Report to
The Vermont Legislature

Pharmacy Best Practices and Cost Control Program Report

In Accordance with 33 V.S.A. § 2001(c)

Submitted to: House Committee on Appropriations
House Committee on Health Care
House Committee on Human Services
Senate Committee on Appropriations
Senate Committee on Health and Welfare

Submitted by: DaShawn Groves
Commissioner, Department of Vermont Health Access

Prepared by: Lisa Hurteau, Pharm.D.
Director of Pharmacy Services
Department of Vermont Health Access

Report Date: October 30, 2026

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Table of Contents

Introduction 2

Issues Related to Drug Cost and Utilization 3

The Effect of National Trends and Comparison to Other States 6

Administration of Vermont's Pharmaceutical Assistance Programs 7

Drug Utilization Review Board, The Preferred Drug List and Prior Authorization 7

Appendix: Cost and Utilization Charts 9

INTRODUCTION

The purpose of this legislative report is to meet the requirements in 33 V.S.A. § 2001 concerning prescription drug cost containment. It also offers an overview of the pharmacy benefit programs managed by the Department of Vermont Health Access (DVHA). The report addresses topics related to drug cost and utilization, effects of national trends on pharmacy programs, comparisons to other state Medicaid programs, DVHA's administration of the pharmaceutical assistance programs, the use of prior authorization requirements for prescription drugs, management of the Drug Utilization Review Board, and inclusion of drugs on the preferred drug list.

During state fiscal year 2026 (SFY 2026) enrollment in Vermont Medicaid and pharmacy utilization continued to steadily decline resulting in fewer prescription claims. The average monthly Medicaid and dual-eligible enrollment declined from 156,541 members in SFY 2025 to 151,342 members in SFY 2026, a 3.3% decrease. (Chart 2) Medicaid and dual-eligible pharmacy claims declined 4.9%, from 1,646,836 to 1,566,799. (Chart 1)

Despite lower utilization, gross Medicaid pharmacy spending increased from $284.5 million to $294.5 million, and net spending increased from $117.4 million to $125.1 million. (Chart 1) The increase in spending was driven in part by higher net costs per claim, as illustrated in chart 1, year over year. The trend in net costs per prescription was attributed to the continued use of high-cost specialty medications and growth in several therapeutic areas. Specialty medications accounted for approximately $98.3 million in gross spending in SFY 2026 and there was an increase of about 2,000 specialty prescriptions billed. (Chart 11A) (Chart 11B)These high-cost products represented approximately 34% of Medicaid gross pharmacy spending, averaging approximately $7,300 in gross cost per claim. (Chart 12B) Several non-specialty categories also contributed substantially to increased spending, including GLP-1 receptor agonists, antineoplastic enzyme inhibitors, and cystic fibrosis agents. (Chart 11B)

Another factor contributing to the cost increases outlined in this report is the rising launch prices of newly FDA-approved drugs. Recent data indicate that new therapies are increasingly entering the market with annual costs in the six-figure range. The Institute for Clinical and Economic Review (ICER) found that the median annual list price for novel drugs increased from $249,257 in 2022 to $308,749 in 2024, while the median net price increased from $182,271 to $274,795, a 51% inflation-adjusted increase in net launch price. This trend is particularly relevant to SFY 2026, as many of the recent FDA approvals are specialty, orphan, or oncology therapies. For example, Zycubo (copper histidinate), approved in January 2026 as the first FDA-approved treatment for Menkes disease, has an estimated annual therapy cost ranging from approximately $681,000 to $1.36 million depending on patient age and dosing.[1] The growing number of new therapies entering the market at annual costs of $200,000–$500,000 or more can therefore substantially increase the average cost of newly approved drugs and contribute to overall pharmacy spending growth, even when utilization remains relatively low.

[1]VitylOne, Insights Report (June 2026). Available from: vytlone.com/wp-content/uploads/2026/06/VytlOne__Insights_Report_Published_2026-1.pdf?

The report also demonstrates the continued role of rebates and utilization management in controlling net pharmacy expenditures. The net costs represented a reduction of 171.1 million in spending using federal rebates, state supplemental rebates, and 340B discounts using acquisition costs. (Chart 1) Looking ahead to SFY 2027, we anticipate changes reported in net costs compared to this year's figures. Participation in the new federal GENEROUS model may create opportunities for retroactive rebates, which could reduce the net cost of drug expenditures from prior years as well as moving forward.

These rebate programs, together with the Preferred Drug List (PDL), prior authorization, generic and biosimilar use, and other utilization-management tools, remain important components of DVHA's pharmacy cost-control strategy.

ISSUES RELATED TO DRUG COST AND UTILIZATION

DVHA reimbursed pharmacies over **$296 million** for Medicaid prescription claims, in SFY 2026, compared to $285 million in SFY 2025. This represents an increase in gross expenditure of approximately 11 million **(**3% increase), despite a decrease in the number of claims paid.
The increase in gross and net spending occurred in the context of lower enrollment and fewer claims. The number of members utilizing pharmacy services declined by approximately 5.5%. The change in spending therefore reflects a higher average cost per prescription, as shown in Chart 1, where the net cost per claim increased from $63.43 to $72.71 for all pharmacy programs combined. (Chart 1) A number of factors contributed to the increases seen in drug spending reported in SFY 2026.

Top Drugs by Cost and Utilization
Drug spending in SFY 2026 remained concentrated in several therapeutic areas, including inflammatory conditions, psoriasis biologics, opioid use disorder, diabetes, cystic fibrosis, attention-deficit/hyperactivity disorder (ADHD), and oncology. The highest-grossing therapeutic class was antipsoriatics at approximately $22.6 million, followed by anti-TNF-alpha monoclonal antibodies at approximately $21.6 million and opioid partial agonists at approximately $20.7 million. (Chart 5)

GLP-1 receptor agonists remain a significant source of spending. Gross spending for this class increased from approximately $16.9 million in SFY 2025 to $19.7 million in SFY 2026, an increase of 16.7%, while claim volume increased 14.7%. Specifically, the GLP-1 drug Trulicity represented a gross spend increase of 63.1% and claim volume increased 64.7%. GLP -1 drugs have continued to receive new indications such as obstructive sleep apnea and noncirrhotic metabolic dysfunction. However, GLP-1 drugs have received notable attention for their use in weight loss. At this time, Vermont Medicaid does not cover drugs used for weight loss per the Medicaid State Plan.
Antineoplastic enzyme inhibitors increased 37% in gross spending and 39.3% in claim volume. The increase in spending reflects both greater prescription volume and the continued use of newer, higher-cost oncology treatments. A few drugs contributing to this increase include Verzenio (CDK4/6 inhibitor indicated breast cancer), Voranigo (indicated for certain brain tumors/astrocytomas), and Brukinsa (indicated for blood cancers). Cystic fibrosis agents represented a $600,000 increase in spend despite a reduction in claims. This increase is likely attributed to a newer, higher net cost, drug Alyftrek that has been developed to replace Trikafta (number 4 in top drugs by gross spend).

