Agenda

Drug Utilization Review Board

Tuesday, September 2, 2025
3:00 –5:00 PM

Microsoft Teams meeting

Click here to join the meeting
Meeting ID: 281 978 810 103
Passcode: om2KR3er

Dial in by phone
+1 248-509-0316,,133789476# United States, Troy
Find a local number
Phone conference ID: 133 789 476#

If you need the services below to join, please contact the MDHHS Section 1557 Coordinator 517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax), MDHHS-ComplianceOffice@michigan.gov

Provide free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

Pursuant to DUR Board Bylaws and to facilitate increased external stakeholder participation this will be a virtual meeting.

3:00 – 3:05 **Welcome and Introductions – Chairperson Jennifer Stanley, MD**

3:05 - 3:10 **Review of Minutes – Chairperson Jennifer Stanley, MD**

3:10 – 3:40 **MDHHS Updates – Trish Bouck**

3:40 – 4:15 **Whole Health Rx Update – Kristen Cherwinski, PharmD**

- **Review 3Q 2025 Initiatives**
- **Discuss 4Q 2025 Algorithm Selection**

4:15 – 4:50 **RetroDUR – Mark England, PharmD**

- **Anti-Obesity Agents Utilization Trends**
- **GLP-1 Agonist Utilization**
- **Gabapentin Utilization**
- **Opioids**
  - **MME Trends**
  - **Opioid-related Standards**
  - **SUPPORT Act/ Opioid Potentiators**
- **COVID-19 and Influenza Vaccine Utilization Trends – Hold for December Meeting**
- **CMS Letter Review**

4:50 – 5:00 **Public Comment, Chairperson Jennifer Stanley, MD**

5:00 **Adjourn**

Meeting Minutes
Drug Utilization Review (DUR) Board
June 3, 2025
Draft

Board Members Present: Jennifer Stanley (Chair, Clinton County), James Forshee (Kent County), Jacob Manteuffel (Wayne County), Geraldine Marks (Oakland County), Susan DeVuyst-Miller (Kent County), Chris Meny (Oakland County)

Board Members Absent: None

MDHHS/Magellan Present: Trish Bouck (MDHHS), Glenda England (MDHHS), Grace Gere (MDHHS), Linda VanCamp (MDHHS), Jed Miller (MDHHS), Danielle Waggoner (MDHHS), David Wartinger (MDHHS), Kristen Cherwinski (Prime Therapeutics), Adan Becerra (Prime Therapeutics), Donna Johnson (Prime Therapeutics), Mark England (Prime Therapeutics), Hannah Silaphath (Prime Therapeutics)

The MDHHS DUR Board meeting was held via Microsoft Teams web conference with teleconference only option of participation also available.

Dr. Stanley opened the meeting at 3:04 pm with roll call of the members present and their location in accordance with the Michigan Open Meetings Act. The minutes from the March meeting were approved.

Trish Bouck presented the MDHHS department updates. She reported that the Governor's FY2026 Recommendations were released in February and are posted at https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Executive-Budget/Current-Exec-Rec/FY25-General-Omnibus.pdf . She noted that no changes in either pharmacy benefit copayments or dispensing fees were included in the Recommendations. The Legislature is continuing its review and budget discussion but the budget for FY 2026 has not yet been finalized.

Ms. Bouck noted that the current Single PDL and Brand over Generics, effective 5/1/2025 are posted on the website at https://mi.primetherapeutics.com > Providers > Documents. Quarterly, the MCO Common Formulary workgroup provides input and recommendations on Single PDL coverage for P&T Workgroup consideration before each full P&T Committee meeting. The P&T Committee makes clinical recommendations for both the Michigan Pharmaceutical Product List (MPPL) and the subset of drugs on the Single PDL. Ms. Bouck stated that a quarterly Summary of PDL changes update is available following the P&T Committee meetings at https://mi.primetherapeutics.com > Providers > Recent Changes - MI Single Preferred Drug List (Single PDL). The next quarterly update will list the changes effective 8/1/2025.

Ms. Bouck provided an update on the CMS Annual DUR Reports. The Medicaid Drug Utilization Review Medicaid Drug Utilization Review webpage contains additional background about the annual reporting requirements for State Medicaid programs, the survey templates and historical published reports. The next annual CMS Drug Utilization Review (DUR) reports for FFY2024 are due to CMS on June 30, 2025. Fee-For-Service and each of the 9 MCOs are required to submit surveys using the CMS provide template.

Ms. Bouck announced one finalized policy. MMP 25-19 Pharmacy Coverage for Outcomes-Based Contracts and Other Select High-Cost Physician-Administered Drugs or Therapies will be effective July 1, 2025. It establishes policy to clarify pharmacy coverage for drugs/therapies where an outcomes-based contract between MDHHS and the drug manufacturer exists and for other high-cost physician-administered drugs/therapies. This policy also clarifies prior authorization procedures for these drugs/therapies. The list of the drugs included in this policy on the PBM website: https://mi.primetherapeutics.com >> Provider Portal >> Documents >> Other Drug Information >> Select High-Cost Physician-Administered Drugs or Therapies.

MDHHS received CMS approval in October 2018 to pursue Outcomes/Value-Based Purchasing Agreements with drug manufacturers to address high-cost drugs. MDHHS currently has six active Outcomes/Value-Based Contract Agreements with others also under review. Agreements that allow MDHHS staff to track outcomes instead of by a third-party data aggregator are preferred. MDHHS also prefers contracts where the outcomes can be easily tracked using claims data such as orphan drugs where the eligible patient population is small or for drugs where the eligible patient population is large, and outcomes are based on volume and adherence. Contact Rita Subhedar (SubhedarR1@michigan.gov) or MDHHS-MSAIndustryRequests@michigan.gov to start discussions (See Procedure).

Lastly, Ms. Bouck provided the website links to additional resources such as MDHHS policy bulletins, web announcements, DUR Board and P&T Committee.

Dr. Becerra presented the Whole Health outcomes analysis for intervention period of January 2024 to June 2024. The algorithms that encompassed this analysis included: Atypical Antipsychotic Polypharmacy, Behavioral Health Polypharmacy- 6 or more medications, SSRI/SNRI Polypharmacy, Dose Optimization-Aripiprazole 10mg per day, Concurrent Utilization of Stimulant and Benzodiazepine, High Diazepam Equivalent Dose, and High Morphine Milligram Equivalents (≥ 90) and Benzodiazepines. Results discussed showed robust outcome gap closure rates ranging from 20% - 67% during the 6-month post intervention period for these algorithms.

Dr. Cherwinski then discussed current initiatives for Quarter 2 2025 which included: Atypical Antipsychotic Polypharmacy, Concurrent Stimulant+Benzodiazepine, and SUPD (Statin Use in Patients with Diabetes). She discussed the overall insights for each initiative. Most notable for the Atypical Antipsychotic Polypharmacy algorithm: combinations of 1-2 oral agents +/-LAI. Specific agents seen higher in frequency on the reporting include Olanzapine, Risperidone, and Seroquel. Also reflected in the reporting is above FDA approved max dose Olanzapine (dose ranges: 30-60mg/d) mainly for TRS, or when other agents have been trialed and failed, and patient is not a candidate for Clozaril. Dr. Cherwinski noted higher dosages of Olanzapine being utilized in heavy smokers. Other trends on the reporting include the combination of 2 LAI's in optimized dosages for patients that have had compliance issues, or Clozaril+LAI in cases where patients are intended to be converted to Clozaril monotherapy, however side effects limit dose escalation, and patient remains symptomatic. In addition, many antipsychotic polypharmacy cases of patients with polysubstance use, who are traditionally tougher to medically manage and often require polypharmacy for stabilization. Some cases of PRN Olanzapine or Risperdal added on to another antipsychotic to manage aggressive behaviors typically seen in AFC/group home settings in lieu of benzodiazepine therapy. Some cases of Abilify added for hyperprolactinemia, or as adjunctive therapy for irritability associated with ASD. Dr. Cherwinski noted some providers report success in transitioning patients from dual antipsychotic therapy to monotherapy with Cobenfy. Due to the recent approval of Cobenfy, and limited clinical experience, many providers wish to gain additional data on safety and efficacy prior to widespread usage.

Most notable trends for Concurrent Stimulant+Benzodiazepine include providers reporting a bulk of inherited cases and are amenable to discussing Generic Dispensing Rates (GDR's) of Benzodiazepines/stimulant dose reduction on a continual basis. Also reported this cycle is an influx of middle-aged patients requesting specific stimulant formulations (namely Adderall IR), that have never been diagnosed with ADHD previously. In addition, above max dose stimulant prescribing seen on the reporting (namely for Adderall IR) in dosages totaling ≥90mg/d- typically seen in patients with ADHD and comorbid conditions. Discussions with providers have been centering around stimulant dose reduction, trialing longer acting formulations where appropriate, or alternative augmentation strategies to keep the stimulant dose within FDA approved guidelines. In addition, many cases of BZD's utilized for maintenance therapy with the absence of a controller medication, where discussions center around the addition of a maintenance therapy for anxiety. Also noted is a significant amount of dr/pharmacy shopping where patients are receiving the medication combination from alternate providers- discussions center around coordination of care to ensure all providers are aware of the treatment plan. Dr. Cherwinski noted that she has had good success in discussing and implementing benzodiazepine GDR's with providers, either through the provision of provider resources created around BZD tapering, or provision of individualized patient tapering schedules where requested. She also noted providers engaged previously have been vigilant in re-evaluating prescribing practices.

