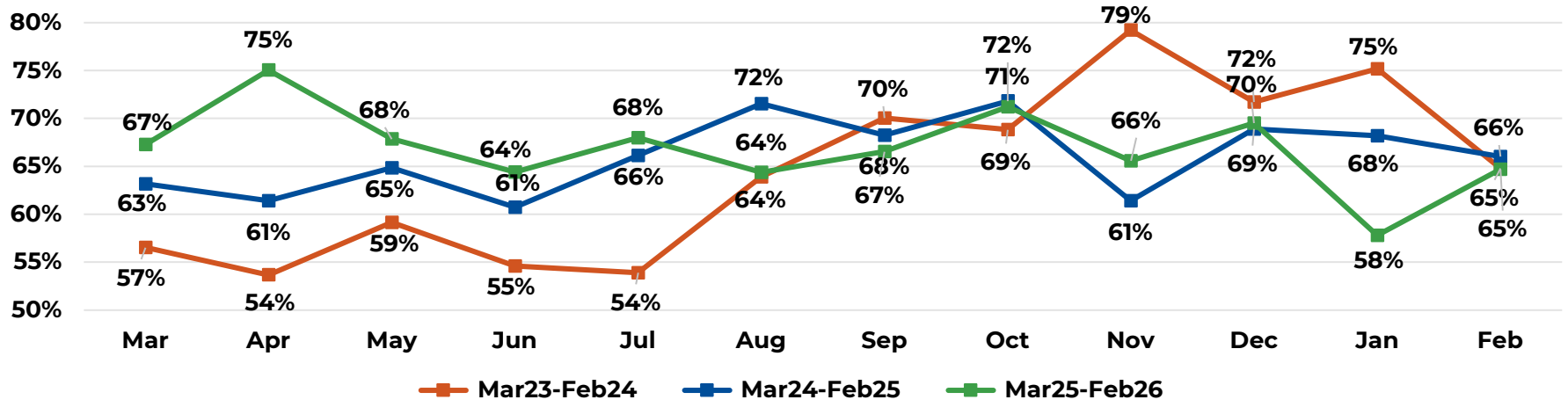


Percent of Children & Parent/Caretaker Enrolled Members Served

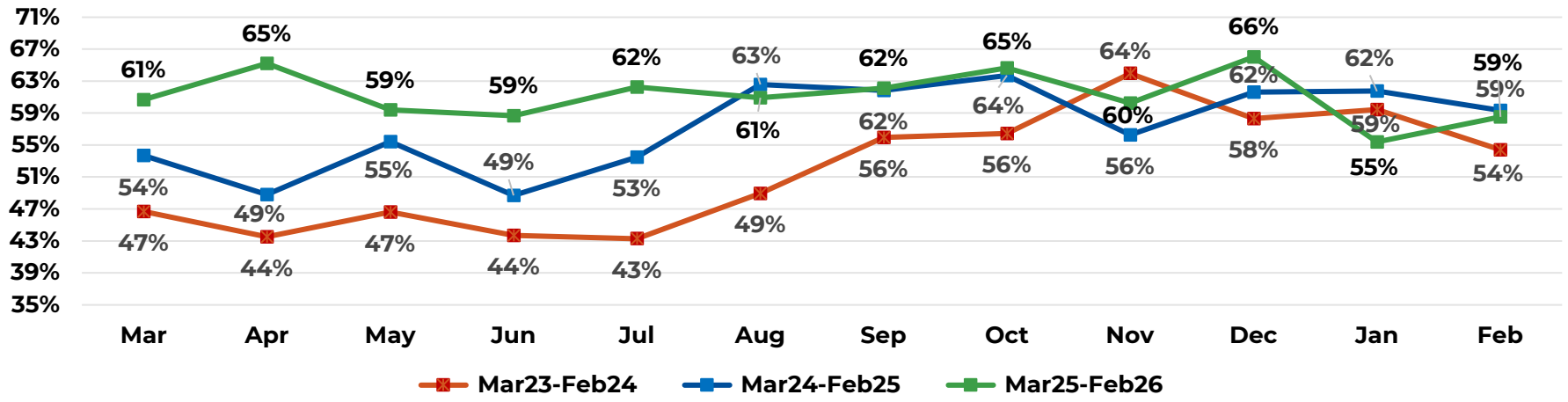


Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Served

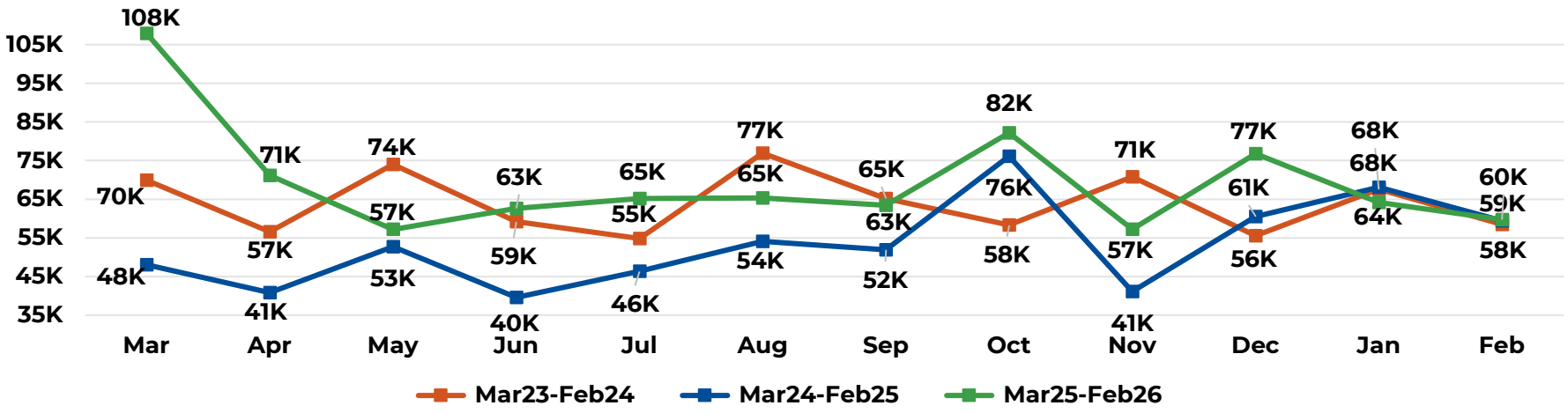


Percent of Expansion Enrolled Members Served

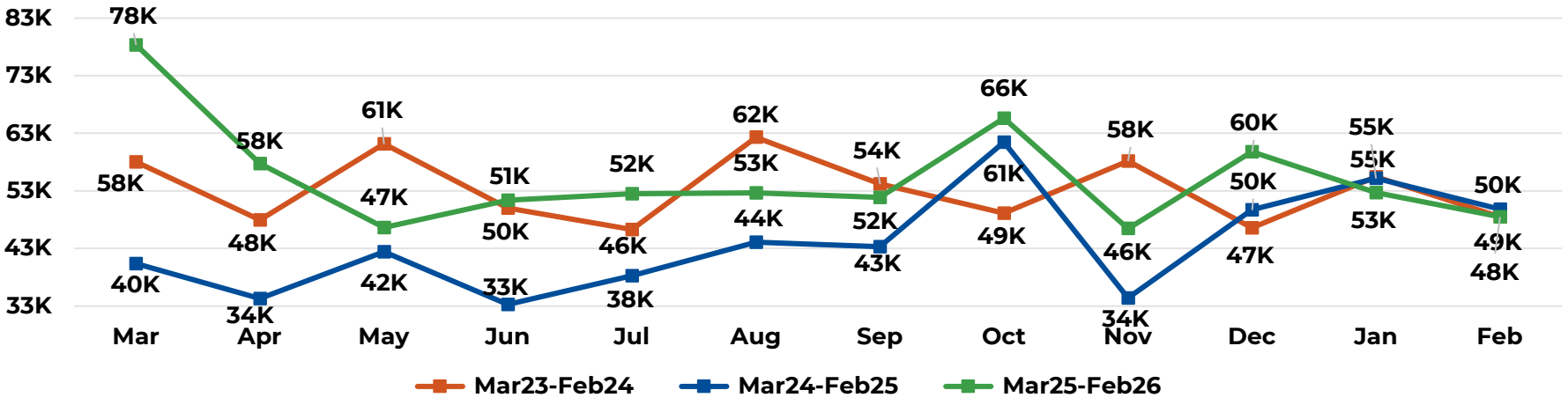


Utilization

Emergency Department - Visits (Claims)

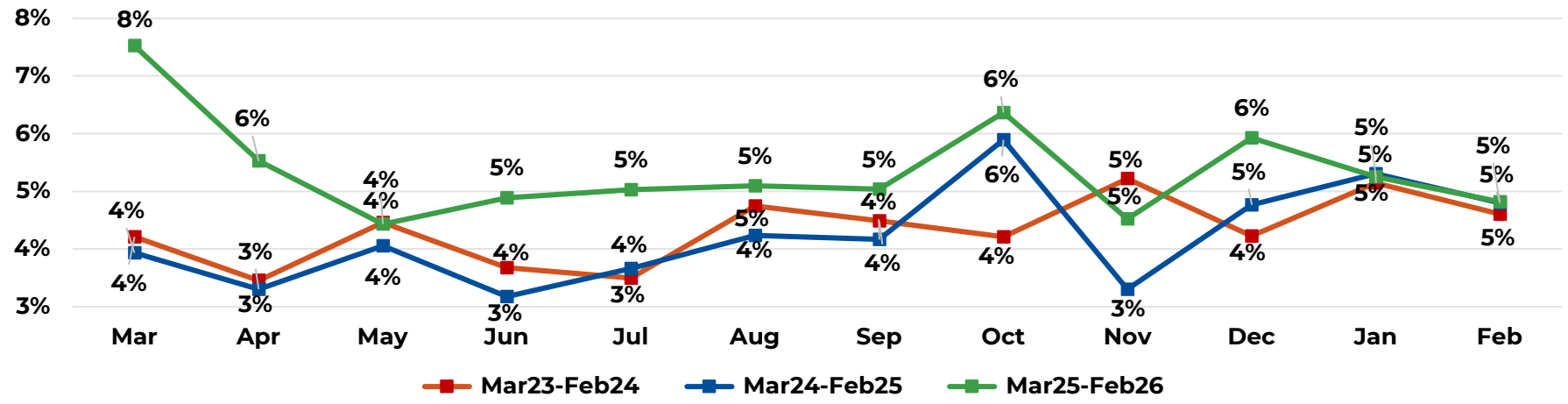


Emergency Department - Members Served



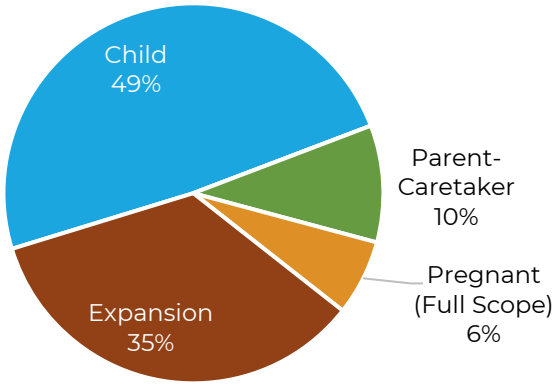
Utilization (Cont.)

Emergecy Department - Percent Total Enrolled Members Served

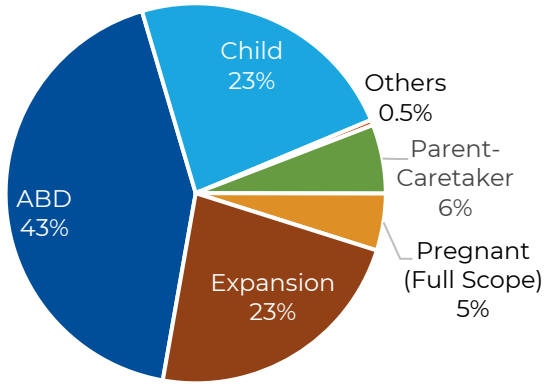


Emergency Department - Members Served By Qualifying Group (Feb2026)

MCE

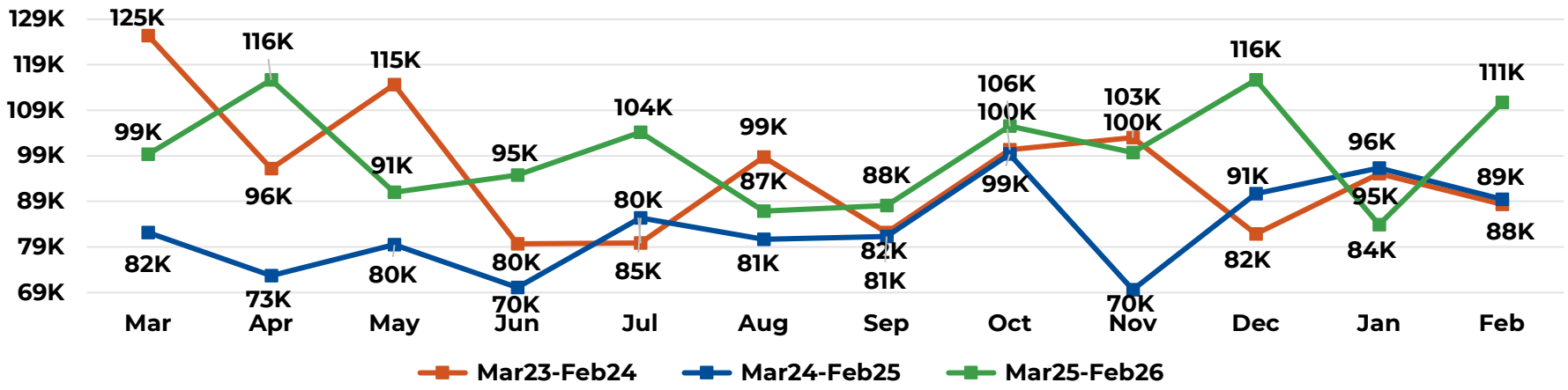


FFS

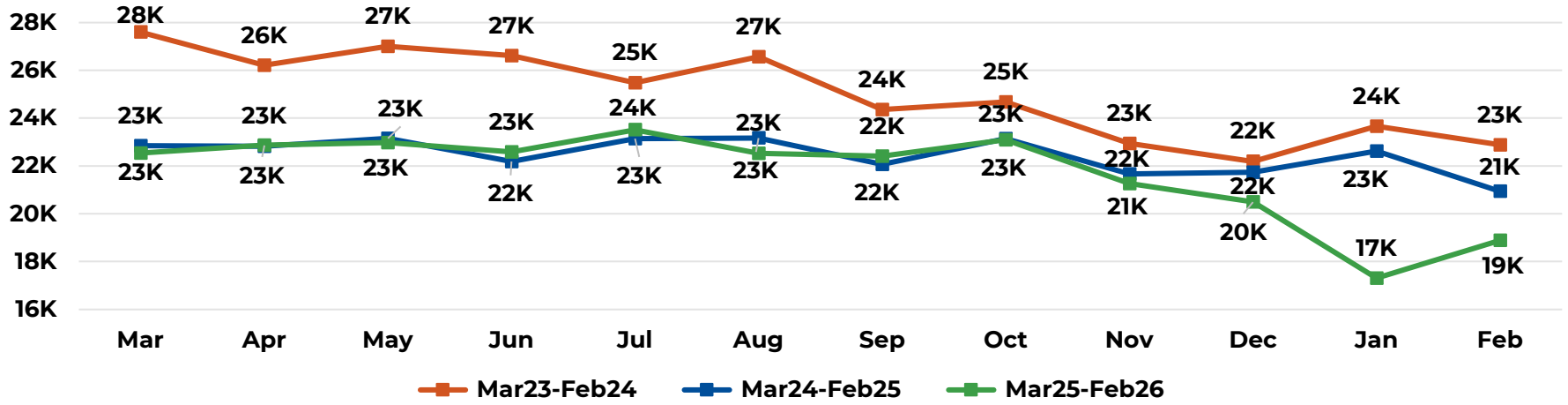


Utilization (Cont.)

