



# TennCare Drug Utilization Review Advisory Board

October 28, 2025

# Agenda

- Call to Order/Introductions
- Approval of Previous Minutes
- TennCare Update – Ronya Green, MD
- TennCare Pharmacy Update – Renee Williams-Clark, PharmD
- Public Testimony
- Old Business/Follow Up Items
- New Business
  - Retrospective Class Review: Assessment of Hydroxyurea Utilization in Sickle Cell Disease
  - Retrospective Class Review: Heart Failure Therapy Adherence
  - Retrospective Class Review: Opioid Use Among Members with a History of Overdose
- Standing Business
- TennCare Utilization Data
- ProDUR Data
- RetroDUR Initiatives
- Adjournment



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# Review of Minutes

April 29, 2025



# TennCare Update

Ronya Green, MD MPH MBA  
Associate Medical Director

October 28, 2025

# Agenda

- **New** Dental Benefits Manager
- Diaper benefit

# Dental Benefit Manager

- Renaissance will assume care for TennCare members on November 1, 2025
- Supporting TennCare Medicaid and CoverKids CHIP dental members, and the providers who care for them.
- No action required for members.
- Dental providers should respond to outreach & credential with Renaissance



**TennCare***Diaper***Benefit** 

# TennCare *Diaper* Benefit

**Who** Any TennCare or CoverKids member under age 2 is eligible for the benefit.

**What** Up to 100 diapers per month from the list of approved brands/types of diapers

**When** Members are able to access the diapers beginning in August 2024 at participating pharmacies across TN.

**Where** Members obtain diapers from the pharmacy counter at participating pharmacy locations. A list of participating pharmacies is available online.



# Resources & Communications Toolkit

- TennCare has created materials to assist our partners in sharing information about the diaper benefit with eligible TennCare and CoverKids families
  - Flyer for Members
  - Social Media Messages
  - Content for Newsletters and Emails
  - Videos



## SMS Template

TennCare and CoverKids members under age two can get up to 100 diapers a month at participating pharmacies with their pharmacy ID. Learn more, [TennCare Diapers](#).

## Website Banner

Find out more about TennCare's new diaper benefit. Go to [TennCare Diapers](#).

## Link to a Downloadable Flyer

- A [general diaper benefit flyer](#)

## Social media

### Post 1

TennCare has added a new benefit! Children under two who are covered by TennCare or CoverKids can now receive up to 100 diapers per month at no cost! Here's how to use the benefit:

1. Visit a participating pharmacy.
2. Show your child's pharmacy card at the pharmacy counter. For newborns, your pharmacy can use your pharmacy card or Social Security Number until the newborn receives their own ID.

TennCare will cover a variety of popular diaper brands to meet your family's needs. You can find more information and a list of participating pharmacies at [TN.gov/TennCare/diapers](#).

### Post 2

NEW TennCare Benefit! Children under 2 with TennCare or CoverKids can receive up to 100 diapers per month at participating pharmacies. Just show your child's pharmacy card to the pharmacist. For newborns, you can use the mother's pharmacy card or Social Security number. For more information, visit [TN.gov/TennCare/diapers](#).

### Post 3

Introducing TennCare's Diaper Benefit! TennCare now provides up to 100 diapers per month for TennCare and CoverKids children under age two. Simply visit a participating pharmacy and present your child's pharmacy card. If your newborn doesn't have a card yet, you can use the mother's pharmacy card or Social Security number.

TennCare will cover a variety of popular diaper brands. For more details and a list of participating pharmacies, please visit [TN.gov/TennCare/diapers](#).

## TennCare Diaper Benefit



# Diaper benefit update

- As of October 16<sup>th</sup> : 78,604 unique members have accessed the diaper benefit
- Diapers are being distributed in 92 counties in over 420 pharmacies
- 39.9M diapers dispensed

# Diaper benefit update

- On February 15, 2025, TennCare enhanced the reimbursement of covered diaper brands for pharmacies. TennCare now reimburses covered UPCs based on the **brand and size** of the product dispensed
- Effective February 28, 2025, TennCare allows pharmacies to submit claims for diapers not on the Covered UPC list utilizing a Generic Diaper UPC. The reimbursement is based on the size of the product dispensed.

Questions?



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# TennCare Pharmacy Update

Renee Williams-Clark, PharmD  
Chief Pharmacy Officer, TennCare



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**Old Business**



# Follow Up Items

Kimberly Barnes, PharmD

# HIV Adherence Initiative follow up

- OptumRx presented a DUR initiative on HIV adherence at the July 2024 DUR meeting.
- As a result of this initiative, a retrospective letter campaign was implemented.
- OptumRx would like to provide a follow up data analysis after implementation of the retrospective letter campaign.

# Claims Review (Design)

| Claim Review                               | Original              | Current                   |
|--------------------------------------------|-----------------------|---------------------------|
| Time Frame                                 | June 2023 – June 2024 | August 2024 – August 2025 |
| Paid Claim Count                           | 22,500                | 21,362                    |
| Unique Members                             | 3,034                 | 2,524                     |
| Results: % Non-adherent on HIV Medications | 1,725 (56.9%)         | 1,1201 (47.6%)            |

**Non-adherence is defined as a proportion of days covered (PDC) of less than 95%.**

# HIV Adherence Initiative Next steps

- OptumRx will continue to monitor members with HIV who are non-adherent and refer these members to MCO case management.
- Should we implement another letter campaign?
- Other recommendations or feedback?



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**New Business**



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# **Assessment of Hydroxyurea Utilization in Sickle Cell Disease**

Kimberly Barnes, PharmD

# Review

- Background
- Treatments
- PDL and Criteria Placement
- Treatment Guidelines/Literature Findings
- Retrospective Review of TennCare Claims
  - Review Design
  - Findings
- Discussion and Board Recommendations

# Background

- It is estimated that Sickle cell disease (SCD) affects 100,000 Americans (Centers for Disease Control and Prevention [CDC] Web site 2024).
- Most of those affected are of African ancestry or self-identify as Black (NIH 2014). Although SCD is associated with major morbidity, currently, more than 90% of children with SCD in the U.S. and the United Kingdom survive into adulthood; however, their lifespans remain shortened by 2 or 3 decades compared to the general population.

## References

- Centers for Disease Control and Prevention (CDC). Sickle Cell Disease (SCD). CDC Web site. Updated May 15, 2024. <https://www.cdc.gov/sickle-cell/data/index.html>. Accessed May 30, 2024.
- Department of Health and Human Services. National Institutes of Health (NIH). National Heart, Lung, and Blood Institute. Evidence-based management of sickle cell disease. Expert panel report, 2014. [https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%2020816\\_0.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%2020816_0.pdf). Accessed May 30, 2024.

# Background

- Sickle cell disease (SCD) is caused by a single mutation of the gene that codes for hemoglobin S (HbS), which substantially impacts the stability of the hemoglobin molecule and each RBC as a whole, as they form a sickle shape. Due to the mutation, the hemoglobin becomes more coagulable in its normal environment and the RBCs become poor carriers of oxygen. (National Institutes of Health [NIH] 2014, Vichinsky 2022[a]).
- The most common SCD genotypes include homozygous hemoglobin SS (HbSS, referred to as sickle cell anemia [SCA]) and HbS  $\beta^0$ -thalassemia; these genotypes are clinically similar and are associated with the most severe clinical manifestations.

## References

- Department of Health and Human Services. National Institutes of Health (NIH). National Heart, Lung, and Blood Institute. Evidence-based management of sickle cell disease. Expert panel report, 2014. [https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816\\_0.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf). Accessed May 30, 2024.
- Vichinsky EP. Overview of the clinical manifestations of sickle cell disease. UpToDate Web site. Updated May 11, 2022(b). [www.uptodate.com](http://www.uptodate.com). Accessed May 30, 2024.

# Background

- Vaso-occlusive phenomena (eg, vaso-occlusive crises [VOCs] or vaso-occlusive events [VOEs]) and hemolysis are the major clinical features of SCD (Field & Vichinsky 2022).
- Vaso-occlusion results in recurrent pain episodes (also termed sickle cell crises [SCCs]) and various organ system complications that can lead to lifelong disabilities and death, including serious infection, acute chest syndrome (ACS), renal failure, hepatobiliary complications, anemia, cerebrovascular and cardiovascular events, priapism, ocular disorders, neuropathy, and splenic sequestration (Food and Drug Administration [FDA] Multidiscipline Review [OXBRYTA] 2018, Vichinsky 2022[b]).
- VOC pain episodes are the most frequent cause of recurrent morbidity in SCD and account for most SCD-related hospitalizations (FDA Multidiscipline Review [ADAKVEO] 2018).

## References

- Field JJ, Vichinsky EP. Overview of the management and prognosis of sickle cell disease. UpToDate Web site. Updated October 18, 2023. [www.uptodate.com](http://www.uptodate.com). Accessed May 30, 2024
- Food and Drug Administration. Multidiscipline Review: Adakveo. 2018. FDA Web site. [https://www.accessdata.fda.gov/drugsatfda\\_docs/nda/2019/761128Orig1s000MultidisciplineR.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/nda/2019/761128Orig1s000MultidisciplineR.pdf). Accessed May 30, 2024.
- Food and Drug Administration. Multidiscipline Review: Oxbryta. 2018. FDA Web site. [https://www.accessdata.fda.gov/drugsatfda\\_docs/nda/2019/213137Orig1s000Multidiscipline.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/nda/2019/213137Orig1s000Multidiscipline.pdf). Accessed May 30, 2024.
- Vichinsky EP. Overview of the clinical manifestations of sickle cell disease. UpToDate Web site. Updated May 11, 2022(b). [www.uptodate.com](http://www.uptodate.com). Accessed May 30, 2024.

# Background

- Treatment options for SCD are different for each patient and depend on the symptoms (Field & Vichinsky 2023). In addition to lifelong supportive care (eg, RBC transfusions, pain management strategies, vaccinations, antibiotic prophylaxis) or treatment during an acute VOC (eg, pain management with non-steroidal anti-inflammatories [NSAIDs] or opioids, intravenous (IV) fluids, supplemental oxygen), patients may be placed on disease-modifying agents (FDA Multidiscipline Review, 2018).
- Currently, hydroxyurea (Droxia®, Siklos®, Xromi®, or Hydrea®) is the only guideline-recommended agent for treatment of SCD and has been shown to reduce or prevent several complications (NIH 2014, NIH 2024). It is recommended that children and adults with HbSS or HbS  $\beta$ 0-thalassemia who have frequent painful episodes, recurrent chest crises, or severe anemia receive hydroxyurea daily.
- References
  - Food and Drug Administration. Multidiscipline Review: Oxbryta. 2018. FDA Web site. [https://www.accessdata.fda.gov/drugsatfda\\_docs/nda/2019/213137Orig1s000Multidiscipline.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/nda/2019/213137Orig1s000Multidiscipline.pdf). Accessed May 30, 2024.
  - Department of Health and Human Services. National Institutes of Health (NIH). National Heart, Lung, and Blood Institute. Evidence-based management of sickle cell disease. Expert panel report, 2014. [https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816\\_0.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf).
  - Accessed May 30, 2024.

# Background

- Endari (L-glutamine) received FDA approval in 2017, to reduce the acute complications of SCD in adult and pediatric patients  $\geq 5$  years of age (Drugs@FDA 2024).
- As of December 2023, the FDA approved 2 cell-based gene therapies for SCD, Casgevy® (exagamglogene autotemcel) and Lyfgenia® (lovotibeglogene autotemcel), in patients 12 years of and older with recurrent or history of VOCs/ VOEs (FDA web site 2023, NIH 2024).
- References
  - Food and Drug Administration (FDA). Casgevy approval letter. 2023. <https://www.fda.gov/vaccines-blood-biologics/casgevy>. Accessed January 20, 2024.
  - Food and Drug Administration (FDA). Lyfgenia summary basis for regulatory action. 2023. <https://www.fda.gov/vaccines-blood-biologics/lyfgenia>. Accessed January 10, 2024.
  - Food and Drug Administration News Release: FDA approves first gene therapies to treat patients with sickle cell disease. FDA Web site. Updated December 8, 2023. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-gene-therapies-treat-patients-sickle-cell-disease>. Accessed May 31, 2024.
  - Department of Health and Human Services (DHHS). National Institutes of Health (NIH). National Heart, Lung, and Blood Institute (NHLBI). Evidence-based management of sickle cell disease. Expert panel report, 2014. Web site. [https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816\\_0.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf). Accessed December 18, 2023.

# Key Arguments

- Hydroxyurea is the only guideline-recommended agent for treatment of SCD and has been shown to reduce or prevent several complications.
- A maximally tolerated dose of hydroxyurea can be used as a substitute for regular blood transfusions in children with SCD
- Many patients with SCD do not utilize hydroxyurea or are not compliant with therapy.

# Indications: Hydroxyurea products

| Indication                                                                                                                                                               | Droxia<br>(hydroxyurea) | Hydrea<br>(hydroxyurea) | Siklos<br>(hydroxyurea) | Xromi |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|-------------------------|-------|
| Treatment of resistant CML                                                                                                                                               |                         | ✓                       |                         |       |
| For the management of locally advanced squamous cell carcinomas of the head and neck (excluding lip cancer) in combination with chemoradiation therapy                   |                         | ✓                       |                         |       |
| Reduce frequency of painful crises and the need for blood transfusions in patients with SCA with recurrent moderate to severe painful crises in adults                   | ✓                       | ✓                       | ✓                       |       |
| Reduce frequency of painful crises and the need for blood transfusions in patients with SCA with recurrent moderate to severe painful crises in children and adolescents |                         | ✓                       | ✓                       | ✓     |

# Adverse Events/Contraindications: Hydroxyurea

- **Boxed Warnings/Key Warnings:**
  - **Boxed warning:** myelosuppression and malignancies in patients receiving long term treatment for myeloproliferative disorders (Droxia® and Siklos®)
  - hematological, gastrointestinal symptoms, and anorexia
  - infections and neutropenia in pediatric patients and headache and dry skin in adults (Siklos®)
- **Contraindications**
  - patients who are hypersensitive to any component of the product

# Indications: Endari

| Indication                                                                                     | Endari (L-glutamine oral powder) |
|------------------------------------------------------------------------------------------------|----------------------------------|
| To reduce the acute complications of SCD in adult and pediatric patients $\geq 5$ years of age | ✓                                |

# Adverse Events/Contraindications: L-glutamine

- Boxed Warnings/Key Warnings:
  - *Constipation, nausea, headache, abdominal pain, cough, pain in extremity, back pain, chest pain*
  - *hypersplenism, abdominal pain, dyspepsia, burning sensation, and hot flash*
- Contraindications:
  - N/A

## 2020 ASH guidelines on prevention, diagnosis, and treatment of cerebrovascular disease in children and adults with SCD

- Maximally tolerated dose of hydroxyurea can be used as a substitute for regular blood transfusions in children with SCD and in children with abnormal transcranial doppler (TCD) ultrasound results who have been receiving transfusions for at least 1 year and are interested in stopping transfusions (DeBaun et al 2020).
- Maximally tolerated hydroxyurea in children with HbSS, HbS $\beta$ 0-thalassemia, or compound heterozygous SCD with abnormal TCD ultrasound results who live in low to middle-income settings where regular blood transfusion and chelation therapy are not feasible.

### Reference(s):

- DeBaun MR, Jordan LC, King AA, et al. American Society of Hematology 2020 guidelines for sickle cell disease: prevention, diagnosis, and treatment of cerebrovascular disease in children and adults. Blood Adv. 2020;4(8):1554-1588. doi: 10.1182/bloodadvances.2019001142.

# PDL Placement

| Sickle Cell Disease |                |                         |            |
|---------------------|----------------|-------------------------|------------|
| Droxia®             | Hydroxyurea    | Endari® PA, QL          | Siklos® PA |
| Altace® QL          | Perindopril QL | L-glutamine pack PA, QL | Xromis® PA |

## Legend:

PA – Prior Authorization required, subject to specific PA criteria

QL – Quantity Limit (PA & NP agents require PA before dispensing)

## 2014 National Institutes of Health (NIH). National Heart, Lung, and Blood Institute (NHLBI). Evidence-based management of SCD

- The only proven disease-modifying therapies for SCD are hydroxyurea and chronic blood transfusions. Although neither has been shown to prevent all SCD-related organ damage, these treatment modalities can improve the QOL for individuals with SCD.
- Treatment with hydroxyurea is underutilized for many patients with SCD who could benefit from it.

### Reference(s):

- National Institutes of Health (NIH); Department of Health and Human Services. National Heart, Lung, and Blood Institute. Evidence-based management of sickle cell disease. Expert panel report, 2014. [https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816\\_0.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf). Accessed April 16, 2024.

## 2014 National Institutes of Health (NIH). National Heart, Lung, and Blood Institute (NHLBI). Evidence-based management of SCD (continued)

- Recommendations for the use of hydroxyurea are as follows:
  - Adults with SCA who have  $\geq 3$  moderate to severe SCCs in a 12-month period should receive hydroxyurea
  - Adults with SCA who have sickle cell-associated pain that interferes with daily activities and QOL should receive hydroxyurea
  - Adults with a history of severe and/or recurrent ACS should receive hydroxyurea
  - Adults with SCA who have severe symptomatic chronic anemia that interferes with daily activities and QOL should receive hydroxyurea
  - For infants  $\geq 9$  months of age, children, and adolescents, treatment with hydroxyurea should be offered regardless of clinical severity to reduce SCD-related complications

### Reference(s):

- National Institutes of Health (NIH); Department of Health and Human Services. National Heart, Lung, and Blood Institute. Evidence-based management of sickle cell disease. Expert panel report, 2014. [https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816\\_0.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf). Accessed April 16, 2024.

# Literature Findings

Indian J Hematol Blood Transfus. 2013 May 24;30(2):91–96. doi: 10.1007/s12288-013-0261-4

## **Hydroxyurea in Sickle Cell Disease: Drug Review**

Rohit Kumar Agrawal, Rakesh Kantilal Patel, Varsha shah, Lalit Nainiwal, Bhadra Trivedi

Author information Article notes Copyright and License information

PMCID: PMC4022916 PMID: 24839362

### Abstract

Hydroxyurea, a myelosuppressive agent, is the only effective drug proven to reduce the frequency of painful episodes. It raises the level of HbF and the haemoglobin level. It usually decreases the rate of painful episodes by 50 %. It was first tested in sickle cell disease in 1984. It also decreases the rate of ACS episodes and blood transfusions by ~50 % in adults. It was developed as an anticancer drug and has been used to treat myeloproliferative syndromes-leukemia, melanoma, and ovarian cancer. It was approved for use by FDA in adults. Side effects includes neutropenia, bone marrow suppression, elevation of hepatic enzymes, anorexia, nausea, vomiting and infertility.

