



NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

MEDICATION ASSISTANCE PROGRAM (MAP) - ADAP

RAMSELL CORPORATION

RAMSELLMAC ADVISORY REPORT
PART 1 – PUBLIC POSTING

FIRST AND SECOND QUARTER, CY 2026
JANUARY 1, 2026 – JUNE 30, 2026

COMMITTEE MEETING: OCTOBER 28, 2026
PRE-MEETING WORKING DRAFT: OCTOBER 20, 2026

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Nevada NMAP | RamsellMAC Advisory Summary

January to June 2026 · Advisory Committee meeting 28 October 2026 · Nevada Division of Public and Behavioral Health

Part I is the public-facing summary of the RamsellMAC advisory report, subject to Nevada’s review and posting requirements. It carries program-level findings and consolidated committee feedback. Part II, the detailed advisory report, is prepared for the sponsor and is not intended for public posting.

21	5	8
ADVISORY SIGNALS	PRIORITY FINDINGS	FORMULARY REQUESTS
7 Action · 5 Monitor · 9 Stable	Agenda discussion topics	Medications for consideration

Action findings

Priority finding	Packet reference	Advisory Signal
New ARV formulary and cost positioning: Idvynso and Bixlenvo	3.2d, 3.2d.1, 3.4b	Action
Coverage gap for chronic hepatitis delta	3.2d, 3.2d.1	Action
Formulary maintenance of retained low and no-utilization ARVs	3.2b, 3.2c, 3.2e	Action
Antiretroviral adherence and refill delay	3.1f, 3.1g, 3.1h	Action
Claim rejects and access friction	3.3e, and the Section 4 deferral note	Monitor

Five Monitor signals and nine Stable signals are reported in full in Part II.

This Part I reflects the reporting-period findings and the written reviewer feedback received before the meeting. The discussion of 28 October 2026 is incorporated into the final report.

Priority clinical findings

The five matters on which committee input was sought, in the order they are taken at the 28 October meeting. Each follows the same sequence: the finding, what it means clinically, the Ramsell Clinical recommendation as issued, the committee perspectives received, and the decision for Nevada.

1. New antiretroviral therapies: Idvynso and Bixlenvo

ACTION

3.2d, New Drug Review, carries Action.

Finding

2	0	9
NEW ARV REGIMENS	IDVYNZO CLAIMS IN PERIOD	REPORTING-PERIOD APPROVALS
Idvynso, April 2026, in period · Bixlenvo, August 2026, post-period	Bixlenvo was approved after the period, so no claims were possible	1 HIV · 1 HDV · 1 other anti-infective · 6 comorbidity

Clinical significance Idvynso is a new two-drug combination regimen approved during the period. It contains doravirine, already covered as Pifeltro and Delstrigo, and islatravir, which is not currently covered, so it is not simply a repositioning of covered agents. Bixlenvo was approved on 27 August 2026, after the period closed, so it is not one of the nine reporting-period approvals. Neither agent recorded any claims.

Ramsell Clinical recommendation Targeted Review. Review Idvynso for formulary consideration alongside the doravirine-containing regimens already covered, and evaluate pricing.

Committee feedback

Perspective	Recommendation
Recommends adding Idvynso	Recommends adding Idvynso to the formulary.
Supports considering the new agents	Supports considering the newly approved agents for formulary inclusion, as a benefit to people living with HIV in Nevada and because most are referenced in current guidelines. Names no individual agent.
Agrees with the signal and follow-up	Agrees with the Advisory Signal and the proposed targeted review.

One perspective recommends adding Idvynso; that is one reviewer's recommendation, not a committee position, and no perspective recorded one on Bixlenvo. The benchmarks shown are wholesale acquisition cost: \$4,455 for Idvynso and \$4,595 for Bixlenvo. No negotiated ADAP price is currently available for Bixlenvo, so no budget impact can be derived from that figure; for Idvynso the position has not been verified.

Supporting context. Biktarvy accounts for 64.61% of program drug spend and the top three cost drivers for 86.81% (3.4b, Action).

Proposed Ramsell Clinical direction
Favor targeted addition of Idvynso for clinically eligible switch patients, subject to clinical criteria and financial review. Eligibility should consider virologic suppression, prior treatment and resistance history, and hepatitis B status: both agents are tenofovir-sparing, so a client receiving hepatitis B-active treatment through a tenofovir-containing regimen would need that coverage maintained on switching. For Bixlenvo, favor advancing it for formulary consideration, with clinical positioning, eligibility criteria and a negotiated ADAP price evaluated before any final coverage recommendation.
For Nevada's consideration
Should Idvynso be added for clinically eligible switch clients, and on what clinical criteria? What pricing information does Nevada require before deciding, and should Bixlenvo be carried to the next cycle once an ADAP price exists?
<i>Evidence: Part II, 3.2d, 3.2d.1 and 3.4b; Section 7.</i>

2. Hepatitis delta coverage gap: Hepcludex

ACTION

3.2d, New Drug Review, carries Action.