In contrast, opioid partial agonists declined 4.9% in gross spending and 16.8% in claims. While large reductions were seen in Suboxone film prescriptions, there was steady growth in the long-acting injectable formulations of medications used for opioid-use disorder (MOUD).(Chart 14) Both Sublocade and Brixadi represented increased spending and claim counts, indicating more members utilizing long-acting products with lower potential for misuse over oral, daily use, films. Anti-TNF-alpha monoclonal antibodies declined 8.9% in gross spending and 12.4% in claims. At the individual drug level, Humira Pen remained the highest-grossing product at approximately $20.1 million, followed by Suboxone at $12.2 million, Vyvanse at $10.9 million, Trikafta at $10.5 million, and Concerta at $8.4 million. Dupixent increased 18.5% in gross spending, while Skyrizi increased 138.6% in gross spending and 94.3% in claims. These changes illustrate that both utilization growth and shifts among products within therapeutic classes can materially affect total pharmacy expenditures.bookmark://chart7/bookmark://chart9/

Specialty Pharmacy
DVHA requires any pharmacy dispensing specialty drugs to be certified by a national accreditation organization, this distinction from standard pharmacies includes more comprehensive patient care and drug management. The list of specialty medications and accredited pharmacies is updated quarterly and can be found on DVHA's provider resources and clinical programs website. More information about DVHA's classification of specialty drugs can be found in the pharmacy provider manual. https://dvha.vermont.gov/providers/manuals

In SFY 2026, gross spending on specialty medications was approximately $98.3 million. (Chart 11B) Specialty claims totaled approximately 13,591 prescriptions (17% increase year over year) and represented about 0.9% of Medicaid pharmacy claims yet accounted for approximately 34% of Medicaid gross pharmacy spending. (Chart 11A, Chart 12A) The average gross cost of a specialty prescription was approximately $7,230. These figures demonstrate the continuing impact of high-cost, low-volume specialty products on the Medicaid pharmacy budget. Examples of high-cost specialty products represented in the report include Trikafta for cystic fibrosis, Skyrizi and Taltz for inflammatory conditions, and Dupixent for asthma and atopic dermatitis. (Chart 11B) These four drugs alone accounted for $30.6 million in gross spending (10.3% of the total gross spend). (Chart 7) The Department received significant increases in net costs attributed to growth in prescriptions for Dupixent (immune modulator) at a 40% increase in claims volume, Skyrizi (indicated for inflammatory conditions) at a 117% increase in claims volume, and Hemlibra (hemophilia treatment) at a 28% increase in claims volume.

Pharmacy Care Management Program
The Department of Vermont Health Access in collaboration with the pharmacy benefit administrator, Optum, manages and enrolls patients in a Pharmacy Care Management (PCM) program. The primary goals of the PCM program are to optimize medication use and assure adherence to prescribed regimens. Increased medication adherence leads to the highest likelihood of benefit from medications, either to cure an illness (i.e. Hepatitis C) or prevent adverse health events. It has been estimated that non-optimized medication regimens have resulted in an estimated $528.4 billion in

avoidable US healthcare expenditures annually.[2] On June 19, 2026, Optum reimplemented the PCM application and resumed the program following a significant cybersecurity outage in February 2024. Reporting will resume as the program progresses.

Medicaid Rebate Programs
The Department of Vermont Health Access manages multiple rebate programs designed to reduce the net cost of prescription drugs for Vermont Medicaid. In SFY 2026, federal and supplemental rebates together represented a substantial offset to gross pharmacy expenditures. Across all programs, gross pharmacy spending was approximately $296.4 million and net spending after invoice rebates was approximately $125.3 million.

Federal Rebates, Supplemental, and Diabetic Supply Rebates
In SFY 2026, DVHA invoiced manufacturers for rebates through a variety of contracted programs. Almost all drug manufacturers offer federal rebates to state Medicaid programs, with rebate amounts determined by a federal formula that uses standardized pricing metrics. These financial concessions are available to all Medicaid entities that include the manufacturers' drugs in their coverage. The two primary calculations used for determining federal rebates are the "best price" and the "average manufacturer price" (AMP). Drugs with substantial federal rebates may be preferred due to their lower net cost to the state. Generally, the collection of federal rebates increases in proportion to overall drug usage and the duration the drugs are available on the market. This is partly because rebates are adjusted based on the Consumer Price Index to account for inflation.

Supplemental rebates are additional payments negotiated in addition to the mandated federal rebates on drugs. Diabetic supply rebates are provided as state-only discounts and are provided separately from federal rebates. Supplemental rebates are negotiated by DVHA in conjunction with the Sovereign States Drug Consortium (SSDC), Sovereign States Drug Consortium. The SSDC is a Medicaid rebate pool composed of the largest, independent, state-administered, Medicaid supplemental rebate program in the country. The SSDC primarily focuses on negotiating and acquiring rebates from manufacturers to obtain pricing that results in lower net cost to state Medicaid programs. Vermont contracts for SSDC-negotiated supplemental rebates via its own supplemental rebate agreement, enabling the State to retain control and flexibility in managing its preferred drug list while taking advantage of the additional leverage provided by the 14 million members covered by this group.

