THE QUARTERLY COMPASS

Winter 2024 Newsletter

President's Message

Happy New Year to all! As I reflect on the start to the new year and my short time at the Health Alliance, I think about the Saint Alphonsus promise, We Listen, We Partner, We Make it Easy. This promise not only applies to how we care for patients, but believe it is no less important in how we partner with clinicians. Given the strong history of the Health Alliance clinically integrated network(CIN) I think the new year is a great time to reflect on HOW we do this.

We Listen.....we want to hear from you. How can we at the Alliance help support you to ensure success in caring for patients and being good resource stewards? In addition to the Health Alliance staff, our board and committees consist of both Saint Alphonsus and independent clinicians who best represent our network participants and ensure their interests are prioritized. These individuals are listed on our website or if you have questions or concerns you wish to discuss, please reach to me directly.

We Partner.....our staff are often physically out working in clinics to be an additional resource and extra set of hands to help get the work done. We share best practices, gather quality data and how to create efficiencies. Our team helps to ensure providers are getting credit for the great care they deliver and maximize performance under advanced payment models/value-based contracts.

Warm Regards,

Stacy Meyr, DC
President
Saint Alphonsus Health Alliance

We Make it Easy....most things in healthcare are not easy, but we at the Health Alliance strive to eliminate barriers, smooth processes and bring the caring, human-element to this work in support of our network participants. Our role is to bring forth resources that do make things easier to care for patients, conduct the business of health care and be reasonably compensated for the effort.

We look forward to the new year ahead and working closely with you and your care teams to serve patients in the Treasure Valley and surrounding areas.

Annual Wellness and Preventative Care Visits

As we enter a new year, it is crucial for healthcare providers to prioritize the scheduling of Annual Wellness Visits (AWVs) to ensure comprehensive care of their patients. Utilizing your patient roster(s) at the beginning of the year to perform outreach can significantly improve the success rate in scheduling these important visits. Paying attention to the "new" column on your roster is essential to ensure that patients who are new to your practice, new to the plan, and especially new to Medicare, are scheduled for their AWVs or Preventative Care Visits (PCVs). This approach allows for the capture of all active conditions including those diagnosed prior to Medicare enrollment.

In line with best practices and to reduce the need for outreach, it is recommended to proactively schedule each patient for next year's AWV at the time of checkout. AWVs may be our only face to face opportunity to address all active chronic conditions within the calendar year and should represent the patient's overall state of health at the time of service. The Saint Alphonsus Health Alliance All in One Report and Pre-Visit Planning Sheets are helpful resources in performing some of the cognitive work of the provider by identifying past reported chronic conditions. By implementing these strategies and staying diligent in scheduling AWVs, providers can enhance patient care, improve recapture and documentation of active conditions, contributing to a more comprehensive and coordinated approach to healthcare delivery.

A more accurate Risk Adjustment Factor (RAF) may be measured by implementing The Saint Alphonsus Health Alliance provided Clinic Rosters, All in One Report, and Pre-Visit Planning Sheets to increase both the number of AWVs scheduled and chronic condition recapture rate in your daily practice.

Medicaid | Well & Sick Visits

Combining Well Visit with Sick Visits

Q: Can you bill Medicaid for a sick and well visit on the same patient encounter?

A: YES! Medicaid will accept and pay claims for a sick and well visit that occur during the same patient appointment.

- ☐ Report the additional CPT code with Modifier-25
- ☐ Based on the guidelines from the AMA: https://www.ama-assn.org/practice-management/cpt/can-physicians-bill-both-preventive-and-em-services-same-visit

If provider has time to do so – conducting well visit services during sick visit appointment means:

- Patients receive additional, appropriate care.
- Practice receives increased reimbursement.
- VCO Program quality measures have better chance of being met.

Statin use with Diabetics (DM) and Cardiovascular Disease (CVD)

CMS continues to grade how many of our patients with DM or CVD are prescribed and taking statins. But what if the patient is intolerant to statins?

