SJVIA PHARMACY OVERVIEW

CONSULTANTS REPORT ON PHARMACY

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Pharmacy Financial Baseline

Annualized Based on January–May 2026 Claims Experience (Pre-Rebate)

Board Takeaway:
Current pharmacy spend is projected at approximately $40 million annually ($235 PMPM). Anti-obesity medications alone contribute approximately $54 PMPM, highlighting why GLP-1 strategy has become one of the most significant financial decisions for the 2027 pharmacy benefit.

SJVIA - CarelonRx - Q1 2026 Highlights

Total plan cost decreased 12% in Q1 2026 compared to Q4 2025.
Overall script count decreased, likely influenced by transition timing and late December fills.
Specialty claims plan cost decreased in Q1 2026.

Entity	Q4 2025	Q1 2026	QoQ Change
SJVIA	$10,845,833	$9,535,999	-12%
Tulare	$4,364,072	$4,002,517	-8%
Fresno	$6,481,761	$3,659,655	-44%

Category	Q4 2025	Q1 2026	QoQ Change
Specialty	$3,309,561	$2,687,218	($622,343)

Category	Q4 2025	Q1 2026	QoQ
Retail Brand	6,096	8,396	2,300
Retail Generic	16,491	10,541	(5,950)
Retail 90 Brand	1,061	2,603	1,542
Retail 90 Generic	9,029	5,845	(3,184)
Mail Brand	128	93	(35)
Mail Generic	355	150	(205)
Specialty	855	847	(8)
TOTAL	34,015	28,475	(5,540)

Board Takeaway:
Pharmacy costs declined in Q1; however, this appears largely related to the PBM transition and refill timing rather than a structural reduction in pharmacy spend. Additional experience is needed before concluding that trend has improved.

Jan-May 2026 Paid Claims Snapshot

Total Plan Cost

$16.6M

Pre-rebate

Gross Allowed Cost

$18.1M

Plan + member

Paid Claims

60,596

Jan-May 2026

Utilizing Members

8,893

Encrypted IDs

Cost / Utilizer

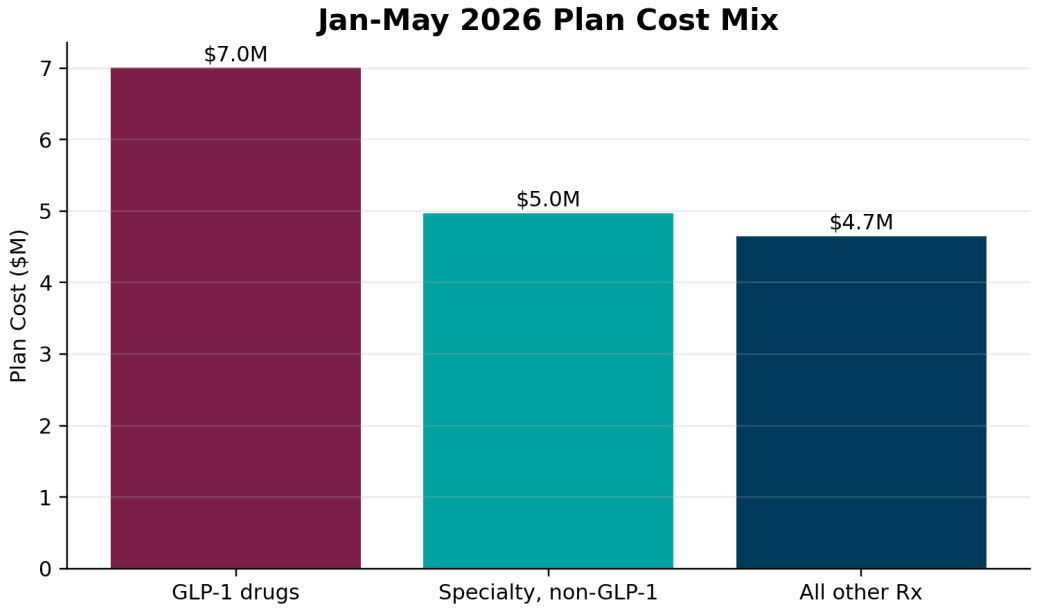
$1.9K

Not PMPM

Member Cost Share

$1.5M

8.2% of allowed



Interpretation: SJVIA's pharmacy spend is highly concentrated in GLP-1s and high-cost specialty therapies. The strategy should focus on governance, clinical criteria, and transparent PBM economics—not broad generic utilization alone.

