National Medicaid Fee-For-Service (FFS) FFY 2020 Drug Utilization Review (DUR) Annual Report

Executive Summary
National Medicaid Drug Utilization Review (DUR)
Federal Fiscal Year (FFY) 2020
Fee-For-Service (FFS) Annual Report

(FFY 2020 Data: October 2019-September 2020)

Consistent with Section 1927(g)(3)(D) of the Social Security Act (the Act), the Centers for Medicare and Medicaid Services (CMS) requires each State Medicaid Program to submit to CMS an annual survey on the operation of its Medicaid Drug Utilization Review (DUR) fee-for-service (FFS) program. States are required to report on the nature and scope of the prospective and retrospective DUR programs, including a summary of the interventions used in retrospective DUR, an assessment of the education programs deployed, a description of DUR Board activities, as well as an overall assessment of the DUR program's impact on quality of care, and cost savings generated from their DUR programs.[1]

Prospective DUR (ProDUR) is one component of the DUR process, and requires the electronic monitoring of prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, and clinical misuse or abuse prior to dispensing of the prescription to the patient. Retrospective DUR (RetroDUR) involves an ongoing periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, medically unnecessary care and implementation of corrective action(s) when applicable after a prescription has been dispensed.

A high-level comparison of states' DUR FFS survey responses can be found in this report summary. Detailed individual state responses including this national summary can also be found on Medicaid.gov.

I. Demographic Information

Forty-nine states and the District of Columbia have submitted a Medicaid DUR Annual Survey encompassing FFY 2020 reported responses.[2] The information in this report is focused on national Medicaid FFS DUR activities.

- FFY 2020 reported responses include 21,244,679 beneficiaries (28%) enrolled in national FFS Medicaid programs and 53,786,492 beneficiaries (72%) enrolled in national Medicaid Managed Care programs. This represents a 2% decrease in beneficiary enrollment in the national FFS Medicaid program.

II. Prospective DUR (ProDUR)

ProDUR functions are performed at the point-of-sale (POS) when the prescription is being processed at the pharmacy. FFY 2020 reported responses show 47 states (94%) continue to contract with an outside vendor to process their POS claims, and that 3 states (6%) process their own claims, consistent with FFY 2019. Additionally:

- FFY 2020 reported responses confirm all states set early prescription refill thresholds as a way of preventing prescriptions from being over utilized:
    - Non-controlled substances: State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 81% of the prescription

[1] All data presented within these reports originate from state responses to the FFY 2020 DUR FFS Survey.

[2] The Annual DUR survey was not submitted by Arizona (AZ) because of the state's existing waiver of these DUR requirements included in their approved 1115 Demonstration are valid until September 2021.

being used, before a prescription could be refilled, a 1% increase from FFY 2019.
    - Controlled substances (CIII to CV): State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 86% of
    - Controlled substances (CII): State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 86% of the prescription being used, before a subsequent prescription could be dispensed, a 1% increase from FFY 2019 prescription being used, before a new prescription can be filled, consistent with FFY 2019.
- In FFY 2020 reported responses, 26 states (52%) utilize a system-accumulation edit as part of their ProDUR edits for preventing early prescription refills, a 12% increase from FFY 2019. Of the 24 states not having an accumulation edit, 10 states (42%) plan to implement this edit in the future.

III. Retrospective DUR (RetroDUR)

The RetroDUR process allows states to use evidence-based literature, clinical data, and existing guidelines, to evaluate patients' prescription data to identify patterns of clinical concerns. These functions reside primarily with a state vendor in 35 states (70%) and with an academic institution in 11 states (22%), consistent with FFY 2019. The remainder of the states utilize a combination of resources. Additionally, 49 states (98%) customize their RetroDUR vendor criteria based on state specific requirements.

IV. DUR Board Activity

Each state establishes a DUR board responsible for application, review, evaluation, and re-evaluation of DUR standards, reviews and interventions on an ongoing basis. DUR boards are comprised of physicians, pharmacists and members of the public. These boards, on an average, meet quarterly and are open to the public. All states provided a summary of their DUR Board activities. Based on FFY 2020 reported responses, 10 states (20%) reported utilization of a Medication Therapy Management (MTM) program, a professional service provided by pharmacists, a 30% increase from FFY 2019.

V. Physician Administered Drugs

Physician-administered drugs are drugs, other than vaccines, that are covered outpatient drugs under section 1927(k)(2) of the Social Security Act, and are typically administered by a medical professional in a physician's office or other outpatient clinical setting. According to FFY 2020 reported responses, 15 states (30%) have incorporated physician administered drugs into DUR criteria for ProDUR reviews, consistent from FFY 2019, and 10 states (29%) plan to incorporate these drugs in the future. Additionally, 22 states (44%) have incorporated physician administered drugs into their DUR criteria for RetroDUR reviews, a 14% increase from FFY 2019, while 7 states (25%) plan to incorporate these drugs in their RetroDUR reviews in the future.

VI. Generic Policy and Utilization Data

In an ongoing effort to reduce spending on prescription drugs, states continue to encourage the use of lower-cost generic drugs. The FFY 2020 national percent average for generic utilization rate was 85%, a 3% increase from FFY 2019. FFY 2020 reported responses confirm that many states base decisions of "brand-versus-generic" product preferred status on the net cost of the drug to the state, taking into consideration federal and supplemental rebate

dollars on brand and generics.

An additional question in this year's DUR survey was added and intended to inquire how states are incorporating "Biosimilar" FDA approved products in their program. A Biosimilar product is a biologic medical product that is almost an identical copy of an original product that is manufactured by a different company. Biosimilars are officially approved versions of original "innovator" products and can be manufactured when the original product's patent expires. State policies related to Biosimilars are included in this report.

VII. Program Evaluation / Cost Savings / Cost Avoidance

All states reported their ProDUR, RetroDUR and other program cost savings/cost avoidance in addition to their estimated percent impact. State cost savings/cost avoidance methodology can be found in this report. Other state responses for FFY 2020 can be accessed under *State FFS Individual Reports* on Medicaid.gov.

VIII. Fraud, Waste and Abuse Detection

A. Lock-In or Patient Review and Restriction Programs

Lock-In or Patient Review and Restriction Programs restrict beneficiaries whose utilization of medical services is documented as being potentially unsafe, excessive or could benefit from increased coordination of care. In some instances, beneficiaries are restricted to specific provider(s) to monitor services being utilized and reduce unnecessary or inappropriate utilization. According to FFY 2020 state responses, 46 states (92%) have a Lock-In program for beneficiaries, consistent with FFY 2019. Additionally, 27 states (59%) restrict beneficiaries to a specific prescriber and 39 states (85%) restrict beneficiaries to a specific pharmacy.

FFY 2020 reported responses show an increase in the number of states with a process to identify possible fraudulent practices of health care providers. For example, 47 states (94%) have processes in place to identify potential fraudulent practices by prescribers, a 2% increase from FFY 2019 and 46 states (92%) have processes in place to identify potential fraudulent practices by pharmacies, a 2% increase from FFY 2019.

These reviews trigger actions such as denying claims written by that prescriber, denying claims submitted by that pharmacy, alerting the state integrity or compliance unit, and/or making referrals to the appropriate licensing board.

B. Prescription Drug Monitoring Program (PDMP)

PDMPs are statewide electronic databases that collect designated data on controlled substances that are prescribed and dispensed in the state. Depending on the state, prescribers and pharmacists have access to these databases to identify patients that are engaging in potential fraud or misuse of controlled substances. FFY 2020 state responses confirm 49 states (98%) have a PDMP, consistent with FFY 2019. It should be noted that according to survey responses, the state of Missouri has a partial PDMP program. Additionally, state responses indicate:

- 18 states (36%) have the ability to query their states' PDMP database directly as opposed to 8 states (16%) that receive PDMP data from their state upon request.

  - 17 (65%) of these 26 states that have the ability to directly query or receive PDMP data from their state, also have access to border state PDMP information. In contrast, 24 states (48%) are unable to access their states' PDMP data in any form.
- 38 states (76%) require that prescribers access the patient history in the PDMP database prior to prescribing controlled substances, a 45% increase from FFY 2019. Additionally, only 17 states (34%) require pharmacists to check the PDMP prior to dispensing, a new FFY 2020 survey question this year.
- 42 states (84%) responded that they face a range of barriers that hinder their ability to fully access and utilize the PDMP database to curb abuse, a 10% increase from FFY 2019.

C. Opioids

States have POS safety edits in place to limit the quantity dispensed of an initial opioid prescription. Based on FFY 2020 reported responses, 35 states (70%) apply this POS edit to all opioid prescriptions, a 14% increase from FFY 2019 and 15 states (30%) apply this edit to some opioids. The median days' supply for an initial opioid prescription for an opioid naïve patient based on FFY 2020 reported responses is 7 days which includes a national range of 5 to 100 days', an additional survey question this year. These limitations and restrictions include both short-acting and long-acting opioid formulations depending on state specific criteria. Clinical criteria, such as step therapy, may assist in avoiding the prescribing of more high potency addictive therapies. Other approaches to controlling and managing the amount of opioids dispensed include: prescriber intervention letters, morphine milligram equivalent (MME) daily dose programs and pharmacist overrides. Requirements for obtaining high dose or large quantities of opioids may include documentation of urine drug screening results, pain management contracts or patient-provider agreements. Additionally:

- 47 states (94%) have prospective edits in place to monitor duplicate therapy of opioid prescriptions, a 1% increase from FFY 2019.
- 32 states (64%) have an automated retrospective claims review process to monitor opioid prescriptions exceeding state limitations, a 19% increase from FFY 2019.
- 49 states (98%) have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently, a 12% increase from FFY 2019.
- 34 states (68%) have prospective edits or a retrospective claims review process to monitor opioids and sedatives being used concurrently, a 6% increase from FFY 2019.
- 46 states (92%) have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently, a 11% increase from FFY 2019.
- 33 states (66%) utilize abuse deterrent opioids to prevent misuse and abuse, a 3% increase from FFY 2019.
- 42 states (84%) develop and/or provide prescribers with pain management or opioid prescribing guidelines, a 12% increase from FFY 2019.

D. Morphine Milligram Equivalent (MME) Daily Dose

MME is the amount of morphine, in milligrams, equivalent to the strength of the opioid

dose prescribed. Using an MME approach allows comparison between the strength of different types of opioids. A total of 48 states (96%) limit maximum MME daily doses to reduce potential patient harm, abuse and/or diversion, a 10% increase from FFY 2019. The median MME daily dose for FFY 2020 reported responses is 90mg/day which includes a national range of 30 to 500mg/day, each state having their specific methodology used for MME calculation. FFY 2020 reported responses confirm that 36 states (72%) provide information to their prescribers on how to calculate an MME or provide a calculator to determine a patient specific MME daily dose, a 3% increase from FFY 2019. Additionally:

- 45 states (90%) have an edit in their POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded, a 13% increase from FFY 2019.
- 30 states (60%) have an automated retrospective claims review process to monitor the total daily dose of MMEs for opioid prescriptions dispensed, a 33% increase from FFY 2019.

E. Opioid Use Disorder (OUD) Treatment

Naltrexone, methadone, buprenorphine and buprenorphine/naloxone combination drugs, in conjunction with behavioral health counselling, are used to treat OUD. Based on FFY 2020 reported responses, 43 states (86%) set total milligrams per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs, a 2% increase from FFY 2019. Accordingly, 5 states (10%) also set limitations on allowable length of treatment for a beneficiary receiving buprenorphine and buprenorphine/naloxone combination drugs while 45 states (90%) have no limits assessed, a 13% increase from FFY 2019. FFY 2020 reported responses confirm 43 states (86%) provide at least one buprenorphine and buprenorphine/naloxone combination drug without a prior authorization requirement while 7 states (14%) require prior authorization for these products, a 13% decrease from FFY 2019. Additionally, 38 states (76%) have system edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of medication-assisted treatment (MAT), a 5% increase from FFY 2019.

Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist and can reverse and block the effects of opioids. Naloxone is available without prior authorization in all states. Additionally, all states allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols.

F. Outpatient Treatment Programs (OTP)

According to FFY 2020 reported responses, methadone is a drug that is indicated for both chronic pain and/or as part of an Opioid Treatment Program (OTP) (formerly referred to as a methadone treatment center). Due to methadone's potential opioid-related harms, CMS, in conjunction with the CDC recommends that states remove methadone for pain (outside of end of life care) from their preferred drug lists and not be considered a drug of first choice by prescribers for chronic non-cancer pain. However, the FDA has approved methadone as one of three drugs for treatment of OUD within an OTP. Based on FFY 2020 reported responses, 46 states (92%) provide coverage for methadone for OUD through an OTP, a 7% increase from FFY 2019 as 4 states (8%) provide no methadone coverage for OUD.

G. Antipsychotics / Stimulants

Antipsychotic Medication

According to FFY 2020 reported responses, all states have a program in place for managing or monitoring appropriate use of antipsychotic drugs in children. Additionally, all states manage or monitor antipsychotic medication for all children in foster care.

Stimulant Medication

According to FFY 2020 reported responses, 44 states (88%) have a program in place for managing or monitoring appropriate use of stimulant drugs in children, a 5% increase from FFY 2019. Additionally, 100% of these 44 states manage or monitor stimulant medication for all children in foster care.

IX. Innovative Practices

A new survey question in FFY 2020 polled states to determine if any states participate in demonstrations or have waivers to allow for importation, from Canada or other countries, of certain drugs that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries. Reported responses show only 1 state currently participating in a demonstration or having a waiver to allow for drug importation.

Sharing of new ideas and best practices is an invaluable resource to all states. FFY 2020 reported responses include 45 state (90%) submissions for DUR innovative practices. Currently submitted state innovative practices can be found in this report. Previously submitted innovative practices from FFY 2014 to FFY 2020 can be accessed on Medicaid.gov.

X. Managed Care Organizations (MCOs)

All MCOs have submitted the FFY 2020 DUR annual survey. Based on FFY 2020 reported responses, 39 states (78%) have active MCOs encompassing 259 programs. Furthermore, 4 of the 39 states (10%) (MO, TN, WI, and WV) carve out their drug benefit and submitted an abbreviated MCO survey for each of their programs. National MCO, State MCO and Abbreviated MCO reports can be accessed on Medicaid.gov.

XI. Executive Summary

Forty-nine states and the District of Columbia have submitted Executive Summaries and can be accessed at the end of this report.

Table of Contents

PLEASE NOTE: This is a standalone report posted on Medicaid.gov.

Detailed summaries, "other" explanations, and narratives, pertaining to responses in this report can be found on Medicaid.gov in the State FFS Individual Report table.

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List of Tables

National
Medicaid Fee-For-Service (FFS)
FFY 2020 DUR Annual Report

Section I - Enrollees

1. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?

Figure 1 - Number of Beneficiaries Enrolled in FFS with a Pharmacy Benefit

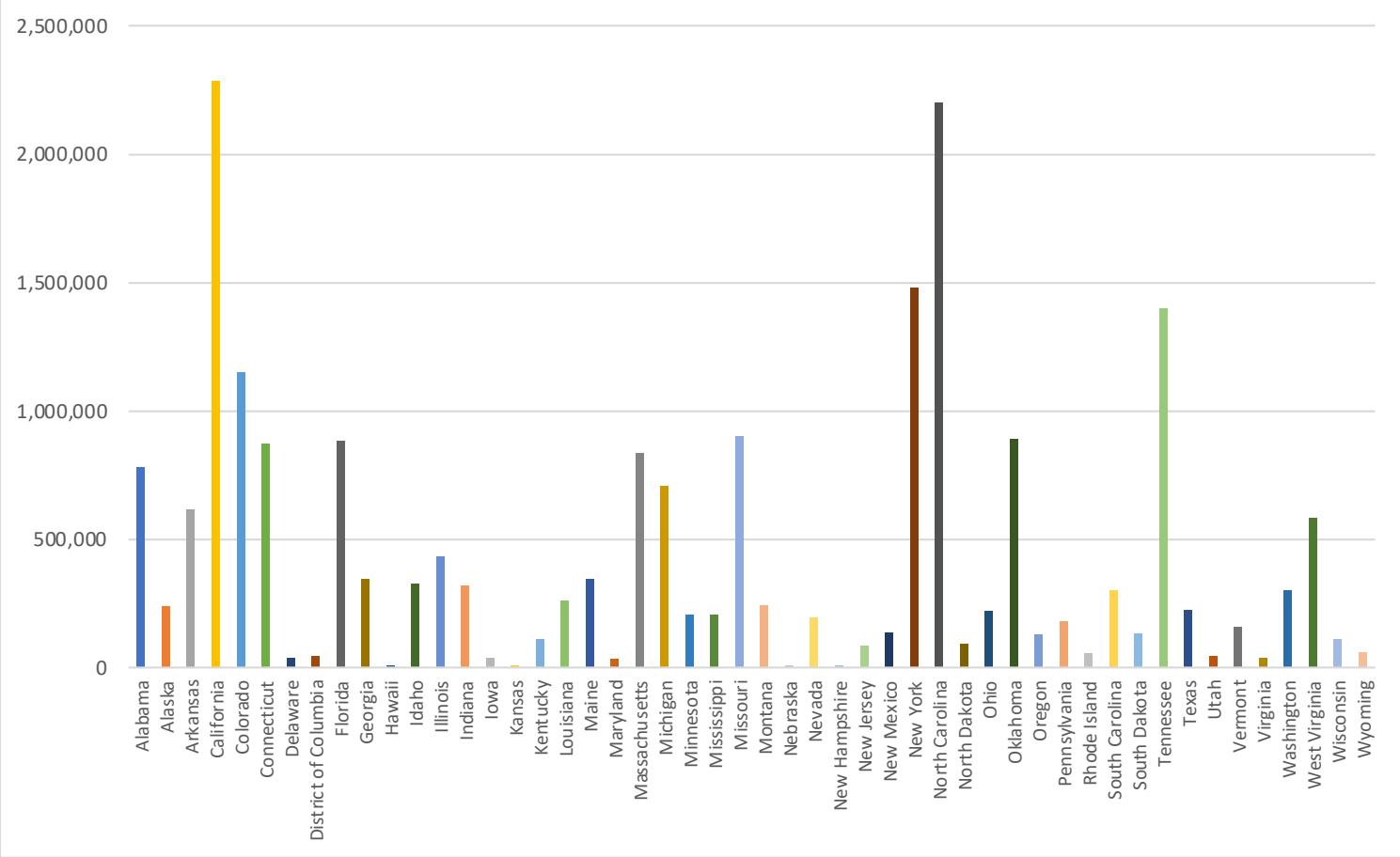

Table 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Alabama	778,876
Alaska	240,000
Arkansas	614,258
California	2,285,589
Colorado	1,149,623

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Connecticut	871,582
Delaware	35,916
District of Columbia	46,000
Florida	883,878
Georgia	345,368
Hawaii	50
Idaho	325,000
Illinois	432,605
Indiana	320,632
Iowa	38,979
Kansas	1,424
Kentucky	110,700
Louisiana	261,631
Maine	345,023
Maryland	34,460
Massachusetts	836,839
Michigan	708,533
Minnesota	205,263
Mississippi	205,185
Missouri	899,837
Montana	241,662
Nebraska	2,500
Nevada	195,856
New Hampshire	2,008
New Jersey	85,180
New Mexico	136,602
New York	1,478,000
North Carolina	2,199,408
North Dakota	91,308
Ohio	222,240
Oklahoma	889,437
Oregon	130,180
Pennsylvania	180,000
Rhode Island	57,440
South Carolina	300,000
South Dakota	132,000
Tennessee	1,400,000
Texas	224,944
Utah	46,661
Vermont	158,274

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Virginia	37,263
Washington	301,671
West Virginia	582,981
Wisconsin	111,846
Wyoming	59,967
Total	21,244,679

2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?

Figure 2 - Medicaid Beneficiaries Enrolled in MCOs by State

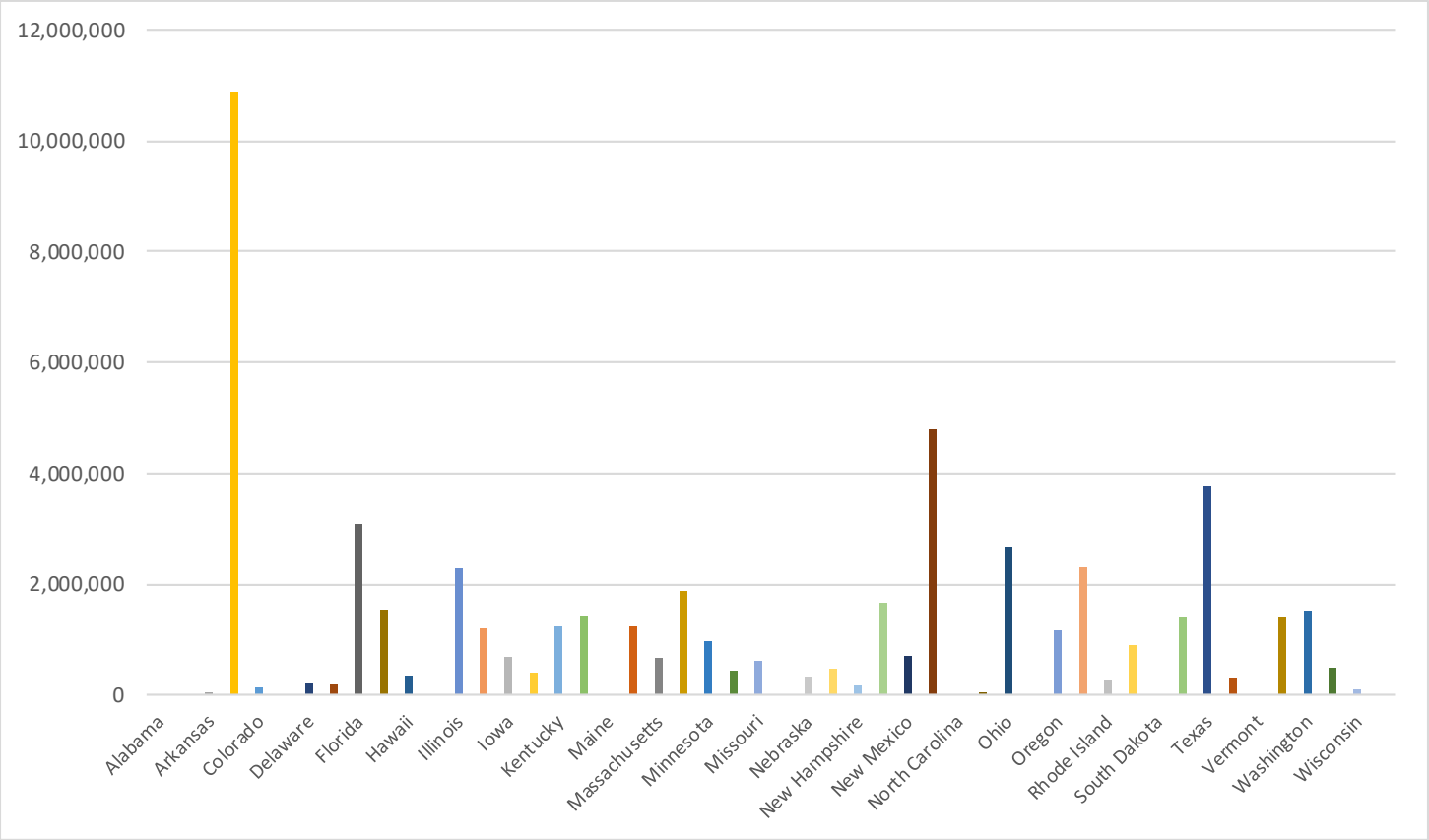

Table 2 - Medicaid Beneficiaries Enrolled in MCOs by State

State	Number of Beneficiaries Enrolled in MCO Plans
Alabama	0
Alaska	0
Arkansas	42,766
California	10,883,898

State	Number of Beneficiaries Enrolled in MCO Plans
Colorado	128,888
Connecticut	0
Delaware	204,266
District of Columbia	190,000
Florida	3,084,941
Georgia	1,535,917
Hawaii	340,000
Idaho	0
Illinois	2,282,828
Indiana	1,199,966
Iowa	679,048
Kansas	398,281
Kentucky	1,240,800
Louisiana	1,418,535
Maine	0
Maryland	1,232,929
Massachusetts	673,368
Michigan	1,868,601
Minnesota	969,381
Mississippi	441,091
Missouri	618,198
Montana	0
Nebraska	321,000
Nevada	476,416
New Hampshire	170,284
New Jersey	1,660,080
New Mexico	708,827
New York	4,781,000
North Carolina	0
North Dakota	21,070
Ohio	2,674,171
Oklahoma	0
Oregon	1,156,989
Pennsylvania	2,300,000
Rhode Island	259,274
South Carolina	900,000
South Dakota	0
Tennessee	1,400,000
Texas	3,760,023
Utah	284,980

State	Number of Beneficiaries Enrolled in MCO Plans
Vermont	0
Virginia	1,392,050
Washington	1,518,287
West Virginia	479,931
Wisconsin	88,408
Wyoming	0
Total	53,786,492

Section II - Prospective DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) Vendor.

Figure 3 - Pharmacy POS Type of Vendor

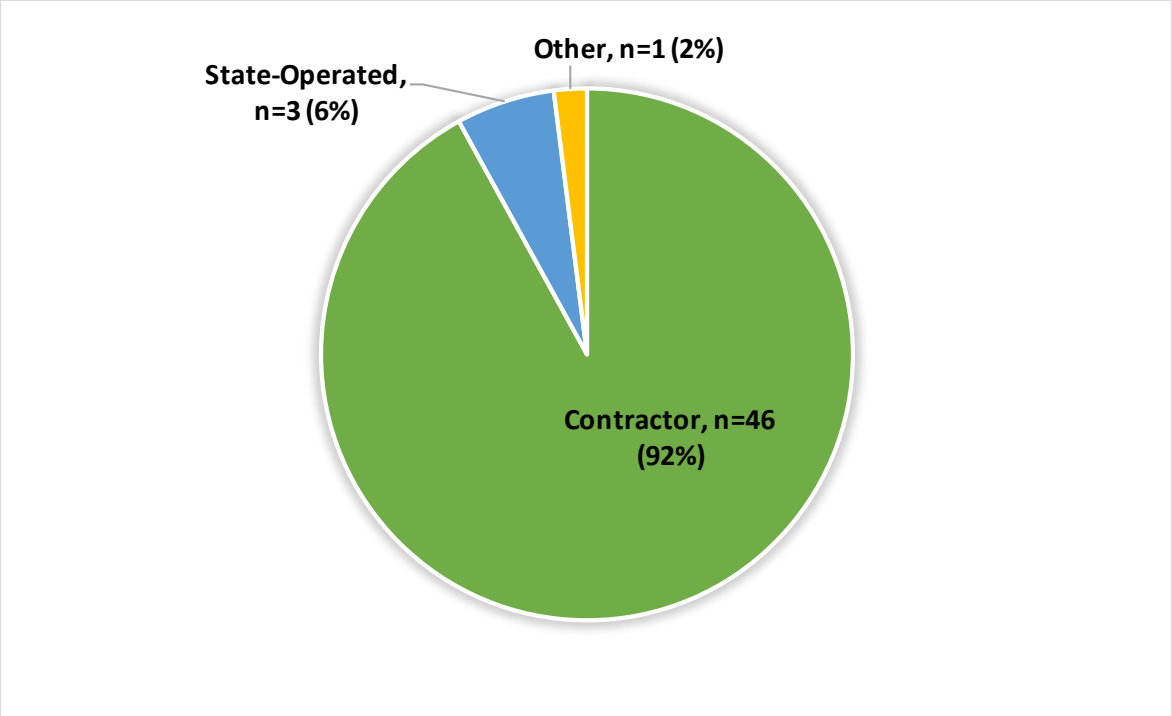

Table 3 - Pharmacy POS Type of Vendor

Response	States	Count	Percentage
Contractor	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	46	92.00%
State-Operated	Minnesota, North Dakota, Washington	3	6.00%
"Other"	Illinois	1	2.00%
Total		50	100.00%

a. Vendor Name

Table 4 - POS Vendor Name

Response	States	Count	Percentage
Gainwell Technologies	Alabama, Delaware, Kansas, Oregon, Pennsylvania, West Virginia, Wisconsin	7	14.89%
Magellan	Alaska, Arkansas, District of Columbia, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, South Carolina, Virginia	11	23.40%
DXC Technology	California, Connecticut, Louisiana, New Jersey	4	8.51%
Magellan Health, Inc.	Colorado	1	2.13%
OptumRx	Georgia, Nevada, South Dakota, Tennessee	4	8.51%
Conduent	Hawaii, Maryland, Massachusetts, Mississippi, Missouri, Montana, New Mexico, Texas	8	17.02%
State operated using Change Healthcare Pharmacy Benefits Management System (PBMS) to process claims.	Illinois	1	2.13%
OptumRx Administrative Services, LLC. (OptumRx)	Indiana	1	2.13%
Change Healthcare	Iowa, Maine, Ohio, Utah, Vermont, Wyoming	6	12.77%
General Dynamics Information Technology	New York	1	2.13%
GDIT	North Carolina	1	2.13%
Gainwell	Oklahoma	1	2.13%
DXC Technology (now Gainwell Technologies)	Rhode Island	1	2.13%
Total		47	100.00%

b. Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions?

Figure 4 – Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions

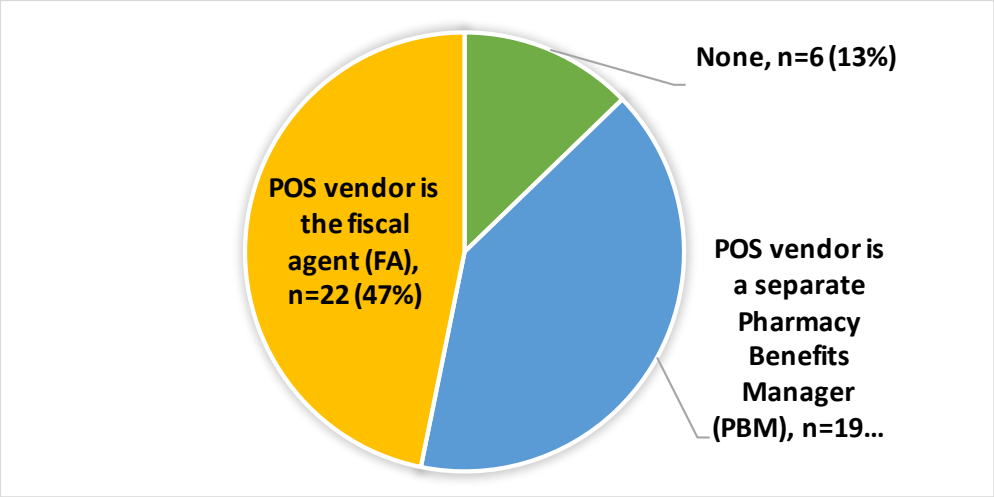

Table 5 - Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions

Response	States	Count	Percentage
None	Arkansas, Florida, Indiana, Missouri, South Dakota, Utah	6	12.77%
POS vendor is a separate Pharmacy Benefits Manager (PBM)	Alaska, Colorado, District of Columbia, Georgia, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Michigan, Mississippi, Nebraska, Nevada, New Hampshire, Ohio, South Carolina, Vermont, Wyoming	19	40.43%
POS vendor is the fiscal agent (FA)	Alabama, California, Connecticut, Delaware, Hawaii, Kansas, Louisiana, Massachusetts, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, West Virginia, Wisconsin	22	46.81%
Total		47	100.00%

2. Identify your ProDUR table driven criteria source.
This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity.

Figure 5 - ProDUR Criteria Source

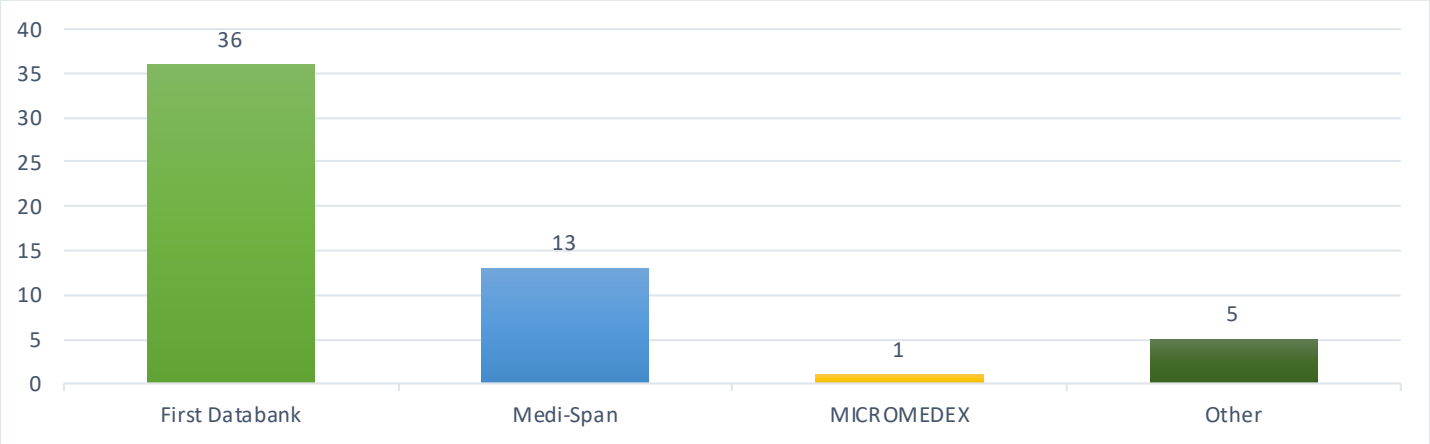

Table 6 - ProDUR Criteria Source

Response	States	Count	Percentage
First Databank	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, West Virginia, Wisconsin	36	65.45%
Medi-Span	Georgia, Illinois, Indiana, Iowa, Maine, Nevada, Ohio, South Dakota, Tennessee, Utah, Vermont, Washington, Wyoming	13	23.64%
MICROMEDEX	Mississippi	1	1.82%
Other	Illinois, Louisiana, Texas, Vermont, Washington	5	9.09%
Total		55	100.00%

If "Other," please specify

Table 7 - "Other" State Explanations for ProDUR Criteria Source

State	"Other" Explanations
Illinois	Additional criteria are developed by HFS with input from the DUR Board and some are based on state and federal legislation or HFS policies.
Louisiana	First Data Bank is the data source. The prospective DUR criteria source is the result of collaboration by pharmacists at LDH, DXC technology, and the University of Louisiana-Monroe.
Texas	Some criteria are developed inhouse.
Vermont	Clinical literature and FDA safety alerts
Washington	Pre-set DUR criteria and functionality are provided through the POS vendor's built in DUR module. Additional DUR criteria based on medically accepted indications/dosing are developed by state staff.

3. When the pharmacist receives a ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service, and resolution)?

Figure 6 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

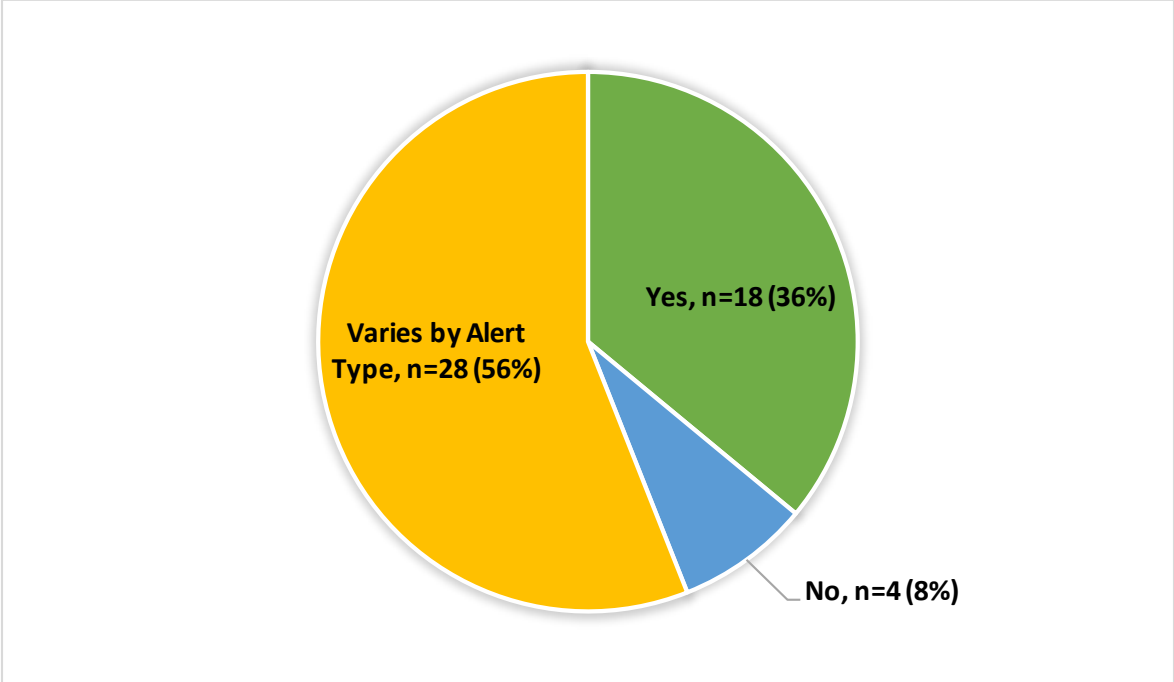

Table 8 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

Response	States	Count	Percentage
Yes	Alaska, California, Connecticut, District of Columbia, Florida, Maryland, Michigan, Mississippi, Missouri, Nebraska, New Mexico, Ohio, Oregon, Rhode Island, Utah, Vermont, Virginia, Wyoming	18	36.00%
No	Illinois, Iowa, Maine, New Jersey	4	8.00%

Response	States	Count	Percentage
Varies by Alert Type	Alabama, Arkansas, Colorado, Delaware, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Washington, West Virginia, Wisconsin	28	56.00%
Total		50	100.00%

If "Yes" or "Varies by Alert Type,".

Figure 7 – "Yes" or "Varies by Alert Type" Override

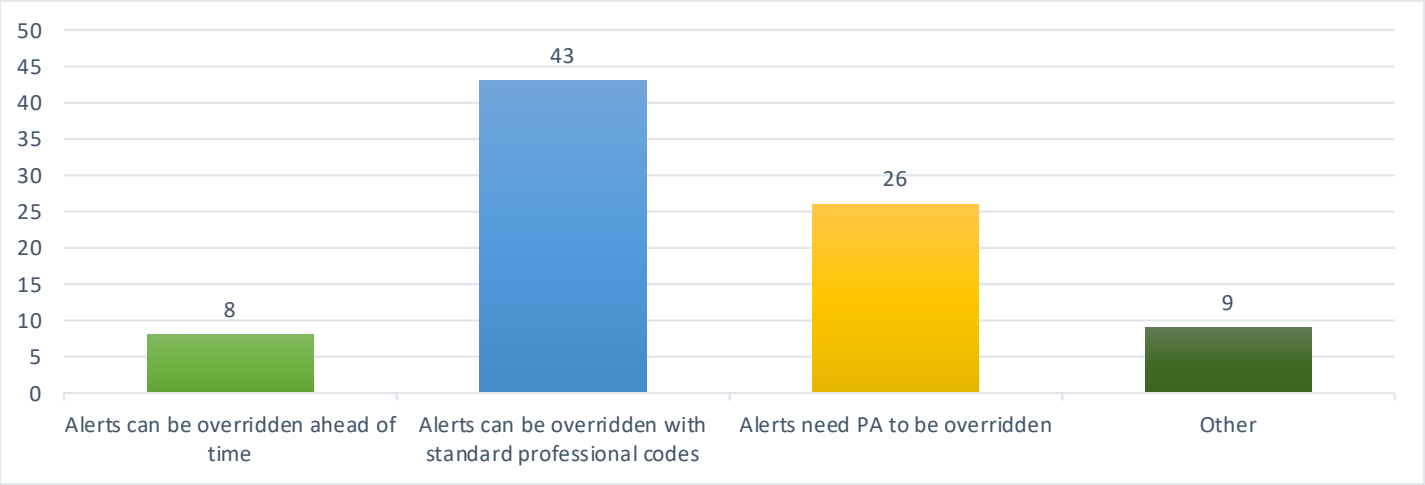

Table 9 - "Yes" or "Varies by Alert Type" Override

Response	States	Count	Percentage
Alerts can be overridden ahead of time	California, Hawaii, North Carolina, Oklahoma, South Carolina, Texas, West Virginia, Wisconsin	8	9.30%
Alerts can be overridden with standard professional codes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	43	50.00%
Alerts need PA to be overridden	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Hawaii, Indiana, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Washington, West Virginia, Wisconsin	26	30.23%
"Other"	Arkansas, Colorado, Idaho, Indiana, Kentucky, New Hampshire, North Carolina, Tennessee, Wisconsin	9	10.47%
Total		86	100.00%

If "Other," please explain.

Table 10 - Explanation for "Other" ProDUR Alert Message Override

State	Explanations
Arkansas	Most level-one alerts can be overridden by the pharmacist at point-of-sale (POS) using standard professional codes. The Early Refill (ER) alert for controlled and non-controlled medications would be an exception. ER DUR alerts cannot be overridden at POS and require a manual review by the contractor's help desk.
Colorado	Selected ProDUR alerts may be overridden by pharmacists with standard professional codes.
Idaho	PA needed for override
Indiana	A pharmacist may override level-one drug-drug interactions only when the pharmacy has received direction to discontinue one of the drugs involved in the interaction. All other level-one drug-drug interactions will require prior authorization.
Kentucky	Most can be overridden, with exceptions. These exceptions include therapeutic duplication of opioids, stimulants, buprenorphine products, or antipsychotics.
New Hampshire	Early refill overrides require a phone call to the technical call center.
North Carolina	For the early refill alert, controlled substances can only be overridden at the pharmacy for change of therapy.
Tennessee	Pharmacist can override with PPS codes for claims that have been denied with soft edits. When claims are denied with hard edits, prior authorization is required.
Wisconsin	There are drugs in the ER alert that require a call to the Drug Authorization Policy Override center to require an override before dispensing the medication. All other prospective DUR alerts allow the pharmacist to override the alert. During the federal public health emergency, the pharmacist currently has the ability to override the ER alert for all drugs except for Schedule II drugs.

4. Does your state receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?

Figure 8 - Receive/Review Follow-up Periodic Reports Providing Individual Pharmacy Provider DUR Alerts Override

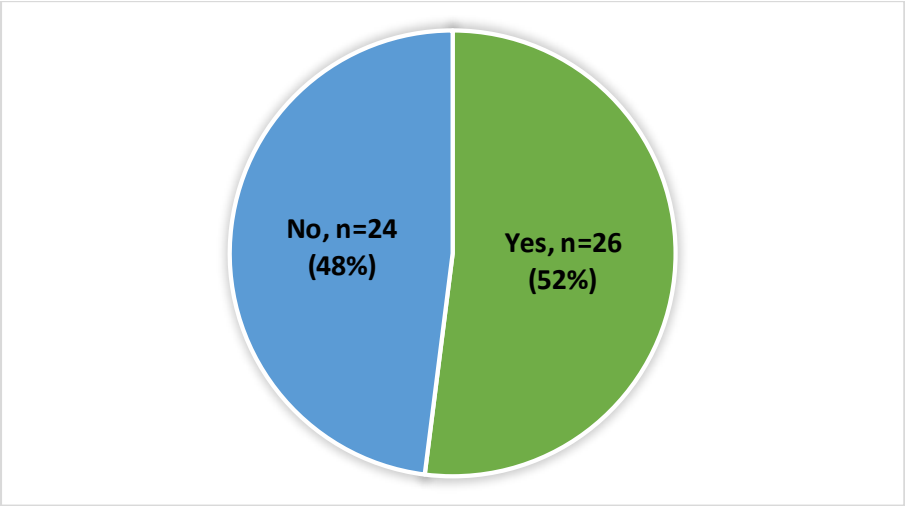

Table 11 - Receive/Review Follow-up Periodic Reports Providing Individual Pharmacy Provider DUR Alerts Override

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Kentucky, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, Virginia	26	52.00%
No	Arkansas, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, New York, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, Wyoming	24	48.00%
Total		50	100.00%

a. How often does your state receive reports?

Figure 9 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alerts Override

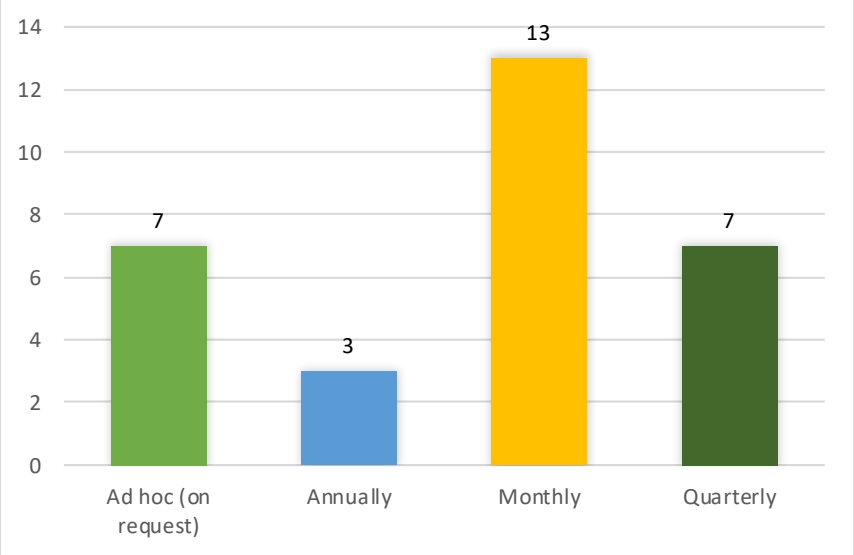

Table 12 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alerts Override

Response	States	Count	Percentage
Ad hoc (on request)	Alaska, California, Colorado, Hawaii, North Carolina, North Dakota, South Dakota	7	23.33%
Annually	Alaska, California, Rhode Island	3	10.00%
Monthly	Alabama, Connecticut, Delaware, District of Columbia, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, Ohio, Pennsylvania, Virginia	13	43.33%
Quarterly	Alabama, Michigan, North Carolina, Oklahoma, Oregon, South Carolina, Vermont	7	23.33%
Total		30	100.00%

If "Other," please explain.

Table 13 – "Other" Explanation for Frequency of Reports Providing Individual Pharmacy Provider DUR Alerts Override

State	"Other" Explanations
Illinois	Additional criteria are developed by HFS with input from the DUR Board and some are based on state and federal legislation or HFS policies.

b. If you receive reports, does your state follow up with those providers who routinely override with interventions?

Figure 10 - Follow-up with Providers who Routinely Override with Interventions

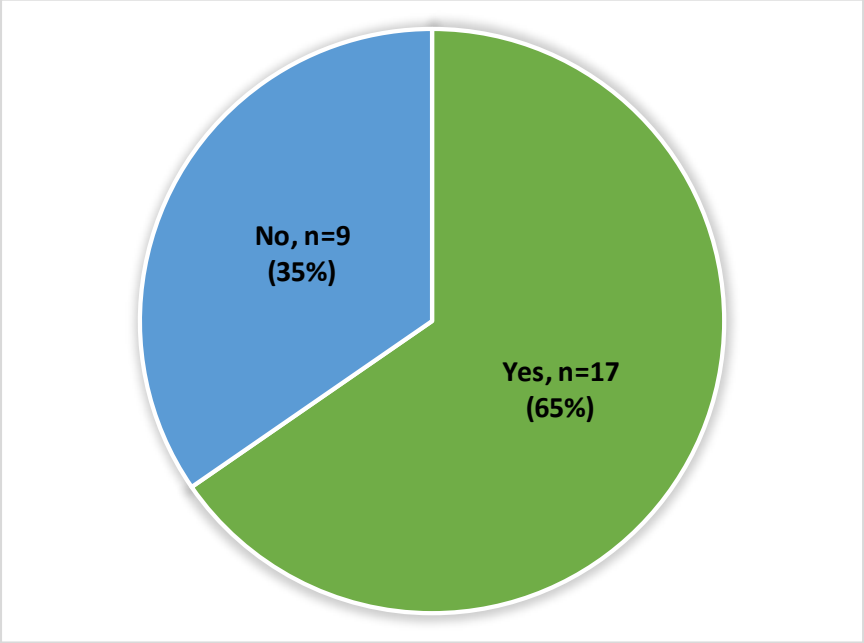

Table 14 - Follow-up with Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Delaware, District of Columbia, Hawaii, Kentucky, Massachusetts, Michigan, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Virginia	17	65.38%
No	Connecticut, Mississippi, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont	9	34.62%
Total		26	100.00%

If "Yes," by what method does your state follow up?

Figure 11 – Follow-up Methods for Providers who Routinely Override with Interventions

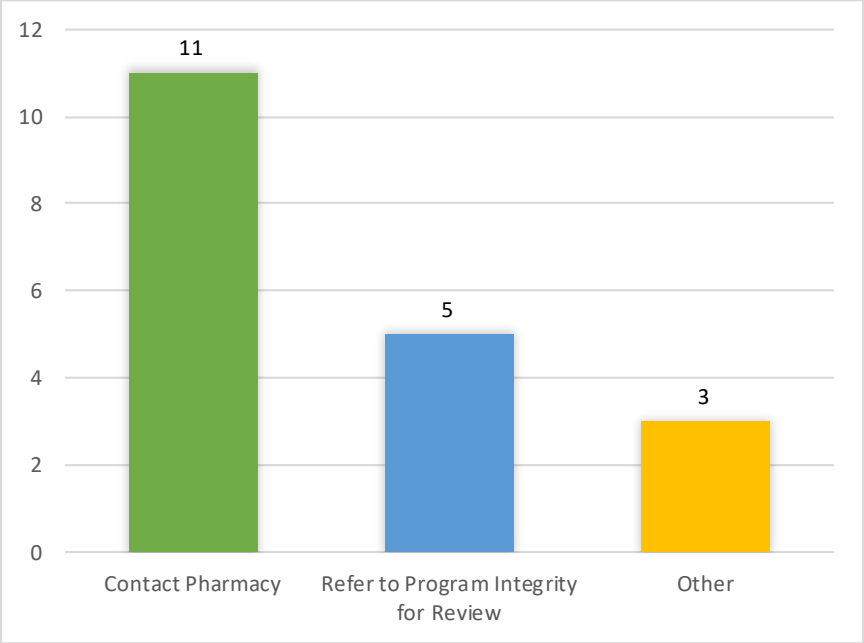

Table 15 – Follow-up Methods for Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Contact Pharmacy	Alaska, California, Delaware, District of Columbia, Hawaii, Massachusetts, Michigan, Nebraska, North Dakota, Oklahoma, South Dakota	11	57.89%
Refer to Program Integrity for Review	Colorado, Michigan, South Carolina, South Dakota, Virginia	5	26.32%
Other	Alabama, Kentucky, Ohio	3	15.79%
Total		19	100.00%

If "Other," please explain.

Table 16 – "Other" Explanations for Follow-up Methods for Providers who Routinely Override with Interventions

State	"Other" Explanations
Alabama	Alabama Medicaid has an Academic Detailing program that provides scheduled face-to-face visits to providers.
Kentucky	Both/either-may contact pharmacy or refer to Program Integrity depending on the case.
Ohio	The information collected may be used to guide other policy decisions.

If "No," please explain.

Table 17 – Explanations for No Follow-up Methods for Providers who Routinely Override with Interventions

State	Explanations
Connecticut	No, we do not follow-up with providers who routinely override interventions.
Mississippi	Due to time-restriction of DOM staff, we are unable to perform real-time evaluation and intervention. When our new fiscal agent goes live in 2022, we anticipate adding such interventions.
New Hampshire	NH has not found any trend in this information requiring follow up with providers. There is a very low Fee-for-Service population to manage.
New Mexico	System edit overrides are allowed through the Conduent pharmacy helpdesk and state Pharmacists at this time. Follow-up is only on a case-by-case basis.
North Carolina	The DUR Board reviews the DUR Alert Overrides quarterly, but there is no follow up interventions with individual providers.
Oregon	We do not specifically audit providers use of the intervention and outcome codes. We can identify if a provider seems to be overriding alerts, but that has not been an issue in our State. Only two ProDUR alerts are set to deny claims: Early refill and Pregnancy.
Pennsylvania	The most severe alerts require agency review for medical necessity.
Rhode Island	Fee-for-Service is routinely secondary payer.
Vermont	Policy allows the pharmacist too override the interventions as allowed by NCPDP format. This is used to alert the pharmacist of potential DDI, therapy conflicts and other required interventions. The override allows the pahrmacist to make clinical decision based on the information and alert notice.

5. Early Refill

a. At what percent threshold does your state set your system to edit?

Figure 12 - Non-Controlled Drugs Early Refill Percent Edit Threshold

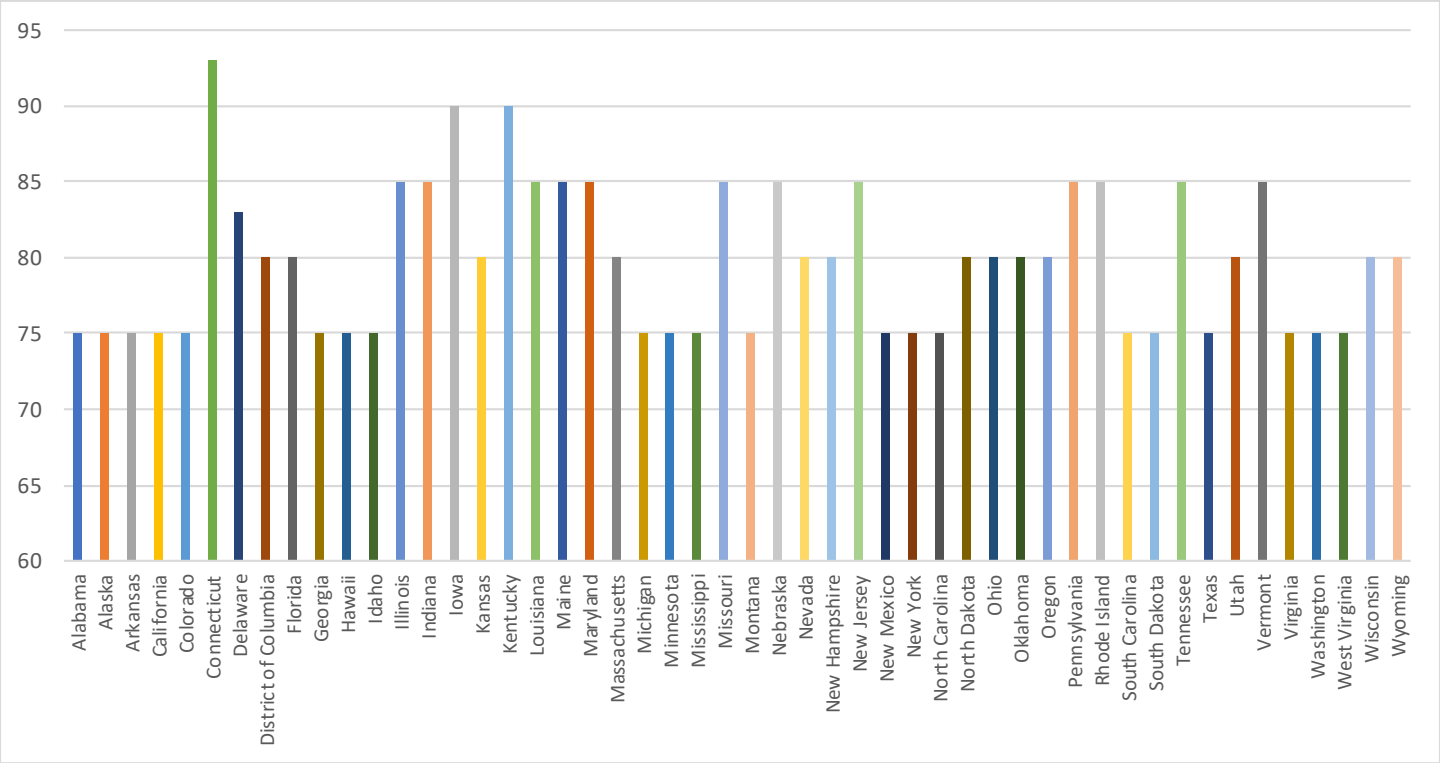

Figure 13 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold

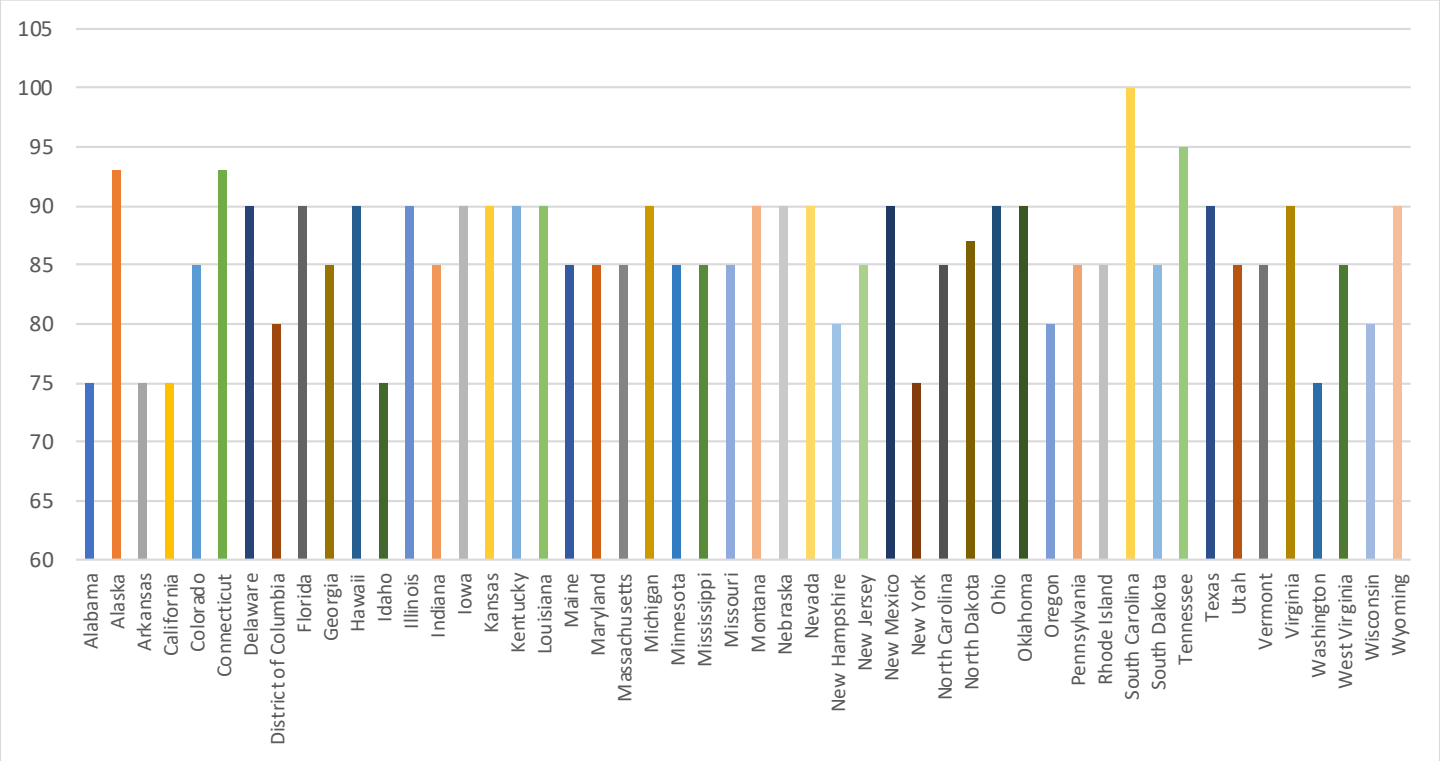

Figure 14 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold

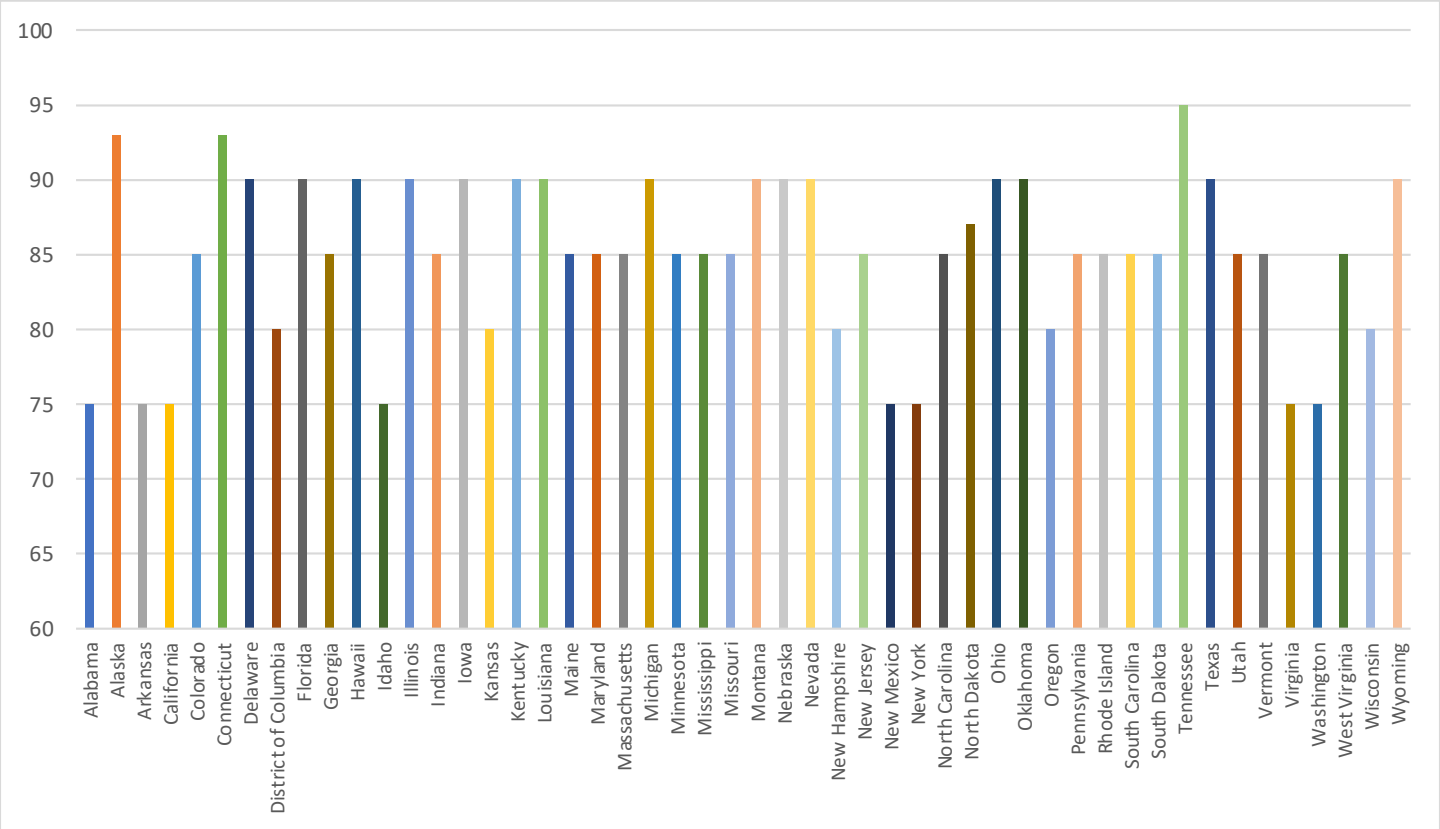

Table 18 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Alabama	75.00%	75.00%	75.00%
Alaska	75.00%	93.00%	93.00%
Arkansas	75.00%	75.00%	75.00%
California	75.00%	75.00%	75.00%
Colorado	75.00%	85.00%	85.00%
Connecticut	93.00%	93.00%	93.00%
Delaware	83.00%	90.00%	90.00%
District of Columbia	80.00%	80.00%	80.00%
Florida	80.00%	90.00%	90.00%
Georgia	75.00%	85.00%	85.00%
Hawaii	75.00%	90.00%	90.00%
Idaho	75.00%	75.00%	75.00%
Illinois	85.00%	90.00%	90.00%
Indiana	85.00%	85.00%	85.00%
Iowa	90.00%	90.00%	90.00%
Kansas	80.00%	90.00%	80.00%
Kentucky	90.00%	90.00%	90.00%

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Louisiana	85.00%	90.00%	90.00%
Maine	85.00%	85.00%	85.00%
Maryland	85.00%	85.00%	85.00%
Massachusetts	80.00%	85.00%	85.00%
Michigan	75.00%	90.00%	90.00%
Minnesota	75.00%	85.00%	85.00%
Mississippi	75.00%	85.00%	85.00%
Missouri	85.00%	85.00%	85.00%
Montana	75.00%	90.00%	90.00%
Nebraska	85.00%	90.00%	90.00%
Nevada	80.00%	90.00%	90.00%
New Hampshire	80.00%	80.00%	80.00%
New Jersey	85.00%	85.00%	85.00%
New Mexico	75.00%	90.00%	75.00%
New York	75.00%	75.00%	75.00%
North Carolina	75.00%	85.00%	85.00%
North Dakota	80.00%	87.00%	87.00%
Ohio	80.00%	90.00%	90.00%
Oklahoma	80.00%	90.00%	90.00%
Oregon	80.00%	80.00%	80.00%
Pennsylvania	85.00%	85.00%	85.00%
Rhode Island	85.00%	85.00%	85.00%
South Carolina	75.00%	100.00%	85.00%
South Dakota	75.00%	85.00%	85.00%
Tennessee	85.00%	95.00%	95.00%
Texas	75.00%	90.00%	90.00%
Utah	80.00%	85.00%	85.00%
Vermont	85.00%	85.00%	85.00%
Virginia	75.00%	90.00%	75.00%
Washington	75.00%	75.00%	75.00%
West Virginia	75.00%	85.00%	85.00%
Wisconsin	80.00%	80.00%	80.00%
Wyoming	80.00%	90.00%	90.00%

b. For non-controlled drugs: when an early refill message occurs, does your state require a PA?

Figure 15 - Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

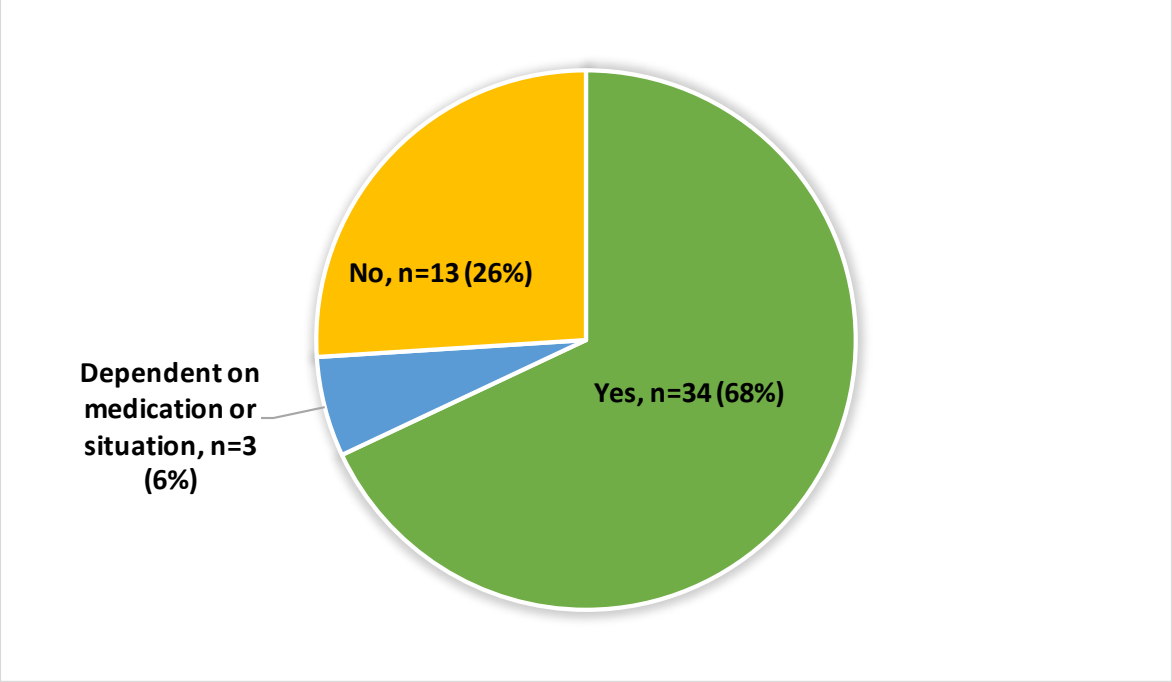

Table 19 - Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, Oklahoma, Pennsylvania, Tennessee, Utah, Vermont, Virginia, West Virginia, Wyoming	34	68.00%
Dependent on medication or situation	North Dakota, South Carolina, Washington	3	6.00%
No	California, Kansas, Louisiana, Nebraska, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Texas, Wisconsin	13	26.00%
Total		50	100.00%

If "Yes" or "Dependent on medication or situation," who obtains authorization?

Figure 16 - Non-Controlled Drugs Early Refill Authorization Sources

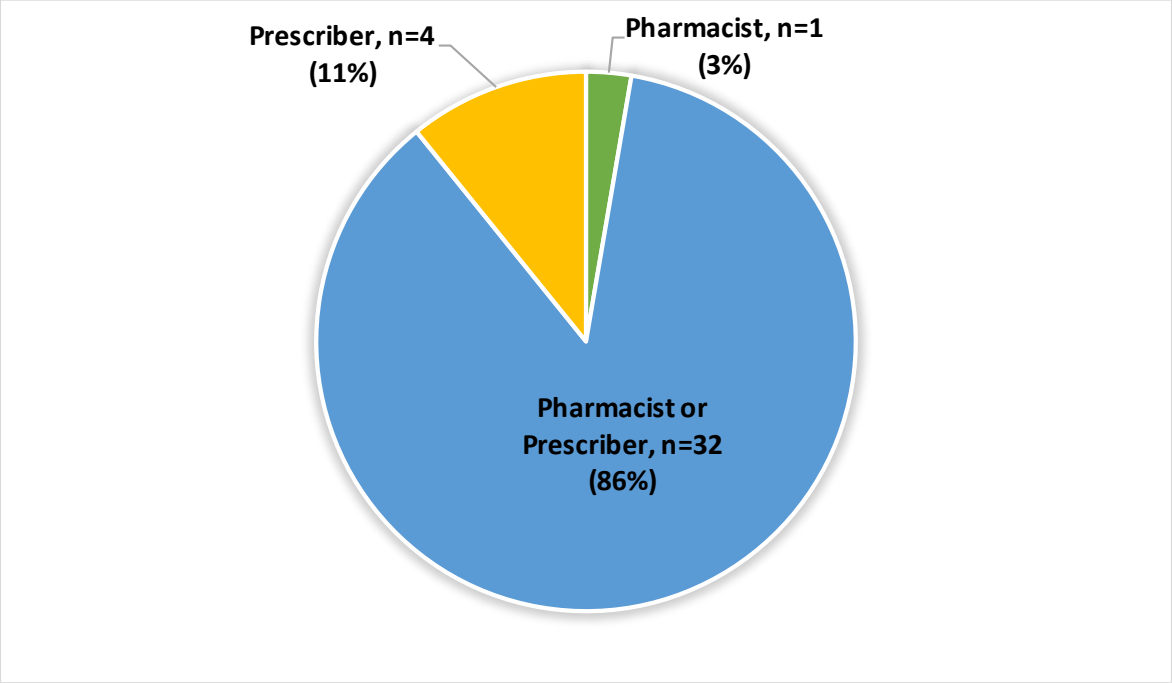

Table 20 - Non-Controlled Drugs Early Refill Authorization Sources

Response	States	Count	Percentage
Pharmacist	Oklahoma	1	2.70%
Pharmacist or Prescriber	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	32	86.49%
Prescriber	Idaho, Indiana, Iowa, New York	4	10.81%
Total		37	100.00%

If "No," can the pharmacist override at the POS?

Figure 17 - Non-Controlled Drugs: Pharmacist Override at Point of Service

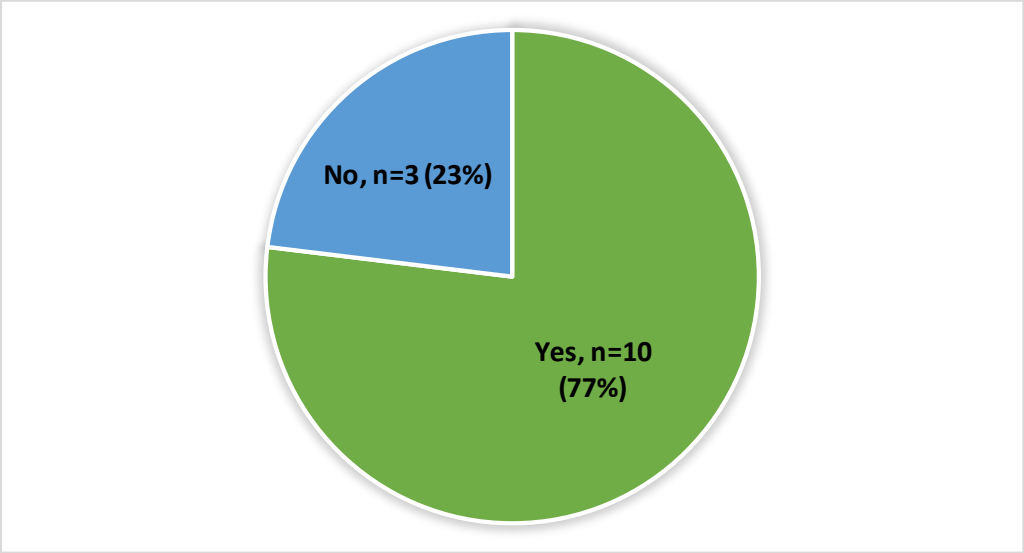

Table 21 - Non-Controlled Drugs: Pharmacist Override at Point of Service

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, Nebraska, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Wisconsin	10	76.92%
No	New Hampshire, New Jersey, Texas	3	23.08%
Total		13	100.00%

c. For controlled drugs: when an early refill message occurs, does your state require a PA?

Figure 18 - For Controlled Drugs, Early Refill Requirement for Prior Authorization

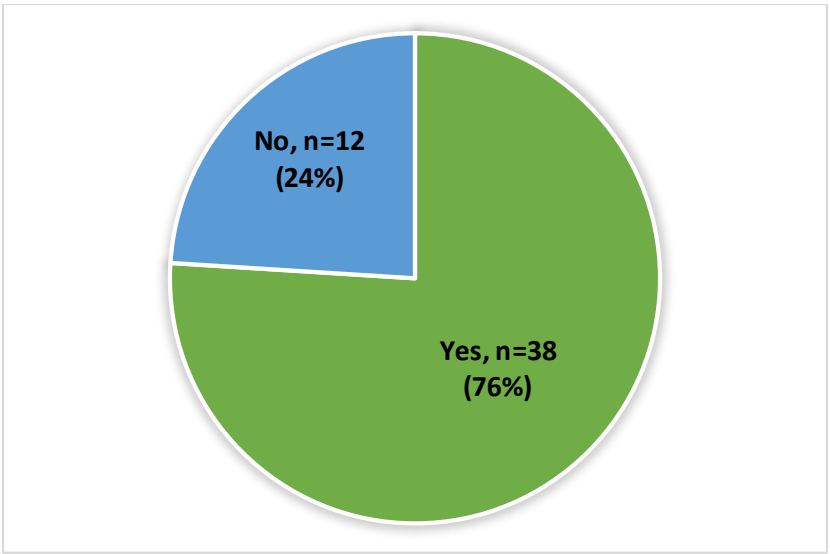

Table 22 - For Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	38	76.00%
No	California, Kansas, Louisiana, Mississippi, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Texas	12	24.00%
Total		50	100.00%

If "Yes," who obtains authorization?

Figure 19 - Controlled Drugs Early Refill Authorization Source

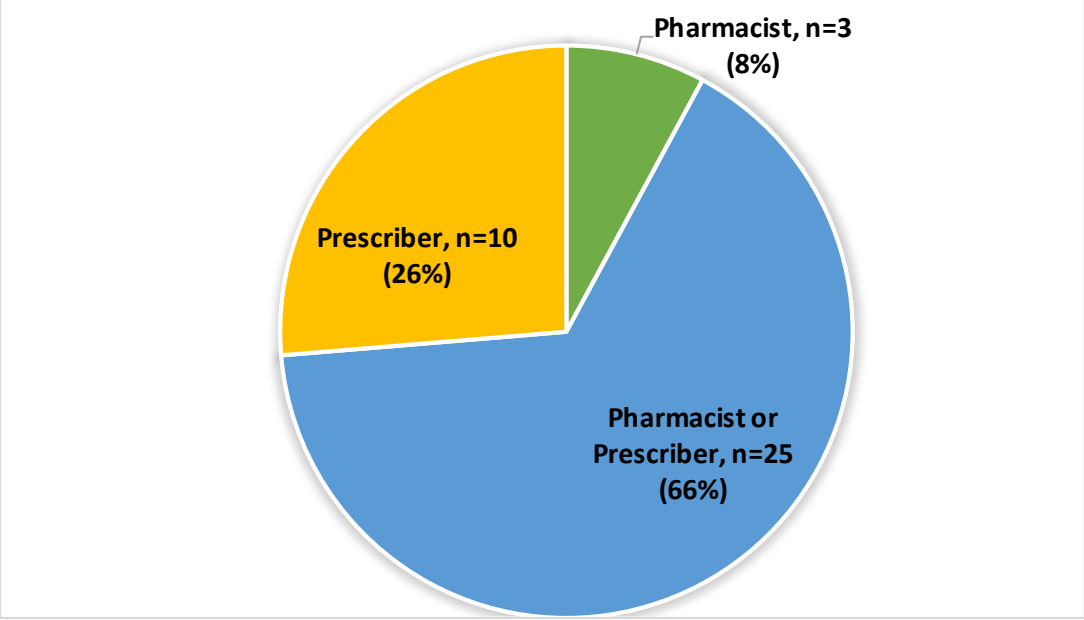

Table 23 - Controlled Drugs Early Refill Authorization Source

Response	States	Count	Percentage
Pharmacist	Massachusetts, Oklahoma, Wisconsin	3	7.89%
Pharmacist or Prescriber	Alabama, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Illinois, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, Wyoming	25	65.79%
Prescriber	Alaska, Connecticut, Florida, Hawaii, Idaho, Indiana, Iowa, Kentucky, New York, Vermont	10	26.32%
Total		38	100.00%

If "No," can the pharmacist override at the POS?

Figure 20 - Controlled Drugs: Pharmacist Override at Point of Service

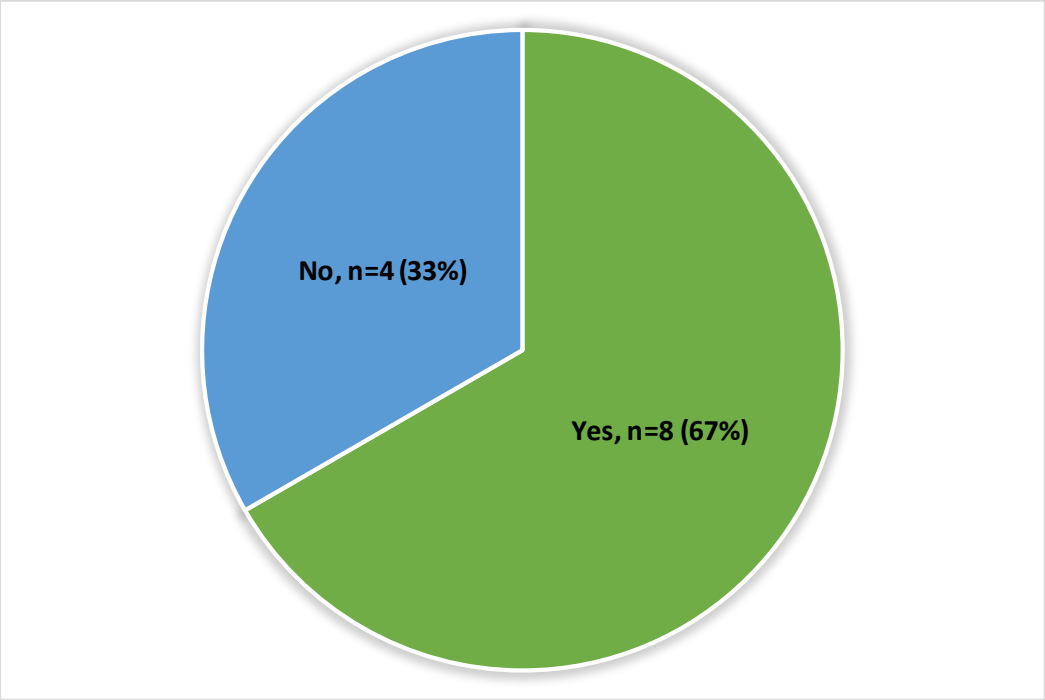

Table 24 - Controlled Drugs: Pharmacist Override at Point of Service

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, Mississippi, North Carolina, Oregon, Rhode Island, South Dakota	8	66.67%
No	New Hampshire, New Jersey, Ohio, Texas	4	33.33%
Total		12	100.00%

6. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as:

a. Lost/stolen Rx

Figure 21 - Allows for Pharmacist Overrides for an Early Refill for Lost/Stolen Rx

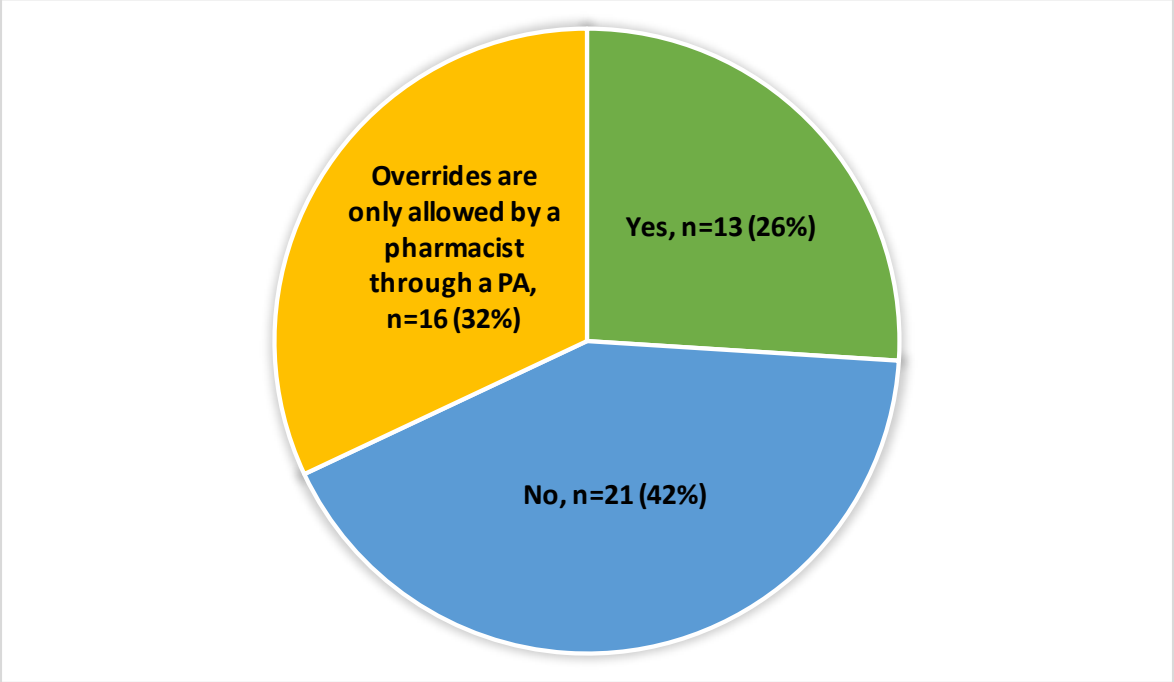

Table 25 - Allows for Pharmacist Overrides for an Early Refill for Lost/Stolen Rx

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, Nebraska, New Mexico, North Carolina, Oregon, Rhode Island, South Dakota, Utah, Virginia, Washington, Wisconsin	13	26.00%
No	Alaska, Arkansas, Colorado, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Michigan, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New York, Ohio, Texas, Vermont, West Virginia, Wyoming	21	42.00%
Overrides are only allowed by a pharmacist through a PA	Alabama, Connecticut, District of Columbia, Georgia, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee	16	32.00%
Total		50	100.00%

b. Vacation

Figure 22 - Allows for Pharmacist Overrides for an Early Refill for Vacation

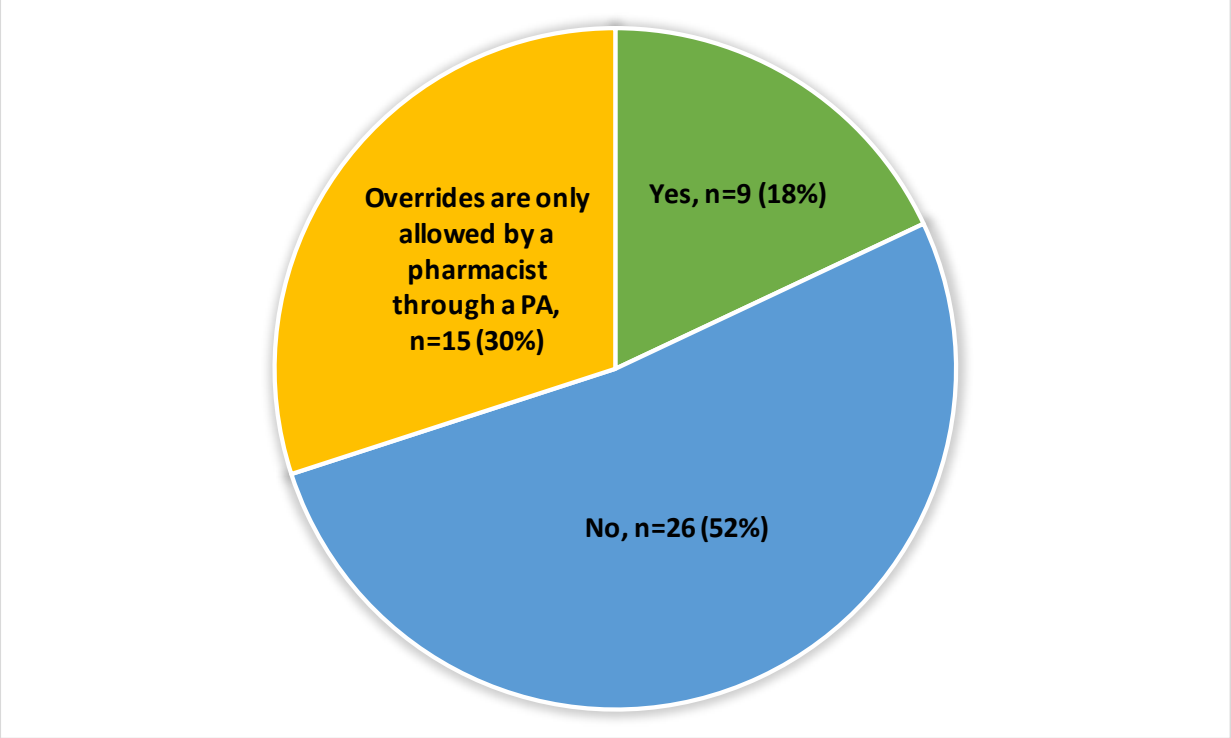

Table 26 - Allows for Pharmacist Overrides for an Early Refill for Vacation

Response	States	Count	Percentage
Yes	California, Louisiana, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, Virginia, Wisconsin	9	18.00%
No	Alaska, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Mississippi, Montana, Nevada, New Jersey, New York, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, Utah, Vermont, West Virginia, Wyoming	26	52.00%
Overrides are only allowed by a pharmacist through a PA	Alabama, Connecticut, District of Columbia, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, North Dakota, Pennsylvania, South Carolina, Tennessee, Washington	15	30.00%
Total		50	100.00%

c. "Other"

Please Explain.

Table 27 - "Other" Explanations for Allowing Pharmacist Overrides for an Early Refill

State	"Other" Explanations
Alaska	Lost or stolen only in the event a police report has been filed and upon coordination/approval of the prescriber.
Arkansas	Pharmacists are not allowed to override an early refill DUR message at POS for lost/stolen prescriptions or for vacations. Early refills for any reason must be reviewed by the State with a prior authorization request. An exception was made beginning March 23, 2020 due to COVID-19. To bypass early refill edits on non-controlled drugs, a pharmacist can enter professional codes to override the early refill alert. Controlled drugs were not included in the COVID-19 exception. The early refill edits for non-controlled drugs will be reinstated after the declaration of emergency has been lifted.
California	The pharmacist can override the early refill DUR alert message if medically necessary.
Colorado	Pharmacist overrides at the POS are not allowed for lost/stolen Rx's or vacation requests. However, pharmacists may contact the pharmacy call center help desk to request authorization to override these edits.
Connecticut	For non-CS for lost or stolen or vacation, either the pharmacist or prescriber can override with a PA. For CS for lost or stolen or vacation, only the prescriber can request a PA.
Delaware	Overrides by pharmacist are allowed for changes in dosage with a prior authorization, or entry of Submission Clarification code 5 and any required standard professional codes.
Hawaii	Not in use by current covered population. but available for other reasons for early refill: 1. change in dose 2. additional therapy authorized 3. member was readmitted to a long term care facility 4. discharged from hospital without medication
Idaho	Overrides are allowed for change of dose only.
Illinois	No other early refill overrides may be given by the pharmacist.
Iowa	Pharmacists are not able to do any override at the POS. Any lost/stolen prescriptions or vacation overrides are handled through the POS Helpdesk where the technician can provide an override if appropriate.
Kansas	Therapy change is also a reason to allow a pharmacist override. Clarification- Only beneficiaries 18yo and younger qualify for the lost or spilled medication early refill override.
Kentucky	N/A
Louisiana	Other situations may be overridden using the pharmacist's professional judgement.
Maine	Nursing home admissions are allowed by the pharmacist override at the store level
Nebraska	Lost or stolen controlled substance prescriptions require a prior authorization.
New Hampshire	NH allows for other early refill reasons such as increased/variable dose, transitioning to a facility, school/daycare supply and destroyed medications. The pharmacist must call the technical call center to request an override.
New Jersey	Prospective DUR alerts cannot be overridden by the pharmacy provider.
North Carolina	For controlled substances, the only override allowed is for change of therapy.
Oklahoma	All early refill overrides require a prior authorization.
Oregon	As long as they enter a valid Submission Clarification Code and the appropriate intervention and outcome codes, they can use whichever codes apply to the situation. We do not limit which codes can be used.

State	"Other" Explanations
South Carolina	Lost/Stolen required documentation (police report/documentation) and notification/approval by prescriber if Control Rx and forwarded to the State for their review/consideration. Spills/Stability (meds left in car/unrefrigerated/heat, etc.) are forwarded to the State for review/consideration Vacation override requests are referred to the State for their review
Tennessee	Vacation supply early refills for members travelling out of the country must be called in by the pharmacy or provider to the PBM's call center, and these are forwarded to the State along with copies of the member's travel itinerary for a decision on each request.
Texas	The dispensing pharmacist must call FFS Pharmacy program Help Desk and provide a reasonable explanation for an override.
Utah	Pharmacies may place a 72-hour override on a pharmacy claim for emergency situations.
Vermont	Pharmacist must call the pharmacy helpdesk for an override, then if appropriate an override may be applied or may require a PA when the situation is warranted.
Washington	Pharmacists may also self-authorize early refills for situations where separate supplies are needed for separate locations, such as a home supply and a school supply, or when the patient is being actively monitored by the prescriber.
West Virginia	Retail pharmacists cannot override the early refill edit.
Wisconsin	Wisconsin allows for dosage change, natural disaster and when the member misunderstood the directions from the prescriber.

7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

Figure 23 - System Accumulation Edit for Prevention of Early Prescription Filling

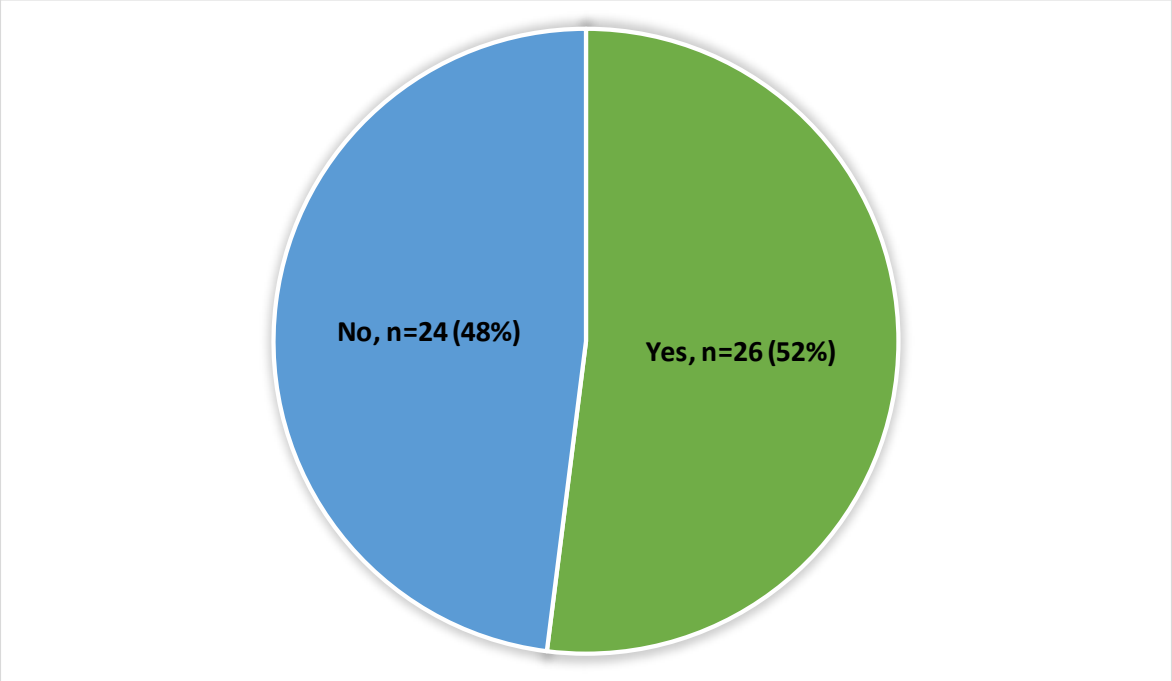

Table 28 - System Accumulation Edit for Prevention of Early Prescription Filling

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wyoming	26	52.00%
No	California, Connecticut, District of Columbia, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin	24	48.00%
Total		50	100.00%

If "Yes," please explain your edit

Table 29 - Explanations for System Accumulation Edit for Prevention of Early Prescription Filling

State	Explanations
Alabama	Claims that exceed, or result in, the accumulation of more than seven days' worth of medication in a 120-day time period will deny at the point-of-sale (POS).
Alaska	Alaska Medicaid allows a 7 day accumulation over a 120 day look-back for control medications and a 21 day accumulation over 120 days for non-controlled medication filled for 90 days.
Arkansas	The Early Refill Accumulation Limit allows a maximum accumulation in a 180-day look-back period identifying the same drug/same strength/same dosage form. The limit adds up the days' supply for each time the drug is filled early during the look-back period. Clients with non-controlled drugs are allowed a 12 days' supply extra in the 180-day period, and clients with controlled drugs are allowed only 7 days' supply extra in the 180-day period. An exception was made beginning March 23, 2020 due to COVID-19 for non-controlled drugs. The accumulation limit edit for non-controlled drugs will be reinstated after the declaration of emergency has been lifted.
Colorado	A cumulative total of 20 days is allowed over a 180-day period for non-mail order transactions.
Delaware	Delaware posts an edit on claims if the accumulative refills are greater than 4 fills in a 120 lookback day period.
Florida	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, and controlled substances). The edit counts refills over a particular time frame to prohibit a total accumulation amount.
Georgia	The claims processing system will evaluate the days supply for historical claims against the days supply of new claims.
Hawaii	Not in use by current covered population.
Idaho	The pharmacy claims system is set to look at a maximum quantity per day as well as a rolling accumulation edit to not allow for early refill.
Illinois	Refill too soon edit where early refill days accumulate from month to month and refill tolerance must be met based on day supply on hand.
Indiana	The claims processing system will evaluate the days' supply for historical claims against the days' supply of new claims. If the new claim's daily dose has increased, the system will calculate the next date of fill automatically based on remaining supply. If the new daily dose has not increased, the system will calculate the next date of fill based on the remaining supply from all historical claims.
Kentucky	Kentucky allows a three (3) day tolerance per month.

State	Explanations
Louisiana	Proton pump inhibitor (PPI) duration of therapy edit: PPIs are limited to a maximum 180-day duration of therapy in a rolling 365-day period. The pharmacist may override the maximum duration of therapy after consultation with the prescribing provider. Morphine milligram equivalent (MME) edit: The MME per day for all active opioid prescriptions for that beneficiary is calculated each time an opioid prescription is submitted and limited to a maximum of 90 MME per day. There are exemptions for certain conditions. If the conditions do not exist, authorization is required to override this edit.
Maine	the accumulation allows for refill accumulation up to 7 days of additional medications then stops the next early refill and requires a prior authorization or override with clinical rationale.
Michigan	MI has refill tolerance and dispensing fee accumulation edits to prevent patients from continuously filling prescriptions early.
New Jersey	Resulting from approved legislation, limits were placed on accumulative day supply to be no more than 120 days on hand during the public health emergency.
New Mexico	An exception code posts to the pharmacy indicating the date when the medication can be filled.
New York	At the time of refill the edit allows for an existing supply of no more than 10 days of medication which is determined by a refill look back of 90 days. For controlled substances the existing supply at the time of refill must be no more than 7 days as determined by a 90 day look back.
North Dakota	Allow 15 days accumulation per 180 days for non-controlled. 10 days for controlled.
Oklahoma	We have an accumulation edit for stimulants and buprenorphine/naloxone only. The claim will deny for cumulative early refill when the member received an early fill in the past 240 days and the combined extra days' supply is 110% of the days' supply on the new day claim being submitted.
Rhode Island	Only allows one original RX and 5 refills per prescriptions.
South Carolina	75% of fill required for non controls and 85% for controls (excluding CII)
Vermont	Control substance allow for a rolling accumulation of 7 days of medication and then a PA is required once the accumulation threshold is achieved.
Virginia	If the patient accumulates more than 15 days early in a 183 day period the claim will deny.
West Virginia	The edit keeps members from getting a thirteen month supply in 12 months by not allowing them to refill their prescriptions early each month, based on the total number of units obtained during a rolling 12-month period.
Wyoming	Scheduled drugs II-V require 90% of the days supply to be used before a refill or new claim for the same medication will be allowed. For each claim that is filled, the number of days that the claim is filled early will be added to the day supply submitted on all subsequent claims, and the 90% refill tolerance will be calculated on that accumulated total. All other medications require 80% of the days supply be used before a refill or new claim for the same medication will be allowed. For each claim that is filled, the number of days that the claim is filled early will be added to the day supply submitted on all subsequent claims, and the 80% refill tolerance will be calculated on that accumulated total.

If "No," does your state plan to implement this edit?

Figure 24 - Plans to Implement A System Accumulation Edit

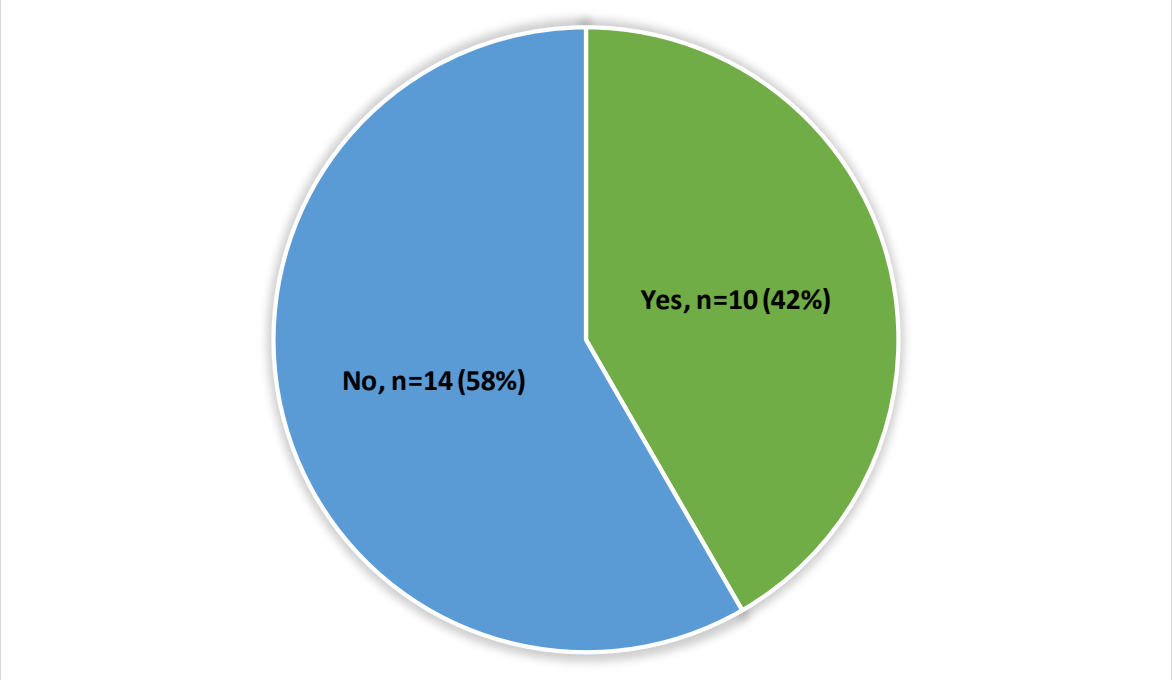

Table 30 - Plans to Implement A System Accumulation Edit

Response	States	Count	Percentage
Yes	District of Columbia, Iowa, Maryland, Massachusetts, Mississippi, Montana, North Carolina, Ohio, Utah, Washington	10	41.67%
No	California, Connecticut, Kansas, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Wisconsin	14	58.33%
Total		24	100.00%

8. Does the state Medicaid program have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

Figure 25 - State Auto-Refill Policy Prohibiting Auto Refill

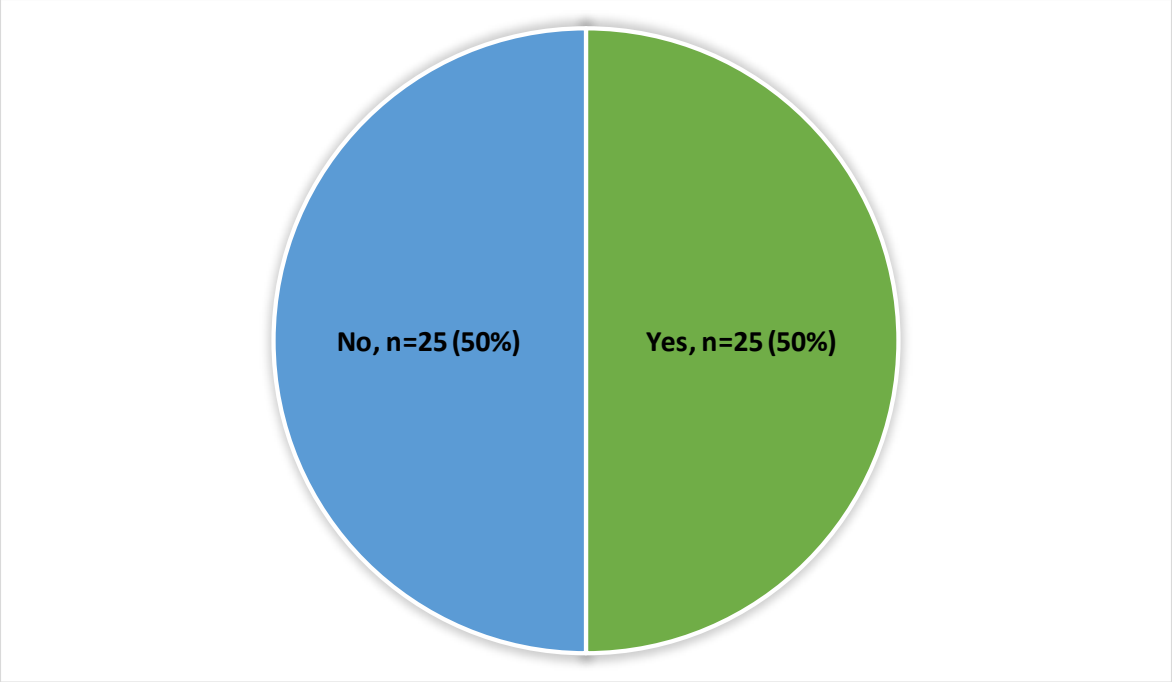

Table 31 - State Auto-Refill Policy Prohibiting Auto Refill

Response	States	Count	Percentage
Yes	Alabama, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Maryland, Massachusetts, Mississippi, Nebraska, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wyoming	25	50.00%
No	Alaska, Arkansas, California, Colorado, District of Columbia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Mexico, Ohio, Pennsylvania, Rhode Island, Vermont, Washington, Wisconsin	25	50.00%
Total		50	100.00%

9. For drugs not on your Preferred Drug List (PDL), does your Medicaid program have a documented process (i.e., PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

Figure 26 - Documented Process to for the Beneficiary to Access Any Covered Outpatient Drug (COD) when Medically Necessary

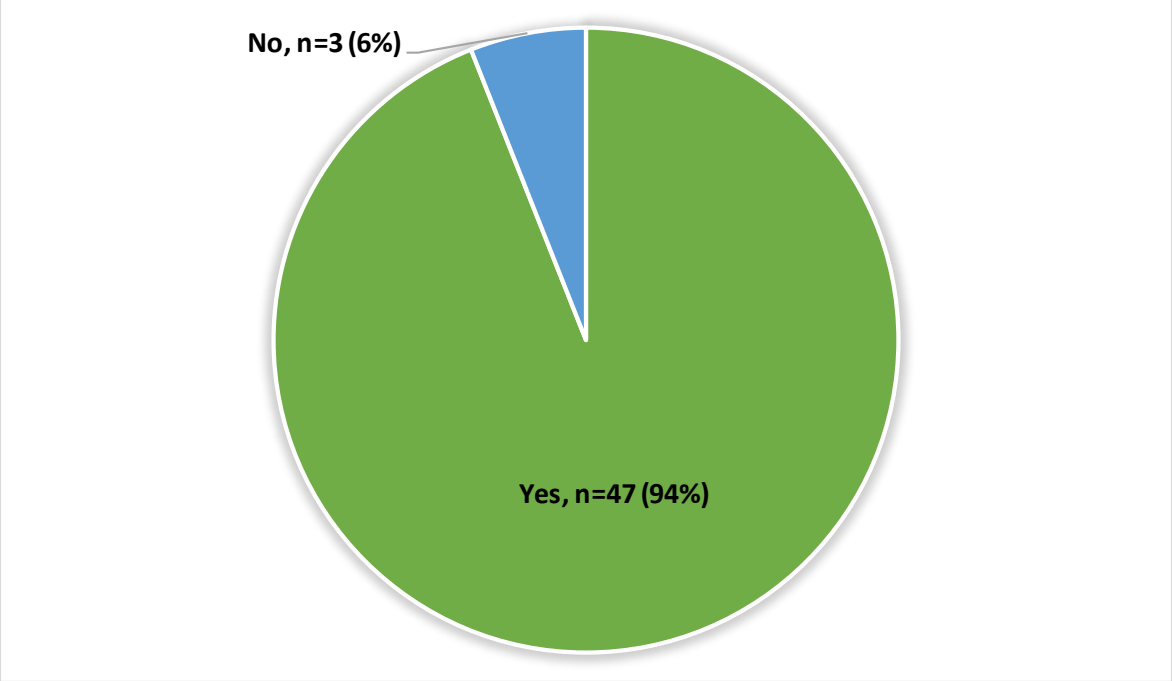

Table 32 - Documented Process to for the Beneficiary to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	Hawaii, New Jersey, South Dakota	3	6.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 27 – Documented Process for the Beneficiary to Access Any Covered Outpatient Drug (COD) when Medically Necessary

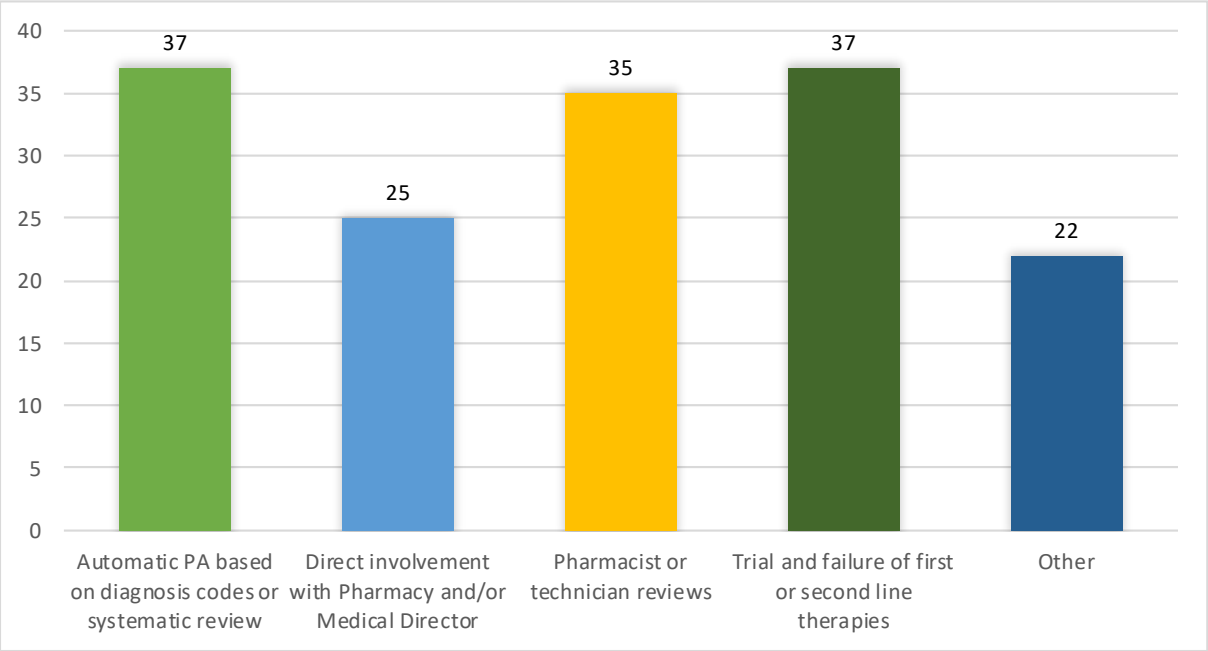

Table 33 - Documented Process for the Beneficiary to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	States	Count	Percentage
Automatic PA based on diagnosis codes or systematic review	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, Washington, West Virginia, Wisconsin, Wyoming	37	23.72%
Direct involvement with Pharmacy and/or Medical Director	Alaska, Delaware, District of Columbia, Idaho, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, Washington, West Virginia, Wyoming	25	16.03%
Pharmacist or technician reviews	Alaska, Colorado, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	35	22.44%
Trial and failure of first or second line therapies	Alabama, Alaska, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky,	37	23.72%

Response	States	Count	Percentage
	Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin		
Other	Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Texas, Utah, Washington, West Virginia, Wisconsin	22	14.10%
Total		156	100.00%

If "Other," please explain.

Table 34 - Explanations for "Other" Processes for The Beneficiary to access a Covered Outpatient Drug when it is Medically Necessary.

State	Explanations
Arkansas	Drugs not on the preferred drug list will either process without a PA, process with POS edits based on diagnosis codes/lab values, or require manual review by prior authorization with specific DUR Board approved criteria. Criteria for manual review or POS edits for many drugs can be found on the PA criteria document and provider memos accessed through the contractor website. https://arkansas.magellanrx.com/client/documents. PA requests are only accepted from Medicaid enrolled prescribers. Prescribers must submit a letter of medical necessity, completed PA form (if required), chart notes, and labs (if warranted). Each request is reviewed on a case-by-case basis with guidance from the DUR Board approved criteria, FDA approved package insert, clinical trials, clinical guidelines, and support in MicroMedex. If a drug new to the market belongs to a drug class already on the PDL, the new medication will be added as a non-preferred option. If the new drug is novel, requires significant monitoring, or is a specialty drug, it will be designated as manual review and placed on the the upcoming DUR Board agenda. Requests for new drugs prior to placement on the DUR Board agenda are reviewed with reference to the FDA approved package insert, clinical trials, and treatment guidelines.
California	The Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug not on the Medi-Cal Fee-for-Service List of Contract Drugs (CDL) with an approved Treatment Authorization Request.
Colorado	Prescribers may submit a pharmacy prior authorization request to the State's PBM, 24 hours a day/7 days a week, by phone or fax. Prior authorization denials are eligible for expanded clinical review after the prescriber submits additional patient-specific documentation and/or clinical literature to support medical necessity. If the expanded review also results in a denial, a formal appeals process is available for both prescribers and members.
Florida	Non-preferred medications with set criteria and prior authorization forms are posted on the Agency for Health Care Administration Pharmacy Policy site (https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/paforms.shtml). Medications that do not have set criteria can be submitted on the miscellaneous prior authorization form. The forms list the requirements and documentation necessary for review. The clinical reviewers have 24 hours to review the prior authorization request and provide a response.
Georgia	Coverage can be requested through the Appeal's process by the prescriber submitting a letter of medical necessity.

State	Explanations
Illinois	In the POS, if a non-preferred medication is requested, it rejects with a prior authorization required message. The pharmacist or prescriber can submit a prior authorization request via the hotline, fax, or through the prescriber portal, IMPACT. Criteria must be met for prior authorization approval. Prior approval can be requested by the prescriber even before the prescription is sent or presented at the pharmacy. The only automatic PA based on diagnosis is for non-preferred seizure medications if there is a seizure diagnosis tag from 7 medical claims.
Indiana	All covered outpatient drugs are part of the formulary. Certain agents may require prior authorization due to non-preferred status or drug-specific criteria.
Iowa	Prescribers submit PA requests for drugs with clinical PA criteria and/or a non-preferred status on the PDL via fax for consideration.
Kansas	We cover all drugs deemed Covered Outpatient Drugs (CODs) by CMS standards. For drugs with a prior authorization requirement, our process is as follows: Soft edit for some drugs by NCPDP override code approval. Hard stop PA at the point-of-sale (and via medical claims request) followed by manual/automated review of submitted provider information and prior authorization criteria approved by the DUR Board. We provide a 72 hours supply of drugs for emergent situations.
Maryland	Maryland Medicaid utilizes a prior authorization process to provide coverage for all non-preferred covered outpatient drug products. When a claim is rejected for prior authorization, a message is provided through the POS system that alerts the pharmacy provider. The prescriber is then contacted with the prior authorization rejection information as well as any contact information provided. Prescribers must then contact the appropriate party to resolve the claim denial. This may include diagnostic or laboratory data, attestation of baseline and subsequent evaluations, or patient specific past medical history required to assure the safe and appropriate use of the requested drug product. Additionally, prior authorization forms are available online at https://mmcp.health.maryland.gov/pap/Pages/Pharmacy-Program-Forms.aspx
Michigan	Not all medications are included in the MI PDL. For those medications that are not included in the overall MI formulary of covered products, MI has a non-formulary prior authorization process. Prescribers must submit a request stating the clinical necessity of the non-formulary medication over similar covered formulary products. All requests are reviewed on a case-by-case basis by the MDHHS physicians.
Minnesota	Some non-PDL drugs don't require any sort of PA and this wouldn't apply to them.
Nevada	Drugs not on the PDL, but within drug classes reviewed by the Silver State Scripts Board (formerly known as the P&T Committee), require prior authorization, unless exempt under NRS or federal law or excluded through recommendations of the Silver State Scripts Board or excluded by DHCFP. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard Preferred Drug List Criteria.
New Hampshire	The Medicaid beneficiary's prescriber my request prior authorization from the State's PBM by calling, faxing or submitting a prior authorization request electronically. All prior authorization criteria and prior authorization request forms are available on the Department's website, https://www.dhhs.nh.gov/ombp/pharmacy/authorization.htm.
New Mexico	The provider can contact a Pharmacist at New Mexico Human Services Department when a drug has a prior authorization requirement.
North Carolina	For children, prescribers can submit an EPSDT PA request for non-formulary drugs. The request will be reviewed using EPSDT criteria for approval. Rebateable, active drugs not listed on the PDL and not requiring a PA are covered if allowed by CMS.
Ohio	An online drug lookup tool is available on the ODM website to assist in determining coverage of a specific product. If the Drug Lookup Tool indicates that the drug requires a prior authorization,

State	Explanations
	there is a process in place to access a drug when medically necessary. Prior authorization forms are available on our website with instructions regarding submission.
Texas	For drugs that are on Texas formulary and are designated as non-preferred, a PDL PA is required. When a drug is CMS rebatable but is not yet on the Texas formulary, the claim will be denied for NDC not covered and if prescriber requests coverage for medical necessity, we quickly take the necessary actions to provide access to the drug.
Utah	There are drugs that are not listed on the PDL and do not require PA. For drugs that require PA, there are two pathways. The first pathway is identified by the PDL. For these drugs, prior authorization is available for non-drug specific (Medication Coverage Exception PA Form) and drug specific. The second pathway is when a prior authorization requirement is identified at the point of sale for drugs that are not listed on the PDL, the prescriber may submit a Medication Coverage Exception Form.
Washington	Some drugs have PA requirements that may be self-authorized by a pharmacist with use of expedited authorization (EA) code.
West Virginia	Prior authorization criteria must be met. The request goes to Rationale Drug Therapy for clinical review. If the request is denied by RDTP the physician can request an appeal that gets reviewd by a pharmacist at BMS along with the medical director who makes a final decision.
Wisconsin	Wisconsin's PDL has a limited number of drugs and drug classes. Many covered outpatient drugs that are not part of the Wisconsin PDL are covered without prior authorization (PA) requirements. When a covered outpatient drug does have a PA requirement, Wisconsin has a documented PA policy and procedure to obtain a PA.

If "No," please explain.

Table 35 - Explanations for not Having a Process for The Beneficiary to access a Covered Outpatient Drug when it is Medically Necessary.

State	Explanations
Hawaii	The state does not have a PDL.
New Jersey	NJ FFS has an open formulary. Medicaid FFS beneficiaries have access to all covered outpatient drugs when deemed necessary.
South Dakota	South Dakota Medicaid does not have a PDL.

a. Does your program provide for the dispensing of at least a 72-hour supply of a COD in an emergency situation?

Figure 28 - Provide for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

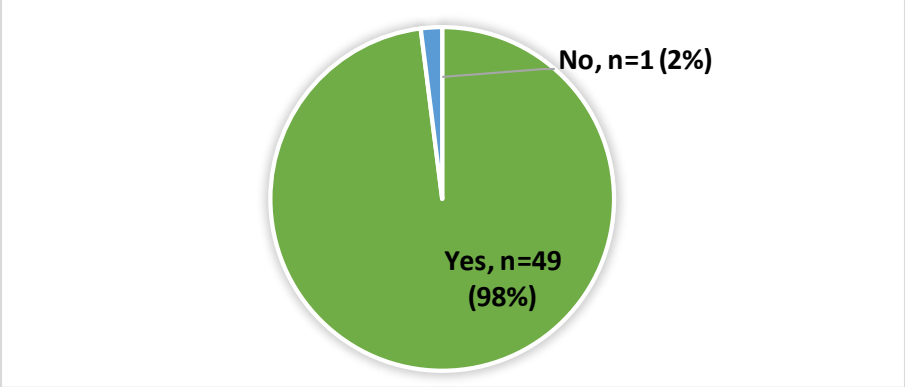

Table 36 - Provide for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
No	New Mexico	1	2.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 29 – Process for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

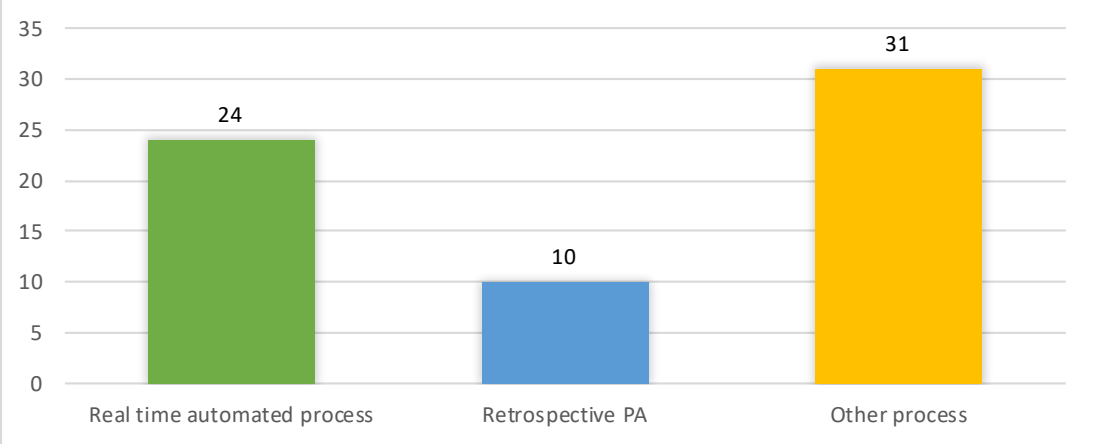

Table 37 - Process for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

Response	States	Count	Percentage
Real time automated process	Arkansas, Delaware, Florida, Hawaii, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, West Virginia, Wisconsin, Wyoming	24	36.92%
Retrospective PA	Delaware, Illinois, Minnesota, Missouri, Montana, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas	10	15.38%
Other process	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Maryland, Michigan, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	31	47.69%
Total		65	100.00%

"Other" process, please explain.

Table 38 - Explanations for "Other" Process for Providing for the Dispensing of at least a 72-Hour Supply in an Emergency Situation.

State	Explanations
Alabama	The use of the emergency prior authorization (PA) code is to be used only in cases of emergency. Federal Law makes a provision for a 72-hour supply by using the following authorization number: 0000999527.
Alaska	The pharmacist may call for a 5 day emergency override.
Arkansas	In an emergency, an Arkansas Medicaid enrolled pharmacy may dispense up to a five day supply of a drug that requires a prior authorization. This provision applies only in an emergency situation when the contractor's prescription drug help desk and the State Medicaid pharmacy program offices are closed, AND the pharmacist is not able to contact the prescribing provider to change the prescription. The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-long term care clients and once per 60 days per drug class for long term care clients. To file a claim using this emergency provision, the pharmacy provider will submit a "03" in the level of service field.
California	The pharmacy may manually bill a 72-hour supply of a covered outpatient prescription drug in an emergency situation.
Colorado	Pharmacists or prescribers may call the Magellan pharmacy help desk t request an emergency override to dispense a 3-day supply of a medication in an emergency situation.
Connecticut	The pharmacist has the ability to perform a one time override at POS.
District of Columbia	Pharmacy providers can override the PA requirement for a non-preferred drug by entering "3" (emergency) in the Level of Service field (NCPDP field #418-DI).
Florida	In the event of a natural disaster, the Bureau Chief will selectively open payment to counties under threat. In the event of a fire or catastrophic loss, one early refill per year may be granted for certain non-controlled substances.
Georgia	If a pharmacist deems it necessary to dispense a 72 hour supply of medication, they may provide the medication, then contact the State for billing and reimbursement approval.
Hawaii	Manual billing or real time automated process after verbal PA approval for PA desk of pharmacy fiscal agent.
Idaho	Pharmacy can submit the appropriate ProDUR fields that allow the emergency supply to pay at POS.
Illinois	Pharmacist can dispense a 72 hour fill and submit for prior authorization and reimbursement for 72-hour emergency fill. For insulin, pharmacies dispense a full vial of insulin in an emergency and can be reimbursed.
Indiana	Pharmacies may submit a 4-day supply via point-of-sale with a level of service override of 03 to indicate emergency supply.
Kansas	PROVIDER MANUAL GUIDANCE LANGUAGE: When a prescription is dispensed that requires PA in an emergency or after regular office hours, the pharmacy should call and leave a message on the voicemail indicating the date, time, beneficiary ID, and medication being dispensed. This will be taken as intent to begin the PA process. When medications are needed without delay and PA is not available, an emergency 3-day supply (72-hour) should be dispensed to the beneficiary until PA can be secured. The PA department will return the telephone message the next working day and process the request. If the PA request is approved, the remainder of the prescription will be considered for reimbursement. If PA is denied, only the portion of the medication dispensed emergently during nonworking hours/days will be considered for reimbursement.

State	Explanations
Maryland	In the event that a participant requires a 72 hour supply of a covered outpatient drug in an emergency situation, the dispensing pharmacy must contact the POS vendor and request an override to fill an emergency supply.
Michigan	A Medical Emergency override requires that the Registered Pharmacist's or Licensed Prescriber's first and last names be documented by support center staff. This protocol allows for override of all applicable drug coverage edits with the exception of plan-excluded products. The required requester must attest to the following statement of a Medical Emergency as defined by MDHHS: Emergency care is defined as medically necessary services provided to an individual who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions. Please note that if upon post payment review/audit this request is not deemed an emergency, then the payment for the medication is subject to recovery. The allowed quantity is typically a 72-hour supply; however, the supply may be increased to cover longer weekends/holidays as authorized by MDHHS.
Nebraska	The pharmacy can contact the PBM or plan to request a 72 hour supply to assist in processing.
Nevada	Nevada Medicaid allows dispensing of up to a 96-hour supply for a COD in an emergency situation. Prior authorization of payment is required for drugs that require prior authorization. The pharmacy may call the OptumRx call center to request emergency situation coverage.
New Hampshire	Pharmacies must request payment for the 72-hour supply from the member's prescription plan, either Fee-For-Service or the appropriate Medicaid MCO. On each provider notice we include the following. Emergency Drug Coverage Pharmacies are reminded that federal statute requires Medicaid programs (Fee-for-Service and managed care) provide payment for dispensing of at least a 72-hour supply for any drugs requiring prior authorizations if prior authorization cannot be obtained outside of Medicaid business hours. (Section 1927 of the Social Security Act. Codified as Section 1396r-8 of Title 42.(d)(5) (B))
North Carolina	A 72-hour emergency supply may be provided if a beneficiary is waiting for prior authorization request determination. The pharmacy is reimbursed for the supply even if the prescription is changed to an alternative medication. A "3" in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill. The claims will only allow a 72-hour supply. Co-payments will apply and only the drug cost will be reimbursed.
Ohio	For controlled medications, the pharmacy is required to call the helpdesk. For non-controlled medications, the pharmacy can use a submission clarification code.
Oklahoma	Oklahoma doesn't have a PDL, but rather has a product based prior authorization program. Products/categories that require clinical criteria and/or step therapy are posted on our website, including the approval criteria and access to the prior authorization forms. Products/categories not posted on our website are generally covered with open access; however, these products/categories may have age restrictions or quantity limits in place. Prescribers also have access to covered products through their e-prescribing platform. Pharmacies can obtain authorization for coverage of a 3-day emergency supply of medication by calling the Pharmacy Help Desk. For members who have an initial prior authorization request during the time the Help Desk is closed, the pharmacy may dispense an emergency 3-day supply, and an authorization can be approved retroactively when the Help Desk reopens.

State	Explanations
Oregon	Pharmacy can call the Oregon Pharmacy Call Center 7 days a week to request a 96-hour emergency supply for a drug that is needing a prior authorization submitted. Emergency supplies permitted as long as drug is rebatable and covered.
South Carolina	provider/pharmacy may fax/call the Call Center, which also provide authorizations. Policy/procedure (Controlled Substance Act/DHEC) are applied with regard to controlled substances.
Tennessee	Claim must be denied for non-preferred or requiring PA. --The pharmacist should determine if an immediate threat of severe adverse consequences exists should the patient not receive an emergency supply. --In the pharmacist's judgment, if the dispensing of an emergency supply is warranted, determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed. --Resubmit the adjusted claim to the PBM, including both a Prior Authorization Type Code (NCPDP Field 461-EU) of 8 and Prior Authorization Number (NCPDP Field 462-EV) of 88888888888 to override the POS denial. --The enrollee is not charged a co-pay for the emergency supply. --The emergency supply DOES count toward the monthly prescription limit. --Only one emergency supply is provided per drug per member per year. --Recipients are not permitted to receive, nor will TennCare pay for the remainder of the original prescription at any pharmacy unless the prescriber has received a PA. If the prescriber obtains a PA OR changes the drug to an alternative not requiring a PA in the same month, the remainder of the prescription and/or substitute prescription does not count toward the monthly limit. --To exempt the remainder of the prescription from the prescription limit once a PA is obtained, or to exempt the replacement prescription from counting toward the prescription limit, the value of 5 must be submitted in the Submission Clarification Code (NCPDP Field 420-DK) on the incoming claim within 14 days of the initial prescription.
Texas	The 72-hours supply can be dispensed on drugs when a prior authorization is required. Providing 72-hours emergency supply is based on the pharmacist's professional discretion. The 72-hour supply may be repeated on the same claim if the prescriber is not reachable after the first 72-hrs but it should not be used for routine and continuous overrides of the drug prior-approval process. a 72-hour emergency supply does not count towards pharmacies 3 RX limit in FFS program.
Utah	Pharmacist can place an override on the claim using PA Type Code (461-EU) = 2 and PA number: (462-EV) = 72
Virginia	The pharmacist may dispense a 72-hour supply of the prescribed medication if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays, and the pharmacist, in his or her professional judgment, consistent with current standards of practice, feels that the patient's health would be compromised without the benefit of the drug.
Washington	Washington Apple Health (Medicaid) Emergency Fill Policy guarantees claim payment for emergency fills. The policy allows the dispensing pharmacist to use their professional judgment to meet a client's urgent medical needs and dispense the medication, up to a 34 day supply. Once the prescription has been dispensed, the pharmacy requests an authorization for reimbursement of the emergency fill.
West Virginia	No copay is required for a 3-day emergency supply. The 3-day emergency supply does not count as a refill and no Prior Authorization (PA) is required. However, an override code of 99 must be submitted in the Submission Clarification Code. The claim for a 3-day emergency

State	Explanations
	supply could be the original filling waiting for a PA or a refill during off hours. Only three 3-day emergencies are allowed for the life of a given prescription, but there is no limit on the total number of different prescriptions that a member can receive a 3-day emergency supply for. Both controlled and non-controlled products may be obtained with a 3-day emergency supply, but products in bottles or glass containers specifically are not allowed to be obtained with a 3-day emergency supply.
Wisconsin	Wisconsin has two types of emergency medication dispensing, standard and expedited. Wisconsin allows pharmacy providers to submit claims for standard emergency medication drugs that are not included in the expedited emergency dispensing medication process when the prescriber cannot be reached and the pharmacist determines the member should begin taking their medication immediately. Pharmacy providers must include specific information about why the standard emergency supply is being requested. The pharmacy providers may provide up to a 14-day supply of medication. For medications that are in an unbreakable package the pharmacy provider is directed to use the smallest package size and dispense up to a 34-day supply. Expedited emergency supply is available for certain drugs on the PDL and is available through the specialized transmission approval technology- prior authorization system. Pharmacy providers are given a real-time response on the expedited emergency supply request. Pharmacy providers may provider up to a 14-day supply; some drugs are allowed to be provided up to a 34-day or 100-day supply.

If "No," please explain

Table 39 - Explanations for not Providing for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

State	Explanations
New Mexico	Nothing is mandated by State Medicaid rules. However, a pharmacist can use his or her professional judgement to dispense up to a 5-day supply of a non-narcotic prescription in an emergency situation.

10. Top Drug Claims Data Reviewed by the DUR Board.

Table 40 - Top Drug Claims Data Reviewed by the DUR Board

Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Top 10 Drug Names by Amount Paid, report at generic ingredient level	Top 10 Drug Names by Claim Count, report at generic ingredient level
Aripiprazole	Anticonvulsant Agents	Prior Authorization Required	Adalimumab	Gabapentin
Hydrocodone/ acetaminophen	Analgesics, Narcotic Agents	Therapeutic Duplication	Bictegravir/ emtricitabine/ tenofovir	Albuterol
Methylphenidate	Antipsychotic Agents	Plan Limitations Exceeded	Lurasidone	Cetirizine
Buprenorphine/ naloxone	Stimulants and Related Agents	Early Refill: Overuse Precaution	Paliperidone	Amoxicillin
Risperidone	Proton Pump Inhibitor Agents	Product/service Not Covered - Plan/benefit Exclusion	Insulin Glargine	Quetiapine
Oxycodone	Anticonvulsants		Sofosbuvir/velpatasvir	Ibuprofen
Quetiapine	Miscellaneous		Buprenorphine/ naloxone	Omeprazole
Dextroamphetamine/ amphetamine	Antidepressant Agents		Lisdexamfetamine	Fluticasone
Oxycodone/ acetaminophen	Insulin		Elexacaftor/ tezacaftor/ivacaftor	Buprenorphine/ naloxone
Omeprazole	Opioid Analgesics		Methylphenidate	Montelukast

* This table has been developed and formulated using weighted averages to reflect the relative beneficiary size of each reporting State.

11. Who in your state has responsibility for monitoring compliance with the oral counseling requirement?
    Section 1927(g)(A) of the Social Security Act (the Act) requires that the pharmacist offer patient counseling at the time of dispensing.

Figure 30 – Monitoring Oral Counseling Requirements

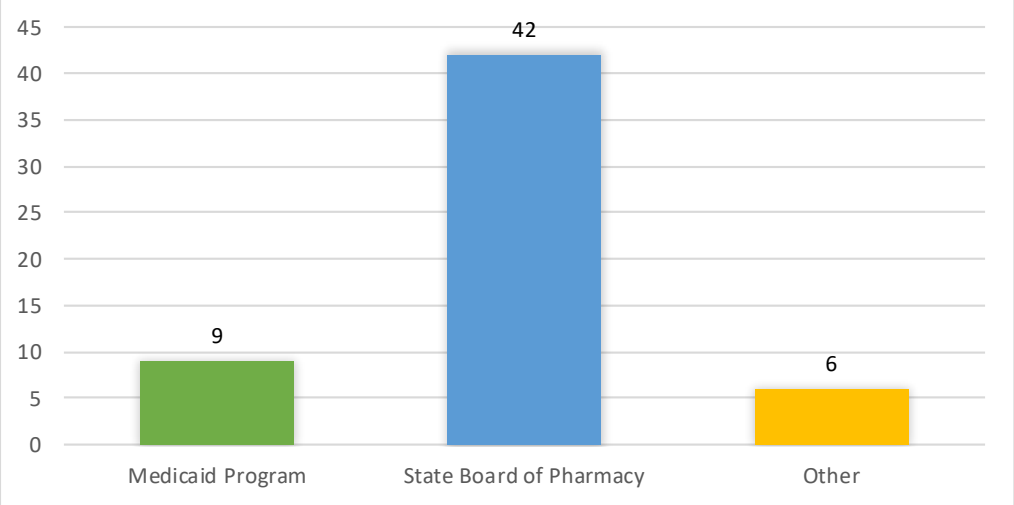

Table 41 – Monitoring Oral Counseling Requirements

Response	States	Count	Percentage
Medicaid Program	Alaska, Colorado, Connecticut, Florida, Hawaii, Kansas, Michigan, Minnesota, South Carolina	9	15.79%
State Board of Pharmacy	Alabama, Alaska, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	42	73.68%
Other	Illinois, Maine, Missouri, New York, Tennessee, Washington	6	10.53%
Total		57	100.00%

If "Other," please explain

Table 42 - "Other" Explanations for Monitoring Oral Counseling Requirements

State	"Other" Explanations
Illinois	The Illinois Department of Financial and Professional Regulation (IDFPR) licenses pharmacists in the State of Illinois and the IDFPR pharmacy inspectors during the course of pharmacy inspections evaluate compliance with the requirement for prospective drug regimen review and counseling. IDFPR inspectors report findings to the State Board of Pharmacy which disciplines pharmacists and pharmacies.
Maine	ATTACHMENT 1 PHARMACY ORAL COUNSELING COMPLIANCE REPORT The Maine Board of Pharmacy, in coordination with Maine Medicaid promulgated patient counseling regulations in STATUTORY AUTHORITY: 32 M.R.S.A. 13720, 13721(1), 13722, 13723, 13784. The Maine Board of pharmacy is the controlling authority over the patient counseling regulations of OBRA '90 for the MaineCare program. The Board of Pharmacy inspects pharmacies and measures compliance with patient counseling requirements. All consumer complaints or disciplinary actions regarding patient counseling are forwarded directly to the Maine Board of Pharmacy. The State's Department of Program Integrity supplements this process in its on-site visits for appropriate record keeping when conducting claims auditing with involved non-compliance with MaineCare Benefits Manual (MBM), Chapter II, Section 80.07-6F: Upon dispensing the prescription in person, the pharmacy provider must obtain a signature verifying receipt from the member or person picking up the prescription. 392 MAINE BOARD OF PHARMACY Chapter 25: PATIENT COUNSELING Summary: This chapter sets forth the pharmacist's obligation to counsel patients. 1. New Prescription Drug Orders With each new prescription dispensed, the pharmacist shall: 1. Review Review the individual's patient profile for the following potential drug therapy problems: A. Therapeutic duplication; B. Drug disease contraindications when such information has been provided to the pharmacist; C. Drug interactions; D. Incorrect drug dosage or duration; E. Drug allergy interactions; and F. Clinical abuse or misuse. 2. Explain Orally explain to the patient or the authorized agent of the patient the directions for use and any additional information, in writing if necessary, to assure the proper utilization of the

medication or device prescribed. Such explanations may include, but are not limited to, the following:

A. Name and description of the medication;
B. Dosage form, dosage, route of administration and duration of therapy;
C. Special directions, precautions for the preparation, administration and use by the patient;
D. Common significant side effects, adverse effects of interactions, and therapeutic contraindications;
E. Techniques for self monitoring;
F. Proper storage;
G. Refill information; and
H. Actions in the case of missed dosages.

For prescriptions which are not supplied directly to the patient or to the caregiver responsible for administering the medication or device to the patient, the pharmacist shall make the required counseling available to the patient through access to a telephone service which is toll-free for long distance calls.

2. Refill Prescription Drug Orders

With each refill prescription dispensed, the pharmacist shall offer to counsel the patient on the medication or device being dispensed, or to review with the patient the clinical information provided with the initial dispensing. This offer may be made in the manner determined by the professional judgment of the pharmacist, and may include any one or more of the following:

1. Face-to-face communication with the pharmacist or designee;
2. A notation affixed to or written on the bag in which the prescription is dispensed;
3. A notation contained on the prescription container; or
4. Telephone conversation.

The offer to counsel may be made by a designee of the pharmacist, but only the pharmacist may counsel the patient.

3. Refusal to Accept Counseling

Nothing in this chapter shall be construed as requiring a pharmacist to provide counseling when the patient, the patient's caregiver or the authorized agent of the patient refuses to accept counseling. The pharmacist shall document the refusal.

4. Documentation of Intervention

The pharmacist shall record in the patient profile any significant intervention in the patient's medication utilization that has occurred, in the judgment of the pharmacist, as a result of the counseling required by this chapter.

5. Patients in Hospital or Institution

State	"Other" Explanations
	The obligation to perform or offer counseling set forth in Section 1(2) and Section 2 of this chapter does not apply to those prescriptions for patients in hospitals or institutions where the medication is to be administered by a nurse or other individual licensed to administer medications or to those prescriptions for patients who are to be discharged from a hospital or institution. 6. Opiate Treatment Programs The obligation to perform or offer counseling set forth in Section 1(2) and Section 2 of this chapter does not apply to prescriptions for opiate agonist treatment medications dispensed at an opioid treatment program licensed by the board pursuant to Chapter 36 of the board's rules. The dispensing pharmacist shall discharge the pharmacist's statutory obligation to offer counseling in connection with new prescriptions by ensuring that written directions for use and other information relating to proper utilization of the medication prescribed are included with each new prescription delivered by the opioid treatment program. The written information must include a telephone number at which the pharmacist in charge may be contacted by patients. STATUTORY AUTHORITY: 32 M.R.S.A. 13720, 13721(1), 13722, 13723, 13784 EFFECTIVE DATE: November 8, 2004 - filing 2004-527 AMENDED: March 11, 2012 filing 2012-70 December 11, 2013 filing 2013-311
Missouri	The Missouri Medicaid Audit and Compliance Unit monitors compliance with the oral counseling requirement.
New York	The State Education of New York through the Office of Professional Discipline which performs routine periodic onsite inspections has the responsibility for monitoring compliance.
Tennessee	State B of P is checked as pharmacy must offer consultation with every new prescription in the state of Tennessee, and there is a corresponding responsibility for the PBM vendor to also be responsible, as the PBM manages the provider network. Within the provider agreement between the pharmacy providers and the PBM, the pharmacy providers agree to follow all State and Federal Laws, and therefore the PBM is responsible to ensure that providers are following State and Federal Law.
Washington	Pharmacy Quality Assurance Commission (PQAC) of Washington State is responsible for monitoring compliance for oral counseling.

Section III - Retrospective DUR (RetroDUR)

1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.

Figure 31 – Type of Vendor Performing RetroDUR Activities

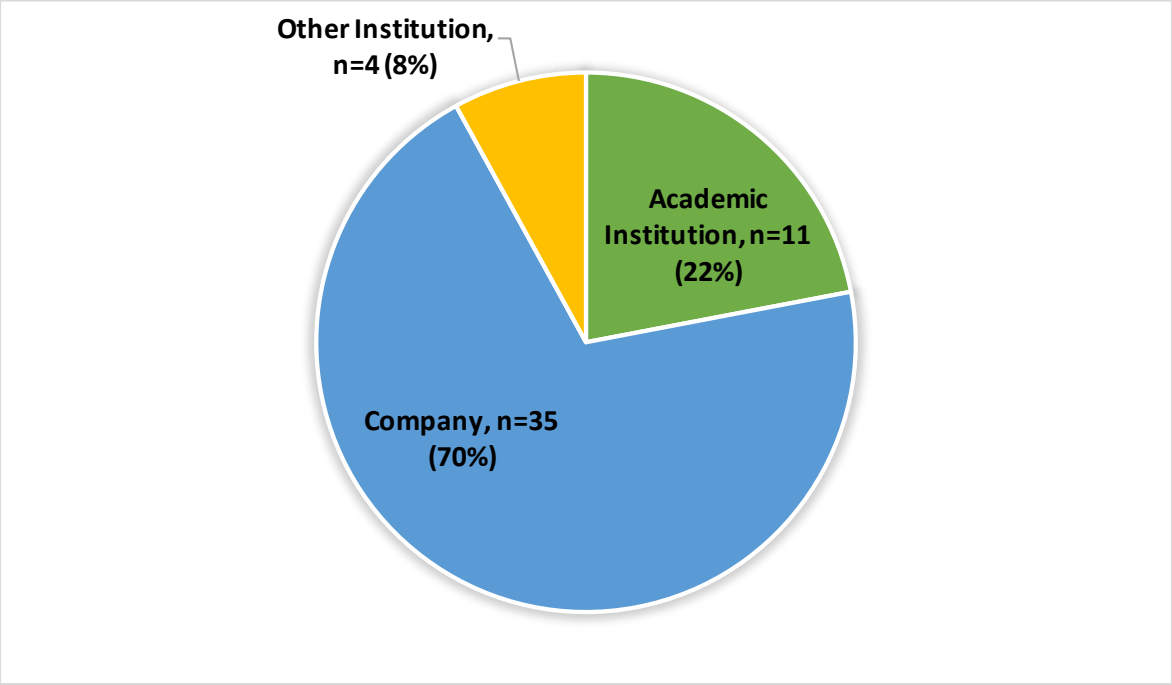

Table 43 – Type of Vendor Performing RetroDUR Activities

Response	States	Count	Percentage
Academic Institution	California, Colorado, Illinois, Massachusetts, Mississippi, Oklahoma, Oregon, South Carolina, Utah, West Virginia, Wyoming	11	22.00%
Company	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Wisconsin	35	70.00%
Other Institution	Hawaii, Montana, Nebraska, Washington	4	8.00%
Total		50	100.00%

a. Identify, by name, your RetroDUR vendor.

Table 44 - Vendor Names

Response	States	Count	Percentage
Health Information Designs	Alabama, Connecticut, New York, South Dakota, Wisconsin	5	14.29%
Magellan	Alaska, Florida, Idaho, Kentucky, Michigan, New Hampshire, Virginia	7	20.00%
Health Information Designs (Until 6/30/2020) and Magellan RX Management (Beginning 7/1/2020)	Arkansas	1	2.86%
Gainwell Technologies	Delaware	1	2.86%
Conduent	District of Columbia, Minnesota, Missouri, New Mexico, Texas	5	14.29%
Northstart Healthcare Consulting	Georgia	1	2.86%
OptumRx	Indiana, Nevada	2	5.71%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	14.29%
Kepro	Kansas, North Dakota	2	5.71%
DXC Technology	Louisiana, New Jersey	2	5.71%
Health Information Designs/Kepro	Maryland	1	2.86%
Magellan Medicaid Administration, through subcontract with GDIT	North Carolina	1	2.86%
KEPRO	Rhode Island	1	2.86%
Magellan and OptumRx	Tennessee	1	2.86%
Total		35	100.00%

Table 45 - Academic/ "Other" Institution Names

State	Academic/ "Other" Institution Name
California	University of California, San Francisco (UCSF)
Colorado	The Regents of the University of Colorado School of Pharmacy
Hawaii	State and Conduent State HealthCare LLC
Illinois	University of Illinois College of Pharmacy staff and Change Healthcare RetroDUR for other reviews
Massachusetts	University of Massachusetts Medical School
Mississippi	MS-DUR, University of Mississippi School of Pharmacy
Montana	Mountain Pacific Quality Health Foundation
Nebraska	Nebraska Medicaid DHHS
Oklahoma	University of Oklahoma College of Pharmacy: Pharmacy Management Consultants (PMC)
Oregon	Oregon State University, College of Pharmacy, Drug Use Research & Management (DURM) Program
South Carolina	MUSC/Magellan
Utah	University of Utah Drug Regimen Review Center (DRRC) and Utah Medicaid Pharmacy team
Washington	Health Care Authority
West Virginia	West Virginia Retrospective Pharmacy DUR Coalition- Marshall University
Wyoming	University of Wyoming, School of Pharmacy

b. Is the RetroDUR vendor the Medicaid Management Information System (MMIS) fiscal agent?

Figure 32 – Is RetroDUR Vendor the State MMIS Fiscal Agent

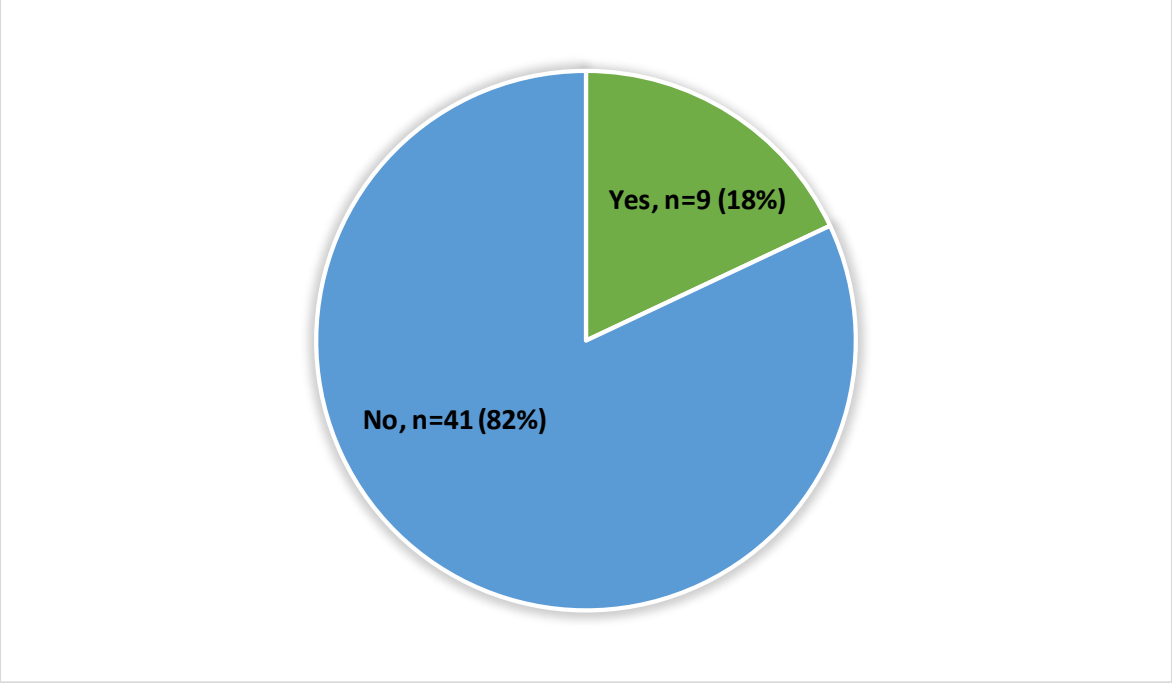

Table 46 – Is RetroDUR Vendor the State MMIS Fiscal Agent

Response	States	Count	Percentage
Yes	Delaware, District of Columbia, Hawaii, Nebraska, New Jersey, New Mexico, South Carolina, Virginia, Washington	9	18.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, Wyoming	41	82.00%
Total		50	100.00%

c. Is the RetroDUR vendor also the developer/supplier of your retrospective DUR criteria?

Figure 33 – Is RetroDUR Vendor the Developer/Supplier of RetroDUR Criteria

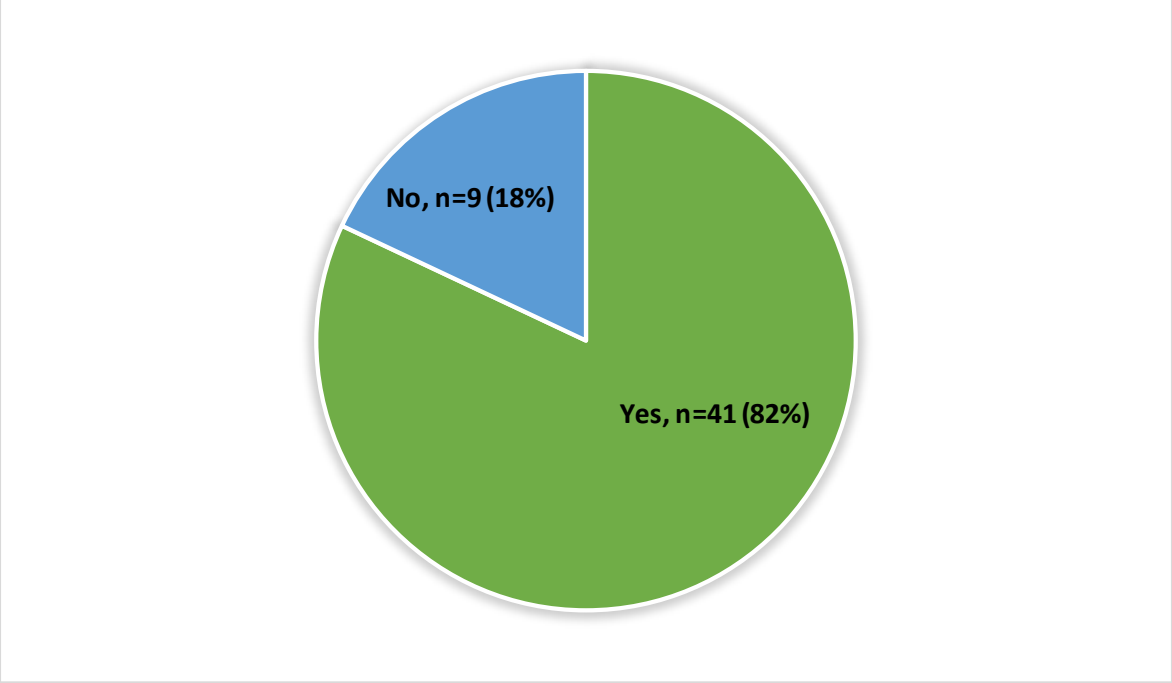

Table 47 - Is RetroDUR Vendor the Developer/Supplier of RetroDUR Criteria

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	82.00%
No	California, Florida, Hawaii, Idaho, Louisiana, Nebraska, Pennsylvania, South Carolina, Utah	9	18.00%
Total		50	100.00%

Please explain "Yes" or "No," response.

Table 48 - Explanations for why the RetroDUR Vendor is or is not the Developer/Supplier of Retrospective DUR Criteria

State	Explanations
Alabama	Health Information Designs develops and maintains RDUR criteria for AL Medicaid.
Alaska	Magellan has both predefined and customizable reports for retrospective reviews.

State	Explanations
Arkansas	Retrospective DUR criteria is developed by the RetroDUR vendor. Possible RetroDUR criteria is presented to the DUR Board quarterly for a approval of monthly criteria for the next quarter. The State Medicaid pharmacy program requests ad hoc criteria as well.
California	Retrospective DUR criteria are developed jointly by UCSF and DHCS with input and recommendation by the DUR board. Final approval of criteria is made by DHCS.
Colorado	Initial draft criteria are developed each quarter by faculty at the University of Colorado Skaggs School of Pharmacy (the vendor) then finalized in collaboration with the State's clinical pharmacist team prior to DUR Board review.
Connecticut	The RetroDUR vendor is the developer/supplier of the retrospective DUR criteria. Criteria is supplied and reviewed by the DUR Board on a quarterly basis.
Delaware	Gainwell provides both services for the State of Delaware
District of Columbia	Conduent develops retrospective DUR criteria rules and criteria for the District's review and approval on a monthly basis ans as requested by the DUR Board.
Florida	The developer of the retrospective DUR criteria is provided by the State DUR Board in collaboration with the Agency.
Georgia	The RetroDUR vendor is the developer/supplier of the retrospective DUR criteria.
Hawaii	In conjunction with the State the RetroDUR program is tailored to the current covered population.
Idaho	The Medicaid Pharmacy Staff Clinical Pharmacists develop the retrospective DUR criteria with input from the DUR Board and P&T Committee as necessary.
Illinois	ChangeHealthcare provides the RetroDUR program that identifies participants every 2 months who have potential medication related issues to address with the prescriber. Prior authorization and Medication Review and Academic Detailing staff review the issues and notify the prescriber, providing education as needed to ensure appropriate prescribing. Pharmacists from the University of Illinois College of Pharmacy identify issues/criteria for drug-focused retrospective drug utilization review with input from the DUR Board.
Indiana	OptumRx presents proposed retro-DUR criteria, Dear Dr. Letters, and Newsletters to the DUR Board for review and approval prior to implementation.
Iowa	Change Healthcare utilizes MediSpan for retrospective DUR criteria involving a complex screening process for member profile reviews (conducted 4 times per year). The DUR Board discusses RetroDUR educational initiatives and provides input as to what data points are needed for further discussion and potential outreach to providers.
Kansas	In addition to state required RDUR analyses, the RetroDUR vendor evaluates pharmacy and medical claims data against a library of clinical criteria for potential patient safety and provider education needs.
Kentucky	N/A
Louisiana	Retrospective DUR criteria are developed through collaboration of pharmacists at LDH, DXC technology, and the University of Louisiana-Monroe.
Maine	This is discussed as part of the RetroDUR process with the DUR committee to get consensus on initiatives and parameters around the RetroDUR.
Maryland	The RetroDUR vendor presents new criteria to the DUR Board at quarterly meetings for the Board to review and vote if it should be added to the monthly monitoring cycle. Additionally, the DUR Board must approve any educational interventions proposed by the RetroDUR vendor.
Massachusetts	The RetroDUR vendor develops, implements and maintains the DUR criteria.
Michigan	Magellan has a catalog of RetroDUR criteria from which the DUR Board can select as needed for various topics.

State	Explanations
Minnesota	Conduent's criteria is reviewed by the DUR Board.
Mississippi	In coordination with the DUR Coordinator pharmacist in the DOM office of pharmacy, the vendor, MS-DUR develops and maintains the retro-DUR criteria on behalf of the state.
Missouri	The vendor creates the criteria and presents their proposed criteria to the state and DUR Board for review/approval.
Montana	The RetroDUR vendor is our DUR Board Coordinator. They work with the State and DUR Board to develop retrospective DUR criteria.
Nebraska	DHHS is vendor
Nevada	The DUR Board provides topics and reviews but does not approve final initiatives.
New Hampshire	Magellan maintains an extensive database of retrospective DUR activities that may be implemented for the NH FFS population. Approximately 200 activities are summarized and presented with an estimate of impacted members, impacted prescribers, and total payment amount for medications within the intervention. The DUR board selects activities from the list or recommends topics for development and implementation by Magellan. These activities are implemented over the preceding 6 months and are summarized at the next DUR meeting.
New Jersey	DXC Technology clinical staff assist with the development of DUR criteria, which is recommended by the DURB/State prior to implementation.
New Mexico	Conduent develops and supplies the retrospective DUR criteria based on state-specific needs and DUR Board member requests.
New York	HID maintains a comprehensive list of approved criteria that all claims are run against each month. The criteria include drug/drug interactions, drug/disease contraindication and precautions, overutilization, underutilization, disease state management, and cost savings. Criteria are defined as minor, moderate, or severe according to medical literature. The number of pharmacies and physicians a patient sees is taken into consideration with each drug-related problem. Criterion are added, deleted, or modified per instructions from the Clinical Review Board. Additions and changes are presented to the committee each quarter for approval. All drug classes must be reviewed periodically for the addition of new drugs and new drug-drug interactions, precautions, and contraindications. RetroDUR activity is also performed by Academia on an ad hoc basis. When performed in this manner findings needing attention may be brought to the DUR Board for review and final action where appropriate..
North Carolina	The RetroDUR vendor supplies criteria, but the DUR Board and the Division of Health Benefits also recommends criteria.
North Dakota	Kepro develops the criteria and the state and DUR Board review the criteria before implementing.
Ohio	Change Healthcare develops the RetroDUR criteria and receives recommendations from the DUR Committee and Board and approval from the State.
Oklahoma	PMC develops, implements, and maintains the RetroDUR criteria in collaboration with the Oklahoma Health Care Authority (OHCA) and/or the DUR Board. In relation to RetroDUR activities, PMC clinical pharmacists complete calls and send letters and faxes to prescribers, perform academic detailing in person or virtually with prescribers, and complete prescriber and member newsletter articles. PMC clinical pharmacists also review the RetroDUR criteria and present the results to the DUR Board at the monthly DUR Board meeting.
Oregon	DURM evaluates drugs, conducts drug class reviews, and performs drug use and policy evaluations based on sound evidence-based research and processes widely accepted by the medical profession. These evidence summaries and drug use evaluations are presented to the DUR Board/P&T Committee and inform the recommendations for management of the PDL and

State	Explanations
	clinical prior authorization criteria. Recommendations are aimed to encourage safe, effective, and innovative drug policies that promote high value medications for patients served by the Oregon Health Plan (OHP). DURM also publish and distribute educational information to prescribers and pharmacists regarding the committee activities and the drug use review programs.
Pennsylvania	The state agency's clinicians and DUR Board develop the RetroDUR criteria.
Rhode Island	KEPRO runs the DUR Board meetings and develops the RetroDUR criteria with the board's approval.
South Carolina	Currently the State is contracted with MUSC (Medical University of South Carolina) for initiatives which focus primarily on opioids, while the State continues efforts to restructure the DUR board. Magellan continues to focus on Compound Claims, which has identified opportunities regarding coding, policy/language and processes (ketogenic diets/coordination with prescribers).
South Dakota	Criteria are supplied by Health Information Designs.
Tennessee	We listed both PBM's because Tennessee went through a PBM Vendor change on 1/1/2020 from Magellan to OptumRx. The PBM is the supplier of retrospective DUR, however the ideas and suggestions may be from the State, the DUR Board and other sources.
Texas	Conduent uses Cyberformance, a web-based tool, in order to conduct clinical analysis of drug therapy and disease states using both pharmacy and medical claims data. This method allows clinical issues affecting thousands of members to be addressed without the need to individually review each profile. The retrospective criteria are reviewed by the Texas DUR Board prior to implementation. To allow for development of physician outlier profiles based on the number of beneficiaries who are receiving sub-optimal therapy, the Prescribing physicians who treat only one or two members flagged for intervention are filtered. This approach produces a large multiplier effect for a single intervention.
Utah	The Retro-DUR criteria are developed by the Medicaid Pharmacy team and implemented jointly by the Medicaid Pharmacy Team and the Universiy of Utah DRRC.
Vermont	The RetroDUR vendor Change Healthcare develops a list of Retrospective DUR criteria in collaboration with the state of Vermont and the DUR Board. DUR Board votes on topic of interest as well as makes suggestions to the design and implementation of the Retro DUR topics.
Virginia	The Magellan Clinical Team develops new clinical criteria for all new DUR drugs. The clinical criteria then gets discussed and reviewed at the Virginia DUR Board meetings. After discussion at the DUR Board meetings the Board will make updates if needed and then approve for implementation.
Washington	RetroDUR criteria is developed by the Health Care Authority and approved by both the State DUR Board and the Health Care Authority. Some activities included as RetroDUR are initiated and completed by other program sections within the Health Care Authority and are not approved by the State DUR Board; examples of these activities include Program Integrity activities and provider oversight resulting in provider education or care gap analysis that include a pharmacy component but are not solely pharmacy based.
West Virginia	The vendor offers suggestions for RetroDUR interventions that are presented at our DUR board meetings. The members will vote and rank the offered suggestions and the vendor will implement the top choices and create criteria by working with the RetroDUR board and BMS clinical staff.

State	Explanations
Wisconsin	Health Information Designs, LLC (HID) is responsible for Wisconsin's retrospective DUR criteria. Each month HID evaluates pharmacy claims data against criteria for several hundred potential drug therapy issues. Standard criteria are developed by HID with any customizable applications presented to the DUR Board for approval and implementation.
Wyoming	Retrospective criteria is developed by the DUR Manager.

d. Does your state customize your RetroDUR vendor criteria?