Patients will be removed from the list if there is documentation of an intolerance of statin, but one of **the following exclusion codes must be submitted at least annually within a visit**:

- **G72.0 Drug-induced myopathy**
- G72.9 Myopathy, unspecified
- M60.80 Other myositis, unspecified
- M60.9 Myositis, unspecified
- M62.82 Rhabdomyolysis

Please remember to add to the problem list to ensure the code is submitted annually during the annual wellness visit.

Hypertension in Patients 81-85

Did you know we are graded on blood pressure control in adults aged 18-85? For those who are on the older age of that spectrum we can exclude those who are medically frail.

Patients will be excluded from the list if they are aged 81-85 and there is documentation of a frailty code. **One of the following must be submitted at least annually within a visit:**

R53.1 Weakness

R53.83 Other fatigue

W01.0XXA-W01.198S, W06.XXXAW10.9XXS, W18.00XA-W19.XXXS Fall

Z73.6 Limitation of activities due to disability

Z74.09 Other reduced mobility

Z74.1 Need for assistance with personal care

Z91.81 History of falling

Please remember to add to the problem list to ensure the code is submitted annually during the annual wellness visit.

Post-Acute Care and Treasure Valley Skilled Nursing Facilities

We care about the care our patients receive in a skilled nursing facility (SNFs) and if the facility our patients choose, provides quality, optimized, safe care. Our Post-Acute Care Management Team monitors CMS quality metrics, Trinity Health quality metrics and individual skilled facility data monthly. We have recently updated our Quality of Care Profiles (QoCP) which are patient materials provided to patients and families when helping them choose a facility for next site of care. We ask our SNF partners listed as 'quality' to share in our quality measures and hold them accountable for performance related to readmissions, optimized length of stay, and Star Ratings. We also monitor and track health inspections, staffing, and SNF quality measures to ensure they provide safe and just care for all. When necessary, we also meet with our SNF partners to discuss concerning readmissions or patient care issues that we have been notified of.

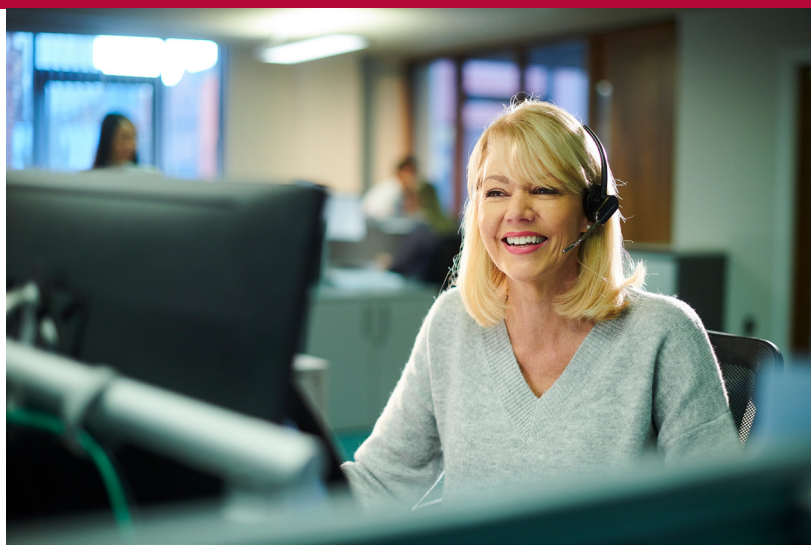
To earn and maintain their listing on the QoCP, SNFs must achieve and maintain an average length of stay of less than 22 days, and have 30 and 60 day readmissions of less than 18%. The SNF must also allow our RNs to participate in patient care meetings, fax medication lists, discharge appointments, and home health agency information to our Health Information Management fax for immediate uploading after discharge.

Our mission and expectations of the QoCP is to provide safe and just care for all. Saint Alphonsus understands there may be unique circumstances where it is not possible to meet all metric expectations. With regular and robust communication, we can improve the quality of care for our shared patients and safely transition them back to the Primary Care Provider.

