



## IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

1305 East Walnut – Des Moines, IA 50309 ☐ (515) 974-3131 ☐ Fax 1-866-626-0216

Holly Randleman, Pharm.D.  
Melissa Klotz, Pharm.D.  
Jason Kruse, D.O.

Caitlin Reinking, Pharm.D.  
Charles Wadle, D.O.  
Bryon Schaeffer, M.D.

Jennifer Johnson, Pharm.D.  
Abby Cate, Pharm.D.  
Jordan Thoman, Pharm.D.

Professional Staff:

Pam Smith, R.Ph.  
DUR Project Coordinator

August 6, 2026

Abby Cate, Pharm.D.  
Pharmacy Consultant  
Iowa Medicaid  
1305 East Walnut  
Des Moines, Iowa 50309

Dear Abby:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 5, 2026. At this meeting, Commission members reviewed and discussed prior authorization (PA) criteria for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products; Cardiac Myosin Inhibitors; Incretin Mimetics for Non-Diabetes Indications; and Setmelanotide (Imcivree). In addition, they discussed removal of prior authorization for topical clindamycin products with implementation of ProDUR quantity limits and removal of quantity limits for lamotrigine chewable tablets. The following recommendations have been made by the DUR Commission:

### **Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products**

#### Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the established dosage limits per month. Payment for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.

PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trials and therapy failure with a preferred agent in this class. Note Aprepitant (Emend) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

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

~~Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the established dosage limits per month. Payment for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.~~

~~PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trials and therapy failure with a preferred agent in this class. Note Aprepitant (Emend) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.~~

*Prior authorization (PA) is required for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin agents under the following conditions:*

- 1. Request adheres to all FDA approved labeling for requested drug and indication(s), including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.*
- 2. Requests for a non-preferred Antiemetic-5HT3 Receptor Antagonist/Substance P Neurokinin agent must document a previous trial and therapy failure with a preferred agent in this class, unless otherwise stated in criteria.*
- 3. Requests for aprepitant (Emend) will only be considered when used in combination with other antiemetic agents (5HT3 agent and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.*
- 4. Requests for tradipitant (Nereus) will be considered under the following conditions:*
  - a. Is prescribed for the prevention of motion-induced vomiting; and*
  - b. Member has a planned event expected to cause vomiting induced by motion; and*
  - c. Documentation of a previous trial and therapy failure with transdermal scopolamine; and*
  - d. Documentation of previous trials and therapy failures with 2 antihistamines used for motion sickness (e.g., diphenhydramine, meclizine, promethazine); and*
  - e. Request is for the maximum number of days of the planned event expected to cause vomiting induced by motion.*
  - f. Requests for more than 90 doses per 365-day period will not be considered.*

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

## **Cardiac Myosin Inhibitors**

(formerly Mavacamten [Camzyos])

### Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for mavacamten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and

3. Patient exhibits symptoms of New York Heart Association (NYHA) class II or III symptoms; and
4. Is prescribed by or in consultation with a cardiologist; and
5. Patient has a left ventricular ejection fraction (LVEF)  $\geq 55\%$ ; and
6. Patient has a peak left ventricular outflow tract (LVOT) gradient  $\geq 50$  mmHg at rest or with provocation; and
7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:
  - a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and
  - b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and
  - c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker.

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

Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.

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

Prior authorization (PA) is required for *cardiac myosin inhibitors mavacamten (Camzyos)*.

Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and
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4. Is prescribed by or in consultation with a cardiologist; and
5. Patient has a left ventricular ejection fraction (LVEF)  $\geq 55\%$ ; and
6. Patient has a peak left ventricular outflow tract (LVOT) gradient  $\geq 50$  mmHg at rest or with provocation; and
7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:
  - a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and
  - b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and
  - c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker; *and*
8. *Will not be used in combination with another cardiac myosin inhibitor.*

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

Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.

## **Incretin Mimetics for Non-Diabetes Indications**

### Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus; and
3. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
  - a. Patient has established CVD, i.e. coronary artery disease (angina, MI), cerebrovascular disease (stroke, transient ischemic attack), peripheral arterial disease, heart failure, atrial fibrillation and other arrhythmias, valvular heart disease, congenital heart disease, cardiomyopathies, aortic disease (aneurysm, dissection), DVT or PE; and
  - b. Patient has a baseline body mass index (BMI)  $\geq 27$  kg/m<sup>2</sup> (attach documentation), obtained within 6 months of request; and
  - c. Patient has been evaluated for cardiovascular standard of care treatment; and
  - d. For Wegovy:
    - i. Patient is  $\geq 18$  years of age; and
    - ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
    - iii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; or
4. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and
  - a. Patient has a baseline BMI  $\geq 30$  kg/m<sup>2</sup>; and
  - b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI)  $\geq 15$  events per hour, as documented by a polysomnography (PSG) or at-home sleep study (document AHI); and
  - c. For Zepbound:
    - i. Patient meets the FDA approved age for OSA; and
    - ii. Initiation and escalation dosages will be permitted up to a maximum of 20 weeks prior to reaching the recommended maintenance dosage of 10 mg to 15 mg once weekly; and
    - iii. Maintenance dosages other than 10 mg to 15 mg once weekly will not be approved for maintenance treatment; or
5. Patient has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH); and
  - a. Patient has moderate to advanced liver fibrosis (stages F2 to F3 fibrosis) as confirmed by one of the following (attach results from testing documenting fibrosis stage);

- i. Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g. FibroScan), with a LSM of 8 kPa to 15 kPa; or
  - ii. LSM by magnetic resonance elastography (MRE) with a LSM of 3.1 kPa to 4.4 kPa; or
  - iii. Liver biopsy with a non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS)  $\geq 4$  with a score of 1 or more in steatosis, lobular inflammation, and hepatocyte ballooning; and
- b. Patient has been evaluated for cardiometabolic standard of care treatment; and
- c. Concurrent use of an incretin mimetic with resmetirom (Rezdiffra) for the treatment of MASH will only be considered after documented trials of each agent individually at therapeutic doses, with evidence of inadequate response; and
- d. Patient has not had significant alcohol consumption within the past year ( $> 20$  g per day in women or  $> 30$  g per day in men); and
- e. For Wegovy:
  - i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
  - ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment (see requests for continuation of therapy below for maintenance dose requirement); and
- 6. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
- 7. The requested agent will not be used in combination with other incretin mimetics.

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

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose will be considered at 12-month intervals when:

- 1. The requested drug will be used to reduce the risk of MACE; and
  - a. Patient has been evaluated for cardiovascular standard of care treatment; and
  - b. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; or
- 2. The requested drug will be used to treat moderate to severe OSA; and
  - a. Documentation of a positive response to therapy is provided; and
  - b. The maintenance dose is requested and maintained (Zepbound 10 mg to 15 mg once weekly); or
- 3. The requested drug will be used for noncirrhotic MASH; and
  - a. Documentation of a positive response to therapy (e.g., improvement in or stabilization of fibrosis, improvement in liver function such as reduction in alanine aminotransferase [ALT], improvement in LSM by VCTE, MRE, or biopsy); and
  - b. Patient has not progressed to cirrhosis; and
  - c. For Wegovy, a maintenance dose of 2.4 mg once weekly is requested, or 1.7 mg weekly with documentation of an adequate trial and intolerance to the maintenance dose of 2.4 mg once weekly. Patient must have a retreat of the recommended maintenance dose of 2.4 mg once weekly at least annually before a maintenance dose of 1.7 mg will be reauthorized; and
- 4. Patient does not have type 1 or type 2 diabetes; and

5. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted, and/or stricken)  
 Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
- ~~2. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus; and~~
3. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
  - a. Patient has established CVD, i.e. coronary artery disease (angina, MI), cerebrovascular disease (stroke, transient ischemic attack), peripheral arterial disease, heart failure, atrial fibrillation and other arrhythmias, valvular heart disease, congenital heart disease, cardiomyopathies, aortic disease (aneurysm, dissection), DVT or PE; and
  - b. Patient has a baseline body mass index (BMI)  $\geq 27$  kg/m<sup>2</sup> (attach documentation), obtained within 6 months of request; and
  - c. Patient has been evaluated for cardiovascular standard of care treatment; and
  - d. For Wegovy (*injection or tablet*):
    - i. Patient is  $\geq 18$  years of age; and
    - ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
    - iii. *For Wegovy injection: Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; or*
    - iv. *For Wegovy tablets: Maintenance dosages other than 25 mg once daily will not be approved for maintenance treatment (if patient does not tolerate the 25 mg once daily maintenance dosage, consider switching to Wegovy injection 1.7 mg once weekly); or*
4. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and
  - a. Patient has a baseline BMI  $\geq 30$  kg/m<sup>2</sup>; and
  - b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI)  $\geq 15$  events per hour, as documented by a polysomnography (PSG) or at-home sleep study (document AHI); and
  - c. For Zepbound:
    - i. Patient meets the FDA approved age for OSA; and
    - ii. Initiation and escalation dosages will be permitted up to a maximum of 20 weeks prior to reaching the recommended maintenance dosage of 10 mg to 15 mg once weekly; and
    - iii. Maintenance dosages other than 10 mg to 15 mg once weekly will not be approved for maintenance treatment; or
5. Patient has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH); and

- a. Patient has moderate to advanced liver fibrosis (stages F2 to F3 fibrosis) as confirmed by one of the following (attach results from testing documenting fibrosis stage);
  - i. Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g. FibroScan), with a LSM of 8 kPa to 15 kPa; or
  - ii. LSM by magnetic resonance elastography (MRE) with a LSM of 3.1 kPa to 4.4 kPa; or
  - iii. Liver biopsy with a non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS)  $\geq 4$  with a score of 1 or more in steatosis, lobular inflammation, and hepatocyte ballooning; and
- b. Patient has been evaluated for cardiometabolic standard of care treatment; and
- c. Concurrent use of an incretin mimetic with resmetirom (Rezdiffra) for the treatment of MASH will only be considered after documented trials of each agent individually at therapeutic doses, with evidence of inadequate response; and
- d. Patient has not had significant alcohol consumption within the past year ( $> 20$  g per day in women or  $> 30$  g per day in men); and
- e. For Wegovy *injection*:
  - i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
  - ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment (see requests for continuation of therapy below for maintenance dose requirement); and
6. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
7. The requested agent will not be used in combination with other incretin mimetics.

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

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose will be considered at 12-month intervals when:

1. The requested drug will be used to reduce the risk of MACE; and
  - a. Patient has been evaluated for cardiovascular standard of care treatment; and
  - b. For Wegovy *injection*, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; or
  - c. *For Wegovy tablets, a maintenance dose of 25 mg once daily is requested; or*
2. The requested drug will be used to treat moderate to severe OSA; and
  - a. Documentation of a positive response to therapy is provided; and
  - b. The maintenance dose is requested and maintained (Zepbound 10 mg to 15 mg once weekly); or
3. The requested drug will be used for noncirrhotic MASH; and
  - a. Documentation of a positive response to therapy (e.g., improvement in or stabilization of fibrosis, improvement in liver function such as reduction in alanine aminotransferase [ALT], improvement in LSM by VCTE, MRE, or biopsy); and
  - b. Patient has not progressed to cirrhosis; and
  - c. For Wegovy *injection*, a maintenance dose of 2.4 mg once weekly is requested, or 1.7 mg weekly with documentation of an adequate trial and

intolerance to the maintenance dose of 2.4 mg once weekly. Patient must have a retreat of the recommended maintenance dose of 2.4 mg once weekly at least annually before a maintenance dose of 1.7 mg will be reauthorized; and

- ~~4. Patient does not have type 1 or type 2 diabetes; and~~
5. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

### **Setmelanotide (Imcivree)**

#### Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for setmelanotide (Imcivree). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Documentation of the patient's baseline weight (kg) and body mass index (BMI) obtained within the past 60 days is provided; and
3. Patient must have a diagnosis of obesity (BMI > 30 kg/m<sup>2</sup> for adults or 95<sup>th</sup> percentile using growth chart assessments for pediatric patients) (attach growth chart assessments for pediatric patients); and
4. Patient has a diagnosis of obesity due to one of the following:
  - a. Proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, and
    - i. Genetic testing demonstrates that variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance (attach results); or
  - b. Bardet-Biedl syndrome (BBS) as evidenced by documentation in the patient's chart notes (attach documentation); or
  - c. Acquired hypothalamic obesity (HO) as evidenced by documentation in the patient's chart notes (attach documentation) of having or had a hypothalamic tumor, hypothalamic lesion, or hypothalamic damage or injury; and
5. Is prescribed by or in consultation with an endocrinologist, a geneticist, or an expert in rare genetic disorders of obesity.

If criteria for coverage is met, initial requests will be approved for 1 year. Additional approvals will be considered under the following conditions:

1. Patient's current weight (kg) and BMI document a decrease of at least 5% of baseline body weight (or at least 5% baseline BMI for patients with continued growth potential, attach growth chart assessment) since initiating treatment.

### **Topical Acne and Rosacea Products – Removal of Topical Clindamycin from PA**

The Commission reviewed topical clindamycin products and recommended removing the prior authorization requirement and implementing quantity limits. The recommendation is expected to reduce administrative burden on providers, as the majority of prior authorization requests for these products are approved. Implementation of quantity limits will support appropriate utilization while maintaining access to therapy.

**Recommended Quantity Limits**

| <b>Drug Product</b>                                        | <b>Package Size</b> | <b>Maximum Quantity Per 30 Days</b> |
|------------------------------------------------------------|---------------------|-------------------------------------|
| Clindamycin 1% gel<br>(generic to Cleocin T gel)           | 30 g tube           | 60 g (2 tubes)                      |
|                                                            | 60 g tube           | 120 g (2 tubes)                     |
| Clindamycin 1% gel<br>(generic to Clindagel)               | 75 mL bottle        | 150 mL (2 bottles)                  |
| Clindamycin 1% lotion<br>(generic to Cleocin T lotion)     | 60 mL bottle        | 120 mL (2 bottles)                  |
| Clindamycin 1% solution<br>(generic to Cleocin T solution) | 30 mL bottle        | 60 mL (2 bottles)                   |
|                                                            | 60 mL bottle        | 120 mL (2 bottles)                  |
| Clindamycin 1% foam<br>(generic to Evoclin)                | 50 g aerosol can    | 100 grams (2 cans)                  |
|                                                            | 100 g aerosol can   | 200 grams (2 cans)                  |
| Clindamycin 1% pledget<br>(generic to Cleocin T pledget)   | 60 applicators      | 120 applicators<br>(2 packages)     |

Note: Availability of branded products may vary; they are included as reference points.

**Lamotrigine Chewable Tablets – Removal of Quantity Limits**

The Commission reviewed the existing quantity limits for lamotrigine 5 mg and 25 mg chewable tablets and recommended removal of the quantity limits. The proposed change is expected to decrease provider administrative burden and facilitate appropriate dosing for patients who are unable to swallow tablets and rely on the chewable formulation to meet their prescribed dose requirements.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations regarding prior authorization for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products; Cardiac Myosin Inhibitors; Incretin Mimetics for Non-Diabetes Indications; and Setmelanotide (Imcivree); as well as removal of prior authorization for topical clindamycin products with the implementation of ProDUR quantity limits and removal of quantity limits for lamotrigine 5 mg and 25 mg chewable tablets.

Sincerely,

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

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



| DATA TYPE                         | March 2026 through May 2026 | June 2026 through August 2026 | Total  |
|-----------------------------------|-----------------------------|-------------------------------|--------|
| TOTAL PAID AMOUNT                 | 89,616,766.37               | 92,622,646.69                 | 3.35%  |
| UNIQUE USERS                      | 89,182.00                   | 86,134.00                     | -3.42% |
| COST PER USER                     | 1,004.88                    | 1,075.33                      | 7.01%  |
| TOTAL PRESCRIPTIONS               | 608,692.00                  | 596,271.00                    | -2.04% |
| AVERAGE PRESCRIPTION PER USER     | 6.83                        | 6.92                          | 1.32%  |
| AVERAGE COST PER PRESCRIPTION     | 147.23                      | 155.34                        | 5.51%  |
| # GENERIC PRESCRIPTIONS           | 543,535.00                  | 530,069.00                    | -2.48% |
| % GENERIC                         | 0.89                        | 0.89                          | -0.45% |
| \$ GENERIC                        | 10,760,126.32               | 10,488,759.49                 | -2.52% |
| AVERAGE GENERIC PRESCRIPTION COST | 19.80                       | 19.79                         | -0.05% |
| AVERAGE GENERIC DAYS SUPPLY       | 31.30                       | 31.78                         | 1.53%  |
| # BRAND PRESCRIPTIONS             | 65,157.00                   | 66,202.00                     | 1.60%  |
| % BRAND                           | 0.11                        | 0.11                          | 3.72%  |
| \$ BRAND                          | 78,856,640.05               | 82,133,887.20                 | 4.16%  |
| AVERAGE BRAND PRESCRIPTION COST   | 1,210.26                    | 1,240.66                      | 2.51%  |
| AVERAGE BRAND DAYS SUPPLY         | 29.71                       | 29.47                         | -0.81% |

| AGE   | March 2026 through May 2026 | June 2026 through August 2026 |
|-------|-----------------------------|-------------------------------|
| 0-6   | 28,523                      | 24,440                        |
| 7-12  | 41,105                      | 37,871                        |
| 13-18 | 51,551                      | 49,189                        |
| 19-64 | 476,650                     | 476,970                       |
| 65+   | 10,863                      | 7,793                         |

| GENDER | AGE   | March 2026 through May 2026 | June 2026 through August 2026 |
|--------|-------|-----------------------------|-------------------------------|
| F      | 0-6   | 12,371                      | 10,508                        |
|        | 7-12  | 16,182                      | 15,089                        |
|        | 13-18 | 26,325                      | 25,178                        |
|        | 19-64 | 309,936                     | 309,917                       |
|        | 65+   | 6,826                       | 4,906                         |
| M      | 0-6   | 16,152                      | 13,932                        |
|        | 7-12  | 24,923                      | 22,782                        |
|        | 13-18 | 25,226                      | 24,011                        |
|        | 19-64 | 166,714                     | 167,053                       |

|     |       |       |
|-----|-------|-------|
| 65+ | 4,037 | 2,887 |
|-----|-------|-------|

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
**202606-202608**

| RANK | PHARMACY NAME                                    | PHARMACY CITY  | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT        | AVG COST RX | PREVIOUS RANK |
|------|--------------------------------------------------|----------------|----------------|--------------------|-----------------|-------------|---------------|
| 1    | U OF I HOSPITALS & CLINICS AMBULATORY CARE PHARM | IOWA CITY      | IA             | 10,724             | \$ 7,338,974.51 | \$684.35    | 1             |
| 2    | RIGHT DOSE PHARMACY                              | ANKENY         | IA             | 5,326              | \$ 331,088.50   | \$62.16     | 2             |
| 3    | WALGREENS #4405                                  | COUNCIL BLUFFS | IA             | 5,021              | \$ 451,206.51   | \$89.86     | 3             |
| 4    | HY-VEE PHARMACY #2 (1138)                        | DES MOINES     | IA             | 4,123              | \$ 445,711.42   | \$108.10    | 4             |
| 5    | WALGREENS #5042                                  | CEDAR RAPIDS   | IA             | 3,955              | \$ 311,664.76   | \$78.80     | 5             |
| 6    | DRILLING PHARMACY                                | SIOUX CITY     | IA             | 3,836              | \$ 255,298.55   | \$66.55     | 8             |
| 7    | BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY    | DES MOINES     | IA             | 3,757              | \$ 335,539.62   | \$89.31     | 6             |
| 8    | MEDICAP PHARMACY LTC IOWA CITY                   | IOWA CITY      | IA             | 3,699              | \$ 132,145.37   | \$35.72     | 12            |
| 9    | GREENWOOD DRUG ON KIMBALL AVE.                   | WATERLOO       | IA             | 3,673              | \$ 417,226.85   | \$113.59    | 7             |
| 10   | HY-VEE PHARMACY (1403)                           | MARSHALLTOWN   | IA             | 3,645              | \$ 340,144.88   | \$93.32     | 9             |
| 11   | SIOUXLAND COMMUNITY HEALTH CENTER                | SIOUX CITY     | IA             | 3,426              | \$ 203,179.32   | \$59.31     | 10            |
| 12   | HY-VEE PHARMACY #5 (1151)                        | DES MOINES     | IA             | 3,182              | \$ 287,223.77   | \$90.27     | 13            |
| 13   | WALGREENS #5239                                  | DAVENPORT      | IA             | 3,129              | \$ 174,205.07   | \$55.67     | 11            |
| 14   | HY-VEE DRUGSTORE (7060)                          | MUSCATINE      | IA             | 3,113              | \$ 303,882.43   | \$97.62     | 15            |
| 15   | HY-VEE PHARMACY #5 (1109)                        | DAVENPORT      | IA             | 3,007              | \$ 285,565.31   | \$94.97     | 14            |
| 16   | HY-VEE PHARMACY #1 (1092)                        | COUNCIL BLUFFS | IA             | 2,872              | \$ 312,957.97   | \$108.97    | 16            |
| 17   | WAGNER PHARMACY                                  | CLINTON        | IA             | 2,804              | \$ 224,834.89   | \$80.18     | 20            |
| 18   | HY-VEE DRUGSTORE (7065)                          | OTTUMWA        | IA             | 2,755              | \$ 232,119.64   | \$84.25     | 21            |
| 19   | IMMC OUTPATIENT PHARMACY                         | DES MOINES     | IA             | 2,700              | \$ 157,783.12   | \$58.44     | 23            |
| 20   | WALMART PHARMACY 10-0559                         | MUSCATINE      | IA             | 2,693              | \$ 243,570.95   | \$90.45     | 22            |
| 21   | HY-VEE PHARMACY (1075)                           | CLINTON        | IA             | 2,670              | \$ 283,860.38   | \$106.31    | 19            |
| 22   | HY-VEE PHARMACY (1449)                           | NEWTON         | IA             | 2,668              | \$ 289,051.67   | \$108.34    | 24            |
| 23   | EXACTCARE                                        | VALLEY VIEW    | OH             | 2,642              | \$ 240,592.74   | \$91.06     | 27            |
| 24   | NEIGHBORHOOD LTC PHARMACY                        | URBANDALE      | IA             | 2,618              | \$ 139,904.93   | \$53.44     | 79            |
| 25   | MEDICAP PHARMACY LTC                             | INDIANOLA      | IA             | 2,560              | \$ 92,974.40    | \$36.32     | 18            |
| 26   | WALGREENS #15647                                 | SIOUX CITY     | IA             | 2,495              | \$ 186,953.14   | \$74.93     | 17            |
| 27   | HY-VEE PHARMACY (1192)                           | FT DODGE       | IA             | 2,493              | \$ 239,563.52   | \$96.09     | 25            |
| 28   | WALGREENS #7455                                  | WATERLOO       | IA             | 2,441              | \$ 175,601.21   | \$71.94     | 26            |
| 29   | HY-VEE PHARMACY #3 (1866)                        | WATERLOO       | IA             | 2,435              | \$ 270,598.40   | \$111.13    | 29            |
| 30   | COMMUNITY HEALTH CARE PHARMACY                   | DAVENPORT      | IA             | 2,402              | \$ 138,223.67   | \$57.55     | 42            |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
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| RANK | PHARMACY NAME                 | PHARMACY CITY   | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT      | AVG COST RX | PREVIOUS RANK |
|------|-------------------------------|-----------------|----------------|--------------------|---------------|-------------|---------------|
| 31   | HY-VEE PHARMACY #2 (1044)     | BURLINGTON      | IA             | 2,384              | \$ 209,232.95 | \$87.77     | 28            |
| 32   | HY-VEE PHARMACY #3 (1056)     | CEDAR RAPIDS    | IA             | 2,372              | \$ 225,874.56 | \$95.23     | 34            |
| 33   | WALGREENS #5721               | DES MOINES      | IA             | 2,370              | \$ 158,077.56 | \$66.70     | 39            |
| 34   | HY-VEE PHARMACY #1 (1610)     | SIOUX CITY      | IA             | 2,360              | \$ 207,710.60 | \$88.01     | 37            |
| 35   | WALGREENS #359                | DES MOINES      | IA             | 2,334              | \$ 159,162.14 | \$68.19     | 36            |
| 36   | GREENWOOD COMPLIANCE PHARMACY | WATERLOO        | IA             | 2,304              | \$ 320,149.82 | \$138.95    | 30            |
| 37   | HY-VEE PHARMACY #4 (1148)     | DES MOINES      | IA             | 2,284              | \$ 162,328.25 | \$71.07     | 35            |
| 38   | WALMART PHARMACY 10-2889      | CLINTON         | IA             | 2,266              | \$ 184,743.61 | \$81.53     | 44            |
| 39   | CVS PHARMACY #08544           | WATERLOO        | IA             | 2,259              | \$ 228,250.18 | \$101.04    | 41            |
| 40   | HY-VEE DRUGSTORE #1 (7020)    | CEDAR RAPIDS    | IA             | 2,257              | \$ 269,635.83 | \$119.47    | 32            |
| 41   | NELSON FAMILY PHARMACY        | FORT MADISON    | IA             | 2,256              | \$ 131,726.75 | \$58.39     | 31            |
| 42   | CVS PHARMACY #10282           | FORT DODGE      | IA             | 2,247              | \$ 142,181.43 | \$63.28     | 33            |
| 43   | WALMART PHARMACY 10-0797      | WEST BURLINGTON | IA             | 2,244              | \$ 178,896.91 | \$79.72     | 51            |
| 44   | WALGREENS #3700               | COUNCIL BLUFFS  | IA             | 2,212              | \$ 168,222.98 | \$76.05     | 40            |
| 45   | HY-VEE PHARMACY (1074)        | CHARLES CITY    | IA             | 2,202              | \$ 145,535.92 | \$66.09     | 63            |
| 46   | MAHASKA DRUGS INC             | OSKALOOSA       | IA             | 2,200              | \$ 210,753.03 | \$95.80     | 43            |
| 47   | HY-VEE PHARMACY #3 (1142)     | DES MOINES      | IA             | 2,181              | \$ 181,709.13 | \$83.31     | 49            |
| 48   | HY-VEE PHARMACY (1530)        | PLEASANT HILL   | IA             | 2,173              | \$ 203,475.39 | \$93.64     | 46            |
| 49   | UNION PHARMACY                | COUNCIL BLUFFS  | IA             | 2,150              | \$ 161,045.18 | \$74.90     | 64            |
| 50   | HY-VEE PHARMACY #5 (1061)     | CEDAR RAPIDS    | IA             | 2,133              | \$ 190,722.70 | \$89.42     | 57            |
| 51   | HY-VEE PHARMACY (1396)        | MARION          | IA             | 2,132              | \$ 198,197.65 | \$92.96     | 48            |
| 52   | WALMART PHARMACY 10-3590      | SIOUX CITY      | IA             | 2,117              | \$ 165,505.77 | \$78.18     | 50            |
| 53   | HY-VEE PHARMACY (1071)        | CLARINDA        | IA             | 2,113              | \$ 201,566.18 | \$95.39     | 53            |
| 54   | HY-VEE PHARMACY #1 (1504)     | OTTUMWA         | IA             | 2,103              | \$ 160,912.10 | \$76.52     | 47            |
| 55   | MERCYONE WATERLOO PHARMACY    | WATERLOO        | IA             | 2,085              | \$ 284,084.96 | \$136.25    | 60            |
| 56   | WALMART PHARMACY 10-1509      | MAQUOKETA       | IA             | 2,063              | \$ 159,911.07 | \$77.51     | 38            |
| 57   | HY-VEE DRUGSTORE (7056)       | MASON CITY      | IA             | 2,055              | \$ 217,650.16 | \$105.91    | 55            |
| 58   | SOUTH SIDE DRUG               | OTTUMWA         | IA             | 2,049              | \$ 146,281.59 | \$71.39     | 45            |
| 59   | WALGREENS #7453               | DES MOINES      | IA             | 2,021              | \$ 147,139.05 | \$72.81     | 61            |
| 60   | CVS PHARMACY #08658           | DAVENPORT       | IA             | 2,013              | \$ 196,290.50 | \$97.51     | 52            |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
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| RANK | PHARMACY NAME                               | PHARMACY CITY   | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT      | AVG COST RX | PREVIOUS RANK |
|------|---------------------------------------------|-----------------|----------------|--------------------|---------------|-------------|---------------|
| 61   | TOWNCREST LTC                               | IOWA CITY       | IA             | 2,004              | \$ 111,498.08 | \$55.64     | 62            |
| 62   | UI HEALTHCARE - IOWA RIVER LANDING PHARMACY | CORALVILLE      | IA             | 1,989              | \$ 134,165.74 | \$67.45     | 68            |
| 63   | GENOA HEALTHCARE, LLC                       | SIOUX CITY      | IA             | 1,973              | \$ 453,819.15 | \$230.01    | 65            |
| 64   | HY-VEE PHARMACY (1459)                      | OELWEIN         | IA             | 1,965              | \$ 157,997.67 | \$80.41     | 56            |
| 65   | SCOTT PHARMACY                              | FAYETTE         | IA             | 1,947              | \$ 147,589.71 | \$75.80     | 75            |
| 66   | HY-VEE PHARMACY #1 (1281)                   | IOWA CITY       | IA             | 1,939              | \$ 124,158.75 | \$64.03     | 73            |
| 67   | HY-VEE PHARMACY (1058)                      | CENTERVILLE     | IA             | 1,936              | \$ 186,200.59 | \$96.18     | 54            |
| 68   | WALGREENS #4714                             | DES MOINES      | IA             | 1,922              | \$ 155,637.06 | \$80.98     | 59            |
| 69   | HY-VEE PHARMACY (1522)                      | PERRY           | IA             | 1,914              | \$ 146,478.42 | \$76.53     | 69            |
| 70   | PEOPLES CLINIC PHARMACY                     | WATERLOO        | IA             | 1,904              | \$ 28,954.41  | \$15.21     | 58            |
| 71   | LEWIS FAMILY DRUG #28                       | ONAWA           | IA             | 1,889              | \$ 241,413.55 | \$127.80    | 80            |
| 72   | MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY  | DAVENPORT       | IA             | 1,887              | \$ 166,015.47 | \$87.98     | 77            |
| 73   | HY-VEE PHARMACY (1011)                      | ALTOONA         | IA             | 1,872              | \$ 157,563.65 | \$84.17     | 71            |
| 74   | WALMART PHARMACY 10-0985                    | FAIRFIELD       | IA             | 1,812              | \$ 152,679.16 | \$84.26     | 67            |
| 75   | HY-VEE PHARMACY #3 (1615)                   | SIOUX CITY      | IA             | 1,794              | \$ 169,235.56 | \$94.33     | 70            |
| 76   | WALMART PHARMACY 10-1723                    | DES MOINES      | IA             | 1,793              | \$ 166,758.42 | \$93.01     | 72            |
| 77   | WALGREENS #11942                            | DUBUQUE         | IA             | 1,781              | \$ 115,010.74 | \$64.58     | 82            |
| 78   | MERCYONE FOREST PARK PHARMACY               | MASON CITY      | IA             | 1,753              | \$ 182,921.76 | \$104.35    | 108           |
| 79   | HY-VEE PHARMACY (1241)                      | HARLAN          | IA             | 1,750              | \$ 233,944.53 | \$133.68    | 87            |
| 80   | THOMPSON DEAN DRUG                          | SIOUX CITY      | IA             | 1,744              | \$ 158,537.64 | \$90.90     | 100           |
| 81   | WALMART PHARMACY 10-5115                    | DAVENPORT       | IA             | 1,736              | \$ 146,036.69 | \$84.12     | 66            |
| 82   | CR CARE PHARMACY                            | CEDAR RAPIDS    | IA             | 1,735              | \$ 463,598.76 | \$267.20    | 98            |
| 83   | WALMART PHARMACY 10-3394                    | ATLANTIC        | IA             | 1,725              | \$ 118,520.81 | \$68.71     | 90            |
| 84   | MEDICAP PHARMACY                            | CRESTON         | IA             | 1,702              | \$ 142,605.07 | \$83.79     | 84            |
| 85   | WALMART PHARMACY 10-0646                    | ANAMOSA         | IA             | 1,694              | \$ 146,977.49 | \$86.76     | 81            |
| 86   | HY-VEE PHARMACY (1895)                      | WINDSOR HEIGHTS | IA             | 1,684              | \$ 137,213.09 | \$81.48     | 93            |
| 87   | PREFERRED CARE PHARMACY                     | CEDAR RAPIDS    | IA             | 1,684              | \$ 95,900.61  | \$56.95     | 85            |
| 88   | MCMH PHARMACY                               | RED OAK         | IA             | 1,676              | \$ 188,268.85 | \$112.33    | 104           |
| 89   | HY-VEE PHARMACY #3 (1107)                   | DAVENPORT       | IA             | 1,676              | \$ 162,360.17 | \$96.87     | 78            |
| 90   | HY-VEE DRUGSTORE (7031)                     | DES MOINES      | IA             | 1,672              | \$ 115,833.77 | \$69.28     | 96            |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
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| RANK | PHARMACY NAME                             | PHARMACY CITY  | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT      | AVG COST RX | PREVIOUS RANK |
|------|-------------------------------------------|----------------|----------------|--------------------|---------------|-------------|---------------|
| 91   | HY-VEE PHARMACY (1022)                    | ANKENY         | IA             | 1,666              | \$ 159,724.44 | \$95.87     | 88            |
| 92   | GENOA HEALTHCARE, LLC                     | DAVENPORT      | IA             | 1,663              | \$ 378,709.53 | \$227.73    | 97            |
| 93   | WALMART PHARMACY 10-3150                  | COUNCIL BLUFFS | IA             | 1,659              | \$ 145,092.48 | \$87.46     | 76            |
| 94   | HY-VEE PHARMACY (1052)                    | CEDAR FALLS    | IA             | 1,646              | \$ 132,540.54 | \$80.52     | 94            |
| 95   | CRESCENT COMMUNITY HEALTH CENTER PHARMACY | DUBUQUE        | IA             | 1,635              | \$ 154,100.68 | \$94.25     | 102           |
| 96   | WALMART PHARMACY 10-1393                  | OSKALOOSA      | IA             | 1,610              | \$ 190,434.37 | \$118.28    | 86            |
| 97   | DANIEL PHARMACY                           | FT DODGE       | IA             | 1,594              | \$ 157,458.74 | \$98.78     | 107           |
| 98   | WALGREENS #3875                           | CEDAR RAPIDS   | IA             | 1,591              | \$ 145,491.80 | \$91.45     | 74            |
| 99   | HY-VEE PHARMACY (1065)                    | CHARITON       | IA             | 1,589              | \$ 123,974.72 | \$78.02     | 112           |
| 100  | CVS PHARMACY #10032                       | MARION         | IA             | 1,582              | \$ 125,259.28 | \$79.18     | 110           |

**TOP 100 PHARMACIES BY PAID AMOUNT**  
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| RANK | PHARMACY NAME                                               | PHARMACY CITY  | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT       | AVG COST<br>MEMBER | PREVIOUS RANK |
|------|-------------------------------------------------------------|----------------|----------------|--------------------|----------------|--------------------|---------------|
| 1    | U OF I HOSPITALS & CLINICS AMBULATORY CARE PHARM            | IOWA CITY      | IA             | 10,724             | \$7,338,974.51 | \$3,267.58         | 1             |
| 2    | WALGREENS SPECIALTY PHARMACY #16528                         | DES MOINES     | IA             | 656                | \$4,153,167.32 | \$16,480.82        | 2             |
| 3    | CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY   | LENEXA         | KS             | 504                | \$3,848,791.48 | \$17,736.37        | 3             |
| 4    | UNITYPOINT AT HOME                                          | URBANDALE      | IA             | 758                | \$2,794,116.75 | \$10,387.05        | 5             |
| 5    | ACCREDITO HEALTH GROUP INC                                  | MEMPHIS        | TN             | 213                | \$2,518,474.05 | \$25,439.13        | 4             |
| 6    | PANTHERX SPECIALTY PHARMACY                                 | CORAOPOLIS     | PA             | 62                 | \$1,945,266.71 | \$88,421.21        | 6             |
| 7    | PANTHERX SPECIALTY PHARMACY                                 | COLLIERVILLE   | TN             | 45                 | \$1,729,901.53 | \$108,118.85       | 7             |
| 8    | AMBER SPECIALTY PHARMACY                                    | OMAHA          | NE             | 161                | \$1,211,684.85 | \$18,084.85        | 9             |
| 9    | THE NEBRASKA MEDICAL CENTER CLINIC PHARMACY                 | OMAHA          | NE             | 837                | \$929,499.14   | \$5,996.77         | 10            |
| 10   | CVS/SPECIALTY                                               | MONROEVILLE    | PA             | 136                | \$863,581.98   | \$18,374.08        | 11            |
| 11   | ACARIAHEALTH PHARMACY #11                                   | HOUSTON        | TX             | 105                | \$818,960.58   | \$11,374.45        | 8             |
| 12   | WALGREENS SPECIALTY PHARMACY #21250                         | IOWA CITY      | IA             | 134                | \$805,212.32   | \$10,594.90        | 13            |
| 13   | ANOVORX GROUP, LLC                                          | MEMPHIS        | TN             | 59                 | \$798,988.30   | \$38,047.06        | 12            |
| 14   | BIOLOGICS BY MCKESSON                                       | FORT WORTH     | TX             | 33                 | \$797,725.73   | \$79,772.57        | 17            |
| 15   | CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY | MT PROSPECT    | IL             | 61                 | \$742,661.26   | \$33,757.33        | 19            |
| 16   | OPTUM PHARMACY 702, LLC                                     | JEFFERSONVILLE | IN             | 75                 | \$679,572.53   | \$19,416.36        | 14            |
| 17   | WALGREENS SPECIALTY PHARMACY #16270                         | OMAHA          | NE             | 66                 | \$639,339.10   | \$23,679.23        | 16            |
| 18   | ACCREDITO HEALTH GROUP INC                                  | WARRENDALE     | PA             | 29                 | \$569,793.61   | \$71,224.20        | 15            |
| 19   | WALGREENS SPECIALTY PHARMACY #15443                         | FRISCO         | TX             | 72                 | \$552,588.62   | \$16,252.61        | 18            |
| 20   | EXPRESS SCRIPTS SPECIALTY DIST SVCS                         | SAINT LOUIS    | MO             | 33                 | \$535,835.73   | \$48,712.34        | 21            |
| 21   | MEDICAP PHARMACY                                            | URBANDALE      | IA             | 591                | \$515,709.82   | \$6,785.66         | 25            |
| 22   | CR CARE PHARMACY                                            | CEDAR RAPIDS   | IA             | 1,735              | \$463,598.76   | \$2,679.76         | 22            |
| 23   | ALLEN CLINIC PHARMACY                                       | WATERLOO       | IA             | 1,061              | \$460,987.25   | \$1,320.88         | 27            |
| 24   | PARAGON PARTNERS                                            | OMAHA          | NE             | 1,130              | \$456,055.47   | \$5,124.22         | 29            |
| 25   | EVERSANA LIFE SCIENCE SERVICES, LLC                         | CHESTERFIELD   | MO             | 9                  | \$455,440.12   | \$151,813.37       | 30            |
| 26   | GENOA HEALTHCARE, LLC                                       | SIOUX CITY     | IA             | 1,973              | \$453,819.15   | \$2,269.10         | 31            |
| 27   | WALGREENS #4405                                             | COUNCIL BLUFFS | IA             | 5,021              | \$451,206.51   | \$435.95           | 32            |
| 28   | HY-VEE PHARMACY #2 (1138)                                   | DES MOINES     | IA             | 4,123              | \$445,711.42   | \$663.26           | 26            |
| 29   | ONCO360                                                     | LOUISVILLE     | KY             | 35                 | \$422,252.06   | \$28,150.14        | 20            |
| 30   | GREENWOOD DRUG ON KIMBALL AVE.                              | WATERLOO       | IA             | 3,673              | \$417,226.85   | \$1,216.40         | 28            |
| 31   | OPTUM INFUSION SERVICES 550, LLC.                           | URBANDALE      | IA             | 88                 | \$410,235.25   | \$29,302.52        | 36            |

**TOP 100 PHARMACIES BY PAID AMOUNT**  
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| RANK | PHARMACY NAME                                 | PHARMACY CITY     | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT     | AVG COST<br>MEMBER | PREVIOUS RANK |
|------|-----------------------------------------------|-------------------|----------------|--------------------|--------------|--------------------|---------------|
| 32   | OPTUM FRONTIER THERAPIES, LLC                 | FLINT             | MI             | 10                 | \$400,640.92 | \$133,546.97       | 33            |
| 33   | ORSINI PHARMACEUTICAL SERVICES LLC            | ELK GROVE VILLAGE | IL             | 21                 | \$393,474.03 | \$65,579.01        | 37            |
| 34   | GENOA HEALTHCARE, LLC                         | DAVENPORT         | IA             | 1,663              | \$378,709.53 | \$2,366.93         | 40            |
| 35   | CVS PHARMACY #00102                           | AURORA            | CO             | 50                 | \$377,749.70 | \$17,988.08        | 24            |
| 36   | SENDERRA RX PHARMACY                          | PLANO             | TX             | 36                 | \$374,368.71 | \$24,957.91        | 46            |
| 37   | MERCYONE GENESIS FIRSTMED SPECIALTY PHARMACY  | DAVENPORT         | IA             | 477                | \$354,412.89 | \$2,549.73         | 39            |
| 38   | GENOA HEALTHCARE, LLC                         | MARSHALLTOWN      | IA             | 1,073              | \$346,199.06 | \$3,328.84         | 38            |
| 39   | WALGREENS SPECIALTY PHARMACY #16280           | FRISCO            | TX             | 12                 | \$345,551.30 | \$69,110.26        | 23            |
| 40   | HY-VEE PHARMACY (1403)                        | MARSHALLTOWN      | IA             | 3,645              | \$340,144.88 | \$463.41           | 41            |
| 41   | BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY | DES MOINES        | IA             | 3,757              | \$335,539.62 | \$455.90           | 34            |
| 42   | RIGHT DOSE PHARMACY                           | ANKENY            | IA             | 5,326              | \$331,088.50 | \$848.94           | 45            |
| 43   | GREENWOOD COMPLIANCE PHARMACY                 | WATERLOO          | IA             | 2,304              | \$320,149.82 | \$2,238.81         | 43            |
| 44   | HY-VEE PHARMACY #1 (1092)                     | COUNCIL BLUFFS    | IA             | 2,872              | \$312,957.97 | \$1,032.86         | 44            |
| 45   | WALGREENS #5042                               | CEDAR RAPIDS      | IA             | 3,955              | \$311,664.76 | \$341.74           | 49            |
| 46   | HY-VEE DRUGSTORE (7060)                       | MUSCATINE         | IA             | 3,113              | \$303,882.43 | \$579.93           | 47            |
| 47   | HY-VEE PHARMACY (1449)                        | NEWTON            | IA             | 2,668              | \$289,051.67 | \$636.68           | 55            |
| 48   | HY-VEE PHARMACY #5 (1151)                     | DES MOINES        | IA             | 3,182              | \$287,223.77 | \$546.05           | 51            |
| 49   | HY-VEE PHARMACY #5 (1109)                     | DAVENPORT         | IA             | 3,007              | \$285,565.31 | \$612.80           | 53            |
| 50   | PRIMARY HEALTHCARE PHARMACY                   | DES MOINES        | IA             | 946                | \$285,413.66 | \$1,448.80         | 61            |
| 51   | MERCYONE WATERLOO PHARMACY                    | WATERLOO          | IA             | 2,085              | \$284,084.96 | \$673.19           | 70            |
| 52   | HY-VEE PHARMACY (1075)                        | CLINTON           | IA             | 2,670              | \$283,860.38 | \$660.14           | 56            |
| 53   | ACCREDITO HEALTH GROUP, INC.                  | WHITESTOWN        | IN             | 53                 | \$280,675.82 | \$11,227.03        | 48            |
| 54   | MERCYONE ANKENY PHARMACY                      | ANKENY            | IA             | 465                | \$277,418.35 | \$2,331.25         | 42            |
| 55   | SOLEO HEALTH INC.                             | WOODRIDGE         | IL             | 7                  | \$277,313.23 | \$277,313.23       | 35            |
| 56   | ARJ INFUSION SERVICES, LLC                    | CEDAR RAPIDS      | IA             | 25                 | \$270,819.11 | \$67,704.78        | 94            |
| 57   | HY-VEE PHARMACY #3 (1866)                     | WATERLOO          | IA             | 2,435              | \$270,598.40 | \$822.49           | 58            |
| 58   | HY-VEE DRUGSTORE #1 (7020)                    | CEDAR RAPIDS      | IA             | 2,257              | \$269,635.83 | \$755.28           | 50            |
| 59   | AVERA SPECIALTY PHARMACY                      | SIOUX FALLS       | SD             | 71                 | \$258,332.84 | \$9,567.88         | 62            |
| 60   | DRILLING PHARMACY                             | SIOUX CITY        | IA             | 3,836              | \$255,298.55 | \$787.96           | 57            |
| 61   | FOUNDATION CARE LLC                           | CHESTERFIELD      | MO             | 30                 | \$255,035.26 | \$9,809.05         | 241           |
| 62   | SANFORD PHARMACY BROADWAY                     | FARGO             | ND             | 12                 | \$245,288.70 | \$61,322.18        | 165           |

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| RANK | PHARMACY NAME                       | PHARMACY CITY | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT     | AVG COST<br>MEMBER | PREVIOUS RANK |
|------|-------------------------------------|---------------|----------------|--------------------|--------------|--------------------|---------------|
| 63   | WALMART PHARMACY 10-0559            | MUSCATINE     | IA             | 2,693              | \$243,570.95 | \$532.98           | 63            |
| 64   | LEWIS FAMILY DRUG #28               | ONAWA         | IA             | 1,889              | \$241,413.55 | \$924.96           | 72            |
| 65   | RIVER HILLS PHARMACY                | OTTUMWA       | IA             | 814                | \$240,629.07 | \$1,552.45         | 86            |
| 66   | EXACTCARE                           | VALLEY VIEW   | OH             | 2,642              | \$240,592.74 | \$2,129.14         | 59            |
| 67   | HY-VEE PHARMACY (1192)              | FT DODGE      | IA             | 2,493              | \$239,563.52 | \$620.63           | 52            |
| 68   | MEDICAP PHARMACY                    | DES MOINES    | IA             | 1,508              | \$237,230.30 | \$2,550.86         | 81            |
| 69   | UI HEALTH CARE DES MOINES PHARMACY  | DES MOINES    | IA             | 39                 | \$234,587.15 | \$19,548.93        | 98            |
| 70   | HY-VEE PHARMACY (1241)              | HARLAN        | IA             | 1,750              | \$233,944.53 | \$764.52           | 76            |
| 71   | HY-VEE DRUGSTORE (7065)             | OTTUMWA       | IA             | 2,755              | \$232,119.64 | \$520.45           | 74            |
| 72   | CVS PHARMACY #08544                 | WATERLOO      | IA             | 2,259              | \$228,250.18 | \$471.59           | 64            |
| 73   | HY-VEE PHARMACY #3 (1056)           | CEDAR RAPIDS  | IA             | 2,372              | \$225,874.56 | \$518.06           | 65            |
| 74   | WAGNER PHARMACY                     | CLINTON       | IA             | 2,804              | \$224,834.89 | \$772.63           | 66            |
| 75   | HY-VEE DRUGSTORE (7056)             | MASON CITY    | IA             | 2,055              | \$217,650.16 | \$580.40           | 85            |
| 76   | ACARIAHEALTH PHARMACY #26, INC.     | TAMPA         | FL             | 27                 | \$217,484.80 | \$9,885.67         | 223           |
| 77   | MAHASKA DRUGS INC                   | OSKALOOSA     | IA             | 2,200              | \$210,753.03 | \$625.38           | 67            |
| 78   | HY-VEE PHARMACY #2 (1044)           | BURLINGTON    | IA             | 2,384              | \$209,232.95 | \$540.65           | 79            |
| 79   | HY-VEE PHARMACY #1 (1610)           | SIOUX CITY    | IA             | 2,360              | \$207,710.60 | \$437.29           | 71            |
| 80   | WALGREENS SPECIALTY PHARMACY #15438 | CANTON        | MI             | 22                 | \$204,424.19 | \$18,584.02        | 113           |
| 81   | HY-VEE PHARMACY (1530)              | PLEASANT HILL | IA             | 2,173              | \$203,475.39 | \$525.78           | 78            |
| 82   | SIOUXLAND COMMUNITY HEALTH CENTER   | SIOUX CITY    | IA             | 3,426              | \$203,179.32 | \$310.67           | 68            |
| 83   | HY-VEE PHARMACY (1071)              | CLARINDA      | IA             | 2,113              | \$201,566.18 | \$704.78           | 69            |
| 84   | CURANT HEALTH GEORGIA LLC           | SMYRNA        | GA             | 4                  | \$201,271.32 | \$100,635.66       | 92            |
| 85   | HY-VEE PHARMACY (1396)              | MARION        | IA             | 2,132              | \$198,197.65 | \$524.33           | 82            |
| 86   | CVS PHARMACY #08658                 | DAVENPORT     | IA             | 2,013              | \$196,290.50 | \$596.63           | 73            |
| 87   | MEDICAP PHARMACY                    | NEWTON        | IA             | 1,555              | \$192,919.22 | \$979.29           | 80            |
| 88   | HY-VEE PHARMACY #5 (1061)           | CEDAR RAPIDS  | IA             | 2,133              | \$190,722.70 | \$508.59           | 93            |
| 89   | WALMART PHARMACY 10-1393            | OSKALOOSA     | IA             | 1,610              | \$190,434.37 | \$777.28           | 88            |
| 90   | MCMH PHARMACY                       | RED OAK       | IA             | 1,676              | \$188,268.85 | \$863.62           | 169           |
| 91   | WALGREENS #15647                    | SIOUX CITY    | IA             | 2,495              | \$186,953.14 | \$273.32           | 111           |
| 92   | HY-VEE PHARMACY (1058)              | CENTERVILLE   | IA             | 1,936              | \$186,200.59 | \$862.04           | 75            |
| 93   | ORSINI PHARMACEUTICAL SERVICES, LLC | COLUMBUS      | OH             | 3                  | \$185,911.89 | \$185,911.89       | 185           |

**TOP 100 PHARMACIES BY PAID AMOUNT**  
**202606-202608**

| RANK | PHARMACY NAME                 | PHARMACY CITY   | PHARMACY STATE | PRESCRIPTION COUNT | PAID AMT     | AVG COST<br>MEMBER | PREVIOUS RANK |
|------|-------------------------------|-----------------|----------------|--------------------|--------------|--------------------|---------------|
| 94   | WALMART PHARMACY 10-2889      | CLINTON         | IA             | 2,266              | \$184,743.61 | \$478.61           | 97            |
| 95   | GENOA HEALTHCARE, LLC         | MASON CITY      | IA             | 744                | \$184,035.89 | \$1,752.72         | 143           |
| 96   | MERCYONE FOREST PARK PHARMACY | MASON CITY      | IA             | 1,753              | \$182,921.76 | \$601.72           | 115           |
| 97   | HY-VEE PHARMACY #3 (1142)     | DES MOINES      | IA             | 2,181              | \$181,709.13 | \$463.54           | 84            |
| 98   | WALMART PHARMACY 10-1683      | SHENANDOAH      | IA             | 1,422              | \$180,759.90 | \$860.76           | 109           |
| 99   | WALMART PHARMACY 10-0797      | WEST BURLINGTON | IA             | 2,244              | \$178,896.91 | \$421.93           | 114           |
| 100  | WALGREENS #7455               | WATERLOO        | IA             | 2,441              | \$175,601.21 | \$240.22           | 100           |

**TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**202606-202608**

| RANK | NPI NUM    | PRESCRIBER NAME     | PAID AMOUNT  | PRESCRIPTION COUNT | AVG SCRIPTS PER MEMBER | PREVIOUS RANK |
|------|------------|---------------------|--------------|--------------------|------------------------|---------------|
| 1    | 1982605762 | JEFFREY WILHARM     | \$58,779.24  | 1,706              | 25.85                  | 1             |
| 2    | 1528365277 | MINA SALIB          | \$326,531.32 | 959                | 4.42                   | 3             |
| 3    | 1013115369 | BOBBITA NAG         | \$34,596.19  | 942                | 5.26                   | 2             |
| 4    | 1689325524 | BRIAN AYERSMAN      | \$146,268.44 | 862                | 8.45                   | 9             |
| 5    | 1730849647 | MELANIE PARRISH     | \$27,398.11  | 856                | 6.07                   | 4             |
| 6    | 1306559786 | ROY HENRY           | \$34,391.85  | 839                | 9.02                   | 18            |
| 7    | 1659358620 | CARLOS CASTILLO     | \$21,468.48  | 828                | 6.90                   | 5             |
| 8    | 1306475413 | AUTUMN ANDERSON     | \$41,147.29  | 797                | 8.66                   | 11            |
| 9    | 1992402655 | SHANE EBERHARDT     | \$169,112.75 | 762                | 5.91                   | 8             |
| 10   | 1023542271 | FLYNN MCCULLOUGH    | \$128,933.06 | 753                | 8.37                   | 19            |
| 11   | 1801463245 | ANN MOJEIKO         | \$79,619.91  | 751                | 7.51                   | 12            |
| 12   | 1245960350 | MARY WELBORN        | \$57,239.91  | 748                | 6.29                   | 28            |
| 13   | 1417941188 | DEBRA NEUHARTH      | \$53,355.13  | 733                | 6.55                   | 13            |
| 14   | 1598183493 | JENA ELLERHOFF      | \$62,214.72  | 730                | 9.13                   | 25            |
| 15   | 1184056822 | ABBY KOLTHOFF       | \$377,513.43 | 715                | 6.88                   | 14            |
| 16   | 1770933046 | SHELBY BILLER       | \$124,369.06 | 709                | 7.46                   | 16            |
| 17   | 1053630640 | JENNIFER DONOVAN    | \$101,789.93 | 700                | 7.37                   | 10            |
| 18   | 1902478811 | JOAN ANDERSON       | \$177,455.03 | 696                | 7.25                   | 15            |
| 19   | 1114681889 | KELSEY BAUER        | \$52,980.65  | 692                | 6.85                   | 57            |
| 20   | 1811960768 | ANGELA VEENSTRA     | \$60,117.76  | 685                | 8.56                   | 22            |
| 21   | 1619153137 | JOADA BEST          | \$69,511.03  | 681                | 7.25                   | 23            |
| 22   | 1275763047 | REBECCA BOWMAN      | \$116,866.32 | 669                | 9.16                   | 21            |
| 23   | 1649248378 | KATHLEEN WILD       | \$19,578.49  | 665                | 7.82                   | 24            |
| 24   | 1205393386 | JESSICA HUDSPETH    | \$57,736.26  | 664                | 7.81                   | 26            |
| 25   | 1538149042 | ERIC PETERSEN       | \$21,690.05  | 660                | 7.02                   | 37            |
| 26   | 1801998372 | WENDY HANSEN-PENMAN | \$31,212.97  | 655                | 7.62                   | 29            |
| 27   | 1215125216 | REBECCA WALDING     | \$74,916.91  | 645                | 7.96                   | 20            |
| 28   | 1265841845 | MARY SCHWERING      | \$61,108.21  | 644                | 7.58                   | 17            |
| 29   | 1467907394 | CYNTHIA COENEN      | \$73,180.01  | 642                | 9.58                   | 40            |
| 30   | 1609532373 | ERIN FOX-HAMMEL     | \$36,665.90  | 642                | 6.62                   | 34            |
| 31   | 1457914657 | SEEMA ANTONY        | \$107,004.46 | 641                | 6.22                   | 31            |
| 32   | 1407415128 | SONDRA PHILIPS      | \$40,745.33  | 633                | 6.66                   | 35            |
| 33   | 1467092049 | HEIDI PEDERSEN      | \$105,196.85 | 626                | 8.82                   | 39            |

**TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**202606-202608**

| RANK | NPI NUM    | PRESCRIBER NAME     | PAID AMOUNT  | PRESCRIPTION COUNT | AVG SCRIPTS PER MEMBER | PREVIOUS RANK |
|------|------------|---------------------|--------------|--------------------|------------------------|---------------|
| 34   | 1144588476 | RACHEL FILZER       | \$86,908.20  | 625                | 7.27                   | 52            |
| 35   | 1326798992 | JENNA MULLINS       | \$70,038.89  | 625                | 4.56                   | 62            |
| 36   | 1992103386 | MELISSA LARSEN      | \$74,567.17  | 606                | 7.39                   | 33            |
| 37   | 1477926434 | JACKIE SHIPLEY      | \$34,082.20  | 595                | 5.41                   | 32            |
| 38   | 1811419815 | GRETCHEN WENGER     | \$56,540.62  | 592                | 5.59                   | 7             |
| 39   | 1902358443 | MELISSA KONKEN      | \$117,966.13 | 590                | 7.97                   | 45            |
| 40   | 1720698335 | DANIKA HANSEN       | \$75,016.12  | 590                | 6.21                   | 58            |
| 41   | 1053963900 | NICOLE MCCLAVY      | \$114,041.36 | 588                | 7.00                   | 42            |
| 42   | 1467431445 | SUSAN CASADY        | \$28,927.01  | 584                | 14.60                  | 145           |
| 43   | 1487194791 | STACY HENNIGAR      | \$44,767.90  | 571                | 5.39                   | 88            |
| 44   | 1992314108 | LYNZEE MAKOWSKI     | \$610,315.83 | 569                | 5.47                   | 30            |
| 45   | 1073156295 | KASIE CHRISTENSEN   | \$41,517.26  | 569                | 6.39                   | 50            |
| 46   | 1255823506 | NICOLE DELAGARDELLE | \$102,158.26 | 565                | 5.33                   | 55            |
| 47   | 1790135176 | EMILY REITER        | \$48,664.73  | 565                | 6.65                   | 43            |
| 48   | 1043434525 | ROBERT KENT         | \$45,994.80  | 560                | 6.44                   | 53            |
| 49   | 1528329398 | ERIN ROWAN          | \$29,757.72  | 559                | 5.54                   | 54            |
| 50   | 1538368170 | CHRISTOPHER MATSON  | \$38,744.63  | 557                | 7.63                   | 67            |
| 51   | 1598786097 | STEPHANIE GRAY      | \$181,798.62 | 551                | 9.18                   | 96            |
| 52   | 1457667610 | LEAH SCHUPP         | \$36,844.63  | 551                | 5.40                   | 132           |
| 53   | 1043703887 | TENAEA JEPPESON     | \$61,843.40  | 548                | 8.30                   | 48            |
| 54   | 1821268335 | JACQUELINE MCINNIS  | \$115,270.26 | 547                | 11.40                  | 38            |
| 55   | 1164538674 | JOSEPH WANZEK       | \$99,366.02  | 545                | 9.56                   | 44            |
| 56   | 1215981758 | LISA PISNEY         | \$80,458.42  | 542                | 6.86                   | 47            |
| 57   | 1477199198 | SAJO THOMAS         | \$132,823.15 | 541                | 7.12                   | 27            |
| 58   | 1679573893 | PATTY HILDRETH      | \$124,524.43 | 538                | 6.56                   | 36            |
| 59   | 1962418640 | BARCLAY MONASTER    | \$56,363.78  | 534                | 4.27                   | 95            |
| 60   | 1295830115 | ALAN BOLLINGER      | \$15,507.49  | 533                | 7.11                   | 101           |
| 61   | 1649763079 | KATE JARVIS         | \$122,181.55 | 529                | 5.57                   | 59            |
| 62   | 1942721584 | SHAWNA FURY         | \$35,780.34  | 529                | 4.34                   | 66            |
| 63   | 1184657603 | SARA RYGOL          | \$78,283.17  | 527                | 6.06                   | 56            |
| 64   | 1821600594 | CARRIE GOODWIN      | \$89,881.29  | 524                | 8.88                   | 74            |
| 65   | 1619380680 | TARA BROCKMAN       | \$50,220.56  | 524                | 5.70                   | 80            |
| 66   | 1881095503 | KAROWESO CHIPENDO   | \$43,795.03  | 515                | 6.06                   | 72            |

**TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**202606-202608**

| RANK | NPI NUM    | PRESCRIBER NAME     | PAID AMOUNT  | PRESCRIPTION COUNT | AVG SCRIPTS PER MEMBER | PREVIOUS RANK |
|------|------------|---------------------|--------------|--------------------|------------------------|---------------|
| 67   | 1831731298 | HEATHER WILSON      | \$37,476.07  | 515                | 6.69                   | 90            |
| 68   | 1154815330 | BRUCE PEHL          | \$32,223.53  | 511                | 6.23                   | 46            |
| 69   | 1538699806 | JENNIFER HUTCHINSON | \$52,469.52  | 509                | 7.95                   | 108           |
| 70   | 1689077018 | STACY ROTH          | \$97,706.29  | 508                | 6.68                   | 61            |
| 71   | 1902912538 | CHRISTIAN JONES     | \$36,428.70  | 508                | 5.84                   | 41            |
| 72   | 1871021543 | SUSAN WILSON        | \$44,696.04  | 505                | 7.32                   | 97            |
| 73   | 1245227099 | DONNA DOBSON TOBIN  | \$65,129.19  | 504                | 7.75                   | 70            |
| 74   | 1922144088 | THOMAS HOPKINS      | \$19,910.68  | 501                | 4.21                   | 83            |
| 75   | 1215581251 | ANNA THROCKMORTON   | \$49,261.14  | 497                | 9.94                   | 65            |
| 76   | 1841182052 | AKSANA THARP        | \$131,149.38 | 496                | 11.54                  | 91            |
| 77   | 1902574361 | LAURA OWENS         | \$38,600.95  | 495                | 7.62                   | 109           |
| 78   | 1316471154 | NICOLE WOOLLEY      | \$27,195.83  | 490                | 5.63                   | 89            |
| 79   | 1841220290 | KENT KUNZE          | \$11,034.49  | 490                | 7.54                   | 73            |
| 80   | 1871375543 | MONICA NUCKOLLS     | \$70,678.20  | 485                | 8.22                   | 310           |
| 81   | 1649247362 | PATRICK PUCELIK     | \$29,245.55  | 484                | 8.49                   | 133           |
| 82   | 1437238110 | GENEVIEVE NELSON    | \$109,980.21 | 483                | 8.05                   | 51            |
| 83   | 1427766559 | KORIE EISCHEID      | \$34,455.50  | 483                | 6.62                   | 85            |
| 84   | 1184125262 | JENIFER EDSTROM     | \$13,112.74  | 480                | 4.17                   | 76            |
| 85   | 1144240805 | DANIEL ROWLEY       | \$31,211.37  | 479                | 10.89                  | 123           |
| 86   | 1891146999 | BECKY JOHNSON       | \$539,004.40 | 477                | 7.02                   | 79            |
| 87   | 1023469798 | WEI SHIPENG         | \$34,718.47  | 476                | 14.00                  | 100           |
| 88   | 1467502286 | CHARLES TILLEY      | \$76,613.88  | 474                | 7.52                   | 64            |
| 89   | 1336853415 | KATHERINE LOWARY    | \$24,977.63  | 472                | 13.11                  | 84            |
| 90   | 1831710987 | MARGARET WHITE      | \$37,328.40  | 471                | 6.63                   | 69            |
| 91   | 1891707832 | LISA KLOCK          | \$31,375.58  | 470                | 4.43                   | 78            |
| 92   | 1043418809 | MICHAEL CILIBERTO   | \$252,342.54 | 469                | 7.95                   | 86            |
| 93   | 1609218304 | AMANDA GARR         | \$62,448.13  | 467                | 5.91                   | 199           |
| 94   | 1952955692 | TRINA SMITH         | \$46,576.65  | 464                | 8.92                   | 106           |
| 95   | 1659108090 | TERESA HANSON       | \$192,065.07 | 463                | 5.86                   | 221           |
| 96   | 1639607757 | MICHAEL GERBER      | \$52,153.90  | 463                | 5.58                   | 338           |
| 97   | 1609946243 | SINA LINMAN         | \$24,548.66  | 461                | 5.49                   | 68            |
| 98   | 1891306452 | JENNIFER TOMLIN     | \$46,391.26  | 460                | 5.29                   | 71            |
| 99   | 1881266914 | ALICIA KNOX         | \$66,112.16  | 459                | 6.12                   | 94            |

TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT  
202606-202608

| RANK | NPI NUM    | PRESCRIBER NAME | PAID AMOUNT | PRESCRIPTION COUNT | AVG SCRIPTS PER MEMBER | PREVIOUS RANK |
|------|------------|-----------------|-------------|--------------------|------------------------|---------------|
| 100  | 1043211303 | ALI SAFDAR      | \$39,225.61 | 459                | 6.47                   | 142           |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**202606-202608**

| RANK | DOCTOR NUM | PRESCRIBER NAME     | AVG_SCRIPTS_PER_MEMBER | PAID AMOUNT  | AVG COST RX | PREVIOUS RANK |
|------|------------|---------------------|------------------------|--------------|-------------|---------------|
| 1    | 1326034984 | KATHERINE MATHEWS   | 44                     | \$976,200.27 | \$22,186.37 | 1             |
| 2    | 1942937388 | CARLY TRAUSCH       | 437                    | \$698,113.25 | \$1,597.51  | 6             |
| 3    | 1285626390 | KATHLEEN GRADOVILLE | 150                    | \$694,835.00 | \$4,632.23  | 10            |
| 4    | 1477761328 | AMY CALHOUN         | 69                     | \$667,449.42 | \$9,673.18  | 2             |
| 5    | 1295091510 | REBECCA WEINER      | 282                    | \$659,202.46 | \$2,337.60  | 4             |
| 6    | 1669184511 | CHANDRA MILLER      | 31                     | \$634,739.79 | \$20,475.48 | 9             |
| 7    | 1992314108 | LYNZEE MAKOWSKI     | 569                    | \$610,315.83 | \$1,072.61  | 3             |
| 8    | 1114214541 | DIMAH SAADE         | 56                     | \$577,463.99 | \$10,311.86 | 11            |
| 9    | 1013126705 | JANICE STABER       | 35                     | \$554,360.86 | \$15,838.88 | 8             |
| 10   | 1891146999 | BECKY JOHNSON       | 477                    | \$539,004.40 | \$1,129.99  | 12            |
| 11   | 1417443953 | RODNEY CLARK        | 362                    | \$512,542.34 | \$1,415.86  | 13            |
| 12   | 1316934318 | STEVEN LENTZ        | 21                     | \$479,301.75 | \$22,823.89 | 7             |
| 13   | 1700561826 | PEDRO HSIEH         | 53                     | \$395,009.42 | \$7,453.01  | 16            |
| 14   | 1033221916 | ADRIAN LETZ         | 114                    | \$386,999.21 | \$3,394.73  | 20            |
| 15   | 1215333091 | NADIA NAZ           | 181                    | \$381,598.33 | \$2,108.28  | 21            |
| 16   | 1780788844 | TAMMY WICHMAN       | 36                     | \$380,698.46 | \$10,574.96 | 5             |
| 17   | 1588616171 | HEATHER THOMAS      | 133                    | \$378,012.10 | \$2,842.20  | 29            |
| 18   | 1184056822 | ABBY KOLTHOFF       | 715                    | \$377,513.43 | \$527.99    | 14            |
| 19   | 1356753859 | KATIE LUTZ          | 118                    | \$330,371.60 | \$2,799.76  | 18            |
| 20   | 1528365277 | MINA SALIB          | 959                    | \$326,531.32 | \$340.49    | 19            |
| 21   | 1437121407 | LINDA CADARET       | 65                     | \$320,497.45 | \$4,930.73  | 15            |
| 22   | 1366065047 | BRITTANIA SCHOON    | 163                    | \$317,892.24 | \$1,950.26  | 46            |
| 23   | 1376777383 | JONATHON HENNINGS   | 108                    | \$314,560.82 | \$2,912.60  | 24            |
| 24   | 1619382942 | EIRENE ALEXANDROU   | 98                     | \$300,105.96 | \$3,062.31  | 1375          |
| 25   | 1326410499 | TARA EASTVOLD       | 310                    | \$297,325.94 | \$959.12    | 27            |
| 26   | 1326211889 | JAMES FRIEDLANDER   | 52                     | \$281,828.39 | \$5,419.78  | 65            |
| 27   | 1356445886 | MEGAN EISEL         | 156                    | \$280,782.46 | \$1,799.89  | 17            |
| 28   | 1093382632 | GAIL DOOLEY         | 179                    | \$278,095.38 | \$1,553.61  | 43            |
| 29   | 1891158275 | ANDREW GROVES       | 35                     | \$273,045.92 | \$7,801.31  | 31            |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**202606-202608**

| RANK | DOCTOR NUM | PRESCRIBER NAME    | AVG_SCRIPTS_PER_MEMBER | PAID AMOUNT  | AVG COST RX | PREVIOUS RANK |
|------|------------|--------------------|------------------------|--------------|-------------|---------------|
| 30   | 1427258367 | ALI JABBARI        | 80                     | \$267,895.26 | \$3,348.69  | 88            |
| 31   | 1609131770 | SREENATH GANGANNA  | 268                    | \$266,445.74 | \$994.20    | 42            |
| 32   | 1093162075 | MEGHAN RYAN        | 105                    | \$264,711.09 | \$2,521.06  | 37            |
| 33   | 1467449579 | BRIAN WAYSON       | 86                     | \$260,567.89 | \$3,029.86  | 26            |
| 34   | 1932831971 | KRISTEN EMODI      | 49                     | \$255,061.48 | \$5,205.34  | 50            |
| 35   | 1043418809 | MICHAEL CILIBERTO  | 469                    | \$252,342.54 | \$538.04    | 25            |
| 36   | 1093455636 | CHRISTY JOHNSON    | 22                     | \$245,695.93 | \$11,168.00 | 6713          |
| 37   | 1568097244 | ELIZABETH DASSOW   | 108                    | \$235,119.88 | \$2,177.04  | 33            |
| 38   | 1235792912 | FARAAZ ZAFAR       | 93                     | \$234,293.62 | \$2,519.29  | 22            |
| 39   | 1023108701 | RONALD ZOLTY       | 37                     | \$227,710.98 | \$6,154.35  | 32            |
| 40   | 1922772839 | PATRICK THOMPSON   | 294                    | \$223,506.61 | \$760.23    | 175           |
| 41   | 1225263833 | LINDSAY ORRIS      | 69                     | \$217,744.97 | \$3,155.72  | 90            |
| 42   | 1952539447 | ANTHONY FISCHER    | 122                    | \$217,422.73 | \$1,782.15  | 30            |
| 43   | 1477968303 | JOSEPH LARSON      | 217                    | \$215,544.78 | \$993.29    | 34            |
| 44   | 1437513520 | SUSSETTE GONZALEZ  | 116                    | \$211,270.58 | \$1,821.30  | 99            |
| 45   | 1861277980 | KATHRYN EWOLDT     | 127                    | \$210,384.11 | \$1,656.57  | 35            |
| 46   | 1558808501 | JESSICA BRAKSIEK   | 35                     | \$209,465.62 | \$5,984.73  | 36            |
| 47   | 1730153503 | ROBERT FRANTZ      | 11                     | \$205,879.87 | \$18,716.35 | 696           |
| 48   | 1306071915 | THOMAS PIETRAS     | 74                     | \$205,689.59 | \$2,779.59  | 71            |
| 49   | 1124096698 | SOOKYONG KOH       | 123                    | \$204,394.00 | \$1,661.74  | 48            |
| 50   | 1235518507 | ADEKUNLE AJISEBUTU | 18                     | \$198,485.07 | \$11,026.95 | 63            |
| 51   | 1366809923 | KELLY HOOVER       | 453                    | \$193,096.15 | \$426.26    | 68            |
| 52   | 1659108090 | TERESA HANSON      | 463                    | \$192,065.07 | \$414.83    | 75            |
| 53   | 1336602846 | DRAKE BOUZEK       | 98                     | \$190,739.76 | \$1,946.32  | 109           |
| 54   | 1043565328 | SARA MOELLER       | 52                     | \$189,811.97 | \$3,650.23  | 39            |
| 55   | 1538693700 | KAMEL SHIBBANI     | 43                     | \$188,881.90 | \$4,392.60  | 113           |
| 56   | 1275836751 | HOLLY KRAMER       | 153                    | \$186,759.78 | \$1,220.65  | 41            |
| 57   | 1679569495 | WENDIANNE WILSON   | 13                     | \$183,135.38 | \$14,087.34 | 274           |
| 58   | 1598786097 | STEPHANIE GRAY     | 551                    | \$181,798.62 | \$329.94    | 59            |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**202606-202608**

| RANK | DOCTOR NUM | PRESCRIBER NAME      | AVG_SCRIPTS_PER_MEMBER | PAID AMOUNT  | AVG COST RX | PREVIOUS RANK |
|------|------------|----------------------|------------------------|--------------|-------------|---------------|
| 59   | 1972560597 | BERNARD LEMAN        | 32                     | \$181,499.77 | \$5,671.87  | 117           |
| 60   | 1356752067 | KELLY DELANEY-NELSON | 56                     | \$179,234.04 | \$3,200.61  | 69            |
| 61   | 1902478811 | JOAN ANDERSON        | 696                    | \$177,455.03 | \$254.96    | 64            |
| 62   | 1245468768 | THOMAS SCHMIDT       | 84                     | \$176,445.46 | \$2,100.54  | 120           |
| 63   | 1245353242 | SANDY HONG           | 99                     | \$176,106.21 | \$1,778.85  | 95            |
| 64   | 1134981038 | CASSIDY CHALUPA      | 68                     | \$175,635.54 | \$2,582.88  | 67            |
| 65   | 1730406356 | CHRISTINA WARREN     | 95                     | \$175,514.83 | \$1,847.52  | 74            |
| 66   | 1912208323 | LISA MEYER           | 390                    | \$174,678.70 | \$447.89    | 52            |
| 67   | 1578958542 | HEIDI CURTIS         | 129                    | \$174,202.17 | \$1,350.40  | 51            |
| 68   | 1649419219 | HEATHER HUNEMULLER   | 123                    | \$172,757.49 | \$1,404.53  | 49            |
| 69   | 1407065469 | CHRISTOPH RANDAK     | 245                    | \$170,646.34 | \$696.52    | 28            |
| 70   | 1841548161 | CRYSTAL MEYER        | 53                     | \$170,329.92 | \$3,213.77  | 47            |
| 71   | 1992402655 | SHANE EBERHARDT      | 762                    | \$169,112.75 | \$221.93    | 57            |
| 72   | 1386084747 | JENNIFER CONDON      | 135                    | \$169,089.19 | \$1,252.51  | 60            |
| 73   | 1912979261 | DAVID VISOKEY        | 115                    | \$168,126.81 | \$1,461.97  | 84            |
| 74   | 1689942518 | PATRIA ALBA APONTE   | 250                    | \$165,704.78 | \$662.82    | 58            |
| 75   | 1437533130 | KATIE BROSHUIS       | 137                    | \$163,891.72 | \$1,196.29  | 40            |
| 76   | 1629213509 | TERI DEVINE          | 48                     | \$163,315.80 | \$3,402.41  | 4027          |
| 77   | 1134249832 | STEVEN CRAIG         | 101                    | \$161,246.30 | \$1,596.50  | 54            |
| 78   | 1992810956 | CHRISTOPHER RONKAR   | 51                     | \$161,218.49 | \$3,161.15  | 66            |
| 79   | 1508148511 | YOGESH REDDY         | 10                     | \$159,953.69 | \$15,995.37 | 145           |
| 80   | 1578132940 | ALEC STEILS          | 324                    | \$159,799.49 | \$493.21    | 97            |
| 81   | 1437541661 | KAY SIMONS           | 281                    | \$151,102.64 | \$537.73    | 1852          |
| 82   | 1891754404 | DAVID SPECTOR        | 24                     | \$150,743.65 | \$6,280.99  | 101           |
| 83   | 1780029090 | DIVYA PATI           | 150                    | \$150,477.53 | \$1,003.18  | 73            |
| 84   | 1548143977 | TIERNEY KOZAL        | 91                     | \$148,434.94 | \$1,631.15  | 134           |
| 85   | 1477765584 | SANGEETA SHAH        | 323                    | \$148,309.32 | \$459.16    | 183           |
| 86   | 1649826140 | TAYLOR MYERS         | 118                    | \$148,246.67 | \$1,256.33  | 23            |
| 87   | 1043429087 | KAYELYN WAGNER       | 13                     | \$147,948.83 | \$11,380.68 | 393           |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**202606-202608**

| RANK | DOCTOR NUM | PRESCRIBER NAME        | AVG_SCRIPTS_PER_MEMBER | PAID AMOUNT  | AVG COST RX | PREVIOUS RANK |
|------|------------|------------------------|------------------------|--------------|-------------|---------------|
| 88   | 1255743928 | CHRISTINE GILL         | 50                     | \$146,861.01 | \$2,937.22  | 91            |
| 89   | 1689325524 | BRIAN AYERSMAN         | 862                    | \$146,268.44 | \$169.69    | 76            |
| 90   | 1154975928 | HIMA DOPPALAPUDI       | 35                     | \$145,489.19 | \$4,156.83  | 116           |
| 91   | 1447519038 | ERIN RICHARDSON        | 117                    | \$144,961.89 | \$1,238.99  | 56            |
| 92   | 1003315201 | ABIGAIL BEHRENS        | 55                     | \$142,336.36 | \$2,587.93  | 96            |
| 93   | 1558820084 | ABBIE CHRISTENSEN      | 95                     | \$141,799.78 | \$1,492.63  | 161           |
| 94   | 1669443230 | KENNETH ADAMS          | 49                     | \$141,567.45 | \$2,889.13  | 94            |
| 95   | 1770324220 | CASIE HALE             | 389                    | \$140,976.85 | \$362.41    | 61            |
| 96   | 1821684564 | ERIN CULLEN            | 57                     | \$140,242.99 | \$2,460.40  | 238           |
| 97   | 1336346352 | HANNA ZEMBRZUSKA       | 42                     | \$137,455.94 | \$3,272.76  | 55            |
| 98   | 1811666118 | JESSIANN DRYDEN-PARISH | 97                     | \$136,404.95 | \$1,406.24  | 81            |
| 99   | 1558333005 | RALITZA GAVRILOVA      | 4                      | \$136,120.56 | \$34,030.14 | 140           |
| 100  | 1295554822 | JOANNA ANDERSON        | 413                    | \$134,435.12 | \$325.51    | 137           |