Figure 34 – Does State Customize RetroDUR Vendor Criteria

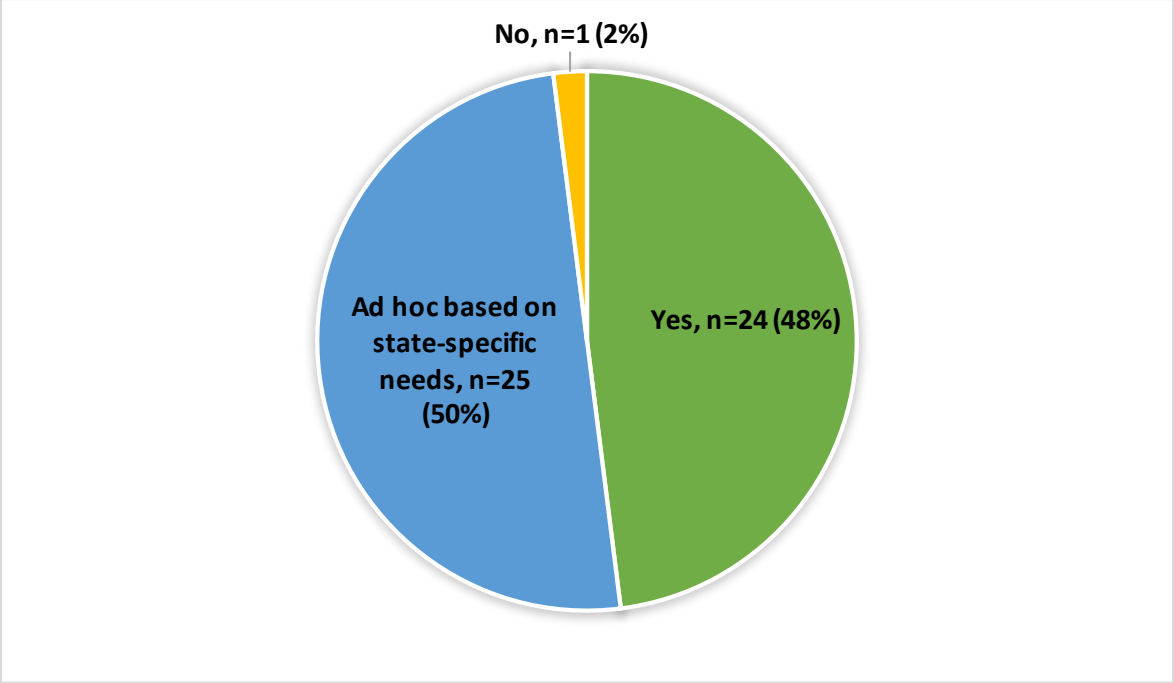

Table 49 - Does State Customize RetroDUR Vendor Criteria

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Connecticut, Indiana, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, West Virginia	24	48.00%
Ad hoc based on state-specific needs	Alaska, Arkansas, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Mississippi, New Mexico, New York, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, Wisconsin, Wyoming	25	50.00%
No	Nebraska	1	2.00%
Total		50	100.00%

2. How often does your state perform retrospective practitioner-based education?

Figure 35 – Frequency of State Performed Retrospective Practitioner-Based Education

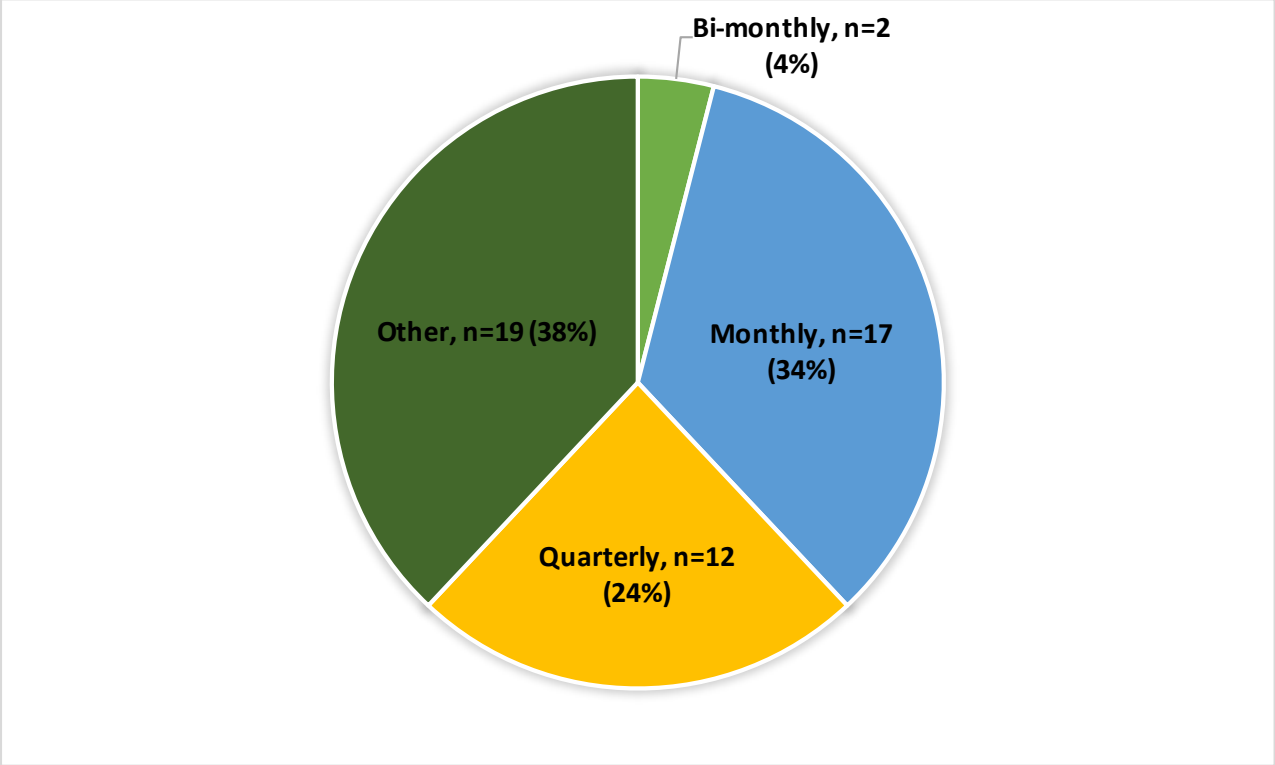

Table 50 - Frequency of State Performed Retrospective Practitioner-Based Education

Response	States	Count	Percentage
Bi-monthly	Nebraska, Oregon	2	4.00%
Monthly	Arkansas, Connecticut, Louisiana, Massachusetts, Michigan, Mississippi, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Virginia	17	34.00%
Quarterly	Alabama, Alaska, Colorado, District of Columbia, Georgia, Kentucky, Maine, Minnesota, Missouri, New Mexico, Tennessee, Wyoming	12	24.00%
Other	California, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Nevada, New Jersey, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	19	38.00%
Total		50	100.00%

If "Other," please specify.

Table 51 - "Other" Explanations for Frequency of State Performed Retrospective Practitioner-Based Education

State	"Other" Explanations
California	Practitioner-based education is performed at least on a quarterly basis and more frequently as needed.
Delaware	Delaware sends out retroDUR letters that are generated weekly based on DUR criteria that has been established by the DUR Board members. Additionally, we send out blast faxes and the prescriber notifications on an ad hoc basis.
Florida	Retrospective practitioner based education is determined by the DUR Board in collaboration with the Agency and can occur at varying intervals depending on topic discussion.
Hawaii	Ad hoc per current RetroDUR project with quarterly provider bulletin for a medical providers as a supplement.
Idaho	Depending on the outreach, it can vary from monthly to quarterly.
Illinois	Practitioner-based education may occur as part of the prior authorization process. After completion of RetroDUR 300 evaluation and after a focused retrospective review practitioner education may be done and is targeted to individual patients or an individual drug issue. Retrospective review may identify need for an educational item that would benefit all prescribers. That educational item is either prepared or a link to pertinent publicly available materials is posted on the DUR Board Education page. The posted information may be shared with prescribers when pertinent during the PA process.
Indiana	OptumRx provides practitioner-based education at least twice per year and no more often than quarterly.
Iowa	Education is provided two times annually through the DUR newsletter and other education through provider specific letters as issues arrise.
Kansas	The frequency varies, depending on specific RDUR requirements given in state policy and also requirements set in vendor contract(s).
Maryland	The RetroDUR vendor performs retrospective practitioner based educational interventions depending on the criteria and direction from the DUR Board. For the reporting perioid, there were one-time, monthly and quarterly interventions performed.
Nevada	Ad hoc
New Jersey	Practitioner based education is performed on an ongoing basis based on patient specific retrospective review.
South Carolina	Varies by intervention- typically quarterly, at a minimum.
Texas	There is no set frequency for mailing educational letters. Per the program requirement, vendor must perform seven to ten retrospective interventions per year. Proposed intervention criteria and the educational letters that receive approval by the DUR Board, are mailed out within 1-3 months.
Utah	Practitioner-based education is an ongoing process that is integrated into day to day activities.
Vermont	The frequency of Retrospective practitioner-based education depends on the topic and outcome of the Retro DUR analyses.
Washington	Retrospective practitioner-based education occurs on an ad hoc basis based on state specific needs or as a result of provider oversight activities.
West Virginia	We hold monthly meeting where the RetroDUR board reviews patient profiles and sends letters to physicians when appropriate. The RetroDUR vendor also puts out a quarterly educational newsletters that is posted on our site for clinicians to view.
Wisconsin	Some retrospective practitioner-based education letters are completed monthly, quarterly and on an as needed basis (i.e., development of newsletters).

a. How often does your state perform retrospective reviews that involve communication of client specific information to healthcare practitioners (through messaging, fax, or mail)? Check all that apply.

Figure 36 – Frequency of State Performed Retrospective Reviews involving Communication of Client-specific Information to Healthcare Practitioners

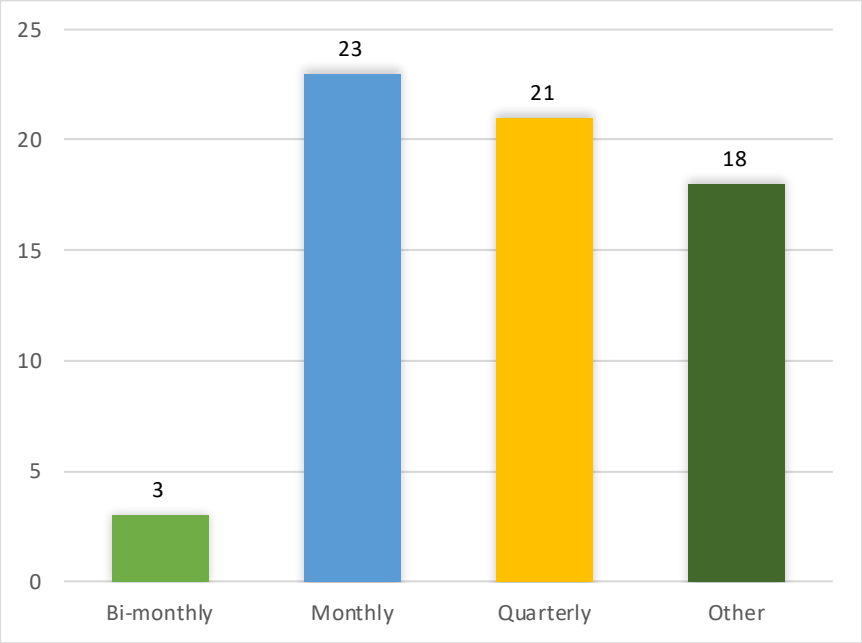

Table 52 – Frequency of State Performed Retrospective Reviews involving Communication of Client-specific Information to Healthcare Practitioners

Response	States	Count	Percentage
Bi-monthly	Illinois, Maine, Utah	3	4.62%
Monthly	Arkansas, Connecticut, District of Columbia, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Hampshire, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, Wyoming	23	35.38%
Quarterly	Alabama, Alaska, Colorado, District of Columbia, Georgia, Idaho, Iowa, Kentucky, Maine, Maryland, Minnesota, Missouri, Nevada, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Utah, Wisconsin, Wyoming	21	32.31%
Other	Arkansas, California, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Nebraska, New Jersey, Oregon, South Carolina, Texas, Utah, Vermont, Washington, Wyoming	18	27.69%
Total		65	100.00%

If "Other," please specify.

Table 53 - "Other" Explanations for Frequency of State Performed Retrospective Reviews involving Communication of Client-specific Information to Healthcare Practitioners

State	"Other" Explanations
Arkansas	The DUR Board reviews multiple criteria options during each quarterly meeting provided by the RetroDUR vendor. The DUR Board narrows the criteria options down to one or two criteria per month. Medicaid clients are analyzed with the DUR Board voted criteria by the RetroDUR vendor. Clients identified through the analysis prompt patient specific communication to be mailed to the specific providers.
California	Retrospective reviews that involve communication of client specific information to healthcare practitioners are performed at least on a quarterly basis and more frequently as needed.
Delaware	Delaware sends out retroDUR letters that are generated weekly based on DUR criteria that has been established by the DUR Board members. We also send out messaging on an ad hoc based on specific DUR Board request .
Florida	Retrospective communication is determined by the DUR Board in collaboration with the Agency and can occur at varying intervals depending on topic discussion.
Hawaii	Ad hoc per current RetroDUR project.
Idaho	Depending on the outreach, it can vary from monthly to quarterly.
Illinois	Upon completion of RetroDUR 300 evaluation and adhoc based on focused retrospective reviews client-specific information may be shared. If staff review of the RetroDUR 300 identified issue does deem the problem requires prescriber outreach, information is not shared.
Indiana	OptumRx provides retrospective reviews at least twice per year and no more often than quarterly.
Kansas	The frequency varies, depending on specific RDUR requirements given in state policy and also requirements set in vendor contract(s). For FFY 2020, there were two provider RDUR reviews that led to communication of client specific information to healthcare practitioners.
Nebraska	Whenever needed
New Jersey	Practitioner based education is performed on an ongoing basis based on patient specific retrospective review.
Oregon	Retrospective reviews that involve communication of client specific information to healthcare practitioners are faxed weekly.
South Carolina	Quarterly initiatives are planned, which include mailings, sometimes paired with Academic Detailing, resources and CE via the tipSC webiste, as well as presentations at academic meetings/conferences.
Texas	With each retrospective intervention package mailed, individual client's claims information is included.
Utah	Practitioner-based education is an ongoing process that is integrated into day to day activities. Additionally, there are quarterly/monthly newletters and ad hoc communication delivered en masse for provider udates.
Vermont	The frequency of Retrospective practitioner based education that is client-specific depends on the topic and these are customized to the specific outcome of the retrospective review. In general we identify clients when it's helpful to providers in effecting a change in therapy. In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. The Board then determines if follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers. In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected,

State	"Other" Explanations
	prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file.
Washington	Retrospective reviews that involve communication of client specific information to practitioners occurs on an ad hoc basis based on state specific needs or as a result of provider oversight activities and care gap analysis.
Wyoming	Prescription Drug Monitoring Program letters are sent weekly.

b. What is the preferred mode of communication when performing RetroDUR initiatives? Check all that apply.

Figure 37 – Preferred Mode of Communication When Performing RetroDUR initiatives

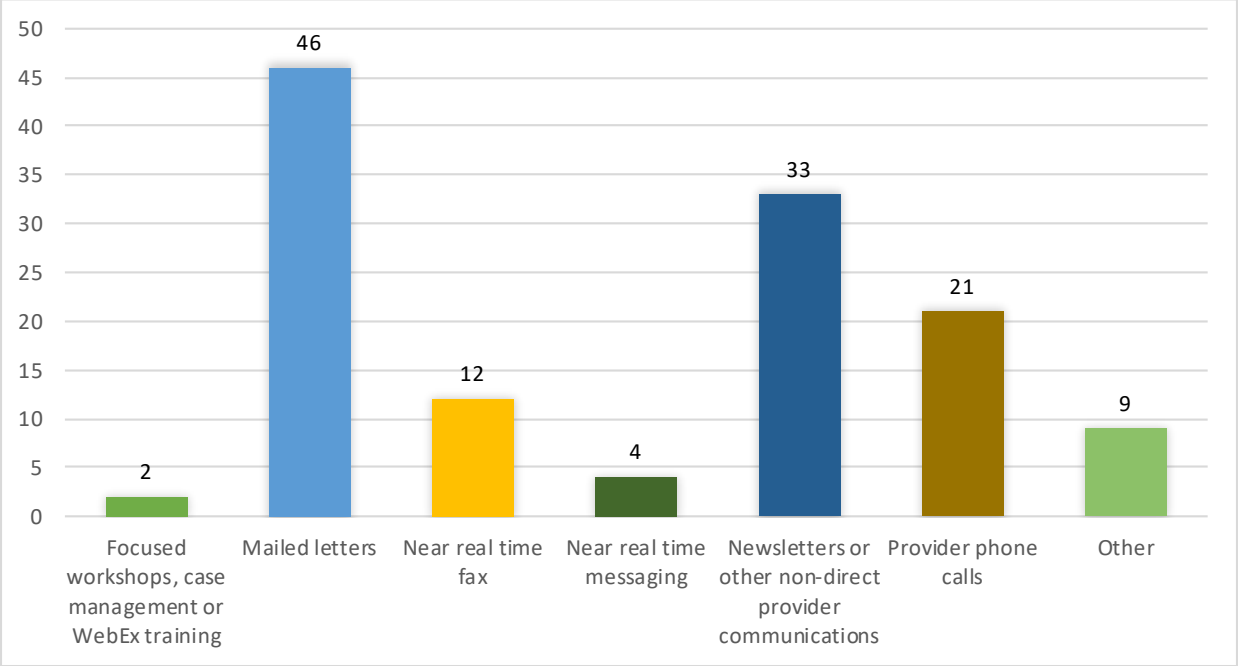

Table 54 – Preferred Mode of Communication When Performing RetroDUR initiatives

Response	States	Count	Percentage
Focused workshops, case management or WebEx training	Florida, South Carolina	2	1.57%
Mailed letters	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina,	46	36.22%

Response	States	Count	Percentage
	North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
Near real time fax	Arkansas, Georgia, Illinois, Indiana, Massachusetts, Nebraska, New Jersey, Oklahoma, Oregon, South Carolina, Washington, West Virginia	12	9.45%
Near real time messaging	Florida, Massachusetts, Nebraska, Washington	4	3.15%
Newsletters or other non-direct provider communications	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Utah, Vermont, West Virginia, Wisconsin, Wyoming	33	25.98%
Provider phone calls	Alaska, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Massachusetts, Michigan, Montana, Nebraska, New Jersey, Ohio, Oklahoma, South Carolina, Utah, Vermont, Washington, Wisconsin	21	16.54%
Other	Hawaii, Illinois, Michigan, New Mexico, North Carolina, Ohio, South Carolina, Vermont, Washington	9	7.09%
Total		127	100.00%

If "Other," please specify.

Table 55 - "Other" Explanations for Preferred Mode of Communication When Performing RetroDUR initiatives

State	"Other" Explanations
Hawaii	State or fiscal agent pharmacist directly contacts the billing pharmacy by phone and email.
Illinois	For educational materials- posting on DUR Board Education page.
Michigan	office visits
New Mexico	Email and/or Fax
North Carolina	Mailed letters are our primary mode of communication for RetroDUR activities, but we also use the Medicaid monthly newsletter as well as direct communications through the NCTracks provider portal.
Ohio	Faxes
South Carolina	Mode of communication varies by initiative. During the Issue No.9: Acute Non-Cancer Pain Treatment consisted of 661 mailings and resulted in the completion of 3 practitioners providing 0.5 CME hours. Another initiative around naloxone "Pharmacists Edition: Naloxone can save a life," included 960 mailings with 52 Academic Detailing Visits conducted by MUSC pharmacy students on community pharmacy rotations. Subsequent CME activity (0.5hrs) was obtained by 9 practitioners. Conferences provide another platform/method of communication. Opioid Use Disorder : Overview, Screening, Diagnosis and Treatment was presented during the 7th Rural Communities Opioid Response Consortium Meeting to 40 providers during the February 2020 meeting. During the

State	"Other" Explanations
	February 20, 2020 MUSC Dental Alumni CME Conference in Charleston, "Opioid Epidemic from a Dental Prospective" was presented to 65 attendees.
Vermont	Provider email, mail and Fax blasts to providers and pharmacies.
Washington	Meetings and outreach with Washington State professional and quality assurance boards, commissions, and associations.

3. Summary 1 – RetroDUR Educational Outreach Summary

Summary 1: RetroDUR Educational Outreach is a year-end summary report on retrospective screening and educational interventions. This year-end summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.

Table 56 - RetroDUR Educational Outreach

State	Retrospective DUR Educational Outreach
Alabama	1. Therapeutic Appropriateness - Appropriate Use of Opioids 2. Therapeutic Duplication - Duplicate Antipsychotic Therapy 3. Drug-Drug Precaution - SUPPORT Act of 2018 4. Overutilization - Overuse of Stimulants 5. Drug-Drug Precaution - SUPPORT Act of 2018 6. Therapeutic Appropriateness - Adverse Metabolic Effects 7. Overuse Precaution - Appropriate Use of Opioids 8. Therapeutic Appropriateness - Adverse Antipsychotic Effects 9. Therapeutic Appropriateness - Adverse Metabolic Effects 10. Drug-Drug Precaution - Appropriate Use Recipients Reviewed Recipients Selected for Intervention Letters Generated Letters Mailed Appropriate Use of Opioids 1,151 292 312 306 Duplicate Antipsychotic Therapy 525 12 15 15 SUPPORT Act of 2018 501 385 404 404 Overuse of Stimulants 472 348 366 363 SUPPORT Act of 2018 449 187 199 197 Adverse Metabolic Effects 289 207 219 214 Appropriate Use of Opioids 220 172 299 295 Adverse Antipsychotic Effect 217 31 37 37 Adverse Metabolic Effects 191 39 53 52 Appropriate Use of Opioid, Skeletal Muscle Relaxant, and Benzodiazepine 163 31 41 41 Totals 4,178 1,704 1,945 1,924
Alaska	General Information The Alaska Medicaid Drug Utilization Review (DUR) Committee was established to comply with Sec. 1927(g) of the Social Security Act, Title 42 CFR 456 and Alaska Administrative Code 7 AAC 120.120. Retrospective screening and educational interventions for FFY 2020 are summarized below: Highlighted Activities

State	Retrospective DUR Educational Outreach
	Opioid Morphine Equivalent Dose prescriber education; letters sent to providers; patient outreach; ongoing MME was reduced to 200 - Education runs concurrent with long-acting opioid PA requests and letters sent to providers with patients in excess of the established MME Opioids in combination with benzodiazepines and antipsychotics were continually reviewed by the DUR Board quarterly - Pharmacist level overrides were made available after consultation with the prescriber Benzodiazepines and sedative (Z-Drugs) - Letters sent to prescribers regarding potential overuse, misuse, interactions, and potentiation of other medications ICD-10 code requirement for stimulants in ages 21 and up - Monitoring for appropriate diagnosis and overutilization especially when taken with sedating medication Review of antipsychotics in children -Worked in collaboration with OCS in reviewing profiles and sending cases to pediatric psychiatry specialists for second level reviews Retrospective Drug Utilization Review (RetroDUR) The DUR Committee conducts retrospective reviews approximately once per quarter. The criteria for claims review is typically selected by the committee coordinator or suggested drug related issues by the committee members. For profile reviews, the committee evaluates a recipient's medication history for the criteria under review in addition to therapeutic duplications, drug interactions, overutilization, and poly-provider situations. Introduced starting in FFY2016, the utilization of FDA FAERS reports and the evaluation of impact on Alaska Medicaid beneficiaries has continued. RetroDUR issues are generally addressed with educational interventions such as prescriber letters or direct prescriber contact via phone. Additional means, such as web-based notices, newsletters, and email bulletins, were utilized for outreach. The logistics of face-to-face interactions with prescribers is difficult due to the large geography of the state and many communities have limited road access. The DUR Committee may also refer potential cases of overutilization or fraud, waste or abuse identified during the RetroDUR to the Care Management program and/or the Program Integrity unit.
Arkansas	Health Information Designs, LLC was the RetroDUR vendor for Arkansas Medicaid for most of FFY2020 (10/1/2019-6/30/2020). Magellan Rx Management became the RetroDUR vendor on 7/1/2020. REPORT FROM HEALTH INFORMATION DESIGNS, LLC: Criteria were developed by HID and presented to the Arkansas Medicaid Drug Utilization Review Board for approval and implementation. The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed

State	Retrospective DUR Educational Outreach

by members of the Arkansas Medicaid Retrospective Drug Utilization Review Committee to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. This approach provides prescribers and pharmacies with the information needed to fully review and evaluate each recipient's drug history.

Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle.

ARKANSAS EDUCATIONAL OUTREACH FFY 2020

RETROSPECTIVE DUR INTERVENTION SUMMARY:

TYPE	NUMBER	CRITERIA DESCRIPTION	# RECIPIENTS	# LETTERS	# RESPONSES
DD	3592	Opioid & Benzodiazepine Use	953	1,284	115
TA	5286	Proton Pump Inhibitors	849	863	73
DD	10203	Gabapentin and Opioids	450	710	4
DD	10890	Opioids and Antipsychotic Use	283	502	41
TA	3408	Benzodiazepine Use (Long-Term)	327	331	12
LR	1985	Underutilization of ARBs	182	122	7
LR	547	Underutilization of Lipid-Lowering	115	121	2
LR	8477	Underutilization of Levetiracetam	100	95	1
LR	1570	Underutilization of Aripiprazole	79	83	5
DD	10457	Inappropriate Use of IR Opioids	77	82	20
		Total Top 10	3415	4,193	280 (6.7%)
		Total all letters	4,611	5,885	584 (9.9%)

State	Retrospective DUR Educational Outreach

PROVIDER RESPONSES TO INTERVENTION LETTERS:
A total of 5,885 DUR educational intervention letters were mailed to prescribers during HID's covered timeframe of FFY2020, and 584 responses were received for a response rate of 9.9%. A summary of all coded responses from prescribers is listed in the table below.

Prescriber Response	Total
BENEFITS OF THE DRUG OUTWEIGHT THE RISKS	34
MD UNAWARE OF WHAT OTHER MD PRESCRIBING	9
PT IS NO LONGER UNDER THIS MD'S CARE	24
MD SAYS PROB INSIGNIF NO CHG THX	167
MD WILL REASSESS AND MODIFY DRUG THERAPY	34
MD TRIED TO MODIFY THERAPY, PT NON-COOP	12
PT UNDER MY CARE BUT NOT SEEN RECENTLY	17
PATIENT DECEASED	1
PATIENT WAS NEVER UNDER MD CARE	9
HAS APPT TO DISCUSS THERAPY	57
MD DID NOT RX DRUG ATTRIBUTED TO HIM.	28
AWARE OF INTERACTION, MONITORING PATIENT	1
TRIED TO MODIFY THERAPY, SX RECURRED	27
MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD	8
PHARMACY CAN'T PROVIDE MD INFORMATION	153
SPOKE TO MD, EXPECT MODIFICATION IN THER.	3
TOTAL OF ALL RESPONSES	584
Response Rate	9.9%

CONCLUSION
For HID's covered timeframe of FFY 2020, a total of 4,193 intervention letters for the top 10 criteria alerts were mailed to prescribers, with a response rate of 6.7%. There was also a 9.9% physician response rate for all criteria alerts, and 19% of prescribers who responded to the letters indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter. The estimated cost savings are calculated by looking at actual drug claims history for 85-150 days before intervention and 85-150 days following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between November 2019 and January 2020 there was an estimated cost savings of $193,378.

REPORT FOR MAGELLAN RX MANAGEMENT:
Criteria were developed by Magellan and presented to the Arkansas Medicaid Drug Utilization Review Board for approval and implementation. Magellan Rx Management routinely performs retrospective reviews on the prescribing and dispensing of outpatient prescription drugs to ensure that prescriptions are appropriate, medically necessary, and are not at risk of adverse medical outcomes. The DUR Board approves intervention criteria for active and ongoing

State	Retrospective DUR Educational Outreach
	educational outreach programs to educate practitioners, with the aim of improving prescribing or dispensing practices. RETROSPECTIVE DUR INTERVENTION SUMMARY: MONTH NUMBER CRITERIA DESCRIPTION # RECIPIENTS # LETTERS # RESPONSES 9/2020 7779 Opioids and Gabapentin- Concurrent use 520 556 8 9/2020 7946 Atypical Antipsychotics in Children ages 0-17 574 971 n/a 8/2020 8022 Two or more claims for Benzodiazepines in the recent 1824 2075 6 90 days without a SSRI or SNRI in the last 6 months. 7/2020 7982 Concurrent use of Opioids and Antipsychotics 319 665 10 Complete provider response and outcome from interventions from the Magellan Rx Management criteria are not available since the vendor had been in place for only 3 months at the end of FFY2020.
California	1. Global Initiative for Asthma (GINA) Guidelines: Educational alert published October 2019 to notify providers of the 2019 GINA Report that concluded there is sufficient evidence to recommend that adults and adolescents with asthma should receive either symptom-driven (in mild asthma) or daily ICS-containing treatment in order to reduce risk of serious exacerbations and asthma-related death. Provider letter sent January 2020 to inform health care providers of the updated GINA guidelines. A total of 346 letters were mailed to prescribers between January 16, 2020, and January 30, 2020, regarding Medi-Cal FFS beneficiaries in their practice with paid claims for short-acting beta2-agonists (SABAs) alone and a diagnosis of asthma. Beneficiaries were excluded from the mailing if they had medical claims for a condition that may complicate asthma treatment. Each prescriber was sent a letter that included the names and birthdates of the identified patient(s) in their practice, the Medi-Cal DUR alert on the GINA guidelines, and a provider survey. 2. Gabapentin: Educational bulletin published December 2019 to review the U.S. Food and Drug Administration (FDA) approved indications for gabapentinoids (gabapentin and pregabalin), described potential risks associated with combining gabapentin with opioids, and summarize best practices for responsible prescribing of gabapentin. Provider letter sent January 2020 to inform health care providers of the serious risks associated with gabapentin use. A total of 150 letters were mailed on January 30, 2020, to the top 150 prescribers of gabapentin (by total paid claims) in the Medi-Cal program. While these prescribers represented only 1.8% of all prescribers of gabapentin, they were responsible for over 10% of all prescriptions of gabapentin. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on gabapentin and a provider survey. The decision was made to send an additional letter to address patient-specific concomitant use of

State	Retrospective DUR Educational Outreach
	gabapentin and opioids, with special attention on those gabapentin claims as moderate (> 900 mg) or high (>1800 mg) average daily dose of gabapentin. 3. Additive toxicity (AT) alert provider letter sent January 2020 to 1) identify beneficiaries at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants; and 2) help inform health care providers and patients of the serious risks attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics. The study population included 29 beneficiaries who were continuously eligible in the Medi-Cal fee-for-service program between October 1, 2019, and January 31, 2020. Each beneficiary generated an AT alert with pharmacist override during December 2019 and had at least one paid claim for both an opioid and a benzodiazepine, as well as paid claims for at least two additional CNS depressants between October 1, 2019, and December 31, 2019. Those with claims with practice locations including SNF, ICF, home health, and hospice, and diagnostic codes indicating palliative care or cancer treatment were excluded. A total of 73 prescribers were identified for educational outreach letters, which were mailed on January 30, 2020. 4. Montelukast: Education bulletin published March 2020 in response to the U.S. Food and Drug Administration (FDA) announcement that it would be strengthening existing warnings about serious behavior and mood-related changes associated with montelukast. Provider letter sent April 2020 to inform health care providers of the possible risks associated with use of montelukast. A total of 223 letters were mailed on April 24, 2020, to the top 223 prescribers of montelukast (by total number of FFS patients prescribed montelukast during 2020) in the Medi-Cal program. While these prescribers represented only 3% of all prescribers of montelukast, they were responsible for 26% of all montelukast prescriptions to FFS patients. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on montelukast and a provider survey. 5. Ranitidine: Education bulletin published April 2020 in response to the U.S. Food and Drug Administration (FDA) announcement that it has requested a manufacturer's market withdrawal of ranitidine and ranitidine products will not be available for new or existing prescriptions or OTC use in the U.S. Provider letter sent May 2020 to inform health care providers about the immediate withdrawal of ranitidine from the US market and to offer health care providers alternate treatment options, including no treatment (when indicated). A total of 597 prescriber letters were mailed on May 8, 2020, regarding paid claims for 706 FFS beneficiaries with prescriptions for ranitidine active beyond April 1, 2020. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on ranitidine, patient name and date of birth, ranitidine claims data, and a provider survey. 6. Fluoroquinolone Antibiotics: Education bulletin published April 2020 described the recent U.S. Food and Drug Administration (FDA) drug safety communications for fluoroquinolones, identified potential adverse effects associated with use of fluoroquinolones, and summarized best practices for

State	Retrospective DUR Educational Outreach
	responsible prescribing of fluoroquinolones. Provider letter sent July 2020 to inform health care providers about the risks associated with fluoroquinolones and to offer health care providers alternate treatment options for uncomplicated UTI. Letters were mailed on July 10, 2020, to a total of 136 prescribers of fluoroquinolones for an uncomplicated UTI to at least two community-dwelling Medi-Cal FFS beneficiaries without documented allergies to other antibiotic medications or treatment failures since January 1, 2020. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on fluoroquinolones and a provider survey. 7. Clinical Guideline: Reproductive Health in Rheumatic and Musculoskeletal Diseases published May 2020 to notify providers that the American College of Rheumatology recently published the organization's first guideline on how to manage reproductive health issues in patients with rheumatic and musculoskeletal diseases (RMDs), including a review of medication use in men and women for preconception, and in women during pregnancy and while breastfeeding. 8. Concomitant use of gabapentin and opioids provider letter sent July 2020 to inform health care providers about the risks associated with concomitant use of gabapentin with opioids. Letters were sent on July 10, 2020, to 242 prescribers that prescribed concomitant gabapentin and opioids to at least two Medi-Cal FFS beneficiaries since January 1, 2020. For the purposes of this mailing, concomitant prescriptions were defined as paid claims filled at the same pharmacy on the same day prescribed by the same prescriber. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on gabapentin and a provider survey. 9. Clinical Review: 2020 Standards of Care for Treatment of Type 2 Diabetes educational bulletin published August 2020 and reviewed recommendations provided in the American Diabetes Association (ADA) Standards of Medical Care 2020 addressing the pharmacologic approach to glycemic control for patients with type 2 diabetes, described patient factors to consider when prescribing antihyperglycemic agents, and summarized the boxed warnings for antihyperglycemic agents. 10. 2020 Immunization Updates: Vaccination during COVID-19, Flu, HepA, and Tdap educational bulletin published September 2020 to provide updates on immunization guidelines, products, policy and/or research each year. Links to recommended immunization schedules for 2020 in the United States were also provided. The summary for 2020 included updates for influenza vaccine, Hepatitis A (HepA) vaccine, tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine, as well as a review of strategies to improve vaccination rates of children and adults during the COVID-19 pandemic and beyond.
Colorado	Interventional letters that contain patient-specific information are prepared and mailed on a quarterly basis. These letters tend to include rotating clinical topics such as high risk opioid prescribing, high risk benzodiazepine prescribing and high risk psychotropic prescribing in children. During FFY 2020 over 3,000

State	Retrospective DUR Educational Outreach
	interventional and educational letters were mailed to Colorado Medicaid prescribers. Q1 (Oct 1 to Dec 31, 2019) TOTAL 599 165 Opioid comparative letters 95 Children receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 339 Opioid plus BZD plus muscle relaxant Q2 (Jan 1 to Mar 31, 2020) TOTAL 967 165 Opioid comparative letters 95 Children receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 339 Opioid plus BZD plus muscle relaxant 309 Receiving 2 or more BZDs for 90 out of 180 days using most recent data 59 Immune Globulin informational letters Q3 (Mar 31 to Jun 30, 2020) TOTAL 818 120 Opioid comparative letters 88 Children receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 358 Opioid plus BZD plus muscle relaxant 252 Receiving 2 or more BZDs for 90 out of 180 days using most recent data Q4 (Jul 1 to Sep 30, 2020) TOTAL 642 83 Children receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 328 Opioid plus BZD plus muscle relaxant 231 Receiving 2 or more BZDs for 90 out of 180 days using most recent data
Connecticut	Executive Summary This report prepared for the Connecticut Medial Assistance Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2020. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 12,789 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary and a response rate of 16% was achieved for the top 10 criteria reviewed and a response rate of 13% was achieved overall for all interventions performed during FFY 2020. Program Background Health Information Designs, LLC (HID) currently provides RDUR services for the Connecticut fee-for-service Medicaid population as a subcontractor with DXC Technology. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria monthly to identify recipients with

State	Retrospective DUR Educational Outreach
	drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month HID evaluates Connecticut fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by HID and presented to the Connecticut Drug Utilization Review Board and DXC for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by a HID clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of educational outreach letters mailed for the top 10 retrospective DUR interventions based on number of letters mailed for FFY 2020. CRITERIA TYPE, CRITERIA DESCRIPTION, # OF CASES CREATED, # INTERVENTION LETTERS MAILED TO PRESCRIBERS, # PRESCRIBER RESPONSES LI, Connecticut lock-in (LI) criteria, 1268, 3544, 453 TA, Our records indicate your patient is receiving a proton pump inhibitor (PPI) chronically. PPIs are very effective agents but are not without adverse effects, especially with long-term use. The agents have been associated with increased risk of Clostridium difficile, bone fractures, vitamin B-12 deficiency, hypomagnesemia, fund gland polyps, and hospital- and community-acquired pneumonia. Consider the risks and benefits of proton pump inhibitor therapy and fully inform patients of side effects before prescribing., 2432, 2420, 268 DD, The concurrent use of an opioid with an antipsychotic may cause hypotension, profound sedation, respiratory depression, coma, and death. Because of these risks, reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. If co-administration is required, consider dosage reduction of one or both agents. The SUPPORT Act of 2018 requires that Medicaid monitor the concurrent use of opioids and antipsychotics., 856, 1669, 241

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	DD, Co-administration of opioids and benzodiazepines should be done with extreme caution as the combination may result in respiratory depression, hypotension, profound sedation, coma, and death. If concurrent administration is clinically warranted, consider dosage reduction of one or both agents. Re-evaluate the patient's treatment plan on a regular basis to determine the necessity for continued concomitant use of these agents. The SUPPORT Act of 2018 requires that Medicaid monitor the concurrent use of opioids and benzodiazepines., 827, 1268, 214 TA, The use of antibiotics during the first year of life has been associated with an increased risk of developing childhood asthma. The risk increases with the use of multiple courses of antibiotics and the use of broad-spectrum antibiotics. The risk may be reduced by the judicious and appropriate prescribing of antibiotics, particularly avoiding the use of broad-spectrum cephalosporins., 735, 820, 291 TA, The effects of prolonged use of atypical antipsychotics in pediatric patients are unknown. Preliminary evidence suggests that pediatric patients experience more prevalent and severe adverse effects than those reported in adults (e.g., weight gain, extrapyramidal side effects, and insulin resistance). If therapy with these agents is clinically necessary, use the lowest effective dose and observe patients closely for adverse events. If adverse effects cannot be controlled, consider switching, if clinically possible, to a second-generation antipsychotic with a more favorable adverse effect profile. The SUPPORT Act of 2018 requires that Medicaid monitor antipsychotic prescribing for children., 762, 780, 103 TA, The Connecticut DCF Psychotropic Medication Monitoring Guidelines recommend that all children and adolescents on an SSRI should have follow-up every 3 months for height, weight, BMI/BMI percentile, blood pressure and pulse., 643, 644, 124 TA, Immediate-release opioids should be reserved for pain severe enough to require opioid treatment for which alternative treatment options such as non-opioid analgesics are inadequate or not tolerated. These agents expose patients to the risks of opioid addiction, abuse, and misuse, potentially harmful interactions, and adverse effects on the endocrine system. Prolonged use of immediate-release opioids in pregnant women can also result in NOWS (neonatal opioid withdrawal syndrome)., 576, 638, 96 TA, All children and adolescents on stimulant medications should have routine follow-up studies and monitoring every 3 months for blood pressure, pulse, weight, height, and BMI/BMI percentile. , 491, 520, 176 TA, The safety and efficacy of sertraline for the treatment of depression, panic disorder, PTSD, PMDD, or social anxiety disorder have not been established in the pediatric population. Sertraline is approved in pediatric patients 6 years of age and older for obsessive compulsive disorder (OCD). Anyone considering the use of sertraline in a child or adolescent must balance the potential risks with the clinical need., 488, 486, 97 , Total Top 10, 9,078, 12,789, 2,063 , Total all letters for all criteria, 19,284, 23,799, 3,158 LI-Lock In, DD-Drug Drug, TA-Therapeutic Appropriateness Prescriber Response Tabulation

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	In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments. Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 12,789 DUR educational intervention letters were mailed for the top 10 interventions to prescribers during FFY 2020, however, a total of 23,799 letters were mailed for all interventions performed during FFY 2020. 3,158 responses were received during FFY 2020 for a total response rate of 13%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response, Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS, 284 MD UNAWARE OF WHAT OTHER MD PRESCRIBING, 61 PT IS NO LONGER UNDER THIS MD's CARE, 185 MD SAYS PROB INSIGNIF NO CHG THX, 1,358 MD WILL REASSESS AND MODIFY DRUG THERAPY, 184 MD TRIED TO MODIFY THERAPY, PT NON-COOP, 66 PT UNDER MY CARE BUT NOT SEEN RECENTLY, 128 PATIENT DECEASED, 2 PATIENT WAS NEVER UNDER MD CARE, 36 HAS APPT TO DISCUSS THERAPY, 356 MD DID NOT RX DRUG ATTRIBUTED TO HIM., 210 TRIED TO MODIFY THERAPY, SX RECURRED, 101 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD, 186 SPOKE TO MD, EXPECT MODIFICATION IN THERAPY, 1 Total responses for FFY 2020, 3,158 Response Rate, 13% Conclusion The top 10 interventions to prescribers were conducted for the Connecticut Medical Assistance Program population during FFY 2020 which resulted in 9,078 cases created, 12,789 prescriber letters mailed, and 2,063 responses received. The response rate for the top 10 interventions, was 16% during FFY 2020.
Delaware	For FFY 2020, Delaware Medicaid continued to operate under a Medicaid Management Information System (MMIS) and third-party vendor contracts. Delaware used its improved electronic drug utilization review process and a concurrent review functionality that accounts for both pharmacy and medical claim types in the drug utilization review process for the Fee for Service (FFS) program. Delaware FFS retrospective screening and educational interventions continue to benefit the providers, members, and state by providing a more complete picture of drug utilization issues to improve health outcomes while ensuring continued financial sustainability.

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	During FFY 2020, the State continued to closely monitor and prioritized outreach to assist in educating providers on safe opioid prescribing. For example, auto-generated letters were sent to 337 providers in FFY 2020 to alert providers of high dose warnings and drug-drug interactions. Of note, , educational outreach to providers began in the Fall 2019 that was in accordance with the DUR requirements of the SUPPORT Act. These letters alerted providers of combinations of opioid-antipsychotic, opioid-muscle relaxant, opioid-benzodiazepine, as well as opioid-sedative combinations. Often these combinations were being provided by multiple prescribers who may have been unaware of the patient's other prescribers and medications. DE's goal is that by increasing awareness of these interactions, the State hopes to increase patient safety, increase coordination of care, and decrease adverse outcomes in this population. Moreover, providers continue to be notified when their patients reached the threshold of greater than 90 MME on opioid pharmacy prescriptions. Another method through which Delaware utilizes RetroDUR to improve client health and fiscal responsibility is through targeted provider outreach. Channels used include blast faxes to pharmacies, bulletins to providers, and notifications on our webpage. For example, Delaware sent out a blast fax to pharmacies reminding them of the naloxone protocol for dispensing, and the zero patient cost for this rescue medication.
District of Columbia	SUMMARY The District of Columbia DUR Board conducts monthly clinical reviews of patient profiles for retrospective DUR screening and interventions. At least 300 patient profiles are presented at each DUR Board Meeting during the program year. During this program period, 11 months of data was reviewed and profiled for intervention mailings to providers. The DUR Board selected several population-based clinical interventions to focus on recurring drug therapy issues encountered during individual patient profile reviews. The top DUR clinical interventions and their clinical analysis are listed below with the results. Diabetes Management: This intervention is designed to determine opportunities for improving the quality and safety of drug therapy for patients with type II diabetes mellitus following the American Diabetes Association (ADA) 2018 clinical practice recommendations. Indicator #1: Increased Risk of Adverse Drug Events with Non-insulin Antidiabetics Certain medical conditions may predispose patients receiving non-insulin antidiabetic agents to adverse drug events. Candidates (denominator): All patients receiving non-insulin antidiabetic agents in the last 30 days. Exception Criteria (numerator): Candidates with a history of a comorbid condition in the last 2 years that places them at increased risk of a serious adverse event (Table 2). (Defined as a severity level 1 drug disease interaction by First Databank).5 Indicator #2: Underutilization of Angiotensin-Modulators in Diabetics with Kidney Disease

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	In patients with diabetes, clinical studies have shown that ACE inhibitors reduce major cardiovascular disease outcomes and angiotensin receptor blockers (ARBs) can slow the rate of progression of microalbuminuria to advanced nephropathy and end-stage renal disease (ESRD).1,2,6 Guidelines from the American Diabetes Association and Kidney Disease Outcomes Quality Initiative recommend the use of an ACE inhibitor or ARB in non-pregnant diabetic patients with hypertension or albuminuria > 30mg/g.7 Candidates (denominator): All patients with a diagnosis of diabetes (ICD-10 code or inferred from drug therapy) in the last 2 years and kidney disease (submitted ICD-10 code required), who do not have a documented contraindication or relative contraindication to angiotensin-modulating therapy (i.e., anuric renal failure, renal artery stenosis, pregnancy or a history of angioneurotic edema). Exception Criteria (numerator): Candidates not receiving an angiotensin-modulating agent (ACE inhibitor or ARB) in the past 1 year. Indicator #3: Underutilization of Antilipemics Clinical studies have shown that the HMG-CoA reductase inhibitors consistently reduce ASCVD events in patients with coronary heart disease. Current treatment guidelines, based on these studies, identified certain groups of individuals who are most likely to benefit from HMG-CoA reductase inhibitor therapy, particularly at appropriate intensity of HMG-CoA reductase inhibitor therapy. One such group is diabetic patients. See Tabel 3 for recommendations on high and moderate Intensity statin therapy .1,2,8 . Candidates (denominator): All patients with a diagnosis or drugs indicative of diabetes in their medical and pharmacy claims history: Age 40-75 Diabetes Antidiabetic therapy No claims for Welchol (colesevelam) in the past year Exception Criteria (numerator): Candidates who did not receive an HMG-CoA reductase inhibitor in the past year and have no contraindications to HMG-CoA reductase inhibitor therapy Indicator #4: Underutilization of Metformin A consensus statement from the ADA and the European Association for the Study of Diabetes recommends early intervention with metformin in combination with lifestyle changes.1,9 This recommendation is based upon metformin's effect on glycemia, absence of weight gain or hypoglycemia, generally low level of side effects, high level of acceptance, and relatively low cost. Furthermore, the UKPDS demonstrated a beneficial effect of metformin therapy on cardiovascular disease9. The consensus statement recommends that patients should be titrated, as tolerated, to a dose of at least 850mg twice daily of metformin to realize the benefits of therapy. Candidates (denominator): All patients with type 2 diabetes without contraindications to metformin. Patients who have been treated exclusively with insulins for the past year will be excluded. Exception Criteria (numerator):

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	Candidates who meet any of the following criteria: 1) History of an antidiabetic in the last 90 days, but no history of metformin in the past year. 2) History of metformin therapy in the past year but no history of metformin therapy in the past 90 days. 3) Metformin dose <1500 mg/day on the most recent claim. Indicator #5: Underutilization of Antiplatelets The American Diabetes Association recommends the use of aspirin therapy (75-162 mg/d) as a primary prevention strategy in diabetic individuals at high-risk for CVD and as a secondary prevention strategy in diabetic individuals with a history of CVD. Other antiplatelet agents (e.g., clopidogrel) are recommended alternatives for patients who are not candidates for aspirin therapy (e.g., contraindications, allergy). 1,2 Candidates (denominator): All patients 18 years of age or older with a history of diabetes (submitted ICD-10 diagnosis code for diabetes or inferred from drug therapy) in the last 2 years. Exception Criteria (numerator): Candidates meeting any of the following criteria: 1) History of antiplatelet therapy in the last year, but no claim in the last 90 days. 2) History of antiplatelet therapy in the last year with < 60 days of therapy in the last 90 days. 3) History of CVD (diagnosis or procedure) in the last 2 years without antiplatelet therapy in the last 45 days. 4) Males > 45 to 79 years or Females > 55 to 79 years of age and at least one risk factor (listed below) in the last year without antiplatelet therapy in the last 45 days. Risk factors include: hypertension (diagnosis or inferred from drug therapy), hyperlipidemia (diagnosis or inferred from drug therapy), family history of CVD, albuminuria, or history of smoking. Indicator #6: Nonadherence with Non-insulin Antidiabetics, Antihypertensives, and Antilipemics Adherence with prescribed maintenance drug regimens is paramount to successful patient outcomes. Because of the various complications associated with diabetes, such as dyslipidemia and hypertension, many diabetic patients are receiving multiple medications, thus increasing the risk of non-adherence.1,2 Candidates (denominator): All patients with diabetes in the last 2 years receiving chronic non-insulin antidiabetic, antihypertensive, and/or antilipemic drug therapy in the most recent 45 days and 90 to 135 days ago (identify chronic therapy). Exception Criteria (numerator): Candidates who received less than a 60-day supply of the medication during a 90-day period. Indicator #7: Duplicate Therapy with Non-insulin Antidiabetics and GLP-1 Agonist/DPP-4 Inhibitor Combination Combination therapy with diabetes medications with complementary mechanisms of action is often required for adequate glycemic control. However, duplicate within-class drug therapy has not been shown to increase efficacy and may increase the risk of adverse drug events, particularly if coordination of care

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	issues play a role. GLP-1 agonists and DPP-4 inhibitors are not FDA-approved for use in combination with one another, nor do treatment guidelines recommend use of the combination. There is no solid evidence to support the use of these drugs together.1,2 Candidates (denominator): All patients receiving sulfonylureas, thiazolidinediones, meglitinides, alpha-glucosidase inhibitors, DPP-4 inhibitors, GLP-1 agonists, or SGLT2 inhibitors in the past 90 days. Exception Criteria (numerator): Candidates receiving multiple sulfonylureas or multiple thiazolidinediones or multiple meglitinides or multiple alpha-glucosidase inhibitors or multiple DPP-4 inhibitors or multiple GLP-1 agonists or multiple SGLT2 inhibitor in the past 60 days. Candidates will also include individuals receiving a GLP-1 agonist and a DPP-4 inhibitor in combination in the past 60 days. Polypharmacy Management This population-based mailing intervention was undertaken as a quality management program to assist in caring for beneficiaries using multiple drug therapies. Patients who receive multiple medications are at an increased risk of drug-drug or drug-disease interactions, duplicate or unnecessary therapy, non-adherence, and hospitalization. Improvements in communication between providers and better coordination of care may lessen potential problems. A reduction in the number of medications taken per patient can result when multiple drug therapy regimens are brought to the attention of the prescriber(s). Indicator #1: Increased Risk of Adverse Drug Event: Receipt of 10 to 19 medications within a 30-day time frame Multi-drug therapy regimens may be necessary to treat certain medical conditions. However, all multi-drug therapy regimens merit periodic review to minimize potential risk or development of drug related problems. Communication with other providers about potential concerns should be undertaken when necessary. Candidates (denominator): All patients 18 years of age and older with pharmacy claims activity within the most recent 30 days. Antibiotics are excluded. Exception Criteria (numerator): Candidates receiving 10 to 19 medications within the most recent 30-day time frame. Clinical Results: The targeted patient population was seeing 5.9 providers, receiving 12.2 prescriptions per month, and taking an average of 17.4 intervention-related drugs at baseline. Overall, the clinical indicator decreased by 27% in the target group over the six-month intervention period. The post-intervention period was November 2019 to April 2020. This intervention bridged two consecutive fiscal years, FY19 and FY20.
Florida	RetroDUR Educational Outreach Summary 1. Post impact analysis of opioid and benzodiazepine hard edit to monitor therapy appropriateness and safety a. The DUR Board voted to create a hard edit denying concomitant therapy at the point of sale following a provider educational campaign. The edit deployed on 11/20/19. The DUR Board reviewed the post impact of the edit during the

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	June 2020 DUR Board meeting. The DUR Board approved concomitant therapy criteria. 2. Recipients with overlapping stimulant and benzodiazepine claims to monitor therapeutic appropriateness, overutilization, and safety a. The DUR Board reviewed the post impact of the hard edit during the April 2020 DUR Board meeting and approved concomitant therapy criteria at the June 2020 DUR Board meeting. 3. Recipients utilizing more than one Dipeptidyl peptidase-4 (DPP-4) inhibitor, Glucagon-like peptide-1 (GLP-1) agonist, or the two concomitantly to monitor therapeutic duplication a. The edit denies claims if a recipient is utilizing more than one DPP-4 or more than one GLP-1 or a combination of both within 90 days. The pharmacist may override first claim denial; however, subsequent claim requests will require a prior authorization. During the December 2019 DUR Board meeting, the DUR Board reviewed the post impact data. 4. Recipients using more than two antipsychotic therapies to monitor therapeutic appropriateness, overutilization, and safety a. The DUR Board voted to implement an edit to limit a recipient to two antipsychotics of the same chemical entity. The third antipsychotic requires a clinical prior authorization. The DUR Board reviewed the post impact of the edit during the June 2020 DUR Board meeting and determined that no further action is needed. 5. Review utilization of non-benzodiazepine sedatives including concomitant use with opiates to monitor safety a. The DUR Board voted to create a hard edit for concomitant therapy. The edit deployed on 11/20/19. The DUR Board reviewed the post impact of the edit during the June 2020 DUR Board meeting and approved concomitant therapy criteria. 6. Overutilization of selected topical products and review of off-label usage to monitor therapeutic appropriateness, overutilization, and safety a. The DUR Board voted to implement an automated prior authorization on all formulations of Calcipotriene for age, diagnosis, and duration of therapy and the DUR Board voted to create an automated prior authorization for Doxepin 5% cream to include diagnosis. The DUR Board reviewed the post impact results during the March 2020 DUR Board meeting. 7. Review concomitant utilization of opiates and antipsychotics to monitor safety a. In response to the SUPPORT Act, the Agency implemented a soft edit to deny claims at the point of sale requiring pharmacist intervention to enter DUR codes for payment. The DUR Board reviewed the post impact during the April 2020 DUR Board meeting. 8. Review pancreatic enzyme utilization based on FDA approved indication to monitor therapeutic appropriateness and overutilization a. The DUR Board voted to implement an automated prior authorization including an FDA diagnosis look back. The DUR Board reviewed the post impact data during the September 2020 DUR Board meeting and determined no further action is necessary.

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	9. To determine overall utilization of Lyrica and off-label usage to monitor therapeutic appropriateness and safety a. The DUR Board reviewed off-label use and concomitant use with opiates. During the June 2020 DUR Board meeting, the DUR Board voted for an automated prior authorization based on FDA approved indications. 10. To review short acting (SA) opiate utilization since the increased access to buprenorphine/naloxone products and various opiate edits to monitor overutilization and safety a. Given the opioid epidemic the Agency in conjunction with the DUR Board and P&T Committee have made steps to increase access to opioid dependency treatment and curb abuse. The DUR Board reviewed SA opiate utilization trends from January to June for years 2017, 2018, and 2019. There was a successful decline in SA opiate utilization over the review period.
Georgia	1. Use of High Dose Opioids and Alert of Change in Opioid Quantity Limits -In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published guidelines for the use of opioids in chronic, non-cancer pain in 2016. In the Guidelines for Prescribing Opioids for Chronic Pain, the CDC recommends careful justification for titrating opioid doses above an average of 90 morphine milligram equivalents (MME) per day to avoid potential overdose. In an effort to reduce the risk of opioid-related harms while preserving access to appropriate pain treatment, Georgia Medicaid Fee-For-Service (FFS) will be implementing a prior authorization for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day. -Opioid prescribing continues to decrease quarter-over-quarter. 2. Newsletter on REMDESIVIR FOR TREATMENT OF 2019 NOVEL CORONAVIRUS (SARS-COV-2). 3. Newsletter on THERAPEUTIC RECOMMENDATIONS FOR THE 2019 NOVEL CORONAVIRUS (SARS-COV-2) 4. Newsletter on VACCINES TO PREVENT 2019 NOVEL CORONAVIRUS (SARS-COV-2) INFECTION
Hawaii	With the current FFS population limited to organ and tissue transplant and intentional termination of pregnancy (ITOP) as well as the dental program, retrospective drug utilization review (RDUR) screening was based on new and updated laws and regulations. Educational interventions were in the form of provider memorandums and reminders in provider bulletins for all providers. They are as follows: 1. SUPPORT Act minimum standards; 2. Quantity prescribed indicators for point of sale (POS) claims processing; 3. Hawaii Revised Statute 329-38(c) initial opioids fills concurrent with benzodiazepines have a quantity maximum set at a 7 day limit; 4. Hawaii Revised Statute 329-38.2 exceptions to the requirement of No prescriber shall prescribe a schedule II, III, or IV controlled substance without first requesting, receiving, and considering records of the ultimate user from the state electronic prescription accountability system (also known as PDMP) as needed to reduce the risk of abuse of or addiction to a controlled substance, as needed to

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	avoid harmful drug interactions, or as otherwise medically necessary: end of life, terminal disease treatment in hospice or other types of palliative care; less than or equal to 3 days supply from emergency room or post-op pain or prescribed while the state PDMP is nonfunctional; 5. Setting 120 morphine milligram equivalents (MME), calculation of MME and chronic pain guidance per CDC; 6. End of Life drug treatment policy (known as Our Care, Our Choice Act) using 100% state funds; and 7. National Average Drug Acquisition Cost (NADAC) as basis of drug reimbursement. These RDUR are in addition to our usual manual RDUR for expensive claims payment, eligibility, medical necessity and outliers. Little to no claims were found in these areas. Of note are the following: 1. Hawaii Revised Statute 329-38.2 had impact on the dental program as post-operative pain treatment: RDUR was on MME, prescribing trends by location, outliers and specialty, patient location, age, and diagnosis and pharmacy locations. Prospective DUR and provider education in form of provider memorandums will be implemented in FFY2021, driven by FFY2020 RDUR findings. Changes to the formulary, quantity limits and days supply will occur. 2. RDUR post NADAC implementation found no impact on prescriber, dispenser or patient access. Cost savings were identified for brands and generics. 3. Patient profile review for medical necessity identified a possible change of eligibility from FFS to and MCO. One claim was not corrected by the pharmacy. Phone and email contact with the pharmacy were initiated in FFY2021. 4. Total drug spend increased due to Hawaii Medicaid's first and only Zolgensma prescription (65% of FFS drug spend). FFS paid for the MCO's patient's drug. RDUR is the responsibility of the MCO as FFS does not have access to the claims data.
Idaho	Butalbital Migraine Medications: Effective June 1, 2019, Prior Authorization was required for all butalbital containing medications. A quantity limit of 12 tablets per 30 days was also instituted. This allowed the opportunity for the Idaho clinical pharmacists to have discussions with prescribers of butalbital and the appropriate use of the medication. Naloxone Utilization: All States and DC have passed legislation increasing naloxone access. Naloxone access laws that grant authority to pharmacists to dispense naloxone have been associated with reduced fatal opioid overdoses. Most recent Idaho Statute July 1, 2019, 54-1733B Opioid Antagonists stated that any Health Professional licensed or registered under this title (Pharmacist or Pharmacy Technician) may prescribe and dispense an opioid antagonist to: A person at risk of experiencing an opiate-related overdose, A person in a position to assist a person at risk of experiencing an opiate-related overdose, A person who, in the course of his official duties or business may encounter a person experiencing an opiate-related overdose, A person who, in the opinion of the health professional licensed or registered under this title, has valid reason to be in the possession of an opioid antagonist. A Pharmacist Educational Intervention Letter was sent out for high risk identified patients, addressed to Pharmacist in

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	Charge which provided a brief background information on opioid overdose statistics, risk factors to help identify appropriate patients to receive naloxone, an instructional video link for naloxone administration, English and Spanish Naloxone Brochures, Emphasized that Idaho Medicaid will pay if they dispense to Patient, Family Member, Caregiver, Close Friend and stated How to bill Medicaid: emphasizing NO COPAY, and provided a List of Specific Patients, MID# and Current Opioid prescriptions, and a response form (offered, dispensed, refused, etc.). Benzodiazepines and Opioids: Idaho Medicaid Clinical Pharmacists are working with an identified 44 patients who had >= 300 MME opioids and overlapping days of benzodiazepines to slowly and safely taper patients down on both opioids and benzodiazepines. Typical prior authorization approvals are for 1-6 months depending on the taper schedule. Deprescribing Benzodiazepines: The Pharmacy and Therapeutics Committee in Idaho recommended that interventions should be divided into two main areas: initial therapy and continuation of long-term therapy for current utilizers. Initial prescriptions should be for bridging treatment for anxiety disorders while waiting for maintenance treatment with an SSRI or an SNRI to take effect. Long-term therapy for anxiety disorders should be limited to small quantities for as needed treatment for acute anxiety episodes. Beginning August 17, 2020, Idaho Medicaid participants who have not received benzodiazepines within the previous 6 months will be limited to a 14 day supply and those over that will require a PA and work will begin with the Idaho Clinical Call Center Pharmacists on alternatives. Vimpat Cardiac Rhythm and Conduction Abnormalities: 22 educational letters were sent out to prescribers for patients who were taking Vimpat along with a beta blocker or a calcium channel blocker warning of the risks and asking if the patient had an ECG done while on both medications. Antipsychotics and Opioids: Educational letter to prescribers and pharmacies for patients who received opioids with any length of antipsychotics along with a list of their panel of identified patients were sent out.
Illinois	Retrospective reviews and related educational efforts conducted throughout FFY20 are summarized below. One-on-one provider discussion and faxes continued as strategies to address appropriate medication use. Antipsychotic use in children. State Fiscal Year 2020 antipsychotic utilization in FFS Youth in Care children under age 18, atypical antipsychotic use in children less than 8 years of age as well as antipsychotic FFS and MCO utilization in non Youth in Care children and non Third party insurance FFS children 8 through 17 years of age was reviewed. Currently FFS has quantity limits, high dose edits, and prior authorization (PA) requirements for use in children less than 8 years of age, Youth in Care children, long acting injectable atypical antipsychotics, and antipsychotic use in longterm care facilities. DocAssist review and peer to peer consultation are available for prescribers of mental health medications in children. The DUR Board prescribers recommended adding metabolic parameters (glucose, lipids, weight)

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	and DocAssist availability for consultation to the PA form rather than an educational item because providers are now inundated with emails and continuing education opportunities. Minimally the last 2 weights would facilitate identifying an increasing trend and need for further monitoring and management since being overweight can be a risk marker for diabetes and hyperlipidemia. Further review of antipsychotic polypharmacy in children 8 through 17 years of age was recommended. Opioids with sedative hypnotics. Concomitant chronic opioid and sedative hypnotic utilization in FFS and MCO populations from July through December 2019 was reviewed. Three to 5 percent of chronic opioid users (3 or more 30 day prescription claims) were filling concomitant sedative-hypnotic therapy. The lower than expected use may be due to the allowance of only 8 sedative-hypnotic units per month as well as cash payment for sedative hypnotics beyond the allowed quantity. The DUR Board members recommended working with ILPDMP to determine the scope of concomitant utilization including cash payments. Montelukast monotherapy/steroid containing inhaler prescriber intervention. Prescriber outreach encourages steroid inhaler use in adults with only asthma who are receiving montelukast monotherapy. Impact of the montelukast education with corticosteroid prescription forms sent from April 2018 through February 2020 on steroid inhaler prescribing was evaluated. Steroid inhaler fills after the letter occurred in approximately 41% of participants who had not previously filled any steroid inhalers. About 42% of participants with previous low steroid inhaler use (less than 12 inhalers ever) and 47% of those with previous higher steroid inhaler use (13 or more inhalers ever) filled more steroid inhalers after letter receipt. As the number of steroid inhaler fills increased, fewer montelukast fills were evident. It was too early to see impact of the form on prescribing of spacer devices that were added to the form in November 2019. Prescriber outreach continued in FFY20. From November through February, 10 letters were sent to prescribers. The 83% decrease from FFY19 in numbers of letters sent was due to COVID pandemic-related temporary lift of the Four Prescription Policy that generates montelukast PA requests. Concomitant opioid utilization. Concomitant use of opioids with benzodiazepines or antipsychotics from May through August 2019 was reviewed in the combined HFS FFS and MCO population. Concomitant opioid and benzodiazepine therapy. About 20% of participants were filling concomitant benzodiazepine and opioid therapy. High alprazolam use was noted. The DUR Board recommended prescriber outreach for benzodiazepine naive chronic opioid users prescribed a benzodiazepine. Prescribers of concomitant benzodiazepine and opioid therapy can be considered for academic detailing visits. It was recommended to require prior authorization for co-prescribing a benzodiazepine and opioid, using a look-back period of 90 days for drug-naive participants. A benzodiazepine and opioid drug interaction hard edit was implemented in FFY20. During the prior authorization process for concomitant benzodiazepine and opioid therapy, pharmacists educate prescribers about the FDA black box warning regarding concomitant use. Alternatives to benzodiazepines and/or opioids are

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	recommended. Minimal dosing and duration as well as taper options are addressed. Concomitant opioid and antipsychotic therapy. Over 9% of chronic opioid users are filling an antipsychotic and almost 4% of chronic opioid users are filling an opioid, benzodiazepine, and antipsychotic concomitantly. An informational (soft) edit was recommended and put in place in FFY20 for concomitant opioid and antipsychotic therapy. Theophylline. Four Prescription Policy PA requests highlighted use of theophylline. Updated clinical asthma and chronic obstructive pulmonary disease (COPD) guidelines do not recommend theophylline as first- or second-line therapy. A focused theophylline retrospective review was conducted quarter 1 of FFY20 to determine why theophylline was being prescribed, ensure appropriate monitoring was conducted, and to educate prescribers regarding current evidence-based management of these conditions. Of all of the FFS and MCO participants filling theophylline who still had eligibility at time of review, 27% had a diagnosis of asthma, 33% had a diagnosis of COPD, 31% had asthma and COPD, and 8% either did not have a respiratory medical diagnosis present yet in the HFS database or no longer had HFS coverage. Thirty-three percent of the contacted FFS prescribers responded. Prescriber outreach resulted in therapeutic drug monitoring with dose adjustment due to subtherapeutic dose and discontinuation of theophylline upon steroid inhaler therapy initiation. Education. During FFY20, the DUR Board approved the educational items, Improving safety of ketorolac use and Call for pharmacists to help patients with asthma. The link for the HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long term opioid analgesics was approved for posting on the DUR education page at https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/DrugUtilizationReview.aspx. The DUR Board members were also educated about the National Academies of Sciences, Engineering, and Medicine's consensus study report, Framing opioid prescribing guidelines for acute pain: Developing the evidence, and the montelukast black box warning regarding serious behavior and mood related changes in patients with or without history of mental illness. The DUR Board members recommended addressing safety issues in the montelukast-corticosteroid inhaler prescriber letters. The DUR Board members also learned about Illinois ADVANCE (Academic Detailing Visits And New evidence CEnter) and approved posting the Illinois ADVANCE link on the DUR Board education page. Benzodiazepines. Provider outreach continued to prescribers of chronic benzodiazepine therapy for the management of anxiety in the absence of first-line therapies, such as SSRIs. The adjudicating pharmacist notes recommendations regarding benzodiazepine therapy and/or tapers in the determination letters sent from the HFS PA system. Prescribers are asked to provide anxiety management and benzodiazepine taper plans. During FFY20, at least 2,057 benzodiazepine determination letters for 1,411 participants were sent to 1,186 prescribers. This 45% decrease in the number of benzodiazepine PA requests compared to FFY19 was a result of more patients transitioning to Managed Care as well as the COVID pandemic-related temporary lift of the Four Prescription Policy. Besides

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	determination letters with recommendations, an additional 14 benzodiazepine faxes citing evidence-based literature were sent to prescribers that needed further education. Opioid pain management. During FFY20, review of 6,028 opioid prior authorization requests resulted in a total of 755 individualized faxes to prescribers of participants filling opioids chronically (16 for methadone). Recommendations for improving pain management using appropriate medications for specific pain conditions, updated FDA black box warnings, and opioid concomitant therapy with benzodiazepines, antipsychotics, or sedatives were addressed. The 57.5% decrease from FFY19 was a result of more patients transitioning to Managed Care as well as COVID pandemic-related temporary lift of the Four Prescription Policy. Medication adherence. The PA staff continues to monitor adherence for medications to treat cystic fibrosis, direct-acting oral anticoagulant therapy (DOAC), and hepatitis C infection. Prescribers are contacted regarding adherence issues. Website information. Educational information regarding new initiatives is placed on the DUR Websites. The DUR Board Web page provides information about the DUR Board, while the Drug Utilization Review Web page provides educational materials or links for prescribers to help with medication-related issues identified by the DUR Board in the HFS population. During FFY20, the main DUR Board Web page was accessed 955 times (a 2.2% increase over FFY19) and the DUR Education Web page was accessed 1,483 times (a 93.4% increase over FFY19). The Pharmacy Services Web page providing forms and PA criteria was accessed 224 times, a 98.7% decrease. This may be reflective of prescriber focus on the COVID-19 pandemic and less need for other PA criteria and forms. The new coronavirus (COVID-19) updates webpage was viewed 58,812 times April through September 2020.
Indiana	The following information is an annualized analysis of retro-DUR activities and outcomes that were approved by the DUR Board and performed by OptumRx pharmacists through facsimile of retro-DUR education materials. A savings summary and detailed outcomes report for each retro-DUR program type is provided below. The detailed outcomes report for each retro-DUR intervention also includes savings (cost avoided, if any). Real savings, while controlling for changes over time, are calculated using the comparison and intervention groups where possible. All savings amounts are reported as state and federal Medicaid dollars combined. May 2019 Caring for Your Patients with Long-Term Sedative Hypnotic Use Members utilizing greater than 30 days of sedative-hypnotic therapy (eszopiclone, zolpidem, zaleplon) in the past 90 days have a near real-time letter faxed to the prescriber. The goal of this program is to ensure members are receiving guideline-recommended treatment and standard of care in the treatment of insomnia. Evaluation will be made to determine if members have the sedative-hypnotic discontinued.

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	Claims data for members utilizing sedative-hypnotic therapy were reviewed from January 1, 2018 to January 1, 2019. During this period, 416 unique utilizers of sedative-hypnotic agents greater than 30 days in 90 days were identified (average day supply of 165 days). 2,427 claims were processed (43% zolpidem 10mg) totaling $29,122.71 during the reporting period. OptumRx proposed this intervention at the March and April 2019 DUR Board meetings and obtained approval of this topic. The retro-DUR intervention began processing letters on August 9, 2019. At the one-year completion, 858 of these interventions were eligible for outcome. Of those eligible, 247 (28.8%) had discontinued sedative-hypnotic therapy, resulting in a savings of $3,102. November 2019 Caring for your Patients with Potential Off-Label Gabapentin Use Members utilizing at least 30 days of gabapentin without an FDA-labeled or approved compendia diagnosis found in their medical claims data will have a near real-time letter faxed to the prescriber. The goal of this program is to ensure members are receiving appropriate gabapentin therapy, especially considering recent overdose deaths with concurrent opioids and benzodiazepines. Evaluation will be made to determine if members have the gabapentin therapy discontinued. Claims data for members utilizing gabapentin therapy were reviewed from August 1, 2018 to August 1, 2019. During this period, 7,590 unique utilizers of gabapentin for at least 30 days were identified. A total of 2,869 claims were processed (38%) during the reporting period that did not have an FDA-labeled or approved compendia diagnosis found in their medical profile, totaling $99,519.18. OptumRx proposed this intervention at the September 2019 DUR Board meeting and obtained approval of this topic. The retro-DUR intervention began processing letters on January 6, 2020. As of June 30, 2020, 2,024 members were identified for a near real-time fax intervention. Of those eligible (771 individuals), 104 (13.49%) had discontinued gabapentin therapy, resulting in a savings of $9,276.49. Further data will be provided at the one-year follow-up in the FFY2021 report. August 2020 Caring for your Patients with Sickle Cell Disease Members diagnosed with sickle cell disease that have not received hydroxyurea therapy based on a review of claims history will have a near real-time letter faxed to the prescriber. The goal of this program is to increase the utilization of hydroxyurea therapy due to guideline recommendations. Per the Management of Sickle Cell Disease: Recommendations from the 2014 Expert Panel Report, hydroxyurea works primarily by increasing levels of fetal hemoglobin, which does not sickle. Hydroxyurea is indicated in patients 2 years of age and older (use in children nine months and older is recommended) to reduce sickle cell symptoms, such as frequency of painful episodes, acute chest syndrome (ACS) events, blood transfusion requirements, and sickle cell-related hospitalizations. Discontinuation of hydroxyurea is recommended for pregnant women, those planning to become pregnant, and those that are breastfeeding. Long-term observational studies demonstrate that the use of hydroxyurea has long-term beneficial effects across all age groups with limited side effects. Evaluation will be made to determine if members have hydroxyurea therapy added.

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	Claims data for members with a diagnosis of sickle cell disease were reviewed from June 1, 2019 to May 31, 2020. During this period, 467 unique members were identified as having sickle cell disease. Of these members, 445 were not utilizing hydroxyurea (only 4.7% of patients utilize hydroxyurea). During this time period, 100 claims for hydroxyurea were processed for 22 members, totaling $3,937.86. OptumRx proposed this intervention at the July 2020 DUR Board meeting and obtained approval of this topic. The retro-DUR intervention began processing letters on October 5, 2020. Further data will be provided at the one-year follow-up in the FFY2021 report.
Iowa	Drug Class Interventions % of Problem Type Not Optimal Dose Dipeptidyl Peptidase-4 (DPP-4) Inhibitors 1 0.4739% Therapeutic Duplication Antipsychotics - Misc. 5 0.9766% Dibenzapines 3 0.1403% Benzisoxazoles 2 0.1325% Antiadrenergic Antihypertensives 1 0.0257% Antihistamines - Ethanolamines 1 0.5587% Antihistamines - Non-Sedating 1 0.0353% ADHD Agents 1 0.1036% Biguanides 1 0.0565% Central Muscle Relaxants 1 0.0529% Dipeptidyl Peptidase-4 (DPP-4) Inhibitors 1 0.4739%
Kansas	Summary 1 Retrospective DUR Educational Outreach for FFY 2020 Prepared by Health Information Designs, LLC This report prepared for the Kansas Medical Assistance Program shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2020 (FFY 2020). The drug claims for the selected beneficiaries were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters.

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	The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there were no cost savings observed. During FFY 2020, HID reviewed 38 beneficiaries with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once beneficiaries have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 38 beneficiaries met the criteria for intervention letters during FFY 2020. Of the 38 beneficiaries, 8 met the criteria for the therapeutic appropriateness intervention and were included in the cost savings calculation. The remaining 30 beneficiaries met the criteria for the underutilization intervention which is not included in the calculation. Underutilization interventions are intended to improve compliance which, while they may decrease medical and hospital expenses, may increase pharmacy costs. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of beneficiaries who were not chosen for RDUR intervention letters. For a beneficiary to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, beneficiaries were analyzed using 150 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug

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expenditures and claims for the six months prior to and six months after the letters were mailed.
Table 1 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for therapeutic appropriateness exceptions during FFY 2020.

Table 1 Estimated Cost Savings for FFY 2020

Intervention Group	Change between 6 Month Pre- and Post-	Comparison Group	Change between 6 Month Pre- and Post-	Difference
Single Intervention	-$1,451	-$9,788		-$8,337

For FFY 2020, cost savings were calculated using the pre- and post- costs for the beneficiaries with therapeutic appropriateness exceptions (adverse effects of PPIs). HID found the intervention group had an increase of 2.5% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 103%. Although there were no actual cost savings in the intervention group, their costs did not increase to the same extent as the comparison group. The difference between the groups resulted in an estimated cost avoidance of $1,042.13 per beneficiary who received an intervention during FFY 2020.

Results Discussion

All drug claims and some medical claims or diagnosis data are available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide a complete as possible drug and diagnosis history for each beneficiary. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions, other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures.

Conclusion

The RDUR program provides an important educational service to providers enrolled in the Kansas Medical Assistance Program. During FFY 2020, 38 beneficiaries were identified for RDUR intervention letters. The RDUR intervention program alerted the beneficiary's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. There were no cost savings in FFY 2020, but a cost avoidance of $1,042.13 per beneficiary was observed.

Criteria-Reviewed	Criteria Type	Criteria Description		Number of TCEs Generated	
of Letters Sent	Number of Cases Prescriber Responses	Number of Letters	Response Rate		Number
3564, 3771, 9526, 9832, 10420, 10636	Underutilization				Non-adherence
to Antiretroviral Agents	30	29	31	31	0	0%

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	7718 Therapeutic Appropriateness Adverse effects of PPIs 8 8 8 8 4 50% TCE- Therapeutic Criteria Exceptions The number of letters generated, and the number of letters sent may exceed the number of cases because cases in which more than one prescriber is involved result in multiple alert letters.
Kentucky	During FFY 2020, Kentucky performed the following RetroDUR activities: In FFY 1Q2020, Kentucky identified members with a diagnosis of diabetes who were not also taking a ACE inhibitor or an ARB. Prescribers were sent letters, which included medication and medical claims history, asking that a reevaluation of the member's medication regimen be completed to determine if an ACE inhibitor or ARB should be included. In FFY 2Q2020, Kentucky identified members who did NOT have a diagnosis of asthma and were taking a leukotriene modifier. Prescribers were sent letters identifying all Kentucky FFS Medicaid members who fit that criteria asking them to reconsider leukotriene therapy for their patients. In FFY 3Q2020, Kentucky identified members who were using a short-acting bronchodilator chronically and were not taking a medication used to control asthma (i.e. inhaled corticosteroid). Prescribers were sent letters identifying all Kentucky FFS Medicaid members who fit that criteria asking them to consider adding a controller medication to their patients' asthma regimen. In FFY 4Q2020, Kentucky identified members who were non adherent with antihypertensive medications. Prescribers were sent letters, which included medication and medical claims history, asking that they consider counseling the member on the importance of adherence.
Louisiana	Summary 1. Retrospective DUR Educational Outreach. Top Ten Problems. 1. Opioids and antipsychotic agents: Concurrent use Recipient Profiles Screened: 132 Interventions: 130 2. A1C testing: Underutilization Recipient Profiles Screened: 130 Interventions: 90 3. Short-acting opioid: Exceeds 15 days supply Recipient Profiles Screened: 83 Interventions: 68 4. Opioids and benzodiazepines/sleep agents: Concurrent use Recipient Profiles Screened: 77 Interventions: 73 5. Short-acting opioid: Exceeds quantity limit Recipient Profiles Screened: 70 Interventions: 61 6. Albuterol inhaler: Overutilization Recipient Profiles Screened: 59 Interventions: 35 7. Sleep agents: Adherence Recipient Profiles Screened: 41 Interventions: 36

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	8. Antipsychotic agents: Adherence Recipient Profiles Screened: 35 Interventions: 19 9. NSAID: Drug use precaution with heart failure Recipient Profiles Screened: 31 Interventions: 23 10. Metformin IR: Adherence Recipient Profiles Screened: 17 Interventions: 14
Maine	Retrospective Drug Utilization Review (RetroDUR) and Educational Outreach Program FFY 2020 The goal of the Maine RetroDUR Program is to promote the safe and appropriate prescribing and use of medications. RetroDUR identifies prescribing, dispensing, and utilization patterns which may be clinically and therapeutically inappropriate and may not meet the established clinical practice guidelines. Data is collected and reviewed in detail and presented to the DUR Committee. Further analysis is conducted as needed. Depending on the specific issue identified, various interventions are then employed to correct these situations. Prospective edits in the Point of Sale System, educational mailings or new utilization controls such as prior authorization or quantity limits, among others are employed as appropriate. The Maine RetroDUR program takes an individualized approach to identifying, evaluating and developing improvements specific to each intervention. The cornerstone of the RetroDUR process is based on a review of peer-reviewed evidence as well as considerations of recognized guidelines and best practices. This information is evaluated in the context of the claims reviewed and then reviewed with the DUR Committee for input and then interventions, as appropriate are implemented. Retrospective DUR (FFY 2020) o Use of Multiple Antipsychotics in Children and Adolescents o Use of statins in members with diabetes mellitus o Use of Buprenorphine for MAT o Prescriber PDL Compliance o Prep HIV therapy prescribing rates Educational Outreach Summary (FFY 2020) Description Provider Newsletter October 2019 PDL Changes Pharmacy Benefit Update Winter 2019 Provider Newsletter February 2020 PDL Changes Provider Newsletter- Pharmacist prescribing and billing naloxone Provider Newsletter- MaineCare COVID-19 activities effective March 18, 2020 MaineCare COVID-19 Pharmacist Prescriber Guidance Provider Newsletter April 2020 PDL Update MaineCare Coverage of COVID- 19 Testing at Pharmacies Provider Newsletter July 2020 PDL Update Provider Newsletter- Quantity Prescribed

State	Retrospective DUR Educational Outreach
Maryland	Summary 1: Retrospective Educational Outreach Summary (Annual DUR report) Executive Summary This report prepared for the Office of Pharmacy Services (OPS) summarizes the Retrospective Drug Utilization Review (RDUR) Program in the state of Maryland for Federal Fiscal Year (FFY) 2020. The report presents a summary of RDUR interventions performed using provider education letters. Intervention letters are mailed to prescribers and pharmacy providers to encourage appropriate prescribing and improve drug utilization which, in turn, will prevent possible adverse drug reactions and improve patient outcomes in the targeted participant population. The following educational interventions were conducted during FFY 2020: potentially inappropriate use of opioids (Corrective Managed Care Program), therapeutic duplication of sedative/hypnotic agents, overutilization of gabapentin, concurrent use of an opioid and medium-high dose gabapentin, concurrent use of gabapentin and pregabalin, and concurrent use of an opioid, benzodiazepine and carisoprodol-containing product. A total of 1,743 unique participants were selected for intervention, and 3,021 prescriber letters were mailed. Each letter included a response form soliciting feedback from the prescriber. Responses are voluntary, and a response rate of 17% was achieved. Prescribers were also asked to evaluate the usefulness of the intervention letters. Of those who responded, 88% of prescribers found the letters to be either useful or extremely useful. Copies of intervention letters were also sent to each dispensing pharmacy. A total of 2,298 pharmacy letters were mailed, and a response rate of 30% was achieved. Of those who responded, 97% of pharmacy providers found the letters to be useful. Program Background Health Information Designs, LLC (HID), a KEPRO company, currently provides RDUR services for the Maryland Medicaid fee-for-service population. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria on a monthly basis to identify participants with potential drug therapy issues and mails the corresponding educational intervention letters to those participants' prescribers and to the dispensing pharmacy providers. A copy of the participant's complete drug and diagnosis history, which also lists all medications prescribed by other providers, is included with the letter. Based on this information, prescribers have the opportunity to review the entire drug and diagnosis history and make changes to the participant's drug therapies. Analysis Methodology Each month, HID evaluates Maryland Medicaid pharmacy claims data against criteria for potential overutilization and inappropriate use of opioids. Other criteria, developed in conjunction with HID, OPS, and the Maryland Drug Utilization Review Board are selected for DUR evaluation on a quarterly basis. For FFY 2020, the following criteria were evaluated, and intervention letters were mailed to providers: 1. Potentially inappropriate use of controlled substances (known as the Corrective Managed Care Program). 2. Therapeutic duplication of sedative/hypnotic agents.

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	3. Overutilization of gabapentin. 4. Concurrent use of an opioid, benzodiazepine and carisoprodol-containing product. 5. Therapeutic appropriateness of medium-high dose gabapentin and an opioid with increased risk of morbidity/mortality. 6. Concurrent use of gabapentin and pregabalin. Overuse of Opioid Criteria (Corrective Managed Care Program) The following criteria were used to determine potentially inappropriate use of opioids: 1. Utilization of narcotics in participants with a diagnosis of a history of substance use disorders. 2. Simultaneous utilization of any narcotic and buprenorphine or buprenorphine/naloxone-containing products for substance use disorders. 3. Long-term use of short-acting narcotics with no utilization of a long-acting narcotic agent. 4. Participants with at least a 120-day supply of any opioid within the most recent 90-day time period based on an evaluation of the day supply field. 5. Overutilization of hydrocodone/chlorpheniramine ER suspension (Tussionex). 6. Identification of all participants with claims for methadone. Participants newly initiating methadone therapy are selected for intervention in an effort to caution providers on the use of methadone due to its long half-life. Participant Selection The drug history and diagnosis profile for each participant who meets the selected criteria are reviewed by a HID clinical pharmacist to determine if the participant should be selected for intervention. Patients are not selected if it appears that interacting drugs are not being taken concurrently, dose titrations are being implemented, the patient has a diagnosis to support therapy, or the patient appears to be receiving the same regimen routinely during the previous six months. After participants are selected for intervention, educational intervention letters are mailed to all prescribers and pharmacy providers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past six months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a participant is selected for intervention, the specific criteria are suppressed by the RDUR system for that participant for six months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, participants could be selected for additional criteria exceptions later in the year. Participants may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Criteria Exception and Intervention Summary The table below provides a summary of criteria exceptions and educational outreach letters mailed for all retrospective DUR interventions for FFY 2020. The table includes the criteria description, number of criteria exceptions, number of participants with claims for the targeted drugs, and number of intervention letters mailed to prescribers and pharmacy providers.

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MARYLAND MEDICAID PHARMACY PROGRAM RETROSPECTIVE EDUCATIONAL OUTREACH SUMMARY REPORT FOR FFY 2020

CRITERIA TYPE	CRITERIA DESCRIPTION	PARTICIPANTS WHO MET CRITERIA	PARTICIPANTS SELECTED FOR INTERVENTION1	INTERVENTION LETTERS PRESCRIBERS2	INTERVENTION LETTERS PHARMACIES2
TD	Therapeutic duplication of sedative/hypnotics	1058	170	232	198
ER	Over-utilization of Tussionex	11	5	4	5
TA	Appropriate use of methadone	44	7	11	7
ER	Over-utilization of narcotic agents (opioids) based on days supply	1034	214	436	323
ER	Over-utilization of narcotic agents (opioids) based on dose per day	10	2	1	2
TA	Concurrent use of opioid, benzodiazepine and carisoprodol-containing product	4	4	8	5
ER	Over-utilization of gabapentin	148	71	102	96
LI	Long-term therapy with short-acting opioids in absence of long-acting agent	135	37	58	45
LI	Buprenorphine/naloxone containing products for opioid abuse/dependence and another opioid	1927	217	225	222
MC	Opioids and history of Substance Use Disorder	412	94	197	151
DD	Concurrent use of an opioid and medium-high dose gabapentin	1132	548	1133	776
DD	Concurrent use of gabapentin and pregabalin	986	374	614	468
Totals		6901	1743	3021	2298

1. Not all participants are selected for intervention. Selection is based on review by a Clinical Pharmacist.
2. Letters mailed are noted in this table. Copies of intervention letters are also mailed to the dispensing pharmacy. Some letters cannot be mailed due to inaccurate/missing address information. Participants may also use multiple prescribers and/or pharmacies.

Provider Response Tabulation

In addition to the intervention letter and the participant's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers and pharmacy providers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and also provides space for handwritten comments. The form also includes an evaluation question asking providers to indicate if the letter was useful or not.

Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Information presented to the Maryland Drug Utilization Board is reported anonymously.

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	Results Provider Responses to Intervention Letters A total of 3,021 DUR educational intervention letters were mailed to prescribers, and 515 responses were received for a response rate of 17%. A summary of all coded responses from prescribers is listed in the table below: Prescriber Response Number of Responses PRESCRIBER DISCONTINUED MEDICATIONS 139 PROVIDER DID NOT PRESCRIBE DRUG ATTRIBUTED TO HIM/HER 54 PARTICIPANT HAS APPOINTMENT TO DISCUSS THERAPY 54 PARTICIPANT IS NO LONGER UNDER THIS PROVIDER'S CARE 52 BENEFITS OF THERAPY OUTWEIGH THE RISKS 52 PARTICIPANT NO LONGER SEES PROVIDER 50 PRESCRIBER WILL REASSESS AND MODIFY DRUG THERAPY 27 PRESCRIBER TRIED TO MODIFY THERAPY, SYMPTOMS RECURRED 20 QA ISSUE 1 20 PARTICIPANT UNDER PRECRIBER'S CAREBUT NOT SEEN RECENTLY 17 PRESCRIBER TRIED TO MODIFY THERAPY, PARTICIPANT NON-COOPERATIVE 12 PARTICIPANT HAS DIAGNOSIS THAT SUPPO
Massachusetts	CMS Report FFY 2020 Summary 1 Report Date: 5/7/2021 Retrospective Educational Outreach Summary Top 10 Problems By Number of Exceptions, With Number of Interventions NCPDP Reject Code 75, Prior Authorization Required Date Range: 10/1/19 - 9/30/20 Problem Number of Exceptions Letters Sent Calls To Prescriber Drug requires prior authorization 489,831 67,195 6,602 Pediatric behavioral health initiative 132,891 11,538 2,045 Prior authorization required for quantity over limit 39,134 4,780 365 Polypharmacy/duplicate therapy 25,843 2,203 355 Age restriction 19,050 4,603 362

State	Retrospective DUR Educational Outreach
	Brand name requires prior authorization 5,808 1,502 92 Polypharmacy restrictions and quantity limits 3,855 140 20 Polypharmacy restriction for drug that requires prior authorization 3,834 168 9 Quantity limit exceeded for drug that requires prior authorization 3,669 669 78 High dose 3,536 1,503 328
Michigan	RetroDUR letters and prescriber visits were performed on five algorithms involving 6,764 distinct prescribers and 8,554 distinct members. Below is a summary of each. 1. Fluoxetine Dose Optimization: a. 659 Prescribers; 693 members b. 26.9% reduction in utilization of fluoxetine 20mg at 2 caps or tabs/day c. At six months post initial identification of members, 48% of the gaps in care were closed (334 members no longer prescribed two tablets/capsules per day) d. 20% reduction in fluoxetine 20 mg spend where the PEMPM pharmacy spend decreased from $13.47 to $10.71. e. Observed estimated pharmacy spend savings of $16,702 when comparing the six-month pre and post periods. 2. Behavioral Health Polypharmacy- 5 or More Medications: a. 2,861 Prescribers; 2,097 members b. Observed a 7.5% reduction in utilization of behavioral health medications. c. At six months post initial identification of members, 51% of the gaps in care were closed (1,064 members) d. 6.5% reduction in behavioral health medication spend where the PEMPM pharmacy spend decreased from $650.00 to $607.92. e. Observed estimated pharmacy spend savings of $529,497 when comparing the six-month pre and post periods. 3. Atypical Antipsychotic Polypharmacy: a. 1,996 prescribers; 3,303 members b. Observed a 9.1% reduction in atypical antipsychotic utilization. c. At six months post initial identification of members, 46% of the gaps in care were closed (1,538 members) d. 8.1% reduction in atypical antipsychotic spend where the PEMPM pharmacy spend decreased from $865.63 to $795.53. e. Observed estimated pharmacy spend savings of $823,317 when comparing the six-month pre and post periods. 4. Pediatric Behavioral Health Polypharmacy- 4 or More Medications: a. 898 prescribers; 2,108 members b. Observed a 7% reduction in utilization if behavioral health medications.

State	Retrospective DUR Educational Outreach
	c. At six months post initial identification of members, 57% of the gaps in care were closed (1205 members) d. 1% reduction in behavioral health medication spend where the PEMPM pharmacy spend decreased from $407 to $403. e. Observed estimated pharmacy spend savings of $54,885 when comparing the six-month pre and post periods. 5. Pediatric Antipsychotic Polypharmacy: a. 350 prescribers; 353 members b. Observed a 18.9% reduction in antipsychotic medication utilization. c. At six months post initial identification of members, 49% of the gaps in care were closed (174 members) d. 4.8% reduction in antipsychotic medication spend where the PEMPM spend decreased from $342 to $325. e. Estimated pharmacy spend savings of $34,973 when comparing the six-month pre and post periods.
Minnesota	Problem Type | Indicator Group | Drug Class | Denominator | Number of Exceptions | Ratio | Patient Profile Review | Population-based interventions | All Letters Pediatric-related | Child Psych Polypharmacy | Mental Health | 29,567 | 1,867 | 0.0631 | 0 | 1364 | 1364 Increased Risk of ADE | Atypical Antipsychotic Lipid Monitoring | Mental Health | 2,512 | 1,412 | 0.5621 | 0 | 1241 | 1241 Increased Risk of ADE | Atypical Antipsychotic Blood Glucose Monitoring | Mental Health | 2,512 | 1,397 | 0.5561 | 0 | 1180 | 1180 Underutilization | Nonadherence with Antidiabetics | Diabetes | 9,122 | 1,375 | 0.1507 | 0 | 1222 | 1222 Increased Risk of ADE | Diabetes Dx: No Eye Exam Within Last 550d | Diabetes | 9,122 | 3,451 | 0.3783 | 0 | 2965 | 2965 Increased Risk of ADE | Diabetes Dx No Lipid Panel in 550d | Diabetes | 9,122 | 6,234 | 0.6834 | 0 | 2955 | 5844 Increased Risk of ADE | Diabetes -- Increased ADE with Non-insulin Antidiabetics | Diabetes | 9,122 | 2,456 | 0.2692 | 0 | 1134 | 1134 Underutilization | Diabetes -- Underutilization of Antiplatelets | Diabetes | 9,122 | 1,244 | 0.1364 | 0 | 794 | 794 Increased Risk of ADE | Diabetes Dx <2 Hemoglobin A1C Labs in 550d | Diabetes | 9,122 | 6,315 | 0.6923 | 0 | 2034 | 2934 Increased Risk of ADE | Polypharmacy: > 4 Psychotropic Medications | Mental Health | 6,337 | 1,456 | 0.2298 | 0 | 1364 | 1364 Increased Risk of ADE | Non-Adherence with Maintenance ADHD Stimulants, Antidepressants, Bipolar Medications, and SGAs | Mental Health | 6,337 | 1,527 | 0.2410 | 0 | 2419 | 2419
Mississippi	During FFY2020, our retrospective DUR (retroDUR) program educational and intervention activities were targeted at improving adherence to safety recommendations, early notification of providers about policy changes to avoid disruptions in treatment, and improvement of vaccine completion rates. The retroDUR vendor continued educational outreach efforts where most of our

State	Retrospective DUR Educational Outreach
	exceptions monitoring and intervention activities were directed at improving performance on pharmacy quality measures relevant to the Medicaid population. Each month MS-DUR conducts educational mailings or phone contacts directed at DUR issues identified by DOM, the DUR Board or through exceptions monitoring. These mailings were targeted to the prescribers with the greatest need for the information or intervention that was the focus of each month's mailing. In addition to target provider mailings, DOM also distributed provider notices through provider member organizations and DOM's Provider Bulletins. Summaries of each educational outreach are below: 1 Opioid Provider Shopping Letter Objective - To identify beneficiaries without a cancer diagnosis that had an opioid prescription filled the prior month and had opioid prescriptions filled from four (4) or more prescribers and four (4) or more pharmacies during the prior six months. Results - This ongoing monthly mailing to providers and pharmacies began in November 2017 and continues. A total of 369,875 prescription claims were screened during FFY 2020. In FFY 2020, 202 mailings were sent to providers and pharmacies addressing 204 beneficiaries. 2 TCA (Tricyclic Antidepressants) Prescribing Letter Objective: To identify beneficiaries under age 25 who were prescribed TCAs. This educational mailing went out to prescribers prior to the implementation of a prior authorization requirement for TCAs in patients of this age group. Results: This mailing was distributed in May 2020 prior to the implementation of a prior authorization requirement for TCAs in patients in this age group. Letters were mailed to 507 providers impacting approximately 1,220 beneficiaries. 3 HPV Vaccine Completion Provider Bulletin Article Objective: To encourage providers to encourage beneficiaries to fully complete the HPV vaccine series by reinforcing the importance that physician recommendations play in vaccination success. This article included helpful tips on successful strategies and communication techniques for use with parents about HPV vaccination to avoid missed opportunities to improve HPV vaccination rates.
Missouri	POPULATION-BASED INTERVENTION SUMMARY Conduent completed two population-based interventions in the FFY 2020. Table 1 includes a summary of the outcomes reports for the Long-Term Opioids and Benzodiazepines Intervention and Sedative Hypnotics Intervention. Long-Term Opioids and Benzodiazepines Intervention Overall, there was a 28.6% reduction in the clinical indicators for the Long-Term Opioids and Benzodiazepines (e.g., increase risk of ADE) over the six-month intervention period. Additionally, there was a decrease in targeted drug costs of $85,397.08 for the six-month period. The total annualized decrease in costs would be expected to be $170,794.16. Sedative Hypnotics Intervention

State	Retrospective DUR Educational Outreach
	Overall, there was a 26.4% reduction in the clinical indicators for the Naloxone intervention (e.g., increased risk of ADE, Dosage, Duration, and Duplicate Therapy) over the six-month period. Additionally, there was a decrease in targeted drug costs of $34,542.01 for the six-month period. The total annualized decrease in costs would be expected to be $69,084.02. CONCLUSION The population-based interventions were effective in improving quality of care for Missouri Medicaid beneficiaries. When considering changes in drug costs only, the FFY 2020 net cost avoidance for the population-based interventions for the RetroDUR program administered by Conduent is estimated to be a decrease in costs of $239,878.18.
Montana	Criteria Type / Criteria Description / # TCEs Reviewed / # Cases / # Letters Sent Therapeutic Appropriateness (TA) / Chronic Opioid w/o Naloxone / 95 / 66 / 81 Drug-Drug Interaction (DDI) / Invega Sustenna/Oral Antipsychotic / 84 / 52 / 110 Drug-Disease Interaction / Medication-Related Poisoning/Opioids / 46 / 37 / 50 DDI / Support Act (Opioid with quetiapine) / 53 / 36 / 75 DDI / Support Act (Opioid with olanzapine) / 47 / 32 / 65 Drug-Disease Interaction / Respiratory Depression/Gabapentinoids and CNS Depressants / 30 / 24 / 27 DDI / Support Act (Opioid with ziprasidone) / 30 / 22 / 46 DDI / Support Act (Opioid with haloperidol) / 21 / 19 / 36 TA / Chronic Opioids w/o Naloxone (2nd intervention) / 20 / 16 / 18 DDI / Support Act (Opioid with lurasidone) / 25 / 16 / 33 OPIOID USE DISORDER (OUD): Medication Assisted Treatment Provider outreach: -174 interventions with MAT providers aimed at addressing complex medication authorization requests. --66 Sublocade --106 buprenorphine/naloxone --2 Vivitrol Combining our CM efforts with the prior authorization of both agents, we have been able to decrease the number of concomitant opioids, benzodiazepines, and tramadol medication use in Medicaid members receiving MAT therapy. This has also diminished the risk of overdose in this population by restricting their access to other opioid medications while receiving MAT therapy. CO-PRESCRIBING OF OPIOIDS AND ANTIPSYCHOTICS: -Letters and white papers were sent to providers prior to the COVID 19 Public Health Emergency. -Tracking of this initiative had to be stopped due to COVID-19 complications. NON-FATAL OVERDOSE INTERVENTION: -Letters, faxback forms, and fact sheets were sent to providers prior to the Covid 19 Public Health Emergency. -Tracking of this initiative had to be stopped due to COVID-19 complications. REDUCTION IN CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING:

State	Retrospective DUR Educational Outreach
	-Evidence-based prescribing guidelines were shared with providers (often multiple) who have prescribed this combination and education provided regarding risks. PROVIDER OUTREACH FOR OPIOID MME REDUCTION EFFORTS: -219 patients were initially identified by the Department at doses greater than 90 MME, but less than or equal to 120 MME. Of these 140 were identified as chronic non-cancer pain patients. Prior to implementation of the limit reduction on 1/8/2020, 72 different providers at 54 clinics were contacted for the 127 patients who had ongoing Medicaid eligibility and remained above 90 MME. -CM contacted each provider associated with those patients to inform and provide education on the CDC's recommended opioid guidelines (2016). Providers were given time to consider possible opioid tapers with their patients and were also given opportunity to attest that their patient has an appropriate clinical need for the dose they are currently on. -This was the final phase of the initial phase of the high dose opioid reduction project. We will continue to review and revise this plan especially as all settings transition out of the COVID-19 pandemic. FOSTER CARE REVIEW AND PSYCHOTROPIC DRUG OVERSIGHT: Increased coordination of care for psychotropic medications in children within the Foster Care program. The purpose of this project is to improve the prescribing and monitoring of psychotropic medication use through educational and clinical interventions. Monthly claims are used to identify the number and type of psychotropic medications being prescribed in foster care children 18 years of age and under. The reviews utilize the following criteria, but is not limited to (*indicates criteria which prompts further review/intervention): 1 or more Antipsychotic* 2 or more Atypical Antipsychotics* 3 or more Psychotropic Medications* Less than 8 Years of Age on an Atypical Antipsychotic* Greater than 1 ADHD Treatment* No Well Child Check Within 365 Days* 2 or more Prescribers of Psychotropic Medications* Diagnosis/Indication FDA Approved Dosing Medication Compliance Lowest Effective Dose Appropriate Lab Monitoring Drug-Drug Interactions Medication misuse/abuse Polypharmacy Multiple Pharmacies/Physicians FY2020 Data Outcomes: -460 clinical reviews were performed on 224 individual children. -Of those reviews, 220 interventions were made to providers/caseworkers regarding issues noticed on the patient's profile based on the above criteria.

State	Retrospective DUR Educational Outreach
	-38% of the children who were taking a medication that required metabolic monitoring did not have current metabolic syndrome lab monitoring in claims databases. -After CM intervention, 63% of the children obtained metabolic labs or drug discontinuation. This testing may lead to decreased long term risks (e.g. diabetes, heart disease, obesity, and joint problems) associated with these medications. -27% of the children did not have any current psychotherapy claims in databases upon review, but 67% began psychotherapy after working with individual providers. -Two providers indicated that therapy was not appropriate for members. -55% provider response rate ATYPICAL ANTIPSYCHOTIC MEDICATION IN CHILDREN AGES 7 AND UNDER: By identifying children less than or equal to 7 years of age who are receiving antipsychotic medications and associated providers, we have been able to better coordinate prescribing (often multiple different prescribers are involved) and reduce the number of and/or dose of atypical antipsychotic medications in this population. -51 prior authorization requests for atypical antipsychotic medications for children less than or equal to 7 years of age were reviewed in FY2020 --Baseline metabolic lab were obtained in 100% of the members less than or equal to 7 years of age receiving an antipsychotic medication. --Two prescriptions were withdrawn after discussion with provider, therefore metabolic labs were not completed on these members. --Initial drug starting dose recommendation was accepted in one of the patients requesting an atypical antipsychotic. DRUG NOT COVERED PROGRAM: 7 members updated to new contracted providers -3 members had restrictions on opioids --1 changed due to change in clinic provider --2 members moved to a different community -2 members had restriction changes on benzodiazepines --1 member entered MAT and provider wanted to be the only prescriber for benzodiazepines as well as Suboxone --1 member was discontinued from their benzodiazepine drug not covered at provider's request. The member is now in a controlled living environment (group home) -2 members had restrictions on gabapentin or Lyrica --1 member entered MAT and provider wanted to be the only prescriber for gabapentinoids as well as Suboxone --1 member was fired from the prior clinic for breach of opioid contract. The primary provider requested the drug not covered on the member's Lyrica only be transferred to the primary provider

State	Retrospective DUR Educational Outreach
	1 new member was placed on Drug Not Covered for benzodiazepines 1 new member was placed on Drug Not Covered for opioids FRAUD/ABUSE REVIEW: -29 members were reviewed by case management for potential abuse or misuse of medications --9 members were referred to the Department for review for Fraud or Abuse. 6 were referred for Fraud. 3 were referred for Abuse Program Successes We have highlighted the following significant program successes for the Pharmacy Case Management Program. 1. Hepatitis C Management - Due to changes in the prior authorization criteria, the number of patients accessing treatment and therefore achieving a cure, increased in FY 2020. In addition, the Pharmacy CM staff have extended education and resources to providers to assist in the appropriate selection of the Hep C drug regimen which has allowed the state to enhance the treatment of this infection. This has led to increased efficiency and better care for the patients, while allowing providers to utilize our case management pharmacists for more complex cases. 2. Foster Care Program - this program has proven to be successful not only in terms of provider education of antipsychotic medication treatment and corresponding clinical management including metabolic lab monitoring, but the greatly improved outcomes for Foster Children and their drug therapy management. 3. MME reduction efforts - using our CM pharmacy staff and embedding the effort in Mountain Pacific's prior authorization processes has realized a significant reduction in the number of Medicaid members receiving high MME prescriptions as well as preventing new therapy starts exceeding CDC recommended MME levels. 4. Provider relationships - Pharmacy Case Management has been very successful in building great provider relationships with the programs we administer for Montana Medicaid. Our staff has become a very respected and reliable source of patient information, clinical acumen, and literature/evidence source for providers. 5. CM Outcome Tracking Protocol Development-we have strategically developed and built more robust tracking protocols utilizing our SharePoint infrastructure. This will allow for more efficient data tracking within various CM programs. 6. Antipsychotic Use in Pediatrics- after consultation with our DUR Board, the age limit for review was increased by a year from 6 years old to 7 years old with additional expansion of age approved. Mountain-Pacific staff will continue to evaluate and review cases for more children as time and resources allow. 7. SUPPORT Act Requirement Implementation-Due to proactive implementation of SUPPORT Act requirements prior to October 1st of 2019, most requirements were already being met. However, implementation of RetroDUR

State	Retrospective DUR Educational Outreach
	and education for concomitant usage of opioid/benzodiazepine or opioid/antipsychotic was initiated during this fiscal year.
Nebraska	MME decrease to 120 mg MME for FY 2020; NOW in 2021 it is down to 90 mg MME. Hepatitis C criteria has changed from F2 to F0. SUPPORT Act review, education, and program launch completed in FY 2020.
Nevada	The following information is an annualized analysis of retro-DUR activities and outcomes that were reviewed by the DUR Board and performed by OptumRx pharmacists through letter mailings of retro-DUR education materials. The top retro-DUR activities for Fiscal Year 2020 were as follows: Chronic triptan medication use for migraine with concurrent preventative treatment on November 2019. Letters were sent to 29 prescribers and 31 recipients. Of those mailed, seven (22.6%) responses were received. Hepatitis C treatment completion sent December 2019. Letters were sent to 149 recipients and 53 prescribers. Of those mailed, 46 (30.9%) responses were received. Extended high-dose utilization of zolpidem in female patients in March 2020. Letters were sent to 40 prescribers and 40 recipients with zero responses. Members with a COPD diagnosis not receiving maintenance therapy that had an emergency department or urgent care visit for COPD exacerbation during the second quarter of 2020. Letters were mailed to 27 recipients and 26 prescribers with four (14.8%) responses received. SUPPORT ACT retro-DUR review was performed reviewing patients on opioids and antipsychotics as well as opioids and benzodiazepines. Letters were mailed to 98 recipients and 75 prescribers for opioids with antipsychotics. The response rate for this retro-DUR was 7.14% (seven responses). Letters were mailed to 111 recipients and 81 prescribers for opioids with benzodiazepines. The response rate for this retro-DUR was 13.51% (15 responses). A survey was conducted of continuous glucose monitor utilization. Letters were mailed to 119 recipients and 43 prescribers with a response rate of 24.37% (29 responses).
New Hampshire	Letters were mailed on twelve algorithms involving 595 distinct prescribers and 523 distinct members. Below is a summary of each. 1. Update for Prescribers: ACC/AHA Guidelines for Blood Pressure Management a. 175 prescribers; 159 members b. 25.1% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 2. FDA Alert: Antiepileptic drugs and the increased risk of suicidal thoughts and behaviors a. 122 prescribers; 106 members

State	Retrospective DUR Educational Outreach
	b. 22.1% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 3. FDA Alert: Medication Guides required to alert patients to possible cardiovascular and psychiatric risks with ADHD drug products a. 56 prescribers; 47 members b. 17.9% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 4. Diabetes medication claims and no claims for Blood Glucose Monitoring supplies a. 46 prescribers; 38 members b. 8.7% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 5. Acetaminophen may be associated with Stevens-Johnson syndrome a. 42 prescribers; 40 members b. 23.8% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 6. High Risk Medications in persons 65 or older a. 31 prescribers; 25 members b. 12.9% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 7. NSAIDS increase the risk of stroke or heart attack_FDA warning change a. 29 prescribers; 29 members b. 10.3% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 8. Antidepressant Medications: Black Box Warning a. 28 prescribers; 27 members b. 14.3% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 9. FDA Alert: Possible association between use of Montelukast and behavior/mood changes, suicidality, and suicide a. 24 prescribers; 24 members b. 4.2% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 10. Proton Pump Inhibitor duplication with H2 Receptor Antagonist a. 21 prescribers; 12 members b. 4.8% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 11. Medications that increase the risk of falls in the elderly a. 14 prescribers; 8 members

State	Retrospective DUR Educational Outreach
	b. 21.4% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 12. Benzodiazepines; 2 or more claims in 90 days without an SSRI in the last year a. 7 prescribers; 8 members b. 14.3% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary
New Jersey	1. Retrospective Compliance of HIV drugs - Goal is to improve adherence to HIV drug treatment. During this reporting period, a monthly average of 12 profiles were reviewed, for a total of 148 profiles, and 2 retroDUR letters were sent to prescribers. 2. Retrospective Compliance of Oral Diabetes Medications - Goal is to improve adherence to oral hypoglycemic medications. During this reporting period, a monthly average of 58 profiles were reviewed, for a total of 693 profiles. 3. Retrospective Review of claims exceeding claim payment >$4000 - FFS and Encounter claims were reviewed for appropriateness, clinical drug related issues, and correct billing. One claim required intervention yielding a cost-savings of $19,759. 4. Retrospective Review of Opioid/Benzodiazepine and Opioid/Antipsychotic utilization - Goal is to notify prescribers of drug-drug interactions involving the concurrent use of opioids with benzodiazepines, sedatives, hypnotics, and/or antipsychotics. During this reporting period, a monthly average of 12 profiles were reviewed, for a total of 142 profiles, and 32 retroDUR letters were sent to prescribers.
New Mexico	Summary for October 1, 2019 through September 30, 2020 1. Opioid/Benzodiazepines/Antipsychotics: Date of Intervention: 10/31/2019/ # of Recipients Targeted: 47/# of Physicians Targeted: 70 2. Shingrix Newsletter: Date of Intervention: 01/07/2020/ # of Pharmacies Targeted: 359/# of Physicians Targeted: 2,779 3. Opioid MME Letter #1: Date of Intervention: 02/13/2020/ # of Recipients Targeted: 27/# of Physicians Targeted: 28 4. Opioid MME Letter #2: Date of Intervention: 04/17/2020/ # of Recipients Targeted: 10/# of Physicians Targeted: 11 5. Postpartum Depression: Date of Intervention: 04/24/2020/ # of Recipients Targeted: 10/# of Physicians Targeted: 18 6. Influenza 2019-2020 Newsletter: Date of Intervention: 07/01/2020/ # of Recipients Targeted: 26/# of Pharmacies Targeted: 310/# of Physicians Targeted: 29 7. Gabapentins and Opioids: Date of Intervention: 09/24/2020/ # of Recipients Targeted: 147/# of Physicians Targeted: 230
New York	NEW YORK STATE EDUCATIONAL OUTREACH FFY 2020 Criteria Description Recipients Interventions Physician Responses Concurrent opioids benzo's 317 653 37

State	Retrospective DUR Educational Outreach
	Concurrent opioids antipsych's 266 590 36 Chronic use PPI's 385 505 28 Concurrent use opioid gabapentin 207 413 23 above 900 mg per day Concurrent use gabapentin CNS depressant 227 336 6 Cholesterol guidelines in diabetic patients 187 292 8 age 40-75 DPP4 inhibitors risk of arthralgia 183 229 6 Antipsychotic use in diabetics 99 224 17 Immediate release opioids for pain mgt 141 217 7 Duplicate tx of atypical antipsychotics 119 214 9 Total top 10 2131 3673 177 Total all letters sent 4607 7643 382 This report summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2020. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 3,673 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary. A response rate of 5% was achieved for the top 10 criteria and a response rate of 5% was achieved for total interventions during FFY 2020. In their responses, 29% of prescribers indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter.
North Carolina	During October 2019 through September 2020, the North Carolina Medicaid Drug Utilization Review (DUR) Board reviewed several therapeutics areas such as anxiolytics, opioids, behavioral health medications, and medications associated with FDA safety communications. Educational outreach primarily consisted of educational letters to prescribers identifying their patients impacted. Educational outreach was also provided by pharmacy newsletters that are auto-generated and electronically mailed to subscribers; the newsletter is also posted on North Carolina Medicaid's website. The most prominent areas addressed were related to benzodiazepines and opioids.

State	Retrospective DUR Educational Outreach
	The North Carolina Medicaid DUR Board reviewed aspects of benzodiazepine use throughout the year including 3-year utilization trending, utilization of claims > 4 mg lorazepam equivalents daily, concurrent use of benzodiazepines and stimulants, concurrent use of benzodiazepines and opioids, top benzodiazepine prescribers and their specialties, top geographic locations of benzodiazepine beneficiaries, chronic use of benzodiazepines, and chronic use of benzodiazepines without the use of a SSRI, SNRI, or TCA. Many of these topics were examined taking into consideration concomitant diagnoses such as seizures, psychosis, or schizophrenia. The Board observed a decrease in the number of patients using benzodiazepines overall. Utilization of benzodiazepines > 4 mg lorazepam equivalents daily was most prominent in the 18-64-year-old age group. The concurrent use of benzodiazepines and stimulants remained relatively stable over time while the concurrent use of benzodiazepines and opioids decreased. Prescribers writing for benzodiazepines varied in specialties and there was no one specialty that stood out from the rest. Most patients who were prescribed a benzodiazepine took the medication long-term and less than half of benzodiazepine users had a SSRI, SNRI, or TCA prescription. The North Carolina DUR Board made several recommendations to the Department of Health Benefits throughout the year pertaining to benzodiazepines including point-of-sale edits, prior authorizations, North Carolina Medical Board collaboration, and continued monitoring. North Carolina beneficiaries' use of opioids was closely examined and monitored during October 2019 through September 2020. The Board examined trending for patients who received opioid claims at quantities more than 90 milligram morphine equivalent (MME) daily who did not have a diagnosis of cancer or sickle cell. For the time frame examined, the number of patients who received and the number of prescribers who wrote for high dose opioids decreased. The Board also reviewed prescribing information for the top 25 opioid prescribers in the Medicaid program. CMS advised State DUR programs on the requirement for monitoring concurrent use of opioids and antipsychotics as part of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) act, Title 1-Section 1004. Throughout October 2019 and September 2020, the Board reviewed the information. Monthly reporting was reviewed by the Board which showed the number of patients and prescribers associated with concurrent use of opioids and antipsychotics using a 45 day look back period for the previous 12 months. Overall, North Carolina observed a decreased in the number of patients using opioids and antipsychotics together. Over the course of the year, the Board continued to monitor duplication of therapy for short-acting opioids. The DUR Board screenings primarily included the monitoring of prescribing trends since 2014 which showed a decrease in the number of patients who received multiple short-acting opioids. The Board recommended the Department of Health Benefits continue to monitor prescribing trends.

State	Retrospective DUR Educational Outreach
	Patients with a diagnosis of fibromyalgia using opioids were reviewed over multiple quarters for overall use as well as chronic use. The Board reviewed 2-year prescribing trends of opioid use within the population. Additionally, the Board evaluated this populations' use of non-opioid medications for the treatment of fibromyalgia and the use of non-pharmaceutical treatments including physical therapy, occupational therapy, or chiropractor services. Top prescribers and their specialties were also assessed. Data showed the number of patients diagnosed with fibromyalgia decreased as well as the use of opioids for those diagnosed with fibromyalgia only. The Board requested the Department of Health Benefits implement prior authorization requirements and point-of-sale educational messages to pharmacies. Patients with migraines who were chronic opioid users were examined over 3 quarterly Board meetings. Within the examined time frame, there were several thousand patients with a migraine diagnosis. Data indicated that chronic opioid users represented 6% of this population and chronic opioid users without evidence of a triptan or a preventative migraine medication represented 5% and 2%, respectively. The Board also examined the prevalence of prescriptions originating from emergency room visits which represented approximately 10% of prescriptions. The Board took into consideration concomitant disease states which may warrant the use of opioids within the patient population. The Board recommended continued monitoring for this topic if significant utilization changes occur. FDA safety communications were also reviewed from October 2019 through September 2020 including breathing difficulties associated with gabapentin and pregabalin, strengthened warnings on montelukast, and EpiPen and authorized generic dosing concerns. The FDA issued a warning regarding gabapentin and pregabalin involving the medications' risk of serious breathing difficulties, including fatal respiratory depression, in those who have respiratory risk factors. The risk factors included concurrent use of opioids and other CNS depressants and conditions such as chronic obstructive pulmonary disease (COPD). The Board previously examined the use of gabapentin when combined with opioids and benzodiazepines as well as utilization of high dose gabapentin. Therefore, the Board examined patients diagnosed with COPD who also took gabapentin or pregabalin plus another CNS depressant. The data showed approximately 20% of patients with a gabapentin or pregabalin prescription during this time frame had diagnosis of COPD. Of those patients, approximately 88% also had been prescribed one or more medications with CNS depressive effects. The Board recommended prescriber outreach and continued monitoring. After conducting a review of available information and consulting with outside experts the FDA determined montelukast required a Boxed Warning for serious behavior and mood-related changes. The FDA explained that montelukast should only be used for allergic rhinitis when symptoms are not effectively treated with other medications or in those who cannot tolerate other allergy medications. The FDA stated the medication should not be a first-choice treatment especially when

State	Retrospective DUR Educational Outreach
	allergic rhinitis symptoms are mild. When examining the data, the North Carolina DUR Board observed approximately 6% of montelukast users had a diagnosis of allergic rhinitis and no asthma diagnoses. The top prescribers within this population were also reviewed and approximately 25% were identified as allergy specialists. The Board recommended educational outreach to prescribers. The FDA alerted patients and health care providers that EpiPen, EpiPen Jr., and the authorized generics may have a delayed injection or be prevented from properly injecting. The FDA announcement provided several examples of how these issues were occurring (i.e., device failure from spontaneous activation caused by using sideways force to remove the blue safety release, device failure from inadvertent or spontaneous activation due to a raised blue safety release, difficulty removing the device from the carrier tube, user errors). The manufacturer provided additional details to each issue identified which was published in the FDA safety announcement. The Board examined the information from the FDA in addition to the number of North Carolina beneficiaries impacted and recommended prescriber outreach. In summary, the North Carolina DUR Board monitored several topics during 2019 and 2020 focusing on benzodiazepines, opioids, and FDA safety communications. Educational outreach was performed through letters to prescribers and electronically mailed newsletters. The newsletters are also posted on the Department of Health Benefit's website. Overall, the program witnessed a decrease in opioid and benzodiazepine use due to the Department of Health Benefits' prospective and retrospective programs and the North Carolina medical community's commitment to improving the health of North Carolina Medicaid beneficiaries.
North Dakota	Below is a list of the most prominent 10 problems identified in the North Dakota Medicaid Retrospective DUR Educational Outreach program, based on those with the largest number of exceptions. The list includes the criteria name and type of problem identified, followed by parentheses containing the number of exceptions identified, the number of cases reviewed for that exception, the number of physician education letters sent for identified cases, the physician response rate, the number of pharmacy education letters sent for identified cases, and the pharmacy response rate (all numbers are presented in this order, separated by commas). 1: Statin Use and Risk of Hepatotoxicity - Therapeutic Appropriateness (306, 149, 149, 19.5%, 149, 21.5%) 2: Underutilization of ACE Inhibitors - Underutilization (234, 186, 203, 9.4%, 195, 30.3%) 3: Use of NSAIDs in Patients with Diabetes Mellitus - Drug/Disease Interaction (234, 175, 235, 8.5%, 184, 35.9%) 4: Utilization of Sedative/Hypnotic Agents in Patients with Depression - Drug/Disease Interaction (212, 171, 181, 14.4%, 172, 15.1%) 5: No Statin in Patient with Diabetes and Elevated ASCVD Risk - Therapeutic Appropriateness (204, 198, 231, 6.9%, 202, 27.7%) 6: Underutilization of Beta-Blocking Agents - Underutilization (162, 154, 160, 6.3%, 158, 24.1%)

State	Retrospective DUR Educational Outreach
	7: Coadministration of Benzodiazepines and Opioids - Drug/Drug Conflicts (145, 103, 160, 19.4%, 113, 24.8%) 8: Overutilization of Zolpidem Immediate Release - Overuse Precaution (128, 107, 111, 18.3%, 110, 20.9%) 9: Overutilization of Cyclobenzaprine - Overuse Precaution (119, 89, 104, 18.3%, 93, 20.4%) 10: Appropriate Use of Immediate-Release Opioid Analgesic Agents - Therapeutic Appropriateness (114, 85, 116, 25.0%, 95, 29.5%)
Ohio	MAT + Opioid/Benzodiazepine Outreach Every month, outreach is made to each prescriber whose patients are taking MAT in combination with an opioid and/or a benzodiazepine. The outreach is made to determine if the prescriber has knowledge of the medication combination and to ensure that Ohio Automated RX Reporting System (OARRS), Ohio's Prescription Drug Monitoring Program (PDMP), is utilized. An outreach is also made to each pharmacy to determine if they contacted the prescriber and checked OARRS before dispensing these medications. Concurrent Use of Opioids and Benzodiazepines Intervention Additionally, in December 2019, a RetroDUR intervention was completed. A letter was sent to prescribers whose patients received a combination of opioid and benzodiazepine. Prescribers were educated that this combination increases potential harm to patients and is associated with drug interactions and adverse events. When benzodiazepines are prescribed concurrently with opioids, they have the potential for sedation, respiratory depression, cognitive dysfunction, and sleep apnea. Adults who received prescriptions for both opioids and benzodiazepines, compared to opioids alone, were more likely to visit the emergency department or have an inpatient admission for opioid overdose. ODM identified 311 members for this intervention. DUR Digest Every quarter, ODM publishes a DUR Digest. This is a newsletter that consists of a clinical overview of RetroDUR interventions and re-reviews of RetroDUR interventions performed the previous year. It also consists of FDA updates, PDL updates, and relevant clinical information. This newsletter is included in RetroDUR mailings to prescribers and posted on the ODM website. Coordinated Services Program (CSP) Enrollment ODM reviewed profiles of members proposed for enrollment in CSP. November 2019: 10 members identified, February 2020: 30 members identified, May 2020: 30 members identified, August 2020: 13 members identified Adherence to Antiepileptic Medications Intervention In January 2020, a RetroDUR intervention was performed for prescribers whose patient adherence rate (proportion of days covered) to their antiepileptic medications was less than or equal to 70% based on pharmacy claims. Patients with suboptimal adherence levels to antiepileptic medications are more likely to have seizures that are associated with increased number of hospital admissions

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	and healthcare costs, a higher incidence of relapse, and a higher incidence of refractory epilepsy. 82 members were identified for this intervention. Opioids and Gabapentin Intervention In July 2020, a RetroDUR intervention was completed by sending letters to prescribers whose patients were receiving opioid medications in combination with > 2,400mg of gabapentin per day. Prescribers were educated on the abuse potential when gabapentin is combined with opioids, muscle relaxants, or anxiolytics. Respiratory function is suppressed, and risk of death is increased when opioids are combined with gabapentin. 118 members were identified for this intervention. Pediatric Metabolic Monitoring: Atypical Antipsychotics Intervention In July 2020, RetroDUR educational communication to prescribers was released to increase awareness on metabolic monitoring for pediatric patients taking atypical antipsychotics. Prescribers were educated on metabolic risks associated with the atypical antipsychotic medication class including weight gain, glucose intolerance, and onset of diabetes, dyslipidemia, and hypertension. Baseline screening and regular monitoring should be performed; Baseline screening measures include fasting plasma glucose and/or HbA1C, fasting lipid panel, weight, and blood pressure. 633 members were identified for this intervention. Opioids and Stimulants Intervention In September 2020, RetroDUR intervention was sent to prescribers whose patients were receiving opioid medications in combination with a stimulant. Prescribers were educated that concurrent use of these drugs is associated with an increased risk of substance use disorder, chronic pain, depression, anxiety, COPD, and cardiovascular disease. Prescribers were asked to consider the use of non-opioid medications as part of their multimodal treatment strategy, opioid taper if appropriate, pain management referral, palliative care consult, behavioral health modalities, reassessing or reducing stimulant therapy, prescribing physical therapy, acupuncture, chiropractic care and/or counseling which are covered services by Ohio Medicaid. 62 members were identified for this intervention. Influenza Vaccine Outreach In September 2020, a fax was sent to all pharmacies enrolled with ODM to educate on opportunities to offer an influenza vaccine to their Ohio Medicaid patients. RetroDUR Re-Reviews The purpose of a RetroDUR re-review is to determine the impact of an intervention. Re-reviews are performed one year after the intervention. Re-Review: Opioids, Benzodiazepines, and Sedative Hypnotics Members were originally enrolled in our RetroDUR intervention for receiving opioid medications in combination with benzodiazepines and sedative hypnotics. In October 2018, 107 members were identified to meet these criteria; this dropped to 85 members in October 2019. Outcomes included 26 members no

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	longer taking opioids (31%), 19 members no longer taking benzodiazepines (22%), 39 members no longer taking sedative hypnotics (49%), and 49 members showing overall improvement in these criteria (58%). Re-Review: Adherence to Non-Insulin Antidiabetic Medication Members were originally enrolled in our RetroDUR intervention for adherences rates <60% to non-insulin antidiabetic medications based on pharmacy claims. In January 2018, 353 members were identified to meet these criteria; this dropped to 208 members in January 2019. Outcomes included 165 members increasing adherence rates to their non-insulin antidiabetic medications (79%). Re-Review: Insulin Without Glucose Test Strip Claims Members were originally enrolled in our RetroDUR intervention if they received insulin without blood glucose test strip claims. In March 2019, 500 members were identified to meet this criterion; this dropped to 369 members in March 2020. Outcomes included 83 members newly receiving glucose test strips (23%). Re-Review: Tamiflu Without Influenza Vaccine This re-review was performed prior to the 1- year timeline due to the nature of influenza season. Members were originally enrolled in our RetroDUR intervention if they received a Tamiflu prescription without an influenza vaccine claim. Originally, 474 members were identified to meet this criterion; this dropped to 418 members in April 2020. Outcomes included 21 members receiving an influenza vaccine (5%). Re-Review: Adherence to Atypical Antipsychotic Medications Members were originally enrolled in our RetroDUR intervention if they were less than or equal to 18 years old with less than or equal to 70% adherence, or > 18 years old with less than or equal to 50% adherence to their atypical antipsychotic medications. In September 2019, 128 members less than or equal to 18 years old and 413 members >18 years old were identified to meet these criteria; this dropped to 102 members less than or equal to 18 years old and 293 members >18 years old in September 2020. Outcomes included 56 of 102 members less than or equal to 18 years old improving adherence rates (55%) and 132 out of 293 members >18 years old improving adherence rates (45%).
Oklahoma	RetroDUR Educational Outreach Summary: Federal Fiscal Year 2020 (10/01/2019 - 09/30/2020) Date|Medication Category|Educational Intervention Criteria|Cases Reviewed|Cases Intervened|Affected Members|Total Members|Total Claims|Minimum Cost Savings 10/2019|SGA|ADMP|48,755|22,823|12,355|64,877|528,438|CO 11/2019|CMA|DM/CV|37,190|4,783|17,139|37,190|193,074|CO 12/2019|SGA (Peds)|ADMP|5,972|682|5,972|21,365|21,369|CO 01/2020|SGA|ADMP|49,892|29,467|12,883|64,858|529,222|CO 01/2020 |ACEI/ARB/ARNI: Use in Members with Chronic Heart Failure|133|133|149|149|N/A|CO

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	02/2020|DM/CV|CMA|36,741|7,777|16,986|36,741|190,225|CO 04/2020|SGA|ADMP|51,045|29,467|13,287|66,728|545,312|CO 05/2020|CMA|DM/CV|36,434|7,488|16,263|36,434|188,971|CO 06/2020|PNV: Deliveries with PNV Use|246,402|246,402|88,108|158,294|352,800|CO 06/2020|Montelukast: Use in Pediatric Members without Asthma Diagnosis|7,978|7,978|28,300|28,300|113,685|CO 07/2020|SGA (Peds)|ADMP|5,707|452|5,707|20,827|20,827|CO 07/2020|SGA|ADMP|51,876|29,332|13,299|67,231|551,883|CO 08/2020|CMA|DM/CV|36,470|7,262|15,866|36,470|190,094|CO 09/2020|ABX: Academic Detailing Program Update|57,602|49,777|29,251|234,896|373,896|$834,021^ SGA: second-generation (atypical) antipsychotics; DM/CV: diabetes/cardiovascular; Peds: pediatrics; ACEI/ARB/ARNI: angiotensin converting enzyme inhibitor/angiotensin II receptor blocker/angiotensin receptor-neprilysin inhibitor; PNV: prenatal vitamins; ABX: antibiotics ADMP: adherence/diagnosis/metabolic monitoring/polypharmacy; CMA: chronic medication adherence CO: clinical outcomes ^ cost savings inclusive of all federal and supplemental rebates N/A = not applicable
Oregon	Change forms: Fluoxetine tabs to caps: Faxes sent - 1,095; Rx changed w/in six months-616; cumulative pharmacy payment reduction (12 months)-$65,104 Venlafaxine tabs to caps: Faxes sent - 567 ; Rx changed w/in six months-359; cumulative pharmacy payment reduction (12 months)-$326,711 Dose optimization: Faxes sent - 143; Rx changed to recommended dose w/in three months-45; Rx changed to alternative dose w/in three months-37; cumulative pharmacy payment reduction (12 months)-$257,195 Expert Consultation Referral for Antipsychotic Use in Children: Profiles sent for expert review-35; Prescribers successfully notified-29; Change in antipsychotic drug in following 90 days-2; DC antipsychotic therapy in following 90 days-7 Non-Adherence to antipsychotics in people w/schizophrenia: Prescribers successfully notified-221; Patients with claims for the same antipsychotic within the next 90 days-112; Patients with claims for the same antipsychotic within the next 90 days-16 Safety Net: Combination Opioid-Sedative: Prescribers successfully notified-429; Patients with discontinuation of therapy within next 90 days-86; Patients with new prescription for naloxone within next 90 days-12; ICS/LABA denied claim w/ no PA request: Faxes sent-4

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	TCAs in Children: Prescribers successfully notified-14; Patients with claims for a TCA within the next 90 days-7; Patients with claims for an alternate drug (SSRI, migraine prevention, or diabetic neuropathy) within the next 90 days-1
Pennsylvania	The Pennsylvania Medicaid RDUR Program performs retroDUR and educational outreach through problem-focused reviews. Problem-focused reviews narrow the emphasis of review to a specific issue that has been determined to be an area where a targeted educational effort to providers may be valuable. Topics for review are selected from reviews of medical literature, emerging trends in local or national news, or suggestions by DUR Board members, as well as other avenues. Criteria are developed to identify the members who may benefit from an intervention and educational materials are disseminated to their providers. Providers are encouraged to voluntarily respond. The member profile is generated again in an appropriate amount of time (typically 6 months) to determine the impact rate of the intervention, along with any fiscal considerations. Activities of the RDUR Program were evaluated for interventions performed in the previous fiscal year (FFY20). The activities of the RDUR program resulted in a calculated cost savings of $141,996.15 (pre-rebate dollars), equating to a savings of 16 cents for every $1.00 of combined federal and state dollars spent administratively on the RDUR program. During this evaluation period, 6,446 educational intervention letters were mailed to prescribers regarding medication therapy. Providers are invited to voluntarily respond to RDUR Program letters. Providers returned 651 responses to these letters, resulting in an overall response rate by the providers of 10.10 percent. In these 6,446 educational letters, the RDUR Program made 8,469 observations and subsequent education. The suggested change was implemented in 3,281 cases, resulting in an overall impact rate of 38.74 percent. Implementation of these therapeutic suggestions resulted in a cost savings of $141,966.15 for the 6,446 patients evaluated, or a savings of $22.03 per patient.
Rhode Island	Executive Summary This report prepared for the Rhode Island Medial Assistance Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2020. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 2,024 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary and a response rate of 21% was achieved for the top 10 criteria and a response rate of 18% was achieved for total interventions during FFY 2020. In their responses. Program Background

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	Health Information Designs, LLC (HID) currently provides RDUR services for the Rhode Island fee-for-service Medicaid population as a subcontractor with DXC Technology. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria monthly to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month HID evaluates Rhode Island fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by HID and presented to the Rhode Island Drug Utilization Review Board and DXC for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by a HID clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of educational outreach letters mailed for the top 10 retrospective DUR interventions based on number of letters mailed for FFY 2020. CRITERIA TYPE, CRITERIA DESCRIPTION, # RECIPIENTS SELECTED FOR INTERVENTION, # INTERVENTION LETTERS MAILED TO PRESCRIBERS, # PRESCRIBER RESPONSES TA, Antidepressants may increase risk of suicidal thinking, 340, 331, 76 TA, NSAIDs can increase the risk of heart attack or stroke in patients with or without heart disease or risk factors for heart disease., 321, 322, 56 TA, A review of the patient medical and prescription history revealed that the patient was recently discharged from the hospital and is currently receiving a proton pump inhibitor (PPI) with no supporting indication for PPI use., 271, 270, 57 TA, The use of second-generation antipsychotics (SGAs) has been associated with the development of serious health risks (e.g., cardiovascular disease, diabetes, dramatic weight gain, and atherogenic lipid profiles)., 239, 234, 28

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	TA, The patient is receiving a drug that has the potential to cause adverse outcomes in the elderly unless specific benefits outweigh the risks and the patient is monitored appropriately., 195, 213, 43 TA, Diabetic would benefit from addition of an ACE or ARB, 152, 151, 25 TA, Misuse of amphetamines and cardiovascular warning, 153, 143, 49 DD, Diabetic would benefit from addition of an ACE or ARB, 137, 137, 55 TD, Therapeutic duplication of antihistamine agents may be occurring., 77, 112, 22 TA, ACC/AHA Blood Cholesterol Guidelines recommend the use of moderate-intensity statin therapy as primary prevention to reduce the risk of atherosclerotic cardiovascular disease in diabetic patients 40 to 75 years of age with a LDL-C of 70 - 189 mg/dL, unless contraindicated. If the diabetic patient has an estimated 10-year ASCVD risk of 7.5% or greater high-intensity statin therapy is recommended. Refer to the ACC/AHA guidelines for agents and dosage., 106, 111, 18 , Total Top 10, 1,991, 2,024, 429 (21%) , Total all letters, 5,294, 5,555, 980 (18%) Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments. Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 2,024 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 429 responses were received for a response rate of 21%. A summary of all coded responses from prescribers is listed in the table below. Response Description Count BENEFITS OF THE DRUG OUTWEIGH THE RISKS 203 MD UNAWARE OF WHAT OTHER MD PRESCRIBING 10 PT IS NO LONGER UNDER THIS MD's CARE 5 MD SAYS PROB INSIGNIF NO CHG THX 32 MD WILL REASSESS AND MODIFY DRUG THERAPY 65 MD TRIED TO MODIFY THERAPY, PT NON-COOP 25 PT UNDER MY CARE BUT NOT SEEN RECENTLY 18 PATIENT DECEASED 1 PATIENT WAS NEVER UNDER MD CARE 10 HAS APPT TO DISCUSS THERAPY227 MD DID NOT RX DRUG ATTRIBUTED TO HIM. 28 AWARE OF INTERACTION, MONITORING PATIENT 164 TRIED TO MODIFY THERAPY,SX RECURRED 60 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD67

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	I AM PROVIDING THE DIAG CODE ASSOCIATED WITH MEDICATION(S) BEING PRE 65 Total of all responses 980 Results Discussion With respect to prescriber responses to all RDUR letters, a response rate of 18% was achieved. All intervention letters include the recipient's drug claims data within the previous 6 months and any available diagnosis data to provide as complete of a drug and diagnosis history as possible. This approach provides prescribers and pharmacies with the information needed to fully review and evaluate each recipient's drug history. Conclusion For FFY 2020, a total of 2,024 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 21% was achieved for the top 10 criteria alerts.
South Carolina	The COVID pandemic converted past discussions about virtual AD visits into a tipSC outreach reality. March 12th, 2020 was the last face-to-face AD visit to a primary care practice this reporting period; March 27th was our first ever tele-AD visit. We were able to continue in person educational outreach through pharmacy students trained by SCORxE academic detailers who met face-to-face with their community pharmacy preceptors in May and June to discuss our latest tip SC topic Naloxone Can Save a Life. Utilizing pharmacy students to expand our AD reach to the pharmacy community, an innovative initiative implemented by the SCOR x E AD Service, was a planned strategy that pre-dated the pandemic. The acute pain topic completed earlier this reporting period focuses on multi-modal pain care non-pharmacologic approaches, non-opioid medications, and opioids, and provides the foundation for our fall topic on behavioral and physical non-pharmacologic treatments for acute and chronic pain, including post-surgery pain. January 2020 thru June 2020 tipSC deliveries, as per previous reporting period, included AD visits from SCORxE clinical pharmacy consultants (i.e., academic detailers), presentations that incorporated multiple tip SC issues, US mailings, and visits to the tip SC webpages. Unlike previous reporting periods, AD reach also included visits from pharmacy students in an innovative initiative to expand our face-to-face educational outreach to pharmacists.
South Dakota	For the reporting period recipient profiles were reviewed and educational letters were sent for the following months: October 2019 (Focused review: underutilization of hypertensives in people with diabetes) November 2019 (General review) January 2020 (General review) February 2020 (Focused review: underutilization of statins in patients with diabetes) June 2020 (General Review) July 2020 (General Review) August 2020 (General Review) September 2020 (Focused review: Concomitant opioid and benzo use, also reviewed proposed new criteria) Due to Covid reviews were not conducted for March-May 2020.

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Tennessee	Sept 2020 Zolpidem Use in Female Patients-- A RetroDUR initiative was conducted to identify female patients receiving zolpidem 10mg immediate release or zolpidem 12.5mg extended release between December 2019 and May 2020. The recommended dose of zolpidem for women is 5 mg for immediate release products and 6.25 mg for extended release products. The U.S. Food and Drug administration (FDA) recommends the lower strengths for women as blood levels in some patients may still be high enough the morning after to impair driving and other activities requiring mental alertness. Claims data for female members on zolpidem (10mg immediate release or zolpidem 12.5mg extended release) between December 2019 and May 2020 were reviewed. 134 unique members were identified and a Retro-DUR intervention was initiated. Letters were sent to corresponding prescribers. A follow up claims data review was done after the intervention which resulted in a savings of $1,139.00.
Texas	Population-Based Intervention Summary 1. Influenza Prevention was mailed out on 10/18/2019 to 3,411 physicians. This intervention focused on improving influenza vaccination, antiviral prescribing practices, and reducing the overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 27.5%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $0.65 in the post-intervention period. This yielded an overall estimated increase of $265,938.40 in intervention-related drug expenditures on an annualized basis. 2. Diabetes Disease Management was delivered on 05/05/2020 to 930 physicians and impacted 2,715 clients. This intervention focused on improving prescription drug therapy as well as the recommended laboratory tests in patients with type I or type II diabetes. During the intervention. Targeted patients saw average reductions in clinical indicators by 22.4%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $3.20 in the post-intervention period. This yielded an overall estimated increase of $395,111.52 in intervention-related drug expenditures on an annualized basis. 3. Cough and Cold Remedies was delivered on 10/22/2019 to 485 physicians. This intervention focused on improving prescribing practices based on patient safety. Targeted patients saw average reductions in clinical indicators by 24.8%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $0.55 in the post-intervention period. This yielded an overall estimated increase of $95,130.20 in intervention-related drug expenditures on an annualized basis. 4. Anticonvulsants Drug Use Evaluation was delivered on 10/14/2019 to 337 physicians and impacted 342 clients. This intervention focused on improving prescribing practices, treatment adherence, and reducing adverse events associated with duplicative therapies, drug-drug and drug-disease interactions,

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	etc. During the intervention. Targeted patients saw average reductions in clinical indicators by 23.4%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $1.37 in the post-intervention period. This yielded an overall estimated decrease of $192,737.08 in intervention-related drug expenditures on an annualized basis. 5. Psychotropic Drugs in Youth was delivered on 03/23/2020 to 222 physicians and impacted 272 clients. This intervention focused on improving prescribing practices, treatment adherence, reducing duplicative therapies and drug adverse effects. During the intervention. Targeted patients saw average reductions in clinical indicators by 25.7%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $5.77 in the post-intervention period. This yielded an overall estimated decrease of $2,169,719.61 in intervention-related drug expenditures on an annualized basis. 6. Caring for Patients with Asthma was delivered on 08/20/2020 to 134 physicians and impacted 120 Patients. This intervention focused on improving overall prescribing of the short acting and long acting bronchodilators, as well as, reducing the risk of hospitalization and emergency visits due to uncontrolled asthma symptoms. Targeted patients saw average reductions in clinical indicators by 28.9%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.82 in the post-intervention period. This yielded an overall estimated decrease of $69,324.44 in intervention-related drug expenditures on an annualized basis. 7. NSAIDs intervention was mailed out on 06/24/2020 to 105 physicians and impacted 104 clients. This intervention focused on improving prescribing practices and reducing the risks associated with NSAID therapy. Targeted patients saw average reductions in clinical indicators by 32.7%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.69 in the post-intervention period. This yielded an overall estimated decrease of $10,792.98 in intervention-related drug expenditures on an annualized basis. 8. Post-Traumatic Stress Disorder (PTSD) was delivered on 09/15/2020 to 95 physicians and impacted 74 clients. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 37.9%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.23 in the post-intervention period. This yielded an overall estimated decrease of $9,166.88 in intervention-related drug expenditures on an annualized basis.

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	9. ADHD Medications was delivered on 05/18/2020 81 to 73 physicians and impacted 81 clients. This intervention focused on improving prescribing practices and reducing the risks associated with over utilization and duplicative therapies. During the intervention. Targeted patients saw average reductions in clinical indicators by 26.8%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $2.35 in the post-intervention period. This yielded an overall estimated decrease of $148,346.10 in intervention-related drug expenditures on an annualized basis. 10. Pain Management was mailed out on 02/28/2020 to 54 physicians and impacted 57 clients. This intervention focused on improving prescribing practices and reducing opioid overutilization and decreasing he overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 39.6%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.64 in the post-intervention period. This yielded an overall estimated decrease of $3,728.64 in intervention-related drug expenditures on an annualized basis. 11. Opioid/Benzo/ Antipsychotics was mailed on 01/08/2020 to 9 physicians and impacted 9 clients. This intervention focused on improving prescribing practices and reducing risks associated with drug abuse, and to reduce overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 42.9%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $7.24 in the post-intervention period. This yielded an overall estimated decrease of $31,580.88 in intervention-related drug expenditures on an annualized basis.
Utah	Retrospective DUR is performed primarily through the peer-to-peer program that aim to achieve qualitative measurements through direct and focused provider engagement by Utah State Medicaid Department. Beginning on October 1, 2019, a peer-to-peer intervention was launched to monitor and manage antipsychotic medications prescribed to members 19 years of age and younger. Peer to peer educational interventions, aligned with the American Academy of Child and Adolescent Psychiatry, would address the following: Use of other first-line available services (psychosocial counseling and safer medication alternatives) prior to initiation of antipsychotic medication. Dosing of antipsychotic medication following the start low and go slow approach Careful and frequent monitoring of side-effects related to antipsychotic medication use Metabolic screening, Body Mass Index (weight gain), Movement disorder assessments Use of multiple concurrent antipsychotic medications In October, 2019, there were 16 children under the age of 6 receiving an antipsychotic, 16 children on more than one antipsychotic, and 61 children on

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	high dose antipsychotic exceeding literature recommendations. Out of 1,972 children on antipsychotic, only 22% received metabolic screenings. Between October 2019 to Oct 2020, 58 provider-specific letters were sent and 102 peer-to-peer phone conversations were conducted. In October 2020, analysis showed a reduction in number of children under 6 receiving an antipsychotic, on more than one antipsychotic, and on doses higher than recommended to 11, 12, and 34, respectively. Also, metabolic testing rate declined to 19%, and the total number of children receiving antipsychotics was reduced to 1,815 children. Note that during this same period the number of children covered by Utah Medicaid increased by 24,901 or 13.3%. The second peer-to-peer program was launched on November 1, 2020 to 9 local pharmacies. The program focused on surveying pharmacies' dispensing practice for high opioids MME, concomitant use of opioids with benzodiazepines, understanding naloxone standing orders, and Controlled Substances Database registration. The peer-to-peer pharmacist educated the pharmacies about UT Medicaid's restriction on the concurrent use of opioids and benzodiazepines, encouraged filling pharmacists to routinely check the controlled substance database, counsel members on respiratory risk depression, and to dispense naloxone to high-risk members.. The third peer-to-peer program, launched on January 1, 2020 concomitantly with gabapentin/pregabalin restriction edits, focused on reducing the misuse and abuse of gabapentin and pregabalin. Following education points were address in 82 member specific letters to providers: FDA warning on concurrent use of gabapentin or pregabalin with opioid increases the risks of respiratory depression. Concurrent use of gabapentin and pregabalin increases the risks of misuse and abuse After one year of edit implementation, from 186 members on concurrent gabapentin and pregabalin and 87 on high dose gabapentin and pregabalin, by October, 2020, only 4 members had concurrent claims on both gabapentin and pregabalin in transitioning to only 1 medication, and 2 members had claims on high dose gabapentin. The fourth peer-to-peer program started in June 2020 to monitor ADHD stimulants medication used in children under 4 years of age or 6 years of age for some specific medications. Following education points were reviewed during outreach calls and follow up letters with 7 providers: Use of behavioral parent training behavioral management or behavioral classroom intervention as first-line treatments for children with ADHD. Literature supports the use of methylphenidate at least 4 years of age, and there is not sufficient evidence for treatment for children under 4 years of age. The intervention reduced the number of 7 members under 4 and 6 years of age on ADHD stimulant medications in June 2020 to only 1 member under 6 years old received Jornay indicated for 6 years and above in October 2020.

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	An update on opioid high dose peer-to-peer program that was started in FFY 2019 and is ongoing. In January 1, 2019, a threshold of 90 MME was establish for opioid naive member, and 180 MME for opioid experience member. The higher MME threshold would be reduced over time to achieve a common 90 MME standard for all Utah Medicaid members. In Oct 2019, a total of 64 FFS Medicaid members were receiving opioids at 90 MME or greater. The MME limit reduced to 90 MME during FFY 2020. The peer to peer pharmacist continued to contact the prescribers of these members for educational outreach. In Oct 2020 the number of members receiving opioids at 90 MME or greater decreased by 50% to 32 members (during this same period UT Medicaid enrollment increased 22%). All peer-to-peer work is evaluated by and receives approval from the DUR Board. Beginning April 1, 2020, the Hepatitis C Adherence program between clinical pharmacists and FFS members was launched to improve member's adherence to hepatitis C treatments. The following points were discussed during outreach with members: Counseling members on expected adverse drug events, medication directions The importance of adhering to Hepatitis C medications to cure hepatitis C Utilized motivational interviewing to motivate members to adhere to therapy By October 2020, with 179 members enrolled in the program, the adherence rate increased from 80.9% at baseline to 90.1%.
Vermont	RetroDUR Analyses FFY 2020 Appropriate Use of Asthma Controller Medications The National Heart, Lung and Blood Institute has published Guidelines for the Diagnosis and Management of Asthma. The treatment of asthma is done in a step-wise manner, and depending on disease severity, a combination of several agents may be needed. For anyone who requires use of a short acting agent > 2 days/week, a controller medication daily is recommended. The Guidelines state that the frequency of short acting beta-adrenergic inhaler (SABA) use can be clinically useful as a measure of disease activity since increased use of a SABA has been associated with increased risk for death or near death in patients who have asthma. Use of more than one SABA canister every one to two months is also associated with an increased risk of an acute exacerbation. Therefore, the use of more than one SABA canister (e.g., albuterol 200 puffs per canister) during a one-month period most likely indicates over-reliance on this drug and suggests inadequate control of asthma. Additionally, inhaled corticosteroids (ICS) are the preferred long-term control therapy in asthma for all ages, although leukotriene receptor antagonists (LTRA) are listed as an alternative. Long-acting beta-adrenergic inhalers (LABAs) should never be used without first using ICS inhalers due to the increased risk of asthma exacerbations and death. We reviewed paid, non-reversed Medicaid pharmacy claims from January 2018 through December 2018. We reviewed pharmacy and medical claims with dates of service from 1/1/2018 through 12/31/2018, excluding members who had a diagnosis of cystic fibrosis, COPD or emphysema. Members were stratified by age and the number of short acting inhalers used per year. In addition, the number of members in each group who had an ER visit or hospitalization associated with an asthma diagnosis during the study period were reported. Additional analysis was done on those

State	Retrospective DUR Educational Outreach
	using more than 12 short acting inhalers/year and sorted geographically. The board voted to send a targeted mailing to prescribers that have patients on >12 inhalers a year who are not on a controller medication. Additionally this data was presented to the Asthma Advisory panel by a DVHA pharmacy intern. Inappropriate use of Antibiotics: Overuse of antibiotics is associated with both adverse events and resistance. Some classes of antibiotics have idiosyncratic toxicities, such as tendon rupture with fluroquinolones. There are a few conditions for which prolonged use of antibiotics has been shown to be effective and considered now to be standard of care (for example cystic fibrosis, severe acne, TB, MAC, recurrent UTIs). Prolonged use of antibiotics is a practice that is unsupported in conditions such as chronic Lyme disease. We reviewed Vermont pharmacy and medical claims with dates of service from 7/1/18-6/30/19 excluding members who had a diagnosis of cystic fibrosis, chronic bronchitis, chronic UTIs, rosacea, acne, or hidradenitis suppurativa. For the remaining members, 2 types of analysis were done. The first looked at members prescribed more than 12 consecutive weeks of fluroquinolones. The second analysis looked at members with the diagnoses of Lyme disease, anaplasmosis or babesiosis and evaluated the use of antibiotics in that population, both long-term use of one antibiotic or cycling of antibiotics. The prescribers for these members were identified to look at those who are possibly practicing outside of guideline recommendations, perhaps identifying those who would be appropriate for more targeted education. The Board decision was to have DVHA review a sample of medical chart records for members with a tick-borne illness diagnosis. Which was completed via the Quality-of-care process without significant findings. We also explored what cumulative edits are possible across different antibiotic classes to limit use without a PA to 12 weeks, but it determined this would be difficult to implement. Concurrent Use of Opioids and Benzodiazepines We reviewed Medicaid pharmacy and medical claims from calendar year 2019. Members who were prescribed an opioid for at least 90 days (within a 180-day span) were identified we determined how many also had an overlapping prescription for a benzodiazepine with continued use of the opioid. We also looked to see if the member had any hospital admissions or ED visits due to respiratory depression, over-sedation, accidents or death, and whether the provider of the opioid and benzodiazepine was the same or different. Members with a cancer diagnosis were excluded. There were a significant number of members on more than 30 days of a benzodiazepine while also on chronic opioids. Additionally, there are some members with a high number of hospital admissions and/or ED visits. The Board voted to outreach prescribers of patients exceeding 10 ER/hospital visits in 2019. They also were interested in the members' total daily dose for both the opiate and the benzodiazepine which was completed and brought back to the board for review. Blood Pressure Medication Adherence and Long-term NSAID Use in Chronic Kidney Disease (CKD)

State	Retrospective DUR Educational Outreach
	CKD is epidemic in the United States with an estimated 15% of the adult population (37 million) affected, per the CDC as of July 2019. CKD is an independent risk factor for cardiovascular disease, including stroke, CAD and death. There are many causes of kidney disease, including diabetes, hypertension (HTN), hyperlipidemia, inflammatory conditions and drug toxicities, and it is estimated that 80-95% of those with CKD have concurrent hypertension. Many of those with CKD will have multiple risk factors. It is recognized that controlling hypertension can slow the progression of disease and decrease albuminuria, and there are guidelines for treatment that take into account the baseline blood pressure, stage of disease, presence or absence of albuminuria. In general, first line therapies for treating HTN in CKD are ACE inhibitors and ARBs, regardless of whether there is albuminuria. If edema is present, loop diuretics are recommended and calcium channel blockers are recommended as second- or third- line therapy. We reviewed paid, non-reversed Medicaid pharmacy and medical claims from SFY 2019. We identified members with Stage 3 or later CKD, including members on dialysis, and stratified each stage into those with and without HTN. In each group, we identified those on antihypertensive medications, including ACE, ARB, loop diuretics and CCB medications, and medication possession ratio was evaluated to assess compliance. Based on the results the board voted on sending out a general education letter. Concurrent Use of Opioids and Antipsychotics The prevalence of substance use disorder is elevated among those with schizophrenia. Opioid Use Disorder is estimated in the schizophrenic population to be around 4-11%. Antipsychotics, used to treat schizophrenia, are also used to treat other behavioral health conditions, such as mania associated with bipolar disease, depression, PTSD, obsessive-compulsive disorder and anxiety, which are also known to have a high rate of concurrence with Substance Use Disorder. The concern with co-prescribing opioids and antipsychotics is the risk of over-sedation, respiratory depression and death. CMS has highlighted the need to monitor co-prescribing of opioids and antipsychotics for side effects and adverse reactions. Section 1004 of the SUPPORT ACT requires states to implement drug review and utilization requirements including Opioid and Antipsychotic Concurrent Fill Reviews. This analysis used non-reversed Medicaid pharmacy and medical claims from Calendar Year 2019. Members were identified who were prescribed an opioid for at least 90 days and examine how many were given an overlapping antipsychotic prescription along with continued use of the opioid. The data was stratified by age cohorts. We looked to see if the members, while prescribed both types of drugs, had ED visits or hospitalizations that were not behavioral health related, and if the medications were prescribed by the same, or different, prescribers. Members with a cancer diagnosis were excluded. Approximately 10% of members who were taking an opiate for at least 90 days were also prescribed an overlapping antipsychotic. There were also a significant number of ER visits or hospitalizations. The board recommended adding a DUR edit to alert the dispensing pharmacist. PrEP Therapy to Prevent HIV in at-risk Populations: PrEP with antiretroviral drugs has become standard of care for those at high risk of contracting HIV. This

State	Retrospective DUR Educational Outreach
	analysis used paid, non-reversed Medicaid pharmacy claims from Calendar Year 2019 and medical claims from October 2018 through calendar year 2019. Analysis identified members getting either Truvada or Descovy, with no other antiretroviral medication, examined medical claims to see if the guidelines for monitoring had been followed. This includes an HIV test every 3 months, medication adherence counseling, side effect assessment and STD symptom assessment. Renal function should be assessed at 3 months, and if stable, every 6 months thereafter. Women should have a pregnancy test every 3 months. In general there was poor adherence to monitoring members on PrEP therapy. The Board decided on sending educational letters to prescribers of PrEP therapy reminding them that once the decision is made to star PrEP therapy it is necessary to educate the patient about the adherence to necessary monitoring in order to continue therapy .
Virginia	Profile Cycle Profile/Criteria Criteria Description Total Interventions Total Members Total RPhs Total to Nursing Homes Average Response Month-Year Review Date Oct-19 Nov-19 Non-compliance to Antidepressants 139 113 0 0 26.6% Nov-19 Dec-19 Non-compliance to Anticonvulsants 125 100 0 0 22.4% Dec-19 Jan-20 Atypical Antipsychotics in Children Less than 18 Years of Age 237 220 0 0 32.9% Without Metabolic Testing Jan-20 Feb-20 Aripiprazole Without an FDA Approved Indication in History 246 245 0 0 31.3% in the Last 365 days Feb-20 Mar-20 Quetiapine Without an FDA Approved Indication in History 9 9 0 0 11.1% in the Last 365 days Mar-20 Apr-20 CNS Stimulants May Retard Growth in Pediatric Patients 350 314 0 0 34.0% Ages 4 -10 Apr-20 May-20 Bipolar Disorder with Antidepressants and 61 61 0 0 26.2% No Mood Stabilizer May-20 Jun-20 ADHD Amphetamines Linked to Higher Risk of Psychosis 242 242 0 0 25.6%

State	Retrospective DUR Educational Outreach
	Jun-20 Jul-20 FDA Alert: Possible association between use of montelukast 316 316 0 0 14.6% and behavior/mood changes, suicidality, and suicide Jul-20 Aug-20 Use of Antibiotics for URI - Antibiotic Overutilization and 88 73 0 0 12.5% Resistance Aug-20 Sep-20 Non-compliance with Atypical Antipsychotics 43 35 0 0 44.2% Sep-20 Oct-20 SSRI Non-Compliance 72 61 0 0 25.0%
Washington	For FFY 2020 the Agency focused our efforts on completing a single Apple Health Preferred Drug List (AHPDL) to be used by the fee-for-service (FFS) and all five Managed Care (MCOs) pharmacy programs. The pharmacy program in collaboration with The Optimal PDL Solution (TOP$) supplemental rebate vendor reviewed utilization data (FFS claims and MCO encounters) and conducted quarterly analysis that resulted in 95 drug classes being added to the AHPDL and 10 updates to existing AHPDL drug classes. Along with the AHPDL implementation, we developed thirteen drug or drug class policies during FFY 2020 (see list below). These policies are used as part of our prospective DUR prior authorization review to determine medical necessity, safety and efficacy, or less costly alternatives. The policies and drug classes were reviewed and approved by the State DUR board during the open public meetings held throughout FFY 2020. The Agency published all meeting materials and finalized AHPDLs and policies on our Pharmacy webpage and sent provider notices announcing the changes. Policies implemented or updated during FFY 2020: 1. Antiasthmatic Monoclonal Antibodies - Anti-IgE Antibodies 2. Antiasthmatic Monoclonal Antibodies - IL-5 Antagonists 3. Antivirals - HIV Combinations 4. Antivirals : HIV - emtricitabine / tenofovir alafenamide (Descovy) 5. Atopic Dermatitis Agents: Dupilumab (Dupixent) 6. Atopic Dermatitis Agents - Topical Immunosuppressive 7. Atopic Dermatitis Agents - Topical Phosphodiesterase 4 (PDE4) Inhibitors 8. Bone Density Regulators 9. Cytokine & CAM Antagonists 10. Medication Treatment Guidelines for Substance Use Disorders (SUDs) - Transmucosal Buprenorphine 11. Methadone 12. Analgesics: Opioid Agonists 13. Transmucosal Fentanyl Products
West Virginia	Clinical Intervention Program Recognizing that West Virginia has unique health care needs, the Marshall DUR Coalition sought to identify specific clinical interventions that would have the

State	Retrospective DUR Educational Outreach
	most benefit for WV Medicaid clients as well as cost savings. The following clinical interventions were approved and prioritized by the WV DUR Board. In order of prioritization: 1. Concurrent Opioid and Benzodiazepine Therapy Patients who receive an opioid equivalent to 50 MME or greater and receive a benzodiazepine are at a higher risk of respiratory failure. Lower opioid dosages with underlying lung disease or other therapy which contributes to respiratory depression place the patient at risk. Total profiles reviewed: 1387 Letters sent: 911 Letter rate: 66% 2. GERD and PPI therapy greater than 90 days. The usual duration of PPI therapy in GERD is 8 weeks (about 60 days). Long-term PPI therapy is associated with osteoporosis and fractures, pneumonia, hypomagnesemia, and Clostridium difficile (C. diff) infections. Total profiles reviewed: 286 Letters sent: 156 Letter rate: 55% 3. Diagnosis of Diabetes Mellitus (DM) without either an ACE Inhibitor or an ARB. Many studies have demonstrated the benefit of ACE inhibitors or ARBs in DM patients, including the prevention of both macrovascular and microvascular complications, with moderate hypertension. Data from the ONTARGET Trial showed that both telmisartan and ramipril offered equivalent renal protection. Clinical guidelines for the management of DM strongly recommend the use of an ACE Inhibitor or ARB if tolerated. RetroDUR Committee clinicians look for diagnoses or signs of adverse effect which may restrict the use of ACE Inhibitors or ARBs prior to prescribers receiving a letter. Total profiles reviewed: 286 Letters sent: 156 Letter rate: 55% 4. Diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD) without statin therapy. The 2018 Cholesterol Clinical Practice Guidelines recommend intensive statin therapy for patients who are 75 years of age or younger with clinical ASCVD. Intensive statin therapy can only be achieved with atorvastatin or rosuvastatin. Evidence is suggestive that cholesterol-lowering alone does not explain all the benefits of statin therapy in ASCVD. RetroDUR Committee clinicians look for evidence that a statin is not tolerated prior to prescribers receiving a letter. Total profiles reviewed: 286

State	Retrospective DUR Educational Outreach
	Letters sent: 156 Letter rate: 55% 5. Concurrent GLP-1 receptor agonists and DPP-4 inhibitor therapy. The mechanisms of actions of GLP-1 receptor agonists and DPP-4 inhibitor therapy overlap to some degree leading to the likelihood concurrent therapy is less beneficial than if another agent had been selected. DPP4-inhibitors decrease the elimination of gut incretins and GLP-1 is a gut incretin. Prescribers receive a letter explaining this overlap of mechanisms of action. Total profiles reviewed: 105 Letters sent: 44 Letter rate: 42% 6. CHF and concurrent NSAID therapy. NSAIDs are not to be used in patients with CHF per the Heart Failure guidelines. There are several mechanisms of adverse effects however the most rapid adverse effect is fluid accumulation due to inhibiting prostaglandin activity in the kidneys. NSAIDs also have been shown to blunt the effects of diuretics in CHF patients. Patients who have CHF and are receiving systemic NSAIDs have a greatly increased incidence of hospitalizations due to acute CHF exacerbation. The American Heart Association guidelines on heart failure strongly discourage their use and indicate these agents cause harm to such patients. Total profiles reviewed: 98 Letters sent: 44 Letter rate: 45% 7. Diagnosis of Helicobacter pylori and PPI therapy greater than 14 days. The usual maximal duration of therapy for the treatment of Helicobacter pylori is 14 days with PPI therapy. Long-term PPI therapy is associated with osteoporosis and fractures, pneumonia, hypomagnesemia, and Clostridium difficile (C. diff) infections. Total profiles reviewed: 39 Letters sent: 17 Letter rate: 44% 8. Heart Failure with Reduced Ejection Fraction (HFrEF) and on diltiazem or verapamil. Diltiazem and verapamil are non-dihydropyridine calcium channel blockers and have strong negative inotropic effects further suppressing the ability of the heart to contract adequately. The American Heart Association guidelines on heart failure strongly discourage their use and indicate these agents cause harm to HFrEF patients. Total profiles reviewed: 4 Letters sent: 3

State	Retrospective DUR Educational Outreach
	Letter rate: 75% 9. CHF and on a thiazolidinedione (pioglitazone or rosiglitazone). The thiazolidinedione class has been proven to increase the risk of and worsen existing CHF. The American Heart Association guidelines on heart failure discourages their concurrent use with CHF and warn these agents cause harm to CHF patients. Likewise, the 2020 American Diabetes Association's Standards of Medical Care also recommends avoiding the thiazolidinedione class in patients who are at risk for CHF or have existing CHF. Total profiles reviewed: 53 Letters sent: 31 Letter rate: 55% 10. CHF and Dronedarone therapy. Several clinical trials have established an increased risk of mortality and stroke in CHF patients. Dronedarone has a Black Box Warning against use in patients with decompensated heart failure. The American Heart Association guidelines on heart failure discourages their concurrent use of Dronedarone with CHF. Total profiles reviewed: 2 Letters sent: 2 Letter rate: 100% 2308 members were reviewed for Clinical Letters to be mailed to physicians. Of those, 1335 (57%) clinical intervention letters were mailed to prescribers. A total of 258 feedback forms were received via fax over the course of the year. Of those 258 faxes, it was found that 127 (49%) were marked Useful, 80 (31%) were marked Neutral, 28 (11%) were marked Not A Patient and 23 (8.9%) were marked Not Useful. After assessing the issue with Not Useful, it was found subsequently that it is a non-compliance issue on part of the patient more than a prescriber issue. We will make necessary revisions to the letters for quality assurance. The overall tone of the letters was changed this year to decrease the number of negative or hostile comments that we received. Fine tuning these letters left us with a decrease in the number of negative comments and irate calls. The Marshall DUR Coalition overall saw a 52% reduction in ED visits and a 50% reduction in patients being admitted. This results in an 18% reduction in ED charges and a 53% reduction in IP charges.
Wisconsin	Summary 1: Retrospective Educational Outreach Summary [SUM1-2020-WI-REOS] Prepared by Health Information Designs, LLC June 2021 Executive Summary

State	Retrospective DUR Educational Outreach
	This report prepared for the Wisconsin Badger Care Plus, Medicaid and SeniorCare Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of criteria exceptions reviewed during Federal Fiscal Year (FFY) 2020. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. Program Background Health Information Designs, LLC (HID) currently provides RDUR services for the Wisconsin Badger Care Plus, Medicaid and SeniorCare population. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria on a monthly basis to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month HID evaluates Wisconsin Badger Care Plus, Medicaid and SeniorCare pharmacy claims data against criteria for several hundred potential drug therapy issues. Standard criteria are developed by HID with any customized applications presented to the Wisconsin Drug Utilization Review Board for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by an HID clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 12 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for up to 12 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of standard educational outreach letters mailed for the top 10 retrospective DUR interventions based on the number of therapeutic criteria exceptions reviewed for each criteria type. For FFY 2020, Wisconsin reviewed at least one recipient in each of 340 different criteria. In addition to these standard HID criteria, Wisconsin performs targeted interventions that

State	Retrospective DUR Educational Outreach
	include custom prescriber education letters addressing potential medication issues. These interventions include an opioid and benzodiazepine intervention, recipients receiving a drug in each of the following five drug classes: opioids, opioid dependency agents, stimulants, benzodiazepines, and sedative hypnotics, and recipients receiving a drug in each of the four following drug classes: opioids, benzodiazepines, sedative hypnotics, and skeletal muscle relaxants. WISCONSIN BADGER CARE PLUS, MEDICAID AND SENIORCARE STANDARD EDUCATIONAL OUTREACH SUMMARY FFY 2020 CRITERIA CRITERIA DESCRIPTION RECIPIENTS SELECTED LETTERS MAILED PRESCRIBER TYPE FOR INTERVENTION RESPONSES LI OVERUTILIZATION OF CONTROLLED SUBTANCES 779 1,135 186 DD CONCURRENT OPIOID/ANTIPSYCHOTIC USE (SUPPORT ACT) 981 2,441 334 ER APPROPRIATE USE OF IMMEDIATE RELEASE OPIOIDS 26 34 5 TA MULTI-CLASS POLYPSYCHOPHARMACY 33 42 7 ER OVERUTILIZATION OF STIMULANTS/HIGH DOSE 67 88 15 TA SECOND GENERATION ANTIPSYCHOTICS METABOLIC SCREENING 11 16 2 ER HIGH MME OPIOID THERAPY (SUPPORT ACT) 187 229 55 LI OVERUTILIZATION OF CONTROLLED SUBTANCES W/ POISIONING 266 477 99 DB STIMULANTS CONTRAINDICATED IN AGITATED STATES 433 505 71 TA ANTIDEPRESSANT BEHAVIOR CHANGES IN PEDS/YOUNG ADULTS 131 175 32 TOTAL 2,914 5,142 806 RESPONSE RATE 16% Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments.