Quality of Care Metrics

https://mytrinityhealth.sharepoint.com/sites/SAHS-PostAccuteCareMgmt/Shared%20Documents/Forms/AllItems.aspx

Patient Care Liaisons



Saint Alphonsus Health Alliance has dedicated clinical Patient Care Liaisons for your patients to assist with navigation throughout our healthcare system.

- Assist with coordination of referrals or scheduling, including inpatient, outpatient, post-acute and practice-based care settings
- Help your patients find in-network providers to avoid/minimize patient out-of-pocket costs
- Assist with proactive gap authorization when out-of-network services are truly required
- Assist with payer authorizations if you are running into roadblocks in certain cases
- Assist with all pediatric referral questions

Please be aware that Saint Alphonsus Health Alliance network has providers who can handle certain pediatric specialty services, the challenge is that many of these services have age-determined restrictions. Referrals to non-network providers will likely cause a much higher out of pocket expense for your patients.

Call our patient care liason department:

Monday - Friday (8am-5pm MST)

Aetna/Trinity - Saint Alphonsus Colleague Plan
(208) 367-SAHS

Blue Cross of Idaho - Connected Care
Alpha Prefix: XMO, XMU, ISN
(208) 367-INFO

Saint Alphonsus Health Plan - formerly MediGold
(208) 367-INFO

Mountain Health Co-op - Access Care
(208) 367-INFO

Regence Blue Shield of Idaho - Individual & Family Network (IAFN)/Accord
(208) 367-INFO

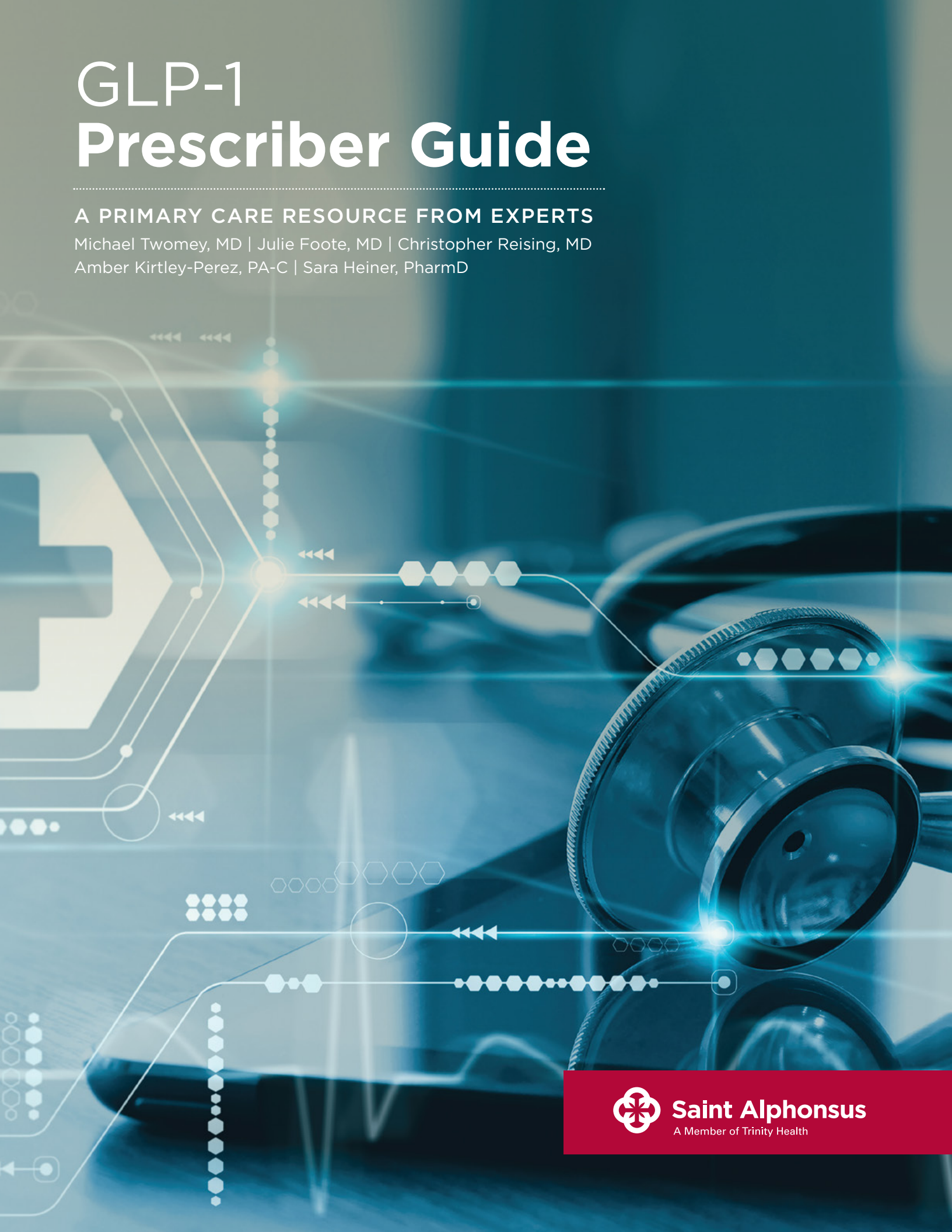
MODA - Select Individual & Group Plans
(208) 367-INFO