Notable for SUPD (Statin Use in Patients with Diabetes): Most providers are amenable to initiating statin therapy during the outreach and/or discussing with patients at upcoming appointments if indicated. Dr. Cherwinski noted that she has had good traction in taking a proactive approach with offices to ensure a note is in the chart to discuss with patients at upcoming appointments. Some cases of patients on GLP-1's for alternate indications (OSA, weight loss) without a diabetes diagnosis or metformin for prediabetes or weight loss- she confirmed excluding these patients from future outreach efforts. She noted some cases of newly diagnosed diabetics where patients are adjusting to being on antidiabetic agents/insulin, and providers have not yet had a chance to address statin therapy. In addition, some reports of patients having trialed statin therapy in the past with significant side effects (typically myalgias). She noted discussions centering around trailing an alternate hydrophilic statin/alternate dosing schedule, or another agent based on cardiovascular risk factors/history. Dr. Cherwinski noted that there are some reports of patients declining statin retrial based on previous history of side effects, or contraindications.

Dr. Cherwinski discussed that the buprenorphine/opioid algorithm was halted due to legal concerns around upholding 42 CFR Part 2 guidance from CMS. She explained that since we are not obtaining patient consent to disclose SUD information to a prescriber of an opioid, that this would not be feasible to run as a formalized algorithm. She noted that the primary challenge is the ability to properly restrict how this information is being disclosed to providers. She noted that she would be amenable to conduct clinical outreach on specific cases identified by MDHHS ad hoc.

Dr. Cherwinski then discussed selection of Q3 2025 algorithms with members of the DUR board. The following algorithms were selected and approved by the DUR board for Q3 2025 WHRx program outreach: SNRI/SSRI Polypharmacy, Pediatric Antipsychotic Polypharmacy, and Pediatric Behavioral Health Polypharmacy 5 or more medications.

DRAFT

Dr. Cherwinski noted that at the next DUR board meeting in 9/2025, she will be presenting an update on the Q3 2025 initiatives and field insights and discuss Q4 2025 algorithm selection for approval by the DUR board at that time.

Dr. Johnson presented a summary of the FFS utilization of the anti-obesity medications since MDHHS implemented coverage on February 1, 2022. All the medications were added to the single PDL as preferred with clinical prior authorization (PA) for appropriateness. Dr. Johnson reported that the newer agents, Saxenda (liraglutide) and Wegovy (semaglutide) comprise the largest portion of the utilization. The quarterly trend analysis showed an increase in utilization overall compared to first quarter of 2024, most likely due to beneficiary re-enrollment. A review of the continuation/renewal rate of these medications revealed that 60% of the beneficiaries prescribed the medication continued their therapy for 3 months or longer. Dr. Johnson reported that approximately 10% of the 8,116 beneficiaries with claims for anti-obesity medications during the service period from February 2022 to March 2025 had a diagnosis of diabetes mellitus in their medical claims' history during this time. Dr. Johnson reported that 516 (6.4%) of the 8,116 beneficiaries had a diagnosis of pre-diabetes in their medical claims' history.

Dr. Johnson presented a summary of the GLP-1 agonist agents indicated for type 2 diabetes. She noted that effective February 1, 2024, a clinical prior authorization (PA) was placed on the PDL preferred agents that requires that the beneficiary have a diagnosis of type 2 diabetes (T2D) and no concurrent therapy with another GLP-1 agonist. On 2/1/2025, the clinical PA was revised to also require the discontinuation of concurrent use of DPP-4 inhibitors with GLP-1 agonists. Dr. Johnson also presented a utilization comparison of those GLP-1 agonists that are approved to treat T2D as well as weight loss management.

Effective May 31, 2024, Michigan's Licensing and Regulatory Affairs agency (LARA) removed the categorization of Schedule 5 controlled substance from gabapentin. Gabapentin is classified as an anticonvulsant medication. Anticonvulsants, that are not controlled substances, are legislatively protected from restriction. With the change in the controlled substance schedule, MDHHS removed the dosage edit that limited the accumulated daily dose of gabapentin to 3600 mg per day. Dr. Johnson presented an analysis of the trend in utilization and accumulated daily dosages of the gabapentin products before the schedule change and after. There has been a gradual increase in claims and in the number of beneficiaries with daily doses > 3600 mg after the changes were made, although the number of beneficiaries exceeding 3600mg per day is still very low compared to the total number of gabapentin utilizers. The Board will continue to monitor these agents.

Dr. Johnson presented information on the current morphine milligram equivalents (MME) edit. The Department lowered the threshold from 120 MME per day to 90 MME on July 1, 2021. She presented a graph that showed the monthly number of beneficiaries with high MME utilization from April 2024 through March 2025.

Dr. Johnson provided information and utilization data on the opioid related standards. Claims and call center data were presented on the Department's edit that limits the coverage of short-acting narcotic analgesics for Fee-For-Service (FFS) members who are opioid treatment-naïve to a 7-day supply.

Dr. Johnson presented a summary of the SUPPORT Act and the requirements for both the FFS and MHP DUR programs. She presented reports showing the concurrent utilization of opioids with antipsychotics and with benzodiazepines for both the FFS and MHP populations for first quarter 2025.

Dr. Johnson also presented a report on concurrent utilization of opioids and a potentiator medication in both adult and pediatric patients during the same period. She stated that concurrent use is determined by a 30 day or greater overlap in both an opioid and a potentiator. Potentiator medications are those that enhance the opioid effect such as amphetamines, benzodiazepines, gabapentinoids, muscle relaxers, sedative hypnotics, and antipsychotics.

Dr. Johnson presented the pharmacy FFS claim utilization data on the COVID-19 vaccines since coverage began on 12/1/2020. She also presented the utilization data on the flu vaccines for the current season. Dr. Johnson presented the trends in the influenza vaccine utilization submitted as FFS pharmacy claims for the current influenza season from August 2024 through April 2025. At the March meeting, Mr. Meny requested that an additional analysis be performed to identify beneficiaries that had a diagnosis of influenza, and a paid pharmacy claim for an influenza antiviral but no claim for an influenza vaccine during this current season. Also, identify beneficiaries who got the influenza vaccine and then subsequently had a diagnosis of influenza in their medical claims' history. Dr. Johnson presented this data as requested. The analysis identified 3,329 beneficiaries had a diagnosis of influenza in their medical claims' history. Further analysis revealed that 3,315 (99.6%) beneficiaries of those with a diagnosis of influenza did not have a paid pharmacy claim for an influenza vaccine.

At the request of the P&T Committee, the Board reviewed the FFS utilization of atenolol. Dr. Johnson presented the number of claims and total number of beneficiaries for the service period of 10/1/2024 through 4/30/2025. She also presented the number of beneficiaries with diagnoses for the approved indications as well as off-label indications and warnings.

DRAFT

Lastly, the Board reviewed a letter sent by CMS to the State Medicaid Directors to ensure that state Medicaid agencies are monitoring medical interventions for gender dysphoria in children and consider any actions to take with respect to their DUR programs. The Board will discuss how to monitor the appropriate use of medications in this population at the next meeting.

The next meeting will be held on September 2, 2025 at 3pm.

Meeting adjourned at 4:02 PM.

DRAFT

Drug Utilization Review Board

September 2, 2025

MDHHS
Michigan Department of Health & Human Services

Mission

MDHHS provides services and administers programs to improve the health, safety, and prosperity of the residents of the state of Michigan.

Budget Updates

- Governor's FY2026 Recommendations were released in February at: https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Executive-Budget/Current-Exec-Rec/FY25-General-Omnibus.pdf
  - FY2026: October 2025 thru September 2026
- The Legislature is continuing its review and budget discussions but a budget for FY2026 has not yet been finalized.

Single PDL Updates

Single PDL & Brand Over Generics: Effective 9/1/2025

1. **Brand over Generic List** can be found here: https://mi.primetherapeutics.com/ > **Providers** > **Documents**

2. Quarterly, the MCO Common Formulary workgroup provides recommendations on Single PDL coverage for P&T Workgroup consideration. The P&T Committee makes clinical recommendations for both the Michigan Pharmaceutical Product List (MPPL) and the subset of drugs on the Single PDL.

3. New quarterly web posting '**Summary of PDL changes**' to better inform prescribers and pharmacies.
   a. https://mi.primetherapeutics.com/ > Providers > "Recent Changes – MI Single Preferred Drug List (Single PDL)

4. The next quarterly PDL updates will take effect November 1, 2025.

CMS Annual DUR Reports

- The Medicaid Drug Utilization Review webpage contains additional background about the annual reporting requirements for State Medicaid programs, the survey templates and historical published reports.

- The FFY2024 annual CMS Drug Utilization Review (DUR) reports for Fee-For-Service and each of the 9 MCOs were submitted by the deadline of June 30, 2025.

- CMS contacted us to revise and resubmit one of the MCO surveys that appeared to be incomplete. That was completed mid July. The Department is comparing all the submitted surveys for compliance and to prepare in advance for the FFY2025 surveys.