Value Based Agreements
A CMS final rule regarding value-based purchasing for drugs covered by Medicaid, effective July 1, 2022, allowed State Medicaid Programs to attain value-based rebate contracts with manufacturers.[3,4]

---

[2]Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug Related Morbidity and Mortality. Annals of Pharmacotherapy. 2018;52(9):829837. Doi:10.1177/1060028018765159
[3]Medicaid Program. Center for Medicare and Medicaid Services. (2020). Available From: https://www.regulations.gov/document/CMS-2020-0072-30223
[4]Medicaid Program. Center for Medicare and Medicaid Services. (2021). Available From: https://www.federalregister.gov/documents/2021/11/19/2021-25009/medicaid-program-delay-of-effective-date-for-provision-relating-to-manufacturer-reporting-of

The concept of value-based agreements (VBA) results in the net cost of a drug being reduced and tied to the efficacy or expected clinical outcomes after administration. DVHA utilizes a few mechanisms to negotiate and review VBA contracts. This includes multi-state negotiations by the SSDC, reviewing manufacturer-submitted VBA contracts on CMS's web-based Enterprise Portal, and directly negotiating with manufacturers. DVHA participates in the Cell and Gene Therapy Access Model (CGT Model), which provides a CMS-led approach to negotiating and administering outcomes-based agreements for selected high-cost cell and gene therapies. These models are particularly relevant as high-cost, low-volume therapies continue to enter the Medicaid market. In addition, the Pharmacy Unit has successfully negotiated value-based agreements directly with manufactures to further reduce the net costs of high-cost treatments in the event of a therapeutic failure. https://www.cms.gov/priorities/innovation/innovation-models/cgt

EFFECT OF NATIONAL TRENDS ON PHARMACY PROGRAMS COMPARISON TO OTHER STATES

Due to its small population Vermont's net Medicaid prescription drug spending is among the lower tiers when compared nationally.[5] Vermont ranks third from the bottom in gross Medicaid Drug spending reflecting its small population and cost control measures. Although Vermont ranks among states with the lowest total Medicaid prescription drug expenditures, gross and net spending increased in SFY 2026 despite declining overall utilization. Increased specialty drug utilization and higher costs per prescription contributed to this trend.

Vermont has been leveraging Supplemental Rebates as part of the SSDC for many years and is now a pioneer with participation in the GENEROUS model GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model | CMS leveraging savings opportunities as part of the model in its early stages. A recent publication aimed to capture the impact of supplemental rebate negotiations as well as whether there is benefit to states joining multi-state purchasing groups such as the SSDC.[6] The growth in supplemental rebates coincided with rising drug spending and increased use of preferred drug lists and utilization management.

Supplemental rebates are becoming an increasingly important tool to counter rising Medicaid drug spending and states participating in purchasing groups received higher rebates than those negotiating independently. Measuring the trends in supplemental rebates per Medicaid beneficiary demonstrated the SSDC to be the most successful purchasing group, with the highest supplemental rebate per member.The study suggests additional leverage for Medicaid to contain costs might require changes to the Medicaid Drug Rebate Program (MDRP), allowing states more flexibility on what is covered on Preferred Drug Lists.[6]

In the coming years from 2026-2034, national spending and utilization are expected to rise more rapidly due to increasing use of new, more expensive drugs in the market. Net prescription drug expenditures are anticipated to increase steadily with an annual growth rate of 5.2-5.9% for each of the next five years. The most apparent driver of increased spending is in the recent trends around

---

[5] Gross Medicaid Prescription Drug Spending (2024). Kaiser Family Foundation. Available from: https://www.kff.org/medicaid/state-indicator/gross-medicaid-prescription-drug-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[6] Max C. Yates, Jason B. Gibbons, Aaron S. Kesselheim, and Benjamin N. Rome
Health Affairs 2026 45:10, 1117-1124 10.1377/hlthaff.2026.00122.
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2026.00122

GLP-1 medications, specialty drugs and gene therapy. Although utilization of gene therapies has remained limited, the high cost of these treatments presents a potential source of expenditure volatility for Medicaid programs with relatively small populations, including Vermont. A small number of patients requiring these treatments could result in significant year-over-year changes in pharmacy expenditures.

States with aggressive rebate programs like VT may see slower net spend growth, but coverage reductions could increase overall program costs. The bottom line is the forecast points to sustained high net Medicaid prescription drug expenditures, with the 2025 policy shift and specialty drug market dynamics as the main determinants of whether growth accelerates or moderates in the coming years.[7]

ADMINISTRATION OF VERMONT'S PHARMACEUTICAL ASSISTANCE PROGRAMS

VPharm is Vermont's State Pharmaceutical Assistance Programs (SPAP) that provides supplemental pharmaceutical coverage for Vermonters with Medicare drug coverage who are not eligible for Medicaid and who have a household income no greater than 225% of the federal poverty level (FPL). VPharm began January 1, 2006, and is codified in state statute at 33 V.S.A. § 2073. VPharm is also authorized through Vermont's Global Commitment to Health 1115 Demonstration waiver.

VPharm provides coverage for Medicare prescription drug cost-sharing, including deductibles, co-payments, and coinsurance. In addition, this program provides coverage for certain categories of Medicare-excluded drug classes, such as certain prescription vitamins, drugs used for weight gain or treatment of anorexia, and some over-the-counter drugs. Prescription coverage under VPharm is the same as general Medicaid coverage. In SFY 2026, VPharm processed 156,784 prescription claims with gross payments of approximately $1.94 million. Net paid spending after invoiced rebates was approximately $253,527. Compared with SFY 2025, VPharm claims declined 24.9%, gross spending declined 56.7%, and net spending declined 86.1%. (Chart 1) Importantly, the significant decrease in VPharm spending in SFY 2026 is partially attributable to the Medicare Part D benefit redesign implemented in 2025. The redesign eliminated the Part D coverage gap ("donut hole") and established a $2,000 annual out-of-pocket maximum, shifting a greater portion of prescription drug costs to Medicare Part D plans and reducing the amount of drug spending borne by Medicaid for Medicare-eligible members.[8] There has also been a drop in VPharm eligibility because many of these people qualified for Medicare Savings Programs (MSP). More information about the VPharm program can be found here: https://dvha.vermont.gov/members/vermont-medicaid-programs/member-information/member-handbooks

DRUG UTILIZATION REVIEW BOARD, THE PREFERRED DRUG LIST AND PRIOR AUTHORIZATION

Drug Utilization Review Board

The Drug Utilization Review Board (DUR Board) is an advisory board required by federal law. The

[7] Medicaid Drug Spending Dashboard. Centers for Medicare and Medicaid Services (2024). Available from: https://data.cms.gov/tools/medicaid-drug-spending-dashboard

[8] CMS Releases 2025 Medicare Part D Bid Information and Announces Premium Stabilization Demonstration. Centers for Medicare and Medicaid Services. (2024) Available from: https://www.cms.gov/newsroom/fact-sheets/cms-releases-2025-medicare-part-d-bid-information-announces-premium-stabilization-demonstration

Board applies criteria and standards in the application of drug utilization review activities, reviews and reports the results of those activities performed by the Department or the Department's pharmacy benefit administrator and recommends and evaluates interventions such as provider education or other types of provider communications. The Board also provides drug coverage guidance and assistance with the development of the Preferred Drug List.