Keywords: Hydroxyurea, HbF level, Neutropenia

# Claims Review

- **Review Design:**
  - Paid claims for hydroxyurea from September 2024–September 2025 were reviewed (**REPORT 1**).
    - 2,948 claims
  - Profiles for unique members on a hydroxyurea product from September 2024–September 2025 were reviewed (**REPORT 2**).
    - 444 unique members
  - Profiles for unique members with a diagnosis of SCD from September 2024–September 2025 were reviewed (**REPORT 2**).
    - 1,642 unique members
- **Results:**
  - Of the **1,642** unique members who had a diagnosis of SCD, **1,197 (73%)** were **not** on a hydroxyurea product from September 2024–September 2025.
  - **1,093 (66%) members out of 1642 members** who had a diagnosis of SCD have not been on a hydroxyurea product since January 2020.

# Why are members not taking hydroxyurea?

## Examining Intentional and Unintentional Barriers to Hydroxyurea Use in a Sickle Cell Population: A Qualitative Study

| Component of Adherence | Unintentional Barriers (69.9%)                                                                                                                                                                                                                                                      | Intentional Barriers (30.1%)                                                                                                                                                                                                                  |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Initiation             | There's a friend of mine. Well not of mine, my dad's friend, that takes it, and he had the negative side effects that I heard about happen to him. He wasn't the same after he took it, meaning appearance-wise. And so, it kind of scared me into not taking it.                   | Well, I don't really know what it is. I'm not sure if I've ever been offered to take it just as far as my medical history goes. I'm not sure if my mom or anything has ever been offered it, but as far as I know, I've never had to take it. |
| Implementation         | So just remembering to take my medicine, all my meds that I have is the barrier that I have with taking my meds.                                                                                                                                                                    | For a while I was taking it pretty consistently, now like I will attempt to take it when I feel like my sickle cell's kind of rearing its head a little bit, but I mostly don't take it.                                                      |
| Discontinuation        | But I will say that the hydroxyurea did help me as far as my crisis. It kept me from being in crisis more than I was prior to taking it. But the side effect of that was I developed leg ulcer, and that in itself was probably more detrimental than any crisis I've ever been in. | Honestly, I just didn't trust [hydroxyurea]. I can't touch the meds with my hands and I have to bypass my body, but it's being ingested into my body, that's something about that doesn't sound right, you know?                              |

### Additional Data:

- Participants: 90 interviewed
- Mean Age: 29.6 years ( $\pm$  8.2)
- Gender: 50% Female
- Hydroxyurea Status:
  - o Never taken: 12
  - o Taken: 78
- Taken in past: 26
- On hydroxyurea: 52

**Authors:** Jason R. Hodges, Shannon Phillips, Sarah Norell, Chinonyelum Nwosu, Hamda Khan, Lingzi Luo, Sherif M. Badawy, Allison King, Paula Tanabe, Marsha Treadwell, Lucia Rojas-Smith, Cecelia Calhoun, Jane S. Hankins, Jerlyn Porter

# Discussion Questions

- What is your perspective on hydroxyurea utilization in patients with SCD?
- What approaches would you recommend to make prescribers and patients aware of the benefits of hydroxyurea?
- Additional thoughts or comments?



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## **Adherence to ACE Inhibitors (ACEIs), Angiotensin II Receptor (ARBs) Blockers, or Angiotensin II Receptor/Neprilysin Inhibitors (ARNIs)**

Kimberly Barnes, PharmD

# Review

- Background/Disease State
- Indications/Adverse Events
- PDL Placement
- Guidelines/Literature Findings
- Retrospective review of TennCare Claims
  - Review Design
  - Findings
- Discussion and Board Recommendations

# Background: Heart Failure

- The estimated prevalence of heart failure (HF) is 6.7 million for Americans aged  $\geq 20$  years. Projections show that the prevalence of HF will increase by 46% from 2012 to 2030, resulting in  $> 8$  million people  $\geq 18$  years of age with HF (Martin et al 2025).
- The cardinal symptoms of HF are dyspnea and fatigue. HF leads to exercise intolerance, fluid retention, pulmonary congestion, and peripheral edema, often resulting in hospitalization (Heidenreich et al 2022).
- The forms of HF include
  - HF with reduced ejection fraction (HFrEF) or systolic HF: ejection fraction (EF)  $\leq 40\%$
  - HF with preserved ejection fraction (HFpEF) or diastolic HF: EF  $\geq 50\%$

## References:

- Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA guideline for the management of heart failure. J Am Coll Cardiol. 2022;79(17):e263-e421
- Martin SS, Aday AW, Allen NB, American Heart Association Council on Epidemiology and Prevention Statistics Committee and Stroke Statistics Committee, et al. 2025 Heart disease and stroke statistics: A report of US and global data from the American Heart Association. Circulation. 2025;151(8):e41-e660. doi: 10.1161/CIR.0000000000001303.

# Background: Heart Failure

- After establishing a diagnosis of HFrEF, guideline-directed medical therapy (GDMT) should be initiated, ACE-Is are a mainstay of treatment for patients with Stage C HFrEF and a New York Heart Association (NYHA) II-IV classification (Heidenreich et al 2022).
- ARBs are generally an alternative treatment to ACE-Is for patients with Stage C HFrEF and a New York Heart Association (NYHA) II to IV classification. ARBs are also a treatment option in patients with heart failure with preserved ejection fraction (HFpEF) (Kittleson et al 2023).
- Sacubitril/valsartan, the only approved angiotensin receptor-neprilysin inhibitor (ARNI), is recommended to reduce morbidity and mortality in patients with HFrEF and NYHA class II to III symptoms (Heidenreich et al 2022).

## References:

- Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA guideline for the management of heart failure. J Am Coll Cardiol. 2022;79(17):e263-e421.
- Kittleson M, Panjrath G, Amancherla K, et al. 2023 ACC expert consensus decision pathway on management of heart failure with preserved ejection fraction. J Am Coll Cardiol. 2023;81(18):1835-1878.

# Key Arguments

- Adherence to heart failure medications such as ACEIs, ARBs, or ARNIs are crucial to reducing heart failure complications which may lead to hospitalization.
- Non-adherence to heart failure medications lead to poor outcomes.
- Guidelines suggest that educational initiatives as well as incorporating the patient's perspective into treatment planning process is associated with improved adherence.

## Indications: ACE Inhibitors

[illegible]

# Adverse Events/Contraindications: ACE Inhibitors

- Boxed Warnings/Key Warnings:

- anaphylactoid reactions including head and neck angioedema and intestinal angioedema
- hypotension, hyperkalemia, and cholestatic jaundice and hepatic failure
- headache, dizziness, and cough
- electrolyte abnormalities and elevations of blood urea nitrogen (BUN) and creatinine.

- Contraindications

- angioedema or with a history of hereditary or idiopathic angioedema
- Concurrent use with a neprilysin inhibitor (eg, sacubitril)
- Concurrent use with aliskiren in patients with DM; the combination should also be avoided in patients with renal impairment (glomerular filtration rate [GFR] < 60 mL/min/1.73m<sup>2</sup>)

## Indication: Angiotensin II Receptor Blockers (ARBs)

| Indication                                                                                                                                  | Atacand<br>(candesartan) | Avapro<br>(irbesartan) | Benicar<br>(olmesartan) | Cozaar<br>(losartan) | Diovan<br>(valsartan) | Edarbi<br>(azilsartan) | Micardis<br>(telmisartan) |
|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------|-------------------------|----------------------|-----------------------|------------------------|---------------------------|
| Hypertension in adults                                                                                                                      | ✓                        | ✓                      | ✓                       | ✓                    | ✓                     | ✓                      | ✓                         |
| Hypertension in children ages 1 to < 17 years                                                                                               | ✓                        |                        |                         |                      | ✓                     |                        |                           |
| Hypertension in children ages 6 to 16 years                                                                                                 |                          |                        | ✓                       | ✓                    |                       |                        |                           |
| Treatment of diabetic nephropathy in hypertensive patients with type 2 DM, an elevated serum creatinine, and proteinuria                    |                          | ✓                      |                         | ✓                    |                       |                        |                           |
| HF (NYHA Class II to IV) in adults                                                                                                          | ✓                        |                        |                         |                      | ✓                     |                        |                           |
| Reduction in the risk of stroke in patients with hypertension and LV hypertrophy                                                            |                          |                        |                         | ✓                    |                       |                        |                           |
| Post-MI: Reduction of CV mortality in clinically stable patients with LV failure or LV dysfunction                                          |                          |                        |                         |                      | ✓                     |                        |                           |
| Cardiovascular risk reduction in patients 55 years of age or older at high risk of developing major CV events who are unable to take ACE-Is |                          |                        |                         |                      |                       |                        | ✓                         |
|                                                                                                                                             |                          |                        |                         |                      |                       |                        |                           |

# Adverse Events/Contraindications: ARBs

- Boxed Warnings/Key Warnings:
  - fetal toxicity, hypotension (especially in volume- or salt-depleted patients), impaired renal function,
  - hyperkalemia/electrolyte imbalances
- Contraindications
  - Concurrent use with aliskiren in patients with DM; the combination should also be avoided in patients with renal impairment (glomerular filtration rate [GFR] < 60 mL/min/1.73m<sup>2</sup>)

## Indication: ARB Combinations

| Drug                                     | Hypertension | Reduction in the Risk of CV Death and HF Hospitalization in Adults with Chronic HF | Reduction in the Risk of Stroke in Patients with Hypertension and LV Hypertrophy | Symptomatic HF in pediatric patients $\geq 1$ year |
|------------------------------------------|--------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------|
| Hyzaar<br>(losartan/hydrochlorothiazide) | ✓            | -                                                                                  | ✓                                                                                | -                                                  |
| ARB/Neprilysin inhibitor Combination     |              |                                                                                    |                                                                                  |                                                    |
| Entresto<br>(sacubitril/valsartan)       | -            | ✓                                                                                  | -                                                                                | ✓                                                  |

# Adverse Events/Contraindications: ARNIs

- Boxed Warnings/Key Warnings:

- angioedema, hypotension, a risk of decreased or impaired renal function in susceptible patients, and hyperkalemia

- Contraindications

- history of angioedema related to previous ACE-I or ARB therapy
- concomitant use with aliskiren in patients with diabetes, or ACE-Is in all patients
- Concomitant use within 36 hours of switching from or to an ACE-I

# PDL Placement: ACE Inhibitors

| Ace Inhibitors (AEIs) |                        |                                        |                                     |
|-----------------------|------------------------|----------------------------------------|-------------------------------------|
| Benazepril            | Lisinopril             | Accupril                               | Moexipril <sup>QL</sup>             |
| Enalapril             | Ramipril <sup>QL</sup> | Altace® <sup>QL</sup>                  | Perindopril <sup>QL</sup>           |
|                       |                        | Captopril <sup>PA ≤ 19 years</sup>     | Qbres® Soln <sup>PA ≤ 8 years</sup> |
|                       |                        | Epaned® <sup>PA ≤ 9 years</sup>        | Quinapril                           |
|                       |                        | Enalapril Susp <sup>PA ≤ 9 years</sup> | Trandolapril <sup>QL</sup>          |
|                       |                        | Fosinopril                             | Vastotec®                           |
|                       |                        | Lotensin®                              | Zestril®                            |

## Legend:

PA – Prior Authorization required, subject to specific PA criteria QL – Quantity

Limit (PA & NP agents require PA before dispensing)

# PDL Placement: ARBS

**Legend:**

PA – Prior Authorization required, subject to specific PA criteria

QL – Quantity Limit (PA & NP agents require PA before dispensing)

## Angiotensin II Receptor Blockers (ARBs)

|                                                 |                               |                                                  |                                  |
|-------------------------------------------------|-------------------------------|--------------------------------------------------|----------------------------------|
| Irbesartan <sup>QL</sup>                        | Olmesartan <sup>QL</sup>      | Atacand <sup>® QL</sup>                          | Diovan <sup>® QL</sup>           |
| Losartan <sup>QL</sup>                          | Valsartan <sup>QL</sup>       | Avapro <sup>® QL</sup>                           | Edarbi <sup>® QL</sup>           |
|                                                 |                               | Benicar <sup>® QL</sup>                          | Micardis <sup>® QL</sup>         |
|                                                 |                               | Candesartan <sup>QL</sup>                        | Telmisartan <sup>QL</sup>        |
|                                                 |                               | Cozaar <sup>QL</sup>                             | Valsartan Soln <sup>PA, QL</sup> |
| ARB + Diuretic                                  |                               |                                                  |                                  |
| Irbesartan/HCTZ <sup>QL</sup>                   | Olmesartan/HCTZ <sup>QL</sup> | Atacand HCT <sup>® QL</sup>                      | Edarbyclor <sup>® QL</sup>       |
| Losartan/HCTZ <sup>QL</sup>                     | Valsartan/HCTZ <sup>QL</sup>  | Avalide <sup>® QL</sup>                          | Hyzaar <sup>® QL</sup>           |
|                                                 |                               | Benicar HCT <sup>® QL</sup>                      | Micardis HCT <sup>® QL</sup>     |
|                                                 |                               | Candesartan/HCTZ <sup>QL</sup>                   | Telmisartan/HCTZ <sup>QL</sup>   |
|                                                 |                               | Diovan HCT <sup>® QL</sup>                       |                                  |
| ARB + Nephilysin Inhibitor <sup>PA, QL</sup>    |                               |                                                  |                                  |
| Entresto <sup>® tablets</sup> <sup>PA, QL</sup> |                               | Entesto <sup>® sprinkles</sup> <sup>PA, QL</sup> |                                  |

## 2024 ACC Expert Consensus Decision Pathway for HFrEF

- Pharmacological therapies used for chronic HFrEF include renin-angiotensin inhibitors such as angiotensin II receptor/neprilysin inhibitors (ARNIs), angiotensin-converting enzyme (ACE) inhibitors, and angiotensin receptor blockers (ARBs), as well as evidence-based beta-blockers, sodium-glucose cotransporter (SGLT-2) inhibitors, mineralocorticoid antagonists, loop diuretic agents, hydralazine/isosorbide dinitrate (HYD/ISDN), ivabradine, and vericiguat.
- Nonadherence among patients with HFrEF can range from 20% to 50%, with some difference by drug. Nonadherence is correlated to poor outcomes in HF.

### Reference(s):

- Maddox TM, Januzzi JL, Allen LA. 2024 ACC expert consensus decision pathway for treatment of heart failure with reduced ejection fraction: a report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2024;83(15):1444-1488. doi: 10.1016/j.jacc.2023.12.024.

# 2024 ACC Expert Consensus Decision Pathway for HFrEF

- The main reasons for patient nonadherence is perceived lack of efficacy, lack of educational health, physical or mental disability, seclusion, and cognitive decline.
- Strategies to improve adherence include:
  - ensure that the patient has a simple medication treatment regimen
  - incorporate the patient's perspective into the treatment plan
  - educate patients on the importance of adherence prior to symptom decline
  - address barriers to treatment (e.g., access, cost)
  - implement an interdisciplinary team approach
  - recommend pill boxes, alarms, and smartphone reminder alerts

## Reference(s):

- Maddox TM, Januzzi JL, Allen LA. 2024 ACC expert consensus decision pathway for treatment of heart failure with reduced ejection fraction: a report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2024;83(15):1444-1488. doi: 10.1016/j.jacc.2023.12.024.

# Literature

Meta-Analysis J Am Heart Assoc. 2016 Jun 17;5(6):e002606. doi: 10.1161/JAHA.115.002606.

## **Medication Adherence Interventions Improve Heart Failure Mortality and Readmission Rates: Systematic Review and Meta-Analysis of Controlled Trials**

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Affiliations Expand

PMID: 27317347 PMCID: PMC4937243 DOI: 10.1161/JAHA.115.002606

### **Abstract**

Background: Poor adherence to medications is a common problem among heart failure (HF) patients. Inadequate adherence leads to increased HF exacerbations, reduced physical function, and higher risk for hospital admission and death. Many interventions have been tested to improve adherence to HF medications, but the overall impact of such interventions on readmissions and mortality is unknown.

### **Methods and results:**

We conducted a comprehensive search and systematic review of intervention studies testing interventions to improve adherence to HF medications. Mortality and readmission outcome effect sizes (ESs) were calculated from the reported data. ESs were combined using random-effects model meta-analysis methods, because differences in true between-study effects were expected from variation in study populations and interventions. ES differences attributed to study design, sample, and intervention characteristics were assessed using moderator analyses when sufficient data were available. We assessed publication bias using funnel plots. Comprehensive searches yielded 6665 individual citations, which ultimately yielded 57 eligible studies. Overall, medication adherence interventions were found to significantly reduce mortality risk among HF patients (relative risk, 0.89; 95% CI, 0.81, 0.99), and decrease the odds for hospital readmission (odds ratio, 0.79; 95% CI, 0.71, 0.89). Heterogeneity was low. Moderator analyses did not detect differences in ES from common sources of potential study bias.

**Conclusions:** Interventions to improve medication adherence among HF patients have significant effects on reducing readmissions and decreasing mortality. Medication adherence should be addressed in regular follow-up visits with HF patients, and interventions to improve adherence should be a key part of HF self-care programs.

Keywords: heart failure; hospitalization; intervention; medication adherence; meta - analysis; mortality; readmission; systematic review.

# Claims Review (Design)

- Review Design:
  - Paid claims for ACEIs, ARBs, and ARNIs from Sept 2024 – Sept 2025 were reviewed (**REPORT 1**).
    - 301,252 paid claims
  - Profiles for unique members on ACEIs, ARBs, and ARNIs from Sept 2024 – Sept 2025 were reviewed (**REPORT 2**).
    - 47,164 unique members
  - Profiles for unique members with a diagnosis of HF from Sept 2024 – Sept 2025 were reviewed (**REPORT 3**).
    - 17,621 unique members
- Results:
  - **2,983 (16.9%) out of 17,621** unique members with a diagnosis of heart failure who were on ACEIs, ARBs, and ARNIs from Sept 2024 – Sept 2025 were nonadherent to their heart failure medication

# Discussion

- What strategies would you recommend to improve adherence to heart failure medications?
- Should TennCare incorporate a letter campaign to notify prescribers?
- What other actions would you recommend?
- Additional thoughts or comments?



TM

# Opioid Use Among Members with a History of Opioid Overdose

Kimberly Barnes, PharmD

# Review

- Background/Disease State
- Indications/Adverse Events
- PDL Placement
- Guidelines/Literature Findings
- Retrospective review of TennCare Claims
  - Review Design
  - Findings
- Discussion and Board Recommendations

# Background: Opioids

- It is estimated that approximately 20.4% of adults in the United States have chronic pain with a prevalence of 7.4% who have high-impact chronic pain (i.e., pain that limits life or work activities on most days) (Zelaya et al 2019).
- Pain is one of the most common and debilitating patient complaints, with persistent pain having the potential to lead to functional impairment such as disability, psychological distress, and sleep deprivation (Cohen et al 2024).
- Pain can be acute or chronic:
  - Acute pain (defined as duration of < 1 month) is usually sudden in onset and often results from injury or inflammation (e.g., surgery) or trauma.
  - In contrast, chronic pain, often defined as pain persisting for > 3 months. (Centers for Disease Control and Prevention [CDC] 2024, Cohen et al 2024, Dowell 2022).

