IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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Dear Abby:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 6, 2025. At this meeting, the DUR Commission members discussed prior authorization (PA) criteria for Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors; Anti-Diabetic Non-Insulin Agents; Dupilumab (Dupixent); Givinostat (Duvyzat); IL-5 Antagonists; Janus Kinase (JAK) Inhibitors; Lebrikizumab-lbkz (Ebglyss); Nemolizumab-ilto (Nemluvio); Olezarsen (Tryngolza); Omalizumab (Xolair); and Palopegteriparatide (Yorvipath). Additionally, the DUR Commission recommends a ProDUR edit for the concurrent use of a DPP-4 inhibitor containing agent with a GLP-1 receptor agonist containing agent. The following recommendations have been made by the DUR Commission:

Please note: The DUR Commission has revised its process for reviewing new and updated prior authorization (PA) criteria, as well as other changes impacting the outpatient pharmacy program, including ProDUR edits. Beginning with the August 6, 2025 meeting, all items will be reviewed and voted on during a single meeting.

- If no major changes are proposed during discussion, the Commission will proceed with a vote, and the recommendation will be submitted to the Department for consideration.
- If significant revisions are suggested, the item will be deferred to the next meeting for further review and voting before a recommendation is made.

Recommendations from the August 6, 2025 meeting also include items initially discussed at the May 6, 2025 meeting and subsequently re-reviewed.

Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions:

1. Patient meets the FDA approved age; and
2. Documentation of adherence to prescribed lipid lowering medications

(including a maximally tolerated statin), prior to ACL inhibitor therapy, for the previous 90 days is provided (further defined below, by diagnosis); and
3. Documentation is provided that medication will be used in combination with a maximally tolerated statin; and
4. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; and
5. Patient will continue to follow an appropriate low-fat diet; and
6. Is prescribed by or in consultation with a lipidologist, cardiologist, or endocrinologist; and
7. If patient is taking in combination with:
    a. Simvastatin, dose does not exceed 20mg per day; or
    b. Pravastatin, dose does not exceed 40mg per day; and
8. Concurrent use with a PCSK9 inhibitor will not be considered; and
9. Goal is defined as a 50% reduction in untreated baseline LDL-C; and
10. Is prescribed for one of the following diagnoses:
    a. Heterozygous Familial Hypercholesterolemia (HeFH):
        i. Documentation is provided verifying diagnosis (attach documentation/results), as evidenced by:
            1. Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) or:
            2. Confirmation of diagnosis by gene or receptor testing; and
        ii. Documentation of untreated LDL-C ≥ 190 mg-dL; and
        iii. Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily; or
    b. Clinical Atherosclerotic Cardiovascular Disease (ASCVD):
        i. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and
        ii. Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily.

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:

1. Patient continues therapy with a maximally tolerated statin dose and remains at goal; and
2. Patient continues to follow an appropriate low-fat diet; and
3. Documentation of LDL reduction is provided.

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

<u>Proposed Clinical Prior Authorization Criteria</u> (changes italicized/highlighted and/or stricken)
Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered 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* ~~Patient meets the FDA approved age~~; and
2. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to *lipid lowering medication* ~~pharmacologic~~ therapy; and
3. Patient will continue to follow an appropriate low-fat diet; and
4. *Patient has one of the following diagnoses:*
    a. *Heterozygous familial hypercholesterolemia (HeFH); or*
    b. *Primary hyperlipidemia; or*
    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*
    d. *At risk for a CVD event but without established CVD (e.g. diabetes mellitus (type 1 or type 2), a Reynolds Risk score > 20% or a SCORE Risk score > 7.5% over 10 years, a coronary artery calcium score > 300 Agatston units); and*
5. *Meets one of the following:*
    ~~a. Documentation of adherence to prescribed lipid lowering medications (including a maximally tolerated statin), prior to ACL inhibitor therapy, for the previous 90 days is provided (further defined below, by diagnosis); and~~
    b. Patient *must be adherent to lipid lowering medication therapy and* is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials, *including atorvastatin and rosuvastatin, at maximally tolerated doses,* used in combination with *ezetimibe for a minimum of 90 consecutive days* ~~other lipid lowering medications~~. ~~Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily~~*; or*
    c. Patient is statin intolerant as documented by an inability to tolerate at least two chemically distinct statins; or
    d. Patient has an FDA labeled contraindication to all statins; and
6. Goal is defined as a 50% reduction in untreated baseline LDL-C.
~~7. Documentation is provided that medication will be used in combination with a maximally tolerated statin; and~~
~~8. Is prescribed by or in consultation with a lipidologist, cardiologist, or endocrinologist; and~~
~~9. If patient is taking in combination with:~~
    ~~a. Simvastatin, dose does not exceed 20mg per day; or~~
    ~~b. Pravastatin, dose does not exceed 40mg per day; and~~
10. Concurrent use with a PCSK9 inhibitor will not be considered.~~;~~ ~~and~~
~~11. Is prescribed for one of the following diagnoses:~~
    ~~a. Heterozygous Familial Hypercholesterolemia (HeFH):~~
        ~~i. Documentation is provided verifying diagnosis (attach documentation/results), as evidenced by:~~
            ~~1. Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) or:~~
            ~~2. Confirmation of diagnosis by gene or receptor testing; and~~
        ~~ii. Documentation of untreated LDL-C ≥ 190 mg-dL; and~~
        ~~iii. Patient is unable to reach LDL-C goal with a minimum of two~~

~~separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily; or~~

~~b. Clinical Atherosclerotic Cardiovascular Disease (ASCVD):~~

~~i. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and~~

~~ii. Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily.~~

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:

1. Patient continues ~~therapy~~ with *lipid lowering therapy at* a maximally tolerated ~~statin~~ dose ~~and remains at goal~~; *or* ~~and~~
2. *Patient is intolerant to or has a contraindication to statins; and*
3. Patient continues to follow an appropriate low-fat diet; and
4. Documentation of *a positive response to therapy (e.g.,* LDL-*C* reduction*)* ~~is provided~~.

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

Anti-Diabetic Non-Insulin Agents

Current Clinical Prior Authorization Criteria

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:

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. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and
3. 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.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Requests for weight loss are not a covered diagnosis of use and will be denied.

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

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:

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. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and
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*
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.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Requests for weight loss*, which is* ~~are~~ not a covered diagnosis of use*,* ~~and~~ will be denied.

Dupilumab (Dupixent)

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Patient has failed to respond to good skin care and regular use of emollients; and
    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
    c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    d. Patient will continue with skin care regimen and regular use of emollients; or
4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and
    a. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and
    b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long-acting beta $_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims;

and
    c. Patient must have one of the following, in addition to the regular maintenance medications defined above:
        i. One (1) or more exacerbations in the previous year or
        ii. Require daily oral corticosteroids for at least 3 days; or
5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
    a. Documentation dupilumab will be used as an add-on maintenance treatment; and
    b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
        i. Nasal corticosteroid spray; and
        ii. Oral corticosteroid; or
6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and
    a. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
    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
    c. Documentation of previous trials and therapy failures with all of the following:
        i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
        ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and
        iii. Dietary therapy; or
7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
    a. Patient has experienced severe to very severe pruritus, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
    b. Patient has ≥ 20 nodular lesions (attach documentation); and
    c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; ~~and~~ *or*
8. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and
    a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:
        i. FEV1/FVC ratio < 0.7, and
        ii. FEV1 % predicted between 30% to 79%; and
    b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and
    c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:
        i. Triple therapy with all of the following treatments:
            1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
            2. Long-acting beta agonist (LABA); and
            3. Inhaled corticosteroid (ICS); or
        ii. Double therapy with all of the following if ICS is contraindicated
            1. LABA; and
            2. LAMA; and
    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
    e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; and
9. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 6 months for all the above indications, except for COPD, 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.

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

Proposed Clinical Prior Authorization Criteria (changed italicized/highlighted and/or stricken) Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Patient has failed to respond to good skin care and regular use of emollients; and
    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
    c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    d. Patient will continue with skin care regimen and regular use of emollients; or
4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and
    a. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and
    b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long-acting beta $_2$ agonist [LABA], *or* leukotriene receptor antagonist [LTRA]~~, oral theophylline~~) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
    c. Patient must have one of the following, in addition to the regular maintenance medications defined above:
        i. One (1) or more exacerbations in the previous year or
        ii. Require daily oral corticosteroids for at least 3 days; or
5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal

polyposis (CRSwNP); and
    a. Documentation dupilumab will be used as an add-on maintenance treatment; and
    b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
        i. Nasal corticosteroid spray; and
        ii. Oral corticosteroid; or
6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and
    a. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
    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
    c. Documentation of previous trials and therapy failures with all of the following:
        i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
        ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and
        iii. Dietary therapy; or
7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
    a. Patient has experienced severe to very severe pruritus, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
    b. Patient has ≥ 20 nodular lesions (attach documentation); and
    c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; ~~and~~ *or*
8. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and
    a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:
        i. FEV1/FVC ratio < 0.7, and
        ii. FEV1 % predicted between 30% to 79%; and
    b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and
    c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:
        i. Triple therapy with all of the following treatments:
            1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
            2. Long-acting beta agonist (LABA); and
            3. Inhaled corticosteroid (ICS); or
        ii. Double therapy with both of the following if ICS is contraindicated
            1. LABA; and
            2. LAMA; and
    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
    e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; ~~and~~ *or*
9. *Patient has a diagnosis of chronic spontaneous urticaria (CSU) with no known cause; and*

a. *Patient has documentation of an adequate trial and therapy failure with a preferred second generation H1 receptor antihistamine for at least 2 weeks.*

~~10. Dose does not exceed the FDA approved dosing for indication.~~

If criteria for coverage are met, initial authorization will be given for 6 months for all the above indications, except for COPD *and CSU*, 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*.

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

Givinostat (Duvyzat)

Newly Proposed Clinical Prior Authorization Criteria

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:

1. Patient has a diagnosis of Duchene muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and
2. Request adheres to all FDA approved labeling for requested drug and indication, including, age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Is prescribed by or in consultation with a physician who specializes in treatment of DMD; and
4. Patient has documentation of a trial and inadequate response to an oral glucocorticoid for at least 6 months; and
5. Givinostat will be prescribed concurrently with an oral glucocorticoid; and
6. Patient's current body weight in kilograms (kg) is provided.

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:

1. Documentation of a positive response to therapy (e.g. improved strength, pulmonary function test, or functional assessments); and
2. Patient continues to receive concomitant glucocorticoid therapy; and
3. Patient's current body weight in kg is provided.

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

IL-5 Antagonists

Current Clinical Prior Authorization Criteria

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

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

If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP to assess the need for continued therapy. Requests for

continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met:
Severe Asthma with an Eosinophilic Phenotype:

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

Eosinophilic Granulomatosis with Polyangiitis

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

Hypereosinophilic Syndrome:

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

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

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

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

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

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and
    a. Patient has a pretreatment blood eosinophil count of ≥ 150 cells/mcL within the previous 6 weeks or blood eosinophils ≥ 300 cells/ mcL within 12 months prior to initiation of therapy; and
    b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and
    c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and

d. A pretreatment forced expiratory volume in 1 second (FEV_1) < 80% predicted in adults and < 90% in adolescents; or

3. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and
    a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and
    b. One of the following:
        i. Eosinophil count > 1000 cells/mcL; or
        ii. Eosinophil count > 10% of the total leukocyte count; ~~and~~ *or*
4. Patient has a diagnosis of hypereosinophilic syndrome (HES); and
    a. Patient has been diagnosed with HES for ≥ 6 months prior to starting treatment; and
    b. Documentation that non-hematologic secondary causes of HES have been ruled out; and
    c. Documentation patient does not have FIP1L1-PDGFRα kinase-positive HES: and
    d. Documentation of ≥ 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and
    e. Patient has a blood eosinophil count ≥ 1,000 cells/mcL; and
    f. Medication will be used in combination with stable doses of at least one other HES therapy; ~~and~~ *or*
5. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); and
    a. Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; and
    b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
        i. Nasal corticosteroid; and
        ii. Oral corticosteroid; ~~and~~ *or*
6. *Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype; and*
    a. *Patient has moderate to very severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:*
        i. *FEV_1/FVC ratio < 0.7, and*
        ii. *FEV_1% predicted of 20% and 80%; and*
    b. *Patient has a minimum blood eosinophil count of 150 cells/mcL, measured with in the past 12 months; and*
    c. *Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to therapy with:*
        i. *Triple therapy with all of the following treatments:*
            1. *Long-acting muscarinic antagonist/anticholinergic (LAMA); and*
            2. *Long-acting beta2-agonist (LABA); and*
            3. *Inhaled corticosteroid (ICS); or*
        ii. Double therapy with both of the following if ICS is contraindicated:
            1. LABA; and
            2. LAMA; and
    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

e. *Documentation mepolizumab will be used as an add-on maintenance treatment with triple or double therapy (as defined above); and*

7. *Medication will be administered in the patient's home; and*
8. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist.

If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis*,* ~~or~~ 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP*, 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:
Severe Asthma with an Eosinophilic Phenotype:

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

Eosinophilic Granulomatosis with Polyangiitis

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

Hypereosinophilic Syndrome:

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

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

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

Chronic Obstructive Pulmonary Disease (COPD)

1. *Patient has demonstrated positive clinical response to therapy; and*
2. *Continues to receive add-on maintenance therapy with triple or double therapy (as defined above).*

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

Janus Kinase (JAK) Inhibitors

Current Clinical Prior Authorization
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:

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Patient has a diagnosis of:
    a. Moderate to severe rheumatoid arthritis; with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
        ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
    b. Psoriatic arthritis; with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR
    c. Moderately to severely active ulcerative colitis; with
        i. A documented trial and inadequate response with a preferred TNF inhibitor; and
        ii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR
    d. Moderately to severely active Crohn's disease; with
        i. A documented trial and inadequate response with a preferred TNF inhibitor; OR
    e. Polyarticular Course Juvenile Idiopathic Arthritis; with
        i. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
    f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with
        i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
        ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR
    g. Atopic dermatitis; with
        i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
        ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
        iii. A documented trial and therapy failure with a topical

immunomodulator for a minimum of 4 weeks; and
iv. For mild to moderate atopic dermatitis:
a. Affected area is less than 20% of body surface area (BSA); and
b. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
v. For moderate to severe atopic dermatitis
a. A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and
b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; or
h. Nonsegmental vitiligo; with
i. A documented trial and inadequate response with a potent topical corticosteroid; or
ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and
iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable.

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

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

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Patient has a diagnosis of:
a. Moderate to severe rheumatoid arthritis; with
i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
b. Psoriatic arthritis; with
i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR
c. Moderately to severely active ulcerative colitis; with

i. A documented trial and inadequate response with a preferred TNF inhibitor; and
ii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR

d. Moderately to severely active Crohn's disease; with
   i. A documented trial and inadequate response with a preferred TNF inhibitor; OR
e. Polyarticular Course Juvenile Idiopathic Arthritis; with
   i. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
   ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with
   i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
   ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR
g. Atopic dermatitis; with
   i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
   ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
   iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
   iv. For mild to moderate atopic dermatitis:
      1. Affected area is less than 20% of body surface area (BSA); and
      2. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
   v. For moderate to severe atopic dermatitis:
      1. A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and
      2. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; or
h. Nonsegmental vitiligo; with
   i. A documented trial and inadequate response with a potent topical corticosteroid; or
   ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and
   iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable*; or*
i. Giant Cell Arteritis; with
   i. Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids.

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

Lebrikizumab-lbkz (Ebglyss)

Newly Proposed Clinical Prior Authorization Criteria
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:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Patient has failed to respond to good skin care and regular use of emollients; and
    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
    c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    d. Patient will continue with skin care regimen and regular use of emollients.

If criteria for coverage are met, initial authorization will be given for 16 weeks to 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.

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

Nemolizumab-ilto (Nemluvio)

Newly Proposed Clinical Prior Authorization Criteria
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:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Patient has failed to respond to good skin care and regular use of

emollients; and
   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
   c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
   d. For initial therapy, will be used in combination with a topical corticosteroid and/or a topical immunomodulator; and
   e. Patient will continue with skin care regimen and regular use of emollients; or
4. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
   a. Patient has experienced severe to very severe pruritus, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
   b. Patient has ≥ 20 nodular lesions (attach documentation); and
   c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days.

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.

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

Olezarsen (Tryngolza)

Newly Proposed Clinical Prior Authorization Criteria
Prior authorization (PA) is required for olezarsen (Tryngolza). 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 (≤ 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.

If the criteria for coverage are met, initial requests will be given for 6 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 (≤ 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.

Omalizumab (Xolair)

Current Clinical Prior Authorization Criteria

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 under the following conditions:

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
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
3. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist, or pulmonologist; and
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
5. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and
6. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced.

Moderate to Severe Persistent Asthma

1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
2. Patient has a history of positive skin or RAST test to a perennial aeroallergen; and
3. Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND a leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy.

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair)

therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist.

Chronic Idiopathic Urticaria

1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and
2. Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and
3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and
4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and
5. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine.

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.

Nasal Polyps

1. Patient has a diagnosis of nasal polyps; and
2. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and
3. Will be used concurrently with a nasal corticosteroid.

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.

IgE Mediated Food Allergy

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
2. Diagnosis is confirmed by a skin prick test or in vitro test (attach results); and
3. Will be used in conjunction with food allergen avoidance.

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

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

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
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
3. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist, or pulmonologist; and
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
5. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and
6. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced.

Moderate to Severe Persistent Asthma

1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
2. Patient has a history of positive skin or RAST test to a perennial aeroallergen; and
3. *Symptoms are inadequately controlled with documentation of current treatment with* ~~Patient is currently using~~ a high-dose inhaled corticosteroid *(ICS)*~~,~~ *given in combination with a controller medication (e.g.* long-acting beta$_2$-agonist [LABA], ~~AND~~ *or* a leukotriene receptor antagonist *[LTRA])*, ~~and is compliant with therapy and asthma symptoms are not adequately controlled after at least~~ *for a minimum of* three (3) *consecutive* months of therapy. *Patient must be compliant with therapy, based on pharmacy claims.*

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)*~~, long-acting beta-agonist, and leukotriene receptor antagonist~~.

Chronic *Spontaneous* ~~Idiopathic~~ Urticaria

1. Patient has a diagnosis of moderate to severe chronic *spontaneous* ~~idiopathic~~ urticaria; and
2. ~~2.~~ Patient has documentation of a*n adequate* trial and therapy failure with ~~at least one~~ *a* preferred second generation *H1 receptor* antihistamine *for at least two weeks.* ~~, one of which must be cetirizine at a dose up to 20 mg per day; and~~
3. ~~Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and~~
4. ~~Patient has documentation of a trial and therapy failure with at least one~~

~~preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and~~

5. ~~Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine.~~

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.

Chronic Rhinosinusitis with Nasal Polyps *(CRSwNP)*

1. Patient has a diagnosis of *chronic rhinosinusitis with* nasal polyps; and
2. Patient has documentation of an adequate trial and *therapy failure* ~~inadequate response~~ with at least *one* ~~two~~ *preferred medication from each of the following categories:*
    a. Nasal corticosteroid~~s~~ *spray* ~~at a maximally tolerated dose~~; and
    b. Oral corticosteroid; and
3. Will be used *as an add on maintenance treatment* ~~concurrently with a nasal corticosteroid~~.

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.

IgE Mediated Food Allergy

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
2. Diagnosis is confirmed by a skin prick test or in vitro test (attach results); and
3. Will be used in conjunction with food allergen avoidance.

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

Palopegteriparatide (Yorvipath)

Newly Proposed Clinical Prior Authorization Criteria

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:

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 chronic hypoparathyroidism; and
3. Patient has had an inadequate response to maximally tolerated oral calcium and vitamin D analog (e.g., calcitriol) therapy; and
4. Documentation of baseline lab results (attach results obtained within 2 weeks prior to starting therapy) for:

a. Serum 25 hydroxyvitamin D (25(OH)D) level within the normal range (20 to 80 ng/mL); and
b. Albumin-corrected serum calcium level ≥ 7.8 g/dL; and

5. Is prescribed by or in consultation with an endocrinologist or nephrologist.

If criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 12-month intervals with:

1. 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).

ProDUR Edit

The DUR Commission recommends implementing a ProDUR edit to prevent concurrent use of GLP-1 receptor agonists (GLP-1 RA), including dual GIP/GLP-1 RA agents (e.g., tirzepatide), and DPP-4 inhibitors (DPP-4i).

- A 90-day lookback will be used to identify claims for a GLP-1 RA, including dual GIP/GLP-1 RA, or DPP-4i.
- If concurrent use is detected, the claim will be rejected at the pharmacy point-of-sale (POS).
- Prior authorization will be required if a member is switching from one agent to the other.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors; Anti-Diabetic Non-Insulin Agents; Dupilumab (Dupixent); Givinostat (Duvyzat); IL-5 Antagonists; Janus Kinase (JAK) Inhibitors; Lebrikizumab-lbkz (Ebglyss); Nemolizumab-ilto (Nemluvio); Olezarsen (Tryngolza); Omalizumab (Xolair); and Palopegteriparatide (Yorvipath); and the ProDUR edit for the concurrent use of a DPP-4 inhibitor containing agent with a GLP-1 receptor agonist containing agent.

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

Iowa Health Link
Iowa HHS

iowa total care.

Iowa Total Care Claims
Quarterly Statistics

REPORT_DATE	Mar 2025 through May 2025	Jun 2025 through Aug 2025	% CHANGE
TOTAL PAID AMOUNT	$81,618,942.34	$83,651,463.30	2.49%
UNIQUE USERS	93,573	88,453	-5.47%
COST PER USER	$872.25	$945.72	8.42%
TOTAL PRESCRIPTIONS	660,678	632,369	-4.28%
AVERAGE PRESCRIPTION PER USER	7.06	7.15	1.26%
AVERAGE COST PER PRESCRIPTION	$123.54	$132.28	7.08%
# GENERIC PRESCRIPTIONS	593,434	566,078	-4.61%
% GENERIC	90.00%	90.00%	-0.34%
$ GENERIC	$10,784,122.33	$10,564,207.83	-2.04%
AVERAGE GENERIC PRESCRIPTION COST	$18.17	$18.66	2.70%
AVERAGE GENERIC DAYS SUPPLY	28	29	3.74%
# BRAND PRESCRIPTIONS	66,176	65,283	-1.35%
% BRAND	10.00%	10.00%	3.07%
$ BRAND	$70,790,918.60	$73,063,631.81	3.21%
AVERAGE BRAND PRESCRIPTION COST	$1,069.74	$1,119.18	4.62%
AVERAGE BRAND DAYS SUPPLY	29	29	0.33%

UTILIZATION BY AGE

AGE		Mar 2025 through May 2025	Jun 2025 through Aug 2025
0-6		34,931	28,010
7-12		48,842	44,163
13-18		60,956	57,442
19-64		503,279	495,484
65+		6,323	6,075

UTILIZATION BY GENDER AND AGE

GENDER	AGE		Mar 2025 through May 2025	Jun 2025 through Aug 2025
F	0-6		15,025	12,269
	7-12		19,044	17,238
	13-18		32,390	30,525
	19-64		322,235	318,037
	65+		3,867	3,756
M	0-6		19,906	15,741
	7-12		29,798	26,925
	13-18		28,566	26,917
	19-64		181,044	177,447
	65+		2,456	2,319

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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	10,540	$6,739,912.73	$639.46	1
2	RIGHT DOSE PHARMACY	ANKENY	IA	5,984	$268,902.79	$44.94	2
3	WALGREENS #4405	COUNCIL BLUFFS	IA	4,945	$368,750.65	$74.57	4
4	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,814	$283,190.79	$58.83	3
5	WALGREENS #5042	CEDAR RAPIDS	IA	4,448	$306,009.68	$68.80	5
6	DRILLING PHARMACY	SIOUX CITY	IA	4,090	$264,519.88	$64.67	6
7	WALGREENS #5239	DAVENPORT	IA	3,960	$231,079.44	$58.35	7
8	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	3,944	$362,968.39	$92.03	9
9	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	3,944	$276,662.38	$70.15	8
10	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,679	$176,964.89	$48.10	12
11	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	3,641	$291,654.72	$80.10	11
12	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	3,608	$269,506.19	$74.70	10
13	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,581	$375,974.71	$104.99	17
14	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	3,183	$228,116.99	$71.67	14
15	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,105	$257,034.04	$82.78	13
16	WALGREENS #5721	DES MOINES	IA	3,064	$245,168.95	$80.02	15
17	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,045	$288,999.38	$94.91	19
18	NUCARA LTC PHARMACY #3	IOWA CITY	IA	2,950	$125,333.96	$42.49	25
19	HY-VEE PHARMACY (1192)	FT DODGE	IA	2,936	$237,015.81	$80.73	18
20	WALGREENS #7455	WATERLOO	IA	2,920	$212,650.82	$72.83	16
21	WALGREENS #15647	SIOUX CITY	IA	2,823	$217,282.89	$76.97	20
22	WAGNER PHARMACY	CLINTON	IA	2,778	$228,594.33	$82.29	27
23	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,653	$288,232.36	$108.64	31
24	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	2,609	$181,414.50	$69.53	22
25	WALGREENS #7453	DES MOINES	IA	2,560	$192,007.71	$75.00	21
26	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	2,551	$113,423.80	$44.46	36
27	NELSON FAMILY PHARMACY	FORT MADISON	IA	2,544	$165,990.01	$65.25	24
28	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,529	$238,735.44	$94.40	28
29	MEDICAP PHARMACY LTC	INDIANOLA	IA	2,528	$97,682.28	$38.64	32
30	WALGREENS #359	DES MOINES	IA	2,520	$186,478.02	$74.00	23
31	HY-VEE PHARMACY (1449)	NEWTON	IA	2,506	$239,589.98	$95.61	34
32	HY-VEE PHARMACY (1075)	CLINTON	IA	2,432	$196,415.64	$80.76	37
33	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,410	$188,200.32	$78.09	42
34	MAHASKA DRUGS INC	OSKALOOSA	IA	2,396	$193,374.89	$80.71	40
35	SOUTH SIDE DRUG	OTTUMWA	IA	2,365	$160,243.72	$67.76	26
36	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	2,359	$239,408.52	$101.49	69
37	CVS PHARMACY #10282	FORT DODGE	IA	2,352	$119,749.33	$50.91	29
38	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	2,340	$324,452.32	$138.65	52
39	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,317	$163,953.43	$70.76	43
40	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,313	$178,077.43	$76.99	35
41	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,277	$153,949.08	$67.61	48
42	WALGREENS #4041	DAVENPORT	IA	2,276	$149,506.89	$65.69	39
43	WALGREENS #3700	COUNCIL BLUFFS	IA	2,260	$120,353.63	$53.25	47
44	HY-VEE PHARMACY (1396)	MARION	IA	2,241	$237,418.59	$105.94	38
45	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,235	$198,200.37	$88.68	51

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46	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,223	$212,789.60	$95.72	33
47	WALMART PHARMACY 10-2889	CLINTON	IA	2,199	$151,746.55	$69.01	59
48	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,181	$182,735.01	$83.78	41
49	WALMART PHARMACY 10-1509	MAQUOKETA	IA	2,150	$148,433.36	$69.04	50
50	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	2,150	$98,743.65	$45.93	30
51	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	2,148	$170,930.52	$79.58	46
52	SCOTT PHARMACY	FAYETTE	IA	2,139	$167,347.90	$78.24	56
53	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	2,139	$143,559.30	$67.12	44
54	LEWIS FAMILY DRUG #28	ONAWA	IA	2,114	$180,640.50	$85.45	65
55	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,113	$119,404.27	$56.51	45
56	TOWNCREST LTC	IOWA CITY	IA	2,089	$142,051.24	$68.00	49
57	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,087	$185,611.32	$88.94	54
58	WALMART PHARMACY 10-0985	FAIRFIELD	IA	2,072	$149,674.43	$72.24	75
59	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,038	$412,100.10	$202.21	55
60	CVS PHARMACY #08544	WATERLOO	IA	2,015	$157,904.21	$78.36	53
61	CVS PHARMACY #08658	DAVENPORT	IA	2,005	$159,434.37	$79.52	57
62	EXACTCARE	VALLEY VIEW	OH	1,987	$174,420.18	$87.78	99
63	HY-VEE PHARMACY (1522)	PERRY	IA	1,972	$143,749.83	$72.90	68
64	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	1,969	$213,754.30	$108.56	62
65	PREFERRED CARE PHARMACY	CEDAR RAPIDS	IA	1,952	$113,954.41	$58.38	74
66	HY-VEE PHARMACY (1180)	FAIRFIELD	IA	1,949	$206,287.40	$105.84	86
67	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,941	$159,512.12	$82.18	58
68	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,940	$446,263.71	$230.03	79
69	UNION PHARMACY	COUNCIL BLUFFS	IA	1,928	$130,617.59	$67.75	60
70	WALGREENS #10855	WATERLOO	IA	1,909	$123,951.78	$64.93	61
71	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	1,908	$111,648.93	$58.52	64
72	MEDICAP PHARMACY	CRESTON	IA	1,906	$122,403.50	$64.22	71
73	WALGREENS #7454	ANKENY	IA	1,878	$120,105.92	$63.95	97
74	WALGREENS #5470	SIOUX CITY	IA	1,873	$122,466.19	$65.39	63
75	DANIEL PHARMACY	FT DODGE	IA	1,862	$134,779.86	$72.38	70
76	HY-VEE PHARMACY (1241)	HARLAN	IA	1,848	$200,137.10	$108.30	88
77	WALMART PHARMACY 10-5115	DAVENPORT	IA	1,838	$134,733.28	$73.30	104
78	MEDICAP PHARMACY	NEWTON	IA	1,831	$196,678.82	$107.42	80
79	HY-VEE PHARMACY #1 (1281)	IOWA CITY	IA	1,830	$113,976.61	$62.28	94
80	HY-VEE PHARMACY (1382)	LEMARS	IA	1,828	$153,341.59	$83.88	95
81	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	1,820	$135,543.32	$74.47	77
82	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	1,818	$135,438.00	$74.50	66
83	INFOCUS PHARMACY SERVICES LLC	DUBUQUE	IA	1,812	$93,061.22	$51.36	91
84	WALGREENS #11942	DUBUQUE	IA	1,799	$143,691.19	$79.87	73
85	HY-VEE PHARMACY (1011)	ALTOONA	IA	1,785	$124,213.70	$69.59	84
86	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	1,778	$146,842.07	$82.59	78
87	WALGREENS #4714	DES MOINES	IA	1,771	$142,586.32	$80.51	81
88	WALMART PHARMACY 10-1393	OSKALOOSA	IA	1,770	$158,667.64	$89.64	105
89	WALMART PHARMACY 10-1723	DES MOINES	IA	1,765	$130,379.90	$73.87	67
90	WALMART PHARMACY 10-0646	ANAMOSA	IA	1,758	$155,537.45	$88.47	96

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91	WALMART PHARMACY 10-1431	KEOKUK	IA	1,757	$110,051.40	$62.64	89
92	THOMPSON DEAN DRUG	SIOUX CITY	IA	1,744	$146,556.40	$84.03	100
93	LAGRANGE PHARMACY	VINTON	IA	1,734	$127,608.39	$73.59	83
94	HY-VEE PHARMACY (1095)	CRESTON	IA	1,724	$119,139.15	$69.11	82
95	WALGREENS #7452	DES MOINES	IA	1,721	$142,114.56	$82.58	76
96	WALGREENS #3875	CEDAR RAPIDS	IA	1,717	$141,753.40	$82.56	102
97	HY-VEE PHARMACY (1022)	ANKENY	IA	1,714	$130,958.27	$76.41	85
98	HARTIG PHARMACY SERVICES	DUBUQUE	IA	1,709	$173,310.00	$101.41	103
99	WALMART PHARMACY 10-3394	ATLANTIC	IA	1,683	$115,878.70	$68.85	109
100	HY-VEE PHARMACY (1324)	KEOKUK	IA	1,647	$156,721.34	$95.16	92

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RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	U OF I HOSPITALS & CLINICS AMBULATORY CARE PHARM	IOWA CITY	IA	10,540	$6,739,912.73	$3,232.57	1
2	WALGREENS SPECIALTY PHARMACY #16528	DES MOINES	IA	674	$3,500,321.72	$13,159.10	2
3	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	407	$3,397,066.23	$20,840.90	3
4	UNITYPOINT AT HOME	URBANDALE	IA	568	$2,075,932.42	$9,700.62	5
5	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	156	$2,000,388.02	$31,256.06	4
6	PANTHERX SPECIALTY PHARMACY	CORAOPOLIS	PA	53	$1,275,864.48	$63,793.22	9
7	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,114	$1,169,668.99	$8,475.86	6
8	ACARIAHEALTH PHARMACY #11	HOUSTON	TX	144	$1,106,280.25	$16,268.83	7
9	CVS/SPECIALTY	MONROEVILLE	PA	149	$912,087.08	$16,890.50	8
10	AMBER PHARMACY	OMAHA	NE	153	$868,730.78	$15,795.11	11
11	WALGREENS SPECIALTY PHARMACY #21250	IOWA CITY	IA	255	$842,125.79	$7,322.83	10
12	CVS PHARMACY #00102	AURORA	CO	76	$754,622.74	$24,342.67	12
13	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	41	$675,942.89	$67,594.29	16
14	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	84	$636,065.56	$15,513.79	13
15	MERCYONE GENESIS FIRSTMED SPECIALTY PHARMACY	DAVENPORT	IA	435	$459,240.92	$3,479.10	14
16	WALGREENS SPECIALTY PHARMACY #16270	OMAHA	NE	50	$458,381.57	$19,099.23	15
17	THE NEBRASKA MED CENTER CLINIC PHCY	OMAHA	NE	729	$451,309.50	$3,393.30	17
18	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,940	$446,263.71	$2,625.08	18
19	PARAGON PARTNERS	OMAHA	NE	1,112	$443,979.57	$4,577.11	19
20	SOLEO HEALTH INC.	WOODRIDGE	IL	6	$422,325.06	$422,325.06	159
21	BIOLOGICS BY MCKESSON	FORT WORTH	TX	19	$419,047.39	$59,863.91	21
22	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	2,038	$412,100.10	$2,091.88	20
23	WALGREENS SPECIALTY PHARMACY #16280	FRISCO	TX	16	$401,853.70	$80,370.74	32
24	ALLEN CLINIC PHARMACY	WATERLOO	IA	1,011	$395,219.29	$1,231.21	24
25	UI HEALTH CARE DES MOINES PHARMACY	DES MOINES	IA	38	$391,666.22	$26,111.08	726
26	HY-VEE PHARMACY SOLUTIONS	OMAHA	NE	92	$391,658.47	$21,758.80	30
27	GENOA HEALTHCARE, LLC	DAVENPORT	IA	1,522	$386,423.20	$2,493.05	25
28	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,581	$375,974.71	$1,182.31	29
29	WALGREENS #4405	COUNCIL BLUFFS	IA	4,945	$368,750.65	$362.23	23
30	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	3,944	$362,968.39	$650.48	26
31	ANOVORX GROUP, LLC	MEMPHIS	TN	38	$357,065.92	$27,466.61	27
32	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	2,340	$324,452.32	$2,439.49	38
33	WALGREENS #5042	CEDAR RAPIDS	IA	4,448	$306,009.68	$302.08	28
34	JUNE E. NYLEN CANCER CENTER	SIOUX CITY	IA	18	$292,365.00	$73,091.25	53
35	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	3,641	$291,654.72	$530.28	41
36	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	3,045	$288,999.38	$862.68	34
37	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,653	$288,232.36	$704.72	48
38	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,814	$283,190.79	$395.52	33
39	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	18	$282,964.88	$40,423.55	35
40	EVERSANA LIFE SCIENCE SERVICES, LLC	CHESTERFIELD	MO	9	$280,516.27	$93,505.42	178
41	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	3,944	$276,662.38	$400.96	47
42	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	3,608	$269,506.19	$519.28	44
43	RIGHT DOSE PHARMACY	ANKENY	IA	5,984	$268,902.79	$647.96	50
44	DRILLING PHARMACY	SIOUX CITY	IA	4,090	$264,519.88	$764.51	36
45	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	8	$257,648.30	$85,882.77	58
46	ACCREDO HEALTH GROUP, INC.	WHITESTOWN	IN	37	$257,114.84	$17,140.99	202

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47	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,105	$257,034.04	$584.17	31
48	WALGREENS #5721	DES MOINES	IA	3,064	$245,168.95	$330.42	49
49	SENDERRA RX PHARMACY	PLANO	TX	22	$244,512.76	$22,228.43	86
50	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	956	$244,246.12	$1,403.71	52
51	HY-VEE PHARMACY (1449)	NEWTON	IA	2,506	$239,589.98	$585.79	55
52	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	2,359	$239,408.52	$551.63	100
53	ORSINI PHARMACEUTICAL SERVICES INC	ELK GROVE VILLAGE	IL	18	$238,950.57	$39,825.10	54
54	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	2,529	$238,735.44	$682.10	56
55	HY-VEE PHARMACY (1396)	MARION	IA	2,241	$237,418.59	$723.84	45
56	HY-VEE PHARMACY (1192)	FT DODGE	IA	2,936	$237,015.81	$578.09	39
57	MAXOR SPECIALTY PHARMACY	LUBBOCK	TX	22	$232,618.38	$116,309.19	88
58	WALGREENS #5239	DAVENPORT	IA	3,960	$231,079.44	$257.33	42
59	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	77	$229,658.64	$7,919.26	106
60	WAGNER PHARMACY	CLINTON	IA	2,778	$228,594.33	$840.42	40
61	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	3,183	$228,116.99	$502.46	59
62	GENOA HEALTHCARE, LLC	MARSHALLTOWN	IA	1,005	$226,264.35	$2,381.73	93
63	ONCO360	LOUISVILLE	KY	20	$226,200.98	$28,275.12	37
64	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	42	$222,310.29	$13,894.39	43
65	WALGREENS #15647	SIOUX CITY	IA	2,823	$217,282.89	$293.63	60
66	OPTUM INFUSION SERVICES 550, LLC.	URBANDALE	IA	63	$215,083.88	$23,898.21	64
67	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	1,969	$213,754.30	$848.23	66
68	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,223	$212,789.60	$812.17	51
69	WALGREENS #7455	WATERLOO	IA	2,920	$212,650.82	$263.18	57
70	MAYO CLINIC PHARMACY	ROCHESTER	MN	20	$211,262.80	$35,210.47	75
71	WALGREENS SPECIALTY PHARMACY #15443	FRISCO	TX	18	$208,625.15	$34,770.86	70
72	HY-VEE PHARMACY (1180)	FAIRFIELD	IA	1,949	$206,287.40	$787.36	78
73	MERCYONE WATERLOO PHARMACY	WATERLOO	IA	1,604	$200,689.92	$629.12	85
74	HY-VEE PHARMACY (1241)	HARLAN	IA	1,848	$200,137.10	$656.19	84
75	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,235	$198,200.37	$540.06	77
76	MEDICAP PHARMACY	NEWTON	IA	1,831	$196,678.82	$1,086.62	67
77	HY-VEE PHARMACY (1075)	CLINTON	IA	2,432	$196,415.64	$507.53	82
78	MAHASKA DRUGS INC	OSKALOOSA	IA	2,396	$193,374.89	$573.81	61
79	WALGREENS #7453	DES MOINES	IA	2,560	$192,007.71	$325.99	46
80	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	2,410	$188,200.32	$514.21	79
81	WALGREENS #359	DES MOINES	IA	2,520	$186,478.02	$288.67	73
82	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	2,087	$185,611.32	$648.99	62
83	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,181	$182,735.01	$532.76	90
84	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	2,609	$181,414.50	$449.05	65
85	LEWIS FAMILY DRUG #28	ONAWA	IA	2,114	$180,640.50	$775.28	83
86	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,313	$178,077.43	$544.58	76
87	WALMART PHARMACY 10-1496	WATERLOO	IA	1,579	$177,404.88	$581.66	104
88	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,679	$176,964.89	$300.45	69
89	EXACTCARE	VALLEY VIEW	OH	1,987	$174,420.18	$2,180.25	95
90	HARTIG PHARMACY SERVICES	DUBUQUE	IA	1,709	$173,310.00	$1,575.55	113
91	ARJ INFUSION SERVICES, LLC	CEDAR RAPIDS	IA	16	$170,981.82	$56,993.94	103
92	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	2,148	$170,930.52	$481.49	80

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TOP 100 PHARMACIES BY PAID AMOUNT
202506 - 202508

RANK	PHARMACY NAME	PHARMACY CITY	PHARMACY STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
93	SCOTT PHARMACY	FAYETTE	IA	2,139	$167,347.90	$849.48	99
94	NELSON FAMILY PHARMACY	FORT MADISON	IA	2,544	$165,990.01	$496.98	71
95	MEDICAP PHARMACY	DES MOINES	IA	1,336	$165,356.04	$1,879.05	107
96	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	2,317	$163,953.43	$384.87	94
97	HY-VEE PHARMACY #6 (1155)	DES MOINES	IA	1,579	$163,941.08	$762.52	72
98	SOUTH SIDE DRUG	OTTUMWA	IA	2,365	$160,243.72	$525.39	102
99	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,941	$159,512.12	$449.33	122
100	CVS PHARMACY #08658	DAVENPORT	IA	2,005	$159,434.37	$487.57	110

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TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
202506 - 202508

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
1	1356359871	Rhea Hartley	$144,378.81	1,301	5.38	1
2	1982605762	Jeffrey Wilharm	$87,258.89	1,231	18.94	2
3	1013115369	Bobbita Nag	$37,488.73	960	5.71	3
4	1659358620	Carlos Castillo	$20,980.86	921	6.98	5
5	1528365277	Mina Salib	$329,703.32	909	4.35	11
6	1811419815	Gretchen Wenger	$78,703.76	900	6.04	44
7	1730849647	Melanie Rock	$30,675.58	863	6.35	6
8	1184056822	Abby Kolthoff	$435,495.46	840	7.71	12
9	1457584740	Eric Meyer	$67,974.44	817	5.79	10
10	1770933046	Shelby Biller	$84,727.14	807	6.90	14
11	1619153137	Joada Best	$66,936.86	790	7.25	9
12	1992402655	Shane Eberhardt	$178,475.54	776	5.50	39
13	1417941188	Debra Neuharth	$56,742.89	772	7.88	8
14	1467907394	Cynthia Coenen	$94,785.01	770	10.13	15
15	1821268335	Jacqueline Mcinnis	$112,718.40	766	10.79	20
16	1043703887	Tenaea Jeppeson	$128,058.01	755	8.88	23
17	1477199198	Sajo Thomas	$120,609.41	743	6.88	7
18	1609532373	Erin Fox-Hammel	$46,383.09	736	9.81	40
19	1043434525	Robert Kent	$60,161.88	733	8.14	22
20	1801998372	Wendy Hansen-Penman	$23,946.94	727	8.17	16
21	1538368170	Christopher Matson	$36,712.32	719	7.57	21
22	1275763047	Rebecca Bowman	$115,080.17	710	8.55	18
23	1467502286	Charles Tilley	$85,667.70	700	7.07	17
24	1922455096	Dean Guerdet	$85,146.77	675	6.62	19
25	1538149042	Eric Petersen	$19,836.65	673	7.32	25
26	1184395162	Danielle Van Oosbree	$171,472.63	666	11.10	34
27	1992103386	Melissa Larsen	$79,675.32	660	8.35	37
28	1053630640	Jennifer Donovan	$90,577.34	652	7.33	31
29	1164538674	Joseph Wanzek	$78,156.82	652	11.24	38
30	1457914657	Seema Antony	$55,131.18	650	5.65	24
31	1134854128	Dzevida Pandzic	$62,855.89	649	5.23	41
32	1902478811	Joan Anderson	$170,077.07	645	8.27	26
33	1265841845	Mary Schwering	$44,051.69	644	6.71	62
34	1306559786	Roy Henry	$22,954.35	628	6.98	74
35	1215125216	Rebecca Walding	$52,170.99	623	7.60	27
36	1528329398	Erin Rowan	$37,089.30	618	6.65	42
37	1245960350	Mary Welborn	$35,569.68	618	5.52	28
38	1154815330	Bruce Pehl	$39,131.68	615	7.41	60
39	1891422606	Emily Clawson	$60,689.06	611	6.71	48
40	1649248378	Kathleen Wild	$16,675.83	610	7.82	36
41	1598183493	Jena Ellerhoff	$43,386.56	606	8.78	51
42	1902358443	Melissa Konken	$103,978.72	602	8.85	35
43	1437238110	Genevieve Nelson	$95,458.02	601	8.97	29
44	1477926434	Jackie Shipley	$32,981.96	592	5.15	46
45	1205393386	Jessica Hudspeth	$63,093.68	591	8.10	49
46	1689077018	Stacy Roth	$84,073.47	587	5.75	33

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TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
202506 - 202508

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
47	1114681889	Kelsey Bauer	$62,111.58	587	6.60	47
48	1902912538	Christian Jones	$38,705.93	586	5.80	43
49	1295830115	Alan Bollinger	$13,079.18	573	9.10	125
50	1841220290	Kent Kunze	$12,265.76	571	8.52	55
51	1649763079	Kate Jarvis	$91,290.97	570	6.40	66
52	1023542271	Flynn Mccullough	$55,896.15	569	7.90	89
53	1255823506	Nicole Delagardelle	$70,105.71	568	6.53	65
54	1417241621	Ashley Mathes	$31,949.78	563	5.63	61
55	1053963900	Nicole Mcclavy	$71,170.90	561	6.76	57
56	1720698335	Danika Hansen	$68,883.98	561	6.84	50
57	1811960768	Angela Veenstra	$38,931.15	561	8.13	99
58	1144214248	Kristi Walz	$75,170.09	551	8.22	45
59	1982030946	Jacklyn Besch	$33,950.77	550	5.79	52
60	1215981758	Lisa Pisney	$89,465.38	548	5.83	71
61	1902596828	Lindsay Harms	$40,288.36	545	10.69	85
62	1942721584	Shawna Fury	$27,305.77	545	5.34	69
63	1750845954	Stephanie Giesler	$113,404.40	544	8.12	84
64	1144588476	Rachel Filzer	$53,575.70	539	6.42	72
65	1871105916	Lacie Theis	$42,945.46	537	6.97	58
66	1588746515	Amy Badberg	$38,034.66	534	7.85	73
67	1891306452	Jennifer Tomlin	$35,861.50	533	6.27	68
68	1184657603	Sara Rygol	$64,406.70	531	6.17	93
69	1316471154	Nicole Woolley	$25,790.36	525	7.19	53
70	1972758126	Rebecca Bollin	$32,686.65	522	5.87	67
71	1891707832	Lisa Klock	$27,620.04	514	5.24	132
72	1992573786	Lashelle Goode	$26,748.78	514	5.78	152
73	1730173766	Frank Babcock	$15,712.09	514	13.53	105
74	1902384118	Nichole O'brien	$50,676.92	507	5.63	108
75	1538157383	David Wenger-Keller	$27,922.95	505	10.98	64
76	1679573893	Patty Hildreth	$100,010.75	504	7.10	87
77	1558770974	Marc Baumert	$42,898.41	504	5.42	83
78	1760965032	Melissa Miller	$14,348.24	502	5.84	30
79	1043418809	Michael Ciliberto	$236,995.26	500	7.94	82
80	1043211303	Ali Safdar	$43,696.01	499	5.94	59
81	1831710987	Margaret White	$29,001.24	499	6.74	86
82	1134191018	Dustin Smith	$27,324.14	497	6.06	63
83	1053398800	Steven Scurr	$26,649.43	497	7.10	104
84	1215581251	Anna Throckmorton	$30,766.36	496	9.02	122
85	1467449710	Michelle Malloy	$32,001.95	484	6.45	117
86	1215184726	Babuji Gandra	$24,585.55	481	5.94	75
87	1013355759	Dylan Greene	$23,251.36	481	5.53	76
88	1013639749	Robert Husemann	$58,944.50	479	7.26	151
89	1942660204	Kimberly Rutledge	$65,809.70	478	6.21	119
90	1851161228	Kala Clark	$61,856.28	478	8.10	128
91	1831731298	Heather Wilson	$28,478.96	477	6.91	94
92	1407415128	Sondra Philips	$24,076.50	477	6.36	167

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TOP PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
202506 - 202508

RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS PER MEMBER	PREVIOUS RANK
93	1154790517	Jamie Schumacher	$20,033.71	476	7.44	106
94	1891146999	Becky Johnson	$549,155.16	475	6.25	56
95	1275742090	Ashar Luqman	$174,706.66	475	6.09	107
96	1871021543	Susan Wilson	$57,713.23	473	7.06	79
97	1528060134	Julie Graeve	$34,903.21	472	6.65	90
98	1477045797	Chantal Rozmus	$56,937.79	468	6.50	138
99	1497276505	Laurie Schultz	$30,566.70	468	5.44	113
100	1952761736	Lindsey Weirather	$21,569.90	467	5.84	131