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

| CATEGORY DESCRIPTION                              | 202603 - 202605     |               |                   | 202606 - 202608    |              |                  |          |
|---------------------------------------------------|---------------------|---------------|-------------------|--------------------|--------------|------------------|----------|
|                                                   | PREVIOUS TOTAL COST | PREVIOUS RANK | PREVIOUS % BUDGET | CURRENT TOTAL COST | CURRENT RANK | CURRENT % BUDGET | % CHANGE |
| ANTIDIABETICS                                     | \$10,911,577.49     | 2             | 12.18 %           | \$11,514,738.20    | 1            | 12.43 %          | 0.26 %   |
| DERMATOLOGICALS                                   | \$11,065,397.09     | 1             | 12.35 %           | \$11,198,322.03    | 2            | 12.09 %          | -0.26 %  |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS                   | \$10,249,830.01     | 3             | 11.44 %           | \$10,729,484.06    | 3            | 11.58 %          | 0.15 %   |
| ANALGESICS - ANTI-INFLAMMATORY                    | \$6,334,190.49      | 4             | 7.07 %            | \$6,432,273.32     | 4            | 6.94 %           | -0.12 %  |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS     | \$5,163,507.38      | 5             | 5.76 %            | \$5,573,784.75     | 5            | 6.02 %           | 0.26 %   |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS           | \$4,640,390.42      | 6             | 5.18 %            | \$4,840,581.31     | 6            | 5.23 %           | 0.05 %   |
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | \$4,103,590.02      | 7             | 4.58 %            | \$4,587,758.28     | 7            | 4.95 %           | 0.37 %   |
| RESPIRATORY AGENTS - MISC.                        | \$3,381,210.89      | 8             | 3.77 %            | \$3,385,509.20     | 8            | 3.66 %           | -0.12 %  |
| ANTIVIRALS                                        | \$2,804,813.37      | 10            | 3.13 %            | \$2,933,338.96     | 9            | 3.17 %           | 0.04 %   |
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES          | \$2,852,403.29      | 9             | 3.18 %            | \$2,829,072.14     | 10           | 3.05 %           | -0.13 %  |
| ENDOCRINE AND METABOLIC AGENTS - MISC.            | \$2,731,458.77      | 11            | 3.05 %            | \$2,821,863.78     | 11           | 3.05 %           | 0.00 %   |
| MIGRAINE PRODUCTS                                 | \$2,624,526.97      | 12            | 2.93 %            | \$2,796,259.59     | 12           | 3.02 %           | 0.09 %   |
| ANTICONVULSANTS                                   | \$2,618,049.93      | 13            | 2.92 %            | \$2,712,054.77     | 13           | 2.93 %           | 0.01 %   |
| HEMATOLOGICAL AGENTS - MISC.                      | \$2,419,447.19      | 15            | 2.70 %            | \$2,501,614.58     | 14           | 2.70 %           | 0.00 %   |
| NEUROMUSCULAR AGENTS                              | \$2,467,739.62      | 14            | 2.75 %            | \$2,392,713.22     | 15           | 2.58 %           | -0.17 %  |
| GASTROINTESTINAL AGENTS - MISC.                   | \$1,852,441.82      | 17            | 2.07 %            | \$1,961,434.12     | 16           | 2.12 %           | 0.05 %   |
| CARDIOVASCULAR AGENTS - MISC.                     | \$1,949,008.27      | 16            | 2.17 %            | \$1,824,078.33     | 17           | 1.97 %           | -0.21 %  |
| ANTIDEPRESSANTS                                   | \$1,666,320.20      | 18            | 1.86 %            | \$1,695,160.58     | 18           | 1.83 %           | -0.03 %  |
| ANTICOAGULANTS                                    | \$1,090,623.60      | 19            | 1.22 %            | \$1,138,727.66     | 19           | 1.23 %           | 0.01 %   |
| MISCELLANEOUS THERAPEUTIC CLASSES                 | \$801,547.19        | 20            | 0.89 %            | \$726,725.06       | 20           | 0.78 %           | -0.11 %  |

**TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT**

| CURRENT CATEGORY DESCRIPTION                  | 202603 - 202605 |               | 202606 - 202608 |              | % CHANGE |
|-----------------------------------------------|-----------------|---------------|-----------------|--------------|----------|
|                                               | PREVIOUS CLAIMS | PREVIOUS RANK | CURRENT CLAIMS  | CURRENT RANK |          |
| ANTIDEPRESSANTS                               | 72,147          | 1             | 70,782          | 1            | -1.89 %  |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | 40,008          | 2             | 39,725          | 2            | -0.71 %  |
| ANTICONVULSANTS                               | 39,203          | 3             | 39,335          | 3            | 0.34 %   |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS       | 33,919          | 4             | 32,670          | 4            | -3.68 %  |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS               | 31,500          | 5             | 31,509          | 5            | 0.03 %   |
| ANTIDIABETICS                                 | 29,500          | 6             | 29,784          | 6            | 0.96 %   |
| ANTIANKXIETY AGENTS                           | 29,176          | 7             | 29,465          | 7            | 0.99 %   |
| ANTIHYPERTENSIVES                             | 23,802          | 8             | 23,336          | 8            | -1.96 %  |
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS   | 20,740          | 9             | 20,056          | 9            | -3.30 %  |
| DERMATOLOGICALS                               | 18,502          | 10            | 19,710          | 10           | 6.53 %   |
| ANTI HISTAMINES                               | 18,190          | 11            | 18,026          | 11           | -0.90 %  |
| ANALGESICS - OPIOID                           | 14,728          | 13            | 14,831          | 12           | 0.70 %   |
| ANTIHYPERLIPIDEMICS                           | 14,069          | 14            | 14,205          | 13           | 0.97 %   |
| ANALGESICS - ANTI-INFLAMMATORY                | 13,561          | 15            | 13,019          | 14           | -4.00 %  |
| MUSCULOSKELETAL THERAPY AGENTS                | 11,132          | 17            | 11,280          | 15           | 1.33 %   |
| BETA BLOCKERS                                 | 11,234          | 16            | 10,976          | 16           | -2.30 %  |
| PENICILLINS                                   | 14,781          | 12            | 10,214          | 17           | -30.90 % |
| ANALGESICS - NonNarcotic                      | 10,010          | 18            | 9,746           | 18           | -2.64 %  |
| HEMATOPOIETIC AGENTS                          | 8,836           | 20            | 8,962           | 19           | 1.43 %   |
| CORTICOSTEROIDS                               | 9,694           | 19            | 8,478           | 20           | -12.54 % |

TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION      | 202603 - 202605      |               | 202606 - 202608     |              | PERCENT CHANGE |
|-----------------------|----------------------|---------------|---------------------|--------------|----------------|
|                       | PREVIOUS PAID AMOUNT | PREVIOUS RANK | CURRENT PAID AMOUNT | CURRENT RANK |                |
| OZEMPIC               | \$4,686,134.31       | 1             | \$4,593,347.46      | 1            | -1.98 %        |
| DUPIXENT PEN          | \$3,408,774.32       | 2             | \$3,503,635.56      | 2            | 2.78 %         |
| VRAYLAR               | \$3,170,670.86       | 3             | \$3,323,991.96      | 3            | 4.84 %         |
| HUMIRA(CF) PEN        | \$3,075,216.87       | 4             | \$3,071,079.02      | 4            | -0.14 %        |
| TRIKAFTA              | \$2,788,933.84       | 5             | \$2,729,643.90      | 5            | -2.13 %        |
| MOUNJARO              | \$1,856,165.91       | 8             | \$2,642,210.84      | 6            | 42.35 %        |
| DUVYZAT               | \$1,922,880.86       | 6             | \$1,911,994.67      | 7            | -0.57 %        |
| SKYRIZI PEN           | \$1,893,591.73       | 7             | \$1,900,814.89      | 8            | 0.38 %         |
| INVEGA SUSTENNA       | \$1,697,067.56       | 9             | \$1,826,086.95      | 9            | 7.60 %         |
| ZEPBOUND              | \$1,183,330.88       | 12            | \$1,570,419.44      | 10           | 32.71 %        |
| BIKTARVY              | \$1,569,736.78       | 10            | \$1,559,617.93      | 11           | -0.65 %        |
| JARDIANCE             | \$1,250,910.60       | 11            | \$1,254,216.05      | 12           | 0.26 %         |
| CAPLYTA               | \$1,015,444.80       | 14            | \$1,143,256.79      | 13           | 12.59 %        |
| INGREZZA              | \$956,536.92         | 15            | \$1,114,179.59      | 14           | 16.48 %        |
| REXULTI               | \$1,080,625.59       | 13            | \$1,079,267.71      | 15           | -0.13 %        |
| DUPIXENT SYRINGE      | \$818,602.24         | 18            | \$1,004,942.04      | 16           | 22.76 %        |
| TALTZ AUTOINJECTOR    | \$810,853.20         | 20            | \$907,776.53        | 17           | 11.95 %        |
| ARISTADA              | \$817,345.75         | 19            | \$858,506.48        | 18           | 5.04 %         |
| AUSTEDO XR            | \$690,524.25         | 24            | \$848,543.18        | 19           | 22.88 %        |
| NURTEC ODT            | \$782,084.77         | 21            | \$819,963.06        | 20           | 4.84 %         |
| TRULICITY             | \$927,428.57         | 16            | \$818,610.12        | 21           | -11.73 %       |
| RINVOQ                | \$821,837.95         | 17            | \$811,493.56        | 22           | -1.26 %        |
| ELIQUIS               | \$694,367.56         | 23            | \$736,672.96        | 23           | 6.09 %         |
| TRELEGY ELLIPTA       | \$625,542.27         | 27            | \$693,091.20        | 24           | 10.80 %        |
| COSENTYX UNOREADY PEN | \$661,862.20         | 25            | \$664,569.05        | 25           | 0.41 %         |
| ALTUVIIIO             | \$566,193.64         | 32            | \$655,188.40        | 26           | 15.72 %        |
| BIMZELX AUTOINJECTOR  | \$465,520.34         | 42            | \$640,132.72        | 27           | 37.51 %        |
| SYMBICORT             | \$618,234.49         | 28            | \$612,528.93        | 28           | -0.92 %        |
| STRENSIQ              | \$375,390.65         | 53            | \$609,395.31        | 29           | 62.34 %        |
| ILARIS                | \$536,861.48         | 34            | \$608,310.74        | 30           | 13.31 %        |
| ABILIFY MAINTENA      | \$599,472.22         | 29            | \$608,137.71        | 31           | 1.45 %         |
| WAKIX                 | \$636,407.45         | 26            | \$584,094.24        | 32           | -8.22 %        |
| STELARA               | \$695,376.33         | 22            | \$581,903.79        | 33           | -16.32 %       |
| INVEGA TRINZA         | \$482,856.35         | 39            | \$556,286.05        | 34           | 15.21 %        |

TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION            | 202603 - 202605      |               | 202606 - 202608     |              | PERCENT CHANGE |
|-----------------------------|----------------------|---------------|---------------------|--------------|----------------|
|                             | PREVIOUS PAID AMOUNT | PREVIOUS RANK | CURRENT PAID AMOUNT | CURRENT RANK |                |
| JORNAY PM                   | \$536,194.55         | 35            | \$553,447.33        | 35           | 3.22 %         |
| ENBREL SURECLICK            | \$599,360.35         | 30            | \$549,375.63        | 36           | -8.34 %        |
| LYBALVI                     | \$521,334.91         | 37            | \$540,081.34        | 37           | 3.60 %         |
| SKYRIZI ON-BODY             | \$444,685.91         | 45            | \$533,534.66        | 38           | 19.98 %        |
| UBRELVY                     | \$489,937.43         | 38            | \$523,787.66        | 39           | 6.91 %         |
| LISDEXAMFETAMINE DIMESYLATE | \$528,646.63         | 36            | \$522,931.88        | 40           | -1.08 %        |
| SEPHIENCE                   | \$543,877.56         | 33            | \$507,494.41        | 41           | -6.69 %        |
| AJOVY AUTOINJECTOR          | \$450,179.70         | 44            | \$507,409.23        | 42           | 12.71 %        |
| EPIDIOLEX                   | \$466,295.15         | 41            | \$491,197.83        | 43           | 5.34 %         |
| XOLAIR                      | \$397,409.50         | 48            | \$486,156.51        | 44           | 22.33 %        |
| XYWAV                       | \$455,033.27         | 43            | \$479,718.90        | 45           | 5.43 %         |
| TRINTELLIX                  | \$480,316.03         | 40            | \$478,022.96        | 46           | -0.48 %        |
| QELBREE                     | \$443,992.02         | 46            | \$440,774.30        | 47           | -0.73 %        |
| TREMFYA PEN                 | \$598,160.93         | 31            | \$427,920.91        | 48           | -28.46 %       |
| WEGOVY                      | \$288,656.14         | 69            | \$426,545.28        | 49           | 47.77 %        |
| NORDITROPIN FLEXPRO         | \$440,691.29         | 47            | \$414,342.45        | 50           | -5.98 %        |
| SKYCLARYS                   | \$351,651.86         | 58            | \$408,372.30        | 51           | 16.13 %        |
| CRENESSITY                  | \$394,936.30         | 49            | \$394,936.30        | 52           | 0.00 %         |
| TREMFYA ONE-PRESS           | \$381,157.72         | 51            | \$390,428.37        | 53           | 2.43 %         |
| TAKHZYRO                    | \$324,202.38         | 62            | \$379,856.79        | 54           | 17.17 %        |
| FARXIGA                     | \$380,412.88         | 52            | \$379,645.82        | 55           | -0.20 %        |
| XARELTO                     | \$367,507.05         | 54            | \$363,096.13        | 56           | -1.20 %        |
| KESIMPTA PEN                | \$275,570.93         | 71            | \$357,623.53        | 57           | 29.78 %        |
| ABILIFY ASIMTUFII           | \$317,578.00         | 63            | \$352,300.31        | 58           | 10.93 %        |
| ALBUTEROL SULFATE HFA       | \$349,758.73         | 59            | \$351,525.70        | 59           | 0.51 %         |
| LIVMARLI                    | \$314,863.35         | 64            | \$349,844.62        | 60           | 11.11 %        |
| QULIPTA                     | \$346,146.50         | 60            | \$348,397.04        | 61           | 0.65 %         |
| KISQALI                     | \$387,147.97         | 50            | \$346,184.49        | 62           | -10.58 %       |
| ALYFTREK                    | \$355,396.59         | 57            | \$343,981.03        | 63           | -3.21 %        |
| WINREVAIR (2 PACK)          | \$306,069.90         | 66            | \$336,676.89        | 64           | 10.00 %        |
| TEZSPIRE                    | \$288,024.34         | 70            | \$324,148.15        | 65           | 12.54 %        |
| WINREVAIR                   | \$336,793.82         | 61            | \$321,485.01        | 66           | -4.55 %        |
| FINTEPLA                    | \$365,101.15         | 56            | \$313,226.05        | 67           | -14.21 %       |
| MAVYRET                     | \$246,260.34         | 76            | \$311,571.46        | 68           | 26.52 %        |

TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION             | 202603 - 202605      |               | 202606 - 202608     |              | PERCENT CHANGE |
|------------------------------|----------------------|---------------|---------------------|--------------|----------------|
|                              | PREVIOUS PAID AMOUNT | PREVIOUS RANK | CURRENT PAID AMOUNT | CURRENT RANK |                |
| VALTOCO                      | \$227,289.31         | 81            | \$306,297.75        | 69           | 34.76 %        |
| UZEDY                        | \$307,134.13         | 65            | \$303,775.16        | 70           | -1.09 %        |
| HEMLIBRA                     | \$234,125.03         | 80            | \$292,579.27        | 71           | 24.97 %        |
| ADYNOVATE                    | \$365,933.60         | 55            | \$277,313.23        | 72           | -24.22 %       |
| OTEZLA                       | \$291,940.79         | 68            | \$273,218.29        | 73           | -6.41 %        |
| RUCONEST                     | \$133,130.63         | 140           | \$266,261.26        | 74           | 100.00 %       |
| SPIRIVA RESPIMAT             | \$262,026.88         | 74            | \$265,790.65        | 75           | 1.44 %         |
| AGAMREE                      | \$273,869.48         | 72            | \$261,701.96        | 76           | -4.44 %        |
| MAVENCLAD                    | \$170,906.96         | 105           | \$245,173.15        | 77           | 43.45 %        |
| EPINEPHRINE                  | \$177,333.72         | 101           | \$233,683.98        | 78           | 31.78 %        |
| LANTUS SOLOSTAR              | \$258,230.83         | 75            | \$224,078.99        | 79           | -13.23 %       |
| EMGALITY PEN                 | \$217,228.47         | 84            | \$221,847.72        | 80           | 2.13 %         |
| PULMOZYME                    | \$197,616.38         | 91            | \$217,398.66        | 81           | 10.01 %        |
| AUSTEDO                      | \$219,944.88         | 83            | \$215,059.32        | 82           | -2.22 %        |
| ADVAIR HFA                   | \$241,971.54         | 78            | \$213,367.88        | 83           | -11.82 %       |
| BRIVIACT                     | \$220,114.52         | 82            | \$212,441.87        | 84           | -3.49 %        |
| NEMLUVIO                     | \$159,713.14         | 114           | \$211,518.22        | 85           | 32.44 %        |
| INSULIN LISPRO KWIKPEN U-100 | \$216,620.07         | 85            | \$203,188.63        | 86           | -6.20 %        |
| BREZTRI AEROSPHERE           | \$182,000.12         | 98            | \$202,622.01        | 87           | 11.33 %        |
| OJEMDA                       | \$116,140.59         | 155           | \$201,684.66        | 88           | 73.66 %        |
| ZENPEP                       | \$207,767.06         | 87            | \$199,404.24        | 89           | -4.03 %        |
| VOXZOGO                      | \$238,865.41         | 79            | \$196,471.65        | 90           | -17.75 %       |
| GATTEX                       | \$96,151.28          | 184           | \$194,705.82        | 91           | 102.50 %       |
| SKYTROFA                     | \$265,004.37         | 73            | \$192,817.50        | 92           | -27.24 %       |
| ORKAMBI                      | \$172,919.37         | 104           | \$189,008.14        | 93           | 9.30 %         |
| NUCALA                       | \$107,081.69         | 159           | \$188,551.27        | 94           | 76.08 %        |
| XTANDI                       | \$104,506.32         | 162           | \$188,510.14        | 95           | 80.38 %        |
| OPSUMIT                      | \$293,949.00         | 67            | \$186,596.90        | 96           | -36.52 %       |
| AIMOVIG AUTOINJECTOR         | \$173,931.42         | 103           | \$183,973.90        | 97           | 5.77 %         |
| DEXTROAMPHETAMINE-AMPHET ER  | \$186,419.82         | 95            | \$183,249.25        | 98           | -1.70 %        |
| CREON                        | \$185,994.93         | 96            | \$180,312.47        | 99           | -3.06 %        |
| METHYLPHENIDATE ER           | \$191,308.41         | 93            | \$179,894.76        | 100          | -5.97 %        |

TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION            | 202603 - 202605             |               | 202606 - 202608            |              | PERCENT CHANGE |
|-----------------------------|-----------------------------|---------------|----------------------------|--------------|----------------|
|                             | PREVIOUS PRESCRIPTION COUNT | PREVIOUS RANK | CURRENT PRESCRIPTION COUNT | CURRENT RANK |                |
| TRAZODONE HCL               | 12,504                      | 1             | 12,457                     | 1            | -0.38 %        |
| ALBUTEROL SULFATE HFA       | 11,732                      | 2             | 11,685                     | 2            | -0.40 %        |
| BUPROPION XL                | 11,316                      | 3             | 11,525                     | 3            | 1.85 %         |
| SERTRALINE HCL              | 10,015                      | 5             | 9,619                      | 4            | -3.95 %        |
| HYDROXYZINE HCL             | 9,528                       | 6             | 9,470                      | 5            | -0.61 %        |
| GABAPENTIN                  | 8,768                       | 7             | 8,770                      | 6            | 0.02 %         |
| BUSPIRONE HCL               | 8,569                       | 9             | 8,621                      | 7            | 0.61 %         |
| FLUOXETINE HCL              | 8,619                       | 8             | 8,236                      | 8            | -4.44 %        |
| CETIRIZINE HCL              | 8,059                       | 10            | 7,987                      | 9            | -0.89 %        |
| OMEPRAZOLE                  | 8,007                       | 11            | 7,707                      | 10           | -3.75 %        |
| MONTELUKAST SODIUM          | 7,815                       | 13            | 7,626                      | 11           | -2.42 %        |
| ESCITALOPRAM OXALATE        | 7,935                       | 12            | 7,586                      | 12           | -4.40 %        |
| QUETIAPINE FUMARATE         | 6,894                       | 14            | 6,909                      | 13           | 0.22 %         |
| ARIPIPRAZOLE                | 6,833                       | 15            | 6,675                      | 14           | -2.31 %        |
| AMOXICILLIN                 | 10,944                      | 4             | 6,668                      | 15           | -39.07 %       |
| DEXTROAMPHETAMINE-AMPHET ER | 6,828                       | 16            | 6,631                      | 16           | -2.89 %        |
| ATORVASTATIN CALCIUM        | 6,621                       | 18            | 6,561                      | 17           | -0.91 %        |
| LEVOTHYROXINE SODIUM        | 6,750                       | 17            | 6,485                      | 18           | -3.93 %        |
| LAMOTRIGINE                 | 6,183                       | 19            | 6,191                      | 19           | 0.13 %         |
| LISDEXAMFETAMINE DIMESYLATE | 6,108                       | 20            | 6,137                      | 20           | 0.48 %         |
| CLONIDINE HCL               | 5,678                       | 24            | 5,551                      | 21           | -2.24 %        |
| HYDROCODONE-ACETAMINOPHEN   | 5,479                       | 25            | 5,445                      | 22           | -0.62 %        |
| PREDNISONE                  | 5,943                       | 21            | 5,412                      | 23           | -8.94 %        |
| METHYLPHENIDATE ER          | 5,696                       | 23            | 5,241                      | 24           | -7.99 %        |
| LISINOPRIL                  | 5,356                       | 27            | 5,219                      | 25           | -2.56 %        |
| CYCLOBENZAPRINE HCL         | 5,125                       | 30            | 5,148                      | 26           | 0.45 %         |
| DULOXETINE HCL              | 5,206                       | 29            | 5,083                      | 27           | -2.36 %        |
| ONDANSETRON ODT             | 5,828                       | 22            | 5,076                      | 28           | -12.90 %       |
| TOPIRAMATE                  | 5,053                       | 31            | 4,963                      | 29           | -1.78 %        |
| FLUTICASONE PROPIONATE      | 5,415                       | 26            | 4,846                      | 30           | -10.51 %       |
| OZEMPIC                     | 4,865                       | 32            | 4,742                      | 31           | -2.53 %        |
| PANTOPRAZOLE SODIUM         | 4,700                       | 33            | 4,598                      | 32           | -2.17 %        |

TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION               | 202603 - 202605             |               | 202606 - 202608            |              | PERCENT CHANGE |
|--------------------------------|-----------------------------|---------------|----------------------------|--------------|----------------|
|                                | PREVIOUS PRESCRIPTION COUNT | PREVIOUS RANK | CURRENT PRESCRIPTION COUNT | CURRENT RANK |                |
| CEPHALEXIN                     | 4,070                       | 42            | 4,498                      | 33           | 10.52 %        |
| CLONAZEPAM                     | 4,348                       | 37            | 4,456                      | 34           | 2.48 %         |
| DEXTROAMPHETAMINE-AMPHETAMINE  | 4,421                       | 35            | 4,418                      | 35           | -0.07 %        |
| FAMOTIDINE                     | 4,546                       | 34            | 4,332                      | 36           | -4.71 %        |
| AMLODIPINE BESYLATE            | 4,365                       | 36            | 4,264                      | 37           | -2.31 %        |
| LORATADINE                     | 4,322                       | 38            | 4,195                      | 38           | -2.94 %        |
| AMOXICILLIN-CLAVULANATE POTASS | 5,263                       | 28            | 4,186                      | 39           | -20.46 %       |
| ALPRAZOLAM                     | 4,099                       | 41            | 4,169                      | 40           | 1.71 %         |
| JARDIANCE                      | 4,046                       | 43            | 4,002                      | 41           | -1.09 %        |
| RISPERIDONE                    | 4,108                       | 40            | 3,993                      | 42           | -2.80 %        |
| GUANFACINE HCL ER              | 3,963                       | 45            | 3,985                      | 43           | 0.56 %         |
| IBUPROFEN                      | 4,139                       | 39            | 3,918                      | 44           | -5.34 %        |
| TRIAMCINOLONE ACETONIDE        | 3,450                       | 52            | 3,845                      | 45           | 11.45 %        |
| [No Value Provided]            | 4,040                       | 44            | 3,819                      | 46           | -5.47 %        |
| ASPIRIN EC                     | 3,711                       | 47            | 3,665                      | 47           | -1.24 %        |
| LOSARTAN POTASSIUM             | 3,584                       | 49            | 3,546                      | 48           | -1.06 %        |
| MIRTAZAPINE                    | 3,522                       | 51            | 3,524                      | 49           | 0.06 %         |
| VENLAFAXINE HCL ER             | 3,698                       | 48            | 3,495                      | 50           | -5.49 %        |
| LORAZEPAM                      | 3,194                       | 55            | 3,412                      | 51           | 6.83 %         |
| ACETAMINOPHEN                  | 3,544                       | 50            | 3,411                      | 52           | -3.75 %        |
| POLYETHYLENE GLYCOL 3350       | 3,331                       | 53            | 3,298                      | 53           | -0.99 %        |
| OXYCODONE HCL                  | 3,119                       | 59            | 3,246                      | 54           | 4.07 %         |
| ALLERGY RELIEF                 | 3,089                       | 60            | 3,238                      | 55           | 4.82 %         |
| ROSUVASTATIN CALCIUM           | 2,977                       | 65            | 3,237                      | 56           | 8.73 %         |
| METFORMIN HCL ER               | 3,226                       | 54            | 3,201                      | 57           | -0.78 %        |
| METOPROLOL SUCCINATE           | 3,150                       | 56            | 3,107                      | 58           | -1.37 %        |
| LEVETIRACETAM                  | 3,138                       | 58            | 3,096                      | 59           | -1.34 %        |
| FOLIC ACID                     | 3,015                       | 63            | 3,041                      | 60           | 0.86 %         |
| HYDROXYZINE PAMOATE            | 3,084                       | 61            | 3,001                      | 61           | -2.69 %        |
| PROPRANOLOL HCL                | 3,051                       | 62            | 2,993                      | 62           | -1.90 %        |
| PRAZOSIN HCL                   | 2,986                       | 64            | 2,865                      | 63           | -4.05 %        |
| METFORMIN HCL                  | 2,916                       | 66            | 2,763                      | 64           | -5.25 %        |

TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION              | 202603 - 202605             |               | 202606 - 202608            |              | PERCENT CHANGE |
|-------------------------------|-----------------------------|---------------|----------------------------|--------------|----------------|
|                               | PREVIOUS PRESCRIPTION COUNT | PREVIOUS RANK | CURRENT PRESCRIPTION COUNT | CURRENT RANK |                |
| TRAMADOL HCL                  | 2,741                       | 72            | 2,745                      | 65           | 0.15 %         |
| MELOXICAM                     | 2,845                       | 67            | 2,730                      | 66           | -4.04 %        |
| SYMBICORT                     | 2,764                       | 70            | 2,730                      | 66           | -1.23 %        |
| METRONIDAZOLE                 | 2,666                       | 76            | 2,710                      | 68           | 1.65 %         |
| FEROSUL                       | 2,677                       | 75            | 2,703                      | 69           | 0.97 %         |
| FLUCONAZOLE                   | 2,683                       | 74            | 2,694                      | 70           | 0.41 %         |
| ATOMOXETINE HCL               | 2,644                       | 78            | 2,671                      | 71           | 1.02 %         |
| VALACYCLOVIR                  | 2,699                       | 73            | 2,652                      | 72           | -1.74 %        |
| POTASSIUM CHLORIDE            | 2,766                       | 69            | 2,650                      | 73           | -4.19 %        |
| MOUNJARO                      | 1,882                       | 93            | 2,646                      | 74           | 40.60 %        |
| AZITHROMYCIN                  | 3,902                       | 46            | 2,574                      | 75           | -34.03 %       |
| LANTUS SOLOSTAR               | 2,831                       | 68            | 2,565                      | 76           | -9.40 %        |
| MUPIROCIN                     | 2,018                       | 90            | 2,548                      | 77           | 26.26 %        |
| GUANFACINE HCL                | 2,756                       | 71            | 2,546                      | 78           | -7.62 %        |
| OLANZAPINE                    | 2,425                       | 80            | 2,416                      | 79           | -0.37 %        |
| SPIRONOLACTONE                | 2,417                       | 81            | 2,372                      | 80           | -1.86 %        |
| ELIQUIS                       | 2,302                       | 86            | 2,368                      | 81           | 2.87 %         |
| METHYLPHENIDATE HCL           | 2,651                       | 77            | 2,355                      | 82           | -11.17 %       |
| TIZANIDINE HCL                | 2,339                       | 85            | 2,344                      | 83           | 0.21 %         |
| BACLOFEN                      | 2,346                       | 84            | 2,332                      | 84           | -0.60 %        |
| FUROSEMIDE                    | 2,375                       | 82            | 2,254                      | 85           | -5.10 %        |
| VRAYLAR                       | 2,156                       | 88            | 2,251                      | 86           | 4.41 %         |
| PREGABALIN                    | 2,057                       | 89            | 2,220                      | 87           | 7.92 %         |
| DEXMETHYLPHENIDATE HCL ER     | 2,349                       | 83            | 2,162                      | 88           | -7.96 %        |
| SULFAMETHOXAZOLE-TRIMETHOPRIM | 1,891                       | 92            | 2,089                      | 89           | 10.47 %        |
| ONDANSETRON HCL               | 2,291                       | 87            | 2,040                      | 90           | -10.96 %       |
| NYSTATIN                      | 1,993                       | 91            | 1,976                      | 91           | -0.85 %        |
| NALTREXONE HCL                | 1,866                       | 94            | 1,899                      | 92           | 1.77 %         |
| ALBUTEROL SULFATE             | 2,604                       | 79            | 1,896                      | 93           | -27.19 %       |
| CEFDINIR                      | 3,142                       | 57            | 1,847                      | 94           | -41.22 %       |
| HYDROCHLOROTHIAZIDE           | 1,855                       | 95            | 1,814                      | 95           | -2.21 %        |
| ZOLPIDEM TARTRATE             | 1,785                       | 97            | 1,774                      | 96           | -0.62 %        |

TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION      | 202603 - 202605             |               | 202606 - 202608            |              | PERCENT CHANGE |
|-----------------------|-----------------------------|---------------|----------------------------|--------------|----------------|
|                       | PREVIOUS PRESCRIPTION COUNT | PREVIOUS RANK | CURRENT PRESCRIPTION COUNT | CURRENT RANK |                |
| KETOCONAZOLE          | 1,671                       | 99            | 1,752                      | 97           | 4.85 %         |
| SUMATRIPTAN SUCCINATE | 1,748                       | 98            | 1,734                      | 98           | -0.80 %        |
| AMITRIPTYLINE HCL     | 1,792                       | 96            | 1,667                      | 99           | -6.98 %        |
| CLOPIDOGREL           | 1,608                       | 101           | 1,648                      | 100          | 2.49 %         |

Agenda Item 4.b.

| MOLINA HEALTHCARE OF IOWA CLAIMS<br>QUARTERLY STATISTICS |                        |                          |          |
|----------------------------------------------------------|------------------------|--------------------------|----------|
| Category                                                 | March 2026 to May 2026 | June 2026 to August 2026 | % Change |
| Total paid Amount                                        | \$69,394,209.07        | \$72,917,379.37          | 5.08%    |
| Unique users                                             | 81,232                 | 77,710                   | -4.34%   |
| Cost Per user                                            | \$854.27               | \$938.33                 | 9.84%    |
| Total prescriptions                                      | 490,728                | 484,804                  | -1.21%   |
| Average Prescriptions per user                           | 6.04                   | 6.24                     | 3.27%    |
| Average cost per prescription                            | \$141.41               | \$150.41                 | 6.36%    |
| # Generic Prescriptions                                  | 438,984                | 431,300                  | -1.75%   |
| % Generic                                                | 89.5%                  | 89.0%                    | -0.55%   |
| \$ Generic                                               | \$8,484,035.71         | \$8,317,240.79           | -1.97%   |
| Average Generic Prescription Cost                        | \$19.33                | \$19.28                  | -0.22%   |
| Average Generic Days' Supply                             | 31.13                  | 31.77                    | 2.08%    |
| # Brand Prescriptions                                    | 51,744                 | 53,504                   | 3.40%    |
| % Brand                                                  | 10.54%                 | 11.04%                   | 4.66%    |
| \$ Brand                                                 | \$60,910,173           | \$64,600,139             | 6.06%    |
| Average Brand Prescription cost                          | \$1,177.14             | \$1,207.39               | 2.57%    |
| Average Brand Days' Supply                               | 28.55                  | 28.64                    | 0.29%    |

| UTILIZATION BY AGE |                        |                          |
|--------------------|------------------------|--------------------------|
| Age                | March 2026 to May 2026 | June 2026 to August 2026 |
| 0 to 6             | 12,385                 | 10,041                   |
| 7 to 12            | 10,316                 | 9,079                    |
| 13 to 18           | 10,261                 | 9,792                    |
| 19 to 64           | 47,325                 | 47,797                   |
| 65+                | 1,344                  | 1,427                    |
| Total              | 81,631                 | 77,710                   |

| UTILIZATION BY GENDER AND AGE |              |                        |                          |
|-------------------------------|--------------|------------------------|--------------------------|
| Gender                        | Age          | March 2026 to May 2026 | June 2026 to August 2026 |
| F                             | 0 to 6       | 5,855                  | 4,742                    |
|                               | 7 to 12      | 4,581                  | 4,035                    |
|                               | 13 to 18     | 5,785                  | 5,626                    |
|                               | 19 to 64     | 30,320                 | 30,634                   |
|                               | 65+          | 861                    | 904                      |
|                               | Gender Total | 47,402                 | 45,941                   |
| M                             | 0 to 6       | 6,530                  | 5,297                    |
|                               | 7 to 12      | 5,735                  | 5,045                    |
|                               | 13 to 18     | 4,477                  | 4,165                    |
|                               | 19 to 64     | 17,001                 | 17,163                   |
|                               | 65+          | 483                    | 524                      |
|                               | Gender Total | 34,226                 | 32,194                   |
| Grand Total                   |              | 81,628                 | 78,135                   |

### Top 100 Pharmacies by Prescription Count

June 2026 to August 2026

| RANK | Pharmacy NAME            | Pharmacy City  | State | Prescription Count | Paid Amount    | Average Cost RX | Previous RANK |
|------|--------------------------|----------------|-------|--------------------|----------------|-----------------|---------------|
| 1    | UIHC AMBULATORY CARE PHC | IOWA CITY      | IA    | 7,663              | \$5,149,417.61 | \$671.98        | 1             |
| 2    | BROADLAWNS MED CTR OP PH | DES MOINES     | IA    | 4,386              | \$442,431.04   | \$100.87        | 3             |
| 3    | WALGREENS 04405          | COUNCIL BLUFFS | IA    | 4,106              | \$312,494.14   | \$76.11         | 2             |
| 4    | WALGREENS 05042          | CEDAR RAPIDS   | IA    | 3,673              | \$259,923.50   | \$70.77         | 4             |
| 5    | HY-VEE PHARMACY 1138     | DES MOINES     | IA    | 3,470              | \$310,645.14   | \$89.52         | 8             |
| 6    | SIOUXLAND COMM HLTH CTR  | SIOUX CITY     | IA    | 3,344              | \$270,105.94   | \$80.77         | 5             |
| 7    | HY-VEE PHARMACY 1403     | MARSHALLTOWN   | IA    | 3,278              | \$331,782.31   | \$101.21        | 7             |
| 8    | RIGHT DOSE PHARMACY      | ANKENY         | IA    | 3,149              | \$208,528.53   | \$66.22         | 6             |
| 9    | NUCARA LTC PHARMACY 3    | IOWA CITY      | IA    | 2,961              | \$85,268.70    | \$28.80         | 11            |
| 10   | WALGREENS 05239          | DAVENPORT      | IA    | 2,935              | \$163,038.63   | \$55.55         | 9             |
| 11   | HY-VEE PHARMACY 1109     | DAVENPORT      | IA    | 2,896              | \$298,232.80   | \$102.98        | 10            |
| 12   | HY-VEE PHARMACY 1092     | COUNCIL BLUFFS | IA    | 2,843              | \$268,762.89   | \$94.53         | 13            |
| 13   | HY-VEE PHARMACY 1075     | CLINTON        | IA    | 2,773              | \$231,377.93   | \$83.44         | 12            |
| 14   | COMMUNITY HEALTH CARE PH | DAVENPORT      | IA    | 2,558              | \$132,221.27   | \$51.69         | 17            |
| 15   | HY-VEE PHARMACY 1056     | CEDAR RAPIDS   | IA    | 2,539              | \$201,203.51   | \$79.25         | 16            |
| 16   | HY-VEE DRUGSTORE 7060    | MUSCATINE      | IA    | 2,456              | \$181,614.88   | \$73.95         | 22            |
| 17   | WALGREENS 05721          | DES MOINES     | IA    | 2,453              | \$160,250.10   | \$65.33         | 15            |
| 18   | HY-VEE PHARMACY 1142     | DES MOINES     | IA    | 2,421              | \$235,878.08   | \$97.43         | 21            |
| 19   | GREENWOOD DRUG ON KIMBAL | WATERLOO       | IA    | 2,369              | \$269,294.70   | \$113.67        | 25            |
| 20   | WALGREENS 03700          | COUNCIL BLUFFS | IA    | 2,366              | \$194,992.78   | \$82.41         | 20            |
| 21   | HY-VEE DRUGSTORE 7020    | CEDAR RAPIDS   | IA    | 2,353              | \$204,677.46   | \$86.99         | 24            |
| 22   | WALGREENS 15647          | SIOUX CITY     | IA    | 2,272              | \$156,393.94   | \$68.84         | 14            |
| 23   | WALGREENS 00359          | DES MOINES     | IA    | 2,253              | \$185,908.74   | \$82.52         | 26            |

|    |                           |                 |    |       |              |          |    |
|----|---------------------------|-----------------|----|-------|--------------|----------|----|
| 24 | WALGREENS 07455           | WATERLOO        | IA | 2,245 | \$165,033.25 | \$73.51  | 18 |
| 25 | HY-VEE PHARMACY 1151      | DES MOINES      | IA | 2,226 | \$156,506.90 | \$70.31  | 30 |
| 26 | IMMC OUTPATIENT PHARMACY  | DES MOINES      | IA | 2,189 | \$132,013.73 | \$60.31  | 19 |
| 27 | CVS PHARMACY 08544        | WATERLOO        | IA | 2,136 | \$176,084.75 | \$82.44  | 23 |
| 28 | HY-VEE PHARMACY 1192      | FORT DODGE      | IA | 2,087 | \$148,001.55 | \$70.92  | 32 |
| 29 | WALGREENS 07453           | DES MOINES      | IA | 2,086 | \$180,393.37 | \$86.48  | 31 |
| 30 | MEDICAP PHARMACY LTC 8405 | INDIANOLA       | IA | 2,078 | \$77,417.80  | \$37.26  | 29 |
| 31 | HY-VEE DRUGSTORE 7065     | OTTUMWA         | IA | 2,027 | \$154,828.02 | \$76.38  | 27 |
| 32 | CVS PHARMACY 10282        | FORT DODGE      | IA | 1,939 | \$165,981.32 | \$85.60  | 28 |
| 33 | HY-VEE PHARMACY 1610      | SIOUX CITY      | IA | 1,938 | \$221,498.07 | \$114.29 | 36 |
| 34 | HY-VEE PHARMACY 1530      | PLEASANT HILL   | IA | 1,933 | \$199,116.70 | \$103.01 | 37 |
| 35 | DRILLING PHARMACY 67      | SIOUX CITY      | IA | 1,907 | \$150,199.72 | \$78.76  | 33 |
| 36 | WALMART PHARMACY 10-5115  | DAVENPORT       | IA | 1,888 | \$197,669.18 | \$104.70 | 38 |
| 37 | CVS PHARMACY 08658        | DAVENPORT       | IA | 1,833 | \$112,388.07 | \$61.31  | 39 |
| 38 | HY-VEE PHARMACY 1044      | BURLINGTON      | IA | 1,819 | \$155,275.81 | \$85.36  | 34 |
| 39 | HY-VEE PHARMACY 1522      | PERRY           | IA | 1,795 | \$175,207.08 | \$97.61  | 49 |
| 40 | HY-VEE PHARMACY 1281      | IOWA CITY       | IA | 1,771 | \$112,249.37 | \$63.38  | 48 |
| 41 | WALMART PHARMACY 10-2889  | CLINTON         | IA | 1,758 | \$165,679.15 | \$94.24  | 46 |
| 42 | HY-VEE PHARMACY 1061      | CEDAR RAPIDS    | IA | 1,757 | \$140,976.24 | \$80.24  | 35 |
| 43 | NELSON FAMILY PHARMACY    | FORT MADISON    | IA | 1,677 | \$112,401.02 | \$67.03  | 40 |
| 44 | HY-VEE PHARMACY 1074      | CHARLES CITY    | IA | 1,672 | \$108,248.60 | \$64.74  | 43 |
| 45 | CR CARE PHARMACY          | CEDAR RAPIDS    | IA | 1,668 | \$498,100.85 | \$298.62 | 93 |
| 46 | WALMART PHARMACY 10-3150  | COUNCIL BLUFFS  | IA | 1,652 | \$239,688.81 | \$145.09 | 41 |
| 47 | WALMART PHARMACY 10-0797  | WEST BURLINGTON | IA | 1,650 | \$112,640.99 | \$68.27  | 51 |
| 48 | WALMART PHARMACY 10-3590  | SIOUX CITY      | IA | 1,629 | \$132,341.89 | \$81.24  | 42 |
| 49 | WALMART PHARMACY 10-0559  | MUSCATINE       | IA | 1,618 | \$134,002.23 | \$82.82  | 45 |
| 50 | SCOTT PHARMACY INC        | FAYETTE         | IA | 1,612 | \$125,809.83 | \$78.05  | 58 |

|    |                          |              |    |       |              |          |    |
|----|--------------------------|--------------|----|-------|--------------|----------|----|
| 51 | WALMART PHARMACY 10-1723 | DES MOINES   | IA | 1,603 | \$143,697.88 | \$89.64  | 55 |
| 52 | HY-VEE PHARMACY 1148     | DES MOINES   | IA | 1,603 | \$189,622.43 | \$118.29 | 47 |
| 53 | MAHASKA DRUGS            | OSKALOOSA    | IA | 1,598 | \$144,691.81 | \$90.55  | 52 |
| 54 | WALGREENS 05852          | DES MOINES   | IA | 1,593 | \$94,281.60  | \$59.18  | 73 |
| 55 | UI HEALTHCARE            | CORALVILLE   | IA | 1,589 | \$76,833.31  | \$48.35  | 64 |
| 56 | HY-VEE PHARMACY 1107     | DAVENPORT    | IA | 1,585 | \$196,588.70 | \$124.03 | 72 |
| 57 | MAIN AT LOCUST PHARMACY  | DAVENPORT    | IA | 1,584 | \$121,247.59 | \$76.55  | 60 |
| 58 | HY-VEE PHARMACY 1396     | MARION       | IA | 1,575 | \$152,586.66 | \$96.88  | 50 |
| 59 | WALMART PHARMACY 10-3394 | ATLANTIC     | IA | 1,561 | \$132,905.91 | \$85.14  | 62 |
| 60 | PEOPLES CLINIC PHARMACY  | WATERLOO     | IA | 1,557 | \$22,302.19  | \$14.32  | 44 |
| 61 | HY-VEE PHARMACY 1615     | SIOUX CITY   | IA | 1,545 | \$150,778.27 | \$97.59  | 56 |
| 62 | HY-VEE PHARMACY 1241     | HARLAN       | IA | 1,530 | \$116,516.33 | \$76.15  | 53 |
| 63 | HY-VEE PHARMACY 1058     | CENTERVILLE  | IA | 1,512 | \$234,528.81 | \$155.11 | 63 |
| 64 | HY-VEE PHARMACY 1866     | WATERLOO     | IA | 1,494 | \$150,967.14 | \$101.05 | 59 |
| 65 | WALMART PHARMACY 10-0581 | MARSHALLTOWN | IA | 1,491 | \$156,250.28 | \$104.80 | 57 |
| 66 | FOREST PARK CLINIC PHCY  | MASON CITY   | IA | 1,481 | \$108,019.02 | \$72.94  | 77 |
| 67 | HY-VEE PHARMACY 1065     | CHARITON     | IA | 1,467 | \$96,362.43  | \$65.69  | 84 |
| 68 | WALGREENS 03875          | CEDAR RAPIDS | IA | 1,466 | \$97,605.06  | \$66.58  | 74 |
| 69 | HY-VEE PHARMACY 1873     | WAUKEE       | IA | 1,455 | \$139,013.26 | \$95.54  | 61 |
| 70 | HY VEE PHARMACY 1459     | OELWEIN      | IA | 1,451 | \$109,891.73 | \$75.74  | 54 |
| 71 | HY-VEE PHARMACY 1180     | FAIRFIELD    | IA | 1,417 | \$107,427.30 | \$75.81  | 78 |
| 72 | LEWIS FAMILY DRUG 28     | ONAWA        | IA | 1,416 | \$152,497.76 | \$107.70 | 70 |
| 73 | WALMART PHARMACY 10-1496 | WATERLOO     | IA | 1,411 | \$135,503.05 | \$96.03  | 82 |
| 74 | COVENANT FAMILY PHARMACY | WATERLOO     | IA | 1,411 | \$266,807.37 | \$189.09 | 68 |
| 75 | WALMART PHARMACY 10-2764 | ALTOONA      | IA | 1,400 | \$142,696.99 | \$101.93 | 97 |
| 76 | WALMART PHARMACY 10-0985 | FAIRFIELD    | IA | 1,388 | \$136,170.75 | \$98.11  | 81 |
| 77 | WALMART PHARMACY 10-2716 | CEDAR RAPIDS | IA | 1,383 | \$110,700.00 | \$80.04  | 80 |

|     |                           |                |    |       |              |          |     |
|-----|---------------------------|----------------|----|-------|--------------|----------|-----|
| 78  | WAGNER PHARMACY           | CLINTON        | IA | 1,376 | \$68,523.65  | \$49.80  | 69  |
| 79  | WALMART PHARMACY 10-0646  | ANAMOSA        | IA | 1,374 | \$135,553.16 | \$98.66  | 85  |
| 80  | ALL CARE HEALTH CENTER    | COUNCIL BLUFFS | IA | 1,370 | \$116,726.68 | \$85.20  | 108 |
| 81  | WELLS HOMETOWN DRUG KEOS  | KEOSAUQUA      | IA | 1,367 | \$97,559.41  | \$71.37  | 87  |
| 82  | SOUTH SIDE DRUG, INC.     | OTTUMWA        | IA | 1,360 | \$111,939.80 | \$82.31  | 66  |
| 83  | HY-VEE PHARMACY 1504      | OTTUMWA        | IA | 1,355 | \$96,555.25  | \$71.26  | 76  |
| 84  | CVS PHARMACY 10032        | MARION         | IA | 1,353 | \$107,509.77 | \$79.46  | 91  |
| 85  | CVS PHARMACY 10329        | DES MOINES     | IA | 1,348 | \$128,408.90 | \$95.26  | 90  |
| 86  | HY-VEE PHARMACY 1013      | AMES           | IA | 1,348 | \$81,509.94  | \$60.47  | 86  |
| 87  | HY-VEE PHARMACY 1759      | URBANDALE      | IA | 1,347 | \$108,446.77 | \$80.51  | 67  |
| 88  | EASTERN IOWA HEALTH CENT  | CEDAR RAPIDS   | IA | 1,345 | \$107,608.44 | \$80.01  | 88  |
| 89  | WALGREENS 07452           | DES MOINES     | IA | 1,334 | \$93,314.17  | \$69.95  | 92  |
| 90  | HY-VEE PHARMACY 1202      | FORT MADISON   | IA | 1,327 | \$90,458.25  | \$68.17  | 75  |
| 91  | HY-VEE PHARMACY 1052      | CEDAR FALLS    | IA | 1,326 | \$109,010.56 | \$82.21  | 89  |
| 92  | HY-VEE DRUGSTORE 7056     | MASON CITY     | IA | 1,315 | \$105,930.73 | \$80.56  | 79  |
| 93  | EXACT CARE PHARMACY LLC   | VALLEY VIEW    | OH | 1,303 | \$115,551.63 | \$88.68  | 100 |
| 94  | HY-VEE PHARMACY 1106      | DAVENPORT      | IA | 1,290 | \$115,226.21 | \$89.32  | 103 |
| 95  | OMNICARE OF URBANDA 48236 | URBANDALE      | IA | 1,286 | \$33,996.68  | \$26.44  | 71  |
| 96  | WALGREENS 04041           | DAVENPORT      | IA | 1,284 | \$120,646.67 | \$93.96  | 96  |
| 97  | HY-VEE PHARMACY 1271      | INDIANOLA      | IA | 1,278 | \$85,488.65  | \$66.89  | 113 |
| 98  | NEIGHBORHOOD LTC PHARMAC  | URBANDALE      | IA | 1,267 | \$134,501.35 | \$106.16 | 212 |
| 99  | HY-VEE PHARMACY 1155      | DES MOINES     | IA | 1,260 | \$129,583.59 | \$102.84 | 126 |
| 100 | HY-VEE PHARMACY 1054      | CEDAR RAPIDS   | IA | 1,260 | \$121,568.83 | \$96.48  | 104 |

| <b>Top 100 Pharmacies by Paid Amount</b><br>June 2026 to August 2026 |                            |                |       |                    |                |                 |               |
|----------------------------------------------------------------------|----------------------------|----------------|-------|--------------------|----------------|-----------------|---------------|
| RANK                                                                 | Pharmacy NAME              | Pharmacy City  | State | Prescription Count | Paid Amount    | Average Cost RX | Previous RANK |
| 1                                                                    | CAREMARK SPECIALTY P 1702  | LENEXA         | KS    | 946                | \$7,244,153.62 | \$7,657.67      | 1             |
| 2                                                                    | UIHC AMBULATORY CARE PHC   | IOWA CITY      | IA    | 7,663              | \$5,149,417.61 | \$671.98        | 2             |
| 3                                                                    | COMMUNITY, A WALGRE 16528  | DES MOINES     | IA    | 512                | \$3,537,525.13 | \$6,909.23      | 3             |
| 4                                                                    | UNITYPOINT AT HOME         | URBAN DALE     | IA    | 676                | \$2,198,469.44 | \$3,252.17      | 4             |
| 5                                                                    | CVS SPECIALTY 02921        | MONROEVILLE    | PA    | 212                | \$1,472,101.39 | \$6,943.87      | 5             |
| 6                                                                    | ACCREDITO HEALTH GROUP INC | MEMPHIS        | TN    | 59                 | \$870,360.88   | \$14,751.88     | 7             |
| 7                                                                    | MEDICAP PHARMACY 8008      | URBAN DALE     | IA    | 844                | \$830,199.96   | \$983.65        | 11            |
| 8                                                                    | COMMUNITY A WALGREE 21250  | IOWA CITY      | IA    | 125                | \$813,442.92   | \$6,507.54      | 9             |
| 9                                                                    | CAREMARK SPECIALTY 48031   | MOUNT PROSPECT | IL    | 86                 | \$801,642.57   | \$9,321.43      | 8             |
| 10                                                                   | PANTHERX SPECIALTY PHARM   | CORAOPOLIS     | PA    | 30                 | \$735,496.42   | \$24,516.55     | 6             |
| 11                                                                   | CR CARE PHARMACY           | CEDAR RAPIDS   | IA    | 1,668              | \$498,100.85   | \$298.62        | 14            |
| 12                                                                   | AMBER PHARMACY             | OMAHA          | NE    | 90                 | \$494,707.07   | \$5,496.75      | 18            |
| 13                                                                   | BROADLAWNS MED CTR OP PH   | DES MOINES     | IA    | 4,386              | \$442,431.04   | \$100.87        | 15            |
| 14                                                                   | ANOVORX GROUP LLC          | MEMPHIS        | TN    | 34                 | \$404,529.36   | \$11,897.92     | 30            |
| 15                                                                   | CARE PLUS CVS/PHARM 00102  | AURORA         | CO    | 51                 | \$399,401.70   | \$7,831.41      | 13            |
| 16                                                                   | EVERSANA LIFE SCIENCE SE   | CHESTERFIELD   | MO    | 9                  | \$394,575.59   | \$43,841.73     | 28            |
| 17                                                                   | ALLEN CLINIC PHARMACY      | WATERLOO       | IA    | 977                | \$391,346.59   | \$400.56        | 27            |
| 18                                                                   | CVS/SPECIALTY 1703         | REDLANDS       | CA    | 23                 | \$366,335.52   | \$15,927.63     | 10            |
| 19                                                                   | GENOA HEALTHCARE LL 20171  | DAVENPORT      | IA    | 1,164              | \$365,981.99   | \$314.42        | 24            |
| 20                                                                   | PANTHERX SPECIALTY PHARM   | COLLIERVILLE   | TN    | 9                  | \$358,930.86   | \$39,881.21     | 827           |
| 21                                                                   | AVERA SPECIALTY PHARMACY   | SIOUX FALLS    | SD    | 99                 | \$354,927.94   | \$3,585.13      | 17            |
| 22                                                                   | OPTUM PHARMACY             | JEFFERSONVILLE | IN    | 47                 | \$331,810.04   | \$7,059.79      | 12            |
| 23                                                                   | HY-VEE PHARMACY 1403       | MARSHALLTOWN   | IA    | 3,278              | \$331,782.31   | \$101.21        | 23            |

|    |                           |                   |    |       |              |             |    |
|----|---------------------------|-------------------|----|-------|--------------|-------------|----|
| 24 | NEBRASKA MED CTR CLINIC   | OMAHA             | NE | 408   | \$319,096.49 | \$782.10    | 19 |
| 25 | WALGREENS 04405           | COUNCIL BLUFFS    | IA | 4,106 | \$312,494.14 | \$76.11     | 20 |
| 26 | HY-VEE PHARMACY 1138      | DES MOINES        | IA | 3,470 | \$310,645.14 | \$89.52     | 25 |
| 27 | PRIMARY HEALTHCARE PHARM  | DES MOINES        | IA | 952   | \$307,017.72 | \$322.50    | 21 |
| 28 | EXPRESS SCRIPTS SPECIALT  | ST. LOUIS         | MO | 16    | \$298,410.04 | \$18,650.63 | 22 |
| 29 | HY-VEE PHARMACY 1109      | DAVENPORT         | IA | 2,896 | \$298,232.80 | \$102.98    | 33 |
| 30 | GENOA HEALTHCARE LL 20459 | MARSHALLTOWN      | IA | 580   | \$291,877.63 | \$503.24    | 38 |
| 31 | SIOUXLAND COMM HLTH CTR   | SIOUX CITY        | IA | 3,344 | \$270,105.94 | \$80.77     | 43 |
| 32 | GREENWOOD DRUG ON KIMBAL  | WATERLOO          | IA | 2,369 | \$269,294.70 | \$113.67    | 39 |
| 33 | HY-VEE PHARMACY 1092      | COUNCIL BLUFFS    | IA | 2,843 | \$268,762.89 | \$94.53     | 32 |
| 34 | COVENANT FAMILY PHARMACY  | WATERLOO          | IA | 1,411 | \$266,807.37 | \$189.09    | 44 |
| 35 | WALGREENS 05042           | CEDAR RAPIDS      | IA | 3,673 | \$259,923.50 | \$70.77     | 29 |
| 36 | BIOLOGICS BY MCKESSON     | CARY              | NC | 14    | \$244,437.66 | \$17,459.83 | 16 |
| 37 | WALMART PHARMACY 10-3150  | COUNCIL BLUFFS    | IA | 1,652 | \$239,688.81 | \$145.09    | 45 |
| 38 | ARJ INFUSION SERVICES LL  | CEDAR RAPIDS      | IA | 31    | \$237,197.91 | \$7,651.55  | 36 |
| 39 | HY-VEE PHARMACY 1142      | DES MOINES        | IA | 2,421 | \$235,878.08 | \$97.43     | 47 |
| 40 | HY-VEE PHARMACY 1058      | CENTERVILLE       | IA | 1,512 | \$234,528.81 | \$155.11    | 52 |
| 41 | HY-VEE PHARMACY 1075      | CLINTON           | IA | 2,773 | \$231,377.93 | \$83.44     | 35 |
| 42 | MAYO CLINIC PHARMACY      | ROCHESTER         | MN | 135   | \$227,979.90 | \$1,688.74  | 31 |
| 43 | GENOA HEALTHCARE LL 20304 | SIOUX CITY        | IA | 1,006 | \$226,749.45 | \$225.40    | 40 |
| 44 | GREENWOOD COMPLIANCE PHA  | WATERLOO          | IA | 1,064 | \$222,269.54 | \$208.90    | 57 |
| 45 | HY-VEE PHARMACY 1610      | SIOUX CITY        | IA | 1,938 | \$221,498.07 | \$114.29    | 53 |
| 46 | BIOLOGICS BY MCKESSON     | FORT WORTH        | TX | 13    | \$216,532.63 | \$16,656.36 | 26 |
| 47 | ORSINI PHARMACEUTICAL SE  | ELK GROVE VILLAGE | IL | 10    | \$213,348.17 | \$21,334.82 | 37 |
| 48 | RIGHT DOSE PHARMACY       | ANKENY            | IA | 3,149 | \$208,528.53 | \$66.22     | 55 |
| 49 | SANFORD PHARMACY BROADWA  | FARGO             | ND | 21    | \$207,942.16 | \$9,902.01  | 68 |
| 50 | HY-VEE DRUGSTORE 7020     | CEDAR RAPIDS      | IA | 2,353 | \$204,677.46 | \$86.99     | 56 |

|    |                          |                |    |       |              |             |     |
|----|--------------------------|----------------|----|-------|--------------|-------------|-----|
| 51 | HY-VEE PHARMACY 1056     | CEDAR RAPIDS   | IA | 2,539 | \$201,203.51 | \$79.25     | 69  |
| 52 | HY-VEE PHARMACY 1530     | PLEASANT HILL  | IA | 1,933 | \$199,116.70 | \$103.01    | 94  |
| 53 | WALMART PHARMACY 10-5115 | DAVENPORT      | IA | 1,888 | \$197,669.18 | \$104.70    | 61  |
| 54 | HY-VEE PHARMACY 1107     | DAVENPORT      | IA | 1,585 | \$196,588.70 | \$124.03    | 67  |
| 55 | S-S PHARMACY             | COUNCIL BLUFFS | IA | 758   | \$195,128.52 | \$257.43    | 46  |
| 56 | WALGREENS 03700          | COUNCIL BLUFFS | IA | 2,366 | \$194,992.78 | \$82.41     | 41  |
| 57 | HY-VEE PHARMACY 1148     | DES MOINES     | IA | 1,603 | \$189,622.43 | \$118.29    | 58  |
| 58 | WALGREENS 00359          | DES MOINES     | IA | 2,253 | \$185,908.74 | \$82.52     | 62  |
| 59 | HY-VEE DRUGSTORE 7060    | MUSCATINE      | IA | 2,456 | \$181,614.88 | \$73.95     | 66  |
| 60 | WALGREENS 07453          | DES MOINES     | IA | 2,086 | \$180,393.37 | \$86.48     | 59  |
| 61 | CVS PHARMACY 08544       | WATERLOO       | IA | 2,136 | \$176,084.75 | \$82.44     | 63  |
| 62 | HY-VEE PHARMACY 1522     | PERRY          | IA | 1,795 | \$175,207.08 | \$97.61     | 91  |
| 63 | HY-VEE PHARMACY 1449     | NEWTON         | IA | 1,166 | \$174,903.46 | \$150.00    | 117 |
| 64 | WALGREENS 16270          | OMAHA          | NE | 26    | \$172,106.49 | \$6,619.48  | 50  |
| 65 | CVS PHARMACY 10282       | FORT DODGE     | IA | 1,939 | \$165,981.32 | \$85.60     | 77  |
| 66 | WALMART PHARMACY 10-2889 | CLINTON        | IA | 1,758 | \$165,679.15 | \$94.24     | 80  |
| 67 | WALGREENS 07455          | WATERLOO       | IA | 2,245 | \$165,033.25 | \$73.51     | 74  |
| 68 | WALGREENS 05239          | DAVENPORT      | IA | 2,935 | \$163,038.63 | \$55.55     | 65  |
| 69 | SENDERRA SPECIALTY PHARM | PLANO          | TX | 16    | \$162,209.16 | \$10,138.07 | 42  |
| 70 | FIRST MED EAST PHARMACY  | DAVENPORT      | IA | 529   | \$161,256.64 | \$304.83    | 34  |
| 71 | WALGREENS 05721          | DES MOINES     | IA | 2,453 | \$160,250.10 | \$65.33     | 98  |
| 72 | HY-VEE PHARMACY 1151     | DES MOINES     | IA | 2,226 | \$156,506.90 | \$70.31     | 95  |
| 73 | WALGREENS 15647          | SIOUX CITY     | IA | 2,272 | \$156,393.94 | \$68.84     | 64  |
| 74 | WALMART PHARMACY 10-0581 | MARSHALLTOWN   | IA | 1,491 | \$156,250.28 | \$104.80    | 60  |
| 75 | HY-VEE PHARMACY 1044     | BURLINGTON     | IA | 1,819 | \$155,275.81 | \$85.36     | 92  |
| 76 | HY-VEE DRUGSTORE 7065    | OTTUMWA        | IA | 2,027 | \$154,828.02 | \$76.38     | 76  |
| 77 | HY-VEE PHARMACY 1042     | BURLINGTON     | IA | 1,133 | \$153,716.73 | \$135.67    | 71  |

|     |                          |              |    |       |              |             |     |
|-----|--------------------------|--------------|----|-------|--------------|-------------|-----|
| 78  | HY-VEE PHARMACY 1396     | MARION       | IA | 1,575 | \$152,586.66 | \$96.88     | 126 |
| 79  | LEWIS FAMILY DRUG 28     | ONAWA        | IA | 1,416 | \$152,497.76 | \$107.70    | 79  |
| 80  | HY-VEE PHARMACY 1866     | WATERLOO     | IA | 1,494 | \$150,967.14 | \$101.05    | 82  |
| 81  | HY-VEE PHARMACY 1615     | SIOUX CITY   | IA | 1,545 | \$150,778.27 | \$97.59     | 83  |
| 82  | DRILLING PHARMACY 67     | SIOUX CITY   | IA | 1,907 | \$150,199.72 | \$78.76     | 49  |
| 83  | WALMART PHARMACY 10-1621 | CENTERVILLE  | IA | 1,151 | \$150,077.90 | \$130.39    | 84  |
| 84  | PARAGON PARTNERS         | OMAHA        | NE | 122   | \$149,150.60 | \$1,222.55  | 51  |
| 85  | HY-VEE PHARMACY 1192     | FORT DODGE   | IA | 2,087 | \$148,001.55 | \$70.92     | 85  |
| 86  | SENDERRA RX PHARMACY     | PLANO        | TX | 17    | \$147,424.67 | \$8,672.04  | N/A |
| 87  | OPTIME CARE INC          | EARTH CITY   | MO | 3     | \$145,495.65 | \$48,498.55 | 48  |
| 88  | OPTION CARE              | OMAHA        | NE | 3     | \$145,428.55 | \$48,476.18 | 149 |
| 89  | MAHASKA DRUGS            | OSKALOOSA    | IA | 1,598 | \$144,691.81 | \$90.55     | 72  |
| 90  | WALMART PHARMACY 10-1723 | DES MOINES   | IA | 1,603 | \$143,697.88 | \$89.64     | 102 |
| 91  | WALMART PHARMACY 10-2764 | ALTOONA      | IA | 1,400 | \$142,696.99 | \$101.93    | 143 |
| 92  | HY-VEE PHARMACY 1061     | CEDAR RAPIDS | IA | 1,757 | \$140,976.24 | \$80.24     | 96  |
| 93  | HY-VEE PHARMACY 1873     | WAUKEE       | IA | 1,455 | \$139,013.26 | \$95.54     | 97  |
| 94  | OPTUM INFUSION SERVICES  | URBAN DALE   | IA | 27    | \$138,731.03 | \$5,138.19  | 202 |
| 95  | CHCSI PHARMACY           | LEON         | IA | 811   | \$136,197.03 | \$167.94    | 93  |
| 96  | WALMART PHARMACY 10-0985 | FAIRFIELD    | IA | 1,388 | \$136,170.75 | \$98.11     | 133 |
| 97  | WALMART PHARMACY 10-0646 | ANAMOSA      | IA | 1,374 | \$135,553.16 | \$98.66     | 88  |
| 98  | WALMART PHARMACY 10-1496 | WATERLOO     | IA | 1,411 | \$135,503.05 | \$96.03     | 70  |
| 99  | NEIGHBORHOOD LTC PHARMAC | URBAN DALE   | IA | 1,267 | \$134,501.35 | \$106.16    | 119 |
| 100 | WALMART PHARMACY 10-0559 | MUSCATINE    | IA | 1,618 | \$134,002.23 | \$82.82     | 125 |

| Top 100 Prescribing Providers by Prescription Count<br>June 2026 to August 2026 |            |                      |              |                    |                        |               |
|---------------------------------------------------------------------------------|------------|----------------------|--------------|--------------------|------------------------|---------------|
| RANK                                                                            | NPI Num    | Prescriber Name      | Paid Amount  | Prescription Count | Average Scripts Member | Previous Rank |
| 1                                                                               | 1982605762 | JEFFREY WILHARM      | \$48,240.29  | 1,665              | 26.9                   | 1             |
| 2                                                                               | 1528365277 | MINA SALIB           | \$350,214.78 | 780                | 4.4                    | 2             |
| 3                                                                               | 1013115369 | BOBBITA NAG          | \$40,159.31  | 694                | 5.0                    | 3             |
| 4                                                                               | 1326798992 | JENNA MULLINS        | \$89,090.12  | 662                | 4.9                    | 8             |
| 5                                                                               | 1992402655 | SHANE EBERHARDT      | \$125,520.93 | 660                | 5.2                    | 6             |
| 6                                                                               | 1689077018 | STACY ROTH           | \$42,345.00  | 660                | 8.7                    | 11            |
| 7                                                                               | 1609218304 | AMANDA GARR          | \$102,357.57 | 625                | 6.4                    | 12            |
| 8                                                                               | 1477199198 | SAJO THOMAS          | \$78,781.97  | 616                | 7.8                    | 10            |
| 9                                                                               | 1306559786 | ROY HENRY            | \$137,567.49 | 598                | 8.2                    | 7             |
| 10                                                                              | 1477926434 | JACKIE SHIPLEY       | \$40,386.66  | 590                | 5.0                    | 16            |
| 11                                                                              | 1811960768 | ANGELA VEENSTRA      | \$36,343.87  | 579                | 8.3                    | 13            |
| 12                                                                              | 1811419815 | GRETCHEN WENGER      | \$52,193.09  | 563                | 4.7                    | 4             |
| 13                                                                              | 1053630640 | JENNIFER DONOVAN     | \$71,448.87  | 563                | 9.1                    | 57            |
| 14                                                                              | 1114681889 | KELSEY BAUER         | \$77,704.15  | 557                | 6.6                    | 34            |
| 15                                                                              | 1417941188 | DEBRA NEUHARTH       | \$62,473.31  | 548                | 5.9                    | 35            |
| 16                                                                              | 1730849647 | MELANIE PARRISH      | \$18,487.45  | 536                | 6.3                    | 15            |
| 17                                                                              | 1144588476 | RACHEL FILZER        | \$103,218.71 | 527                | 7.0                    | 25            |
| 18                                                                              | 1245960350 | MARY WELBORN         | \$47,484.10  | 526                | 5.4                    | 18            |
| 19                                                                              | 1649763079 | KATE JARVIS          | \$83,082.76  | 525                | 6.3                    | 19            |
| 20                                                                              | 1578327094 | NICKETA BURCHELL     | \$43,796.39  | 525                | 4.6                    | 87            |
| 21                                                                              | 1326578725 | JACQUELINE BLACKBURN | \$29,180.39  | 515                | 5.1                    | 29            |
| 22                                                                              | 1619380680 | TARA BROCKMAN        | \$29,507.49  | 509                | 5.4                    | 36            |