Program Savings and Rebate Reporting

2025 Metric	Q1	Q2	Q3	Q4	Total
Rebates	$1.756M	$2.175M	$1.825M	$2.468M	$8.225M
Clinical savings	$1.051M	$2.070M	$1.956M	$1.477M	$6.555M

$901.6K
Patient Saver Plus savings
May-Dec 2025

$1.8M
Annual clinical savings guarantee

CarelonRx Q1 2026 Program	Reported Actual Savings
Cost management savings	$1,616,780
Medical specialty utilization management	$91,110
Manufacturer coupon savings program	$157,116
Ensure Rx savings	$76
Total actual product/program savings	$1,865,782

USI Insights:
Reported savings should be validated against claims experience, contract guarantees, and operational performance.

Top Clinical Cost Drivers by Drug - Q1 2026

Rank	Drug	Specialty	Claims	Plan Cost	Unique Utilizers
1	ZEPBOUND		1,379	$1,435,643	592
2	MOUNJARO		800	$963,122	353
3	WEGOVY		649	$860,021	289
4	OZEMPIC		574	$734,755	292
5	TREMFYA	Y	18	$254,406	14
6	DUPIXENT	Y	63	$222,284	34
7	SKYRIZI	Y	9	$184,602	10
8	FABHALTA	Y	3	$141,532	1
9	BIKTARVY	Y	27	$129,225	13
10	KISQALI	Y	10	$120,668	2
11	JARDIANCE		161	$120,664	145
12	NURTEC		78	$99,037	57

Key observation
The top four drugs are all GLP-1 therapies. Zepbound represented more than $1.4M in Q1 plan cost.

Strategy implication
A revamp GLP-1 strategy is highly recommended for 2027. It should include coverage criteria, tier placement, weight management integration, and alternative purchasing scenarios.

Specialty implication
Traditional specialty remains meaningful, but AOM/GLP-1 spend now rivals traditional specialty as a budget driver.