Drug Utilization Review Board Activities in 2025 - 2026

REVIEW TOPIC	SFY2026 TOTAL
Therapeutic Drug Classes: Periodic Review	45
Full New Drug Reviews	37
FDA Safety Alerts	9
Abbreviated for new dosage formulations	21
Newly Developed/Revised Criteria	49
RetroDUR/ProDUR Reviews	6
New Managed Therapeutic Drug Classes	3
BioSimilar Drug Reviews	7

More information about the DURB along with detailed minutes of meetings and specific changes and decisions voted on by the Board can be found at https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board.

Preferred Drug List and Prior Authorization

The Preferred Drug List (PDL) for Vermont Medicaid identifies preferred and non-preferred drugs within therapeutic classes for various diseases and conditions, including generic alternatives. This tool helps to reduce the cost of the pharmacy benefit while maintaining access to clinically appropriate prescription drug therapies. The PDL is not a complete list of all drugs covered by the pharmacy benefit; however, it does contain over 180 different therapeutic categories representing thousands of drugs. If a drug is not listed as "preferred" in a category on the PDL, prescribers can submit a prior authorization (PA) for the drug to be covered. Most preferred drugs do not require PA unless there is a clinical or safety issue that warrants a review prior to dispensing to a patient. Many drugs have specific criteria, such as a specific diagnosis or lab test result, while other drugs have more general criteria and simply require a trial of or contraindication to a preferred, equally effective drug. There are some drugs on the PDL that allow for automated criteria review, in which the claims system identifies previous drug therapy or a pre-existing diagnosis and uses this information to approve or deny the claim. The automated PA process helps to reduce provider burden, expedites PA review, and assures clinical and financial integrity of DVHA's pharmacy programs. The PDL for Vermont Medicaid can be found here, https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria,

In SFY 2026, DVHA received 25,479 prior authorization requests, and the overall prior authorization denial rate was 34.0%, increased from 33.1% in SFY25. (Chart 4) The 2026 data should be considered in the context of continued utilization of GLP-1 receptor agonists and requests for uses that are not covered under the Vermont Medicaid State Plan, including weight-loss treatment. The prior authorization process also supports management of changes in the Medicaid Drug Rebate Program by directing utilization toward preferred and rebated alternatives when products are

discontinued or otherwise become unavailable for Medicaid rebate purposes. Due to changes in Medicaid rebate calculations, colloquially referred to as AMP-Cap removal, drug manufacturers continued discontinuing drugs that were substantially rebated for Medicaid programs. In late-SFY 2025 and 2026, the department notified providers about changes to coverage for products including Pulmicort, Xifaxan (and other products) as the manufacturers of these products no longer participate in the Medicaid Drug Rebate. In these cases, DVHA directs providers and members to preferred guideline-recommended alternatives with notification ahead of any changes.

Generic utilization remained strong in SFY 2026. For Medicaid, including dual-eligible members, the generic utilization rate increased from 80.76% to 81.33%, while the generic substitution rate was 79.97%. These measures demonstrate continued use of generic products when there are therapeutically equivalent generic alternatives available. The prior authorization process helps direct utilization of prescription drugs toward preferred, rebated products with similar efficacy, tolerability, and expected outcomes.

APPENDIX: COST AND UTILIZATION CHARTS

Chart 1: Pharmacy Claims and Gross and Net Spend, SFY 2024 – 2026 (All Programs)

All Pharmacy Claims										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2026	1,723,583	-7.11%	$296,394,241	4.18%	$171.96	12.16%	$125,323,321	7.35%	$72.71	15.58%
2025	1,855,566	-4.48%	$284,508,404	-0.81%	$153.33	3.83%	$117,704,210	-3.37%	$63.43	1.14%
2024	1,942,532		$286,845,571		$147.67		$121,812,489		$62.71	
Medicaid Claims (includes Duals)										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2026	1,566,799	-4.86%	$294,458,219	5.17%	$187.94	10.55%	$125,069,794	8.82%	$79.83	14.38%
2025	1,646,836	-4.27%	$280,032,905	-0.60%	$170.04	3.73%	$115,885,348	-3.09%	$70.37	1.14%
2024	1,718,569		$281,721,292		$163.93		$119,577,239		$69.58	
VPharm Claims										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2026	156,784	-24.88%	$1,936,023	-57.20%	$12.35	-43.03%	$253,527	-85.97%	$1.62	-81.33%
2025	208,730	-6.8%	$4,475,499	-12.66%	$21.44	-6.29%	$1,818,862	-18.63%	$8.71	-12.73%
2024	223,963		$5,124,279		$22.88		$2,235,250		$9.98	

Note: Gross Spend reflects pharmacy payments only, excluding refunds/reconciled claims (340B). Net spend is based on rebates invoiced, not rebates collected, and reflects an estimated 340B Acquisition Cost Discount. Dual-Eligible: DVHA only pays for non-Part D eligible drugs, primarily over the counter (OTC) drugs. VPharm: DVHA pays secondary to Part D and for non-Part D drugs, primarily OTC drugs.

Chart 2: Pharmacy Services: Eligible and Utilizing Members

Calculated as average monthly eligible members vs. average monthly utilizers, enrollment run as of 09/28/2023 (excludes VPharm).

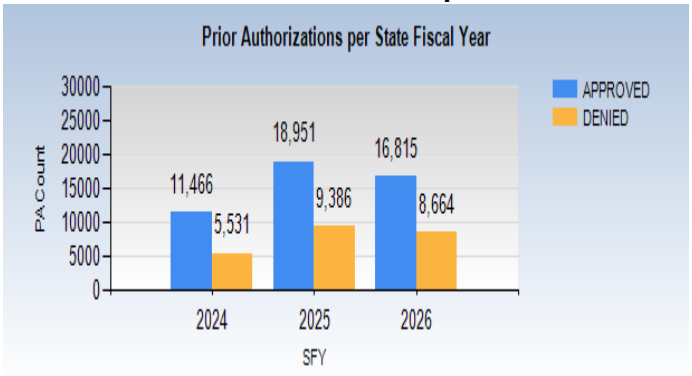
All	2024	2025	2026
Medicaid and Duals Eligible All Ages	171,639	156,541	151,342
Medicaid and Duals Utilizers All Ages	50,256	47,287	44,676
Medicaid and Duals Utilization Percent All Ages	29%	30%	30%
Adult			
Medicaid and Duals Eligible Adults	113,204	101,736	98,064
Medicaid and Duals Utilizers Adults	37,932	34,986	33,324
Medicaid and Duals Utilization Percent Adults	34%	34%	34%
Children			
Medicaid and Duals Eligible Children	58,435	54,804	53,278
Medicaid and Duals Utilizers Children	12,323	12,300	11,351
Medicaid and Duals Utilization Percent Children	21%	22%	21%