## Reference(s):

- Centers for Disease Control (CDC). Opioid therapy and different types of pain. CDC Web Site. <https://www.cdc.gov/overdose-prevention/manage-treat-pain/index.html>. Updated May 8, 2024. Accessed September 25, 2024.
- Cohen SP. Chapter 26. Pain. In: Goldman L, Cooney KA. eds. Goldman-Cecil Medicine, 27e. Philadelphia, PA: Elsevier, Inc.; 2024. Available by subscription at: [www.clinicalkey.com](http://www.clinicalkey.com). Accessed August 5, 2024.
- Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2022. MMWR Recomm Rep. 2022;71(3):1-95.
- Zelaya C, Dahlhamer J, Lucas J, Connor EM. Chronic pain and high-impact chronic pain among US adults, 2019. NCHS Data Brief. 2020;(390): 1-8. <https://www.cdc.gov/nchs/products/databriefs/db390.htm>. Accessed August 5, 2024.

# Background: Opioids

- Opioids have been the mainstay of pain treatment for several years, and there is well-documented evidence of their effectiveness (Cohen et al 2024).
- Opioids primarily produce intense analgesia via their full and partial agonist actions at mu receptors, which are found in large numbers within the CNS (Cohen et al 2024, Micromedex 2025).
- Due to the rise of opioid use disorder (OUD) and opioid overdose, opioids should be reserved for pain (acute and chronic pain) if benefits are expected to outweigh the risks, and the patient is aware of the risks before starting or continuing therapy. Clinicians are advised to maximize the use of non-pharmacological and non-opioid treatment (Dowell et al 2022).

## Reference(s):

- Cohen SP. Chapter 26. Pain. In: Goldman L, Cooney KA. eds. Goldman-Cecil Medicine, 27e. Philadelphia, PA: Elsevier, Inc.; 2024. Available by subscription at: [www.clinicalkey.com](http://www.clinicalkey.com). Accessed August 5, 2024.
- Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2022. MMWR Recomm Rep. 2022;71(3):1-95.
- Micromedex Solutions Web site. 2025. Accessed February 11, 2025. <http://www.micromedexsolutions.com/home/dispatch>.

# Background: Opioid Overdose

- Opioid overdose continues to be a major public health problem in the United States (U.S.).
- It has contributed significantly to accidental deaths among those who use or abuse illicit and prescription opioids.
- Overdose deaths involving opioids accounted for more than 75% of the nearly 105,000 drug overdose deaths in 2023 (CDC 2025).
- In general, the risk of overdose with prescription opioids increases with increasing opioid doses (FDA Drug Safety Communication 2023).

## Reference(s):

- Centers for Disease Control and Prevention (CDC). Understanding the opioid overdose epidemic. Updated June 9, 2025. Accessed July,14, 2025. <https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html>.
- FDA Drug Safety Communication: FDA updates prescribing information for all opioid pain medicines to provide additional guidance for safe use. US Food & Drug Administration. Updated April 13, 2023. Accessed July 14, 2025. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-prescribing-information-all-opioid-pain-medicines-provide-additional-guidance-safe-use>.

# Background: Opioid Overdose

- Death following opioid overdose can be averted by emergency basic life support and/or the timely administration of an opioid antagonist such as naloxone or nalmefene.
- Naloxone and nalmefene are narcotic antagonists that displace opioids from receptor sites in the brain and reverse respiratory depression, which is usually the cause of overdose deaths (SAMHSA 2025], World Health Organization [WHO] 2014).

## Reference(s):

- SAMSCA Overdose Prevention and Response Toolkit. Substance Abuse and Mental Health Services Administration Web site. July 2025. Accessed July 14, 2025. <https://store.samhsa.gov/product/overdose-prevention-response-toolkit/pep23-03-00-001>.
- World Health Organization: Community management of opioid overdose. World Health Organization Web site. Updated November 2, 2014. Accessed July 15, 2025. <https://www.who.int/publications/i/item/9789241548816>.

# Key Arguments

- There has been a rise in deaths due to opioid overdose, and it continues to be a major health issue in the U.S.
- Opioid overdose accounted for over 75% of overdose deaths in 2023.
- The risk of opioid overdose increases in patients who are consistently taking higher opioid doses.

# Indications: Long-Acting Opioids

| Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                      | buprenorphine | fentanyl | hydrocodone | hydromorphone | levorphanol | methadone | morphine | oxycodone | oxymorphone |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------|-------------|---------------|-------------|-----------|----------|-----------|-------------|
| Management of severe and persistent pain that requires an extended treatment period with a daily opioid analgesic and for which alternative treatment options are inadequate in adults                                                                                                                                                                                                                                                                           | ✓             |          | ✓           |               |             | ✓         | ✓        | ✓         | ✓           |
| Management of severe and persistent pain that requires an extended treatment period with a daily opioid analgesic and for which alternative treatment options are inadequate in opioid-tolerant pediatric patients ≥ 11 years of age who are already receiving and tolerate a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent                                                                                                     |               |          |             |               |             |           |          | ✓         |             |
| Management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate                                                                                                                                                                                                                                                                                                                                              |               |          |             |               | ✓           |           |          |           |             |
| Management of severe and persistent pain in opioid-tolerant patients that requires an extended-treatment period with a daily opioid analgesic in opioid-tolerant patients, and for which alternative treatment options are inadequate                                                                                                                                                                                                                            |               | ✓        |             | ✓             |             |           |          |           |             |
| Management of neuropathic pain associated with diabetic peripheral neuropathy (DPN) in adults severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate                                                                                                                                                                                                                            |               |          |             |               |             |           |          |           |             |
| Detoxification treatment of opioid addiction (heroin or other morphine-like drugs)                                                                                                                                                                                                                                                                                                                                                                               |               |          |             |               |             | ✓         |          |           |             |
| Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with social and medical services                                                                                                                                                                                                                                                                                                                                 |               |          |             |               |             | ✓         |          |           |             |
| <b>Limitations of Use:</b> Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with ER opioid formulations, reserve this agent for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. | ✓             | ✓        | ✓           | ✓             | ✓           | ✓         | ✓        | ✓         | ✓           |
| Limitations of Use: Not indicated as an as-needed (prn) analgesic.                                                                                                                                                                                                                                                                                                                                                                                               | ✓             | ✓        | ✓           | ✓             |             | ✓         | ✓        | ✓         | ✓           |

# Adverse Events/Contraindications: Long-Acting Opioids

- Common Adverse Events:

- **Boxed warnings:** potential for abuse and misuse; life-threatening respiratory depression; neonatal opioid withdrawal syndrome; accidental ingestion; increase in CNS risks with the concomitant use of benzodiazepines, alcohol, or other CNS depressants, life-threatening QT prolongation (methadone)
- nausea, vomiting, constipation, and somnolence

- Contraindications

- acute or severe bronchial asthma, significant respiratory depression, and known or suspected paralytic ileus

## Indications: Short-Acting Opioids

| Indication                                                                                                                            | butorphanol | codeine | hydromorphone | meperidine | morphine               | nalbuphine | oxycodone              | oxymorphone |
|---------------------------------------------------------------------------------------------------------------------------------------|-------------|---------|---------------|------------|------------------------|------------|------------------------|-------------|
| Management of mild to moderate pain where treatment with an opioid is appropriate and for which alternative treatments are inadequate |             | ✓       |               |            |                        |            |                        |             |
| Management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate                   | ✓           |         | ✓             | ✓          | ✓                      | ✓          | ✓                      | ✓           |
| Supplement to balanced anesthesia                                                                                                     |             |         |               |            |                        | ✓          |                        |             |
| Preoperative and postoperative analgesia                                                                                              |             |         |               |            |                        | ✓          |                        |             |
| Obstetrical analgesia during labor and delivery                                                                                       |             |         |               |            |                        | ✓          |                        |             |
| Relief of acute and chronic pain in opioid-tolerant adult patients                                                                    |             |         |               |            | ✓ (oral solution only) |            | ✓ (oral solution only) |             |

# Adverse Events/Contraindications: Short-Acting Opioids

- Common Adverse Events:

- **Boxed warnings:** potential for abuse and misuse; life-threatening respiratory depression; neonatal opioid withdrawal syndrome; accidental ingestion; increase in CNS risks with the concomitant use of benzodiazepines, alcohol, or other CNS depressants,
- light-headedness, dizziness, sedation, nausea

- Contraindications

- acute or severe bronchial asthma, significant respiratory depression, and known or suspected paralytic ileus

# PDL Placement

| Narcotics, Long-Acting                                  |                                                        |                                    |
|---------------------------------------------------------|--------------------------------------------------------|------------------------------------|
| Fentanyl patch 12, 25, 50, 75, 100mcg <sup>PA, QL</sup> | Belbuca® <sup>PA, QL</sup>                             | Methadone <sup>PA, QL</sup>        |
| Morphine ER tabs <sup>PA, QL</sup>                      | Buprenorphine patch <sup>PA, QL</sup>                  | Methadose® <sup>PA, QL</sup>       |
| Tramadol ER <sup>PA, QL</sup>                           | Butrans® <sup>PA, QL</sup>                             | Morphine ER caps <sup>PA, QL</sup> |
|                                                         | ConZip® <sup>PA, QL</sup>                              | MS Contin® <sup>PA, QL</sup>       |
|                                                         | Fentanyl patch 37.5, 62.5, & 87.5mcg <sup>PA, QL</sup> | Oxycodone ER <sup>PA, QL</sup>     |
|                                                         | Hydrocodone ER <sup>PA, QL</sup>                       | OxyContin® <sup>PA, QL</sup>       |
|                                                         | Hydromorphone ER <sup>PA, QL</sup>                     | Oxymorphone ER <sup>PA, QL</sup>   |
|                                                         | Hysingla® ER <sup>PA, QL</sup>                         |                                    |

## Legend:

**PA – Prior Authorization required, subject to specific PA criteria**

**QL – Quantity Limit (PA & NP agents require PA before dispensing)**

# PDL Placement

| Narcotics, Short-Acting                   |                                            |                                                |                                          |
|-------------------------------------------|--------------------------------------------|------------------------------------------------|------------------------------------------|
| codeine/APAP <sup>PA ≤ 18 years, QL</sup> | oxycodone/APAP 325 mg <sup>QL</sup>        | Apadaz® <sup>QL</sup>                          | morphine suppositories <sup>PA, QL</sup> |
| Endocet® <sup>QL</sup>                    | Oxycodone conc <sup>PA, QL</sup>           | benzhydrocodone/APAP <sup>PA, QL</sup>         | Nalocet® <sup>PA, QL</sup>               |
| hydrocodone/APAP 325 mg <sup>QL</sup>     | oxycodone tabs <sup>QL</sup>               | butalbital/APAP/caff/codeine <sup>PA, QL</sup> | Oxaydo® <sup>PA, QL</sup>                |
| hydrocodone/ibuprofen <sup>QL</sup>       | oxycodone soln <sup>QL</sup>               | butalbital/ASA/caff/codeine <sup>PA, QL</sup>  | oxycodone/ApAp 300 mg <sup>QL</sup>      |
| hydromorphone tabs <sup>QL</sup>          | tramadol <sup>PA ≤ 18 years, QL</sup>      | codeine <sup>PA, QL</sup>                      | oxycodone caps <sup>PA, QL</sup>         |
| morphine IR tabs <sup>QL</sup>            | tramadol/APAP <sup>PA ≤ 18 years, QL</sup> | dihydrocodeine/APAP/cafeine <sup>PA, QL</sup>  | oxymorphone <sup>PA, QL</sup>            |
| morphine soln <sup>PA, QL</sup>           |                                            | Dilaudid® <sup>PA, QL</sup>                    | Percocet® <sup>PA, QL</sup>              |
|                                           |                                            | Fioricet with codeine <sup>PA, QL</sup>        | Prolate® <sup>PA, QL</sup>               |
|                                           |                                            | hydrocodone/APAP 300 mg <sup>PA, QL</sup>      | Qdolo® <sup>PA, QL</sup>                 |
|                                           |                                            | hydromorphone liquid <sup>PA, QL</sup>         | Roxicodone® <sup>PA, QL</sup>            |
|                                           |                                            | hydromorphone suppositories <sup>PA</sup>      | ROxybond® <sup>PA, QL</sup>              |
|                                           |                                            | levorphanol <sup>PA, QL</sup>                  | Seglantis® <sup>PA, QL</sup>             |
|                                           |                                            | Lortab® <sup>PA, QL</sup>                      | Ultracet® <sup>PA, QL</sup>              |
|                                           |                                            | meperidine <sup>PA, QL</sup>                   |                                          |

Legend:

PA – Prior Authorization required, subject to specific PA criteria

QL – Quantity Limit (PA & NP agents require PA before dispensing)

## 2022 Centers for Disease Control (CDC): Clinical Practice Guideline for Prescribing Opioids for Pain

- Clinicians should use PDMP data and toxicology screening as appropriate to assess for concurrent substance use that might place patients at higher risk for opioid use disorder and overdose.
- Clinicians should provide specific counseling on increased risks for overdose when opioids are combined with other drugs or alcohol and ensure that patients are provided or receive effective treatment for substance use disorders when needed.

### Reference(s):

- Centers for Disease Control (CDC). Opioid therapy and different types of pain. CDC Web Site. <https://www.cdc.gov/overdose-prevention/manage-treat-pain/index.html>. Updated May 8, 2024. Accessed September 27, 2024.

# 2022 CDC Clinical practice guideline for prescribing opioids for pain

- Strategies proposed to reduce opioid overdose and subsequent mortality include treatment of opioid use disorder with opioid agonist therapies (and possibly other medications), the provision of naloxone to lay persons (including co-prescribing in patients at high risk for overdose), and increased caution in opioid prescribing for pain management (Coffin 2025, Dowell 2022).

## Reference(s):

- Coffin PO, Behar E, Rowe C, et al. Nonrandomized intervention study of naloxone coprescription for primary care patients receiving long-term opioid therapy for pain. *Ann Intern Med.* 2016;165(4):245-252.
- Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical practice guideline for prescribing opioids for pain - United States, 2022. *MMWR Recomm Rep.* 2022;71(3):1-95.

# 2022 U.S. Department of Health & Human Services (DHHS)

- Recommends prescribing or co-prescribing naloxone to all patients who are at risk for opioid overdose, including:
  - patients receiving opioids at a dosage of 50 milligram morphine equivalents (MME) per day or greater;
  - patients with respiratory conditions who are prescribed opioids;
  - patients who have been prescribed benzodiazepines along with opioids;
  - patients prescribed opioids who have a non-opioid substance use disorder, report excessive alcohol use, or have a mental health disorder (U.S. DHHS 2018, U.S. DHHS 2022).

## Reference(s):

- US Department of Health & Human Services (HHS). Naloxone: the opioid reversal drug that saves lives. December 2018. Accessed July 14, 2025. <https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf>.
- US Department of Health & Human Services (HHS). U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose. April 2022. <https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-naloxone/index.html>

# Literature

Ann Intern Med. Author manuscript; available in PMC: 2010 Dec 10.  
Published in final edited form as: Ann Intern Med. 2010 Jan 19;152(2):85–92. doi:  
10.1059/0003-4819-152-2-201001190-00006

PMCID: PMC3000551 EMSID: UKMS32216 PMID: 20083827

## Abstract

### Background

Chronic opioid therapy for chronic non-cancer pain (CNCP) is increasingly common in community practice. Concomitant with this practice change, rates of fatal opioid overdose have increased. It is not known to what extent overdose risks are elevated among patients receiving medically prescribed chronic opioid therapy.

# Literature

## Objective

To estimate rates of opioid overdose and their association with average prescribed daily opioid dose among patients receiving medically prescribed chronic opioid therapy.

## Design

Cox proportional hazards models were used to estimate overdose risk as a function of average daily opioid dose (morphine equivalents) received at time of overdose.

## Setting

Health maintenance organization.

## Patients

Individuals (n=9940) who received 3+ opioid prescriptions within 90-days for CNCP between 1997 and 2005.

## Measurements

Average daily opioid dose over the previous 90 days from automated pharmacy data.

Primary outcomes, non-fatal and fatal overdoses, were identified through diagnostic codes from inpatient and outpatient care and death certificates and confirmed by medical record review.

# Literature

## Results

Fifty-one opioid-related overdoses were identified, including six deaths. Compared to patients receiving 1-20mg of opioids per day (0.2% annual overdose rate), patients receiving 50-99 mg had a 3.7 fold increase in overdose risk (95% C.I. 1.5, 9.5) and a 0.7% annual overdose rate. Patients receiving 100mg or more per day had an 8.9 fold increase in overdose risk (95% C.I. 4.0, 19.7) and a 1.8% annual overdose rate.

## Limitations

Increased overdose risk among patients on higher dose regimens may be due to confounding by patient differences and by use of opioids in ways not intended by prescribing physicians. The small number of overdoses in the study cohort is also a limitation.

## Conclusions

Patients receiving higher doses of prescribed opioids are at increased risk of opioid overdose, underscoring the need for close supervision of these patients.

# Claims Review (Design)

- Review Design:
  - Paid claims for opioids (18 years and over) from March 2025 – September 2025 were reviewed (**REPORT 1**).
    - 65,501 paid claims
  - Profiles of unique members (18 years and over) with a history of opioid overdose March 2025 – September 2025 were reviewed (**REPORT 2**).
    - 1,575 unique members
  - Profiles of unique members (18 years and over) who were chronic or extended opioid users from March 2025 – September 2025 were reviewed (**REPORT 3**).
    - 3,970 unique members
- Results:
  - **414 (26.2%) out of 1,575** members who had a history of opioid overdose and were chronic or extended opioid users
  - **298 (72%) out of 414** members who had a history of opioid overdose and on opioids but **not** on naloxone or nalmefene within the last year

# Discussion

- What strategies would you incorporate to notify prescribers of their members who have a history of opioid overdose and still on chronic opioids?
- Should TennCare incorporate a **letter campaign and/or an edit** to notify prescribers?
- What other actions would you recommend?
- Additional thoughts or comments?