Telemedicine - Total Visits (Claims)

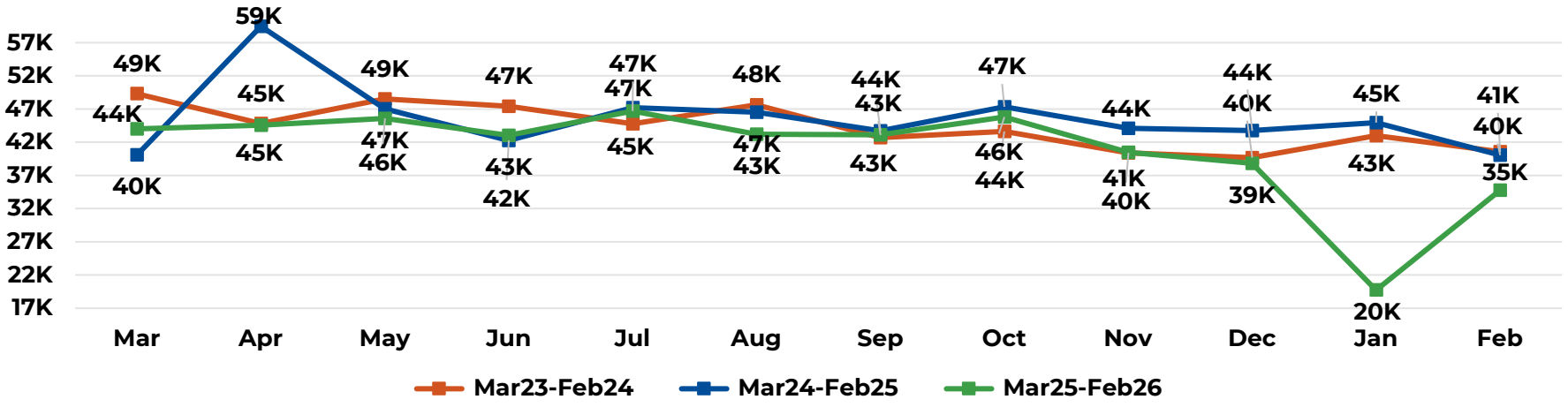


Opioid Claims - Members Served



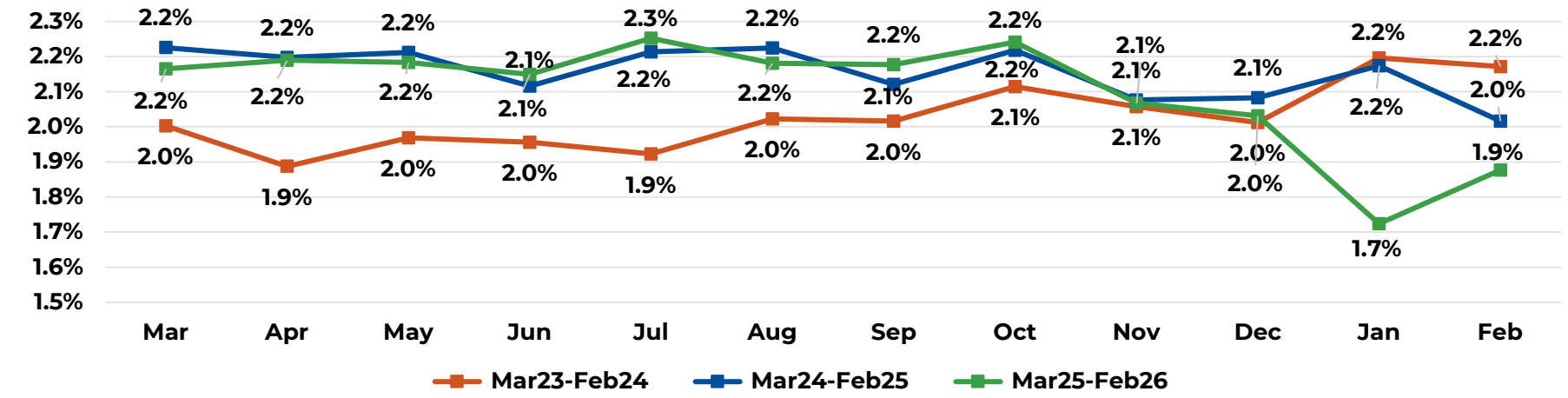
Utilization (Cont.)

Opioid Claims - Total Claims

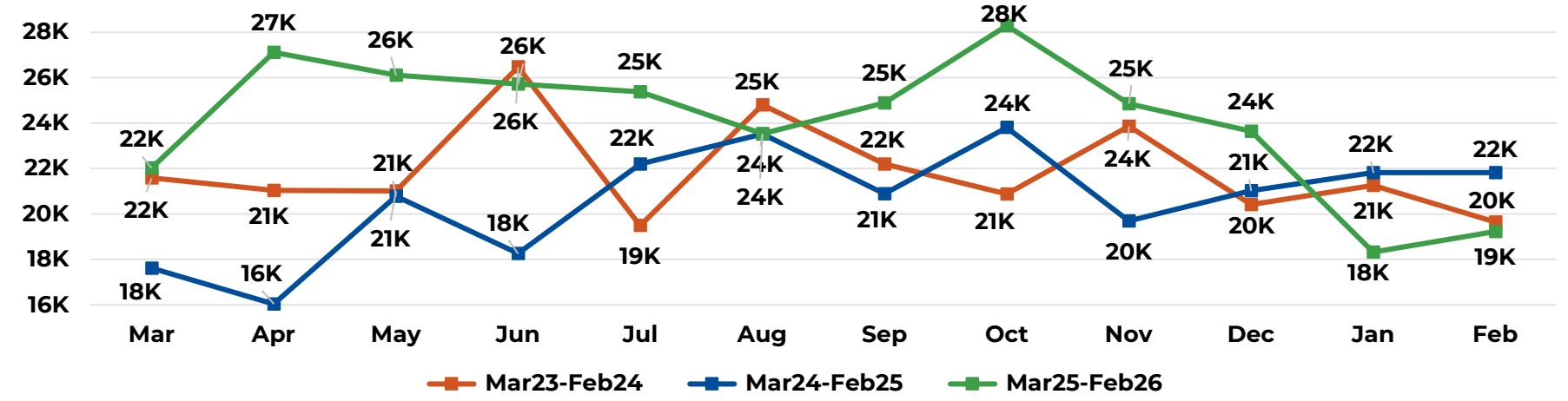


Utilization (Cont.)

Opioid Claims - Percent Total Enrolled With Opioid Claims



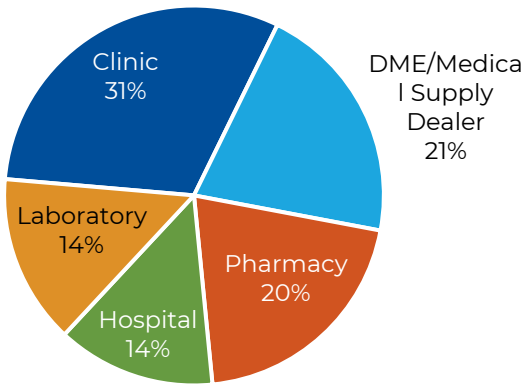
Out of State Services (Non Border County) - Total Members Served



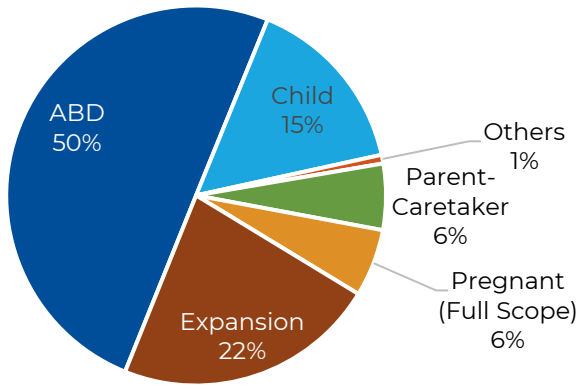
Utilization (Cont.)

Out of State Services (Non Border County) - Total Members Served By Provider Type & Qualifying Group (Feb2026)

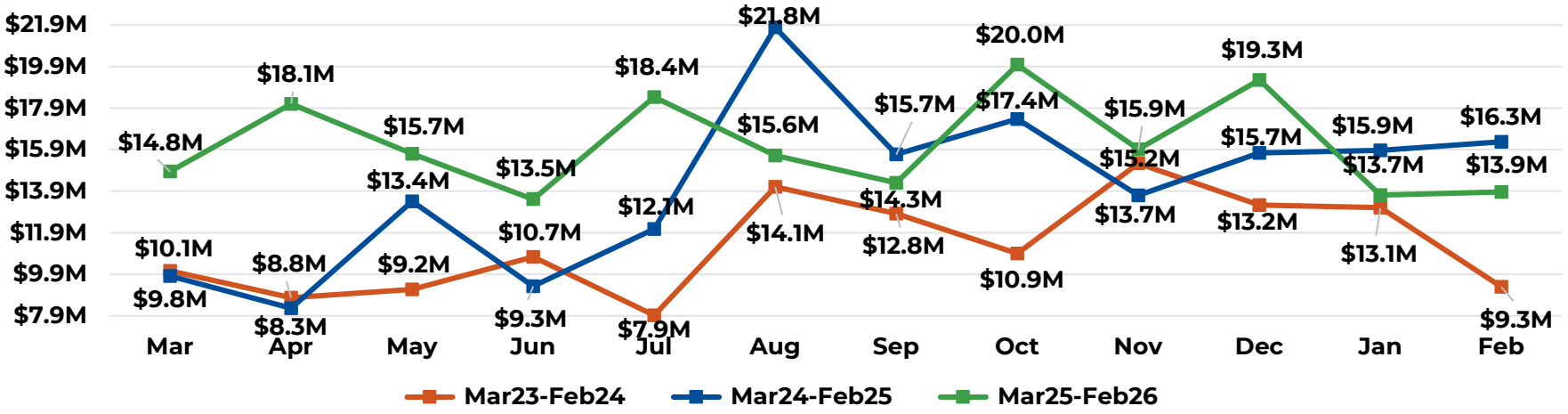
Provider Type (Top 5)



Qualifying Group (All Members)

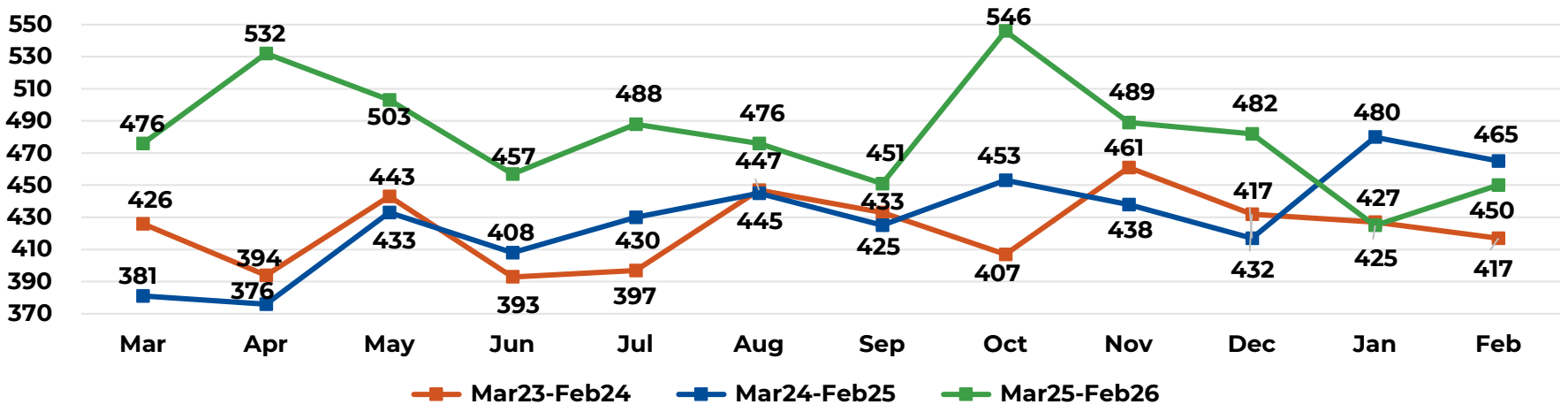


Out of State Services (Non Border County) - Total Expenditures

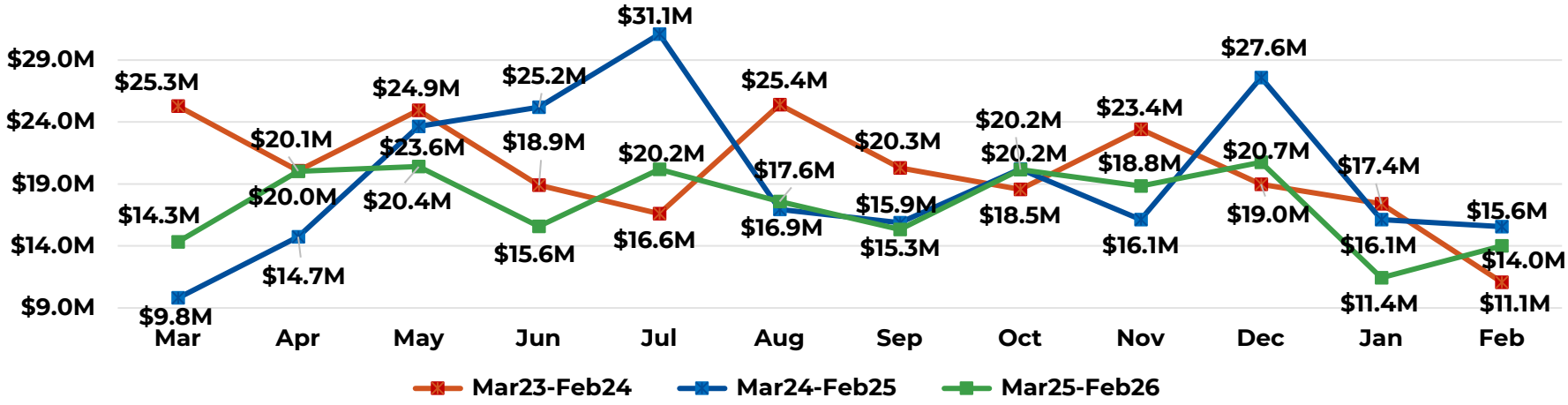


Utilization (Cont.)