AOM: Anti-obesity medications

USI Claims Lens: Jan-May 2026

What the claims file adds beyond the quarterly report

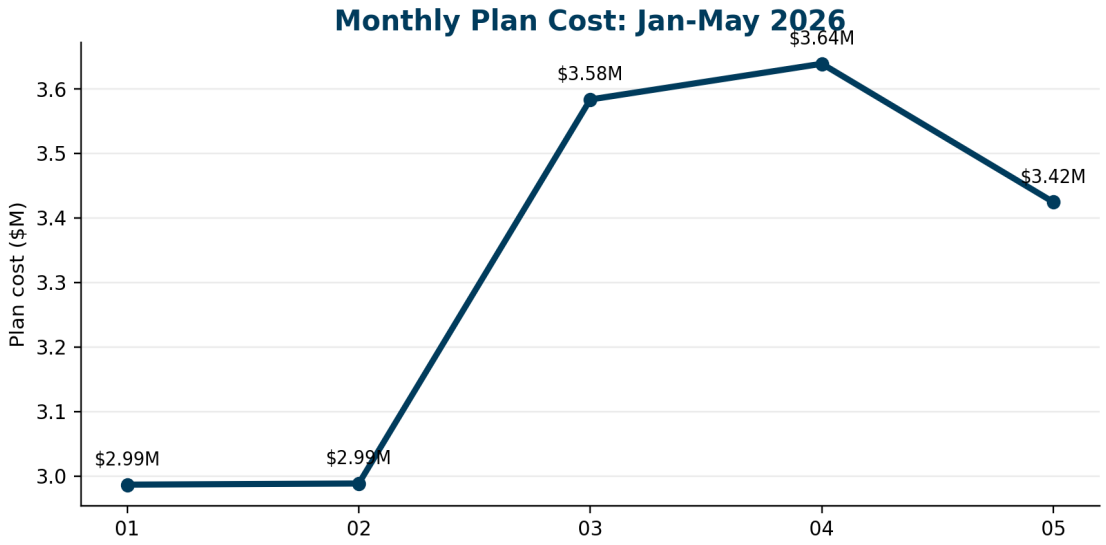
$16.6M
Total plan cost
Jan-May 2026

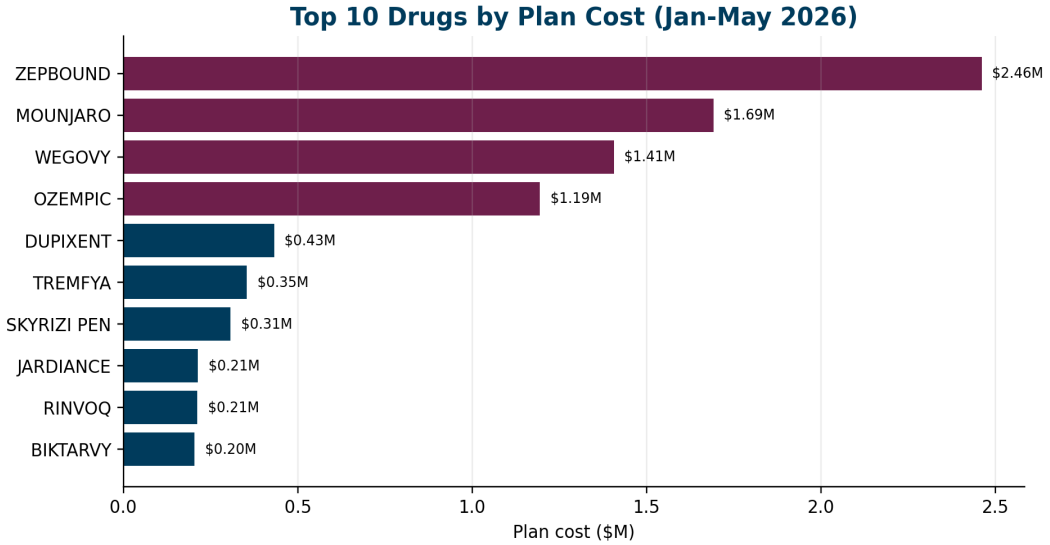
60,596
Paid claims

8,893
Unique utilizers
Encrypted IDs only

$7.0M
42% of ALL pharmacy spend