**Standing Business**



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# Population Statistics

# TennCare Population

| Eligibility                                                 | Q3 25     | Q2 25     | Q3 24     | % Change<br>(Period/<br>Period) | % Change<br>(Year/Year) |
|-------------------------------------------------------------|-----------|-----------|-----------|---------------------------------|-------------------------|
| Avg Total TennCare Population                               | 1,388,558 | 1,391,822 | 1,407,787 | -0.2%                           | -1.4%                   |
| Non-Dual Children                                           | 868,265   | 868,741   | 1,004,252 | -0.1%                           | -0.3%                   |
| Non-Dual Adults with Rx Limit                               | 364,835   | 366,831   | 376,333   | -0.5%                           | -3.1%                   |
| Non-Dual Adults without Rx Limit                            | 8,548     | 8,528     | 8,642     | 0.2%                            | -1.1%                   |
| Dual Eligible Children                                      | 409       | 701       | 637       | -41.7%                          | -35.8%                  |
| Dual Eligible Adults                                        | 146,956   | 147,500   | 151,601   | -0.4%                           | -3.1%                   |
| Avg Pharmacy Utilizing Members<br>per Month < 21 (Children) | 181,584   | 180,115   | 179,302   | 0.8%                            | 0.5%                    |
| Avg Pharmacy Utilizing Members<br>per Month ≥ 21 (Adults)   | 158,639   | 159,445   | 165,195   | -0.5%                           | -3.5%                   |

# TennCare Utilizing Members

| Utilization                           | Q3 25         | Q2 25         | Q3 24         | %Change<br>(Period/<br>Period) | %Change<br>(Year/<br>Year) |
|---------------------------------------|---------------|---------------|---------------|--------------------------------|----------------------------|
| # Utilizing Members / Month           | 340,162       | 339,503       | 344,426       | 0.4%                           | -12.5%                     |
| # Prescriptions / Month               | 985,869       | 979,511       | 1,009,087     | 0.9%                           | -9.9%                      |
| Total Amount Paid / Month             | \$148,211,159 | \$141,627,412 | \$133,448,146 | 1.4%                           | -7.5%                      |
| Avg # of Rx / Utilizing Member/ Month | 2.90          | 2.89          | 2.93          | 0.3%                           | 3.2%                       |
| Avg Amount Paid / Claim               | \$150.34      | \$144.70      | \$132.37      | 0.5%                           | 2.6%                       |
| Avg Amount Paid / Utilizing Member    | \$435.88      | \$417.70      | \$388.69      | 1.2%                           | 5.9%                       |
| Avg Amount Paid / Eligible Member     | \$106.74      | \$101.76      | \$94.79       | 2.7%                           | 12.4%                      |

The logo consists of a red square with the letters 'TN' in white, serif font. Below the red square is a thin dark blue horizontal bar.

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# Utilization Data

Total Population

# Top 10 Therapeutic Classes by Claim Volume

| Rank | Therapeutic Class              | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|--------------------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 1    | Antidepressants                | 245,764           | 1          | 243,899           | 1          | 247,180           | 0.8%        | -0.6%       |
| 2    | ADHD & Narcolepsy Medications  | 153,127           | 2          | 146,177           | 3          | 143,964           | 4.8%        | 6.4%        |
| 3    | 2nd Generation Anticonvulsants | 143,530           | 3          | 142,443           | 2          | 145,274           | 0.8%        | -1.2%       |
| 4    | Atypical Antipsychotics        | 103,887           | 5          | 102,908           | 5          | 103,860           | 1.0%        | 0.0%        |
| 5    | Penicillins                    | 94,819            | 4          | 103,759           | 4          | 111,155           | -8.6%       | -14.7%      |
| 6    | Antihistamines                 | 88,197            | 6          | 96,757            | 7          | 93,375            | -8.8%       | -5.5%       |
| 7    | Anti-Anxiety                   | 88,136            | 7          | 85,624            | 9          | 84,157            | 2.9%        | 4.7%        |
| 8    | Inhaled Bronchodilators        | 85,261            | 8          | 85,170            | 6          | 95,459            | 0.1%        | -10.7%      |
| 9    | NSAIDs                         | 84,818            | 9          | 82,072            | 8          | 86,748            | 3.3%        | -2.2%       |
| 10   | Proton Pump Inhibitors         | 71,081            | 10         | 70,252            | 10         | 71,812            | 1.2%        | -1.0%       |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year



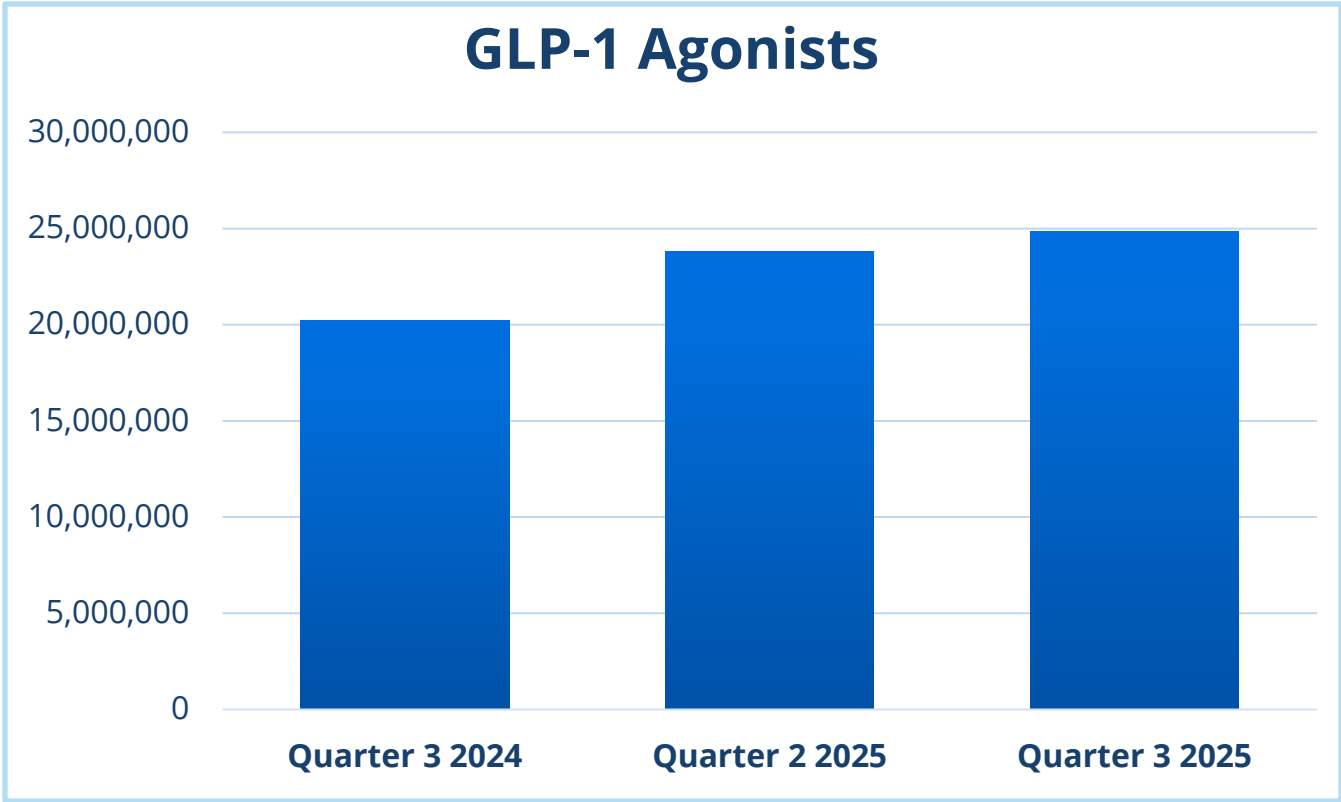
# Top 10 Therapeutic Classes by Payment Amount

| Rank | Therapeutic Class              | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|--------------------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 1    | Chronic Inflammatory Disease   | \$71,915,206  | 1          | \$65,761,925  | 1          | \$61,189,662  | 9.4%        | 17.5%       |
| 2    | Atypical Antipsychotics        | \$36,926,104  | 2          | \$36,500,200  | 2          | \$35,332,484  | 1.2%        | 4.5%        |
| 3    | ADHD & Narcolepsy Medications  | \$25,960,661  | 3          | \$24,999,363  | 3          | \$24,982,654  | 3.8%        | 3.9%        |
| 4    | GLP-1 Agonists                 | \$24,837,739  | 4          | \$23,798,727  | 4          | \$20,222,695  | 4.4%        | 22.8%       |
| 5    | Oncology                       | \$21,605,521  | 5          | \$20,292,188  | 5          | \$18,787,263  | 6.5%        | 15.0%       |
| 6    | 2nd Generation Anticonvulsants | \$18,040,247  | 6          | \$16,811,543  | 6          | \$16,303,921  | 7.3%        | 10.6%       |
| 7    | Cystic Fibrosis                | \$15,654,489  | 7          | \$13,845,707  | 7          | \$14,313,237  | 13.1%       | 9.4%        |
| 8    | HIV-Multiclass Combo           | \$12,280,128  | 8          | \$12,015,718  | 8          | \$12,169,557  | 2.2%        | 0.9%        |
| 9    | Migraine                       | \$11,366,457  | 9          | \$10,711,506  | 10         | \$9,524,649   | 6.1%        | 19.3%       |
| 10   | SGLT-2 Inhibitors & Combos     | \$10,345,051  | 10         | \$10,100,379  | 9          | \$9,575,179   | 2.4%        | 8.0%        |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year



# Top 10 Therapeutic Classes by Payment Amount



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 4    | GLP-1 Agonists    | \$24,837,739  | 4          | \$23,798,727  | 4          | \$20,222,695  | 4.4%        | 22.8%       |

# Top 10 Drugs by Claim Volume

| Rank | Drug                   | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|------------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 1    | Albuterol Sulfate      | 79,988            | 1          | 79,941            | 1          | 88,725            | 0.1%        | -9.8%       |
| 2    | Diapers and Supplies   | 63,899            | 4          | 58,003            | 29         | 26,918            | 10.2%       | 137.4%      |
| 3    | Amoxicillin            | 61,740            | 2          | 68,294            | 2          | 74,198            | -9.6%       | -16.8%      |
| 4    | Cetirizine             | 56,422            | 3          | 63,685            | 3          | 59,219            | -11.4%      | -4.7%       |
| 5    | Buprenorphine-Naloxone | 47,728            | 5          | 47,524            | 5          | 47,608            | 0.4%        | 0.3%        |
| 6    | Gabapentin             | 44,534            | 7          | 45,528            | 6          | 47,247            | -2.2%       | -5.7%       |
| 7    | Sertraline             | 42,523            | 8          | 42,510            | 8          | 42,541            | 0.0%        | 0.0%        |
| 8    | Fluticasone Propionate | 41,922            | 6          | 45,755            | 7          | 44,978            | -8.4%       | -6.8%       |
| 9    | Ibuprofen              | 41,280            | 9          | 39,853            | 9          | 41,352            | 3.6%        | -0.2%       |
| 10   | Hydroxyzine            | 37,405            | 10         | 36,021            | 13         | 35,042            | 3.8%        | 6.7%        |

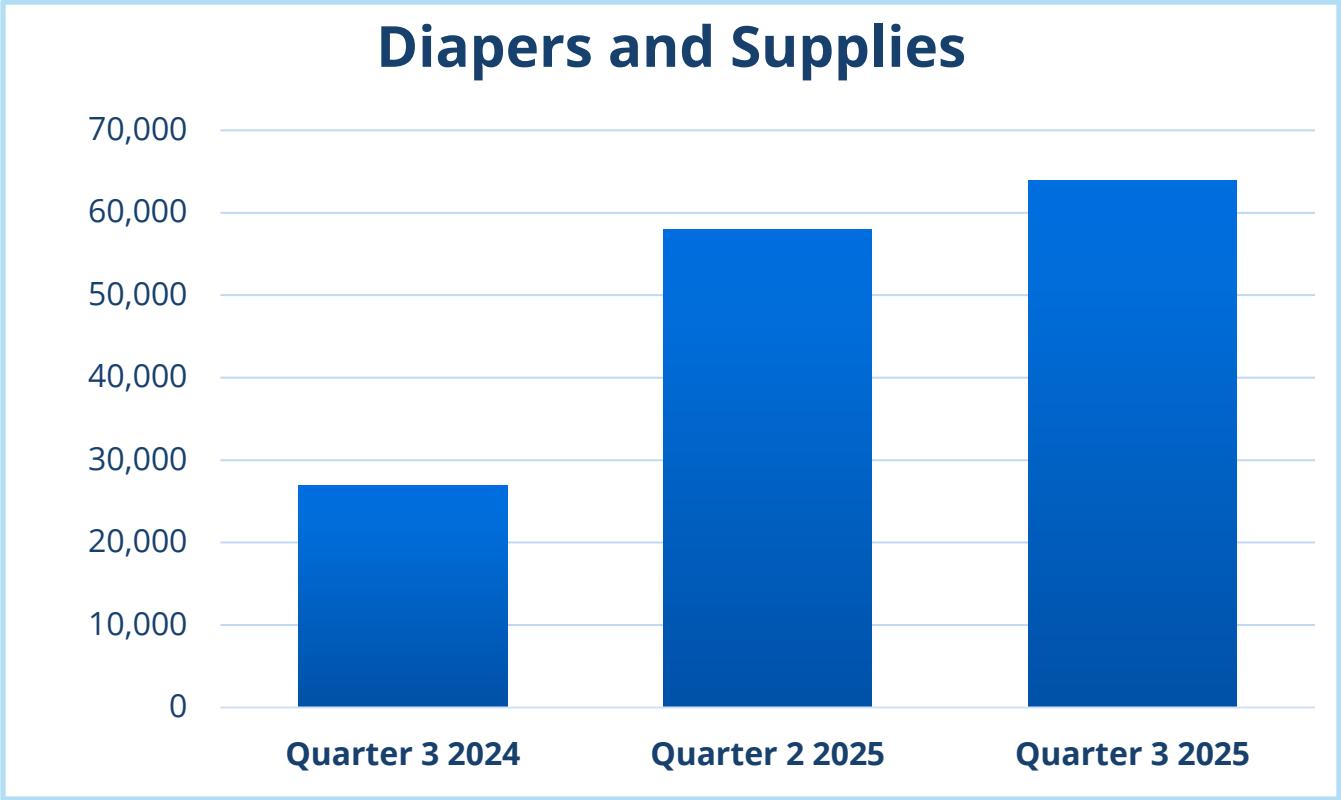
PMPM – Per Member Per Month

POP – Period Over Period

YOY – Year Over Year



# Top 10 Drugs by Claim Volume



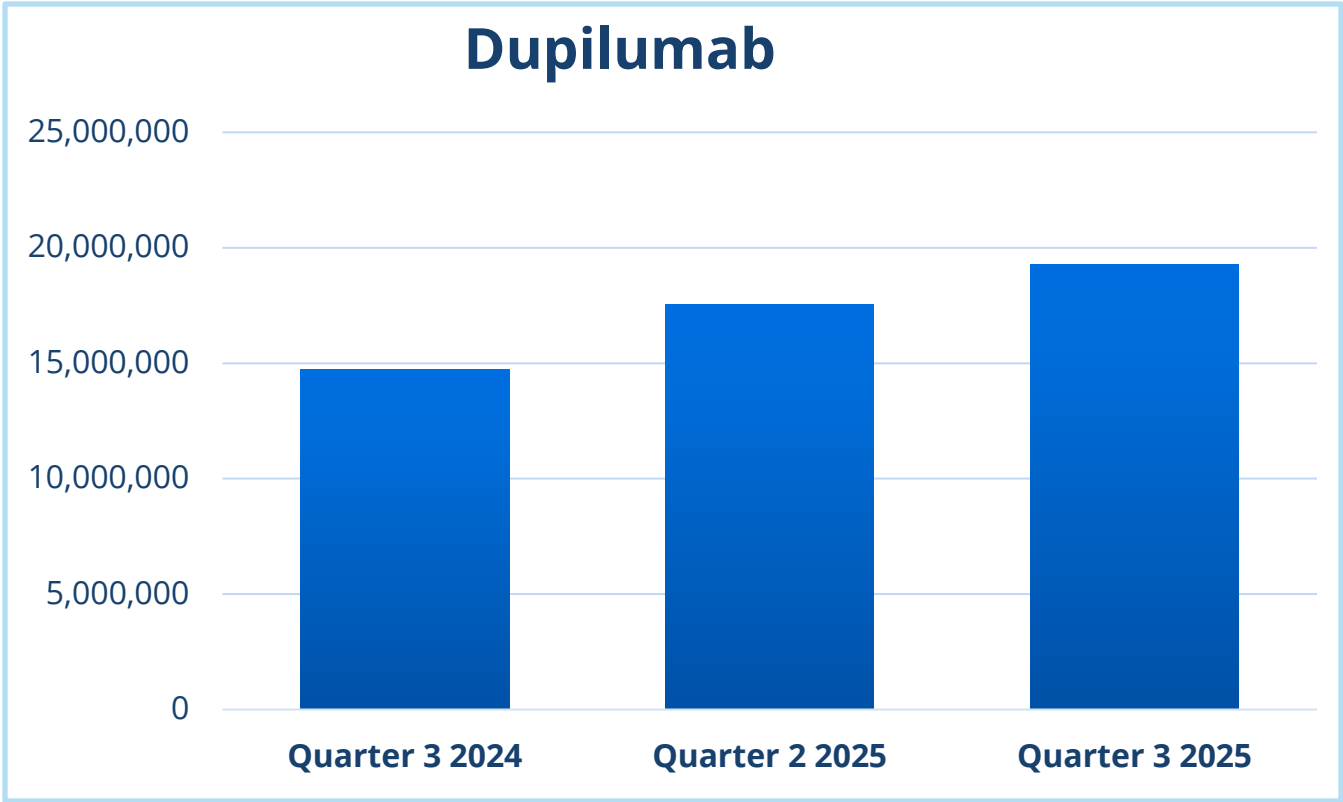
| Rank | Drug                 | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|----------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 2    | Diapers and Supplies | 63,899            | 4          | 58,003            | 29         | 26,918            | 10.2%       | 137.4%      |

# Top 10 Drugs by Payment Amount

| Rank | Drug                                | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM % Δ POP | PMPM% Δ YOY |
|------|-------------------------------------|---------------|------------|---------------|------------|---------------|--------------|-------------|
| 1    | Dupilumab                           | \$19,294,292  | 1          | \$17,538,994  | 2          | \$14,708,143  | 10.0%        | 31.2%       |
| 2    | Adalimumab                          | \$15,802,982  | 2          | \$15,929,748  | 1          | \$17,685,586  | -0.8%        | -10.6%      |
| 3    | Semaglutide                         | \$15,238,148  | 3          | \$15,326,492  | 3          | \$14,702,048  | -0.6%        | 3.6%        |
| 4    | Cariprazine                         | \$13,056,667  | 4          | \$13,148,237  | 4          | \$13,185,011  | -0.7%        | -1.0%       |
| 5    | Elexacaftor-Tezacaftor-Ivacaftor    | \$12,549,034  | 5          | \$12,058,774  | 5          | \$12,444,720  | 4.1%         | 0.8%        |
| 6    | Lisdexamfetamine                    | \$9,658,142   | 6          | \$9,472,575   | 6          | \$9,610,252   | 2.0%         | 0.5%        |
| 7    | Tirzepatide                         | \$9,129,278   | 9          | \$7,937,196   | 14         | \$4,861,535   | 15.0%        | 87.8%       |
| 8    | Methylphenidate                     | \$8,624,877   | 8          | \$8,339,082   | 7          | \$8,547,140   | 3.4%         | 0.9%        |
| 9    | Paliperidone                        | \$8,558,301   | 7          | \$8,757,233   | 8          | \$8,202,824   | -2.3%        | 4.3%        |
| 10   | Bictegravir-Emtricitabine-Tenofovir | \$7,684,543   | 10         | \$7,459,635   | 10         | \$6,619,407   | 3.0%         | 16.1%       |