Out of State Services (Non Border County) - Total Active Billing Providers

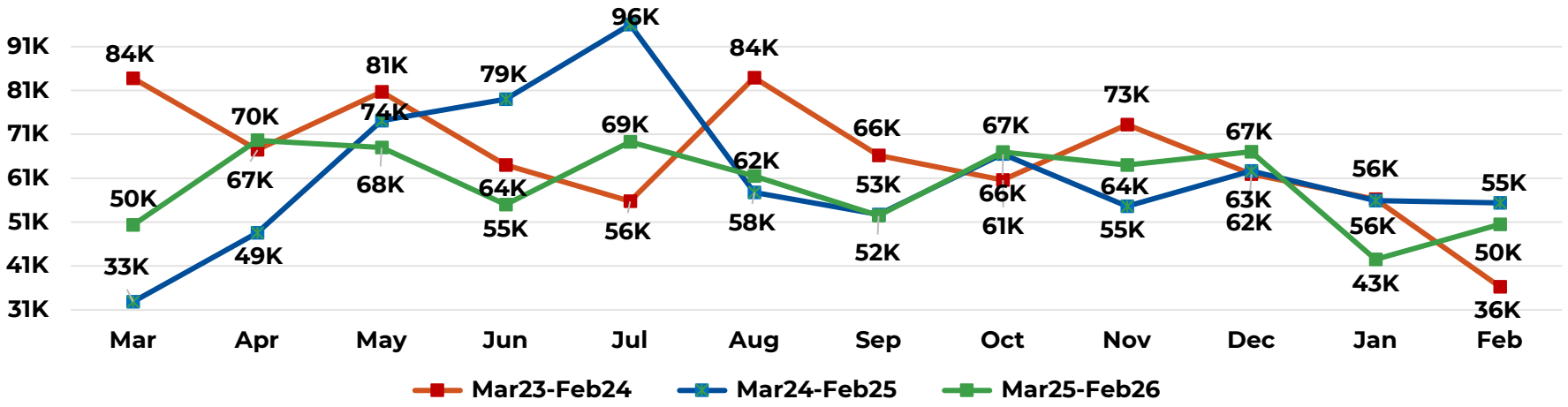


Dental Claims - Expenditures

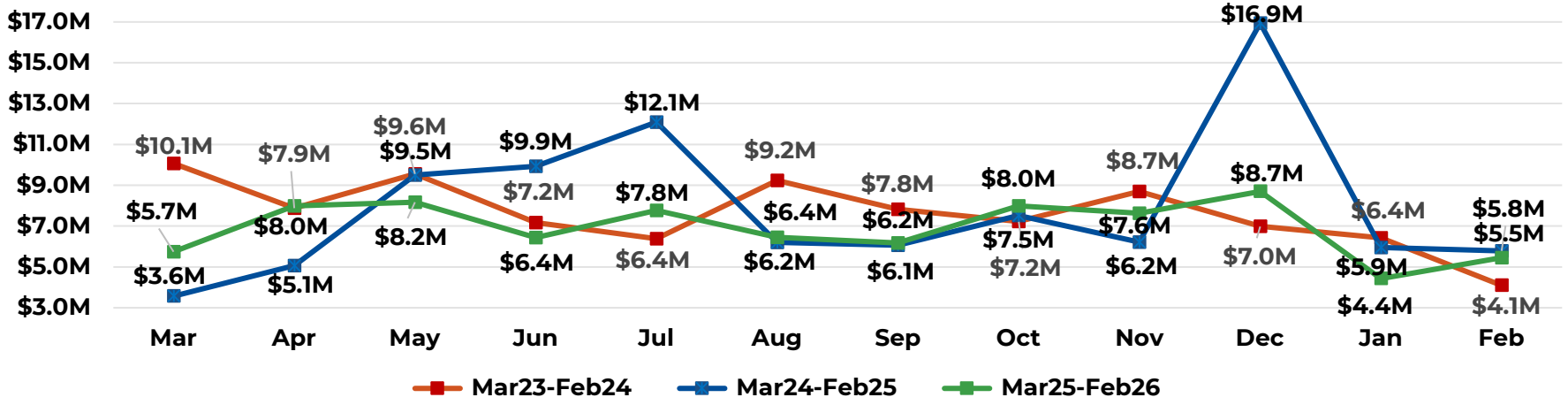


Utilization (Cont.)

Dental Claims - Members Served

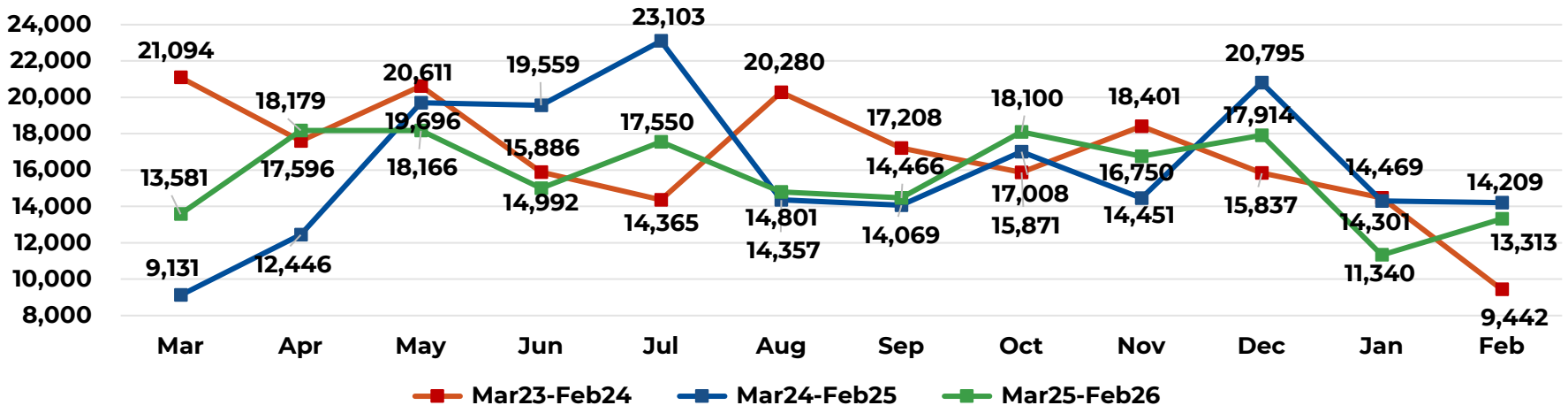


Adult Dental Claims (21 & Over) - Expenditures

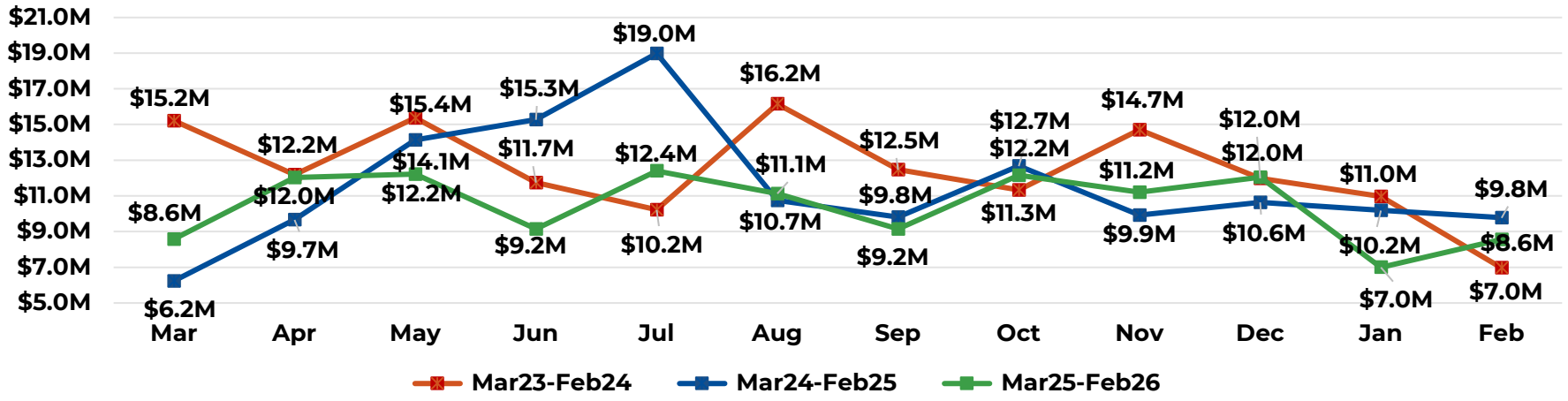


Utilization (Cont.)

Adult Dental Claims (21 & Over) - Members Served

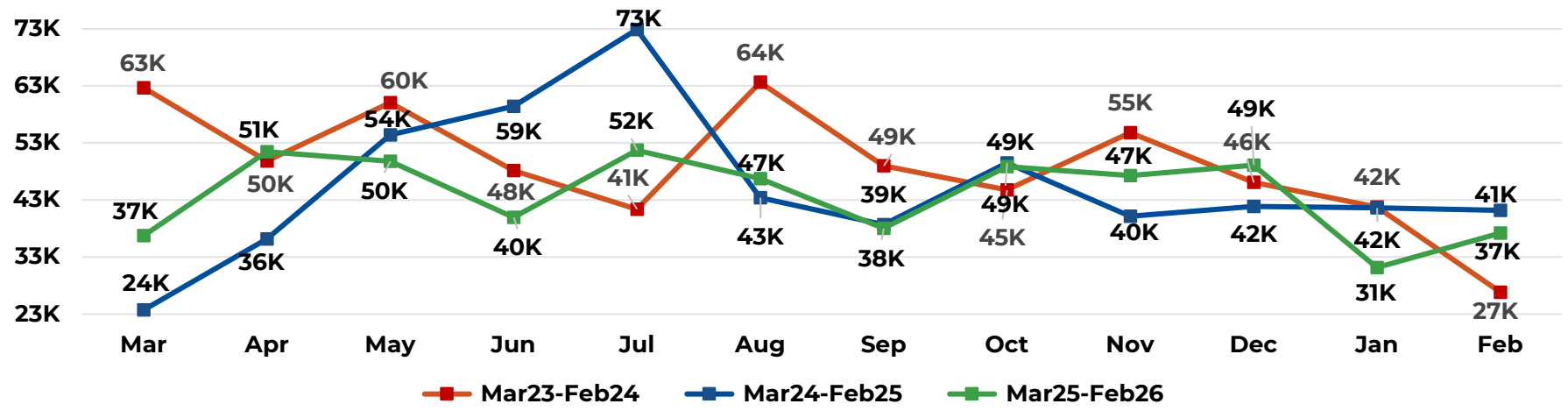


Children Dental Claims (Under 21) - Expenditures



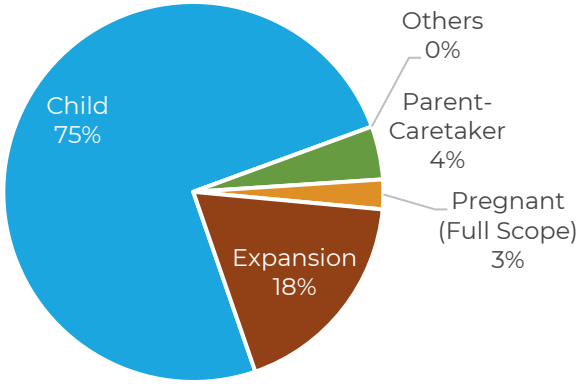
Utilization (Cont.)

Children Dental Claims (Under 21) - Members Served

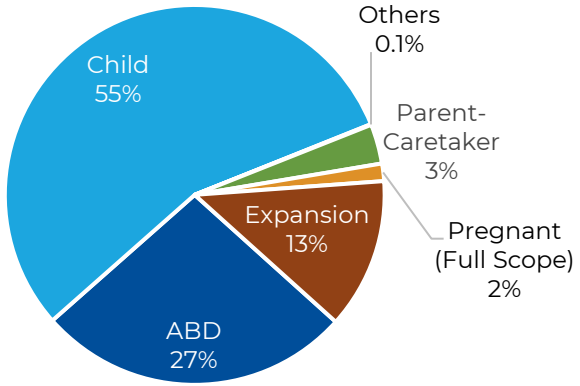


Dental Claims - Members Served By Qualifying Group (Feb2026)

MCE

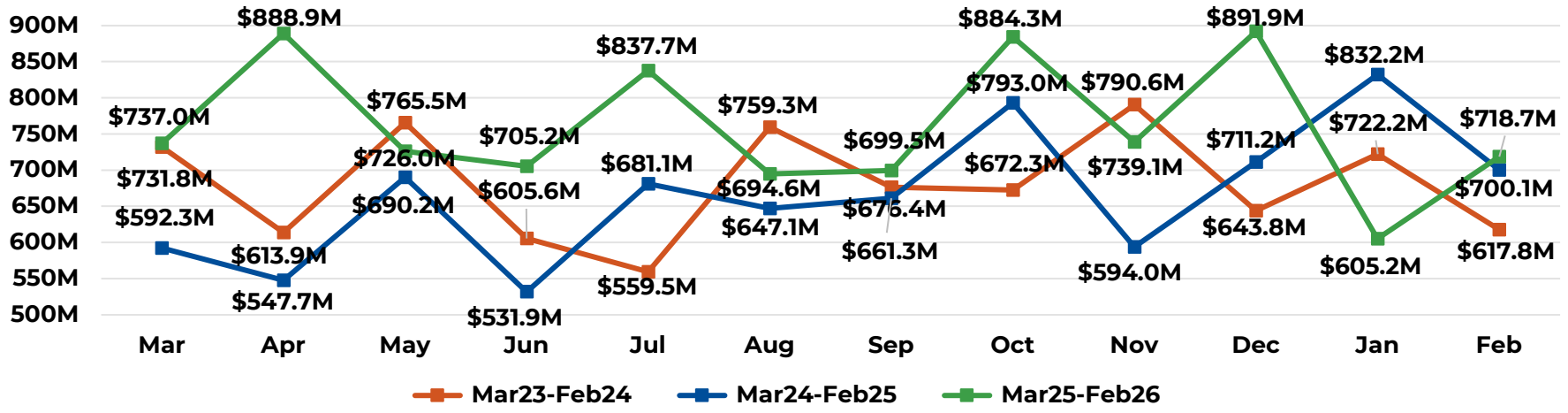


FFS



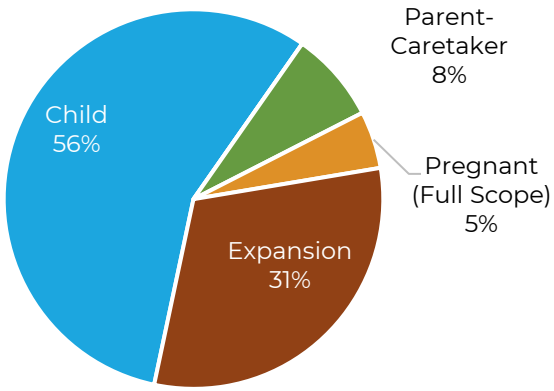
Financials

Total Agency Expenditures

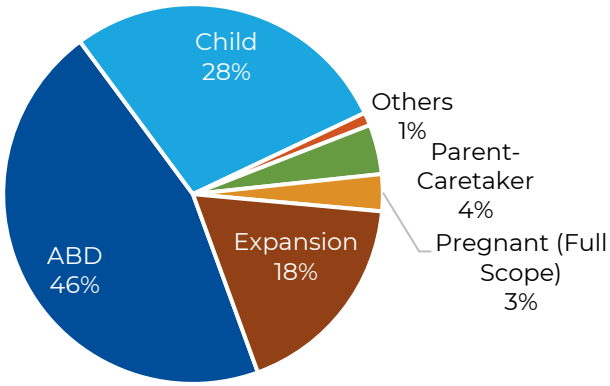


Total Agency Utilization - Members Served By Qualifying Group (Feb2026)