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	Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 5,142 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 806 responses were received for a response rate of 16%. A summary of all coded responses from prescribers is listed in the table below. RESPONSE CODE PRESCRIBER RESPONSE # OF RESPONSES AA BENEFITS OF THE DRUG OUTWEIGH THE RISKS 137 AB PHYSICIAN UNAWARE OF CONCURRENT USE10 AE PATIENT IS NO LONGER UNDER THIS PHYSICIAN'S CARE 96 AF PHYSICIAN FEELS PROBLEM IS INSIGNIFICANT. NO CHANGE IN TX. 10 AG PHYSICIAN WILL REASSESS AND MODIFY DRUG THERAPY 51 AI PATIENT HAS DISCONTINUED OR WILL DISCONTINUE THE DRUG 51 AK MD DOES NOT DISCUSS DRUG THERAPY CONFLICT 3 AP PHYSICIAN TRIED TO MODIFY THERAPY; PATIENT NON-COOPERATIVE 17 AS IS MY PATIENT BUT HAVE NOT SEEN IN MOST RECENT 6 MONTHS 44 AW PATIENT DECEASED 2 BA PATIENT NEVER UNDER THIS PHYSICIAN'S CARE 38 BB PATIENT HAS APPT. TO DISCUSS DRUG THERAPY PROBLEM 123 BE MD DID NOT PRESCRIBE DRUG ATTRIBUTED TO HIM/HER 41 BG AWARE OF INTERACTION, MONITORING PATIENT 183 TOTAL RESPONSES 806 Results Discussion With respect to prescriber responses to RDUR letters, a response rate of 16% was achieved. Approximately 54% of prescribers indicated that some positive action resulted from the intervention letter. These actions include: prescriber was alerted to unknown concurrent use, patient has an appointment to discuss therapy, will reassess and modify drug therapy, therapy was discontinued, tried to modify therapy, currently monitoring patient. All standard, and most customized, intervention letters include the recipient's drug claims data within the previous 12 months and any available diagnosis data to provide as complete of a drug and diagnosis history as possible. This approach provides prescribers with the information needed to fully review and evaluate each recipient's drug history. Conclusion

State	Retrospective DUR Educational Outreach
	For FFY 2020, a total of 5,142 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 16% was achieved. In their responses, 54% of prescribers indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter.
Wyoming	Wyoming converted from the traditional retrospective profile review and individual letters to comparative prescriber reports on targeted prescribing issues in FFY15. The Wyoming DUR program sent education letters or comparative reports on the following topics in FFY20: Concurrent use of antipsychotics and opioids, at least quarterly (155) Narcotic use and pregnancy, monthly (13) Prescription Drug Monitoring Program, weekly (77) 7-day initial fill limit on opioids (904) Montelukast black box letters (456) Fluconazole use in pregnancy (45) Initial treatment of tobacco dependence (152) Gabapentin off-label use comparative prescriber reports (10) Montelukast black box comparative prescriber reports (19) Substance abuse disorder and opioid use (87) Antipsychotic and opioids comparative prescriber report (16)

Section IV - DUR Board Activity

1. Summary 2 – DUR Board Activities Summary

Summary 2: DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.

Table 57 - DUR Board Activities

State	DUR Board Activities Report
Alabama	Summary 2 DUR Board Activities The Alabama Medicaid Drug Utilization Review (DUR) Board held four meetings during fiscal year 2020. Meetings were held in October 2019 and January, April, and July of 2020. The following retrospective DUR (RDUR) therapeutic categories were added: Therapeutic Appropriateness Overutilization Drug-Disease Interaction Drug-Drug Interaction High Dose Non-Adherence Therapeutic Effectiveness Therapeutic Duplication Appropriate Use There were no RDUR therapeutic categories deleted during fiscal year 2020. Retrospective DUR and Prospective DUR (ProDUR) are both utilization review techniques; however, the methods used in each type of review differ. ProDUR is an online review that assists the pharmacist in screening drugs for potential drug therapy problems before the prescription is ever delivered to the patient. Reports generated from prospective DUR can show trends and patterns to focus on during a manual review using Retro DUR techniques and provides valuable targeting for educational intervention. DUR Board policy establishes activities of the DUR Board and states that the DUR Board shall identify and develop topics of education for practitioners based on common identified drug therapy problems as needed to improve prescribing or dispensing practices. During FFY 2020, the DUR Board recommended articles for the quarterly newsletter, as well as verbiage for electronic based intervention letters to providers that contain patient specific information. Articles included information regarding the 2019 Global Initiative for Asthma (GINA) guidelines; changes to pharmacy vaccine administration billing; Summary of the 2019 American College of Cardiology/American Heart Association (ACC/AHA) guidelines; information regarding the Cumulative Daily MME limit decrease; updated treatment guidelines for attention deficit/hyperactivity disorder (ADHD); pharmacy updates related to COVID-19; updated American Gastrological Association (AGA) guidelines for the treatment of ulcerative colitis; and guidelines regarding the use of Dispense as Written (DAW) code of 9. During FFY 2020, the DUR Board reviewed palivizumab utilization and reviewed the short-acting opioid naive and MME edits that were implemented.

State	DUR Board Activities Report
	DUR minutes can be located at the following link: http://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.3_DUR_Board.aspx
Alaska	General Information The Alaska Medicaid Drug Utilization Review (DUR) Committee was established to comply with Sec. 1927 (g) of the Social Security Act, Title 42 CFR 456 and Alaska Administrative Code 7 AAC 120.120. During FFY 2020 the committee was comprised primarily of 4 physicians and 4 pharmacists, who were licensed and actively practicing health care professionals in the State of Alaska. The DUR committee met four times during FFY 2020 and discussed the following retrospective and prospective criteria: November 2019 Prospective DUR - Interim prior authorization 6 month review - Firdapse/Ruzurgi (review of criteria) - Vyndaqel/Vyndamax (review of criteria) - Corlanor (review of criteria) - Xiaflex (review of criteria) - Oxycodone IR (review of criteria) - Hydromorphone (review of criteria) Retrospective DUR - Opioids, utilization patterns with benzodiazepines and antipsychotics, ICD-10 compliance and member MME's - ADHD drug utilization and stimulant criteria - Reviewed HSS guidance for opioid dose reduction January 2020 Prospective DUR - Interim prior authorization 6 month review - Jynarque (review of criteria) - Evenity (review of criteria) - Vumerity (review of criteria) - Tecfidera (review of criteria) - Cosentyx (review of criteria) - Hepatitis C all genotypes (review of criteria) Retrospective DUR - Opioids, utilization patterns with benzodiazepines and antipsychotics, ICD-10 compliance and member MME's - Reviewed GINA guidelines and usage of short acting beta agonist April 2020 Prospective DUR - Interim prior authorization 6 month review - Dupixent (review of criteria) - Xolair (review of criteria) - Oxbryta (review of criteria) - Interleukin-5 inhibitors (review of criteria) - Orexin antagonists (review of criteria) - Retrospective DUR

State	DUR Board Activities Report
	- Opioids, utilization patterns with benzodiazepines and antipsychotics, ICD-10 compliance and member MME's Sept 2020 Prospective DUR - Interim prior authorization 6 month review - Strensiq (review of criteria) - Nexletol/Nexlizet (review of criteria) - Oxervate (review of criteria) - CGRP antagonist Injectable-Oral (review of criteria) - Epidiolex (review of criteria) - Orilissa/ Oriahnn (review of criteria) Retrospective DUR - Opioids, utilization patterns with benzodiazepines and antipsychotics, ICD-10 compliance and member MME's - Reviewed concomitant use of sedatives with benzodiazepines and sent provider letters Prospective Drug Utilization Review (ProDUR) The DUR Committee has continued their attention on ProDUR issues during FFY 2020. New prior authorizations and quantity limit edits were approved to address issues of actual or potential fraud, waste, abuse, misuse, overuse or medically unnecessary care. Emphasis was also given to review of existing criteria to ensure relevancy and medical appropriateness. ProDUR interventions are monitored periodically and presented to the committee to assess the success of the intervention and to determine if additional edits are required to address safety or utilization issues. Modifying current edits to other drug classes has been a good tool in maintaining cost effective use of generics and reduce the amount of possible waste and overutilization. The biggest challenge and most consuming issues during FFY 2020 revolved around COVID 19 and edits made to the POS system. Retrospective Drug Utilization Review (RetroDUR) The DUR Committee conducted retrospective reviews during FFY 2020. The criteria for claims review are frequently selected by the committee coordinator based on trend reports or suggested drug related issues by the committee members. In addition to the selected criteria members review for therapeutic duplication, drug interactions, overutilization, and poly-providers usage. The retrospective reviews periodically unearthed opportunities to consider the development of prospective edits. RetroDUR issues are generally addressed with educational interventions such as prescriber letters or direct prescriber contact via phone. The logistics of face-to-face interactions with prescribers is difficult due to the large geography of the state with many communities having limited road access. The DUR Committee may also refer potential cases of overutilization or fraud, waste or abuse identified during the RetroDUR to the Care Management program and/or the Program Integrity unit. Relaying relevant prescription information to providers is a challenge. One enhancement the committee is attempting to use to further communicate with providers is automatic emails delivered by GovDelivery. Additionally, data trends identified by other organizations such the FDA (e.g. FAERS reports), Pharmacy Quality Alliance [PQA] (e.g. quality measures), and the Drug Abuse Warning Network [DAWN] (e.g. DAWN reports) have been incorporated to aid in directing our focus on nationally identified issues. Given our smaller relative patient population and regional isolation, trends observed nationally may not have

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	triggered signals in our data. By evaluating nationally identified trends in our own data, we hope to catch the early signals and work on prevention initiatives before they blossom into larger issues. Meeting Agendas and Minutes The meeting agendas and minutes for the four meetings during FFY 2020 can be found on the State Medicaid website.
Arkansas	ARKANSAS MEDICAID DUR BOARD ACTIVITIES SUMMARY FFY2020 The Arkansas Medicaid DUR Board meets quarterly (January, April, July, and October) on the 3rd Wednesday of the meeting month. The Arkansas Medicaid Drug Review Committee (DRC) meets quarterly (February, May, August, and November) on the 2nd Wednesday of the meeting month to discuss preferred drug list changes. The DUR Board is comprised of 11 voting members with 6 pharmacists and 5 physicians. Also, the DUR Board contains 5 non-voting members which includes 3 members that represent each MCO, the Department of Human Services Medical Director as an advisor, and the Secretary of Health from the Arkansas Department of Health as an advisor. The DRC is comprised of 7 voting members with 4 pharmacists and 3 physicians as well as 3 non-voting members which represent each MCO. Both the DUR Board and DRC meetings are open to the public. During FFY2020, the DRC added the following therapeutic drug classes to the PDL (effective 10/1/2019 through 9/30/2020): MAT injections, hypoglycemic agents, injectable CGRP antagonists, ophthalmic immunomodulators, and osteoporosis agents. The DRC updated the following therapeutic drug classes in the PDL: inhaled antibiotics, growth hormones, otic anti-infectives, pancreatic enzymes, topical anti-parasitic, short-acting opioids, ophthalmic agents, topical corticosteroids, testosterone products, bladder relaxants, long and short-acting beta agonists, intranasal rhinitis agents, topical antifungals, triptans, COPD agents, inhaled glucocorticoids, multiple sclerosis agents, NSAIDs, long-acting opioids, and pulmonary arterial hypertension agents. The DUR Board reviews and approves ProDUR edits used in screening drug claims at POS for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug duration, drug-allergy interactions, and clinical abuse/misuse. ProDUR alert level is set at the highest severity level to avoid false positive messages. The pharmacy contractor provides quarterly updates on ProDUR edits based on POS claims. ProDUR reports were provided by the contractor quarterly to the DUR Board which included drugs with ProDUR alert overrides along with percentages of claims overridden. FFY2020 QUARTERLY REPORT: 1st Quarter (Oct-Dec 2019): On average, 69.3% of paid claims were screened for a ProDUR edit. The average ProDUR alerts overridden by the pharmacists at POS for therapeutic duplication (TD) was 34.4%, early refill (ER) was 0.47%, drug-drug interaction (DD) was 16.8%, incorrect duration (ID) was 52.5%, and high dose (HD) was 52.5%. 2nd Quarter (Jan-Mar 2020):

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	On average, 68.7% of paid claims were screened for a ProDUR edit. The average ProDUR alerts overridden by the pharmacists at POS for therapeutic duplication (TD) was 34.6%, early refill (ER) was 0.41%, drug-drug interaction (DD) was 16.7%, incorrect duration (ID) was 54.5%, and high dose (HD) was 54.5%. 3rd Quarter (Apr-June 2020): On average, 71.6% of paid claims were screened for a ProDUR edit. The average ProDUR alerts overridden by the pharmacists at POS for therapeutic duplication (TD) was 34.3%, early refill (ER) was 0.16%, drug-drug interaction (DD) was 17.6%, incorrect duration (ID) was 42.7%, and high dose (HD) was 42.7%. 4th Quarter (July-Sept 2020): On average, 68.8% of paid claims were screened for a ProDUR edit. The average ProDUR alerts overridden by the pharmacists at POS for therapeutic duplication (TD) was 34.2%, early refill (ER) was 0.15%, drug-drug interaction (DD) was 17.6%, incorrect duration (ID) was 48.4%, and high dose (HD) was 48.4%. The DUR Board approves POS edits based on billed diagnoses, lab values, and previous therapies tried through paid claims on the client's Medicaid profile. Updates to POS edits for FFY 2020 include: *Removed PA criteria for PrEP therapy *Removed manual review PA criteria for Entresto, Sensipar, erythropoiesis stimulating agents, Lovaza, and Lysteda and added POS criteria for all of these agents based on lab values and billed diagnoses *Added a POS denial edit for Leucovorin based on autism diagnosis *Added age edits for targeted immune modulators *Added quantity/maximum dose edits for gabapentin The DUR Board reviews data presented for RetroDUR screening to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The RetroDUR program typically provides the following information to the DUR Board: top therapeutic categories by claims cost, top drugs by claims cost, program summary with cost PMPM, prescribing/pharmacy outliers, and state comparison. This data impacts recommendations on claim edits or clinical criteria edits. There are no Board policies that establish how results of ProDUR impacts RetroDUR or how results from RetroDUR impacts ProDUR. Though many times results of RetroDUR reports prompt updates to ProDUR criteria and PDL changes. The DUR Board reviews and approves all RDUR educational intervention criteria for the RetroDUR review for the next quarter based on recommendations by the contractor. Educational letters based on the Board approved criteria are mailed to providers who have patients identified with the review criteria. Health Information Designs was the contractor from October 2019 to June 2020. Magellan Rx Management was the contractor from July 2020 to present. See more information on RetroDUR educational interventions in Section III of this survey. Note that therapeutic categories based on SUPPORT Act requirements and overutilization/underutilization were the most common categories for educational intervention for FFY2020. The DUR Board reviews proposals for prior approval criteria algorithms for drugs covered by the Arkansas Medicaid Pharmacy Program and provide recommendations for approval.

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	Recommendations for manual review and POS criteria take into consideration the following factors: (1) Differing but acceptable modes of treatment; (2) Methods of delivering care within the range of appropriate diagnosis; (3) Treatment consistent with professionally recognized and evidence-based patterns of care; and (4) Consideration of Medicaid's obligation to pay only for care that is in fact medically necessary and delivered efficiently and economically. New and updated clinical criteria and edits for FFY2020 include the following drugs and drug classes: 1st Quarter: Ingrezza, Austedo, Hemlibra, Cablivi, Piqray, Xpovio, Iressa, Nubeqa, Turalio, Inrebic, Nucala, Baqsimi, Rozlytrek, 2nd Quarter: Idiopathic pulmonary fibrosis agents, asthma treatment update, Temodar, Nourianz, Egaten, Trikafta, Feiba, Novoseven RT, Pretomanid, Nayzilam, Oxbryta, 3rd Quarter: Brukinsa, Tazverik, Ayvakit, Revlimid, Spravato, 4th Quarter: Repatha, Praluent, Acthar, Isturisa, Koselugo, Tukysa, Pemazyre, Palforzia, Tabrecta, Retevmo, Sunosi, Wakix, and Xyrem. In FFY2020, the DUR Board was provided an update on opioid utilization for Arkansas Medicaid clients, update on medication-assisted treatment criteria, and update on opioid and benzodiazepine utilization for Arkansas Medicaid clients. These updates demonstrated the positive impact made by previous DUR Board decisions. Providing education to prescribers and pharmacies is an important part of our DUR program. Quarterly, a provider memo is posted on the contractor website and Medicaid website with new information approved during the DUR and DRC meetings. The provider memo also contains useful links and tips on various topics (i.e., MAT treatment, billing vaccines, emergency overrides, early refill thresholds, and opioid information). The contractor tracks changes made during the DUR Board meeting and DRC meeting by updating a PA criteria document with links to memos and criteria that is posted on their website. Prescribers and pharmacy providers are emailed the link to the new memos when posted.
California	The DUR Board met four times during FFY 2020. The first two meetings were full-length, in-person meetings. Due to the coronavirus disease 2019 (COVID-19) pandemic, the meetings held in May 2020 and September 2020 were abbreviated, webinar-only meetings. Prospective DUR Criteria Presented 1. Review of new Generic Code Number (GCN) sequence numbers: The DUR Board recommended turning on additional alerts for 49 new GCNs that matched drugs appearing on the Medi-Cal target drug list for prospective DUR. Retrospective DUR Criteria Presented 1. Review of Retrospective DUR Criteria: New Additions to the Medi-Cal List of Contract Drugs in FFY 2018. During FFY 2018 there were a total of 22 new prescription medications added to the Medi-Cal List of Contract Drugs. Utilization data (total number of paid claims and utilizing beneficiaries with at least one paid claim) were reviewed for each of these drugs. Fourteen drugs had low utilization (< 20 utilizing beneficiaries during all of the months reviewed) and were not reported in detail. The Board did not suggest additional evaluation for any of these drugs.

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	2. Antihyperglycemic Medications. A presentation by Board member Dr. Robert Mowers provided a brief overview of pharmacologic approaches to glycemic treatment, noting treatment should be patient-centered and efficacy and patient factors should be considered when choosing pharmacologic treatment of blood glucose. Dr. Mowers then reported on recent literature showing sodium-glucose co-transporter 2 (SGLT-2) inhibitors and glucagon-like peptide-1 receptor agonists (GLP-1 RA) may decrease the risk of cardiovascular events, hospitalizations, and death, while decreasing the total cost of care. Dr. Mowers then showed high-level data looking at antihyperglycemic medication use in the Medi-Cal population, stratified by both FFS and MCP enrollees. Dr. Mowers reported low adoption for SGLT-2 and GLP1-RA medications in the Medi-Cal population and proposed that non-endocrinologists don't feel comfortable prescribing SGLT-2 or GLP1-RA. Dr. Mowers proposed writing a DUR educational bulletin discussing the current American Diabetes Association (ADA) and American College of Cardiology (ACC) policies on using SGLT2 inhibitors and GLP1-RA in the treatment of T2DM. This educational bulletin was published in August 2020. 3. ADHD Medications. A summary of the Office of Inspector General report, Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Followup Care, which was published on August 13, 2019 was presented. It was noted that a follow-up visit after ADHD medication will be a part of the DHCS Quality Improvement Strategy for 2020. 4. Fluoroquinolones. Utilization of fluoroquinolones showed a 40% decrease in the total number of Medi-Cal fee-for-service beneficiaries identified with at least one paid claim for a fluoroquinolone during the measurement year from a similar analysis in 2016. The eligible Medi-Cal fee-for-service population during this same time period decreased by only 10%, so the use of fluoroquinolone medications decreased beyond what would be expected from a simple decrease in the eligible population. There was also an overall decrease in potentially inappropriate use of fluoroquinolones among the study population by 11%. A review of female beneficiaries in the study population with potentially inappropriate use of fluoroquinolones during the measurement year showed the lowest improvement (a decrease from 71% to 61%), most likely impacted by the greater use of fluoroquinolones to treat uncomplicated UTI in this population. The Board recommended updating a previous bulletin on fluoroquinolones and sending another provider letter focused on fluoroquinolone use for uncomplicated UTI. 5. Hepatitis C Virus (HCV) Drugs. Paid claims for HCV medications with dates of service between October 1, 2018, and September 30, 2019 (FFY 2019), in both the Medi-Cal FFS and MCP population, were reviewed. In comparison with FFY 2018, there was increased use of glecaprevir/pibrentasvir and sofosbuvir/velpatasvir. HCV treatment policy guidelines were modified by DHCS in March 2020, in order to more closely align with American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) guidelines. All beneficiaries continue to be required to have a baseline HCV-RNA level and comprehensive metabolic panel before initiating treatment, and that while there are analytical limitations including a lack of clinical data, prescribing trends remain in line with guidelines and there is very limited evidence of retreatment over time (< 20 beneficiaries). These findings were similar to three prior annual reviews of HCV treatment, and the Board decided these data no longer needed to be reviewed annually.

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	6. Beers Criteria Drugs. Paid claims were analyzed for Medi-Cal beneficiaries age 65 years and older not eligible for Medicare (FFS and MCP). The measurement year was calendar year 2019 (1/1/19-12/31/19) and drugs were identified using the most recent National Drug Code (NDC) list from the Use of High-risk Medications in Older Adults (DAE) HEDIS measure. The top 20 drugs by utilizing beneficiaries were reported for both the Medi-Cal FFS and MCP populations. FFS non-duals with a paid claim for a DAE drug represented 4% of all FFS beneficiaries 65+ years of age and 19% of all FFS non-duals, while MCP non-duals with a paid claim for a DAE drug represented 6% of all MCP beneficiaries 65+ years of age and 21% of all MCP non-duals. The rate of beneficiaries with at least one high-risk medication (19% FFS and 21% MCP) is slightly higher than national averages for Medicare beneficiaries, which was 14.6% (HMO) and 13.5% (PPO) in 2018. The Board agreed there may be opportunities for educational outreach within this population, as the non-dual 65+ years of age population has not been the focus of any recent outreach. DUR Board Involvement in Provider-specific Interventions: The DUR Board advises and makes recommendations for educational articles, alerts, and provider intervention letters. The Board chair may appoint a Board member with subject matter expertise to perform a focused review, as appropriate. Educational articles and alerts: 1. Alert: New Global Guidelines for the Treatment of Asthma 2. Improving the Quality of Care: Risks Associated with Use of Gabapentin 3. Drug Safety Communication: Mental Health Side Effects from Montelukast 4. Drug Safety Communication: Withdrawal of All Ranitidine Products 5. Improving Quality of Care: Update of Risks Associated with Use of Fluoroquinolones 6. Clinical Guideline: Reproductive Health in Rheumatic and Musculoskeletal Diseases 7. Clinical Review: 2020 Standards of Care for Treatment of Type 2 Diabetes 8. 2020 Immunization Updates: Vaccination during COVID-19, Flu, HepA, and Tdap Provider intervention letters: 1. GINA Guidelines Letter (January 2020) 2. Gabapentin Letter (January 2020) 3. Additive Toxicity Letter (January 2020) 4. Montelukast Letter (April 2020) 5. Ranitidine Letter (May 2020) 6. Fluoroquinolones and UTI Letter (July 2020) 7. Gabapentin/Opioids Letter (July 2020) Ongoing DUR Board projects: The DUR Board goals for FFY 2020 were as follows: Support DHCS Medi-Cal Rx initiative Continue to promote dialogue, collaboration among MCOs Present innovative practices and projects Share approaches and lessons learned Disseminate DUR educational bulletins to MCPs Integrate/align FFS and MCO DUR action items Align goals with DHCS Comprehensive Quality Strategy Align goals with California Advancing and Innovating Medi-Cal (CalAIM) Revisit Healthcare Effectiveness Data and Information Set (HEDIS) measures

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	Continue to use the Vital Directions Framework to focus on the three DUR priority areas: 1. Optimizing Drug Prescribing and Dispensing, including specialty drugs 2. Optimizing Pain Management and Opioid Use 3. Optimizing Chronic Disease Management, including prevention
Colorado	Four DUR Board meetings were held in FFY 2020: November 12, 2019 (in person) February 11, 2020 (in person) May 12, 2020 (virtual) August 11, 2020 (virtual) Summary of DUR Board meeting discussion and motions made in regard to reviewed ProDUR criteria additions/deletions: November 12, 2019: Anti-emetics: Discussion regarding chemotherapy-induced nausea and vomiting, as well as duration of approval for agents indicated for nausea and vomiting associated with pregnancy. Hepatitis C Virus Treatments (Direct Acting Antivirals): Motion made regarding requirement of SVR 24 occurred for State to investigate further. Pulmonary Arterial Hypertension (PAH) Agents (Endothelial Antagonists): Motion made regarding addition of REMS language to criteria. Targeted Immune Modulators: Motion made regarding addition of contraindication to definition of failure and trial of TNF inhibitors for receipt of non-preferred agents. February 11, 2020: Antimigraine Agents (Calcitonin Gene-Related Peptide (CGRP) Inhibitors): Motion made to accept proposed criteria changes with clarification for Emgality dosing by indication and medication overuse headache literature review. Multiple Sclerosis Agents: Motion made to accept criteria proposals with added language to protect patients of childbearing age and teratogenesis. Immune Globulins: Motion made to accept criteria with addition of LTC or home health clause. Atypical Antipsychotics: Motion made for State to reevaluate criteria for Abilify MyCite. Motion was made to accept changes and adjust aripiprazole quantity limits for pediatric patients if incremental dosing is not achievable by currently set limits. Growth Hormones: Motion was made to add qualifying diagnoses of symptomatic neonatal growth hormone deficiency and small gestational age. May 12, 2019: Non-Opioid Analgesics: Motion made to accept proposed criteria changes with consideration for expanding access to Tresiba for children. Opioids (Short-Acting): Discussion occurred regarding the age requirement for tramadol with consideration that the drug is highly utilized, particularly in children with complex medical conditions. Additionally, recommendation was made to add under the supervision of a pediatric specialist. Androgenic Agents: Motion made regarding feedback provided from pediatricians at Children's Hospital that there is no need for breast exam and PSA when used in children, and to recommend adding onset of primary hypogonadism prior to this age 12 years of age and older to the criteria. Respiratory Inhalants: Discussion occurred regarding the number of Proair inhalers per month being high. Motion made that quantity limits should change to 2 inhalers per 30 days. Nayzilam: Discussion regarding the need for these products and consideration for access occurred. Motion made to remove the need for trial and failure of midazolam vial. Valtoco: Motion made to change the criteria to reflect that of Nayzilam.

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	August 11, 2020: Anticonvulsants (oral): State DUR Pharmacist introduced the discussion for this class and highlighted changes made to this class as the result of previous reviews, including addressing clinical needs, improving access, and providing a fairly extensive preferred agent list. In addition, clarifying DAW1 designations for brand versions of preferred agents in this class for preferred agents do not require PA. Board requested clarification on minimum ages in criteria table for Depakote, Depakene and generic divalproex and valproic acid products, such as the greater than/equal to 10 years age limit being applicable to all valproic acid-containing products. Motion made to change Epidiolex (cannabidiol) criteria so that all bullet points, for consistency, include the phrase diagnosis of seizures associated with for Lennox Gastaut and Dravet syndromes in order to match FDA-approved language. Motion made to create a separate, specific section of criteria for Fintepla (fenfluramine) to be consistent with other anticonvulsants indicated for the management of seizures associated with Dravet syndrome for two bullet points: 1. Member age greater than 2 years and 2. Fintepla being used for the treatment of seizures associated with Dravet syndrome. Discussion occurred regarding value in consultations with providers at National Jewish Health and UCHealth when making therapeutic decisions involving agents in this drug class, explaining that consultation process creates a system of checks and balances between primary care providers and specialists. The Board asked for clarification about new information released from a Phase IV trial with Aptiom (eslicarbazepine) that was mentioned during speaker testimony from Sunovion. Clarification was provided that this trial has not yet been peer reviewed or published at this time leading to Board discussion for not considering any changes to criteria at this time. Motion made to change language in criteria for non-preferred, newly started anticonvulsants to be prescribed by or in consultation with a neurologist. Stimulants and other ADHD Agents: Motion made to create PA criteria to allow for the use of methylphenidate IR for 4 and 5 year old members whose ADHD symptoms are not controlled despite adequate behavior interventions, based on the American Academy of Pediatrics ADHD Practice Guideline published in October 2019. Discussion occurred regarding possibly making changes in the criteria for Journay PM with consensus to wait until more data becomes available for that product. Diabetes Management Classes (GLP1 Analogues): Discussion regarding GLP1 medication availability to members who are not able to use an injectable dosage form; since many GLP1 analogues are delivered via a pen, important to consider physical inability to use a pen delivery system (such as lack of manual dexterity) as a treatment failure. Motion made to add inability to self-administer due to dexterity limitations to the list that defines failures. Diabetes Management Classes (SGLT2 Inhibitors): Discussion occurred regarding new evidence regarding the benefits of SGLT2 inhibitors (dapagliflozin and empagliflozin) in heart failure, with or without concomitant diabetes; concluding that based on this evidence, the requirement for a 3 month trial of metformin may be considered for removal. Anticoagulants: Motion was made to add VTE prophylaxis in the setting of malignancy to criteria for Eliquis (apixiban). Colony Stimulating Factors: Motion was made to modify criteria for Udenyca to include lack of caregiver or support system or inadequate access to healthcare facility or home care interventions as bypass criteria for use of the long-acting agent. Bone Resorption Suppression and Related Agents: Motion was made to change no history of vertebral fracture to no history of low trauma or fragility fracture in section describing bisphosphonate use after 5 years of therapy.

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	Board policies that establish whether and how results of RetroDUR screening are used to adjust ProDUR screens: The DUR Board reviews trends in the RDUR reports on a quarterly basis. This process has, in some cases, led to further analyses being conducted by the CO-DUR team, with subsequent recommendations provided to the Colorado Department of Health Care Policy and Financing (HCPF). Inversely, ProDUR criteria can influence RDUR activity when there are utilization trends for a specific drug product or within a specific therapeutic class. This drug use activity may lead to further investigation of the impact of ProDUR changes on prescribing patterns (such as for opioids, benzodiazepines, or psychotropic medications in pediatric members). DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.): RetroDUR prescriber educational outreach letters are reviewed by the DUR Board for input and recommendations. No DUR Newsletters were published during FFY 2020, as funds originally designated to produce two annual DUR Newsletter publications were reallocated to manage a significant increase in contractual expenses required for provision of pain management telephone consultation services. Policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring): Interventional letters that contain patient-specific information are sent to prescribers on a quarterly basis. There is no specific policy to determine the areas of focus for these interventions, although clinical topics are often identified through utilization patterns, changes in FDA product labeling, and clinical module analyses (see Colorado Summary 5: Innovative Practices). The letters tend to include rotating clinical topics such as high risk opioid prescribing, high risk benzodiazepine prescribing and high risk psychotropic prescribing in children.
Connecticut	Indicate the number of DUR Board meetings held. Four DUR Board meetings were held during FFY 2020; December 2019, March 2020, June 2020, and September 2020. See link below for meeting minutes. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf DUR BOARD MEMBERSHIP - 10/01/2019 to 09/30/2020 Kenneth Fisher, R.Ph. (Chair), Dennis Chapron, M.S., R.Ph., Richard Gannon, Pharm.D., Keith Lyke, R.Ph., Bhupesh Mangla, M.D., MPH., Ram Illindala, M.D., Carol Drufva, R.Ph., Angela Boggs, Pharm.D. BCPP, Damian Dos Santos, M.D. List additions/deletions to DUR Board approved criteria. 1. For prospective DUR, list problem type/drug combinations added or deleted. No Prospective DUR criteria were added, deleted or modified during FFY 2020 by the DUR Board. 2. For retrospective DUR, list therapeutic categories added or deleted. Based on this survey's character count restrictions, criteria therapeutic categories could not be included in summary 2. See link below for meeting minutes, which includes criteria reviewed by DUR Board included. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf

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	Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. No specific Board policies were in place for the coordination of prospective and retrospective DUR screenings. The Retrospective DUR vendor, Health Information Designs Inc. account representatives attended DUR Board meetings and RetroDUR criteria were proposed to the Board. It has always been standard practice for the state of Connecticut to expect that the Retrospective DUR vendor would be familiar with and report any pharmacy who was consistently overriding ProDUR alerts through the retrospective review of client-specific, prescriber, and most certainly pharmacy-specific profiling reviews. The RetroDUR vendor was aware of the ProDUR criteria and the clinical review pharmacists kept the ProDUR criteria in mind with each client-specific profile review. Retrospective DUR screens have always been used by the state of Connecticut, Department of Social Services to help in establishing new cost-containment and appropriate therapy policies and programs, including changes to ProDUR edits when necessary. If pharmacies are found to be overriding ProDUR criteria excessively then the problem is investigated for creative solutions. Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). The quantities of RetroDUR intervention types are set contractually by CT Medical Assistance Program Department of Social Services. The DUR vendor reviews prescription drug history and diagnosis claims data to perform monthly interventions. Numbers and types of interventions are included in summary 2. The contractor is required to review 2,000 patient profiles per month for the regular RetroDUR program based upon criteria approved by the DUR Board. 1,000 monthly profiles focus on an adult intervention and 1,000 monthly profiles focus on a pediatric intervention. Separate from the RetroDUR program is the Lock-In Program. For the Lock-In Program, the contractor is required to review 800 patient profiles per month. The contractor is required to conduct educational interventions with prescribers based upon criteria involving overuse of drugs with potential for abuse, doctor shopping, and pharmacy shopping. Patients are warned and if their excessive use does not change within 90 days, the recipients are locked-in to one pharmacy for one year, at which time their drug usage is re-evaluated. The criteria reviewed by the DUR Board during FFY 2020 are included in Summary 3 including which criteria were approved, tabled, or rejected. Four educational newsletters were mailed to targeted prescribers and pharmacies during FFY 2020. See link below for DUR newsletters. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Newsletters.pdf

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Delaware	Although faced with the challenges of the COVID-19 public health emergency, Delaware was successful in adapting and transitioning to hold its DUR Board meeting virtually. As in past years, the DUR Board Meeting was held in conjunction with the P&T Committee meeting. By having one cohesive board, Delaware facilitates broad ranging discussions on drug utilization, drug coverage policies and feedback from the community. The annual DUR/P&T Meeting occurred September 24, 2020. Both managed care organizations' pharmacy directors, which represent 85% of the Medicaid population in Delaware, participated in the DUR/P&T committee meeting. In Fall 2019, Delaware added the following Drug-Drug interaction alerts to create real time POS warnings and automated retroactive prescriber outreach specifically to address the SUPPORT Act requirement requiring electronic notifications (safety edits) around drug interactions with opioids: %u2022Opioid-Antipsychotic %u2022Opioid-Sedative %u2022Opioid-Muscle Relaxant %u2022Opioid-Benzodiazepine It is DE's and the DUR Board's goal that these new alerts coupled with our provider education outreach initiatives will promote safety and proper use and prevent abuse of opioids in our member population. Throughout FFY 2020 various ProDUR alerts were added monthly through FDB DUR updates. For example, below is a sampling of some of the most useful alerts adopted for new drugs released in FFY 2020: %u2022Drug-Geriatric Warnings o Maxquin o Valtoco %u2022Drug-Pediatric Warnings o Fintepla o Reblozyl %u2022Drug-Disease Warnings o Wakix o Ayvakit %u2022Drug-Drug Warnings o Zeposia: warning for MAOIs o Nourianz: warning for CYP3A4 Inhinitors o Tabrecta: warning for Clozapine
District of Columbia	There were twelve (12) meetings of the DUR Board held once monthly during FY20. Beginning in March 2020, Board meetings were switched to a virtual format due to COVID-19 emergency restrictions in place in the District of Columbia. List additions/deletions to DUR Board approved criteria a) For prospective DUR, list problem type/drug combinations added or deleted. Benzodiazepine and opiate concurrent use clinical criteria: ProDUR edits elevated to level 1 severity alert requiring pharmacist intervention Sickle Cell Disease clinical criteria: Oxbryta criteria added to establish accurate diagnosis via gene sequencing. Adakveo criteria added to capture hemoglobulin levels and hematologist specialty prescribing COVID-19 Treatment clinical criteria: Remove EKG testing criteria for hydroxychloroquine and azithromycin concomitant use during PHE

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	Antiretroviral medications and statin interactions: ProDUR edits added with POS on-screen messaging Zolgensma Prior Approval criteria- approved for medical benefit only Buprenorphine and buprenorphine/naloxone: Add pharmacogenetic testing PA requirements for daily dosage >24 mg PrEP criteria and PA form: Remove 3-month lab report criteria and HBV testing requirement b) For retrospective DUR, list therapeutic categories added or deleted Clonidine use in Opioid withdrawal symptoms alleviation Evaluation of albuterol inhaler utilization patterns during PHE Polypharmacy: target opiate and antipsychotic concurrent use to include all CII to V drugs Vitamin D utilization in COVID-19 treatment PrEP utilization patterns Board members routinely raise concerns about issues encountered during their retrospective review of patient profiles. By motion and voice vote, the Board states the problem encountered and requests the District and/or the FFS Pharmacy Benefit Manager staff to research root causes and to present proposed interventions at subsequent meetings for Board review. One example is when Board members raised concerns about the effectiveness of severity level 1 alert messages sent to pharmacists during point of sale electronic claims processing, the PBM staff was able to provide an analysis that gave the incidence of level one hard edit stops and the reasons entered for any subsequent system overrides. As a result, provider communications on the most frequent drug-drug interactions resulting in severity level one alerts were included in the bi-monthly Provider Bulletin sent to all Medicaid enrolled providers. Another example of Board initiated action was when concerns about the frequency and severity of the drug interactions between statins and HIV antiretroviral medications were voiced by one of the members. This led to a proposal for soft messaging edits at POS alerting the pharmacist to any potential adverse effects. Led by the efforts of a DHCF staff clinical pharmacist, the Board worked with community-based thought leaders and Medicaid providers to prepare a working document entitled Guidelines for Collaborative Management of Opioid Use which addressed the opioid epidemic in the District. Discussion with these providers assisted the Board members in drafting recommendations for opioid treatment clinical criteria and best practices. Balancing the requirements and goals of the SUPPORT Act and the District's legislative mandate to removal barriers to all MAT modalities, including medications, has been a Board focus again this year to assure that appropriate prospective edits and retrospective reviews are in place. Members share peer-reviewed articles of interest and provide critiques and recommendations for District Medicaid staff follow-up where applicable. Each month Board members review 300 randomly generated patient profiles to make determinations on the type of provider specific intervention that will be sent to give an update on new treatment guidelines or as a reminder of current peer-reviewed standards of care. Although the onset of the COVID-19 pandemic momentarily delayed the review process, members have been able to complete their reviews through a courier service pick-up and delivery orchestrated by the retroDUR contractor. Most of these interventions take place in the form of a letter addressed to the prescriber detailing the individual patient, medication(s), and treatment protocol in question. In some cases, Board members have initiated direct peer-to-peer contact with a prescriber to discuss the rationale for a particular treatment protocol and whether

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	clinically supported alternatives are available. Additionally, Board members select four population-based disease management topics each year that are used in a more general education/awareness campaign.
Florida	The DUR Board reviews and approves drug use criteria and standards for both prospective and retrospective drug use reviews. It applies these criteria and standards in the application of DUR activities. The goal of the Florida Medicaid DUR program is to promote appropriate prescribing and use of medications. Magellan Medicaid Administration's ProDUR system is an integrated component of the online, real-time point of sale (POS) system. It compiles both medical and pharmacy claims data into comprehensive online beneficiary health summaries. Pharmacy claims are evaluated according to approved criteria against each member's summary. Claims history includes current, historical, paid, and denied claims data, regardless of the media source of the claims submission. The real-time evaluation of POS claims permits identification of drug therapy problems prior to dispensing. The RetroDUR utilization analyses, as described below, provides information which assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians to potential drug therapy problems, identifies opportunities to improve drug therapy and makes recommendations to avoid drug therapy problems. The ongoing operation of the RetroDUR program is a shared responsibility of Magellan Medicaid Administration, a Magellan Medicaid Administration Company, and the Agency for Health Care Administration (Agency). Each quarter, specific therapeutic areas that have been approved by the DUR Board are targeted for focused review under the RetroDUR program. Magellan Medicaid Administration applies the specified criteria established by the Board to the prescription and health claims files and identifies medication regimens that violate the criteria. Results of analyses are provided to the Board during quarterly meetings. Electronic educational letters are created by Magellan Medicaid Administration, regarding targeted criteria. Letters are reviewed and approved by the DUR Board and the Agency. The electronic letters are posted to a designated provider alert area of the Agency's website for the provider community. (http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml). With enhanced technology, Magellan Medicaid Administration offered the DUR Board the ability to provide recommendations to the Agency for POS edits to assist in the mission of the Board, which include educating physicians and positively impacting prescribing for Florida Medicaid recipients. The DUR Board reviews the potential edits and makes recommendations based on their clinical expertise and knowledge. DUR Board members frequently collaborate with colleagues regarding drug utilization issues and bring the results of those discussions back to the DUR Board for consideration. The Florida Medicaid DUR Board met four times during the Federal Fiscal Year 2020. During this timeframe, Magellan Medicaid Administration recommended RetroDUR criteria associated with drug to drug interactions, inappropriate dosing, therapeutic duplication, polypharmacy, safety precautions and overutilization of medications. Magellan Medicaid Administration produces a monthly newsletter/Clinical Alert to educate the provider community about the most recent issues in the pharmaceutical industry and new drug information. These newsletters are available on the Magellan Medicaid Administration website and can be accessed at: https://www1.magellanrx.com/magellan-rx/publications/pharmacy-clinical-alerts.aspx Summary of DUR Board activities: Review the top 20 therapeutic classes by claims volume and expenditure to identify appropriate therapies and intervention opportunities.

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	The DUR Board voted to implement a soft edit denying an inhaled corticosteroid if an asthma recipient did not receive rescue therapy within the previous 6 months. The DUR Board reviewed the post impact data. Given the updated 2020 GINA guidelines, the DUR Board removed the edit for recipients 12 years of age and older. The edit remains for recipients less than 12 years of age. Review recipients on Long Acting Injectable Antipsychotics (LAI AP). The DUR Board reviewed utilization of LAI AP via the automated prior authorization including barriers to treatment. The Agency removed on the oral tolerability requirement from the automation logic on 07/21/20 to increase access to therapy. The DUR Board reviewed concomitant use of opiates and benzodiazepines. The DUR Board voted to create a hard edit denying concomitant therapy at the POS following a provider educational campaign. The DUR Board reviewed the post impact of the edit during the June 2020 DUR Board meeting. The DUR Board reviewed concomitant use of stimulants and benzodiazepines. The DUR Board voted to move from a soft edit to a hard edit denial. The DUR Board reviewed the post impact of the hard edit during the April 2020 DUR Board meeting. The DUR Board continued the review of recipients receiving antidepressants greater than FDA approved limits. The DUR Board reviewed physician specialties for recipients exceeding the FDA dosing limits with a subset review for children 6 to 17 years of age. The DUR Board continued to review polypharmacy in Tumor Necrosis Factor (TNF) inhibitors. The DUR Board reviewed polypharmacy recipients including if claims are from the same physician, determined physician specialty, and further research into trends in data (cost and product utilization). The DUR Board reviewed antipsychotic polypharmacy and voted to implement edit to limit a recipient to two antipsychotics of the same chemical entity. The third antipsychotic would require a clinical prior authorization. The DUR Board reviewed the post impact of the edit during the June 2020 DUR Board meeting and determined that no further action is needed. The DUR Board voted to create a hard edit for opiates and non-benzodiazepine sedative concomitant therapy. The DUR Board reviewed the post impact of the edit during the June 2020 DUR Board meeting. The DUR Board voted to implement an automated prior authorization on all formulations of calcipotriene for age, diagnosis, and duration of therapy and the DUR Board voted to create an automated prior authorization for doxepin 5% cream to include diagnosis. The DUR Board reviewed the post impact results during the March 2020 DUR Board meeting. The DUR Board voted to create a therapeutic duplication edit for statin and long acting insulin therapeutic classes. The DUR Board reviewed an extended pre and post study period to better determine impact of each edit during the September 2020 DUR Board meeting. The DUR Board requested a comprehensive look at FDA approved indications for the anticonvulsant class to determine the percentage prescribed for an FDA approved indication. The DUR Board voted to implement a soft edit for recipients on multiple anticonvulsants (>2 unique anticonvulsants per 30 days). DUR intervention codes will be required at the POS to allow for claim processing. Products to treat acute increased seizure activity are excluded. The DUR Board reviewed the post impact during the September DUR Board meeting and will continue to review anticonvulsant data. The DUR Board reviewed Hepatitis C utilization and retreatment trends over a 3-year period. The DUR Board reviewed opiates and antipsychotic concomitant therapy. In response to the SUPPORT Act, the Agency implemented a soft edit to deny claims at the POS requiring pharmacist intervention to enter DUR codes for claim payment. The DUR Board reviewed the post impact during the March 2020 DUR Board meeting.

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	The DUR Board voted to implement an automated prior authorization for pancreatic enzymes including an FDA diagnosis look back. The DUR Board reviewed further data on physician specialty and a deeper review of potential off-label use. The DUR Board reviewed the post impact data during the September DUR Board meeting and determined no further action is necessary. The DUR Board reviewed utilization and clinical trends for Spinal Muscular Atrophy (SMA) therapy. The DUR Board reviewed utilization of Lyrica. The DUR Board reviewed off-label use. The DUR Board voted for an automated prior authorization for Lyrica based on FDA approved indications. The DUR Board reviewed utilization of gabapentin. The DUR Board received input from a pain specialist during the September 2020 DUR Board meeting. The DUR Board voted for a 3,600 mg daily quantity limit and a soft edit for concomitant use of gabapentin with benzodiazepines, opiates, skeletal muscle relaxants or Lyrica. Given the opioid epidemic the Agency in conjunction with the DUR Board and P&T Committee have made steps to increase access to opioid dependency treatment and curb abuse. The DUR Board reviewed short acting (SA) opiate utilization trends from January to June for years 2017, 2018, and 2019. There was a successful decline in SA opiate utilization over the review period. The DUR Board reviewed Medication Assisted Treatment (MAT) access in pregnancy for potential intervention opportunities. An edit was deployed to increase access to MAT therapy in pregnant women with Opiate Use Disorder (OUD). The DUR Board reviewed the post impact of the edit during the September DUR Board meeting. The DUR Board discussed utilization and access to Makena. The DUR Board reviewed utilization of insulin therapy. The DUR Board reviewed the influenza vaccine utilization and antiviral utilization trends over 3 seasons. Summary of additions/deletions to DUR Board approved criteria: The DUR Board reviewed and voted to approve the concomitant therapy criteria. The DUR Board reviewed and updated the Hepatitis C criteria. Automated prior authorization (Auto-PA) criteria developed for topical therapies Doxepin and Calcipotriene. Auto-PA criteria for pancreatic enzymes. The DUR Board created and reviewed criteria for SMA therapy. Auto-PA criteria for Lyrica. Buprenorphine induction criteria updated. Growth Hormone criteria updated.
Georgia	-4 meetings were conducted on the following dates in 2020: Tuesday, February 4; Tuesday, May 5; Tuesday, August 4; Tuesday, November 3. -New drugs reviewed included: Adakveo Oxbryta Aklief Annovera Beovu Nourianz Rinvoq Vumerity Xenleta Nurtec ODT Reyvow

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	Ubrelvy Vyepti Vyondys 53 Wakix Caplyta Esperoct Nexletol Palforzia Xcopri Xepi Due to limited characters that can be inputted, detailed meeting information cannot be provided here. However, meeting minutes for all DURB meetings can be found at: https://dch.georgia.gov/providers/provider-types/pharmacy/drug-utilization-review-board/2020-durb-meeting-information
Hawaii	Hawaii's FFS DUR Board meetings are held quarterly. Due to lack of quorum pre-COVID, 2 out to 4 meetings were possible. Virtual meetings were held during COVID shelter-in place requirements. Additions/deletions to the DUR Board approved criteria were as follows: ProDUR, type/drug combinations added or deleted: none, opioids review for FFY2021 additions and deletions were initiated. RetroDUR, therapeutic categories added or deleted: antiviral for hepatitis C. Board policies respect that Hawaii's demographics does not fit the usual clinical study participants' profiles. ProDUR screening is the beginning for RetroDUR screens to identify variation from expected clinical norms, and then RetroDUR screens are adjusted to meet Hawaii's demographics before ProDUR screening can be validated. Clinical ProDUR is not always reality for our Hawaii population, i.e. quantity limits for patient access due to rural and island geography. RetroDUR must adjust to prescriber's physical availability on-island or patient's need to travel off-island. Continued loss of prescribers on neighbor islands also creates outliers and trend shifts due to poor supply and continued demand for service. (One loophole was evaluated with RetroDUR screening adjustment to reduce the risk of abuse of or addiction to a controlled substance, as needed to avoid harmful drug interactions, or as otherwise medically necessary.) RetroDUR screening is used to adjust ProDUR screens to ensure medically necessary access to drugs. For example, Synagis RetroDUR determines ProDUR for the start and end dates for the next season. Northern and Southern hemisphere exposure to viruses due to the extensive tourist industry usually expands our coverage period beyond what is noted on the Mainland (other 49 states). Recommendations are provided by the DUR Board for the State to efficiently and effectively reach targeted providers: quantity of information, specific provider types and type of outreach. For example, dental information should not be combined with non-dental; the dental vendor bulletin as well as the medical vendor bulletin is to publish a modified notice; and MCOs are advised of changes to the FFS program, beside the FFS provider memorandum.

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	The mix of patient or provider specific intervention types is defined by the experience of our DUR Board members. The knowledge of our members' practice settings and professional organization activities are valued resources tapped. Past interventions successes and failures are evaluated for future improvements to interventions and/or monitoring for trends. Phone intervention has been very success for individual pharmacies with a specific educational opportunity shared.
Idaho	The DUR Board conducted three meetings during the year, with Board members playing an active role in intervention selection and decision making. DATES October 17, 2019 January 16, 2020 April 16, 2020 During FFY20, the following RetroDUR activities were performed on behalf of the Idaho DUR Board: SUPPORT Act Butalbital Migraine Medications Anticoagulants Testosterone Injection Idaho Opioid Equivalent Dosing Project Methadone Naloxone Utilization High Dose Opioid Use Participants and Naloxone Use Vimpat Cardiac Rhythm and Conduction Abnormalities Clonazepam Rectal Diazepam Benzodiazepines and Opioids Deprescribing Benzodiazepines Foster Children and Behavioral Health Drugs Antipsychotics and Opioids Sublocade Esketamine Board policies on prospective and retrospective DUR screens. Prospective DUR messages are presented and reviewed quarterly at the DUR Meetings. If the Board feels that results from these reviews warrant action prospective DUR screens are adjusted accordingly. Results from retrospective interventions undergo assessment by the DUR staff on a quarterly basis as well. Areas of prescribing and dispensing practices that are inappropriate and potentially widespread are identified. These may require the addition of prospective screens via the on-line system and are presented at the next Board meeting and voted on for approval. Describe DUR Board involvement in the DUR education program. The DUR Board, with recommendations from the DUR staff, approves all intervention strategies deemed necessary to improve the quality of care for Medicaid recipients. Data in summary 1 of this report indicates the type and quantity of interventions involved in this program. For example,

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	providers receive direct personal communications from the Board requesting information and documentation for specific drug use decisions, when prescribing practices have not met the criteria adopted by the Board. These interventions have been mailed to both physicians and pharmacists where possible. The DUR Board approves which type of educational leaflets are enclosed for each intervention mailing to inform the provider of the criteria and literature used to support the intervention.
Illinois	The Illinois Drug Utilization Review (DUR) Board conducted two meetings during FFY20. Fewer meetings were held due to interim Bureau Chief transition in FFY20 quarter 1 and due to COVID-19 pandemic changes during FFY20 quarter 3. Meeting agendas and minutes are available on the Illinois Department of Healthcare and Family Services (HFS) Drug Utilization Review Board Web site. Clinical staff from HFS Medical Programs and the University of Illinois at Chicago College of Pharmacy develop prospective criteria for DUR Board approval at the quarterly meetings. Medication utilization review, adjudication processes, and Illinois DUR Board discussion are used to generate prospective and retrospective DUR items for evaluation and edits. Retrospective review prompts creation of new or adjustment of established prospective criteria and/or prescriber/pharmacist educational initiatives. Prior authorization criteria and forms are posted on the Prior Authorization Web. During FFY20, the following topics related to prospective edits were discussed and/or approved and implemented: H2-blockers: discussion of N nitrosodimethylamine (NDMA) findings in ranitidine and nizatidine and Food and Drug Administration (FDA) recommendations. Pharmacy claims review demonstrated approximately 75% decrease of ranitidine claims and stable nizatidine fills. Since nizatidine can no longer be ordered by pharmacies from wholesalers and ranitidine claims have decreased, the DUR Board recommended following FDA recommendations and no prospective edits at this time. Tofacitinib (Xeljanz) was reviewed in light of new FDA black box warnings regarding increased rate of all-cause mortality and thrombosis in patients with cardiovascular risk factors taking the 10-mg dose. Since tofacitinib is preferred with prior authorization to ensure appropriate and safe use, no additional prospective edits were deemed necessary at this time. The FDA boxed warnings should be used to guide appropriateness of therapy during adjudication of tofacitinib prior authorization claims. Changes due to COVID-19 pandemic were reviewed. The Four Prescription Policy and 3-Brand limit edits were temporarily lifted for the duration of the pandemic. Medication access was also facilitated by adjustments to days' supply, quantities for supplies, medications used for symptomatic treatment of COVID-19, and OTC coverage changes. The 90-day supply allowed list of medications was expanded due to COVID-19. More information regarding edit adjustments due to COVID-19 made during FFY20 are available in the March 20, 2020 and May 20, 2020 provider notices posted on the HFS Coronavirus (COVID-19) updates Web page (https://www.illinois.gov/hfs/Pages/coronavirus.aspx). HFS extended prior approval for chronic hydroxychloroquine therapy and instituted a limited days' supply edit for new pharmacy claims based on the March 2020 FDA Emergency Use

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	Authorization for hydroxychloroquine. The FDA revoked the hydroxychloroquine EUA on June 15, 2020. Review of less than or equal to 8-days' supply hydroxychloroquine claims demonstrated uptake in April and May with usage decreasing June through August 2020. Opioid-related prospective edits implemented based on SUPPORT for Patients and Communities Act (SUPPORT Act) were reviewed: 7-day initial opioid fill, 90 MME edit for opioid naive participants, 120 MME edit for chronic opioid users identified at time of edit implementation, drug interaction edit for concomitant opioid and benzodiazepine use, and an informational edit regarding concomitant opioid and antipsychotic use. The duplicate edit for short-acting narcotics was re-instituted. The edit requires prior authorization for two strengths of the same medication or for two drugs that are designated as short-acting narcotics (for example, Tramadol will reject against Norco). Since all long-acting opioids require prior authorization, duplicate long-acting opioids are addressed during adjudication of long-acting opioid prior authorization requests. The Illinois DUR Board addressed the following drug classes and issues retrospectively during FFY20: Concomitant opioid and benzodiazepine or antipsychotic use. Recommendations for prospective edits were made by the DUR Board. Prospective edits were implemented as noted in the prospective edit summary. Antipsychotic use in children. The DUR Board made recommendations for changes to the prior authorization request forms and recommended additional review to identify antipsychotic polypharmacy in children 8 through 17 years of age. Concomitant opioids and sedative hypnotic use. Further review with Illinois Prescription Monitoring Program data that captures cash payment for these medications was recommended to confirm low concomitant use. Montelukast monotherapy and steroid-containing inhaler prescriber interventions for adult participants with asthma from April 2018 through February 2020 were reviewed. The prescriber interventions facilitated a 41% increase in steroid inhaler use in participants previously treated with montelukast monotherapy and a 42% and 47% increase in steroid inhaler fills in participants with previous low and high steroid inhaler use, respectively. Inclusion of new montelukast safety issues in the prescriber intervention letters was recommended. The DUR Board and Drug Utilization Review Web pages continued to be used as educational vehicles for providers during FFY20. The following educational topics were discussed and/or links approved for posting for providers on the Drug Utilization Review Web site: Prescriber educational item targeting ketorolac and NSAIDs: Improving safety of ketorolac use Educational item for pharmacists: Call for pharmacists to help patients with asthma HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long term opioid analgesics

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	National Academies of Sciences, Engineering, and Medicine's consensus study report: Framing opioid prescribing guidelines for acute pain: Developing the evidence Montelukast black box warning regarding serious behavior and mood related changes in patients with or without history of mental illness Illinois Advance (Academic Detailing Visits And New evidence CEnter) initiative.
Indiana	DUR Board meetings are held monthly. Nine meetings were held during FFY 2020. Due to the COVID-19 pandemic, three meetings were canceled until accommodations for virtual meetings could be obtained. For prospective DUR, the DUR Board focuses on three major initiatives: SilentAuth applications, prior authorization criteria, and mental health medication utilization edits. During FFY 2020, the DUR Board reviewed and approved the continued use of SilentAuth, an automated point-of-sale prior authorization application. New and updated SilentAuth prior authorization criteria were implemented for the targeted immunomodulators, opiates, stimulants, monoclonal antibodies for the treatment of respiratory conditions, multiple sclerosis agents, COX II inhibitors and select non-steroidal anti-inflammatory agents (NSAIDs), and aromatase inhibitors. The DUR Board reviewed and approved the following new and updated manual prior authorization criteria: hepatitis C agents, cystic fibrosis agents, testosterones, narcolepsy agents, antimigraine agents, movement disorder agents, pulmonary antihypertensive agents, PCSK9 inhibitors, Spinraza%u00ae, and muscular dystrophy agents. The DUR Board removed prior authorization criteria for buprenorphine and buprenorphine naloxone and gonadotropin-releasing hormone (GnRH) analogs. The DUR Board approved additional utilization edits on mental health medications. This is an ongoing effort to enhance quality and appropriateness of mental health prescribing practices. Claims that exceed or do not meet the established utilization edit will require prior authorization. No therapeutics categories for retro-DUR were added or deleted during the reporting period. Analyses of both pro-DUR edits and retro-DUR criteria are used by the Office of Medicaid Policy and Planning (OMPP) (through its contractors and the DUR Board) to help establish new cost-containment initiatives and to monitor rational drug use and prescribing. It has been standard practice by the OMPP and DUR Board to expect that OptumRx will develop and present innovative ideas on cost containment & therapeutic appropriateness through DUR program efforts. The DUR Board advises on the Preferred Drug List (PDL), pro-DUR and retro-DUR programs, PA programs, and newsletters that address educational issues that relate to the prescribing and utilization of prescription drugs in the most cost-effective manner. Provider Bulletins and DUR Board Newsletters that notify and educate prescribers and pharmacists on specific topics associated with the prospective DUR and retro-DUR programs are reviewed and approved by the DUR Board. These documents are posted publicly online for review and referenced in retro-DUR faxes. For more information regarding the DUR Board review, please utilize the following link to access DUR Board minutes, Dear Dr. Letters, Newsletters, and other pertinent documentation. https://inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp
Iowa	Additions/deletions to DUR Board approved criteria Prospective DUR: Currently, the DUR Board does not review the Prospective DUR criteria specific to problem type/drug combinations. Change Healthcare utilizes MediSpan for prospective DUR criteria.

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	Retrospective DUR: Currently, the DUR Board does not review the Retrospective DUR criteria. Change Healthcare, utilizes MediSpan for retrospective DUR criteria involving a complex screening process. Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens and whether results of retrospective DUR screening are used to adjust prospective DUR screens: Prospective DUR system reporting has not been developed to support this function. When conflicts between the ProDUR and RetroDUR systems are discovered, the Board determines appropriate resolution of these conflicts and recommends appropriate actions. The Iowa DUR program has several prior authorization categories that prospectively promote therapeutically appropriate and cost-effective use of medications. DUR Board involvement in the DUR education program and policies adopted to determine mix of patient or provider specific intervention types: Interventions are directed to both physician and pharmacist providers. The DUR Board approves all educational information that is utilized when performing interventions. Letter intervention is utilized in most cases. Telephone intervention may be utilized, particularly when patients are using multiple providers in a patterned fashion or in serious or life threatening circumstances. When no provider response is received following letter intervention and the medication therapy continues to put the patient at risk for an adverse event, another intervention may be attempted such as a registered letter, a telephone intervention, or a face-to-face intervention. Selection of an intervention depends on the severity of patient risk and is determined on a case-by-case basis. The need for these more intensive interventions is rare. Patient-focused reviews are completed with the review of select Fee-for-Service (FFS) patient profiles coinciding with each meeting (four times annually). The DUR contractor generates these profiles through a complex screening process. The first step of the screening process subjects' member profiles to a therapeutic criteria screen. If a profile is found to have failed one or more therapeutic criteria, the patient profiles are then assigned a level of risk based on their medication history and potential for adverse events regarding medication. The profiles with the highest level of risk are then selected for review. Six months of prescription claims data and medical claims data, if available, are assessed to determine this risk factor. The DUR modules developed by MediSpan are used to screen for therapeutic problems. Problem-focused reviews target specific issues for an in-depth educational effort. Issues stimulating review are selected from findings of patient-focused reviews, reviews of medical literature, as well as the Board members' practice experiences. Criteria are developed to identify the patients who may benefit from intervention. Patient profile selection is developed for each problem-focused review. All initiatives are discussed at DUR meetings in coordination with the MCOs with all entities reviewing their member population. The DUR Board develops and distributes a newsletter two times annually. The DUR Board also maintains a web site, www.iadur.org.
Kansas	SUMMARY OF DUR BOARD ACTIVITIES FOR FFY 2020 1. Four DUR Board meetings. 2. a. Additions Changes Deletions to DUR Board Approved Criteria are listed below. 2. b. DUR contractor RDUR report activity is given in other DUR survey sections. 3. DUR Board responsibilities and activities are part of FFS and MCO contracts and direction for the DUR Program is predominantly determined by the State. 4. We have increased DUR Board inclusion of provider education and have discussed that a more effective and engaging process needs to be initiated. 5. The DUR pharmacist creates quarterly newsletters for the providers.

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	6. We use provider bulletin notices regarding drugs requiring prior authorizations and pharmacy-related changes in general. These bulletins are also posted to the Kansas Medical Assistance Program website,. Some provider notices are also sent through our global messaging system. OCTOBER 09, 2019 DUR BOARD MEETING Adult Rheumatoid Arthritis Agents Atopic Dermatitis Agents Crohn's Disease Agents Ulcerative Colitis Agents Multiple Sclerosis Agents Opioid Products Indicated for Pain Management Blanket Statement PDL Criteria Inclusion Blanket Statement List of immunomodulating biologic agents/Janus Kinase Inhibitors Antidepressant Medications Safe Use for All Ages Antipsychotic Medications Safe Use for All Ages JANUARY 8, 2020 DUR BOARD MEETING Hepatitis C Agents Lyrica CR Multiple Sclerosis Agents Minimum Requirements Prior Authorization Narcolepsy Agents JULY 8, 2020 DUR BOARD MEETING Botulinum Toxins Type 2 Diabetes Mellitus Agents Opioid Products Indicated for Pain Management Atopic Dermatitis Agents Ulcerative Colitis Agents Revised Criteria Plaque Psoriasis Agents Hepatitis C Agents Multiple Sclerosis Agents Antidepressant Medications Safe Use for All Ages Antidepressant Medications Safe Use for All Ages Antipsychotic Medications Safe Use for All Ages ADHD Medications Safe Use for All Ages RDUR Criteria Further Review Migraine Prophylaxis Agents Migraine Acute Treatment Agents Duchenne Muscular Dystrophy Agents Advanced Medical Hold Manual Review Fee-for-Service Retrospective Drug Utilization Review Topic Selections Minimum Requirements Prior Authorization

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	Codeine Products in Children SEPTEMBER 10, 2020 DUR BOARD MEETING Minimum Requirements Prior Authorization Opioid Dependence Agents Spinal Muscular Atrophy Agents Tecartus Antidepressant Medications Safe Use for All Ages Antipsychotic Medications Safe Use for All Ages
Kentucky	The operation of the DUR program is a shared responsibility of Magellan Medicaid Administration (MMA), the Kentucky Cabinet for Health and Family Services and the Drug Management Review Advisory Board (DMRAB). The DMRAB did not meet during FFY2020. During FFY2020, the following RetroDUR activities were performed on behalf of the DMRAB: Prescriber-lettering activities: Diabetes without an ACE Inhibitor or ARB Leukotrienes without a diagnosis of asthma Short-acting bronchodilator without a controller medication Adherence to antihypertensive agents Newsletter features: FDA Warnings about Oral Diabetes Agents Black Boxed Warning for Antidepressants Metformin Extended Release Product Recalls Flu Vaccine Coverage for Medicaid Recipients All specific drug and drug classes reviewed are targeted for focused review under the RetroDUR program monthly with additional quarterly in-depth review. MMA then applies the specified criteria established to the prescription drug and health claims files and identifies medication regimens that are not congruent to the criteria established. Copies of individual claims history profiles that are not consistent with the criteria are generated by MMA and sent to clinical reviewers for in-depth review. If, based on the professional judgment of the clinical reviewers or the MMA Kentucky Medicaid Clinical Manager, an aberrant pattern of prescribing and/or utilization is indeed present, an educational letter is sent to the prescribing physician and/or the dispensing pharmacist informing the provider of the suspected problem. MMA produces and mails provider letters documenting the therapeutic effects of the RetroDUR program and tracks provider responses associated with the interventions. Based on provider responses and recommendations from DMRAB, the Pharmacy and Therapeutics (P&T) Advisory Committee, and the Kentucky Pharmacy Program, the RetroDUR criteria may be changed or specific ProDUR edits or clinical prior authorization criteria may be added to the drug or drug class. Additionally, the program's quarterly newsletter is used to provide general education to prescribers and pharmacists about FDA alerts and other safety concerns.
Louisiana	Summary 2. DUR Board Activity

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	- The Louisiana Drug Utilization Review Board held four meetings during federal fiscal year 2020. - As a component of quality improvement in the DUR program, existing POS edits were modified or inactivated. Examples are the removal of diagnosis requirements in the antineoplastic and cystic fibrosis agent categories. - POS edits were implemented for new drug products. Examples include new drugs in the antiretroviral and migraine agent categories. - POS edits were implemented for newly identified issues of concern. An example is the implementation of quantity limits for the doxepin topical product. - Retrospective DUR criteria: Criteria focused on opioids safety, duplication of muscle relaxants, antipsychotic agent adherence, and sleep agent duration. - Clinical authorization: Criteria were defined for a wide range of drug categories. Examples include agents to treat sickle cell disease, infectious disease, and behavioral health. - Medically necessary criteria: Clinical criteria were defined for overriding POS diagnosis requirements and quantity limit safety edits. Indicate the number of meetings held 4 For prospective DUR, list problem type/drug combinations approved by the DUR Board, added or deleted. New Diagnosis requirement: Doxepin (topical), Asenapine transdermal, Ibalizumab-uiyk, Quinine sulfate, Lumateperone, Tiotropium, Glucose strips and lancets, Hemophilia agents, Enzyme replacement therapy agents, AbobotulinumtoxinA, Risdiplam Diagnosis bypass for prior authorization: Generic cefixime Concurrent use: GLP-1 receptor agonists with DPP-4 inhibitors, Agalsidase beta with migalastat Therapeutic duplication: Sulfonylureas, Doxepin (topical), Asenapine transdermal (with oral antipsychotic agents), Lumateperone, Empagliflozin/linagliptin/metformin Quantity limit: Doxepin (topical), Asenapine transdermal, Quinine sulfate (with duration), Lasmiditan, Diroximel, Ubrogepant, Rimegepant, Eptinezumab, Lembroxerant, Empagliflozin/linagliptin/metformin (with dose limit), Sedative-hypnotic agents, Desmopressin, Acne agents, Glucose strips and lancets, Selective anti-infective, antifungal, and corticosteroid medications Dose-age limit: Lumateperone Dose limit: Lembroxerant Age limit: Doxepin (topical), Asenapine transdermal, Trufaritebe, Dichlorphenamide Prior drug use requirement: Empagliflozin/linagliptin/metformin New for MCO Diagnosis requirement: Botulinum agents, Pulmonary arterial hypertension agents, Miscellaneous agents Removed Diagnosis requirement: Oral immunomodulators, Lumacaftor/ivacaftor (FFS), COX2 inhibitors Diagnosis bypass for POS override: COX2 inhibitors Provider specialty and auto-injectable epinephrine requirements: Grass pollen allergen extract, House dust mite allergen extract, Peanut allergen powder New educational alerts Therapeutic Duplication, Level One Educational Alerts (FFS)

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	B65, 1ST GEN ANTIHIST-ANALGESIC-EXPECT-XANTHINE COMBO B66, GEN1 ANTIHIST-DECON-ANALGESIC;SAL;NON-SAL-XANTHINE C4Y, ANTIHYPERGLY-SGLT-2 INHIB;DPP-4 INHIB;BIGUANIDE CB H1D, CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS H23, NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR H24, ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD) H4E, ANTICONVULSANT - CANNABINOID TYPE H8Z, ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST N1I, ERYTHROID MATURATION AGENTS P4Q, BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR; MONO S7H, NEUROMUSCULAR BLOCKING AGENTS (COSMETIC) S7I, SKELETAL MUSCLE RELAXANT-NON-SALICYLATE ANALGESICS W0K, ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB. Drug Interactions, Level One Educational Alerts (FFS) APOMORPHINE/SELECTED 5-HT3 ANTAGONISTS ASUNAPREVIR/EFAVIRENZ; NEVIRAPINE ASUNAPREVIR/ELAGOLIX ASUNAPREVIR/GEMFIBROZIL ATORVASTATIN <= 20 MG/GEMFIBROZIL BUROSUMAB/ORAL PHOSPHATES; ACTIVE VITAMIN D ANALOGS CARBIDOPA-LEVODOPA-ENTACAPONE/SELECTED MAOIS CILOSTAZOL (> 50 MG)/STRONG & MOD 2C19 INHIB THAT PROLONG QT CILOSTAZOL (> 50 MG)/STRONG & MOD 3A4 INHIB THAT PROLONG QT CILOSTAZOL (> 50MG)/SLT STRONG & MODERATE CYP2C19 INHIBITORS CILOSTAZOL (>50MG)/SLT STRONG & MODERATE CYP3A4 INHIBITORS DAPAGLIFLOZIN-SAXAGLIPTIN-METFORMIN/STRONG CYP3A4 INHIBITORS DISOPYRAMIDE/CLASS IB; II; AND IV ANTIARRHYTHMICS FLUOROURACIL & FLUOROURACIL PRODRUGS/BRIVUDINE FLUVA (>20MG);LOVA (>20MG);SIMVA(>20MG)/ELBASVIR-GRAZOPREVIR FLUVASTATIN/GEMFIBROZIL LERCANIDIPINE/CYCLOSPORINE LERCANIDIPINE/STRONG CYP3A4 INHIBITORS LEVOMETHADONE/SELECTED MAOIS LIDOCAINE/SAQUINAVIR LURASIDONE (> 80 MG)/SELECTED CYP3A4 MODERATE INHIBITORS METHOTREXATE/NITROUS OXIDE NERATINIB/RITONAVIR OMBITASVIR-PARITAPREVIR-RITONAVIR/THIORIDAZINE PIMOZIDE/BUPROPION PITAVASTATIN <= 2 MG/GEMFIBROZIL PITAVASTATIN > 2 MG/GEMFIBROZIL ROSUVASTATIN (>10 MG)/OMBITASVIR-PARITAPREVIR-RITONAVIR ROSUVASTATIN <= 10 MG/GEMFIBROZIL ROSUVASTATIN > 10 MG/GEMFIBROZIL SELECTED ANTIARRHYTHMICS/AMPRENAVIR; FOSAMPRENAVIR SOFOSBUVIR-CONTAINING HEPATITIS C PRODUCTS/RIFABUTIN TIVOZANIB/ST. JOHN'S WORT TRIAZOLAM/SELECTED STRONG CYP3A4 INHIBITORS

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	UBROGEPANT/STRONG CYP3A4 INHIBITORS For retrospective DUR, list therapeutic categories added or deleted. New Overutilization: Opiates safety monitoring Concurrent use: Opiates with gabapentin/pregabalin Therapeutic duplication: Muscle relaxants Adherence: Antipsychotic agents (new for MCOs) Duration of therapy: Sedative-hypnotic agents (new for MCOs) Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. - Discussions at the Louisiana DUR Board meetings include prospective DUR and its impact on established retrospective DUR criteria. Policies are not written for global implementation; rather, criteria or drug classes are reviewed for effectiveness in prospective DUR and applicable modifications in retrospective criteria. For example, the prospective duration of therapy edit for high-dose anti-ulcer drugs have reduced the need for examining this issue retrospectively. - The Board has recommended implementation of prospective DUR criteria based on exception reports from retrospective reviews. Again, criteria or drug classes are reviewed individually. For example, retrospective reviews targeting therapeutic duplication of non-steroidal anti-inflammatory agents led to the implementation of a prospective DUR edit. Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). - The DUR Board recommends topics for educational articles to be included in the Provider Update newsletter targeting Louisiana Medicaid providers. Educational efforts by individual DUR Board members may include writing articles for the Provider Update newsletter or sharing the DUR Annual Report with interested parties. DUR Board-initiated criteria recommendations for prospective and retrospective DUR supply providers with additional educational information. - In the prospective DUR process, pharmacy providers receive educational alerts or "deny" edits on selected medication-related issues. In the retrospective DUR process, recipient-specific profiles along with therapeutic criteria are sent to physician and pharmacy providers. Additional educational information is included for selected criteria topics.
Maine	Drug Utilization Review Board Activity Summary FFY2020 The ME Medicaid (MaineCare) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met (5) five times in FFY2020. The combined functions of the DUR Board results in the DUR Board having a unique perspective on the evaluation and Preferred Drug List (PDL) placement of newly released drugs. As new drugs are brought forward for evaluation, the DUR Board chooses to manage these medications in a manner that will result in appropriate prescribing from the time of introduction of the drug (prospectively) rather than in a retrospective manner when inappropriate patterns of prescribing may have become ingrained. This results in the early adoption of quantity limits, step therapy and promotion of generic drug choices. At the same time, as new drugs are evaluated, patterns of prescribing for alternative drugs may become apparent and lead the Board to undertake retrospective drug utilization review activities for those other medications. Additionally, the DUR Board will recommend that follow-up RetroDUR be performed of relatively new drugs to ensure

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	that the adopted clinical criteria are appropriate and result in patterns of utilization that are clinically appropriate and cost-effective. In FFY 2020, the ME DUR Board activities included: 102 New Drug Reviews 11 Revised Clinical Coverage Criteria 47 Therapeutic Class Reviews 5 Quantity Limits established for new or previously reviewed drugs 19 FDA Safety Alerts reviewed RetroDUR Analyses o Use of Multiple Antipsychotics in Children and Adolescents o Use of statins in members with diabetes mellitus o Use of Buprenorphine for MAT o Prescriber PDL Compliance o Prep HIV therapy prescribing rates The Drug Utilization Review (DUR) Board will advise MaineCare on how best to educate providers and address the impact of pharmacy manufacturers advertising. In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. The Board then determines if follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers. In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file. To educate providers on general PBM Program coverage activities, various methods are used. Most frequently, mailings are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. The mailing topics are generally complimentary so that pharmacies understand the communications that have been sent to prescribers. These mailings are also sent electronically to provider affiliates and representatives so that these organizations can use their proprietary methods to distribute the materials. Providers may find all general pharmacy benefit management materials posted on the MaineCare webpage at http://www.mainecarepdl.org/ These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions and alerts. DUR COMMITTEE AGENDA Date: Tuesday, October 8, 2019 Time: 1:00PM to 4:30PM Location: Augusta Armory, 179 Western Avenue, Augusta, ME 1) Call to Order 2) MaineCare Updates 3) Public Comments 4) Old Business Review of Minutes 5) Closed Session

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	Drug Financial Information Review 6) Revised clinical criteria/ preferred products 7) New Business (open session) A. Present Retro-DUR Initiatives for 2020 B. Present 2020 Meeting Schedule C. Open session to review and vote categories subject to potential changes Alzheimer/ Antidementia Agents Analgesics, Narcotics, Long-Acting Analgesics, Narcotics, Short- Acting Analgesics, NSAIDS Topical Androgenic Agents Antibiotic- Inhaled-CF Anticoagulants Anticonvulsants Antipsychotics Antiretrovirals Bronchodilators, Beta Agonists Cardiovascular Misc. COPD Agents Cytokine and CAM Antagonists Dermatologic- Atopic Dermatitis Dermatologic- Lidocaine Dermatologic- Scabicides/Ped DME- Diabetic Supplies Endometrosis, Oral Factor Deficiency Products Growth Hormones GI- IBS GI- Ulcerative Colitis Hematopoietics Hepatitis C Agents Hereditary Angioedema Hypoglycemics, Incretin Memetics Hypoglycemics, Insulins & Related Agents Hypoglycemics, Misc Agents Influenza Agents Migraine Movement Disorders Multiple Sclerosis Agents Neurotoxins Ophthalmic Antiallergics Ophthalmic Antibiotics Ophthalmic Anti-inflammatories Ophthalmic Modulators Opiate Dependence & Overdose Treatments Pancreatic Enzymes Phosphate Binders Pulmonary Hypertension

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	Platelet Aggregation Inhibitors Resp. Steroid/Anticholinergic Stimulants & Related Agents Urinary Antispasmodic Vaginal Anti-Infectives D. FDA Safety Alerts FDA review finds no increased risk of prostate cancer with Parkinson's disease medicines containing entacapone (Comtan, Stalevo) https://www.fda.gov/drugs/drug-safety-and-availability/fda-review-finds-no-increased-risk-prostate-cancer-parkinsons-disease-medicines-containing?utm_campaign=New%20FDA%20Drug%20Safety%20Communication%20on%20medicines%20containing%20entacapone&utm_medium=email&utm_source=Eloqua SOVALDI and HARVONI: New dosage forms and use in pediatric patients 3 years of age to less than 12 years of age http://s2027422842.t.en25.com/e/es?s=2027422842&e=250032&elqTrackId=376c7bc788024cd5a73d955f2e3dcbdc&elq=794ae4ee00af4d12be56b65e3ee2ce12&elqaid=9298&elqat=1 FDA warns about rare but severe lung inflammation with Ibrance, Kisqali, and Verzenio for breast cancer https://www.fda.gov/drugs/drug-safety-and-availability/fda-warns-about-rare-severe-lung-inflammation-ibrance-kisqali-and-verzenio-breast-cancer?utm_campaign=New%20FDA%20Drug%20Safety%20Communication%20on%20Ibrance%20%28palbociclib%29%2C%20Kisqali%20%28ribociclib%29%2C%20and%20Verzenio&utm_medium=email&utm_source=Eloqua E. Next Meeting (Tuesday, December 10, 2019 (from 5:30pm to 8:30pm) F. Adjournment: 4:30PM ProDUR is an integral part of the Maine Medicaid claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed; reviewing the available medical history; focusing on those patients at the highest severity of risk for harmful outcome; and intervening and/or counseling when appropriate. Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation and counseling components of pre-dispensing drug therapy screening. The ProDUR system addresses situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists pharmacists in ensuring that patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available. Because ProDUR examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. While the pharmacist uses his/her education and professional judgment in all aspects of dispensing, ProDUR is intended an informational tool to aid the pharmacist. Not only does Maine utilize Medispan's DUR module, but CHC (PBM) has the ability to add POS edits within the POS to further expand on Pro-DUR

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	capabilities and utilize, claim information, State Plan design, specific medication restrictions and member diagnosis to be proactive in the proper utilization or review of specific plan benefit.
Maryland	Summary 2: DUR Board Activities Summary Indicate the number of DUR Board meetings held The Maryland Medicaid Drug Utilization Review Board met four (4) times during FFY 2020. Meetings were held on the first Thursday of the months of March, June, September and December. List additions/deletions to DUR Board approved criteria. a) For prospective DUR, list problem type/drug combinations added or deleted. Prospective DUR screening criteria utilized by the current vendor (Conduent State Healthcare, LLC) are based on First Data Bank criteria. All First Data Bank severity level 1 drug-drug interaction alerts are activated by the ProDUR vendor on an ongoing basis. At each DUR Board meeting a review of the top 20 prospective DUR alerts is presented by the prospective DUR vendor for the following types of alerts: Drug-Drug Interactions Early Refill Therapeutic Duplication Early refill alerts require a prior authorization (PA). Calls requesting a PA can be made by the pharmacist or prescriber. Therapeutic duplication alerts can be overridden at point of service by the pharmacy by entering the appropriate NCPDP conflict, intervention and outcome codes. A summary of conflict, intervention and outcome codes entered by the pharmacy to override therapeutic duplication claims is reviewed by the DUR Board at each meeting. A summary of other edits that include low dose, high dose, drug age and drug gender alerts is also reviewed at each meeting. Estimated cost savings/cost avoidance and the number of calls taken by the call center help desk is reviewed at each meeting as well. During FFY 2013, the DUR Board requested a therapeutic duplication alert be developed for the concurrent use of clonazepam and another benzodiazepine. This particular alert is not included in the standard therapeutic duplication alert for benzodiazepines since clonazepam is classified as an anticonvulsant. The alert was implemented in FFY 2014 and continues to be presented to the DUR Board on a quarterly basis. b) For retrospective DUR, list therapeutic categories added or deleted. During FFY 2020, retrospective DUR interventions were performed to identify participants with potentially inappropriate use of controlled drug substances, therapeutic duplication of sedative/hypnotic medications, concomitant use of an opioid, benzodiazepine and carisoprodol-containing product, overutilization of gabapentin, concurrent use of an opioid and medium-high dose gabapentin, and therapeutic duplication of gabapentin and pregabalin. The DUR Board is presented with new relevant criteria from the RDUR vendor at each quarterly meeting. The Board votes to approve the addition of criteria for monitoring purposes and for

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	potential future interventions. Criteria added during FFY2020 may be found in the DUR Board meeting minutes available at https://mmcp.health.maryland.gov/pap/Pages/dur-minutes.aspx Describe Board policies that establish whether and how results of prospective DUR screenings are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. The Maryland DUR Board meets quarterly to review Prospective and Retrospective DUR information. If information is presented that is concerning to Board members, such as overutilization of high risk medications, inappropriate therapeutic use of medications, or high rates of drug interactions with common medications, a request may be made to retrospectively analyze the claims information to determine if a true issue exists within the participant population. In some instances, an intervention may become a recurring intervention that is performed continuously due to the findings from the initial intervention. Conversely, when retrospective DUR interventions are performed, if the outcomes show an unacceptable improvement in practice, the Board may create a Prospective alert, when possible, to further prevent adverse drug events for the participant population, and ensure safe and effective use of medications. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring). Information regarding newsletters and upcoming continuing education events are discussed with the DUR Board at each meeting. The DUR Board members routinely offer recommendations for topics in the newsletter as well as continuing education programs. Board members also attend continuing education events in support of the Program. During FFY2017, the DUR Board recommended further review of provider responses that may indicate fraudulent activity. Educational intervention letters include a voluntary response form that the provider may use to indicate follow-up actions in response to the information provided. Some responses include that the provider was incorrectly identified as the prescriber or that the participant was never under the provider's care. In those instances, the RDUR vendor was instructed to contact the provider directly to further investigate the prescription claim and determine if fraud or abuse by the participant was occurring. In some instances, copies of the prescription(s) were obtained for evaluation. This practice continued into FFY2020. Further review of these discrepancies has not uncovered any illicit activity by participants. Additionally, the DUR Board and RDUR vendor initiated an update to the intervention letters that would identify providers by name instead of Medicaid identification number, in order to facilitate communication between providers in instances where multiple providers are involved in a potential drug therapy problem. This update to the RDUR intervention letters has decreased the instances where a provider may indicate they did not prescribe a medication for a particular participant, and decreased concerns related to potential fraud, waste or abuse. Annually, the Maryland Department of Health Office of Pharmacy Services (OPS) has sponsored a live continuing education program. In FFY 2020, OPS sponsored two live programs for Maryland Medicaid healthcare providers. The first program, Treatment of Hepatitis C and Comorbid Conditions was held in December 2019, and the second program, Stimulants: A therapeutic

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	review was held in July 2020. Members of the DUR Board have actively participated as speakers at these events in past years, provided recommendations for potential speakers, and attended the presentations. Continuing education program details are available at www.mmppi.com/previous_seminars.htm.
Massachusetts	The purpose of the DUR Program is to ensure that prescribed drugs are appropriate, medically necessary, and not likely to result in medication related problems. DUR Board Activities 1. To advise and assist the Office of Medicaid in the performance of DUR within the MassHealth Program and in compliance with the Omnibus Budget Reconciliation Act of 1990 as codified in 42 USC 1396r - 8 and 42 CFR 456.700 et seq. 2. To advise the DUR Program on the criteria, standards, and content of the MassHealth Drug List (MHDL); 3. To make recommendations concerning ongoing types of provider and MassHealth Member interventions as part of the DUR Program and participate in the evaluation of the results; 4. To prepare an annual DUR Report describing the nature and scope of the DUR Board's activities, an assessment of the DUR Program, and a statement of goals and objectives; 5. To evaluate the use of criteria and standards; to assess the operational effect of the criteria and standards; to identify inappropriate or medically unnecessary care provided by physicians and other providers, to individuals receiving benefits under the MassHealth Pharmacy Program; 6. To oversee the operation of the DUR Program by ensuring that that criteria and standards applied are consistent across all DUR activities; and 7. To identify educational needs and develop educational plans to improve prescribing or dispensing practice, and to evaluate the effect of these educational interventions. DUR Board Meetings Three Quarterly meetings of the MassHealth DUR Board were held for the Federal Fiscal Year period October 1, 2019 to September 30, 2020 (one meeting was cancelled due to COVID-19 Pandemic). The DUR Board also participated in seven monthly Clinical Workgroup meetings to address ongoing clinical updates and issues. Clinical Work groups are held during the months between DUR Board Meetings. DUR presentations to the Board include New Drug Reviews, Drugs in Development, Guidelines Quality Assurance, and Performance Metrics. The Guideline Quality Assurance presentations include utilization trends, prior authorization volume and trends and the most recently published evidenced based medical information for a particular guideline. These reviews lead to the expansion of the scope of retrospective DUR screens and guide future prospective DUR criteria development and implementation strategies. DUR Board Educational Activities The DUR Board also approves changes to the MassHealth Drug List website where educational materials are posted, such as Hepatitis C Clinical Information, MassHealth Pain Initiative, and MassHealth ADHD Initiative. The MassHealth Website posts the Prescriber e-Letter, also available by web mail. One hundred fifty guidelines were reviewed for changes to prospective DUR criteria. Of which, 128 had additions to criteria and 22 had deletions of criteria. A retrospective DUR review was performed for 47 therapeutic classes. Of which, 35 had additions to criteria and 12 had deletions of criteria. In addition, 38 criteria were related to underutilization, 30 related to appropriate use of generics, 27 related to overutilization, 25 criteria related to insufficient dose, 15 related to drug/disease contraindication, 14 related to incorrect duration,

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	and six related to therapeutic duplication. All classes except two were related to at least two different retro-DUR categories with an average of three categories per therapeutic class.
Michigan	The Michigan Medicaid DUR Board meets quarterly in March, June, September and December of each year. The last two meetings during FFY 2020 were held virtually due to the Emergency Order for the COVID-19 pandemic. The Board reviewed activities and reporting associated with both prospective DUR (ProDUR) and retrospective DUR (RetroDUR). The MI Medicaid pharmacy claims processing system utilizes clinical criteria for ProDUR provided by First Data Bank (FDB). The DUR Board selected specific problem types and therapeutic classes that will deny at point-of-sale (POS) and require pharmacy level overrides as well as those problem types that will return an alert message only. The denials for therapeutic duplication (TD) are for drugs in the narcotic analgesic class only. For denials other than narcotic TDs, the pharmacist may override the edit by entering the appropriate override code as established by the MDHHS. Early refill, narcotic TD and drug-to-gender alerts may only be overridden after consultation by the dispensing pharmacy or prescriber with the clinical personnel at Magellan Rx Management (MRx). At each meeting, the DUR Board reviews utilization patterns as well as RetroDUR activity recommendations. During FFY 2020, the DUR Board reviewed analyses targeting appropriate prescribing patterns and recommended guidelines for medications such as narcotics, gabapentin, naloxone, MAT medications, influenza vaccinations and non-seasonal vaccination utilization trends. The Board also monitored utilization patterns as a result of the COVID-19 pandemic and the emergency measures enacted to ensure access to medications. A review of opioid utilization patterns including high morphine milligram equivalent (MME) daily doses and concurrent utilization with opioid potentiators is reviewed at each meeting. Also, medication assisted treatment (MAT) utilization metrics, patient demographics, patient diagnoses and prescriber taxonomies for these medications are reviewed. On October 1, 2019, CMS implemented the SUPPORT Act to ensure minimum opioid standards are followed within Medicaid FFS and managed care programs. The MI DUR Board had already been monitoring these measures for FFS but began monitoring the MME and opioid potentiator patterns for the managed care (MCO) plans at each meeting as well. The DUR Board also oversees an academic detailing program, called WholeHealthRx, designed to identify prescribing patterns that are inconsistent with evidence based, best practice guidelines for behavioral health and opioid medications. The program reaches out to the primary care or behavioral health provider to engage in a personalized consultation. The interventions and outcomes for the activities are reviewed at each meeting.
Minnesota	The Minnesota Department of Human Services (DHS) Drug Utilization Board met for three quarterly meetings during Federal Fiscal Year 2020. Due to Covid-19, the March 18, 2020 was canceled. Highlights of each DUR Board meeting below reflect discussions on criteria. October 16, 2019 DUR Board Meeting New Business: Anticonvulsant Medication Management Proposal The proposal was reviewed in the context of replacing Diabetes Mellitus Proposal. The recommendation was to continue the Diabetes Mellitus intervention. Of the proposed

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	performance indicators, there was most interest was in Anticonvulsant Adherence criteria for which there were 1,010 occurrences. Review of Stand-Alone DUR Interventions that had never been chosen. There were twenty-five DUR interventions not chosen in the past as stand-alone interventions though some of the performance indicators have been incorporated into mailed interventions. These interventions were grouped into six categories for comment and review. 1. Biologics Rheumatoid Arthritis The DUR Board voted that this intervention topic could potentially be re-visited after publication of the new guidelines. 2. Chronic Disease The DUR Board decided not to do stand-alone interventions for Hyperlipidemia, Hypertension, and Stroke Prevention as these topics have been covered in previous Diabetes RetroDUR Interventions 3. Infectious Disease The DUR Board recommended not to pursue further. 4. Mental Health ADHD Medication Management, Bipolar Disorder and Major Depressive Disorder performance indicators are included in the Psychotropic Drugs in Adults Intervention. Mental Health Disorders was not recommended as a stand-alone intervention. It was recommended that Benzodiazepine chronic use > 4 months (n=507) and Sedative/Hypnotic chronic use > 4 months (n=329) criteria be added to the Psychotropic Drugs in Adults interventions: 5. Pain SUPPORT Act performance indicators are used instead. 6. Respiratory The DUR Board recommended not pursuing Allergic Rhinitis as a stand-alone intervention as these drug therapies are primarily OTC. The DUR Board recommended the Respiratory Disease Management intervention as a possible future intervention as the new Asthma (GINA) and COPD (GOLD) 2019 guidelines are available. There was an idea of developing a new RetroDUR Intervention regarding the Inappropriate Duration of Drug Therapy. Drugs for inclusion could be benzodiazepines, PPIs, sedative/hypnotics, antidepressants, skeletal muscle relaxants, and others yet to be determined. June 17, 2020 DUR Board Meeting New Business: Potential RetroDUR Intervention Diabetes Mellitus Management 2020 Criteria is based on the American Diabetes Association (ADA) 2020 clinical practice recommendations and American Association of Clinical Endocrinology (AACE) 2020 Comprehensive Type 2 Diabetes Management algorithms. Performance Indicator #1: Increased Risk of Adverse Events: 1. Lack of annual dilated eye exams. N=3,169. 2. Lack of recommended laboratory monitoring. N=6,228.

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	3. Annual recommended routine labs include metabolic panel, lipid panel, serum creatinine, B12, eGFR, microalbuminuria screen. 4. Increased risk of adverse drug events (ADE) with non-insulin antidiabetics agents in the last 30 days with a history of a comorbid condition in the last 2 years based on severity level 1 drug-disease interaction by First Databank). N=1,276. The ADE with the highest occurrence at n= 982 (77%) was metformin and metformin combination products: renal disease or renal dysfunction; contraindicated if eGFR is less than 30 mL/min/1.73m2, age greater than 79 years, acute or unstable heart failure, acute or chronic metabolic acidosis, hepatic disease or hepatic impairment. Performance Indicator #2: Underutilization (N=1,379) 1. Underutilization of Angiotensin-Modulators with Kidney Disease (n=10) 2. Underutilization of Antilipemics (n=445). ICD 10 codes for myopathies and rhabdomyolysis are excluded. 3. Underutilization of Antiplatelet Therapy (n=402) i. The ADA recommends use of aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with diabetes and a history of with diabetes and a history of atherosclerotic cardiovascular disease (ASCVD). Aspirin therapy (75-162 mg/day) may be considered as a primary prevention strategy in those with diabetes who are at increased CV risk, after a discussion with the patient on the benefits versus increased risk of bleeding. ii. Patients receiving a direct oral anticoagulant (DOAC) are excluded under any kind of anticoagulant in the last 45 days. 4. Underutilization of Metformin (n=522): All patients with type 2 diabetes without contraindications to metformin (patients who have been treated exclusively with insulins for the past year will be excluded) and meet any of the following criteria: i. History of a drug to treat diabetes mellitus in the last 90 days, but no history of metformin in the past year. ii. History of metformin therapy in the past year but no history of metformin therapy in the past 90 days. iii. Metformin dose < 1500 mg/day on the most recent claim. iv. ESRD is included in a broader list of ICD-10 codes of renal impairment that are used as exclusion criteria. Performance Indicator #3: Nonadherence Criteria is all patients with diabetes in the last 2 years receiving chronic oral antidiabetic, antihypertensive, and/or antilipemic drug therapy in the most recent 45 days and 90 to 135 days ago (identify chronic therapy) who received less than a 60-day supply of medication during a 90-day period. i. Non-insulin drugs to treat diabetes mellitus (n=792), ii. Antihypertensives (n=771), and iii. Antilipemics (n=445). Performance Indicator #4: Duplicate Therapy Non-insulin Antidiabetics and GLP-1 Agonist/DPP-4 Inhibitor Combination (n=11). Aspirin recommendation was updated as secondary prevention in the educational summary. The Diabetes Mellitus Management 2020 intervention was approved by roll call vote.

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	August 19, 2020 DUR Board Meeting New Business: Respiratory Disease Management Performance Indicator #1: Overutilization of short-acting beta2-agonist (SABA) inhalers in patients with asthma Criteria: All patients with a history of asthma in the last 2 years greater than four SABA inhalers in the last 120 days. Performance Indicator #2: Underutilization of Inhaled Corticosteroids (ICS) in Patients with Asthma Criteria: All patients with a history of asthma in the last 2 years with 2 or more SABA claims or greater than 3 packs of a SABA in the last 120 days. Performance Indicator #3: Use of Long-Acting Beta-Agonist (LABA) inhaler without a SABA Inhaler and/or ICS in Patients with Asthma Criteria: All patients receiving a LABA in the last 90 days without: An inhaled or nebulized SABA in the last 1 year OR an ICS in the last 90 days Performance Indicator #4: Use of LABA inhaler without Long-Acting Antimuscarinic Antagonist (LAMA) inhaler in patients with Chronic Stable COPD Criteria: All patients with history of chronic stable COPD receiving a LABA or LAMA in the last 90 days. LABA inhaler without LAMA inhaler in the past 60 days LAMA inhaler without LABA inhaler in the past 60 days Performance Indicator #5: Use of SABA inhaler without Short-Acting Antimuscarinic Antagonist (SAMA) inhaler in patients with Chronic Stable COPD Criteria: All patients with history of chronic stable COPD receiving a SABA or SAMA in the last 90 days. SABA inhaler without SAMA inhaler in the past 60 days SAMA inhaler without SABA inhaler in the past 60 days Performance Indicator #6: Use of ICS without a LABA inhaler in Patients with COPD Criteria: All patients with history of moderate to severe COPD receiving an ICS in the last 90 days without history of LABA in the last 60 days. Performance Indicator #7: Duplicate Ingredient Inhalers in Patients with Asthma and/or COPD Criteria: All patients receiving inhaler therapy during the last 90 days with 35 or more days of duplicate ingredient overlapping therapy (i.e., duplicate SABAs, LABAs, SAMAs, LAMAs, or ICSs). Provider letters will be updated to reference the Expert Panel Report-3: Guidelines for Diagnosis and Management of Asthma and the COPD: Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease 2020 Report. The Respiratory Disease Management intervention was approved by roll call vote. Proton Pump Inhibitors Proposal

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	Performance Indicator #1: Extended Duration of PPI Therapy with No Indication for Long-Term Use Criteria: All patients receiving a PPI in the last 45 days who are receiving PPIs for greater than 60 days out of 120 days of claims history. Exclude patients with a diagnosis Zollinger-Ellison syndrome, erosive esophagitis, Barrett's esophagitis, and concurrent NSAID use. Include PUD and GERD diagnosis as criteria is for greater than 60 days of PPI. Performance Indicator #2: Extended Duration of PPI Therapy in Patients with PUD without Test or Treatment for H. pylori Criteria: Patients receiving a PPI for greater than 12 weeks within the last 16 weeks of claims history without history of H. pylori diagnosis, test, or treatment in the last 2 years. The PPI intervention was approved by roll call vote.
Mississippi	FFY2020 DUR Board Activities Summary Mississippi Division of Medicaid uses two provider boards to provide review and input on prospective and retrospective DUR efforts. The Pharmacy and Therapeutics (P&T) Committee reviews selected drug classes on a regular basis and makes recommendations regarding the Preferred Drug List and clinical edits for specific products and/or classes. The DUR Board reviews utilization reports and retrospective studies conducted by the DUR Vendor and makes recommendations about prospective and retrospective utilization management interventions that should be taken for specific drugs and/or therapeutic classes and what items should be included or deleted from the retrospective exceptions monitoring program. The two groups are closely coordinated with prospective DUR vendor representatives and retrospective DUR vendor representatives attending both meetings. During P&T Committee meetings, issues are frequently identified for retrospective review for potential further action by the DUR Board. Two P&T Committee meetings were held during the fiscal year on the following dates: October 22, 2019 August 11, 2020 Four DUR Board meetings were held during the fiscal year on the following dates: December 5, 2019 March 19, 2020 June 11, 2020 September 17, 2020 The following is a summary of initiatives reviewed and recommendations made by the DUR Board during FFY2020: December 5, 2019 The Board reviewed the use of antidepressants in children and adolescents, focusing on the use of tricyclic antidepressants (TCAs). At the time of this review, there were no age restrictions in the pharmacy claims processing system, via POS or SMART PA 3 programming. As a result of this review, the Board made the following recommendations: 1. Implement an electronic edit for TCA therapy with minimum age limit of 25 years. 2. The P&T Committee should review the TCA class for addition to the UPDL as non-preferred.

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	3. Draft a provider education piece on the appropriateness of TCA therapy in children, adolescents, and young adults with MS DUR and DOM. The Board reviewed a report detailing HPV vaccine completion rates among Medicaid. Despite having higher HPV-associated cancers compared to national data, Mississippi's adolescent up-to-date rate on HPV vaccine was only 28.8% compared to the 49% rate nationally. After this review, the Board made the following recommendations: 1. Develop provider education emphasizing the importance of timely follow-up for beneficiaries initiating HPV vaccination series. 2. Develop an initiative to encourage pharmacists to be more involved in both the initiation and completion of HPV vaccinations. 3. Explore ways to collaborate with the Mississippi State Department of Health (MSDH) to develop strategies to increase HPV vaccination completion rates in Mississippi. The Board reviewed an analysis of buprenorphine prescribing trends among Medicaid beneficiaries. Medicaid has taken multiple steps to increase beneficiary access to buprenorphine for medication assisted therapy (MAT), which was reflected in the trends. The Board recommended the following additional steps to further increase beneficiary access to MAT: 1. Develop education information targeting providers currently prescribing buprenorphine products to: a. inform providers of buprenorphine product utilization among Medicaid beneficiaries. b. encourage long-term (30 days supply) prescribing for buprenorphine products. 2. Develop a provider bulletin to be distributed to provider member organizations to: a. educate providers on the importance of MAT in combating opioid use disorder. b. increase awareness in not only the need but how more Medicaid providers can obtain SAMHSA certification as an Opioid Treatment Program and authorized to prescribe buprenorphine products. 3. Collaborate with MSDH (Mississippi Department of Health) to improve access to MAT across the state of Mississippi. March 19, 2020 The Board reviewed a report on adherence to antiretroviral therapies for the treatment of HIV. Analysis using Pharmacy Quality Alliance's Proportion of Days Covered: Antiretroviral Medications Measure (PDC-ARV-2019) revealed only 42.1% of Mississippi Medicaid beneficiaries 18 and older achieved the recommended PDC > 90% during the study period of calendar year 2019. Following discussion by the Board, the subsequent recommendations were made: 1. Collaborate with MSDH, UMMC Infectious Disease Department, and state medical/pharmacy/nursing associations on ART adherence issues. 2. Conduct targeted outreach to providers to focusing on commending providers having patients with PDCs > 90 and seeking guidance on best practices; and educating provider with patients having PDCs <90. 3. Expand analysis to include beneficiaries less than 18 years and include providers treating patients less than 18 years in educational mailings. The Board reviewed a report detailing potential gaps in care for patients diagnosed with atrial fibrillation (Afib). Using the CHA2DS2VASC risk assessment criteria, the report identified Medicaid beneficiaries with Afib diagnosis, high CHA2DS2VASC score (> 3 females; >2 males), and no prior bleeding events as potential candidates for anticoagulant drug therapy. Among those

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	beneficiaries, anticoagulant drug utilization during the study period was determined. Subsequent to review and discussion of this report, the Board recommended that DOM implement an educational intervention notifying prescribers of those beneficiaries diagnosed with Afib that are potential candidates for anticoagulant therapy. The board revisited the issue of deprescribing proton pump inhibitors as previously reviewed in March 2018. After this review, the Board reaffirmed the previous recommendations to: 1. Set an electronic PA edit to limit the maximum days supply for PPI therapy to 90 days in a 12 month period before a PA is required. 2. For therapy exceeding the 90 day limit, implement electronic or manual PA requirements for the maximum number of days supply based on diagnoses. 3. Develop an educational initiative notifying providers of the new PPI prescribing criteria and guidance on deprescribing. June 11, 2020 The Board was presented an overview of sickle cell disease (SCD) followed by an analysis of SCD treatment in DOM. This analysis included a forecast of potential candidates for treatment with either crizanlizumab (Adakveo) or voxelotor (Oxbryta). Following discussion, the following recommendations were proposed: 1. Create manual prior authorization criteria for crizanlizumab and voxelotor for review/approval of appropriate use of these products. 2. The pharmacy programs (FFS and MCOs) should provide patient education on the role of hydroxyurea and encourage greater utilization among beneficiaries with sickle cell disease. 3. Expand the analysis to stratify sickle cell-related hospitalizations by the use of medications (hydroxyurea, Endari, or no preventive medications). The Board reviewed a report on the utilization of agents in the cytokine and cell-adhesion molecule (CAM) antagonist category. Prescribing trends were analyzed, and the presence of target diagnosis information was noted. Following this review and subsequent discussion, the following recommendation were made: 1. Implement an electronic PA edit to add a diagnosis check for utilization of TNF inhibitors in the Cytokine & CAM antagonists' category. 2. Continue to monitor this category of drugs to determine whether future step-therapy requirements would be appropriate, especially with the advent of biosimilars. The Board was presented an overview of Hepatitis C treatment among Medicaid beneficiaries since the introduction of direct acting antivirals (DAAs) in 2013. Descriptive characteristics of beneficiaries treated, pharmacologic regimens prescribed, and completion rates were presented. It was noted that although few beneficiaries were impacted, one area with frequent suboptimal completion rates was among those beneficiaries that switched pharmacy programs during DAA therapy. When examining beneficiaries requiring liver transplants, it appeared that treatment with DAA therapy reduced the proportion of Hep C positive beneficiaries receiving liver transplant during the study period. After discussion, the board recommended that DOM restrict beneficiaries from switching pharmacy programs while taking DAA therapy if possible or develop some type of hand-off process for beneficiaries switching pharmacy programs to ensure continuity of care September 17, 2020 The Board was presented an overview report of the trends associated with opioid prescribing for the period beginning January 2018 through June 2020. During this period, Medicaid implemented

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	four Opioid Initiatives in August 2019. The data demonstrated that significant improvement occurred in opioid prescribing trends. Following discussion, the following recommendations were proposed: 1. Continue monitoring trends in opioid prescribing related to the Opioid Initiatives and explore other metrics for measuring appropriate opioid prescribing. 2. Explore the impacts of COVID-19 on the prescribing of opioids. 3. Develop a summary of the Opioid Trends Report to be included in an upcoming Provider Bulletin. The Board reviewed sedative hypnotic use among Medicaid beneficiaries. Increased interest has recently been given to this group of medications with the approval of new agents in this class and with the release of proposed rule changes to the minimum standards for Medicaid State Drug Utilization Review by the Centers for Medicare and Medicaid Services (CMS) to include additional DUR reviews for opioids and sedatives. Results of overall sedative hypnotic use were presented, along with analysis specifically focused on the concomitant use of opioids and sedative hypnotics. The following recommendations were considered: 1. Implement provider education around the concomitant use of sedative hypnotics and opioids
Missouri	The DUR Board held four meetings during FFY 2020. At the October 2019 meeting, the DUR board reviewed and approved the following edits: BiDil Clinical Edit, Botulinum Toxin Clinical Edit, Diacomit Clinical Edit, DMD Clinical Edit, Emsam Clinical Edit, LEMS Clinical Edit, Narcolepsy Inhibitors Clinical Edit, Oxandrin Clinical Edit, Psychotropic Medications Polypharmacy Clinical Edit, Ranexa Clinical Edit, SNRI Clinical Edit, SSRI Clinical Edit, Synagis Clinical Edit, Transthyretin-Mediated Amyloidosis (ATTR) Clinical Edit, Zolgensma Clinical Edit, Zometa Clinical Edit, ACE Inhibitors/Calcium Channel Blocker Combination Agents, ACE Inhibitors and ACE Inhibitors Diuretic Combination Agents, ADHD - Amphetamines - Short Acting Agents, ADHD - Methylphenidate - Long Acting Agents, ADHD - Methylphenidate - Short Acting Agents, ADHD - Amphetamines - Long Acting Agents, ADHD - Non-stimulant Agents, ARB and ARB Diuretic Combination Agents, Angiotensin II Receptor/Calcium Channel Blocker Combination Agents, Anticoagulant Agents: Oral and Subcutaneous, Antiplatelet Agents, Beta Adrenergic Blocker and Beta Adrenergic Blocker Diuretic Combination Agents, Calcium Channel Blocker Agents (Dihydropyridines), Calcium Channel Blocker Agents (Non-Dihydropyridines), Direct Renin Inhibitors and Direct Renin Inhibitors Combination Agents, Dry Eye Disease Agents - NEW, Lipotropic Agents: Homozygous Familial Hypercholesterolemia Products, Lipotropic Agents: Niacin Derivatives, Lipotropic Agents: Proprotein Convertase Subtilisin-Kexin Type 9 (PCSK9) Inhibitors, Lipotropic Agents: Statins (HMG Co-A Reductase Inhibitors) and Statin Combination Products, Lipotropic Agents: Triglyceride Lowering Agents, Proton Pump Inhibitor Agents, Pulmonary Arterial Hypertension (PHA) Agents: Inhaled/Injectable, Pulmonary Arterial Hypertension (PHA) Agents: Oral Endothelin Receptor Antagonists (ETRAs), Pulmonary Arterial Hypertension (PHA) Agents: Oral Phosphodiesterase-5 (PDE5) Inhibitors and Soluble Guanylate Cyclase (SCG) Stimulators, Pulmonary Arterial Hypertension (PHA) Agents: Oral Prostacyclin Pathway Agonists, Sympatholytic Antihypertensive Agents. At the January 2020 meeting, the DUR board reviewed and approved the following edits: 15 Day Supply- Oral Oncology Fiscal Edit, 15 Day Supply Fiscal Edit, Acetaminophen Cumulative Dose Clinical Edit, Biosimilar Fiscal Edit, Corlanor Clinical Edit, Cystic Fibrosis Clinical Edit, Diabetic Supply Quanity Limit Fiscal Edit, Entresto Clinical Edit, High Cost Medication Kits Fiscal Edit, MME Accumulation Clinical Edit, Non-Oral Contraceptive Clinical Fiscal Edit, PrEP Fiscal Edit, Short-Acting Opioid, Combinations Clinical Edit, Short-Acting Opioid

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	Single Agents Clinical Edit, TIRF Clinical Edit, Typical (1st Generation) Antipsychotic Clinical Edit, Zulresso Clinical Edit, Alzheimer's Agents, Antiandrogenic Agents PDL Edit ,Antiemetic Agents: 5-HT3, NK1 & Other Agents, Antiemetic Agents: THC Derivatives, Anti-Migraine Agents: Serotonin (5-HT1) Receptor Agonists Anti-Parkinsonism: MAO-B Inhibitor Agents, Anti-Parkinsonism: Non-Ergot Dopamine Agonists, Calcitonin Gene-Related Peptide (CGRP) Inhibitors, Cox-II Inhibitor Agents, Fibromyalgia, GI Motility Agents, Glucagon Products, Hereditary Angioedema Agents, Long-Acting Opioid Agents, Neuropathic Pain Agents, NSAIDs, Opioid Dependence Agents, Opioid Emergency Reversal Agents, Respiratory Monoclonal Antibodies (RMA), Sedative Hypnotic Agents, Skeletal Muscle Relaxants, Tramadol-Like Agents, Atypical (2nd Generation), Antipsychotics, Antiretrovirals Treatment. At the April 2020 meeting, the DUR board reviewed and approved the following edits: Acne or Rosacea - Select Topical Agents, Clobazam Agents, DMD, Epidiolex, Galafold, Givlaari, Megestrol Acetate, Nocturnal Polyuria, Reblozyl, Sickle Cell Disease, Spravato, Systemic Antifungals, Actinic Keratosis Agents - Topical, Androgenic Agents, Antibiotics - Inhaled Agents, Antifungals Agents - Oral, Antifungals Agents - Topical, Antihistamines - Intranasal, Antihistamines - Ophthalmic, Antihistamines/Decongestant Combinations - Low Sedating (2nd Generation), Antiparasitic Agents - Topical, Antiviral Agents - Herpes Oral, Antiviral Agents - Topical, Atopic Dermatitis Agents - Immunomodulators, Benzoyl Peroxide/Antibiotic Combinations, Beta-Adrenergic Agents - Long Acting, Beta-Adrenergic Agents - Nebulized, Beta-Adrenergic Agents - Short Acting, COPD Agents, Corticosteroids Oral - Inhaled, Corticosteroids and Rhinitis Agents - Intranasal, Corticosteroids - Ophthalmic Soft Steroids, Corticosteroids - Topical, Cough and Cold Preparations, Epinephrine Self-Injectable Agents, Fluoroquinolones - Ophthalmic, Fluoroquinolones - Otic, Glaucoma Agents, Leukotriene Receptor Modifiers, Mast Cell Stabilizers - Ophthalmic, NSAIDs - Ophthalmic, Pancreatic Enzyme Agents, Psoriasis Agents - Oral, Psoriasis Agents - Topical, Retinoids - Topical, Ulcerative Colitis Agents - Oral, Ucerative Colitis Agents - Rectal. At the July 2020 meeting, the DUR board reviewed and approved the following edits: Ampyra Clinical Edit, Crysvita Clinical Edit, Diacomit Clinical Edit, Gamifant Clinical Edit, Iron - Injectable Step Therapy Edit, Koselugo Clinical Edit, Luxturna Clinical Edit, Orilissa Clinical Edit, Oxervate Clinical Edit, Palynziq Clinical Edit, Parathyroid Hormone and Bone Resorption Suppression Related Agents Clinical Edit, Reblozyl Clinical Edit, Synagis Clinical Edit, Tepezza Clinical Edit, Tolvaptan Clinical Edit (formerly Jynarque Clinical Edit), Alpha-Glucosidase Inhibitors PDL Edit, Amylin Analogs PDL Edit, Antibiotics, Gastrointestinal (GI), Oral Agents PDL Edit, Antibiotics Vaginal Agents PDL Edit, Antihyperuricemic Agents PDL Edit, Anti-Migraine Agents Alternative Oral Agents PDL Edit, Biguanides & Combination Agents PDL Edit, Bile Salt Agents PDL Edit, Bone Ossification Agents PDL Edit, Benign Prostatic Hyperplasia Agents PDL Edit, Cryopyrin-Associated Periodic Syndrome (CAPS) Agents PDL Edit, Cephalosporins PDL Edit, Colony Stimulating Factors PDL Edit, DPP-IV Inhibitors & Combination Agents PDL Edit, Electrolyte Depleters, Phosphate Lowering Agents PDL Edit, Electrolyte Depleters, Potassium Lowering Agents PDL Edit, Erythropoiesis Stimulating Agents PDL Edit, Fluoroquinolones, Oral PDL Edit, Growth Hormones & Growth Hormone Releasing Factors Select Agents PDL Edit, Growth Hormones, Somatropin Agents Edit, Glucagon-Like Peptide -1 (GLP-1) Receptor Agonists & Combination Agents PDL Edit, Hepatitis C Agents PDL Edit, Insulins, Long Acting PDL Edit, Insulins, Mixed PDL Edit, Insulins, Non-Analogs PDL Edit, Insulins, Rapid Acting PDL Edit, Macrolides PDL Edit, Meglitinides PDL Edit, Methotrexate Agents PDL Edit, Multiple Sclerosis, Injectable Agents PDL Edit, Multiple Sclerosis Oral Agents PDL Edit, Penicillins PDL Edit, Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors & Combination Agents PDL Edit, Sulfonylureas, 2nd Generation PDL Edit, Tetracyclines PDL Edit, Thiazolidinediones & Combination Agents PDL Edit, Thrombocytopenia Agents PDL Edit, Targeted Immune Modulators, Interleukin-6 (IL-6) Receptor Inhibitors PDL Edit, Targeted Immune Modulators, Interleukin (IL)-17

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	Antibody/IL-17 Receptor Antagonists, IL-23 Inhibitors and IL-23/IL-12 Inhibitors PDL Edit, Targeted Immune Modulators, Janus Kinase (JAK) Inhibitors, Targeted Immune Modulators, Select Agents PDL Edit, Targeted Immune Modulators, Tumor Necrosis Factor (TNF) Inhibitors PDL Edit, Urinary Tract Antispasmodics PDL Edit.
Montana	Report on DUR Board Activities (FFY 2020) A. Number of DUR Board Meetings Held Six (6) DUR Board meetings were held in FFY 2020. B. Deletions or Additions to Prospective DUR Criteria The following drug criteria were approved and added: New Drug Reviews Palynziq - criteria for use developed with QL limit Sunosi - criteria for use developed with QL limit Vyndamax - criteria for use developed with QL limit Vynaqel - criteria for use developed with QL limit Wakix - criteria for use developed with QL limit Trikafta - criteria for use developed with QL limit Vumerity - criteria for use developed with QL limit Reyvow - criteria for use developed with QL limit Xofluza - criteria for use developed with QL limit Nurtec - criteria for use developed with QL limit Ubrelvy - criteria for use developed with QL limit Updated Drug Criteria Zolpidem use in women - starting dose of 5 mg/6.25 mg for ER, current users grandfathered Vascepa - updated criteria Dupixent - new indication (nasal polyps) Modafinil/armodafinil - exclude under 18 y.o. Atypical Antipsychotics under age 8 - per updated guidelines and DUR Board direction C. Deletions or Additions to Retrospective DUR Criteria Criteria changes/additions/deletions have been incorporated into existing criteria sets and are available in full criteria format upon request. D. Describe Retrospective DUR Criteria that resulted in changes to prospective DUR and vice-versa Prospective DUR criteria are provided by a different vendor than the Retrospective criteria. The DUR Board recognized the need for consistency between criteria sets and attempts to align them as closely as possible. In all cases, prospective criteria are more selective and refined because of internal access to the criteria development process.

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	The DUR Board also matched Retrospective DUR criteria to those that are utilized by the Formulary and Prior Authorization Program. The Formulary and Prior Authorization criteria are reflected in both the Retrospective and Prospective DUR systems. This accounts for lower than anticipated cost savings on the Retrospective side of the program, i.e. that many of the potential conflicts are solved before they appear in the Retrospective program. E. Describe DUR Board involvement in the DUR education program The DUR Board directs development of both educational and prior authorization formularies, and the review of educational intervention letters generated to providers. The DUR Board makes recommendations to the DUR coordinator for quarterly newsletter topics. The Board has also been involved in direct peer-to-peer interventions when necessary. Through the Formulary and Prior Authorization program, the DUR Board also directed a consensus effort of physicians and pharmacists to create several educational formulary guidelines as well as strict formulary guidelines that are used in the Prior Authorization Program. Since 2004, when the Montana Medicaid began development of a Preferred Drug List (PDL), the DUR Board has made recommendations to the Department based on evidence and literature-based evaluation of drug therapy for the PDL. The DUR Board and the Department collaborated in developing a pharmacy case management intervention tool that makes phone appointments with physicians to discuss utilization issues, counter-detailing, and cost appropriateness. In addition, our pharmacy case management program provided academic detailing to providers in FFY2020. A link to on-line quarterly newsletters are distributed to nearly 1000 pharmacies and providers with timely drug utilization review topics and newly developed criteria information.
Nebraska	Three meetings in FY 2020 due to COVID-19 precautions --- also virtual meetings. MME decrease to 120 mg MME for FY 2020; NOW in 2021 it is down to 90 mg MME. Hepatitis C criteria has changed from F2 to F0. SUPPORT Act review, education, and program launch completed in FY 2020. DHHS has provider bulletins.
Nevada	The DUR Board meets quarterly to monitor drugs for: therapeutic appropriateness, over or under-utilization, therapeutic duplications, drug-disease contraindications, and quality care. The DUR Board does this by establishing prior authorization and quantity limits to certain drugs/drug classes based on utilization data, experience, and testimony presented at the DUR Board meetings. This includes retrospective evaluation of interventions, and prospective drug review that is done electronically for each prescription filled at the Point of Sale (POS). During the Federal Fiscal Year 2020, the DUR Board was comprised of five physicians (1 pain specialist, 1 psychiatrist, 1 internal medicine and 2 family practice physicians) and five pharmacists (2 hospital pharmacists and 3 ambulatory care pharmacists) from various backgrounds and locations around the State of Nevada. Other non-voting members who contribute to Board discussions include employees from DHCFP, a Deputy Attorney General and representatives from the contractors for MMIS and PBM services. The three managed care organizations also participate, and each have non-voting representation on the Board. The public is welcome to provide testimony to the board before they vote on topics. Clinical reviews and proposed prior authorization criteria for the Board are supplied by OptumRx. Additional input is provided by pharmaceutical manufacturers, members of the public and the DUR Boards unique experiences and research.

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	All DUR Board meeting information is posted on the fiscal agent's website for the public before each meeting. This includes all clinical drug reviews, meeting materials and proposed criteria. At the October 2019 meeting, prior authorization (PA) criteria were added for Zolgensma. PA criteria were updated for the erythropoiesis stimulating agents, topical local anesthetics, and Eucrisa. PA criteria were removed from Regranex, inhaled anticholinergic agents, Daliresp, and Natroba. During this meeting opioid and benzodiazepine utilization was reviewed regarding top prescribers and members. In addition, naloxone utilization, Aranesp utilization, and antibiotic utilization was reviewed. At the January 2020 meeting, PA criteria were added to the multiple sclerosis agents, Zelnorm, and Nayzilam. PA criteria was updated for monoclonal antibodies for asthma and narcolepsy agents. During this meeting opioid and benzodiazepine utilization was reviewed regarding top prescribers and members. At the April 2020 meeting, PA criteria was added to the calcitonin gene-related peptide (CGRP) receptor inhibitors, Trikafta, Wakix, Adakveo, and Oxbryta. Criteria was updated for the proton pump inhibitors, tobacco cessation products, and ketorolac. During this meeting reports regarding opioid utilization, methadone utilization and place of service, and antibiotic utilization. At the July 2020 meeting, PA criteria was added to Valtoco nasal spray and Somavert. PA criteria was removed from Vivitrol. PA criteria was updated for the psychotropic medications in children and adolescents regarding polypharmacy from a board-certified child psychiatrist. In addition, reporting regarding top opioid prescribers and members was reviewed.
New Hampshire	The NH Medicaid DUR Board met twice during FFY20 on October 28, 2019 and June 30, 2020. Drug utilization patterns for prospective and retrospective activities were discussed as well as 25 current clinical criteria updates and 4 new clinical criteria. During FFY 2020, the following clinical criteria were updated with new medications, new indications, and guideline changes: 1. Allergen Extract 2. Anti-Fungal Medication for Onychomycosis 3. Anti-Obesity 4. Asthma/Allergy Immunomodulators 5. Atopic Dermatitis 6. Bowel Disorders/GI Motility, Chronic 7. Brand Name Multiple Source Prescription Drug Product 8. Buprenorphine/naloxone and Buprenorphine (Oral) 9. Calcitonin Gene-Related Peptide (CGRP) Inhibitor 10. CNS Stimulant and ADHD/ADD Medications 11. Fibromyalgia 12. Hepatitis C 13. Long-Acting Opioid Analgesics 14. Lyrica 15. Methadone (Pain Management Only) 16. Morphine Milligram Equivalent (MME) 17. New Drug Product 18. Oral NSAIDs and Combinations Legend (RX required) 19. Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9)

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	20. Pulmonary Arterial Hypertension (Phosphodiesterase Type 5 (PDE-5) Inhibitors) 21. Rho Kinase Inhibitor 22. Short Acting Fentanyl 23. Synagis 24. Systemic Immunomodulators 25. Topical NSAIDS Legend The following were new clinical criteria approved during FFY 2020: 1. Dupixent 2. Psychoactive Medication Duplicate Therapy (patients 6 years and older) 3. Psychoactive Medication for Children (5 years of age or younger) 4. Zolgensma NH DUR Board continues to monitor Therapeutic Duplications, Drug-Drug Interactions, Duplicate Ingredients, and Early Refills. NH Medicaid continues to utilize First Data Bank for Prospective DUR Criteria. The NH DUR Board reviews the summary of potential impacts to prescribers and members for over 200 RetroDUR activities at each meeting. The NH DUR Board selects the interventions that will be performed until the next DUR Board meeting. These interventions include letters to prescribers and/or members depending on the topics selected.
New Jersey	The DUR Board held three meetings on October 2019, January 2020 and July 2020. October 2019 1. Protocol for hereditary transthyretin-mediated amyloidosis (hATTR) products. The Board reviewed and made recommendations for the use of the products Onpattro and Tegsedi for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or aTTR. They also recommended Vyndaqel and Vyndamax for the treatment of cardiomyopathy of wild type aTTR. 2. Protocol Elaprase (idursulfase). The Board reviewed and recommended the use of Elaprase for the treatment of Hunter syndrome. 3. Protocol for Gaucher disease products. The Board reviewed and made recommendations for the use of three products (Cerezyme, Elelyso and Vpriv) as enzyme replacement therapy for the treatment of Gaucher disease. They also reviewed and made recommendations for products Cerdelga and Zavesca for use as substrate replacement therapy for the same disease. 4. Protocol for Cablivi (caplacizumab-yhdp). The Board reviewed and recommended Cablivi, a product approved by the FDA for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura or aTTP. January 2020 1. Protocol for Fabry disease products. The Board reviewed and recommended the use of the products Fabrazyme and Galafold for the treatment of patients with Fabry disease. 2. Protocol for Lambert-Eaton Myasthenic Syndrome products. The Board reviewed and recommended the use of Firdapse and Ruzurgi for the treatment of patients with Lambert-Eaton Myasthenic Syndrome (LEMS), a rare autoimmune disorder of the neuromuscular junction. 3. Protocol for Strensiq (asfotase). The Board reviewed and recommended the use of Strensiq for the treatment of hypophosphatasia (HPP), a rare inherited disorder characterized by the abnormal development of bones and teeth. 4. The Board reviewed a report on Nicotine Replacement Therapy (NRT) Utilization products with comparative data for SFY 2017, 2018 and 2019.

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	July 2020 1. An addendum to Dupixent (dupilumab) protocol. The Board reviewed and recommended an addendum to the protocol for dupilumab, an interleukin4 receptor alpha antagonist indicated for the treatment of moderate-to-severe atopic dermatitis. The update included the removal of criterion prohibiting concomitant utilization of other biologics since the products listed were not indicated for atopic dermatitis. 2. An addendum to Emflaza (deflazacort) protocol. The Board reviewed and recommended an addendum for deflazacort protocol. The update included changes to criterion allowing utilization in pediatric patients from age 5 and greater to age 2 and greater and adjusting the prednisone trial at the optimal dose of 0.75 mg/kg/day from 6 months to 3 months. 3. An addendum to PCSK9 Inhibitors protocol. The Board reviewed and recommended an addendum for proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors. The change was the addition of criterion that allows use for secondary prevention to the products, Praluent (alirocumab) and Repatha (evolocumab) according to recent guidelines. 4. Protocol for Varubi (rolapitant). The Board reviewed and recommended the use of rolapitant in combination with other antiemetic agents in adults for the prevention of nausea and vomiting associated with chemotherapy. 5. Protocol for Vyondys 53 (golodirsen). The Board reviewed and approved the use of golodirsen for the treatment of Duchenne muscular dystrophy (DMD). 6. Protocol for Cryopyrin-associated periodic syndromes (CAPS) products. The Board approved and made recommendations for the use of Arcalyst (rilonacept), Ilaris (canakinumab) and Kineret (anakinra) for the treatment of Cryopyrin-Associated Periodic Syndromes (CAPS). 7. Protocol for Spravato (esketamine)- The Board reviewed and made recommendations for the use of esketamine (Spravato) for use in treatment-resistant depression in conjugation with an oral antidepressant. 8. The Board reviewed and made recommendations for an educational newsletter on medication-assisted treatment (MAT). The DUR Board was involved in the following DUR education program (i.e. newsletters, continuing education, etc.); + MAT drugs educational newsletter explaining the benefits and risks associated with MAT program medications + Reviewed and compared opioid utilization above 120 MME and 200 MME + Reviewed Top 25 drugs utilization for (2017 thru 2019)
New Mexico	A. Number of DUR Board meetings held. Four meetings were held in FFY 2020. B. Additions/deletions to DUR Board approved criteria. 1. For prospective DUR, problem type/drug combinations added or deleted. The DUR Board did not approve, delete, or change any NCPDP ProDUR criteria. 2. For retrospective DUR, therapeutic categories added or deleted.

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	The DUR Board approved and completed two educational newsletters and five interventions for Federal Fiscal Year 2020. C. Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. There are no written DUR Board policies per se. D. Policies used to encourage the use of therapeutically equivalent generic drugs. Include relevant documentation, if available. New Mexico Medicaid reimburses for the generic cost only if a brand drug is dispensed when a generic is available. E. DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). Two educational outreach newsletters were delivered to fee-for-service providers and pharmacies and five patient-focused interventions were delivered to selected providers in FFY 2020. The newsletters contained articles reviewing clinical topics approved by the New Mexico DUR Board. The first intervention focused on Opioids/Benzodiazepines/Antipsychotics, the next two interventions focused on Morphine Milligram Equivalents, the fourth intervention focused on Postpartum Depression, and the fifth intervention focused on Gabapentinoids and Opioids.
New York	Meetings held; February 23, 2020 July 23, 2020 February 23 Meeting Drug Utilization Reviews (DUR) 1. Management of Non Acute Pain Utilization of Opioids and Morphine Milligram Equivalent Parameters DOH Recommendation to the DUR Board. The purpose of the review was to evaluate the use of opioids for non-acute pain, defined as pain extending past 7 days,in both Medicaid Fee for Service (FFS) and Managed Care (MC) programs and establish maximum daily morphine milligram equivalent (MME) safety edits for the treatment of non-acute pain. Prior authorization is required when utilizing greater than or equal to 90 MME per day. a Non acute pain is defined as greater than 7 days of opioid therapy. b Prior authorization will not be required for members established on greater than 90MME per day. The MME parameter will not apply for members with cancer, sickle cell disease, or receiving hospice care. 2. Management of Eosinophilic Asthma (EA) Utilization of Medication for EA and Place in Asthma Therapy. The presentation was initiated with a review of the biologic agents used in treating this condition (benralizumab, dupilumab, and mepolizumab). The second part of the review was to evaluate the place in therapy of these medications as supported by the Food and Drug Administration (FDA) approved labeling and asthma treatment guidelines. DOH Recommendation Prior authorization is required when there is

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	a. no history of corticosteroid utilization and b. no concurrent use of a corticosteroid 3. Management of Oral Second Generation Antipsychotics (SGAs) Utilization of SGAs and Maximum Daily Dosages (MDD). The purpose was to examine the utilization of oral Second Generation Antipsychotics (SGAs) and characterize the utilization in relation to MDDs recommended in the respective product labeling. DOH Recommendation Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. a. Prior authorization will not be required for members established on a dose greater than the highest MDD. Clinical Editing Updates 1. Utilization Trends for Products Used for the Treatment of Opioid Use Disorder The purpose was to assess the impact of currently employed clinical edits on opioid use disorder medications within the New York State Medicaid Program inclusive of both the Fee For Service (FFS) and Managed Care (MC) populations. It was recommended to the DUR Board that the current FFS quantity limits and duration edits established for the products used for OUD in the Medicaid program remain in effect. In addition, a 30 day maximum supply of 60 tablets and 30 tablets be placed on the product buprenorphine/naloxone SL tablets (Zubsolv) 8.6mg/2.1 mg and 11.4mg/2.9 mg respectively. 2. Utilization Trends for Long Acting Opioids Used for the Management of Pain. The purpose of the review was to evaluate long acting opioid (LAO) therapy exceeding the individual LAO quantity limit and to determine the average morphine milligram equivalents (MME) per day calculated for LAO claims. In summary, it was concluded that current NYS Medicaid LAO quantity limits have been effective, 9% of members exceeded the NYS Medicaid LAO quantity limits per claim during this time frame. It was recommended to continue with current LAO quantity limits. General Program Updates 1. Medicaid Retrospective Drug Utilization Review (RetroDUR) Fluoroquinolone Project. The update was an assessment of a mailed letter intervention to promote appropriate use of the fluoroquinolone class of antibiotics. The intervention letter was intended to reinforce the FDA message and labeling changes. The report concluded that the educational letter appears to have had a modest effect (15.1%) on decreasing potentially inappropriate fluoroquinolone prescribing in targeted prescribers. It was acknowledged that the letter may not have been the only influence for any changes in prescribing habits during this time period. 2. Medicaid Prescriber Education Program Antibiotic Stewardship The presentation provided an overview of the NYSMPEP activities including the newest educational module which is Antibiotic Stewardship. The goal of the program is to optimize the quality of care for NYS Medicaid members by providing the most current unbiased evidence based information on best practices in pharmacotherapy. NYSMPEP resources and current available educational modules were identified. This newest NYSMPEP educational module focuses on two key messages the promotion of appropriate antibiotic use in a routine practice and the use of delayed prescribing or watchful waiting. The role of proper hand and respiratory hygiene remains an important foundation for infection control. It is expected that the outreach for educational contacts with prescribers will

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	occur during the months of February and March. Additional activities performed by the Prescriber Education Program (PEP) were highlighted. July 23, 2020 DURB Meeting Preferred Drug Program (PDP) Clinical Review The following drug categories were reviewed for additions and/or changes to the preferred and non-preferred status on drugs in the following categories listed on the States Preferred Drug list. Financial discussions for each category occurred in Executive Committee however clinical discussions were held in the public meeting. 1. Non Steroidal Anti inflammatory Agents 2. Hepatitis C Agents Direct Acting 3. CNS Stimulants 4. Acne Agents Topical 5. Topical Steroids High Potency 6. Glucagon-Like Peptide (GLP-1) Agonists 7. Sodium Glucose Co Transporter 2 Inhibitors (SGLT2) 8. Sulfasalazine Derivatives 9. Immunosuppressives Oral 10. Phosphate Binders Regulators Based upon presented clinical and financial information the DUR Board recommended changes to the States Preferred Drug program and forwarded those changes to the Commissioner of Health for final determination. Drug Cap Review Spinraza (nusinersen) A background summary of the Drug Cap legislation was presented and followed by a utilization review of Spinraza. Drugs piercing the State Medicaids Drug Cap and having no consensus on a negotiated drug rebate value are by law sent to the States Drug Utilization Review Board (DURB) to determine a calculated target value. The following areas were the subject of the first public presentation prior to any target value being calculated and agreed to by the Board: a. Patients with severe forms of spinal muscular atrophy (SMA) have a life expectancy of less than 2 years. Patients with less severe disease can survive until adulthood. Severe SMA is more common with Type 1 accounting for greater than 50%. b. Two nusinersen phase 3 trials were terminated as results showed favorable outcomes. Post marketing studies showed benefits in adults with spinal muscular atrophy (SMA). c.The incidence of spinal muscular atrophy (SMA) in New York State approximates 20 to 30 cases per 253000 births. New York includes SMA testing in newborn screening. d.Between April 2017 and September 2019 there were 336 claims for nusinersen for NY Medicaid members (Fee For Service and Managed Care). e.Total WAC for initial year of nusinersen therapy was presented publicly total WAC for maintenance year therapy was presented publicly. f.Coverage policies (Medicaid programs, commercial insurance) in other states and countries specify criteria andor restrictions for nusinersen coverage. A second public presentation was presented to the Board outlining considerations in calculating a target value. A value assessment of Spinraza was presented and included the following elements in determining a reasonable price for pharmaceuticals. a.Elements of a cost effectiveness threshold. b.Cost effectiveness threshold

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	c.Spinraza improves patient health outcomes compared to best supportive care alone for all subpopulations of SMA. Its greatest impact appears to be when used for pre symptomatic infants. d.In proportion to the clinical benefits, the added cost of Spinraza therapy exceeds commonly used thresholds for cost-effectiveness for all patient subpopulations. e.The modified societal perspective scenario analysis did not notably improve the cost effectiveness of Spinraza. Drug Cap financial review of Spinraza (nusinersen) was performed in Executive Session. Upon their return from Executive Committee the Board agreed to a supplemental rebate target amount and forwarded their recommendation to the Commissioner of Health
North Carolina	The North Carolina Drug Utilization Review (DUR) Board meets quarterly in January, April, July, and October of each year. During each DUR Board meeting the DUR Board is presented prospective and retrospective DUR information. The DUR Board uses prospective screenings to identify areas for additional retrospective research. The research findings are then presented at a future DUR Board meeting. During each quarterly meeting, the DUR Board is presented with several retrospective topics. After discussion, the DUR Board may recommend to the Department of Health Benefits the addition of prospective point-of-sale edits or prior authorizations. The following prospective DUR categories are reviewed with the DUR Board during each meeting: drug disease contraindication alerts, drug-drug interaction alerts, overuse alerts, high dose alerts, ingredient duplication alerts, low dose alerts, drug underuse alerts, drug age alerts, pregnancy alerts, and therapeutic duplication alerts. The top drug-disease contraindication alerts were antihyperglycemic, biguanide type (C4L), skeletal muscle relaxants (H6H), and treatment for ADHD/narcolepsy (H2V). Opioid analgesics (H3A), narcotic, analgesic and non-salicylate analgesic (H3U), SSRIs (H2S), and anticonvulsants (H4B) were the top drug-drug interaction alerts. The top overuse alerts consisted of antipsychotic, atypical, dopamine, serotonin antagonist (H7T), adrenergics, aromatic, non-catecholamine (J5B), and treatment for ADHD/narcolepsy (H2V). The top high dose alerts were antipsychotic, atypical, dopamine, serotonin antagonist (H7T), SSRIs (H2S), treatment for ADHD/narcolepsy (H2V), adrenergics, aromatic, non-catecholamine (J5B), and antihistamines- 2nd generation (Z2Q). Treatment for ADHD/narcolepsy (H2V), adrenergics, aromatic, non-catecholamine (J5B), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), and beta-adrenergics agents, inhaled, short acting (B6W) were the highest ranked ingredient duplication alerts. The top low dose alerts were macrolides (W1D), lincosamide antibiotics (W1K), penicillins (W1A), beta-adrenergic and glucocorticoid combo, inhaled (B63), and anti-anxiety-BZD (H20). The highest ranked drug underuse alerts were anticonvulsants (H4B), SSRIs (H2S), treatment for ADHD/narcolepsy (H2V), and adrenergics, aromatic, non-catecholamine (J5B). The top drug age alerts included antihistamines- 1st generation (Z2P), absorbable sulfonamide antibacterial agents (W2A), antiparkinsonism drugs, anticholinergic (H6B), non-opioid antitussive-1st generation antihistamine-decongest (B3R), and topical immunosuppressive agents (Q5K). The top pregnancy alerts were anticonvulsants (H4B), SSRIs (H2S), and contraceptives, oral (G8A). Anticonvulsants (H4B), SSRIs (H2S), and antipsychotic, atypical, dopamine, serotonin antagonist (H7T) were ranked the highest for therapeutic duplication alerts. During each quarterly meeting, the Board reviews the top 15: drugs (GSN) by total amount paid, drugs (GSN) by total amount paid (all strengths), drugs (GSN) by total claims, and GC3 classes by payment amount. The top drugs (GSN) by total claims were albuterol HFA (~37K to ~40K claims), cetirizine 10 mg tab (~29K to ~31K claims), cetirizine 1 mg/ml sol (~25K to ~31K claims), oseltamivir 6 mg/mL oral (~39K claims), Amoxil 400 mg/5 mL (~37K claims), and fluticasone nasal

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	(~25K claims). The top drugs (GSN) by total amount paid were Humira CF Pen (~$3.5M to ~$5.4M), albuterol HFA (~$3.3M to ~$3.5M), Suboxone Film (~$3M to ~$3.5M), and Biktarvy 50-200-25 tab (~$3.6M). The top drugs (GSN) by total amount paid, all strengths included Humira (~$6.3M to ~$7.7M), Invega (~$3.9M to ~$4.1M), Latuda (~$4M to ~$4.2M), Vyvanse (~$4.3M), Tamiflu (~$6.1M), and Concerta (~$4.2M to ~$5.6M). The top GC3 classes by payment amount included atypical, dopamine, serotonin antagonist (H7T; ~$8.3M to ~$9.3M), anticonvulsants (H4B; ~$7.5M), insulins (C4G; ~$7.3M to ~$7.9M), anti-narcolepsy/anti-hyperkinesis (H2V; ~$8.3M to ~$8.6M), and anti-inflammatory tumor necrosis factor (S2J; $7.8M to ~$8.1M). During this FFY, ProDUR screening results did not lead to adjustments in RetroDUR screens, nor did RetroDUR screening result in changes to our ProDUR alerts. Our ProDUR screenings have been fairly consistent. We have been able to select topics for potential RetroDUR intervention based on reports run by our vendor and topics brought to the table by Board members. In 2019 and 2020 the retrospective drug utilization categories included the examination of the following opioid topics: short-acting oxycodone utilization and substance abuse diagnosis, patients diagnosed with fibromyalgia who are using opioids without non-opioid medications, patients diagnosed with migraines who are using opioids without triptans or other preventative medications, patients on opioids and antipsychotics, duplication of therapy for short-acting opioids, codeine use in pediatrics, and overall prescribing trends of opioids. Additionally, the Board examined benzodiazepine use including benzodiazepine use without a SSRI, SNRI, or TCA and overall trending of use. The Board also reviewed clozapine utilization, montelukast strengthened warnings, FDA notices on improper dosing of EpiPen and Authorized Generics, and breathing difficulties associated with gabapentin and pregabalin. DUR Board recommendations throughout the year consisted of prescriber and pharmacist letters, newsletters, prospective DUR recommendations, collaboration with the Medical Board, and continued monitoring.
North Dakota	North Dakota Summary of DUR Board Activities FFY 2020 Four North Dakota Medicaid DUR Board meetings were held during FFY 2020. The meeting were held during the 1st Wednesday of December 2019, March 2020, June 2020, and September 2020. For prospective DUR, prior authorization criteria was put in place for the following problem types/drugs by the DUR Board: glucagon overutilization, Ofev, Conjupri, ATP Citrate Lyase (ACL) inhibitors, antifibrinolytic agents, Palforzia, Mytesi, and agents for the treatment of cystic fibrosis, eosinophilic asthma, and aspergillus & candidiasis infections. No deletions of DUR Board approved prospective DUR criteria occurred in FFY 2020. For retrospective DUR (RDUR), the DUR Board voted to approve and add a total of 372 criteria designed to evaluate potential problems including drug utilization (overutilization and nonadherence/underutilization), therapeutic appropriateness (based on age, length of therapy, gender, etc), drug-drug interactions, drug-disease state interactions, and needed drug education. The therapeutic categories with new criteria added included agents for the treatment of narcolepsy, antipsychotic agents, CNS stimulants, antirheumatic agents, antiviral agents, agents for treatment of diabetes, immunomodulatory agents, non-steroidal anti-inflammatory agents, treatments for ALS, anti-neoplastic agents, antihypertensive agents, antihelmintics, agents for the treatment of migraine, antidepressants, potassium channel blockers, treatments for idiopathic pulmonary fibrosis, antibiotics, opioid analgesics, anticonvulsants, respiratory agents, renal and genitourinary agents, treatments of sickle cell disease, and sedative/hypnotic agents.

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	No deletions of DUR Board approved retrospective DUR criteria occurred in FFY 2020. The RDUR vendor for the North Dakota Medicaid program, Health Information Designs, LLC uses results from RDUR screens to make determinations on potentially beneficial adjustments to RDUR criteria (new criteria additions or changes to current criteria.). Any new RDUR criteria is brought to the DUR Board for review and approval before being implemented. If information from RDUR screens indicates an issue that could be prevented via new prospective DUR edits, the state implements those edits. The ND DUR Board is directly involved in the DUR educational program. All new outpatient pharmacy prior authorization criteria and RDUR criteria are reviewed by the DUR Board at the quarterly meetings, and all criteria and prior authorization request forms are re-reviewed annually. The Board offers suggestions for educational endeavors and provides input on the quarterly newsletters that are developed. North Dakota also participates in Academic Detailing with quarterly visits with pharmacies and prescribers to discuss PDL changes, new edits, targeted provider interventions and education, and other pertinent information important in supporting the provider community. Drug utilization information and provider prescribing rates are used to determine candidates for in-person targeted educational interventions, which are conducted during the same time as academic detailing visits. Targeted education letters are sent out based on provider drug utilization, based on the intervention topic.
Ohio	The Ohio Department of Medicaid (ODM) Drug Utilization Review (DUR) Board met four times during FFY 2020: November 12, 2019, February 11, 2020, May 12, 2020, and September 22, 2020. All interventions and results listed in Summary 2 were presented to the DUR Board. Results of prospective DUR screenings are used to adjust retrospective DUR screenings and vice versa. November 12, 2019 DUR Board Meeting A summary of prescriber responses for the RetroDUR intervention targeting patients <18 years old and less than or equal to 70% adherent and >18 years old and less than or equal to 50% adherent to their atypical antipsychotics was presented. The re-review results from the RetroDUR intervention directed at the prescribers of patients who were taking opioids in combination with benzodiazepines and sedative hypnotics was presented. An update to the Board on the CSP membership was provided. Next, an overview of the prescriber benchmark data was presented. Prescribers were selected based on their opioid prescribing habits and were compared to other prescribers in the same specialty and county. The SUPPORT Act was then reviewed. Lastly, annual DUR Board elections took place. February 12, 2020 DUR Board Meeting An overview of a RetroDUR intervention directed at the prescribers of patients taking concurrent opioids and benzodiazepines was presented. The re-review results from the intervention directed at the prescribers of patients who were not adherent to their non-insulin antidiabetic medications were presented. The SUPPORT Act was reviewed. Profiles for members taking four or more psychotropic drugs and members < 18 years old taking two atypical antipsychotics were reviewed at the DUR Committee. Profile reviews occurred on members taking opioids and antipsychotics. The Board discussed educational materials mailed to prescribers of antipsychotic medications for pediatric patients to ensure metabolic monitoring and adverse event evaluation is performed regularly. The Board was updated on CSP membership. Next, an overview of an adherence intervention letter directed at prescribers of antiepileptic medications for patients less than or

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	equal to 70% adherent to their medication was presented. A summary of oncology medications processing through the FFS pharmacy benefit was presented. It was requested that the Board consider allowing a clinical review prior to claims processing to assure appropriate use of these medications and safeguard against experimental use. The Board discussed the prior authorization and appeals process and was informed that members already taking these medications will be grandfathered. There was discussion about the Ohio State Board of Pharmacy adjusting gabapentin to a controlled substance status. The Board discussed an opioid and gabapentin intervention and voted to change the gabapentin refill threshold from 80% to 90%. May 12, 2020 DUR Board Meeting A summary of the RetroDUR intervention letter directed at prescribers whose patients were taking opioids with > 2,400mg/day of gabapentin was presented. The re-review results from the intervention directed at members who received a prescription for Tamiflu but did not receive an influenza vaccine during the previous flu season were presented. An update was provided on CSP membership status. An overview of an educational outreach to prescribers on the importance of pediatric metabolic monitoring when taking antipsychotic medications was presented. While reviewing DUR digest topics, the Board recommended to include information on emergency Telehealth rules. Next, a provider DUR survey created to accompany all DUR interventions was presented and feedback was collected. Various reports regarding prior authorization, claim count, and high cost medications was summarized. Lastly, emergency changes made to the pharmacy benefit in both FFS and the managed care plans (MCPs) in response to the COVID-19 pandemic were presented. September 22, 2020 DUR Board Meeting The re-review results from the RetroDUR intervention directed at prescribers whose patients were less than or equal to 18 years old who were less than or equal to 70% adherent and patients >18 years old who were less than or equal to 50% adherent to their atypical antipsychotic medication were presented. Next, a re- review of the package size edit for nitroglycerin sublingual tablets was presented. An update to the Board on the CSP membership was provided. An overview of a RetroDUR intervention which notified prescribers that their patients were taking opioid medications in combination with a stimulant was presented. Next, an educational fax intervention was reviewed which discussed opportunities to immunize members with the influenza vaccine. The Board discussed preparation strategies for COVID-19 point of care testing in pharmacies. It was announced that ODM was reviewing coverage and utilization of bulk powders and excipients that are used in compounds.
Oklahoma	During FFY 2020 the DUR Board met 11 times. Meetings were held in October, November, and December 2019, and January, February, March, April, May, June, July, and September 2020. In accordance with state legislative mandate, 20 speakers addressed the DUR Board during public comment. DUR Board topics include Product-Based Prior Authorization (PBPA) and Criteria-Based Prior Authorization (CBPA) categories and product additions, changes, and reviews. CBPA/PBPA selections come from new product approvals, new indications of existing products, new therapeutic guidelines, or safety updates. These medications require a manual prior authorization (PA) and claims will reject at the point of sale if the member does not meet automated criteria in claims history or diagnosis profile. If the member has clinical exceptions for medical necessity, a manual PA from the provider is required for coverage consideration. Categories/Products Added or Modified during FFY 2020: CBPA Categories/Products Added:

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	Sorilux, Piqray, Talzenna, Herzuma, Kanjinti, Ontruzant, Trazimera, Nubeqa, Harvoni Oral Pellets, Sovaldi, Vyndaqel, Vyndamax, Recarbrio, Xenleta, Turalio, Elzonris, Inrebic, Aemcolo, Motegrity, Zelnorm, Ibsrela, Bevyxxa, Avaclyr, Ultomiris, Korlym, Duaklir Pressair, Scenesse, Givlaari, Ruzurgi, Xcopri, Esperoct, Asparlas, Daurismo, Idhifa, Lumoxiti, Tibsovo, Xospata, Azedra, Tepezza, Mayzent, Mavenclad, Vumerity, Ayvakit, Bynfezia Pen, Tazverik, Aliqopa, Brukinsa, Polivy, Ruxience, Pemfexy, Rozlytrek, Zirabev, Ziextenzo, Palforzia, Nourianz, Wakix, Absorica LD, Amzeeq, Aprizio Pak, Exservan, Metronidazole 1% Gel, Noritate, Procysbi, Pyridostigmine 30mg Tablet, Quzyttir, Slynd, Talicia, Tirosint, Iluvien, Ozurdex, Retisert, Isturisa, Koselugo, Pemazyre, Qinlock CBPA Categories/Products Modified: Praluent, Halaven, Ibrance, Kadcyla, Lynparza, Erleada, Xtandi, Zytiga, Kalydeco, Symdeko, Onpattro, Tegsedi, Avycaz, Zerbaxa, Baxdela, Ciprofloxacin 100mg Tablet, Ciprofloxacin 500mg and 1,000mg ER Tablet, Ofloxacin 300mg and 400mg Tablet, Bavencio, Keytruda, Dupixent, Benlysta, Symproic, Xarelto, Doptelet, Emflaza, Soliris, Fasenra, Nucala, Sabril, Emgality, Calquence, Gazyva, Tasigna, Venclexta, Imfinzi, Tecentriq, Esbriet, Ofev, Grastek, Oralair, Ragwitek, Odactra, Klor-Con, Epiklor, Erythromycin 2% Swab, Dextenza, Yutiq PBPA Categories/Products Added: Ezallor Sprinkle, Welchol Chewable Bar, Eticovo, Hadlima, Hyrimoz, Rinvoq, Skyrizi, Drizalma Sprinkle, Spravato, Citalopram 20mg/10mL, Escitalopram 10mg/10mL, and Fluoxetine 20mg/5mL Unit Dose Cups, Rocklatan, Tosymra, Reyvow, Ubrelvy, ProAir Digihaler, Evenity, Katerzia, Conjupri, Dayvigo, Qternmet XR, Riomet ER, Rybelsus, Trijardy XR, Secuado, Caplyta, Caldolor, Relafen DS, Tramadol 100mg Tablet PBPA Categories/Products Modified: Otezla, Rituxan, Humira, Cardene, Hetlioz, Anti-Diabetic Medications, Methylin, Halog RetroDUR topics come from various sources, including: Annual Reviews: Each CBPA/PBPA category/product is reviewed annually for market updates, utilization trends, and cost-effective treatments. FDA/DEA Updates: FDA alerts and safety updates and DEA changes are reviewed monthly to educate providers if necessary. Therapeutic Guidelines: Practice guidelines are reviewed for changes in recommendations and updates are made to the corresponding clinical categories. SoonerPsych Program: This program is an educational quarterly mailing to prescribers of members utilizing atypical antipsychotics. Mailing include a gauge showing prescribers how their prescribing patterns compare to those of other SoonerCare prescribers of atypical antipsychotics regarding potential differences from evidence-based prescribing practices. Mailings also include an informational page with evidence-based material related to the mailing topic. Mailing topics include 4 modules: polypharmacy, medication adherence, metabolic monitoring, and appropriate diagnosis. Chronic Medication Adherence (CMA) Program: This program provides educational quarterly mailings to prescribers with members utilizing chronic maintenance medications for diabetes, hypertension, or cholesterol to encourage medication adherence and improve the quality of care for SoonerCare members utilizing these medications. Academic Detailing Program: This program provides educational, evidence-based, in-person meetings to prescribers of targeted medication categories including Attention-Deficit/Hyperactivity Disorder (ADHD) medications, atypical antipsychotics, and antibiotics and is intended to encourage evidence-based prescribing practices among SoonerCare prescribers.

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	Educational Initiatives: Project goals include reviewing current usage and educating prescribers, pharmacies, and members of access and necessity of selected medications. Various communication methods (e.g., letters, faxes, website, newsletters) are employed to increase awareness. RetroDUR Topics Reviewed during FFY 2020: Fall 2019 Pipeline Update; Overview of FDA Safety Alerts; Maintenance Drug List; Atopic Dermatitis Prescriber Specialty Analysis; SoonerCare Opioid Initiative Update; Narrow Therapeutic Index Drug List; ADHD Prescription Use in Reproductive-Aged Women; SoonerPsych Program Update; Prenatal Vitamin Utilization Update; Spring 2020 Pipeline Update; Annual Review of the SoonerCare Pharmacy Benefit; Use of Angiotensin Converting Enzyme Inhibitor/Angiotensin Receptor Blocker/Angiotensin Receptor-Neprilysin Inhibitor Therapy in Patients with Chronic Heart Failure (HF) Mailing Update; CMA Program Prescriber Mailing Update; Academic Detailing Program Update ProDUR Edits Implemented during FFY 2020: Cumulative daily MME limit decreased to 90 MME; Maintenance Drug List created allowing 90-day supply of many maintenance medications; Due to COVID-19, edits temporarily relaxed to allow 90-day supply for certain medications; PA implemented for chloroquine/hydroxychloroquine to ensure appropriate use during COVID-19 (edit implemented to grandfather members with rheumatoid arthritis or systemic lupus erythematosus); Co-pays waived for medications used for COVID-19 treatment with confirmed COVID-19 diagnosis; Edit implemented requiring prescribed quantity on pharmacy claims for CII medications to identify partial fills vs refills; Categories continuously reviewed and quantity limits implemented/updated according to FDA recommended dosing where appropriate Annual reviews of all PA categories were presented or made available to the DUR Board for review in FFY 2020. Oklahoma State Statutes require any drug/category placed on PA to be reviewed 12 months after placement. Categories/Products Reviewed and Presented to the DUR Board during FFY 2020: CBPA Drugs/Categories: Acute Lymphoblastic Leukemia and Chronic Myeloid Leukemia Medications, Cystic Fibrosis Transmembrane Conductance Regulator Modulators, Amyloidosis Medications, Various Systemic Antibiotics, Hepatitis C Medications, Signifor LAR, Skin Cancer Medications, Atopic Dermatitis Medications, Constipation and Diarrhea Medications, Anticoagulants and Platelet Aggregation Inhibitors, Antivirals, Thrombocytopenia Medications, Soliris, Muscular Dystrophy Medications, Carbaglu, Revcovi, Gamifant, Firdapse, Leukemia Medications, Factor Replacement Products, Anticonvulsants, Lymphoma Medications, Lutathera, Vitrakvi, Anti-Emetics, Lung Cancer Medications, Balversa, Granulocyte Colony-Stimulating Factors, Allergen Immunotherapies, Parkinson's Disease Medications, Idiopathic Pulmonary Fibrosis Medications, Aldurazyme, Naglazyme, Various Special Formulations, Amyloidosis Medications, Breast Cancer Medications, Prostate Cancer Medications, Sickle Cell Disease Medications, Synagis, Givlaari, Scenesse, Actinic Keratosis Medications, Alpha1-Proteinase Inhibitors, Alzheimer's Medications, Amyotrophic Lateral Sclerosis Medications, Systemic Antifungals, Arcalyst, Benzodiazepines, Bowel Preparation Medications, Brineura, Butalbital Medications, Cholbam, Chorionic Gonadotropin Medications, Corticosteroid Special Formulations, Defitelio, Diabetic Supplies, Elaprase, Erythropoietin Stimulating Agents, Fabry Disease Medications, Gattex, Gaucher Disease Medications, Gout Medications, H.P. Acthar Gel, HF Medications (Corlanor/Entresto), Hereditary Angioedema Medications, Hyperkalemia Medications, Inhaled Anti-Infectives, Injectable and Vaginal

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	Progesterone Products, Iron Chelating Agents, Jynarque, Kanuma, Keveyis, Leukotriene Modulators, Lidocaine Topical Products, Lumizyme, Luxturna, Mepsevii, Mozobil, Myalept, Mytesi, Naloxone Medications, Northera, Nuedexta, Ocaliva, Pancreatic Enzymes, Parathyroid Medications, Phosphate Binders, Prenatal Vitamins, Procysbi, Pulmonary Hypertension Medications, Qbrexza, Qualaquin, Qutenza, Ravicti, Smoking Cessation Products, Strensiq, Symlin, Sylvant, Topical Acne Products, Ulcerative Colitis and Crohn's Disease Medications, Vasomotor Symptom Medications, Vesicular Monoamine Transporter 2 Inhibitors, Vimizim, Xgeva, Xiaflex, Xuriden, Zinplava PBPA Categories: Targeted Immunomodulator Agents, Antidepressants, Maintenance Asthma and Chronic Obstructive Pulmonary Disease Medications, Glaucoma Medications, Anti-Migraine Medications, Osteoporosis Medications, Inhaled Short-Acting Beta2 Agonists, Multiple Sclerosis Medications, Anti-Diabetic Medications, Antihypertensives, Insomnia Medications, Atypical Antipsychotics, ADHD and Narcolepsy Medications, Ophthalmic Anti-Inflammatory Medications, Topical Corticosteroids, Opioid Analgesics, Opioid Medication Assisted Treatment Medications, Oral Antihistamines, Anti-Ulcer Medications, Benign Prostatic Hypertrophy Medications, Bladder Control Medications, Fibromyalgia Meds, Gonadotropin-Releasing Hormone Meds, Growth Hormone Products, Muscle Relaxants, Nasal Allergy Meds, Systemic Nonsteroidal Anti-Inflammatory Drugs, Ophthalmic Allergy Meds, Ophthalmic Antibiotics, Otic Anti-Infectives, Pediculicides, Testosterone Products, Topical Antibiotics, Topical Antifungals
Oregon	DUR Board meetings held: 4 Additions/deletions to DUR Board approved criteria: Substance Use Disorders: Remove the PA requirement for all OUD products except for dose limit of 24 mg buprenorphine per day for transmucosal products Antidepressant Use in Children: Implement a safety edit for initiation of TCA therapy in children younger than the FDA approved minimum age limit with the goal of preventing off label use Revise the dupilumab PA criteria to include chronic rhinosinusitis with nasal polyposis Orphan Drug PA Policy: Implement proposed criteria to require PA for all new drugs designated as Orphan Drug by FDA to ensure appropriate use and require the medication be prescribed by or in consultation with an appropriate specialist Opioids: Update the PA criteria for short and long acting opioids to prevent harm from abrupt discontinuation and reinforce a shared patient and provider decision for appropriate dosage reduction Febuxostat PA Update: add a requirement to the PA criteria that the patient has been assessed for CV risk and the benefits outweigh the risks Oncology PA Policy: implement proposed Oncology Agents PA criteria for all antineoplastic drugs originally approved by the FDA on 1/1/2008 or later; all new molecular entities and new formulations of antineoplastic drugs that already require PA; and all new FDA approved antineoplastic agents Hepatitis C, Direct Acting Antivirals: amend DAA PA criteria to include new FDA approved indications in pediatric patients; remove requirement for a pregnancy test and address w/ case management; update Table of recommended regimens to accommodate any expanded or new FDA indications for current recommended regimens and to add guidance for patients who have a contraindication or intolerance to ribavirin ProDUR reports are presented quarterly and results inform potential changes to PA criteria and RetroDUR initiatives

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	RetroDUR reviews and Drug Use Evaluations inform changes to PA criteria and ProDUR edits DUR Board involvement in education (e.g. Newsletters): Update on Recent Guidance and Safety Alerts for Opioid Use in Non-cancer Pain CGRP Antagonists in Migraine Prophylaxis Evidence for Drugs that are Heavily Marketed Biosimilar Medications: Key Considerations for Providers Coronavirus Management: Evidence for Treatment and Drug Shortage Updates Optimizing the Use of NPH Insulin in Patients with Type 2 Diabetes Mellitus Shifts in the Treatment of Community Acquired Pneumonia New Disease-Modifying Anti-Rheumatic Drugs for Management of Rheumatoid Arthritis Cardiovascular Outcomes Associated with Newer Therapy Classes for Type 2 Diabetes Mellitus
Pennsylvania	DUR BOARD ACTIVITIES a) The DUR Board met once in FFY 2020 on the following dates: 1. October 21, 2020 The March 2020 DUR Board meeting was cancelled due to the COVID-19 Public Health Emergency. b) The DUR Board recommends prospective hard edits and develops prior authorization guidelines to help to ensure that the medications are used appropriately with respect to indications, duration, dosage and avoidance of potential drug or disease interactions. The following topics were identified during FFY 2020 as focus areas for the DUR Board to assess and promote appropriate utilization: 1. New clinical prior authorization of the following: a. Crysvita (burosumab-twza) b. Evrysdi (risdiplam) c. Palforzia [Peanut(Arachis hypogaea) Allergen Powder-dnfp] d. Tepezza (teprotumumab-trbw) e. Xywav (calcium, magnesium, potassium, and sodium oxybates) 2. Revisions to the following prior authorization guidelines: a. Complement Inhibitors b. Corlanor (ivabradine) c. Cystic Fibrosis Transmembrane Regulator (CFTR) Modulator Therapies d. Cytokine and CAM Antagonists e. Duchenne Muscular Dystrophy Antisense Oligonucleotides f. Spinraza (nusinersen) g. Tysabri (natalizumab) c) Prospective DUR interventions made prior to claim adjudication is more effective than retrospective DUR interventions for modifying prescribing patterns and preventing adverse outcomes. Therefore, the Department mines the pharmacy data on an ongoing basis to determine where there are aberrant prescribing patterns that could lead to detrimental health and safety issues for the Medical Assistance Recipients of Pennsylvania. The DUR Board suggests

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	the prospective claims edits and develops the prior authorization guidelines used by the Department's clinical reviewers to determine medical necessity. d) The Department provides feedback to the DUR Board on the retrospective DUR program and consults with them on the development of new clinical guidelines.
Rhode Island	Indicate the number of DUR Board meetings held The Rhode Island Medicaid Drug Utilization Review Board met four (3) times during FFY 2020. The April 2020 DUR meeting was canceled due to COVID and information from the canceled meeting was presented during the June 2020 DUR meeting. List additions/deletions to DUR Board approved criteria. For prospective DUR, list problem type/drug combinations added or deleted. For retrospective DUR, list therapeutic categories added or deleted. Prospective DUR Prospective DUR criteria are not routinely reviewed by the DUR Board. However, specific criteria may be brought up for discussion. All severity level 1 First Databank criteria are active in the prospective DUR system. Retrospective DUR Rhode Island Medicaid uses a comprehensive list of retrospective DUR criteria, which include alerts for drug interaction, overuse, therapeutic duplication, black box warnings, and underuse (non-adherence). Each month, claims data are run against criteria and approximately 1,000 recipient drug profiles are selected for review and evaluation by a clinical pharmacist. Many different types of criteria may be selected for review each month. For FFY 2020, the top 10 alerts are noted in attachment 2. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. For the most part, prospective screening operates independently from retrospective screening. However, the Board has recommended that drug interactions that are black box warnings in the product labeling also be alerted as retrospective interventions, even though these alerts are included in the prospective DUR screening. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring). For retrospective DUR, list therapeutic categories added or deleted. Currently, educational efforts include mailing of alert letters to prescribers based on criteria exceptions and further review by a clinical pharmacist. Therapeutic duplication, drug interaction, and underuse (non-adherence) retrospective and prospective DUR criteria are in place. In addition, drug interaction and therapeutic duplication alerts were mailed. These alerts included patients with specific diseases not found to have claims for drugs that are recommended as part of national guidelines. Specific examples include diabetic patients not taking lipid lowering therapy or ACE inhibitors. There continues to be a focus on appropriate use of opioids. Patients identified as possibly misusing opioids can be restricted to a single pharmacy as part of the State's Lock-In program. Individual outreach was also made to prescribers who did not respond to any DUR letters mailed.