Select Health - SAHA Individual & Group Plans
(208) 367-INFO

GLP-1
Prescriber Guide

A PRIMARY CARE RESOURCE FROM EXPERTS

Michael Twomey, MD | Julie Foote, MD | Christopher Reising, MD
Amber Kirtley-Perez, PA-C | Sara Heiner, PharmD



Saint Alphonsus
A Member of Trinity Health

GLP-1 **Prescriber Guide**

A PRIMARY CARE RESOURCE FROM EXPERTS

Saint Alphonsus
A Member of Trinity Health

As providers grapple with the right way to manage chronic diseases, medical costs seem to be skyrocketing while quality of care appears just out of reach.

GLP-1 agonists are one class of medication at the crossroads of improved quality and pharmaceutical profit. How can we use these drugs effectively? Can we be a steward of value in a landscape that highlights financial and health inequities?

Our panel attempted to take a crack at these difficult questions and give primary care providers a guide for how to interpret the myriad of studies. We strive to provide you with the knowledge of the current prescription landscape, the true cost of GLP-1 medications, and philosophies of use in the chronic diseases of diabetes and obesity.

For too long, non-insulin diabetic treatments comprised of medications which exacerbated or worsened cardiac disease. Treatment was necessary but came with a medical burden. With the advent of the SGLT2i and GLP-1 classes came a paradigm shift. We now had treatments beyond Metformin with proven reduction in the risk of heart attack, stroke, and death. Patients and providers flocked to these new classes for good reason.

DATA

Speaking to the GLP-1 class alone, Ozempic (semaglutide) showed a Number Needed to Treat (NNT) to prevent one cardiovascular (CV) event of 45 in the SUSTAIN[1] trial of diabetics while Victoza (liraglutide) showed an NNT of 66 in the LEADER trial.[2] For perspective, the NNT for statins is 28 for our highest risk patients[3] and is 70 or greater in the moderate to low-risk spectrum.[4]

This class represents powerful A1c reduction for your patients. A1c improvement ranges from 0.4 to 1.5 for non-insulin medications. GLP-1s routinely score at the top of that spectrum representing one of our best tools we have to optimize control. The difference between a controlled A1c and an uncontrolled A1c could be over 3.5 years to your patient's life![5]

But enough about living longer—lets talk about weight! For many, the most visible benefit of these medications is the weight loss potential. Average starting weight in these trials was 220 pounds with a total weight loss of up to 12 – 46 pounds depending on medication.