MCE

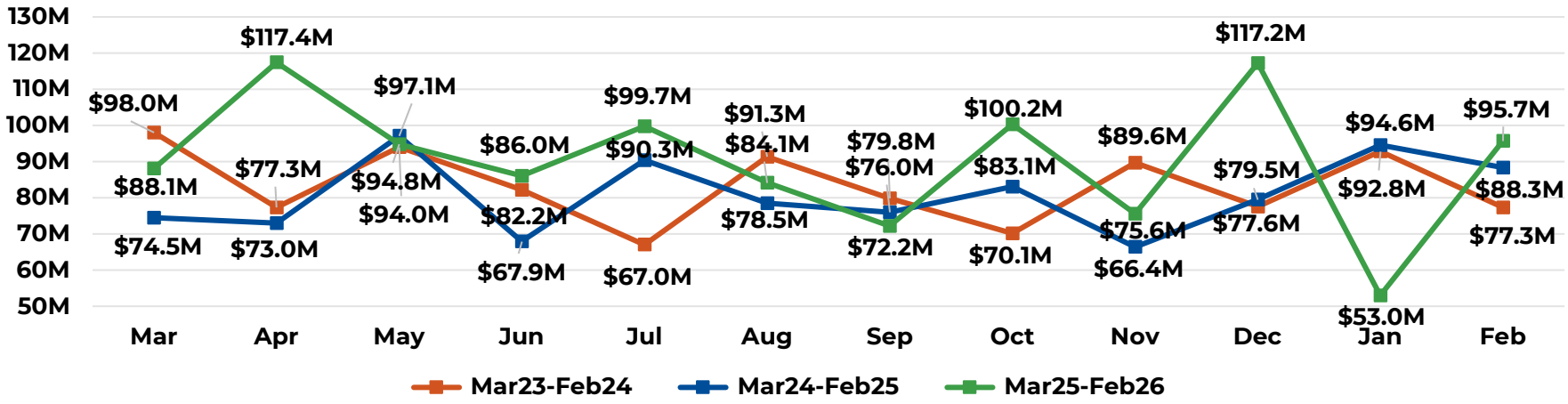


FFS



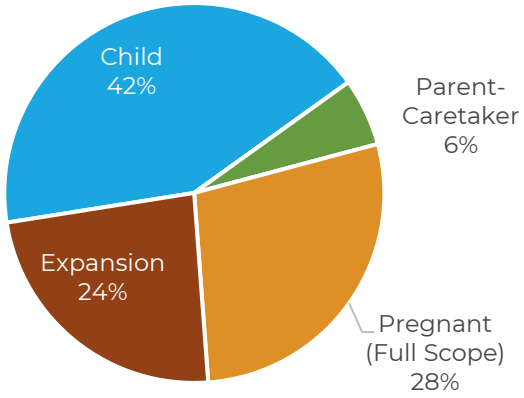
Financials (Cont.)

Inpatient Services - Expenditures

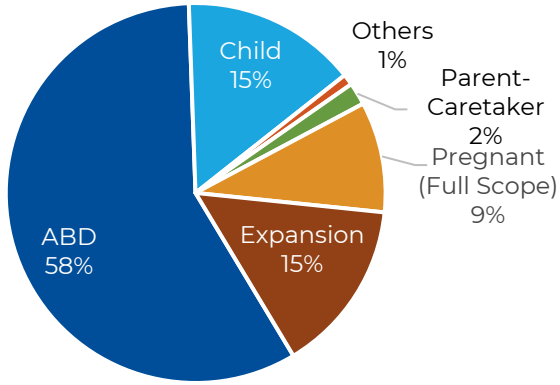


Inpatient Services - Members Served by Qualifying Group (Feb2026)

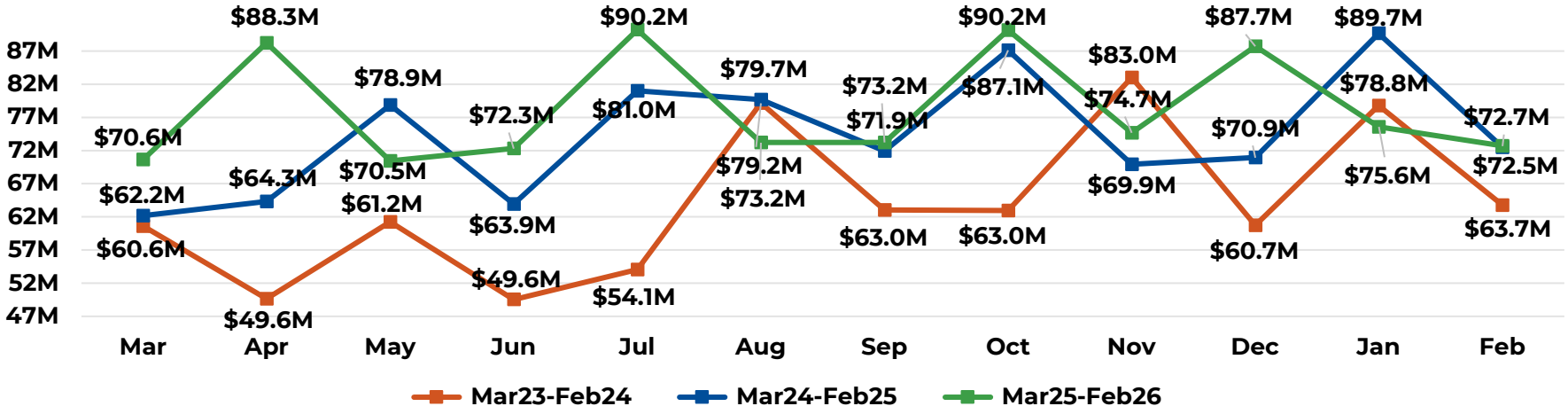
MCE



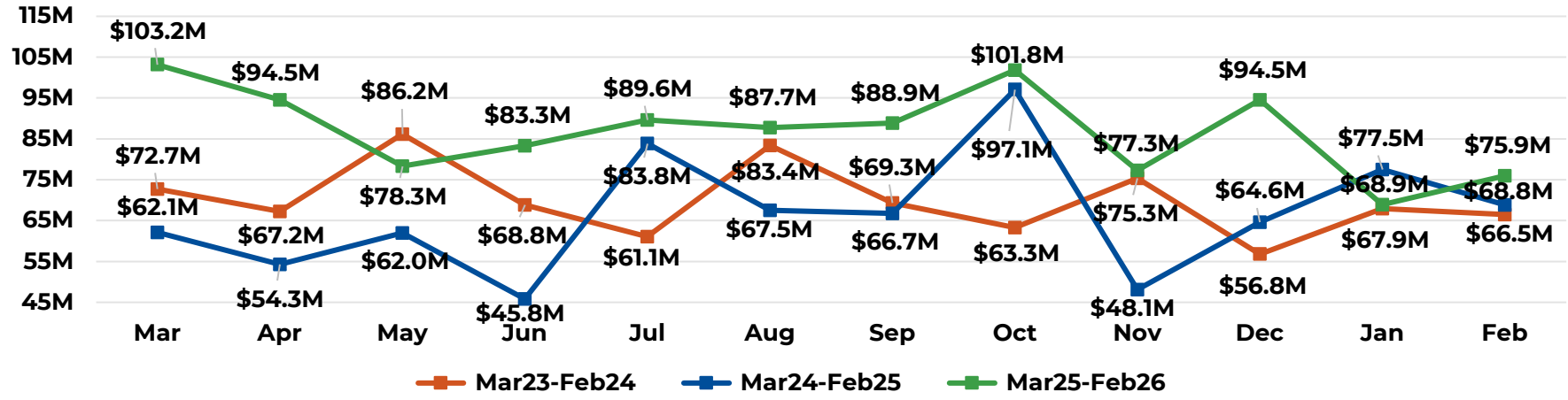
FFS



Nursing Facility Services - Expenditures

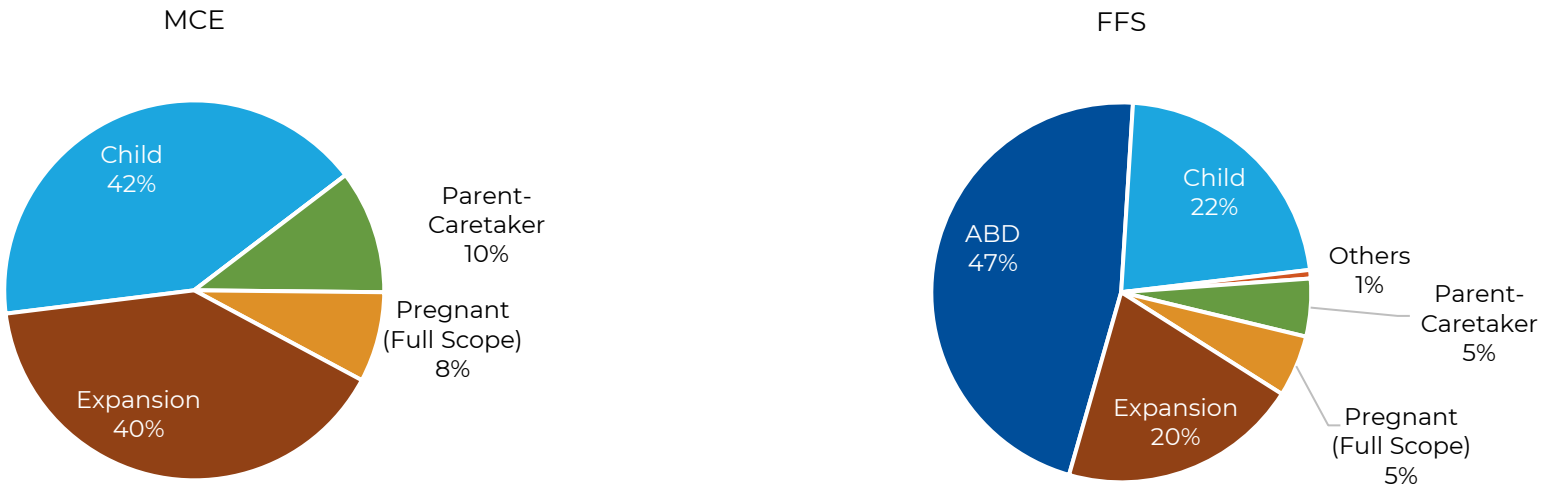


Outpatient Hospital Services - Expenditures

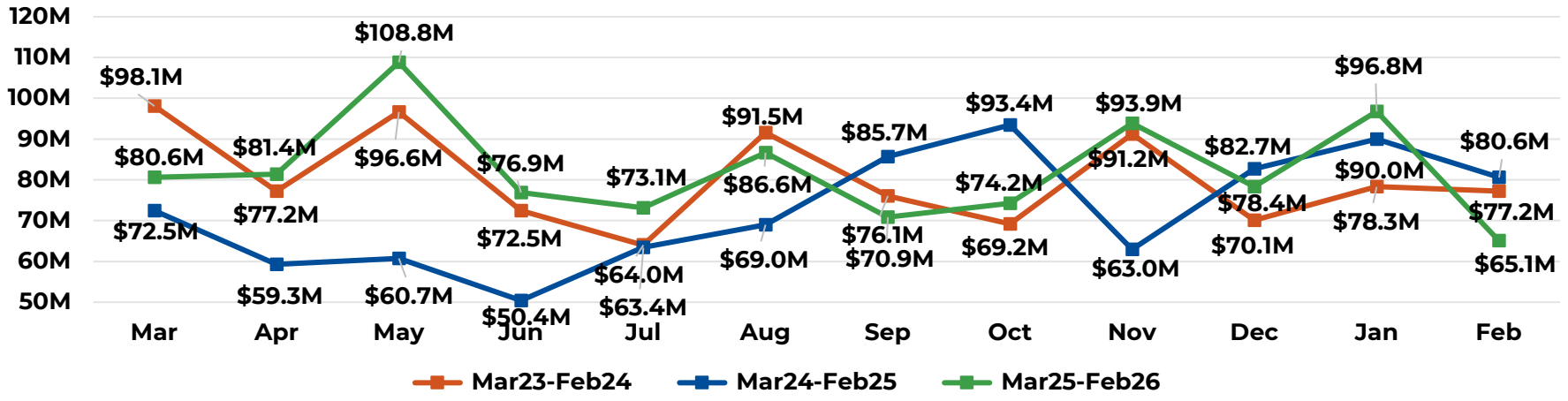


Financials (Cont.)

Outpatient Hospital Services - Members Served By Qualifying Group (Feb2026)



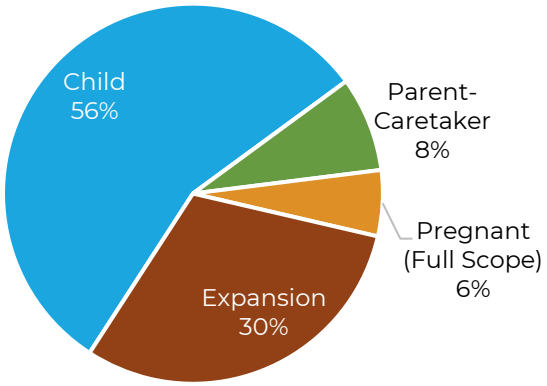
Physician Services - Expenditures



Financials (Cont.)

