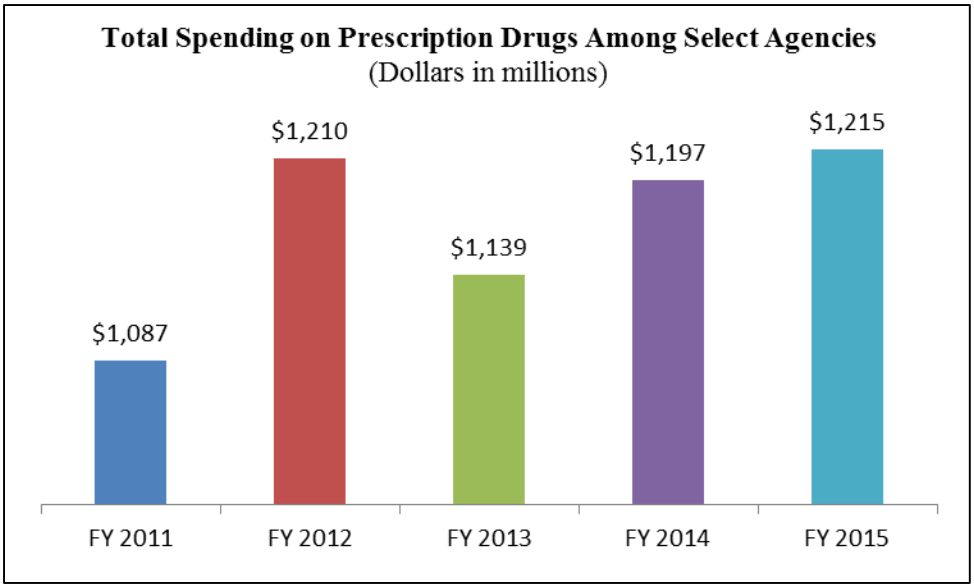
High-Cost Prescription Drugs in Virginia

Introduction and Mandate

The cost of prescription drugs has risen steadily over the last several years. This increase is evident in commercial market plans and state agency prescription drug budgets alike. Virginia's total spending on prescription drugs has consistently trended upward over the past five years and exceeded $1.2 billion in FY 2015 from all fund sources. Rising drug costs also drive increases in Medicare and private insurance premiums, including those on the Exchange, thereby negatively impacting Virginia consumers.



Agencies reporting include:

Department of Medical Assistance Services, Department of Behavioral Health & Developmental Services, Department of Health, Department of Corrections, Department of Juvenile Justice and Department of Human Resources Management.

Budget language from the 2016 General Assembly directed the Secretary of Health and Human Resources to review this trend and recommend options to address this issue. Specifically,

> *The Secretary of Health and Human Resources, in consultation with the Secretary of Public Safety and the Secretary of Administration, shall convene a work group including, but not limited to, the Department of Medical Assistance Services, Department of Social Services, Department of Health, Department of Behavioral Health and Developmental Services, Department of Corrections, Department of Juvenile Justice, the Compensation Board, the Department of Human Resource Management and other relevant state agencies to examine the current costs of and protocols for purchasing high-cost medications in order to improve the care and treatment of individuals served by these agencies.*

National and State Reviews

National Academy for State Health Policy (NASHP) Report

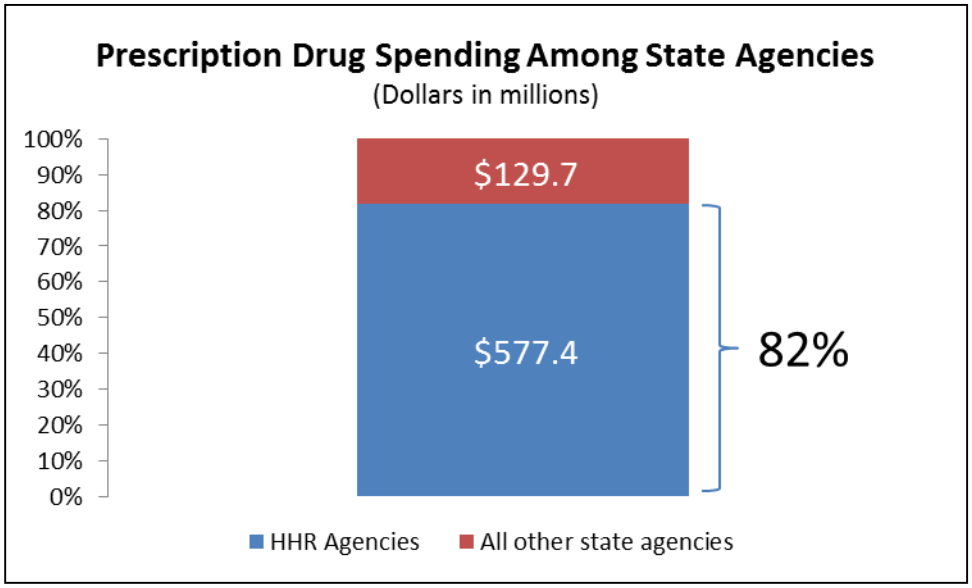
Virginia is not unique in its experience with rising prescription drug costs. As states have continued to grapple with rising prices and taken different approaches to lower their spending, a workgroup with the National Academy for State Health Policy (NASHP) released a comprehensive report (http://nashp.org/wp-content/uploads/2016/10/Rx-Paper.pdf) in October 2016 which identified options for states that may help to lower or slow costs. Those options include strategies that would:

- Increase price transparency to create public visibility and accountability;
- Create a public utility model to oversee in-state drug prices;
- Purchase in bulk and distribute high-priced, broadly-indicated drugs that protect public health;
- Use state unfair trade and consumer protection laws to address high drug prices;
- Seek the ability to re-import drugs from Canada on a state-by-state basis;
- Pursue Medicaid waivers and legislative changes to promote greater purchasing flexibility;
- Enable states to operate as pharmacy benefit managers to broaden their purchasing and negotiating powers;
- Pursue return on investment pricing and forward financing approaches to allow flexible financing based on long-term, avoided costs;
- Ensure state participation in Medicare Part D through Employer Group Waiver Plans;
- Protect consumers against misleading marketing; and
- Use shareholder activism through state pension funds to influence pharmaceutical company actions.

Variations on these recommendations were discussed by Virginia's High Cost Prescription Drug Study workgroup and are included later in this report.

Virginia General Fund Prescription Drug Spend

State General Fund expenditures on prescription drugs totaled $707 million in FY 2015. This includes purchasing within the Medicaid fee-for-service and managed care programs, corrections, the state employee health plans, local health departments and community services. Eighty-two percent of general fund spending on prescription drugs can be attributed to Health and Human Resources agencies (primarily the state's Medicaid program). Prescription drug spending accounts for 11 percent of all general fund dollars spent among HHR agencies.



2002 JLARC Reports

In January 2002, the Joint Legislative Audit and Review Commission (JLARC) produced "A Review of Selected Programs in the Department of Medical Assistance Services" (http://jlarc.virginia.gov/pdfs/reports/Rpt275.pdf) in which pharmacy costs were cited as one of four areas requiring "immediate review because they are in a period of transition or because of escalating costs." While it was noted that DMAS had already adopted the most common strategies to control costs, JLARC also recommended that DMAS: "improve the prior authorization process, lower pharmacy reimbursement rates, and improve the recovery of third party payments." The 2002 General Assembly approved several measures to reduce prescription drug costs consistent with JLARCs recommendations including reducing reimbursements to pharmacies and increasing recoveries from pharmaceutical manufacturers.

Later in 2002, JLARC produced a special "follow-up" report "State Spending on Medical Supplies and Pharmaceuticals" (http://jlarc.virginia.gov/pdfs/reports/Rpt292.pdf) that provided a more comprehensive review of the drivers of pharmaceutical spending in state agencies as well as recommendations to reduce the total spend. The major recommendation that culminated from JLARCs secondary review was the creation of a Preferred Drug List or PDL by the 2003 General Assembly.

