State Fiscal Year 2022 Print Annual Reviews
Quarter 3

Count	Category/Medication
1.	Actinic Keratosis Medications
2.	Antihypertensive Medications
3.	Anti-Parasitic Medications
4.	Benign Prostatic Hyperplasia (BPH) Medications
5.	Benzodiazepines
6.	Inhaled Anti-Infective Medications
7.	Injectable and Vaginal Progesterone Products
8.	Mozobil® (Plerixafor)
9.	Muscular Dystrophy Medications
10.	Myalept® (Metreleptin)
11.	Mytesi® (Crofelemer)
12.	Osteoporosis Medications
13.	Parkinson's Disease Medications
14.	Prenatal Vitamins
15.	Procysbi® (Cysteamine Bitartrate)
16.	Qbrexza® (Glycopyrronium)
17.	Qualaquin® (Quinine Sulfate)
18.	Strensiq® (Asfotase Alfa)
19.	Xgeva® (Denosumab)
20.	Xuriden® (Uridine Triacetate)

Fiscal Year 2022 = July 1, 2021 – June 30, 2022

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

Fiscal Year 2022 Annual Review of Actinic Keratosis Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Carac® (Fluorouracil 0.5% Cream) Approval Criteria:

1. An FDA approved diagnosis of multiple actinic or solar keratoses of the face and anterior scalp in adults; and
2. Carac® must be prescribed by a dermatologist or an advanced care practitioner with a supervising physician who is a dermatologist; and
3. A patient-specific, clinically significant reason why the member cannot use fluorouracil 5% cream, fluorouracil 5% solution, or fluorouracil 2% solution must be provided.

Picato® (Ingenol Mebutate Gel) Approval Criteria:

1. An FDA approved diagnosis of actinic keratosis (AK); and
2. Member must be 18 years of age or older; and
3. Patient-specific information must be documented on the prior authorization form, including all of the following:
   a. Number of AK lesion(s) being treated; and
   b. Size of each lesion being treated; and
   c. Location of lesion(s) being treated; and
4. Approval quantity and length will be based on patient-specific information provided, in accordance with package labeling and FDA approved dosing regimen.

Solaraze® (Diclofenac 3% Gel) Approval Criteria:

1. An FDA approved diagnosis of actinic keratosis (AK); and
2. Patient-specific information must be documented on the prior authorization form, including all of the following:
   a. Number of AK lesion(s) being treated; and
   b. Size of each lesion being treated; and
   c. Anticipated duration of treatment; and
3. Approval quantity and length will be based on patient-specific information provided, in accordance package labeling and FDA approved dosing regimen.

Zyclara® (Imiquimod 2.5% and 3.75% Cream) Approval Criteria:

1. An FDA approved indication for topical treatment of 1 of the following:
   a. Actinic keratosis (AK) of the full face or balding scalp in immunocompetent adults; or

b. External genital and perianal warts/condyloma acuminate (EGW) in members 12 years and older; and

2. Member must be 12 years of age or older; and
3. Requests for a diagnosis of molluscum contagiosum in children 2 to 12 years of age will generally not be approved; and
4. A patient-specific, clinically significant reason why the member cannot use generic imiquimod 5% cream in place of Zyclara® (imiquimod 2.5% and 3.75%) must be provided.

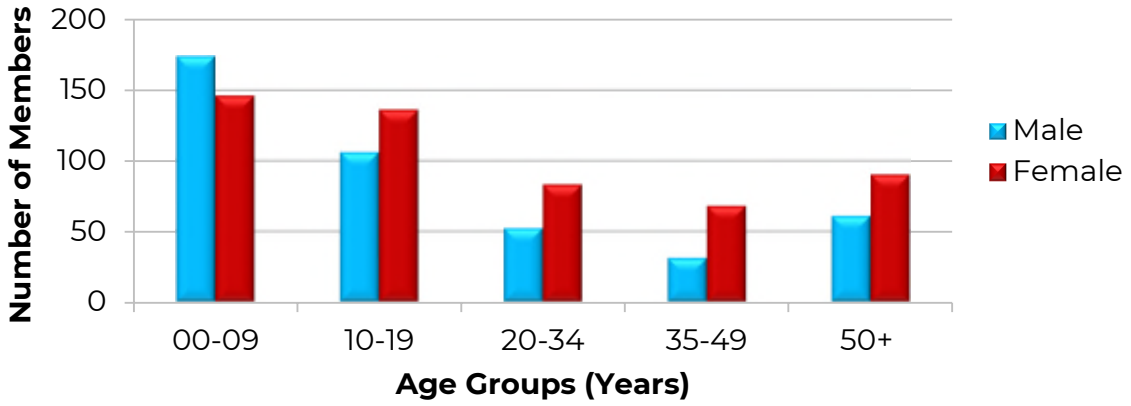
Utilization of Actinic Keratosis Medications: Fiscal Year 2022

Comparison of Fiscal Years

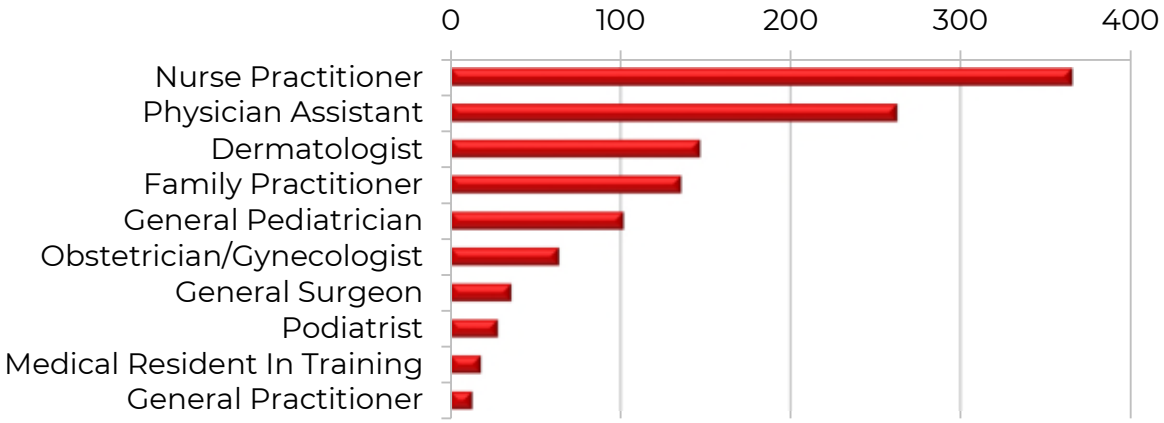
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	714	955	$29,834.46	$31.24	$0.88	15,833	34,013
2022	947	1,240	$40,103.07	$32.34	$0.92	22,248	43,477
% Change	**32.60%**	**29.80%**	**34.40%**	**3.50%**	**4.50%**	**40.50%**	**27.80%**
Change	**233**	**285**	**$10,268.61**	**$1.10**	**$0.04**	**6,415**	**9,464**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Actinic Keratosis Medications



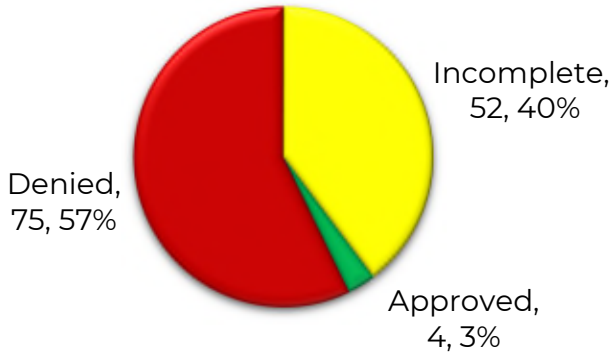
Top Prescriber Specialties of Actinic Keratosis Medications by Number of Claims



Prior Authorization of Actinic Keratosis Medications

There were 131 prior authorization requests submitted for actinic keratosis medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[1]

Anticipated Patent Expiration(s):

- Zyclara® (imiquimod 2.5% and 3.75% cream): December 2029
- Picato® (ingenol mebutate gel): May 2033

Recommendations

The College of Pharmacy does not recommend any changes to the current actinic keratosis medications prior authorization criteria at this time.

Utilization Details of Actinic Keratosis Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
IMIQUIMOD CRE 5%	1,050	796	$24,412.97	$25.16	1.32	65.86%
FLUOROURACIL CRE 5%	188	153	$12,503.13	$66.16	1.23	31.18%
FLUOROURACIL SOL 5%	1	1	$67.85	$67.85	1	0.17%
IMIQUIMOD CREAM 3.75%	1	1	$1,119.12	$1,119.12	1	2.79%
TOTAL	**1,240**	**947***	**$40,103.07**	**$32.34**	**1.31**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CRE = cream; SOL= solution
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 02/2023. Last accessed 02/24/2023.

Fiscal Year 2022 Annual Review of Antihypertensive Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

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

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

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

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

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

⁺All strengths other than 32mg.
*All strengths other than 360mg.
CD = controlled-delivery; ER, XR, XL = extended-release; LA = long-acting; SR = sustained-release

Antihypertensive Medications Tier-2 Approval Criteria:
(or Tier-3 approval criteria when no Tier-2 medications exist)

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

Antihypertensive Medications Tier-3 Approval Criteria:

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

Antihypertensive Medications Special Prior Authorization (PA) Approval Criteria:

1. **Angiotensin I Converting Enzyme Inhibitors (ACEIs):**
    a. **Epaned® (Enalapril Solution) Approval Criteria:**
        i. An age restriction of 7 years or older will apply with the following criteria:
            1. A patient-specific, clinically significant reason why the member cannot use the oral tablet formulation in place of the oral solution formulation, even when the tablets are crushed, must be provided.
    b. **Qbrelis® (Lisinopril Oral Solution) Approval Criteria:**
        i. A patient-specific, clinically significant reason why the member cannot use lisinopril oral tablets in place of the oral

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

2. **ACEI/Hydrochlorothiazide (HCTZ) Combination Products:**
    a. **Monopril-HCT® (Fosinopril/HCTZ) Approval Criteria:**
        i. A patient-specific, clinically significant reason why the member cannot use the individual components separately must be provided.
3. **Calcium Channel Blockers (CCBs):**
    a. **Cardizem® CD (Diltiazem CD 360mg Capsules) Approval Criteria:**
        i. A patient-specific, clinically significant reason why the member cannot use (2) 180mg Cardizem® CD (diltiazem CD) capsules must be provided.
    b. **Conjupri® (Levamlodipine Tablets) Approval Criteria:**
        i. A patient-specific, clinically significant reason why the member cannot use amlodipine oral tablets, which are available without prior authorization, must be provided.
    c. **Consensi® (Amlodipine/Celecoxib Tablets) Approval Criteria:**
        i. A patient-specific, clinically significant reason why the member cannot use the individual components separately, which are available without prior authorization, must be provided; and
        ii. A quantity limit of 30 tablets per 30 days will apply.
    d. **Katerzia® (Amlodipine Oral Suspension) and Norliqva® (Amlodipine Oral Solution) Approval Criteria:**
        i. An FDA approved diagnosis of 1 of the following:
            1. Hypertension in adults and pediatric members 6 years of age and older; or
            2. Coronary artery disease; or
            3. Chronic stable angina; or
            4. Vasospastic angina; and
        ii. A patient specific, clinically significant reason why the member cannot use amlodipine oral tablets, even when the tablets are crushed, must be provided; and
        iii. A quantity limit of 300mL per 30 days will apply.
4. **ACEI/CCB Combination Products:**
    a. **Prestalia® (Perindopril/Amlodipine) Approval Criteria:**
        i. An FDA approved diagnosis; and
        ii. Documented trials of inadequate response to 2 Tier-1 angiotensin I converting enzyme inhibitors (ACEIs) in combination with amlodipine; and
        iii. A patient-specific, clinically significant reason why the member cannot use the individual components separately must be provided; and
        iv. A quantity limit of 30 tablets per 30 days will apply.

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

CaroSpir® (Spironolactone Oral Suspension) Approval Criteria:

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

Hemangeol® (Propranolol Hydrochloride Oral Solution) Approval Criteria:

1. An FDA approved indication for the treatment of proliferating infantile hemangioma requiring systemic therapy.

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

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

Nymalize® (Nimodipine Oral Solution) Approval Criteria:

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

Sotylize® (Sotalol Oral Solution) Approval Criteria:

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

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

1. An FDA approved diagnosis; and
2. Member must be 6 years of age or older; and
3. A recent trial, within the previous 6 months and at least 4 weeks in duration, of an angiotensin I converting enzyme inhibitor (ACEI) [or an angiotensin II receptor blocker (ARB) if previous trial of an ACEI] and a diuretic, used concomitantly at recommended doses, that did not yield adequate blood pressure control; and
4. May be used in either monotherapy or combination therapy; and

5. For Tekturna® oral pellets, a patient-specific, clinically significant reason why the member cannot use Tekturna® oral tablets must be provided.

Vecamyl® (Mecamylamine) Approval Criteria:

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

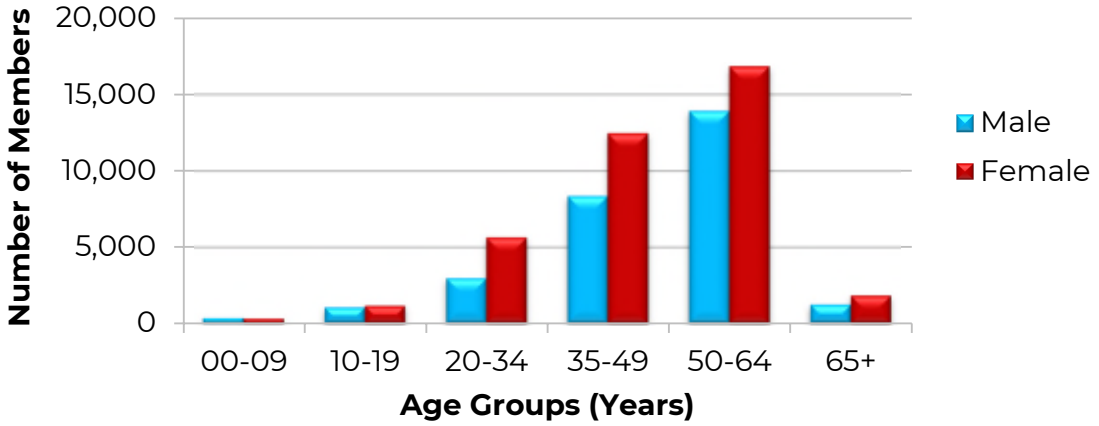
Utilization of Antihypertensive Medications: Fiscal Year 2022

Comparison of Fiscal Years

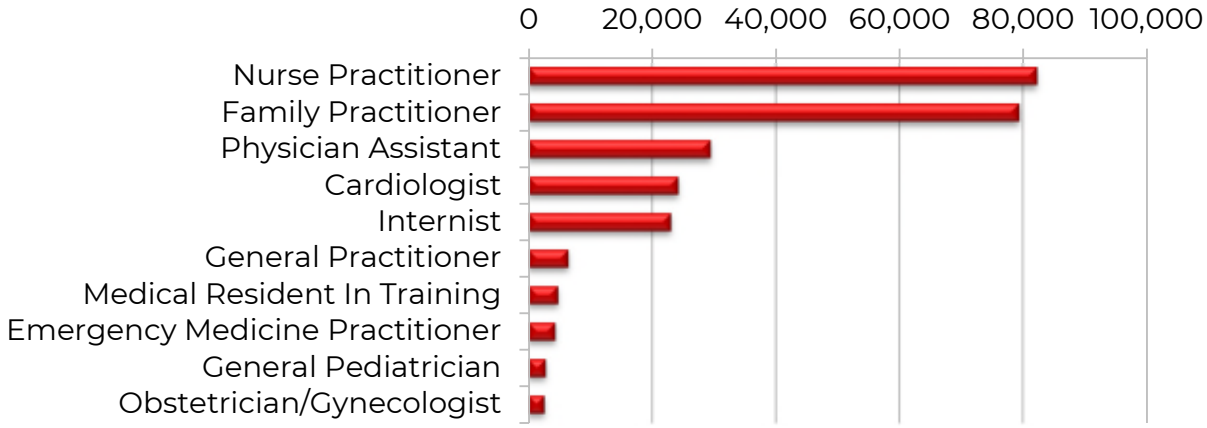
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	35,688	165,902	$2,900,124.55	$17.48	$0.32	10,892,296	9,084,259
2022	65,955	276,045	$4,290,193.81	$15.54	$0.27	18,504,082	15,788,882
% Change	**84.80%**	**66.40%**	**47.90%**	**-11.10%**	**-15.60%**	**69.90%**	**73.80%**
Change	**30,267**	**110,143**	**$1,390,069.26**	**-$1.94**	**-$0.05**	**7,611,786**	**6,704,623**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Antihypertensive Medications



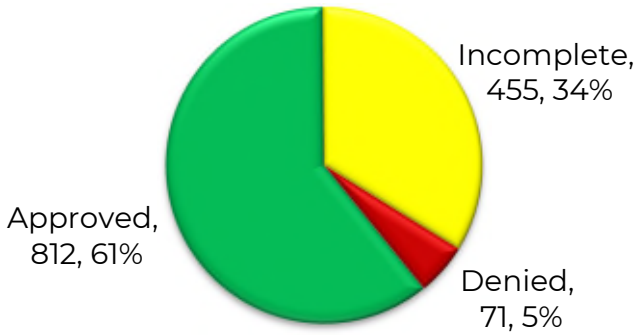
Top Prescriber Specialties of Antihypertensive Medications by Number of Claims



Prior Authorization of Antihypertensive Medications

There were 1,338 prior authorization requests submitted for antihypertensive medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[1]

Anticipated Patent Expiration(s):

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

Recommendations

The College of Pharmacy does not recommend any changes to the antihypertensive medications PBPA category or prior authorization criteria at this time.