Physician Services - Members Served By Qualifying Group (Feb2026)

MCE



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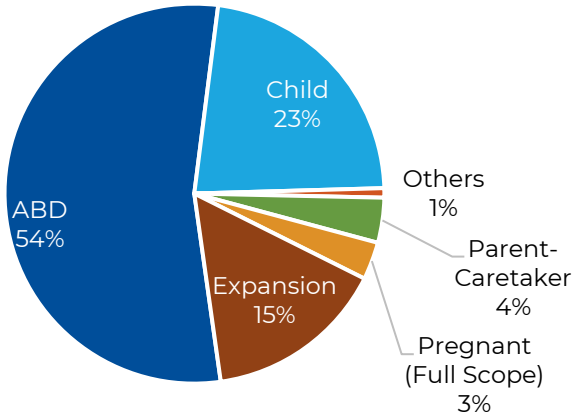
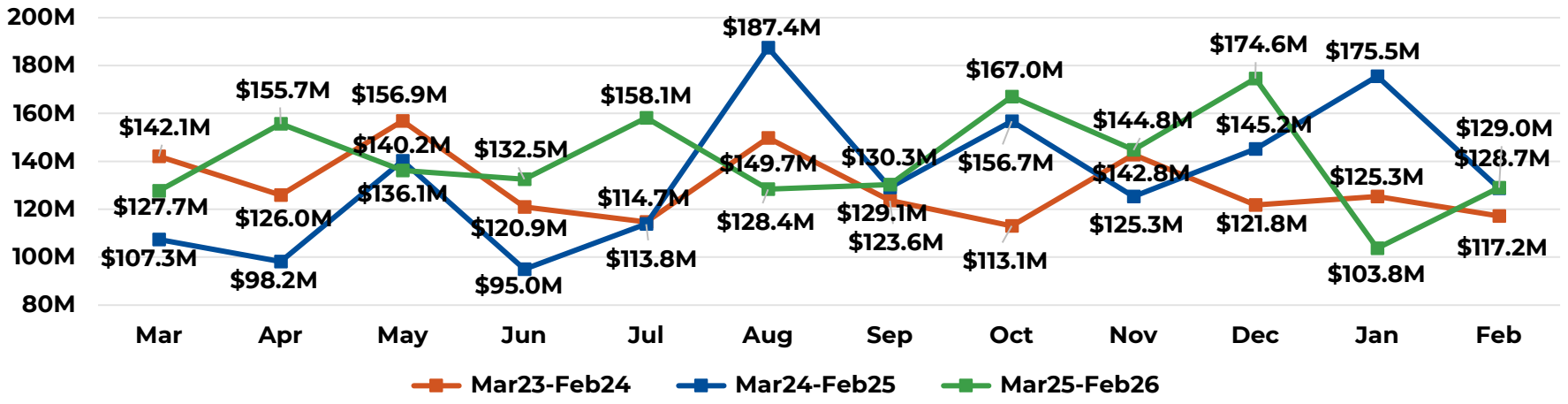


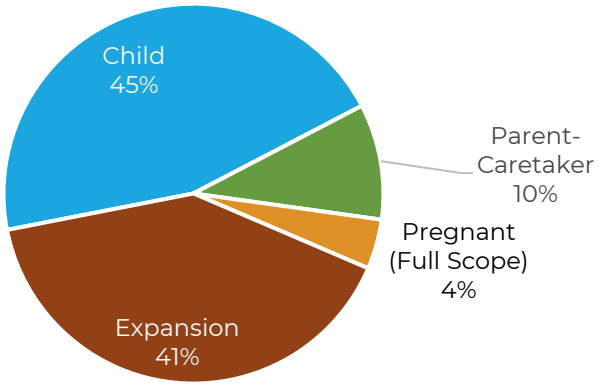
Prescribed Drugs - Expenditures



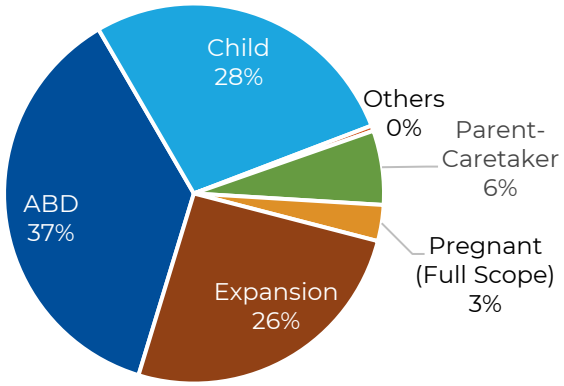
Financials (Cont.)

Prescribed Drugs - Members Served By Qualifying Group (Feb2026)

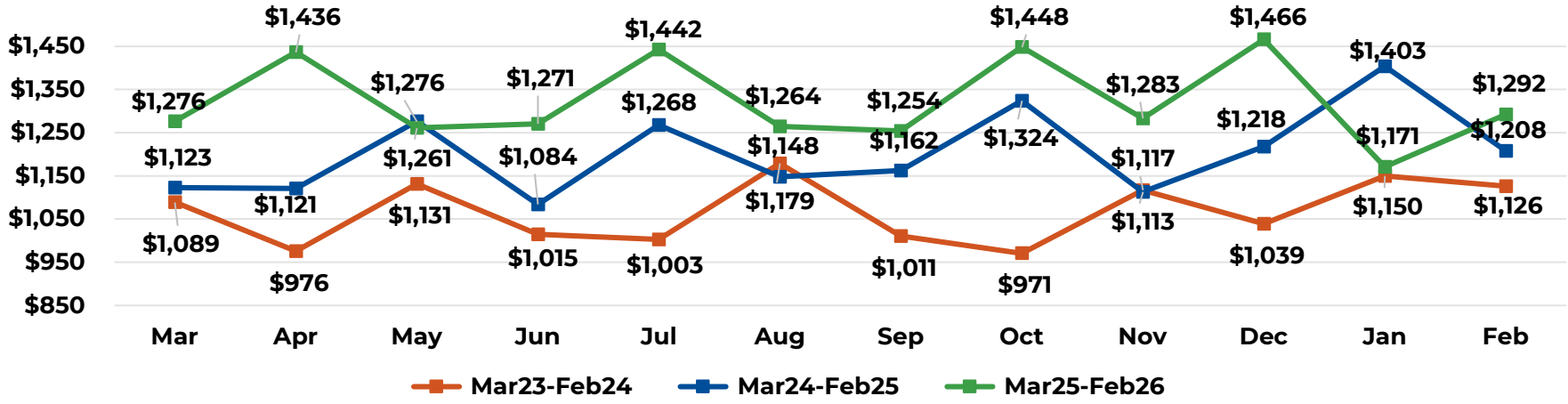
MCE



FFS

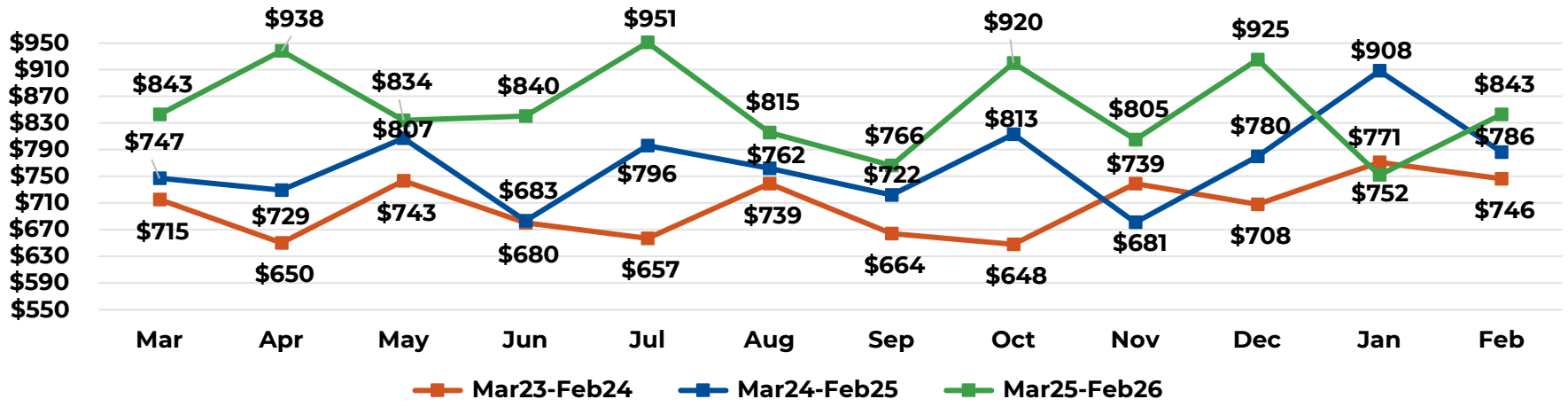


Average Expenditure Per Total Members Served

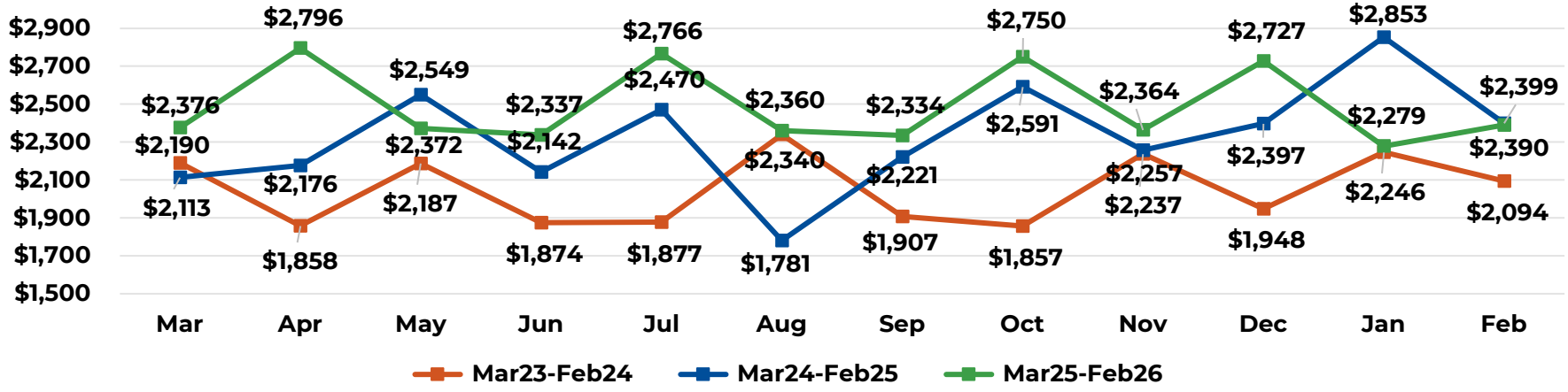


Financials (Cont.)

Average Expenditure Per Child (Under 21) Member Served

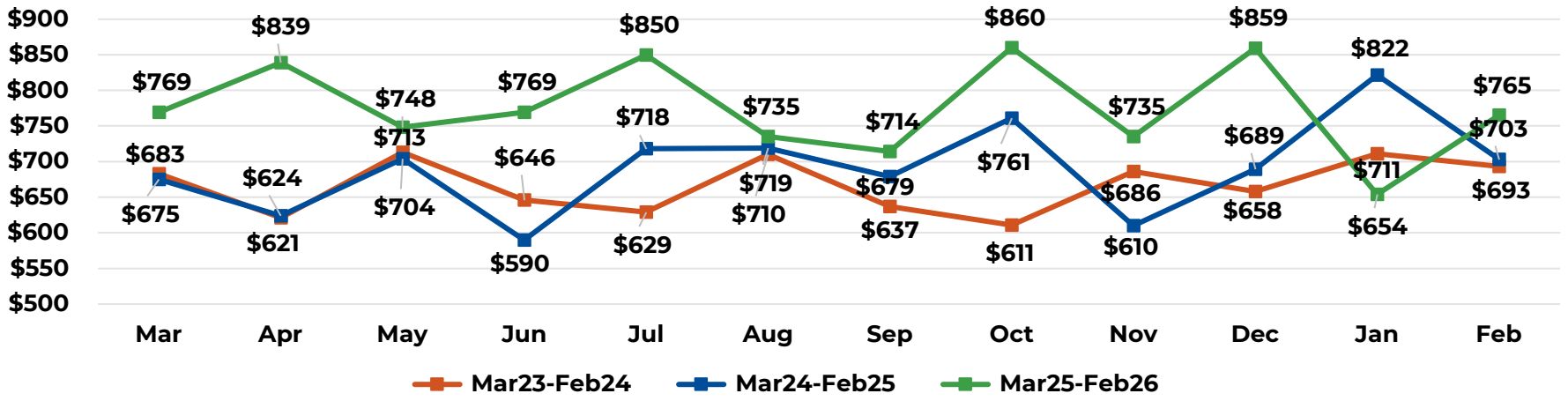


Average Expenditure Per Aged/Blind/Disabled Member Served

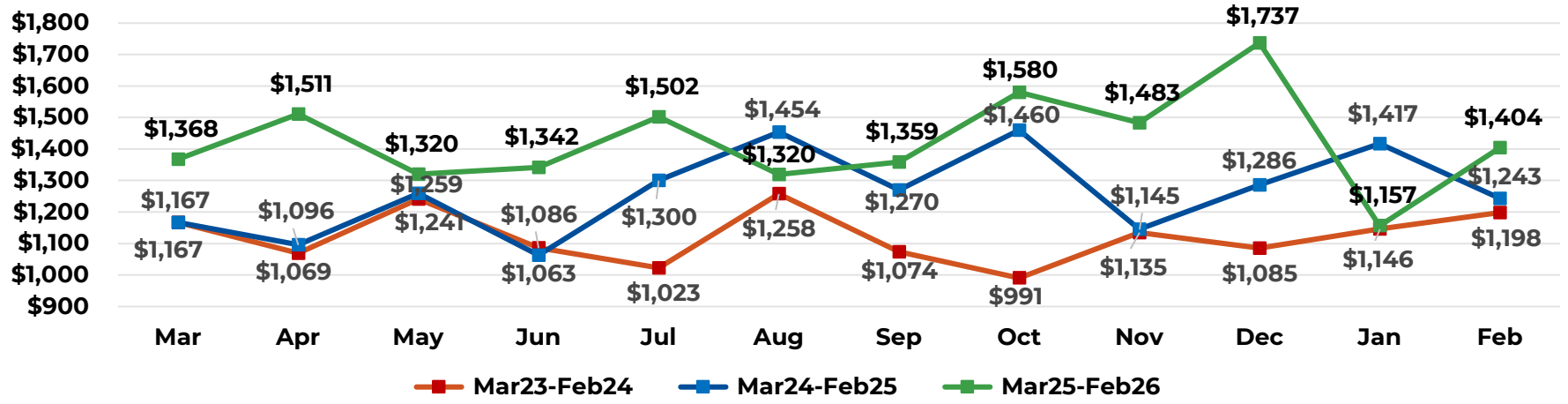


Financials (Cont.)