Many of the drivers of pharmacy spending have not changed; prices are set by pharmaceutical companies and subsequently reduced through rebates and group purchasing strategies. The inconsistency in the final price paid for the same drug by different agencies continues today as a result of that process. For example, while some state agencies are able to access special pricing through the federal 340B Drug Pricing Program of the Public Health Services Act, a complex discount purchasing mechanism based on programs and populations served, the option is only available for outpatient drugs. The discounts employed by the state university hospitals (University of Virginia and Virginia Commonwealth University) and the Virginia Department of Health for certain outpatient drugs are not accessible to or are not used by other agencies. Further, many local agencies like Community Services Boards and local/regional jails have individual purchasing contracts that vary significantly across the state (See Appendix C).

Current State Spending on Pharmaceuticals by Program

I. Medicaid

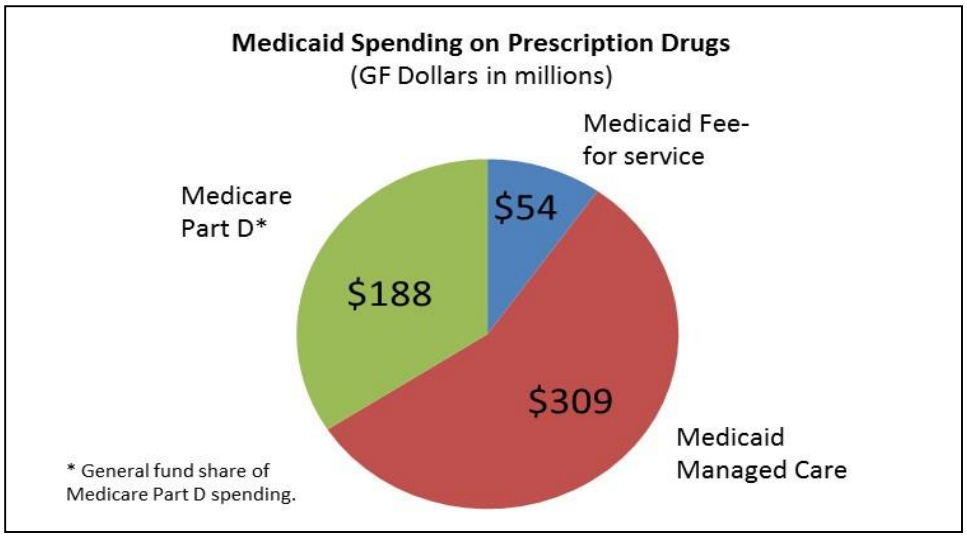
HHR spending on prescription drugs accounts for more than 80 percent of all general fund pharmacy costs. Medicaid spent $551 million on prescribed drugs in FY 2015. More than half of this amount was within Medicaid managed care organizations. Medicaid's share of spending on Medicaid managed care has increased significantly over the past decade as more populations are shifted from fee for service delivery systems to managed care.

There are federal requirements that impact the choice and cost of drugs on the Medicaid formulary. Rebates are negotiated at the federal level, and a significant increase in rebates was generated by the Affordable Care Act (ACA). In FY 2016, the Commonwealth

received $39 million in general fund rebates for the fee-for-service program but more than $142 million in general fund rebates from Medicaid managed care organizations. If the ACA is repealed, the Commonwealth is at-risk of losing more than $142 million in general fund revenues to offset Medicaid pharmacy costs. Further, Medicaid can negotiate additional rebates on drugs used for members in the fee for service program but is not allowed to receive further rebates on the drugs that are provided through managed care. Due to the rebates and the pricing strategies for generic drugs, brand name drugs may be less expensive to the state than generic drugs.

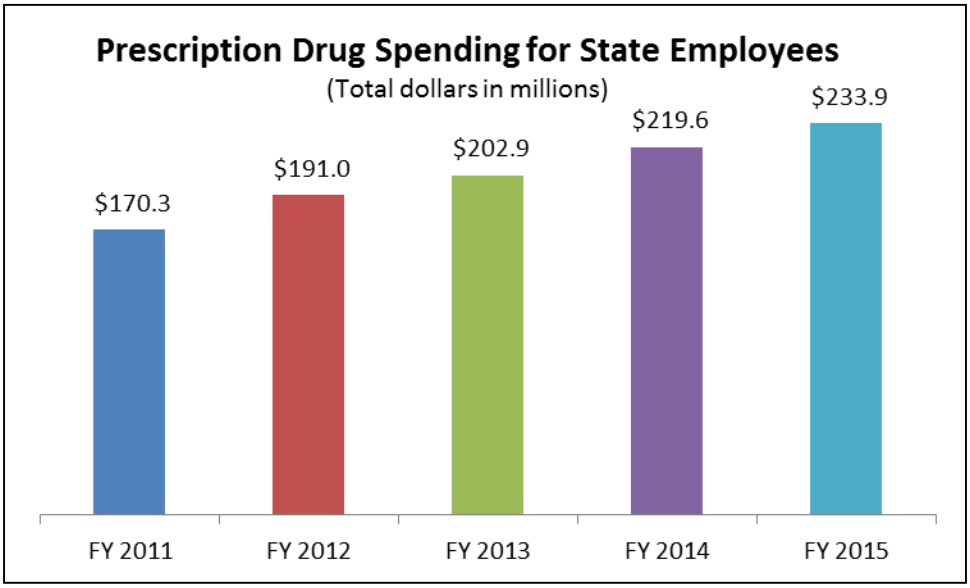
The next largest share of Medicaid spending on prescription drugs is the state share of Medicare Part D which provides prescription drugs for Medicare recipients who are also enrolled in Medicaid, i.e., the dually eligible (see Appendix A for drugs listed by price). The state share of Medicare Part D is mandated by the federal government and the Commonwealth has no control over the amount.

Medicaid spending on the remaining population of fee for service enrollees accounts for the balance of Medicaid spending on prescription drugs.



II. The State Employee Health Plan

In FY 2015, $234 million in total funds was spent on pharmaceuticals for state employees. Costs for prescription drugs reflect state general fund appropriations as well as premiums paid by state employees. Prescription drugs for state employees are managed through the managed care organizations (MCO's) which use a tiered pricing structure to incentivize appropriate demand, as well as techniques such as pre-authorizations and pharmacist reviews.

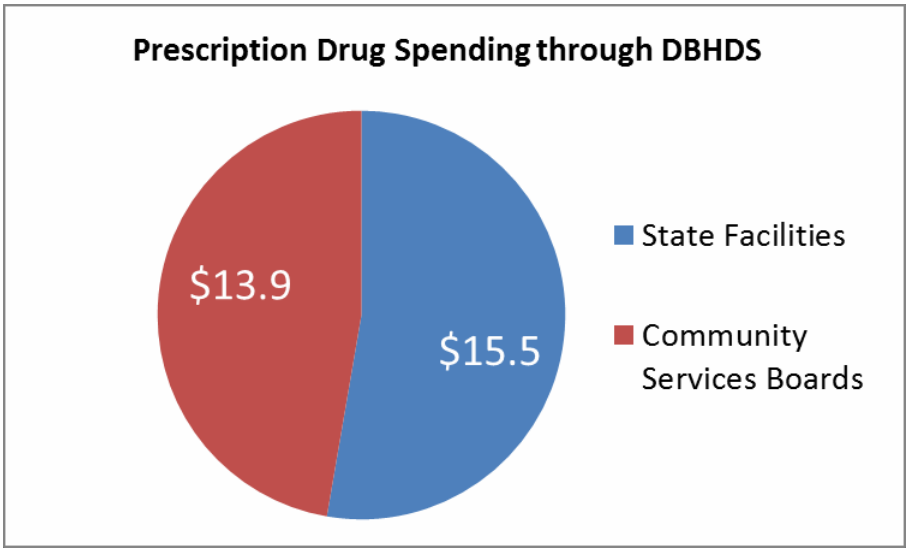


III. Behavioral Health

The Commonwealth spends more than $29 million from all fund sources for prescription drugs provided through the Department of Behavioral Health and Developmental Services (DBHDS). Almost one-half of spending was allocated to 12 state facilities, with the balance of spending accounted for through the state's 40 community services boards. It should be noted that the $13.9 M figure from the CSBs likely understates actual pharmacy spending because it does not reflect local funds CSBs may set aside for prescription drugs that are not reported through the state's accounting system.