Brand	Generic	Weight Loss on Max Dose	Time Frame	Trial
Mounjaro	Tirzepatide	20.9%	26 weeks	SURMOUNT[6]
Victoza	Liraglutide	5.8%	56 weeks	SCALE[7]
Ozempic	Semaglutide	17.4%	68 weeks	STEP[7]

Of course, there is more to the story...

DATA

Here are some nuances to help us understand how to apply these medications in our practices. Ozempic's SUSTAIN Trial was of course comprised of diabetics, but 83% had established CV disease or seen as high risk. In a low-risk patient, the NNT for prevention of any CV event could be much higher. In a population of high-risk obese patients without diabetes, Wegovy (high dose semaglutide) showed an NNT of 63. That number alone looks intriguing, however the cost of prevention for each event is $1.1 million.[8]

As providers, we know quality of life is invaluable and prevention of any event is important. However, with many possible interventions regarding heart disease, it is valuable to first prioritize those most cost effective. Make sure that we do not lose sight of the value of generic treatments such as ACEi, statins, beta blockers and aspirin where appropriate.

Meanwhile, all weight loss studies used motivated, engaged patients, with the addition of lifestyle changes. The differences between placebo and medication were incredible, but it is difficult to recreate the important support structure in a busy primary care center. In the real world, only 50% of patients are adherent to therapy at 12 months[9] and many suffer from significant nausea or other side effects.

ACCESS

As the popularity of these drugs has risen, it has become increasingly more difficult to prescribe. Insurances have initiated prior authorizations and step-throughs to combat rising claim costs and access is very difficult to ensure. Too often a patient is calling multiple pharmacies searching for any available prescription of a GLP-1. Some of the supply issues will improve in time, but expect increasing restrictions from insurance companies over the next few years.

COST

Even compared to other branded diabetic medications, these drugs pack a heavy punch. SGLT2i are $4,000-$7,000 per year prior to rebates. Unfortunately, GLP-1s are double the cost ranging from $10,800 for Byetta all the way to $19,200 for Wegovy. For comparison, an average hospitalization (4.5 days) cost $12,974 in 2021! No matter what the patient's copay, this represents a large medical cost to the system. Overall, pharmacy spending accounts for 25% of total costs. Diabetic medication represents about a quarter of the pharmacy claims. As costs increase, we continue see them often passed on to the patient through higher deductibles, copays, and premiums.

In Medicare plans, the donut hole represents an additional burden. Let's follow a patient example on a GLP-1:

As you can see, the donut hole creates an expensive situation where patients may be surprised by the cost changes. With just a GLP-1 medication, the patient will be stuck in the donut hole for the rest of the year but experience big fluctuations to their out-of-pocket cost. Non-compliance is common during this period and some patients end up discontinuing all of their prescriptions due to cost.

JANUARY

At the beginning of the year, a patient's first fill will hit the deductible. This could be up to **$505** and depends on the plan.

FEBRUARY - MAY

The next few fills will be around **$50** and will represent just the plan's branded co-payment.

JUNE - DECEMBER

After about five months of therapy, **the patient will fall into the donut hole** and suddenly be charged ~**$275** per month (25% of the total cost of the medication). This will continue for the rest of the year or until the patient pays over **$8,000** out of pocket in drug costs!


Julie Foote, MD


Christopher Reising, MD


Michael Twomey, MD


Amber Kirtley-Perez PA-C

Sara Heiner, PharmD

So, what should you do?

To help guide us through the weight of these complex medical decisions we empaneled Dr. Foote, MD in Endocrinology, Dr. Reising, MD in Bariatric Surgery, Amber Kirtley-Perez, PA-C in Wellness, and Sara Heiner, Pharm-D to help.

TYPE 2 DIABETES

Diabetic care is inherently individual, and the right class of medication will depend on many factors. We still recommend starting with metformin. In order to maximize the tolerance of this drug, consider extended-release forms to reduce GI upset and have them take it with their largest meal. The most improvement in A1c occurs from 0 – 1000mg so any amount the patient can take helps! Always consider ways you can restart or increase metformin use. In patients on insulin, but without current metformin, restarting therapy can reduce insulin use by 7-20U per day! This could be a cost savings of $1,200 per year while reducing weight gain and insulin resistance.

