Arkansas Medicaid DUR Board Meeting Minutes

Date / Time:	October 21, 2026 8:30 AM– 12:30 PM Central	**Location:**	ZOOM webinar
Chair:	Cindi Pearson, Pharm.D.	**Reports:**	Jeniffer Martin, Pharm.D. Prime Therapeutics Karen Evans, P.D. Prime Therapeutics Allison Sweeney, Pharm.D. Prime Therapeutics

Attendance		**Panelist (voting members)**		**Panelist (non-voting members)**	**Organization**
		Geri Bemberg, Pharm.D.	X	Ginny Yates, Pharm.D.	ATC
	X	Clint Boone, Pharm.D.	X	Lisa Lu, Pharm.D.	Empower
	X	Natasha Bottoms, M.D.	X	Lauren Jimerson, Pharm.D.	Summit
	X	Ashley Crawley, Pharm.D.	X	Jessica Lawson, Pharm.D.	CareSource
	X	Gabriella Douglass, Pharm.D.	X	Cindi Pearson, Pharm.D.	DHS, DUR Chair
	X	Trenton Dunn, Pharm.D.		Cynthia Neuhofel, Pharm.D.	DHS pharmacy
	X	Lana Gettman, Pharm.D.		Elizabeth Pitman	DHS DMS director
	X	John Dawson Irvin, M.D.	X	William Golden, M.D.	DHS advisor
	X	Michael Mancino, M.D.	X	Christopher Smith, M.D.	DHS advisor
	X	Melissa Max, Pharm.D.	X	Shane David, Pharm.D.	ADH advisor
	X	Brenna Neumann, Pharm.D.	X	Karen Evans, P.D.	Prime Therapeutics
		Daniel Pace, M.D.	X	Jeniffer Martin, Pharm.D.	Prime Therapeutics
	X	Paula Podrazik, M.D.	X	Lesley Irons, Pharm.D.	Prime Therapeutics
	X	Chad Rodgers, M.D.	X	Linsey Gillam, Pharm.D.	Prime Therapeutics
		Shailendra Singh, MBBS, FACP	X	Alyson Greenwood, Pharm.D.	Prime Therapeutics
		[redacted]	X	Allison Sweeney, Pharm.D.	Prime Therapeutics
			X	Brooke Owens, Pharm.D.	Prime Therapeutics

Call to order		Meeting held virtually by Teams webinar. A quorum was present, and the chair called the meeting to order at 8:35 am.
Public comments		1. Paul Cockrum, PharmD (Vera Therapeutics) – TRUTAKNA 2. Uche Ndefo, PharmD (UCB) – BIMZELX 3. Beth Lubelczyk, PharmD (Eli Lilly) – MOUNJARO 4. Richard Oliver, MD (Liquidia) – YUTREPIA 5. Emily Flynn, PharmD was supposed to speak on Tyvaso DPI, but she did not attend the meeting.
Announce-ments		1. All attending Board members had no conflict of interest. Dr. Pearson, Dr. Martin, Dr. Evans, Dr. Sweeney and Dr. Greenwood had no conflict of interest. 2. Dr. Pearson welcomed a new DUR Board member, Dr. Natashia Bottoms. Dr. Bottoms fills the psychiatrist position. 3. Quarterly provider newsletter—https://ar.primetherapeutics.com/documents/d/arkansas/arkansas-medicaid-quarterly-newsletter-october-2026 4. System edits updates from previous meeting. 5. General information on new oncology meds, FUROSCIX, and overdose report (no vote required)
PAD monograph		The PAD Subcommittee approved PAD monograph updates during the September 9th meeting. The medications included DATROWAY, IMFINZI, KEYTRUDA, OCREVUS, TECENTRIQ, TRODELVY, TZIELD, ADSTILADRIN, KISUNLA, TEVIMBRA, YARTEMLEA, YEZTUGO, ZIIHERA, and ZUSDURI. The DUR Board voted to give the final approval of the monograph updates as presented. The motion was made by Dr. Douglass; second by Dr. Podrazik. All voting members present voted for approval of the PAD monograph updates as presented. Motion passed.