CSBs report using a variety of methods to lower prescription drug costs for their clients, including dispensing of samples, individual contracts with local pharmacy providers for low-cost generic drugs, and accessing prescription assistance programs.

DBHDS operated a Community Resource Pharmacy until 2010, when it was closed as a budget cutting exercise. It is unclear how much cost shifting or cost savings resulted from this closure.



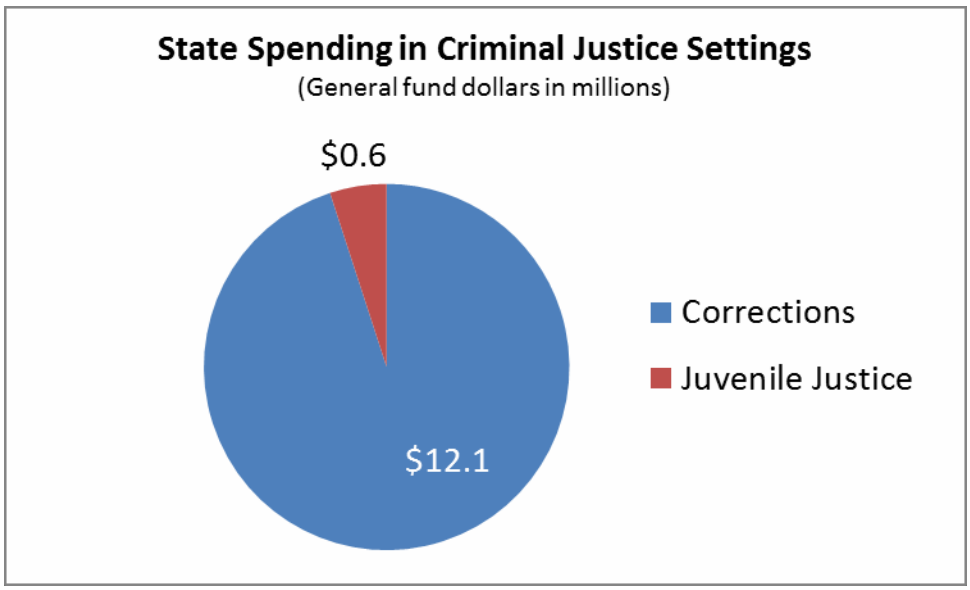
IV. Public Safety

State spending on prescription drugs in the Department of Corrections and the Department of Juvenile Justice accounts for the smallest share of total state general fund spend on pharmaceuticals, even though spending on prescription drugs in these settings relies solely upon state dollars. Local and regional jails are also purchasers of prescription drugs, and much like CSBs they rely on a mix of funding and often have agreements with local pharmacies to provide their prescription services. A definitive number for this total taxpayer cost is not available.

Drug purchasing strategies tend to vary by jail. Not surprisingly, regional jails and jails from larger or better-resourced localities appear to have more comprehensive plans to manage their

prescription drug programs. Some of the reported strategies jails use include use of a drug formulary, contracting with outside entities to manage drug purchases, adhering to most recent practitioner guidelines, returning unused drugs, using generic drugs when available and less expensive, seeking rebates or discounts from manufacturers and purchasing frequently used drugs in bulk. Some jails participate in the Minnesota Multi-State Compact, while other jails have trained staff to manage drug usage. Jail health care is often provided by third party contractors.

Major concerns for jails and correctional facilities going forward are the prevalence of hepatitis and opiate addiction in their populations. The most successful drug for hepatitis costs upwards of $90,000 per course of treatment. The drug of choice for medically assisted treatment (MAT) in the jail setting has a list price of more than $1,000 for a monthly dose.



Commercial Health Plan Spending on Pharmaceuticals

Consumers with commercial health plans in Virginia paid $2.0 billion for prescription drugs in 2015. According to a report by IMS health, prescription drug prices rose an average of 12% in 2015, and similar rate increases have been the norm for several years. As these costs continue to rise, media attention and public frustration grow as well. There has been a renewed focus on the reasons for these increases.

Pharmaceutical Industry Pricing Strategies

All drug prices begin with a list price that is established by pharmaceutical companies. Negotiations with MCOs, pharmacy benefit managers (PBMs) and various discount programs generally result in paid cost being lower than the list price, and the "savings" depend on the market power of the buyer. When new drugs are placed under patent by their makers, they enjoy a several-year period of market exclusivity (21 CFR 314.108) in which they hold near-monopolies on the specific drug. It is common practice to extend the patent for as long as possible. Often minor modifications are made to the drug to obtain the protection.

When drugs are no longer protected by patents, two main strategies are used to maintain pricing. One such strategy is to contract with a generic manufacturer to delay introduction of a generic equivalent. Another is that the company which holds the generic patent will often become the generic manufacturer. In both cases the market is ineffective.

Several mechanisms are in place to arrive at a final price paid for a drug by both public and private payers. The Medicaid Drug Rebate Program [42 U.S.C. 1396r–8] (a) directs that all new drugs must be submitted to the Centers for Medicare and Medicaid Services (CMS) in order to establish rebates. All approved drugs have rebates based on statutory formulas for different categories of drugs. These rebates are paid out quarterly and shared between state and federal budgets.

While Medicare is prohibited by the Medicare Modernization Act of 2003 (which established Part D) from directly negotiating drug prices, health plan pharmacy benefit managers intercede to lower costs for individual plans in much the way they do for commercial plans. Commercial insurers (and state Medicaid programs) also contract with third-party entities known as PBMs to maintain formularies and negotiate down from the list price so that insured consumers ultimately have a lower out-of-pocket payment for a drug.

Pharmacy benefit managers remain unregulated in the Commonwealth. Lack of transparency has been a common complaint. Some pharmacists have complained that they are receiving lower payments from the PBM than is required by contract for private insurance plans or by law for public plans.

Individuals who are uninsured (or whose formularies do not include certain necessary prescriptions) do not benefit from discounts and are often faced with paying the list price in the absence of a health plan to negotiate on their behalf. Patient assistance programs (also called "co-pay charities") offer deep discounts on specific drugs for consumers who cannot afford the total cost or their co-pay shares. By creating charities and subsequently partnering with pharmaceutical companies who fund those charities

directly, these patient assistance programs can get needed prescription drugs to individuals while pharmaceutical companies maintain a margin of profit.

The Virginia Association of Health Plans (VAHP) has expressed concerns in the practices of pharmaceutical companies that are used to "expand market share and drive demand for their products. The use of rebates and incentives provided to patients in plans undermines the economic incentives in the plan design and contributes to rising expenses for the plan." In addition to the rebates and patient assistance programs that support artificially high list prices, the federal Orphan Drug Act creates effective monopolies on products for several years. The VAHP notes that marketing to providers and consumers alike creates demand for prescription drugs that may not otherwise exist.

The VAHP has observed that extreme price increases for generic drugs or drugs with recently-expired patents (like Turin Pharmaceuticals' well-documented nearly 4,000% increase in the list price of Daraprim) dramatically increase profits for pharmaceutical companies to the detriment of consumers.

Overview of Agency Purchasing

Currently, Virginia's state and local agencies approach pharmaceutical purchasing and attempt to control their costs in different ways.