Be careful of duplicate therapy! We still see patients on both a DPP-4i and a GLP-1. These are easy to identify in your practice by simply focusing on reduced use of the DPP-4i class entirely. Most would benefit more from a cardioprotective standpoint by shifting to an SGLT2i for a similar cost & A1c reduction.

Avoid adding on any diabetic medication if the patient has a well-controlled A1c < 7. The risk of side effects and polypharmacy is real, and the benefit is less clear in these scenarios. The major exception to this rule is patients with both diabetes and established heart disease. Data is clear that adding on an SGLT2i will reduce the risk of cardiovascular hospitalization and they are separately indicated in cardiovascular disease.

Afterwards, it really is a patient and physician discussion. Consider co-morbid diseases and identify if the patient will benefit greater from an SGLT2i vs GLP1. From a quality standpoint, both classes are superior in comparison to the older sulfonylureas or thiazolidinediones. However, it is unrealistic to expect all patients to be able to tolerate or afford these medications and there is still room for use of older medications classes. Most of the time, your patients would benefit from both SGLT2i and GLP1's prior to adding insulin. If cost becomes a concern, there are income programs provided by the drug manufacturer that may help. Reach out to a CHW or pharmacist through an EPIC referral to help. Remember, you may be burdened by multiple prescription rejections after dealing with prior authorizations, drug shortages, and sticker shock. In the end, the best medication is the one your patient can take. Being honest about the total cost of care will ensure both you and the patient are realistic about medication adherence.

OBESITY

No weight loss program works without providing a multimodal and multidisciplinary treatment approach. The right patient is motivated and engaged to achieve a long-term outcome. The bariatric philosophy is to provide this partnership for at least six months prior to any surgical intervention to gage this readiness. Those resources are not always available in a busy clinical practice and GLP-1s are not a panacea to a poor lifestyle structure. Although they help with weight loss in the first year, once discontinued, two-thirds of the weight is gained back in one year and the patient is usually back to initial weight just two years later. In the end, the weight loss medications are tempting, but there isn't a BMI level where we should be pushing them on patients. Instead, a focus on managing macro-nutrients through education and dietary services with medication as an adjunct is the correct perspective. Here are some helpful hints for your practice.

Best management for patients asking for GLP-1s for weight loss is to create a strategic plan prior to initiation. Start with a face-to-face appointment with an initial weight and discuss the pros and cons of therapy. Remind patients they will not be successful in the long run without lifestyle changes. Meet with them monthly with weight loss, macronutrient, and activity (not necessarily exercise) goals. Providers can benefit from requiring a visit with a dietician during the initial stages of management. Unfortunately, Medicare does not cover dietician services and exceptions may need to be made for those patients. If they are not meeting goals (intolerance, lack of weight loss, no-shows), the medication should be discontinued, and alternative therapy should be considered. Set clear expectations for when to stop the medication and support the patients after stopping to avoid rebound weight gain. Discourage the use of compounded medications and non-FDA approved forms of drugs as their safety is unclear.

Finally, refer to bariatrics for more extensive support. Consider wellness and health coaches. Utilize embedded community programs that encourage socialization, accountability with other like-minded members, and share education.

WELLNESS

As you know, we cannot manage these chronic disease states with medication alone. Our aspirations as providers must be greater to achieve true quality in our practice. It is through community that patients can help hold themselves accountable outside of your office visit—where all the magic happens! Fortunately, help is on the horizon. The exciting space of wellness medicine is focused on building those small groups of patients—allowing them to share and educate each other. Currently working on heart health, our wellness team is looking to touch every cardiac rehab patient to improve outcomes. As we move forward, health coaches, chronic case management from nurses, and community health resources will be vital to the management of both diabetes and obesity. For now, use your existing resources. Get patients engaged with nursing for education and management, give a number to a local support group of patients with the same disease, use diabetic education regularly, refer to CHW's for social determinants of health, and refer to wellness medicine if appropriate.