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Minutes		Motion to approve the July 2026 DUR meeting minutes as presented was made by Dr. Rodgers; second by Dr. Podrazik. All voting members present voted for approval of the minutes as written. Motion passed.
Reports		• Dr. Pearson presented the PASSE ProDUR report for April through June 2026. • Dr. Evans from Prime Therapeutics presented the FFS ProDUR report for July through September 2026. • Dr. Sweeney from Prime Therapeutics provided a RDUR recommendation for upcoming reviews for November through January. o Long-term PPI use o Noncompliance with antihyperlipidemics o Noncompliance with oral diabetes medications She also presented the Lock-In Report from July through September as well as the Top 25 products by total claims and products by pharmacy reimbursement. She also went over outcome analysis reviews. **ACTION:** Motion to approve next quarter's clinical review for RDUR was made by Dr. Crawley for the above criteria; second by Dr. Mancino. All other members present voted for the motion. Motion passed.
PDL Class Review		**1) Hepatitis C Agents** Dr. Martin presented a PowerPoint with the following information. a) Overview of medications with indications b) DAA key class considerations c) Treatment guidelines from American Association for the Study of Liver Diseases/Infectious Diseases Society of America d) Claims summary from 07/01/2025-06/30/2026 Dr. Pearson presented to the board the GENEROUS model and recommended that this class be deferred to the cost committee for review to determine which products to move to preferred only and to remove all PA criteria. The only criteria that we are going to put forth for review is for VOSEVI since it is not preferred, but the manufacturer made a GENEROUS offer. We are adding specific criteria that the patient must be an adult with a confirmed hepatitis C diagnosis based on their labs. They must be refractory to previous treatment with generic EPCLUSA and/or MAVYRET. If a patient fails EPCLUSA then the next step would be MAVYRET before moving to VOSEVI, but if they failed with MAVYRET they could not use EPCLUSA before VOSEVI. **DISCUSSION:** Dr. Douglass stated she fully supports removing unnecessary barriers for hepatitis C treatment, and she thinks expanding access is going to be incredibly important, particularly for our state. With removing the PA, she thinks that the only thing to highlight would be having clear implementation and clinical support strategy in place. Clinical support is important since we only recently removed fibrosis and sobriety restrictions, and we would be removing the specialist only treatment which opens to a much broader group of primary care providers. Dr. Douglass asked how we are ensuring those providers are aware of these changes and that it's being prescribed appropriately. She also had questions regarding what dispensing would look like and if they would be given the whole regimen or do one month at a time. She stated that there are criteria in terms of how many doses are missed, and then we would need to adjust how the patients are treated. She expressed supporting this change, but this needs to be translated into safe appropriate treatment and documented cures. Dr. Golden added that we do have an active PCMH program that has multiple providers and primary care sites involved. So, it would be a very good vehicle for education as well as a robust data infrastructure that sends information about utilization or patients that have

DRAFT

confirmed diagnosis of Hepatitis C. Dr. Golden stated that the question he has is whether UAMS has any kind of ECHO like activity. Dr Golden stated that they had talked about whether GI consultants are on call or available, and he was not sure where that stands right now like we do for psychiatrics in the field. Dr. Douglass stated that they do have through ARCARE where the South-Central ATC ECHO program its HIV, but on Wednesdays we have collaborated with the Department of Health to do Hepatitis C ECHO's to move to a broader group of folks that could have access. She stated that having an ECHO program in place for a provider to present a case or to get education is great. Dr Golden stated he could get something together for the Arkansas Medical Journal too. Dr. Pearson stated that she would have a chat with the health department and maybe they could provide outreach and send out newsletters as well. Dr. Pearson stressed the importance of making sure that providers are very educated about what is expected. Dr. Pearson and Dr. Douglass agreed to collaborate on this. Dr. David also stated that he is happy to participate in whatever is needed. Dr. Douglass wanted clarification on sending this to the cost committee first and asked once the cost committee approves it then the formulary will be updated. Dr. Pearson stated that we look at the criteria here, and then the cost committee looks at the cost and makes their recommendation. The state will look at this board's recommendation and the cost committee's recommendation together. Dr Rodgers asked if we should follow two separate motions, one to refer to cost committee and then a second to approve criteria. Dr. Pearson said she planned on doing them as one but is fine with that as well.

ACTION:
Motion was made by Dr. Rodgers to defer PDL placement to cost committee and approve VOSEVI criteria as presented; second by Dr. Max. All other members in attendance voted for the motion. Motion passed.