|    |            |                      |              |     |      |     |
|----|------------|----------------------|--------------|-----|------|-----|
| 23 | 1265841845 | MARY SCHWERING       | \$53,935.58  | 507 | 6.0  | 20  |
| 24 | 1336904432 | KATIE CLARK          | \$43,707.89  | 506 | 6.3  | 53  |
| 25 | 1306124557 | STACY STEWART        | \$33,968.40  | 500 | 6.2  | 26  |
| 26 | 1942721584 | SHAWNA FURY          | \$42,577.57  | 495 | 4.2  | 14  |
| 27 | 1770933046 | SHELBY BILLER        | \$67,660.24  | 494 | 6.2  | 23  |
| 28 | 1851916837 | AMANDA HARVEY FOLSOM | \$39,706.80  | 489 | 7.8  | 31  |
| 29 | 1437209434 | JON THOMAS           | \$39,669.20  | 487 | 5.9  | 33  |
| 30 | 1023542271 | FLYNN MCCULLOUGH     | \$28,628.81  | 484 | 7.4  | 17  |
| 31 | 1164538674 | JOSEPH WANZEK        | \$39,272.71  | 482 | 7.5  | 27  |
| 32 | 1871021543 | SUSAN WILSON         | \$27,723.25  | 472 | 7.7  | 32  |
| 33 | 1992562458 | ALISON FAUBLE        | \$31,321.24  | 470 | 5.3  | 28  |
| 34 | 1275763047 | REBECCA BOWMAN       | \$67,540.27  | 470 | 6.9  | 44  |
| 35 | 1184657603 | SARA RYGOL           | \$67,784.69  | 461 | 6.2  | 54  |
| 36 | 1689325524 | BRIAN AYERSMAN       | \$85,982.16  | 459 | 7.0  | 41  |
| 37 | 1437238110 | GENEVIEVE NELSON     | \$56,755.41  | 456 | 9.5  | 39  |
| 38 | 1962418640 | BARCLAY MONASTER     | \$42,108.34  | 454 | 4.9  | 37  |
| 39 | 1164823092 | JAMEY GREGERSEN      | \$28,922.76  | 454 | 6.8  | 21  |
| 40 | 1801998372 | WENDY HANSEN-PENMAN  | \$21,142.15  | 453 | 7.0  | 60  |
| 41 | 1881095503 | KAROWESO CHIPENDO    | \$49,970.07  | 447 | 6.3  | 68  |
| 42 | 1982030946 | JACKLYN BESCH        | \$25,267.01  | 443 | 4.8  | 50  |
| 43 | 1891955423 | LEAH SIEGFRIED       | \$202,469.40 | 441 | 10.0 | 64  |
| 44 | 1811512064 | ADRIANNA MITCHELL    | \$88,719.85  | 441 | 8.0  | 147 |
| 45 | 1003053653 | STANLEY MATHEW       | \$26,373.18  | 441 | 13.0 | 81  |
| 46 | 1902912538 | CHRISTIAN JONES      | \$36,300.27  | 439 | 5.6  | 40  |
| 47 | 1598183493 | JENA ELLERHOFF       | \$8,739.16   | 432 | 8.8  | 24  |
| 48 | 1992573786 | LASHELLE GOODE       | \$26,230.05  | 426 | 6.1  | 48  |
| 49 | 1477534279 | EDMUND PIASECKI      | \$54,392.57  | 423 | 7.3  | 95  |

|    |            |                    |              |     |      |     |
|----|------------|--------------------|--------------|-----|------|-----|
| 50 | 1053963900 | NICOLE MCCLAVY     | \$75,545.98  | 423 | 6.5  | 45  |
| 51 | 1801463245 | ANN MOJEIKO        | \$26,736.40  | 421 | 6.6  | 22  |
| 52 | 1467092049 | HEIDI PEDERSEN     | \$74,640.53  | 415 | 6.6  | 46  |
| 53 | 1891306452 | JENNIFER TOMLIN    | \$39,622.11  | 414 | 6.3  | 55  |
| 54 | 1306475413 | AUTUMN ANDERSON    | \$79,603.85  | 414 | 7.8  | 42  |
| 55 | 1831731298 | HEATHER WILSON     | \$32,975.40  | 413 | 5.8  | 38  |
| 56 | 1619153137 | JOADA BEST         | \$38,929.26  | 412 | 5.9  | 69  |
| 57 | 1013639749 | ROBERT HUSEMANN    | \$12,910.58  | 412 | 7.6  | 93  |
| 58 | 1568468007 | ALEXANDER LOCASCIO | \$13,175.63  | 410 | 10.8 | 179 |
| 59 | 1215981758 | LISA PISNEY        | \$51,291.16  | 407 | 8.7  | 73  |
| 60 | 1588746515 | AMY BADBERG        | \$17,163.96  | 406 | 5.0  | 63  |
| 61 | 1184125262 | JENIFER EDSTROM    | \$20,173.50  | 405 | 3.9  | 89  |
| 62 | 1891707832 | LISA KLOCK         | \$31,830.20  | 402 | 3.9  | 58  |
| 63 | 1205393386 | JESSICA HUDSPETH   | \$29,532.79  | 400 | 6.6  | 67  |
| 64 | 1679573893 | PATTY HILDRETH     | \$77,207.05  | 399 | 6.4  | 30  |
| 65 | 1699658245 | AMY STRIM          | \$28,330.51  | 398 | 6.0  | 75  |
| 66 | 1487194791 | STACY HENNIGAR     | \$28,811.76  | 398 | 5.0  | 80  |
| 67 | 1831710987 | MARGARET WHITE     | \$53,916.81  | 394 | 6.2  | 101 |
| 68 | 1013355759 | DYLAN GREENE       | \$33,598.26  | 393 | 4.9  | 65  |
| 69 | 1043434525 | ROBERT KENT        | \$38,972.56  | 392 | 6.0  | 56  |
| 70 | 1467502286 | CHARLES TILLEY     | \$153,077.39 | 391 | 8.5  | 99  |
| 71 | 1437692803 | CASSANDRA DUNLAVY  | \$34,365.88  | 389 | 5.3  | 62  |
| 72 | 1063277671 | AMANDA FRY         | \$66,963.95  | 389 | 5.8  | 91  |
| 73 | 1427766559 | KORIE EISCHEID     | \$27,231.22  | 387 | 6.9  | 43  |
| 74 | 1043211303 | ALI SAFDAR         | \$50,497.00  | 384 | 5.3  | 183 |
| 75 | 1891215190 | THI NGUYEN CHAU    | \$55,776.22  | 378 | 5.4  | 83  |
| 76 | 1073369070 | NICHOLAS BLIEU     | \$52,261.21  | 378 | 5.8  | 107 |

|     |            |                     |              |     |      |     |
|-----|------------|---------------------|--------------|-----|------|-----|
| 77  | 1184056822 | ABBY KOLTHOFF       | \$213,396.49 | 377 | 5.7  | 104 |
| 78  | 1417241621 | ASHLEY MATHES       | \$27,706.12  | 376 | 5.6  | 126 |
| 79  | 1417679168 | PAIGE REED          | \$62,000.70  | 376 | 7.1  | 129 |
| 80  | 1023469798 | WEI SHIPENG         | \$18,112.66  | 375 | 17.0 | 112 |
| 81  | 1114704004 | AMANDA LAUER        | \$19,062.86  | 373 | 4.8  | 266 |
| 82  | 1083439145 | AMANDA MONROE       | \$13,297.49  | 371 | 6.9  | 105 |
| 83  | 1538368170 | CHRISTOPHER MATSON  | \$17,615.34  | 369 | 5.1  | 88  |
| 84  | 1780877878 | CHRISTOPHER JACOBS  | \$56,918.26  | 368 | 5.2  | 90  |
| 85  | 1750176244 | JESSICA BOWMAN      | \$23,775.71  | 368 | 6.6  | 212 |
| 86  | 1679986350 | JENNIFER SPOERL     | \$52,151.24  | 368 | 6.6  | 70  |
| 87  | 1760965032 | MELISSA MILLER      | \$13,758.27  | 366 | 6.0  | 49  |
| 88  | 1598345415 | LAUREN MANCIERI     | \$21,364.00  | 366 | 5.2  | 110 |
| 89  | 1255823506 | NICOLE DELAGARDELLE | \$65,378.37  | 365 | 5.3  | 71  |
| 90  | 1134191018 | DUSTIN SMITH        | \$30,726.08  | 363 | 5.7  | 51  |
| 91  | 1215125216 | REBECCA WALDING     | \$32,740.37  | 363 | 5.7  | 155 |
| 92  | 1295830115 | ALAN BOLLINGER      | \$21,601.72  | 361 | 7.7  | 132 |
| 93  | 1417214321 | LEAH BRANDON        | \$10,105.45  | 360 | 13.3 | 296 |
| 94  | 1467431445 | SUSAN CASADY        | \$32,680.31  | 358 | 13.8 | 59  |
| 95  | 1326443342 | SHARON PITT         | \$21,285.36  | 357 | 8.3  | 134 |
| 96  | 1902358443 | MELISSA KONKEN      | \$80,203.01  | 356 | 6.0  | 96  |
| 97  | 1992314108 | LYNZEE MAKOWSKI     | \$150,158.20 | 356 | 5.2  | 158 |
| 98  | 1568758746 | DANIEL BINKOWSKI    | \$15,683.38  | 356 | 3.9  | 137 |
| 99  | 1356788129 | RACHAEL PARKER      | \$44,014.08  | 356 | 8.7  | 136 |
| 100 | 1467907394 | CYNTHIA COENEN      | \$53,951.84  | 355 | 8.7  | 151 |

| Top 100 Prescribing Providers by Paid Amount<br>June 2026 to August 2026 |            |                       |              |             |                    |               |
|--------------------------------------------------------------------------|------------|-----------------------|--------------|-------------|--------------------|---------------|
| RANK                                                                     | NPI Num    | Prescriber Name       | Paid Amount  | Avg cost RX | Prescription Count | Previous Rank |
| 1                                                                        | 1114214541 | DIMAH SAADE           | \$766,857.96 | \$18,703.85 | 41                 | 1             |
| 2                                                                        | 1700561826 | PEDRO HSIEH           | \$656,878.88 | \$19,905.42 | 33                 | 5             |
| 3                                                                        | 1942937388 | CARLY TRAUSCH         | \$627,391.05 | \$1,889.73  | 332                | 3             |
| 4                                                                        | 1821046087 | ARCHANA VERMA         | \$495,023.61 | \$8,115.14  | 61                 | 9             |
| 5                                                                        | 1891146999 | BECKY JOHNSON         | \$462,683.03 | \$1,385.28  | 334                | 7             |
| 6                                                                        | 1285626390 | KATHLEEN GRADOVILLE   | \$411,444.33 | \$3,774.72  | 109                | 23            |
| 7                                                                        | 1295091510 | REBECCA WEINER        | \$395,002.71 | \$2,025.65  | 195                | 2             |
| 8                                                                        | 1013126705 | JANICE STABER         | \$389,140.73 | \$12,552.93 | 31                 | 13            |
| 9                                                                        | 1528365277 | MINA SALIB            | \$350,214.78 | \$448.99    | 780                | 11            |
| 10                                                                       | 1417443953 | RODNEY CLARK          | \$343,551.32 | \$1,137.59  | 302                | 15            |
| 11                                                                       | 1821866856 | LAUREN CRAWFORD       | \$328,684.56 | \$1,703.03  | 193                | 18            |
| 12                                                                       | 1578958542 | HEIDI CURTIS          | \$317,331.57 | \$1,652.77  | 192                | 8             |
| 13                                                                       | 1336602846 | DRAKE BOUZEK          | \$311,124.39 | \$3,240.88  | 96                 | 29            |
| 14                                                                       | 1669137832 | TIFFANY HEIAR         | \$287,379.13 | \$1,830.44  | 157                | 10            |
| 15                                                                       | 1376525196 | RANDOLPH ROUGH        | \$276,024.29 | \$3,943.20  | 70                 | 89            |
| 16                                                                       | 1861277980 | KATHRYN EWOLDT        | \$275,278.27 | \$2,572.69  | 107                | 4             |
| 17                                                                       | 1477761328 | AMY CALHOUN           | \$274,564.33 | \$5,383.61  | 51                 | 6             |
| 18                                                                       | 1437533130 | KATIE BROSHUIS        | \$271,022.30 | \$2,852.87  | 95                 | 28            |
| 19                                                                       | 1952423071 | SAKEER HUSSAIN        | \$264,013.05 | \$17,600.87 | 15                 | 12            |
| 20                                                                       | 1275836751 | HOLLY KRAMER          | \$240,416.18 | \$2,054.84  | 117                | 99            |
| 21                                                                       | 1184056822 | ABBY KOLTHOFF         | \$213,396.49 | \$566.04    | 377                | 36            |
| 22                                                                       | 1144829300 | KATIE SHANNON         | \$213,150.75 | \$3,494.27  | 61                 | 54            |
| 23                                                                       | 1801831870 | SEEMA HARICHAND-HERDT | \$211,159.58 | \$11,113.66 | 19                 | 2,354         |
| 24                                                                       | 1235792912 | FARAAZ ZAFAR          | \$205,848.18 | \$1,979.31  | 104                | 35            |

|    |            |                     |              |             |     |       |
|----|------------|---------------------|--------------|-------------|-----|-------|
| 25 | 1194945691 | ANJALI SHARATHKUMAR | \$205,387.58 | \$4,564.17  | 45  | 56    |
| 26 | 1891955423 | LEAH SIEGFRIED      | \$202,469.40 | \$459.11    | 441 | 33    |
| 27 | 1437513520 | SUSSETTE GONZALEZ   | \$197,402.06 | \$3,525.04  | 56  | 16    |
| 28 | 1437121407 | LINDA CADARET       | \$194,642.42 | \$3,414.78  | 57  | 24    |
| 29 | 1093382632 | GAIL DOOLEY         | \$193,963.92 | \$1,356.39  | 143 | 48    |
| 30 | 1841607900 | SHAYLA SANDERS      | \$190,255.27 | \$3,459.19  | 55  | 45    |
| 31 | 1902191059 | AMBER TIERNEY       | \$185,526.33 | \$5,622.01  | 33  | 21    |
| 32 | 1366065047 | BRITTANIA SCHOON    | \$184,986.43 | \$1,516.28  | 122 | 49    |
| 33 | 1063792026 | JILL MILLER         | \$184,264.96 | \$711.45    | 259 | 46    |
| 34 | 1467449579 | BRIAN WAYSON        | \$182,233.09 | \$9,591.22  | 19  | 14    |
| 35 | 1376512244 | RAYMOND KUWAHARA    | \$176,869.57 | \$2,807.45  | 63  | 284   |
| 36 | 1194382119 | ERIK ARNESON        | \$175,546.15 | \$1,290.78  | 136 | 247   |
| 37 | 1457986671 | PAITON CALVERT      | \$171,372.10 | \$2,856.20  | 60  | 38    |
| 38 | 1033221916 | ADRIAN LETZ         | \$171,154.25 | \$14,262.85 | 12  | 20    |
| 39 | 1801405832 | SARAH HIEMER        | \$170,403.38 | \$1,271.67  | 134 | 19    |
| 40 | 1932468576 | MEREDITH SCHAFFNER  | \$169,704.25 | \$24,243.46 | 7   | 25    |
| 41 | 1659108090 | TERESA HANSON       | \$168,395.63 | \$511.84    | 329 | 69    |
| 42 | 1184989428 | SANTIAGO ENCALADA   | \$167,768.78 | \$3,050.34  | 55  | 44    |
| 43 | 1427697069 | KYLA INGRAM         | \$159,101.63 | \$1,272.81  | 125 | 74    |
| 44 | 1215333091 | NADIA NAZ           | \$158,391.70 | \$1,331.02  | 119 | 47    |
| 45 | 1598438095 | LALAURO LOGAN       | \$156,999.67 | \$835.10    | 188 | 50    |
| 46 | 1497101919 | ALEXANDER STALLER   | \$156,632.28 | \$14,239.30 | 11  | 75    |
| 47 | 1356325914 | JANET LEGARE        | \$153,342.52 | \$38,335.63 | 4   | 4,438 |
| 48 | 1467502286 | CHARLES TILLEY      | \$153,077.39 | \$391.50    | 391 | 87    |
| 49 | 1992314108 | LYNZEE MAKOWSKI     | \$150,158.20 | \$421.79    | 356 | 30    |
| 50 | 1265420095 | ELIZABETH COOPER    | \$150,154.56 | \$3,662.31  | 41  | 81    |
| 51 | 1841673738 | RACHEL PERSON       | \$145,830.53 | \$3,645.76  | 40  | 128   |

|    |            |                      |              |             |     |       |
|----|------------|----------------------|--------------|-------------|-----|-------|
| 52 | 1104933878 | DAVID MERCER         | \$145,462.08 | \$36,365.52 | 4   | 93    |
| 53 | 1356752067 | KELLY DELANEY-NELSON | \$145,261.01 | \$2,690.02  | 54  | 52    |
| 54 | 1306071915 | THOMAS PIETRAS       | \$143,964.49 | \$3,599.11  | 40  | 62    |
| 55 | 1649419219 | HEATHER HUNEMULLER   | \$139,453.40 | \$1,483.55  | 94  | 53    |
| 56 | 1952194680 | LAUREN BALES         | \$138,995.63 | \$1,311.28  | 106 | 133   |
| 57 | 1699161919 | ALEJANDRA JIMENEZ    | \$138,054.56 | \$2,510.08  | 55  | 91    |
| 58 | 1952539447 | ANTHONY FISCHER      | \$137,656.97 | \$1,995.03  | 69  | 26    |
| 59 | 1306559786 | ROY HENRY            | \$137,567.49 | \$230.05    | 598 | 57    |
| 60 | 1982852414 | JOHN EATON           | \$137,202.03 | \$27,440.41 | 5   | 6,416 |
| 61 | 1245353242 | SANDY HONG           | \$136,726.38 | \$2,441.54  | 56  | 17    |
| 62 | 1164408548 | MAXWELL COSMIC       | \$136,007.28 | \$3,885.92  | 35  | 67    |
| 63 | 1043565328 | SARA MOELLER         | \$130,862.14 | \$3,443.74  | 38  | 268   |
| 64 | 1144214248 | KRISTI WALZ          | \$130,799.35 | \$484.44    | 270 | 65    |
| 65 | 1588616171 | HEATHER THOMAS       | \$130,725.59 | \$1,485.52  | 88  | 41    |
| 66 | 1558028852 | CARRIE O'CONNELL     | \$129,519.60 | \$406.02    | 319 | 77    |
| 67 | 1538111356 | THANAI PONGDEE       | \$128,577.78 | \$21,429.63 | 6   | 59    |
| 68 | 1568423192 | JOHN WOLLNER         | \$128,187.16 | \$1,913.24  | 67  | 162   |
| 69 | 1811377989 | LILIYA GANDRABUR     | \$126,751.48 | \$1,491.19  | 85  | 200   |
| 70 | 1194797449 | DIANNA PROKUPEK      | \$126,694.09 | \$1,863.15  | 68  | 70    |
| 71 | 1902792856 | TIMOTHY HOFFMANN     | \$125,731.41 | \$561.30    | 224 | 106   |
| 72 | 1992402655 | SHANE EBERHARDT      | \$125,520.93 | \$190.18    | 660 | 109   |
| 73 | 1972914844 | UGUR SENER           | \$125,064.65 | \$20,844.11 | 6   | 63    |
| 74 | 1235894122 | KRISHNA HUGHES       | \$123,151.56 | \$3,003.70  | 41  | 27    |
| 75 | 1255658175 | ASHLEY DESCHAMP      | \$121,965.04 | \$3,387.92  | 36  | 90    |
| 76 | 1093162075 | MEGHAN RYAN          | \$118,484.26 | \$1,942.36  | 61  | 108   |
| 77 | 1225263833 | LINDSAY ORRIS        | \$116,556.02 | \$2,649.00  | 44  | 199   |
| 78 | 1700240579 | JACOB MURRAY         | \$116,056.29 | \$2,189.74  | 53  | 923   |

|     |            |                 |              |             |     |       |
|-----|------------|-----------------|--------------|-------------|-----|-------|
| 79  | 1306230230 | SONAM PATEL     | \$115,151.99 | \$2,878.80  | 40  | 121   |
| 80  | 1245468768 | THOMAS SCHMIDT  | \$114,053.25 | \$1,481.21  | 77  | 61    |
| 81  | 1003315201 | ABIGAIL BEHRENS | \$113,445.35 | \$2,224.42  | 51  | 32    |
| 82  | 1073811352 | KYLE ROSE       | \$113,185.44 | \$16,169.35 | 7   | 82    |
| 83  | 1427685791 | DELANEY SCHARA  | \$111,774.32 | \$2,191.65  | 51  | 72    |
| 84  | 1760562466 | ARTHUR BEISANG  | \$110,231.26 | \$36,743.75 | 3   | 40    |
| 85  | 1326602459 | IAN JACKSON     | \$109,974.18 | \$12,219.35 | 9   | #N/A  |
| 86  | 1548143977 | TIERNEY KOZAL   | \$109,692.15 | \$2,193.84  | 50  | 451   |
| 87  | 1275607608 | RHONDA WRIGHT   | \$109,668.29 | \$3,427.13  | 32  | 39    |
| 88  | 1285946566 | HAZIM ZAGHLOUL  | \$109,566.99 | \$2,381.89  | 46  | 96    |
| 89  | 1316942212 | JEFFREY GOLDMAN | \$109,559.68 | \$3,130.28  | 35  | 64    |
| 90  | 1134981038 | CASSIDY CHALUPA | \$108,467.45 | \$2,711.69  | 40  | 117   |
| 91  | 1548623135 | ISABELLA HERMAN | \$108,382.35 | \$4,014.16  | 27  | 2,730 |
| 92  | 1720416563 | CRYSTAL OBERLE  | \$107,629.36 | \$904.45    | 119 | 103   |
| 93  | 1194176586 | PAUL FENTON     | \$106,198.24 | \$4,424.93  | 24  | 256   |
| 94  | 1174047781 | ALISON BERGER   | \$106,103.97 | \$2,720.61  | 39  | 71    |
| 95  | 1003264185 | ELIZABETH BOWEN | \$106,055.52 | \$3,657.09  | 29  | 230   |
| 96  | 1932831971 | KRISTEN EMODI   | \$105,324.31 | \$2,925.68  | 36  | 37    |
| 97  | 1356754337 | CYNDI MCCORMICK | \$103,465.56 | \$556.27    | 186 | 173   |
| 98  | 1144588476 | RACHEL FILZER   | \$103,218.71 | \$195.86    | 527 | 107   |
| 99  | 1871039917 | ELIZABETH ALLEN | \$103,201.68 | \$1,779.34  | 58  | 66    |
| 100 | 1356655336 | AASIYA MATIN    | \$102,622.83 | \$12,827.85 | 8   | 80    |

| Top 20 Therapeutic Class by Paid Amount           |                                   |               |                   |                                     |              |                  |          |
|---------------------------------------------------|-----------------------------------|---------------|-------------------|-------------------------------------|--------------|------------------|----------|
| Category Description                              | March 2026 to May 2026 Total Cost | Previous Rank | Previous % Budget | June 2026 to August 2026 Total Cost | Current Rank | Current % Budget | % Change |
| DERMATOLOGICALS                                   | \$10,216,039.54                   | 1             | 14.72%            | \$10,603,982.14                     | 1            | 14.54%           | 3.80%    |
| ANTIDIABETICS                                     | \$8,665,990.91                    | 2             | 12.49%            | \$9,488,118.19                      | 2            | 13.01%           | 9.49%    |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS                   | \$7,701,512.36                    | 3             | 11.10%            | \$8,206,280.66                      | 3            | 11.25%           | 6.55%    |
| ANALGESICS - ANTI-INFLAMMATORY                    | \$4,412,252.27                    | 4             | 6.36%             | \$4,558,686.70                      | 4            | 6.25%            | 3.32%    |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS     | \$4,071,991.23                    | 5             | 5.87%             | \$4,450,750.51                      | 5            | 6.10%            | 9.30%    |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS           | \$3,692,988.00                    | 6             | 5.32%             | \$3,716,118.24                      | 6            | 5.10%            | 0.63%    |
| ANTIVIRALS                                        | \$2,961,651.57                    | 7             | 4.27%             | \$3,209,393.46                      | 7            | 4.40%            | 8.36%    |
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | \$2,383,842.68                    | 9             | 3.44%             | \$2,772,339.29                      | 8            | 3.80%            | 16.30%   |
| GASTROINTESTINAL AGENTS - MISC.                   | \$2,346,901.03                    | 10            | 3.38%             | \$2,711,600.68                      | 9            | 3.72%            | 15.54%   |
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES          | \$2,786,300.13                    | 8             | 4.02%             | \$2,338,791.13                      | 10           | 3.21%            | -16.06%  |
| HEMATOLOGICAL AGENTS - MISC.                      | \$2,138,246.85                    | 11            | 3.08%             | \$2,228,246.37                      | 11           | 3.06%            | 4.21%    |
| MIGRAINE PRODUCTS                                 | \$1,905,719.65                    | 13            | 2.75%             | \$2,122,944.67                      | 12           | 2.91%            | 11.40%   |
| RESPIRATORY AGENTS - MISC.                        | \$2,125,326.08                    | 12            | 3.06%             | \$1,964,818.21                      | 13           | 2.69%            | -7.55%   |
| ENDOCRINE AND METABOLIC AGENTS - MISC.            | \$1,600,305.69                    | 14            | 2.31%             | \$1,649,377.61                      | 14           | 2.26%            | 3.07%    |
| ANTICONSULTANTS                                   | \$1,415,423.07                    | 15            | 2.04%             | \$1,452,211.24                      | 15           | 1.99%            | 2.60%    |
| ANTIDEPRESSANTS                                   | \$1,253,022.75                    | 16            | 1.81%             | \$1,347,483.85                      | 16           | 1.85%            | 7.54%    |
| CARDIOVASCULAR AGENTS - MISC.                     | \$886,119.23                      | 19            | 1.28%             | \$1,249,794.11                      | 17           | 1.71%            | 41.04%   |
| NEUROMUSCULAR AGENTS                              | \$1,192,464.60                    | 17            | 1.72%             | \$1,204,442.35                      | 18           | 1.65%            | 1.00%    |
| ANTICOAGULANTS                                    | \$944,367.19                      | 18            | 1.36%             | \$989,857.09                        | 19           | 1.36%            | 4.82%    |
| MISCELLANEOUS THERAPEUTIC CLASSES                 | \$580,122.37                      | 20            | 0.84%             | \$432,505.50                        | 20           | 0.59%            | -25.45%  |

| Top 20 Therapeutic Class by Prescription Count |                                        |               |                                          |              |          |
|------------------------------------------------|----------------------------------------|---------------|------------------------------------------|--------------|----------|
| Category Description                           | March 2026 to May 2026<br>Total Claims | Previous Rank | June 2026 to August 2026<br>Total Claims | Current Rank | % Change |
| ANTIDEPRESSANTS                                | 57,180                                 | 1             | 57,025                                   | 1            | -0.27%   |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS  | 33,163                                 | 2             | 32,112                                   | 2            | -3.17%   |
| ANTICONVULSANTS                                | 29,747                                 | 3             | 30,191                                   | 3            | 1.49%    |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS        | 28,171                                 | 4             | 26,513                                   | 4            | -5.89%   |
| ANTIDIABETICS                                  | 24,723                                 | 5             | 25,481                                   | 5            | 3.07%    |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS                | 23,186                                 | 6             | 23,870                                   | 6            | 2.95%    |
| ANTIANXIETY AGENTS                             | 22,940                                 | 7             | 23,610                                   | 7            | 2.92%    |
| ANTIHYPERTENSIVES                              | 18,673                                 | 8             | 18,266                                   | 8            | -2.18%   |
| DERMATOLOGICALS                                | 15,988                                 | 10            | 17,368                                   | 9            | 8.63%    |
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS    | 16,002                                 | 9             | 15,598                                   | 10           | -2.52%   |
| ANALGESICS - OPIOID                            | 12,726                                 | 12            | 13,368                                   | 11           | 5.04%    |
| ANTIHISTAMINES                                 | 11,628                                 | 13            | 11,505                                   | 12           | -1.06%   |
| ANTIHYPERTENSIVES                              | 11,195                                 | 14            | 11,442                                   | 13           | 2.21%    |
| ANALGESICS - ANTI-INFLAMMATORY                 | 11,122                                 | 15            | 11,141                                   | 14           | 0.17%    |
| PENICILLINS                                    | 14,688                                 | 11            | 9,909                                    | 15           | -32.54%  |
| MUSCULOSKELETAL THERAPY AGENTS                 | 8,763                                  | 17            | 8,907                                    | 16           | 1.64%    |
| BETA BLOCKERS                                  | 8,936                                  | 16            | 8,713                                    | 17           | -2.50%   |
| CORTICOSTEROIDS                                | 8,707                                  | 18            | 7,524                                    | 18           | -13.59%  |
| ANALGESICS - NONNARCOTIC                       | 6,832                                  | 20            | 7,068                                    | 19           | 3.45%    |
| ANTIEMETICS                                    | 7,797                                  | 19            | 6,887                                    | 20           | -11.67%  |

| Top 100 Drugs by Paid Amount |                                   |               |                                     |              |          |
|------------------------------|-----------------------------------|---------------|-------------------------------------|--------------|----------|
| Drug Description             | March 2026 to May 2026 Total Cost | Previous Rank | June 2026 to August 2026 Total cost | Current Rank | % Change |
| Dupixent                     | \$3,453,428.42                    | 2             | \$3,677,764.77                      | 1            | 6.50%    |
| Ozempic                      | \$3,652,703.38                    | 1             | \$3,628,470.81                      | 2            | -0.66%   |
| Vraylar                      | \$2,348,318.39                    | 3             | \$2,447,502.63                      | 3            | 4.22%    |
| Mounjaro                     | \$1,529,100.83                    | 7             | \$2,384,171.94                      | 4            | 55.92%   |
| Skyrizi Pen                  | \$1,836,047.53                    | 4             | \$2,153,751.11                      | 5            | 17.30%   |
| Humira (2 Pen)               | \$1,672,397.24                    | 5             | \$1,974,759.55                      | 6            | 18.08%   |
| Biktarvy                     | \$1,506,092.80                    | 8             | \$1,741,810.43                      | 7            | 15.65%   |
| Zepbound                     | \$1,223,003.54                    | 10            | \$1,506,527.75                      | 8            | 23.18%   |
| Trikafta                     | \$1,565,405.10                    | 6             | \$1,344,689.28                      | 9            | -14.10%  |
| Invega Sustenna              | \$1,249,471.95                    | 9             | \$1,338,507.22                      | 10           | 7.13%    |
| Jardiance                    | \$971,094.61                      | 12            | \$1,008,169.86                      | 11           | 3.82%    |
| Skyrizi                      | \$845,720.94                      | 13            | \$918,910.04                        | 12           | 8.65%    |
| Duvyzat                      | \$756,826.13                      | 17            | \$916,197.11                        | 13           | 21.06%   |
| Caplyta                      | \$796,024.70                      | 15            | \$913,414.70                        | 14           | 14.75%   |
| Cosentyx UnoReady            | \$1,009,797.84                    | 11            | \$850,404.59                        | 15           | -15.78%  |
| Hemlibra                     | \$763,458.83                      | 16            | \$797,036.41                        | 16           | 4.40%    |
| Altuviiio                    | \$564,964.26                      | 26            | \$765,368.58                        | 17           | 35.47%   |
| Rexulti                      | \$643,001.62                      | 20            | \$732,455.72                        | 18           | 13.91%   |
| Taltz                        | \$843,626.96                      | 14            | \$701,153.90                        | 19           | -16.89%  |
| Rinvoq                       | \$712,145.53                      | 18            | \$694,010.22                        | 20           | -2.55%   |
| Trulicity                    | \$688,709.35                      | 19            | \$640,996.67                        | 21           | -6.93%   |
| Abilify Maintena             | \$629,677.76                      | 21            | \$638,555.04                        | 22           | 1.41%    |

|                             |              |    |              |    |         |
|-----------------------------|--------------|----|--------------|----|---------|
| Nurtec                      | \$551,197.50 | 27 | \$623,908.93 | 23 | 13.19%  |
| Eliquis                     | \$573,744.13 | 25 | \$616,313.07 | 24 | 7.42%   |
| Aristada                    | \$599,226.84 | 22 | \$613,550.09 | 25 | 2.39%   |
| Bimzelx                     | \$592,466.35 | 23 | \$605,913.75 | 26 | 2.27%   |
| Trelegy Ellipta             | \$527,697.15 | 28 | \$552,422.65 | 27 | 4.69%   |
| Austedo XR                  | \$371,678.82 | 38 | \$538,670.78 | 28 | 44.93%  |
| Kesimpta                    | \$339,682.19 | 44 | \$521,187.82 | 29 | 53.43%  |
| Tremfya One-Press           | \$367,329.36 | 40 | \$505,077.87 | 30 | 37.50%  |
| Enbrel SureClick            | \$495,571.70 | 30 | \$496,071.27 | 31 | 0.10%   |
| Symbicort                   | \$497,261.24 | 29 | \$484,903.86 | 32 | -2.49%  |
| Gattex                      | \$432,680.76 | 33 | \$484,361.29 | 33 | 11.94%  |
| Ingrezza                    | \$439,417.85 | 32 | \$484,110.05 | 34 | 10.17%  |
| Tremfya Pen                 | \$309,502.22 | 49 | \$459,377.51 | 35 | 48.42%  |
| Ubrelvy                     | \$384,055.27 | 37 | \$448,810.84 | 36 | 16.86%  |
| Stelara                     | \$580,199.64 | 24 | \$416,799.17 | 37 | -28.16% |
| Lisdexamfetamine Dimesylate | \$416,622.43 | 35 | \$406,566.72 | 38 | -2.41%  |
| Wegovy                      | \$241,128.21 | 56 | \$405,340.72 | 39 | 68.10%  |
| Invega Trinza               | \$439,481.97 | 31 | \$402,434.18 | 40 | -8.43%  |
| Norditropin FlexPro         | \$426,898.32 | 34 | \$387,269.65 | 41 | -9.28%  |
| Ajovy                       | \$338,033.38 | 46 | \$377,763.42 | 42 | 11.75%  |
| Lybalvi                     | \$344,130.76 | 42 | \$375,444.37 | 43 | 9.10%   |
| Jornay PM                   | \$369,821.98 | 39 | \$362,974.79 | 44 | -1.85%  |
| Farxiga                     | \$343,217.51 | 43 | \$352,031.87 | 45 | 2.57%   |
| Xarelto                     | \$326,360.44 | 47 | \$332,452.39 | 46 | 1.87%   |
| Trintellix                  | \$316,985.10 | 48 | \$325,364.79 | 47 | 2.64%   |
| Humira (2 Syringe)          | \$339,245.43 | 45 | \$286,359.93 | 48 | -15.59% |
| Albuterol Sulfate HFA       | \$281,455.53 | 51 | \$276,730.42 | 49 | -1.68%  |

|                   |              |     |              |    |         |
|-------------------|--------------|-----|--------------|----|---------|
| Uzedy             | \$223,869.71 | 61  | \$275,146.48 | 50 | 22.90%  |
| Xywav             | \$257,463.19 | 52  | \$260,988.19 | 51 | 1.37%   |
| Livmarli          | \$157,458.23 | 82  | \$259,618.35 | 52 | 64.88%  |
| Qelbree           | \$247,812.58 | 54  | \$258,815.96 | 53 | 4.44%   |
| Alyftrek          | \$242,527.91 | 55  | \$257,162.48 | 54 | 6.03%   |
| Ilaris            | \$361,552.87 | 41  | \$254,078.49 | 55 | -29.73% |
| Abilify Asimtufii | \$205,209.06 | 70  | \$247,628.37 | 56 | 20.67%  |
| Mavyret           | \$409,573.03 | 36  | \$243,996.72 | 57 | -40.43% |
| Wakix             | \$240,997.01 | 57  | \$239,395.47 | 58 | -0.66%  |
| Emgality          | \$215,982.10 | 64  | \$237,502.34 | 59 | 9.96%   |
| Tezspire          | \$171,234.54 | 75  | \$224,272.46 | 60 | 30.97%  |
| Nemludio          | \$219,216.40 | 62  | \$223,668.40 | 61 | 2.03%   |
| Creon             | \$224,467.89 | 60  | \$216,505.76 | 62 | -3.55%  |
| Winrevair         | \$76,544.05  | 159 | \$214,270.19 | 63 | 179.93% |
| Qulipta           | \$207,274.99 | 69  | \$211,614.38 | 64 | 2.09%   |
| Opsumit           | \$237,246.75 | 58  | \$206,594.73 | 65 | -12.92% |
| Ebglyss           | \$201,180.27 | 71  | \$206,009.33 | 66 | 2.40%   |
| EPINEPHrine       | \$153,447.19 | 85  | \$198,567.41 | 67 | 29.40%  |
| Xolair            | \$208,528.33 | 68  | \$195,728.67 | 68 | -6.14%  |
| Lantus SoloStar   | \$214,926.07 | 65  | \$190,860.97 | 69 | -11.20% |
| Fasenra Pen       | \$214,391.62 | 66  | \$188,729.18 | 70 | -11.97% |
| Epidiolex         | \$165,417.83 | 78  | \$181,826.85 | 71 | 9.92%   |
| Uptravi           | \$72,713.40  | 175 | \$181,787.34 | 72 | 150.01% |
| Nubeqa            | \$140,203.33 | 89  | \$180,789.55 | 73 | 28.95%  |
| Advair HFA        | \$198,024.30 | 72  | \$178,284.05 | 74 | -9.97%  |
| Adempas           | \$133,356.87 | 92  | \$177,809.16 | 75 | 33.33%  |
| Evrysdi           | \$249,180.23 | 53  | \$176,731.65 | 76 | -29.07% |

|                              |              |     |              |     |         |
|------------------------------|--------------|-----|--------------|-----|---------|
| Austedo                      | \$228,716.38 | 59  | \$175,216.02 | 77  | -23.39% |
| Breztri Aerosphere           | \$155,205.23 | 84  | \$172,681.51 | 78  | 11.26%  |
| Dovato                       | \$148,600.00 | 87  | \$171,254.05 | 79  | 15.24%  |
| Skytrofa                     | \$134,511.19 | 91  | \$168,668.86 | 80  | 25.39%  |
| Insulin Lispro (1 Unit Dial) | \$183,901.57 | 74  | \$166,018.71 | 81  | -9.72%  |
| Yorvipath                    | \$118,448.15 | 110 | \$165,827.41 | 82  | 40.00%  |
| Sofosbuvir-Velpatasvir       | \$119,908.95 | 109 | \$163,895.35 | 83  | 36.68%  |
| Takhzyro                     | \$216,134.92 | 63  | \$162,911.53 | 84  | -24.63% |
| Spiriva Respimat             | \$166,935.35 | 77  | \$158,571.48 | 85  | -5.01%  |
| Tremfya-CD/UC Induction      | \$123,048.31 | 106 | \$154,519.47 | 86  | 25.58%  |
| Yuviwel                      | \$0.00       | N/A | \$153,342.52 | 87  | N/A     |
| Nucala                       | \$91,455.89  | 139 | \$151,709.60 | 88  | 65.88%  |
| Aimovig                      | \$131,017.37 | 95  | \$149,526.74 | 89  | 14.13%  |
| Orladeyo                     | \$193,994.20 | 73  | \$145,495.65 | 90  | -25.00% |
| Alprolix                     | \$141,792.10 | 88  | \$145,361.34 | 91  | 2.52%   |
| Sogroya                      | \$78,633.34  | 154 | \$145,020.35 | 92  | 84.43%  |
| Auvelity                     | \$130,355.98 | 97  | \$143,488.95 | 93  | 10.07%  |
| Verzenio                     | \$161,906.97 | 81  | \$142,434.02 | 94  | -12.03% |
| Toujeo Max SoloStar          | \$106,470.04 | 120 | \$141,961.90 | 95  | 33.34%  |
| Briviact                     | \$139,622.28 | 90  | \$139,473.83 | 96  | -0.11%  |
| Zenpep                       | \$156,348.79 | 83  | \$138,734.43 | 97  | -11.27% |
| Otezla                       | \$152,517.03 | 86  | \$136,034.25 | 98  | -10.81% |
| Cholbam                      | \$128,941.44 | 101 | \$134,957.24 | 99  | 4.67%   |
| Linzess                      | \$129,449.63 | 99  | \$134,631.74 | 100 | 4.00%   |

### Top 100 Drugs by Prescription Count

| Drug Description            | March 2026 to May 2026 Total Claims | Previous Rank | June 2026 to August 2026 Total Claims | Current Rank | % Change |
|-----------------------------|-------------------------------------|---------------|---------------------------------------|--------------|----------|
| traZODone HCl               | 9,624                               | 3             | 9,811                                 | 1            | 1.94%    |
| Albuterol Sulfate HFA       | 10,041                              | 1             | 9,691                                 | 2            | -3.49%   |
| buPROPion HCl ER (XL)       | 9,319                               | 4             | 9,446                                 | 3            | 1.36%    |
| hydrOXYzine HCl             | 7,365                               | 7             | 7,637                                 | 4            | 3.69%    |
| Gabapentin                  | 7,508                               | 6             | 7,531                                 | 5            | 0.31%    |
| Sertraline HCl              | 7,764                               | 5             | 7,509                                 | 6            | -3.28%   |
| busPIRone HCl               | 6,711                               | 8             | 6,889                                 | 7            | 2.65%    |
| FLUoxetine HCl              | 6,355                               | 9             | 6,161                                 | 8            | -3.05%   |
| Escitalopram Oxalate        | 6,078                               | 11            | 6,095                                 | 9            | 0.28%    |
| Atorvastatin Calcium        | 5,935                               | 12            | 5,952                                 | 10           | 0.29%    |
| Amoxicillin                 | 9,777                               | 2             | 5,934                                 | 11           | -39.31%  |
| Omeprazole                  | 6,195                               | 10            | 5,923                                 | 12           | -4.39%   |
| QUetiapine Fumarate         | 5,372                               | 13            | 5,561                                 | 13           | 3.52%    |
| Amphetamine-Dextroamphet ER | 5,334                               | 15            | 5,184                                 | 14           | -2.81%   |
| Montelukast Sodium          | 5,353                               | 14            | 5,150                                 | 15           | -3.79%   |
| ARIPiprazole                | 5,019                               | 19            | 5,147                                 | 16           | 2.55%    |
| Levothyroxine Sodium        | 5,105                               | 17            | 4,948                                 | 17           | -3.08%   |
| lamoTRigine                 | 4,772                               | 21            | 4,906                                 | 18           | 2.81%    |
| Lisdexamfetamine Dimesylate | 4,796                               | 20            | 4,702                                 | 19           | -1.96%   |
| predniSONE                  | 5,081                               | 18            | 4,656                                 | 20           | -8.36%   |
| Ondansetron                 | 5,262                               | 16            | 4,549                                 | 21           | -13.55%  |
| HYDROcodone-Acetaminophen   | 4,484                               | 23            | 4,416                                 | 22           | -1.52%   |
| Cetirizine HCl              | 4,267                               | 26            | 4,369                                 | 23           | 2.39%    |

|                               |       |    |       |    |         |
|-------------------------------|-------|----|-------|----|---------|
| Lisinopril                    | 4,368 | 24 | 4,283 | 24 | -1.95%  |
| Cyclobenzaprine HCl           | 4,276 | 25 | 4,234 | 25 | -0.98%  |
| DULoxetine HCl                | 4,033 | 29 | 3,978 | 26 | -1.36%  |
| Amphetamine-Dextroamphetamine | 4,131 | 28 | 3,950 | 27 | -4.38%  |
| Cephalexin                    | 3,484 | 36 | 3,868 | 28 | 11.02%  |
| clonidine HCl                 | 4,180 | 27 | 3,867 | 29 | -7.49%  |
| Ozempic                       | 3,851 | 31 | 3,820 | 30 | -0.80%  |
| amlodipine Besylate           | 3,776 | 32 | 3,710 | 31 | -1.75%  |
| Pantoprazole Sodium           | 3,608 | 35 | 3,640 | 32 | 0.89%   |
| Topiramate                    | 3,664 | 34 | 3,619 | 33 | -1.23%  |
| Fluticasone Propionate        | 3,999 | 30 | 3,602 | 34 | -9.93%  |
| Amoxicillin-Pot Clavulanate   | 4,539 | 22 | 3,598 | 35 | -20.73% |
| Methylphenidate HCl ER (OSM)  | 3,671 | 33 | 3,447 | 36 | -6.10%  |
| Ibuprofen                     | 3,270 | 37 | 3,355 | 37 | 2.60%   |
| clonazepam                    | 3,202 | 41 | 3,326 | 38 | 3.87%   |
| ALPRAZolam                    | 3,075 | 43 | 3,293 | 39 | 7.09%   |
| Jardiance                     | 3,215 | 39 | 3,278 | 40 | 1.96%   |
| Famotidine                    | 3,244 | 38 | 3,163 | 41 | -2.50%  |
| Losartan Potassium            | 3,092 | 42 | 3,150 | 42 | 1.88%   |
| Triamcinolone Acetonide       | 2,818 | 47 | 3,064 | 43 | 8.73%   |
| oxycodone HCl                 | 2,658 | 50 | 3,022 | 44 | 13.69%  |
| Venlafaxine HCl ER            | 3,056 | 44 | 2,987 | 45 | -2.26%  |
| Metoprolol Succinate ER       | 2,975 | 45 | 2,933 | 46 | -1.41%  |
| risperidone                   | 2,742 | 48 | 2,716 | 47 | -0.95%  |
| Mirtazapine                   | 2,582 | 52 | 2,695 | 48 | 4.38%   |
| guanfacine HCl ER             | 2,594 | 51 | 2,572 | 49 | -0.85%  |
| Lantus SoloStar               | 2,874 | 46 | 2,519 | 50 | -12.35% |

|                               |       |    |       |    |         |
|-------------------------------|-------|----|-------|----|---------|
| Pregabalin                    | 2,396 | 56 | 2,488 | 51 | 3.84%   |
| Rosuvastatin Calcium          | 2,309 | 59 | 2,484 | 52 | 7.58%   |
| hydrOXYzine Pamoate           | 2,542 | 53 | 2,476 | 53 | -2.60%  |
| metFORMIN HCl ER              | 2,453 | 54 | 2,469 | 54 | 0.65%   |
| metroNIDAZOLE                 | 2,377 | 57 | 2,427 | 55 | 2.10%   |
| Propranolol HCl               | 2,406 | 55 | 2,374 | 56 | -1.33%  |
| LORazepam                     | 2,301 | 61 | 2,366 | 57 | 2.82%   |
| levETIRAcetam                 | 2,307 | 60 | 2,363 | 58 | 2.43%   |
| Meloxicam                     | 2,368 | 58 | 2,355 | 59 | -0.55%  |
| traMADol HCl                  | 2,266 | 63 | 2,336 | 60 | 3.09%   |
| Mounjaro                      | 1,538 | 90 | 2,334 | 61 | 51.76%  |
| Fluconazole                   | 2,147 | 69 | 2,331 | 62 | 8.57%   |
| metFORMIN HCl                 | 2,298 | 62 | 2,326 | 63 | 1.22%   |
| Folic Acid                    | 2,255 | 65 | 2,286 | 64 | 1.37%   |
| Aspirin Low Dose              | 2,235 | 66 | 2,243 | 65 | 0.36%   |
| Symbicort                     | 2,264 | 64 | 2,201 | 66 | -2.78%  |
| valACYclovir HCl              | 2,148 | 68 | 2,161 | 67 | 0.61%   |
| Azithromycin                  | 3,209 | 40 | 2,137 | 68 | -33.41% |
| Prazosin HCl                  | 2,115 | 72 | 2,112 | 69 | -0.14%  |
| Loratadine                    | 2,130 | 70 | 2,064 | 70 | -3.10%  |
| Spironolactone                | 2,006 | 73 | 2,030 | 71 | 1.20%   |
| Eliquis                       | 1,905 | 75 | 2,002 | 72 | 5.09%   |
| Mupirocin                     | 1,540 | 89 | 1,993 | 73 | 29.42%  |
| Furosemide                    | 1,880 | 76 | 1,941 | 74 | 3.24%   |
| tiZANidine HCl                | 1,827 | 78 | 1,932 | 75 | 5.75%   |
| Methylphenidate HCl           | 2,119 | 71 | 1,911 | 76 | -9.82%  |
| Sulfamethoxazole-Trimethoprim | 1,661 | 81 | 1,871 | 77 | 12.64%  |

|                                |       |     |       |     |         |
|--------------------------------|-------|-----|-------|-----|---------|
| Allergy Relief Cetirizine      | 1,827 | 79  | 1,859 | 78  | 1.75%   |
| OLANzapine                     | 1,801 | 80  | 1,802 | 79  | 0.06%   |
| Atomoxetine HCl                | 1,863 | 77  | 1,792 | 80  | -3.81%  |
| Ondansetron HCl                | 1,945 | 74  | 1,728 | 81  | -11.16% |
| Nystatin                       | 1,545 | 87  | 1,683 | 82  | 8.93%   |
| Vraylar                        | 1,605 | 85  | 1,682 | 83  | 4.80%   |
| FeroSul                        | 1,642 | 82  | 1,659 | 84  | 1.04%   |
| hydroCHLORothiazide            | 1,621 | 84  | 1,621 | 85  | 0.00%   |
| Naltrexone HCl                 | 1,529 | 91  | 1,599 | 86  | 4.58%   |
| Cefdinir                       | 2,719 | 49  | 1,599 | 87  | -41.19% |
| Baclofen                       | 1,541 | 88  | 1,572 | 88  | 2.01%   |
| guanFACINE HCl                 | 1,641 | 83  | 1,519 | 89  | -7.43%  |
| Buprenorphine HCl-Naloxone HCl | 1,374 | 96  | 1,511 | 90  | 9.97%   |
| Zepbound                       | 1,193 | 108 | 1,474 | 91  | 23.55%  |
| Albuterol Sulfate              | 2,191 | 67  | 1,470 | 92  | -32.91% |
| Acetaminophen Extra Strength   | 1,357 | 99  | 1,445 | 93  | 6.48%   |
| SUMatriptan Succinate          | 1,489 | 92  | 1,418 | 94  | -4.77%  |
| Naproxen                       | 1,402 | 94  | 1,409 | 95  | 0.50%   |
| Doxycycline Hyclate            | 1,382 | 95  | 1,386 | 96  | 0.29%   |
| Zolpidem Tartrate              | 1,338 | 101 | 1,385 | 97  | 3.51%   |
| Dexmethylphenidate HCl ER      | 1,553 | 86  | 1,376 | 98  | -11.40% |
| Ketoconazole                   | 1,209 | 106 | 1,347 | 99  | 11.41%  |
| Clopidogrel Bisulfate          | 1,343 | 100 | 1,305 | 100 | -2.83%  |

**Quarterly Monthly Statistics**

| CATEGORY                          | March 2026 / May 2026 | June 2026 / August 2026 | % CHANGE |
|-----------------------------------|-----------------------|-------------------------|----------|
| TOTAL PAID AMOUNT                 | \$113,188,774         | \$113,432,271           | 0.2%     |
| UNIQUE USERS                      | 103,098               | 99,094                  | -3.9%    |
| COST PER USER                     | \$1,097.88            | \$1,144.69              | 4.3%     |
| TOTAL PRESCRIPTIONS               | 752,681               | 723,969                 | -3.8%    |
| AVERAGE PRESCRIPTIONS PER USER    | 7.30                  | 7.31                    | 0.1%     |
| AVERAGE COST PER PRESCRIPTION     | \$150.38              | \$156.68                | 4.2%     |
| # GENERIC PRESCRIPTIONS           | 663,385               | 638,009                 | -3.8%    |
| % GENERIC                         | 88.14%                | 88.13%                  | 0.0%     |
| \$ GENERIC                        | \$13,782,643          | \$13,467,613            | -2.3%    |
| AVERAGE GENERIC PRESCRIPTION COST | \$20.78               | \$21.11                 | 1.6%     |
| AVERAGE GENERIC DAYS SUPPLY       | 31.47                 | 31.96                   | 1.6%     |
| # BRAND PRESCRIPTIONS             | 89,296                | 85,960                  | -3.7%    |
| % BRAND                           | 11.86%                | 11.87%                  | 0.1%     |
| \$ BRAND                          | \$99,406,131          | \$99,964,658            | 0.6%     |
| AVERAGE BRAND PRESCRIPTION COST   | \$1,113.22            | \$1,162.92              | 4.5%     |
| AVERAGE BRAND DAYS SUPPLY         | 27.85                 | 27.98                   | 0.4%     |

| UTILIZATION BY AGE |                               |                       |                         |
|--------------------|-------------------------------|-----------------------|-------------------------|
| AGE                | March 2026 / May 2026         |                       | June 2026 / August 2026 |
| 0-6                | 31,522                        |                       | 25,226                  |
| 7-12               | 56,886                        |                       | 50,703                  |
| 13-18              | 73,890                        |                       | 68,322                  |
| 19-64              | 590,330                       |                       | 579,638                 |
| 65+                | 7,926                         |                       | 7,899                   |
| TOTAL              | 760,554                       |                       | 731,788                 |
|                    | UTILIZATION BY GENDER AND AGE |                       |                         |
| GENDER             | AGE                           | March 2026 / May 2026 | June 2026 / August 2026 |
| F                  |                               |                       |                         |
|                    | 0-6                           | 13,830                | 11,215                  |
|                    | 7-12                          | 22,003                | 19,560                  |
|                    | 13-18                         | 37,953                | 35,243                  |
|                    | 19-64                         | 392,792               | 385,367                 |
|                    | 65+                           | 4,881                 | 4,985                   |
|                    | Gender Total                  | 471,459               | 456,370                 |
| M                  |                               |                       |                         |
|                    | 0-6                           | 17,692                | 14,011                  |
|                    | 7-12                          | 34,883                | 31,143                  |
|                    | 13-18                         | 35,937                | 33,079                  |
|                    | 19-64                         | 197,538               | 194,271                 |
|                    | 65+                           | 3,045                 | 2,914                   |
|                    | Gender Total                  | 289,095               | 275,418                 |
| Grand Total        |                               | 760,554               | 731,788                 |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
**June 2026 / August 2026**

| RANK | PHARMACY NAME                                    | PHARMACY CITY  | STATE | PRESCRIPTION COUNT | PAID AMT       | AVG COST RX | PREVIOUS RANK |
|------|--------------------------------------------------|----------------|-------|--------------------|----------------|-------------|---------------|
| 1    | U OF I HOSPITALS & CLINICS AMBULATORY CARE PHARM | IOWA CITY      | IA    | 11,997             | \$5,644,411.02 | \$470.49    | 1             |
| 2    | RIGHT DOSE PHARMACY                              | ANKENY         | IA    | 6,527              | \$294,664.47   | \$45.15     | 2             |
| 3    | WALGREENS #4405                                  | COUNCIL BLUFFS | IA    | 5,909              | \$604,329.85   | \$102.27    | 3             |
| 4    | HY-VEE PHARMACY #5 (1109)                        | DAVENPORT      | IA    | 5,288              | \$507,036.64   | \$95.88     | 5             |
| 5    | WALGREENS #5042                                  | CEDAR RAPIDS   | IA    | 5,203              | \$439,233.71   | \$84.42     | 4             |
| 6    | MEDICAP PHARMACY LTC IOWA CITY                   | IOWA CITY      | IA    | 4,894              | \$210,978.30   | \$43.11     | 7             |
| 7    | HY-VEE PHARMACY #2 (1138)                        | DES MOINES     | IA    | 4,459              | \$416,525.31   | \$93.41     | 6             |
| 8    | HARTIG PHARMACY SERVICES                         | DUBUQUE        | IA    | 4,341              | \$405,925.38   | \$93.51     | 11            |
| 9    | HY-VEE PHARMACY (1075)                           | CLINTON        | IA    | 4,188              | \$392,529.04   | \$93.73     | 8             |
| 10   | HY-VEE PHARMACY #1 (1092)                        | COUNCIL BLUFFS | IA    | 4,098              | \$514,969.26   | \$125.66    | 9             |
| 11   | WALGREENS #5239                                  | DAVENPORT      | IA    | 4,092              | \$271,033.01   | \$66.23     | 10            |
| 12   | HY-VEE PHARMACY #5 (1151)                        | DES MOINES     | IA    | 4,004              | \$331,195.88   | \$82.72     | 12            |
| 13   | GREENWOOD DRUG ON KIMBALL AVE.                   | WATERLOO       | IA    | 3,875              | \$304,922.19   | \$78.69     | 13            |
| 14   | DRILLING PHARMACY                                | SIOUX CITY     | IA    | 3,837              | \$275,611.24   | \$71.83     | 16            |
| 15   | HY-VEE PHARMACY (1403)                           | MARSHALLTOWN   | IA    | 3,772              | \$357,724.33   | \$94.84     | 14            |
| 16   | HY-VEE DRUGSTORE (7060)                          | MUSCATINE      | IA    | 3,588              | \$328,861.58   | \$91.66     | 15            |
| 17   | WAGNER PHARMACY                                  | CLINTON        | IA    | 3,473              | \$300,257.47   | \$86.45     | 19            |
| 18   | HY-VEE PHARMACY #3 (1056)                        | CEDAR RAPIDS   | IA    | 3,370              | \$354,110.00   | \$105.08    | 18            |
| 19   | BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY    | DES MOINES     | IA    | 3,369              | \$239,834.59   | \$71.19     | 17            |
| 20   | HY-VEE PHARMACY #5 (1061)                        | CEDAR RAPIDS   | IA    | 3,123              | \$345,889.86   | \$110.76    | 21            |
| 21   | HY-VEE PHARMACY (1192)                           | FT DODGE       | IA    | 3,041              | \$241,995.72   | \$79.58     | 25            |
| 22   | HY-VEE PHARMACY (1074)                           | CHARLES CITY   | IA    | 3,010              | \$227,657.81   | \$75.63     | 20            |
| 23   | WALGREENS #359                                   | DES MOINES     | IA    | 2,914              | \$252,079.70   | \$86.51     | 22            |
| 24   | HY-VEE PHARMACY #3 (1142)                        | DES MOINES     | IA    | 2,861              | \$252,198.64   | \$88.15     | 24            |
| 25   | CVS PHARMACY #08658                              | DAVENPORT      | IA    | 2,844              | \$226,879.14   | \$79.77     | 27            |

|    |                                             |                 |    |       |              |          |     |
|----|---------------------------------------------|-----------------|----|-------|--------------|----------|-----|
| 26 | HY-VEE DRUGSTORE #1 (7020)                  | CEDAR RAPIDS    | IA | 2,833 | \$237,111.75 | \$83.70  | 37  |
| 27 | WALMART PHARMACY 10-5115                    | DAVENPORT       | IA | 2,832 | \$274,545.18 | \$96.94  | 28  |
| 28 | HY-VEE PHARMACY (1449)                      | NEWTON          | IA | 2,792 | \$246,096.46 | \$88.14  | 26  |
| 29 | MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY  | DAVENPORT       | IA | 2,774 | \$239,915.82 | \$86.49  | 34  |
| 30 | HY-VEE PHARMACY #4 (1148)                   | DES MOINES      | IA | 2,767 | \$269,412.38 | \$97.37  | 38  |
| 31 | WALGREENS #15647                            | SIOUX CITY      | IA | 2,751 | \$235,890.19 | \$85.75  | 23  |
| 32 | UI HEALTHCARE - IOWA RIVER LANDING PHARMACY | CORALVILLE      | IA | 2,751 | \$157,582.92 | \$57.28  | 35  |
| 33 | WALGREENS #5721                             | DES MOINES      | IA | 2,748 | \$220,480.21 | \$80.23  | 33  |
| 34 | WALGREENS #7455                             | WATERLOO        | IA | 2,710 | \$221,842.73 | \$81.86  | 41  |
| 35 | WALMART PHARMACY 10-1509                    | MAQUOKETA       | IA | 2,709 | \$272,343.29 | \$100.53 | 31  |
| 36 | WALGREENS #3700                             | COUNCIL BLUFFS  | IA | 2,703 | \$219,055.34 | \$81.04  | 42  |
| 37 | MERCYONE FOREST PARK PHARMACY               | MASON CITY      | IA | 2,696 | \$301,267.69 | \$111.75 | 49  |
| 38 | HY-VEE DRUGSTORE (7065)                     | OTTUMWA         | IA | 2,680 | \$264,157.17 | \$98.57  | 30  |
| 39 | COMMUNITY HEALTH CARE PHARMACY              | DAVENPORT       | IA | 2,664 | \$188,433.04 | \$70.73  | 46  |
| 40 | SIOUXLAND COMMUNITY HEALTH CENTER           | SIOUX CITY      | IA | 2,616 | \$184,252.37 | \$70.43  | 36  |
| 41 | HY-VEE PHARMACY #2 (1044)                   | BURLINGTON      | IA | 2,585 | \$253,346.92 | \$98.01  | 48  |
| 42 | WALMART PHARMACY 10-0797                    | WEST BURLINGTON | IA | 2,579 | \$221,975.79 | \$86.07  | 44  |
| 43 | NELSON FAMILY PHARMACY                      | FORT MADISON    | IA | 2,579 | \$180,924.85 | \$70.15  | 40  |
| 44 | HY-VEE PHARMACY (1396)                      | MARION          | IA | 2,563 | \$212,477.78 | \$82.90  | 32  |
| 45 | IMMC OUTPATIENT PHARMACY                    | DES MOINES      | IA | 2,554 | \$148,438.08 | \$58.12  | 29  |
| 46 | WALGREENS #11942                            | DUBUQUE         | IA | 2,508 | \$214,075.95 | \$85.36  | 39  |
| 47 | SCOTT PHARMACY                              | FAYETTE         | IA | 2,491 | \$163,671.11 | \$65.70  | 50  |
| 48 | CVS PHARMACY #08544                         | WATERLOO        | IA | 2,466 | \$185,753.62 | \$75.33  | 51  |
| 49 | MEDICAP PHARMACY LTC                        | INDIANOLA       | IA | 2,463 | \$94,595.73  | \$38.41  | 43  |
| 50 | CVS PHARMACY #10282                         | FORT DODGE      | IA | 2,462 | \$190,934.65 | \$77.55  | 45  |
| 51 | NEIGHBORHOOD LTC PHARMACY                   | URBANDALE       | IA | 2,437 | \$112,951.34 | \$46.35  | 118 |
| 52 | CVS PHARMACY #10032                         | MARION          | IA | 2,434 | \$197,116.57 | \$80.98  | 70  |
| 53 | HY-VEE DRUGSTORE (7056)                     | MASON CITY      | IA | 2,425 | \$210,035.82 | \$86.61  | 57  |
| 54 | HERITAGE PARTNERS PHARMACY                  | WEST BURLINGTON | IA | 2,425 | \$167,719.58 | \$69.16  | 58  |

|    |                                           |                |    |       |              |          |    |
|----|-------------------------------------------|----------------|----|-------|--------------|----------|----|
| 55 | WALMART PHARMACY 10-2889                  | CLINTON        | IA | 2,414 | \$213,980.33 | \$88.64  | 52 |
| 56 | SOUTH SIDE DRUG                           | OTTUMWA        | IA | 2,403 | \$256,091.41 | \$106.57 | 56 |
| 57 | GENOA HEALTHCARE, LLC                     | DAVENPORT      | IA | 2,401 | \$482,114.75 | \$200.80 | 60 |
| 58 | WALMART PHARMACY 10-0559                  | MUSCATINE      | IA | 2,396 | \$211,165.12 | \$88.13  | 47 |
| 59 | UNION PHARMACY                            | COUNCIL BLUFFS | IA | 2,376 | \$267,543.82 | \$112.60 | 55 |
| 60 | HY-VEE PHARMACY #1 (1610)                 | SIOUX CITY     | IA | 2,375 | \$229,743.85 | \$96.73  | 53 |
| 61 | WALGREENS #7453                           | DES MOINES     | IA | 2,373 | \$213,639.13 | \$90.03  | 54 |
| 62 | HY-VEE PHARMACY (1530)                    | PLEASANT HILL  | IA | 2,354 | \$224,128.41 | \$95.21  | 62 |
| 63 | WALGREENS #4714                           | DES MOINES     | IA | 2,343 | \$205,986.81 | \$87.92  | 61 |
| 64 | HY-VEE PHARMACY (1058)                    | CENTERVILLE    | IA | 2,322 | \$302,177.34 | \$130.14 | 64 |
| 65 | HY-VEE PHARMACY (1873)                    | WAUKEE         | IA | 2,274 | \$182,100.67 | \$80.08  | 72 |
| 66 | HY-VEE PHARMACY #3 (1107)                 | DAVENPORT      | IA | 2,198 | \$189,850.07 | \$86.37  | 68 |
| 67 | HY-VEE PHARMACY (1065)                    | CHARITON       | IA | 2,191 | \$180,681.25 | \$82.47  | 66 |
| 68 | HY-VEE PHARMACY (1522)                    | PERRY          | IA | 2,179 | \$241,947.89 | \$111.04 | 75 |
| 69 | WALMART PHARMACY 10-0985                  | FAIRFIELD      | IA | 2,174 | \$175,682.05 | \$80.81  | 69 |
| 70 | PREFERRED CARE PHARMACY                   | CEDAR RAPIDS   | IA | 2,149 | \$134,846.21 | \$62.75  | 83 |
| 71 | HARTIG DRUG CO                            | DUBUQUE        | IA | 2,148 | \$185,949.89 | \$86.57  | 81 |
| 72 | HY-VEE PHARMACY (1241)                    | HARLAN         | IA | 2,137 | \$236,113.30 | \$110.49 | 76 |
| 73 | WALMART PHARMACY 10-3394                  | ATLANTIC       | IA | 2,132 | \$199,775.73 | \$93.70  | 82 |
| 74 | WALGREENS #9708                           | DUBUQUE        | IA | 2,130 | \$167,693.34 | \$78.73  | 59 |
| 75 | WALMART PHARMACY 10-3150                  | COUNCIL BLUFFS | IA | 2,126 | \$301,329.59 | \$141.74 | 85 |
| 76 | HY-VEE PHARMACY #3 (1615)                 | SIOUX CITY     | IA | 2,123 | \$213,908.22 | \$100.76 | 84 |
| 77 | MAHASKA DRUGS INC                         | OSKALOOSA      | IA | 2,110 | \$153,378.41 | \$72.69  | 65 |
| 78 | WALMART PHARMACY 10-1723                  | DES MOINES     | IA | 2,099 | \$170,915.67 | \$81.43  | 90 |
| 79 | WALGREENS #7454                           | ANKENY         | IA | 2,088 | \$161,795.48 | \$77.49  | 71 |
| 80 | MEDICAP PHARMACY                          | NEWTON         | IA | 2,084 | \$150,739.44 | \$72.33  | 97 |
| 81 | CRESCENT COMMUNITY HEALTH CENTER PHARMACY | DUBUQUE        | IA | 2,073 | \$148,597.89 | \$71.68  | 88 |
| 82 | MEDICAP PHARMACY                          | KNOXVILLE      | IA | 2,054 | \$202,167.30 | \$98.43  | 63 |
| 83 | HY-VEE PHARMACY (1071)                    | CLARINDA       | IA | 2,040 | \$258,923.34 | \$126.92 | 73 |

|     |                            |              |    |       |              |          |     |
|-----|----------------------------|--------------|----|-------|--------------|----------|-----|
| 84  | LEWIS FAMILY DRUG #28      | ONAWA        | IA | 2,034 | \$191,252.31 | \$94.03  | 79  |
| 85  | HY-VEE PHARMACY (1224)     | GRIMES       | IA | 2,020 | \$171,642.25 | \$84.97  | 92  |
| 86  | HY-VEE PHARMACY #3 (1866)  | WATERLOO     | IA | 2,017 | \$235,010.07 | \$116.51 | 67  |
| 87  | HY-VEE PHARMACY #1 (1054)  | CEDAR RAPIDS | IA | 2,016 | \$207,616.13 | \$102.98 | 89  |
| 88  | HY-VEE PHARMACY #2 (1018)  | AMES         | IA | 2,004 | \$253,020.58 | \$126.26 | 93  |
| 89  | HY-VEE PHARMACY #6 (1155)  | DES MOINES   | IA | 2,001 | \$209,666.69 | \$104.78 | 77  |
| 90  | WALGREENS #7452            | DES MOINES   | IA | 1,995 | \$166,253.81 | \$83.34  | 87  |
| 91  | HY-VEE PHARMACY (1433)     | MT PLEASANT  | IA | 1,989 | \$186,234.30 | \$93.63  | 94  |
| 92  | HY-VEE PHARMACY #1 (1504)  | OTTUMWA      | IA | 1,980 | \$170,326.17 | \$86.02  | 80  |
| 93  | MEDICAP PHARMACY           | DES MOINES   | IA | 1,979 | \$187,326.58 | \$94.66  | 100 |
| 94  | HY-VEE PHARMACY (1437)     | MUSCATINE    | IA | 1,960 | \$177,643.56 | \$90.63  | 109 |
| 95  | HY-VEE PHARMACY (1459)     | OELWEIN      | IA | 1,956 | \$174,146.36 | \$89.03  | 78  |
| 96  | MERCYONE WATERLOO PHARMACY | WATERLOO     | IA | 1,936 | \$389,462.10 | \$201.17 | 106 |
| 97  | GENOA HEALTHCARE, LLC      | SIOUX CITY   | IA | 1,927 | \$380,033.98 | \$197.22 | 91  |
| 98  | WALMART PHARMACY 10-0784   | MT PLEASANT  | IA | 1,927 | \$158,871.91 | \$82.45  | 105 |
| 99  | HY-VEE PHARMACY #3 (1162)  | DUBUQUE      | IA | 1,916 | \$173,777.02 | \$90.70  | 116 |
| 100 | WALMART PHARMACY 10-0646   | ANAMOSA      | IA | 1,916 | \$163,152.36 | \$85.15  | 107 |

| TOP 100 PHARMACIES BY PAID AMOUNT<br>June 2026 / August 2026 |                                                             |                   |       |                    |                |                 |               |
|--------------------------------------------------------------|-------------------------------------------------------------|-------------------|-------|--------------------|----------------|-----------------|---------------|
| RANK                                                         | PHARMACY NAME                                               | PHARMACY CITY     | STATE | PRESCRIPTION COUNT | PAID AMT       | AVG COST MEMBER | PREVIOUS RANK |
| 1                                                            | U OF I HOSPITALS & CLINICS AMBULATORY CARE PHARM            | IOWA CITY         | IA    | 11,997             | \$5,644,411.02 | \$2,421.45      | 2             |
| 2                                                            | CVS/SPECIALTY                                               | MONROEVILLE       | PA    | 552                | \$5,168,929.78 | \$23,710.69     | 1             |
| 3                                                            | UNITYPOINT AT HOME                                          | URBANDALE         | IA    | 1,127              | \$4,387,312.96 | \$12,086.26     | 4             |
| 4                                                            | WALGREENS SPECIALTY PHARMACY #16528                         | DES MOINES        | IA    | 782                | \$4,364,128.06 | \$15,985.82     | 3             |
| 5                                                            | CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY   | LENEXA            | KS    | 448                | \$3,590,265.83 | \$17,599.34     | 7             |
| 6                                                            | CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY | MT PROSPECT       | IL    | 285                | \$3,320,020.62 | \$40,488.06     | 5             |
| 7                                                            | BIOPLUS SPECIALTY PHARMACY SERVICES, LLC                    | ALTAMONTE SPRINGS | FL    | 444                | \$3,224,732.35 | \$17,915.18     | 6             |
| 8                                                            | WALGREENS SPECIALTY PHARMACY #21250                         | IOWA CITY         | IA    | 285                | \$2,031,883.62 | \$15,751.04     | 8             |
| 9                                                            | PANTHERX SPECIALTY PHARMACY                                 | CORAOPOLIS        | PA    | 64                 | \$1,229,909.12 | \$55,904.96     | 9             |
| 10                                                           | AMBER SPECIALTY PHARMACY                                    | OMAHA             | NE    | 173                | \$1,024,087.99 | \$15,516.48     | 11            |
| 11                                                           | SOLEO HEALTH INC.                                           | WOODRIDGE         | IL    | 5                  | \$954,420.03   | \$477,210.02    | 10            |
| 12                                                           | ACCREDITO HEALTH GROUP INC                                  | MEMPHIS           | TN    | 61                 | \$839,933.63   | \$32,305.14     | 13            |
| 13                                                           | CVS PHARMACY #00102                                         | AURORA            | CO    | 96                 | \$839,337.23   | \$20,471.64     | 14            |
| 14                                                           | WALGREENS SPECIALTY PHARMACY #16280                         | FRISCO            | TX    | 33                 | \$833,422.71   | \$75,765.70     | 15            |
| 15                                                           | CAREMARK LLC, DBA CVS/SPECIALTY                             | REDLANDS          | CA    | 72                 | \$781,236.33   | \$31,249.45     | 12            |
| 16                                                           | PANTHERX SPECIALTY PHARMACY                                 | COLLIERVILLE      | TN    | 33                 | \$754,242.70   | \$53,874.48     | 37            |
| 17                                                           | ANOVORX GROUP, LLC                                          | MEMPHIS           | TN    | 52                 | \$705,527.84   | \$39,195.99     | 24            |
| 18                                                           | CR CARE PHARMACY                                            | CEDAR RAPIDS      | IA    | 1,891              | \$609,656.92   | \$3,142.56      | 18            |
| 19                                                           | WALGREENS #4405                                             | COUNCIL BLUFFS    | IA    | 5,909              | \$604,329.85   | \$517.41        | 22            |