Utilization Details of Antihypertensive Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
ANGIOTENSIN I CONVERTING ENZYME INHIBITORS (ACEIs)						
TIER-1 UTILIZATION						
LISINOPRIL TAB 20MG	24,580	9,531	$242,798.19	$9.88	2.58	5.66%
LISINOPRIL TAB 10MG	23,923	9,635	$223,487.29	$9.34	2.48	5.21%
LISINOPRIL TAB 40MG	12,679	4,477	$155,271.08	$12.25	2.83	3.62%
LISINOPRIL TAB 5MG	10,504	4,100	$97,706.49	$9.30	2.56	2.28%
LISINOPRIL TAB 2.5MG	4,658	1,734	$43,935.21	$9.43	2.69	1.02%
LISINOPRIL TAB 30MG	1,759	643	$19,543.64	$11.11	2.74	0.46%
ENALAPRIL TAB 20MG	779	226	$16,317.74	$20.95	3.45	0.38%
ENALAPRIL TAB 2.5MG	688	152	$12,052.64	$17.52	4.53	0.28%
ENALAPRIL TAB 5MG	686	167	$12,571.88	$18.33	4.11	0.29%
ENALAPRIL TAB 10MG	644	199	$11,203.57	$17.40	3.24	0.26%
BENAZEPRIL TAB 20MG	389	135	$4,899.59	$12.60	2.88	0.11%
BENAZEPRIL TAB 40MG	318	99	$3,854.60	$12.12	3.21	0.09%
RAMIPRIL CAP 10MG	207	74	$2,688.11	$12.99	2.8	0.06%
BENAZEPRIL TAB 10MG	205	58	$2,659.73	$12.97	3.53	0.06%
RAMIPRIL CAP 5MG	101	48	$1,107.12	$10.96	2.1	0.03%
QUINAPRIL TAB 40MG	84	21	$1,419.12	$16.89	4	0.03%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
RAMIPRIL CAP 2.5MG	80	27	$920.81	$11.51	2.96	0.02%
RAMIPRIL CAP 1.25MG	68	26	$1,004.81	$14.78	2.62	0.02%
BENAZEPRIL TAB 5MG	65	26	$825.49	$12.70	2.5	0.02%
QUINAPRIL TAB 20MG	64	18	$1,056.64	$16.51	3.56	0.02%
FOSINOPRIL TAB 20MG	40	11	$782.25	$19.56	3.64	0.02%
FOSINOPRIL TAB 40MG	30	6	$583.05	$19.44	5	0.01%
FOSINOPRIL TAB 10MG	24	11	$498.63	$20.78	2.18	0.01%
QUINAPRIL TAB 10MG	13	3	$192.36	$14.80	4.33	0.00%
PERINDOPRIL TAB 8MG	11	3	$265.75	$24.16	3.67	0.01%
MOEXIPRIL TAB 15MG	7	3	$349.38	$49.91	2.33	0.01%
QUINAPRIL TAB 5MG	5	1	$96.18	$19.24	5	0.00%
TRANDOLAPRIL TAB 2MG	5	2	$103.36	$20.67	2.5	0.00%
PERINDOPRIL TAB 2MG	4	1	$93.96	$23.49	4	0.00%
TRANDOLAPRIL TAB 4MG	4	1	$86.52	$21.63	4	0.00%
PERINDOPRIL TAB 4MG	4	2	$123.58	$30.90	2	0.00%
TIER-1 SUBTOTAL	**82,628**	**31,440**	**$858,498.77**	**$10.39**	**2.63**	**20.01%**
TIER-2 UTILIZATION						
CAPTOPRIL TAB 50MG	60	10	$3,172.07	$52.87	6	0.07%
CAPTOPRIL TAB 25MG	59	15	$2,122.66	$35.98	3.93	0.05%
CAPTOPRIL TAB 100MG	12	1	$1,055.28	$87.94	12	0.02%
CAPTOPRIL TAB 12.5MG	1	1	$56.80	$56.80	1	0.00%
TIER-2 SUBTOTAL	**132**	**27**	**$6,406.81**	**$48.54**	**4.89**	**0.15%**
SPECIAL PRIOR AUTHORIATION (PA) UTILIZATION						
EPANED SOL 1MG/ML	667	165	$232,183.50	$348.10	4.04	5.41%
ENALAPRIL SOL 1MG/ML	636	162	$162,020.97	$254.75	3.93	3.78%
QBRELIS SOL 1MG/ML	138	22	$59,679.60	$432.46	6.27	1.39%
SPECIAL PA SUBTOTAL	**1,441**	**349**	**$453,884.07**	**$314.98**	**4.13**	**10.58%**
ACEI TOTAL	**84,201**	**31,816**	**$1,318,789.65**	**$15.66**	**2.65**	**30.74%**
CALCIUM CHANNEL BLOCKERS (CCBs)						
TIER-1 UTILIZATION						
AMLODIPINE TAB 10MG	26,704	9,458	$268,832.63	$10.07	2.82	6.27%
AMLODIPINE TAB 5MG	21,331	8,403	$208,148.32	$9.76	2.54	4.85%
AMLODIPINE TAB 2.5MG	3,156	1,245	$31,814.23	$10.08	2.53	0.74%
NIFEDIPINE TAB 30MG ER	1,751	957	$32,880.80	$18.78	1.83	0.77%
DILTIAZEM CAP 120MG ER	983	384	$19,877.19	$20.22	2.56	0.46%
NIFEDIPINE TAB 60MG ER	975	413	$21,261.97	$21.81	2.36	0.50%
DILTIAZEM CAP 240MG ER	852	266	$22,077.33	$25.91	3.2	0.51%
DILTIAZEM CAP 180MG ER	722	265	$17,485.94	$24.22	2.72	0.41%
NIFEDIPINE TAB 30MG ER	655	329	$12,926.08	$19.73	1.99	0.30%
NIFEDIPINE TAB 60MG ER	574	235	$13,025.96	$22.69	2.44	0.30%
NIFEDIPINE CAP 10MG	453	283	$15,386.50	$33.97	1.6	0.36%
VERAPAMIL TAB 240MG ER	421	116	$8,059.28	$19.14	3.63	0.19%
VERAPAMIL TAB 120MG ER	323	112	$7,668.98	$23.74	2.88	0.18%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
NIFEDIPINE TAB 90MG ER	319	128	$10,157.44	$31.84	2.49	0.24%
DILTIAZEM TAB 30MG	298	110	$5,306.73	$17.81	2.71	0.12%
DILTIAZEM TAB 60MG	291	100	$6,586.81	$22.64	2.91	0.15%
VERAPAMIL TAB 180MG ER	243	87	$4,910.10	$20.21	2.79	0.11%
NIFEDIPINE TAB 90MG ER	225	91	$7,407.60	$32.92	2.47	0.17%
DILTIAZEM TAB 120MG	220	73	$5,718.90	$26.00	3.01	0.13%
VERAPAMIL TAB 80MG	176	69	$2,367.02	$13.45	2.55	0.06%
VERAPAMIL TAB 40MG	155	56	$3,457.10	$22.30	2.77	0.08%
VERAPAMIL TAB 120MG	151	48	$2,375.41	$15.73	3.15	0.06%
DILT-XR CAP 240MG	118	43	$5,735.70	$48.61	2.74	0.13%
NIFEDIPINE CAP 20MG	117	75	$9,691.14	$82.83	1.56	0.23%
DILTIAZEM CAP 360MG ER	114	40	$4,849.73	$42.54	2.85	0.11%
DILTIAZEM CAP 300MG ER	110	34	$3,656.13	$33.24	3.24	0.09%
DILTIAZEM CAP 120MG/24HR	105	52	$2,668.37	$25.41	2.02	0.06%
DILT-XR CAP 120MG	96	47	$2,533.76	$26.39	2.04	0.06%
DILT-XR CAP 180MG	79	28	$2,726.85	$34.52	2.82	0.06%
DILTIAZEM CAP 240MG/24HR	71	38	$3,061.56	$43.12	1.87	0.07%
DILTIAZEM TAB 90MG	68	24	$1,906.75	$28.04	2.83	0.04%
CARTIA XT CAP 120MG/24HR	59	29	$1,184.35	$20.07	2.03	0.03%
DILTIAZEM CAP 180MG/24HR	35	19	$1,186.65	$33.90	1.84	0.03%
DILTIAZEM CAP 240MG ER	29	10	$1,191.70	$41.09	2.9	0.03%
FELODIPINE TAB 5MG ER	27	10	$462.92	$17.15	2.7	0.01%
FELODIPINE TAB 10MG ER	22	10	$452.12	$20.55	2.2	0.01%
DILTIAZEM CAP 300MG ER	20	8	$928.48	$46.42	2.5	0.02%
CARTIA XT CAP 180MG/24HR	20	15	$493.33	$24.67	1.33	0.01%
CARTIA XT CAP 240MG/24HR	19	12	$538.23	$28.33	1.58	0.01%
NIMODIPINE CAP 30MG	16	10	$2,565.43	$160.34	1.6	0.06%
TIADYLT CAP 240MG/24HR	14	6	$508.91	$36.35	2.33	0.01%
TIADYLT CAP 120MG/24HR	13	5	$335.76	$25.83	2.6	0.01%
DILTIAZEM CAP 420MG/24HR	8	3	$725.01	$90.63	2.67	0.02%
DILTIAZEM ER TAB 420MG	6	2	$1,035.97	$172.66	3	0.02%
DILTIAZEM CAP 180MG ER	6	5	$240.39	$40.07	1.2	0.01%
TIADYLT CAP 360MG/24HR	6	3	$181.29	$30.22	2	0.00%
CARTIA XT CAP 300MG/24HR	4	3	$142.21	$35.55	1.33	0.00%
TIADYLT CAP 180MG/24HR	1	1	$32.88	$32.88	1	0.00%
FELODIPINE TAB 2.5MG ER	1	1	$22.16	$22.16	1	0.00%
TAZTIA XT CAP 360MG/24HR	1	1	$64.16	$64.16	1	0.00%
TIER-1 SUBTOTAL	**62,163**	**23,762**	**$776,854.26**	**$12.50**	**2.62**	**18.11%**
TIER-2 UTILIZATION						
VERAPAMIL CAP 120MG SR	35	7	$1,701.27	$48.61	5	0.04%
DILTIAZEM ER TAB 180MG	33	10	$3,999.16	$121.19	3.3	0.09%
VERAPAMIL CAP 180MG SR	31	14	$3,273.96	$105.61	2.21	0.08%
VERAPAMIL CAP 360MG SR	31	12	$9,896.51	$319.24	2.58	0.23%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
DILTIAZEM CAP 60MG ER	25	11	$3,443.42	$137.74	2.27	0.08%
AMLOD/ATORVA TAB 10/40MG	21	5	$2,813.33	$133.97	4.2	0.07%
DILTIAZEM CAP 120MG ER	22	8	$5,012.46	$227.84	2.75	0.12%
VERAPAMIL CAP 240MG SR	19	7	$1,838.69	$96.77	2.71	0.04%
DILTIAZEM CAP 90MG ER	19	7	$2,257.96	$118.84	2.71	0.05%
DILTIAZEM ER TAB 360MG	17	8	$4,015.58	$236.21	2.13	0.09%
MATZIM LA TAB 420MG/24HR	16	3	$2,317.75	$144.86	5.33	0.05%
VERAPAMIL CAP 100MG ER	15	3	$2,641.70	$176.11	5	0.06%
DILTIAZEM ER TAB 240MG	13	6	$2,244.65	$172.67	2.17	0.05%
VERAPAMIL CAP 300MG ER	12	3	$6,521.35	$543.45	4	0.15%
AMLOD/ATORVA TAB 10/10MG	11	4	$1,823.17	$165.74	2.75	0.04%
AMLOD/ATORVA TAB 10/80MG	11	3	$3,393.95	$308.54	3.67	0.08%
AMLOD/ATORVA TAB 5/40MG	11	3	$2,766.57	$251.51	3.67	0.06%
NICARDIPINE CAP 20MG	10	2	$2,814.06	$281.41	5	0.07%
AMLOD/ATORVA TAB 10/20MG	9	2	$1,776.53	$197.39	4.5	0.04%
AMLOD/ATORVA TAB 5/20MG	8	4	$996.97	$124.62	2	0.02%
VERAPAMIL CAP 200MG ER	8	3	$2,797.52	$349.69	2.67	0.07%
VERAPAMIL CAP 240MG ER	7	3	$685.98	$98.00	2.33	0.02%
VERAPAMIL CAP 180MG ER	7	3	$653.72	$93.39	2.33	0.02%
VERAPAMIL CAP 120MG ER	6	2	$556.06	$92.68	3	0.01%
MATZIM LA TAB 360MG/24HR	6	2	$1,213.41	$202.24	3	0.03%
ISRADIPINE CAP 2.5MG	5	2	$266.83	$53.37	2.5	0.01%
AMLOD/ATORVA TAB 5/10MG	4	1	$813.10	$203.28	4	0.02%
MATZIM LA TAB 180MG/24HR	4	1	$756.07	$189.02	4	0.02%
MATZIM LA TAB 240MG/24HR	4	2	$735.63	$183.91	2	0.02%
AMLOD/ATORVA TAB 2.5/20MG	4	1	$1,901.48	$475.37	4	0.04%
ISRADIPINE CAP 5MG	2	2	$128.23	$64.12	1	0.00%
CARDIZEM LA TAB 120MG	2	2	$456.61	$228.31	1	0.01%
DILTIAZEM CAP 120MG ER	1	1	$24.14	$24.14	1	0.00%
TIER-2 SUBTOTAL	**429**	**147**	**$76,537.82**	**$178.41**	**2.92**	**1.78%**
SPECIAL PA UTILIZATION						
KATERZIA SUS 1MG/ML	241	51	$89,175.83	$370.02	4.73	2.08%
DILTIAZEM CAP 360MG CD	12	5	$1,397.05	$116.42	2.4	0.03%
NORLIQVA SOL 1MG/ML	1	1	$347.57	$347.57	1	0.01%
SPECIAL PA SUBTOTAL	**254**	**57**	**$90,920.45**	**$357.95**	**4.46**	**2.12%**
CCB TOTAL	**62,846**	**23,966**	**$944,312.53**	**$15.03**	**2.62**	**22.01%**
METOPROLOL PRODUCTS						
NO PA REQUIRED						
METOPROLOL TAR TAB 25MG	12,973	4,658	$127,245.90	$9.81	2.79	2.97%
METOPROLOL SUC TAB 25MG ER	11,577	4,497	$162,823.03	$14.06	2.57	3.80%
METOPROLOL SUC TAB 50MG ER	9,105	3,370	$140,295.10	$15.41	2.7	3.27%
METOPROLOL TAR TAB 50MG	8,768	2,949	$86,873.61	$9.91	2.97	2.02%
METOPROLOL SUC TAB 100MG ER	4,553	1,589	$86,674.05	$19.04	2.87	2.02%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
METOPROLOL TAR TAB 100MG	2,976	999	$30,577.17	$10.27	2.98	0.71%
METOPROLOL SUC TAB 200MG ER	793	235	$20,341.49	$25.65	3.37	0.47%
METOPROLOL TAR TAB 75MG	128	62	$3,667.98	$28.66	2.06	0.09%
METOPROLOL TAR TAB 37.5MG	54	17	$848.78	$15.72	3.18	0.02%
NO PA SUBTOTAL	**50,927**	**18,376**	**$659,347.11**	**$12.95**	**2.77**	**15.37%**
SPECIAL PA UTILIZATION						
KAPSPARGO CAP 50MG	7	1	$416.18	$59.45	7	0.01%
KAPSPARGO CAP 25MG	3	1	$177.30	$59.10	3	0.00%
SPECIAL PA SUBTOTAL	**10**	**2**	**$593.48**	**$59.35**	**5**	**0.01%**
METOPROLOL TOTAL	**50,937**	**18,378**	**$659,940.59**	**$12.96**	**2.77**	**15.38%**
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) AND ARB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LOSARTAN POT TAB 50MG	10,696	4,243	$141,820.06	$13.26	2.52	3.31%
LOSARTAN POT TAB 100MG	8,992	3,233	$128,768.78	$14.32	2.78	3.00%
LOSARTAN POT TAB 25MG	7,564	3,051	$89,099.64	$11.78	2.48	2.08%
LOSAR/HCTZ TAB 100/25MG	1,887	735	$36,769.33	$19.49	2.57	0.86%
LOSAR/HCTZ TAB 50/12.5MG	1,743	733	$26,131.39	$14.99	2.38	0.61%
LOSAR/HCTZ TAB 100/12.5MG	1,139	416	$19,389.34	$17.02	2.74	0.45%
OLMESARTAN TAB 40MG	769	266	$13,440.30	$17.48	2.89	0.31%
OLMESARTAN TAB 20MG	725	311	$11,225.09	$15.48	2.33	0.26%
VALSARTAN TAB 80MG	678	282	$14,598.79	$21.53	2.4	0.34%
VALSARTAN TAB 160MG	645	275	$15,376.71	$23.84	2.35	0.36%
VALSARTAN TAB 320MG	365	137	$10,126.54	$27.74	2.66	0.24%
VALSARTAN TAB 40MG	343	132	$7,271.98	$21.20	2.6	0.17%
TELMISARTAN TAB 40MG	342	106	$9,878.47	$28.88	3.23	0.23%
IRBESARTAN TAB 150MG	331	112	$6,255.17	$18.90	2.96	0.15%
IRBESARTAN TAB 300MG	313	100	$7,456.47	$23.82	3.13	0.17%
OLMESAR/HCTZ TAB 40/25MG	261	101	$7,217.90	$27.65	2.58	0.17%
VALSAR/HCTZ TAB 160/12.5MG	257	88	$5,522.92	$21.49	2.92	0.13%
TELMISARTAN TAB 80MG	245	85	$7,365.61	$30.06	2.88	0.17%
CANDESARTAN TAB 8MG	209	78	$11,015.48	$52.71	2.68	0.26%
CANDESARTAN TAB 16MG	201	78	$9,232.21	$45.93	2.58	0.22%
OLMESARTAN TAB 5MG	168	53	$2,400.82	$14.29	3.17	0.06%
VALSAR/HCTZ TAB 160/25MG	168	64	$4,550.00	$27.08	2.63	0.11%
VALSAR/HCTZ TAB 320/25MG	166	72	$5,804.66	$34.97	2.31	0.14%
IRBESARTAN TAB 75MG	164	52	$3,274.41	$19.97	3.15	0.08%
OLMESAR/HCTZ TAB 20/12.5MG	161	61	$3,177.28	$19.73	2.64	0.07%
OLMESAR/HCTZ TAB 40/12.5MG	154	53	$4,318.45	$28.04	2.91	0.10%
AMLOD/VALSAR TAB 5/160MG	144	68	$4,704.66	$32.67	2.12	0.11%
TELMISARTAN TAB 20MG	140	53	$3,417.89	$24.41	2.64	0.08%
CANDESARTAN TAB 4MG	135	47	$7,678.76	$56.88	2.87	0.18%
VALSAR/HCTZ TAB 80/12.5MG	130	40	$3,030.92	$23.31	3.25	0.07%
AMLOD/VALSAR TAB 10/320MG	116	47	$5,037.40	$43.43	2.47	0.12%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
AMLOD/VALSAR TAB 10/160MG	110	39	$3,983.40	$36.21	2.82	0.09%
IRBESAR/HCTZ TAB 150/12.5MG	90	34	$2,129.75	$23.66	2.65	0.05%
IRBESAR/HCTZ TAB 300/12.5MG	77	30	$2,127.77	$27.63	2.57	0.05%
VALSAR/HCTZ TAB 320/12.5MG	69	32	$2,527.78	$36.63	2.16	0.06%
AMLOD/OLMESAR TAB 10/40MG	61	17	$2,193.70	$35.96	3.59	0.05%
AMLOD/VALSAR TAB 5/320MG	33	12	$1,278.79	$38.75	2.75	0.03%
AMLOD/OLMESAR TAB 5/20MG	27	16	$938.15	$34.75	1.69	0.02%
AMLOD/OLMESAR TAB 10/20MG	18	9	$624.08	$34.67	2	0.01%
AMLOD/OLMESAR TAB 5/40MG	18	5	$469.39	$26.08	3.6	0.01%
BENICAR TAB 20MG	11	1	$2,615.40	$237.76	11	0.06%
EXFORGE HCT TAB 10/320/25MG	8	1	$1,575.16	$196.90	8	0.04%
MICARDIS TAB 40MG	4	1	$2,357.10	$589.28	4	0.05%
EXFORGE HCT TAB 10/160/25MG	3	2	$927.15	$309.05	1.5	0.02%
COZAAR TAB 50MG	3	1	$1,464.01	$488.00	3	0.03%
EXFORGE HCT TAB 10/160/12.5MG	3	1	$927.15	$309.05	3	0.02%
AMLOD/VALSAR/HCTZ TAB 10/320/25MG	2	1	$108.16	$54.08	2	0.00%
MICARDIS TAB 80MG	1	1	$414.98	$414.98	1	0.01%
TIER-1 SUBTOTAL	**39,889**	**15,375**	**$652,019.35**	**$16.35**	**2.59**	**15.20%**
TIER-2 UTILIZATION						
CANDESARTAN TAB 32MG	50	22	$3,585.06	$71.70	2.27	0.08%
TELMISAR/HCTZ TAB 40/12.5MG	43	10	$3,175.20	$73.84	4.3	0.07%
TELMISAR/HCTZ TAB 80/12.5MG	36	8	$2,660.93	$73.91	4.5	0.06%
OLMESAR/AMLOD/HCTZ TAB 40/10/25MG	20	4	$1,758.80	$87.94	5	0.04%
TELMISAR/HCTZ TAB 80/25MG	19	5	$1,720.85	$90.57	3.8	0.04%
OLMESAR/AMLOD/HCTZ TAB 20/5/12.5MG	10	4	$604.96	$60.50	2.5	0.01%
OLMESAR/AMLOD/HCTZ TAB 40/5/25MG	7	4	$1,042.91	$148.99	1.75	0.02%
OLMESAR/AMLOD/HCTZ TAB 40/5/12.5MG	2	2	$84.27	$42.14	1	0.00%
OLMESAR/AMLOD/HCTZ TAB 40/10/12.5MG	2	1	$295.03	$147.52	2	0.01%
TIER-2 SUBTOTAL	**189**	**60**	**$14,928.01**	**$78.98**	**3.15**	**0.35%**
SPECIAL PA UTILIZATION						
EDARBYCLOR TAB 40/25MG	21	4	$4,431.62	$211.03	5.25	0.10%
EDARBYCLOR TAB 40/12.5	15	3	$4,355.26	$290.35	5	0.10%
CANDESAR/HCTZ TAB 16/12.5MG	9	2	$636.33	$70.70	4.5	0.01%
CANDESAR/HCTZ TAB 32/12.5MG	2	1	$227.75	$113.88	2	0.01%
CANDESAR/HCTZ TAB 32/25MG	1	1	$142.60	$142.60	1	0.00%
SPECIAL PA SUBTOTAL	**48**	**11**	**$9,793.56**	**$204.03**	**4.4**	**0.23%**
ARB TOTAL	**40,126**	**15,446**	**$676,740.92**	**$16.87**	**2.6**	**15.77%**
SPIRONOLACTONE PRODUCTS						
NO PA REQUIRED						
SPIRONOLACTONE TAB 25MG	8,982	3,271	$110,471.61	$12.30	2.75	2.57%
SPIRONOLACTONE TAB 50MG	5,017	1,879	$82,987.38	$16.54	2.67	1.93%
SPIRONOLACTONE TAB 100MG	3,270	1,164	$67,604.08	$20.67	2.81	1.58%
SPIRONOLACTONE POW	16	2	$303.64	$18.98	8	0.01%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
NO PA SUBTOTAL	**17,285**	**6,316**	**$261,366.71**	**$15.12**	**2.74**	**6.09%**
SPECIAL PA UTILIZATION						
CAROSPIR SUS 25MG/5ML	213	50	$81,985.54	$384.91	4.26	1.91%
SPECIAL PA SUBTOTAL	**213**	**50**	**$81,985.54**	**$384.91**	**4.26**	**1.91%**
SPIRONOLACTONE TOTAL	**17,498**	**6,366**	**$343,352.25**	**$19.62**	**2.75**	**8.00%**
ACEI/HYDROCHLOROTHIAZIDE (HCTZ) COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
LISINOPRIL/HCTZ TAB 20/12.5MG	6,502	2,397	$78,667.14	$12.10	2.71	1.83%
LISINOPRIL/HCTZ TAB 20/25MG	6,035	2,141	$63,436.29	$10.51	2.82	1.48%
LISINOPRIL/HCTZ TAB 10/12.5MG	3,938	1,554	$42,448.08	$10.78	2.53	0.99%
ENALAPRIL/HCTZ TAB 10/25MG	118	37	$2,181.89	$18.49	3.19	0.05%
BENAZEPRIL/HCTZ TAB 20/12.5MG	63	21	$2,712.99	$43.06	3	0.06%
BENAZEPRIL/HCTZ TAB 10/12.5MG	51	16	$2,209.75	$43.33	3.19	0.05%
ENALAPRIL/HCTZ TAB 5/12.5MG	50	12	$989.25	$19.79	4.17	0.02%
BENAZEPRIL/HCTZ TAB 20/25MG	39	16	$1,657.30	$42.49	2.44	0.04%
BENAZEPRIL/HCTZ TAB 5/6.25MG	13	4	$983.24	$75.63	3.25	0.02%
QUINAPRIL/HCTZ TAB 20/12.5MG	11	2	$445.86	$40.53	5.5	0.01%
QUINAPRIL/HCTZ TAB 10/12.5MG	2	1	$59.63	$29.82	2	0.00%
TIER-1 SUBTOTAL	**16,822**	**6,201**	**$195,791.42**	**$11.64**	**2.71**	**4.56%**
ACEI/HCTZ TOTAL	**16,822**	**6,201**	**$195,791.42**	**$11.64**	**2.71**	**4.56%**
ACEI/CCB COMBINATION PRODUCTS						
TIER-1 UTILIZATION						
AMLOD/BENAZPRIL CAP 10/20MG	368	118	$6,370.70	$17.31	3.12	0.15%
AMLOD/BENAZPRIL CAP 10/40MG	292	99	$5,597.88	$19.17	2.95	0.13%
AMLOD/BENAZPRIL CAP 5/20MG	199	80	$3,403.13	$17.10	2.49	0.08%
AMLOD/BENAZPRIL CAP 5/10MG	155	69	$2,455.65	$15.84	2.25	0.06%
AMLOD/BENAZPRIL CAP 5/40MG	86	23	$1,486.95	$17.29	3.74	0.03%
AMLOD/BENAZPRIL CAP 2.5/10MG	23	10	$428.43	$18.63	2.3	0.01%
TIER-1 SUBTOTAL	**1,123**	**399**	**$19,742.74**	**$17.58**	**2.81**	**0.46%**
ACEI/CCB TOTAL	**1,123**	**399**	**$19,742.74**	**$17.58**	**2.81**	**0.46%**
MISCELLANEOUS (MISC) COMBINATION PRODUCTS						
NO PA REQUIRED						
ATENOLOL/CHLOR TAB 50/25MG	261	80	$7,795.08	$29.87	3.26	0.18%
BISOPROLOL/HCTZ TAB 10/6.25MG	224	70	$7,335.19	$32.75	3.2	0.17%
BISOPROLOL/HCTZ TAB 5/6.25MG	222	70	$6,143.43	$27.67	3.17	0.14%
ATENOLOL/CHLOR TAB 100/25MG	126	44	$5,489.62	$43.57	2.86	0.13%
BISOPROLOL/HCTZ TAB 2.5/6.25MG	98	35	$2,836.67	$28.95	2.8	0.07%
METOPROLOL/HCTZ TAB 50/25MG	87	30	$6,375.37	$73.28	2.9	0.15%
METOPROLOL/HCTZ TAB 100/25MG	32	12	$2,931.38	$91.61	2.67	0.07%
METOPROLOL/HCTZ TAB 100/50MG	2	2	$299.58	$149.79	1	0.01%
NO PA SUBTOTAL	**1,052**	**343**	**$39,206.32**	**$37.27**	**3.07**	**0.91%**
MISC TOTAL	**1,052**	**343**	**$39,206.32**	**$37.27**	**3.07**	**0.91%**
PROPRANOLOL SOLUTION (SOL) PRODUCTS						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
NO PA REQUIRED						
PROPRANOLOL SOL 20MG/5ML	926	218	$22,519.79	$24.32	4.25	0.52%
PROPRANOLOL SOL 40MG/5ML	30	9	$931.68	$31.06	3.33	0.02%
NO PA SUBTOTAL	**956**	**227**	**$23,451.47**	**$24.53**	**4.21**	**0.55%**
SPECIAL PA UTILIZATION						
HEMANGEOL SOL 4.28MG/ML	33	12	$23,052.51	$698.56	2.75	0.54%
SPECIAL PA SUBTOTAL	**33**	**12**	**$23,052.51**	**$698.56**	**2.75**	**0.54%**
PROPRANOLOL SOL TOTAL	**989**	**239**	**$46,503.98**	**$47.02**	**4.14**	**1.08%**
SOTALOL PRODUCTS						
NO PA REQUIRED						
SOTALOL HCL TAB 80MG	250	71	$3,701.31	$14.81	3.52	0.09%
SOTALOL HCL TAB 120MG	97	25	$1,719.54	$17.73	3.88	0.04%
SOTALOL AF TAB 80MG	28	10	$490.77	$17.53	2.8	0.01%
SOTALOL HCL TAB 160MG	16	6	$430.74	$26.92	2.67	0.01%
SOTALOL AF TAB 120MG	1	1	$10.87	$10.87	1	0.00%
NO PA SUBTOTAL	**392**	**113**	**$6,353.23**	**$16.21**	**3.47**	**0.15%**
SPECIAL PA UTILIZATION						
SOTYLIZE SOL 5MG/ML	59	11	$39,460.18	$668.82	5.36	0.92%
SPECIAL PA SUBTOTAL	**59**	**11**	**$39,460.18**	**$668.82**	**5.36**	**0.92%**
SOTALOL TOTAL	**451**	**124**	**$45,813.41**	**$101.58**	**3.64**	**1.07%**
TOTAL	**276,045**	**65,955***	**$4,290,193.81**	**$15.54**	**4.19**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
AF = atrial fibrillation; AMLOD = amlodipine; ATORVA = atorvastatin; CANDESAR = candesartan; CAP = capsule; CD = controlled-delivery; CHLOR = chlorthalidone; ER = extended-release; HCL = hydrochloride; HCTZ = hydrochlorothiazide; HR = hour; INJ = injection; IRBESAR = irbesartan; LA = long-acting; LOSAR = losartan; OLMESAR = olmesartan; POT = potassium; SOL = solution; SR = sustained-release; SUC = succinate; SUS = suspension; TAB = tablet; TAR = tartrate; TELMISAR = telmisartan; VALSAR = valsartan; XR = extra-release; XT = extra-time
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 03/2023. Last accessed 03/10/2023.