- **340B Purchasing:** The 340B Drug Pricing Program of the Public Health Services Act allows eligible health care covered entities to purchase pharmaceuticals from a manufacturer at a discounted price to serve low-income, under-served residents. The 340B program covers FDA-approved outpatient prescription drugs and insulin; over-the-counter drugs written on a prescription; and biological products dispensed by prescription (other than vaccines).

  There are 16 types of covered entities that can participate in the federal 340B program, including certain hospitals, federally qualified health centers (FQHCs), health centers providing services for American Indians or Native Hawaiians, or programs receiving federal funds for specific programs such as family planning, sexually transmitted infections, tuberculosis control, Ryan White, black lung and hemophilia.

  State and local health departments in Virginia are considered covered entities and thus eligible due to the receipt of federal funds under the following four programs: (1) AIDS Drug Assistance Program, (2) Sexually Transmitted Disease Program, (3) Tuberculosis Program and (4)Title X Family Planning Program.

  Title X funding plays an important role in Virginia's ability to serve women in need of publicly-funded family planning services. VDH generates savings in reduced drug costs of greater than $16 million annually for family planning patients.

- **Purchasing agreements:** Local agencies, such as Community Services Boards and local/regional jails, often enter into contractual purchasing agreements with pharmacies to provide low cost prescription drugs for the clients they serve. Further, Wal-Mart and CVS provide prescription generics at very low cost, which allows these agencies to pass on savings to their clients.

- **Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP):** Virginia participates in the MMCAP, which is a group purchasing organization for government facilities that provide healthcare services. This group purchasing provides leverage for discounted pharmaceutical costs to eligible government facilities.

- **Managed Care:** Both DMAS and DHRM contract with managed care health plans, in which the costs of prescription drugs are covered through per member, per month premium payments and pharmacy benefit managers working for the individual plans negotiate prices on plan formularies. Thus, prescription drug costs are absorbed into these premiums and savings are reflected in patient co-pays.

Strategies to Reduce State Prescription Drug Spending

There are a number of strategies that the Commonwealth could employ to slow the growth of prescription drug spending among state agencies. Some of these strategies are consistent with NASHP's work group that examined the high cost of prescription drugs in its recent study. Each of the options the Secretary of Health and Human Resources considered is discussed below.

- **Taxpayer supported pharmacy approaches**

    - **Creation of a Statewide formulary for taxpayer support purchasers**

        Maintaining one formulary for use across service settings (Community Services Boards, local/regional jails, state hospitals, Department of Corrections facilities, and within the Medicaid programs) would standardize the prescriptions that individuals receive, particularly for people who move among the community behavioral health, state hospital, and criminal justice systems, thus ensuring consistency of care. Historically, each entity relies upon its own formulary when providing prescription drugs to the populations they serve.

        Those formularies often operate on a "fail first" model. The individual is prescribed medicine that is deemed to have the best "value". If the drug does not improve the individual's condition or results in complicating side effects, a more effective drug from the formulary is used. This second tier drug is generally more expensive.

        A consistent statewide drug formulary will allow the individual to continue receiving the drug that has been effective for him or her regardless of the site of service. As individuals move between community providers, corrections or jails, and the state hospital system, this could provide for better continuity of care.

        The treatment implications of changing drugs, especially psychotropic drugs used to treat Serious Mental Illness, can be significant and may be the genesis of perceived behavior issues among inmates and patients when their drugs are changed due to a difference in formulary. These illnesses respond in different ways to different prescription drugs, and often, several drugs or drug

combinations have to be attempted before finding a course of treatment that works. While most jails do not provide the brand name long acting injectable antipsychotics (LAIM) such as aripiprazole, paliperidone, risperidone, these drugs are used in state hospitals.

Creation of a standard formulary in the Commonwealth's Medicaid program is underway. DMAS is currently developing a statewide Common Core Formulary to be used by Medicaid Fee-for-Service providers and the Medicaid health plans contracted for the upcoming Commonwealth Coordinated Care Plus and Medallion 4.0 programs. The new formulary will streamline drug coverage policies for one million Medicaid members and thousands of providers, improving the continuity of care for members and decreasing the administrative burden to providers. At a minimum, all plans will be required to cover the drugs on the Common Core Formulary and will not be allowed to require additional prior authorizations or restrictions beyond those required by DMAS.

Formulary inconsistency

A recent example from a state hospital involves a patient who was admitted from a local jail on a Temporary Detention Order. He was taking prescribed oral aripiprazole in community prior to incarceration, but it was stopped when he was incarcerated. After receiving emergency treatment at the state hospital for not eating, he was put back on the prescription and released back to jail with a 14-day prescription supply and a recommendation to jail staff not to change it.

The DMAS Pharmacy and Therapeutics (P&T) Committee will develop the new formulary that will be used across all of Medicaid's delivery systems. Drugs on the formulary will be based on clinical, quality, and financial considerations, such as rebates. The DMAS P&T Committee is comprised of eight Virginia licensed physicians including the DMAS Chief Medical Officer and the Interim Commissioner of DBHDs, and four pharmacists.

- **Develop a Statewide Pharmacy Benefit Manager**

A formulary could be developed and maintained by a Statewide Pharmacy Benefit Manager. This change would centralize pricing negotiations and payments for all current purchasing entities, and would relieve those entities, particularly local/regional jails and CSBs, from having to negotiate with pharmaceutical companies for the individuals that they serve.

DMAS is in the process of procuring a new PBM for its Medicaid pharmacy program. The DMAS PBM will function as a pharmacy benefit administrator, and will follow all DMAS pharmacy policies, including the defined reimbursement methodology to pharmacy providers. This ensures full pricing transparency of

pharmacy provider reimbursement and prevents the PBM from contracting with pharmacy providers at a lower reimbursement rate. The DMAS PBM will also provide clinical and financial information to the DMAS P&T Committee to inform its decisions on the DMAS PDL and Common Core Formulary. This contract could be expanded in the future for a statewide PBM.

The development of a statewide formulary and/or statewide PBM would require significant study and coordination as well as funding.

- **Re-creation of a State Pharmacy**

Before it was closed due to budget cuts in 2010, Virginia operated the Community Resource Pharmacy which leveraged its volume as a state purchaser to buy and distribute prescription drugs to CSBs. Its closure left CSBs to negotiate prescription purchasing on their own.

The Virginia Department of Health operates a central pharmacy that supports the agency's clinical operations and programs that require pharmaceutical support. The VDH central pharmacy operates a mail order program that is located in the Monroe Building and is consistent with the scope needed to support agency pharmacy operations.

With a common state formulary and a unified purchasing model, one option for distribution of drugs would be through a state function. This may not be necessary if existing pharmacies could provide the distribution network.

- **Maximizing group purchasing mechanisms**

  - **Explore federal options to expand 340B pricing**

    It is important to note that this HRSA-administered federal program is complex and all covered entities are responsible to maintain compliance with all 340B program requirements, including but not limited to definitions of covered outpatient drugs, eligible patients, provision of health care services consistent with drugs provided, the Group Purchasing Organization prohibition, and the duplicate discount prohibition. Documentation requirements are numerous and time and resource intensive.

    Exploring eligibility for other entity types, such as FQHC lookalikes, may increase access to 340B discounted prices for additional clients with a wider variety of health needs. In addition, collaborating with national partners, such as the 340B Coalition and the National Academy for State Health Policy, may identify other opportunities to leverage 340B discounts and other cost effective drug access strategies.

    The potential savings realized from 340B expansion could be significant, but it is unclear what level of expansion may be feasible or allowable in Virginia. Pursuing a change in federal law to create a new, not-yet-existent "covered entity" category for local health departments may realize further drug discounts, but without detail it is difficult to predict the cost-benefit impacts.