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
202506 - 202508

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
1	1326034984	Katherine Mathews	64	$741,208.31	$11,581.38	9
2	1013126705	Janice Staber	34	$685,318.53	$20,156.43	12
3	1326410499	Tara Eastvold	338	$558,705.61	$1,652.98	1
4	1891146999	Becky Johnson	475	$549,155.16	$1,156.12	3
5	1316934318	Steven Lentz	40	$545,748.32	$13,643.71	2
6	1285626390	Kathleen Gradoville	205	$537,259.95	$2,620.78	8
7	1780788844	Tammy Wichman	45	$522,560.96	$11,612.47	6
8	1942937388	Carly Trausch	445	$496,517.73	$1,115.77	4
9	1417443953	Rodney Clark	315	$460,718.31	$1,462.60	7
10	1295091510	Rebecca Weiner	319	$436,522.53	$1,368.41	5
11	1184056822	Abby Kolthoff	840	$435,495.46	$518.45	10
12	1477761328	Amy Calhoun	44	$363,725.39	$8,266.49	20
13	1528365277	Mina Salib	909	$329,703.32	$362.71	11
14	1700561826	Pedro Hsieh	49	$318,276.16	$6,495.43	14
15	1700417169	Courtney Reints	231	$307,008.64	$1,329.04	13
16	1437121407	Linda Cadaret	115	$296,557.34	$2,578.76	19
17	1407065469	Christoph Randak	155	$293,158.64	$1,891.35	28
18	1356753859	Katie Lutz	81	$289,786.96	$3,577.62	31
19	1477968303	Joseph Larson	238	$284,760.32	$1,196.47	39
20	1326211889	James Friedlander	51	$281,248.26	$5,514.67	18
21	1952539447	Anthony Fischer	139	$275,816.82	$1,984.29	47
22	1730406356	Christina Warren	173	$269,752.87	$1,559.27	17
23	1588616171	Heather Thomas	110	$262,456.74	$2,385.97	15
24	1861463275	Donald Wender	29	$261,488.64	$9,016.85	44
25	1043565328	Sara Moeller	69	$257,863.33	$3,737.15	16
26	1861277980	Kathryn Ewoldt	332	$255,331.56	$769.07	104
27	1376525196	Randolph Rough	74	$255,076.47	$3,446.98	111
28	1770324220	Casie Hale	377	$252,947.72	$670.95	89
29	1356577951	Christopher Mulder	57	$242,542.79	$4,255.14	21
30	1043418809	Michael Ciliberto	500	$236,995.26	$473.99	22
31	1659093292	Kathryn Foy	53	$218,188.37	$4,116.76	25
32	1558808501	Jessica Braksiek	29	$216,952.31	$7,481.11	33
33	1649943689	Jessica Coffey	127	$210,043.31	$1,653.88	42
34	1992314108	Lynzee Makowski	401	$206,709.67	$515.49	247
35	1215333091	Nadia Naz	169	$200,141.57	$1,184.27	1130
36	1093162075	Meghan Ryan	97	$197,725.74	$2,038.41	24
37	1366065047	Brittania Schoon	103	$192,635.87	$1,870.25	56
38	1568097244	Elizabeth Dassow	69	$192,332.41	$2,787.43	37
39	1609131770	Sreenath Ganganna	279	$191,042.09	$684.74	32
40	1629342662	Rosa Stocker	99	$190,446.83	$1,923.71	848
41	1780995506	Quanhathai Kaewpoowat	41	$182,813.03	$4,458.85	60
42	1386084747	Jennifer Condon	153	$179,183.89	$1,171.14	48
43	1992402655	Shane Eberhardt	776	$178,475.54	$229.99	49
44	1841548161	Crystal Meyer	60	$175,922.94	$2,932.05	52
45	1649826140	Taylor Myers	175	$175,052.85	$1,000.30	35
46	1275742090	Ashar Luqman	475	$174,706.66	$367.80	78

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
202506 - 202508

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
47	1184395162	Danielle Van Oosbree	666	$171,472.63	$257.47	66
48	1902478811	Joan Anderson	645	$170,077.07	$263.69	34
49	1629213509	Teri Devine	41	$167,583.24	$4,087.40	2668
50	1134981038	Cassidy Chalupa	84	$165,992.56	$1,976.10	54
51	1134249832	Steven Craig	70	$165,708.48	$2,367.26	53
52	1033221916	Adrian Letz	87	$165,115.59	$1,897.88	1411
53	1265870950	Danita Velasco	3	$164,767.89	$54,922.63	61
54	1619382942	Eirene Alexandrou	142	$162,938.92	$1,147.46	26
55	1417449570	Alex Sieg	35	$160,938.57	$4,598.24	51
56	1790986925	Tahuanty Pena	26	$160,564.23	$6,175.55	114
57	1306071915	Thomas Pietras	78	$160,521.90	$2,057.97	30
58	1912208323	Lisa Meyer	342	$160,512.14	$469.33	46
59	1467449579	Brian Wayson	81	$157,853.58	$1,948.81	27
60	1578958542	Heidi Curtis	149	$156,319.88	$1,049.13	23
61	1245353242	Sandy Hong	88	$154,407.22	$1,754.63	141
62	1457031817	Corinne Conley	81	$154,304.17	$1,904.99	85
63	1093382632	Gail Dooley	159	$153,177.34	$963.38	40
64	1043429087	Kayelyn Wagner	12	$152,877.74	$12,739.81	133
65	1134440886	Melissa Wells	98	$150,997.79	$1,540.79	72
66	1023108701	Ronald Zolty	32	$150,496.05	$4,703.00	36
67	1649419219	Heather Hunemuller	145	$148,824.45	$1,026.38	63
68	1275836751	Holly Kramer	120	$148,184.13	$1,234.87	84
69	1356359871	Rhea Hartley	1,301	$144,378.81	$110.98	67
70	1508281619	Kelly Marine	98	$144,105.49	$1,470.46	99
71	1578132940	Alec Steils	336	$141,957.30	$422.49	118
72	1508008566	Brian Lindsay	156	$136,846.09	$877.22	349
73	1891955423	Leah Siegfried	317	$133,958.75	$422.58	65
74	1225263833	Lindsay Orris	84	$130,908.74	$1,558.44	121
75	1386902682	Melissa Willis	71	$129,988.27	$1,830.82	41
76	1851965875	Jessica Ogden	51	$128,445.55	$2,518.54	105
77	1043703887	Tenaea Jeppeson	755	$128,058.01	$169.61	80
78	1902864739	Anoop Aggarwal	48	$128,056.32	$2,667.84	103
79	1144900861	Lizabeth Sheets	356	$127,977.02	$359.49	43
80	1225143316	Susan Jacobi	101	$127,748.82	$1,264.84	58
81	1437147386	Douglas Hornick	64	$127,270.66	$1,988.60	266
82	1235792912	Faraaz Zafar	82	$127,159.95	$1,550.73	142
83	1851568703	Mathew Davey	65	$126,113.20	$1,940.20	59
84	1841607900	Shayla Sanders	59	$125,571.09	$2,128.32	73
85	1437533130	Katie Broshuis	117	$125,285.39	$1,070.82	110
86	1912979261	David Visokey	118	$122,987.98	$1,042.27	64
87	1720036353	Erik Swenson	68	$121,303.45	$1,783.87	135
88	1598786097	Stephanie Gray	400	$121,035.70	$302.59	94
89	1477199198	Sajo Thomas	743	$120,609.41	$162.33	38
90	1679521728	Jill Fliege	28	$120,399.54	$4,299.98	29
91	1487648705	Karen Hunke	72	$119,811.12	$1,664.04	55
92	1285710764	Jitendrakumar Gupta	265	$118,008.33	$445.31	134

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TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT

202506 - 202508

RANK	DOCTOR NUM	PRESCRIBER NAME	PRESCRIPTION COUNT	PAID AMOUNT	AVG COST RX	PREVIOUS RANK
93	1710510987	Nyshia Garcia	188	$117,796.42	$626.58	261
94	1114214541	Dimah Saade	40	$116,081.07	$2,902.03	45
95	1811666118	Jessiann Dryden-Parish	96	$115,340.01	$1,201.46	74
96	1275763047	Rebecca Bowman	710	$115,080.17	$162.08	138
97	1245349182	Mark Burdt	74	$114,384.93	$1,545.74	226
98	1871868984	Hana Niebur	63	$113,905.80	$1,808.03	75
99	1205859170	Michael Chen	283	$113,888.42	$402.43	109
100	1447519038	Erin Richardson	146	$113,514.61	$777.50	582

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TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

	202503 - 202505			202506 - 202508			
CATEGORY DESCRIPTION	**PREVIOUS TOTAL COST**	**PREVIOUS RANK**	**PREVIOUS % BUDGET**	**CURRENT TOTAL COST**	**CURRENT RANK**	**CURRENT % BUDGET**	**% CHANGE**
ANTIDIABETICS	$11,169,487.12	1	13.68 %	$11,580,980.40	1	13.84 %	0.16 %
DERMATOLOGICALS	$9,251,670.23	2	11.34 %	$9,592,077.80	2	11.47 %	0.13 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$9,083,003.34	3	11.13 %	$9,160,731.73	3	10.95 %	-0.18 %
ANALGESICS - ANTI-INFLAMMATORY	$6,668,607.76	4	8.17 %	$6,735,488.46	4	8.05 %	-0.12 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$4,330,091.43	5	5.31 %	$4,331,312.44	5	5.18 %	-0.13 %
RESPIRATORY AGENTS - MISC.	$3,437,050.54	7	4.21 %	$3,735,370.06	6	4.47 %	0.25 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$3,894,257.62	6	4.77 %	$3,716,700.34	7	4.44 %	-0.33 %
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC	$3,005,941.27	10	3.68 %	$3,223,067.78	8	3.85 %	0.17 %
ANTIVIRALS	$3,292,854.26	8	4.03 %	$3,168,144.15	9	3.79 %	-0.25 %
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,119,690.60	9	3.82 %	$2,903,224.36	10	3.47 %	-0.35 %
HEMATOLOGICAL AGENTS - MISC.	$2,154,952.25	13	2.64 %	$2,552,762.14	11	3.05 %	0.41 %
ANTICONVULSANTS	$2,318,011.60	11	2.84 %	$2,362,284.34	12	2.82 %	-0.02 %
MIGRAINE PRODUCTS	$2,193,075.40	12	2.69 %	$2,291,699.68	13	2.74 %	0.05 %
CARDIOVASCULAR AGENTS - MISC.	$2,098,884.83	14	2.57 %	$2,205,255.59	14	2.64 %	0.06 %
ENDOCRINE AND METABOLIC AGENTS - MISC.	$1,842,293.51	15	2.26 %	$2,016,826.43	15	2.41 %	0.15 %
ANTIDEPRESSANTS	$1,804,593.90	16	2.21 %	$1,753,975.12	16	2.10 %	-0.11 %
ANTICOAGULANTS	$1,483,398.99	17	1.82 %	$1,469,978.72	17	1.76 %	-0.06 %
GASTROINTESTINAL AGENTS - MISC.	$952,137.57	18	1.17 %	$1,333,222.04	18	1.59 %	0.43 %
NEUROMUSCULAR AGENTS	$819,622.65	19	1.00 %	$1,001,496.74	19	1.20 %	0.19 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$582,662.99	20	0.71 %	$560,092.56	20	0.67 %	-0.04 %

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TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

	202503 - 202505		202506 - 202508		
CURRENT CATEGORY DESCRIPTION	PREVIOUS CLAIMS	PREVIOUS RANK	CURRENT CLAIMS	CURRENT RANK	% CHANGE
ANTIDEPRESSANTS	82,938	1	79,908	1	-3.65 %
ANTICONVULSANTS	39,441	2	38,990	2	-1.14 %
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	37,582	3	35,585	3	-5.31 %
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	36,449	4	33,945	4	-6.87 %
ANTIDIABETICS	31,689	5	31,282	5	-1.28 %
ANTIPSYCHOTICS/ANTIMANIC AGENTS	31,184	6	30,143	6	-3.34 %
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	31,036	7	29,730	7	-4.21 %
ANTIHYPERTENSIVES	30,881	8	28,950	8	-6.25 %
ANTIANXIETY AGENTS	28,127	9	28,149	9	0.08 %
DERMATOLOGICALS	18,100	12	19,542	10	7.97 %
ANTIHISTAMINES	19,315	10	18,652	11	-3.43 %
ANTIHYPERLIPIDEMICS	18,994	11	17,549	12	-7.61 %
ANALGESICS - ANTI-INFLAMMATORY	15,563	14	15,442	13	-0.78 %
ANALGESICS - OPIOID	14,382	15	14,246	14	-0.95 %
BETA BLOCKERS	14,370	16	13,731	15	-4.45 %
THYROID AGENTS	12,724	17	12,394	16	-2.59 %
PENICILLINS	16,400	13	10,956	17	-33.20 %
MUSCULOSKELETAL THERAPY AGENTS	10,515	19	10,463	18	-0.49 %
DIURETICS	10,934	18	10,229	19	-6.45 %
ANALGESICS - NonNarcotic	9,586	21	9,617	20	0.32 %

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TOP 100 DRUGS BY PAID AMOUNT

	202503 - 202505		202506 - 202508		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Ozempic	4057343.42	1	4336505.53	1	6.88 %
Humira Pen	3570049.33	2	3578868.55	2	0.25 %
Dupixent	3184635.92	3	3317001.88	3	4.16 %
Trikafta	2810835.71	4	2849844.37	4	1.39 %
Vraylar	2770121.77	5	2781346.41	5	0.41 %
Jardiance	1977280.39	6	2044424.82	6	3.40 %
Invega Sust	1675955.49	7	1692061.39	7	0.96 %
Skyrizi Pen	1417269.31	9	1539366.12	8	8.61 %
Biktarvy	1602108.07	8	1527544.46	9	-4.65 %
Mounjaro	1197534.56	12	1397580.31	10	16.70 %
Stelara	1250355.3	10	1154182.09	11	-7.69 %
Taltz	1236506.49	11	1101925.82	12	-10.88 %
Eliquis	1073755.45	14	1061254.28	13	-1.16 %
Trulicity	1074936.27	13	1043497.78	14	-2.92 %
Rexulti	894318.87	16	975068.4	15	9.03 %
Ingrezza	895285.35	15	866473.93	16	-3.22 %
Aristada	801578.26	17	786149.84	17	-1.92 %
Nurtec	655933.95	18	703404.14	18	7.24 %
Altuviiio	504287.13	25	668440.54	19	32.55 %
Enbrel Srclk	625165.51	20	658030.28	20	5.26 %
Lisdexamfeta	562805.35	23	633603.88	21	12.58 %
Caplyta	585527.19	21	616505.54	22	5.29 %
Invega Trinz	651109.69	19	597547.17	23	-8.23 %
Farxiga	577872.12	22	555172.1	24	-3.93 %
Abilify Main	503077.03	26	540766.81	25	7.49 %
Symbicort	515668.67	24	530928.94	26	2.96 %
Tremfya	253473.22	68	502315.42	27	98.17 %
Skyrizi	322341.87	50	491779.7	28	52.56 %
Cosentyx Uno	496508.3	27	485877.34	29	-2.14 %
Trelegy	469839.85	31	475478.48	30	1.20 %
Austedo Xr	293440.97	58	475092.37	31	61.90 %
Rinvoq	460271.28	33	472577.91	32	2.67 %
Entresto	468789.05	32	464306.3	33	-0.96 %
Lybalvi	454947.19	34	454226.6	34	-0.16 %
Trintellix	472238.58	30	446071.54	35	-5.54 %
Mavyret	416484.51	39	437148.26	36	4.96 %
Ilaris	490162.81	28	436572.61	37	-10.93 %
Ajovy	423781.93	38	434028.26	38	2.42 %

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TOP 100 DRUGS BY PAID AMOUNT

	202503 - 202505		202506 - 202508		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Jornay Pm	432647.6	36	431742.91	39	-0.21 %
Adynovate	115516.71	138	422325.06	40	265.60 %
Duvyzat	228528.15	72	421330.04	41	84.37 %
Winrevair	389520.71	41	420576.86	42	7.97 %
Opsumit	401944.54	40	414899.52	43	3.22 %
Ubrelvy	372813.41	43	385354.87	44	3.36 %
Kisqali	302913.78	54	380387.02	45	25.58 %
Albuterol	423919.84	37	377309.3	46	-11.00 %
Xarelto	370201.22	44	373800.44	47	0.97 %
Spiriva	364296.25	45	369288.66	48	1.37 %
Norditropin	374356.99	42	368594.07	49	-1.54 %
Epidiolex	339813.49	47	363253.7	50	6.90 %
Kesimpta	335324.55	48	359337.58	51	7.16 %
Qelbree	331076.78	49	331070.47	52	0.00 %
Rebinyn	211577.1	79	310339.53	53	46.68 %
Xifaxan	315306.41	52	309768.85	54	-1.76 %
Hemlibra	446550.11	35	309724.93	55	-30.64 %
Zepbound	126161.45	131	303110	56	140.26 %
Strensiq	315797.15	51	302058.52	57	-4.35 %
Skyclarys	294798.84	57	297364.15	58	0.87 %
Cosentyx Pen	261702.17	63	291044.02	59	11.21 %
Abilify Asim	252055.05	69	288830.51	60	14.59 %
Humira	303806.29	53	287842.19	61	-5.25 %
Qulipta	256689.86	65	284646.61	62	10.89 %
Wakix	342169.64	46	284315.84	63	-16.91 %
Alyftrek	28414.85	351	284148.5	64	900.00 %
Ravicti	236634.41	71	283957.04	65	20.00 %
Evrysdi	296295.66	56	282802.55	66	-4.55 %
Insulin Lisp	270273.06	62	265647.32	67	-1.71 %
Ruconest	258421.26	64	258421.26	68	0.00 %
Linzess	254720.63	67	256519.77	69	0.71 %
Vyvanse	486258.44	29	255494.95	70	-47.46 %
Lantus Solos	246610.13	70	254886	71	3.36 %
Methylphenid	285047.58	60	254782.56	72	-10.62 %
Advair Hfa	255445.27	66	247373.5	73	-3.16 %
Xolair	169869.1	101	246922.35	74	45.36 %
Valtoco	139815.65	119	233355.57	75	66.90 %
Epinephrine	168247.39	103	226211.56	76	34.45 %

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TOP 100 DRUGS BY PAID AMOUNT

	202503 - 202505		202506 - 202508		
DRUG DESCRIPTION	PREVIOUS PAID AMOUNT	PREVIOUS RANK	CURRENT PAID AMOUNT	CURRENT RANK	PERCENT CHANGE
Amphet/dextr	225789.97	74	226161.59	77	0.16 %
Bimzelx	285372.7	59	221957.72	78	-22.22 %
Creon	185653.43	87	220368.16	79	18.70 %
Emgality	207266.55	81	215892.22	80	4.16 %
Enbrel Mini	213291.36	78	214148.58	81	0.40 %
Fintepla	217785.84	77	210926.25	82	-3.15 %
Takhzyro	105432.18	148	210864.36	83	100.00 %
Insulin Aspa	196397.04	84	210798.37	84	7.33 %
Tresiba Flex	228270.47	73	209416.44	85	-8.26 %
Verzenio	136647.94	123	198708.16	86	45.42 %
Voxzogo	193491.78	85	197343.78	87	1.99 %
Austedo	270503.73	61	193112.98	88	-28.61 %
Uptravi	218043.25	76	192765.9	89	-11.59 %
Pulmozyme	219957.42	75	190099.82	90	-13.57 %
Xywav	207723.19	80	187942.56	91	-9.52 %
Briviact	177172.81	95	186288.43	92	5.15 %
Toujeo Max	179967.49	92	184893.97	93	2.74 %
Hizentra	299454.86	55	181489.84	94	-39.39 %
Orencia Clck	166341.23	105	180928.77	95	8.77 %
Quillichew	202361.63	83	177851.53	96	-12.11 %
Skytrofa	165365.4	106	177595.03	97	7.40 %
Livmarli	0	0	177391.09	98	
Promacta	185010.88	89	176525.13	99	-4.59 %
Uzedy	125452.31	132	172808.99	100	37.75 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202503 - 202505		202506 - 202508		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Omeprazole	13,441	2	12,702	1	-5.50 %
Albuterol	14,232	1	12,680	2	-10.91 %
Trazodone	12,343	4	11,974	3	-2.99 %
Bupropion	11,857	5	11,801	4	-0.47 %
Sertraline	12,528	3	11,646	5	-7.04 %
Levothyroxin	11,715	6	11,362	6	-3.01 %
Fluoxetine	10,301	9	9,721	7	-5.63 %
Atorvastatin	10,570	8	9,660	8	-8.61 %
Amphet/dextr	9,531	10	9,334	9	-2.07 %
Gabapentin	9,406	12	9,232	10	-1.85 %
Escitalopram	9,440	11	9,088	11	-3.73 %
Cetirizine	9,139	13	8,866	12	-2.99 %
Hydroxyz Hcl	8,714	14	8,865	13	1.73 %
Buspirone	8,072	18	8,135	14	0.78 %
Methylphenid	8,697	15	7,856	15	-9.67 %
Montelukast	7,975	19	7,757	16	-2.73 %
Metformin	8,192	16	7,630	17	-6.86 %
Lisinopril	8,103	17	7,369	18	-9.06 %
Pantoprazole	7,413	21	7,156	19	-3.47 %
Quetiapine	7,413	20	7,144	20	-3.63 %
Clonidine	7,092	22	6,964	21	-1.80 %
Amoxicillin	10,743	7	6,652	22	-38.08 %
Guanfacine	6,949	24	6,449	23	-7.20 %
Duloxetine	6,504	26	6,349	24	-2.38 %
Aripiprazole	6,518	25	6,233	25	-4.37 %
Lamotrigine	6,036	29	6,145	26	1.81 %
Ondansetron	7,039	23	6,106	27	-13.25 %
Famotidine	5,957	30	5,746	28	-3.54 %
Amlodipine	6,135	27	5,482	29	-10.64 %
Prednisone	6,112	28	5,419	30	-11.34 %
Hydroco/apap	5,476	32	5,407	31	-1.26 %
Venlafaxine	5,318	33	5,096	32	-4.17 %
Topiramate	5,220	34	5,070	33	-2.87 %
Metoprol Suc	5,182	35	5,061	34	-2.34 %
Lisdexamfeta	4,396	43	4,927	35	12.08 %
Cyclobenzapr	4,937	39	4,885	36	-1.05 %
Ibuprofen	4,964	37	4,884	37	-1.61 %
Fluticasone	5,575	31	4,850	38	-13.00 %
Loratadine	4,950	38	4,780	39	-3.43 %
Ozempic	4,408	42	4,673	40	6.01 %
Aspirin Low	4,310	44	4,278	41	-0.74 %
Cephalexin	3,681	51	4,258	42	15.68 %
Losartan Pot	4,616	41	4,234	43	-8.28 %
Clonazepam	4,228	46	4,220	44	-0.19 %
Alprazolam	4,217	47	4,109	45	-2.56 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202503 - 202505		202506 - 202508		
DRUG DESCRIPTION	PREVIOUS PRESCRIPTION COUNT	PREVIOUS RANK	CURRENT PRESCRIPTION COUNT	CURRENT RANK	PERCENT CHANGE
Propranolol	4,143	48	4,070	46	-1.76 %
Risperidone	4,278	45	4,030	47	-5.80 %
Amox/k Clav	5,040	36	3,821	48	-24.19 %
Jardiance	3,624	52	3,793	49	4.66 %
Triamcinolon	3,287	56	3,698	50	12.50 %
Meloxicam	3,720	49	3,678	51	-1.13 %
Rosuvastatin	3,684	50	3,443	52	-6.54 %
Levetiraceta	3,377	53	3,317	53	-1.78 %
Lorazepam	3,193	58	3,231	54	1.19 %
Mirtazapine	3,235	57	3,195	55	-1.24 %
Prazosin Hcl	3,313	55	3,137	56	-5.31 %
Folic Acid	2,998	61	3,080	57	2.74 %
Furosemide	3,065	59	2,993	58	-2.35 %
Azithromycin	4,698	40	2,955	59	-37.10 %
Lantus Solos	2,717	66	2,793	60	2.80 %
Pregabalin	2,775	64	2,779	61	0.14 %
Tramadol Hcl	2,733	65	2,748	62	0.55 %
Spironolact	3,012	60	2,738	63	-9.10 %
Oxycodone	2,661	68	2,726	64	2.44 %
Fluconazole	2,588	71	2,674	65	3.32 %
Hydroxyz Pam	2,777	62	2,666	66	-4.00 %
Ferosul	2,697	67	2,606	67	-3.37 %
Hydrochlorot	2,775	63	2,563	68	-7.64 %
Allergy Reli	2,592	70	2,516	69	-2.93 %
Doxycyc Mono	2,657	69	2,478	70	-6.74 %
Divalproex	2,476	73	2,450	71	-1.05 %
Pot Chloride	2,285	80	2,445	72	7.00 %
Metronidazol	2,500	72	2,444	73	-2.24 %
Symbicort	2,368	75	2,421	74	2.24 %
Olanzapine	2,323	77	2,331	75	0.34 %
Atomoxetine	2,282	81	2,279	76	-0.13 %
Tizanidine	2,300	78	2,268	77	-1.39 %
Valacyclovir	2,362	76	2,266	78	-4.06 %
Acetamin	2,214	82	2,246	79	1.45 %
Amitriptylin	2,294	79	2,223	80	-3.10 %
Mupirocin	1,809	95	2,166	81	19.73 %
Baclofen	2,157	83	2,081	82	-3.52 %
Eliquis	2,073	84	2,035	83	-1.83 %
Cefdinir	3,338	54	2,023	84	-39.39 %
Insulin Lisp	2,068	85	2,021	85	-2.27 %
Vraylar	1,991	87	2,009	86	0.90 %
Tamsulosin	1,992	86	1,919	87	-3.66 %
Nystatin	1,624	101	1,914	88	17.86 %
Clindamycin	1,816	93	1,913	89	5.34 %
Polyeth Glyc	1,946	88	1,805	90	-7.25 %

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TOP 100 DRUGS BY PRESCRIPTION COUNT

	202503 - 202505		202506 - 202508		
DRUG DESCRIPTION	**PREVIOUS PRESCRIPTION COUNT**	**PREVIOUS RANK**	**CURRENT PRESCRIPTION COUNT**	**CURRENT RANK**	**PERCENT CHANGE**
Citalopram	1,846	89	1,781	91	-3.52 %
Zolpidem	1,741	96	1,762	92	1.21 %
Naltrexone	1,817	90	1,745	93	-3.96 %
Oxcarbazepin	1,739	97	1,739	94	0.00 %
Sumatriptan	1,816	92	1,721	95	-5.23 %
Naproxen	1,816	94	1,710	96	-5.84 %
Desvenlafax	1,682	99	1,687	97	0.30 %
Clopidogrel	1,600	103	1,651	98	3.19 %
Smz/tmp Ds	1,451	108	1,640	99	13.03 %
Prednisolone	2,446	74	1,633	100	-33.24 %

Iowa Health Link Iowa HHS | MOLINA HEALTHCARE

MOLINA HEALTHCARE OF IOWA CLAIMS QUARTERLY STATISTICS			
Category	March 2025 to May 2025	June 2025 to August 2025	% Change
Total paid Amount	$57,684,601.03	$57,616,741.44	-0.12%
Unique users	76,692	76,607	-0.11%
Cost Per user	$752.16	$752.11	-0.01%
Total prescriptions	479,338	478,450	-0.19%
Average Prescriptions per user	6.25	6.25	-0.07%
Average cost per prescription	$120.34	$120.42	0.07%
# Generic Prescriptions	433,917	433,104	-0.19%
% Generic	90.5%	90.5%	0.00%
$ Generic	$7,959,104.13	$7,930,457.23	-0.36%
Average Generic Prescription Cost	$18.34	$18.31	-0.17%
Average Generic Days' Supply	27.15	27.14	-0.06%
# Brand Prescriptions	45,421	45,346	-0.17%
% Brand	9.48%	9.48%	0.02%
$ Brand	$49,743,201	$49,686,284	-0.11%
Average Brand Prescription cost	$1,095.16	$1,095.71	0.05%
Average Brand Days' Supply	28.27	28.26	-0.05%

UTILIZATION BY AGE		
Age	March 2025 to May 2025	June 2025 to August 2025
0 to 6	12,247	12,229
7 to 12	9,904	9,881
13 to 18	9,970	9,945
19 to 64	44,103	44,070
65+	855	868
Total	77,079	76,993

UTILIZATION BY GENDER AND AGE			
Gender	Age	March 2025 to May 2025	June 2025 to August 2025
F	0 to 6	5,641	5,629
	7 to 12	4,449	4,437
	13 to 18	5,647	5,632
	19 to 64	28,067	28,039
	65+	520	528
	Gender Total	44,324	44,265
M	0 to 6	6,598	6,590
	7 to 12	5,454	5,443
	13 to 18	4,320	4,308
	19 to 64	16,024	16,019
	65+	333	337
	Gender Total	32,729	32,697
Grand Total		77,079	76,993

Top 100 Pharmacies by Prescription Count June 2025 to August 2025							
RANK	Pharmacy NAME	Pharmacy City	State	Prescription Count	Paid Amount	Average Cost RX	Previous RANK
1	UIHC AMBULATORY CARE PHC	IOWA CITY	IA	7,421	$4,326,356.68	$582.99	1
2	BROADLAWNS MED CTR OP PH	DES MOINES	IA	4,758	$230,258.29	$48.39	2
3	WALGREENS 04405	COUNCIL BLUFFS	IA	4,637	$335,926.34	$72.44	3
4	WALGREENS 05042	CEDAR RAPIDS	IA	4,220	$191,307.51	$45.33	4
5	RIGHT DOSE PHARMACY	ANKENY	IA	3,368	$170,705.20	$50.68	6
6	HY-VEE PHARMACY 1403	MARSHALLTOWN	IA	3,323	$237,858.99	$71.58	5
7	WALGREENS 05239	DAVENPORT	IA	3,310	$169,305.66	$51.15	7
8	WALGREENS 05721	DES MOINES	IA	2,998	$159,792.48	$53.30	8
9	SIOUXLAND COMM HLTH CTR	SIOUX CITY	IA	2,931	$158,486.04	$54.07	9
10	HY-VEE DRUGSTORE 7060	MUSCATINE	IA	2,822	$195,372.90	$69.23	10
11	WALGREENS 07455	WATERLOO	IA	2,813	$174,543.01	$62.05	11
12	HY-VEE PHARMACY 1138	DES MOINES	IA	2,722	$230,339.75	$84.62	12
13	WALGREENS 03700	COUNCIL BLUFFS	IA	2,670	$163,625.11	$61.28	13
14	HY-VEE PHARMACY 1109	DAVENPORT	IA	2,557	$191,669.63	$74.96	14
15	HY-VEE PHARMACY 1092	COUNCIL BLUFFS	IA	2,522	$235,501.94	$93.38	15
16	HY-VEE DRUGSTORE 7020	CEDAR RAPIDS	IA	2,497	$191,757.83	$76.80	16
17	WALGREENS 15647	SIOUX CITY	IA	2,494	$194,372.41	$77.94	17
18	WALGREENS 07453	DES MOINES	IA	2,477	$160,363.94	$64.74	18
19	HY-VEE PHARMACY 1075	CLINTON	IA	2,403	$172,206.71	$71.66	19
20	HY-VEE PHARMACY 1056	CEDAR RAPIDS	IA	2,358	$120,624.88	$51.16	20
21	COMMUNITY HEALTH CARE PH	DAVENPORT	IA	2,339	$90,303.70	$38.61	21
22	DRILLING PHARMACY 67	SIOUX CITY	IA	2,320	$144,930.12	$62.47	22
23	HY-VEE PHARMACY 1192	FORT DODGE	IA	2,219	$131,197.79	$59.12	24

24	HY-VEE PHARMACY 1151	DES MOINES	IA	2,212	$123,270.52	$55.73	23
25	WALMART PHARMACY 10-2889	CLINTON	IA	2,164	$169,880.01	$78.50	26
26	HY-VEE DRUGSTORE 7065	OTTUMWA	IA	2,162	$162,489.23	$75.16	25
27	CVS PHARMACY 08544	WATERLOO	IA	2,109	$134,632.11	$63.84	27
28	WALGREENS 00359	DES MOINES	IA	2,076	$130,219.92	$62.73	28
29	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,048	$111,917.94	$54.65	29
30	HY-VEE PHARMACY 1142	DES MOINES	IA	2,039	$135,652.27	$66.53	30
31	WALGREENS 04041	DAVENPORT	IA	2,018	$139,118.11	$68.94	31
32	HY-VEE PHARMACY 1061	CEDAR RAPIDS	IA	1,898	$99,337.93	$52.34	32
33	CVS PHARMACY 10282	FORT DODGE	IA	1,867	$89,595.76	$47.99	33
34	HY-VEE PHARMACY 1044	BURLINGTON	IA	1,833	$102,305.91	$55.81	34
35	GREENWOOD DRUG ON KIMBAL	WATERLOO	IA	1,822	$132,241.08	$72.58	35
36	NELSON FAMILY PHARMACY	FORT MADISON	IA	1,795	$109,132.58	$60.80	36
37	MAHASKA DRUGS	OSKALOOSA	IA	1,761	$163,994.57	$93.13	37
38	WALMART PHARMACY 10-3394	ATLANTIC	IA	1,739	$140,219.45	$80.63	38
39	HY VEE PHARMACY 1459	OELWEIN	IA	1,719	$96,762.69	$56.29	39
40	WALGREENS 10855	WATERLOO	IA	1,715	$127,117.71	$74.12	40
41	HY-VEE PHARMACY 1522	PERRY	IA	1,713	$122,714.45	$71.64	42
42	HY-VEE PHARMACY 1281	IOWA CITY	IA	1,712	$84,653.97	$49.45	41
43	HY-VEE PHARMACY 1530	PLEASANT HILL	IA	1,671	$111,828.02	$66.92	43
44	HY-VEE PHARMACY 1615	SIOUX CITY	IA	1,667	$146,921.28	$88.14	44
45	WALMART PHARMACY 10-5115	DAVENPORT	IA	1,635	$127,783.95	$78.16	45
46	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,627	$119,628.15	$73.53	47
47	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	1,627	$189,181.48	$116.28	46
48	HY-VEE PHARMACY 1180	FAIRFIELD	IA	1,619	$112,043.36	$69.21	48
49	HY-VEE PHARMACY 1074	CHARLES CITY	IA	1,603	$105,118.13	$65.58	49
50	SCOTT PHARMACY INC	FAYETTE	IA	1,596	$113,759.45	$71.28	56

51	WALGREENS 05852	DES MOINES	IA	1,590	$98,211.67	$61.77	50
52	UI HEALTHCARE	CORALVILLE	IA	1,589	$51,458.83	$32.38	51
53	NUCARA LTC PHARMACY 3	IOWA CITY	IA	1,575	$36,884.67	$23.42	54
54	HY-VEE PHARMACY 1396	MARION	IA	1,570	$103,703.73	$66.05	52
55	WALGREENS 03875	CEDAR RAPIDS	IA	1,564	$81,271.76	$51.96	55
56	CVS PHARMACY 08658	DAVENPORT	IA	1,563	$93,265.52	$59.67	53
57	WALMART PHARMACY 10-0646	ANAMOSA	IA	1,547	$106,362.42	$68.75	57
58	HY-VEE PHARMACY 1504	OTTUMWA	IA	1,534	$71,939.81	$46.90	59
59	HY-VEE DRUGSTORE 7056	MASON CITY	IA	1,533	$121,535.63	$79.28	60
60	WALGREENS 05470	SIOUX CITY	IA	1,532	$93,544.98	$61.06	58
61	WALGREENS 07452	DES MOINES	IA	1,519	$92,779.87	$61.08	61
62	WALGREENS 07454	ANKENY	IA	1,516	$71,221.75	$46.98	62
63	LEWIS FAMILY DRUG 28	ONAWA	IA	1,501	$129,053.74	$85.98	63
64	HY-VEE PHARMACY 1610	SIOUX CITY	IA	1,479	$118,213.06	$79.93	64
65	WALGREENS 05362	DES MOINES	IA	1,477	$105,716.37	$71.58	65
66	HY-VEE PHARMACY 1148	DES MOINES	IA	1,449	$91,023.47	$62.82	66
67	HY-VEE PHARMACY 1058	CENTERVILLE	IA	1,435	$200,835.99	$139.96	67
68	WALMART PHARMACY 10-1496	WATERLOO	IA	1,415	$100,731.67	$71.19	68
69	WALMART PHARMACY 10-0559	MUSCATINE	IA	1,408	$94,426.41	$67.06	70
70	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	1,405	$126,024.74	$89.70	71
71	ALL CARE HEALTH CENTER	COUNCIL BLUFFS	IA	1,404	$49,559.16	$35.30	72
72	INFOCUS PHARMACY SERVICE	DUBUQUE	IA	1,403	$68,200.79	$48.61	69
73	WAGNER PHARMACY	CLINTON	IA	1,393	$89,553.93	$64.29	74
74	HY-VEE PHARMACY 1866	WATERLOO	IA	1,388	$130,164.78	$93.78	73
75	HY-VEE PHARMACY 1241	HARLAN	IA	1,379	$93,789.00	$68.01	75
76	WALMART PHARMACY 10-0797	WEST BURLINGTON	IA	1,376	$61,846.22	$44.95	76

77	WALMART PHARMACY 10-0985	FAIRFIELD	IA	1,371	$66,731.30	$48.67	77
78	HY-VEE PHARMACY 1042	BURLINGTON	IA	1,341	$110,888.21	$82.69	79
79	HY-VEE DRUGSTORE 7026	CEDAR RAPIDS	IA	1,339	$94,683.37	$70.71	80
80	SOUTH SIDE DRUG, INC.	OTTUMWA	IA	1,333	$88,825.32	$66.64	81
81	MEDICAP PHARMACY 8405	INDIANOLA	IA	1,329	$42,338.13	$31.86	78
82	OMNICARE OF URBANDA 48236	URBANDALE	IA	1,328	$56,474.37	$42.53	85
83	CVS PHARMACY 10329	DES MOINES	IA	1,326	$141,189.68	$106.48	83
84	HY-VEE PHARMACY 1449	NEWTON	IA	1,322	$119,570.57	$90.45	82
85	HY-VEE PHARMACY 1054	CEDAR RAPIDS	IA	1,306	$108,655.72	$83.20	84
86	WALMART PHARMACY 10-1393	OSKALOOSA	IA	1,288	$102,139.48	$79.30	86
87	MEDICAP PHARMACY 8095	ELDORA	IA	1,280	$76,286.39	$59.60	87
88	HY-VEE PHARMACY 1107	DAVENPORT	IA	1,276	$99,491.09	$77.97	89
89	WALMART PHARMACY 10-1723	DES MOINES	IA	1,275	$55,950.83	$43.88	90
90	MAIN AT LOCUST PHARMACY	DAVENPORT	IA	1,274	$101,830.75	$79.93	88
91	HY-VEE PHARMACY 1013	AMES	IA	1,270	$73,347.56	$57.75	91
92	HY-VEE PHARMACY 1065	CHARITON	IA	1,259	$66,536.89	$52.85	92
93	COVENANT FAMILY PHARMACY	WATERLOO	IA	1,258	$104,433.36	$83.02	93
94	FOREST PARK CLINIC PHCY	MASON CITY	IA	1,256	$76,795.12	$61.14	96
95	WALMART PHARMACY 10-0810	MASON CITY	IA	1,252	$118,845.28	$94.92	95
96	WALGREENS 05777	DES MOINES	IA	1,250	$74,214.50	$59.37	94
97	WALMART PHARMACY 10-1621	CENTERVILLE	IA	1,240	$126,157.22	$101.74	97
98	WALMART PHARMACY 10-1431	KEOKUK	IA	1,233	$84,794.31	$68.77	98
99	HY-VEE PHARMACY 1009	ALBIA	IA	1,223	$70,919.33	$57.99	99
100	HY-VEE PHARMACY 1052	CEDAR FALLS	IA	1,221	$93,437.64	$76.53	100

Top 100 Pharmacies by Paid Amount June 2025 to August 2025							
RANK	Pharmacy NAME	Pharmacy City	State	Prescription Count	Paid Amount	Average Cost Member	Previous RANK
1	CAREMARK SPECIALTY P 1702	LENEXA	KS	626	$4,719,269.90	$7,538.77	1
2	UIHC AMBULATORY CARE PHC	IOWA CITY	IA	7,421	$4,326,356.68	$582.99	2
3	COMMUNITY, A WALGRE 16528	DES MOINES	IA	517	$3,015,886.43	$5,833.44	3
4	CVS SPECIALTY 02921	MONROEVILLE	PA	185	$1,330,912.40	$7,194.12	4
5	UNITYPOINT AT HOME	URBANDALE	IA	352	$1,249,415.36	$3,549.48	5
6	NUCARA SPECIALTY PHARMAC	PLEASANT HILL	IA	997	$1,087,541.70	$1,090.81	6
7	PANTHERX SPECIALTY PHARM	CORAOPOLIS	PA	30	$887,489.07	$29,582.97	7
8	CAREMARK SPECIALTY 48031	MOUNT PROSPECT	IL	84	$777,246.80	$9,252.94	8
9	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	42	$660,483.84	$15,725.81	9
10	COMMUNITY A WALGREE 21250	IOWA CITY	IA	157	$625,384.26	$3,983.34	10
11	CARE PLUS CVS/PHARM 00102	AURORA	CO	54	$526,230.43	$9,745.01	11
12	OPTUM PHARMACY	JEFFERSONVILLE	IN	56	$498,367.32	$8,899.42	12
13	ANOVORX GROUP LLC	MEMPHIS	TN	27	$428,121.22	$15,856.34	13
14	CVS/SPECIALTY 1703	REDLANDS	CA	18	$363,528.87	$20,196.05	14
15	EXPRESS SCRIPTS SPECIALT	ST. LOUIS	MO	20	$351,762.60	$17,588.13	15
16	WALGREENS 04405	COUNCIL BLUFFS	IA	4,637	$335,926.34	$72.44	16
17	AMBER PHARMACY	OMAHA	NE	61	$331,338.38	$5,431.78	17
18	EVERSANA LIFE SCIENCE SE	CHESTERFIELD	MO	9	$321,102.48	$35,678.05	18
19	ACARIAHEALTH PHARMACY 11	HOUSTON	TX	24	$292,848.04	$12,202.00	19
20	PRIMARY HEALTHCARE PHARM	DES MOINES	IA	1,072	$270,183.40	$252.04	20
21	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	59	$269,603.03	$4,569.54	21
22	ARJ INFUSION SERVICES LL	CEDAR RAPIDS	IA	42	$260,982.47	$6,213.87	22
23	CR CARE PHARMACY	CEDAR RAPIDS	IA	1,017	$251,585.89	$247.38	23

24	HY-VEE PHARMACY 1403	MARSHALLTOWN	IA	3,323	$237,858.99	$71.58	24
25	HY-VEE PHARMACY 1092	COUNCIL BLUFFS	IA	2,522	$235,501.94	$93.38	25
26	HY-VEE PHARMACY 1138	DES MOINES	IA	2,722	$230,339.75	$84.62	26
27	BROADLAWNS MED CTR OP PH	DES MOINES	IA	4,758	$230,258.29	$48.39	27
28	GENOA HEALTHCARE LL 20171	DAVENPORT	IA	1,082	$211,306.84	$195.29	28
29	SIOUXLAND REGIONAL CANCE	SIOUX CITY	IA	14	$207,065.59	$14,790.40	29
30	MEDICAL ONCOLOGY & HEMAT	DES MOINES	IA	23	$205,926.34	$8,953.32	30
31	GENOA HEALTHCARE LL 20304	SIOUX CITY	IA	1,111	$201,090.20	$181.00	31
32	HY-VEE PHARMACY 1058	CENTERVILLE	IA	1,435	$200,835.99	$139.96	32
33	HY-VEE DRUGSTORE 7060	MUSCATINE	IA	2,822	$195,372.90	$69.23	33
34	WALGREENS 15647	SIOUX CITY	IA	2,494	$194,372.41	$77.94	34
35	S-S PHARMACY	COUNCIL BLUFFS	IA	642	$194,036.47	$302.24	36
36	HY-VEE DRUGSTORE 7020	CEDAR RAPIDS	IA	2,497	$191,757.83	$76.80	37
37	HY-VEE PHARMACY 1109	DAVENPORT	IA	2,557	$191,669.63	$74.96	35
38	WALGREENS 05042	CEDAR RAPIDS	IA	4,220	$191,307.51	$45.33	38
39	ALLEN CLINIC PHARMACY	WATERLOO	IA	742	$190,061.47	$256.15	39
40	BIOLOGICS BY MCKESSON	CARY	NC	13	$189,353.08	$14,565.62	40
41	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	1,627	$189,181.48	$116.28	41
42	CHILDRENS HOME HEALTHCAR	OMAHA	NE	12	$185,723.68	$15,476.97	42
43	FIRST MED EAST PHARMACY	DAVENPORT	IA	363	$176,392.72	$485.93	43
44	WALGREENS 07455	WATERLOO	IA	2,813	$174,543.01	$62.05	44
45	HY-VEE PHARMACY 1075	CLINTON	IA	2,403	$172,206.71	$71.66	45
46	RIGHT DOSE PHARMACY	ANKENY	IA	3,368	$170,705.20	$50.68	48
47	WALMART PHARMACY 10-2889	CLINTON	IA	2,164	$169,880.01	$78.50	46
48	WALGREENS 05239	DAVENPORT	IA	3,310	$169,305.66	$51.15	47
49	SOLEO HEALTH INC	DUBLIN	OH	4	$165,902.36	$41,475.59	49
50	MAHASKA DRUGS	OSKALOOSA	IA	1,761	$163,994.57	$93.13	50

51	WALGREENS 03700	COUNCIL BLUFFS	IA	2,670	$163,625.11	$61.28	51
52	HY-VEE DRUGSTORE 7065	OTTUMWA	IA	2,162	$162,489.23	$75.16	52
53	WALGREENS 07453	DES MOINES	IA	2,477	$160,363.94	$64.74	53
54	WALGREENS 05721	DES MOINES	IA	2,998	$159,792.48	$53.30	54
55	SIOUXLAND COMM HLTH CTR	SIOUX CITY	IA	2,931	$158,486.04	$54.07	55
56	PARAGON PARTNERS	OMAHA	NE	146	$148,538.47	$1,017.39	56
57	HY-VEE PHARMACY 1615	SIOUX CITY	IA	1,667	$146,921.28	$88.14	57
58	HARTIG PHARMACY SERVICES	DUBUQUE	IA	775	$146,274.31	$188.74	58
59	DRILLING PHARMACY 67	SIOUX CITY	IA	2,320	$144,930.12	$62.47	59
60	HY-VEE PHCY SOLUTIONS	OMAHA	NE	23	$142,817.81	$6,209.47	60
61	CVS PHARMACY 10329	DES MOINES	IA	1,326	$141,189.68	$106.48	61
62	AON PHARMACY	FORT MYERS	FL	9	$140,550.85	$15,616.76	62
63	WALMART PHARMACY 10-3394	ATLANTIC	IA	1,739	$140,219.45	$80.63	63
64	WALGREENS 04041	DAVENPORT	IA	2,018	$139,118.11	$68.94	64
65	HY-VEE PHARMACY 1142	DES MOINES	IA	2,039	$135,652.27	$66.53	66
66	CVS PHARMACY 08544	WATERLOO	IA	2,109	$134,632.11	$63.84	65
67	GREENWOOD DRUG ON KIMBAL	WATERLOO	IA	1,822	$132,241.08	$72.58	67
68	HY-VEE PHARMACY 1192	FORT DODGE	IA	2,219	$131,197.79	$59.12	69
69	MEDICAP PHARMACY 8052	DES MOINES	IA	994	$130,999.57	$131.79	68
70	WALGREENS 00359	DES MOINES	IA	2,076	$130,219.92	$62.73	71
71	HY-VEE PHARMACY 1866	WATERLOO	IA	1,388	$130,164.78	$93.78	70
72	LEWIS FAMILY DRUG 28	ONAWA	IA	1,501	$129,053.74	$85.98	72
73	WALMART PHARMACY 10-5115	DAVENPORT	IA	1,635	$127,783.95	$78.16	73
74	ONCO360	LOUISVILLE	KY	14	$127,532.72	$9,109.48	74
75	WALGREENS 10855	WATERLOO	IA	1,715	$127,117.71	$74.12	75
76	WALMART PHARMACY 10-1621	CENTERVILLE	IA	1,240	$126,157.22	$101.74	76
77	WALMART PHARMACY 10-0581	MARSHALLTOWN	IA	1,405	$126,024.74	$89.70	77

78	GENOA HEALTHCARE LL 20459	MARSHALLTOWN	IA	452	$123,647.13	$273.56	79
79	HY-VEE PHARMACY 1151	DES MOINES	IA	2,212	$123,270.52	$55.73	78
80	GENOA HEALTHCARE LL 20523	SIOUX CITY	IA	364	$122,814.15	$337.40	80
81	HY-VEE PHARMACY 1522	PERRY	IA	1,713	$122,714.45	$71.64	81
82	HY-VEE DRUGSTORE 7056	MASON CITY	IA	1,533	$121,535.63	$79.28	82
83	HY-VEE PHARMACY 1056	CEDAR RAPIDS	IA	2,358	$120,624.88	$51.16	83
84	FIFIELD DRUG STORE	DES MOINES	IA	858	$120,466.84	$140.40	84
85	WALMART PHARMACY 10-3590	SIOUX CITY	IA	1,627	$119,628.15	$73.53	86
86	HY-VEE PHARMACY 1449	NEWTON	IA	1,322	$119,570.57	$90.45	85
87	WALMART PHARMACY 10-0810	MASON CITY	IA	1,252	$118,845.28	$94.92	87
88	HY-VEE PHARMACY 1610	SIOUX CITY	IA	1,479	$118,213.06	$79.93	88
89	WALGREENS 16270	OMAHA	NE	20	$116,498.65	$5,824.93	89
90	CHCSI PHARMACY	LEON	IA	928	$116,136.51	$125.15	90
91	SCOTT PHARMACY INC	FAYETTE	IA	1,596	$113,759.45	$71.28	95
92	HY-VEE PHARMACY 1180	FAIRFIELD	IA	1,619	$112,043.36	$69.21	91
93	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,048	$111,917.94	$54.65	92
94	HY-VEE PHARMACY 1530	PLEASANT HILL	IA	1,671	$111,828.02	$66.92	93
95	HY-VEE PHARMACY 1042	BURLINGTON	IA	1,341	$110,888.21	$82.69	94
96	NELSON FAMILY PHARMACY	FORT MADISON	IA	1,795	$109,132.58	$60.80	96
97	HY-VEE PHARMACY 1054	CEDAR RAPIDS	IA	1,306	$108,655.72	$83.20	97
98	MAYO CLINIC PHARMACY	ROCHESTER	MN	139	$106,853.48	$768.73	98
99	WALMART PHARMACY 10-0646	ANAMOSA	IA	1,547	$106,362.42	$68.75	99
100	WALGREENS 05362	DES MOINES	IA	1,477	$105,716.37	$71.58	100

Top 100 Prescribing Providers by Prescription Count June 2025 to August 2025						
RANK	NPI Num	Prescriber Name	Paid Amount	Prescription Count	Average Scripts Member	Previous Rank
1	1982605762	JEFFREY WILHARM	$40,955.21	1,195	15.9	1
2	1356359871	RHEA HARTLEY	$91,146.92	1019	4.8	2
3	1013115369	BOBBITA NAG	$32,725.76	798	5.0	3
4	1477199198	SAJO THOMAS	$99,909.51	655	6.9	5
5	1982030946	JACKLYN BESCH	$28,417.11	653	8.3	4
6	1811419815	GRETCHEN WENGER	$43,715.06	632	5.0	6
7	1689077018	STACY ROTH	$46,226.58	620	5.8	7
8	1659358620	CARLOS CASTILLO	$16,801.03	613	7.0	9
9	1639780414	NICOLETTE LOVITT	$19,854.14	609	8.5	8
10	1598183493	JENA ELLERHOFF	$30,577.33	605	9.0	10
11	1730849647	MELANIE ROCK	$16,386.71	601	7.0	11
12	1205540804	SAKETA POLK	$31,451.40	585	8.7	12
13	1770933046	SHELBY BILLER	$69,747.43	573	6.7	13
14	1164823092	JAMEY GREGERSEN	$25,752.92	567	8.5	14
15	1417941188	DEBRA NEUHARTH	$38,543.68	556	5.9	15
16	1164538674	JOSEPH WANZEK	$29,765.73	555	7.9	17
17	1992402655	SHANE EBERHARDT	$106,649.69	547	5.2	16
18	1043434525	ROBERT KENT	$24,886.36	540	7.1	18
19	1134854128	DZEVIDA PANDZIC	$34,886.56	534	4.5	19
20	1477926434	JACKIE SHIPLEY	$21,846.76	532	4.8	21
21	1144588476	RACHEL FILZER	$97,315.23	532	7.6	20
22	1528365277	MINA SALIB	$402,373.04	527	4.1	22
23	1467502286	CHARLES TILLEY	$103,961.40	521	7.0	23