Fiscal Year 2022 Annual Review of Anti-Parasitic Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Albenza® (Albendazole) Approval Criteria:

1. A quantity of 6 tablets will process without prior authorization.
2. For infections requiring additional doses, a prior authorization will need to be submitted and the following criteria will apply:
    a. An FDA approved indication for treatment of 1 of the following:
        i. Parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, *Taenia solium*; or
        ii. Cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, *Echinococcus granulosus*.

Benznidazole Tablets Approval Criteria:

1. An FDA approved diagnosis of Chagas disease (American trypanosomiasis) caused by *Trypanosoma cruzi*; and
2. Benznidazole must be prescribed by, or in consultation with, an infectious disease specialist; and
3. Female members of reproductive potential must have a negative pregnancy test prior to treatment with benznidazole; and
4. Female members of reproductive potential must be willing to use effective contraception during treatment with benznidazole tablets and for 5 days after the last dose; and
5. Member must not have taken disulfiram within the last 2 weeks; and
6. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug according to package labeling. The approval duration will be for 60 days of therapy.

Daraprim® (Pyrimethamine) Approval Criteria:

1. An FDA approved indication for the treatment of 1 of the following:
    a. Toxoplasmosis; or
    b. Susceptible strains of acute malaria; and
2. Member must take Daraprim® concomitantly with a sulfonamide; and
3. Approval length will be based on recommended dosing regimen specific to the member's diagnosis.

Emverm® (Mebendazole) Approval Criteria:

1. An FDA approved indication for treatment of 1 of the following:
    a. *Enterobius vermicularis* (pinworm); or
    b. *Trichuris trichiura* (whipworm); or
    c. *Ascaris lumbricoides* (roundworm); or
    d. *Ancylostoma duodenale* (hookworm); or
    e. *Necator americanus* (hookworm); and
2. For the treatment of *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (hookworm), or *Necator americanus* (hookworm), a patient-specific, clinically significant reason why a more cost-effective anthelmintic therapy, such as albendazole or pyrantel pamoate, cannot be used must be provided; and
3. The following quantity limits will apply:
    a. *Enterobius vermicularis* (pinworm): 2 tablets per approval.
    b. *Trichuris trichiura* (whipworm): 6 tablets per approval.
    c. *Ascaris lumbricoides* (roundworm): 6 tablets per approval.
    d. *Ancylostoma duodenale* (hookworm): 6 tablets per approval.
    e. *Necator americanus* (hookworm): 6 tablets per approval.

Impavido® (Miltefosine) Approval Criteria:

1. An FDA approved indication for treatment of 1 of the following:
    a. Visceral leishmaniasis due to *Leishmania donovani*; or
    b. Cutaneous leishmaniasis due to *Leishmania braziliensis*, *Leishmania guyanensis*, or *Leishmania panamensis*; or
    c. Mucosal leishmaniasis due to *Leishmania braziliensis*; and
2. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation. Female members must be willing to use effective contraception while on therapy and for 5 months after completion of therapy; and
3. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
4. A quantity limit of 84 capsules per 28 days will apply.

Lampit® (Nifurtimox) Approval Criteria:

1. An FDA approved diagnosis of Chagas disease (American trypanosomiasis) caused by *Trypanosoma cruzi*; and
2. Member must be younger than 18 years of age and weigh ≥2.5kg; and
3. Lampit® must be prescribed by, or in consultation with, an infectious disease specialist; and
4. Prescriber must agree to counsel the member on the contraindication and potential drug interaction that may occur with concomitant use of Lampit® with alcohol, if applicable, based on package labeling; and

5. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiating treatment with Lampit®; and
6. Female members of reproductive potential must be willing to use effective contraception during treatment with Lampit® and for 6 months after the last dose; and
7. Male members with female partners of reproductive potential must be willing to use condoms for contraception during treatment with Lampit® and for 3 months after the last dose; and
8. Prescriber must agree to monitor the member's weight every 14 days and adjust the Lampit® dosage accordingly, as recommended in the package labeling; and
9. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
10. Initial approvals will be for 30 days. For continuation of therapy after 30 days, an updated weight must be provided in order to authorize the appropriate amount of drug required for the remaining 30 days of treatment. The total approval duration will be for 60 days of treatment; and
11. A quantity limit of 270 tablets per 30 days will apply to the 30mg tablet, and a quantity limit of 225 tablets per 30 days will apply to the 120mg tablet.

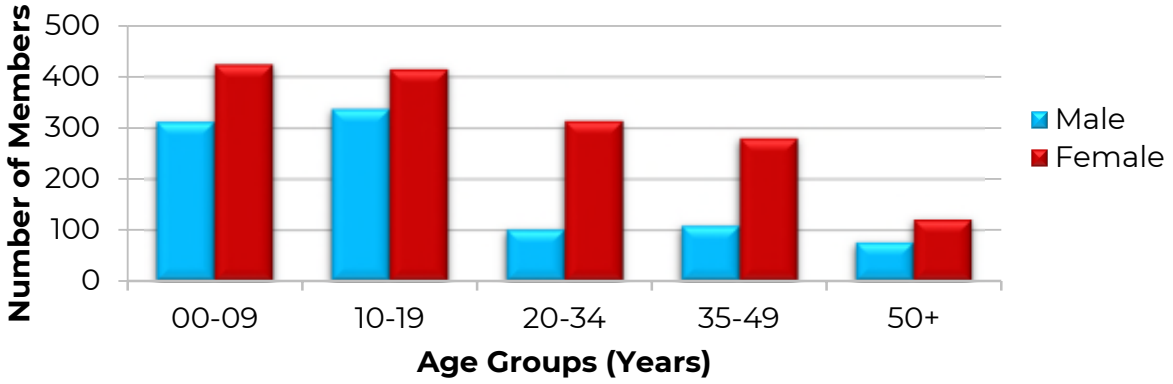
Utilization of Anti-Parasitic Medications: Fiscal Year 2022

Comparison of Fiscal Years

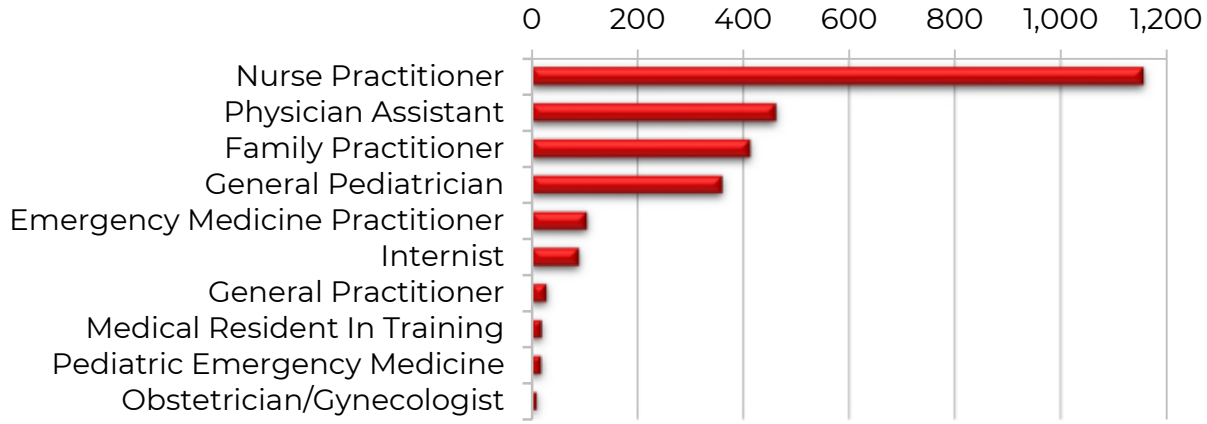
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	2,236	2,593	$274,262.37	$105.77	$13.71	15,806	20,000
2022	2,479	2,724	$219,513.76	$80.59	$10.25	31,919	21,412
% Change	**10.9%**	**5.1%**	**-20.0%**	**-23.8%**	**-25.2%**	**101.9%**	**7.1%**
Change	**243**	**131**	**-$54,748.61**	**-$25.18**	**-$3.46**	**16,113**	**1,412**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Anti-Parasitic Medications



Top Prescriber Specialties of Anti-Parasitic Medications by Number of Claims



Prior Authorization of Anti-Parasitic Medications

There were 471 prior authorization requests submitted for anti-parasitic medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions

Market News and Updates[1]

Anticipated Exclusivity Expiration(s):

- Lampit® (nifurtimox tablets): August 2027

Recommendations

The College of Pharmacy does not recommend any changes to the current anti-parasitic medications prior authorization criteria at this time.

Utilization Details of Anti-Parasitic Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
IVERMECTIN TAB 3MG	1,452	1,352	$113,982.14	$78.50	1.07	51.92%
ALBENDAZOLE TAB 200MG	1,249	1,112	$92,775.35	$74.28	1.12	42.26%
PRAZIQUANTEL TAB 600MG	19	19	$3,219.20	$169.43	1	1.47%
PYRIMETHAMINE TAB 25MG	2	2	$8,766.24	$2,383.12	1	3.99%
EMVERM CHW 100MG	2	2	$770.83	$385.42	1	0.35%
TOTAL	**2,724**	**2,479***	**$219,513.76**	**$80.59**	**1.1**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CHW = chewable tablet; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 03/2023. Last accessed 03/10/2023.

Fiscal Year 2022 Annual Review of Benign Prostatic Hyperplasia (BPH) Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

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

BPH Medications Tier-2 Approval Criteria:

1. An FDA approved diagnosis; and
2. A 4-week trial of 2 Tier-1 medications from different pharmacological classes within the past 90 days; or
3. Documented adverse effect, drug interaction, or contraindication to all available Tier-1 medications.

BPH Medications Tier-3 Approval Criteria:

1. An FDA approved diagnosis of benign prostatic hyperplasia (BPH); and
2. A 4-week trial of at least 2 Tier-1 medications from different pharmacological classes; and
3. A 4-week trial of all Tier-2 medications within the past 5 months; or
4. Documented adverse effect, drug interaction, contraindication, or lack of efficacy to all available Tier-1 and Tier-2 medications; and
5. Authorizations for Cialis® (tadalafil) will be granted for the 5mg tablets only.

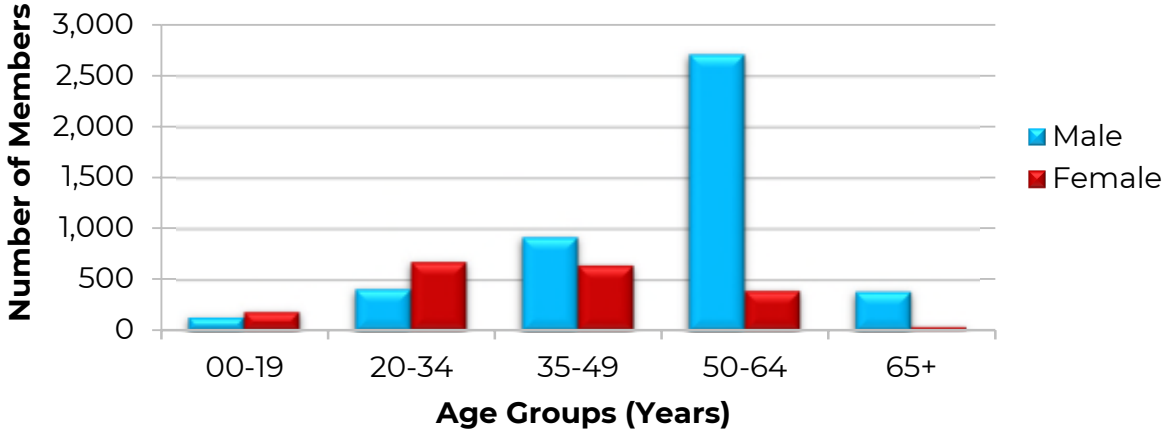
Utilization of BPH Medications: Fiscal Year 2022

Comparison of Fiscal Years

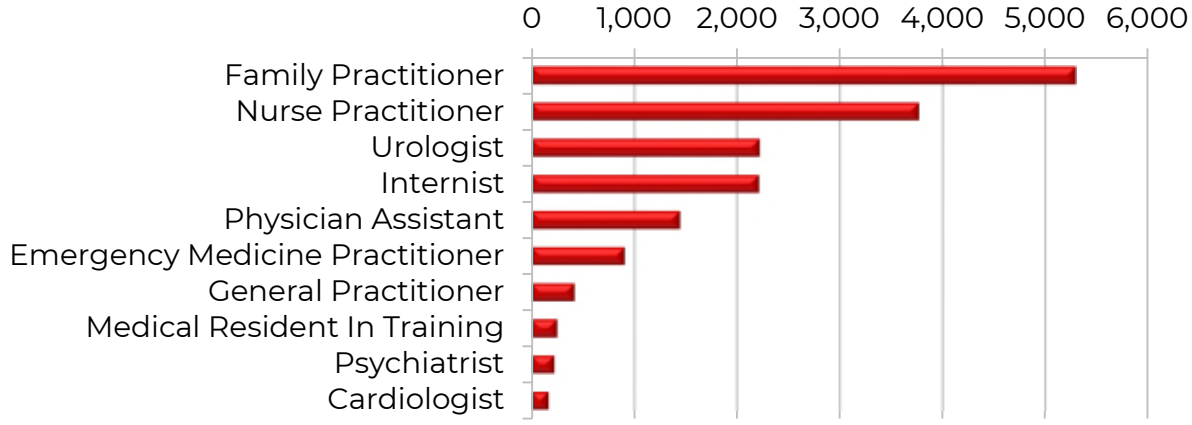
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	3,556	11,634	$157,362.42	$13.53	$0.30	576,953	516,557
2022	6,484	17,890	$236,624.39	$13.23	$0.29	903,181	817,371
% Change	**82.3%**	**53.8%**	**50.4%**	**-2.2%**	**-3.3%**	**56.5%**	**58.2%**
Change	**2,928**	**6,256**	**$79,261.97**	**-$0.30**	**-$0.01**	**326,228**	**300,814**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing BPH Medications

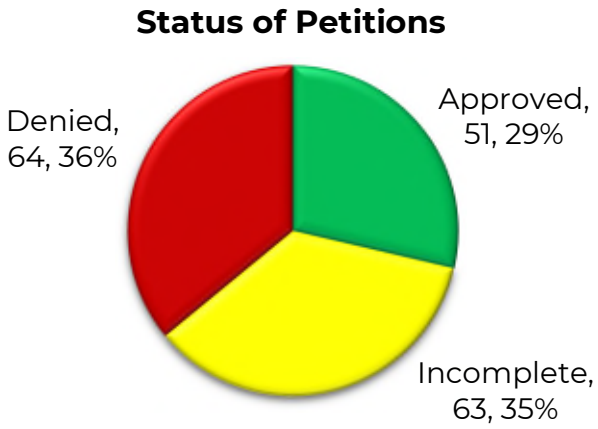


Top Prescriber Specialties of BPH Medications by Number of Claims



Prior Authorization of BPH Medications

There were 178 prior authorization requests submitted for BPH medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.



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

Pipeline:

- **Fexapotide (NX-1207):** Nymox has completed Phase 3 studies evaluating fexapotide for the treatment of BPH. The studies followed patients for up to 7 years and showed statistically significant improvements in BPH symptoms compared to placebo, with a favorable safety profile. Fexapotide is a novel injectable protein administered by transrectal ultrasound guided intraprostatic injection in an office setting by a urologist and works by inducing apoptosis, selectively removing cells in the enlarged prostate gland. In Phase 3 studies, patients were followed over the course of 1 year following a single fexapotide injection. The primary outcome was the change from baseline in BPH symptoms at 1 year. Additionally, patients could be enrolled into an open-label re-injection study in which patients could voluntarily elect to receive no further treatment, conventional oral BPH treatment, surgical treatment, or an additional fexapotide injection. In March 2022, Nymox announced they submitted a New Drug Application (NDA) for fexapotide for the treatment of BPH, but the company received a Refusal to File (RTF) letter from the FDA in May 2022 which requested additional long-term safety data for fexapotide. In September 2022, Nymox announced they have received feedback from the FDA regarding the additional information needed, and they are currently in the process of preparing the information for resubmission to the FDA. Nymox is also currently evaluating fexapotide for the treatment of early-stage prostate cancer.

Recommendations

The College of Pharmacy does not recommend any changes to the BPH medications Product Based Prior Authorization (PBPA) category at this time.

Utilization Details of BPH Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-1 UTILIZATION						
TAMSULOSIN CAP 0.4MG	13,301	5,568	$167,175.29	$12.57	2.39	70.65%
FINASTERIDE TAB 5MG	1,507	471	$19,931.36	$13.23	3.2	8.42%
DOXAZOSIN TAB 4MG	744	192	$10,928.15	$14.69	3.88	4.62%
DOXAZOSIN TAB 2MG	573	181	$7,833.34	$13.67	3.17	3.31%
ALFUZOSIN TAB 10MG ER	281	92	$4,380.07	$15.59	3.05	1.85%
DOXAZOSIN TAB 8MG	261	63	$4,069.22	$15.59	4.14	1.72%
DOXAZOSIN TAB 1MG	261	106	$3,320.21	$12.72	2.46	1.40%
TERAZOSIN CAP 1MG	230	87	$3,648.24	$15.86	2.64	1.54%
TERAZOSIN CAP 2MG	203	75	$3,662.61	$18.04	2.71	1.55%
DUTASTERIDE CAP 0.5MG	178	56	$3,460.25	$19.44	3.18	1.46%
TERAZOSIN CAP 5MG	157	56	$3,086.61	$19.66	2.8	1.30%
TERAZOSIN CAP 10MG	100	31	$1,990.25	$19.90	3.23	0.84%
SUBTOTAL	**17,796**	**6,477***	**$233,485.60**	**$13.12**	**2.75**	**98.67%**
TIER-2 UTILIZATION						
SILODOSIN CAP 8MG	63	9	$1,675.78	$26.60	7	0.71%
SILODOSIN CAP 4MG	18	4	$445.05	$24.73	4.5	0.19%
DUTAST/TAMSU CAP 0.5-0.4MG	4	1	$792.50	$198.13	4	0.33%
SUBTOTAL	**85**	**14***	**$2,913.33**	**$34.27**	**6.07**	**1.23%**
TIER-3 UTILIZATION						
TADALAFIL TAB 5MG	9	2	$225.46	$25.05	4.5	0.10%
SUBTOTAL	**9**	**2***	**$225.46**	**$25.05**	**4.5**	**0.10%**
TOTAL	**17,890**	**6,484***	**$236,624.39**	**$13.23**	**2.76**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; DUTAST/TAMSU = dutasteride/tamsulosin; ER = extended-release; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] Nymox Pharmaceutical Corp. Fexapotide for BPH. Available online at: https://nymox.com/science/fexapotide-for-bph. Last accessed 03/16/2023.
[2] Nymox Pharmaceutical Corp. Nymox Announces Submission of New Drug Application (NDA) to the FDA for Fexapotide Triflutate. *Globe Newswire*. Available online at: https://www.globenewswire.com/news-release/2022/03/03/2396544/10918/en/NYMOX-Announces-Submission-of-New-Drug-Application-NDA-to-the-FDA-for-Fexapotide-Triflutate.html. Issued 03/03/2022. Last accessed 03/16/2023.
[3] Nymox Pharmaceutical Corp. Nymox Receives RTF Letter from FDA. Available online at: https://nymox.com/files/download/888827752806557. Issued 05/23/2022. Last accessed 03/30/2023.
[4] Nymox Pharmaceutical Corp. Nymox Provides Current Update. Available online at: https://nymox.com/files/download/f797182b8680a40. Issued 09/13/2022. Last accessed 03/30/2023.

Fiscal Year 2022 Annual Review of Benzodiazepine Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Benzodiazepine Medications Approval Criteria for Members 19 Years of Age and Older:

1. Currently there is no prior authorization required; however, quantity limits are set at a maximum of 3 units per day for most products (except alprazolam 2mg, which is set at 2 units per day); and
2. Approval for dosing >3 times daily requires a chronic physical diagnosis; for these diagnoses, the maximum allowed dosing would be 4 times daily (no anxiolytic benzodiazepine therapy >3 times daily dosing if member also concurrently taking an insomnia medication); and
    a. Member may receive >3 units per day if the following criteria exist:
        i. The number of units per day is >3, but is less than the maximum daily dose for the product (or for a total daily dosing of 3 times daily); or
        ii. The member has a chronic diagnosis and a clinical reason for excessive units has been provided; and
3. Current members will be given 2 months to taper dosing to no more than 3 doses daily.

Benzodiazepine Medications Approval Criteria for Members Younger than 19 Years of Age:

1. Member must have a chronic behavioral health-related diagnosis or a chronic physical diagnosis; and
2. Approval criteria for a chronic behavior health-related diagnosis:
    a. No concurrent stimulant ADHD medications; and
    b. Maximum dosing of 3 times daily will apply; or
3. Approval criteria for a chronic physical diagnosis:
    a. Maximum dosing of 3 times daily will apply if a hypnotic medication is being used concurrently; or
    b. Maximum dosing of 4 times daily will apply if no hypnotic medication is being used concurrently; and
4. Exceptions can be granted for administration prior to procedures; and
5. Members 12 years of age or younger will have the same criteria as above, and the prescription must be originally written by a psychiatrist or neurologist.

Loreev XR® [Lorazepam Extended-Release (ER) Capsule] Approval Criteria:

1. An FDA approved diagnosis for the treatment of anxiety disorders; and
2. Member must be 18 years of age or older; and
3. Member must be receiving stable, evenly divided, 3 times daily dosing of lorazepam tablets; and
4. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use the immediate-release formulation must be provided; and
5. A quantity limit of 30 capsules per 30 days will apply.

Niravam® (Alprazolam Orally Disintegrating Tablet) Approval Criteria:

1. An FDA approved diagnosis; and
2. A diagnosis indicating that the member has a condition that prevents him/her from swallowing tablets; and
3. The physician's signature is required for approval; and
4. Dosing regimens that involve splitting of tablets will not be covered.