$5.0M
Specialty plan cost
29.9% of total

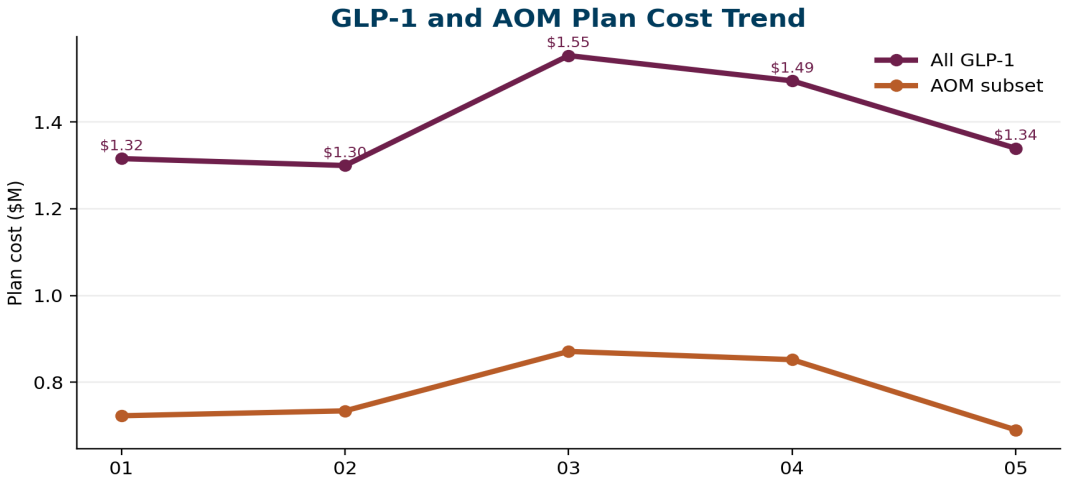


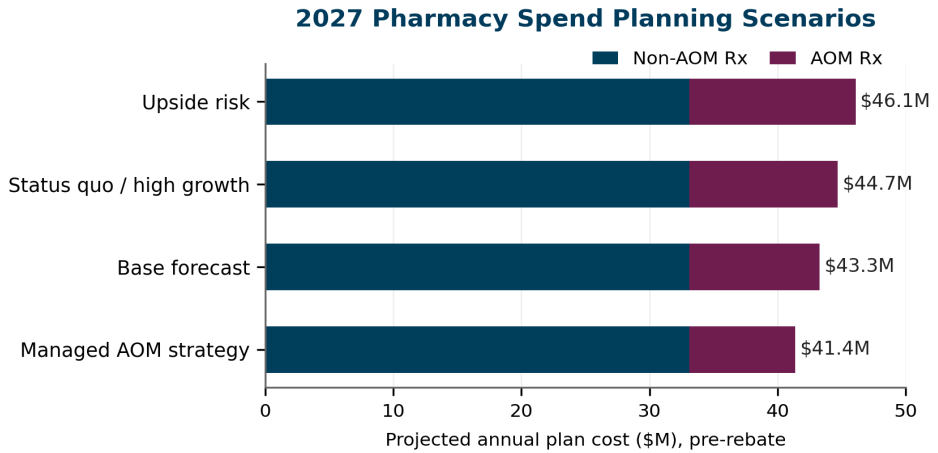


USI Insights:
Spend is not evenly distributed: top drugs and GLP-1 therapies are driving a disproportionate share of gross plan cost. Rebate data was not included, so values are pre-rebate.