Chart 3: Generic Usage Rates

Medicaid (Includes Duals)			
Generic Indicator	2024	2025	2026
Generic Substitution Rate (GSR)	79.67%	80.33%	79.97%
Generic Utilization Rate (GUR)	79.77%	80.76%	81.33%
VPharm			
Generic Indicator	2024	2025	2026
Generic Substitution Rate (GSR)	89.62%	90.36%	90.03%
Generic Utilization Rate (GUR)	83.17%	84.40%	85.67%

GUR: Generic use as a percentage of prescriptions for all drugs dispensed.
GSR: Generic use as a percentage of prescriptions when a generic equivalent is available

Chart 4: Prior Authorization Requests



SFY	PA DENIAL RATE
2024	32.54%
2025	33.10%
2026	34.00%

Chart 5: Top Therapeutic Classes by Gross Spend

Therapeutic Class/Treatment Category	2025 Gross Paid	2026 Gross Paid	2025 Claim Count	2026 Claim Count	Total Amount Paid Change	Claim Count Change
Antipsoriatics	$22,185,009.23	$22,556,723.90	2,033	2,096	1.68%	3.10%
Anti-Tnf-Alpha Monoclonal Antibodies	$23,676,543.24	$21,571,605.23	2,690	2,356	-8.89%	-12.42%
Opioid Partial Agonists	$21,807,097.81	$20,745,672.63	91,060	75,777	-4.87%	-16.78%
GLP-1 Receptor Agonists	$16,926,415.86	$19,744,909.98	15,453	17,731	16.65%	14.74%
Cystic Fibrosis Agents	$12,845,142.89	$13,473,613.59	707	701	4.89%	-0.85%
Amphetamines	$12,793,065.94	$12,185,473.62	70,110	70,702	-4.75%	0.84%
Stimulants - Misc.	$11,303,384.02	$11,551,789.11	56,701	57,168	2.20%	0.82%
Antineoplastic Enzyme Inhibitors	$7,528,407.09	$10,313,310.15	530	738	36.99%	39.25%
Sympathomimetics	$10,015,748.23	$8,981,509.28	68,590	62,797	-10.33%	-8.45%
Dermatologic Agents	$5,657,058.77	$7,172,958.86	2,558	4,315	26.80%	68.69%

Chart 6: Non-Insulin Antidiabetic Drugs

Non-Insulin Antidiabetic Drugs	2025 Gross Paid	2026 Gross Paid	2025 Claim Count	2026 Claim Count	Total Amont Paid Change
GLP-1 Receptor Agonists	$16,926,416	$19,744,910	15,453	17,731	16.65%
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	$6,406,262	$5,148,894	4,847	4,705	-19.63%
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	$698,302	$385,410	736	500	-44.81%
Diabetic Other	$285,618	$366,282	584	709	28.24%
Biguanides	$180,932	$177,836	12,001	11,399	-1.71%
Antidiabetic Combinations	$122,636	$85,985	143	127	-29.89%
Sulfonylureas	$33,428	$31,890	1,996	1,718	-4.60%

Chart 7 Top Drugs by Gross Spend

Current Rank	Drug Name	2025 Gross Paid	2026 Gross Paid	2025 Claim Count	2026 Claim Count	Total Amount Paid Change	Claim Count Change
1	Humira Pen (Adalimumab)	$21,371,831.81	$20,078,919.60	2,422	2,107	-6.05%	-13.01%
2	Suboxone (buprenorphine /naloxone)	$14,531,611.66	$12,220,604.90	54,614	41,239	-15.90%	-24.49%
3	Vyvanse (Lisdex amfetamine)	$10,823,433.77	$10,864,413.93	30,509	30,581	0.38%	0.24%
4	Trikafta (elexacaftor, tezacaftor, ivacaftor)	$11,770,227.31	$10,485,497.04	505	433	-10.92%	-14.26%

5	Concerta (methylphenidate)	$8,055,982.50	$8,440,047.99	19,938	20,829	4.77%	4.47%
6	Dupixent (dupilumab)	$6,879,759.80	$8,150,658.02	1,709	1,953	18.47%	14.28%
7	Trulicity (dulaglutide)	$4,779,952.60	$7,796,337.16	4,371	7,199	63.10%	64.70%
8	Ozempic(semaglutide)	$10,022,367.89	$7,638,027.50	8,995	6,586	-23.79%	-26.78%
9	Skyrizi Pen (risankizumab-rzaa)	$2,753,002.02	$6,567,897.38	157	305	138.57%	94.27%
10	Taltz (ixekizumab)	$5,767,126.10	$5,456,094.15	728	654	-5.39%	-10.16%

Chart 8 Top Therapeutic Classes by Utilization

Current Rank	Category Name	2025 Gross Paid	2026 Gross Paid	2025 Claim Count	2026 Claim Count	Gross Paid Change	Claim Count Change
1	Selective Serotonin Reuptake Inhibitors (SSRIs)	$1,299,303.41	$1,223,850.84	85,535	81,429	-5.81%	-4.80%
2	Opioid Partial Agonists	$21,807,097.81	$20,745,672.63	91,060	75,777	-4.87%	-16.78%
3	Amphetamines	$12,793,065.94	$12,185,473.62	70,110	70,702	-4.75%	0.84%
4	Anticonvulsants misc.	$4,402,906.53	$4,267,940.94	68,520	67,069	-3.07%	-2.12%
5	Sympathomimetics	$10,015,748.23	$8,981,509.28	68,590	62,797	-10.33%	-8.45%
6	Stimulants misc.	$11,303,384.02	$11,551,789.11	56,701	57,168	2.20%	0.82%
7	Antianxiety Agents misc.	$434,630.92	$446,592.44	33,584	34,722	2.75%	3.39%
8	Proton Pump Inhibitors	$973,747.19	$901,607.36	34,411	32,498	-7.41%	-5.56%
9	Antiadrenergic Antihypertensives	$421,631.59	$398,189.26	28,602	27,982	-5.56%	-2.17%
10	Nonsteroidal Anti-Inflammatory Agents (NSAIDs)	$416,650.15	$378,386.10	25,278	24,594	-9.18%	-2.71%