Finding

1

FIRST-IN-CLASS THERAPY

Hepcludex, approved May 2026

0

HDV AGENTS COVERED

The formulary carries no hepatitis delta therapy

0

CLAIMS IN PERIOD

Not on the closed formulary

Clinical significance Hepcludex is the first therapy approved in the United States for chronic hepatitis delta virus infection. The formulary covers hepatitis B vaccination and treatment, which are preventive against HDV because the virus requires hepatitis B to replicate, but it carries no agent directed at HDV itself. This is therefore a coverage gap rather than a substitution for something already listed.

Ramsell Clinical recommendation Targeted Review. Determine whether Hepcludex should be added, given that no hepatitis delta therapy is currently covered, and evaluate its pricing alongside the other agents carrying coverage-gap implications.

Committee feedback

No perspective recorded a medication-specific written recommendation on Hepcludex. The general support for considering the newly approved agents, recorded at priority 1, applies to this agent as part of that group; it simply does not name it. This is the one agenda item carrying no agent-specific clinical input, so the 28 October discussion is where that detail is established rather than confirmed. Pricing. The benchmark shown is \$21,733.60 wholesale acquisition cost for a 28-day supply, and the optimal treatment duration has not been established. Whether a negotiated ADAP price exists has not been verified.

Proposed Ramsell Clinical direction

Favor a restricted coverage pathway for clinically eligible patients, since no HDV-directed therapy is currently covered. Defined clinical criteria with specialist oversight are the appropriate form: the product carries a boxed warning for severe acute exacerbations of hepatitis B and hepatitis D after discontinuation, it holds accelerated approval with clinical benefit not yet established, and the labeling states that the optimal treatment duration is unknown. Whether that pathway is formulary inclusion with prior authorization or another mechanism is Nevada's determination. Eligibility criteria, treatment duration and acquisition cost require evaluation.

For Nevada's consideration

Does the absence of any HDV-directed therapy on the formulary warrant formulary review?
What clinical criteria would define eligibility, given that the optimal treatment duration has not been established, and what cost information does Nevada require?

Evidence: Part II, 3.2d and 3.2d.1.

3. Low- and non-utilized antiretrovirals

ACTION

3.2b and 3.2c carry Action. 3.2e, Formulary Changes, carries Monitor.

Finding

8

LOW-UTILIZATION ARVs

2 at a single prescription; 6 more at 2 to 5

31

ZERO-UTILIZATION ARVs

against 38 antiretrovirals utilized

16

DRUG ENTRIES WITH NDC REMOVALS

29 NDCs, all at zero utilization

Clinical significance Low or zero utilization does not by itself establish that an agent should be removed. A closed ADAP formulary retains older agents so salvage, resistance, intolerance and continuity cases can be filled without exception handling, and three of the zero-utilization listings are pediatric formulations not expected to show adult use. The Action designation reflects the threshold test, not restricted access.

Ramsell Clinical recommendation Targeted Review. Confirm whether the eight low-volume antiretrovirals should be retained or flagged for review, and for the non-utilized agents confirm the clinical rationale for retention and whether each remains recommended under current guidance.

Committee feedback

Perspective	Recommendation
Favors removal with salvage protection	Remove older antiretrovirals that are no longer guideline-recommended, while retaining appropriate agents for clients on salvage regimens.
Favors removal of named agents	Remove atazanavir and efavirenz from the low-utilization group. For the non-utilized agents, remove all except twelve named agents, because the program has current clients on salvage antiretrovirals.
Favors continued monitoring	Continue monitoring rather than remove. Flag for future review under continued monitoring of discontinuations; older agents may remain listed until no longer marketed.

Reviewers recognize the importance of preserving appropriate salvage options, and differ on removal versus continued monitoring. Two perspectives independently identify ritonavir (Norvir) and tenofovir/emtricitabine (Truvada) for retention.

Two points need clarification. One perspective agreed to removing efavirenz while its exception list retains Sustiva, the brand name for efavirenz. The same list names Yeztugo, lenacapavir approved for pre-exposure prophylaxis, where the salvage use intended would point to Sunlenca.

Ramsell Clinical separately proposes a restriction on new starts for older therapies where clients are stable and virologically suppressed: continued supply, no new initiations. This is Ramsell Clinical's proposal, not a committee recommendation.