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	DUR Board meeting minutes can be found on the Rhode Island Drug Utilization Review webpage at: http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Pharmacy/DrugUtilizationReview.aspx
South Carolina	Since the State is in the process of restructuring the DUR Board, we have listed DUR activities performed in the last review period. Support of the Agreement between SCDHHS and MUSC for the provision of drug utilization review (DUR) services for this reporting period included the completion of the first pediatric model to identify the trajectory of opioid dependence/chronic opioid use post-surgery tonsillectomy with or without adenoidectomy (T&A). Data updates, including receipt of Medicare Part D data, filled previously identified gaps in the un-identified Medicaid claims data received from the South Carolina Revenue and Fiscal Affairs Office (RFA) and allowed us to prepare for a robust analysis and development of our first adult model, total knee replacement (total knee). Educational outreach this reporting period chronicled three academic detailing (AD) firsts: pharmacy student involvement; visits to pharmacists, and virtual visits (tele-AD). An innovative pharmacy student education initiative allowed us to extend our educational outreach to pharmacists to help reduce stigma and promote expansion of naloxone while training the next generation of pharmacists to do the same. Our focus on expanding access to naloxone turned out to be very timely amidst the COVID-19 pandemic where our state has seen a sizeable increase in naloxone administration by First Responders (nearly 50% increase in May). Readying ourselves to interactively meet 'face-to-face' with providers remotely during this time of social distancing prepares us to extend our AD reach post-pandemic through a blended face-to-face and virtual visit strategy. The data updates and quality checks to ensure we accurately filled the previously identified gaps in prescription data (specifically missing quantity fields in Fee for Service claims and Medicare Part D prescriptions), were important analytical tasks undertaken this reporting period that had little impact on our pediatric analyses but significant implications for adult data. Once we had a more complete prescription file, we were able to focus our efforts on a robust total knee analysis to prepare for development of our intended first adult model. Last reporting period, we substituted the development of an adult T&A model for total knee as a first look at adult surgeries, since unlike total knee, there were very few patients ages 65 and older who underwent a tonsillectomy during the analysis timeframe. Those efforts were beneficial as they have provided us with valuable educational outreach content to share with specialists we would likely not have researched without the necessity to circumvent the Medicare Part D data gap. The COVID pandemic converted past discussions about virtual AD visits into a tipSC outreach reality. March 12th was the last face-to-face AD visit to a primary care practice this reporting period; March 27, 2021 was the first ever tele-AD visit.. In person educational outreach through pharmacy students trained by SCORxE academic detailers met face-to-face with their community pharmacy preceptors in May and June to discuss our latest tipSC topic Naloxone Can Save a Life. Utilizing pharmacy students to expand our AD reach to the pharmacy community, an innovative initiative implemented by the SCORxE AD Service, was a planned strategy that pre-dated the pandemic. The acute pain topic completed earlier this reporting period focuses on multi-modal pain care , non-pharmacologic approaches, non-opioid medications, and opioids , and provides the foundation for our fall topic on behavioral and physical non-pharmacologic treatments for acute and chronic pain, including post-surgery pain. Additional initiatives/interventions can be found at https://msp.scdhhs.gov/tipsc/site-page/tipsc-issues
South Dakota	The RDUR Review Committee conducted patient profile reviews 8 of the 12 months. Reviews did not take place for three months due to Covid.

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	The Committee reviewed and added the following RDUR criteria: 11817 X Nurtec ODT (rimegepant) may be over-utilized. The recommended maximum dose of rimegepant is 75 mg in a 24-hour period. The safety of treating more than 15 migraines in a 30-day period has not been established. 11818 X The safety and effectiveness of Nurtec ODT (rimegepant) in pediatric patients have not been established. 11819 X Avoid the use of Nurtec ODT (rimegepant) in patients with severe hepatic impairment. In clinical studies, plasma concentrations of rimegepant were significantly higher in subjects with severe (Child-Pugh C) hepatic impairment. No dosage adjustment rimegepant is required in patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment. 11820 X Avoid the use of Nurtec ODT (rimegepant) in patients with end-stage renal disease (CLcr < 15 mL/min). Rimegepant has not been studied in patients with end-stage renal disease and patients on dialysis. No dosage adjustment of rimegepant is required in patients with mild, moderate, or severe renal impairment. 11821 X Avoid the concomitant administration of Nurtec ODT (rimegepant) with strong inhibitors of CYP3A4. The co-administration of rimegepant, a CYP3A4 substrate, with strong inhibitors of CYP3A4 may result in a significant increase in rimegepant exposure. 11822 X Concomitant administration of Nurtec ODT (rimegepant) with moderate inhibitors of CYP3A4 may result in increased exposure of rimegepant. Avoid another dose of rimegepant within 48 hours when it is concomitantly administered with moderate inhibitors of CYP3A4. 11823 X The concurrent use of Nurtec ODT (rimegepant) with strong or moderate CYP3A4 inducers should be avoided. Rimegepant is a CYP3A4 substrate, and concurrent use with a strong or moderate CYP3A4 inducer may result in decreased rimegepant exposure and loss of rimegepant efficacy. 11824 X Nurtec ODT (rimegepant) is a substrate of P-gp and BCRP efflux transporters. Concomitant administration of rimegepant with inhibitors of P-gp or BCRP may result in a significant increase in rimegepant exposure. Avoid concurrent use of rimegepant with inhibitors of P-gp or BCRP. 11825 X There are no adequate data on the developmental risk associated with the use of Nurtec ODT (rimegepant) in pregnant patients. In animal studies, oral administration of rimegepant during organogenesis resulted in adverse effects on development in rats (decreased fetal body weight and increased incidence of fetal variations) at exposures greater than those used clinically and which were associated with maternal toxicity. 11826 X There are no data on the presence of Nurtec ODT (rimegepant) in human milk, the effects of rimegepant on the breastfed infant, or the effects of rimegepant on milk production. There are no animal data on the excretion of rimegepant in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for rimegepant and any potential adverse effects on the breastfed infant from rimegepant or from the underlying maternal condition. 11989 X Copiktra (duvelisib) may be over-utilized. The recommended daily dose of duvelisib is 25 mg twice daily with or without food, for a cycle of 28 days. 11990 X The safety and effectiveness of Copiktra (duvelisib) have not been established in pediatric patients. 11991 X Based on findings from animal studies and the mechanism of action, Copiktra (duvelisib) can cause fetal harm when administered to a pregnant patient. Advise patients of reproductive potential and males with partners of reproductive potential to use effective contraception during treatment and for at least 1 month after the last duvelisib dose.

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	11992 X There are no data on the presence of Copiktra (duvelisib) and/or its metabolites in human milk, the effects on the breastfed child, or milk production. Because of the potential for serious adverse reactions from duvelisib in a breastfed child, advise lactating patients not to breastfeed while taking duvelisib and for at least 1 month after the last dose. 11993 X Advise patients of reproductive potential to use effective contraception during treatment with Copiktra (duvelisib) and for at least 1 month after the last dose. Based on findings in animals and its mechanism of action, duvelisib can cause fetal harm when administered to a pregnant patient. Pregnancy testing should be conducted before the initiation of duvelisib treatment. 11994 X Advise male patients with partners of reproductive potential to use effective contraception during treatment with Copiktra (duvelisib) and for at least 1 month after the last dose. 11995 X The concurrent use of Copiktra (duvelisib) with strong CYP3A4 inducers should be avoided. Duvelisib is a CYP3A4 substrate, and co-administration with a strong CYP3A4 inducer may result in decreased duvelisib exposure and loss of duvelisib therapeutic efficacy. 11996 X The concurrent use of Copiktra (duvelisib) with strong CYP3A4 inhibitors should be avoided. Duvelisib is a CYP3A4 substrate, and co-administration with a strong CYP3A4 inhibitor may result in increased duvelisib exposure and increased risk of duvelisib-related toxicities. 11997 X The concurrent use of Copiktra (duvelisib) with a drug that is a sensitive 3A4 substrate may cause an increase in the AUC of a sensitive CYP3A4 substrate, which may increase the risk of toxicities of these drugs. Consider reducing the dose of the sensitive CYP3A4 substrate, and monitor for signs of toxicities of the coadministered sensitive CYP3A substrate. 11998 X Serious, including fatal, infections have occurred in patients receiving Copiktra (duvelisib). The most common serious infections were pneumonia, sepsis, and lower respiratory infections. Treat infections prior to initiation of duvelisib. Advise patients to report any new or worsening signs and symptoms of infection. Refer to the official prescribing information for dose modification to manage duvelisib toxicities. 11999 X Copiktra (duvelisib) can cause hepatotoxicity. Monitor hepatic function during treatment with duvelisib. For Grade 2 ALT/AST elevation (greater than 3 to 5 ULN), maintain duvelisib dose and monitor at least weekly until return to less than 3 ULN. For Grade 3 ALT/AST elevation (greater than 5 to 20 ULN), withhold duvelisib and monitor at least weekly until return to less than 3 ULN. Resume duvelisib at the same dose (first occurrence) or a reduced dose for subsequent occurrence. For grade 4 ALT/AST elevation (greater than 20 ULN), discontinue duvelisib. 12000 X Serious, including fatal, diarrhea or colitis occurred in 18% of patients receiving Copiktra (duvelisib). Advise patients to report any new or worsening diarrhea. Refer to the official prescribing information for therapy modification to manage duvelisib-related diarrhea or colitis. 12009 X Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML), including cases with fatal outcome, have been reported in patients who received Zejula (niraparib) monotherapy in clinical trials. Discontinue niraparib if MDS/AML is confirmed. 12010 X The safety and effectiveness of Zejula (niraparib) have not been established in pediatric patients. 12011 X Hypertension and hypertensive crisis have been reported in patients treated with Zejula (niraparib). Monitor blood pressure and heart rate at least weekly for the first two months, then monthly for the first year and periodically thereafter during treatment with niraparib. Closely monitor patients with cardiovascular disorders, especially coronary insufficiency, cardiac

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	arrhythmias, and hypertension. Medically manage hypertension with antihypertensive medications and adjustment of the niraparib dose, if necessary. 12012 X Hematologic adverse reactions (thrombocytopenia, anemia, and neutropenia) have been reported in patients treated with Zejula (niraparib). Do not start niraparib until patients have recovered from hematological toxicity caused by previous chemotherapy (</= Grade 1). Monitor complete blood counts weekly for the first month, monthly for the next 11 months of treatment, and periodically after this time. If hematological toxicities do not resolve within 28 days following interruption, discontinue niraparib, and refer the patient to a hematologist for further investigations, including bone marrow analysis and blood sample for cytogenetics. 12013 X Based on its mechanism of action, Zejula (niraparib) can cause fetal harm when administered to pregnant patients. There are no data regarding the use of niraparib in pregnant patients to inform the drug-associated risk. Niraparib has the potential to cause teratogenicity and/or embryo-fetal death since niraparib is genotoxic and targets actively dividing cells in animals and patients (e.g., bone marrow). Due to the potential risk to a fetus based on its mechanism of action, animal developmental and reproductive toxicology studies were not conducted with niraparib. Apprise pregnant patients of the potential risk to a fetus. 12014 X Advise patients of reproductive potential to use effective contraception during treatment with Zejula (niraparib) and for at least 6 months following the last dose. Niraparib can cause fetal harm when administered to a pregnant patient. 12015 X No data are available regarding the presence of Zejula (niraparib) or its metabolites in human milk or on its effects on the breastfed infant, or milk production. Because of the potential for serious adverse reactions in breastfed infants from niraparib, advise a lactating patient not to breastfeed during treatment with niraparib for 1 month after receiving the final dose. 12016 X Based on refill history, your patient may be under-utilizing Zejula (niraparib). Non-adherence to the prescribed dosing regimen may
Tennessee	The operation of the DUR program is a shared responsibility of OptumRx and the Division of TennCare. During FFY20, the TennCare DUR Board was scheduled to meet quarterly, however only met twice due to issues with quorum. Board meetings were held in January of 2020 and July of 2020; however the meeting in January of 2020 did not reach quorum so the meeting was unofficial, and no minutes are available. Unfortunately, two additional meetings were cancelled. We have noted in past yearly reports that maintaining quorum with the requisite numbers of physicians has been an issue for at least two years through FFY2020 (some physicians were not attending meetings, and one of our long-standing physician members passed away very suddenly); however this has been resolved for future CMS yearly reporting for FFY2021 and beyond. TennCare's pharmacy program has two different committees, with the PAC (Pharmacy Advisory Committee) being written in State Statue has having overall responsibility for the PDL, and for criteria and approvals. The DUR Board normally meets to review trends in TennCare's drug use along with reviewing drugs for potential over utilization, therapeutic duplication, drug to disease interactions, drug to drug interactions, appropriate dose and duration guidelines and adverse effects. Utilization management edits and limits may be recommended to the PAC by the DUR Board, however the ultimate responsibility for the final recommendation to the State is with the PAC.

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	With only one official DUR Board meeting in FFY2020, we are not able to count many accomplishments. Generally as stated in earlier sections of this annual report, the Board does not review all ProDUR edits, however the Board does review issues as they arise in utilization trends and makes recommendations on ProDUR edits as needed. During FFY2020, there were not any recommended changes, but we did report to the Board, the issues seen with abnormally large quantities of specific products being used for "foot baths". In many of these products MAX doses are not found in the MediSpan (or FDB) database, which was the root of the problem-- if there is no MAX dose, and there is not a specific quantity limit, pharmacies can take advantage by submitting claims for abnormal quantities. Examples found were mupirocin 2% ointment, ciclopirox 0.77% suspension, clobetasol 0.5% solution, and lidocaine/prilocaine 2.5%/2.5% cream. The problems found were resolved by instituting quantity limits rather than using the MAX dose ProDUR edit. For RetroDUR activities, based on member profile analysis, or provider education activities, we routinely ask Board members at every meeting for their suggestions and then base future activities on their requests. RetroDUR activities are also based on FDA news, industry trends, and topics requested by the DUR Vendor and State Agency.
Texas	During the FFY 2020, the Board held four quarterly meetings. The Board's activities consist of the following: 1. Review drugs within each therapeutic class for preferred/non-preferred recommendations 2. Retrospective criteria reviews on drugs or drug classes- these criteria may be used as the basis for prospective and retrospective DUR proposals. Reviewed criteria include: maximum daily dose in adults and pediatrics, Drug-Drug interaction, Therapeutic duplication, Over utilization, etc. 3. Retrospective DUR intervention proposals- Educational letters for provider outreach are developed and mailed to those with outlier prescribing activities. 4. Review of the prospective clinical prior authorization (PA) criteria proposal: Clinical prior authorizations are developed with input from State DUR staff, Medicaid managed care organizations(MCOs), and the PA vendor. Criteria are mainly based on the available references such as drug Package insert, treatment practice guidelines, etc. Retrospective Criteria Reviews During FFY 2020, the following retrospective criteria were reviewed: a. Atypical Antipsychotics -long-acting injectable b. Atypical Antipsychotics (oral) c. Exogenous Insulin Products d. Nitazoxanide (Alinia) e. Promethazine Use in Children < 2 Years of Age f. Quetiapine (low-dose) g. fentanyl Inhalation/oral/transdermal h. Gabapentin i. Hydrocodone Bitartrate/ Hydrocodone Polistirex j. Ivacaftor (Kalydeco) and Combination Therapy k. Topical Calcineurin Inhibitors Pimecrolimus (Elidel) Tacrolimus (Protopic) l. Tramadol (Ultram) m. Direct Oral Anticoagulants n. Complement Inhibitor and Enzyme/Protein Replacement Therapy o. Low-Molecular-Weight Heparins (LMWHs) p. Nebulized Bronchodilators

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	q. Hydroxymethylglutaryl-Coenzyme A (HMG-CoA) Reductase Inhibitors (Statins) r. Benzodiazepines (Nonsedative/ Hypnotics) s. Immune Globulins t. Oral/Rectal Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) u. Non-sedating Antihistamines v. Oral Fluoroquinolones w. Rifaximin (Xifaxan) x. Skeletal Muscle Relaxants y. Sickle Cell Disease Products Retrospective DUR Intervention Proposals- Educational letters for provider- During FFY 2020, the following retrospective intervention topics were reviewed: a. Opioids, Benzodiazepines, and Antipsychotics b. Pain Management with Opioids c. Diabetes Disease Management d. Monitoring of Psychotropic Drugs in Youth e. Postpartum Depression f. Caring for Your Patients with Asthma g. NSAID Drug Usage Evaluation (DUE) h. Pharmacotherapy of Post-Traumatic Stress Disorder i. Appropriate Use of Antibiotics j. Contraception: Drug Use Evaluation k. Gabapentinoid Drug Use Evaluation For the FFY 2020, the Board reviewed the following clinical prior authorization criteria a. Benjesta/Diclegis - criteria included: age check, FDA-approved diagnosis check, number of units per day b. Cytokine and CAM Antagonists- Rinvoq- criteria included: age check, FDA-approved diagnosis, concurrent use of methotrexate or inadequate response/intolerance to methotrexate, no evidence of contraindicated diagnosis or contraindicated drugs, number of units per day c. Diacomet - criteria included: age check, current claim for clobazam, and diagnosis of Dravet syndrome d. Sunosi - criteria included: age check, FDA-approved diagnosis, procedure code for CPAP/BiPAP for those with obstructive sleep apnea, no evidence of use of contraindicated drugs, quantity per day, prescriber specialty e. Cystic Fibrosis Agents - Trikafta- criteria included: age check, FDA- approved diagnosis/F508del gene mutation, no evidence of contraindicated diagnosis or drugs, no duplicated therapy with Kalydeco, Orkambi, or Symdeko, f. Inhaled antibiotics (revisions) - addition of non-CF bronchiectasis or colonization with P. aeruginosa. The Board did not approve the revisions g. Oxbryta - criteria included: age check, FDA-approved diagnosis, no evidence of contraindicated drugs, dose check h. PAH Agents- addition of oral and inhaled agents to the existing inj. agents- criteria included: FDA-approved diagnosis, and confirmed contraindication to right heart catheterization or pulmonary angiogram i. Monoclonal Antibody for Asthma - Fasenra and Nucalal - criteria included: age check, FDA-approved diagnosis, indications of current use of asthma controller, no evidence of contraindicated diagnosis, initial and maintenance daily doses.

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	k. Ophthalmic Immunomodulators - Cequa, Restasis, Xiidra - criteria included: age check, FDA-approved diagnosis, prescriber specialty, dosing and quantity check l. Transthyretin Agents - Vyndamax, Vyndaqel, Tegsedi - criteria included: specialist prescribing, age check, FDA-approved diagnosis, labs, approved dose/day, no evidence of concurrent therapy with contraindicated agents. m. Age-Based Tricyclic Antidepressants - criteria included: aged check- The criteria did not pass the Board's approval n. Acthar gel (revision)- removed the non-FDA-approved indications from automatic PA approval o. Oxervate Ophthalmic Solution - criteria included - age check, FDA-approved diagnosis, no evidence of prior treatment with cenegermin, therapy duration p. Palforzia - criteria included: age check, FDA-approved diagnosis, evidence of epinephrine prescription, no history of uncontrolled asthma q. Spravato Nasal Solution - criteria included: age check, specialist prescribing, FDA-approved diagnosis, trial of 2 augmentation therapies, no evidence of contraindicated therapies, does check.
Utah	IV. DUR BOARD ACTIVITY Summary 2 DUR Board Activities Summary Summary 2: DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported. Please provide a summary below: Indicate the number of DUR Board meetings held. List additions/deletions to DUR Board approved criteria: o For ProDUR, list problem type/drug combinations added or deleted. o For RetroDUR, list therapeutic categories added or deleted. Describe Board policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens. Describe policies that establish whether and how results of RetroDUR screening are used to adjust ProDUR screens. Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.). Describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring). Answer: ProDUR: Oct 2019 The Board discussed and approved the updated Fluocinonide Acetate (Intravitreal Implants) prior authorization criteria to include the requirement to try biosimilar adalimumab and limit treatment to one eye per approval. The Board also approved the prior authorization criteria for Zulresso used in postpartum depression. Nov 2019 The Pharmacy team informed the Board that MME edits further decreased from 150 MME to 120 MME effective Jan 2020. The Board approved the updated Hepatitis C prior authorization, including Mavyret label expansion. The Board discussed pharmacy edits surrounding antipsychotics use in children and approved the Antipsychotic Use in Children prior authorization. Jan 2020 The Board discussed and approved the updated Cystic Fibrosis Gene Therapy prior authorization to include the Trikafta. The Pharmacy team provided education on gabapentin/pregabalin abuse and misuse, and discussed the edits to prevent gabapentin/pregabalin misuse and abuse.

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	Feb 2020 Education on ADHD Medication Use in Children was provided. The Board approved the age edit limits and prior authorization criteria. The Board also discussed allowing refill tolerance for controlled substance medication CII-CV at 85%. Mar 2020 Education on ADHD Medication Use in Adults was provided. The Board approved the edit limits and prior authorization criteria. April 2020 The Board discussed the Opioid Use Disorder Treatments in Pregnancy, Concurrent use of Opioid/MAT. The Board approved the maximum daily requirement edits and removed the psychosocial support requirement for buprenorphine/buprenorphine-naloxone prior authorization. May 2020 The Board discussed and reviewed the nine months data on Spravato. The Board approved the updated Spravato prior authorization. Jun 2020 Education was provided regarding Rybelsus. The Board approved the Rybelsus prior authorization criteria. The Board also approved the updated CGRP prior authorization that includes the abortive CGRP criteria. Jul 2020 Annual Training on Open Public Meeting Act. Aug 2020 The Board discussed and approved the Hemlibra prior authorization and the Rare Disease prior authorization. Education on Biological Treatments for Asthma was provided. The Board approved the Anti-asthmatic Monoclonal Antibodies prior authorization. Sept 2020 The Board discussed and approved the Palfozia prior authorization. Findings from Prospective and Retrospective Drug Utilization Review directly affect each other. When focusing on prospective drug review, this may be motivated by new drug approvals, changes/updates to clinical practice guidelines, anticipation of misuse, follow up to prior authorization placement, or internal or external interest. In FFY220, prospective DUR also involved further decrease MME limits to align with CDC standards, developing safety edits for antipsychotics used in children, and further increasing access to MAT therapies. A comprehensive list of PRO-DUR edits is below: 10/1/2019 - Implementation of a DUR Hard Edit, which triggered when a claim for an opioid that was dispensed with an active claim for high risk medication, benzodiazepine, on patient's profile. This edit functioned bidirectionally. This edit required the dispensing pharmacist to enter a Professional Service Code and Reason of Service Code to ensure appropriate proactive counseling measurements were taken place. 10/1/2019 - Opioid limits were updated, specifically day supply limit, for pregnant Medicaid members 10/16/2019 PDL updated to set quantity limit for Lidocaine medications 11/13/2019 PDL updated to remove quantity limit of fluoxetine 90 mg 11/13/2019 PDL updated to set quantity limit of test strips to 200 test strips per 24 days. 1/1/2020 Removed prior authorization required for butalbital, updated minimal age to 18 years old, and limited 20 tablets per month. 1/1/2020 Further reduced MME limit to 120 MME 1/1/2020 Required diagnosis code for new antipsychotics claims for children 19 years of age. Implemented age edit, dose edit and multiple antipsychotics agents edit. 1/1/2020 Removed prior authorization requirement for brand Suboxone, kept dose limit to 24 mg/day 1/1/2020 Removed sole source pharmacy designation for Hemophilia medication. Refill tolerance for Hemophilia medication set at 80% 1/6/2020 PDL updated on preferred/non-preferred status

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	1/6/2020 PDL updated to require prior authorization on Adcetris 1/13/2020 PDL updated to remove prior authorization on topical immunomodulating agents (pimecrolimus, Protopic, Elidel, tacrolimus, Eucrisa) 2/14/2020 PDL updated on brand over generic 3/5/2020 olanzapine, risperidone, olanzapine ODT, hydroxychloroquine removed from 90 days supply requirements. 3/30/2020 Ubrely and Nurtec required prior authorization. Quantity limits to 9 tablets per month 4/1/2020 Implemented dose edit limits on gabapentin and pregabalin. Also, require prior authorization for co 4/15/2020 PDL updated to remove 90 days supply requirements on selected medications 5/20/2020 Implemented age edit for Caplyta 5/20/2020 Added coverage for Cialis 5 mg (GPI: 40304080000305) with prior authorization 6/10/2020 PDL updated to require prior authorization to immune globulin 6/25/2020 Required prior authorization for Hemlibra 7/1/2020 Implementation of ADHD Stimulant medication edits: limit medication to 4 years and up (6 years and up for selected medications) 8/3/2020 PDL updated to only allow long-acting injectable antipsychotics for 18 years and older 9/2/2020 Removed prior authorization requirements for Dupixent, Leuprolide acetate, and Ocervus 9/2/2020 Required prior authorization for Cinqair, Palfozia, and Glassia
Vermont	The VT Medicaid (DVHA) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met 7(seven) times in FFY2020. The combined functions of the DUR Board results in a unique perspective on the evaluation and PDL placement of newly released drugs. As new drugs are brought forward for evaluation, the DUR Board chooses to manage these medications in a manner that will result in appropriate prescribing from the time of introduction of the drug (prospectively) rather than in a retrospective manner when inappropriate patterns of prescribing may have become ingrained. This results in the early adoption of quantity limits, step therapy and promotion of lowest net cost drug choices. At the same time, as new drugs are evaluated, patterns of prescribing for alternative drugs may become apparent and lead the Board to undertake retrospective DUR activities for those other medications. Additionally, the DUR Board will recommend that follow-up RetroDUR be performed of relatively new drugs to ensure that the adopted clinical criteria are appropriate and result in patterns of utilization that are appropriate and cost-effective. In FFY 2020, the DUR Board activities included: 1 Biosimilar New Drug Review ,57 New Drug Reviews, 1 Revised Clinical Coverage Criteria, 75 Therapeutic Class Reviews, 53 Quantity Limits established for new or previously reviewed drugs, 8 FDA Safety Alerts reviewed. RetroDUR Analyses:Long Term Use of Antibiotics,Appropriate Use of Asthma Controller Medications,Concurrent Use of Opioids and Benzodiazepines,Blood Pressure Medication Adherence and Long-term NSAID Use in Chronic Kidney Disease, Concurrent Use of Opioids and Antipsychotics- Pro DUR added,PREP HIV Therapy Prescribing Rates in Those who had Post-Exposure Prophylaxis ProDUR is an integral part of the Vermont Medicaid claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed; reviewing the available medical history; focusing on those patients at the highest severity of risk for harmful outcome; and intervening and/or counseling when appropriate. ProDUR encompasses the detection, evaluation and counseling components of pre-dispensing drug therapy screening. The ProDUR system addresses situations where potential drug problems may exist. ProDUR

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	performed prior to dispensing assists pharmacists in ensuring that patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available. We have implemented Pro-DUR edits to members at the highest severity of risk for harmful outcome. Severity levels are applied utilizing the Medispan DUR module. The following ProDUR Reason of Service types will deny for the Vermont Medicaid program: Drug-to-Drug Interaction (Highest Severity Levels) Therapeutic Duplication . ProDUR Edits that deny may be overridden at POS using the interactive NCPDP DUR override codes. pharmacies may override the denial by submitting the appropriate Professional Service and Result of Service codes. Below details the Professional Service and Result of Service codes that will override a claim that has been denied for drug-to-drug interaction and/or therapeutic duplication. Note: that the designated Professional Service code must accompany the appropriate Result of Service code as indicated in the chart to allow the override. The valid DUR Reason for Service Codes for Vermont Medicaid are: DD Drug-Drug Interaction TD Therapeutic Duplication The only acceptable Professional Service Codes are: MR Medication Review M0 Prescriber Consulted R0 Pharmacist Consulted Other The goal of the Vermont RetroDUR Program is to promote the safe and appropriate prescribing and use of medications. RetroDUR identifies prescribing, dispensing, and utilization patterns which may be clinically and therapeutically inappropriate and may not meet the established clinical practice guidelines. Data is collected and reviewed in detail and presented to the Board. Further analysis is conducted as needed. Depending on the specific issue identified, various interventions are then employed to correct these situations. Prospective edits in the Point of Sale System, educational mailings or new utilization controls such as prior authorization or quantity limits, among others are employed as appropriate. The DVHA RetroDUR program takes an individualized approach to identifying, evaluating and developing improvements specific to each intervention. The cornerstone of the RetroDUR process is based on a review of peer-reviewed evidence as well as considerations of recognized guidelines and best practices. This information is evaluated in the context of the claims reviewed and then reviewed with the DUR Board for input and then interventions, as appropriate are implemented. The DUR Board advises DVHA on how best to educate providers and address the impact of pharmacy manufacturer advertising. In these meetings counter-detailing opportunities are considered. DVHA partners with The Vermont Academic Detailing Program which is a university-based prescriber education and support program that operates out of AHEC (Area Health Education Center Programs) to identify mutual areas of interest. The goal of the Vermont Academic Detailing Program is to promote high quality, evidence-based, patient-centered, and cost-effective treatment decisions by healthcare professionals. AHEC staff visit prescriber offices for person-to-person educational sessions. In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. The Board then determines if follow-up is appropriate either with the

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	identified prescribers or with a clinical advisory to all providers. In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file. To educate providers on general PBM Program coverage activities, various methods are used. Most frequently, mailings are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. The mailing topics are generally complimentary so that pharmacies understand the communications that have been sent to prescribers. These mailings are also sent electronically to provider affiliates and representatives so that these organizations can use their proprietary methods to distribute the materials. Examples of these organizations include the Vermont Medical Society and the Vermont Pharmacists Association. Providers may find all general pharmacy benefit management materials posted on the DVHA webpage at http://dvha.vermont.gov/for-providers. These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions and alerts. Sample DUR Board Meeting Agenda for SFY 2020 Department of Vermont Health Access Pharmacy Benefits Management Program October 22, 2019: 5:30 8:30 p.m. Executive Session 5:00 6:00 Introductions and Approval of DUR Board Minutes 6:00-6:05 (Public Comment Prior to Board Action) DVHA Pharmacy Administration Updates 6:05-6:10 Medical Director Update 6:10-6:15 Follow-up Items from Previous Meetings 6:15-6:15 RetroDUR/ProDUR 6:15-6:15 Clinical Update: Drug Reviews 6:15-6:15 (Public comment prior to Board action) Biosimilar Drug Reviews None at this time Full New Drug Reviews New Managed Therapeutic Drug Classes 6:15-6:15 (Public comment prior to Board action) Therapeutic Drug Classes Periodic Review 6:15-6:15 (Public comment prior to Board action) Review of Newly-Developed/Revised Criteria 6:15- 8:15 (Public comment prior to Board action) ADHD, AHF/Factor IX ,AHF/Factor VIII,Alzheimer's Medications,Analgesics/NSAIDS Naproxen,Analgesics/Long-acting Opioids,Anticoagulants/NOACs,Antidiabetics/Insulin,,Antihypertensives/Beta Blockers,Antipsychotics/LAIs,,Botulinum Toxins,Derm-Atopic Dermatitis,Derm-Lidocaine Patches,Derm-Scabicides,Endometriosis GI-Mesalamine (Oral and Rectal),Hematopoietics-ESA, Hematopoietics-TPO RA's, Hereditary Angioedema,Migraine Products-CGRP Inhibitors,Ophthalmics/Anti-

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	inflammatories, Ophthalmic/Antibiotic & Steroid Combinations, Ophthalmic/Carbonic Anhydrase Inhibitors, Phosphate Binders, Resp-Inhaled Anticholinergics, Urinary Antispasmodics, Vaginal Anti-infectives General Announcements 8:15 - 8:30 Selected FDA Safety Alerts FDA review finds no increased risk of prostate cancer with Parkinson's disease medicines containing entacapone (Comtan, Stalevo) https://www.fda.gov/drugs/drug-safety-and-availability/fda-review-finds-no-increased-risk-prostate-cancer-parkinsons-disease-medicines-containing?utm_campaign=New%20FDA%20Drug%20Safety%20Communication%20on%20medicines%20containing%20entacapone&utm_medium=email&utm_source=Eloqua FDA warns about rare occurrence of serious liver injury with use of hepatitis C medicines Mavyret, Zepatier, and Vosevi in some patients with advanced liver disease https://www.fda.gov/drugs/drug-safety-and-availability/fda-warns-about-rare-occurrence-serious-liver-injury-use-hepatitis-c-medicines-mavyret-zepatier-and?utm_campaign=Hep%20C%20DSC%20liver%20injury&utm_medium=email&utm_source=Eloqua Adjourn 8:30
Virginia	Virginia Medicaid DUR Board quarterly meetings were held on December 12, 2019, June 11 and September 10, 2020 for FFY 2020 to review, revise and approve criteria for new drugs as well as criteria for service authorizations and retrospective DUR (RetroDUR). The Board, along with the state and Magellan Rx Management, selects the criteria that will be used for RetroDUR activities for the subsequent months until the next quarterly meeting. The FFY 2020 RetroDUR intervention activities are reported in Summary 1- RetroDUR Educational Outreach Summary. For FFY 2020, the problem types addressed in the RetroDUR intervention letters were overutilization, underutilization, drug-disease contraindications, inappropriate use and duration as well as adverse drug reactions. During FFY 2020, the DUR Board continued to review more closely some of the physician administered drugs as well as specialty drugs. Magellan Rx Management along with DMAS work together to create clinical service authorization criteria for several of these drugs which get reviewed at the DUR Board Meetings. The DUR Board continued to address and review topics in reference to the SUPPORT Act. During FFY 2020, the DUR board continued to review and address concurrent use of opioids and benzodiazepines as well as concurrent use of opioids and antipsychotics utilization reports. DMAS also continues to review reports looking at members utilizing opioids with risk factors and without a claim for naloxone. DMAS has also implemented two soft edits for the SUPPORT Act. The first edit triggers a soft message to the pharmacist when opioid and antipsychotic claims overlap, which was implemented on March 10, 2020. The second edit triggers a soft message to the pharmacist when the member is getting an opioid prescription filled and the member is opioid na%u00efve, which was implemented on April 6, 2020. DMAS has also recently decreased the MME further down to 90 MME in addition to the existing quantity limits on all short and long acting opioids.

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	Also, Magellan Rx Management has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. DUR Quarterly Newsletters were created and posted on VA Medicaid website. The summary of the minutes for each of the FFY 2020 DUR Board meetings are included below. Minutes Summary - December 12, 2019 RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Reports and the Criteria Exception Estimates Report for Lab Values, which includes MCO data. New Drugs: The DUR Board reviewed Inrebic%u00ae (fedratinib), Nourianz%u2122 (istradefylline), Nubeqa%u00ae (darolutamide), Rozlytrek%u2122 (entrectinib), Slynd%u2122 (drospirenone), Temixys%u2122 (lamivudine and tenofovir disoproxil fumarate), Trikafta%u2122 (elexacaftor/tezacaftor/ivacaftor), Turalio%u2122 (pexidartinib), Xenleta%u2122 (lefamulin), and Xpovio%u2122 (selinexor). Physician Administered Drugs: The DUR Board reviewed the service authorization criteria and utilization for Luxturna%u00ae (voretigene neparvovec-rzyl) and Zolgensma%u00ae (onasemnogene abeparvovec-xioi). Minutes Summary - June 11, 2020 (Electronic Meeting) RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Reports and the Criteria Exception Estimates Report for Lab Values, which includes MCO data. New Drugs: The DUR Board reviewed Ayvakit%u2122 (avapritinib), Baqsimi%u2122 (glucagon), Brukinsa%u2122 (zanubrutinib), Fasenra%u00ae Pen (benralizumab), Gvoke%u2122 (glucagon), Oxbryta%u2122 (voxelotor), Pretomanid, and Tazverik%u2122 (tazemetostat). Specialty Drugs: The DUR Board reviewed impact reports for new drugs crizanlizumab IV and semaglutide oral. MRx Pipeline: The DUR Board reviewed the Magellan MRx Pipeline report. SUPPORT Act Update: DMAS presented an update on the SUPPORT Act and mentioned how DMAS is already monitoring these issues with several new and old edits and reports. Concurrent Use of Opioids and Benzodiazepines: The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines utilization reports for FFS and MCOs. Concurrent Use of Opioids and Antipsychotics: The DUR Board reviewed Concurrent Use of Opioids and Antipsychotics utilization reports for FFS and MCOs.

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	Opioid Use with Risk Factors and No Naloxone or Getting Naloxone: The DUR Board reviewed Opioid Use with Risk Factors and No Naloxone or Getting Naloxone reports for FFS and MCOs. ProDUR, RetroDUR and Utilization Analysis Reports: The DUR Board reviewed the standard ProDUR, RetroDUR and Utilization Analysis reports. The DMAS Addiction and Recovery Treatment Services (ARTS) Summary report and the February 2020 Virginia Commonwealth University ARTS Access and Utilization During the Second-Year report were reviewed. Minutes Summary %u2013 September 10, 2020 (Electronic Meeting) RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Reports and the Criteria Exception Estimates Report for Lab Values, which includes MCO data. New Drugs: The DUR Board reviewed Koselugo%u2122 (selumetinib), Oriahnn%u2122 (elagolix, estradiol, and norethindrone acetate; elagolix), Pemazyre%u2122 (pemigatinib), Qinlock%u2122 (ripretinib), Retevmo%u2122 (selpercatinib), Tabrecta%u2122 (capmatinib), and Tukysa%u2122 (tucatinib). MRx Pipeline: The DUR Board reviewed the Magellan MRx Pipeline report and the MRx Pipeline + Bonus COVID-19 report. Concurrent Use of Opioids and Benzodiazepines %u2013 The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines utilization reports for FFS and MCOs. Concurrent Use of Opioids and Antipsychotics: The DUR Board reviewed Concurrent Use of Opioids and Antipsychotics utilization reports for FFS and MCOs. Antipsychotic Medications in Children: The DUR Board reviewed antipsychotic medications in children reports for FFS and MCOs. Opioid Use with Risk Factors and No Naloxone or Getting Naloxone %u2013 The DUR Board reviewed Opioid Use with Risk Factors and No Naloxone or Getting Naloxone reports for FFS and MCOs. Synagis: The DUR Board reviewed Synagis utilization reports for the previous season. ProDUR, RetroDUR and Utilization Analysis Reports: The DUR Board reviewed the standard ProDUR, RetroDUR and Utilization Analysis reports.
Washington	During the FFY 2020, the DUR Board met five times with meetings focused on reviewing Apple Health Preferred Drug List classes and clinical policies. There were 18 clinical policies reviewed by the DUR board and 17 were approved. A draft policy for Radicava was presented to the DUR board however it was not approved as the DUR board recommended to reconsider reauthorization criteria as well as recommended a consultation with an ALS specialist about a score of 2 or better on all 12 items of the ALSFRS-R score proposed in the criteria. The clinical policies reviewed by the DUR board go through an extensive review process that includes reviews

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	from internal agency clinicians and the Managed Care Organization (MCO) clinicians. After the DUR board approves the policies, they go through a 2-3 month review process until the final draft is created. Once the final draft is completed, we are required to give the MCOs a 90 day notice for implementation. Due to the 90 day notice we are required to give the MCOs, 13 out of the 17 DUR board approved policies were implemented in FFY 2020. For both prospective and retrospective DUR interventions, the DUR Board does not have set policies on what types of interventions need to be adopted however if interventions are identified they are determined on a topic-by-topic basis. The following 83 drug classes and 18 clinical polices were reviewed by the DUR board: I. October 16, 2019 Meeting A. Drug Classes Reviewed o Antivirals: HIV o Asthma and COPD Agents - Long acting muscarinic agents - Anticholinergics - Long acting muscarinic/long acting beta agonist combinations - PDE4 inhibitors - Beta agonists- Short acting - Beta agonists- long acting - Inhaled corticosteroids - Inhaled Corticosteroid combinations o Dermatologics: Antipsoriatics - Oral - Topical o Dermatologics: Emollients o Dermatologics: Kerolytic/Antimitotic Agents o Dermatologics: Immunomodulating Agents-Topical o Dermatologics: Agents for external genital and perianal warts B. Policies Reviewed - All approved by DUR Board o 44.60.30- Antiasthmatic Monoclonal Antibodies- Anti-IgE Antibodies o 44.60.40- Antiasthmatic Monoclonal Antibodies- IL-5 Antagonists o 90.23.00- Atopic Dematitis Agents- Topical PDE4 Inhibitors o 90.27.30.20- Dupixent o 90.78.40- Atopic Dermatitis Agents- Topical Immunosuppressive II. December 19, 2019 Meeting A. Drug Classes Reviewed o Antipsychotics: 1st generation o Antimanic Agents o Antimigraine Agents: Triptans and Other o Antihypertensives - Angiotensin modulators - Beta blockers - Calcium channel blockers - Diuretics o Cardiovascular Agents - Coronary Vasodilators - Sinus Node inhibitors

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	- Pulmonary Hypertension Agents Oral and Inhaled o Bone Density Regulators: Bone Resportion Inhibitors o Antiemetics/Antivertigo Agents o Substance Use Disorder: Opiate Dependence o Prostatic Hypertrophy Agents o Androgenic Agents: Testosterone III. February 2, 2020 Meeting A. Drug Classes Reviewed o Insulin and related agents - Rapid Acting - Short Acting - Pre-Mixed - Intermediate Acting - Long Acting o Thiazolidinediones o Pancreatic Enzymes o Growth Hormone Releasing Hormones (GHRH) o Growth Hormones o Ulcerative Colitis Agents: Inflammatory Bowel Agents o Cystic Fibrosis Agents o Inhaled Antibiotics - Aminoglycosides - Monobactams o Anticoagulants: Factor Xa and Thrombin Inhibitors o Topical Antiparasitics: Scabicides and Pediculicides o Lipotropics - PCSK-9 Inhibitors - Microsomal Triglyceride Transfer Protein Inhibitor (MTP) IV. April 15, 2020 Meeting- Cancelled due to COVID Restrictions V. June 16, 2020 Meeting (Webinar) A. Drug Classes Reviewed o CYTOKINE AND CAM ANTAGONISTS o HEMATOPOIETIC AGENTS : ERYTHROPOIESIS-STIMULATING AGENTS (ESAS) o HEMATOPOIETIC AGENTS : GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF) o HEMATOPOIETIC AGENTS : SICKLE CELL ANEMIA o IMMUNE MODULATORS : MYELODYSPLASTIC SYNDROMES o ONCOLOGY AGENTS : ALKYLATING AGENTS - ORAL o ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL o ONCOLOGY AGENTS : ANTINEOPLASTICS MISC - ORAL o ONCOLOGY AGENTS : BCL-2 INHIBITORS - ORAL o ONCOLOGY AGENTS : HISTONE DEACETYLASE INHIBITORS - ORAL o ONCOLOGY AGENTS : IMMUNOMODULATORS - ORAL o ONCOLOGY AGENTS : ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS - ORAL o ONCOLOGY AGENTS : ISOCITRATE DEHYDROGENASE-2 (IDH2) INHIBITORS -ORAL o ONCOLOGY AGENTS : JANUS ASSOCIATED KINASE (JAK) INHIBITORS - ORAL o ONCOLOGY AGENTS : PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS- ORAL o ONCOLOGY AGENTS : PROTEASOME INHIBITORS - ORAL o ONCOLOGY AGENTS : XPO1 INHIBITORS - ORAL

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	B. Policies Reviewed o 21.60.00.45- Lutathera (Approved by DUR) o 23.10.00- Testosterone Replacement Therapy (Approved by DUR) o 30.90.20.30- Revcovi (Approved by DUR) o 30.90.95- Crysvita (Approved by DUR) o 74.50.90- Radicava (Not approved by DUR) - DUR Board recommended to reconsider the reauthorization criteria and consult with an ALS specialist about score of 2 or better on all 12 items of ALSFRS-R score o 86.37.00- Luxturna (Approved by DUR) VI. August 19, 2020 Meeting (Webinar) A. Drug Classes Reviewed o ONCOLOGY AGENTS: ANDROGEN BIOSYNTHESIS INHIBITORS - ORAL o ONCOLOGY AGENTS: ANTIANDROGENS - ORAL o ONCOLOGY AGENTS: ANTINEOPLASTICS - MISC COMBINATIONS- ORAL o ONCOLOGY AGENTS: BRAF KINASE INHIBITORS - ORAL o ONCOLOGY AGENTS: CYCLIN DEPENDENT KINASES (CDK) INHIBITORS- ORAL o ONCOLOGY AGENTS: FGFR KINASE INHIBITORS - ORAL o ONCOLOGY AGENTS: HEDGEHOG PATHWAY INHIBITORS- ORAL o ONCOLOGY AGENTS: MEK INHIBITORS - ORAL o ONCOLOGY AGENTS: MTOR KINASE INHIBITORS - ORAL o ONCOLOGY AGENTS: MULTIKINASE INHIBITORS - ORAL o ONCOLOGY AGENTS: POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - ORAL o ONCOLOGY AGENTS: RETINOIDS - ORAL o ONCOLOGY AGENTS: TOPOISOMERASE INHIBITORS - ORAL o ONCOLOGY AGENTS: TROPOMYOSIN RECEPTOR KINASE INHIBITORS - ORAL o ONCOLOGY AGENTS: TYROSINE KINASE INHIBITORS - ORAL o OPHTHALMIC AGENTS: GLAUCOMA AGENTS o OPHTHALMIC AGENTS: IMMUNOMODULATORS o RESPIRATORY AGENTS: PULMONARY FIBROSING AGENTS o SMOKING DETERRENTS: MISC - OTHER B. Policies Reviewed - All approved by DUR o 21.53.40- Tyrosine Kinase Inhibitors- Oral o 24.00.00- Gender Dysphoria o 59.40.00.18- Vraylar o 66.27.00- Cytokine and CAM Antagonists o 67.70.10- CGRP Receptor Antagonists (Acute) o 67.70.20- CGRP Receptor Antagonists (treatment) o 68.00.00- Gout Agents
West Virginia	The West Virginia Drug Utilization Review Board (DUR) and the Pharmaceutical and Therapeutics Committee (P&T) meet separately once during each quarter of the year. During FFY 2020 the DUR Board met a total of four times. The first DUR Board meeting of the 2020 Federal Fiscal Year was held on November 20, 2019. The Pharmacy Services calendar is structured so that the P&T Committee meets two to four weeks before three of the four DUR Board meetings. Reports are presented at each DUR Board meeting by the MMIS Vendor, the prior authorization agent, and the RetroDUR vendor. The MMIS Vendor, Gainwell Technologies (formerly known as DXC), presents several reports to the DUR Board. These reports include a list of the top 25 therapeutic classes by amount paid and

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	prescription count, a generic utilization summary, and an overall summary comparing statistics for the quarter to the previous year. Our prior authorization vendor, the Rational Drug Therapy Program (RDTP), is part of the West Virginia University School of Pharmacy. RDTP presents data on the number of prior authorizations approved, denied and pended and the level of service provided. An additional report is presented on the number of edit overrides approved. The Board uses the data presented to evaluate prior authorization programs and edits currently in place. Additions/Deletions to DUR Board: Approved Criteria Four (prospective) DUR Board meetings were held in the period between Oct 1, 2019 and Sept 30, 2020. The following indicates clinical criteria which were added or altered during these meetings. November 20, 2019 Prospective DUR topics covered included: Helimbra, Sunosi, Cytokine agents- Acitretin for plaque psoriasis, CGRP Antagonists, Testosterone Replacement Therapy, Atypical Antipsychotics - Latuda, Orilissa, MS Agents, PCSK9 inhibitors, Zetia, Linzess, Motegrity, Ophthalmics, anti-inflammatories-immunomodulators, Rho-kinase Inhibitors, Fasenra, Trikafta February 19, 2020 Prospective DUR topics covered included: Xhance, Dupixent, PCSK-9 Inhibitors, Exondys 51, Vyondys 53, Lipotropics, Other (non-statins) - Vascepa May 27, 2020 Prospective DUR topics covered included: Tosymra, Katerzia Suspension, Duaklir Pressair, Ezallor Sprinkle, Drizalma Sprinkle, Wakix, Ruconest, GLP1/SGLT2 September 23, 2020 Prospective DUR topics covered included: Nurtec ODT, Ubrelvy, Reyvow, Gloperba Solution, OFEV, MAT Involvement with Retrospective DUR: The WV Retrospective DUR committee is a sub-committee of the DUR Board and is composed of 4 members, along with bureau of medical services staff members, who meet once per month to perform retrospective reviews on patient profiles which hit on criteria. Each member reviews approximately 75 profiles as well as 10 Lock-in profiles. As new drug entities arrive and as current research dictates, our RetroDUR vendor, Marshall DUR Coalition, will submit new criteria to the RetroDUR committee for review. Any criteria approved are then implemented in the following cycle. Retrospective DUR reviews often provide the impetus for development of new DUR policy for our Medicaid program. Marshall uses data from these reviews and from claims extract files to make recommendations to the DUR Board for population-based educational interventions targeting disease states and observed patterns of medication use.

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	Below is a list of newsletter topics, a list of targeted RDUR interventions, population health initiatives reviewed from 10/1/19 to 9/30/2020. Information about our lock-in program is also described below. A total of 2 Newsletters containing 7 articles were posted during this time,. The topics of the articles are listed below: 1. AMERICAN HEART MONTH Focus on Spontaneous Coronary Artery Dissection (SCAD) 2. Gabapentinoids and the Risk of Respiratory Depression 3. Prescribers Suggestions to Avoid e-Prescribing Errors for Medicaid Patients 4. Suicide Prevention during the COVID-19 Pandemic 5. Deprescribing %u2013 What is it and what Choices Do we Have? 6. Management of Hypertension of Patients with Diabetes Mellitus Revisited 7. Preparing for the 2020-2021 Influenza Season Targeted Education/Interventions: 1. Concurrent opioid and benzodiazepine therapy. 2. Gastroesophageal reflux disease (GERD) and Proton Pump Inhibitor (PPI) therapy greater than 90 days. 3. Diagnosis of Diabetes Mellitus (DM) without Angiotensin II receptor blocker (ARB) or angiotensin converting enzyme inhibitor (ACE Inhibitor) therapy. 4. Diagnosis of Atherosclerotic Cardiovascular Disease without statin therapy. 5. Concurrent Glucagon-like peptide-1 (GLP-1) receptor agonists and dipeptidyl peptidase-4 (DPP-4) inhibitor therapy. 6. Congestive Heart Failure (CHF) and non-steroidal anti-inflammatory drugs (NSAIDs). 7. Diagnosis of Helicobacter pylori and PPI therapy greater than 14 days. 8. Heart Failure with Reduced Ejection Fraction (HFrEF) and on diltiazem or verapamil. 9. Congestive Heart Failure and on a thiazolidinedione (pioglitazone or rosiglitazone). 10. Congestive Heart Failure and Dronedarone therapy. Population Health Initiatives Completed: Diagnosis of Opioid Dependency and patient is on an opioid. Patients concurrently prescribed opioids, benzodiazepines, and gabapentin or pregabalin. Population Health Initiatives Approved and Pending: 1. Patients concurrently prescribed opioids and antipsychotics as defined in the National Target Support Act. 2.. Patient prescribed sedative for sleep disorder while concurrently prescribed stimulant. 3. Appropriate dosing of stimulants in adolescents. 4. Quality improvement of pediatric antibiotic prescribing. 5. Proton pump inhibitor prescribing and usage. 6. Patients with Hepatitis C. Monitor for appropriate documentation, immunizations, SVR12, Medicaid criteria for approval to treat. 7. Patients with chronic obstructive pulmonary disease (COPD) prescribed benzodiazepines. 8. Patients prescribed medications that interfere with QT interval that are also prescribed methadone. 9. Male patients prescribed Risperdal. Lock-In Program:

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	The Lock-In Program reviews at-risk patients who may be misusing controlled substance therapy and may restrict the patient to receiving their prescriptions for controlled substances from a single pharmacy. Patients with cancer are excluded from the review. Similarly, Suboxone is not reviewed as a controlled substance for patients in recovery from substance abuse. Some of the criteria used to flag potential misuse include: High Average Daily Dose: 120 morphine milligram equivalents or more per day over the past 90 days (patients with a cancer diagnosis are excluded). Overutilization: Filling of seven or more claims for any controlled substances in the past 60 days. Prescriber Shopping: Having three or more prescribers writing for any controlled substance in the past 60 days. Pharmacy Shopping: Having three or more pharmacies filling controlled substance prescriptions in the past 60 days. Use of a controlled substance with a History of Dependence: Any use of a controlled substance in the past 60 days with at least two occurrences of a medical claim for Substance Abuse or Dependence in the past 720 days. Use with a History of Overdose: Any use of a controlled substance in the past 60 days with at least 1 occurrence of a medical claim for controlled substance overdose in the past 720 days. Frequent Flyer: Three or more emergency department visits in the last 60 days. 2069 members have been reviewed for Lock-In consideration. 2% were Locked-In, 46% received a warning letter, and 52% were determined they should receive no letter by clinicians in the RetroDUR Program.
Wisconsin	Summary of Wisconsin Drug Utilization Review Board Activities Summary_2CMS FFY 2020 The Wisconsin DUR Board convened in Madison, WI for two regularly scheduled quarterly meetings, and convened virtually for two regularly scheduled quarterly meetings. A quorum of members was present at each meeting. Below are the DUR activities: For Prospective DUR: - Implemented the high morphine milligram equivalent (MME) safety edit, which includes a suggestion to consider the use of naloxone for the identified member. This edit alerts on a claim that is greater than or equal to 90 MME. - Updated the drugs included in the short acting opioid quantity limit edit. - Temporary COVID-19 changes to prospective DUR edits (excluding Schedule II drugs) include allowing pharmacies to override the Early Refill alert, removing quantity limit restrictions for drugs and diabetic supplies, and allowing pharmacies to dispense a 90 days' supply of medications. For Retrospective DUR: - Continued addition of RDUR criteria based on established guidelines with subcontractor HID as new criteria were created.

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	- Updated the current RDUR criteria that identifies the use of opioids in conjunction with buprenorphine products for MAT to ensure members with continued concurrent utilization are identified, rather than members who are transitioning into treatment. - Reviewed Quarterly Reports of RDUR activity. - Continued focused intervention to address chronic use of benzodiazepines consisted of sending educational letters to identified prescribers with members meeting specific duration and dosing thresholds for diazepam and alprazolam. Letters focused on risks of chronic use and approaches to deprescribing benzodiazepines. Additional peer to peer outreach calls were made to select prescribers with a high volume of qualifying members to address techniques for deprescribing benzodiazepines. - Worked on the development of a benzodiazepine newsletter to address benzodiazepine prescribing, appropriate indications, and challenges associated with deprescribing these medications. - Targeted intervention to address the use of gabapentinoids in conjunction with CNS depressants and underlying respiratory disorders (with or without concurrent CNS depressant use). - Targeted intervention to address the use of high dose gabapentin. - Initiation of a focused quarterly intervention to address the risks associated with the chronic use of multiple CNS depressants. Intervention letters are sent on members who have claims for all four of the following drug classes: opioids, benzodiazepines, sedative hypnotics, and skeletal muscle relaxants. Of note, this intervention was started in FFY 2020, but initial letters were sent outside of FFY 2020. - Continued focused quarterly interventions on members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed for possible inclusion in the Lock-In program. DUR Activities for SUPPORT Act - Prospective DUR -Prospective Safety edits on opioid prescriptions include: -Opioid script limit: Limits the number of opioid claims allowed in a calendar month. -Opioid quantity limits: Limits the amount of short-acting and/or select long-acting opioids dispensed in a rolling calendar month. -Early refill: Limits when a subsequent opioid prescription can be filled. -Therapeutic Duplication: Limits duplicate fills of select drug classes (i.e., opioids, benzodiazepines, etc.) per DUR Board recommendations. -Morphine milligram equivalents (MME): Alerts the pharmacy when the MME on a claim exceeds the 90 MME limit identified by the state. - Retrospective DUR -Retrospective Lock-In/High Utilization criteria: Review of MMEs, multiple high dose short-acting opioids, receiving more narcotics than intended or is using short-acting opioids when a long-acting formulation is available. -Outreach calls are being made to prescribers after intervention letters are sent. Prescribers are selected for intervention based on continued high MME or an MME increase after the intervention letter was sent. -Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. - Program to Monitor Antipsychotic Use in Children

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	-Antipsychotic agents are reviewed for appropriateness in all children including foster children based on approved indications and clinical guidelines. -Peer to peer outreach calls are being made to prescribers on children identified as being on two or more antipsychotic medications, focusing specifically on children with higher doses of both medications. -Retrospective letters are sent to prescribers when a child is on an antipsychotic medication that does not have an indication for use in children. - Fraud and Abuse Identification -The DUR program utilizes the Pharmacy Services Lock-In program to identify potential fraud or abuse of controlled substances by enrolled members. Members are identified and reviewed for possible inclusion in the program via a systematic algorithm or referral by a prescriber or other agency. Yearly results of the Lock-In program are reported to the DUR Board. There are no specific policies of this Board which establish whether or how results of prospective DUR screens are used to adjust retrospective DUR screens. Likewise, there are no specific policies that establish whether or how results of retrospective DUR screening are used to adjust prospective DUR screens. The Board considers issues related to screenings on a case-by-case basis. The Wisconsin DUR Board takes an active advisory role in determining all aspects of the DUR education program. There are no specific policies of this Board which establish which intervention type should be utilized for patient or prescriber outreach. The Board considers the method of outreach on a case-by-case basis. The Board reviews criteria for and results of monthly prescriber intervention lettering. Monthly, 1,000 member profiles are reviewed for regular RDUR and an additional 400 member profiles are reviewed for the Pharmacy Services Lock-In program.
Wyoming	Four P&T Committee meetings were held. The meetings were convened quarterly in Cheyenne. A quorum of members was present at each meeting. The meetings begin with the business and professional discussions followed by an open comment period. The second half of the meeting is devoted to discussions of cost and individual patients or providers. Prospective criteria additions/changes are listed below: Drug/indication limits: Letrozole Rinvoq Dupixent Nayzilam Fasenra Descovy Trikafta Valtoco Palforzia Oriahnn Kynmobi Fintepla Rukobia Concurrent therapy:

State	DUR Board Activities Report
	Daliresp/Spiriva (limit deleted) Duration of therapy: Clopidogrel (limit deleted) Oriahnn Other PA criteria/step therapy: Baqsimi Gvoke Rybelsus Duaklir Wakix Procrit Aranesp Aptiom Briviact Oxtellar XR Trokendi XR Abilify Maintena Secuado Talicia Vumerity Reyvow Ubrelvy Nurtec Caplyta Nexletol Dayvigo Zeposia In-depth Utilization Reviews Targeted Immune Modulators Letrozole Calcitonin for pain Osteoporosis agents Policies regarding the interaction between prospective DUR and retrospective DUR criteria and utilization reviews Utilization issues identified during prospective review of claims are presented to the P&T Committee as necessary to determine if prior authorization criteria should be added, changed or deleted. When needed, in-depth retrospective review is completed to determine the type of problem and most reasonable solution. Similarly, retrospective reviews often identify utilization issues that require prospective criteria to be added. Both prospective and retrospective reviews drive the selection of education projects. P&T Committee involvement in the education program

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	The following topics were included in provider education letters sent from the DUR Program during FFY 2020: Concurrent use of antipsychotics and opioids (at least quarterly) Narcotic use and pregnancy (monthly) Prescription Drug Monitoring Program (weekly) 7-day initial fill limit on opioids Montelukast black box Fluconazole use in pregnancy Initial treatment of tobacco dependence The following topics were included in comparative prescriber reports sent from the DUR Program during FFY 2020: Concurrent use of antipsychotics and opioids Gabapentin off-label use Substance use disorder and opioid use Montelukast black box warning DUR Newsletters Four quarterly WY-DUR Newsletters were sent during FFY2020. Newsletters are sent to approximately 2600 prescribers and pharmacists in Wyoming and the surrounding area. The P&T Committee provides recommendations regarding topics for general and targeted education letters and newsletter articles. Newsletters can be viewed at www.uwyo.edu/DUR. When appropriate, specific Committee members will draft and sign education letters.

2. Does your state have an approved Medication Therapy Management (MTM) Program?

Figure 38 - State has an Approved Medication Therapy Management Program

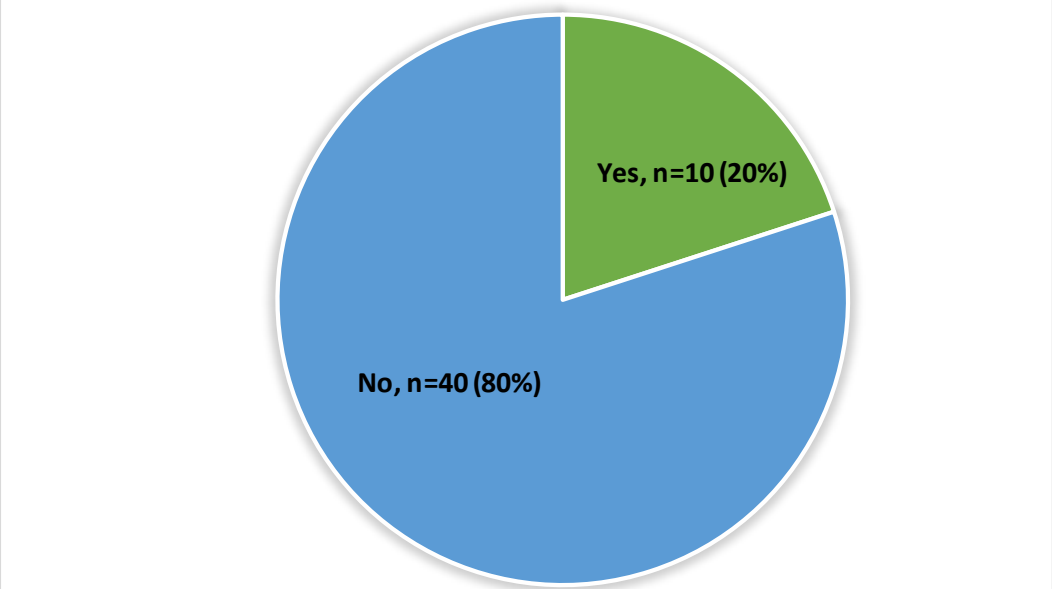

Table 58 - State has an Approved Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Florida, Michigan, Minnesota, Mississippi, Missouri, North Dakota, Oklahoma, Tennessee, Vermont, Wisconsin	10	20.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, Wyoming	40	80.00%
Total		50	100.00%

Section V - Physician Administered Drugs (PAD)

The Deficit Reduction Act required collection of national drug code (NDC) numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MMIS been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

Figure 39 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

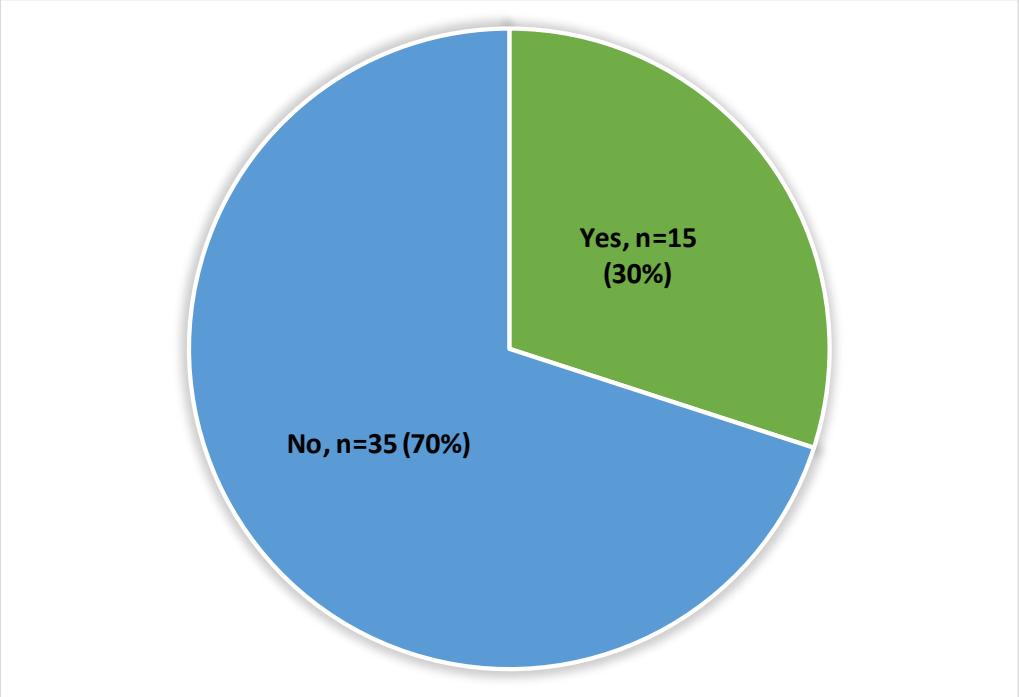

Table 59 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Alaska, Delaware, Georgia, Hawaii, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Pennsylvania, South Carolina, Utah, Virginia, Washington	15	30.00%
No	Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin, Wyoming	35	70.00%
Total		50	100.00%

If "No," does your state have a plan to include this information in your DUR criteria in the future?

Figure 40 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

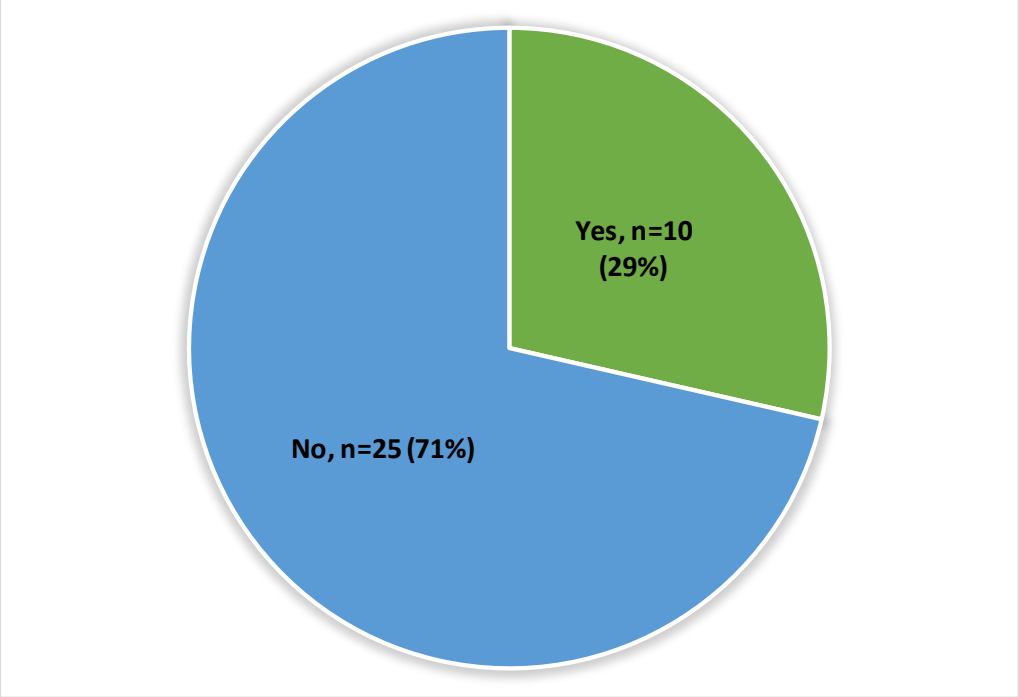

Table 60 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Florida, Illinois, Maryland, Mississippi, Nevada, New Jersey, North Dakota, Vermont	10	28.57%
No	Alabama, Arkansas, California, Connecticut, Idaho, Indiana, Iowa, Kansas, Louisiana, Minnesota, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming	25	71.43%
Total		35	100.00%

2. RetroDUR?

Figure 41 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

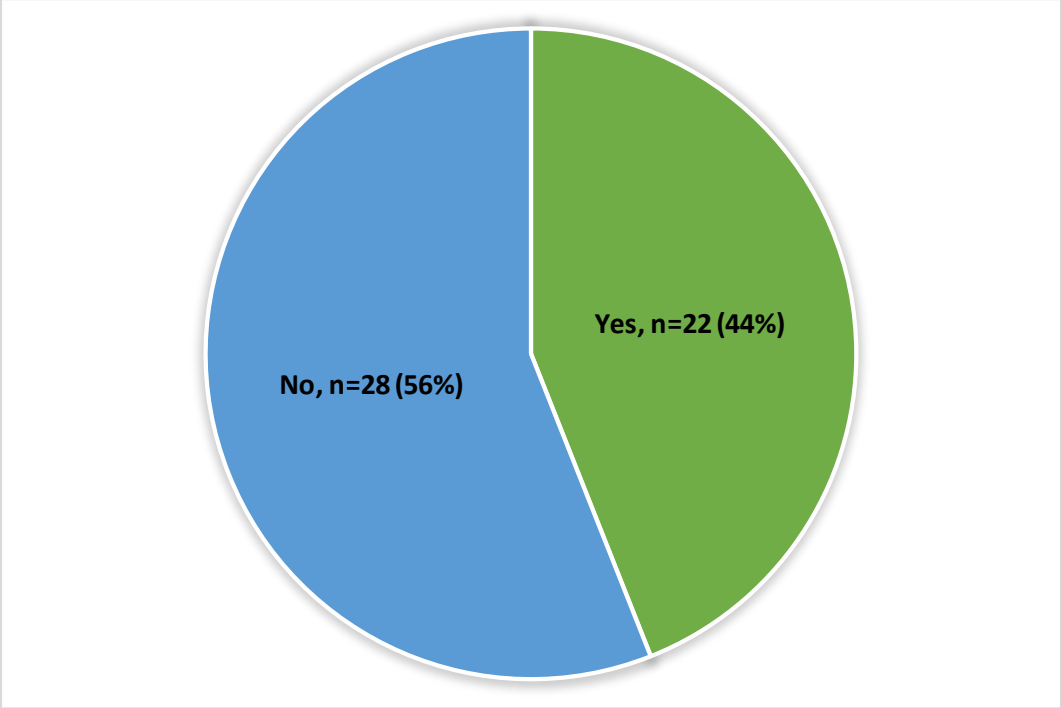

Table 61 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Alaska, California, Florida, Georgia, Hawaii, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, South Carolina, Utah, Virginia, Washington	22	44.00%
No	Alabama, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Mississippi, Montana, Nebraska, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin, Wyoming	28	56.00%
Total		50	100.00%

If "No," does your state have a plan to include this information in your DUR criteria in the future?

Figure 42 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

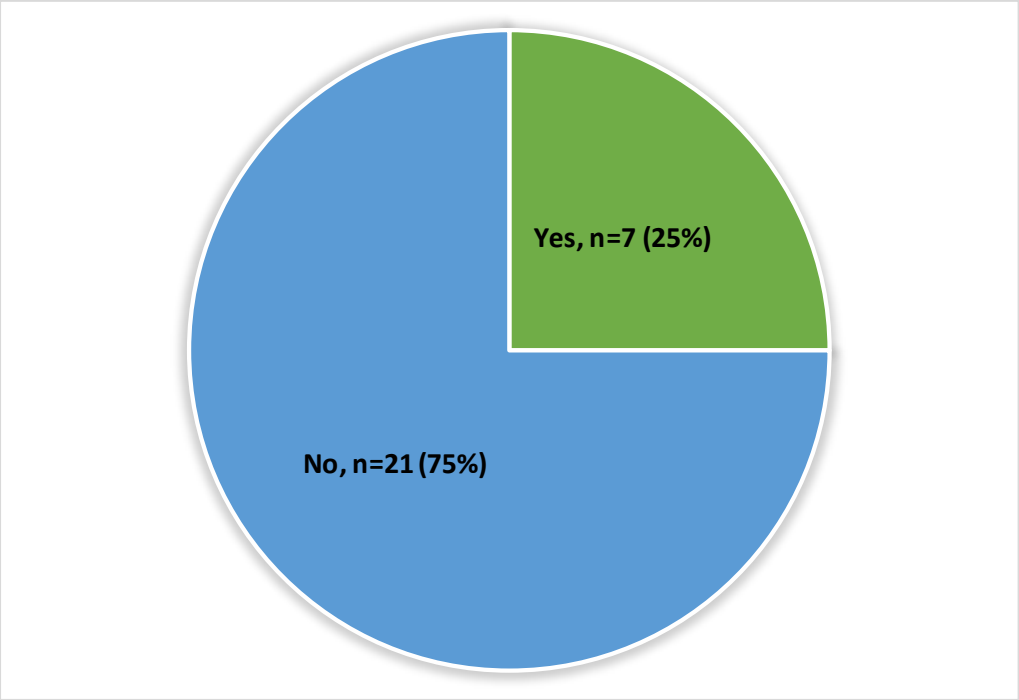

Table 62 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Idaho, Mississippi, North Carolina, Tennessee, Vermont	7	25.00%
No	Alabama, Arkansas, Connecticut, Delaware, Illinois, Indiana, Iowa, Kansas, Maryland, Montana, Nebraska, New Mexico, New York, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, West Virginia, Wisconsin, Wyoming	21	75.00%
Total		28	100.00%

Section VI - Generic Policy and Utilization Data

1. Summary 3 – Generic Drug Substitution Policies

Summary 3: Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, PDL policies, educational initiatives, technology or promotional factors, or other state specific factors that affects your generic utilization rate.

Table 63 – Generic Drug Substitution Policies

State	Generic Drug Substitution Policies
Alabama	Alabama Medicaid mandates generic substitution of therapeutically equivalent drugs. If the doctor requests that brand name be dispensed, he/she must submit an override request, including medical justification for the use of the brand name medication over the generic and a completed FDA MedWatch form; exclusions exist for certain drugs. The Alabama Medicaid program encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. As another way to encourage the substitution of therapeutically equivalent generic drugs, the Alabama Medicaid Agency has implemented a maintenance supply program. This program allows for the dispensing of a 3-month supply of certain medications for Medicaid recipients. Medications included in the maintenance supply program are primarily generic medications used to treat chronic conditions. Alabama Medicaid also makes use of a Preferred Drug List (PDL) as a way to promote use of generic products. The majority of generic drugs are preferred and providers are urged to utilize the PDL through provider education and academic detailing. Alabama Medicaid's academic detailing program utilizes a team of Medicaid Pharmacy Specialists (MPS) who live in and travel throughout their specific area making prescheduled visits to pharmacists and providers. The MPSs provide education regarding the preferred drug list, new edits, and other priority initiatives designated by the Alabama Medicaid Agency.
Alaska	The use of generic medications is encouraged through regulation 7 AAC 120.112(7). Additional initiatives to encourage the use of generic medications were continued by the Department in FFY 2020. This includes continuation of a point of sale edit which requires a prior authorization for brand name drug claims submitted with a DAW = 1. To the extent possible, and considering the net-net cost of therapeutic equivalents, PDL preferred drug selection encourages generic drug utilization. Educating providers and recipients that generic medications are therapeutically equivalent to the brand name product can be challenging due to periodically held perceptions that generic products are not as effective or potent as the brand product. Patients must trial a minimum of two generic products prior to utilization of a branded product to minimize selection bias. 7 AAC 120.112 Non-covered drugs Notwithstanding 7 AAC 120.110, the department will not pay for- (7) a brand-name covered outpatient drug described in 7 AAC 120.110(b) if a therapeutically equivalent generic covered outpatient drug is on the market, unless

State	Generic Drug Substitution Policies
	(A) the brand-name covered outpatient drug is included as a preferred medication on the Alaska Medicaid Preferred Drug List, adopted by reference in 7 AAC 160.900; or (B) the prescriber writes on the prescription "brand-name medically necessary"; the information may be submitted electronically or telephonically; if the information is submitted telephonically, the prescriber must document it in the recipient's record; the department may require prior authorization under 7 AAC 120.130 for a brand-name covered outpatient drug with a therapeutically equivalent generic covered outpatient drug on the market;
Arkansas	The Arkansas Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: 1) Brand medically necessary edit: This edit requires that physicians indicate that a multi-source brand drug is required for their patient. Claims for multi-source brand drugs will be paid at the MAC price if available unless the prescriber requests a prior authorization (PA) for the priced as brand multi-source product. Based on the Arkansas Medicaid definition of their brand versus generic pricing, the average rate of generic utilization is Eighty-five percent (85%) for FFY 2020. 2) Maximum Allowable Cost (MAC): Arkansas Medicaid establishes and manages their MAC reimbursement levels. MAC reimbursement levels are generally applied to multi-source brand and generic products. However, MAC reimbursement may also be applied to single source drugs or drug classifications where appropriate (e.g. antihemophilic factors). 3) Preferred Drug List (PDL): The PDL drives market shift to the generic drugs when the pricing is less than the brand pricing net of CMS and supplemental rebates. The patents of the original brand drugs in many of the therapeutic classes have expired. These older drugs have been replaced with several generic versions that are now priced at MAC. 4) Tiered copays for brand/generic drugs: Arkansas Medicaid requires $.50 to $3 per prescription depending on drug cost for Medicaid beneficiaries age 18 years and older (who have a pharmacy benefit and who are not LTC residents). Medicaid Maximum Amount Recipient Co-pay $10.00 or less $0.50 $10.01 to $25.00 $1.00 $25.01 to $50.00 $2.00 $50.01 or more $3.00 5) Lesser of methodology: The pricing methodology is lesser of methodology that applies to all brand or generic drugs for usual and customary charge, or NADAC, or ACA FUL, or SAAC. If the NADAC is not available, the allowed ingredient cost shall be WAC + 0%, SAAC, or ACA FUL. The Professional Dispensing Fee has been increased to $9 for Brand Drugs and $10.50 for Preferred Brand Drugs and all Generics. When possible, pharmacies should use the generic option for best dispending fee. CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug. These sourcing status indicators are identified as follows:

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	A) Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. B) Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market. C) Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity. Utilizing these indicators to determine generic utilization will allow for consistent reporting across all states. Based on calculations using these indicators, Arkansas Medicaid has a generic utilization of 85% for all outpatient claims comprising 17.6% of total drug expenditures for FFY 2020.
California	Among possible factors contributing to the Medi-Cal fee-for-service generic utilization percentage, the most impactful are the following: 1) supplemental rebate contracts with manufacturers; 2) carve-out drugs; and 3) generic drug pricing policies. 1) Restrictions to the Medi-Cal List of Contract Drugs The Medi-Cal Drug Rebate program negotiates supplemental rebate contracts with pharmaceutical manufacturers and collects rebates greater than rebates obtainable through federal contracts alone. As a result, the net cost to the State for some brand name drugs can be lower than the therapeutically equivalent generic drug. In some cases, contracted drugs are payable at the point of service, while their generic equivalents require prior authorization. On the Medi-Cal List of Contract Drugs, these drugs can be identified through restrictions to the NDC labeler code. 2) Carve-out Pharmacy Benefits The Medi-Cal fee-for-service program pays for certain carved-out therapeutic classes of drugs for beneficiaries in both the Medi-Cal fee-for-service program and the Medi-Cal managed care program. Most notably, this applies to selected psychiatric drugs, alcohol and heroin detoxification and dependency treatment drugs, coagulation factors, and drugs used in treatment of Human Immunodeficiency Virus (HIV) and AIDS. These classes of drugs are largely single-source innovator products and consistently account for a large portion of Medi-Cal drug benefit expenditures in the Medi-Cal fee-for-service population. 3) Policies encouraging generic equivalent substitution for drugs dispensed through the Medi-Cal program. In cases where generic drugs are more cost-effective, Medi-Cal encourages use of generic drugs. The providers, to the extent permitted by law, shall dispense the lowest cost drug product within the generic drug type in stock, which meets the medical needs of the beneficiary. Reimbursement for any legend and non-legend drug covered under the Medi- Cal program is the lowest of: 1. Actual acquisition cost (AAC) plus a professional dispensing fee. The AAC is equal to the lowest of the following: National Average Drug Acquisition Cost (NADAC), or when no NADAC is available, the wholesale acquisition cost (WAC)

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	Maximum Allowable Ingredient Cost (MAIC) Federal Upper Limit (FUL) 2. The pharmacy's usual and customary charge. Among these, whenever available, MAIC and FUL promote the use of generic equivalents unless restricted on the Medi-Cal List of Contract Drugs. The rates established by MAIC or FUL are generally much lower than the cost of branded products, which discourages providers from filling prescriptions with name brand drugs. Full reimbursement of prescription ingredient cost requires use of a brand of a multiple source drug, which costs no more than the program specified price limits. When medically necessary for a specific recipient, approval of reimbursement may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting authorization from a Medi-Cal consultant. National Average Drug Acquisition Cost (NADAC) The National Average Drug Acquisition Cost (NADAC) is used as the basis for the actual acquisition cost-based ingredient cost reimbursement for covered outpatient drugs. The NADAC is a national drug-pricing benchmark determined by a federal survey, representing the national average invoice price for drug products based on invoices from wholesalers and manufacturers submitted by retail community pharmacies. Wholesale acquisition cost (WAC) plus 0 percent is used as the basis for reimbursement when a NADAC is not available. The methodology reimburses the lower of the NADAC, WAC, federal upper limit (FUL), maximum allowable ingredient cost (MAIC) or the pharmacy's usual and customary charge. Maximum Allowable Ingredient Cost (MAIC) The Maximum Allowable Ingredient Cost (MAIC) program establishes maximum ingredient cost limits for generically equivalent drugs. Each cost limit is established only when there are three or more generically equivalent drugs available for purchase and dispensing by retail pharmacies within California. Federal Upper Limit (FUL) Federal Upper Limit (FUL) is an upper limit of reimbursement for certain multiple source drugs established independently from the California MAIC Program by the United States Department of Health and Human Services (DHHS). The federally required FUL is administered by the Medi-Cal program in a similar manner as the MAIC program. The major difference is that changes to the FUL list of drugs and respective price limits are issued periodically by DHHS and then implemented by Medi-Cal. When a drug is listed on both the MAIC and FUL price lists, the reimbursement rate is the lower of the MAIC or FUL.
Colorado	Policy for mandated use of generic product formulations (generic mandate): Brand name drug products that have generic equivalent product formulations (multi-source innovator products) require a prior authorization. Exceptions to this policy include: The brand name drug has been exempted based on indicated use for the following circumstances: The Department designates favored coverage of the brand drug product based on net cost for the brand product being lower than that of the generic equivalent The physician is of the opinion that a transition to the generic equivalent of a brand drug product would be unacceptably disruptive to the patient's stabilized drug regimen The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician

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	Medications used for the treatment of the following disease states are exempt from the generic mandate policy (no PA is required). Biologically Based Mental Illness (as defined in 10-16-104 (5.5) C.R.S.) Cancer Epilepsy HIV AIDS Other drug management strategies to encourage use of generic product formulations: Our program has implemented a Preferred Drug List (PDL) which, by incorporating available evidence-based research and public testimony, provides clinical guidance for necessary drug therapies. During implementation of these clinical recommendations, the program provides advantage to products that are most cost effective. We have been able to enhance generic utilization in a clinically appropriate way without sacrificing quality of care by preferring generic drug options when clinically appropriate.
Connecticut	Currently the Connecticut DUR Board has no specific written policies concerning the use of generics. The DUR Board does encourage prescribers to consider judicious, wise use of limited public Medicaid funds while providing quality treatment. The Board does not feel that judicious use of funds and quality care are diametrically opposing goals. Prior to October 2002, the Connecticut Department of Social Services Medical Assistance pharmacy program had no specific policies, but encouraged the use of generics through: 1.) Educational monographs issued to the prescribing and dispensing providers, and 2.) Applying a $0.50 generic substitution incentive professional dispensing fee to prescriptions filled by licensed pharmacies for generic drugs dispensed to Medicaid recipients. Effective 10/1/02, pursuant to Section 50 of General Assembly Bill 6004 of the May 9, 2002 Special Legislative Session, the $0.50 generic substitution incentive professional dispensing fee applied to prescriptions filled by licensed pharmacies for generic drugs dispensed to Medicaid recipients was repealed. Current Connecticut Department of Social Services Medical Assistance pharmacy program policies designed to encourage the use of generics and to promote generic substitution are: 1.) NADAC Pricing List: Effective April 1, 2017, the Connecticut Medical Assistance Program implemented a new drug pricing methodology using National Average Drug Acquisition Cost (NADAC) files. This change was in compliance with the Patient Protection and Affordable Care Act of 2010. NACAC pricing is based on the average acquisition cost for covered outpatient drugs. a. Pharmacy claims were updated to price using NADAC values for dispense dates on or after April 1, 2017. Brand name single source and multisource drugs reimburse at the Brand NADAC price while generic drugs reimburse at the Generic NADAC price. Claims for drugs without a NADAC price will reimburse at the lesser of the Federal Upper Limit (FUL) or the Wholesale Acquisition Cost (WAC) with the following exceptions, which will always reimburse at WAC: i. Preferred brand name medications (as identified on the Preferred Drug List (PDL), and

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	ii. Medications submitted with a Dispense as Written (DAW) Code of 1 (Substitution Not Allowed-Brand Medically Necessary), for all HUSKY A, HUSKY C, HUSKY D, TB AND FAMPL recipients. 2.) FUL Pricing List: DSS previously adopted the federal upper limit (FUL) list for pricing which helps to promote generic substitution. 3.) WAC Pricing List: Effective 4/1/2017, the average wholesale price (AWP) pricing segment is only being used to calculate the WAC rate for reimbursement when an NDC has no NADAC rate on file. The WAC rate is calculated by dividing the AWP rate by 1.2. 4.) State MAC Pricing List: The SMAC Program was end dated on 3/31/2017 with the implementation of NADAC Pricing changes to pharmacy reimbursement. 5.) Prior Authorization for Brand Drugs when 2 Generic Equivalents are available: Prior authorization is required if a prescriber believed that a documented clinical reason existed for a client to receive a brand name drug (Brand Medically Necessary) when two generic drug products plus brand that the FDA considered to be therapeutically equivalent, A-rated, was available. Exemptions: PA is not required for: A.) Compounded claims, B.) Brand name atypical antipsychotics for recipients who have had this medication filled within the last year; C.) HIV medications and D.) Non-maintenance medications prescribed for less than a 15-day supply E.) Cyclosporine or Levothyroxine products (due to the narrow therapeutic window). 6.) Preferred Drug List: While generics are preferred for most therapeutic classes, there are some instances where the brand is preferred over the generic because of the supplemental rebate contracts. In addition, there are instances where the generic is not preferred when new to the market because there is not significant enough pricing differences between brand and generic.
Delaware	In federal fiscal year 2020, DMMA policy continued the goal of encouraging generic usage unless there is a price guarantee offered by the labeler, regardless of the federal rebate, to lessen the cost burden on the DMMA Medicaid program. When it was deemed more appropriate to use brand multi-sourced products, the brand name product is listed as preferred on the PDL in bold to draw the prescriber's attention to the fact that the brand name is being preferred over the generic. Leveraging this policy has resulted in an 82.8% generic utilization for paid claims for the year. Delaware Medicaid continues to mandate generic dispensing on all drug categories except for members with a seizure diagnosis and drugs deemed to be narrow therapeutic index medications. All other instances of brand name dispensing when generics are available require prior authorization. For members with a seizure diagnosis, the provider includes the diagnosis on the prescription and the pharmacy submits the diagnosis code in the corresponding NCPDP field which will override the need for any paper prior authorization to be submitted. Our state law requires that a doctor must write Brand Medically Necessary on the face of prescriptions for brand name, but Medicaid takes additional steps to ensure the medical necessity of a brand name dispensing. If a patient requests brand and the pharmacy submits a DAW code of two, this code is automatically rejected in our point of sale system. Delaware also continues to mandate that a Med Watch form be submitted as part of the prior authorization process for brand name multi%u2010sourced medications. First and foremost, Med Watch forms are detailed descriptions of the generic product that failed and the type of failure that occur. Using this form means that a generic must be tried prior to the request for a brand name product. A minimum of a two%u2010week trial period is required unless an

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	objective adverse event occurs that necessitates the medication being stopped. The Med Watch form must be completely filled out with the National Drug Code (NDC) and lot number. Along with this required information, the physician must document a valid side effect or lack of efficacy that occurred with the member utilizing a generic. The majority of Med Watch forms submitted to Delaware Medicaid do not meet our criterion for prior authorization approval as they lack information, have too short of a trial period, or listed symptoms that cannot be linked to the generic product itself. Delaware has had this policy requiring the Med Watch form to deter brand name dispensing of multi%u2010source drugs for many years and continues to find it to be effective in decreasing unnecessary and costly use of brand name products.
District of Columbia	The District of Columbia Medicaid program implemented a District Maximum Allowable Cost (DMAC) Program on April 1, 2010. The list is updated quarterly and the current listing is available on the Medicaid website at www.dc-medicaid.com and on the PBM website at www.dc-pbm.com. The DMAC program works in concert with the District's long standing policy of mandating the substitution of an AB rated therapeutically equivalent generic product for a prescribed brand name product. If a prescriber has indicated on a written prescription that a branded product is medically necessary for his/her patient, the pharmacist must request a prior authorization before submitting the claim with DAW 1. Additionally, the District utilizes a Preferred Drug List to manage selected classes of drugs that are vetted for efficacy, safety and therapeutic equivalency. Preferred brand drugs are subject to a manufacturer supplemental rebate payable to the District based on utilization of the product. At times the net cost to the District for a brand product is more advantageous than if a generic product is preferred mainly due to high federal and supplemental rebates on the brand product. In these instances, the District will make a brand product preferred over a generic. This fiscally sound practice however may negatively influence the generic utilization rate.
Florida	Generic Drug Substitution Policies Florida Medicaid has a prescribed-drug spending-control program that includes the Medicaid preferred drug list (PDL). The PDL is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee. The primary goal of this Committee is to ensure availability of medications that are safe, efficacious, and cost-effective, via the PDL, to Florida Medicaid recipients. In many cases, generic drug utilization is encouraged as the most suitable medication for recipients. The Florida Agency for Health Care Administration is authorized to seek any federal waivers necessary to implement cost-control programs and to continue participation in the federal Medicaid rebate program. Due to the participation in the federal and supplemental rebate program, occasionally Florida Medicaid is afforded the opportunity to realize more cost savings when a branded product is dispensed versus the generic counterpart. In those instances, the branded product is included on the PDL and the generic is excluded. Florida Medicaid also promotes generic substitution through point of sale edits such as requiring a clinical prior authorization for any branded drug for which there is a generic available and implementation of a maximum allowable cost (MAC) program. Florida Medicaid continues to encourage generic substitution when possible. This is demonstrated by Florida Medicaid's generic utilization rate of 83% for Federal Fiscal Year 2020.

State	Generic Drug Substitution Policies
Georgia	The Georgia Department of Community Health (DCH) maintains a policy for generic dispensing. The generic dispensing rate is accomplished through various initiatives implemented over the course of several years. Preferred brand or generic medications have a co-payment of $0.50 and non-preferred brand or generic medications have a range of co-payments from greater than $0.50 to $3.00, depending on the cost of the drug. Activities include the use of an aggressive Maximum Allowable Cost (MAC) program and favorable placement of cost-effective brands and generics on the Preferred Drug List (PDL), being mindful of clinical appropriateness. DCH also continues to employ a generic mandatory program.
Hawaii	The state has a generic mandatory law as well as 2 generics must be documented as tried and failed for anti-depressants and anti-anxiety drugs before a brand will be paid. Majority of FFS claims count are dental for which the formulary is primarily generic drugs. Implementation of National Average Drug Acquisition Cost (NADAC) had a cost savings effect for generic drugs: 49% of all paid claims were generic NADAC; 1% of all paid claims were brand NADAC; and State maximum allowed cost (SMAC) paid for 16% of all paid claims. Only 9% of all paid claims were reimbursed at wholesale acquisition cost (WAC). The generic drug expenditure percentage decreased due to Hawaii Medicaid's first and only Zolgensma prescription being paid by FFS for a MCO patient. 65% of FFS drug spend was for one Zolgensma claim. There is no PDL because Hawaii's FFS population size is too small to justify the cost.
Idaho	The use of generic medications is encouraged under the appropriate parameters set forth by different agencies. The State Board of Pharmacy gives definitions as to therapeutic equivalents; The Department of Health and Welfare has put forth rules to encourage the use of generic medications; and the Department has contracted with Myers and Stauffer to provide assistance in establishing and maintaining the Actual Acquisition Cost (AAC) list for all drugs. Working under these parameters, we have established Prior Authorizations of medications, utilized step wise edits when appropriate, and have an established Preferred Drug List which all encourage the use of generic medications when appropriate. The Department's Preferred Drug List is based on the principle of preferring those drugs primarily with the best comparative efficacy and safety profile. When those are equal then a comparative cost is done, with the net cost being the acquisition cost minus the federal rebate and minus any supplemental rebate. There are frequent incidences when because of competitive rebates, the brand name may be more cost effective. To judge a program by the percentage of generic use vs overall cost savings is thus misleading.
Illinois	Illinois Medicaid uses multiple strategies to shift utilization to generic drugs: Illinois Medicaid's PBMS system requires prior authorization for use of a brand product if a generic product is available except when the innovator's product is the preferred drug product based on net pricing. The prescriber must request prior approval and demonstrate that the brand name product is medically necessary. During FFY20, some brand and generic formulations were changed to preferred status due to their use as a treatment modality related to the COVID-19 pandemic, for example Ventolin, Proventil, Xopenex, albuterol, and

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	levalbuterol were all made preferred. Additionally, the 3-Brand limit edit was temporarily lifted in the second half of FFY20 due to the COVID-19 pandemic. Illinois Medicaid uses State Maximum Allowable Cost (SMAC) pricing on generic drugs that establishes the reimbursement rate on the acquisition cost of the generic products. The SMAC and Specialty medication SMAC lists are available at http://www.ilsmac.com/list. Effective July 15, 2019, the Fee-for-Service professional dispensing fee for brand and generic products is the same. There are different dispensing fees for 340B claims, Critical Access Pharmacies (CAP) and non-CAP pharmacies. Illinois Medicaid uses tiered copayments to encourage utilization of generic products. During FFY20, the copayment for brand name drugs remained at $3.90 and the copayment for generic drugs and over-the-counter drugs was $2. The copayment is automatically deducted from the provider's reimbursement and collected from participants by the provider. Copayments for medications and other Medicaid benefits were waived in the second half of FFY20 due to the COVID-19 pandemic. Illinois Medicaid uses the Preferred Drug List (PDL) to shift utilization to generic products. In classes that contain generic products, generic products are preferred, and brand products are non-preferred, unless they offer a financial advantage over the generic products. Effective January 1, 2020, Illinois has one PDL for the state, which facilitates continuation of medications even if patients move between Fee-for-Service and managed care Medicaid plans. The PDL was updated and adjusted as needed based on shortages of preferred medications during the COVID-19 pandemic. With some exceptions, Illinois Medicaid limits the number of brand name drugs participants age 21 and over may receive each month. Prior approval is required for a brand name drug when the department has already been billed for three brand name drugs in the preceding 30-day period. The 3-Brand limit edit was temporarily lifted effective March 30, 2020 due to the COVID-19 pandemic. Billing of a 90-day supply is allowed for certain generic, oral, non-narcotic, maintenance medications for disease states such as hypertension, diabetes, and hypothyroidism. Additional medications were added to the 90-day supply list of maintenance medications effective May 20, 2020 due to the COVID-19 pandemic. In FFY20, the Illinois Medicaid generic utilization rate was 88.56% of total paid claims, an increase of 2.47 percentage points compared to the FFY19 generic utilization rate of 86.09%. In FFY20, brand name single-source drugs accounted for 6.35% of the total paid claims, which was 0.65% lower than in FFY19. In FFY20 innovator multiple source drugs accounted for 5.06% of the total paid claims, at least 1.84% percent lower than in FFY19. Many drugs that are considered innovator multiple source drugs are not traditional brand name drugs, but rather, authorized generics. Authorized generics are drugs sold by the brand name drug manufacturer or innovator company but distributed as generics with generic labels.
Indiana	Indiana statute mandates substitution of a generically equivalent drug for a prescribed brand name drug, unless the prescribing practitioner properly signs and indicates %u201cBrand Medically Necessary%u201d on the prescription and obtains prior authorization. Excluded

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	from the prior authorization requirement are those claims for Coumadin%u00ae, Provera%u00ae, Synthroid%u00ae, Tegretol%u00ae, Lanoxin%u00ae, Premarin%u00ae, and Dilantin%u00ae, as well as claims with a dispense as written (DAW)/product selection code 01 indicating %u201cBrand Medically Necessary.%u201d In addition, brand name agents that are preferred by the plan due to cost savings do not require prior authorization or a prescription indicating %u201cBrand Medically Necessary.%u201d For your reference, the Indiana generic substitution law, Indiana Administrative Code on generic substitution are Indiana Code 16-42-22. Section 10 of the Indiana code describes the requirements for dispensing brand name drugs when a generically equivalent drug product is available (section provided below). The 405 Indiana Administrative Code 5-24-8 provides the requirements for brand name drugs dispensed to Medicaid beneficiaries. Sec. 10. (a) If a prescription is filled under the traditional Medicaid program (42 U.S.C. 1396 et seq.) or the Medicare program (42 U.S.C 1395 et seq.), the pharmacist shall substitute a generically equivalent drug product and inform the customer of the substitution if the substitution would result in a lower price unless: %u2022the words %u201cBrand Medically Necessary%u201d are written in the practitioner's own writing on the form; or %u2022the practitioner has indicated that the pharmacist may not substitute a generically equivalent drug product by orally stating that a substitution is not permitted. If a practitioner orally states that a generically equivalent drug product may not be substituted, the practitioner must subsequently forward to the pharmacist a written prescription with the %u201cBrand Medically Necessary%u201d instruction appropriately indicated in the physician's own handwriting. This section does not authorize any substitution other than substitution of a generically equivalent drug product. The Indiana Medicaid program does prefer certain brand agents with generic equivalents available to maximize the cost savings through Federal and Supplemental rebate to the state. A list of current brand preferred agents can be found on the pharmacy services website on the pharmacy criteria and forms page at: https://inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp. Pharmacy providers need not obtain a brand medically necessary prior authorization or prescription for agents in which the state prefers the brand product. For these claims submissions, a dispense as written code of 9 is utilized.
Iowa	While use of therapeutically equivalent generic drugs is encouraged, there are instances where a brand name drug is preferred over the generic equivalent. The Pharmaceutical & Therapeutics Committee (P&T) determines placement of drugs on the Preferred Drug List (PDL), taking into consideration the therapeutics and the cost of the drug. The overall cost determination of brand and generic drugs are based on a review of the net cost to the program, subtracting out all CMS and supplemental rebates. Because of varying rebates for brand name drugs, it is not uncommon for the net cost of brand name drug to be less than that of its generic counterparts thus making it preferred for Medicaid programs.
Kansas	Kansas State Board of Pharmacy allows for pharmacist substitution of generic drugs unless- - If the physician insists that brand name be dispensed, he/she must write dispense as written on the face of the prescription in his/her own handwriting. - A note stating Dispense as Written on an electronically sent prescription. - Verbally request was made when phoning in a prescription order. - The FDA has determined that a drug is not bioequivalent to the prescribed drug.

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	Kansas Medicaid has a policy regarding generic drug use and requirements for when a provider requests brand drugs. When a prescriber specifies Dispense as Written (DAW) on a drug which has a bioequivalent generic substitute available, the pharmacy may seek greater reimbursement by following the DAW Documentation Required process described in this manual. This process requires the pharmacy, in collaboration with the prescriber, to obtain a prior authorization.
Kentucky	Kentucky law requires pharmacists to substitute and dispense US Food and Drug Administration (FDA)-approved generic drugs when presented with a prescription for a brand name drug, unless otherwise instructed by the patient or prescribing practitioner. (KRS 217.822) The prescriber may direct the pharmacist to forego the substitution regulation and dispense brand name medications. The prescriber can direct the pharmacist through a designation written on the prescription such as; Do Not Substitute (DNS), Dispense as Written (DAW), or Brand Medically Necessary (BMN). The patient may direct the pharmacist to forego the substitution regulation and dispense brand name medications verbally. However, a patient may be required to forego full reimbursement or pay a higher co-payment if the patient directs the pharmacist to dispense a brand name when the prescriber has not indicated that the brand is necessary. Kentucky Medicaid also promotes generic substitution through point-of-sale edits such as requiring a clinical prior authorization for any branded drug for which there is a generic available and implementation of a maximum allowable cost (MAC) program. For patients that have a copay, a higher copayment for branded products is assessed unless the plan prefers a brand when a generic of that same product is available. As discussed above, generic utilization is encouraged whenever possible; however, generics must be cost effective as well. There are times when a branded product, after all rebates have been considered, proves to be more cost-effective to the Commonwealth. In those instances, the claims adjudication system is coded to require pharmacies to dispense the more cost effective (brand) product and generic utilization numbers are negatively impacted.
Louisiana	1. When Brand name drugs are preferred on the PDL and the generic requires prior authorization. From the POS Manual: 4.2.3 Drugs with PA Criteria. Claim payments for Brand Name drugs at Brand reimbursement are allowed when the Brand drug is on the PDL and the generic drug requires Prior Authorization. Edits. The generic reimbursement of a Brand Name drug can be overridden when the Brand drug is on the PDL and the generic drug requires Prior Authorization. Louisiana Medicaid POS User Manual Revised Date: 08/11/14, Page 15 of 73

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	Override. Enter a value of 9 which is substitution allowed by prescriber but plan requests brand in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Documentation. When 9 is entered in NCPDP field #408-D8, it will not be necessary for the Brand Medically Necessary to be handwritten on the prescription by the prescriber. 2. When the physician requests the Brand for medical necessity. From the POS Manual: 4.2.2 Federal Upper Limits (FUL). Claim payments are adjusted in accordance with the Maximum Allowable Reimbursement Methodology for drugs with FUL. Edits. The FUL can be overridden when the prescribing practitioner utilizing his/her medical judgment certifies in his/her own handwriting that a specific brand name drug is medically necessary for a specific patient. Override. Enter a value of 1 which is substitution not allowed in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Please consult the pharmacy system vendor manual or your pharmacy system documentation or contact your software vendor on what codes need to be entered in this field. If a code is entered in this field, it could affect the amount received. Documentation. The certification must be written either directly on or must be a signed and dated attachment (which may be faxed) to the prescription. The certification must be in the prescriber's handwriting
Maine	Generic Drug Substitution Policy The state encourages generic prescribing by virtue of a mandatory generic law, a Preferred Drug List that prefers all cost-effective generics and a rigorous prior authorization requirement for branded products that does not allow DAW 1 overrides at the pharmacies. Generic prescribing encouraged by: Generic and therapeutically equivalent substitution A written prescription issued by a practitioner in this State may contain a box in the lower right-hand corner of the prescription form. The following words must appear to the left of this box: "Any drug that is the generic and therapeutic equivalent of the drug or any biological product that is an interchangeable biological product of the biological product specified above in this prescription must be dispensed, provided that no check mark ( ) has been handwritten in the box in the lower right-hand corner." [PL 2019, c. 34, 4 (AMD).] Except with regard to a patient who is paying for a drug or biological product with the patient's own resources, any pharmacist receiving a prescription in which no handwritten check mark ( ) is found in the box provided shall substitute a generic and therapeutically equivalent drug for the drug or an interchangeable biological product for the biological product specified on the prescription if the substituted drug or interchangeable biological product is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug or interchangeable biological product does not exceed the price of the drug or biological product specified by the practitioner; except that, when the cost of a prescription is to be reimbursed under the

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	MaineCare program pursuant to Title 22, chapter 855, the pharmacist shall substitute a generic and therapeutically equivalent drug or an interchangeable biological product only when the Department of Health and Human Services has determined that the substitute drug or interchangeable biological product would be a more cost-effective alternative than the drug or biological product prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug or biological product with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug or for either the prescribed biological product or interchangeable biological product and dispense the drug or biological product that the patient prefers. [PL 2019, c. 34, 4 (AMD).] Except with regard to a patient who is paying for a drug or biological product with the patient's own resources, if a written prescription issued by a practitioner in this State does not contain the box described in this section, a pharmacist shall substitute a generic and therapeutically equivalent drug for the drug or an interchangeable biological product for the biological product specified on the prescription if the substituted drug or interchangeable biological product is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug or interchangeable biological product does not exceed the price of the drug or biological product specified by the practitioner, unless a practitioner has handwritten on the prescription form, along with the practitioner's signature, "dispense as written," "DAW," "brand," "brand necessary" or "brand medically necessary"; except that, when the cost of a prescription is to be reimbursed under the MaineCare program pursuant to Title 22, chapter 855, the pharmacist shall substitute a generic and therapeutically equivalent drug or an interchangeable biological product only when the Department of Health and Human Services has determined that the substitute drug or interchangeable biological product would be a more cost-effective alternative than the drug or biological product prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug or biological product with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug or for either the prescribed biological product or interchangeable biological product and dispense the drug or biological product that the patient prefers. [PL 2019, c. 34, 4 (AMD).] Any pharmacist who substitutes a generic and therapeutically equivalent drug or an interchangeable biological product under this section shall inform the person to whom the drug or interchangeable biological product is dispensed of the substitution. When any substitution is made under this section, the pharmacist shall cause all information as required by section 13794, the name of the generic and therapeutically equivalent drug and the name or abbreviation of the drug manufacturer or distributor of that substitute drug or, in the case of an interchangeable biological product, the proper name and the name of the manufacturer of the interchangeable biological product, to appear on the container label of the drug or interchangeable biological product dispensed. [PL 2019, c. 34, 4 (AMD).] This section does not apply to prescriptions ordered by practitioners for patients in hospitals when those prescriptions are filled by a hospital pharmacy or in any institution where a formulary system is established. [PL 1987, c. 710, 5 (NEW).] Within 5 business days after a pharmacist dispenses a biological product, the dispensing pharmacist or the pharmacist's designee shall enter in an electronic records system that is

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	electronically accessible to the practitioner who prescribed the biological product the specific biological product dispensed, including the name of the biological product and the manufacturer. For purposes of this paragraph, "electronic records system" means an interoperable electronic medical records system, an electronic prescribing technology, a pharmacist benefit management system or an electronic pharmacy record. Entry into an electronic records system as described in this paragraph is presumed to provide notice to the practitioner. If a pharmacist cannot make an entry in an electronic records system, the pharmacist shall notify the practitioner of the specific biological product dispensed by facsimile, telephone, electronic transmission or other similar means. Notice to a practitioner under this paragraph is not required if the federal Food and Drug Administration has not approved an interchangeable biological product for the product prescribed or a refill prescription is not changed from the biological product dispensed on the prior filling of the prescription. [PL 2019, c. 34, 4 (NEW).] The board shall maintain a link on the board's publicly accessible website to the current list of all biological products determined by the federal Food and Drug Administration to be an interchangeable biological product. [PL 2019, c. 34, 4 (NEW).] For the purposes of this section, "drug" does not include biological products. [PL 2019, c. 34, 4 (NEW).]
Maryland	Section 15 118 of the Annotated Code of Maryland encourages the use of therapeutically equivalent generic drugs. Under this section, the generic form of the drug shall be used to fill the prescription, except for drugs generally not available in the State. The branded form may be used if the prescriber directs otherwise on the prescription or on a signed certification of need, and the pharmacist calls Medicaid for prior authorization of a branded drug. Generics include drugs that have been rated AB (product meets necessary bioequivalence requirements) by the Food and Drug Administration. These ratings are published in the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (the "Orange Book"). Current Maryland Medicaid policy is to require the approval of a prior authorization, supported by the submission of an FDA Medwatch form, for a brand name drug to be dispensed for which there is an FDA approved equivalent generic agent on the market. The exception to this policy is that, in some instances, the multisource brand name drug is preferred on the Preferred Drug List (PDL) because the branded drug is more cost-effective than its generic counterpart. In the survey question VI. Generic Policy and Utilization Data, sub question 3, we have reported generic utilization percentage of 82%. However, due to the reason stated above, recalculated generic use rate would be 89%.
Massachusetts	Within the MassHealth Pharmacy Program, generic utilization is part of an evidence-based approach to clinical decisions and program design. Generic utilization is also encouraged and mandated by several Massachusetts regulations. Less Costly Alternatives: Massachusetts regulation 130 CMR 450.204 states that The Division will not pay a provider for services that are not medically necessary. (A) A service is "medically necessary" if ... (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the Division. Preferred Copayment for generic medications: Massachusetts regulation 130 CMR 450.130 states that MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 450.130(D) or (E). The copayment for pharmacy services is (a) $1 for each prescription and refill for each generic drug, and non-legend drug covered by MassHealth in

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	the following classes: antihypertensives, antihyperglycemics, antihyperlipidemics and (b) $3.65 for each prescription and refill for all other drugs covered by MassHealth. Limitations on Coverage of Drugs: 406.413: (A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent unless (1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 406.422); and (2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated. (Interchangeable Drug Product - a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A"-rated) by the Food and Drug Administration Center for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.) Limitations on Cost: Maximum Allowable Cost (MAC), also known as Massachusetts Upper-Limit Price (MULP) - an upper-limit price for multiple-source drugs as defined by DHCFP in 114.3 CMR 31.00. MassHealth Brand Name Preferred Over Generic Drug List - A list of brand name drugs that MassHealth prefers over their generic equivalents because the net cost of the brand name drugs adjusted for rebates is lower than the net cost of the generic equivalents. This list may be updated often and is subject to change at any time. MassHealth may require prior authorization (PA) for clinical reasons. Drugs that require additional PA requirements are noted with "PA" on this list and are subject to 130CMR 406.000 and other MassHealth regulations. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent. MassHealth Supplemental Rebate/Preferred Drug List - A list of drugs for which MassHealth has entered into a supplemental rebate agreement with drug manufacturers, allowing MassHealth the ability to provide medications at the lowest possible costs. The items are listed alphabetically by therapeutic class, then by the name of the drug or drug ingredients. MassHealth may still require prior authorization for clinical reasons. Drugs that require additional prior authorization requirements are noted with PA on this list and are subject to 130CMR 406.000 and other MassHealth regulations. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.
Michigan	The Michigan Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include a brand medically necessary edit, maximum allowable cost (MAC) pricing, National Average Drug Acquisition Cost (NADAC) pricing, preferred drug list (PDL) and tiered copays for brand and generic drugs.
Minnesota	The Minnesota Department of Human Service's Pharmacy Program encourages the use of therapeutically equivalent generic drugs when appropriate. Pursuant to Minnesota Statutes, section 151.21, subdivision 3: When a pharmacist receives a written prescription on which the prescriber has not personally written in handwriting dispense as written or D.A.W., or an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated, and there is available in the pharmacist's stock a less expensive generically equivalent drug that, in the pharmacist's professional judgment, is safely interchangeable with

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	the prescribed drug, then the pharmacist shall, after disclosing the substitution to the purchaser, dispense the generic drug, unless the purchaser objects. A pharmacist may also substitute pursuant to the oral instructions of the prescriber. A pharmacist may not substitute a generically equivalent drug product unless, in the pharmacist's professional judgment, the substituted drug is therapeutically equivalent and interchangeable to the prescribed drug. A pharmacist shall notify the purchaser if the pharmacist is dispensing a drug other than the brand name drug prescribed. Pursuant to Minnesota Statutes, section 256B.0625, subd. 13g (e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates dispense as written-brand necessary on the prescription as required by section 151.21, subdivision 2. Effective January 1, 2004, there was a change in the authorization of DAW Prescriptions. Authorization is required when prescribing a brand name drug if a generic equivalent is available. Prescribers must write DAW - brand medically necessary on a prescription and must obtain prior authorization meeting criteria approved by the Drug Formulary Committee authorizing payment for a brand name drug. There are select brand name preferred drugs if the net cost is less for the brand name drug.
Mississippi	Mississippi Medicaid Generic Drug Substitution Policies Under the Mississippi Code Annotated Section 43-13-117(9)(1972, as amended), the Mississippi Division of Medicaid (DOM) mandates generic substitution of therapeutically equivalent drugs. The following is an excerpt from Section 31.11 of the Mississippi Medicaid Provider Policy Manual: Mississippi law requires that Medicaid shall not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive. The only exceptions to this policy are: - Observed allergy to a component of the generic drug; or - An attributable adverse event; or - Drugs generally accepted as narrow therapeutic index (NTI) drugs. In the absence of a specific request for the brand name drug from the prescriber to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent. The prescriber must indicate the following on a written or faxed prescription: - Brand name medically necessary or - Dispense as written or - Do not substitute. Prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except NTI drugs. If a beneficiary requires a brand name multisource drug, the prescriber must request a prior authorization by seeking approval from DOM's Pharmacy Prior Authorization (PA) unit. The following medications are identified as NTI drugs: - Coumadin - Dilantin - Lanoxin

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	- Synthroid - Tegretol Please note that the Division of Medicaid does not have a state maximum allowable costs (MAC) program for multisource generic drugs; please refer to Westlaw system 20 So.3d 1236 (Miss. 2009). DOM does have a robust preferred drug list (PDL) with associated supplemental rebates. For some agents, the combination of Federal and supplemental rebates result in the branded agents being the least expensive to both the state and to the federal government. State law limits the adult non-institutionalized beneficiary to 6 drugs monthly of which no more than 2 may be branded - preferred brands do not count toward the two brand monthly prescription limit (effective 01/12/2012). There are some situations where a more expensive generic drug is co-preferred with the branded agent in order for beneficiary access.
Missouri	Effective for dates of service January 1, 2010 and beyond, the MO HealthNet Pharmacy Program began paying pharmacy providers a generic product preferred incentive fee. This program initiative will continue to emphasize the preference for generic utilization within the MO HealthNet pharmacy program by paying pharmacy providers an enhanced incentive fee. Effective April 1, 2017 the enhanced preferred generic product incentive fee increased from $4.00 to $5.00 for each eligible claim. Eligible generic products are identified as NDCs that have a First Data Bank Innovator Indicator of 0 and Generic Indicator of 1 (for Multi-Source Product). This enhanced preferred generic product incentive fee is paid in addition to the existing dispensing fee(s). The preferred generic product incentive fee is NOT applied to MORx coordination-of-benefit claims, but is applied to eligible generic Part D Excludable medications for dual eligible participants. All other third party coordination-of-benefit claims for eligible generic products that receive the existing dispensing fee(s), are eligible for the preferred generic product incentive fee. The preferred generic product incentive fee is applied to eligible claims for compounded generic prescriptions. The preferred generic incentive payment is structured to reimburse In-State pharmacies only. MO HealthNet does pay for a small number of brand name products which are listed as preferred under our preferred drug list edits. In these cases the net cost of the brand product, secondary to supplemental rebate is cheaper than the generic.
Montana	The Montana Medicaid Program prefers the use of generics except when the brand multisource drug is preferred and offers a better net cost over the generic. Pharmacy system edits drive the proper utilization of preferred brands and generics. Brand name drugs may be overridden when the prescriber personally writes that the brand medication is medically necessary on the face of the prescription and the pharmacy obtains a prior authorization.
Nebraska	PDL inclusion is based primarily on rebates. Therefore, most PDL medications are trade name products.
Nevada	NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand name; and d) is of the same generic type as the drug prescribed by brand name. If the

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	pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are available to him or her for substitution. Before a pharmacist dispenses a drug in substitution for a drug prescribed by brand name, the pharmacist shall: a) advise the person who presents the prescription that the pharmacist intends to dispense a drug in substitution; and b) advise the person that he or she may refuse to accept the drug that the pharmacist intends to dispense in substitution, unless the pharmacist is being paid for the drug by a governmental agency. If a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense the drug in substitution.
New Hampshire	New Hampshire law requires pharmacists to substitute an FDA A rated generic equivalent (AA, AN, AO, AP, AT or AB) listed in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) for a multi-source legend medication product. New Hampshire Medicaid policy requires a Prior Authorization for all multi-source legend medications unless: A. Patient must have experienced a therapeutic failure (inadequate response) to the A rated generic or the patient must have experienced an adverse reaction to the A rated generic OR B. In the prescriber's opinion, transition to another generic in the same therapeutic category would represent an unacceptable risk to the patient OR C. The patient has a documented allergy to one of the components of the generic (i.e. dye). If multiple generics are available, the patient must try another generic AND D. In accordance with FDA regulations, the prescriber must submit a MedWatch form to the FDA to verify a documented failure and/or adverse reaction on an A-B rated generic product. To further encourage generic utilization, New Hampshire Medicaid continues to enhance the maximum allowable cost (MAC) program. New Hampshire Medicaid participates in the National Medicaid Pooling Initiative (NMPI), a multi-state purchasing pool that allow states to aggregate their eligible lives thereby leveraging pharmaceutical purchasing power as a group to achieve more supplemental rebates than could be achieved on their own. By being part of this initiative, it lowers the net cost of brand drugs and the overall pharmacy spend through a competitive bidding process
New Jersey	The New Jersey Division of Medical Assistance and Health Services (DMAHS) implemented a Mandatory Generic Substitution Program on July 8, 2003. New Jersey FamilyCare/Medicaid fee-for-service payments for brand-name multi-source drugs require prior authorization, with exceptions for: - brand name drugs determined less costly than multi-source drugs; - the dispensing of a ten (10) days supply of the brand-name multi-source drug without prior authorization to allow the practitioner the opportunity to request prior authorization; and - Narrow Therapeutic Index (NTI) drugs, including: behavioral health meds, AIDS/HIV Drugs, anticonvulsants, digoxin, warfarin, cyclosporine, levothyroxine, theophylline and lithium carbonate.

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	On October 21, 2011, the New Jersey Drug Utilization Review Board reviewed and approved an updated State's Mandatory Generic Substitution Exempt List from 2003. Changes were as follows: + The atypical antipsychotics would now be referred to as Behavioral Health Drugs + Hormone replacement therapy drugs will no longer be exempt + Transplant or anti-rejection drugs will be exempt The Board also discussed the current national drug shortage and the impact of this on the ever present debate about generic versus brand name drug substitution.
New Mexico	New Mexico Medicaid works to ensure that whenever possible therapeutically equivalent generic drugs are used in place of more expensive brand name alternatives. Covered drugs are subject to generic-first coverage provisions. The recipient must first use one or more generic items available to treat a condition before the Medical Assistance Division (MAD) covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD or its designee, based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items. The generic-first provision does not apply to Indian Health Service (IHS) facilities and PL 93-638 operated hospitals and clinics. The following categories of drug items are exempt from the generic-first requirements: - Anti-asthmatic and other respiratory drugs - Anticoagulants - Anticonvulsants - Antipsychotics and antidepressants - Cancer chemotherapy items, and - Thyroid hormones - Oral birth control pills Some categories of drugs, brand names will not be covered. The following categories of drug items, only generic items will be covered: - Acne medications - Cough and cold medication
New York	New York State Medicaid administers a DISPENSE BRAND WHEN LESS EXPENSIVE THAT GENERIC (BLTG) program which promotes the use of certain multisource brand name drugs when the cost of the brand name is less expensive to the Medicaid Program than the generic equivalent. Branded drugs on the Preferred Drug List that are determined to be nonpreferred can be reimbursed provided the prescriber obtain a prior authorization. Prescribers also have the ability to request branded products over their generic counterpart by including the statement DISPENSE AS WRITTEN on the prescription.
North Carolina	Generic Substitution Policies NC Medicaid and Health Choice Outpatient Pharmacy Clinical Coverage Policy No: 9 Revised Date: January 13, 2020 5.8 Generic Substitution The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available is considered an order for the drug by its generic

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	name, except when the prescriber personally indicates in his or her own handwriting on the prescription order "medically necessary." Current Session Law states: "Dispensing of generic drugs. -- Notwithstanding G.S. 90-85.27 through G.S. 90- 85.31, or any other law to the contrary, under the Medical Assistance Program (Title XIX of the Social Security Act), and except as otherwise provided in this subsection for drugs listed in the narrow therapeutic index, a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber has determined, at the time the drug is prescribed, that the brand-name drug is medically necessary and has written on the prescription order the phrase "medically necessary." An initial prescription order for a Medicaid or NCHC beneficiary that is for a drug listed in the narrow therapeutic drug index that does not contain the phrase "medically necessary" shall be considered an order for the drug by its established or generic name, except that a pharmacy shall not substitute a generic or established name prescription drug for subsequent brand or trade name prescription orders of the same prescription drug without explicit oral or written approval of the prescriber given at the time the order is filled. Generic drugs shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand-name drugs. Notwithstanding this subdivision to the contrary, the Secretary of Health and Human Services may prevent substitution of a generic equivalent drug, including a generic equivalent that is on the state maximum allowable cost list, when the net cost to the State of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent. As used in this subsection, "brand name" means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and "established name" has the same meaning as in section 502(e)(3) of the Federal Food, Drug, and Cosmetic Act, as amended, 21 U.S.C. 352(e)(3). The selection of a drug product must not be more expensive than the brand or trade name originally written by the prescriber. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy, unless a specific brand or trade name is specified by the prescriber in the required manner or the net cost to the State of the brand-name drug has been determined to be less than the cost of the generic equivalent. NC Medicaid may use a certification form and procedures for "medically necessary" brand-name drugs. For audit purposes, the brand name and manufacturer must be documented on the prescription. The current list of eleven NTI drugs is reviewed on an annual basis and submitted to the Office of Administrative Hearings by the N.C. Board of Pharmacy for publication in the N.C. Register. (As published in the N.C. Register, Volume 23, Issue 17, March 2, 2009) 5.2 N.C. Medicaid and N.C. Health Choice PDL The N.C. General Assembly [Session Law 2009-451, Sections 10.66(a)-(d)] authorized the establishment of the N.C. Medicaid Preferred Drug List (PDL), which allows the Division of Medical Assistance to obtain better prices for covered outpatient drugs through supplemental rebates. All therapeutic drug classes for which the drug manufacturer provides a supplemental rebate under the Medicaid program are considered for inclusion on the list. B. Directions for Drug Reimbursement Reimbursement is determined using the cost per unit times the quantity dispensed plus the dispensing fee. Reimbursement is limited to the applicable price in effect on the date of service, not on the date of payment. Refer to Section B.4, Cost of the Drug.

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	B.1 Vaccines Vaccines must be billed using a professional claim with the appropriate CPT codes. Pharmacies shall use their NPI and proper taxonomy to bill vaccines. B.2 Dispensing Fee The dispensing fee for generic drugs or brand name drugs is added to the cost of the drug to equal the maximum allowed "Billed Amount" for each claim. The dispensing fee for generic drugs is based on a pharmacy's quarterly generic dispensing rate. Applicable dispensing fees are available in the State Plan, Attachment 4.19-B, Section 12, Page 1a, on NC Medicaid's website at https://medicaid.ncdhhs.gov/. The dispensing fee is automatically deducted from each repeated drug within the same calendar month. B.3 Definition of Repeat or Refill Drugs in the Same Month of Service The pharmacy program mandates that a dispensing fee, or professional fee, cannot be paid for repeats or refills of the same drug twice within the same calendar month; nor shall two prescriptions for the same drug be billed on the same day. The following defines what constitutes the same or different drug in the same month of service: a. A drug in which the active portion is different and is not generically equivalent to any other drug dispensed to the same beneficiary in the same calendar month shall be considered a different drug. Such as: Tetracycline, pilocarpine, and meprobamate are three different drugs. b. A different dosage form (liquid, tablet, suppository, injection, etc.) of the same drug constitutes a different drug. Such as: Phenergan tablets and suppositories are two different drugs. c. A different strength of the same drug constitutes a different drug. Such as: Mellaril 10 mg and 50 mg are two different drugs. d. A different chemical form of the same basic drug does not constitute a different drug if the dosage form and strength is the same. Such as: Tetracycline hydrochloride and tetracycline metaphosphate buffered are the same drug. e. A generic equivalent by different trade name does not constitute a different drug. Such as: Tetracycline by Geneva, tetracycline by Rugby, and Achromycin are all the same drug. B.4 Cost of Drug Cost data is currently being obtained from First Data Bank. The cost of the drug is calculated from the North Carolina Average Acquisition Cost (AAC); North Carolina shall base brand and generic drug ingredient pricing on an average acquisition cost (AAC). The AAC is defined as the price paid by pharmacies based on an average of actual acquisition costs determined by a survey of retail pharmacy providers. The National Average Drug Acquisition Cost (NADAC) pricing must be used for AAC when available and the lessor of NADAC or Usual and Customary & Reasonable Charges (UCR) determines the cost of the drug. If NADAC is unavailable, then the AAC is defined as Wholesale Acquisition Cost (WAC). If WAC is used then the lessor of WAC; the state MAC price; the hemophilia enhanced specialty discount, if applicable; or the UCR determines the cost of the drug. WACs are updated weekly via File Transfer Protocol (FTP) from First Data Bank. State MACs are updated monthly. 340B Provision as It Pertains to the Cost for the Drug 340B providers must submit the actual purchased drug price in the usual and customary charge field. Providers who maintain two separate inventories--one for the 340B beneficiaries and a

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	purchased inventory for non-340B beneficiaries--may not dispense a 340B-purchased drug and bill Medicaid or NCHC the calculated Medicaid price for non-340B beneficiaries. B.5 State Maximum Allowable Cost List The state MAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers. The State's MAC reimbursement is based on the application of a percentage factor applied to the lowest priced generic. In cases where the calculated MAC rate, based on the primary percentage factor, results in a price less than the cost of the second lowest generic product, at least an additional 10 percent margin is added to the cost of the second-lowest drug to establish the MAC price. The MAC pricing factor is set by NC Medicaid and may change as deemed appropriate. The additional margin is variable due to the wide range of differences in cost from product to product. The SMAC list is posted on the NC Medicaid website, https://medicaid.ncdhhs.gov/. For established generic drugs with only one supplier, the MAC price is established between the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, MAC pricing is substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product. Drugs subjected to MAC pricing must be in adequate supply. Drug shortage information is verified through national pharmacy websites as well as through information provided by national drug wholesalers. Due to the many variations in the ingredients in prenatal vitamins and the corresponding variation in the ingredient cost, a single MAC rate for prenatal vitamins is established and maintained. Current marketplace acquisition cost, average wholesale price and wholesale acquisition cost are evaluated to determine the single MAC rate. There were 163 Preferred Brands (at the GSN level) with Non-Preferred Generics on the Preferred Drug List (PDL) as of September 25, 2020 (brand use required unless prior approval for generic).
North Dakota	North Dakota Medicaid mandates generic substitution of therapeutically equivalent drugs when there is federal upper limit (FUL) or state maximum allowable cost (MAC) pricing on the drug. If the doctor insists that brand name be dispensed, he/she must write "Brand Necessary" on the face of the prescription in his/her own handwriting. Starting April 13, 2005, ND Medicaid requires Prior Authorization for "Brand Necessary" prescriptions and will only pay for the brand when a trial and failure of a generic has occurred. The North Dakota Medicaid program also encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. North Dakota Medicaid also requires brand name products in some situations where the costs net of rebate justify such preference. North Dakota Medicaid has room to do this as our MAC program gives us room on the 'in the aggregate' calculation for compliance with FUL requirements. Some of the brands that are preferred can be higher volume products which can impact generic percentage calculations by a fair amount and increase the total reimbursement amount significantly. The specific products can vary, but some examples include Adderall XR and Concerta, both high volume, high dollar ADHD medications.
Ohio	To assist with generic utilization, ODM has set $0 copays on generic medications, $2 copays on selected brand name medications, and $3 copays on any medication requiring prior authorization. If there is a drug shortage or availability issue on a generic medication, ODM may temporarily cover the brand name medication until the generic is available again.

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	Due to COVID-19, ODM has enacted several changes to allow greater access to pharmacotherapy that may have affected the generic utilization rates including lifting prior authorizations on certain medications, extending prior authorizations by 6 months on certain medications, allowing refills too soon, in some cases, and waiving copays.
Oklahoma	OHCA requires the use of generic drugs when available. Dispensing a branded medication that is available generically requires a brand override prior authorization. Approval of a brand override request requires a documented clinically significant reason to dispense the branded product. Exceptions are made to this rule for select drugs with a narrow therapeutic index or for those branded agents that are preferred over the generic due to net cost. Adult members who do not reside in long-term care facilities are limited to two brand medications per month with limited exceptions. Generic medications typically occupy the first tier in Product Based Prior Authorization categories and are commonly available without prior authorization.
Oregon	By Administrative rule OAR 410-121-0030 (5)(a)&(b) pharmacy providers dispense prescriptions in generic form unless requested by practitioner request otherwise pursuant to OAR 410-121-0155 and/or OAR 410-121-0040. Providers shall obtain prior authorization (PA) for the brand drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060. If the cost of the brand name drug, after receiving discounted process and rebates, is equal to or less that the cost of the generic version of the drug, then the Division may prefer the brand product over the generic after notifying pharmacies of the policy change. Mental health drugs are carved out of CCO budgets and are reimbursed directly by FFS. Because mental health drug utilization is very strongly skewed toward generics, the overall FFS generic percentage is also skewed more toward generics than the percentages reported by CCOs.
Pennsylvania	PURPOSE: The purpose of this bulletin is to inform pharmacies and licensed prescribers enrolled in the Medical Assistance (MA) Program that effective July 18, 1994, the Department will require prior authorization on all multisource brand name drugs identified by the Department as having equivalent generic drug products available for substitution. SCOPE: This bulletin applies to pharmacies and licensed prescribers enrolled in the Medical Assistance Program. BACKGROUND: In January 1993, the Department adopted certain modifications to the scope of medical benefits available to persons who are eligible for Medical Assistance. Those modifications were challenged by Medical Assistance eligible clients as being in violation of their rights under federal and state law. The name of this class action litigation was Felix, et al. v Casey, et al., C.A. No. 92-CV-7376 (E.D., Pa.). Under the terms of a Stipulation of Settlement that was negotiated to resolve this litigation, the Department agreed to rescind certain modifications and the plaintiffs agreed to accept certain modifications and agreed as well to the

State	Generic Drug Substitution Policies
	Department's requiring all Medical Assistance recipients to obtain prior authorization with respect to all brand name drugs for which there are generic equivalents but limited to drugs listed in the FDA approved "A" list and also not precluded by state law. The Department will also require prior authorization to override the drug cost limit for any drug subject to a State MAC. The Department currently uses the full average wholesale price (AWP) to compute the maximum payment amount for all multisource brand name products prescribed for eligible medical assistance recipients unless the drug cost is limited by the State Maximum Allowable Cost (MAC). The Department also uses the full AWP for a brand name multisource drug subject to State MAC when the phrase "Brand Necessary" or "Brand Medically Necessary" appears on the prescription in the prescriber's own handwriting and the pharmacist indicates on the claim form or with the electronic transmission that the prescriber specified the brand name drug is medically necessary. DISCUSSION: The Department will require prior authorization on those multisource brand name drugs that have "A" rated generics available for substitution as a condition for payment through the Medical Assistance Program. The Department will also require prior authorization as the override mechanism to pay the brand name rate for any State MAC drug. The prior authorization requirement will become effective beginning with claims submitted on or after a date of service of July 18, 1994. The Department will issue a periodic list of those brand name drugs which require prior authorization to all pharmacies and licensed prescribers enrolled in the Medical Assistance Program. All brand name drugs on the Medical Assistance Program's list will be treated as noncovered services. Therefore, the Department will not provide any payment for a multisource legend brand name product which can be filled with an "A" rated generic unless the prescriber receives approval from the Medical Assistance Program to do so. The Department will provide payment for those nonlegend multisource products having a State MAC up to the amount of the State MAC price. The full AWP will apply if prior authorization is requested by the prescriber and approved by the Department. Furthermore, if the prescriber does not receive approval for the brand name product but the recipient prefers the brand name product or the prescriber still does not permit substitution, the recipient will have to purchase the product at his or her own expense. The Department will issue Prior Authorization if the prescriber is able to provide documentation to the Department that the individual patient is in danger of an adverse reaction from the use of the generic equivalent drug and that use of the prescribed brand name drug would eliminate the danger of the adverse reaction. The prescriber will be required to maintain this documentation in the individual patient's medical file and be able to provide it to the Department in writing upon request. POLICY Effective July 18, 1994, the Department will apply 55 Pa. Code Chapter 1121 as follows:

State	Generic Drug Substitution Policies
	Section 1121.52 Payment conditions for various services. (a) Medical Assistance prescriptions, including those for recipients in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded, which have been either written or verbally ordered by a licensed prescriber, shall contain on the prescription form: * * * * * 6. The indication for "brand medically necessary" and the prior authorization number, when applicable, as specified in Section 1121.53(b) (relating to limitations on payment). * * * * * (b) The following services requires prior authorization as specified in Section 1101.67 (relating to prior authorization): (1) Multisource brand name products identified by the Department as having therapeutically equivalent "A" rated generic products available for substitution. (2) Multisource brand name products that are subject to a State MAC. * * * * * Section 1121.53 Limitations on payment. * * * * * (b) The Department establishes a maximum allowable cost (MAC) Program which sets a limit on the drug cost portion of the reimbursement formula on selected multisource drugs. The Department will send periodic notices to pharmacies listing the drug entities subject to the State MAC. The State MAC does not apply if either of the following exists: (1) The licensed prescriber does all of the following: (i) Certifies a specified brand is medically necessary by writing on the prescription for "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting. (ii) Receives a prior authorization from the Department to use the brand name product and indicates the prior authorization number on the prescription form. (2) In the case of a telephone prescription, the licensed prescriber sends a properly completed prescription, as described in paragraph (1), to the pharmacy within 15 days of the date of service. * * * * *

State	Generic Drug Substitution Policies
	Section 1121.54. Noncompensable services and items. Payment will not be made to a pharmacy for the following services and items: * * * * * (26) Multisource legend brand name products, identified by the Department as having therapeutically equivalent "A" rated generic products available for substitution, except when the licensed prescriber receives prior authorization from the Department certifying that the particular brand name product is medically necessary for a specific recipient and indicates the prior authorization number on the prescription form. The Department will issue a periodic list of those brand name products which will require prior authorization. * * * * * PROCEDURE 1. The Department issued Medical Assistance Bulletins 01-94-15, 03-94-03, and 04-94-04 to prescribers listing the multisource brand name drugs which will require prior authorization and instructions for requesting prior authorization for these drugs. The Department issued Medical Assistance Bulletin 19-94-10 to pharmacies listing the multisource brand name drugs which will require prior authorization and instructions for submitting claims for payment of these drugs.
Rhode Island	The following impact the generic utilization percentage for the State of Rhode Island. A pharmacist may substitute drugs containing all the same active chemical ingredients of the same strength, quantity, and dosage form as the drug requested by the prescriber. The director shall permit substitution of less expensive generic, chemical, or brand name drugs and pharmaceuticals considered by the director as therapeutically equivalent and interchangeable with specific brand name drugs and pharmaceuticals. 21-31-16.1 Substitution of generic drugs. (a) Product selection. The director shall permit substitution of less expensive generic, chemical, or brand name drugs and pharmaceuticals considered by the director as therapeutically equivalent and interchangeable with specific brand name drugs and pharmaceuticals, if they are found to be in compliance with 21-31-16 and standards set forth by the United States Food and Drug Administration under 505 and 507 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355 and 357. The director shall consider, but not be limited to, the determination of the United States Food and Drug Administration, or its successor agency, as published under 505 and 507 of the Federal Food, Drug, and Cosmetic Act. The director shall provide for the distribution of copies of lists of prescription drug products that the director deems after evaluation not to be therapeutically equivalent, and revisions to the lists, among physicians and pharmacists licensed and actively engaged in practice within the state, and other appropriate individuals, and shall supply a copy to any person on request. The list shall be revised from time to time so as to include new

State	Generic Drug Substitution Policies
	pertinent information on approved prescription drug products, reflecting current information as to standards for quality, safety, effectiveness, and therapeutic equivalence. Rhode Island implemented a Preferred Drug List (PDL) which encourages the use of generic medications by requiring a prior authorization for most brand name drug products in the therapeutic classes that are managed by the PDL. Rhode Island implemented a State Maximum Allowable Cost (SMAC) list for generic drugs and brands that have a generic equivalent when there are three or more manufacturers of the product.
South Carolina	Medicaid does not routinely cover brand name products for which there are therapeutically equivalent, less costly generics available except for the following brand name products (traditionally categorized as Narrow Therapeutic Index [NTI] drugs): digoxin, warfarin, theophylline (controlled release), levothyroxine, pancrelipase, phenytoin and carbamazepine. In addition, continuity of care (beneficiary moves from MCO to FFS) where established on a Brand/clinical rationale.
South Dakota	Brand drugs with an available generic are priced at MAC. Brand necessary claims require PA.
Tennessee	TennCare's primary tool to drive generic utilization is a benefit design that limits adult recipients to two brand prescription fills per month. Under this benefit design, recipients are charged a $1.50 copayment for generic prescriptions and $3.00 for brand prescriptions. Generic utilization is also attributable to drug status on the TennCare Preferred Drug List. TennCare places most multi-source brand products in the non-preferred status. Furthermore, TennCare's point of sale system is configured to not accept Dispense as Written (DAW) -1 or -2 claims. When a multi-source brand is clinically necessary, the prescriber must submit a prior authorization request. In addition to the TennCare initiatives, the State of Tennessee has mandatory generic substitution legislation in place that complements TennCare's requirements. Tennessee law requires pharmacists to substitute and dispense US Food and Drug Administration (FDA)-approved generic equivalent when presented with a prescription for a brand name drug, unless otherwise instructed by the patient or prescribing practitioner. The prescriber may direct the pharmacist to forego the substitution regulation and dispense brand name medications. Under Tennessee regulations, the prescriber must write: Brand name medically necessary, dispense as written medically necessary brand name no generic; or, any abbreviation of this language when a generic product is available and the prescriber wishes the brand name product to be dispensed. The patient may direct the pharmacist to forego the substitution regulation and dispense brand name medications orally under the circumstance the patient is individually paying the entire cost of the prescription at the time of dispensing and objects to any substitution (Tenn. Code Ann. 53-10-205).
Texas	1. Texas Government Code Sec 531.303, Generic Equivalent Authorized, requires that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, the dispensing pharmacies may select a generic equivalent of the prescribed drug. However, if a brand name drug is preferred on Texas formulary, the pharmacy does not have to ask for prescriber to certify medically necessary. In this case Texas Medicaid reimburses pharmacy for the brand name product without requiring a PDL prior authorization. 2. The single formulary and PDL is still in effect in Texas. Medicaid outpatient drug formulary includes covered generic drugs. The factors that may potentially affect our generic utilization percentage include the PDL decisions within a therapeutic class. The MCOs are required to cover the same preferred brands as the FFS.

State	Generic Drug Substitution Policies
Utah	As a result of the Pharmacy Practice Act, Medicaid has placed all name brand products on prior approval if a generic is available, except when allowed rebates bring the cost of the brand name products lower than generic.
Vermont	Vermont is a mandatory generic state as outlined in the Vermont statues below: Pharmacies must dispense generics unless the prescriber expressly requires the brand. The Vermont Statutes Title 18: Health Chapter 91: PRESCRIPTION DRUG COST CONTAINMENT 18 V.S.A. 4605. Alternative drug or biological selection (a)(1) When a pharmacist receives a prescription for a drug that is listed either by generic name or brand name in the most recent edition of or supplement to the U.S. Department of Health and Human Services' publication Approved Drug Products With Therapeutic Equivalence Evaluations (the Orange Book) of approved drug products, the pharmacist shall select the lowest priced drug from the list which is equivalent as defined by the Orange Book, unless otherwise instructed by the prescriber, or by the purchaser if the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher-priced drug. (2) When a pharmacist receives a prescription for a biological product, the pharmacist shall select the lowest-priced interchangeable biological product unless otherwise instructed by the prescriber, or by the purchaser if the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher priced biological product. (3) Notwithstanding subdivisions (1) and (2) of this subsection, when a pharmacist receives a prescription from a Medicaid beneficiary, the pharmacist shall select the preferred brand-name or generic drug or biological product from the Department of Vermont Health Access's preferred drug list. (b) The purchaser shall be informed by the pharmacist or his or her representative that an alternative selection as provided under subsection (a) of this section will be made unless the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher-priced drug or biological product. (c) When refilling a prescription, pharmacists shall receive the consent of the prescriber to dispense a drug or biological product different from that originally dispensed, and shall inform the purchaser that a substitution shall be made pursuant to this section unless the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher-priced drug or biological product. (d) Any pharmacist substituting a generically equivalent drug or interchangeable biological product shall charge no more than the usual and customary retail price for that selected drug or biological product. This charge shall not exceed the usual and customary retail price for the prescribed brand. (e)(1) Except as described in subdivision (4) of this subsection, within five business days following the dispensing of a biological product, the dispensing pharmacist or designee shall communicate the specific biological product provided to the patient, including the biological

State	Generic Drug Substitution Policies
	product's name and manufacturer, by submitting the information in a format that is accessible to the prescriber electronically through one of the following: (A) an interoperable electronic medical records system; (B) an electronic prescribing technology; (C) a pharmacy benefit management system; or (D) a pharmacy record. (2) Entry into an electronic records system as described in subdivision (1) of this subsection shall be presumed to provide notice to the prescriber. (3)(A) If a pharmacy does not have access to one VT Medicaid PDL Management of Generic Drugs PDL Categories: Preferred Drugs: Whenever possible, preferred drugs in a category will be generic. Clinical criteria for branded products will generally include a step through a generic product when available (generic first). The DUR Board heavily promotes the use of generics in general and directly through identified classes in the PDL by means of automated step therapies and/or prior authorizations. New generic entries: When a new generic product becomes available within a PDL-managed therapeutic category, DVHA manages the addition of such generic product to the PDL without formal evaluation by the DUR Board, once the pricing of that product warrants PDL inclusion. Movement of such generic products to preferred status would be limited to AB-rated (bioequivalent) drug products where there exists no significant evidence of increased safety risk or diminished efficacy as compared to alternative PDL options. Additionally, per positive vote of the OVHA DUR Board on May 9, 2006, OVHA reserves the right to restrict coverage of a new generic entity if the net pricing of its branded alternative remains lower to the State. Such coverage restrictions will remain in place until the time when generic pricing falls to a level representative of greater cost savings to the State versus the branded alternative. This policy negatively affects the overall generic dispensing rate but reduces net spend for the state. Maximum Allowable Cost (MAC) List: DVHA employs a MAC list provided by their PBM contractor, Change HealthCare. A drug is considered for inclusion in the MAC list when a combination of the following conditions is met: The drug must be a multi-source product (available from more than one source) per the Medi-Span multi-source drug indicator (an industry standard metric that indicates that a drug is available from more than one source/manufacturer) and/or the drug has a generic equivalent. The availability and the number of A-rated generic equivalent products using the Medi-Span Orange Book Code is considered. This criterion is designed to discourage inappropriate generic substitution for brand products with low therapeutic indices. Drugs that are widely available on the market as a generic formulation from multiple manufacturers without shortages are considered eligible for inclusion. Finally, the utilization of the generic product in the DVHA population is considered if a highly utilized generic drug is not present on the MAC list per the previously defined & systematically discovered criteria, the clinical team will manually review the characteristics of that drug and make a decision regarding its eligibility for inclusion on the list.

State	Generic Drug Substitution Policies
	Methodology is employed by the contractor to ensure that the reimbursement pharmacies receive will allow them to procure the products and achieve a reasonable return within the MAC pricing schema. In order to operate at maximum efficacy, MAC lists are updated on monthly basis. This ensures the most correct pricing at any given moment and secures provider cooperation and satisfaction. Pricing data received from Medi-Span is updated weekly, while additional acquisition pricing is updated quarterly at a minimum. Once per quarter, MAC pricing files are completely refreshed. Generic market conditions are dynamic (e.g., drug shortages causing inflation of acquisition prices for drugs) and so there are a number of processes to capture price change information and the capability to update MAC pricing within one business day. To promote generic utilization, it is important that pharmacy providers are satisfied with the DVHA MAC pricing. When a discrepancy is reported by a pharmacy provider, a formal pricing dispute process is initiated. Pharmacies file a Pricing Dispute form located on the DVHA website, and the drug/strength/dosage form, current MAC price, and detailed pricing issue is recorded. This information is forwarded to the Clinical and MAC Team who verify/validate the MAC price against current acquisition pricing through research and application of the algorithm logic. Investigation into the availability of the drug is conducted. A final disposition is made and the provider is contacted per statutory requirement with an explanation of findings.
Virginia	The Virginia Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: %u2022Brand medically necessary edit: This edit requires that physicians indicate that a multi-source brand drug is required for their patient. This edit is based on the DMAS-specific definition of brand and generic drugs. The drug ingredient cost reimbursement shall be the lowest of: (1) The national average drug acquisition cost (NADAC) of the drug, the federal upper limit (FUL), or the provider's usual and customary (U&C) charge to the public as identified by the claim charge; or (2) When no NADAC is available, DMAS shall reimburse at the lowest of the wholesale acquisition cost plus 0%, the FUL, or the provider's U&C charge to the public as identified by the claim charge. Based on the Virginia Medicaid definition of their brand versus generic pricing, the average rate of generic utilization is eighty-seven percent (87%) for FFY 2020. %u2022Preferred Drug List (PDL): The PDL drives market shift to the generic drugs when the pricing is less than the brand pricing net of CMS and supplemental rebates. The patents of the original brand drugs in many of the therapeutic classes have expired. These older drugs have been replaced with several generic versions. %u2022Tiered copays for brand/generic drugs: Virginia Medicaid requires $1 copayment for each generic drug dispensed, and a $3 copayment for each brand name drug dispensed, in general, for Medicaid beneficiaries age 21 years and older. CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug. These sourcing status indicators are identified as follows: %u2022Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market.

State	Generic Drug Substitution Policies
	%u2022Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market. %u2022Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity. Utilizing these indicators to determine generic utilization will allow for consistent reporting across all states. Based on calculations using these indicators, Virginia Medicaid has a generic utilization of 87% for all outpatient claims comprising 23% of total drug expenditures for FFY 2020.
Washington	Washington Apple Health (Medicaid) utilizes various strategies to increase and maintain generic utilization rates. The following strategies employed could affect Washington State Medicaid's generic utilization percentage: - Coverage of less costly generic over-the-counter (OTC) products Washington Apple Health (Medicaid) covers many OTC products in various drug classes as less costly alternatives to prescription medications. - Standard generic substitution Washington Apple Health (Medicaid) follows generic substitution rules as authorized under State law. All prescriptions of any format (written, oral, electronic, out of state) must indicate whether generic substitution is permitted or if the prescription must be 'Dispense as written' - Prior authorization requirements and clinical policies Under the Washington Administrative Code 182-530-3100, Washington Apple Health (Medicaid) may require prior authorization on covered outpatient drugs for medical necessity. Drugs approved by the FDA are evaluated by the agency's clinical team based on quality evidence contained in compendia of drug information and peer-reviewed medical literature. The information evaluated includes but is not limited to evidence for efficacy and safety, cost comparisons of drugs with similar existing drugs, potential for misuse and abuse, drugs with a narrow therapeutic index, and cost and outcome data demonstrating the cost effectiveness of the drug. Clinical policies are created by Washington State Medicaid staff, which may include step-through less costly generic drugs with the same indication first before another drug product may be authorized . - Use of single PDL and PDL selection process Drugs listed on the Apple Health Preferred Drug List (AHPDL) reflect all pharmacy point-of-sale drugs covered under Washington State Medicaid. The AHPDL is used by both Fee-for-Service and Managed Care Organizations (MCOs) and governs those organizations to use brand and generic drugs that are preferred or non-preferred. The PDL selection process takes into account product-by-product comparisons based on quality evidence reviews, utilization trends, market price, and if applicable, supplemental rebate offers. The drugs selected for preferred status represent the drug products which are least costly to the State and typically consist of generic drugs. All non-preferred products require a trial of two preferred products with the same indication before a non-preferred drug will be authorized unless contraindicated, not clinically appropriate, or only one product is preferred.

State	Generic Drug Substitution Policies
	- Therapeutic Interchange Program Under the Revised Code of Washington 69.41.190 and 70.14.050, State laws allow for substitution of a therapeutically equivalent drug that is not the generic active ingredient of the prescribed drug. Certain drug products that have been reviewed by the Washington Pharmacy and Therapeutics Committee can be interchanged for a different drug that is therapeutically equivalent (e.g: substituting one ACE inhibitor for another). This allows pharmacists a broader range of potential substitution for products that may not have a generic equivalent but may have a therapeutic equivalent with a different active ingredient. The therapeutic interchange program impacts classes on both the Washington PDL and AHPDL. - State Maximum Allowable costs Washington State applies state maximum allowable costs (MAC) as a pricing strategy to help ensure that only the least costly generic options available fall within established reimbursement rates. These MAC rates incentivize pharmacies to stock those least costly generic versions for which they pay less than the reimbursement rate provided by Medicaid.
West Virginia	West Virginia State Law requires the substitution of a generic drug whenever an AB rated agent is available. West Virginia Medicaid does not pay for brand name agents unless they are on the PDL and priced as a generic drug unless the prescriber writes Brand Medically Necessary on the prescription in his own handwriting. The prescriber is also required to fill out a Med Watch if he/she states that the generic is not as effective as the brand name formulation. WV Medicaid pays a flat dispensing fee of $10.49 for both brand and generic drugs. An aggressive State Maximum Allowable Cost (SMAC) Program further encourages the use of generics agents.
Wisconsin	Wisconsin Medicaid utilizes numerous policies to encourage the use of therapeutically equivalent generic drugs: 1. The Brand Medically Necessary (BMN) policy requires providers to prescribe generic equivalents to brand products when there is a cost effective generic available. The prescriber is required to document why it is medically necessary for the member to receive the brand name drug on the PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment). Criteria for approval of a PA request for a brand name drug include the following: - At least 30 consecutive days of BMN drug use and had a measurable therapeutic response. - Documentation of how the BMN drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction. - The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the generic equivalent drug from at least two different manufacturers. 2. The Brand Before Generic (BBG) policy requires providers to prescribe brand named products over generic equivalents when the brand name product is more cost effective to Wisconsin Medicaid. Criteria for approval of a PA for a generic drug that requires BBG PA include: - At least 30 consecutive days of generic drug use and had a measurable therapeutic response. - The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the brand equivalent drug.

State	Generic Drug Substitution Policies
	3. Wisconsin Medicaid implemented three month supply program on January 20, 2010. Dispensing a three-month supply of drugs was implemented to streamline the prescription filling process for pharmacy providers, encourage the use of generic, maintenance drugs when medically appropriate for a members, and result in savings to ForwardHealth programs. The three month supply program includes certain drugs that are required to be dispensed in a three month supply and other drugs that may be dispensed in a three month supply. Pharmacy providers may contact a specialized call center staffed by certified pharmacy technicians to request an override for drugs required to be dispensed in a three month supply. Examples of when a request override to dispense less than a three-month supply may be approved include, but are not limited to, the following: - The member's primary insurance does not allow a three-month supply. - The prescriber or pharmacist is concerned about dispensing a three-month supply to a member. Due to the public health emergency, the three-month supply policy has been significantly expanded on a temporary basis.
Wyoming	On 11/1/05, the Wyoming Medicaid program mandated generic substitution by implementing a generic mandatory policy. This policy requires a prior authorization for any brand name medication for which there are two or more A-rated generic equivalents available. Clients may receive the brand name following trial and failure of a generic equivalent in the specific class of drugs, or with a documented adverse effect caused by the generic formulation. Copays are lower for generic medications at $0.65 per prescription vs. $3.65 per prescription for brand-name medications. In addition, the Wyoming Medicaid Pharmacy Program encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. Federal and State MAC lists for pricing also help to enforce generic substitution.

2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?

Figure 43 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

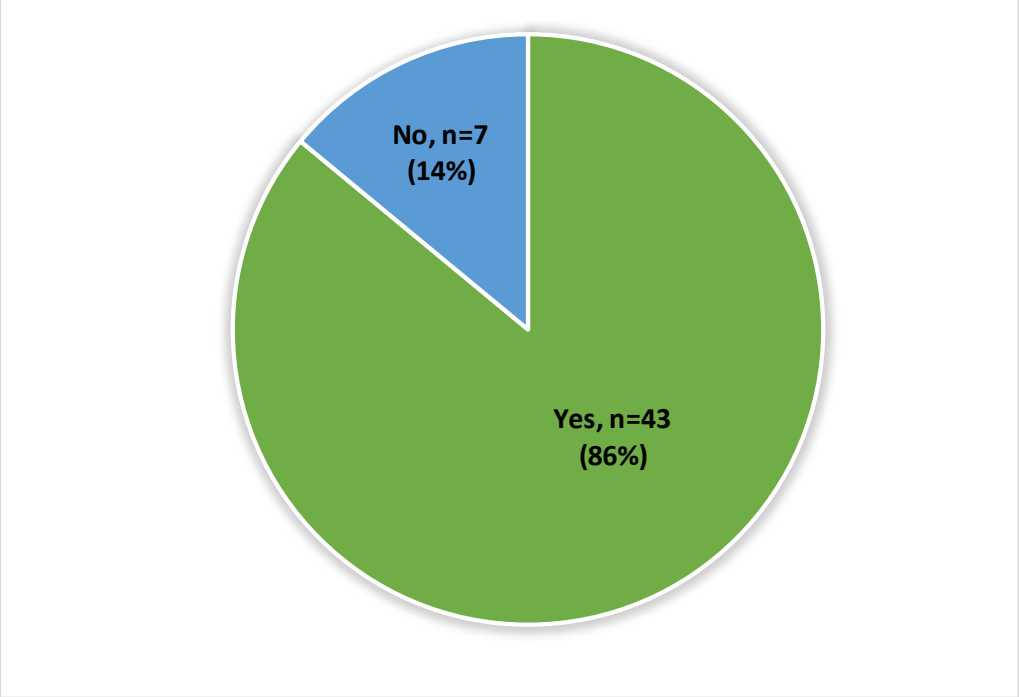

Table 64 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	43	86.00%
No	Alabama, Florida, Hawaii, Louisiana, New Mexico, Rhode Island, Virginia	7	14.00%
Total		50	100.00%

If "Yes," please continue.

Figure 44 - Additional Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

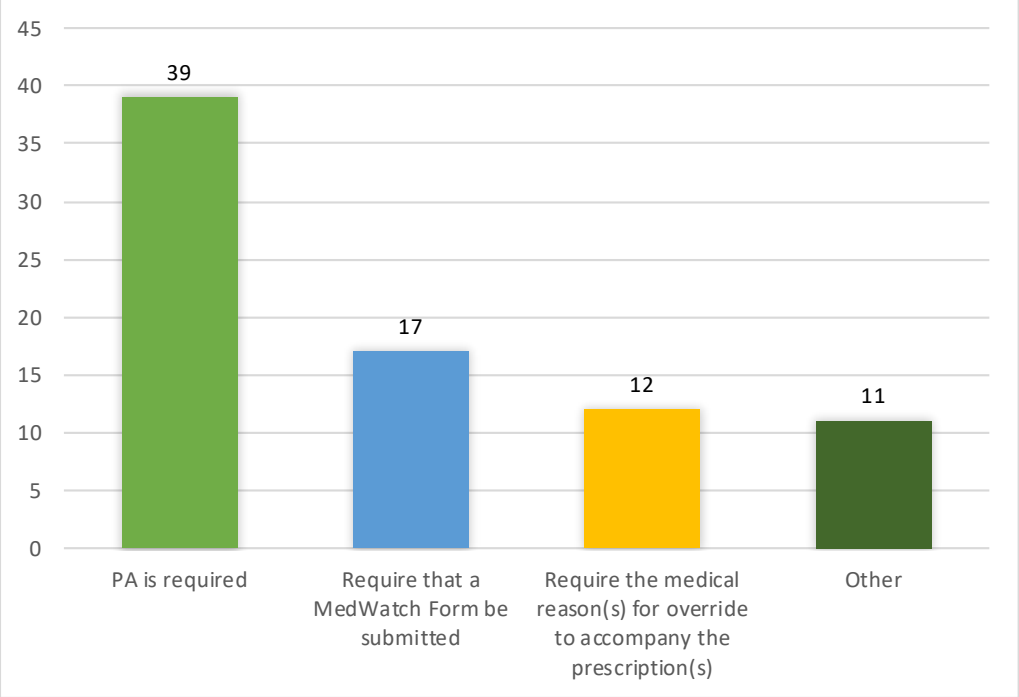

Table 65 - Additional Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States	Count	Percentage
PA is required	Alaska, Arkansas, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	39	49.37%
Require that a MedWatch Form be submitted	Alaska, Arkansas, Connecticut, Delaware, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Mississippi, Nevada, North Dakota, South Carolina, Tennessee, West Virginia, Wyoming	17	21.52%
Require the medical reason(s) for override to accompany the prescription(s)	Delaware, District of Columbia, Idaho, Mississippi, Missouri, Montana, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, West Virginia	12	15.19%
Other	California, Colorado, Connecticut, Delaware, Idaho, Michigan, Nebraska, Nevada, North Carolina, Texas, Wisconsin	11	13.92%
Total		79	100.00%

If "Other," please explain.

Table 66 – "Other" Explanations for Additional Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

State	"Other" Explanations
California	If a brand name drug does not appear on the Medi-Cal List of Contract Drugs, an approved Treatment Authorization Request demonstrating medical necessity may be required before dispensing.
Colorado	Prescriptions for multisource innovator medications may require prior authorization with prescriber attestation that (1) transition to the generic equivalent of the brand name product would be unacceptably disruptive to the member's stabilized drug regimen, or (2) that the member is unable to continue treatment with the generic, as determined by the prescriber, following initial treatment.
Connecticut	A BMN PA is required unless the brand name drug is on the PDL. A DAW-1 submitted on electronic prescriptions is acceptable.
Delaware	A Medwatch form is used to determine the reason why a brand name drug is required
Idaho	Must fail two seperate (different) manufacturer products
Michigan	Select drug classes determined by the State Legislature are exempt from prior authorization.
Nebraska	Prescriber must complete a form MC-6, which declares that the brand name medication is medically necessary.
Nevada	Trial/Failure of two generics (if available)
North Carolina	Several drug classes on the Preferred Drug List have brand name drugs as non-preferred, thus requiring the try and failure of preferred drugs before using these non-preferred brands.
Texas	For brand name drugs designated as preferred, the prescriber does not have to certify "Brand Necessary" on the prescription.
Wisconsin	Wisconsin has identified select drugs that do not require a prior authorization (i.e., anticonvulsants, thyroid replacement drugs).

Generic Drug Utilization Data (to be utilized for completion of question 3 and 4 below)

Computation Instructions

KEY

Single Source (S) – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.

Non-Innovator Multiple-Source (N) – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market

Innovator Multiple-Source (I) – Drugs which have an NDA and no longer have patent exclusivity.

1. **Generic Utilization Percentage:** To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

$$N \div (S + N + I) \times 100 = \text{Generic Utilization Percentage}$$

2. **Generic Expenditures:** To determine the generic expenditure percentage (rounded to the nearest $1000) for all covered outpatient drugs for this reporting period use the following formula:

$$\$N \div (\$S + \$N + \$I) \times 100 = \text{Generic Expenditure Percentage}$$

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found at Medicaid.gov (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr. 2020 Excel file).

Please provide the following utilization data for this DUR reporting period for all covered outpatient drugs paid. Exclude Third Party Liability.