Average Expenditure Per Children & Parent/Caretaker Member Served

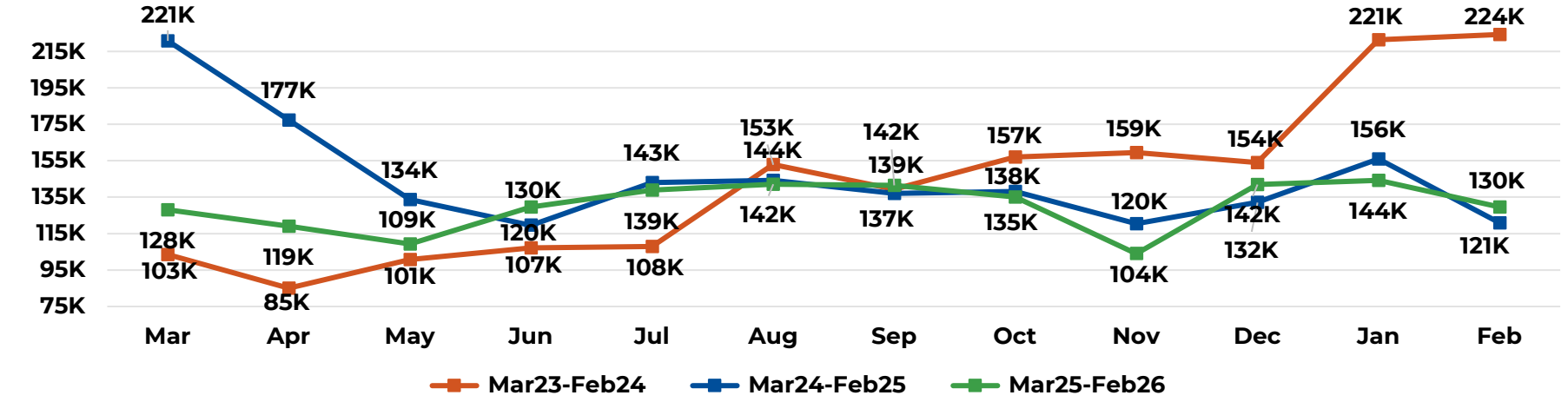


Average Expenditure Per Expansion Member Served

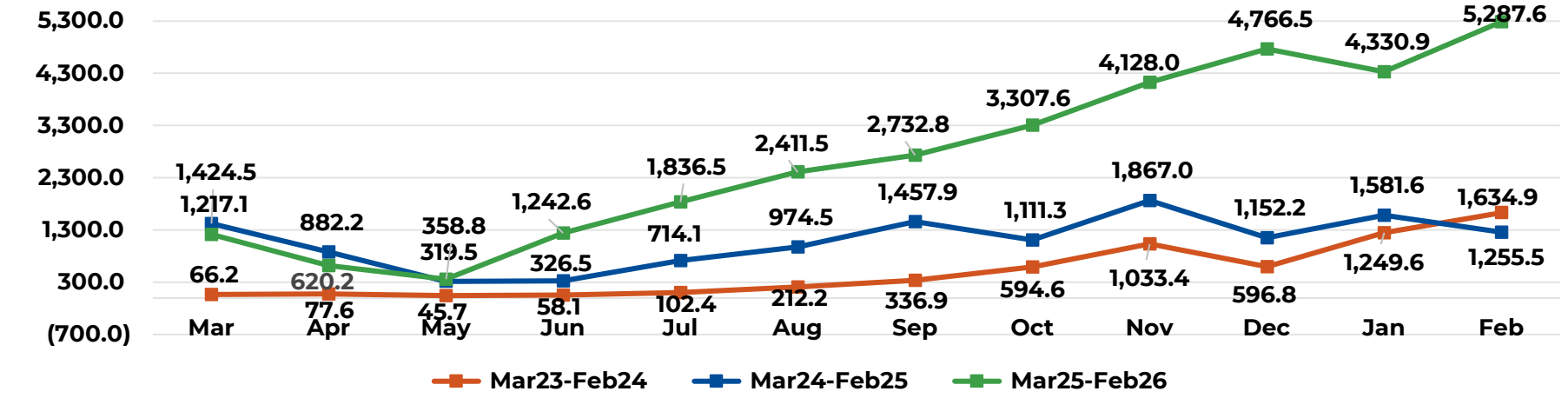


Call Center

Call Center - Member Calls Answered

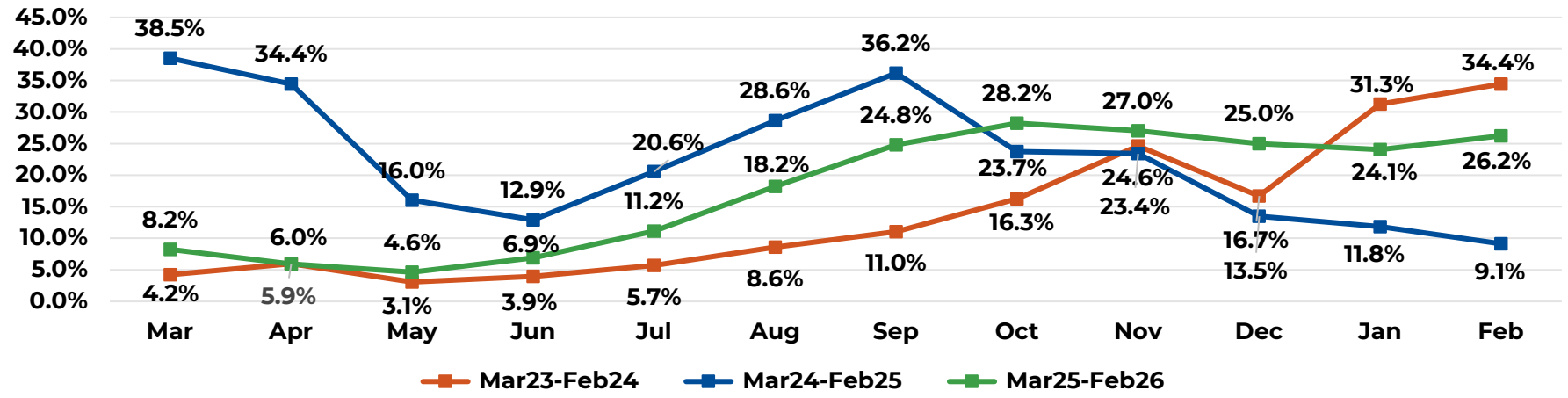


Call Center - Average Wait Time (In Seconds)



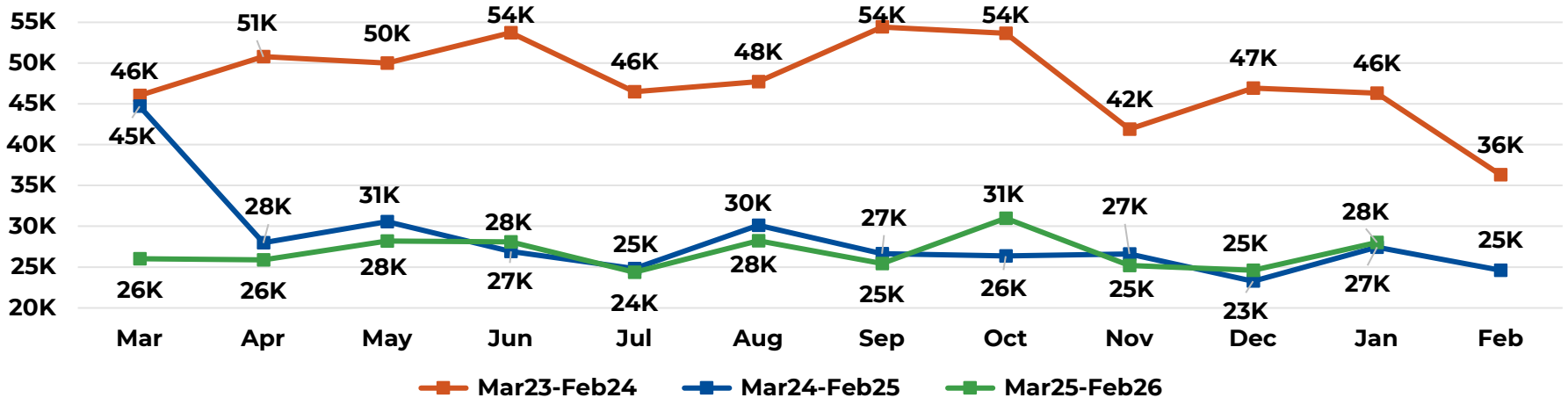
Call Center (Cont.)

Call Center - Abandoned Call Rate



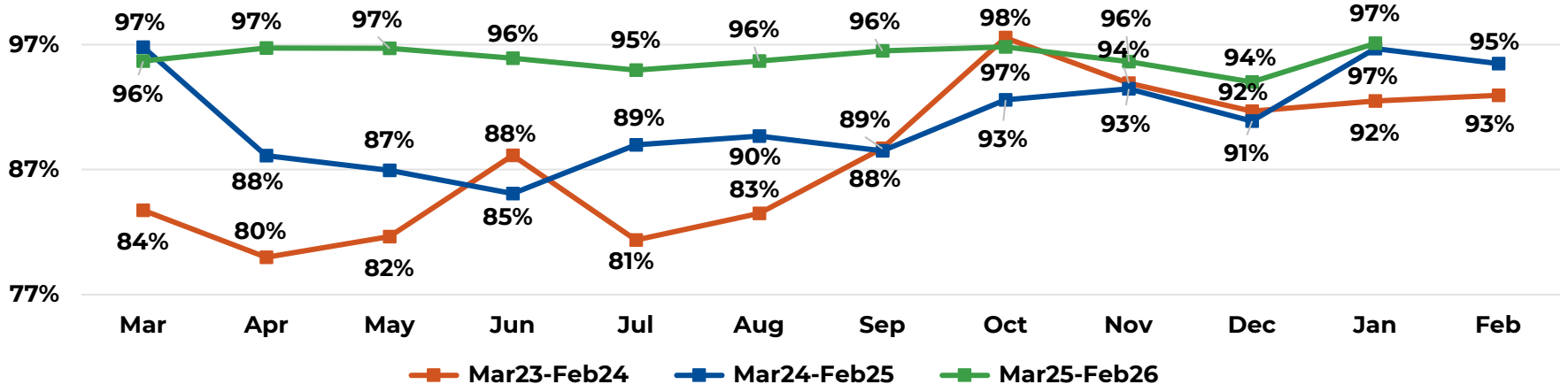
Prior Authorization

Fee-For-Service Prior Authorization - Total Combined - Total Completed PA Volume



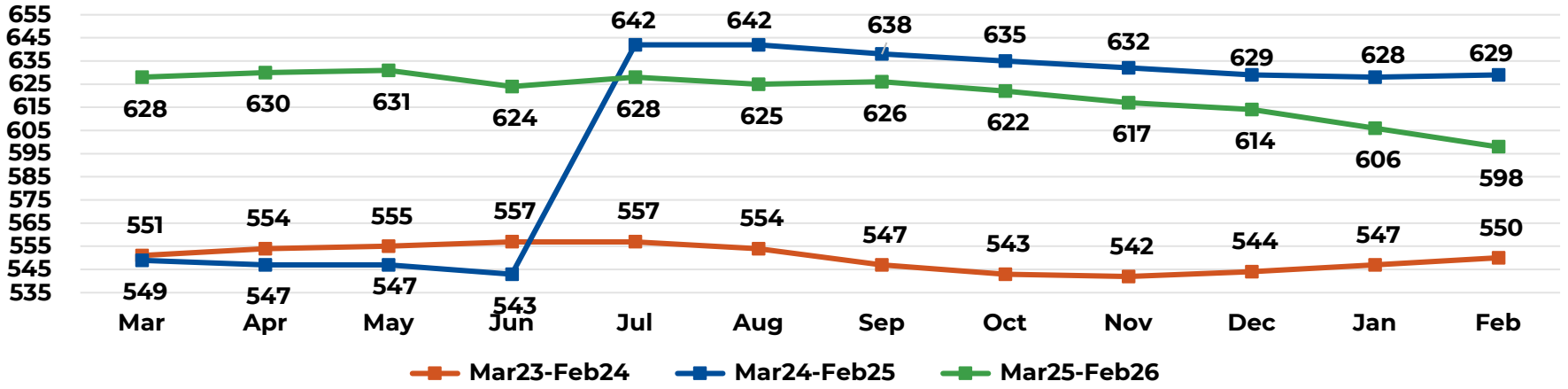
Prior Authorization (Cont.)

Fee-For-Service Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



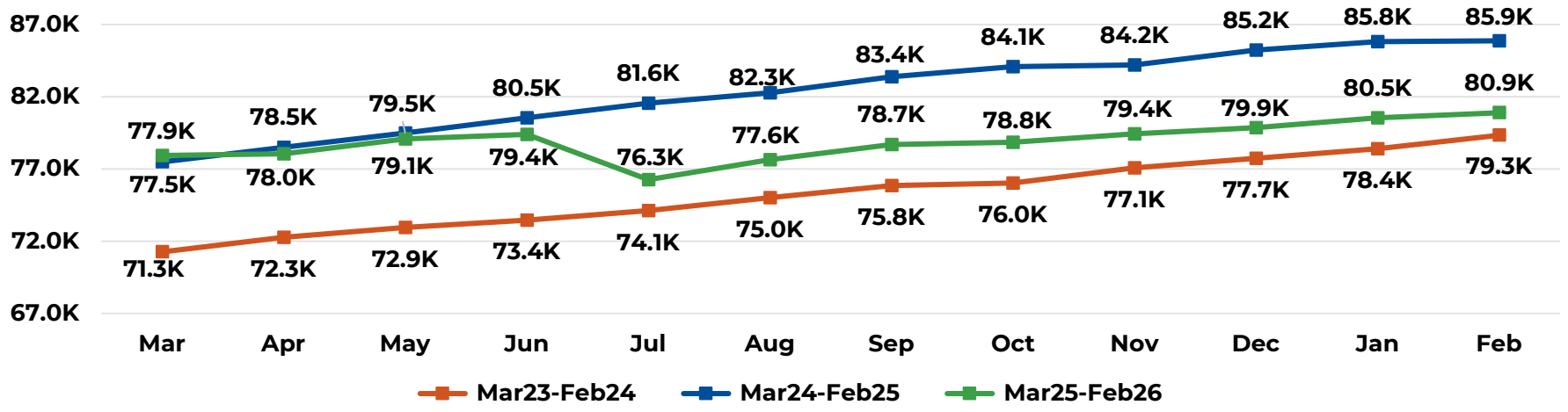
Agency Stats & Provider Network

OHCA Admin - Number of FTEs

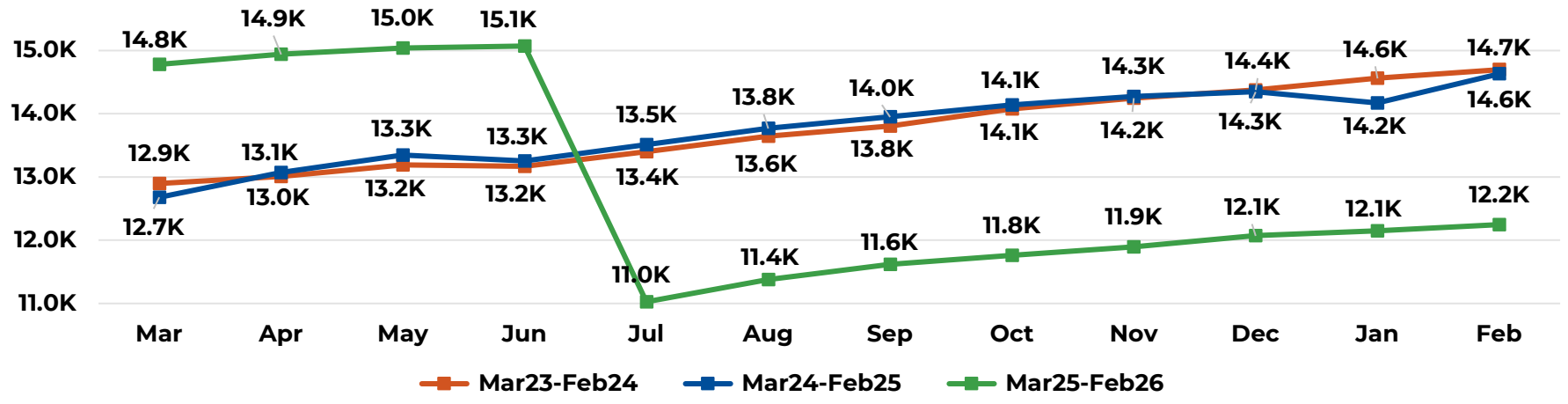


Agency Stats & Provider Network (Cont.)