24	1649763079	KATE JARVIS	$69,052.53	514	6.9	24
25	1306559786	ROY HENRY	$25,087.45	495	8.3	25
26	1437238110	GENEVIEVE NELSON	$48,296.64	492	8.6	26
27	1811960768	ANGELA VEENSTRA	$34,028.78	486	9.0	27
28	1942721584	SHAWNA FURY	$24,636.38	476	6.0	28
29	1437209434	JON THOMAS	$36,472.45	474	6.3	31
30	1902912538	CHRISTIAN JONES	$37,360.41	473	5.8	30
31	1891146999	BECKY JOHNSON	$493,224.14	473	6.1	29
32	1053963900	NICOLE MCCLAVY	$55,813.12	460	7.0	32
33	1245227099	DONNA DOBSON TOBIN	$45,147.82	455	9.9	33
34	1588746515	AMY BADBERG	$16,017.09	447	6.4	34
35	1154815330	BRUCE PEHL	$30,489.43	445	6.8	35
36	1831731298	HEATHER WILSON	$30,228.24	439	7.1	36
37	1538368170	CHRISTOPHER MATSON	$19,661.53	435	6.1	39
38	1114681889	KELSEY BAUER	$43,033.91	432	7.0	38
39	1538157383	DAVID WENGER-KELLER	$36,543.14	431	11.6	40
40	1457914657	SEEMA ANTONY	$38,140.22	429	4.5	37
41	1679986350	JENNIFER SPOERL	$64,649.92	426	7.9	41
42	1003053653	STANLEY MATHEW	$24,217.59	425	15.2	73
43	1760965032	MELISSA MILLER	$23,314.75	423	7.1	42
44	1346621059	MARK ZACHARJASZ	$27,547.22	422	10.0	43
45	1407141336	TERRA GOLDSBERRY	$5,384.55	421	35.1	45
46	1316510324	SANDY MARCUS	$29,009.19	420	5.9	44
47	1245960350	MARY WELBORN	$22,176.65	414	5.3	47
48	1619153137	JOADA BEST	$32,501.29	411	6.0	46
49	1871021543	SUSAN WILSON	$25,586.24	408	7.7	48
50	1205393386	JESSICA HUDSPETH	$56,338.05	407	6.4	49

51	1275763047	REBECCA BOWMAN	$53,016.23	406	7.4	50
52	1437692803	CASSANDRA DUNLAVY	$24,590.27	405	5.5	52
53	1427766559	KORIE EISCHEID	$20,831.85	405	7.5	51
54	1689139669	BENJAMIN BOLMEIER	$13,985.84	400	7.0	53
55	1467907394	CYNTHIA COENEN	$48,175.08	398	9.3	54
56	1225140809	SUNDARA MUNAGALA VENKATA	$48,056.45	396	5.6	55
57	1821333774	BRITTNI BENDA	$26,552.11	394	5.9	57
58	1609218304	AMANDA GARR	$62,108.60	391	7.7	58
59	1053398800	STEVEN SCURR	$35,557.64	390	7.6	77
60	1053630640	JENNIFER DONOVAN	$48,317.14	390	7.6	56
61	1922455096	DEAN GUERDET	$51,063.91	389	6.4	59
62	1902596828	LINDSAY HARMS	$31,281.51	389	9.0	61
63	1215184726	BABUJI GANDRA	$10,842.71	389	4.9	62
64	1013355759	DYLAN GREENE	$20,774.40	389	5.0	60
65	1780877878	CHRISTOPHER JACOBS	$42,014.83	388	6.3	63
66	1013639749	ROBERT HUSEMANN	$21,056.52	383	6.5	64
67	1891707832	LISA KLOCK	$19,448.40	382	5.0	65
68	1558770974	MARC BAUMERT	$19,572.17	380	5.1	68
69	1316471154	NICOLE WOOLLEY	$25,030.34	380	5.4	66
70	1902358443	MELISSA KONKEN	$68,701.41	379	7.7	70
71	1265841845	MARY SCHWERING	$16,560.07	379	5.6	67
72	1407415128	SONDRA PHILIPS	$16,092.47	378	6.4	69
73	1063277671	AMANDA FRY	$38,791.74	376	7.1	71
74	1184657603	SARA RYGOL	$39,350.62	375	5.4	72
75	1417241621	ASHLEY MATHES	$19,053.36	373	5.1	74
76	1144240805	DANIEL ROWLEY	$22,893.54	372	10.1	75
77	1891422606	EMILY CLAWSON	$42,648.00	368	6.5	78

78	1962418640	BARCLAY MONASTER	$22,929.10	367	4.8	76
79	1912345992	AMY WINGERT	$12,804.78	363	4.8	79
80	1093034266	ERIC BOYUM	$48,537.62	361	4.9	80
81	1417214321	LEAH BRANDON	$11,785.33	360	11.6	86
82	1649469826	KATHERINE LUTYENS	$45,042.51	358	4.4	81
83	1619380680	TARA BROCKMAN	$16,436.33	358	5.1	85
84	1215981758	LISA PISNEY	$44,973.26	358	6.5	84
85	1144214248	KRISTI WALZ	$115,184.00	358	6.9	87
86	1508846007	ANGELA TOWNSEND	$21,652.17	357	4.2	83
87	1306124557	STACY STEWART	$25,521.28	357	5.3	88
88	1184125262	JENIFER EDSTROM	$13,250.37	357	4.4	95
89	1649209933	RICHARD BLUNK	$29,741.00	356	4.2	82
90	1477112688	FELICIA HOERNER	$25,936.94	355	6.5	89
91	1710548581	LEEANN BERG	$14,675.85	354	6.8	90
92	1184056822	ABBY KOLTHOFF	$200,432.14	353	6.4	91
93	1932531316	BROOKE JOHNSON	$35,245.79	352	5.4	92
94	1902478811	JOAN ANDERSON	$38,243.89	349	8.1	93
95	1467465716	JEFFREY BRADY	$18,733.76	346	5.2	96
96	1134819600	SHELBY SHEEHAN	$36,552.84	346	6.4	94
97	1992573786	LASHELLE GOODE	$31,169.21	345	4.9	97
98	1992103386	MELISSA LARSEN	$43,549.99	340	6.7	99
99	1023542271	FLYNN MCCULLOUGH	$23,953.06	339	5.8	100
100	1932859477	SOPHIE MCKEE	$14,079.04	312	7.4	103

Top 100 Prescribing Providers by Paid Amount June 2025 to August 2025						
RANK	NPI Num	Prescriber Name	Paid Amount	Avg cost RX	Prescription Count	Previous Rank
1	1114214541	DIMAH SAADE	$781,758.89	$18,180.44	43	1
2	1891146999	BECKY JOHNSON	$493,224.14	$1,042.76	473	2
3	1316934318	STEVEN LENTZ	$482,678.38	$17,238.51	28	3
4	1942937388	CARLY TRAUSCH	$442,933.35	$1,442.78	307	4
5	1417443953	RODNEY CLARK	$421,428.60	$1,510.50	279	5
6	1528365277	MINA SALIB	$402,373.04	$763.52	527	6
7	1295091510	REBECCA WEINER	$384,575.14	$2,235.90	172	8
8	1437533130	KATIE BROSHUIS	$364,828.64	$3,648.29	100	7
9	1952423071	SAKEER HUSSAIN	$328,859.04	$10,608.36	31	9
10	1194945691	ANJALI SHARATHKUMAR	$326,170.32	$5,722.29	57	10
11	1013126705	JANICE STABER	$320,265.74	$11,043.65	29	11
12	1760562466	ARTHUR BEISANG	$319,503.78	$53,250.63	6	12
13	1073722112	RIAD RAHHAL	$312,977.22	$2,464.39	127	13
14	1700561826	PEDRO HSIEH	$301,633.77	$21,545.27	14	14
15	1649943689	JESSICA COFFEY	$292,668.41	$1,876.08	156	15
16	1437121407	LINDA CADARET	$274,762.40	$4,737.28	58	16
17	1588616171	HEATHER THOMAS	$256,345.63	$2,848.28	90	17
18	1245353242	SANDY HONG	$230,639.57	$5,363.71	43	18
19	1861277980	KATHRYN EWOLDT	$229,000.03	$1,040.91	220	19
20	1649826140	TAYLOR BOLDT	$223,568.92	$1,574.43	142	20
21	1477761328	AMY CALHOUN	$220,269.86	$6,293.42	35	21
22	1003315201	ABIGAIL BEHRENS	$213,767.37	$3,098.08	69	22
23	1700417169	COURTNEY REINTS	$209,337.21	$1,246.05	168	23
24	1821046087	ARCHANA VERMA	$203,779.25	$2,612.55	78	24

25	1932831971	KRISTEN EMODI	$203,474.61	$4,844.63	42	25
26	1184056822	ABBY KOLTHOFF	$200,432.14	$567.80	353	26
27	1467449579	BRIAN WAYSON	$197,583.65	$3,592.43	55	27
28	1669740957	COURTNEY KREMER	$187,432.11	$1,993.96	94	28
29	1265420095	ELIZABETH COOPER	$179,379.33	$5,125.12	35	29
30	1578958542	HEIDI CURTIS	$176,569.49	$1,307.92	135	30
31	1710463708	MARY MILLS	$174,288.95	$24,898.42	7	31
32	1144455502	JENNIFER PETTS	$168,998.50	$1,351.99	125	32
33	1356752067	KELLY DELANEY-NELSON	$165,894.10	$1,764.83	94	33
34	1871039917	ELIZABETH ALLEN	$161,819.20	$2,022.74	80	34
35	1861876526	NIBASH BUDHATHOKI	$154,540.56	$4,292.79	36	35
36	1285626390	KATHLEEN GRADOVILLE	$153,689.80	$925.84	166	36
37	1093382632	GAIL DOOLEY	$152,221.84	$1,436.06	106	37
38	1134981038	CASSIDY CHALUPA	$144,904.42	$1,725.05	84	38
39	1841607900	SHAYLA SANDERS	$140,310.68	$3,507.77	40	39
40	1376525196	RANDOLPH ROUGH	$136,225.25	$2,270.42	60	40
41	1972560597	BERNARD LEMAN	$134,261.03	$3,274.66	41	41
42	1215333091	NADIA NAZ	$133,196.37	$1,752.58	76	42
43	1588618359	BARBARA BURKLE	$131,485.07	$3,206.95	41	43
44	1306071915	THOMAS PIETRAS	$130,988.05	$4,851.41	27	44
45	1407065469	CHRISTOPH RANDAK	$127,680.86	$2,455.40	52	45
46	1699887133	DANIEL DIMEO	$123,323.85	$3,853.87	32	46
47	1598438095	LALAURA LOGAN	$122,417.96	$408.06	300	47
48	1437147386	DOUGLAS HORNICK	$120,660.08	$9,281.54	13	48
49	1972616316	JEFFREY BRANNEN	$120,106.93	$1,319.86	91	49
50	1386084747	JENNIFER CONDON	$115,696.50	$1,033.00	112	50
51	1669137832	TIFFANY NAVRKAL	$115,254.61	$1,266.53	91	51

52	1144214248	KRISTI WALZ	$115,184.00	$321.74	358	52
53	1134440886	MELISSA WELLS	$114,264.13	$1,904.40	60	53
54	1790986925	TAHUANTY PENA	$111,765.77	$3,020.70	37	54
55	1780905729	JONATHAN FAHLER	$111,550.92	$8,580.84	13	55
56	1730406356	CHRISTINA WARREN	$111,175.22	$992.64	112	56
57	1669443230	KENNETH ADAMS	$110,232.20	$2,505.28	44	57
58	1558808501	JESSICA BRAKSIEK	$109,661.24	$6,092.29	18	58
59	1992402655	SHANE EBERHARDT	$106,649.69	$194.97	547	59
60	1720036353	ERIK SWENSON	$106,086.92	$2,306.24	46	60
61	1063792026	JILL MILLER	$105,613.97	$384.05	275	61
62	1700080538	EDUARDO CARLIN	$105,601.21	$1,160.45	91	62
63	1851568703	MATHEW DAVEY	$104,614.61	$4,548.46	23	63
64	1194797449	DIANNA PROKUPEK	$104,552.72	$1,432.23	73	64
65	1225263833	LINDSAY ORRIS	$104,038.63	$2,667.66	39	65
66	1467502286	CHARLES TILLEY	$103,961.40	$199.54	521	66
67	1295217529	HEATHER STEHR	$102,801.91	$340.40	302	67
68	1902100746	AMI PATEL	$100,883.46	$2,882.38	35	68
69	1962663674	NIDHI MISHRA	$100,547.49	$11,171.94	9	69
70	1477199198	SAJO THOMAS	$99,909.51	$152.53	655	70
71	1801405832	SARAH HIEMER	$99,116.58	$1,238.96	80	71
72	1245468768	THOMAS SCHMIDT	$98,731.29	$1,316.42	75	72
73	1811666118	JESSIANN DRYDEN-PARISH	$98,193.07	$1,636.55	60	76
74	1144588476	RACHEL FILZER	$97,315.23	$182.92	532	74
75	1902191059	AMBER TIERNEY	$96,800.82	$4,400.04	22	75
76	1831200542	RANEEN SCHULTE	$96,081.82	$4,177.47	23	77
77	1891955423	LEAH SIEGFRIED	$95,266.47	$297.71	320	73
78	1225266364	SARAH BLIGH	$94,576.62	$2,306.75	41	78

79	1427685791	DELANEY SCHARA	$93,738.08	$1,768.64	53	79
80	1003470923	EARLENE ANGELL	$92,934.22	$277.42	335	80
81	1629417191	SUSAN SLYCORD	$92,315.80	$2,715.17	34	81
82	1609003011	JOHN BERNAT	$92,221.89	$30,740.63	3	82
83	1356359871	RHEA HARTLEY	$91,146.92	$89.45	1019	83
84	1780995506	QUANHATHAI KAEWPOOWAT	$88,965.88	$1,218.71	73	84
85	1366850711	FAISAL RADWI	$86,488.70	$4,804.93	18	85
86	1386938447	THERESA CZECH	$85,777.14	$801.66	107	86
87	1144900861	LIZABETH SHEETS	$85,313.51	$341.25	250	87
88	1073811352	KYLE ROSE	$85,093.55	$12,156.22	7	88
89	1720414006	JILL JOHNSON	$84,649.51	$397.42	213	89
90	1750376034	DUANGCHAI NARAWONG	$84,602.88	$1,031.74	82	90
91	1326410499	TARA EASTVOLD	$82,729.92	$336.30	246	91
92	1174970453	DANIEL HINDS	$82,089.86	$943.56	87	92
93	1295054542	ANGELA DELECARIS	$81,909.22	$3,723.15	22	93
94	1538111356	THANAI PONGDEE	$81,695.26	$40,847.63	2	94
95	1730135070	JAMES WALLACE	$81,627.60	$8,162.76	10	95
96	1598501330	AMY HUYNH	$80,279.10	$1,130.69	71	96
97	1609268762	JORDAN MEEKER	$79,055.36	$3,952.77	20	97
98	1467716027	AMIR ORANDI	$78,443.68	$11,206.24	7	98
99	1528000940	SHELBY DAMES	$77,138.63	$3,353.85	23	99
100	1457986671	PAITON CALVERT	$76,986.79	$1,115.75	69	100

Top 20 Therapeutic Class by Paid Amount							
Category Description	March 2025 to May 2025 Total Cost	Previous Rank	Previous % Budget	June 2025 to August 2025 Total Cost	Current Rank	Current % Budget	% Change
ANTIDIABETICS	$7,694,269.91	1	13.34%	$7,688,680.42	1	13.34%	-0.07%
DERMATOLOGICALS	$7,324,052.13	2	12.70%	$7,313,572.35	2	12.69%	-0.14%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$5,736,936.67	3	9.95%	$5,716,343.75	3	9.92%	-0.36%
ANALGESICS - ANTI-INFLAMMATORY	$4,783,525.17	4	8.29%	$4,771,381.29	4	8.28%	-0.25%
ANTIVIRALS	$3,042,068.57	5	5.27%	$3,041,917.63	5	5.28%	0.00%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$2,929,199.68	6	5.08%	$2,926,504.37	6	5.08%	-0.09%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$2,594,192.67	7	4.50%	$2,590,573.14	7	4.50%	-0.14%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$2,122,503.08	8	3.68%	$2,124,576.31	8	3.69%	0.10%
RESPIRATORY AGENTS - MISC.	$1,861,926.81	9	3.23%	$1,861,926.81	9	3.23%	0.00%
HEMATOLOGICAL AGENTS - MISC.	$1,845,074.15	10	3.20%	$1,845,081.98	10	3.20%	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$1,527,624.09	11	2.65%	$1,525,261.80	11	2.65%	-0.15%
GASTROINTESTINAL AGENTS - MISC.	$1,483,370.52	12	2.57%	$1,480,863.22	12	2.57%	-0.17%
MIGRAINE PRODUCTS	$1,378,880.78	13	2.39%	$1,378,582.23	13	2.39%	-0.02%
NEUROMUSCULAR AGENTS	$1,251,263.98	14	2.17%	$1,251,263.98	14	2.17%	0.00%
ANTIDEPRESSANTS	$1,236,506.78	15	2.14%	$1,233,903.54	15	2.14%	-0.21%
ANTICONVULSANTS	$1,203,891.71	16	2.09%	$1,203,619.56	16	2.09%	-0.02%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$1,198,254.38	17	2.08%	$1,197,909.61	17	2.08%	-0.03%
ANTICOAGULANTS	$1,158,390.67	18	2.01%	$1,156,258.22	18	2.01%	-0.18%
CARDIOVASCULAR AGENTS - MISC.	$1,020,517.42	19	1.77%	$1,018,597.14	19	1.77%	-0.19%
MISCELLANEOUS THERAPEUTIC CLASSES	$530,418.36	20	0.92%	$531,661.24	20	0.92%	0.23%

Top 20 Therapeutic Class by Prescription Count					
Category Description	March 2025 to May 2025 Total Claims	Previous Rank	June 2025 to August 2025 Total Claims	Current Rank	% Change
ANTIDEPRESSANTS	60,884	1	60,755	1	-0.21%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	27,613	2	27,572	2	-0.15%
ANTICONVULSANTS	26,542	3	26,507	3	-0.13%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	25,989	4	25,912	4	-0.30%
ANTIDIABETICS	23,757	5	23,724	5	-0.14%
ANTIHYPERTENSIVES	22,082	6	22,031	6	-0.23%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	21,848	7	21,823	7	-0.11%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	20,625	8	20,600	8	-0.12%
ANTIANXIETY AGENTS	20,615	9	20,567	9	-0.23%
PENICILLINS	14,252	10	14,236	10	-0.11%
DERMATOLOGICALS	14,111	11	14,028	11	-0.59%
ANTIHYPERLIPIDEMICS	13,295	12	13,275	12	-0.15%
ANALGESICS - ANTI-INFLAMMATORY	11,805	13	11,759	13	-0.39%
ANALGESICS - OPIOID	11,543	14	11,545	14	0.02%
ANTIHISTAMINES	11,401	15	11,366	15	-0.31%
BETA BLOCKERS	10,411	16	10,393	16	-0.17%
THYROID AGENTS	9,015	17	9,003	17	-0.13%
CORTICOSTEROIDS	8,727	18	8,721	18	-0.07%
DIURETICS	8,133	19	8,127	19	-0.07%
MUSCULOSKELETAL THERAPY AGENTS	7,557	20	7,541	20	-0.21%

Top 100 Drugs by Paid Amount					
Drug Description	March 2025 to May 2025 Total Cost	Previous Rank	June 2025 to August 2025 Total cost	Current Rank	% Change
Ozempic	$2,986,980.22	1	$2,986,063.18	1	-0.03%
Dupixent	$2,262,477.45	2	$2,268,477.98	2	0.27%
Humira (2 Pen)	$2,099,044.26	3	$2,085,603.58	3	-0.64%
Vraylar	$1,807,252.34	4	$1,806,439.67	4	-0.04%
Biktarvy	$1,622,821.86	5	$1,621,468.62	5	-0.08%
Skyrizi Pen	$1,462,021.66	6	$1,440,426.95	6	-1.48%
Trikafta	$1,428,459.03	7	$1,428,459.03	7	0.00%
Jardiance	$1,421,476.98	8	$1,420,010.53	8	-0.10%
Stelara	$1,119,789.29	9	$1,119,789.29	9	0.00%
Invega Sustenna	$1,047,003.43	10	$1,042,028.93	10	-0.48%
Duvyzat	$837,448.19	11	$837,448.19	11	0.00%
Eliquis	$822,722.44	12	$822,287.04	12	-0.05%
Taltz	$717,844.02	13	$717,844.02	13	0.00%
Trulicity	$695,063.56	14	$695,219.62	14	0.02%
Mounjaro	$684,561.41	15	$684,884.38	15	0.05%
Hemlibra	$670,622.74	16	$670,622.74	16	0.00%
Rinvoq	$659,450.80	17	$659,450.80	17	0.00%
Altuviiio	$603,534.90	18	$603,534.90	18	0.00%
Enbrel SureClick	$562,859.35	19	$562,859.35	19	0.00%
Abilify Maintena	$484,234.09	20	$484,234.09	20	0.00%
Rexulti	$463,344.27	21	$461,583.31	21	-0.38%
Cosentyx UnoReady	$450,500.99	24	$456,263.45	22	1.28%

Aristada	$459,854.16	22	$456,209.59	23	-0.79%
Skyrizi	$453,800.62	23	$453,800.62	24	0.00%
Farxiga	$447,621.47	25	$447,506.62	25	-0.03%
Ilaris	$443,030.87	26	$443,030.87	26	0.00%
Nurtec	$434,393.67	27	$433,400.03	27	-0.23%
Mavyret	$423,842.45	28	$423,842.45	28	0.00%
Vyvanse	$417,196.46	29	$417,579.73	29	0.09%
Lisdexamfetamine Dimesylate	$415,322.61	30	$415,176.31	30	-0.04%
Symbicort	$406,964.14	31	$405,345.25	31	-0.40%
Ingrezza	$397,246.14	32	$397,246.14	32	0.00%
Entresto	$386,881.06	33	$384,952.92	33	-0.50%
Norditropin FlexPro	$369,512.55	34	$369,512.55	34	0.00%
Invega Trinza	$357,293.91	35	$357,293.91	35	0.00%
Caplyta	$350,373.38	36	$345,488.23	36	-1.39%
Daybue	$319,503.78	37	$319,503.78	37	0.00%
Trintellix	$313,093.62	38	$311,898.61	38	-0.38%
Trelegy Ellipta	$310,748.00	39	$310,748.00	39	0.00%
Xywav	$309,910.71	40	$309,910.71	40	0.00%
Xarelto	$295,346.77	41	$293,733.56	41	-0.55%
Albuterol Sulfate HFA	$277,703.77	42	$276,718.51	42	-0.35%
Ubrelvy	$247,688.35	43	$247,688.35	43	0.00%
Ajovy	$246,673.93	44	$247,587.63	44	0.37%
Jornay PM	$239,011.73	45	$238,549.69	45	-0.19%
Xifaxan	$238,206.55	46	$238,206.55	46	0.00%
Gattex	$234,516.60	47	$234,516.60	47	0.00%
Lybalvi	$227,459.44	48	$225,455.64	48	-0.88%
Lenalidomide	$220,405.76	49	$220,405.76	49	0.00%

Tremfya One-Press	$208,410.52	52	$218,656.05	50	4.92%
Livmarli	$209,498.58	50	$209,498.58	51	0.00%
Humira (2 Syringe)	$209,350.68	51	$209,350.68	52	0.00%
Alyftrek	$202,823.70	53	$202,823.70	53	0.00%
Lantus SoloStar	$198,476.45	54	$197,649.52	54	-0.42%
Sofosbuvir-Velpatasvir	$197,355.88	55	$197,355.88	55	0.00%
Cosentyx Sensoready (300 MG)	$190,190.06	56	$182,548.20	56	-4.02%
Hizentra	$177,240.47	58	$177,240.47	57	0.00%
Linzess	$177,775.95	57	$177,212.28	58	-0.32%
Qelbree	$176,767.07	59	$175,297.71	59	-0.83%
Advair HFA	$172,746.08	60	$171,362.02	60	-0.80%
Fasenra Pen	$169,566.24	61	$169,566.24	61	0.00%
Emgality	$166,945.28	62	$166,945.28	62	0.00%
Eloctate	$165,902.36	63	$165,902.36	63	0.00%
Epidiolex	$160,422.45	64	$160,422.45	64	0.00%
Bimzelx	$158,542.74	65	$158,542.74	65	0.00%
Spiriva Respimat	$157,790.98	66	$157,790.98	66	0.00%
Opsumit	$155,587.32	67	$155,587.32	67	0.00%
Abilify Asimtufii	$153,368.44	68	$149,217.42	68	-2.71%
Erleada	$142,843.82	70	$147,919.14	69	3.55%
Winrevair	$144,253.15	69	$144,253.15	70	0.00%
Alprolix	$142,218.58	71	$142,218.58	71	0.00%
Qulipta	$138,267.41	73	$138,267.41	72	0.00%
EPINEPHrine	$139,030.83	72	$137,811.62	73	-0.88%
Vijoice	$136,542.51	74	$136,542.51	74	0.00%
Hetlioz LQ	$136,240.48	75	$136,240.48	75	0.00%
Otezla	$135,595.42	76	$135,595.42	76	0.00%

Jakafi	$132,085.04	77	$132,085.04	77	0.00%
Skytrofa	$131,107.21	79	$131,107.21	78	0.00%
Methylphenidate HCl ER (OSM)	$131,466.03	78	$131,071.36	79	-0.30%
Jynarque	$130,489.36	81	$130,769.88	80	0.21%
Verzenio	$130,725.68	80	$130,725.68	81	0.00%
Xolair	$125,294.46	85	$129,211.18	82	3.13%
Ebglyss	$127,904.10	82	$127,904.10	83	0.00%
Insulin Lispro (1 Unit Dial)	$126,816.94	83	$126,582.24	84	-0.19%
QuilliChew ER	$126,469.10	84	$126,098.54	85	-0.29%
Creon	$123,454.51	87	$125,037.87	86	1.28%
Tresiba FlexTouch	$124,199.80	86	$124,098.20	87	-0.08%
Kisqali (400 MG Dose)	$123,257.52	88	$123,257.52	88	0.00%
Amoxicillin	$122,521.01	89	$122,394.16	89	-0.10%
Uzedy	$121,417.64	90	$121,417.64	90	0.00%
Zepbound	$121,280.80	92	$121,280.80	91	0.00%
Januvia	$121,399.77	91	$120,737.91	92	-0.55%
Xtandi	$119,363.12	93	$119,363.12	93	0.00%
buPROPion HCl ER (XL)	$116,062.65	94	$115,848.49	94	-0.18%
Azstarys	$114,395.77	95	$114,395.77	95	0.00%
Austedo XR	$113,720.99	96	$113,720.99	96	0.00%
Sprycel	$113,552.60	97	$113,552.60	97	0.00%
Amphetamine-Dextroamphet ER	$112,624.91	98	$112,482.25	98	-0.13%
Descovy	$111,934.33	99	$111,934.33	99	0.00%
Scemblix	$111,878.70	100	$111,878.70	100	0.00%

Top 100 Drugs by Prescription Count					
Drug Description	March 2025 to May 2025 Total Claims	Previous Rank	June 2025 to August 2025 Total Claims	Current Rank	% Change
Omeprazole	9,814	1	9,788	1	-0.26%
Amoxicillin	9,380	2	9,371	2	-0.10%
Sertraline HCl	9,282	3	9,260	3	-0.24%
Albuterol Sulfate HFA	9,000	4	8,970	4	-0.33%
traZODone HCl	8,646	5	8,641	5	-0.06%
Levothyroxine Sodium	8,326	6	8,315	6	-0.13%
buPROPion HCl ER (XL)	8,293	7	8,277	7	-0.19%
Atorvastatin Calcium	7,673	8	7,662	8	-0.14%
FLUoxetine HCl	7,475	9	7,440	9	-0.47%
Escitalopram Oxalate	7,291	10	7,268	10	-0.32%
Gabapentin	6,787	11	6,768	11	-0.28%
hydrOXYzine HCl	6,481	12	6,449	12	-0.49%
busPIRone HCl	6,010	13	5,998	13	-0.20%
Lisinopril	5,998	14	5,996	14	-0.03%
Pantoprazole Sodium	5,246	15	5,249	15	0.06%
QUEtiapine Fumarate	5,051	16	5,041	16	-0.20%
Montelukast Sodium	4,986	17	4,975	17	-0.22%
predniSONE	4,961	18	4,963	18	0.04%
Amphetamine-Dextroamphet ER	4,737	19	4,731	19	-0.13%
DULoxetine HCl	4,673	20	4,667	20	-0.13%
amLODIPine Besylate	4,638	21	4,639	21	0.02%
cloNIDine HCl	4,580	22	4,563	22	-0.37%
ARIPiprazole	4,544	23	4,543	23	-0.02%

HYDROcodone-Acetaminophen	4,385	24	4,386	24	0.02%
Amoxicillin-Pot Clavulanate	4,378	25	4,374	25	-0.09%
lamoTRIgine	4,160	27	4,153	26	-0.17%
Ondansetron	4,177	26	4,147	27	-0.72%
Cetirizine HCl	4,089	28	4,081	28	-0.20%
Fluticasone Propionate	3,998	29	3,970	29	-0.70%
Venlafaxine HCl ER	3,867	30	3,864	30	-0.08%
Metoprolol Succinate ER	3,812	32	3,810	31	-0.05%
Cyclobenzaprine HCl	3,817	31	3,808	32	-0.24%
Famotidine	3,760	33	3,753	33	-0.19%
Azithromycin	3,713	34	3,712	34	-0.03%
Losartan Potassium	3,614	35	3,609	35	-0.14%
Methylphenidate HCl ER (OSM)	3,529	36	3,515	36	-0.40%
Amphetamine-Dextroamphetamine	3,398	37	3,398	37	0.00%
Ibuprofen	3,323	38	3,310	38	-0.39%
Topiramate	3,286	39	3,279	39	-0.21%
Ozempic	3,272	40	3,270	40	-0.06%
Lisdexamfetamine Dimesylate	3,201	41	3,203	41	0.06%
Cephalexin	3,176	42	3,166	42	-0.31%
clonazePAM	3,131	43	3,127	43	-0.13%
metFORMIN HCl	3,106	44	3,099	44	-0.23%
ALPRAZolam	2,978	45	2,981	45	0.10%
Cefdinir	2,911	46	2,905	46	-0.21%
metFORMIN HCl ER	2,854	47	2,846	47	-0.28%
Meloxicam	2,794	48	2,786	48	-0.29%
Jardiance	2,648	49	2,649	49	0.04%
Lantus SoloStar	2,634	50	2,626	50	-0.30%

Triamcinolone Acetonide	2,627	51	2,613	51	-0.53%
risperiDONE	2,569	52	2,579	52	0.39%
Rosuvastatin Calcium	2,548	53	2,545	53	-0.12%
Aspirin Low Dose	2,361	54	2,366	54	0.21%
Doxycycline Monohydrate	2,334	55	2,331	55	-0.13%
Propranolol HCl	2,320	56	2,315	56	-0.22%
oxyCODONE HCl	2,283	57	2,285	57	0.09%
Spironolactone	2,278	58	2,269	58	-0.40%
hydroCHLOROthiazide	2,239	59	2,233	59	-0.27%
Prazosin HCl	2,232	60	2,221	60	-0.49%
Albuterol Sulfate	2,221	61	2,211	61	-0.45%
Mirtazapine	2,208	62	2,204	62	-0.18%
Furosemide	2,164	64	2,167	63	0.14%
hydrOXYzine Pamoate	2,168	63	2,162	64	-0.28%
Fluconazole	2,155	66	2,155	65	0.00%
metroNIDAZOLE	2,155	65	2,153	66	-0.09%
LORazepam	2,140	67	2,142	67	0.09%
levETIRAcetam	2,132	68	2,131	68	-0.05%
guanFACINE HCl ER	2,115	69	2,118	69	0.14%
Loratadine	2,085	70	2,082	70	-0.14%
traMADol HCl	2,076	71	2,074	71	-0.10%
guanFACINE HCl	1,984	72	1,976	72	-0.40%
Folic Acid	1,970	74	1,972	73	0.10%
Methylphenidate HCl	1,976	73	1,968	74	-0.40%
valACYclovir HCl	1,887	75	1,877	75	-0.53%
Symbicort	1,880	76	1,874	76	-0.32%
Pregabalin	1,775	77	1,776	77	0.06%

Amitriptyline HCl	1,739	78	1,729	78	-0.58%
Allergy Relief Cetirizine	1,634	79	1,631	79	-0.18%
OLANZapine	1,629	80	1,625	80	-0.25%
Eliquis	1,597	81	1,603	81	0.38%
tiZANidine HCl	1,565	82	1,562	82	-0.19%
Atomoxetine HCl	1,561	83	1,560	83	-0.06%
Ondansetron HCl	1,529	84	1,542	84	0.85%
Sulfamethoxazole-Trimethoprim	1,497	85	1,499	85	0.13%
FeroSul	1,463	87	1,461	86	-0.14%
Naproxen	1,464	86	1,457	87	-0.48%
prednisoLONE Sodium Phosphate	1,462	88	1,455	88	-0.48%
Mupirocin	1,447	89	1,434	89	-0.90%
Dexmethylphenidate HCl ER	1,395	90	1,389	90	-0.43%
Citalopram Hydrobromide	1,362	91	1,359	91	-0.22%
Tamsulosin HCl	1,342	92	1,338	92	-0.30%
Baclofen	1,320	93	1,322	93	0.15%
Vraylar	1,308	94	1,307	94	-0.08%
SUMAtriptan Succinate	1,299	95	1,293	95	-0.46%
Desvenlafaxine Succinate ER	1,289	96	1,290	96	0.08%
Nystatin	1,279	97	1,278	97	-0.08%
Naltrexone HCl	1,260	98	1,258	98	-0.16%
Metoprolol Tartrate	1,234	99	1,234	99	0.00%
Vyvanse	1,228	100	1,229	100	0.08%

Iowa Health Link
Iowa HHS

Wellpoint

Quarterly Monthly Statistics

CATEGORY	March 2025 / May 2025	June 2025 / August 2025	% CHANGE
TOTAL PAID AMOUNT	$104,906,784	$107,645,344	2.6%
UNIQUE USERS	101,985	97,193	-4.7%
COST PER USER	$1,028.65	$1,107.54	7.7%
TOTAL PRESCRIPTIONS	808,007	780,225	-3.4%
AVERAGE PRESCRIPTIONS PER USER	7.92	8.03	1.3%
AVERAGE COST PER PRESCRIPTION	$129.83	$137.97	6.3%
# GENERIC PRESCRIPTIONS	722,540	695,155	-3.8%
% GENERIC	89.42%	89.10%	-0.4%
$ GENERIC	$13,831,804	$14,286,205	3.3%
AVERAGE GENERIC PRESCRIPTION COST	$19.14	$20.55	7.4%
AVERAGE GENERIC DAYS SUPPLY	27.66	28.55	3.2%
# BRAND PRESCRIPTIONS	85,467	85,070	-0.5%
% BRAND	10.58%	10.90%	3.1%
$ BRAND	$91,074,980	$93,359,139	2.5%
AVERAGE BRAND PRESCRIPTION COST	$1,065.62	$1,097.44	3.0%
AVERAGE BRAND DAYS SUPPLY	27.77	27.74	-0.1%

UTILIZATION BY AGE		
AGE	March 2025 / May 2025	June 2025 / August 2025
0-6	32,924	26,291
7-12	57,936	52,382
13-18	77,237	71,194
19-64	639,863	630,295
65+	8,380	8,048
TOTAL	816,340	788,210

UTILIZATION BY GENDER AND AGE			
GENDER	AGE	March 2025 / May 2025	June 2025 / August 2025
F			
	0-6	14,254	11,354
	7-12	22,800	20,669
	13-18	39,832	36,810
	19-64	425,358	417,926
	65+	5,331	5,050
	Gender Total	507,575	491,809
M			
	0-6	18,670	14,937
	7-12	35,136	31,713
	13-18	37,405	34,384
	19-64	214,505	212,369
	65+	3,049	2,998
	Gender Total	308,765	296,401
Grand Total		816,340	788,210

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June 2025 / August 2025

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	12,347	$5,680,011.93	$460.03	1
2	RIGHT DOSE PHARMACY	ANKENY	IA	7,610	$316,183.24	$41.55	2
3	WALGREENS #4405	COUNCIL BLUFFS	IA	6,385	$509,276.15	$79.76	3
4	WALGREENS #5042	CEDAR RAPIDS	IA	6,135	$476,545.53	$77.68	4
5	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	5,652	$538,914.04	$95.35	5
6	WALGREENS #5239	DAVENPORT	IA	5,139	$313,654.67	$61.03	6
7	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	4,764	$465,680.69	$97.75	7
8	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,628	$400,776.60	$86.60	9
9	HY-VEE PHARMACY (1075)	CLINTON	IA	4,427	$383,229.22	$86.57	12
10	HARTIG PHARMACY SERVICES	DUBUQUE	IA	4,407	$366,483.62	$83.16	10
11	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	4,355	$331,573.62	$76.14	11
12	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,351	$255,061.70	$58.62	8
13	DRILLING PHARMACY	SIOUX CITY	IA	4,240	$323,201.66	$76.23	17
14	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	3,969	$295,051.90	$74.34	14
15	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	3,941	$304,940.74	$77.38	16
16	WALGREENS #5721	DES MOINES	IA	3,750	$265,836.08	$70.89	13
17	NUCARA LTC PHARMACY #3	IOWA CITY	IA	3,622	$153,630.14	$42.42	15
18	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	3,578	$313,941.01	$87.74	20
19	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	3,533	$242,414.87	$68.61	19
20	WALGREENS #7453	DES MOINES	IA	3,478	$239,514.75	$68.87	18
21	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	3,455	$363,268.26	$105.14	22
22	WAGNER PHARMACY	CLINTON	IA	3,411	$270,478.66	$79.30	31
23	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,395	$254,544.39	$74.98	21
24	WALGREENS #15647	SIOUX CITY	IA	3,391	$265,970.23	$78.43	23
25	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,307	$225,239.70	$68.11	40
26	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	3,301	$230,100.22	$69.71	34

27	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	3,296	$270,595.85	$82.10	32
28	WALGREENS #4041	DAVENPORT	IA	3,283	$211,449.84	$64.41	24
29	WALGREENS #359	DES MOINES	IA	3,276	$233,004.22	$71.12	28
30	CVS PHARMACY #08658	DAVENPORT	IA	3,194	$236,548.41	$74.06	27
31	WALGREENS #3700	COUNCIL BLUFFS	IA	3,162	$224,179.73	$70.90	33
32	WALGREENS #7455	WATERLOO	IA	3,156	$206,344.18	$65.38	25
33	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,115	$265,037.90	$85.08	30
34	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,109	$285,025.11	$91.68	35
35	HY-VEE PHARMACY (1449)	NEWTON	IA	3,078	$236,632.19	$76.88	37
36	WALMART PHARMACY 10-5115	DAVENPORT	IA	3,071	$282,370.11	$91.95	44
37	SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	3,053	$147,369.65	$48.27	36
38	WALMART PHARMACY 10-1509	MAQUOKETA	IA	3,037	$253,170.35	$83.36	29
39	UI HEALTHCARE - IOWA RIVER LANDING PHARMACY	CORALVILLE	IA	2,944	$127,663.85	$43.36	26
40	HY-VEE PHARMACY (1396)	MARION	IA	2,862	$241,511.14	$84.39	47
41	NELSON FAMILY PHARMACY	FORT MADISON	IA	2,853	$178,222.18	$62.47	39
42	WALGREENS #11942	DUBUQUE	IA	2,830	$191,650.50	$67.72	38
43	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	2,776	$224,487.07	$80.87	43
44	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,773	$219,333.92	$79.10	42
45	MAHASKA DRUGS INC	OSKALOOSA	IA	2,745	$253,769.73	$92.45	45
46	WALMART PHARMACY 10-2889	CLINTON	IA	2,705	$195,190.85	$72.16	49
47	COMMUNITY HEALTH CARE PHARMACY	DAVENPORT	IA	2,705	$158,379.97	$58.55	50
48	WALMART PHARMACY 10-0985	FAIRFIELD	IA	2,668	$202,879.83	$76.04	58
49	MEDICAP PHARMACY	KNOXVILLE	IA	2,604	$299,569.10	$115.04	53
50	HY-VEE PHARMACY (1065)	CHARITON	IA	2,602	$198,849.08	$76.42	52
51	CVS PHARMACY #10282	FORT DODGE	IA	2,573	$171,519.14	$66.66	48
52	SCOTT PHARMACY	FAYETTE	IA	2,545	$163,817.24	$64.37	51
53	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,543	$235,656.77	$92.67	55
54	WALGREENS #9708	DUBUQUE	IA	2,522	$176,367.23	$69.93	46
55	PREFERRED CARE PHARMACY	CEDAR RAPIDS	IA	2,497	$159,557.37	$63.90	54
56	CVS PHARMACY #08544	WATERLOO	IA	2,436	$152,107.46	$62.44	65
57	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	2,431	$141,447.74	$58.19	60

58	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	2,430	$198,283.10	$81.60	99
59	UNION PHARMACY	COUNCIL BLUFFS	IA	2,416	$200,865.53	$83.14	64
60	HY-VEE PHARMACY (1522)	PERRY	IA	2,407	$251,280.50	$104.40	76
61	LEWIS FAMILY DRUG #28	ONAWA	IA	2,400	$213,308.25	$88.88	70
62	LAGRANGE PHARMACY	VINTON	IA	2,399	$212,613.12	$88.63	56
63	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,387	$219,448.25	$91.93	57
64	SOUTH SIDE DRUG	OTTUMWA	IA	2,344	$206,871.68	$88.26	68
65	HY-VEE PHARMACY (1433)	MT PLEASANT	IA	2,330	$186,798.38	$80.17	67
66	MERCYONE FOREST PARK PHARMACY	MASON CITY	IA	2,320	$189,509.93	$81.69	80
67	CVS PHARMACY #10032	MARION	IA	2,295	$191,146.71	$83.29	69
68	WALMART PHARMACY 10-0559	MUSCATINE	IA	2,294	$169,751.68	$74.00	66
69	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,290	$278,411.42	$121.58	101
70	OSTERHAUS PHARMACY	MAQUOKETA	IA	2,280	$125,550.38	$55.07	61
71	HY-VEE PHARMACY (1180)	FAIRFIELD	IA	2,266	$176,722.33	$77.99	78
72	WALGREENS #7454	ANKENY	IA	2,253	$179,803.20	$79.81	93
73	HY-VEE PHARMACY (1459)	OELWEIN	IA	2,251	$189,614.59	$84.24	62
74	HERITAGE PARTNERS PHARMACY	WEST BURLINGTON	IA	2,233	$181,455.26	$81.26	81
75	EXACTCARE	VALLEY VIEW	OH	2,216	$223,340.15	$100.79	104
76	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,216	$205,801.25	$92.87	63
77	HARTIG DRUG CO	DUBUQUE	IA	2,196	$186,320.01	$84.85	83
78	HY-VEE PHARMACY #6 (1155)	DES MOINES	IA	2,188	$194,777.82	$89.02	85
79	HY-VEE PHARMACY (1530)	PLEASANT HILL	IA	2,188	$181,818.24	$83.10	77
80	INFOCUS PHARMACY SERVICES LLC	DUBUQUE	IA	2,187	$132,884.33	$60.76	73
81	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	2,177	$217,750.90	$100.02	84
82	MEDICAP PHARMACY	NEWTON	IA	2,176	$171,289.28	$78.72	90
83	WALGREENS #4714	DES MOINES	IA	2,169	$165,357.10	$76.24	74
84	WALMART PHARMACY 10-3394	ATLANTIC	IA	2,141	$201,505.77	$94.12	87
85	MCMH PHARMACY	RED OAK	IA	2,131	$208,167.64	$97.69	97
86	HY-VEE PHARMACY (1895)	WINDSOR HEIGHTS	IA	2,111	$147,885.27	$70.05	79
87	WALGREENS #3875	CEDAR RAPIDS	IA	2,101	$154,082.42	$73.34	59
88	MEDICAP PHARMACY LTC	INDIANOLA	IA	2,090	$69,271.90	$33.14	41

89	DANIEL PHARMACY	FT DODGE	IA	2,085	$212,453.00	$101.90	107
90	HY-VEE PHARMACY #1 (1504)	OTTUMWA	IA	2,084	$147,096.59	$70.58	72
91	HY-VEE PHARMACY (1241)	HARLAN	IA	2,076	$205,997.54	$99.23	75
92	WALGREENS #7452	DES MOINES	IA	2,074	$147,028.38	$70.89	88
93	HY-VEE PHARMACY #2 (1018)	AMES	IA	2,060	$237,767.18	$115.42	108
94	CR CARE PHARMACY	CEDAR RAPIDS	IA	2,042	$589,208.33	$288.54	103
95	WALMART PHARMACY 10-0784	MT PLEASANT	IA	2,039	$147,062.60	$72.12	96
96	GENOA HEALTHCARE, LLC	DAVENPORT	IA	2,034	$300,161.40	$147.57	119
97	HY-VEE PHARMACY (1850)	WASHINGTON	IA	2,019	$161,298.49	$79.89	82
98	WALGREENS #10855	WATERLOO	IA	2,017	$150,177.31	$74.46	89
99	THOMPSON DEAN DRUG	SIOUX CITY	IA	2,001	$191,946.10	$95.93	126
100	PREFERRED CARE PHARMACY	BETTENDORF	IA	1,993	$148,730.58	$74.63	111

TOP 100 PHARMACIES BY PAID AMOUNT
June 2025 / August 2025

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	12,347	$5,680,011.93	$2,506.62	1
2	CVS/SPECIALTY	MONROEVILLE	PA	571	$4,989,248.21	$19,720.35	2
3	WALGREENS SPECIALTY PHARMACY #16528	DES MOINES	IA	918	$4,030,902.40	$13,664.08	3
4	UNITYPOINT AT HOME	URBANDALE	IA	877	$3,364,643.69	$11,931.36	6
5	CAREMARK ILLINOIS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	MT PROSPECT	IL	275	$3,187,616.18	$31,251.14	5
6	PANTHERX SPECIALTY PHARMACY	CORAOPOLIS	PA	100	$2,441,723.14	$69,763.52	7
7	CAREMARK KANSAS SPECIALTY PHARMACY, LLC DBA CVS/SPECIALTY	LENEXA	KS	293	$2,423,609.71	$13,770.51	4
8	BIOPLUS SPECIALTY PHARMACY SERVICES, LLC	ALTAMONTE SPRINGS	FL	262	$2,285,038.81	$19,202.01	10
9	WALGREENS SPECIALTY PHARMACY #21250	IOWA CITY	IA	452	$1,981,380.32	$10,652.58	8
10	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	1,220	$1,271,697.68	$9,282.46	11
11	CAREMARK LLC, DBA CVS/SPECIALTY	REDLANDS	CA	76	$1,125,285.74	$29,612.78	14
12	AMBER SPECIALTY PHARMACY	OMAHA	NE	176	$1,065,933.77	$17,765.56	13
13	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	43	$847,717.96	$42,385.90	12
14	WALGREENS SPECIALTY PHARMACY #16280	FRISCO	TX	47	$832,453.29	$69,371.11	15
15	SOLEO HEALTH INC.	WOODRIDGE	IL	3	$769,332.69	$769,332.69	9
16	CVS PHARMACY #00102	AURORA	CO	86	$767,839.54	$21,328.88	19
17	ANOVORX GROUP, LLC	MEMPHIS	TN	66	$698,448.36	$30,367.32	18
18	BIOLOGICS BY MCKESSON	CARY	NC	36	$697,680.52	$53,667.73	17
19	ORSINI PHARMACEUTICAL SERVICES LLC	ELK GROVE VILLAGE	IL	36	$694,462.01	$57,871.83	16
20	OPTUM PHARMACY 702, LLC	JEFFERSONVILLE	IN	76	$603,770.28	$15,888.69	20
21	CR CARE PHARMACY	CEDAR RAPIDS	IA	2,042	$589,208.33	$3,006.16	25
22	WALGREENS SPECIALTY PHARMACY #16270	OMAHA	NE	107	$575,951.75	$26,179.63	21
23	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	5,652	$538,914.04	$886.37	26
24	WALGREENS #4405	COUNCIL BLUFFS	IA	6,385	$509,276.15	$435.65	23
25	MERCYONE GENESIS FIRSTMED SPECIALTY PHARMACY	DAVENPORT	IA	755	$501,984.01	$3,324.40	30
26	EXPRESS SCRIPTS SPECIALTY DIST SVCS	SAINT LOUIS	MO	32	$483,136.65	$37,164.36	24