Generic Drug Utilization Data

Figure 45 – Single Source (S) Drugs Total Number of Claims by State

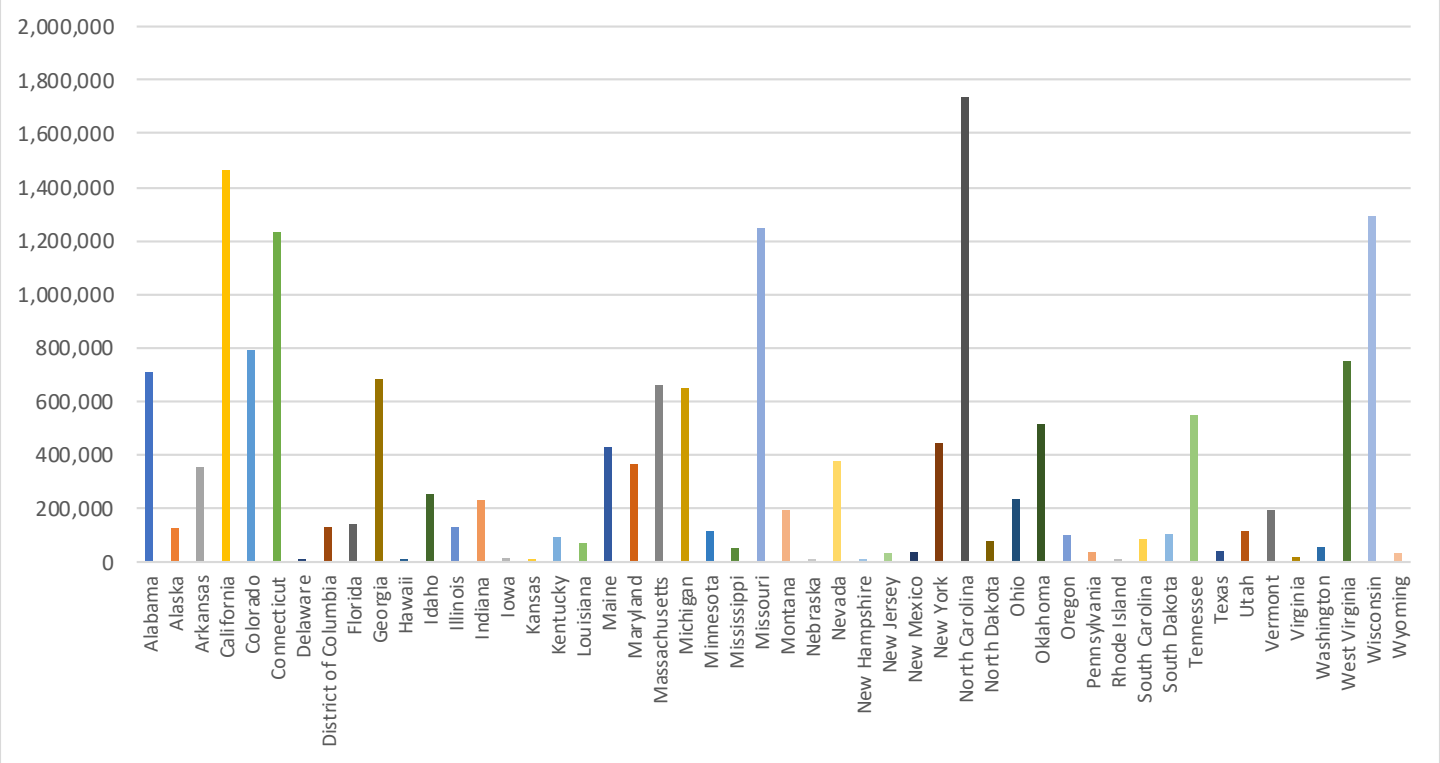

Figure 46 – Non-Innovator Source (N) Drugs Total Number of Claims by State

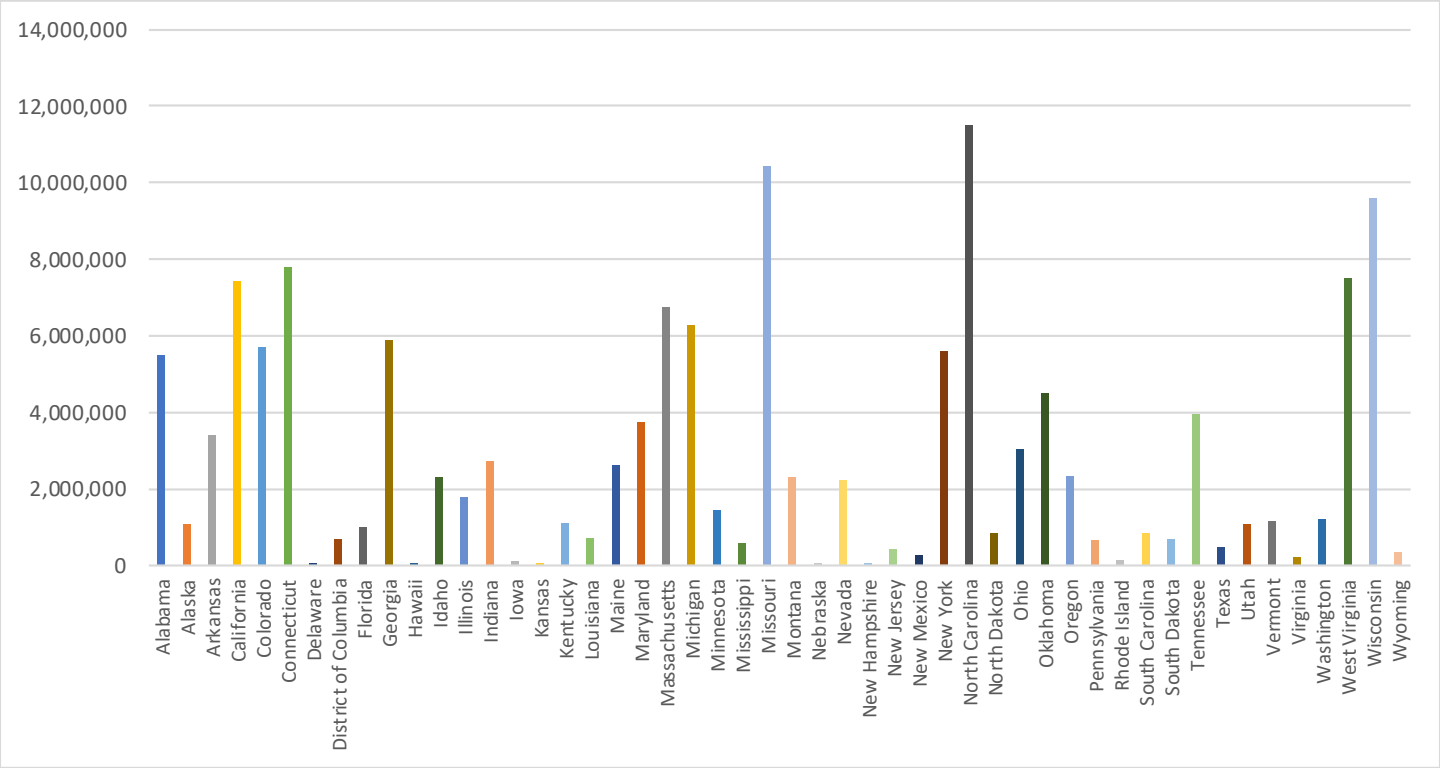

Figure 47 – Innovator Multi-Source (I) Drugs Total Number of Claims by State

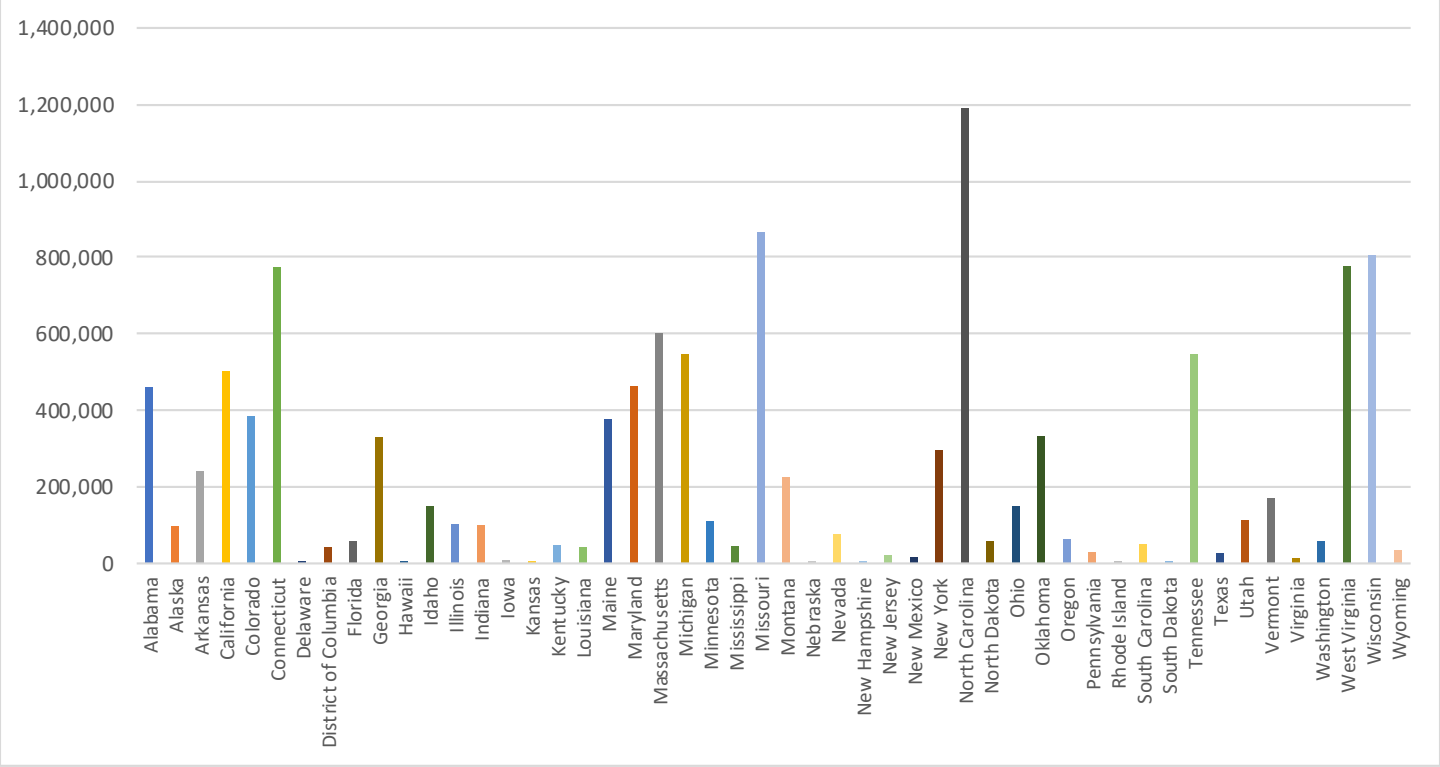

Table 67 – Drug Utilization Number of Claims by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	709,744	5,514,077	460,924
Alaska	126,956	1,087,588	96,455
Arkansas	352,132	3,408,340	241,000
California	1,461,004	7,440,599	503,245
Colorado	790,685	5,709,729	384,445
Connecticut	1,231,992	7,813,032	774,450
Delaware	10,127	74,590	5,362
District of Columbia	129,227	681,567	43,934
Florida	141,896	999,862	57,566
Georgia	682,098	5,898,335	331,530
Hawaii	103	4,630	75
Idaho	252,901	2,316,082	150,627
Illinois	129,080	1,799,765	103,321
Indiana	229,602	2,721,960	101,559
Iowa	12,388	117,317	9,465
Kansas	1,593	28,864	871
Kentucky	90,844	1,114,472	47,093
Louisiana	70,299	705,262	43,534
Maine	428,600	2,616,788	378,472
Maryland	365,160	3,750,705	464,579
Massachusetts	660,416	6,748,635	601,973
Michigan	646,676	6,290,583	548,429
Minnesota	113,711	1,447,061	111,303
Mississippi	51,601	577,204	44,166
Missouri	1,247,448	10,434,306	867,573
Montana	192,514	2,320,148	224,541
Nebraska	367	5,604	286
Nevada	376,444	2,238,853	75,619
New Hampshire	1,263	10,281	672
New Jersey	33,487	427,558	21,801
New Mexico	35,523	273,640	17,812
New York	441,924	5,610,005	297,557
North Carolina	1,735,446	11,527,375	1,189,933
North Dakota	78,477	856,591	57,666
Ohio	235,093	3,053,560	150,954
Oklahoma	512,641	4,496,426	333,275
Oregon	98,361	2,332,726	64,687

State	"S" Drugs	"N" Drugs	"I" Drugs
Pennsylvania	34,463	658,904	28,573
Rhode Island	8,091	132,145	5,060
South Carolina	84,401	847,006	49,608
South Dakota	104,614	679,111	731
Tennessee	548,147	3,954,439	546,505
Texas	38,367	489,370	27,923
Utah	113,535	1,087,792	113,817
Vermont	193,113	1,167,274	171,860
Virginia	17,839	222,892	14,560
Washington	54,867	1,214,166	57,829
West Virginia	747,174	7,527,416	776,269
Wisconsin	1,291,817	9,596,762	806,896
Wyoming	30,290	360,759	34,952
Total	16,944,541	140,392,156	11,441,337

Figure 48 – Single Source (S) Drugs Total Reimbursement Amount Less Co-Pay by State

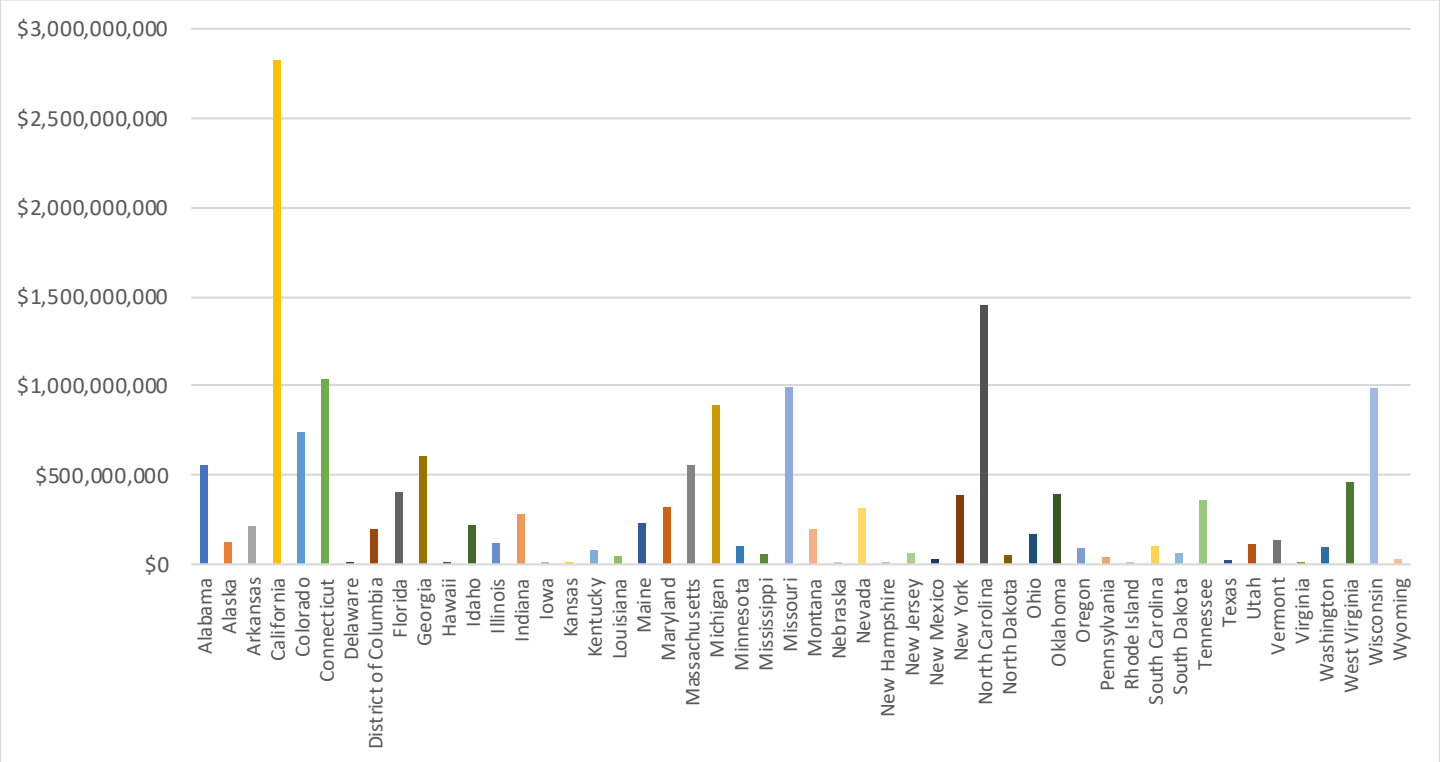

Figure 49 – Non-Innovator Source (N) Drugs Total Reimbursement Amount Less Co-Pay by State

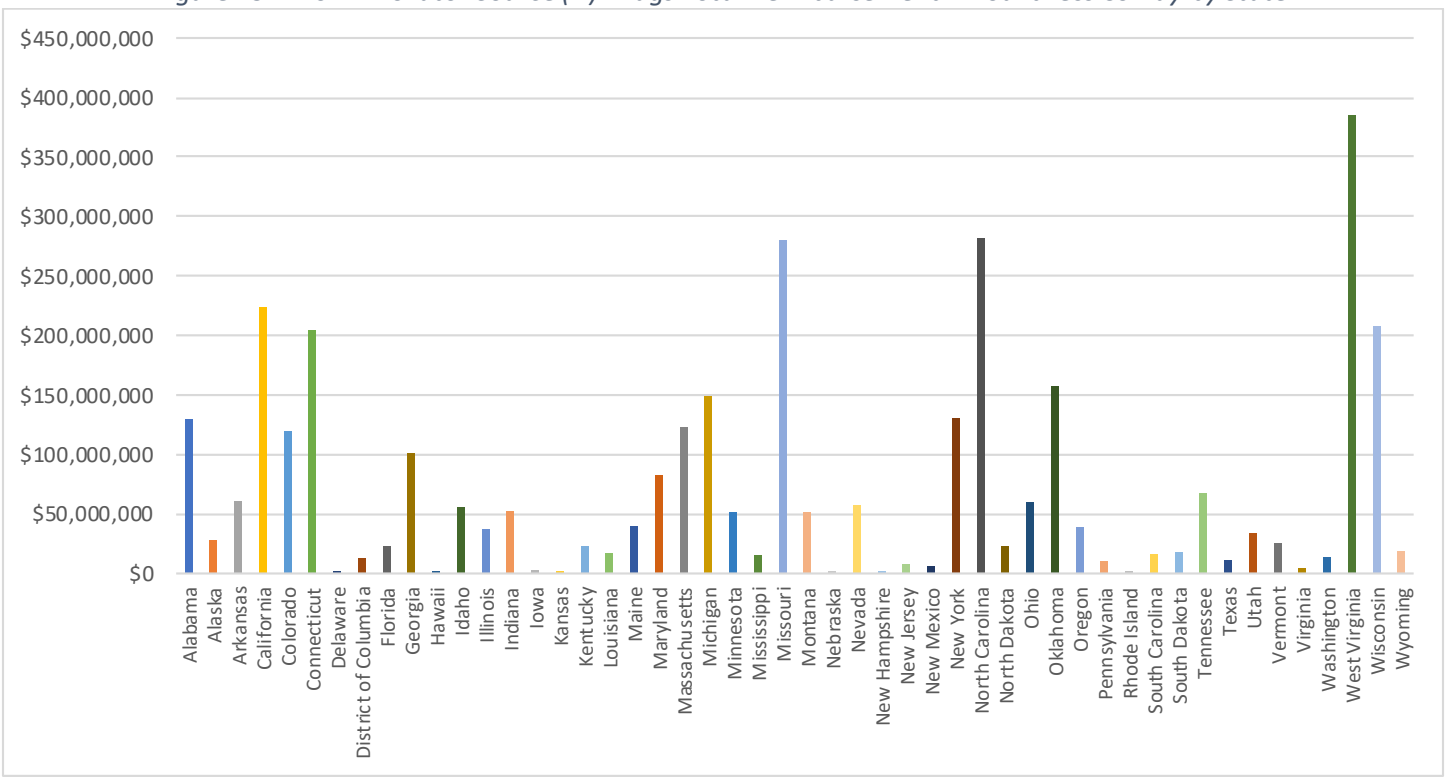

Figure 50 – Innovator Multi-Source (I) Drugs Total Reimbursement Amount Less Co-Pay by State

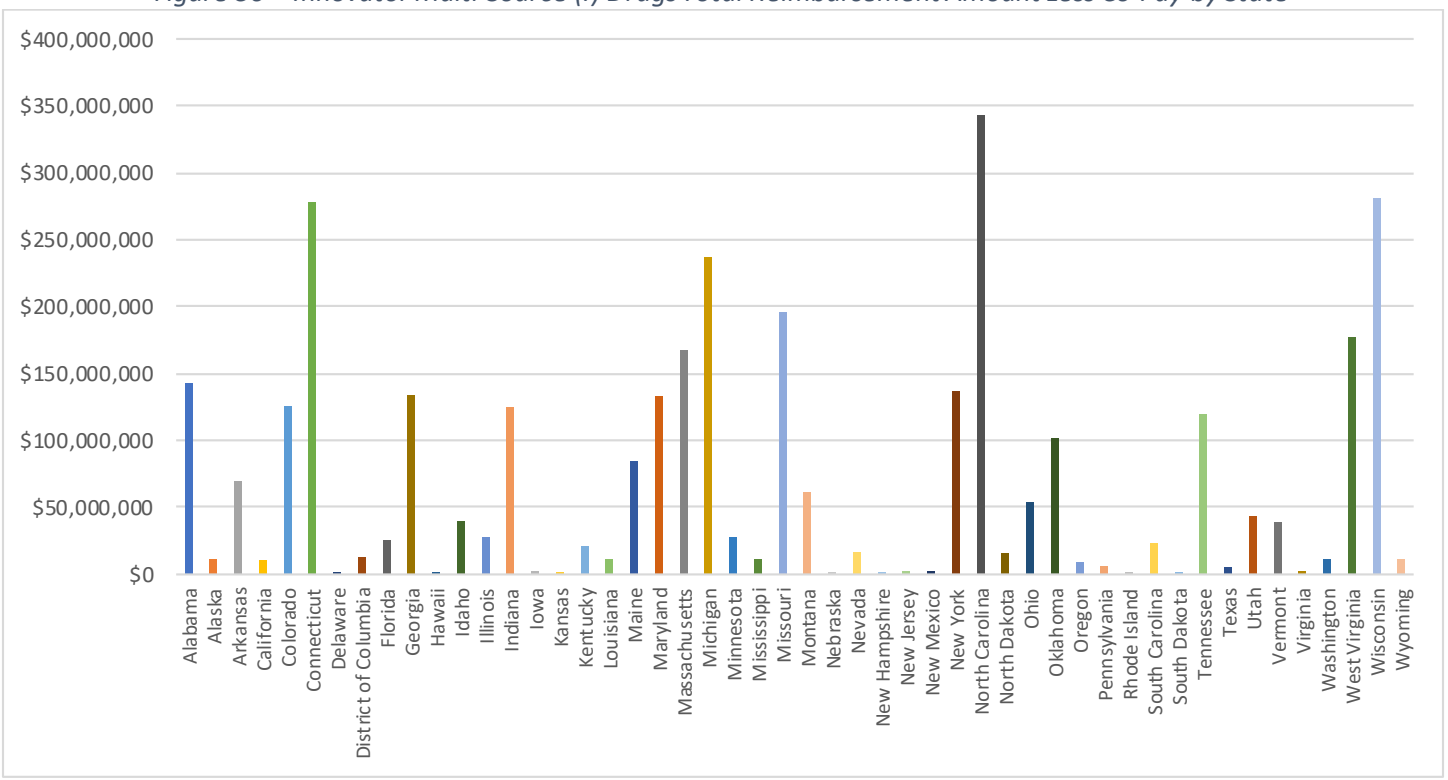

Table 68 – Drug Utilization Total Reimbursement Amount by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	$553,368,785	$129,424,974	$143,073,320
Alaska	$126,006,141	$27,978,275	$11,491,917
Arkansas	$215,732,032	$60,782,616	$69,562,707
California	$2,822,411,970	$223,807,088	$10,565,022
Colorado	$740,671,604	$119,405,601	$125,431,438
Connecticut	$1,035,280,493	$204,245,667	$278,298,121
Delaware	$3,718,691	$1,304,935	$767,269
District of Columbia	$195,266,060	$12,963,952	$12,918,187
Florida	$406,586,783	$23,348,570	$25,394,892
Georgia	$608,253,636	$101,362,923	$133,892,286
Hawaii	$3,071,992	$346,122	$30,452
Idaho	$220,975,785	$55,989,594	$39,842,108
Illinois	$116,104,401	$37,779,201	$27,787,911
Indiana	$282,058,585	$52,186,106	$124,806,228
Iowa	$5,709,745	$3,241,201	$2,208,592
Kansas	$2,123,000	$654,000	$97,000
Kentucky	$77,071,131	$22,984,913	$21,066,479
Louisiana	$47,349,025	$16,782,336	$11,313,894
Maine	$228,093,144	$39,710,699	$85,042,097
Maryland	$322,372,861	$82,932,407	$132,970,716
Massachusetts	$553,940,448	$122,965,801	$167,618,530
Michigan	$892,718,581	$148,952,622	$237,199,724
Minnesota	$101,336,476	$51,288,217	$28,174,307
Mississippi	$56,896,440	$15,270,363	$11,435,965
Missouri	$991,575,028	$279,912,122	$195,933,053
Montana	$195,175,019	$51,375,838	$61,700,004
Nebraska	$199,828	$81,608	$38,826
Nevada	$315,860,235	$57,548,685	$16,840,872
New Hampshire	$11,353,901	$208,364	$221,053
New Jersey	$59,711,667	$8,067,687	$2,398,855
New Mexico	$28,570,355	$6,527,395	$2,707,898
New York	$385,235,149	$130,355,662	$136,811,392
North Carolina	$1,450,057,338	$281,748,611	$343,076,800
North Dakota	$52,842,759	$23,330,009	$16,254,829
Ohio	$167,025,427	$60,468,098	$53,906,147
Oklahoma	$391,656,046	$157,697,978	$101,961,022
Oregon	$92,948,917	$38,732,975	$9,538,686

State	"S" Drugs	"N" Drugs	"I" Drugs
Pennsylvania	$37,305,691	$10,696,289	$6,578,865
Rhode Island	$5,611,725	$1,906,227	$1,101,320
South Carolina	$102,102,179	$15,957,830	$23,568,733
South Dakota	$61,843,504	$18,332,827	$491,310
Tennessee	$357,908,512	$67,870,544	$119,458,609
Texas	$23,278,906	$11,125,955	$5,709,095
Utah	$114,094,520	$33,992,307	$43,597,961
Vermont	$132,329,655	$25,501,200	$39,205,320
Virginia	$11,927,636	$4,469,468	$2,678,487
Washington	$97,335,381	$13,728,190	$11,107,378
West Virginia	$460,852,348	$384,955,066	$177,677,099
Wisconsin	$985,483,331	$208,213,015	$281,499,944
Wyoming	$28,411,006	$19,248,142	$11,146,207
Total	$16,177,813,872	$3,467,760,275	$3,366,198,927

3. Indicate the generic utilization percentage for all CODs paid during this reporting period. Use the computation instructions in Table 2 – Generic Drug Utilization Data.

Figure 51 - Generic & Total Claims by State

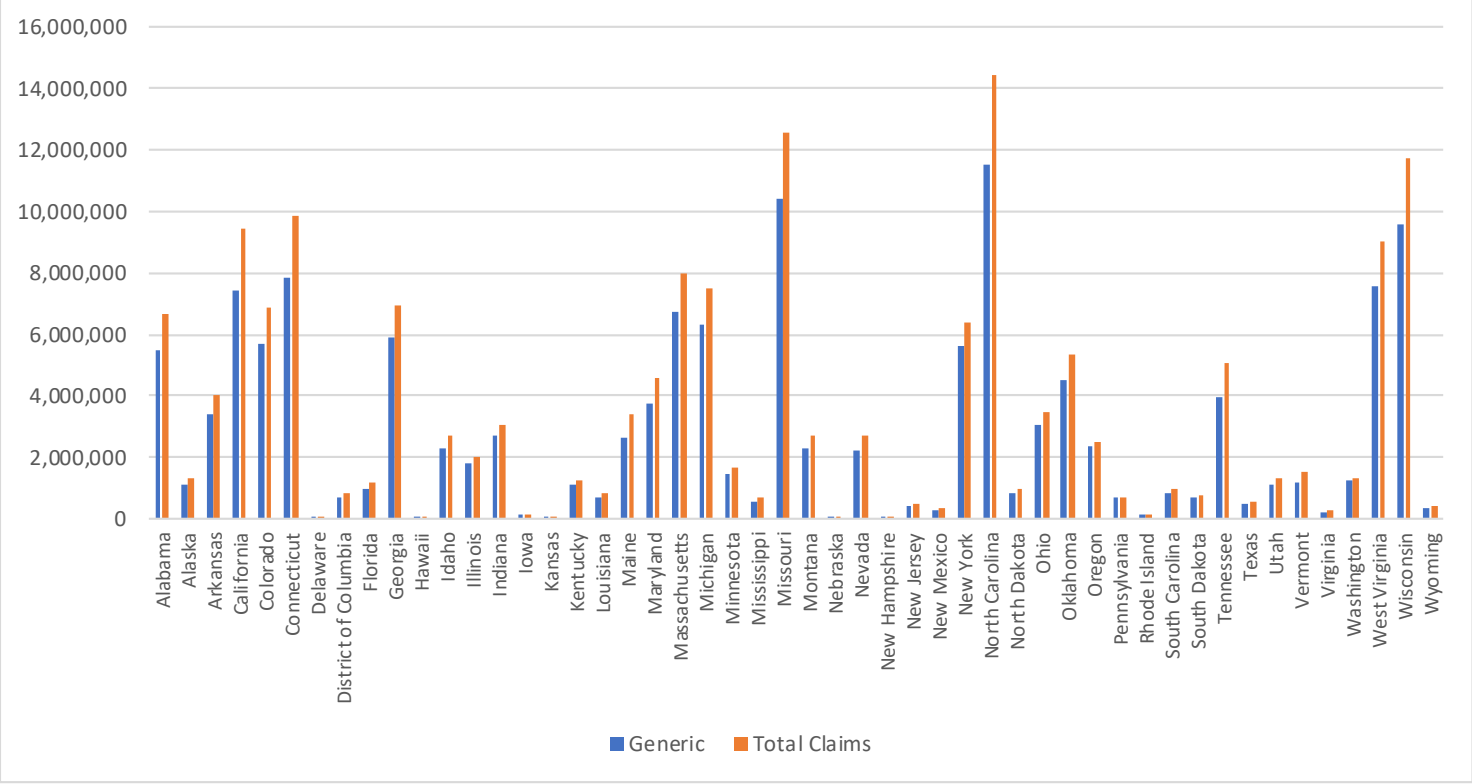

Table 69 - Generic & Total Claims by State

State	Generic Claim Count	Total Claim Count	Percentage
Alabama	5,514,077	6,684,745	82.49%
Alaska	1,087,588	1,310,999	82.96%
Arkansas	3,408,340	4,001,472	85.18%
California	7,440,599	9,404,848	79.11%
Colorado	5,709,729	6,884,859	82.93%
Connecticut	7,813,032	9,819,474	79.57%
Delaware	74,590	90,079	82.81%
District of Columbia	681,567	854,728	79.74%
Florida	999,862	1,199,324	83.37%
Georgia	5,898,335	6,911,963	85.34%
Hawaii	4,630	4,808	96.30%
Idaho	2,316,082	2,719,610	85.16%
Illinois	1,799,765	2,032,166	88.56%
Indiana	2,721,960	3,053,121	89.15%
Iowa	117,317	139,170	84.30%
Kansas	28,864	31,328	92.13%
Kentucky	1,114,472	1,252,409	88.99%
Louisiana	705,262	819,095	86.10%
Maine	2,616,788	3,423,860	76.43%
Maryland	3,750,705	4,580,444	81.89%
Massachusetts	6,748,635	8,011,024	84.24%
Michigan	6,290,583	7,485,688	84.03%
Minnesota	1,447,061	1,672,075	86.54%
Mississippi	577,204	672,971	85.77%
Missouri	10,434,306	12,549,327	83.15%
Montana	2,320,148	2,737,203	84.76%
Nebraska	5,604	6,257	89.56%
Nevada	2,238,853	2,690,916	83.20%
New Hampshire	10,281	12,216	84.16%
New Jersey	427,558	482,846	88.55%
New Mexico	273,640	326,975	83.69%
New York	5,610,005	6,349,486	88.35%
North Carolina	11,527,375	14,452,754	79.76%
North Dakota	856,591	992,734	86.29%
Ohio	3,053,560	3,439,607	88.78%
Oklahoma	4,496,426	5,342,342	84.17%

State	Generic Claim Count	Total Claim Count	Percentage
Oregon	2,332,726	2,495,774	93.47%
Pennsylvania	658,904	721,940	91.27%
Rhode Island	132,145	145,296	90.95%
South Carolina	847,006	981,015	86.34%
South Dakota	679,111	784,456	86.57%
Tennessee	3,954,439	5,049,091	78.32%
Texas	489,370	555,660	88.07%
Utah	1,087,792	1,315,144	82.71%
Vermont	1,167,274	1,532,247	76.18%
Virginia	222,892	255,291	87.31%
Washington	1,214,166	1,326,862	91.51%
West Virginia	7,527,416	9,050,859	83.17%
Wisconsin	9,596,762	11,695,475	82.06%
Wyoming	360,759	426,001	84.69%

4. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period.
(Use the computation instructions in Table 2: Generic Drug Utilization Data)

Figure 52 - Generic/Total Amount Paid by State

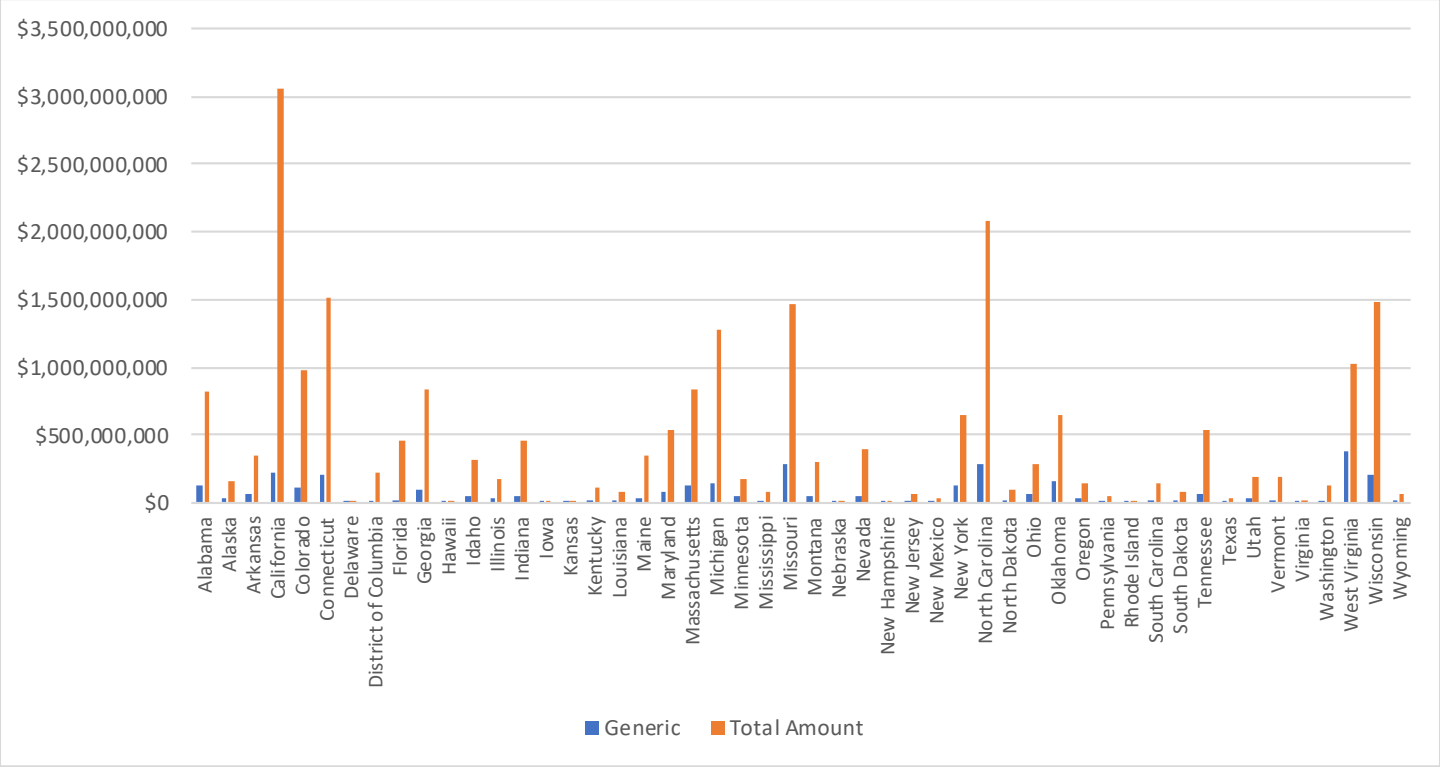

Table 70 - Generic/Total Amount Paid by State

State	Generic Claim Amount	Total Claim Amount	Percentage
Alabama	$129,424,974	$825,867,079	15.67%
Alaska	$27,978,275	$165,476,333	16.91%
Arkansas	$60,782,616	$346,077,355	17.56%
California	$223,807,088	$3,056,784,080	7.32%
Colorado	$119,405,601	$985,508,643	12.12%
Connecticut	$204,245,667	$1,517,824,281	13.46%
Delaware	$1,304,935	$5,790,895	22.53%
District of Columbia	$12,963,952	$221,148,199	5.86%
Florida	$23,348,570	$455,330,245	5.13%
Georgia	$101,362,923	$843,508,845	12.02%
Hawaii	$346,122	$3,448,566	10.04%
Idaho	$55,989,594	$316,807,487	17.67%
Illinois	$37,779,201	$181,671,513	20.80%
Indiana	$52,186,106	$459,050,920	11.37%
Iowa	$3,241,201	$11,159,538	29.04%
Kansas	$654,000	$2,874,000	22.76%
Kentucky	$22,984,913	$121,122,523	18.98%
Louisiana	$16,782,336	$75,445,255	22.24%
Maine	$39,710,699	$352,845,940	11.25%
Maryland	$82,932,407	$538,275,984	15.41%
Massachusetts	$122,965,801	$844,524,779	14.56%
Michigan	$148,952,622	$1,278,870,927	11.65%
Minnesota	$51,288,217	$180,799,000	28.37%
Mississippi	$15,270,363	$83,602,769	18.27%
Missouri	$279,912,122	$1,467,420,204	19.08%
Montana	$51,375,838	$308,250,861	16.67%
Nebraska	$81,608	$320,262	25.48%
Nevada	$57,548,685	$390,249,792	14.75%
New Hampshire	$208,364	$11,783,318	1.77%
New Jersey	$8,067,687	$70,178,209	11.50%
New Mexico	$6,527,395	$37,805,648	17.27%
New York	$130,355,662	$652,402,203	19.98%
North Carolina	$281,748,611	$2,074,882,749	13.58%
North Dakota	$23,330,009	$92,427,597	25.24%
Ohio	$60,468,098	$281,399,672	21.49%
Oklahoma	$157,697,978	$651,315,046	24.21%
Oregon	$38,732,975	$141,220,578	27.43%

State	Generic Claim Amount	Total Claim Amount	Percentage
Pennsylvania	$10,696,289	$54,580,846	19.60%
Rhode Island	$1,906,227	$8,619,272	22.12%
South Carolina	$15,957,830	$141,628,741	11.27%
South Dakota	$18,332,827	$80,667,641	22.73%
Tennessee	$67,870,544	$545,237,665	12.45%
Texas	$11,125,955	$40,113,956	27.74%
Utah	$33,992,307	$191,684,788	17.73%
Vermont	$25,501,200	$197,036,175	12.94%
Virginia	$4,469,468	$19,075,592	23.43%
Washington	$13,728,190	$122,170,949	11.24%
West Virginia	$384,955,066	$1,023,484,513	37.61%
Wisconsin	$208,213,015	$1,475,196,290	14.11%
Wyoming	$19,248,142	$58,805,355	32.73%

5. Does your state have any policies related to Biosimilars? Please Explain.

Table 71 – Explanations for Policies Related to Biosimilars

State	Explanations
Alabama	AL Medicaid follows FDA-approved indications for Biosimilars.
Alaska	Alaska is actively working on criteria for biosimilar usage to be implemented in the future.
Arkansas	There are no policies specific to biosimilars which are treated like any other outpatient drug that is eligible for rebate. Biosimilars new to the market are viewed like the original reference product. If a new to market biosimilar belongs to a drug class on the preferred drug list, the biosimilar will be considered non-preferred.
California	No, there is not a special state policy unique to Biosimilars.
Colorado	Colorado law allows pharmacists to substitute a prescribed biologic for a biosimilar that has been determined by the FDA to be interchangeable, provided that the prescriber has not indicated Dispense as Written on the order. Pharmacists must notify both the prescriber and the prescription purchaser of the substituted product. Reference biological products and biosimilars are managed on the PDL and Appendix P for the pharmacy benefit.
Connecticut	No, our state does not have any policies related to biosimilars.
Delaware	**Since 2014, Delaware legislation allows for the substitution of FDA approved, interchangeable biosimilar biologic product for prescribed biological reference products with certain safeguards. To substitute a biosimilar product pharmacists must notify the patient and prescriber in writing; record information on the label and dispensing record; and maintain a 3 year record of such substitutions. This bill also provided liability protections for pharmacists who substitute biosimilars. In the Medicaid program, biosimilars are covered with the same clinical criteria as the reference product and are addressed within the same policies as the reference product. The MCos have language within all policies to ensure compliance to the FFS Preferred Drug List (PDL) and the placement and preference of biosimilars according to the PDL
District of Columbia	No

State	Explanations
Florida	Biosimilar products are reviewed during the therapeutic class review quarterly at the Pharmaceutical and Therapeutics (P&T) Committee meetings.
Georgia	No.
Hawaii	Not at this time.
Idaho	We have no policy, but biosimilars are evaluated during P&T class reviews looking at utilization and cost. We do not allow interchange or substitution.
Illinois	No formal policy. Generally HFS evaluates if biosimilar medication is actually equivalent and then considers what is most cost effective for the state.
Indiana	No policy established at this time. Depending on the drug class, biosimilars may be included on the PDL.
Iowa	No policies related to biosimilars.
Kansas	The Kansas Medicaid PDL Committee and DUR Board members allow addition of biosimilars to the same PDL class whereby the biosimilar has the same indication as the Reference Product in that PDL class.
Kentucky	N/A
Louisiana	Currently, we do not have any policies specifically relating to biosimilars. Biosimilars are include in Louisiana's PDL.
Maine	Biosimilars are incorporated into the overall Preferred Drug List and evaluated to the brand product currently on the PDL as we would for a generic; clinically and cost effectively.
Maryland	For the reporting period, there were no policies related to the use of biosimilars for the State of Maryland.
Massachusetts	Biosimilars are evaluated class by class, including net cost, to determine if the biosimilar or innovator product is preferred and/or requires prior authorization.
Michigan	None at this time.
Minnesota	With respect to the MN Uniform Preferred Drug List, either the referenced biologic product or the biosimilar may be selected as preferred. In order to obtain the nonpreferred product, the member must have an allergic or adverse reaction to inactive ingredients of the preferred product or have therapeutic success while taking a nonpreferred product and therapeutic failure with the preferred product; or the patient has a diagnosis not included in the FDA-approved indications of the preferred product but is included in the FDA-approved indications of the non-preferred product.
Mississippi	Not at this time.
Missouri	Yes, Missouri utilizes a Biosimilar vs Reference Products Fiscal Edit to ensure appropriate utilization and control of biosimilar agents and their reference products.
Montana	Our DUR Board has requested that we treat Biosimilars like generics and, when making coverage decisions, select the Biologic or corresponding Biosimilar that is most cost effective for the State.
Nebraska	ICD-10 diagnosis code is needed. Needs FDA approved indication. Non-preferred agents will be approved for FDA approved indications in patients who have failed a trial of ONE preferred agent within drug class or upon diagnosis for non-preferred agent with FDA approved indication if no preferred agent has FDA approval for diagnosis.
Nevada	None. There are no policies.
New Hampshire	No. In drug classes that do not undergo review for status on the Preferred Drug List, there is no policy regarding Biosimilar coverage. Biosimilars are reviewed alongside reference products in consideration of PDL placement when there are biosimilars present in PDL classes.
New Jersey	No policies related to Biosimilars are in place.
New Mexico	Not at this time. Under review to determine diagnosis related treatments in FFY21 or FFY22.

State	Explanations
New York	No not at this time
North Carolina	Biosimilars are added to the Preferred Drug List (PDL) as applicable. All biosimilars are covered if rebate eligible.
North Dakota	North Dakota Medicaid requires prior authorization on non-preferred biosimilar agents. The criteria requires that the patient must have an FDA-approved indication for use (must meet label recommendations for age and diagnosis, and the requesting provider must submit clinical justification explaining why the patient is unable to use the preferred agents (justification is subject to review by clinical pharmacist).
Ohio	No
Oklahoma	Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.
Oregon	When a product becomes available that is a biosimilar for one or more drugs that have been reviewed for the PDL, where applicable, the product will be designated a nonpreferred drug until the P&T Committee reviews the product.
Pennsylvania	There are no specific policies for biosimilars. Biosimilars are treated the same as any generic.
Rhode Island	No
South Carolina	Authority of a pharmacist to substitute interchangeable biological products SECTION 2. Section 39-24-30 of the 1976 Code is amended to read: "Section 39-24-30. (A) As provided in Section 39-24-40, upon receiving a prescription for a brand name product, a registered pharmacist may substitute a drug product of the same dosage form and strength which, in his professional judgment, is a therapeutically equivalent drug product. (B) As provided in Section 39-24-40, upon receiving a prescription for a specific biological product, a registered pharmacist may substitute an interchangeable biological product." https://www.scstatehouse.gov/sess122_2017-2018/bills/3438.htm
South Dakota	Not at this time.
Tennessee	No policies. These products are reviewed by Tennessee's P&T (PAC Committee) when the particular drug's therapeutic category is reviewed. In most cases, the biosimilar drugs are non-preferred, as they are not competitive on a net cost basis.
Texas	No, biosimilars are subject to the same PDL and clinical prior authorization criteria as the original single sours products.
Utah	UT Medicaid uses the FDA Purple Book as a reference and unless otherwise limited through the prior authorization process, the State does not mandate interchange of biosimilars unless they are listed interchangeable.
Vermont	Biosimilars are controlled as part of the preferred drug list and looked at by comparison to the branded drug in the PDL category. Once evaluated they are placed as preferred or non-preferred within the therapeutic category.
Virginia	Code of Virginia %u00a7 54.1-3408.04. Dispensing of interchangeable biosimilars permitted. A. A pharmacist may dispense a biosimilar that has been licensed by the U.S. Food and Drug Administration as interchangeable with the prescribed product unless (i) the prescriber

State	Explanations
	indicates such substitute is not authorized by specifying on the prescription "brand medically necessary" or (ii) the patient insists on the dispensing of the prescribed biological product. In the case of an oral prescription, the prescriber's oral dispensing instructions regarding dispensing of an interchangeable biosimilar shall be followed. No pharmacist shall dispense a biosimilar in place of a prescribed biological product unless the biosimilar has been licensed as interchangeable with the prescribed biological product by the U.S. Food and Drug Administration. B. When a pharmacist dispenses an interchangeable biosimilar in the place of a prescribed biological product, the pharmacist or his designee shall inform the patient prior to dispensing the interchangeable biosimilar. The pharmacist or his designee shall also indicate, unless otherwise directed by the prescriber, on both the record of dispensing and the prescription label, the brand name or, in the case of an interchangeable biosimilar, the product name and the name of the manufacturer or distributor of the interchangeable biosimilar. Whenever a pharmacist substitutes an interchangeable biosimilar pursuant to a prescription written for a brand-name product, the pharmacist or his designee shall label the drug with the name of the interchangeable biosimilar followed by the words "Substituted for" and the name of the biological product for which the prescription was written. Records of substitutions of interchangeable biosimilars shall be maintained by the pharmacist and the prescriber for a period of not less than two years from the date of dispensing.
Washington	Yes. Biosimilars are treated like a brand product in the class and selection for preferred or non-preferred status is via the same process as other products on the AHPDL.
West Virginia	We do not have any specific policies in place at this time.
Wisconsin	Wisconsin does not have any specific policies related to Biosimilars. If there are Biosimilars that are included on the PDL, decisions on preferred or non-preferred status are made on an individual basis.
Wyoming	Cost analysis is performed and preferred agents are selected based on net-pricing.

Section VII - Program Evaluation / Cost Savings / Cost Avoidance

1. Did your state conduct a DUR program evaluation of the estimated cost savings/cost avoidance?

Figure 53 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

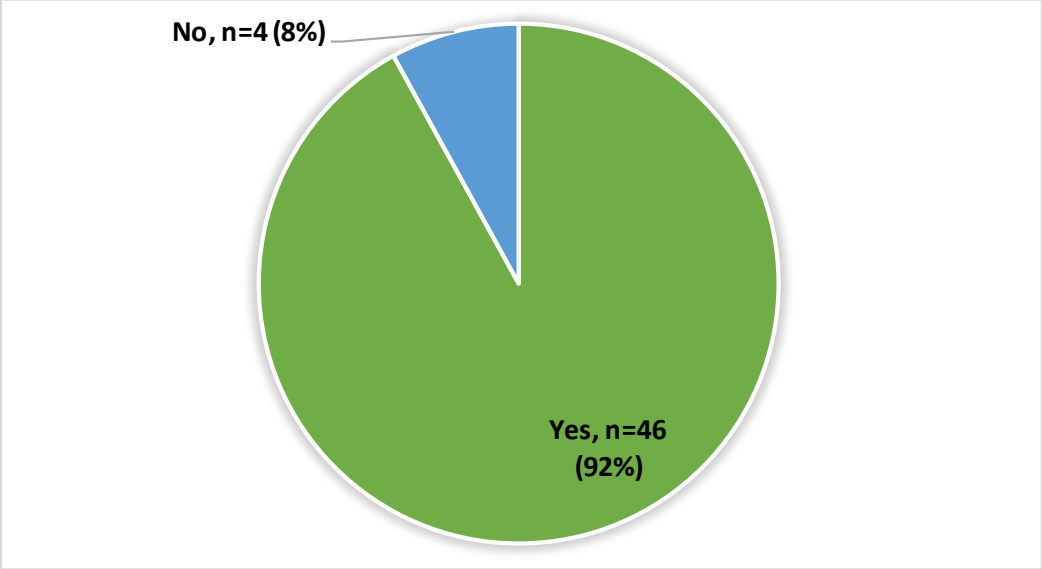

Table 72 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Nebraska, Oregon, South Carolina, Washington	4	8.00%
Total		50	100.00%

If "Yes," identify, by name and type, the institution that conducted the program evaluation.

Figure 54 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

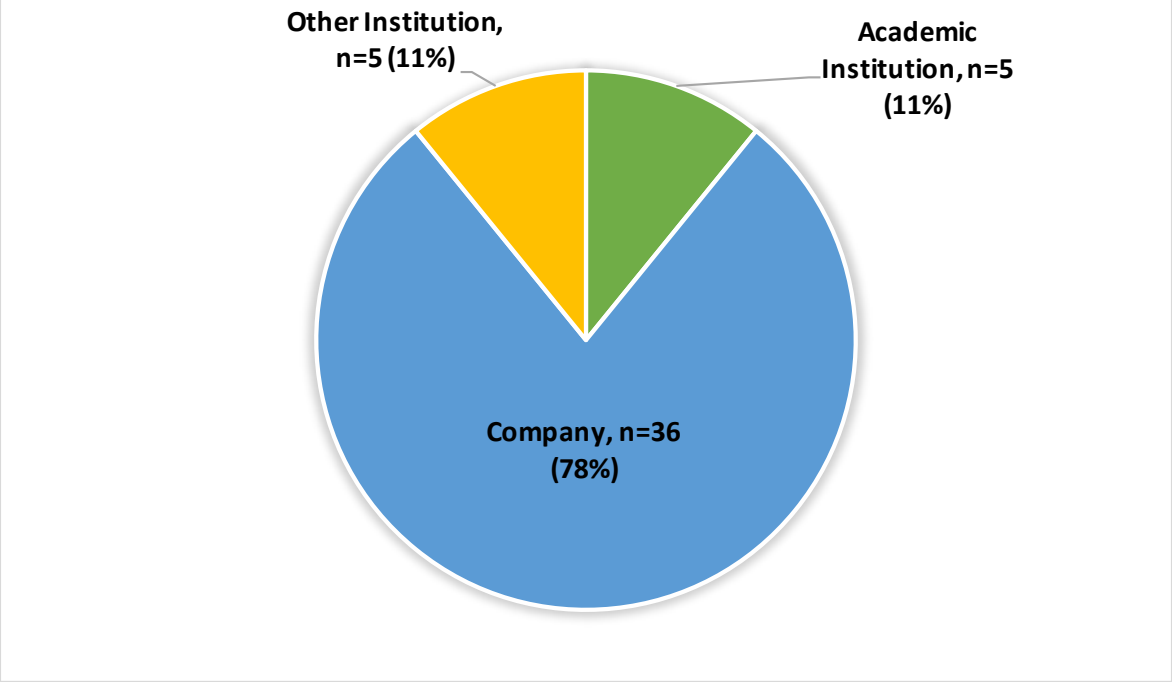

Table 73 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Academic Institution	California, Massachusetts, Oklahoma, Utah, Wyoming	5	10.87%
Company	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Wisconsin	36	78.26%
Other Institution	Hawaii, Illinois, Minnesota, Montana, West Virginia	5	10.87%
Total		46	100.00%

Table 74 - Vendors by State that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Health Information Design	Alabama, South Dakota	2	5.56%
Magellan	Alaska, Florida, Idaho, Kentucky, Michigan, New Hampshire, Virginia	7	19.44%
Health Information Design and Magellan Rx Management	Arkansas	1	2.78%

Response	States	Count	Percentage
Magellan Health, Inc	Colorado	1	2.78%
Prospective DUR cost savings by DXC. Retrospective DUR cost savings by HID.	Connecticut	1	2.78%
Gainwell Technologies	Delaware, Kansas	2	5.56%
Magellan and Conduent	District of Columbia	1	2.78%
OptumRx	Georgia, Indiana, Nevada, Tennessee	4	11.11%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	13.89%
DXC Technology	Louisiana, New Jersey	2	5.56%
Condent State Healthcare, LLC and Health Information Designs/Kepro	Maryland	1	2.78%
Conduent and Change Healthcare	Mississippi	1	2.78%
Conduent	Missouri, New Mexico	2	5.56%
Kepra, Health Information and Design	New York	1	2.78%
Myers and Stauffer, additional savings /avoidance provided by GDIT and Magellan	North Carolina	1	2.78%
KEPRO	North Dakota, Rhode Island	2	5.56%
Conduent; KePro	Texas	1	2.78%
Health Information Design, LLC	Wisconsin	1	2.78%
Total		36	100.00%

Table 75 - Academic/ "Other" Institutions that Conducted the Cost Savings/Avoidance Program Evaluation

State	Academic/ "Other" Institution Name
California	University of California, San Francisco (UCSF)
Hawaii	the state Medicaid program pharmacist
Illinois	Illinois HFS Bureau of Professional and Ancillary Services and Change Healthcare for SMAC.
Massachusetts	University of Massachusetts Medical School
Minnesota	Minnesota does internally except for the RetroDUR savings is completed Conduent.
Montana	Mountain Pacific Quality Health Foundation
Oklahoma	University of Oklahoma College of Pharmacy: Pharmacy Management Consultants (PMC)
Utah	University of Utah Drug Regimen Review Center
West Virginia	Gainwell Technologies and Marshall DUR Coalition
Wyoming	University of Wyoming, School of Pharmacy

2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance.

See the "State FFS Individual Reports" for details at Medicaid.gov.

3. Estimated Percent Impact

The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 5, then multiplying this value by 100.

See the "State FFS Individual Reports" for details at Medicaid.gov.

4. Summary 4 – Cost Savings/Cost Avoidance Methodology

Summary 4 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by the state or contractor.

Table 76 – Cost Savings/Cost Avoidance Methodology

State	Cost Savings/Cost Avoidance Methodology
Alabama	This report prepared for the Alabama Medicaid Program shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2020 (FFY 2020). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there was an estimated cost savings of $1,154,074. Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings All Interventions $1,082,173 (-$71,901) $1,154,074 During FFY 2020, HID reviewed 1,755 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general

State	Cost Savings/Cost Avoidance Methodology
	categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. A total of 4,439 recipients met the criteria for intervention letters during FFY 2020. To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2020). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed. All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions, other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. The RDUR program provides an important educational service to providers enrolled in the Alabama Medicaid Program. During FFY 2020, 1,755 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug

State	Cost Savings/Cost Avoidance Methodology
	therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,154,074 for FFY 2020.
Alaska	Prospective Drug Utilization Review (ProDUR) A cost savings estimate was prepared for the State of Alaska by Magellan Medicaid Administration. The cost savings estimate was calculated by identifying claims with ProDUR messages that were either reversed and resubmitted or reversed but not resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the allowable payment amounts of the resubmitted claim. Summary (ProDUR Paid Claims Savings Report, Severity Level 1) Total # of Reversed Claims 21,141 Allowable Amount ($) of Reversed Claims $5,174,488.97 Total # of Resubmitted Claims 11,842 Allowable Amount ($) of Resubmitted Claims $2,866,080.16 Net Cost Savings $2,308,408.79 Summary (ProDUR Denied Claims Savings Report, Severity Level 1) Total # of Claims 37,918 Allowable Amount ($) of Claims $12,484,431.49 Total # of Resubmitted Claims 17,862 Allowable Amount ($) of Resubmitted Claims $3,785,392.06 Net Cost Savings $8,699,039.43 Retrospective Drug Utilization Review (RetroDUR) A cost savings estimate was not prepared for the State of Alaska by Magellan Medicaid Administration due to systems limitations. Summary The total cost savings estimate for ProDUR and RetroDUR interventions for FFY 2020 was $11,007,448.
Arkansas	ARKANSAS MEDICAID COST SAVINGS/COST AVOIDANCE FFY2020 RETROSPECTIVE DRUG UTILIZATION REVIEW METHODOLOGY To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated 85-150 days before and 85-150 days after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre- and post-intervention periods. For the purpose of this report, recipients were analyzed using 85-150 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the

State	Cost Savings/Cost Avoidance Methodology
	post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient HIDs covered timeframe). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. The RDUR program provides an important educational service to providers enrolled in the Arkansas Medicaid Program. During HIDs covered timeframe, 1,914 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $193,378 for HIDs covered timeframe. Magellan RX Management did not provide cost savings data for the RDUR program since the contract began 7/1/2020, and no outcomes data was available by end of the FFY. PROSPECTIVE DRUG UTILIZATION REVIEW METHODOLOGY The ProDUR cost avoidance report is based on data collected from an online ProDUR system and calculations from those electronically submitted claims. If an alert is triggered upon submission of a claim, the pharmacist must make the appropriate response to the alert. The response is captured electronically. By responding to the alert, the claim may be adjudicated, and the pharmacist would thereby dispense the medication and receive payment for the claim. This type of alert response to adjudicate a claim is referred to as a soft edit. The point of sale (POS) responses in the ProDUR system reflect the actions taken by pharmacists when presented with soft ProDUR alerts while dispensing prescriptions to Arkansas Medicaid beneficiaries. The codes 1A, 1B, and 1G are override codes and would not produce any program savings since no changes in the dispensed prescription took place. The pharmacist determines to his best professional judgment, with or without the communicated judgment of the prescriber, that the benefits of dispensing the medication outweigh the potential risks associated with the alert. Codes 1C, 1D, 1E, and 1F are adjustments made to the prescription in response by the pharmacist to the ProDUR alert which could produce program savings or increase in program costs depending on the response. Magellan's system has the ability to identify what alert was sent and when the response codes 1C, 1D, 1E, and 1F were used. The codes 2A and 2B are outcome codes for a cancellation response to a ProDUR alert and no claim was processed. A non-response to an alert indicates that the pharmacist did not respond to the soft alert. If a pharmacist does not respond to a ProDUR alert within seven days, the claim is denied, and no program funds are expended. This ProDUR cost avoidance estimate was prepared for the State of Arkansas by Magellan Rx Management and was calculated by identifying claims with ProDUR messages due to early refill (ER), therapeutic duplication (TD), drug-drug interaction (DD) and high dose (HD) alerts that

State	Cost Savings/Cost Avoidance Methodology
	were either denied claims that were not resubmitted or reversals of paid claims that were not resubmitted. When a claim is denied due to a prospective edit, there may or may not be a replacement or substitute claim. Each denied claim is compared and matched with paid subsequent claims based on the internal patient ID and the AHFS code. Only the last denied edit of the adjudicated claim will be utilized in order to not overestimate saving. ProDUR ESTIMATED COST AVOIDANCE Paid claim savings (Reversed claims not resubmitted) $14,797,252.33 Denied claim savings (Denied claims not resubmitted) $201,253,242.41 TOTAL ESTIMATED ProDUR SAVINGS $216,050,494.74 OTHER EDIT METHODOLOGIES AR Medicaid Pharmacy Program has an extensive list of drugs that require prior approval (PA) to override established clinical criteria edits and drug claim edits. Although patient safety and appropriate drug utilization are the focus when developing clinical algorithms and drug claim edits, generally the end result is cost containment or cost avoidance for the pharmacy program. The clinical criteria edits may use either POS clinical approval algorithms or a clinical manual review PA for approval of a particular drug. If a beneficiary does not meet the established prior approval criteria, the prescriber may submit a request in writing to provide additional documentation to substantiate the medical necessity of the beneficiary receiving the drug in question, or the prescriber may change the drug to an alternative drug that does not require prior approval. Drug claim edits (DUR reject error) are limitations placed on drugs or drug classes using gender, age, daily dose, monthly quantity allowed, quantity allowed per claim, or accumulation quantity edits that allow up to a certain quantity over a period of time. In addition to clinical edits and claim edits, AR Medicaid Pharmacy Program has a preferred drug list (PDL), and the drugs may be listed as preferred status, preferred status with criteria, non-preferred status, or non-preferred status with criteria. The non-preferred drugs on the preferred drug list will deny at POS and require an approved manual review prior authorization approval in order for the claim to pay. The prescribing provider must submit a request in writing explaining the medical necessity for the beneficiary to receive the non-preferred drug over the preferred drug(s), or the prescriber can change the prescription to a preferred drug as an alternative that does not require a prior approval. For the purposes of this cost avoidance or cost savings report, this section will only report the Matched and Unmatched claims data that pertains to drugs that denied at POS for Prior Authorization (PA) Required, Plan Limits Exceeded, AND DUR Reject Error. The following definitions are offered for terminology used in the POS Magellan cost analysis system: 1) Unique Denied Claims: Some claims can stop for multiple edits, such as prior authorization edits plus drug claim quantity edits. The POS cost analysis system tracks the drug claim to the ultimate outcome and only counts the rejected claim one time as a unique denied claim so as not to overestimate the impact of the denied claim.

State	Cost Savings/Cost Avoidance Methodology
	2) Matched Claim: The POS analysis system can track the rejected claim for matches to a suitable replacement, alternative, or substitute drug claim that paid. The cost difference between the rejected drug claim and the dispensed drug claim is the cost avoidance or cost savings. o If the POS analysis system tracks the rejected claim until it ultimately paid (for example due to an approved prior authorization at a Call Center), then it is not counted as a cost savings or a cost avoidance. These paid claims are not included in this report. 3) Unmatched Claim: If the POS analysis tracks a rejected claim and it is never matched to an alternative paid drug claim, it is called an unmatched claim. This means there was never a paid claim, or it was not replaced with a suitable replacement drug claim. The cost of the rejected drug is the cost avoidance or cost savings. 4) Other Drug Claim Edits: The POS analysis tracker can monitor a rejected drug claim that rejected due to specific drug claim edits on the drug, such as gender edits, age edits, daily dose edits, monthly quantity edits, and accumulation quantity edits. The rejected claim due to one of these types of edits is also monitored to determine the outcome. The cost difference between the rejected drug claim and the dispensed drug claim is the cost avoidance or cost savings. If it did not result in a paid claim with the original drug or it was not replaced with a suitable alternative, the cost of the rejected drug is the cost avoidance or cost savings. COST AVOIDANCE BY QUARTER FOR PA REQUIRED, PLAN LIMITS EXCEEDED, AND DUR REJECT ERROR DUR ALERTS/REJECTIONS — ESTIMATED COST AVOIDANCE 1Q-FFY 2019 (OCT 1, 2019-DEC 31, 2019) — $19,415,311 2Q-FFY 2019 (JAN 1, 2020-MAR 31, 2020) — $19,349,593 3Q-FFY 2019 (APR 1, 2020-JUNE 30, 2020) — $17,194,048 4Q-FFY 2019 (JULY 1, 2020-SEPT 30, 2020) — $19,932,538 TOTAL FOR FFY 2020 — $75,891,490
California	Prospective DUR alerts and educational bulletins provide health care providers and pharmacists with specific, focused, and comprehensive drug information. If DUR alerts and educational bulletins are reviewed as intended, then notification of a potential drug therapy problem through a DUR alert or the knowledge gained from educational bulletins will lead to appropriate action, including: 1. Discontinuing unnecessary prescriptions 2. Reducing quantities of medications prescribed 3. Switching to safer drug therapies 4. Adding a drug therapy recommended in evidence-based guidelines 5. Appropriate monitoring of patients taking prescription drugs The Medi-Cal DUR program has saved money by encouraging appropriate drug therapy in order to reduce total healthcare expenditures. Estimated prescription drug savings as a direct result of the prospective DUR system for FFY 2020 were calculated by taking each individual prospective DUR alert and multiplying the total claims cancelled or not overridden by the average reimbursement dollars paid to pharmacies per claim and a multiplier (allows for an adjustment of estimated costs using a conservative estimate that 90% of early refill claims are resubmitted

State	Cost Savings/Cost Avoidance Methodology
	and paid and that 20% of the remaining alerts are duplicate alerts for the same claim) in order to get the total estimated costs avoided through prospective DUR. Of note, multiple alerts can be generated per claim, so there may be duplicate alerts cancelled or overridden and the average reimbursement dollars paid to pharmacies per claim was calculated for each alert by looking at the total number of paid claims (including overrides) and total reimbursement dollars paid to pharmacies per claim (does not include adjustment for any rebates) for all drugs that generated that particular alert in FFY 2020.
Colorado	Paid Claims Cost Avoidance is calculated by taking the paid dollar amount of claims with a ProDUR message that paid, but were subsequently reversed and subtracting the paid amount the claims resubmitted within 72 hours. (Claim Amount - Reversal Amount + Resubmit Amount) Denied Claims Cost Avoidance is calculated by taking the submitted dollar value of the claims that were initially denied and had a ProDUR message and subtracting any of those claims that were then resubmitted within the same calendar month and then paid. (Claim Amount - Resubmit Amount) ProDUR Total Estimated Avoided Costs = Denied Claims Cost Avoidance + Paid Claims Cost Avoidance
Connecticut	This report prepared for the Connecticut Medical Assistance shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2020 (FFY 2020). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there was an estimated cost savings of $6,028,169. , Intervention Group Change between 6 Month Pre- and Post-, Comparison Group Change between 6 Month Pre- and Post-, Estimated Cost Savings All Interventions, $4,476,784, ($1,551,385), $6,028,169 During FFY 2020, HID reviewed 17,676 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Drug Therapy Problem Distribution Therapeutic Appropriateness 55% Drug-Drug Interactions 17% Over-Utilization 11% Under-Utilization 10% Drug Disease Interaction 7%

State	Cost Savings/Cost Avoidance Methodology
	Analysis Methodology Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 33,899 recipients met the criteria for intervention letters during FFY 2020. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2020). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed . Table 3 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for recipients with single and multiple interventions during FFY 2020. Table 3 - Estimated Cost Savings for FFY 2020 , Intervention Group Change between 6 Month Pre- and Post-, Comparison Group Change between 6 Month Pre- and Post-, Estimated Cost Savings Single Intervention, $4,185,425, ($1,377,805), $5,563,230 Multiple Intervention, $291,359, ($173,580), $464,939 Total Estimated Cost Savings, $6,028,169 HID found the intervention group had a decrease of 6.27% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 7.50%. These changes resulted in an estimated cost savings of $376.81 per recipient who received an intervention during FFY 2020. Results Discussion

State	Cost Savings/Cost Avoidance Methodology
	All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions, other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Connecticut Medical Assistance. During FFY 2020, 17,676 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $6,028,169 for FFY 2020. 4b PRO-DUR SAVINGS PLEASE NOTE: ProDUR Savings Calculation Methodology Savings for Pro-DUR alerts are derived from the soft-edit Pro-DUR alerts. A soft-edit alert notifies the dispensing pharmacist of a potential problem; the pharmacist evaluates the alert based upon the patient's situation and decides whether to override the alert or whether to cancel filling the prescription due to the alert. ProDUR Savings are estimated from the number of cancelled & no response prescriptions after the soft edit alert hits. The cancelled & no response prescriptions are also called the number of denied claims that are reviewed by pharmacists who decide not to fill the prescriptions after hitting a soft edit. Methodology of how DXC calculated the ProDUR savings is either DXC multiplied the number of cancelled & no response prescriptions by the average cost per prescription for each ProDUR Alert type; or, DXC tracked what the cancelled & no response prescriptions would have cost if they had been dispensed. Then each alert type savings were added to create a sum of all savings labeled, Cost Savings Total in Summary 4b. ProDUR Savings ProDUR savings for FFY 2020, as calculated by the claims processor and fiscal agent DXC , was estimated to be a total of $112,215,597 on 4,191,384 prescriptions for patients. ALERT TYPE, # of Claims Cost Savings, Reporting the year of 10/01/2019 - 09/30/2020, Reporting the year of 10/01/2019 - 09/30/2020 , , , , , Total # of Claims, Total Cost Savings Drug-Drug, Rx, 122,260, DD, $, , $1,015,703

State	Cost Savings/Cost Avoidance Methodology
	Early Refill, Rx, 2,609,894, ER, $, , $96,962,864 High Dose, Rx, 16,060, HD, $, , $65,705 Ingredient Duplication, Rx, 1,111,833, ID, $, , $10,916,858 Drug-Age, Rx, 3,540, PA, $, , $5,947 Drug-Pregnancy, Rx, 34,862, PG, $, , $113,737 Therapeutic Duplication, Rx, 292,935, TD, $, , $3,134,783 , , , TOTALS, Rx, 4,191,384, , $, , $112,215,597
Delaware	Delaware has continued to take a conservative approach in estimating our cost savings due to pro%u2010DUR. While early refill denials could be considered, Delaware has always deemed these savings to be more of cost deferral rather than cost avoidance. Additionally, due to the Covid-19 public health emergency this year, some of the early refill restrictions were lifted to facilitate easier medication access during the uncertainty of the pandemic. However, the refill percentage in Delaware is normally set at 83% for non-controlled drugs and for prior authorization claims we even tighten this percentage more by the date range and quantity for which the drug is approved. The two edits that Delaware uses to calculate cost savings/cost avoidance are therapeutic duplication and dose optimization. The list of medications that hit for these two edits are extensive and have produced cost savings on the unnecessary dispensation of additional products or additional units of medication. At point of sale, therapeutic duplication within classes is the best way to proactively prevent duplicate therapy and unnecessary expenditures. Fee for service comprises about 15% of the Medicaid population. In addition, most newly eligible Medicaid members ultimately transition to an MCO administered benefit. In federal fiscal year 2020, the estimated therapeutic duplication alerts for FFS deferred the dispensing of 4,284 units with an estimated savings of $520,931. Delaware has a long%u2010standing history of maximizing dose optimization since its implementation in February 2005. Setting optimal dose edits ensures that the member receives a dose that maximizes compliance and therapeutic appropriateness, and as a result, decreases expenditures for the state by dispensing the minimum units and beneficial healthcare outcomes which drive future cost savings. One current trend that continues to be identified in Delaware by the dose optimization audit, are those healthcare providers who prescribe an FDA approved drug for once daily dosing to be dosed multiple times per day. Research has continued to indicate that there is no benefit from more than once daily dosing. For FFY 2020, the drug classes of proton pump inhibitors, blood pressure medications and antipsychotics were the predominant classes that triggered the edit for %u201cquantity units billed outside the limits%u201d. Utilizing dose optimization produces savings and does not sacrifice level of member care; in fact, dose optimization reduces the dosing frequency or number of units taken which often leads to improving patient compliance. Even for products that are indicated with a dosing range such as once to twice daily, Delaware utilized the once daily regimen first and needs to see failure before

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	twice daily dosing would be considered for approval. It is estimated during federal fiscal year 2020, Delaware's dose optimization edits prevented over 67,666 units of medication from being dispensed resulting in an estimated savings of $88,438. Delaware continues to review each drug as it enters the market and add it to the dose optimization list when appropriate.
District of Columbia	PRO DUR METHODOLOGY Step 1: Denied claims are extracted from the study quarter's data and linked to the external NCPDP error codes Step 2: Paid claims that do not fall into a refill' designation are extracted and matched to the respective denied claims becoming replacement claims Paid claims that have been filled with the same GSN within 90 days from the member's fill date are excluded Step 3: Denied and replacement claims are matched by patient ID and the GPI6 Code to ensure that the replacement claim is for the same therapy The replacement claim should have a service date on or after the denial claim date The window between the service date for the denial claim and the paid claim should be 14 days (denied date lesser than or equal to paid date The denied and replacement claims will lastly be matched by the HIC3, GSN, BRAND NAME, GENERIC NAME , NDC, and STANDARD THERAPEUTIC CLASS CODE Equation of Saving: Cost Avoidance = Unmatched Denied Payment + (Matched Denied Amount minus Replacement Paid Amount)
Florida	Maximum Allowable Cost The Maximum Allowable Cost (MAC) program establishes a maximum price per unit at which Florida Medicaid will reimburse pharmacy providers for generic medications. By using the MAC price, the Medicaid Program reimburses at the same rate for the included products. This enables pharmacy providers to select the agent that is most effective for them without disadvantaging the Medicaid Program. MAC program savings are calculated by re-pricing each claim that paid at MAC as if the MAC price had not existed at the point of adjudication. MAC savings is the difference between the MAC price and the recalculated payment amount. During FFY 2020, the MAC program provided savings of $2,140,227. Preferred Drug List (PDL) Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings are generated by shifting the market from more expensive, non-preferred products, to less expensive, preferred products. The total savings provided by the PDL program during FFY 2020 was $2,954,885. Retrospective DUR For all edits or criteria approved by the DUR Board, a pre-implementation analysis is conducted demonstrating the number of claims, number of recipients, and total amount paid that would be impacted by such an edit or criteria. At a reasonable amount of time after implementation of the edit or criteria, a post-implementation analysis is performed demonstrating the number of claims, number of recipients and total amount paid for a similar period of time. The standard post implementation analysis is conducted three months after deployment of the edit but may vary depending on the nature of the edit and the time needed to measure an impact. For example, if an edit allows for a six-month window before claims denial, the impact of the edit

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	would not be assessed until approximately nine months after the edit is deployed. The cost savings is considered to be the difference in the total amount paid between the pre-implementation and the post-implementation. These figures are then annualized to calculate the RetroDUR cost savings impact. The total savings measured at the time of report submission for RetroDUR edits in FFY2020 was $2,302,793.18. Prospective DUR- ProDUR cost avoidance for the Florida Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. The ProDUR cost avoidance for FFY 2020 was $246,961,716. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, it is not known what the complete impact this has on the program. There are many prescriptions that are switched after point of sale to alternative medications, which would have an improved therapeutic benefit to the patient and would not generate a ProDUR edit. The cost of this alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influenced this calculation was multiple claim submission for an individual recipient's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims, the calculations would be inflated.
Georgia	Pharmacy savings were based on the claims status associated with the claim transaction: Paid, Reversed, Rejected Paid Claims with CDUR edit(s) are those which had an override by a pharmacist Rejected claims with CDUR edit(s) include both hard and soft rejects Reversed claims with CDUR edit(s) include Paid claims which were reversed, originating with a message and an override by a pharmacist"
Hawaii	National Average Drug Acquisition Cost (NADAC) was included and implemented in the reimbursement of claims methodology. The cost savings for the top ten drugs by cost were evaluated for NADAC presence. When compared to no NADAC in reimbursement methodology, a cost savings of $39,000 was identified. Previously, Wholesale Acquisition Cost (WAC) was the basis of our reimbursement of claims methodology. Incorrectly paid claim was identified in FFY2020 during quarterly RetroDUR of expensive claims. Pharmacy did not reverse adjudicated claim when retroactive eligibility occurred for patient eligibility (transferred from FFS to MCO). Initiated in FFY 2020 and cost savings of $90,500 will occur in FFY 2021.
Idaho	ProDUR cost savings estimate was calculated by identifying claims with ProDUR messages that were reversed and those that were reversed but resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the amounts of the resubmitted claim. RetroDUR savings were calculated by looking at expenditures prior to intervention for included drugs minus expenditures after intervention.
Illinois	Four Prescription Policy. The Department requires adults to obtain a prior authorization to fill a prescription beyond four in a 30-day period. Medications that do not count toward or require prior authorization due to the Four Prescription Policy included antineoplastic agents, antiretroviral agents, antipsychotics, immunosuppressive agents, and anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder in Department records. As pharmacies and prescribers learn what requires prior authorization, requests for prior authorization for the Four Prescription Policy are submitted prospectively to resolve issues before claims are processed. In FFY20 at least 108,316 pharmacy claims rejected due to the Four

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	Prescription Policy edit. The Four Prescription Policy edit was temporarily lifted effective March 30, 2020 in order to reduce participant visits to the pharmacy, promote social distancing, reduce barriers to participant access to medications, and ease the burden on pharmacies and prescribers due to the COVID-19 pandemic. Prior authorization. The prior authorization requirement for medications that are not preferred or preferred but require prior authorization to ensure clinical criteria are met resulted in an initial rejection of 415,068 unique claims. Final cost savings are impacted by meeting clinical criteria and will vary due to changes in drug therapy, such as the prescribing of a different drug or drug dosage. Several edits were temporarily lifted or adjusted during FFY20 as a result of the COVID-19 pandemic. COVID-19-related adjustments effective March 30, 2020 included the following: Encouragement of medicine synchronization use, a process that was introduced August 2019. Reduction of Refill-Too-Soon (RTS) tolerances on all medications Allowing pharmacies to submit Submission Clarification Code (420-DK) 13, Payer-Recognized Emergency/Disaster Assistance Request, to override rejecting claims for RTS. Pharmacists' clinical judgement was used to determine appropriateness of overriding claims. Days' supply edit for insulin was increased to allow a 90-day supply fill. Preferred Drug List was updated and adjusted as needed based on shortages of preferred medications. For example, all albuterol HFA inhalers and levalbuterol inhalers and generic levalbuterol nebulizer solutions were changed to preferred. Quantity of glucose test strips was increased to maximum of 300 and lancet quantity was increased to a maximum of 400. Effective May 20, 2020, the following adjustments were made due to the COVID-19 pandemic: Medications were added to the 90-day supply list of maintenance medications Temporary coverage of over-the-counter acetaminophen, ibuprofen, naproxen, and cough suppressants containing guaifenesin and/or dextromethorphan. Drug Utilization Review (DUR) Edits. Illinois Medicaid revised edits used to address DUR with implementation of the new PBMS. In FFY20, HFS rejected approximately 164,517 unique claims as a result of DUR edits addressing duplicate therapy, duration of therapy, daily dose, excess quantity, excess accumulated quantity, age, gender, and high dose. Some participants had more than one claim impacted by a DUR edit. In FFY20, Illinois reimbursed pharmacies $83.56 per prescription on average. Based on the average cost of a claim, Illinois rejected approximately $13,746,346 in pharmacy claims as a result of DUR editing. Cost savings will vary due to changes in drug therapy, such as the prescribing of a different drug or drug dosage. Cost savings were also impacted by temporary relaxation of select edits due to the COVID-19 pandemic. Generic Product Utilization. During FFY20, Illinois Fee-for-Service Medicaid's generic dispensing ratio increased by 2.47%. During FFY20, the average brand name/innovator prescription was reimbursed $619.16, while the average generic prescription was reimbursed at $20.99. Illinois Medicaid reimbursed providers for approximately 2.03 M prescriptions. Each percentage point shift from brand/innovator to generic utilization would result in about 12.2 M in savings. State Maximum Allowable Cost (SMAC). Illinois uses Change Healthcare Pharmacy Solutions as the SMAC vendor. The SMAC savings is calculated based on Illinois utilization data. Actual SMAC savings is calculated as the difference between the SMAC price and the lesser of estimated acquisition cost (EAC), the Federal Upper Limit (FUL) and National Average Drug Acquisition Cost

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(NADAC) price. The difference is then multiplied by the total units dispensed with a SMAC price. Effective 7/15/2019 the EAC for generic drugs changed from WAC to WAC minus 17.5%. The FUL price is determined by the Centers for Medicare and Medicaid Services (CMS). During FFY20, the SMAC pricing program saved Illinois Medicaid $8,240,308 (state and federal dollars).

Illinois Pharmaceutical State Maximum Allowable Cost Saving FFY20

Month	Total units with SMAC	Actual SMAC savings	Quarter	Actual SMAC savings by quarter
October 2019	13,753,284	$749,238	Q1 FFY20	$2,179,306
Nov 2019	12,530,105	$687,906		
Dec 2019	12,677,524	$742,162		
Jan 2020	13,385,190	$960,878	Q2 FFY20	$2,306,817
Feb 2020	10,607,820	$603,005		
Mar 2020	10,728,415	$742,934		
Apr 2020	9,629,698	$684,175		
May 2020	10,540,817	$665,106	Q3 FFY2020	$2,010,137
June 2020	10,637,661	$660,856		
July 2020	9,105,105	$631,852		
August 2020	8,367,718	$570,527	Q4 FFY2020	$1,744,048
September 2020	7,645,156	$541,669		
(rounded)			Total	$8,240,308

Illinois Medicaid Preferred Drug List. Illinois Medicaid maintains a Preferred Drug List (PDL) in order to promote clinically appropriate utilization of pharmaceuticals in a cost-effective manner. The Illinois Medicaid PDL process ensures that the PDL is developed based on safety, effectiveness, and clinical outcomes. If these factors indicate no therapeutic advantage among the drugs being considered in the same drug class, then HFS considers the net economic impact of such drugs when recommending drugs for inclusion in the PDL. Effective January 1, 2020, Illinois has one PDL for the state, which facilitates continuation of medications even if patients move between Fee-for-Service and managed care Medicaid plans. In FFY20, the PDL generated approximately 4.7 M in supplemental rebates from brand name drug manufacturers. Effective January 1, 2020 with initiation of one state Medicaid Preferred Drug List all state supplementary rebates are based on Fee-for-Service and Medicaid Managed Care utilization. Additional savings is achieved by using the PDL to encourage the use of lower cost generic alternative drugs.

Three Brand Name Drug Limit. The Department limits the number of brand name drugs participants age 21 and older may obtain each month. Prior approval is required for a fourth brand name drug in a 30-day period. This edit was temporarily lifted effective March 30, 2020. The three brand limit does not impact the following drug categories: Drugs for which there are no alternative generic therapies for the condition being treated; Drugs for which the generic alternatives are deemed clinically inappropriate for the majority of participants; Brand name drugs that are less expensive to the Department than their generic alternatives; Drugs in the following classes: antiretroviral agents, antineoplastic agents, immunosuppressive agents.

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	Lost, Stolen, or Destroyed Medications and Vacation Supplies of Medications. As of September 12, 2014, HFS does not cover lost, stolen, or destroyed over-the-counter (OTC) medications for all participants. Lost, stolen, or destroyed prescription medications are not covered for adults except for contraceptives, anticonvulsants prescribed for seizures, albuterol inhaler prescribed for asthma or chronic obstructive pulmonary disease, immunosuppressive agents for transplant participants, insulin vials, and antipsychotics for schizophrenia. For children through the age of 20, one single approval per 365-day period can be approved if the medicine was lost, stolen, or destroyed. Vacation supplies of medications for adults are not covered and are reviewed on a case-by-case basis for children through age 20. 14-day Supply of Medications for Long Term Care Residents. Effective May 1, 2013, the Department requires certain medications to be dispensed to nursing home residents in 14-day supplies in order to increase efficiencies and reduce waste. Medications include certain brand-name, solid oral drugs. Solid oral doses of antibiotics and drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or that are customarily dispensed in their original packaging to assist participants with compliance, such as oral contraceptives, are excluded from this requirement and may be dispensed in days' supplies greater than 14.
Indiana	In 1994, the CMS contracted a panel of advisors with extensive experience in both DUR and program evaluation studies to develop the %u201cGuidelines for Estimating the Impact of Medicaid DUR.%u201d%u00b9 The guidelines were developed because the CMS recognized the difficulty in producing legitimate estimates of savings associated with DUR programs with an acceptable level of rigor given very real operational and resource limitations. Studies must be rigorous enough to be confident that the results are attributable to DUR activities. According to the Guidelines, limiting the DUR savings results to global estimates of savings in the drug budget or overall Medicaid expenditures is not acceptable. Pro-DUR savings estimates should specifically track results relative to individual cases affected by pro-DUR alerts. One cannot sum dollar amounts associated with all denials and/or reversals and claim these as the total pro-DUR cost savings, either. The reason being: one cannot assume that all denials of prescriptions through on-line pro-DUR edits results in changes in drug use and expenditures. If the claim is filled with a substitute medication or is delayed by several days in filling, states should track the net effects upon expenditures. Likewise, one must use caution in estimating the costs avoided from %u201creversal%u201d of claims and only measure costs avoided from true reversals that remain reversed. Tracking and calculating costs associated with pharmacists' actions resulting from pro-DUR edit alerts have always been difficult at best. Comparison group designs are normally recommended; however, with on-line pro-DUR, comparison populations who are not receiving an alert are not possible. Zimmerman, T. Collins, E. Lipowski, D. Kreling, J. Wiederholt. %u201cGuidelines for Estimating the Impact of Medicaid DUR." Contract #500-93-0032. United States Department of Health and Human Services, Health Care Financing Administration: Medicaid Bureau. August 1994 OptumRx's outcomes measures of therapy improvements and cost savings were not dependent upon receiving prescriber responses about the faxed letter. Instead, actions were measured from claims data to determine what prescribing patterns have actually changed as a result of educational interventions. Drug savings estimates from retro-DUR were measured by the claims 180 days before and after interventions.

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	To analyze recipients' drug use, OptumRx followed the 1994 CMS %u201cGuidelines for Estimating the Impact of Medicaid DUR.%u201d OptumRx compared the cost of all prescription drugs for each recipient before and after physicians received faxed alert letters. By following CMS' guidelines, our analysis measured %u201cthe substitution effect.%u201d That is, prescribers may substitute another drug in the same therapeutic class in place of the drug about which the faxed alert letter was sent. Therefore, OptumRx's analysis also included the cost of other drugs in the same therapeutic class. OptumRx calculated each period's costs using the exact quantities of each drug dispensed and the cost of the claims (defined as reimbursement formula specified in the plan). Cases were analyzed using 180 days of claims data before and after the faxed letter/intervention. The number of prescriptions and cost of drug therapy were then compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was evaluated compared to a control group. Any savings that occurred can then be attributed to the DUR intervention and not some other effect. The Indiana Medicaid DUR program has been shown to be beneficial to the state, provider community, and beneficiary population served. OMPP will continue to monitor and improve the retro-DUR and pro-DUR programs.
Iowa	Patient Focused Review Summary Profiles Reviewed - 19 Number of Suggestions Made - 20 Number of Changes Made - 10 Total Dollars Saved on Medication - $10,173.48 Problem Focused Review Summary Duplicate SSRIs: members evaluated - 3; positive impact - 3 (100%); Cost Savings - $238.56 The goal of Drug Utilization Review (DUR) is to evaluate cost savings and provide quality assurance of medication use. The DUR Commission works in conjunction with the pharmacy medical program at the Iowa Medicaid Enterprise to contribute to the overall success of the program. The Drug Utilization program: *Evaluates three areas of activity including Patient-focused Drug Utilization Reviews, Problem-focused Drug Utilization Reviews, and Administrative Activities. *Examines only direct drug costs. DUR evaluation does not have the ability to quantify its impact on other health services such as hospitalizations, ER visits, and physician visits. *Reports pre-rebate savings since access to supplemental rebates is not within the scope of the DUR program. *Often provides recommendations that are qualitative, such as improved health outcomes, rather than quantitative in nature. As a general principle, evaluations are based upon an observed change in the targeted prescribing or dispensing pattern, as well as changes seen in therapy of the individual patients. One evaluation approach is to observe and quantify changes in prescribing due to a given intervention compared to a control group of providers who do not receive the intervention. The intervention's impact on prescribing may be more readily detectable by this method and could be measured by comparing the two groups of patients or prescribers. However, it is very difficult to design a scientifically sound control group given the many variables surrounding

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	patient care. Therefore, in most instances the DUR Commission has chosen to forego use of a control group to achieve the greatest impact. Although the evaluation of the intervention may be less scientific, intervention on behalf of all the patients is more desirable. In this instance, prescribing trends may not be available for comparison, but savings and benefit can still be quantified at the individual patient level. Patient-focused DUR Patient-focused DUR concentrates efforts on specific suggestions made about an individual patient. Each suggestion, or template, attempts to make a change in therapy. These changes are either therapeutic or cost-saving in nature; however, these situations are not necessarily mutually exclusive. A therapeutic change -- one that improves the patient's therapy in some way -- may also produce cost savings. Cost-saving changes are attempted when a patient is not receiving a medication in the most economical form. The intervention does not change the medication but points out that the same medication could be given in a more cost-effective manner. Each template and intervention is evaluated to determine if the proposed change was implemented and, if so, what economic implications can be calculated. The calculation relating to therapeutic and cost saving interventions is tabulated by comparing a member's initial profile with the member's re-review profile. Each member profile is a six-month snapshot of medications covered by the Medicaid program. Pertinent information such as patient name and ID, date of service, drug name, strength, and quantity, RX number, day supply, prescriber and pharmacy ID, total price submitted, and amount paid appear on each profile. There are nine months in between the initial and re-review profiles to accommodate for provider review, response, and implementation for therapeutic and or cost changes. For each intervention, the total amount paid on the initial profile for any one intervention is noted. According to the intervention at hand, the re-review profile is evaluated for change. The amount paid on the re-review profile for the same intervention is also noted. A comparison between the profiles is calculated by subtracting the total amount paid from the initial profile with the total amount paid from the re-review profile. This calculation is then annualized multiplying the number by 2 to get the pre-rebate annualized savings. All savings for patient-focused review are based on annualized savings for one year only. Reporting on patient-focused interventions will provide the following information: Total number of templates mentioned Number of templates that were therapeutic in nature Number of templates that were cost-saving in nature Total number of changes implemented Number of changes that were therapeutic in nature Number of changes with positive impact without savings Number of changes that were cost-saving in nature Total dollars saved from therapeutic changes Total dollars saved from cost-saving changes Total dollars saved Impact of interventions expressed as a percentage All templates are described by one of sixteen classifications. These classifications indicate the general type of intervention addressed by the template. Reports will also include a breakdown by classification (therapeutic or cost-saving) of the templates used in the patient-focused letters.

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	This data will show which templates are cited most often, result in change most often, and result in higher cost savings. Templates that are therapeutic in nature include: Not Optimal Drug Not Optimal Dose Not Optimal Duration of Use Unnecessary Drug Use Therapeutic Duplication High Cost Drug Drug-Drug Interaction Drug-Disease Interaction Adverse Drug Reaction Patient Overuse Patient Underuse Therapeutic Alternative Missing Drug Therapy Templates that are cost saving in nature include: Not Optimal Dosage Form Potential Generic Use Inappropriate Billing Problem-focused DUR Problem-focused DUR concentrates efforts on a specific problem or trend in prescribing. While patient-focused reviews may address a multitude of situations, a problem-focused review addresses only one concern. The DUR Commission uses guidelines, literature and peer-group prescribing to identify particular clinical situations that need addressed. This process ensures that each intervention is unique due to the subject matter and may differ in steps of evaluation. Reporting for problem-focused interventions will include the types of intervention done and the resulting savings. Savings are always calculated based on one year of therapy only and are calculated in the same manner as explained in the patient-focused DUR section. Administrative Review The Drug Utilization Review (DUR) program is a component of the Pharmacy Medical Division of the Iowa Medicaid Enterprise (IME). DUR contributes expertise and information that leads to implementation in other programmatic areas including, but not limited to: Prospective Drug Utilization Review, Prior Authorization, Preferred Drug List, Disease Management, and Supplemental Rebates. Although the DUR program impacts all of the different pharmacy programs it is difficult to determine where its impact begins and ends. Therefore, the savings associated with DUR contribution in other pharmacy areas cannot be determined.
Kansas	Take the averaged PA timespan (days) per assignment code multiplied by average FFS utilization units per day multiplied by an averaged price per unit (PPU) from the FFY.
Kentucky	ProDUR: ProDUR cost avoidance for the Kentucky Medicaid Fee-for-Service (FFS) Program is the sum of the claims that were reversed or denied and not resubmitted. The estimated ProDUR cost avoidance for FFY2020 was $79,700,436. However, cost avoidance should not be interpreted as

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	true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, the complete impact this has on the program is unknown. There are many prescriptions that are switched at point-of-sale to alternative medications, which have an equivalent or improved therapeutic benefit and therefore do not generate a ProDUR edit. The cost of the alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influences this calculation is multiple claim submissions for an individual beneficiary's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims the calculations would be inflated. MAC: The Maximum Allowable Cost (MAC) program establishes a maximum price per unit at which the Kentucky Medicaid FFS Program will reimburse pharmacy providers for generic medications. By using the MAC price, the Medicaid Program reimburses at the same rate for the included products, regardless of the Wholesale Acquisition Cost (WAC). This enables pharmacy providers to select the agent that is most effective for them without disadvantaging the Medicaid Program. MAC program savings are calculated by re-pricing each claim that paid at MAC as if the MAC price had not existed at the point of adjudication. MAC savings is the difference between the MAC price and the recalculated payment amount. During FFY 2020, the MAC program provided an estimated cost avoidance of $1,591,998. PDL: Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings is generated by shifting the market from more expensive, non-preferred products, to less expensive, preferred products. The estimated savings provided by the PDL program during FFY 2020 was $11,261,490. Preferring Brand Products over Generics: When a new generic comes to market, often times it is granted a six (6) month exclusivity period to allow the generic manufacturer time to recoup some of the monetary investment required to get that generic to market. During this time, there are no competitors; therefore, the price is not driven down by competition in the market. In order to maintain their current position in the market space, manufacturers of the branded product will continue to pay supplemental rebates as long as their branded drug is preferred over the new generic product. This results in the branded product being less costly to the Commonwealth; net of federal and supplemental rebates. As more generic products enter the market and the price is driven down by competition, the branded product, net of federal and supplemental rebates, eventually will become more costly than the generic product; and at this time, the generic will be preferred over the brand. By preferring more cost-effective branded products over generics the Commonwealth has experienced an estimated cost avoidance of $4,871,564 during FFY 2020. Dose Optimization and Quantity Limits: The Dose Optimization Program encourages prescribers and pharmacies to use fewer tablets of a higher strength as opposed to more tablets of a lower strength. In many cases, all strengths of a medication have similar, if not identical, prices. This program promotes cost-effective drug

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	utilization, without compromising quality of care. Dose optimization also serves to increase compliance by simplifying dosage regimens. Kentucky FFS Medicaid has instituted a limit to the number of dosage units per day that can be billed to Medicaid for certain drug products. FDA approved dosages and reports from clinical literature were considered when developing these limits. In addition to ensuring that Medicaid is not billed for inappropriate doses of the affected medications, this program also serves as a safety measure to Kentucky FFS Medicaid beneficiaries, ensuring that they do not receive inappropriate doses of these medications. Quantity limits also prevent billing errors and subsequent overpayment. Together, the dose optimization and quantity limit programs produced an estimated cost avoidance of $5,366,661 during FFY 2020. Diabetic Supplies Program: Kentucky FFS Medicaid requires that diabetic supplies be billed through the pharmacy benefit. Similar to the PDL, the Diabetic Supplies Program solicits bids for rebates from the manufacturers of blood glucose monitors and test strips. Additionally, market shift savings is generated by shifting the market from more expensive, non-preferred products, to less expensive, preferred products. During FFY 2020, the KY FFS program invoiced for $719,724 in supplemental rebates for preferred diabetic supplies. Retro DUR: Magellan Medicaid Administration uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. Indirect effects arise when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a twelve (12) month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. The RetroDUR cost savings during FFY 2020 is estimated to be $22,131. Monthly cost savings may vary due to a variety of factors, including: the class selection and problem type chosen for review, intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system, the lag time before the next physician visit when changes in drug therapy may occur, and/or the incremental educational and familiarity impact on the prescriber after receiving intervention letters. Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve (12) consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the fiscal year, have not all completed

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	follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2020 will not be known until after the end of FFY 2021. Overall Cost Avoidance and/or Savings: During FFY 2020 the combined cost avoidance or savings generated by all of the above initiatives was estimated to be $103,534,004.
Louisiana	Prospective DUR methodology: Cost avoidance attributed to prospective DUR in FFY20 is $33,108,585. The analysis included all claims that generated clinical alert messages. All claims that were denied or reversed for clinical alert issues that were not paid by subsequent resubmission were identified. These claims were grouped by alert type and included in the cost avoidance calculations. Claims which were first denied due to the early refill edit then were subsequently paid as the early refill threshold was reached were included in the report based on the following methodology: Dollar cost per day of the medication multiplied by the number of days span between the date the claim was initially denied and the date of which the claim was subsequently paid. Retrospective DUR (LADUR) methodology: Cost avoidance attributed to retrospective DUR interventions in FFY20 is $18,633. The approach to measurement of cost avoidance was based on several conservative premises. Only recipients reviewed in the LADUR process were included. No extrapolation was made to any other segment of the Medicaid population. Recipients excluded from the process include: 1) Recipients whose eligibility did not extend continuously from three months prior to the profile review meeting date through six months following the date of review. 2) Recipients who expired prior to the post review period. Only expenditures in pharmacy services were measured. No attempt was made to measure changes in professional services, hospitalization, or ancillary medical services. No factor was included to adjust for escalating prescription ingredient costs, utilization of high-priced new drugs or changes in drug mix to more expensive products in the follow-up review period. Data indicates that significant drug utilization pattern changes and reductions universally occur in prescribing and utilization patterns within six months following drug utilization review intervention. The cost avoidance methodology used in this report measured two periods. Period one: each recipient's drug cost per day was calculated in a three-month period prior to the LADUR review. Period two: each recipient's drug cost per day was calculated in a three-month period following the LADUR review. This interval allows time for physician intervention and follow-up claim data to appear on the history file. Lock-in Program methodology: Cost avoidance attributed to the Lock-in Program in FFY20 is $8,000. The estimated cost savings attributable to the FFS Lock-in Program was based on a review of Medicaid claims pre and post Lock-in enrollment. An estimated member month savings was

State	Cost Savings/Cost Avoidance Methodology
	determined based on a cohort of beneficiaries and multiplied by the number of Lock-in member months during FFY 20.
Maine	Total cost savings are based off of aggressive management of the MaineCare Preferred Drug list through careful management of SMAC savings, lower of cost pricing of pharmacy claims, timely PDL management and strong SR negotiations to maximize lower program cost and maintaining excellent quality care choices. Savings include AWP savings from a calculated claim level and rather than looking at ProDUR or RetroDUR as reflections of cost avoidance since these claims may come in through prior authorization or changed to another medication of choice and captured through PDL savings estimates. We look at true cost avoidance through TPL cost avoidance which is included in the estimates above
Maryland	1 PDMU1000-RC002 MARYLAND MEDICAID PAGE 1 AS OF 2020-09-30 ACS PRESCRIPTION BENEFIT MANAGEMENT RUN DATE 12/25/2020 P R O S P E C T I V E D U R S A V I N G S R A N K E D B Y A M O U N T P A I D CLAIMS PAID FROM 2019-10-01 - 2020-09-30 GROUP:CAID MARYLAND - DIVISION OF ME DUR ALERTS SUMMARY 0 CC DESCRIPTION PAID CLM PAID AMT DENIED CLM DENIED AMT REVERSE CLM REVERSE AMT TOTAL SAVINGS DD DRUG-DRUG INTERACTION 1,802,501 158,490,888 0 0 188,509 22,798,141 $22,798,141 TD THERAPEUTIC DUP (NOT D.0 USE) 715,251 91,098,002 0 0 81,717 13,820,046 $13,820,046 ID INGREDIENT DUPLICATION 654,039 36,191,378 0 0 65,061 5,563,479 $5,563,479 ER OVERUSE 50,153 7,127,943 144,779 20,575,991 0 0 $20,575,991 LD LOW DOSE 87,640 4,905,844 0 0 12,319 907,276 $907,276 HD HIGH DOSE 54,902 1,840,418 0 0 3,005 400,408 $400,408 PA DRUG-AGE 11,963 298,266 0 0 1,084 50,503 $50,503 SX DRUG-GENDER (NOT D.0 USE) 97 28,993 0 0 19 8,868 $8,868 0 3,376,546 299,981,736 144,779 20,575,991 351,714 43,548,724 $64,124,716 0 SUMMARY LINE ALL CONFLICTS 2,521,702 241,521,334 144,779 13,865,484 267,787 34,983,538 $48,849,023 0 PLEASE NOTE: 1. A CLAIM IS COUNTED AS DENIED ONLY IF IT IS NOT FOLLOWED BY A PAID CLAIM FOR THE SAME INDIVIDUAL/DATE OF SERVICE/DRUG COMBINATION. 2. A CLAIM IS COUNTED AS REVERSED ONLY IF IT HAS BEEN REVERSED WITHIN 24 HOURS (A SAME DAY REVERSAL). 3. A DENIED CLAIM IS COUNTED AS DENIED ONLY ONCE IF FOLLOWED BY MULTIPLE DENIES FOR THE SAME INDIVIDUAL/D O S/DRUG COMBINATION.

State	Cost Savings/Cost Avoidance Methodology
	4. SAVINGS ATTRIBUTABLE TO EARLY REFILL (ER) ARE PRIMARILY COSTS DELAYED. IN OTHER WORDS, APPROXIMATELY 80% OF ER CLAIMS GO ON TO BE FILLED AFTER WAITING A FEW DAYS. THEREFORE, ER SAVINGS ARE CONSERVATIVELY CALCULATED AS 20% OF THE CLAIMS THAT HIT ER (AND DO NOT GO ON TO BE FILLED LATER). 5. A CLAIM REVERSED FOR LOW DOSE (LD) WAS CONSIDERED SAVINGS, BECAUSE THE PRESCRIPTION WAS NOT DISPENSED IN AN INEFFECTIVE DOSE. 6. THIS REPORT ONLY USES CONFLICT CODES ASSOCIATED WITH ACTUAL SAVINGS. CONFLICT CODES INCLUDED IN SAVINGS CALCULATIONS ARE: --DC, DD, ER, GA, HD, ID, LD, LI, MC, MX, PA, PG, SX, TD Table 3 - Estimated Cost Savings for FFY 2020 Single/Multiple Interventions Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings Single Intervention $601,187 $142,672 $458,515 Multiple Intervention $11,388 ($-14,610) $25,998 Total Estimated Cost Savings $484,513 HID found the intervention group had a decrease of 24.12% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had a decrease of 7.45%. These changes resulted in an estimated cost savings of $285.51 per recipient who received an intervention during FFY 2020. Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions or other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Maryland Medicaid Program. During FFY 2020, 1,679 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $484,513 for FFY 2020.
Massachusetts	MassHealth CMS DUR Report FFY 2020 Cost Avoidance Methodology To calculate cost avoidance, prescription denials for FFY2020 were analyzed. Because a prescription can be denied multiple times at the point of service (POS), unique MassHealth utilizers rather than claims were used to count claim denials. MassHealth has a prescription duration limit of 30 days for most drugs, and most prescriptions are for 30 days. Therefore, every member with a claim in a month for any drug was counted as one denial for that drug in that month.

State	Cost Savings/Cost Avoidance Methodology
	Drugs were classified by ingredient, strength, and dosage form using the First DataBank Generic Sequence Number (GSN). They were also divided into brand and generic using fields S, N, I as defined on the NDC extract file provided by CMS (see Table 2 of this survey). Drug category N Non-innovator Multiple-Source was used for generic drugs as in Table 2, and categories S (Single-Source) and I Innovator Multiple-Source were grouped together as brand drugs. Average cost per claim for each drug + brand/generic classification was computed using MassHealth paid claims for FFY 2020. Third party claims, and drugs not classified by CMS were not included in the computation. This cost avoidance calculation was restricted to denied claims with utilization review and early refill rejections. This includes NCPDP reject codes 75 (Prior Authorization Required), 79 (Refill Too Soon), and 88 (DUR Reject Error). Third party claims were not included. The amount that would have been paid for these claims was calculated, and then the presumed cost after utilization review was subtracted from this total. Reject Code 75 (Prior Authorization Required) The Drug Utilization Review Program reviews all prior authorizations (PAs) for prescription drugs. In this analysis, percentages of prior authorizations approved and denied for each drug by GSN were used as a proxy for prescription disposition after denial. For each drug denied with reject code 75, the average cost per claim (brand and generic) was computed using paid claims for FFY 2020. Subsequent member prescription history was estimated using First DataBank therapeutic classes. Each GSN was matched with the least costly GSN in its therapeutic class to represent the least costly alternative (LCA). To estimate potential cost avoidance, the following formulas were used: For each drug: Number of denied claims = Total denied claims by member count X prior authorization denial rate Cost savings = Number of denied claims X (average cost per claim minus cost of LCA) To estimate cost avoidance for the year, the totals for each month were multiplied by the number of months remaining in the year. Reject Code 88 (DUR Reject Error) The Drug Utilization Review Program reviews a proportion of reject code 88 denials through its call center. The percentages of reject code 88 denials approved and denied through phone submissions was computed. Then the same formulas used above for reject code 75 were applied. For each drug: Number of denied claims = Total denied claims by member count X phone override denial rate Cost savings = Number of denied claims X (average cost per claim minus cost of LCA) To estimate cost avoidance for the year, the totals for each month were multiplied by the number of months remaining in the year. Reject Code 79 (Refill Too Soon) The Drug Utilization Review Program monitors early refill percentages and administers emergency early refill overrides through its call center. Early refill thresholds for MassHealth are 80% for nonscheduled drugs and 85% for scheduled drugs. For MassHealth early refill denials, the average percent of days used was determined to be 51% for nonscheduled drugs and 64% for scheduled drugs. Using a pickup time estimate of 85% for nonscheduled drugs and 90% for

State	Cost Savings/Cost Avoidance Methodology
	scheduled drugs, the percent of days' supply avoided was calculated at 85% - 51% = 34% of days' supply for nonscheduled drugs, and 90% - 64% = 26% of days' supply for scheduled drugs. For each drug: Cost savings = Total denied claims by member count X average cost per claim X % of days' supply avoided Totals were calculated as a one-time savings for each member and month. Hepatitis C Prescriber Outreach on Hepatitis C Prior Authorization Requests - Projected Cost-Avoidance Cost-avoidance projections Following the Food and Drug Administration (FDA)-approval of Sovaldi (sofosbuvir) and Olysio (simeprevir) in late 2013, all prior authorization (PA) requests for hepatitis C regimens have been reviewed by Drug Utilization Review (DUR) to promote selection of the most cost-effective regimen. Several other products, Harvoni (ledipasvir/sofosbuvir), Viekira Pak and Viekira XR (ombitasvir/paritaprevir/ritonavir and dasabuvir), Technivie (ombitasvir/paritaprevir/ritonavir), Mavyret (glecaprevir/pibrentasvir), Daklinza (daclatasvir), Epclusa (velpatasvir/sofosbuvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier (elbasvir/grazoprevir) were also included in the prescriber outreach to discuss treatment alternatives following their FDA-approvals. At the time PA request for one of the above products is received by the DUR, a clinical pharmacist may contact the prescriber to discuss an alternative, more clinically appropriate or more cost-effective regimen. If the prescriber agrees to switch the member to the suggested regimen, prescriber may resubmit the PA request for that regimen and receive an approval. In order to estimate cost-avoidance generated from switching members to alternative regimens, members were included in the analysis if a regimen change facilitated by the DUR pharmacist led to a virologic cure. Cost-avoidance is calculated as the difference between the cost of the initially requested regimen and the cost of the recommended and approved regimen. Additional costs that may have been incurred whenever a more a clinically appropriate, but not necessarily less costly regimens were recommended by the DUR pharmacist to the prescriber are included. Limitations: Cure rates from treatment with the initially requested and subsequently approved pharmacist-recommended regimen were assumed to be equal. Thus, cost-avoidance may be higher when adjusting for higher expected cure rates with the pharmacist-recommended regimen. While additional cost may have been incurred from extension of treatment duration, additional cost-avoidance is likely to have been generated from improved cure rates in these members.
Michigan	ProDUR cost avoidance for the Michigan Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. Cost Avoidance for paid claims is calculated by taking the dollar amount of paid claims with a ProDUR message that were subsequently reversed and subtracting the paid amount of the claims that were resubmitted within 72 hours. Cost Avoidance for denied claims is calculated by taking the submitted dollar value of the claims that were initially denied that had a ProDUR message and subtracting any of those claims that were then resubmitted within the same calendar month that paid. The DUR Board continually monitors prescribing patterns and drug appropriateness through trend analyses. They oversee the specialized RetroDUR academic detailing program, WholeHealthRx, that targets the prescribing practices for behavioral health and opioid medications through intervention letters and face-to-face consultations. The program's evaluation methodology monitors for continuous enrollment for the targeted beneficiaries.

State	Cost Savings/Cost Avoidance Methodology
	Beneficiaries with no claims during the post intervention period are excluded for the analysis. A cross-sectional analysis compared the pharmacy spend six months pre- and post- evaluation. The consultation date served as the index date. Consultations were conducted between September 2019 and June 2020. A total of 6,764 prescribers of 8,554 distinct beneficiaries were targeted. The program measures the success in closing gaps in care for the targeted intervention. The interventions during this period ranged from 46% to 57% of gaps in care closed. The estimated cost savings generated from these interventions was $1,459,374.
Minnesota	The five areas included are prospective drug utilization review (ProDUR) edits, the refill-too-soon hard edit, the Minnesota SMAC (state maximum allowable cost) program, prior authorization of brand name drugs, and the retrospective drug utilization review (RetroDUR) program. This does not include savings from uniform Preferred Drug List (PDL) or from the Specialty Pharmaceutical Reimbursement Rate. Prospective DUR The Minnesota Department of Human Services (DHS) on-line prospective drug utilization review program (ProDUR) moved into production in MMIS II on February 27, 1996. On August 6, 1996, the first DUR edit, for overutilization, was set to deny. Additional edits were set to deny over the next year. For FFY 2020, the gross calculated allowable reimbursement amount for claims denied by ProDUR edits minus amounts that would have been paid by third party liability was $7,067,664. However, the gross amount does not take into account factors such as claim resubmissions and changes in the drug prescribed. In 1996, the Reports and Forecasts Division developed a method to estimate actual savings attributable to the ProDUR Program. Using this method estimated actual savings is in the range of $19,370,400 to 51,807,087. Refill-too-soon hard edit On January 22, 2004, there was a significant change in ProDUR edits. The refill-too-soon edit became a hard edit where claims are stopped if less than 75% of the previous prescription was utilized for non-controlled substances and 85% for controlled substances. Pharmacy providers now have to call the provider help desk in order to obtain an override where previously, the pharmacy providers only needed to enter an online DUR reason code and resend the claim. Reasons to allow the provider help desk to override the refill-too soon were developed by the pharmacy policy area. The gross calculated allowable reimbursement amount for claims less TPL (third party liability) denied with the refill-to-soon edit was $46,684,269. Out of 331,941 denied claims, only 1,967 (0.6%) were given overrides by the provider help desk. The amount paid for claims with an override for refill too soon less TPL totaled $839,105 with an estimated savings in the range of $11,438,368 to $30,592,478 for the refill-too-soon edit. Minnesota State Maximum Allowable Cost (SMAC) program Beginning June 1, 2011, Change Healthcare entered into a contract with Minnesota Department of Human Services to provide suggested SMAC prices. Minnesota FFS drug cost reimbursement is based on the CMS National Average Drug Acquisition pricing, NADAC-brand and NADAC-generic pricing. When NADAC pricing is not available, the ingredient price is based on the lower of SMAC or WAC-2 percentage (WAC is the wholesaler acquisition cost). The Minnesota SMAC program's cost avoidance compared to the National Average Drug Acquisition (NADAC) aggregate cap was $1,231,243. Specialty Pharmaceutical Reimbursement Rates continue to be provided by Change Healthcare and are not included in this savings calculation.

State	Cost Savings/Cost Avoidance Methodology
	Prior authorization of brand name drugs To further encourage the use of generics, brand name legend drug prescriptions require prior authorization in addition to the prescriber writing DAW-brand name necessary. This requirement became effective January 1, 2004. Administratively, this edit is tied to generic pricing either the NADAC-generic or SMAC. If the drug is has NADAC-generic pricing or SMAC pricing, the claim will adjudicate and pay for the legend, brand name drug at lower price unless a prior authorization for DAW-brand name necessary has been granted. Therefore, using prior authorization along to override generic pricing continues to provide a high rate of generic utilization. Retrospective DUR During FFY 2020, there were six population-based DUR mailings. The DUR Board reviewed the Conduent population-based proposals and provided their recommendations to the criteria, letter content, and educational material. To determine cost savings, only those patients are who still eligible in the post intervention period are included and only targeted drugs costs are included. Because the contract with Conduent ended September 30, 2020. There was not a full six months of data post intervention for the last three interventions, Polypharmacy 2020 had only four months of data and for Diabetes there was only 1.5 months of data, and Psychotropic Drugs in Youth #2 has no data. Cost outcomes were available for (1) Opioid, Benzodiazepines, and Antipsychotics which showed costs decreased by $56,746 (2) Psychotropic Drugs in Youth #1 which showed costs decreased by $920,726 (3) Psychotropic Drugs in Adults 2020 showed costs decreased by $617,910 (4) Polypharmacy which showed costs decreased by $656,463 (based on only a four months post intervention and annualized, (5) Diabetes which showed costs increased by $107,198 (based on one and half months post intervention which was annualized and (6) Psychotropic Drugs in Youth #2 (which was not determined as the mailing occurred two weeks before the contract ended). Therefore, the total net effect of the retro-DUR was a decrease of $2,144,647 in drug expenditures reduced by the amount of $120,000 per year for the RetroDUR contract equals $2,024,647 with an estimated savings range of $505,149 to $1,351,047.
Mississippi	The prospective DUR cost savings estimate provided by Conduent was generated by summing all claims that post a DUR reject error, NCPDP reject code 88, during the 2020 Federal Fiscal Year (October 1, 2019 - September 30, 2020), then subtracting the alerts that were overridden.
Missouri	For each Retrospective Drug Utilization Review that is performed there are members and prescribers identified with performance indicators. These indicators are suggestions that medical and pharmaceutical care can be improved by changing prescribing habits. These may include Drug-Drug Interaction, Medication Adherence, Underutilization, Overutilization, Coordination of Care and Risk of Adverse Drug Event. We mail on a specified date. When we have six-months of data following the mailing we then analyze utilization for the targeted members use of intervention drugs identified. From this we determine the targeted members PMPM (per-member-per-month) costs for the six-months prior to mailing (the pre period) and for the six months following the mailing (post period). Subtracting the post period PMPM from the pre period PMPM provides the savings per member per month for the target members. This is multiplied the number of member-months that the targeted members had in the post period. This gives us projected cost savings for the six-month period following the mailing. We then multiply this by two to obtain the annualized savings (cost avoidance) provided by each individual Retrospective Drug Utilization Review. These are summed to provide the total cost avoidance (Savings) for the entire RetroDUR program.
Montana	ProDUR--Prior Authorizations

State	Cost Savings/Cost Avoidance Methodology
	Total PA Requests 68409 / Approved 30390 / Denied 28316 / Denial Rate 48% / Non-Clinical Rate 14% / Total savings $23,376,647 Case Management--Other Cost Avoidance Total Cases Reviewed 3113 Total Clinical Interventions 2408 cost savings assigned 213 cost savings unable to determine 2195 Selection Method PA 227 CM 2181 Other 0 Contact Type MD 882 RN 643 RX 217 PA 148 NP 399 Other 590 Outcome Compliance Noted 4 Dose Changed 4 Drug Changed 1 Drug Discontinued 0 Labs Completed 4 Pending Response 592 No Change 31 Other Change 502 Per Plan 1983 Not specified 5 Criteria Selection Abuse Refer to DPHHS 3 Academic Detailing 219 Atypical Antipsych PA Required 123 Atypical High Cost 49 CF 55 Clinical- General 92 Drug Dosage 21 Drug Not Covered 105 Drug Recommendation Request 0 Drug -Disease Contraindication 18 Drug-Drug Interaction 18 Duration of Treatment 0 Eosinophilic Asthma 42 Foster Care Psychotropics 436 Fraud Refer to DPHHS 6

State	Cost Savings/Cost Avoidance Methodology

HAE 16
Hep C 256
ITP/Severe Aplastic Anemia 15
MAT 168
Medication Overutilization 1
Movement Disorders 89
Multiple Medications 7
Multiple Pharmacies/MDs 54
Overutilization 18
PA Requests Higher Level Clinical Review 296
PA Required (Old) 1
PBA 13
Potential Clinical Abuse or Misuse 33
Team Care 196
Therapeutic Appropriateness 49
Therapeutic Duplication 7
Underutilization 2

Total in Progress 728
Total Completed 2384

Operational Monthly Cost Savings* $958

CM Monthly Cost Savings $485,837
Annualized CM Cost Savings $5,832,419
Total YTD Cost Savings (=YTD Operational Cost Savings + Annualized CM Cost Savings) $5,833,377

Analysis Methodology
Each month, pharmacy and medical claims data are reviewed against a library of clinical criteria. Once members have been identified and RetroDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends.
Beneficiary Selection: A total of 684 members met the criteria for intervention letters during FFY 2020.
Estimated Cost Savings Methodology
To determine the impact of RetroDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RetroDUR intervention letters.
The comparison group consisted of a random group of members who were not chosen for RetroDUR intervention letters. For a member to be included in the analysis for either the

State	Cost Savings/Cost Avoidance Methodology
	intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, members were analyzed using 180 days of claims data before and after the RetroDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RetroDUR intervention letters. Members were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RetroDUR interventions on the same member within FFY 2020). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after intervention. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RetroDUR criteria. Educational interventions were completed with providers during federal fiscal year 2020. The drug claims for the selected members were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RetroDUR interventions. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there was an estimated cost savings of $180,209. Intervention Group. Change between 6 Month Pre and Post: $182,514 Comparison Group. Change between 6 Month Pre and Post: $2,305 Estimated Cost Savings: $180,209
Nebraska	When a claim is denied due to a prospective edit, there may or may not be a replacement claim. Each denied claim is compared and matched with paid subsequent claims based on the internal patient id and the GPI6 codes. Due to our Magellan RX system limitation, we cannot decisively link a subsequent paid claim to the original denied claim. To work around this limitation, each denied claim is compared and matched with paid subsequent claims based on the internal patient id and the GPI6 codes. Detail of process: Step 1: Identification of a denied claim: Claims that have been denied for the study quarter /yearly are extracted from the database. These claims are further linked to the external error codes which defines the reason for the denial of the edit. Clinical and nonclinical edits can be identified based on the NCPDP error codes and the internal response codes. Only last denied edit of the adjudicated claim will be utilized in order to not overestimate saving. Step 2: Identification of a paid -replacement claim: Claims that have been paid for the study quarter/yearly are extracted from the database. Refilled claims are identified. Paid claims that have been filled with the same GPI6 and within the previous 90 days from the members' filled date will be omitted and not be considered as a replacement claim. The paid claims are further matched to the respective denied claims.

State	Cost Savings/Cost Avoidance Methodology
	Methodology Steps: The denied and replacement claims will first be matched by patient ID and the GPI6 to ensure that the replacement claim is for the same therapy. The replacement claim should have a service date on or after the denial claim date and within 14 days. The window between the service date for the denial claim and the paid claim should be 14 days (denied date lesser than or equal to paid date). The denied and replacement claims will lastly be matched by the GPI6_code, HIC3, GSN, BRAND NAME, GENERIC NAME , NDC, and STANDARD THERAPEUTIC CLASS CODE, QTY, DAYS_SUPPLY. Based on these matches, the scores will be generated. Equation of Saving: Cost Avoidance = Unmatched Denied Payment + (Matched Denied Amount Replacement Paid Amount) PMPM = (Cost Avoidance /Membership per time period)/# of Months % Total Cost=Cost Avoidance/(Total Paid Amount + Total Denied Paid Amount)
Nevada	OptumRx calculates the ProDUR savings by summing the amounts on claims either reversed or denied due to a ProDUR edit. We understand these numbers will be inflated as there is no way to track if the medication was later filled again after consulting with the prescriber or patient or taken to a different pharmacy.
New Hampshire	Magellan Health Services uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. This indirect effect arises when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. ProDUR Cost Savings The cost saving for Prospective Drug Utilization is based on cost avoidance when claims are reversed and not resubmitted. For FFY 2020 cost savings for ProDUR $3,135,734. RetroDUR Cost Savings The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a 12-month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. The RetroDUR cost savings including polypharmacy cost savings during FFY 2020 was $0. Table 4A shows the cumulative cost savings for the RetroDUR program. Table 4A New Hampshire Medicaid Program RetroDUR Cost Savings FFY 2020 New Hampshire Medicaid RetroDUR and PolyPharmacy Cost Savings Report Cycle FFY 2020 Therapeutic Description Cost Savings Amt Muscle Relaxants $1,068.87 CNS Stimulants $1,446.16

State	Cost Savings/Cost Avoidance Methodology
	Bronchial Dilators $1,769.30 Antiarthritics ($15,426.10) Anticonvulsants ($72,212.68) Hypotensives, Other $354.04 Total Savings ($83,000.42) Monthly cost savings may vary due to a variety of factors, including: 1. the class selection and problem type chosen for review 2. intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system 3. the lag time before the next physician visit when changes in drug therapy may be made 4. the incremental educational and familiarity impact on the prescriber after receiving intervention letters Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the fiscal year, have not all completed follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2020 will not be known until the end of FFY 2021. Maximum Allowable Cost (MAC) Program The New Hampshire MAC program determines a maximum allowable cost Medicaid will reimburse pharmacy providers for medications. The cost savings is determined by re-pricing the claim paid at MAC as if the MAC price was not established. The New Hampshire MAC program cost savings during FFY 2020 was $54,162. Dose Optimization Program The New Hampshire Dose optimization program promotes the use of commercially available dosage forms for fewer tablet and cost-effective drug utilization when pricing across dosage forms are similar. The New Hampshire Dose Optimization cost savings during FFY 2020 was $10,542.
New Jersey	The New Jersey Division of Medical Assistance and Health Services conducts an on-going analysis of cost savings resulting from the PDUR program. Contributing to this analysis is output from a denied claims report that assesses pharmacy claim activities after PDUR edits have denied initial payments. PDUR interventions manifest themselves in two ways. The first is through PDUR responses returned to pharmacies by the point-of-sale system. In these situations, the pharmacist makes a decision to intervene with the patient and/or practitioner to resolve the PDUR issue. These types of interventions are referred to as having a sentinel effect. Typically these types of interventions result in a PDUR service continuing to be denied or a change in medication or dosage. The second type of PDUR intervention involves the Medical Exception Process (MEP). Certain PDUR edits are set to deny payments without prior authorization. In either situation, the PDUR edits have identified reasons for denying payment without some type of intervention. In order to appreciate the cost savings from these PDUR interventions, a production report (see below) is in place that analyzes claim activities sixty (60) days after a pharmacy service has been denied payment due to a PDUR edit. Cost savings identified in the report reflect costs for PDUR claims denied by a PDUR Edit for which no future paid claims were identified for the 60-day

State	Cost Savings/Cost Avoidance Methodology
	period following the date of denial. The reported cost savings is limited to the absence of a payment for a single PDUR claim. Extrapolated savings are not reflected in this report. The analysis is also performed at the Generic Code Number (GCN) level to capture claim information for all drugs with the same description, strength and route of administration. MEDICAID PDUR SAVINGS* - Total Denied Claims (Nursing Home and Retail Combined) from reruns of report ID Q2862R01 Quarter/CY Year Total Amount 4th quarter 2019 $1,276,848 1st quarter 2020 $1,375,243 2nd quarter 2020 $1,465,486 3rd quarter 2020 $949,227 ProDUR Total $5,066,804 Additional RetroDUR Total Estimated Avoided Costs of $19,759 result in a Grand Total Estimated Avoided Costs of $5,086,563. *Note: Reported cost savings may vary due to changes in drug therapy, such as the prescribing of a different drug or drug dosage.
New Mexico	DUR serves a vital monitoring purpose. Prospective DUR (ProDUR) and Retrospective DUR (RetroDUR) each serve a unique purpose in alerting practitioners and pharmacists with specific, focused and comprehensive drug information available from no other source. If practitioners and pharmacists use DUR as intended, then notification of a potential drug therapy problem will lead to appropriate action taken in response to a ProDUR alert or Retro-DUR intervention. Appropriate actions include discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, switching to safer drug therapies, or even adding a therapy recommended in published (evidence-based) guidelines from an expert panel. ProDUR Savings Ranked by Amount Saved for Paid Date Range October 1, 2019 through September 30, 2020 Conflict Code Description/ # of Paid Claims/ Paid Amount / # of Denied Claims / Denied Amount Paid/ Reverse Claim/ Reverse Amount/ Total Savings DD DRG-DRG INT 36,383 2,993,502 0 $0 4,406 $696,019 $696,019 ER OVERUSE 4,918 587,694 2,695 $332,231 2 $437 $332,669 HD HIGH DOSE 2,374 837,252 106 $34,118 491 $366,495 $400,618 ID INGRED DUP 17,103 1,512,692 0 $0 2,395 $391,469 $391,469 LD LOW DOSE 5,431 1,161,979 0 $0 678 $194,594 $194,594 PA DRG-AGE 295 4,600 0 $0 30 $457 $457 PG DRG-PREG 99 4,676 0 $0 14 $2,062 $2,062 SX DRG-GEN 51 6,224 0 $0 8 $3,092 $3,092 TD THER DUP 22,343 3,940,170 1,508 $268,673 3,601 $1,038,468 $1,307,149

State	Cost Savings/Cost Avoidance Methodology
	Summary Line 88,997 11,048,789 4,309 $635,022 11,625 $2,693,093 $3,328,129 Please note: 1. A claim is counted as denied only if it is not followed by a paid claim for the same individual/date of service/drug combination. 2. A claim is counted as reversed only if it has been reversed within 24 hours (a same day reversal). 3. A denied claim is counted as denied only once if followed by multiple denials for the same individual/D O S/drug combination. 4. Savings attributable to early refill (ER) are primarily costs delayed. In other words, approximately 80% of ER claims go on to be filled after waiting a few days. Therefore, ER savings are conservatively calculated as 20% of the claims that hit ER (and do not go on to be filled later). 5. A claim reversed for low dose (LD) was considered savings, because the prescription was not dispensed in an ineffective dose. 6. This report only uses conflict codes associated with actual savings. Conflict codes included in savings calculations are: DC, DD, ER, GA, HD, ID, LD, LI, MC, MX, PA, PG RetroDUR Cost Savings Estimates for October 1, 2019 through September 30, 2020 Retro DUR Intervention / Savings per Targeted Member per Month / Projected FFY20 Savings Opioids/Benzodiazepines/Antipsychotics N/A ($413.36) Shingrix Newsletter N/A N/A Opioid 90 MME Letter N/A $3,209.08 Opioid 90 MME Letter #2 N/A $732.58 Postpartum Depression N/A ($277.22) Influenza Newsletter N/A $17,050.90 Gabapentinoids and Opioids N/A $17,473.88 Total N/A $37,775.86 In conclusion for FFY 2020, the total estimated new savings for ProDUR and RetroDUR programs for New Mexico was $3,328,129. The RetroDUR estimated savings were $37,775.86 while the ProDUR estimated savings were $3,365,904.86.
New York	State Report: During the reporting period for Federal Fiscal Year (FFY) 2020, there were 1.8 million on-line claim rejections where pharmacists encountered dispensing issues that were avoided due to ProDUR safety edits. On-line claim rejections encountered during the review period encompassed early fill, drug-drug interactions, therapeutic duplication, prescriber consult, drug-disease concerns, and high-low dose complications. The over-all cost per prescription as determined by cost (net of rebates) over prescription volume for the survey period was calculated at $46.94 dollars. Calculated savings from the ProDUR Program amounted to approximately $84.5 million dollars in savings (as determined by multiplying the number of on-line claim rejections by the average prescription cost).

State	Cost Savings/Cost Avoidance Methodology
	Contractor Report:This report prepared by Health Information Designs (HID) for the New York State Medicaid Program shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2020 (FFY 2020). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there was an estimated cost savings of $3,873,340. Table 1 Estimated Cost Savings for FFY 2020 All Interventions Intervention Group Comparison Group Estimated Cost Savings Change between 6 Month Pre- and Post- Change between 6 Month Pre- and Post All Interventions $3,965,378 $92,038 $3,873,340 During FFY 2020, HID reviewed 3,477 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Recipients reviewed for under-utilization issues are excluded from the cost savings calculation, as a cost increase would be expected in response to this type of intervention. For FFY 2020, 3,467 recipients were included in the intervention group. Analysis Methodology Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 6,000 recipients met the criteria for intervention letters during FFY 2020. Of those recipients, 5,581 were enrolled in fee for service (FFS), and 419 were enrolled in a managed care organization (MCO). The cost savings in this report is calculated for FFS recipients only. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or

State	Cost Savings/Cost Avoidance Methodology
	comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2020). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed . Table 3 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for recipients with single and multiple interventions during FFY 2020. Table 3 - Estimated Cost Savings for FFY 2020- Single/Multiple Interventions Intervention Group Comparison Group Change between 6 Month Pre- and Post- Change between 6 Month Pre- and Post- Estimated Cost Savings Single Intervention $3,919,731 $108,737 $3,810,994 Multiple Intervention $45,648 (-$16,698) $62,346 Total Estimated Cost Savings $3,873,340 HID found the intervention group had a decrease of 12.46% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had a decrease of 4.61%. These changes resulted in an estimated cost savings of $1,117.20 per recipient who received an intervention during FFY 2020. The intervention group utilized for the cost savings calculation included 3,467 recipients. Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems including inappropriate use of drugs and increased risk for drug interactions other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the New York State Medicaid Program. During FFY 2020, 3,477 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug

State	Cost Savings/Cost Avoidance Methodology
	therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $3,873,340 for FFY 2020. Additional savings during the survey period: Brand Less than Generic Program; $9.6 million Preferred Drug Program; $3.3 million Lock-In savings; $39.9 million (included MCO data reported by OMIG)
North Carolina	October 1, 2019 to September 30, 2020 Estimated Savings: ProDUR $ 910 million RetoDUR $ 25.2 thousand PA $ 10.9 million PDL $ 96.0 million TOTAL $ 1,017 million ProDUR = Prospective Drug Utilization Review RetroDUR = Retrospective Drug Utilization Review PA = Prior Authorization Program (other than PDL) PDL = Preferred Drug List Program (includes Supplemental Rebates) The ProDUR Cost Avoidance is calculated from the saving of not dispensing prescriptions that denied due to a Pro-DUR edit being applied to the claim. Period Cost Saving Reversals Non-responses Oct 2019 to Sep 2020 $910,213,740 3,064,935 3,605,741 The RetroDUR Savings are calculated from the Retro-DUR activities described in Section III of the Annual Report. Period Cost Savings Oct 2019 to Sep 2020 $25,170 The PDL Savings are the sum of the Supplemental Rebates collected as well as the Market Shift caused by the PDL. The calculations were provided by Magellan Medicaid Administration. Period Supplemental Rebate and Market Shift 2019 Q4 $23,365,673 2020 Q1 $21,503,081 2020 Q2 $15,997,514 2020 Q3 $35,110,928 Oct 2019 to Sep 2020 $95,977,196 The PA Cost Avoidance is calculated by the cost of drugs requiring Prior Approval when the requests were denied. The savings calculated were for drugs not on the PDL. Period Cost Savings Oct 2019 to Sep 2020 $10,939,893 The State of North Carolina contracts with Myers and Stauffer to provide reports on DUR Program Evaluation and Cost Savings/Avoidance. However, at the time of this Annual Report, the reports were not complete.

State	Cost Savings/Cost Avoidance Methodology
North Dakota	Summary: ProDUR and Other cost avoidance amounts are listed as 0 as ND is not aware of the methodology that should be used to calculate those numbers. The RetroDUR cost savings report was prepared by Health Information Designs, LLC for the North Dakota Medicaid Program to illustrate the expected estimated cost savings from their retrospective drug utilization review (RDUR) program and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2020 (FFY 2020). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there was an estimated cost savings of $1,077,097. During FFY 2020, HID reviewed 3,082 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Analysis Methodology: Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. The methodology is validated by independent third party. Estimated Cost Savings Methodology: To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2020). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug

State	Cost Savings/Cost Avoidance Methodology
	price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results: For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed. During this time, the intervention group consisting of single interventions and the intervention group with multiple interventions experienced an estimated cost savings of $852,625 and $88,745 respectively. During this period, the 2 comparison groups experienced a total cost increase of $135,727 (-$135,727 in cost savings). Subtracting the estimated cost savings of the comparison groups (-$135,727) from the estimated cost savings from the intervention groups ($941,370) resulted in a total estimated cost savings of $1,077,097. Further analysis found the intervention group had a decrease of 9.30% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 6.39%. These changes resulted in an estimated cost savings of $462.87 per recipient who received an RDUR intervention during FFY 2020. Results Discussion: All drug claims and some medical claims or diagnosis data is available for analysis, and all medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems including inappropriate use of drugs and increased risk for drug interactions other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion: The RDUR program provides an important educational service to providers enrolled in the North Dakota Medicaid Program. During FFY 2020, 3,082 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,077,097 for FFY 2020.
Ohio	Reversal reason scripts savings DD 58,029 $9,824,977 DD, HD 1,711 $646,418 DD, HD, LD 2 $55 DD, HD, LD, TD 1 $18 DD, HD, TD 436 $295,914 DD, LD 3,999 $575,313 DD, LD, TD 852 $118,805 DD, TD 18,230 $2,945,738 HD 12,403 $3,231,829 HD, LD 6 $74 HD, TD 661 $470,876 LD 22,602 $2,834,140 LD, TD 1,979 $317,268 TD 20,779 $5,603,614 TOTAL 141,690 $26,865,038

State	Cost Savings/Cost Avoidance Methodology
	Claims rejected with DUR Code 88 that are not subsequently accepted DUR 88 - Hard Rejects 65,688 $3,307,787 Total Pro DUR Cost Savings 207,378 $30,172,825
Oklahoma	ProDUR: The ProDUR cost avoidance calculation for the 2020 Federal Fiscal Year (FFY) focused on four ProDUR system edits and twenty-one additional edits that have been identified within the scope of ProDUR but are not accounted for in the ProDUR system. Examples of these additional edits are: Refill Too Soon, Age Restrictions, and Day Supply Restrictions. Claims resulting from these edits were filtered to only include denied claims giving a true cost avoidance from the ProDUR program. Voided claims and claims with products classified as non-drug items by First Data Bank (FDB) were excluded altogether. The ProDUR cost avoidance was calculated by multiplying the total number of denied claims by the average cost per prescription (split into brand and generic cost). The average costs per prescription were calculated to be $468.26 and $37.25, respectively. The brand and generic average costs per prescription were multiplied by the number of claims for brand and generic, respectively, for each edit. These were summed to give a total cost avoidance for ProDUR. Then, this total cost avoidance was multiplied by 40% to account for the 60% rebate recovery percentage (Rebate Recovery percentage is based on the SFY 2020 Annual Report). Therefore, the total estimated ProDUR cost avoidance is $56,568,560.68 for FFY 2020. Notes: 1. This cost avoidance does not take into consideration subsequent paid claims related to changes in pharmacotherapy resulting in the pharmacy alert edits. 2. The average cost per prescription calculation was based on traditional drug spend and excluded specialty drug spend from the calculation to prevent cost avoidance inflation. However, the specialty drug claim count was still included in the total claims, and cost for these claims were also calculated based on brand or generic status as stated above. RetroDUR: Academic Detailing (AD): Antibiotic (ABX) Treatment of Upper Respiratory Infections Outcomes are reported as an annual average per provider during the 5-year Pre-AD period and as a 1-year average per provider during the Post-AD period. Non-drug cost comparisons were assessed by examining non-ambulatory health care service utilization within the 14 days after an initial ABX prescription claim. Changes in Academic Detailing Outcomes [AD Providers (N=43)] Pre-AD|Post-AD|Change*|% Change* ABX Claims 204.7|161.5|-43.2|-21.1% ABX Costs $6,547|$4,215|-$2,332|-35.6% Hospital 0.95|0.47|-0.48|-50.5% Length of Stay 5.15|2.42|-2.73|-53.0% ED Visits 15.7|1.60|-14.1|-89.8% *Negative indicates improvement. Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. AD = Academic detailing; N = Number of providers; ED = Emergency department Total drug cost savings of $2,332 resulted from ABX-AD. In the Pre-AD period, these 43 prescribers cared for patients who completed an average of 675 ED visits per year, with a total annual cost of $739,909. In the Post-AD period, the patients of

State	Cost Savings/Cost Avoidance Methodology
	these prescribers completed a total of 69 ED visits, with a total annual cost of $75,404. Total ED annual cost savings of $664,505 resulted from ABX-AD. In the Pre-AD period, these prescribers cared for patients who completed an average 42 hospital stays per year, with a total annual cost of $330,885. In the Post-AD period, the patients of these prescribers completed a total of 20 hospital stays, with a total cost of $163,701. Total hospitalization annual cost savings of $167,184 resulted from ABX-AD. Estimated cost savings were based on national averages for ED and hospitalization costs as described by the Medical Expenditure Panel Survey (MEPS). Average cost was $1,096 per ED visit and $8,100 per pediatric hospital stay for Medicaid patients. Across all parameters, ABX-AD providers decreased their ABX prescribing and health care utilization. Total annual cost savings of $834,021, or nearly $20,000 per provider, resulted from ABX-AD. Other Cost Avoidance Other Cost Avoidance includes the savings generated from state maximum allowable costs (SMAC) and cost avoidance on claims that require step therapy and/or have clinical Prior Authorization (PA) criteria identified by our Product Based Prior Authorization (PBPA) report. To calculate the SMAC savings, paid claims with a SMAC pricing indicator were identified for the FFY. Then, the SMAC for each claim was subtracted from the potential Wholesale Acquisition Cost (WAC) for each claim to establish the SMAC savings per claim. The total SMAC savings is calculated by summing each claim's SMAC savings and is estimated to be $41,765,521.24 for FFY 2020. For the Product Based Prior Authorization (PBPA) report savings, FFY 2020 PAs are used to identify the total number of members that had a denied PA based on the drugs' National Drug Codes (NDCs). Next, the average cost of each drug is calculated by taking the total reimbursement amount for the drug, subtracting out any federal and/or supplemental rebates claimed for that drug, then dividing that amount by the total paid claim count for that drug. Next, the number of members who were denied a PA was multiplied by the average cost of the drug (as calculated above) to get a total cost avoidance for the drug. This process is done for each drug with a denied PA as shown in the PBPA report. Finally, all drugs' cost avoidances are summed to get a total cost avoidance for the PBPA report. This is estimated to be $9,840,069.16 for FFY 2020. Lastly, Pharmacy Management Consultants (PMC) is responsible for creating clinical prior authorization and step therapy requirements, as well as responsible for approving/denying prior authorizations for members. The total other cost avoidance is derived by adding SMAC cost avoidance and PBPA cost avoidance together and subtracting PMC's contract cost to get a true net other cost avoidance of $47,306,272.84.
Oregon	ProDUR Cost Savings Methodology: Claims that trigger ProDUR alerts are not always denied. The pharmacist will receive a denial for early refill or pregnancy alerted claims, but does not receive a denial when entering a claim that triggers any other informational alerts. Instead, the pharmacist receives an informational alert message that may help them make decisions about dispensing the drug. After receiving a denied ProDUR alert or an informational alert, the pharmacist may choose to override the alert, cancel the claim, resubmit a different claim, or take no action. The cost savings due to claims that were not dispensed because of these alerts is defined as being cancelled and then not being reprocessed again at a later date. ProDUR Cost Savings Methodology: The DURM group created a cost-avoidance methodology designed to conservatively estimate cost avoidance and avoid common overestimations. The methodology calculates savings by considering the ultimate therapy received by the member and the duration of cost avoidance. When payment for a claim is denied for PA required or non-

State	Cost Savings/Cost Avoidance Methodology
	preferred status, all subsequent claims (paid and denied) for the member within the drug class are monitored. Cost avoidance is then calculated based on the initial claim (index event) and the final disposition of therapy within the drug class. The type of cost avoidance are: deferred, therapeutic duplication, switched, add-on, discontinued, and other. Deferred cost avoidance include claims for which the requested therapy is eventually approved and saving are calculated based on the time from the initial request to the first paid claim. Therapeutic duplication, switched and add-on cost avoidance categories address different scenarios when a drug is denied when there are already paid claims for an alternative in the same drug class. Switch cost avoidance covers situations when a restricted access drug (PA required or non-preferred) is denied, but an alternative within the PDL class is subsequently paid. Each cost avoidance type has a distinctive calculation for the duration of cost avoidance and the amount saved, based on the most likely clinical treatment pathway. For example, the switched cost avoidance type only considers the difference between the initial drug requested and the actual drug dispensed. Factors considered for each cost avoidance type include: duration of eligibility for the fee for service program, enrollment into CCOs, maintenance drug indicator, cost of alternative therapy, and the number of paid and denied claims in the drug class. There are limitations to the DURM cost avoidance methodology. Our method is dependent upon detecting a denied claim. Situation such as member new to the Medicaid program or newly marketed medications are adequately tracked and modeled. Providers who have learned the Fee-For-Service Medicaid PDL (or have learned to consult it) will prescribe preferred and unrestricted medications without first generating a denied claim for a drug requiring prior authorization. These types of long-term behavior modifications represent significant cost saving for the FFS program, but are difficult to reliably quantify. Another limitation of the methodology occurs at the beginning and end of the reporting periods. Only costs avoided during the reporting period due to an initial denied claim during the reporting period are included. When an index event occurs immediately before the reporting period, there are savings associated with that event which are not counted in the report. Likewise, when the initial denied claim occurs immediately before the end of the reporting period, the costs avoided after the end of the reporting period are not counted. Significant savings go uncounted with the DURM methodology in the interest of conservative, rather than aggressive, reporting.
Pennsylvania	During this evaluation period, 6,446 educational intervention letters were mailed to prescribers regarding medication therapy. Providers are invited to voluntarily respond to RDUR Program letters. Providers returned 651 responses to these letters, resulting in an overall response rate by the providers of 10.10 percent. In these 6,446 educational letters, the RDUR Program made 8,469 observations and subsequent education. The suggested change was implemented in 3,281 cases, resulting in an overall impact rate of 38.74 percent. Implementation of these therapeutic suggestions resulted in a cost savings of $141,966.15* for the 6,446 patients evaluated, or a savings of $22.03* per patient. *Savings reported are pre-rebate, total dollars
Rhode Island	Retrospective DUR Cost Savings Methodology To determine the impact of the intervention letters on overall drug expenditures, total drug utilization (claims for all drugs) in the targeted population was evaluated 6 months before and 6 months after intervention letters were mailed. Total drug utilization was evaluated since a

State	Cost Savings/Cost Avoidance Methodology
	complete drug history was included with the educational intervention letters and prescribers could make changes to the entire drug regimen, in addition to the drugs noted in the letter. For a recipient to be included in the analysis for cost avoidance, they had to have at least one claim for any drug during the pre-intervention time period and at least one claim for any drug during the post-intervention period. Patients who had no claims data during the post intervention period were not included in the cost savings analysis. The total drug cost measured was based on the amount reimbursed to the dispensing pharmacy. For those recipients who were selected for more than one intervention, drug utilization was calculated before and after each intervention. Each intervention represents a specific recipient case. See Table below for calculation of estimated cost avoidance. There are some limitations of the analysis, one is that no continuous eligibility data was available to determine whether recipients maintained eligibility for Medicaid for the full 6 months before and after intervention letters were mailed. Therefore, the reduction in drug utilization and expenditures could be effected by multiple factors. Another limitation to cost-savings estimates relates to the type of interventions performed. Many retrospective interventions target non-adherence or underutilization of medications leading to increased use of medications hence the increased expenditures. Cost avoidance estimates are based on total drug expenditure as calculated by the reimbursed amount paid to the dispensing pharmacy. This does not include any federal or supplemental rebates. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR program. However, it is suspected that by reducing potentially inappropriate use of medications and alerting prescribers to drug therapy concerns, other associated medical costs would be reduced in addition to the reduction in drug expenditures. , Number of Recipients Included in Cost Savings Analysis , Cost 6 Months PRE Intervention*, Cost 6 Months POST Intervention*, Estimated Cost Avoidance Single Intervention, 2,659, $1,371,917 , $681,433 , $690,484 Multiple Interventions, 1,146, $1,354,241 , $1,455,467 , ($101,227) Totals, , $2,726,158 , $2,136,901 , $589,257 * Total drug cost reimbursed to pharmacy does not include any rebates.
South Carolina	ProDUR Paid Claims Savings/Denied- Cost avoidance claims denied/alternate therapy (switch therapy), reversals and resubmissions. Other cost avoidance: MAC pricing/PDL management, PA Criteria, Medical Directors review/guidance of criteria and review of initial/renewal for specific therapies/cases (SMA, DMD, etc.) RetroDUR: SCDHHS has engaged in an aggressive provider education campaign to promote opioid risk reduction strategies and expand access to MAT, named tipSC. Working with physicians, pharmacists and other experts from the Medical University of South Carolina, tipSC develops and disseminates targeted, practical information to help prescribers make safer prescribing decisions. These educational programs offer continuing education credit for providers. As a result, the ability to place a cost saving/avoidance for the program for impact on cost avoidance from overdose/accidental exposure, prescribing practices, education and potential lives saved/linkage to care/MAT services make it difficult to quantify in terms of a dollar amount.
South Dakota	ProDUR: Pharmacy savings were based on the claims status associated with the claim transaction: Paid, Reversed, and Rejected. Paid Claims with CDUR edit(s) are those which had an

State	Cost Savings/Cost Avoidance Methodology
	override by a pharmacist. Rejected claims with CDUR edit(s) include both hard and soft rejects. Reversed claims with CDUR edit(s) include Paid claims which were reversed, originating with a message and an override by a pharmacist. RDUR: To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters.
Tennessee	RetroDUR Cost Savings/Cost Avoidance methodology: OptumRx's RetroDUR cost savings were measured based on a review of the Zolpidem claims data for female members on higher strengths of zolpidem (10mg immediate release or zolpidem 12.5mg extended release) and the changes in prescribing patterns. The goal of the intervention was to recommend the FDA recommended dose of 5 mg and 6.52 mg in female patients. Cost savings estimates were measured by Zolpidem claims 180 days before and after the intervention which resulted in a savings of $1,139.00. ProDUR Cost Savings/Cost Avoidance Methodology According to the Guidelines, limiting the DUR savings results to global estimates of savings in the drug budget or overall Medicaid expenditures is not acceptable. Pro-DUR savings estimates should specifically track results relative to individual cases affected by pro-DUR alerts. One cannot sum dollar amounts associated with all denials and/or reversals and claim these as the total pro-DUR cost savings, either. The reason being: one cannot assume that all denials of prescriptions through on-line pro-DUR edits results in changes in drug use and expenditures. If the claim is filled with a substitute medication or is delayed by several days in filling, states should track the net effects upon expenditures. Likewise, one must use caution in estimating the costs avoided from reversal of claims and only measure costs avoided from true reversals that remain reversed. Tracking and calculating costs associated with pharmacists' actions resulting from pro-DUR edit alerts have always been difficult at best. Comparison group designs are normally recommended; however, with on-line pro-DUR, comparison populations who are not receiving an alert are not possible. References Used: 1 Zimmerman, T. Collins, E. Lipowski, D. Kreling, J. Wiederholt. Guidelines for Estimating the Impact of Medicaid DUR. Contract #500-93-0032. United States Department of Health and Human Services, Health Care Financing Administration: Medicaid Bureau. August 1994
Texas	RetroDUR Program Summary RetroDUR report provides an analysis estimating the cost savings generated by eleven RetroDUR Population-Based Interventions (PBIs) delivered to Texas Medicaid providers for the period of October 1, 2019 through September 30, 2020.

State	Cost Savings/Cost Avoidance Methodology
	PBIs are developed to target a specific disease state or drug-use evaluation. A proposal is developed with specific performance indicators that have been identified for the intervention. A clinical rules engine is used to identify the number of candidates with exceptions for each performance indicator. The clinical rules engine applies criteria on a focused topic for an entire member population to identify members with a specific issue. Intervention proposals are prepared and presented at the quarterly DUR Board Meetings for feedbacks and approval. The intervention packages are delivered to outlier providers. The package includes a provider letter with referenced educational materials and modified patient profiles. If a provider replies to any of the intervention letters, the vendor will provide the necessary response. An analysis of the intervention outcomes is completed 6 months post-intervention. Total Paid 6-month pre and post total drug costs can be defined as the total amount of paid intervention-related drug claims for a time period for the prescribers in the control and target groups. The target group consisted of those prescribers who had prescribed intervention-related drug therapy to more than two Medicaid patients. The control group consisted of all other prescribers who prescribed intervention-related drug therapy agents in the designated time periods. Average Number of Panel Patients per Month - during the 6-month pre and post time periods, the number of unique Medicaid patients with a drug claim submitted using a respective provider number is captured each month. Medicaid patients that did not have a drug claim were not counted in the prescriber's panel. The monthly numbers are summed then divided by six to calculate the monthly average. By evaluating all patients seen by a specific physician, changes in prescribing patterns can be evaluated on existing and new patients. Average Cost per Patient per Month is calculated by dividing the total dollars paid for drug claims during the analysis time period by the total number of Medicaid panel patients during the respective time period. 6-Month and 12-Month Total Savings - the Intervention Average Cost Savings per Patient per Month is multiplied by the total number of targeted patients served over the 6-month time frame. 6-Month State General Revenue Funds Savings= 6-Month Total State Savings X 0.4001. Total State Savings = 6-Month State General Revenue Funds Savings X 2. The estimated cost savings calculated is $1,879,216.49 ProDUR Program Summary KePro (HID) provides the Prior Authorization Services for the VDP fee-for-service population. In general, prescribers must obtain prior authorization for all non-preferred drugs in each drug class on the preferred drug list (PDL). In addition, some drugs are subject to clinical edits prior to authorization for dispensing. Due to the high percentage of automated decisions made by RxPert, a high percentage of prior authorizations are obtained at point-of-sale (POS) without requiring a call to the HID call center for approval. Working from criteria supplied by HHSC, the RxPert system provides a determination as to whether it is appropriate for the client to receive the requested drug. Prior authorization denial activities across all request methods (including duplicates) are used for the estimated cost savings calculation. Total cost saving= total cost savings for unique denials with subsequent therapy + total cost savings for unique denials without follow-up approval and substitution therapy. Total Cost Savings for Unique Denials with Substitute Therapy: SUM (Estimated Denial Cost per unique denial: Reimbursement amount of substitute therapy within 7 days of unique denial) Where Estimated Denial Cost is the aggregated cost per unit for all paid claims for the same GCN within the specified time frame times the number of units for the denied request. If there were no paid claims for the GCN, then the cost per unit was established by looking for paid claims at the HICL sequence number or HIC3 category until paid claims were found to calculate an

State	Cost Savings/Cost Avoidance Methodology
	aggregated cost per unit. When no paid claims were found to calculate the aggregated cost per unit, no cost savings were associated with the original denied request. Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy: SUM all Estimated Denial Cost per unique denial Where Estimated Denial Cost is the aggregated cost per units for all paid claims for the same GCN within the specified time frame times the number of units for the denied request. If there were no paid claims for the NDC, then the cost per unit was established by looking for paid claims at the HICL sequence number or HIC3 category until paid claims were found to calculate an aggregated cost per unit. When no paid claims were found to calculate the aggregated cost per unit, no cost savings were associated with the original denied request. Total Cost savings associated with ProDUR was $6,787,550 The Lock-In Program receives referrals from the public, providers, Managed Care Organizations (MCOs) and law enforcement officials via the Waste, Abuse, Fraud Electronic Referral System (WAFERS). Each referral is reviewed for lock-in criteria match. In addition, the Lock-In Program makes referrals to the Office of Inspector General (OIG) internal divisions, law enforcement and Child and Adult Protective Services and other state agencies as appropriate. The cost avoidance associated with the Lock-in program in FFS was 7,071.36.
Vermont	For ProDUR savings, we evaluated all reversed claims for which a DUR soft message or DUR reject was triggered. If a reversed claim was not followed within 60 days by a successfully adjudicated claim with the same date of service, prescription number, and pharmacy we assumed it did not result in a paid claim and therefore we counted it as cost avoidance. Other cost savings are based on aggressive management of the Vermont Medicaid preferred drug list through carefully applying SMAC pricing attributing to SMAC savings, lower of pricing of pharmacy claims, timely PDL management and strong SR negotiations to lower overall pharmacy drug cost.
Virginia	ProDUR Analysis ProDUR cost avoidance for the Virginia Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. The ProDUR cost avoidance for FFY 2020 was $7,901,042. The following table summarizes the FFY 2020 data. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, it is not known what the complete impact this has on the program. There are many prescriptions that are switched after point of sale to alternative medications, which would have an improved therapeutic benefit to the patient and would not generate a ProDUR edit. The cost of this alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influenced this calculation was multiple claim submission for an individual beneficiary's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims, the calculations would be inflated. ProDUR Cost Avoidance Calculations Paid Claims Reversed and Not Resubmitted Denied Claims Not Resubmitted

State	Cost Savings/Cost Avoidance Methodology
	$5,325,165.75 + $2,575,877.02 = $7,901,042.77

Month-Year	Total # Paid PRODUR Drug Claims Not Overridden	Total Payment Amount Reversals	PAID ProDUR Savings From ProDUR # Alerts Reversals	ProDUR # Claims Not Overridden	Savings From ProDUR Total PAID ProDUR Cost Savings
October-19	22,948	$1,643,668.14	3,694	2,320	$243,641.84 $680,611.77
November-19	21,471	$1,607,057.13	3,249	1,962	$288,960.20 $751,928.94
December-19	22,812	$1,814,498.78	3,477	2,010	$271,497.26 $791,164.90
January-20	23,471	$2,101,815.34	3,788	2,224	$296,094.52 $988,309.31
February-20	21,600	$1,606,251.72	3,240	1,926	$196,795.19 $599,222.57
March-20	26,111	$2,271,900.89	3,801	2,232	$220,534.70 $844,700.82
April-20	21,919	$1,933,772.25	3,279	1,989	$254,908.74 $781,111.86
May-20	17,453	$1,307,935.44	2,408	1,411	$167,276.70 $517,133.25
June-20	17,055	$1,436,980.43	2,502	1,544	$196,937.58 $594,521.26
July-20	16,843	$1,211,744.16	2,258	1,381	$178,788.18 $495,294.46
August-20	15,658	$1,203,590.77	2,163	1,260	$164,974.43 $507,059.96
September-20	14,906	$1,093,797.75	2,060	1,188	$95,467.68 $349,983.67
FFY 20 Averages	20,187	$1,602,751.07	2,993	1,787	$214,656.42 $658,420.23

State	Cost Savings/Cost Avoidance Methodology
	FFY 20 Totals 242,247 $19,233,012.80 35,919 $5,325,165.75 21,447 $2,575,877.02 $7,901,042.77 RetroDUR Cost Analysis The provision of high quality drug therapy not only results in improved patient health but may also result in program cost avoidance. It is important to quantify the effect of interventions on the cost of drug therapy. When fully applied, the Magellan Rx Management cost analysis model has the ability to capture not only cost avoidance that is a direct result of the RetroDUR letter intervention process, but also avoidance due to indirect effects. This indirect effect arises when a physician applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost avoidance is tracked over a 12-month period beginning six months after the provider is sent a letter/intervention. Changes in prescription drug costs are totaled to yield overall cost avoidance for the review period. The total cost avoidance, attributed to RetroDUR, during FFY 2020 was $502,960.75. Monthly cost avoidance may vary due to a variety of factors, including: %u2022the class selection and problem type chosen for review %u2022the lag time before the next physician visit when changes in drug therapy may be made %u2022the incremental educational and familiarity impact on the prescriber after receiving intervention letters Month-by-month cost avoidance for all active interventions (i.e. interventions which have not completed twelve consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the fiscal year, have not all completed follow-up review for one year. Consequently, the cumulative cost avoidance effect of intervention letters mailed during FFY 2020 will not be known until the end of FFY 2021. Dose Optimization and Maximum Quantity Limits Analysis In January 2008, Virginia Medicaid implemented dose optimization and quantity limits on selected medications. The purpose of a dose optimization program is to change multiple dose medications to a single daily dose where appropriate. Quantity limits provide a baseline for the recommended amount of medication that should be dispensed over a certain time period. These limits are based upon the drug manufacturer's recommendations and FDA guidelines. For FFY 2020, the savings for the dose optimization edit was $694,811.59 and for the quantity limits edit was $285,269.37. The combined savings for both edits was $980,080.96.
Washington	For FFY 2020, Washington Medicaid's cost savings/cost avoidance analysis includes savings based on prospective drug utilization review (ProDUR) and cost avoidance from prior

State	Cost Savings/Cost Avoidance Methodology
	authorization. For FFY 2020 Washington Medicaid has not included any direct savings based on retrospective drug utilization review (RetroDUR) activities. Savings based on ProDUR looked at unique prescription occurrences for payable claims that rejected for NCPDP reject 88 DUR and never resulted in a paid claim (i.e., not overridden by a pharmacy with DUR codes). All other NCPDP rejections and third part payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings of $12,584,654. The estimated savings does not reflect medication changes that may have occurred based on the reject 88 and may have resulted in separately payable claims that would reduce this savings. Savings based on cost avoidance from prior authorization looked at payable claims (claims for eligible clients, no missing or invalid data, all NDCs were rebate eligible, etc.) that rejected for NCPDP reject 75 and did not result in a paid claim. All other NCPDP rejections and third part payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings or cost avoidance of $24,487,770. The estimated cost avoidance savings does not reflect medication changes that may have occurred based on the need for prior authorization and would result in separately payable claims that would reduce this savings.
West Virginia	Total estimated costs savings for the West Virginia Medicaid Pro-DUR program were estimated by our POS vendor, Gainwell Technologies, to be $50,056,597.71 for FFY2020. The methodology used by Gainwell to calculate these savings is as outlined below. Annual FFY2020 DUR Cost Save Report Data Gathering 1. Set date range for fiscal year 2020 (FY2020) a. Start Date = 10/01/2019 b. End Date = 09/30/2020 2. Calculate average total paid amount per claim for FY2020 a. Exclude claims with ADAP/LPS planID b. Claim start date must fall within the Start Date and End Date of FY2020 c. Claim status in the claim table is one of the following: PAY, WAITPAY, or PAID d. Claim has not been reversed 3. Get claims for FY2020 which denied due to a DUR edit a. Claim start date must fall within the Start Date and End Date of FY2020 b. Claim must have a status of DENY in the claimedit table c. DENY edit must be one of the following DUR edits: 7067, 7069, 7071, 7073, 7075, 7079, 7202, 7203, 7204, 7205, 7206, 7170, 7171, 7172, 7173, 7175, 7250, 7251, 7252, 7077, 7245 d. Exclude claims with ADAP/LPS planID e. Claim was not later paid with EO or DUR/PPS override (also not reversed) 4. Get all RX claims for the fiscal year that had a DUR override associated with them and the following conditions must also apply: a. Claim has not been reversed b. Claim is not a reversed claim c. Claim start date must fall within the Start Date and End Date of FY2020 d. Claim status in the claim table is PAID e. Exclude claims with ADAP/LPS planID f. Claim has Edit Override Authorization ID in the claim table or has a Professional Service Code

State	Cost Savings/Cost Avoidance Methodology
	5. Create a temporary table to store summary data for each conflict type (DD, ER, etc.). Data in this table will be used for the report. a. Update denied dollar amount for each conflict type using table created in step 3 above (total amount for each conflict type) b. Update override dollar amount for each conflict type using table created in step 4 above (total amount for each conflict type) c. Update cost savings dollar amount for each conflict type using the data collected in a and b above by subtracting override dollar amount from denied dollar amount. If the result is <= 0, then cost savings = 0. Below is the information gathered from the DUR Alerts Summary: DD, Drug-Drug Interactions: Denied Dollars: $39,078,583.69 Override Dollars: $34,203,119.92 Cost savings: $4,875,463.77 Percent savings: 9.73% ER, Early Refill: Denied Dollars: $41,092,446.10 Override Dollars: $1,290,567.28 Cost savings: $39,801,878.82 Percent savings: 79.51% HD, High Dose Denied Dollars: $3,156,798.15 Override Dollars: $8,360,463.21 Cost savings: $0.00 Percent savings: 0.00% ID, Ingredient Duplication Denied Dollars: $8,846,432.15 Override Dollars: $3,535,140.80 Cost savings: $5,311,291.35 Percent savings: 10.61% TD, Therapeutic Duplication Denied Dollars: $16,316,232.94 Override Dollars: $37,367,343.20 Cost savings: $0.00 Percent savings: 0.00% PG, Pregnancy Precaution Denied Dollars: $1,524,246.05 Override Dollars: $1,825,658.75 Cost savings: $0.00 Percent savings: 0.00%

State	Cost Savings/Cost Avoidance Methodology
	LR, Late Refill Denied Dollars: $353,860.60 Override Dollars: $285,896.83 Cost savings: $67,963.77 Percent savings: 0.13% Marshall University Cost Methodology: For each program, a retrospective pre-post evaluation was done to evaluate financial impact. Each intervention, (e.g., Lock-In, Congestive Heart Failure with thiazolidinediones (TZD's), Prescription of Opioid with Benzodiazepines, etc.,) was evaluated separately and patients were matched pre-post. The evaluation was based on presence of Common Procedural Technology (CPT codes) signifying either Emergency Department (ED) visits or hospital admissions. The pre-intervention period was 90 days prior to the intervention date. A 30-day waiting period after intervention was used to allow the letter to be sent, the provider to engage with their patient, and to respond to the letter. After the 30-day waiting period, there was a 90-day post-intervention period where ED visits and admissions were again measured. Charges for ED visits were extracted from the Medicaid data for the claims associated with the same Dates of Service (DoS) where the primary diagnosis (PDx) was within the scope of the metrics. For the admissions, as the admission data and Diagnosis-related Group (DRG) are not available, the PDx were mapped to appropriate Medicare Severity-Diagnosis Related Group (MS-DRG) cluster, with severity of the admission CPT designating the position of the DRG within the cluster (e.g., a higher severity CPT would result in a higher weighted DRG within the appropriate DRG cluster.) DRG weights were taken from the Content Management System (CMS) 2020 List of Medicare Severity Diagnosis-Related Groups (MS-DRGS), Relative Weighting Factors. The Base rate used was the CMS Operating Base Rate 2020 with no modifiers. While it is well known that the predicted compared to the final DRGs often change, this method allows for cost of care to be conservatively estimated based on the PDx at the time of admission. In addition, where a sentinel PDx was identified in a metric, the visit may be excluded due to the visit being primarily attributed to another condition. For example, gastrointestinal (GI) bleeding associated with myocardial infarcation (MI) often presents as a distinct syndrome that differs from either disease alone. GI bleeding, particularly when massive, may precipitate MI from hypovolemia, hemodynamic compromise, and myocardial hypoperfusion. For a metric where MI is indicated, and GI bleeding, hypovolemia, etc, were present, the patient would be excluded. Methodology for financial estimation is intentionally conservative. Annual DUR Coalition estimates indicate a total savings of $543,217 for the RDUR Program. Breaking out the Lock-In and Clinical components of the RDUR Program, conservative estimates of savings are -$174,223 for the Lock-In and $717,440 for the Clinical components. Analysis of claims saw a 52% reduction in ED visits and a 50% reduction in patients being admitted. This results in an 18% reduction in ED charges and an estimated 53% reduction in inpatient charges. The phenomena of reduced savings for the Lock-In Program is consistent with the literature where a concomitant increase in use of illegal opioids has been associated with patients being locked-in which results in increased ED and inpatient visits associated with illegal opioid use. Ideally, lock-in programs improve care coordination, connection to appropriate opioid use disorder treatment when needed. The extent to which lock-in program restrictions influence enrollees to seek opioids outside of the health care system, thus increasing ED and inpatient

<table>
<tr><th>State</th><th>Cost Savings/Cost Avoidance Methodology</th></tr>
<tr><td></td><td>visits related to misuse, abuse, and overdose is unknown. The Marshall DUR Coalition is researching the phenomena longitudinally and findings will be reported. Financial breakdown by metric for the year are: Dx of CHF w/NSAIDS ($710,431) ; Dx of CHF w/Select Drugs (-$4,877) ; Dx of CHF w/TZDs ($106,902) ; Dx of DM w/o ACE or ARB ($26,648) ; Dx of GERD w/PPI Therapy >60 Days ($41,544) ; Dx of HFrEF w/Select Drugs ($169,767) ; Rx of Opioid & Benzodiazepine (-$332,974) ; and Lock In (-$174,223)</td></tr>
<tr><td>Wisconsin</td><td>Wisconsin RDUR Estimated Cost Savings
[SUM4-2020-WI-CSCAM]

This report prepared for the Wisconsin Medicaid Program shows the estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization.

In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2020 (FFY 2020). The drug claims for the selected members were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters.

The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2019 and September 30, 2020, there was an estimated cost savings of $1,969,222.
Table 1 - Estimated Cost Savings for FFY 2020 - All Interventions
Intervention Group Change between 6 Month Pre- and Post- Cost Savings | Comparison Group Change between 6 Month Pre- and Post- | Estimated Cost Savings
All Interventions $1,794,289 (-$174,933) $1,969,222

Table 2 - Estimated Cost Savings for FFY 2020 - Lock-Ins only
Intervention Group Change between 6 Month Pre- and Post- Cost Savings | Comparison Group Change between 6 Month Pre- and Post- | Estimated Cost Savings
Lock-Ins Only $358,181 $69,035 $289,146

During FFY 2020, HID reviewed 5,798 members with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Members reviewed for under-utilization issues are excluded from the cost savings calculation, as a cost increase would be expected in response to this type of intervention. For FFY 2020, 5,248 members were included in the intervention group.