GLP-1 / AOM Spend Forecast

Baseline view for 2027 planning, pre-rebate



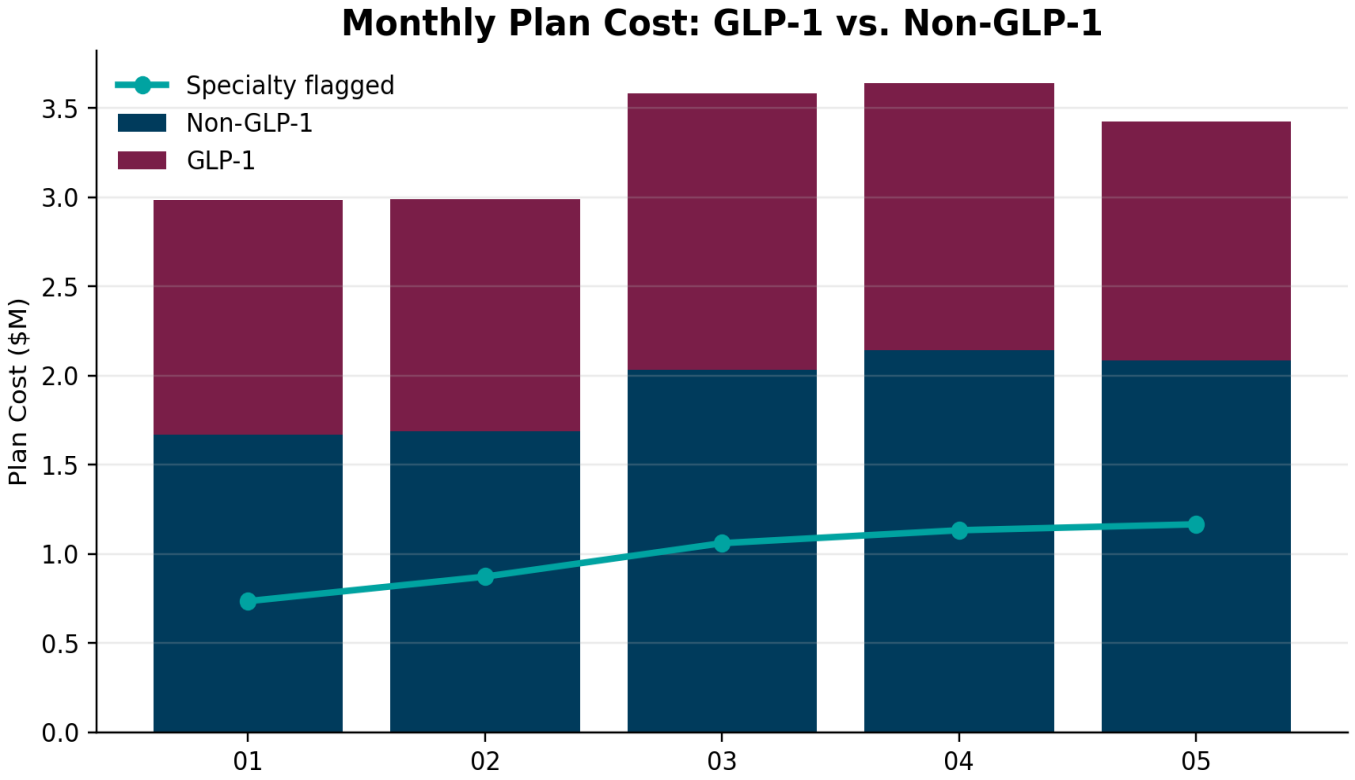


Metric	Jan-May 2026	Annualized Run-Rate
Total Rx plan cost	$16.6M	$39.9M
All GLP-1 plan cost	$7.0M	$16.8M
AOM subset (Wegovy / Zepbound)	$3.9M	$9.3M

Planning point

Based on Jan-May gross claims, AOM drugs are tracking near a $9.3M annual run-rate before rebates and before any 2027 trend. This is why benefit design and purchasing strategy should be modeled before renewal.

Monthly Cost Trend: GLP-1s Remain Consistently Material



Key observations

Monthly plan cost ranged from $3.0M to $3.6M.

GLP-1 cost is not an isolated spike; it is a recurring monthly cost driver.

Specialty flagged spend increased through May, requiring continued monitoring as pipeline therapies expand.