- **Explore state options to expand 340B pricing**

  Expanding 340B pricing to covered entities identified in the Public Health Services Act that currently do not participate could yield savings for Virginia. Specifically, exploring the means by which 340B pricing could be expanded to cover pharmaceutical services currently provided by state agencies that are not currently eligible for 340B pricing (e.g., Department of Corrections) could potentially save the state between 20 - 40% on the cost of those pharmaceutical services. This could also potentially include expanding the role of services provided by Disproportionate Share Hospitals such as UVA and VCU Health systems. Another opportunity for expansion is to identify and engage those FQHCs that are not currently registered in the 340B program. Collaborating with state-level associations (e.g., VHHA, Virginia Community Healthcare Association, Virginia Association of Free and Charitable Clinics) may help identify other opportunities to leverage additional 340B discounts.

Procurement Modifications

Currently, in the eVA Agency Procurement and Surplus Property Manual (APSPM), there is an exception from eVA for purchases made under a multistate drug contract (MMCAP). A similar exclusion for direct purchases made through the 340B section of the Public health Service Act would reduce drug costs if able to be excluded from eVA fees when purchasing directly from 340B participants, increase procurement efficiency (reduce staff time in making direct 340B procurements vs. current procurement requirements), enhance service levels due to the delay in procurement transaction time, improve inventory control by being able to place smaller orders on a more frequent basis, and would still be subject to all other procurement controls.

Explore legislation to encourage pricing transparency

Pricing information that is public and easily accessible by consumers would unveil some of the complexity in prices that are set by pharmaceutical companies. Implementation of a public-facing website or page on an existing state website would be beneficial. The site would detail in plain language the costs of each prescription drug as well as how pharmaceutical companies arrived at those costs and how insurance affects the final cost to the consumer/state.

Legislation from the 2016 General Assembly, SB487 (Hanger) to create prescription drug pricing transparency was continued to the 2017 Session and could be used to review this issue again.

Additionally, the 2016 Department of Health Professions Report of the Pharmacy Benefit Managers Workgroup addressed various concerns regarding pharmacy benefit manager oversight. Those representing pharmacists, pharmacies, and the Medical Society of Virginia on the Workgroup generally supported a recommendation for increasing oversight of the administration of pharmacy benefit managers. An increase in oversight could potentially support efforts to create pricing transparency.

Conclusion

The rising cost of prescription drugs remains a vexing problem for public and private insurance providers. Prescription drugs have become a critical component of treatment for chronic conditions such as heart disease, asthma or mental illness. When used effectively, these "new and improving" drugs can help contribute to a productive workforce and thriving economy. To be effective, however, these drugs need to be accessible and affordable for consumers.

Prescription drug pricing is complex and increasing the transparency of pricing must be a priority. The prevalence of discounts, rebates and marketing drive the use of more and more expensive drugs, and the General Assembly should consider mechanisms to encourage clarity of pricing and overall cost of drugs.

Further, addressing the rising cost of pharmaceuticals requires solutions at multiple levels. Some of these initiatives will require federal action, but in the meantime, state and local government purchasers must find ways to lower costs through existing discount programs, pooling purchasing power and negotiations. All tax-payer funded entities should purchase through a single compact if 340B or other federal purchasing programs are not available to them.

Finally, the General Assembly should fund the development of a business plan to establish, at a minimum, a common formulary based on the Medicaid program's formulary that would be used for all state-funded pharmaceutical purchases. Other tax-payer funded entities should be permitted to use this formulary.

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Appendix A

Medicaid Cost per Prescription (2015)

Drugs that are used to treat complex conditions, sometimes called "specialty drugs," often have list prices that are much higher than other pharmaceuticals (Hepatitis C and cancer treatments often fall into this category). Although they generally treat more rare conditions and are therefore prescribed and purchased less often, they do have a particularly strong impact on both state and commercial markets.

For Claims Paid in 2015			
Drug Name	**Total Scripts**	**Total Drug Spend**	**Cost per Script**
MEDICAID	**1625**	**$37,776,007.80**	**$23,246.77**
LEMTRADA	1	$99,531.09	$99,531.09
RAVICTI	14	$890,299.84	$63,592.85
MONONINE	3	$185,905.49	$61,968.50
H.P. ACTHAR	19	$1,105,001.58	$58,157.98
CINRYZE	10	$581,060.26	$58,106.03
ALPROLIX	3	$141,633.94	$47,211.31
LUMIZYME	3	$135,634.74	$45,211.58
BENEFIX	13	$530,823.89	$40,832.61
ELAPRASE	4	$139,798.11	$34,949.53
ZAVESCA	28	$950,172.45	$33,934.73
PROCYSBI	22	$731,274.77	$33,239.76
ACTIMMUNE	37	$1,222,462.80	$33,039.54
ADAGEN	12	$388,024.92	$32,335.41
SYPRINE	16	$509,093.62	$31,818.35
VIEKIRA PAK	5	$157,441.40	$31,488.28
HARVONI	428	$13,155,546.84	$30,737.26
REMODULIN	56	$1,710,496.79	$30,544.59
BERINERT	2	$60,472.96	$30,236.48
FIRAZYR	9	$260,474.34	$28,941.59
NATPARA	13	$350,032.99	$26,925.61
SOVALDI	106	$2,836,015.46	$26,754.86
VIMIZIM	1	$25,483.03	$25,483.03
KALYDECO	44	$1,046,597.22	$23,786.30
DAKLINZA	8	$176,191.03	$22,023.88
ADVATE	73	$1,566,589.15	$21,460.13
SUPPRELIN LA	14	$292,121.68	$20,865.83
ORKAMBI	25	$478,511.12	$19,140.44
ICLUSIG	16	$302,411.40	$18,900.71
HYALURONIC ACID SODIUM SA	1	$17,714.53	$17,714.53
CAPRELSA	6	$104,661.78	$17,443.63
VENTAVIS	19	$318,070.98	$16,740.58

ILARIS	29	$479,478.75	$16,533.75
HELIXATE FS	75	$1,120,473.79	$14,939.65
TYVASO STARTER	2	$28,874.75	$14,437.38
NOVOSEVEN RT	2	$27,660.43	$13,830.22
TYVASO REFILL	37	$485,766.97	$13,128.84
TARGRETIN	1	$13,063.52	$13,063.52
XALKORI	8	$98,844.09	$12,355.51
VELETRI	24	$291,263.50	$12,135.98
STELARA	49	$591,867.23	$12,078.92
AFINITOR DISPERZ	18	$216,390.88	$12,021.72
GLASSIA	21	$247,004.95	$11,762.14
LONSURF	3	$34,720.57	$11,573.52
IBRANCE	49	$550,803.68	$11,240.89
POMALYST	9	$100,679.15	$11,186.57
ZOLINZA	2	$22,289.08	$11,144.54
SUBSYS	17	$188,909.21	$11,112.31
REVLIMID	230	$2,410,970.55	$10,482.48
STIVARGA	37	$387,026.49	$10,460.18
INLYTA	1	$10,370.01	$10,370.01

Appendix B

The National Academy for State Health Policy convened a workgroup to review how states have responded to recent increases in state spends on prescription drugs. The following is a chart that was reported out by the workgroup in September 2016[5].