2) Pulmonary Arterial Hypertension Agents

Dr. Martin presented a PowerPoint with the following information.

a) Summary of medications with indications
b) Treatment guidelines from the American College of Chest Physicians (CHEST) 2019, European Society of Cardiology/European Respiratory Society, and 7th World Symposium on Pulmonary Hypertension 2024
c) Summary of treatment considerations
d) Claims summary from 07/01/2025-06/30/2026

Dr. Pearson noted that this class was brought to review by NMPI recommendation, and the PDL status should be deferred to the cost committee for review. There are some updates to the PAH criteria, but triple and quadruple therapy will remain on a case-by-case basis for those patients that are already using a PDE/ERA.

RECOMMENDED APPROVAL CRITERIA :

- Prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Treatment regimen requesting
  - Provide 6MWD
  - Documentation of WHO-Functional Class
    - WHO-FC I (low risk): No limitation of physical activity
    - WHO-FC 2 (low risk): Slight limitation; comfortable at rest
    - WHO-FC 3 (intermediate risk): Marked limitation, comfortable at rest, but less than ordinary activity causes symptoms

DRAFT

        - WHO-FC 4 (high risk): Symptoms at rest, signs of right heart failure, inability to perform any activity without symptoms
- Treatment options by risk status
    - Initial therapies and those at low risk should receive an endothelin receptor antagonist (ERA) and a phosphodiesterase type-5 inhibitor (PDE5i)
    - Intermediate risk patient despite ERA/PDE5i therapy
        - Add selexipag; OR
        - Switch from PDE5i to riociguat
    - Intermediate high to high risk patient despite oral therapy
        - Add IV epoprostenol or IV/SC Treprostinil; OR
        - Add selexipag; OR
        - Switch from PDE5i to riociguat
- Triple and quadruple therapy will continue to be reviewed on a case-by-case basis for medical necessity over PDE/ERA therapy alone based on treatment guidelines.
- Diagnoses other than PAH WHO Group 1 will be reviewed on a case-by-case basis.

DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Irvin to defer to the cost committee for the preferred medication(s) and approve the criteria for PAH as presented; second by Dr. Rodgers. All other members in attendance voted for the motions. Motions passed.

3) <u>Erythropoiesis Stimulating Agents</u>

Dr. Martin presented a PowerPoint with the following information.

a) Summary of medications with indications
b) Guidelines The American Society of Clinical Oncology and the American Society of Hematology, National Comprehensive Cancer Network, and Kidney Disease: Improving Global Outcomes Group.
c) Claims summary from 7/1/2025-6/30/2026

Dr. Pearson noted this class was brought to the Board due to recommendations based on GENEROUS model and stated there may need to be some PDL changes. She also recommended that this class be deferred to the cost committee for review and to not make any changes to the POS criteria.

DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Irvin to defer to the cost committee for the preferred medication(s); second by Dr. Podrazik. All other members in attendance voted for the motions. Motions passed.

4) Narcolepsy Agents

Dr. Martin presented a PowerPoint with the following information.

a) Summary of medications with indications
b) Treatment Considerations
c) Claims summary from 7/1/2025-6/30/2026

DRAFT

Dr. Pearson noted that this class was brought to review by NMPI recommendation, and the PDL status should be deferred to the cost committee for review. Dr. Pearson stated that this review would not include LUMRYZ and ORZEYFUL since they are not on the market and stated that when they become available, they will be added as non-preferred until the next review. Recommended updates to criteria as below were shared with the Board.

- Requests for non-preferred medications for beneficiary ≥ 19 years of age require a documented trial and failure of at least one agent from each drug class that is FDA-approved for this indication (e.g., CII stimulants and preferred CIII and CIV narcolepsy agents) in the last year with documentation of the medical necessity over the preferred medications.
- Requests for non-preferred medications for beneficiary ≥ 7 years of age and < 19 years of age require a documented trial and failure of at least one agent from each drug class that is FDA-approved for this indication (e.g., CII stimulant and preferred CIII narcolepsy agent) in the last year with documentation of the medical necessity over the preferred medications.

DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Rodgers to defer to the cost committee for the preferred medication(s) and approve the criteria as presented; second by Dr. Crawley. All other members in attendance voted for the motions. Motions passed.