Chart 9: Top Drugs by Utilization

Current Rank	Category Name	2024 Gross Paid	2025 Gross Paid	2024 Claim Count	2025 Claim Count	Gross Paid Change	Claim Count Change
1	Suboxone (buprenorphine/naloxone)	$14,531,611.66	$12,220,604.90	54,614	41,239	-15.90%	-24.49%
2	Amphetamine/ Dextroamphetamine	$906,001.16	$932,165.43	35,010	38,041	2.89%	8.66%
3	Vyvanse (lisdexamfetamine)	$10,823,433.77	$10,864,413.93	30,509	30,581	0.38%	0.24%
4	Gabapentin	$486,239.86	$441,915.06	29,845	27,952	-9.12%	-6.34%
5	Sertraline HCL	$354,166.90	$326,805.72	26,659	25,036	-7.73%	-6.09%

6	Fluoxetine HCL	$369,545.26	$350,580.22	24,373	24,330	-5.13%	-0.18%
7	Albuterol Sulfate HFA	$497,534.55	$777,112.42	14,718	24,194	56.19%	64.38%
8	Bupropion HCL	$368,141.65	$340,034.30	22,538	21,774	-7.63%	-3.39%
9	Concentra	$8,055,982.50	$8,440,047.99	19,938	20,829	4.77%	4.47%
10	Methylphenidate HCL	$532,296.88	$543,331.02	20,378	20,356	2.07%	-0.11%

Chart 10A: Number of Members Using Opioids: 3-year Trend

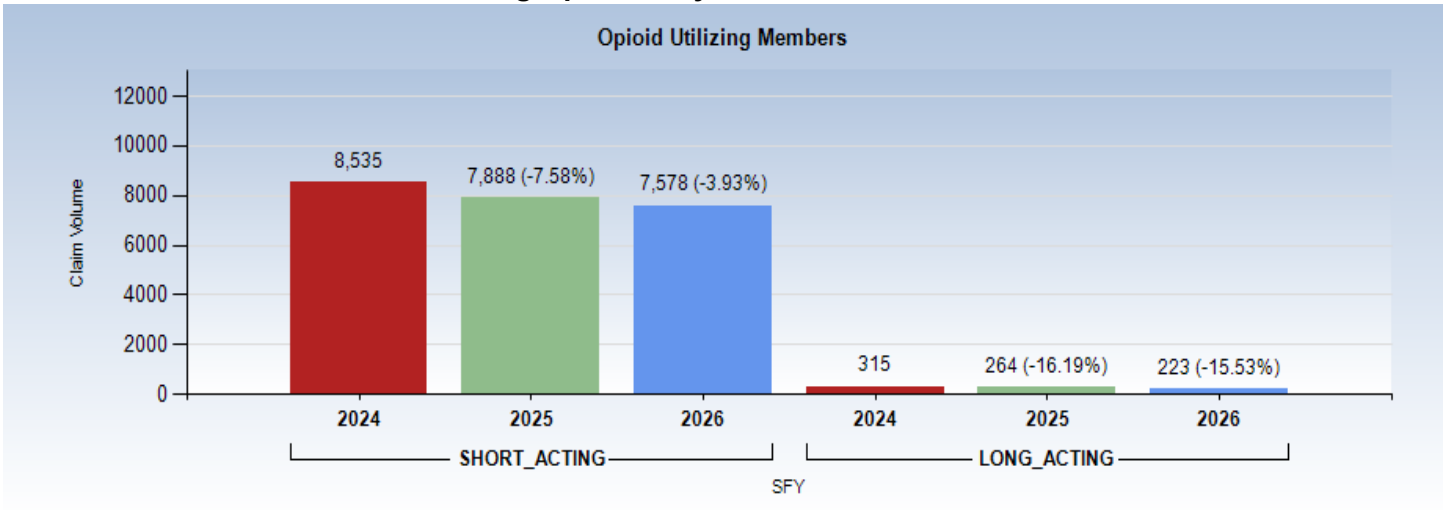


Chart 10B: Number of Prescriptions for Opioids: 3-year Trend

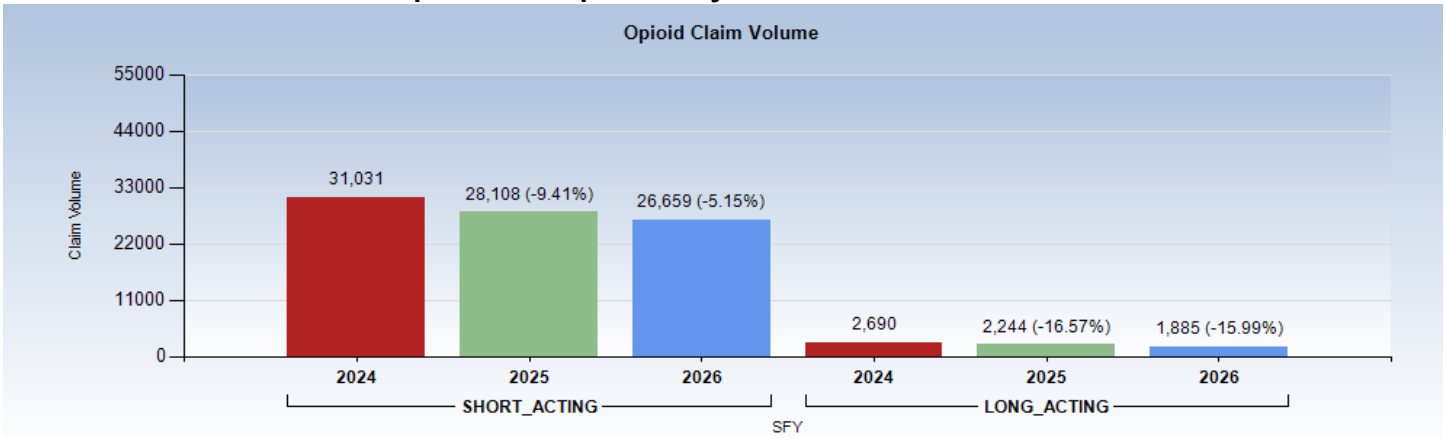


Chart 10C: Number of Prescriptions Per 1,000 Members per Month for Opioids: 3-year Trend