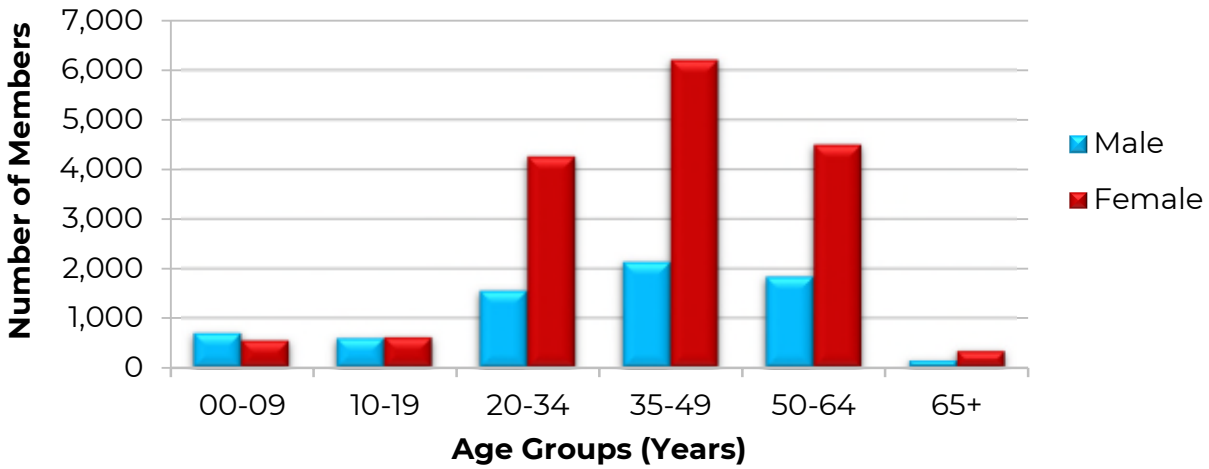
Utilization of Benzodiazepine Medications: Fiscal Year 2022

Comparison of Fiscal Years

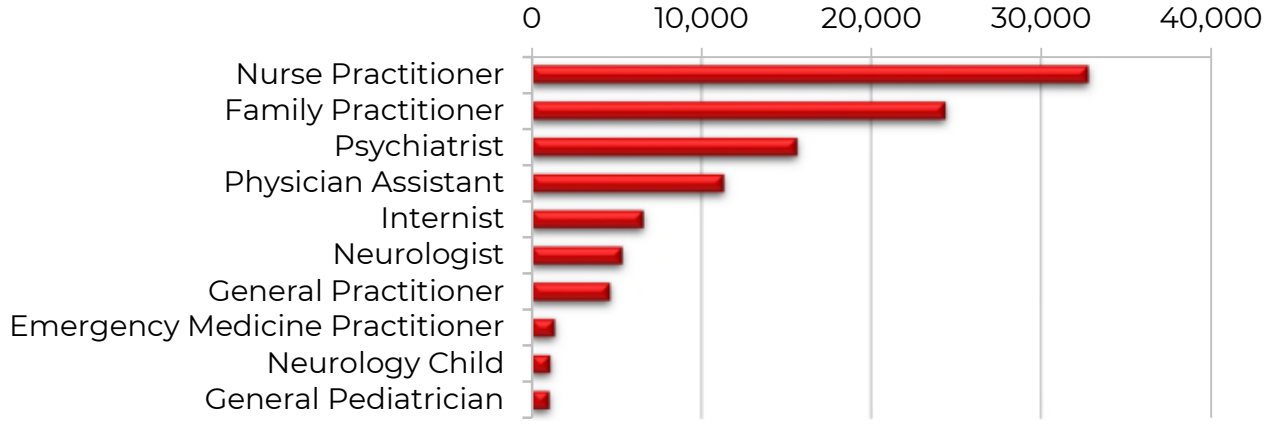
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	15,820	84,995	$1,985,134.10	$23.36	$0.87	4,973,481	2,278,866
2022	23,324	110,368	$3,030,090.33	$27.45	$1.04	6,240,361	2,900,220
% Change	**47.40%**	**29.90%**	**52.60%**	**17.50%**	**19.50%**	**25.50%**	**27.30%**
Change	**7,504**	**25,373**	**$1,044,956.23**	**$4.09**	**$0.17**	**1,266,880**	**621,354**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Benzodiazepine Medications



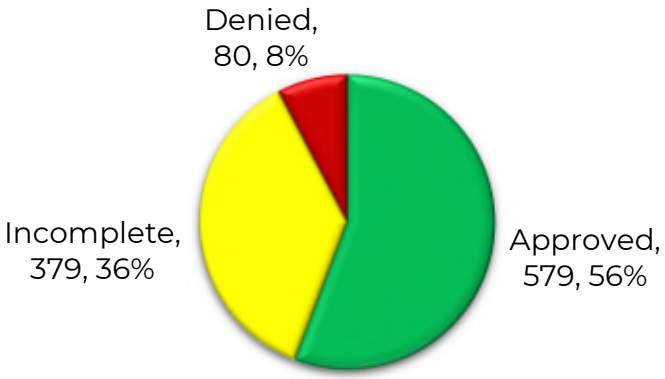
Top Prescriber Specialties of Benzodiazepine Medications by Number of Claims



Prior Authorization of Benzodiazepine Medications

There were 1,038 prior authorization requests submitted for benzodiazepine medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[1]

Anticipated Patent Expiration(s):

- Valtoco® (diazepam nasal spray): March 2029
- Loreev XR® (lorazepam extended-release capsule): January 2034

Recommendations

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

Utilization Details of Benzodiazepine Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
ALPRAZOLAM PRODUCTS						
ALPRAZOLAM TAB 1MG	23,049	3,695	$250,061.40	$10.85	6.24	8.25%
ALPRAZOLAM TAB 0.5MG	12,241	3,053	$127,554.14	$10.42	4.01	4.21%
ALPRAZOLAM TAB 2MG	6,909	983	$85,611.00	$12.39	7.03	2.83%
ALPRAZOLAM TAB 0.25MG	3,848	1,257	$39,191.60	$10.18	3.06	1.29%
ALPRAZOLAM TAB 2MG ER	217	46	$4,206.10	$19.38	4.72	0.14%
ALPRAZOLAM TAB 1MG ER	158	47	$2,326.84	$14.73	3.36	0.08%
ALPRAZOLAM TAB 1MG XR	144	43	$2,028.11	$14.08	3.35	0.07%
ALPRAZOLAM TAB 2MG XR	136	27	$2,685.95	$19.75	5.04	0.09%
ALPRAZOLAM TAB 0.5MG ER	76	38	$1,202.18	$15.82	2	0.04%
ALPRAZOLAM TAB 0.5MG XR	40	17	$566.82	$14.17	2.35	0.02%
ALPRAZOLAM TAB 3MG ER	31	11	$639.38	$20.63	2.82	0.02%
ALPRAZOLAM TAB 3MG XR	27	4	$505.25	$18.71	6.75	0.02%
ALPRAZOLAM ODT 0.25MG	1	1	$28.50	$28.50	1	0.00%
ALPRAZOLAM ODT 1MG	1	1	$38.32	$38.32	1	0.00%
SUBTOTAL	**46,878**	**9,223**	**$516,645.59**	**$11.02**	**5.08**	**17.05%**
CLONAZEPAM PRODUCTS						
CLONAZEPAM TAB 1MG	15,204	2,911	$168,332.16	$11.07	5.22	5.56%
CLONAZEPAM TAB 0.5MG	13,867	3,461	$144,246.09	$10.40	4.01	4.76%
CLONAZEPAM TAB 2MG	3,504	606	$39,124.47	$11.17	5.78	1.29%
CLONAZEPAM ODT 0.25MG	1,206	437	$51,213.30	$42.47	2.76	1.69%
CLONAZEPAM ODT 0.125MG	760	301	$27,758.18	$36.52	2.52	0.92%
CLONAZEPAM ODT 0.5MG	698	222	$27,087.37	$38.81	3.14	0.89%
CLONAZEPAM ODT 1MG	355	125	$13,647.03	$38.44	2.84	0.45%
CLONAZEPAM ODT 2MG	85	22	$3,576.28	$42.07	3.86	0.12%
SUBTOTAL	**35,679**	**8,085**	**$474,984.88**	**$13.31**	**4.41**	**15.68%**
DIAZEPAM PRODUCTS						
DIAZEPAM TAB 5MG	5,721	2,273	$56,156.67	$9.82	2.52	1.85%
DIAZEPAM TAB 10MG	5,255	1,691	$53,321.10	$10.15	3.11	1.76%
DIAZEPAM TAB 2MG	1,427	612	$14,094.03	$9.88	2.33	0.47%
DIAZEPAM GEL 10MG	957	667	$371,613.03	$388.31	1.43	12.26%
VALTOCO SPR 10MG	688	466	$655,426.64	$952.66	1.48	21.63%
DIAZEPAM SOL 5MG/5ML	244	49	$8,341.85	$34.19	4.98	0.28%
DIAZEPAM GEL 20MG	238	107	$110,826.49	$465.66	2.22	3.66%
VALTOCO SPR 15MG	200	150	$209,750.00	$1,048.75	1.33	6.92%
DIASTAT ACDL GEL 5-10MG	170	142	$79,308.03	$466.52	1.2	2.62%
VALTOCO SPR 20MG	136	80	$119,330.37	$877.43	1.7	3.94%
VALTOCO SPR 5MG	108	71	$115,456.14	$1,069.04	1.52	3.81%
DIAZEPAM GEL 2.5MG	66	56	$24,125.74	$365.54	1.18	0.80%
DIASTAT ACDL GEL 12.5-20MG	58	34	$28,340.07	$488.62	1.71	0.94%
DIAZEPAM CON 5MG/ML	22	6	$821.31	$37.33	3.67	0.03%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
DIASTAT PED GEL 2.5MG	14	14	$5,481.98	$391.57	1	0.18%
DIAZEPAM INJ 5MG/ML	11	1	$2,501.36	$227.40	11	0.08%
DIAZEPAM POW	6	4	$78.89	$13.15	1.5	0.00%
SUBTOTAL	**15,321**	**6,423**	**$1,854,973.70**	**$121.07**	**2.39**	**61.22%**
LORAZEPAM PRODUCTS						
LORAZEPAM TAB 1MG	5,493	1,886	$62,116.97	$11.31	2.91	2.05%
LORAZEPAM TAB 0.5MG	4,225	1,540	$48,584.14	$11.50	2.74	1.60%
LORAZEPAM TAB 2MG	1,532	445	$20,061.60	$13.10	3.44	0.66%
LORAZEPAM CON 2MG/ML	94	43	$2,821.51	$30.02	2.19	0.09%
LORAZEPAM POW	55	15	$979.83	$17.82	3.67	0.03%
LORAZEPAM INJ 2MG/ML	17	7	$619.77	$36.46	2.43	0.02%
SUBTOTAL	**11,416**	**3,936**	**$135,183.82**	**$11.84**	**2.9**	**4.46%**
CHLORDIAZEPOXIDE PRODUCTS						
CHLORDIAZEP CAP 25MG	355	267	$3,954.38	$11.14	1.33	0.13%
CHLORDIAZEP CAP 10MG	157	99	$1,894.52	$12.07	1.59	0.06%
CHLORDIAZEP CAP 5MG	106	67	$1,416.28	$13.36	1.58	0.05%
SUBTOTAL	**618**	**433**	**$7,265.18**	**$11.76**	**1.43**	**0.24%**
CLORAZEPATE PRODUCTS						
CLORAZ DIPOT TAB 3.75MG	154	27	$11,820.70	$76.76	5.7	0.39%
CLORAZ DIPOT TAB 7.5MG	127	21	$12,878.08	$101.40	6.05	0.43%
CLORAZ DIPOT TAB 15MG	86	14	$10,530.63	$122.45	6.14	0.35%
SUBTOTAL	**367**	**62**	**$35,229.41**	**$95.99**	**5.92**	**1.16%**
OXAZEPAM PRODUCTS						
OXAZEPAM CAP 30MG	38	7	$3,299.96	$86.84	5.43	0.11%
OXAZEPAM CAP 15MG	26	5	$1,467.17	$56.43	5.2	0.05%
OXAZEPAM CAP 10MG	25	8	$1,040.62	$41.62	3.13	0.03%
SUBTOTAL	**89**	**20**	**$5,807.75**	**$65.26**	**4.45**	**0.19%**
TOTAL	**110,368**	**23,324***	**$3,030,090.33**	**$27.45**	**4.73**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
ACDL = AcuDial; CAP = capsule; CHLORDIAZEP = chlordiazepoxide; CLORAZ DIPOT = clorazepate dipotassium; CON = concentrate; ER = extended-release; INJ = injection; ODT = orally disintegrating tablet; PED = pediatric; POW = powder; SOL = solution; SPR = spray; TAB = tablet; XR = extended-release
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 03/2023. Last accessed 03/02/2023.

Fiscal Year 2022 Annual Review of Inhaled Anti-Infective Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Arikayce® (Amikacin Liposome Inhalation Suspension) Approval Criteria:

1. An FDA approved indication for the treatment of *Mycobacterium avium* complex (MAC) lung disease in adults who have limited or no alternative treatment options; and
2. Member must have had a minimum of 6 consecutive months of a multidrug background regimen therapy used compliantly and not achieved negative sputum cultures within the last 12 months. Dates of previous treatments and regimens must be listed on the prior authorization request; and
    a. If claims for a multidrug background regimen are not in the member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the prescriber; and
3. Member must continue a multidrug background regimen therapy while on Arikayce®, unless contraindicated, or provide reasoning why continuation of a multidrug background regimen is not appropriate for the member; and
4. A patient-specific, clinically significant reason why the member requires an inhaled aminoglycoside in place of an intravenous or intramuscular aminoglycoside (e.g., amikacin, streptomycin) must be provided; and
5. Arikayce® will not be approved for members with non-refractory MAC lung disease; and
6. Arikayce® must be prescribed by, or in consultation with, a pulmonary disease or infectious disease specialist (or an advanced care practitioner with a supervising physician who is a pulmonary disease or infectious disease specialist); and
7. Initial approvals will be for the duration of 6 months after which time the prescriber must document the member is responding to treatment for continued approval; and
8. A quantity limit of 28 vials per 28 days will apply.

Cayston® (Aztreonam), Pulmozyme® (Dornase Alfa), and Inhaled Tobramycin Products (Bethkis®, Kitabis® Pak, Tobi®, and Tobi® Podhaler®) Approval Criteria:

1. Use of inhaled tobramycin products, Pulmozyme® (dornase alfa), and Cayston® (aztreonam) is reserved for members who have a diagnosis of cystic fibrosis (CF).
    a. Kitabis® Pak and generic tobramycin 300mg/5mL nebulized solution are the preferred inhaled tobramycin products. Authorization of Bethkis® or Tobi® Podhaler® requires a patient-specific, clinically significant reason why the preferred inhaled tobramycin products (Kitabis® Pak and generic tobramycin 300mg/5mL nebulized solution) are not appropriate for the member.
    b. Preferred inhaled tobramycin products (Kitabis® Pak and generic tobramycin 300mg/5mL nebulized solution), dornase alfa, and aztreonam inhalation will not require a prior authorization and claims will pay at the point of sale if member has a reported diagnosis of CF within the past 12 months of claims history.
    c. If the member does not have a reported diagnosis, a manual prior authorization will be required for coverage consideration.
2. Use of inhaled tobramycin products and Cayston® (aztreonam) is restricted to 28 days of therapy every 56 days to ensure cycles of 28 days on therapy followed by 28 days off therapy.
    a. Use outside of this recommended regimen may be considered for coverage via a manual prior authorization submission with a patient-specific, clinically significant reason why the member needs treatment outside of the FDA approved dosing regimen.
    b. Pharmacies should process the prescription claim with a 56-day supply.

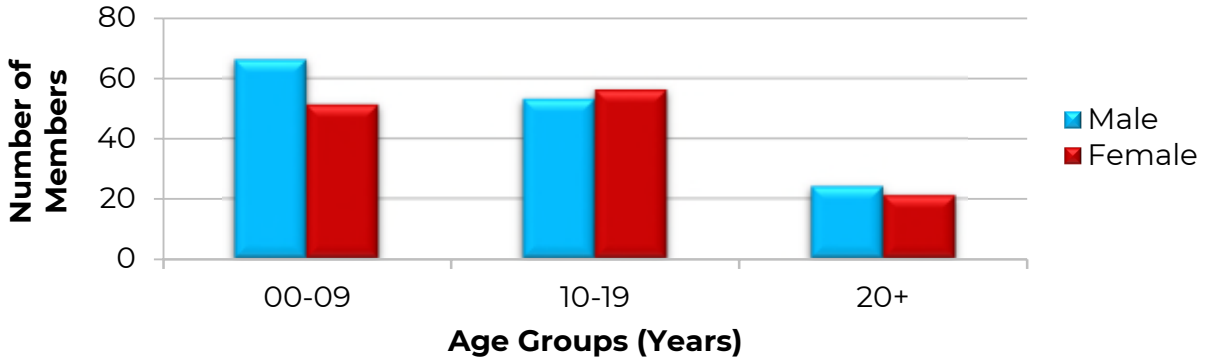
Utilization of Inhaled Anti-Infective Medications: Fiscal Year 2022

Comparison of Fiscal Years

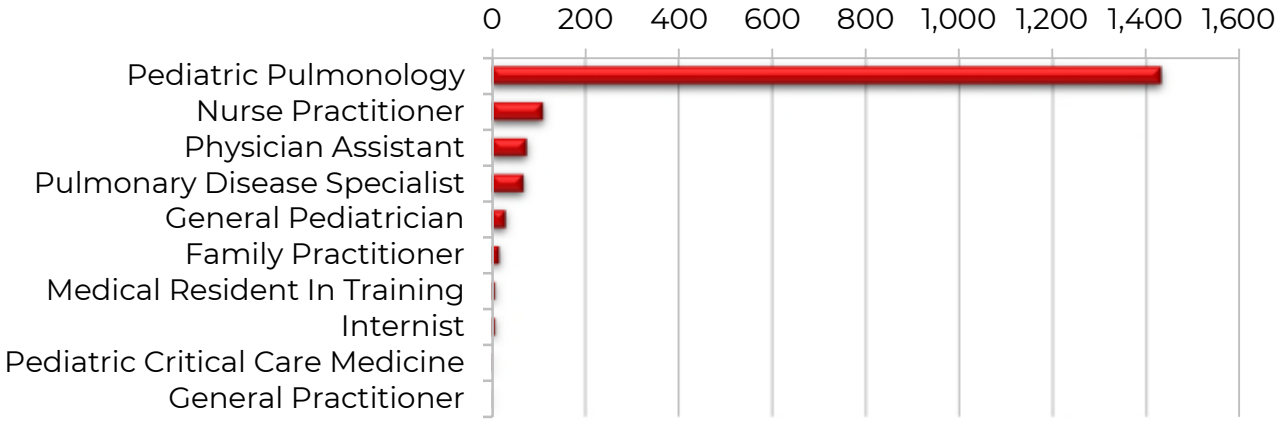
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	249	1,628	$5,747,658.16	$3,530.50	$91.20	222,236	63,025
2022	271	1,756	$6,133,392.21	$3,492.82	$88.78	241,005	69,086
% Change	**8.80%**	**7.90%**	**6.70%**	**-1.10%**	**-2.70%**	**8.40%**	**9.60%**
Change	**22**	**128**	**$385,734.05**	**-$37.68**	**-$2.42**	**18,769**	**6,061**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Inhaled Anti-Infective Medications



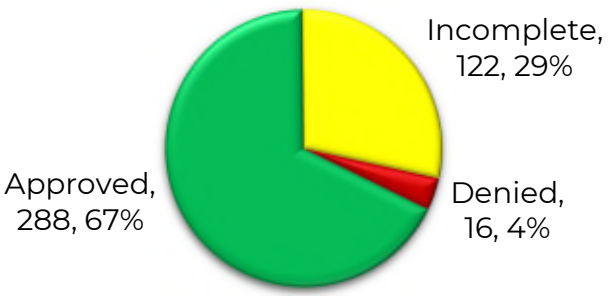
Top Prescriber Specialties of Inhaled Anti-Infective Medications by Number of Claims



Prior Authorization of Inhaled Anti-Infective Medications

There were 426 prior authorization requests submitted for inhaled anti-infective medications during fiscal year 2022. Computer edits are in place to detect a cystic fibrosis (CF) diagnosis in a member's recent diagnosis claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[1]

Anticipated Patent Expiration(s):

- Tobi® Podhaler® (tobramycin inhalation powder): November 2030
- Arikayce® (amikacin liposome inhalation suspension): May 2035

Recommendations

The College of Pharmacy does not recommend any changes to the current inhaled anti-infective medications prior authorization criteria at this time.

Utilization Details of Inhaled Anti-Infective Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
DORNASE ALFA PRODUCTS						
PULMOZYME SOL 1MG/ML	1,212	170	$4,540,192.29	$3,746.03	7.13	74.02%
SUBTOTAL	**1,212**	**170***	**$4,540,192.29**	**$3,746.03**	**7.13**	**74.02%**
TOBRAMYCIN NEBULIZED PRODUCTS						
TOBRAMYCIN NEB 300MG/5ML	402	126	$385,722.12	$959.51	3.19	6.29%
TOBRAMYCIN NEB 300MG/4ML	31	12	$151,200.01	$4,877.42	2.58	2.47%
KITABIS PAK NEB 300MG/5ML	14	7	$63,159.74	$4,511.41	2	1.03%
TOBI NEB 300MG/5ML	1	1	$7,708.77	$7,708.77	1	0.13%
SUBTOTAL	**448**	**145***	**$607,790.64**	**$1,356.68**	**3.09**	**9.91%**
AZTREONAM PRODUCTS						
CAYSTON INH 75MG	58	17	$576,908.88	$9,946.70	3.41	9.41%
SUBTOTAL	**58**	**17***	**$576,908.88**	**$9,946.70**	**3.41**	**9.41%**
TOBRAMYCIN POWDER PRODUCTS						
TOBI PODHALER CAP 28MG	28	10	$274,664.20	$9,809.44	2.8	4.48%
SUBTOTAL	**28**	**10***	**$274,664.20**	**$9,809.44**	**2.8**	**4.48%**
AMIKACIN PRODUCTS						
ARIKAYCE SUS 590MG/8.4ML	10	3	$133,836.20	$13,383.62	3.33	2.18%
SUBTOTAL	**10**	**3***	**$133,836.20**	**$13,383.62**	**3.33**	**2.18%**
TOTAL	**1,756**	**271***	**$6,133,392.21**	**$3,492.82**	**6.48**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; INH = inhalation; NEB = nebulized; PAK = pack; SOL = solution; SUS = suspension
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 03/2023. Last Accessed 03/02/2023.

Fiscal Year 2022 Annual Review of Injectable and Vaginal Progesterone Products

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Crinone® (Progesterone Vaginal Gel) Approval Criteria:

1. Current singleton pregnancy; and
2. Member must not have history of previous singleton spontaneous preterm delivery (SPTD); and
3. Cervical length of ≤20mm; and
4. Gestational age between 20 weeks, 0 days and 26 weeks, 6 days of gestation; and
5. A patient-specific, clinically significant reason why the member cannot use Endometrin® (progesterone vaginal insert) must be provided; and
6. Authorizations will be given for treatment through 36 weeks, 6 days of gestation; and
7. Crinone® will not be approved for use with assisted reproductive technology (ART) for female infertility.

Endometrin® (Progesterone Vaginal Insert) Approval Criteria:

1. Current singleton pregnancy; and
2. Member must not have history of previous singleton spontaneous preterm delivery (SPTD); and
3. Cervical length of ≤20mm; and
4. Gestational age between 20 weeks, 0 days and 26 weeks, 6 days of gestation; and
5. Authorizations will be given for treatment through 36 weeks, 6 days of gestation; and
6. Endometrin® will not be approved for use with assisted reproductive technology (ART) for female infertility.

Hydroxyprogesterone Caproate 250mg/mL Injection (Generic Delalutin®/Delta-Lutin®) Approval Criteria:

1. An FDA approved indication of 1 of the following in non-pregnant women:
   a. For the treatment of advanced adenocarcinoma of the uterine corpus (Stage III or IV); or
   b. For the management of amenorrhea (primary and secondary) or abnormal uterine bleeding due to hormonal imbalance in the

absence of organic pathology, such as submucous fibroids or uterine cancer; or
    c. As a test for endogenous estrogen production or for the production of secretory endometrium and desquamation; and
2. The quantity approved will be patient-specific depending on member's diagnosis, maximum recommended dosage, and manufacturer packaging; and
3. Requests for the prevention of preterm birth in pregnant women with a history of previous singleton spontaneous preterm delivery (SPTD) prior to 37 weeks gestation will not be approved for generic Delalutin®/Delta-Lutin® and should be resubmitted for authorization consideration of Makena® (hydroxyprogesterone caproate).