5) Targeted Immunomodulators

Dr. Martin presented a PowerPoint with the following information.

a) Summary of medications with indications and designated by mechanism of action
b) Clinical Guidelines: Crohn's Disease – American College of Gastroenterology and American Gastroenterological Association, Ulcerative Colitis- American College of Gastroenterology and American Gastroenterological Association, and Axial Spondyloarthritis- American College of Rheumatology/Spondylitis Association of America/ Spondyloarthritis Research and Treatment Network, and Juvenile idiopathic arthritis ACR 2026
c) UPADACITINIB vs TOFACITINIB in Ulcerative Colitis
d) Claims summary from 7/1/2025-6/30/2026

Dr. Pearson noted that this class was brought to the Board based on recommendations of GENEROUS model and NMPI. She recommended that PDL placement be deferred to the cost committee. Dr. Pearson presented to the Board the criteria created for the new disease state, DERMATOMYOSITIS, and updates needed for Crohn's Disease, Ulcerative Colitis, and Still's Disease. Dr. Pearson also provided drug information for LISRAYA.

Recommended Ulcerative Colitis changes

- The beneficiary has a history of at least **ONE** of the following:
  - Hospitalized for ulcerative colitis; **OR**
  - Trialed multiple days of IV glucocorticoids; **OR**
  - Trialed ≥ 2 months of oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)

DRAFT

- ~~The beneficiary has been hospitalized for ulcerative colitis or had a trial and failure with of ≥ 2 months of oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone) of standard of care drug therapy with at least two of the following for induction or maintenance of remission:~~
    - ~~Immunosuppressants (e.g., azathioprine, 6-mercaptopurine, cyclosporine)~~
    - ~~Oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone); OR~~
    - ~~Oral/rectal 5-aminosalicylic acid agents (e.g., mesalamine, sulfasalazine)~~

Recommended Crohn's Disease changes

- The beneficiary has been hospitalized with Crohn's Disease OR been diagnosed with a fistula or abscess OR had a trial and failure with ≥ 2 months of oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone) ~~standard of care drug therapy with at least two of the following for induction or maintenance of remission:~~
    - ~~Immunosuppressants (e.g., azathioprine, 6-mercaptopurine, cyclosporine)~~
    - ~~Oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)~~
    - ~~Oral/rectal 5-aminosalicyclic acid agents (e.g., mesalamine, sulfasalazine); OR methotrexate~~

Recommended Still's Disease changes

- New onset ~~AOSD~~ therapy
    - ~~Trial and failure of NSAIDs or oral glucocorticoids at the maximum indicated dose unless a contraindication or intolerance for mild to moderate disease~~
    - Initial recommended therapy for patient without macrophage activation syndrome is either an IL-1 or Il-6 biologic (e.g., tocilizumab, canakinumab)
    - If macrophage activation syndrome is suspected, high dose IV corticosteroids, cyclosporine, or a biologic may be warranted (UpToDate® recommends anakinra as the biologic in these beneficiaries)
- ~~Established AOSD still needing~~ Subsequent therapy (without response to or intolerant to initial therapy)
    - An alternate IL-1 or IL-6 biologic; **OR**
    - Janus kinase inhibitor (JAKi); **OR**
    - DMARD; **OR**
    - Glucocorticoid
    - ~~Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):~~
        - ~~methotrexate; **OR**~~
        - ~~leflunomide~~

RECOMMENDED APPROVAL CRITERIA FOR DERMATOMYOSITIS:

(Lisraya)

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating dermatomyositis
- The beneficiary has a documented diagnosis of dermatomyositis
    - Documentation of idiopathic inflammatory myopathy (IIM) with muscle weakness and/or inflammation; AND
    - Dermatomyositis subgroup of IIM supported by patient specific symptoms
- The beneficiary must have been treated with corticosteroids along with a trial ≥ 3 months of at least TWO of the following:

DRAFT

- Methotrexate; OR
- Hydroxychloroquine; OR
- Mycophenolate mofetil; OR
- Azathioprine; OR
- Leflunomide; OR
- Sulfasalazine

- The beneficiary may also be prescribed topical corticosteroids and/or topical calcineurin inhibitors
- The prescriber must submit the following:
  - Current chart notes
  - Previous treatment for dermatomyositis
  - Medical necessity over other guideline recommended options (e.g., IVIG, rituximab)
  - Patient specific symptoms to confirm diagnosis
    - Cutaneous findings (e.g., Gottron's papules, Gottron's sign, heliotrope eruption)
    - Lab evidence of myositis (serum creatine kinase and aldolase levels)
    - Muscle weakness
    - Skin biopsy if ambiguous cutaneous findings
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Mancino to approve the criteria as presented for dermatomyositis; second by Dr. Irvin. All other members in attendance voted for the motions. Motions passed.