Outcomes/Value-Based Purchasing Agreements

- **MDHHS received CMS approval October 2018 to pursue Outcomes/Value-Based Purchasing Agreements with drug manufacturers to address high-cost drugs**

- **MDHHS has six active Outcomes/Value-Based Contract agreements and others also under review:**
  - **Novartis Gene Therapies (Zolgensma – August 2020)**
  - **Abbvie (Mavyret – April 2021 We Treat Hep C initiative)**
  - **BlueBird Bio (Zynteglo – August 2023)**
  - **BlueBird Bio (Lyfgenia – January 2024)**
  - **Vertex (Casgevy – June 2024)**
  - **Sarepta (Elevidys – January 2025)**

- **MDHHS agreement preferences:**
  - Track Outcomes via MDHHS staff instead of a third-party aggregator
  - Contracts where outcomes tracked using claims data such as:
    - Orphan drugs where eligible patient population is small
    - Drug where eligible population is large and outcomes are based on volume/adherence
  - Contact Rita Subhedar (SubhedarR1@michigan.gov) or MDHHS-MSAIndustryRequests@michigan.gov to start discussions (See Procedure)

Additional Resources

- MDHHS Policy Bulletins:
  - www.michigan.gov/medicaidproviders > *Policy, Letters & Forms*
- Web Announcements:
  - https://mi.primetherapeutics.com/ > **Providers** >
- DUR Board:
  - https://mi.primetherapeutics.com/provider/drug-utilization-review
- P&T Committee:
  - https://mi.primetherapeutics.com/provider/pharmacy-therapeutic
- PBM (Prime Therapeutics) Technical Call Center Phone: **877-624-5204**
- MDHHS Pharmacy Services contact: MDHHSPharmacyServices@Michigan.gov
- Trish Bouck (Director, Pharmacy Management Division) BouckT@michigan.gov

MDHHS Fee-For-Service Pharmacy

Whole Health Rx

An Innovative Approach to Behavioral Health and Opioid Management

Kristen Cherwinski, PharmD

9/2/2025

Overview

- **Review current Quarter 3 2025 Initiatives**
- **4th Quarter 2025 Algorithm Selection Discussion**

CONFIDENTIAL © 2024 Prime Therapeutics LLC

Prime THERAPEUTICS™

Current Initiatives: Quarter 3 2025

Current Algorithms

1

SSRI/SNRI Polypharmacy

- Identifies members (18+) taking more than 1 SSRI/SNRI concomitantly for a period of >30 days, within the preceding 90-day timeframe

2

Pediatric Antipsychotic Polypharmacy

- Identifies members (<18y/o) taking more than 1 antipsychotic concomitantly for a period of >30 days, within the preceding 90-day timeframe

3

Pediatric Behavioral Health Polypharmacy 5+

- Identifies members (<18y/o) taking 5+ behavioral health medications concomitantly for a period of >30 days, within the preceding 90-day timeframe

CONFIDENTIAL © 2024 Prime Therapeutics LLC

Field Insights

SSRI/SNRI Polypharmacy

Clinical Insights

- Most often two providers involved in co prescribing
  - Coordination of care discussions ongoing for patients with multiple providers (frequently Psych/PCP or Neuro/PCP)
- Some instances of reporting capturing overlap during cross taper
- Many cases of 2 lower doses of SSRI's or SSRI/SNRI combination-indication depression+anxiety or OCD/anxiety (PCP/mid-level providers)
- Some cases of triple therapy SSRI/SNRI/serotonin modulator
  - Consolidation of the regimen/augmentation with a medication from a different class discussed and reviewed
- Many cases of discontinued medications (SSRI/SNRI) actively being filled at the pharmacy
  - discussions around ensuring past refills have been discontinued/patient education
  - Some cases of SSRI/SNRI being filled at different pharmacies

CONFIDENTIAL © 2024 Prime Therapeutics LLC

Field Insights

Pediatric Antipsychotic Polypharmacy

Clinical Insights

- Most common medications seen on reporting are aripiprazole, risperidone, lurasidone, quetiapine, olanzapine
  - Risperidone utilized once or twice daily for aggression/irritability, tics, autism, hyperactivity
  - Olanzapine ODT utilized prn for extreme agitation/aggression in addition to another atypical antipsychotic
  - Quetiapine 25-50mg used for insomnia in conjunction with another atypical antipsychotic
- Polypharmacy seen in higher acuity cases-treatment resistance or patients with multiple co-morbid diagnoses (ASD/ADHD/ODD/DMDD/genetic disorders) who exhibit a partial response to one antipsychotic but remain symptomatic
- Some cases of inherited patients where attempts to wean/cross taper have proven to be unsuccessful, and there is an exacerbation of symptoms
  - Many cases of patients stable on current regimen and patient/caregiver declines provider attempts to optimize/consolidate
- Older adolescents (LAI+oral agent)- po dose provided during last week of injection or for breakthrough symptoms

CONFIDENTIAL © 2024 Prime Therapeutics LLC

Field Insights

Pediatric Behavioral Health Polypharmacy 5+

Clinical Insights

- Multiple agents to assist with ADHD symptom management- stimulants (IR +ER), selective NRI, Kapvay, Intuniv
- Many cases of patients on the reporting with multiple co-morbid conditions (seizure disorders/in utero exposure, autism, intermittent explosive disorder, genetic mutations), or patients in PHP's
    - Providers note limited mental health/school resources contribute to polypharmacy, namely in rural areas (lack of therapy services, long wait times for pscyh referrals)
- Multiple mood stabilizers- Lithium, Lamictal, Depakote-opportunities for consolidation
- Providers report post hospitalization polypharmacy, and lack of coordination of care with outpatient psychiatrist as additional barriers
    - Outpatient providers working to consolidate regimens if clinically appropriate based on previous trials and patient history
- Opportunities for discontinuation- patients on multiple agents for insomnia (trazodone, seroquel, hydroxyzine, clonidine)

CONFIDENTIAL © 2024 Prime Therapeutics LLC

Prime THERAPEUTICS™

Algorithm Selection: Quarter 4 2025

Potential Algorithm Selection and Considerations

Prime THERAPEUTICS

Potential Algorithm Report: July 2025 Data

Algorithm Triggered	Unique Providers per Algorithm	Unique Members per Algorithm
ADHERENCE: Antidepressant adherence	12288	58767
ADHERENCE: Antipsychotic adherence	6783	32204
MD ED: New Start Psychotropic Medications in Children	4798	26815
POLYPHARM: Polypharmacy Trigger 5 or More Behavioral Health Medications	7252	12508
DUPLICATE: antipsychotic polypharmacy	2583	7744
ADHERENCE: respiratory maintenance regimen (low MPR)	4105	7601
ESCALATE TX: Low dose Seroquel	3283	7099
DUPLICATE: atypical antipsychotic polypharmacy	2379	6083
ADHERENCE: statin (PA)	3327	5859
ADHERENCE: RASA (PA)	3356	5277
ADHERENCE: oral antidiabetic (MPR)	3137	5073
POLYPHARM: Concurrent Utilization Stimulant, Benzodiazepine (adult)	3015	4727
POLYPHARM: Polypharmacy Trigger 5 or More Behavioral Health Medications - 30 days overlap	3303	4658
ADD MED: statin in DM (PA only)	2730	3985
POLYPHARM: Polypharmacy Trigger 5 or More Behavioral Health Medications - 60 days overlap	2039	2458
POLYPHARM: 10+ controlled substance (90 days)	2831	2272
DUPLICATE: Serotonin-Norepinephrine Reuptake Inhibitor (SSRI/SNRI) Polypharmacy	2454	2180
ADHERENCE: HIV (PDC < 90 per drug group)	553	1953
POLYPHARM: Pediatric Behavioral Health Polypharmacy - 4 or more medications	1035	1866
DOSE: stimulant max dose	1022	1656
POLYPHARM: Concurrent Utilization Stimulant, Benzodiazepine, Antipsychotic (adult)	1423	1552

Algorithm Triggered	Unique Providers per Algorithm	Unique Members per Algorithm
DOSE: gabapentin max dose	246	134
HRM: benzodiazepines in elderly	173	133
REDUCE TX: High Morphine Milligram Equivalents (>=90)	115	130
PT ED: doctor/pharmacy shopping (4 or more)	94	105
ADHERENCE: Dose Optimization-Lisdexamfetamine 20 mg 2 tabs per day	88	101
ADHERENCE: Dose Optimization-Mirtazapine Tab 7.5 mg 2 tabs per day	79	89
ADHERENCE: Dose optimization - Aripiprazole 15 mg 2 tabs per day	68	76
REDUCE TX: High Morphine Milligram Equivalents (>=50) with Concomitant Benzodiazepine Use	71	76
DUPLICATE: duplicate inhaler	124	75
ADHERENCE: Dose Optimization-Dexmethylphenidate HCl ER Cap 20 mg 2 tabs per day	56	72
HRM: sulfonylurea (elderly)	68	71
REDUCE TX: High Morphine Milligram Equivalents (>=120)	62	71
HRM: muscle relaxants (elderly)	78	69
ADHERENCE: Dose Optimization-Citalopram Hydrobromide Tab 10 mg 2 tabs per day	64	68
ADHERENCE: Dose Optimization-Lurasidone 20 mg 2 tabs per day	63	67
ADHERENCE: Dose Optimization-Dexmethylphenidate HCl ER Cap 10 mg 2 tabs per day	60	64
ADHERENCE: Dose Optimization-Paroxetine HCl Tab 10 mg 2 tabs per day	54	59
HRM: amitriptyline --> duloxetine/trazodone (anticholinergic elderly)	67	59
ADHERENCE: Dose Optimization-Dexmethylphenidate HCl ER Cap 5 mg 2 tabs per day	53	58
ADHERENCE: Dose Optimization-Lisdexamfetamine 10 mg 2 tabs per day	52	58
ADHERENCE: Dose optimization - Aripiprazole 5 mg 3 tabs per day	47	55
ADHERENCE: Dose Optimization-Olanzapine Tab 7.5 mg 2 tabs per day	53	53
ADHERENCE: Dose Optimization-Dexmethylphenidate HCl Cap SR 24 HR 15 mg 2 tabs per day	49	51
REDUCE TX: High Diazepam Equivalent Dose	48	51
ADHERENCE: Dose Optimization-Olanzapine Tab 2.5 mg 3 tabs per day	44	50
DUPLICATE: NSAID	74	48
ADHERENCE: Dose Optimization-Lurasidone 40 mg 2 tabs per day	37	43
ADHERENCE: Dose Optimization-Lurasidone 60 mg 2 tabs per day	40	42
ADHERENCE: Dose Optimization-Mirtazapine Tab 30 mg 1.5 tabs per day	37	39
ADHERENCE: Dose Optimization-Olanzapine Tab 5 mg 1.5 tabs per day	38	39