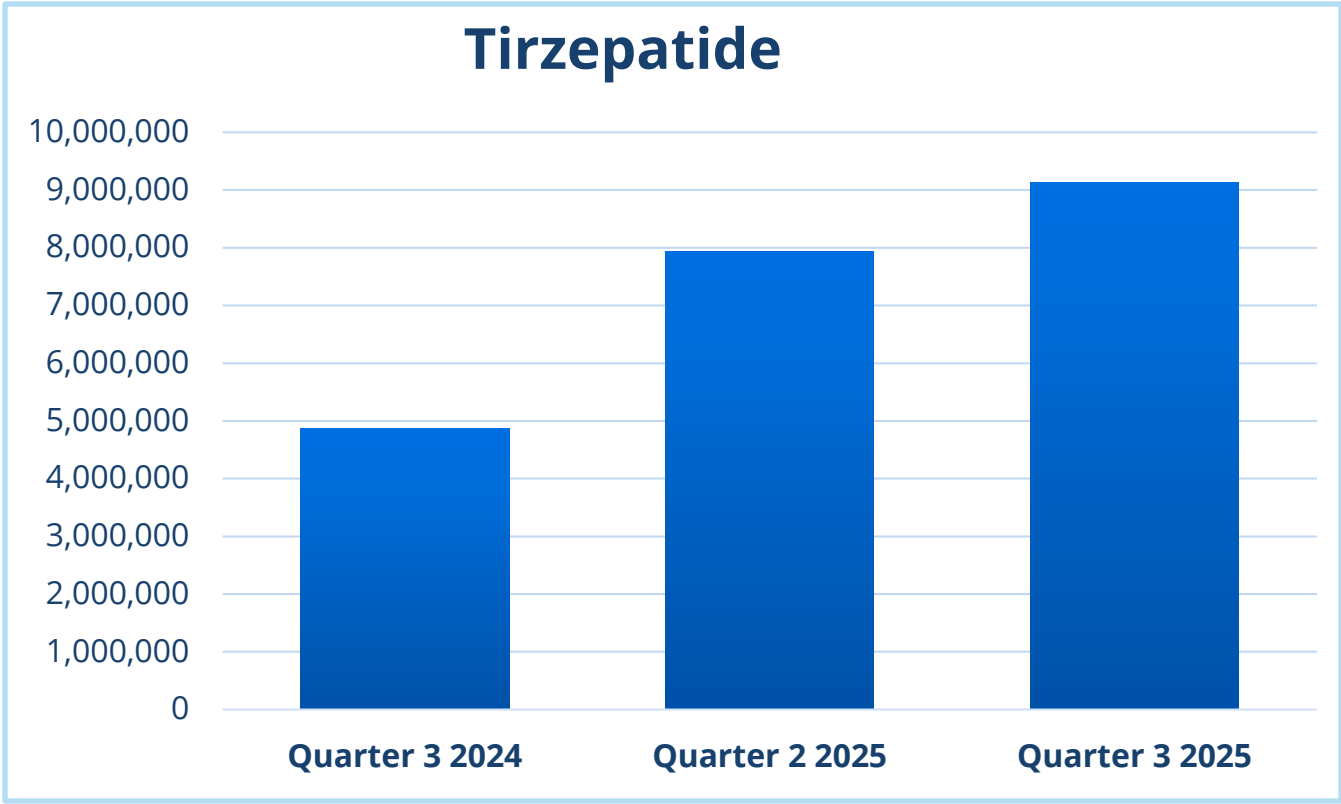
PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year

# Top 10 Drugs by Payment Amount



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 1    | Dupilumab         | \$19,294,292  | 1          | \$17,538,994  | 2          | \$14,708,143  | 10.0%       | 31.2%       |

# Top 10 Drugs by Payment Amount



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 7    | Tirzepatide       | \$9,129,278   | 9          | \$7,937,196   | 14         | \$4,861,535   | 15.0%       | 87.8%       |



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# Utilization Data

Adult Population  
(Ages 21 and Older)

# Top 10 Therapeutic Classes by Claim Volume (Adults)

| Rank | Therapeutic Class                          | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|--------------------------------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 1    | Antidepressants                            | 179,241           | 1          | 178,438           | 1          | 181,285           | 0.5%        | -1.1%       |
| 2    | 2 <sup>nd</sup> Generation Anticonvulsants | 105,122           | 2          | 104,797           | 2          | 107,745           | 0.3%        | -2.4%       |
| 3    | Atypical Antipsychotics                    | 71,442            | 3          | 70,725            | 3          | 71,448            | 1.0%        | 0.0%        |
| 4    | NSAIDs                                     | 63,071            | 4          | 61,865            | 4          | 64,848            | 1.9%        | -2.7%       |
| 5    | Anti-Anxiety Agents                        | 62,656            | 5          | 61,303            | 5          | 59,460            | 2.2%        | 5.4%        |
| 6    | PPIs                                       | 57,841            | 6          | 57,072            | 6          | 58,288            | 1.3%        | -0.8%       |
| 7    | Statins & Combos                           | 52,284            | 7          | 52,426            | 7          | 54,290            | -0.3%       | -3.7%       |
| 8    | Opioid Partial Agonists                    | 49,391            | 8          | 49,204            | 8          | 49,465            | 0.4%        | -0.1%       |
| 9    | Muscle Relaxants & Combos                  | 48,831            | 9          | 47,835            | 9          | 48,651            | 2.1%        | 0.4%        |
| 10   | Inhaled Bronchodilators                    | 43,993            | 10         | 45,834            | 10         | 48,404            | -4.0%       | -9.1%       |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year



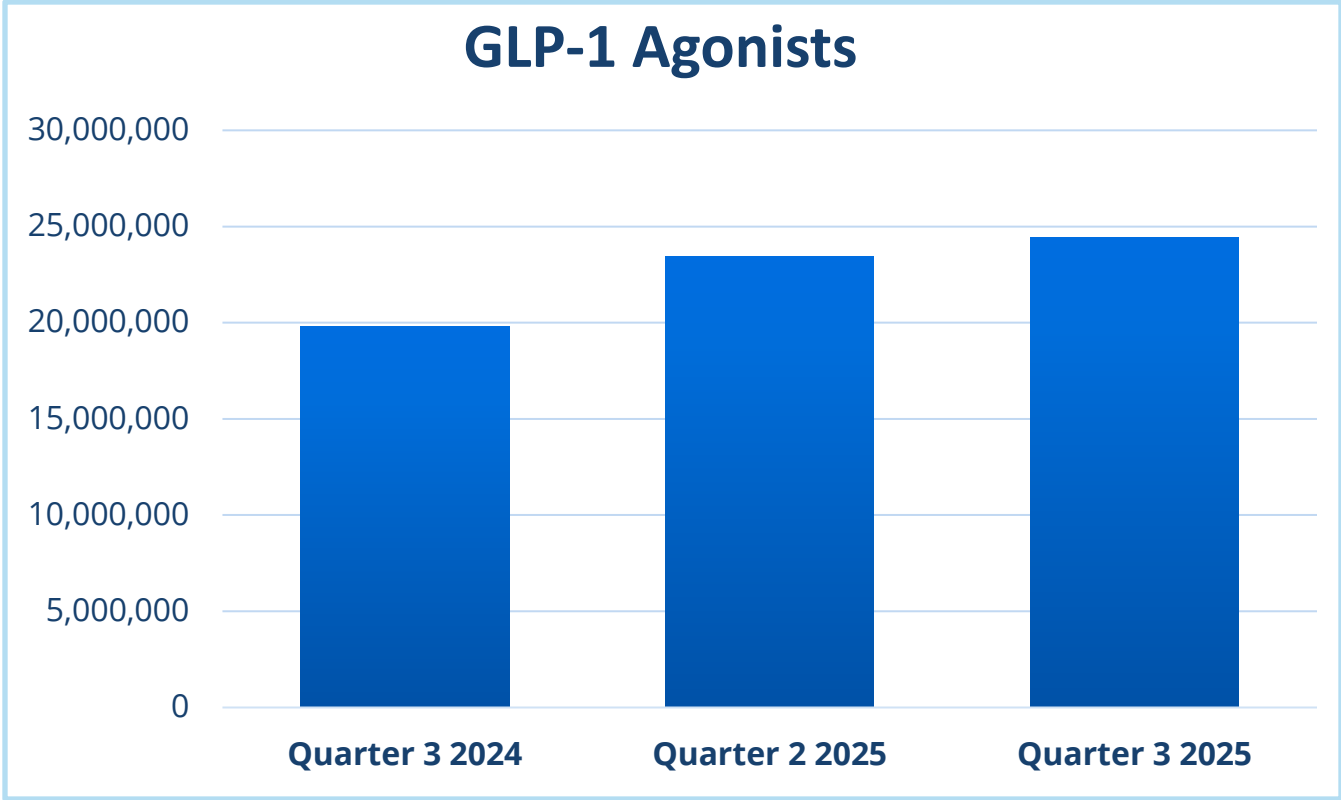
# Top 10 Therapeutic Classes by Payment Amount (Adults)

| Rank | Therapeutic Class                          | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|--------------------------------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 1    | Chronic Inflammatory Disease               | \$48,693,175  | 1          | \$46,930,955  | 1          | \$41,729,887  | 3.8%        | 16.7%       |
| 2    | Atypical Antipsychotics                    | \$34,019,344  | 2          | \$33,551,416  | 2          | \$32,055,681  | 1.4%        | 6.1%        |
| 3    | GLP-1 Agonists                             | \$24,419,647  | 3          | \$23,432,256  | 3          | \$19,794,099  | 4.2%        | 23.4%       |
| 4    | Oncology                                   | \$19,008,509  | 4          | \$18,111,300  | 4          | \$17,525,911  | 5.0%        | 8.5%        |
| 5    | HIV-Multiclass Combo                       | \$11,607,699  | 5          | \$11,416,257  | 5          | \$11,503,718  | 1.7%        | 0.9%        |
| 6    | Migraine                                   | \$10,776,295  | 6          | \$10,207,472  | 8          | \$8,996,262   | 5.6%        | 19.8%       |
| 7    | SGLT-2 Inhibitors and Combo                | \$10,229,692  | 7          | \$9,988,570   | 6          | \$9,429,643   | 2.4%        | 8.5%        |
| 8    | 2 <sup>nd</sup> Generation Anticonvulsants | \$8,095,680   | 8          | \$8,044,728   | 9          | \$8,362,550   | 0.6%        | -3.2%       |
| 9    | Hepatitis C                                | \$7,398,631   | 9          | \$6,746,207   | 7          | \$9,152,882   | 9.7%        | -19.2%      |
| 10   | Inhaled Asthma/COPD Combo                  | \$6,632,959   | 10         | \$6,665,679   | 10         | \$6,173,852   | -0.5%       | 7.4%        |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year



# Top 10 Therapeutic Classes by Payment Amount (Adults)



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 3    | GLP-1 Agonists    | \$24,419,647  | 3          | \$23,432,256  | 3          | \$19,794,099  | 4.2%        | 23.4%       |

# Top 10 Drugs by Claim Volume (Adults)

| Rank | Drug                   | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|------------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 1    | Buprenorphine-Naloxone | 47,561            | 1          | 47,351            | 1          | 47,430            | 0.4%        | 0.3%        |
| 2    | Gabapentin             | 42,178            | 2          | 43,156            | 2          | 44,918            | -2.3%       | -6.1%       |
| 3    | Albuterol Sulfate      | 40,097            | 3          | 41,914            | 3          | 43,719            | -4.3%       | -8.3%       |
| 4    | Atorvastatin           | 30,905            | 4          | 31,088            | 4          | 32,111            | -0.6%       | -3.8%       |
| 5    | Buspirone              | 28,862            | 5          | 28,496            | 6          | 29,145            | 1.3%        | -1.0%       |
| 6    | Omeprazole             | 28,246            | 6          | 28,099            | 5          | 29,786            | 0.5%        | -5.2%       |
| 7    | Levothyroxine          | 26,828            | 7          | 26,949            | 7          | 28,186            | -0.4%       | -4.8%       |
| 8    | Sertraline             | 25,543            | 8          | 25,680            | 10         | 25,976            | -0.5%       | -1.7%       |
| 9    | Ibuprofen              | 25,392            | 11         | 24,851            | 11         | 25,965            | 2.2%        | -2.2%       |
| 10   | Trazodone              | 25,171            | 9          | 25,029            | 13         | 25,020            | 0.6%        | 0.6%        |

PMPM – Per Member Per Month

POP – Period Over Period

YOY – Year Over Year



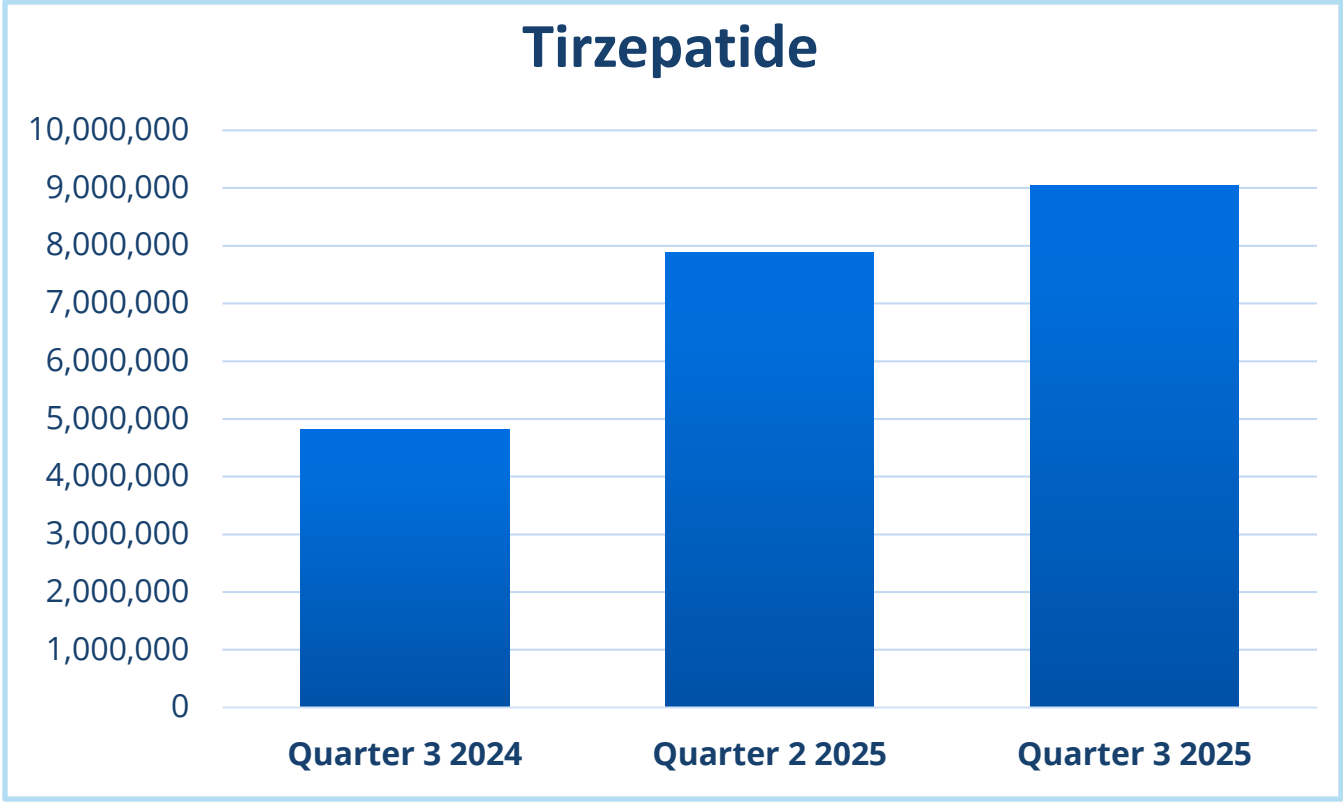
# Top 10 Drugs by Payment Amount

| Rank | Drug                                    | \$ Paid<br>Q3 25 | Rank<br>Q2 25 | \$ Paid<br>Q2 25 | Rank<br>Q3 24 | \$ Paid<br>Q3 24 | PMPM%<br>Δ POP | PMPM%<br>Δ YOY |
|------|-----------------------------------------|------------------|---------------|------------------|---------------|------------------|----------------|----------------|
| 1    | Semaglutide                             | \$14,920,096     | 1             | \$15,057,927     | 1             | \$14,442,324     | -0.9%          | 3.3%           |
| 2    | Cariprazine                             | \$11,903,311     | 2             | \$11,983,302     | 3             | \$11,967,579     | -0.7%          | -0.5%          |
| 3    | Adalimumab                              | \$11,207,046     | 3             | \$11,237,568     | 2             | \$12,568,361     | -0.3%          | -10.8%         |
| 4    | Tirzepatide                             | \$9,047,785      | 5             | \$7,885,013      | 9             | \$4,819,763      | 14.7%          | 87.7%          |
| 5    | Paliperidone                            | \$8,240,298      | 4             | \$8,434,763      | 4             | \$7,837,488      | -2.3%          | 5.1%           |
| 6    | Bictegravir-Emtricitabine-<br>Tenofovir | \$7,135,394      | 6             | \$6,979,867      | 6             | \$6,178,429      | 2.2%           | 15.5%          |
| 7    | Dupilumab                               | \$5,791,913      | 8             | \$5,397,508      | 10            | \$4,287,024      | 7.3%           | 35.1%          |
| 8    | Empagliflozin                           | \$5,670,483      | 7             | \$5,578,345      | 7             | \$5,273,572      | 1.7%           | 7.5%           |
| 9    | Sofosbuvir-Velpatasvir                  | \$5,670,081      | 10            | \$4,975,492      | 5             | \$7,582,305      | 14.0%          | -25.2%         |
| 10   | Ixekizumab                              | \$5,086,300      | 9             | \$5,236,061      | 8             | \$4,982,137      | -2.9%          | 2.1%           |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year