27	WALGREENS #5042	CEDAR RAPIDS	IA	6,135	$476,545.53	$394.82	29
28	HY-VEE PHARMACY #1 (1092)	COUNCIL BLUFFS	IA	4,764	$465,680.69	$1,012.35	31
29	EVERSANA LIFE SCIENCE SERVICES, LLC	CHESTERFIELD	MO	11	$445,607.24	$111,401.81	28
30	AVERA SPECIALTY PHARMACY	SIOUX FALLS	SD	93	$418,277.24	$12,675.07	27
31	THE NEBRASKA MEDICAL CENTER CLINIC PHARMACY	OMAHA	NE	609	$406,955.79	$3,130.43	22
32	UI HEALTH CARE DES MOINES PHARMACY	DES MOINES	IA	44	$402,809.93	$21,200.52	650
33	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	4,628	$400,776.60	$682.75	33
34	HY-VEE PHARMACY (1075)	CLINTON	IA	4,427	$383,229.22	$646.26	39
35	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	17	$376,039.87	$53,719.98	0
36	HARTIG PHARMACY SERVICES	DUBUQUE	IA	4,407	$366,483.62	$1,156.10	36
37	HY-VEE PHARMACY #5 (1061)	CEDAR RAPIDS	IA	3,455	$363,268.26	$873.24	35
38	ONCO360	LOUISVILLE	KY	33	$362,652.46	$36,265.25	38
39	MAYO CLINIC PHARMACY	ROCHESTER	MN	93	$350,215.27	$16,676.92	43
40	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	4,355	$331,573.62	$479.15	42
41	HY-VEE PHARMACY SOLUTIONS	OMAHA	NE	57	$329,744.57	$13,739.36	100
42	DRILLING PHARMACY	SIOUX CITY	IA	4,240	$323,201.66	$947.81	53
43	RIGHT DOSE PHARMACY	ANKENY	IA	7,610	$316,183.24	$788.49	44
44	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	3,578	$313,941.01	$627.88	34
45	WALGREENS #5239	DAVENPORT	IA	5,139	$313,654.67	$296.18	48
46	ALLEN CLINIC PHARMACY	WATERLOO	IA	990	$306,154.70	$1,020.52	47
47	HY-VEE DRUGSTORE (7060)	MUSCATINE	IA	3,941	$304,940.74	$565.75	51
48	GENOA HEALTHCARE, LLC	DAVENPORT	IA	2,034	$300,161.40	$1,515.97	37
49	MEDICAP PHARMACY	KNOXVILLE	IA	2,604	$299,569.10	$1,426.52	46
50	HY-VEE PHARMACY #5 (1151)	DES MOINES	IA	3,969	$295,051.90	$562.00	49
51	HY-VEE DRUGSTORE #1 (7020)	CEDAR RAPIDS	IA	3,109	$285,025.11	$695.18	58
52	WALMART PHARMACY 10-5115	DAVENPORT	IA	3,071	$282,370.11	$631.70	64
53	GENOA HEALTHCARE, LLC	SIOUX CITY	IA	1,821	$279,890.78	$1,496.74	41
54	WALGREENS SPECIALTY PHARMACY #15443	FRISCO	TX	38	$278,477.57	$25,316.14	61
55	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	2,290	$278,411.42	$1,046.66	67
56	MAIN AT LOCUST PHARMACY AND MEDICAL SUPPLY	DAVENPORT	IA	3,296	$270,595.85	$1,109.00	68

57	WAGNER PHARMACY	CLINTON	IA	3,411	$270,478.66	$764.06	62
58	WALGREENS #15647	SIOUX CITY	IA	3,391	$265,970.23	$359.91	52
59	WALGREENS #5721	DES MOINES	IA	3,750	$265,836.08	$312.75	50
60	HY-VEE DRUGSTORE (7065)	OTTUMWA	IA	3,115	$265,037.90	$587.67	40
61	PARAGON PARTNERS	OMAHA	NE	896	$262,375.84	$3,123.52	63
62	BROADLAWNS MEDICAL CENTER OUTPATIENT PHARMACY	DES MOINES	IA	4,351	$255,061.70	$375.64	56
63	HY-VEE PHARMACY (1192)	FT DODGE	IA	3,395	$254,544.39	$585.16	55
64	MAHASKA DRUGS INC	OSKALOOSA	IA	2,745	$253,769.73	$699.09	71
65	WALMART PHARMACY 10-1509	MAQUOKETA	IA	3,037	$253,170.35	$582.00	60
66	FIFIELD PHARMACY	DES MOINES	IA	1,653	$252,086.55	$1,636.93	92
67	HY-VEE PHARMACY (1522)	PERRY	IA	2,407	$251,280.50	$766.10	69
68	MERCYONE WATERLOO PHARMACY	WATERLOO	IA	1,656	$246,842.75	$754.87	105
69	SANFORD CANCER CENTER ONCOLOGY CLINIC PHARMACY	SIOUX FALLS	SD	76	$244,650.82	$9,786.03	89
70	HARTIG DRUG CO	DUBUQUE	IA	1,755	$244,394.55	$1,057.99	54
71	HY-VEE PHARMACY (1074)	CHARLES CITY	IA	3,533	$242,414.87	$520.20	59
72	HY-VEE PHARMACY (1396)	MARION	IA	2,862	$241,511.14	$635.56	86
73	WALGREENS #7453	DES MOINES	IA	3,478	$239,514.75	$341.19	77
74	GREENWOOD COMPLIANCE PHARMACY	WATERLOO	IA	1,504	$238,902.16	$2,319.44	57
75	HY-VEE PHARMACY #2 (1018)	AMES	IA	2,060	$237,767.18	$822.72	79
76	HY-VEE PHARMACY (1449)	NEWTON	IA	3,078	$236,632.19	$587.18	70
77	CVS PHARMACY #08658	DAVENPORT	IA	3,194	$236,548.41	$532.77	74
78	HY-VEE DRUGSTORE (7056)	MASON CITY	IA	2,543	$235,656.77	$559.75	72
79	WALGREENS #359	DES MOINES	IA	3,276	$233,004.22	$314.45	78
80	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	3,301	$230,100.22	$511.33	93
81	HERITAGE SPECIALTY PHARMACY	LEES SUMMIT	MO	11	$226,788.51	$113,394.26	213
82	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	1,980	$226,448.92	$820.47	84
83	GREENWOOD DRUG ON KIMBALL AVE.	WATERLOO	IA	3,307	$225,239.70	$726.58	80
84	PRIMARY HEALTHCARE PHARMACY	DES MOINES	IA	956	$224,812.11	$1,362.50	81
85	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	2,776	$224,487.07	$554.29	106
86	WALGREENS #3700	COUNCIL BLUFFS	IA	3,162	$224,179.73	$376.77	76

87	EXACTCARE	VALLEY VIEW	OH	2,216	$223,340.15	$2,567.13	97
88	HY-VEE PHARMACY (1058)	CENTERVILLE	IA	2,387	$219,448.25	$778.19	66
89	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	2,773	$219,333.92	$584.89	65
90	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	2,177	$217,750.90	$837.50	112
91	LEWIS FAMILY DRUG #28	ONAWA	IA	2,400	$213,308.25	$956.54	98
92	LAGRANGE PHARMACY	VINTON	IA	2,399	$212,613.12	$793.33	95
93	DANIEL PHARMACY	FT DODGE	IA	2,085	$212,453.00	$900.22	139
94	WALGREENS #4041	DAVENPORT	IA	3,283	$211,449.84	$309.14	94
95	MCMH PHARMACY	RED OAK	IA	2,131	$208,167.64	$937.69	107
96	SOUTH SIDE DRUG	OTTUMWA	IA	2,344	$206,871.68	$718.30	108
97	WALGREENS #7455	WATERLOO	IA	3,156	$206,344.18	$275.49	75
98	HY-VEE PHARMACY (1241)	HARLAN	IA	2,076	$205,997.54	$662.37	87
99	HY-VEE PHARMACY (1071)	CLARINDA	IA	2,216	$205,801.25	$668.19	118
100	WALMART PHARMACY 10-0985	FAIRFIELD	IA	2,668	$202,879.83	$576.36	109

TOP 100 PRESCRIBING PROVIDERS BY PRESCRIPTION COUNT
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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1982605762	Jeffrey Wilharm	$103,927.10	2,121	6.95	1
2	1356359871	Rhea Hartley	$119,325.13	1,496	2.55	2
3	1063491645	Allyson Wheaton	$126,465.09	1,345	2.63	3
4	1902850845	Deborah Bahe	$97,240.52	1,315	4.96	4
5	1467502286	Charles Tilley	$157,625.36	1,281	3.54	5
6	1215146055	Rebecca Wolfe	$64,945.81	1,174	2.72	6
7	1467907394	Cynthia Coenen	$149,742.60	1,171	4.15	9
8	1922455096	Dean Guerdet	$103,855.82	1,103	3.79	11
9	1043434525	Robert Kent	$61,274.28	1,073	3.98	12
10	1790163848	Hesper Nowatzki	$112,777.60	1,053	3.36	14
11	1730849647	Melanie Rock	$30,625.73	1,037	2.96	15
12	1457584740	Eric Meyer	$72,075.26	1,035	2.62	13
13	1043418809	Michael Ciliberto	$525,330.29	1,034	2.83	20
14	1437238110	Genevieve Nelson	$229,849.89	1,020	3.27	10
15	1902912538	Christian Jones	$94,370.28	1,013	3.15	17
16	1013115369	Bobbita Nag	$61,728.59	1,001	2.45	16
17	1730434069	Larissa Biscoe	$72,952.31	996	2.61	8
18	1528365277	Mina Salib	$476,368.95	993	2.31	28
19	1770933046	Shelby Biller	$183,807.44	983	2.87	19
20	1477199198	Sajo Thomas	$160,201.07	981	3.59	18
21	1902478811	Joan Anderson	$232,549.85	971	3.37	21
22	1902574361	Laura Owens	$95,348.36	965	3.43	36
23	1164538674	Joseph Wanzek	$76,533.69	931	4.63	21
24	1306559786	Roy Henry	$52,480.76	888	3.54	42
25	1003470923	Earlene Angell	$99,000.23	884	3.68	26

26	1609532373	Erin Fox-Hammel	$76,183.45	877	4.05	39
27	1154815330	Bruce Pehl	$66,653.95	876	3.49	32
28	1659358620	Carlos Castillo	$25,248.00	876	3.01	23
29	1184657603	Sara Rygol	$115,931.33	848	3.09	39
30	1013639749	Robert Husemann	$68,921.84	839	3.28	45
31	1902358443	Melissa Konken	$128,271.87	829	3.61	31
32	1134854128	Dzevida Pandzic	$76,922.90	826	2.64	72
33	1205393386	Jessica Hudspeth	$111,167.25	814	4.47	44
34	1457914657	Seema Antony	$123,226.35	808	2.80	25
35	1679573893	Patty Hildreth	$207,916.55	799	3.43	38
36	1871105916	Lacie Theis	$39,006.50	799	2.64	54
37	1992103386	Melissa Larsen	$85,753.19	789	2.97	26
38	1649248378	Kathleen Wild	$30,384.33	786	3.17	35
39	1417214321	Leah Brandon	$27,758.59	783	4.78	67
40	1275763047	Rebecca Bowman	$131,625.61	777	3.48	41
41	1982030946	Jacklyn Besch	$49,709.51	772	2.95	24
42	1801998372	Wendy Hansen-Penman	$34,033.45	768	3.62	46
43	1144214248	Kristi Walz	$85,421.70	765	3.95	52
44	1215184726	Babuji Gandra	$25,314.89	765	2.52	33
45	1316356496	Kimberly Roberts	$34,770.84	762	3.43	7
46	1053963900	Nicole Mcclavy	$150,292.85	759	3.42	37
47	1215981758	Lisa Pisney	$114,497.87	758	3.17	74
48	1215125216	Rebecca Walding	$52,856.45	757	3.76	29
49	1043703887	Tenaea Jeppeson	$102,727.44	756	3.63	65
50	1538368170	Christopher Matson	$23,845.06	756	3.14	34
51	1417941188	Debra Neuharth	$32,995.52	740	3.13	61
52	1992402655	Shane Eberhardt	$134,231.31	733	2.72	78
53	1528329398	Erin Rowan	$52,265.79	732	3.06	53
54	1144588476	Rachel Filzer	$77,327.51	731	2.74	62
55	1689077018	Stacy Roth	$86,022.45	728	2.75	56

56	1013978089	Jennifer Bradley	$176,596.84	727	5.38	47
57	1134191018	Dustin Smith	$51,261.83	723	3.32	50
58	1598183493	Jena Ellerhoff	$24,913.57	721	4.10	51
59	1811419815	Gretchen Wenger	$67,119.14	720	2.34	116
60	1649763079	Kate Jarvis	$104,952.25	717	3.14	86
61	1639780414	Nicolette Lovitt	$25,410.16	702	6.95	221
62	1053630640	Jennifer Donovan	$105,039.82	695	2.97	80
63	1245960350	Mary Welborn	$56,075.55	692	2.82	119
64	1619153137	Joada Best	$39,241.99	688	3.32	60
65	1295967255	Mary Robinson	$49,939.85	686	4.01	66
66	1407585623	Colette Demoss	$122,959.73	679	3.69	134
67	1255405338	Bryan Netolicky	$84,839.69	678	2.81	55
68	1922144088	Thomas Hopkins	$20,107.76	675	2.46	57
69	1609946243	Sina Linman	$34,956.94	673	2.54	64
70	1023469798	Shipeng Wei	$46,853.31	672	7.47	100
71	1043211303	Ali Safdar	$119,565.68	671	2.70	30
72	1588746515	Amy Badberg	$33,114.09	671	2.77	49
73	1639607757	Michael Gerber	$80,173.74	659	3.26	73
74	1023542271	Flynn McCullough	$70,859.55	656	3.58	109
75	1073156295	Kasie Christensen	$79,096.91	656	2.85	75
76	1790754695	Joel Vander Meide	$29,730.10	646	4.69	63
77	1649209933	Richard Blunk	$39,129.30	636	2.18	57
78	1437209434	Jon Thomas	$40,826.15	634	2.95	79
79	1265841845	Mary Schwering	$53,425.23	632	3.02	81
80	1124006770	Wook Kim	$33,263.74	631	3.02	48
81	1255058640	Shelli Brown	$119,168.47	629	3.33	77
82	1891707832	Lisa Klock	$42,030.25	627	2.61	84
83	1154790517	Jamie Schumacher	$20,979.64	623	3.30	101
84	1215581251	Anna Throckmorton	$29,515.10	623	4.97	96
85	1568431880	Pomilla Kumar	$46,540.93	623	3.54	107

86	1477926434	Jackie Shipley	$36,625.24	618	2.74	70
87	1558770974	Marc Baumert	$49,681.06	615	2.61	88
88	1255823506	Nicole Delagardelle	$102,663.95	613	2.94	133
89	1750867248	Mikhail Shkiryak	$108,112.63	611	2.51	109
90	1649438383	Qadnana Anwar	$28,705.92	607	2.98	115
91	1457667610	Leah Schupp	$39,172.82	599	3.10	68
92	1164823092	Jamey Gregersen	$50,405.23	598	3.23	112
93	1447680848	Mindy Roberts	$55,170.39	598	2.62	102
94	1588662050	Jason Davis	$34,116.76	597	2.74	92
95	1811960768	Angela Veenstra	$33,888.64	597	3.33	145
96	1114521721	Tarrah Holliday	$131,160.47	596	2.96	127
97	1396181012	Heather Kruse	$44,417.53	596	4.48	99
98	1356724405	Beth Colon	$76,902.76	595	2.31	82
99	1346621059	Mark Zacharjasz	$62,936.80	593	3.73	102
100	1932582988	Dianne Humphrey	$43,257.95	593	3.23	118

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
1	1326034984	Katherine Mathews	$1,039,346.70	$13,675.61	76	2
2	1841632965	Ahmad Al-Huniti	$936,712.33	$49,300.65	19	1
3	1437121407	Linda Cadaret	$823,908.33	$6,487.47	127	7
4	1326211889	James Friedlander	$769,329.29	$10,538.76	73	4
5	1023108701	Ronald Zolty	$699,946.53	$11,474.53	61	5
6	1477761328	Amy Calhoun	$689,302.08	$9,314.89	74	3
7	1942937388	Carly Trausch	$630,548.74	$1,429.82	441	13
8	1285626390	Kathleen Gradoville	$611,879.21	$2,437.77	251	6
9	1700417169	Courtney Reints	$552,270.15	$1,683.75	328	8
10	1043418809	Michael Ciliberto	$525,330.29	$508.06	1034	11
11	1952420705	Eric Rush	$521,791.56	$43,482.63	12	10
12	1528365277	Mina Salib	$476,368.95	$479.73	993	9
13	1891146999	Becky Johnson	$476,178.73	$1,107.39	430	12
14	1316934318	Steven Lentz	$474,604.46	$18,984.18	25	46
15	1376525196	Randolph Rough	$466,475.42	$3,380.26	138	24
16	1861277980	Kathryn Ewoldt	$437,282.12	$1,002.94	436	33
17	1750470118	Laura Graeff-Armas	$411,883.89	$82,376.78	5	95
18	1932153830	Michael Stephens	$380,791.86	$27,199.42	14	17
19	1649943689	Jessica Coffey	$377,242.13	$2,314.37	163	20
20	1043565328	Sara Moeller	$371,339.19	$3,094.49	120	21
21	1295091510	Rebecca Weiner	$344,355.74	$1,187.43	290	15
22	1417443953	Rodney Clark	$342,633.83	$1,297.86	264	14
23	1285620583	Michael Tansey	$303,445.36	$2,809.68	108	34
24	1326410499	Tara Eastvold	$294,997.74	$842.85	350	27
25	1356753859	Katie Lutz	$292,658.00	$2,398.84	122	41
26	1629415922	Alyssa Lakin	$279,147.72	$1,508.91	185	35
27	1609820240	James Harper	$276,243.64	$11,049.75	25	16

28	1730318205	Diana Bayer-Bowstead	$274,164.49	$2,265.82	121	40
29	1508091109	Melissa Muff-Luett	$259,338.84	$5,894.06	44	2133
30	1669184511	Chandra Miller	$252,527.13	$10,979.44	23	53
31	1295054542	Angela Delecaris	$247,421.78	$4,056.09	61	22
32	1285748004	Bruce Hughes	$245,488.63	$3,317.41	74	78
33	1386084747	Jennifer Condon	$243,896.64	$1,263.71	193	19
34	1174970453	Daniel Hinds	$241,692.00	$774.65	312	30
35	1902191059	Amber Tierney	$241,055.48	$5,128.84	47	58
36	1447373832	Joshua Wilson	$240,703.52	$4,628.91	52	65
37	1902478811	Joan Anderson	$232,549.85	$239.50	971	31
38	1821046087	Archana Verma	$230,384.87	$3,113.31	74	26
39	1437238110	Genevieve Nelson	$229,849.89	$225.34	1020	56
40	1578132940	Alec Steils	$229,152.04	$782.09	293	77
41	1437533130	Katie Broshuis	$228,564.36	$1,970.38	116	101
42	1871868984	Hana Niebur	$226,093.18	$3,588.78	63	32
43	1700561826	Pedro Hsieh	$215,935.70	$12,702.10	17	116
44	1730293705	Robert Jackson	$214,355.67	$3,349.31	64	48
45	1679573893	Patty Hildreth	$207,916.55	$260.22	799	37
46	1184056822	Abby Kolthoff	$207,575.53	$443.54	468	25
47	1285331058	Natalie Reitz	$204,051.89	$3,091.70	66	45
48	1134249832	Steven Craig	$200,206.19	$2,063.98	97	42
49	1932464971	Kari Ernst	$193,757.88	$1,761.44	110	118
50	1134981038	Cassidy Chalupa	$187,196.65	$2,636.57	71	107
51	1447519038	Erin Richardson	$185,749.94	$740.04	251	112
52	1891955423	Leah Siegfried	$185,294.71	$645.63	287	59
53	1770933046	Shelby Biller	$183,807.44	$186.99	983	63
54	1003315201	Abigail Behrens	$181,743.14	$2,455.99	74	110
55	1194176586	Paul Fenton	$180,936.62	$2,513.01	72	74
56	1649826140	Taylor Myers	$180,659.46	$1,422.52	127	44
57	1558543595	Gordon Buchanan	$180,247.78	$858.32	210	55
58	1811666118	Jessiann Dryden-Parish	$177,657.42	$1,184.38	150	93

59	1013978089	Jennifer Bradley	$176,596.84	$242.91	727	51
60	1245737097	Ashley Patrick	$173,674.67	$2,346.96	74	165
61	1245468768	Thomas Schmidt	$171,640.80	$2,067.96	83	38
62	1174748180	Mohammad Alsharabati	$169,986.26	$1,222.92	139	134
63	1558808501	Jessica Braksiek	$169,865.62	$3,088.47	55	66
64	1407065469	Christoph Randak	$168,451.16	$1,203.22	140	47
65	1225332463	Molly Schooley	$167,587.40	$1,047.42	160	370
66	1588616171	Heather Thomas	$164,763.79	$2,890.59	57	85
67	1104804053	Winthrop Risk	$164,100.23	$340.46	482	82
68	1609003011	John Bernat	$161,318.34	$11,522.74	14	75
69	1477199198	Sajo Thomas	$160,201.07	$163.30	981	69
70	1649419219	Heather Hunemuller	$160,076.71	$1,053.14	152	43
71	1841607900	Shayla Sanders	$158,392.48	$1,703.14	93	64
72	1467502286	Charles Tilley	$157,625.36	$123.05	1281	62
73	1285710764	Jitendrakumar Gupta	$157,106.07	$689.06	228	70
74	1467449579	Brian Wayson	$157,076.67	$2,039.96	77	109
75	1639226731	Meriner Pereira	$154,178.60	$1,195.18	129	94
76	1306823281	Molly Franke	$153,233.88	$2,512.03	61	111
77	1134402373	Julie Schuck	$152,734.26	$4,242.62	36	179
78	1699018721	Shilpi Relan	$152,618.82	$1,038.22	147	131
79	1053963900	Nicole Mcclavy	$150,292.85	$198.01	759	96
80	1306071915	Thomas Pietras	$150,002.00	$1,530.63	98	29
81	1467907394	Cynthia Coenen	$149,742.60	$127.88	1171	80
82	1265420095	Elizabeth Cooper	$149,360.09	$1,157.83	129	149
83	1093162075	Meghan Ryan	$149,260.90	$1,286.73	116	120
84	1851161228	Kala Clark	$149,043.96	$261.48	570	115
85	1508967837	Laura Amidon	$148,488.83	$8,249.38	18	117
86	1073722112	Riad Rahhal	$148,122.21	$644.01	230	49
87	1053372029	Stefanie Yearian	$147,612.45	$318.13	464	126
88	1992314108	Lynzee Makowski	$147,365.21	$390.89	377	508
89	1174584072	Bradley Lair	$147,163.31	$3,422.40	43	28

90	1609131770	Sreenath Thati Ganganna	$145,742.78	$303.00	481	113
91	1851568703	Mathew Davey	$145,179.76	$1,613.11	90	137
92	1477142289	Andrea Johnson	$144,835.27	$267.72	541	145
93	1629537576	Jordan Evans	$143,835.27	$1,141.55	126	68
94	1023539848	Jeffrey Zavala	$141,933.56	$1,448.30	98	320
95	1063792026	Jill Miller	$141,689.50	$256.68	552	83
96	1104933878	David Mercer	$141,390.02	$4,875.52	29	187
97	1598782518	Michell Pascarella	$140,285.40	$2,299.76	61	249
98	1124216676	Wendy Sanders	$136,793.66	$449.98	304	98
99	1134440886	Melissa Wells	$136,452.47	$1,406.73	97	209
100	1225263833	Lindsay Orris	$136,139.22	$1,237.63	110	73

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TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March 2025 / May 2025	PREVIOUS RANK	% BUDGET	June 2025 / August 2025	CURRENT RANK	% BUDGET	% CHANGE
ANTIDIABETICS	$13,800,912	1	13.2%	$14,489,029	1	13.5%	5.0%
DERMATOLOGICALS	$11,223,328	2	10.7%	$12,890,518	2	12.0%	14.9%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$10,781,970	3	10.3%	$10,815,062	3	10.0%	0.3%
ANALGESICS - ANTI-INFLAMMATORY	$7,682,196	4	7.3%	$7,454,765	4	6.9%	-3.0%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$5,688,983	6	5.4%	$5,700,023	5	5.3%	0.2%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$5,712,471	5	5.4%	$5,644,166	6	5.2%	-1.2%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$4,149,381	7	4.0%	$4,175,801	7	3.9%	0.6%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$3,850,172	8	3.7%	$4,120,718	8	3.8%	7.0%
ANTICONVULSANTS	$3,767,122	9	3.6%	$3,924,076	9	3.6%	4.2%
MIGRAINE PRODUCTS	$3,338,958	13	3.2%	$3,673,558	10	3.4%	10.0%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,743,354	10	3.6%	$3,372,640	11	3.1%	-9.9%
CARDIOVASCULAR AGENTS - MISC.	$2,990,778	14	2.9%	$3,333,574	12	3.1%	11.5%
ANTIVIRALS	$3,439,717	12	3.3%	$3,226,459	13	3.0%	-6.2%
HEMATOLOGICAL AGENTS - MISC.	$3,640,059	11	3.5%	$3,083,878	14	2.9%	-15.3%
RESPIRATORY AGENTS - MISC.	$2,766,679	15	2.6%	$2,691,756	15	2.5%	-2.7%
GASTROINTESTINAL AGENTS - MISC.	$2,019,067	17	1.9%	$2,414,422	16	2.2%	19.6%
ANTIDEPRESSANTS	$2,216,135	16	2.1%	$2,294,584	17	2.1%	3.5%
ANTICOAGULANTS	$1,759,187	18	1.7%	$1,762,184	18	1.6%	0.2%
NEUROMUSCULAR AGENTS	$1,509,273	19	1.4%	$1,587,703	19	1.5%	5.2%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$831,131	20	0.8%	$823,085	20	0.8%	-1.0%

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March 2025 / May 2025	PREVIOUS RANK	June 2025 / August 2025	CURRENT RANK	% CHANGE
ANTIDEPRESSANTS	101,555	1	98,730	1	-2.8%
ANTICONVULSANTS	49,664	2	49,477	2	-0.4%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	48,238	3	45,515	3	-5.6%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	44,154	4	41,858	4	-5.2%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	40,115	5	39,187	5	-2.3%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	38,806	6	38,250	6	-1.4%
ANTIDIABETICS	38,415	7	38,081	7	-0.9%
ANTIHYPERTENSIVES	37,058	8	34,792	8	-6.1%
ANTIANXIETY AGENTS	34,863	9	34,592	9	-0.8%
ANTIHISTAMINES	24,893	10	24,716	10	-0.7%
DERMATOLOGICALS	21,697	12	23,141	11	6.7%
ANTIHYPERLIPIDEMICS	23,198	11	21,700	12	-6.5%
ANALGESICS - ANTI-INFLAMMATORY	18,719	13	18,352	13	-2.0%
ANALGESICS - OPIOID	16,948	15	16,788	14	-0.9%
BETA BLOCKERS	17,443	14	16,413	15	-5.9%
THYROID AGENTS	16,078	17	15,446	16	-3.9%
MUSCULOSKELETAL THERAPY AGENTS	13,250	18	13,296	17	0.3%

DIURETICS	13,243	19	12,347	18	-6.8%
ANALGESICS - NonNarcotic	11,262	21	11,332	19	0.6%
PENICILLINS	16,729	16	11,049	20	-34.0%

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March 2025 / May 2025	PREVIOUS RANK	June 2025 / August 2025	CURRENT RANK	% CHANGE
OZEMPIC	$5,221,080	1	$5,359,096	1	2.6%
VRAYLAR	$3,600,895	3	$3,645,351	2	1.2%
HUMIRA(CF) PEN	$3,924,708	2	$3,625,199	3	-7.6%
DUPIXENT PEN	$2,410,011	4	$2,735,121	4	13.5%
MOUNJARO	$1,957,154	8	$2,290,100	5	17.0%
JARDIANCE	$2,226,212	5	$2,271,464	6	2.0%
STELARA	$2,130,766	7	$2,249,309	7	5.6%
TRIKAFTA	$2,208,807	6	$2,043,366	8	-7.5%
SKYRIZI PEN	$1,621,206	10	$1,956,088	9	20.7%
INVEGA SUSTENNA	$1,867,466	9	$1,907,955	10	2.2%
BIKTARVY	$1,540,738	11	$1,532,428	11	-0.5%
REXULTI	$1,381,751	12	$1,329,352	12	-3.8%
ELIQUIS	$1,255,820	13	$1,271,376	13	1.2%
TALTZ AUTOINJECTOR	$1,249,228	14	$1,209,057	14	-3.2%
TRULICITY	$1,167,904	15	$1,206,699	15	3.3%
NURTEC ODT	$1,083,728	16	$1,169,757	16	7.9%
STRENSIQ	$727,733	23	$933,663	17	28.3%
ALTUVIIIO	$963,861	17	$874,273	18	-9.3%
INGREZZA	$829,843	19	$856,079	19	3.2%
WAKIX	$700,091	26	$853,747	20	21.9%
DUPIXENT SYRINGE	$696,215	27	$814,678	21	17.0%
RINVOQ	$628,419	33	$806,364	22	28.3%

EVRYSDI	$787,769	21	$780,985	23	-0.9%
ENBREL SURECLICK	$852,635	18	$764,076	24	-10.4%
TRELEGY ELLIPTA	$722,924	24	$759,010	25	5.0%
BIMZELX AUTOINJECTOR	$324,966	72	$745,411	26	129.4%
LISDEXAMFETAMINE DIMESYLATE	$635,964	32	$738,350	27	16.1%
SKYRIZI ON-BODY	$530,812	47	$737,556	28	38.9%
ABILIFY MAINTENA	$738,638	22	$733,598	29	-0.7%
CAPLYTA	$675,390	30	$718,887	30	6.4%
EPIDIOLEX	$683,962	29	$708,999	31	3.7%
ARISTADA	$691,145	28	$676,726	32	-2.1%
AJOVY AUTOINJECTOR	$600,276	35	$657,916	33	9.6%
ZEPBOUND	$416,730	60	$656,739	34	57.6%
UBRELVY	$560,440	39	$654,961	35	16.9%
LYBALVI	$548,469	41	$648,102	36	18.2%
COSENTYX UNOREADY PEN	$567,111	38	$643,631	37	13.5%
FARXIGA	$658,793	31	$631,353	38	-4.2%
TREMFYA	$466,203	55	$627,638	39	34.6%
CRYSVITA	$536,604	45	$625,828	40	16.6%
AUSTEDO XR	$567,259	37	$616,932	41	8.8%
TYVASO DPI	$365,574	67	$584,909	42	60.0%
NORDITROPIN FLEXPRO	$570,180	36	$581,219	43	1.9%
SYMBICORT	$530,822	46	$566,080	44	6.6%
TRINTELLIX	$618,405	34	$565,961	45	-8.5%
FINTEPLA	$544,717	42	$562,754	46	3.3%
HEMLIBRA	$506,083	49	$538,522	47	6.4%

JORNAY PM	$556,290	40	$532,824	48	-4.2%
UPTRAVI	$518,738	48	$509,053	49	-1.9%
LINZESS	$487,475	53	$503,601	50	3.3%
ENTRESTO	$492,069	52	$491,399	51	-0.1%
INVEGA TRINZA	$539,545	43	$475,510	52	-11.9%
TAKHZYRO	$395,387	64	$474,466	53	20.0%
DUVYZAT	$494,035	51	$459,625	54	-7.0%
XARELTO	$457,604	57	$441,359	55	-3.6%
TOLVAPTAN	$33,764	395	$438,929	56	1200.0%
ORENITRAM ER	$486,465	54	$433,008	57	-11.0%
QELBREE	$401,949	61	$418,276	58	4.1%
AUSTEDO	$445,007	58	$409,948	59	-7.9%
OTEZLA	$397,760	63	$409,796	60	3.0%
XIFAXAN	$366,469	66	$404,977	61	10.5%
OPSUMIT	$440,831	59	$391,991	62	-11.1%
XOLAIR	$262,237	81	$379,399	63	44.7%
COSENTYX SENSOREADY (2 PENS)	$344,740	70	$378,339	64	9.7%
QULIPTA	$320,062	74	$376,520	65	17.6%
ALBUTEROL SULFATE HFA	$400,212	62	$372,876	66	-6.8%
RAVICTI	$496,819	50	$372,614	67	-25.0%
KESIMPTA PEN	$378,685	65	$362,650	68	-4.2%
VYVANSE	$710,392	25	$339,690	69	-52.2%
ELOCTATE	$105,720	181	$325,110	70	207.5%
KISQALI	$320,275	73	$323,798	71	1.1%
WINREVAIR (2 PACK)	$86,552	207	$319,087	72	268.7%

VALTOCO	$145,102	138	$311,222	73	114.5%
FASENRA PEN	$353,994	69	$304,262	74	-14.0%
MAVYRET	$460,940	56	$299,684	75	-35.0%
LANTUS SOLOSTAR	$283,304	76	$291,853	76	3.0%
XYWAV	$342,914	71	$290,141	77	-15.4%
ORFADIN	$316,559	75	$284,474	78	-10.1%
NUCALA	$220,163	98	$282,637	79	28.4%
ALYFTREK	$249,893	82	$281,820	80	12.8%
GATTEX	$234,517	89	$281,420	81	20.0%
SPIRIVA RESPIMAT	$277,907	77	$275,080	82	-1.0%
MAVENCLAD		-	$274,879	83	0.0%
BREZTRI AEROSPHERE	$276,039	78	$273,567	84	-0.9%
NAYZILAM	$220,270	97	$268,887	85	22.1%
PULMOZYME	$193,664	112	$266,379	86	37.5%
SKYCLARYS	$126,481	154	$260,579	87	106.0%
EMGALITY PEN	$221,304	95	$260,307	88	17.6%
PROCYSBI	$214,429	101	$257,272	89	20.0%
AIMOVIG AUTOINJECTOR	$269,626	80	$255,885	90	-5.1%
UZEDY	$207,181	105	$255,451	91	23.3%
ALPROLIX	$225,502	92	$250,504	92	11.1%
HIZENTRA	$199,046	109	$249,931	93	25.6%
BRIVIACT	$217,801	100	$245,358	94	12.7%
VERZENIO	$360,891	68	$245,111	95	-32.1%
CALQUENCE	$209,510	103	$241,293	96	15.2%
EPINEPHRINE	$188,127	115	$238,632	97	26.8%

CREON	$223,148	94	$237,532	98	6.4%
ADVAIR HFA	$240,567	84	$236,687	99	-1.6%
HAEGARDA	$174,306	119	$232,408	100	33.3%

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March 2025 / May 2025	PREVIOUS RANK	June 2025 / August 2025	CURRENT RANK	% CHANGE
OMEPRAZOLE	17,220	1	16,619	1	-3.5%
TRAZODONE HCL	14,892	3	14,779	2	-0.8%
SERTRALINE HCL	14,899	2	14,507	3	-2.6%
LEVOTHYROXINE SODIUM	14,837	4	14,236	4	-4.1%
BUPROPION XL	12,917	5	12,875	5	-0.3%
ALBUTEROL SULFATE HFA	12,533	7	12,140	6	-3.1%
FLUOXETINE HCL	12,168	8	11,774	7	-3.2%
ATORVASTATIN CALCIUM	12,640	6	11,611	8	-8.1%
GABAPENTIN	11,210	9	11,047	9	-1.5%
ESCITALOPRAM OXALATE	11,166	10	10,750	10	-3.7%
HYDROXYZINE HCL	10,600	12	10,640	11	0.4%
CETIRIZINE HCL	10,472	13	10,457	12	-0.1%
MONTELUKAST SODIUM	9,978	14	9,804	13	-1.7%
BUSPIRONE HCL	9,930	15	9,741	14	-1.9%
PANTOPRAZOLE SODIUM	9,136	17	9,095	15	-0.4%
LISINOPRIL	9,377	16	8,612	16	-8.2%

CLONIDINE HCL	8,624	18	8,205	17	-4.9%
QUETIAPINE FUMARATE	7,985	19	7,991	18	0.1%
LAMOTRIGINE	7,741	22	7,757	19	0.2%
ARIPIPRAZOLE	7,889	21	7,637	20	-3.2%
DULOXETINE HCL	7,919	20	7,625	21	-3.7%
DEXTROAMPHETAMINE-AMPHET ER	7,593	23	7,454	22	-1.8%
FAMOTIDINE	7,333	24	7,123	23	-2.9%
AMOXICILLIN	10,689	11	6,494	24	-39.2%
TOPIRAMATE	6,412	29	6,380	25	-0.5%
AMLODIPINE BESYLATE	6,916	26	6,313	26	-8.7%
HYDROCODONE-ACETAMINOPHEN	6,423	28	6,302	27	-1.9%
PREDNISONE	7,008	25	6,301	28	-10.1%
FLUTICASONE PROPIONATE	6,912	27	6,251	29	-9.6%
CYCLOBENZAPRINE HCL	5,939	33	5,937	30	0.0%
VENLAFAXINE HCL ER	6,203	30	5,867	31	-5.4%
LORATADINE	5,707	35	5,838	32	2.3%
OZEMPIC	5,644	36	5,748	33	1.8%
METOPROLOL SUCCINATE	6,162	31	5,741	34	-6.8%

LISDEXAMFETAMINE DIMESYLATE	4,926	45	5,717	35	16.1%
METHYLPHENIDATE ER	6,068	32	5,459	36	-10.0%
RISPERIDONE	5,465	39	5,311	37	-2.8%
DEXTROAMPHETAMINE-AMPHETAMINE	5,316	40	5,195	38	-2.3%
ONDANSETRON ODT	5,803	34	5,186	39	-10.6%
ALPRAZOLAM	5,245	42	5,100	40	-2.8%
CLONAZEPAM	5,216	43	5,060	41	-3.0%
LOSARTAN POTASSIUM	5,467	38	4,965	42	-9.2%
IBUPROFEN	4,760	46	4,721	43	-0.8%
CEPHALEXIN	4,128	52	4,621	44	11.9%
METFORMIN HCL ER	4,979	44	4,609	45	-7.4%
MELOXICAM	4,704	47	4,545	46	-3.4%
METFORMIN HCL	4,554	48	4,457	47	-2.1%
ASPIRIN EC	4,498	49	4,450	48	-1.1%
JARDIANCE	4,038	57	4,118	49	2.0%
AMOXICILLIN-CLAVULANATE POTASS	5,472	37	4,097	50	-25.1%
ROSUVASTATIN CALCIUM	4,261	51	4,030	51	-5.4%
ALLERGY RELIEF	4,046	56	4,020	52	-0.6%

MIRTAZAPINE	4,119	53	4,020	53	-2.4%
PRAZOSIN HCL	3,981	58	4,009	54	0.7%
PROPRANOLOL HCL	4,096	54	3,953	55	-3.5%
GUANFACINE HCL ER	4,271	50	3,920	56	-8.2%
TRIAMCINOLONE ACETONIDE	3,522	67	3,910	57	11.0%
LORAZEPAM	3,952	59	3,894	58	-1.5%
ACETAMINOPHEN	3,815	61	3,883	59	1.8%
GUANFACINE HCL	4,088	55	3,830	60	-6.3%
FUROSEMIDE	3,927	60	3,817	61	-2.8%
LEVETIRACETAM	3,668	63	3,730	62	1.7%
LANTUS SOLOSTAR	3,493	69	3,630	63	3.9%
FOLIC ACID	3,562	66	3,571	64	0.3%
POLYETHYLENE GLYCOL 3350	3,593	65	3,549	65	-1.2%
HYDROXYZINE PAMOATE	3,473	71	3,542	66	2.0%
PREGABALIN	3,506	68	3,529	67	0.7%
AZITHROMYCIN	5,253	41	3,348	68	-36.3%
SPIRONOLACTONE	3,796	62	3,310	69	-12.8%
FEROSUL	3,285	75	3,258	70	-0.8%

FLUCONAZOLE	3,143	76	3,183	71	1.3%
HYDROCHLOROTHIAZIDE	3,367	73	3,173	72	-5.8%
TRAMADOL HCL	2,872	83	3,095	73	7.8%
OXYCODONE HCL	3,058	78	3,089	74	1.0%
VALACYCLOVIR	3,077	77	3,032	75	-1.5%
METHYLPHENIDATE HCL	3,476	70	3,000	76	-13.7%
BACLOFEN	3,003	79	2,994	77	-0.3%
DOXYCYCLINE MONOHYDRATE	3,347	74	2,951	78	-11.8%
OLANZAPINE	2,996	80	2,941	79	-1.8%
METRONIDAZOLE	2,891	81	2,930	80	1.3%
ATOMOXETINE HCL	2,876	82	2,810	81	-2.3%
POTASSIUM CHLORIDE	2,835	84	2,765	82	-2.5%
TIZANIDINE HCL	2,750	85	2,658	83	-3.3%
VRAYLAR	2,600	87	2,613	84	0.5%
SYMBICORT	2,448	90	2,577	85	5.3%
ALBUTEROL SULFATE	3,422	72	2,443	86	-28.6%
MUPIROCIN	2,094	101	2,422	87	15.7%
SULFAMETHOXAZOLE-TRIMETHOPRIM	2,164	98	2,412	88	11.5%

ELIQUIS	2,393	91	2,408	89	0.6%
VENTOLIN HFA	2,719	86	2,364	90	-13.1%
ZOLPIDEM TARTRATE	2,316	93	2,320	91	0.2%
MOUNJARO	1,974	103	2,285	92	15.8%
DEXMETHYLPHENIDATE HCL ER	2,582	88	2,258	93	-12.5%
ONDANSETRON HCL	2,304	94	2,231	94	-3.2%
CEFDINIR	3,594	64	2,188	95	-39.1%
SUMATRIPTAN SUCCINATE	2,271	95	2,167	96	-4.6%
OXCARBAZEPINE	2,207	97	2,165	97	-1.9%
CITALOPRAM HBR	2,346	92	2,118	98	-9.7%
TAMSULOSIN HCL	2,130	99	2,105	99	-1.2%
AMITRIPTYLINE HCL	2,458	89	2,086	100	-15.1%

IOWA | Health and Human Services

Fee for Service Claims
Quarterly Statistics

	March through May 2025	June through August 2025	% CHANGE
TOTAL PAID AMOUNT	$3,027,061	$3,310,065	9.3%
UNIQUE USERS	3,572	3,261	-8.7%
COST PER USER	$847.44	$1,015.05	19.8%
TOTAL PRESCRIPTIONS	23,202	21,727	-6.4%
AVERAGE PRESCRIPTIONS PER USER	6.50	6.66	2.5%
AVERAGE COST PER PRESCRIPTION	$130.47	$152.35	16.8%
# GENERIC PRESCRIPTIONS	20,995	19,661	-6.4%
% GENERIC	90.5%	90.5%	0.0%
$ GENERIC	$1,090,904	$998,668	-8.5%
AVERAGE GENERIC PRESCRIPTION COST	$51.96	$50.79	-2.3%
AVERAGE GENERIC DAYS SUPPLY	27	27	0.0%
# BRAND PRESCRIPTIONS	2,207	2,066	-6.4%
% BRAND	9.5%	9.5%	0.0%
$ BRAND	$1,936,158	$2,311,398	19.4%
AVERAGE BRAND PRESCRIPTION COST	$877.28	$1,118.78	27.5%
AVERAGE BRAND DAYS SUPPLY	29	28	-3.4%

UTILIZATION BY AGE		
AGE	**March through May 2025**	**June through August 2025**
0-6	170	161
7-12	363	330
13-18	619	566
19-64	2,393	2,183
65+	27	21
	3,572	3,261

	UTILIZATION BY GENDER AND AGE		
GENDER	**AGE**	**March through May 2025**	**June through August 2025**
F			
	0-6	95	72
	7-12	154	132
	13-18	303	286
	19-64	1,482	1,395
	65+	16	12
		2,050	1,897
M			
	0-6	75	89
	7-12	209	198
	13-18	316	280
	19-64	911	788
	65+	11	9
		1,522	1,364

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TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2025

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
1	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	883	$106,847.78	$121.01	2
2	MESKWAKI PHARMACY	TAMA	IA	757	$606,349.97	$800.99	1
3	SIOUXLAND COMMUNITY HEALTH CENTE	SIOUX CITY	IA	691	$39,357.32	$56.96	3
4	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	508	$30,517.48	$60.07	4
5	WALGREENS #15647	SIOUX CITY	IA	486	$43,211.65	$88.91	5
6	RIGHT DOSE PHARMACY	ANKENY	IA	366	$11,509.27	$31.45	7
7	THOMPSON-DEAN DRUG	SIOUX CITY	IA	318	$19,690.66	$61.92	6
8	WALGREEN #04405	COUNCIL BLUFFS	IA	214	$10,504.81	$49.09	9
9	GENOA HEALTHCARE LLC	SIOUX CITY	IA	210	$18,138.02	$86.37	8
10	CVS PHARMACY #17554	CEDAR FALLS	IA	170	$16,875.29	$99.27	17
11	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	166	$9,647.25	$58.12	10
12	MAIN AT LOCUST PHARMACY	DAVENPORT	IA	154	$8,962.48	$58.20	11
13	WCHS PHARMACY	WINNEBAGO	NE	142	$113,742.00	$801.00	13
14	HY-VEE PHARMACY #3 (1866)	WATERLOO	IA	141	$5,042.84	$35.76	31
15	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	133	$6,000.80	$45.12	18
16	UNITY POINT HEALTH PHARMACY	CEDAR RAPIDS	IA	133	$1,982.88	$14.91	12
17	DRUGTOWN PHARMACY #1 (7020)	CEDAR RAPIDS	IA	130	$1,950.15	$15.00	39
18	WAL-MART PHARMACY #10-0646	ANAMOSA	IA	126	$4,344.90	$34.48	37
19	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	125	$8,463.42	$67.71	22
20	WALGREEN COMPANY #05470	SIOUX CITY	IA	125	$14,651.96	$117.22	25
21	WALGREEN #05239	DAVENPORT	IA	124	$6,127.43	$49.41	23
22	WALGREEN COMPANY #3700	COUNCIL BLUFFS	IA	124	$2,728.63	$22.01	20
23	HY-VEE STORE CLINIC 1023-039	GRIMES	IA	123	$8,579.81	$69.75	29
24	COMMUNITY HEALTH CARE INC	DAVENPORT	IA	121	$15,213.27	$125.73	30
25	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	120	$10,020.72	$83.51	32
26	NUCARA PHARMACY #27	PLEASANT HILL	IA	119	$10,704.75	$89.96	19

IOWA | Health and Human Services

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2025

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
27	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	118	$7,334.94	$62.16	26
28	HY-VEE PHARMACY 1068	CHEROKEE	IA	118	$2,071.98	$17.56	33
29	HY-VEE PHARMACY (1075)	CLINTON	IA	111	$8,323.53	$74.99	48
30	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	111	$10,121.33	$91.18	27
31	REUTZEL PHARMACY	CEDAR RAPIDS	IA	107	$2,138.03	$19.98	28
32	CVS PHARMACY #10282	FORT DODGE	IA	105	$2,530.61	$24.10	47
33	PHARMACY MATTERS LTC	IOWA CITY	IA	103	$1,688.26	$16.39	45
34	ALL CARE HEALTH CENTER	COUNCIL BLUFFS	IA	100	$3,344.05	$33.44	79
35	NUCARA LTC PHARMACY 4	WATERLOO	IA	98	$1,200.63	$12.25	51
36	IMMC OUTPATIENT PHARMACY	DES MOINES	IA	97	$3,252.37	$33.53	34
37	MERCY FAMILY PHARMACY - REGENCY	MASON CITY	IA	96	$3,551.38	$36.99	64
38	WALGREEN #359	DES MOINES	IA	95	$5,013.16	$52.77	72
39	HY-VEE PHARMACY (1403)	MARSHALLTOWN	IA	95	$1,392.14	$14.65	55
40	COVENANT FAMILY PHARMACY	WATERLOO	IA	95	$2,505.62	$26.37	14
41	WALGREEN #05721	DES MOINES	IA	92	$8,884.96	$96.58	40
42	MEDICAP PHARMACY	INDIANOLA	IA	91	$1,485.86	$16.33	126
43	HY-VEE DRUGSTORE #7026	CEDAR RAPIDS	IA	90	$9,539.54	$105.99	42
44	DOTZLER PHARMACIES INC	HARLAN	IA	90	$11,046.38	$122.74	54
45	HARTLEY HOMETOWN PHARMACY	HARTLEY	IA	88	$4,797.36	$54.52	123
46	WAL-MART PHARMACY 10-1723	DES MOINES	IA	86	$4,617.87	$53.70	87
47	NELSON FAMILY PHARMACY	FORT MADISON	IA	85	$11,917.89	$140.21	36
48	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	84	$19,935.73	$237.33	15
49	HY-VEE PHARMACY (1071)	CLARINDA	IA	84	$10,173.77	$121.12	41
50	MERCY OUTPATIENT PHARMACY	DES MOINES	IA	84	$1,384.21	$16.48	103
51	MERCY MEDICAL CENTER NORTH IA DB	MASON CITY	IA	82	$3,237.09	$39.48	16
52	WALGREEN CO DBA	ALTOONA	IA	82	$4,387.26	$53.50	60

IOWA | Health and Human Services

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2025

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
53	CVS PHARMACY #08658	DAVENPORT	IA	81	$6,558.36	$80.97	68
54	GREENVILLE PHARMACY INC	SIOUX CITY	IA	81	$5,685.13	$70.19	69
55	KOERNER WHIPPLE PHARMACY	HAMPTON	IA	80	$8,358.01	$104.48	96
56	WALGREENS #03876	MARION	IA	80	$17,307.51	$216.34	52
57	GREENWOOD DRUG ON KIMBALL AVENUE	WATERLOO	IA	79	$3,222.85	$40.80	21
58	WAL-MART PHARMACY #10-1625	LE MARS	IA	78	$5,139.74	$65.89	81
59	HY-VEE PHARMACY #1 (1054)	CEDAR RAPIDS	IA	78	$1,808.42	$23.18	98
60	LEWIS FAMILY DRUG #28	ONAWA	IA	78	$4,343.17	$55.68	107
61	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	78	$14,902.25	$191.05	58
62	WAL-MART PHARMACY #10-0581	MARSHALLTOWN	IA	78	$2,077.51	$26.63	158
63	MEDICAP PHARMACY	BOONE	IA	76	$7,153.98	$94.13	38
64	HY-VEE PHARMACY 1011	ALTOONA	IA	75	$3,069.43	$40.93	56
65	WAL-MART PHARMACY 10-2889	CLINTON	IA	75	$1,166.39	$15.55	86
66	HY-VEE PHARMACY (1065)	CHARITON	IA	75	$1,238.59	$16.51	89
67	HERITAGE PARK PHARMACY	WEST BURLINGTON	IA	75	$5,280.49	$70.41	24
68	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	74	$5,633.65	$76.13	74
69	MAHASKA DRUG INC	OSKALOOSA	IA	74	$4,146.79	$56.04	57
70	HY-VEE PHARMACY (1009) DBA	ALBIA	IA	74	$7,487.47	$101.18	66
71	HY-VEE PHARMACY #2 (1044)	BURLINGTON	IA	74	$1,627.20	$21.99	73
72	CVS PHARMACY #8544	WATERLOO	IA	73	$6,634.44	$90.88	124
73	HY-VEE PHARMACY #3 (1056)	CEDAR RAPIDS	IA	73	$4,836.25	$66.25	77
74	WALGREEN #03595	DAVENPORT	IA	72	$2,415.96	$33.56	162
75	HY VEE PHARMACY #1449	NEWTON	IA	70	$6,507.00	$92.96	82
76	ELIZABETHS PHARMACY ON MAIN	BRITT	IA	69	$6,861.08	$99.44	49
77	HERITAGE PARK PHARMACY INC D/B/A	WEST BURLINGTON	IA	68	$1,163.45	$17.11	76
78	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	68	$7,510.40	$110.45	44