Table 3 - Drug Therapy Problem Distribution
Overutilization- 30%</td></tr>
</table>

State	Cost Savings/Cost Avoidance Methodology
	Drug/drug interaction - 28% Therapeutic duplication- 19% Drug-disease interactions- 13% Underutilization- 10% Analysis Methodology Each month HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once members have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Member Selection A total of 16,926 members met the criteria for intervention letters during FFY 2020. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of members who were not chosen for RDUR intervention letters. For a member to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre- and post-intervention periods. For the purpose of this report, members were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Members were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same member within FFY 2020). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed . Table 4 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for members with single and multiple interventions during FFY 2020. Table 4 - Estimated Cost Savings for FFY 2020 - Single/Multiple Interventions Intervention Group Comparison Group Estimated Cost

State	Cost Savings/Cost Avoidance Methodology

	Change between 6 Month Pre- and Post-	Change between 6 Month Pre- and Post-	Savings Cost Savings
Single Intervention	$1,769,667	(-$169,992)	$1,939,659
Multiple Intervention	$24,622	(-$4,941)	$29,563
Total Estimated Cost Savings	$1,969,222		

HID found the intervention group had a decrease of 6.39% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 2.86%. These changes resulted in an estimated cost savings of $375.23 per member who received an intervention during FFY 2020. The intervention group utilized for the cost savings calculation included 5,248 members.

Table 5- Cost Savings of Members' Total Prescription Medications for the Pre-and Post-Intervention Periods - Single Interventions

Single Intervention			
Pre 6 Months		Post 6 Months	
Members	5,058	Members	5,058
Average Cost/Member	$5,379	Average Cost/Member	$5,029
Total Claims Cost	$27,206,342	Total Claims Cost	$25,436,675

Comparison Group (Single Intervention)			
Pre 6 Months		Post 6 Months	
Members	5,058	Members	5,058
Average Cost/Member	$1,179	Average Cost/Member	$1,212
Total Claims Cost	$5,962,497	Total Claims Cost	$6,132,488

Single Intervention Outcomes	
Percent Change in Claims Cost	-6.50%
Change in Claims Cost	$1,769,667
Comparison Group Claims Cost Change	- $169,992
Total Savings for Single Interventions	$1,939,659

Table 6- Cost Savings of Members' Total Prescription Medications for the Pre-and Post-Intervention Periods - Multiple Interventions

Multiple Interventions			
Pre 6 Months		Post 6 Months	
Members	190	Members	190
Average Cost/Member	$4,675	Average Cost/Member	$4,545
Total Claims Cost	$888,157	Total Claims Cost	$863,535

State	Cost Savings/Cost Avoidance Methodology
	Comparison Multiple Interventions Pre 6 Months Post 6 Months Members 190 Members 190 Average Cost/Member $790 Average Cost/Member $816 Total Claims Cost $150,072 Total Claims Cost $155,014 Multiple Intervention Outcomes Percent Change in Claims Cost -2.77% Change in Claims Cost $24,622 Comparison Group Claims Cost Change -$4,942 Total Savings for Multiple Interventions $29,564 Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each member. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems-including inappropriate use of drugs and increased risk for drug interactions-other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Wisconsin Medicaid program. During FFY 2020, 5,798 members were identified for RDUR intervention letters. The RDUR intervention program alerted the member's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,969,222 for FFY 2020.
Wyoming	For prospective cost avoidance: Total savings = Denied amount + reversed amount Denied amount is based on the average paid amount for accepted claims, grouped by conflict code. Reversed amount is the total amount paid for reversed claims that generated DUR messages (sum of absolute values since this amount is negative for reversed claims), grouped by conflict code. For retrospective cost avoidance: Total cost (medical + pharmacy) is calculated for the quarter prior to intervention and a quarter at least six months after intervention. The difference between cost before and cost after is converted to cost/eligible claimant and multiplied by eligible claimants in the post period. This quarterly amount is then multiplied by 4 to estimate annualized cost avoidance. For prescriber reports looking solely at prescribing trends, only pharmacy costs are included.

Section VIII - Fraud, Waste and Abuse Detection

A. Lock-In or Patient Review and Restrictions Programs

1. Does your state have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?

Figure 55 - Documented Process in Place by States to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

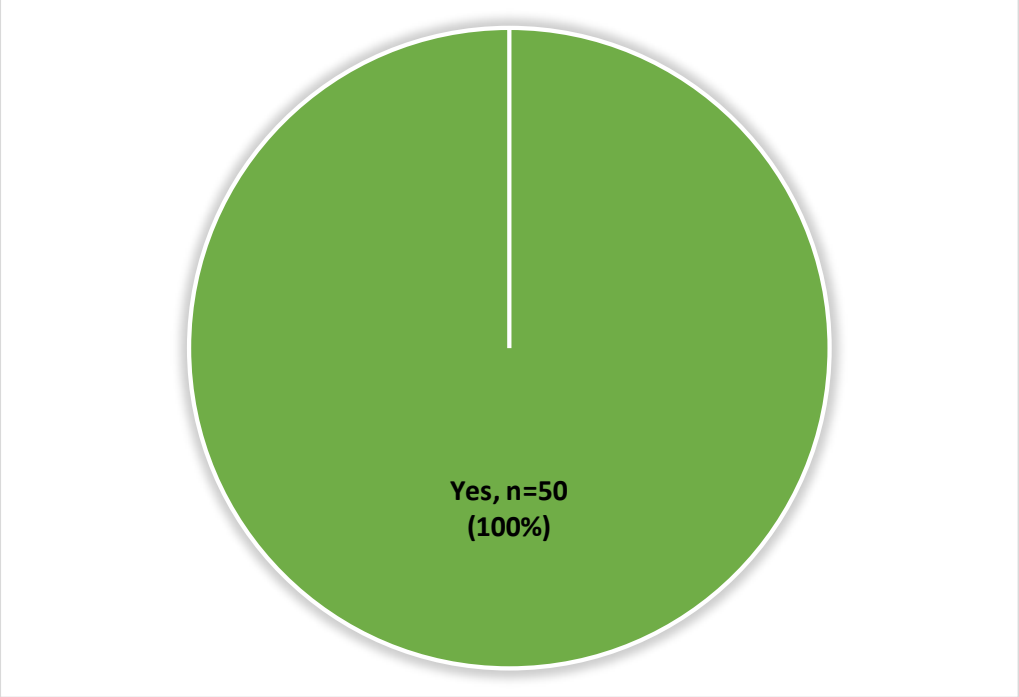

Table 77 - Documented Process in Place to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%
Total		50	100.00%

If "Yes," what actions does this process initiate?

Figure 56 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

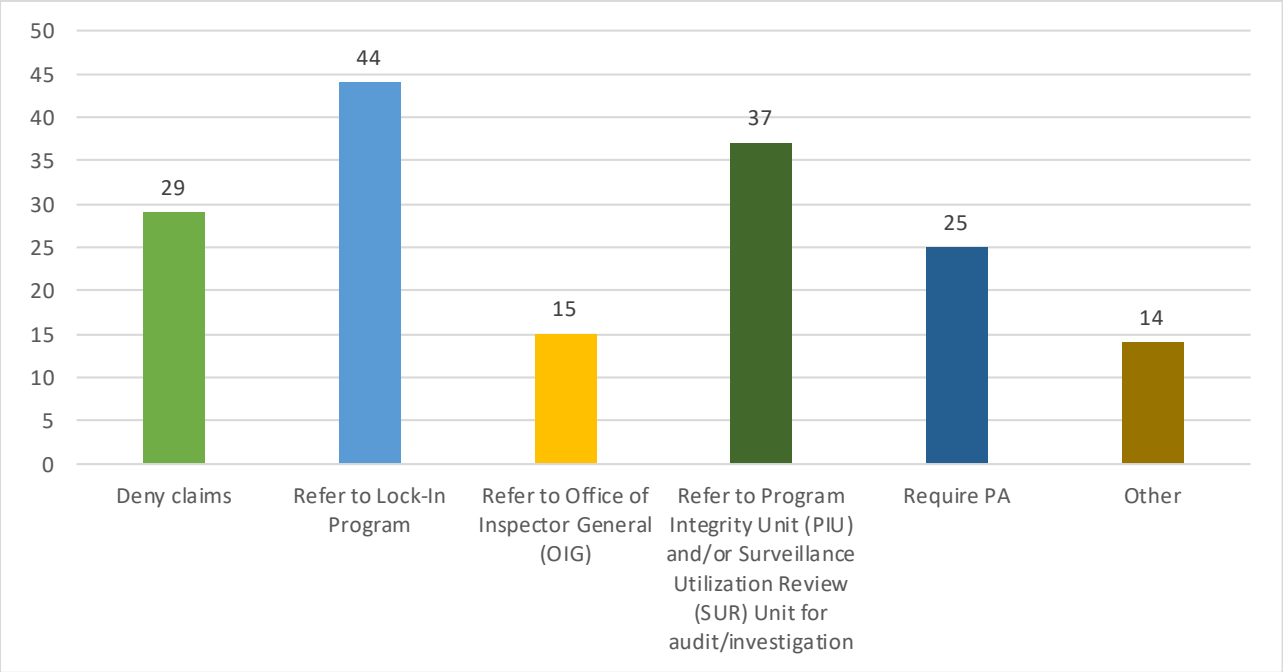

Table 78 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

Response	States	Count	Percentage
Deny claims	Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia	29	17.68%
Refer to Lock-In Program	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	26.83%
Refer to Office of Inspector General (OIG)	Arkansas, Indiana, Kentucky, Maryland, Michigan, Minnesota, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Wisconsin	15	9.15%
Refer to Program Integrity Unit (PIU) and/or	Alabama, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas,	37	22.56%

Response	States	Count	Percentage
Surveillance Utilization Review (SUR) Unit for audit/investigation	Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wyoming		
Require PA	Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New York, North Dakota, Oregon, South Carolina, Tennessee, Utah, Vermont, Virginia, West Virginia	25	15.24%
Other	Alabama, Alaska, California, Connecticut, Florida, Indiana, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, Texas, Vermont, Virginia	14	8.54%
Total		164	100.00%

If "Other," please explain.

Table 79 - "Other" Explanations for Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

State	Explanations
Alabama	Refer to MFCU if necessary.
Alaska	SURS, MFCU
California	22CCR 50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits, including being subjected to one or more of the following forms of utilization restriction: (1) Prior authorization for all Medi-Cal services. (2) Prior authorization for specific Medi-Cal services. (3) Restriction to utilization of a specific, beneficiary- or Department-selected pharmacy. (4) Restriction to a specific, beneficiary- or Department-selected primary provider of medical services. Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.
Connecticut	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
Florida	Deny claims and require a prospective drug utilization review by the pharmacist at the point of sale.
Indiana	Submit to FSSA Bureau of Investigations for member investigation
Mississippi	According to Code of Federal Regulations (CFR) 455.2 for (Abuse), beneficiary related issues are referred to appropriate areas from a Federal (CMS, DOJ, ATF); State (State Attorney General, Medicaid Fraud Control Units (MFCU); local law enforcement, or other entities such as federal/state task forces.

State	Explanations
Montana	We follow a member through a fraud review determination and when fraud may be occurring the member is referred to the Division of Criminal Investigation
New Hampshire	Members can be referred to the Program Integrity Unit. However, the Program Integrity Unit performs the review function and manages the Lock-In Program. Program Integrity may also refer cases to the Medicaid Fraud Control Unit and/or the Office of the Inspector General. Providers may also be reported to the Office of Professional Licensure and Certification (OPLC).
New Jersey	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Office of the State Comptroller's, Medicaid Fraud Division to look for unusual patterns in claim reimbursement from providers.
North Carolina	All potential beneficiary fraud and abuse leads are referred by Program Integrity to the beneficiary's county Department of Social Services for further investigation and disposition. Claims are denied for lock-in beneficiaries if not using designated providers.
Texas	The Lock-In Program receives referrals from the public, providers, Managed Care Organizations (MCOs) and law enforcement officials via the Waste, Abuse, Fraud Electronic Referral System (WAFERS). Each referral is reviewed for lock-in criteria match. In addition to the Office of Inspector General (OIG) , the Lock-In Program makes referrals to the internal divisions, law enforcement and Child and Adult Protective Services and other state agencies as appropriate.
Vermont	There is a standard operating procedure that outlines the process for review of data-mined claims information, screening for claims indicating a high number of prescribers, multiple ED visits, and/or use of multiple pharmacies. Team members outreach providers, pharmacies, and EDs describing the Team Care program criteria, guidelines and referral process. Provider notification through banner and mailing.
Virginia	Java- Server Utilization Review System (JSURS) identified members to review for enrollment in DMAS Client Medical Management Program (Lock- In program)

2. Does your state have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

Figure 57 - Lock-In Program

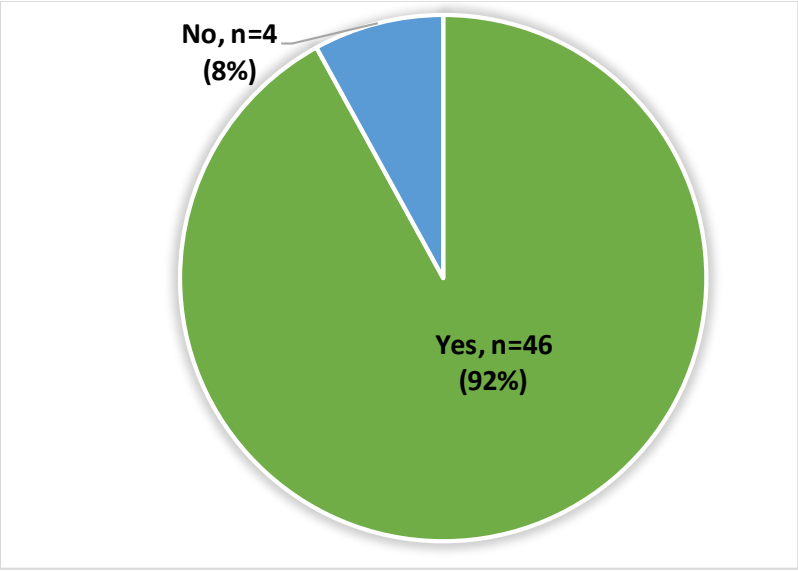

Table 80 - Lock-In Program

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	California, Florida, Iowa, South Dakota	4	8.00%
Total		50	100.00%

If "Yes," please continue.

a. What criteria does your state use to identify candidates for Lock-In? Check all that apply.

Figure 58 - Lock-In Program Candidate Identification Criteria

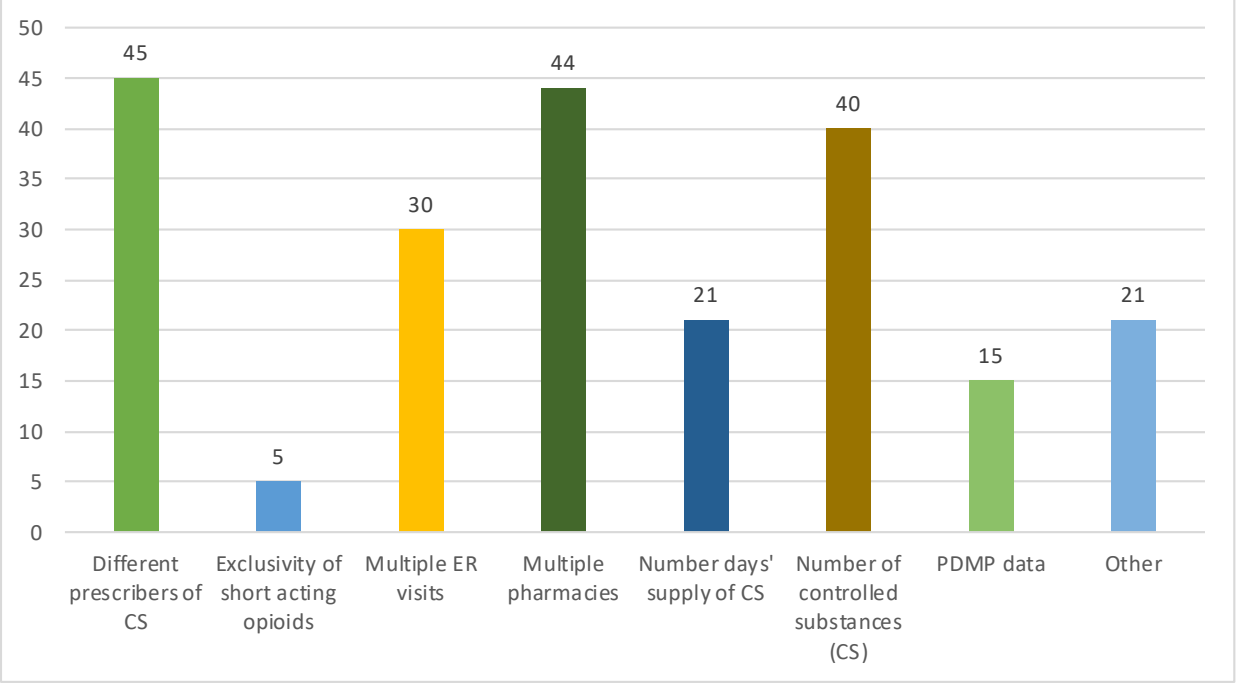

Table 81 - Lock-In Program Candidate Identification Criteria

Response	States	Count	Percentage
Different prescribers of CS	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	20.36%
Exclusivity of short acting opioids	Delaware, Georgia, Maryland, New York, North Dakota	5	2.26%
Multiple ER visits	Alabama, Alaska, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	30	13.57%
Multiple pharmacies	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	19.91%
Number days' supply of CS	Alabama, Arkansas, Connecticut, Delaware, Georgia, Kansas, Louisiana, Maryland, Michigan, Missouri, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin	21	9.50%
Number of controlled substances (CS)	Alabama, Alaska, Arkansas, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	40	18.10%
PDMP data	Alaska, Arkansas, Georgia, Idaho, Indiana, Michigan, Mississippi, Montana, Nevada, North Dakota, Oklahoma, Tennessee, Utah, Virginia, West Virginia	15	6.79%
Other	Arkansas, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Maine, Mississippi, Montana, Nebraska, Nevada, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	21	9.50%
Total		221	100.00%

If "Other," please explain.

Table 82 - "Other" Explanations for Lock-In Program Candidate Identification Criteria

State	Explanations
Arkansas	RDUR program monitors clients for lock-in placement. If a beneficiary has utilized pharmacy services at a frequency or amount that is not medically necessary, as determined by a computerized algorithm and clinical review process, DMS can lock-in the beneficiary by requiring him or her to choose a single provider of pharmacy services. After lock-in, DMS will deny claims for pharmacy services submitted by any provider other than the selected provider. The selected provider will be notified prior to lock-in, so that adequate time is allowed for selection of another pharmacy if the selected provider cannot provide the needed services. If a beneficiary fails or refuses to choose one provider, a list of providers used by the beneficiary will be reviewed and a provider will be chosen ensuring reasonable access, taking into account geographic location and reasonable travel time, to pharmacy services of adequate quality. Criteria for lock-in: Any client displaying any of the following scenarios will be locked in: 1) >= 3 prescribers; AND 2) >= 3 pharmacies in the last 90 days; AND 3) >= 3 GCNs out the the following list--opioids, controlled ADHD, benzodiazepines, gabapentin, muscle relaxants, Suboxone, sedative hypnotics, narcolepsy agents, or Xyrem; AND 4) >= 18 years of age Excluded clients 1) Cancer patients 2) Long-term care patients 3) Meets above criteria due to recent surgery Diagnosis of poisoning or overdose is monitored monthly. Clients are monitored for a billed diagnosis consistent with poisoning or overdose for opioids, narcotics, barbiturates, benzodiazepines, and unspecified drug or substances.
Connecticut	CT uses the number of days' supply of CS to initially identify patients for LI review but all methods listed above are used to assess whether a patient should be restricted to the LI program once they are identified initially by the days' supply criteria.
District of Columbia	Polypharmacy criteria is 10 or more prescriptions within a thirty day look back period.
Idaho	Referrals from Board of Pharmacy, Prescribers, Pharmacies or Program Integrity.
Illinois	Recipient Analysis Unit staff use the PMP as a reference only. Determination to restrict is based on claim history that may (or may not) include supporting diagnoses warranting quantities and durations of controlled substance prescribed, alternative options such as referrals to specialists and number of prescribing providers and pharmacies used.
Indiana	Number of office visits
Maine	Provider referrals (prescriber, pharmacist and State)

State	Explanations
Mississippi	Additional criteria that can be used to determine individuals for lock-in also include: - When an individual utilizes cash payments to purchase control substances - When any written prescription is stolen, forged, or altered - When the Division of Medicaid has received a proven report of fraud, waste, and/or abuse from either a prescriber, pharmacy, medical provider or law enforcement entity.
Montana	We review referrals from providers, pharmacists, and PA staff. We will also enroll members in the lock-in program at the request of their provider.
Nebraska	Provider Referral
Nevada	Recipient diagnosed with a drug dependency related condition or other drug seeking behaviors and if the dispensed quantities per prescription appears excessive.
Ohio	Additional criteria includes diagnosis of or treated for addiction or poisoning overdose, and medications including muscle relaxants and gabapentin. Refer to OAC rule 5160-20-01 for further details.
Pennsylvania	Other criteria that warrants placement in the Lock-In program includes beneficiaries with an identified pattern of obtaining early refills in addition to one or more of the above listed criteria, have forged or altered prescriptions, using another beneficiaries card or sharing a card with an ineligible individual to obtain medical services.
South Carolina	In accordance with 42 CFR 431.54 (e), the Department will identify Members through SURs reporting who are using Medicaid services at a frequency or amount that is not Medically Necessary. Identified Members will be restricted to one pharmacy for a period of two years. Prior to the restriction and per 42 CFR 431.54 (e)(1)(2) and (3): The Member must be given notice and opportunity for a fair hearing before imposing the restriction. The Member must have reasonable access (taking into account geographic location and reasonable travel) to Medicaid services of adequate Quality. The restrictions do not apply to emergency services furnished to the Member. Enrollment in the Department's Statewide Pharmacy Lock-In Program (SPLIP) will not result in the denial, suspension, termination, reduction or delay of medical assistance to any Member. As required by 42 CFR 431 Subpart E, any Medicaid Member who has been notified in writing by the Department of a pending restriction due to mis-utilization of Medicaid services may exercise his/her right to a fair hearing, conducted pursuant to R126-150 et. Seq. Section 11.10.1: PI will generate a quarterly report that will review all Medicaid Member's Claims for a six (6) month period. The report will look at twenty (20) different weighted criteria as established by PI based on research; with most of them analyzing the use of pain medications. The report will then assign a score and rank the Member based on that 15 | P a g e Question Response score. It will then select Members for enrollment into SPLIP based on a score determined by the SPLIP. The twenty (20) criteria are as follows: FFS and Encounter Claims included Pharmacy Dispensed Dates: XX/XX/20XX - XX/XX/20XX (6 months) Voids Removed Excluded Members in Hospice, with a date of death or no longer Medicaid eligible Excluded Members currently in the lock-in Program Only included Members with a Score > 0 Excludes members with sickle cell disease (ICD9 codes 282.60 thru 282.9 and ICD10 codes D57.00 thru D57.1 and D57.20 thru D57.219 and D57.4 thru D57.819) Excluded Members Age <= 16 and (Aid Category = 57 (TEFRA) or certain waiver programs Composite Score Measures 1. CII Without Prof Claim in Previous Six (6) Mo Identifies any Member with a DEA Schedule II prescription without a professional Claim in the previous six (6) months. The professional Claims look back was not limited to the time period of this report. (1) 2. Fifteen or More RX in Thirty (30) Days Identifies Members with fifteen (15) or more prescriptions (any schedule) within a thirty Day

	(30) period. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. (0.5) 3. Five or More Controls in Thirty (30) Days Identifies Members with five (5) or more DEA Schedule II-V prescriptions within a thirty-Day period. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. (3) 4. Two or More ER Visits In Thirty (30) Days and Controlled RX Identifies Members with two (2) or more Non-Emergent ER visits within a thirty-Day period and a DEA Schedule II-V prescription within the same thirty (30) Days. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. fac_revenue_cd = '0450','0451' 16 | P a g e Question Response OUTPAT_SERVICE_LEVEL = '1' OUTPAT_SERVICE_LEVEL was tagged to Encounter Claims from Diagnosis record based on primary diagnosis code. (1) 5. GT 3600 mg Oxycodone HCL in Thirty (30) Days Identifies Members with more than 3600 mg of Oxycodone HCL (generic name for Oxycontin) in a thirty-Day period. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. Total mg per prescription = strength * quantity dispensed (1) 6. Two or More Out of State Pharmacies for Controls Identifies Members with DEA Schedule II-V prescriptions from two (2) or more out of State pharmacies. (2) 7. Two Controls From Two (2) Pharmacies within Two (2) Days Identifies Members with two (2) or more DEA Schedule II-V prescriptions dispensed by two (2) different pharmacies on two (2) consecutive Days. (1) 8. Suboxone within Six (6) Months Identifies Members with Suboxone prescriptions during the time period of this report. generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride' (1) 9. Opioid Within Thirty (30) Days After Suboxone Identifies Members with an opiod prescription within thirty (30) Days after a Suboxone prescription. Suboxone: generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride') Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' (10) 10. Ten or More Pills Per Day For Controlled RX Identifies Members with DEA Schedule II-V prescriptions allowing for ten (10) or more pills per Day. Master Form = Capsule or Tablet Qty_Dispensed / Days_Supply >= 10 (2) 11. Pill Count for Controls GT 600 Identifies Members with a pill count exceeding 600 for all DEA Schedule II-V prescriptions dispensed during the six (6) month time period of this report. Master Form = Capsule 17 | P a g e Question Response or Tablet (2) 12. Hist of Drug Dependence with Benzo or Opiate RX Identifies Members with a drug dependence diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report. Diagnosis code like '304*' - checked all diagnosis codes on professional and hospital Claims Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV' (1) 13. Hist of Poison Overdose with Benzo or Opiate RX Identifies Members with a poisoning/overdose diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report. Diagnosis code = '960' to '9799' - checked all diagnosis codes on professional and hospital Claims Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV' (1) 14. Five or More Prescribers Identifies Members with five or more prescribers during the six (6) month time period of this report. All prescriptions included. (0.5) 15. Two or More Opioid Prescribers Identifies Members with two or more prescribers issuing an opioid prescription during the six (6) month time period of this report. Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' (1)

State	Explanations
	16. Three or More Prescribers for Controlled Substance Identifies Members with three (3) or more prescribers issuing a controlled substance (DEA Schedule II-V) during the six (6) month time period of this report. (1) 18 | P a g e Question Response 17. Four or More Pharmacies Identifies Members with drugs dispensed by four (4) or more pharmacies during the six (6) month time period of this report. All prescriptions included. (0.5) 18. Two or More Pharmacies for Controlled Substance Identifies Members with controlled substances (DEA Schedule II-V) dispensed by two or more pharmacies during the six (6) month time period of this report. (1) 19. Three or More Cntrl Subst and Drugs of Concern Identifies Member with three (3) or more drugs between controlled substances (DEA Schedule II-V) and other drugs of concern. Other drugs of concern incl tramadol, cyclobenzaprine, methocarbamol, tizanidine and metaxalone. Unique count of generic_name > 3 (1) 20. On Cocktail Reports Identifies Members also found on the "Holy Trinity" or "The Cocktail" reports for the same six (6) month time period. These reports identify Members who were dispensed all components of a known drug cocktail during a thirty-Day (30) period. (3) The Department can revise these criteria as needed; for example to include current drugs being sought by abusers according to national trends. The report will also automatically assign a Lock-In Pharmacy for the Member based on the pharmacy they have utilized the most during the six month period. https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20PP%20July%202020%20FINAL%20P%26P%20V2.pdf
Tennessee	Enrollees are also subject to Lock-In and Prior Authorization Status if arrested for a drug offense, arrested for TennCare doctor shopping, drug sales or TennCare fraud, Convicted of TennCare drug sales, doctor shopping or fraud, or if they have been found with a diagnosis of poisoning due to an illicit substance.
Texas	1. Treatment that exceeds therapeutic daily Morphine Equivalent Dose (MED) Prescription combination with abuse potential 2. Overlapping or duplicative psychotropic prescriptions from 2 or more unaffiliated prescribers; 3. ER visits or hospitalizations due to suicide attempt; poisoning or overdose of drugs (intentional self-harm) 4. A diagnosis of alcohol or drug abuse including non-therapeutic, recreational or illegal drug use 5. Two or more occurrences of violating a pain contract with the same prescriber or with different prescriber(s) 6. Conviction of a crime related to restricted medications within the past year (e.g., forgery, theft, distribution or Medicaid fraud)
Utah	Multiple PCP's and specialty providers; cash payments for Medicaid covered services.
Vermont	Review claims and referral documentation, Health Information Exchange (HIE) documents, etc, for beneficiaries who are referred to Team Care to determine if enrollment criteria is met.
Washington	The Lock-In Program placement criteria: A. Two or more of the following occurred in a period of ninety consecutive calendar days in a twelve month period: 1. Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice; 2. Had prescriptions filled by four or more different pharmacies;

State	Explanations
	3. Received ten or more prescriptions; 4. Had prescriptions written by four or more different prescribers not located in the same clinic or practice; 5. Received similar services in the same day not located in the same clinic or practice; or 6. Had ten or more office visits. B. Any one of the following occurred in a period of ninety consecutive calendar days in the twelve month period: 1. Made two or more emergency department visits; 2. Exhibits "at-risk" usage patterns; 3. Made repeated efforts to seek health care services that are not medically necessary; or 4. Was counseled at least once by a health care provider, or an agency or MCO staff member with clinical oversight, about the appropriate use of health care services. C. Received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the ninety-day review period; D. Has a medical history or billing history, or both, that demonstrates a pattern of the following at any time: 1. Using health care services in a manner that is duplicative, excessive, or contraindicated; 2. Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice.
West Virginia	Use of opioids or other controlled substance with a history of overdose or abuse.
Wisconsin	Medical claim are reviewed for recent emergency room visits and if there is a diagnosis of medication poisoning.

b. Does your state have the capability to restrict the beneficiary to:

i. Prescriber only

Figure 59 - Prescriber Only Restriction Capability

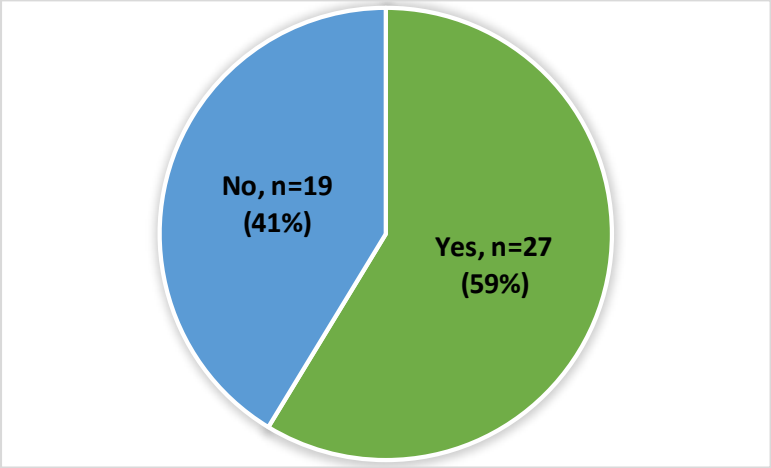

Table 83 - Prescriber Only Restriction Capability

Response	States	Count	Percentage
Yes	Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Texas, Vermont, Virginia, Washington, West Virginia	27	58.70%
No	Alabama, Alaska, Arkansas, Connecticut, District of Columbia, Louisiana, Maryland, Massachusetts, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin, Wyoming	19	41.30%
Total		46	100.00%

ii. Pharmacy only

Figure 60 - Pharmacy Only Restriction Capability

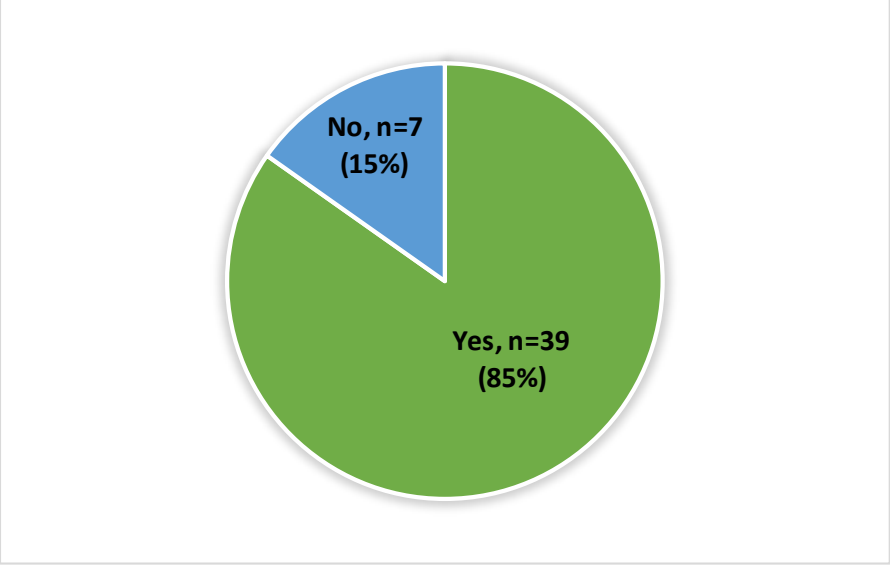

Table 84 - Pharmacy Only Restriction Capability

Response	States	Count	Percentage
Yes	Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	39	84.78%
No	Alabama, Alaska, Nebraska, North Carolina, Oklahoma, Utah, Wisconsin	7	15.22%
Total		46	100.00%

iii. Prescriber and pharmacy

Figure 61 - Prescriber and Pharmacy Restriction Capability

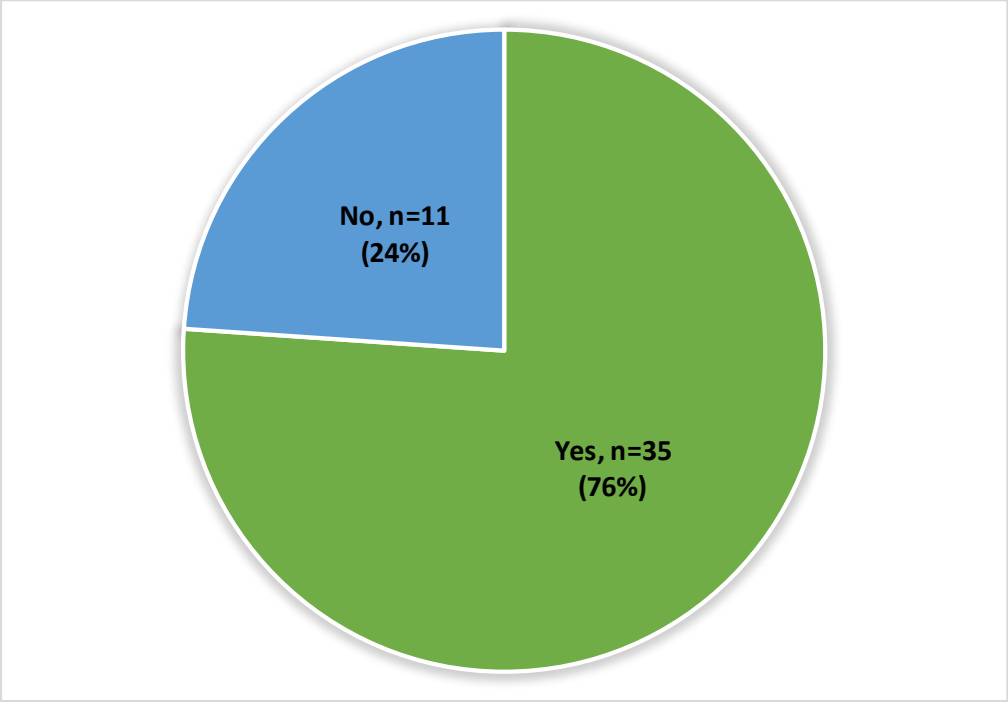

Table 85 - Prescriber and Pharmacy Restriction Capability

Response	States	Count	Percentage
Yes	Alabama, Alaska, Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	35	76.09%
No	Arkansas, Connecticut, District of Columbia, Maryland, Massachusetts, New Hampshire, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming	11	23.91%
Total		46	100.00%

c. What is the usual lock-In time period?

Figure 62 - Lock-In Time Period

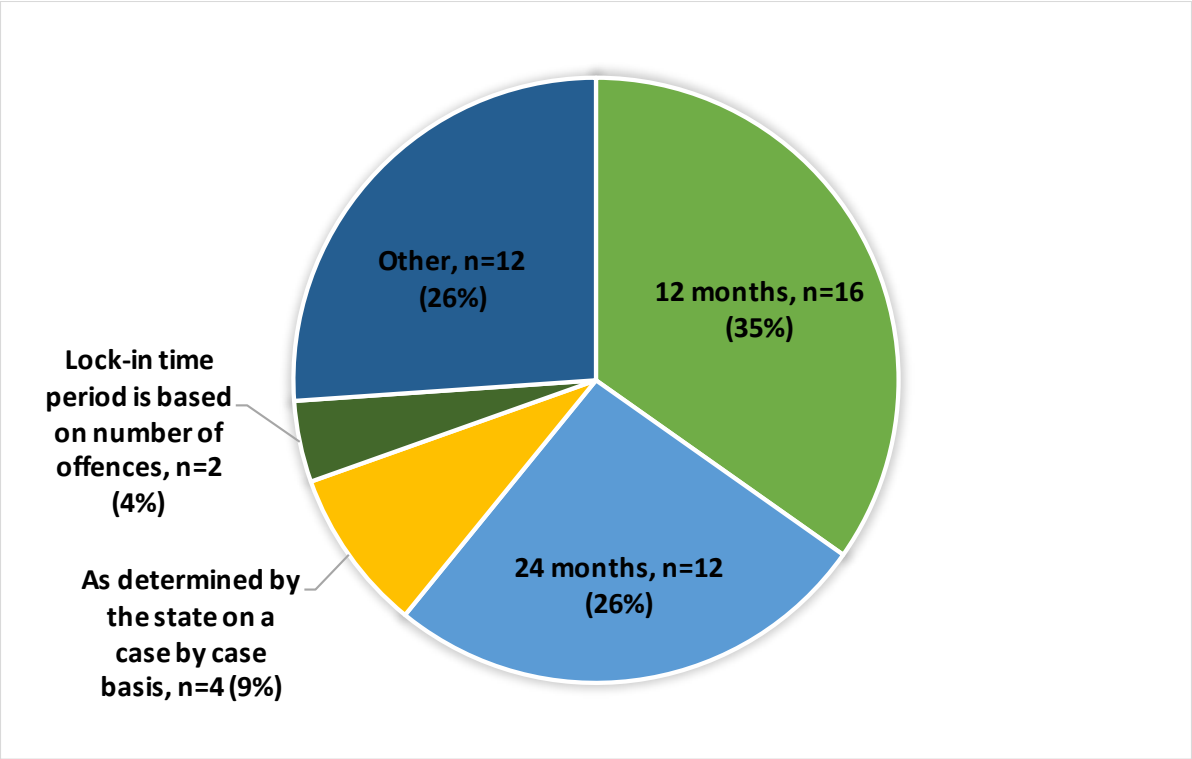

Table 86 - Lock-In Time Period

Response	States	Count	Percentage
12 months	Alabama, Alaska, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Mississippi, Montana, New Hampshire, Oregon, Rhode Island, South Carolina, Utah, Virginia, West Virginia	16	34.78%
24 months	Hawaii, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, North Carolina, Ohio, Washington, Wisconsin	12	26.09%
As determined by the state on a case by case basis	Nevada, New Jersey, New Mexico, North Dakota	4	8.70%
Lock-in time period is based on number of offences	New York, Wyoming	2	4.35%
Other	Arkansas, Delaware, Illinois, Indiana, Maine, Massachusetts, Minnesota, Oklahoma, Pennsylvania, Tennessee, Texas, Vermont	12	26.09%
Total		46	100.00%

If "Other," please explain.

Table 87 - "Other" Explanations for Lock-In Time Period

State	Explanations
Arkansas	Lock-in clients are initially locked in for one year and then re-reviewed by the RDUR lock-in committee annually. The restriction will be removed after demonstration by the client that the abusive situation has been corrected.
Delaware	Lock in period does not have an end date but can be reviewed at the member's request
Illinois	he initial FFS client lock-in is for 12 months. All subsequent lock-ins for same recipient are implemented for 24 months.
Indiana	Two years, and then re-evaluation for graduation or re-enrollment.
Maine	Varies on severity of the infraction coupled with the review of the urinalysis and medical chart notes and behavior changes.
Massachusetts	Minimum of 12 months, and reviewed on a case by case basis.
Minnesota	Initial 24 months with possibility of a 36 month renewal.
Oklahoma	The initial lock-in time period is 24 months. After the initial 24 months, members in the lock-in program are reviewed at least every 12 months for the continued need of lock-in status.
Pennsylvania	Restrictions are lifted after a period of five years if improvement in use of services is demonstrated. An additional five-year Lock-In period is implemented if the beneficiary continues to abuse medical services including medications.
Tennessee	There is no time limitation. Members are re-reviewed at least yearly, and are not unlocked or removed from PA Status until they qualify according to our Rules. If Arrested for TennCare doctor shopping, drug sales or fraud there is no re-review and they remain until convicted or acquitted, nolled or dismissed, and if convicted, they are subject to Lock-In and PA Status as long as they have the benefit at any time.
Texas	The Lock-In time periods are cumulative eligibility time frames of 36-months, 60-months and Lifetime determined on a case by case basis.
Vermont	Initial enrollment period is 24 months for most members, but this can be adjusted as appropriate on a case by case basis. Once enrolled in the lock-in program (Team Care), and the initial enrollment period has elapsed, periodic reviews of claims data are conducted. Periodic reviews are conducted in intervals as the case warrants, based on the claims data and other sources of information (such as provider input, HIE records). Typically, these are annual reviews but can be as soon as 3 months or up to 12 months until the next review. If members being reviewed no longer meet Team Care criteria, they are dis-enrolled as appropriate. A follow up review for dis-enrolled members is conducted 6-12 months following dis-enrollment.

d. On average, what percentage of the FFS population is in Lock-In status annually?

Figure 63 - Percentage of FFS Population in Lock-In Status Annually

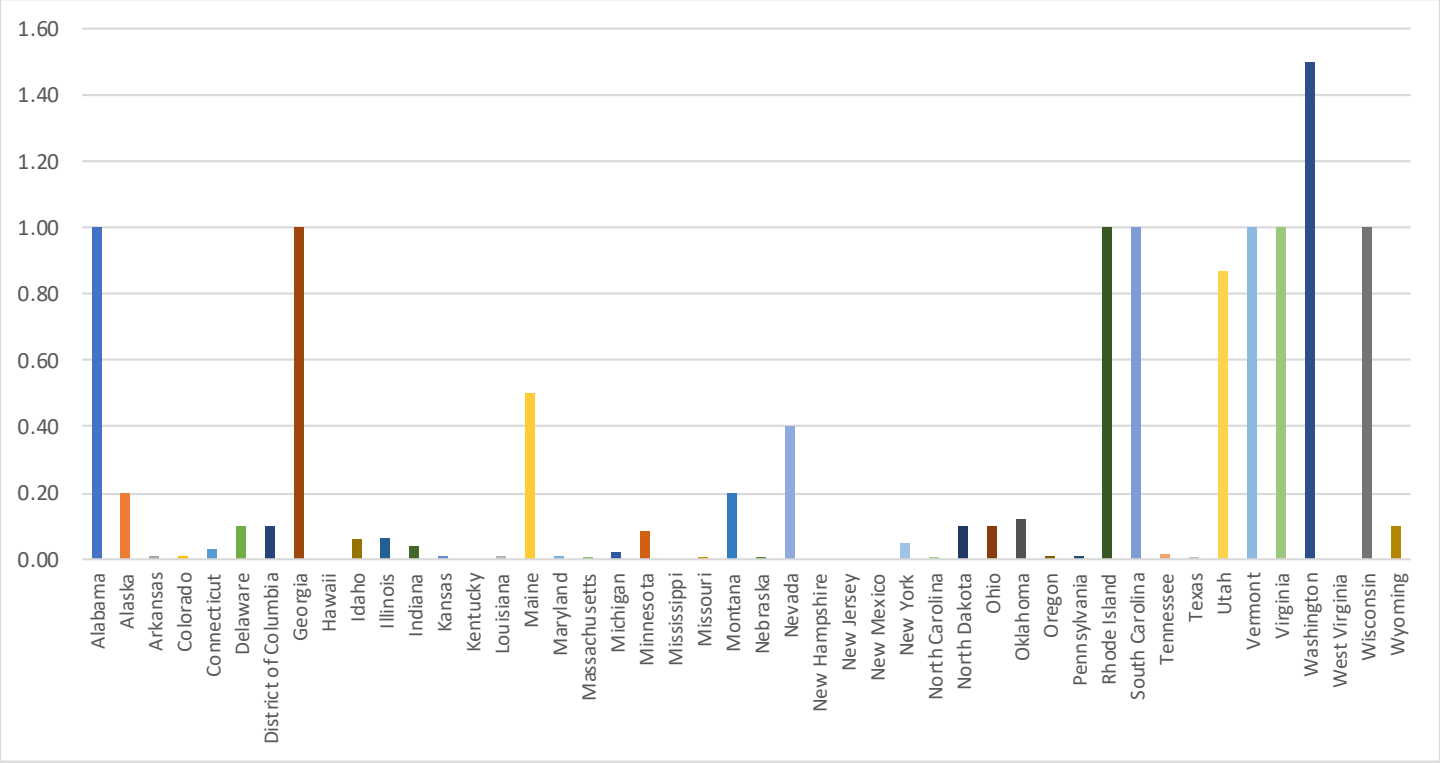

Table 88 - Percentage of FFS Population in Lock-In Status Annually

State	Percent
Alabama	1.0000%
Alaska	0.2000%
Arkansas	0.0100%
Colorado	0.0100%
Connecticut	0.0300%
Delaware	0.1000%
District of Columbia	0.1000%
Georgia	1.0000%
Hawaii	0.0000%
Idaho	0.0600%
Illinois	0.0640%
Indiana	0.0400%
Kansas	0.0100%
Kentucky	0.0000%
Louisiana	0.0100%
Maine	0.5000%
Maryland	0.0100%
Massachusetts	0.0030%
Michigan	0.0210%
Minnesota	0.0843%

State	Percent
Mississippi	0.0000%
Missouri	0.0020%
Montana	0.2000%
Nebraska	0.0004%
Nevada	0.4000%
New Hampshire	0.0000%
New Jersey	0.0000%
New Mexico	0.0000%
New York	0.0500%
North Carolina	0.0045%
North Dakota	0.1000%
Ohio	0.1000%
Oklahoma	0.1200%
Oregon	0.0100%
Pennsylvania	0.0100%
Rhode Island	1.0000%
South Carolina	1.0000%
Tennessee	0.0140%
Texas	0.0024%
Utah	0.8700%
Vermont	1.0000%
Virginia	1.0000%
Washington	1.5000%
West Virginia	0.0000%
Wisconsin	1.0000%
Wyoming	0.1000%

3. Does your state have a documented process in place that identifies possible FWA of controlled drugs by prescribers?

Figure 64 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

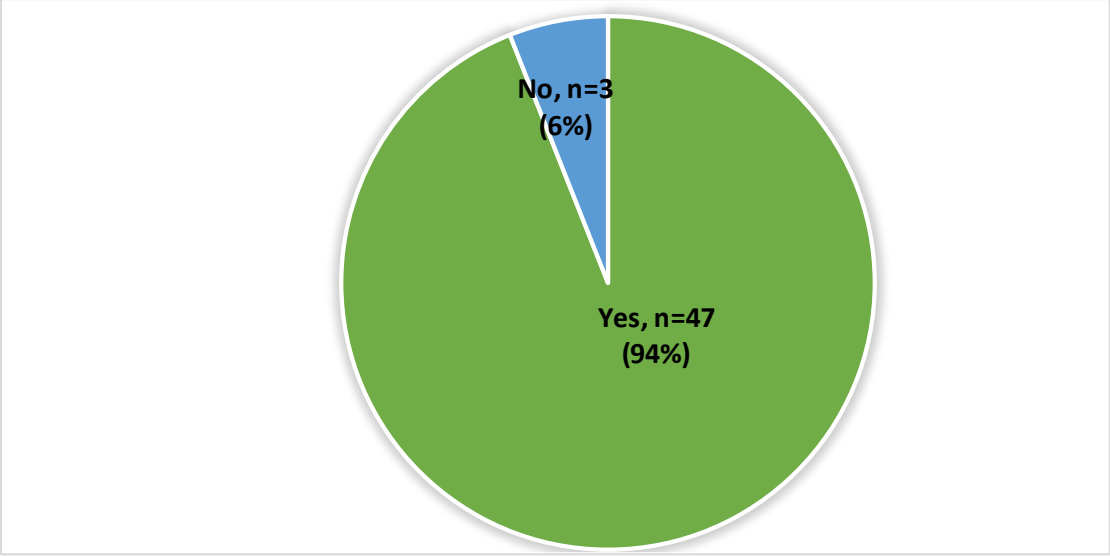

Table 89 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	Idaho, Montana, Nevada	3	6.00%
Total		50	100.00%

If "Yes," what actions does this process initiate?

Figure 65 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

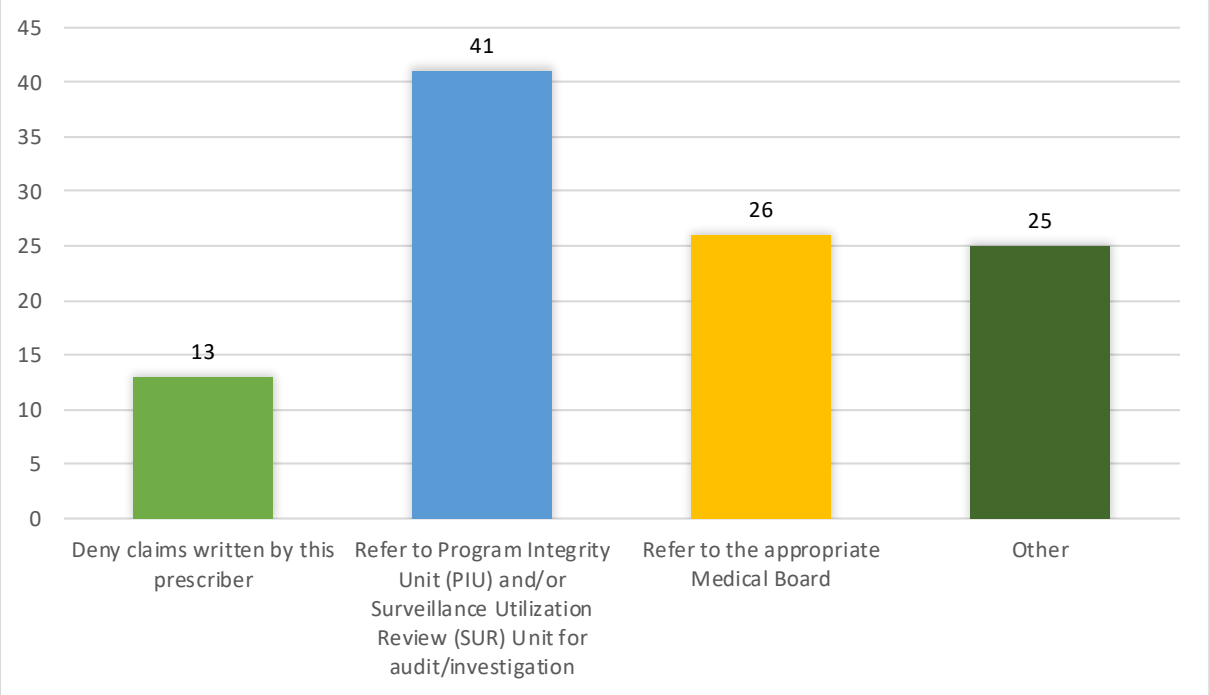

Table 90 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

Response	States	Count	Percentage
Deny claims written by this prescriber	California, Florida, Georgia, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oregon, Vermont, West Virginia	13	12.38%
Refer to Program Integrity Unit (PIU) and/or Surveillance	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts,	41	39.05%

Response	States	Count	Percentage
Utilization Review (SUR) Unit for audit/investigation	Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming		
Refer to the appropriate Medical Board	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Vermont, West Virginia, Wyoming	26	24.76%
Other	Alaska, Arkansas, California, Connecticut, Georgia, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin	25	23.81%
Total		105	100.00%

If "Other," please explain.

Table 91 - "Other" Explanations for Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

State	Explanations
Alaska	Alaska is currently utilizing JSURS to identify prescriber trends. The state is also working on the integration of the PDMP. Trends are reviewed by the DUR committee.
Arkansas	Arkansas Medicaid RDUR program identifies prescribing outliers which are presented to our DUR board for consideration. Depending on the situation, a peer-to-peer outreach may be recommended or referral to Arkansas Office of Medicaid Inspector General (AR OMIG). AR OMIG also performs random sampling for adherence to state and federal policies and procedures and for claim integrity. If AR OMIG identifies possible fraudulent behavior of a prescriber, the Medicaid Fraud Control Unit (MFCU) is notified.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving possible fraud or abuse of controlled drugs by prescribers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and (if warranted) assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and prescribing trends. Current utilization controls include suspended provider lists, provider sanctions for a specified time period, provider sanctions from prescribing select medications, contracted drug list compliance, code 1 restrictions, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.
Connecticut	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
Georgia	Deny claims written by this prescriber, Refer to Program Integrity Unit, Refer to the appropriate Medical Board

State	Explanations
Illinois	Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses. System edits will deny claims if the prescriber has been tagged in the system by HFS as prescriber not authorized to prescribe.
Kansas	Referrals can be made to the Attorney General's Office.
Louisiana	The Program Integrity audit process identifies possible fraud or abuse by prescribers.
Maryland	This process may result in a referral to Office of Inspector General. HID, through the RxExplorer software, is able to produce various reports to identify the top prescribers of controlled substances, as well as provide the average prescribing rate for a specified period of time. Using this information, HID can further pull a detailed prescriber claims profile for a specified time and review for trends and/or red flags as determined by the Department. This information is submitted to the Department for further review and determination of potential fraud or abuse. Additionally, claims data reports can be pulled for any opioid claim for a specified timeframe. This information will identify the Participant, Prescriber and Dispensing pharmacy in one report. Review of this information for concerning trends or red flags will identify those participants, prescribers or pharmacies that may require a more focused review. These reports can be submitted to the Department.
Michigan	Prescribers may be suspended or sanctioned and prescriptions written by these prescribers would then be denied at point-of-sale.
Minnesota	Refer to DHS's Office of Inspector General based on hotline tips. Also, there are direct referrals from anyone including law enforcement, state agencies, and local advocates.
Mississippi	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit.
Nebraska	Program Integrity Unit reviews reports through the data warehouse of outliers for further review.
New Hampshire	Prescribers may be suspended or sanctioned and prescriptions written by these prescribers would then be denied at point-of-sale.
New Mexico	There is a threshold for refilling controlled prescriptions where 90% of the original days' supply must be used prior to dispensing a refill.
New York	Academic retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of the Inspector General (OMIG) for further review and/or possible investigation.
North Carolina	An audit of specific claims may be performed. If fraud is suspected, a referral is made to the NC DOJ.
Pennsylvania	The Bureau of Program Integrity (BPI) monitors prescribers for possible fraud, waste and abuse of controlled substances. BPI reviews the prescriber's medical and fiscal records, paid claims and historical allegations or complaints. If it is determined there is a credible allegation of fraud, BPI refers the prescriber to the Office of Attorney General's Medicaid Fraud Control Section and evaluates for possible payment suspension. A referral is sent to the Medical Board for concerns of quality of care following the completion of any criminal investigation. For reviews that are identified as possible abuse only, the BPI process is to notify the provider of the violation of PA MA regulations in a two-step process resulting in possible recovery of restitution of the medications reimbursement amount.
South Carolina	Managed by Program Integrity
Tennessee	May also be referred to TennCare's DUR Board for a vote of referral to Tennessee's Provider Review committee for further consideration
Texas	The Lock-In Program makes referrals to other OIG divisions, law enforcement or licensing body when applicable. Lock-In may refer a provider within the OIG for a preliminary investigation. If

State	Explanations
	findings merit a full-scale investigation, an initial notification is made to the Medicaid Fraud Control Unit (MFCU). If criminal elements are identified, MFCU and OIG coordinate on the case. The OIG may also close and refer a case to a board/licensing body.
Utah	Peer to peer outreach.
Vermont	Refer to Medicaid Fraud and Residential Abuse Unit
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

If "No," please explain.

Table 92 - No Explanations for Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

State	Explanations
Idaho	We do not have a documented process. In general, the department would refer to the program integrity unit. No referrals have been done during the FFY of this report.
Montana	We do not have a documented process in place to identify possible fraud or abuse of controlled drugs by prescribers. However, if we see inappropriate prescribing, case management will reach out to the prescriber to provide education. These are usually identified by the PA unit when a prescriber or pharmacy calls to get a prior authorization. The number of instances has decreased dramatically in recent years, but if we continue to see inappropriate prescribing despite education efforts, we will report severe cases to the medical board or DEA.
Nevada	Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the Surveillance and Utilization Review (SUR) Unit for investigation.

4. Does your state have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?

Figure 66 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

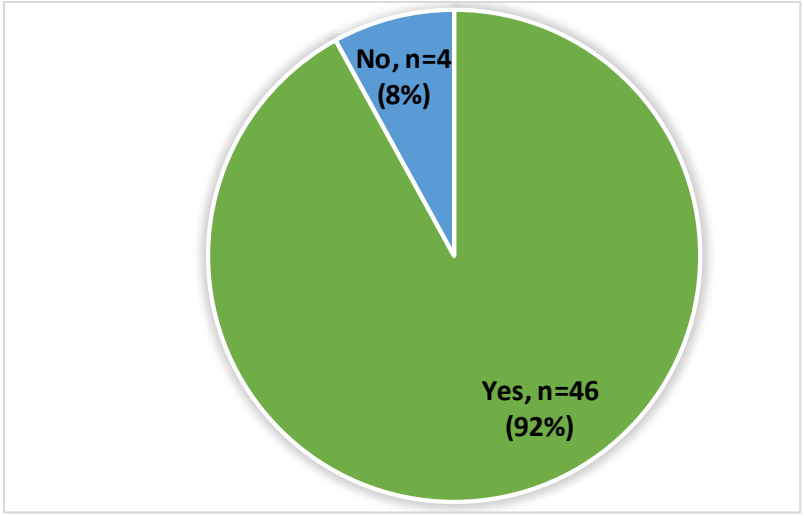

Table 93 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Idaho, Kansas, Montana, Nevada	4	8.00%
Total		50	100.00%

If "Yes," what actions does this process initiate?

Figure 67 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

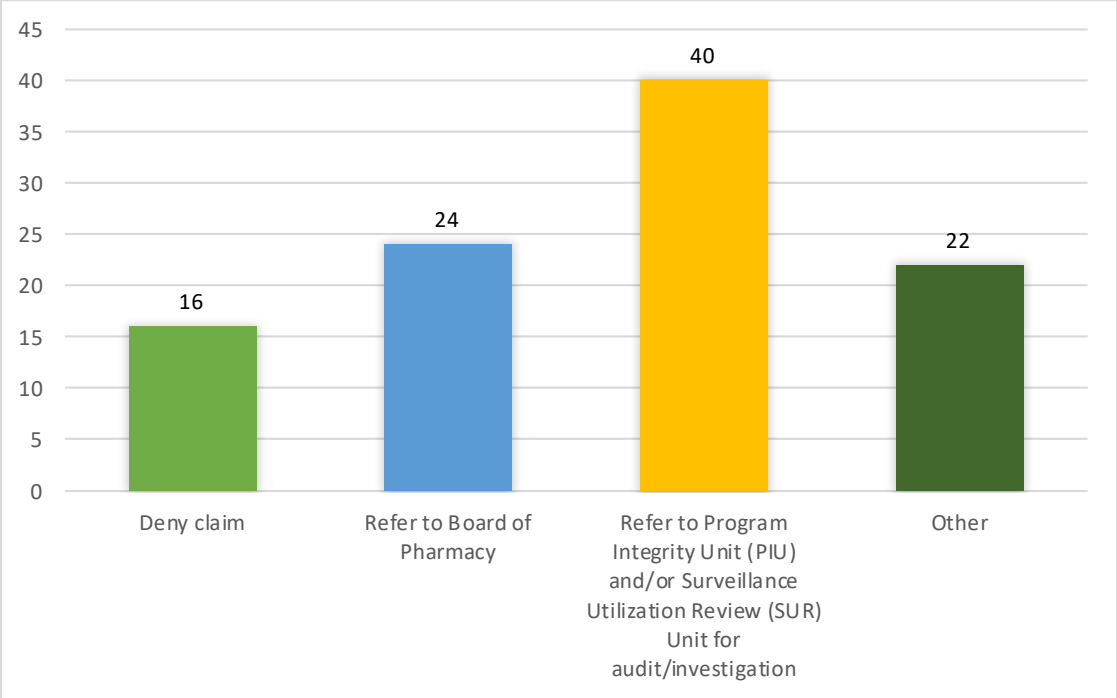

Table 94 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

Response	States	Count	Percentage
Deny claim	California, Florida, Georgia, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oregon, Vermont, West Virginia	16	15.69%

Response	States	Count	Percentage
Refer to Board of Pharmacy	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Vermont, West Virginia, Wyoming	24	23.53%
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	40	39.22%
Other	Alaska, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin	22	21.57%
Total		102	100.00%

If "Other," please explain.

Table 95 - "Other" Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

State	Explanation
Alaska	Alaska is currently utilizing JSURS to identify prescriber trends. the state is also working on the integration of the PDMP. Trends are reviewed by the DUR committee.
Arkansas	AR OMIG performs random sampling for adherence to state and federal policies and procedures and for claim integrity. AR OMIG performs pharmacy audits twice a year on all Arkansas Medicaid enrolled pharmacies. The RDUR program, through periodic examination of claims data, will identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care. Any pharmacy suspected of FWA will be forwarded to AR OMIG for further investigation.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving potential fraud or abuse of controlled drugs by pharmacy providers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and (if warranted) assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and pharmacy dispensing trends. Current utilization controls include suspended pharmacy provider lists, restrictions placed upon individual pharmacist licenses by the State Board of Pharmacy, contracted drug list compliance, code 1 restrictions documentation, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.
Connecticut	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.

State	Explanation
Florida	Claims will deny that exceed the limits set by the Agency (i.e., Morphine Milligram Equivalent (MME), quantity limits, and day supply limits).
Georgia	Pharmacy will be referred for audit; we have an active pharmacy audit program; explanation of benefit surveys to patients regarding pharmacy claims.
Illinois	Refer to Provider Analysis Unit for evaluation. Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
Indiana	Audit recoupment, Prepayment review program
Maryland	A compliance pharmacist performs desktop audits to identify potential fraud, waste and abuse by pharmacies. Additionally, HID, through the RxExplorer software, is able to produce various reports to identify the top dispensing pharmacies of controlled substances. Using this information, HID can further pull a detailed claims profile for a specified time and review for trends and/or red flags as determined by the Department. This information is submitted to the Department for further review and determination of potential fraud or abuse. Further, claims data reports can be pulled for any opioid claim for a specified timeframe. This information will identify the Participant, Prescriber and Dispensing pharmacy in one report. Review of this information for concerning trends or red flags will identify those participants, prescribers or pharmacies that may require a more focused review. These reports can be submitted to the Department.
Michigan	Pharmacies may be suspended or sanctioned which results in in the denial of claims submitted by the pharmacy at point-of-sale.
Minnesota	These can be referred to DHS's Office of Inspector General based on hotline tips. Also, there are direct referrals from anyone including law enforcement, state agencies, and local advocates.
Mississippi	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit.
Nebraska	Program Integrity Unit reviews reports through the data warehouse of outliers for further review.
New Hampshire	Pharmacies may be suspended or sanctioned which results in in the denial of claims submitted by the pharmacy at point-of-sale.
North Carolina	An audit of specific claims may be performed. If fraud is suspected, a referral is made to the NC DOJ.
Pennsylvania	BPI refers to the PA Attorney General, Medicaid Fraud Control Section (MFCS).
South Carolina	Managed by Program Integrity
Tennessee	May also be referred to TennCare's DUR Board for a vote of referral to Tennessee's Provider Review committee for further consideration
Texas	The Lock-In Program makes referrals to other OIG divisions, law enforcement or licensing body when applicable. If Lock-In refers a provider within the OIG for investigation there is a preliminary investigation. If findings merit a full-scale investigation, an initial notification is made to the Medicaid Fraud Control Unit (MFCU). If criminal elements are identified, MFCU and OIG coordinate on the case. The OIG may also close and refer a case to a board/licensing body.
Utah	Peer to peer outeach.
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

If "No," please explain.

Table 96 - No Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

State	Explanation
Idaho	Although we do not have a documented process, questions and potential fraud and abuse are referred to the Board of Pharmacy when deemed appropriate.
Kansas	Many of the FFS beneficiaries reside in the nursing home or only have only Aids Drug Assistance Program benefit. Only a small percent of patients remain covered by FFS. The majority of the Kansas Medicaid population is covered under the Managed Care Organizations.
Montana	We feel that our edits regarding duplicate fills, early fills, quantity limits, MME limits, etc. and not allowing pharmacist to override these edits prevents pharmacy providers from most forms of fraud or abuse of controlled drugs.
Nevada	Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR Unit for investigation.

5. Does your state have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by beneficiaries?

Figure 68 - Documented Process to Identify Possible FWA of Non-Controlled Drugs by Beneficiaries

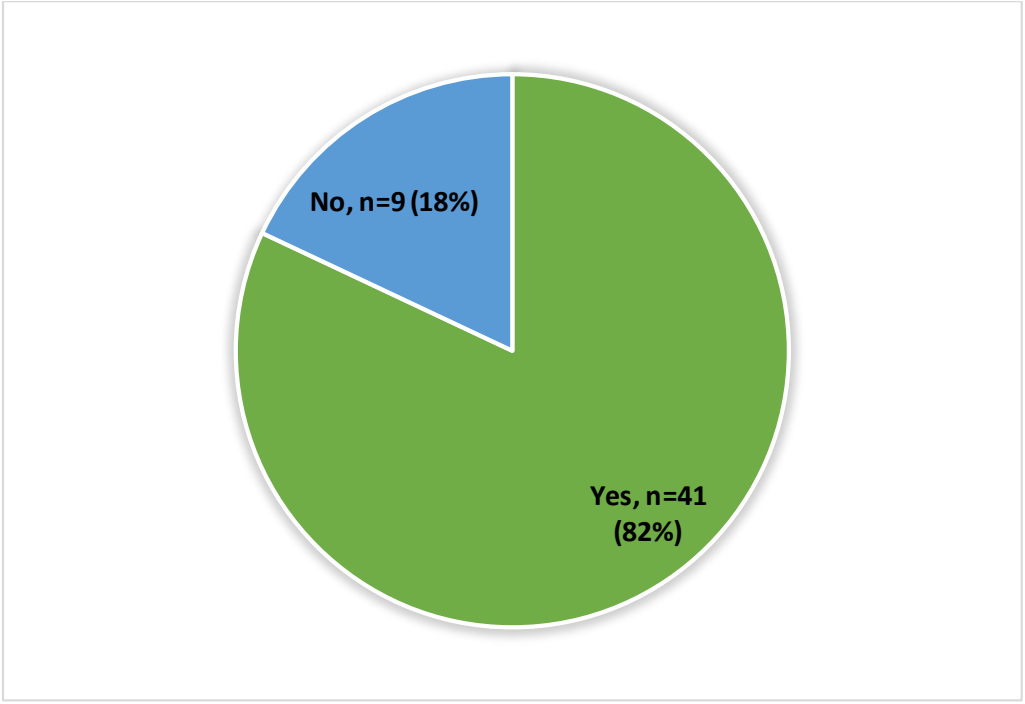

Table 97 - Documented Process to Identify Possible FWA of Non-Controlled Drugs by Beneficiaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	82.00%
No	Delaware, Idaho, Louisiana, Maryland, Missouri, Montana, Nevada, North Carolina, Rhode Island	9	18.00%
Total		50	100.00%

If "Yes," please explain your program for FWA of non-controlled substances.

Table 98 – Explanations of Documented Processes to Identify Possible FWA of Non-Controlled Drugs by Beneficiaries

State	Explanations
Alabama	Through eligibility and URC, recipients are referred to MFCU.
Alaska	The state utilizes quantity limits, days supply, therapeutic duplication, and prior authorization edits to identify/prevent potential abuse.
Arkansas	To prevent FWA, point-of-sale prescribing limits (e.g., quantity limits, therapeutic duplication) are in place for many non-controlled medications based on treatment guidelines and package inserts. Refill too soon edits, ProDUR alerts, accumulation edits, and prior authorization criteria help prevent fraud, waste, and abuse by clients. To identify FWA, the RDUR program lock-in reviews include muscle relaxers and gabapentin as non-controlled drugs in the review algorithm. Also Arkansas Medicaid has an internal controls and compliance group that investigate potential fraud and abuse by clients and forwards the information to the local prosecutor. If AR OMIG identifies potential fraud and abuse by clients during random sampling, information gathered is forwarded to the local prosecutor. Also, a fraud hotline and integrity reporting form are available for concerned citizens to bring attention to possible FWA by a client.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of non-controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and (if warranted) assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.
Colorado	Retrospective DUR analyses and prior authorization are used to identify these issues. Beneficiaries are referred to the Program Integrity Unit that works with individual counties.
Connecticut	A referral form exists to allow the clinical pharmacist to document suspected fraud and abuse of controlled and non-controlled drugs by beneficiaries, pharmacies and prescribers and send the referral form to the DSS program integrity unit for referral or further review.
District of Columbia	The Beneficiary Lock-in review process includes enforcing non-controlled substances polypharmacy criteria targeting ten or more non-controlled substances prescribed within a thirty day period.

State	Explanations
Florida	There are prescribing limits (i.e., quantity limits, duration of therapy) on non-controlled drugs based on FDA prescribing guidelines and package inserts.
Georgia	Deny claims and require prior authorization; quantity limits; refer to Program Integrity
Hawaii	Post payment (RetroDUR) review for expensive claims is done quarterly and manually. Potential FWA of non-controlled drugs are not seen in the current covered population.
Illinois	Recipient and Provider Analysis Units look at correlating diagnoses to support use of all medications and medical benefits by beneficiaries. The Units also look to see if alternative services to drug therapy are ordered for recipients such as physical therapy, specialty providers, assistive devices etc. that would indicate standards of care being provided. The Units will also contact ordering provider to validate need. If fraud or abuse of non-narcotics are suspected Units work together with appropriate unit(s) to implement cost avoidance measures such as quantity limits and product cost reduction, for example worked with Pharmacy Services to adjust quantity limit and obtain lower cost for lidocaine 5%.
Indiana	Pharmacies are able to supply tips on members to the fraud control line if member fraud and abuse is suspected.
Iowa	If fraud or abuse of a non-controlled substance is identified, the member would be referred to Program Integrity for further investigation.
Kansas	Our FFS Surveillance and Utilization Review Subsystem team monitors drug use against standards set in our pharmacy provider manual.
Kentucky	Refill too soon, ProDUR checks, desk audits, RetroDUR audits, quantity limits for dose optimization, dose accumulation edits, and other general DUR activities or system edits enabled/supported by FirstData Bank and vendor capabilities.
Maine	referral process to identify over use and internal clinical review for placement in the lock-in (IBM) Intensive Benefit Program
Massachusetts	MassHealth monitors through dose limits, quantity limits and case reviews at a therapeutic class management workgroup.
Michigan	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
Minnesota	Questionable utilization is referred to the SURS program and they determine the action from there.
Mississippi	Medicaid utilizes a maximum daily dose edit to prevent potential fraud or abuse of non-controlled drugs.
Nebraska	Early refill limits and daily quantity limits.
New Hampshire	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
New Jersey	Lock into a pharmacy and utilize negative PA. Negative PA will block payment of a prescription service. Number of referrals are low due to transition of beneficiaries to Medicaid Managed Care.
New Mexico	A threshold for filling or refilling non-controlled prescriptions exists where 75% of the original days' supply must be used prior to dispensing the medication.
New York	Academic retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of the Inspector General (OMIG) for further review and/or possible investigation.
North Dakota	ND Medicaid identifies medications that are not controlled substances yet have the potential for fraud, waste, or abuse and we ensure that there are appropriate quantity limits, diagnosis requirements, prior authorization, and other edits to limit the FWA potential.

State	Explanations
Ohio	Muscle relaxants are monitored in our Coordinated Services Program. Additionally, we partner with other state agencies and investigative units to monitor potential misuse of prescriptions.
Oklahoma	In addition to controlled medications, we also evaluate muscle relaxants and gabapentin claims for potential abuse when doing a lock-in review.
Oregon	Early refill edit.
Pennsylvania	Beneficiaries are placed in the Lock-In program when a pattern of fraud, waste or abuse of any medication is identified.
South Carolina	Managed by Program Integrity
South Dakota	Retrospective DUR Reviews.
Tennessee	Tennessee combats potential FWA for both controlled and non-controlled substances, in several different ways: 1. Our ProDUR edits are strong, and prevent some problems from occurring on the front end. Where we have found that ProDUR edits like Max Quantity have not worked in the case of topicals, ophthalmics and otics, we have established strong quantity limits to prevent inappropriately large quantities from being paid for. 2. Our PBM vendor looks at inappropriately large quantities of all paid claims on a daily basis, and contacts pharmacy providers the same day or the following day, when it appears that an extra zero has been added to a quantity. This type of problematic claim is stopped prior to the claim ever being paid for by the State. 3. Our Office of Provider Integrity analyzes claims for outliers for controlled substances, non-controlled substances and all other types of claims from pharmacies and from MCO medical claims, in order to combat FWA.
Texas	Referrals are made to the OIG-Lock-In Program, OIG-Investigations and Reviews, law enforcement, and Texas Department of Family and Protective Services as appropriate. Upon referral through the Waste, Abuse and Fraud Electronic Referral System (WAFERS), the Lock-In Program restricts referred Medicaid recipients to a provider and/or pharmacy. In addition, managed care organizations make referrals to the Lock-In Program
Utah	To prevent fraud, waste, or abuse of non-controlled substances utilization management edits are in place. These edits vary depending on the medication, include but are not limited to: quantity limits, day supply limits, and prior authorization.
Vermont	Quantity limits and early refill limits. Additional replacement fills for lost or stolen medication require a call to the help desk for appropriate documentation (possible PA) and override.
Virginia	Refer to Program Integrity Unit
Washington	A referral would be made to the Lock-In (Patient Review and Coordination) program for assessment.
West Virginia	Our early refill edit and quantity limit edit protect against a member obtaining more than 12 months supply of any drug in a year. Drugs requiring a PA typically require at minimum an approved diagnosis.
Wisconsin	Fraud and abuse must be reported regardless if the drug is a controlled or non-controlled drug. Fraud and abuse may be reported by going to the Office of the Inspector General fraud and abuse website or by calling the fraud and abuse hotline.
Wyoming	The DUR Manager may identify patterns of fraud, waste or abuse of non-controlled substances during retrospective analysis. When this occurs, beneficiaries are referred to the program integrity unit for further review.

If "No," please explain.

Table 99 – Explanations of Documented Processes to Identify Possible FWA of Non-Controlled Drugs by Beneficiaries

State	Explanations
Delaware	Delaware does not have a structured plan in place to identify FWA but currently works closely with the SURs Investigation Team when FWA is suspected or reported. Delaware may develop a more structured program in the future
Idaho	Presently we do not have a documented process. We work very closely with Board of Pharmacy with referral going both ways (from them to us or us to them). The Board of Pharmacy also will work with the licensing agency for the prescriber if necessary.
Louisiana	When potential patterns of fraud, waste, or abuse by beneficiaries are identified, the beneficiary may be referred to the Lock-in Program, and/or their prescriber may be contacted.
Maryland	The Maryland Department of Health (MDH) did not have a process in place that identifies and/or prevents potential fraud or abuse of non-controlled medications however, may develop one in future.
Missouri	We do not have a process in place to monitor non-controlled drugs for fraud/abuse.
Montana	We only have duplicate fill, early fill, and some quantity limit or criteria POS edits to prevent potential fraud or abuse of non controlled drugs by beneficiaries. We do not have a retrospective review process.
Nevada	Currently, the program does not include regular reviews to identify pharmacy providers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR Unit for investigation.
North Carolina	We do not have a process at this time.
Rhode Island	Fee-for-Service is usually the secondary payer.

B. Prescription Drug Monitoring Program (PDMP)

Note: Section 5042 of the SUPPORT for Patients and Communities Act requires states to report metrics in reference to their state's PDMP. CMS has included questions to reference these metrics to help your state establish processes to be in compliance with provisions outlined in Section 5042 and CMS reporting, beginning in FFY 2023.

1. Does your Medicaid program have the ability to query the state's PDMP database?

Figure 69 – State Able to query PDMP Database

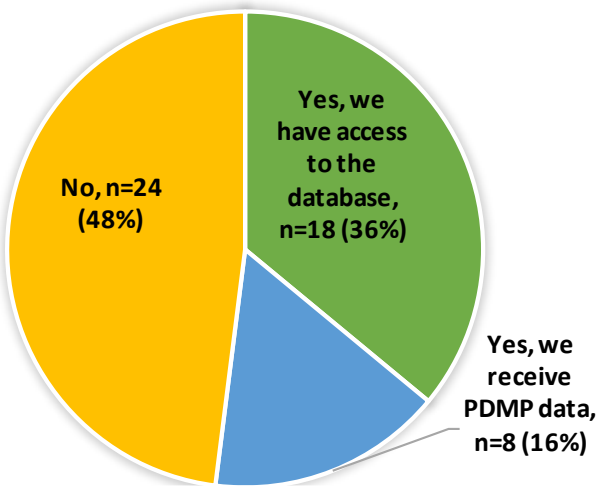

Table 100 - State Able to query PDMP Database

Response	States	Count	Percentage
Yes, have direct access to the database	Alabama, Alaska, Arkansas, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, North Carolina, Pennsylvania, South Dakota, Utah, Vermont	18	36.00%
Yes, receive PDMP data	Nevada, North Dakota, Ohio, Oklahoma, Tennessee, Washington, West Virginia, Wisconsin	8	16.00%
No	California, Colorado, Delaware, District of Columbia, Florida, Hawaii, Indiana, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, South Carolina, Texas, Virginia, Wyoming	24	48.00%
Total		50	100.00%

If "Yes," you receive PDMP data.

Figure 70 – Frequency of PDMP Data Received

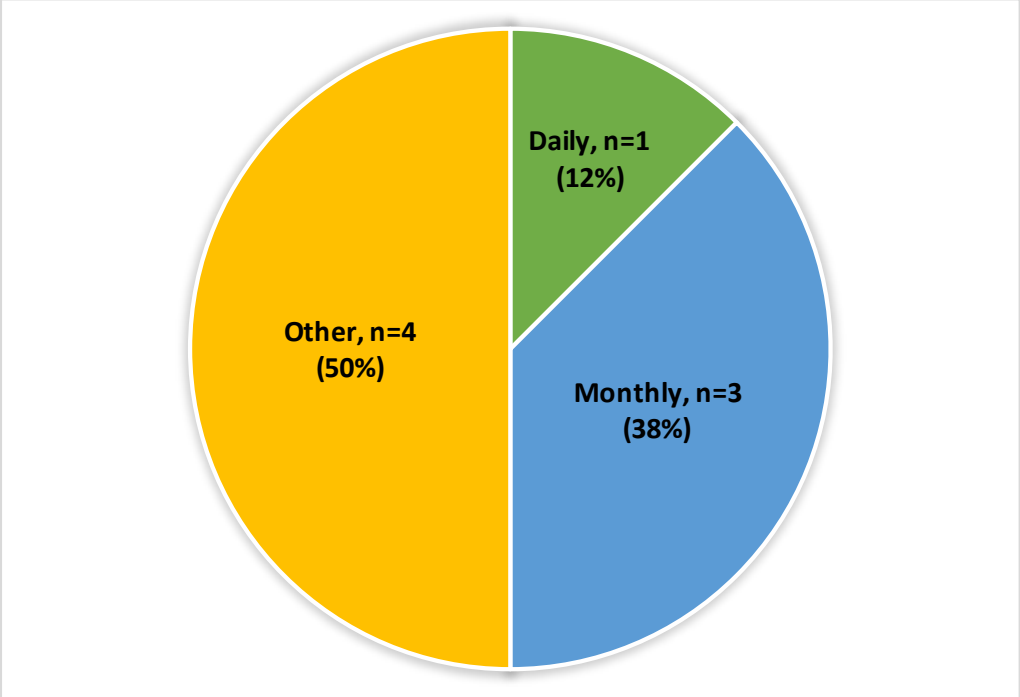

Table 101 - Frequency of PDMP Data Received

Response	States	Count	Percentage
Daily	Nevada	1	12.50%
Monthly	North Dakota, Tennessee, Wisconsin	3	37.50%
Other	Ohio, Oklahoma, Washington, West Virginia	4	50.00%
Total		8	100.00%

If "Other," please explain.

Table 102 – "Other" Explanations of Frenquency of PDMP Data Received

State	Explanations
Ohio	As needed
Oklahoma	by client (see below)
Washington	HCA receives PMP transactional data monthly. HCA may also query the database directly for specific patients/clients.
West Virginia	We are allowed to delegate authority to our PA vendor so that they may also review patient's before granting overrides and PAs.

If "Yes," you have direct access to the database.

Figure 71 – State's Access to the PDMP Database

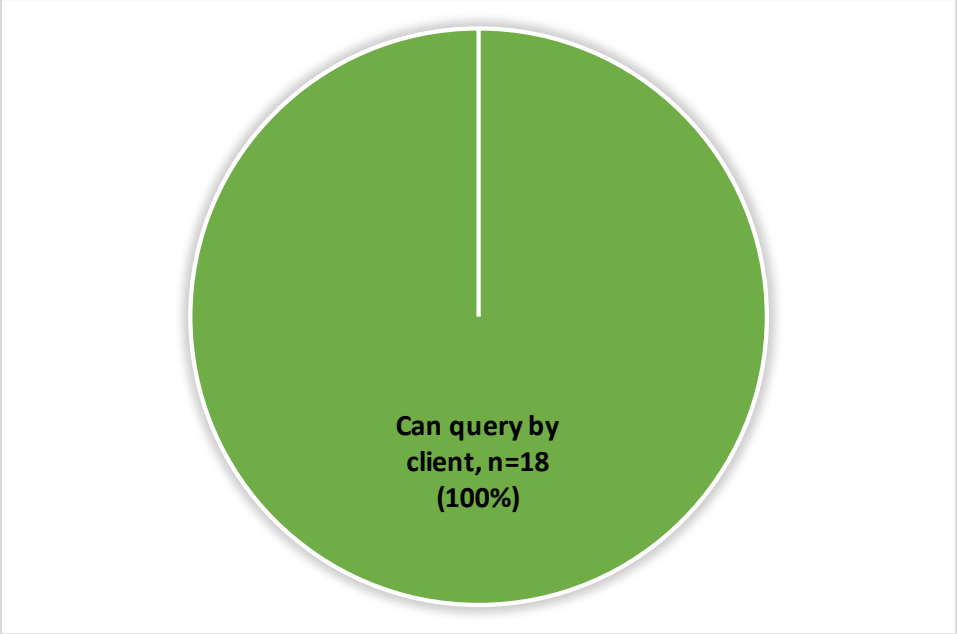

Table 103 - State's Access to the PDMP Database

Response	States	Count	Percentage
Can query by client	Alabama, Alaska, Arkansas, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, North Carolina, Pennsylvania, South Dakota, Utah, Vermont	18	100.00%
Total		18	100.00%

If "No," please explain.

Table 104 – Explanations Why State Has No Access to Query PDMP Database

State	Explanations
California	California state law does not allow access to client data for this type of analysis.
Colorado	The State is prohibited by law from accessing the PDMP. In our DUR criteria, we highly encourage providers to access the PDMP prior to prescribing any opioid, although pre-prescribing use of the PDMP is not required.
Delaware	The Medicaid program does not have access to the Delaware PDMP at this time.
District of Columbia	The PDMP is administered and regulated by the DC Department of Health which states that the PDMP data is not to be used by DC Medicaid to support the Pharmacy Lock-in Program and any other pharmacy-related program.
Florida	Sections 893.055, and 893.0551, Florida Statutes does not authorize the release of PDMP information to the Agency for Health Care Administration. For cases involving Medicaid fraud, the Attorney General may request the information if the case involves prescribed controlled substances.
Hawaii	Access is not yet allowed by state to Medicaid.
Indiana	The state is currently working on obtaining this functionality for the agency.
Iowa	The Iowa Board of Pharmacy only allows access to the PMP to authorized prescribers and pharmacists to obtain information regarding their patients' use of controlled substances when actively engaged in the patient's healthcare.
Kansas	We do not have access at the State Medicaid agency, but the Kansas pharmacies/pharmacists have access. FFS and MCO Pharmacy Directors have limited access.
Maine	According to AG interpretation of the State PDMP data, the State agency is not entitled to non de-identified personal data within the PDMP for management of member benefits.
Maryland	Maryland Medicaid administrative staff cannot query the PDMP database unless the FFS program provides a bonafide formal investigation to obtain the data from the PDMP. Requests must be approved by the Secretary of the Maryland Department of Health (MDH). Information is obtained through the MDH's PDMP. Only healthcare providers with a treatment relationship with the patient can query the PDMP or investigators with authority designated by statute.
Michigan	Medicaid program staff can request Third Party Benefits Reviewer access. This access role allows for submission of a request for PDMP report on a particular client. The report is not autogenerated. Instead, the State Agency responsible for the PDMP has staff review and manually generate the requested report during regular business days/hours only. The turn around time varies on volume of requests and staffing resources at the State Agency responsible for the PDMP.
Minnesota	Administrative use of PDMP is not permitted by law. The exception is the SURS program can query on an individual recipient to determine if the individual should be placed in the Restricted program.
Missouri	Missouri does not have a state wide PDMP.
New Hampshire	The Department is prohibited by NH statute from accessing the PDMP.
New Jersey	NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and are in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR is considered unauthorized users since they are not directly delivering healthcare.
New Mexico	Information is obtained on a case-by-case situation by a state Pharmacist's personal access to confirm inappropriate behaviors.

State	Explanations
New York	No direct sharing of the PDPM program and Medicaid at this time
Oregon	We are statutorily prohibited from accessing PDMP data.
Rhode Island	State law requires the users of the PDMP to have a DEA number.
South Carolina	under the Prescription Monitoring Act the information D (5) notes the provision of the information to Medicaid: SECTION 44-53-1650. Confidentiality; persons to whom data may be released. (A) Prescription information submitted to drug control is confidential and not subject to public disclosure under the Freedom of Information Act or any other provision of law, except as provided in subsections (C) and (D). (B) Drug control shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed, except as provided for in subsections (C) and (D). (C) If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, drug control shall notify the appropriate law enforcement or professional licensure, certification, or regulatory agency or entity and shall provide prescription information required for an investigation. (D) Drug control may provide data in the prescription monitoring program to the following persons: (1) a practitioner or pharmacist or authorized delegate who requests information and certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide patient; (2) an individual who requests the individual's own prescription monitoring information in accordance with procedures established pursuant to state law; (3) a designated representative of the South Carolina Department of Labor, Licensing and Regulation responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons authorized to prescribe, administer, or dispense controlled substances and who is involved in a bona fide specific investigation involving a designated person; (4) a local, state, or federal law enforcement or prosecutorial official engaged in the administration, investigation, or enforcement of the laws governing licit drugs and who is involved in a bona fide specific drug related investigation involving a designated person; (5) the South Carolina Department of Health and Human Services regarding Medicaid program recipients; (6) a properly convened grand jury pursuant to a subpoena properly issued for the records; (7) personnel of drug control for purposes of administration and enforcement of this article; (8) qualified personnel for the purpose of bona fide research or education; however, data elements that would reasonably identify a specific recipient, prescriber, or dispenser must be deleted or redacted from such information prior to disclosure. Further, release of the information only may be made pursuant to a written agreement between qualified personnel and the department in order to ensure compliance with this subsection. https://scdhec.gov/laws-regulations/prescription-monitoring
Texas	Texas Law prohibits access to PDMP database
Virginia	Not allowed to access by state law
Wyoming	The Wyoming Department of Health is not allowed access by the Wyoming Board of Pharmacy due to interpretation of the statute creating the PDMP.

If "Yes," please continue.

a. Please explain how the state applies this information to control FWA of controlled substances.

Table 105 – Explanations of Application of Information to Control FWA

State	Explanations
Alabama	Used in conjunction with Lock-in reviews.
Alaska	If fraud or abuse is suspected, we are able to confirm it during case review.
Arkansas	The Arkansas Department of Health facilitates the PDMP and grants access for prescribers (physician, nurse practitioner, dentist, etc.), pharmacists, delegates of prescribers/pharmacists, professional licensing boards, and certified law enforcement . The RDUR Medicaid program is responsible for monitoring the lock-in program. When reviewing potential lock-in clients, the PDMP is used to ascertain that controlled substances were used by the client in addition to what has been billed and found on the client's Medicaid profile. Arkansas has a poisoning/overdose edit that requires a prior authorization for opioids and benzodiazepines if the beneficiary has a billed diagnosis of poisoning or overdose on their profile. The prior authorization reviewer (clinical pharmacist) consults the PDMP on these requests.
Connecticut	State law requires all prescribers to review a patient's controlled substance history report if writing for more than a 72-hour supply. The provider agreement with the agency requires prescribers to adhere to all state laws and regulations. QA can open cases for investigating potential FWA.
Georgia	Assessment for Lock-In Program
Idaho	The clinical pharmacy staff at IDHW will access the PDMP in cases where it is brought to their attention that possible fraud and/or abuse is occurring. The PDMP is also used to identify patients who are paying cash (private pay) for controlled substance outside of the Idaho Medicaid benefit. The PDMP gives us a more complete picture of what controlled substances a beneficiary may be receiving.
Illinois	Recipient Analysis Unit staff use the PDMP as a reference only during their review of the recipient. No restriction decisions are based entirely on PDMP data. The Recipient Analysis Unit will also review claims data for correlating office visits by primary care providers and specialists who may be ordering alternative therapies as an adjunct to medications. When evaluating requests for controlled substances, Prior authorization staff will check PDMP. Potential fraud and abuse may be communicated to the prescriber. PDMP information is used for reference to augment agency fill history information.
Kentucky	Prescribers must attest to the fact that the PDMP report was reviewed in order for certain PAs to be approved.
Louisiana	PMP queries are pulled on Medicaid recipients only to help determine lock-in recommendations.
Massachusetts	MassHealth checks MassPAT for outlier behavior episodically and develops corrective action.
Mississippi	State's Program Integrity Unit can audit the PDMP to verify suspected fraud and abuse. DUR vendor has access to both claims and cash-pay data to analyze claims for suspected fraud and abuse based on prescriber and pharmacy providers.
Montana	We review utilization between FlexibleRx and the PDMP looking for cash pay on the PDMP that are not found in FlexibleRx.
Nebraska	Can access for probable cause.
Nevada	A query may be used during a Lock-In evaluation of a recipient.
North Carolina	If supporting information is needed for an investigation, the PDMP is available.
North Dakota	State staff review the information and use it for patient specific actions.

State	Explanations
Ohio	This data is used for data mining projects with SURS.
Oklahoma	On the legal and medical side, OHCA has limited access to the Oklahoma Prescription Monitoring Program (PMP) (PDMP = PMP in Oklahoma) database. The pharmacy side does not have direct access to query or retrieve PMP information due to Oklahoma laws.
Pennsylvania	BPI has the ability to query the data base if abuse is suspected. If fraud is suspected, BPI would refer the pharmacy provider to MFCS. BPI is a civil agency and cannot act as an agent for MFCS.
South Dakota	On a case by case basis to verify if prescriptions were obtained outside of Medicaid.
Tennessee	We have an agreement with the TN Department of Health, who owns the PDMP, referred to in Tennessee as the Controlled Substance Monitoring Database (CSMD), which allows TennCare to receive CSMD data, but in the agreement we are unable to use the data on an individual basis for fraud, controlled substance investigation, etc. TennCare's primary use of the information is in Dashboard benchmarking. We have also used this data in Re-Reviews of those members in the Lock-In program, to help in making a determination if the member has qualified to be removed from Lock-In, or PA Status.
Utah	The Medicaid pharmacy personnel will query by client when a prior authorization is received for opioids. Specifically, for high dose opioids and also long-acting opioid and benzodiazepine combinations.
Vermont	Only the medical director may query the PDMP as needed on a case by case basis
Washington	HCA is incorporating the PMP transactional data into our reports used to monitor controlled substances relating to the Support Act. We are continuing to work with the PMP vendor to update our data share agreement to include provider query data to monitor that prescribers and pharmacists are querying the PMP no more than ten days prior to prescribing a controlled substance and no more than two days after dispensing a controlled substance. The Pharmacy Oversight specialist will then be conducting analysis and making recommendations for follow-up oversight activities to one of the following: HCA Program Integrity, HCA Quality Management Team, Managed Care Review and Analytics Team, Patient Review and Coordination Team, or to the Pharmacy Team for a DUR activity.
West Virginia	If the PDMP indicates that a member is obtaining a controlled substance by more than one payer source the matter is referred to the Medicaid Fraud unit. Information obtained through this query may also be used when evaluating a request for prior authorization.
Wisconsin	The State of Wisconsin is working on incorporating the PDMP data into DUR activities.

b. Does your state also have access to Border States' PDMP information?

Figure 72 - Access to Border State PDMP Information

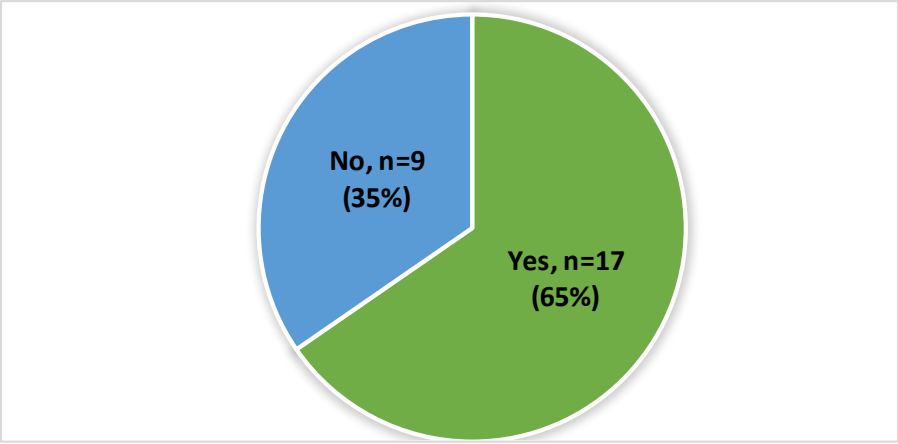

Table 106 - Access to Border State PDMP Information

Response	States	Count	Percentage
Yes	Alaska, Connecticut, Idaho, Illinois, Kentucky, Massachusetts, Mississippi, Montana, Nebraska, Nevada, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Vermont, Wisconsin	17	65.38%
No	Alabama, Arkansas, Georgia, Louisiana, North Carolina, North Dakota, Utah, Washington, West Virginia	9	34.62%
Total		26	100.00%

c. Does your state also have PDMP data integrated into your POS edits?

Figure 73 - PDMP Data Integration into POS Edit

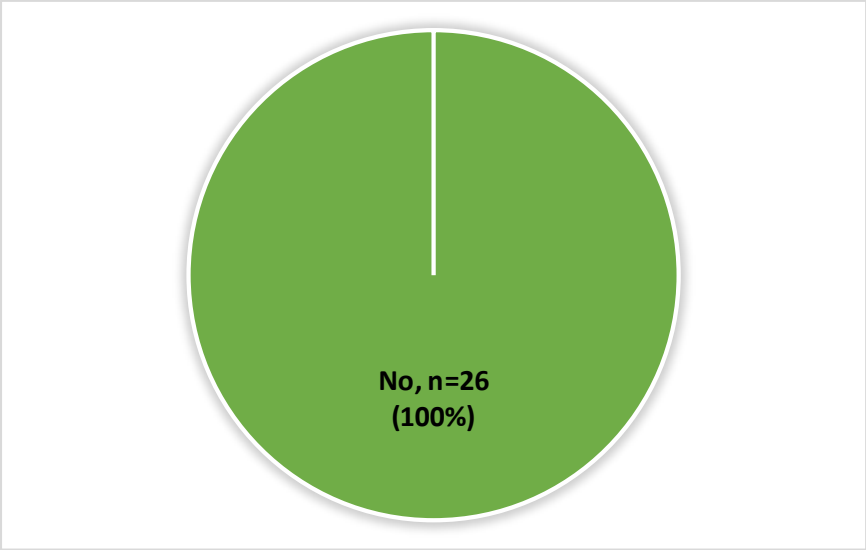

Table 107 - PDMP Data Integration into POS Edit

Response	States	Count	Percentage
No	Alabama, Alaska, Arkansas, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin	26	100.00%
Total		26	100.00%

2. Does your state or your professional board require prescribers to access the PDMP patient history before prescribing controlled substances?

Figure 74 - Prescribers Requirement to Access the PDMP Patient History Before Prescribing Controlled Substances

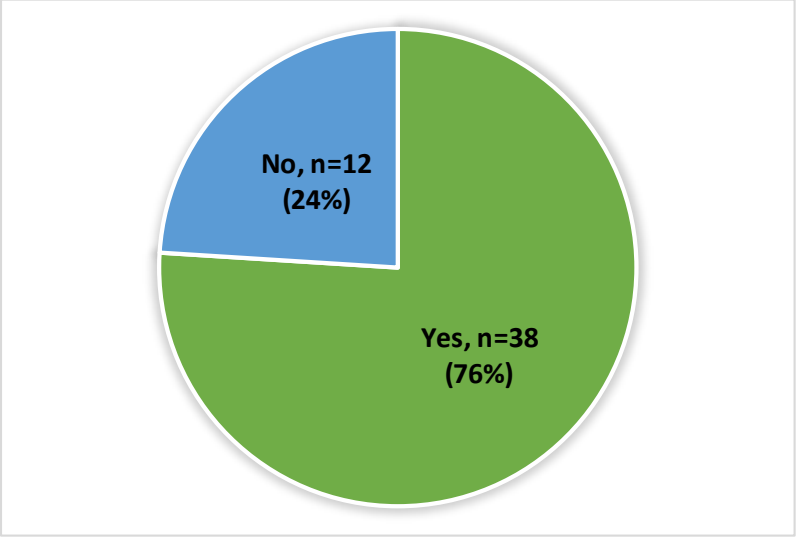

Table 108 - Prescribers Requirement to Access the PDMP Patient History Before Prescribing Controlled Substances

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	38	76.00%
No	Alabama, Colorado, District of Columbia, Idaho, Indiana, Kansas, Maryland, Missouri, Montana, Nebraska, Oregon, South Dakota	12	24.00%
Total		50	100.00%

If "No," please explain.

Table 109 – Explanations Why State Does Not Require Prescribers to Access PDMP Patient History Before Prescribing Controlled Substances

State	Explanations
Alabama	Accessing the PDMP is not required for all controlled substances. Prescribers must check for opioids per Board of Medical Examiners (BME) guidelines. The BME requires prescribers to query the PDMP for certain morphine milligram equivalent (MME) levels per day.
Colorado	Colorado statute requires prescribers with a DEA number and Colorado license to establish and maintain a Colorado PDMP account. Pharmacists licensed in Colorado are also required to have and maintain PDMP user accounts. There is no requirement for prescribers to use the PDMP tool before prescribing controlled substances, although it is highly encouraged.
District of Columbia	District legislation to require PDMP query prior to prescribing is under consideration.

State	Explanations
Idaho	not at this time
Indiana	The prescribing board within the state strongly advises for checking the PDMP prior to prescribing controlled substances but does not make this requirement mandatory.
Kansas	This is not required for KS providers yet. For KS Medicaid providers, this was optional during the FFY 2020 survey time period, but the Kansas Medicaid providers will be required to check the state PDMP website by 10/01/2021.
Maryland	Since 2018 the Maryland PDMP use mandate requires providers to query a patient's dispense history when beginning a new course of opioids or benzodiazepines (as opposed to the wording in the question regarding "controlled substances") in certain clinical situations. Exceptions can be found here: https://health.maryland.gov/pdmp/Pages/pdmp-use-mandate-information.aspx
Missouri	Missouri does not have a state wide PDMP.
Montana	Currently prescribers are not required to check the PDMP before prescribing controlled substances. However, a law was passed in the 2019 legislative session to require prescribers to review the PDMP before issuing a prescription for an opioid or a benzodiazepine effective July 1, 2021.
Nebraska	Not mandated.
Oregon	The Oregon Board of Pharmacy does not require prescribers to access the PDMP patient history before prescribing controlled substances.
South Dakota	The Board of Pharmacy does not require prescribers to access the PDMP prior to prescribing a controlled substance.

If "Yes," please continue.

a. Are there protocols involved in checking the PDMP?

Figure 75 – Are Protocols Involved Checking the PDMP

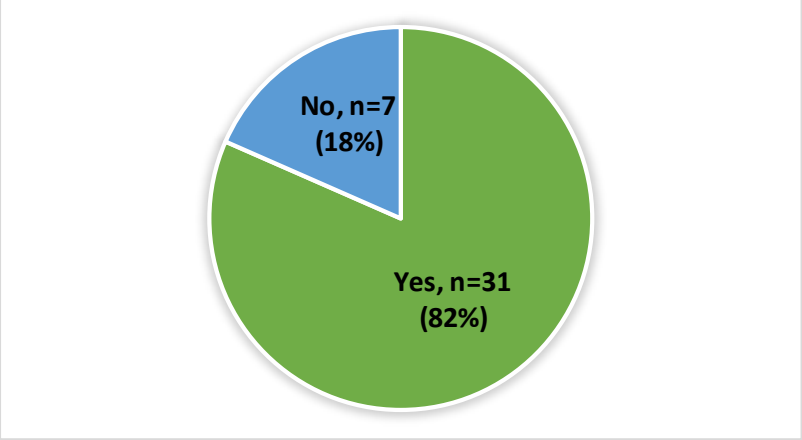

Table 110 - Are Protocols Involved Checking the PDMP

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Maine, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	31	81.58%

Response	States	Count	Percentage
No	Hawaii, Massachusetts, Minnesota, New Mexico, North Carolina, North Dakota, Pennsylvania	7	18.42%
Total		38	100.00%

If "Yes," please explain.

Table 111 – Explanations of Protocols Involved in Checking the PDMP

State	Barrier Explanations
Alaska	The state requires that a prescriber or their agent check the PDMP prior to prescribing controlled substances.
Arkansas	Per Act 820 from 2017, a prescriber should check the PDMP every time a schedule II or Schedule III opioid is prescribed and the first time a benzodiazepine is prescribed. The Act does document exceptions to the requirement including palliative care patients, residents in a licensed nursing home. and for those doses actually administered by the prescriber. Act 820 verbiage: (d) (1) Except as required in subdivision (d)(2) of this section, practitioners are encouraged to access or check the information in the controlled substance database created under this subchapter before prescribing, dispensing, or administering medications. (2) (A) A prescriber shall check the information in the program when prescribing: (i) An opioid from Schedule II or Schedule III for every time prescribing the medication to a patient; and (ii) A benzodiazepine medication for the first time prescribing the medication to a patient. (B) A licensing board that licenses practitioners who have the authority to prescribe shall adopt rules requiring the practitioners to check the information in the program as described in subdivision (d)(2)(A) of this section. (C) This subdivision (d)(2) does not apply to: (i) A practitioner administering a controlled substance: (a) Immediately before or during surgery; (b) During recovery from a surgery while in a healthcare facility; (c) In a healthcare facility; or (d) Necessary to treat the patient in an emergency situation at the scene of an emergency, in a licensed ground ambulance or air ambulance, or in the intensive care unit of a licensed hospital; (ii) A practitioner prescribing or administering a controlled substance to: (a) A palliative care or hospice patient; or (b) A resident in a licensed nursing home facility; or (iii) Situations in which the program is not accessible due to technological or electrical failure. (D) The State Board of Health may amend, by rule, the exemptions listed in subdivision (d)(2)(C) of this section upon a recommendation from the Secretary of the Department of Health and a showing that the exemption or lack of exemption is unnecessarily burdensome or has created a hardship. (3) A licensed oncologist shall check the program when prescribing to a patient on an initial malignant episodic diagnosis and every three (3) months following the diagnosis while continuing treatment.

State	Barrier Explanations
California	Prescribers are required to check the PDMP under the following circumstances: 1. The first time a patient is prescribed, ordered, administered, or furnished a controlled substance, unless an exemption applies. 2. Within the twenty-four hour period, or the previous business day, before prescribing, ordering, administering, or furnishing a controlled substance, unless an exemption applies. 3. Before subsequently prescribing a controlled substance, if previously exempt. 4. At least once every six months if the controlled substance remains a part of the patient's treatment plan. Exemptions include: 1. While the patient is admitted to, or during an emergency transfer between a: Licensed Clinic, or Outpatient Setting, or Health Facility, or County Medical Facility 2. In the emergency department of a general acute care hospital, and the controlled substance does not exceed a non-refillable seven-day supply. 3. As part of a patient's treatment for a surgical procedure, and the controlled substance does not exceed a non-refillable seven-day supply when a surgical procedure is performed at a: Licensed Clinic, or Outpatient Setting, or Health Facility, or County Medical Facility, or Place of Practice (defined as a Dental Office pursuant to Business and Professions Code 1658) 4. The patient is receiving hospice care.
Connecticut	Public Act 16-43 became effective 7/1/2016. Whenever a prescribing practitioner prescribes greater than a 72-hour supply of any Schedule V controlled substance for the treatment of any patient, such prescriber, or such prescriber's authorized agent, shall review, not less than annually, the patient's records in the CPMRS. Public Act 15-198 became effective 10/1/2015. MANDATORY USAGE -Prior to prescribing greater than a 72-hour supply of any controlled substance (Schedule II - V) to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the CPMRS at https://connecticut.pmpaware.net. -Whenever a prescribing practitioner prescribes controlled substances for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent shall review not less than once every 90 days, the patient's records in the CPMRS. -If the CPMRS is not operational, prescriber may prescribe greater than a 72-hour supply of a controlled substance to a patient during the time that the system is down as long as the prescriber or prescriber's authorized agent reviews the records of the patient in the CPMRS not more than twenty-four hours after regaining access to the system. -Public Act 13-172 was signed into law on June 21, 2013 and became effective immediately. This Public Act will have two direct effects on prescribers in the state of Connecticut. MANDATORY REGISTRATION All prescribers in possession of a Connecticut Controlled Substance Registration issued by the State of Connecticut, Department of Consumer Protection, will be required to register as a user with the Connecticut Prescription Monitoring and Reporting System (CPMRS) at https://connecticut.pmpaware.net.
Delaware	%u2022 Delaware's Medicaid provider manual states the following: In accordance with the Delaware Prescription Monitoring Act, all DMAP providers must comply with the Delaware Prescription Monitoring Program (PMP) when generating a prescription for a controlled substance for a DMAP member. Providers are required to review the member's patient utilization report. The query should include Delaware and all of the surrounding states; New Jersey, Pennsylvania and Maryland. For medications that are Drug General Policy Provider Policy Manual Enforcement Agency (DEA) Schedule III-V, the PMP website should be queried at least every six months. For Schedule II medications that are prescribed for chronic conditions,

State	Barrier Explanations
	the PMP website should be queried every three months. DMAP requires providers to document in the patient record all controlled substances that have been prescribed and filled inside and outside of the provider's practice. Providers must document all actions taken to collaborate with other clinicians prescribing controlled substances in the patient record in regards to mutual patients.
Florida	Section 893.055, Florida Statutes and Rules 64K-1.003, Florida Administrative Code, includes guidance related to the PDMP.
Georgia	There are protocols involved in checking the PDMP. Must have an NPI to access PDMP. The State checks the PDMP on an ad-hoc basis for the Lock-In Program as well as MME opioid edits.
Illinois	Illinois state law requires that all prescribers (or their designees) attempt to check the PDMP before writing an initial prescription for a Schedule II opioid; that attempt must be documented in the patient's medical record. Exceptions to this requirement include prescriptions for oncology treatment; palliative care; and acute traumatic medical conditions, when a supply of seven days or less is prescribed in the emergency department.
Iowa	In CY 2020 Iowa licensing boards adopted rules requiring their respective licensees to utilize the PMP database prior to issuing an opioid prescription. PMP Program rules and protocols are in Iowa Administrative Code 657 Chapter 37 under the purview of the Board of Pharmacy. Providers are not obligated to take any action in response to reports or alerts from the PMP program but should use their professional judgment in determining any subsequent action based on the information.
Kentucky	Kentucky statute and regulation describe frequency and method of querying, and ultimately prescribing controlled substances.
Louisiana	A prescriber or his delegate shall access and review the patient's record in the PMP prior to initially prescribing any opioid to a patient and shall access the PMP and review the patient's record at least every ninety days if the patient's course of treatment continues for more than ninety days. The requirement established shall not apply in the following instances: (a) The drug is prescribed or administered to a hospice patient or to any other patient who has been diagnosed as terminally ill (b) The drug is prescribed or administered for the treatment of cancer-related chronic or intractable pain (c) The drug is ordered or administered to a patient being treated in a hospital. (d) The PMP is inaccessible or not functioning properly due to an internal or external electronic issue. However, the prescriber or his delegate shall check the prescription monitoring program once electronic accessibility has been restored and note the cause for the delay in the patient's chart. (e) No more than a single seven-day supply of the drug is prescribed or administered to a patient.
Maine	The law makes five major changes to opioid prescribing: 1. It mandates use of the State's Prescription Monitoring Program and expands those who use it; 2. Enacts strict limits on opioid prescribing for acute and chronic pain (ALL opioids, not just Schedule II); 3. Mandates education for opioid prescribers; 4. Mandates electronic prescribing of opioids; 5. Provides for a Partial Fill at a pharmacy, at the direction of the patient
Michigan	State legislation, professional medical and pharmacy boards, and the Department of Licensing and Regulatory Affairs (LARA) establish protocols for checking Michigan's PDMP called Michigan Automated Prescription System (MAPS) for prescribers of controlled substances.
Mississippi	The following are prescriber requirements for PMP usage from the MS Board of Medical Licensure: Pain Management Providers/Practices must review a PMP before a Rx for a controlled substance is authorized. All licensees must review the PMP at each encounter wherein an opioid is prescribed for acute or chronic non-cancer/non-terminal pain. All licensees must review the PMP before prescribing a benzodiazepine for non-cancer/non-terminal, chronic medical or psychiatric conditions. Essentially, if you prescribe a benzodiazepine, you must check the PMP first. All non-pain provider/practice licensees must review the PMP upon initial contact with new patients and every 3 months thereafter before prescribing controlled substances other than opioids. This rule pertains

State	Barrier Explanations
	to those patients treated for chronic conditions requiring controlled substances who are seen outside a registered pain practice setting. Documentation evidencing a licensee has run the PMP as required must be recorded in the patient record [Rule 1.3]. An example of this would be printing a copy of the PMP and placing it into the record. Simply making a note it was reviewed and was appropriate (or inappropriate) satisfies this requirement as well. PMP review is not required when issuing prescriptions for Lomotil, Lyrica, Testosterone, Pseudoephedrine, or Amphetamines prescribed to pediatric patients under 16 for the treatment of ADHD. PMP use is not required when treating patients in an inpatient setting. However, PMP review is required before a patient is discharged if the decision is made to issue a prescription for a controlled substance.
Nevada	The Nevada State Board of Pharmacy has specific protocols and guidance to access the PDMP.
New Hampshire	The Office of Professional Licensure and Certification (OPLC) has administrative rules that prescribing providers must follow.
New Jersey	Prescribers are required to access the NJPMP for a patient the first time that they prescribe any Schedule II medication or opioid for acute or chronic pain, any Schedule III, or IV benzodiazepine; every 3 months thereafter, if continuing to prescribe one of the above; and any time the patient appears to be seeking CDS for any purpose other than the treatment of an existing medical condition (misuse, abuse, or diversion).
New York	Practitioners (except veterinarians) are required to check the PDMP registry prior to prescribing or dispensing a controlled substance in schedules II, III, IV for a patient. Pharmacists also have access to the same information found on the PDMP but are not required to check the site. Pharmacists and dispensing practitioners are required to submit controlled substance dispensing data to the Bureau of Narcotic Enforcement. Data will be submitted to the Bureau on a "real time" basis as defined by the Commissioner within the regulations. Dispensers are required to report refills and partial refills to the Department of Health.
Ohio	See Ohio Administrative Code 4731-11-11: Standards and procedures for review of "Ohio Automated Rx Reporting System" (OARRS).
Oklahoma	By Oklahoma law, it is mandatory that providers check the Oklahoma PMP prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.
Rhode Island	Title 216 Ch 20 Subchapter 20 4.4.E. The Prescription Drug Monitoring Program shall be reviewed prior to starting any opioid.
South Carolina	SECTION 44-53-1645. Requirement to review patient's prescription history. (A) A practitioner, or the practitioner's authorized delegate, shall review a patient's controlled substance prescription history, as maintained in the prescription monitoring program, before the practitioner issues a prescription for a Schedule II controlled substance. If an authorized delegate reviews a patient's controlled substance prescription history, the practitioner must consult with the authorized delegate regarding the prescription history before issuing a prescription for a Schedule II controlled substance. The consultation must be documented in the patient's medical record. (B) The requirements of this section do not apply to: (1) a practitioner issuing a prescription for a Schedule II controlled substance to treat a hospice-certified patient; (2) a practitioner issuing a prescription for a Schedule II controlled substance that does not exceed a five-day supply for a patient; (3) a practitioner prescribing a Schedule II controlled substance for a patient with whom the practitioner has an established relationship for the treatment of a chronic condition; however, the practitioner must

State	Barrier Explanations
	review the patient's controlled substance history maintained in the prescription monitoring program at least every three months; (4) a practitioner approving the administration of a Schedule II controlled substance by a health care provider licensed in South Carolina; (5) a practitioner prescribing a Schedule II controlled substance for a patient in a skilled nursing facility, nursing home, community residential care facility, or an assisted living facility and the patient's medications are stored, given, and monitored by staff; or (6) a practitioner who is temporarily unable to access the prescription monitoring program due to exigent circumstances; however, the exigent circumstances and the potential adverse impact to the patient if the prescription is not issued timely must be documented in the patient's medical record. (C) A practitioner is deemed to be in compliance with this section if the practitioner utilizes technology that automatically displays the patient's controlled substance prescription history from the prescription monitoring program in the practitioner's electronic medical record system. The practitioner must be able to demonstrate that this technology has been deployed in his practice, but no additional documentation is required in the patient's medical record https://scdhec.gov/laws-regulations/prescription-monitoring
Tennessee	Registration: Prescribers who provide direct care and prescribe controlled substances to patients in Tennessee for more than 15 days per year or dispense in practice providing direct care to patients in Tennessee for more than 15 days per year, are required to register with the CSMD. Required Checks: All healthcare practitioners are required to check before prescribing an opioid or benzodiazepine to a human patient as a new episode of treatment and every six (6) months thereafter when said controlled substance remains a part of the treatment. A new episode of treatment means a prescription for a controlled substance that has not been prescribed by that healthcare practitioner within the previous six (6) months. A new episode of treatment includes not only changes to specific drugs, but all changes to the strength of the drug prescribed, and the frequency with which the drug is taken. All healthcare practitioners are also required to check before dispensing an opioid or benzodiazepine as a new episode of treatment to a human patient the first time at that practice site and every six (6) months thereafter when said controlled substance remains a part of the treatment for that human patient after the initial dispensing. However, healthcare practitioners are not required to check, pursuant to statute, if: (a) the controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care; (b) the committee has determined that healthcare practitioners in a particular medical specialty do not have to check as a result of the low potential for abuse by patients receiving treatment in that medical specialty; (c) the quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, three-day treatment period and does not allow a refill; or (d) the controlled substance is prescribed for administration directly to a patient during the course of inpatient or residential treatment in a hospital or nursing home licensed under title 68. Before prescribing or dispensing, a healthcare practitioner is also required to check the database if the healthcare practitioner is aware or reasonably certain that a person is attempting to obtain a Schedule II-V

State	Barrier Explanations
	controlled substance, identified by the committee or commissioner as demonstrating a potential for abuse, for fraudulent, illegal, or medically inappropriate purposes, in violation of 53-11-402. An authorized healthcare practitioner's delegate may check the database on behalf of the healthcare practitioner. Licensed veterinarians are not required to check the database before prescribing a controlled substance to a non-human patient. However, changes to the scheduling of certain drugs, most pertinently Gabapentin, may affect the requirements related to the treatment of non-human patients.
Texas	Prescribers are required to check the Texas Prescription Monitoring Program (PMP) before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol per House Bill 3285 effective in the 86th Legislature. Practitioners are not required to check the PMP before ordering controlled substances in the inpatient setting. The mandate applies to outpatient and discharge prescriptions. Patients diagnosed with cancer and terminally ill under hospice care are exempt. The prescriber must clearly note in the prescription record that the patient has this diagnosis or that the patient is receiving hospice care. Prescribers are not subject to the mandate if unique circumstances outside of the prescriber's control prohibit access to the PMP after a good faith attempt to comply.
Utah	According to Utah Code 58-37f-304 (2), prescriber must check the PDMP before the first time the prescriber issues a Schedule II or III opioid. The prescriber is also required to periodically check the database or similar records if the prescriber is repeatedly prescribing Schedule II or III opioids to a patient.
Vermont	The Standards and guidelines for health care providers and dispenser are found in the Vermont Statutes online Vermont Laws 18 V.S.A. 4289 https://legislature.vermont.gov/statutes/section/18/084A/04289 Vermont Prescription Monitoring System Rule https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_vpms-20170701.pdf https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf
Virginia	The prescriber checks the PDMP to get the member's last fill date of an opioid prescription, get the member's active daily MME, and to check to see if the member got a prescription filled for a benzodiazepine in the past 30 days.
Washington	Washington Administrative Code (WAC) 182-530-1080 which will require prescribers and pharmacists to query the PMP no more than ten days prior to prescribing a controlled substance and pharmacists no more than two days after dispensing a controlled substance. This new WAC goes into effect October 1, 2021. Prescribers and pharmacists are required to document the date and time they reviewed the PMP.
West Virginia	WV Code %u00a760A-9-5a (b) All persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and who are licensed by the Board of Medicine as set forth in %u00a730-3-1 et seq. of this code, the Board of Registered Professional Nurses as set forth in %u00a730-7-1 et seq. of this code, the Board of Dental Examiners as set forth in %u00a730-4-1 et seq. of this code, the Board of Osteopathic Medicine as set forth in %u00a730-14-1 et seq. of this code, the West Virginia Board of Optometrists as set forth in %u00a730-8-1 et seq. of this code, and a pharmacist licensed by the West Virginia Board of Pharmacy as set forth in %u00a730-5-1 et seq. upon initially prescribing or dispensing any Schedule II controlled substance, any opioid or any benzodiazepine to a patient who is not suffering from a terminal illness, and at least annually thereafter should the practitioner or dispenser continue to treat the patient with a controlled substance, shall access the West Virginia Controlled Substances Monitoring Program Database for information regarding specific patients. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program Database for the patient shall be documented in the patient's medical record maintained by a private prescriber or any

State	Barrier Explanations
	inpatient facility licensed pursuant to the provisions of chapter 16 of this code. A pain-relieving controlled substance shall be defined as set forth in %u00a730-3A-1 of this code.
Wisconsin	1. Yes. A practitioner, or a practitioner delegate assisting the practitioner in accordance with the standards of practice for the practitioner's profession, shall review the monitored prescription drug history report about a patient before the practitioner issues a prescription order for the patient unless any of the following conditions are met: a. The patient is receiving hospice care, as defined in s. 50.94 (1) (a). b. The prescription order is for a number of doses that is intended to last the patient 3 days or less and is not subject to refill. c. The monitored prescription drug is lawfully administered to the patient. d. The practitioner is unable to review the patient's monitored prescription drug history reports before issuing a prescription order for the patient due to an emergency. e. The practitioner is unable to review the patient's records under their program because the PDMP system is not operational or due to other technological failure that the practitioner reports to the board. 2. Reviews of reports or other information not provided by the board as part of the program that summarize or analyze PDMP data do not satisfy the requirement to review a monitored prescription drug history report under sub. (1). 3. The board may refer a practitioner that fails to review a monitored prescription drug history report about a patient prior to issuing a prescription order for that patient to the appropriate licensing or regulatory board for discipline.
Wyoming	Effective July 1, 2019, per Wyoming Statute 35-7-1060, the practitioner, or his delegate, is required to check the PDMP before issuing the first controlled substance prescription and every three months thereafter as long as the controlled substance is being prescribed.

b. Are providers required to have protocols for responses to information from the PDMP that is contradictory to the direction that the practitioner expects from the client?

Figure 76 – Providers Required to Have Protocols for Responses to Information from PDMP that is Contradictory to Direction Expected from Client

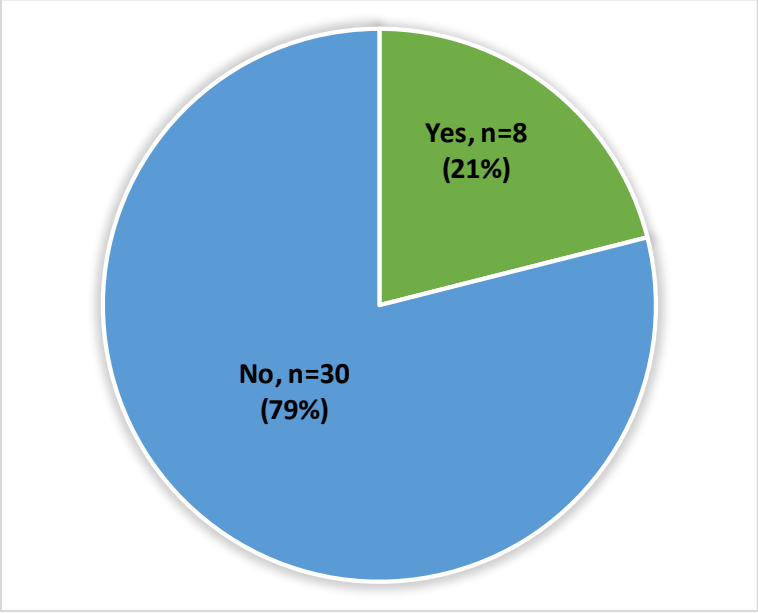

Table 112 - Providers Required to Have Protocols for Responses to Information from PDMP that is Contradictory to Direction Expected from Client

Response	States	Count	Percentage
Yes	Delaware, Georgia, Maine, Michigan, Nevada, New York, Virginia, West Virginia	8	21.05%
No	Alaska, Arkansas, California, Connecticut, Florida, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming	30	78.95%
Total		38	100.00%

c. If a provider is not able to conduct PDMP check, does your state require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?

Figure 77 – State Requires Prescriber to Document A Good Faith Effort if Unable to Conduct a PDMP Check

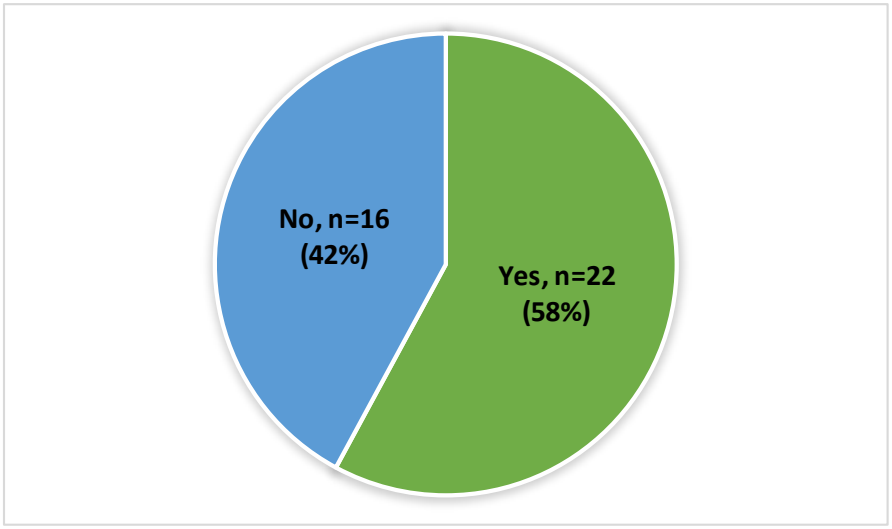

Table 113 - State Requires Prescriber to Document A Good Faith Effort if Unable to Conduct a PDMP Check

Response	States	Count	Percentage
Yes	Alaska, California, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Louisiana, Maine, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, South Carolina, Texas, Washington, West Virginia	22	57.89%
No	Arkansas, Hawaii, Iowa, Massachusetts, Minnesota, New Mexico, North Carolina, North Dakota, Oklahoma, Rhode Island, Tennessee, Utah, Vermont, Virginia, Wisconsin, Wyoming	16	42.11%
Total		38	100.00%

If "No," please explain.

Table 114 – Explanations for Why State Does Not Require Good Faith Effort Documentation from Prescriber

State	Explanations
Arkansas	Act 820 does not stipulate documentation of the inability to conduct the check, but an exception to checking the PDMP may be due to technological or electrical failure.
Hawaii	It is in the best interest of the prescriber to document but is not required.
Iowa	Iowa Code section 124.551A provides that the prescribing practitioner or the prescribing practitioner's designated agent shall utilize the program database prior to issuing an opioid prescription as prescribed by rules adopted by the prescribing practitioner's licensing board to assist the prescribing practitioner in determining appropriate treatment options and to improve the quality of patient care. See also Iowa Administrative Code rule 653-13.2(7). Physicians are not required to utilize the PMP to assist in the care of patients in inpatient hospice care, and long-term care settings.
Massachusetts	The state requires provider to check the PDMP before each prescription of a controlled substance but does not have any additional requirements.
Minnesota	There are recommendations from the Opioid Prescribing Workgroup.
New Mexico	PDMP checks are required and monitored by the state Medical Board.
North Carolina	The prior approval criteria for opioid analgesics requires the prescribing clinician to check the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System. (https://northcarolina.pmpaware.net/login).
North Dakota	Not applicable as they all can access it.
Oklahoma	In instances that a provider is not able to conduct a PMP check, Oklahoma law does not require providers to document a good faith effort, including the reasons why the provider was not able to conduct the check. The PMP check is one step in a multilevel prescribing guideline that is not intended to replace clinical judgment in the appropriate care of patients.
Rhode Island	Not at this time
Tennessee	The law requires that each person or entity operating a practice site where a controlled substance is prescribed or dispensed to a human patient shall provide for electronic access to the database at all times when a healthcare practitioner provides healthcare services to a human patient potentially receiving a controlled substance. A violation of this requirement is punishable by a civil penalty not to exceed one hundred dollars per day assessed against the person or entity operating the practice site; the penalty shall only be imposed when there is a continued pattern or practice of not providing electronic access to the database.
Utah	According to Utah Code 58-37f-340(2) prescriber is not required to check PDMP in these situations 1) in an emergency situation 2) when the CSD is not working or 3) when the internet is not working. However, the prescriber is not required to document reason why the prescriber was not able to conduct the check.
Vermont	While there are no state required rules, the board of medical practice recommends documentation.
Virginia	The long and short acting clinical criteria for opioids states the provider must check the PMP to gather the member's active daily MME, check for last fill date of an opioid prescription, and to check if the member has had a benzodiazepine prescription filled in the past 30 days.
Wisconsin	Wisconsin does not have a statute in place requiring providers to perform this action.
Wyoming	This is not included in state statute, rule or policy.

If "Yes," does your state require the provider to submit, upon request, documentation to the State?

Figure 78 – State Requires Prescriber, on request, to Submit Documentation

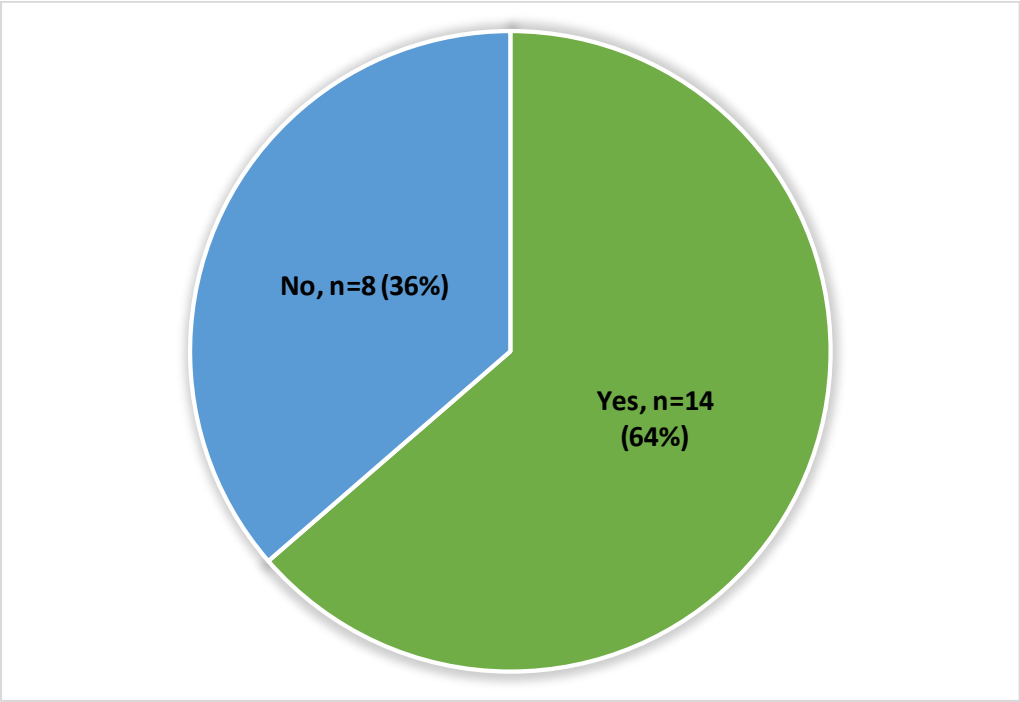

Table 115 - State Requires Prescriber, on request, to Submit Documentation

Response	States	Count	Percentage
Yes	Alaska, Connecticut, Georgia, Kentucky, Maine, Michigan, Mississippi, Nevada, New Hampshire, New York, Ohio, Pennsylvania, South Carolina, Washington	14	63.64%
No	California, Delaware, Florida, Illinois, Louisiana, New Jersey, Texas, West Virginia	8	36.36%
Total		22	100.00%

If "No," please explain.

Table 116 – Explanations for Why State Does Not Require Prescriber to Submit Documentation

State	Explanations
California	The prescriber must document the reason for not consulting the PDMP in the patient's medical record.
Delaware	Since the Medicaid program does not have access to the PDMP, nothing can be verified and the state has not asked for such documentation.
Florida	A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system shall document the reason he or she did not consult the system in the patient's medical record or prescription record and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to the patient.
Illinois	It is up to the prescribers and the health care organizations to develop internal policies to ensure compliance with the documentation portion set forth in Public Act 100-0564.

State	Explanations
Louisiana	If the PMP is inaccessible or not functioning properly due to an internal or external electronic issue. However, the prescriber or his delegate shall check the prescription monitoring program once electronic accessibility has been restored and note the cause for the delay in the patient's chart.
New Jersey	NJPMP statutes and regulations do not explicitly state that providers are required to submit documentation regarding a good faith effort to access the NJPMP. It would be expected, however, if necessary for a disciplinary hearing that the provider would be able to provide this information to the respective state Board as explanatory proof as to why the PMP was not accessed as required by law at the time of prescribing.
Texas	The state does not require the provider to submit upon request documentation to the state.
West Virginia	For SEMPP (which would be for those using >= 50 MME over the last 90 days, we require that the prescriber report via the form to have reviewed the PDMP. If they state that they have not, we only do a short term approval until they attest that they have. We, at this time, do not ask for a reason they have not checked. However, that is very rare. In 2021 so far, the % of prescribers reporting to have checked is 98-99% each month. Some do submit documentation, but at this time, we do not require they print and fax.

3. Does the State require pharmacists to check the PDMP prior to dispensing?

Figure 79 – State Requires Pharmacist to Check PDMP Prior to Dispensing

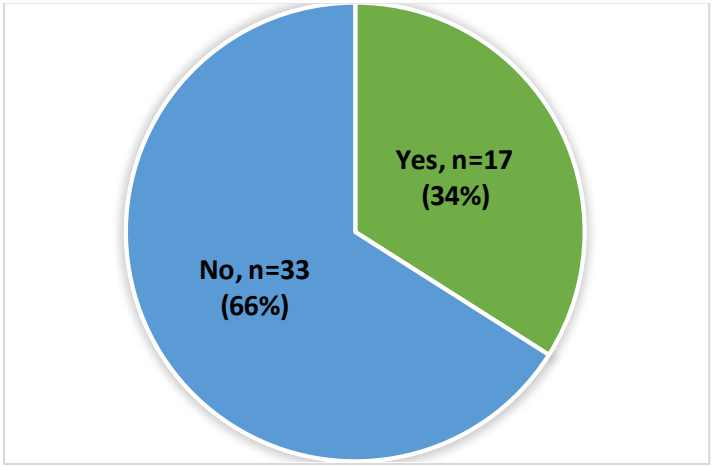

Table 117 - State Requires Pharmacist to Check PDMP Prior to Dispensing

Response	States	Count	Percentage
Yes	Florida, Georgia, Maine, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Tennessee, Texas, Vermont, West Virginia	17	34.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Montana, Nebraska, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Virginia, Washington, Wisconsin, Wyoming	33	66.00%
Total		50	100.00%

If "No," please explain.

Table 118 – Explanations for Why State Does Not Require Pharmacist to Check PDMP Prior to Dispensing

State	Explanations
Alabama	Pharmacists are not required to check
Alaska	The state recommends the pharmacist check the PDMP prior to dispensing, but is not required at this time.
Arkansas	Pharmacists have access to the PDMP through the Department of Health. Currently, there is no legislation, Board of Pharmacy requirements, or Medicaid policies/ procedures that require pharmacists to check the PDMP prior to dispensing.
California	The mandatory PDMP consultation requirement does not apply to dispensing pharmacists.
Colorado	State statute does not require pharmacists to check the PDMP prior to dispensing, although this practice is highly encouraged, and may be required by specific pharmacist employers in the State.
Connecticut	Prior to any dispensation, a pharmacist may choose to review a patients PDMP and make a professional decision based on that information to not dispense at all, without reason if decided. Typically, the pharmacist will first discuss the prescription(s) in question with the patient's prescriber and/or the patient before any other decision is made by the pharmacist to dispense.
Delaware	Delaware Medicaid Pharmacy providers are required to review the Prescription Monitoring Program (PMP) patient utilization report with the receipt of every Schedule III-V prescription. Schedule II prescriptions should be reviewed each time, unless the member is receiving these medications for a chronic illness. Medications prescribed for chronic illnesses should be monitored at least every three months. Pharmacy providers must document that the PMP was reviewed and adhere to in-house documented protocols when the PMP indicates potential controlled substance abuse or a clinical issue.
District of Columbia	Pharmacies must report dispensing to the PDMP within 24 hours after dispensing.
Hawaii	State law requires prescriber to check. Pharmacies are compliant with checking but are not required by state law. Pharmacies must enter the information and enter the pharmacist name that dispensed. The pharmacist is not required to check prior to dispensing.
Idaho	not at this time
Illinois	The state does not require pharmacists to check the PDMP prior to dispensing. If PDMP access is available, it is good clinical practice to evaluate PDMP data prior to dispensing the prescription.
Indiana	The Board of Pharmacy does not currently require review of the PDMP prior to dispensing a controlled substance. The PDMP is integrated into several pharmacy point-of-sale systems within the state to permit easier review.
Iowa	Board of Pharmacy requirements relative to pharmacists checking the PMP prior to dispensing states: A pharmacist may access a patient's or client's prescription history report; proactive alerts or system user notes, such as peer-to-peer communication; and NarxCare reports rule 657 - 37.16(2) . A pharmacist shall review a patient's or client's prescription history report prior to dispensing a Schedule V controlled substance without a prescription pursuant to rule 657-10.33.
Kansas	This is optional, at this time.
Kentucky	Although pharmacists have the authority to query KASPER, and several large chains have automated mechanisms that auto-query all dispenses, there isn't a requirement to do so.
Louisiana	Pharmacists are required to enter dispensed prescriptions for controlled substances into the PMP database, including information about the patient, the prescribing doctor, the medication, and the dispensing pharmacy

State	Explanations
Maryland	Since 2018 the Maryland PDMP use mandate requires providers to query a patient's dispense history when beginning a new course of opioids or benzodiazepines (as opposed to the wording in the question regarding "controlled substances") in certain clinical situations. Exceptions can be found here: https://health.maryland.gov/pdmp/Pages/pdmp-use-mandate-information.aspx
Minnesota	This is not a requirement.
Missouri	Missouri does not have a state wide PDMP.
Montana	Only prescribers will be required to access the PDMP prior to prescribing. The law does not address pharmacists checking the PDMP prior to dispensing.
Nebraska	Not mandated.
New York	Pharmacists will have the ability to access the same information as prescribers on the PDMP should they have an individual Health Commerce Account but are not required to check prior to dispensing.
Oklahoma	Oklahoma law does not require pharmacists to check the PMP prior to dispensing. The PMP check is one step in a multilevel prescribing guideline that is not intended to replace clinical judgment in the appropriate care of patients.
Oregon	not required
Pennsylvania	There is no requirement for a pharmacist to check the PDMP prior to dispensing.
Rhode Island	Title 216 CH 20 Subchapter does not address this question.
South Carolina	SECTION 44-53-1680. Violations and penalties. (E) Nothing in this chapter requires a pharmacist to obtain information about a patient from the prescription monitoring program. A practitioner or authorized delegate of a practitioner who knowingly fails to review a patient's controlled substance prescription history, as maintained in the prescription monitoring program, or a practitioner who knowingly fails to consult with his authorized delegate regarding a patient's controlled substance prescription history before issuing a prescription for a Schedule II controlled substance, as required by this article, must be reported to his respective board for disciplinary action https://scdhec.gov/laws-regulations/prescription-monitoring
South Dakota	The Board of Pharmacy does not require pharmacists to check the PDMP prior to dispensing a controlled substance.
Utah	This is not required at this time.
Virginia	The provider prescribing the opioid must check the PDMP.
Washington	HCA allows the pharmacist to check the PMP up to two days after dispensing a controlled substance. This is to account for the impact to workflow.
Wisconsin	Wisconsin does not have a statute requiring pharmacists to check the PDMP prior to dispensing.
Wyoming	Pharmacists were not included in the state statute creating requirements to check the PDMP.

If "Yes," are there protocols involved in checking the PDMP?

Figure 80 – State Has Protocols Involved in Checking PDMP

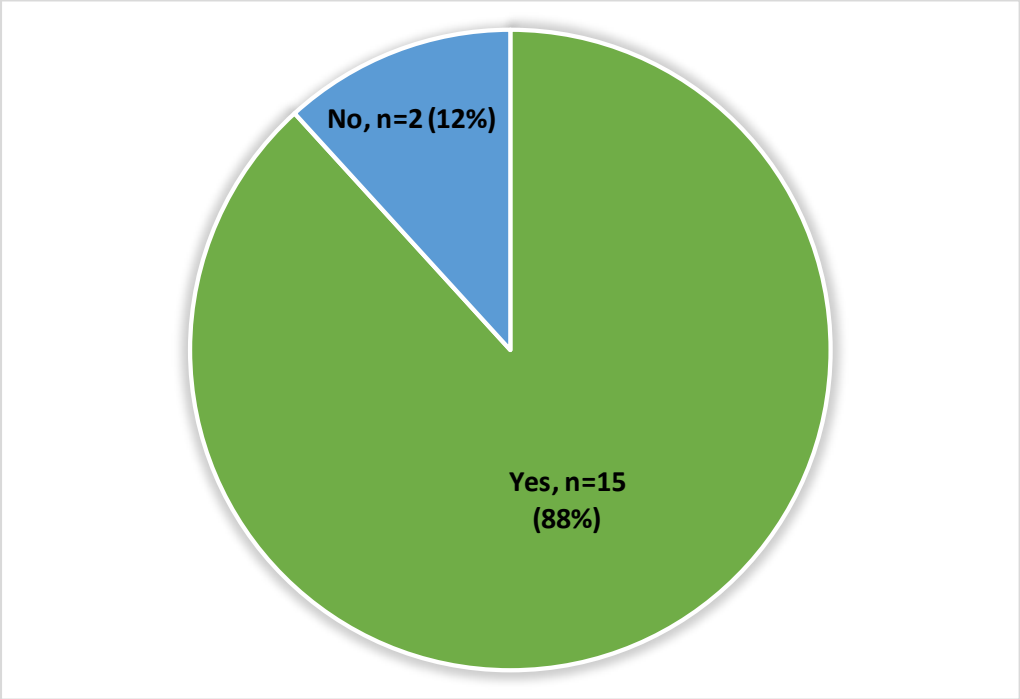

Table 119 - State Has Protocols Involved in Checking PDMP

Response	States	Count	Percentage
Yes	Florida, Georgia, Maine, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Tennessee, Texas, Vermont, West Virginia	15	88.24%
No	Massachusetts, North Dakota	2	11.76%
Total		17	100.00%

If "Yes," please explain.

Table 120 – Explanations for Why State Has Protocols Involved in Checking PDMP

State	Explanations
Florida	Each dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is dispensed to a patient age 16 or older unless a statutory exemption applies. Statutory exemptions include prescribing or dispensing a nonopioid controlled substance listed in schedule V; if the system is nonoperational; if the prescriber cannot access the system because there is a temporary technological or electrical failure. If the system was not consulted only a 3-day supply may be prescribed, and the prescriber must document in the prescription record the reason the system was not consulted.
Georgia	Yes, there are protocols involved in checking the PDMP.

State	Explanations
Maine	Requires dispensers to check the PMP prior to dispensing a benzodiazepine or opioid under the following circumstances: A. The person is not a resident of the State; B. The prescription is from a prescriber with an address outside of this State; C. The person is paying cash when the person has a prescription insurance on file; D. According to the pharmacy record, the person has not had a prescription for a benzodiazepine or an opioid medication in the previous 12 months. Requires that dispensers withhold a prescription until the dispenser is able to contact the prescriber if the dispenser has reason to believe that the prescription is fraudulent or duplicative Adds veterinarians to definition of prescriber Allows staff authorized by the Chief Medical Officer of a hospital to access the PMP for patients of the hospital or emergency department and allows the CMO to access prescription reports of prescribers he/she employs Allows on-duty pharmacists to authorize staff to access the PMP for customers filling prescriptions Requires the Department of Health and Human Services to include enhancements to the PMP, including a calculator to convert dosages to and from MMEs and increased access for staff members of prescribers to access the program with authorization
Michigan	State legislation, professional medical and pharmacy boards, and the Department of Licensing and Regulatory Affairs (LARA) establish protocols for checking Michigan's PDMP called Michigan Automated Prescription System (MAPS) for pharmacists prior to dispensing controlled substances.
Mississippi	Prior to dispensing a prescription for a Schedule II opiate, a pharmacist shall review the prescription monitoring program based on any of the following circumstances: a. The patient is a new customer to that pharmacy; or b. The patient has not had an opioid prescription filled at that pharmacy within six (6) months; 5. The prescription monitoring program shall be reviewed at least once every six (6) months for any patient receiving controlled substances.
Nevada	The Nevada State Board of Pharmacy has specific protocols and guidance to check the PDMP.
New Hampshire	The Office of Professional Licensure and Certification (OPLC) has administrative rules that dispensing providers must follow.
New Jersey	Pharmacists are required to access the NJPMP if they have a reasonable belief that the patient may be seeking a controlled dangerous substance, in whole or in part, for any purpose other than the treatment of an existing medical condition, such as for purposes of misuse, abuse, or diversion.
New Mexico	A Pharmacist has to enter a professional service code (M0) into the POS system stating that the PDMP was checked prior to dispensing. This exception code posts every 90 days.
North Carolina	Yes, in some circumstances. The STOP Act provides that a dispenser "shall review" a CSRS report on a patient "for the preceding 12-month period and document this review" when any of the following circumstances exist: (1) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user's existing medical condition. (2) The prescriber is located outside of the usual geographic area served by the dispenser. (3) The ultimate user resides outside of the usual geographic area served by the dispenser. (4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser. (5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following: (a) Over-utilization of the controlled substance. (b) Requests for early refills. (c) Utilization of multiple prescribers. (d) An appearance of being overly sedated or intoxicated upon presenting a prescription. (e) A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks. Each of these circumstances is a typical "red flag" indicating potential misuse or abuse of a controlled substance. Additional resources are available here: http://www.ncbop.org/faqs/Pharmacist/faq_RedFlagsCS.html and http://www.ncbop.org/faqs/DrugDiversionPocketcard.pdf The STOP Act also provides that if a pharmacist "has reason to believe that a prescription for a targeted controlled substance is fraudulent or duplicative," then the pharmacist "shall withhold delivery of the prescription until the [pharmacist] is able to contact the prescriber and verify that the prescription is medically appropriate."

State	Explanations
Ohio	See OAC 4729-5-20: Prospective drug utilization review.
Tennessee	When dispensing a controlled substance, all healthcare practitioners, unless otherwise exempted under this part, shall check the controlled substance database prior to dispensing one (1) of the controlled substances identified in subdivision (e)(4) to a human patient the first time that patient is dispensed a controlled substance at that practice site. The dispenser shall check the controlled substance database again at least once every twelve (12) months for that human patient after the initial dispensing. The initial dispensing check fulfills the first annual check. An authorized healthcare practitioner's delegate may check the controlled substance database on behalf of the healthcare practitioner.
Texas	All Texas-licensed pharmacies are required to report all dispensed controlled substances records to the Texas Prescription Monitoring Program (PMP) no later than the next business day after the prescription is filled. The reporting requirement applies to all Schedule II, III, IV, and V controlled substances. Pharmacists and prescribers (other than a veterinarian) will be required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. Pharmacists and prescribers are encouraged to check the PMP to help eliminate duplicate and overprescribing of controlled substances, as well as to obtain critical controlled substance history information.
Vermont	Yes this is spelled out in the Vermont Prescription Monitoring System Rule https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_vpms-20170701.pdf 5.0 Requirements for Pharmacists 5.1 Pharmacist Registration with the VPMS 5.1.1 All Vermont-licensed pharmacists shall register to query the VPMS. 5.2 Pharmacist Required Querying of the VPMS All dispensers, with the exception of hospital-based dispensers dispensing a quantity of a Schedule II, III, or IV opioid controlled substance that is sufficient to treat a patient for fewer than 48 hours shall query the Vermont Prescription Monitoring System in the following circumstances: 5.2.1 Prior to dispensing a prescription for a Schedule II, III, or IV opioid controlled substance to a patient who is new to the pharmacy; 5.2.2 When an individual pays cash for a prescription for a Schedule II, III, or IV opioid controlled substance and the individual has prescription drug coverage on file; 5.2.3 When a patient requests a refill of a prescription for a Schedule II, III, or IV opioid controlled substance substantially in advance of when a refill would ordinarily be due; and 5.2.4 When the dispenser is aware that the patient is being prescribed Schedule II, III, or IV opioid controlled substances by more than one prescriber. 5.3 Pharmacist Delegates Pharmacists may designate a delegate or delegates to access and query the VPMS system subject to Section 7.2 of this rule
West Virginia	WV Code 60A-9-5a (b) All persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and who are licensed by the Board of Medicine as set forth in 30-3-1 et seq. of this code, the Board of Registered Professional Nurses as set forth in 30-7-1 et seq. of this code, the Board of Dental Examiners as set forth in 30-4-1 et seq. of this code, the Board of Osteopathic Medicine as set forth in 30-14-1 et seq. of this code, the West Virginia Board of Optometrists as set forth in 30-8-1 et seq. of this code, and a pharmacist licensed by the West Virginia Board of Pharmacy as set forth in 30-5-1 et seq. upon initially prescribing or dispensing any Schedule II controlled substance, any opioid or any benzodiazepine to a patient who is not suffering from a terminal illness, and

State	Explanations
	at least annually thereafter should the practitioner or dispenser continue to treat the patient with a controlled substance, shall access the West Virginia Controlled Substances Monitoring Program Database for information regarding specific patients. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program Database for the patient shall be documented in the patient's medical record maintained by a private prescriber or any inpatient facility licensed pursuant to the provisions of chapter 16 of this code. A pain-relieving controlled substance shall be defined as set forth in 30-3A-1 of this code.

4. In the State's PDMP system, which of the following pieces of information with respect to a beneficiary is available to prescribers as close to real-time as possible?
Check all that apply.

Figure 81 – Information Available to Prescribers with Respect to a Beneficiary

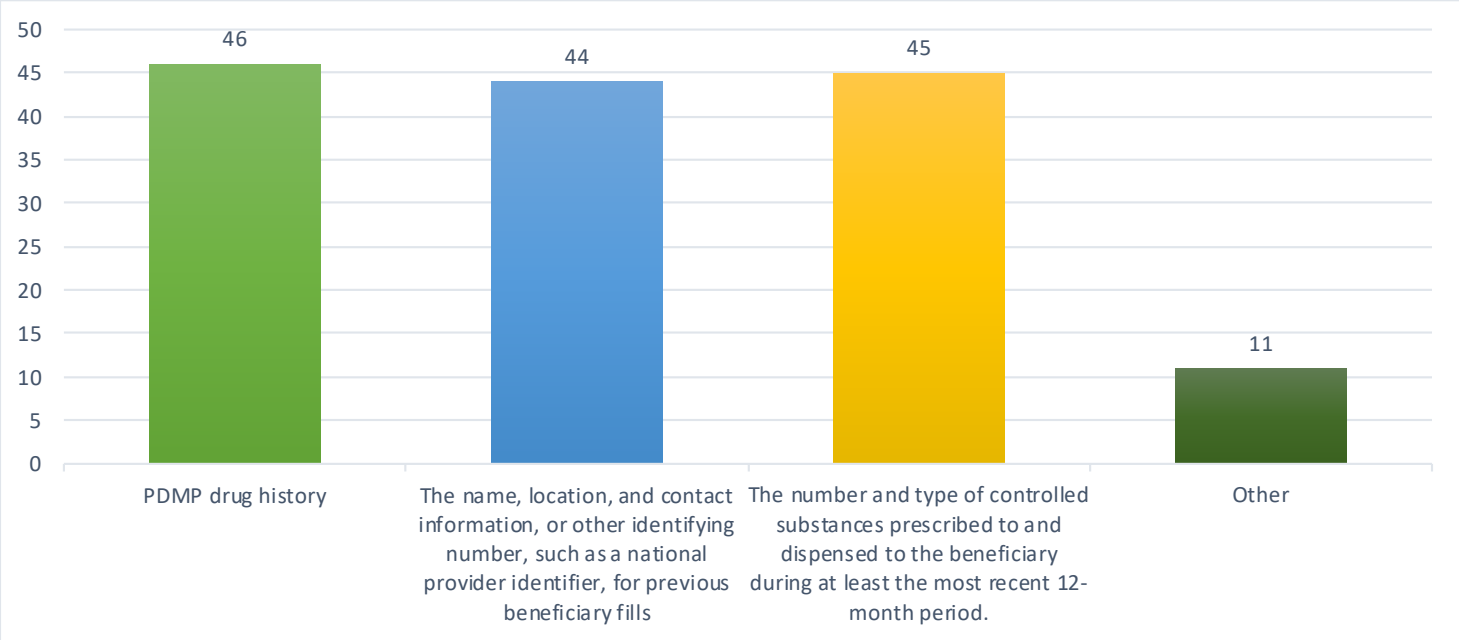

Table 121 - Information Available to Prescribers with Respect to a Beneficiary

Response	States	Count	Percentage
PDMP drug history	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah,	46	31.51%

Response	States	Count	Percentage
	Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	44	30.14%
The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period.	Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	30.82%
Other	Connecticut, Florida, Hawaii, Illinois, Kansas, Massachusetts, Minnesota, Missouri, Tennessee, Vermont, West Virginia	11	7.53%
Total		146	100.00%

If "Other," please explain.

Table 122 – "Other" Explanations for Information Available to Prescribers with Respect to a Beneficiary

State	Explanations
Connecticut	MME, Payor information, name of previous prescribing provider, name of previous pharmacy dispensing, list of pharmacies within the last 12 months, also checks select states outside of CT.
Florida	Additional information is provided through a NARXCARE report, this includes risk factors, overdose risk scores, and narcotic risk scores for the prescriber and dispensers consideration.
Hawaii	Current MME. Medicaid agency does not have access to PDMP at this time.
Illinois	Payment method, total number of prescriptions, total number of prescribers, total number of pharmacies where controlled substances filled, whether patient has opioids above 90 MME per day, overlapping opioid prescriptions, overlapping benzodiazepine and opioid prescriptions, presence of long-acting opioids in opioid naive patient, opioid prescriptions only page, map to locations where prescriptions filled, naloxone administration by EMS, or Suboxone fills. Prescribers also have section MyPMP where can create and monitor designees and see list of their patients for whom controlled substances have been prescribed.
Kansas	Pharmacy Name

State	Explanations
Massachusetts	Payment type, current total MME, 30 day average MME, buprenorphine claims are also available fields.
Minnesota	Details regarding the prescription, prescriber, and dispenser are available for the most recent 12 month period. This includes names, location, and contact information. No additional data sets are included in the Minnesota Prescription Monitoring Program. As well as controlled substances, Minnesota also collects gabapentin and all formulations of butalbital.
Missouri	Missouri does not have a state wide PDMP.
Tennessee	Name/Location of both the prescriber and the pharmacy for previous fills All addresses for the patient on file Payment method for all past prescriptions (although this is based on pharmacy input and is not reliable information) Clinical flags denoting: = 4 or > 5 practitioners in the last 90 days Clinical flags denoting: = 4 or > 5 pharmacies in the last 90 days Clinical flag denoting if patient has >= 120 active cumulative MME per day Clinical flag denoting if patient is a female of child bearing age (15-45 y/o) Flag denoting if patient is locked into a pharmacy by TennCare
Vermont	The PDMP displays information on the patient, drug dispensed, prescriber and pharmacy.
West Virginia	The report includes the following information: Below are the information headers from a typical report. You also get a daily MME calculation. The report can be run out to 60 months if necessary. Prescriber Name, Prescriber DEA & Zip, Dispenser Name, Dispenser DEA & Zip, Rx Written Date, Rx Dispense Date & Date Sold, Rx Number, Product Name, MEDD Status, Strength, Quanity, Days, # of Refill Schedule, Payment Type. A daily MME is also available. The report can be run out to 60 months if necessary.

a. Are there barriers that hinder the Medicaid agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?

Figure 82 – Barriers Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA

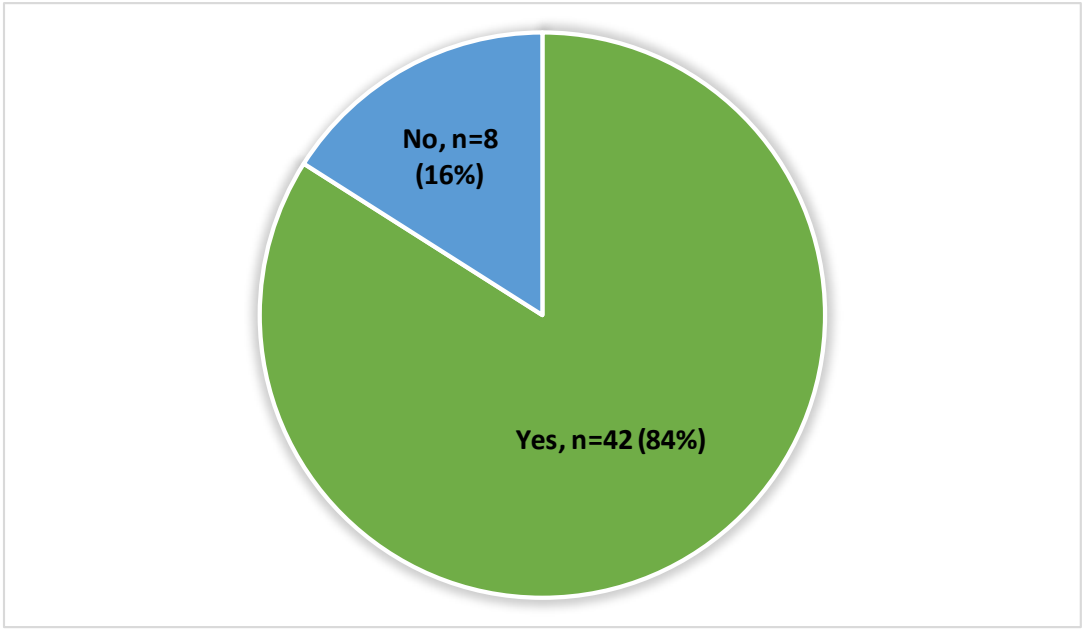

Table 123 - Barriers Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	42	84.00%
No	Kentucky, Louisiana, Mississippi, Ohio, Pennsylvania, South Carolina, South Dakota, Utah	8	16.00%
Total		50	100.00%

If "Yes," please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).

Table 124 – Explanations of Barriers That Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA

State	Explanations
Alabama	Medicaid has limited access to PDMP as the oversight is with another State agency. Prescribers/pharmacies are not required to access prior to writing/dispensing prescriptions.
Alaska	The PDMP is not currently integrated into the Point-of-Sale system, limiting the efficiency of the pharmacist when checking previous prescription history.
Arkansas	Arkansas Medicaid has the following barriers: 1) Act 820 requires prescribers to access the PDMP each time an opioid is prescribed and for each new benzodiazepine. There is no requirements for other controls, and prescribers do not access 100% of the time. 2) Arkansas Medicaid pharmacy program clinical pharmacists have access to the PDMP, but we have no access to neighboring states. 3) MCOs do not have access to the PDMP. 4) The PDMP is managed by a different agency. Getting data to answer the questions in this survey will be difficult. 5) The PDMP data is not incorporated into the Medicaid data system for use in Pro/DUR edits, RDUR review, or clinical POS edits.
California	1. Inability to access border states' PDMP information 2. Lag time for prescription data being submitted 3. Ambiguous regulations governing access to PDMP data
Colorado	The State is prohibited by legislation from accessing the PDMP. In our DUR criteria we highly encourage providers to access the PDMP prior to prescribing controlled substances.
Connecticut	Access is restricted to our Medicaid Fraud Unit only.
Delaware	The current barrier is that there is no direct access by Medicaid agency; any request must go through the PDMP agency
District of Columbia	In addition to DC Department of Health regulations restricting Medicaid access to the PDMP, there is no mandatory query requirement for prescribers in place at this time. Of course, there is the unavoidable lag in prescription data submission by pharmacy providers as dispensing files are loaded into the PDMP usually on a nightly basis.

State	Explanations
Florida	Sections 893.055, and 893.0551, Florida Statutes does not authorize the release of PDMP information to the Agency for Health Care Administration.
Georgia	Limited to claim-level detail (cannot query by prescriber) and must have an NPI to access PDMP
Hawaii	State does not yet allow Medicaid access to PDMP. Lag time is up to 1 week. Emergency room and post-operative pain treatment if prescribed for less than or equal to 3 days supply, it is not required of prescriber to requesting, receiving, and considering records PDMP.
Idaho	Can only access by specific patient and not able to look for patterns by patient, prescriber or pharmacy. There is a lag time in information available from the 6 border states. We are not able to generate aggregate reports such as cash (private pay) payments by the beneficiary or total MME over a set amount from all sources. We do not have the ability to see Outpatient Drug Treatment clinics (methadone).
Illinois	We can only view one patient at a time. HFS has no way to verify if prescriber checked ILPMP prior to writing prescription.
Indiana	Prescribers not accessing data, pharmacists not reviewing data before filling prescriptions, unable to query and monitor the database for review.
Iowa	No access to the PMP by Medicaid as only authorized prescribers and pharmacists may to obtain information regarding their patients' use of controlled substances when actively engaged in the patient's healthcare.
Kansas	The request has to be sent to the State Board of Pharmacy and then they send back a report to the Medicaid MCO / FFS. We cannot access the PDMP database and query in real time.
Maine	Lag time in prescription data being submitted and the fact that PDMP data is not available in a non de-identified format.
Maryland	The FFS program must have a bonafide formal investigation to access the PDMP. Requests must be approved by the Secretary of the Maryland Department of Health (MDH). Information is obtained through the MDH's PDMP. This may lead to a lag time between requests and the receipt of information. Additionally, technical issues including system downtime maintenance and delay of claims submission by providers.
Massachusetts	No aggregate data, 42CFR part 2, Methadone maintenance is not uploaded into MassPAT, DUR program does not have access to MassPAT
Michigan	The State Medicaid agency has limited access to the PDMP system via ad hoc member specific report requests only. As such the State Medicaid agency is unable to fully access and utilize PDMP data in POS system edits and DUR activities for safety or to prevent FWA.
Minnesota	There is very strict criteria as to when SURS can access the PDMP in the case of a patient under investigation for fraud and abuse.
Missouri	Missouri does not have a state wide PDMP.
Montana	Our new PDMP program by Appriss does not allow searching by date of birth only. This prevents us from finding duplicate MPDR profiles. It also causes providers to mistakenly assume that a member might not have a controlled drug fill history at all if either the pharmacy or provider misspells the members name even by a letter.
Nebraska	Probable cause.
Nevada	Only one state employee can access the system and the PBM vendor is not able to view the information.

State	Explanations
New Hampshire	The Department is prohibited by NH statute from accessing the PDMP.
New Jersey	As intended, the NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and are in good standing with their respective licensing boards. One potential enhancement would be allowing access to licensed Medicaid and Managed Care Organization pharmacy staff conducting DUR, which is not currently permitted because they are not directly delivering healthcare.
New Mexico	Currently unable to directly link Medicaid electronic health records with the PDMP.
New York	The Medicaid Agency cannot access the PDMP at this time.
North Carolina	Some pharmacies have restricted internet access, delays in processing data submitted, prescribers complain of time required to log in. There are some security issues with department access to the PDMP.
North Dakota	Other state information (e.g. border states). Loading information into our POS.
Oklahoma	The agency has very limited access to the PMP. The agency may only query one member at a time and is unable to access aggregated prescriber data. Access to the PMP cannot be granted to contractors who perform lock-in functions.
Oregon	Payers do not have access to the PDMP in Oregon.
Rhode Island	State law requires the users of the PDMP to have a DEA number.
Tennessee	Yes and No. The real barrier is matching CSMD records to Medicaid eligibility records. There are mathematical formulae used, but the basic issue is that the members record in the CSMD is identified only by Name and DOB, and this information is dependent upon pharmacy input.
Texas	Health plans access to PMP is prohibited by law.
Vermont	VPMS was created to support evidence-based clinical decisions in prescribing and dispensing controlled substances. The system is used by approved, registered users to review prescriptions received by individuals to avoid contraindicated prescription combinations or overlapping prescriptions of similar drugs. It may also identify potential misuse of prescriptions and provide an opportunity to discuss substance abuse screening, referral, and treatment options.
Virginia	Not allowed to access by state law
Washington	Many prescribers do not have the PMP integrated into their electronic medical record system and therefore checking does have a significant impact on their current workflow.
West Virginia	Access to the PDMP is limited to one person at our department and queries are capable of only pulling up one member at a time. We are also unable to access information outside our borders even though we enroll pharmacies as far as 30 miles from the border.
Wisconsin	The PDMP is managed by a different agency.
Wyoming	Current interpretation of Wyoming State Law does not allow Medicaid to access the PDMP.

5. Have you had any changes to your state's PDMP during this reporting period that have improved the Medicaid program's ability to access PDMP data?