State	Bill	Status	Category	Summary
AK	175	Pending	Pharmacy Benefit Managers	General regulation and oversight of PBMs, including requirement that PBM specify methods used to establish MAC pricing.
AL	459	Failed	Reimportation	This bill would have prohibited reimportation from Canada.
CA	463	Failed	Transparency	Requires each manufacturer of a prescription drug that has a wholesale acquisition cost of $10,000 or more annually or per course of treatment, to file a disclosure report on the costs for each qualifying drug to the Office of Statewide Health Planning and Development.
CA	1010	Failed	Transparency	Focus on the cost of most expensive Rx built into the rates developed by insurers.
CA	2711	Pending	Transparency	Relates to government bids and purchasing contracts with manufacturers and suppliers of single source multisource pharmaceticals.
CA	2095	Pending	Study	Legislative study on brand drugs v biosimilars thru Medi-Cal.
CA	2436	Pending	Transparency	Requires insurers to notify enrollees of the cost of a prescription they obtain under their coverage.
CO	1102	Failed	Transparency	Requires that manufactuers subit a report to a commision for all drugs for which the wholesale acquisition cost is greater then or equal to $50,000 per year.
CT	309	Enacted	Study	Establishes a legislative task force to study value-based pricing of Rx drugs by January 1, 2017.
DE	284	Enacted	Pharmacy Benefit Managers	This bill requires pharmacy benefit managers who employ "maximum allowable cost," or "MAC" pricing for multi-sourced drugs to follow set standards in composing and updating the list, to provide information on MAC and how it is determined to pharmacies in their networks, and to create an appeal process for a participating pharmacy who believes the MAC has been set in error. This bill will encourage more efficient operation of the prescription drug market by setting ground rules and encouraging transparency, resulting in savings to consumers and protecting pharmacies who are small businesses. Similar laws have been passed in at least 11 states.
GA	473	Failed	Pharmacy Benefit Managers	Would have codified fiduciary responsibility of PBMs to covered entities; had a second reading but died upon adjuournment.
GA	1000	Failed	Pharmacy Benefit Managers	General regulation and oversight of PBMs serving the state employee health program population.
GA	1576	Failed	Study	Resolution would have created a legislative committee to study pricing of Rx drugs by Dec 1, 2016.
HI	1681	Failed	Volume Purchasing	Would have established the Hawaii Rx Program, a discount drug program open to all residents of the state. Notion = volume purchasing would yield lower prices for all. Akin to OR/WA statewide prescription drug discount program. Any manufacturer not agreeing to a discount would have its products placed on a PA list.
HI	1682	Failed	Volume Purchasing	Much like HB 1681, but names of non-participating manufacturers would be publiclized. Would have established a list of preferred drugs, comprising the lowest cost drugs that were medically efficacious.
IL	559	Pending	Pharmacy Benefit Managers	General regulation and oversight of PBMs; bill provides that the IL insurance department regulates the drug pricing practices of PBMs.
IL	4079	Pending	Pharmacy Benefit Managers	Provides that the Department shall regulate the drug pricing process used by pharmacy benefits managers, and specifies the appeals process for such pricing.
IN	18	Failed	Study	Proposes a legislative study of prescription drug pricing and access to specialty prescription drugs. Died at adjournment.
IN	273	Failed	Study	This study would have specifically included a look at what other states were doing to stem prescription drug costs.
KS	2026	Failed	Pharmacy Benefit Managers	Would have established requirements and fiduciary duties for pharmacy benefits managers under the state health care benefits program.
LA	961	Pending	Transparency	Would require manufacturers to include information re: costs in all detailing information. Failure to do so would constitute unfair trade practice.
MA	1027	Pending	Reimportation	Would direct the Governor to request a waiver from the Secretary of State to allow drug reimportation from Canada. This bill has been pending since last spring.
MA	1048	Failed	Transparency	Would have required a state commission to develop a list of "critical" drugs and require manufacturers of those drugs to report on a set of data/information related to those drugs including the development of pricing for the drug, the cost of the drug to public programs, the current cost of the drug in MA, etc.
MA	1508	Failed	Other	Would have repealed the tax exemption for direct to consumer advertising for Rx manufacturers.
ME	1150	Enacted	Pharmacy Benefit Managers	Requires disclosure of Rx costs to plan sponsors by PBMs.
ME	1422	Failed	Reimportation	Would have allowed personal drug reimportation from Canada.
MI	502	Enacted	Other	Legislates that discounts provided by manufacturers or wholesalers for Rx drugs do not violate MI false claims act.
MN	2430	Failed	Pharmacy Benefit Managers	Bills would have allowed personal reimportation of prescription drugs.
MN	2239	Failed	Reimportation	Would have required Commissioner of Hum Svcs to establish a program to make discounted drugs acquired through the state negotiation of price with and reimportation of drugs from Canada, to all state residents.

[5] http://www.nashp.org/wp-content/uploads/2016/09/Legislative-Tracker-NASHP-Rx-Cost-Workgroup-Sept-14.pdf