IOWA | Health and Human Services

TOP 100 PHARMACIES BY PRESCRIPTION COUNT
June through August 2025

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST RX	PREVIOUS RANK
79	HY-VEE PHARMACY #1 (1860)	WATERLOO	IA	68	$3,213.06	$47.25	91
80	WAL-MART PHARMACY #10-2935	KNOXVILLE	IA	67	$8,281.03	$123.60	109
81	WALGREEN #04041	DAVENPORT	IA	66	$2,484.58	$37.65	78
82	PARAGON PARTNERS	OMAHA	NE	66	$17,592.12	$266.55	105
83	GENOA HEALTHCARE LLC	MASON CITY	IA	66	$5,194.42	$78.70	92
84	HY-VEE PHARMACY #2 (1614)	SIOUX CITY	IA	65	$4,179.47	$64.30	122
85	WRIGHTWAY LTC PHARMACY	CLINTON	IA	65	$4,674.77	$71.92	102
86	HY-VEE PHARMACY (1396)	MARION	IA	64	$16,494.95	$257.73	106
87	MEDICAP PHARMACY #7	GRINNELL	IA	63	$6,253.98	$99.27	104
88	MEDICAP PHARMACY	DES MOINES	IA	63	$6,348.23	$100.77	50
89	MEDICAP PHARMACY	KNOXVILLE	IA	62	$4,840.27	$78.07	61
90	WHITE DRUG ENTERPRISES INC	SPENCER	IA	62	$2,957.77	$47.71	289
91	HY-VEE PHARMACY #3 (1142)	DES MOINES	IA	62	$2,742.22	$44.23	94
92	CHEROKEE MAIN STREET PHARMACY	CHEROKEE	IA	62	$5,669.31	$91.44	35
93	NUCARA PHARMACY #20	WEST UNION	IA	61	$4,113.71	$67.44	368
94	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	60	$13,944.56	$232.41	127
95	WALGREEN #05362	DES MOINES	IA	59	$2,877.79	$48.78	237
96	PARKVIEW PHARMACY	NEVADA	IA	58	$742.75	$12.81	90
97	HY VEE PHARMACY 7072	TOLEDO	IA	58	$7,826.48	$134.94	99
98	HY-VEE PHARMACY (1052)	CEDAR FALLS	IA	58	$507.60	$8.75	108
99	HY-VEE PHARMACY (1437)	MUSCATINE	IA	58	$3,515.16	$60.61	130
100	WALGREENS 10682	PRAIRIE DU CHIEN	WI	57	$1,377.05	$24.16	173

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TOP 100 PHARMACIES BY PAID AMOUNT
June through August 2025

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
1	MESKWAKI PHARMACY	TAMA	IA	757	$606,349.97	$2,495.27	1
2	ACCREDO HEALTH GROUP INC	WARRENDALE	PA	11	$161,664.38	$40,416.10	504
3	WALGREENS SPECIALTY PHARMACY #16	DES MOINES	IA	20	$154,912.45	$17,212.49	4
4	COMMUNITY A WALGREENS PHARMACY	IOWA CITY	IA	12	$118,813.23	$19,802.21	5
5	WCHS PHARMACY	WINNEBAGO	NE	142	$113,742.00	$2,068.04	3
6	PANTHERX SPECIALTY PHARMACY	CARAOPOLIS	PA	5	$112,493.67	$37,497.89	
7	UIHC AMBULATORY CARE PHARMACY	IOWA CITY	IA	883	$106,847.78	$624.84	6
8	CAREMARK KANSAS SPEC PHARMACY LL	LENEXA	KS	23	$83,583.54	$8,358.35	7
9	CAREMARK LLC	REDLANDS	CA	2	$72,487.42	$72,487.42	24
10	CVS PHARMACY #00102	AURORA	CO	6	$66,039.71	$33,019.86	8
11	ANOVORX GROUP INC	MEMPHIS	TN	7	$61,476.17	$20,492.06	233
12	ACCREDO HEALTH GROUP INC	WHITESTOWN	IN	7	$54,683.14	$18,227.71	11
13	ACCREDO HEALTH GROUP INC	MEMPHIS	TN	16	$46,396.88	$6,628.13	2
14	WALGREENS #15647	SIOUX CITY	IA	486	$43,211.65	$366.20	16
15	SIOUXLAND COMMUNITY HEALTH CENTE	SIOUX CITY	IA	691	$39,357.32	$342.24	9
16	UNITY POINT AT HOME	URBANDALE	IA	24	$36,351.33	$4,039.04	12
17	NUCARA SPECIALTY PHARMACY	PLEASANT HILL	IA	36	$31,550.50	$3,943.81	15
18	FRED LEROY HEALTH & WELLNESS	OMAHA	NE	39	$31,239.00	$2,603.25	14
19	DRILLING MORNINGSIDE PHARMACY IN	SIOUX CITY	IA	508	$30,517.48	$610.35	13
20	WAL-MART PHARMACY #10-0985	FAIRFIELD	IA	50	$28,282.24	$2,828.22	17
21	CVS CAREMARK	MOUNT PROSPECT	IL	6	$23,841.68	$11,920.84	85
22	SENDERRA RX PHARMACY	RICHARDSON	TX	3	$22,294.63	$11,147.32	10
23	PRIMARY HEALTH CARE PHARMACY	DES MOINES	IA	84	$19,935.73	$604.11	26
24	THOMPSON-DEAN DRUG	SIOUX CITY	IA	318	$19,690.66	$410.22	19
25	GENOA HEALTHCARE LLC	SIOUX CITY	IA	210	$18,138.02	$585.10	23

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TOP 100 PHARMACIES BY PAID AMOUNT
June through August 2025

RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
26	CARL T CURTIS HEALTH ED CENTER P	MACY	NE	22	$17,622.00	$1,762.20	32
27	PARAGON PARTNERS	OMAHA	NE	66	$17,592.12	$8,796.06	28
28	WALGREENS #03876	MARION	IA	80	$17,307.51	$1,153.83	27
29	CVS PHARMACY #17554	CEDAR FALLS	IA	170	$16,875.29	$1,687.53	22
30	HY-VEE PHARMACY (1396)	MARION	IA	64	$16,494.95	$1,649.50	29
31	WAL-MART PHARMACY 10-1732	DENISON	IA	36	$15,312.60	$2,552.10	30
32	COMMUNITY HEALTH CARE INC	DAVENPORT	IA	121	$15,213.27	$894.90	55
33	WALMART PHARMACY 10-3150	COUNCIL BLUFFS	IA	78	$14,902.25	$2,483.71	25
34	WALGREEN COMPANY #05470	SIOUX CITY	IA	125	$14,651.96	$488.40	18
35	SANFORD CANCER CTR ONC CLINIC PH	SIOUX FALLS	SD	1	$14,508.50	$14,508.50	
36	HY-VEE DRUGSTORE #7031	DES MOINES	IA	35	$14,199.74	$3,549.94	126
37	WAL MART PHARMACY 10-1621	CENTERVILLE	IA	60	$13,944.56	$3,486.14	35
38	GENESIS FIRST MED PHARMACY	DAVENPORT	IA	21	$13,186.98	$2,197.83	37
39	CR CARE PHARMACY	CEDAR RAPIDS	IA	48	$13,184.41	$2,636.88	34
40	WALGREEN #06623	WEST DES MOINES	IA	20	$12,909.67	$6,454.84	36
41	HY-VEE PHARMACY (1522)	PERRY	IA	18	$12,571.41	$2,095.24	271
42	NELSON FAMILY PHARMACY	FORT MADISON	IA	85	$11,917.89	$1,489.74	109
43	MEDICAP PHARMACY	NEWTON	IA	34	$11,638.70	$1,939.78	20
44	RIGHT DOSE PHARMACY	ANKENY	IA	366	$11,509.27	$605.75	41
45	DOTZLER PHARMACIES INC	HARLAN	IA	90	$11,046.38	$5,523.19	44
46	CHI HEALTH PHARMACY 42ND AND L	OMAHA	NE	2	$11,037.60	$11,037.60	39
47	NUCARA PHARMACY #27	PLEASANT HILL	IA	119	$10,704.75	$2,140.95	60
48	WALGREENS 07968	DES MOINES	IA	36	$10,641.56	$2,128.31	43
49	WALGREEN #04405	COUNCIL BLUFFS	IA	214	$10,504.81	$262.62	63
50	REINBECK PHARMACY	REINBECK	IA	45	$10,207.35	$3,402.45	58
51	HY-VEE PHARMACY (1071)	CLARINDA	IA	84	$10,173.77	$924.89	46

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
52	HY-VEE PHARMACY #4 (1148)	DES MOINES	IA	111	$10,121.33	$843.44	40
53	WAL MART PHARMACY 10-3590	SIOUX CITY	IA	120	$10,020.72	$527.41	62
54	WAL-MART PHARMACY #10-1415	SPIRIT LAKE	IA	43	$10,015.24	$1,251.91	38
55	BROADLAWNS MEDICAL CENTER	DES MOINES	IA	166	$9,647.25	$219.26	87
56	HY-VEE DRUGSTORE #7026	CEDAR RAPIDS	IA	90	$9,539.54	$953.95	59
57	MAIN AT LOCUST PHARMACY	DAVENPORT	IA	154	$8,962.48	$896.25	42
58	WALGREEN #05721	DES MOINES	IA	92	$8,884.96	$444.25	73
59	HY-VEE STORE CLINIC 1023-039	GRIMES	IA	123	$8,579.81	$571.99	50
60	HY-VEE PHARMACY #3 (1615)	SIOUX CITY	IA	125	$8,463.42	$423.17	56
61	KOERNER WHIPPLE PHARMACY	HAMPTON	IA	80	$8,358.01	$1,393.00	106
62	HY-VEE PHARMACY (1075)	CLINTON	IA	111	$8,323.53	$640.27	74
63	WAL-MART PHARMACY #10-2935	KNOXVILLE	IA	67	$8,281.03	$2,070.26	52
64	WAL-MART PHARMACY #10-1285	OTTUMWA	IA	6	$7,995.07	$3,997.54	51
65	HY VEE PHARMACY 7072	TOLEDO	IA	58	$7,826.48	$978.31	267
66	WAL-MART PHARMACY #10-1965	COUNCIL BLUFFS	IA	56	$7,735.79	$1,933.95	54
67	MT VERNON PHARMACY	MT VERNON	IA	24	$7,717.88	$1,929.47	21
68	UI HEALTH CARE DES MOINES PHARMA	DES MOINES	IA	1	$7,650.68	$7,650.68	
69	HY-VEE PHARMACY #2 (1138)	DES MOINES	IA	68	$7,510.40	$682.76	66
70	HY-VEE PHARMACY (1009) DBA	ALBIA	IA	74	$7,487.47	$1,497.49	72
71	LEWIS FAMILY DRUG #69	ROCK VALLEY	IA	46	$7,370.79	$1,474.16	75
72	HY-VEE PHARMACY #1 (1610)	SIOUX CITY	IA	118	$7,334.94	$188.08	45
73	MEDICAP PHARMACY	BOONE	IA	76	$7,153.98	$1,192.33	198
74	ELIZABETHS PHARMACY ON MAIN	BRITT	IA	69	$6,861.08	$1,715.27	57
75	WAL-MART PHARMACY 10-1546	IOWA FALLS	IA	50	$6,771.31	$846.41	53
76	CVS PHARMACY #8544	WATERLOO	IA	73	$6,634.44	$442.30	202
77	CVS PHARMACY #08658	DAVENPORT	IA	81	$6,558.36	$546.53	108

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RANK	PHARMACY NAME	PHARMACY CITY	STATE	PRESCRIPTION COUNT	PAID AMT	AVG COST MEMBER	PREVIOUS RANK
78	HY VEE PHARMACY #1449	NEWTON	IA	70	$6,507.00	$591.55	77
79	MEDICAP PHARMACY	DES MOINES	IA	63	$6,348.23	$6,348.23	88
80	MEDICAP PHARMACY #7	GRINNELL	IA	63	$6,253.98	$2,084.66	81
81	WALGREENS #07833	DES MOINES	IA	43	$6,219.86	$888.55	144
82	WALGREEN #05239	DAVENPORT	IA	124	$6,127.43	$266.41	64
83	WALGREEN COMPANY #05042	CEDAR RAPIDS	IA	133	$6,000.80	$181.84	65
84	ALLIANCERX WALGREENS PRIME #1628	PITTSBURGH	PA	3	$5,996.97	$5,996.97	31
85	HY-VEE PHARMACY #1 (1042)	BURLINGTON	IA	41	$5,900.10	$1,180.02	80
86	GREENVILLE PHARMACY INC	SIOUX CITY	IA	81	$5,685.13	$437.32	82
87	CHEROKEE MAIN STREET PHARMACY	CHEROKEE	IA	62	$5,669.31	$1,889.77	155
88	HY-VEE PHARMACY #5 (1109)	DAVENPORT	IA	74	$5,633.65	$402.40	254
89	HY-VEE PHARMACY 1297	JEFFERSON	IA	51	$5,518.40	$1,103.68	107
90	HY-VEE PHARMACY (1080)	CORALVILLE	IA	29	$5,473.99	$608.22	68
91	WAL-MART PHARMACY #10-1721	IOWA CITY	IA	53	$5,373.66	$767.67	61
92	HY-VEE DRUGSTORE #7025	CEDAR RAPIDS	IA	42	$5,357.92	$1,785.97	213
93	HERITAGE PARK PHARMACY	WEST BURLINGTON	IA	75	$5,280.49	$480.04	76
94	WAL-MART PHARMACY 10-1526	STORM LAKE	IA	23	$5,255.05	$2,627.53	164
95	WAL-MART PHARMACIES #10-0753	CEDAR FALLS	IA	43	$5,231.26	$747.32	70
96	RIVER HILLS PHARMACY	OTTUMWA	IA	17	$5,223.36	$1,741.12	478
97	GENOA HEALTHCARE LLC	MASON CITY	IA	66	$5,194.42	$1,298.61	297
98	WAL-MART PHARMACY #10-1625	LE MARS	IA	78	$5,139.74	$571.08	134
99	WALGREEN #05886	KEOKUK	IA	14	$5,080.25	$1,270.06	92
100	HY-VEE PHARMACY (1544)	RED OAK	IA	44	$5,044.75	$1,681.58	353

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
1	1053340661	LEIGHTON FROST MD	$161,833.64	205	2.85	1
2	1043418809	MICHAEL CILIBERTO	$104,528.98	187	5.67	2
3	1194888024	ALICIA D WAGER NP	$88,323.84	131	2.05	3
4	1912991183	MOLLY EARLEYWINE PA	$8,599.81	126	9.69	10
5	1982605762	JEFFREY DEAN WILHARM MD	$858.22	124	20.67	4
6	1902358443	MELISSA KONKEN ARNP	$5,815.97	101	7.21	8
7	1659358620	CARLOS CASTILLO MD	$1,837.24	91	8.27	5
8	1811123318	AARON KAUER MD	$5,120.99	91	18.20	28
9	1144214248	KRISTI WALZ MD	$22,955.51	84	10.50	9
10	1417214321	LEAH BRANDON DO	$3,112.51	80	10.00	20
11	1093141129	LARRY MARTIN NEWMAN ARNP	$56,899.67	72	2.67	15
12	1780877878	CHRISTOPHER JACOBS ARNP	$4,712.47	70	7.78	11
13	1780820860	LAUREN GRAHAM MD	$55,269.00	69	2.76	92
14	1538671961	JAMIE WRIGHT ARNP	$1,918.47	65	5.00	29
15	1407836513	NATHAN R NOBLE DO	$2,554.03	64	4.27	18
16	1457584740	ERIC DENNIS MEYER ARNP	$745.93	63	5.25	12
17	1164481362	MELISSA PEARSON ARNP	$49,676.34	63	1.58	7
18	1104251776	ANTHONY ERIK GLYDWELL	$48,860.89	61	1.42	6
19	1356337273	LISA JAYNE MENZIES MD	$1,258.36	59	6.56	24
20	1093272668	RICARDO OSARIO ARNP	$2,241.93	59	4.54	31
21	1215125216	REBECCA EVELYN WALDING	$4,618.47	58	4.83	14
22	1821481045	SHAWN T PLUNKETT PMHNP	$579.95	55	13.75	108
23	1447519038	ERIN E RICHARDSON MD	$2,482.98	53	7.57	50
24	1225140809	SUNDARA R MUNAGALA VENKATA MD	$2,187.13	53	4.82	124
25	1083248256	ERIN LYNNE REWERTS ARNP	$1,716.89	51	51.00	75
26	1841220290	KENT E KUNZE MD	$718.77	51	17.00	47

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
27	1528037082	RODNEY J DEAN MD	$812.20	50	25.00	72
28	1932493749	NICHOLAS CHARLES BECHTOLD DO	$3,777.13	50	10.00	33
29	1033890918	DINA IRWIN ARNP	$4,172.67	50	2.94	22
30	1013355759	DYLAN C GREENE MD	$1,855.52	50	5.56	16
31	1629265368	HANNAH LOKENVITZ PA	$1,957.31	49	24.50	58
32	1821268335	JACQUELINE MCINNIS PAC	$1,066.76	49	9.80	25
33	1053376475	DANIEL GILLETTE MD	$2,837.61	49	12.25	43
34	1174840656	JOSEPHINE DUNN-JUNIES MD	$776.58	49	24.50	135
35	1700356334	BRIANNA J SCHAFFER ARNP	$4,961.84	48	16.00	39
36	1407585623	COLETTE MARIE DEMOSS PA	$1,340.42	48	6.86	26
37	1760965032	MELISSA MILLER ARNP	$766.36	48	4.36	17
38	1619153137	JOADA JEAN BEST ARNP	$4,412.42	47	5.88	30
39	1326036062	JON AHRENDSEN MD	$881.78	46	7.67	46
40	1013115369	BOBBITA NAG MD	$1,343.18	46	5.75	45
41	1053600296	JESSICA MCCOOL MD	$5,423.48	45	22.50	67
42	1467502286	CHARLES R TILLEY PA	$4,832.29	45	6.43	91
43	1205249562	KELLY RYDER MD	$594.77	44	4.00	38
44	1932943206	ANDREW J KILGER DO	$3,177.61	43	43.00	269
45	1962418640	BARCLAY MONASTER MD	$4,283.87	42	7.00	114
46	1720698335	DANIKA LEIGH HANSEN ARNP	$2,223.82	42	2.63	71
47	1215146055	REBECCA JEAN MARIE WOLFE MD	$736.99	42	10.50	80
48	1417679168	PAIGE REED ARNP	$2,710.14	41	13.67	52
49	1104498039	BRENDA L CAIN ARNP	$6,282.02	41	8.20	35
50	1578123915	BRIANNA BROWNLEE DO	$2,925.42	41	8.20	40
51	1487194791	STACY NICOLE HENNIGAR ARNP	$2,492.21	41	13.67	96
52	1881095503	KAROWESO CHIPENDO ARNP	$496.15	40	5.00	262

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
53	1255823506	NICOLE MARIE DELAGARDELLE	$600.64	39	9.75	118
54	1922455096	DEAN L GUERDET ARNP	$3,725.97	39	9.75	57
55	1528796430	RACHEL KLUG APRN	$1,427.08	38	4.75	27
56	1982630703	JODI VANSICKLE MD	$293.73	38	6.33	54
57	1932582988	DIANNE HUMPHREY ARNP	$7,980.18	38	19.00	69
58	1134854128	DZEVIDA PANDZIC PAC	$440.48	38	5.43	440
59	1215981758	LISA D PISNEY ARNP	$1,980.88	37	7.40	266
60	1457346231	DAWN RENAE EBACH MD	$1,219.11	37	3.70	59
61	1073249306	MELISSA WATCHORN ARNP	$4,123.54	37	7.40	19
62	1679920045	BREANNE VOGEL ARNP	$858.12	37	12.33	68
63	1043211493	VIKRANT SALARIA MD	$5,480.98	36	18.00	99
64	1205675444	MAGGIE MAY HULING ARNP	$1,182.72	36	6.00	87
65	1891422606	EMILY CLAWSON ARNP	$453.50	36	9.00	125
66	1912498981	KATHRYN SIENNA LINKENMEYER MD	$2,289.02	36	18.00	51
67	1588920151	AMANDA H CROXTON DO	$6,700.81	35	7.00	121
68	1598750432	CHRISTOPHER OKIISHI MD	$735.94	35	8.75	107
69	1770933046	SHELBY BILLER	$10,744.85	35	8.75	61
70	1730117615	HARRY KLEIN MD	$3,544.44	35	35.00	166
71	1790986925	TAHUANTY PENA MD	$23,864.33	35	17.50	110
72	1801992532	KELLY RAGALLER M ARNP	$404.09	35	8.75	97
73	1477045797	CHANTAL J ROZMUS DO	$3,311.54	34	11.33	62
74	1649922410	CASSANDRA MARIE ZIMMERMAN ARNP	$1,049.16	34	34.00	65
75	1205141835	ANDREA K DIETZENBACH PA	$2,147.82	34	17.00	891
76	1336158666	LISA KONGABLE ARNP	$428.13	34	17.00	147
77	1295217529	HEATHER STEHR APRN	$1,006.39	33	3.30	48
78	1164093399	JENNIFER GRAVENISH ARNP	$647.47	33	33.00	171

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RANK	NPI NUM	PRESCRIBER NAME	PAID AMOUNT	PRESCRIPTION COUNT	AVG SCRIPTS MEMBER	PREVIOUS RANK
79	1396741385	MORDECHAI LEDERMAN DO	$379.04	33	33.00	181
80	1932531316	BROOKE JOHNSON ARNP	$5,345.15	33	16.50	76
81	1124648696	SEAN KARL SUTPHEN DO	$1,720.37	33	16.50	141
82	1407479355	SPENCER J ALDRIDGE DO	$452.85	33	33.00	119
83	1033634407	KRISTEN KRAKOVEC MD	$927.50	33	33.00	1679
84	1548874688	HEIDI MARIE HASSLER PA	$437.93	32	2.67	362
85	1164538674	JOSEPH MATTHEW WANZEK III DO	$434.42	32	16.00	120
86	1699483404	KATIE JO RIEHL ARNP	$2,270.84	32	8.00	232
87	1104804053	WINTHROP S RISK II MD	$5,836.96	32	10.67	158
88	1508846007	ANGELA TOWNSEND MD	$779.35	32	6.40	81
89	1154859452	DAVID KING PA	$2,902.34	32	10.67	221
90	1003884107	RANDALL ALLEN KAVALIER DO	$280.27	32	6.40	86
91	1700080538	EDUARDO CARLIN MD	$3,828.11	32	2.67	106
92	1558039495	SARAH HIETBRINK ARNP	$9,104.98	32	16.00	112
93	1336418425	DENA R NEIMAN ARNP	$743.27	32	2.91	53
94	1427617471	SUSAN GRAVES PA	$4,879.07	32	6.40	34
95	1194272930	EMILY FITZPATRICK ARNP	$4,234.13	31	31.00	127
96	1073795928	HEATHER A JOHNSON ARNP	$959.49	31	10.33	100
97	1861678997	ELIZABETH WESSLING PA	$408.66	31	1.72	212
98	1932652757	KELSIE JO SWISHER APRN	$287.55	31	10.33	328
99	1346349388	THOMAS BRENT HOEHNS MD	$2,365.21	31	31.00	137
100	1427164789	MICHAEL J OURADA MD	$549.30	31	15.50	63

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1	1053340661	LEIGHTON FROST MD	$161,833.64	$789.43	205	1
2	1043418809	MICHAEL CILIBERTO	$104,528.98	$558.98	187	10
3	1194888024	ALICIA D WAGER NP	$88,323.84	$674.23	131	3
4	1609131770	SREENATH THATI GANGANNA MBBS	$80,906.12	$2,789.87	29	22
5	1114214541	DIMAH NAYEF SAADE MD	$80,882.17	$8,986.91	9	20
6	1033347521	DREW M THODESON MD	$80,788.58	$26,929.53	3	2
7	1326034984	KATHERINE DIANNE MATHEWS MD	$76,721.09	$9,590.14	8	713
8	1093141129	LARRY MARTIN NEWMAN ARNP	$56,899.67	$790.27	72	7
9	1780820860	LAUREN GRAHAM MD	$55,269.00	$801.00	69	19
10	1629719737	CLAIRE NIEVINSKI PA	$53,967.14	$6,745.89	8	8
11	1669184511	CHANDRA MILLER ARNP	$53,889.34	$8,981.56	6	11
12	1164481362	MELISSA PEARSON ARNP	$49,676.34	$788.51	63	5
13	1104251776	ANTHONY ERIK GLYDWELL	$48,860.89	$801.00	61	4
14	1730128653	KRISTI ROBSON PA	$42,966.24	$21,483.12	2	34
15	1356752067	KELLY DELANEY-NELSON MD	$36,142.70	$2,581.62	14	28
16	1043441264	KATHERINE A BLOMGREN PA-C	$33,682.59	$16,841.30	2	1366
17	1235518507	ADEKUNLE OLADEGA AJISEBUTU MD	$33,366.70	$16,683.35	2	
18	1578958542	HEIDI E CURTIS ARNP	$31,156.68	$15,578.34	2	13
19	1427690387	KELSEY BIEGHLER ARNP	$30,581.56	$15,290.78	2	
20	1942937388	CARLY J TRAUSCH ARNP	$28,944.60	$1,608.03	18	50
21	1184056822	ABBY IRENE KOLTHOFF ARNP	$28,350.23	$1,090.39	26	15
22	1588618359	BARBARA BURKLE ARNP	$28,323.99	$28,323.99	1	3455
23	1265048870	KELLY ALEXIS MERCHIE PA	$28,192.77	$2,168.67	13	16
24	1891146999	BECKY L JOHNSON ARNP	$24,502.58	$790.41	31	31
25	1790986925	TAHUANTY PENA MD	$23,864.33	$681.84	35	25
26	1730293705	ROBERT JACKSON DO	$23,854.44	$2,981.81	8	24
27	1740246008	DANIEL LAMPTEY MD	$22,972.35	$7,657.45	3	1729

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28	1144214248	KRISTI WALZ MD	$22,955.51	$273.28	84	12
29	1598733891	JERRY WILLE MD	$22,428.00	$801.00	28	6
30	1750648275	SARAH GROSS MD	$21,538.22	$5,384.56	4	26
31	1417307497	EMILY BOES DO	$21,286.48	$2,128.65	10	3120
32	1194990945	SANDEEP GUPTA MD	$21,097.22	$1,318.58	16	23
33	1245227099	DONNA RAE DOBSON TOBIN ARNP	$20,580.82	$1,210.64	17	121
34	1255319422	DAVID STAUB MD	$20,167.37	$6,722.46	3	72
35	1154929230	CHELSEA JONES ARNP	$18,423.00	$801.00	23	30
36	1780995506	QUANHATHAI KAEWPOOWAT MD	$16,696.23	$5,565.41	3	
37	1124216882	KELLY JESSICA PEARSON ARNP	$15,790.48	$1,754.50	9	1367
38	1447488325	ABDELAZIZ ELHADDAD MD	$15,332.49	$3,833.12	4	14
39	1366402505	KUNAL KUMAR PATRA MD	$15,254.49	$693.39	22	37
40	1073852059	AMBER HANSEN MD	$15,219.00	$801.00	19	21
41	1912345992	AMY WINGERT MD	$15,176.27	$843.13	18	285
42	1790874055	SHAILENDER SINGH MD	$14,869.04	$3,717.26	4	41
43	1649678582	LAURA STULKEN PA C	$14,772.47	$1,846.56	8	3247
44	1104088202	PATRICK SAFO MD	$14,577.07	$14,577.07	1	17
45	1811493679	JUNE MYLER ARNP	$14,452.91	$688.23	21	35
46	1760675177	LORI SWANSON ARNP	$12,816.00	$801.00	16	59
47	1598967291	RADHIKA DHAMIJA MD	$12,765.04	$2,553.01	5	40
48	1114521721	TARRAH HOLLIDAY ARNP	$12,597.50	$419.92	30	47
49	1891955423	LEAH SIEGFRIED PA	$12,530.12	$569.55	22	201
50	1417931700	SUDHIR C KUMAR MD	$12,389.46	$4,129.82	3	
51	1619526076	KATHRYN C HUBER PA C	$11,931.92	$662.88	18	66
52	1295109478	EMILY KRUSE PA-C	$11,741.60	$1,304.62	9	131
53	1205817061	VIJAY DEWAN MD	$11,037.60	$5,518.80	2	42
54	1336111855	LILY WONG-KISIEL	$11,033.50	$1,003.05	11	81

IOWA | Health and Human Services

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2025

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
55	1770933046	SHELBY BILLER	$10,744.85	$307.00	35	43
56	1215386578	MARISSA ANN CROWDIS DO	$10,552.82	$422.11	25	
57	1285490896	KARISSA MARIE WEAVER APRN	$10,384.87	$358.10	29	68
58	1043878705	DORTHEA WHEELER MD	$10,346.10	$1,724.35	6	44
59	1083102933	COLOMBIA PTACEK	$10,274.19	$604.36	17	45
60	1740953439	WILMAR GARCIA NP-C	$10,029.08	$1,253.64	8	36
61	1396724878	WHITNEY ELIZABETH MOLIS MD	$9,679.85	$1,075.54	9	33
62	1306349956	KATIE LADEHOFF ARNP	$9,612.00	$801.00	12	38
63	1811621865	AMY COOPER	$9,151.26	$435.77	21	191
64	1558039495	SARAH HIETBRINK ARNP	$9,104.98	$284.53	32	61
65	1639157373	CALVIN J HANSEN MD	$9,020.68	$9,020.68	1	
66	1689077018	STACY ROTH ARNP	$8,815.22	$383.27	23	78
67	1740951110	REBECCA RAY LECHNER APRN	$8,811.00	$801.00	11	181
68	1912991183	MOLLY EARLEYWINE PA	$8,599.81	$68.25	126	126
69	1598113888	CRAIG CUNNINGHAM MD	$8,274.07	$4,137.04	2	52
70	1275836751	HOLLY M KRAMER ARNP	$8,270.95	$751.90	11	113
71	1235976374	OLIVIA ANN HANSEN ARNP	$8,242.81	$2,747.60	3	3176
72	1568758746	DANIEL BINKOWSKI DDS	$8,108.43	$450.47	18	89
73	1568097244	ELIZABETH DASSOW PA	$7,986.72	$1,597.34	5	55
74	1932582988	DIANNE HUMPHREY ARNP	$7,980.18	$210.00	38	51
75	1629415922	ALYSSA LAKIN PA-C	$7,688.52	$3,844.26	2	39
76	1881228732	TAYLOR MORRIS PA-C	$7,650.68	$7,650.68	1	
77	1568459329	SHERRY L PARKS PA-C	$7,252.81	$302.20	24	686
78	1679573893	PATTY HILDRETH ARNP	$7,106.33	$308.97	23	86
79	1225143316	SUSAN MARIE JACOBI MD	$6,796.87	$970.98	7	1444
80	1588920151	AMANDA H CROXTON DO	$6,700.81	$191.45	35	664
81	1417435462	ALLISON R OWINGS NP-C	$6,561.83	$273.41	24	220

IOWA | Health and Human Services

TOP 100 PRESCRIBING PROVIDERS BY PAID AMOUNT
June through August 2025

RANK	DOCTOR NUM	PRESCRIBER NAME	PAID AMOUNT	AVG COST RX	PRESCRIPTION COUNT	PREVIOUS RANK
82	1104498039	BRENDA L CAIN ARNP	$6,282.02	$153.22	41	79
83	1326410499	TARA M EASTVOLD ARNP	$6,253.13	$521.09	12	70
84	1386938447	THERESA CZECH MD	$6,192.22	$294.87	21	311
85	1114243052	OLGA TARASCHENKO MD	$6,074.67	$1,518.67	4	165
86	1265924138	MELINDA A STRUTHOFF ARNP	$5,982.99	$230.12	26	1553
87	1497247688	SETH THOMAS STREETER DO	$5,891.70	$245.49	24	106
88	1104804053	WINTHROP S RISK II MD	$5,836.96	$182.41	32	159
89	1902358443	MELISSA KONKEN ARNP	$5,815.97	$57.58	101	143
90	1134981038	CASSIDY CHALUPA ARNP	$5,776.87	$962.81	6	29
91	1578777231	AMANDA L HECK ARNP	$5,772.56	$288.63	20	189
92	1952810087	JESSICA LEE STREETER ARNP	$5,741.02	$717.63	8	141
93	1841657236	KATE ELIZABETH BOLICK	$5,732.53	$382.17	15	250
94	1205504669	JENNIFER SWANSON ARNP	$5,607.00	$801.00	7	147
95	1598326217	PETER SCHINDLER MD	$5,607.00	$801.00	7	91
96	1770249054	JOSIE M RUTHERFORD CNM	$5,607.00	$801.00	7	174
97	1881251189	JENNIFER HARRISON APRN	$5,607.00	$801.00	7	109
98	1346557550	ROBERT BRYAN BOYLE ARNP	$5,533.21	$204.93	27	95
99	1043211493	VIKRANT SALARIA MD	$5,480.98	$152.25	36	155
100	1316942212	JEFFREY GOLDMAN MD	$5,436.42	$604.05	9	76

IOWA | Health and Human Services

TOP 20 THERAPEUTIC CLASS BY PAID AMOUNT

CATEGORY DESCRIPTION	March through May 2025	RANK	% BUDGET	June through August 2025	RANK	% BUDGET	% CHANGE
ANTIDIABETICS	$359,869	1	11.9%	$361,251	1	10.9%	0.4%
NEUROMUSCULAR AGENTS	$171,205	5	5.7%	$292,744	2	8.8%	71.0%
DERMATOLOGICALS	$245,600	2	8.1%	$291,876	3	8.8%	18.8%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$220,650	3	7.3%	$241,407	4	7.3%	9.4%
ANTICONVULSANTS	$151,563	8	5.0%	$231,640	5	7.0%	52.8%
ANALGESICS - ANTI-INFLAMMATORY	$187,710	4	6.2%	$225,365	6	6.8%	20.1%
ANTIVIRALS	$139,696	9	4.6%	$179,339	7	5.4%	28.4%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$152,508	7	5.0%	$169,840	8	5.1%	11.4%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$167,496	6	5.5%	$137,063	9	4.1%	-18.2%
ANTIDEPRESSANTS	$115,031	11	3.8%	$108,189	10	3.3%	-5.9%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$116,472	10	3.8%	$107,086	11	3.2%	-8.1%
ENDOCRINE AND METABOLIC AGENTS - MISC.	$46,127	16	1.5%	$93,451	12	2.8%	102.6%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$35,046	23	1.2%	$72,480	13	2.2%	106.8%
ANTIHYPERTENSIVES	$63,063	12	2.1%	$53,295	14	1.6%	-15.5%
MIGRAINE PRODUCTS	$35,573	22	1.2%	$51,079	15	1.5%	43.6%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	$47,301	14	1.6%	$50,711	16	1.5%	7.2%
ANTIHYPERLIPIDEMICS	$38,827	19	1.3%	$38,304	17	1.2%	-1.3%
ANALGESICS - OPIOID	$39,016	18	1.3%	$33,557	18	1.0%	-14.0%
ANTI-INFECTIVE AGENTS - MISC.	$49,437	13	1.6%	$32,169	19	1.0%	-34.9%
CONTRACEPTIVES	$36,816	21	1.2%	$31,965	20	1.0%	-13.2%

IOWA | Health and Human Services

TOP 20 THERAPEUTIC CLASS BY PRESCRIPTION COUNT

CATEGORY DESCRIPTION	March through May 2025	PREV RANK	June through August 2025	CURR RANK	PERC CHANGE
ANTIDEPRESSANTS	2,727	1	2,522	1	-7.5%
ANTICONVULSANTS	1,708	2	1,619	2	-5.2%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	1,507	3	1,402	3	-7.0%
ANTIPSYCHOTICS/ANTIMANIC AGENTS	1,128	7	1,117	4	-1.0%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	1,161	4	1,080	5	-7.0%
ANTIDIABETICS	1,130	6	1,068	6	-5.5%
ANTIHYPERTENSIVES	1,152	5	1,029	7	-10.7%
ANTIANXIETY AGENTS	1,024	9	1,001	8	-2.2%
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	1,040	8	966	9	-7.1%
ANTIHISTAMINES	667	10	612	10	-8.2%
DERMATOLOGICALS	542	13	576	11	6.3%
ANALGESICS - OPIOID	551	12	566	12	2.7%
ANALGESICS - ANTI-INFLAMMATORY	512	14	511	13	-0.2%
ANTIHYPERLIPIDEMICS	556	11	510	14	-8.3%
MUSCULOSKELETAL THERAPY AGENTS	391	18	406	15	3.8%
BETA BLOCKERS	446	15	386	16	-13.5%
THYROID AGENTS	400	17	380	17	-5.0%
DIURETICS	366	20	345	18	-5.7%
ANALGESICS - NONNARCOTIC	336	21	334	19	-0.6%
ANTI-INFECTIVE AGENTS - MISC.	333	22	321	20	-3.6%

IOWA | Health and Human Services

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
EVRYSDI	$171,205.03	1	$216,143.30	1	26.25%
OZEMPIC	$154,551.27	2	$157,652.55	2	2.01%
HUMIRA PEN	$88,973.69	4	$106,330.30	3	19.51%
VRAYLAR	$93,515.65	3	$97,255.71	4	4.00%
BIKTARVY	$76,543.21	5	$96,409.84	5	25.95%
DUVYZAT		999	$76,600.63	6	%
RAVICTI	$19,515.84	31	$72,487.42	7	271.43%
DUPIXENT	$61,979.10	7	$68,324.49	8	10.24%
JARDIANCE	$69,783.53	6	$65,695.44	9	-5.86%
SKYRIZI PEN	$43,189.42	11	$64,449.36	10	49.22%
FINTEPLA	$1,324.92	290	$60,647.82	11	4,477.47%
KISQALI	$30,581.56	17	$53,523.02	12	75.02%
ENBREL SURECLICK	$44,201.39	9	$47,538.42	13	7.55%
INGREZZA	$24,666.42	23	$40,653.73	14	64.81%
KESIMPTA	$44,102.59	10	$37,090.78	15	-15.90%
VYVANSE	$46,556.50	8	$33,946.10	16	-27.09%
WAKIX		999	$33,366.70	17	%
REXULTI	$31,988.64	15	$33,248.46	18	3.94%
COSENTYX UNOREADY	$30,544.18	19	$31,156.68	19	2.01%
STELARA		999	$28,323.99	20	%
EPIDIOLEX	$14,992.05	42	$27,594.91	21	84.06%
ONFI	$21,984.99	27	$26,857.46	22	22.16%
ARISTADA	$13,181.62	49	$26,531.91	23	101.28%
ALBUTEROL SULFATE HFA	$35,127.10	12	$25,981.56	24	-26.04%
TRIKAFTA	$30,557.87	18	$23,567.89	25	-22.87%
ESCITALOPRAM OXALATE	$23,034.97	25	$23,529.41	26	2.15%
SOFOSBUVIR/VELPATASVIR		999	$22,972.35	27	%

IOWA | Health and Human Services

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
LISINOPRIL	$22,402.76	26	$22,849.62	28	1.99%
TRULICITY	$27,149.49	22	$21,900.83	29	-19.33%
TALTZ	$35,083.85	13	$21,105.19	30	-39.84%
EBGLYSS		999	$21,018.26	31	%
INVEGA SUSTENNA	$20,130.13	30	$20,380.75	32	1.24%
ELIQUIS	$30,884.65	16	$20,349.54	33	-34.11%
ROSUVASTATIN CALCIUM	$15,465.93	40	$20,219.11	34	30.73%
HUMIRA PEN-CD/UC/HS START	$4,551.07	158	$20,207.43	35	344.01%
IBUPROFEN	$24,078.52	24	$19,355.82	36	-19.61%
PANTOPRAZOLE SODIUM	$15,129.53	41	$18,962.41	37	25.33%
AMLODIPINE BESYLATE	$9,855.62	69	$18,575.73	38	88.48%
CETIRIZINE HYDROCHLORIDE	$32,218.52	14	$18,549.73	39	-42.43%
CREON	$16,146.34	38	$17,902.38	40	10.88%
ENTRESTO	$21,279.87	28	$17,498.25	41	-17.77%
JORNAY PM	$18,765.87	34	$17,123.15	42	-8.75%
APTIOM	$2,097.82	234	$16,866.30	43	703.99%
LYBALVI	$13,327.00	48	$16,723.83	44	25.49%
CEPHALEXIN	$17,691.94	37	$15,587.60	45	-11.89%
NORDITROPIN FLEXPRO	$17,730.84	36	$15,232.02	46	-14.09%
AMOXICILLIN	$21,045.99	29	$15,172.87	47	-27.91%
METHYLPHENIDATE HYDROCHLO	$19,288.66	32	$14,985.88	48	-22.31%
MOUNJARO	$6,452.49	114	$14,587.31	49	126.07%
TREMFYA	$29,154.14	21	$14,577.07	50	-50.00%
KOSELUGO		999	$14,508.50	51	%
SYMBICORT	$12,599.05	52	$13,899.21	52	10.32%
FARXIGA	$10,638.76	65	$13,585.36	53	27.70%
HUMIRA		999	$13,444.53	54	%

IOWA | Health and Human Services

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
GUANFACINE HYDROCHLORIDE	$11,493.75	56	$13,391.53	55	16.51%
TRAZODONE HYDROCHLORIDE	$11,364.11	58	$12,708.40	56	11.83%
OMEPRAZOLE	$13,619.03	46	$12,601.64	57	-7.47%
WESTAB PLUS	$9,245.42	75	$12,445.32	58	34.61%
XIFAXAN	$18,905.14	33	$12,161.16	59	-35.67%
TRINTELLIX	$10,978.63	62	$12,052.58	60	9.78%
NURTEC	$8,787.99	80	$11,898.06	61	35.39%
AMPHETAMINE/DEXTROAMPHETA	$9,784.94	70	$11,879.18	62	21.40%
AJOVY	$5,928.84	119	$11,836.50	63	99.64%
MONTELUKAST SODIUM	$4,806.00	151	$11,801.26	64	145.55%
NUCALA	$11,430.36	57	$11,504.34	65	0.65%
ABILIFY ASIMTUFII	$11,003.96	61	$11,037.60	66	0.31%
ASPIRIN LOW DOSE	$6,614.87	106	$10,612.91	67	60.44%
LANTUS SOLOSTAR	$18,078.59	35	$10,506.18	68	-41.89%
INVEGA TRINZA	$10,319.64	68	$10,319.92	69	0.00%
ATORVASTATIN CALCIUM	$13,388.12	47	$9,827.58	70	-26.59%
FLUTICASONE PROPIONATE	$11,853.30	55	$9,776.15	71	-17.52%
PREDNISONE	$15,487.75	39	$9,690.63	72	-37.43%
AMOXICILLIN/CLAVULANATE P	$10,743.29	64	$9,510.95	73	-11.47%
ACETAMINOPHEN	$5,258.72	137	$9,468.07	74	80.05%
TEZSPIRE	$14,054.40	44	$9,369.60	75	-33.33%
EPINEPHRINE	$5,217.00	139	$9,320.58	76	78.66%
VIMPAT	$6,926.40	101	$9,199.84	77	32.82%
QELBREE	$7,909.38	92	$9,191.02	78	16.20%
LISDEXAMFETAMINE DIMESYLA	$8,624.21	83	$9,177.66	79	6.42%
SERTRALINE HCL	$5,979.29	117	$8,969.11	80	50.00%
BUPROPION HYDROCHLORIDE E	$14,143.34	43	$8,751.25	81	-38.12%

IOWA | Health and Human Services

TOP 100 DRUGS BY PAID AMOUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
SERTRALINE HYDROCHLORIDE	$8,872.55	79	$8,689.58	82	-2.06%
EMGALITY	$6,514.26	109	$8,516.89	83	30.74%
TRIAMCINOLONE ACETONIDE	$6,816.90	102	$8,492.13	84	24.57%
MAVYRET	$9,364.68	74	$8,436.59	85	-9.91%
HYDROXYZINE HYDROCHLORIDE	$4,564.67	156	$8,244.79	86	80.62%
GENVOYA	$8,287.66	84	$8,229.78	87	-0.70%
GABAPENTIN	$9,158.02	77	$8,224.29	88	-10.20%
ALPRAZOLAM	$7,496.55	97	$8,103.36	89	8.09%
TRAMADOL HYDROCHLORIDE	$10,612.67	66	$8,063.08	90	-24.02%
HYDROCHLOROTHIAZIDE	$5,599.05	124	$7,979.23	91	42.51%
ABILIFY MAINTENA	$11,207.20	60	$7,966.10	92	-28.92%
CEFDINIR	$6,484.87	112	$7,773.40	93	19.87%
VALTOCO 15 MG DOSE	$2,487.94	213	$7,743.04	94	211.22%
LOSARTAN POTASSIUM	$11,938.55	54	$7,722.37	95	-35.32%
NAYZILAM	$12,944.20	51	$7,565.44	96	-41.55%
JANUVIA	$2,011.56	237	$7,527.86	97	274.23%
AUSTEDO XR	$30,056.52	20	$7,514.13	98	-75.00%
CONCERTA	$7,967.14	90	$7,464.65	99	-6.31%
HYDROCODONE BITARTRATE/AC	$11,234.12	59	$7,440.91	100	-33.77%

IOWA | Health and Human Services

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
TRAZODONE HYDROCHLORIDE	460	1	407	1	-11.52%
FLUOXETINE HYDROCHLORIDE	421	2	377	2	-10.45%
ALBUTEROL SULFATE HFA	402	3	370	3	-7.96%
GABAPENTIN	368	5	356	4	-3.26%
ESCITALOPRAM OXALATE	370	4	342	5	-7.57%
METHYLPHENIDATE HYDROCHLO	362	6	338	6	-6.63%
LEVOTHYROXINE SODIUM	345	8	334	7	-3.19%
SERTRALINE HYDROCHLORIDE	327	9	321	8	-1.83%
CETIRIZINE HYDROCHLORIDE	325	11	307	9	-5.54%
CLONIDINE HYDROCHLORIDE	349	7	299	10	-14.33%
ATORVASTATIN CALCIUM	327	10	292	11	-10.70%
AMPHETAMINE/DEXTROAMPHETA	311	12	291	12	-6.43%
HYDROXYZINE HYDROCHLORIDE	273	15	280	13	2.56%
BUPROPION HYDROCHLORIDE E	252	17	252	14	0.00%
QUETIAPINE FUMARATE	282	14	245	15	-13.12%
BUSPIRONE HYDROCHLORIDE	226	23	230	16	1.77%
MONTELUKAST SODIUM	236	20	223	17	-5.51%
LISINOPRIL	254	16	220	18	-13.39%
ARIPIPRAZOLE	231	22	218	19	-5.63%
OMEPRAZOLE	246	19	216	20	-12.20%
RISPERIDONE	190	31	206	21	8.42%
PANTOPRAZOLE SODIUM	232	21	204	22	-12.07%
AMLODIPINE BESYLATE	196	28	195	23	-0.51%
OZEMPIC	191	30	192	24	0.52%
LEVETIRACETAM	185	33	189	25	2.16%
GUANFACINE HYDROCHLORIDE	307	13	188	26	-38.76%
PREDNISONE	208	25	186	27	-10.58%

IOWA | Health and Human Services

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
LAMOTRIGINE	201	26	186	28	-7.46%
DULOXETINE HYDROCHLORIDE	196	27	185	29	-5.61%
ONDANSETRON ODT	175	35	179	30	2.29%
FLUTICASONE PROPIONATE	215	24	179	31	-16.74%
FAMOTIDINE	188	32	178	32	-5.32%
CEPHALEXIN	157	37	177	33	12.74%
IBUPROFEN	179	34	177	34	-1.12%
HYDROCODONE BITARTRATE/AC	193	29	168	35	-12.95%
AMOXICILLIN	250	18	166	36	-33.60%
CYCLOBENZAPRINE HYDROCHLO	143	44	160	37	11.89%
OMEPRAZOLE DR	156	38	159	38	1.92%
OXYCODONE HYDROCHLORIDE	117	56	158	39	35.04%
METFORMIN HYDROCHLORIDE	155	39	150	40	-3.23%
GUANFACINE HYDROCHLORIDE	307	13	145	41	-52.77%
HYDROXYZINE PAMOATE	145	43	145	42	0.00%
TOPIRAMATE	148	42	141	43	-4.73%
METFORMIN HYDROCHLORIDE E	135	49	132	44	-2.22%
LOSARTAN POTASSIUM	154	40	126	45	-18.18%
ASPIRIN LOW DOSE	122	53	125	46	2.46%
JARDIANCE	139	46	121	47	-12.95%
AMOXICILLIN/CLAVULANATE P	151	41	121	48	-19.87%
PROPRANOLOL HYDROCHLORIDE	133	50	120	49	-9.77%
BACLOFEN	140	45	119	50	-15.00%
CLONAZEPAM	128	51	118	51	-7.81%
VENLAFAXINE HYDROCHLORIDE	119	54	115	52	-3.36%
SERTRALINE HCL	119	55	113	53	-5.04%
LISDEXAMFETAMINE DIMESYLA	104	64	111	54	6.73%

IOWA | Health and Human Services

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
LANTUS SOLOSTAR	135	48	110	55	-18.52%
ROSUVASTATIN CALCIUM	110	59	109	56	-0.91%
TRIAMCINOLONE ACETONIDE	89	76	108	57	21.35%
METRONIDAZOLE	102	67	108	58	5.88%
LORATADINE	112	58	105	59	-6.25%
METOPROLOL SUCCINATE ER	138	47	105	60	-23.91%
FUROSEMIDE	99	69	104	61	5.05%
FEROSUL	96	70	102	62	6.25%
MELOXICAM	87	77	102	63	17.24%
OLANZAPINE	79	79	98	64	24.05%
PRAZOSIN HYDROCHLORIDE	105	63	97	65	-7.62%
TRAMADOL HYDROCHLORIDE	110	60	96	66	-12.73%
MIRTAZAPINE	115	57	95	67	-17.39%
PREGABALIN	101	68	94	68	-6.93%
DOXYCYCLINE MONOHYDRATE	106	62	92	69	-13.21%
HYDROCHLOROTHIAZIDE	95	74	92	70	-3.16%
LORAZEPAM	95	72	92	71	-3.16%
AZITHROMYCIN	170	36	92	72	-45.88%
ALPRAZOLAM	106	61	91	73	-14.15%
SPIRONOLACTONE	103	66	91	74	-11.65%
VYVANSE	125	52	90	75	-28.00%
POLYETHYLENE GLYCOL 3350	78	80	89	76	14.10%
SULFAMETHOXAZOLE/TRIMETHO	104	65	87	77	-16.35%
FLUCONAZOLE	76	81	84	78	10.53%
ZOLPIDEM TARTRATE	72	83	83	79	15.28%
DEXMETHYLPHENIDATE HYDROC	95	73	82	80	-13.68%
ALBUTEROL SULFATE	96	71	82	81	-14.58%