Figure 83 – Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

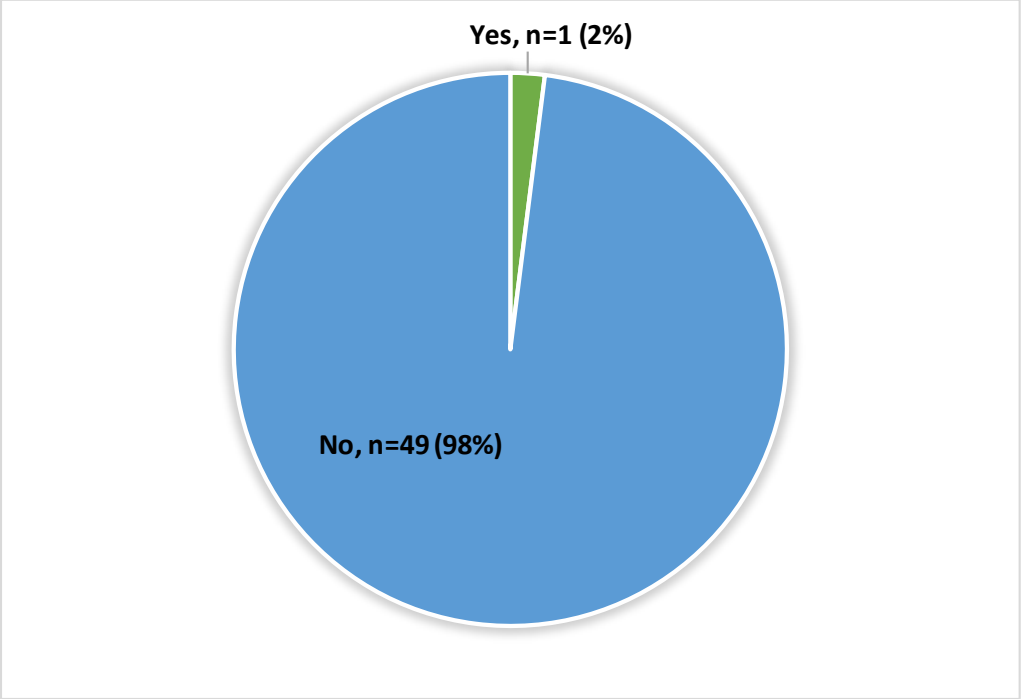

Table 125 - Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

Response	States	Count	Percentage
Yes	Utah	1	2.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
Total		50	100.00%

If "Yes," please explain.

Table 126 - Explanations of Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

State	Explanations
Utah	Medicaid pharmacists were granted access to Utah's PDMP in March 2020.

6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?

Figure 84 – Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period

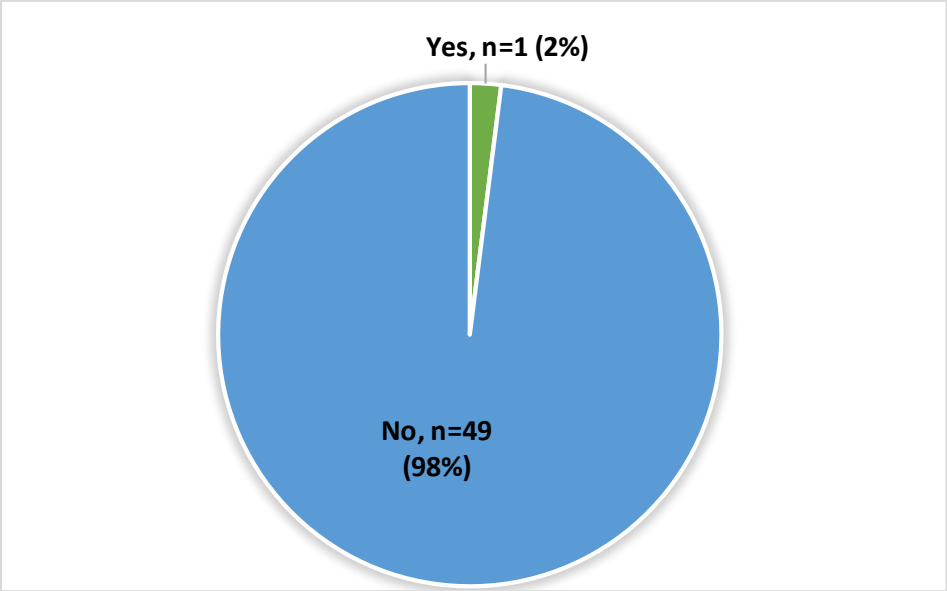

Table 127 - Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period

Response	States	Count	Percentage
Yes	Oregon	1	2.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
Total		50	100.00%

If "Yes," please summarize breach, the number of individuals impacted, a description of the steps the State has taken to address each such breach, and if law enforcement or the affected individuals were notified of the breach.

Table 128 – Summary of Breach

State	Explanations
Oregon	There was one breach during the reporting period that was reported to the PDMP. The breach impacted one individual. An authorized PDMP user accessed the PDMP on a personal contact. The individual impacted was contacted, the licensing board was notified, and the Oregon Dept. of Justice and Oregon's Information Security Office were consulted on appropriate actions. The PDMP was directed to revoke access from the individual.

C. Opioids

1. Does your state currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?

Figure 85 - POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

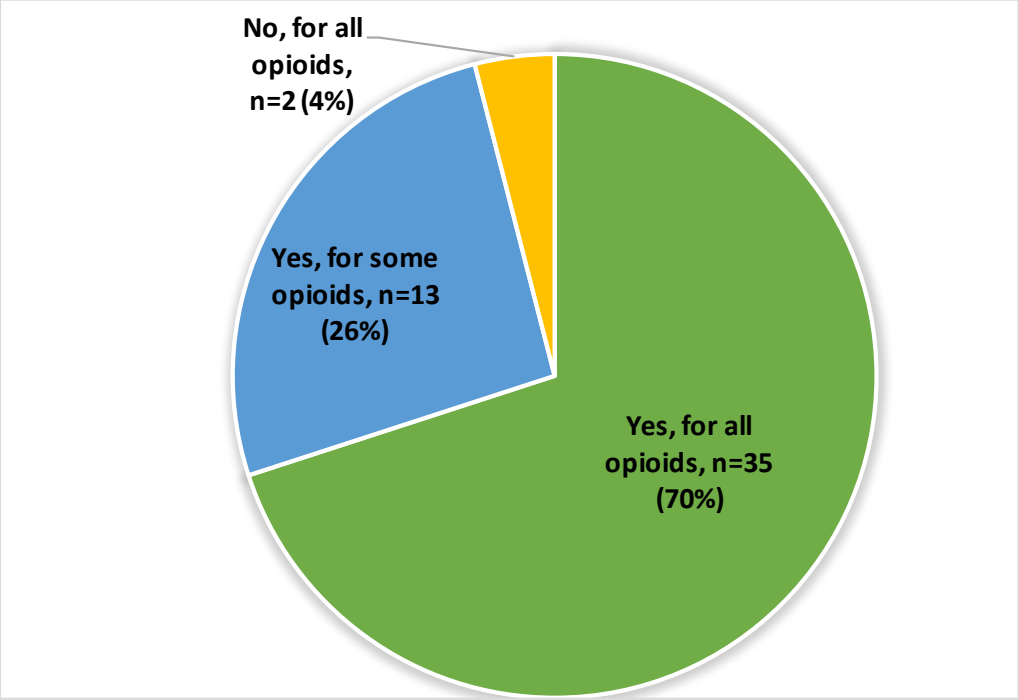

Table 129 - POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

Response	States	Count	Percentage
Yes, for all opioids	Alabama, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wyoming	35	70.00%
Yes, for some opioids	California, Kansas, Louisiana, Michigan, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Rhode Island, Vermont, West Virginia, Wisconsin	13	26.00%
No, for all opioids	Alaska, Iowa	2	4.00%
Total		50	100.00%

Please explain response.

Table 130 - Explanations of POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

State	Explanations
Alabama	AL Medicaid has a short-acting opioid naive days' supply edit. Quantity limits are also in place for opioids.
Alaska	For state laws regarding maximum dosage for opioid prescriptions, refer to AS.08.64.363, AS.08.68.705, AS.08.36.355, AS.08.72.276.
Arkansas	Opioid naive is defined as no claims for any opioid drugs for pain in the client's Medicaid drug profile in the previous 60 days. Opioid naive clients may receive a maximum of 50 MME/day. The initial prescription for the treatment naive client for the short-acting opioid is limited to a 7-day supply with the corresponding quantity limit of up to 6 tablets or capsules per day. The opioid naive limitation does not apply to clients with a cancer diagnosis. All new starts for long-acting opioids require a prior authorization or documentation of opioid tolerance unless the client is LTC eligible, has cancer, or has an NPO diagnosis.
California	Opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
Colorado	Opioid naive members are limited to short-acting opioids and quantities of 8 pills per day for up to a 7 day supply. Non-opioid naive members are limited to 4 pills per day of short-acting opioids for up to a 30 day supply. Long-acting opioids are subject to quantity limits listed on the preferred drug list (PDL) and are eligible for up to a 30 day supply. Dental prescriptions are limited to a three day supply of short-acting opioids.
Connecticut	CT state law requires that prescribers limit initial opioid prescriptions for patients to a 7 days' supply.
Delaware	The initial fill of any long acting opioid requires a prior authorization. The first fill of a short acting opioid cannot exceed 7 day supply. In addition, DMMA limits the quantity allowed based on day's supply, MME per day as well as global number of units per year. For example, oxycodone 15, 20, and 30MG have monthly, quarterly and yearly limits in place
District of Columbia	The POS safety edit limits the quantity dispensed of an initial opioid prescription to a 7 day supply. The POS system performs a claims history look back of 180 days.
Florida	For opioid treatment naive recipients, the limit is 90 MME. For treatment experienced recipients there is a soft edit at 50 MME. There are also product specific limits per FDA package inserts.
Georgia	Quantity level limits in place. MEDLIMIT 50 MME: For treatment na%u00efve members, edit check for a cumulative SAO & LAO dose check for >50 MME/day. MEDLIMIT 7 DAY SUPPLY: For treatment naive members: Edit check for SAO prescriptions for >7 day supply
Hawaii	Yes less than 5 days supply for dental prescriptions, and 30 days supply for other FFS programs but no claims being received.
Idaho	Idaho Medicaid does not currently have a 3-7 day initial limit for opioid naive recipients. The drug specific daily and monthly quantity limit plus cumulative MME edit with all other opioids is applied.
Illinois	Yes, a 7-day initial opioid quantity for opioid naive individuals.
Indiana	60MME for new opioid utilizers of short-acting opioids only, quantity limits applied to all long-acting agents if approved via PA or for those current utilizers. Patients with cancer, sickle cell,

State	Explanations
	and other terminal diagnoses associated with significant pain are not subject to the initial quantity limits for new utilizers.
Iowa	Quantity limit up to a 31 day supply
Kansas	We have an initial fill limit of a 7 day supply for short-acting opioids. Patients with cancer, sickle cell anemia, palliative-hospice care, and those whom reside in an assisted or custodial care facility are exempt from this requirement. Cough/cold products, compounding ingredients, and injectables which contain opioids are not included in our initial quantity limit edit. Opioid Use Disorder medications do not have an initial quantity limit. No prior authorization is required for prescriptions equal to or for no more than a cumulative 14 day supply of opioids in the last 60 days within allowed limits. o Maximum of 7 day supply is allowed per fill. o Cumulative opioid dose must not exceed 90 MME per day. o Drug must not exceed maximum FDA approved dosage. o Drug requested must not be a long-acting opioid
Kentucky	Short-acting opioids are subject to days' supply limit. Most long- and short-acting opioids also have daily quantity limits.
Louisiana	Opioid policy, naive: Short-acting opioid, 28 units / 7 days. Exceptions: Short-acting fentanyl (not addressed); oxycodone/ibuprofen, 14 units / 7 days; liquid opioid, lesser of 180ml or a 7-day supply There are exemptions for certain medical conditions.
Maine	initial quantity limits are in place as adjudication edits
Maryland	Quantity limits are in place and are expressed as a cap of 90MME/day. All opioids have quantity limits in place regardless of the patient's length of treatment or history of use of the medication. The Maryland Medicaid Opioid Drug Utilization Review Workgroup implemented recommendations located at: https://mmcp.health.maryland.gov/healthchoice/opioid-durworkgroup/ Pages/medicaid-opioid-response.aspx Quantity limit information is available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	Massachusetts law established a maximum seven-day supply on prescriptions for opioids when issued to an adult for the first time. The law also sets a maximum seven-day supply on all opioid prescriptions for minors. A prescriber may issue a prescription for more than a seven-day supply of an opioid to adult or minor patients if, in the prescriber's medical judgment, a greater supply is necessary to treat an acute medical condition, chronic pain, pain associated with a cancer diagnosis or for palliative care. In such a case, the condition must be documented in the patient's medical record and the prescriber must indicate that a non-opioid alternative was not appropriate to address the medical condition. This new law does not apply to opioid medications that are designed for the treatment of substance abuse or opioid dependence.
Michigan	Prescriptions for short acting narcotics in opioid naive patients are limited to a 7 days supply unless a prior authorization is requested with attestation that the prescription is for chronic pain
Minnesota	There is a 7-day initial limit if initial opioid prescription.

State	Explanations
Mississippi	Patients who have not routinely filled an opioid prescription (e.g., 1 claim per month for the past 3 consecutive months will be considered as new to opioids or opioid naive). Patients who have routinely filled any opioid prescriptions (e.g. 1 claim per month for the past 3 consecutive months) will be considered chronic opioid users. The claims system will allow opioid-naive patients to fill 2 x 7 day supplies in a rolling 30 days for a total of three months without prior authorization. After three months of filling these prescriptions the patient would then be considered to have chronic pain.
Missouri	Short-acting opioids and combination products are limited to less than or equal to a 7 days supply and less than or equal to 50 MME per day for an initial fill.
Montana	We only have quantity limits on oxycodone IR. However we have a 7-day supply limit on opioid prescriptions for opioid naive members and a cumulative opioid limit of 90 MME for all opioid prescriptions
Nebraska	For short acting opiate max quantity of #150 per 30 days
Nevada	All opioids are limited to 60 morphine equivalents, a max of seven-day supply and a maximum of 13 fills per rolling 12 months for adults. For children under 18 years of age, the day supply is limited to three.
New Hampshire	Medicaid limits all opioid prescriptions to a 34 day supply. We do not have a lower limit for initial prescriptions.
New Jersey	Limits in place are based on total daily dosage. Claims exceeding maximum daily dosage are denied with a DUR edit. State regulations limit initial opioid prescriptions to a 5 day supply.
New Mexico	If an opioid prescription is not on file in the past 60 days, they are restricted to a 7 day supply.
New York	A quantity limit of a 7-day supply is a POS edit for initial opioid prescriptions for acute pain in recipients who are opioid naive. Exceptions are for recipients with a diagnosis of cancer or sickle cell disease.
North Carolina	Other than Schedule V, opioid claims are limited by daily dose, quantity dispensed, days supply, and morphine equivalency limits.
North Dakota	Immediate release products are limited to an initial 7 day supply. Extended release products require prior authorization.
Ohio	Initial prescriptions for short acting opioids are limited to a seven day supply. All prescriptions for long- acting opioids require prior authorization and then are limited to a 34 day supply.
Oklahoma	Opioid safety edits are in place at the point-of-sale, including, but not limited to, day supply, early refills, duplicate fills, quantity limitations, and maximum daily morphine milligram equivalent (MME) safety edits. MME safety edits will automatically decline reimbursement of prescription drugs that exceed an established daily MME limit. An automated claims review process monitors concurrent use of opioid(s) with benzodiazepine(s) and/or antipsychotic(s).
Oregon	LAO require a prior authorization. SAO limited to 7 day supply. All opioids have quantity limit at 90 morphine ME.
Pennsylvania	Pennsylvania has quantity limits on all opioids.
Rhode Island	Based on 30 mme and 20 doses - Different depending on the short acting drug.
South Carolina	Effective with dates of service on or after May 1, 2018, prescribers must limit the initial prescribing of opioid medications for the treatment of acute or post-operative pain to the lowest effective dose and for a quantity no more than necessary for the expected duration of pain. Providers must not exceed a five-day supply or 90 morphine milligram equivalents (MMEs) daily, except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care or medication-assisted treatment for substance use disorder. If, in a prescriber's clinical judgement, an initial supply of more than five days or 90

State	Explanations
	MMEs is medically necessary, the prescriber must document that need in the patient's medical record. Failure to adhere to these requirements is a violation of SCDHHS coverage policy and shall result in the recoupment of Medicaid funds for the service during which the prescription was issued. SCDHHS intends to initiate necessary recoupments beginning with claims for dates of service on or after July 1, 2018.
South Dakota	Limited to 7 day supply and 60 daily morphine equivalents for opioid naive patients.
Tennessee	For treatment naive patients, Opioids are limited to not more than 15 days supply per 180 days, at no greater than 60MME per day. The first prescription can be filled for 5 days supply without Prior Authorization. After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required.
Texas	For the initial opioid prescription the quantity is for 10 days supply.
Utah	Initial prescriptions for over a 7-day supply of the cumulative 90 MME limit require prior authorization. A prescription is considered initial if the drug has not been filled for the patient in the past 60 days. Subsequent prescriptions maybe for a 30-days' supply and do not require prior authorization if the quantities prescribed is less than or equal to the cumulative 90 MME limit. In addition, all initial opioid prescriptions by a dental provider are limited to a 3-day supply.
Vermont	The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients greater than or equal to 18 years of age OR 24 MME and 3-day supply for patients less than or equal to 17 years of age.
Virginia	There is a quantity limit currently in place to limit the quantity dispensed for all short and long acting opioids. Each opioid has a specific quantity limit on it.
Washington	FFS and MCOs apply a quantity limit of 18 dosages per prescription for children (less than or equal to 20 years of age) and 42 dosages per prescription for adults (greater than or equal to 21 years of age).
West Virginia	Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.
Wisconsin	Wisconsin has some opioid quantity limits in place.
Wyoming	Initial fills are limited to a seven day supply. After 42 days of acute therapy, long-acting medications are limited to a maximum of 120 MME per day and short-acting are limited to four tablets per day.

If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.

a. *Is there more than one quantity limit for the various opioids? Additionally, please explain ramifications when addressing COVID-19 if applicable?*

Figure 86 - More than One Quantity Limit for Various Opioids

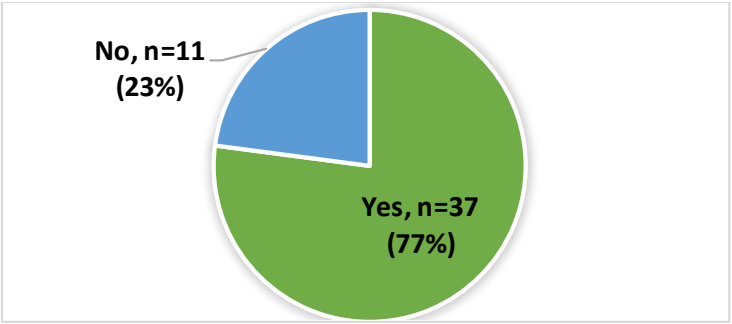

Table 131 - More than One Quantity Limit for Various Opioids

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	37	77.08%
No	Delaware, District of Columbia, Kentucky, Maine, Massachusetts, Mississippi, Nevada, New Mexico, North Carolina, Texas, Virginia	11	22.92%
Total		48	100.00%

If "Yes," please explain.

Table 132 - Explanations for More than One Quantity Limit for Various Opioids

State	Explanations
Alabama	Quantity limit is dependent on the particular product.
Arkansas	Initial prescription for short-acting opioids have a quantity limit of #42 for a 7-day supply (6 tablets or capsules per day) with a maximum of 50 MME/day. Beyond an initial claim for short-acting opioids, the maximum monthly quantity is #93/31 days and 90 MME/day. Cancer patients may receive up to #124/31 days of a short-acting opioid without a prior authorization needed. Long-acting opioids have individual quantity limits based on MME and typical dosing recommendations. COVID-19 caused no impact on controlled drugs pertaining to quantity limits or early refills.
California	Opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
Colorado	Opioid naive members are limited to short-acting opioids and quantities of 8 pills per day for up to a 7 day supply. Non-opioid naive members are limited to 4 pills per day of short-acting opioids for up to a 30 day supply. Long-acting opioids are subject to quantity limits listed on the preferred drug list and are eligible for up to a 30 day supply. Dental prescriptions are limited to a three day supply of short-acting opioids. COVID-19 early refill policy implemented on 3/20/20 allowed pharmacies to enter POS overrides allowing early refill of opioids for circumstances related to COVID-19 with refill tolerance of >50% previous fill utilized.
Connecticut	Quantity limits are dependent on dosage form.
Florida	For opioid treatment naive recipients, the limit is 90 MME. For treatment experienced recipients there is a soft edit at 50 MME. There are also product specific limits per FDA package inserts. There were no known ramifications related to COVID-19 as these edits were already in place.
Georgia	Quantity limit varies based on drug, duration of action (e.g., short-acting vs. long-acting), and drug strength.

State	Explanations
Hawaii	less than 5 days supply determines the quantity limit for various drug potency in dental formulary.
Idaho	We apply drug specific drug quantity limits plus MME limits for all concurrent opioid prescriptions.
Illinois	Short-acting opioids: 186. Long-acting opioids: 124. No quantity changes due to COVID-19.
Indiana	60MME for new opioid utilizers of short-acting opioids only, quantity limits applied to all long-acting agents if approved via PA.
Kansas	We have an initial fill limit of a 7 day supply for short-acting opioids. Patients with cancer, sickle cell anemia, palliative-hospice care, and those whom reside in an assisted or custodial care facility are exempt from this requirement. Cough and cold product, injectables, and compounding ingredients which contain opioids are not included in our initial quantity limit edit. Opioid Use Disorder medications do not have an initial quantity limit. Quantities above the usual doses/day based on the drug in question or for durations exceeding 7consecutive days require prior authorization. All long-acting opioid require prior authorization with the initial fill and are limited in the doses per day based on MME and the usual dosing frequency for the product and dose optimization controls for the strengths available. No changes were made for COVID-19 pandemic.
Louisiana	Opioid policy, naive: Short-acting opioid, 28 units / 7 days. Exceptions: Short-acting fentanyl (not addressed); oxycodone/ibuprofen, 14 units / 7 days; liquid opioid, lesser of 180ml or a 7-day supply Opioid policy, non-naive: Short-acting opioid, quantity specific to drug / 30 days There are exemptions for certain medical conditions. No changes were made to the policy for controlled substances during the COVID-19 pandemic.
Maryland	Units per day depend on the product. Please use this link for further quantity limits: https://mmcp.health.maryland.gov/pap/docs/QL.pdf. Quantity limits were not impacted for opioids during the COVID-19 pandemic.
Michigan	In addition to the quantity limit for the initial fill of short-acting opioids, specific quantity limits are set for most of the short-acting and long-acting opioids. Quantity limits were not eased for opioids during the COVID-19 pandemic as they were for non-controlled substances.
Minnesota	There is a 7-day initial limit if opio
Missouri	Missouri applies an MME limit which can result in a different quantity limit for different products.
Montana	In addition to the quantity limit for oxycodone IR, we also have daily quantity limits on LA opioids in line with FDA approved dosages as well as daily MME limits. None of these edits were adjusted during the COVID PHE
Nebraska	For short acting opiate max quantity of #150 per 30 days
New Hampshire	Quantity limits are based on FDA approved dose.
New Jersey	Limits in place are based on total daily dosage. Claims exceeding maximum daily dosage are denied with a DUR edit. For short-acting opioids (SAO), daily dosing is limited to 50 MME for an opioid naive patient or 120 MME for an opioid tolerant patient. Opioid naive patients are defined as those receiving no opioid therapy in the previous 90 days. For long-acting opioids (LAO), daily dosing is limited to 120 MME. These limitations do not apply to cancer patients, sickle cell patients, or those on hospice, palliative or end of life care.
New York	Quantity limits are placed on various opioids based upon the maximum dosing guidelines established by the FDA extended over a 30 day period.
North Dakota	All products are limited to their FDA approved use / frequency and / or MME = 90 limits.

State	Explanations
Ohio	Initial short-acting opioid prescriptions are limited to 30 MED per day for seven days. Long-acting opioid prescriptions require prior authorization and then are limited to 80 MED per day for 34 days.
Oklahoma	We have an acute vs. chronic opioid edit in place that allows up to 8 units per day for 7 days on short acting opioids (acute use) and 4 units per day for 30 days for short acting opioids (chronic use). Quantity limits on long acting opioids are based on FDA approved dosing regimens and are limited to a 30-day supply. We do not have any system edits in place to look for an initial prescription; however, state law limits the initial opioid prescription to 7-day supply.
Oregon	LAO require a prior authorization. SAO limited to 7 day supply. All opioids have quantity limit at 90 morphine ME.
Pennsylvania	Varies by drug
Rhode Island	Depending on the strength. n/a
South Carolina	Controlled Substances Due to COVID 19, along with the possible interruption of services and communications throughout South Carolina, SC DHEC Bureau of Drug Control hereby authorizes a ONE TIME early refill of Schedule III-V prescriptions for valid refills that are due within the next seven (7) days. Dispensers shall pull all original controlled substances prescriptions and document any early refill information in full detail; including, but not limited to, the date, time, reason for early refill, and the pharmacist signature associated with the transaction. Compliance with this Order supersedes any conflicting requirement of Regulation 61-4. https://llr.sc.gov/coronavirusbop/
South Dakota	Quantity limits vary by product according to FDA approved dosages.
Tennessee	All opioids have different quantity limits all based on MME.
Utah	UT Medicaid FFS routinely reviews quantity limits of individual opioid medications to align with MME standards and safe practice. Some opioids, such as high dose Fentanyl patches and high dose methadone are restricted to cancer-related pain only. No adjustments were made to opioid limits for the COVID-19 pandemic.
Vermont	There are quantity limits related to the potency (MME) of the medication being requested. For example: OXYCODONE (plain) (For tablets, Qty limit = 12 tablets/day) HYDROMORPHONE tablets (compare to Dilaudid) (Qty limit = 16 tablets/day)
Washington	FFS and MCOs apply the following: - Quantity limit of 18 dosages per prescription for children (%u226420 years of age) and 42 dosages per prescription for adults (%u226521 years of age). - Attestation form for anyone receiving chronic opioid therapy defined as Opioids exceeding 42 calendar days within a rolling 90-day period. - Attestation for high dose attestation for a single or combined dose exceeding 120 MME a day and a prior authorization for medical necessity for single or combined doses of 200 MME or above.
West Virginia	Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.
Wisconsin	Wisconsin has a detailed opioid quantity limit table that is published on the pharmacy portal. During the federal public health emergency, quantity limit restrictions are being loosened, except for when the drug is a Schedule II controlled substance.

State	Explanations
Wyoming	Initial fills are limited to a seven day supply. After 42 days of acute therapy, long-acting medications are limited to a maximum of 120 MME per day and short-acting are limited to four tablets per day.

b. What is the maximum number of days' supply allowed for an initial opioid prescription for an opioid naïve patient?

Figure 87 - Maximum Number of Days Allowed for an Initial Opioid Prescription for an Opioid Naïve Patient

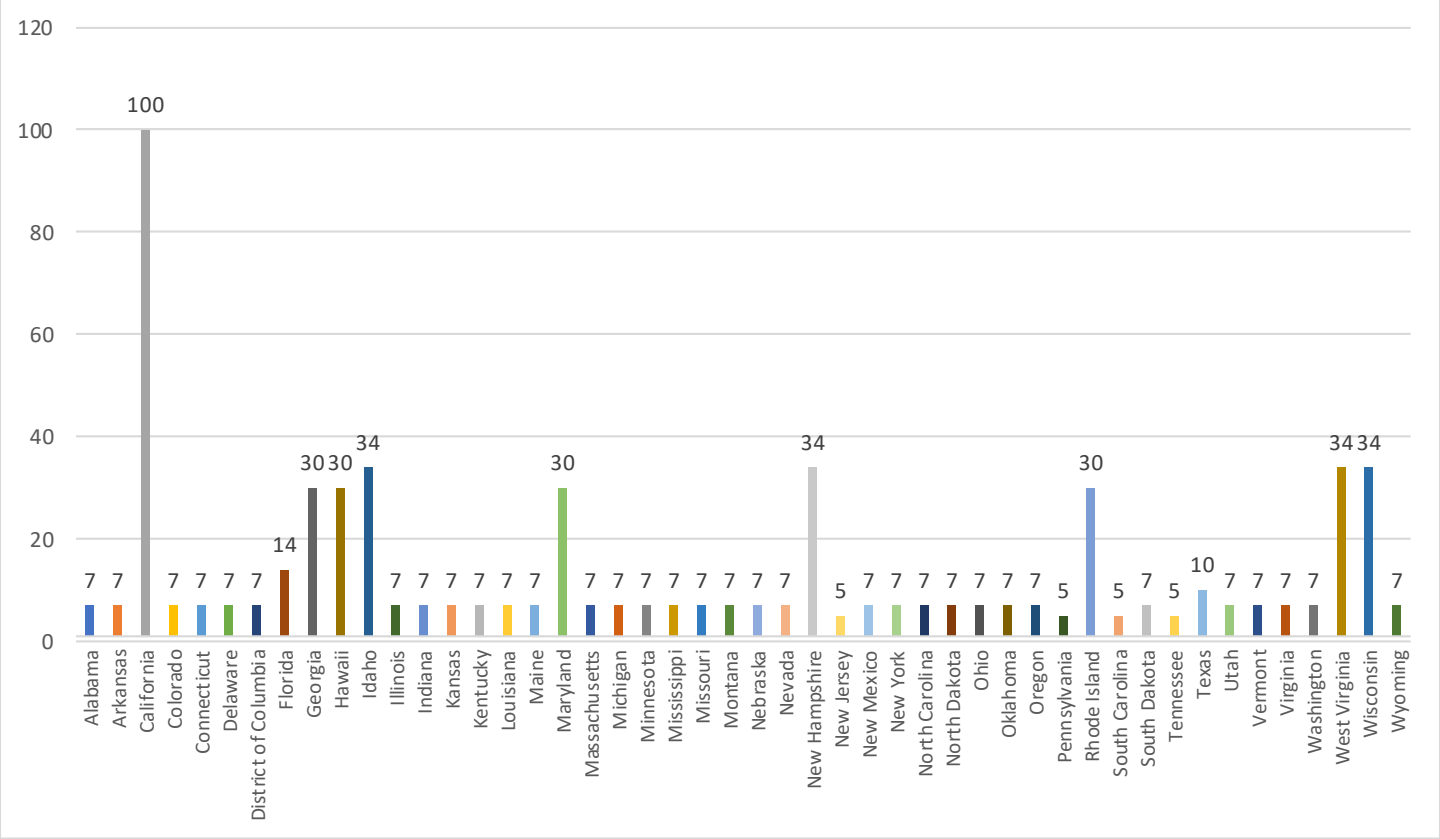

Table 133 - Maximum Number of Days Allowed for an Initial Opioid Prescription for an Opioid Naïve Patient

State	Maximum Days
Alabama	7
Arkansas	7
California	100
Colorado	7
Connecticut	7
Delaware	7
District of Columbia	7
Florida	14
Georgia	30
Hawaii	30

State	Maximum Days
Idaho	34
Illinois	7
Indiana	7
Kansas	7
Kentucky	7
Louisiana	7
Maine	7
Maryland	30
Massachusetts	7
Michigan	7
Minnesota	7
Mississippi	7
Missouri	7
Montana	7
Nebraska	7
Nevada	7
New Hampshire	34
New Jersey	5
New Mexico	7
New York	7
North Carolina	7
North Dakota	7
Ohio	7
Oklahoma	7
Oregon	7
Pennsylvania	5
Rhode Island	30
South Carolina	5
South Dakota	7
Tennessee	5
Texas	10
Utah	7
Vermont	7
Virginia	7
Washington	7
West Virginia	34
Wisconsin	34
Wyoming	7

c. Does this days' supply limit apply to all opioid prescriptions?

Figure 88 - Initial Day Limit Applies to All Opioid Prescriptions

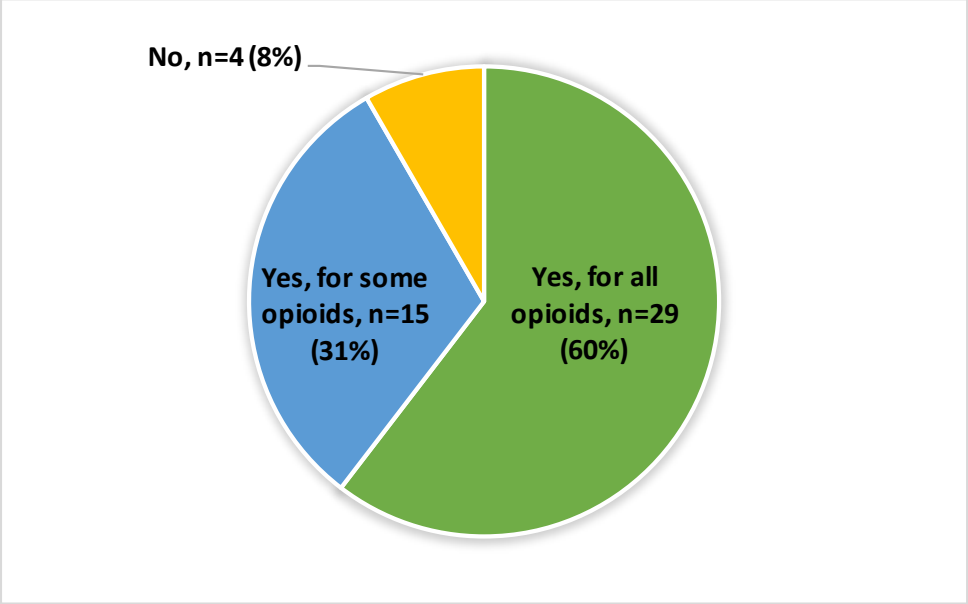

Table 134 - Initial Day Limit Applies to All Opioid Prescriptions

Response	States	Count	Percentage
Yes, for all opioids	Alabama, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming	29	60.42%
Yes, for some opioids	Arkansas, California, Colorado, Delaware, Florida, Kansas, Michigan, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Vermont, Virginia, Washington	15	31.25%
No	Hawaii, Louisiana, South Carolina, Utah	4	8.33%
Total		48	100.00%

Please explain response.

Table 135 - Explanations of Different Days' Limit to various Opioid Prescriptions

State	Explanations
Alabama	All opioids have quantity limits and will hit the short-acting opioid naive edit.
Arkansas	This limit applies to short-acting opioids only unless the client has cancer. Long-acting opioids require a prior authorization and/or documentation of opioid tolerance and can be filled for a 31 day supply once approved.
California	Opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.

State	Explanations
Colorado	The 7 day supply limitation for the first, second, and third fills of opioid prescriptions for opioid naive members applies to short-acting opioids. Prescriptions for long-acting opioids for opioid naive members require prior authorization. Dental prescriptions are limited to a 3 day supply of short-acting opioids for up to three fills.
Connecticut	CT state law requires that prescribers limit initial opioid prescriptions for patients to a 7 days' supply or less (not a hard edit).
Delaware	a
District of Columbia	The POS safety edit limits the quantity dispensed of an initial opioid prescription to a 7 day supply. The POS system performs a claims history look back of 180 days.
Florida	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" on prescription Max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 Long Acting (LA) Narcotic every 30 days.
Georgia	Yes, for all opioids.
Hawaii	Dental is limited to acute and initial care. Other FFS programs are not limited due to the nature of the specialty population: organ and tissue transplant and reproductive services.
Idaho	n/a
Illinois	For all opioid naive participants (no opioids filled for 60 days) prior authorization is required if an opioid claim for a duration over 7 days is received. This is an automated PBM system edit.
Indiana	The above days' supply limitation applies to all opioid na%u00efve patients that do not have a cancer, sickle cell, or other terminal illness associated with significant pain diagnosis(es).
Kansas	Claims for patients with cancer, sickle cell anemia, palliative-hospice care, and those whom reside in an assisted or custodial care facility are exempt from this requirement. Cough-cold products, compounding ingredients, and injectables which contain opioids are not included in our initial quantity limit edit. Opioid Use Disorder medications do not have an initial quantity limit. Limit applies to short acting opioids. Long acting products, as they are not intended for acute use in opioid naive patients, require prior authorization for appropriate prescribing.
Kentucky	Members aged <18 are allowed up to an initial 3 days' supply, if opioid naive Members aged 18 and over are allowed up to an initial 7 days' supply, if opioid naive
Louisiana	Opioid policy, naive: Short-acting opioid, 28 units / 7 days. Exceptions: Short-acting fentanyl (not addressed); oxycodone/ibuprofen, 14 units / 7 days; liquid opioid, lesser of 180ml or a 7-day supply Opioid policy, non-naive: Short-acting opioid, quantity specific to drug / 30 days Long-acting opioids: 30 day supply per 30 rolling days There are exemptions for certain medical conditions.
Maine	it applies to all opioids
Maryland	All opioid prescriptions have a days supply limit of 30 days regardless of product.
Massachusetts	Massachusetts law established a maximum seven-day supply on prescriptions for opioids when issued to an adult for the first time. The law also sets a maximum seven-day supply on all opioid prescriptions for minors.
Michigan	Applies only to short-acting narcotics for opioid-naive patients
Minnesota	yes, this applies to both short-acting and long-acting. Long-acting on PA is still only 7-day for the first opioid prescription

State	Explanations
Mississippi	The policy for initial prescriptions for opioid-naive beneficiaries applies to all short-acting opioids. Long-acting opioid prescriptions would not be approved for opioid-naive beneficiaries regardless of quantity or days supply.
Missouri	This applies to short-acting opioids and combination products
Montana	This includes all opioids including opioid cough preparations. It does not apply to members with a cancer diagnosis.
Nebraska	All
Nevada	All opioid prescriptions over seven (7) days for adults and three (3) days for children require prior authorizations.
New Hampshire	Medicaid limits all opioid prescriptions to a 34 day supply. We do not have a lower limit for initial prescriptions.
New Jersey	State regulations limit all initial opioid prescriptions to a 5 day supply. These limitations do not apply to cancer patients, sickle cell patients, or those on hospice, palliative or end of life care.
New Mexico	Limited to opioids in the State Therapeutic Class H3A: Analgesics, Narcotics; H3N: Analgesics, Narcotic Agonist and NSAID Combination; and H3U: Narcotic Analgesic and Non-Salicylate Analgesic.
New York	The 7 day limit applies to naive recipients being treated for acute pain.
North Carolina	The maximum days supply for initial prescriptions for opioid naive patients coincides with NC's STOP Act. Additionally, the maximum amount that can be filled for beneficiaries who take opioids on a chronic basis is a 34-day supply.
North Dakota	Initial supply of extended release opioids are controlled through prior authorization and prior use of immediate release products is required (so they will not be opioid naive).
Ohio	Initial prescriptions for short acting opioids are limited to a seven day supply. All prescriptions for long- acting opioids require prior authorization and then are limited to a 34 day supply.
Oklahoma	We have an acute vs. chronic opioid edit in place that allows up to 8 units per day for 7 days on short acting opioids (acute use) and 4 units per day for 30 days for short acting opioids (chronic use). Quantity limits on long acting opioids are based on FDA approved dosing regimens and are limited to a 30-day supply. We do not have any system edits in place to look for an initial prescription; however, state law limits the initial opioid prescription to 7-day supply.
Oregon	Short acting opioids
Pennsylvania	All prescriptions for short-acting opioids require prior authorization after 3 days for children under 21 and after 5 days for adults.
Rhode Island	30
South Carolina	Providers must not exceed a five-day supply or 90 morphine milligram equivalents (MMEs) daily, except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care or medication-assisted treatment for substance use disorder. If, in a prescriber's clinical judgement, an initial supply of more than five days or 90 MMEs is medically necessary, the prescriber must document that need in the patient's medical record.May 1, 2020 MB# 20-017
South Dakota	Supply restricted to 7 days for opioid naive patients.
Tennessee	See the answer to C.1.-- For treatment naive patients, Opioids are limited to not more than 15 days supply per 180 days, at no greater than 60MME per day. The first prescription can be filled for 5 days supply without Prior Authorization. After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required.

State	Explanations
Texas	The 10-day limit only applies to the initial opioid prescriptions for an opioid-naive client. A person is considered "opioid-naive" if the person has taken opioids for a duration that is less than or equal to seven days in the last 60 days.
Utah	The initial edit applies only to short-acting opioid. The initial fill of a short-acting opioid is restricted to a maximum 7-day supply for non-dental prescribes and a maximum 3-days' supply for dental prescribes. The system will now allow the fill of a long-acting opioid without at least a 7-day trial of a short-acting opioid within the last 60 days. UT Medicaid also restricts 7 days' supply of opioid for pregnant women and children under 18 years of age.
Vermont	This days supply limit is in conjunction with Vermont's rule Governing the Prescribing of Opioids for Pain. The limits apply to patients who are opioid naive and are receiving their first prescriptions not administered in a healthcare setting https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf
Virginia	All short-acting narcotics will be limited to two 7-day supplies within 60 days
Washington	The days' supply applies to short-acting opioids. Long-acting opioids reject for prior authorization if there is no chronic attestation on file.
West Virginia	34 days is the days' supply limit for all opioid prescriptions.
Wisconsin	Opioid prescriptions are limited to a 34-days' supply.
Wyoming	The limit applies to all opioids.

2. For subsequent prescriptions, does your state have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?

Figure 89 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

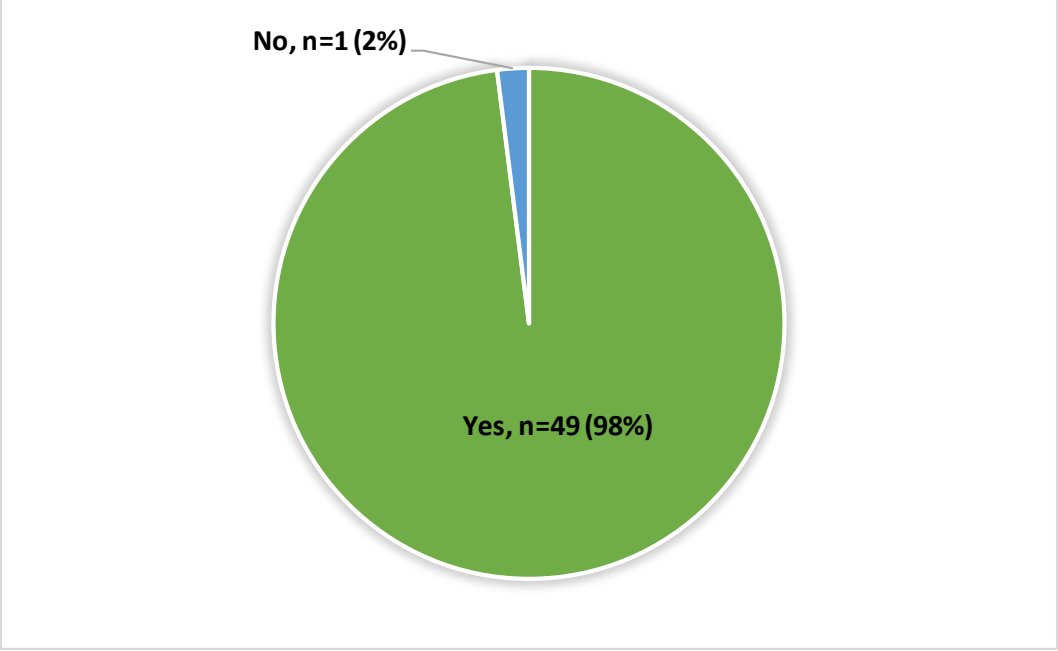

Table 136 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
No	Texas	1	2.00%
Total		50	100.00%

If "Yes," what is your maximum days' supply per prescription limitation?

Figure 90 - Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

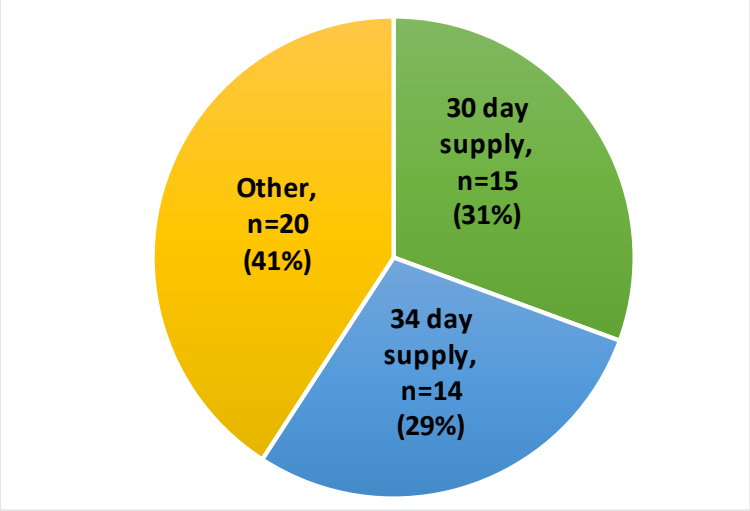

Table 137 - Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

Response	States	Count	Percentage
30 day supply	Connecticut, Georgia, Idaho, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Nebraska, Oklahoma, Rhode Island, South Carolina, South Dakota, Utah, Vermont	15	30.61%
34 day supply	Alabama, Alaska, Kentucky, Michigan, Minnesota, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, West Virginia, Wisconsin, Wyoming	14	28.57%
Other	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Missouri, Nevada, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Virginia, Washington	20	40.82%
Total		49	100.00%

If "Other," please explain.

Table 138 - "Other" Explanation of Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

State	"Other" Explanations
Arkansas	31 days' supply
California	Short-acting opioids have an established maximum quantity per dispensing and have either a maximum of three dispensings within any 75-day period or a maximum of 60 days' supply with refills allowed every 25 days.
Colorado	Opioid naive members are limited to three 7 day supply prescriptions of short-acting opioids and require prior authorization for the fourth fill. Non-opioid naive members are limited to a 30 day supply per prescription fill. Dental prescriptions are limited to a three day supply of short-acting opioids for up to three fills.
Delaware	The total dose of opioid cannot exceed 90mg MME per 24 hours. The total quantity of short acting opioids may not exceed 120 per 30 days with a total of 720 units per year.
District of Columbia	Beneficiaries who have more than 120 days of opioid history in the last 180 days are limited to 7 days supply with a cumulative total of 30 days per 180 days
Florida	7 day supply.
Hawaii	30day although ProDUR and RetroDUR have not identified any need within our specialty populations. Dental is limited to acute and initial care and not subsequent fill.
Illinois	31 day supply
Indiana	For initial utilizers of opioids, a seven-day supply followed by an additional seven-day supply in a rolling 45-day period is permitted without prior authorization.
Iowa	Maximum day supply is up to a 31 day supply
Kansas	After the first 7 days supply, prior authorization is required to exceed 14 day supply of opioid medication in last 60 days. If continued opioid use is needed, a PA will be required and the day supply limit going forward is 31 days per fill. If there is a need for treat an acute on chronic pain for a patient, then there is an additional 21 day limit for this situation.
Missouri	31 day supply
Nevada	All fills are limited to seven-day supply without obtaining prior authorization.
New Jersey	On subsequent prescriptions, the limit is a 34 days supply or a maximum quantity of 100 units, whichever is greater. Quantity is dependent upon the FDA approved dosing per the manufacturer's package insert. New Jersey regulations also dictate that a patient shall not be provided with more than a 30-day supply of a Schedule II medication at one time.
New York	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30-day period. Patients are limited to a total of 4 opioid prescriptions every 30 days. PA is required for use of opioids equal to or greater than 90 MME per day for management of nonacute pain defined as pain greater than 7 days. (exception for patients diagnosed with cancer or Sickle Cell disease). PA required for continuation of opioid therapy beyond an initial 7 day supply in patients established on gabapentin or pregabalin. PA is required for patients prescribed an opioid while on established opioid dependence therapy.
Oregon	Allow second fill of 7 day supply. After that a PA is required.
Pennsylvania	All prescriptions for short-acting opioids require prior authorization after 3 days for children under 21 and after 5 days for adults. The day supply approved is determined on a case-by-case basis.

State	"Other" Explanations
Tennessee	After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required, all at no more than 60MME per day. There are exceptions to this rule if the enrollee has burns or corrosion damage over a large percent of body area, the limit is 45 days per 90 days with a limit of 60MME per day, and this same exception is in place for those in LTC facilities, and those with sickle cell disease.
Virginia	Any Short-Acting Opioid prescribed for > 7 days or two (2) 7 day supplies in a 60-day period will require a service authorization. The Virginia Board of Medicine Regulations limit the treatment of acute pain with opioids to 7 days and post-op pain to no more than 14 days.
Washington	Limited to 42 calendar days within a rolling 90-day period.

If "No," please explain.

Table 139 - No Explanation of POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

State	Explanations
Texas	There is no a quantity limit for the refills or subsequent prescriptions because the patient is not considered opioid naive. However, the maximum daily MME will be at a 90 MME limit.

3. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?

Figure 91 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

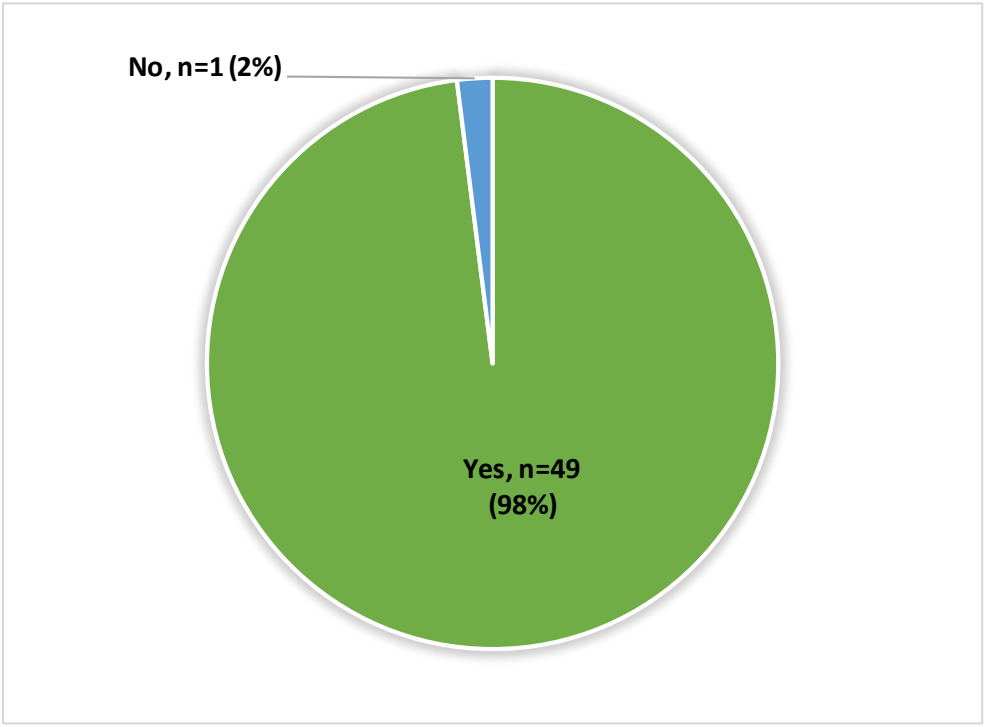

Table 140 - POS Edits In Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
No	Texas	1	2.00%
Total		50	100.00%

If "Yes," what is your maximum days' supply per prescription limitation?

Figure 92 - Long-Acting Opioid Maximum Days' Supply per Prescription Limitation

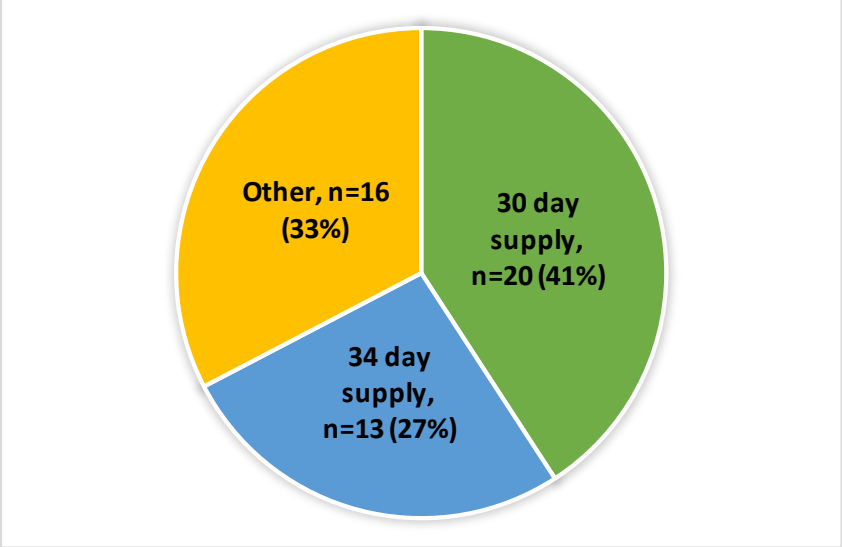

Table 141 - Long-Acting Opioid Maximum Days' Supply per Prescription Limitation

Response	States	Count	Percentage
30 day supply	Colorado, Connecticut, Florida, Georgia, Idaho, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Nebraska, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont	20	40.82%
34 day supply	Alabama, Alaska, Kentucky, Michigan, Minnesota, Montana, New Hampshire, New Mexico, North Carolina, Ohio, West Virginia, Wisconsin, Wyoming	13	26.53%
Other	Arkansas, California, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kansas, Missouri, Nevada, New Jersey, New York, Pennsylvania, Virginia, Washington	16	32.65%
Total		49	100.00%

If "Other," please explain.

Table 142 - "Other" Explanation of Long-Acting Opioid Maximum Days' Supply per Prescription Limitation

State	"Other" Explanations
Arkansas	31 days' supply
California	Long-acting opioids have an established maximum quantity per dispensing and either a maximum of three dispensings within any 75-day period or a maximum of 90 days' supply with refills allowed every 25 days.
Delaware	Total dose of opioid cannot exceed 90mg MME per 24 hours
District of Columbia	Beneficiaries who have more than 120 days of opioid history in the last 180 days are limited to 7 days supply with a cumulative total of 30 days per 180 days
Hawaii	30day although ProDUR and RetroDUR have not identified any need within our specialty populations. Dental is limited to acute and initial care and not subsequent fill.
Illinois	31 day supply
Indiana	For initial utilizers, PA is required. For current opioid utilizers, days' supply is limited to 34 as a non-maintenance medication, along with applicable quantity limits.
Iowa	Maximum day supply is up to a 31 day supply
Kansas	After use of the short-acting opioids and chronic need of opioids is determined, the patient can use long-acting opioids up to a 31 day supply limit per fill.
Missouri	31 day supply
Nevada	Recipients can get up-to 34-day supply with an approved PA. A recipient limited to a seven-day supply without a PA.
New Jersey	On subsequent prescriptions, the limit is a 34 days supply or a maximum quantity of 100 units, whichever is greater. Quantity is dependent upon the FDA approved dosing per the manufacturer's package insert. New Jersey regulations also dictate that a patient shall not be provided with more than a 30-day supply of a Schedule II medication at one time.
New York	Quantity limits are based upon FDA maximum daily doses extended for a maximum of 30 days. In addition there is a POS limitation of no more than 4 opioid prescriptions obtained within a 30 day period. Exceptions to this are prescriptions for the treatment of Sickle Cell disease and cancer. PA is required for patient initiating opioid therapy while on established opioid dependency therapy. Patients are limited to a total of 4 opioid prescriptions every 30 days (except in patients with a diagnosis of cancer or Sickle Cell disease). PA required for use if the amount of opioid per day for the management of nonacute pain (pain greater that 7 days) is greater than or equal to 90MME. PA required for initiation of long acting opioid therapy in opioid naive patients. PA required for any additional long acting opioid prescription for patients currently on long acting opioid therapy.
Pennsylvania	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.
Virginia	34 days supply
Washington	Limited to 34-day supply and limited to 42 calendar days within a rolling 90-day period.

If "No," please explain.

Table 143 - No Explanation of Long-Acting Opioid Maximum Days' Supply per Prescription Limitation

State	Explanations
Texas	The 10-day supply does not apply to the long-acting opioids because they re not approved for initial opioid therapy for an opioid naive client. A long-acting prescription for an opioid naive patient will require a prior authorization.

4. Does your state have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?

Figure 93 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

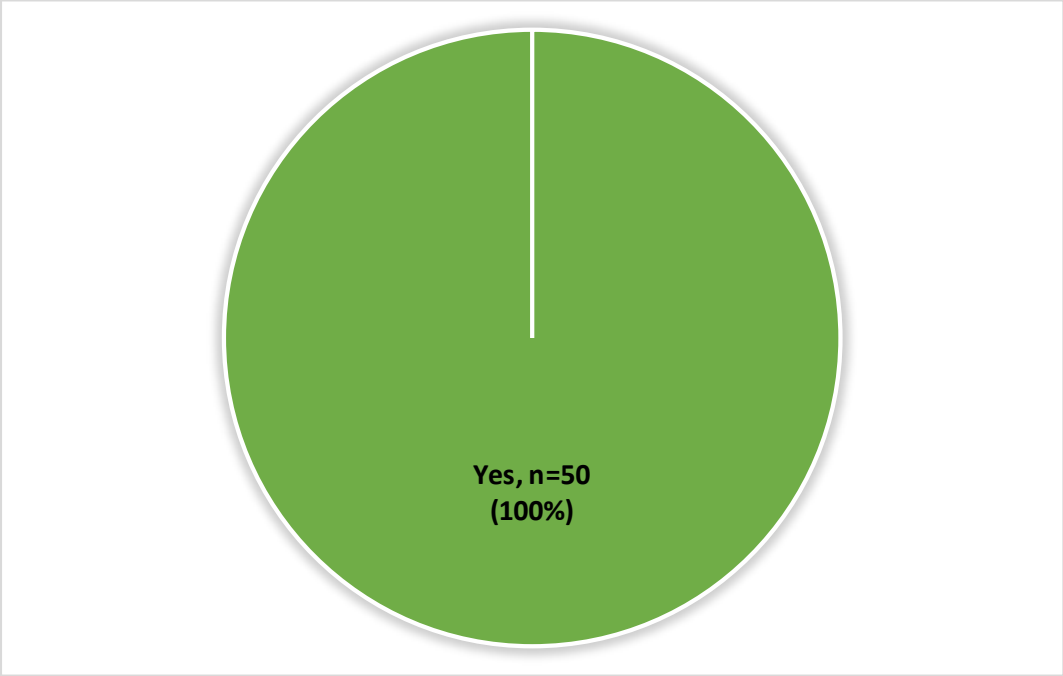

Table 144 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%
Total		50	100.00%

If "Yes," please continue.

Figure 94 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

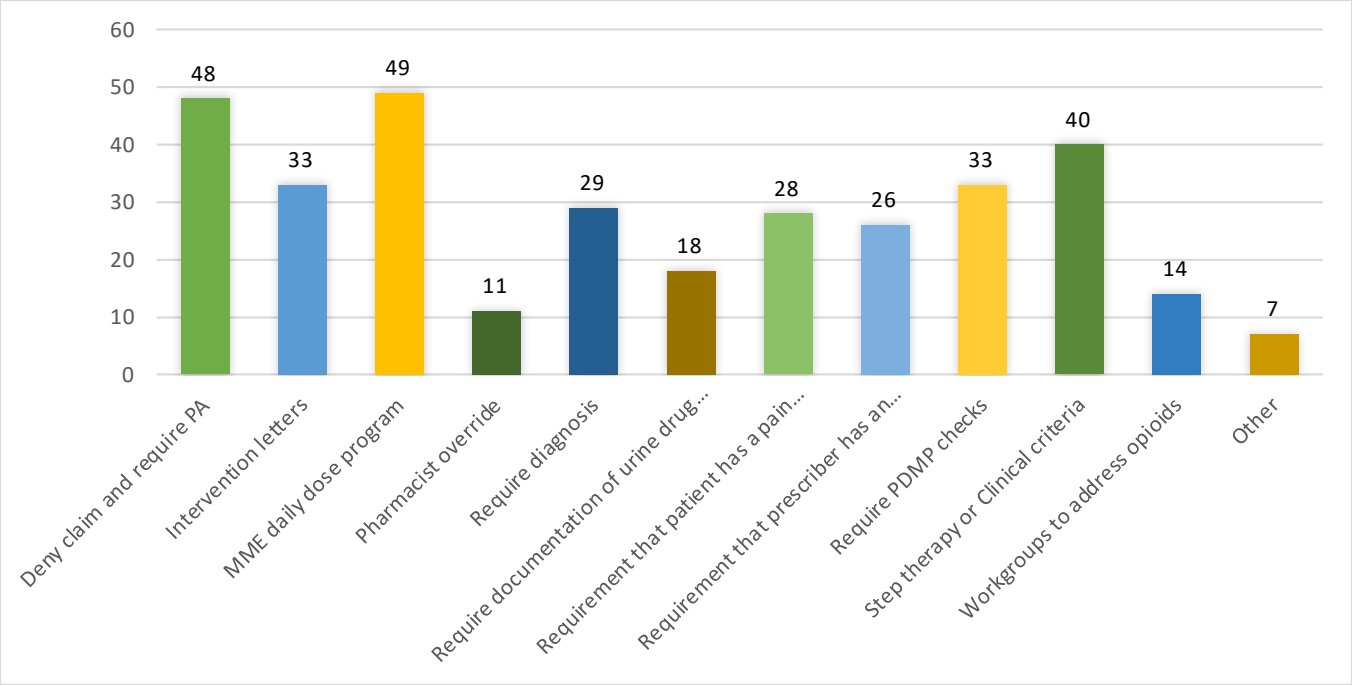

Table 145 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Deny claim and require PA	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	48	14.29%
Intervention letters	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Wisconsin, Wyoming	33	9.82%

Response	States	Count	Percentage
MME daily dose program	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	49	14.58%
Pharmacist override	Alabama, Georgia, Idaho, Louisiana, Mississippi, Nebraska, North Carolina, South Carolina, Utah, West Virginia, Wisconsin	11	3.27%
Require diagnosis	Alabama, Alaska, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington	29	8.63%
Require documentation of urine drug screening results	Alabama, Alaska, Delaware, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, North Dakota, Ohio, Oregon, Pennsylvania, Vermont, Virginia, Washington	18	5.36%
Requirement that patient has a pain management contract or Patient-Provider agreement	Alabama, Alaska, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia	28	8.33%
Requirement that prescriber has an opioid treatment plan for patients	Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Montana, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia	26	7.74%
Require PDMP checks	Alabama, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington	33	9.82%

Response	States	Count	Percentage
Step therapy or Clinical criteria	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	40	11.90%
Workgroups to address opioids	Alabama, Alaska, California, District of Columbia, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Missouri, South Carolina, Utah, Vermont	14	4.17%
Other	Arkansas, Colorado, Illinois, Indiana, Kansas, Louisiana, Vermont	7	2.08%
Total		336	100.00%

Please provide details on these opioid prescribing controls in place.

Table 146 – Detail for Opioid Prescribing Controls in Place

State	Explanations
Alabama	Maximum quantity limits; therapeutic duplication; short-acting opioid naive edit; MME edit; PA for non-preferred agents
Alaska	The opioid prescribing controls are integrated into the point-sale-system and reviewed by the state and DUR committee.
Arkansas	Opioid naive clients may receive up to a 7-day supply with a maximum of 6 tablets/capsules per day (total #42) for short-acting opioids. Opioid experienced clients are defined as those with an opioid on their Medicaid profile in the previous 60 days. Opioid experienced clients may receive up to a 31-day supply with a maximum of 3 tablets/capsules per day (total #93). Clients with a cancer diagnosis may receive up to #124 tablets/capsules per 31 days. The initial prescription for an opioid naive client must not exceed 50 MME/day. Subsequent prescriptions must not exceed 90 MME/day. Prescriptions outside of these limits will require a prior authorization request from the prescriber.
California	Deny claim and require PA: Restrictions that may deny claim and require PA include, but are not limited to, age restrictions and duration of therapy restrictions. Intervention letters: In FFY 2020, intervention letters were sent to prescribers for the following topics: 1. Patients at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants. 2. Concomitant gabapentin and opioids prescribed at the same time. Morphine Milligram Equivalent (MME) daily dose program: For the treatment of chronic pain, dose is to not exceed 500 MME/daily without an approved Treatment Authorization Request.

State	Explanations
	This safety edit assists in identifying members at potentially high-clinical risk who may benefit from close monitoring and care coordination. Require PDMP checks - Assembly Bill 2760 (Wood, Chapter 324) was signed into law in 2018 and became effective on January 1, 2019. California prescribers are now required to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication when one or more of the following conditions are present: 1. The prescription dosage for the patient is greater than or equal to 90 mg MME/day. 2. An opioid medication is prescribed concurrently with a prescription for a benzodiazepine. 3. The patient presents with an increased risk for overdose, including a history of overdose, a history of substance use disorder, or a risk for returning to a high dose of opioid medication to which the patient is no longer tolerant. The bill also requires a prescriber, consistent with the existing standard of care, to provide education on overdose prevention and the use of naloxone or other similar drug approved by the FDA to a patient and his or her designee or, if the patient is a minor, to the patient's parent or guardian. Workgroups to address opioids: California has a Prescription Drug Overdose Prevention Initiative. The goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD.
Colorado	Prescriptions are limited to one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for opioid prior authorization approvals. Opioid-naive members are limited to short-acting opioids only. Prescriber opioid treatment plans are documented as part of provider-to-provider telephone consultations that are required for certain opioid prior authorizations.
Connecticut	Deny claim and require a PA - Connecticut Medicaid requires a PA for all new LAO and SAO prescriptions. Intervention letters Retrospective DUR Intervention letters are mailed on a monthly basis to assist with monitoring and managing opioid utilization. MME - In August 2019, the Department of Social Services (DSS) selected a date of 10/16/2019 to implementing a new prior authorization for short acting opioid agents. Prior authorization is required for prescriptions for long acting opioid agents. The new prior authorization for short acting opioid claims in which the days' supply exceeds 7 days and/or the patient's cumulative morphine milligram equivalence (MME) exceeds 630 over the past 120-day window. Require PDMP checks - Prior to prescribing greater than a 72-hour supply of any controlled substance (Schedule II - V) to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the CPMRS at https://connecticut.pmpaware.net.
Delaware	Prior Authorization criteria contains the following requirements: verification that the prescriber verified the PDMP, verification of first line drug therapies used for treatment based on diagnosis provided, pain assessment and pain contract, and urine drug screen
District of Columbia	The DUR Board is working in collaboration with the Department of Health to provide feedback to the City Council Committee considering enactment of legislation to mandate PDMP query by

State	Explanations
	prescribers prior to prescribing opioids, benzodiazepines, cyclobenzaprine and gabapentin. The DUR Board is preparing a comprehensive clinical guideline for safe opioid prescribing for dissemination to the District provider community.
Florida	Any opioid claim outside of the established quantity limits, MME limits, or daily supply limits will deny for a prior authorization. In addition, there are various concomitant therapy edits for opioids and other agents.
Georgia	See above
Hawaii	Although in place for restriction, ProDUR and RetroDUR have not identified any occurrences within our dental and specialty populations
Idaho	Pharmacist override exists only for edits not involving doses, quantities or MME limits. For example general edits like a drug interaction override is allowed. Claims are denied at POS and a PA is required for quantities, MME, therapy duplication and non-preferred drugs. Intervention letters are done through the DUR Board on focused topics. The Morphine Milligram Equivalent (MME) daily dose program is an automated edit that adds up all opioid MME for all drugs and doses and denies for a cumulative MME exceeding 90 MME. Step therapy or clinical criteria are done at each drug GCN or class level for preferred status, prior drug trials and indication. The State has two major workgroups assigned to ensure appropriate opioid use . 1. Idaho Opioid Misuse and Overdose Strategic Plan Working Group with work groups for specific goals including opioid prescribing, patient, prescriber and public education; improvement in PDMP use: and Opioid Use Disorder treatment. Idaho Medicaid Pharmacists and our Medical Director are directly involved with this group and its specific subgroups. 2. Governor's Opioid and Substance Use Disorder Advisory Group.
Illinois	Patients flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If patient has used opioids 3 or more months, the prescriber must fill out a pain management program form with medical justification. If approved, at approval expiration, must justify medical need for continued therapy. The methadone pain management program requires additional safety monitoring, including submission of recent urine drug screen. All chronic opioid use requires use of short acting narcotics and/or preferred long-acting opioids first. Only one short and one long-acting opioid are allowed at a time. Exceptions can be made for patients with cancer. All patients in the pain management program must have a patient-prescriber pain contract and a pain diagnosis for which opioid therapy is appropriate. State law requires PDMP check before the first Schedule II prescription. The prescriber notes date PDMP checked on the Four Prescription Policy pain management program forms. All prescribers within the pain program receive an intervention letter/response with recommendations after review of submitted pain forms.
Indiana	System edits are utilized to identify the number of prescribers; restrictions for concurrent use with benzodiazepines, carisoprodol products, buprenorphine, or buprenorphine/naloxone; current utilizers limited to one long-acting and one short-acting opioid product.
Iowa	Prior authorization (PA) in required for non-preferred opioids, allowing the pharmacist to review and determine if therapy is appropriate and for an age edit override for codeine or tramadol for patients under 18 years of age. MME is in place, requiring PA for MME > 90 mg/day. Step therapy and clinical criteria is embedded as part of the overall PDL/PA process. Any opioid requiring PA must document patient has a pain management contract with the provider in addition, the prescriber must document the PMP has been reviewed.

State	Explanations
Kansas	We have a clinical prior authorization (PA) in place for opioids products used for pain management. This PA includes many other factors. The website link for this PA is https://www.kdheks.gov/hcf/pharmacy/PA_Criteria/Opioid_PA_Criteria.pdf For opioid drug renewal requests, urine screens and checking PDMP are a provider attestation on the PA form, not a requirement. We have a policy in place that requires following this PA and also sent provider bulletins about this policy and PA criteria. The bulletin links are below: https://www.kmap-stateks.us/Documents/Content/Bulletins/18027%20-%20General%20-%20Opioid_2.pdf https://www.kmap-stateks.us/Documents/Content/Bulletins/18101%20-%20General%20-%20Opioid_2.1.pdf https://www.kmap-stateks.us/Documents/Content/Bulletins/18112%20-%20General%20-%20Opioid_2.3.pdf
Kentucky	Please see opioid criteria available online at: https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KYRx_PDL_prior_authorization_criteria.pdf
Louisiana	There are exemptions for certain medical conditions. 1. Diagnosis code requirement. Pharmacy claims for all Schedule II opioid prescriptions must be submitted with a valid diagnosis code. Pharmacy claims for fentanyl buccal and sublingual agents must be submitted with a cancer-related diagnosis code. 2. MME. The cumulative daily morphine milligram equivalent (MME) for all active opioid prescriptions will be limited to a maximum of 90 MME per day. 3. Clinical monitoring is required for methadone. 4. Long-acting opioid prescriptions require prior use of a short or long-acting opioid within the previous 90 days. 5. Age limit. Codeine single-ingredient products, 18 years or older; codeine combination products, 12 years or older; tramadol and tramadol/acetaminophen, 17 years or older. 6. Maximum dose limit. Tapentadol, 700mg per day; tramadol IR, 400mg/day for 75 years or younger; tramadol IR, 300mg/day for 76 years or older; tramadol/acetaminophen, 8 tablets/day; buprenorphine buccal film, 1800mcg/24hr; buprenorphine transdermal, 480mcg/24hr (20mcg/hr); morphine sulfate ER (Avinza), 1600mg/day. 7. Therapeutic duplication for opioid prescriptions written by different prescribers Therapeutic duplication of short-acting opiates Therapeutic duplication of long-acting opiates Special POS edits to monitor the use of opioids with buprenorphine-containing agents 8. Concurrent use. Opioids with benzodiazepines. 9. Intervention letters. The retrospective DUR program addresses opioid safety with interventions for concurrent use of opioids with antipsychotic agents, benzodiazepines, and sleep agents. Overrides of the opioid POS edits are addressed with interventions for >90MME, >quantity limit, >2 days early, duplication of therapy, and > days supply.
Maine	see above responses listed above, these are all used in some fashion on controls on the prescribing of opiates

State	Explanations
Maryland	Providers must obtain a prior authorization every six months to prescribe long-acting opioids, fentanyl products, methadone for pain, and opioids greater than 90milligram equivalents per day. This includes: Attestation of a patient-provider agreement; A medical justification for high-dose and/or long-acting opioid prescription; Attestation of screen patient with random drug screen(s) before and during treatment; and Attestation that a naloxone prescription was given or offered to the patient/patient's household member. The prior authorization form with more information is available at https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Documents/pa_form_universal_formatted_102017.pdf
Massachusetts	https://masshealthdruglist.ehs.state.ma.us/MHDL/pubtheradetail.do?id=8
Michigan	These point-of-sale edits prevent claims hitting these additional safety edits from processing. In essence they trigger a comprehensive medical necessity prior authorization review to occur to further evaluate the opioid treatment plan for safety and appropriateness and provide an opportunity to recommend a naloxone prescription for individuals at risk for opioid overdose. The prior authorization reviews provide opportunity for State staff to acquire additional details on utilization and prescribing trends to further monitor and manage the prescribing of opioids in our program. The Medicaid Opioid Workgroup reviews other State Best Practices, utilization trends, and policies and evaluates opportunities for modification of the program to better monitor and manage the prescribing of opioids. Our comprehensive RetroDUR opioid review monitors for trends and targets prescribers of the highest risk Medicaid beneficiaries with additional education and resources to manage the safe and appropriate prescribing of opioids and referral options for MAT and additional behavioral health support services.
Minnesota	If the opioid claim is greater than 90mg MME, then the claims rejects at POS. Prior authorization is required which includes a Clinic Tool for the Assessment and Management of Persistent Pain which is completed and signed by both prescriber and patient. The prescriber must also complete the High Dose Opioid Drug Authorization found at High Dose Opioid Drug Authorization (PDF) (DHS-7072). This includes a PDMP attestation signature. Clinic Tool for the Assessment and Management of Persistent Pain (PDF) (DHS-6109) must be completed by prescriber and patient.
Mississippi	DOM implemented opioid prescribing criteria that sets cumulative MME limits to 90 and prohibits concomitant use with benzodiazepines.
Missouri	MO HealthNet utilizes clinical edits. These edits look for appropriate diagnosis, duplicate therapy, quantity and day supply limits, and accumulative MME limits. When participants do not meet the clinical criteria, claims are denied and require a clinical review.
Montana	Quantity per day limits on IR oxycodone. Limits on # of prescribers of opioids. Limit on # LA opioid prescription. 90MME limit. Provider attestation of risk vs benefit analysis, OUD analysis, failure of taper, failure of alternate therapy, offer of Narcan, etc to keep legacy patient on greater than 90mme.
Nebraska	Non-preferred opioids require PA.
Nevada	All of the following criteria must be met in order for a recipient to exceed the number of seven-day prescriptions, to exceed the seven-day limit or to exceed the 60 mg morphine equivalents or less per day: 1) the recipient has chronic pain or requires extended opioid therapy and is under the supervision of a licensed prescriber; 2) the pain cannot be controlled

State	Explanations
	through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants, anti-seizure medications, physical therapy, etc.); and 3) the lowest effective dose is being requested and a pain contract is on file.
New Hampshire	All long-acting opioid prescriptions require prior authorization. In addition, NH has a daily MME edit of 100mg. When a beneficiary exceeds 100mg MME prior authorization is triggered, even if the beneficiary already had a prior authorization in place for opioids. The prior authorization criteria require step therapy through non-opioid pain relievers, diagnosis information, justification for higher dosing, and multiple prescriber attestations targeting pain management contract, prior PDMP review, risk/benefit discussions with the patient, and naloxone prescribing. Patients with diagnoses of cancer or sickle cell anemia are exempt in addition to hospice and end-of-life patients.
New Jersey	MME daily dosing is calculated via an automated prospective review and will be denied at POS if exceeding the maximum allowed by DURB protocols. Initial fills of high dose opioids require a PA to confirm diagnosis and titration of dosage. Beneficiaries on short-acting opioids 90 days or more require prior authorization to obtain justification of continued use.
New Mexico	Opioid naive claims require an initial 7 day supply of an immediate release (IR) opioid, extended release (ER) not initially covered. Additional fills of IR and ER after a 7 day IR supply can be filled at a 90 percent threshold up to a 34 day supply not to exceed 90 MME dosage per day with a claim on file within the last 60 days. Exceptions are cancer treatment, hospice or palliative care, and residents in a long term care facility or facility where such drugs are dispensed to a resident. Pharmacy point of sale PDMP check verification edit on opioids required on initial fill and every 90 days.
New York	Claims may be subject to PA requirements subject to peer to peer review with the State's Medicaid Management Administrator. PA's can be required on select opioids as directed by the States DUR Board (ie required diagnosis). DUR Board may require educational letters addressing prescribing habits and retro-dur reviewers may subject non-compliant prescribers to intervention letters. DUR Board has determined the following for opioid prescribing; a 90 MME maximum daily dose requirement, diagnosis requirement, step therapy and clinical criteria for select opioids. State legislation also requires physicians to check the State's PDMP patient listing prior to writing prescriptions for opioids.
North Carolina	Prior approval is required for greater than 5 days supply for acute pain and 7 days supply for postoperative pain. Prior approval requests should include the beneficiary's diagnosis and reason for exceeding dose per day limits and duration (days supply) limits. The prescribing clinician shall review the North Carolina Medical Board's statement on use of controlled substances for the treatment of pain (https://www.ncmedboard.org/resourcesinformation/professional-resources/laws-rules-positionstatements/ positionstatements/Policy_for_the_use_of_opiates_for_the_treatment_of_pain), and is adhering as medically appropriate to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate. The prescribing clinician shall check the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System. (https://northcarolina.pmpaware.net/login). The prescribing clinician shall review the CDC Guideline for Prescribing Opioids for Chronic Pain . (https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm).
North Dakota	North Dakota applies quantity limits to all opioid medications consistent with FDA labeling or 90 MME per day, whichever is less. Opioid naive patients are limited to a 7 day supply on their

State	Explanations
	first fill. Long acting opioids by clinical criteria, require 90 days of previous opioid therapy, access to Narcan, counseling on overdose risk, and PDMP review. Regimens exceeding 90 MME per day must either be written by an oncologist or a pain management specialist who has a contract with patient including drug screens and appropriate goals. Certain high dose immediate release opioids also require clinical criteria including diagnosis checks for cancer only drugs and appropriate long acting to short acting ratios. An underutilization edit also identifies inappropriate prn use of long acting opioids.
Ohio	Initial short-acting opioid prescriptions are limited to 30 MED per day for a seven day supply. All long- acting opioids require a PA and are limited to 80 MED per day for a 34 day supply. For PAs, a diagnosis is required as well as a list of non-pharmacological treatment tried, non-opioid analgesics tried, and concurrent therapies. Prescribers must review the PDMP. The prescriber must discuss benefits and risks of opioid therapy with the patient and provide documentation of a current treatment plan and demonstrated adherence to the treatment plan.
Oklahoma	MME is limited to 90 MME per day. PA/override requests for MME quantities greater than the 90 MME limit require documentation that prescriber has a tapering plan in place. Cancer, hemophilia, and sickle cell diagnoses are excluded from the MME limit. Quantity limits were updated in November 2018 to limit short acting opioids to 8 units per day for 7 days for acute use and 4 units per day for 30 days for chronic use.
Oregon	Prescriber must attest they are enrolled in the Oregon PDMP and that they have reviewed at least once in the past 3 months the scheduled substances the patient has recently been prescribed from other providers.
Pennsylvania	The prior authorization guidelines can be found at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx
Rhode Island	Prior authorizations are required on all long acting opioids and criteria is in place for most short acting around the MME daily dose program.
South Carolina	Timely Information for Providers in South Carolina (tipSC) SCDHHS has engaged in an aggressive provider education campaign to promote opioid risk reduction strategies and expand access to MAT, named tipSC. Working with physicians, pharmacists and other experts from the Medical University of South Carolina, tipSC develops and disseminates targeted, practical information to help prescribers make safer prescribing decisions. These educational programs offer continuing education credit for providers. These materials are available at https://msp.scdhhs.gov/tipsc/. Though corresponding liability rests with pharmacists who fill and ultimately dispense the prescription, pharmacists are not obligated to verify compliance. However, pharmacies may choose to implement their own verification procedures for prescriptions in accordance with the requirements of S.C. Pharmacy Practice Act. Pharmacists continue to have the authority under state law to refuse to fill a prescription if they are concerned about the legitimate nature of the prescription. S.918, in addition to establishing the abovementioned limitations for initial opioid prescriptions, requires DHEC to develop and maintain as part of the PMP a system to provide prescription report cards to practitioners to inform the practitioner about certain prescribing trends. Although DHEC currently provides prescription report cards to practitioners, the new

State	Explanations
	law requires the report cards to provide a different set of metrics to practitioners beginning November 15, 2018. H.4117 authorizes DHEC's Drug Control to provide data in the PMP to the presiding judge of a drug court pertaining to a specific case involving a designated person.
South Dakota	Prescriptions exceeding 90 morphine equivalents or the quantity limit for that product will require PA. RDUR review process reviews opioid utilization.
Tennessee	In addition to the information described above for non-chronic use, those who are chronic users are limited to 200MME per day
Texas	There are multiple PAs in place for opioids. The purpose of these PAs is to reduce overutilization as well as inappropriate prescribing behaviors. The population-based retrospective interventions are performed annually and are intended to flag patterns of opioid abuse and gross overuse. Educational letters are mailed to the prescribers. The opioid policy is set to monitor daily MME levels for all opioids. For clients with certain diagnosis, including Cancer, sickle cell, or in-hospice care, the 90 MME is not applicable. For the rest, a daily dose above 90 MME requires a prior authorization.
Utah	to be filled out
Vermont	Important Changes to Refill Tolerance for Controlled Substances To minimize the risk of misuse, abuse and diversion of controlled substances, Vermont Medicaid periodically reviews the prospective safety edits in place in the Pharmacy Point-of-Sale System. To support ongoing efforts to lower the risk to Medicaid members, DVHA implemented a more restrictive refill tolerance edit. Historically, the refill too soon calculation is based only on the most recent fill date. Over time, however, a succession of early refills could allow the member to accumulate additional units (tabs, caps, milliliters, etc.), leading to members having significantly more medication on hand than medically needed. This new edit cumulatively counts early refills beginning on 01/09/2020, and a maximum accumulation of seven (7) extra days of medication is allowed at any given time. This change is an important step in reducing the availability of unused or unnecessary medication and preventing medication misuse.
Virginia	* The prescriber has checked the Virginia's Prescription Monitoring Program (PMP) database on the date of the request to rule out use of other opioids or dangerous combinations (such as opioids and benzodiazepines). Document the date of the last opioid Rx, the date of the last benzodiazepine Rx. If benzodiazepine filled in past 30 days, prescriber attests that patient has been counseled on warnings associated with combined use and Naloxone has been prescribed; AND * Document the Morphine Milligram Equivalents (MME) per day from the PMP site. If MME %u2265 90, prescriber attests to the following: patient's long term opioid therapy will be managed, VA BOM Regulations for Opioid Prescribing has been reviewed, Naloxone has been

State	Explanations
	prescribed and acknowledges the warnings associated with high dose opioid therapy including fatal overdose and that therapy is medically necessary for the patient; AND * For female patients between 18-45 years of age, the prescriber has discussed risk of neonatal abstinence syndrome and provided counseling on contraceptives options; AND * Attestation from the prescriber that a signed physician/patient treatment plan/agreement with goals addressing the benefits and harm of opioids has been established; AND * The prescriber has ordered and reviewed a urine drug screen (UDS) or serum blood medication level prior to initiating opioid treatment. For renewals - Prescriber has ordered and reviewed a UDS or serum blood medication level at least every 3 months for the 1st year of treatment and at least every 6 months thereafter to ensure adherence.
Washington	Prescriber must attest that the client meets the following: A. on-going clinical need for chronic opioid use B. non-pharmacologic therapies have been used C. tried a short-acting opioid for at least 42 days D. conduct periodic pain assessments E. screened for mental health disorders, substance use disorder, naloxone use F. conduct periodic urine drug screens G. checked the PDMP to determine if the patient is receiving other opioid therapy H. discussed with my patient the realistic goals of pain management therapy I. confirmed that my patient understands and accepts these conditions
West Virginia	Patients who are receiving more than 50 MME/day for at least the last 90 days are required to receive a PA through our SEMP (Safe and Effective Management of Pain) Program. The PA process requires identification of previous therapies, a plan of care and encourages providers to titrate to the lowest effective dose whenever possible.
Wisconsin	Wisconsin has an Early Refill hard alert for certain opioid prescriptions dispensing that requires a prior authorization from a specialized call center. Wisconsin has a monthly opioid script limit that limits the dispensing of opioids to five per month. Wisconsin has a Therapeutic Duplication alert for opioids and a Patient Age alert for tramadol, codeine, and hydrocodone or codeine cough syrups that a dispensing pharmacist may override. In addition, Wisconsin has a number of retrospective intervention letters addressing opioid prescribing issues, including the pharmacy Lock-In program.
Wyoming	Intervention letters are sent regarding pregnant patients who have filled 14+ days of opioids on a monthly basis. Quarterly letters are sent to mental health providers for patients who are on antipsychotic medications and opioids. Letters are sent as needed for providers who indicate on an opioid PA form that they did not check the PDMP prior to prescribing an opioid. Following a 42 day acute treatment period, long-acting medications are limited to a maximum of 120 MME per day and short-acting medications are limited to a maximum of four tablets per day. Step therapy is required for fentanyl and buprenorphine.

If "Other," please specify.

Table 147 – Detail for "Other" Opioid Prescribing Controls in Place

State	"Other" Explanations
Arkansas	Both short-acting and long-acting opioids are on the PDL with preferred agents. Opioid naive patients may receive short-acting opioids only. Long-acting opioids require a prior authorization with the exception of long-term care clients, cancer patients, or clients identified as NPO. Continuation of coverage without an additional PA request requires a paid claim for an opioid on the client profile in the previous 60 days. POS edits help manage the use of opioids in patients with a billed diagnosis of poisoning or overdose. An opioid claim will deny at POS and require a prior authorization if there is a billed diagnosis of poisoning or overdose in the previous year. Also, opioids will deny at POS and require a prior authorization if the client has billed pharmacy claims for medication assisted treatment in the last 90 days.
Colorado	Prescriptions are limited to one long-acting opioid and one short-acting opioid Opioid-naive members are limited to short-acting opioids only.
Illinois	1. Benzodiazepine and opioid drug interaction hard edit. 2. Antipsychotic and opioids drug interaction soft/informational edit. 3. All long -acting opioids require prior authorization.
Indiana	System edits are utilized to identify the number of prescribers; restrictions for concurrent use with benzodiazepines, carisoprodol products, buprenorphine, or buprenorphine/naloxone; current utilizers limited to one long-acting and one short-acting opioid product.
Kansas	We have a clinical prior authorization (PA) in place for opioids products used for pain management. This PA includes many other factors. The website link for this PA is https://www.kdheks.gov/hcf/pharmacy/PA_Criteria/Opioid_PA_Criteria.pdf
Louisiana	Other: Age limit. Maximum dose limit Therapeutic duplication Concurrent use Bypass diagnosis
Vermont	Cumulative Days Supply edit This new edit began 01/09/2021 to cumulatively count early refills and a maximum accumulation of seven (7) extra days of medication will be allowed at any given time.

If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

Table 148 - Explanations of Measures in lieu of or not in place to Either Manage or Monitor the Prescribing of Opioids

State	Explanations
Mississippi	RESTRICTED QUANTITIES AND DAYS

5. Does your state have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent?

Figure 95 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

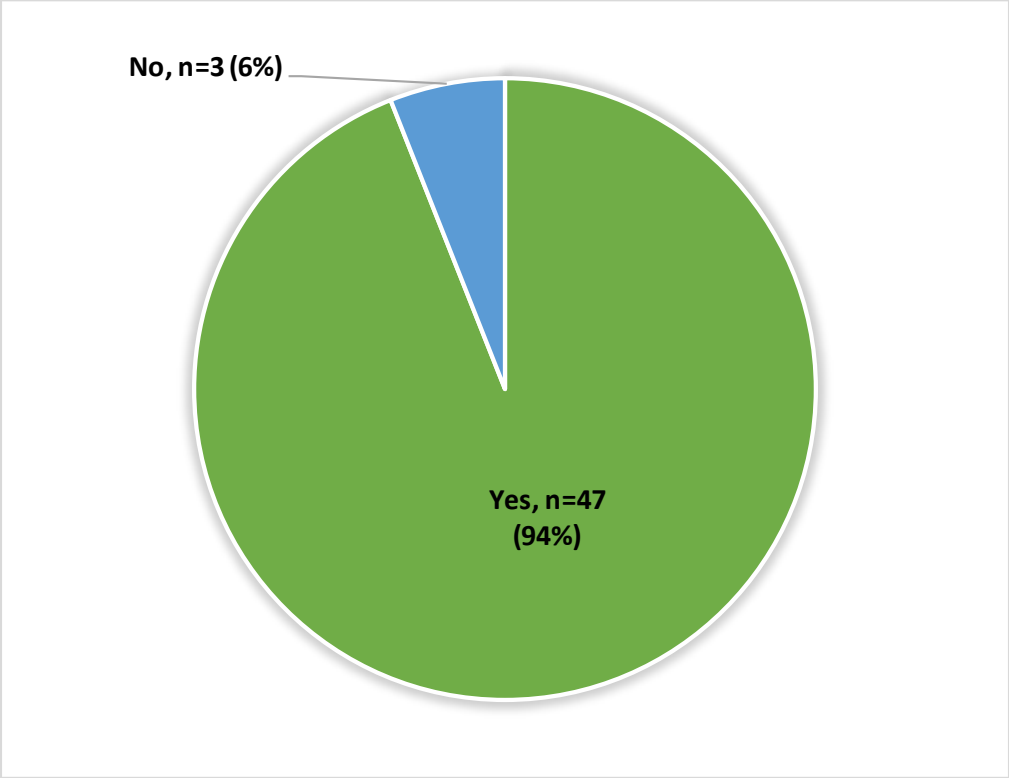

Table 149 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	Colorado, New Mexico, Oregon	3	6.00%
Total		50	100.00%

Please explain response.

Table 150 - Explanations of POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

State	Explanations
Alabama	Therapeutic duplication edit.
Alaska	There is a point-of-sale prescription lookback and produr edits identify duplicate therapy.
Arkansas	There is a maximum quantity edit for short-acting opioids of #93 over a rolling 31 days. This edit would allow multiple short-acting opioids to be billed, but a total for all claims cannot exceed 93 pills in a 31 day rolling timeframe. Early refill thresholds apply to each fill. Therapeutic duplication edit exists between short-acting opioids with more than 25% of the days' supply remaining on the previous claim. Patients who have a diagnosis of malignant cancer in the past 12 months are exempt from the therapeutic duplication requirement. Opioid claims will deny at POS if the client has a billed claim of a buprenorphine product in the previous 90 days.
California	POS edits are in place to monitor duplicate therapy of opioid prescriptions that do not have an approved Treatment Authorization Request.
Colorado	Duplicate therapy limitations, including limit of one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for concomitant use, are managed by limiting PA approval on file for opioid medications prescribed.
Connecticut	Same day/duplicate fills are not allowed and will trigger early refill notifications. Additionally, there are ProDUR alerts triggered by duplication of ingredients within the same therapeutic class.
Delaware	Duplicate claims are identified by comparing the current drug claim to drugs in claim history having the same generic sequence number or the same therapeutic class with overlapping day supply date ranges. Claim is flagged for Pharmacy verification, and a prior authorization is required to override duplicate therapy or the use of submission clarification code of 5 to override in the case of a therapeutic change by prescriber.
District of Columbia	There are POS edits in place to monitor for duplicate therapy claims for opioid products. The PA process will identify and allow the concurrent prescribing of a single extended release product and a breakthrough short acting agent.
Florida	Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 long-acting narcotic every 30 days.
Georgia	Members are limited to 5 narcotic (opioid pain relievers) fills per 30 days. Treatment naive members: Edit checks for a LAO with no paid claim for a SAO. Purpose is to verify patient receives IR prior to ER use. MME limits in place for overall opioid use.
Hawaii	Yes, duplicative therapy alert to the pharmacy created by First Data Bank.
Idaho	ProDUR edit plus cumulative MME total for all opioids.
Illinois	Duplicate therapy edit for short-acting narcotics. For long-acting opioids, which all currently require prior authorization, the adjudicating pharmacist manually checks for duplicate therapy.
Indiana	System monitors for more than one long-acting and one short-acting agent in current utilizers and requires PA if more are present.
Iowa	Soft edits are used to message pharmacies.

State	Explanations
Kansas	Concurrent opioid use is limited to one short-acting opioid and one long-acting opioid, with the exception of the following scenario: We allow for the main opioid prescriber plus an intermittent prescriber for a surgical/trauma type situation where increased opioid use would be needed. *The prescriber has to have reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program (PDMP) aka K-TRACS. *Prescriber must attest that the patient has been counseled on potential respiratory depression. *Cumulative opioid dose must not exceed 90 MME per day. *Total day supply for the requested medication must not exceed 21 days (3weeks).
Kentucky	An NCPDP 88 duplicate therapy denial will present when there are overlapping days' supply of 2 short-acting or 2 long-acting opioids. An NCPDP ProDUR denial will also present when there are overlapping days' supply of an opioid and a buprenorphine-containing product. Prior authorization is required for all of the above instances.
Louisiana	Long-acting opioid prescriptions require the prior use of a short- or long-acting opioid within the previous 90 days Therapeutic duplication for opioid prescriptions written by different prescribers Therapeutic duplication of short-acting opiates Therapeutic duplication of long-acting opiates Special POS edits to monitor the use of opioids with buprenorphine-containing agents
Maine	ProDUR messaging sent to the pharmacies during adjudication
Maryland	Prospective DUR edits are in place to identify therapeutic duplication of opioids and can be overridden at the point of sale (POS) after review by a pharmacist.
Massachusetts	Claims for any combination of the following long-acting agents: Arymo ER, Belbuca, buprenorphine transdermal, Conzip, Embeda, fentanyl transdermal system, hydrocodone ER capsule, hydromorphone ER, Hysingla ER, levorphanol tablet, methadone injection, methadone oral, MorphaBond ER, morphine ER capsule (Avinza, Kadian), morphine CR tablet, Nucynta ER, oxycodone ER tablet, oxymorphone ER oral, tramadol ER, or Xtampza ER, and there is greater than 2 months of duplicate claims in POPS history, the claim will usually reject at the pharmacy as prior authorization required. Claims for any combination of the following short-acting, opioid powders, and combination product agents: Abstral, acetaminophen/codeine, apomorphine powder, benzhydrocodone/acetaminophen, Buprenex, buprenorphine powder, butalbital/acetaminophen/caffeine/codeine, butalbital/aspirin/caffeine/codeine, butorphanol nasal spray, carisoprodol/aspirin/codeine, cocaine powder, codeine, codeine powder, dihydrocodeine/acetaminophen/caffeine, dihydrocodeine/aspirin/caffeine, fentanyl buccal tablet, fentanyl powder, fentanyl transmucosal system, hydrocodone powder, hydrocodone/acetaminophen, hydrocodone/ibuprofen, hydromorphone, hydromorphone powder, Lazanda, levorphanol powder, meperidine, methadone powder, morphine IR, morphine sulfate powder, Nucynta, Oxaydo, oxycodone IR, oxycodone powder, oxycodone/acetaminophen, oxycodone/aspirin, oxycodone/ibuprofen, oxymorphone IR oral, pentazocine/naloxone, Prialt, Subsys, sufentanil powder, tramadol IR, tramadol/acetaminophen, Qdolo, or Xartemis XR and there is greater than 2 months of duplicate claims in POPS history, the claim will usually reject at the pharmacy as prior authorization required.
Michigan	The POS therapeutic duplication edit denies and requires a call center override. Provider level overrides are not permitted on this edit.

State	Explanations
Minnesota	If it is the same drug, strength, and dose form of the opioid, then the claim rejects as a duplicate claim.
Mississippi	POS edits capture duplicate opioid prescriptions.
Missouri	Missouri allows one short acting opioid at a time. We also have an accumulative MME edit and evaluate the total therapy when the MME limit is exceeded.
Montana	Rx system will recognize same drug and strength and deny for duplicate.
Nebraska	Drug-drug alerts are sent to pharmacies.
Nevada	Pro-DUR edits are in place to monitor duplicate therapy.
New Hampshire	POS edits will deny opioid prescriptions for therapeutic duplication. If the prescription is medically necessary and clinically appropriate the pharmacy can request an override.
New Jersey	DUR edits deny a claim if 2 or more short-acting or long-acting opioid prescriptions are requested.
New Mexico	Monthly reports are generated by Conduent for state staff review of opioid overutilization.
New York	POS edits determine therapeutic duplicates of opioids (and other agents) for pharmacist review at time of order entry. PA is required in situations where patients are receiving more than 4 opioids within a 30 day period, for recipients receiving any opioid while on opioid dependence therapy, for additional long acting opioids prescribed for patients currently on long acting opioid therapy.
North Carolina	DUR Alerts for Therapeutic Duplication and Ingredient Duplication. The MME limit is cumulative for all opioid prescriptions.
North Dakota	We limit all to only one extended release product at a time, and we limit all to only one immediate release product at a time.
Ohio	DUR edits are in place to monitor duplicate therapy.
Oklahoma	Limited to one short acting and one long acting opioid.
Oregon	All LAOs require PA, so manual review precludes the need for POS edits.
Pennsylvania	Therapeutic duplication POS edits apply to all opioid claims. When therapy duplication is identified, the incoming duplicate drug claim denies at the POS and requires review for medical necessity.
Rhode Island	ProDUR edits
South Carolina	Yes, FDB edits for TD/DDI, 90 MME edits across all opioids
South Dakota	Use of more than one short acting product and/or one long acting product requires PA.
Tennessee	Yes, duplicate therapy ProDUR edits will trigger with multiple opioids, and the use of multiple opioids is also controlled via the benefit limit for non-chronic users and PA's required. For chronic users, ProDUR edits would be triggered, however the enrollees benefit allows up to 200MME, so with the hard duplicate therapy edit, if the enrollee is below 200MME, the enrollee/practitioner can acquire coverage with PA submitted via CoverMyMeds or a call to the call center.
Texas	The cumulative opioid dosing for any combinations opioid prescriptions must be less than 90 MME. In addition, the Opioid Overutilization PA criteria dictate how many claims or how much opioids a client can receive: if client has a diagnosis of sickle cell, cancer, palliative care or hospice care, the client can have less than 3 different opioids in the last 60 days, or less than 4 opioid claims in the last 60 days, or less than a 90 day supply of opioids in the last 60 days. For any other conditions, the client can have less than 2 different opioids in the last 60 days, or less than 3 opioid claims in the last 60 days, or less a 90 day supply of opioids in the last 60 days.

State	Explanations
Utah	Opioid prescriptions of the same medication and dose will hit a refill too soon edit if filled before 85% is exhausted. The system will allow opioid in the same class or dose to fill concurrently if accumulative MME is less than 90.
Vermont	Duplicate fill edits are in place. NCPDP Reject Code 88/DUR REJECT ERROR. Must be overridden by the dispensing pharmacy by submitting the appropriate Professional Service and Result of Service Codes. Allowable professional service codes (intervention) are: "MR" Medication Review, "M0" Prescriber Consulted, "R0" Pharmacist Consulted Other Allowable Result of Service Code (Outcome) are: "1B" Filled Prescription as is, "1C" Filled with Different Dose, "1D" Filled with Different Directions, "3E" Therapy Changed
Virginia	There are ProDUR edits for duplication of therapy for opioids
Washington	For acute use POS adds the prescriptions to verify if they exceed the allowed number of doses based on the client's age. For chronic use (exceeding 42 days in a rolling 90-day period) only the opioids approved through the attestation prior authorization process will pay; all others will reject 75 for prior authorization required.
West Virginia	We allow long-acting to be used with short-acting but cannot have multiple of either. Edit will fire that requires override by the pa vendor RDTP (SEV 1 EDIT).
Wisconsin	Wisconsin has a prospective DUR alert for therapeutic duplication in certain therapeutic classes, including opioid analgesics.
Wyoming	Medicaid clients are allowed one long-acting and one short-acting medication at a time.

6. Does your state have POS edits and automated retrospective claim reviews to monitor early refills of opioid prescriptions dispensed?

Figure 96 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

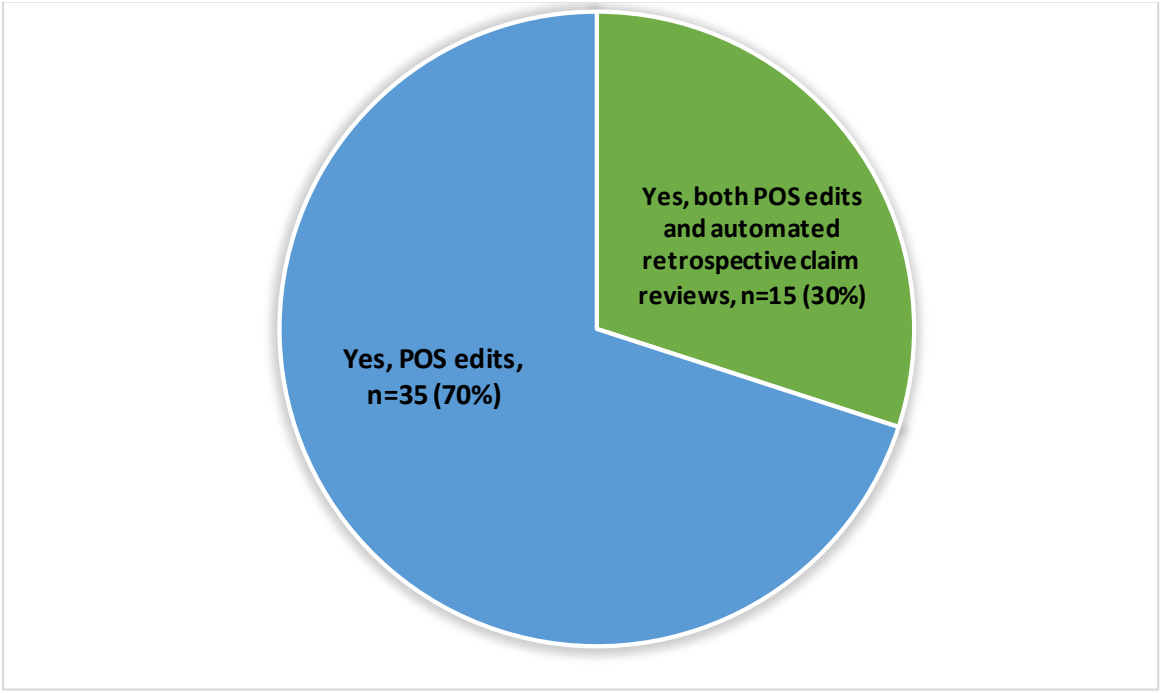

Table 151 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	States	Count	Percentage
Yes, both POS edits and automated retrospective claim reviews	Arkansas, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Iowa, Louisiana, Maryland, New Jersey, New York, Ohio, South Carolina, Vermont, Washington	15	30.00%
Yes, POS edits	Alabama, Alaska, California, Delaware, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming	35	70.00%
Total		50	100.00%

If any response is "Yes," please explain scope and nature of reviews and edits in place.

Table 152 - Explanation for Scope and Nature of Reviews and Edits In Place

State	Explanations
Alabama	Early refill edits: 75% threshold Schedule II controlled drugs; 85% threshold for opioid agonists and partial agonists.
Alaska	There is a point-of-sale prescription lookback and produr edits identify early refills.
Arkansas	POS edits for all controlled medications include an early refill threshold that requires at least 75% of dispensed medications to be utilized before a refill would be allowed (Effective 1/20/2021, the early refill threshold was changed to 90%). Also an accumulation edit for controlled drugs will allow an extra 7-days' supply accumulation through early fills in the previous 180 day period. If a client refills a prescription when 75% of the previous fill has been utilized (which would equate to approximately 7 days early), then refills for subsequent months until that 7 days early in 180 falls off must be filled on time. POS edits include maximum quantities and MME restrictions for opioids which are so strict that very few beneficiaries will have claims that exceed our limitations which mirror the CDC recommendations. Behind the scenes, the RetroDUR vendor is monitoring for overutilization of opioids. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics.
California	POS edits are in place to monitor early refills of opioid prescriptions that do not have an approved Treatment Authorization Request.
Colorado	All opioid claims are subject to 85% early refill tolerance and a cumulative total of 20 early refill days over a 180 day period. An early refill policy was implemented during 3/20/20-9/25/20 that permitted pharmacies to enter POS overrides allowing early refill of opioids for circumstances related to COVID-19 with refill tolerance of > 50% previous fill utilized.
Connecticut	POS - Claims < 15 Day Supply, or if the pharmacy is out of state, require that 85 % of the days' supply on the previous prescription be used before allowing the current claim to pay. Claims >

State	Explanations
	or =15 Days of Supply require that 93 % of the days' supply on the previous prescription be used before allowing the current claim to pay. Automated retrospective process - The automated retrospective process utilizes the lock-in criteria to identify patients and the early refill specific letter (letter type 47) to send notification to prescribers whose patients are identified as receiving early refills.
Delaware	Early refills for opioid claims are denied if less than 90% of the day supply has been used
District of Columbia	The POS system uses automated First Data Bank early refill edits on all claims including opioid prescription claims. The automated retrospective claims review process uses District and DUR Board approved rules engines to identify opioid claims that exceed days supply and quantity limitations.
Florida	The early refill percent threshold is set at 90% for opioid prescriptions.
Georgia	Early refill edit in place. Members are limited to 5 narcotic (opioid pain relievers) fills per 30 days
Hawaii	All opioids are reviewed. No early refills have been identified.
Idaho	ProDUR edit for early refill. Also the MME edit is set up so if early refill then both original fill and refill will count toward cumulative MME limit. If over 90 then will deny.
Illinois	HFS has a refill-too-soon threshold of 90% for Schedule II-V controlled substances. Prior authorization is required for all early refills.
Indiana	Early refill is monitored, and PA is required if 85% of supply is not exhausted.
Iowa	All prescriptions have refill threshold of 90%. Hard edits are in place for early refill and early refill reports are reviewed quarterly.
Kansas	We have all required federal edits and additional state edits at the Point of Sale, which were in place within this FFY time frame.
Kentucky	Early refill edits are in place at POS. PA is required before the medication can be dispensed.
Louisiana	POS edit. Pharmacy claims for an opioid will deny if submitted before 90% used or before 2 days early. Retrospective review. Claims were reviewed for opioid prescriptions filled before 2 days early and zero interventions were required during FFY20.
Maine	Accumulator edits are in place to minimize early refill use and require prior authorization
Maryland	POS edits were in place to identify early refills of opioids (85% threshold or claim will deny). The automated retrospective claims review process identifies participants who may be receiving early refills of opioid prescriptions through the Corrective Managed Care Lock-In program.
Massachusetts	POS rules will not allow less than 85% of days supply utilized. Prior authorization is required to override.
Michigan	The POS system requires 90% of the opioid claim to be utilized otherwise the claim will deny. No provider level overrides are allowed. The call center must review and approve. For beneficiaries enrolled in our Benefits Monitoring Program (BMP), the POS system requires 95% of the opioid claim to be utilized before a refill is allowed.
Minnesota	All controlled substances are set at the 85% refill too soon threshold.
Mississippi	Claims are subject to an 85% threshold for next fill.
Missouri	Missouri's early refill edit limits opioids to be filled at 85% and is not overridable by the pharmacist though the POS system.
Montana	Rx system will deny same drug and strength as refill too soon if >10% remaining.
Nebraska	30 day supply
Nevada	Point-of-sale edits are in place for early refills and duplicate of opioid prescriptions.

State	Explanations
New Hampshire	POS edits will deny opioid prescriptions for early refill. If the prescription is medically necessary and clinically appropriate the pharmacy can request an override.
New Jersey	Early refill edits deny claims for opioid prescriptions that have not exceeded 85% completion. Ad hoc quarterly reports are generated for claims review and provider follow up as needed.
New Mexico	All prescriptions are subject to early refill POS edits.
New York	Early refills of opioid prescriptions are denied at POS if the remaining amount is greater than a 7 day supply of an opioid medication which has been obtained over a period of 90 days. Where necessary the DUR Board will require retrodur utilization review reports be performed by academia at the University of the State of New York at Buffalo and presented to the Board for the need for specific action. In addition, pharmacists review individual requests for early fill services of opioid prescriptions reviewing the request, background for the need, and supply amounts where necessary with the prescribing practitioner.
North Carolina	Early Refill Edit hits for claims with less than 85% consumption.
North Dakota	All therapeutic duplication, early refill, accumulation, and contraindication edits are automatic and cause the claim to deny and require prior authorization.
Ohio	We utilize early refill edits at POS. The pharmacy cannot override and must call the help desk if an override is required. Also, the Coordinated Services Program monitors opioid prescriptions.
Oklahoma	The early refill threshold is set at 90% completion for opioids.
Oregon	Retrospective claim reviews are performed manually on a quarterly basis.
Pennsylvania	A hard edit on early refills of all opioids at less than 85% requires prior authorization by the prescriber.
Rhode Island	There are no refills allowed for opioid prescriptions. A new prescription needs to be written.
South Carolina	Yes, Prescription edits limit refill of Control Medications - 85% of control medications must be exhausted prior to a prescription refill. Claim will reject/deny NCPDP early refill and cannot be overridden by Pharmacy (Federal/State laws apply example: Authorization for Emergency Dispensing
South Dakota	Early refill threshold set at 85%.
Tennessee	The early refill edit is not only for opioids, but is for all controlled substances. The refill percent threshold for non-controlled substances is 85%, so for a 30-day supply, the prescription cannot be refilled until the 26th day. For all controlled substances, the refill percent threshold is 95%, so any additional fills cannot be filled until the 30th day for a 30-day supply.
Texas	The daily cumulative opioid dosing for any combinations opioid prescriptions must be at 90 MME or less. In addition, the Opioid Overutilization PA criteria dictates how many claims or how much opioids a client can receive: if client has a diagnosis of sickle cell, cancer, palliative care or hospice care, the client can have less than 3 different opioids in the last 60 days, or less than 4 opioid claims in the last 60 days, or less than a 90 day supply of opioids in the last 60 days. For any other conditions, the client can have less than 2 different opioids in the last 60 days, or less than 3 opioid claims in the last 60 days, or less a 90 day supply of opioids in the last 60 days.
Utah	Opioid prescriptions have a refill tolerance of 85%.
Vermont	Early refill edits are currently in place. Cumulative refill edits have also been added "Carryover Count" Maximum of 7 extra days on hand for any controlled substance. Implementation date 1/9/20. Applies at the GPI_14 level (each unique medication and strength has its own CC)
Virginia	There is an early refill edit with a percent threshold for schedule II controlled drugs of 90%.

State	Explanations
Washington	Our point-of-sale system has been programmed to require eighty percent of an opioid medication to be used based on the prescriptions day supply before another fill will pay. This edit cannot be overridden by the pharmacy and requires a PA. Washington Apple Health (Medicaid) has developed reports to measure the SUPPORT Act requirements and is hiring an Oversight Specialist to help monitor opioid use. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects.
West Virginia	Early refill edit is set at 85% which can be overridden by rational drug therapy program (prior authorization vendor).
Wisconsin	Wisconsin has a prospective DUR alert for early refill. This alert requires pharmacies to call into a specialized call center to obtain a policy override before the opioid prescription can be dispensed. All opioid prescriptions are monitored by a prospective early refill alert or by a quantity limit.
Wyoming	Scheduled drugs II-V require 90% of the days supply to be used before a refill or new claim for the same medication will be allowed. For each claim that is filled, the number of days that the claim is filled early will be added to the day supply submitted on all subsequent claims, and the 90% refill tolerance will be calculated on that accumulated total.

If "No," please explain.

Table 153- Explanation for Not Monitoring Early Refills of Opioid Prescriptions Dispensed

State	Explanations
Mississippi	AUTOMATED RETROSPECTIVE-OPIOID PRESCRIPTS DISPENSED

7. Does your state have a comprehensive automated retrospective claims review process to monitor opioid prescriptions exceeding these state limitations?

Figure 97 - Claims Review Automated Retrospective Process to Monitor Opioid Prescriptions Exceeding State Limitations

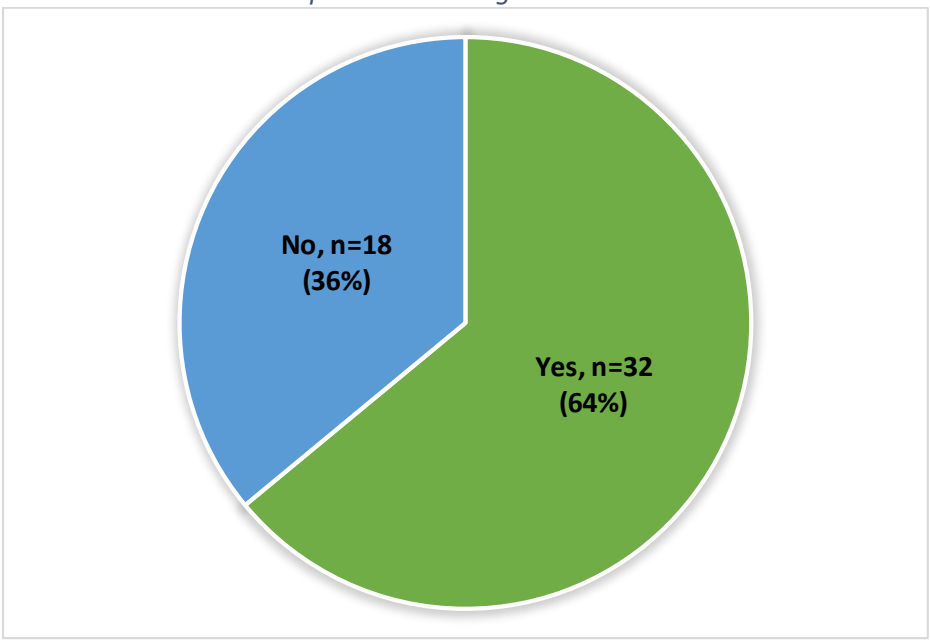

Table 154 - Claims Review Automated Retrospective Process to Monitor Opioid Prescriptions Exceeding State Limitations

Response	States	Count	Percentage
Yes	Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin	32	64.00%
No	Alabama, California, Delaware, Idaho, Illinois, Kansas, Maine, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, Oklahoma, South Dakota, Vermont, West Virginia, Wyoming	18	36.00%
Total		50	100.00%

If "Yes," please explain in detail scope and nature of these retrospective reviews.

Table 155 - Scope and Nature of Claims Review Automated Retrospective Process

State	Scope and nature of these retrospective reviews
Alaska	The opioid report generated is reviewed by the state and with the DUR committee quarterly.
Arkansas	As stated previously, POS edits include maximum quantities and MME restrictions for opioids which are very strict. When the early refill and accumulation edits are factored in, very few clients would be isolated for overutilization of opioids on a RDUR review. Only clients with cancer or those manually approved by a PA will exceed these limitations. The RDUR program does monitor patients for lock-in potential. Any outliers filling multiple controlled substances may hit the lock-in algorithm.
Colorado	Retrospective review is conducted on a case-by-case basis at the claims level as part of a Prior Authorization requirement triggered by MME > 200mg or the 4th fill of an opioid for a previously opioid-naive member or the 4th fill of an opioid prescribed by a dental provider.
Connecticut	The automated retrospective process utilizes the lock-in criteria to identify patients and the early refill specific letter (letter type 47) to send notification to prescribers whose patients are identified as receiving early refills.
District of Columbia	The automated retrospective claims review process uses District and DUR Board approved rules engines to identify opioid claims that exceed days supply and quantity limitations.
Florida	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Georgia	We have the ability to retrospectively monitor opioid use in patients.
Hawaii	All opioids are reviewed. Manual review using a set standard assesses compliance and/or need to adjust current policy.
Indiana	Opioid claims are reviewed annually for MME limits, quantity, number of utilizers, and concurrent utilization with other therapies.
Iowa	State PDL has quantity limits, duplicate therapy and MME edits. Reports for those members exceeding limits are reviewed quarterly.

State	Scope and nature of these retrospective reviews
Kentucky	A quarterly report is provided to KY Medicaid to identify potential opioid over-utilization. This includes high MME, opioids used with drugs that potentiate overdose (e.g., antipsychotics, benzodiazepines, gabapentin, sedative hypnotics), change in dosage and top prescribers and pharmacies.
Louisiana	Retrospective review. In FFY 20, claims were reviewed for: MME >90mg daily, 3 interventions. Exceeding quantity limit, 61 interventions. Therapeutic duplication, 4 interventions. >2 days early, 0 interventions. Exceeding days supply, 68 interventions.
Maryland	The Retrospective DUR (RDUR) vendor, Health Information Design, LLC (HID), monitors criteria to look at over-utilization of opioids as part of the Corrective Managed Care program, and performs interventions monthly. Additionally, HID has pre-built RDUR criteria that identifies duplicate use of short acting opioids, duplicate use of long acting opioids, inappropriate use of opioids based on diagnosis, days supply or dose. This criteria is activated and monitored with the monthly claims data evaluation through the RxExplorer system. HID has RDUR criteria to identify participants receiving greater than or equal to 50mg MME, with a comment that the MME is 90mg. This criteria has been in place since 2016. The criteria remains active. On case by case basis If approved by the DUR Board, HID performs an intervention with this criteria.
Michigan	We have standard RetroDUR reports that monitor monthly opioid MME trends (e.g. under 90, 90 to 120, and greater than 120. Our contracted lead academic detailing pharmacist manually reviews the high MME utilizers each month and performs additional outreach and education to the prescribers using our standard High MME education packet.
Mississippi	We are in the process of developing a system to monitor for opioid prescription exceptions.
Nebraska	Drug alert sent to pharmacy
New Jersey	Ad hoc quarterly reports are generated for claims review and provider follow up as needed.
New Mexico	The system searches for claims in the past 60 days to allow greater than a 7-day supply, 90 MME max dosage per day is calculated, and a PDMP initial fill and every 90 day confirmation is required.
New York	Opioid claims are reviewed retrospectively by pharmacy academia from the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia from the State University of New York at Buffalo are used by the Board in identifying the effectiveness of State limitations. Depending on the outcome, targeted educational letters, stricter point of service edits, additional , quantity limits and day's supply durations would be determined by the DUR Board.
North Carolina	NC has automated reports on drugs hitting the Early Refill Edit.
North Dakota	Later
Ohio	We utilize a high quantity/day supply algorithm that identifies opioids where the quantity and day supply do not match. If the maximum daily dose or quantity is exceeded, the claim must go through prior authorization.
Oregon	RetroDUR Program for High-Risk Opioid Patients: We conduct quarterly manual utilization review for FFS patients who are determined to be highest risk. This program applies to non-excluded FFS patients with a paid or denied opioid claim in the past quarter. Patients are automatically included in the program and are prioritized based on the number of inclusion

State	Scope and nature of these retrospective reviews
	criteria met (see list below). Those meeting the greatest number of inclusion criteria are reviewed manually each quarter. Criteria for inclusion: 1. High dose: Patients with cumulative opioid dose >90 MME (for all opioid formulations) for >60 days (with <=7 day gap in therapy) in a 120 day lookback; OR 2. SAO and LAO: Patients with paid claims in the Opioids, Short-acting PDL class AND claims in the Opioids, Long-acting PDL class for >60 days overlap with <=7 day gap in therapy in a 120 day lookback; OR 3. Multiple opioids: Patients with paid claims for 2 or more GSNs in a given opioid PDL class (opioids, short-acting or long-acting) for >60 days overlap with <=7 day gap in therapy in a 120 day lookback; OR 4. >110% covered days: Patients with sum of >110% of covered days for a specific opioid (based on HSN) in a 120 day lookback (filling an extra 12 days of opioids approximately); OR 5. Opioid and Benzodiazepine: Patients with paid claims for opioids (opioids, short-acting OR opioids, long-acting PDL classes) AND paid claims in the Benzodiazepines PDL class for >60 days overlap with <=7 day gap in therapy in a 120 day lookback; OR 6. Multiple denied claims: Patients with >=3 unique denied claims for an opioid in the past 120 days which may indicate cash-paying (PDL classes: opioids, short-acting or opioids, long-acting). Count only denied claims for unique prescription numbers for which there is not a paid pharmacy claim for the same prescription number. Count each prescription only once if there are multiple denials for the same prescription number; OR 7. Overdose history: Patients with a history of opioid overdose in the past 2 years; OR 8. Substance use disorder: Patients with a diagnosis of substance use disorder (excluding alcohol) in the past 2 years or patients prescribed medication assisted treatment (PDL class: substance use disorders, opioid and alcohol) within the past 6 months. FFS clients are excluded from manual review if any of the following apply: 1. Patients with a malignant cancer diagnosis (ICD-10 codes beginning with C) or claim for palliative care (Z51.5) based on medical claims in the past year 2. Patients with a diagnosis of sickle cell disease in the past year (ICD-10 D57xxx) 3. Patients with currently active primary insurance or Medicare coverage (this population will bypass our edits) 4. Patients previously reviewed with this initiative in the last 6 months 5. Patients who have had a provider letter sent regarding concomitant use of opioid and sedating medications in the past 6 months
Pennsylvania	Prior authorization is required for all opioids. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	Claims review automated retrospective processes were established during FFY 2020 to monitor opioid prescriptions exceed state limitations set prospectively.
South Carolina	Yes, POS edits apply to medications, with a 90days lookback in history (opioid naiive)
Tennessee	Yes. All claims are denied if over 200 MME for chronic opioid users, or after the first 5-day fill a no greater than 60 MME for non-chronic opioid users. These limits are set in TennCare Rules (approved via the State legislature), so there are no exceptions with prior authorization. The only way for an enrollee to pass the benefit limits would be via appeal and this would include a hearing in front of an Administrative Law Judge.
Texas	The system monitors opioid claims for appropriate utilization based on the 90% threshold limit.
Utah	An automatic retrospective review identifies prescriptions that exceeded the MME limit, quantity limit, and 85% refill threshold in a designated time period of 30 days. Claims are

State	Scope and nature of these retrospective reviews
	evaluated by member prescription profile and provider prescribing patterns for opioid. Next, peer-to-peer outreach is done to encourage a decrease in prescribing of high dose opioid with the following goals: 1) educate healthcare providers on the availability of non-pharmacology and non-opioid pain options and selected opioid use disorder treatment 2) Provide healthcare providers with resources on both Medicaid and CDC website 3) Educate providers on Utah Medicaid opioid policies.
Virginia	Every quarter we review members utilizing opioids chronically and that have high risk activity (e.g., opioid/substance abuse, high MME, ER visits) and see if they are getting naloxone along with the opioid. We also review quarterly as part of the SUPPORT Act members on concurrent opioids and benzodiazepine therapy and concurrent opioids and antipsychotics.
Washington	Washington Apple Health (Medicaid) is hiring an Oversight Specialist to help monitor opioid use exceeding all state limits. The reports developed to monitor the thresholds established by the SUPPORT Act include MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. The reports are automatically updated each week with new claims data and monitored frequently to address concerns.
Wisconsin	Wisconsin has a prospective early refill, duplicative fills, quantity limits and days' supply requirements, so this is not separately monitored on a retrospective basis. Wisconsin monitors opioid prescriptions with overutilization and lock-in retrospective reviews.

If "No," please explain.

Table 156 – Explanation of No Comprehensive Automated Retrospective Review Process

State	Scope and nature of these retrospective reviews
Alabama	AL Medicaid has prospective edits.
California	While there is a regular, comprehensive claims review to monitor opioid prescriptions exceeding these state limitations, the review process is not automated.
Delaware	Claims that are denied and subsequently overridden are flagged for review. This review may be used for a potential prescriber score card report generation project, and ongoing provider education. Since the FFS population is often comprised of dual eligible individuals with Medicaid as secondary payor, this poses a challenge in creating a automated comprehensive retrospective claims review. Individual provider outreach is done to educate providers when patient's dose exceeds state limits.
Idaho	The State does not have an automated retrospective process, but has employed a quarterly retrospective reporting package to look at all members exceeding limitations.
Illinois	The automated retrospective process to date selects 300 patients based on Medispan criteria, not just opioid prescriptions. HFS periodically reviews impact of opioid edits to determine whether edit changes are needed. The PBM is working on reports to provide HFS feedback in FFY21 on Support Act edits.
Kansas	We have all required federal edits and additional state edits at the Point of Sale, which were in place within this FFY time frame. We have a policy that requires RDUR per the SUPPORT Act requirements but our FFS vendor could not implement until early CY 2021, due to delays in the new Medicaid Modular Information System build.
Maine	Claims exceeding State limitations are evaluated through the PA process with clinical review. Those found to be in excess or abusing the process are entered into the Intensive Benefit Management program (IBM).

State	Scope and nature of these retrospective reviews
Massachusetts	Process is not automated, however opioid prescriptions exceeding state limitations under specific conditions require prior authorization and review by a Therapeutic Class Management Group
Minnesota	There is nothing automated. All drugs that exceed state opioid prescription limits which is 90mg MME require prior authorization so these prescriptions have already gone through the prior authorization review process.
Missouri	All claims that exceed the ProDUR limits for opioid prescriptions are thoroughly reviewed in the prospective process. Claims are reviewed in aggregate semi-annually to detect and address potential utilization issues and the ProDUR edits are updated accordingly.
Montana	As we deny claims that exceed these limitations at point of sale and require prior authorization, all claims that exceed these limitations have been authorized. We run an ad hoc reports to ensure any members exceeding 90 MME have a prior authorization provider attestation on file and that the provider has not increased the MME above the approved amount.
Nevada	RetroDUR is a manual review process and opioid reports are presented to the DUR Board.
New Hampshire	The state has an MME limit implemented that requires prior authorization for all claims above an MME of 100 daily. Patients with average daily MME > 100 are reviewed monthly.
Oklahoma	We did not have an automated retrospective review during this federal fiscal year.
South Dakota	The RDUR process reviews all prescription claims of which opioid overutilization is one criteria reviewed.
Vermont	Claims would deny for early refill edit.
West Virginia	We have prospective edits in place that prevent members from exceeding state limitations. Retrospective review cannot access PDMP.
Wyoming	Retrospective reviews are done approximately annually, however, the process is not automated. As all prescriptions exceeding state limitations require prior authorization, and PDMP data is not available, regular retrospective review is not necessary

8. Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and benzodiazepines being used concurrently?

Figure 98 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Benzodiazepines Being Used Concurrently

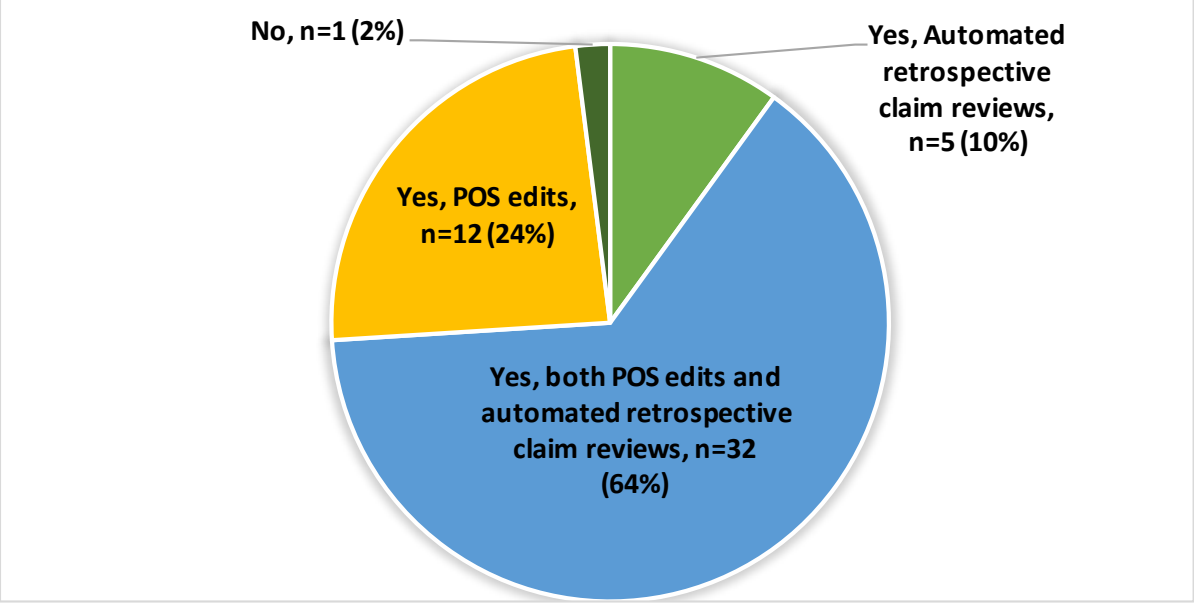

Table 166 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Benzodiazepines Being Used Concurrently

Response	States	Count	Percentage
Yes, Automated retrospective claim reviews	Alabama, Hawaii, Michigan, Washington, Wisconsin	5	10.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia	32	64.00%
Yes, POS edits	Illinois, Kentucky, Maine, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Oklahoma, Tennessee, Wyoming	12	24.00%
No	New Mexico	1	2.00%
Total		50	100.00%

Please explain response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the state justifies pain medications, i.e. Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e. quantity limits/practitioner education titration programs).

Table 157- Explanations of Scope and Nature of Reviews and Edits for Opioids and Benzodiazepines Being Used Concurrently

State	Explanations
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Point-of-Sale overrides are available when the pharmacist contacts the prescriber to discuss potential interactions. A report with concurrent use is reviewed by the DUR committee.
Arkansas	Arkansas Medicaid has POS edits in place that manage the use of benzodiazepines and opioids in patients with poisoning/overdose diagnoses billed in the previous year. This edit began as a 90 day look-back in March 2018 and was extended to a year look-back in November 2018. Any client with these billed diagnoses will need a prior authorization for using benzodiazepines or opioids excluding patients with a billed diagnosis of cancer in the last year. Behind the scenes, the RetroDUR vendor is monitoring for concomitant use of opioids and benzodiazepines per the SUPPORT Act. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics.
California	Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties. One mailing on this topic was initiated in FFY2019 after retrospective reviews showed beneficiaries with concurrent use of opioids, benzodiazepines, and two additional medications with CNS depressant properties. In addition, the total number of Medi-Cal FFS beneficiaries with concomitant use of opioids and

State	Explanations
	benzodiazepines during each calendar month has been tracked each calendar month since October 1, 2019.
Colorado	ProDUR alert systems edits are in place when concomitant opioid and benzodiazepine claims are submitted. Automated retrospective review of claims history identifies long-term use of either an opioid or benzodiazepine medication, and subsequent claims submitted for the respective concomitant medication will then deny for PA required. Retrospective DUR is also conducted and letters are sent to providers regarding member concomitant use of these medications.
Connecticut	RDUR criteria is designed to target recipients who receive any benzodiazepine (30-day supply in 90 days) concurrently with any opioid (30-day supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
Delaware	**Prior authorization for all opiates can only be approved if the member is not receiving a concurrent benzodiazepine. In addition, providers are notified retroactively via a provider letter when the drug-drug interaction alert flags for one of their patients for opioid-benzodiazepine combinations.
District of Columbia	Claims review process includes monthly reports to identify trends on concomitant use of benzodiazepines and opioids. DUE edits includes: BENZODIAZEPINES/OPIOIDS (COUGH AND COLD) , BENZODIAZEPINES/OPIOIDS (IMMEDIATE RELEASE) , BENZODIAZEPINES/OPIOIDS (EXTENDED RELEASE) , LEVOMETHADONE; METHADONE FOR MAT/BENZODIAZEPINES. Lock-in review process includes MTM and providers education. Interested providers are referred to pain specialists for consultation on a particular beneficiary's treatment plan.
Florida	The DUR Board voted for the hard edit to start with benzodiazepine treatment naive recipients. Treatment naive is defined by the recipient having no paid claims for a benzodiazepine in the prior 60 days. An additional 2 month soft edit is provided for benzodiazepine treatment experienced recipients with Point of Sale (POS) messaging that the third fill of concomitant therapy will deny for a prior authorization. The prior authorization is required for the benzodiazepine only. The hard edit excludes seizure, cancer, sickle cell and Long Term Care Facility (LTCF) recipients. The hard edit only includes long acting opiates to allow for acute treatment of pain with short acting opiates.
Georgia	Members filling opioid and benzos will trigger POS message that this combination is not recommended. See RDUR section previously for more details on retrospective claims
Hawaii	All opioids concurrently prescribed with benzodiazepines are reviewed once a year. No occurrence was identified within the current covered population.
Idaho	FDB ProDUR edits and RetroDUR reviews.
Illinois	HFS instituted a drug interaction edit that requires prior authorization if a participant is taking an opioid and tries to fill a benzodiazepine or if a participant who is taking a benzodiazepine tries to fill an opioid prescription. Prescriber must provide medical justification for concomitant therapy. Prescribers are reminded of the FDA black box warning regarding potentially fatal respiratory depression with concomitant use and encouraged to consider tapering of one of the agents and/or prescribing naloxone since the patient is at higher risk for potentially fatal respiratory depression. Benzodiazepine taper regimens and

State	Explanations
	recommendations from the VA, Pennsylvania and city of New York are posted on the DUR Board Education Webpage for prescribers. Prescribers are encouraged to prescribe first-line SSRI-SNRI for participants noted to be treated with benzodiazepine monotherapy. Opioids if approved in patients taking chronic benzodiazepine therapy are subject to current opioid edits.
Indiana	Claims are reviewed annually for concurrent utilization. In addition, prior authorization with prescriber attestation is required for concurrent use in new starts. Prior authorization requires diagnosis(es) and previously trialed therapies. If duplication is absolutely necessary, the minimum effective dose for the shortest duration of time is utilized in the PA review.
Iowa	Soft edits are in place, messaging pharmacies. Additionally, a retrospective report is generated identifying members with concurrent use of an opioid and benzodiazepine and reviewed.
Kansas	We have all required federal edits and additional state edits at the Point of Sale, which were in place within this FFY time frame. This includes an RDUR reporting process.
Kentucky	An NCPDP 88 ProDUR denial will present when there are overlapping days' supply of an opioid and a benzodiazepine. Prior authorization is required.
Louisiana	POS edit. Pharmacy claims for an opioid will deny if there is an active claim on the beneficiary's profile for a benzodiazepine, and for a benzodiazepine if there is an active claim on the profile for an opioid. There are exemptions for certain medical conditions. Retrospective review. 66 interventions were mailed to prescribers regarding beneficiaries who had concurrent prescriptions for opioids and benzodiazepines in FFY20. The retrospective intervention provides a statement to remind prescribers not to abruptly discontinue benzodiazepines.
Maine	ProDUR soft messaging back to the pharmacies and RetroDUR analysis are done
Maryland	The POS system has pay and report messaging on claims to monitor opioids and benzodiazepines when used concurrently since Oct. 1, 2019 as part of the SUPPORT ACT (HR-6) mandates. HID has RDUR claims review criteria to identify and monitor opioids and benzodiazepines in both populations, Fee-for-Service (FFS) and MCOs since Oct. 1, 2019. as part of the SUPPORT ACT (HR-6) mandates. Since antipsychotics and benzodiazepines are carved out of the MCO benefit and paid FFS, this program covers all Medicaid beneficiaries.
Massachusetts	All benzodiazepines (with the exception of clobazam, diazepam rectal gel, diazepam nasal spray, midazolam nasal spray and injectable products) require prior authorization if use concomitantly with an opioid for 60 out if the past 90 days under the Concomitant Opioid and Benzodiazepine Initiative. A taper plan for either the benzodiazepine or opioid is required for prior authorization approval.
Michigan	Concurrent utilization reports of opioids and benzodiazepines are reviewed regularly. In addition, our WholeHealthRx program performs academic detailing outreach to prescribers of members taking opioids in doses greater than or equal to 90 MME concurrently with benzodiazepines.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. DHS can elect to choose a population-based intervention with this criteria
Mississippi	When we initiated hard edits for such concurrent utilization, we discontinued the automated retrospective claims reviews. We are in the process of developing a system to monitor for opioid prescription exceptions.
Missouri	We have a retrospective interventions to monitor concurrent use of opioids and benzodiazepines. This intervention evaluates the use of opioids and benzodiazepines concurrently for an extended duration. Patients with current opioid claims for the past 60

State	Explanations
	days and 30 days of overlapping benzodiazepines are identified, and their providers receive educational materials. We also send drug-drug interactions between benzodiazepines and opioids from FDB to the pharmacy for review at POS along with a POS edit to monitor concurrent utilization of benzodiazepines and opioids.
Montana	We prospectively limit benzodiazepines when used with methadone. We retrospectively outreach to providers who prescribe benzodiazepine and/or opioids to members who receive both.
Nebraska	Drug-drug alert sent with each fill.
Nevada	ProDUR edits are in place to warn of combination of opioids and benzodiazepines. The RetroDUR program includes initiatives to address the combination of opioids and benzodiazepines.
New Hampshire	POS edits will deny overlapping claims for benzodiazepines and long-acting opioid with a warning message requesting DUR review. The pharmacist provider may override the denial using specific intervention, professional service codes and outcome/result of service codes for the first 2 consecutive months. On the third fill of both benzodiazepine and long-acting opioid, the benzodiazepine claim will deny for prior authorization required. Patients with long term care indicators are excluded from these series of edits in addition to patients with cancer, sickle cell disease, or seizure diagnosis in claims history over the last 2 years.
New Jersey	POS safety edits are in place including, but not limited to, drug conflicts with concurrent use of opioids and benzodiazepines. Based on routine, ad hoc reporting, the State performs monthly retrospective reviews. This encompasses an outreach to the prescriber to determine medical necessity, as well as alert the prescriber of the potential complications with continued concurrent use with opioids. Based on the information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	NY Medicaid put into place a POS edit requiring prior authorization for claims submitted with concurrent use of opioids and benzodiazepines. Claims of concurrent use of these agents are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo as ad hoc presentations to the DUR Board. The DUR Board, after reviewing the utilization data from the reports, will determine the course of action.
North Carolina	NC has an edit for concurrent use of opioids and benzodiazepines. NC also does retrospective DUR reviews of concurrent use.
North Dakota	Later
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with a benzodiazepine. The pharmacist is able to override this edit using clinical judgment. Additionally, we performed a RetroDUR intervention for members who were taking an opioid with a benzodiazepine.
Oklahoma	ProDUR edits are in place at the point-of-sale (POS) for concurrent use of opioids and benzodiazepines to alert the pharmacist to review; this ProDUR edit does not currently require prior authorization.
Oregon	Several programs monitor concurrent opioids and benzodiazepines. First, prior authorization is required for chronic concurrent therapy. Whenever a benzodiazepine or opioid is denied for prior authorization a manual review is performed to assess for concurrent use. All long-acting opioids require prior authorization, short-acting opioids require prior authorization when exceeding quantity (90 MME/day) or days' supply limits of 7 days, and benzodiazepines require prior authorization when exceeding 30 days supply every 120 days. Second, 2 retrospective review programs assess concurrent benzodiazepine and opioid use. In the first retroDUR program, patients are included based on the following criteria: Patients currently enrolled in fee-for-service [FFS] Medicaid AND Patients prescribed both an opioid and another

State	Explanations
	sedating medication (as defined above) within the past 120 days AND meeting at least one of the following characteristics: 1) Patients with prescriptions for opioids and sedatives which overlap by at least 7 days written by more than one provider OR 2) Patients with prescriptions for opioids and sedatives from 3 or more unique providers in the past 120 days OR 3) Members with a history of sedative poisoning or adverse events within the past 2 years Patients are exclude if they meet any of the following criteria: 1) Patients not currently enrolled in Medicaid 2) Patients who have been had a letter sent within the past 3 months 3) Providers who have been messaged for the same patient within the past 12 months In this program, patients are identified weekly and the prescriber of the most recent sedative or opioid will receive the letter. A second RetroDUR Program for High-Risk Opioid Patients (described elsewhere in the report) also identifies patients prescribed concurrent opioids and benzodiazepines for quarterly review.
Pennsylvania	Prior authorization is required on all opioids and concurrent use with benzodiazepines is evaluated during the medical necessity review. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	This RDUR criteria is designed to target recipients who receive any benzodiazepine (30-day supply in 90 days) concurrently with any opioid (30-day supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications/diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
South Carolina	POS edits identify concomitant therapy - Pharmacies may override duplication of therapy edits/clinical discretion SC requires prescribers review PDMP prior to prescribing opioids. F) A pharmacist or practitioner does not have a duty and must not be held liable in damages to any person in any civil or derivative criminal or administrative action for injury, death, or loss to person or property on the basis that the pharmacist or practitioner did or did not seek or obtain information from the prescription monitoring program. A pharmacist or practitioner acting in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting or receiving information from the

State	Explanations
	prescription monitoring program. https://scdhec.gov/sites/default/files/media/document/PMPLaw_0.pdf Timely Information for Providers in South Carolina (tipSC) SCDHHS has engaged in an aggressive provider education campaign to promote opioid risk reduction strategies and expand access to MAT, named tipSC. Working with physicians, pharmacists and other experts from the Medical University of South Carolina, tipSC develops and disseminates targeted, practical information to help prescribers make safer prescribing decisions. These educational programs offer continuing education credit for providers. Below are some of the programs/initiatives targeting Opioids/Benzos: Tapering Opioids and/or Benzodiazepines to Reduce Risk of Overdose March 2018 - Issue No. 3: Opioids & Benzodiazepines Just Don't Mix Short-Term Medications to Assist with Opioid Withdrawal Symptoms Healthy Sleep Patient Handout Benzodiazepine Equivalency Table Test your practical understanding of opioid and benzodiazepine tapering in clinical practice https://msp.scdhhs.gov/tipsc/site-page/tipsc-issues
South Dakota	Use of an opioid and benzodiazepine results in a message sent to the pharmacy with the POS adjudication information. The RDUR process reviews all claims for various inappropriate utilization of which use of an opioid and benzo is one combination that is reviewed.
Tennessee	Prior to 2014, Tennessee did not cover BZO for adults. When mandated in 2014, our criteria for approval was so stringent, that we cover around 1% of our enrollees' total use of BZO (found from data from the PDMP). BZO criteria has always included a denial if the enrollee was using opioids. Opioids are not also denied if the enrollee is using BZO, unless the BZO is being prescribed by a mental health provider, per Tennessee's Chronic Opioid (non-cancer) Prescribing Guidelines. We are not allowed as mentioned earlier to use the PDMP data for the purposes of enforcement with individuals, but the retrospective review from the PDMP showed us that we have very little BZO coverage, and even less for BZO and Opioid concomitant usage.
Texas	The POS edit checks for concurrent claims for opioid and benzodiazepine with a 14-day overlap. Rectal diazepam and clobazam will be excluded from the edit. In response to one of the requirements from the Federal Support Act, a retro-DUR review and intervention for Opioid,-Benzodiazepines combination, as well as, Antipsychotic - opioids combination was conducted in April of 2020.
Utah	When a claim for either a long-acting opioid or a benzodiazepine is submitted, the system will look back 45 days to find any paid claims for either benzodiazepines or long-acting opioid. If a paid claim for a benzodiazepine is found, the long-acting claim will reject. Likewise, if a paid claim for a long-acting opioid is found, the benzodiazepine claim will reject.
Vermont	DVHA DUR program currently has a retrospective DUR review process for these drugs combinatons This is also a prospective DUR for drug-drug interaction via Medispan which provides soft messaging back to dispensing pharmacist.
Virginia	As part of the Service Authorization process: the prescriber must enter on the opioid service authorization fax form the patient's last fill date of Benzodiazepine prescription from the

State	Explanations
	prescription monitoring program (PMP). The opioid service authorization fax form then asks: -- If benzodiazepine filled in past 30 days, does the prescriber attest that he/she has counseled the patient on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations? Also we run reports twice a year looking at concurrent use of opioids and benzodiazepines and review/discuss them at the DUR Board Meetings. Also: First Data Bank's ProDUR edits
Washington	Washington Apple Health (Medicaid) has developed a co-prescribing report that allows us to monitor opioids and ten drug classes with psychotropic effects (ADHD, anticonvulsants, antidepressants, antipsychotics, barbiturates, benzodiazepines, gabapentinoid, muscle relaxers, sedative hypnotics, and other psychotropics). The data in the co-prescribing report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	Yes we have both. For POS a warning fired but does not stop a claim from going through. Retrospectively there is a flag which prompts review by the RetroDur Board.
Wisconsin	Wisconsin has developed educational letters to inform prescribers when a member is receiving opioids and benzodiazepines concurrently. The letter discusses the clinical concern as well as recommending consideration of naloxone prescribing. Wisconsin has an additional retrospective educational letter that focuses on prescribers with multiple patients receiving opioids and benzodiazepine concurrently. Prescriber phone calls are conducted when the prescriber continues to remain an outlier.
Wyoming	Concurrent use of an opioid and a benzodiazepine is not allowed. Claims are denied at point of sale. As we do not have access to the PDMP, no retrospective claims review is completed.

If "No," please explain.

Table 158 - Explanations of not Having POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Benzodiazepines Being Used Concurrently

State	Explanations
New Mexico	Development in process for FFY22.

9. Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and sedatives being used concurrently?

Figure 99 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Sedatives Being Used Concurrently

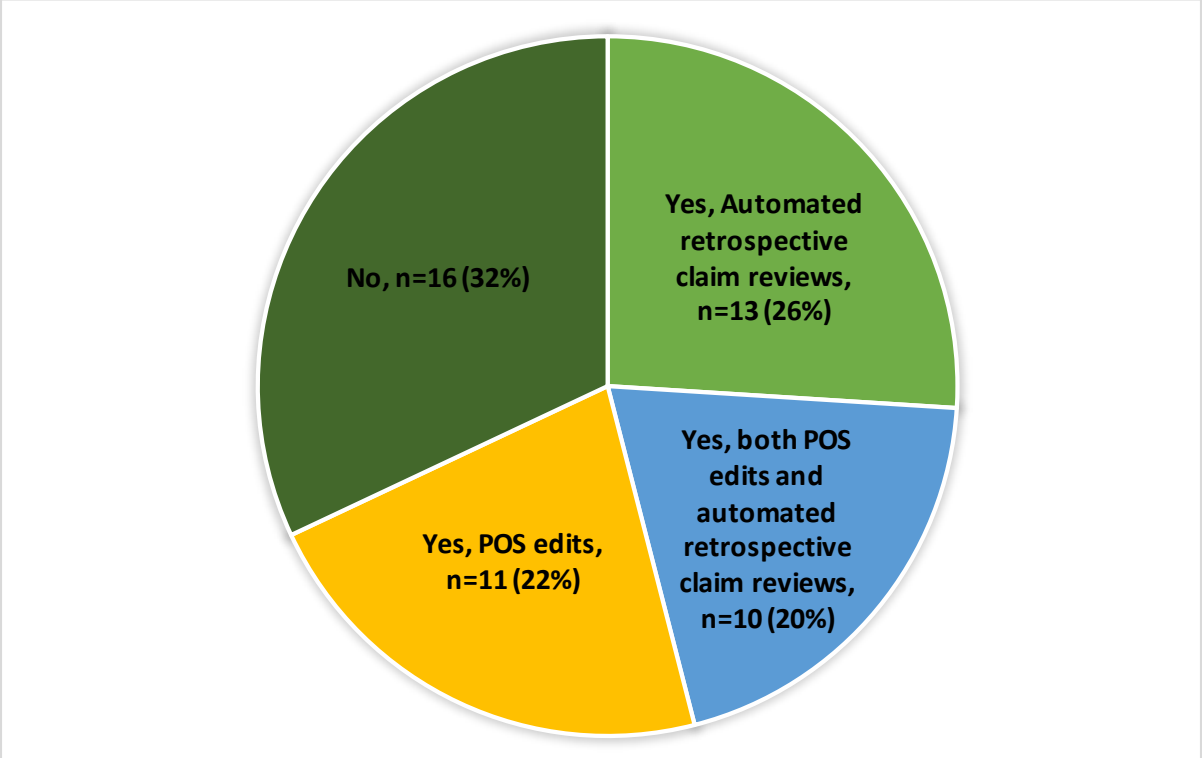

Table 159- POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Sedatives Being Used Concurrently

Response	States	Count	Percentage
Yes, Automated retrospective claim reviews	Alabama, Alaska, Arkansas, Connecticut, Georgia, Hawaii, Louisiana, Maryland, Michigan, New York, Rhode Island, Washington, Wisconsin	13	26.00%
Yes, both POS edits and automated retrospective claim reviews	Delaware, Florida, Idaho, Minnesota, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota	10	20.00%
Yes, POS edits	California, District of Columbia, Maine, Mississippi, Nebraska, Nevada, New Jersey, North Dakota, Vermont, Virginia, West Virginia	11	22.00%
No	Colorado, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Missouri, Montana, New Hampshire, New Mexico, Oklahoma, Tennessee, Texas, Utah, Wyoming	16	32.00%
Total		50	100.00%

Please explain response and detail scope and nature of reviews and edits.

Table 160- Explanations of Scope and Nature of Reviews and Edits for Opioids and Sedatives Being Used Concurrently

State	Explanations
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Reviewed quarterly at the DUR committee meetings.
Arkansas	Currently, there are no POS edits for the concomitant use of opioids and sedatives. Behind the scenes, the RetroDUR vendor is monitoring for concomitant use of opioids and sedatives per the SUPPORT Act. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics.
California	Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties.
Connecticut	RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any sedative/hypnotic (1-day supply in 90 days). During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention periodically.
Delaware	POS alert and retrospective provider notification letters are activated for high and medium severity Drug-Drug interactions between opioid and sedative combinations. High and medium severity combinations were chosen to avoid alert fatigue
District of Columbia	DUE edits include SLEEP DRUGS; TRANQUILIZERS/OPIOIDS, ANTIPSYCHOTICS; PHENOTHIAZINES/OPIOIDS, MUSCLE RELAXANTS/OPIOIDS and others. These edits can be overriden by a pharmacists employing the appropriate PPS codes in the POS system.
Florida	The DUR Board voted to create a hard edit for recipients on concomitant therapy. The edit will start with the Non-BZD sedative treatment naive recipients. Treatment naive is defined by the recipient having no paid claims for Non-BZD in the prior 60 days. An additional 2 month soft edit will be provided for Non-BZD sedative treatment experienced recipients with POS messaging advising the third fill of concomitant therapy will deny for a prior authorization. The prior authorization would be required for the Non-BZD sedative only. The hard edit includes long acting opiates only to allow for acute treatment of pain with short acting opiates. Seizure recipients, cancer/palliative care, Sickle Cell and Long-Term Care Facility (LTCF) recipients are excluded from the hard edit.
Georgia	We have the ability to monitor retrospectively and take action as needed.
Hawaii	All opioids concurrently prescribed with sedatives are reviewed once a year. No occurrence was identified within the current covered population.
Idaho	FDB ProDUR edits and RetroDUR reviews.
Louisiana	Retrospective review. 13 interventions were mailed to prescribers regarding beneficiaries who had concurrent prescriptions for opioids and sedatives in FFY20.
Maine	ProDUR messaging is sent to the Pharmacies during the adjudication of the claims

State	Explanations
Maryland	RDUR vendor, HID LLC., a KEPRO company, has criteria which they monitor on an ongoing basis.
Michigan	Routine utilization reviews are performed to look at concurrent use of opioids and all potentiators which includes sedatives.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. DHS can elect to choose a population-based intervention with this criteria
Mississippi	When we initiated hard edits for such concurrent utilization, we discontinued the automated retrospective claims reviews. We are in the process of developing a system to monitor for opioid prescription exceptions.
Nebraska	Drug-drug alert sent with each fill.
Nevada	ProDUR edits are in place to warn of the combination of opioids and sedatives being used concurrently.
New Jersey	POS safety edits are in place including, but not limited to, drug conflicts with concurrent use of opioids and sedatives. Based on routine, ad hoc reporting, the State performs monthly retrospective reviews. This encompasses an outreach to the prescriber to determine medical necessity, as well as alert the prescriber of the potential complications with continued concurrent use with opioids. Based on the information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	A POS drug to drug interaction warning will alert pharmacists of concurrent use of sedatives and opioids on a patient. These claims are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo as ad hoc presentations to the DUR Board. The DUR Board, after reviewing the utilization data from the reports, will determine the course of action.
North Carolina	NC has an edit for concurrent use of opioids and benzodiazepines. NC also does retrospective DUR reviews of concurrent use.
North Dakota	Later
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with a sedative. In the past, we have performed a RetroDUR intervention for members who were taking an opioid with a benzodiazepine and sedative hypnotic. Also, these medications are reviewed in our Coordinated Services Program.
Oregon	Same as above for RetroDUR PA is required for concurrent chronic therapy. PA is required if exceeding quantity limits for more that 15 days of sedative every 30 days and more than 7 days of SAOs
Pennsylvania	Prior authorization is required on all opioids and concurrent use with sedatives is evaluated during the medical necessity review. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	RDUR criteria was implemented during FFY 2020
South Carolina	POS edits identify concomitant therapy - Pharmacies may override duplication of therapy edits/clinical discretion. SC requires prescribers review PDMP prior to prescribing opioids.
South Dakota	These edits are present in the POS as real time edits and in the RDUR system.
Vermont	This is also a prospective DUR for drug-drug interaction via Medispan which provides soft messaging back to dispensing pharmacist.
Virginia	First Data Bank's ProDUR edits
Washington	Washington Apple Health (Medicaid) has developed a co-prescribing report that allows us to monitor opioids and ten drug classes with psychotropic effects (ADHD, anticonvulsants,

State	Explanations
	antidepressants, antipsychotics, barbiturates, benzodiazepines, gabapentinoid, muscle relaxers, sedative hypnotics, and other psychotropics). The data in the co-prescribing report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	At the POS level there is a SEV 2 which can be overridden at the retail level. There is no retrospective review for this currently.
Wisconsin	Wisconsin has developed educational letters to inform prescribers when a member is receiving opioids and benzodiazepines concurrently. A number of sedatives are benzodiazepines. Wisconsin also has developed educational letters to inform prescribers when a member is receiving multiple CNS depressants (opioids, benzodiazepines, skeletal muscle relaxants and sedative hypnotics).

If "No," please explain.

Table 161- Explanations of not Having POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Sedatives Being Used Concurrently

State	Explanations
Colorado	There are no edits in place for opioids and sedatives at this time.
Illinois	No current POS edits address concomitant sedative and opioid therapy. Fee-for-Service only allows 8 sedative units per month. The automated retrospective process to date selects 300 patients based on Medispan criteria, not just sedatives and opioids.
Indiana	The current focus is around concurrent opioid and benzodiazepine utilization. OMPP continues to review edits for opioids and the potential for edits around other sedatives.
Iowa	Will be a future DUR meeting topic for discussion and consideration of appropriate initiatives.
Kansas	We have not formally addressed this combination during the time of the FFY 2020. However, our Opioid Products for Pain Management PA has the following provider education language: - Provider attests to limiting and avoiding where possible the concurrent use of CNS depressants, especially benzodiazepines, when prescribing opioids. - Before starting & periodically, an evaluation of risk factors for opioid related harms should be done. - Prescriber must attest to reviewing KTRACS prior to writing every new opioid prescription There is a policy in place requiring POS edits and RDUR for concurrent use of opioids and sedatives, effective during FFY 2021.
Kentucky	These types of issues are addressed with RetroDUR lettering campaigns.
Massachusetts	Hypnotic benzodiazepines are included in the Concomitant Opioid and Benzodiazepine Initiave.
Missouri	MO HealthNet does not currently have anything in place.

State	Explanations
Montana	Currently we are only doing provider outreach for members receiving opioids and benzodiazepines or sedating antipsychotics. No other sedatives are being monitored for use with opioids.
New Hampshire	A POS edit to begin denying overlapping claims at point of sale (POS) for Sedative Hypnotics and Opioid therapy (excluding acute therapy), as a hard edit, Prior Authorization (PA) required, when the recipient is Sedative Hypnotic/ Opioid treatment naive is in the process of being implemented. If the recipient is Sedative Hypnotic/Opioid experienced the edit will allow an additional two-month soft edit, which allows pharmacist to enter appropriate DUR codes via POS with messaging. The third fill of concomitant therapy will deny for a hard edit, PA required. Please note that the prior authorization logic will impact Sedative Hypnotic therapy only.
New Mexico	A quarterly retrospective report is in progress for state review
Oklahoma	We did not have edits in place or automated retrospective claims review to monitor opioids and sedatives being used concurrently during this federal fiscal year.
Tennessee	Retrospective reviews only. We are not aware of a standard ProDUR edit addressing the concomitant use of opioids and sedatives (we are having to assume that "sedatives" could be referring to hypnotic drugs, carisoprodol, and other CNS depressants). We do address this issue in retrospective reviews of controlled substance prescribing of practitioners in an algorithm that takes into account not only opioids + BZO, but also opioids + carisoprodol, opioids + stimulants, opioids + hypnotics and combinations of these, for example the "Trinity" of opioids + BZO + carisoprodol.
Texas	The program uses a POS edit to deny sedative claim to those with substance use disorder diagnosis but it does not deny concurrent use of opioid - sedatives if diagnosis of SUD is not found. for the FFY 2020, retrospective claims review for combination of opioids and sedatives was not conducted.
Utah	Might implement in the future.
Wyoming	Retrospective review is completed, however, the process is not automated.

10. Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and antipsychotics being used concurrently?

Figure 100 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

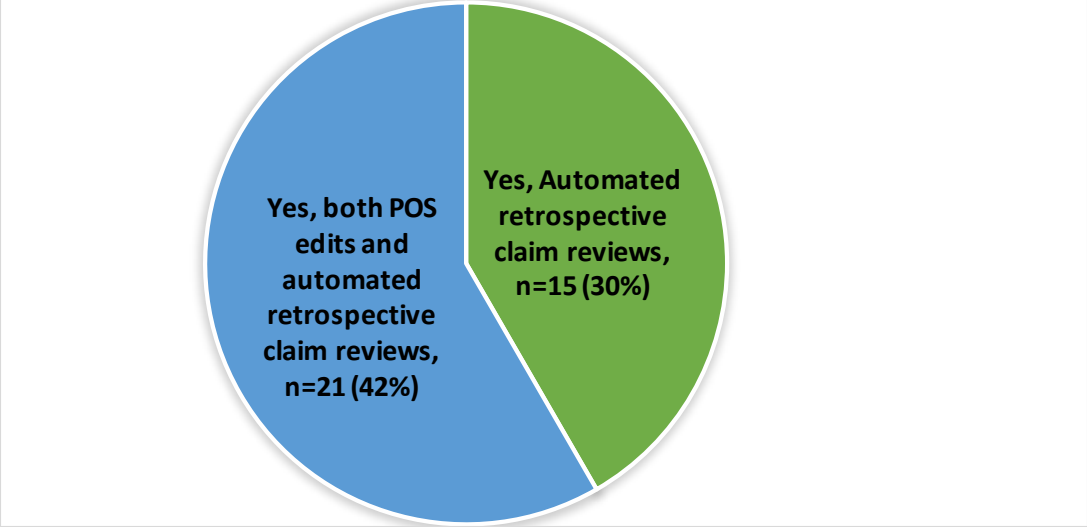

Table 162- POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States	Count	Percentage
Yes, Automated retrospective claim reviews	Alabama, Arkansas, Hawaii, Idaho, Louisiana, Michigan, Montana, Oregon, Pennsylvania, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming	15	30.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, California, Connecticut, Delaware, Florida, Indiana, Iowa, Maryland, Minnesota, Mississippi, Missouri, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia	21	42.00%
Yes, POS edits	Colorado, District of Columbia, Georgia, Illinois, Kansas, Massachusetts, Nebraska, Nevada, New Jersey, North Dakota	10	20.00%
No	Kentucky, Maine, New Mexico, Tennessee	4	8.00%
Total		50	100.00%

Please explain in detail scope and nature of reviews and edits.

Table 163 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Antipsychotics Being Used Concurrently

State	Explanations
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Point-of-Sale overrides are available when the pharmacist contacts the prescriber to discuss potential interactions. A report with concurrent use is reviewed by the DUR committee.
Arkansas	Currently, there are no POS edits for the concomitant use of opioids and antipsychotics. Behind the scenes, the RetroDUR vendor is monitoring for concomitant use of opioids and antipsychotics per the SUPPORT Act. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics. Additionally, the State receives monthly reports on antipsychotic usage.
California	Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties. In addition, the total number of Medi-Cal FFS beneficiaries with concomitant use of opioids and antipsychotics during each calendar month has been tracked retrospectively each calendar month since October 1, 2019.
Colorado	Due to the risk of increased sedation with concomitant use, pharmacy claims for members receiving an opioid and quetiapine in combination require entry of POS DUR service codes (Reason for Service, Professional Service, Result of Service) in order to override an opioid-quetiapine drug-drug interaction.
Connecticut	RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any antipsychotic (30 days' supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this

State	Explanations
	intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
Delaware	POS alert and retrospective provider notification letters are activated for high and medium severity Drug-Drug interactions between opioid and antipsychotic combinations. High and medium severity combinations were chosen to avoid alert fatigue
District of Columbia	Although is not automated, claims review process includes monthly reports to identify trends on concomitant use of antipsychotics and opioids. Reported DUE edits include: ANTICHOLINERGICS/SELECT ANTIPSYCHOTICS;SELECT PHENOTHIAZINES, SELECTED ANTIPSYCHOTICS;/TRAMADOL (IR), ANTIPSYCHOTICS; PHENOTHIAZINES/OPIOIDS, SELECTED ANTIPSYCHOTICS THAT PROLONG QT intervals
Florida	In response to the SUPPORT Act, the Agency proceeded with deployment of a soft edit for individuals prescribed opioids and antipsychotics concomitantly. The pharmacist has the capability to enter approved DUR intervention codes to allow claim payment. The edit excludes cancer, sickle cell, and LTCF recipients. The DUR Board reviews the impact of the edit yearly.
Georgia	Member filling an opioid and antipsychotic will trigger POS message "Antipsych + Opioid- monitor use".
Hawaii	All opioids concurrently prescribed with antipsychotics are reviewed once a year. No occurrence was identified within the current covered population.
Idaho	The DUR Board has an annual review that includes * the number of beneficiaries receiving both drug classes concurrently * number of days of combination therapy * number of pediatric vs adult patients * drugs from both classes with highest incidence in combination use * evaluation of whether the same or different prescribers are prescribing component of combinations An Educational Letter with response request is sent to both the prescriber and dispensing pharmacy.
Illinois	An informational (soft) drug interaction edit is in place for concomitant antipsychotic and opioid therapy.
Indiana	Claims for concurrent opioids and antipsychotics prompt a message to pharmacies notifying them of the concurrent utilization. Reports are reviewed annually of claims with concurrent utilization.
Iowa	Soft edits are in place, messaging pharmacies. Additionally, a retrospective report is generated identifying members with concurrent use of an opioid and antipsychotic and reviewed.
Kansas	We have all required federal edits and additional state edits at the Point of Sale, which were in place within this FFY time frame. This includes an RDUR reporting process.
Louisiana	Retrospective reviews. 130 interventions were mailed to prescribers regarding beneficiaries who had concurrent prescriptions for opioids and antipsychotic agents in FFY20.
Maryland	The POS system has pay and report messaging on claims to monitor opioids and antipsychotics when used concurrently since Oct. 1, 2019 as part of the SUPPORT ACT (HR-6) mandates. HID has RDUR claims review criteria to identify and monitor opioids and antipsychotics in both populations, Fee-for-Service (FFS) and MCOs since Oct. 1, 2019. as part of the SUPPORT ACT (HR-6) mandates. Since antipsychotics and benzodiazepines are carved out of the MCO benefit and paid FFS, this program covers all Medicaid beneficiaries.
Massachusetts	HR6 coding is in place to capture opioids and antipsychotics being used concurrently when there are paid claims for at least 60 days of concurrent therapy out of the last 90 days of an opioid agent with an antipsychotic agent.
Michigan	Concurrent use of opioids and antipsychotics is included in our comprehensive review of opioids each quarter.