Total Providers Enrolled

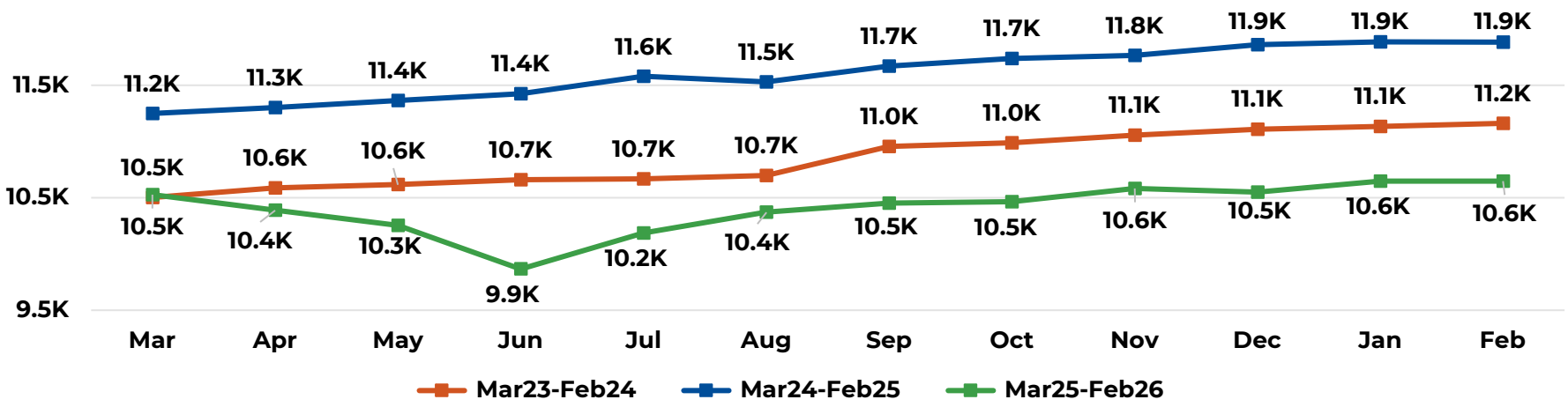


Mental Health Providers Enrolled (In-State Only)

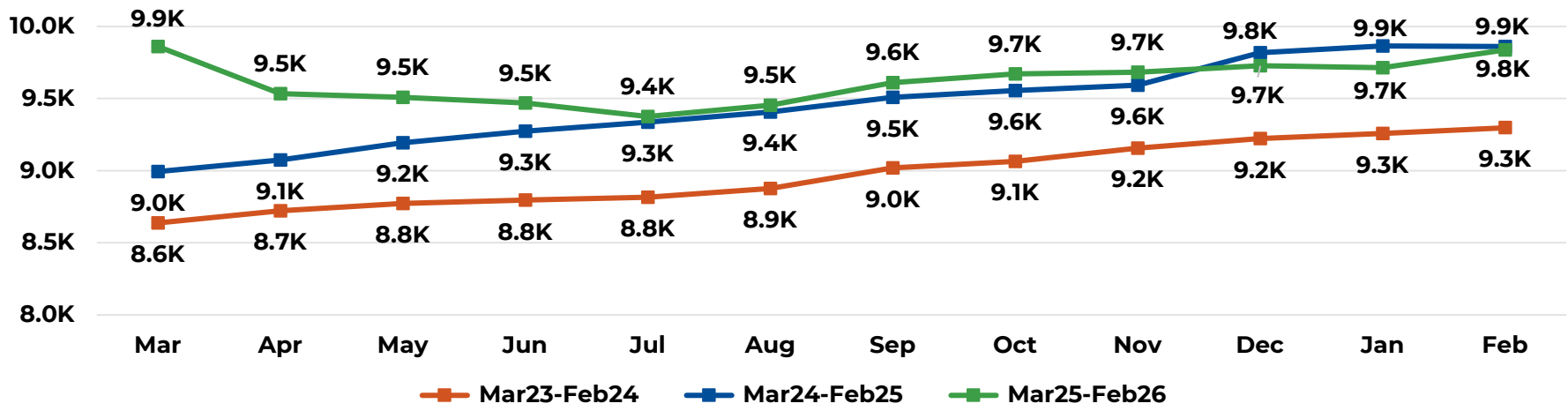


Agency Stats & Provider Network (Cont.)

Physicians Enrolled (In-State Only)

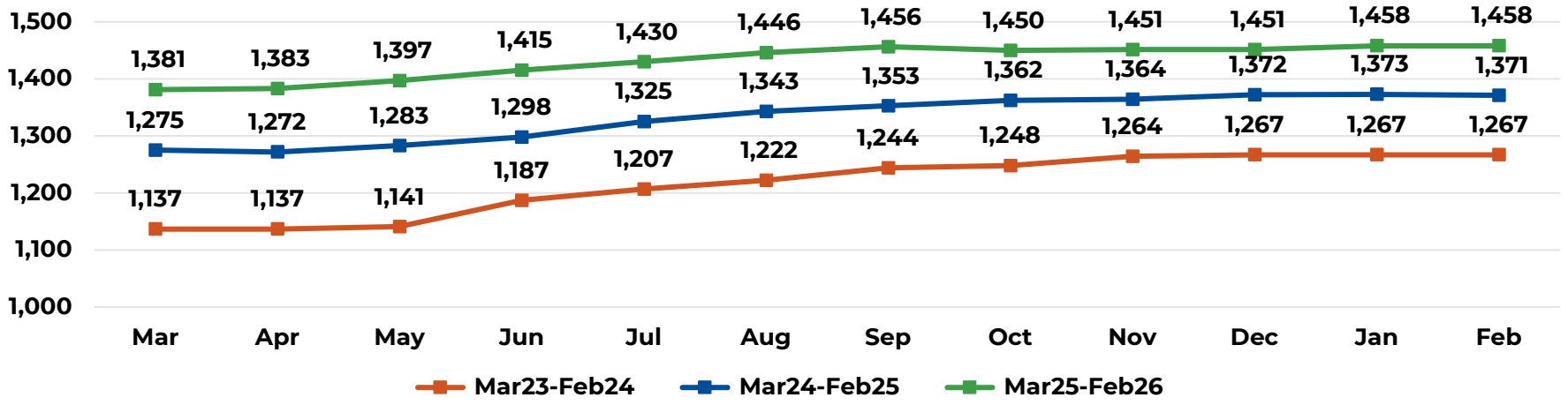


Primary Care Providers Enrolled (In-State Only)

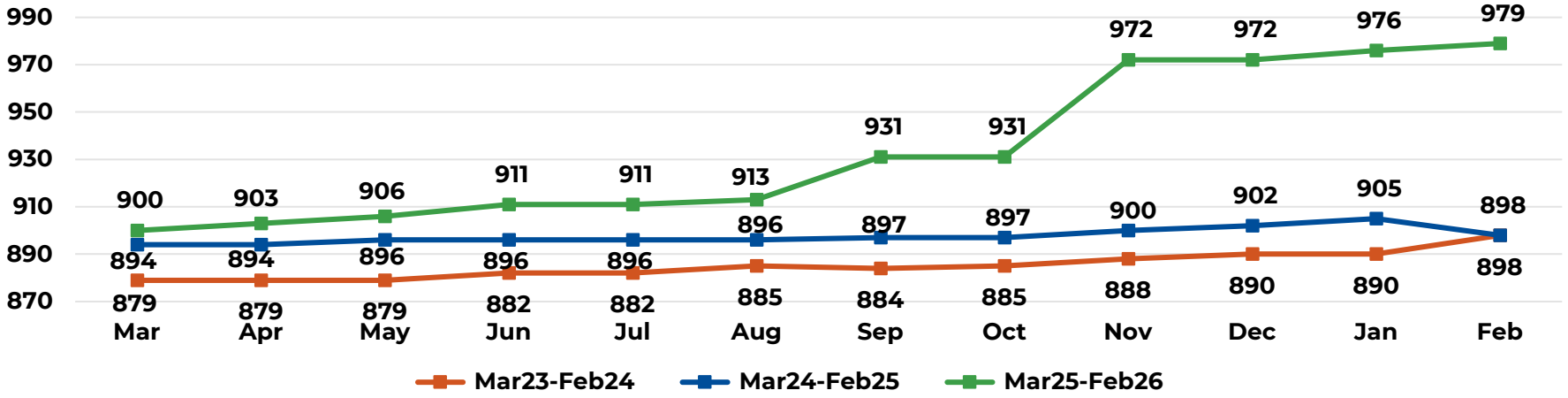


Agency Stats & Provider Network (Cont.)

Dentists Enrolled (In-State Only)

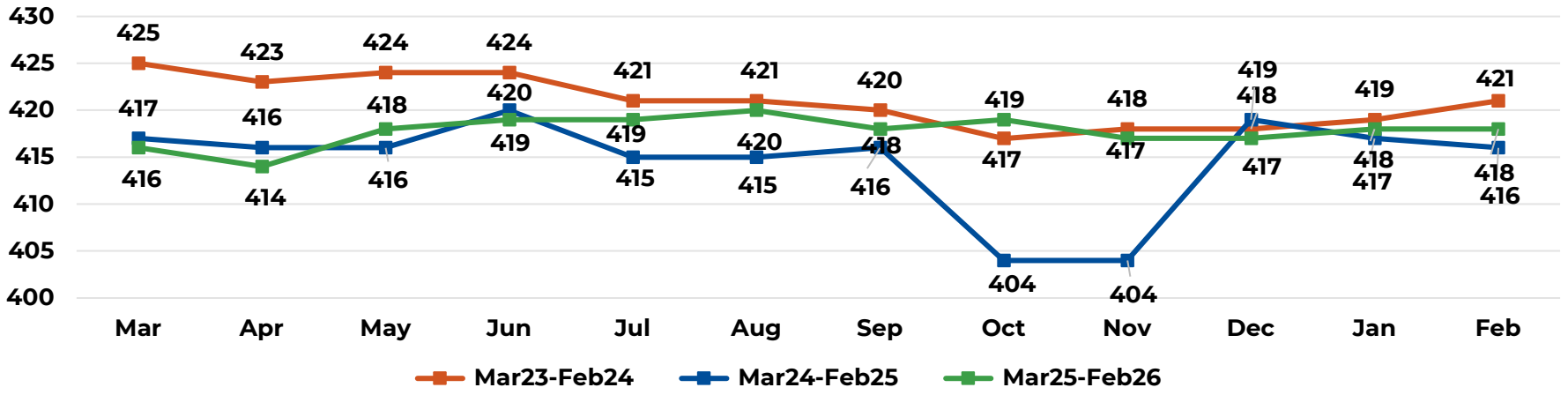


Pharmacy Enrolled (In-State Only)

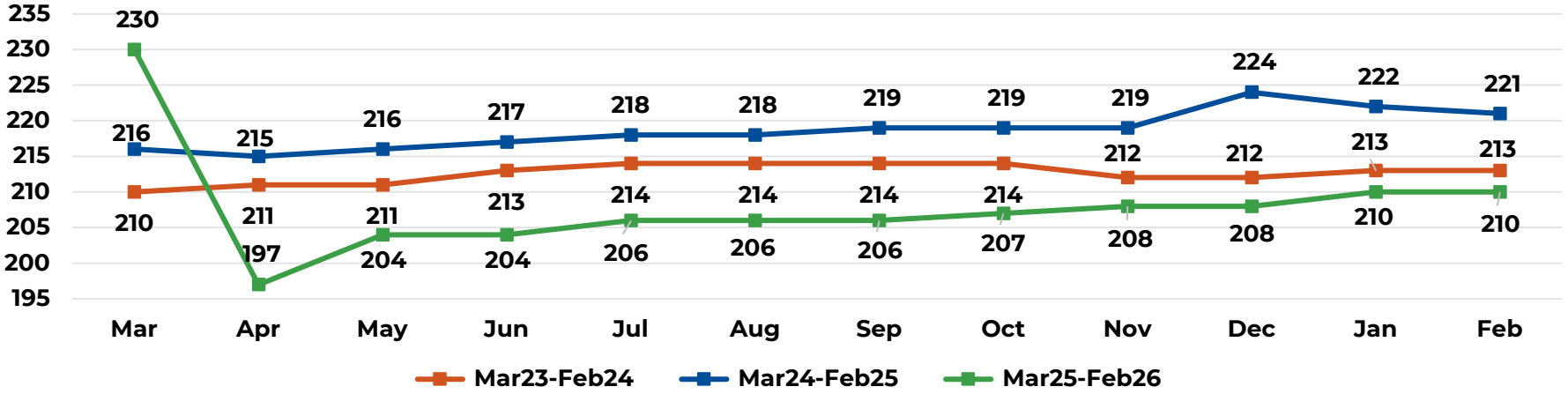


Agency Stats & Provider Network (Cont.)

Extended Care Facilities Enrolled (In-State Only)

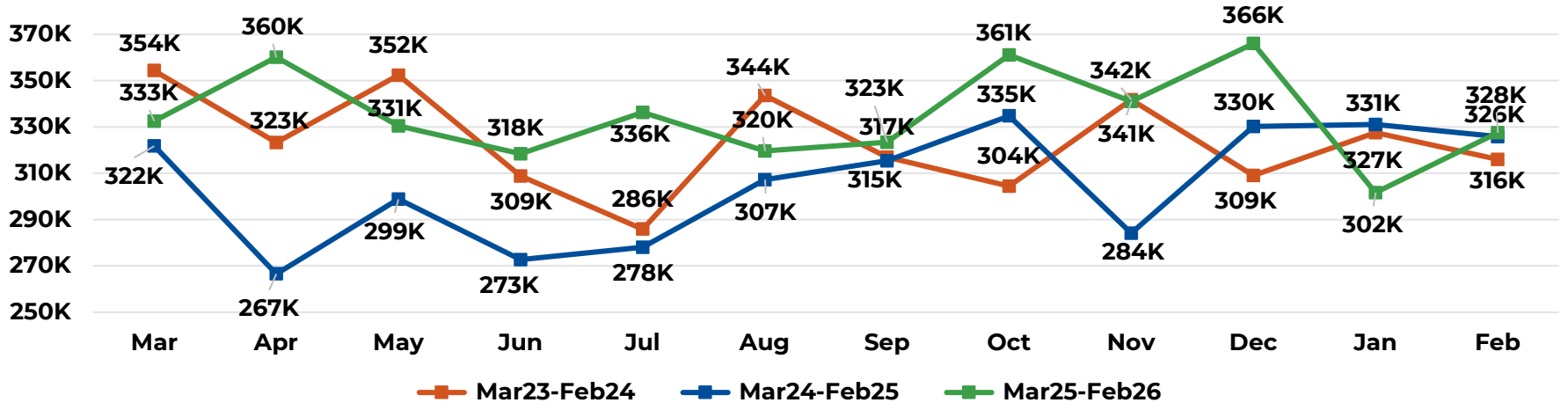


Hospitals Enrolled (In-State Only)



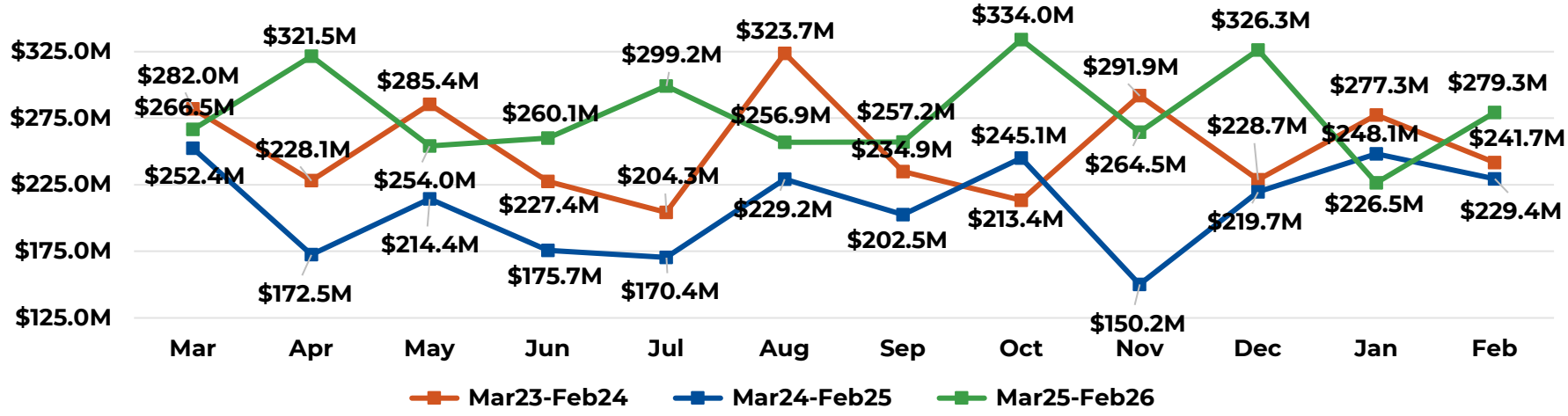
MCE Utilization

Total MCE Members Served - Medical & Dental (All MCEs)