Proposed Ramsell Clinical direction

Review the older agents for current clinical relevance while preserving salvage and continuity-of-care options. Removal should follow a clinical judgment on each agent rather than zero utilization alone. Ramsell Clinical's no-new-starts proposal is available where it is justified and remains separate from the committee's recommendations.

For Nevada's consideration

Should the non-utilized antiretrovirals no longer guideline-recommended be removed, with a defined salvage exception, or retained under continued monitoring? If removal proceeds, which agents are excepted?

Does Nevada wish to adopt the Ramsell Clinical no-new-starts restriction, and if so for which agents?

Evidence: Part II, 3.2b, 3.2c and 3.2e.

4. Adherence and refill delay

ACTION

3.1f, 3.1g and 3.1h all carry Action.

Finding

87.42%

AVERAGE ARV ADHERENCE

Against the 90% benchmark, down 1.77 points

5.71

AVERAGE DAYS LATE

Up from 3.69, an increase of 2.02 days

2

GROUPS BELOW BENCHMARK

Insured 87.53% · Uninsured 85.49%

Committee feedback

Perspective	Recommendation
Favors monitoring over targeted review	Alternate interpretation: monitor rather than conduct a targeted review. A review of a measure as complex as adherence is resource-intensive, and some decline may be expected given the near doubling of the measured population. Proposed alternate follow-up: monitor whether the trend persists or stabilizes as sample size changes.
Supports investigating refill delay	Supports investigating the increase in time to pick up medication, noting that a prolonged delay carries a public-health dimension as well as an individual one, because loss of viral suppression can affect transmission risk.
Agrees; suggests examining coverage type	Agrees as presented. Because a single agent was substantially affected, investigation should be straightforward. Also recommends examining the impact of coverage type.

Proposed Ramsell Clinical direction

Favor targeted review.

For Nevada's consideration

Should Ramsell Clinical proceed with a targeted review, or continue monitoring the trend into the next reporting period?

Evidence: Part II, 3.1f, 3.1g and 3.1h.

5. Sponsor-submitted formulary requests

Three requests covering eight medications were received during the reporting period. None is currently on the closed formulary and none recorded a paid claim. Reject counts below are claim-reject events, not client counts.

Medication	Therapeutic area	Current status and demand signal	Benchmark
Tamsulosin	Benign prostatic hyperplasia	Not on formulary; no alpha-blocker covered. No claims. 129 claim rejects, 87 under Product/Service Not Covered — the highest of the requested agents	\$1.49 NADAC
Finasteride	Benign prostatic hyperplasia	Not on formulary; no 5-alpha-reductase inhibitor covered. No claims. 52 claim rejects, 41 under Product/Service Not Covered — the second highest	\$2.05 NADAC
Mirabegron	Overactive bladder	Not on formulary; no beta-3 agonist covered. No claims. 5 claim rejects, 3 under Product/Service Not Covered	\$288.81 NADAC
Solifenacin	Overactive bladder	Not on formulary; no urinary antimuscarinic covered. No claims. 2 claim rejects, 1 under Product/Service Not Covered	\$4.80 NADAC
Donepezil	Cognitive impairment	Not on formulary; no cholinesterase inhibitor covered. No claims. 2 claim rejects, 1 under Product/Service Not Covered	\$1.43 NADAC
Memantine	Cognitive impairment	Not on formulary; no NMDA receptor antagonist covered. No claims and no claim rejects	\$3.84 NADAC
Pylera	H. pylori eradication	Not on formulary; none of its three components covered. No claims for the product or its components, and no related rejects	\$291.40 NADAC
Idvynso	HIV, complete oral regimen	Not on formulary; doravirine component covered, islatravir not covered. No claims. Doravirine-containing products recorded 115 prescriptions. Also at priority 1	\$4,455 WAC

Evidence: Part II, Section 7.

Committee feedback. Two perspectives expressed support for formulary expansion, expressed differently. One explicitly recommended adding all eight requested medications. A second supported considering the requested agents for inclusion, citing the growing need to manage age-related comorbidities among people living with HIV, including cardiovascular, cognitive and urologic conditions, and noting that more than half of people living with HIV in the United States are over 50. That second perspective named no individual medication. The third recorded no response to these requests, and an absence of comment is not recorded as agreement. Neither response is a committee position; the 28 October discussion is where a collective position would be established.

The second perspective also referenced erectile dysfunction. None of the eight requested medications addresses that indication, so the reference is recorded as broader clinical context rather than as a request.

The benchmarks shown are NADAC for seven medications and wholesale acquisition cost for Idvynso. These are different pricing bases and are not directly comparable: NADAC reflects a survey of average acquisition cost, while wholesale acquisition cost is a list price. Neither is an ADAP acquisition price. Pricing review is outstanding for all eight.