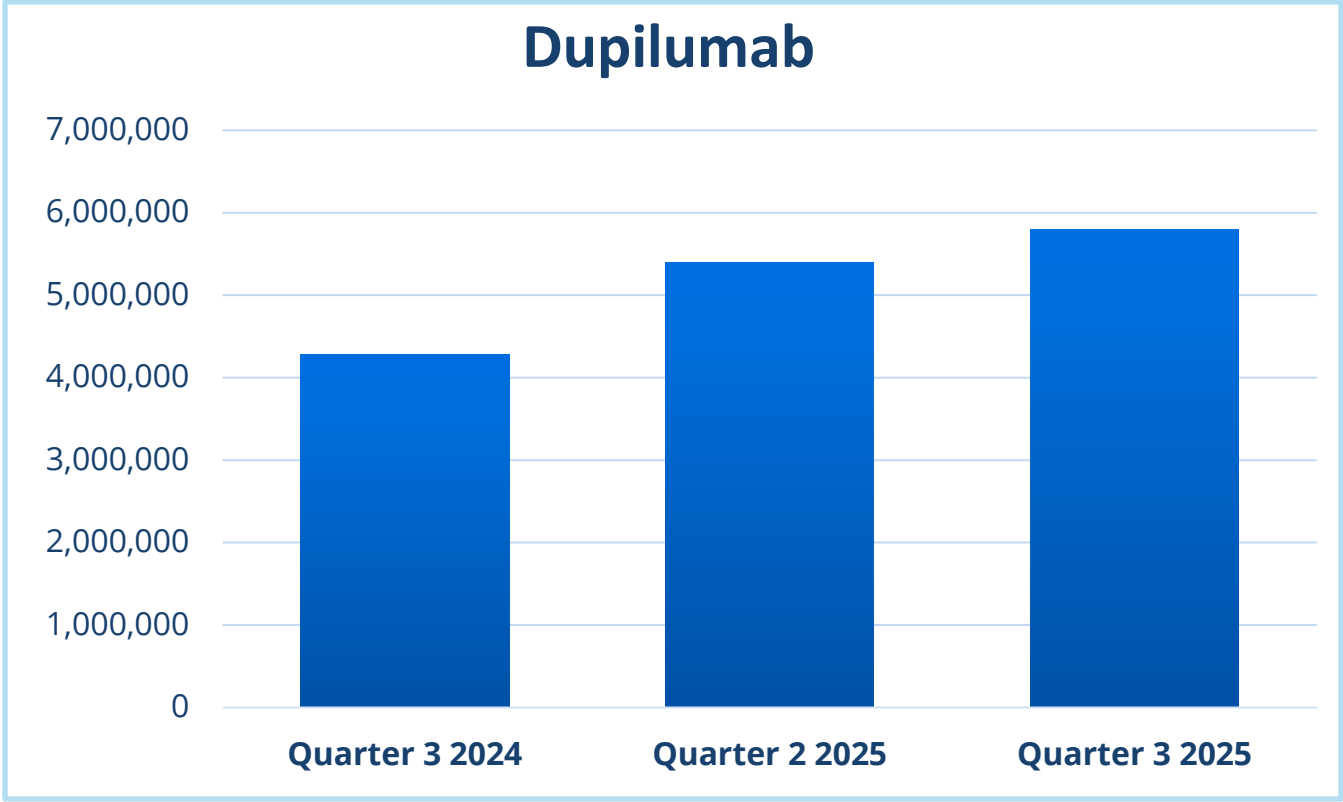


# Top 10 Drugs by Payment Amount (Adults)



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 4    | Tirzepatide       | \$9,047,785   | 5          | \$7,885,013   | 9          | \$4,819,763   | 14.7%       | 87.7%       |

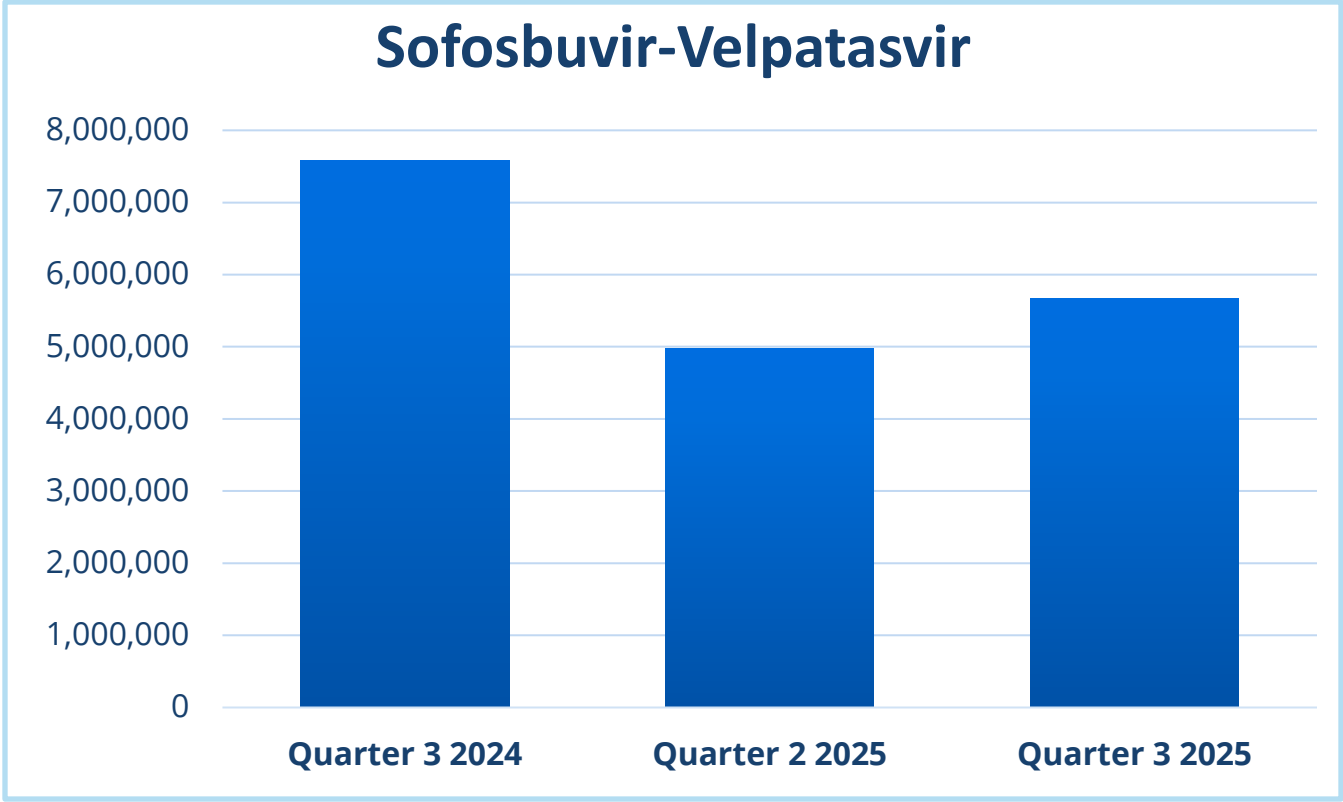
# Top 10 Drugs by Payment Amount (Adults)



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 7    | Dupilumab         | \$5,791,913   | 8          | \$5,397,508   | 10         | \$4,287,024   | 7.3%        | 35.1%       |

# Top 10 Drugs by Payment Amount

(Adults)



| Rank | Therapeutic Class      | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|------------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 9    | Sofosbuvir-Velpatasvir | \$5,670,081   | 10         | \$4,975,492   | 5          | \$7,582,305   | 14.0%       | -25.2%      |

The logo consists of a red square with the letters 'TN' in white, serif font. Below the red square is a thin dark blue horizontal bar.

**TN**

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# Utilization Data

Child Population  
(Ages 0 through 20)

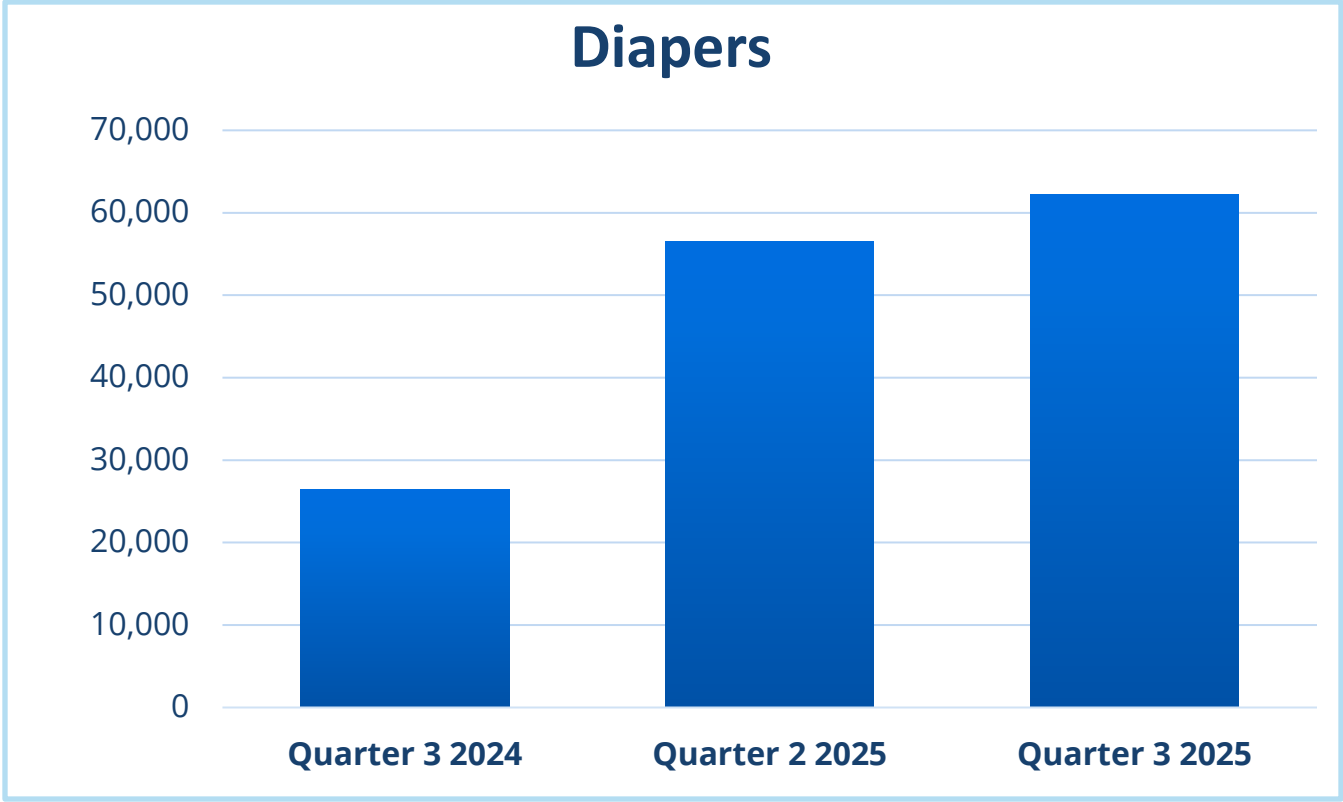
# Top 10 Therapeutic Classes by Claim Volume (Children)

| Rank | Therapeutic Class                | # of Claims<br>Q3 25 | Rank<br>Q2 25 | # of Claims<br>Q2 25 | Rank<br>Q3 24 | # of Claims<br>Q3 24 | PMPM%<br>Δ POP | PMPM%<br>Δ YOY |
|------|----------------------------------|----------------------|---------------|----------------------|---------------|----------------------|----------------|----------------|
| 1    | ADHD & Narcolepsy Medications    | 129,745              | 1             | 124,083              | 1             | 123,167              | 4.6%           | 5.3%           |
| 2    | Antihistamines                   | 74,161               | 2             | 82,682               | 3             | 80,107               | -10.3%         | -7.4%          |
| 3    | Antidepressants                  | 66,436               | 4             | 65,421               | 4             | 64,395               | 1.6%           | 3.2%           |
| 4    | Penicillin                       | 65,601               | 3             | 73,885               | 2             | 80,107               | -11.2%         | -18.1%         |
| 5    | Diapers                          | 62,163               | 5             | 56,539               | 13            | 26,464               | 9.9%           | 134.9%         |
| 6    | Inhaled Bronchodilators          | 41,199               | 6             | 39,305               | 5             | 46,228               | 4.8%           | -10.9%         |
| 7    | Anticonvulsants - 2nd Generation | 38,356               | 7             | 37,637               | 6             | 36,976               | 1.9%           | 3.7%           |
| 8    | Antiadrenergic Antihypertensives | 37,226               | 8             | 36,090               | 7             | 35,486               | 3.1%           | 4.9%           |
| 9    | Atypical Antipsychotics          | 32,419               | 9             | 32,164               | 9             | 31,892               | 0.8%           | 1.7%           |
| 10   | Cephalosporins                   | 30,480               | 10            | 31,829               | 8             | 34,737               | -4.2%          | -12.3%         |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year



# Top 10 Therapeutic Classes by Claim Volume (Children)



| Rank | Therapeutic Class | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 5    | Diapers           | 62,163            | 5          | 56,539            | 13         | 26,464            | 9.9%        | 134.9%      |

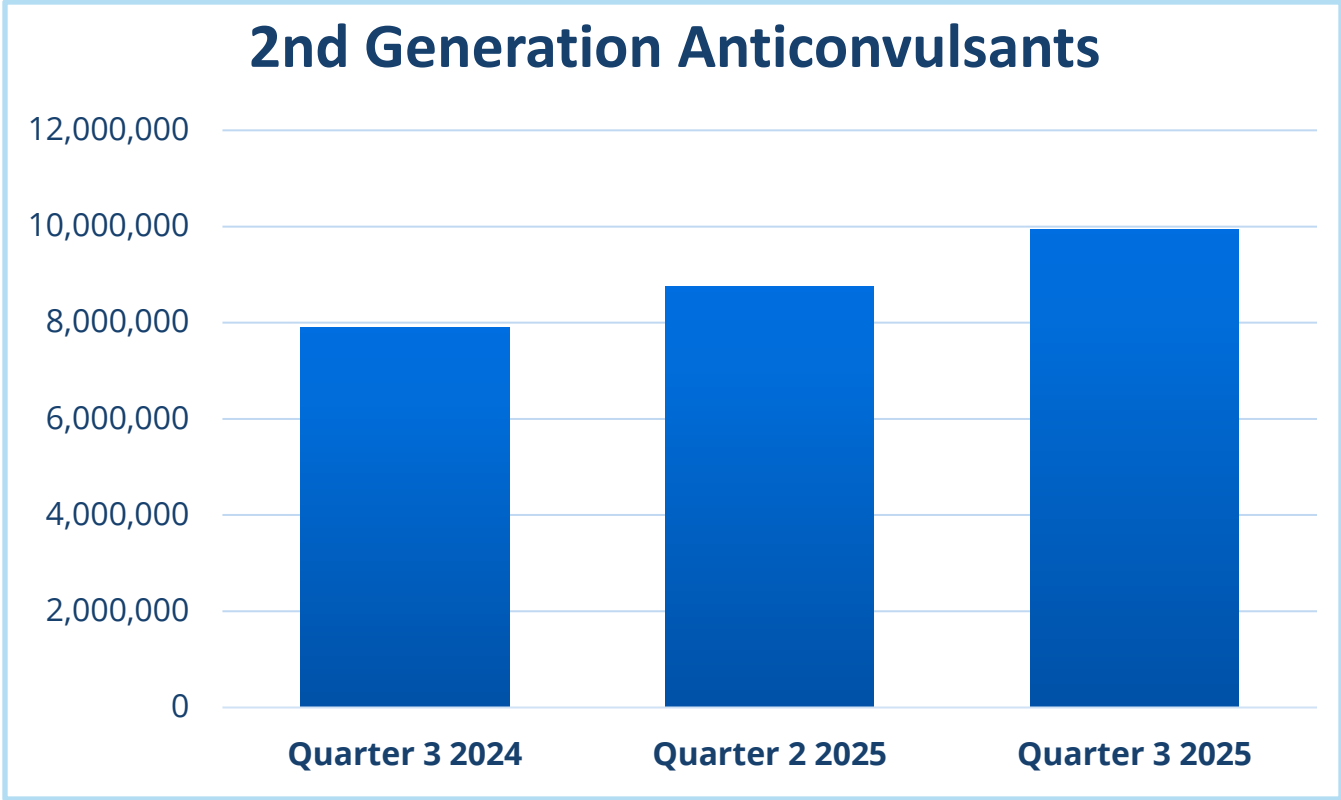
# Top 10 Therapeutic Classes by Payment Amount (Children)

| Rank | Therapeutic Class              | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|--------------------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 1    | ADHD & Narcolepsy Medications  | \$23,840,345  | 1          | \$22,880,544  | 1          | \$22,799,320  | 4.2%        | 4.6%        |
| 2    | Chronic Inflammatory Disease   | \$23,130,826  | 2          | \$21,677,807  | 2          | \$19,101,200  | 6.7%        | 21.1%       |
| 3    | Cystic Fibrosis                | \$12,379,458  | 3          | \$11,502,681  | 3          | \$10,941,366  | 7.6%        | 13.1%       |
| 4    | 2nd Generation Anticonvulsants | \$9,936,029   | 4          | \$8,762,806   | 4          | \$7,897,453   | 13.4%       | 25.8%       |
| 5    | Antihemophilic Products        | \$6,000,524   | 5          | \$6,311,993   | 5          | \$5,101,561   | -4.9%       | 17.6%       |
| 6    | GLP-1 Anti-Obesity Agents      | \$5,433,459   | 6          | \$4,626,195   | 11         | \$2,470,770   | 17.4%       | 119.9%      |
| 7    | Growth Hormones                | \$3,550,908   | 7          | \$3,443,271   | 6          | \$3,233,208   | 3.1%        | 9.8%        |
| 8    | GLP-2 Analogs                  | \$3,473,938   | 12         | \$2,878,607   | 10         | \$2,474,435   | 20.7%       | 40.4%       |
| 9    | Asthma                         | \$3,400,738   | 8          | \$3,226,521   | 8          | \$2,946,793   | 5.4%        | 15.4%       |
| 10   | Diapers                        | \$3,352,568   | 9          | \$3,066,763   | 20         | \$1,261,346   | 9.3%        | 165.8%      |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year