Makena® [Hydroxyprogesterone Caproate Intramuscular (IM) Injection and Subcutaneous (Sub-Q) Auto-Injector] Approval Criteria:

1. Documented history of previous singleton spontaneous preterm delivery (SPTD) prior to 37 weeks gestation; and
2. Current singleton pregnancy; and
3. Gestational age between 16 weeks, 0 days and 26 weeks, 6 days of gestation; and
4. Authorizations will be for once weekly administration by a health care professional through 36 weeks, 6 days of gestation; and
5. For Makena® sub-Q auto-injector:
    a. Initial dose must be administered by a health care professional; and
    b. Member and caregiver must be trained by a health care professional on sub-Q administration and storage of Makena® sub-Q auto-injector; and
    c. A patient-specific, clinically significant reason why Makena® IM injection cannot be used must be provided.* (*The manufacturer of Makena® has currently provided a supplemental rebate to make the sub-Q auto-injector available with the current Makena® criteria; however, use of Makena® sub-Q auto-injector will require a reason why Makena® IM injection cannot be used if the manufacturer chooses not to participate in supplemental rebates.)

When it is determined to be appropriate to use the compounded hydroxyprogesterone caproate product, this product is covered through SoonerCare as a medical-only benefit without a prior authorization requirement.

Utilization of Injectable and Vaginal Progesterone Products: Fiscal Year 2022

Please note, the compounded hydroxyprogesterone caproate product is billed by medical claims only and not reflected in the following pharmacy

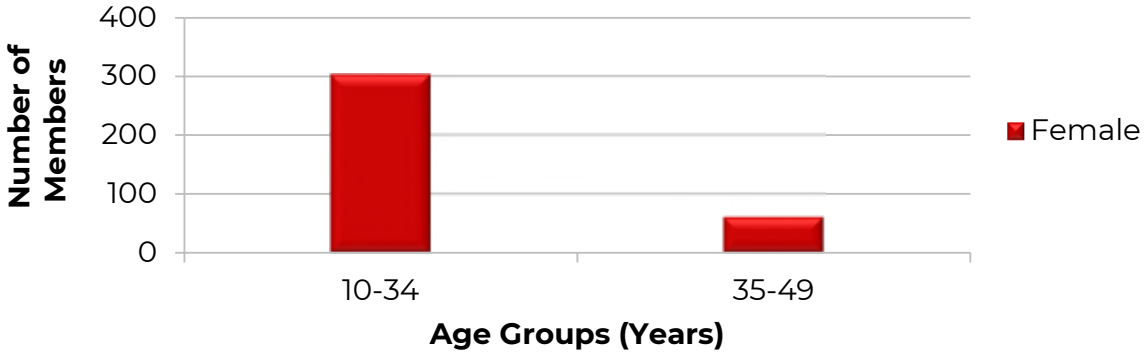
claims data. Fiscal year 2022 medical claim utilization details for the compounded hydroxyprogesterone caproate product can be found at the end of this report. The following utilization details include pharmacy claims data only.

Comparison of Fiscal Years: Pharmacy Claims

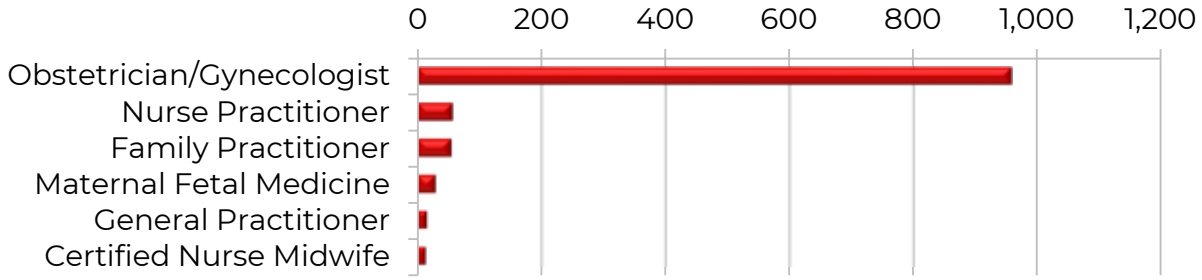
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	403	1,314	$3,632,774.68	$2,764.67	$98.67	5,602	36,817
2022	362	1,131	$2,778,526.28	$2,456.70	$89.06	5,086	31,198
% Change	**-10.20%**	**-13.90%**	**-23.50%**	**-11.10%**	**-9.70%**	**-9.20%**	**-15.30%**
Change	**-41**	**-183**	**-$854,428.40**	**-$307.97**	**-$9.61**	**-516**	**-5,619**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Injectable and Vaginal Progesterone Products



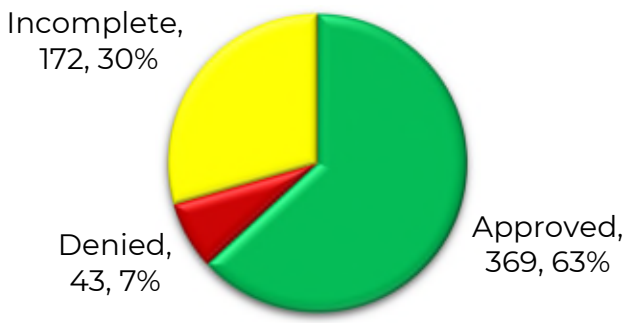
Top Prescriber Specialties of Injectable and Vaginal Progesterone Products by Number of Claims



Prior Authorization of Injectable and Vaginal Progesterone Products

There were 584 prior authorization requests submitted for 351 unique members for injectable and vaginal progesterone products during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



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

Anticipated Patent Expiration(s):

- Makena® [hydroxyprogesterone subcutaneous (sub-Q) auto-injector]: May 2036

News:

- **October 2022:** After a 3 day hearing, members of the U.S. Food and Drug Administration's (FDA) Obstetrics, Reproductive, and Urologic Drugs Advisory Committee voted 14-1 that Makena® (hydroxyprogesterone caproate) should not remain on the market while an additional confirmatory study is designed and conducted. The FDA advisory committee also voted 15-0 that the post marketing, confirmatory study did not show any benefit to infants and 13-1, with 1 abstention, that the evidence did not show that Makena® reduced the risk of preterm birth in women who have a history of spontaneous preterm delivery (SPTD).
- **March 2023:** Covis Pharma announced it is withdrawing Makena® from the market. The company said in its statement that the FDA rejected its proposal to slowly discontinue the product over several months. The company proposed slow discontinuation to give women who are already receiving Makena® time to finish their course of treatment. In a separate filing, the FDA's drug regulators recommended making the withdrawal immediately effective, noting there is no indication of harm from discontinuing Makena®, such as signs or symptoms of withdrawal. The FDA is expected to decide soon on the fate of Makena®. The FDA granted Makena® accelerated approval in 2011 based on a small study in women with a history of SPTD. The expedited approval was conditioned on a larger follow-up study. In 2019, results from that 1,700-patient international study showed Makena® neither reduced premature births nor resulted in healthier outcomes for infants. The American College of Obstetricians and Gynecologists (ACOG) has stated its current guidelines, which recommend offering vaginal or intramuscular

progesterone to patients with a singleton pregnancy and a prior SPTD, will remain in effect until the FDA makes a final decision.

Recommendations

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

Utilization Details of Injectable and Vaginal Progesterone Products: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
HYDROXYPROGESTERONE INJECTABLE PRODUCTS						
MAKENA INJ 275MG	715	234	$2,179,509.54	$3,048.27	3.06	78.44%
HYDROXYPROG INJ 250MG/ML	406	132	$593,941.80	$1,462.91	3.08	21.38%
SUBTOTAL	**1,121**	**359***	**$2,773,451.34**	**$2,474.09**	**3.12**	**99.82%**
PROGESTERONE VAGINAL PRODUCTS						
ENDOMETRIN SUP 100MG	10	3	$5,074.94	$507.49	3.33	0.18%
SUBTOTAL	**10**	**3***	**$5,074.94**	**$507.49**	**3.33**	**0.18%**
TOTAL	**1,131**	**362***	**$2,778,526.28**	**$2,456.70**	**3.12**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
HYDROXYPROG = hydroxyprogesterone; INJ = injection; SUP = suppository
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS†	TOTAL MEMBERS*	TOTAL COST	COST/ CLAIM
S5000 HYDROXYPROGESTERONE CAPROATE INJ	6	4	$66.78	$11.13
TOTAL	**6**	**4**	**$66.78**	**$11.13**

Costs do not reflect rebated prices or net costs.
†Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 03/2023. Last Accessed 03/09/2023.
[2] Gumbrecht J. FDA Advises Vote to Recommend Preterm Birth Drug Makena® be Removed from Market. *CNN Health*. Available online at: https://www.cnn.com/2022/10/19/health/makena-preterm-birth-fda-advisers/index.html. Issued 10/19/2022. Last accessed 03/09/2023.
[3] Perrone M. Maker of Unproven Birth Drug Makena® to Pull from US Market. *AP News*. Available online at: https://apnews.com/article/makena-covis-fda-premature-birth-drug-withdrawal-d93619b2728d0c729890c03b2caf38d9. Issued 03/08/2023. Last accessed 03/09/2023.
[4] American College of Obstetricians and Gynecologists (ACOG). ACOG Statement on Announcement Regarding the Voluntary Removal of Makena® (17-OHPC) from the Market. Available online at: https://www.acog.org/news/news-releases/2023/03/acog-statement-on-announcement-regarding-the-voluntary-removal-of-makena-17-ohpc-from-the-market. Issued 03/08/2023. Last accessed 03/17/2023.

Fiscal Year 2022 Annual Review of Mozobil® (Plerixafor)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Mozobil® (Plerixafor) Approval Criteria:

1. An FDA approved indication for use in combination with a granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in members with non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM); and
2. Member must have an oncology diagnosis of NHL or MM. This medication is not covered for the diagnosis of leukemia; and
3. Mozobil® must be prescribed by an oncologist; and
4. Member must be 18 years of age or older; and
5. Mozobil® must be used in combination with the G-CSF filgrastim; and
6. The following dosing restrictions will apply (current body weight in kilograms is required):
    a. Recommended dose is 0.24mg/kg (maximum dose is 40mg/day) administered 11 hours prior to apheresis for up to 4 consecutive days; or
    b. For members with renal impairment (creatinine clearance ≤50mL/min), the recommended dose is 0.16mg/kg (maximum dose is 27mg/day); and
7. Approvals will be for the duration of 2 months.

Utilization of Mozobil® (Plerixafor): Fiscal Year 2022

Fiscal Year 2022 Utilization: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2022	2	3	$180,827.47	$60,275.82	1.5

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2022 = 07/01/2021 to 06/30/2022
Please note: There were no paid pharmacy claims for Mozobil® during fiscal year 2021 (07/01/2020 to 06/30/2021) to allow for a fiscal year comparison.

Comparison of Fiscal Years: Medical Claims

Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2021	3	4	$10,654.40	$2,663.60	1.33
2022	0	0	$0.00	$0.00	0
% Change	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**
Change	**-3**	**-4**	**-$10,654.40**	**-$2,663.60**	**-1.33**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Mozobil® (Plerixafor)

- Due to the limited number of members utilizing Mozobil® (plerixafor), detailed demographic information could not be provided.

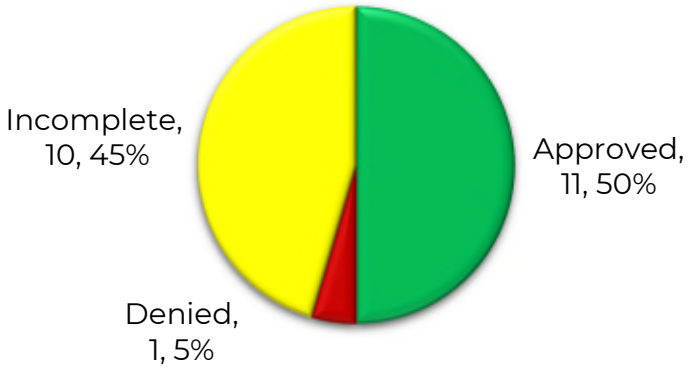
Top Prescriber Specialties of Mozobil® (Plerixafor) by Number of Claims

- The only prescriber specialty listed on paid pharmacy claims for Mozobil® (plerixafor) during fiscal year 2022 was hematologist/ oncologist.

Prior Authorization of Mozobil® (Plerixafor)

There were 22 prior authorization requests submitted for 10 unique members for Mozobil® (plerixafor) during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[1,2,3]

Anticipated Patent Expiration(s):

- Mozobil® (plerixafor): July 2023

Pipeline:

- **Aphexda® (Motixafortide):** In November 2022, BioLineRx announced the U.S. Food and Drug Administration (FDA) accepted the company's New Drug Application (NDA) for Aphexda® (motixafortide). Motixafortide is a CXCR4 inhibitor that is being studied in multiple myeloma as a primary stem cell mobilization agent in combination with granulocyte-colony stimulating factor (G-CSF) in patients undergoing autologous stem cell transplantation (ASCT). The FDA has assigned the NDA a Prescription Drug User Fee Act (PDUFA) target action date of September 9, 2023. The NDA is supported by the results from the GENESIS Phase 3 trial of motixafortide with G-CSF (versus placebo with G-CSF) in stem cell mobilization for ASCT in multiple myeloma patients. The trial met all primary and secondary endpoints with a very high degree of statistical significance ($p<0.0001$). The combination was also found to be safe and well tolerated.

Recommendations

The College of Pharmacy does not recommend any changes to the current Mozobil® (plerixafor) prior authorization criteria at this time.

Utilization Details of Mozobil® (Plerixafor): Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
MOZOBIL INJ	3	2	$180,827.47	$60,275.82	1.5
TOTAL	**3**	**2***	**$180,827.47**	**$60,275.82**	**1.5**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 03/2023. Last accessed 03/02/2023.
[2] BioLineRx Ltd. BioLineRx Announces U.S. FDA Acceptance of New Drug Application for Aphexda® (Motixafortide) in Stem Cell Mobilization. Available online at: https://ir.biolinerx.com/news-releases/news-release-details/biolinerx-announces-us-fda-acceptance-new-drug-application. Issued 11/10/2022. Last accessed 03/02/2023.
[3] BioLineRx Ltd. Motixafortide (BL-8040). Available online at: https://www.biolinerx.com/clinical-studies/#bl-8040. Last accessed 03/02/2023.

Fiscal Year 2022 Annual Review of Muscular Dystrophy Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Amondys 45™ (Casimersen), Exondys 51® (Eteplirsen), Viltepso® (Viltolarsen), and Vyondys 53™ (Golodirsen) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD); and
2. Member must have a confirmed mutation of the *DMD* gene that is amenable to exon skipping for the requested medication (results of genetic testing must be submitted); and
3. Must be prescribed by a neurologist or specialist with expertise in the treatment of DMD (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of DMD); and
4. Prescriber must verify the member's renal function will be appropriately assessed prior to initiation of therapy and monitored during treatment; and
5. Member must be on a stable dose of a corticosteroid (at least 3 months in duration) or a patient-specific, clinically significant reason why corticosteroids are not appropriate for the member must be provided; and
6. A baseline assessment must be provided using at least 1 of the following exams as functionally appropriate:
    a. 6-minute walk test (6MWT); or
    b. Forced vital capacity percent predicted (FVCpp); and
7. The requested exon-skipping therapy will not be approved for concurrent use with any other exon-skipping therapies for DMD; and
8. Initial authorizations will be for the duration of 6 months, at which time the prescriber must verify the member is responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment; and
9. Subsequent approvals will be for the duration of 1 year. For yearly approvals, the prescriber must verify the member is responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment; and

10. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Emflaza® (Deflazacort) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD); and
2. Member must be 2 years of age or older; and
3. Emflaza® must be prescribed by, or in consultation with, a prescriber who specializes in the treatment of DMD; and
4. Member must have a minimum 6-month trial of prednisone that resulted in inadequate effects or intolerable adverse effects that are not expected to occur with Emflaza®; and
5. A patient-specific, clinically significant reason why the member cannot use prednisone even when the tablets are crushed must be provided; and
6. Patients already established on deflazacort via the ACCESS DMD Program must also document a patient-specific, clinically significant reason why the member cannot use prednisone even when the tablets are crushed; and
7. For Emflaza® suspension, a patient-specific, clinically significant reason why the member cannot use the tablet formulation in the place of oral suspension even when the tablets are crushed must be provided; and
8. Prescriber must verify the member has had a baseline eye examination; and
9. The member's recent weight must be provided in order to authorize the appropriate amount of drug required according to package labeling; and
10. For the tablets, a quantity limit of 30 tablets per 30 days will apply, and for the suspension, a quantity limit of 39mL (3 bottles) per 30 days will apply. Quantity limit override requests will be approved as appropriate based on the member's recent weight taken within the last 30 days.

Utilization of Muscular Dystrophy Medications: Fiscal Year 2022

Comparison of Fiscal Years

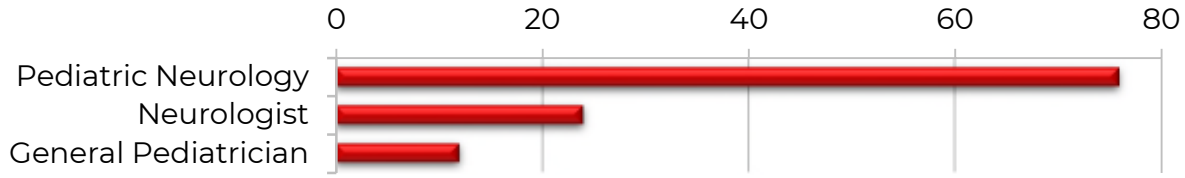
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	8	72	$4,038,570.78	$56,091.26	$2,031.47	5,288	1,988
2022	10	112	$8,191,595.81	$73,139.25	$2,566.29	10,848	3,192
% Change	**25.00%**	**55.60%**	**102.80%**	**30.40%**	**26.30%**	**105.10%**	**60.60%**
Change	**2**	**40**	**$4,153,025.03**	**$17,047.99**	**$534.82**	**5,560**	**1,204**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Muscular Dystrophy Medications

- Due to the limited number of members utilizing muscular dystrophy medications during fiscal year 2022, detailed demographic information could not be provided.

Top Prescriber Specialties of Muscular Dystrophy Medications by Number of Claims



Prior Authorization of Muscular Dystrophy Medications

There were 27 prior authorization requests submitted for muscular dystrophy medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions

Market News and Updates[1,2,3]

Anticipated Patent Expiration(s):

- Vyondys 53™ (golodirsen injection): June 2025
- Amondys 45™ (casimersen injection): November 2030
- Viltepso® (viltolarsen injection): August 2031
- Exondys 51® (eteplirsen injection): March 2034

Pipeline:

- **Delandistrogene Moxeparvovec:** In September 2022, Sarepta Therapeutics submitted a Biologics License Application (BLA) to the U.S. Food and Drug Administration (FDA) for approval of an investigational gene therapy, delandistrogene moxeparvovec, to treat ambulant patients with Duchenne muscular dystrophy (DMD). An analysis from 3 Phase 1 and 2 studies (ENDEAVOR, SRP-9001-101, and

SRP-9001-102) included data from >80 boys with DMD who were 3 to 7 years of age. The analysis reported positive results across multiple time points, including 1, 2, and 4 years after treatment with a consistent safety profile. Key findings in the ENDEAVOR study were based on the North Star Ambulatory Assessment (NSAA) 52 weeks after treatment compared to a propensity-score weighted external control. In the ENDEAVOR study (N=20, ages 4 to 7 years), patients treated with delandistrogene moxeparvovec demonstrated a 3.8-point improvement (unadjusted means) and a 3.2-point improvement [least squares mean (LSM)] on the NSAA 1 year after treatment when compared to a propensity-score weighted external control (P=0.0001). At 1 year, using unadjusted means, NSAA total scores in the patients treated with delandistrogene moxeparvovec improved 4 points (from 22.1 to 26.1), and patients in the external control group improved 0.2 points (from 21.9 to 22.1). In long-term results from the SRP-9001-101 study, after 4 years, patients treated with delandistrogene moxeparvovec (N=4, ages 4 to 7 years at time of treatment) had a positive mean 7.0-point difference on total NSAA scores compared to baseline. These patients are now on average older than 9 years of age, an age where rapid decline in function would be expected with DMD. When compared to a propensity-weighted external control, total NSAA scores for the patients treated with delandistrogene moxeparvovec were 9.9 points (unadjusted means) and 9.4 points (LSM) greater (P=0.0125). Currently, the Phase 3 EMBARK study is evaluating the safety and efficacy of delandistrogene moxeparvovec in 125 ambulatory boys 4 to 7 years of age with DMD, with results expected in late 2023. If FDA approved, delandistrogene moxeparvovec would be the first gene transfer therapy indicated to treat boys affected by DMD.

Recommendations

The College of Pharmacy does not recommend any changes to the current muscular dystrophy medications prior authorization criteria at this time.

Utilization Details of Muscular Dystrophy Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
VYONDYS 53 INJ 100MG/2ML	53	5	$3,751,004.73	$70,773.67	10.6
AMONDYS 45 INJ 50MG/ML	31	3	$4,256,305.21	$137,300.17	10.33
EMFLAZA TAB 30MG	23	2	$123,889.37	$5,386.49	11.5
EMFLAZA TAB 36MG	5	1	$60,396.50	$12,079.30	5
TOTAL	**112**	**10***	**$8,191,595.81**	**$73,139.25**	**11.2**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
INJ = injection; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 03/2023. Last accessed 03/01/2023.
[2] Sarepta Therapeutics, Inc. Sarepta Therapeutics Submits Biologics License Application for SRP-9001 for the Treatment of Ambulant Patients with Duchenne Muscular Dystrophy. Available online at: https://investorrelations.sarepta.com/news-releases/news-release-details/sarepta-therapeutics-submits-biologics-license-application-srp. Issued 09/29/2022. Last accessed 03/02/2023.
[3] Sarepta Therapeutics, Inc. Sarepta Therapeutics' Investigational Gene Therapy SRP-9001 for Duchenne Muscular Dystrophy Demonstrates Significant Functional Improvements Across Multiples Studies. Available online at: https://investorrelations.sarepta.com/news-releases/news-release-details/sarepta-therapeutics-investigational-gene-therapy-srp-9001. Issued 07/06/2022. Last accessed 03/02/2023.

Fiscal Year 2022 Annual Review of Myalept® (Metreleptin)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Myalept® (Metreleptin) Approval Criteria:

1. An FDA approved diagnosis of leptin deficiency in members with congenital or acquired generalized lipodystrophy; and
2. Approvals will not be granted for the following diagnoses:
   a. Metabolic disease without current evidence of generalized lipodystrophy; or
   b. Human immunodeficiency virus (HIV)-related lipodystrophy; or
   c. General obesity not associated with congenital leptin deficiency; and
3. Myalept® must be prescribed by an endocrinologist; and
4. Prescriber must agree to test for neutralizing antibodies in members who experience severe infections or if they suspect Myalept® is no longer effective; and
   a. Baseline hemoglobin A1c (HbA1c), fasting glucose, and fasting triglycerides must be included on prior authorization request; and
   b. Subsequent approvals will require recent lab values (HbA1c, fasting glucose, and fasting triglycerides) to ensure neutralizing antibodies have not developed; and
5. Prescriber and pharmacy must be enrolled in the Myalept® Risk Evaluation and Mitigation Strategies (REMS) program; and
6. Approvals will be for the duration of 3 months to evaluate compliance and ensure the prescriber is assessing continued efficacy; and
7. A quantity limit of 1 vial per day will apply.