Proposed Ramsell Clinical directions

Developed after reviewing the committee's written feedback. These are not recommendations contained in the 1 October packet and they are not committee decisions. Coverage criteria and affordability would be assessed before any addition.

Medication	Proposed direction	Supporting rationale
Tamsulosin	Favor addition	Strongest demand signal of the eight: 129 claim rejects, 87 under Product/Service Not Covered. Provides a BPH option where no alpha-blocker is covered.
Finasteride	Favor addition	Second-highest demand signal: 52 claim rejects, 41 under Product/Service Not Covered. Complements alpha-blocker therapy for appropriate BPH patients.
Mirabegron	Favor conditional addition	For overactive bladder where anticholinergic therapy is inappropriate, poorly tolerated or presents significant cognitive risk, which matters in an aging population. Establish clinical criteria covering blood pressure, relevant contraindications, prior therapy and cost, against an acquisition-cost benchmark well above the anticholinergic alternatives.

Medication	Proposed direction	Supporting rationale
Solifenacin	Consider addition as an alternative	Lower-cost overactive-bladder option, but anticholinergic adverse effects and cognitive risk warrant patient-selection criteria.
Donepezil	Favor targeted addition	Addresses a formulary gap for appropriately diagnosed Alzheimer disease, rather than cognitive impairment generally.
Memantine	Consider targeted addition	As part of an Alzheimer disease treatment pathway, particularly moderate-to-severe disease or appropriate use alongside a cholinesterase inhibitor, with coverage requiring an established diagnosis. The clinical rationale is sound; what is absent is program-specific demand, with no claims and no rejects recorded.
Pylera	Favor access to a guideline-recommended regimen	The aim is access to an effective H. pylori eradication regimen rather than to this brand. Evaluate whether Pylera or coverage of the individual components is the more clinically suitable and cost-effective route, noting that its labeled course is 10 days with a proton pump inhibitor and its indication is tied to duodenal ulcer disease, while guideline-preferred bismuth quadruple therapy is commonly 14 days.
Idvynso	Favor targeted addition with eligibility criteria	New HIV switch regimen; one perspective explicitly recommends addition. Eligibility should consider virologic suppression, prior treatment and resistance history, and hepatitis B status, since the regimen is tenofovir-sparing. Acquisition cost should inform coverage criteria. The same agent appears at priority 1 and carries one consolidated decision, not two.
For Nevada's consideration		
Which of the eight medications does Nevada wish to add, not add, or defer pending further clinical or pricing information, and under what coverage conditions?		

Sponsor Decision Summary

One row per decision, in the order the matters are taken at the 28 October meeting. This page consolidates what the committee has advised and what remains for Nevada to decide. It does not record a decision.

#	Finding	Signal	Proposed Ramsell Clinical direction	Committee feedback	For Nevada's consideration
1	New antiretroviral therapies: Idvynso and Bixlenvo	Action	Favor targeted addition of Idvynso for eligible switch patients, with eligibility covering suppression, resistance history and hepatitis B status; advance Bixlenvo for consideration pending pricing	Add Idvynso — one perspective. General support for considering the new approvals. No recommendation on Bixlenvo.	Position each agent for eligible switch clients; confirm what pricing information is required first.
2	Hepatitis delta coverage gap: Hepcludex	Action	Favor a restricted coverage pathway with clinical criteria and specialist oversight; the mechanism is Nevada's determination	No medication-specific recommendation. General support for considering the new approvals applies as part of that group.	Decide whether the coverage gap warrants formulary review, and on what criteria.
3	Low- and non-utilized antiretrovirals	Action	Review older agents for clinical relevance while preserving salvage and continuity options	Three different recommendations: remove with salvage protection; remove named agents with an exception list; continue monitoring.	Remove with a defined salvage exception, or retain under monitoring. If removal, which agents are excepted.
4	Adherence and refill delay	Action	Favor targeted investigation of groups below benchmark	Perspectives differ on targeted review versus monitoring, not on whether the criteria were met.	Direct a targeted review, or continue monitoring into the next reporting period.
5	Sponsor-submitted formulary requests, eight medications	—	Consider expansion for age-related comorbidities; tamsulosin and finasteride show the clearest demand; mirabegron, memantine and an H. pylori regimen carry conditions; pricing review outstanding for all eight	Two perspectives support formulary expansion: one recommends adding all eight, one supports consideration citing age-related comorbidity needs without naming an agent. One did not respond. Not a committee position.	Confirm for each medication: add, do not add, or defer pending further information.

RamsellMAC is advisory. The committee provides clinical expertise and recommendations. Final formulary and program decisions remain with the Nevada ADAP sponsor.