Motion was made by Dr. Podrazik to approve the criteria as presented for disease states UC, CD, and Still's disease; second by Dr. Irvin. All other members in attendance voted for the motions. Motions passed.

Motion was made by Dr. Irvin to defer to the cost committee; second by Dr. Podrazik. All other members in attendance voted for the motions. Motions passed.

6) Calcium Channel Blockers

Dr. Martin presented a PowerPoint with the following information

a) Summary of medications with therapeutic overview
b) Formulation comparison for amlodipine liquid preparations
c) Claims summary from 07/01/2025-06/30/2026

Dr. Pearson noted that this class was brought to the Board based on recommendations of NMPI, and she asked to defer to the cost committee for review.

DISCUSSION:
Dr. Boone stated he did not see availability of ordering SDAMLO, so he was not sure he would make a recommendation to put that as a PDL over the other two. Dr. Pearson stated that availability was important, but it could change. Dr. Boone stated that it might, but even if they had to mix that each time puts it in a different class. Dr. Pearson stated she would let him go ahead and make the motion if he would. Dr. Neumann stated that she had a comment about NIFEDIPINE IR being non-preferred and asked if there was a POS edit for certain indications for it? Dr. Pearson stated that she thought it was preferred and Dr. Neumann stated that it was but wanted to know the POS edits. Dr. Pearson

DRAFT

		stated that she sees more of that in acute need than the hospital with someone with high blood pressure, but they do not have limitations on either one as far as which ones preferred which is good, but they are picking the cheaper one. Dr. Pearson asked Dr. Boone if his recommendation was to have at least NORLIQVA as preferred and have cost committee review. Dr. Boone agreed. **ACTION:** Motion was made by Dr. Boone for NORLIQVA to be preferred and defer to the cost committee; second by Dr. Irvin. All other members in attendance voted for the motions. Motions passed. **7) Bronchodilators** Dr. Martin presented a PowerPoint with the following information a) Summary of medications with therapeutic overview b) Global Initiative for COPD (GOLD) 2026 guidelines c) COPD inhaler formulations d) Global Initiative for Asthma (GINA) 2026 guidelines on LAMA add-on Therapy in Asthma e) Claims summary from 07/01/2025-06/30/2026 Dr. Pearson noted that this class was brought to the Board based on recommendations of GENEROUS model and NMPI. She recommended PDL status review be deferred to the cost committee unless there are products deemed superior clinically that need to be preferred. She also recommended adding PA criteria to ICS/LABA/LAMA bronchodilators. The PDL review includes the following o LAMA Bronchodilators o LABA/LAMA Bronchodilators o ICS/LABA/LAMA Bronchodilators **DISCUSSION:** Dr. Max had a question about the criteria for no duplication of other inhalers with triple therapy product. Dr. Max wanted to know if they are switching to a triple would that just be a contact for a prior authorization approval during that time of switching from maybe two different ones to the triple if that makes sense. Dr. Pearson stated that she understood the question but was not sure the best way to prevent the first one needing a PA. Dr. Evans said they could write therapeutic duplication criteria and just look at the triple therapy as a therapeutic duplication. Dr. Pearson said they can prevent patients from transitioning to this to be an issue, and we need to try to code it correctly. We don't want them to get one of these triple therapies and try to get SYMBICORT also. **ACTION:** Motion was made by Dr. Max to defer to the cost committee and for the triple therapy criteria as presented; second by Dr. Rodgers. All other members in attendance voted for the motion. Motion passed.
New Business		**1) LYNAVOY (linerixibat) 40 mg tablet** **<u>Dr. Pearson provided the following on:</u>** • Indication, gross cost, and dosing • Contraindications and warnings • Mechanism of action • Clinical trial information • Treatment options for primary biliary cholangitis • Draft criteria

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DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Irvin to approve criteria as presented; second by Dr. Mancino. All other members in attendance voted for the motion. Motion passed.