|    |                                              |                   |    |       |              |              |    |
|----|----------------------------------------------|-------------------|----|-------|--------------|--------------|----|
| 20 | ACCREDITO HEALTH GROUP INC                   | WARRENDAL         | PA | 21    | \$587,833.49 | \$97,972.25  | 17 |
| 21 | WALGREENS SPECIALTY PHARMACY #16270          | OMAHA             | NE | 83    | \$575,863.09 | \$26,175.60  | 28 |
| 22 | OPTUM PHARMACY 702, LLC                      | JEFFERSONVILLE    | IN | 85    | \$571,959.48 | \$14,665.63  | 26 |
| 23 | MEDICAP PHARMACY                             | URBANDALE         | IA | 926   | \$548,134.47 | \$4,938.15   | 30 |
| 24 | EXPRESS SCRIPTS SPECIALTY DIST SVCS          | SAINT LOUIS       | MO | 31    | \$539,118.52 | \$38,508.47  | 21 |
| 25 | THE NEBRASKA MEDICAL CENTER CLINIC PHARMACY  | OMAHA             | NE | 744   | \$526,315.00 | \$3,508.77   | 20 |
| 26 | HY-VEE PHARMACY #1 (1092)                    | COUNCIL BLUFFS    | IA | 4,098 | \$514,969.26 | \$1,170.38   | 27 |
| 27 | MERCYONE GENESIS FIRSTMED SPECIALTY PHARMACY | DAVENPORT         | IA | 932   | \$508,482.57 | \$2,607.60   | 19 |
| 28 | HY-VEE PHARMACY #5 (1109)                    | DAVENPORT         | IA | 5,288 | \$507,036.64 | \$733.77     | 29 |
| 29 | BIOLOGICS BY MCKESSON                        | CARY              | NC | 17    | \$491,863.85 | \$81,977.31  | 25 |
| 30 | EVERSANA LIFE SCIENCE SERVICES, LLC          | CHESTERFIELD      | MO | 10    | \$483,906.61 | \$120,976.65 | 16 |
| 31 | GENOA HEALTHCARE, LLC                        | DAVENPORT         | IA | 2,401 | \$482,114.75 | \$2,221.73   | 33 |
| 32 | ORSINI PHARMACEUTICAL SERVICES LLC           | ELK GROVE VILLAGE | IL | 34    | \$470,338.65 | \$47,033.87  | 23 |
| 33 | WALGREENS #5042                              | CEDAR RAPIDS      | IA | 5,203 | \$439,233.71 | \$391.47     | 31 |
| 34 | ALLEN CLINIC PHARMACY                        | WATERLOO          | IA | 1,035 | \$426,018.05 | \$1,283.19   | 38 |
| 35 | HY-VEE PHARMACY #2 (1138)                    | DES MOINES        | IA | 4,459 | \$416,525.31 | \$616.16     | 32 |
| 36 | HARTIG PHARMACY SERVICES                     | DUBUQUE           | IA | 4,341 | \$405,925.38 | \$1,256.73   | 35 |
| 37 | AVERA SPECIALTY PHARMACY                     | SIOUX FALLS       | SD | 86    | \$404,857.33 | \$12,651.79  | 41 |
| 38 | HY-VEE PHARMACY (1075)                       | CLINTON           | IA | 4,188 | \$392,529.04 | \$642.44     | 34 |
| 39 | MERCYONE WATERLOO PHARMACY                   | WATERLOO          | IA | 1,936 | \$389,462.10 | \$1,027.60   | 40 |
| 40 | GENOA HEALTHCARE, LLC                        | SIOUX CITY        | IA | 1,927 | \$380,033.98 | \$1,958.94   | 36 |
| 41 | HY-VEE PHARMACY (1403)                       | MARSHALLTOWN      | IA | 3,772 | \$357,724.33 | \$525.29     | 39 |
| 42 | HY-VEE PHARMACY #3 (1056)                    | CEDAR RAPIDS      | IA | 3,370 | \$354,110.00 | \$669.40     | 43 |

|    |                                     |                |    |       |              |             |     |
|----|-------------------------------------|----------------|----|-------|--------------|-------------|-----|
| 43 | PARAGON PARTNERS                    | OMAHA          | NE | 965   | \$353,886.10 | \$4,114.95  | 44  |
| 44 | ONCO360                             | LOUISVILLE     | KY | 29    | \$352,765.38 | \$32,069.58 | 54  |
| 45 | HY-VEE PHARMACY #5 (1061)           | CEDAR RAPIDS   | IA | 3,123 | \$345,889.86 | \$798.82    | 47  |
| 46 | WALGREENS SPECIALTY PHARMACY #15443 | FRISCO         | TX | 47    | \$344,114.72 | \$19,117.48 | 101 |
| 47 | HY-VEE PHARMACY #5 (1151)           | DES MOINES     | IA | 4,004 | \$331,195.88 | \$550.16    | 42  |
| 48 | HY-VEE DRUGSTORE (7060)             | MUSCATINE      | IA | 3,588 | \$328,861.58 | \$591.48    | 45  |
| 49 | PRIMARY HEALTHCARE PHARMACY         | DES MOINES     | IA | 836   | \$322,183.99 | \$1,851.63  | 48  |
| 50 | RIVER HILLS PHARMACY                | OTTUMWA        | IA | 763   | \$321,003.25 | \$2,018.89  | 75  |
| 51 | GREENWOOD DRUG ON KIMBALL AVE.      | WATERLOO       | IA | 3,875 | \$304,922.19 | \$856.52    | 50  |
| 52 | HY-VEE PHARMACY (1058)              | CENTERVILLE    | IA | 2,322 | \$302,177.34 | \$1,071.55  | 79  |
| 53 | WALMART PHARMACY 10-3150            | COUNCIL BLUFFS | IA | 2,126 | \$301,329.59 | \$965.80    | 56  |
| 54 | MERCYONE FOREST PARK PHARMACY       | MASON CITY     | IA | 2,696 | \$301,267.69 | \$740.22    | 55  |
| 55 | WAGNER PHARMACY                     | CLINTON        | IA | 3,473 | \$300,257.47 | \$804.98    | 46  |
| 56 | HARTIG DRUG CO                      | DUBUQUE        | IA | 1,797 | \$294,873.21 | \$1,198.67  | 49  |
| 57 | RIGHT DOSE PHARMACY                 | ANKENY         | IA | 6,527 | \$294,664.47 | \$775.43    | 65  |
| 58 | GREENWOOD COMPLIANCE PHARMACY       | WATERLOO       | IA | 1,676 | \$287,358.00 | \$2,520.68  | 60  |
| 59 | DRILLING PHARMACY                   | SIOUX CITY     | IA | 3,837 | \$275,611.24 | \$767.72    | 52  |
| 60 | WALMART PHARMACY 10-5115            | DAVENPORT      | IA | 2,832 | \$274,545.18 | \$600.76    | 63  |
| 61 | WALMART PHARMACY 10-1509            | MAQUOKETA      | IA | 2,709 | \$272,343.29 | \$614.77    | 57  |
| 62 | WALGREENS #5239                     | DAVENPORT      | IA | 4,092 | \$271,033.01 | \$277.13    | 51  |
| 63 | ARJ INFUSION SERVICES, LLC          | CEDAR RAPIDS   | IA | 53    | \$270,070.03 | \$30,007.78 | 155 |
| 64 | HY-VEE PHARMACY #4 (1148)           | DES MOINES     | IA | 2,767 | \$269,412.38 | \$663.58    | 70  |
| 65 | UNION PHARMACY                      | COUNCIL BLUFFS | IA | 2,376 | \$267,543.82 | \$1,331.06  | 71  |
| 66 | MCMH PHARMACY                       | RED OAK        | IA | 1,879 | \$266,995.17 | \$1,197.29  | 87  |

|    |                                               |               |    |       |              |              |     |
|----|-----------------------------------------------|---------------|----|-------|--------------|--------------|-----|
| 67 | HY-VEE DRUGSTORE (7065)                       | OTTUMWA       | IA | 2,680 | \$264,157.17 | \$625.96     | 58  |
| 68 | HY-VEE PHARMACY (1071)                        | CLARINDA      | IA | 2,040 | \$258,923.34 | \$799.15     | 53  |
| 69 | SOUTH SIDE DRUG                               | OTTUMWA       | IA | 2,403 | \$256,091.41 | \$877.03     | 66  |
| 70 | HY-VEE PHARMACY #2 (1044)                     | BURLINGTON    | IA | 2,585 | \$253,346.92 | \$565.51     | 92  |
| 71 | HY-VEE PHARMACY #2 (1018)                     | AMES          | IA | 2,004 | \$253,020.58 | \$887.79     | 83  |
| 72 | HY-VEE PHARMACY #3 (1142)                     | DES MOINES    | IA | 2,861 | \$252,198.64 | \$509.49     | 77  |
| 73 | WALGREENS #359                                | DES MOINES    | IA | 2,914 | \$252,079.70 | \$333.88     | 69  |
| 74 | HY-VEE PHARMACY (1449)                        | NEWTON        | IA | 2,792 | \$246,096.46 | \$554.27     | 72  |
| 75 | HY-VEE PHARMACY (1192)                        | FT DODGE      | IA | 3,041 | \$241,995.72 | \$533.03     | 62  |
| 76 | HY-VEE PHARMACY (1522)                        | PERRY         | IA | 2,179 | \$241,947.89 | \$777.97     | 84  |
| 77 | MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY    | DAVENPORT     | IA | 2,774 | \$239,915.82 | \$987.31     | 81  |
| 78 | BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY | DES MOINES    | IA | 3,369 | \$239,834.59 | \$362.84     | 80  |
| 79 | CURANT HEALTH GEORGIA LLC                     | SMYRNA        | GA | 4     | \$239,434.52 | \$239,434.52 | 138 |
| 80 | HY-VEE DRUGSTORE #1 (7020)                    | CEDAR RAPIDS  | IA | 2,833 | \$237,111.75 | \$576.91     | 93  |
| 81 | HY-VEE PHARMACY (1241)                        | HARLAN        | IA | 2,137 | \$236,113.30 | \$709.05     | 88  |
| 82 | WALGREENS #15647                              | SIOUX CITY    | IA | 2,751 | \$235,890.19 | \$354.19     | 78  |
| 83 | HY-VEE PHARMACY #3 (1866)                     | WATERLOO      | IA | 2,017 | \$235,010.07 | \$707.86     | 68  |
| 84 | BIOPLUS SPECIALTY PHARMACY, INC               | LAKE MARY     | FL | 35    | \$230,051.80 | \$13,532.46  | 108 |
| 85 | HY-VEE PHARMACY #1 (1610)                     | SIOUX CITY    | IA | 2,375 | \$229,743.85 | \$516.28     | 95  |
| 86 | FIFIELD PHARMACY                              | DES MOINES    | IA | 1,313 | \$227,672.55 | \$1,528.00   | 73  |
| 87 | HY-VEE PHARMACY (1074)                        | CHARLES CITY  | IA | 3,010 | \$227,657.81 | \$469.40     | 86  |
| 88 | CVS PHARMACY #08658                           | DAVENPORT     | IA | 2,844 | \$226,879.14 | \$509.84     | 82  |
| 89 | HY-VEE PHARMACY (1530)                        | PLEASANT HILL | IA | 2,354 | \$224,128.41 | \$604.12     | 130 |

|     |                           |                 |    |       |              |            |     |
|-----|---------------------------|-----------------|----|-------|--------------|------------|-----|
| 90  | WALMART PHARMACY 10-0797  | WEST BURLINGTON | IA | 2,579 | \$221,975.79 | \$485.72   | 94  |
| 91  | WALGREENS #7455           | WATERLOO        | IA | 2,710 | \$221,842.73 | \$297.78   | 123 |
| 92  | WALGREENS #5721           | DES MOINES      | IA | 2,748 | \$220,480.21 | \$303.27   | 131 |
| 93  | WALGREENS #3700           | COUNCIL BLUFFS  | IA | 2,703 | \$219,055.34 | \$384.98   | 90  |
| 94  | GENOA HEALTHCARE, LLC     | MARSHALLTOWN    | IA | 806   | \$218,346.42 | \$2,599.36 | 67  |
| 95  | WALGREENS #11942          | DUBUQUE         | IA | 2,508 | \$214,075.95 | \$434.23   | 98  |
| 96  | WALMART PHARMACY 10-2889  | CLINTON         | IA | 2,414 | \$213,980.33 | \$473.41   | 91  |
| 97  | HY-VEE PHARMACY #3 (1615) | SIOUX CITY      | IA | 2,123 | \$213,908.22 | \$735.08   | 125 |
| 98  | WALGREENS #7453           | DES MOINES      | IA | 2,373 | \$213,639.13 | \$391.28   | 105 |
| 99  | HY-VEE PHARMACY (1396)    | MARION          | IA | 2,563 | \$212,477.78 | \$539.28   | 74  |
| 100 | LAGRANGE PHARMACY         | VINTON          | IA | 1,912 | \$212,074.34 | \$834.94   | 100 |

# TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT

June 2026 / August 2026

| RANK | NPI NUM    | PRESCRIBER NAME   | PAID AMOUNT  | PRESCRIPTION COUNT | AVG SCRIPTS MEMBER | PREVIOUS RANK |
|------|------------|-------------------|--------------|--------------------|--------------------|---------------|
| 1    | 1982605762 | Jeffrey Wilharm   | \$119,358.00 | 3,075              | 11.48              | 1             |
| 2    | 1730849647 | Melanie Parrish   | \$34,050.68  | 1,068              | 2.71               | 5             |
| 3    | 1306559786 | Roy Henry         | \$91,229.88  | 1,057              | 3.75               | 7             |
| 4    | 1528365277 | Mina Salib        | \$326,243.01 | 1,051              | 2.18               | 6             |
| 5    | 1215146055 | Rebecca Wolfe     | \$84,763.65  | 1,020              | 2.57               | 2             |
| 6    | 1902478811 | Joan Anderson     | \$239,841.48 | 976                | 3.40               | 8             |
| 7    | 1902850845 | Deborah Bahe      | \$98,357.49  | 976                | 4.16               | 12            |
| 8    | 1063491645 | Allyson Wheaton   | \$101,925.64 | 964                | 2.41               | 3             |
| 9    | 1790163848 | Hesper Nowatzki   | \$166,662.11 | 961                | 3.19               | 13            |
| 10   | 1467907394 | Cynthia Coenen    | \$136,840.43 | 951                | 3.48               | 14            |
| 11   | 1992402655 | Shane Eberhardt   | \$190,001.21 | 945                | 3.12               | 17            |
| 12   | 1013115369 | Bobbita Nag       | \$53,643.92  | 918                | 2.53               | 4             |
| 13   | 1043434525 | Robert Kent       | \$84,380.84  | 907                | 3.83               | 9             |
| 14   | 1609532373 | Erin Fox-Hammel   | \$105,028.93 | 906                | 3.46               | 22            |
| 15   | 1417214321 | Leah Brandon      | \$37,723.85  | 905                | 5.32               | 20            |
| 16   | 1043418809 | Michael Ciliberto | \$477,418.73 | 890                | 2.57               | 11            |
| 17   | 1184657603 | Sara Rygol        | \$187,012.74 | 887                | 3.26               | 19            |
| 18   | 1639607757 | Michael Gerber    | \$176,788.35 | 873                | 3.17               | 41            |
| 19   | 1770933046 | Shelby Biller     | \$140,994.27 | 845                | 2.76               | 21            |
| 20   | 1467502286 | Charles Tilley    | \$184,748.25 | 834                | 3.64               | 16            |

|    |            |                  |              |     |      |    |
|----|------------|------------------|--------------|-----|------|----|
| 21 | 1023542271 | Flynn McCullough | \$79,483.01  | 817 | 3.25 | 24 |
| 22 | 1306475413 | Autumn Anderson  | \$44,734.17  | 798 | 3.49 | 31 |
| 23 | 1902574361 | Laura Owens      | \$85,608.83  | 794 | 2.95 | 15 |
| 24 | 1679573893 | Patty Hildreth   | \$221,685.18 | 773 | 3.50 | 26 |
| 25 | 1801463245 | Ann Mojeiko      | \$125,179.38 | 771 | 3.23 | 25 |
| 26 | 1245960350 | Mary Welborn     | \$55,237.75  | 763 | 2.90 | 27 |
| 27 | 1659358620 | Carlos Castillo  | \$23,827.20  | 763 | 2.85 | 23 |
| 28 | 1437238110 | Genevieve Nelson | \$176,622.03 | 760 | 3.04 | 17 |
| 29 | 1902912538 | Christian Jones  | \$97,598.76  | 743 | 2.65 | 29 |
| 30 | 1376244954 | Cory Slusher     | \$59,603.27  | 734 | 2.37 | 64 |
| 31 | 1275763047 | Rebecca Bowman   | \$119,472.24 | 727 | 3.69 | 33 |
| 32 | 1477199198 | Sajo Thomas      | \$149,048.73 | 724 | 3.29 | 34 |
| 33 | 1144588476 | Rachel Filzer    | \$63,155.44  | 723 | 3.04 | 48 |
| 34 | 1689077018 | Stacy Roth       | \$117,690.22 | 713 | 2.90 | 44 |
| 35 | 1326798992 | Jenna Mullins    | \$89,412.90  | 710 | 2.22 | 64 |
| 36 | 1053963900 | Nicole McClavy   | \$129,077.23 | 693 | 3.24 | 27 |
| 37 | 1053630640 | Jennifer Donovan | \$130,737.57 | 685 | 3.27 | 38 |
| 38 | 1982030946 | Jacklyn Besch    | \$54,555.58  | 685 | 2.60 | 45 |
| 39 | 1922144088 | Thomas Hopkins   | \$20,520.48  | 683 | 2.43 | 37 |
| 40 | 1154815330 | Bruce Pehl       | \$50,572.18  | 673 | 3.47 | 52 |
| 41 | 1023469798 | Shipeng Wei      | \$35,765.87  | 670 | 7.12 | 50 |
| 42 | 1215125216 | Rebecca Walding  | \$51,192.16  | 661 | 3.15 | 43 |
| 43 | 1649763079 | Kate Jarvis      | \$108,369.65 | 660 | 3.24 | 48 |
| 44 | 1205393386 | Jessica Hudspeth | \$86,150.77  | 659 | 3.27 | 32 |

|    |            |                   |              |     |      |     |
|----|------------|-------------------|--------------|-----|------|-----|
| 45 | 1215184726 | Babuji Gandra     | \$21,449.62  | 652 | 2.46 | 40  |
| 46 | 1043703887 | Tenaea Jeppeson   | \$40,408.20  | 650 | 3.33 | 70  |
| 47 | 1649248378 | Kathleen Wild     | \$31,943.44  | 648 | 2.97 | 36  |
| 48 | 1285490896 | Karissa Weaver    | \$130,936.31 | 646 | 3.46 | 90  |
| 49 | 1295967255 | Mary Robinson     | \$37,557.55  | 645 | 4.05 | 68  |
| 50 | 1134191018 | Dustin Smith      | \$54,083.31  | 639 | 4.09 | 53  |
| 51 | 1265841845 | Mary Schwering    | \$64,848.37  | 634 | 2.85 | 42  |
| 52 | 1609946243 | Sina Linman       | \$26,064.69  | 633 | 2.39 | 39  |
| 53 | 1477142289 | Andrea Johnson    | \$126,187.70 | 625 | 3.53 | 51  |
| 54 | 1164538674 | Joseph Wanzek     | \$85,569.18  | 624 | 3.35 | 34  |
| 55 | 1588746515 | Amy Badberg       | \$32,256.28  | 624 | 2.62 | 87  |
| 56 | 1891707832 | Lisa Klock        | \$43,601.66  | 624 | 2.70 | 60  |
| 57 | 1992103386 | Melissa Larsen    | \$91,529.96  | 622 | 2.74 | 56  |
| 58 | 1457007270 | Lindsay Schock    | \$78,937.94  | 620 | 3.35 | 66  |
| 59 | 1720698335 | Danika Hansen     | \$69,148.74  | 614 | 3.08 | 75  |
| 60 | 1992314108 | Lynzee Makowski   | \$320,268.14 | 614 | 2.40 | 93  |
| 61 | 1881095503 | Karoweso Chipendo | \$84,563.22  | 609 | 2.60 | 80  |
| 62 | 1457667610 | Leah Schupp       | \$46,142.01  | 608 | 2.58 | 102 |
| 63 | 1467092049 | Heidi Pedersen    | \$83,726.82  | 608 | 3.77 | 54  |
| 64 | 1992573786 | Lashelle Goode    | \$37,903.05  | 603 | 2.95 | 96  |
| 65 | 1114681889 | Kelsey Bauer      | \$71,206.51  | 602 | 3.46 | 106 |
| 66 | 1609218304 | Amanda Garr       | \$96,336.69  | 599 | 2.93 | 119 |
| 67 | 1356359871 | Rhea Hartley      | \$51,346.29  | 598 | 1.94 | 10  |
| 68 | 1619153137 | Joad Best         | \$55,296.52  | 597 | 2.56 | 62  |

|    |            |                     |              |     |      |     |
|----|------------|---------------------|--------------|-----|------|-----|
| 69 | 1790499648 | Maria Brickner      | \$110,325.39 | 592 | 5.15 | 55  |
| 70 | 1417941188 | Debra Neuharth      | \$37,336.89  | 591 | 3.06 | 60  |
| 71 | 1457914657 | Seema Antony        | \$75,984.18  | 591 | 2.76 | 47  |
| 72 | 1447061353 | Jacob Ernst         | \$51,301.18  | 587 | 2.68 | 180 |
| 73 | 1073156295 | Kasie Christensen   | \$52,653.40  | 585 | 2.50 | 85  |
| 74 | 1255823506 | Nicole Delagardelle | \$170,076.81 | 584 | 2.50 | 117 |
| 75 | 1689325524 | Brian Ayersman      | \$105,545.40 | 584 | 3.42 | 132 |
| 76 | 1942721584 | Shawna Fury         | \$36,579.41  | 584 | 2.16 | 59  |
| 77 | 1194425223 | Mary Boksa          | \$63,662.14  | 581 | 2.53 | 73  |
| 78 | 1316782311 | Courtney Studer     | \$37,116.37  | 581 | 3.54 | 102 |
| 79 | 1760455083 | Thomas Schmadeke    | \$79,338.09  | 573 | 2.98 | 98  |
| 80 | 1356724405 | Beth Colon          | \$55,999.57  | 572 | 2.18 | 101 |
| 81 | 1215981758 | Lisa Pisney         | \$62,109.41  | 571 | 2.89 | 30  |
| 82 | 1316356496 | Kimberly Roberts    | \$34,859.87  | 567 | 3.90 | 97  |
| 83 | 1891306452 | Jennifer Tomlin     | \$66,720.68  | 566 | 2.82 | 106 |
| 84 | 1336853415 | Katherine Lowary    | \$49,571.17  | 565 | 4.38 | 114 |
| 85 | 1528329398 | Erin Rowan          | \$39,869.32  | 564 | 2.67 | 81  |
| 86 | 1821481045 | Shawn Plunkett      | \$69,924.96  | 563 | 3.37 | 88  |
| 87 | 1053398800 | Steven Scurr        | \$39,494.63  | 560 | 3.51 | 58  |
| 88 | 1902358443 | Melissa Konken      | \$127,483.49 | 560 | 2.88 | 71  |
| 89 | 1003470923 | Earlene Angell      | \$153,972.21 | 559 | 3.45 | 122 |
| 90 | 1790135176 | Emily Reiter        | \$55,724.21  | 556 | 2.75 | 119 |
| 91 | 1346621059 | Mark Zacharjasz     | \$51,899.75  | 555 | 3.46 | 81  |
| 92 | 1811960768 | Angela Veenstra     | \$23,492.07  | 552 | 2.66 | 69  |

|     |            |                    |              |     |      |     |
|-----|------------|--------------------|--------------|-----|------|-----|
| 93  | 1851161228 | Kala Clark         | \$178,332.72 | 545 | 3.25 | 110 |
| 94  | 1710941000 | Laurie Warren      | \$68,805.90  | 543 | 3.31 | 78  |
| 95  | 1790013209 | Tracy Tschudi      | \$69,706.70  | 537 | 2.89 | 81  |
| 96  | 1073369070 | Nicholas Blieu     | \$72,103.94  | 536 | 2.45 | 163 |
| 97  | 1538368170 | Christopher Matson | \$34,970.34  | 534 | 2.69 | 78  |
| 98  | 1477926434 | Jackie Shipley     | \$31,634.16  | 533 | 2.20 | 104 |
| 99  | 1043211303 | Ali Safdar         | \$100,709.86 | 531 | 2.47 | 67  |
| 100 | 1447680848 | Mindy Roberts      | \$53,219.42  | 531 | 2.39 | 86  |

# TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

June 2026 / August 2026

| RANK | NPI NUM    | PRESCRIBER NAME     | PAID AMOUNT    | AVG COST RX | PRESCRIPTION COUNT | PREVIOUS RANK |
|------|------------|---------------------|----------------|-------------|--------------------|---------------|
| 1    | 1437121407 | Linda Cadaret       | \$1,309,740.37 | \$8,342.30  | 157                | 2             |
| 2    | 1841632965 | Ahmad Al-Huniti     | \$1,126,240.26 | \$53,630.49 | 21                 | 1             |
| 3    | 1285626390 | Kathleen Gradoville | \$773,307.78   | \$2,771.71  | 279                | 8             |
| 4    | 1023108701 | Ronald Zolty        | \$758,105.07   | \$10,830.07 | 70                 | 5             |
| 5    | 1942937388 | Carly Day           | \$696,898.97   | \$1,598.39  | 436                | 4             |
| 6    | 1417443953 | Rodney Clark        | \$578,643.65   | \$1,510.82  | 383                | 7             |
| 7    | 1326211889 | James Friedlander   | \$499,535.03   | \$6,323.23  | 79                 | 3             |
| 8    | 1275836751 | Holly Kramer        | \$485,606.94   | \$2,624.90  | 185                | 59            |
| 9    | 1043418809 | Michael Ciliberto   | \$477,418.73   | \$536.43    | 890                | 10            |
| 10   | 1861277980 | Kathryn Ewoldt      | \$460,967.03   | \$2,259.64  | 204                | 20            |
| 11   | 1609003011 | John Bernat         | \$415,400.54   | \$41,540.05 | 10                 | 22            |
| 12   | 1376525196 | Randolph Rough      | \$411,594.03   | \$4,332.57  | 95                 | 12            |
| 13   | 1891146999 | Becky Johnson       | \$400,769.25   | \$1,318.32  | 304                | 11            |
| 14   | 1043565328 | Sara Moeller        | \$399,711.58   | \$3,918.74  | 102                | 23            |
| 15   | 1326034984 | Katherine Mathews   | \$385,242.78   | \$8,755.52  | 44                 | 13            |
| 16   | 1477761328 | Amy Calhoun         | \$375,942.10   | \$4,371.42  | 86                 | 9             |
| 17   | 1528365277 | Mina Salib          | \$326,243.01   | \$310.41    | 1051               | 16            |
| 18   | 1295091510 | Rebecca Weiner      | \$324,147.89   | \$1,038.94  | 312                | 6             |
| 19   | 1992314108 | Lynzee Makowski     | \$320,268.14   | \$521.61    | 614                | 17            |
| 20   | 1356753859 | Katie Lutz          | \$304,847.50   | \$2,628.00  | 116                | 14            |

|    |            |                         |              |             |     |      |
|----|------------|-------------------------|--------------|-------------|-----|------|
| 21 | 1053520759 | Alicia Gerke            | \$294,142.12 | \$7,353.55  | 40  | 42   |
| 22 | 1114214541 | Dimah Saade             | \$291,699.42 | \$5,833.99  | 50  | 36   |
| 23 | 1508091109 | Melissa Muff-Luett      | \$290,943.36 | \$6,465.41  | 45  | 30   |
| 24 | 1750913406 | Carrissa Riggs          | \$286,206.44 | \$2,981.32  | 96  | 25   |
| 25 | 1578958542 | Heidi Curtis            | \$284,650.44 | \$1,430.40  | 199 | 71   |
| 26 | 1093162075 | Meghan Ryan             | \$280,613.47 | \$1,976.15  | 142 | 24   |
| 27 | 1477765584 | Sangeeta Shah           | \$278,390.06 | \$788.64    | 353 | 21   |
| 28 | 1386084747 | Jennifer Condon         | \$271,947.68 | \$1,477.98  | 184 | 31   |
| 29 | 1326410499 | Tara Eastvold           | \$269,402.93 | \$746.27    | 361 | 39   |
| 30 | 1952420705 | Eric Rush               | \$263,572.74 | \$43,928.79 | 6   | 37   |
| 31 | 1366065047 | Brittania Schoon        | \$263,164.84 | \$1,241.34  | 212 | 110  |
| 32 | 1710529961 | Sarah Peters            | \$261,192.61 | \$2,441.05  | 107 | 1635 |
| 33 | 1649826140 | Taylor Myers            | \$255,660.27 | \$1,787.83  | 143 | 27   |
| 34 | 1306071915 | Thomas Pietras          | \$253,464.16 | \$2,560.24  | 99  | 38   |
| 35 | 1629415922 | Alyssa Lakin            | \$253,389.78 | \$1,784.44  | 142 | 15   |
| 36 | 1528334406 | Chittalsinh Raulji      | \$252,305.22 | \$42,050.87 | 6   | 40   |
| 37 | 1245468768 | Thomas Schmidt          | \$251,165.26 | \$2,537.02  | 99  | 47   |
| 38 | 1902478811 | Joan Anderson           | \$239,841.48 | \$245.74    | 976 | 29   |
| 39 | 1639833601 | Mathieu Levesque        | \$239,335.31 | \$2,118.01  | 113 | 1668 |
| 40 | 1902191059 | Amber Tierney           | \$235,610.15 | \$5,890.25  | 40  | 86   |
| 41 | 1609131770 | Sreenath Thati Ganganna | \$233,613.88 | \$455.39    | 513 | 62   |
| 42 | 1730318205 | Diana Bayer-Bowstead    | \$233,517.98 | \$1,556.79  | 150 | 51   |
| 43 | 1871868984 | Hana Niebur             | \$231,796.08 | \$3,738.65  | 62  | 28   |
| 44 | 1669184511 | Chandra Miller          | \$229,911.98 | \$9,579.67  | 24  | 72   |

|    |            |                         |              |            |     |      |
|----|------------|-------------------------|--------------|------------|-----|------|
| 45 | 1811666118 | Jessiann Dryden-Parish  | \$228,982.23 | \$1,579.19 | 145 | 61   |
| 46 | 1902792856 | Timothy Hoffmann        | \$228,843.02 | \$738.20   | 310 | 109  |
| 47 | 1679573893 | Patty Hildreth          | \$221,685.18 | \$286.79   | 773 | 44   |
| 48 | 1508750761 | Rogério Pastore Bassitt | \$220,713.64 | \$6,306.10 | 35  | 1663 |
| 49 | 1245239623 | Timothy Abrahamson      | \$211,341.23 | \$2,322.43 | 91  | 113  |
| 50 | 1316435399 | Maria Parra Villasmil   | \$210,786.02 | \$1,756.55 | 120 | 156  |
| 51 | 1952539447 | Anthony Fischer         | \$196,222.42 | \$2,422.50 | 81  | 407  |
| 52 | 1285620583 | Michael Tansey          | \$192,350.76 | \$2,068.29 | 93  | 19   |
| 53 | 1356752067 | Kelly Delaney-Nelson    | \$192,127.32 | \$2,911.02 | 66  | 104  |
| 54 | 1174584072 | Bradley Lair            | \$191,820.58 | \$3,552.23 | 54  | 102  |
| 55 | 1447519038 | Erin Richardson         | \$191,146.22 | \$793.14   | 241 | 70   |
| 56 | 1992402655 | Shane Eberhardt         | \$190,001.21 | \$201.06   | 945 | 96   |
| 57 | 1184657603 | Sara Rygol              | \$187,012.74 | \$210.84   | 887 | 69   |
| 58 | 1467502286 | Charles Tilley          | \$184,748.25 | \$221.52   | 834 | 57   |
| 59 | 1144455502 | Jennifer Petts          | \$183,110.66 | \$698.90   | 262 | 67   |
| 60 | 1508291717 | Jacob Ridder            | \$180,936.80 | \$2,206.55 | 82  | 148  |
| 61 | 1558543595 | Gordon Buchanan         | \$180,470.65 | \$1,093.76 | 165 | 95   |
| 62 | 1851161228 | Kala Clark              | \$178,332.72 | \$327.22   | 545 | 79   |
| 63 | 1639607757 | Michael Gerber          | \$176,788.35 | \$202.51   | 873 | 114  |
| 64 | 1437238110 | Genevieve Nelson        | \$176,622.03 | \$232.40   | 760 | 52   |
| 65 | 1821046087 | Archana Verma           | \$175,993.87 | \$2,046.44 | 86  | 33   |
| 66 | 1770324220 | Casie Hale              | \$175,099.30 | \$459.58   | 381 | 41   |
| 67 | 1306823281 | Molly Franke            | \$174,433.22 | \$1,959.92 | 89  | 60   |
| 68 | 1134440886 | Melissa Chiston         | \$173,041.63 | \$2,472.02 | 70  | 105  |

|    |            |                     |              |            |     |     |
|----|------------|---------------------|--------------|------------|-----|-----|
| 69 | 1801405832 | Sarah Hiemer        | \$172,954.10 | \$891.52   | 194 | 63  |
| 70 | 1841607900 | Shayla Sanders      | \$172,635.46 | \$2,157.94 | 80  | 137 |
| 71 | 1881649523 | Andrew Bean         | \$171,272.16 | \$6,587.39 | 26  | 182 |
| 72 | 1255823506 | Nicole Delagardelle | \$170,076.81 | \$291.23   | 584 | 123 |
| 73 | 1063792026 | Jill Miller         | \$168,873.31 | \$335.73   | 503 | 90  |
| 74 | 1437513520 | Sussette Szachowicz | \$166,775.09 | \$992.71   | 168 | 78  |
| 75 | 1790163848 | Hesper Nowatzki     | \$166,662.11 | \$173.43   | 961 | 66  |
| 76 | 1891952552 | Nicholas Fustino    | \$165,469.01 | \$2,507.11 | 66  | 43  |
| 77 | 1235894122 | Krishna Hughes      | \$164,166.62 | \$1,908.91 | 86  | 84  |
| 78 | 1801459730 | Laura Thorson       | \$163,843.35 | \$4,201.11 | 39  | 751 |
| 79 | 1801888300 | James Tracy         | \$163,661.11 | \$1,203.39 | 136 | 197 |
| 80 | 1932464971 | Kari Ernst          | \$163,023.63 | \$1,895.62 | 86  | 76  |
| 81 | 1386938447 | Theresa Czech       | \$162,936.01 | \$461.58   | 353 | 189 |
| 82 | 1447373832 | Joshua Wilson       | \$162,760.00 | \$2,959.27 | 55  | 64  |
| 83 | 1104804053 | Winthrop Risk       | \$161,765.10 | \$330.81   | 489 | 54  |
| 84 | 1598354912 | Lindsay Dail        | \$161,638.53 | \$1,282.85 | 126 | 88  |
| 85 | 1972982619 | John Scott          | \$160,860.20 | \$1,767.69 | 91  | 233 |
| 86 | 1649419219 | Heather Hunemuller  | \$160,473.75 | \$1,283.79 | 125 | 73  |
| 87 | 1558808501 | Jessica Braksiek    | \$159,418.22 | \$2,898.51 | 55  | 50  |
| 88 | 1568097244 | Elizabeth Dassow    | \$158,478.02 | \$2,438.12 | 65  | 93  |
| 89 | 1922772839 | Patrick Thompson    | \$158,409.88 | \$713.56   | 222 | 785 |
| 90 | 1184056822 | Abby Kolthoff       | \$158,105.71 | \$410.66   | 385 | 75  |
| 91 | 1639226731 | Meriner Pereira     | \$158,030.94 | \$1,476.92 | 107 | 56  |
| 92 | 1669786273 | Seth Robb           | \$157,102.13 | \$4,909.44 | 32  | 241 |

|     |            |                     |              |            |     |     |
|-----|------------|---------------------|--------------|------------|-----|-----|
| 93  | 1285710764 | Jitendrakumar Gupta | \$155,268.97 | \$649.66   | 239 | 112 |
| 94  | 1821468927 | Kelley Dawley       | \$155,004.43 | \$1,220.51 | 127 | 214 |
| 95  | 1528419066 | Benjamin Pottebaum  | \$154,716.37 | \$1,432.56 | 108 | 135 |
| 96  | 1649943689 | Jessica Wolfe       | \$154,168.01 | \$4,404.80 | 35  | 49  |
| 97  | 1003470923 | Earlene Angell      | \$153,972.21 | \$275.44   | 559 | 161 |
| 98  | 1730293705 | Robert Jackson      | \$153,481.16 | \$3,935.41 | 39  | 80  |
| 99  | 1790986925 | Tahuanty Pena       | \$153,473.06 | \$1,764.06 | 87  | 118 |
| 100 | 1457031817 | Corinne Conley      | \$153,160.52 | \$1,578.97 | 97  | 177 |

**TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT**

| CATEGORY DESCRIPTION                              | March 2026 /<br>May 2026 | PREVIOUS<br>RANK | %<br>BUDGET | June 2026 /<br>August 2026 | CURRENT<br>RANK | %<br>BUDGET | %<br>CHANGE |
|---------------------------------------------------|--------------------------|------------------|-------------|----------------------------|-----------------|-------------|-------------|
| DERMATOLOGICALS                                   | \$15,347,616             | 1                | 13.6%       | \$15,597,126               | 1               | 13.8%       | 1.6%        |
| ANTIDIABETICS                                     | \$13,918,506             | 2                | 12.3%       | \$14,417,631               | 2               | 12.7%       | 3.6%        |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS                   | \$12,253,745             | 3                | 10.8%       | \$12,400,441               | 3               | 10.9%       | 1.2%        |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS     | \$7,181,467              | 5                | 6.3%        | \$7,674,373                | 4               | 6.8%        | 6.9%        |
| ANALGESICS - ANTI-INFLAMMATORY                    | \$7,225,092              | 4                | 6.4%        | \$7,481,165                | 5               | 6.6%        | 3.5%        |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS           | \$6,249,866              | 6                | 5.5%        | \$6,084,747                | 6               | 5.4%        | -2.6%       |
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | \$4,545,336              | 7                | 4.0%        | \$4,766,732                | 7               | 4.2%        | 4.9%        |
| MIGRAINE PRODUCTS                                 | \$4,089,880              | 9                | 3.6%        | \$4,001,323                | 8               | 3.5%        | -2.2%       |
| ANTICONVULSANTS                                   | \$3,770,519              | 10               | 3.3%        | \$3,870,201                | 9               | 3.4%        | 2.6%        |
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES          | \$3,353,906              | 12               | 3.0%        | \$3,415,429                | 10              | 3.0%        | 1.8%        |
| ENDOCRINE AND METABOLIC AGENTS - MISC.            | \$4,301,004              | 8                | 3.8%        | \$3,405,407                | 11              | 3.0%        | -20.8%      |
| CARDIOVASCULAR AGENTS - MISC.                     | \$3,428,066              | 11               | 3.0%        | \$3,396,466                | 12              | 3.0%        | -0.9%       |
| ANTIVIRALS                                        | \$3,155,631              | 13               | 2.8%        | \$2,954,762                | 13              | 2.6%        | -6.4%       |
| HEMATOLOGICAL AGENTS - MISC.                      | \$2,905,917              | 14               | 2.6%        | \$2,953,895                | 14              | 2.6%        | 1.7%        |
| GASTROINTESTINAL AGENTS - MISC.                   | \$2,853,206              | 15               | 2.5%        | \$2,865,005                | 15              | 2.5%        | 0.4%        |
| RESPIRATORY AGENTS - MISC.                        | \$2,806,534              | 16               | 2.5%        | \$2,783,479                | 16              | 2.5%        | -0.8%       |
| ANTIDEPRESSANTS                                   | \$2,130,997              | 17               | 1.9%        | \$2,166,884                | 17              | 1.9%        | 1.7%        |
| NEUROMUSCULAR AGENTS                              | \$1,512,486              | 18               | 1.3%        | \$1,335,234                | 18              | 1.2%        | -11.7%      |
| ANTICOAGULANTS                                    | \$1,298,878              | 19               | 1.1%        | \$1,302,912                | 19              | 1.1%        | 0.3%        |
| MISCELLANEOUS THERAPEUTIC CLASSES                 | \$1,073,668              | 20               | 0.9%        | \$827,937                  | 20              | 0.7%        | -22.9%      |

### TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

| CATEGORY DESCRIPTION                          | March 2026 / May 2026 | PREVIOUS RANK | June 2026 / August 2026 | CURRENT RANK | % CHANGE |
|-----------------------------------------------|-----------------------|---------------|-------------------------|--------------|----------|
| ANTIDEPRESSANTS                               | 87,972                | 1             | 84,593                  | 1            | -3.8%    |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | 53,498                | 2             | 51,574                  | 2            | -3.6%    |
| ANTICONVULSANTS                               | 49,924                | 3             | 48,775                  | 3            | -2.3%    |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS       | 43,384                | 4             | 40,607                  | 4            | -6.4%    |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS               | 39,250                | 5             | 38,606                  | 5            | -1.6%    |
| ANTIDIABETICS                                 | 36,277                | 6             | 35,766                  | 6            | -1.4%    |
| ANTIANKXIETY AGENTS                           | 35,472                | 7             | 35,211                  | 7            | -0.7%    |
| ANTIHYPERTENSIVES                             | 28,071                | 8             | 26,514                  | 8            | -5.5%    |
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS   | 26,716                | 9             | 25,222                  | 9            | -5.6%    |
| DERMATOLOGICALS                               | 23,453                | 11            | 24,650                  | 10           | 5.1%     |
| ANTI HISTAMINES                               | 24,428                | 10            | 23,546                  | 11           | -3.6%    |
| ANALGESICS - OPIOID                           | 17,023                | 12            | 17,146                  | 12           | 0.7%     |
| ANTIHYPERLIPIDEMICS                           | 16,794                | 13            | 16,264                  | 13           | -3.2%    |
| ANALGESICS - ANTI-INFLAMMATORY                | 15,590                | 15            | 15,127                  | 14           | -3.0%    |
| MUSCULOSKELETAL THERAPY AGENTS                | 13,635                | 16            | 13,395                  | 15           | -1.8%    |
| BETA BLOCKERS                                 | 13,045                | 17            | 12,440                  | 16           | -4.6%    |
| ANALGESICS - NonNarcotic                      | 11,698                | 18            | 11,472                  | 17           | -1.9%    |
| PENICILLINS                                   | 16,552                | 14            | 11,253                  | 18           | -32.0%   |
| HEMATOPOIETIC AGENTS                          | 10,800                | 20            | 10,716                  | 19           | -0.8%    |
| CORTICOSTEROIDS                               | 11,403                | 19            | 9,643                   | 20           | -15.4%   |

# TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION      | March 2026 / May 2026 | PREVIOUS RANK | June 2026 / August 2026 | CURRENT RANK | % CHANGE |
|-----------------------|-----------------------|---------------|-------------------------|--------------|----------|
| OZEMPIC               | \$5,601,215           | 1             | \$5,440,671             | 1            | -2.9%    |
| VRAYLAR               | \$4,007,613           | 2             | \$4,148,837             | 2            | 3.5%     |
| MOUNJARO              | \$3,273,864           | 4             | \$4,082,747             | 3            | 24.7%    |
| DUPIXENT PEN          | \$3,906,505           | 3             | \$4,027,971             | 4            | 3.1%     |
| HUMIRA(CF) PEN        | \$3,125,155           | 5             | \$3,413,838             | 5            | 9.2%     |
| SKYRIZI PEN           | \$2,295,946           | 6             | \$2,634,142             | 6            | 14.7%    |
| ZEPBOUND              | \$1,887,806           | 7             | \$2,264,947             | 7            | 20.0%    |
| INVEGA SUSTENNA       | \$1,871,899           | 8             | \$1,748,731             | 8            | -6.6%    |
| BIKTARVY              | \$1,521,201           | 10            | \$1,509,839             | 9            | -0.7%    |
| TRIKAFTA              | \$1,498,822           | 11            | \$1,500,380             | 10           | 0.1%     |
| JARDIANCE             | \$1,399,428           | 12            | \$1,415,540             | 11           | 1.2%     |
| CAPLYTA               | \$1,101,138           | 18            | \$1,334,751             | 12           | 21.2%    |
| REXULTI               | \$1,386,356           | 13            | \$1,271,464             | 13           | -8.3%    |
| RINVOQ                | \$1,160,127           | 16            | \$1,215,599             | 14           | 4.8%     |
| NURTEC ODT            | \$1,202,485           | 15            | \$1,132,856             | 15           | -5.8%    |
| STELARA               | \$1,543,319           | 9             | \$1,110,089             | 16           | -28.1%   |
| TALTZ AUTOINJECTOR    | \$1,247,022           | 14            | \$1,106,305             | 17           | -11.3%   |
| WAKIX                 | \$874,725             | 24            | \$1,079,632             | 18           | 23.4%    |
| SKYRIZI ON-BODY       | \$1,127,525           | 17            | \$1,058,594             | 19           | -6.1%    |
| DUPIXENT SYRINGE      | \$944,764             | 21            | \$1,037,101             | 20           | 9.8%     |
| COSENTYX UNOREADY PEN | \$1,034,623           | 20            | \$979,693               | 21           | -5.3%    |

|                             |             |    |           |    |        |
|-----------------------------|-------------|----|-----------|----|--------|
| TRULICITY                   | \$1,036,802 | 19 | \$967,932 | 22 | -6.6%  |
| ALTUVIII                    | \$895,881   | 23 | \$886,733 | 23 | -1.0%  |
| TRELEGY ELLIPTA             | \$859,382   | 25 | \$872,632 | 24 | 1.5%   |
| BIMZELX AUTOINJECTOR        | \$932,643   | 22 | \$865,403 | 25 | -7.2%  |
| ENBREL SURECLICK            | \$765,874   | 32 | \$852,885 | 26 | 11.4%  |
| ARISTADA                    | \$853,868   | 27 | \$849,578 | 27 | -0.5%  |
| AUSTEDO XR                  | \$735,404   | 36 | \$834,621 | 28 | 13.5%  |
| ABILIFY MAINTENA            | \$833,731   | 28 | \$834,147 | 29 | 0.0%   |
| ELIQUIS                     | \$807,564   | 29 | \$831,816 | 30 | 3.0%   |
| UBRELVY                     | \$785,806   | 31 | \$794,684 | 31 | 1.1%   |
| AJOVY AUTOINJECTOR          | \$763,444   | 33 | \$750,125 | 32 | -1.7%  |
| INGREZZA                    | \$790,377   | 30 | \$735,688 | 33 | -6.9%  |
| ALYFTREK                    | \$716,601   | 38 | \$733,957 | 34 | 2.4%   |
| UPTRAVI                     | \$714,236   | 39 | \$716,970 | 35 | 0.4%   |
| LYBALVI                     | \$748,659   | 35 | \$712,725 | 36 | -4.8%  |
| EPIDIOLEX                   | \$756,938   | 34 | \$699,910 | 37 | -7.5%  |
| NORDITROPIN FLEXP           | \$699,592   | 40 | \$695,073 | 38 | -0.6%  |
| EVRYSDI                     | \$855,395   | 26 | \$692,782 | 39 | -19.0% |
| TREMFYA ONE-PRESS           | \$726,974   | 37 | \$665,925 | 40 | -8.4%  |
| SYMBICORT                   | \$667,188   | 42 | \$647,125 | 41 | -3.0%  |
| TREMFYA PEN                 | \$482,510   | 51 | \$628,363 | 42 | 30.2%  |
| LISDEXAMFETAMINE DIMESYLATE | \$605,423   | 44 | \$623,373 | 43 | 3.0%   |
| JORNAY PM                   | \$626,588   | 43 | \$619,451 | 44 | -1.1%  |
| KESIMPTA PEN                | \$499,935   | 50 | \$579,548 | 45 | 15.9%  |

|                       |           |    |           |    |        |
|-----------------------|-----------|----|-----------|----|--------|
| INVEGA TRINZA         | \$598,455 | 46 | \$576,190 | 46 | -3.7%  |
| TRINTELLIX            | \$581,577 | 48 | \$573,068 | 47 | -1.5%  |
| XOLAIR                | \$559,453 | 49 | \$535,329 | 48 | -4.3%  |
| TYVASO DPI            | \$582,400 | 47 | \$531,754 | 49 | -8.7%  |
| FINTEPLA              | \$377,614 | 65 | \$521,269 | 50 | 38.0%  |
| WINREVAIR (2 PACK)    | \$336,677 | 73 | \$520,319 | 51 | 54.5%  |
| CRYSVITA              | \$604,215 | 45 | \$512,136 | 52 | -15.2% |
| QULIPTA               | \$464,695 | 55 | \$469,213 | 53 | 1.0%   |
| TAKHZYRO              | \$405,258 | 61 | \$462,139 | 54 | 14.0%  |
| ORENITRAM ER          | \$424,995 | 58 | \$459,357 | 55 | 8.1%   |
| QELBREE               | \$467,266 | 54 | \$457,680 | 56 | -2.1%  |
| WEGOVY                | \$332,343 | 74 | \$431,220 | 57 | 29.8%  |
| XARELTO               | \$443,045 | 57 | \$427,331 | 58 | -3.5%  |
| UZEDY                 | \$394,770 | 64 | \$396,143 | 59 | 0.3%   |
| OTEZLA                | \$416,929 | 59 | \$392,700 | 60 | -5.8%  |
| NUCALA                | \$326,992 | 76 | \$383,476 | 61 | 17.3%  |
| FARXIGA               | \$399,809 | 63 | \$381,037 | 62 | -4.7%  |
| VALTOCO               | \$270,935 | 92 | \$379,382 | 63 | 40.0%  |
| XYWAV                 | \$454,991 | 56 | \$373,863 | 64 | -17.8% |
| HEMLIBRA              | \$402,725 | 62 | \$370,760 | 65 | -7.9%  |
| ALBUTEROL SULFATE HFA | \$376,397 | 66 | \$367,914 | 66 | -2.3%  |
| AUSTEDO               | \$372,743 | 67 | \$355,177 | 67 | -4.7%  |
| EMGALITY PEN          | \$340,552 | 72 | \$341,153 | 68 | 0.2%   |
| TEZSPIRE              | \$283,974 | 85 | \$334,845 | 69 | 17.9%  |

|                              |           |     |           |    |        |
|------------------------------|-----------|-----|-----------|----|--------|
| ABILIFY ASIMTUFII            | \$318,979 | 78  | \$332,603 | 70 | 4.3%   |
| NEMLUVIO                     | \$223,189 | 106 | \$324,112 | 71 | 45.2%  |
| DUVYZAT                      | \$318,678 | 79  | \$318,699 | 72 | 0.0%   |
| COSENTYX SENSOREADY (2 PENS) | \$372,446 | 68  | \$310,141 | 73 | -16.7% |
| ORFADIN                      | \$470,535 | 53  | \$307,985 | 74 | -34.5% |
| LINZESS                      | \$284,787 | 84  | \$304,185 | 75 | 6.8%   |
| GATTEX                       | \$288,454 | 83  | \$290,857 | 76 | 0.8%   |
| VERZENIO                     | \$415,745 | 60  | \$290,600 | 77 | -30.1% |
| BREZTRI AEROSPHERE           | \$309,454 | 80  | \$290,196 | 78 | -6.2%  |
| PROCYSBI                     | \$289,608 | 82  | \$289,608 | 79 | 0.0%   |
| TOLVAPTAN                    | \$320,756 | 77  | \$286,992 | 80 | -10.5% |
| ILARIS                       | \$351,924 | 71  | \$286,870 | 81 | -18.5% |
| EPINEPHRINE                  | \$213,112 | 111 | \$277,687 | 82 | 30.3%  |
| MAVYRET                      | \$357,967 | 70  | \$274,629 | 83 | -23.3% |
| SPIRIVA RESPIMAT             | \$275,825 | 91  | \$265,151 | 84 | -3.9%  |
| STRENSIQ                     | \$693,432 | 41  | \$263,573 | 85 | -62.0% |
| NAYZILAM                     | \$227,933 | 104 | \$258,191 | 86 | 13.3%  |
| ALPROLIX                     | \$252,871 | 95  | \$256,542 | 87 | 1.5%   |
| CREON                        | \$278,226 | 90  | \$252,828 | 88 | -9.1%  |
| AIMOVIG AUTOINJECTOR         | \$264,854 | 94  | \$246,230 | 89 | -7.0%  |
| HUMIRA(CF)                   | \$206,050 | 113 | \$246,200 | 90 | 19.5%  |
| FASENRA PEN                  | \$327,151 | 75  | \$245,287 | 91 | -25.0% |
| AQNEURSA                     | \$179,576 | 122 | \$239,435 | 92 | 33.3%  |
| DEXTROAMPHETAMINE-AMPHET ER  | \$243,038 | 97  | \$236,637 | 93 | -2.6%  |

|                              |           |     |           |     |        |
|------------------------------|-----------|-----|-----------|-----|--------|
| SKYCLARYS                    | \$234,157 | 102 | \$233,734 | 94  | -0.2%  |
| LANTUS SOLOSTAR              | \$282,444 | 87  | \$233,475 | 95  | -17.3% |
| ADVAIR HFA                   | \$241,950 | 99  | \$228,038 | 96  | -5.8%  |
| KISQALI                      | \$279,167 | 89  | \$226,726 | 97  | -18.8% |
| BRIVIACT                     | \$247,942 | 96  | \$226,417 | 98  | -8.7%  |
| AUVELITY                     | \$196,395 | 116 | \$224,890 | 99  | 14.5%  |
| INSULIN LISPRO KWIKPEN U-100 | \$243,020 | 98  | \$221,331 | 100 | -8.9%  |

### TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION            | March 2026 / May 2026 | PREVIOUS RANK | June 2026 / August 2026 | CURRENT RANK | % CHANGE |
|-----------------------------|-----------------------|---------------|-------------------------|--------------|----------|
| TRAZODONE HCL               | 14,950                | 1             | 14,425                  | 1            | -3.5%    |
| BUPROPION XL                | 13,493                | 2             | 13,548                  | 2            | 0.4%     |
| ALBUTEROL SULFATE HFA       | 13,295                | 3             | 12,768                  | 3            | -4.0%    |
| SERTRALINE HCL              | 11,618                | 4             | 11,049                  | 4            | -4.9%    |
| HYDROXYZINE HCL             | 11,025                | 5             | 10,745                  | 5            | -2.5%    |
| GABAPENTIN                  | 10,666                | 6             | 10,307                  | 6            | -3.4%    |
| BUSPIRONE HCL               | 10,123                | 9             | 10,039                  | 7            | -0.8%    |
| CETIRIZINE HCL              | 10,503                | 8             | 10,016                  | 8            | -4.6%    |
| MONTELUKAST SODIUM          | 9,641                 | 12            | 9,389                   | 9            | -2.6%    |
| FLUOXETINE HCL              | 10,053                | 10            | 9,370                   | 10           | -6.8%    |
| OMEPRAZOLE                  | 9,955                 | 11            | 9,160                   | 11           | -8.0%    |
| ESCITALOPRAM OXALATE        | 8,949                 | 13            | 8,420                   | 12           | -5.9%    |
| ATORVASTATIN CALCIUM        | 8,625                 | 14            | 8,109                   | 13           | -6.0%    |
| DEXTROAMPHETAMINE-AMPHET ER | 8,399                 | 15            | 8,081                   | 14           | -3.8%    |
| QUETIAPINE FUMARATE         | 8,181                 | 17            | 8,000                   | 15           | -2.2%    |
| ARIPIRAZOLE                 | 8,039                 | 19            | 7,963                   | 16           | -0.9%    |
| LEVOTHYROXINE SODIUM        | 8,346                 | 16            | 7,910                   | 17           | -5.2%    |
| LAMOTRIGINE                 | 8,058                 | 18            | 7,869                   | 18           | -2.3%    |
| LISDEXAMFETAMINE DIMESYLATE | 6,991                 | 20            | 7,270                   | 19           | 4.0%     |
| AMOXICILLIN                 | 10,572                | 7             | 6,606                   | 20           | -37.5%   |

|                                |       |    |       |    |        |
|--------------------------------|-------|----|-------|----|--------|
| CLONIDINE HCL                  | 6,765 | 22 | 6,366 | 21 | -5.9%  |
| TOPIRAMATE                     | 6,594 | 24 | 6,241 | 22 | -5.4%  |
| HYDROCODONE-ACETAMINOPHEN      | 6,246 | 27 | 6,194 | 23 | -0.8%  |
| ONDANSETRON ODT                | 6,792 | 21 | 5,933 | 24 | -12.6% |
| CYCLOBENZAPRINE HCL            | 6,069 | 28 | 5,886 | 25 | -3.0%  |
| PREDNISONE                     | 6,701 | 23 | 5,855 | 26 | -12.6% |
| METHYLPHENIDATE ER             | 6,301 | 26 | 5,778 | 27 | -8.3%  |
| DEXTROAMPHETAMINE-AMPHETAMINE  | 5,840 | 32 | 5,756 | 28 | -1.4%  |
| OZEMPIC                        | 5,875 | 31 | 5,732 | 29 | -2.4%  |
| FLUTICASONE PROPIONATE         | 6,578 | 25 | 5,728 | 30 | -12.9% |
| LISINOPRIL                     | 6,034 | 29 | 5,651 | 31 | -6.3%  |
| DULOXETINE HCL                 | 5,938 | 30 | 5,634 | 32 | -5.1%  |
| PANTOPRAZOLE SODIUM            | 5,723 | 33 | 5,524 | 33 | -3.5%  |
| LORATADINE                     | 5,650 | 34 | 5,351 | 34 | -5.3%  |
| CLONAZEPAM                     | 5,161 | 38 | 5,148 | 35 | -0.3%  |
| ALPRAZOLAM                     | 5,115 | 39 | 5,124 | 36 | 0.2%   |
| RISPERIDONE                    | 5,427 | 36 | 5,118 | 37 | -5.7%  |
| FAMOTIDINE                     | 5,372 | 37 | 5,003 | 38 | -6.9%  |
| CEPHALEXIN                     | 4,346 | 46 | 4,802 | 39 | 10.5%  |
| AMLODIPINE BESYLATE            | 4,717 | 40 | 4,500 | 40 | -4.6%  |
| JARDIANCE                      | 4,485 | 43 | 4,489 | 41 | 0.1%   |
| IBUPROFEN                      | 4,327 | 47 | 4,346 | 42 | 0.4%   |
| ASPIRIN EC                     | 4,482 | 44 | 4,276 | 43 | -4.6%  |
| AMOXICILLIN-CLAVULANATE POTASS | 5,540 | 35 | 4,235 | 44 | -23.6% |

|                          |       |    |       |    |       |
|--------------------------|-------|----|-------|----|-------|
| MIRTAZAPINE              | 4,324 | 48 | 4,207 | 45 | -2.7% |
| VENLAFAXINE HCL ER       | 4,503 | 41 | 4,201 | 46 | -6.7% |
| GUANFACINE HCL ER        | 4,441 | 45 | 4,133 | 47 | -6.9% |
| LORAZEPAM                | 3,933 | 53 | 4,120 | 48 | 4.8%  |
| ALLERGY RELIEF           | 4,077 | 50 | 4,068 | 49 | -0.2% |
| ACETAMINOPHEN            | 4,040 | 51 | 4,058 | 50 | 0.4%  |
| TRIAMCINOLONE ACETONIDE  | 3,716 | 57 | 4,038 | 51 | 8.7%  |
| MOUNJARO                 | 3,225 | 70 | 3,969 | 52 | 23.1% |
| METOPROLOL SUCCINATE     | 4,173 | 49 | 3,953 | 53 | -5.3% |
| POLYETHYLENE GLYCOL 3350 | 3,968 | 52 | 3,903 | 54 | -1.6% |
| LOSARTAN POTASSIUM       | 3,903 | 54 | 3,784 | 55 | -3.0% |
| LEVETIRACETAM            | 3,789 | 55 | 3,701 | 56 | -2.3% |
| PREGABALIN               | 3,580 | 60 | 3,646 | 57 | 1.8%  |
| PROPRANOLOL HCL          | 3,767 | 56 | 3,609 | 58 | -4.2% |
| FOLIC ACID               | 3,515 | 64 | 3,542 | 59 | 0.8%  |
| OXYCODONE HCL            | 3,323 | 68 | 3,461 | 60 | 4.2%  |
| HYDROXYZINE PAMOATE      | 3,539 | 62 | 3,420 | 61 | -3.4% |
| METFORMIN HCL ER         | 3,613 | 59 | 3,392 | 62 | -6.1% |
| PRAZOSIN HCL             | 3,535 | 63 | 3,357 | 63 | -5.0% |
| ROSUVASTATIN CALCIUM     | 3,230 | 69 | 3,325 | 64 | 2.9%  |
| FEROSUL                  | 3,363 | 65 | 3,214 | 65 | -4.4% |
| FLUCONAZOLE              | 3,211 | 71 | 3,190 | 66 | -0.7% |
| VALACYCLOVIR             | 3,329 | 67 | 3,180 | 67 | -4.5% |
| METFORMIN HCL            | 3,354 | 66 | 3,164 | 68 | -5.7% |

|                               |       |    |       |    |        |
|-------------------------------|-------|----|-------|----|--------|
| MELOXICAM                     | 3,202 | 74 | 3,160 | 69 | -1.3%  |
| METHYLPHENIDATE HCL           | 3,572 | 61 | 3,111 | 70 | -12.9% |
| ATOMOXETINE HCL               | 3,205 | 72 | 3,082 | 71 | -3.8%  |
| LANTUS SOLOSTAR               | 3,628 | 58 | 3,068 | 72 | -15.4% |
| METRONIDAZOLE                 | 3,062 | 77 | 3,028 | 73 | -1.1%  |
| OLANZAPINE                    | 2,993 | 79 | 3,024 | 74 | 1.0%   |
| AZITHROMYCIN                  | 4,494 | 42 | 2,952 | 75 | -34.3% |
| SYMBICORT                     | 3,024 | 78 | 2,926 | 76 | -3.2%  |
| GUANFACINE HCL                | 3,203 | 73 | 2,889 | 77 | -9.8%  |
| TRAMADOL HCL                  | 2,951 | 81 | 2,888 | 78 | -2.1%  |
| VRAYLAR                       | 2,747 | 87 | 2,870 | 79 | 4.5%   |
| BACLOFEN                      | 2,955 | 80 | 2,847 | 80 | -3.7%  |
| POTASSIUM CHLORIDE            | 2,847 | 83 | 2,810 | 81 | -1.3%  |
| TIZANIDINE HCL                | 2,849 | 82 | 2,803 | 82 | -1.6%  |
| FUROSEMIDE                    | 2,829 | 84 | 2,787 | 83 | -1.5%  |
| SPIRONOLACTONE                | 2,819 | 86 | 2,733 | 84 | -3.1%  |
| ELIQUIS                       | 2,608 | 88 | 2,632 | 85 | 0.9%   |
| MUPIROCIN                     | 2,206 | 92 | 2,544 | 86 | 15.3%  |
| DEXMETHYLPHENIDATE HCL ER     | 2,823 | 85 | 2,537 | 87 | -10.1% |
| ONDANSETRON HCL               | 2,528 | 89 | 2,329 | 88 | -7.9%  |
| ZEPBOUND                      | 1,943 | 99 | 2,326 | 89 | 19.7%  |
| SULFAMETHOXAZOLE-TRIMETHOPRIM | 2,010 | 98 | 2,300 | 90 | 14.4%  |
| ALBUTEROL SULFATE             | 3,140 | 75 | 2,279 | 91 | -27.4% |
| NYSTATIN                      | 2,078 | 96 | 2,247 | 92 | 8.1%   |

|                       |       |     |       |     |        |
|-----------------------|-------|-----|-------|-----|--------|
| ZOLPIDEM TARTRATE     | 2,328 | 90  | 2,237 | 93  | -3.9%  |
| KETOCONAZOLE          | 2,199 | 93  | 2,172 | 94  | -1.2%  |
| SUMATRIPTAN SUCCINATE | 2,211 | 91  | 2,159 | 95  | -2.4%  |
| NALTREXONE HCL        | 2,050 | 97  | 2,066 | 96  | 0.8%   |
| OXCARBAZEPINE         | 2,137 | 95  | 2,045 | 97  | -4.3%  |
| HYDROCHLOROTHIAZIDE   | 2,187 | 94  | 2,028 | 98  | -7.3%  |
| CEFDINIR              | 3,098 | 76  | 1,999 | 99  | -35.5% |
| SENNA                 | 1,872 | 100 | 1,916 | 100 | 2.4%   |

## Fee for Service Claims Quarterly Statistics

|                                   | March through May 2026 | June through August 2026 | % CHANGE |
|-----------------------------------|------------------------|--------------------------|----------|
| TOTAL PAID AMOUNT                 | \$3,197,150            | \$3,410,496              | 6.7%     |
| UNIQUE USERS                      | 3,331                  | 3,081                    | -7.5%    |
| COST PER USER                     | \$959.82               | \$1,106.94               | 15.3%    |
| TOTAL PRESCRIPTIONS               | 21,718                 | 19,633                   | -9.6%    |
| AVERAGE PRESCRIPTIONS PER USER    | 6.52                   | 6.37                     | -2.3%    |
| AVERAGE COST PER PRESCRIPTION     | \$147.21               | \$173.71                 | 18.0%    |
| # GENERIC PRESCRIPTIONS           | 19,455                 | 17,437                   | -10.4%   |
| % GENERIC                         | 89.6%                  | 88.8%                    | -0.9%    |
| \$ GENERIC                        | \$955,835              | \$1,084,324              | 13.4%    |
| AVERAGE GENERIC PRESCRIPTION COST | \$49.13                | \$62.19                  | 26.6%    |
| AVERAGE GENERIC DAYS SUPPLY       | 29                     | 31                       | 6.9%     |
| # BRAND PRESCRIPTIONS             | 2,263                  | 2,196                    | -3.0%    |
| % BRAND                           | 10.4%                  | 11.2%                    | 7.3%     |
| \$ BRAND                          | \$2,241,315            | \$2,326,172              | 3.8%     |
| AVERAGE BRAND PRESCRIPTION COST   | \$990.42               | \$1,059.28               | 7.0%     |
| AVERAGE BRAND DAYS SUPPLY         | 28                     | 28                       | 0.0%     |

| UTILIZATION BY AGE |                        |                          |
|--------------------|------------------------|--------------------------|
| AGE                | March through May 2026 | June through August 2026 |
| 0-6                | 153                    | 123                      |
| 7-12               | 348                    | 289                      |
| 13-18              | 574                    | 530                      |
| 19-64              | 2,223                  | 2,118                    |
| 65+                | 33                     | 21                       |
|                    | 3,331                  | 3,081                    |

| UTILIZATION BY GENDER AND AGE |       |                        |                          |
|-------------------------------|-------|------------------------|--------------------------|
| GENDER                        | AGE   | March through May 2026 | June through August 2026 |
| F                             |       |                        |                          |
|                               | 0-6   | 75                     | 62                       |
|                               | 7-12  | 151                    | 125                      |
|                               | 13-18 | 282                    | 261                      |
|                               | 19-64 | 1,400                  | 1,377                    |
|                               | 65+   | 17                     | 11                       |
|                               |       | 1,925                  | 1,836                    |
| M                             |       |                        |                          |
|                               | 0-6   | 78                     | 61                       |
|                               | 7-12  | 197                    | 164                      |
|                               | 13-18 | 292                    | 269                      |
|                               | 19-64 | 823                    | 741                      |
|                               | 65+   | 16                     | 10                       |
|                               |       | 1,406                  | 1,245                    |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | PHARMACY NAME                    | PHARMACY CITY  | STATE | PRESCRIPTION COUNT | PAID AMT     | AVG COST RX | PREVIOUS RANK |
|------|----------------------------------|----------------|-------|--------------------|--------------|-------------|---------------|
| 1    | MESKWAKI PHARMACY                | TAMA           | IA    | 975                | \$805,350.00 | \$826.00    | 2             |
| 2    | UIHC AMBULATORY CARE PHARMACY    | IOWA CITY      | IA    | 763                | \$172,402.36 | \$225.95    | 1             |
| 3    | SIOUXLAND COMMUNITY HEALTH CENTE | SIOUX CITY     | IA    | 714                | \$52,964.67  | \$74.18     | 3             |
| 4    | DRILLING MORNINGSIDE PHARMACY IN | SIOUX CITY     | IA    | 502                | \$44,588.80  | \$88.82     | 5             |
| 5    | WALGREENS #15647                 | SIOUX CITY     | IA    | 396                | \$43,482.91  | \$109.81    | 4             |
| 6    | THOMPSON-DEAN DRUG               | SIOUX CITY     | IA    | 311                | \$17,618.79  | \$56.65     | 6             |
| 7    | GENOA HEALTHCARE LLC             | SIOUX CITY     | IA    | 213                | \$19,189.60  | \$90.09     | 9             |
| 8    | RIGHT DOSE PHARMACY              | ANKENY         | IA    | 208                | \$6,563.36   | \$31.55     | 7             |
| 9    | HY-VEE PHARMACY #3 (1615)        | SIOUX CITY     | IA    | 143                | \$11,059.92  | \$77.34     | 13            |
| 10   | WALGREEN #04405                  | COUNCIL BLUFFS | IA    | 143                | \$8,061.73   | \$56.38     | 8             |
| 11   | COMMUNITY HEALTH CARE INC        | DAVENPORT      | IA    | 141                | \$18,200.30  | \$129.08    | 15            |
| 12   | GREENVILLE PHARMACY INC          | SIOUX CITY     | IA    | 136                | \$5,026.45   | \$36.96     | 27            |
| 13   | HY-VEE PHARMACY (1075)           | CLINTON        | IA    | 130                | \$19,438.81  | \$149.53    | 30            |
| 14   | COVENANT FAMILY PHARMACY         | WATERLOO       | IA    | 126                | \$2,985.74   | \$23.70     | 19            |
| 15   | HY-VEE PHARMACY #1 (1610)        | SIOUX CITY     | IA    | 124                | \$7,841.41   | \$63.24     | 23            |
| 16   | CHEROKEE MAIN STREET PHARMACY    | CHEROKEE       | IA    | 123                | \$6,450.86   | \$52.45     | 24            |
| 17   | WALGREEN COMPANY #05042          | CEDAR RAPIDS   | IA    | 122                | \$11,208.92  | \$91.88     | 16            |
| 18   | UNITY POINT HEALTH PHARMACY      | CEDAR RAPIDS   | IA    | 118                | \$4,472.62   | \$37.90     | 20            |
| 19   | HY-VEE PHARMACY #3 (1866)        | WATERLOO       | IA    | 116                | \$3,966.62   | \$34.20     | 14            |
| 20   | BROADLAWNS MEDICAL CENTER        | DES MOINES     | IA    | 115                | \$7,110.64   | \$61.83     | 10            |
| 21   | WCHS PHARMACY                    | WINNEBAGO      | NE    | 115                | \$94,990.00  | \$826.00    | 38            |
| 22   | DRUGTOWN PHARMACY #1 (7020)      | CEDAR RAPIDS   | IA    | 112                | \$23,418.91  | \$209.10    | 17            |
| 23   | CVS PHARMACY #08658              | DAVENPORT      | IA    | 111                | \$19,575.10  | \$176.35    | 31            |
| 24   | NEIGHBORHOOD LTC PHARMACY        | URBANDALE      | IA    | 106                | \$1,299.16   | \$12.26     | 190           |
| 25   | NELSON FAMILY PHARMACY           | FORT MADISON   | IA    | 105                | \$12,803.80  | \$121.94    | 47            |
| 26   | HARTIG PHARMACY SERVICES         | DUBUQUE        | IA    | 105                | \$5,594.64   | \$53.28     | 88            |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | PHARMACY NAME                    | PHARMACY CITY  | STATE | PRESCRIPTION COUNT | PAID AMT    | AVG COST RX | PREVIOUS RANK |
|------|----------------------------------|----------------|-------|--------------------|-------------|-------------|---------------|
| 27   | CVS PHARMACY #10282              | FORT DODGE     | IA    | 104                | \$6,469.81  | \$62.21     | 33            |
| 28   | WAL MART PHARMACY 10-3590        | SIOUX CITY     | IA    | 101                | \$7,652.47  | \$75.77     | 12            |
| 29   | REUTZEL PHARMACY                 | CEDAR RAPIDS   | IA    | 101                | \$4,073.05  | \$40.33     | 36            |
| 30   | WALMART PHARMACY 10-3150         | COUNCIL BLUFFS | IA    | 99                 | \$18,292.76 | \$184.78    | 29            |
| 31   | MEDICAP PHARMACY                 | OGEDEN         | IA    | 99                 | \$5,401.64  | \$54.56     | 35            |
| 32   | IOWA VETERANS HOME               | MARSHALLTOWN   | IA    | 97                 | \$3,405.21  | \$35.11     | 26            |
| 33   | IMMC OUTPATIENT PHARMACY         | DES MOINES     | IA    | 97                 | \$3,285.33  | \$33.87     | 22            |
| 34   | HY-VEE STORE CLINIC 1023-039     | GRIMES         | IA    | 96                 | \$4,376.33  | \$45.59     | 25            |
| 35   | EASTERN IOWA HEALTH CENTER PHARM | CEDAR RAPIDS   | IA    | 95                 | \$4,247.14  | \$44.71     | 40            |
| 36   | MAIN AT LOCUST PHARMACY          | DAVENPORT      | IA    | 93                 | \$3,569.71  | \$38.38     | 11            |
| 37   | CVS PHARMACY #17554              | CEDAR FALLS    | IA    | 87                 | \$1,486.32  | \$17.08     | 18            |
| 38   | WAL-MART PHARMACY #10-3394       | ATLANTIC       | IA    | 83                 | \$5,294.72  | \$63.79     | 62            |
| 39   | CVS PHARMACY #8544               | WATERLOO       | IA    | 83                 | \$10,492.22 | \$126.41    | 43            |
| 40   | WHITE DRUG ENTERPRISES INC       | SPENCER        | IA    | 83                 | \$3,016.73  | \$36.35     | 79            |
| 41   | HY VEE PHARMACY 1459             | OELWEIN        | IA    | 82                 | \$7,084.62  | \$86.40     | 95            |
| 42   | ALL CARE HEALTH CENTER PHARMACY  | COUNCIL BLUFFS | IA    | 82                 | \$3,038.04  | \$37.05     | 46            |
| 43   | WALGREEN #05721                  | DES MOINES     | IA    | 82                 | \$7,048.05  | \$85.95     | 42            |
| 44   | HY-VEE PHARMACY 1382             | LE MARS        | IA    | 82                 | \$4,787.63  | \$58.39     | 44            |
| 45   | WAL-MART PHARMACY #10-0646       | ANAMOSA        | IA    | 79                 | \$5,767.24  | \$73.00     | 37            |
| 46   | HY-VEE PHARMACY (1396)           | MARION         | IA    | 79                 | \$8,613.40  | \$109.03    | 78            |
| 47   | MEDICAP PHARMACY                 | INDIANOLA      | IA    | 78                 | \$2,290.16  | \$29.36     | 28            |
| 48   | LEWIS FAMILY DRUG #28            | ONAWA          | IA    | 75                 | \$10,681.01 | \$142.41    | 84            |
| 49   | GENOA HEALTHCARE LLC             | SIOUX CITY     | IA    | 75                 | \$7,302.99  | \$97.37     | 137           |
| 50   | KOERNER WHIPPLE PHARMACY         | HAMPTON        | IA    | 72                 | \$7,681.85  | \$106.69    | 51            |
| 51   | GREENWOOD DRUG ON KIMBALL AVENUE | WATERLOO       | IA    | 71                 | \$1,241.73  | \$17.49     | 41            |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | PHARMACY NAME                    | PHARMACY CITY | STATE | PRESCRIPTION COUNT | PAID AMT    | AVG COST RX | PREVIOUS RANK |
|------|----------------------------------|---------------|-------|--------------------|-------------|-------------|---------------|
| 52   | HY-VEE DRUGSTORE # 1180          | FAIRFIELD     | IA    | 70                 | \$6,452.57  | \$92.18     | 76            |
| 53   | WALGREEN #05239                  | DAVENPORT     | IA    | 70                 | \$10,341.49 | \$147.74    | 21            |
| 54   | NUCARA LTC PHARMACY 4            | WATERLOO      | IA    | 69                 | \$954.41    | \$13.83     | 52            |
| 55   | HY-VEE PHARMACY 1068             | CHEROKEE      | IA    | 69                 | \$4,479.41  | \$64.92     | 39            |
| 56   | HY-VEE PHARMACY (1192)           | FORT DODGE    | IA    | 69                 | \$1,272.69  | \$18.44     | 54            |
| 57   | HY-VEE PHARMACY (1619)           | SHENANDOAH    | IA    | 69                 | \$5,034.34  | \$72.96     | 45            |
| 58   | WAL-MART PHARMACY #10-0797       | W. BURLINGTON | IA    | 68                 | \$11,512.58 | \$169.30    | 154           |
| 59   | UI HEALTHCARE RIVER LANDING PHAR | CORALVILLE    | IA    | 67                 | \$4,751.54  | \$70.92     | 60            |
| 60   | PEOPLES CLINIC PHARMACY          | WATERLOO      | IA    | 66                 | \$811.47    | \$12.30     | 32            |
| 61   | HY-VEE PHARMACY (1403)           | MARSHALLTOWN  | IA    | 66                 | \$3,680.64  | \$55.77     | 34            |
| 62   | HY-VEE PHARMACY #5 (1151)        | DES MOINES    | IA    | 66                 | \$3,494.06  | \$52.94     | 81            |
| 63   | WALGREEN #03595                  | DAVENPORT     | IA    | 66                 | \$1,040.34  | \$15.76     | 149           |
| 64   | MERCY OUTPATIENT PHARMACY        | DES MOINES    | IA    | 65                 | \$1,476.19  | \$22.71     | 165           |
| 65   | WAL-MART PHARMACY 10-1546        | IOWA FALLS    | IA    | 64                 | \$10,503.71 | \$164.12    | 109           |
| 66   | CR CARE PHARMACY                 | CEDAR RAPIDS  | IA    | 64                 | \$15,993.36 | \$249.90    | 295           |
| 67   | WALGREEN COMPANY #05470          | SIOUX CITY    | IA    | 63                 | \$2,953.87  | \$46.89     | 50            |
| 68   | WAL-MART PHARMACY 10-2889        | CLINTON       | IA    | 63                 | \$4,324.37  | \$68.64     | 89            |
| 69   | HY-VEE PHARMACY (1052)           | CEDAR FALLS   | IA    | 62                 | \$571.10    | \$9.21      | 69            |
| 70   | HY-VEE PHARMACY 1071             | CLARINDA      | IA    | 62                 | \$29,582.34 | \$477.13    | 49            |
| 71   | WALGREEN CO DBA                  | ALTOONA       | IA    | 62                 | \$7,684.21  | \$123.94    | 86            |
| 72   | WRIGHTWAY LTC PHARMACY           | CLINTON       | IA    | 61                 | \$3,318.25  | \$54.40     | 75            |
| 73   | MEDICAP PHARMACY #7              | GRINNELL      | IA    | 61                 | \$5,934.53  | \$97.29     | 94            |
| 74   | HY-VEE PHARMACY (1009) DBA       | ALBIA         | IA    | 59                 | \$11,432.87 | \$193.78    | 221           |
| 75   | WAL MART PHARMACY 10-1621        | CENTERVILLE   | IA    | 59                 | \$7,971.53  | \$135.11    | 98            |
| 76   | MAIN STREET DRUG                 | CHARLES CITY  | IA    | 58                 | \$5,203.49  | \$89.72     | 77            |
| 77   | PHARMACY MATTERS LTC             | IOWA CITY     | IA    | 57                 | \$3,408.82  | \$59.80     | 70            |