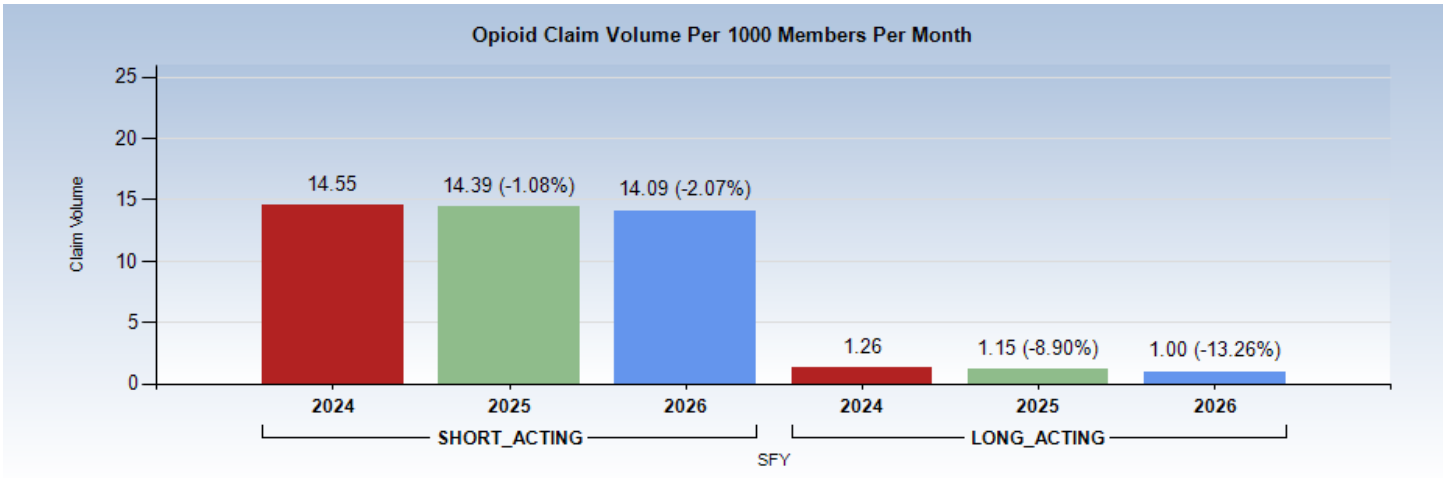


Chart 11A: Specialty Drugs as a Percent of Total Gross Drug Cost

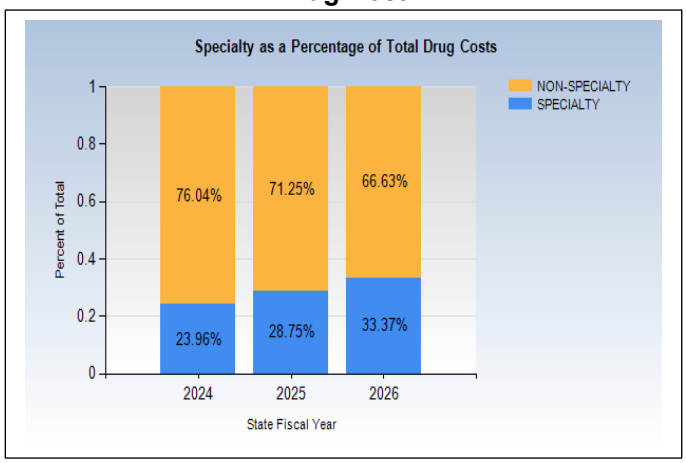


Chart 11B: Specialty Drugs, Gross Paid Amount

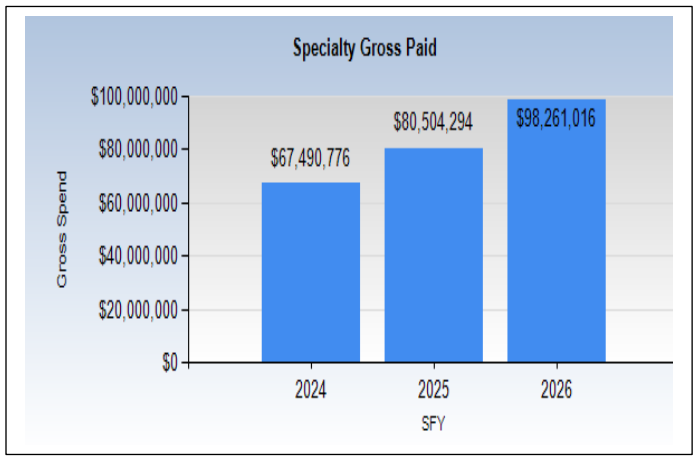


Chart 12A: Specialty Drugs by Number of Claims

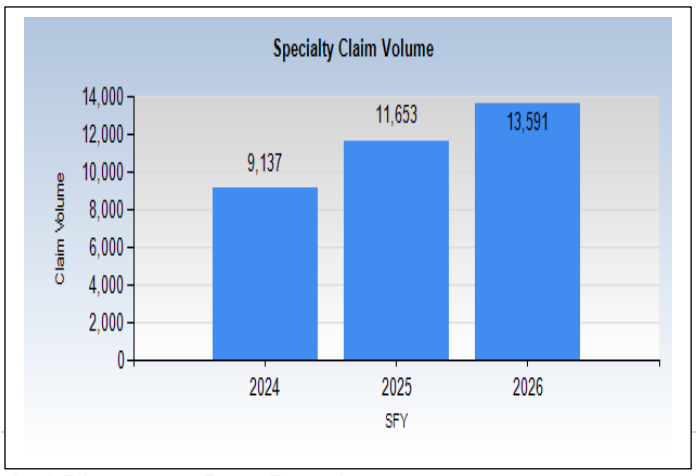


Chart 12B: Specialty Drugs, Gross Paid Per Rx

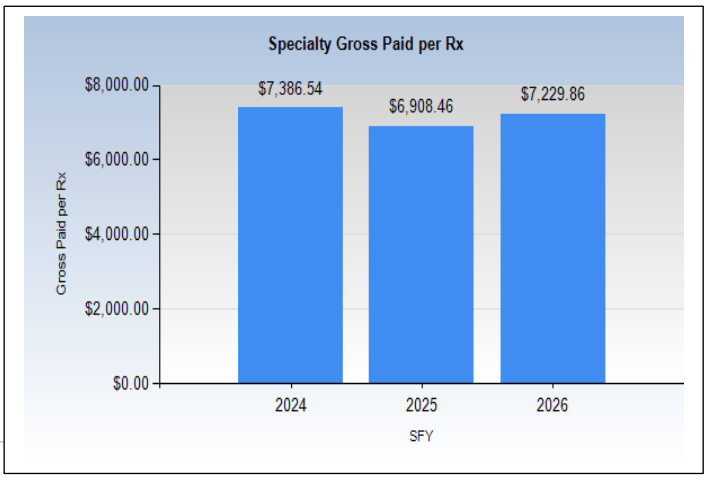


Chart 13: Hepatitis C, Cystic Fibrosis, and Oral Cancer Category Total Spend

Drug Category	2025 Gross Paid	2026 Gross Paid	2025 Claim Count	2026 Claim Count	Gross Paid Change	Claim Count Change
Hepatitis C DAA	$4,140,330	$3,709,586	352	335	-10.74%	-4.83%
Cystic Fibrosis	12,980,930	$13,617,602	744	740	4.9%	-0.54%
Oral Cancer	5,980,321	$7,207,985	354	428	20.53%	20.9%