Annualized Total RX PMPM

$235 PMPM

GLP-1 Exposure: The Primary Pharmacy Cost Driver

GLP-1 Cost

$7.00M

42.1% of plan cost

GLP-1 Claims

5,899

1,775 utilizers

Cost / GLP-1 User

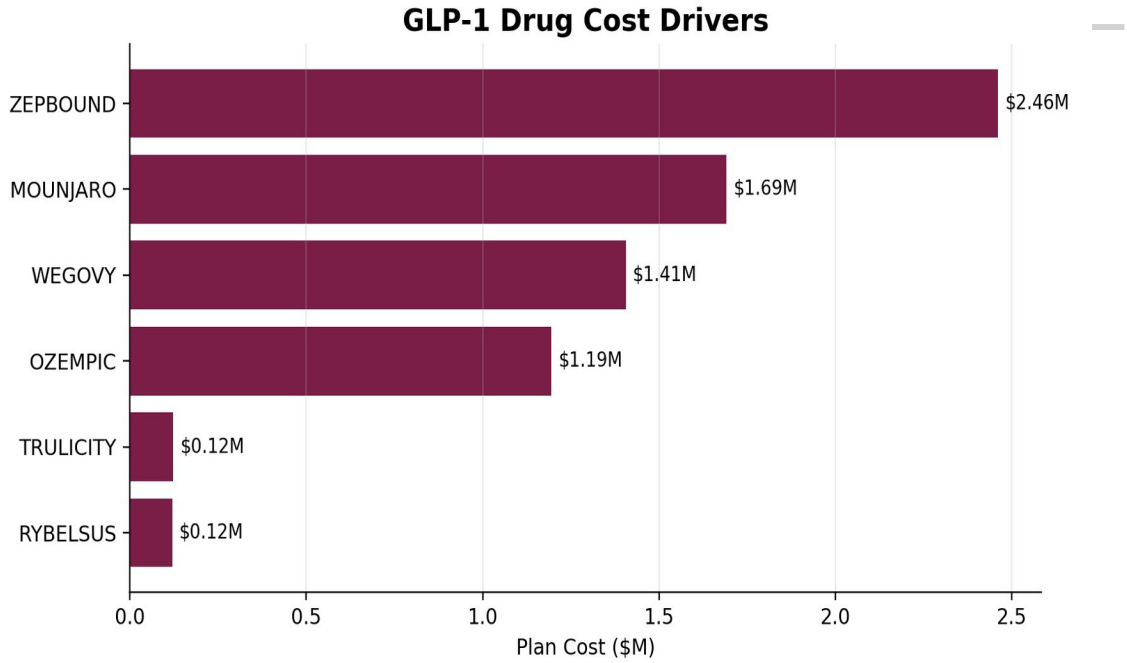
$3.9K

Jan-May

Wegovy + Zepbound

$3.87M

999 members



Implication: GLP-1 strategy should be treated as a separate benefit governance issue. These drugs are not just a pharmacy trend item; they affect renewal strategy, member communications, vendor oversight, and long-term plan affordability.

Rx Benefit Design Strategy: Illustrative Financial Modeling

Financial impact should be modeled before adopting plan design changes

Option	Illustrative Jan-May Plan Cost Shift	Members/Claims Impacted	Client considerations
$250 brand deductible	$739.8K	3,168 members	Broad impact; may increase member disruption
$500 brand deductible	$1.4M	3,168 members	Higher cost shift; evaluate public-sector sensitivity
Specialty 20% coinsurance, $250 cap	$97.7K	686 claims	Modest shift due to existing cost share and cap
Specialty 20% coinsurance, $500 cap	$190.4K	689 claims	Greater exposure for specialty members
AOM 20% coinsurance, $250 cap	$667.9K	3,360 claims	Directly targets high-growth category
AOM 20% coinsurance, $500 cap	$702.4K	3,361 claims	Most targeted but higher member impact

Brand deductible
Will create immediate plan savings, but this will impact many chronic brand users beyond GLP-1s.

Specialty cost share
Useful to model, but specialty affordability and adherence risks need to be managed carefully.

AOM specialty-tier strategy
Targeted to the highest growth category. Best paired with clinical criteria and weight management support.

GLP-1 AOM Benefit Strategy Spectrum

Move from coverage decision to active program design

1. Current state
PBM PA only
Lowest disruption; least financial control

2. Enhanced PA
BMI/comorbidity + continuation criteria
Improves appropriateness; requires monitoring

3. Specialty tier
Treat AOMs like specialty for cost share
Targets cost but creates affordability concerns

4. Weight program
Medication paired with coaching/dietary support
Better outcomes narrative; requires vendor coordination

5. DTC carve-out
Cash/direct pathway through physician group
Can bypass PBM spread/rebate issues; needs compliance review

6. HRA/cash strategy
Special-purpose HRA for eligible cash-pay drugs
Flexible but administratively complex

Recommended direction
Model options 2-6 before renewal. Do not rely solely on the current PA structure given the cost concentration and recent PA configuration issue.