IOWA | Health and Human Services

TOP 100 DRUGS BY PRESCRIPTION COUNT

DRUG DESCRIPTION	March through May 2025	PREVIOUS RANK	June through August 2025	RANK	PERCENT CHANGE
SYMBICORT	69	85	77	82	11.59%
GLYCOPYRROLATE	69	86	76	83	10.14%
ACETAMINOPHEN	55	102	72	84	30.91%
VRAYLAR	68	88	71	85	4.41%
NALTREXONE HYDROCHLORIDE	70	84	71	86	1.43%
MUPIROCIN	55	105	65	87	18.18%
ONDANSETRON HYDROCHLORIDE	56	101	63	88	12.50%
CARVEDILOL	67	90	62	89	-7.46%
TIZANIDINE HYDROCHLORIDE	55	103	62	90	12.73%
NAPROXEN	61	95	57	91	-6.56%
DIVALPROEX SODIUM DR	56	100	56	92	0.00%
HYDROXYZINE HCL	67	92	56	93	-16.42%
DESVENLAFAXINE ER	63	94	55	94	-12.70%
BENZTROPINE MESYLATE	49	115	55	95	12.24%
METOPROLOL TARTRATE	60	98	55	96	-8.33%
OXCARBAZEPINE	67	89	55	97	-17.91%
FERROUS SULFATE	47	118	54	98	14.89%
ALLERGY RELIEF	50	112	54	99	8.00%
VALACYCLOVIR HYDROCHLORID	92	75	54	100	-41.30%

Medicaid Statistics for Prescription Claims
June through August 2025

Tri-Monthly Statistics

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare	Total**
Total Dollars Paid	$3,310,065	$107,645,344	$83,651,463	$57,616,741	$252,223,614
Users	3,261	97,193	88,453	76,607	265,514
Cost Per User	$1,015.05	$1,107.54	$945.72	$752.11	
Total Prescriptions	21,727	780,225	632,369	478,450	1,912,771
Average Rx/User	6.66	8.03	7.15	6.25	
Average Cost/Rx	$152.35	$137.97	$132.28	$120.42	
# Generic Prescriptions	19,661	695,155	566,078	433,104	
% Generic	90.5%	89.1%	90.0%	90.5%	
$ Generic	$998,668	$14,286,205	$10,564,208	$7,930,457	
Average Generic Rx Cost	$50.79	$20.55	$18.66	$18.31	
Average Generic Days Supply	27	28.55	29	27.14	
# Brand Prescriptions	2,066	85,070	65,283	45,346	
% Brand	9.5%	10.9%	10.0%	9.5%	
$ Brand	$2,311,389	$93,359,139	$73,063,362	$49,686,284	
Average Brand Rx Cost	$1,118.78	$1,097.44	$1,119.18	$1,095.71	
Average Brand Days Supply	28	27.7	29	28.3	

**All reported dollars are pre-rebate

Top 20 Therapeutic Class by Paid Amount*

June through August 2025

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

* Pre-rebate

Top 20 Therapeutic Class by Prescription Count

June through August 2025

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

Top 25 Drugs by Paid Amount**

June through August 2025

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
1	EVRYSDI	OZEMPIC	OZEMPIC	OZEMPIC
2	OZEMPIC	VRAYLAR	HUMIRA PEN	DUPIXENT
3	HUMIRA PEN	HUMIRA (CF) PEN	DUPIXENT	HUMIRA (2 PEN)
4	VRAYLAR	DUPIXENT PEN	TRIKAFTA	VRAYLAR
5	BIKTARVY	MOUNJARO	VRAYLAR	BIKTARVY
6	DUVYZAT	JARDIANCE	JARDIANCE	SKYRIZI PEN
7	RAVICTI	STELARA	INVEGA SUSTENNA	TRIKAFTA
8	DUPIXENT	TRIKAFTA	SKYRIZI PEN	JARDIANCE
9	JARDIANCE	SKYRIZI PEN	BIKTARVY	STELARA
10	SKYRIZI PEN	INVEGA SUSTENNA	MOUNJARO	INVEGA SUSTENNA
11	FINTEPLA	BIKTARVY	STELARA	DUVYZAT
12	KISQALI	REXULTI	TALTZ	ELIQUIS
13	ENBREL SURECLICK	ELIQUIS	ELIQUIS	TALTZ
14	INGREZZA	TALTZ AUTOINJECTOR	TRULICITY	TRULICITY
15	KESIMPTA	TRULICITY	REXULTI	MOUNJARO
16	VYVANSE	NURTEC ODT	INGREZZA	HEMLIBRA
17	WAKIX	STRENSIQ	ARISTADA	RINVOQ
18	REXULTI	ALTUVIIIO	NURTEC	ALTUVIIIO
19	COSENTYX UNOREADY	INGREZZA	ALTUVIIIO	ENBREL SURECLICK
20	STELARA	WAKIX	ENBREL SURECLICK	ABILIFY MAINTENA
21	EPIDIOLEX	DUPIXENT SYRINGE	LISDEXAMFETAMINE	REXULTI
22	ONFI	RINVOQ	CAPLYTA	COSENTYX UNOREADY
23	ARISTADA	EVRYSDI	INVEGA TRINZA	ARISTADA
24	ALBUTEROL SULFATE HFA	ENBREL SURECLICK	FARXIGA	SKYRIZI
25	TRIKAFTA	TRELEGY ELLIPTA	ABILIFY MAINTENA	FARXIGA

** Pre-rebate

Top 25 Drugs by Prescription Count

June through August 2025

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
1	TRAZODONE	OMEPRAZOLE	OMEPRAZOLE	OMEPRAZOLE
2	FLUOXETINE	TRAZODONE	ALBUTEROL	AMOXICILLIN
3	ALBUTEROL	SERTRALINE	TRAZODONE	SERTRALINE
4	GABAPENTIN	LEVOTHYROXINE	BUPROPION	ALBUTEROL HFA
5	ESCITALOPRAM	BUPROPION XL	SERTRALINE	TRAZODONE
6	METHYLPHENIDATE	ALBUTEROL HFA	LEVOTHYROXINE	LEVOTHYROXINE
7	LEVOTHYROXINE	FLUOXETINE	FLUOXETINE	BUPROPION XL
8	SERTRALINE	ATORVASTATIN	ATORVASTATIN	ATORVASTATIN
9	CETIRIZINE	GABAPENTIN	AMPHET/DEXTROAMPHET	FLUOXETINE
10	CLONIDINE	ESCITALOPRAM	GABAPENTIN	ESCITALOPRAM
11	ATORVASTATIN	HYDROXYZINE HCL	ESCITALOPRAM	GABAPENTIN
12	AMPHETAMINE/DEXTROAMPHET	CETIRIZINE	CETIRIZINE	HYDROXYZINE HCL
13	HYDROXYZINE HCL	MONTELUKAST	HYDROXYZINE HCL	BUSPIRONE
14	BUPROPION	BUSPIRONE	BUSPIRONE	LISINOPRIL
15	QUETIAPINE	PANTOPRAZOLE	METHYLPHENIDATE	PANTOPRAZOLE
16	BUSPIRONE	LISINOPRIL	MONTELUKAST	QUETIAPINE
17	MONTELUKAST	CLONIDINE	METFORMIN	MONTELUKAST
18	LISINOPRIL	QUETIAPINE	LISINOPRIL	PREDNISONE
19	ARIPIPRAZOLE	LAMOTRIGINE	PANTOPRAZOLE	AMPHET/DEXTROAMPHET
20	OMEPRAZOLE	ARIPIPRAZOLE	QUETIAPINE	DULOXETINE
21	RISPERIDONE	DULOXETINE	CLONIDINE	AMLODIPINE
22	PANTOPRAZOLE	AMPHET/DEXTROAMPHET ER	AMOXICILLIN	CLONIDINE
23	AMLODIPINE	FAMOTIDINE	GUANFACINE	ARIPIPRAZOLE
24	OZEMPIC	AMOXICILLIN	DULOXETINE	HYDROCODONE/APAP
25	LEVETIRACETAM	TOPIRAMATE	ARIPIPRAZOLE	AMOXICILLIN/CLAVULANATE

Risk of Hyperthermia with Scopolamine Patch
RetroDUR
Data

Purpose
Identify prescribers of scopolamine patch to educate them on the recent U.S. Food and Drug Administration (FDA) safety warning about the risk of hyperthermia. This outreach will help ensure that critical safety information reaches prescribers of this medication.

Background
- The FDA recently issued a Drug Safety Communication warning about Transderm Scōp (scopolamine transdermal system) due to reports of hyperthermia linked to its use, which have resulted in hospitalizations or deaths.
- Most instances occurred within 72 hours of patch application.
- Children under 18 and adults over 60 appear to be at greater risk, with hyperthermia occurring within 72 hours of application.
- Transderm Scōp (scopolamine transdermal system) is an anticholinergic indicated in adults for the prevention of:
    - Nausea and vomiting associated with motion sickness.
    - Post-operative nausea and vomiting associated with recovery from anesthesia and/or opiate analgesia and surgery.
- Transderm Scōp (scopolamine transdermal system) is not FDA-approved for pediatric use, though it may be prescribed in children to manage excessive drooling in children with cerebral palsy or other neurological disorders.
    - Transderm Scōp is preferred on the preferred drug list (PDL) while the generic scopolamine patch is non-preferred.
- The FDA has required the prescribing information be revised to include a warning and other information about the risk of hyperthermia.

DUR Criteria
- Time Period: April 1, 2025 through June 30, 2025
- Identify members with one or more claims for scopolamine transdermal patch
    - Break out by members < 18 years of age, 18 to 59 years of age, and 60+ years of age.
    - Report the number of unique prescribers

Data

	ITC		MHC		WLP		FFS	
Age Band	**Mbr**	**Presc.**	**Mbr**	**Presc.**	**Mbr**	**Presc.**	**Mbr**	**Presc.**
< 18	6	6	6	6	13	13	2	2
18-59	19	18	60	62	46	44	2	2
60+	2	2	2	2	3	3	0	0
Total	27	25	62	70	62	59	4	4

FFS – Fee-for-Service; ITC - Iowa Total Care; Mbr – member; MHC = Molina Healthcare; Presc. – prescriber; WLP – Wellpoint

Next Steps

1. Send letters to all prescribers identified as prescribing scopolamine patch to educate them on the recent FDA safety warning about the risk of hyperthermia to ensure that critical safety information reaches prescribers of this medication?
2. Send letters to prescribers of members in the high-risk groups (< 18 and ≥ 60 years old) to educate them on the recent FDA safety warning about the risk of hyperthermia?
3. Other?
4. None?

Utilization of SGLT2 Inhibitors in Members with Chronic Kidney Disease
RetroDUR
Data

Purpose
To identify members with chronic kidney disease (CKD) without a sodium-glucose co-transporter 2 (SGLT2) inhibitor in pharmacy claims.

Background
- SGLT2 inhibitors have been proven to reduce the progression of CKD and lower cardiovascular risk in patients with or without diabetes.
- Clinical guidelines from KDIGO and ADA recommend SGLT2 inhibitors as first-line therapy in eligible patients.
- Despite this, evidence suggests that uptake remains low.
- Preferred SGLT2 inhibitors do not require prior authorization (PA).
- Single agent SGLT2 inhibitors vary in indications.
- Combination agent SGLT2 inhibitors are FDA approved only for the treatment of type 2 diabetes.

SGLT2 Inhibitors (Preferred agents as of 7/1/2025 PDL bolded and italicized)

Single Agent SGLT2 Inhibitors	Combination Agent SGLT2 Inhibitors
Dapagliflozin (***Farxiga***)	Empagliflozin + linagliptin (Glyxambi)
Empagliflozin (***Jardiance***)	Empagliflozin + metformin (***Synjardy***)
Canagliflozin (Invokana)	Empagliflozin + linagliptin + metformin XR (Trijardy XR)
Etrugliflozin (Steglatro)	Dapagliflozin + saxagliptin (Qtern)
	Dapagliflozin + metformin (***Xigduo XR***)
	Canagliflozin + metformin (Invokamet XR)
	Ertugliflozin + sitagliptin (Steglujan)
	Ertugliflozin + metformin (Segluromet)

Single Agent SGLT2 Inhibitor Indications

Medication	FDA-Approved Indications
Dapagliflozin (***Farxiga***)	• Type 2 diabetes (adults and children ≥ age 10) • Heart failure (regardless of ejection fraction) • CKD with or without diabetes
Empagliflozin (***Jardiance***)	• Type 2 diabetes (adults and children ≥ age 10) • Cardiovascular death risk reduction in T2D + CVD • CKD risk reduction
Canagliflozin (Invokana)	• Type 2 diabetes (adults) • Cardiovascular death risk reduction in T2D + CVD • Diabetic kidney disease with albuminuria: delay CKD progression and reduce heart failure
Ertugliflozin (Steglatro)	• Type 2 diabetes (adults)

CKD – chronic kidney disease; CVD – cardiovascular disease; T2D – type 2 diabetes

RDUR Criteria

- Members ≥ 18 years of age with a diagnosis of CKD (ICD-10 N18.xxx)
    - With continuous eligibility during the 6-month pharmacy claim period
    - Medical claims: January 1, 2024 through June 30, 2025
- Pharmacy claims: January 1, 2025 through June 30, 2025
    - Exclude members where Medicaid is the secondary payor
- Identify members with and without a pharmacy claim for a SGLT2 inhibitor (single and combination agent); report total for each
    - Break those members out by those with and without diabetes (ICD-10 E11.xxx)
- Exclude members with end stage renal disease (ESRD) or dialysis (ICD-10 N18.6, Z99.2, Z91.15)

Data

Iowa Total Care

Distinct Member Count	Diabetes Dx		
SGLT2 Claim	N	Y	Grand Total
N	1477	415	1892
Y	113	279	392
Grand Total	**1590**	**694**	**2284**

Molina

Distinct Member Count	Diabetes Dx		
SGLT2 Claim	N	Y	Grand Total
N	407	242	649
Y	36	81	117
Grand Total	**443**	**323**	**766**

Wellpoint

Distinct Member Count	Diabetes Dx		
SGLT2 Claim	N	Y	Grand Total
N	70	968	1038
Y	1282	258	1540
Grand Total	**1352**	**1226**	**2578**

FFS

Distinct Member Count	Diabetes Dx		
SGLT2 Claim	N	Y	Grand Total
N	33	24	57
Y	0	12	12
Grand Total	**33**	**36**	**69**

Next Steps

1. Send letters to prescribers identified as having members with a diagnosis of CKD without a claim for an SGLT2 inhibitor, outlining current guideline recommendations for SGLT2 inhibitors as first line therapy in eligible patients and include details on preferred agents within the class?
2. Send letters to prescribers identified as having a diagnosis of CKD and diabetes without a claim for an SGLT2 inhibitor, outlining current guideline recommendations for SGLT2 inhibitors as first line therapy in eligible patients and include details on preferred agents within the class?
3. DUR Digest Article?
4. Other?

Duplicate Short-Acting Opioids
RetroDUR
Proposal

Purpose
Identify members that have overlapping claims for two or more chemically distinct short-acting opioids.

Background
- Concurrent use of short-acting opioids may increase the risk of overdose, sedation, and misuse.
- The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act required states to implement minimum opioid standards within their Medicaid programs.
- One of the provisions of the SUPPORT Act requires states to monitor duplicate therapy with opioids.
- Review of these claims consistently finds chronic use of two or more short-acting opioids.
- The CDC's 2022 Clinical Practice Guideline does not recommend routine use of multiple opioids.
- Current Iowa Medicaid opioid restrictions include:
    - PA for MME > 90
    - Short-acting opioids limited to 6 units per day, unless otherwise indicated on the quantity limit list

DUR Criteria
- Time Period: August 1, 2025 through October 31, 2025
- Identify members with ≥ 2 chemically distinct short-acting opioids with ≥ 60 days overlap in the 90-day period
    - Break out by members < 18 years of age and 18+ years of age
- Report number of member and number of prescribers
- Exclude members with sickle cell disease (D57) and cancer (C00-C97)

Drug Holiday in Long-term Bisphosphonate Utilizers Proposal

Purpose

- Identify members with long-term bisphosphonate utilization of greater than three years who may be candidates for a drug holiday.

Background

- A drug holiday from bisphosphonates may be considered on a case-by-case basis for members with low/moderate risk of fracture that have been taking the medication for three to five years.[1]
- Risk of atypical femoral fractures increase with duration of use.
- Package inserts for Fosamax and Boniva include an optimal duration Limitation of Use.
- Alendronate is preferred on the PDL without PA.

RDUR Criteria

- Pharmacy claim lookback: October 1, 2022, through October 1, 2025.
- Members with utilization of an oral bisphosphonate for ≥3 years.
    - Members must have continuous eligibility during the pharmacy claim lookback period.
    - Member data from Molina will be effective starting July 1, 2023.
- Report on unique members and unique providers.
- Medications:
    - Alendronate (Fosamax)
    - Ibandronate (Boniva)
    - Risedronate (Actonel)

References

1. Eastell R., Rosen C.J., Black D.M., Cheung A.M., Murad M.H., Shoback D. Pharmacological Management of Osteoporosis in Postmenopausal Women: An Endocrine Society* Clinical Practice Guideline. J. Clin. Endocrinol. Metab. 2019;104:1595–1622. doi: 10.1210/jc.2019-00221

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 10/01/2025

Acute Migraine Treatments *Use Acute Migraine Treatments PA form*	No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions: 1. A diagnosis of acute migraine; and 2. Patient meets the FDA approved age for requested agent; and 3. For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or 4. For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or 5. For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or 6. For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
ADD/ADHD/ NARCOLEPSY AGENTS *Use CNS Stimulants PA form*	*See CNS Stimulants Prior Authorization (PA) Criteria.*
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors	Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions: 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 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 3. Patient will continue to follow an appropriate low-fat diet; and 4. Patient has one of the following diagnoses: a. Heterozygous familial hypercholesterolemia (HeFH); or b. Primary hyperlipidemia; or 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 d. At risk for a CVD event but without established CVD (e.g. diabetes mellitus (type 1 or 2), a Reynolds Risk score > 20% or a SCORE Risk score > 7.5% over 10 years, a coronary artery calcium score > 300 Agatston units); and 5. Meets one of the following: a. Patient must be adherent to lipid lowering medication therapy and is unable to reach LDL-C goal with a minimum of two separate,

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

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

Updated 10/01/2025

Use Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors PA form	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 b. Patient is statin intolerant as documented by an inability to tolerate at least two chemically distinct statins; or c. Patient has an FDA labeled contraindications to all statins; and 6. Goal is defined as a 50% reduction in untreated baseline LDL-C. 7. Concurrent use with a PCSK9 inhibitor will not be considered. 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: 1. Patient continues with lipid lowering therapy at a maximally tolerated dose; or 2. Patient is intolerant to or has a contraindication to statins; and 3. Patient continues to follow an appropriate low-fat diet; and 4. Documentation of a positive response to therapy (e.g., LDL-C reduction). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Age Edit Override – Codeine or Tramadol *Use Age Edit Override-Codeine or Tramadol PA form*	An age edit override for codeine or tramadol is required for patients under 18 years of age. Payment will be considered under the following conditions: 1. Member is 12 years of age or older; and 2. Medication is not being prescribed to treat pain after surgery following tonsil and/or adenoid procedure for members 12 to 18 years of age; and 3. If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m^2), does not have obstructive sleep apnea, or severe lung disease.
Alpelisib (Vijoice) *Use Alpelisib (Vijoice) PA form*	Prior authorization (PA) is required for alpelisib (Vijoice). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and *2.* Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing demonstrating a *PIK3CA* mutation; and 3. Patient's condition is severe or life-threatening requiring systemic therapy as determined by treating prescriber: and 4. Patient has at least one target lesion identified on imaging. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by a reduction in sum of measurable lesion volume across 1 to 3 target lesions.

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Alpha$_1$-Proteinase Inhibitor Enzymes *Use Alpha$_1$-Proteinase Inhibitor Enzymes PA form*	Prior authorization (PA) is required for Alpha$_1$-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha$_1$-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following is met: 1. Patient has a diagnosis of congenital alpha$_1$-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or a. 80mg/dl if measured by radial immunodiffusion, or b. 50mg/dl if measured by nephelometry; and 2. Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and 3. Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV$_1$); and 4. Patient is 18 years of age or older; and 5. Patient is currently a non-smoker; and 6. Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and 7. Medication will be administered in the member's home by home health or in a long-term care facility. If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met: 1. Evidence of clinical efficacy, as documented by: a. An elevation of AAT levels (above protective threshold i.e., > 11µM/L); and b. A reduction in rate of deterioration of lung function as measured by a decrease in the FEV$_1$ rate of decline; and 2. Patient continues to be a non-smoker; and 3. Patient continues supportive therapy for obstructive lung disease.
Amylino Mimetic (Symlin) *Use Amylino Mimetic (Symlin) PA form*	Prior authorization (PA) is required for amylino mimetics (Symlin). Payment will be considered under the following conditions: 1. Diagnosis of Type 1 or Type 2 diabetes mellitus, 2. Concurrent use of insulin therapy, 3. Documentation of blood glucose monitoring three or more times daily, 4. Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments. Initial authorizations will be approved for six months; additional PAs will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial PA period.

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 10/01/2025

Antidepressants *Aplenzin* *Auvelity* *Fetzima* *Use Antidepressants PA form*	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: 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 a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and 3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant; and 5. Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and 6. Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and 7. Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and 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 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Anti-Diabetics, Non-Insulin Agents *Use Anti-Diabetics, Non-Insulin PA form*	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: 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. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and 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 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Requests for weight loss, which is not a covered diagnosis of use, will be denied.

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

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

Updated 10/01/2025

Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents *Use Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents form*	Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. Payment for Antiemetic-5HT3 Receptor Agonists/ Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation. PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy. Aprepitant (N)/Emend (P): 4 – 125mg capsules 8 – 80mg capsules Dolasetron (N)/Anzemet (N): 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) Granisetron (N): 8 – 1mg tablets 8 vials (1mg/mL) 2 vials (4mg/mL) Akynzeo (N): 2 – 300/0.5mg capsules Ondansetron (P)/Zofran (N): 60 – 4mg tablets 60 – 8mg tablets 4 – 24mg tablets 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) Ondansetron ODT (P)/Zofran ODT (N): 60 – 4mg tablets 60 – 8mg tablets Ondansetron Oral Solution (N)/ Zofran Oral Solution (N) 50mL/month – oral solution (4mg/5mL)
Anti-Fungal- Oral / Injectable *Use Anti-Fungal PA form*	Prior authorization (PA) is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. PA will be required for all non-preferred antifungal therapy beginning the first day of therapy. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for any antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This PA requirement does not apply to nystatin.
Antihistamines *Use Antihistamine PA form*	Prior authorization (PA) is required for all non-preferred oral antihistamines. Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require PA, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine. Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

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

Updated 10/01/2025

Apremilast (Otezla) *Use Apremilast (Otezla) PA form*	Prior authorization (PA) is required for apremilast (Otezla). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 2. Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); with a. Documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 3. Patient has a diagnosis of plaque psoriasis; with a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; or 4. Patient has a diagnosis of Behçet disease; with a. Documentation of active oral ulcers associated with Behçet disease; and b. Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Aprocitentan (Tryvio) *Use Aprocitentan (Tryvio) PA form*	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: 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) inhibitors or angiotensin receptor blockers (ARB); b. Calcium Channel-blockers (CCB); c. Diuretics; 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.

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Updated 10/01/2025

Aripiprazole Tablets with Sensor (Abilify MyCite) *Use Aripiprazole Tablets with Sensor (Abilify MyCite) PA form*	Prior authorization is required for aripiprazole tablets with sensor (Abilify MyCite). Payment will be considered under the following conditions: 1. Patient has a diagnosis of Schizophrenia, Bipolar I Disorder, or Major Depressive Disorder; and 2. Patient meets the FDA approved age for use of the Abilify MyCite device; and 3. Dosing follows the FDA approved dose for the submitted diagnosis; and 4. Documentation of patient adherence to generic aripiprazole tablets is less than 80% within the past 6 months (prescriber must provide documentation of the previous 6 months' worth of pharmacy claims for aripiprazole documenting non-adherence); and 5. Documentation all the following strategies to improve patient adherence have been tried without success: a. Utilization of a pill box b. Utilization of a reminder device (e.g. alarm, application, or text reminder) c. Involving family members or friends to assist d. Coordinating timing of dose with dosing of another daily medication; and 6. Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; and 7. Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite. Initial approvals will be given for one month. Prescriber must review member adherence in the web-based portal and document adherence for additional consideration. If non-adherence continues, prescriber must document a plan to improve adherence. If adherence is improved, consideration to switch member to generic aripiprazole tablets must be considered. Note, the ability of Abilify MyCite to improve patient compliance has not been established, 8. Requests will not be considered for patients in long-term care facilities. 9. A once per lifetime approval will be allowed. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Baclofen *Use Baclofen PA form*	Prior authorization (PA) is required for non-preferred baclofen dosage forms. Payment for a non-preferred agent will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient has a diagnosis of spasticity resulting from multiple sclerosis (relief of flexor spasms and concomitant pain, clonus, and muscular rigidity) or spinal cord injuries/diseases; and 2. Patient meets the FDA approved age; and 3. Documentation of a patient-specific, clinically significant reason (beyond convenience) why the member cannot use baclofen oral tablets, even when tablets are crushed and sprinkled on soft food or liquid. Presence of a nasogastric (NG) tube/J-tube alone are not reasons for approval; and 4. Request does not exceed the maximum dosage of 80mg daily.

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Updated 10/01/2025

Benzodiazepines *Use Benzodiazepine PA form*	Prior authorization (PA) is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member. PA will be approved for up to 12 months for documented: 1. Generalized anxiety disorder. 2. Panic attack with or without agoraphobia. 3. Seizure. 4. Non-progressive motor disorder. 5. Dystonia. PA requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines. For patients taking concurrent opioids, the prescriber must document the following: 1. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and 2. Documentation as to why concurrent use is medically necessary is provided; and 3. A plan to taper the opioid or benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Biologicals for Arthritis *Use Biologicals for Arthritis PA form*	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: 1. Patient has a diagnosis of rheumatoid arthritis (RA); with a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxycholoroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated); or 2. Patient has a diagnosis of moderate to severe psoriatic arthritis; with a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 3. Patient has a diagnosis of juvenile idiopathic arthritis with oligoarthritis; with 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 4. Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (pJIA); with 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 5. Patient has a diagnosis of systemic juvenile idiopathic arthritis (sJIA). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Biologicals for Axial Spondyloarthritis *Use Biologicals for Axial Spondyloarthritis PA form*	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: 1. Patient has a diagnosis of: a. ankylosing spondylitis (AS) or b. nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and 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 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 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Biologicals for Inflammatory Bowel Disease *Use Biologicals for Inflammatory Bowel Disease PA form*	Prior authorization (PA) is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling 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: 1. Patient has a diagnosis of moderate to severe Crohn's Disease; or 2. Patient has a diagnosis of moderate to severe Ulcerative Colitis; and 3. Medication will be administered in the patient's home by patient or patient's caregiver. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Biologicals for Hidradenitis Suppurativa *Use Biologicals for Hidradenitis Suppurativa PA form*	Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 3. Patient has at least three (3) abscesses or inflammatory nodules; and 4. Patient has documentation of adequate trials and therapy failures with the following: a. Daily treatment with topical clindamycin; b. Oral clindamycin plus rifampin; c. Maintenance therapy with a preferred tetracycline. If criteria for coverage are met, initial requests will be given for 4 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Biologicals for Plaque Psoriasis *Use Biologicals for Plaque Psoriasis PA form*	Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling 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: 1. Patient has a diagnosis of moderate to severe plaque psoriasis; and 2. Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2025

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

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Updated 10/01/2025

Cholic Acid (Cholbam) *Use Cholic Acid (Cholbam) PA form*	Prior authorization (PA) is required for cholic acid (Cholbam). Payment will be considered under the following conditions: 1. Is prescribed by a hepatologist or pediatric gastroenterologist; and 2. Is prescribed for a diagnosis of bile acid synthesis disorder due to a single enzyme defect (SED) including: a. 3-beta-hydroxy-delta-5C27-steroid oxidoreductase deficiency (3β-HSD), b. aldo-keto reductase 1D1 (AKR1D1), c. alpha-methylacyl-CoA racemase deficiency (AMACR deficiency), d. sterol 27-hydroxylase deficiency (cerebrotendinous xanthomatosis [CTX]), e. cytochrome P450 7A1 (CYP7A1), f. 25-hydroxylation pathway (Smith-Lemli-Opitz); OR 3. Is prescribed as an adjunctive treatment of a peroxisomal disorder (PD) in patients who exhibit manifestations of liver disease, steatorrhea, or complications from fat soluble vitamin absorption. Peroxisomal disorders include Zellweger syndrome (ZWS), neonatal adrenoleukodystrophy (NALD), or infantile refsum disease (IRD); and 4. Diagnosis is confirmed by mass spectrometry or other biochemical testing or genetic testing (attach results); and 5. Baseline liver function tests are taken prior to initiation of therapy (AST, ALT, GGT, ALP, total bilirubin, INR) and provided with request; and 6. Patient must have elevated serum aminotransferases (AST and ALT) with normal serum gamma glutamyltransferase (GTT); and 7. Patient is at least 3 weeks old. When criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 12 months at a time requiring documentation of response to therapy by meeting two of the following criteria: 1. Body weight has increased by 10% or is stable at $\geq 50^{th}$ percentile, 2. Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) < 50 U/L or baseline levels reduced by 80%, 3. Total bilirubin level reduced to ≤1mg/dL.

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Updated 10/01/2025

CNS Stimulants	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: 1. Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening, and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. Use of an amphetamine agent plus a methylphenidate agent will not be considered for a diagnosis of ADHD. 2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist. 4. Binge Eating Disorder (Vyvanse only) a. Patient is 18 to 55 years of age; and b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and c. Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and d. Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and e. Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and f. Patient has a BMI of 25 to 45; and g. Patient does not have a history of cardiovascular disease; and h. Patient has no history of substance abuse; and i. Is not being prescribed for the treatment of obesity or weight loss; and j. Doses above 70mg per day will not be considered. k. Initial requests will be approved for 12 weeks. l. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week. <u>DSM-5 Criteria</u> i. Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control overeating; and ii. The binge eating episodes are marked by at least three of the following:

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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 10/01/2025

Use CNS Stimulants or Binge Eating Disorder Agents PA form	1. Eating more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of embarrassment by the amount of food consumed 5. Feeling disgusted with oneself, depressed, or guilty after overeating; and iii. Episodes occur at least 1 day a week for at least 3 months; and iv. No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and v. Does not occur solely during the course of bulimia nervosa or anorexia nervosa. <u>Moderate to Severe BED</u> Based on the number of binge eating episodes per week: Moderate - 4 to 7 Severe – 8 to 13 Extreme – 14 or more Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred extended-release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Crisaborole (Eucrisa) *Use Crisaborole (Eucrisa) PA form*	Prior authorization (PA) is required for Eucrisa (crisaborole). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of mild to moderate atopic dermatitis; and 3. Patient has failed to respond to good skin care and regular use of emollients; and 4. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 5. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 6. Patient will continue with skin care regimen and regular use of emollients. 7. Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2025

Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) *Use Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) PA form*	Prior authorization (PA) is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and 3. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and 4. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and 5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 6. Is not prescribed in combination with other ophthalmic cyclosporine products. The required trials may be overridden when documented evidence is provided that 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.
Cystic Fibrosis Agents, Oral *Kalydeco* *Orkambi* *Symdeko* *Trikafta* *Use Cystic Fibrosis Agents, Oral PA form*	Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of cystic fibrosis; and 3. Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and 4. Prescriber is a CF specialist or pulmonologist; and 5. Baseline liver function tests (AST, ALT, and bilirubin) are provided; and 6. Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and 7. Will not be used with other CFTR modulator therapies. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Adherence to oral cystic fibrosis therapy is confirmed; and 2. Liver function tests (AST, ALT, and bilirubin) are assessed every 3 months during the first year of treatment and annually thereafter.
Dalfampridine (Ampyra) *Use Dalfampridine (Ampyra™) PA form*	Prior authorization (PA) is required for dalfampridine (Ampyra). Payment will be considered under the following conditions: 1. For patients that have a gait disorder associated with MS. 2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3. Additional PAs will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. PAs will not be considered for patients with a seizure diagnosis or in patients with moderate to severe renal impairment.

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Updated 10/01/2025

Deferasirox (Exjade) *Use Deferasirox (Exjade) PA form*	Prior authorization (PA) is required for deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions: 1. Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance <40mL/min; and 2. Patient does not have a poor performance status; and 3. Patient does not have a high-risk myelodysplastic syndrome; and 4. Patient does not have advanced malignancies; and 5. Patient does not have a platelet count < 50 x 10^9/L. **Transfusional Iron Overload** Initiation of Therapy 1. Patient is 2 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overlaod; and 4. Serum ferritin is consistently > 1000 mcg/L (attach lab results dates within the past month); and 5. Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6. Initial requests will be considered for up to 3 months. Continuation of Therapy 1. Serum ferritin has been measured within 30 days of continuation of therapy request (attach documentation); and 2. Ferritin levels are > 500mcg/L; and 3. Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day. **Non-Transfusional Iron Overload** Initiation of Therapy 1. Patient is 10 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4. Serum ferritin levels are > 300mcg/L; and 5. LIC are > 5mg Fe/g dw; and 6. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7. Initial authorization will be considered for up to 6 months. Continuation of Therapy 1. Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and 2. Serum ferritin levels are ≥ 300mcg/L; and 3. LIC is ≥ 3mg Fe/g dw; and 4. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw).

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Updated 10/01/2025

Deucravacitinib (Sotyktu) *Use Deucravacitinib (Sotyktu) PA form*	Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis; and a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine is provided; and b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Dextromethorphan and Quinidine (Nuedexta) *Use Dextromethorphan and Quinidine (Nuedexta) PA form*	Prior authorization (PA) is required for Nuedexta. Payment will be considered under the following conditions: 1. Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition. 2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and 3. Patient has documentation of a current EKG (within the past 3 months) without QT prolongation. 4. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire. 5. Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Dornase Alfa (Pulmozyme) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Pulmozyme. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.

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Dupilumab (Dupixent)	Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient's current weight in kilograms (kg) is provided; and 3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and a. Patient has failed to respond to good skin care and regular use of emollients; and 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 c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and d. Patient will continue with skin care regimen and regular use of emollients; or 4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and a. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta $_2$ 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 c. Patient must have one of the following, in addition to the regular maintenance medications defined above: i. One (1) or more exacerbations in the previous year or ii. Require daily oral corticosteroids for at least 3 days; or 5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and a. Documentation dupilumab will be used as an add-on maintenance treatment; and b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid spray; and ii. Oral corticosteroid; or 6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and

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	a. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and 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 c. Documentation of previous trials and therapy failures with all of the following: i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and iii. Dietary therapy; or 7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and a. Patient has experienced severe to very severe pruritits, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and b. Patient has ≥ 20 nodular lesions (attach documentation); and 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 8. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following: i. FEV1/FVC ratio < 0.7, and ii. FEV1 % predicted between 30% and 79%; and b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to: i. Triple therapy with all of the following treatments: 1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and 2. Long-acting beta agonist (LABA); and 3. Inhaled corticosteroid (ICS); or ii. Double therapy with both of the following if ICS is contraindicated: 1. LABA; and 2. LAMA; and 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 e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; or 9. Patient has a diagnosis of chronic spontaneous urticaria (CSU) with no known cause; and a. Patient has documentation of an adequate trial and therapy failure with a preferred second generation H1 receptor antihistamine for at least 2 weeks.
Use Dupilumab (Dupixent) PA form	If criteria for coverage are met, initial authorization will be given for 6 months for all the above indications, except for COPD and CSU, 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Duplicate Therapy Edits **Antipsychotics** **NSAIDs** *Use Duplicate Therapy Edit Override PA form*	Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.
Eluxadoline (Viberzi) *Use Eluxadoline (Viberzi) PA form*	Prior authorization (PA) is required for eluxadoline. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age. 2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D). 3. Patient does not have any of the following contraindications to therapy: a. Patient is without a gallbladder. b. Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction. c. Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day. d. A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction). e. Severe hepatic impairment (Child-Pugh Class C). f. Severe constipation or sequelae from constipation. g. Known or suspected mechanical gastrointestinal obstruction. 4. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with both of the following: a. A preferred antispasmodic agent (dicyclomine or hyoscyamine). b. A preferred antidiarrheal agent (loperamide). If criteria for coverage are met, initial authorization will be given for 3 months to assess the response to treatment. Requests for continuation of therapy will require the following: 1. Patient has not developed any contraindications to therapy (defined above). 2. Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following: a. Improvement in abdominal cramping or pain. b. Improvement in stool frequency and consistency. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Updated 10/01/2025

Ensifentrine (Ohtuvayre) *Use Ensifentrine (Ohtuvayre) PA form*	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: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe COPD when all of the following are met: a. FEV1/FVC ratio < 0.7; and b. Post-bronchodilator FEV1 % predicted of 30% to 79%; and c. Modified Medical Research Council (mMRC) dyspnea score of ≥ 2 or a COPD Assessment Test (CAT) score ≥ 10; and 3. Patient is adherent with COPD treatments, meeting one of the following criteria: a. The patient has a blood eosinophil of ≥ 100 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 b. The patient has a blood eosinophil of < 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 4. Dual or triple combination regimen will be continued in combination with ensifentrine (Ohtuvayre). 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 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.
Eplerenone (Inspra) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Inspra. Payment will be authorized only in cases where there is documented trial and therapy failure on spironolactone or documented cases of gynecomastia from spironolactone therapy.

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Erythropoiesis Stimulating Agents *Use Erythropoesis Stimulating Agent PA form*	Prior authorization (PA) is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Patients who meet all of the following criteria may receive PA for the use of erythropoiesis stimulating agents: 1. Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values must be dated within four weeks of the prior authorization request. 2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request. 3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy. 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
Extended Release Formulations *Use Extended Release Formulations PA form*	Payment for a non-preferred extended release formulation will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Prior authorization (PA) is required for the following extended release formulation(s): Amoxicillin & 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, Kapspargo, Memantine ER, Motpoly XR, Oxcarbazepine ER, Oxtellar XR, Pramipexole ER, Pregabalin ER, Qudexy XR, Rayos, Ropinirole ER, Rythmol SR, Topiramate ER, Trokendi XR.
Fentanyl, Short Acting Products *Use Short Acting Fentanyl Products PA form*	Prior authorization (PA) is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a **Black Box Warning**. Short acting fentanyl products: 1. Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain. 2. Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.

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

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

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

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Givinostat (Duvyzat) *Use Givinostat (Duvyzat) PA form*	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: 1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene: and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Is prescribed by or in consultation with a physician who specializes in treatment of DMD; and 4. Patient has documentation of a trial and inadequate response to an oral glucocorticoid for at least 6 months; and 5. Givinostat will be prescribed concurrently with an oral glucocorticoid; and 6. Patient's current body weight in kilograms (kg) is provided. 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: 1. Documentation of a positive response to therapy (e.g. improved strength, pulmonary function test, or functional assessments); and 2. Patient continues to receive concomitant glucocorticoid therapy; and 3. Patient's current body weight in kg is provided. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
GLP-1 Agonist/Basal Insulin Combinations *Use GLP-1 Agonist/Basal Insulin Combinations PA form*	Prior authorization (PA) is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met: 1. A diagnosis of type 2 diabetes mellitus; and 2. Patient is 18 years of age or older; and 3. The patient has not achieved HgbA1C goals after a minimum three-month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and 4. Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and 5. Will not be used concurrently with prandial insulin; and 6. Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and 7. Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of: a. Soliqua below 15 units or over 60 units, or b. Xultophy persistently below 16 units or over 50 units.

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

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Granulocyte Colony Stimulating Factor Agents *Use Granulocyte Colony Stimulating Factor PA form*	Prior authorization (PA) is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses: 1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy. 2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant. 3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy. 4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients. On current chemotherapy drug(s) that would cause severe neutropenia.
Growth Hormone	Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied: Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). Payment will be considered under the following conditions: Children with Growth Hormone Deficiency 1. Standard deviation of 2.0 or more below mean height for chronological age; and 2. No expanding intracranial lesion or tumor diagnosed by MRI; and 3. Growth rate below five centimeters per year; and 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and 5. Annual bone age testing is required. A Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. Pediatric Chronic Kidney Disease 1. Is prescribed by or in consultation with a nephrologist; and 2. Standard deviation of 2.0 or more below mean height for chronological age; and 3. No expanding intracranial lesion or tumor diagnosed by MRI; and 4. Growth rate below five centimeters per year; and 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. Turner's Syndrome 1. Chromosomal abnormality showing Turner's syndrome; and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. No expanding intracranial lesion or tumor diagnosed by MRI; and 5. Growth rate below five centimeters per year; and 6. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 7. Epiphyses open.

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Use Growth Hormone PA form	Prader Willi Syndrome 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. Noonan Syndrome 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 5. Epiphyses open. SHOX (Short stature Homeobox) 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. Adults with Growth Hormone Deficiency 1. Patients who were growth hormone deficient during childhood (childhood onset) and who have a continued deficiency; or 2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g., panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and 3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of ≤ 5 mcg/L after stimulation. Adults with AIDS Wasting/Cachexia 1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and 2. Patient is currently being treated with antiviral agents; and 3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol). Short Bowel Syndrome If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel Syndrome. PA will be considered for a maximum of 4 weeks. If the criteria for coverage is met, initial requests will be given for 12-month periods, unless otherwise stated above. Additional PAs will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.

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Updated 10/01/2025

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

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Updated 10/01/2025

Hepatitis C Treatments, Direct Acting Antivirals *Use Hepatitis C Treatments, Direct Acting Antivirals PA form*	Prior authorization (PA) is required for hepatitis C direct-acting antivirals (DAA). 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. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1. Patient has a diagnosis of chronic hepatitis C; and 2. Patient has had testing for hepatitis C virus (HCV) genotype; and 3. Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 4. Patient's prior HCV DAA treatment history is provided (treatment naïve or treatment experienced); and 5. DAAs approved for pediatric use will be considered for those under the age of 18 when used in accordance with current AASLD guidelines and patient's weight is provided; and 6. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. 7. If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on length of therapy for the particular treatment. 8. The 72-hour emergency supply rule does not apply to DAAs. Requests for treatment-experienced patients (with previous DAA) will be considered under the following conditions: 1. Patient must meet all criteria for treatment approval above; and 2. The requested therapy is FDA approved as therapy for treatment-experienced patients and follows current AASLD guidelines; and 3. HCV retreatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 4. Patient has not been previously treated with and failed the requested DAA therapy; and 5. Documentation is provided patient has a documented presence of detectable HCV RNA at least 12 weeks after completing previous DAA treatment.

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High Dose Opioids	Prior authorization (PA) is required for use of high-dose opioids ≥ 90 morphine milligram equivalents (MME) per day (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html). Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met: 1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and 2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and 3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants; and 5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and 6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and 7. Pain was inadequately controlled by 2 other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and 8. Chart notes from a recent office visit or telehealth visit for pain management are included documenting the following: a. Treatment plan – including all therapies to be used concurrently (pharmacologic and non-pharmacologic); and b. Treatment goals; and 9. Patient has been informed of the risks of high-dose opioid therapy; and 10. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and 11. The patient's risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and 12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and 13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and 14. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation] within the prior 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 15. Patient has been educated on opioid overdose prevention; and 16. Patient's household members have been educated on the signs of opioid overdose and how to administer an opioid reversal agent; and

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

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

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

Updated 10/01/2025

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

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	b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid; and ii. Oral corticosteroid; or 6. Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype; and a. Patient has moderate to very severe airflow limitation, measured within the past 12 months, as evidenced by both of the following: i. FEV_1/FVC ratio- < 0.7, and ii. FEV_1% predicted of 20% and 80%, and b. Patient has a minimum blood eosinophil count of 150 cells/mcL, measured within the past 12 months; and c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to therapy with: i. Triple therapy with all of the following treatments: 1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and 2. Long-acting beta2-agonist (LABA); and 3. Inhaled corticosteroid (ICS); or ii. Double therapy with both of the following if ICS is contraindicated; 1. LABA, and 2. LAMA; and 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 e. Documentation mepolizumab will be used as an add-on maintenance treatment with triple or double therapy (as defined above); and 7. Medication will be administered in the patient's home; and 8. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist. If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis, 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: Severe Asthma with an Eosinophilic Phenotype: 1. Patient continues to receive therapy with an ICS, LABA and LTRA; and 2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3. Patient has experienced a decrease in administration of rescue medication (albuterol); or 4. Patient has experienced a decrease in exacerbation frequency; or 5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline. Eosinophilic Granulomatosis with Polyangiitis 1. Patient has demonstrated a positive clinical response to therapy (increase in remission time). Hypereosinophilic Syndrome:

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

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

Updated 10/01/2025

Use IL-5 Antagonists PA form	1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and 2. Medication continues to be used in combination with stable doses or at least one other HES therapy. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) 1. Patient has demonstrated positive clinical response to therapy (improvement in symptoms); and 2. Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray. Chronic Obstructive Pulmonary Disease (COPD) 1. Patient has demonstrated positive clinical response to therapy; and 2. Continues to receive add-on maintenance therapy with triple or double therapy (as defined above). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Immunomodulators-Topical *Elidel* *Tacrolimus* *Use Immunomodulators-Topical PA form*	Prior authorization (PA) is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel) or tacrolimus 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.
Incretin Mimetics for Non-Diabetes Indications	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 (attach current lab results, obtained within 6 months of request, documenting A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); 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 with history of one of the following (attach chart notes documenting diagnosis); i. Prior myocardial infarction (MI); ii. Prior stroke (ischemic or hemorrhagic); iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2, 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 ≥ 45 years of age; and ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and

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

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

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Use Incretin Mimetics for Non-Diabetes Indications PA form	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 ≥ 30 kg/m^2; and b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 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; and 5. Patient will 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. 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: 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; and 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); and 3. Patient does not have type 1 or type 2 diabetes; and 4. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and 5. The requested agent will not be used in combination with other incretin mimetics.

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 10/01/2025

Initial Days' Supply Limit Override *Use Initial Days' Supply Limit Override PA form*	Requests for medications exceeding the initial days' supply limit require prior authorization. Payment will be considered under the following conditions: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Medical rationale for exceeding the initial days' supply limit is provided; and 4. Requests for opioids exceeding the 7 day initial supply limit will be considered: a. For patients with active cancer, patients experiencing acute sickle cell crises, end-of-life/palliative care, or on an individual case-by-case basis based on medical necessity documentation provided; and b. Request must meet all other opioid requirements (quantity limits, morphine milligram equivalents (MME), and the preferred drug list (PDL). If requests do not comply with these requirements, separate, additional, prior authorization is required. Please reference and use the following prior authorization (PA) forms at www.iowamedicaidpdl.com where appropriate: i. Quantity Limit Override Form (exceeds established quantity limit) ii. High Dose Opioid PA Form (exceeds established MME limit) iii. Short-Acting Opioids PA Form (non-preferred short-acting opioids) iv. Long-Acting Opioids PA Form (non-preferred long-acting opioids); or 5. Requests for benzodiazepines exceeding the 7 day initial supply limit will be considered: a. For patients with active cancer, end-of-life/palliative care, seizure disorder, or on an individual case-by-case basis based on medical necessity documentation provided; and b. For patients taking concurrent opioids, the prescriber must document the following: i. The risks of using an opioid and benzodiazepine concurrently have been discussed with the patient; and ii. Documentation is provided as to why concurrent use is medically necessary; and iii. A plan to taper the opioid is provided, if appropriate; and c. Request must meet all other benzodiazepine requirements (quantity limit, PDL, etc). If requests do not comply with these requirements, separate, additional prior authorization is required. Please use the following PA forms at www.iowamedicaidpdl.com where appropriate: i. Benzodiazepines (non-preferred benzodiazepine) ii. Quantity Limit Override (as posted at www.iowamedicaidpdl.com under Billing/Quantity Limits); and 6. Requests for drugs or drug classes subject to the initial days' supply limit not listed above, will be considered on an individual case-by-case basis, based on medical necessity documentation provided.

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

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

Updated 10/01/2025

Isotretinoin (Oral) *Use Oral Isotretinoin PA form*	Prior authorization (PA) is required for oral isotretinoin therapy. Payment will be considered for preferred oral isotretinoin products for moderate to severe acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative (tretinoin or adapalene) therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative therapy are not required for approval for treatment of acne conglobata; and 2. Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE program. Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 24 weeks. A minimum of 8 weeks without therapy is required to consider subsequent authorizations. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Ivabradine (Corlanor) *Use Ivabradine (Corlanor) PA form*	Prior authorization (PA) is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and a. Patient is 18 years of age or older; and b. Patient has documentation of a left ventricular ejection fraction ≤35%; and c. Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and d. Patient has documentation of blood pressure ≥90/50 mmHg; or 2. Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class ll to lV) due to dilated cardiomyopathy, and a. Pediatric patient age 6 months and less than 18 years old; and b. Patient has documentation of a left ventricular ejection fraction ≤45%; and b. Patient is in sinus rhythm with a resting heart rate (HR) defined below; i. 6 to 12 months – HR ≥ 105 bpm ii. 1 to 3 years- HR ≥ 95 bpm iii. 3 to 5 years- HR ≥ 75 bpm iv. 5 to 18 years- HR ≥ 70 bpm; and 3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and 4. Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Janus Kinase Inhibitors	Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata or other excluded medical use(s), as defined in Section 1927 (d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met: 1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Patient has a diagnosis of: a. Moderate to severe rheumatoid arthritis; with i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR b. Psoriatic arthritis; with i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR c. Moderately to severely active ulcerative colitis; with i. A documented trial and inadequate response with a preferred TNF inhibitor; OR d. Moderately to severely active Crohn's disease; with i. A documented trial and inadequate response with a preferred TNF inhibitor; OR e. Polyarticular Course Juvenile Idiopathic Arthritis; with i. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and

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

Updated 10/01/2025

Use Janus Kinase Inhibitor PA form	ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR g. Atopic dermatitis; with i. Documentation patient has failed to respond to good skin care and regular use of emollients; and ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and iv. For mild to moderate atopic dermatitis: a. Affected area is less than 20% of body surface area (BSA); and b. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or v. For moderate to severe atopic dermatitis: a. A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; OR h. Nonsegmental vitiligo; with i. A documented trial and inadequate response with a potent topical corticosteroid; or ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable; OR i. Giant Cell Arteritis; with i. Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Ketorolac *Use Ketorolac PA form*	Prior authorization (PA) is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a **Black Box Warning**. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions: 1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum intranasal dose is 126mg/day. Maximum combined duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred non-steroidal anti-inflammatory drugs at therapeutic doses.