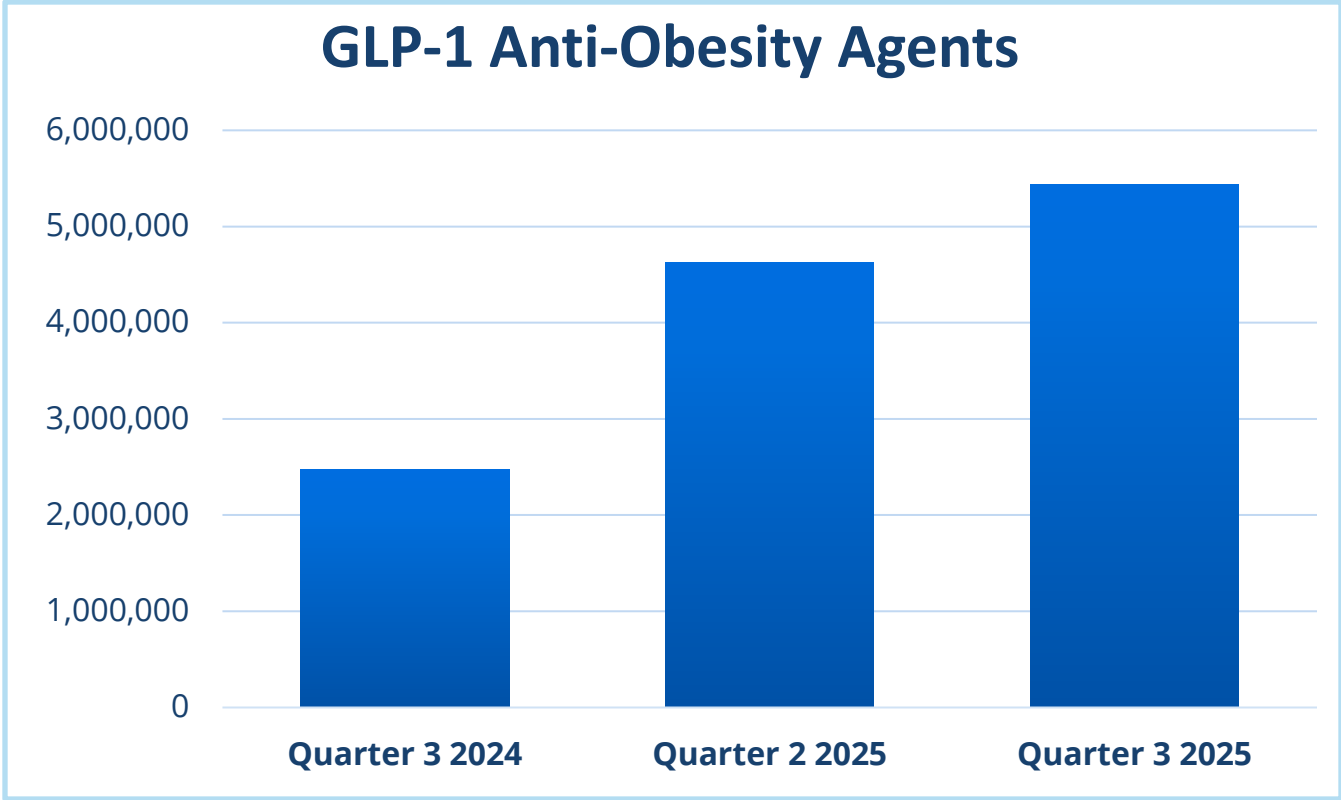


# Top 10 Therapeutic Classes by Payment Amount (Children)



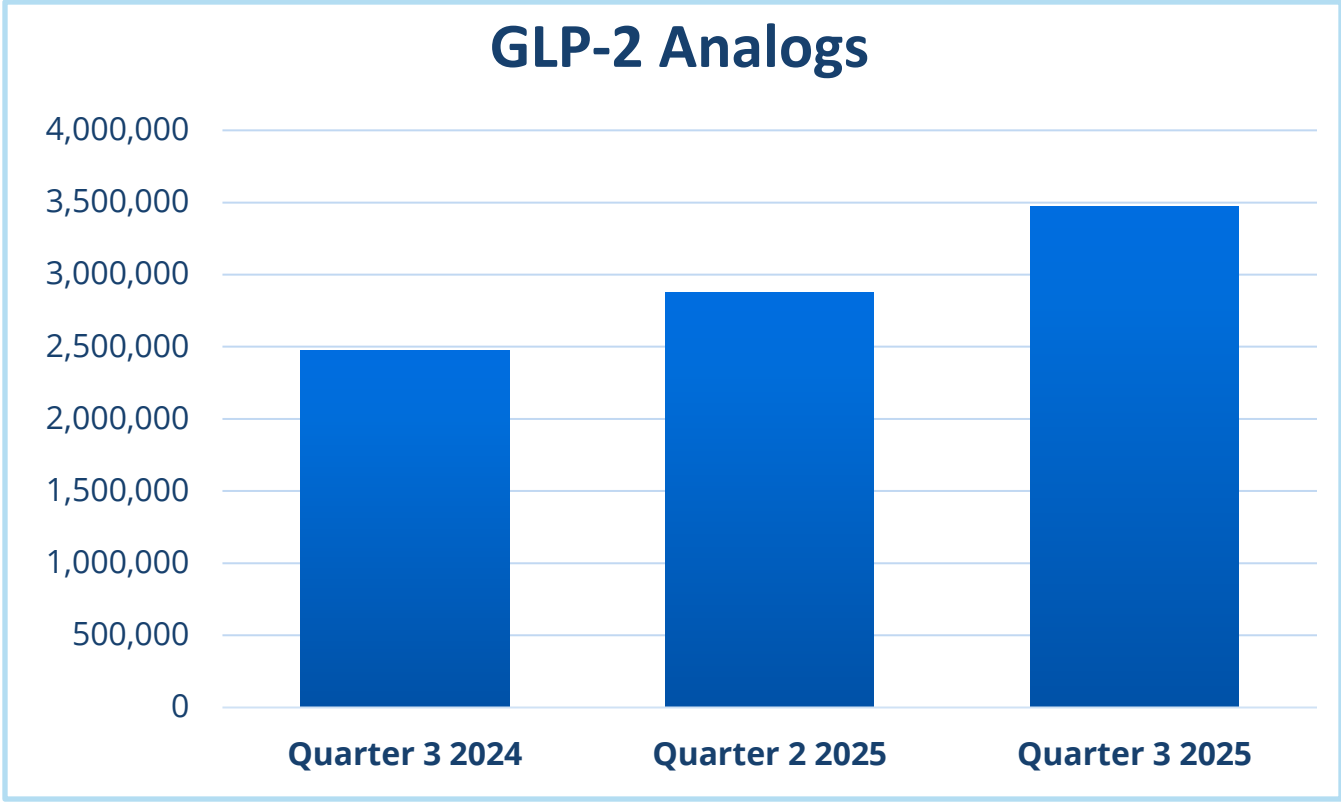
| Rank | Therapeutic Class              | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|--------------------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 4    | 2nd Generation Anticonvulsants | \$9,936,029   | 4          | \$8,762,806   | 4          | \$7,897,453   | 13.4%       | 25.8%       |

# Top 10 Therapeutic Classes by Payment Amount (Children)



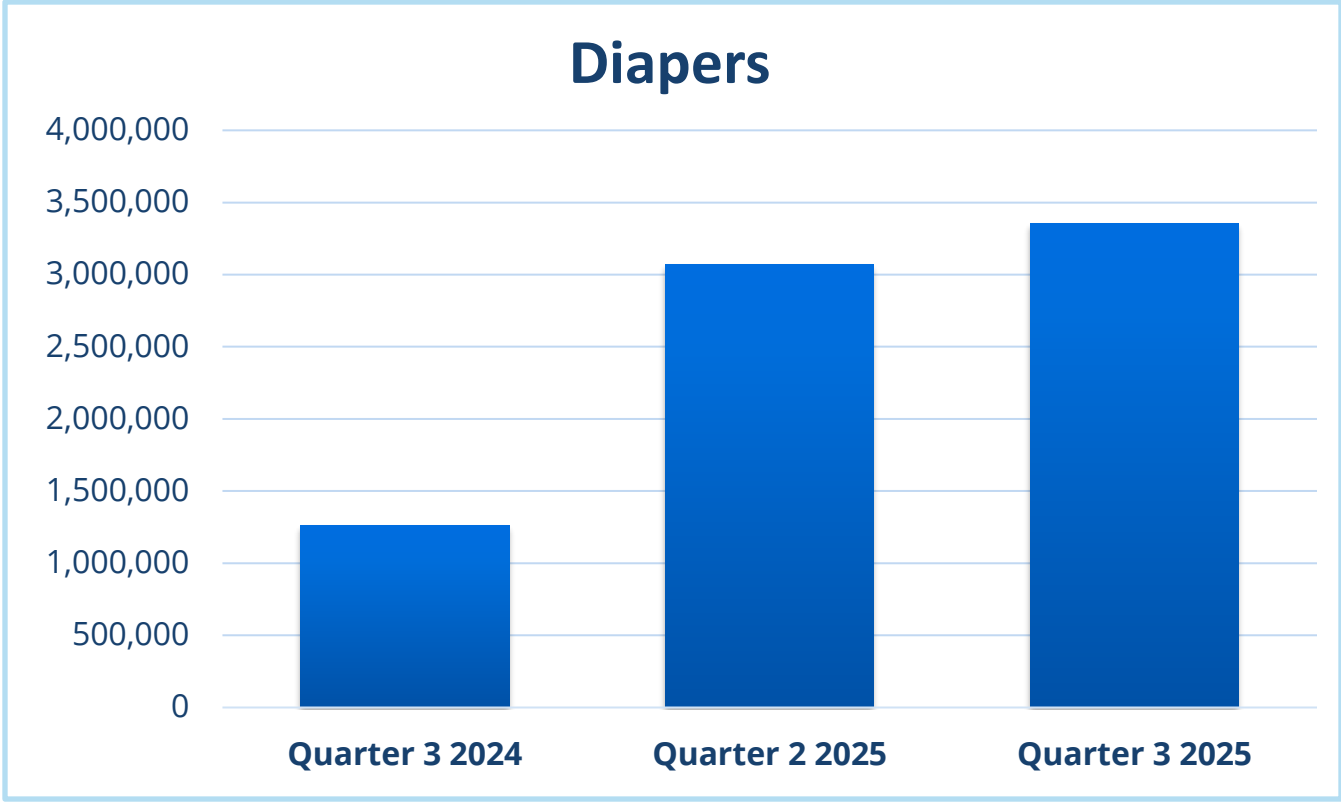
| Rank | Therapeutic Class         | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|---------------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 6    | GLP-1 Anti-Obesity Agents | \$5,433,459   | 6          | \$4,626,195   | 11         | \$2,470,770   | 17.4%       | 119.9%      |

# Top 10 Therapeutic Classes by Payment Amount (Children)



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 8    | GLP-2 Analogs     | \$3,473,938   | 12         | \$2,878,607   | 10         | \$2,474,435   | 20.7%       | 40.4%       |

# Top 10 Therapeutic Classes by Payment Amount (Children)



| Rank | Therapeutic Class | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 10   | Diapers           | \$3,352,568   | 9          | \$3,066,763   | 20         | \$1,261,346   | 9.3%        | 165.8%      |

# Top 10 Drugs by Claim Volume (Children)

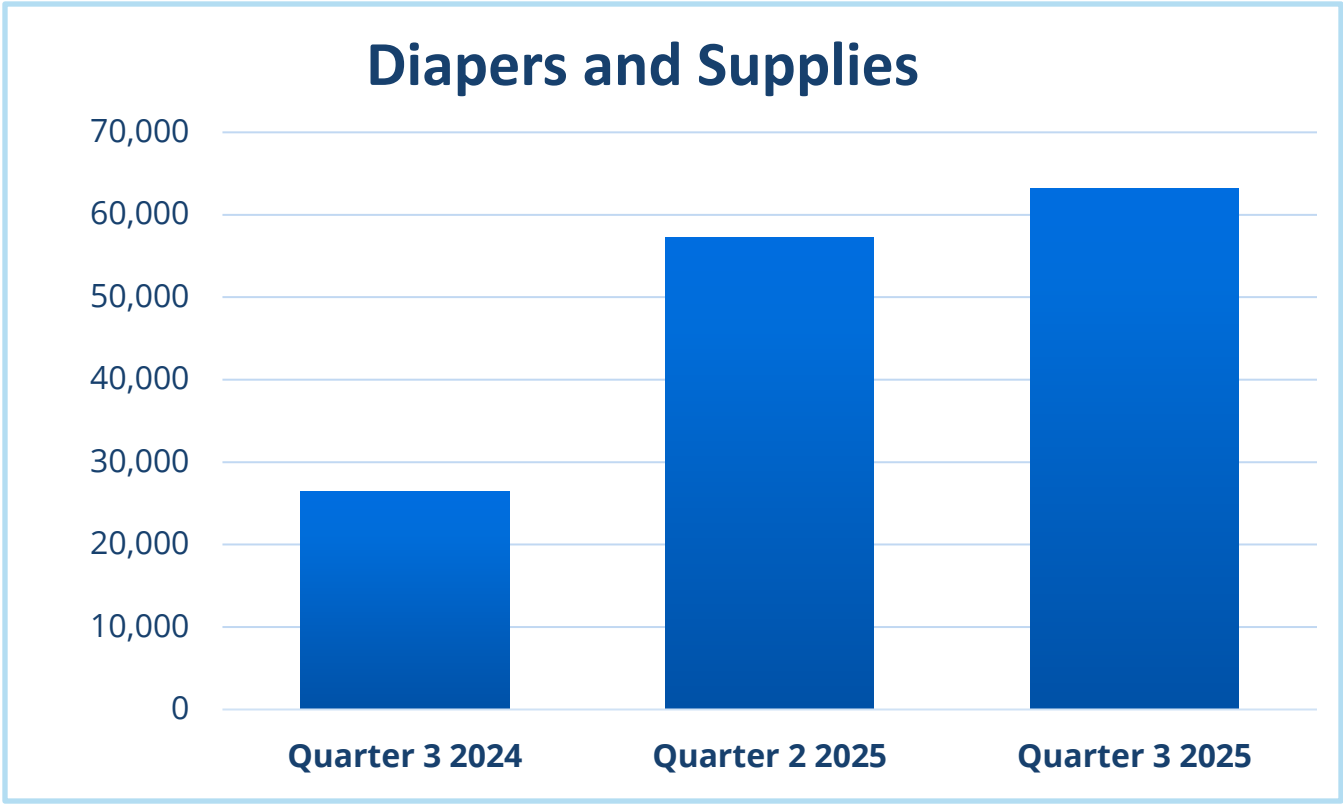
| Rank | Drug                   | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|------------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 1    | Diapers and Supplies   | 63,160            | 2          | 57,281            | 6          | 26,464            | 10.3%       | 138.7%      |
| 2    | Cetirizine             | 56,292            | 1          | 63,605            | 2          | 59,124            | -11.5%      | -4.8%       |
| 3    | Amoxicillin            | 48,892            | 3          | 54,902            | 1          | 60,257            | -10.9%      | -18.9%      |
| 4    | Albuterol Sulfate      | 39,769            | 4          | 37,967            | 3          | 44,957            | 4.7%        | -11.5%      |
| 5    | Fluticasone Propionate | 26,883            | 5          | 29,629            | 4          | 28,583            | -9.3%       | -5.9%       |
| 6    | Methylphenidate        | 26,578            | 6          | 25,504            | 5          | 26,709            | 4.2%        | -0.5%       |
| 7    | Clonidine              | 25,387            | 7          | 24,438            | 8          | 23,831            | 3.9%        | 6.5%        |
| 8    | Lisdexamfetamine       | 24,702            | 8          | 23,716            | 7          | 24,239            | 4.2%        | 1.9%        |
| 9    | Guanfacine             | 20,857            | 10         | 20,279            | 13         | 19,393            | 2.9%        | 7.5%        |
| 10   | Montelukast            | 20,143            | 9          | 22,201            | 9          | 22,461            | -9.3%       | -10.3%      |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year



# Top 10 Drugs by Claim Volume

(Children)



| Rank | Drug                 | # of Claims Q3 25 | Rank Q2 25 | # of Claims Q2 25 | Rank Q3 24 | # of Claims Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|----------------------|-------------------|------------|-------------------|------------|-------------------|-------------|-------------|
| 1    | Diapers and Supplies | 63,160            | 2          | 57,281            | 6          | 26,464            | 10.3%       | 138.7%      |

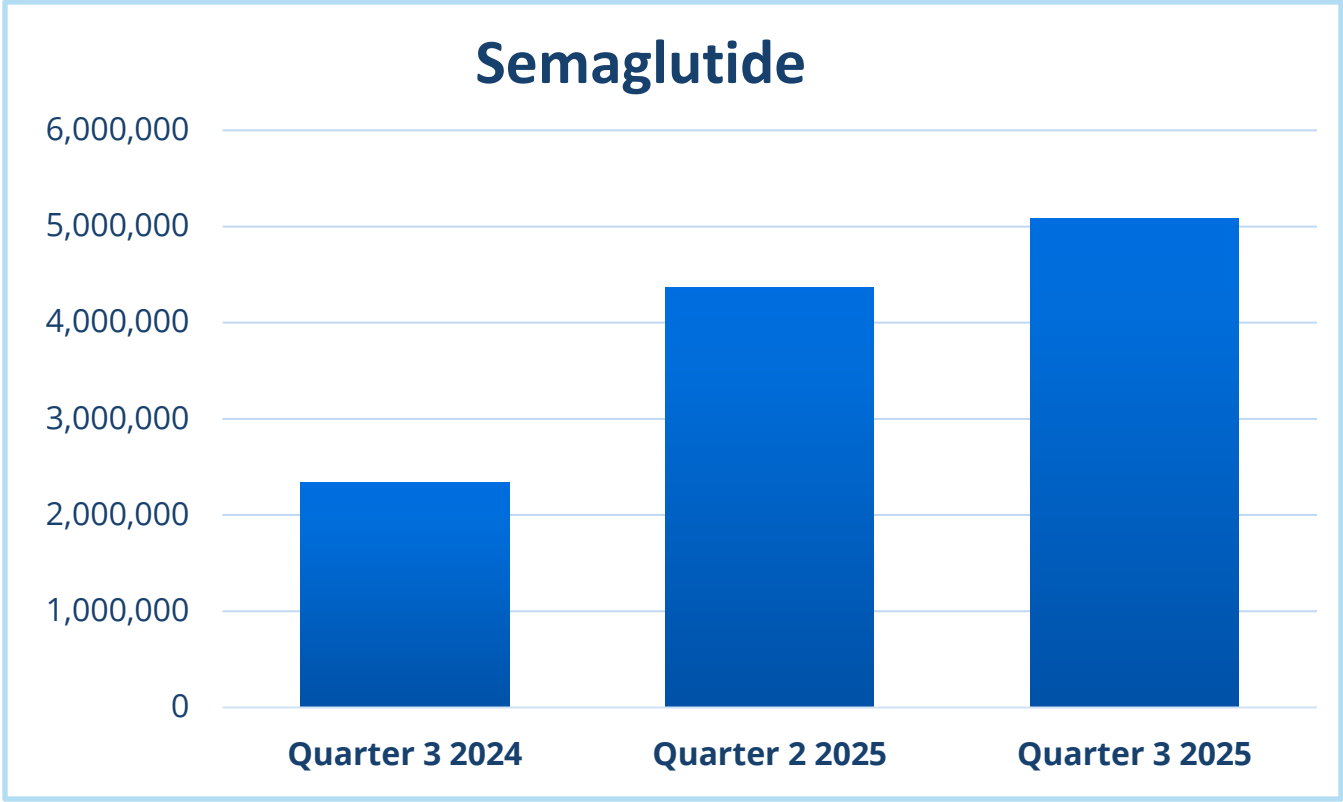
# Top 10 Drugs by Payment Amount (Children)

| Rank | Drug                                 | \$ Paid<br>Q3 25 | Rank<br>Q2 25 | \$ Paid<br>Q2 25 | Rank<br>Q3 24 | \$ Paid<br>Q3 24 | PMPM%<br>Δ POP | PMPM%<br>Δ YOY |
|------|--------------------------------------|------------------|---------------|------------------|---------------|------------------|----------------|----------------|
| 1    | Dupilumab                            | \$13,432,997     | 1             | \$12,118,387     | 1             | \$10,406,381     | 10.8%          | 29.1%          |
| 2    | Elexacaftor/Tezacaftor/<br>Ivacaftor | \$9,609,437      | 2             | \$9,307,729      | 2             | \$9,252,752      | 3.2%           | 3.9%           |
| 3    | Lisdexamfetamine                     | \$8,612,797      | 3             | \$8,354,161      | 3             | \$8,420,593      | 3.1%           | 2.3%           |
| 4    | Methylphenidate                      | \$8,401,681      | 4             | \$8,112,978      | 4             | \$8,337,452      | 3.6%           | 0.8%           |
| 5    | Semaglutide                          | \$5,086,491      | 7             | \$4,364,501      | 10            | \$2,337,687      | 16.5%          | 117.6%         |
| 6    | Adalimumab                           | \$4,555,753      | 5             | \$4,645,219      | 5             | \$5,117,225      | -1.9%          | -11.0%         |
| 7    | Emicizumab                           | \$4,177,780      | 6             | \$4,526,817      | 6             | \$3,457,314      | -7.7%          | 20.8%          |
| 8    | Teduglutide                          | \$3,473,938      | 10            | \$2,878,607      | 9             | \$2,474,435      | 20.7%          | 40.4%          |
| 9    | Diapers and Supplies                 | \$3,388,248      | 8             | \$3,092,839      | 19            | \$1,261,346      | 9.6%           | 168.6%         |
| 10   | Viloxazine                           | \$3,112,388      | 9             | \$2,923,156      | 8             | \$2,480,203      | 6.5%           | 25.5%          |