MN	2525	Failed	Transparency	Would require disclosure of certain information by Rx manufacturers related to the ultra-high cost drugs.
MN	2565	Failed	Transparency	Would have required manufacturers to report certain information on an annual basis for drugs costing $1k or more.
MN	2947	Failed	Transparency	Senate companion bill to H 2525.
MO	2045	Failed	Pharmacy Benefit Managers	Bill would have delineated the process used by PBMs to establish MAC prices. Note that similar bills MO HB 2316 and SB 908 - also failed
MO	2215	Failed	Study	Would have established a leg study committee on Medicaid Rx costs and potential cost saving strategies.
NC	451	Failed	Pharmacy Benefit Managers	Requires pharmacy benefits managers (PBMs) to adjust the cost prices every seven business days, including ""in order to place a prescription drug on the maximum allowable cost (MAC) price list, the drug must be available for purchase by pharmacies from national or regional wholesalers"" and must be listed on FDA's ""Approved Drug Products with Therapeutic Equivalence Evaluations"" or Orange Book listing or have a or ""a similar rating by a nationally recognized reference.""
NC	839	Failed	Transparency	Cost and price transparency. Requires manufacturers of pharmaceutical drugs to report cost and utilization information. For seven specified categories of drugs (including cancer and all biologics) brand manufacturers would report: (1) Total costs derived in the production of the drug, (2) Average wholesale cost including increases by month over a 5-year period, (3) Total research and development costs paid by the manufacturer, (4) Total administrative costs, marketing and advertising costs for the promotion of the drug, and costs associated with direct to consumer coupons and amount redeemed, (5) Total profit as represented in totaldollars and a percentage of total company profit derived from the sale of the drug, and (6) Total amount of financial assistance the manufacturer has provided through patient prescription assistance programs.
NE	521	Failed	Pharmacy Benefit Managers	Would have established a leg study committee to examine the business practices of PBMs.
NH	1664	Enacted	Pharmacy Benefit Managers	Increases transparency of PBM methods of establishing MAC pricing.
NJ	329	Failed	Pharmacy Benefit Managers	Regulates certain auditing and disclosure practices of pharmacy benefits management companies.
NJ	2353	Pending	Pharmacy Benefit Managers	Prescrition Drug Consumer Transparency Act would require disclosure of methods used by PBMs to establish MAC pricing.
NJ	617	Pending	Pharmacy Benefit Managers	Regulates pharmacy benefits management (PBM) companies and requires increased disclosure.
NJ	898	Pending	Pharmacy Benefit Managers	Regulates certain practices of pharmacy benefits management companies.
NJ	958	Pending	Pharmacy Benefit Managers	Regulates certain practices of pharmacy benefits management companies.
NJ	762	Pending	Transparency	Establishes Prescription Drug Review Commission, requires transparency by manufacturers, including production costs to be reported for certain high-cost prescription drugs.
NM	4	Failed	Study	Requests that the legislative finance committee study pharmaceutical prices and make recommendations on how to mitigate the effects of rising pharmaceutical prices.
NM	86	Failed	Transparency	Requests the Legislative Finance Committee to analyze and make recommendations regarding prescription drug costs and possibilities for maximizing the use of discount drug pricing available under Federal Law and leveraging the state's purchasing power, requests the Office of the State Auditor to assess for possible designation a state agency or agencies for a special audit with regard to prescription drug purchasing practices
NY	4971	Pending	Pharmacy Benefit Managers	Prohibits pharmacy benefits managers, HMOs, insurers and health plans from offering incentives to health care providers to switch from one prescription drug to another specific prescription drug.
NY	7150	Pending	Pharmacy Benefit Managers	Enacts provisions governing the conduct of audits of pharmacies by pharmacy benefit managers (PBMs) intended to protect rights of pharmacists,
NY	461	Pending	Price Regulation	Relates to establishing the New York state prescription medication cost containment program.
NY	470	Pending	Price Regulation	Relates to establishing the New York state prescription medication cost containment program.
NY	1999		Price Regulation	Relates to establishing the NYS prescription medication cost containment program.
NY	2291	Pending	Price Regulation	Establishes the prescription drug discount program, establishes that the purpose of the program is to provide access to prescription drugs to participants at a discounted price and to allow for the negotiating of rebates that are exempt from the ""best price"" rule of the federal social security act, provides for the distribution of rebate funds and repeals a certain provision of the public health law relating thereto.
NY	A 2312	Pending	Price Regulation	Broad prescription drug oversight bill which, in part, establishes fiduciary duty of PBMs.
NY	6718	Pending	Price Regulation	Relates to establishing the New York state prescription medication cost containment program.
NY	7022	Pending	Price Regulation	Prohibits price gouging by manufacturers of prescription drugs.
NY	2288	Pending	Reimportation	Relates to consumer protection from prescription drug re-importation and unlawful practices and enforcement and penalties.
NY	676	Pending	Pharmacy Benefit Managers	Relates to establishing a pharmacy benefit manager contract appeals process.
NY	2623	Pending	Study	Cost and Benefit Analysis of Pharmaceutical Advertising
NY	2625	Pending	Transparency	Requires manufacturers and labelers of prescription drugs dispensed in the State which engage in marketing activities in the State to annually report marketing expenses to the Department of Health, imposes a civil fine for failure to report, eliminates tax deductibility for certain expenses incurred in the advertising of prescription drugs
NY	3780	Pending	Transparency	Requires pharmaceutical drug manufacturers and wholesalers to annually report to the New York department of health, for disclosure to the general public, all of its gifts to health care practitioners that prescribe drugs when such gifts have a value of seventy-five dollars or more.
NY	5338	Pending	Transparency	Enacts the Pharmaceutical Cost Transparency Act of 2015 requiring prescription drug manufacturers to file a report disclosing certain financial information pertaining to prescription drugs which have a wholesale acquisition cost of a certain sum or more annually or per course of treatment.
NY	7686	Pending	Transparency	Relates to prescription drug cost transparency. Requires manufacturers of a brand and generic medication that is made available in New York state to file a report annually on pharmaceutical costs for products with a price of $1,000 or more for a 30 day supply or an increased prices within a 3-month period of 3 times the CPI (consumer price index) with detailed statistics on each of 15 segments of actual costs including research, clinical trials, production, marketing, direct-to-consumer advertising, prescriber education, beginning in 2017
NY	8265	Pending	Transparency	Enacts the pharmaceutical cost transparency act of 2015 requiring prescription drug manufacturers to file a report disclosing certain financial information pertaining to prescription drugs which have a wholesale acquisition cost of $10,000 or more annually or per course of treatment.
NY	10026	Pending	Transparency	Requires prescription drug cost transparency. The manufacturer of a pharmaceutical drug that has a wholesale acquisition cost of one thousand dollars for a thirty day supply or cumulative price increase of three times the consumer price index in a 3-month period, shall file a report
OH	127	Pending	Pharmacy Benefit Managers	Regulates pharmacy benefit managers (PBMs), requiring registration with the state and pharmacies' access to ""a current list of the sources used to determine maximum allowable cost (MAC) pricing. The pharmacy benefit manager shall update the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible. Includes penalties for non-compliance.
OH	1505	Failed	Pharmacy Benefit Managers	Authorizes Department of Consumer and Business Services to adopt by rule fees that are calculated to pay costs associated with administrating laws regulating pharmacy benefit managers (PBMs), provides department with power to civilly enforce laws regulating PBMs.
PA	669	Failed	Pharmacy Benefit Managers	Provides for registration of pharmacy benefits managers, provides for maximum allowable cost transparency.
PA	947	Pending	Pharmacy Benefit Managers	Provides for registration of pharmacy benefits managers and for maximum allowable cost transparency
PA	2029	Pending	Price Regulation	Establishes the new Prescription Drug Program within the department of Human Services. ''The purposes of the program shall be to: (1) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates. (2) Make prescription drugs available at the lowest possible cost to participants in the program. (3) Maximize the purchasing power of prescription drug consumers in this Commonwealth in order to negotiate the lowest possible prices for the consumers.'' The department shall automatically enroll all consumers receiving pharmaceuticals through another department or an agency or entity of the Commonwealth into the program.
PA	1042	Pending	Transparency	Cost and price transparency: Amends the state insurance act, provides for pharmaceutical cost transparency. Establishes that for any ''prescription drug with an average wholesale price of $5,000 or more annually or per course of treatment, a health insurance policy or government program providing benefits for prescriptions shall not be required to provide the benefits if the manufacturer of the prescription drug has not filed a report on the drug'' that details the costs of production, research and development, clinical trials and regulatory requirements, marketing and other expenses.
PR	2558	Pending	Pharmacy Benefit Managers	Creates the Trade Practices Act to provide transparency within the Pharmacy Benefit Managers