**TOP 100 PHARMACIES BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | PHARMACY NAME                    | PHARMACY CITY  | STATE | PRESCRIPTION COUNT | PAID AMT    | AVG COST RX | PREVIOUS RANK |
|------|----------------------------------|----------------|-------|--------------------|-------------|-------------|---------------|
| 78   | PARAGON PARTNERS                 | OMAHA          | NE    | 57                 | \$30,102.17 | \$528.11    | 71            |
| 79   | SUMPTER PHARMACY                 | ADEL           | IA    | 56                 | \$879.40    | \$15.70     | 157           |
| 80   | HY-VEE DRUGSTORE #7026           | CEDAR RAPIDS   | IA    | 55                 | \$7,442.52  | \$135.32    | 129           |
| 81   | HY-VEE PHARMACY #3 (1056)        | CEDAR RAPIDS   | IA    | 55                 | \$5,188.10  | \$94.33     | 48            |
| 82   | HY VEE DRUGSTORE 7007-039        | AMES           | IA    | 54                 | \$4,753.74  | \$88.03     | 97            |
| 83   | WAL-MART PHARMACY #10-1389       | BOONE          | IA    | 54                 | \$7,494.01  | \$138.78    | 105           |
| 84   | WALGREEN COMPANY #3700           | COUNCIL BLUFFS | IA    | 54                 | \$786.70    | \$14.57     | 90            |
| 85   | MERCY MEDICAL CENTER NORTH IA DB | MASON CITY     | IA    | 54                 | \$1,808.28  | \$33.49     | 74            |
| 86   | WAL-MART PHARMACIES #10-0753     | CEDAR FALLS    | IA    | 54                 | \$3,908.27  | \$72.38     | 111           |
| 87   | WALGREENS #12393                 | CEDAR RAPIDS   | IA    | 53                 | \$1,969.21  | \$37.15     | 57            |
| 88   | HY-VEE PHARMACY #2 (1614)        | SIOUX CITY     | IA    | 52                 | \$8,349.54  | \$160.57    | 55            |
| 89   | WALGREENS #03876                 | MARION         | IA    | 52                 | \$5,428.77  | \$104.40    | 56            |
| 90   | MEDICAP PHARMACY                 | DES MOINES     | IA    | 51                 | \$1,065.58  | \$20.89     | 126           |
| 91   | HY VEE PHARMACY #6 1155          | DES MOINES     | IA    | 51                 | \$1,811.28  | \$35.52     | 383           |
| 92   | PRIMARY HEALTH CARE PHARMACY     | DES MOINES     | IA    | 50                 | \$3,700.19  | \$74.00     | 53            |
| 93   | WALGREEN #7452                   | DES MOINES     | IA    | 50                 | \$6,720.30  | \$134.41    | 72            |
| 94   | HY-VEE PHARMACY (1038)           | BOONE          | IA    | 49                 | \$4,831.25  | \$98.60     | 180           |
| 95   | CVS PHARMACY #10032              | MARION         | IA    | 49                 | \$692.39    | \$14.13     | 153           |
| 96   | BLOEMKE PHARMACY                 | BELMOND        | IA    | 49                 | \$5,859.53  | \$119.58    | 124           |
| 97   | GREENE COUNTY PHARMACY           | JEFFERSON      | IA    | 49                 | \$1,474.48  | \$30.09     | 123           |
| 98   | WHITE DRUG ENTERPRISES INC       | DENISON        | IA    | 48                 | \$552.78    | \$11.52     | 114           |
| 99   | WAL-MART PHARMACY #10-1241       | DAVENPORT      | IA    | 48                 | \$629.21    | \$13.11     | 118           |
| 100  | WAL-MART PHARMACY #10-2935       | KNOXVILLE      | IA    | 48                 | \$2,249.14  | \$46.86     | 150           |

| TOP 100 PHARMACIES BY PAID AMOUNT<br>June through August 2026 |                                  |                |       |                    |              |                 |               |
|---------------------------------------------------------------|----------------------------------|----------------|-------|--------------------|--------------|-----------------|---------------|
| RANK                                                          | PHARMACY NAME                    | PHARMACY CITY  | STATE | PRESCRIPTION COUNT | PAID AMT     | AVG COST MEMBER | PREVIOUS RANK |
| 1                                                             | MESKWAKI PHARMACY                | TAMA           | IA    | 975                | \$805,350.00 | \$3,694.27      | 1             |
| 2                                                             | UIHC AMBULATORY CARE PHARMACY    | IOWA CITY      | IA    | 763                | \$172,402.36 | \$1,214.10      | 3             |
| 3                                                             | WALGREENS SPECIALTY PHARMACY #16 | DES MOINES     | IA    | 22                 | \$161,001.22 | \$20,125.15     | 2             |
| 4                                                             | WCHS PHARMACY                    | WINNEBAGO      | NE    | 115                | \$94,990.00  | \$2,968.44      | 7             |
| 5                                                             | ACCREDITO HEALTH GROUP INC       | MEMPHIS        | TN    | 8                  | \$79,205.35  | \$15,841.07     | 5             |
| 6                                                             | ACCREDITO HEALTH GROUP INC       | WHITESTOWN     | IN    | 4                  | \$71,170.66  | \$35,585.33     | 4             |
| 7                                                             | UNITY POINT AT HOME              | URBANDALE      | IA    | 25                 | \$68,059.84  | \$7,562.20      | 12            |
| 8                                                             | CAREMARK KANSAS SPEC PHARMACY LL | LENEXA         | KS    | 21                 | \$66,628.70  | \$8,328.59      | 6             |
| 9                                                             | COMMUNITY A WALGREENS PHARMACY   | IOWA CITY      | IA    | 7                  | \$65,901.99  | \$21,967.33     | 8             |
| 10                                                            | ACCREDITO HEALTH GROUP INC       | WARRENDALE     | PA    | 3                  | \$56,708.38  | \$28,354.19     | 16            |
| 11                                                            | SIOUXLAND COMMUNITY HEALTH CENTE | SIOUX CITY     | IA    | 714                | \$52,964.67  | \$441.37        | 9             |
| 12                                                            | HY-VEE PHARMACY #2 (1106)        | DAVENPORT      | IA    | 40                 | \$48,807.88  | \$9,761.58      | 11            |
| 13                                                            | DRILLING MORNINGSIDE PHARMACY IN | SIOUX CITY     | IA    | 502                | \$44,588.80  | \$857.48        | 14            |
| 14                                                            | WALGREENS #15647                 | SIOUX CITY     | IA    | 396                | \$43,482.91  | \$462.58        | 10            |
| 15                                                            | GENOA HEALTHCARE LLC             | MARSHALLTOWN   | IA    | 23                 | \$41,046.63  | \$41,046.63     | 355           |
| 16                                                            | SENDERRA RX PHARMACY             | PLANO          | TX    | 4                  | \$39,674.04  | \$19,837.02     | 26            |
| 17                                                            | OPTUM PHARMACY 702 LLC           | JEFFERSONVILLE | IN    | 3                  | \$38,544.94  | \$38,544.94     | 13            |
| 18                                                            | ALLIANCERX WALGREENS PRIME #1628 | PITTSBURGH     | PA    | 3                  | \$37,653.17  | \$18,826.59     | 25            |
| 19                                                            | FRED LEROY HEALTH & WELLNESS     | OMAHA          | NE    | 39                 | \$32,214.00  | \$3,579.33      | 24            |
| 20                                                            | PARAGON PARTNERS                 | OMAHA          | NE    | 57                 | \$30,102.17  | \$6,020.43      | 15            |
| 21                                                            | HY-VEE PHARMACY 1071             | CLARINDA       | IA    | 62                 | \$29,582.34  | \$3,697.79      | 33            |
| 22                                                            | PANTHERX SPECIALTY PHARMACY      | COLLIERVILLE   | TN    | 1                  | \$28,933.03  | \$28,933.03     |               |
| 23                                                            | SANFORD CANCER CTR ONC CLINIC PH | SIOUX FALLS    | SD    | 1                  | \$28,077.13  | \$28,077.13     | 29            |
| 24                                                            | DRUGTOWN PHARMACY #1 (7020)      | CEDAR RAPIDS   | IA    | 112                | \$23,418.91  | \$1,301.05      | 36            |
| 25                                                            | CVS PHARMACY #08658              | DAVENPORT      | IA    | 111                | \$19,575.10  | \$1,631.26      | 32            |

| TOP 100 PHARMACIES BY PAID AMOUNT<br>June through August 2026 |                                  |                   |       |                    |             |                 |               |
|---------------------------------------------------------------|----------------------------------|-------------------|-------|--------------------|-------------|-----------------|---------------|
| RANK                                                          | PHARMACY NAME                    | PHARMACY CITY     | STATE | PRESCRIPTION COUNT | PAID AMT    | AVG COST MEMBER | PREVIOUS RANK |
| 26                                                            | HY-VEE PHARMACY (1075)           | CLINTON           | IA    | 130                | \$19,438.81 | \$1,214.93      | 40            |
| 27                                                            | GENOA HEALTHCARE LLC             | SIOUX CITY        | IA    | 213                | \$19,189.60 | \$619.02        | 35            |
| 28                                                            | PROCARE PHARMACY DIRECT LLC      | MONROEVILLE       | PA    | 2                  | \$18,617.61 | \$18,617.61     | 52            |
| 29                                                            | WALMART PHARMACY 10-3150         | COUNCIL BLUFFS    | IA    | 99                 | \$18,292.76 | \$1,219.52      | 28            |
| 30                                                            | COMMUNITY HEALTH CARE INC        | DAVENPORT         | IA    | 141                | \$18,200.30 | \$1,011.13      | 37            |
| 31                                                            | WAL-MART PHARMACY #10-0892       | ANKENY            | IA    | 40                 | \$18,072.27 | \$2,259.03      | 19            |
| 32                                                            | THOMPSON-DEAN DRUG               | SIOUX CITY        | IA    | 311                | \$17,618.79 | \$429.73        | 27            |
| 33                                                            | WAL-MART PHARMACY #10-0985       | FAIRFIELD         | IA    | 43                 | \$17,519.38 | \$2,189.92      | 21            |
| 34                                                            | ANOVORX GROUP INC                | MEMPHIS           | TN    | 9                  | \$16,709.49 | \$4,177.37      | 22            |
| 35                                                            | CR CARE PHARMACY                 | CEDAR RAPIDS      | IA    | 64                 | \$15,993.36 | \$1,599.34      | 367           |
| 36                                                            | CARL T CURTIS HEALTH ED CENTER P | MACY              | NE    | 19                 | \$15,694.00 | \$1,426.73      | 20            |
| 37                                                            | BIOPLUS SPECIALTY PHARMACY SERVI | ALTAMONTE SPRINGS | FL    | 1                  | \$14,748.96 | \$14,748.96     |               |
| 38                                                            | MEDICAP PHARMACY                 | NEWTON            | IA    | 31                 | \$13,749.82 | \$3,437.46      | 18            |
| 39                                                            | CVS PHARMACY #00102              | AURORA            | CO    | 2                  | \$13,429.30 | \$6,714.65      | 17            |
| 40                                                            | WORLD'S FAIR PHARMACY            | OAKLAND GARDENS   | NY    | 3                  | \$12,991.89 | \$12,991.89     | 114           |
| 41                                                            | NELSON FAMILY PHARMACY           | FORT MADISON      | IA    | 105                | \$12,803.80 | \$1,422.64      | 44            |
| 42                                                            | WAL-MART PHARMACY #10-0797       | W. BURLINGTON     | IA    | 68                 | \$11,512.58 | \$885.58        | 76            |
| 43                                                            | HY-VEE PHARMACY (1009) DBA       | ALBIA             | IA    | 59                 | \$11,432.87 | \$2,286.57      | 105           |
| 44                                                            | WALGREEN COMPANY #05042          | CEDAR RAPIDS      | IA    | 122                | \$11,208.92 | \$415.15        | 72            |
| 45                                                            | HY-VEE PHARMACY #3 (1615)        | SIOUX CITY        | IA    | 143                | \$11,059.92 | \$502.72        | 48            |
| 46                                                            | LEWIS FAMILY DRUG #28            | ONAWA             | IA    | 75                 | \$10,681.01 | \$562.16        | 34            |
| 47                                                            | CARE RX MANASKA HEALTH           | OSKALOOSA         | IA    | 24                 | \$10,666.76 | \$5,333.38      | 75            |
| 48                                                            | THE NEBRASKA MED CENTER CLIN PHA | OMAHA             | NE    | 14                 | \$10,648.96 | \$3,549.65      | 115           |
| 49                                                            | CVS PHARMACY #17133              | DES MOINES        | IA    | 16                 | \$10,518.99 | \$10,518.99     | 23            |
| 50                                                            | WAL-MART PHARMACY 10-1546        | IOWA FALLS        | IA    | 64                 | \$10,503.71 | \$1,312.96      | 55            |
| 51                                                            | CVS PHARMACY #8544               | WATERLOO          | IA    | 83                 | \$10,492.22 | \$582.90        | 54            |

| TOP 100 PHARMACIES BY PAID AMOUNT<br>June through August 2026 |                                  |                |       |                    |             |                 |               |
|---------------------------------------------------------------|----------------------------------|----------------|-------|--------------------|-------------|-----------------|---------------|
| RANK                                                          | PHARMACY NAME                    | PHARMACY CITY  | STATE | PRESCRIPTION COUNT | PAID AMT    | AVG COST MEMBER | PREVIOUS RANK |
| 52                                                            | WALGREEN #05239                  | DAVENPORT      | IA    | 70                 | \$10,341.49 | \$544.29        | 49            |
| 53                                                            | WELLS BROS PHARMACY SERVICES VAN | KEOSAUQUA      | IA    | 39                 | \$9,972.39  | \$3,324.13      | 117           |
| 54                                                            | HY-VEE PHARMACY (1396)           | MARION         | IA    | 79                 | \$8,613.40  | \$957.04        | 67            |
| 55                                                            | HY-VEE PHARMACY #2 (1614)        | SIOUX CITY     | IA    | 52                 | \$8,349.54  | \$759.05        | 58            |
| 56                                                            | NELSON LONG TERM CARE PHARMACY   | FORT MADISON   | IA    | 3                  | \$8,227.20  | \$8,227.20      | 63            |
| 57                                                            | WALGREEN #04405                  | COUNCIL BLUFFS | IA    | 143                | \$8,061.73  | \$223.94        | 39            |
| 58                                                            | WAL MART PHARMACY 10-1621        | CENTERVILLE    | IA    | 59                 | \$7,971.53  | \$1,992.88      | 43            |
| 59                                                            | HY-VEE PHARMACY #1 (1610)        | SIOUX CITY     | IA    | 124                | \$7,841.41  | \$224.04        | 71            |
| 60                                                            | HY-VEE PHARMACY #1872            | WAVERLY        | IA    | 36                 | \$7,760.58  | \$2,586.86      | 69            |
| 61                                                            | GENOA HEALTHCARE LLC             | MASON CITY     | IA    | 10                 | \$7,750.80  | \$2,583.60      | 372           |
| 62                                                            | WALGREEN CO DBA                  | ALTOONA        | IA    | 62                 | \$7,684.21  | \$698.56        | 121           |
| 63                                                            | KOERNER WHIPPLE PHARMACY         | HAMPTON        | IA    | 72                 | \$7,681.85  | \$1,280.31      | 112           |
| 64                                                            | WAL MART PHARMACY 10-3590        | SIOUX CITY     | IA    | 101                | \$7,652.47  | \$364.40        | 30            |
| 65                                                            | WAL-MART PHARMACY #10-1389       | BOONE          | IA    | 54                 | \$7,494.01  | \$1,249.00      | 77            |
| 66                                                            | HY-VEE DRUGSTORE #7026           | CEDAR RAPIDS   | IA    | 55                 | \$7,442.52  | \$1,240.42      | 89            |
| 67                                                            | GENOA HEALTHCARE LLC             | SIOUX CITY     | IA    | 75                 | \$7,302.99  | \$1,460.60      | 183           |
| 68                                                            | BROADLAWNS MEDICAL CENTER        | DES MOINES     | IA    | 115                | \$7,110.64  | \$203.16        | 128           |
| 69                                                            | HY VEE PHARMACY 1459             | OELWEIN        | IA    | 82                 | \$7,084.62  | \$708.46        | 145           |
| 70                                                            | WALGREEN #05721                  | DES MOINES     | IA    | 82                 | \$7,048.05  | \$469.87        | 70            |
| 71                                                            | PELLA REGIONAL HEALTH CENTER PHA | PELLA          | IA    | 42                 | \$6,731.42  | \$1,346.28      | 167           |
| 72                                                            | WALGREEN #7452                   | DES MOINES     | IA    | 50                 | \$6,720.30  | \$1,344.06      | 131           |
| 73                                                            | HY-VEE PHARMACY (1080)           | CORALVILLE     | IA    | 36                 | \$6,612.03  | \$944.58        | 56            |
| 74                                                            | RIGHT DOSE PHARMACY              | ANKENY         | IA    | 208                | \$6,563.36  | \$546.95        | 53            |
| 75                                                            | CVS PHARMACY #10282              | FORT DODGE     | IA    | 104                | \$6,469.81  | \$281.30        | 129           |
| 76                                                            | HY-VEE DRUGSTORE # 1180          | FAIRFIELD      | IA    | 70                 | \$6,452.57  | \$586.60        | 150           |
| 77                                                            | CHEROKEE MAIN STREET PHARMACY    | CHEROKEE       | IA    | 123                | \$6,450.86  | \$1,290.17      | 88            |

| TOP 100 PHARMACIES BY PAID AMOUNT<br>June through August 2026 |                                 |                 |       |                    |            |                 |               |
|---------------------------------------------------------------|---------------------------------|-----------------|-------|--------------------|------------|-----------------|---------------|
| RANK                                                          | PHARMACY NAME                   | PHARMACY CITY   | STATE | PRESCRIPTION COUNT | PAID AMT   | AVG COST MEMBER | PREVIOUS RANK |
| 78                                                            | HY-VEE PHARMACY #2 (1101)       | COUNCIL BLUFFS  | IA    | 21                 | \$6,438.97 | \$3,219.49      | 79            |
| 79                                                            | MEDICAP PHARMACY #7             | GRINNELL        | IA    | 61                 | \$5,934.53 | \$1,978.18      | 87            |
| 80                                                            | BLOEMKE PHARMACY                | BELMOND         | IA    | 49                 | \$5,859.53 | \$5,859.53      | 81            |
| 81                                                            | WAL-MART PHARMACY #10-1509      | MAQUOKETA       | IA    | 40                 | \$5,784.69 | \$826.38        | 342           |
| 82                                                            | WAL-MART PHARMACY #10-0646      | ANAMOSA         | IA    | 79                 | \$5,767.24 | \$823.89        | 60            |
| 83                                                            | MEDICAP PHARMACY                | ALTOONA         | IA    | 28                 | \$5,746.63 | \$1,436.66      | 86            |
| 84                                                            | HARTIG PHARMACY SERVICES        | DUBUQUE         | IA    | 105                | \$5,594.64 | \$799.23        | 198           |
| 85                                                            | WAL-MART PHARMACY 10-4256       | AMES            | IA    | 28                 | \$5,489.94 | \$914.99        | 102           |
| 86                                                            | HY-VEE PHARMACY #4 (1890)       | WEST DES MOINES | IA    | 48                 | \$5,444.19 | \$777.74        | 158           |
| 87                                                            | WALGREENS #03876                | MARION          | IA    | 52                 | \$5,428.77 | \$542.88        | 38            |
| 88                                                            | WAL-MART PHARMACY #10-0581      | MARSHALLTOWN    | IA    | 40                 | \$5,421.27 | \$492.84        | 174           |
| 89                                                            | COMMUNITY PHARMACY OF LAKE CITY | LAKE CITY       | IA    | 26                 | \$5,410.28 | \$1,803.43      | 124           |
| 90                                                            | MEDICAP PHARMACY                | OGEDEN          | IA    | 99                 | \$5,401.64 | \$771.66        | 50            |
| 91                                                            | WAL-MART PHARMACY #10-3394      | ATLANTIC        | IA    | 83                 | \$5,294.72 | \$588.30        | 93            |
| 92                                                            | FIFIELD PHARMACY                | DES MOINES      | IA    | 46                 | \$5,257.84 | \$525.78        | 140           |
| 93                                                            | MAIN STREET DRUG                | CHARLES CITY    | IA    | 58                 | \$5,203.49 | \$2,601.75      | 192           |
| 94                                                            | HY-VEE PHARMACY #3 (1056)       | CEDAR RAPIDS    | IA    | 55                 | \$5,188.10 | \$576.46        | 57            |
| 95                                                            | WALGREEN #06677                 | WEST DES MOINES | IA    | 42                 | \$5,145.21 | \$857.54        | 94            |
| 96                                                            | SOUTH SIDE DRUG                 | OTTUMWA         | IA    | 30                 | \$5,134.20 | \$1,711.40      | 92            |
| 97                                                            | GENOA HEALTHCARE LLC            | DAVENPORT       | IA    | 40                 | \$5,063.71 | \$723.39        | 139           |
| 98                                                            | HY-VEE PHARMACY 1628-039        | MILFORD         | IA    | 32                 | \$5,059.71 | \$1,686.57      | 130           |
| 99                                                            | HY-VEE PHARMACY (1619)          | SHENANDOAH      | IA    | 69                 | \$5,034.34 | \$1,006.87      | 51            |
| 100                                                           | GREENVILLE PHARMACY INC         | SIOUX CITY      | IA    | 136                | \$5,026.45 | \$251.32        | 84            |

**TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | NPI NUM    | PRESCRIBER NAME             | PAID AMOUNT  | PRESCRIPTION COUNT | AVG SCRIPTS MEMBER | PREVIOUS RANK |
|------|------------|-----------------------------|--------------|--------------------|--------------------|---------------|
| 1    | 1053340661 | LEIGHTON FROST MD           | \$260,260.83 | 321                | 4.12               | 1             |
| 2    | 1093141129 | LARRY M NEWMAN ARNP         | \$115,073.67 | 152                | 3.04               | 4             |
| 3    | 1194888024 | ALICIA D WAGER NP           | \$119,811.59 | 149                | 2.10               | 3             |
| 4    | 1043418809 | MICHAEL CILIBERTO MD        | \$11,917.11  | 123                | 4.92               | 2             |
| 5    | 1780820860 | LAUREN GRAHAM MD            | \$88,096.99  | 108                | 3.38               | 7             |
| 6    | 1164481362 | MELISSA PEARSON ARNP        | \$87,556.00  | 106                | 2.04               | 5             |
| 7    | 1013355759 | DYLAN C GREENE MD           | \$5,291.07   | 90                 | 6.43               | 10            |
| 8    | 1154929230 | CHELSEA JONES ARNP          | \$2,924.51   | 89                 | 4.94               | 31            |
| 9    | 1659358620 | CARLOS CASTILLO MD          | \$1,189.93   | 79                 | 7.90               | 9             |
| 10   | 1811512064 | ADRIANNA DENISE MITCHELL MD | \$594.09     | 76                 | 38.00              | 12            |
| 11   | 1417214321 | LEAH BRANDON DO             | \$2,666.66   | 76                 | 6.33               | 8             |
| 12   | 1699658245 | AMY STRIM ANRP              | \$4,516.24   | 74                 | 4.35               | 27            |
| 13   | 1215125216 | REBECCA EVELYN WALDING      | \$12,754.29  | 69                 | 5.75               | 13            |
| 14   | 1619153137 | JOADA JEAN BEST ARNP        | \$5,416.97   | 68                 | 5.23               | 17            |
| 15   | 1104498039 | BRENDA CAIN ARNP            | \$8,621.05   | 58                 | 6.44               | 39            |
| 16   | 1780877878 | CHRISTOPHER JACOBS ARNP     | \$2,478.81   | 58                 | 6.44               | 20            |
| 17   | 1033890918 | DINA IRWIN ARNP             | \$3,751.77   | 55                 | 3.44               | 14            |
| 18   | 1902358443 | MELISSA KONKEN ARNP         | \$6,963.91   | 55                 | 6.88               | 6             |
| 19   | 1770933046 | SHELBY BILLER APRN          | \$16,129.10  | 52                 | 10.40              | 23            |
| 20   | 1285490896 | KARISSA MARIE WEAVER APRN   | \$8,898.43   | 52                 | 4.00               | 270           |
| 21   | 1073369070 | NICHOLAS BLIEU ARNP         | \$2,355.80   | 50                 | 5.56               | 34            |
| 22   | 1760965032 | MELISSA MILLER ARNP         | \$929.63     | 50                 | 5.56               | 15            |
| 23   | 1891756128 | PHILIP JOSEPH MULLER DO     | \$976.10     | 48                 | 6.00               | 16            |
| 24   | 1144214248 | KRISTI WALZ MD              | \$13,018.70  | 48                 | 8.00               | 11            |
| 25   | 1972100618 | DAVID TILLMAN ANRP          | \$2,294.41   | 47                 | 3.92               | 121           |
| 26   | 1023542271 | FLYNN MCCULLOUGH DO         | \$8,362.62   | 46                 | 7.67               | 32            |

**TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | NPI NUM    | PRESCRIBER NAME                  | PAID AMOUNT | PRESCRIPTION COUNT | AVG SCRIPTS MEMBER | PREVIOUS RANK |
|------|------------|----------------------------------|-------------|--------------------|--------------------|---------------|
| 27   | 1811123318 | AARON KAUER MD                   | \$3,964.13  | 46                 | 5.75               | 40            |
| 28   | 1821268335 | JACQUELINE MCINNIS PAC           | \$1,081.75  | 45                 | 15.00              | 33            |
| 29   | 1356337273 | LISA JAYNE MENZIES MD            | \$2,339.39  | 45                 | 5.63               | 46            |
| 30   | 1700080538 | EDUARDO CARLIN MD                | \$2,007.33  | 43                 | 3.58               | 29            |
| 31   | 1558147868 | JAMIE KARSTENS ARNP              | \$11,910.58 | 42                 | 3.82               | 234           |
| 32   | 1548874688 | HEIDI MARIE HASSLER PA           | \$510.65    | 41                 | 5.86               | 26            |
| 33   | 1871375543 | MONICA NUCKOLLS ARNP             | \$651.53    | 41                 | 10.25              | 28            |
| 34   | 1013115369 | BOBBITA NAG MD                   | \$851.01    | 41                 | 5.13               | 49            |
| 35   | 1831731298 | HEATHER J WILSON ARNP            | \$1,196.13  | 40                 | 5.00               | 50            |
| 36   | 1932652757 | KELSIE SWISHER ARNP              | \$621.77    | 40                 | 13.33              | 35            |
| 37   | 1215146055 | REBECCA JEAN MARIE WOLFE MD      | \$615.49    | 40                 | 8.00               | 48            |
| 38   | 1679920045 | BREANNE VOGEL ARNP               | \$298.16    | 40                 | 20.00              | 89            |
| 39   | 1942896691 | VIRIDIANA MUNOZ DE GONZALEZ ARNP | \$6,436.56  | 40                 | 5.71               | 126           |
| 40   | 1629265368 | HANNAH LOKENVITZ PA              | \$1,563.26  | 40                 | 40.00              | 91            |
| 41   | 1093272668 | RICARDO OSARIO ARNP              | \$2,673.34  | 39                 | 4.33               | 25            |
| 42   | 1902574361 | LAURA L OWENS APRN               | \$516.11    | 39                 | 7.80               | 56            |
| 43   | 1164194155 | JESSICA R WEBB ARNP              | \$2,473.78  | 38                 | 9.50               | 106           |
| 44   | 1639134034 | ELIZABETH PRATT ARNP             | \$526.57    | 38                 | 2.11               | 24            |
| 45   | 1326798992 | JENNA MULLINS MD                 | \$2,964.21  | 37                 | 6.17               | 42            |
| 46   | 1508846007 | ANGELA S TOWNSEND MD             | \$2,516.40  | 37                 | 7.40               | 137           |
| 47   | 1609946243 | SINA LINMAN ARNP                 | \$2,571.09  | 37                 | 5.29               | 212           |
| 48   | 1104804053 | WINTHROP S RISK II MD            | \$9,228.92  | 37                 | 12.33              | 74            |
| 49   | 1992766299 | PATRICK K CHAU MD                | \$673.32    | 37                 | 12.33              | 522           |
| 50   | 1578123915 | BRIANNA BROWNE DO                | \$3,600.48  | 36                 | 7.20               | 52            |
| 51   | 1912991183 | MOLLY EARLEYWINE PA              | \$3,439.78  | 36                 | 3.60               | 18            |
| 52   | 1982605762 | JEFFREY DEAN WILHARM MD          | \$970.90    | 36                 | 12.00              | 38            |

**TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | NPI NUM    | PRESCRIBER NAME                | PAID AMOUNT | PRESCRIPTION COUNT | AVG SCRIPTS MEMBER | PREVIOUS RANK |
|------|------------|--------------------------------|-------------|--------------------|--------------------|---------------|
| 53   | 1912208323 | LISA M MEYER ARNP              | \$4,823.69  | 35                 | 3.50               | 257           |
| 54   | 1932493749 | NICHOLAS CHARLES BECHTOLD DO   | \$3,915.27  | 35                 | 7.00               | 66            |
| 55   | 1174640528 | AMY JO PAYNE PA                | \$2,961.47  | 35                 | 2.33               | 95            |
| 56   | 1285710764 | JITENDRAKUMAR S GUPTA MD       | \$19,103.40 | 34                 | 4.25               | 96            |
| 57   | 1407836513 | NATHAN R NOBLE DO              | \$1,451.12  | 34                 | 2.83               | 21            |
| 58   | 1770044950 | EREZ R NAGGAR DO               | \$466.04    | 34                 | 17.00              | 44            |
| 59   | 1932531316 | BROOKE JOHNSON ARNP            | \$5,729.05  | 34                 | 11.33              | 45            |
| 60   | 1629506829 | MARIAH SKELLEY ARNP            | \$41,542.09 | 33                 | 16.50              | 82            |
| 61   | 1386938447 | THERESA CZECH MD               | \$1,049.62  | 33                 | 5.50               | 64            |
| 62   | 1306559786 | ROY E HENRY ARNP               | \$874.96    | 33                 | 11.00              | 156           |
| 63   | 1205249562 | KELLY RYDER MD                 | \$2,880.09  | 33                 | 4.13               | 41            |
| 64   | 1679991038 | KATHLEEN MARIE VONDERHAAR MD   | \$348.41    | 33                 | 4.13               | 65            |
| 65   | 1194272930 | EMILY FITZPATRICK ARNP         | \$4,651.00  | 32                 | 16.00              | 37            |
| 66   | 1609218304 | AMANDA CHRISTINE GARR APRN     | \$2,636.88  | 32                 | 6.40               | 120           |
| 67   | 1407479355 | SPENCER J ALDRIDGE DO          | \$2,509.39  | 32                 | 16.00              | 47            |
| 68   | 1558198416 | ELIZABETH MCDERMOTT ARNP       | \$1,615.08  | 32                 | 4.00               | 447           |
| 69   | 1609131770 | SREENATH THATI GANGANNA MBBS   | \$7,443.29  | 31                 | 3.10               | 43            |
| 70   | 1679324149 | ASHLEE DAILEY ARNP             | \$540.26    | 31                 | 2.58               | 76            |
| 71   | 1457412280 | KRISTA MARIE JOHNSON MD        | \$1,673.63  | 30                 | 30.00              | 113           |
| 72   | 1649922410 | CASSANDRA MARIE ZIMMERMAN ARNP | \$376.42    | 30                 | 30.00              | 108           |
| 73   | 1073235925 | KRISTINA L BECK ARNP           | \$2,631.95  | 30                 | 6.00               | 57            |
| 74   | 1114681889 | KELSEY BAUER ARNP              | \$869.39    | 30                 | 4.29               | 457           |
| 75   | 1427164789 | MICHAEL J OURADA MD            | \$491.10    | 30                 | 15.00              | 77            |
| 76   | 1477199198 | SAJO THOMAS ARNP               | \$1,211.65  | 29                 | 7.25               | 160           |
| 77   | 1790499648 | MARIA BRICKNER ARNP            | \$399.98    | 29                 | 9.67               | 168           |
| 78   | 1841220290 | KENT E KUNZE MD                | \$279.61    | 29                 | 7.25               | 73            |

**TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT**  
**June through August 2026**

| RANK | NPI NUM    | PRESCRIBER NAME              | PAID AMOUNT | PRESCRIPTION COUNT | AVG SCRIPTS MEMBER | PREVIOUS RANK |
|------|------------|------------------------------|-------------|--------------------|--------------------|---------------|
| 79   | 1679545354 | KATHERINE COLLEEN NICKELS MD | \$8,489.44  | 28                 | 9.33               | 60            |
| 80   | 1457584740 | ERIC MEYER ARNP              | \$196.51    | 28                 | 14.00              | 36            |
| 81   | 1144455502 | JENNIFER PETTS DO            | \$1,837.56  | 28                 | 9.33               | 230           |
| 82   | 1639666340 | YASAMEEN MUZAHIM MD          | \$548.63    | 28                 | 14.00              | 130           |
| 83   | 1053600296 | JESSICA MCCOOL MD            | \$3,708.26  | 28                 | 28.00              | 61            |
| 84   | 1346349388 | THOMAS BRENT HOEHNS MD       | \$1,425.57  | 28                 | 28.00              | 227           |
| 85   | 1073795928 | HEATHER A JOHNSON ARNP       | \$875.31    | 28                 | 9.33               | 88            |
| 86   | 1568458354 | MARSHA COLLINS PA-C          | \$5,173.22  | 28                 | 14.00              | 79            |
| 87   | 1356827968 | MARIA A AZPEITIA ARNP        | \$5,684.48  | 27                 | 6.75               | 211           |
| 88   | 1871572990 | DOMINICK ERVELLI DO          | \$2,283.94  | 27                 | 27.00              | 134           |
| 89   | 1467431445 | SUSAN CASADY DO              | \$13,839.67 | 27                 | 9.00               | 2562          |
| 90   | 1063903870 | ADAM VERHOEF MD              | \$1,753.88  | 27                 | 13.50              | 163           |
| 91   | 1053376475 | DANIEL W GILLETTE MD         | \$2,704.18  | 27                 | 9.00               | 19            |
| 92   | 1720698335 | DANIKA LEIGH HANSEN ARNP     | \$2,587.49  | 27                 | 3.86               | 30            |
| 93   | 1689077018 | STACY ROTH ARNP              | \$9,033.18  | 27                 | 6.75               | 141           |
| 94   | 1801145776 | ANDREA LYNN HARRIS ARNP      | \$704.71    | 27                 | 2.08               | 1147          |
| 95   | 1437766201 | JACQUELINE A ELLISON ARNP    | \$939.74    | 27                 | 13.50              | 174           |
| 96   | 1578535639 | BRENDA OBERHELMAN ARNP       | \$365.86    | 27                 | 27.00              | 84            |
| 97   | 1174583157 | JOANNE STARR ARNP            | \$368.62    | 26                 | 8.67               | 102           |
| 98   | 1871271403 | OLIVIA SKAARE ARNP           | \$341.97    | 26                 | 4.33               | 101           |
| 99   | 1700356334 | BRIANNA J SCHAFFER ARNP      | \$2,342.34  | 26                 | 8.67               | 176           |
| 100  | 1932582988 | DIANNE HUMPHREY ARNP         | \$5,271.63  | 26                 | 26.00              | 67            |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**June through August 2026**

| RANK | DOCTOR NUM | PRESCRIBER NAME                  | PAID AMOUNT  | AVG COST RX | PRESCRIPTION COUNT | PREVIOUS RANK |
|------|------------|----------------------------------|--------------|-------------|--------------------|---------------|
| 1    | 1053340661 | LEIGHTON FROST MD                | \$260,260.83 | \$810.78    | 321                | 2             |
| 2    | 1326034984 | KATHERINE MATHEWS MD             | \$127,285.45 | \$14,142.83 | 9                  | 1             |
| 3    | 1194888024 | ALICIA D WAGER NP                | \$119,811.59 | \$804.10    | 149                | 3             |
| 4    | 1093141129 | LARRY M NEWMAN ARNP              | \$115,073.67 | \$757.06    | 152                | 4             |
| 5    | 1780820860 | LAUREN GRAHAM MD                 | \$88,096.99  | \$815.71    | 108                | 6             |
| 6    | 1164481362 | MELISSA PEARSON ARNP             | \$87,556.00  | \$826.00    | 106                | 5             |
| 7    | 1013126705 | JANICE STABER MD                 | \$58,240.86  | \$3,882.72  | 15                 | 13            |
| 8    | 1467449579 | BRIAN P WAYSON ARNP              | \$57,117.32  | \$7,139.67  | 8                  | 8             |
| 9    | 1619021144 | CHRISTOPHER M GIBBS MD           | \$54,013.04  | \$4,910.28  | 11                 | 7             |
| 10   | 1578958542 | HEIDI E CURTIS ARNP              | \$51,014.97  | \$10,202.99 | 5                  | 11            |
| 11   | 1225263833 | LINDSAY J ORRIS DO               | \$45,692.76  | \$15,230.92 | 3                  | 9             |
| 12   | 1629506829 | MARIAH SKELLEY ARNP              | \$41,542.09  | \$1,258.85  | 33                 | 14            |
| 13   | 1043441264 | KATHERINE LEM PA-C               | \$40,783.01  | \$10,195.75 | 4                  | 40            |
| 14   | 1104088202 | PATRICK SAFO MD                  | \$30,610.78  | \$15,305.39 | 2                  | 35            |
| 15   | 1265048870 | KELLY ALEXIS MERCHIE PA          | \$30,363.66  | \$3,795.46  | 8                  | 12            |
| 16   | 1992290969 | EMMA KILLORAN MD                 | \$28,933.03  | \$28,933.03 | 1                  |               |
| 17   | 1659722478 | JORDAN ELIZABETH FRITCH-HANSON M | \$28,077.13  | \$28,077.13 | 1                  | 27            |
| 18   | 1801459730 | LAURA THORSON PA                 | \$26,923.80  | \$8,974.60  | 3                  | 1872          |
| 19   | 1982828133 | PAVAN CHEPYALA MD                | \$24,637.21  | \$8,212.40  | 3                  | 74            |
| 20   | 1457986671 | PAITON A CALVERT ARNP            | \$23,849.05  | \$23,849.05 | 1                  | 2395          |
| 21   | 1750648275 | SARAH GROSS MD                   | \$22,964.45  | \$2,870.56  | 8                  | 17            |
| 22   | 1811377989 | LILIYA GANDRABUR MD              | \$20,444.35  | \$2,920.62  | 7                  | 39            |
| 23   | 1356752067 | KELLY DELANEY-NELSON MD          | \$20,411.90  | \$3,401.98  | 6                  | 23            |
| 24   | 1396724878 | WHITNEY ELIZABETH MOLIS MD       | \$19,741.68  | \$2,820.24  | 7                  | 37            |
| 25   | 1285710764 | JITENDRAKUMAR S GUPTA MD         | \$19,103.40  | \$561.86    | 34                 | 143           |
| 26   | 1073852059 | AMBER HANSEN MD                  | \$18,998.00  | \$826.00    | 23                 | 36            |
| 27   | 1255658175 | ASHLEY DESCHAMP MD               | \$18,820.51  | \$855.48    | 22                 | 62            |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**June through August 2026**

| RANK | DOCTOR NUM | PRESCRIBER NAME            | PAID AMOUNT | AVG COST RX | PRESCRIPTION COUNT | PREVIOUS RANK |
|------|------------|----------------------------|-------------|-------------|--------------------|---------------|
| 28   | 1447373832 | JOSHUA B WILSON MD         | \$17,829.26 | \$8,914.63  | 2                  | 15            |
| 29   | 1508043985 | SHAWNA FREEMAN ARNP        | \$17,123.60 | \$17,123.60 | 1                  |               |
| 30   | 1245241116 | LAURIE A HUGHELL PA        | \$16,721.39 | \$1,857.93  | 9                  |               |
| 31   | 1063792026 | JILL NELLIE MILLER         | \$16,292.98 | \$1,357.75  | 12                 | 60            |
| 32   | 1770933046 | SHELBY BILLER APRN         | \$16,129.10 | \$310.18    | 52                 | 38            |
| 33   | 1538664149 | LAURIE JORGENSEN ARNP      | \$15,379.19 | \$1,183.01  | 13                 | 20            |
| 34   | 1649678582 | LAURA STULKEN PA C         | \$15,124.16 | \$2,160.59  | 7                  | 142           |
| 35   | 1518257047 | LAURA A WHITTINGTON DO     | \$15,029.58 | \$7,514.79  | 2                  | 19            |
| 36   | 1023489382 | NICOLE DEVOE CNP           | \$14,748.96 | \$14,748.96 | 1                  | 2784          |
| 37   | 1811493679 | JUNE MYLER ARNP            | \$14,055.66 | \$780.87    | 18                 | 57            |
| 38   | 1942923339 | WILLY A GARCIA CNP         | \$14,014.09 | \$1,167.84  | 12                 | 22            |
| 39   | 1295091510 | REBECCA WEINER MD          | \$13,997.28 | \$1,076.71  | 13                 | 30            |
| 40   | 1730293705 | ROBERT JACKSON DO          | \$13,855.20 | \$2,771.04  | 5                  | 21            |
| 41   | 1467431445 | SUSAN CASADY DO            | \$13,839.67 | \$512.58    | 27                 | 325           |
| 42   | 1194990945 | SANDEEP S GUPTA MD         | \$13,586.65 | \$1,358.67  | 10                 | 29            |
| 43   | 1518285725 | DOUGLAS M SMITH MD         | \$13,050.65 | \$1,864.38  | 7                  | 135           |
| 44   | 1144214248 | KRISTI WALZ MD             | \$13,018.70 | \$271.22    | 48                 | 32            |
| 45   | 1235976374 | OLIVIA ANN HANSEN ARNP     | \$12,953.23 | \$4,317.74  | 3                  | 45            |
| 46   | 1215125216 | REBECCA EVELYN WALDING     | \$12,754.29 | \$184.84    | 69                 | 90            |
| 47   | 1124216882 | KELLY JESSICA PEARSON ARNP | \$12,713.82 | \$1,059.49  | 12                 | 48            |
| 48   | 1861442915 | SARAH POWELL MD            | \$12,430.85 | \$2,071.81  | 6                  | 68            |
| 49   | 1639565328 | DEBRA HOAG APRN            | \$12,390.00 | \$826.00    | 15                 | 31            |
| 50   | 1588226104 | LAURA SUE KERSEY ARNP      | \$12,385.00 | \$952.69    | 13                 | 1865          |
| 51   | 1043418809 | MICHAEL CILIBERTO MD       | \$11,917.11 | \$96.89     | 123                | 28            |
| 52   | 1558147868 | JAMIE KARSTENS ARNP        | \$11,910.58 | \$283.59    | 42                 | 158           |
| 53   | 1518567056 | KATIE K BARKMEIER ARNP     | \$11,481.35 | \$675.37    | 17                 | 78            |
| 54   | 1215428115 | PRESTON SEREG MD           | \$10,614.87 | \$505.47    | 21                 | 112           |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**June through August 2026**

| RANK | DOCTOR NUM | PRESCRIBER NAME              | PAID AMOUNT | AVG COST RX | PRESCRIPTION COUNT | PREVIOUS RANK |
|------|------------|------------------------------|-------------|-------------|--------------------|---------------|
| 55   | 1265420095 | ELIZABETH COOPER PA          | \$10,422.61 | \$10,422.61 | 1                  | 1953          |
| 56   | 1982731741 | ANUMA ULU MD                 | \$9,912.00  | \$826.00    | 12                 |               |
| 57   | 1114521721 | TARRAH HOLLIDAY ARNP         | \$9,554.96  | \$1,061.66  | 9                  | 52            |
| 58   | 1639607757 | MICHAEL GERBER ARNP          | \$9,448.11  | \$472.41    | 20                 | 2058          |
| 59   | 1104804053 | WINTHROP S RISK II MD        | \$9,228.92  | \$249.43    | 37                 | 66            |
| 60   | 1649866138 | SHANIA MARDIAN PA            | \$9,077.29  | \$3,025.76  | 3                  | 127           |
| 61   | 1952488058 | MELISSA LAMB NP              | \$9,063.26  | \$4,531.63  | 2                  |               |
| 62   | 1689077018 | STACY ROTH ARNP              | \$9,033.18  | \$334.56    | 27                 | 64            |
| 63   | 1285490896 | KARISSA MARIE WEAVER APRN    | \$8,898.43  | \$171.12    | 52                 | 262           |
| 64   | 1497647937 | WESTON BIETZ ARNP            | \$8,702.59  | \$2,175.65  | 4                  | 73            |
| 65   | 1104498039 | BRENDA CAIN ARNP             | \$8,621.05  | \$148.64    | 58                 | 102           |
| 66   | 1679545354 | KATHERINE COLLEEN NICKELS MD | \$8,489.44  | \$303.19    | 28                 | 96            |
| 67   | 1023542271 | FLYNN MCCULLOUGH DO          | \$8,362.62  | \$181.80    | 46                 | 166           |
| 68   | 1346358603 | LINDA A STEIMLING PA C       | \$8,360.37  | \$1,393.40  | 6                  | 169           |
| 69   | 1366402505 | KUNAL KUMAR PATRA MD         | \$8,309.14  | \$593.51    | 14                 | 72            |
| 70   | 1720416563 | CRYSTAL MARIE OBERLE         | \$8,265.70  | \$1,033.21  | 8                  | 50            |
| 71   | 1942937388 | CARLY J DAY ARNP             | \$8,265.05  | \$2,755.02  | 3                  | 26            |
| 72   | 1083169270 | DAWN E TINGWALD ARNP         | \$8,132.92  | \$325.32    | 25                 | 77            |
| 73   | 1629415922 | ALYSSA LAKIN PA              | \$8,125.15  | \$2,708.38  | 3                  | 49            |
| 74   | 1285765354 | CORY B PITTMAN MD            | \$8,041.08  | \$4,020.54  | 2                  | 25            |
| 75   | 1407333065 | YACOUNB SALLAM MD            | \$8,005.44  | \$500.34    | 16                 | 223           |
| 76   | 1346993763 | TRISTA L GROSSNICKLE ARNP    | \$7,881.87  | \$492.62    | 16                 | 419           |
| 77   | 1609131770 | SREENATH THATI GANGANNA MBBS | \$7,443.29  | \$240.11    | 31                 | 190           |
| 78   | 1396904587 | RONETTE L LAMMERS ARNP       | \$7,434.00  | \$826.00    | 9                  | 3466          |
| 79   | 1326080409 | JAMES OWENS MD               | \$7,143.10  | \$340.15    | 21                 | 87            |
| 80   | 1477142289 | ANDREA LYNNE JOHNSON ARNP    | \$7,092.20  | \$2,364.07  | 3                  | 3055          |
| 81   | 1245353242 | SANDY DUYEN HONG MD          | \$7,044.59  | \$587.05    | 12                 |               |

**TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT**  
**June through August 2026**

| RANK | DOCTOR NUM | PRESCRIBER NAME                  | PAID AMOUNT | AVG COST RX | PRESCRIPTION COUNT | PREVIOUS RANK |
|------|------------|----------------------------------|-------------|-------------|--------------------|---------------|
| 82   | 1326410499 | TARA M EASTVOLD ARNP             | \$7,008.78  | \$350.44    | 20                 | 221           |
| 83   | 1902358443 | MELISSA KONKEN ARNP              | \$6,963.91  | \$126.62    | 55                 | 47            |
| 84   | 1013911692 | JEFFREY S SARTIN MD              | \$6,722.15  | \$1,680.54  | 4                  | 67            |
| 85   | 1942457981 | MUDAPPA KALAIAH MD               | \$6,715.15  | \$6,715.15  | 1                  | 41            |
| 86   | 1255319422 | DAVID STAUB MD                   | \$6,714.15  | \$6,714.15  | 1                  | 42            |
| 87   | 1285932822 | KELSEY JO MITCHELL PAC           | \$6,697.72  | \$956.82    | 7                  | 1702          |
| 88   | 1821861840 | MAURICE ELLIS BLACKBIRD APRN     | \$6,608.00  | \$826.00    | 8                  | 319           |
| 89   | 1831175629 | GREGORY A CHRISTIANSEN MD        | \$6,608.00  | \$826.00    | 8                  | 239           |
| 90   | 1023213030 | REBECCA JOY TIMMER BENSON MD     | \$6,516.01  | \$310.29    | 21                 | 94            |
| 91   | 1942896691 | VIRIDIANA MUNOZ DE GONZALEZ ARNP | \$6,436.56  | \$160.91    | 40                 | 153           |
| 92   | 1750348496 | VANESSA ANN CURTIS MD            | \$6,374.11  | \$637.41    | 10                 | 69            |
| 93   | 1811666118 | JESSIANN DRYDEN-PARISH RN        | \$6,370.63  | \$910.09    | 7                  | 276           |
| 94   | 1881044089 | NATHAN THOMAS MD                 | \$6,352.55  | \$397.03    | 16                 | 92            |
| 95   | 1619526076 | KATHRYN C HUBER PA C             | \$6,240.53  | \$520.04    | 12                 | 65            |
| 96   | 1497356125 | ASHLEEN BLACKBIRD                | \$5,782.00  | \$826.00    | 7                  | 238           |
| 97   | 1932531316 | BROOKE JOHNSON ARNP              | \$5,729.05  | \$168.50    | 34                 | 107           |
| 98   | 1356827968 | MARIA A AZPEITIA ARNP            | \$5,684.48  | \$210.54    | 27                 | 174           |
| 99   | 1427214170 | HARPREET KAUR MD                 | \$5,642.83  | \$512.98    | 11                 | 372           |
| 100  | 1427617471 | SUSAN GRAVES PA                  | \$5,553.42  | \$241.45    | 23                 | 103           |

### TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

| CATEGORY DESCRIPTION                     | March through May 2026 | RANK | % BUDGET | June through August 2026 | RANK | % BUDGET | % CHANGE |
|------------------------------------------|------------------------|------|----------|--------------------------|------|----------|----------|
| ANTIDIABETICS                            | \$377,148              | 1    | 11.8%    | \$406,933                | 1    | 11.9%    | 7.9%     |
| DERMATOLOGICALS                          | \$325,560              | 3    | 10.2%    | \$396,840                | 2    | 11.6%    | 21.9%    |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS          | \$275,304              | 4    | 8.6%     | \$304,652                | 3    | 8.9%     | 10.7%    |
| ANALGESICS - ANTI-INFLAMMATORY           | \$337,986              | 2    | 10.6%    | \$264,093                | 4    | 7.7%     | -21.9%   |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX | \$183,674              | 5    | 5.7%     | \$179,330                | 5    | 5.3%     | -2.4%    |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS  | \$140,914              | 8    | 4.4%     | \$169,512                | 6    | 5.0%     | 20.3%    |
| ANTICONVULSANTS                          | \$165,056              | 7    | 5.2%     | \$158,049                | 7    | 4.6%     | -4.2%    |
| ANTIDEPRESSANTS                          | \$84,737               | 11   | 2.7%     | \$139,134                | 8    | 4.1%     | 64.2%    |
| NEUROMUSCULAR AGENTS                     | \$172,445              | 6    | 5.4%     | \$127,651                | 9    | 3.7%     | -26.0%   |
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT | \$104,985              | 9    | 3.3%     | \$93,735                 | 10   | 2.7%     | -10.7%   |
| ANTIVIRALS                               | \$101,167              | 10   | 3.2%     | \$76,372                 | 11   | 2.2%     | -24.5%   |
| ANTIHYPERTENSIVES                        | \$53,857               | 14   | 1.7%     | \$76,144                 | 12   | 2.2%     | 41.4%    |
| RESPIRATORY AGENTS - MISC.               | \$71,011               | 12   | 2.2%     | \$75,672                 | 13   | 2.2%     | 6.6%     |
| MIGRAINE PRODUCTS                        | \$67,139               | 13   | 2.1%     | \$66,041                 | 14   | 1.9%     | -1.6%    |
| HEMATOLOGICAL AGENTS - MISC.             | \$33,127               | 19   | 1.0%     | \$62,928                 | 15   | 1.8%     | 90.0%    |
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERG | \$42,273               | 15   | 1.3%     | \$58,362                 | 16   | 1.7%     | 38.1%    |
| ANTIHYPERLIPIDEMICS                      | \$25,178               | 23   | 0.8%     | \$47,574                 | 17   | 1.4%     | 89.0%    |
| ANTIANXIETY AGENTS                       | \$40,889               | 16   | 1.3%     | \$38,354                 | 18   | 1.1%     | -6.2%    |
| ANALGESICS - NONNARCOTIC                 | \$31,582               | 20   | 1.0%     | \$37,685                 | 19   | 1.1%     | 19.3%    |
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES | \$24,691               | 24   | 0.8%     | \$35,720                 | 20   | 1.0%     | 44.7%    |

### TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

| CATEGORY DESCRIPTION                     | March through May 2026 | PREV RANK | June through August 2026 | CURR RANK | PERC CHANGE |
|------------------------------------------|------------------------|-----------|--------------------------|-----------|-------------|
| ANTIDEPRESSANTS                          | 2,252                  | 1         | 2,004                    | 1         | -11.0%      |
| ANTICONVULSANTS                          | 1,653                  | 2         | 1,470                    | 2         | -11.1%      |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX | 1,558                  | 3         | 1,328                    | 3         | -14.8%      |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS          | 1,186                  | 4         | 1,070                    | 4         | -9.8%       |
| ANTIDIABETICS                            | 1,102                  | 5         | 1,061                    | 5         | -3.7%       |
| ANTIANKXIETY AGENTS                      | 1,021                  | 7         | 986                      | 6         | -3.4%       |
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS  | 1,098                  | 6         | 976                      | 7         | -11.1%      |
| ANTIHYPERTENSIVES                        | 892                    | 8         | 785                      | 8         | -12.0%      |
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERG | 806                    | 9         | 721                      | 9         | -10.5%      |
| ANTIHISTAMINES                           | 628                    | 10        | 569                      | 10        | -9.4%       |
| DERMATOLOGICALS                          | 545                    | 12        | 557                      | 11        | 2.2%        |
| ANALGESICS - OPIOID                      | 551                    | 11        | 481                      | 12        | -12.7%      |
| ANALGESICS - ANTI-INFLAMMATORY           | 500                    | 13        | 438                      | 13        | -12.4%      |
| ANTIHYPERLIPIDEMICS                      | 436                    | 15        | 397                      | 14        | -8.9%       |
| MUSCULOSKELETAL THERAPY AGENTS           | 402                    | 16        | 371                      | 15        | -7.7%       |
| BETA BLOCKERS                            | 393                    | 17        | 353                      | 16        | -10.2%      |
| PENICILLINS                              | 451                    | 14        | 340                      | 17        | -24.6%      |
| LAXATIVES                                | 362                    | 18        | 336                      | 18        | -7.2%       |
| ANTI-INFECTIVE AGENTS - MISC.            | 305                    | 23        | 304                      | 19        | -0.3%       |
| ANALGESICS - NONNARCOTIC                 | 358                    | 19        | 302                      | 20        | -15.6%      |

### TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION     | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|----------------------|------------------------|---------------|--------------------------|------|----------------|
| HUMIRA PEN           | \$218,559.38           | 1             | \$185,708.19             | 1    | -15.03%        |
| OZEMPIC              | \$132,246.28           | 3             | \$130,728.01             | 2    | -1.15%         |
| EVRYSDI              | \$172,064.51           | 2             | \$127,401.04             | 3    | -25.96%        |
| DUPIXENT             | \$115,429.06           | 4             | \$106,352.82             | 4    | -7.86%         |
| SKYRIZI PEN          | \$79,513.16            | 6             | \$92,351.68              | 5    | 16.15%         |
| VRAYLAR              | \$93,792.49            | 5             | \$87,405.10              | 6    | -6.81%         |
| MOUNJARO             | \$65,559.97            | 8             | \$87,184.62              | 7    | 32.98%         |
| TRIKAFTA             | \$70,952.57            | 7             | \$75,672.11              | 8    | 6.65%          |
| COSENTYX UNOREADY    | \$33,989.38            | 15            | \$50,984.07              | 9    | 50.00%         |
| INVEGA SUSTENNA      | \$44,534.27            | 11            | \$47,573.85              | 10   | 6.83%          |
| JARDIANCE            | \$40,416.26            | 14            | \$46,500.99              | 11   | 15.06%         |
| HEMLIBRA             | \$29,531.80            | 17            | \$44,641.70              | 12   | 51.16%         |
| BIKTARVY             | \$47,013.99            | 10            | \$40,968.27              | 13   | -12.86%        |
| NUCALA               | \$26,483.66            | 21            | \$40,839.10              | 14   | 54.20%         |
| LISINOPRIL           | \$19,118.17            | 33            | \$37,827.52              | 15   | 97.86%         |
| AUSTEDO XR           | \$22,541.35            | 26            | \$34,972.36              | 16   | 55.15%         |
| ARISTADA             | \$29,827.18            | 16            | \$31,563.06              | 17   | 5.82%          |
| ZEPBOUND             | \$22,407.92            | 27            | \$31,351.34              | 18   | 39.91%         |
| TREMFYA              | \$15,305.39            | 47            | \$30,610.78              | 19   | 100.00%        |
| KESIMPTA             | \$60,629.82            | 9             | \$30,313.41              | 20   | -50.00%        |
| FILSUEVZ             |                        | 999           | \$28,933.03              | 21   | %              |
| GOMEKLI              |                        | 999           | \$28,077.13              | 22   | %              |
| CAPLYTA              | \$19,024.23            | 35            | \$27,714.03              | 23   | 45.68%         |
| RINVOQ               | \$41,412.36            | 13            | \$27,608.24              | 24   | -33.33%        |
| REXULTI              | \$20,525.48            | 30            | \$25,788.12              | 25   | 25.64%         |
| ESCITALOPRAM OXALATE | \$17,861.37            | 37            | \$25,005.80              | 26   | 40.00%         |
| ALBUTEROL SULFATE    | \$24,424.37            | 24            | \$24,786.37              | 27   | 1.48%          |

### TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION                  | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|-----------------------------------|------------------------|---------------|--------------------------|------|----------------|
| VYVANSE                           | \$27,631.07            | 19            | \$24,634.32              | 28   | -10.85%        |
| JORNAY PM                         | \$26,462.26            | 22            | \$24,170.49              | 29   | -8.66%         |
| CETIRIZINE HCL                    | \$29,117.95            | 18            | \$22,913.23              | 30   | -21.31%        |
| ROSUVASTATIN CALCIUM              | \$9,359.17             | 80            | \$22,567.74              | 31   | 141.13%        |
| LYBALVI                           | \$15,637.96            | 43            | \$22,121.53              | 32   | 41.46%         |
| IBUPROFEN                         | \$21,974.54            | 28            | \$20,774.44              | 33   | -5.46%         |
| NURTEC                            | \$15,126.25            | 49            | \$20,393.95              | 34   | 34.82%         |
| TEZSPIRE                          | \$14,755.68            | 52            | \$19,674.24              | 35   | 33.33%         |
| METFORMIN HCL                     | \$10,770.39            | 73            | \$18,736.25              | 36   | 73.96%         |
| TRAZODONE HCL                     | \$11,372.64            | 67            | \$18,648.34              | 37   | 63.98%         |
| FARXIGA                           | \$15,078.49            | 50            | \$18,564.91              | 38   | 23.12%         |
| AMLODIPINE BESYLATE               | \$12,934.03            | 63            | \$18,536.64              | 39   | 43.32%         |
| OMEPRAZOLE                        | \$13,723.09            | 59            | \$18,283.38              | 40   | 33.23%         |
| RHAPSIDO                          | \$4,531.63             | 140           | \$18,126.52              | 41   | 300.00%        |
| AMPHETAMINE-<br>DEXTROAMPHETAMINE | \$15,017.11            | 51            | \$18,087.91              | 42   | 20.45%         |
| ASPIRIN                           | \$14,652.99            | 54            | \$17,862.66              | 43   | 21.90%         |
| NEMLUVIO                          | \$26,743.89            | 20            | \$17,829.26              | 44   | -33.33%        |
| ZURZUVAE                          |                        | 999           | \$17,123.60              | 45   | %              |
| ACETAMINOPHEN                     | \$15,690.78            | 42            | \$16,823.48              | 46   | 7.22%          |
| ENBREL SURECLICK                  | \$41,609.65            | 12            | \$16,643.87              | 47   | -60.00%        |
| UZEDY                             | \$8,227.20             | 94            | \$16,443.56              | 48   | 99.87%         |
| AJOVY                             | \$15,555.04            | 44            | \$16,316.38              | 49   | 4.89%          |
| WESTAB PLUS                       | \$13,676.00            | 60            | \$16,221.76              | 50   | 18.61%         |
| ELIQUIS                           | \$14,733.89            | 53            | \$15,717.15              | 51   | 6.67%          |
| SYMBICORT                         | \$14,195.33            | 55            | \$15,700.78              | 52   | 10.61%         |
| METHYLPHENIDATE HCL               | \$18,459.85            | 36            | \$15,318.97              | 53   | -17.01%        |

### TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION     | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|----------------------|------------------------|---------------|--------------------------|------|----------------|
| NORDITROPIN FLEXPPO  | \$16,804.95            | 38            | \$15,257.58              | 54   | -9.21%         |
| AGAMREE              | \$22,544.37            | 25            | \$15,029.58              | 55   | -33.33%        |
| PANTOPRAZOLE SODIUM  | \$8,669.52             | 87            | \$14,897.49              | 56   | 71.84%         |
| FANAPT               | \$3,785.44             | 153           | \$14,771.04              | 57   | 290.21%        |
| TALTZ                | \$7,379.79             | 103           | \$14,748.96              | 58   | 99.86%         |
| PREDNISONE           | \$8,902.10             | 85            | \$14,717.23              | 59   | 65.32%         |
| BUPROPION HCL        | \$10,847.20            | 70            | \$14,585.64              | 60   | 34.46%         |
| KEPPRA               | \$15,915.63            | 41            | \$14,225.78              | 61   | -10.62%        |
| EMGALITY             | \$11,959.33            | 65            | \$14,175.72              | 62   | 18.53%         |
| EPIDIOLEX            | \$25,417.11            | 23            | \$14,015.59              | 63   | -44.86%        |
| TRULICITY            | \$21,363.47            | 29            | \$13,635.00              | 64   | -36.18%        |
| NOVOSEVEN RT         |                        | 999           | \$13,402.52              | 65   | %              |
| VALTOCO 10 MG DOSE   | \$1,904.09             | 219           | \$13,244.31              | 66   | 595.57%        |
| ATORVASTATIN CALCIUM | \$10,495.60            | 75            | \$13,141.56              | 67   | 25.21%         |
| HUMALOG KWIKPEN      | \$6,644.50             | 113           | \$13,115.04              | 68   | 97.38%         |
| HYFTOR               | \$4,430.63             | 144           | \$12,991.89              | 69   | 193.23%        |
| GENVOYA              | \$15,416.80            | 45            | \$12,953.23              | 70   | -15.98%        |
| ARIPIRAZOLE          | \$8,595.42             | 91            | \$12,938.75              | 71   | 50.53%         |
| LOSARTAN POTASSIUM   | \$10,319.25            | 76            | \$12,789.00              | 72   | 23.93%         |
| NAYZILAM             | \$4,147.21             | 148           | \$12,672.35              | 73   | 205.56%        |
| SERTRALINE HCL       | \$13,085.22            | 61            | \$12,606.43              | 74   | -3.66%         |
| AMOXICILLIN          | \$19,843.31            | 31            | \$12,350.41              | 75   | -37.76%        |
| NOVOLOG              | \$13,732.79            | 58            | \$12,298.12              | 76   | -10.45%        |
| LANTUS SOLOSTAR      | \$15,396.70            | 46            | \$12,272.24              | 77   | -20.29%        |
| MONTELUKAST SODIUM   | \$8,142.87             | 95            | \$12,124.65              | 78   | 48.90%         |
| CREON                | \$16,160.44            | 40            | \$11,275.62              | 79   | -30.23%        |
| HYDROCHLOROTHIAZIDE  | \$4,743.36             | 135           | \$11,192.75              | 80   | 135.97%        |

### TOP 100 DRUGS BY PAID AMOUNT

| DRUG DESCRIPTION               | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|--------------------------------|------------------------|---------------|--------------------------|------|----------------|
| QELBREE                        | \$10,790.01            | 72            | \$11,037.06              | 81   | 2.29%          |
| TRINTELLIX                     | \$5,789.63             | 124           | \$10,762.65              | 82   | 85.90%         |
| LISDEXAMFETAMINE DIMESYLATE    | \$11,270.60            | 68            | \$10,701.34              | 83   | -5.05%         |
| UBRELVY                        | \$15,191.39            | 48            | \$10,559.08              | 84   | -30.49%        |
| INVEGA TRINZA                  | \$10,551.86            | 74            | \$10,551.86              | 85   | 0.00%          |
| METOPROLOL SUCCINATE           | \$5,520.98             | 126           | \$10,460.50              | 86   | 89.47%         |
| NOVOLOG FLEXPEN                | \$10,813.70            | 71            | \$10,438.86              | 87   | -3.47%         |
| SKYRIZI                        | \$299.00               | 419           | \$10,422.61              | 88   | 3,385.82%      |
| RISPERDAL CONSTA               | \$6,413.74             | 115           | \$10,255.06              | 89   | 59.89%         |
| SYNTHROID                      | \$5,868.19             | 122           | \$10,226.54              | 90   | 74.27%         |
| ALPRAZOLAM                     | \$11,821.95            | 66            | \$10,206.37              | 91   | -13.67%        |
| FLUTICASONE PROPIONATE (NASAL) | \$7,860.18             | 98            | \$10,106.39              | 92   | 28.58%         |
| LAMOTRIGINE                    | \$6,672.15             | 111           | \$10,014.11              | 93   | 50.09%         |
| POLYETHYLENE GLYCOL 3350       | \$11,023.40            | 69            | \$9,856.76               | 94   | -10.58%        |
| CEPHALEXIN                     | \$7,320.26             | 105           | \$9,789.82               | 95   | 33.74%         |
| GABAPENTIN                     | \$8,666.85             | 89            | \$9,570.87               | 96   | 10.43%         |
| TRESIBA FLEXTOUCH              | \$6,292.26             | 116           | \$9,427.00               | 97   | 49.82%         |
| TRAMADOL HCL                   | \$10,038.90            | 77            | \$9,123.33               | 98   | -9.12%         |
| HYDROXYZINE HCL                | \$9,088.31             | 83            | \$9,000.39               | 99   | -0.97%         |
| APTIOM                         | \$16,475.14            | 39            | \$8,843.17               | 100  | -46.32%        |

### TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION                  | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|-----------------------------------|------------------------|---------------|--------------------------|------|----------------|
| ALBUTEROL SULFATE                 | 457                    | 1             | 398                      | 1    | -12.91%        |
| TRAZODONE HCL                     | 417                    | 3             | 390                      | 2    | -6.47%         |
| CETIRIZINE HCL                    | 422                    | 2             | 366                      | 3    | -13.27%        |
| AMPHETAMINE-<br>DEXTROAMPHETAMINE | 352                    | 5             | 331                      | 4    | -5.97%         |
| HYDROXYZINE HCL                   | 333                    | 8             | 319                      | 5    | -4.20%         |
| GABAPENTIN                        | 334                    | 6             | 291                      | 6    | -12.87%        |
| FLUOXETINE HCL                    | 333                    | 7             | 275                      | 7    | -17.42%        |
| BUPROPION HCL                     | 287                    | 10            | 257                      | 8    | -10.45%        |
| QUETIAPINE FUMARATE               | 281                    | 11            | 252                      | 9    | -10.32%        |
| METHYLPHENIDATE HCL               | 359                    | 4             | 252                      | 10   | -29.81%        |
| SERTRALINE HCL                    | 320                    | 9             | 245                      | 11   | -23.44%        |
| ARIPIRAZOLE                       | 272                    | 12            | 243                      | 12   | -10.66%        |
| ESCITALOPRAM OXALATE              | 270                    | 14            | 243                      | 13   | -10.00%        |
| BUSPIRONE HCL                     | 246                    | 18            | 239                      | 14   | -2.85%         |
| OMEPRAZOLE                        | 271                    | 13            | 235                      | 15   | -13.28%        |
| CLONIDINE HCL                     | 265                    | 15            | 212                      | 16   | -20.00%        |
| MONTELUKAST SODIUM                | 228                    | 19            | 210                      | 17   | -7.89%         |
| METFORMIN HCL                     | 220                    | 20            | 204                      | 18   | -7.27%         |
| LAMOTRIGINE                       | 210                    | 23            | 200                      | 19   | -4.76%         |
| ATORVASTATIN CALCIUM              | 258                    | 16            | 199                      | 20   | -22.87%        |
| LEVOTHYROXINE SODIUM              | 219                    | 21            | 185                      | 21   | -15.53%        |
| POLYETHYLENE GLYCOL 3350          | 206                    | 24            | 183                      | 22   | -11.17%        |
| LEVETIRACETAM                     | 199                    | 26            | 181                      | 23   | -9.05%         |
| FLUTICASONE PROPIONATE (NASAL)    | 195                    | 28            | 180                      | 24   | -7.69%         |
| IBUPROFEN                         | 212                    | 22            | 176                      | 25   | -16.98%        |
| LISINAPRIL                        | 184                    | 31            | 174                      | 26   | -5.43%         |

### TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION              | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|-------------------------------|------------------------|---------------|--------------------------|------|----------------|
| TOPIRAMATE                    | 155                    | 43            | 168                      | 27   | 8.39%          |
| PREDNISONE                    | 166                    | 37            | 168                      | 28   | 1.20%          |
| ASPIRIN                       | 177                    | 35            | 165                      | 29   | -6.78%         |
| AMOXICILLIN & POT CLAVULANATE | 180                    | 34            | 165                      | 30   | -8.33%         |
| FERROUS SULFATE               | 193                    | 29            | 165                      | 31   | -14.51%        |
| RISPERIDONE                   | 200                    | 25            | 164                      | 32   | -18.00%        |
| OZEMPIC                       | 163                    | 38            | 160                      | 33   | -1.84%         |
| PANTOPRAZOLE SODIUM           | 184                    | 32            | 158                      | 34   | -14.13%        |
| ONDANSETRON                   | 198                    | 27            | 157                      | 35   | -20.71%        |
| HYDROCODONE-ACETAMINOPHEN     | 192                    | 30            | 157                      | 36   | -18.23%        |
| AMOXICILLIN                   | 246                    | 17            | 154                      | 37   | -37.40%        |
| LISDEXAMFETAMINE DIMESYLATE   | 156                    | 42            | 152                      | 38   | -2.56%         |
| HYDROXYZINE PAMOATE           | 162                    | 39            | 150                      | 39   | -7.41%         |
| CYCLOBENZAPRINE HCL           | 155                    | 44            | 148                      | 40   | -4.52%         |
| OXYCODONE HCL                 | 148                    | 45            | 142                      | 41   | -4.05%         |
| DULOXETINE HCL                | 161                    | 41            | 142                      | 42   | -11.80%        |
| GUANFACINE HCL (ADHD)         | 183                    | 33            | 138                      | 43   | -24.59%        |
| JARDIANCE                     | 136                    | 50            | 134                      | 44   | -1.47%         |
| FAMOTIDINE                    | 145                    | 46            | 133                      | 45   | -8.28%         |
| CEPHALEXIN                    | 132                    | 51            | 132                      | 46   | 0.00%          |
| AMLODIPINE BESYLATE           | 145                    | 47            | 131                      | 47   | -9.66%         |
| ACETAMINOPHEN                 | 170                    | 36            | 127                      | 48   | -25.29%        |
| PROPRANOLOL HCL               | 137                    | 49            | 120                      | 49   | -12.41%        |
| LORATADINE                    | 117                    | 53            | 118                      | 50   | 0.85%          |
| LOSARTAN POTASSIUM            | 116                    | 54            | 115                      | 51   | -0.86%         |
| METOPROLOL SUCCINATE          | 113                    | 56            | 114                      | 52   | 0.88%          |
| ALPRAZOLAM                    | 112                    | 57            | 113                      | 53   | 0.89%          |

### TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION                  | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|-----------------------------------|------------------------|---------------|--------------------------|------|----------------|
| ROSUVASTATIN CALCIUM              | 100                    | 61            | 111                      | 54   | 11.00%         |
| LANTUS SOLOSTAR                   | 140                    | 48            | 107                      | 55   | -23.57%        |
| METRONIDAZOLE                     | 93                     | 68            | 106                      | 56   | 13.98%         |
| TRIAMCINOLONE ACETONIDE (TOPICAL) | 89                     | 72            | 101                      | 57   | 13.48%         |
| MIRTAZAPINE                       | 101                    | 59            | 101                      | 58   | 0.00%          |
| VENLAFAXINE HCL                   | 100                    | 60            | 101                      | 59   | 1.00%          |
| ATOMOXETINE HCL                   | 114                    | 55            | 95                       | 60   | -16.67%        |
| FUROSEMIDE                        | 95                     | 67            | 95                       | 61   | 0.00%          |
| CLONAZEPAM                        | 104                    | 58            | 94                       | 62   | -9.62%         |
| BACLOFEN                          | 122                    | 52            | 93                       | 63   | -23.77%        |
| MELOXICAM                         | 81                     | 75            | 92                       | 64   | 13.58%         |
| PRAZOSIN HCL                      | 90                     | 71            | 91                       | 65   | 1.11%          |
| AZITHROMYCIN                      | 161                    | 40            | 91                       | 66   | -43.48%        |
| SPIRONOLACTONE                    | 92                     | 70            | 90                       | 67   | -2.17%         |
| LORAZEPAM                         | 98                     | 63            | 89                       | 68   | -9.18%         |
| SULFAMETHOXAZOLE-TRIMETHOPRIM     | 96                     | 65            | 87                       | 69   | -9.38%         |
| TRAMADOL HCL                      | 96                     | 66            | 87                       | 70   | -9.38%         |
| DEXMETHYLPHENIDATE HCL            | 100                    | 62            | 87                       | 71   | -13.00%        |
| MOUNJARO                          | 67                     | 93            | 85                       | 72   | 26.87%         |
| NALTREXONE HCL                    | 72                     | 86            | 83                       | 73   | 15.28%         |
| PREGABALIN                        | 78                     | 78            | 83                       | 74   | 6.41%          |
| ZOLPIDEM TARTRATE                 | 77                     | 80            | 81                       | 75   | 5.19%          |
| ONDANSETRON HCL                   | 70                     | 91            | 80                       | 76   | 14.29%         |
| SYMBICORT                         | 77                     | 82            | 80                       | 77   | 3.90%          |
| FLUCONAZOLE                       | 70                     | 90            | 79                       | 78   | 12.86%         |
| TIZANIDINE HCL                    | 80                     | 76            | 77                       | 79   | -3.75%         |

### TOP 100 DRUGS BY PRESCRIPTION COUNT

| DRUG DESCRIPTION            | March through May 2026 | PREVIOUS RANK | June through August 2026 | RANK | PERCENT CHANGE |
|-----------------------------|------------------------|---------------|--------------------------|------|----------------|
| OLANZAPINE                  | 81                     | 73            | 77                       | 80   | -4.94%         |
| INSULIN LISPRO              | 73                     | 84            | 70                       | 81   | -4.11%         |
| SENNOSIDES                  | 68                     | 92            | 68                       | 82   | 0.00%          |
| DIVALPROEX SODIUM           | 79                     | 77            | 68                       | 83   | -13.92%        |
| GUANFACINE HCL              | 93                     | 69            | 67                       | 84   | -27.96%        |
| JORNAY PM                   | 72                     | 85            | 67                       | 85   | -6.94%         |
| NITROFURANTOIN MONOHD MACRO | 58                     | 98            | 65                       | 86   | 12.07%         |
| FOLIC ACID                  | 77                     | 79            | 65                       | 87   | -15.58%        |
| OXYBUTYNIN CHLORIDE         | 71                     | 87            | 64                       | 88   | -9.86%         |
| OXCARBAZEPINE               | 77                     | 81            | 62                       | 89   | -19.48%        |
| DOXYCYCLINE HYCLATE         | 65                     | 95            | 62                       | 90   | -4.62%         |
| WESTAB PLUS                 | 52                     | 106           | 61                       | 91   | 17.31%         |
| VRAYLAR                     | 62                     | 97            | 61                       | 92   | -1.61%         |
| NAPROXEN                    | 71                     | 88            | 61                       | 93   | -14.08%        |
| GLYCOPYRROLATE              | 71                     | 89            | 61                       | 94   | -14.08%        |
| DESVENLAFAXINE SUCCINATE    | 62                     | 96            | 59                       | 95   | -4.84%         |
| DIAZEPAM                    | 51                     | 108           | 58                       | 96   | 13.73%         |
| CLOBAZAM                    | 96                     | 64            | 57                       | 97   | -40.63%        |
| FARXIGA                     | 53                     | 104           | 57                       | 98   | 7.55%          |
| MUPIROCIN                   | 44                     | 116           | 56                       | 99   | 27.27%         |
| VALACYCLOVIR HCL            | 74                     | 83            | 56                       | 100  | -24.32%        |

Owner: Pam Smith

Creation Date: 10/21/2013

Author: Jon Ehle

Report Description: This report is a compilation of 11 different reports. Bi-monthly statistics are compiled for Utilization by Age, Top 100 Pharmacies by Prescription Count/Paid Amount, Top 100 Prescribers by Prescription Count/Paid Amount, Top 20 Drug Categories by Prescription Count/Paid Amount for GPI2, Top 20 Drug Categories by Prescription Count/Paid Amount for Drug Name, and the Top 100 Drugs by Paid Amount/Prescription Count.

|                                                        |                                                     |                                                    |                                                      |
|--------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|------------------------------------------------------|
| Report Period Default                                  | Claim Date used with parameters                     | GPI / NDC Criteria                                 | Plans                                                |
| <input type="checkbox"/> Daily                         | <input type="checkbox"/> Adjudication Date          | <input type="checkbox"/> Specify GPI / NDC         | <input type="checkbox"/> All Plans Included          |
| <input type="checkbox"/> Weekly                        | <input checked="" type="checkbox"/> Date of Service | <input type="checkbox"/> Exclude Non-Drugs         | <input checked="" type="checkbox"/> Exclude Plan 400 |
| <input type="checkbox"/> Monthly                       |                                                     | <input type="checkbox"/> Exclude Diabetic Supplies | <input type="checkbox"/> Exclude Plan 500            |
| <input type="checkbox"/> Quarterly                     | Reversals                                           | <input type="checkbox"/> Exclude Medical Devices   | <input type="checkbox"/> Exclude Plan 600            |
| <input type="checkbox"/> SFY                           | <input type="checkbox"/> Include                    |                                                    |                                                      |
| <input checked="" type="checkbox"/> Other - Bi-Monthly | <input checked="" type="checkbox"/> Exclude         |                                                    | <input type="checkbox"/> Non-Paid Claims Only        |

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**Medicaid Statistics for Prescription Claims**  
**June 2026 through August 2026**

**Tri-Monthly Statistics**

|                                    | FFS         | Wellpoint     | Iowa Total Care | Molina Healthcare | Total**       |
|------------------------------------|-------------|---------------|-----------------|-------------------|---------------|
| <b>Total Dollars Paid</b>          | \$3,410,496 | \$113,432,271 | \$92,622,647    | \$72,917,379      | \$282,382,793 |
| <b>Users</b>                       | 3,081       | 99,094        | 86,134          | 77,710            | 266,019       |
| <b>Cost Per User</b>               | \$1,106.94  | \$1,144.69    | \$1,075.33      | \$938.33          |               |
| <b>Total Prescriptions</b>         | 19,633      | 723,969       | 596,271         | 484,804           | 1,824,677     |
| <b>Average Rx/User</b>             | 6.37        | 7.31          | 6.92            | 6.24              |               |
| <b>Average Cost/Rx</b>             | \$173.71    | \$156.68      | \$155.34        | \$150.41          |               |
| <b># Generic Prescriptions</b>     | 17,437      | 638,009       | 530,069         | 431,300           |               |
| <b>% Generic</b>                   | 88.8%       | 88.2%         | 89.0%           | 89.0%             |               |
| <b>\$ Generic</b>                  | \$1,084,324 | \$13,467,613  | \$10,488,759    | \$8,317,241       |               |
| <b>Average Generic Rx Cost</b>     | \$62.19     | \$21.11       | \$19.79         | \$19.28           |               |
| <b>Average Generic Days Supply</b> | 31          | 31.96         | 31.78           | 31.77             |               |
| <b># Brand Prescriptions</b>       | 2,196       | 85,960        | 66,202          | 53,504            |               |
| <b>% Brand</b>                     | 11.2%       | 11.9%         | 11.0%           | 11.0%             |               |
| <b>\$ Brand</b>                    | \$2,326,172 | \$99,964,658  | \$82,133,887    | \$64,600,139      |               |
| <b>Average Brand Rx Cost</b>       | \$1,059.28  | \$1,162.92    | \$1,240.66      | \$1,207.39        |               |
| <b>Average Brand Days Supply</b>   | 28          | 28.0          | 29.47           | 28.6              |               |

\*\*All reported dollars are pre-rebate

**Top 20 Therapeutic Class by Paid Amount\***

June 2026 through August 2026

|    | FFS                                               | Wellpoint                                         | Iowa Total Care                                   | Molina Healthcare                                    |
|----|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|------------------------------------------------------|
| 1  | ANTIDIABETICS                                     | DERMATOLOGICALS                                   | ANTIDIABETICS                                     | DERMATOLOGICALS                                      |
| 2  | DERMATOLOGICALS                                   | ANTIDIABETICS                                     | DERMATOLOGICALS                                   | ANTIDIABETICS                                        |
| 3  | ANTIPSYCHOTICS/ANTIMANIC AGENTS                   | ANTIPSYCHOTICS/ANTIMANIC AGENTS                   | ANTIPSYCHOTICS/ANTIMANIC AGENTS                   | ANTIPSYCHOTICS/ANTIMANIC AGENTS                      |
| 4  | ANALGESICS - ANTI-INFLAMMATORY                    | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS     | ANALGESICS - ANTI-INFLAMMATORY                    | ANALGESICS - ANTI-INFLAMMATORY                       |
| 5  | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS     | ANALGESICS - ANTI-INFLAMMATORY                    | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS     | ADHD/ANTI-NARCOLEPSY AGENTS/ANTI-OBESITY-ANOREXIANTS |
| 6  | ANTIASTHMATIC AND BRONCHODILATOR AGENTS           | ANTIASTHMATIC AND BRONCHODILATOR AGENTS           | ANTIASTHMATIC AND BROCHODILATOR AGENTS            | ANTIASTHMATIC AND BRONCHODILATOR AGENTS              |
| 7  | ANTICONVULSANTS                                   | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | ANTIVIRALS                                           |
| 8  | ANTIDEPRESSANTS                                   | MIGRAINE PRODUCTS                                 | RESPIRATORY AGENTS - MISC.                        | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.    |
| 9  | NEUROMUSCULAR AGENTS                              | ANTICONVULSANTS                                   | ANTIVIRALS                                        | GASTROINTESTINAL AGENTS - MISC.                      |
| 10 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES          | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES          | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES             |
| 11 | ANTIVIRALS                                        | ENDOCRINE AND METABOLIC AGENTS - MISC.            | ENDOCRINE AND METABOLIC AGENTS - MISC.            | HEMATOLOGICAL AGENTS - MISC.                         |
| 12 | ANTIHYPERTENSIVES                                 | CARDIOVASCULAR AGENTS - MISC.                     | MIGRAINE PRODUCTS                                 | MIGRAINE PRODUCTS                                    |
| 13 | RESPIRATORY AGENTS - MISC.                        | ANTIVIRALS                                        | ANTICONVULSANTS                                   | RESPIRATORY AGENTS - MISC.                           |
| 14 | MIGRANE PRODUCTS                                  | HEMATOLOGICAL AGENTS - MISC.                      | HEMATOLOGICAL AGENTS - MISC.                      | ENDOCRINE AND METABOLIC AGENTS - MISC.               |
| 15 | HEMATOLOGICAL AGENTS - MISC.                      | GASTROINTESTINAL AGENTS - MISC.                   | NEUROMUSCULAR AGENTS                              | ANTICONVULSANTS                                      |
| 16 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS       | RESPIRATORY AGENTS - MISC.                        | GASTROINTESTINAL AGENTS - MISC.                   | ANTIDEPRESSANTS                                      |
| 17 | ANTHYPERLIPIDEMICS                                | ANTIDEPRESSANTS                                   | CARDIOVASCULAR AGENTS - MISC.                     | CARDIOVASCULAR AGENTS - MISC.                        |
| 18 | ANTIANKXIETY AGENTS                               | NEUROMUSCULAR AGENTS                              | ANTIDEPRESSANTS                                   | NEUROMUSCULAR AGENTS                                 |
| 19 | ANALGESICS - NONNARCOTIC                          | ANTICOAGULANTS                                    | ANTICOAGULANTS                                    | ANTICONVULSANTS                                      |
| 20 | ANTIENOPLASTICS AND ADJUNCTIVE AGENTS             | MISCELLANEOUS THERAPEUTIC CLASSES                 | MISCELLANDOUS THERAPEUTIC CLASSES                 | MISCELLANEOUS THERAPEUTIC CLASSES                    |

\* Pre-rebate

## Top 20 Therapeutic Class by Prescription Count

June 2026 through August 2026

|    | FFS                                           | Wellpoint                                     | Iowa Total Care                               | Molina Healthcare                             |
|----|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| 1  | ANTIDEPRESSANTS                               | ANTIDEPRESSANTS                               | ANTIDEPRESSANTS                               | ANTIDEPRESSANTS                               |
| 2  | ANTICONVULSANTS                               | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS |
| 3  | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | ANTICONVULSANTS                               | ANTICONVULSANTS                               | ANTICONVULSANTS                               |
| 4  | ANTIPSYCHOTICS/ANTIMANIC AGENTS               | ANTIASTHMATIC AND BRONCHODILATOR AGENTS       | ANTIASTHMATIC AND BRONCHODILATOR AGENTS       | ANTIASTHMATIC AND BRONCHODILATOR AGENTS       |
| 5  | ANTIDIABETICS                                 | ANTIPSYCHOTICS/ANTIMANIC AGENTS               | ANTIPSYCHOTICS/ ANTIMANIC AGENTS              | ANTIDIABETICS                                 |
| 6  | ANTIANKXIETY AGENTS                           | ANTIDIABETICS                                 | ANTIDIABETICS                                 | ANTIPSYCHOTICS/ANTIMANIC AGENTS               |
| 7  | ANTIASTHMATIC AND BRONCHODILATOR AGENTS       | ANTIANKXIETY AGENTS                           | ANTIANKXIETY AGENTS                           | ANTIANKXIETY AGENTS                           |
| 8  | ANTIHYPERTENSIVES                             | ANTIHYPERTENSIVES                             | ANTIHYPERTENSIVES                             | ANTIHYPERTENSIVES                             |
| 9  | ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS  | ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS | ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS | DERMATOLOGICALS                               |
| 10 | ANTIHISTAMINES                                | DERMATOLOGICALS                               | DERMATOLOGICALS                               | ULCER DRUGS/ ANTISPASMODICS/ ANTICHOLINERGICS |
| 11 | DERMATOLOGICALS                               | ANTIHISTAMINES                                | ANTIHISTAMINES                                | ANALGESICS - OPIOID                           |
| 12 | ANALGESICS - OPIOID                           | ANALGESICS - OPIOID                           | ANALGESICS - OPIOID                           | ANTIHISTAMINES                                |
| 13 | ANALGESICS - ANTI-INFLAMMATORY                | ANTIHYPERLIPIDEMICS                           | ANTIHYPERLIPIDEMICS                           | ANTIHYPERLIPIDEMICS                           |
| 14 | ANTIHYPERLIPIDEMICS                           | ANALGESICS - ANTI-INFLAMMATORY                | ANALGESICS - ANTI-INFLAMMATORY                | ANALGESICS - ANTI-INFLAMMATORY                |
| 15 | MUSCULOSKELETAL THERAPY AGENTS                | MUSCULOSKELETAL THERAPY AGENTS                | MUSCULOSKELETAL THERAPY AGENTS                | PENICILLINS                                   |
| 16 | BETA BLOCKERS                                 | BETA BLOCKERS                                 | BETA BLOCKERS                                 | MUSCULOSKELETAL THERAPY AGENTS                |
| 17 | PENICILLINS                                   | ANALGESICS - NONNARCOTIC                      | PENICILLINS                                   | BETA BLOCKERS                                 |
| 18 | LAXATIVES                                     | PENICILLINS                                   | ANALGESICS - NONNARCOTIC                      | CORTICOSTEROIDS                               |
| 19 | ANTI-INFECTIVE AGENTS - MISC.                 | HEMATOPOIETIC AGENTS                          | HEMATOPOIETIC AGENTS                          | ANALGESICS - NONNARCOTIC                      |
| 20 | ANALGESICS - NONNARCOTIC                      | CORTICOSTEROIDS                               | CORTICOSTEROIDS                               | ANTIEMETICS                                   |

## Top 25 Drugs by Paid Amount\*\*

June 2026 through August 2026

|    | FFS               | Wellpoint            | Iowa Total Care    | Molina Healthcare |
|----|-------------------|----------------------|--------------------|-------------------|
| 1  | HUMIRA PEN        | OZEMPIC              | OZEMPIC            | DUPIXENT          |
| 2  | OZEMPIC           | VRAYLAR              | DUPIXENT           | OZEMPIC           |
| 3  | EVRYSDI           | MOUNJARO             | VRAYLAR            | VRAYLAR           |
| 4  | DUPIXENT          | DUPIXENT PEN         | HUMIRA PEN         | MOUNJARO          |
| 5  | SKYRIZI PEN       | HUMIRA (CF) PEN      | TRIKAFTA           | SKYRIZI PEN       |
| 6  | VRAYLAR           | SKYRIZI PEN          | MOUNJARO           | HUMIRA (2 PEN)    |
| 7  | MOUNJARO          | ZEPBOUND             | DUVYZAT            | BIKTARVY          |
| 8  | TRIKAFTA          | INVEGA SUSTENNA      | SKYRIZI PEN        | ZEPBOUND          |
| 9  | COSENTYX UNOREADY | BIKTARVY             | INVEGA SUSTENNA    | TRIKAFTA          |
| 10 | INVEGA SUSTENNA   | TRIKAFTA             | ZEPBOUND           | INVEGA SUSTENNA   |
| 11 | JARDIANCE         | JARDIANCE            | BIKTARVY           | JARDIANCE         |
| 12 | HEMLIBRA          | CAPLYTA              | JARDIANCE          | SKYRIZI           |
| 13 | BIKTARVY          | REXULTI              | CAPLYTA            | DUVYZAT           |
| 14 | NUCALA            | RINVOQ               | INGREZZA           | CAPLYTA           |
| 15 | LISINOPRIL        | NURTEC ODT           | REXULTI            | COSENTYX UNOREADY |
| 16 | AUSTEDO XR        | STELARA              | DUPIXENT SYRINGE   | HEMLIBRA          |
| 17 | ARISTADA          | TALTZ AUTOINJECTOR   | TALTZ AUTOINJECTOR | ALTUVIIO          |
| 18 | ZEPBOUND          | WAKIX                | ARISTADA           | REXULTI           |
| 19 | TREMFYA           | SKYRIZI ON-BODY      | AUSTEDO XR         | TALTZ             |
| 20 | KESIMPTA          | DUPIXENT SYRINGE     | NURTEC ODT         | RINVOQ            |
| 21 | FILSUVEZ          | COSENTYX UNOREADY    | TRULICITY          | TRULICITY         |
| 22 | GOMEKLI           | TRULICITY            | RINVOQ             | ABILIFY MAINTENA  |
| 23 | CAPLYTA           | ALTUVIIO             | ELIQUIS            | NURTEC            |
| 24 | RINVOQ            | TRELEGY ELLIPTA      | TRELEGY ELLIPTA    | ELIQUIS           |
| 25 | REXULTI           | BIMZELX AUTOINJECTOR | COSENTYX UNOREADY  | ARISTADA          |

\*\* Pre-rebate

## Top 25 Drugs by Prescription Count

June 2026 through August 2026

|    | FFS                      | Wellpoint              | Iowa Total Care        | Molina Healthcare      |
|----|--------------------------|------------------------|------------------------|------------------------|
| 1  | ALBUTEROL                | TRAZODONE              | TRAZODONE              | TRAZODONE              |
| 2  | TRAZODONE                | BUPROPION XL           | ALBUTEROL HFA          | ALBUTEROL HFA          |
| 3  | CETIRIZINE               | ALBUTEROL HFA          | BUPROPION XL           | BUPROPION XL           |
| 4  | AMPHETAMINE/DEXTROAMPHET | SERTRALINE             | SERTRALINE             | HYDROXYZINE HCL        |
| 5  | HYDROXYZINE HCL          | HYDROXYZINE HCL        | HYDROXYZINE HCL        | GABAPENTIN             |
| 6  | GABAPENTIN               | GABAPENTIN             | GABAPENTIN             | SERTRALINE             |
| 7  | FLUOXETINE               | BUSPIRONE              | BUSPIRONE              | BUSPIRONE              |
| 8  | BUPROPION                | CETIRIZINE             | FLUOXETINE             | FLUOXETINE             |
| 9  | QUETIAPINE               | MONTELUKAST            | CETIRIZINE             | ESCITALOPRAM           |
| 10 | METHYLPHENIDATE          | FLUOXETINE             | OMEPRAZOLE             | ATORVASTATIN           |
| 11 | SERTRALINE               | OMEPRAZOLE             | MONTELUKAST            | AMOXICILLIN            |
| 12 | ARIPIRAZOLE              | ESCITALOPRAM           | ESCITALOPRAM           | OMEPRAZOLE             |
| 13 | ESCITALOPRAM             | ATORVASTATIN           | QUETIAPINE             | QUETIAPINE             |
| 14 | BUSPIRONE                | AMPHET/DEXTROAMPHET ER | ARIPIRAZOLE            | AMPHET/DEXTROAMPHET ER |
| 15 | OMEPRAZOLE               | QUETIAPINE             | AMOXICILLIN            | MONTELUKAST            |
| 16 | CLONIDINE                | ARIPIRAZOLE            | AMPHET/DEXTROAMPHET ER | ARIPIRAZOLE            |
| 17 | MONTELUKAST              | LEVOTHYROXINE          | ATORVASTATIN           | LEVOTHYROXINE          |
| 18 | METFORMIN                | LAMOTRIGINE            | LEVOTHYROXINE          | LAMOTRIGINE            |
| 19 | LAMOTRIGINE              | LISDEXAMFETAMINE       | LAMOTRIGINE            | LISDEXAMFETAMINE       |
| 20 | ATORVASTATIN             | AMOXICILLIN            | LISDEXAMFETAMINE       | PREDNISONE             |
| 21 | LEVOTHYROXINE            | CLONIDINE              | CLONIDINE              | ONDANSETRON            |
| 22 | POLYETHYLENE GLYCOL 3350 | TOPIRAMATE             | HYDROCODONE-APAP       | HYDROCODONE-APAP       |
| 23 | LEVETIRACETAM            | HYDROCODONE-APAP       | PREDNISONE             | CETIRIZINE             |
| 24 | FLUTICASONE PROP (NASAL) | ONDANSETRON ODT        | METHYLPHENIDATE ER     | LISINOPRIL             |
| 25 | IBUPROFEN                | CYCLOBENZAPRINE        | LISINOPRIL             | CYCLOBENZAPRINE        |

## **Adherence to Disease Modifying Therapy for Multiple Sclerosis RetroDUR Data**

### **Purpose**

- Evaluate the adherence of disease modifying therapies among members diagnosed with multiple sclerosis.

### **Background**

- Multiple sclerosis (MS), a chronic, immune-mediated disease of the central nervous system (CNS), is among the most common causes of neurological disability in young adults.
- MS is characterized by inflammation, demyelination, and degenerative changes in the CNS. Most patients with MS experience relapses and remissions of neurological symptoms, usually early in the disease process, with clinical events that are generally associated with CNS inflammation. There are 4 clinical subtypes of MS:
  - Relapsing-remitting MS (RRMS), which is characterized by acute attacks followed by partial or full recovery. This is the most common form of MS, accounting for an estimated 85% to 90% of cases.
  - Secondary progressive MS (SPMS) begins as RRMS, followed by gradual worsening, which may be accompanied by occasional relapses, remissions, and plateaus. Transition to SPMS from RRMS usually occurs after 10 to 20 years.
  - Primary progressive MS (PPMS) occurs in approximately 10% of patients with MS. Patients have a continuous and gradual decline in function without evidence of acute attacks.
  - Clinically isolated syndrome (CIS) refers to the first episode of neurologic symptoms that lasts at least 24 hours and is caused by inflammation or demyelination in the CNS. Patients who experience CIS may or may not develop MS.
- The approach to treating MS includes the management of symptoms, treatment of acute relapses, and utilization of disease-modifying therapies (DMTs) to reduce the frequency and severity of relapses, reduce lesions on MRI scans, and possibly delay disease and disability progression.
- The American Academy of Neurology (AAN), the European Committee for Treatment and Research of Multiple Sclerosis (ECTRIMS) and the European Academy of Neurology (EAN) guidelines recommend initiation of DMTs early in the patient's disease course.
- Maintaining high adherence to DMTs is essential for optimizing clinical outcomes. Evidence suggests that patients who remain adherent to treatment experience

better disease control, fewer relapses, slower accumulation of disability, and reduced rates of hospitalization.

- Adherence would be measured using the proportion of days covered (PDC) methodology. Patients with a PDC of  $\geq 80\%$  during the study period would be considered adherent.

| <b>Disease Modifying Therapies</b>     |
|----------------------------------------|
| Aubagio (teriflunomide)                |
| Avonex (interferon $\beta$ -1a)        |
| Bafiertam (monomethyl fumarate)        |
| Betaseron (interferon $\beta$ -1b)     |
| Copaxone, Glatopa (glatiramer acetate) |
| Gilenya (fingolimod)                   |
| Kesimpta (ofatumumab)                  |
| Mavenclad (cladribine)                 |
| Mayzent (siponimod)                    |
| Plegridy (peginterferon $\beta$ -1a)   |
| Ponvory (ponesimod)                    |
| Rebif (interferon $\beta$ -1a)         |
| Tascenso ODT (fingolimod)              |
| Tecfidera (dimethyl fumarate)          |
| Vumerity (diroximel fumarate)          |
| Zeposia (ozanimod)                     |

### **RDUR Criteria**

- Diagnosis of multiple sclerosis.
- At least 2 claims for a disease modifying therapy covered under the outpatient pharmacy program during the time period.
- Members must have continuous eligibility during the pharmacy claim lookback period.
- Time Period
  - Pharmacy Claims: February 1, 2026 – July 31, 2026
  - Medical Claims: June 1, 2024 – July 31, 2026

## Data

|                             | ITC | MOL | WLP | FFS |
|-----------------------------|-----|-----|-----|-----|
| Unique Members              | 69  | 28  | 48  | 1   |
| Members with PDC $\geq$ 80% | 35  | 22  | 34  | 1   |
| Members with PDC < 80%      | 7   | 6   | 14  | 0   |
| Unique Prescribers          | 27  | 27  | 29  | 1   |

## Next Steps

1. Send letters to prescribers for patients with a PDC < 80% to share adherence findings and suggest follow-up with the patient.
2. Other.
3. Nothing.

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**Drug-Disease Interaction:  
Thiazide Diuretic Use in Members with Gout  
RetroDUR  
Data**

**Purpose**

- Identify members with a diagnosis of gout who are receiving a thiazide or thiazide-like diuretic.

**Background**

- Gout is a common inflammatory arthritis caused by the deposition of monosodium urate crystals resulting from elevated serum uric acid concentrations.
- Acute gout flare can cause significant pain, reduced quality of life, and increased healthcare utilization.
- Effective management includes both treatment of acute flares and a reduction of modifiable risk factors for hyperuricemia.
- Thiazide and thiazide-like diuretics (hydrochlorothiazide, chlorothiazide, chlorthalidone, indapamide, and metolazone) are commonly used for the treatment of hypertension and edema, which can increase serum uric acid concentrations and have been associated with an increased risk of a gout flare.
- Clinical guidelines recommend considering comorbid conditions, including gout, when selecting antihypertensive therapy.

**RDUR Criteria**

- Identify members with a diagnosis of gout (acute and chronic) and at least one claim for a thiazide or thiazide-like diuretic.
- Time Period:
  - Pharmacy claims: February 1, 2026 – July 31, 2026
  - Medical claims: June 1, 2024 – July 31, 2026

## Data

### Thiazide or Thiazide-Like Diuretic Use Among Members with Gout

|                              | ITC | MOL | WLP | FFS |
|------------------------------|-----|-----|-----|-----|
| Number of Members            | 124 | 88  | 132 | 1   |
| Number of Unique Prescribers | 129 | 95  | 138 | 1   |

## Next Steps

1. Send letter to prescribers of members identified with gout who are receiving a thiazide or thiazide-like diuretic, highlighting the potential for hyperuricemia and gout exacerbation and suggest review of diuretic therapy.
2. DUR Digest article.
3. None.

## References

Stamp LK, Sterns RH. Diuretic-induced hyperuricemia and gout. UpToDate Website. Updated June 5, 2025. Accessed July 2, 2026. [www.uptodate.com](http://www.uptodate.com).

FitzGerald JD, Dalbeth N, Mikuls T, Brignardello-Petersen R, Guyatt G, Abeles AM, et al. 2020 American College of Rheumatology Guideline for the Management of Gout. *Arthritis Care Res (Hoboken)*. 2020;72(6):744-760. doi:10.1002/acr.24180.

## **Evaluation of Concurrent ACE Inhibitor/ARB, Diuretic, and NSAID Utilization and Associated Risk for Acute Kidney Injury**

### **Purpose**

- To evaluate members receiving concurrent therapy with an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), a diuretic, and a nonsteroidal anti-inflammatory drug (NSAID). This combination is associated with an increased risk of acute kidney injury (AKI) due to its combined effects on renal blood flow and glomerular filtration.

### **Background**

- ACE inhibitors and ARBs are commonly prescribed for hypertension, heart failure, diabetes, and chronic kidney disease (CKD).
- Diuretics are commonly prescribed for blood pressure control and volume management.
- NSAIDs are widely used for pain and inflammatory conditions.
- The combination of these agents may adversely affect kidney function through complementary mechanisms.
  - ACE inhibitors and ARBs dilate the efferent arteriole, reducing intraglomerular pressure.
  - Diuretics may contribute to intravascular volume depletion.
  - NSAIDs inhibit prostaglandin-mediated vasodilation of the afferent arteriole, reducing renal blood flow.
- When used concurrently, these effects may result in a significant decline in glomerular filtration and increase the risk of AKI.

### **Potential RDUR Criteria**

- Members  $\geq 18$  years of age
- At least one paid pharmacy claim for an ACE inhibitor or ARB + diuretic + NSAID with at least 30 days of consecutive days of overlapping therapy.
- Time period: July 1, 2026 through September 30, 2026
- Report
  - Number of members
  - Number of unique prescribers

### **References**

Lapi F, Azoulay L, Yin H, Nessim SJ, Suissa S. Concurrent use of diuretics, angiotensin converting enzyme inhibitors, angiotensin receptor blockers, and non-steroidal anti-inflammatory drugs and risk of acute kidney injury: nested case-control study. *BMJ*. 2013;346:e8525. doi:10.1136/bmj.e8525.

Lapi F, Azoulay L, Yin H, Nessim SJ, Suissa S. Triple therapy with diuretics, ACE inhibitors or angiotensin receptor blockers, and NSAIDs and the risk of acute kidney injury. *BMJ*. 2013;346:e8525.

Dreischulte T, Morales DR, Bell S, Guthrie B. Combined use of nonsteroidal anti-inflammatory drugs with diuretics and renin-angiotensin system inhibitors in the community increases the risk of acute kidney injury. *Kidney International*. 2015;88(2):396-403.

Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. *Kidney Int Suppl*. 2024 Update.

## **Recurrent Genitourinary Infections in Members Receiving an SGLT2 Inhibitor**

### **Purpose**

- Identify members receiving a sodium-glucose cotransporter 2 (SGLT2) inhibitor who experience recurrent genitourinary (GU) infections.

### **Background**

- SGLT2 inhibitors increase urinary glucose excretion and provide important glycemic, cardiovascular, heart failure, and kidney benefits.
- GU infections, including genital mycotic infections, are described in SGLT2 inhibitor prescribing information, with genital mycotic infections being the most common adverse reaction listed.
- Most GU infections associated with SGLT2 inhibitors are mild to moderate and respond to standard antimicrobial treatment, without the need to discontinue treatment.
- Patients with a history of GU infections are more likely to develop GU infections while using an SGLT2 inhibitor.
- Patients should be monitored for signs and symptoms of GU infections and treated promptly, if indicated.
- Recurrent infections are defined as more than three episodes per year.
- Recurrent infections may affect comfort, adherence, and continued treatment.
- Reinforcing perineal hygiene reduces the incidence of genital infections.

### **Potential RDUR Criteria**

- Continuous eligibility during the pharmacy and medical claims periods
- Identify members with at least two paid pharmacy claims for an SGLT2 inhibitor
- Identify members with at least two GU infection episodes on separate dates of service, at least 30 days apart, with at least one episode occurring during SGLT2 inhibitor exposure
- Time period:
  - Pharmacy claims: April 1, 2026 through September 30, 2026
  - Medical claims: October 1, 2025 through September 30, 2026
- Report:
  - Number of members with 2 episodes and  $\geq 3$  episodes
  - Number of unique prescribers

### **References**

Gorgojo-Martínez JJ, Górriz JL, Cebrián-Cuenca A, et al. Clinical recommendations for managing genitourinary adverse effects in patients treated with SGLT-2 inhibitors: a multidisciplinary expert consensus. J Clin Med. 2024;13(21):6509. doi:10.3390/jcm13216509.

## **Journavx Age Edit Review ProDUR**

### **Background**

- Journavx (suzetrigine) is a non-opioid sodium channel blocker indicated for the treatment of moderate to severe acute pain, including postoperative pain, in adults.
  - The FDA-approved indication is limited to adults; the safety and effectiveness of suzetrigine has not been established in pediatric patients.
  - Use of Journavx for the treatment of acute pain has not been studied beyond 14 days.
- Journavx is currently preferred on the Preferred Drug List (PDL) and does not require prior authorization (PA).
  - Coverage is limited to a 14-day supply per 60 days.
  - There is currently no age edit to prevent claims for members younger than 18 years of age from processing at the point of sale (POS).
- Because the drug is available without PA, adding a minimum age edit would align with the FDA-approved adult population.

### **Items to Consider**

- Add a minimum age edit of 18 years.
  - Aligns coverage with the FDA-approved adult population.
  - Claims for members younger than 18 years of age would reject at the POS.
- Maintain the current coverage requirements without an age edit.
  - Claims would continue to be subject to the existing limit of a 14-day supply per 60 days, regardless of member age.

### **References**

Journavx (suzetrigine) tablets. Prescribing information. Vertex Pharmaceuticals Incorporated; revised 2026.

## **Tramadol Quantity Limit Review ProDUR**

### **Background**

- FDA approved dosing for tramadol 50 mg tablets allows dosing of 50 to 100 mg every 4 to 6 hours as needed.
  - The maximum recommended daily dose is 400 mg per day (8 tablets per day).
- Tramadol 50 mg tablets are subject to a quantity limit of 6 tablets per day, implemented on October 1, 2020 as part of a broader initiative to limit short-acting opioids to a maximum of 6 units per day.
  - Claims exceeding the current quantity limit are rejected and require prior authorization.
  - Prior authorization requests for a quantity of 7 or 8 tablets per day are consistently approved when the request meets all other applicable requirements, including the minimum age requirement of 18 and the morphine milligram equivalent (MME) limit of 90 MME per day.
- The current quantity limit does not accommodate the maximum recommended dose.
- The SUPPORT Act requires states to monitor opioid prescribing.
  - One requirement is to review prescriptions that exceed established quantity limits.
  - Tramadol 50 mg tablet consistently appears on the report at quantities of 7 or 8 tablets per day.
  - During review of the most current SUPPORT Act reports across both FFS and MCO populations, the high number of tramadol claims identified on the report was discussed.
    - Based on this discussion, a recommendation was made to present the tramadol 50 mg tablet quantity limit to the DUR Commission for review and consideration of increasing the quantity limit.

### **Items to Consider**

- Increase quantity limit to 8 tablets per day.
  - Aligns with the FDA approved maximum daily dose.
  - Reduces quantity limit prior authorization requests and the administrative burden for providers.
- Maintain current quantity limit of 6 tablets per day.
  - Continues the current approach applied broadly to short-acting opioids.

## **Ezetimibe Statin Claims History Edit Review ProDUR**

### **Background**

- In 2013, the Drug Utilization Review (DUR) Commission reviewed ezetimibe because, although ezetimibe lowered lipid levels as monotherapy and in combination with simvastatin, evidence available at that time had not established an effect on cardiovascular morbidity or mortality.
  - The review followed referral by the Pharmacy and Therapeutics (P&T) Committee to consider whether ezetimibe (Zetia®) and ezetimibe/simvastatin (Vytorin®) should remain preferred on the Preferred Drug List (PDL) or whether statin step therapy should be required before ezetimibe use.
  - The resulting point-of-sale (POS) edit prevents an ezetimibe claim from paying unless a statin is identified in the member's pharmacy claims history.
- The evidence and regulatory context have changed since the original review.
  - Current FDA labeling permits ezetimibe with a statin, or alone when additional low-density lipoprotein cholesterol (LDL-C) lowering therapy is not possible, as an adjunct to diet for adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia.
  - In 2023, FDA approved labeling revisions clarifying that ezetimibe monotherapy is appropriate when other additional concomitant LDL-C lowering therapy, including statin or proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor therapy, is not possible. The former limitation stating that an effect on cardiovascular morbidity and mortality had not been determined was removed.
- Current guidelines continue to identify statins as foundational first-line lipid-lowering therapy for most patients while recognizing nonstatin therapy when statins cannot be used or tolerated or when LDL-C goals are not achieved.
  - The 2026 ACC/AHA multi-society dyslipidemia guideline includes treatment pathways for statin intolerance and selection of nonstatin therapy based on cardiovascular risk, LDL-C goals, response, tolerability, cost, and access.

### **Items to Consider**

- **Remove the statin claims-history edit.**
  - Allows ezetimibe claims to process without a statin identified in POS claims history.
  - Recognizes current FDA labeling, available outcomes evidence, and guideline-supported use of nonstatin therapy when statin treatment is not possible.

- Avoids delays for patients whose prior statin use, intolerance, or contraindication cannot be determined from pharmacy claims.
- **Maintain the current edit without change.**
  - Continues to encourage statin use before ezetimibe but may reject FDA-labeled and guideline-consistent monotherapy when no statin claim is visible.

## **References**

Zetia (ezetimibe) tablets. Prescribing information. Organon LLC; revised 2024.

U.S. Food and Drug Administration. Supplemental approval for Zetia (ezetimibe), NDA 021445/S-042. Approved July 19, 2023.

Blumenthal RS, Morris PB, et al. 2026 ACC/AHA multisociety guideline on the management of dyslipidemia. American Heart Association; 2026.

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

Updated 10/01/2026

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| <b>Acute Migraine Treatments</b><br><br><i>Use Acute Migraine Treatments PA form</i> | <p>No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions:</p> <ol style="list-style-type: none"> <li>1. A diagnosis of acute migraine; and</li> <li>2. Patient meets the FDA approved age for requested agent; and</li> <li>3. For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or</li> <li>4. For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or</li> <li>5. For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or</li> <li>6. For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                              |
| <b>ADD/ADHD/ NARCOLEPSY AGENTS</b><br><br><i>Use CNS Stimulants PA form</i>          | <p><i>See CNS Stimulants Prior Authorization (PA) Criteria.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors</b>                         | <p>Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indications(s), including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to lipid lowering medication therapy; and</li> <li>3. Patient will continue to follow an appropriate low-fat diet; and</li> <li>4. Patient has one of the following diagnoses: <ol style="list-style-type: none"> <li>a. Heterozygous familial hypercholesterolemia (HeFH); or</li> <li>b. Primary hyperlipidemia; or</li> <li>c. Established cardiovascular disease (CVD) (e.g. previous myocardial infarction, history of an acute coronary syndrome, angina, previous stroke or transient ischemic attack, coronary artery disease, peripheral arterial disease, coronary or other arterial revascularization); or</li> <li>d. At risk for a CVD event but without established CVD (e.g. diabetes mellitus (type 1 or 2), a Reynolds Risk score &gt; 20% or a SCORE Risk score &gt; 7.5% over 10 years, a coronary artery calcium score &gt; 300 Agatston units); and</li> </ol> </li> <li>5. Meets one of the following: <ol style="list-style-type: none"> <li>a. Patient must be adherent to lipid lowering medication therapy and is unable to reach LDL-C goal with a minimum of two separate,</li> </ol> </li> </ol> |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><i>Use Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors PA form</i></p>                                       | <p>chemically distinct statin trials, including atorvastatin and rosuvastatin, at maximally tolerated doses, used in combination with ezetimibe for a minimum of 90 consecutive days; or</p> <ol style="list-style-type: none"> <li>b. Patient is statin intolerant as documented by an inability to tolerate at least two chemically distinct statins; or</li> <li>c. Patient has an FDA labeled contraindications to all statins; and</li> </ol> <p>6. Goal is defined as a 50% reduction in untreated baseline LDL-C.</p> <p>7. Concurrent use with a PCSK9 inhibitor will not be considered.</p> <p>If criteria for coverage are met, requests will be approved for 3 months. Additional authorizations will be considered at yearly intervals under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient continues with lipid lowering therapy at a maximally tolerated dose; or</li> <li>2. Patient is intolerant to or has a contraindication to statins; and</li> <li>3. Patient continues to follow an appropriate low-fat diet; and</li> <li>4. Documentation of a positive response to therapy (e.g., LDL-C reduction).</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                               |
| <p><b>Age Edit Override – Codeine or Tramadol</b></p> <p><i>Use Age Edit Override-Codeine or Tramadol PA form</i></p> | <p>An age edit override for codeine or tramadol is required for patients under 18 years of age. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Member is 12 years of age or older; and</li> <li>2. Medication is not being prescribed to treat pain after surgery following tonsil and/or adenoid procedure for members 12 to 18 years of age; and</li> <li>3. If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m<sup>2</sup>), does not have obstructive sleep apnea, or severe lung disease.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p><b>Alpelisib (Vijoice)</b></p> <p><i>Use Alpelisib (Vijoice) PA form</i></p>                                       | <p>Prior authorization (PA) is required for alpelisib (Vijoice). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing demonstrating a <i>PIK3CA</i> mutation; and</li> <li>3. Patient's condition is severe or life-threatening requiring systemic therapy as determined by treating prescriber: and</li> <li>4. Patient has at least one target lesion identified on imaging.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by a reduction in sum of measurable lesion volume across 1 to 3 target lesions.</p> |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Alpha<sub>1</sub>-Proteinase Inhibitor Enzymes</b></p> <p><i>Use Alpha<sub>1</sub>-Proteinase Inhibitor Enzymes PA form</i></p> | <p>Prior authorization (PA) is required for Alpha<sub>1</sub>-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha<sub>1</sub>-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of congenital alpha<sub>1</sub>-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or <ol style="list-style-type: none"> <li>a. 80mg/dl if measured by radial immunodiffusion, or</li> <li>b. 50mg/dl if measured by nephelometry; and</li> </ol> </li> <li>2. Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and</li> <li>3. Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV<sub>1</sub>); and</li> <li>4. Patient is 18 years of age or older;and</li> <li>5. Patient is currently a non-smoker; and</li> <li>6. Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and</li> <li>7. Medication will be administered in the member's home by home health or in a long-term care facility.</li> </ol> <p>If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Evidence of clinical efficacy, as documented by: <ol style="list-style-type: none"> <li>a. An elevation of AAT levels (above protective threshold i.e., &gt; 11µM/L); and</li> <li>b. A reduction in rate of deterioration of lung function as measured by a decrease in the FEV<sub>1</sub> rate of decline; and</li> </ol> </li> <li>2. Patient continues to be a non-smoker; and</li> <li>3. Patient continues supportive therapy for obstructive lung disease.</li> </ol> |
| <p><b>Amylino Mimetic (Symlin)</b></p> <p><i>Use Amylino Mimetic (Symlin) PA form</i></p>                                             | <p>Prior authorization (PA) is required for amylin mimetics (Symlin). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of Type 1 or Type 2 diabetes mellitus,</li> <li>2. Concurrent use of insulin therapy,</li> <li>3. Documentation of blood glucose monitoring three or more times daily,</li> <li>4. Inadequate reduction in HbA1C despite multiple titration with basal/bolus insulin dosing regimens.</li> </ol> <p>Initial authorizations will be approved for six months; additional PAs will be considered on an individual basis after review of medical necessity and documented improvement in HbA1C since the beginning of the initial PA period.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Antidepressants</b></p> <p><i>Aplenzin</i><br/><i>Auvelity</i><br/><i>Fetzima</i></p> <p><i>Use Antidepressants PA form</i></p> | <p>Prior authorization (PA) is required for non-preferred antidepressants subject to clinical criteria. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and</li> <li>3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and</li> <li>4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant; and</li> <li>5. Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and</li> <li>6. Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and</li> <li>7. Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and</li> <li>8. If the request is for dextromethorphan and bupropion extended-release tablet (Auvelity), one of the trials must include a previous trial and inadequate response at a therapeutic dose with an extended-release bupropion agent; and</li> <li>9. If the request is for an isomer, prodrug or metabolite of the requested medication, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Anti-Diabetics, Non-Insulin Agents</b></p> <p><i>Use Anti-Diabetics, Non-Insulin PA form</i></p>                                | <p>Prior authorization (PA) is required for select preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and</li> <li>3. Requests for combination therapy with a DPP-4 inhibitor containing agent with a GLP-1 receptor agonist containing agent will not be considered; and</li> <li>4. Requests for non-preferred antidiabetic, non-insulin agents subject to clinical criteria, will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Additionally, requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with at least 3 preferred agents from 3 different drug classes at maximally tolerated doses.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>Requests for weight loss, which is not a covered diagnosis of use, will be denied.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Antiemetic-5HT3 Receptor Antagonists/<br/>Substance P<br/>Neurokinin Agents</b></p> | <p>Prior authorization (PA) is required for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin agents under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication(s), including age, dosing, contraindications, warnings and precautions, drug interactions, and use in special populations.</li> <li>2. Requests for a non-preferred Antiemetic-5HT3 Receptor Antagonist/Substance P Neurokinin agent must document a previous trial and therapy failure with a preferred agent in this class, unless otherwise stated in criteria.</li> <li>3. Requests for aprepitant (Emend) will only be considered when used in combination with other antiemetic agents (5HT3 agent and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.</li> <li>4. Requests for tradipitant (Nereus) will be considered under the following conditions: <ol style="list-style-type: none"> <li>a. Is prescribed for the prevention of motion-induced vomiting; and</li> <li>b. Member has a planned event expected to cause vomiting induced by motion; and</li> <li>c. Documentation of a previous trial and therapy failure with transdermal scopolamine; and</li> <li>d. Documentation of previous trials and therapy failures with 2 antihistamines used for motion sickness (e.g., diphenhydramine, meclizine, promethazine); and</li> <li>e. Request is for the maximum number of days of the planned event expected to cause vomiting induced by motion.</li> <li>f. Requests for more than 90 doses per 365-day period will not be considered.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Anti-Fungal- Oral /<br/>Injectable</b></p> <p><i>Use Anti-Fungal PA form</i></p>    | <p>Prior authorization (PA) is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. PA will be required for all non-preferred antifungal therapy beginning the first day of therapy. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for any antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This PA requirement does not apply to nystatin.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Antihistamines</b></p> <p><i>Use Antihistamine PA form</i></p>                      | <p>Prior authorization (PA) is required for all non-preferred oral antihistamines.</p> <p>Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require PA, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.</p> <p>Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

| Updated 10/01/2020                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| <b>Apolipoprotein C-III (ApoC-III) Inhibitors</b>                            | <p>Prior authorization (PA) is required for apoC-III inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic testing, (e.g., biallelic pathogenic variants in FCS-causing genes [LPL, GPIHBP1, APOA5, APOC2, or LMF1]) (attach genetic testing results); and</li> <li>3. The patient has a current fasting triglyceride level of 880 mg/dL or greater (attach current lipid panel obtained within the past 30 days); and</li> <li>4. The patient will use medication in combination with a low-fat diet (<math>\leq 20</math> grams of total fat per day); and</li> <li>5. Medication will not be used concomitantly with other apoC-III inhibitors; and</li> <li>6. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.</li> </ol> <p>If the criteria for coverage are met, initial requests will be given for 12 months. Requests for continuation of therapy will be considered at 12-month intervals under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Documentation of a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days); and</li> <li>2. Patient continues to use medication in combination with a low-fat diet (<math>\leq 20</math> grams of total fat per day); and</li> </ol> <p>Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.</p> |
| <b>Apremilast (Otezla)</b><br><br><i>Use Apremilast (Otezla)<br/>PA form</i> | <p>Prior authorization (PA) is required for apremilast (Otezla). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and</li> <li>2. Patient has a diagnosis of active psoriatic arthritis (<math>\geq 3</math> swollen joints and <math>\geq 3</math> tender joints); with             <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or</li> </ol> </li> <li>3. Patient has a diagnosis of plaque psoriasis; with             <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; or</li> </ol> </li> <li>4. Patient has a diagnosis of Behçet disease; with             <ol style="list-style-type: none"> <li>a. Documentation of active oral ulcers associated with Behçet disease; and</li> <li>b. Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Aprocitentan (Tryvio)</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Aprocitentan (Tryvio) PA form</i></p> | <div style="text-align: right; font-size: small;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for aprocitentan (Tryvio). Requests for non-preferred agents will be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered for an FDA approved or compendia indications diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of resistant hypertension; and</li> <li>3. Secondary causes of hypertension have been ruled out; and</li> <li>4. Patient has been adherent with standard background antihypertensive therapy, which includes at least one agent from each of the following classes, taken concurrently at maximally tolerated doses:             <ol style="list-style-type: none"> <li>a. Angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB);</li> <li>b. Calcium Channel-blockers (CCB);</li> <li>c. Diuretics;</li> <li>d. Mineralocorticoid receptor antagonist (MRA); and</li> </ol> </li> <li>5. Patient's blood pressure remains above target goal despite adherence with the above agents; and</li> <li>6. Will be used in combination with at least three other antihypertensive agents at maximally tolerated doses.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Aripiprazole Tablets with Sensor (Abilify MyCite)</b></p> <p><i>Use Aripiprazole Tablets with Sensor (Abilify MyCite) PA form</i></p> | <p>Prior authorization is required for aripiprazole tablets with sensor (Abilify MyCite). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of Schizophrenia, Bipolar I Disorder, or Major Depressive Disorder; and</li> <li>2. Patient meets the FDA approved age for use of the Abilify MyCite device; and</li> <li>3. Dosing follows the FDA approved dose for the submitted diagnosis; and</li> <li>4. Documentation of patient adherence to generic aripiprazole tablets is less than 80% within the past 6 months (prescriber must provide documentation of the previous 6 months' worth of pharmacy claims for aripiprazole documenting non-adherence); and</li> <li>5. Documentation all the following strategies to improve patient adherence have been tried without success: <ol style="list-style-type: none"> <li>a. Utilization of a pill box</li> <li>b. Utilization of a reminder device (e.g. alarm, application, or text reminder)</li> <li>c. Involving family members or friends to assist</li> <li>d. Coordinating timing of dose with dosing of another daily medication; and</li> </ol> </li> <li>6. Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; and</li> <li>7. Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite. Initial approvals will be given for one month. Prescriber must review member adherence in the web-based portal and document adherence for additional consideration. If non-adherence continues, prescriber must document a plan to improve adherence. If adherence is improved, consideration to switch member to generic aripiprazole tablets must be considered. Note, the ability of Abilify MyCite to improve patient compliance has not been established,</li> <li>8. Requests will not be considered for patients in long-term care facilities.</li> <li>9. A once per lifetime approval will be allowed.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Baclofen</b></p> <p><i>Use Baclofen PA form</i></p>                                                                                   | <p>Prior authorization (PA) is required for non-preferred baclofen dosage forms. Payment for a non-preferred agent will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of spasticity resulting from multiple sclerosis (relief of flexor spasms and concomitant pain, clonus, and muscular rigidity) or spinal cord injuries/diseases; and</li> <li>2. Patient meets the FDA approved age; and</li> <li>3. Documentation of a patient-specific, clinically significant reason (beyond convenience) why the member cannot use baclofen oral tablets, even when tablets are crushed and sprinkled on soft food or liquid. Presence of a nasogastric (NG) tube/J-tube alone are not reasons for approval; and</li> <li>4. Request does not exceed the maximum dosage of 80mg daily.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Benzodiazepines</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Benzodiazepine PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member.</p> <p>PA will be approved for up to 12 months for documented:</p> <ol style="list-style-type: none"> <li>Generalized anxiety disorder.</li> <li>Panic attack with or without agoraphobia.</li> <li>Seizure.</li> <li>Non-progressive motor disorder.</li> <li>Dystonia.</li> </ol> <p>PA requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines.</p> <p>For patients taking concurrent opioids, the prescriber must document the following:</p> <ol style="list-style-type: none"> <li>The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and</li> <li>Documentation as to why concurrent use is medically necessary is provided; and</li> <li>A plan to taper the opioid or benzodiazepine is provided, if appropriate.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Biologicals for Arthritis</b></p> <p><i>Use Biologicals for Arthritis PA form</i></p> | <p>Prior authorization (PA) is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of rheumatoid arthritis (RA); with             <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxychloroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated); or</li> </ol> </li> <li>2. Patient has a diagnosis of moderate to severe psoriatic arthritis; with             <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or</li> </ol> </li> <li>3. Patient has a diagnosis of juvenile idiopathic arthritis with oligoarthritis; with             <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or</li> </ol> </li> <li>4. Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (pJIA); with             <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response to methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or</li> </ol> </li> <li>5. Patient has a diagnosis of systemic juvenile idiopathic arthritis (sJIA).</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

| <p>Updated 10/01/2020</p>                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| <p><b>Biologicals for Axial Spondyloarthritis</b></p> <p><i>Use Biologicals for Axial Spondyloarthritis PA form</i></p>       | <p>Prior authorization (PA) is required for biologicals used for axial spondyloarthritis conditions. Request must adhere to all approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of:               <ol style="list-style-type: none"> <li>a. ankylosing spondylitis (AS) or</li> <li>b. nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and</li> </ol> </li> <li>2. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration; and</li> <li>3. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and</li> <li>4. Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Biologicals for Inflammatory Bowel Disease</b></p> <p><i>Use Biologicals for Inflammatory Bowel Disease PA form</i></p> | <p>Prior authorization (PA) is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of moderate to severe Crohn's Disease; or</li> <li>2. Patient has a diagnosis of moderate to severe Ulcerative Colitis; and</li> <li>3. Medication will be administered in the patient's home by patient or patient's caregiver.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

| Updated 10/01/2020                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| <p><b>Biologicals for Hidradenitis Suppurativa</b></p><br><br><br><br><br><p><i>Use Biologicals for Hidradenitis Suppurativa PA form</i></p> | <p>Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent.</p> <p>Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and</li> <li>3. Patient has documentation of an adequate trial and therapy failure with at least one oral antibiotic/oral antibiotic combination (e.g., doxycycline, clindamycin, rifampin).</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 4 months. Additional authorizations will be considered upon documentation of a positive response to therapy.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Biologicals for Plaque Psoriasis</b></p><br><br><br><br><br><p><i>Use Biologicals for Plaque Psoriasis PA form</i></p>                 | <p>Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non- preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of moderate to severe plaque psoriasis; and</li> <li>2. Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                              |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

| <div> <div></div> <div>Updated 10/04/2023</div> </div>                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| <div> <div><b>Brenoscaticib (Brinsupri)</b></div> <div> <div></div> <div>Use Brenoscaticib (Brinsupri) PA form</div> </div> </div> | <div> <p>Prior authorization (PA) is required for brenoscaticib (Brinsupri). Payment will be considered for an FDA approved or compendia indicated diagnosis when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest CT scan; and</li> <li>3. Patient is 18 years of age or older with a history of <math>\geq 2</math> pulmonary exacerbations requiring antibiotic treatment in the previous 12 months; or</li> <li>4. Patient is 12 to 17 years of age with <math>\geq 1</math> pulmonary exacerbation requiring antibiotic treatment in the previous 12 months; and</li> <li>5. Patient has experienced at least 2 of the following symptoms in the previous 12 months: cough, chronic sputum production, and/or chronic respiratory infections; and</li> <li>6. Patient has been counseled on the importance of abstinence from tobacco and, if a current smoker, been encouraged to enroll in a smoking cessation program; and</li> <li>7. Is prescribed by or in consultation with a pulmonologist or infectious disease specialist.</li> </ol> <p>Initial requests will be approved for 12 months. Additional authorizations will be considered annually with documentation of a positive clinical response to therapy, demonstrated by at least one of the following:</p> <ol style="list-style-type: none"> <li>1. Improvement in or stabilization of symptoms; or</li> <li>2. Reduction in or stabilization of the frequency, severity, or duration of exacerbations; or</li> <li>3. Reduction in the decline of FEV<sub>1</sub>.</li> </ol> </div> |
| <div> <div><b>Calcifediol (Ryaldee)</b></div> <div> <div></div> <div>Use Calcifediol (Ryaldee) PA form</div> </div> </div>         | <div> <p>Prior authorization (PA) is required for calcifediol (Ryaldee). Initial requests will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient is 18 years of age or older; and</li> <li>2. Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) as documented by a current glomerular filtration rate (GFR); and</li> <li>3. Patient is not on dialysis; and</li> <li>4. Patient has a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL within the past 3 months; and</li> <li>5. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with a preferred vitamin D analog for a minimum of 3 months.</li> <li>6. Initial requests will be considered for a dose of 30 mcg once daily for 3 months.</li> </ol> <p>Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) documented by a current glomerular filtration rate (GFR); and</li> <li>2. Patient has a serum total 25-hydroxyvitamin D level between 30 and 100 ng/mL, a serum corrected total calcium below 9.8 mg/dL, and a serum phosphorus below 5.5 mg/dL.</li> </ol> </div>                                                                                                                                                                                                                                                                                                                                                                          |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Cardiac Myosin Inhibitors</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Cardiac Myosin Inhibitors PA form</i></p> | <div style="text-align: right;">Updated 10/01/2028</div> <p>Prior authorization (PA) is required for cardiac myosin inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and</li> <li>3. Patient exhibits symptoms of New York Heart Association (NYHA) class II or III symptoms; and</li> <li>4. Is prescribed by or in consultation with a cardiologist; and</li> <li>5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and</li> <li>6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and</li> <li>7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:             <ol style="list-style-type: none"> <li>a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and</li> <li>b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and</li> <li>c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker; and</li> </ol> </li> <li>8. Will not be used in combination with another cardiac myosin inhibitor.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.</p> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Cholic Acid (Cholbam)</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Cholic Acid (Cholbam) PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for cholic acid (Cholbam). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>Is prescribed by a hepatologist or pediatric gastroenterologist; and</li> <li>Is prescribed for a diagnosis of bile acid synthesis disorder due to a single enzyme defect (SED) including:             <ol style="list-style-type: none"> <li>3-beta-hydroxy-delta-5C27-steroid oxidoreductase deficiency (3β-HSD),</li> <li>aldo-keto reductase 1D1 (AKR1D1),</li> <li>alpha-methylacyl-CoA racemase deficiency (AMACR deficiency),</li> <li>sterol 27-hydroxylase deficiency (cerebrotendinous xanthomatosis [CTX]),</li> <li>cytochrome P450 7A1 (CYP7A1),</li> <li>25-hydroxylation pathway (Smith-Lemli-Opitz); OR</li> </ol> </li> <li>Is prescribed as an adjunctive treatment of a peroxisomal disorder (PD) in patients who exhibit manifestations of liver disease, steatorrhea, or complications from fat soluble vitamin absorption. Peroxisomal disorders include Zellweger syndrome (ZWS), neonatal adrenoleukodystrophy (NALD), or infantile refsum disease (IRD); and</li> <li>Diagnosis is confirmed by mass spectrometry or other biochemical testing or genetic testing (attach results); and</li> <li>Baseline liver function tests are taken prior to initiation of therapy (AST, ALT, GGT, ALP, total bilirubin, INR) and provided with request; and</li> <li>Patient must have elevated serum aminotransferases (AST and ALT) with normal serum gamma glutamyltransferase (GTT); and</li> <li>Patient is at least 3 weeks old.</li> </ol> <p>When criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 12 months at a time requiring documentation of response to therapy by meeting two of the following criteria:</p> <ol style="list-style-type: none"> <li>Body weight has increased by 10% or is stable at ≥50<sup>th</sup> percentile,</li> <li>Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) &lt; 50 U/L or baseline levels reduced by 80%,</li> <li>Total bilirubin level reduced to ≤1mg/dL.</li> </ol> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <b>CNS Stimulants</b> | <p>Prior authorization (PA) is required for CNS stimulants for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for CNS stimulants will be considered when patient has an FDA approved or compendia indication for requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (<math>\geq 21</math> years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening, and will be limited to one unit dose per day. Children (<math>&lt; 21</math> years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. Use of an amphetamine agent plus a methylphenidate agent will not be considered for a diagnosis of ADHD.</li> <li>2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG).</li> <li>3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.</li> <li>4. Binge Eating Disorder (Vyvanse only) <ol style="list-style-type: none"> <li>a. Patient is 18 to 55 years of age; and</li> <li>b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and</li> <li>c. Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and</li> <li>d. Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and</li> <li>e. Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and</li> <li>f. Patient has a BMI of 25 to 45; and</li> <li>g. Patient does not have a history of cardiovascular disease; and</li> <li>h. Patient has no history of substance abuse; and</li> <li>i. Is not being prescribed for the treatment of obesity or weight loss; and</li> <li>j. Doses above 70mg per day will not be considered.</li> <li>k. Initial requests will be approved for 12 weeks.</li> <li>l. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.</li> </ol> <p style="margin-left: 40px;"><u>DSM-5 Criteria</u></p> <ol style="list-style-type: none"> <li>i. Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control overeating; and</li> <li>ii. The binge eating episodes are marked by at least three of the following:</li> </ol> </li> </ol> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><i>Use CNS Stimulants or Binge Eating Disorder Agents PA form</i></p>            | <ol style="list-style-type: none"> <li>1. Eating more rapidly than normal</li> <li>2. Eating until feeling uncomfortably full</li> <li>3. Eating large amounts of food when not feeling physically hungry</li> <li>4. Eating alone because of embarrassment by the amount of food consumed</li> <li>5. Feeling disgusted with oneself, depressed, or guilty after overeating; and</li> </ol> <ol style="list-style-type: none"> <li>iii. Episodes occur at least 1 day a week for at least 3 months; and</li> <li>iv. No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and</li> <li>v. Does not occur solely during the course of bulimia nervosa or anorexia nervosa.</li> </ol> <p><u>Moderate to Severe BED</u></p> <p>Based on the number of binge eating episodes per week:</p> <p>Moderate - 4 to 7</p> <p>Severe – 8 to 13</p> <p>Extreme – 14 or more</p> <p>Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred extended-release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Crisaborole (Eucrisa)</b></p> <p><i>Use Crisaborole (Eucrisa) PA form</i></p> | <p>Prior authorization (PA) is required for Eucrisa (crisaborole). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of mild to moderate atopic dermatitis; and</li> <li>3. Patient has failed to respond to good skin care and regular use of emollients; and</li> <li>4. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and</li> <li>5. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and</li> <li>6. Patient will continue with skin care regimen and regular use of emollients.</li> <li>7. Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                      |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia)</b></p> <p><i>Use Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) PA form</i></p>                     | <p>Prior authorization (PA) is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and</li> <li>3. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and</li> <li>4. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and</li> <li>5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and</li> <li>6. Is not prescribed in combination with other ophthalmic cyclosporine products.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional authorizations will be considered upon documentation of clinical response to therapy.</p> |
| <p><b>Cystic Fibrosis Agents, Oral</b></p> <p><i>Kalydeco<br/>Orkambi<br/>Symdeko<br/>Trikafta</i></p> <p><i>Use Cystic Fibrosis Agents, Oral PA form</i></p> | <p>Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient meets the FDA approved age; and</li> <li>2. Patient has a diagnosis of cystic fibrosis; and</li> <li>3. Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and</li> <li>4. Prescriber is a CF specialist or pulmonologist; and</li> <li>5. Baseline liver function tests (AST, ALT, and bilirubin) are provided; and</li> <li>6. Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and</li> <li>7. Will not be used with other CFTR modulator therapies.</li> </ol> <p>If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Adherence to oral cystic fibrosis therapy is confirmed; and</li> <li>2. Liver function tests (AST, ALT, and bilirubin) are assessed every 3 months during the first year of treatment and annually thereafter.</li> </ol>                                                                                                                                                                            |
| <p><b>Dalfampridine (Ampyra)</b></p> <p><i>Use Dalfampridine (Ampyra™) PA form</i></p>                                                                        | <p>Prior authorization (PA) is required for dalfampridine (Ampyra). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. For patients that have a gait disorder associated with MS.</li> <li>2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment.</li> <li>3. Additional PAs will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained.</li> </ol> <p>PAs will not be considered for patients with a seizure diagnosis or in patients with moderate to severe renal impairment.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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## Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Deferasirox (Exjade)</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Deferasirox (Exjade)<br/>PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance &lt;40mL/min; and</li> <li>2. Patient does not have a poor performance status; and</li> <li>3. Patient does not have a high-risk myelodysplastic syndrome; and</li> <li>4. Patient does not have advanced malignancies; and</li> <li>5. Patient does not have a platelet count &lt; 50 x 10<sup>9</sup>/L.</li> </ol> <p><b>Transfusional Iron Overload</b></p> <p><u>Initiation of Therapy</u></p> <ol style="list-style-type: none"> <li>1. Patient is 2 years of age or older; and</li> <li>2. Patient has documentation of iron overload related to anemia (attach documentation); and</li> <li>3. Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and</li> <li>4. Serum ferritin is consistently &gt; 1000 mcg/L (attach lab results dates within the past month); and</li> <li>5. Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet.</li> <li>6. Initial requests will be considered for up to 3 months.</li> </ol> <p><u>Continuation of Therapy</u></p> <ol style="list-style-type: none"> <li>1. Serum ferritin has been measured within 30 days of continuation of therapy request (attach documentation); and</li> <li>2. Ferritin levels are &gt; 500mcg/L; and</li> <li>3. Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day.</li> </ol> <p><b>Non-Transfusional Iron Overload</b></p> <p><u>Initiation of Therapy</u></p> <ol style="list-style-type: none"> <li>1. Patient is 10 years of age or older; and</li> <li>2. Patient has documentation of iron overload related to anemia (attach documentation); and</li> <li>3. Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and</li> <li>4. Serum ferritin levels are &gt; 300mcg/L; and</li> <li>5. LIC are &gt; 5mg Fe/g dw; and</li> <li>6. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is &gt; 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is &gt; 15mg Fe/g dw).</li> <li>7. Initial authorization will be considered for up to 6 months.</li> </ol> <p><u>Continuation of Therapy</u></p> <ol style="list-style-type: none"> <li>1. Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and</li> <li>2. Serum ferritin levels are ≥ 300mcg/L; and</li> <li>3. LIC is ≥ 3mg Fe/g dw; and</li> <li>4. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is &gt; 7mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 14mg/kg/day (if LIC is &gt; 7mg Fe/g dw).</li> </ol> |
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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <b>Deucravacitinib (Sotyktu)</b><br><br><i>Use Deucravacitinib (Sotyktu) PA form</i>                                 | <p>Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of plaque psoriasis; and               <ol style="list-style-type: none"> <li>a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine is provided; and</li> <li>b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and</li> <li>c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                       |
| <b>Dextromethorphan and Quinidine (Nuedexta)</b><br><br><i>Use Dextromethorphan and Quinidine (Nuedexta) PA form</i> | <p>Prior authorization (PA) is required for Nuedexta. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition.</li> <li>2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and</li> <li>3. Patient has documentation of a current EKG (within the past 3 months) without QT prolongation.</li> <li>4. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lablity Scale (CNS-LS) questionnaire.</li> <li>5. Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Diazoxide Choline (Vykat XR)</b><br><br><i>Use Diazoxide Choline (Vykat XR) PA form</i>                           | <p>Prior authorization (PA) is required for diazoxide choline (Vykat XR). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of Prader-Willi syndrome confirmed by genetic testing (attach results); and</li> <li>3. Patient has hyperphagia with associated symptoms such as food-seeking behaviors (hoarding, foraging, stealing, and attempting to consume inedible items); and</li> <li>4. Patient's current weight in kg is provided; and</li> <li>5. Is prescribed by or in consultation with an endocrinologist.</li> </ol> <p>If the criteria for coverage is met, initial requests will be approved for 6 months. Additional approvals will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Documentation showing improvement or stabilized signs and symptoms of disease such as decrease in food related behaviors, lessened food preoccupation that affects daily life, etc., and</li> <li>2. Patient's current weight in kg is provided.</li> </ol> |
| <b>Dornase Alfa (Pulmozyme)</b><br><i>Use Miscellaneous PA form</i>                                                  | <p>Prior authorization (PA) is required for Pulmozyme. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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## Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <b>Dupilumab (Dupixent)</b> | <p>Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient's current weight in kilograms (kg) is provided; and</li> <li>3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and             <ol style="list-style-type: none"> <li>a. Patient has failed to respond to good skin care and regular use of emollients; and</li> <li>b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and</li> <li>c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and</li> <li>d. Patient will continue with skin care regimen and regular use of emollients; or</li> </ol> </li> <li>4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count <math>\geq 150</math> cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and             <ol style="list-style-type: none"> <li>a. Has a pretreatment forced expiratory volume in 1 second (FEV<sub>1</sub>) <math>\leq 80\%</math> predicted in adults; <math>&lt; 90\%</math> predicted in adolescents 12 to 17 years of age; and <math>&lt; 95\%</math> predicted in children 6 to 11 years of age; and</li> <li>b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta<sub>2</sub> agonist [LABA], or leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and</li> <li>c. Patient must have one of the following, in addition to the regular maintenance medications defined above:                 <ol style="list-style-type: none"> <li>i. One (1) or more exacerbations in the previous year or</li> <li>ii. Require daily oral corticosteroids for at least 3 days; or</li> </ol> </li> </ol> </li> <li>5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and             <ol style="list-style-type: none"> <li>a. Documentation dupilumab will be used as an add-on maintenance treatment; and</li> <li>b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:                 <ol style="list-style-type: none"> <li>i. Nasal corticosteroid spray; and</li> <li>ii. Oral corticosteroid; or</li> </ol> </li> </ol> </li> <li>6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and             <ol style="list-style-type: none"> <li>a. Patient has <math>\geq 15</math> intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and</li> <li>b. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and</li> <li>c. Documentation of previous trials and therapy failures with all of the following:                 <ol style="list-style-type: none"> <li>i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and</li> <li>ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension); and</li> <li>iii. Dietary therapy; or</li> </ol> </li> </ol> </li> <li>7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and             <ol style="list-style-type: none"> <li>a. Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) <math>\geq 7</math>;</li> </ol> </li> </ol> |
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Updated 10/01/2026