Utilization of Myalept® (Metreleptin): Fiscal Year 2022

Comparison of Fiscal Years

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	1	12	$585,053.66	$48,754.47	$1,725.82	113	339
2022	1	13	$703,067.03	$54,082.08	$1,802.74	130	390
% Change	**0.0%**	**8.3%**	**20.2%**	**10.9%**	**4.5%**	**15.0%**	**15.0%**
Change	**0**	**1**	**$118,013.37**	**$5,327.61**	**$76.92**	**17**	**51**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Myalept® (Metreleptin)

- Due to the limited number of members utilizing Myalept® (metreleptin), detailed demographic information could not be provided.

Top Prescriber Specialties of Myalept® (Metreleptin) by Number of Claims

- The only prescriber specialty listed on paid claims for Myalept® (metreleptin) during fiscal year 2022 was pediatric endocrinologist.

Prior Authorization of Myalept® (Metreleptin)

There were 10 prior authorization requests submitted for Myalept® (metreleptin) for 1 unique member during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions

Recommendations

The College of Pharmacy does not recommend any changes to the current Myalept® (metreleptin) prior authorization criteria at this time.

Utilization Details of Myalept® (Metreleptin): Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
MYALEPT INJ 11.3MG	13	1	$703,067.03	$54,082.08	13	100%
TOTAL	**13**	**1***	**$703,067.03**	**$54,082.08**	**13**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Fiscal Year 2022 Annual Review of Mytesi® (Crofelemer)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Mytesi® (Crofelemer) Approval Criteria:

1. An FDA approved diagnosis of non-infectious diarrhea in adult members with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) currently on anti-retroviral therapy; and
2. Duration of diarrhea has been ≥4 weeks; and
3. Dietary modifications have failed; and
4. Prescribers must verify that infectious diarrhea has been ruled out via confirmation of all of the following:
    a. CD4 count has been measured and possible opportunistic infections have been ruled out; and
    b. Member does not have fever; and
    c. Stool studies for pathogens are negative including:
        i. Bacterial cultures; and
        ii. Ova, parasite, cryptosporidium, and/or giardia; and
        iii. *Clostridium difficile* (*Clostridium difficile* testing should include a glutamate dehydrogenase screen and if positive, should be followed by a confirmatory test or nucleic acid amplification test in members with documented diarrhea; a toxin enzyme immunoassay should not be used as a stand-alone test); and
5. If stool study results are negative and the member has severe symptoms, particularly in the case of advanced immunodeficiency, an endoscopy with biopsy is recommended, at the prescriber's discretion, to rule out inflammatory bowel disease, cancer, cytomegalovirus (CMV) infection, microsporidium, or mycobacterium avium complex (MAC); and
6. A quantity limit of 60 tablets per 30 days will apply. Initial approvals will be for 4 weeks of therapy. Subsequent approvals may be granted for 6 months if the prescriber documents the member is responding well to treatment.

Utilization of Mytesi® (Crofelemer): Fiscal Year 2022

There was no SoonerCare utilization of Mytesi® (crofelemer) during fiscal year 2022 (07/01/2021 to 06/30/2022).

Prior Authorization of Mytesi® (Crofelemer)

There were no prior authorization requests submitted for Mytesi® (crofelemer) during fiscal year 2022.

Market News and Updates[1]

Anticipated Patent Expiration(s):

- Mytesi® (crofelemer): October 2031

Recommendations

The College of Pharmacy does not recommend any changes to the current Mytesi® (crofelemer) prior authorization criteria at this time.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 03/2023. Last accessed 03/07/2023.

Fiscal Year 2022 Annual Review of Osteoporosis Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Osteoporosis Medications*		
Tier-1	**Tier-2**	**Special PA¥**
alendronate tabs (Fosamax®)	alendronate + vitamin D tabs (Fosamax® + D)	abaloparatide inj (Tymlos®)
calcium + vitamin D†	risedronate tabs (Actonel®)	alendronate effervescent tabs (Binosto®)
ibandronate tabs (Boniva®)		alendronate soln (Fosamax®)
zoledronic acid inj (Reclast®)		alendronate 40mg tabs (Fosamax®)
		denosumab inj (Prolia®)
		ibandronate inj (Boniva® IV)
		risedronate 30mg tabs (Actonel®)
		risedronate DR tabs (Atelvia®)
		romosozumab-aqqg (Evenity®)
		teriparatide inj (Forteo®)
		teriparatide inj

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
†OTC calcium + vitamin D must be used at recommended doses in conjunction with Tier-1 bisphosphonates for trial to be accepted unless member has a recent laboratory result showing adequate vitamin D or member is unable to tolerate calcium. OTC calcium + vitamin D are only covered for members with osteoporosis who are being treated with a bisphosphonate.
¥Unique criteria applies to medications in the Special PA Tier.
DR = delayed-release; inj = injection; PA = prior authorization; soln = solution; tabs = tablets

Osteoporosis Medications Tier-2 Approval Criteria:

1. A trial of at least 1 Tier-1 bisphosphonate medication, compliantly used for at least 6 months concomitantly with calcium and vitamin D, that failed to prevent fracture or improve bone mineral density (BMD) scores; or
2. Hypersensitivity to or intolerable adverse effect(s) with all Tier-1 bisphosphonate medications; and
3. Quantity limits apply based on FDA approved maximum doses.

Actonel® (Risedronate 30mg Tablets), Atelvia® [Risedronate Delayed-Release (DR) Tablets], and Binosto® (Alendronate Effervescent Tablets) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all other available Tier-1 and Tier-2 bisphosphonate medications must be provided; or
2. Members with a diagnosis of Paget's disease in claims history will not require prior authorization.

Boniva® [Ibandronate Intravenous (IV) Solution] and Prolia® (Denosumab) Approval Criteria:

1. A minimum of a 12-month trial with a Tier-1 or Tier-2 bisphosphonate medication plus adequate calcium and vitamin D; or
2. Contraindication to or intolerable adverse effects with Tier-1 and Tier-2 bisphosphonate medications.

Evenity® (Romosozumab-aqqg) Approval Criteria:

1. An FDA approved diagnosis of osteoporosis in postmenopausal women at high-risk for fracture; and
2. Member meets 1 of the following:
    a. History of osteoporotic fracture; or
    b. Multiple risk factors for fracture (e.g., T-score ≤-2.5 at the total hip or femoral neck, smoking, corticosteroid use, rheumatoid arthritis); or
    c. Failure of or intolerance to other available osteoporosis therapies; and
3. Prescriber must verify member has not had a myocardial infarction or stroke within the preceding year; and
4. Prescriber must verify calcium levels will be monitored and pre-existing hypocalcemia will be corrected prior to starting therapy; and
5. Prescriber must verify that the member will take adequate calcium and vitamin D supplements during treatment with Evenity® to reduce the risk of hypocalcemia; and
6. Evenity® must be administered by a health care provider; and
7. Approval will be limited to a total duration of 1 year of therapy.

Forteo® (Teriparatide) and Teriparatide Approval Criteria:

1. Member has 1 of the following indications:
    a. Treatment of postmenopausal women with osteoporosis at high risk for fracture; or
    b. To increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture; or
    c. Treatment of men and women with osteoporosis associated with sustained systemic corticosteroid therapy at high risk for fracture; or

    d. Treatment of non-healing fracture (this indication only pertains to Forteo®); and
2. A minimum 12-month trial with a bisphosphonate plus adequate calcium and vitamin D or a patient-specific, clinically significant reason why the member cannot use a bisphosphonate must be provided; and
3. Use of teriparatide will require a patient-specific, clinically significant reason why the member cannot use Forteo® (teriparatide); and
4. The diagnosis of non-healing fracture may be approved for 6 months; and
5. Treatment duration including other parathyroid hormone analogs has not exceeded a total of 24 months during the patient's lifetime; and
6. Approval will be for a maximum of 24 months of parathyroid hormone analog therapy.

Fosamax® (Alendronate Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of osteoporosis or Paget's disease; and
2. A patient-specific, clinically significant reason why the member cannot use the oral tablet formulation must be provided.

Fosamax® (Alendronate 40mg Tablets) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all other available Tier-1 and Tier-2 bisphosphonate medications including a 35mg alendronate tablet in combination with a 5mg alendronate tablet to achieve a 40mg dose must be provided; or
2. Members with a diagnosis of Paget's disease in claims history will not require prior authorization.

Tymlos® (Abaloparatide) Approval Criteria:

1. Diagnosis of postmenopausal osteoporosis confirmed by the following:
    a. History of vertebral fracture(s) or low trauma or fragility fracture(s) (e.g., prior fracture from minor trauma such as falling from standing height or less) within the past 5 years; or
    b. A bone mineral density (BMD) test (T-score at or below -2.5) within the last month in the spine, femoral neck, total hip, or 33% radius; or
    c. A T-score between -1.0 and -2.5 in the spine, femoral neck, total hip, or 33% radius, with a FRAX® 10-year probability for major osteoporotic fracture ≥20% or the 10-year probability of hip fracture ≥3%; and
2. One of the following [if a 12-month bisphosphonate trial is inappropriate for the member, the member must have a trial of Prolia® or a selective estrogen receptor modulator (SERM) or a patient-specific, clinically significant reason why Prolia® or a SERM is not appropriate must be provided]:
    a. A minimum 12-month trial with a bisphosphonate medication plus adequate calcium and vitamin D; or

b. A 12-month trial of Prolia® (denosumab), unless contraindicated, intolerant, or allergic, that did not yield adequate results; or
c. A 12-month trial of a SERM, unless contraindicated, intolerant, or allergic, that did not yield adequate results; and

3. A patient-specific, clinically significant reason why the member cannot use Forteo® (teriparatide) must be provided; and
4. Treatment duration including other parathyroid hormone analogs has not exceeded a total of 24 months during the member's lifetime; and
5. Approval will be for a maximum of 24 months of parathyroid hormone analog therapy; and
6. A quantity limit of 1 pen per 30 days will apply.

Utilization of Osteoporosis Medications: Fiscal Year 2022

Comparison of Fiscal Years: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	562	1,916	$353,738.39	$184.62	$3.34	18,657	105,773
2022	772	2,409	$298,028.10	$123.71	$2.12	23,683	140,787
% Change	**37.4%**	**25.7%**	**-15.7%**	**-33.0%**	**-36.5%**	**26.9%**	**33.1%**
Change	**210**	**493**	**-$55,710.29**	**-$60.91**	**-$1.22**	**5,026**	**35,014**

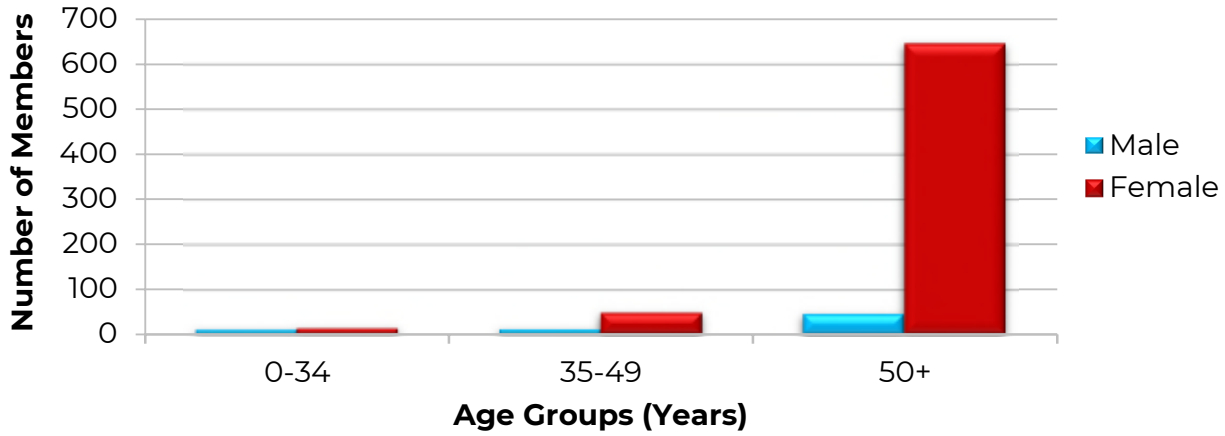
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Comparison of Fiscal Years: Medical Claims

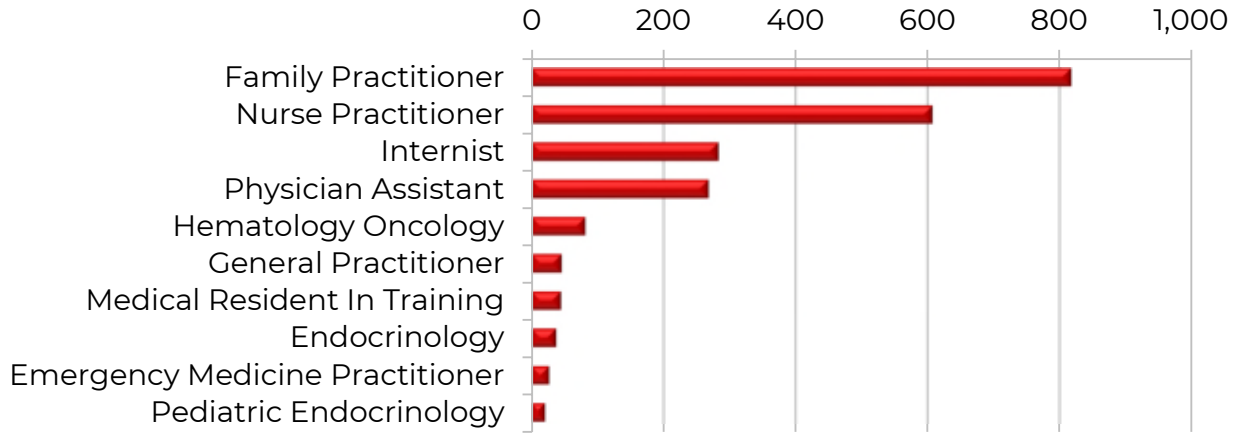
Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2021	115	206	$54,989.29	$266.94	1.79
2022	185	388	$91,950.96	$236.99	2.1
% Change	**60.87%**	**88.35%**	**67.22%**	**-11.22%**	**17.32%**
Change	**70**	**182**	**$36,961.67**	**-$29.95**	**0.31**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Osteoporosis Medications: Pharmacy Claims

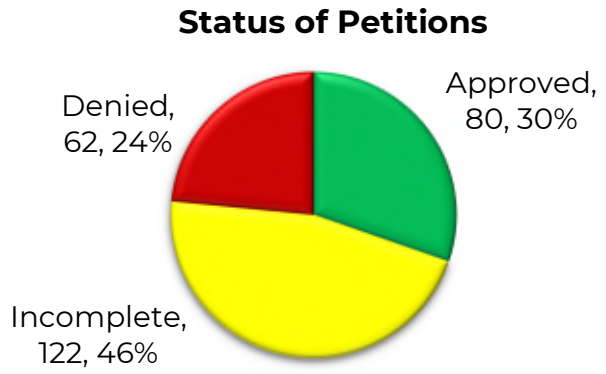


Top Prescriber Specialties of Osteoporosis Medications by Number of Claims: Pharmacy Claims



Prior Authorization of Osteoporosis Medications

There were 264 prior authorization requests submitted for osteoporosis medications during fiscal year 2022. Computer edits are in place to detect lower tiered medications in a member's recent claims history and generate automated prior authorizations where possible. Please note: The status of petitions below includes prior authorization requests for Prolia® (denosumab) only when submitted as a pharmacy claim. When billed as a medical claim, Prolia® (denosumab) and Xgeva® (denosumab) are billed using the same procedure code. The status of petitions for all denosumab products submitted as a medical claim is included in the Fiscal Year 2022 Annual Review of Xgeva® (Denosumab). The following chart shows the status of the submitted petitions for fiscal year 2022.



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

Anticipated Patent Expiration(s):

- Forteo® (teriparatide injection): March 2025
- Atelvia® (risedronate sodium DR tablet): January 2028
- Binosto® (alendronate effervescent tablet): December 2031
- Tymlos® (abaloparatide injection): January 2040

News:

- **December 2021:** A study analyzing more than 100,000 adverse events from the U.S. Food and Drug Administration (FDA) Adverse Events Reporting Systems (FAERS) and the World Health Organization's (WHO) database for adverse drug reactions found that alendronate therapy is significantly associated with depression and anxiety when compared to other first-line osteoporosis treatments. The primary outcome of the study was depression or depressive disorder related adverse events and the cohorts were collected based on drug therapy with alendronate, zoledronate, risedronate, ibandronate, denosumab, and teriparatide. Alendronate had a significantly higher odds ratio for both depression [reported odds ratio (ROR): 14.67; 95% confidence interval (CI): 11.55, 18.63] and anxiety (ROR: 7.10; 95% CI: 5.79, 8.71) compared to the control, teriparatide, in patients 65 years of age or younger. In patients older than 65 years of age, alendronate was the only treatment that had a significantly elevated odds ratio for both depression (ROR: 3.60; 95% CI: 2.82, 4.59) and anxiety (ROR: 2.28; 95% CI: 1.84, 2.84) compared to teriparatide.
- **November 2022:** The FDA issued a Drug Safety Communication regarding the potential increased risk of severe hypocalcemia in patients with advanced kidney disease on dialysis who are treated with Prolia® (denosumab). Based on data from an ongoing safety study, the FDA identified potentially severe outcomes associated with hypocalcemia in these patients, including hospitalization and death. The FDA is advising health care professionals to consider the risk of hypocalcemia in patients on dialysis who are treated with Prolia®, and

these patients should receive adequate calcium and vitamin D supplementation and frequent blood calcium monitoring. Patients on dialysis should be counseled to seek immediate help if they experience symptoms of hypocalcemia.

Pipeline:

- **CT-P41:** CT-P41 is a denosumab biosimilar being developed by Celltrion for the treatment of patients with postmenopausal osteoporosis. It is currently in Phase 3 clinical trials, with an estimated study completion date of March 2023.
- **GP2411:** GP2411 is a denosumab biosimilar being developed by Sandoz and Hexal AG for the treatment of patients with postmenopausal osteoporosis. In February 2023, the FDA accepted Sandoz's Biologics License Application (BLA) for GP2411. Data from the Phase 1/3 ROSALIA clinical trial demonstrated biosimilarity between GP2411 and the reference denosumab product in postmenopausal women with osteoporosis in terms of pharmacokinetics, pharmacodynamics, efficacy, safety, and immunogenicity.
- **SB16:** SB16 is a denosumab biosimilar being developed by Samsung Bioepis for the treatment of patients with postmenopausal osteoporosis. The Phase 3 trial was completed in December 2022, and publication of the results is pending.
- **TVB-009:** TVB-009 is a denosumab biosimilar being developed by Teva Pharmaceuticals for the treatment of patients with postmenopausal osteoporosis. TVB-009 is currently in Phase 3 clinical trials with an estimated completion date of July 2023.

Recommendations

The College of Pharmacy does not recommend any changes to the osteoporosis medications Product Based Prior Authorization (PBPA) category at this time.

Utilization Details of Osteoporosis Medications: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-1 PRODUCTS						
ALENDRONATE PRODUCTS						
ALENDRONATE TAB 70MG	1,904	602	$22,099.60	$11.61	3.16	7.42%
ALENDRONATE TAB 35MG	125	42	$1,535.58	$12.28	2.97	0.52%
ALENDRONATE TAB 10MG	67	20	$914.92	$13.66	3.35	0.31%
SUBTOTAL	**2,096**	**664**	**$24,550.10**	**$11.71**	**3.16**	**8.24%**
IBANDRONATE PRODUCTS						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
IBANDRONATE TAB 150MG	153	62	$3,273.93	$21.40	2.47	1.10%
SUBTOTAL	**153**	**62**	**$3,273.93**	**$21.40**	**2.47**	**1.10%**
ZOLEDRONIC ACID PRODUCTS						
ZOLEDRONIC INJ 5MG/100ML	1	1	$49.15	$49.15	1	0.02%
ZOLEDRONIC INJ 4MG/5ML	1	1	$35.07	$35.07	1	0.01%
SUBTOTAL	**2**	**2**	**$84.22**	**$42.11**	**1**	**0.03%**
TIER-1 SUBTOTAL	**2,251**	**728**	**$27,908.25**	**$12.40**	**3.09**	**9.36%**
TIER-2 PRODUCTS						
RISEDRONATE PRODUCTS						
RISEDRONATE TAB 35MG	15	2	$375.27	$25.02	7.5	0.13%
RISEDRONATE TAB 5MG	11	1	$767.51	$69.77	11	0.26%
TIER-2 SUBTOTAL	**26**	**3**	**$1,142.78**	**$43.95**	**8.67**	**0.38%**
SPECIAL PA PRODUCTS						
TERIPARATIDE PRODUCTS						
FORTEO INJ 600MG/2.4ML	39	11	$140,048.49	$3,590.99	3.56	46.99%
FORTEO INJ 620MG/2.48ML	13	3	$33,880.08	$2,606.16	4.33	11.37%
SUBTOTAL	**52**	**14**	**$173,928.57**	**$3,344.78**	**3.56**	**58.36%**
DENOSUMAB PRODUCTS						
PROLIA SOL 60MG/ML	62	45	$79,321.28	$1,279.38	1.37	26.62%
SUBTOTAL	**62**	**45**	**$79,321.28**	**$1,279.38**	**1.37**	**26.62%**
ALENDRONATE PRODUCTS						
ALENDRONATE SOL 70MG/75ML	12	1	$3,238.02	$269.84	12	1.09%
SUBTOTAL	**12**	**1**	**$3,238.02**	**$269.84**	**12**	**1.09%**
ABALOPARATIDE PRODUCTS						
TYMLOS INJ 3,120MCG/1.56ML	6	1	$12,489.20	$2,081.53	6	4.19%
SUBTOTAL	**6**	**1**	**$12,489.20**	**$2,081.53**	**6**	**4.19%**
SPECIAL PA SUBTOTAL	**119**	**58**	**$268,977.07**	**$2,260.31**	**2.05**	**90.25%**
TOTAL	**2,409**	**772***	**$298,028.10**	**$123.71**	**4.29**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
INJ = injection; PA = prior authorization; SOL = solution; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
ZOLEDRONIC ACID J3489	324	136	$10,731.36	$33.12	2.38
DENOSUMAB J0897 (PROLIA)	64	49	$81,219.60	$1,269.06	1.31
TOTAL	**388⁺**	**185***	**$91,950.96**	**$236.99**	**2.1**

Costs do not reflect rebated prices or net costs.
⁺Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 03/2023. Last accessed 03/13/2023.
[2] Keshishi D, Makunts T, and Abagyan R. Common Osteoporosis Drug Associated with Increased Rates of Depression and Anxiety. *Sci Rep* 2021; 11(1):23956. doi: 10.1038/s41598-021-03214-x.
[3] U.S. FDA. FDA Investigating Risk of Severe Hypocalcemia in Patients on Dialysis Receiving Osteoporosis Medicine Prolia® (Denosumab). Available online at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-investigating-risk-severe-hypocalcemia-patients-dialysis-receiving-osteoporosis-medicine-prolia. Issued 11/22/2022. Last accessed 03/30/2023.
[4] Celltrion. Celltrion Pipeline. Available online at: https://www.celltrion.com/en-us/science/pipelinebiolist. Last accessed 03/14/2023.
[5] Sandoz. Sandoz Biologics License Application for Proposed Biosimilar Denosumab Accepted by US FDA. Available online at: https://www.novartis.com/news/media-releases/sandoz-biologics-license-application-proposed-biosimilar-denosumab-accepted-us-fda. Issued 02/06/2023. Last accessed 03/17/2023.
[6] Samsung Bioepis. Our Pipeline: SB16. Available online at: https://www.samsungbioepis.com/en/product/product02.do. Last accessed 03/13/2023.
[7] Teva Pharmaceutical Industries, Ltd. Teva Specialty & Biosimilar Product Pipeline. Available online at: https://www.tevapharm.com/product-focus/research/pipeline/. Last accessed 03/13/2023.