DTC / DTE Concepts for AOM Drugs

Evaluate alternative purchasing paths without moving too quickly

DTC carve-out to physician group

Potential model: carve AOM prescribing, clinical oversight, and direct manufacturer/cash pharmacy purchasing to a physician-led weight management program. This may improve appropriateness and create a separate cash-price strategy.

Guardrails required

Eligibility rules, clinical criteria, continuation requirements, data sharing, privacy, member communications, and coordination with existing PBM coverage must be designed before launch.

Special-purpose HRA / cash-price support

Potential model: provide a defined employer contribution for eligible AOM users to access approved cash-price pathways. This should be reviewed for plan design, tax, ERISA/public-sector, and nondiscrimination considerations.

Decision point

This is a 2027 strategy option, not a Monday decision. The immediate step is to model claims impact and determine whether SJVIA wants insured coverage, cash-pathway support, or a hybrid model.

Market Update: GLP-1 Pricing and Direct Channels

List price changes and cash-pay channels may affect 2027 strategy

Topic	Update	SJVIA implication
Novo Nordisk list price	Novo announced a $675 monthly list price for Wegovy, Ozempic, and Rybelsus effective Jan. 1, 2027.	Lower list price may reduce member cost tied to WAC, but net plan impact depends on rebates, guarantees, and contract terms.
DTC / self-pay pricing	Novo stated the list price change does not affect direct-to-patient self-pay prices.	Cash pathways should be evaluated separately from PBM contracted pricing.
Direct purchasing	GLP-1 direct purchasing concepts and lower cash pricing	Do not assume commercial plan applicability; use as a benchmark and strategy input, not as guaranteed plan savings.
Pipeline pressure	Oral GLP-1s and expanded indications continue to increase utilization potential. Evaluate for step therapy program: Wegovy Pill, Foundayo and Rybelsus with CarelonRx	Benefit design must be forward-looking, not only reactive to current injectables.

USI Insights

Lower list price does not automatically mean lower net cost. SJVIA should request CarelonRx modeling on gross cost, rebates, guarantees, and net plan impact under the 2027 list price environment.

AWP vs. MAC Pricing Philosophy

How to discuss pricing without getting lost in the mechanics

Concept	What it means	Why SJVIA should care
AWP discount	Benchmark discount off published drug price. Common for brand, specialty, and some generics.	A better AWP discount does not necessarily mean lower net cost if mix, rebates, and spread differ.
MAC pricing	Maximum allowable cost methodology primarily used for multi-source generics.	MAC list governance and update frequency determine whether generic pricing is truly competitive.
Effective rate guarantees	Aggregate guarantee measured over a defined population and period.	Guarantees can hide claim-level outliers and are often subject to exclusions and offsets.
Net cost	Plan cost after rebates, credits, spread/margin, member cost share, and fees.	This is the measure that should drive renewal and market check strategy.

Client translation

AWP and MAC are pricing mechanics. SJVIA should manage to net cost, not only discount guarantees.

CarelonRx question

For 2027, show projected gross cost, rebates, admin fees, margin/spread, and net plan cost by channel.

Market check implication

Use the 18-month market check/RFP readiness process to compare net cost, not isolated discounts.

Specialty Drug Management Strategy

Keep specialty oversight separate from GLP-1 strategy

1. Utilization management

Validate prior authorization, step therapy, reauthorization, diagnosis verification, and quantity limits for high-cost specialty therapies.

2. Biosimilar strategy

Focus on Humira, Stelara, and emerging biosimilar opportunities. Request conversion rates, savings, and exceptions from CarelonRx.

3. Site-of-care and medical/Rx coordination

Target infusion and medical specialty drug crossover. Avoid duplicative pharmacy-only view of specialty exposure.