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| <p><i>Use Dupilumab<br/>(Dupixent) PA form</i></p> | <p>and</p> <ul style="list-style-type: none"> <li>b. Patient has <math>\geq 20</math> nodular lesions (attach documentation); and</li> <li>c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; or</li> </ul> <p>8. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and</p> <ul style="list-style-type: none"> <li>a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following: <ul style="list-style-type: none"> <li>i. FEV1/FVC ratio <math>&lt; 0.7</math>, and</li> <li>ii. FEV1 % predicted between 30% and 79%; and</li> </ul> </li> <li>b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and</li> <li>c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to: <ul style="list-style-type: none"> <li>i. Triple therapy with all of the following treatments: <ul style="list-style-type: none"> <li>1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and</li> <li>2. Long-acting beta agonist (LABA); and</li> <li>3. Inhaled corticosteroid (ICS); or</li> </ul> </li> <li>ii. Double therapy with both of the following if ICS is contraindicated: <ul style="list-style-type: none"> <li>1. LABA; and</li> <li>2. LAMA; and</li> </ul> </li> </ul> </li> <li>d. Patient has history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and</li> <li>e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; or</li> </ul> <p>9. Patient has a diagnosis of chronic spontaneous urticaria (CSU) with no known cause; and</p> <ul style="list-style-type: none"> <li>a. Patient has documentation of an adequate trial and therapy failure with a preferred second generation H1 receptor antihistamine for at least 2 weeks; or</li> </ul> <p>10. Patient has a diagnosis of bullous pemphigoid (BP); and</p> <ul style="list-style-type: none"> <li>a. Is initiated with a tapering course of oral corticosteroids; or</li> </ul> <p>11. Patient has a diagnosis of allergic fungal rhinosinusitis (AFRS); and</p> <ul style="list-style-type: none"> <li>a. Patient has a history of sino-nasal surgery.</li> </ul> <p>If criteria for coverage are met, initial authorization will be given for 6 months for all the above indications, except for COPD, CSU, BP, and AFRS which will receive an initial authorization of 12 months to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and continued use of add-on maintenance therapy, where indicated.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Duplicate Therapy Edits</b></p> <p><b>Antipsychotics</b><br/><b>NSAIDs</b><br/><i>Use Duplicate Therapy Edit Override PA form</i></p> | <p>Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p><b>Eluxadoline (Viberzi)</b></p> <p><i>Use Eluxadoline (Viberzi) PA form</i></p>                                                         | <p>Prior authorization (PA) is required for eluxadoline. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient meets the FDA approved age.</li> <li>2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D).</li> <li>3. Patient does not have any of the following contraindications to therapy:             <ol style="list-style-type: none"> <li>a. Patient is without a gallbladder.</li> <li>b. Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction.</li> <li>c. Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day.</li> <li>d. A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction).</li> <li>e. Severe hepatic impairment (Child-Pugh Class C).</li> <li>f. Severe constipation or sequelae from constipation.</li> <li>g. Known or suspected mechanical gastrointestinal obstruction.</li> </ol> </li> <li>4. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with both of the following:             <ol style="list-style-type: none"> <li>a. A preferred antispasmodic agent (dicyclomine or hyoscyamine).</li> <li>b. A preferred antidiarrheal agent (loperamide).</li> </ol> </li> </ol> <p>If criteria for coverage are met, initial authorization will be given for 3 months to assess the response to treatment. Requests for continuation of therapy will require the following:</p> <ol style="list-style-type: none"> <li>1. Patient has not developed any contraindications to therapy (defined above).</li> <li>2. Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following:             <ol style="list-style-type: none"> <li>a. Improvement in abdominal cramping or pain.</li> <li>b. Improvement in stool frequency and consistency.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Ensifentrine (Ohtuvayre)</b></p>                                                                                                      | <p>Prior authorization (PA) is required for ensifentrine (Ohtuvayre). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><i>Use Ensifentrine (Ohtuvayre) PA form</i></p>                                                           | <p>precautions, drug interactions, and use in specific populations; and</p> <ol style="list-style-type: none"> <li>2. Patient has a diagnosis of moderate to severe COPD when all of the following are met: <ol style="list-style-type: none"> <li>a. FEV1/FVC ratio &lt; 0.7; and</li> <li>b. Post-bronchodilator FEV1 % predicted of 30% to 79%; and</li> <li>c. Modified Medical Research Council (mMRC) dyspnea score of <math>\geq 2</math> or a COPD Assessment Test (CAT) score <math>\geq 10</math>; and</li> </ol> </li> <li>3. Patient is adherent with COPD treatments, meeting one of the following criteria: <ol style="list-style-type: none"> <li>a. The patient has a blood eosinophil of <math>\geq 100</math> and has experienced an exacerbation while adherent to a current 60-day trial of a triple combination regimen consisting of a long-acting beta agonist (LABA), a long-acting muscarinic antagonist (LAMA), and an inhaled corticosteroid (ICS); or</li> <li>b. The patient has a blood eosinophil of &lt; 100 and has experienced an exacerbation while adherent to a 60-day trial of a dual combination regimen consisting of a LABA and LAMA; and</li> </ol> </li> <li>4. Dual or triple combination regimen will be continued in combination with ensifentrine (Ohtuvayre).</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>If the criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Additional authorizations will be considered upon documentation of a response to treatment (e.g. improved dyspnea, decreased exacerbations) and patient continues their dual or triple combination regimen.</p> |
| <p><b>Eplerenone (Inspra)</b><br/><i>Use Miscellaneous PA form</i></p>                                       | <p>Prior authorization (PA) is required for Inspra. Payment will be authorized only in cases where there is documented trial and therapy failure on spironolactone or documented cases of gynecomastia from spironolactone therapy.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Erythropoiesis Stimulating Agents</b><br/><br/><i>Use Erythropoiesis Stimulating Agent PA form</i></p> | <p>Prior authorization (PA) is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.</p> <p>Patients who meet all of the following criteria may receive PA for the use of erythropoiesis stimulating agents:</p> <ol style="list-style-type: none"> <li>1. Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values must be dated within four weeks of the prior authorization request.</li> <li>2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request.</li> <li>3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy.</li> <li>4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.</li> </ol>                                                                                                                                                                                                                                                                                                         |

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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Extended Release Formulations</b></p> <p><i>Use Extended Release Formulations PA form</i></p>                                 | <p>Payment for a non-preferred extended release formulation will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and</li> <li>3. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>Prior authorization (PA) is required for the following extended release formulation(s):<br/> Amoxicillin &amp; Pot Clavulanate ER, Astagraf XL, Cardura XL, Carvedilol ER, Coreg CR, Crexont, Doryx, Elepsia XR, Envarsus XR, Fluoxetine DR 90mg, Fluvoxamine ER, Gabapentin ER, Gocovri, Gralise, Kapsargo, Memantine ER, Motpoly XR, Oxcarbazepine ER, Oxtellar XR, Pramipexole ER, Pregabalin ER, Qudexy XR, Ropinirole ER, Rythmol SR, Topiramate ER, Trokendi XR.</p> |
| <p><b>Fentanyl, Short Acting Products</b></p> <p><i>Use Short Acting Fentanyl Products PA form</i></p>                              | <p>Prior authorization (PA) is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a <b>Black Box Warning</b>.</p> <p>Short acting fentanyl products:</p> <ol style="list-style-type: none"> <li>1. Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.</li> <li>2. Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>Fifteen Day Initial Prescription Supply Limit</b></p> <p><i>Use Fifteen Day Initial Prescription Supply Limit PA form</i></p> | <p>Designated drugs are limited to a fifteen day initial supply. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website <a href="http://www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> under the Preferred Drug Lists tab. Providers must submit a prior authorization (PA) request for override consideration. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

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Updated 10/01/2026

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|                                              | Updated 10/01/2020                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Finerenone (Kerendia)</b>                 | <p>Prior authorization (PA) is required for finerenone (Kerendia). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling, including age, dosing, contraindications, warnings and precautions, and drug interactions; and</li> <li>2. Patient has a diagnosis of chronic kidney disease (CKD) associated with Type 2 Diabetes (T2D); and             <ol style="list-style-type: none"> <li>a. Patient is currently receiving a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB); and</li> <li>b. Patient is currently receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease (i.e., dapagliflozin [Farxiga], empagliflozin [Jardiance]); or</li> </ol> </li> <li>3. Patient has a diagnosis of heart failure; and             <ol style="list-style-type: none"> <li>a. Patient has a left ventricular ejection fraction (LVEF) <math>\geq 40\%</math>; and</li> <li>b. Patient is currently receiving a maximally tolerated dose of a SGLT2 inhibitor indicated for use in patients with heart failure (i.e., dapagliflozin [Farxiga], empagliflozin [Jardiance]); and</li> </ol> </li> <li>4. Patient has the following baseline tests prior to initiation of treatment with finerenone:             <ol style="list-style-type: none"> <li>a. Serum potassium is <math>\leq 5.0</math> mEq/L; and</li> <li>b. Estimated glomerular filtration rate (eGFR) is <math>\geq 25</math> mL/min/<math>1.73m^2</math>; and</li> <li>c. Urine albumin to creatinine ration (UACR) is <math>\geq 30</math> mg/g.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial authorizations will be approved for one year. Additional PAs will be considered with the following documentation:</p> <ol style="list-style-type: none"> <li>1. Patient's eGFR is <math>\geq 25</math> mL/min/<math>1.73m^2</math>; and</li> <li>2. For a diagnosis of CKD associated with T2D:             <ol style="list-style-type: none"> <li>a. Patient's serum potassium is <math>&lt; 5.5</math> mEq/L; and</li> <li>b. Patient remains on a maximally tolerated dose of an ACEi or ARB; and</li> <li>c. Patient remains on a maximally tolerated dose of an SGLT2 inhibitor; or</li> </ol> </li> <li>3. For a diagnosis of heart failure:             <ol style="list-style-type: none"> <li>a. Patient's serum potassium is <math>&lt; 6</math> mEq/L; and</li> <li>b. Patient remains on a maximally tolerated dose of an SGLT2 inhibitor.</li> </ol> </li> </ol> |
| <i>Use Finerenone<br/>(Kerendia) PA form</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Givinostat (Duvyzat)</b></p> <p><i>Use Givinostat (Duvyzat)<br/>PA form</i></p>                                             | <p>Prior authorization (PA) is required for givinostat (Duvyzat). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and</li> <li>2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>3. Is prescribed by or in consultation with a physician who specializes in treatment of DMD; and</li> <li>4. Patient has documentation of a trial and inadequate response to an oral glucocorticoid for at least 6 months; and</li> <li>5. Givinostat will be prescribed concurrently with an oral glucocorticoid; and</li> <li>6. Patient's current body weight in kilograms (kg) is provided.</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 12-month intervals when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Documentation of a positive response to therapy (e.g. improved strength, pulmonary function test, or functional assessments); and</li> <li>2. Patient continues to receive concomitant glucocorticoid therapy; and</li> <li>3. Patient's current body weight in kg is provided.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>GLP-1 Agonist/Basal Insulin Combinations</b></p> <p><i>Use GLP-1<br/>Agonist/Basal Insulin<br/>Combinations PA form</i></p> | <p>Prior authorization (PA) is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. A diagnosis of type 2 diabetes mellitus; and</li> <li>2. Patient is 18 years of age or older; and</li> <li>3. The patient has not achieved HgbA1C goals after a minimum three-month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and</li> <li>4. Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and</li> <li>5. Will not be used concurrently with prandial insulin; and</li> <li>6. Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and</li> <li>7. Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:             <ol style="list-style-type: none"> <li>a. Soliqua below 15 units or over 60 units, or</li> <li>b. Xultophy persistently below 16 units or over 50 units.</li> </ol> </li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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Updated 10/01/2026

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| <p><b>Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral PA form</i></p> | <div style="text-align: right; font-size: small;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> <li>1. Pregnancy has been ruled out; and</li> <li>2. Patient does not have osteoporosis; and</li> <li>3. Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>4. Requests for elagolix (Orilissa) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions:             <ol style="list-style-type: none"> <li>a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and</li> <li>b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and</li> <li>c. Patient has documentation of a previous trial and therapy failure with a GnRH agonist.</li> <li>d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms; and</li> <li>e. Requests will be considered based on drug, dose, and length of therapy:                 <ol style="list-style-type: none"> <li>i. Orilissa- maximum duration of therapy of 24 months for the 150mg dose and six (6) months for the 200mg dose;or</li> <li>ii. Myfembree- maximum duration of therapy of 24 months;or</li> </ol> </li> </ol> </li> <li>5. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (OriaHnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions:             <ol style="list-style-type: none"> <li>a. Patient is premenopausal; and</li> <li>b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and</li> <li>c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and</li> <li>d. Patient has documentation of a previous trial and therapy failure with tranexamic acid.</li> <li>e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement of symptoms.</li> <li>f. Requests will be considered for a maximum duration of therapy of 24 months.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Granulocyte Colony Stimulating Factor Agents</b></p> <p><i>Use Granulocyte Colony Stimulating Factor PA form</i></p> | <p>Prior authorization (PA) is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses:</p> <ol style="list-style-type: none"> <li>1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.</li> <li>2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant.</li> <li>3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy.</li> <li>4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.</li> </ol> <p>On current chemotherapy drug(s) that would cause severe neutropenia.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p><b>Growth Hormone</b></p>                                                                                               | <p>Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied: Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA).<br/>Payment will be considered under the following conditions:</p> <p>Children with Growth Hormone Deficiency</p> <ol style="list-style-type: none"> <li>1. Standard deviation of 2.0 or more below mean height for chronological age; and</li> <li>2. No expanding intracranial lesion or tumor diagnosed by MRI; and</li> <li>3. Growth rate below five centimeters per year; and</li> <li>4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and</li> <li>5. Annual bone age testing is required. A Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and</li> <li>6. Epiphyses open.</li> </ol> <p>Pediatric Chronic Kidney Disease</p> <ol style="list-style-type: none"> <li>1. Is prescribed by or in consultation with a nephrologist; and</li> <li>2. Standard deviation of 2.0 or more below mean height for chronological age; and</li> <li>3. No expanding intracranial lesion or tumor diagnosed by MRI; and</li> <li>4. Growth rate below five centimeters per year; and</li> <li>5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and</li> <li>6. Epiphyses open.</li> </ol> <p>Turner's Syndrome</p> <ol style="list-style-type: none"> <li>1. Chromosomal abnormality showing Turner's syndrome; and</li> <li>2. Prescribed by or in consultation with an endocrinologist; and</li> <li>3. Standard deviation of 2.0 or more below mean height for chronological age; and</li> <li>4. No expanding intracranial lesion or tumor diagnosed by MRI; and</li> <li>5. Growth rate below five centimeters per year; and</li> <li>6. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and</li> <li>7. Epiphyses open.</li> </ol> |

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Updated 10/01/2026

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| <i>Use Growth Hormone PA form</i> | <p><b>Prader Willi Syndrome</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis is confirmed by appropriate genetic testing (attach results); and</li> <li>2. Prescribed by or in consultation with an endocrinologist; and</li> <li>3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and</li> <li>4. Epiphyses open.</li> </ol> <p><b>Noonan Syndrome</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis is confirmed by appropriate genetic testing (attach results); and</li> <li>2. Prescribed by or in consultation with an endocrinologist; and</li> <li>3. Standard deviation of 2.0 or more below mean height for chronological age; and</li> <li>4. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and</li> <li>5. Epiphyses open.</li> </ol> <p><b>SHOX (Short stature Homeobox)</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis is confirmed by appropriate genetic testing (attach results); and</li> <li>2. Prescribed by or in consultation with an endocrinologist; and</li> <li>3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and</li> <li>4. Epiphyses open.</li> </ol> <p><b>Adults with Growth Hormone Deficiency</b></p> <ol style="list-style-type: none"> <li>1. Patients who were growth hormone deficient during childhood (childhood onset) and who have a continued deficiency; or</li> <li>2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g., panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and</li> <li>3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of <math>\leq 5</math> mcg/L after stimulation.</li> </ol> <p><b>Adults with AIDS Wasting/Cachexia</b></p> <ol style="list-style-type: none"> <li>1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and</li> <li>2. Patient is currently being treated with antiviral agents; and</li> <li>3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol).</li> </ol> <p><b>Short Bowel Syndrome</b></p> <p>If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel Syndrome. PA will be considered for a maximum of 4 weeks.</p> <p>If the criteria for coverage is met, initial requests will be given for 12-month periods, unless otherwise stated above. Additional PAs will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.</p> |
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Updated 10/01/2026

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|                                                       | Updated 10/31/2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Hematopoietics/<br/>Chronic ITP</b>                | <p>Prior authorization (PA) is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. A diagnosis of thrombocytopenia with chronic immune thrombocytopenia (ITP) (Alvaiz, Doptelet, Promacta, Nplate, Tavalisse)             <ol style="list-style-type: none"> <li>a. Patient has documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy.</li> </ol> </li> <li>2. A diagnosis of severe aplastic anemia (Alvaiz, Promacta)             <ol style="list-style-type: none"> <li>a. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and</li> <li>b. Patient has a platelet count less than or equal <math>30 \times 10^9/L</math>.</li> <li>c. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration.</li> </ol> </li> <li>3. A diagnosis of thrombocytopenia with chronic liver disease in patients who are scheduled to undergo a procedure with the following documentation (Doptelet, Mulpleta):             <ol style="list-style-type: none"> <li>a. Pre-treatment platelet count; and</li> <li>b. Scheduled dosing prior to procedure; and</li> <li>c. Therapy completion prior to scheduled procedure; and</li> <li>d. Platelet count will be obtained before procedure.</li> </ol> </li> </ol> |
| <i>Use<br/>Hematopoietics/Chronic<br/>ITP PA form</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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Updated 10/01/2026

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| <b>High Dose Opioids</b> | <p>Prior authorization (PA) is required for use of high-dose opioids <math>\geq 90</math> morphine milligram equivalents (MME) per day (See CDC Guideline for Prescribing Opioids for Chronic Pain at <a href="https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html">https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html</a>). Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met:</p> <ol style="list-style-type: none"> <li>1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and</li> <li>2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and</li> <li>3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and</li> <li>4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants; and</li> <li>5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and</li> <li>6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and</li> <li>7. Pain was inadequately controlled by 2 other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and</li> <li>8. Chart notes from a recent office visit or telehealth visit for pain management are included documenting the following: <ol style="list-style-type: none"> <li>a. Treatment plan – including all therapies to be used concurrently (pharmacologic and non-pharmacologic); and</li> <li>b. Treatment goals; and</li> </ol> </li> <li>9. Patient has been informed of the risks of high-dose opioid therapy; and</li> <li>10. The prescriber has reviewed the patient’s use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and</li> <li>11. The patient’s risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and</li> <li>12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and</li> <li>13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and</li> <li>14. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation] within the prior 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and</li> <li>15. Patient has been educated on opioid overdose prevention; and</li> <li>16. Patient’s household members have been educated on the signs of opioid overdose and how to administer an opioid reversal agent; and</li> </ol> |
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Updated 10/01/2026

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| <p><i>Use High Dose Opioids<br/>PA form</i></p>                       | <ol style="list-style-type: none"> <li>17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and</li> <li>18. A documented dose reduction is attempted at least annually.</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of high-dose opioid therapy will be considered every 6 months with the following:</p> <ol style="list-style-type: none"> <li>1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and</li> <li>2. Patient has not experienced an overdose or other serious adverse event; and</li> <li>3. Patient is not exhibiting warning signs of opioid use disorder; and</li> <li>4. The benefits of opioids continue to outweigh the risks; and</li> <li>5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and</li> <li>6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and</li> <li>7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests.</li> <li>8. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP [attach documentation] within 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and</li> <li>9. Patient has been reeducated on opioid overdose prevention; and</li> <li>10. Patient's household members have been reeducated on the signs of opioid overdose and how to administer an opioid reversal agent.</li> </ol>       |
| <p><b>Idiopathic Pulmonary Fibrosis and Related Lung Diseases</b></p> | <p>Prior authorization (PA) is required for medications used to treat idiopathic pulmonary fibrosis and related lung diseases. Payment for non-preferred agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent that is FDA approved or compendia indicated for the submitted diagnosis, when applicable. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Is prescribed by a pulmonologist; and</li> <li>3. Patient does not utilize non-prescribed inhalants, including but not limited to vaping or other inhaled products, prior to initiating therapy and has been instructed to avoid these products while using requested medication(s); and</li> <li>4. Concomitant use of nintedanib and pirfenidone will not be considered; and</li> <li>5. Documentation of an inadequate response to monotherapy with nintedanib or pirfenidone, at up to maximally indicated doses, is required prior to combination therapy with nerandomilast; and</li> <li>6. Patient has a diagnosis of idiopathic pulmonary fibrosis (nerandomilast, nintedanib, or pirfenidone) as confirmed by one of the following (attach documentation): <ol style="list-style-type: none"> <li>a. Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or</li> <li>b. A surgical lung biopsy demonstrating UIP; and</li> <li>c. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational exposures, connective tissue disease, and drug toxicity; and</li> <li>d. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC):</li> </ol> </li> </ol> |

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Updated 10/01/2026

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| <p><i>Use Idiopathic Pulmonary Fibrosis and Related Lung Diseases PA form</i></p> | <ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>i. <math>\geq 50\%</math> predicted for nintedanib or pirfenidone; or</li> <li>ii. <math>\geq 45\%</math> predicted for nerandomilast; and</li> </ul> </li> <li>e. Patient has a carbon monoxide diffusion capacity (%Dlco):           <ul style="list-style-type: none"> <li>i. <math>\geq 30\%</math> predicted for nintedanib or pirfenidone; or</li> <li>ii. <math>\geq 25\%</math> for nerandomilast; or</li> </ul> </li> </ul> <p>7. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation):</p> <ul style="list-style-type: none"> <li>a. Documentation of a HRCT scan showing fibrosis affecting <math>\geq 10\%</math> of the lungs; and</li> <li>b. Patient has documented pulmonary function tests within the prior 60 days showing FVC <math>\geq 40\%</math> predicted; and</li> <li>c. Patient has a %Dlco of <math>\geq 30-89\%</math> predicted; or</li> </ul> <p>8. Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (progressive pulmonary fibrosis [PPF]) (nintedanib or nerandomilast) as confirmed by the following (attach documentation):</p> <ul style="list-style-type: none"> <li>a. Documentation of a HRCT scan showing fibrosis affecting <math>\geq 10\%</math> of the lungs; and</li> <li>b. Patient has documented pulmonary function tests within the prior 60 days showing FVC <math>\geq 45\%</math> predicted; and</li> <li>c. Patient has a %Dlco of:           <ul style="list-style-type: none"> <li>i. <math>\geq 30-79\%</math> predicted for nintedanib; or</li> <li>ii. <math>\geq 25\%</math> predicted for nerandomilast; and</li> </ul> </li> <li>d. Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months:           <ul style="list-style-type: none"> <li>i. A relative decline in the FVC of at least 10% predicted; or</li> <li>ii. A relative decline in the FVC of 5-9% predicted combined with at least one of the following:               <ul style="list-style-type: none"> <li>1. Worsening respiratory symptoms; or</li> <li>2. Increased extent of fibrosis on HRCT; or</li> </ul> </li> <li>iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only.</li> </ul> </li> </ul> <p>If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6-month intervals when the following criteria are met:</p> <ul style="list-style-type: none"> <li>1. Adherence to medication is confirmed; and</li> <li>2. Documentation of a positive response to therapy, defined as meeting at least one of the following:           <ul style="list-style-type: none"> <li>a. Rate of lung function decline slowed; or</li> <li>b. Improved or no worsening of symptoms of cough, shortness of breath; and</li> </ul> </li> <li>3. Documentation is provided that the patient has remained free from use of non-prescribed inhalants, including but not limited to vaping and other inhaled products.</li> </ul> |
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| <p><b>IL-5 Antagonists</b></p> <p><i>Fasenra</i><br/><i>Nucala</i></p> | <p>Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and             <ol style="list-style-type: none"> <li>a. Patient has a pretreatment blood eosinophil count of <math>\geq 150</math> cells/mcL within the previous 6 weeks or blood eosinophils <math>\geq 300</math> cells/mcL within 12 months prior to initiation of therapy; and</li> <li>b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and</li> <li>c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and</li> <li>d. A pretreatment forced expiratory volume in 1 second (FEV<sub>1</sub>) <math>&lt; 80\%</math> predicted in adults and <math>&lt; 90\%</math> in adolescents; or</li> </ol> </li> <li>3. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and             <ol style="list-style-type: none"> <li>a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and</li> <li>b. One of the following:                 <ol style="list-style-type: none"> <li>i. Eosinophil count <math>&gt; 1000</math> cells/mcL; or</li> <li>ii. Eosinophil count <math>&gt; 10\%</math> of the total leukocyte count; or</li> </ol> </li> </ol> </li> <li>4. Patient has a diagnosis of hypereosinophilic syndrome (HES); and             <ol style="list-style-type: none"> <li>a. Patient has been diagnosed with HES for <math>\geq 6</math> months prior to starting treatment; and</li> <li>b. Documentation that non-hematologic secondary causes of HES have been ruled out; and</li> <li>c. Documentation patient does not have FIP1L1-PDGFR<math>\alpha</math> kinase-positive HES; and</li> <li>d. Documentation of <math>\geq 2</math> HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and</li> <li>e. Patient has a blood eosinophil count <math>\geq 1,000</math> cells/mcL; and</li> <li>f. Medication will be used in combination with stable doses of at least one other HES therapy; or</li> </ol> </li> <li>5. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); and             <ol style="list-style-type: none"> <li>a. Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; and</li> </ol> </li> </ol> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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|  | <p>b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:</p> <ol style="list-style-type: none"> <li>i. Nasal corticosteroid; and</li> <li>ii. Oral corticosteroid; or</li> </ol> <p>6. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype; and</p> <ol style="list-style-type: none"> <li>a. Patient has moderate to very severe airflow limitation, measured within the past 12 months, as evidenced by both of the following: <ol style="list-style-type: none"> <li>i. FEV<sub>1</sub>/FVC ratio- &lt; 0.7, and</li> <li>ii. FEV<sub>1</sub>% predicted of 20% and 80%, and</li> </ol> </li> <li>b. Patient has a minimum blood eosinophil count of 150 cells/mcL, measured within the past 12 months; and</li> <li>c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to therapy with: <ol style="list-style-type: none"> <li>i. Triple therapy with all of the following treatments: <ol style="list-style-type: none"> <li>1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and</li> <li>2. Long-acting beta2-agonist (LABA); and</li> <li>3. Inhaled corticosteroid (ICS); or</li> </ol> </li> <li>ii. Double therapy with both of the following if ICS is contraindicated; <ol style="list-style-type: none"> <li>1. LABA, and</li> <li>2. LAMA; and</li> </ol> </li> </ol> </li> <li>d. Patient has a history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and</li> <li>e. Documentation mepolizumab will be used as an add-on maintenance treatment with triple or double therapy (as defined above); and</li> </ol> <p>7. Medication will be administered in the patient's home; and</p> <p>8. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist.</p> <p>If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis, 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP, or 12 months for a diagnosis of COPD to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met:</p> <p>Severe Asthma with an Eosinophilic Phenotype:</p> <ol style="list-style-type: none"> <li>1. Patient continues to receive therapy with an ICS, LABA and LTRA; and</li> <li>2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or</li> <li>3. Patient has experienced a decrease in administration of rescue medication (albuterol); or</li> <li>4. Patient has experienced a decrease in exacerbation frequency; or</li> <li>5. Patient has experienced an increase in predicted FEV<sub>1</sub> from the pretreatment baseline.</li> </ol> <p>Eosinophilic Granulomatosis with Polyangiitis</p> <ol style="list-style-type: none"> <li>1. Patient has demonstrated a positive clinical response to therapy (increase in remission time).</li> </ol> <p>Hypereosinophilic Syndrome:</p> |
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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><i>Use IL-5 Antagonists PA form</i></p>                                                                                                 | <ol style="list-style-type: none"> <li>1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and</li> <li>2. Medication continues to be used in combination with stable doses or at least one other HES therapy.</li> </ol> <p>Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)</p> <ol style="list-style-type: none"> <li>1. Patient has demonstrated positive clinical response to therapy (improvement in symptoms); and</li> <li>2. Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray.</li> </ol> <p>Chronic Obstructive Pulmonary Disease (COPD)</p> <ol style="list-style-type: none"> <li>1. Patient has demonstrated positive clinical response to therapy; and</li> <li>2. Continues to receive add-on maintenance therapy with triple or double therapy (as defined above).</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p><b>Immunomodulators-Topical</b></p> <p><i>Pimecrolimus</i><br/><i>Tacrolimus</i></p> <p><i>Use Immunomodulators-Topical PA form</i></p> | <p>Prior authorization (PA) is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel) or tacrolimus 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with one preferred topical corticosteroid, except on the face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p><b>Incretin Mimetics for Non-Diabetes Indications</b></p>                                                                               | <p>Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and <ol style="list-style-type: none"> <li>a. Patient has established CVD, i.e. coronary artery disease (angina, MI), cerebrovascular disease (stroke, transient ischemic attack), peripheral arterial disease, heart failure, atrial fibrillation and other arrhythmias, valvular heart disease, congenital heart disease, cardiomyopathies, aortic disease (aneurysm, dissection), DVT or PE, and</li> <li>b. Patient has a baseline body mass index (BMI) <math>\geq 27</math> kg/m<sup>2</sup>, obtained within 6 months of request; and</li> <li>c. Patient has been evaluated for cardiovascular standard of care treatment; and</li> <li>d. For Wegovy (injection or tablet): <ol style="list-style-type: none"> <li>i. Patient is <math>\geq 18</math> years of age; and</li> <li>ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and</li> <li>iii. For Wegovy injection: Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; or</li> <li>iv. For Wegovy tablets: Maintenance dosages other than 25 mg once daily will not be approved for maintenance treatment (if patient does not tolerate 25 mg once daily maintenance dosage, consider switching to Wegovy injection 1.7 mg once</li> </ol> </li> </ol> </li> </ol> |

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Updated 10/01/2026

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|  | <p>weekly); or</p> <ol style="list-style-type: none"> <li>3. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and               <ol style="list-style-type: none"> <li>a. Patient has a baseline BMI <math>\geq 30</math> kg/m<sup>2</sup>; and</li> <li>b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) <math>\geq 15</math> events per hour, as documented by a polysomnography (PSG) or at-home sleep study (document AHI); and</li> <li>c. For Zepbound:                   <ol style="list-style-type: none"> <li>i. Patient meets the FDA approved age for OSA; and</li> <li>ii. Initiation and escalation dosages will be permitted up to a maximum of 20 weeks prior to reaching the recommended maintenance dosage of 10 mg to 15 mg once weekly; and</li> <li>iii. Maintenance dosages other than 10 mg to 15 mg once weekly will not be approved for maintenance treatment; or</li> </ol> </li> </ol> </li> <li>4. Patient has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH); and               <ol style="list-style-type: none"> <li>a. Patient has moderate to advanced liver fibrosis (stages F2 to F3 fibrosis) as confirmed by one of the following (attach results from testing documenting fibrosis stage);                   <ol style="list-style-type: none"> <li>i. Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g. FibroScan), with a LSM of 8 kPa to 15 kPa; or</li> <li>ii. LSM by magnetic resonance elastography (MRE) with a LSM of 3.1 kPa to 4.4 kPa; or</li> <li>iii. Liver biopsy with a non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) <math>\geq 4</math> with a score of 1 or more in steatosis, lobular inflammation, and hepatocyte ballooning; and</li> </ol> </li> <li>b. Patient has been evaluated for cardiometabolic standard of care treatment; and</li> <li>c. Concurrent use of an incretin mimetic with resmetirom (Rezdiffra) for the treatment of MASH will only be considered after documented trials of each agent individually at therapeutic doses, with evidence of inadequate response; and</li> <li>d. Patient has not had significant alcohol consumption within the past year (<math>&gt; 20</math> g per day in women or <math>&gt; 30</math> g per day in men); and</li> <li>e. For Wegovy injection:                   <ol style="list-style-type: none"> <li>i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and</li> <li>ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment (see requests for continuation of therapy below for maintenance dose requirement); and</li> </ol> </li> </ol> </li> <li>5. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and</li> <li>6. The requested agent will not be used in combination with other incretin mimetics.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>Requests will be considered for initiation and appropriate dose escalation. Requests for continuation of therapy, once at an established maintenance dose will be considered at 12-month intervals, when:</p> <ol style="list-style-type: none"> <li>1. The requested drug will be used to reduce the risk of MACE; and         <ol style="list-style-type: none"> <li>a. Patient has been evaluated for cardiovascular standard of care treatment; and</li> <li>b. For Wegovy injection, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; or</li> </ol> </li> </ol> |
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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <i>Use Incretin Mimetics<br/>for Non-Diabetes<br/>Indications PA form</i> | <ul style="list-style-type: none"> <li>c. For Wegovy tablets, a maintenance dose of 25 mg once daily is requested; or</li> <li>2. The requested drug will be used to treat moderate to severe OSA; and               <ul style="list-style-type: none"> <li>a. Documentation of a positive response to therapy is provided; and</li> <li>b. The maintenance dose is requested and maintained (Zepbound 10 mg to 15 mg once weekly); and</li> </ul> </li> <li>3. The requested drug will be used for noncirrhotic MASH; and               <ul style="list-style-type: none"> <li>a. Documentation of a positive response to therapy (e.g., improvement in or stabilization of fibrosis, improvement in liver function such as reduction in alanine aminotransferase [ALT], improvement in LSM by VCTE, MRE, or biopsy); and</li> <li>b. Patient has not progressed to cirrhosis; and</li> <li>c. For Wegovy injection, a maintenance dose of 2.4 mg once weekly is requested, or 1.7 mg weekly with documentation of an adequate trial and intolerance to the maintenance dose of 2.4 mg once weekly. Patient must have a retrial of the recommended maintenance dose of 2.4 mg once weekly at least annually before a maintenance dose of 1.7 mg will be reauthorized; and</li> </ul> </li> <li>4. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and</li> <li>5. The requested agent will not be used in combination with other incretin mimetics.</li> </ul> |
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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Initial Days' Supply Limit Override</b></p><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><p><i>Use Initial Days' Supply Limit Override PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Requests for medications exceeding the initial days' supply limit require prior authorization. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has an FDA approved or compendia indication for the requested drug; and</li> <li>2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>3. Medical rationale for exceeding the initial days' supply limit is provided; and</li> <li>4. Requests for opioids exceeding the 7 day initial supply limit will be considered:             <ol style="list-style-type: none"> <li>a. For patients with active cancer, patients experiencing acute sickle cell crises, end-of-life/palliative care, or on an individual case-by-case basis based on medical necessity documentation provided; and</li> <li>b. Request must meet all other opioid requirements (quantity limits, morphine milligram equivalents (MME), and the preferred drug list (PDL). If requests do not comply with these requirements, separate, additional, prior authorization is required. Please reference and use the following prior authorization (PA) forms at <a href="http://www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> where appropriate:                 <ol style="list-style-type: none"> <li>i. Quantity Limit Override Form (exceeds established quantity limit)</li> <li>ii. High Dose Opioid PA Form (exceeds established MME limit)</li> <li>iii. Short-Acting Opioids PA Form (non-preferred short-acting opioids)</li> <li>iv. Long-Acting Opioids PA Form (non-preferred long-acting opioids); or</li> </ol> </li> </ol> </li> <li>5. Requests for benzodiazepines exceeding the 7 day initial supply limit will be considered:             <ol style="list-style-type: none"> <li>a. For patients with active cancer, end-of-life/palliative care, seizure disorder, or on an individual case-by-case basis based on medical necessity documentation provided; and</li> <li>b. For patients taking concurrent opioids, the prescriber must document the following:                 <ol style="list-style-type: none"> <li>i. The risks of using an opioid and benzodiazepine concurrently have been discussed with the patient; and</li> <li>ii. Documentation is provided as to why concurrent use is medically necessary; and</li> <li>iii. A plan to taper the opioid is provided, if appropriate; and</li> </ol> </li> <li>c. Request must meet all other benzodiazepine requirements (quantity limit, PDL, etc). If requests do not comply with these requirements, separate, additional prior authorization is required. Please use the following PA forms at <a href="http://www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> where appropriate:                 <ol style="list-style-type: none"> <li>i. Benzodiazepines (non-preferred benzodiazepine)</li> <li>ii. Quantity Limit Override (as posted at <a href="http://www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> under Billing/Quantity Limits); and</li> </ol> </li> </ol> </li> <li>6. Requests for drugs or drug classes subject to the initial days' supply limit not listed above, will be considered on an individual case-by-case basis, based on medical necessity documentation provided.</li> </ol> |
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### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Isotretinoin (Oral)</b></p> <p><i>Use Oral Isotretinoin PA form</i></p>       | <p>Prior authorization (PA) is required for oral isotretinoin therapy. Payment will be considered for preferred oral isotretinoin products for moderate to severe acne under the following conditions:</p> <ol style="list-style-type: none"> <li>1. There are documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative (tretinoin or adapalene) therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative therapy are not required for approval for treatment of acne conglobata; and</li> <li>2. Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE program.</li> </ol> <p>Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 24 weeks. A minimum of 8 weeks without therapy is required to consider subsequent authorizations.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Ivabradine (Corlanor)</b></p> <p><i>Use Ivabradine (Corlanor) PA form</i></p> | <p>Prior authorization (PA) is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and <ol style="list-style-type: none"> <li>a. Patient is 18 years of age or older; and</li> <li>b. Patient has documentation of a left ventricular ejection fraction <math>\leq 35\%</math>; and</li> <li>c. Patient is in sinus rhythm with a resting heart rate of <math>\geq 70</math> beats per minute; and</li> <li>d. Patient has documentation of blood pressure <math>\geq 90/50</math> mmHg; or</li> </ol> </li> <li>2. Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class II to IV) due to dilated cardiomyopathy, and <ol style="list-style-type: none"> <li>a. Pediatric patient age 6 months and less than 18 years old; and</li> <li>b. Patient has documentation of a left ventricular ejection fraction <math>\leq 45\%</math>; and <ol style="list-style-type: none"> <li>i. 6 to 12 months – HR <math>\geq 105</math> bpm</li> <li>ii. 1 to 3 years- HR <math>\geq 95</math> bpm</li> <li>iii. 3 to 5 years- HR <math>\geq 75</math> bpm</li> <li>iv. 5 to 18 years- HR <math>\geq 70</math> bpm; and</li> </ol> </li> </ol> </li> <li>3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and</li> <li>4. Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |

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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <b>Janus Kinase Inhibitors</b> | <p>Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata or other excluded medical use(s), as defined in Section 1927 (d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and</li> <li>2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>3. Patient has a diagnosis of: <ol style="list-style-type: none"> <li>a. Moderate to severe rheumatoid arthritis; with <ol style="list-style-type: none"> <li>i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and</li> <li>ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR</li> </ol> </li> <li>b. Psoriatic arthritis; with <ol style="list-style-type: none"> <li>i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and</li> <li>ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR</li> </ol> </li> <li>c. Moderately to severely active ulcerative colitis; with <ol style="list-style-type: none"> <li>i. A documented trial and inadequate response with a preferred TNF inhibitor; or</li> <li>ii. If TNF inhibitors are clinically inadvisable, documentation of at least one approved systemic therapy; OR</li> </ol> </li> <li>d. Moderately to severely active Crohn's disease; with <ol style="list-style-type: none"> <li>i. A documented trial and inadequate response with a preferred TNF inhibitor; or</li> <li>ii. If TNF inhibitors are clinically inadvisable, documentation of at least one approved systemic therapy; OR</li> </ol> </li> <li>e. Polyarticular Course Juvenile Idiopathic Arthritis; with <ol style="list-style-type: none"> <li>i. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and</li> </ol> </li> </ol> </li> </ol> |
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Updated 10/01/2026

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| <p><i>Use Janus Kinase Inhibitor PA form</i></p> | <ul style="list-style-type: none"> <li>ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR</li> <li>f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with               <ul style="list-style-type: none"> <li>i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and</li> <li>ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR</li> </ul> </li> <li>g. Atopic dermatitis; with               <ul style="list-style-type: none"> <li>i. Documentation patient has failed to respond to good skin care and regular use of emollients; and</li> <li>ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or</li> <li>iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and</li> <li>iv. For mild to moderate atopic dermatitis (topical treatments):                   <ul style="list-style-type: none"> <li>1. Affected area is less than 20% of body surface area (BSA); and</li> <li>2. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or</li> </ul> </li> <li>v. For moderate to severe chronic hand eczema (topical treatments);                   <ul style="list-style-type: none"> <li>1. Chronic hand eczema has persisted for more than 3 months or recurred two or more times within a 12-month time frame after the initial occurrence with complete clearances between relapses; and</li> <li>2. Patient has been instructed to use no more than 30 grams per 2 weeks or 60 grams per month of topical delgocitinib; or</li> </ul> </li> <li>vi. For moderate to severe atopic dermatitis (oral treatments):                   <ul style="list-style-type: none"> <li>1. A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and</li> <li>2. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; OR</li> </ul> </li> </ul> </li> <li>h. Nonsegmental vitiligo; with               <ul style="list-style-type: none"> <li>i. A documented trial and inadequate response with a potent topical corticosteroid; or</li> <li>ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and</li> <li>iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable; OR</li> </ul> </li> <li>i. Giant Cell Arteritis; with               <ul style="list-style-type: none"> <li>i. Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids.</li> </ul> </li> </ul> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Ketorolac</b></p> <p><i>Use Ketorolac PA form</i></p>                                     | <p>Prior authorization (PA) is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions.</p> <p>This product carries a <b>Black Box Warning</b>. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given.</li> <li>2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum intranasal dose is 126mg/day. Maximum combined duration of therapy is 5 days per month.</li> <li>3. Diagnosis indicating moderately severe, acute pain.</li> </ol> <p>Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred non-steroidal anti-inflammatory drugs at therapeutic doses.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Lebrikizumab-lbkz (Ebglyss)</b></p> <p><i>Use Lebrikizumab-lbkz (Ebglyss) PA form</i></p> | <p>Prior authorization (PA) is required for Ebglyss (lebrikizumab-lbkz). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient's current weight in kilograms (kg) is provided; and</li> <li>3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and <ol style="list-style-type: none"> <li>a. Patient has failed to respond to good skin care and regular use of emollients; and</li> <li>b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and</li> <li>c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and</li> <li>d. Patient will continue with skin care regimen and regular use of emollients.</li> </ol> </li> </ol> <p>If criteria for coverage are met, initial authorization will be given for 16 weeks to allow for initial dosing. Requests for continuation of therapy will be considered at 12-month intervals with documentation of an adequate response to therapy and a dose reduction to maintenance dosing.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |

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Updated 10/01/2026

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| <p><b>Letermovir (Prevymis)</b></p> <p><i>Use Letermovir<br/>(Prevymis) PA form</i></p>           | <p>Prior authorization (PA) is required for oral letermovir. Requests for intravenous letermovir should be directed to the member's medical benefit. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and</li> <li>2. Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and</li> <li>3. Patient has received an allogeneic hematopoietic stem cell transplant (HSCT); and <ol style="list-style-type: none"> <li>a. Patient or donor is CMV-seropositive [R+] (attach documentation);and</li> <li>b. Treatment is initiated between day 0 and day 28 post-transplantation with IV and/or oral therapy (before or after engraftment); and</li> <li>c. Therapy duration will not exceed 100 days post-transplantation or up to 200 days if patient is at high risk for late CMV infection (attach documentation); or</li> </ol> </li> <li>4. Patient is a kidney transplant recipient; and <ol style="list-style-type: none"> <li>a. Donor is CMV-seropositive/recipient is CMV seronegative [D+/R-] (attach documentation); and</li> <li>b. Treatment is initiated between day 0 and day 7 post-transplantation with IV and/or oral therapy (before or after engraftment); and</li> <li>c. Therapy will not exceed 200 days post-transplantation; and</li> </ol> </li> <li>5. Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and</li> <li>6. Date of transplant is provided; and</li> <li>7. Patient's weight (in kg) is provided.</li> </ol> |
| <p><b>Lidocaine Patch (Lidoderm)</b></p> <p><i>Use Lidocaine Patch<br/>(Lidoderm) PA form</i></p> | <p>Prior authorization (PA) is required for topical lidocaine patches. Payment will be considered only for cases in which there is a diagnosis of pain associated with post-herpetic neuralgia. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Linezolid<br/>(Zyvox)</b></p>         | <p>Prior authorization (PA) is required for linezolid. Payment for linezolid will be authorized when there is documentation that:</p> <ol style="list-style-type: none"> <li>The patient has an active infection and meets one of the following diagnostic criteria:             <ol style="list-style-type: none"> <li>Vancomycin-resistant Enterococcus (VRE); or</li> <li>Methicillin-resistant Staph aureus (MRSA); or</li> <li>Methicillin-resistant Staph epidermis (MRSE); or</li> <li>Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and</li> </ol> </li> <li>Patient meets ONE of the following criteria:             <ol style="list-style-type: none"> <li>Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or</li> <li>VRE in a part of the body other than lower urinary tract**, or</li> <li>Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed).</li> </ol> </li> <li>A current culture and sensitivity report is provided documenting sensitivity to linezolid.</li> </ol> <p>*Severe intolerance to vancomycin is defined as:</p> <ol style="list-style-type: none"> <li>Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration</li> <li>Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)</li> </ol> <p>**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.</p> |
| <p><i>Use linezolid (Zyvox) PA form</i></p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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Updated 10/01/2026

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| <b>Long-Acting Opioids</b>                 | <p>Prior authorization (PA) is required for all non-preferred long-acting opioids. PA is also required for members when the total daily opioid use (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment; and</li> <li>2. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and</li> <li>3. Patient has tried and failed at least two nonopioid pharmacologic therapies (e.g., acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and</li> <li>4. There is documentation of previous trial and therapy failure with one preferred long-acting opioid at maximally tolerated dose; and</li> <li>5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization; and</li> <li>6. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and.</li> <li>7. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids.</li> <li>8. Requests for long-acting opioids will only be considered for FDA approved dosing intervals. As-needed (PRN) dosing will not be considered; and</li> <li>9. For patients taking concurrent benzodiazepines, the prescriber must document the following:               <ol style="list-style-type: none"> <li>a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and</li> <li>b. Documentation as to why concurrent use is medically necessary is provided; and</li> <li>c. A plan to taper the benzodiazepine is provided, if appropriate.</li> </ol> </li> </ol> <p>If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient has experienced improvement in pain control and level of functioning; and</li> <li>2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP and has determined continued use of a long-acting opioid is appropriate for this member; and</li> <li>3. For patients taking concurrent benzodiazepines, the prescriber must document the following:           <ol style="list-style-type: none"> <li>a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and</li> <li>b. Documentation as to why concurrent use is medically necessary is provided; and</li> <li>c. A plan to taper the benzodiazepine is provided, if appropriate.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <i>Use Long-Acting Opioids<br/>PA form</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Maralixibat (Livmarli)</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Maralixibat (Livmarli) PA form</i></p> | <div style="text-align: right; font-size: small;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for maralixibat (Livmarli). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS or PFIC; and</li> <li>3. Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a <i>JAG1</i> or <i>NOTCH2</i> mutation or deletion; and             <ol style="list-style-type: none"> <li>a. Patient has cholestasis with moderate to severe pruritis; and</li> <li>b. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:                 <ol style="list-style-type: none"> <li>a. Ursodeoxycholic acid (ursodiol)</li> <li>b. Cholestyramine</li> <li>c. Rifampin; or</li> </ol> </li> </ol> </li> <li>4. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) demonstrating a gene mutation affiliated with PFIC (i.e., ATP8B1, ABCB11, ABCB4, TJP2, or MYO5B); and             <ol style="list-style-type: none"> <li>a. Genetic testing does not indicate PFIC type 2 with ABCB11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and</li> <li>b. Patient has moderate to severe pruritic associated with PFIC; and</li> </ol> </li> <li>5. Patient's current weight in kilograms (kg) is provided.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, initial authorizations will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of an improvement in pruritis symptoms and patient's current weight in kg.</p> |
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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Methotrexate Injection</b></p> <p><i>Otrexup</i><br/><i>Rasuvo</i></p> <p><i>Use Methotrexate Injection PA form</i></p>                             | <p>Prior authorization (PA) is required for non-preferred methotrexate injection. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA) and ALL of the following: <ol style="list-style-type: none"> <li>a. Prescribed by a rheumatologist; and</li> <li>b. Patient has a documented trial and intolerance with oral methotrexate; and</li> <li>c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine); and</li> <li>d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and</li> <li>e. Patient does not reside in a long-term care facility.</li> </ol> </li> <li>2. Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: <ol style="list-style-type: none"> <li>a. Patient is 18 years of age or older; and</li> <li>b. Prescribed by a dermatologist; and</li> <li>c. Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy).</li> <li>d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and</li> <li>e. Patient does not reside in a long-term care facility.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment</b></p> <p><i>Use Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment PA form</i></p> | <p>Prior Authorization (PA) is required for miconazole-zinc oxide-white petrolatum (Vusion) Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>Mifepristone (Korlym)</b></p> <p><i>Use Mifepristone (Korlym) PA form</i></p>                                                                       | <p>Prior authorization (PA) is required for mifepristone (Korlym). Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> <li>1. The patient is 18 years of age or older; and</li> <li>2. Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance; and</li> <li>3. Patient must have failed surgery or is not a candidate for surgery; and</li> <li>4. Prescriber is an endocrinologist; and</li> <li>5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Modified Formulations</b></p> <p><i>Use Modified Formulations PA form</i></p>                   | <p>Payment for a non-preferred isomer, prodrug, or metabolite will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and</li> <li>2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.</p> <p>Payment for a non-preferred alternative delivery system will only be considered for cases in which the use of an alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system as noted in ( ) on the PA form.</p> <p>Prior authorization is required for the following modified dosage forms: Adlarity, Alkindi, Aspruzyo, Atorvaliq, Binosto, Dartisla, Donepezil ODT, Drizalma, Elyxyb, Entresto Sprinkle Caps, Eprontia, Ezallor, FazaClo, Gimoti, Horizant, Lamotrigine ODT, Likmez, Metoclopramide ODT, Norliqva, Remeron SolTab, Risperidone ODT, Sertraline Caps, Sitavig, Spritam, Sympazan, Trilipix, Valsartan Oral Solution, Xopenex HFA, Zyprexa Zydis.</p> |
| <p><b>Multiple Sclerosis Agents-Oral</b></p> <p><i>Use Multiple Sclerosis Agents-Oral PA form</i></p> | <p>For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:</p> <ol style="list-style-type: none"> <li>1. A diagnosis of relapsing forms of multiple sclerosis; and</li> <li>2. Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and</li> <li>3. Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.</li> </ol> <p>Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                      |
| <p><b>Muscle Relaxants</b></p> <p><i>Use Muscle Relaxant PA form</i></p>                              | <p>Prior authorization (PA) is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that the use of these products would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Narcotic Agonist-Antagonist Nasal Sprays</b></p> <p><i>Use Narcotic Agonist/Antagonist Nasal Spray PA form</i></p> | <p>Prior authorization (PA) is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration.</p> <p>Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.</p> <p>Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p><b>Nemolizumab-ilto (Nemluvio)</b></p> <p><i>Use Nemolizumab-ilto (Nemluvio) PA form</i></p>                          | <p>Prior authorization (PA) is required for Nemluvio (nemolizumab-ilto). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient's current weight in kilograms (kg) is provided; and</li> <li>3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and <ol style="list-style-type: none"> <li>a. Patient has failed to respond to good skin care and regular use of emollients; and</li> <li>b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and</li> <li>c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and</li> <li>d. For initial therapy, will be used in combination with a topical corticosteroid and/or a topical immunomodulator; and</li> <li>e. Patient will continue with skin care regimen and regular use of emollients; or</li> </ol> </li> <li>4. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and <ol style="list-style-type: none"> <li>a. Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) <math>\geq 7</math>; and</li> <li>b. Patient has <math>\geq 20</math> nodular lesions (attach documentation); and</li> <li>c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days.</li> </ol> </li> </ol> <p>If criteria for coverage are met, initial authorization will be given for 16 weeks to assess response to therapy. Requests for continuation of therapy will be considered at 12-month intervals with documentation of an adequate response to therapy and a dose reduction to maintenance dosing, where appropriate.</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p> |

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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>New to Market Drugs</b></p> <p><i>Use New to Market Drugs PA form</i></p>                     | <p>Prior authorization (PA) is required for newly marketed drugs. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient has an FDA approved or compendia indication for the requested drug; and</li> <li>2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or</li> <li>3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and</li> <li>4. Request must adhere to all FDA approved labeling.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Once newly marketed drugs are reviewed by the Pharmaceutical &amp; Therapeutics Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p><b>Nocturnal Polyuria Treatments</b></p> <p><i>Use Nocturnal Polyuria Treatments PA form</i></p> | <p>Prior authorization (PA) is required for nocturnal polyuria treatments. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient meets the FDA approved age; and</li> <li>2. Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24-hour urine productions occurring at night; and</li> <li>3. Patient awakens at least 2 times at night to void; and</li> <li>4. Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and</li> <li>5. Patient is not taking a diuretic in the evening; and</li> <li>6. Patient does not have any of the following contraindications: <ol style="list-style-type: none"> <li>a) Current or previous history of hyponatremia; and</li> <li>b) Primary nocturnal enuresis; and</li> <li>c) Polydipsia; and</li> <li>d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and</li> <li>e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and</li> <li>f) Estimated glomerular filtration rate &lt; 50 mL/min.1.73m<sup>2</sup>; and</li> <li>g) Illnesses that can cause fluid or electrolyte imbalance; and</li> <li>h) New York Heart Association (NYHA) Class II-IV congestive heart failure; and</li> <li>i) Uncontrolled hypertension.</li> </ol> </li> </ol> <p>Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following:</p> <ol style="list-style-type: none"> <li>1. Patient continues to meet above criteria; and</li> <li>2. Patient has experienced a decrease in nocturnal voiding; and</li> <li>3. There is no evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).</li> </ol> |

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## Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Non-Biologic Agents for Ulcerative Colitis</b></p> <p><i>Use Non-Biologic Agents for Ulcerative Colitis PA form</i></p>                                                                    | <p>Prior authorization is required for select non-biologicals for ulcerative colitis (UC). Payment for non-preferred select non-biologics for UC may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of moderately to severely active ulcerative colitis (UC) and</li> <li>2. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and</li> <li>3. A documented trial and inadequate response to two preferred conventional therapies (immunomodulators) including aminosalicylates and azathioprine/6-mercaptopurine; and</li> <li>4. A documented trial and inadequate response with a preferred biological DMARD; and</li> <li>5. Will not be taken concomitantly with immunomodulators or biologic therapies.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products</b></p> <p><i>Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form</i></p> | <p>Prior authorization (PA) is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:</p> <ol style="list-style-type: none"> <li>1. Diabetes Insipidus.</li> <li>2. Hemophilia A.</li> <li>3. Von Willebrand's disease.</li> </ol> <p>Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent. Please refer to the Selected Brand-Name Drugs prior authorization form is requesting a non-preferred brand-name product.</p>                                                                                                                                                      |
| <p><b>Non-Preferred Drug</b></p> <p><i>Use Non-Preferred Drug PA form</i></p>                                                                                                                    | <p>Prior authorization (PA) is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be considered for an FDA approved or compendia indicated diagnosis only for cases in which there is documentation of previous trial and therapy failure with the preferred agent(s), unless evidence is provided that use of these agents would be medically contraindicated. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Nonsteroidal Anti-inflammatory Drugs</b></p> <p><i>Use Non-Steroidal Anti-inflammatory Drug PA form</i></p>                                                                                | <p>Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (NSAIDs). Payment for a non-preferred NSAID will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Documentation of previous trials and therapy failures with at least three preferred NSAIDs; and</li> <li>2. Requests for a non-preferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred immediate release NSAID of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                        |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Odevixibat (Bylvay)</b></p> <p><i>Use Odevixibat (Bylvay)<br/>Drug PA form</i></p> | <p>Prior authorization (PA) is required for odevixibat (Bylvay) Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and</li> <li>2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and <ol style="list-style-type: none"> <li>a. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and</li> <li>b. Patient has moderate to severe pruritis associated with PFIC; or</li> </ol> </li> <li>3. Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAG1 or NOTCH2 mutation or deletion; and <ol style="list-style-type: none"> <li>a. Patient has cholestasis with moderate to severe pruritis; and</li> <li>b. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents: <ol style="list-style-type: none"> <li>i. Ursodeoxycholic acid (ursodiol)</li> <li>ii. Cholestyramine</li> <li>iii. Rifampin; and</li> </ol> </li> </ol> </li> <li>4. Patient's current weight in kg is provided; and</li> <li>5. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in PFIC or ALGS</li> </ol> <p>Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient's current weight in kg is provided; and</li> <li>2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.</li> </ol> |
| <p><b>Omalizumab (Xolair)</b></p>                                                        | <p>Prior authorization (PA) is required for omalizumab (Xolair) prefilled syringe and autoinjector. Requests for omalizumab (Xolair) lyophilized powder for reconstitution will not be considered through the pharmacy benefit. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for omalizumab (Xolair) prefilled syringe and autoinjector will be considered when patient has an FDA approved or compendia indication under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Therapy will be initiated in a healthcare setting, under the guidance of a healthcare provider, where the patient can be closely observed for anaphylaxis and safety of therapy has been established after a minimum of 3 doses of omalizumab; and</li> <li>2. The healthcare provider has determined self-administration with omalizumab is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label; and</li> <li>3. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and</li> <li>4. For a diagnosis of asthma, chronic rhinosinusitis with nasal polyps, IgE-mediated food allergy, and any other FDA approved diagnosis where dosing is dependent on serum IgE level and body weight, the pretreatment IgE level and body weight in kilograms (kg), is provided. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment IgE levels and body weight. PA requests will be denied in these instances; and</li> <li>5. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair);</li> </ol>                                                                                                                                                                                              |

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## Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><i>Use Omalizumab (Xolair)<br/>PA form</i></p> | <p>and</p> <p>6. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced.</p> <p><u>Moderate to Severe Persistent Asthma</u></p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and</li> <li>2. Patient has a history of positive skin or RAST test to a perennial aeroallergen; and</li> <li>3. Symptoms are inadequately controlled with documentation of current treatment with a high dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long-acting beta<sub>2</sub>-agonist [LABA], or a leukotriene receptor antagonist [LTRA]), for a minimum of three (3) consecutive months of therapy. Patient must be compliant with therapy, based on pharmacy claims.</li> </ol> <p>If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid and controller medication (as defined above).</p> <p><u>Chronic Spontaneous Urticaria</u></p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of moderate to severe chronic spontaneous urticaria; and</li> <li>2. Patient has documentation of an adequate trial and therapy failure with a preferred second-generation H1 receptor antihistamine for at least 2 weeks.</li> </ol> <p>If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.</p> <p><u>Chronis Rhinosinusitis with Nasal Polyps (CRSwNP)</u></p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps; and</li> <li>2. Patient has documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: <ol style="list-style-type: none"> <li>a. Nasal corticosteroid spray; and</li> <li>b. Oral corticosteroid; and</li> </ol> </li> <li>3. Will be used as an add on maintenance treatment.</li> </ol> <p>If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid.</p> <p><u>IgE Mediated Food Allergy</u></p> <ol style="list-style-type: none"> <li>1. Medication is being prescribed for the reduction of allergic reactions (Type 1) that may occur with accidental exposure to one or more foods in a patient that has an IgE-mediated food allergy; and</li> <li>2. Diagnosis is confirmed by a skin prick test or in vitro test (attach results); and</li> <li>3. Will be used in conjunction with food allergen avoidance.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Ophthalmic Agents for Presbyopia</b></p> <p><i>Use Ophthalmic Agents for Presbyopia PA form</i></p> | <p>Prior authorization (PA) is required for ophthalmic agents indicated for presbyopia. Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment for a non-preferred agent will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a documented diagnosis of presbyopia; and</li> <li>3. Patient is aged 40-55 years old at start of therapy; and</li> <li>4. Is prescribed by or in consultation with an ophthalmologist or optometrist; and</li> <li>5. Patient has documentation of a therapeutic failure with corrective lenses (eyeglasses or contact lenses), unless contraindicated or clinically significant intolerance.</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a documented improvement in presbyopia defined as the patient gained 3 lines or more is mesopic, high contrast, binocular distance corrected near vision acuity (DCNVA), without losing more than 1 line (5 letters) of corrected distance visual acuity (CDVA); and</li> <li>2. Patient is not experiencing adverse effects from the drug.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Oral Constipation Agents</b></p>                                                                    | <p>Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient must have documentation of adequate trials and therapy failures with the following: <ol style="list-style-type: none"> <li>a. Member 18 years of age or older: <ol style="list-style-type: none"> <li>i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and</li> <li>ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); or</li> </ol> </li> <li>b. Member 17 years of age or younger: <ol style="list-style-type: none"> <li>i. Polyethylene glycol; and</li> <li>ii. One other preferred generic laxative, such as lactulose or senna; and</li> </ol> </li> </ol> </li> <li>3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and</li> <li>4. Patient has one of the following diagnoses: <ol style="list-style-type: none"> <li>a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance) <ol style="list-style-type: none"> <li>i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and</li> <li>ii. Patient has two or more of the following symptoms within the last 3 months: <ol style="list-style-type: none"> <li>1. Straining during at least 25% of bowel movements;</li> <li>2. Lumpy or hard stools for at least 25% of bowel movements; and</li> <li>3. Sensation of incomplete evacuation for at least 25% of bowel movements; and</li> </ol> </li> <li>iii. Documentation the patient is not currently taking constipation causing therapies; or</li> </ol> </li> </ol> </li> </ol> |

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### Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><i>Use Oral Constipation Agents PA form</i></p>                                                                                                                                           | <ul style="list-style-type: none"> <li>b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, Ibsrela, Linzess, or Trulance) <ul style="list-style-type: none"> <li>i. Patient is female (Amitiza only); and</li> <li>ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following: <ul style="list-style-type: none"> <li>1. Related to defecation;</li> <li>2. Associated with a change in stool frequency; and/or</li> <li>3. Associated with a change in stool form; or</li> </ul> </li> </ul> </li> <li>c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic) <ul style="list-style-type: none"> <li>i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and</li> <li>ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following: <ul style="list-style-type: none"> <li>1. Hard to very hard stool consistency;</li> <li>2. Moderate to very severe straining; and/or</li> <li>3. Having a sensation of incomplete evacuation; or</li> </ul> </li> </ul> </li> <li>d. A diagnosis of functional constipation (Linzess) <ul style="list-style-type: none"> <li>i. Patient has less than 3 SBMs per week; and 1 or more of the following criteria at least once per week for at least 2 months: <ul style="list-style-type: none"> <li>1. History of stool withholding or excessive voluntary stool retention;</li> <li>2. History of painful or hard bowel movements;</li> <li>3. History of large diameter stools that may obstruct the toilet;</li> <li>4. Presence of a large fecal mass in the rectum;</li> <li>5. At least 1 episode of fecal incontinence per week.</li> </ul> </li> </ul> </li> </ul> <p>If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment and patient continues to meet the age for indication.</p> |
| <p><b>Oral Glucocorticoids for Duchenne muscular dystrophy</b></p> <p>Agamree<br/>Deflazacort<br/>Emflaza</p> <p><i>Use Oral Glucocorticoids for Duchenne muscular dystrophy PA form</i></p> | <p>Prior authorization (PA) is required for oral glucocorticoids used for the treatment of Duchenne muscular dystrophy (DMD). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following criteria are met:</p> <ul style="list-style-type: none"> <li>1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and</li> <li>2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>3. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and</li> <li>4. Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose.</li> </ul> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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

## Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Oral Immunotherapy</b></p> <p><i>Grastek</i><br/><i>Odactra</i><br/><i>Oralair</i><br/><i>Ragwitek</i></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Oral Immunotherapy PA form</i></p> | <p>Prior authorization (PA) is required for sublingual allergen immunotherapy. Payment will be considered when patient has an FDA or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Medication is prescribed by or in consultation with an allergist or immunologist; and</li> <li>3. Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and</li> <li>4. Patient has a documented intolerance to immunotherapy injections; and</li> <li>5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).</li> <li>6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.</li> </ol> <p>Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:</p> <ol style="list-style-type: none"> <li>1. Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; and and</li> <li>2. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.</li> <li>3. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.</li> </ol> <p>Grass Pollen (Grastek and Oralair) In addition to the above criteria being met:</p> <ol style="list-style-type: none"> <li>1. Request is for Oralair; and             <ol style="list-style-type: none"> <li>a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and</li> <li>b. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.</li> <li>c. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season.</li> </ol> </li> <li>2. Request is for Grastek; and             <ol style="list-style-type: none"> <li>a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and</li> <li>b. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).</li> <li>c. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of grass pollen season as follows:                     <ul style="list-style-type: none"> <li>▪ Seasonally, through the end of the grass pollen season, or</li> <li>▪ For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season.</li> </ul> </li> </ol> </li> </ol> <p>House Dust Mite (Odactra) In addition to the above criteria being met:</p> <ol style="list-style-type: none"> <li>1. Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis; and</li> <li>2. Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites; and</li> <li>3. If criteria for coverage are met, authorization will be considered for 12 months.</li> </ol> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Ospemifene (Osphena)</b></p> <p><i>Use Ospemifene (Osphena) PA form</i></p> | <p>Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient is a post-menopausal woman with a diagnosis is moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and</li> <li>2. Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and</li> <li>3. Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and</li> <li>4. Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and</li> <li>5. Patient does not have severe hepatic impairment (Child-Pugh Class C); and</li> <li>6. Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and</li> <li>7. Dose does not exceed the FDA approved dose.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>Oxybate Products</b></p> <p><i>Use Oxybate Products PA form</i></p>         | <p>Prior authorization (PA) is required for oxybate products. Payment for non-preferred agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. A diagnosis of cataplexy associated with narcolepsy <ol style="list-style-type: none"> <li>a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and</li> <li>b. Previous trial and therapy failure with dextroamphetamine; or</li> </ol> </li> <li>3. A diagnosis of excessive daytime sleepiness associated with narcolepsy <ol style="list-style-type: none"> <li>a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and</li> <li>b. Previous trial and therapy failure at a therapeutic dose with modafinil; or</li> </ol> </li> <li>4. A diagnosis of idiopathic hypersomnia <ol style="list-style-type: none"> <li>a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and</li> <li>b. Previous trial and therapy failure at a therapeutic dose with modafinil; and</li> </ol> </li> <li>5. Will not be used in combination with other oxybate products or with pitolisant and/or solriamfetol; and</li> <li>6. Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and</li> <li>7. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting PA.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |

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# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Palopegteriparatide<br/>(Yorvipath)</b></p><br><br><br><br><br><br><br><p><i>Use Palopegteriparatide<br/>(Yorvipath) PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for palopegteriparatide (Yorvipath). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>Patient has a diagnosis of chronic hypoparathyroidism; and</li> <li>Patient has had an inadequate response to maximally tolerated oral calcium and vitamin D analog (e.g., calcitriol) therapy; and</li> <li>Documentation of baseline lab results (attach results obtained within 2 weeks prior to starting therapy) for:             <ol style="list-style-type: none"> <li>Serum 25 hydroxyvitamin D (25(OH)D) level within the normal range (20 to 80 ng/mL); and</li> <li>Albumin-corrected serum calcium level <math>\geq 7.8</math> g/dL; and</li> </ol> </li> <li>Is prescribed by or in consultation with an endocrinologist or nephrologist.</li> </ol> <p>If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 12-month intervals with:</p> <ol style="list-style-type: none"> <li>Documentation of a positive response to therapy, as evidenced by normalized albumin-corrected serum calcium level of 8.3 to 10.6 g/dL (attach lab results).</li> </ol> |
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## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>PCSK9 Inhibitors</b></p> <p><i>Praluent</i><br/><i>Repatha</i></p> | <p>Prior authorization (PA) is required for PCSK9 Inhibitors. Payment for a non-preferred PCSK9 Inhibitor will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient meets the FDA approved age for indication; AND</li> <li>2. Dosing follows the FDA approved dose for the submitted diagnosis; AND</li> <li>3. Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); AND</li> <li>4. Is to be prescribed as an adjunct to a low fat diet; AND</li> <li>5. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; AND</li> <li>6. Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program.</li> <li>7. The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors.</li> <li>8. Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced.</li> <li>9. Lost or stolen medication replacement requests will not be authorized.</li> <li>10. Goal is defined as a 50% reduction in untreated baseline LDL-C.</li> <li>11. Is prescribed for one of the following diagnoses: <ul style="list-style-type: none"> <li><u>Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)</u> <ol style="list-style-type: none"> <li>1. Total cholesterol &gt; 290mg/dL or LDL-C &gt; 190mg/dL; AND <ol style="list-style-type: none"> <li>a. Presence of tendon xanthomas; OR</li> <li>b. In first or second degree relative, one of the following: <ol style="list-style-type: none"> <li>i. Documented tendon xanthomas; or</li> <li>ii. MI at age ≤60 years; or</li> <li>iii. Total cholesterol &gt; 290mg/dL; OR</li> </ol> </li> <li>c. Confirmation of diagnosis by gene or receptor testing (attach results); AND</li> </ol> </li> <li>2. Unable to reach goal LDL-C with a minimum of one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-</li> </ol> </li> </ul> </li> </ol> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><i>Use PCSK9 Inhibitors PA form</i></p> | <p>intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe.</p> <p><u>Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD)</u></p> <ol style="list-style-type: none"> <li>History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; AND</li> <li>Unable to reach goal LDL-C with a minimum of one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe.</li> </ol> <p><u>Diagnosis of Primary Hyperlipidemia (not associated with ASCVD or HeFH)</u></p> <ol style="list-style-type: none"> <li><u>Baseline LDL-C <math>\geq</math> 190 mg/dL; and</u></li> <li><u>Unable to reach goal LDL-C <math>&lt;</math> 100 mg/dL while on high-intensity statin therapy</u> (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe.</li> </ol> <p><u>Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)</u></p> <ol style="list-style-type: none"> <li>Total cholesterol and LDL-C <math>&gt;</math> 600mg/dL and triglycerides within reference range; OR</li> <li>Confirmation of diagnosis by gene or receptor testing (attach results); AND</li> <li>Unable to reach goal LDL-C with a minimum one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional requests will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>Documentation of positive clinical response to PCSK9 Inhibitor therapy (current LDL-C lab provided); and</li> <li>Patient continues therapy with a maximally tolerated statin; and</li> <li>Patient has continued compliance with a low-fat diet.</li> </ol> |
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# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Peanut Allergen Powder-dnfp (Palforzia)</b></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for Peanut (<i>Arachis hypogaea</i>) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>Request adheres to all FDA approved labeling for requested drug and indications, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut <math>\geq 3</math> mm compared to control or a peanut-specific serum IgE <math>\geq 0.35</math> kUA/L (kilos of allergen-specific units per liter); and</li> <li>Patient is 1 to 17 years of age at initiation of therapy or 1 year of age and older for continued up-dosing and maintenance therapy; and</li> <li>Prescribed by or in consultation with an allergist or immunologist; and</li> <li>Patient has access to injectable epinephrine; and</li> <li>Will be used in conjunction with a peanut-avoidant diet; and</li> <li>The initial dose escalation and the first dose of each new up-dosing level is administered under the supervision of a health care professional in a health care setting with the ability to manage potentially severe allergic reactions, including anaphylaxis. Initial dose escalation and the first dose of all up-dosing levels is not to be billed to the Iowa Medicaid outpatient pharmacy program as the initial dose escalation is administered in the provider office and should be billed via the medical benefit and the first dose of all up-dosing levels is provided via the Office Dose Kit; and</li> <li>PA is required for all up-dosing dose levels (dose 1 through 11); and</li> <li>Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.</li> </ol> |
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## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Pegcetacoplan<br/>(Empaveli)</b></p> | <div style="text-align: right; font-size: small;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and</li> <li>2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and             <ol style="list-style-type: none"> <li>a. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and</li> <li>b. History of at least one red blood cell transfusion in the previous 12 months; and</li> <li>c. Documentation of hemoglobin &lt; 10.5 g/dL; or</li> </ol> </li> <li>3. Patient has a diagnosis of complement 3 glomerulopathy (C3G) or immune-complex membraneoproliferative glomerulonephritis (IC-MPGN); and             <ol style="list-style-type: none"> <li>a. Diagnosis is confirmed on renal biopsy; and</li> <li>b. Patient is on maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), and/or sodium glucose cotransporter-2 (SGLT2) inhibitor for at least 3 months prior to starting pegcetacoplan; and</li> <li>c. Patient has a history of a trial and therapy failure with systemic oral glucocorticoids or mycophenolate mofetil; and</li> <li>d. Documentation of a baseline urine protein-to-creatinine ratio (UPCR) ≥ 1g/g; and</li> <li>e. Patient has an eGFR ≥ 30mL/min/1.73m<sup>2</sup>; and</li> </ol> </li> <li>4. For patients under 18 years of age, current weight in kg is provided; and</li> <li>5. Is prescribed by or in consultation with a hematologist or nephrologist; and</li> <li>6. Medication will be administered in the member's home; and</li> <li>7. Member or member's care giver has been properly trained in subcutaneous infusion or subcutaneous injection and prescriber has determined home administration is appropriate; and</li> <li>8. Will not be used with another complement inhibitor or will only be considered for patients switching from one complement inhibitor to pegcetacoplan based on FDA approved labeling.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>Initial authorizations will be approved for the FDA approved recommended time period when switching from a different complement inhibitor to verify treatment has been discontinued, or for 6 months otherwise.</p> <p>Additional authorizations will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Documentation of a positive clinical response to therapy:             <ol style="list-style-type: none"> <li>a. PNH: e.g., increased or stabilization or hemoglobin levels or reduction in transfusions; or</li> <li>b. C3G or IC-MPGN: e.g., reduction on UPCR from baseline and eGFR ≥ 30 mL/min/1.73m<sup>2</sup>; and</li> </ol> </li> <li>2. Is not prescribed concurrently with other complement inhibitors.</li> </ol> |  |
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*Use Pegcetacoplan (Empaveli) PA form*

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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <p><b>Proton Pump Inhibitors</b></p> <p><i>Use Proton Pump Inhibitor PA form</i></p>                                  | <p>Prior authorization (PA) is not required for preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day.</p> <p>Requests for PPIs exceeding one unit per day will be considered for the following diagnoses with additional documentation regarding the medical necessity:</p> <ol style="list-style-type: none"> <li>1. Barrett's esophagus, Erosive esophagitis, or Peptic stricture (Please fax a copy of the scope results with the initial request); or</li> <li>2. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas); or</li> <li>3. Recurrent peptic ulcer disease; or</li> <li>4. Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with the requested PPI at maximal dose within the established quantity limit of one per day. Requests for PPIs exceeding one unit per day will be considered on a short-term basis (up to 3 months). After the three-month period, a dose reduction to the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day; or</li> <li>5. Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection.</li> </ol> <p>Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.</p> |
| <p><b>Pulmonary Arterial Hypertension Agents</b></p> <p><i>Use Pulmonary Arterial Hypertension Agents PA form</i></p> | <p>Prior Authorization (PA) is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of pulmonary arterial hypertension</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p><b>Quantity Limit Override</b></p> <p><i>Use Quantity Limit Override PA form</i></p>                               | <p>Designated drugs are limited to specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website <a href="http://www.iowamedicaidpd.com">www.iowamedicaidpd.com</a> under the Billing/Quantity Limits tab. Providers should submit a Prior Authorization (PA) request for override consideration.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p><b>Remibrutinib (Rhapsido)</b></p> <p><i>Use Remibrutinib (Rhapsido) PA form</i></p>                               | <p>Prior authorization (PA) is required for remibrutinib (Rhapsido). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when the patient has a FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of chronic spontaneous urticaria (CSU) with no known cause; and</li> <li>3. Patient has documentation of an adequate trial and therapy failure with a preferred second generation H1 receptor antihistamine for at least 2 weeks.</li> </ol> <p>If criteria for coverage are met, initial authorization will be given for 12 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                     |

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Updated 10/01/2026

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Updated 10/01/2026

| Updated 10/01/2020                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| <p><b>Sapropterin (Kuvan)</b></p><br><br><br><br><br><br><br><p><i>Use Sapropterin (Kuvan)<br/>PA form</i></p>         | <p>Prior authorization (PA) is required for sapropterin (Kuvan). Requests for doses above the FDA approved dose will not be considered. Initial requests will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of phenylketonuria (PKU); and</li> <li>2. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and</li> <li>3. Patient has a baseline blood Phe level <math>\geq 360</math> micromol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sapropterin therapy (attach lab results); and</li> <li>4. Patient's current weight is provided; and</li> <li>5. Request is for an FDA approved starting dose (10mg/kg/day for patients 1 month to 6 years and 10-20mg/kg/day for patients 7 years and older); and</li> <li>6. Blood Phe levels will be measured after 1 week of therapy and at least one other time during the first month of therapy.</li> </ol> <p>Initial requests will be considered for 1 month to assess response to therapy.</p><br><p>Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient's current weight is provided; and</li> <li>2. Patient continues on a Phe restricted diet; and</li> <li>3. For patients initiated at a dose of 10mg/kg/day and the blood Phe level did not decrease from baseline, dose may be increased to 20mg/kg/day. Approval will be given for 1 month to assess response to therapy.</li> <li>4. For patients initiated at a dose of 20mg/kg/per day or those increased to this dose after 1 month of therapy at 10mg/kg/day, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction in blood Phe level. If blood Phe level does not decrease after 1 month at 20mg/kg/day, the patient is considered a non-responder and no further requests will be approved.</li> <li>5. Maintenance dose requests will be considered for patients that have responded to therapy, based on the above criteria, at 6 month intervals. Documentation of compliance to diet and updated blood Phe levels documenting continued response to therapy are required for further consideration.</li> </ol> |
| <p><b>Satralizumab (Enspryng)</b></p><br><br><br><br><br><br><br><p><i>Use Satralizumab<br/>(Enspryng) PA form</i></p> | <p>Prior authorization (PA) is required for satralizumab (Enspryng). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD); and</li> <li>2. Patient is anti-aquaporin 4 (AQP4) seropositive (attach documentation); and</li> <li>3. Patient meets the FDA approved age and dosing; and</li> <li>4. Patient has a history of at least 1 relapse in the previous 12 months prior to initiation of therapy; and</li> <li>5. Patient has been tested for tuberculosis prior to the initiation of therapy and does not have active or untreated latent tuberculosis; and</li> <li>6. Patient has been tested for hepatitis B virus (HBV) prior to the initiation of therapy and confirmed negative for active HBV; and</li> <li>7. Prescribed by a neurologist.</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 1 year. Additional authorizations will be considered upon documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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Updated 10/01/2026

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| <p><b>Sedative/Hypnotics-Non-Benzodiazepine</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Sedative/Hypnotics-Non-Benzodiazepine PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits.</p> <p>PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>A diagnosis of insomnia; and</li> <li>Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and</li> <li>Enforcement of good sleep hygiene is documented; and</li> <li>All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses; and</li> <li>Will not be used concurrently with a benzodiazepine sedative/hypnotic agent.</li> <li>In addition to the above criteria, requests for an orexin receptor antagonist will require documentation of a trial and therapy failure with at least one non-preferred agent prior to consideration of coverage.</li> <li>Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Select Anticonvulsants</b></p> <p><i>Diacomit</i><br/> <i>Fintepla</i><br/> <i>Ztalmy</i></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Select Anticonvulsants PA form</i></p> | <p>Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations: and</li> <li>2. Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, tuberous sclerosis complex, or cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and</li> <li>3. Is prescribed by or in consultation with a neurologist; and</li> <li>4. Patient's current weight is provided; and</li> <li>5. The total daily dose does not exceed the following:             <ol style="list-style-type: none"> <li>a. Fenfluramine                 <ol style="list-style-type: none"> <li>i. With concomitant stiripentol (plus clobazam): 0.4 mg/kg/day with a maximum of 17 mg per day; or</li> <li>ii. Without concomitant stiripentol: 0.7 mg/kg/day with a maximum of 26 mg per day; or</li> </ol> </li> <li>b. Stiripentol                 <ol style="list-style-type: none"> <li>i. Prescribed concomitantly with clobazam; and</li> <li>ii. 50 mg/kg/day with a maximum of 3,000 mg/day; or</li> </ol> </li> <li>c. Ganaxolone                 <ol style="list-style-type: none"> <li>i. Weight ≤ 28 kg: 63mg/kg/day; or</li> <li>ii. Weight &gt; 28 kg: 1800 mg/day.</li> </ol> </li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Select Preventative Migraine Treatments</b></p><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><p><i>Use Selective Preventative Migraine Treatments PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has one of the following diagnoses:             <ol style="list-style-type: none"> <li>a. Chronic Migraine, defined as:                 <ol style="list-style-type: none"> <li>i. ≥ 15 headache days per month for a minimum of 3 months; and</li> <li>ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or</li> </ol> </li> <li>b. Episodic Migraine, defined as:                 <ol style="list-style-type: none"> <li>i. 4 to 14 migraine days per month for a minimum of 3 months; or</li> </ol> </li> <li>c. Episodic Cluster Headache, defined as:                 <ol style="list-style-type: none"> <li>i. Occurring with a frequency between one attack every other day and 8 attacks per day; and</li> <li>ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥3 months; and</li> <li>iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting &lt;3 months, for at least 1 year); and</li> </ol> </li> </ol> </li> <li>2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and</li> <li>3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and</li> <li>4. Patient has been evaluated for and does not have medication overuse headache; and</li> <li>5. For Episodic Cluster Headache, patient has documentation of             <ol style="list-style-type: none"> <li>a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and</li> <li>b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.</li> </ol> </li> <li>6. Lost, stolen, or destroyed medication replacement requests will not be authorized.</li> </ol> <p>Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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Updated 10/01/2026

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| <p><b>Select Oncology Agents</b></p> <p><i>Use Select Oncology Agents PA form</i></p>  | <p>Prior authorization (PA) is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the PA request: copies of medical records (i.e. diagnostic evaluations and recent chart notes), location of treatment (provider office, facility, home health, etc.) if medication requested is not an oral agent, the original prescription, and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p><b>Select Topical Agents</b></p> <p><i>Use Select Topical Agents PA form</i></p>    | <p>Prior authorization (PA) is required for select topical agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations (note, only FDA-approved indications for each drug and specific dosage form will be considered); and</li> <li>2. Patient has a diagnosis of plaque psoriasis with total overall involvement on scalp and non-scalp areas <math>\leq 25\%</math> of the body surface area (BSA) at baseline. Total non-scalp BSA should not exceed 20%; and <ol style="list-style-type: none"> <li>a. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks; or</li> </ol> </li> <li>3. Patient has a diagnosis of seborrheic dermatitis; and <ol style="list-style-type: none"> <li>a. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred topical corticosteroid (scalp- medium to high potency or nonscalp- low potency) and a preferred topical antifungal for a minimum of 4 consecutive weeks; or</li> </ol> </li> <li>4. Patient has a diagnosis of mild to moderate atopic dermatitis; and <ol style="list-style-type: none"> <li>a. Patient has failed to respond to good skin care and regular use of emollients; and</li> <li>b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or</li> <li>c. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Selected Brand Name Drugs</b></p> <p><i>Use Selected Brand Name PA forms</i></p> | <p>Prior authorization (PA) is required for selected brand-name drugs, as determined by the Department, for which there is available an “A” rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For PA to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with:</p> <ol style="list-style-type: none"> <li>1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.</li> <li>2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.</li> </ol> <p>Trials may be overridden when evidence is provided that the use of the generic product would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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

Updated 10/01/2026

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| <p><b>Sepiapterin<br/>(Sephience)</b></p>              | <div style="text-align: right;">Updated 10/01/2026</div> <p>Prior authorization (PA) is required for sepiapterin (Sephience). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>Patient has a diagnosis of hyperphenylalaninemia (HPA) with sepiapterin-responsive phenylketonuria (PK); and</li> <li>Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and</li> <li>Patient has a baseline blood Phe level <math>\geq 360 \mu\text{mol/L}</math> while following a Phe restricted diet, obtained within 2 weeks of initiation of sepiapterin therapy (attach lab results); and</li> <li>Patient's current weight in kg is provided; and</li> <li>Blood Phe levels will be measured after 2 weeks of therapy and at least one more time before initial renewal; and</li> <li>Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).</li> </ol> <p>Initial requests will be considered for 2 months to assess response to therapy.</p> <p>Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>Patient's current weight in kg is provided; and</li> <li>Patient continues a Phe restricted diet; and</li> <li>After an initial 2-month treatment, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction in blood Phe level. If blood Phe level does not decrease at maximum dose, the patient is considered a non-responder and no further requests will be approved; and</li> <li>Patient continues to respond to therapy as demonstrated by a reduction in Phe blood levels since initiation of therapy; and</li> <li>Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).</li> </ol>                                                                                                                                                                                                            |
| <p><i>Use Sepiaptern<br/>(Sephience) PA form</i></p>   | <p><b>Setmelanotide<br/>(Imcivree)</b></p> <p>Prior authorization (PA) is required for setmelanotide (Imcivree). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>Documentation of the patient's baseline weight (kg) and body mass index (BMI) obtained within the past 60 days is provided; and</li> <li>Patient must have a diagnosis of obesity (<math>\text{BMI} &gt; 30 \text{ kg/m}^2</math> for adults or 95<sup>th</sup> percentile using growth chart assessments for pediatric patients) (attach growth chart assessments for pediatric patients); and</li> <li>Patient has a diagnosis of obesity due to one of the following:             <ol style="list-style-type: none"> <li>Proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, and                 <ol style="list-style-type: none"> <li>Genetic testing demonstrates that variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic or of uncertain significance (attach results); or</li> </ol> </li> <li>Bardet-Biedl- syndrome (BBS) as evidenced by documentation in the patient's chart notes (attach documentation); or</li> <li>Acquired hypothalamic obesity (HO) as evidenced by documentation in the patient's chart notes (attach documentation) of having or had a hypothalamic tumor, hypothalamic lesion, or hypothalamic damage or injury; and</li> </ol> </li> <li>Is prescribed by or in consultation with an endocrinologist, a geneticist, or an expert in rare genetic disorders of obesity.</li> </ol> <p>If criteria for coverage are met, initial requests will be approved for 1 year. Additional approvals will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>Patient's current weight (kg) and BMI document a decrease of at least 5% of baseline body weight (or at least 5% baseline BMI for patients with continued growth potential, attach growth chart assessment) since initiating treatment.</li> </ol> |
| <p><i>Use Setmelanotide<br/>(Imcivree) PA form</i></p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Short Acting Opioids</b></p> <p><i>Use Short Acting Opioids PA form</i></p>    | <p>Prior authorization (PA) is required for all non-preferred short acting opioids. PA is also required for members when the total daily dose (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Patient has pain severe enough to require opioid treatment; and</li> <li>2. Patient has tried and failed at least two non-pharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and</li> <li>3. Patient has tried and failed at least two non-opioid pharmacologic therapies (e.g. acetaminophen or NSAIDs); and</li> <li>4. Patient has documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting opioids (based on opioid ingredient only) at therapeutic doses; and</li> <li>5. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and has determined that use of a short-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and</li> <li>6. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids; and</li> <li>7. For patients taking concurrent benzodiazepines, the prescriber must document the following:             <ol style="list-style-type: none"> <li>a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and</li> <li>b. Documentation as to why concurrent use is medically necessary is provided; and</li> <li>c. A plan to taper the benzodiazepine is provided, if appropriate.</li> </ol> </li> </ol> <p>If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient has experienced improvement in pain control and level of functioning; and</li> <li>2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and has determined continued use of a short-acting opioid is appropriate for this member; and</li> <li>3. For patients taking concurrent benzodiazepines, the prescriber must document the following:             <ol style="list-style-type: none"> <li>b. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and</li> <li>c. Documentation as to why concurrent use is medically necessary is provided; and</li> <li>d. A plan to taper the benzodiazepine is provided, if appropriate.</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents and/or non-pharmacologic therapies would be medically contraindicated.</p> |
| <p><b>Step Therapy Requirements</b></p> <p><i>Use Non-Preferred Drug PA form</i></p> | <p>Designated therapeutic drug classes are subject to step therapy edits. For these therapeutic drug classes, drugs are assigned to numbered steps and appropriate trials must be made of the drugs assigned to each step before payment will be made for drugs assigned to a subsequent step. These therapeutic classes, as well as the specific step edit requirements, are identified on the Iowa Medicaid Preferred Drug List posted on the website <a href="http://www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> under the Preferred Drug Lists tab. Providers should submit a Prior Authorization (PA) request for override consideration.</p> <p>Therapeutic Classes Included: Antipsychotics-Atypicals</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Tasimelteon (Hetlio<sup>z</sup>)</b></p><br><br><br><br><br><br><br><p><i>Use Tasimelteon (Hetlio<sup>z</sup>) PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for tasimelteon (Hetlio<sup>z</sup>). Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment will be considered under the following conditions:</p> <ul style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a documented diagnosis of:             <ul style="list-style-type: none"> <li>a. Non-24-Hour Sleep-Wake Disorder (Non-24); and                 <ul style="list-style-type: none"> <li>i. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and</li> <li>ii. Patient has a documented trial and therapy failure with ramelteon (Rozerem<sup>®</sup>); or</li> </ul> </li> <li>b. Sleep disturbances in Smith-Magenis Syndrome (SMS); and                 <ul style="list-style-type: none"> <li>i. Documentation of confirmed deletion of 17p11.2 (cytogenic analysis or microarray) or RAI1 genemutation is provided (attach results); and</li> <li>ii. Patient has a documented trial and therapy failure with at least one other medication used for sleep disturbances; and</li> </ul> </li> </ul> </li> <li>3. Is prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders; and</li> <li>4. Will not be used concomitantly with other sleep medications.</li> </ul> <p>If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions:</p> <ul style="list-style-type: none"> <li>1. Patient's use of tasimelteon (Hetlio<sup>z</sup>) has been continuous without gaps in treatment; and</li> <li>2. Documentation patient has experienced a positive clinical response to therapy with tasimelteon (Hetlio<sup>z</sup><sup>®</sup>), such as entrainment, significant increases in nighttime sleep, significant decreases in daytime sleep, and/or nighttime sleep quality.</li> </ul> |
| <p><b>Testosterone Products</b></p>                                                                                                  | <p>Prior authorization (PA) is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions:</p> <ul style="list-style-type: none"> <li>1. Patient is male and 18 years of age or older (or 12 years of age or older for testosterone cypionate); and</li> <li>2. Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (please attach lab results); and</li> <li>3. Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below):             <ul style="list-style-type: none"> <li>a. Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:</li> </ul> </li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

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

### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><i>Use Testosterone Products PA form</i></p> | <ul style="list-style-type: none"> <li>• Cryptorchidism</li> <li>• Bilateral torsion</li> <li>• Orchitis</li> <li>• Vanishing testes syndrome</li> <li>• Orchiectomy</li> <li>• Klinefelter's syndrome</li> <li>• Chemotherapy</li> <li>• Toxic damage from alcohol or heavy metals</li> </ul> <p>b. Hypogonadotropic hypogonadism</p> <ul style="list-style-type: none"> <li>• Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency</li> <li>• Pituitary-hypothalamic injury from tumors, trauma, or radiation</li> </ul> <p>4. Patient does not have:</p> <ul style="list-style-type: none"> <li>a. Breast or prostate cancer</li> <li>b. Palpable prostate nodule or prostate-specific antigen (PSA) &gt; 4ng/mL</li> <li>c. Hematocrit &gt; 50%</li> <li>d. Untreated severe obstructive sleep apnea</li> <li>e. Severe lower urinary tract symptoms</li> <li>f. Uncontrolled or poorly controlled heart failure</li> </ul> <p>If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following:</p> <ul style="list-style-type: none"> <li>1. An updated testosterone level (Please attach lab result); and</li> <li>2. Documentation the patient has not experienced a hematocrit &gt; 54% or an increase in PSA &gt; 1.4ng/mL in the past 12 months.</li> </ul> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Tezepelumab-ekko (Tezspire) Prefilled Pen</b></p> <p><i>Use Tezepelumab-ekko (Tezspire) Prefilled Pen PA form</i></p> | <p style="text-align: right;">Updated 10/01/2020</p> <p>Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of severe asthma; and             <ol style="list-style-type: none"> <li>a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and</li> <li>b. Patient must have one of the following, in addition to the regular maintenance medications defined above:                 <ol style="list-style-type: none"> <li>i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months, or</li> <li>ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and</li> </ol> </li> <li>c. This medication will be used as an add-on maintenance treatment; and</li> <li>d. Patient/caregiver will administer medication in patient's home; and</li> <li>e. Is not prescribed in combination with other biologics indicated for asthma; or</li> </ol> </li> <li>3. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP); and             <ol style="list-style-type: none"> <li>a. Documentation that tezepelumab will be used as an add-on maintenance treatment; and</li> <li>b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:                 <ol style="list-style-type: none"> <li>i. Nasal corticosteroid spray; and</li> <li>ii. Oral corticosteroid.</li> </ol> </li> </ol> </li> </ol> <p>If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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**For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05**

## Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Topical Acne and Rosacea Products</b></p> <p><i>Use Topical Acne and Rosacea Products PA form</i></p>         | <p>Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Documentation of diagnosis; and</li> <li>3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and</li> <li>4. Payment for non-preferred topical antibiotic or topical retinoid acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and</li> <li>5. Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and</li> <li>6. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent; and</li> <li>7. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and</li> <li>8. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and</li> <li>9. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Topical Antifungals for Onychomycosis</b></p> <p><i>Use Topical Antifungals for Onychomycosis PA form</i></p> | <p>Kerydin (tavaborole) will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lunula (matrix) involvement; and</li> <li>2. Patient is 18 years of age or older; and</li> <li>3. Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and</li> <li>4. Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and</li> <li>5. Patient is diabetic or immunosuppressed/immunocompromised.</li> </ol> <p>If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection will not be considered.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>Topical Corticosteroids</b></p> <p><i>Use Topical Corticosteroids PA form</i></p>                             | <p>Prior authorization (PA) is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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

# Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Tralokinumab-Idrm (Adbry)</b></p><br><br><br><br><br><br><br><p><i>Use Tralokinumab (Adbry) PA form</i></p> | <p>Prior authorization (PA) is required for tralokinumab-Idrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of moderate to severe atopic dermatitis; and</li> <li>3. Is prescribed by or in consultation with a dermatologist; and</li> <li>4. Patient has failed to respond to good skin care and regular use of emollients; and</li> <li>5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and</li> <li>6. Patient has documentation of a previous trial and therapy failure with a preferred topical immunomodulator for a minimum of 4 weeks; and</li> <li>7. Patient will continue with skin care regimen and regular use of emollients.</li> </ol> <p>If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients.</p> <p>The required trials may be overridden when documented evidence if provided that the use of these agents would be medically contraindicated.</p> |
| <p><b>Triheptanoin (Dojolvi)</b></p><br><br><br><br><br><br><br><p><i>Use Triheptanoin (Dojolvi) PA form</i></p>  | <p>Prior authorization (PA) is required for triheptanoin (Dojolvi). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and</li> <li>2. Patient has a diagnosis of long-chain fatty acid oxidation disorder (LC-FAOD), with supporting documentation of gene mutation(s) associated with LC-FAOD (LC-FOADs include: CPT1, CACT, CPT11, VLCAD, TFP, LCHAD); and</li> <li>3. Patient will not be using another medium chain triglyceride (MCT) product; and</li> <li>4. Documentation of a patient's daily caloric intake (DCI) is provided; and</li> <li>5. Patient's target daily dose is provided as a percentage of the patient's total daily prescribed DCI, not to exceed 35%; and</li> <li>6. Is prescribed by or in consultation with an endocrinologist, geneticist, or metabolic disease specialist.</li> </ol> <p>If the criteria for coverage are met, initial requests will be approved for four months. Additional authorizations will be considered upon documentation of a positive clinical response to therapy.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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Updated 10/01/2026

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| <p><b>Vericiguat (Verquvo)</b></p><br><br><br><br><br><br><br><br><br><br><p><i>Use Vericiguat (Verquvo)<br/>PA form</i></p> | <div style="text-align: right; font-size: small;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for vericiguat (Verquvo). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of symptomatic chronic heart failure (NYHF class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and</li> <li>3. Patient meets one of the following:             <ol style="list-style-type: none"> <li>a. Recent hospitalization for heart failure (within the last 6 months); or</li> <li>b. Recent need for outpatient intravenous diuretics (within the last 3 months); and</li> </ol> </li> <li>4. Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least one month after the last dose; and</li> <li>5. Will not be used concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or phosphodiesterase type 5 (PDE-5) inhibitors (e.g. sildenafil, tadalafil, vardenafil); and</li> <li>6. Documentation of prior or current therapy, at a maximally tolerated dose, with one drug from each category below:             <ol style="list-style-type: none"> <li>a. Renin-angiotensin system inhibitor (angiotensin converting enzyme [ACEI], angiotensin receptor blocker [ARB], or angiotensin receptor-neprilysin inhibitor [ARNI]); and</li> <li>b. Evidence-based beta-blocker (carvedilol, metoprolol succinate, or bisoprolol); and</li> <li>c. Mineralocorticoid receptor antagonist (MRA); and</li> <li>d. Sodium-glucose cotransporter 2 inhibitor (SGLT2i) indicated for the treatment of heart failure (empagliflozin or dapagliflozin); and</li> </ol> </li> <li>7. Initial requests for vericiguat (Verquvo) 2.5 mg and 5 mg tablets will be limited to one 14-day supply for each strength.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> |
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**Iowa Medicaid Drug Prior Authorization Criteria**

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| <p><b>Vesicular Monoamine Transporter (VMAT) 2 Inhibitors</b></p><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><p><i>Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form</i></p> | <div style="text-align: right;">Updated 10/01/2020</div> <p>Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered when the patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>Will not be used concurrently with other vesicular monoamine (VMAT) 2 inhibitors; and</li> <li>Prescribed by or in consultation with a neurologist, psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and</li> </ol> <p><u>Tardive Dyskinesia</u> (Ingrezza or Austedo)</p> <ol style="list-style-type: none"> <li>Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:             <ol style="list-style-type: none"> <li>Involuntary athetoid or choreiform movements</li> <li>Documentation or claims history of current or prior chronic use (<math>\geq 3</math> months or 1 month in patients <math>\geq 60</math> years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)</li> <li>Symptoms lasting longer than 4-8 weeks; and</li> </ol> </li> <li>Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and</li> <li>Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS),</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>Patient continues to meet the criteria for initial approval; and</li> <li>Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS); or</li> </ol> <p><u>Chorea associated with Huntington's disease</u> (Austedo, Ingrezza or tetrabenazine)</p> <ol style="list-style-type: none"> <li>Patient has a diagnosis of Huntington's disease with chorea symptoms; and</li> <li>Patient is not suicidal, or does not have untreated or inadequately treated depression; and</li> <li></li> <li>For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and</li> </ol> <p>If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> <li>Patient continues to meet the criteria for initial approval; and</li> <li>Documentation of improvement in chorea symptoms is provided.</li> </ol> |
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### Iowa Medicaid Drug Prior Authorization Criteria

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

Updated 10/01/2026

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| <p><b>Viloxazine (Qelbree)</b></p> <p><i>Use Viloxazine (Qelbree) PA form</i></p>                | <p>Prior authorization is required for viloxazine (Qelbree). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and</li> <li>3. Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational) and</li> <li>4. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine or a preferred stimulant; and</li> <li>5. Dose does not exceed 400 mg per day for pediatric patients (&lt; 18 years of age) and 600 mg per day for adult patients; and</li> <li>6. Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD.</li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>                                                                                                                                                                         |
| <p><b>Vitamins, Minerals and Multiple Vitamins</b></p> <p><i>Use Vitamin/Mineral PA form</i></p> | <p>Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p><b>Vonoprazan (Voquezna)</b></p> <p><i>Use Vonoprazan (Voquezna) PA form</i></p>              | <p>Prior authorization (PA) is required for vonoprazan (Voquezna), Voquezna Dual Pak, and Voquezna Triple Pak. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of healing of erosive esophagitis (attach endoscopy results for initial diagnosis), maintenance of healed erosive esophagitis (attach endoscopy results for initial diagnosis), and relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD); and <ol style="list-style-type: none"> <li>a. Documentation of an 8-week trial and therapy failure, based on ongoing symptoms, with two preferred PPIs, each twice-daily dosing; or</li> </ol> </li> <li>3. Patient has an active <i>Helicobacter pylori</i> (<i>H. pylori</i>) infection (attach documentation); and <ol style="list-style-type: none"> <li>a. Patient has documentation of a recent trial and therapy failure with a preferred agent(s) for the treatment of <i>H. pylori</i> infection; and</li> <li>b. Request is for the triple pak or dual pak</li> </ol> </li> </ol> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, requests will be evaluated for the dosage and duration of therapy according to the indications specified on the FDA approved label.</p> |

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# Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2026

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| <b>Zuranolone (Zurzuvae)</b>                 | Prior authorization (PA) is required for zuranolone (Zurzuvae). Payment will be considered under the following conditions:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <i>Use Zuranolone (Zurzuvae)<br/>PA form</i> | <ol style="list-style-type: none"> <li>1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and</li> <li>2. Patient has a diagnosis of postpartum depression (PPD); and</li> <li>3. Patient is 12 months or less postpartum on the date of the request (start date of delivery); and</li> <li>4. The onset of the current depressive episode was during the third trimester or within 4 weeks postpartum; and</li> <li>5. Patient has not received brexanolone for the current PPD episode; and</li> <li>6. Only one course of treatment (i.e., 14 days) per pregnancy will be considered. Extension of therapy beyond 14 days will not be authorized.</li> </ol> |

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## **Aldosterone Synthase Inhibitors Prior Authorization**

### **Background**

Baxdrostat (Baxfendy), an aldosterone synthase inhibitor, was approved by the U.S. Food and Drug Administration (FDA) for the treatment of hypertension in combination with other antihypertensive drugs, to lower blood pressure in adults who are not adequately controlled on other agents. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions.

Aldosterone synthase inhibitors (ASIs) are a novel class of antihypertensive agents that target aldosterone biology upstream by inhibiting aldosterone synthesis. By lowering aldosterone production rather than blocking receptor activation alone, ASIs provide a mechanistically distinct approach to reducing aldosterone-mediated sodium retention and potential vascular, cardiac, and renal effects.

The 2025 American College of Cardiology/American Heart Association (ACC/AHA) guideline defines hypertension as an average office systolic blood pressure (SBP)  $\geq 130$  mm Hg or diastolic blood pressure (DBP)  $\geq 80$  mm Hg.

- Resistant hypertension (rHTN) is defined as BP above goal despite the concurrent use of  $\geq 3$  antihypertensive agents with complementary mechanisms, typically including a long-acting calcium channel blocker (CCB), an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB), and a diuretic at maximally tolerated doses, or controlled BP requiring  $\geq 4$  antihypertensive agents. True rHTN requires exclusion of white-coat effect, medication nonadherence, and secondary causes.
- Baxdrostat has not yet been incorporated into current hypertension guidelines.

Treatment includes lifestyle modification and pharmacologic therapy based on BP level and cardiovascular (CV) risk. For rHTN, after evaluating other potential contributors and optimizing treatment with three complementary antihypertensive agents, guidelines recommend adding a mineralocorticoid receptor antagonist (MRA), usually spironolactone, if BP remains uncontrolled. Eplerenone may be used when spironolactone is not tolerated because of antiandrogenic or progestogenic adverse effects. When MRAs are contraindicated or not tolerated, alternative add-on options may include amiloride, beta-blockers, alpha-blockers, central alpha-2 adrenergic agonists, direct vasodilators, or other agents selected based on patient-specific factors.

Baxdrostat is currently being investigated across multiple cardiorenal indications, including chronic kidney disease with hypertension, heart failure and cardiovascular death prevention and primary aldosteronism. Additionally, a second ASI, lorundrostat, is in development for the treatment of hypertension in adults who are not adequately controlled on other agents, with a projected approval date in the fourth quarter of 2026.

In 2024, the FDA approved aprocitentan (Tryvio), an endothelin receptor antagonist indicated for the treatment of hypertension in combination with other antihypertensive drugs to lower blood pressure in adults who are not adequately controlled on other drugs. The prior authorization criteria for baxdrostat (Baxfendy) are modeled after the criteria for aprocitentan (Tryvio).

### **Dosage and Administration**

- Consider the patient's risk of hyperkalemia and hyponatremia before initiation.
- Recommended dosage is 2 mg orally once daily.
- For patients at increased risk of hyperkalemia or hyponatremia, the recommended dosage is 1 mg once daily.

### **Dosage Forms and Strengths**

- Tablets: 1 mg and 2 mg

### **Contraindications**

- None.

### **Warnings and Precautions**

- Serum potassium should be assessed before initiation and periodically thereafter. More frequent assessment is recommended in patients at increased risk of hyperkalemia.
- Serum sodium should be assessed before initiation and periodically thereafter. More frequent assessment is recommended in patients at increased risk of hyponatremia.

### **Adverse Reactions**

- The most common adverse reaction (more frequent than placebo and  $\geq 5\%$  in baxdrostat-treated patients) was hyperkalemia.

### **Pharmacology**

- Baxdrostat is an inhibitor of human aldosterone synthase. Aldosterone contributes to hypertension by promoting the retention of sodium and water by the kidneys, which increases blood volume, and consequently, raises blood pressure. Aldosterone can cause vascular dysfunction, inflammation, and fibrosis. Inhibition of aldosterone synthase by baxdrostat decreases plasma aldosterone concentrations, thereby reducing BP.
- Baxdrostat has greater potency and selectivity for aldosterone synthase than for the closely related enzyme 11 $\beta$ -hydroxylase (the final enzyme in cortisol synthesis). In nonclinical and clinical studies, baxdrostat significantly lowered aldosterone concentrations without affecting cortisol responses over a wide dose range.

- Baxdrostat does not inhibit synthesis of sex hormones such as testosterone and estrone.

### **Clinical Studies**

The efficacy of baxdrostat was assessed in a multipart, phase 3, multicenter trial that included adults with SBP  $\geq 140$  mm Hg and  $< 170$  mm Hg who were prescribed at least two antihypertensive medications, including a diuretic, and who had an eGFR  $\geq 45$  mL/min/1.73 m<sup>2</sup> and a serum potassium level  $\geq 3.5$  and  $< 5.0$  mEq/L. Following a 2-week placebo run-in period, 794 patients with SBP  $\geq 135$  mm Hg were randomized equally to receive Baxfendy 1 mg, Baxfendy 2 mg, or placebo once daily during an initial 12-week, double-blind treatment period. During this period, changes to background antihypertensive medications were prohibited unless patients became hypotensive or required rescue medication. Treatment with potassium supplements or potassium binders was allowed during the trial period, but simultaneous use of an ARB and an ACE inhibitor, or treatment with an MRA or potassium-sparing diuretic, was not allowed.

At the end of 12 weeks, patients entered a 12-week, open-label treatment period. Patients who received Baxfendy 2 mg during the double-blind period continued the same dose; patients who received Baxfendy 1 mg were re-randomized to either Baxfendy 2 mg or standard of care; and patients who received placebo were re-randomized to either Baxfendy or standard of care. At the end of the open-label period, 257 patients who received Baxfendy 2 mg during that period were re-randomized to receive Baxfendy 2 mg or placebo once daily during an 8-week, double-blind, randomized-withdrawal period.

Concomitant antihypertensive medications during the trial included diuretics (100% of patients), either an ACE inhibitor or ARB (90%), a CCB (70%), beta-blockers (34%), and other antihypertensive medications (17%). In addition, approximately 41% of patients were taking three background antihypertensive medications. At baseline, the mean SBP was 149 mm Hg and the mean DBP was 87 mm Hg.

The primary endpoints were change from baseline to week 12 in seated office SBP for Baxfendy 2 mg once daily compared to placebo and for Baxfendy 1 mg once daily compared to placebo.

- The change in mean SBP was -15.7 mm Hg with Baxfendy 2 mg (difference vs. placebo, -9.8 mm Hg; 95% CI, -12.6 to -7.0;  $p < 0.0001$ ), -14.5 mm Hg with Baxfendy 1 mg (difference vs. placebo, -8.7 mm Hg; 95% CI, -11.5 to -5.8;  $p < 0.0001$ ), and -5.8 mm Hg with placebo.

Maintenance of the blood pressure lowering effect of Baxfendy was demonstrated in the double-blind randomized-withdrawal part of the trial.

- The change in mean SBP was -3.7 mm Hg (95% CI, -5.5 to -1.9) in the Baxfendy 2 mg arm and +1.4 mm Hg (95% CI, -1.2 to 4.0) in the placebo arm, for a mean difference from placebo of -5.1 mm Hg (95% CI, -8.3 to -1.9; p = 0.002).

### **Cost**

- Baxfendy (WAC): \$900/month; \$10,800/year
- Comparison (pricing based on AAC at recommended maximum dose, unless otherwise indicated)
  - Spironolactone: \$4.58/month; \$54.98/year
  - Eplerenone: \$23.12/month; \$277.44/year
  - Tryvio (WAC): \$775/month; \$9,300/year

### **Newly Proposed Clinical Prior Authorization Criteria**

Prior authorization (PA) is required for aldosterone synthase inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of resistant hypertension; and
3. Secondary causes of hypertension have been ruled out; and
4. Patient has been adherent with standard background antihypertensive therapy, which includes at least one agent from each of the following classes, taken concurrently at maximally tolerated doses:
  - a. Angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB);
  - b. Calcium channel blocker (CCB);
  - c. Diuretic;
  - d. Mineralocorticoid receptor antagonist (MRA); and
5. Patient's blood pressure remains above target goal despite adherence with the above agents; and
6. Will be used in combination with at least three other antihypertensive agents at maximally tolerated doses.

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

### **References**

Baxfendy. Package insert. AstraZeneca Pharmaceuticals LP; August 2026.

Jones DW, Ferdinand KC, Taler SJ, et al. 2025  
AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for  
the prevention, detection, evaluation, and management of high blood pressure in adults: a  
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## **Apolipoprotein C-III (ApoC-III) Inhibitors Prior Authorization Review**

### **Background**

Tryngolza (olezarsen) received a second indication as an adjunct to diet to reduce triglycerides and the risk of acute pancreatitis in adults with severe hypertriglyceridemia (sHTG: triglycerides  $\geq$  500 mg/dL). Tryngolza is also indicated as an adjunct to diet to reduce triglycerides (TG) in adults with familial chylomicronemia syndrome (FCS).

The [2026 ACC/AHA/Multisociety Guideline on the Management of Dyslipidemia](#) recommend lifestyle management and statins as first-line therapy for patients with TG  $\geq$  500 mg/dL to reduce ASCVD risk, even though they reduce TG less than fibrates or prescription omega-3 fatty acids. However, prescription omega-3 fatty acids or fibric acid derivatives are reasonable to lower TG in adults with sHTG (TG  $\geq$  500 mg/dL) to reduce the risk of pancreatitis. In patients with TG levels  $\geq$  1000 mg/dL, initial priority should be given to lowering TG to reduce the risk of pancreatitis (olezarsen is recommended). Fenofibrate is preferred to gemfibrozil in conjunction with statins due to its lower risk of severe myopathy. Niacin is recommended as a last-line agent for severe hypertriglyceridemia due to relatively high risk of intolerable adverse reactions.

### **Dosage and Administration**

- sHTG: 50 mg subcutaneously once monthly. For patients who tolerate the 50 mg dosage and additional TG reduction is clinically indicated, the dosage may be increased to 80 mg subcutaneously once monthly.

### **Dosage Forms and Strengths**

- 50 mg/0.8 mL and 80 mg/0.8 mL single-dose autoinjector

### **Contraindications**

- History of serious hypersensitivity reactions to olezarsen or any of the excipients in Tryngolza.

### **Warnings and Precautions**

- Hypersensitivity reactions
- Liver enzyme abnormalities

### **Adverse Reactions**

- Most common sHTG ( $\geq$  2% higher than placebo): injection site reactions and liver enzyme increases.

## Pharmacology

- Olezarsen binds to apoC-III mRNA, leading to mRNA degradation and resulting in a reduction of serum apoC-III protein. Reduction of apoC-III leads to increased clearance of plasma TG and very low-density lipoprotein (VLDL).

## Clinical Trials

The safety and efficacy of Tryngolza (50 mg or 80 mg subcutaneously every 4 weeks) for the treatment of sHTG were evaluated in two, randomized, double-blind, placebo-controlled studies (Trial 2 and Trial 3). Adult patients had a fasting TG  $\geq$  500 mg/dL and were on optimized, stable background lipid-lowering therapy prior to enrollment and throughout the trial. The primary endpoint in both studies was the change in TG level from baseline to 6 months compared to placebo.

- In Trial 2, the placebo-adjusted changes from baseline in TG levels was -63% (95% CI: -72%, -54%;  $p < 0.0001$ ) for Tryngolza 50 mg and -72% (95% CI: -81%, -63%;  $p < 0.0001$ ) for Tryngolza 80 mg.
- In Trial 3, the placebo-corrected difference in percent change in fasting TG from baseline to Month 6 was -49% (95% CI: -60%, -39%;  $p < 0.0001$ ) for Tryngolza 50 mg and -55% (95% CI: -65%, -44%;  $p < 0.0001$ ) for Tryngolza 80 mg.

## Manufacturer

- Ionis Pharmaceuticals, Inc.

## Cost

- Tryngolza (WAC): \$3,333/month; \$40,000/year
- Comparative pricing (AAC unless otherwise noted; at max dose)
  - Atorvastatin: \$2/month; \$23/year
  - Fenofibrate: \$3/month; 38/year
  - Icosapent ethyl: \$24/months \$283/year

## Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for apoC-III inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic testing, (e.g., biallelic pathogenic variants in FCS-causing genes [*LPL*, *GPIHBP1*, *APOA5*, *APOC2*, or *LMF1*]) (attach genetic testing results); and
3. The patient has a current fasting triglyceride level of 880 mg/dL or greater (attach current lipid panel obtained within the past 30 days); and

4. The patient will use medication in combination with a low-fat diet ( $\leq 20$  grams of total fat per day); and
5. Medication will not be used concomitantly with other apoC-III inhibitors; and
6. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.

If the criteria for coverage are met, initial requests will be given for 12 months. Requests for continuation of therapy will be considered at 12-month intervals under the following conditions:

1. Documentation of a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days); and
2. Patient continues to use medication in combination with a low-fat diet ( $\leq 20$  grams of total fat per day); and
3. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.

### **Proposed Clinical Prior Authorization Criteria**

Prior authorization (PA) is required for apoC-III inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic testing, (e.g., biallelic pathogenic variants in FCS-causing genes [*LPL*, *GPIHBP1*, *APOA5*, *APOC2*, or *LMF1*]) (attach genetic testing results); and
  - a. The patient has a current fasting triglyceride level of 880 mg/dL or greater (attach current lipid panel obtained within the past 30 days); ~~or~~ and
3. *Patient has a diagnosis of severe hypertriglyceridemia (sHTG); and*
  - a. *While on optimized lipid-lowering therapy with a maximally tolerated statin plus a fibric acid derivative or a prescription omega-3 fatty acid, patient continues to have a fasting triglyceride level  $\geq 500$  mg/dL (attach current lipid panel obtained within the past 30 days); or*
  - b. *Patient has documentation of a fasting triglyceride level  $\geq 1,000$  mg/dL; and*
4. The patient will use medication in combination with a low-fat diet ( $\leq 20$  grams of total fat per day); and
5. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.

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

If the criteria for coverage are met, initial requests will be given for 12 months. Requests for continuation of therapy will be considered at 12-month intervals under the following conditions:

1. Documentation of a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days); and
2. Patient continues to use medication in combination with a low-fat diet ( $\leq 20$  grams of total fat per day); and
3. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.

## **References**

Tryngolza. Package insert. Ionis Pharmaceuticals; June 2026.

Blumenthal RS, Morris PB, Gaudino M, et al.

ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: A report of the American College of Cardiology/American Heart Association joint committee on clinical practice guidelines. J Am Coll Cardiol. 2026:S0735-1097(25)10254-4. doi: 10.1016/j.jacc.2025.11.016.

## **Oral Constipation Agents Proposed Removal of Prior Authorization Criteria and Recommended Age Edits and Quantity Limits**

### **Background**

The current prior authorization (PA) criteria were established to promote appropriate and cost-effective use of oral constipation agents. With changes in medication costs resulting in these therapies becoming more cost-effective to the State, removal of PA criteria is recommended. With removal of PA criteria, age edits and quantity limits are recommended to help ensure use is consistent with FDA-approved indications and dosing.

It is recommended that the clinical PA criteria for the oral constipation agents identified below be removed and that the proposed age edits and quantity limits be implemented to support use consistent with FDA-approved labeling.

### **Current Clinical Prior Authorization Criteria**

Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient must have documentation of adequate trials and therapy failures with the following:
  - a. Members 18 years of age or older:
    - i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
    - ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); or
  - b. Members 17 years of age or younger:
    - i. Polyethylene glycol; and
    - ii. One other preferred generic laxative, such as lactulose or senna; and
3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
4. Patient has one of the following diagnoses:
  - a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance)
    - i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and
    - ii. Patient has two or more of the following symptoms within the last 3 months:

1. Straining during at least 25% of bowel movements;
  2. Lumpy or hard stools for at least 25% of bowel movements;
  3. Sensation of incomplete evacuation for at least 25% of bowel movements; and
- iii. Documentation the patient is not currently taking constipation causing therapies; or
- b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, llsrela, Linzess, or Trulance)
  - i. Patient is female (Amitiza only); and
  - ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following:
    1. Related to defecation;
    2. Associated with a change in stool frequency;
    3. Associated with a change in stool form; or
- c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic)
  - i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
  - ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
    1. Hard to very hard stool consistency;
    2. Moderate to very severe straining;
    3. Having a sensation of incomplete evacuation; or
- d. A diagnosis of functional constipation (Linzess)
  - i. Patient has less than 3 SBMs per week; and 1 or more of the following criteria at least once per week for at least 2 months:
    1. History of stool withholding or excessive voluntary stool retention;
    2. History of painful or hard bowel movements;
    3. History of large diameter stools that may obstruct the toilet;
    4. Presence of a large fecal mass in the rectum;
    5. At least 1 episode of fecal incontinence per week.

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

### Medications Currently Subject to Oral Constipation Agents PA Criteria

| Drug Name & Strengths                                                            | Indication                  | Adult Dosing                                                                           | Pediatric Dosing             |
|----------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------|------------------------------|
| <b>Linzess (linaclotide)</b><br><br>Oral capsule:<br>72 mcg, 145 mcg,<br>290 mcg | IBS-C                       | 290 mcg once daily                                                                     | ≥7 years: 145 mcg once daily |
|                                                                                  | CIC                         | 145 mcg once daily; 72 mcg once daily based on individual presentation or tolerability | N/A                          |
|                                                                                  | FC                          | N/A                                                                                    | ≥2 years: 72 mcg once daily  |
| <b>Amitiza (lubiprostone)</b><br><br>Oral Capsule:<br>8 mcg, 24 mcg              | CIC                         | 24 mcg twice daily                                                                     | N/A                          |
|                                                                                  | OIC, chronic noncancer pain | 24 mcg twice daily                                                                     | N/A                          |
|                                                                                  | IBS-C                       | 8 mcg twice daily                                                                      | N/A                          |
| <b>Movantik (naloxegol)</b><br><br>Oral tablet:<br>12.5 mg, 25 mg                | OIC, chronic noncancer pain | 25 mg once daily; reduce to 12.5 mg once daily if not tolerated                        | N/A                          |
| <b>Motegrity (prucalopride)</b><br><br>Oral tablet:<br>1 mg, 2 mg                | CIC                         | 2 mg once daily                                                                        | N/A                          |
| <b>Ibsrela (tenapanor)</b><br><br>Oral tablet:<br>50 mg                          | IBS-C                       | 50 mg twice daily                                                                      | N/A                          |
| <b>Symproic (naldemedine)</b><br><br>Oral tablet:<br>0.2 mg                      | OIC, chronic noncancer pain | 0.2 mg once daily                                                                      | N/A                          |

CIC: chronic idiopathic constipation; FC: functional constipation; IBS-C: irritable bowel syndrome with constipation; OIC: opioid-induced constipation.

### Proposed Quantity Limits and Age Edits

| Drug Name                           | Strength                 | Quantity Limit Per 30 Days | Age Edit                                                    |
|-------------------------------------|--------------------------|----------------------------|-------------------------------------------------------------|
| <b>Linzess<br/>(linaclotide)</b>    | 72 mcg, 145 mcg, 290 mcg | 30 capsules                | 290 mcg: ≥18 years<br>145 mcg: ≥7 years<br>72 mcg: ≥2 years |
| <b>Amitiza<br/>(lubiprostone)</b>   | 8 mcg, 24 mcg            | 60 capsules                | ≥18 years                                                   |
| <b>Movantik<br/>(naloxegol)</b>     | 12.5 mg, 25 mg           | 30 tablets                 | ≥18 years                                                   |
| <b>Motegrity<br/>(prucalopride)</b> | 1 mg, 2 mg               | 30 tablets                 | ≥18 years                                                   |
| <b>Ibsrela<br/>(tenapanor)</b>      | 50 mg                    | 60 tablets                 | ≥18 years                                                   |
| <b>Symproic<br/>(naldemedine)</b>   | 0.2 mg                   | 30 tablets                 | ≥18 years                                                   |

Proposed age edits and quantity limits are based on FDA-approved dosing. Requests exceeding the established age edit and quantity limit would be subject to PA.

### References

Linaclotide. In: Micromedex DRUGDEX [electronic version]. Merative. Accessed October 13, 2026.  
Lubiprostone. In: Micromedex DRUGDEX [electronic version]. Merative. Accessed October 13, 2026.  
Naloxegol. In: Micromedex DRUGDEX [electronic version]. Merative. Accessed October 13, 2026.  
Prucalopride. In: Micromedex DRUGDEX [electronic version]. Merative. Accessed October 13, 2026.  
Tenapanor. In: Micromedex DRUGDEX [electronic version]. Merative. Accessed October 13, 2026.  
Naldemedine. In: Micromedex DRUGDEX [electronic version]. Merative. Accessed October 13, 2026.

## Select Nephrology Agents Prior Authorization Review

### Background

Filspari (sparsentan) and Vanrafia (atrasentan) are oral endothelin pathway agents used in proteinuric glomerular diseases. Both are indicated in adults for primary immunoglobulin A nephropathy (IgAN). Filspari also has an FDA-approved indication for focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome in patients 8 years of age and older.

| FDA-Approved Indication | Filspari (sparsentan)                                                                                               | Vanrafia (atrasentan)                                                                                                                                                                           |
|-------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IgAN                    | To slow kidney function decline in adults with primary IgAN who are at risk for disease progression                 | To reduce proteinuria in adults with primary IgAN at risk of rapid disease progression, generally UPCR $\geq 1.5$ g/g<br>Accelerated approval; kidney-function benefit has not been established |
| FSGS                    | To reduce proteinuria in adult and pediatric patients 8 years of age and older with FSGS without nephrotic syndrome | No FDA-approved FSGS indication                                                                                                                                                                 |

UPCR – urine protein-to-creatinine ratio

IgAN is a progressive glomerular disease characterized by IgA deposition in the kidneys. Persistent proteinuria is an important marker of risk for disease progression. Patients with IgAN may present with a spectrum of clinical syndromes. Most patients present with either gross hematuria (40% to 50%), often accompanying an upper respiratory infection, or microscopic hematuria with or without mild proteinuria (30% to 40%). Less than 10% of patients present with either nephrotic syndrome or an acute, rapidly progressive glomerulonephritis characterized by edema, hypertension, hematuria, and renal impairment. Rarely, patients may develop acute kidney injury with or without oliguria due to crescentic IgAN or to gross hematuria causing tubular occlusion and/or damage by red cells.

Current KDIGO guidance identifies patients with proteinuria  $\geq 0.5$  g/day, or a UPCR  $\geq 0.5$  g/g, as being at increased risk for progressive kidney function decline. Therapeutic interventions should aim to reduce proteinuria, with a target proteinuria level of less than 0.5 g/day (approximately UPCR  $<0.5$  g/g), as lower proteinuria levels are associated with improved long-term kidney outcomes.

The focus of management for most patients should be to simultaneously prevent or reduce immunoglobulin A-containing immune complex (IgA-IC) formation and IgA-IC-mediated glomerular loss (typically with immunosuppressive therapy), as well as manage the consequences of existing IgAN-induced nephron loss.

- For management of the consequences of IgAN-induced nephron loss and to protect glomerular function, general measures for kidney protection include lifestyle modifications (e.g., sodium restriction, weight control, exercise, smoking and vaping cessation), blood pressure control, and the use of renin-angiotensin system inhibitors (RASi) such as angiotensin-converting enzyme inhibitors (ACEi) or angiotensin receptor blockers (ARBs) in patients with proteinuria; other treatment options include the use of sparsentan or atrasentan combined with RASi therapy (where appropriate), with or without sodium-glucose cotransporter-2 (SGLT2) inhibitor therapy.
- In order to manage IgAN-specific drivers for nephron loss, therapies targeted at stopping the synthesis of pathogenic forms of IgA and IgA-IC formation as well as stopping IgA/IgA-IC mediated kidney injury may be considered including immunosuppressive therapy (e.g., systemic or targeted steroid therapy), complement inhibition, and a proliferation-inducing ligand (APRIL)/B-cell activating factor (BAFF) inhibitors.

Focal segmental glomerulosclerosis (FSGS) is a pattern of glomerular injury characterized by proteinuria, nephrotic syndrome, and progressive kidney dysfunction. Diagnosis requires a kidney biopsy demonstrating focal and segmental glomerular sclerosis, with additional clinical and pathologic evaluation used to distinguish primary, secondary, genetic, and undetermined-cause forms of FSGS. Supportive care, including optimization of renin-angiotensin system blockade and reduction of proteinuria, is recommended for all patients.

**Dosage and Administration** (see prescribing information for complete dosing and administration information)

|                    | <b>Filspari (sparsentan)</b>                                                                                                                                           | <b>Vanrafia (atrasentan)</b>                    |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| IgAN dose          | 200 mg orally once daily for 14 days, then increase to 400 mg once daily as tolerated                                                                                  | 0.75 mg orally once daily, with or without food |
| FSGS dose          | Weight > 50 kg: 400 mg once daily for 14 days, then 800 mg once daily as tolerated. Weight ≤ 50 kg: 200 mg once daily for 14 days, then 400 mg once daily as tolerated | Not applicable                                  |
| Background therapy | Discontinue RAS inhibitors and endothelin receptor antagonists before initiation                                                                                       | May be added to supportive care                 |

## Dosage Forms and Strengths

- Filspari tablets: 200 mg and 400 mg.
- Vanrafia tablets: 0.75 mg.

## Contraindications

|                     | Filspari (sparsentan)                                           | Vanrafia (atrasentan)                                |
|---------------------|-----------------------------------------------------------------|------------------------------------------------------|
| Pregnancy           | Contraindicated.                                                | Contraindicated.                                     |
| Concomitant therapy | Concomitant ARBs, endothelin receptor antagonists, or aliskiren | No labeled class contraindication                    |
| Other               | None                                                            | Hypersensitivity to atrasentan or product components |

## Warnings and Precautions

|               | Filspari (sparsentan)                                                                                             | Vanrafia (atrasentan)                                                             |
|---------------|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Boxed warning | Hepatotoxicity and embryo-fetal toxicity. Available only through the Filspari REMS because of hepatotoxicity risk | Embryo-fetal toxicity                                                             |
| Key warnings  | Hepatotoxicity, embryo-fetal toxicity, hypotension, acute kidney injury, hyperkalemia, and fluid retention        | Embryo-fetal toxicity, hepatotoxicity, fluid retention, and decreased sperm count |

## Adverse Reactions

- Filspari: hyperkalemia, hypotension, peripheral edema, dizziness, anemia, acute kidney injury, and transaminase elevations. In FSGS, common reactions include peripheral edema, hypotension, hyperkalemia, dizziness, anemia, acute kidney injury, and transaminase elevations.
- Vanrafia: peripheral edema, anemia, and liver transaminase elevation.

## Pharmacology

| Filspari (sparsentan)                                                                                                             | Vanrafia (atrasentan)           |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| An endothelin type A receptor (ET <sub>A</sub> R) antagonist and an angiotensin II type 1 receptor (AT <sub>1</sub> R) antagonist | An ET <sub>A</sub> R antagonist |

## Clinical Trials

### Filspari: Primary IGA Nephropathy

The effect of Filspari on proteinuria and kidney function (eGFR) was assessed in a randomized, double-blind, active-controlled, multicenter, global study (PROTECT) in adults with biopsy-proven primary IgA nephropathy, eGFR  $\geq$  30 mL/min/1.73 m<sup>2</sup>, and total urine protein  $\geq$  1.0 g/day on a stable dose of maximally tolerated RAS inhibitor treatment. Patients were randomized to either Filspari or irbesartan. Rescue

immunosuppressive treatment could be initiated at the investigator's discretion during the trial. Concomitant use of SGLT2 inhibitors, other RAS inhibitors, and aldosterone blockers were prohibited. The primary efficacy endpoint was the rate of change in eGFR over a 110-week period following initiation of randomized therapy.

- The mean eGFR slope from baseline to week 110 was -3.0 mL/min/1.73 m<sup>2</sup> per year for Filspari and -4.2 mL/min/1.73 m<sup>2</sup> per year for irbesartan, corresponding to a treatment effect of 1.2 mL/min/1.73 m<sup>2</sup> per year (95% CI: 0.2, 2.1; p=0.0168).

#### Filspari: Focal Segmental Glomerulosclerosis (FSGS)

The approval of Filspari was based on DUPLEX, a randomized, double blind, active-controlled study in patients 8 years and older with biopsy proven FSGS or a genetic mutation known to cause FSGS, UPCR  $\geq$  1.5 g/g, and an eGFR  $\geq$  30 mL/min/1.73 m<sup>2</sup>. Patients were randomized to Filspari or irbesartan. The primary endpoint was the rate of change in estimated glomerular filtration rate (eGFR) from baseline to week 108. Urine protein/creatinine ratio (UPCR) was also evaluated. Given sparsentan's mechanism of action and because key drivers of disease progression may be different in patients with and without nephrotic syndrome, analyses were conducted in the two subgroups.

- In the overall population, the primary efficacy endpoint at the final analysis was not statistically significant. In the overall DUPLEX population, the adjusted mean change from baseline in eGFR was -14.3 mL/min/1.73 m<sup>2</sup> in patients randomized to Filspari and -13.3 mL/min/1.73 m<sup>2</sup> in patients randomized to irbesartan. The percent UPCR reduction was 46% in patients randomized to Filspari and 30% in patients randomized to irbesartan.
- In the subgroup of patients without nephrotic syndrome, the percent UPCR reduction was 48% in patients randomized to Filspari compared to 27% in patients randomized to irbesartan. Compared to irbesartan, patients randomized to Filspari had a 29% (95% CI: 9, 44) reduction in the ratio of the mean UPCR. In contrast, there was no difference between treatment arms in UPCR reduction in the subgroup of patients with nephrotic syndrome.

#### Vanrafia: Primary IgA Nephropathy

The effect of Vanrafia on proteinuria was assessed in a randomized, double-blind, placebo-controlled, multicenter, global study (ALIGN) in adults with biopsy-proven primary IgA nephropathy, eGFR  $\geq$  30 mL/min/1.73 m<sup>2</sup>, and total urine protein  $\geq$  1.0 g/day on a stable dose of maximally tolerated RAS inhibitor. The study included two cohorts: a main cohort of 340 patients and an exploratory cohort of 64 patients who were also on a stable dose of a SGLT2 inhibitor at baseline. Patients were randomized to receive either Vanrafia or placebo. RAS inhibitor therapy was continued throughout the study. Rescue immunosuppressive treatment could be initiated at the investigator's discretion during the trial. The primary endpoint was the percent reduction in UPCR at week 36 relative to baseline. The efficacy analysis included the first 270 patients in the main cohort who reached the week 36 visit.

- The geometric least squares mean percent change in UPCR from baseline at week 36 was -38% for Vanrafia versus -3% for placebo, corresponding to a relative reduction in UPCR of 36% with Vanrafia ( $p < 0.001$ ).
- The treatment effect on UPCR at week 36 was also consistent in the exploratory SGLT2 inhibitor cohort.

### **Manufacturer**

- Filispari: Travele Therapeutics, Inc.
- Vanrafia: Novartis Pharmaceuticals Corporation

### **Cost**

- Filispari (WAC)
  - IgAN: \$13,166/month; \$157,989/year
  - FSGS (weight based): \$13,166 to \$26,332/month; \$157,989 to \$315,978/year
- Vanrafia (WAC): \$14,291/month; \$171,493/year
- Comparison (at max dose)
  - Lisinopril (AAC): \$1.26/month; \$15.14/year
  - Irbesartan (AAC): \$4.13/month; \$49.61/year

### **Newly Proposed Clinical Prior Authorization Criteria**

Prior authorization (PA) is required for select nephrology agents. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of primary immunoglobulin A (IgA) nephropathy confirmed by a kidney biopsy (Filispari or Vanrafia); and
  - a. Patient is at high risk of disease progression, defined as meeting one of the following:
    - i. Proteinuria  $\geq 0.5$  g/day; or
    - ii. Urine protein-to-creatinine ratio (UPCR)  $\geq 0.5$  g/g; and
  - b. Patient has documentation of a trial and inadequate response with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g. angiotensin converting enzyme [ACE] inhibitor or angiotensin receptor blocker [ARB]) for at least 3 months; and
  - c. Patient has received optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification; or

3. Patient has a diagnosis of focal segmental glomerulosclerosis (FSGS) (Filspari); and
  - a. Diagnosis is confirmed by kidney biopsy or documentation of a genetic mutation in the podocyte protein associated with FSGS; and
  - b. Will be used to reduce proteinuria; and
  - c. Patient has a UPCR  $\geq 1.5$  g/g; and
  - d. Patient does not have nephrotic syndrome; and
  - e. Patient has documentation of a trial and inadequate response with a maximally tolerated dose of a RAS inhibitor (e.g. ACE inhibitor or ARB) for at least 3 months; and
  - f. Will not be used in combination with RAS inhibitors; and
4. For Filspari requests, patient will discontinue RAS inhibitor therapy; or
5. For Vanrafia requests, patient will continue RAS inhibitor therapy; and
6. Requested drug will not be used with other endothelin receptor antagonists; and
7. The requested drug is prescribed by or in consultation with a nephrologist.

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

If criteria for coverage are met, initial requests will be approved for 1 year. Additional approvals will be considered when documentation of a positive response to therapy is provided.

## References

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| <b>2026</b><br><b>Vol. 39</b><br><b>No. 1</b>                                                                                                                                                                                                                                                                                                                    |  | <i>The Bulletin of<br/> Medicaid Drug<br/> Utilization Review<br/> in Iowa</i> |
| <b>DUR Commission Members</b><br>Melissa Klotz, PharmD, Chairperson ♦ Jason Kruse, DO, Vice-Chairperson<br>♦ Holly Randleman, PharmD ♦ Jennifer Johnson, PharmD ♦ Bryon Schaeffer, MD<br>Charles Wadle, DO ♦ Caitlin Reinking, PharmD ♦ Jordan Thoman, PharmD ♦ Abby Cate, PharmD<br><b>DUR Professional Staff</b><br>Pamela Smith, RPh, DUR Project Coordinator |                                                                                   |                                                                                |

## **LDL-C Goals Are Back** **Key Updates from the 2026 ACC/AHA Guideline on the Management of Dyslipidemia**

Atherosclerotic cardiovascular disease (ASCVD) remains a leading cause of morbidity and mortality in the United States. Low-density lipoprotein cholesterol (LDL-C) is a well-established casual risk factor for ASCVD, and evidence continues to demonstrate that lowering LDL-C reduces the risk of cardiovascular events. [The 2026 ACC/AHA/Multisociety Guideline on the Management of Dyslipidemia](#) emphasizes that cardiovascular risk is driven by cumulative exposure to atherogenic lipoproteins over time, reinforcing the importance of earlier identification and treatment of elevated LDL-C to improve long-term outcomes.

One of the most notable changes in the 2026 guideline is the return of specific LDL-C treatment goals to guide therapy selection and intensification. While previous guidelines focused primarily on statin intensity and percentage LDL-C reduction, the updated guidance reestablishes LDL-C targets as a practical tool for treatment decisions and therapy intensification. Treatment goals are intended to complement, not replace, percentage LDL-C reduction goals, with goal for percent reduction depending on the level of ASCVD risk.

The guideline recommends tailoring LDL-C goals according to a patient's ASCVD risk.

| Patient ASCVD Risk Category                                         | Recommended LDL-C Goal |
|---------------------------------------------------------------------|------------------------|
| Borderline or intermediate risk<br>(3% to < 10% 10-year ASCVD risk) | < 100 mg/dL            |
| High risk<br>(≥ 10% 10-year ASCVD risk)                             | < 70 mg/dL             |
| Very high-risk<br>(established ASCVD)                               | < 55 mg/dL             |

These goals are intended to complement lifestyle modification and appropriate use of lipid lowering therapy. The guideline continues to emphasize that “lower is better” for LDL-C, particularly among patients at elevated cardiovascular risk.

The 2026 ACC/AHA guideline recommends use of the PREVENT-ASCVD equations to estimate cardiovascular risk and guide lipid management decisions. Clinicians can access the

American Heart Association's PREVENT Risk Calculator online to estimate risk and help determine the appropriate intensity of preventive therapy.

Statins remain the foundation of LDL-C lowering therapy due to their established efficacy, safety profile, and cardiovascular outcome benefits. For patients who do not achieve LDL-C goals with maximally tolerated statin therapy, the guideline supports consideration of additional lipid-lowering agents, including:

- Ezetimibe
- PCSK9 inhibitors
- Inclisiran
- Bempedoic acid

In addition to reinstating LDL-C treatment goals, the 2026 guideline includes several other notable updates:

- Non-high-density lipoprotein cholesterol (HDL-C) treatment goals are reintroduced as part of cardiovascular risk assessment and lipid management.
- Adoption of the PREVENT-ASCVD equations for primary prevention risk assessment.
  - [AHA PREVENT Online Calculator](#)
- Recommendation to measure lipoprotein(a) [Lp(a)] at least once during a patient's lifetime.
  - Elevated Lp(a) is an inherited risk factor associated with an increased risk of ASCVD and may help explain cardiovascular events in individuals without traditional risk factors.
- Expanded use of apolipoprotein B (ApoB) and coronary artery calcium (CAC) scoring to refine cardiovascular risk assessment and treatment decision.
  - ApoB reflects the total burden of cholesterol-containing particles that contribute to atherosclerosis and may help identify patients whose cardiovascular risk is underestimated by LDL-C alone.
  - CAC scoring identifies calcified plaque within the coronary arteries and may help refine cardiovascular risk assessment and guide lipid-lowering treatment decisions when risk is uncertain.

## Medicaid Statistics for Prescription Claims

### June through August 2026

|                                                                                                                                      | FFS                               | Wellpoint                               | Iowa Total Care                         | Molina Healthcare                       |
|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------|-----------------------------------------|-----------------------------------------|
| <b>Total \$ Paid</b>                                                                                                                 | \$3,410,496                       | \$113,432,271                           | \$92,622,647                            | \$72,917,379                            |
| <b># Paid Claims</b>                                                                                                                 | 19,633                            | 723,969                                 | 596,271                                 | 484,804                                 |
| <b>Unique Users</b>                                                                                                                  | 3,081                             | 99,094                                  | 86,134                                  | 77,710                                  |
| <b>Avg Cost/Rx</b>                                                                                                                   | \$173.71                          | \$156.68                                | \$155.34                                | \$150.41                                |
| <b>Top 5 Therapeutic Class by RX Count</b><br><small>Therapeutic class taxonomy may differ among each plan</small>                   | Antidepressants                   | Antidepressants                         | Antidepressants                         | Antidepressants                         |
|                                                                                                                                      | Anticonvulsants                   | ADHD/Anti-Narcolepsy/Anti-Obesity       | ADHD/Anti-Narcolepsy/Anti-Obesity       | ADHD/Anti-Narcolepsy/Anti-Obesity       |
|                                                                                                                                      | ADHD/Anti-Narcolepsy/Anti-Obesity | Anticonvulsants                         | Anticonvulsants                         | Anticonvulsants                         |
|                                                                                                                                      | Antipsychotics/Antimanic Agents   | Antiasthmatic and Bronchodilator Agents | Antiasthmatic and Bronchodilator Agents | Antiasthmatic and Bronchodilator Agents |
|                                                                                                                                      | Antidiabetics                     | Antipsychotics/Antimanic Agents         | Antipsychotics/Antimanic Agents         | Antidiabetics                           |
| <b>Top 5 Therapeutic Class by \$ Amount</b><br><small>(pre-rebate)<br/>Therapeutic class taxonomy may differ among each plan</small> | Antidiabetics                     | Dermatologicals                         | Antidiabetics                           | Dermatologicals                         |
|                                                                                                                                      | Dermatologicals                   | Antidiabetics                           | Dermatologicals                         | Antidiabetics                           |
|                                                                                                                                      | Antipsychotics/Antimanic Agents   | Antipsychotics/Antimanic Agents         | Antipsychotics/Antimanic Agents         | Antipsychotics/Antimanic Agents         |
|                                                                                                                                      | Analgesics – Anti-Inflammatory    | ADHD/Anti-Narcolepsy/Anti-Obesity       | Analgesics – Anti-Inflammatory          | Analgesics – Anti-Inflammatory          |
|                                                                                                                                      | ADHD/Anti-Narcolepsy/Anti-Obesity | Analgesics – Anti-Inflammatory          | ADHD/Anti-Narcolepsy/Anti-Obesity       | ADHD/Anti-Narcolepsy/Anti-Obesity       |
| <b>Top 5 Drugs by Prescription Count</b>                                                                                             | Albuterol                         | Trazodone                               | Trazodone                               | Albuterol HFA                           |
|                                                                                                                                      | Cetirizine                        | Bupropion XL                            | Albuterol HFA                           | Amoxicillin                             |
|                                                                                                                                      | Trazodone                         | Albuterol HFA                           | Bupropion XL                            | Trazodone                               |
|                                                                                                                                      | Methylphenidate                   | Sertraline                              | Sertraline                              | Bupropion XL                            |
|                                                                                                                                      | Amphetamine/Dextroamphetamine     | Hydroxyzine HCl                         | Hydroxyzine HCl                         | Sertraline                              |
| <b>Top 5 Drugs by Paid Amount</b><br><small>(pre-rebate)</small>                                                                     | Humira Pen                        | Ozempic                                 | Ozempic                                 | Dupixent                                |
|                                                                                                                                      | Ozempic                           | Vraylar                                 | Dupixent Pen                            | Ozempic                                 |
|                                                                                                                                      | Evrysdi                           | Mounjaro                                | Vraylar                                 | Vraylar                                 |
|                                                                                                                                      | Dupixent                          | Dupixent Pen                            | Humira (CF) Pen                         | Mounjaro                                |
|                                                                                                                                      | Skyrizi Pen                       | Humira (CF) Pen                         | Trikafta                                | Skyrizi Pen                             |