Algorithm Triggered	Unique Providers per Algorithm	Unique Members per Algorithm
DISEASE-DRUG: efavirenz/rilpivirine (on antipsychotic)	72	38
REDUCE TX: High Morphine Milligram Equivalents (>=90) with Concomitant Benzodiazepine Use	31	34
ADHERENCE: Dose Optimization-Mirtazapine Tab 15 mg 3 tabs per day	32	32
HRM: glyburide/glimepiride -> glipizide (elderly)	30	32
ADHERENCE: Dose optimization - Aripiprazole 10 mg 1.5 tabs per day	29	31
HRM: 1st gen antihistamine (anticholinergic in elderly)	31	31
POLYPHARM: Pharmacy Shopping (3 or more)	114	31
ADHERENCE: Dose Optimization-Olanzapine Tab 5 mg 4 tabs per day	25	28
HRM: hydroxyzine (anticholinergic elderly)	34	28
ADHERENCE: Dose Optimization-Olanzapine Tab 10 mg 1.5 tabs per day	26	27
DUPLICATE: INSTIs	33	25
HRM: hypnotic long-term use (fall risk in elderly)	27	25
DUPLICATE: GLP1 + DPP4	33	23
POLYPHARM: Concurrent Utilization Stimulant, Benzodiazepine, Opioid (adult)	49	23
CHANGE MED: cabotegravir + additional antiretrovirals	18	22
ADHERENCE: Dose Optimization-Olanzapine Tab 2.5 mg 4 tabs per day	21	21
HRM: 2+ anticholinergic agents (lookback 365 days)	29	21
REDUCE TX: High Morphine Milligram Equivalents (>=120) with Concomitant Benzodiazepine Use	19	19
HRM: antispasmodic (anticholinergic in elderly)	21	18
ADHERENCE: Dose Optimization-Lurasidone 20 mg 3 tabs per day	17	17
ADHERENCE: Dose optimization - Aripiprazole 10 mg 3 tabs per day	17	17
HRM: antiepileptic --> levetiracetam (fall risk in elderly)	18	17
HRM: antihypertensives (hypotension, bradycardia in elderly)	22	17
DUPLICATE: HIV duplicate medication	24	16
HRM: TCA --> SSRI/SNRI (anticholinergic in elderly)	17	16
HRM: 2+ anticholinergic agents (measure year)	23	14
ADHERENCE: Dose Optimization-Dexmethylphenidate HCl ER Cap 5 mg 3 tabs per day	11	11
ADHERENCE: Dose Optimization-Paroxetine HCl Tab 20 mg 1.5 tabs per day	11	11
HRM: doxepin --> trazodone (anticholinergic elderly)	12	10
POLYPHARM: Concurrent Utilization: Stimulant, Benzodiazepine, Muscle Relaxer, Opioid (adult)	20	9

4th Quarter 2025 Algorithm Recommendations:

- Above Max Dose Stimulant Algorithm and Subsets

Above Max Dose Stimulant	1022	1656
High Diazepam Equivalent Dose	48	51
High MME >=90+Concomitant Benzodiazepine Use	31	34

CONFIDENTIAL © 2024 Prime Therapeutics LLC

Next DUR Meeting

- Review 4th Quarter 2025 Initiatives
- Discuss 1st Quarter 2026 Algorithm Selection
- Outcomes Report: (July-December 2024)

For questions regarding information in this slide deck, please contact:

Kristen Cherwinski, PharmD
Clinical Pharmacist Specialist
Prime Therapeutics
Kristen.Cherwinski@primetherapeutics.com

Prime THERAPEUTICS™

RetroDUR Reviews 2 Q 2025

Mark England, PharmD

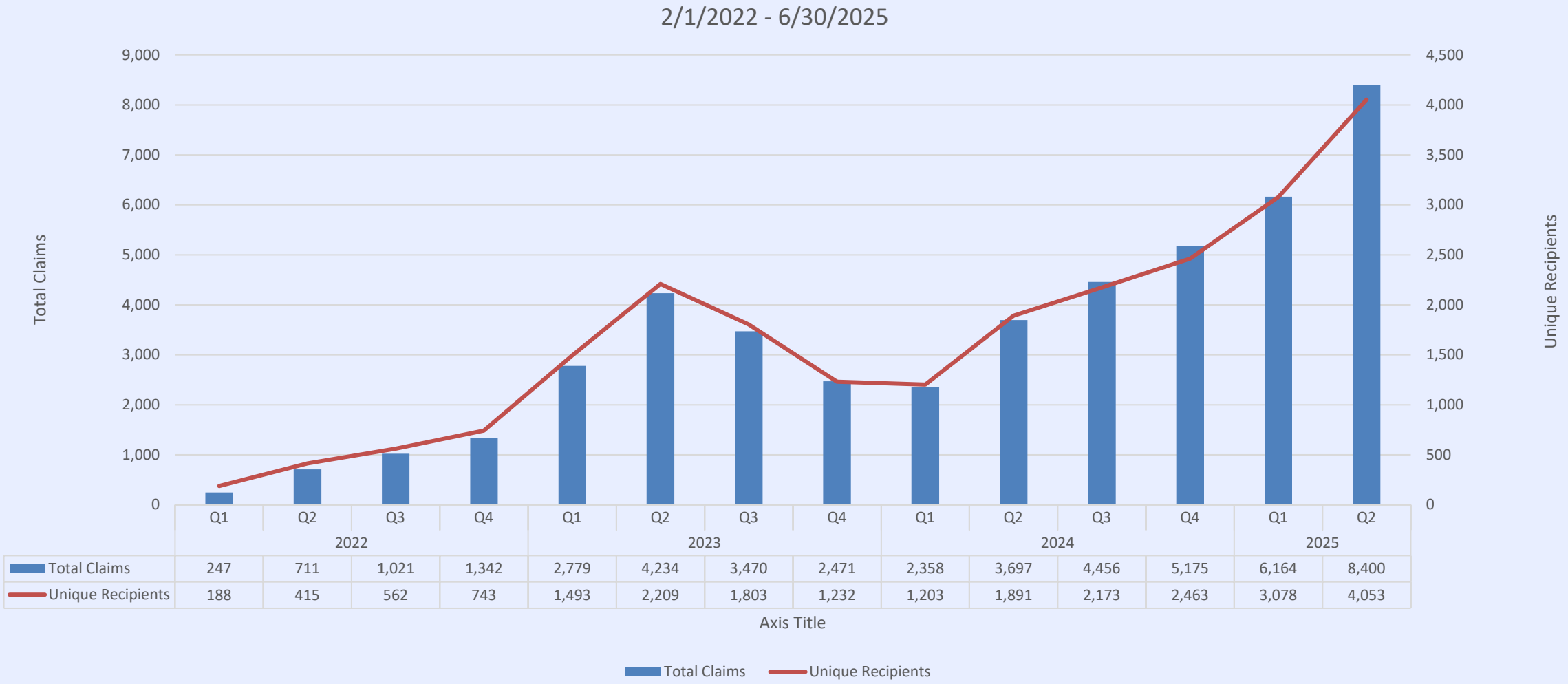
Anti-Obesity Agents

Anti-Obesity Agents - FFS

- Historically, the Medicaid State Plan excluded drugs for weight loss. However, due to the increasing number of non-formulary prior authorization requests for medical necessity, MDHHS implemented policy MSA 21-49 Pharmacy Coverage of Anti-Obesity Drug Products
- Effective February 1, 2022, the anti-obesity drug products may be covered as pharmacy benefit. Extending coverage of these products aligns with current standards of practice and supports recognized treatments of comorbid conditions (e.g., diabetes)
- All agents are preferred with clinical prior authorization on the single PDL.
- The following slides show the utilization trend for these agents since the implementation of their coverage.

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Anti-Obesity Agents - FFS



CONFIDENTIAL © 2025 Prime Therapeutics LLC

Anti-Obesity Agents - FFS

2/1/2022 – 6/30/2025

Brand Name	Generic Name	Dose Form Desc	Unique Recipients	Total Claims	Unique Physicians
WEGOVY	SEMAGLUTIDE	PEN INJCTR	7,106	30,578	3,883
ZEPBOUND	TIRZEPATIDE	PEN INJCTR	2,677	8,337	1,910
SAXENDA	LIRAGLUTIDE	PEN INJCTR	1,804	6,021	1,246
PHENTERMINE HCL	PHENTERMINE HCL	TABLET	361	804	320
PHENTERMINE HCL	PHENTERMINE HCL	CAPSULE	149	340	150
CONTRAVE	NALTREXONE HCL/BUPROPION HCL	TABLET ER	100	268	106
QSYMIA	PHENTERMINE/TOPIRAMATE	CPMP 24HR	18	61	17
LOMAIRA	PHENTERMINE HCL	TABLET	29	57	27
ORLISTAT	ORLISTAT	CAPSULE	14	23	15
DIETHYLPROPION HCL ER	DIETHYLPROPION HCL	TABLET ER	2	14	3
XENICAL	ORLISTAT	CAPSULE	8	13	8
DIETHYLPROPION HCL	DIETHYLPROPION HCL	TABLET	3	4	3
PHENDIMETRAZINE TARTRATE	PHENDIMETRAZINE TARTRATE	TABLET	3	3	3
PHENTERMINE-TOPIRAMATE ER	PHENTERMINE/TOPIRAMATE	CPMP 24HR	2	2	2
BENZPHETAMINE HCL	BENZPHETAMINE HCL	TABLET	1	1	1
Summary			**11,034**	**46,526**	**5,103**

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Anti-Obesity Agents – FFS – Pediatric Use

- Several anti-obesity agents are approved for use in children ages 12 years and older
  - Wegovy (semaglutide), Saxenda (liraglutide) and Xenical (orlistat)
  - Below is the age breakdown to identify the pediatric utilization for service period 2/1/2022 – 6/30/2025

Brand Name	Generic Name	Unique Recipients	
		Ages 12y to 17y	Ages ≥18y
WEGOVY	SEMAGLUTIDE	240	6,882
SAXENDA	LIRAGLUTIDE	34	1,771
ORLISTAT	ORLISTAT	1	12
XENICAL	ORLISTAT	0	8

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Anti-Obesity Agents – FFS – Duration of Therapy

- Anti-obesity claims were reviewed to determine the duration of therapy for the beneficiaries receiving these medications.
- Total beneficiaries on anti-obesity medications for service dates since 2/1/2022 = 11,621
- Medical claims for the 11,621 beneficiaries were queried for a diagnosis of diabetes mellitus (DM) or Prediabetes.
  - 914 beneficiaries were identified with a DM diagnosis.
  - 542 beneficiaries were identified with a Prediabetes diagnosis.
- New starts to therapy in the most recent two months were identified.
  - 1,263 total new start beneficiaries.