Fiscal Year 2022 Annual Review of Parkinson's Disease (PD) Medications

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Duopa® (Carbidopa/Levodopa Enteral Suspension) Approval Criteria:

1. An FDA approved diagnosis of advanced Parkinson's disease (PD); and
2. For long-term administration, member or caregivers must be willing and able to administer Duopa® through a percutaneous endoscopic gastrostomy; and
3. Member must be experiencing 3 hours or more of "off" time on current PD drug treatment and must have demonstrated a clear responsiveness to treatment with levodopa; and
4. Approvals will be for a quantity of 1 cassette per day.

Gocovri® [Amantadine Extended-Release (ER)] Approval Criteria:

1. An FDA approved indication for the treatment of dyskinesia in members with Parkinson's disease (PD) receiving levodopa-based therapy; and
2. Member must use Gocovri® concomitantly with levodopa therapy; and
3. Member must not have end-stage renal disease [ESRD; creatinine clearance (CrCl) <15mL/min/1.73m^2]; and
4. A minimum of a 6-month trial of amantadine immediate-release (IR) that resulted in inadequate effects or intolerable adverse effects that are not expected to occur with amantadine ER; and
5. A patient-specific, clinically significant reason why amantadine IR products cannot be used must be provided; and
6. A patient-specific, clinically significant reason why Osmolex® ER (amantadine ER) cannot be used must be provided; and
7. A quantity limit of (1) 68.5mg capsule or (2) 137mg capsules per day will apply.

Inbrija® (Levodopa Inhalation Powder) Approval Criteria:

1. An FDA approved indication for the treatment of "off" episodes in members with Parkinson's disease (PD) treated with carbidopa/levodopa; and
2. Member must be taking carbidopa/levodopa in combination with Inbrija®. Inbrija® has been shown to be effective only in combination with carbidopa/levodopa; and

3. Member must be experiencing motor fluctuations with a minimum of 2 hours of "off" time and demonstrate levodopa responsiveness; and
4. Member must not be taking nonselective monoamine oxidase inhibitors (MAOIs) concomitantly with Inbrija® or within 2 weeks prior to initiating Inbrija® and
5. A previous failed trial of immediate-release (IR) carbidopa/levodopa formulations alone or in combination with long-acting carbidopa/levodopa formulations or a reason why supplementation with IR carbidopa/levodopa formulations is not appropriate for the member must be provided; and
6. A quantity limit of 10 capsules for inhalation per day will apply.

Kynmobi® [Apomorphine Sublingual (SL) Film] Approval Criteria:

1. An FDA approved diagnosis of acute, intermittent treatment of "off" episodes in patients with Parkinson's disease (PD); and
2. Member must be taking carbidopa/levodopa in combination with Kynmobi®; and
3. Member should be experiencing at least 1 well defined "off" episode per day with a total daily "off" time duration of ≥2 hours during the waking day; and
4. Initial dose titration should occur in an "off" state and in a setting supervised by a health care provider to monitor blood pressure and heart rate; and
5. Member should not use apomorphine concomitantly with 5-HT_3 antagonists (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron); and
6. Prescriber must verify the member has been counseled on separating doses by at least 2 hours; and
7. The maximum single dose approvable is 30mg; and
8. A quantity limit of 5 doses per day will apply.

Mirapex ER® (Pramipexole ER) and Requip XL® [Ropinirole Extended-Release (ER)] Approval Criteria:

1. An FDA approved diagnosis of Parkinson's disease (PD); and
2. A patient-specific, clinically significant reason why the immediate-release products cannot be used must be provided.

Neupro® (Rotigotine Transdermal System) Approval Criteria:

1. For the diagnosis of Parkinson's disease (PD), the following criteria apply:
    a. An FDA approved indication for the treatment of signs and symptoms of PD; and
    b. Member must be 18 years of age or older; and

    c. Failed treatment, intolerance, or a patient-specific, clinically significant reason why the member cannot use oral dopamine agonists must be provided.
2. For the diagnosis of restless leg syndrome (RLS), the following criteria apply:
    a. An FDA approved diagnosis of RLS; and
    b. Member must be 18 years of age or older; and
    c. Documented treatment attempts at the recommended dose with at least 2 of the following that did not yield adequate relief:
        i. Carbidopa/levodopa; or
        ii. Pramipexole; or
        iii. Ropinirole.

Nourianz® (Istradefylline) Approval Criteria:

1. An FDA approved diagnosis of Parkinson's disease (PD); and
2. Member must be taking carbidopa/levodopa in combination with istradefylline (istradefylline has not been shown to be effective as monotherapy for the treatment of PD); and
3. Prescriber must verify the dose is appropriate for the member based on degree of hepatic impairment, concomitant strong CYP3A4 inhibitors, and smoking status of the member; and
4. Member must be experiencing at least 2 hours of "off" time per day; and
5. A quantity limit of 1 tablet per day will apply.

Nuplazid® (Pimavanserin) Approval Criteria:

1. An FDA approved diagnosis of hallucinations and delusions associated with Parkinson's disease (PD) psychosis; and
2. Member must have a concomitant diagnosis of PD; and
3. Member must not be taking concomitant medications known to prolong the QT interval including Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class 3 antiarrhythmics (e.g., amiodarone, sotalol), certain antipsychotic medications (e.g., ziprasidone, chlorpromazine, thioridazine), and certain antibiotics (e.g., gatifloxacin, moxifloxacin); and
4. Member must not have a history of cardiac arrhythmias, as well as other circumstances that may increase the risk of the occurrence of torsade de pointes and/or sudden death, including symptomatic bradycardia, hypokalemia, hypomagnesemia, and the presence of congenital prolongation of the QT interval; and
5. Nuplazid® will not be approved for the treatment of patients with dementia-related psychosis unrelated to the hallucinations and delusions associated with PD psychosis; and

6. Initial approvals will be for the duration of 3 months. For continuation, the prescriber must include information regarding improved response/ effectiveness of this medication; and
7. A quantity limit of 1 tablet per day will apply.

Ongentys® (Opicapone) Approval Criteria:

1. An FDA approved indication of adjunctive treatment to levodopa/carbidopa in members with Parkinson's disease (PD) experiencing "off" episodes; and
2. Member must be taking levodopa/carbidopa in combination with Ongentys®; and
3. Member must not use non-selective monoamine-oxidase inhibitors (MAOIs) concomitantly with Ongentys®; and
4. Member must not have a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms; and
5. Prescriber must verify member has been counseled to avoid eating food 1 hour before and at least 1 hour after taking Ongentys®; and
6. For members with moderate hepatic impairment, the prescriber must verify the dose of Ongentys® will be reduced in accordance with package labeling; and
7. Prescriber must agree to monitor member for changes in heart rate, heart rhythm, and blood pressure in members concurrently taking medications known to be metabolized by catechol-O-methyltransferase (COMT); and
8. A patient-specific, clinically significant reason why the member cannot use entacapone must be provided; and
9. A quantity limit of 30 capsules per 30 days will apply.

Osmolex® ER [Amantadine Extended-Release (ER)] Approval Criteria:

1. An FDA approved indication for the treatment of Parkinson's disease (PD) or drug-induced extrapyramidal reactions in adult members; and
2. Member must not have end-stage renal disease [ESRD; creatinine clearance (CrCl) <15mL/min/1.73m^2]; and
3. A minimum of a 6-month trial of amantadine immediate-release (IR) that resulted in inadequate effects or intolerable adverse effects that are not expected to occur with amantadine ER; and
4. A patient-specific, clinically significant reason why amantadine IR products cannot be used must be provided; and
5. A quantity limit will apply based on FDA approved dosing regimen(s).

Rytary® [Carbidopa/Levodopa Extended-Release (ER) Capsule] Approval Criteria:

1. An FDA approved diagnosis of Parkinson's disease (PD), post-encephalitic parkinsonism, or parkinsonism that may follow carbon monoxide intoxication or manganese intoxication; and

2. A patient-specific, clinically significant reason why the member cannot use other generic carbidopa/levodopa combinations including Sinemet® CR (carbidopa/levodopa ER tablet) must be provided.

Xadago® (Safinamide) Approval Criteria:

1. An FDA approved indication as adjunctive treatment to carbidopa/levodopa in members with Parkinson's disease (PD) experiencing "off" episodes; and
2. Member must be taking carbidopa/levodopa in combination with safinamide (safinamide has not been shown to be effective as monotherapy for the treatment of PD); and
3. A patient-specific, clinically significant reason why the member cannot use rasagiline or other cost-effective monoamine oxidase type B (MAO-B) inhibitors must be provided; and
4. Member must not have severe hepatic impairment; and
5. Member must not be taking any of the following medications concomitantly with safinamide:
   a. Monoamine oxidase inhibitors (MAOIs); or
   b. Linezolid; or
   c. Opioid analgesics (including tramadol); or
   d. Selective norepinephrine reuptake inhibitors (SNRIs); or
   e. Tri- or tetra-cyclic or triazolopyridine antidepressants; or
   f. St. John's wort; or
   g. Cyclobenzaprine; or
   h. Methylphenidate and its derivatives; or
   i. Amphetamine and its derivatives; or
   j. Dextromethorphan; and
6. Prescriber must verify member has been counseled on avoiding foods that contain a large amount of tyramine while taking safinamide; and
7. A quantity limit of 1 tablet per day will apply.

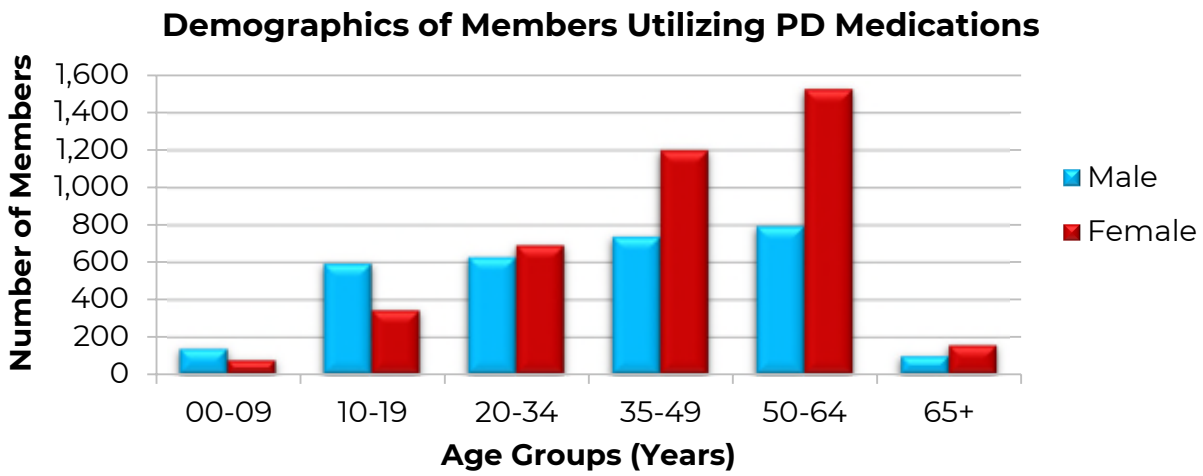
Utilization of PD Medications: Fiscal Year 2022

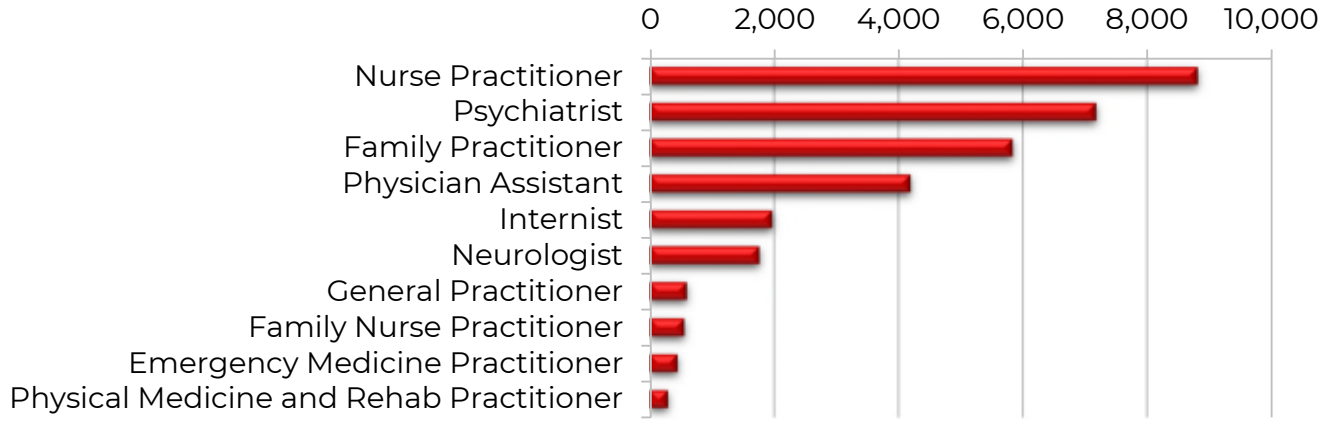
Comparison of Fiscal Years: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	4,739	26,557	$847,416.84	$31.91	$0.97	1,850,630	875,854
2022	6,947	33,312	$899,163.57	$26.99	$0.78	2,293,307	1,149,666
% Change	**46.6%**	**25.4%**	**6.1%**	**-15.4%**	**-19.6%**	**23.9%**	**31.3%**
Change	**2,208**	**6,755**	**$51,746.73**	**-$4.92**	**-$0.19**	**442,677**	**273,812**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

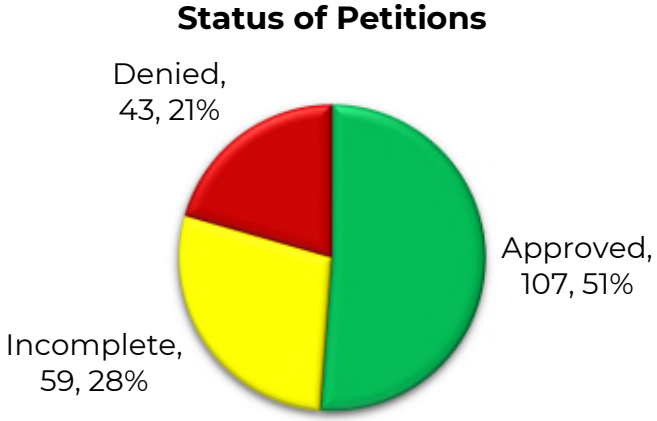
- There were no SoonerCare paid medical claims for Duopa® (carbidopa/levodopa enteral suspension) during fiscal year 2022.





Prior Authorization of PD Medications

There were 209 prior authorization requests submitted for PD medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.



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

Anticipated Patent Expiration(s):

- Azilect® (rasagiline tablet): August 2027
- Nourianz® (istradefylline tablet): September 2027
- Rytary® [carbidopa/levodopa extended-release (ER) capsule]: December 2028
- Xadago® (safinamide tablet): March 2031
- Neupro® (rotigotine transdermal patch): March 2032
- Inbrija® (levodopa inhalation powder): November 2032
- Ongentys® (opicapone capsule): May 2035
- Kynmobi® [apomorphine sublingual (SL) film]: April 2036
- Osmolex® ER (amantadine ER tablet): February 2038
- Gocovri® (amantadine ER capsule): August 2038
- Nuplazid® (pimavanserin tablet): August 2038

News:

- **May 2022:** AbbVie submitted a New Drug Application (NDA) to the U.S. Food and Drug Administration (FDA) for ABBV-951 (foscarbidopa/ foslevodopa) for the treatment of motor fluctuations in patients with advanced PD. ABBV-951 is designed to provide 24-hour, continuous subcutaneous delivery of carbidopa/levodopa. In March 2023, AbbVie announced they received a Complete Response Letter (CRL) from the FDA for ABBV-951, requesting additional information about the administration device. AbbVie intends to resubmit the NDA to the FDA as soon as possible.
- **November 2022:** Amneal Pharmaceuticals announced the FDA has accepted an NDA for IPX203 for the treatment of PD. IPX203 is a novel, oral formulation of carbidopa/levodopa ER capsules that contains both IR granules and ER beads. This formulation is distinct from Rytary® (carbidopa/levodopa ER capsules), Amneal's ER carbidopa/levodopa treatment for PD that was approved by the FDA in 2015. The FDA has assigned a Prescription Drug User Fee Act (PDUFA) date for IPX203 of June 2023.

Pipeline:

- **Buntanetap:** Buntanetap is an oral translational inhibitor of neurotoxic aggregating proteins (TINAPs), which leads to a lower level of neurotoxic proteins and, consequently, less toxicity in the brain. Currently buntanetap is being studied in a Phase 3 early PD study and in a Phase 2/3 study in Alzheimer's disease patients.

Recommendations

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

Utilization Details of PD Medications: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
BENZTROPINE PRODUCTS						
BENZTROPINE TAB 1MG	6,841	1,573	$96,288.71	$14.08	4.35	10.71%
BENZTROPINE TAB 2MG	2,712	553	$43,491.85	$16.04	4.9	4.84%
BENZTROPINE TAB 0.5MG	2,445	569	$34,810.86	$14.24	4.3	3.87%
BENZTROPINE INJ 1MG/ML	1	1	$62.41	$62.41	1	0.01%
SUBTOTAL	**11,999**	**2,696**	**$174,653.83**	**$14.56**	**4.45**	**19.43%**
ROPINIROLE PRODUCTS						
ROPINIROLE TAB 1MG	2,403	713	$29,401.17	$12.24	3.37	3.27%
ROPINIROLE TAB 0.5MG	1,732	644	$21,387.42	$12.35	2.69	2.38%
ROPINIROLE TAB 0.25MG	1,265	479	$15,176.93	$12.00	2.64	1.69%
ROPINIROLE TAB 2MG	1,103	319	$14,076.31	$12.76	3.46	1.57%
ROPINIROLE TAB 3MG	395	109	$5,749.13	$14.55	3.62	0.64%
ROPINIROLE TAB 4MG	354	108	$5,659.18	$15.99	3.28	0.63%
ROPINIROLE TAB 5MG	209	45	$3,210.52	$15.36	4.64	0.36%
ROPINIROLE TAB 2MG ER	5	1	$336.68	$67.34	5	0.04%
ROPINIROLE TAB 12MG ER	3	1	$490.83	$163.61	3	0.05%
SUBTOTAL	**7,469**	**2,419**	**$95,488.17**	**$12.78**	**3.09**	**10.63%**
AMANTADINE PRODUCTS						
AMANTADINE CAP 100MG	3,275	756	$85,087.26	$25.98	4.33	9.46%
AMANTADINE TAB 100MG	2,422	482	$112,738.46	$46.55	5.02	12.54%
AMANTADINE SOL 50MG/5ML	306	60	$6,053.98	$19.78	5.1	0.67%
SUBTOTAL	**6,003**	**1,298**	**$203,879.70**	**$33.96**	**4.62**	**22.67%**
TRIHEXYPHENIDYL PRODUCTS						
TRIHEXYPHENIDYL TAB 2MG	1,553	360	$19,096.17	$12.30	4.31	2.12%
TRIHEXYPHENIDYL TAB 5MG	1,297	228	$20,405.53	$15.73	5.69	2.27%
TRIHEXYPHENIDYL SOL 0.4MG/ML	178	24	$6,026.54	$33.86	7.42	0.67%
SUBTOTAL	**3,028**	**612**	**$45,528.24**	**$15.04**	**4.95**	**5.06%**
PRAMIPEXOLE PRODUCTS						
PRAMIPEXOLE TAB 0.5MG	558	187	$7,132.10	$12.78	2.98	0.79%
PRAMIPEXOLE TAB 0.125MG	544	213	$6,847.32	$12.59	2.55	0.76%
PRAMIPEXOLE TAB 1MG	489	133	$6,812.84	$13.93	3.68	0.76%
PRAMIPEXOLE TAB 0.25MG	422	162	$5,319.12	$12.60	2.6	0.59%
PRAMIPEXOLE TAB 1.5MG	138	32	$2,032.49	$14.73	4.31	0.23%
PRAMIPEXOLE TAB 0.75MG	103	26	$1,322.82	$12.84	3.96	0.15%
SUBTOTAL	**2,254**	**753**	**$29,466.69**	**$13.07**	**2.99**	**3.28%**
CARBIDOPA/LEVODOPA PRODUCTS						
CARB/LEVO TAB 25-100MG	919	211	$18,980.29	$20.65	4.36	2.11%
CARB/LEVO TAB 25-250MG	226	38	$6,195.95	$27.42	5.95	0.69%
CARB/LEVO TAB 10-100MG	170	50	$2,846.66	$16.75	3.4	0.32%
CARB/LEVO ER TAB 50-200MG	150	24	$5,307.23	$35.38	6.25	0.59%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
CARB/LEVO ER TAB 25-100MG	68	19	$1,647.41	$24.23	3.58	0.18%
CARB/LEVO TAB 25-100MG	21	8	$1,045.85	$49.80	2.63	0.12%
CARB/LEVO TAB 25-250MG	13	2	$1,185.71	$91.21	6.5	0.13%
RYTARY CAP 195MG	2	1	$1,559.09	$779.55	2	0.17%
SUBTOTAL	**1,569**	**353**	**$38,768.19**	**$24.71**	**4.44**	**4.31%**
BROMOCRIPTINE PRODUCTS						
BROMOCRIPTINE TAB 2.5MG	524	107	$54,681.63	$104.35	4.9	6.08%
BROMOCRIPTINE CAP 5MG	216	34	$46,352.83	$214.60	6.35	5.16%
SUBTOTAL	**740**	**141**	**$101,034.46**	**$136.53**	**5.25**	**11.24%**
ENTACAPONE PRODUCTS						
ENTACAPONE TAB 200MG	54	8	$1,858.68	$34.42	6.75	0.21%
SUBTOTAL	**54**	**8**	**$1,858.68**	**$34.42**	**6.75**	**0.21%**
CARBIDOPA/LEVODOPA/ENTACAPONE PRODUCTS						
CARB/LEVO/EN 25-100-200MG	20	7	$1,881.10	$94.06	2.86	0.21%
CARB/LEVO/EN 37.5-150-200MG	9	1	$1,276.74	$141.86	9	0.14%
CARB/LEVO/EN 50-200-200MG	6	1	$404.15	$67.36	6	0.04%
CARB/LEVO/EN 18.75-75-200MG	5	1	$826.79	$165.36	5	0.09%
CARB/LEVO/EN 12.5-50-200MG	5	1	$885.77	$177.15	5	0.10%
CARB/LEVO/EN 31.25-125-200MG	5	1	$312.40	$62.48	5	0.03%
SUBTOTAL	**50**	**12**	**$5,586.95**	**$111.74**	**4.17**	**0.61%**
PIMAVANSERIN PRODUCTS						
NUPLAZID CAP 34MG	45	5	$182,299.45	$4,051.10	9	20.27%
NUPLAZID TAB 10MG	1	1	$1,826.41	$1,826.41	1	0.20%
SUBTOTAL	**46**	**6**	**$184,125.86**	**$4,002.74**	**7.67**	**20.47%**
RASAGILINE PRODUCTS						
RASAGILINE TAB 1MG	22	3	$1,687.49	$76.70	7.33	0.19%
RASAGILINE TAB 0.5MG	20	3	$1,913.74	$95.69	6.67	0.21%
SUBTOTAL	**42**	**6**	**$3,601.23**	**$85.74**	**7**	**0.40%**
SELEGILINE PRODUCTS						
SELEGILINE CAP 5MG	30	3	$1,290.09	$43.00	10	0.14%
SELEGILINE TAB 5MG	1	1	$47.87	$47.87	1	0.01%
SUBTOTAL	**31**	**4**	**$1,337.96**	**$43.16**	**7.75**	**0.15%**
ROTIGOTINE PRODUCTS						
NEUPRO 4MG/24HR PATCH	16	2	$10,237.92	$639.87	8	1.14%
NEUPRO 8MG/24HR PATCH	6	1	$2,426.32	$404.39	6	0.27%
NEUPRO 3MG/24HR PATCH	1	1	$738.30	$738.30	1	0.08%
SUBTOTAL	**23**	**4**	**$13,402.54**	**$582.72**	**5.75**	**1.49%**
CARBIDOPA PRODUCTS						
CARBIDOPA TAB 25MG	4	2	$431.07	$107.77	2	0.05%
SUBTOTAL	**4**	**2**	**$431.07**	**$107.77**	**2**	**0.05%**
TOTAL	**33,312**	**6,947***	**$899,163.57**	**$26.99**	**4.8**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; CARB = carbidopa; EN = entacapone; ER = extended release; HR = hour; INJ = injection; LEVO = levodopa; SOL = solution; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 02/2023. Last accessed 02/24/2023.
[2] AbbVie. AbbVie Submits New Drug Application to U.S. FDA for Investigational ABBV-951 (Foscarbidopa/Foslevodopa) for the Treatment of Advanced Parkinson's Disease. *PR Newswire*. Available online at: https://www.prnewswire.com/news-releases/abbvie-submits-new-drug-application-to-us-fda-for-investigational-abbv-951-foscarbidopafoslevodopa-for-the-treatment-of-advanced-parkinsons-disease-301551779.html. Issued 05/20/2022. Last accessed 02/24/2023.
[3] AbbVie. AbbVie Provides Regulatory Update on ABBV-951 (Foscarbidopa/Foslevodopa) New Drug Application. Available online at: https://news.abbvie.com/news/press-releases/abbvie-provides-regulatory-update-on-abbv-951-foscarbidopafoslevodopa-new-drug-application.htm. Issued 03/22/2023. Last accessed 03/30/2023.
[4] Amneal Pharmaceuticals. Amneal Announces U.S. FDA Filing Acceptance of New Drug Application for IPX203 for the Treatment of Parkinson's Disease. Available online at: https://investors.amneal.com/news/press-releases/press-release-details/2022/Amneal-Announces-U.S.-FDA-Filing-Acceptance-of-New-Drug-Application-for-IPX203-for-the-Treatment-of-Parkinsons-Disease/default.aspx. Issued 11/11/2022. Last accessed 02/24/2023.
[5] Annovis Bio. Annovis Bio Announces Patient Enrollment Update for Phase 3 Study of Buntanetap for the Treatment of Parkinson's Disease. Available online at: https://irpages2.eqs.com/websites/annovis/English/431010/us-press-release.html?airportNewsID=34982805-7465-4ec1-93e4-46751a70b467. Issued 01/25/2023. Last accessed 02/24/2023.