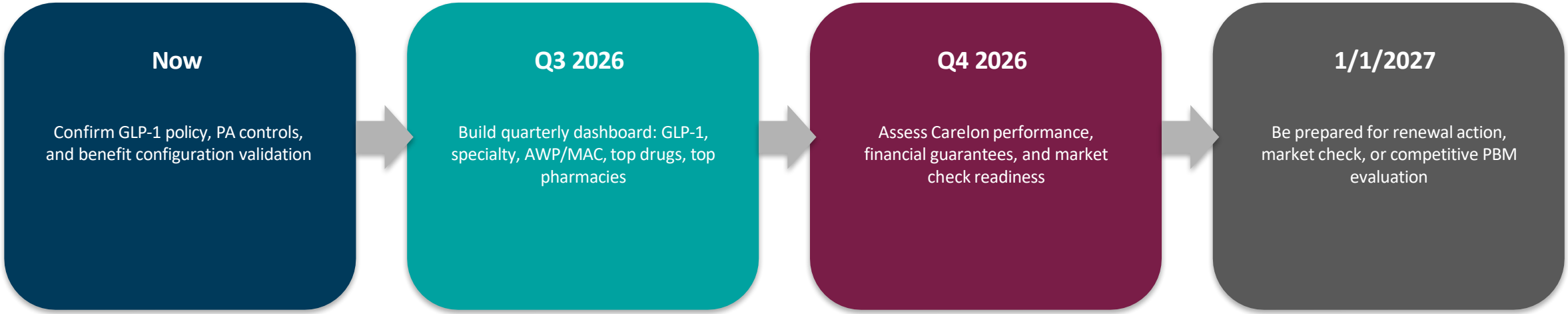
4. High-cost claimant monitoring

Track orphan drugs, oncology, rare disease, and limited-distribution therapies monthly; build a trigger list for claims above defined thresholds.

USI recommendation

Create a quarterly specialty dashboard separating traditional specialty, GLP-1/AOM, diabetes GLP-1, oncology, autoimmune/dermatology, and rare disease therapies.

Recommended Pharmacy Strategy: 2026-2027



Strategic position: SJVIA does not need to decide today whether to change PBMs. However, the program should be managed so SJVIA has leverage, data, and options before committing to the next renewal cycle.

PBM / CarelonRx Questions for Pre-Renewal

Questions that should be answered before final renewal positioning

What is the projected 2027 gross and net cost impact of Novo Nordisk list price reductions?

What is the projected GLP-1/AOM trend by drug, indication, and member cohort?

What PA criteria are currently in place for Wegovy and Zepbound, and how is configuration accuracy validated?

What percentage of specialty drugs are dispensed through CarelonRx specialty versus other pharmacies?

What is the 2027 specialty biosimilar conversion strategy and projected savings?

How will rebate guarantees and exclusions apply under the 2027 GLP-1 price environment?

What margin/spread or non-pass-through economics exist by channel?

What PMA or program credits can be used to fund independent analytics, audit, or GLP-1 management support?

Positioning

These are pre-renewal diligence questions, not accusations. The intent is to create a complete financial and operational view before SJVIA makes 2027 decisions.

Appendix: Concentration and Pharmacy Channel Watchpoints

Top 25 Drugs

$10.5M

63.2% of total

Top 25 Members

$1.8M

11.0% of total

Largest Pharmacy NPI

$3.7M

22.0% of total

Pharmacy	NPI	Plan Cost	Claims	Members
BIOPLUS SPECIALTY PHCY SER LLC	1174517452	$3.65M	689	216
COSTCO PHARMACY	1902916505	$617.89K	1,937	264
CVS PHARMACY	1336181155	$387.26K	1,898	291
CARELONRX PHARMACY INC	1568179489	$333.06K	640	149
CVS PHARMACY	1386688117	$319.04K	1,657	284
BIOLOGICS BY MCKESSON	1578130993	$298.74K	9	2
CVS PHARMACY	1679726236	$286.02K	1,542	268
WALGREENS	1245245570	$250.74K	1,117	190