Duration of Therapy				
	<84 days	**84 – 167 days**	**168 – 335 days**	**≥336 days**
Unique Beneficiaries	5,965 (51%)	2,784 (24%)	1,939 (17%)	933 (8%)
Known DM diagnosis	412	226	181	95
Prediabetes diagnosis	234	123	114	71
Unknown diagnosis	5,319	2,435	1,644	767

CONFIDENTIAL © 2025 Prime Therapeutics LLC

GLP-1 Agonists (Diabetes)

GLP-1 Agonists (Diabetes) - Overview

- Glucagon-like peptide 1 (GLP-1) agonists are a high-efficacy A1c-lowering option used in the treatment of type 2 diabetes (T2D). Mounjaro (tirzepatide) is the first glucose-dependent insulinotropic polypeptide (GIP)/GLP-1 receptor agonist.
- None of the GLP-1 agonists in the table on the next slide are approved for chronic weight management; however, three drugs that have the same active molecular entities are approved for weight management (e.g. Wegovy [semaglutide], Saxenda [liraglutide], Zepbound [tirzepatide]).
- The weight loss benefits, in addition to shortages of Wegovy and Saxenda, created opportunities for off-label use of GLP-1 agonists approved for T2D to be used for weight loss, which has caused access issues for patients who have been stable on GLP-1 agonists for the treatment of T2D.
- To better manage the appropriate use of GLP-1 agonists approved for T2D, on 2/1/2024, MDHHS added a clinical prior authorization edit to the preferred agents that requires a diagnosis of T2D and no concurrent therapy with another GLP-1 agonist. This is an automated edit that requires the submission of a T2D diagnosis on the pharmacy claim and looks back 30 days in the paid pharmacy claims history for the presence of another GLP-1 agonist. The system also looks back 180 days in paid medical claims history for the presence of a T2D diagnosis if none was submitted on the pharmacy claim.
- On 2/1/2025, MDHHS added clinical criteria to the require the discontinuation of concurrent use of DPP-4 inhibitors with GLP-1 agonists (includes GPL-1 agonists approved for diabetes as well as those approved for weight management).
- The following slide shows the utilization of each of the T2D GLP-1 agonists for 2025 Q2.

CONFIDENTIAL © 2025 Prime Therapeutics LLC

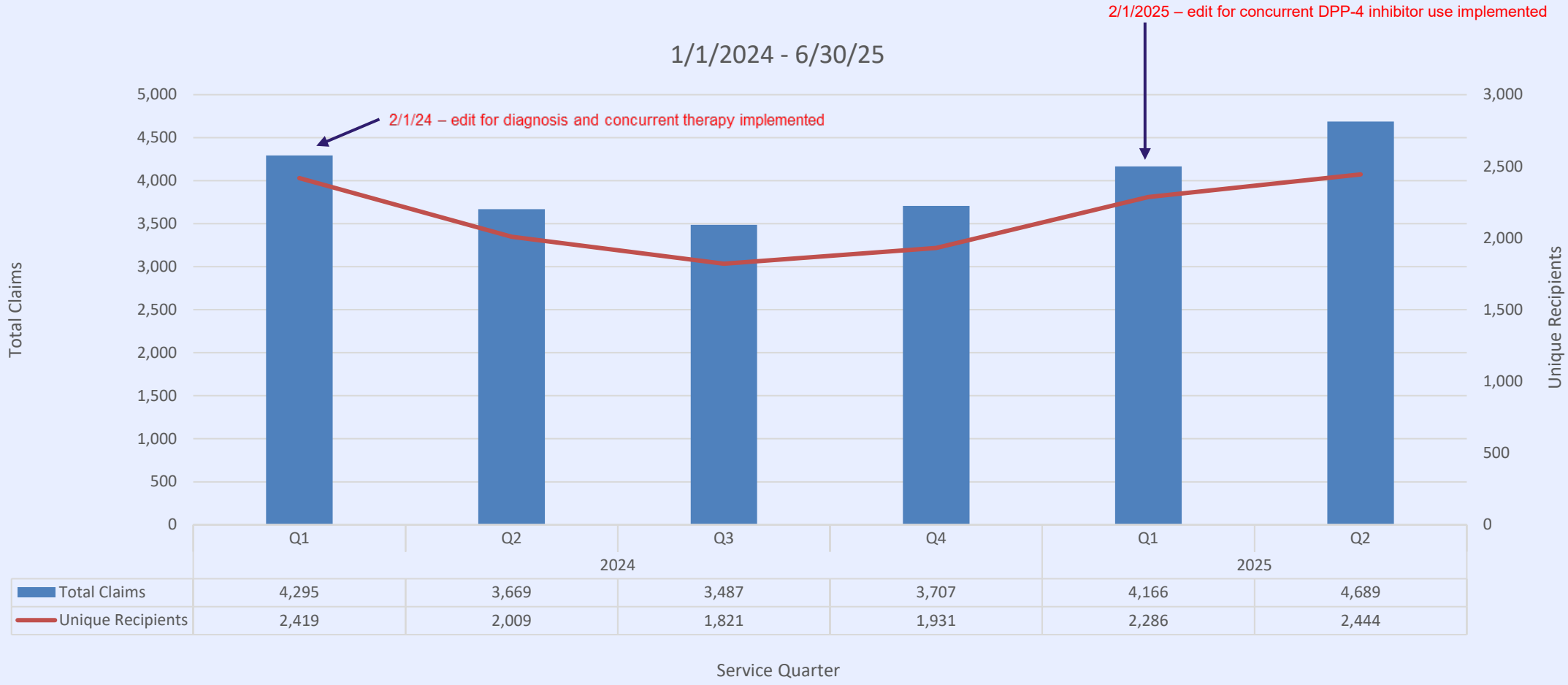
GLP-1 Agonists (Diabetes) – FFS Utilization

4/1/2025 – 6/30/2025				
Brand Name	**Generic Name**	**Dose Form Desc**	**Unique Recipients**	**Total Claims**
OZEMPIC*	SEMAGLUTIDE	PEN INJCTR	960	1,652
MOUNJARO	TIRZEPATIDE	PEN INJCTR	803	1,562
TRULICITY*	DULAGLUTIDE	PEN INJCTR	655	1,369
RYBELSUS	SEMAGLUTIDE	TABLET	40	72
LIRAGLUTIDE	LIRAGLUTIDE	PEN INJCTR	12	17
VICTOZA 3-PAK*	LIRAGLUTIDE	PEN INJCTR	3	9
VICTOZA 2-PAK*	LIRAGLUTIDE	PEN INJCTR	4	5
BYDUREON BCISE	EXENATIDE MICROSPHERES	AUTO INJCT	2	2
SOLIQUA 100-33	INSULIN GLARGINE/LIXISENATIDE	INSULN PEN	1	1
Summary			**2,444**	**4,689**

* PDL Preferred

CONFIDENTIAL © 2025 Prime Therapeutics LLC

GLP-1 Agonists (Diabetes) – FFS Utilization – Quarterly Trend



CONFIDENTIAL © 2025 Prime Therapeutics LLC

GLP-1 Agonists – FFS Utilization

- The tables below compare the utilization of the medications that are available as brands approved to treat T2D (Ozempic, Rybelsus, Victoza, Mounjaro) to those approved for weight loss management (Wegovy, Saxenda, Zepbound) for 2Q 2025.

Semaglutide				
Brand Name	**Generic Name**	**Dose Form Desc**	**Unique Recipients**	**Total Claims**
WEGOVY* (Anti-Obesity)	SEMAGLUTIDE	PEN INJCTR	2,182	4,526
OZEMPIC (Diabetes)	SEMAGLUTIDE	PEN INJCTR	960	1,652
RYBELSUS (Diabetes)	SEMAGLUTIDE	TABLET	40	72
Summary			**3,181**	**6,250**

Liraglutide				
Brand Name	**Generic Name**	**Dose Form Desc**	**Unique Recipients**	**Total Claims**
SAXENDA* (Anti-Obesity)	LIRAGLUTIDE	PEN INJCTR	35	64
VICTOZA 2-PAK (Diabetes)	LIRAGLUTIDE	PEN INJCTR	4	5
VICTOZA 3-PAK (Diabetes)	LIRAGLUTIDE	PEN INJCTR	3	9
LIRAGLUTIDE (Diabetes)	LIRAGLUTIDE	PEN INJCTR	12	17
Summary			**52**	**95**

Tirzepatide				
Brand Name	**Generic Name**	**Dose Form Desc**	**Unique Recipients**	**Total Claims**
ZEPBOUND* (Anti-Obesity)	TIRZEPATIDE	PEN INJCTR	1,793	3,653
MOUNJARO (Diabetes)	TIRZEPATIDE	PEN INJCTR	803	1,562
Summary			**2,584**	**5,215**

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Gabapentin Utilization

Gabapentin – FFS and MCO Utilization

Purpose:

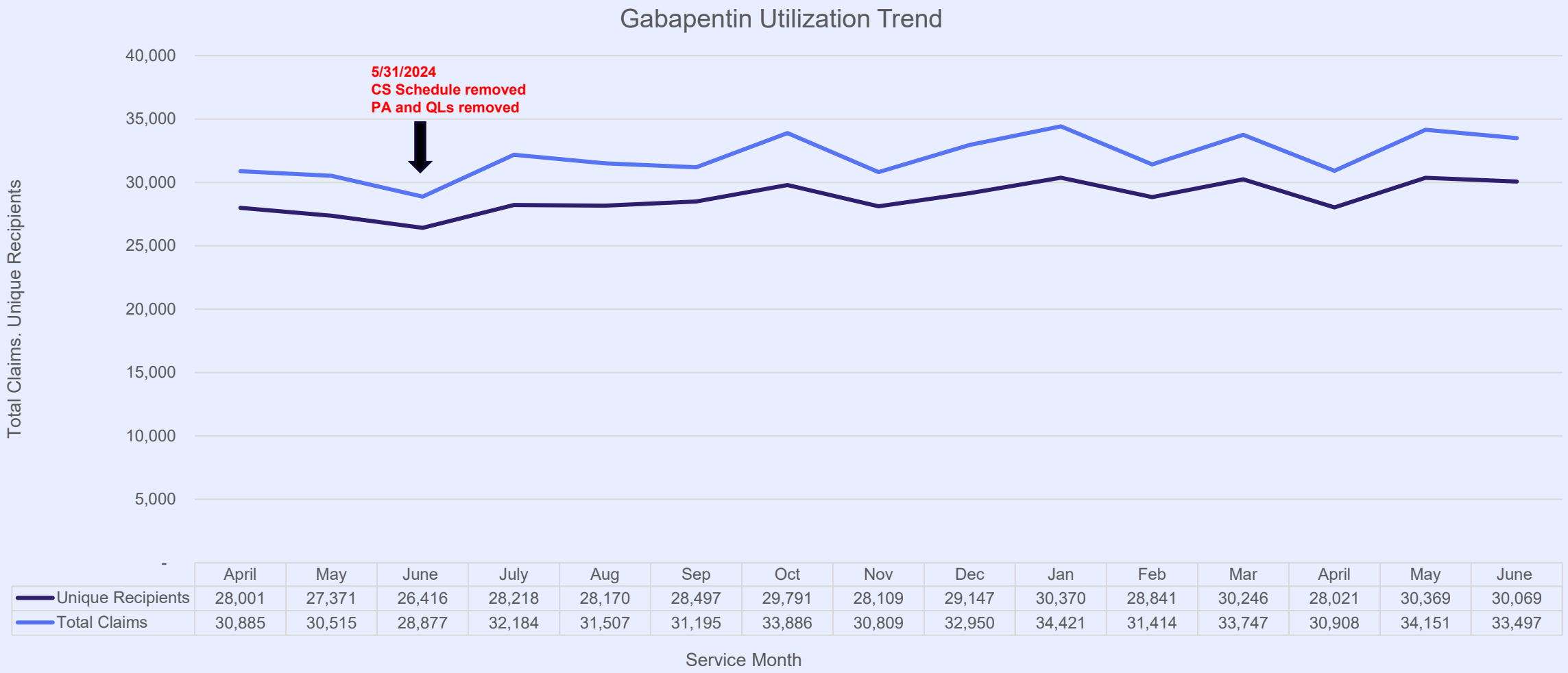
- Evaluate the impact of recent changes made on May 31, 2024 to gabapentin utilization
  - Removal of LARA categorization as a Schedule 5 controlled substance
  - Removal of dosage edit that limits the accumulated daily dose of gabapentin to 3600mg
- Evaluate the prescribed dosages
- Note: gabapentin is on the MCO pharmacy carve out list. Claims are paid as a FFS benefit for both FFS and managed MCO beneficiaries.

Methods:

- Paid pharmacy claims for both FFS and MHP beneficiaries were searched for gabapentin during the service period of 4/1/24 through 6/30/25 to reveal the monthly utilization trend before and after the coverage changes.
- Using service period 4/1/25 through 6/30/25, beneficiaries were identified with paid pharmacy claims for gabapentin and their accumulated daily dosages were calculated.

CONFIDENTIAL © 2025 Prime Therapeutics LLC

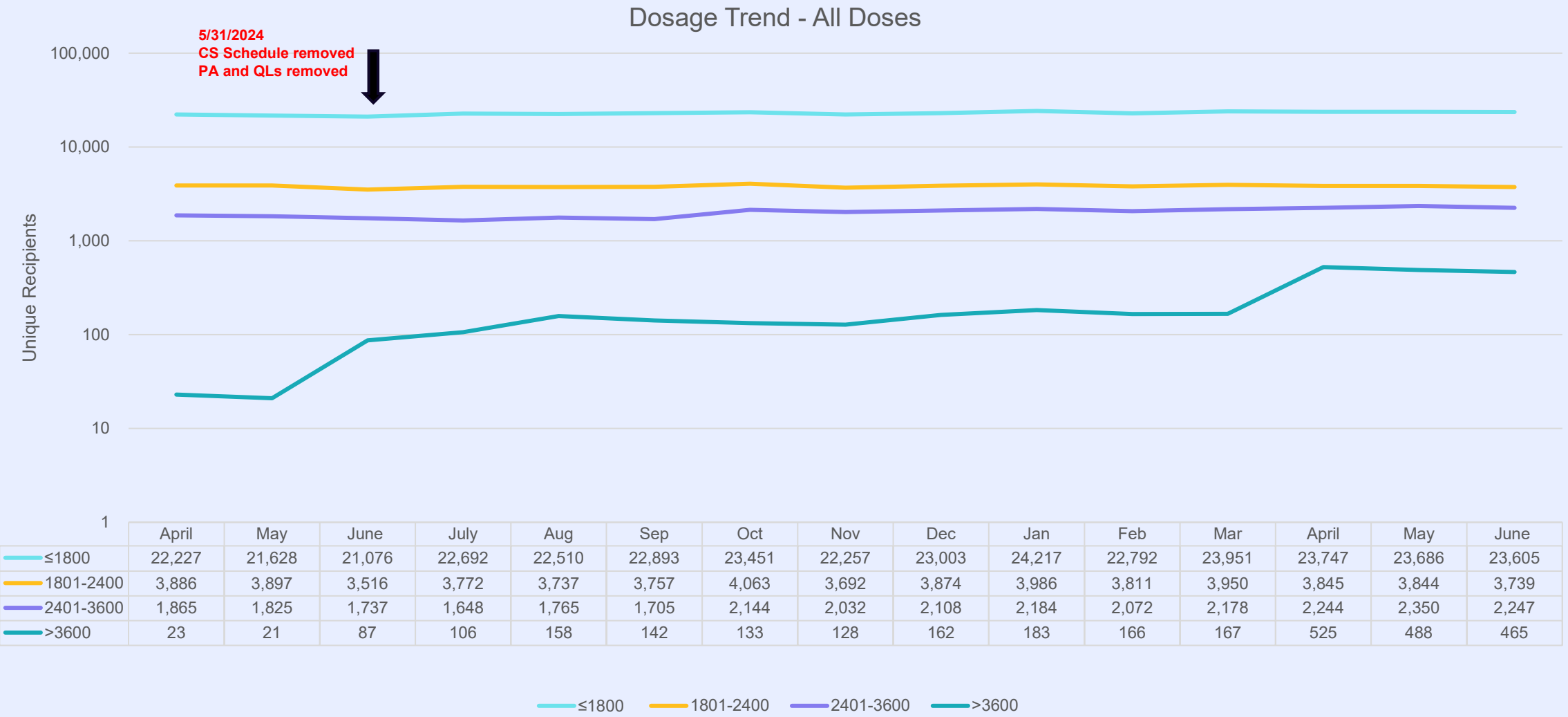
Gabapentin – FFS and MCO Utilization



	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Unique Recipients	28,001	27,371	26,416	28,218	28,170	28,497	29,791	28,109	29,147	30,370	28,841	30,246	28,021	30,369	30,069
Total Claims	30,885	30,515	28,877	32,184	31,507	31,195	33,886	30,809	32,950	34,421	31,414	33,747	30,908	34,151	33,497

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Gabapentin – FFS and MCO Utilization



	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
≤1800	22,227	21,628	21,076	22,692	22,510	22,893	23,451	22,257	23,003	24,217	22,792	23,951	23,747	23,686	23,605
1801-2400	3,886	3,897	3,516	3,772	3,737	3,757	4,063	3,692	3,874	3,986	3,811	3,950	3,845	3,844	3,739
2401-3600	1,865	1,825	1,737	1,648	1,765	1,705	2,144	2,032	2,108	2,184	2,072	2,178	2,244	2,350	2,247
>3600	23	21	87	106	158	142	133	128	162	183	166	167	525	488	465

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Opioids

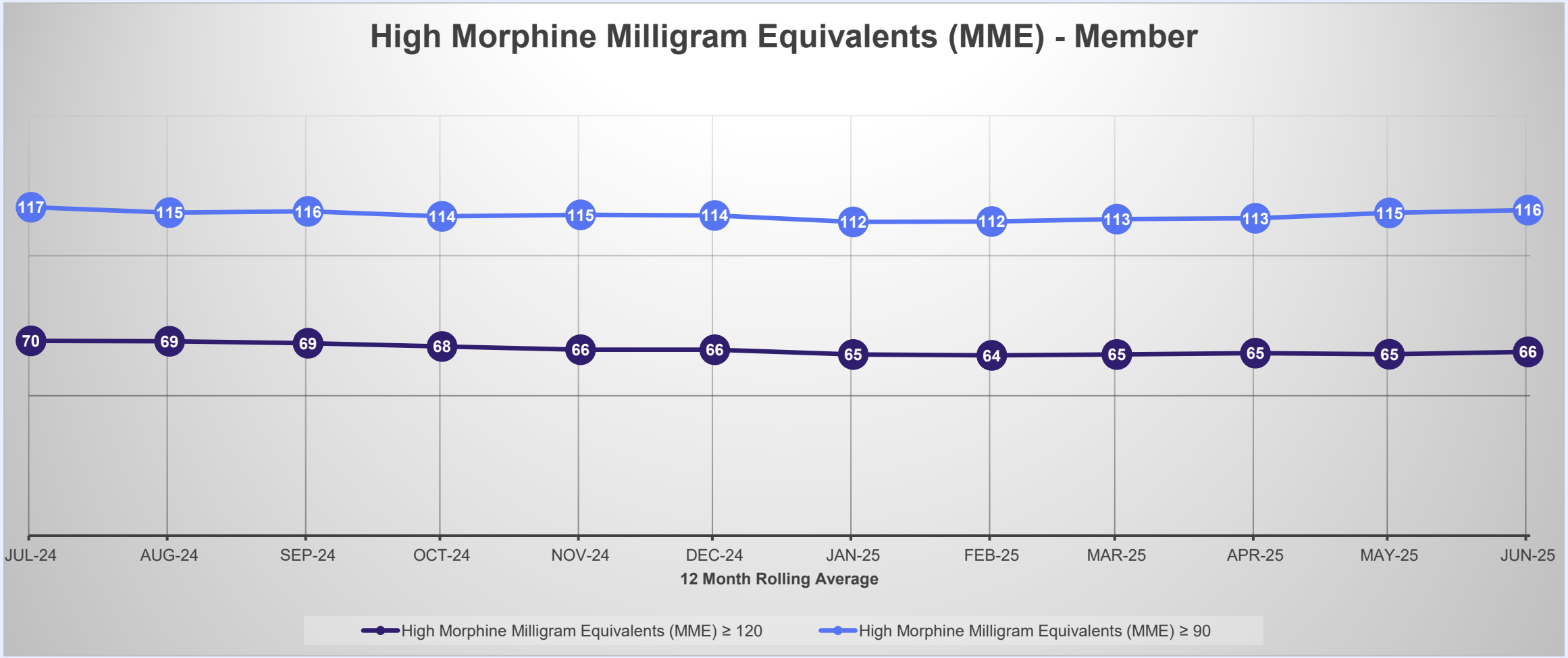
Morphine Milligram Equivalent Daily Dose (MEDD) Threshold