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

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

Updated 10/01/2025

Lebrikizumab-lbkz (Ebglyss) *Use Lebrikizumab-lbkz (Ebglyss) PA form*	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: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient's current weight in kilograms (kg) is provided; and 3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and a. Patient has failed to respond to good skin care and regular use of emollients; and 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 c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and d. Patient will continue with skin care regimen and regular use of emollients. If criteria for coverage are met, initial authorization will be given for 16 weeks to 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Letermovir (Prevymis) *Use Letermovir (Prevymis) PA form*	Prior authorization (PA) is required for oral letermovir. Requests for intravenous letermovir should be directed to the member's medical benefit. Payment will be considered under the following conditions: 1. 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. Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and 3. Patient has received an allogeneic hematopoietic stem cell transplant (HSCT); and a. Patient or donor is CMV-seropositive [R+] (attach documentation):and b. Treatment is initiated between day 0 and day 28 post-transplantation with IV and/or oral therapy (before or after engraftment); and 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 4. Patient is a kidney transplant recipient; and a. Donor is CMV-seropositive/recipient is CMV seronegative [D+/R-] (attach documentation); and b. Treatment is initiated between day 0 and day 7 post-transplantation with IV and/or oral therapy (before or after engraftment); and c. Therapy will not exceed 200 days post-transplantation; and 5. Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and 6. Date of transplant is provided; and 7. Patient's weight (in kg) is provided.
Lidocaine Patch (Lidoderm) *Use Lidocaine Patch (Lidoderm) PA form*	Prior authorization (PA) is required for topical lidocaine patches. Payment will be considered only for cases in which there is a diagnosis of pain associated with post-herpetic neuralgia. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

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Updated 10/01/2025

Linezolid (Zyvox) *Use linezolid (Zyvox) PA form*	Prior authorization (PA) is required for linezolid. Payment for linezolid will be authorized when there is documentation that: 1. The patient has an active infection and meets one of the following diagnostic criteria: a. Vancomycin-resistant Enterococcus (VRE); or b. Methicillin-resistant Staph aureus (MRSA); or c. Methicillin-resistant Staph epidermis (MRSE); or d. Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and 2. Patient meets ONE of the following criteria: a. Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or b. VRE in a part of the body other than lower urinary tract**, or c. Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed). 3. A current culture and sensitivity report is provided documenting sensitivity to linezolid. *Severe intolerance to vancomycin is defined as: 1. Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration 2. Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine) **VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

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 10/01/2025

Long-Acting Opioids *Use Long-Acting Opioids PA form*	Prior authorization (PA) is required for all non-preferred long-acting opioids. PA is also required for members when the total daily opioid use (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1. Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment; and 2. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two nonopioid pharmacologic therapies (e.g., acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and 4. There is documentation of previous trial and therapy failure with one preferred long-acting opioid at maximally tolerated dose; and 5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization; and 6. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and. 7. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids. 8. Requests for long-acting opioids will only be considered for FDA approved dosing intervals. As-needed (PRN) dosing will not be considered; and 9. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP and has determined continued use of a long-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

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

Updated 10/01/2025

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

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

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

Updated 10/01/2025

Mavacamten (Camzyos) *Use Mavacamten (Camzyos) PA form*	Prior authorization (PA) is required for mavacamten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and 3. Patient exhibits symptoms of New York Heart Association (NYHA) class ll or lll symptoms; and 4. Is prescribed by or in consultation with a cardiologist; and 5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and 6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and 7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following: a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker. 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.
Methotrexate Injection *Otrexup* *Rasuvo* *Use Methotrexate Injection PA form*	Prior authorization (PA) is required for non-preferred methotrexate injection. Payment will be considered under the following conditions: 1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA) and ALL of the following: a. Prescribed by a rheumatologist; and b. Patient has a documented trial and intolerance with oral methotrexate; and c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine); and d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and e. Patient does not reside in a long-term care facility. 2. Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: a. Patient is 18 years of age or older; and b. Prescribed by a dermatologist; and c. Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy). d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and e. Patient does not reside in a long-term care facility. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

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

Updated 10/01/2025

Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment *Use Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment PA form*	Prior Authorization (PA) is required for miconazole-zinc oxide-white petrolatum (Vusion) Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that the use of these agents would be medically contraindicated.
Mifepristone (Korlym) *Use Mifepristone (Korlym) PA form*	Prior authorization (PA) is required for mifepristone (Korlym). Payment will be considered for patients when the following is met: 1. The patient is 18 years of age or older: and 2. Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance: and 3. Patient must have failed surgery or is not a candidate for surgery: and 4. Prescriber is an endocrinologist: and 5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.
Modified Formulations *Use Modified Formulations PA form*	Payment for a non-preferred isomer, prodrug, or metabolite will be considered when the following criteria are met: 1. Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. The required trials may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated. 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. 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.

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

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

Updated 10/01/2025

Multiple Sclerosis Agents-Oral *Use Multiple Sclerosis Agents-Oral PA form*	For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided: 1. A diagnosis of relapsing forms of multiple sclerosis; and 2. Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and 3. Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Muscle Relaxants *Use Muscle Relaxant PA form*	Prior authorization (PA) is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that the use of these products would be medically contraindicated.
Narcotic Agonist-Antagonist Nasal Sprays *Use Narcotic Agonist/Antagonist Nasal Spray PA form*	Prior authorization (PA) is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration. Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.

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Updated 10/01/2025

Nemolizumab-ilto (Nemluvio) *Use Nemolizumab-ilto (Nemluvio) PA form*	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: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient's current weight in kilograms (kg) is provided; and 3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and a. Patient has failed to respond to good skin care and regular use of emollients; and 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 c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and d. For initial therapy, will be used in combination with a topical corticosteroid and/or a topical immunomodulator; and e. Patient will continue with skin care regimen and regular use of emollients; or 4. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and a. Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and b. Patient has ≥ 20 nodular lesions (attach documentation); and c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days. 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. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
New to Market Drugs *Use New to Market Drugs PA form*	Prior authorization (PA) is required for newly marketed drugs. Payment will be considered for patients when the following criteria are met: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or 3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and 4. Request must adhere to all FDA approved labeling. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Once newly marketed drugs are reviewed by the Pharmaceutical & Therapeutics Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

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Updated 10/01/2025

Nocturnal Polyuria Treatments *Use Nocturnal Polyuria Treatments PA form*	Prior authorization (PA) is required for nocturnal polyuria treatments. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24-hour urine productions occurring at night; and 3. Patient wakens at least 2 times at night to void; and 4. Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and 5. Patient is not taking a diuretic in the evening; and 6. Patient does not have any of the following contraindications: a) Current or previous history of hyponatremia; and b) Primary nocturnal enuresis; and c) Polydipsia; and d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and f) Estimated glomerular filtration rate < 50 mL/min.1.73m^2; and g) Illnesses that can cause fluid or electrolyte imbalance; and h) New York Heart Association (NYHA) Class ll-lV congestive heart failure; and i) Uncontrolled hypertension. Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following: 1. Patient continues to meet above criteria; and 2. Patient has experienced a decrease in nocturnal voiding; and 3. There is no evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).
Non-Biologic Agents for Ulcerative Colitis *Use Non-Biologic Agents for Ulcerative Colitis PA form*	Prior authorization is required for select non-biologicals for ulcerative colitis (UC). Payment for non-preferred select non-biologics for UC may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment will be considered under the following conditions: 1. Patient has a diagnosis of moderately to severely active ulcerative colitis (UC) and 2. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 3. A documented trial and inadequate response to two preferred conventional therapies (immunomodulators) including aminosalicylates and azathioprine/6-mercaptopurine; and 4. A documented trial and inadequate response with a preferred biological DMARD; and 5. Will not be taken concomitantly with immunomodulators or biologic therapies. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

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Updated 10/01/2025

Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products *Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form*	Prior authorization (PA) is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus. 2. Hemophilia A. 3. Von Willebrand's disease. Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent. Please refer to the Selected Brand-Name Drugs prior authorization form is requesting a non-preferred brand-name product.
Non-Preferred Drug *Use Non-Preferred Drug PA form*	Prior authorization (PA) is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be considered for an FDA approved or compendia indicated diagnosis only for cases in which there is documentation of previous trial and therapy failure with the preferred agent(s), unless evidence is provided that use of these agents would be medically contraindicated. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.
Nonsteroidal Anti-inflammatory Drugs *Use Non-Steroidal Anti-inflammatory Drug PA form*	Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (NSAIDs). Payment for a non-preferred NSAID will be considered under the following conditions: 1. Documentation of previous trials and therapy failures with at least three preferred NSAIDs; and 2. Requests for a non-preferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred immediate release NSAID of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that the the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Odevixibat (Bylvay) *Use Odevixibat (Bylvay) Drug PA form*	Prior authorization (PA) is required for odevixibat (Bylvay) Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and a. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and b. Patient has moderate to severe pruritis associated with PFIC; or 3. Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAGI or NOTCH2 mutation or deletion; and a. Patient has cholestasis with moderate to severe pruritis; and b. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents: i. Ursodeoxycholic acid (ursodiol) ii. Cholesytramine iii. Rifampin; and 4. Patient's current weight in kg is provided; and 5. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in PFIC or ALGS Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met: 1. Patient's current weight in kg is provided; and 2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.
Olezarsen (Tryngolza) *Use Olezarsen (Tryngolza) Drug PA form*	Prior authorization (PA) is required for olezarsen (Tryngolza). 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 (≤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. If the criteria for coverage are met, initial requests will be given for 6 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 (≤ 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.

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

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

Updated 10/01/2025

Omalizumab (Xolair)	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: 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 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 3. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and 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 5. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and 6. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced. <u>Moderate to Severe Persistent Asthma</u> 1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2. Patient has a history of positive skin or RAST test to a perennial aeroallergen; and 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$_2$-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. 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). <u>Chronic Spontaneous Urticaria</u> 1. Patient has a diagnosis of moderate to severe chronic spontaneous urticaria; and 2. Patient has documentation of an adequate trial and therapy failure with a preferred second-generation H1 receptor antihistamine for at least 2 weeks. 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.

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

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

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Use Omalizumab (Xolair) PA form	Chronis Rhinosinusitis with Nasal Polyps (CRSwNP) 1. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps; and 2. Patient has documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: a. Nasal corticosteroid spray; and b. Oral corticosteroid; and 3. Will be used as an add on maintenance treatment. 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. IgE Mediated Food Allergy 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 2. Diagnosis is confirmed by a skin prick test or in vitro test (attach results); and 3. Will be used in conjunction with food allergen avoidance. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Ophthalmic Agents for Presbyopia *Use Ophthalmic Agents for Presbyopia PA form*	Prior authorization (PA) is required for ophthalmic agents indicated for presbyopia. Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment for a non-preferred agent will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of presbyopia; and 3. Patient is aged 40-55 years old at start of therapy; and 4. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 5. Patient has documentation of a therapeutic failure with corrective lenses (eyeglasses or contact lenses), unless contraindicated or clinically significant intolerance. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions: 1. Patient has a documented improvement in presbyopia defined as the patient gained 3 lines or more is mesopic, high contrast, binocular distance corrected near vision acuity (DCNVA), without losing more than 1 line (5 letters) of corrected distance visual acuity (CDVA); and 2. Patient is not experiencing adverse effects from the drug.

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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 10/01/2025

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

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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.

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Use Oral Constipation Agents PA form	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.
Oral Glucocorticoids for Duchenne muscular dystrophy Agamree Deflazacort Emflaza *Use Oral Glucocorticoids for Duchenne muscular dystrophy PA form*	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: 1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Oral Immunotherapy *Grastek* *Oralair* *Ragwitek*	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: 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. Medication is prescribed by or in consultation with an allergist or immunologist; and 3. Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and 4. Patient has a documented intolerance to immunotherapy injections; and 5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration). 6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved. Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met: 1. Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; and and 2. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen. 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. Grass Pollen (Grastek and Oralair) In addition to the above criteria being met: 1. Request is for Oralair; and

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Use Oral Immunotherapy PA form	a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and b. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass. c. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season. 2. Request is for Grastek; and a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and b. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop). 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: ▪ Seasonally, through the end of the grass pollen season, or ▪ For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season. House Dust Mite (Odactra) In addition to the above criteria being met: 1. Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis; and 2. Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites; and 3. If criteria for coverage are met, authorization will be considered for 12 months.
Ospemifene (Osphena) *Use Ospemifene (Osphena) PA form*	Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions: 1. Patient is a post-menopausal woman with a diagnosis is moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and 2. Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and 3. Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and 4. Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and 5. Patient does not have severe hepatic impairment (Child-Pugh Class C); and 6. Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and 7. Dose does not exceed the FDA approved dose. The required trials may be overridden when documented evidence is provided that 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.

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Updated 10/01/2025

Oxybate Products *Use Oxybate Products PA form*	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: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. A diagnosis of cataplexy associated with narcolepsy a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and b. Previous trial and therapy failure with dextroamphetamine; or 3. A diagnosis of excessive daytime sleepiness associated with narcolepsy a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and b. Previous trial and therapy failure at a therapeutic dose with modafinil; or 4. A diagnosis of idiopathic hypersomnia a. Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and b. Previous trial and therapy failure at a therapeutic dose with modafinil; and 5. Will not be used in combination with other oxybate products or with pitolosant and.or solriamfetol; and 6. Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 7. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting PA. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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 10/01/2025

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

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Palopegteriparatide (Yorvipath) *Use Palopegteriparatide (Yorvipath) PA form*	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: 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 chronic hypoparathyroidism; and 3. Patient has had an inadequate response to maximally tolerated oral calcium and vitamin D analog (e.g., calcitriol) therapy; and 4. Documentation of baseline lab results (attach results obtained within 2 weeks prior to starting therapy) for: a. Serum 25 hydroxyvitamin D (25(OH)D) level within the normal range (20 to 80 ng/mL); and b. Albumin-corrected serum calcium level ≥ 7.8 g/dL; and 5. Is prescribed by or in consultation with an endocrinologist or nephrologist. 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: 1. 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).

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 10/01/2025

PCSK9 Inhibitors *Praluent* *Repatha*	Prior authorization (PA) is required for PCSK9 Inhibitors. Payment for a non-preferred PCSK9 Inhibitor will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age for indication; AND 2. Dosing follows the FDA approved dose for the submitted diagnosis; AND 3. Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); AND 4. Is to be prescribed as an adjunct to a low fat diet; AND 5. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; AND 6. Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program. 7. The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors. 8. Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced. 9. Lost or stolen medication replacement requests will not be authorized. 10. Goal is defined as a 50% reduction in untreated baseline LDL-C. 11. Is prescribed for one of the following diagnoses: <u>Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)</u> 1. Total cholesterol > 290mg/dL or LDL-C > 190mg/dL; AND a. Presence of tendon xanthomas; OR b. In first or second degree relative, one of the following: i. Documented tendon xanthomas; or ii. MI at age ≤60 years; or iii. Total cholesterol > 290mg/dL; OR c. Confirmation of diagnosis by gene or receptor testing (attach results); AND 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-

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Updated 10/01/2025

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

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Updated 10/01/2025

Peanut Allergen Powder-dnfp (Palforzia) *Use Peanut Allergen Powder-dnfp (Palforzia) PA form*	Prior authorization (PA) is required for Peanut (*Arachis hypogaea*) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions: 1. 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 2. Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut ≥ 3 mm compared to control or a peanut-specific serum IgE ≥ 0.35 kUA/L (kilos of allergen-specific units per liter); and 3. 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 4. Prescribed by or in consultation with an allergist or immunologist; and 5. Patient has access to injectable epinephrine; and 6. Will be used in conjunction with a peanut-avoidant diet; and 7. 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 8. PA is required for all up-dosing dose levels (dose 1 through 11); and 9. Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.

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Updated 10/01/2025

Pegcetacoplan (Empaveli) *Use Pegcetacoplan (Empaveli) PA form*	Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and 2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and 3. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and 4. History of at least one red blood cell transfusion in the previous 12 months; and 5. Documentation of hemoglobin < 10.5 g/dL; and 6. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross-titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and 7. Is prescribed by or in consultation with a hematologist; and 8. Medication will be administered in the member's home; and 9. Member or member's care giver has been properly trained in subcutaneous infusion and prescriber has determined home administration is appropriate. Initial authorizations will be approved for 4 weeks if within cross-titration period with eculizumab (Soliris) to verify eculizumab has been discontinued, or for 6 months otherwise. Additional authorizations will be considered when the following criteria are met: 1. Documentation of a positive clinical response to therapy (e.g., increased or stabilization or hemoglobin levels or reduction in transfusions); and 2. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris).
Pirfenidone (Esbriet) / Nintedanib (Ofev)	Prior authorization (PA) is required for pirfenidone (Esbriet) and nintedanib (Ofev). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Is prescribed by a pulmonologist; and 3. Patient does not have hepatic impairment as defined below: a. Nintedanib- Patient does not have moderate or severe hepatic impairment (Child Pugh B or C) or b. Pirfenidone- Patient does not have severe hepatic impairment (Child Pugh C); and 4. Patient does not have renal impairment as defined below: a. Nintedanib- Patient does not have severe renal impairment (CrCl <30ml/min) or end-stage renal disease or b. Pirfenidone- Patient does not have end-stage renal disease requiring dialysis; and 5. Patient does not utilize non-prescribed inhalants, such as vaping or other inhaled tobacco products, prior to initiating therapy and has been instructed to avoid tobacco products while using pirfenidone or nintedanib; and 6. Patient has a diagnosis of idiopathic pulmonary fibrosis (nintedanib or pirfenidone) as confirmed by one of the following (attach documentation): a. Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or b. A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and c. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational exposures, connective tissue disease, and drug toxicity; and

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

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Updated 10/01/2025

Use Pirfenidone (Esbriet) / Nintedanib (Ofev) PA form	d. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥50% predicted; and e. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥30% predicted; or 7. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation): a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 40% predicted; and c. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥ 30-89% predicted; or 8. Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (nintedanib) as confirmed by the following (attach documentation): a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 45% predicted; and c. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥ 30-79% predicted; and d. Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months despite standard treatment with an agent other than nintedanib or pirfenidone: i. A relative decline in the FVC of at least 10% predicted; or ii. A relative decline in the FVC of 5-9% predicted combined with at least one of the following: 1. Worsening respiratory symptoms; or 2. Increased extent of fibrosis on HRCT; or iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only. If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met: 1. Adherence to pirfenidone (Esbriet) or nintedanib (Ofev) is confirmed; and 2. Documentation of a positive response to therapy, defined as meeting at least one of the following: a. Rate of lung function decline slowed; or b. Improved or no worsening of symptoms of cough, shortness of breath; and 3. Documentation is provided that the patient has remained tobacco-free; and 4. ALT, AST, and bilirubin are assessed periodically during therapy.

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Updated 10/01/2025

Proton Pump Inhibitors *Use Proton Pump Inhibitor PA form*	Prior authorization (PA) is not required for preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day. Requests for PPIs exceeding one unit per day will be considered for the following diagnoses with additional documentation regarding the medical necessity: 1. Barrett's esophagus, Erosive esophagitis, or Peptic stricture (Please fax a copy of the scope results with the initial request); or 2. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas); or 3. Recurrent peptic ulcer disease; or 4. Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with the requested PPI at maximal dose within the established quantity limit of one per day. Requests for PPIs exceeding one unit per day will be considered on a short-term basis (up to 3 months). After the three-month period, a dose reduction to the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day; or 5. Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection. Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.
Pulmonary Arterial Hypertension Agents *Use Pulmonary Arterial Hypertension Agents PA form*	Prior Authorization (PA) is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions: 1. Diagnosis of pulmonary arterial hypertension
Quantity Limit Override *Use Quantity Limit Override PA form*	Designated drugs are limited to specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website www.iowamedicaidpdl.com under the Billing/Quantity Limits tab. Providers should submit a Prior Authorization (PA) request for override consideration.
Repository Corticotropin Injection (H.P. Acthar Gel) *Use Repository Corticotropin Injection (H.P. Acthar Gel) PA form*	Prior authorization (PA) is required for repository corticotropin injection. Payment will be considered under the following conditions: 1. Patient is under two years of age and 2. Patient has a diagnosis of infantile spasms. Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection. If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.

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Updated 10/01/2025

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

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Updated 10/01/2025

Sapropterin (Kuvan) *Use Sapropterin (Kuvan) PA form*	Prior authorization (PA) is required for sapropterin (Kuvan). Requests for doses above the FDA approved dose will not be considered. Initial requests will be considered for patients when the following criteria are met: 1. Patient has a diagnosis of phenylketonuria (PKU); and 2. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and 3. Patient has a baseline blood Phe level ≥360 micromol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sapropterin therapy (attach lab results); and 4. Patient's current weight is provided; and 5. Request is for an FDA approved starting dose (10mg/kg/day for patients 1 month to 6 years and 10-20mg/kg/day for patients 7 years and older); and 6. Blood Phe levels will be measured after 1 week of therapy and at least one other time during the first month of therapy. Initial requests will be considered for 1 month to assess response to therapy. Continuation of therapy will be considered when the following criteria are met: 1. Patient's current weight is provided; and 2. Patient continues on a Phe restricted diet; and 3. For patients initiated at a dose of 10mg/kg/day and the blood Phe level did not decrease from baseline, dose may be increased to 20mg/kg/day. Approval will be given for 1 month to assess response to therapy. 4. For patients initiated at a dose of 20mg/kg/per day or those increased to this dose after 1 month of therapy at 10mg/kg/day, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction in blood Phe level. If blood Phe level does not decrease after 1 month at 20mg/kg/day, the patient is considered a non-responder and no further requests will be approved. 5. Maintenance dose requests will be considered for patients that have responded to therapy, based on the above criteria, at 6 month intervals. Documentation of compliance to diet and updated blood Phe levels documenting continued response to therapy are required for further consideration.
Satralizumab (Enspryng) *Use Satralizumab (Enspryng) PA form*	Prior authorization (PA) is required for satralizumab (Enspryng). Payment will be considered under the following conditions: 1. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD); and 2. Patient is anti-aquaporin 4 (AQP4) seropositive (attach documentation); and 3. Patient meets the FDA approved age and dosing; and 4. Patient has a history of at least 1 relapse in the previous 12 months prior to initiation of therapy; and 5. Patient has been tested for tuberculosis prior to the initiation of therapy and does not have active or untreated latent tuberculosis; and 6. Patient has been tested for hepatitis B virus (HBV) prior to the initiation of therapy and confirmed negative for active HBV; and 7. Prescribed by a neurologist. If criteria for coverage are met, initial requests will be given for 1 year. Additional authorizations will be considered upon documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse).

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Updated 10/01/2025

Sedative/Hypnotics-Non-Benzodiazepine *Use Sedative/Hypnotics-Non-Benzodiazepine PA form*	Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. A diagnosis of insomnia; and 3. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and 4. Enforcement of good sleep hygiene is documented; and 5. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses; and 6. Will not be used concurrently with a benzodiazepine sedative/hypnotic agent. 7. In addition to the above criteria, requests for an orexin receptor antagonist will require documentation of a trial and therapy failure with at least one non-preferred agent prior to consideration of coverage. 8. Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Updated 10/01/2025

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

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

Updated 10/01/2025

Select Preventative Migraine Treatments	Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions: 1. Patient has one of the following diagnoses: a. Chronic Migraine, defined as: i. ≥ 15 headache days per month for a minimum of 3 months; and ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or b. Episodic Migraine, defined as: i. 4 to 14 migraine days per month for a minimum of 3 months; or c. Episodic Cluster Headache, defined as: i. Occurring with a frequency between one attack every other day and 8 attacks per day; and ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥3 months; and iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting <3 months, for at least 1 year); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and 3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and 4. Patient has been evaluated for and does not have medication overuse headache; and 5. For Episodic Cluster Headache, patient has documentation of a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy. 6. Lost, stolen, or destroyed medication replacement requests will not be authorized. Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Select Oncology Agents *Use Select Oncology Agents PA form*	Prior authorization (PA) is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the PA request: copies of medical records (i.e. diagnostic evaluations and recent chart notes), location of treatment (provider office, facility, home health, etc.) if medication requested is not an oral agent, the original prescription, and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.
Select Topical Agents *Use Select Topical Agents PA form*	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: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and a. Request is for roflumilast 0.3% cream or tapinarof 1% cream; and b. 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 3. Patient has a diagnosis of seborrheic dermatitis; and a. Request is for roflumilast 0.3% foam; and b. 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 4. Patient has a diagnosis of mild to moderate atopic dermatitis; and a. Request is for roflumilast 0.15% cream or tapinarof 1% cream; and b. Patient has failed to respond to good skin care and regular use of emollients; and c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or d. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Selected Brand Name Drugs *Use Selected Brand Name PA forms*	Prior authorization (PA) is required for selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For PA to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with: 1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available. 2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval. Trials may be overridden when evidence is provided that the use of the generic product would be medically contraindicated.

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

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

Updated 10/01/2025

Short Acting Opioids *Use Short Acting Opioids PA form*	Prior authorization (PA) is required for all non-preferred short acting opioids. PA is also required for members when the total daily dose (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1. Patient has pain severe enough to require opioid treatment; and 2. Patient has tried and failed at least two non-pharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two non-opioid pharmacologic therapies (e.g. acetaminophen or NSAIDs); and 4. Patient has documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting opioids (based on opioid ingredient only) at therapeutic doses; and 5. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and has determined that use of a short-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and 6. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids; and 7. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and has determined continued use of a short-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: b. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and c. Documentation as to why concurrent use is medically necessary is provided; and d. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that the use of these agents and/or non-pharmacologic therapies would be medically contraindicated.
Step Therapy Requirements *Use Non-Preferred Drug PA form*	Designated therapeutic drug classes are subject to step therapy edits. For these therapeutic drug classes, drugs are assigned to numbered steps and appropriate trials must be made of the drugs assigned to each step before payment will be made for drugs assigned to a subsequent step. These therapeutic classes, as well as the specific step edit requirements, are identified on the Iowa Medicaid Preferred Drug List posted on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Providers should submit a Prior Authorization (PA) request for override consideration. Therapeutic Classes Included: Antipsychotics-Atypicals

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

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

Updated 10/01/2025

Tasimelteon (Hetlioz) *Use Tasimelteon (Hetlioz) PA form*	Prior authorization (PA) is required for tasimelteon (Hetlioz). Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of: a. Non-24-Hour Sleep-Wake Disorder (Non-24); and i. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and ii. Patient has a documented trial and therapy failure with ramelteon (Rozerem®); or b. Sleep disturbances in Smith-Magenis Syndrome (SMS); and i. Documentation of confirmed deletion of 17p11.2 (cytogenic analysis or microarray) or RAI1 gene mutation is provided (attach results); and ii. Patient has a documented trial and therapy failure with at least one other medication used for sleep disturbances; and 3. Is prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders; and 4. Will not be used concomitantly with other sleep medications. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions: 1. Patient's use of tasimelteon (Hetlioz) has been continuous without gaps in treatment; and 2. Documentation patient has experienced a positive clinical response to therapy with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, significant decreases in daytime sleep, and/or nighttime sleep quality.
Testosterone Products	Prior authorization (PA) is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions: 1. Patient is male and 18 years of age or older (or 12 years of age or older for testosterone cypionate); and 2. Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (please attach lab results); and 3. Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below): a. Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:

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

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

Updated 10/01/2025

Use Testosterone Products PA form	• Cryptorchidism • Bilateral torsion • Orchitis • Vanishing testes syndrome • Orchiectomy • Klinefelter's syndrome • Chemotherapy • Toxic damage from alcohol or heavy metals b. Hypogonadotropic hypogonadism • Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency • Pituitary-hypothalamic injury from tumors, trauma, or radiation 4. Patient does not have: a. Breast or prostate cancer b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL c. Hematocrit > 50% d. Untreated severe obstructive sleep apnea e. Severe lower urinary tract symptoms f. Uncontrolled or poorly controlled heart failure If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following: 1. An updated testosterone level (Please attach lab result); and 2. Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Tezepelumab-ekko (Tezspire) Prefilled Pen *Use Tezepelumab-ekko (Tezspire) Prefilled Pen PA form*	Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of severe asthma; and a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and b. Patient must have one of the following, in addition to the regular maintenance medications defined above: i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months, or ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and c. This medication will be used as an add-on maintenance treatment; and d. Patient/caregiver will administer medication in patient's home; and e. Is not prescribed in combination with other biologics indicated for asthma. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Updated 10/01/2025

Topical Acne and Rosacea Products *Use Topical Acne and Rosacea Products PA form*	Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Documentation of diagnosis; and 3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and 4. Payment for non-preferred topical antibiotic or topical retinoid acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and 5. Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and 6. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent; and 7. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and 8. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and 9. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Topical Antifungals for Onychomycosis *Use Topical Antifungals for Onychomycosis PA form*	Jublia (efinaconazole) and Kerydin (tavaborole) will be considered when the following criteria are met: 1. Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lunula (matrix) involvement; and 2. Patient is 18 years of age or older; and 3. Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and 4. Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and 5. Patient is diabetic or immunosuppressed/immunocompromised. If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection will not be considered. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Topical Corticosteroids *Use Topical Corticosteroids PA form*	Prior authorization (PA) is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

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

Updated 10/01/2025

Tralokinumab-Idrm (Adbry) *Use Tralokinumab (Adbry) PA form*	Prior authorization (PA) is required for tralokinumab-Idrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe atopic dermatitis; and 3. Is prescribed by or in consultation with a dermatologist; and 4. Patient has failed to respond to good skin care and regular use of emollients; and 5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 6. Patient has documentation of a previous trial and therapy failure with a preferred topical immunomodulator for a minimum of 4 weeks; and 7. Patient will continue with skin care regimen and regular use of emollients. If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients. The required trials may be overridden when documented evidence if provided that the use of these agents would be medically contraindicated.
Triheptanoin (Dojolvi) *Use Triheptanoin (Dojolvi) PA form*	Prior authorization (PA) is required for triheptanoin (Dojolvi). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and 2. Patient has a diagnosis of long-chain fatty acid oxidation disorder (LC-FAOD), with supporting documentation of gene mutation(s) associated with LC-FAOD (LC-FOADs include: CPT1, CACT, CPT11, VLCAD, TFP, LCHAD); and 3. Patient will not be using another medium chain triglyceride (MCT) product; and 4. Documentation of a patient's daily caloric intake (DCI) is provided; and 5. Patient's target daily dose is provided as a percentage of the patient's total daily prescribed DCI, not to exceed 35%; and 6. Is prescribed by or in consultation with an endocrinologist, geneticist, or metabolic disease specialist. If the criteria for coverage are met, initial requests will be approved for four months. Additional authorizations will be considered upon documentation of a positive clinical response to therapy.

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

Updated 10/01/2025

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

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

Updated 10/01/2025

Vesicular Monoamine Transporter (VMAT) 2 Inhibitors	Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered when the patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Will not be used concurrently with other vesicular monoamine (VMAT) 2 inhibitors; and 3. Prescribed by or in consultation with a neurologist, psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and <u>Tardive Dyskinesia</u> (Ingrezza or Austedo) 1. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following: a. Involuntary athetoid or choreiform movements b. Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.) c. Symptoms lasting longer than 4-8 weeks; and 2. 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 3. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS), If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS); or <u>Chorea associated with Huntington's disease</u> (Austedo, Ingrezza or tetrabenazine) 1. Patient has a diagnosis of Huntington's disease with chorea symptoms; and 2. Patient is not suicidal, or does not have untreated or inadequately treated depression; and 3. 4. 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
Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form	If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in chorea symptoms is provided.

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

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

Updated 10/01/2025

Viloxazine (Qelbree) *Use Viloxazine (Qelbree) PA form*	Prior authorization is required for viloxazine (Qelbree). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and 3. Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational) and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine or a preferred stimulant; and 5. Dose does not exceed 400 mg per day for pediatric patients (< 18 years of age) and 600 mg per day for adult patients; and 6. Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Vitamins, Minerals and Multiple Vitamins *Use Vitamin/Mineral PA form*	Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)
Vonoprazan (Voquezna) *Use Vonoprazan (Voquezna) PA form*	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: 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 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 a. Documentation of an 8-week trial and therapy failure, based on ongoing symptoms, with two preferred PPIs, each twice-daily dosing; or 3. Patient has an active *Helicobacter pylori (H. pylori)* infection (attach documentation); and a. Patient has documentation of a recent trial and therapy failure with a preferred agent(s) for the treatment of *H. pylori* infection; and b. Request is for the triple pak or dual pak 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.

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

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

Updated 10/01/2025

Zuranolone (Zurzuvae) *Use Zuranolone (Zurzuvae) PA form*	Prior authorization (PA) is required for zuranolone (Zurzuvae). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of postpartum depression (PPD); and 3. Patient is 12 months or less postpartum on the date of the request (start date of delivery); and 4. The onset of the current depressive episode was during the third trimester or within 4 weeks postpartum; and 5. Patient has not received brexanolone for the current PPD episode; and 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.

Brensocatib (Brinsupri)
Prior Authorization Criteria Review

Background
The U.S. Food and Drug Administration (FDA) recently approved brensocatib (Brinsupri) for the treatment of non-cystic fibrosis bronchiectasis (NCFB) in adult and pediatric patients 12 years of age and older.

NCFB is a chronic, progressive, inflammatory lung disease characterized by permanent dilation of the bronchi, with chronic cough, sputum production, respiratory infections and recurrent exacerbations. The "vicious vortex" of bronchiectasis is the driver of disease progression, consisting of chronic airway inflammation (primarily neutrophilic), impaired mucociliary clearance, structural airway damage, and recurrent infection. Management of bronchiectasis has consisted of airway clearance techniques, mucoactive agents, bronchodilators and antibiotics for the treatment of infections but do not treat the underlying cause of inflammation or slow disease progression.

Dosage and Administration
- 10 mg or 25 mg orally once daily

Dosage Forms and Strengths
- Tablet: 10 mg or 25 mg

Contraindications
- None

Warnings and Precautions:
- Dermatologic adverse reactions, gingival and periodontal adverse reactions; live attenuated vaccines

Adverse Reactions
- Most common (≥ 2%): upper respiratory tract infection, headache, rash, dry skin, hyperkeratosis, and hypertension

Mechanism of Action
- Brinsupri is a competitive, reversible inhibitor of dipeptidyl peptidase 1 (DPP1). DPP1 activates pro-inflammatory neutrophil serine proteases (NSPs) during neutrophil maturation in the bone marrow.
- Activated NSPs are implicated in the pathogenesis of neutrophil-mediated NCFB inflammation.
- In cell-based assays, DPP1 inhibition by brensocatib reduces the activity of NSPs including neutrophil elastase, cathepsin G and proteinase 3.

Clinical Studies
The efficacy of Brinsupri was established in two randomized, double-blind, placebo-controlled studies (ASPEN and WILLOW). ASPEN was a 52-week study that included 1,721 adult and pediatric patients 12 years of age and older with NCFB. WILLOW was a 24-week study that included 256 adult patients with NCFB. Eligible patients had a clinical history consistent with bronchiectasis (chronic cough or sputum production or recurrent respiratory tract infections). In both ASPEN and WILLOW, adult patients had a history of confirmed NCFB by chest CT with at least 2 documented pulmonary exacerbations prior to screening in the past 12 months. In ASPEN, pediatric patients 12 years of age and older had at least one pulmonary exacerbation in the prior 12 months. Pulmonary exacerbations were defined as worsening of 3 or more of the following major symptoms over 48 hours: increased cough, increased sputum volume or change in sputum consistency, increased sputum purulence, increased breathlessness, decreased exercise tolerance, fatigue and/or malaise, and hemoptysis, resulting in a healthcare provider's decision to prescribe systemic antibiotics. Pulmonary exacerbations were considered severe if requiring treatment with intravenous antibacterial drugs and/or resulted in hospitalization. In both studies, patients received Brinsupri 10 mg or 25 mg, or placebo, once daily. The primary endpoint was pulmonary exacerbations.

- In ASPEN, the annualized rate of pulmonary exacerbations was 1.29 with placebo, 1.02 with Brinsupri 10 mg, and 1.04 with Brinsupri 25 mg (Brinsupri 10 mg: rate ratio 0.79, 95% CI: 0.68, 0.92; Brinsupri 25 mg: rate ratio 0.81, 95% CI: 0.69, 0.94).
- In WILLOW, the time to first pulmonary exacerbation was longer for patients receiving Brinsupri 10 mg and 25 mg compared to placebo (hazard ratio Brinsupri 10 mg and 25 mg vs. placebo; 0.58 and 0.62, respectively; 95% CI: 0.35 to 0.95 and 0.38 to 0.99, respectively).

Reference the full prescribing information for secondary endpoints.

Manufacturer

- Insmed Inc.

Cost

- WAC: $244.44/tablet; $7333.20/ 30 days; $87,998.40/12 months

Newly Proposed Clinical Prior Authorization Criteria
Prior authorization (PA) is required for brensocatib (Brinsupri). Payment will be considered for an FDA approved or compendia indicated diagnosis 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 non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest CT scan; and

3. Patient is 18 years of age or older with a history of ≥ 2 pulmonary exacerbations requiring antibiotic treatment in the previous 12 months; or
4. Patient is 12 to 17 years of age with ≥ 1 pulmonary exacerbation requiring antibiotic treatment in the previous 12 months; and
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
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
7. Is prescribed by or in consultation with a pulmonologist or infectious disease specialist.

Initial requests will be approved for 6 months. Additional authorizations will be considered annually with documentation of a positive clinical response to therapy, demonstrated by at least one of the following:

1. Improvement in or stabilization of symptoms; or
2. Reduction in or stabilization of the frequency, severity, or duration of exacerbations; or
3. Reduction in the decline of FEV_1.

References

Brinsupri. [Prescribing information]. Bridgewater, ND: Insmed Incorporated: August 2025.

Chalmers, J, Burgel, P, Daley, C, et al. Phase 3 Trial of the DPP-1 Inhibitor Brensocatib in Bronchiectasis. N Engl J Med. 2025;392(16):1569-1581. doi:10.1056/NEJMoa2411664.

Iowa PDL New Drug Review

Proprietary Name: Brinsupri®
Common Name: brensocatib
PDL Category: Dipeptidyl Peptidase 1 (DPP1) Inhibitors

Pharmacology/Usage: Brensocatib, the active ingredient of Brinsupri®, is a dipeptidyl peptidase 1 (DPP1) inhibitor. It is a competitive, reversible inhibitor of DPP1, which activates pro-inflammatory neutrophil serine proteases (NSPs) during neutrophil maturation in the bone marrow. Activated NSPs are implicated in the pathogenesis of neutrophil-mediated non-cystic fibrosis bronchiectasis inflammation. In cell-based assays, DPP1 inhibition by brensocatib reduces the activity of NSPs, including neutrophil elastase, cathepsin G, and proteinase 3.

Indication: For the treatment of non-cystic fibrosis bronchiectasis (NCFB) in adult and pediatric patients 12 years of age and older.

There is no pregnancy category for this medication; however, the risk summary indicates that there are no available data on use in pregnant women to assess for a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. The safety and efficacy of use in the pediatric population younger than 12 years of age have not been established.

Dosage Form: Film-Coated Tablets: 10mg and 25mg.

Recommended Dosage: Take 10mg or 25mg PO QD, with or without food. Patients who miss a dose should take the next dose at their regular time the next day. Do not double the dose to make up for the missed dose.

Drug Interactions: The concomitant use of Brinsupri® and live attenuated vaccines has not been evaluated. It is not known whether administration of live attenuated vaccines during Brinsupri® treatment will affect the safety or effectiveness of these vaccines. The use of live attenuated vaccines should be avoided in patients receiving Brinsupri®.

Box Warning: There is no box warning listed with this product.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Brinsupri® 10mg/25mg) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included upper respiratory tract infection (2%/4%), headache (0%/2%), rash (0%/2%), dry skin (2%/3%), hyperkeratosis (0%/2%), and hypertension (2%/0%).

Treatment with Brinsupri® is associated with an increase in dermatologic adverse reactions, including rash, dry skin, and hyperkeratosis. Monitor patients for development of new rashes or skin conditions and refer patients to a dermatologist for evaluation of new dermatologic findings.

Treatment with Brinsupri® is associated with an increase in gingival and periodontal adverse reactions. Refer patients to dental care services for regular dental checkups while taking Brinsupri®. Advise patients to perform routine dental hygiene.

Contraindications: There are no contraindications listed with this product.

Manufacturer: Insmed Incorporated

Analysis: The efficacy of Brinsupri® was assessed in two randomized, double-blind, placebo-controlled, parallel-group, multicenter, multinational clinical trials (ASPEN and WILLOW). In both studies, all adult patients had a history of confirmed NCFB by chest computed tomography with at least 2 documented pulmonary exacerbations (PEx) prior to screening in the past 12 months. In ASPEN, pediatric patients 12 years of age and older had at least one PEx in the prior 12 months.

ASPEN was a 52-week trial that included adult and pediatric patients 12 years of age and older (N=1721) with NCFB (N=1680 adults and N=41 pediatric patients 12 years of age to less than 18 years of age) who were randomized to Brinsupri® 10mg (N=583), Brinsupri® 25mg (N=575), or placebo (N=563) administered once daily. The mean age of included patients was 60 years, while 64% were female, 74% were White, 30% were former smokers, 29% had ≥3 pulmonary exacerbations in the prior 12 months, and 19% had chronic macrolide therapy. The ppFEV1 post-bronchodilator, mean was 74.

The primary efficacy endpoint in this study was the annualized rate of PEx over the 52-week treatment period. Pulmonary exacerbations were defined as worsening of 3 or more of the following major symptoms over 48 hours, including increased cough, increased sputum volume or change in sputum consistency, increased sputum purulence, increased breathlessness, decreased exercise tolerance, fatigue and/or malaise, and hemoptysis, resulting in a healthcare providers decision to prescribe systemic antibiotics. Pulmonary exacerbations were considered severe if requiring treatment with intravenous antibacterial drugs and/or resulted in hospitalization.

Treatment with Brinsupri® 10mg or 25mg in patients with NCFB demonstrated reductions in the mean rate of PEx over 52 weeks as compared with placebo. Results of the primary endpoint and key secondary endpoints are presented in the table below, which was adapted from the prescribing information.

	Placebo (N=563)	Brinsupri® 10mg (N=583)	Brinsupri® 25mg (N=575)
Annualized Rate of PEx	1.29	1.02	1.04
Rate Ratio		0.79	0.81
Median Time to first PEx (weeks)	36.71	49.00	50.71
Hazard Ratio (HR)		0.81	0.83
Proportion of patients that were PEx Free at week 52, %	40.3%	48.5%	48.5%
Odds Ratio		1.41	1.40
Annualized Rate of Severe PEx	0.19	0.14	0.14
Rate Ratio		0.74	0.74
Least Squares (LS) mean change from baseline in post-bronchodilator FEV1 (ml) at week 52	-62	-50	-24
Difference vs placebo		11	38

WILLOW was a 24-week trial that included adults patients (N=256) with NCFB who were randomized to Brinsupri® 10mg (N=82), Brinsupri® 25mg (N=87), or placebo (N=87) administered once daily. The mean age of included

patients was 64 years, while 68% were female, 88% were White, 34% were former smokers, 33% had ≥3 pulmonary exacerbations in the prior 12 months, and 16% had chronic macrolide therapy. The ppFEV1 post-bronchodilator, mean was 68.

The primary efficacy endpoint of this study was the time to first PEx over the 24-week treatment period. The time to first PEx was longer for patients receiving Brinsupri® 10mg and 25mg compared to placebo (HR Brinsupri® 10mg and 25mg vs placebo: 0.58 and 0.62, respectively).

Place in Therapy: Brinsupri® is a DPP1 inhibitor indicated for the treatment of non-cystic fibrosis bronchiectasis in adult and pediatric patients 12 years of age and older. Gingival and periodontal adverse reactions can occur with use; refer patients to dental care services for regular dental checkups and advise patients to perform routine dental hygiene. The efficacy of Brinsupri® was assessed in two randomized, double-blind, placebo-controlled studies. ASPEN included both adult and pediatric patients 12 years of age and older with NCFB while WILLOW included adults with NCFB. The primary endpoint in the ASPEN study was the annualized rate of PEx over the 52-week treatment period, and results suggested that Brinsupri® 10mg and 25mg treatment in patients with NCFB demonstrated reductions in the mean rate of PEx over 52 weeks as compared with placebo. The primary endpoint in the WILLOW study was the time to first PEx over the 24-week treatment period, and results suggested that the time to first PEx was longer for patients receiving Brinsupri® 10mg and 25mg as compared to placebo. Per the ASPEN full-text study by Chalmers et al[2], statistically significant better results were obtained with Brinsupri® 10mg (p=0.004) and Brinsupri® 25mg (p=0.005) as compared with placebo for the primary endpoint.

Summary

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

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

References

[1] Brinsupri [package insert]. Bridgewater, NJ: Insmed Incorporated; 2025.
[2] Chalmers JD, Burgel PR, Daley CL, et al. Phase 3 trial of the DPP-1 inhibitor brensocatib in bronchiectasis. *NEJM*. 2025; 392)16): 1569-1581.

Diazoxide Choline (Vykat XR)
Prior Authorization Criteria Review

Background
The U.S. Food and Drug Administration (FDA) approved Vykat XR (diazoxide choline) for the treatment of hyperphagia in adults and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS).

PWS is a rare, genetic neurobehavioral and metabolic disorder that occurs due to the loss of function on chromosome 15 leading to disruption in the hypothalamus. Patients experience hypotonia and feeding difficulties in early life followed by hyperphagia and gradual development of obesity in early childhood. Hyperphagia often begins around 3 years of age and progresses until the teenage years. It is coupled with food-seeking behaviors such as hoarding and stealing food as well as attempting to consume inedible items. Control of these behaviors is complex but centers on strategies to limit access to food, limit exposures that make the child think about food, and maintain consistent mealtime routines. Both patients and caregivers carry a significant lifelong psychosocial burden.

See the attached new drug review for additional clinical information.

Cost
- WAC: $148 to $888/tablet; $11,760 to $66,660/30 days; $213,120 to $799,200/12 months (based on minimum and maximum target maintenance dose)

Newly Proposed Clinical Prior Authorization
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:
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 Prader-Willi syndrome confirmed by genetic testing (attach results); and
3. Patient has hyperphagia with associated symptoms such as food-seeking behaviors (hoarding, foraging, stealing, and attempting to consume inedible items); and
4. Patient’s current weight in kg is provided; and
5. Is prescribed by or in consultation with an endocrinologist.

If the criteria for coverage is met, initial requests will be approved for 6 months. Additional approvals will be considered under the following conditions:
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
2. Patient’s current weight in kg is provided.

References

Vykat XR (diazoxide choline) extended-release tablets [prescribing information]. Redwood City, CA: Soleno; March 2025

Miller JL, Gevers E, Bridges N, et al. Diazoxide choline extended-release tablet in people with Prader-Willi Syndrome: A double-blind, placebo-controlled trial. J Clin Endocrinol Metab. 2023;108(7):1676-1685.

McCandless SE; Committee on Genetics. Clinical report—health supervision for children with Prader-Willi syndrome. Pediatrics. 2011;127(1):195-204. doi:10.1542/peds.2010-2820

Iowa PDL New Drug Review

Proprietary Name: Vykat® XR
Common Name: diazoxide choline
PDL Category: Endocrine Metabolic Agents

Pharmacology/Usage: Diazoxide choline, the active ingredient of Vykat® XR, is for oral administration. The exact mechanism of action for its approved indication is not known. Vykat® XR resulted in a reduction in fasting plasma insulin from baseline through 1 year of treatment. It increased uric acid, renin secretion, and IgG concentrations, and decreased cortisol secretion. Diazoxide increases blood glucose.

Indication: For the treatment of hyperphagia in adults and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS).

There is no pregnancy category for this medication; however, the risk summary indicates that the available data from case reports with use during pregnancy are not sufficient to identify a drug-associated risk of major birth defects, miscarriage, or other adverse maternal outcomes. The safety and efficacy of use in the pediatric population below the age of 4 years have not been established.

Dosage Form: Extended-Release Tablets: 25mg, 75mg, 150mg.

Recommended Dosage: Prior to starting treatment, test fasting plasma glucose (FPG) and HbA1c and optimize blood glucose in patients who have hyperglycemia. For fasting glucose and HbA1c monitoring recommendations during Vykat® XR treatment and for dosage modifications based on results, refer to the prescribing information.

Do not substitute Vykat® XR with diazoxide oral suspension because the pharmacokinetic profiles are different.

Administer Vykat® XR with or without food orally once daily. Swallow the tablets whole; do not split, crush, or chew the ER tablets as doing so may compromise the ER characteristics, efficacy, or safety of the product.

The recommended oral dosage is based on body weight. The recommended starting dosage and titration schedule can be found in the prescribing information. The maximum recommended dosage is 5.8mg/kg/day or 525mg per day. Dosages above this have not been assessed in patients with PWS.

After starting treatment, monitor:

- Fasting glucose (FPG or fasting blood glucose) at least once every week for the first 2 weeks, then at least once every 4 weeks and as clinically indicated.
    - Monitor fasting glucose more frequently during the first few weeks of treatment in patients with risk factors for hyperglycemia.
- HbA1c every 3 months and as clinically indicated.
- If clinically significant elevations in fasting glucose or HbA1c occur during treatment, temporarily interrupt Vykat® XR or reduce the dosage until glycemic parameters are appropriately managed. Consider initiation or adjustment of standard antidiabetic therapy(ies). If clinically significant glucose elevations are noted during titration, titrate over a longer duration and/or to a lower dosage.