Chart 14: Medication-Assisted Treatment (MAT) for Opioid Use Disorder

Drug Name	2025 Gross Paid	2026 Gross Paid	2025 RX Count	2026 RX Count	2025 Distinct Members	2026 Distinct Members	Gross Paid Change	Claim Count Change	Distinct Member Change
Suboxone Film (Brand)	$14,531,612	$12,220,605	54,614	41,239	3,337	2,735	-15.90%	-24.49%	-18.04%
Sublocade Injection	$2,800,342	$3,819,043	1,388	1,803	278	350	36.38%	29.90%	25.90%
Brixadi Sosy	$3,129,509	$3,393,475	2,093	2,237	339	346	8.43%	6.88%	2.06%
Vivitrol Susp	$847,712	$1,018,079	529	608	149	159	20.10%	14.93%	6.71%
Buprenorphine HCL/Naloxone Subl Tab	$649,724	$597,252	19,828	18,257	1,449	1,505	-8.08%	-7.92%	3.86%
Buprenorphine HCL Subl Tablets (Mono)	$328,637	$375,369	11,321	11,190	699	655	14.22%	-1.16%	-6.29%
Zubsolv Subl	$158,659	$155,640	551	456	52	52	-1.90%	-17.24%	0.00%
Naltrexone Hcl Tabs	$79,157	$143,688	2,930	3,446	982	1,094	81.52%	17.61%	11.41%
Acamprosate Calcium	$31,097	$45,568	427	489	189	199	46.54%	14.52%	5.29%
Disulfiram Tabs	$22,815	$42,460	318	295	125	116	86.11%	-7.23%	-7.20%

Supplemental Charts: Drug Names and Commonly used FDA Indications

Drug Name Brand (Generic)	Commonly used FDA indications
Acromprosate	Alcohol use disorder
Amoxicillin	Antibiotic/Anti-infective
Amphetamine/ Dextroamphetamine	Attention-deficit/hyperactivity disorder
Brixadi* (buprenorphine)	Opioid use disorder
Buprenorphine/Naloxone	Opioid use disorder
Bupropion HCL	Bipolar disorder, Major depressive disorder
Concerta (methylphenidate)	Attention-deficit/hyperactivity disorder
Dupixent* (dupilumab)	Asthma, Atopic Dermatitis, Eosinophilic esophagitis
Fluoxetine HCL	Bipolar disorder, Generalized anxiety disorder, Major depressive disorder
Gabapentin	Fibromyalgia, Neuropathic pain, Seizures
Humira Pen (adalimumab)	Inflammatory bowel disease, Psoriasis, Rheumatoid arthritis
Jardiance (empagliflozin)	Type 2 Diabetes Mellitus
Methylphenidate	Attention-deficit/hyperactivity disorder
Naltrexone	Alcohol use disorder, Opioid use disorder
Ozempic (semaglutide)	Type 2 Diabetes Mellitus
Sertraline HCL	Bipolar disorder, Generalized anxiety disorder, Major depressive disorder
Stelara* (ustekinumab)	Inflammatory bowel disease, Psoriasis

Suboxone (buprenorphine/naloxone)	Opioid use disorder
Sublocade* (buprenorphine)	Opioid use disorder
Taltz* (ixekizumab)	Psoriasis
Trikafta* (elexacaftor, tezacaftor, and ivacaftor)	Cystic fibrosis
Trulicity (dulaglutide)	Type 2 Diabetes Mellitus
Ventolin HFA	Asthma, Chronic obstructive pulmonary disorder
Vivitrol (naltrexone)	Alcohol use disorder, Opioid use disorder
Vyvanse (Lisdexamfetamine)	Attention-deficit/hyperactivity disorder
Zubsolv (buprenorphine)	Opioid use disorder

*Indicates specialty drug designation

Therapeutic Classes	Associated FDA Indications
Anti-Tnf-Alpha - Monoclonal Antibodies	Inflammatory bowel disease, Psoriasis, Rheumatoid arthritis
Antiadrenergic Antihypertensives	Hypertension, Benign Prostatic Hyperplasia
Amphetamines	Attention-deficit/hyperactivity disorder
Antianxiety Agents- misc.	Generalized anxiety disorder
Anticonvulsants misc.	Epilepsy, Seizure disorders
Antidiabetic Combinations	Type 2 Diabetes Mellitus
Antineoplastic Enzyme Inhibitors	Oncology and various cancer diagnoses
Antipsoriatics	Psoriasis
Biguanides	Type 2 Diabetes Mellitus
Cystic Fibrosis Agents	Cystic Fibrosis
Diabetic Other	Type 2 Diabetes Mellitus
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Type 2 Diabetes Mellitus
Glucagon-like peptide-1 Receptor Agonists	Type 2 Diabetes Mellitus
Hepatitis C Direct Acting Antivirals (DAA)	Hepatitis C
Insulin	Type 1 and 2 Diabetes Mellitus
Nonsteroidal Anti-Inflammatory Agents	Inflammatory Conditions, Pain Reliever
Opioid Partial Agonists	Opioid use disorder
Oral Cancer	Oncology and various cancer diagnoses
Proton Pump Inhibitors	Gastroesophageal reflux disease
Selective Serotonin Reuptake Inhibitors (SSRI)	Bipolar disorder, Generalized anxiety disorder, Major depressive disorder
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	Type 2 Diabetes Mellitus
Stimulants -misc	Attention-deficit/hyperactivity disorder
Sulfonylureas	Type 2 Diabetes Mellitus
Sympathomimetics	Asthma, Chronic obstructive pulmonary disorder