- Effective 9/21/2018, to promote safe opioid prescribing practices, the MDHHS implemented a new safety edit targeting claims with high morphine milligram equivalent daily dose (MEDD).
- The edit requires a clinical prior authorization. To minimize medication disruption, initial requests may be authorized for a 7 days' supply while the prescriber compiles and submits a new prior authorization request with clinical justification supporting the medical necessity of the high MEDD treatment plan and/or a taper plan.
- Prescribers may submit prior authorization requests to exceed these limits. Furthermore, an emergency supply of medication can be requested by the pharmacy (e.g. when the prescriber is unavailable to initiate the clinical prior authorization).
- The MDHHS maximum allowed MEDD was gradually lowered on a periodic basis until the MEDD threshold aligned with guidelines issued by the Centers for Disease Control and Prevention.
- MDHHS lowered the threshold to 90 MEDD on July 1, 2021.

	9/21/2018	1/15/2019	8/1/2019	12/1/2019	7/1/2021
MME Threshold	500	200	150	120	90

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Morphine Milligram Equivalent Daily Dose (MEDD) Threshold



CONFIDENTIAL © 2025 Prime Therapeutics LLC

Opioid Naïve – 7-day Supply Limit Edit

- Michigan law (i.e. MCL 333.7333b) prohibits prescribers from writing more than a 7-day supply of an opioid used to treat acute pain.
- For enforcement purposes, effective 9/5/2018, MDHHS implemented a hard edit limiting coverage of short-acting narcotic analgesics for Fee-For-Service members who are opioid treatment-naïve to a 7-day supply.
- For this edit, opioid treatment-naïve members are defined as those who have not had a claim for a narcotic drug within the past 180 days.
- The 7-day supply limit targets short-acting narcotic analgesics and opioid treatment naïve population in our best attempt to minimize risk of denying coverage of more than a 7-day supply for someone receiving treatment for chronic pain.
- Claims that exceed a 7-day supply will be denied with the supplemental message, "Opioid naïve. More than 7 days' supply. Call 877-864-9014 for chronic use consideration."
  - Pharmacies may submit a partial fill for 7 days' supply using the NCPDP Partial Fill functionality in lieu of calling for authorization for the entire prescription.
  - Either the pharmacy or prescriber can call for authorization of the entire prescription by attesting it is for "chronic" pain

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Opioid Naïve – 7-day Supply Limit Edit

April 1, 2025 – June 30, 2025

Month		Distinct Beneficiaries	Beneficiaries with Subsequent Fills	Call Center Requests	Distinct Beneficiaries
Apr	Denied Claims	1,186		Call Center Requests	45
	Paid Claims	425		Approved	34
	≤7 ds	382	142	Denied	0
	>7 ds	200		Informational	11
May	Denied Claims	1,144		Call Center Requests	40
	Paid Claims	417		Approved	36
	≤7 ds	383	143	Denied	1
	>7 ds	186		Informational	3
June	Denied Claims	1,113		Call Center Requests	82
	Paid Claims	394		Approved	64
	≤7 ds	351	137	Denied	0
	>7 ds	184		Informational	18

Denied pharmacy claims are those that denied for the 7-day supply limit edit. Paid claims were searched for the beneficiaries who initially had denied claims and either decreased the quantity to ≤7-day supply or received a PA to allow a >7-day supply.

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Naloxone Use - Adults

4/1/2025 – 6/30/2025

Adults	Members	P1000M	Naloxone Utilization (n)	Naloxone Utilization (%)
Opioid Dosage >=90 MME/day	271	0.1	36	13.28
Total Members on Opioids	12,078	4.59	635	5.26
Members with naloxone claim – no opioid claim during service period			2,500	

1/1/2025 – 3/31/2025

Adults	Members	P1000M	Naloxone Utilization (n)	Naloxone Utilization (%)
Opioid Dosage >=90 MME/day	262	0.1	36	13.74
Total Members on Opioids	11,814	4.41	609	5.15
Members with naloxone claim – no opioid claim during service period			2,060	

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Naloxone Use - Pediatrics

4/1/2025 – 6/30/2025

Pediatrics	Members	P1000M	Naloxone Utilization (n)	Naloxone Utilization (%)
Opioid Dosage >=90 MME/day	1	0	0	0.00
Total Members on Opioids	812	0.31	25	3.08
Members with naloxone claim – no opioid claim during service period			4	

1/1/2025 – 3/31/2025

Pediatrics	Members	P1000M	Naloxone Utilization (n)	Naloxone Utilization (%)
Opioid Dosage >=90 MME/day	1	0	0	0.00
Total Members on Opioids	779	0.28	23	2.95
Members with naloxone claim – no opioid claim during service period			7	

CONFIDENTIAL © 2025 Prime Therapeutics LLC

SUPPORT Act / Opioid Potentiators

SUPPORT Act

SUPPORT for Patients and Communities Act requires states to implement minimum opioid standards within their FFS and managed care programs.

Requirements for both FFS and MHPs:

- Safety edits including early, duplicate and quantity limits
- Maximum Daily Morphine Milligram Equivalents (MME) Safety Edits
- Concurrent Utilization
  - Opioids and benzodiazepines
  - Opioids and antipsychotics

CONFIDENTIAL © 2025 Prime Therapeutics LLC

SUPPORT Act – Concurrent Utilization

FFS Population							
Opioid Only Utilization and Opioid Concurrent Utilization with Antipsychotics and Benzodiazepines - 2025 Q2 (Dates of Service: 4/1/2025 – 6/30/2025)							
Potentiator Classes (>=30-day overlap)	Current Avg. Daily MME						
	< 30	30-49.9	50-89.9	90-119.9	120-200	>200	Total
Opioids and Antipsychotics Only	193	62	15	4	-	3	277
Opioids and Benzodiazepines Only	51	16	15	-	2	2	82
Opioids, Antipsychotics, and Benzodiazepines	76	29	12	4	9	1	131
Total	**320**	**107**	**38**	**8**	**11**	**6**	**490**
Total Opioids	7,977	3,856	905	152	76	44	13,007

CONFIDENTIAL © 2025 Prime Therapeutics LLC

SUPPORT Act – Concurrent Utilization

HP Population							
Opioid Only Utilization and Opioid Concurrent Utilization with Antipsychotics and Benzodiazepines - 2025 Q2 (Dates of Service: 4/1/2025 – 6/30/2025)							
Potentiator Classes (>=30-day overlap)	Current Avg. Daily MME						
	< 30	30-49.9	50-89.9	90-119.9	120-200	>200	Total
Opioids and Antipsychotics Only	4,091	1,933	607	82	50	24	**6,787**
Opioids and Benzodiazepines Only	3,627	1,908	775	93	85	47	**6,535**
Opioids, Antipsychotics, and Benzodiazepines	1,026	553	222	42	20	13	**1,876**
Total	**8,744**	**4,394**	**1,604**	**217**	**155**	**84**	**15,198**
Total Opioids	47,894	16,343	4,919	558	441	206	**70,361**

CONFIDENTIAL © 2025 Prime Therapeutics LLC

SUPPORT Act – Concurrent Utilization

Total Medicaid Population							
Opioid Only Utilization and Opioid Concurrent Utilization with Antipsychotics and Benzodiazepines - 2025 Q2 (Dates of Service: 4/1/2025 – 6/30/2025)							
Potentiator Classes (>=30-day overlap)	Current Avg. Daily MME						
	< 30	30-49.9	50-89.9	90-119.9	120-200	>200	Total
Opioids and Antipsychotics Only	4,284	1,995	622	86	50	27	**7,064**
Opioids and Benzodiazepines Only	3,678	1,924	790	93	87	49	**6,617**
Opioids, Antipsychotics, and Benzodiazepines	1,102	582	234	46	29	14	**2,007**
Total	**9,064**	**4,501**	**1,642**	**225**	**166**	**90**	**15,688**
Total Opioids	55,871	20,199	5,824	710	517	250	**83,368**