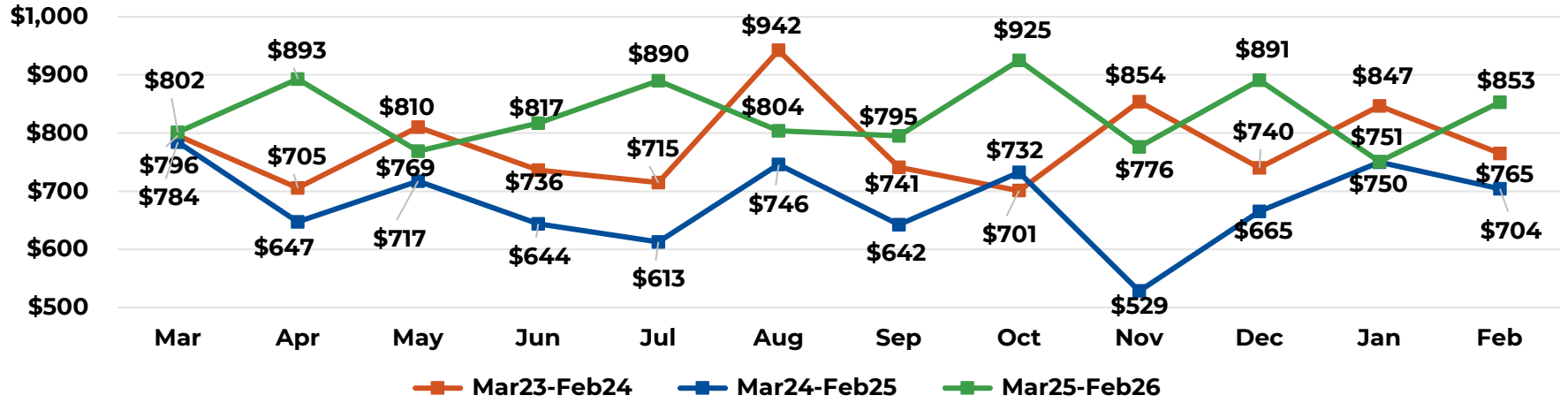
For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 2024 is MCE claims based on MCE claim region codes (30, 68).

Total MCE Expenditures - Medical & Dental (All MCEs)

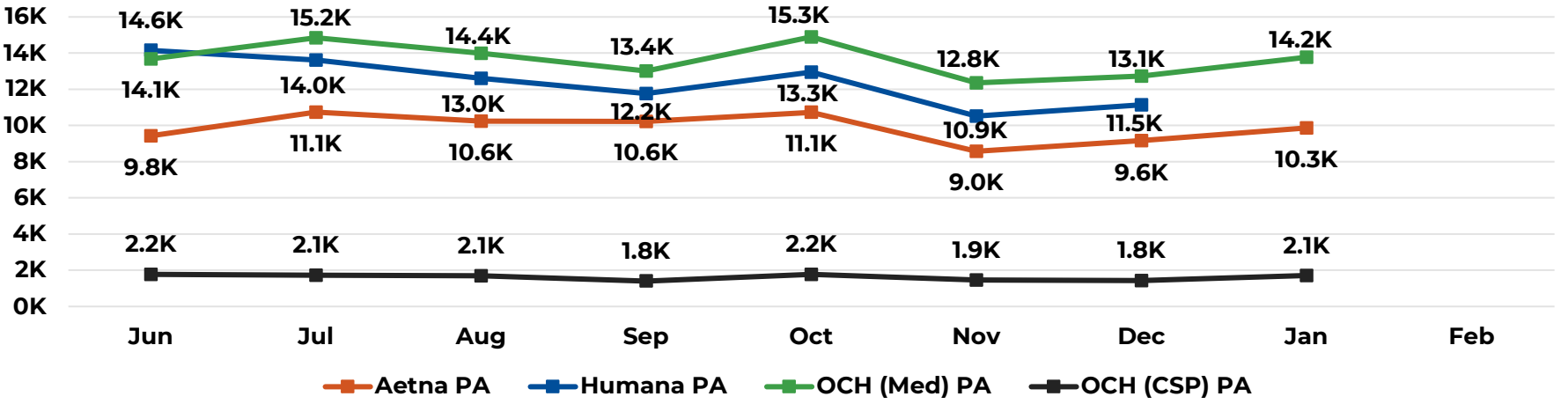


MCE Utilization (Cont.)

Average Expenditure Per Total MCE Members Served - Medical & Dental (All MCEs)

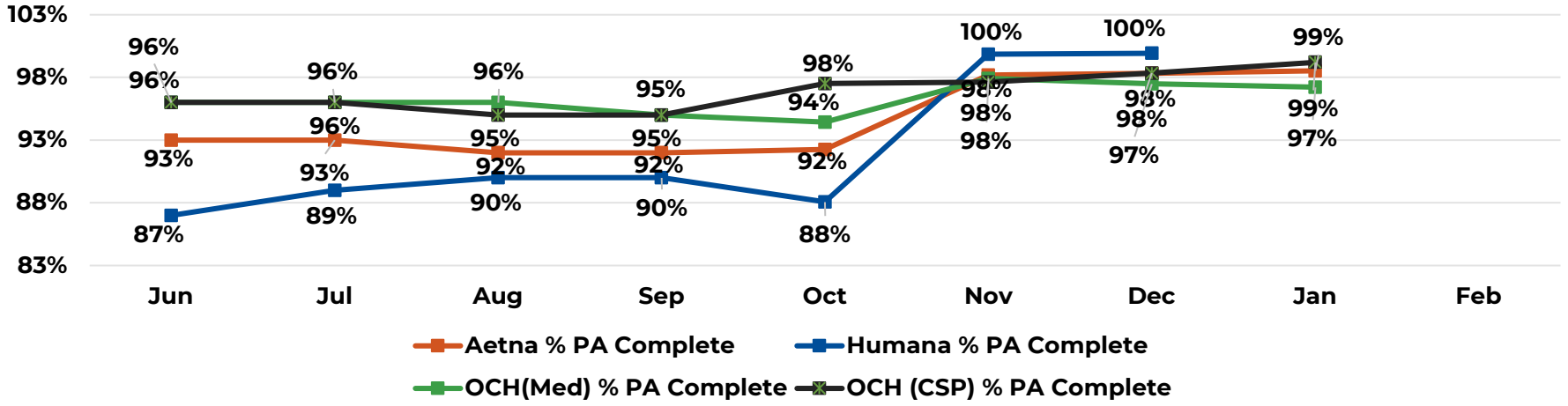


MCE Expedited & Standard Prior Authorization (Medical) - Overall PA Count

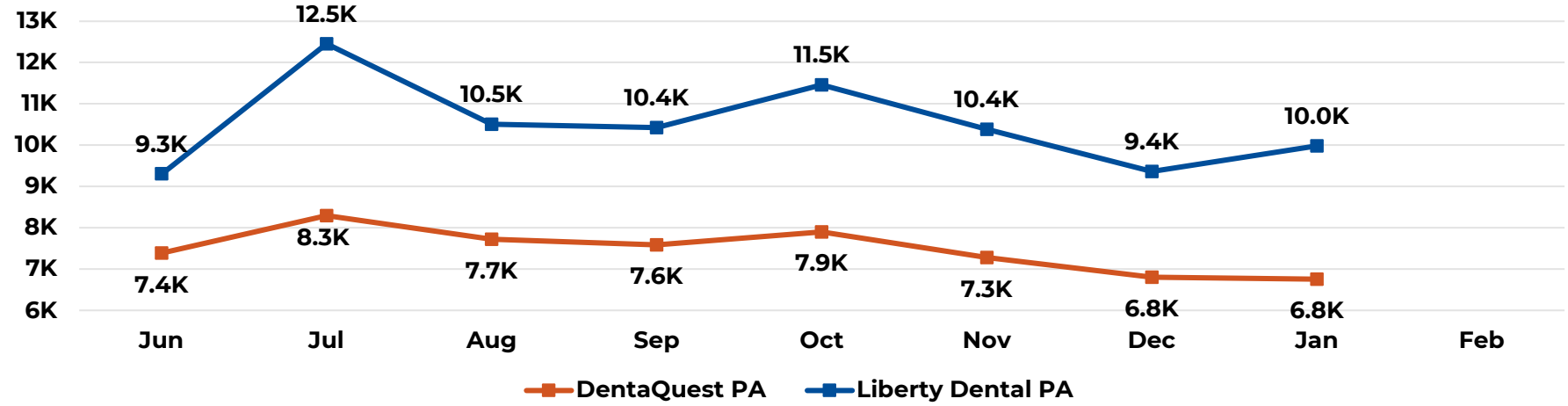


MCE Utilization (Cont.)

MCE Expedited & Standard Prior Authorization (Medical) - % Completed Within Contractually Allotted Base Time

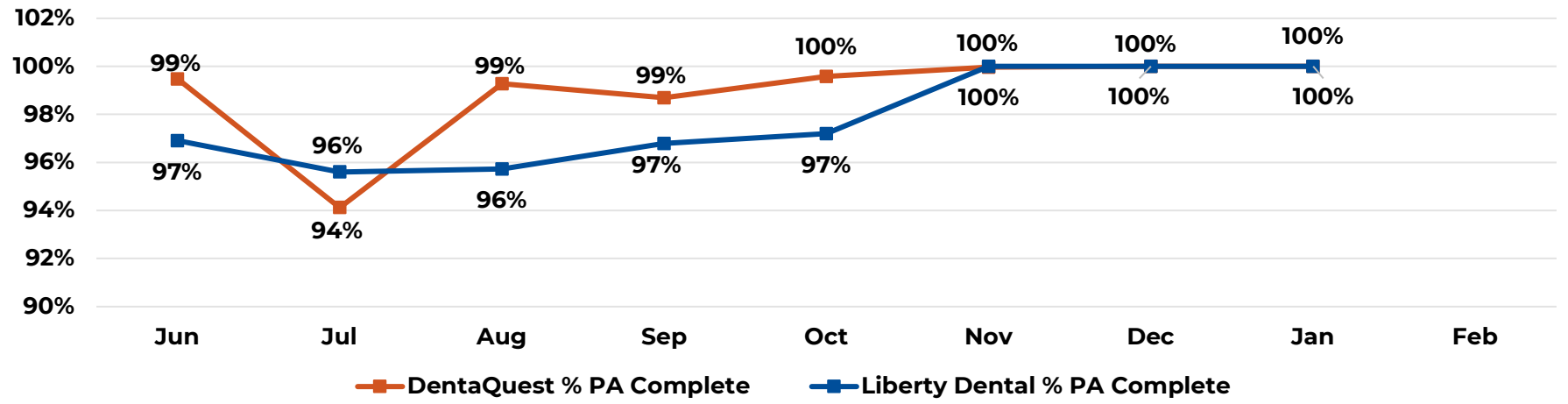


MCE Expedited & Standard Prior Authorization (Dental) - Overall PA Count



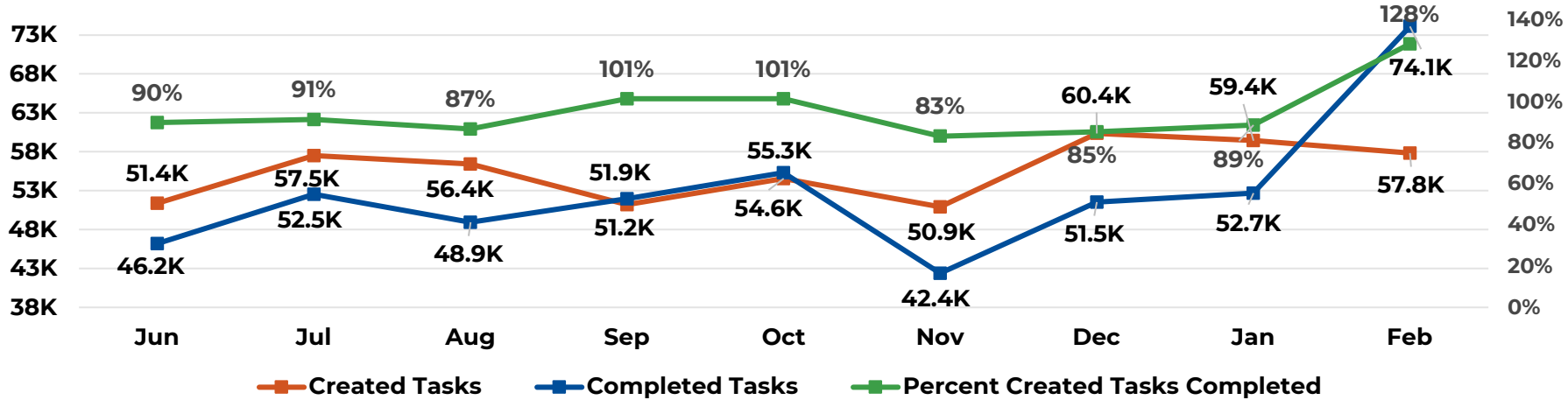
MCE Utilization (Cont.)

MCE Expedited & Standard Prior Authorization (Dental) - Percent Processed Within Contractually Allotted Base Time



Workflow - Productivity

Created & Completed Tasks



Operational Metrics Query Notes:

Enrollment is any point in time and any length of time enrolled during a month.

Enrollment group (Expansion, ABD, etc.) is based on aid category at time of service.

Payment cycles (number of payment processing weeks) is the main driver of most monthly variances.

Paid claims based on paid dates (FFS or MCE paid claim).

Type of claim (Inpatient, Outpatient, etc.) is based on the claim's category of service.

Emergency department claims based on paid facility claims based on paid dates with revenue codes between 450 and 459.

Opioid data is from the Opioid dashboard MME Calculations files.

Out of state is paid claims based on paid dates. Billing provider is not in OK, and address type is service. Results are filtered to just border counties (within 50 miles of border). Data excludes non border county results and specialty pharmacy.

Telemedicine is paid claims based on paid dates. Claim includes procedure codes: Q3014;99441;99442;99443;98966;98967;98968;D9995, or procedure code modifiers GT or 95 or place of service was 02 – telehealth or 10 – telehealth (patients home).

Call center data from Call Center Data_Call Volume Change XLSX (Call Center_Member Calls tab).

Fee-For-Service Prior Authorization data includes Medical, Therapy, Dental and DME PAs. They are based on traditional path PAs. Accelerated path PAs are excluded. Counts include all PA line items (amendments, system added modifiers, etc) and are point in time. Completed PAs are Approved, Cancelled, System Cancelled and Denied. Monthly totals are calculated from the first day of the month to the last Sunday of the month; therefore, monthly totals may not reflect an entire month.

FTE counts from the latest available org chart or from last for a month. Uses agency count OHCA filled number.

For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 20247 is MCE claims based on MCE claim region codes (30, 68).

MCE Prior Authorization data is from SEL-0500 and DEN-0700.