Diabetic Education

Currently offered at Saint Alphonsus Glycemic Boise, 12th Avenue in Nampa, West Chery Lane in Meridian, and SW 9th Street in Ontario. As a reminder there are four great times to refer for Diabetic Education:

1. At diagnosis (10h)
2. Annually or when not meeting treatment targets (2h)
3. When complicating factors develop (2h)
4. When a transition in life or care happens (2h)

Bariatric Support Group

Monthly free bariatric support group open to all patients on at any stage. Currently meets on the third Thursday of every month at 6:00 PM virtually. To sign up for group email notifications patients may fill out a form on the SAHS web: **SaintAlphonsus.org/specialty/bariatric-surgery/education-and-support/support-groups** or call the Saint Alphonsus General Surgery and Bariatric Clinic at **(208) 302-2300**

REGISTERED DIETICIANS	LANGUAGE SPOKEN	ACCEPTING MEDICARE	ACCEPTING MEDICAID	CLINIC NAME	CITY
Erin Rae, RD		No	No	Apex Chiropractic & Wellness	Boise
Kelly Wood, RD		No	No	Be Well Nutrition, LLC	Boise
Jennifer Anthony, RD		Yes	Yes	Full Circle Health – Raymond	Boise
Kelsey Ruszel, RD		Yes	Yes	Full Circle Health – Raymond	Boise
Spring Bean, RD	ASL	Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Medina Blanchet, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Brenda Bourn, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Jennifer Buker, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Margaret Capron, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Maryanne Cunningham, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Deena La Joie, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Rachael Tatko, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Sariah Wilson, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Kelly Wood, RD		Yes	No	Idaho Nutrition Associates, LLC – Wainwright	Boise
Laura Nielsen, RD		Yes	Yes	Saint Alphonsus General Surgery & Bariatrics – Mulvaney	Boise
Sandra Dammarell, RD		Yes	Yes	Saint Alphonsus Glycemic Boise	Boise
Sandra Horrocks, RD		Yes	Yes	Saint Alphonsus Glycemic Boise	Boise
Danielle Rich, RD		Yes	Yes	Saint Alphonsus Glycemic Boise	Boise
Alyson Bores, RD		Yes	Yes	Saint Alphonsus Regional Medical Center	Boise
Lynn Bailey, RD		Yes	No	Whole Body Nutrition & Fitness	Boise
Cindy Nebeker, RD		No	No	Nutrition By Design	Meridian
Marjorie Rich, RD		Yes	Yes	Saint Alphonsus Glycemic – W. Cherry Ln.	Meridian
Lynn Kipp, RD		No	No	Nourish Your Life	Nampa
Danielle Kipp, RD		No	No	Nourish Your Life	Nampa
Lynn Dammarell, RD		Yes	Yes	Saint Alphonsus Glycemic – Caldwell 430	Caldwell
Laura Moulton, RD		No	Yes	Mountain Home Nutrition Services	Mountain Home
Valerie Lawrence, RD		Yes	Yes	Valerie Lynn Lawrence	Emmett
Sanjuanita Aguilar, RD	Spanish	Yes	Yes	Valley Family Health Care – Mobile Access Unit	Payette
Andrea Aguilar, RD	Spanish	Yes	Yes	Valley Family Health Care – Payette	Payette

FOUR CRITICAL TIMES FOR DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT SERVICES