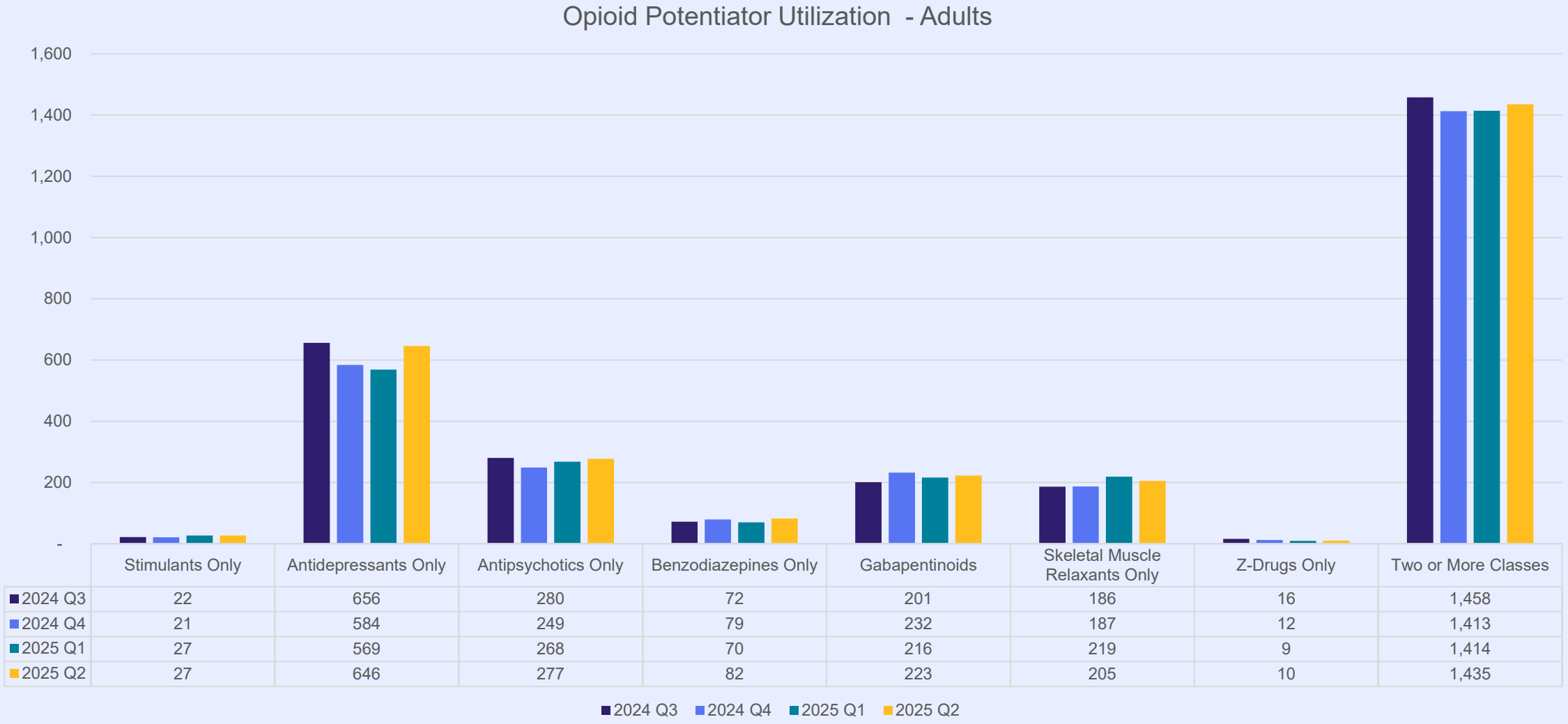
CONFIDENTIAL © 2025 Prime Therapeutics LLC

Opioid Potentiator Utilization

- Paid pharmacy claims were searched for opioids for both adult and pediatric FFS populations
  - Service period 4/1/2025 through 6/30/2025
- Additional analysis was performed on the identified members with concurrent utilization with a 30 day or longer overlap with potentiator medications.
  - Potentiator medications are those that enhance the opioid effect such as amphetamines, antidepressants, antipsychotics, benzodiazepines, gabapentinoids, and muscle relaxers

CONFIDENTIAL © 2025 Prime Therapeutics LLC

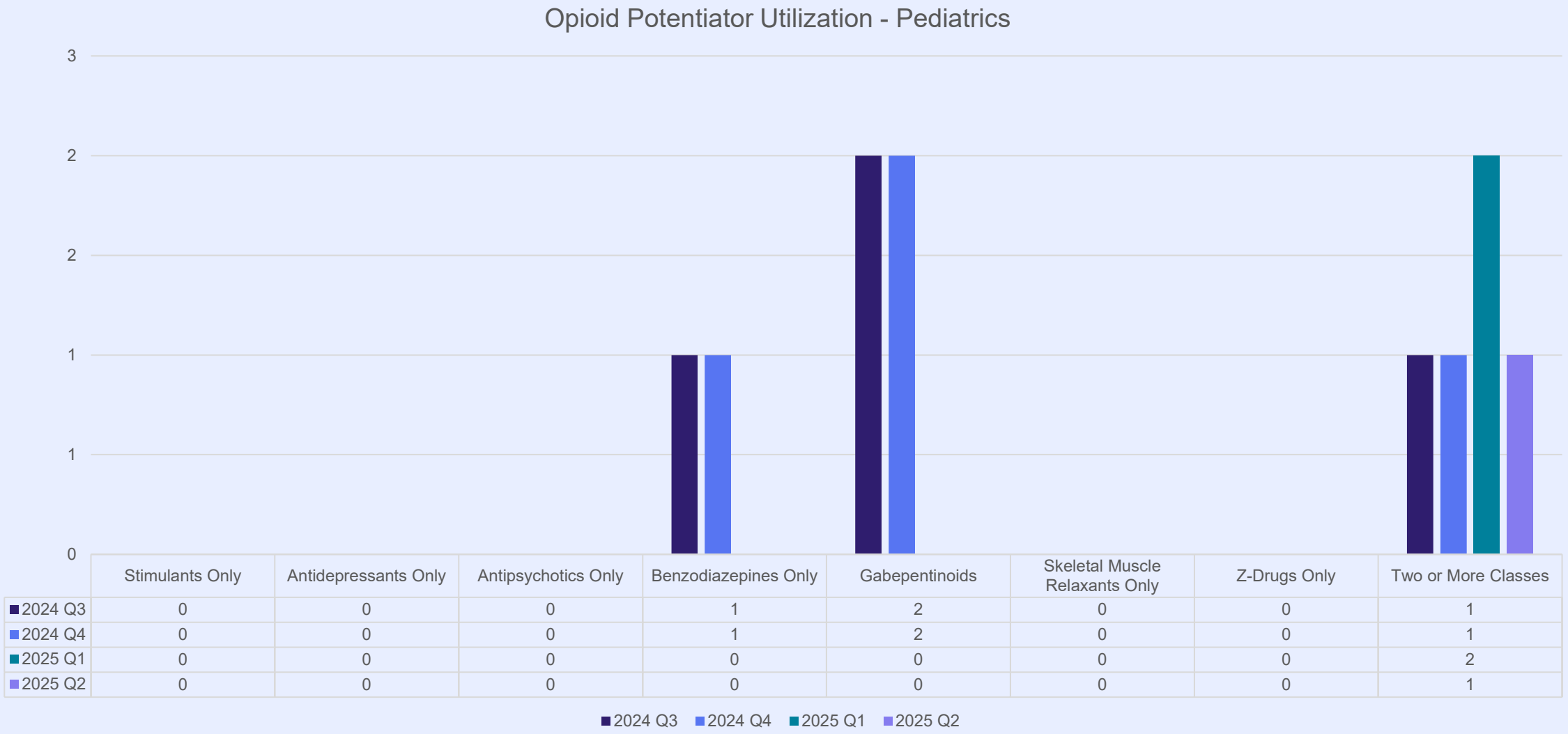
Opioid Potentiator Utilization



	Stimulants Only	Antidepressants Only	Antipsychotics Only	Benzodiazepines Only	Gabapentinoids	Skeletal Muscle Relaxants Only	Z-Drugs Only	Two or More Classes
2024 Q3	22	656	280	72	201	186	16	1,458
2024 Q4	21	584	249	79	232	187	12	1,413
2025 Q1	27	569	268	70	216	219	9	1,414
2025 Q2	27	646	277	82	223	205	10	1,435

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Opioid Potentiator Utilization



	Stimulants Only	Antidepressants Only	Antipsychotics Only	Benzodiazepines Only	Gabepentinoids	Skeletal Muscle Relaxants Only	Z-Drugs Only	Two or More Classes
2024 Q3	0	0	0	1	2	0	0	1
2024 Q4	0	0	0	1	2	0	0	1
2025 Q1	0	0	0	0	0	0	0	2
2025 Q2	0	0	0	0	0	0	0	1

CONFIDENTIAL © 2025 Prime Therapeutics LLC

COVID-19 and Influenza Vaccines

Hold for December Meeting

CMS Letter

CMS Letter

Objective: The DUR Board was tasked with obtaining a high-level overview of diagnosis counts and age breakdowns to begin discussions regarding puberty blockers, cross-sex hormones, and surgery related to gender dysphoria as described in the CMS Letter.

Diagnosis Codes (ICD-10 F64 - Gender identity disorders):	Diagnosis Codes (DSM-5-TR F64 - Gender dysphoria):
•**F64.0** – Transsexualism	•**F64.0 –** Gender Dysphoria in Adolescents and Adults
•**F64.1** – Dual role transvestism	
•**F64.2** – Gender identity disorder of childhood	•**F64.2 –** Gender Dysphoria in Children
•**F64.8** – Other gender identity disorders	•**F64.8 –** Other Specified Gender Dysphoria
•**F64.9** – Gender identity disorder, unspecified	•**F64.9 –** Unspecified Gender Dysphoria

Data Source: Medical claims data from Prime Therapeutics database for Medicaid FFS members with F64 ICD-10 diagnosis codes.

Time Period: August 1, 2024 – July 31, 2025

Results: Less than 600 total individuals were identified.

CONFIDENTIAL © 2025 Prime Therapeutics LLC

Thank you!

Prime THERAPEUTICS™

Questions

CONFIDENTIAL © 2025 Prime Therapeutics LLC