RI	2467	Enacted	Pharmacy Benefit Managers	Would regulate business relationships among pharmacy services providers, group health insurers, and health service organizations by providing department of health oversight. Pharmacy benefit manager (PBM) are required to disclose prices with respect to multi-source generic pricing and provide updates on prices to pharmacies every 10 days. This act would take effect on September 30, 2016
RI	5174	Failed	Pharmacy Benefit Managers	Would regulate the business relationship between providers of pharmacy services and group healthiinsurers, nonprofit hospital service corporations, nonprofit medical service corporations and health maintenance organizations including establishment of the relationship and the requirements needed to be considered an acceptable pharmacy service provider, termination of the relationship, audits, acceptance or denial of benefits, substitution of drugs with therapeutic equivalents and cost limitations. A pharmacy benefits manager may not place a prescription drug on a maximum allowable cost pricing index ""if the prescription drug does not have 3 or more nationally available and therapeutically equivalent drug substitutes."" (Does not specify biologics or biosimilar products.)
RI	7468	Pending	Price Regulation	Relates to commercial law, relates to general regulatory provisions, relates to unfair sales practices, prohibits price gouging of prescribed drugs or pharmaceuticals in times of market emergency or market shortages and would make violators guilty of a felony and subject to injunctive relief.
RI	2560	Pending	Transparency	Cost and price transparency: Would require the Executive Office of Health and Human Services (""EOHHS"") to create a critical prescription drug list where there is a substantial public interest in understanding the development of its pricing. If a prescription drug is placed on the critical prescription drug list, the manufacture of such prescription drug must report certain information to EOHHS. This act would take effect on January 1, 2017.
RI	7839	Pending	Transparency	Cost transparency for high-cost pharmaceuticals: Would require the Executive Office of Health and Human Services (""EOHHS"") to create a critical prescription drug list where there is a substantial public interest in understanding the development of its pricing. If a prescription drug is placed on the critical prescription drug list, the manufacture of such prescription drug must report certain information to EOHHS. This act would take effect on January 1, 2017.
SC	849	Enacted	Pharmacy Benefit Managers	Provides procedures governing the maximum allowable cost reimbursements for generic prescription drugs by pharmacy benefit managers, provides necessary definitions, exempts the Department of Health and Human Services in the performance of its duties in administering Medicaid, provides requirements for placing drugs on maximum allowable cost lists by pharmacy benefit managers, relates to contracts between pharmacies and pharmacy benefit managers.
SC	3159	Pending	Pharmacy Benefit Managers	Enacts the Pharmacy Patient Protection Act, provides for the licensure and registration of pharmacy benefit managers, requirements of a certificate of registration and the conditions under which a prescription benefits manager shall operate, requires financial and utilization information to be made available for review, provides requirements for record keeping, provides for pricing guidelines that must be used, prohibits discrimination when contracting on the basis of copayments or days of supply.
TN	1697	Failed	Pharmacy Benefit Managers	Relates to Pharmacy, relates to Pharmacists, allows a pharmacy to designate a pharmacy services administrative organization to file and handle an appeal challenging the maximum allowable cost set for a particular drug or medical product or device on behalf of the pharmacy.
TN	2206	Failed	Transparency	Relates to prescription drug cost transparency, authorizes the department of health to require certain prescription drug manufacturers to disclose price and cost information, authorizes the department of health to set maximum prices for certain prescription drugs. If the department of health determines that a prescription drug price is significantly high, then the department of health may set the maximum allowable price that the manufacturer can charge for that prescription drug'' in the state.
TN	2442	Failed	Transparency	Authorizes the Department of Health to "develop a list of critical prescription drugs for which there is a substantial public interest in understanding the development of the drugs' pricing.'' require certain prescription drug manufacturers to disclose price in-state compared to prices in other countries, and cost of research, production, marketing information. If the department of health determines that a prescription drug price is significantly high, then it "may set the maximum allowable price that the manufacturer can charge for that prescription drug that is sold for use in the state.''
VA	487	Pending	Transparency	Relates to prescription drug price transparency, requires every manufacturer of a prescription drug that is made available in the Commonwealth and has a wholesale acquisition price of $10,000 or more for a single course of treatment to report to the Commissioner no later than July 1 of each year information related to the cost of developing, manufacturing, and marketing the prescription drug.
VT	216	Enacted	Transparency	Provides for pharmaceutical cost transparency, requiring the state to do an annual identification of up to 15 state purchased prescription drugs ''on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing.'' The state attorney general ""shall require the drug's manufacturer to provide a justification for the increase in the wholesale acquisition cost of the drug"" in a understandable and appropriate format. Requires that rules be adopted requiring certain insurers to provide information about the State Health Benefit Exchange plan's drug formularies, provides further for drug dispensing fees, reimbursement, a related report and out-of-pocket drug limits.
VT	866	Failed	Transparency	Relates to requiring prescription drug manufacturer cost transparency.
WA	2602	Failed	Price Regulation	Addresses prescription drugs and capping consumer costs.
WA	6320	Failed	Price Regulation	It is the minimize consumers' exposure to high cost sharing for prescription drugs by instituting a cap on individual prescription costs. Provides that each health plan offered shall provide a maximum cost sharing for a covered outpatient prescription drug. The copayment, coinsurance, or other cost sharing for an individual prescription for a supply up to 30 days shall not exceed $100. For a nongrandfathered individual or small group health plan, the annual deductible for outpatient drugs, if any, shall not exceed $500
WA	6593	Failed	Price Regulation	Pursues prices that are aligned with or lower than the negotiated prices available to the United States Veterans Administration.
WA	6471	Failed	Transparency	Promotes transparency of prescription drug pricing and costs.
WV	322	Failed	Pharmacy Benefit Managers	Regulates pharmacy benefits managers, define terms, provides that pharmacy benefits managers conducting audits for public health programs are not exempt from pharmacy audit restrictions, provides internal review process applicable to disputed findings of pharmacy benefits manager upon audit, provides notice to purchasers, pharmacists and pharmacies of information relating to maximum allowable costs, establishes a process relating to the appropriate use of maximum allowable cost pricing.
WV	2924	Failed	Transparency	Directs the Health Care Authority to establish a council to investigate and recommend to the authority pricing guides for pharmaceuticals that exclude advertising costs.
WY	35	Enacted	Pharmacy Benefit Managers	Relates to regulation and require licensure of pharmacy benefit managers (PBMs), establishes a new licensing fee of $500 annually, provides requirements for audits conducted by pharmacy benefit managers, provides requirements and restrictions for placing generic drugs on maximum allowable cost lists, protecting the business interests of pharmacies and pharmacists.

Appendix C – CSB

High Cost Medications By Volume	Total Cost	Freq.
Invega	$ 1,062,821.35	48
Seroquel	$ 869,596.90	23
Latuda	$ 651,783.04	27
Risperdal	$ 575,165.58	39
Abilify	$ 365,278.49	23
Aripiprazole	$ 325,739.91	29
Suboxone/Buprenorphine	$ 174,538.83	4
Saphris	$ 121,830.97	6
Zyprexa	$ 76,323.41	5
STRATTERA	$ 41,996.15	8
Chlorpromazine	$ 39,528.76	4
Vivitrol	$ 39,352.89	2
Clozapine	$ 35,564.15	7
Quetiapine	$ 34,911.26	8
Rexulti	$ 33,296.63	4
Buprenorphene	$ 31,274.00	1
MIRTAZAPINE	$ 30,146.84	1
Divalproex	$ 27,079.53	7
Effexor	$ 26,629.90	5
GABAPENTIN	$ 25,397.62	10
Inderal/Propanolol	$ 23,166.40	1
Olanzapine	$ 22,625.09	4
Duloxetine	$ 21,855.05	4
VYVANSE	$ 21,720.91	1
FLUPHENAZINE	$ 21,273.18	5
Haldol	$ 20,248.23	13
Trazadone 100 mg	$ 16,965.11	4
Thorazine (Chlorpromazine) 100mg ($390.78 for #30) every 30 days	$ 15,914.44	4
ZIPRASIDONE	$ 14,384.22	3
Bupropion	$ 14,026.34	5
VENLAFAXINE	$ 9,826.15	3
Pristiq	$ 8,387.52	3
AMPHETAMINE	$ 8,030.95	1
Busiprone 7.5 mg #60	$ 7,891.31	3
PALIPERIDONE ER 3MG TAB - 00591369330	$ 7,064.53	2

Viibryd	$ 4,521.18	2
Fanapt	$ 4,197.48	1
Depakote	$ 3,237.70	3
Sensipar, 30mg, tab	$ 3,161.97	
Carbamazepine	$ 2,860.58	2
Nicotine 21 mg Patches	$ 2,345.34	1
Hydroxyzine	$ 2,188.49	3
Rozerem 8mg	$ 1,633.24	1
Perphenazine 16mg ($102.36 for #30) every 30 days	$ 1,561.93	3
Propanolol 10 mg	$ 1,488.39	3
Emsam 9 mg/24hr patch	$ 1,443.77	1
Epipen 0.3mg	$ 1,338.94	1
Topiramate	$ 1,261.52	2
Lamotrigine (25, 100 mg)	$ 1,250.15	1
Wellbutrin XL (PO) 300 mg #30 (Bupropion)	$ 1,102.56	2
Geodon 20mg	$ 1,095.80	2
Humalog 100U/ml	$ 1,074.96	1
Lithium Citr Sol 8 MEQ/5 ML U	$ 890.96	1
Methylphenidate	$ 807.34	2
Naltrexone 50mg ($57.71 for #30) every 30 days	$ 692.52	1
Cymbalta	$ 605.40	2
Benztropine 1 mg	$ 500.00	1
Trintellix	$ 458.20	1
Concerta Extended Release 18 mg #30	$ 268.44	1
Concerta Extended Release 18 mg #30 (generic is Methylphenadate)	$ 268.44	1
Aplisol 5TU	$ 262.39	1
Lamictal	$ 204.39	1
Meloxicam 15 mg. tab (30)	$ 149.08	1
Sertraline 100 mg tab (30)	$ 106.53	1
Mertazapine 30 mg. tab (30)	$ 86.75	1
Elavil	$ -	1
Tegretol	0	1
Luvox		1
Neudexta 20mg/10mg		1
Neurontin		1
Prolixin		1