2) TRYNGOLZA (olezarsen) injection

Dr. Pearson provided the following for:
- Indication, gross cost, and dosing
- Contraindications and warnings
- Mechanism of action
- Clinical trial information
- Draft criteria

DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Irvin to accept the criteria as presented; second by Dr. Mancino. All other members in attendance voted for the motion. Motion passed.

3) LIPFENDRA (enlicitide) tablet

Dr. Pearson provided the following for:
- Indication, gross cost, and dosing
- Mechanism of action
- Clinical trial information
- Draft criteria

DISCUSSION:
No comments.

ACTION:
Motion was made by Dr. Irvin to accept the criteria as presented; second by Dr. Gettman. All other members in attendance voted for the motion. Motion passed.

4) TRUTAKNA (atacicept-vymj) 150mg/mL injection

Dr. Pearson provided the following for:
- Indication, gross cost, and dosing
- Mechanism of action
- Clinical trial information
- Information for KDIGO
- Draft criteria

DISCUSSION:
No comments.

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ACTION:
Motion was made by Dr. Mancino to accept the criteria as presented; second by Dr. Podrazik. All other members in attendance voted for the motion. Motion passed.

5) LEQEMBI IQLIK (lecanemab) 250mg/1.25mL & 360mg/1.8mL injection

Dr. Pearson provided the following for:
- Indication, gross cost, and dosing
- Contraindications and warnings
- Mechanism of action
- Clinical trial information
- Draft criteria

DISCUSSION:
Dr. Golden stated that everybody who is forgetful doesn't have Alzheimer's and probably one of the most common diagnoses for dementia is vascular disease and has nothing to do with Alzheimer's. So, we've had patients that smoked or had diabetes with forgetfulness when they're 50. Dr. Golden stated that in one case from a neurologist the MRI actually showed small vessel disease that was a contraindication for the use of these drugs. So, there are all sorts of interesting pitfalls in the diagnosis and with all the marketing going on. We have to make sure that people who are forgetful really have Alzheimer's because a lot of them do not. Dr. Podrazik stated she had similar concerns.

ACTION:
Motion was made by Dr. Rodgers to accept the criteria as presented; second by Dr. Crawley. All other members in attendance voted for the motion. Motion passed.

6) MOUNJARO (tirzepatide) injection (MACE indication)

Dr. Pearson provided the following for:
- Indication, gross cost, and dosing
- Contraindications and warnings
- Mechanism of action
- Clinical trial information
- Draft criteria

DISCUSSION:
No comment.

ACTION:
Motion was made by Dr. Podrazik to accept the criteria as presented; second by Dr. Rodgers. All other members in attendance voted for the motion. Motion passed.

7) ISOTRETINOIN capsules (For Acne)

Dr. Pearson provided the following for:
- Indication, gross cost, and dosing
- Contraindications and warnings
- Mechanism of action
- Clinical trial information

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		• New dosing recommendations • Draft criteria **DISCUSSION:** No comment. **ACTION:** Motion was made by Dr. Rodgers to accept the criteria as presented; second by Dr. Irvin. All other members in attendance voted for the motion. Motion passed. **8) Fiscal Integrity Surveillance (FIS) Policy** Dr. Pearson stated that this policy would help manage expenditures for products associated with unpaid or delayed statutory rebates and for high-cost products when clinically comparable, lower-cost alternatives are available. Examples: • Manufacturer for the product, Phexx, has delayed paying required rebates. • New buspirone strengths have a significantly higher cost than older alternatives. o Buspirone 2.5 mg and 12.5 mg tablet ($72) o Buspirone 5 mg tablet ($0.02) o Buspirone 30 mg tablet ($0.12) • New ursodiol strength has a significantly higher cost than other products of different strengths on the market. o Ursolign 150 mg capsule ($40.25) o Ursodiol 500 mg tablet ($0.65) o Ursodiol 300 mg capsule ($0.43) Dr. Pearson presented the policy to the board. **DISCUSSION:** No comment. **ACTION:** Motion was made by Dr. Irvin to accept the criteria as presented; second by Dr. Podrazik. All other members in attendance voted for the motion. Motion passed.
Board comments		None
Adjourn		Meeting was adjourned at 12:08 pm.

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