Fiscal Year 2022 Annual Review of Prenatal Vitamins

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Prenatal Vitamins Approval Criteria:

- Most brand formulation prenatal vitamins require prior authorization for SoonerCare members. Preferred products do not require prior authorization. Products that are not listed on the preferred product list are non-preferred and require prior authorization.
- Updated versions of the preferred products list can be downloaded from the Oklahoma Health Care Authority (OHCA) website: https://oklahoma.gov/ohca/providers/types/pharmacy/pharmacy.html.
- The SoonerCare prenatal vitamins category is modified throughout the fiscal year and adjusted for price fluctuations and supplemental rebate participation.

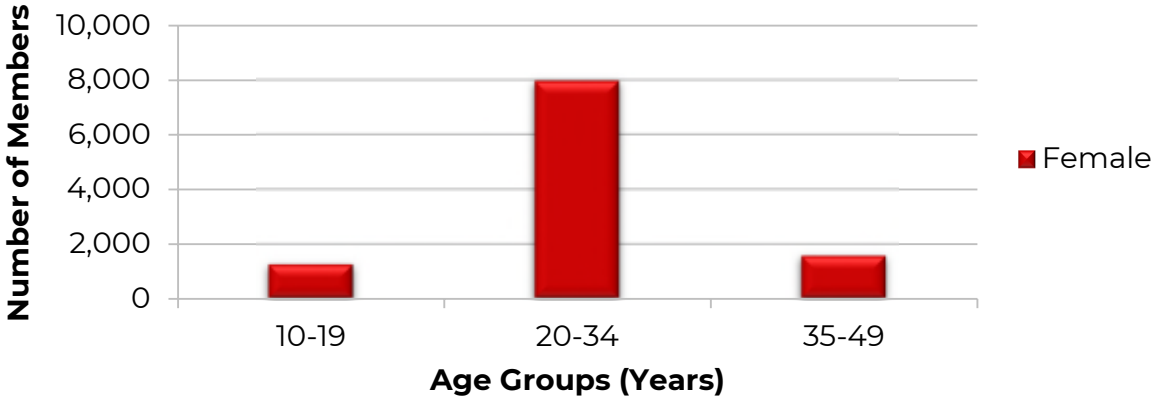
Utilization of Prenatal Vitamins: Fiscal Year 2022

Comparison of Fiscal Years

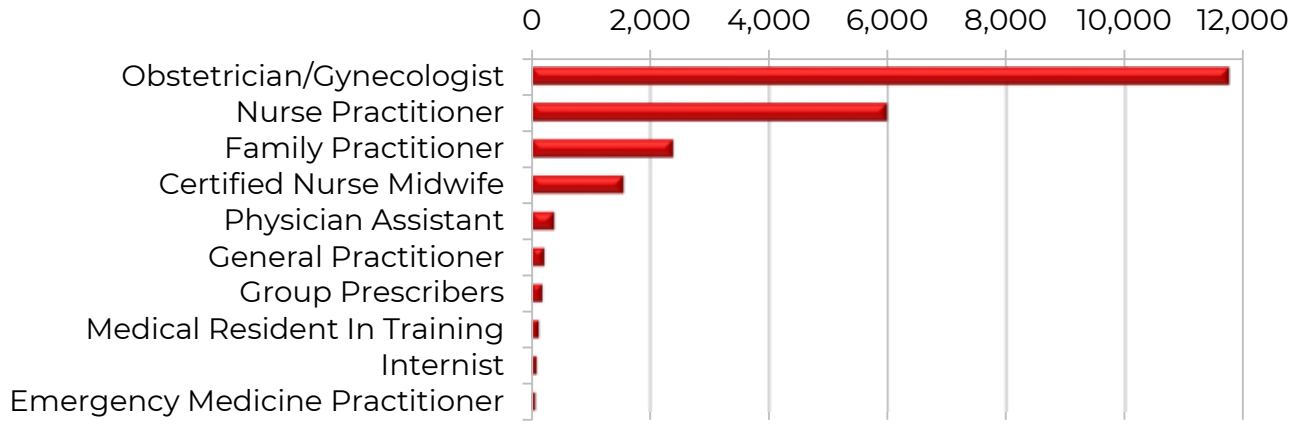
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	12,306	26,952	$2,869,840.31	$106.48	$2.45	1,453,970	1,171,816
2022	10,736	23,045	$2,862,035.16	$124.19	$2.80	1,290,704	1,022,882
% Change	**-12.8%**	**-14.5%**	**-0.3%**	**16.6%**	**14.3%**	**-11.2%**	**-12.7%**
Change	**-1,570**	**-3,907**	**-$7,805.15**	**$17.71**	**$0.35**	**-163,266**	**-148,934**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Prenatal Vitamins



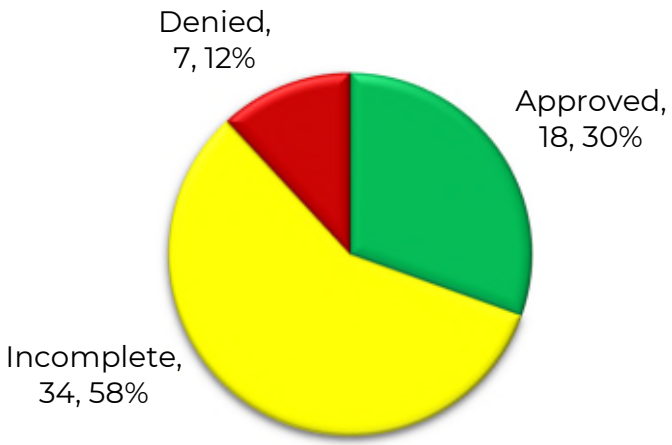
Top Prescriber Specialties of Prenatal Vitamins by Number of Claims



Prior Authorization of Prenatal Vitamins

There were 59 prior authorization requests submitted for prenatal vitamins during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Recommendations

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

Utilization Details of Prenatal Vitamins: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
VITAFOL CAP ULTRA	7,274	3,187	$1,273,585.83	$175.09	2.28	44.50%
VITAFOL CHW GUMMIES	3,433	1,650	$440,488.00	$128.31	2.08	15.39%
CITRANATAL CAP HARMONY	2,234	1,087	$411,249.43	$184.09	2.06	14.37%
PRENATAL TAB 27-1MG	1,686	1,078	$29,855.32	$17.71	1.56	1.04%
FOLIVANE-OB CAP	1,048	693	$41,803.56	$39.89	1.51	1.46%
VIRT-C DHA CAP	734	397	$26,118.26	$35.58	1.85	0.91%
CITRANATAL 90 DHA	721	347	$87,607.50	$121.51	2.08	3.06%
M-NATAL PLUS TAB	694	446	$11,445.02	$16.49	1.56	0.40%
CITRANATAL B-CALM	647	350	$75,127.15	$116.12	1.85	2.62%
TARON-C DHA CAP	615	380	$21,831.78	$35.50	1.62	0.76%
SE-NATAL 19 TAB	551	293	$16,198.99	$29.40	1.88	0.57%
WESTAB PLUS TAB 27-1MG	514	352	$8,319.27	$16.19	1.46	0.29%
VITAFOL-OB TAB 65-1MG	489	274	$109,147.94	$223.21	1.78	3.81%
VITAFOL FE+ CAP	373	179	$63,032.62	$168.99	2.08	2.20%
VITAFOL-ONE CAP	333	154	$62,157.38	$186.66	2.16	2.17%
VITAFOL-OB PAK +DHA	319	132	$44,576.94	$139.74	2.42	1.56%
CITRANATAL PAK DHA	280	147	$32,606.97	$116.45	1.9	1.14%
CITRANATAL PAK ASSURE	265	118	$32,480.95	$122.57	2.25	1.13%
CITRANATAL TAB BLOOM	174	108	$29,118.43	$167.35	1.61	1.02%
SE-NATAL 19 CHW	146	109	$4,974.83	$34.07	1.34	0.17%
VITAFOL-NANO TAB	107	58	$18,268.42	$170.73	1.84	0.64%
PRENATAL VIT TAB LOW IRON	97	75	$1,383.83	$14.27	1.29	0.05%
CITRANATAL RX TAB	88	37	$9,482.82	$107.76	2.38	0.33%
COMPLETE NATAL DHA PAK	66	38	$1,865.45	$28.26	1.74	0.07%
TRINATAL RX TAB 1	39	19	$759.87	$19.48	2.05	0.03%
NIVA-PLUS TAB	32	17	$1,094.67	$34.21	1.88	0.04%
COMPLETENATE CHW	27	19	$969.51	$35.91	1.42	0.03%
TRICARE TAB PRENATAL	14	9	$327.34	$23.38	1.56	0.01%
SELECT-OB+ PAK DHA	11	6	$1,401.54	$127.41	1.83	0.05%
OB COMPLETE TAB	9	7	$545.96	$60.66	1.29	0.02%
ELITE-OB TAB	8	8	$515.58	$64.45	1	0.02%
PRENATE DHA CAP	7	1	$2,218.20	$316.89	7	0.08%
PRENAISSANCE CAP PLUS	6	1	$520.16	$86.69	6	0.02%
OB COMPLETE CAP DHA	3	1	$932.04	$310.68	3	0.03%
VIRT NATE TAB	1	1	$23.60	$23.60	1	0.00%
TOTAL	**23,045**	**10,736***	**$2,862,035.16**	**$124.19**	**2.19**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; CHW = chewable; DHA = omega-3 fatty acid; FE = iron; PAK = package; TAB = tablet; VIT = vitamin
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Fiscal Year 2022 Annual Review of Procysbi® (Cysteamine Bitartrate)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Procysbi® (Cysteamine Bitartrate) Delayed-Release Capsule and Granule Approval Criteria:

1. An FDA approved diagnosis of nephropathic cystinosis; and
2. A patient specific, clinically significant reason why the member cannot use the short-acting formulation, Cystagon® (cysteamine bitartrate), must be provided; and
3. Use of Procysbi® granules will require a patient specific, clinically significant reason why the member cannot use the capsule formulation of Procysbi®.

Utilization of Procysbi® (Cysteamine Bitartrate): Fiscal Year 2022

There was no SoonerCare utilization of Procysbi® (cysteamine bitartrate) during fiscal year 2022 (07/01/2021 to 06/30/2022).

Prior Authorization of Procysbi® (Cysteamine Bitartrate)

There were no prior authorization requests submitted for Procysbi® (cysteamine bitartrate) during fiscal year 2022.

Market News and Updates[1]

Anticipated Patent Expiration(s):

- Procysbi® (cysteamine bitartrate): August 2036

Recommendations

The College of Pharmacy does not recommend any changes to the current Procysbi® (cysteamine bitartrate) prior authorization criteria at this time.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 02/2023. Last accessed 02/16/2023.

Fiscal Year 2022 Annual Review of Qbrexza® (Glycopyrronium)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Qbrexza® (Glycopyrronium) Approval Criteria:

1. An FDA approved diagnosis of primary axillary hyperhidrosis in pediatric members 9 years of age to 20 years of age; and
2. Documentation of assessment by a licensed behavior specialist or the prescribing physician indicating the member's hyperhidrosis is causing social anxiety, depression, or similar mental health-related issues that impact the member's ability to function in day-to-day living must be provided; and
3. Member must have failed a trial of Drysol™ (aluminum chloride 20%) at least 3 weeks in duration; and
4. Prescriber must verify that the member has received counseling on the safe and proper use of Qbrexza®; and
5. A quantity limit of 1 box (30 cloths) per 30 days will apply.

Utilization of Qbrexza® (Glycopyrronium): Fiscal Year 2022

Comparison of Fiscal Years

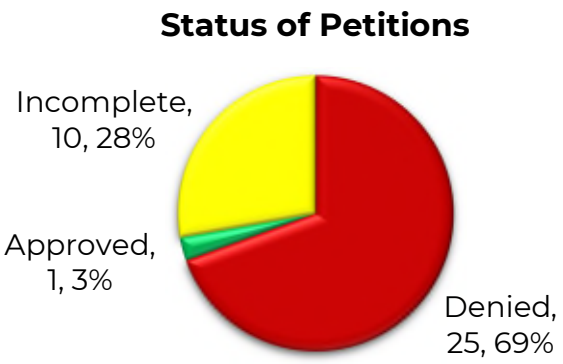
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	6	14	$8,113.72	$579.55	$19.32	420	420
2022	0	0	$0.00	$0.00	$0.00	0	0
% Change	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**
Change	**-6**	**-14**	**-$8,113.72**	**-$579.55**	**-$19.32**	**-420**	**-420**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

- There was no SoonerCare utilization of Qbrexza® (glycopyrronium) during fiscal year 2022 (07/01/2021 to 06/30/2022).

Prior Authorization of Qbrexza® (Glycopyrronium)

There were 36 prior authorization requests submitted for 20 unique members for Qbrexza® (glycopyrronium) during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.



Market News and Updates[1]

Anticipated Patent Expiration(s):

- Qbrexza® (glycopyrronium): February 2033

Recommendations

The College of Pharmacy does not recommend any changes to the current Qbrexza® (glycopyrronium) prior authorization criteria at this time.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 03/2023. Last accessed 03/14/2023.

Fiscal Year 2022 Annual Review of Qualaquin® (Quinine Sulfate)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Qualaquin® (Quinine Sulfate) Approval Criteria:

1. An FDA approved diagnosis of malaria; and
2. Off-label use for the prevention/treatment of leg cramps and other related conditions will not be covered.

Utilization of Qualaquin® (Quinine Sulfate): Fiscal Year 2022

There was no SoonerCare utilization of Qualaquin® (quinine sulfate) during fiscal year 2022 (07/01/2021 to 06/30/2022).

Prior Authorization of Qualaquin® (Quinine Sulfate)

There were 3 prior authorization requests submitted for Qualaquin® (quinine sulfate) during fiscal year 2022, all of which were denied.

Recommendations

The College of Pharmacy does not recommend any changes to the current Qualaquin® (quinine sulfate) prior authorization criteria at this time.

Fiscal Year 2022 Annual Review of Strensiq® (Asfotase Alfa)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Strensiq® (Asfotase Alfa) Approval Criteria:

1. An FDA approved indication for the treatment of members with perinatal/infantile-onset and juvenile-onset hypophosphatasia (HPP); and
2. Confirmed diagnosis by laboratory testing of:
   a. Low age-adjusted alkaline phosphatase (ALP) activity; and
   b. Elevated pyridoxal 5'-phosphate (PLP) levels; and
3. Member's weight (kg) must be provided and must have been taken within the last 4 weeks to ensure accurate weight-based dosing per package labeling; and
4. The 80mg/0.8mL vial should not be used in pediatric members weighing <40kg.

Utilization of Strensiq® (Asfotase Alfa): Fiscal Year 2022

Comparison of Fiscal Years

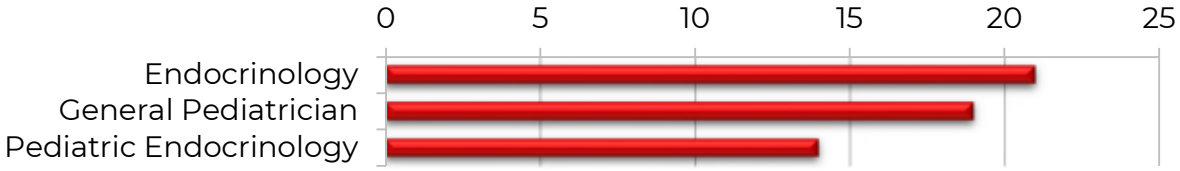
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	3	32	$1,434,941.12	$44,841.91	$1,601.50	386	896
2022	6	54	$3,662,560.14	$67,825.19	$2,422.33	733	1,512
% Change	**100%**	**68.8%**	**155.2%**	**51.3%**	**51.3%**	**89.9%**	**68.8%**
Change	**3**	**22**	**$2,227,619.02**	**$22,983.28**	**$820.83**	**347**	**616**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Strensiq® (Asfotase Alfa)

- Due to the limited number of members utilizing Strensiq® (asfotase alfa), detailed demographic information could not be provided.

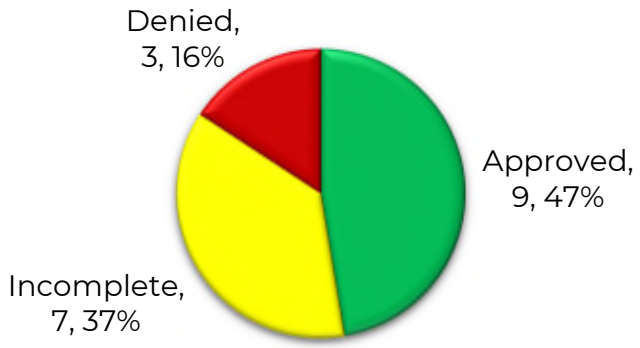
Top Prescriber Specialties of Strensiq® (Asfotase Alfa) by Number of Claims



Prior Authorization of Strensiq® (Asfotase Alfa)

There were 19 prior authorization requests submitted for 6 unique members for Strensiq® (asfotase alfa) during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Recommendations

The College of Pharmacy does not recommend any changes to the current Strensiq® (asfotase alfa) prior authorization criteria at this time.

Utilization Details of Strensiq® (Asfotase Alfa): Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
STRENSIQ INJ 40MG/ML	25	2	$858,285.25	$34,331.41	12.5	23.43%
STRENSIQ INJ 80MG/0.8ML	19	3	$2,608,536.79	$137,291.41	6.33	71.22%
STRENSIQ INJ 18MG/0.45ML	8	1	$123,643.28	$15,455.41	8	3.38%
STRENSIQ INJ 28MG/0.7ML	2	2	$72,094.82	$36,047.41	1	1.97%
TOTAL	**54**	**6***	**$3,662,560.14**	**$67,825.19**	**9**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Fiscal Year 2022 Annual Review of Xgeva® (Denosumab)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Xgeva® (Denosumab) Approval Criteria:

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

Utilization of Xgeva® (Denosumab): Fiscal Year 2022

Comparison of Fiscal Years: Medical Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Claims/ Members
2021	71	305	$717,713.30	$2,353.16	4.3
2022	76	308	$774,280.98	$2,513.90	4.05
% Change	**7.04%**	**0.98%**	**7.88%**	**6.83%**	**-5.81%**
Change	**5**	**3**	**$56,567.68**	**$160.74**	**-0.25**

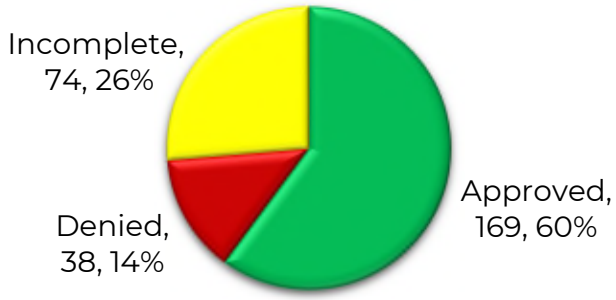
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Prior Authorization of Xgeva® (Denosumab)

There were 281 prior authorization requests submitted for denosumab during fiscal year 2022. Xgeva® (denosumab) and Prolia® (denosumab) are billed using the same procedure code; therefore, the status of petitions includes prior authorization requests for both Xgeva® and Prolia®. Prolia® is reviewed annually with the osteoporosis medications. The following chart shows the

status of the submitted petitions for all denosumab products for fiscal year 2022.

Status of Petitions



Recommendations

The College of Pharmacy does not recommend any changes to the current Xgeva® (denosumab) prior authorization criteria at this time.

Utilization Details of Xgeva® (Denosumab): Fiscal Year 2022

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
J0897 DENOSUMAB INJ (XGEVA)	308	76	$774,280.98	$2,513.90	4.05
TOTAL	**308⁺**	**76***	**$774,280.98**	**$2,513.90**	**4.05**

Costs do not reflect rebated prices or net costs.
⁺Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Fiscal Year 2022 Annual Review of Xuriden® (Uridine Triacetate)

Oklahoma Health Care Authority
Fiscal Year 2022 Print Report

Current Prior Authorization Criteria

Xuriden® (Uridine Triacetate) Approval Criteria:

1. An FDA approved diagnosis of hereditary orotic aciduria defined by at least 1 of the following:
    a. Assay of the orotate phosphoribosyltransferase and orotidylic acid decarboxylase enzymes in the member's erythrocytes showing deficiency in both enzymes or deficiency in orotidylic acid decarboxylase alone; or
    b. Evidence of megaloblastic anemia; and
        i. Normal serum folate and vitamin B12 levels and no evidence of transcobalamine II deficiency; or
    c. Orotic acid crystals visualized in the urine via microscopy; and
2. The member's current weight must be provided on the prior authorization request; and
    a. Weights should be reassessed every 6 months to ensure proper dosing and effectiveness; or
    b. Prescriber can indicate urine orotic acid levels are within normal ranges and dosing remains appropriate; and
3. The prescriber must verify the member or caregiver is able to properly measure and administer medication; and
4. A quantity limit of 4 packets per day will apply.

Utilization of Xuriden® (Uridine Triacetate): Fiscal Year 2022

There was no SoonerCare utilization of Xuriden® (uridine triacetate) during fiscal year 2022 (07/01/2021 to 06/30/2022).

Prior Authorization of Xuriden® (Uridine Triacetate)

There were no prior authorization requests submitted for Xuriden® (uridine triacetate) during fiscal year 2022.

Market News and Updates[1]

Anticipated Patent Expiration(s):

- Xuriden® (uridine triacetate): July 2023

Recommendations

The College of Pharmacy does not recommend any changes to the current Xuriden® (uridine triacetate) prior authorization criteria at this time.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 03/2023. Last accessed 03/02/2023.