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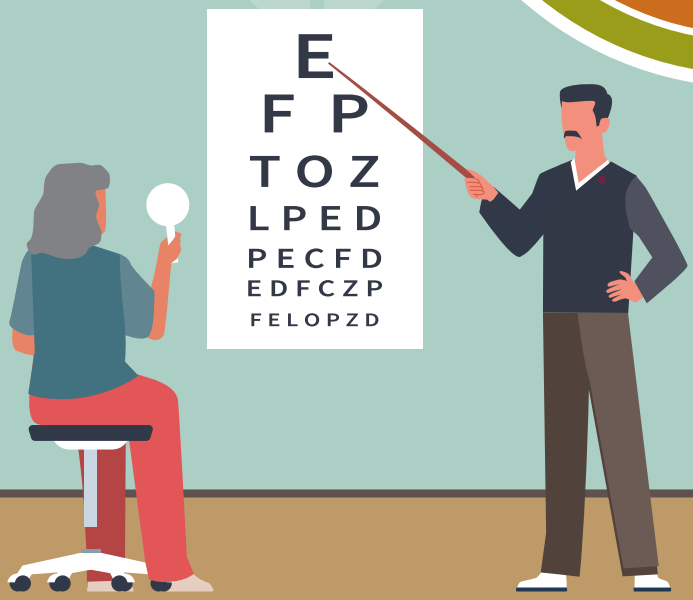
At Diagnosis

Annually and/or When Not Meeting Treatment Targets

When Complicating Factors Develop



When Transitions in Life and Care Occur

Endnotes

[1] Semaglutide and Cardiovascular Outcomes in Patients with Type 2 Diabetes.
Steven P. Marso, Stephen C. Bain, Agostino Consoli, et al. The New England Journal of Medicine. Nov 10, 2016.

[2] Kalra S. Follow the LEADER-Liraglutide Effect and Action in Diabetes: Evaluation of Cardiovascular Outcome Results Trial. Diabetes Ther. 2016 Dec;7(4):601-609. doi: 10.1007/s13300-016-0197-4. Epub 2016 Sep 9. PMID: 27613064; PMCID: PMC5118235.

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[4] Byrne P, Cullinan J, Gillespie P, Perera R, Smith SM. Statins for primary prevention of cardiovascular disease: modelling guidelines and patient preferences based on an Irish cohort. Br J Gen Pract. 2019 Jun;69(683):e373-e380. doi: 10.3399/bjgp19X702701. Epub 2019 Apr 23. PMID: 31015226; PMCID: PMC6532821.

[5] Kianmehr H, Zhang P, Luo J, et al. Potential Gains in Life Expectancy Associated With Achieving Treatment Goals in US Adults With Type 2 Diabetes. JAMA Netw Open. 2022;5(4):e227705. doi:10.1001/jamanetworkopen.2022.7705.

[6] Jastreboff AM, Aronne LJ, Ahmad NN, Wharton S, Connery L, Alves B, Kiyosue A, Zhang S, Liu B, Bunck MC, Stefanski A; SURMOUNT-1 Investigators. Tirzepatide Once Weekly for the Treatment of Obesity. N Engl J Med. 2022 Jul 21;387(3):205-216. doi: 10.1056/NEJMoa2206038. Epub 2022 Jun 4. PMID: 35658024.

[7] Jensterle M, Rizzo M, Haluzík M, Janež A. Efficacy of GLP-1 RA Approvedfor Weight Management in Patients With or Without Diabetes: A Narrative Review. Adv Ther. 2022 Jun;39(6):2452-2467. doi: 10.1007/s12325-022-02153-x. Epub 2022 May 3. PMID: 35503498; PMCID: PMC9063254.

[8] airfinity.com/articles/wegovy-costs-usd1-1m-to-prevent-one-heart-attack-stroke-or-cardiovascular. Accessed 10/31/2023.

[9] Weiss T, Carr RD, Pal S, Yang L, Sawhney B, Boggs R, Rajpathak S, Iglay K. Real-World Adherence and Discontinuation of Glucagon-Like Peptide-1 Receptor Agonists Therapy in Type 2 Diabetes Mellitus Patients in the United States. Patient Prefer Adherence. 2020 Nov 27;14:2337-2345. doi: 10.2147/PPA.S277676. PMID: 33273810; PMCID: PMC7708309.

[10] GoodRx October 2023 prices.