PMPM – Per Member Per Month  
 POP – Period Over Period  
 YOY – Year Over Year

# Top 10 Drugs by Payment Amount

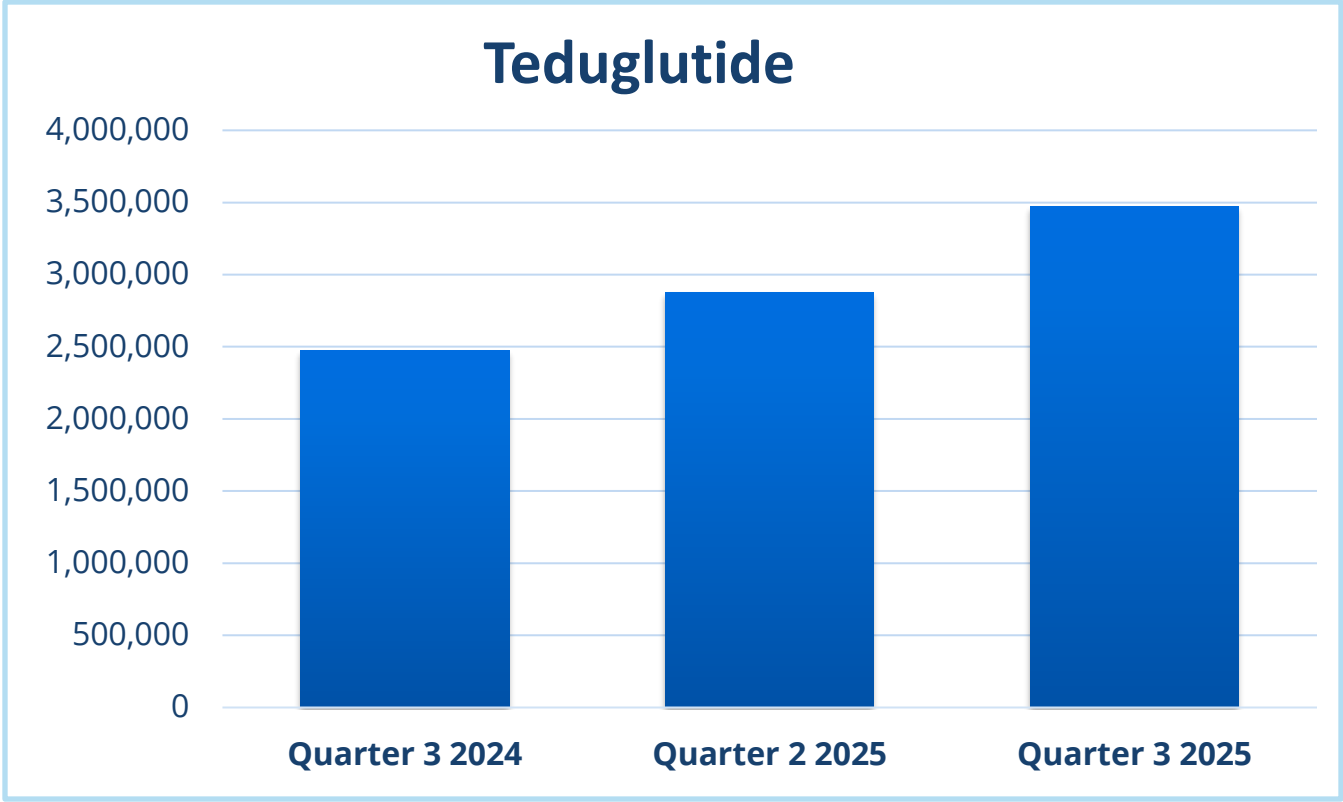
(Children)



| Rank | Drug        | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 5    | Semaglutide | \$5,086,491   | 7          | \$4,364,501   | 10         | \$2,337,687   | 16.5%       | 117.6%      |

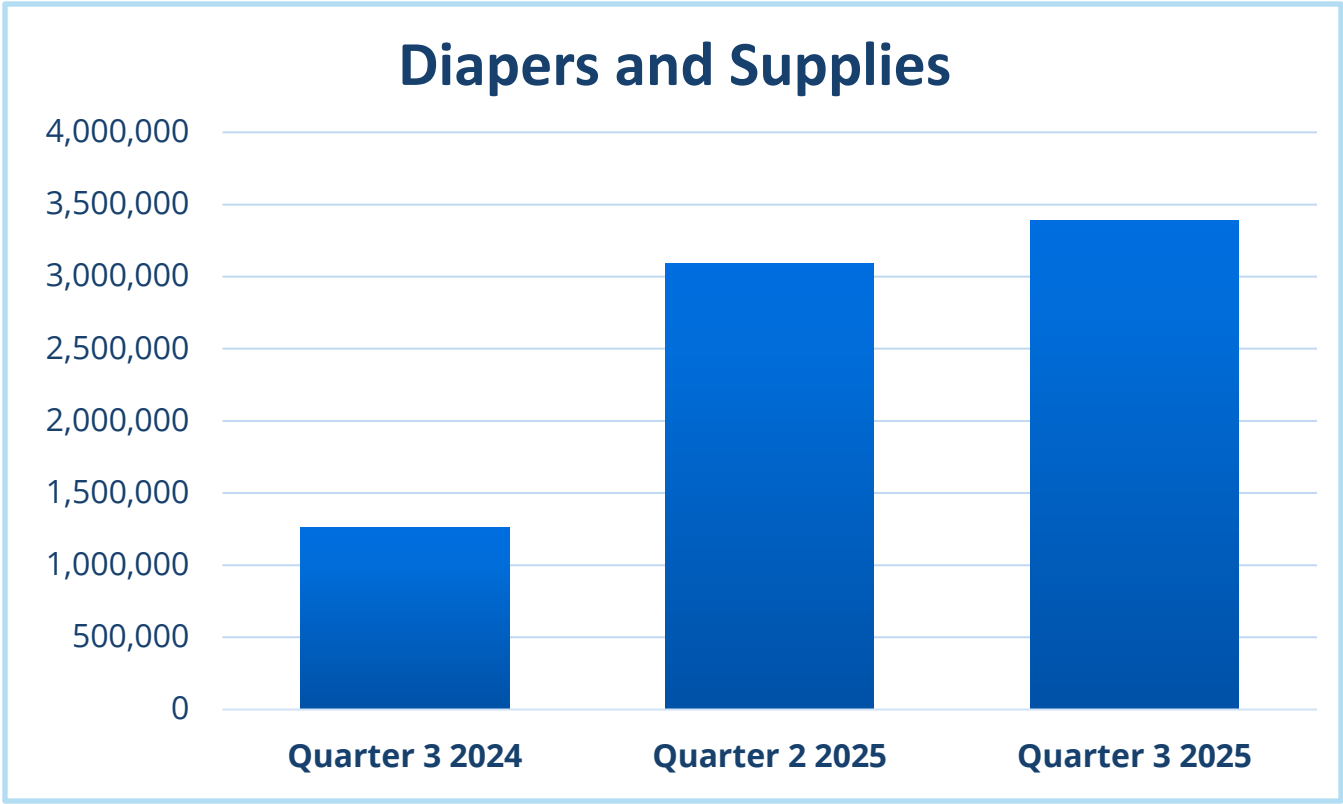
# Top 10 Drugs by Payment Amount

(Children)



| Rank | Drug        | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|-------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 8    | Teduglutide | \$3,473,938   | 10         | \$2,878,607   | 9          | \$2,474,435   | 20.7%       | 40.4%       |

# Top 10 Drugs by Payment Amount (Children)



| Rank | Drug                 | \$ Paid Q3 25 | Rank Q2 25 | \$ Paid Q2 25 | Rank Q3 24 | \$ Paid Q3 24 | PMPM% Δ POP | PMPM% Δ YOY |
|------|----------------------|---------------|------------|---------------|------------|---------------|-------------|-------------|
| 9    | Diapers and Supplies | \$3,388,248   | 8          | \$3,092,839   | 19         | \$1,261,346   | 9.6%        | 168.6%      |



TM

# Prospective Drug Utilization Review (ProDUR)

Q3 2025

# Definitions – Edits / Rejections

## ProDUR Edit

- A computer system review of the member's medication history
- Identifies potential drug therapy problems prior to dispensing the medication.
- Examples would include but not limited to:
  - Therapeutic Duplication (TD)
  - Early Refill (ER)
  - Max Dose
  - Drug to Drug
  - Drug to Inferred Disease
  - Drug to Gender
  - Geriatric and Pediatric Warnings

## Rejections

- **Hard Reject** – These edits will cause the claim to deny at the point of sale (POS)
- **Soft Reject** – These edits will cause the claim to deny at the point of sale.
  - With appropriate documentation the pharmacy will be able to re-submit the rejected claim using Professional Pharmacy Service (PPS) codes.
- **Message** – These edits will cause an alert or warning message to be returned to the dispensing pharmacist to inform them of a potential problem.

# ProDUR Review – Top 10 Therapeutic Duplication

| Drug Name                     | Total  | % Paid |
|-------------------------------|--------|--------|
| QUETIAPINE                    | 13,952 | 51%    |
| GUANFACINE                    | 11,850 | 34%    |
| CLONIDINE                     | 11,182 | 32%    |
| FLUOXETINE                    | 10,760 | 37%    |
| AMPHETAMINE/DEXTROAMPHETAMINE | 10,508 | 39%    |
| ALBUTEROL                     | 9,525  | 33%    |
| ARIPIPRAZOLE                  | 8,871  | 37%    |
| TRAZODONE                     | 8,349  | 25%    |
| SERTRALINE                    | 7,846  | 27%    |
| RISPERIDONE                   | 7,515  | 45%    |

# ProDUR Review – Top 10 Early Refill

| Drug Name                     | Total | % Paid |
|-------------------------------|-------|--------|
| GUANFACINE                    | 6,394 | 39%    |
| CLONIDINE                     | 6,275 | 24%    |
| GABAPENTIN                    | 6,035 | 46%    |
| AMPHETAMINE/DEXTROAMPHETAMINE | 5,662 | 11%    |
| TRAZODONE                     | 5,613 | 50%    |
| FLUOXETINE                    | 5,324 | 23%    |
| ALBUTEROL                     | 5,199 | 27%    |
| SERTRALINE                    | 5,002 | 34%    |
| ESCITALOPRAM                  | 4,769 | 36%    |
| ARIPIPRAZOLE                  | 4,375 | 43%    |

# ProDUR Review – Top 10 Max Dose

| Drug Name                | Total | % Paid |
|--------------------------|-------|--------|
| CEFDINIR                 | 9,485 | 91%    |
| POLYETHYLENE GLYCOL 3350 | 8,018 | 73%    |
| HUMALOG                  | 5,516 | 5%     |
| AMOXICILLIN              | 5,133 | 92%    |
| LANTUS SOLOSTAR          | 5,010 | 65%    |
| AMOXICILLIN/CLAVULANATE  | 4,650 | 87%    |
| EPINEPHRINE              | 3,510 | 75%    |
| FAMOTIDINE               | 3,269 | 75%    |
| VITAMIN D                | 3,080 | 66%    |
| INSULIN LISPRO           | 2,749 | 64%    |

# ProDUR Review – Top 10 Drug to Inferred Diagnosis Pregnancy

| Drug Name      | Total | % Paid |
|----------------|-------|--------|
| IBUPROFEN      | 635   | 92%    |
| METRONIDAZOLE  | 373   | 89%    |
| PROMETHAZINE   | 358   | 92%    |
| FAMOTIDINE     | 345   | 79%    |
| FLUCONAZOLE    | 294   | 94%    |
| LABETALOL      | 288   | 73%    |
| DOCUSATE       | 279   | 11%    |
| NITROFURANTOIN | 261   | 93%    |
| SERTRALINE     | 258   | 73%    |
| VITAMIN D      | 245   | 81%    |

# ProDUR Review – Top 10 Drug to Gender

| Drug Name              | Total  | % Paid |
|------------------------|--------|--------|
| IBUPROFEN              | 20,911 | 91%    |
| FLUOXETINE             | 20,741 | 72%    |
| BUSPIRONE              | 19,062 | 75%    |
| GABAPENTIN             | 18,660 | 78%    |
| SEMAGLUTIDE (WEGOVY)   | 13,821 | 26%    |
| SEMAGLUTIDE (OZEMPIC)  | 11,145 | 36%    |
| ARIPIRAZOLE            | 10,535 | 75%    |
| TIRZEPATIDE (ZEPBOUND) | 9,920  | 17%    |
| VENLAFAXINE            | 9,843  | 74%    |
| TIRZEPATIDE (MOUNJARO) | 9,516  | 30%    |

# ProDUR Review – Top 10 Geriatric Precaution

| Drug Name        | Total | % Paid |
|------------------|-------|--------|
| ATORVASTATIN     | 1,183 | 59%    |
| AMLODIPINE       | 920   | 55%    |
| LISINOPRIL       | 658   | 57%    |
| GABAPENTIN       | 650   | 50%    |
| FUROSEMIDE       | 539   | 61%    |
| TRAZODONE        | 520   | 63%    |
| PANTOPRAZOLE     | 513   | 52%    |
| HYDROCODONE/APAP | 493   | 15%    |
| LEVOTHYROXINE    | 471   | 65%    |
| LEVETIRACETAM    | 454   | 72%    |

# ProDUR Review – Top 10 Pediatric Precaution

| Drug Name                | Total  | % Paid |
|--------------------------|--------|--------|
| LISDEXAMFETAMINE         | 19,716 | 85%    |
| FLUOXETINE               | 14,486 | 72%    |
| HYDROXYZINE              | 13,106 | 82%    |
| ARIPIRAZOLE              | 12,194 | 71%    |
| SERTRALINE               | 10,188 | 73%    |
| ESCITALOPRAM             | 8,449  | 76%    |
| TRAZODONE                | 8,156  | 72%    |
| GUANFACINE               | 7,315  | 78%    |
| POLYETHYLENE GLYCOL 3350 | 6,065  | 73%    |
| PREDNISOLONE             | 5,052  | 74%    |



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# Review of DUR Activities

# RetroDUR Activities: Aug 2024 – February 2025

| Initiative                                               | Faxed | Not Eligible | Successful Response | Unsuccessful or “No” Change |
|----------------------------------------------------------|-------|--------------|---------------------|-----------------------------|
| DDI: Respiratory conditions with high opioid utilization | 2,030 | 161          | 1,157               | 712                         |
| Antiretrovirals Adherence                                | 1,225 | 119          | 123                 | 983                         |

\*Not eligible indicates that patient is no longer a TennCare member or is no longer being seen by the targeted prescriber.

# RetroDUR Activities: Feb 2025 – August 2025

| Initiative                                                                       | Faxed  | Not Eligible | Successful Response | Unsuccessful or “No” Change |
|----------------------------------------------------------------------------------|--------|--------------|---------------------|-----------------------------|
| Antidepressants (exclude TCAs): PDC < 80%                                        | 44,368 | 2,887        | 3,578               | 37,903                      |
| Gap in Care: Triptan overutilization and not on a migraine preventive medication | 835    | 31           | 61                  | 743                         |

\*Not eligible indicates that patient is no longer a TennCare member or is no longer being seen by the targeted prescriber.

# RetroDUR Activities: Ongoing

| Initiative                                                                      | Faxed  | Not Eligible | Successful Response | Unsuccessful or “No” Change |
|---------------------------------------------------------------------------------|--------|--------------|---------------------|-----------------------------|
| Metabolic Monitoring: Using ANTIPSYCHOTICS but Missing LIPID PANEL/GLUCOSE TEST | 24,496 | 1,700        | 68                  | 22,728                      |
| ORM_CONCURRENT_OPIOID_ANTIPSYCH                                                 | 3,342  | 87           | 12                  | 3,243                       |
| ORM_CONCURRENT_OPIOID_BENZODIAZEPINES                                           | 44,368 | 2,887        | 3,578               | 37,903                      |

\*Not eligible indicates that patient is no longer a TennCare member or is no longer being seen by the targeted prescriber.

# Provider Education Initiatives

| NSAID use in Members with Cardiovascular Risks | Results |
|------------------------------------------------|---------|
| Very useful                                    | 28      |
| Useful                                         | 49      |
| Somewhat useful                                | 10      |
| Neutral                                        | 18      |
| Not useful                                     | 13      |

# Next Onsite Meeting

- What month would you recommend for the 2026 Onsite DUR meeting?
  - **January 2026**
  - **April 2026**
  - **July 2026**
  - **October 2026**



# Next Meeting

January 27, 2026