- Monitor for signs or symptoms of edema or fluid overload. Consider dosage reduction or temporary dosage interruption in the event of clinically significant fluid overload. If clinically significant fluid overload is noted during titration, titrate over a longer duration and/or to a lower dosage.
- If fluid overload or elevations in fasting glucose or HbA1c resolve after a dosage reduction:
    - For patients weighing <30kg, titrate the dosage in increments of no more than 25mg every 2 weeks or titrate over longer duration to a maximum dosage of 5.8mg/kg/day.
    - For patients weighing ≥30kg, titrate the dosage in increments of no more than 75mg every 2 weeks or titrate over longer duration to a maximum dosage of 5.8mg/kg/day.

Refer to the prescribing information for recommendations regarding dosage interruptions, missed dose, or discontinuation of treatment.

Vykat® XR has not been studied in patients with renal impairment and in patients with hepatic impairment. Its use is not recommended in patients with renal impairment and in patients with hepatic impairment.

Drug Interactions: Vykat® XR is a CYP1A2 substrate. Reduce the dosage of Vykat® XR when use concomitantly with strong inhibitors of CYP1A2. Refer to the prescribing information for additional information.

Vykat® XR is an inhibitor of CYP1A2. Concomitant use of Vykat® XR with CYP1A2 substrates is not recommended.

Concomitant use of Vykat® XR with strong CYP3A4 inhibitors increases exposure of diazoxide. Monitor the frequency and severity of adverse reactions from Vykat® XR. A dosage reduction of Vykat® XR may be needed when used concomitantly with strong CYP3A4 inhibitors.

Vykat® XR is a substrate of CYP3A4 and CYP1A2. Concomitant use of Vykat® XR with dual strong CYP3A4/moderate CYP1A2 inducers is not recommended.

Diazoxide is highly bound to serum proteins. Monitor INR in patients who use coumarin or its derivatives concomitantly with Vykat® XR. Dosage modification of coumarin or its derivatives may be needed when used concomitantly with Vykat® XR. In addition, monitor diphenylhydantoin serum levels when Vykat® XR is used concomitantly with diphenylhydantoin. Dosage modification of diphenylhydantoin may be needed when used concomitantly with Vykat® XR.

Both diazoxide and thiazides or other diuretics may produce hyperglycemia and hyperuricemia. Monitor for signs and symptoms of hyperglycemia and hyperuricemia when Vykat® XR is used concomitantly with thiazides or other diuretics. Dosage adjustment of Vykat® XR or diuretics may be needed when Vykat® XR is used concomitantly with diuretics.

Box Warning: There is no box warning listed with this product.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Vykat® XR) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included hypertrichosis (22%), edema (15%), hyperglycemia (12%), rash (10%), pyrexia (6%), arthralgia (3%), influenza (3%), and nasopharyngitis (3%).

Vykat® XR increases blood glucose, mainly due to an inhibition of insulin release from the pancreas. Hyperglycemia, including severe adverse reactions associated with diabetic ketoacidosis, occurred in Vykat® XR treated patients during clinical trials. Based on the severity of the hyperglycemia, Vykat® XR may require dosage interruption, reduction, or discontinuation in order to avoid progression to ketoacidosis. Refer to the recommended dosage section for monitoring requirements and the prescribing information for additional information.

Edema, including general, localized, and peripheral edema, occurred in 27% of Vykat® XR-treated patients as compared with 12% of placebo-treated patients in the placebo-controlled trial with treatment-naïve subjects. The antidiuretic property of diazoxide may lead to significant fluid retention, which may precipitate congestive heart

failure in patients with compromised cardiac reserve. Vykat® XR has not been studied in patients with compromised cardiac reserve and should be used with caution in these patients. Monitor for signs or symptoms of edema or fluid overload and consider appropriate clinical management, which may include Vykat® XR dosage reduction or treatment interruption, if clinically significant.

Contraindications: In patients with known hypersensitivity to diazoxide, other components of the product, or to thiazides.

Manufacturer: Soleno Therapeutics, Inc.

Analysis: The efficacy of Vykat® XR for the treatment of hyperphagia in adult and pediatric patients ages 4 years and older with PWS was established in a double-blind, placebo-controlled, randomized withdrawal study period (Study 2-RWP) of 16 weeks in duration, that followed an open-label study period of Vykat® XR. During Study 2-RWP, patients with hyperphagia and PWS (N=77) were randomized to continue their current oral dosage using a weight-based dosage regimen of Vykat® XR or placebo. Prior to participating in Study 2-RWP, patients received double-blind and/or open-label Vykat® XR for a mean duration of 3.3 years (range 2.5 to 4.5 years; Study 1 and Study 2-OLE). Results from Study-2 RWP are presented below.

Baseline characteristics were similar between the Vykat® XR and placebo groups, with the mean age of 14.9 years (range 7 to 29 years) and most being White (86%) and female (56%).

The primary efficacy endpoint was the change from baseline in the Hyperphagia Questionnaire for Clinical Trials (HQ-CT) Total Score at week 16. The HQ-CT is a 9-item, observer-reported outcome measure that assesses a range of hyperphagic and food-related behaviors during the prior 2 weeks. An item score of 0 indicates an absence of behaviors, with a score of 4 indicating the most frequent or severe behaviors. The HQ-CT Total Score may range from 0 to 36, with higher scores indicating greater overall severity of hyperphagic and food-related behaviors.

Results suggested that at the end of the 16-week randomized withdrawal study period, there was statistically significant worsening of hyperphagia in the placebo group relative to the Vykat® XR group, as assessed by the HQ-CT Total Score. Results are presented in the table below, which was adapted from the prescribing information.

Treatment group	# of patients	Mean Baseline Score	Least Squares (LS) mean change from baseline	LS mean difference
Vykat® XR	38	9.0	2.6	-5.0
Placebo	39	8.1	7.6	

Place in Therapy: Vykat® XR is indicated for the treatment of hyperphagia in adult and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS). Prior to starting treatment, test fasting plasma glucose and HbA1c; optimize blood glucose in patients who have hyperglycemia. Do not substitute Vykat® XR with diazoxide oral suspension as the pharmacokinetic profiles differ. The efficacy of Vykat® XR for the treatment of hyperphagia in adult and pediatric patients ages 4 years and older with PWS was assessed in a 16-week, double-blind, placebo-controlled, randomized withdrawal study period that followed an open-label study period of Vykat® XR. The primary efficacy endpoint was the change from baseline in the HQ-CT Total Score at week 16. At the end of the 16-week randomized withdrawal study period, there was statistically significant worsening of hyperphagia in the placebo group relative to the Vykat® XR group, per the HQ-CT Total Score. Vykat® XR is the only FDA-approved treatment for hyperphagia in individuals 4 years of age and older with PWS.

Summary

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

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

References

[1] Vykat XR [package insert]. Redwood City, CA: Soleno Therapeutics, Inc; 2025.

Prepared By: Iowa Medicaid Date: 09/22/2025

Hepatitis C Treatments, Direct Acting Antivirals Prior Authorization Criteria Review and ProDUR Edits

Background
Since the FDA's approval of the first direct-acting antivirals (DAAs) for hepatitis C virus (HCV) in 2011, boceprevir and telaprevir, the landscape of HCV treatment has undergone a dramatic transformation. The introduction of breakthrough therapies in 2013-2014, such as sofosbuvir and ledipasvir/sofosbuvir, ushered in interferon-free regimens with high sustained virologic response (SVR) rates, fewer adverse effects, and shorter treatment durations. This progress continued with the approval of pan-genotypic options in 2016-2017, including sofosbuvir/velpatasvir and glecaprevir/pibrentasvir, which offered the first 8-week regimen for treatment-naïve patients without cirrhosis.

In parallel, prior authorization (PA) criteria have evolved from highly restrictive to more inclusive, aligning with national clinical guidelines. It is now appropriate to take the next step by removing clinical PA requirements for preferred DDAs. Doing so will streamline access to curative therapy, reinforce alignment with evidence-based guidelines, and help prevent disease progression and associated complications.

According to the 2024 Hepatitis C: State of Medicaid Access National Snapshot Report, 29 state Medicaid programs have eliminated PA requirements for hepatitis C treatment. The 2024 Iowa Report Card assigns Iowa a grade of B, citing deductions due to continued PA requirements and additional restrictions (documentation of chronic HCV diagnosis, documentation of genotype, and viral load collected within 12 months of PA request).

This proposal recommends eliminating clinical PA criteria for DAAs. In place of PA, ProDUR edits will be implemented for preferred DAAs to ensure appropriate use, including quantity limits, treatment duration parameters, and a lookback for prior therapy. PA will be required for non-preferred DAAs and for those claims that fall outside the ProDUR edits.

Currently preferred DAAs include Mavyret and sofosbuvir/velpatasvir (generic Epclusa).

Mavyret (glecaprevir/pibrentasvir)
Indications

- for the treatment of adult and pediatric patients 3 years and older with acute or chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis.
- for the treatment of adult and pediatric patients 3 years and older with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4 protease inhibitor, but not both.

Dosing

- Adults and pediatric patients ≥ 12 years or ≥ 45 kg: 3 tablets taken together once

daily.
- Pediatric patients aged 3 to < 12 years or < 45 kg: weight-based using oral pellets once daily with food; ranges from three to five packets once daily. Note, per package labeling, pediatric patients weighing 45 kg and greater who are unable to swallow tablets may take six 50 mg/20 mg packets of oral pellets daily. Dosing with oral pellets has not been studied for pediatric patients weighing greater than 45 kg.

Treatment Duration
- Treatment-naïve: 8 weeks
- Treatment-experienced: 8 to 16 weeks depending on prior regimen, genotype, and if has compensated cirrhosis
- Liver or kidney transplant recipients: 12 to 16 weeks

How Supplied
- Tablets (100 mg glecaprevir/40 mg pibrentasvir): Monthly carton - 84 tablets; 8-week carton – 168 tablets; bottle – 84 tablets
- Oral pellets (50 mg glecaprevir/20 mg pibrentasvir per packet): 28 packets per carton

Sofosbuvir/velpatasvir

Indications
- For the treatment of adult and pediatric patients 3 years and older with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection:
  - without cirrhosis or with compensated cirrhosis
  - with decompensated cirrhosis for use in combination with ribavirin

Dosing
- Adults: 1 tablet taken once daily
- Pediatric patients 3 years of age and older (weight based):
  - ≤ 17 kg: one 150 mg/37.5 mg packet per day
  - 17 kg to ≤ 30 kg: one 200 mg/50 mg packet or one 200 mg/50 mg tablet per day
  - At least 30 kg: two 200 mg/50 mg packets per day or one 400 mg/100 mg tablet once daily (two 200 mg/50 mg tablets once daily can be used for patients who cannot swallow the 400 mg/100 mg tablet)

Treatment Duration
- Treatment-naïve and treatment-experienced without cirrhosis and with compensated cirrhosis: 12 weeks
- Treatment-naïve and treatment-experienced with decompensated cirrhosis: 12 weeks + ribavirin
- Liver transplant recipients without cirrhosis and with compensated cirrhosis: 12 weeks

How Supplied
- Tablets: bottle – 28 tablets
  - Sofosbuvir 400 mg/velpatasvir 100 mg
  - Sofosbuvir 200 mg/velpatasvir 50 mg
- Oral pellets 28 packets per carton
  - Sofosbuvir 200 mg/velpatasvir 50mg

- Sofosbuvir150 mg/velpatasvir 37.5 mg

Current Clinical Prior Authorization Criteria – *Recommendation to remove PA*
Prior authorization (PA) is required for hepatitis C direct-acting antivirals (DAA). 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. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:

1. Patient has a diagnosis of chronic hepatitis C; and
2. Patient has had testing for hepatitis C virus (HCV) genotype; and
3. Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and
4. Patient's prior HCV DAA treatment history is provided (treatment naïve or treatment experienced); and
5. DAAs approved for pediatric use will be considered for those under the age of 18 when used in accordance with current AASLD guidelines and patient's weight is provided; and
6. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions.
7. If patient is recently eligible for Iowa Medicaid and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on length of therapy for the particular treatment.
8. The 72-hour emergency supply rule does not apply to DAAs.

Requests for treatment-experienced patients (with previous DAA) will be considered under the following conditions:

1. Patient must meet all criteria for treatment approval above; and
2. The requested therapy is FDA approved as therapy for treatment-experienced patients and follows current AASLD guidelines; and
3. HCV retreatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and
4. Patient has not been previously treated with and failed the requested DAA therapy; and
5. Documentation is provided patient has a documented presence of detectable HCV RNA at least 12 weeks after completing previous DAA treatment.

Proposed ProDUR Edits

- Quantity limit

Drug Product	Quantity	Days' Supply
Mavyret tablets	84	28
Mavyret pellets	140 packets (5 cartons)	28
Sofosbuvir 400 mg/velpatasvir 100 mg tablets	28	28
Sofosbuvir 200 mg/velpatasvir 50 mg tablets	56	28
Sofosbuvir 200 mg/velpatasvir 50mg pellets	56	28
Sofosbuvir 150 mg/velpatasvir 37.5mg pellets	28	28

- Treatment duration
    - Mavyret: 16 weeks
    - Sofosbuvir/velpatasvir: 12 weeks
- Lookback for treatment (identify treatment experienced):
    - 365 days
    - Other?

Incretin Mimetics for Non-Diabetes Indications
Prior Authorization Criteria Review

Background
The U.S. Food and Drug Administration (FDA) has approved an additional indication for semaglutide (Wegovy) for the treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), in adults with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis), in combination with a reduced calorie diet and increased physical activity. The indication for MASH is approved under accelerated approval based on improvement of MASH and fibrosis. Continued approval for this indication may be contingent upon the verification and description of clinical benefit in a confirmatory trial. This is the first glucagon-like-peptide-1 (GLP1) receptor agonist approved for MASH and the second drug approved for the condition. Resmetirom (Rezdiffra) was approved via accelerated approval in March 2024.

MASH is a progressive liver disease caused by fat accumulation, inflammation, and scarring, not linked to alcohol use. It is a severe form of Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD). MASH is staged from F0 (no fibrosis) to F4 (advanced fibrosis/cirrhosis). MASLD affects about 30% of U.S. adults, and roughly 20% of those progress to MASH. The primary driver of MASLD is dysfunctional visceral adipose tissue, making overweight and obesity major risk factors for MASLD development.

The American Gastroenterological Association (AGA) recommends using the FIB-4 score, a non-invasive tool based on age and routine lab values, to assess MASH risk. A FIB-4 score ≥1.3 suggested higher risk and warrants further evaluation with liver stiffness measurement (LSM) and referral to a hepatologist. Patients with FIB-4 > 2.67, LSM . 22 kPa, or biopsy-confirmed fibrosis are considered to have clinically significant fibrosis. While liver biopsy is used in clinical trials to assess disease severity, it is not routinely performed in practice.

Dosing and Administration (MASH indication)
- Recommended starting dose: 0.25 mg subcutaneously once weekly for 4 weeks. The dosage should be escalated during weeks 5 through 16.
- If patients do not tolerate a dose during dosage escalation, consider delaying dosage escalation for 4 weeks.
- Recommended maintenance dosage: 2.4 mg subcutaneously once weekly.
    - If patients do not tolerate the maintenance dosage of 2.4 mg once weekly, the dosage can be decreased to 1.7 mg once weekly, with consideration of reescalation to 2.4 mg once weekly.

Clinical Trial (MASH indication)
The approval of Wegovy for MASH was based on an interim analysis at week 72 of the ongoing 240-week ESSENCE trial, a randomized, double-blind, placebo-controlled trial in 800 patients with clinically significant MASLD (metabolic dysfunction-associated

steatotic liver disease), defined as MASH with fibrosis stage 2 or 3 and a non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) ≥ 4 with a score of 1 or more in steatosis, lobular inflammation, and hepatocyte ballooning. Patients received Wegovy or placebo once weekly for 72 weeks in addition to standard of care for cardiometabolic comorbidities and healthy lifestyle counseling. The co-primary endpoints were the resolution of steatohepatitis without worsening of liver fibrosis and at least one stage improvement in liver fibrosis without worsening of steatohepatitis, on post-baseline liver biopsies collected at 72 weeks.

- At week 72, 63% of people treated with Wegovy achieved resolution of steatohepatitis with no worsening of liver fibrosis vs. 34% treated with placebo (difference 29, 95% CI: 21, 36; statistically significant)
- At week 72, 37% of people treated with Wegovy achieved improvement in liver fibrosis with no worsening of steatohepatitis compared to 22% treated with placebo (difference 14, 95% CI: 8, 21; statistically significant)

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 (attach current lab results, obtained within 6 months of request, documenting an A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); 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 with history of one of the following (attach chart notes documenting diagnosis):
        i. Prior myocardial infarction (MI);
        ii. Prior stroke (ischemic or hemorrhagic);
        iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and
    b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2 (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 ≥ 45 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* ~~and~~
4. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and
    a. Patient has a baseline BMI ≥ 30 kg/m^2; and
    b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 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; and
5. Patient will 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.

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

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized 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 (attach current lab results, obtained within 6 months of request, documenting an A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); 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 with history of one of the following (attach chart notes documenting diagnosis):
        i. Prior myocardial infarction (MI);
        ii. Prior stroke (ischemic or hemorrhagic);
        iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and
    b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2 (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 ≥ 45 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 ≥ 30 kg/m^2; and
    b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 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; and
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) ≥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; ~~and~~ *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); and
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 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*

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.

Other Items to Consider

1. MACE Indication
    a. Age limit – Update the age restriction for Wegovy (≥ 45 years of age) in people with established cardiovascular disease with overweight or obesity because this population is at increased risk of recurrent MACE to adults (≥ 18 years).
        i. Wegovy was studied in patients over 45 years of age with overweight or obesity.
        ii. Indication is to reduce the risk of MACE in adults with established cardiovascular disease and either obesity or overweight
    b. ASCVD being limited to prior MI, prior stroke, or symptomatic PAD.
        i. Update criteria to read "*Patient has established CVD, e.g. prior MI, prior stroke or symptomatic PA*.", allowing other forms of established CVD; or
        ii. Update criteria to list additional forms of CVD: "*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*".
2. Chart notes requirement for diagnosis – none required for Zepbound; should the same apply to Wegovy?
3. Requirement to include current A1C lab results obtained within 6 months of request. Should this be a prescriber attestation that patient does not have type 1 or type 2 diabetes?

References

Wegovy. [Prescribing information]. Plainsboro, NJ: Novo Nordisk. Inc.: August 2025.

AGA. Metabolic dysfunction-associated steatotic liver disease (MASLD) toolkit – American Gastroenterological Association. Accessed on 8/26/2025

Sanyal AJ, Newsome PN, Kliers I, et al. Phase 3 Trial of Semaglutide in Metabolic Dysfunction-Associated Steatohepatitis. N Engl J Med. 2025;392(21):2089-2099. doi:10.1056/NEJMoa2413258

Janus Kinase (JAK) Inhibitors, Topical
Prior Authorization Criteria Review

Background
Anzupgo (delgocitinib) cream received US Food and Drug Administration (FDA) approval for the topical treatment of moderate to severe chronic hand eczema (CHE) in adults who have had an inadequate response to, or for whom topical corticosteroids are not advisable.

CHE is defined as hand eczema that lasts for three or more months or relapses twice or more within a year. Key clinical signs and symptoms include redness, thickening of the skin, scaling, edema, vesicles, areas of hyperkeratosis, fissures, and erosions. It is the most frequent occupational skin disease, especially among works exposed to “wet work”, such as healthcare workers, food handlers, and hairdressers.

The *Guidelines for diagnosis, prevention, and treatment of hand eczema* recommend the following treatments for hand eczema:

- Moderate hand eczema
  - Recommended: moderate and potent topical corticosteroids
  - Suggested: phototherapy and tacrolimus ointment
- Severe or very severe hand eczema
  - Recommended: moderate and potent topical corticosteroids
  - Suggested: cyclosporine A (off label systemic treatment)

See the attached new drug review for additional clinical information.

Cost

- WAC: $60.20/30 g; $1,986/30 g tube; $3,972/60 g; $47,664/12 months at 60 g per fill

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

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

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

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

c. Moderately to severely active ulcerative colitis; with
i. A documented trial and inadequate response with a preferred TNF inhibitor; OR

d. Moderately to severely active Crohn's disease; with
i. A documented trial and inadequate response with a preferred TNF inhibitor; OR

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

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

g. Atopic dermatitis; with
i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
iv. For mild to moderate atopic dermatitis:
1. Affected area is less than 20% of body surface area (BSA); and
2. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
v. For moderate to severe atopic dermatitis:
1. A documented trial and therapy failure with a systemic

drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and
2. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; or

h. Nonsegmental vitiligo; with
    i. A documented trial and inadequate response with a potent topical corticosteroid; or
    ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and
    iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable; or
i. Giant Cell Arteritis; with
    i. Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids.

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

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

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Patient has a diagnosis of:
    a. Moderate to severe rheumatoid arthritis; with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
        ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
    b. Psoriatic arthritis; with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        ii. Documented trial and therapy failure with one preferred TNF

inhibitor used for psoriatic arthritis; OR

c. Moderately to severely active ulcerative colitis; with
    i. A documented trial and inadequate response with a preferred TNF inhibitor; OR
d. Moderately to severely active Crohn's disease; with
    i. A documented trial and inadequate response with a preferred TNF inhibitor; OR
e. Polyarticular Course Juvenile Idiopathic Arthritis; with
    i. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with
    i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
    ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR
g. Atopic dermatitis; with
    i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
    ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
    iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    iv. For mild to moderate atopic dermatitis (*topical treatments)*:
        1. Affected area is less than 20% of body surface area (BSA); and
        2. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
    v. For moderate to severe chronic hand eczema (topical treatments):
        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
        2. Patient has been instructed to use no more than 30 grams per 2 weeks or 60 grams per month of topical delgocitinib; or
    vi. For moderate to severe atopic dermatitis *(oral treatments)*:
        1. A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and

2. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; or

h. Nonsegmental vitiligo; with
    i. A documented trial and inadequate response with a potent topical corticosteroid; or
    ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and
    iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable; or
i. Giant Cell Arteritis; with
    i. Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids.

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

References

Anzupgo [prescribing information]. Madison, NJ: Leo Pharma Inc.; July 2025.

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Pegcetacoplan (Empaveli)
Prior Authorization Criteria Review

Background
The U.S. Food and Drug Administration (FDA) approved a new indication for Empaveli (pegcetacoplan) injection to treat adults and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria.

C3G and primary IC-MPGN are uncommon, serious kidney disorders characterized by overactivation of the complement cascade, a key component of the immune system. This dysregulation leads to excessive degradation of the protein C3, with its breakdown products accumulating in the kidneys and triggering inflammation and tissue damage.

Although C3G and primary IC-MPGN are classified as separate conditions, they share a remarkably similar underlying mechanism and disease progression. Common signs and symptoms include hematuria, proteinuria, edema (typically in the legs but potentially affecting other areas), elevated blood pressure, and reduced urine output.

If left untreated, these rare kidney diseases frequently progress to kidney failure within five to ten years of diagnosis, often necessitating dialysis or kidney transplantation. Notably, disease recurrence occurs in approximately 90% of patients who undergo a kidney transplant.

Treatment of C3G and primary IC-MPGN has consisted of renoprotective therapies with renin-angiotensin system inhibitors and more currently sodium glucose cotransporter-2 (SGLT2) inhibitors to slow the progression of renal disease. For patients with nephrotic syndrome, severe inflammation, or rapid deterioration of renal function, steroids or mycophenolate mofetil (MMF) are recommended to be added to renoprotective therapy. The use of complement inhibitors is recommended if there is not complete remission.

Dosage and Administration (new indication)
- Adults: 1,080 mg subcutaneously twice weekly.
- Pediatric patients: dependent upon patient weight.
- Can be administered via a commercially available pump or with Empaveli injector.

Adverse Reactions (new indication)
- ≥ 10%: infusion site reactions, pyrexia, nasopharyngitis, influenza, cough, and nausea.

Clinical Trial
The approval of Empaveli for the new indication was based on a double-blind, placebo-controlled study that included 124 adult and pediatric patients aged 12 years and older and weighing at least 30 kg with biopsy-proven, native kidney or post-transplant recurrent C3G, or native kidney primary IC-MPGN, eGFR ≥ 30 mL/min/1.73 m_2,

proteinuria ≥ 1 g/day, and urine protein-to-creatinine ration (UPCR) ≥ 1g/g. For at least 12 weeks before randomization and throughout the 26-week placebo-controlled period, patients were required to be on stable and optimized doses of angiotensin-converting enzyme inhibitors (ACEIs), angiotensin receptor blockers (ARBs) and/or sodium glucose cotransporter-2 (SGLT2) inhibitors. Immunosuppressant medication doses (e.g. steroids no higher than 20 mg daily, mycophenolate mofetil, tacrolimus) had to be stable for at least 12 weeks before randomization and throughout the 26-week placebo-controlled period. Patients were randomized to Empaveli or placebo, administered twice weekly as a subcutaneous (SC) infusion for 26 weeks. The primary endpoint was the log-transformed ratio of UPCR (sampled from first morning urine collections) at week 26 compared to baseline.

- At week 26, the geometric mean UPCR ratio relative to baseline was 0.33 (95% CI: 0.25, 0.43) and 1.03 (95% CI: 0.91, 1.16) in the Empaveli and placebo groups, respectively, resulting in a 68% reduction in UPCR from baseline in the Empaveli group vs. placebo ($p < 0.0001$).

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and
2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and
3. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and
4. History of at least one red blood cell transfusion in the previous 12 months; and
5. Documentation of hemoglobin < 10.5 g/dL; and
6. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross- titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and
7. Is prescribed by or in consultation with a hematologist; and
8. Medication will be administered in the member's home; and
9. Member or member's care giver has been properly trained in subcutaneous infusion and prescriber has determined home administration is appropriate.

Initial authorizations will be approved for 4 weeks if within cross-titration period with eculizumab (Soliris) to verify eculizumab has been discontinued, or for 6 months otherwise.

Additional authorizations will be considered when the following criteria are met:

1. Documentation of a positive clinical response to therapy (e.g., increased or stabilization or hemoglobin levels or reduction in transfusions); and
2. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris).

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

Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and
2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and
    a. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and
    b. History of at least one red blood cell transfusion in the previous 12 months; and
    ~~c.~~ Documentation of hemoglobin < 10.5 g/dL; *or* ~~and~~
    ~~d. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross- titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and~~
3. *Patient has a diagnosis of compliment 3 glomerulopathy (C3G) or immune-complex membranoproliferative glomerulonephritis (IC-MPGN); and*
    a. Diagnosis is confirmed on renal biopsy; and
    b. Patient is on maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) for at least 3 months prior to starting pegcetacoplan; and
    c. Patient has a history of a trial and therapy failure with systemic oral glucocorticoids or mycophenolate mofetil; and
    d. Patient has a reduced baseline C3 (defined as less than 0.85 x lower limit of the laboratory normal range; and
    e. Documentation of a baseline urine protein-to-creatinine ratio (UPCR) ≥ 1g/g; and
    f. Patient has an eGFR ≥ 30 mL/min/1.73 m_2; and
4. *For patients under 18 years of age, current weight in kg is provided; and*
5. Is prescribed by or in consultation with a hematologist *or nephrologist*; and
6. Medication will be administered in the member's home; and
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*
8. *Will not be used with another complement inhibitor or will only be considered for patients switching from one complement inhibitor to pegcetoplan based on FDA approved labeling*.

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 *the FDA approved recommended time period when switching from a different compliment inhibitor* ~~4 weeks if within cross-titration period with eculizumab (Soliris)~~ to verify *treatment* ~~eculizumab~~ has been discontinued, or for 6 months otherwise.

Additional authorizations will be considered when the following criteria are met:

1. Documentation of a positive clinical response to therapy:
    a. *PNH:* e.g., increased or stabilization or hemoglobin levels or reduction in transfusions; *or*
    b. *C3G or IC-MPGN: e,g., reduction in UPCR from baseline and eGFR ≥ 30 mL/min/1.73 m_2;* and
2. ~~2.~~ Is not prescribed concurrently with *other compliment inhibitors* ~~eculizumab (Soliris) or ravulizumab (Ultomiris)~~.

References

Empaveli [package insert], Waltham, MA: Apellis Pharmaceuticals, Inc.; July 2025.

Genetics Home Reference. Available at: https://ghr.nlm.nih.gov/condition/c3-glomerulopathy. Accessed October 2, 2025.

Noris M, Donadelli R, Remuzzi G. Autoimmune abnormalities of the alternative complement pathway in membranoproliferative glomerulonephritis and C3 glomerulopathy. Pediatr Nephrol. 2019 Aug;34(8):1311-1323.

Noris M, Remuzzi G. C3G and Ig-MPGN-treatment standard. Nephrol Dial Transplant. 2024;39(2):202-214. doi:10.1093/ndt/gfad182

Sepiapterin (Sephience)
Prior Authorization Criteria Review

Background
The U.S. Food and Drug Administration (FDA) approved Sephience (sepiapterin) for the treatment of hyperphenylalaninemia (HPA) in adult and pediatric patients one month of age and older with sepiapterin-responsive phenylketonuria (PKU). Sephience is to be used in conjunction with a phenylalanine (Phe)-restricted diet.

PKU or phenylalanine hydroxylase (PAH) deficiency is an autosomal recessive disorder caused by pathogenic variants in the *PAH* gene. With PAH deficiency, Phe can accumulate and lead to brain dysfunction resulting in severe intellectual disability, epilepsy, and behavioral problems.

Current American College of Medical Genetics and Genomics (ACMG) guidelines for the diagnosis and treatment of phenylalanine hydroxylase (PAH) deficiency (inclusive of PKU and HPA) provide key recommendations in the management of PAH. Note, Sephience is not addressed in these guidelines.

- Treatment should be lifelong for individuals with untreated Phe levels > 360 µmol/L .
- Maintain Phe ≤ 360 µmol/L for life because it's associated with higher IQ levels.
- The risk of neurocognitive or psychosocial symptoms in patients with PKU is related to the age of initiation of therapy, lifelong Phe levels, and treatment adherence.
- Individualization of treatment supported by a combination of therapies (dietary restriction, use of medical foods that are Phe-free or low in Phe, sapropterin, Palynziq) is recommended to maintain Phe levels below the threshold.

See the attached new drug review for additional clinical information.

Cost

- WAC: $125 (250mg) or $500 (1000mg)/packet; for a 45-kg patient = $41,250/30 days; $495,000/12 months

Newly Proposed Clinical Prior Authorization
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:

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 hyperphenylalaninemia (HPA) with sepiapterin-responsive phenylketonuria (PK); and
3. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and

4. Patient has a baseline blood Phe level ≥ 360 µmol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sepiapterin therapy (attach lab results); and
5. Patient's current weight in kg is provided; and
6. Blood Phe levels will be measured after 2 weeks of therapy and at least one more time before initial renewal; and
7. Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).

Initial requests will be considered for 2 months to assess response to therapy.

Continuation of therapy will be considered when the following criteria are met:

1. Patient's current weight in kg is provided; and
2. Patient continues a Phe restricted diet; and
3. 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
4. Patient continues to respond to therapy as demonstrated by a reduction in Phe blood levels since initiation of therapy; and
5. Is not prescribed concurrently with sapropterin (Kuvan).

References

Sephience [prescribing information]. Warren, NJ: PTC Therapeutics, Inc.; July 2025

van Spronsen FJ, Blau N, Harding C, et al. Phenylketonuria. Nat Rev Dis Primers. 2021;7(1):36.

Smith WE, Berry SA, Bloom K, et al. Phenylalanine hydroxylase deficiency diagnosis and management: A 2023 evidence-based clinical guideline of the American College of Medical Genetics and Genomics (ACMG). Genet Med. 2025 Jan;27(1):101289.

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Iowa PDL New Drug Review

Proprietary Name: Sephience®
Common Name: sepiapterin
PDL Category: Endocrine Metabolic Agents

Pharmacology/Usage: Sepiapterin, the active ingredient of Sephience®, is a phenylalanine hydroxylase (PAH) activator. It is a precursor of the enzymatic co-factor tetrahydrobiopterin (BH4) which activates PAH.

Indication: For the treatment of hyperphenylalaninemia (HPA) in adult and pediatric patients 1 month of age and older with sepiapterin-responsive phenylketonuria (PKU). Sephience® is to be used in conjunction with a phenylalanine (Phe)-restricted diet.

There is no pregnancy category for this medication; however, the risk summary indicates that the available data on use during pregnancy are not sufficient to assess for a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Uncontrolled blood Phe concentrations before and during pregnancy are associated with an increased risk of adverse pregnancy outcomes and fetal adverse effects. The safety and efficacy of use in the pediatric population younger than 1 month of age have not been established.

Dosage Form: Oral Powder, in unit-dose packets: 250mg or 1,000mg.

If the Sephience® liquid or soft food mixture is not administered immediately, cover and store the mixture at controlled room temperature (between 20 to 25 degrees C) for up to 6 hours or refrigerate for up to 24 hours. If the liquid or soft food mixture is stored, stir for at least 30 or 60 seconds, respectively, prior to administration of the prescribed dose. Discard unused Sephience® mixture after 6 hours at controlled room temperature or after 24 hours if refrigerated.

Recommended Dosage: Important recommendations prior to treatment:

- Treatment with Sephience® should be directed by physicians knowledgeable in the management of PKU.
- Biochemical response to Sephience® treatment cannot generally be pre-determined by laboratory testing (e.g., molecular testing), and should be determined through a therapeutic evaluation of Sephience®.
- Obtain baseline blood Phe concentration before starting treatment.
- All patients with PKU who are treated with Sephience® should be on a dietary protein and Phe-restricted diet that is based on blood Phe levels. Patients should undergo regular dietary assessments, including protein and Phe intake, by their healthcare provider.

The recommended starting dosage is based on the patient's age and is administered orally once daily. Administer with food. Refer to the table below, which was adapted from the prescribing information.

Age	Sephience® (mg/kg) per day*
Less than 6 months	7.5mg/kg
6 months to less than 1 year	15mg/kg

Age	Sephience® (mg/kg) per day*
1 year to less than 2 years	30mg/kg
2 years and older	60mg/kg

* 60mg/kg is the maximum daily dose for all patients.

For calculated daily doses less than 1,000mg, the final concentration of prepared Sephience® liquid mixture is 25mg/ml.

For dosage titration in patients less than 2 years of age: After initiating treatment at the starting dosage by age, check blood Phe levels to determine response to treatment within 2 weeks. If blood Phe does not decrease, Sephience® dosage may be titrated incrementally based on blood Phe levels to a maximum daily dosage of 60mg/kg. Existing dietary protein and Phe intake should not be modified during the evaluation period.

Discontinue Sephience® in patients whose blood Phe does not decrease after 2 weeks of treatment at the maximum daily dosage of 60mg/kg.

Regarding dosage modification and monitoring, monitor blood Phe levels during treatment, and if needed, modify the daily dosage of Sephience® within the range of 7.5mg/kg to 60mg/kg and/or dietary protein and Phe intake to ensure adequate blood Phe level control. Frequent blood Phe monitoring is recommended in the pediatric population.

A missed dose should be taken as soon as possible but 2 doses should not be administered on the same day. Resume the normal dosing schedule the following day.

Refer to the prescribing information for additional information regarding preparation and administration instructions.

Drug Interactions: Avoid concomitant use of drugs known to inhibit folate synthesis dihydrofolate reductase (DHFR; e.g., trimethoprim, methotrexate, trimetrexate, pemetrexed, pralatrexate, raltitrexed, and piritrexim) while taking Sephience®. Concomitant administration of such drugs may reduce sepiapterin metabolism to tetrahydrobiopterin (BH4). If concomitant use is not avoidable, monitor blood Phe levels.

Avoid concomitant use of sepiapterin reductase (SR) inhibitors with Sephience®. Concomitant administration of such drugs may reduce sepiapterin metabolism to BH4. If concomitant use is not avoidable, monitor blood Phe levels.

Sephience® may increase the availability of tyrosine, a precursor of levodopa. Neurologic events were reported post marketing in patients receiving another PAH activator and levodopa concomitantly for a non-PKU indication. Monitor patients for a change in neurologic status when levodopa is administered with Sephience®.

Sephience® and PDE-5 inhibitors induce vasorelaxation, thus concomitant use of Sephience® with PDE-5 inhibitors may reduce blood pressure even further. Monitor for signs and symptoms of hypotension with concomitant use of Sephience® with drugs that affect nitric oxide-mediated vasorelaxation (e.g., PDE-5 inhibitors such as sildenafil, vardenafil, or tadalafil).

Box Warning: There is no box warning listed with this product.

Common Adverse Drug Reactions: *Listed % incidence for adverse drug reactions= reported % incidence for drug (Sephience®) minus reported % incidence for placebo. Please note that an incidence of 0% means the incidence was the same as or less than placebo.* The most frequently reported adverse events included diarrhea (5%), headache (5%), abdominal pain (3%), hypophenylalaninemia (4%), feces discoloration (4%), and oropharyngeal pain (2%). Adverse reactions were similar across both adult and pediatric populations except for hypophenylalaninemia.

Sephience® may increase the risk of bleeding. Bleeding events, including superficial hematomas, prolonged bleeding, and heavy menstrual bleeding have occurred in patients treated with Sephience®. One patient with non-traumatic superficial hematomas and prolonged bleeding was re-challenged at a lower dose of Sephience® with recurrence of symptoms, which led to treatment discontinuation. The patient experienced symptoms 15 days after initial exposure and two days after rechallenge. The patient had normal blood counts and coagulation studies at the time of the bleeding. Inform the patient about the increased risk of bleeding associated with Sephience® and to follow up with a healthcare provider if any signs of increased bleeding occur. Consider treatment interruption with Sephience® in patients with active bleeding.

In clinical trials of Sephience®, some pediatric PKU patients experienced hypophenylalaninemia (low blood Phe), including some with multiple low blood Phe levels, during Sephience® treatment. Prolonged levels of blood Phe that are too low have been associated with catabolism and endogenous protein breakdown, which has been associated with adverse developmental outcomes. Monitor blood Phe levels during treatment and if needed, modify the Sephience® dosage and/or dietary protein and Phe intake to ensure adequate blood Phe level control. Frequent blood Phe monitoring is recommended in the pediatric population.

In a 10-year post-marketing safety surveillance program for a non-PKU indication using another drug that is a PAH activator, 3 patients with underlying neurological disorders experienced seizures, exacerbation of seizures, over-stimulation, and irritability during co-administration with levodopa. Monitor patients who are receiving levodopa for changes in neurological status during Sephience® treatment.

Contraindications: There are no contraindications listed with this product.

Manufacturer: PTC Therapeutics

Analysis: The efficacy of Sephience® was assessed in Trial 1, a two-part trial that included adult and pediatric patients diagnosed with PKU with hyperphenylalaninemia with at least 2 blood Phe measurements ≥600µmol/L. Included patients in the trial were 54% male, 90% White, and with a mean age of 17 years (range 1 to 61). At trial baseline, 8% of patients had blood Phe levels at <360µmol/L, 36% at 360-600µmol/L, 48% at 600-1200µmol/L, and 8% at >1200µmol/L.

In Part 1, patients (N=157) received open-label treatment with Sephience® for 14 days. In this part of the trial, 66% of PKU patients demonstrated a biochemical response to Sephience® with a 30% or greater reduction in Phe level.

In Part 2, after the 2-week washout period from Part 1, 98 patients aged 2 years and older who demonstrated a ≥30% reduction in blood Phe levels to Sephience® treatment in Part 1 were randomized in a double-blind manner to either Sephience® (N=49) or placebo (N=49) for 6 weeks to assess efficacy. Twelve additional patients who had shown a 15% to 30% reduction in blood Phe during Part 1 were enrolled in Part 2 but were not included in the primary efficacy analysis. In this part of the trial, the primary efficacy was assessed in patients who demonstrated a ≥30% reduction in blood Phe levels during Part 1 (N=98) by the mean change in blood Phe level from baseline to weeks 5 and 6 in the Sephience®-treated group as compared to the mean change in the placebo group.

In Part 2 of Trial 1, 55 patients in the Sephience® group and 54 patients in the placebo group completed the treatment period. One patient in the Sephience® group discontinued treatment. The following table, adapted from the prescribing information, presents a reduction in blood Phe level from baseline to weeks 5 and 6 in Part 2 of Trial 1 for Sephience®-treated patients relative to placebo.

	Sephience® (N=49)	**Placebo (N=49)**
Baseline Blood Phe Level (µmol/L)		
Mean	646.1	654
Percentiles (25^{th}, 75^{th})	468.5, 769.5	466, 796

	Sephience® (N=49)	Placebo (N=49)
Weeks 5 and 6		
Mean	236	637.9
Percentiles (25th, 75th)	127.7, 291	453, 776
Mean Change in Blood Phe from Baseline to weeks 5 and 6 (µmol/L)		
Adjusted Mean *	-415.8	-19.9
Percentiles (25th, 75th)	-544, -296.7	-86.7, 63.7
Treatment difference in adjusted mean *	-395.9	
Mean Percent Change in Blood Phe from Baseline to weeks 5 and 6 (%)		
Mean	-62.8	1.4
Percentiles (25th, 75th)	-76.9, -60.7	-12.4, 15
Treatment difference in adjusted mean	-64.2	

*Adjusted mean and standard error, p-value <0.0001 for treatment difference were from a mixed model for repeated measures (MMRM) with change in blood Phe from baseline to post-baseline assessments as the response variable, and fixed effects for treatment, baseline blood Phe, baseline Phe stratum, visit and treatment-by-visit interaction.

Supportive efficacy data were provided from Trial 2, which is an ongoing, multicenter, open-label trial in adult and pediatric patients with a clinical diagnosis of PKU with hyperphenylalaninemia. At the data cutoff date, 169 patients, including 65 adults and 104 pediatric patients (median age: 14 years, range 2 months to 55 years) received Sephience® treatment. Of the 9 patients under the age of 2 years, 6 patients (66%) had a ≥30% decrease in blood Phe from baseline at weeks 1 and 2. The baseline Phe level in patients 2 years and under was 311.4µmol/L and the mean absolute change in Phe from baseline to weeks 1 and 2 in this age group was -125µmol/L.

Place in Therapy: Sephience® is a phenylalanine hydroxylase (PAH) activator indicated for the treatment of hyperphenylalaninemia (HPA) in adult and pediatric patients 1 month of age and older with sepiapterin-responsive phenylketonuria (PKU). Sephience® is to be used in conjunction with a phenylalanine (Phe)-restricted diet, and should be administered once daily with food. Treatment with Sephience® should be directed by physicians knowledgeable in the management of PKU. Obtain baseline blood Phe concentration before starting treatment. Efficacy was assessed in Trial 1, a two-part trial that included adult and pediatric patients diagnosed with PKU with hyperphenylalaninemia with at least 2 blood Phe measurements ≥600µmol/L. In Part 2, the double-blind portion, the primary efficacy was assessed in patients who demonstrated a ≥30% reduction in blood Phe levels during Part 1 (N=98) by the mean change in blood Phe level from baseline to weeks 5 and 6 in the Sephience®-treated group as compared to the mean change in the placebo group. The adjusted mean change was statistically significant between treatment groups, in favor of Sephience®.

Summary

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

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

References

[1] Sephience [package insert]. Warren, NJ: PTC Therapeutics, Inc; 2025.

Select Topical Agents
Prior Authorization Criteria Review

Background
The US Food and Drug Administration (FDA) approved Zoryve (roflumilast) topical foam, for the treatment of plaque psoriasis of the scalp and body in adult and pediatric patients 12 years of age and older. Zoryve cream 0.3% was already indicated for the treatment of plaque psoriasis, including intertriginous areas, in adult and pediatric patients 6 years of age and older.

Prior authorization criteria are being updated to remove the specific agents listed under each indication and update BSA requirements for plaque psoriasis.

Clinical Trial (Zoryve new indication)
The approval of Zoryve foam for the new indication was based on two randomized, double-blind, vehicle-controlled studies (Trial ARRECTOR and Trial 204) in a total of 736 adult and pediatric patients 12 years of age and older with mild to severe plaque psoriasis of the scalp and body. Patients were randomized to Zoryve topical foam or vehicle foam. In ARRECTOR, the extent of scalp psoriasis was ≥ 10% of the total scalp at baseline and the total overall psoriasis involvement on scalp and non-scalp areas was ≤ 25% BSA (not including palms/soles) at baseline. Total non-scalp BSA did not exceed 20%. Trial 204 does not list BSA parameters. Primary endpoints were Scalp Investigator Global Assessment (S-IGA) and Body Investigator Global Assessment (B-IGA) treatment success.

- In Trial ARRECTOR, S-IGA success was achieved in 66.4% and 27.8% of patients with Zoryve and vehicle, respectively (difference 37.1, 95% CI: 27.1, 47.1). B-IGA success was achieved in 45.5% and 20.1% of patients, respectively (difference 24.8, 95% CI: 15.0, 34.6).
- In Trial 204, S-IGA success was achieved in 56.7% and 11.0% of patients with Zoryve and vehicle, respectively (difference 47.7, 95% CI: 37.9, 57.5). B-IGA success was achieved in 39.0% and 7.4% of patients, respectively (difference 32.4, 95% CI: 23.3, 41.6).

Current Clinical Prior Authorization Criteria
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:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and
    a. Request is for roflumilast 0.3% cream or tapinarof 1% cream; and
    b. 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

3. Patient has a diagnosis of seborrheic dermatitis; and
    a. Request is for roflumilast 0.3% foam; and
    b. 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
4. Patient has a diagnosis of mild to moderate atopic dermatitis; and
    a. Request is for roflumilast 0.15% cream or tapinarof 1% cream; and
    b. Patient has failed to respond to good skin care and regular use of emollients; and
    c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
    d. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks.

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

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
Prior authorization (PA) is required for 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:

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
2. Patient has a diagnosis of plaque psoriasis with *total overall* involvement *on scalp and non-scalp areas* ~~estimated to affect~~ ≤ *25* ~~20~~% of the body surface area *(BSA) at baseline. Total non-scalp BSA should not exceed 20%*; and
    ~~a. Request is for roflumilast 0.3% cream or tapinarof 1% cream; and~~
    b. 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
3. Patient has a diagnosis of seborrheic dermatitis; and
    ~~a. Request is for roflumilast 0.3% foam; and~~
    b. 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
4. Patient has a diagnosis of mild to moderate atopic dermatitis; and
    ~~a. Request is for roflumilast 0.15% cream or tapinarof 1% cream; and~~

b. Patient has failed to respond to good skin care and regular use of emollients; and
c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
d. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks.

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

References

Zoryve topical foam [prescribing information]. Westlake Village, CA: Arcutis Biotherapeutics, Inc.; May 2025.

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DUR DIGEST

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New FDA Warning on Cetirizine and Levocetirizine

The U.S. Food & Drug Administration (FDA) issued a warning about rare, but severe, pruritus that may occur after discontinuing long-term use of cetirizine (Zyrtec) and levocetirizine (Xyzal). Additional warnings have been added to the labeling about this risk.

Between April 25, 2017, and July 6, 2023, the FDA identified 209 cases of pruritus following discontinuation of cetirizine or levocetirizine, with 197 reported domestically through the FDA Adverse Event Reporting System (FAERS). In all cases, itching began shortly after stopping the medication, typically within two days, and was often widespread and severe, significantly impacting quality of life. Most affected individuals had used the medication for over three months, with a median duration of 33 months, suggesting that long-term use may increase the risk of this reaction. Serious outcomes included disability (48 cases), hospitalization (3 cases), and reports of suicidal thoughts or self-harm (2 cases). Notably, 99% of patients who restarted and then stopped the medication again experienced a recurrence of symptoms. Restarting cetirizine or levocetirizine resolved pruritus in 90% of cases, and tapering after restarting helped in 38% of those who tried it. These findings highlight the importance of provider awareness and consideration of tapering strategies when discontinuing long-term antihistamine therapy.

Guidelines published by the American Academy of Allergy, Asthma and Immunology recommend inhaled corticosteroids as a first-line agent for allergic rhinitis. If antihistamines are warranted, second-generation, non-sedating agents are recommended over the older first-generation agents. There are several other second-generation agents available other than cetirizine and levocetirizine, such as loratadine, desloratadine, and fexofenadine. Antihistamine nasal sprays are also an option.

The Iowa Medicaid Preferred Drug List (PDL) contains several preferred agents that do not require prior authorization (PA). Providers are encouraged to review preferred options prior to prescribing medication(s).

New FDA Warning for Extended-Release Stimulants for ADHD

The U.S. Food & Drug Administration (FDA) now requires expanded labeling for extended-release simulants used to treat attention-deficit/hyperactivity disorder (ADHD) to include a warning about the increased risks of weight loss and other adverse effects associated with their use in children under 6 years of age. Although extended-release stimulants are not approved for children younger than 6 years, they can be prescribed off label to treat ADHD. The labels of all stimulants used for the treatment of ADHD already contain a boxed warning about the high risk of abuse and dependence associated with their use.

The FDA's analysis of clinical trial data revealed that children under 6 years old being treated with extended-release formulations of amphetamine or methylphenidate experience higher plasma drug levels and greater rates of adverse reactions compared to older children receiving the same dosage. One of the most concerning findings was clinically significant weight loss, defined as a ≥ 10% drop in CDC weight percentile, observed in both short- and long-term studies.

Children under 6 years old who are taking an extended-release stimulant and have weight loss or other adverse effects should be switched to an immediate-release stimulant.

Guidelines published by the American Academy of Pediatrics recommend first line treatment, for preschool-aged children (age 4 to 5 years) with ADHD, evidence-based PTBM and/or behavioral classroom interventions, if available. Methylphenidate may be considered if behavioral interventions do not provide significant improvement and there is moderate-to-severe continued disturbance in the 4- through 5-year-old child's functioning. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication before the age of 6 years against the harm of delaying treatment.

FDA MedWatch Online Voluntary Reporting

Health professionals, consumers, and patients are encouraged to report observed or suspected adverse events with human medical products to the FDA. Voluntary reporting can assist the FDA in identifying an unknown risk for approved medial products. Reporting can be done through the FDA online reporting portal or by downloading, completing and submitting the FDA form 3500 (Health Professional) or 3500B (Consumer/patient) to MedWatch: The Safety Information and Adverse Event Reporting Program.

Information to report to MedWatch includes unexpected side effects or adverse events, product quality problems, product use/medication errors that can be prevented, and therapeutic failures.

Medicaid Statistics for Prescription Claims
September through November 2025

	FFS	Wellpoint	Iowa Total Care	Molina Healthcare
Total $ Paid				
# Paid Claims				
Unique Users				
Avg Cost/Rx				
Top 5 Therapeutic Class by RX Count Therapeutic class taxonomy may differ among each plan				
Top 5 Therapeutic Class by $ Amount (pre-rebate) Therapeutic class taxonomy may differ among each plan				
Top 5 Drugs by Prescription Count				
Top 5 Drugs by Paid Amount (pre-rebate)				