State	Explanations
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. DHS can elect to choose a population-based intervention with this criteria
Mississippi	The DUR Board recently reviewed concurrent use of opioids and antipsychotics. As a result of this review, the board approved a retrospective DUR process to monitor such concurrent utilization.
Missouri	Our retrospective intervention, in compliance with the SUPPORT act, identifies all patients with current drug claims for an opioid in the past 30 days and then flags and sends educational material to providers of those patients who are using antipsychotics concurrently for at least 7 of those days. We also send drug-drug interactions between antipsychotics and opioids from FDB to the pharmacy for review at POS along with a POS edit to monitor concurrent utilization of antipsychotics and opioids.
Montana	We are doing educational outreach to providers who are prescribing either an opioid or a sedating antipsychotic for a member who is receiving both. This education details the risks of prescribing multiple sedating medications as well as the increased risk of OUD in patients with other mental health issues
Nebraska	Drug-drug alert sent with each fill.
Nevada	POS claims are edited with ProDUR edits set to warn pharmacists of the combination of opioids and antipsychotics. RetroDUR activities include letters and information to prescribers for the combination of opioids and antipsychotics.
New Hampshire	Concurrent use of opioids and antipsychotics is included in our comprehensive review of opioids each month. A ProDUR drug to drug edit was implemented recommending naloxone for patients receiving an antipsychotic drug and an opioid. This safety ProDUR edit is intended to alert dispensing pharmacists of the risks with concurrent prescribing and dispense naloxone using the state standing order after review with the patient.
New Jersey	POS safety edits are in place including, but not limited to, drug conflicts with concurrent use of opioids and antipsychotics. Based on routine, ad hoc reporting, the State performs monthly retrospective reviews. This encompasses an outreach to the prescriber to determine medical necessity, as well as alert the prescriber of the potential complications with continued concurrent use with opioids. Based on the information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	A POS drug to drug interaction warning will alert pharmacists of concurrent use of antipsychotic agents and opioids on a patient. These claims are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo as ad hoc presentations to the DUR Board. The DUR Board, after reviewing the utilization data from the reports, will determine the course of action. During this period the Board recommended that prior authorization be required when an oral second generation antipsychotic is utilized above the highest MDD according to FDA labeling.
North Carolina	NC has an edit for concurrent use of opioids and antipsychotics. NC also does retrospective DUR reviews of concurrent use.
North Dakota	Later
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with an antipsychotic. In January 2020, the DUR committee reviewed profiles of members taking opioids in combination with antipsychotics.
Oklahoma	ProDUR edits are in place at the point-of-sale (POS) for the concurrent use of opioids and antipsychotics to alert the pharmacist to review; this ProDUR edit does not currently require

State	Explanations
	prior authorization. Retrospective review of claims is performed to identify outliers in regards to concurrent use of opioids and antipsychotics.
Oregon	Same as above for automated RetroDUR identifying claims for concomitant benzos, sedatives, antipsychotics and muscle relaxants
Pennsylvania	Prior authorization is required on all opioids. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	This RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any antipsychotic (30 days' supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
South Carolina	Child's age, Dosage, Indication, Polypharmacy. RetroDUR edits have also been run periodically for potential polypharmacy.
South Dakota	Results in a message to the pharmacist with the adjudication information. The RDUR process reviews all claims for various inappropriate utilization of which use of an opioid and antipsychotic is one combination that is reviewed.
Texas	A retrospective intervention is performed annually which monitors for concurrent use of opioids and antipsychotics.
Utah	Retrospective queries are performed evaluating for the chronic use of opioid (>30 days) with antipsychotics. Provider outreach is made for identified patients who are prescribed both an opioid and an antipsychotic to 1) Educate on the increased sedative effect of using both together 2) Identify non-adherence to the antipsychotic.
Vermont	DVHA DUR program currently has a retrospective DUR process for these drugs during FFY 2020 Pro DUR edit was added 1/13/21. A claim submitted for drugs tagged as ANTI_PSYCH will trigger a DUR soft message if the claim overlaps with a current active RX for any product tagged OPIOID and a claim submitted for drugs tagged as OPIOID will trigger a DUR soft message if the claim overlaps with a current active RX for any product tagged ANTI_PSYCH.
Virginia	DMAS has a new ProDUR edit that soft messages the pharmacy when concurrent opioid and antipsychotic therapy are being used and mentions to offer naloxone. There are also several FDB ProDUR edits looking at opioids and antipsychotics concurrently. DMAS also runs a report twice a year to monitor opioids and antipsychotics being used concurrently and gets reviewed/discussed at the DUR Board Meetings.
Washington	Washington Apple Health (Medicaid) has developed a co-prescribing report that allows us to monitor opioids and ten drug classes with psychotropic effects (ADHD, anticonvulsants, antidepressants, antipsychotics, barbiturates, benzodiazepines, gabapentinoid, muscle relaxers, sedative hypnotics, and other psychotropics). The data in the co-prescribing report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares

State	Explanations
	their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	At the POS level there is a SEV 2 which can be overridden at the retail level. There is no retrospective review for this currently. However, we are in the process of developing this to flag in order to allow for review by the RetroDUR board.
Wisconsin	Wisconsin performs retrospective review of concurrent utilization of opioids and antipsychotics on an ongoing basis.
Wyoming	Claims are reviewed on a quarterly basis and intervention letters are sent to the mental health provider.

If "No," please explain.

Table 164 - Explanations of not Having POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

State	Explanations
Kentucky	These types of issues are addressed with RetroDUR lettering campaigns. Effective July 1, 2021, pharmacists will be notified at the POS when a claim is submitted for an opioid or antipsychotic if there is a claim for an opioid or antipsychotic in history.
Maine	Soon to be implemented, as COVID-19 requirements delayed implementation. Finalizing the testing of the new edit and will be implemented in the coming weeks.
New Mexico	Development is in process for FFY22.
Tennessee	Retrospective Reviews only. Not aware of a standard POS ProDUR edit yet for concurrent use of opioids and antipsychotics (APsy). We did present a retrospective study to the DUR Board in March of 2019 where we looked at the types of prescribers who were prescribing the antipsychotic to those adult enrollees who were also chronic opioid users. Our main focus during the review was the possibility of the APsy being prescribed by a practitioner not in the same practice as the opioid prescriber, and not knowing about the opioid, as the APsy prescriber would not be legally bound to check the PDMP prior to writing for an APsy. We did not find significant results about any specific provider type or practice type, and found that polypharmacy was existing in all types. We did find that 7.22% of all adult chronic APsy users were also found to be concomitant chronic opioid users. We plan to follow up with looking specifically at quetiapine, also by looking at children under 21. We have also instituted recently in FFY21 (for next year's annual report) a minimum of 200 retrospective chart reviews per month. which will be 1/4th of our DUR Vendor's standard requirement of 800 chart reviews per month, dedicated to concomitant opioids and antipsychotics, with concentration on quetiapine, especially when not prescribed by a mental health provider, or if prescribed by the same provider that is prescribing the opioid.

11. Does your state have POS safety edits or perform automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

Figure 101 - POS Safety Edits or Perform RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

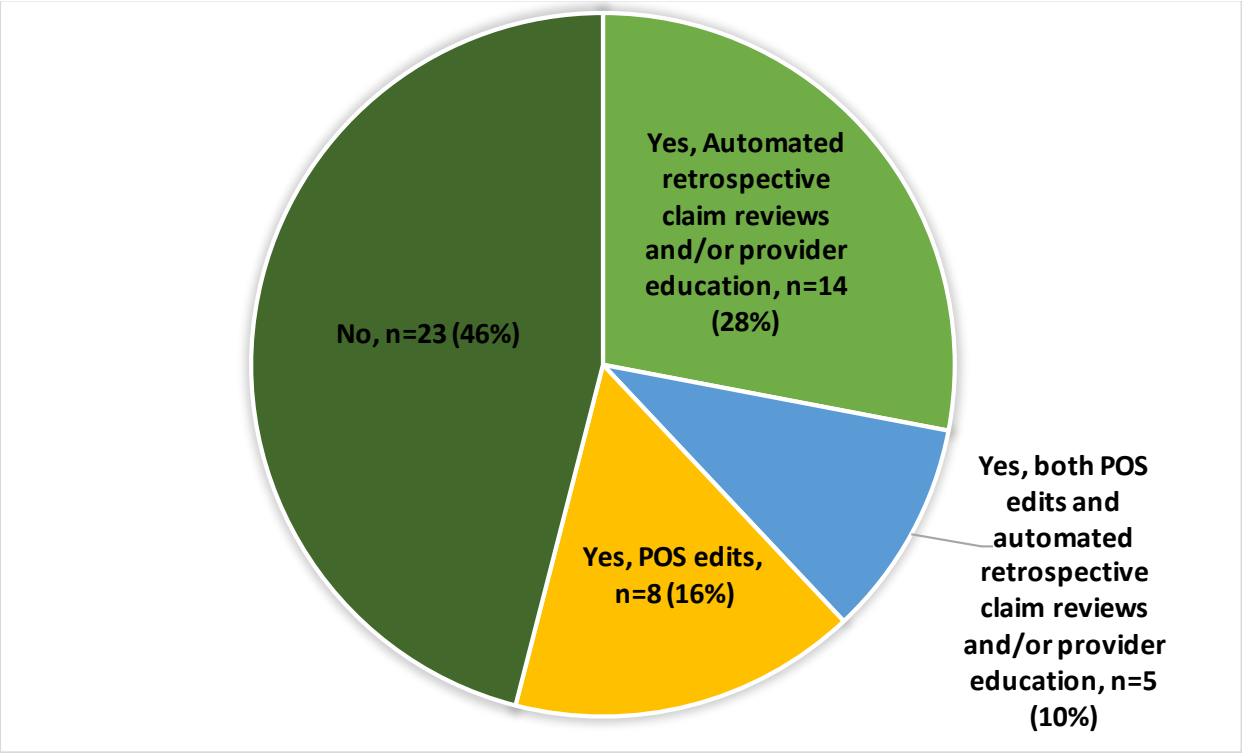

Table 165 - POS Safety Edits or Perform RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Yes, Automated retrospective claim reviews and/or provider education	California, Connecticut, Hawaii, Idaho, Maine, Michigan, Mississippi, Pennsylvania, Rhode Island, South Dakota, Virginia, Washington, West Virginia, Wisconsin	14	28.00%
Yes, both POS edits and automated retrospective claim reviews and/or provider education	Florida, Montana, New Jersey, New York, Ohio	5	10.00%
Yes, POS edits	Arkansas, District of Columbia, Maryland, New Mexico, North Dakota, South Carolina, Tennessee, Texas	8	16.00%
No	Alabama, Alaska, Colorado, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, Oklahoma, Oregon, Utah, Vermont, Wyoming	23	46.00%
Total		50	100.00%

If "Yes, Automated retrospective claims reviews and/or "provider education," please indicate how often.

Figure 102 – How often Retrospective Reviews are Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

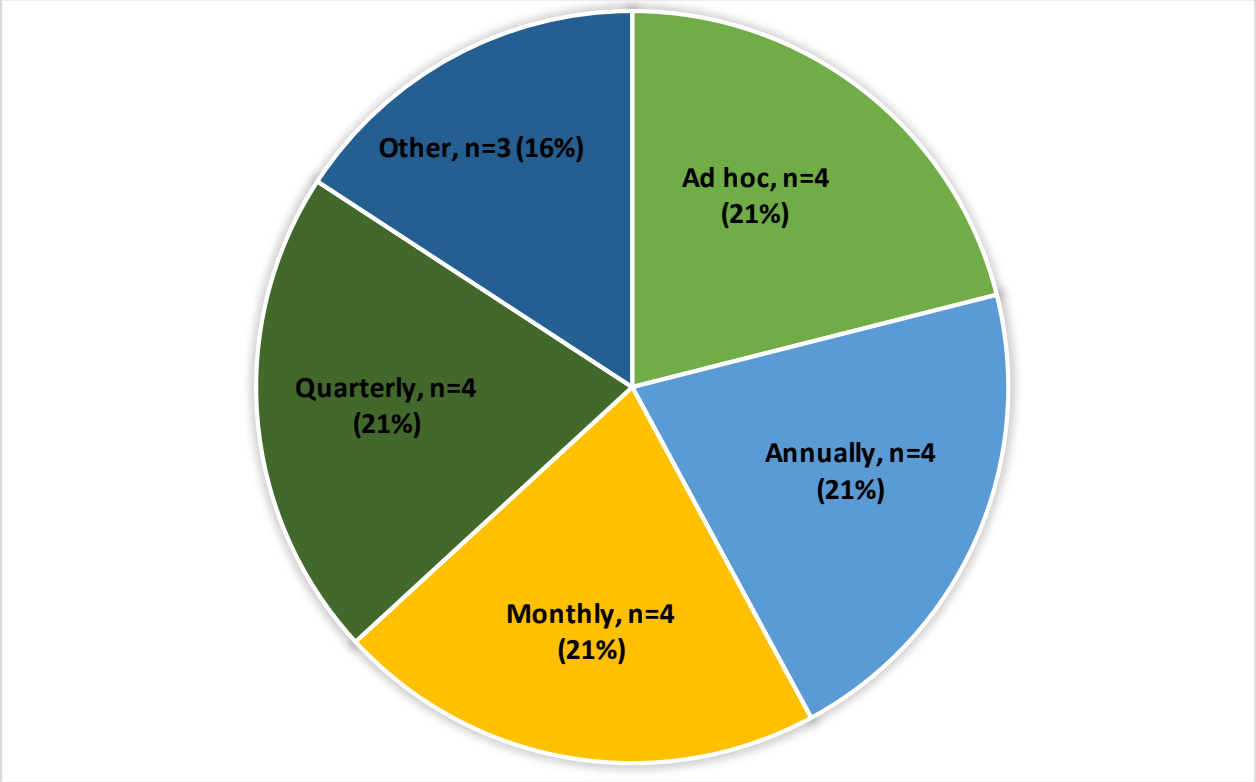

Table 166 - How often Retrospective Reviews are Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Ad hoc	Idaho, Michigan, New Jersey, New York	4	21.05%
Annually	Connecticut, Hawaii, Maine, Rhode Island	4	21.05%
Monthly	Pennsylvania, South Dakota, West Virginia, Wisconsin	4	21.05%
Quarterly	Florida, Mississippi, Ohio, Virginia	4	21.05%
Other	California, Montana, Washington	3	15.79%
Total		19	100.00%

If "Other," please specify.

Table 167 - Explanations of How often Retrospective Reviews are Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

State	Explanations
California	Retrospective reviews of beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis are performed annually and on an ad-hoc basis.
Montana	Prior authorization is required for MAT and for any opioid for a member with a history of OUD. We review the member history and discuss/educate provider each time a member with a history of opioid use disorder receives a prescription for an opioid.
Washington	Quarterly and Ad Hoc.

Please explain nature and scope of edits, reviews and/or provider education reviews performed.

Table 168 - Explanations of Nature and Scope of Edits, Reviews and/or Provider Education Reviews Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

State	Explanations
California	For FFY 2020, provider education efforts included sending educational outreach letters to all prescribers of: 1) at least one paid claim for an opioid prescribed concomitantly with at least one paid claim of gabapentin and 2) at least one paid claim for an opioid prescribed concomitantly with at least one paid claim for a benzodiazepine and two additional CNS depressant medications. Patient profiles were included for both mailings that contained all outpatient office visits, emergency department visits, and inpatient hospitalizations where a diagnosis of opioid use disorder and/or opioid poisoning was indicated.
Connecticut	RDUR criteria is designed to target recipients who receive any controlled substance with a diagnosis of medication related poisoning (including illicit substance poisoning) within the previous 180 period. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them about the poisoning and continued use of controlled substances. Additionally, we perform this review as a targeted intervention annually.
Florida	Opioid prescribing trends and potential fraud and/or abuse will be identified via automated claims review by the DUR Board yearly. Additional topics that will be reviewed include opioid claims utilization, concomitant use of opiates with MAT, claims exceeding the recommended limits, top opioid prescribers, top opioid recipients, average MME, Narcan/naloxone utilization, and overdose data.
Hawaii	This is reviewed once a year. No occurrence was identified within the current covered population.
Idaho	Focused reviews have been done to review the number of patients with OUD diagnoses receiving buprenorphine-based therapy.
Maine	Currently we are not looking at members with opiate poisoning diagnosis with the DUR, this is looked through the Care Management with the ER initiative.
Michigan	Our DUR Board has been monitoring MAT utilization trends each quarter for several years, including review of patient demographics, (e.g. ages, gender, race) to identify disparities along with diagnoses and concurrent utilization. Any concerning utilization trends are reviewed further by our contracted academic detailing pharmacist and additional education is performed to the prescriber for cases where naloxone education may be warranted.

State	Explanations
Mississippi	This information is included in a quarterly retro-DUR report for beneficiaries at high risk for opioid overdose and/or misuse.
Montana	We educate providers prior to paying for buprenorphine products for members they are treating for OUD. This education follows SAMHSA guidelines for MAT prescribing. We also educate providers and discuss member OUD history and treatment plan prior to authorizing opioids for members with OUD.
New Jersey	The State performs a retrospective review. This encompasses an outreach to the prescriber to provide medical necessity as well as alert the prescriber of the potential complications with continued concurrent use with opioid. Based on information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	POS PA's are required for the initiation of opioid therapy on patients receiving established opioid dependence therapy. These claims are retrospectively reviewed monthly by pharmacy academia at the State University of New York at Buffalo. Ad Hoc presentations are provided to the DUR Board which identify clinical issues associated with dual therapy. The DUR Board, after reviewing the utilization data from the reports, will determine the course of action.
Ohio	We have a Coordinated Services Program (CSP) that identifies members with a diagnosis of a history of opioid use disorder or opioid poisoning diagnosis for potential enrollment in the program.
Pennsylvania	The RetroDUR program is used to review beneficiary profiles with a history of OUD.
Rhode Island	This RDUR criteria is designed to target recipients who receive any controlled substance with a diagnosis of medication related poisoning (including illicit substance poisoning) within the previous 180 period. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them about the poisoning and continued use of controlled substances. Additionally, we perform this review as a targeted intervention annually.
South Dakota	This is one criteria reviewed by the RDUR system.
Virginia	We review quarterly, members on chronic opioids and also with high risk activity which includes opioid use disorder and see if they are getting a claim for naloxone as well. We also have lettered prescribers on high risk for an opioid overdose and NO naloxone claims.
Washington	Washington Apple Health (Medicaid) has developed a morphine milligram equivalent (MME) report that allows us to monitor enrollee's opioid MME and if they have a history of opioid use disorder (OUD) or are currently receiving medications used to treat OUD. The data in the MME report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	Reviewed monthly at RetroDUR meetings. It is limited to the Lock-in portion.
Wisconsin	Diagnosis information of opioid use disorder and opioid poisoning are utilized in retrospective profile reviews for lock-in and regular monthly DUR activities.

If "No," does your state plan on implementing automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

Figure 103 – Plans to Implement a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

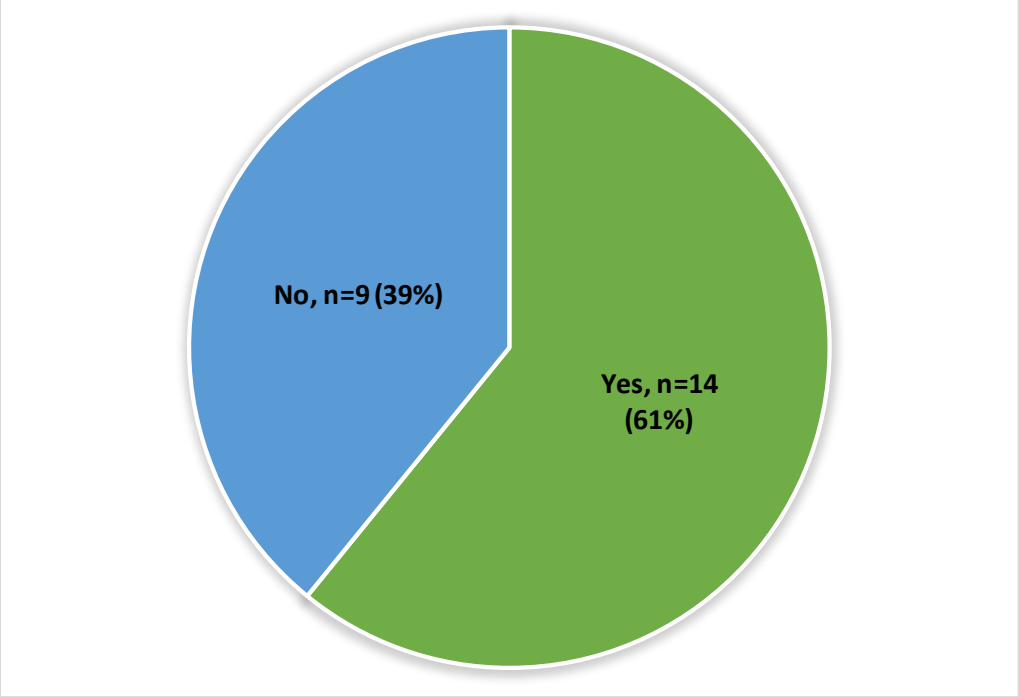

Table 169 - Plans to Implement a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Response	States	Count	Percentage
Yes	Alaska, Colorado, Delaware, Georgia, Illinois, Iowa, Kansas, Nebraska, Nevada, New Hampshire, North Carolina, Oklahoma, Oregon, Utah	14	60.87%
No	Alabama, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Missouri, Vermont, Wyoming	9	39.13%
Total		23	100.00%

If "Yes," when does your state plan on implementing?

Table 170- Plans to Implement a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Explanation	State
Alaska	Alaska Medicaid is exploring data capabilities with our SURS team.
Colorado	Implemented during FFY 2021 (after this reporting period)
Delaware	Continuing collaboration between Department of Public Health (DPH) and Substance Abuse and Mental Health (DSAMH) is ongoing to develop ways of data sharing to assist in identifying

Explanation	State
	patients with a history of Opioid Use Disorder (OUD) with the eventual goal of providing an outreach and intervention alert mechanism for referral to specialized care
Georgia	Planning on implementing in the next year or so.
Illinois	The DUR Board will discuss this topic during FFY21 and recommend next steps.. Further work on an edit will be done in the future once system capabilities identified.
Iowa	FFY 2021
Kansas	This was implemented second quarter CY 2021. Of note, many of the FFS beneficiaries reside in facility settings. The majority of our beneficiaries are provided for under our Managed Care Organizations.
Nebraska	As part of DUR project, will contact provider.
Nevada	Three to five years.
New Hampshire	A RetroDUR program will be developed to address this.
North Carolina	NC will be adding a new claims edit to identify beneficiaries who have a history of OUD or opioid poisoning diagnosis. Implementation projected in the next federal fiscal year.
Oklahoma	We have plans to further evaluate the implementation of point-of-sale (POS) safety edits, automated retrospective claim reviews, and/or provider education in regards to opioid use disorder (OUD) after FFY21 when we implement the new guidelines of HR6 surrounding opioid treatment programs (OTPs).
Oregon	Recently added to our high-risk opioid review program.
Utah	Implementing 2021/2022

If "No," please explain.

Table 171 – Explanation on Implementing a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

State	Explanations
Alabama	n/a
Indiana	RetroDUR disclosures of this nature may violate substance abuse confidentiality regulations 42 CFR Part 2.
Kentucky	We consider diagnosis information when reviewing prior authorization criteria for opioids and/or buprenorphine products.
Louisiana	We are considering provider education to address appropriate treatment of pain disorders for beneficiaries with a diagnosis of opioid use disorder or opioid poisoning in FFY21.
Massachusetts	Ad hoc retrospective reviews including direct outreach to prescribers bi-weekly for members who exceed clinical thresholds.
Minnesota	There is no automated retrospective claim review. However, there are RetroDUR criteria developed around the SUPPORT Act requirements. MN contract requires two SUPPORT Act mailings per year.
Missouri	MO HealthNet currently has safety edits in place for participants actively receiving MAT, this is based on prescription claims instead of diagnosis codes, which may be incomplete.
Vermont	Currently the diagnosis information is not pulled into the POS pharmacy system. At this time there are only preliminary discussions on how to bring this information into the POS system as it would require drastic programming changes.
Wyoming	Data has been reviewed with a small amount of utilization in this population. Data will be monitored regularly.

12. Does your state Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?

Figure 104 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

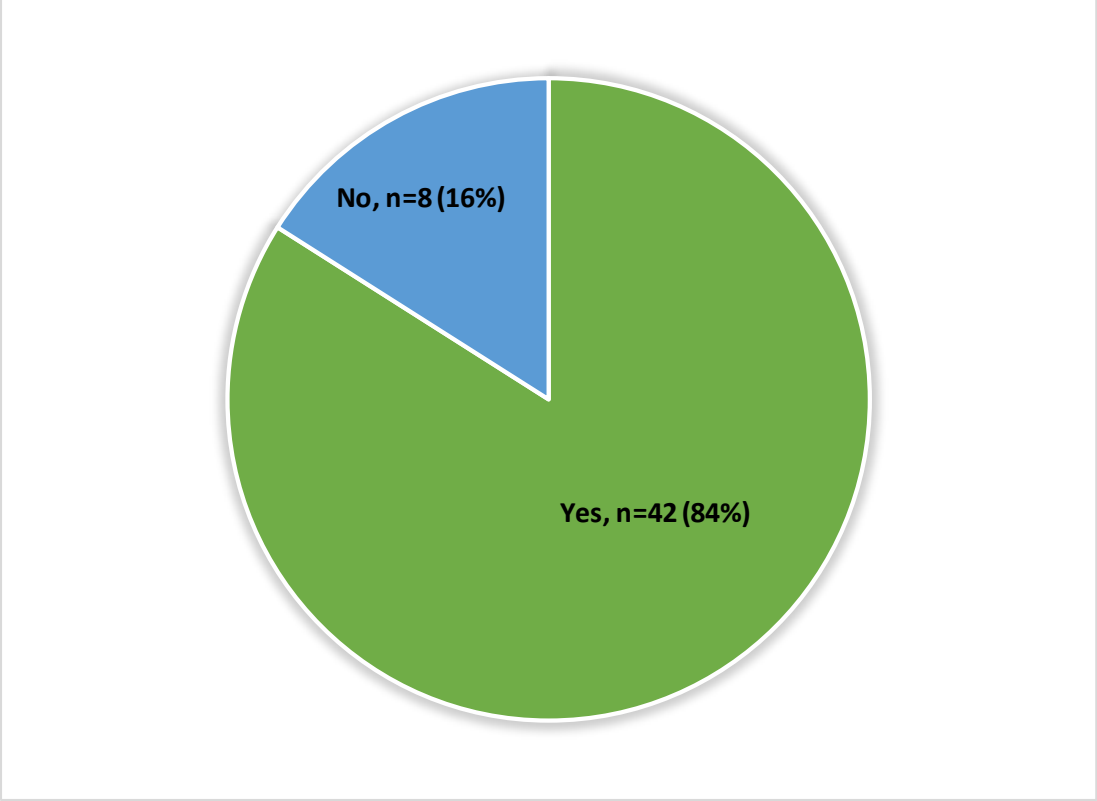

Table 172 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	42	84.00%
No	Louisiana, Maryland, Missouri, Nebraska, New Hampshire, North Dakota, Wisconsin, Wyoming	8	16.00%
Total		50	100.00%

If "Yes," please continue.

Figure 105 - Pain Management / Opioid Prescribing Guidelines Provided

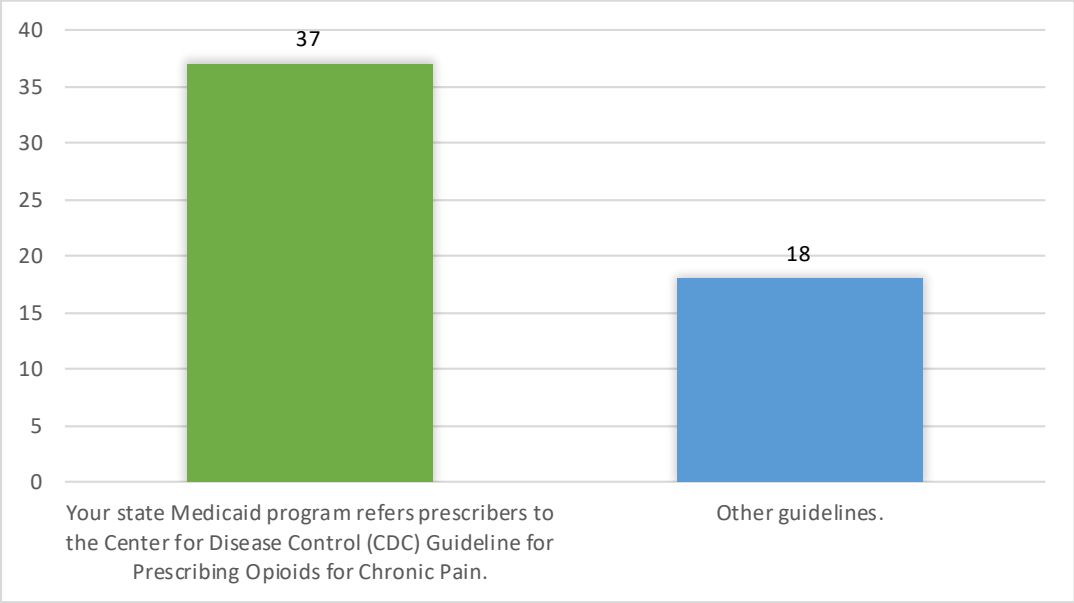

Table 173 - Pain Management / Opioid Prescribing Guidelines Provided

Response	States	Count	Percentage
Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain.	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia	37	67.27%
Other guidelines.	Alabama, Alaska, California, Colorado, Idaho, Illinois, Kansas, Minnesota, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Virginia, Washington, West Virginia	18	32.73%
Total		55	100.00%

If "Other" guidelines, please identify.

Table 174 – "Other" Explanations of Pain Management / Opioid Prescribing Guidelines Provided

State	"Other" Explanations
Alabama	We provide the HHS Guidelines for Reduction and Discontinuation of Opioids on the Agency's website.
Alaska	Washington State AMDG guidelines
California	The Medical Board of California Guidelines for Prescribing Controlled Substances for Pain.
Colorado	Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain, Colorado Dental Board, Colorado Medical Board, State Board of Nursing, and State

State	"Other" Explanations
	Board of Pharmacy, Policy for Prescribing and Dispensing Opioids; State developed policies for opioid use.
Idaho	Appropriate use guidelines are provided on all opioid related PA forms and on the published preferred drug list.
Illinois	HFS uses criteria for opioid use for all long-acting narcotics and for the HFS Pain Management Program for medications that hit for the Four Prescription Policy. As applicable, the prescriber is referred to the DUR Board Education Web page for the following: CDC guideline for prescribing opioids for chronic pain, FDA warnings about concomitant benzodiazepines and narcotics, CDC/Surgeon General recommendations for naloxone use, or Methadone safety: a clinical practice guideline from the American Pain Society and College on problems of drug dependence, in collaboration with the Heart Rhythm Society.
Kansas	Our provider bulletins have CDC Guidelines website links as well as state specific opioid prescribing guidelines, based upon DUR Board approved criteria- https://www.kmap-stateks.us/Documents/Content/Bulletins/18027%20-%20General%20-%20Opioid_2.pdf https://www.kmap-stateks.us/Documents/Content/Bulletins/18101%20-%20General%20-%20Opioid_2.1.pdf https://www.kmap-stateks.us/Documents/Content/Bulletins/18112%20-%20General%20-%20Opioid_2.3.pdf Our Clinical PA has the following guidance for providers, in addition to the PA criteria- GENERAL CRITERIA FOR OPIOID MEDICATION USE- - Prescriber must attest to reviewing K-TRACS prior to writing every new opioid prescription. - Prescriber should calculate total MME per day for concurrent opioid medications. - Initial use of immediate-release opioids is required before use of ER/LA opioids. - Provider attests to limiting and avoiding where possible the concurrent use of CNS depressants, especially benzodiazepines, when prescribing opioids. - Before starting & periodically, an evaluation of risk factors for opioid related harms should be done. - Non-opioid ancillary treatments (e.g., NSAIDs, acetaminophen, antidepressants) and non-pharmacological treatments should be tried first unless contraindicated. - Prescriber has screened patient for depression and substance use disorder. - New dosage forms or strengths to agents listed can be added as they become available. - Drug must not exceed maximum FDA approved dosage. - Physician must consider use of opioids and Neonatal Opioid Withdrawal Syndrome if patient is pregnant.
Minnesota	Minnesota has their own guidelines which are similar to the CDC's Guidelines. https://mn.gov/dhs/opip/opioid-guidelines/
New York	New York State offers licensed prescribers an Opioid Prescribing Training Program available at no charge to prescribers and is accredited for continuing education. The program covers 8 topics required per legislation. New York Medicaid, through its Medicaid Physician Education program (PEP) offers prescriber visits by pharmacy educators on the use of agents for the treatment of chronic non-cancer pain using on-site education programs. Modules are accredited by the Accreditation Council for Continuing Education.
North Carolina	The prescribing clinician shall review the North Carolina Medical Board statement on use of controlled substances for the treatment of pain (https://www.ncmedboard.org/resourcesinformation/professional-resources/laws-rules-positionstatements/ positionstatements/Policy_for_the_use_of_opiates_for_the_treatment_of_pain).

State	"Other" Explanations
Ohio	Ohio Administrative Code Rule 4731-11-13 Prescribing of opiate analgesics for acute pain. Available at: For Prescribers - New Limits on Prescription Opioids for Acute Pain.pdf (ohio.gov). Ohio State Medical Board Overview: Regulations for Chronic and Subacute Opioid Prescriptions. Available at: https://med.ohio.gov/Overview-Regulations-for-Chronic-and-Subacute-Opioid-Prescriptions. Take Charge Ohio Healthcare professionals. Available at: http://www.takechargeohio.org/ Ohio Administrative Code Rule 4731-11-11 Standards and procedures for review of Ohio Automated Rx Reporting System. Located at: https://codes.ohio.gov/ohio-administrative-code/rule-4731-11-11 OARRS guidelines. Available at https://www.ohiopmp.gov/ US Department of Health and Human Services. Available at https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html
Oklahoma	Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting: Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, mental and public health officials, and law enforcement personnel in Oklahoma and throughout the United States. The guidelines are available at http://poison.health.ok.gov.
Oregon	HERC Guidelines: https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Low-Back-Pain-Pharmacologic-Interventions-Final-11-13-14.pdf OHA Opioid task force: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/task-force.aspx HHS Safe Opioid Prescribing: https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html
Pennsylvania	The Department has coordinated with other state agencies to develop Pennsylvania opioid prescribing guidelines to be used by all payers in the state.
South Carolina	MAT Prior Authorization Guidelines SCDHHS, along with the managed care organizations (MCOs) in the South Carolina Medicaid market, provides coverage for all Food and Drug Administration-approved MAT options. MAT coverage criteria are available here. These criteria apply to the fee-for-service Medicaid benefit, as well as to each of the MCOs MBMB# 20-017 May 1, 2020 SCDHHS has engaged in an aggressive campaign of provider education to address the inappropriate use of opioids, named Timely Information for Providers in South Carolina (tipSC). Working with physicians, pharmacists and other experts from the Medical University of South Carolina (MUSC), tipSC develops and disseminates targeted, practical information to help prescribers make safe prescribing decisions. To encourage participation, these educational programs offer continuing education credit for providers. These materials are available at https://msp.scdhhs.gov/tipsc/.

State	"Other" Explanations
Virginia	We have sent out RetroDUR letters to prescribers in reference to members on several opioids and NO naloxone and referenced the opioid prescribing guidelines, alternatives to opioids, and the importance of prescribing naloxone with opioids.
Washington	Our program refers providers to the Center for Disease Control (CDC), the Washington State Agency's Medical Director's Group (AMDG), and the Bree Collaborative for safe and appropriate opioid prescribing and other best practices. Apple Health's fee-for-service and managed care programs have an Opioid Policy that incorporates the requirements of the SUPPORT Act and the CDC, AMDG, and Bree guidelines.
West Virginia	We have a SEMP (Safe and Effective Management of Pain) Program which offers guidance. More information about the program is below and can be found on the website www.semppguidelines.org "A geographically and professionally diverse expert panel of West Virginia professionals was formed with intention of creating guidelines for the safe and effective overall management of pain, which build upon the 2016 CDC Chronic Pain OPIOID Guidelines. These PAIN management guidelines intend to build upon the 2016 OPIOID guidelines of the CDC by providing a risk reduction strategy for the appropriate use of all pain treatments, and secondly, to provide pain management clinical treatment algorithms, similar to such for the treatment of hypertension, diabetes, and so on, in order to safely and effectively manage the pain of and improve the lives of West Virginians and beyond"

If "No", please explain why no guidelines are offered.

Table 175 - Explanations of Why No Guidelines are Offered

State	Explanations
Louisiana	Prescribers are directed to CDC guidelines.
Maryland	The State Medicaid program does not create guidelines for prescribers for pain management as there are national guidelines available that are recommended by various healthcare organizations.
Missouri	MO HealthNet recommends provider's utilize the guidance developed by other 3rd parties, such as the CDC Guideline for Prescribing Opioids for Chronic Pain.
Nebraska	Pain DUR is planned for the future.
New Hampshire	The OPLC has opioid prescribing guidelines for their licensees to follow.
North Dakota	Later
Wisconsin	Wisconsin refers prescribers to the Wisconsin Medical Examining Board opioid guidelines.
Wyoming	The Wyoming Board of Medicine offers guidelines.

13. Does your state have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

Figure 106 - A Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

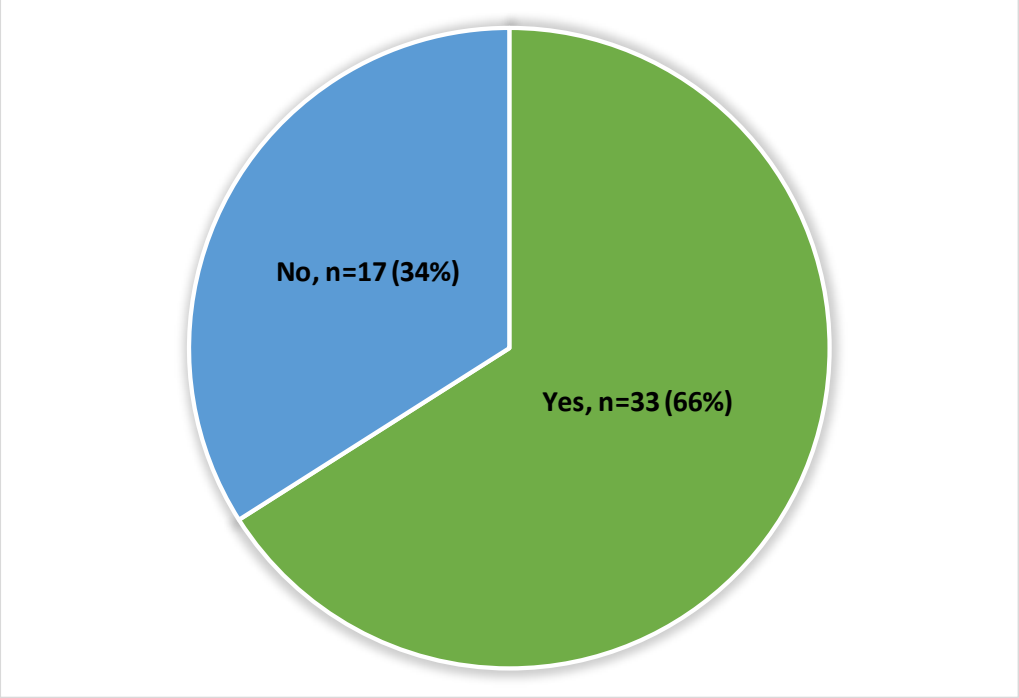

Table 176 - A Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

Response	States	Count	Percentage
Yes	Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	33	66.00%
No	Alabama, Arkansas, Georgia, Idaho, Iowa, Kentucky, Massachusetts, Montana, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Virginia, Wyoming	17	34.00%
Total		50	100.00%

If "Yes," please explain.

Table 177 – Explanation of a Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

State	Explanation
Alaska	We currently have at lest one abuse deterrent formulation on the PDL, as per the recommendation of the Pharmacy and Therapeutics committee.
California	Effective August 1, 2017, multiple strengths of morphine sulfate/naltrexone were added to the Medi-Cal List of Contract Drugs.
Colorado	Preferred status of Embeda (morphine sulfate/naltrexone) during reporting period.
Connecticut	Abuse deterrent opioids are included on the PDL.
Delaware	Abuse deterrent medications do not require prior authorization if member is prescribed one unit per day. A select list of abuse deterrent medications are preferred in Delaware.
District of Columbia	All abuse deterrent opioid products have preferred status on the PDL
Florida	To receive an abuse deterrent opioid system requires recipients to have 2 fills of a short-acting narcotic OR a fill of any Abuse Deterrent Narcotic (ADN) within 60 days to receive an ADN.
Hawaii	Available without restriction for all covered population.
Illinois	Embeda while still on the market during FFY20 was a preferred long-acting opioid.
Indiana	Abuse deterrent opioids are available as preferred on the Preferred Drug List. Those agents with known high levels of abuse and no abuse deterrent are often placed as non-preferred.
Kansas	We have abuse deterrent opioids with preferred PDL status on our preferred drug list (PDL).
Louisiana	There are abuse deterrent opioid agents present on the preferred drug list.
Maine	Abuse deterrent formulations are available as preferred products on the MaineCare PDL.
Maryland	The FFS program has a preferred drug list with the opioid abuse deterrent products Embeda and Xtampza XR that were available as a preferred agent during the reporting period.
Michigan	MDHHS has a clinical prior authorization edit on the Opioid Abuse Deterrent agents to ensure appropriate prescribing. In addition, this class is on the PDL with a preferred abuse deterrent opioid agent.
Minnesota	Suboxone film and buprenorphine/naloxone sublingual tablets are preferred without prior authorization.
Mississippi	Medication Assisted Treatment (MAT) agents are available and included as preferred agents on Mississippi's Universal PDL. Embeda is a preferred agent on the PDL.
Missouri	MO HealthNet has an abuse deterrent opioid with preferred status on our PDL.
Nebraska	Butrans, OXYCONTIN listed on PDL as preferred agents.
Nevada	The preferred drug list contains a drug class specific to abuse deterrent opioids. Members do not have to try a non-abuse deterrent opioid prior to gaining access to abuse deterrent opioids.
New Hampshire	Embeda has preferred status on the NH Medicaid FFS PDL.
New York	New York has abuse deterrent agents available on the preferred section of the State's Preferred Drug List. Opioid antagonists (Narcan Nasal Spray, naloxone, and naltrexone). and injectable opioid dependence agents (Vivitrol and Sublocade) are preferred. Oral trans-mucosal opioid dependent agents (buprenorphine and Suboxone) are preferred but require a PA for initiation of opioid therapy for patients on established opioid dependence therapy.

State	Explanation
North Carolina	Xtampza ER, an abuse deterrent product, is the long-acting oxycodone preferred drug on the state's preferred drug list. Also, prescribers and pharmacists must follow STOP act guidelines. For prescribers: https://www.ncmedboard.org/landing-page/stop-act https://www.ncmedboard.org/images/uploads/article_images/STOPACT-onepager.pdf For pharmacists: http://www.ncbop.org/PDF/GuidanceImplementationSTOPACTJuly2017.pdf
North Dakota	At least one is always a preferred product on our preferred drug list.
Oklahoma	We have limited, lower-strength abuse deterrent opioid medications in tier-1 of the Opioid Analgesics Product Based Prior Authorization (PBPA) category. Additionally, abuse deterrent opioid medications are available in tier-2 of the Opioid Analgesics PBPA category and will fill via an automated prior authorization after trial of an immediate release opioid medication.
Rhode Island	Abuse deterrent opioids are included on the PDL.
South Carolina	Embedda (morphine sulfate/naltrexone- mfg discontinued 11/2019) and Butrans (buprenorphine transdermal).
Texas	Formulary coverage of Embeda (abuse deterrent formulation).
Utah	Abuse deterrent formulations such as Oxycontin ER, Nucynta ER have preferred status on the PDL.
Vermont	Yes we have a preferred abuse deterrent opioid on the PDL Xtampza ER
Washington	WA Medicaid has multiple products as preferred on the AHPDL with lower MME equivalents. This includes abuse deterrent opioids and non- oral formulations.
West Virginia	We have attempted to provide preferred status to at least one abuse-deterrent product, however the majority of our products are not abuse-deterrent.
Wisconsin	Wisconsin has an abuse deterrent agent preferred on the preferred drug list.

D. Morphine Milligram Equivalent (MME) Daily Dose

1. Have you set recommended maximum MME daily dose measures?

Figure 107 - State Recommended Maximum MME Daily Dose Measures

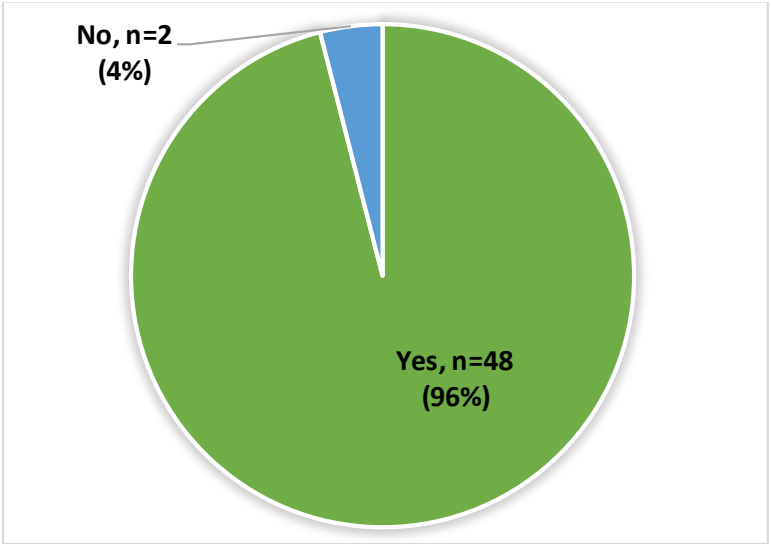

Table 178 - State Recommended Maximum MME Daily Dose Measures

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	48	96.00%
No	Rhode Island, Wisconsin	2	4.00%
Total		50	100.00%

If "Yes," please continue

a. What is your maximum morphine equivalent daily dose limit in milligrams?

Figure 108 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

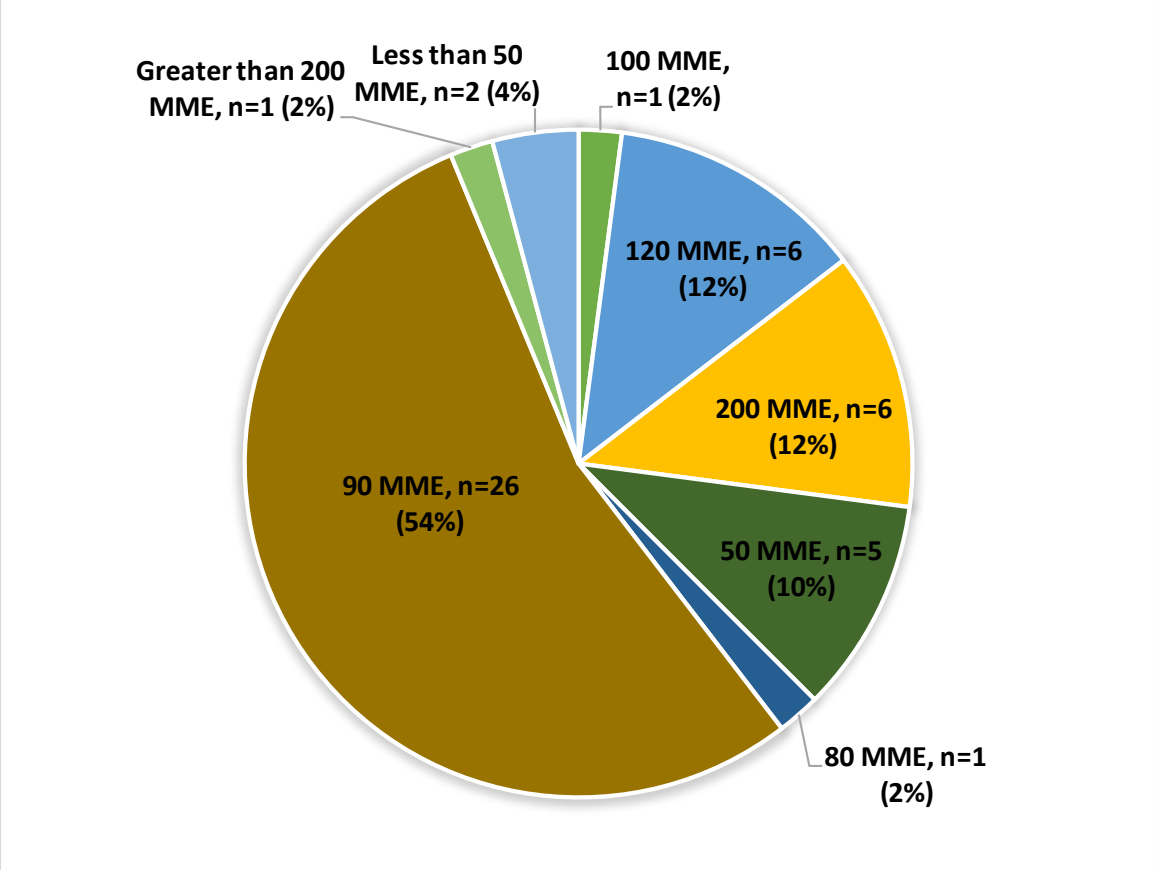

Table 179- Maximum Morphine Equivalent Daily Dose Limit in Milligrams

Response	States	Count	Percentage
100 MME	New Hampshire	1	2.08%
120 MME	Hawaii, Massachusetts, Michigan, New Jersey, Washington, Wyoming	6	12.50%
200 MME	Alabama, Alaska, Colorado, Kentucky, Missouri, Tennessee	6	12.50%
50 MME	Indiana, Nevada, Pennsylvania, Vermont, West Virginia	5	10.42%
80 MME	Georgia	1	2.08%
90 MME	Arkansas, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Virginia	26	54.17%
Greater than 200 MME	California	1	2.08%
Less than 50 MME	Maine, Ohio	2	4.17%
Total		48	100.00%

If Less than 50 MME, please specify.

Table 180: Less Than 50 MME Per Day

State	Less Than 50 MME
Maine	30
Ohio	30

If Greater than 200 MME, please specify.

Table 181: More Than 200 MME Per Day

State	Less Than 50 MME
California	500

b. Please explain nature and scope of dose limit. (i.e. who does the edit apply to? Does the limit apply to all opioids? Are you in the process of tapering patients to achieve this limit)?

Table 182- Explanations for Nature and Scope of Maximum Morphine Equivalent Daily Dose Limit

State	Explanations
Alabama	AL Medicaid began with a cumulative MME edit "phase-in" period for three months. Claims that exceed the cumulative daily MME limit of 150 MME/day will deny at the POS. The Agency will continue to phase down to a goal of 90 MME/day, but the phase down was placed on hold due to COVID-19.
Alaska	A reduction of 50 MME every six moths to a goal of 90MME, as recommended by the CDC and interdisciplinary licensing board.
Arkansas	The maximum MME/day for opioid naive patients is 50 MME/day and limited to #42 pills for a 7 days' supply of short-acting opioids. The maximum daily dose limit for opioid experienced patients is 90 MME/day with a quantity limited to #93 per 31 days with patients having certain cancer diagnoses being exempt from the edit. This edit is additive for all opioid drug claims with overlapping days' supply including long-acting and short-acting opioids.

State	Explanations
California	For the treatment of chronic pain, dose is to not exceed 500 MME/daily without an approved Treatment Authorization Request. This safety edit assists in identifying members at potentially-high clinical risk who may benefit from close monitoring and care coordination.
Colorado	Prior authorization involving prescriber-to-prescriber consult is required for members' prescriptions that exceed the MME limit. An opioid prescribing plan and recommendations for tapering are documented as part of this consult and approval may be placed to allow for tapering.
Connecticut	The maximum MME is defined as exceeding 630 MME in a rolling 120-day window. Patients who exceed these limits will require prior authorization unless their diagnosis is of cancer or sickle cell and their prescriber is in a hematology/oncology taxonomy. This limit applies to short acting opioid only. All long acting opioids require prior authorization with the exception of those prescribed by a hematology/oncology specialist.
Delaware	Delaware follows the most recent CDC recommendations. When the dose is above the current recommended dose, physicians receive retroactive written notification in order to reduce patient risk by encouraging re%u2010evaluation of the necessity of the higher dose. The 90 MME limit is also part of the clinical criteria for approval of PA. The 90 MME limit has been in place since July 1, 2018, however Delaware would further re%u2010evaluate this limit if new recommendations for lower doses are released.
District of Columbia	The 90 MME daily limit applies to all opioids. The District has identified certain patient populations that are exempted from the 90 MME daily limit including patients on active cancer treatment, in palliative care or home hospice, diagnosed with sickle cell disease or who reside in a long term care facility. Beginning in October 2018, patients receiving daily opioid doses in excess of 90 MME were identified and gradually titrated down to the current 90 MME limit over the period of 18 months.
Florida	For opioid treatment naive recipients, the limit is 90 MME. For treatment experienced recipients there is a soft edit at 50 MME.
Georgia	In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published guidelines for the use of opioids in chronic, non-cancer pain in 2016. In the Guidelines for Prescribing Opioids for Chronic Pain, the CDC recommends careful justification for titrating opioid doses above an average of 90 morphine milligram equivalents (MME) per day to avoid potential overdose. In an effort to reduce the risk of opioid-related harms while preserving access to appropriate pain treatment, Georgia Medicaid Fee-For-Service (FFS) implemented a prior authorization for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day. We are currently working on a further tapering plan that was delayed by the pandemic.
Hawaii	120 MME applies to all opioids. Dental is acute and initial care therefore, more restrictive in nature.
Idaho	Edit implemented in July 2017. When a new prescription comes in the edit looks at the cumulative daily MME of currently received prescriptions plus the new prescription and will deny claim if all drugs and doses added together exceed the 90 MME at that point in time. A prior authorization is required for override to allow dispensing.
Illinois	A MME edit was put in place initially as an informational or soft edit. A month later it became a hard edit. At the time the hard edit was implemented, 90 MME was allowed for participants considered opioid naive (no opioids filled in last 60 days via HFS) and 120 MME was allowed for participants who were opioid experienced as determined by history of opioid use within 60 days from edit start date.

State	Explanations
	Once the edit was put in place, all new participants are considered opioid naive when they present with an opioid claim. Prior authorization is required if the opioid claim exceeds 90 MME. If the participant has been taking opioids chronically prior to Fee-for-Service Medicaid coverage, the participant is put into the Pain Management Program. Recommendations for pain management and tapering are made on a case-by-case basis. If opioid therapy is appropriate and higher MME required, patients are not forced to taper down to the new MME requirement. If a taper is started, staff will work with the prescriber to put prior approvals in place as needed to accommodate a taper schedule.
Indiana	Limit is 60mg per day (chose closest range). Current limit applies to initial therapy. Indiana Medicaid anticipates adding tapering requirements and limits to current utilizers in the future.
Iowa	For this time period we were in the process of tapering to a maximum of 90 MME per day from 120 mg per day, with 90 MME per day going into effect October 2020. Applies to all members and all opioids. Prescribers can submit the High Dose Opioids PA form for exceptions.
Kansas	All opioids with the exception of cough/cold products, compounding products, and injectables have an MME limit unless the MME does not apply to that drug and then an FDA maximum daily dose limit is set. Patients with cancer, sickle cell anemia, palliative care, and patients whom reside in an assisted or custodial care environment are exempt from the PA requirements.
Kentucky	200 morphine milligram equivalents (MME) is our ceiling in the POS system. Our quantity limits for individual agents (e.g., oxycodone and hydrocodone/APAP) are configured to allow around 90 MME/day, so this is effectively the limit as a PA would be required if a claim for another opioid of a different kind or strength were submitted due to a therapeutic duplication hard stop. Class Criteria for High Morphine Milligram Equivalent (MME) Requests Over 90 MME per Day Additional criteria shall apply for NEW requests where the cumulative opioid dose across all prescriptions is >90 morphine milligram equivalents (MME): o Note: Buprenorphine products (for opioid addiction treatment or pain) are not assigned an MME value and will not be included in the calculation. o Prescriber is, or has proof of consultation with, a Pain Management Specialist OR specialist in an appropriate discipline (e.g., orthopedist, neurologist, spine specialist, etc.) for evaluation of the source of pain and/or treatment of any underlying conditions; AND o Prescriber must submit clinical justification for exceeding 90 MME/day; AND o Prescriber attests that a naloxone prescription and associated counseling on its use was, or will be, offered to the member. Class Criteria for Approval of Very High MME Requests: Over 200 MME per Day Additional criteria shall apply to ANY request where the cumulative opioid dose across all prescriptions is >200 MME/day: o Note: Buprenorphine products (for opioid addiction treatment or pain) are not assigned an MME value and will not be included in the calculation. o Prescriber is, or has proof of consultation with, a Pain Management Specialist; AND o Prescriber submits clinical justification for exceeding 200 MME/day; AND o Prescriber submits documentation (e.g., progress notes) showing attempts and/or plans to taper below 200 MME/day as well as other non-opioid components (e.g., NSAIDs, physical therapy, etc.) of the treatment plan; AND o Prescriber attests that a naloxone prescription and associated counseling on its use, was or will be given to the member.
Louisiana	Each time an opioid prescription claim is submitted for a beneficiary, the MME per day for all active opioid prescriptions for that beneficiary is calculated and limited to a maximum of 90 MME per day. There are exemptions to the edits for maximum daily MME limits for opioids: cancer, palliative care, sickle cell crisis, and second and third degree burns. Authorization to increase the maximum prescribed MME limit for a recipient may be requested by the prescriber for approved by the PA unit prior to the initiation of the claim submission.
Maine	State of Maine has had 30 MME in place since 2013 and has successfully decreased overall opiate utilization per member drastically since the edit was initiated.

State	Explanations
Maryland	Maryland Medicaid set the maximum morphine equivalent daily dose limit at 90MME in keeping with the published CDC guidelines in FFY 2018. Anyone exceeding a MEDD of 90mg is required to obtain a prior authorization. While patients with sickle cell anemia or patients in Hospice are excluded from the prior authorization process, the program recommends they be kept on the lowest effective dose for the shortest duration required to minimize the risk of harm. There was no requirement to taper patients off of opioids for the reporting period.
Massachusetts	Prior Authorization for MME over 120mg/day requires a tapering schedule or pain specialist consultation to support the dose.
Michigan	MDHHS implemented an accumulated MEDD edit in September 2018 with the initial threshold set at 500 MEDD and will continue to lower the MEDD limit in phases down to the CDC recommendation of 90 MEDD. Currently, the threshold is set at 120 MEDD. Prescribers are referred to CDC tapering tools for assistance.
Minnesota	The POS edit applies to all opioids. The edit used compares the quantity per day limit and quantity per prescription limit against the values in the MMIS drug table. These values are based on a daily max of 90 MME. If either of the values are over, then claim rejects and a prior authorization is required for the high dose opioid claim to adjudicate.
Mississippi	This limit aligns with CDC guidelines and applies to all opioid prescriptions excluding those beneficiaries with an active cancer diagnosis or sickle cell disease.
Missouri	For opioid naive patients, the initial prescription is limited to 50 MME on the initial fill of 7 days and 90 MME thereafter. Patients over 200 MME, claims are denied and require prior authorization and clinical review.
Montana	We started our opioid MME limits at 180 and have gradually lowered them to our final 90MME limit. This applies to opioid naive and non-opioid naive members. It does not apply to members with a cancer diagnosis. Providers with members already over our limits were given time (variable depending on how high the dose was to start) to taper. Providers who could not taper their patients successfully could request a prior authorization to remain at a dose over our limits. They are required to sign an attestation that they have exhausted other non-pharmacologic and non-opioid pharmacologic therapies, that they have reviewed the risks with the member and determined that the benefit exceeds the risk, that they have been assessed for OUD, that they have been unsuccessful in tapering the member, that they will not further escalate the dose, etc.
Nebraska	Cumulative amount of long and short acting agents equal to 90 mg MME as of 12/31/2020.
Nevada	The MME limit applies to all oral opioid products. The maximum MME daily dose limit is actually 60 MME which is not an option above.
New Hampshire	NH Medicaid selected the daily MME at 100 to be consistent with the administrative prescribing rules published by the licensing boards (Medical, Nursing and Dental) that fall under the Office of Professional Licensure and Certification (OPLC). NH has a cumulative POS edit that will deny opioid claims for beneficiaries that exceed the 100mg MME unless there is a prior authorization in place.
New Jersey	For short-acting opioids (SAO), daily dosing is limited to 50 MME for an opioid naive patient or 120 MME for an opioid tolerant patient. Opioid naive patients are defined as those receiving no opioid therapy in the previous 90 days. For long-acting opioids (LAO), a patient must currently be on a short-acting opioid and daily dosing is limited to 120 MME. These limitations do not apply to cancer patients, sickle cell patients, or those on hospice, palliative or end of life care.
New Mexico	Limited to Opioids in State Therapeutic Class H3A-Analgesic Narcotics, H3N-Analgesics, Narcotic Agonist and NSIAD Combination, and H3U-Narcotic Analgesic and non-salicylate analgesic. No prior authorization requests received to assist with tapering patients to 90 MME.
New York	Prior authorization is required for management of non-acute pain when utilizing greater than or equal to 90 MME per day. (Non-acute pain is defined as greater than 7 days of opioid therapy). Prior authorization will not be required for members already established on greater than or equal to 90 MME per day. The MME parameter will not apply for members with cancer, sickle cell disease, or receiving hospice care. POS claim denial will occur on patients treated with opioid use of greater than or equal to 90 MME.

State	Explanations
North Carolina	Beneficiaries requiring more than 90 MME (cumulative for all opioids) are required to meet prior authorization criteria.
North Dakota	Applies to all opioids and prior authorization is required to exceed.
Ohio	Dose limits include 30 MME for initial short- acting opioid prescriptions and 80 MME for long-acting opioid prescriptions. Long-acting opioid prescriptions require a prior authorization.
Oklahoma	The MME limit applies to all opioids. Opioid MME daily totals greater than 90 will require prior authorization with patient-specific, clinically significant reasoning why the member requires greater than 90 MME per day. Members with diagnosis of cancer, sickle cell, and/or hemophilia are excluded from the MME limit.
Oregon	Applies to all new opioid PA requests and 7-day supplies of SAOs. Grandfathered patients on doses exceeding 90 MME are asked to taper or explain why that is not possible and to provide documentation that the member is benefitting from the therapy - as well as meet all other PA criteria (UDS, PDMP, etc)
Pennsylvania	The limit is a threshold for prior authorization. Doses greater than 50 MME/day require prior authorization.
South Carolina	prescribers must limit the initial prescribing of opioid medications for the treatment of acute or post-operative pain to the lowest effective dose and for a quantity no more than necessary for the expected duration of pain. Providers must not exceed a five-day supply or 90 morphine milligram equivalents (MMEs) daily, except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care or medication-assisted treatment for substance use disorder. If, in a prescriber's clinical judgement, an initial supply of more than five days or 90 MMEs is medically necessary, the prescriber must document that need in the patient's medical record. The State continues to monitor for any next steps (outliers, education, alternate therapies, change in MME)
South Dakota	Greater than 90 MME requires PA. Applies to all opioids. This does not apply to patients with a current cancer diagnosis.
Tennessee	Our limit for non-chronic users is 15 days per 180 days with no greater than 60 MME per day. Non-chronic use is defined as 90 days supply within the past 180 calendar days. The only exceptions to this limit are patients with sickle-cell disease, corrosive or other burns over a significant part of the body, and those in LTC facilities, and with these exceptions the limit is 45 days supply per 90 days at no greater than 60 MME per day. For chronic users, the limit is 200 MME per day.
Texas	The 90 ME daily dose is applied to all prescription opioids either for initial or for the subsequent therapies. For those who may require a tapering plan, providers would determine the development and management of a person specific course of therapy to help manage withdrawal symptoms. A prescriber may request a tapering plan through the pharmacy prior authorization process on a case-by-case basis. Prior authorization approval lasts for six-months. Clients are exempt if documented diagnosis of cancer, sickle cell, or hospice/palliative care is found.
Utah	A Morphine Milligram Equivalents (MME) limit was implemented on January 1, 2019, for adjudication of all opioid claims for the treatment of non-cancer pain. Two sets of daily MME thresholds were established, a threshold of 90 MME for opioid-naive individuals, who have not had a claim in the last 60 days and 180 MME for opioid experience individuals who had a claim for an opioid in the last 60 days. The higher MME threshold will be reduced over time, every 6 months to achieve one common MME standard, 90 MME, for all UT Medicaid members. The MME will be gradually reduced for opioid experience based on the timeline: January 1, 2020: MME 120; July 1, 2020: MME 90.
Vermont	The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients 18 years of age or older OR 24 MME and 3-day supply for patients less than or equal to17 years of age
Virginia	A service authorization is required for any cumulative opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug. The service authorization fax form also mentions and provides a link to alternative therapy to schedule II opioids. The service authorization fax form states: Alternative Therapy to Schedule II Opioids. Based on the Virginia Board of Medicines Opioid Prescribing Regulations, Opioids are NOT recommended as first line treatment for acute or chronic pain. For additional information please see: VA Board of Medicine Regulations.

State	Explanations
	Preferred Pain Relievers available without SA include NSAIDS topical and oral, SNRIs, Tricyclic Antidepressants, Gabapentin, Pregabalin capsules, Baclofen, Capsaicin topical cream 0.025% and Lidocaine 5% Patch. Consider alternative therapies to Schedule II opioid drugs due to their high potential for abuse and misuse.
Washington	WA Medicaid has developed and implemented an opioid policy that limits initial use to 18 dosages per prescription for children (less than or equal to 20 years of age) and 42 dosages per prescription for adults (greater than or equal to 21 years of age), requires an attestation for chronic opioid therapy (defined as opioids exceeding 42 calendar days within a rolling 90-day period), requires an attestation documenting the prescriber is following best practices for opioid requests that equal or exceed 120MME, and requires medical justification including treatment plans for requests to exceed 200 MME a day.
West Virginia	Patients who are receiving more than 50 MME/day for at least the last 90 days are required to receive a PA through our SEMP (Safe and Effective Management of Pain) Program. The PA process requires identification of previous therapies, a plan of care and encourages providers to titrate to the lowest effective dose whenever possible.
Wyoming	The MME limit is applied to long-acting opioids. Patients over the limit have submitted a treatment plan outlining the prescribers plan to taper the opioid.

If "No," please explain the measure or program you utilize.

Table 183 - Explanations of the Measure or Program Utilized for Maximum Morphine Equivalent Daily Dose Limit

State	Explanations
Rhode Island	Partial plan in place for naive patients. Project for all not complete until October 2020.
Wisconsin	Wisconsin has a prospective DUR alert for claims with 90MME or greater. This alert notifies the pharmacy the claim is a high dose opioid and recommends the dispensing of naloxone. Wisconsin also monitors these drugs through edits, such as quantity limits, early refill and therapeutic duplication prospective DUR alerts. Wisconsin performs retrospective reviews of all opioids used at 250MME or greater and use of opioids at 50MME or greater with concomitant benzodiazepine. Prescribers identified during these processes receive a letter alerting them to a clinical concern.

2. Does your state have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

Figure 109 - Edit in POS System that Alerts the Pharmacy Provider that the Morphine Equivalent Daily Dose Prescribed has been Exceeded

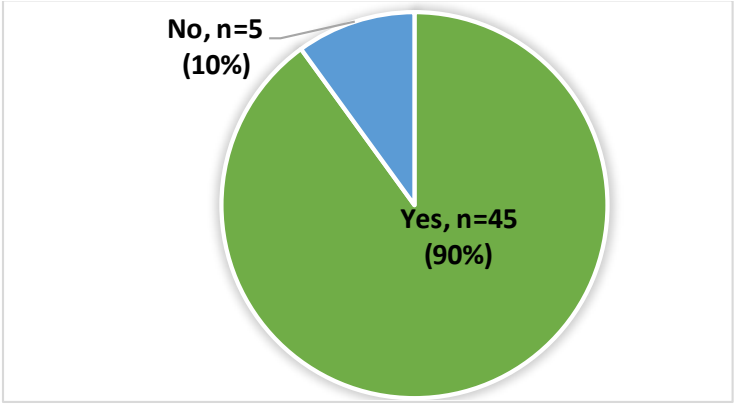

Table 184 - Edit in POS System that Alerts the Pharmacy Provider that the Morphine Equivalent Daily Dose Prescribed has been Exceeded

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	90.00%
No	California, Georgia, Hawaii, Nebraska, Rhode Island	5	10.00%
Total		50	100.00%

If "Yes," does your state require PA if the MME limit is exceeded?

Figure 110 - Prior Authorization Required if MME Limit is Exceeded

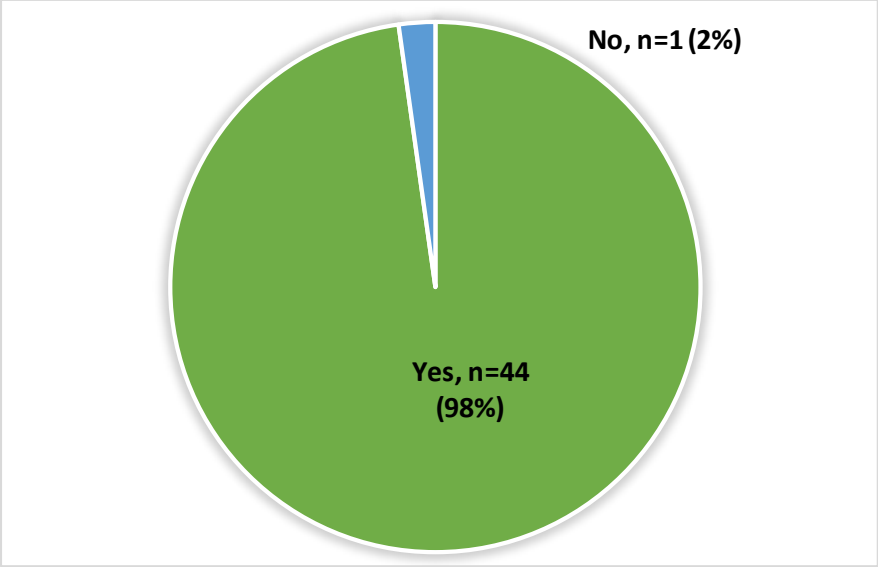

Table 185 - Prior Authorization Required if MME Limit is Exceeded

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	44	97.78%
No	Wisconsin	1	2.22%
Total		45	100.00%

3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?

Figure 111 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

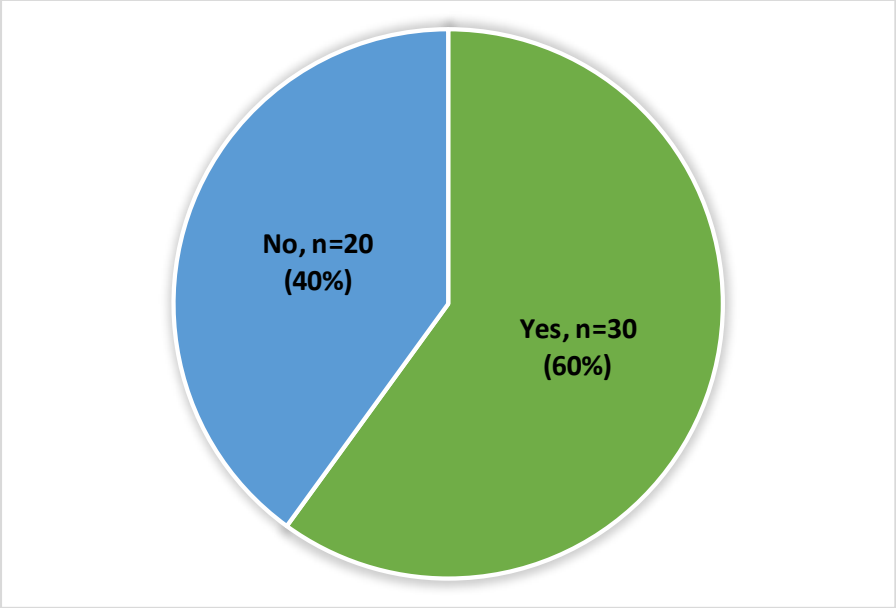

Table 186 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

Response	State	Count	Percentage
Yes	Alaska, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin	30	60.00%
No	Alabama, Arkansas, California, Georgia, Idaho, Illinois, Kentucky, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, Pennsylvania, Rhode Island, South Carolina, Vermont, West Virginia, Wyoming	20	40.00%
Total		50	100.00%

Please explain.

Table 187 - Explanations for Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

State	Explanations
Alabama	Prospective claims only
Alaska	The opioid report includes the total MME daily dose and is reviewed by the state and DUR committee quarterly.
Arkansas	Our strict prospective edits prevent claims from processing at POS with > 90 MME/day.
California	We have completed several retrospective claim reviews to monitor total MME daily dose of opioid prescriptions dispensed, but they are not automated.
Colorado	Magellan Health, Inc., the point of service vendor, calculates the cumulative MME across opioid prescription claims processed for individual members.
Connecticut	Retrospective MME criteria targets any patient receiving > 472.5 MME in 90 days.
Delaware	Providers are notified retroactively in cases where the high dose alert is set on a claim
District of Columbia	There is a quarterly retrospective claims review to monitor MME compliance including claims count over quantity limits, total opioid claims count, day supply and other edits.
Florida	The retrospective claim review to monitor total daily dose (MME) of opioid prescriptions is reviewed by the DUR Board.
Georgia	Not automated at this time.
Hawaii	Quarterly and annual review occurs.
Idaho	We perform retrospective reviews to evaluate total MMEs, but it is not automated.
Illinois	An automated retrospective claims review for > 50 MME and 90 MME is under development for FFY21.
Indiana	Regular review of reports.
Iowa	A retrospective report is generated for review those exceeding the MME limit set. If issues are identified, it is referred to the DUR Commission for discussion and next steps, such as provider education.
Kansas	There is a hard edit and a PA is required for claims to pay, but an RDUR is done quarterly to monitor all opioid claims outside of state set edits.
Kentucky	MME edits are prospective through the PA process.
Louisiana	Claims were reviewed retrospectively for MME exceeding 90 MME daily and 3 interventions were made during FFY20.
Maine	Reports have been developed to identify all members above 30MME
Maryland	During retrospective reviews, the RDUR program is able to identify patients who are receiving greater then 50MME as well as participants receiving over 90MME daily.
Massachusetts	We use claim edits to monitor daily MME, however no automated review. Reports are produced ad-hoc.
Michigan	Our comprehensive quarterly opioid trend report includes the accumulated MME of each member. The report provides claim and member detail if further investigation is required.
Minnesota	Prior authorization is required for of any prescription where the opioid per day exceeds 90mg MME.
Mississippi	A monthly retrospective DUR mailing is sent to providers with beneficiaries above 50 MME opioid dosing. MME values are also included in the quarterly report on beneficiaries at high risk for opioid misuse or abuse.
Missouri	We do have an automated retrospective claims review process in place to monitor daily MME on opioid prescriptions. Our multi-faceted approach combines monthly MME reporting

State	Explanations
	identifying individuals over the set limits, combined with our retrospective, population-based interventions targeting safe opioid utilization. Our retrospective intervention identifies members over the maximum cumulative daily MME, which was set at >/=200MME per day and educates providers on how to obtain prior approval for continued use, or how to safely taper the current opioid dose. The state uses the retrospective lettering process to communicate MME changes to providers and will continue this process as the target MME limit is reduced over time.
Montana	We do not have an automated retrospective review because we deny them prospectively and require prior authorization so any paid claims have already been reviewed and approved. However, we do Ad Hoc reviews to ensure providers whose members have been approved for a higher than 90MME dose have not further escalated the dose as per their attestation.
Nebraska	Coming next FY 2022.
Nevada	The retrospective claim review is a manual review process through the retroDUR program and DUR meeting presentations.
New Hampshire	All claims of MME over 100 require a prior authorization.
New Jersey	Retrospective reviews to monitor MME are currently manually reviewed based on routine, quarterly ad hoc reporting.
New Mexico	A "hard stop" POS edit exists.
New York	Retrospective claims are reviewed monthly by pharmacy academia at the State University at Buffalo. When appropriate, utilization reviews are prepared as a means of identifying clinical issues surrounding MME total daily dose of opioids and are presented to the DUR Board. After their review the Board will recommend any action needed to address outlying concerns.
North Carolina	NC Tracks monitors the total MME of all opioid prescriptions concurrently dispensed. Prior authorization is required for greater than 90 MME
North Dakota	We actually do this prospectively as the edit is within our POS.
Ohio	We use automated retrospective claim reviews that monitor high quantity/day supply of opioids. We also monitor MME threshold through reporting.
Oklahoma	The opioid MME edit calculates the cumulative MME based on the member's claims for active medications.
Oregon	The retoDUR Program for High-Risk Opioid Patients includes patients prescribed opioids in excess of state defined quantity limits of 90 MME per day. The full program is described elsewhere in the report, but includes patients with cumulative opioid dose >90 MME (for all opioid formulations) for >60 days (with <=7 day gap in therapy) in a 120 day lookback. Patients are reviewed quarterly and prescribers are notified as needed. Point of sale edits, including PA criteria and quantity limits address acute prescribing greater than 90 MME per day for new start patients.
Pennsylvania	The current system does not have the capability to calculate total daily MME.
Rhode Island	Not in place until October 2020.
South Carolina	There is not an "automated" claims review retrospectively for these claims, however, analytics and reporting are run periodically, at the States request. The MME limit is prospective for new starts, with exceptions noted in the above.
South Dakota	The ProDUR edits performed during adjudication are automated. The RDUR process reviews all prescription claims, one of the many criteria reviewed is high opioid utilization.
Tennessee	Our PBM vendor worked throughout much of FFY2020 to implement a solution that would enable the automation of MME accumulation edits. This solution is now in place during FFY2021, but was not fully in place during much of FFY 2020. Tennessee will report on the success of automating the review of total MME for the FFY2021 CMS Annual Report.

State	Explanations
Texas	The system monitors for cumulative daily MME levels of 90 MME. The claim that cause this MME limit to exceed will be denied.
Utah	This process is integrated into Prior Authorization work flow and monthly peer-to-peer opioid work.
Vermont	The state does have a retrospective claims review process as part of the Retro DUR topics as reviewed by the DUR Board.
Virginia	We review members on chronic opioids and with high risk activity that includes being on high total daily doses for MME quarterly and present to each DUR Board meeting.
Washington	Washington Apple Health (Medicaid) has developed a morphine milligram equivalent (MME) report that allows us to monitor enrollee's opioid MME and if they have a history of opioid use disorder (OUD) or are currently receiving medications used to treat OUD. The data in the MME report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	We use MME to filter members for some Retrospective reviews. Members who receive an opioid equivalent to 50 MME or greater and also receive a benzodiazepine are flagged for review for higher risk of respiratory failure. High Average Daily Dose: 120 morphine milligram equivalents or more per day over the past 90 days (members with a cancer diagnosis are excluded) are flagged for review in the lock-in program.
Wisconsin	Wisconsin has a prospective DUR alert for claims with 90MME or greater. This alert notifies the pharmacy the claim is a high dose opioid and recommends dispensing of naloxone. Wisconsin also monitors these drugs through edits, such as quantity limits, early refill and therapeutic duplication prospective DUR alerts. Wisconsin performs retrospective reviews of all opioids used at 250MME or greater and use of opioids at 50MME or greater with concomitant benzodiazepines. Prescribers identified during these processes receive a letter alerting them to a clinical concern. Outreach calls are conducted when the prescriber remains an outlier.
Wyoming	Each patient who is exceeding the MME limit has a prior authorization in place and is being monitored by the clinical team at the PA Help Desk.

4. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

Figure 112 – Provide Information to Prescribers to Calculate Morphine Equivalent Daily Dosage or Provide Calculator Elsewhere

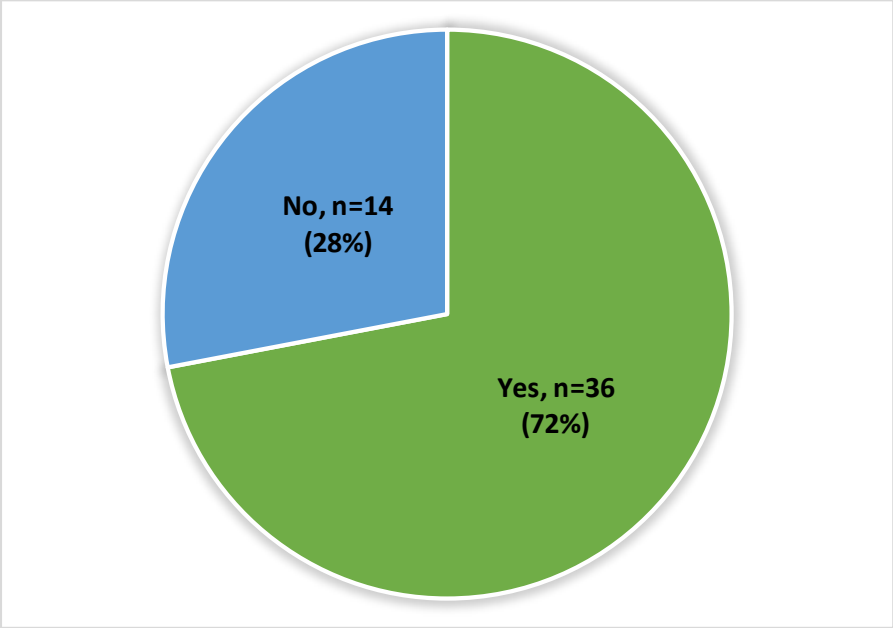

Table 188 - Provide Information to Prescribers to Calculate Morphine Equivalent Daily Dosage or Provide Calculator Elsewhere

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia	36	72.00%
No	Delaware, Georgia, Idaho, Kentucky, Louisiana, Minnesota, Missouri, Nevada, Oklahoma, Pennsylvania, South Dakota, Texas, Wisconsin, Wyoming	14	28.00%
Total		50	100.00%

If "Yes," please continue.

a. Please name the developer of the calculator.

Figure 113 – Developer of Calculator

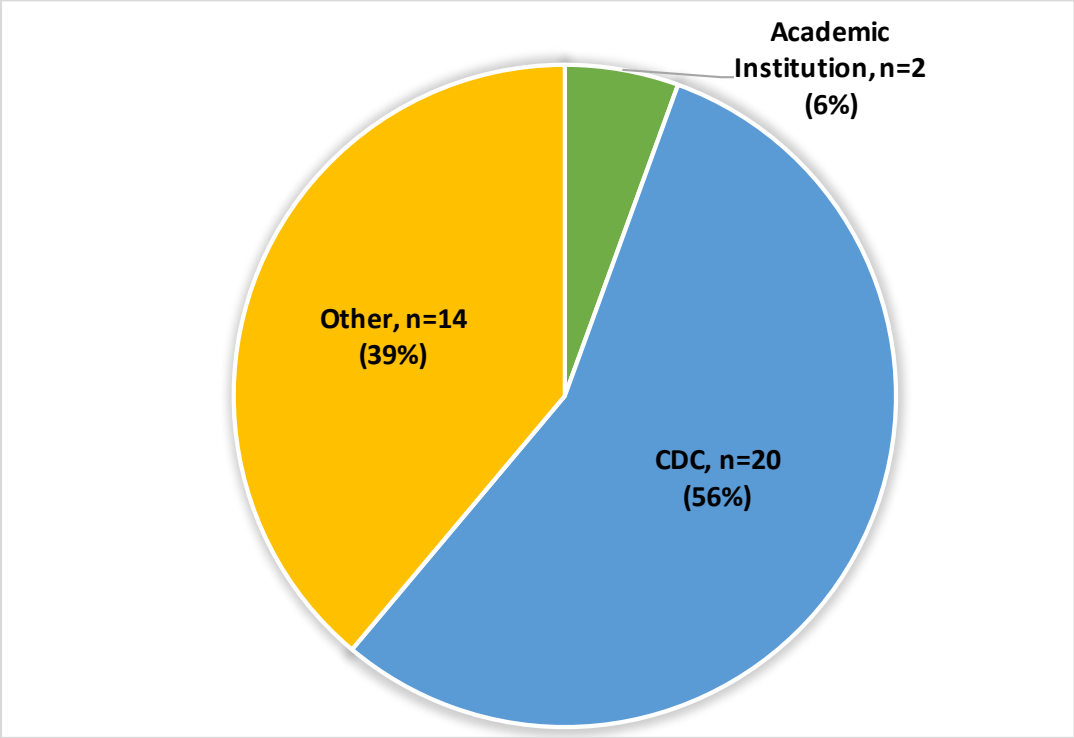

Table 189 - Developer of Calculator

Response	State	Count	Percentage
Academic Institution	North Dakota, Oregon	2	5.56%
CDC	Alabama, Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Iowa, Maine, Maryland, Michigan, Mississippi, Montana, New Jersey, Rhode Island, Tennessee, Utah, Vermont, West Virginia	20	55.56%
Other	Alaska, Colorado, Indiana, Kansas, Massachusetts, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Ohio, South Carolina, Virginia, Washington	14	38.89%
Total		36	100.00%

If "Other," please specify.

Table 190- Explanations for "Other"

State	Explanations
Alaska	Washington AMDG and the Alaska state PDMP website
Colorado	Washington State Agency Medical Directors' Group
Indiana	Drug Utilization Review Board Newsletter, posted electronically, provides opiate conversion charts.
Kansas	We have MME and dose limits on the PA table plus a provider bulletin with the CDC link.

State	Explanations
Massachusetts	MassHealth distributed a prescriber letter re Updated Opioid High Dose Limits with an MEDD table.
Nebraska	NE pain management guidance document
New Hampshire	Washington State Agency Medical Directors' Group
New Mexico	The CDC MME dosage calculator website was provided to providers prior to initiating the 90 MME edits
New York	New York State Opioid Training program addresses opioid prescribing.
North Carolina	NC has a table, not a calculator.
Ohio	Take Charge Ohio Healthcare professionals. OARRS guidelines
South Carolina	incorporated into PDMP and Magellan Call Center
Virginia	SA form states for prescriber to provide pts Daily MME from PMP (http://virginia.pmpaware.net/login)
Washington	HCA- Developed our own using CDC and AMDG which is available on opioid pharmacy webpage

b. How is the information disseminated?

Figure 114 – How Information is Disseminated

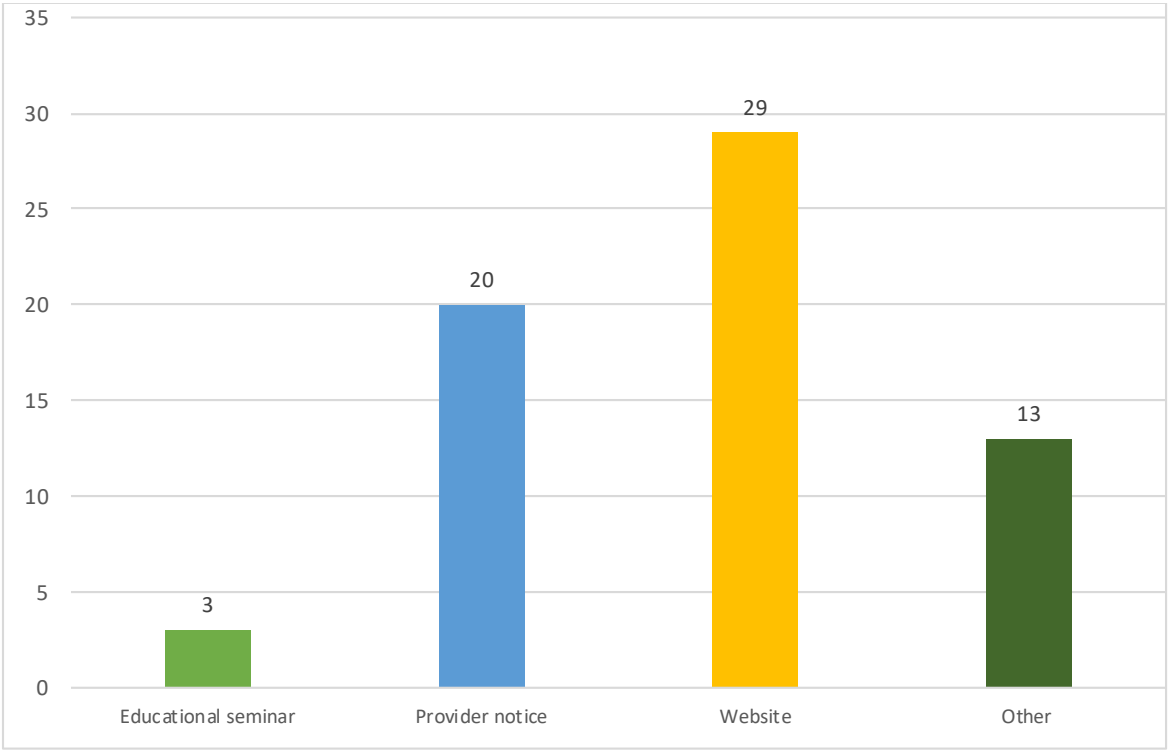

Table 191- How Information is Disseminated

Information Type	State	Count	Percentage
Educational seminar	New York, South Carolina, Washington	3	4.62%
Provider notice	Alabama, Arkansas, California, District of Columbia, Florida, Hawaii, Kansas, Maine, Massachusetts, Mississippi, Montana, Nebraska, New Jersey, New Mexico, Ohio, Rhode Island, Utah, Vermont, Virginia, West Virginia	20	30.77%
Website	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington	29	44.62%
Other	Alabama, Alaska, California, District of Columbia, Massachusetts, Michigan, Montana, Oregon, South Carolina, Tennessee, Utah, Virginia, Washington	13	20.00%
Total		65	100.00%

If "Other," please explain.

Table 192 - Explanations for "Other"

State	Explanations
Alabama	Academic Detailers distribute information to prescribers and providers.
Alaska	Website, prior authorization form, and criteria documents.
California	In February 2019, the Medi-Cal DUR program published an educational bulletin entitled, Clinical Review Update: Morphine Equivalent Daily Dose, to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service and remained on the Medi-Cal DUR website throughout FFY 2020.
District of Columbia	Quarterly Provider Forums
Massachusetts	Direct mail to prescribers.
Michigan	Provided on the prior authorization fax form and RetroDUR education packets to prescribers associated with members with daily MME 90 or above.
Montana	For providers who have patients over the MME limit, we send out educational letters so that they can work to develop a treatment plan for those patients and get a prior authorization in place.
Oregon	Table of MME for individual agents is included on PA criteria: https://www.orpdl.org/durm/PA_Docs/opioids_long-acting.pdf https://www.orpdl.org/durm/PA_Docs/opioids_short-acting.pdf

State	Explanations
South Carolina	SC PDMP: A SCRIPTS report calculates MME per day for each patient prescription (Rx) using a common denominator, MME (Morphine Milligram Equivalents), so that the different Rxs can be added together (Active Daily MME) to help assess cumulative risk in addition to assessing the risk associated with a single opioid Rx. https://msp.scdhhs.gov/tipsc/sites/default/files/tipsc_mailer_Sept%202017_hot_links.pdf References/resources/web links are provided at the below sites https://msp.scdhhs.gov/tipsc/site-page/tipsc-issues https://pharmacy.musc.edu/-/sm/pharmacy/f/selected-resources-insert.ashx?la=en
Tennessee	We list the MME calculations on our website and on all opioid Prior Authorization Forms.
Utah	Quarterly Medicaid Information Bulletin and opioid peer to peer work.
Virginia	A Medicaid Memo was posted to the state website with a blast email sent to those enrolled in the service. A patient specific letter was sent to those prescribers whose patients had received a prescription above the new limit.
Washington	We provide a link to the website and our calculator on our Opioid attestation form.

E. Opioid Use Disorder (OUD) Treatment

1. Does your state have utilization controls (i.e. PDL, PA, QL) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

Figure 115 – State Have Utilization Controls to Monitor or Manage the Prescribing MAT Drugs for OUD

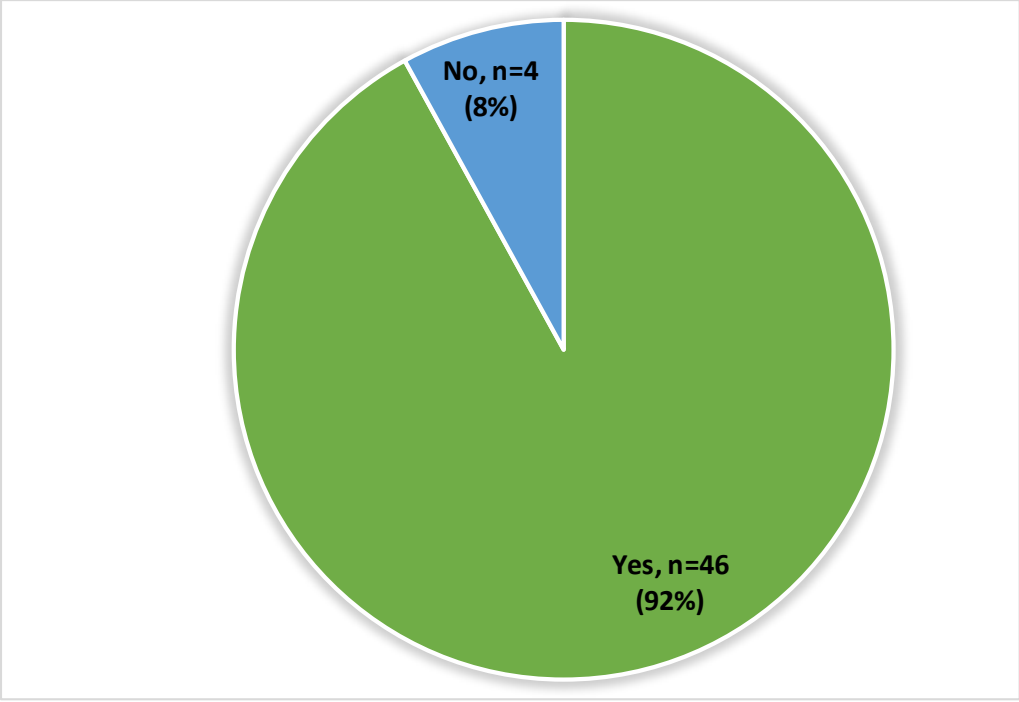

Table 193 - State Have Utilization Controls to Monitor or Manage the Prescribing MAT Drugs for OUD

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	California, Hawaii, Mississippi, Rhode Island	4	8.00%
Total		50	100.00%

If "Yes," please explain.

Table 194 - Explanations of Utilization Controls to Monitor or Manage the Prescribing MAT Drugs for OUD

State	Explanations
Alabama	Prior authorization is required for buprenorphine products. Buprenorphine products are on the Preferred Drug List (PDL) and they also have quantity limits. AL Medicaid requires that an Informed Consent form is submitted along with the PA request form.
Alaska	PDL, PA, QL
Arkansas	Medication Assisted Treatment drugs for OUD are on the preferred drug list. Effective 1/1/2020, prior authorization requirements were removed from preferred oral buprenorphine products. Nonpreferred drugs require a prior authorization request with documentation of the medical necessity over the preferred agents. Quantity limits exist for all buprenorphine containing products with maximum dose based on the manufacturer's package insert recommendations. The current preferred oral agents are Suboxone films and buprenorphine tablets which have a maximum quantity of #93 per 31 days.
Colorado	Prescribers may request assistance with pain management strategies and/or the use of MAT drugs for OUD through the peer-to-peer Health First Colorado Pain Consultation Service. Greater than four prescription fills of an opioid for a previously opioid naive member may require a telephone consultation with a pain management physician.
Connecticut	Drugs that are grouped in the MAT class are subject to PDL requirements.
Delaware	Delaware maintains open access for OUD treatments in accordance with the SUPPORT ACT
District of Columbia	There are POS PA and QL edits in place. However DHCF Transmittal 19-14 published May 15, 2019 allows MAT drug products to be prescribed and dispensed up to the FDA approved maximum daily dose without a PA. Additionally this policy permits MAT drugs to be prescribed and dispensed above the FDA approved maximum daily dose by requiring a PA.
Florida	The DUR Board reviews MAT criteria, utilization, and induction therapy. Prescribers initiating patients on MAT are able to prescribe a 30 day supply of buprenorphine sublingual tablets, buprenorphine/naloxone sublingual tablets, Suboxone film, or Zubsolv sublingual tablets for induction therapy without prior authorization. A complete prior authorization submission will be required beyond the 30 days. In addition, an edit was deployed to allow access to buprenorphine products by way of automation logic, that allows MAT therapy if a recipient has a diagnosis of OUD and pregnancy within the past 365 days of the incoming claim. The edit deployed on 02/13/2020.
Georgia	See below

State	Explanations
Idaho	We utilize max daily quantity limits, PA's for the products, and also do retrospective reviews on the medications.
Illinois	All MAT therapies are preferred.
Indiana	The state has preferred MAT agents on the PDL and quantity limits up to 24mg per day of buprenorphine.
Iowa	Preferred agents on PDL, quantity limits and age edit.
Kansas	At the time during the FFY 2020, we had a prior authorization required, for single oral agent buprenorphine Subutex ONLY.
Kentucky	We have PDL edits, prior authorization, quantity limit, and therapeutic duplication edits in place. Senate Bill 51 requires that PDL edits and prior authorization be removed from OUD treatments. Those edits will be removed 7/1/2021. In compliance with the SUPPORT Act, safety edits, such as quantity limits, therapeutic duplication edits, drug to drug interaction edits, age edits, and pregnancy precautions, will remain in place.
Louisiana	Buprenorphine/naloxone SL and naltrexone are on the PDL. There are quantity limits on buprenorphine, buprenorphine/naloxone, and naltrexone extended-release injectable suspension. Buprenorphine, buprenorphine/naloxone, and naltrexone have age limits.
Maine	MAT's have PDL criteria which allows induction periods and maintenance periods of usage as well as allowances for opiate use for surgeries and other necessary utilization.
Maryland	Maryland Medicaid utilizes the PDL, clinical criteria for use/PA and quantity limits for MAT for OUD. Multiple products are preferred though may require specific criteria for use to be met prior to approving a medication claim. Non-preferred products require a prior authorization for use. Quantity limits are in place for dose optimization purposes. All information is available at https://mmcp.health.maryland.gov/pap/pages/Preferred-Drug-List.aspx
Massachusetts	Suboxone film and Sublocade are preferred; all other buprenorphine and buprenorphine/naloxone formulations require prior authorization.
Michigan	On December 2, 2019, the clinical prior authorization required for all MAT drugs was removed. Claims are now only subject to the PDL edit and quantity limits.
Minnesota	QL per FDA max dose. Nonpreferred drugs need a PA.
Missouri	MO HealthNet utilizes a PDL edit which includes clinical criteria and dosing limits.
Montana	We utilize PDL controls, max daily dose, individual PAs or one time provider attestation. The provider attestation allows providers to attest they will follow all Medicaid requirements for prescribing buprenorphine/naloxone so they don't have to submit an identical PA for each patient. This prevents access issues and delays in treatment.
Nebraska	PDL
Nevada	Utilizations controls include the following: generic first policy, preferred drug list, clinical criteria, and quantity limits.
New Hampshire	Oral buprenorphine-containing products for OUD are on the PDL. Utilization of oral buprenorphine or buprenorphine/naloxone drugs above 16 mg per day require prior authorization. The criteria require diagnosis and age, substance use disorder counseling, and PDMP review.
New Jersey	Total mg per day limitations exist on some MAT products.
New Mexico	Reports are generated by Conduent on the utilization of MAT drugs for state for review.
New York	PA required for initiation of opioid therapy for patients on established opioid dependent therapy. Quantity limits on select opioid dependent agents.

State	Explanations
North Carolina	Opioid dependence therapy agents have prior approval criteria for non-preferred agents and are on the preferred drug list. Quantity limits: Override is needed to exceed 16 mg; limited to maximum of 24 mg.
North Dakota	We follow FDA and compendia for max dosing and ensure dose consolidation.
Ohio	ODM has eliminated prior authorization on all brand and generic forms of oral short acting buprenorphine-containing products for all prescribers of MAT. In order to facilitate patient safety, there are point-of-sale safety edits for oral short-acting buprenorphine-containing products.
Oklahoma	The utilization controls (i.e., PDL, PA, QL) to monitor or manage the prescribing of MAT drugs for OUD are available on our website.
Oregon	Transmucosal buprenorphine products that exceed an average daily dose of 24 mg per day require PA: https://www.orpdl.org/durm/PA_Docs/buprenorphine.pdf
Pennsylvania	Prior authorization is required for non-preferred drugs for OUD as well as quantity limits of 24 mg/day.
South Carolina	Medication Assisted Treatment Guidelines were developed/implemented May 2020 Inconsistencies in the coverage of medication assisted treatment (MAT) among payers is an often-cited barrier to the initiation and maintenance of MAT. To mitigate this barrier, SCDHHS is implementing standard coverage criteria across managed care organizations (MCOs). The coverage guidelines highlighted in this document were developed in concert with addiction treatment experts from across the state. The criteria contained within this document represent the minimum coverage requirements. The use of less restrictive parameters and the approval of therapy for a period longer than indicated in this document are permissible. https://southcarolina.fhsc.com/Downloads/provider/SCRx_Reference_Guide_MAT.pdf https://www.scdhhs.gov/press-release/medicaid-coverage-treatment-opioid-use-disorder
South Dakota	Quantity limits according to FDA approved dosages.
Tennessee	During FFY2020, TennCare used all of the controls listed to manage the coverage of MAT drugs for OUD. Prior Authorization has been in place since 2010 for buprenorphine-containing products, and the PDL in FFY2020 had a sole-preferred product- Bunavail. A new process using a formalized network of MAT providers was also implemented during FFY2020, and will be outlined in the next section, "Innovative Practices".
Texas	There is a prior authorization for buprenorphine agents with the following checks: age, diagnosis of opioid dependence, and concurrent therapy with opioids. Single ingredient buprenorphine products are approved for treatment of opioid dependence if client is pregnant or is intolerant to naloxone. OUD treatment drugs are all preferred. Single ingredient buprenorphine and methadone are for covered treatment under the long-acting narcotics and are subject to both clinical and PDL prior authorizations.
Utah	Preferred Drug List, Prior Authorization for buprenorphine single products, quantity limit.

State	Explanations
Vermont	Yes. The PDL has preferred agents with no PA required: Suboxone film and naltrexone oral. PA is required for Suboxone daily doses over 16mg. Maximum days supply limit for Suboxone is 14 days Vivitrol is preferred after clinical criteria: Vivitrol: There must be a documented trial of oral naltrexone to establish tolerability AND Patient should be opiate free for > 7 -10 days prior to initiation of Vivitrol. If the diagnosis is alcohol dependence, the patient should not be actively drinking at the time of initial Vivitrol administration.
Virginia	The following criteria must ALL be met for approval: %u2022 Patient is at least 16 years of age and older with a diagnosis of Opioid Use Disorder; AND %u2022 Prescriber has reviewed the Virginia Controlled Substance Database PMP before initiation of therapy. For maintenance therapy requests, prescriber must review PMP on the date of the request; AND %u2022 Requests for non-preferred medications will require submission of a completed FDA MedWatch form for adverse reactions to combination products; AND %u2022 Buprenorphine monotherapy (up to 16 mg/day) will be covered for pregnant women ONLY (maximum of 10 months) with documentation of positive pregnancy test submitted with the fax request form. Also document expected date of delivery (EDD). If criteria are met, may approve through EDD plus 30 days; PLUS %u2022 Maximum of 24 mg per day. Doses greater than 24 mg per day will not be approved %u2022 Concurrent Drugs: %u2212 The following medications will NOT be allowed concurrently with therapy: benzodiazepines, tramadol, carisoprodol, sedative hypnotics or other opioids due to the increased risks of adverse events including fatal overdoses. Prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses of these medications. Forward to pharmacist for review. %u2022 During maintenance the prescriber must check random urine drug screens as part of the treatment plan. %u2212 Checking for buprenorphine, norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates.
Washington	Washington Apple Health (Medicaid) has developed a morphine milligram equivalent (MME) report that allows us to monitor enrollee's opioid MME and if they have a history of opioid use disorder (OUD) or are currently receiving medications used to treat OUD. The data in the MME report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity
West Virginia	ADD
Wisconsin	Wisconsin has diagnosis restriction on drugs used for MAT and most drugs prescribed for MAT are preferred on the PDL and do not require PA.

State	Explanations
Wyoming	Buprenorphine products are on the PDL. In addition, clinical criteria is applied. A diagnosis of opioid use disorder or opioid abuse is required. Claims over 16 mg per day require a prior authorization.

2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

Figure 116 - Program Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

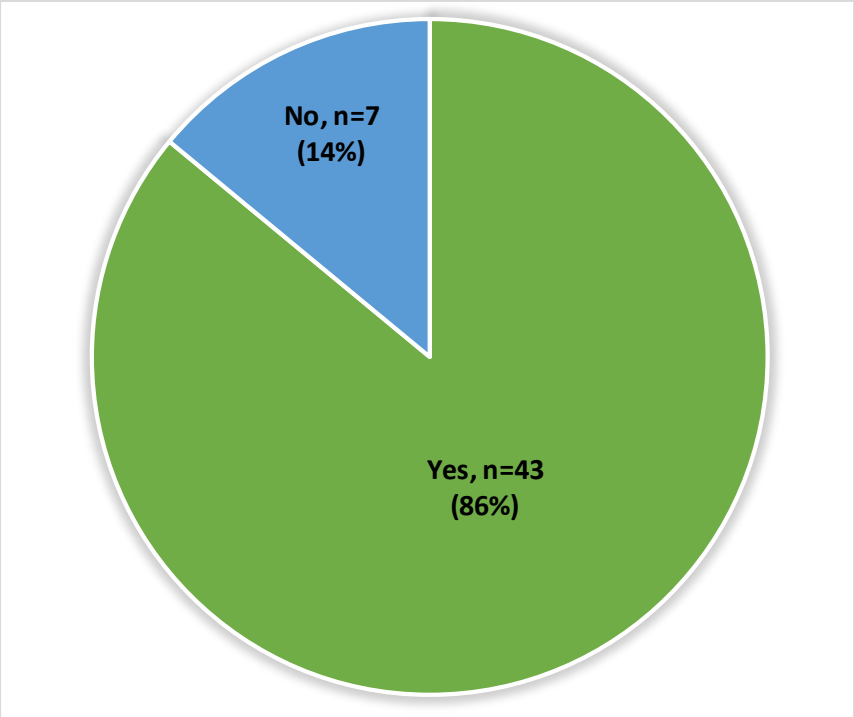

Table 195 - Program Sets Total Milligrams per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	43	86.00%
No	California, Hawaii, New Mexico, Rhode Island, South Dakota, Texas, Wisconsin	7	14.00%
Total		50	100.00%

If "Yes," please specify the total mg/day:

Figure 117 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

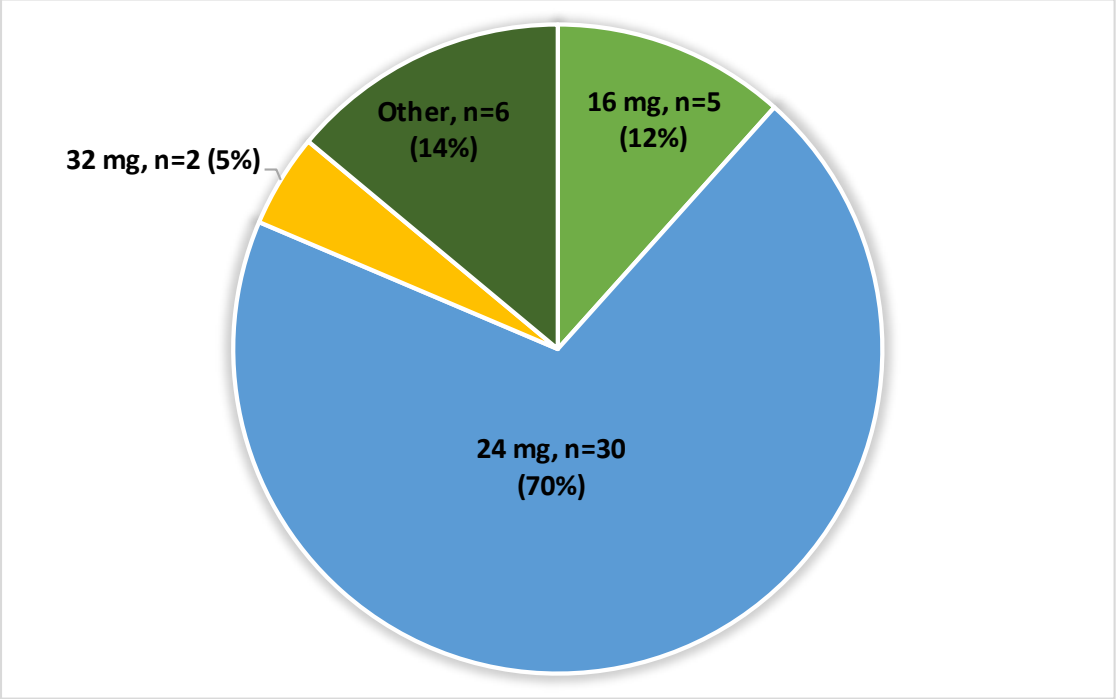

Table 196 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
16 mg	Maine, Oklahoma, Tennessee, Vermont, Wyoming	5	11.63%
24 mg	Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Utah, Virginia, West Virginia	30	69.77%
32 mg	New Jersey, Washington	2	4.65%
Other	Alabama, Connecticut, Illinois, Maryland, North Carolina, Ohio	6	13.95%
Total		43	100.00%

If "Other," please explain.

Table 197 - "Other" Explanations for TotalMilligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

State	"Other" Explanations
Alabama	Per CMS guidelines, the Agency sets the total mg/day for buprenorphine and buprenorphine/naloxone combination drugs at 24mg/day. Bunavail is not approved for > 12.6mg/day and Zubsolv is not approved for > 17.1mg/day.
Connecticut	An Informational alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
Illinois	Buprenorphine tablets total mg/day is 24mg. A group accumulator edit allows up to 93 units per month of any buprenorphine and/or buprenorphine/naloxone combination claims. If prior authorization is requested, the regimen, PMP, and submitted clinical notes are reviewed.
Maryland	Maryland Medicaid employs varying quantity limits based on the drug and dosage form for buprenorphine and buprenorphine-naloxone combination products. Quantity limits are available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
North Carolina	Override is needed to exceed 16 mg; limited to maximum of 24 mg.
Ohio	After 90 days of 24 mg per day, members are required to taper to 16mg per day. A PA is required to exceed these limitations.

3. What are your limitations on the allowable length of this treatment?

Figure 118 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

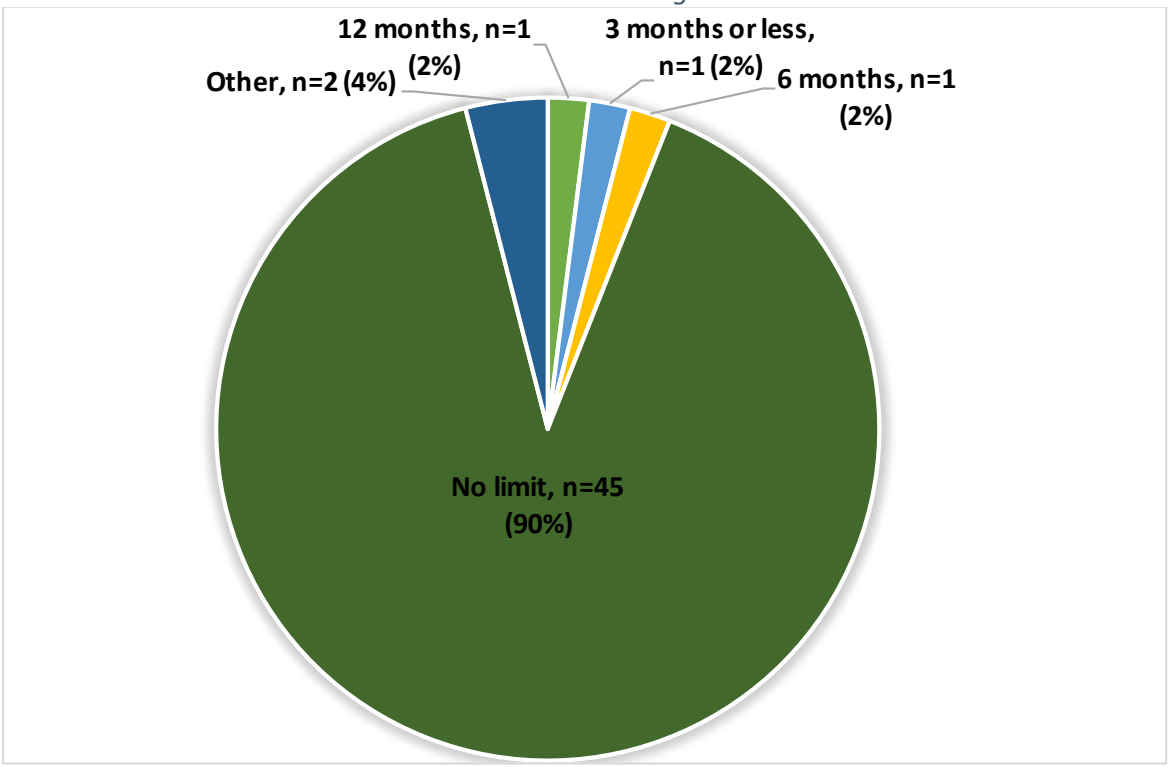

Table 198 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
12 months	Nebraska	1	2.00%
3 months or less	West Virginia	1	2.00%
6 months	Tennessee	1	2.00%
No limit	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming	45	90.00%
Other	Ohio, Virginia	2	4.00%
Total		50	100.00%

If "Other," please explain.

Table 199 – "Other" Explanations for Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

State	"Other" Explanations
Ohio	After 90 days of 24 mg per day, members are required to taper to 16mg per day. A PA is required to exceed these limitations.
Virginia	Length of Authorization: 3 Months (Initial SA), 6 months (Maintenance SA)

4. Does your state require that the maximum mg per day allowable be reduced after a set period of time?

Table 200- Maximum Milligrams per Day Reduction after a Set Period of Time

Response	States	Count	Percentage
Yes	Maine, Ohio, Tennessee, West Virginia	4	8.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	46	92.00%
Total		50	100.00%

If "Yes," please continue.

a. What is your reduced (maintenance) dosage?

Figure 119 - Reduced (Maintenance) Dosage

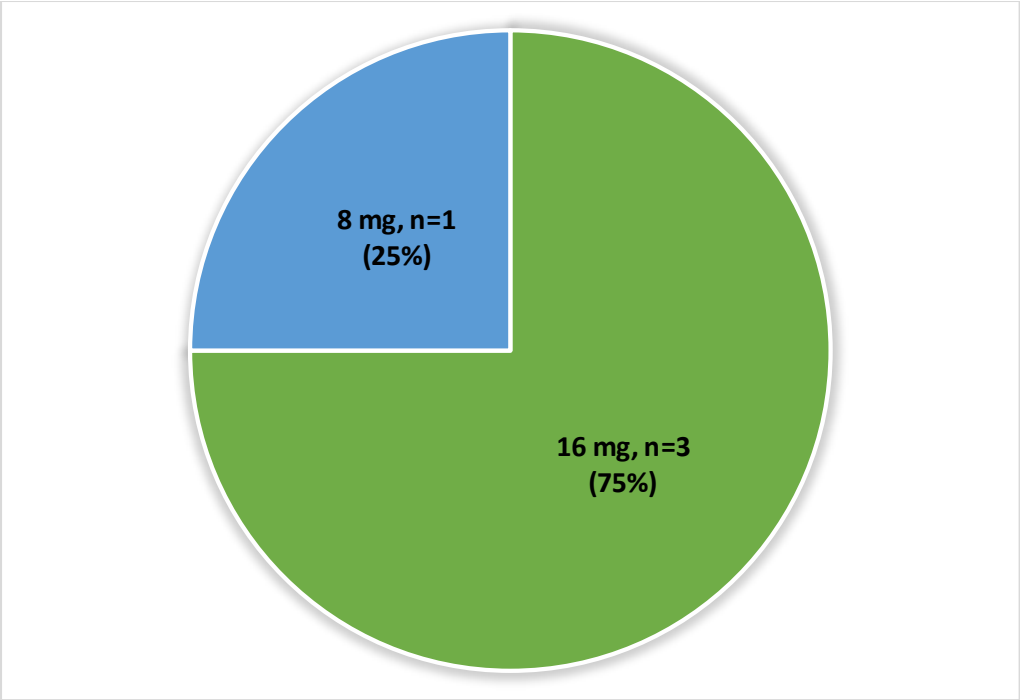

Table 201 - Reduced (Maintenance) Dosage

Response	States	Count	Percentage
16 mg	Maine, Ohio, West Virginia	3	75.00%
8 mg	Tennessee	1	25.00%
Total		4	100.00%

If "Other," please explain.

Table 202– "Other" Explanations for Reduced (Maintenance) Dosage

State	"Other" Explanations
N/A	N/A

b. What are your limitations on the allowable length of the reduced dosage treatment?

Figure 120 - Limitations on the Allowable Length of the Reduced Dosage Treatment of Buprenorphine/Naloxone Combination Drugs

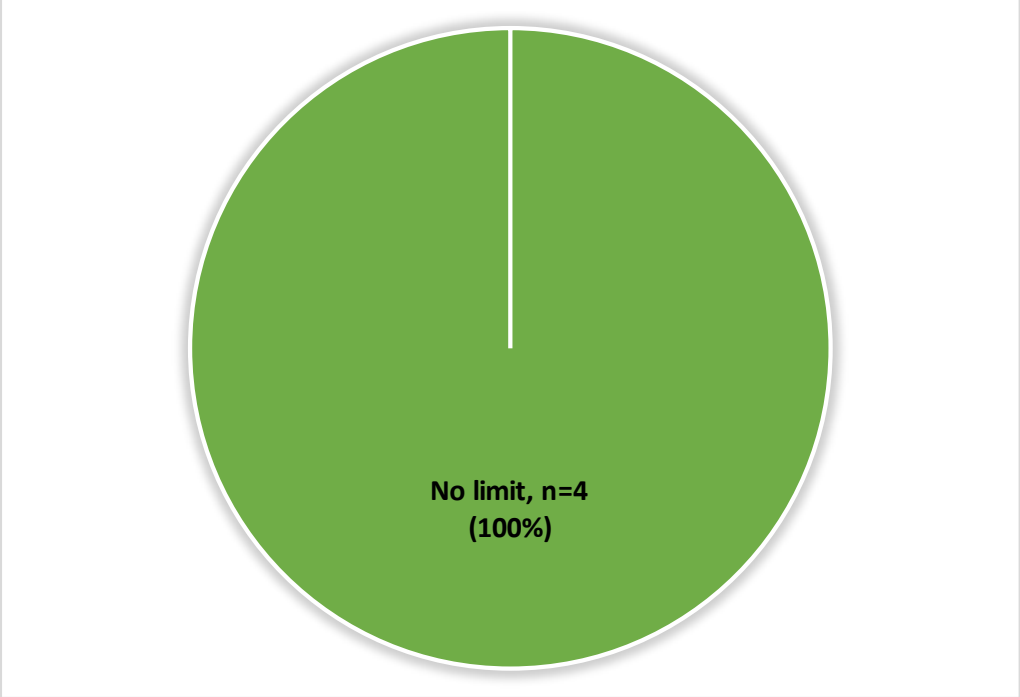

Table 203 - Limitations on the Allowable Length of the Reduced Dosage Treatment on Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
No limit	Maine, Ohio, Tennessee, West Virginia	4	100.00%
Total		4	100.00%

If "Other," please explain.

Table 204 – "Other" Explanations for Limitations on the Allowable Length of the Reduced Dosage Treatment on Buprenorphine/Naloxone Combination Drugs

State	"Other" Explanations
N/A	N/A

5. Does your state have at least one buprenorphine/naloxone combination product available without PA?

Figure 121 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

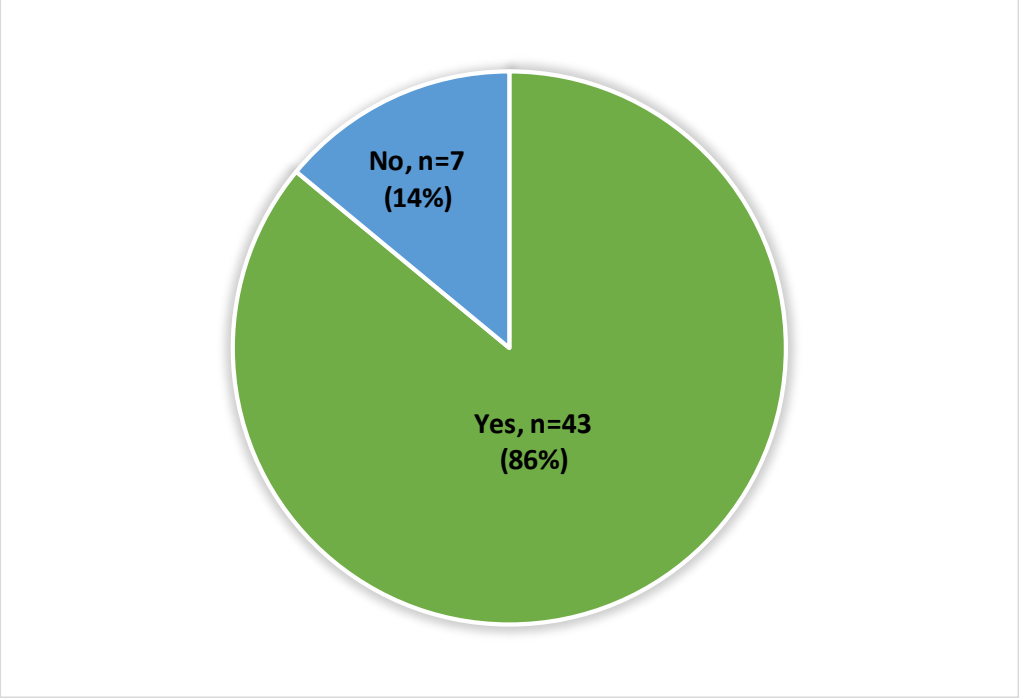

Table 205 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, Wisconsin	43	86.00%
No	Alabama, Colorado, Nevada, Tennessee, Texas, West Virginia, Wyoming	7	14.00%
Total		50	100.00%

6. Does your state currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

Figure 122 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

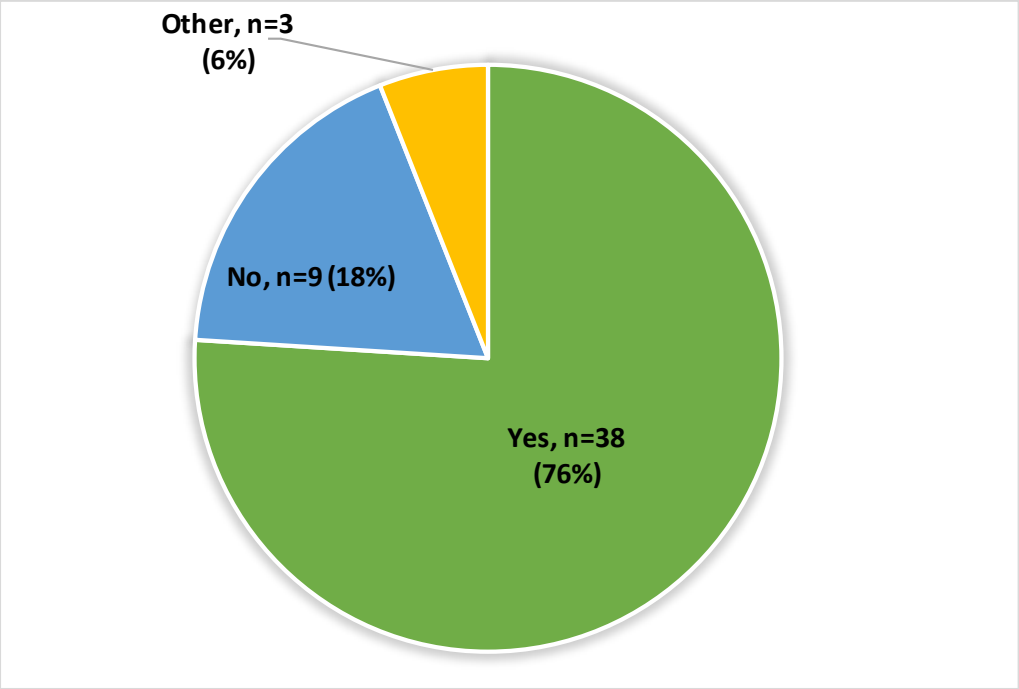

Table 206 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

Response	States	Count	Percentage
Yes	Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	38	76.00%
No	Alabama, California, Hawaii, Iowa, Minnesota, New Mexico, North Carolina, Oregon, Rhode Island	9	18.00%
Other	Connecticut, Kansas, Wisconsin	3	6.00%
Total		50	100.00%

If "Yes," can the POS pharmacist override the edit?

Figure 123 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

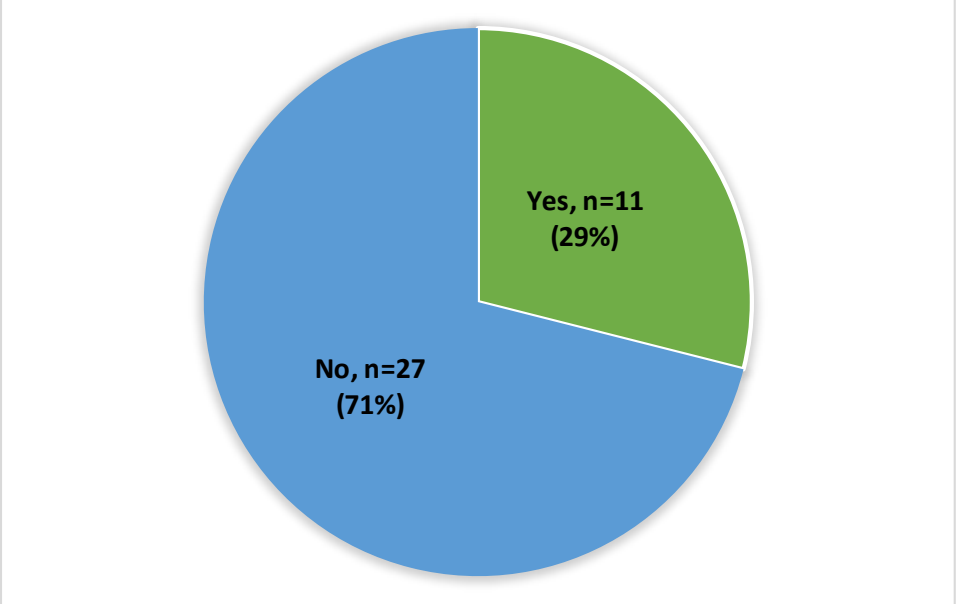

Table 207 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

Response	States	Count	Percentage
Yes	Delaware, Florida, Louisiana, Maryland, Nebraska, Nevada, Ohio, Utah, Vermont, Virginia, Washington	11	28.95%
No	Alaska, Arkansas, Colorado, District of Columbia, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wyoming	27	71.05%
Total		38	100.00%

If "Other," please explain.

Table 208 – "Other" Explanations for Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

State	"Other" Explanations
Connecticut	We currently have RDUR criteria to identify opioids used concurrently with any buprenorphine drug or any form of MAT dispensed at the pharmacy level.
Kansas	During this FFY 2020 survey, only for Subutex, with the prior authorization edit.
Wisconsin	Wisconsin monitors concurrent use of opioids and MAT treatment through retrospective claims review, including lock-in reviews.

7. Is there at least one formulation of naltrexone for OUD available without PA?

Figure 124 - At least one formulation of naltrexone for OUD available without PA

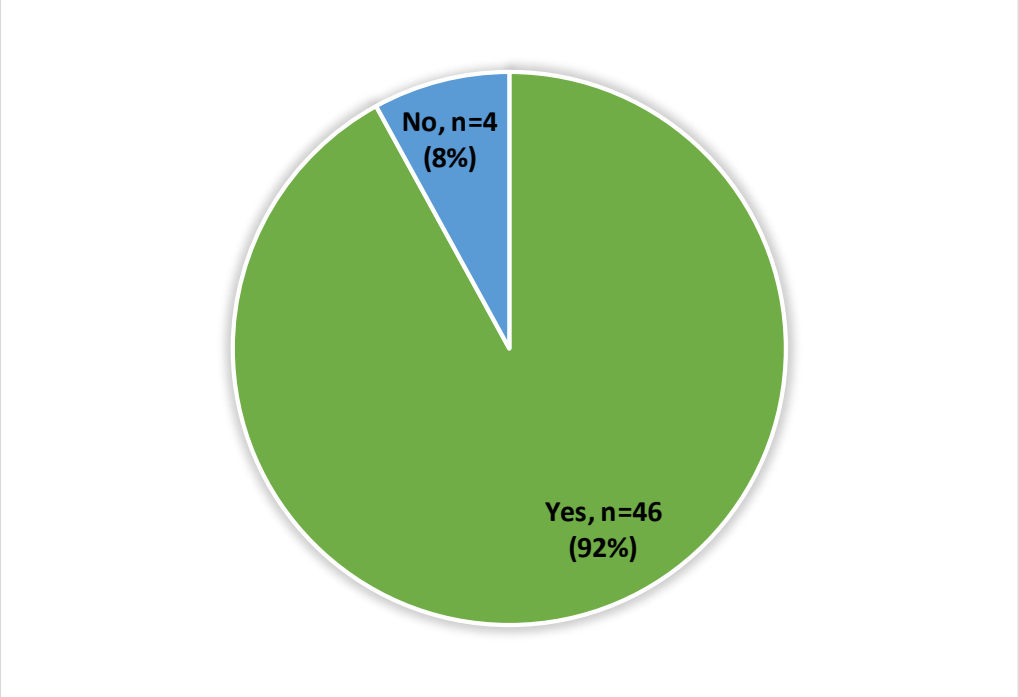

Table 209 - At least one formulation of naltrexone for OUD available without PA

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	46	92.00%
No	Idaho, Missouri, New York, Wyoming	4	8.00%
Total		50	100.00%

8. Does your state have at least one naloxone opioid overdose product available without PA?

Figure 125 – State Have At Least One Naloxone Opioid Overdose Product Available without PA

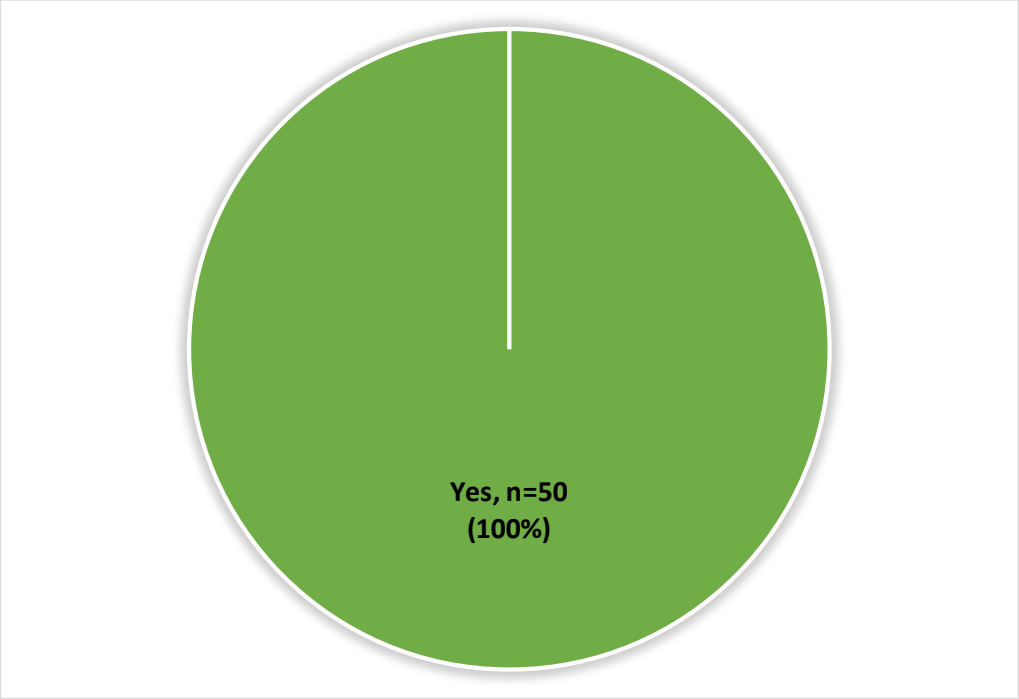

Table 210 - State Have At Least One Naloxone Opioid Overdose Product Available without PA

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%
Total		50	100.00%

9. Does your state retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 126 - State Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

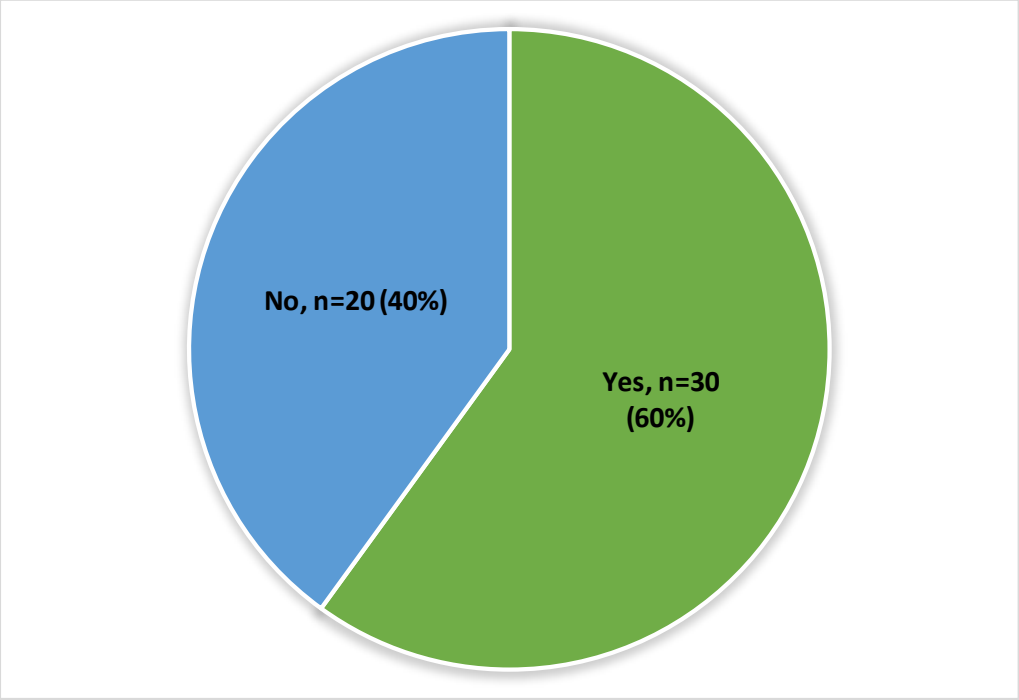

Table 211 - State Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Kentucky, Michigan, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, Wisconsin, Wyoming	30	60.00%
No	Arkansas, Colorado, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, Ohio, Oklahoma, Utah, Vermont, West Virginia	20	40.00%
Total		50	100.00%

If "No," please explain.

Table 212 – Explanations for Not Retrospectively Monitoring and Managing Appropriate Use of Naloxone to Persons at Risk of Overdose

State	Explanations
Arkansas	Prospectively, there is an edit to monitor appropriate use of Naloxone/Opioids. When a second Naloxone claim is billed to Medicaid within a 90 day period, the next opioid claim will deny and require a prior authorization initiated by the prescriber. This specific criterion will exclude terminal cancer patients with a billed diagnosis in the last 365 days. Currently, retrospective monitoring is not done. Ad hoc reporting can be done if the need arises. Arkansas now has a Naloxone protocol that allows POS pharmacists to initiate a prescription for an individual at risk for an opioid related overdose or for a family member, friend, or other person who is in a position to assist an individual with an increased risk of an opioid overdose (which could include Law Enforcement, First Responders, teachers, school nurses).
Colorado	Retrospective analysis and monitoring of naloxone utilization among members at risk for overdose conducted after the FFY 2020 reporting period.
Illinois	State law mandates availability of medications for opioid use disorder and opioid overdose without prior authorization, thus HFS does not manage naloxone use. Naloxone is recommended for patients on chronic opioid therapy as appropriate within the Pain Management Program in the Four Prescription Policy.
Indiana	We are evaluating appropriate processes for monitoring and recommending utilization of naloxone to prescribers for persons at risk of overdose.
Iowa	Prospective safety edit to be implemented in FFY 2021.
Kansas	A policy to require monitoring and managing the appropriate use of naloxone is in place for FFY 2021.
Louisiana	Naloxone availability is being addressed in FFY21.
Maine	The DUR does not actively manage the appropriate use of Naloxone. Naloxone is available on the preferred drug list and the DUR has done a retrospective review of utilization through a DUR initiative but does not monitor on ongoing basis.
Maryland	The FFS program did not monitor or manage this criteria during the reporting period.
Massachusetts	Naloxone is available without prior authorization.
Minnesota	Currently, this is not monitored. MN is planning to add to RetroDUR criteria for the SUPPORT Act RetroDUR mailing.
Montana	We prospectively require providers who are prescribing MAT or opioids over the MME limits to attest that they have reviewed the risk of overdose with their patients and have offered a naloxone prescription.
Nebraska	Patient counseling is offered.
New Hampshire	Prior authorizations for buprenorphine and opioid products require attestation by the prescriber that a prescription for naloxone is provided.
New Mexico	A pro-DUR edit is in process for FFY22.
Ohio	Currently, we do not retrospectively monitor naloxone. However, in opioid RetroDUR interventions we do refer to the naloxone prescribing guidelines on appropriate usage.
Oklahoma	We encourage prescribers to follow guidelines when prescribing opioids. This includes the prescribing of naloxone with the opioid prescription. The utilization of naloxone is reviewed annually with the DUR Board.
Utah	Retrospective review and peer-to-peer education on high dose opioid and concurrent opioid/benzo monthly. Naloxone products don't require prior authorization.

State	Explanations
Vermont	Vermont opioids prescribing rule state that Naloxone should be co-prescribed if opioid dose exceeds 90 MME or if a benzodiazepine is co-prescribed. https://www.healthvermont.gov/sites/default/files/documents/pdf/Opioid%20Prescribing%20Rule%202.1.19.pdf Additionally, Vermont Law for Health Care Professionals (18 VSA 4240 (c)) This law allows health care professionals acting in good faith to prescribe, dispense and distribute an opioid antagonist to a person who is at risk of overdose - or to a family member, friend or other person in a position to help - so long as the recipient of the opioid antagonist has completed a prevention and treatment training program approved by the Vermont Department of Health. Unless acting recklessly, with gross negligence or intentional misconduct, a health professional who prescribes, dispenses or distributes an opioid antagonist under this section shall be immune from civil or criminal liability, regardless of whether the opioid antagonist was administered by or to the person for whom it was provided. https://legislature.vermont.gov/statutes/section/18/084/04240
West Virginia	Currently we are not retrospectively monitoring appropriate use of naloxone however we may have the capability to do so.

10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or "other" predetermined protocols?

Figure 127 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, or "other" Predetermined Protocols

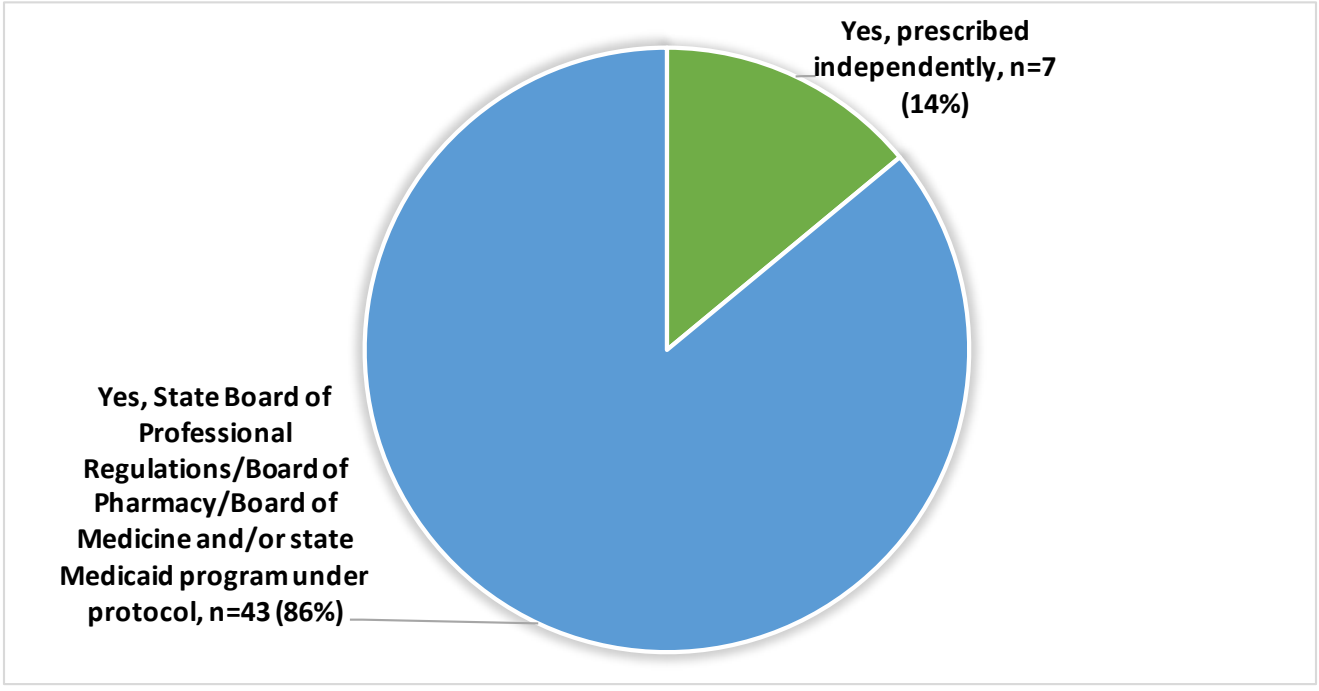

Table 213 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, or "other" Predetermined Protocols

Response	States	Count	Percentage
Yes, prescribed independently	Alaska, Connecticut, Idaho, New Mexico, North Dakota, Oregon, Wyoming	7	14.00%
Yes, State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program under protocol	Alabama, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	43	86.00%
Total		50	100.00%

F. Outpatient Treatment Programs (OTP)

1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services?

Figure 128 – State Cover OTPs that Provide BH and MAT services

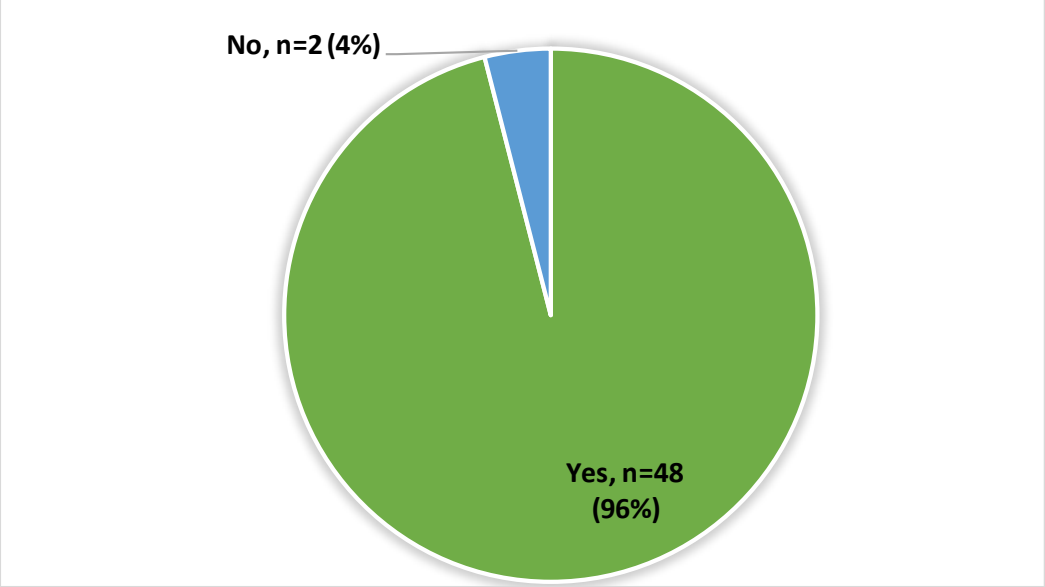

Table 214 - State Cover OTPs that Provide BH and MAT services

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri,	48	96.00%

Response	States	Count	Percentage
	Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin		
No	Hawaii, Wyoming	2	4.00%
Total		50	100.00%

If "Yes," is a referral needed for OUD treatment through OTPs?

Figure 129– Referral needed for OUD treatment through OTPs

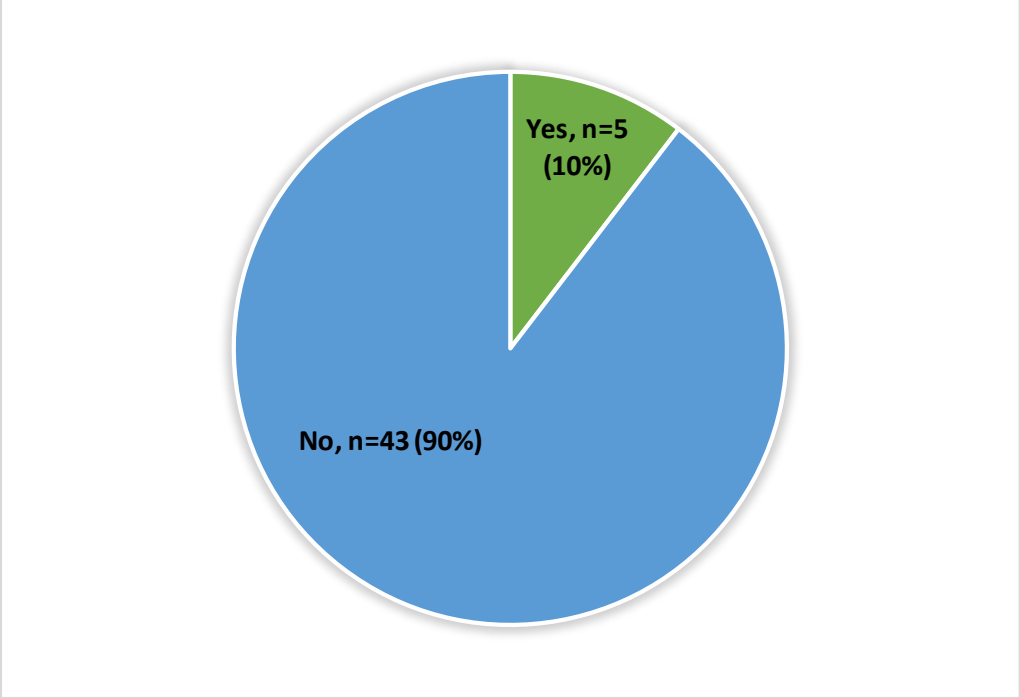

Table 215- Referral needed for OUD treatment through OTPs

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Maine, Michigan, Texas	5	10.42%
No	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	43	89.58%
Total		48	100.00%

If "No," please explain.

Table 216 – Explanations Referral needed for OUD treatment through OTPs

State	Explanations
Alabama	Referral is not needed for OUD treatment through OTPs.
Alaska	Referral is not needed.
Arkansas	Referrals are not needed for OUD treatment through OTPs.
California	The state covers OUD treatment through OTPs and does not require a referral or prior authorization.
Colorado	Reimbursement for services is authorized by Regional Accountable Entities (RAEs) (regional agents administering the State's Medicaid SUD benefit) with submission of an SUD authorization form by qualified providers.
Connecticut	Our state does not require a referral for OUD treatment through OTPs.
Delaware	n/a
District of Columbia	Referrals are needed for individuals seeking methadone treatment in a Department of Behavioral Health DBH certified OTP program
Florida	No referral is needed for OUD treatment through OTPs.
Georgia	n/a
Idaho	Answered all OTP questions for OTP program that went into effect 1/1/2021 so technically was not in place during federal fiscal year covered by this program. Specifically questions 1,2 and 4.
Illinois	State law mandates availability of medications for opioid use disorder. The American Society of Addiction Medicine (ASAM) assessment determines the level of care needed for treatment services, but no special referral is needed.
Indiana	Under Indiana Medicaid, referrals are not required for OUD treatment.
Iowa	Iowa Code 155.35(4) Admission requirements. a. Prior to or at the time of a patient's admission to an opioid treatment program, the program shall conduct a comprehensive assessment so as to determine appropriateness for admission. b. The program shall verify, to the extent possible, the patient's name, address, and date of birth. c. The program physician shall determine and document in the patient's record that the patient is physiologically dependent on narcotic substances and has been physiologically dependent for at least one year prior to the patient's admission. A one-year history of addiction means that the patient was physiologically dependent on a narcotic at a time one year before the patient's admission to a program and was addicted for most of the year preceding admission. (1) When physiological addiction cannot be clearly documented, the program physician or an appropriately trained staff member designated and supervised by the physician shall record in the patient's record the criteria used to determine the patient's current physiologic dependence and history of addiction. In the latter circumstance, the program physician shall review, date, and countersign the supervised staff member's evaluation to demonstrate the physician's agreement with the evaluation. The program physician shall make the final determination concerning a patient's physiologic dependence and history of addiction. The program physician shall also sign, date, and record a statement that the physician has reviewed all the documented evidence to support a one-year history of addiction and current physiologic dependence by the patient and that in the physician's reasonable clinical judgment the patient fulfills the requirements for admission to maintenance treatment. Before the program administers any medication to the

State	Explanations
	patient, the program physician shall complete and record the statement documenting the patient's addiction and current physiologic dependence. (2) When a patient has voluntarily left an opioid treatment program in good standing and seeks readmission within two years of discharge, the program shall document the following information about the patient:1.Prior opioid treatment of six months or more; and 2.That in the physician's medical judgment, treatment of the patient is warranted. Such documentation shall be entered in the patient's record by the program physician. d. The program shall collect a drug screening sample for analysis. Where dependence is substantially verified through other indicators, a negative drug screen will not necessarily preclude admission to the program. e. Prior to a patient's admission, the program shall confirm with the central registry that the patient is not currently enrolled in another opioid treatment program. f. If a potential patient has previously been enrolled in another program, the admitting program shall request from the previous program a copy of the patient's assessment data, treatment plan, and discharge summary including the type of or reason for discharge. All programs subject to these rules shall promptly respond to such a request upon receipt of a valid release of information. g. A person under the age of 18 is required to have had two documented attempts at short-term detoxification or drug-free treatment to be eligible for maintenance treatment. A one-week waiting period is required after such a detoxification attempt, however, before an attempt is repeated. The program physician shall document in the patient's record that the patient continues to be, or is again, physiologically dependent on narcotic drugs. h. Program staff shall ensure that a patient is voluntarily participating in the program, and the patient shall sign a Consent to Treatment Form. i. Pregnant patients may be admitted to opioid treatment in accordance with the following provisions: (1) Evidence of current physiological dependency is not needed if the program physician certifies the pregnancy and, in the physician's reasonable judgment, finds treatment to be justified. Documentation of all findings and justifications for admission shall be documented in the patient's record by the program physician prior to the administration of the initial dose of medication. (2) Pregnant patients shall be offered comprehensive prenatal care. If the program cannot provide prenatal services, the program shall assist the patient in obtaining such services and shall coordinate ongoing care with the collateral provider. (3) The program physician shall document that the patient has been informed of the possible risks to the unborn child from the use of medication and the risks of continued use of illicit substances. (4) Should a program have a waiting list for admission to the program, pregnant patients shall be given priority
Kansas	The provider obtains the patient's medical history and does a physical examination before a dose of medication is given.
Kentucky	N/A
Louisiana	Referrals are not needed.
Maine	simple referral by the provider
Maryland	Maryland Medicaid does not require a referral for opioid use disorder treatment through outpatient treatment programs for participants.
Massachusetts	No referrals are required.
Michigan	Yes, a referral is required.

State	Explanations
Minnesota	During the parallel process (a transfer of authorization methodology for SUD treatment in Minnesota), a client can choose the traditional Rule 25 process through a placing authority (County, Tribe or Managed Care Organization) and seek authorization and referral, or the client can go directly to the OTP for evaluation and possible admission. The parallel process terminates on 1 July, 2022 when all client have the ability to directly access OTPs. Same as true for tribally licensed MAT programs.
Mississippi	No referrel is required, but OTP services must be prior authorized.
Missouri	No referral is needed.
Montana	Medication Assisted Treatment does not require a referral either through and OTP or OBOT
Nebraska	no
Nevada	OTPs are covered and referral is not needed for treatment.
New Hampshire	No referral is required.
New Jersey	Referrals for OUD treatment through OTPs is not required, but services may require authorization for payment.
New Mexico	No documented requirement at this time.
New York	On the Medicaid managed care side, individuals have the ability to self-refer to outpatient services and OTPs are considered essential community providers so they have the ability to rapidly access treatment. State law prohibits prior authorization for these services across insurance products (public/private) that are regulated by NYS.
North Carolina	Beneficiaries can seek treatment and admittance to OUD treatment programs without a referral.
North Dakota	Patients can self refer.
Ohio	OTPs are regulated by the Ohio Department of Mental Health and Addiction Services, the Ohio Board of Pharmacy, and/or SAMHSA and prescribers are required to have DEA waiver.
Oklahoma	Outpatient treatment programs (OTPs) that provide behavioral health and MAT services are covered without a referral.
Oregon	No referral required, but providers have to enroll in State Medicare program, and if it applies, the state Medicaid Managed Care Organization (MCO).
Pennsylvania	This is run through the Office of Mental Health and Substance Abuse.
Rhode Island	No referral needed.
South Carolina	Effective on or after Jan. 1, 2019, SCDHHS will amend the South Carolina Title XIX State Plan to include covered services for OTPs. These services are intended to provide medically necessary treatment to eligible Medicaid beneficiaries with a confirmed diagnosis of opioid use disorder (OUD). These services must be provided in a clinic that is approved to render methadone maintenance therapy by the Drug Enforcement Agency (DEA) and accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA). OTP clinic services provided must be consistent with 42 CFR 8.12. https://www.scdhhs.gov/public-notice/public-notice-final-action-coverage-opioid-treatment-program-otp-services
South Dakota	OUD treatment through an OTP does not require a referral.
Tennessee	Members may receive these services as covered benefits from providers that are registered with the State of Tennessee's Medicaid program and have a currently valid Tennessee Medicaid ID.
Texas	Texas residents 18 and older with moderate to severe opioid use disorder for at least 12 months in a row are eligible for MAT services. Financial eligibility is based on income and expenses, and some out-of-pocket expenses may be needed. Eligible residents may receive Medication-Assisted Treatment Services by calling their local narcotic treatment center provider or call the outreach, screening, assessment and referral center for their region.

State	Explanations
Utah	No referral is needed for treatment.
Vermont	Anyone can call or log on to Vt helplink to get help for Drug or Alcohol Addiction. https://vthelplink.org/ All OTPs have behavioral health counselors on staff, and patients are required to periodically check-in with their counselors.
Virginia	A referral is not needed.
Washington	Clients are able to access benefits right away, there is no PA/referral needed for either prescribed OUD treatment in office-based settings, or in administered and dispensed medication opioid treatment program settings in WA.
West Virginia	A referral is not necessary but they can be accepted.
Wisconsin	Wisconsin does not require a referral for OUD treatment through OTPs.

If "No," please explain.

Table 217 – Explanations for Not Covering OTPs that Provide BH and MAT services

State	Explanations
Hawaii	current population covered does not utilize.
Wyoming	Wyoming does not have any outpatient treatment programs.

2. Does your state Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

Figure 130 – State Program Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

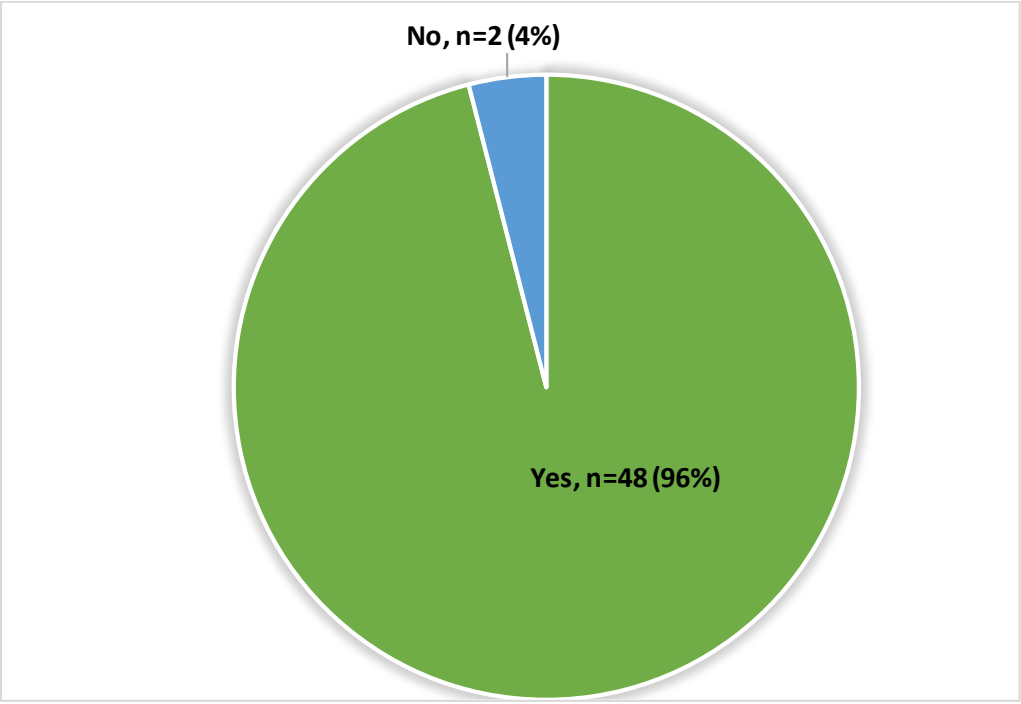

Table 218 - State Program Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	48	96.00%
No	Hawaii, Wyoming	2	4.00%
Total		50	100.00%

If "No," please explain.

Table 219 – Explanations for State Not Covering Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

State	Explanations
Hawaii	both are covered without restriction to services through OTP
Wyoming	Wyoming does not have any outpatient treatment programs.

3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?

Figure 131 – State Program Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

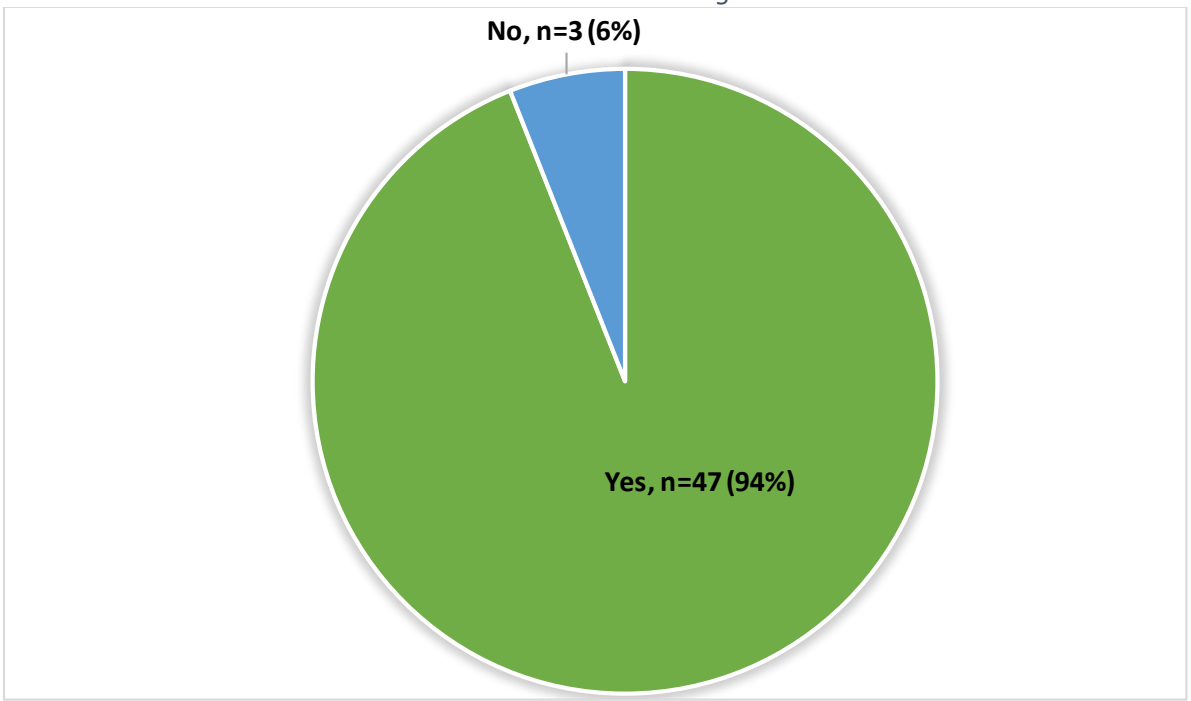

Table 220- State Program Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	California, Hawaii, Louisiana	3	6.00%
Total		50	100.00%

If "No," please explain.

Table 221– Explanations for State Not Covering Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

State	Explanations
California	This is an optional benefit for Drug Medi-Cal Organized Delivery System (DMC-ODS).
Hawaii	covered without restriction to services through OTP
Louisiana	Medical claims for naltrexone are not covered.

4. Does your state Medicaid program cover Methadone for a substance use disorder (i.e. OTPs, Methadone Clinics)?

Figure 132 – State Program Cover Methadone for Substance Abuse Disorder

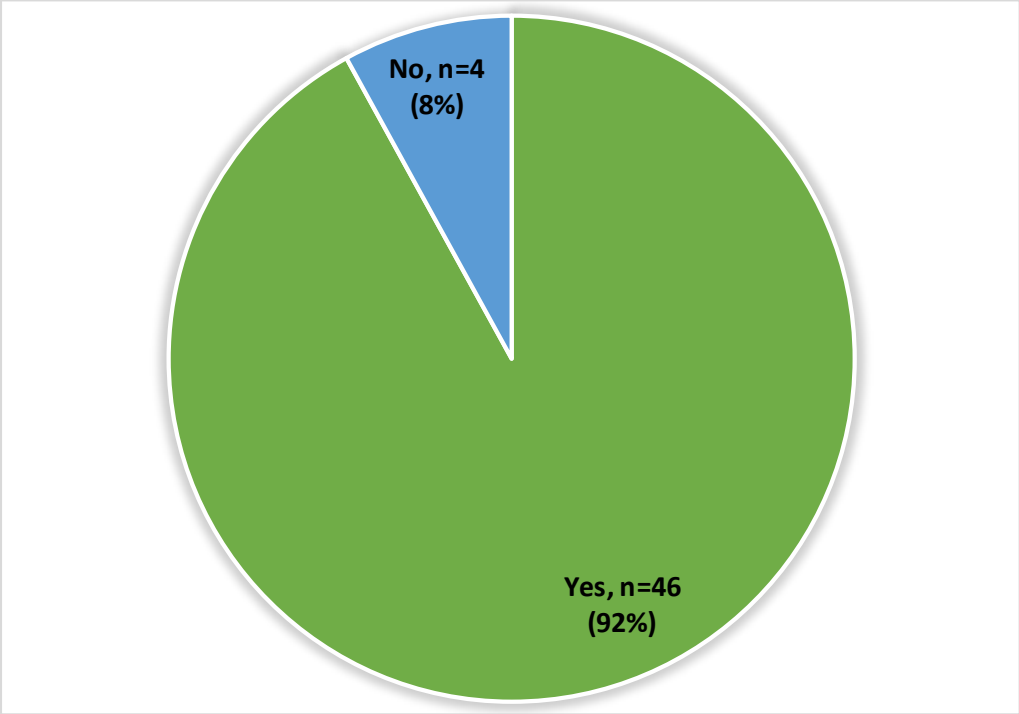

Table 222- State Program Cover Methadone for Substance Abuse Disorder

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	46	92.00%
No	Kansas, Kentucky, South Dakota, Wyoming	4	8.00%
Total		50	100.00%

G. Antipsychotics / Stimulants

Antipsychotics

1. Does your state currently have restrictions in place to limit the quantity of antipsychotics?

Figure 133 - Restrictions to Limit Quantity of Antipsychotics

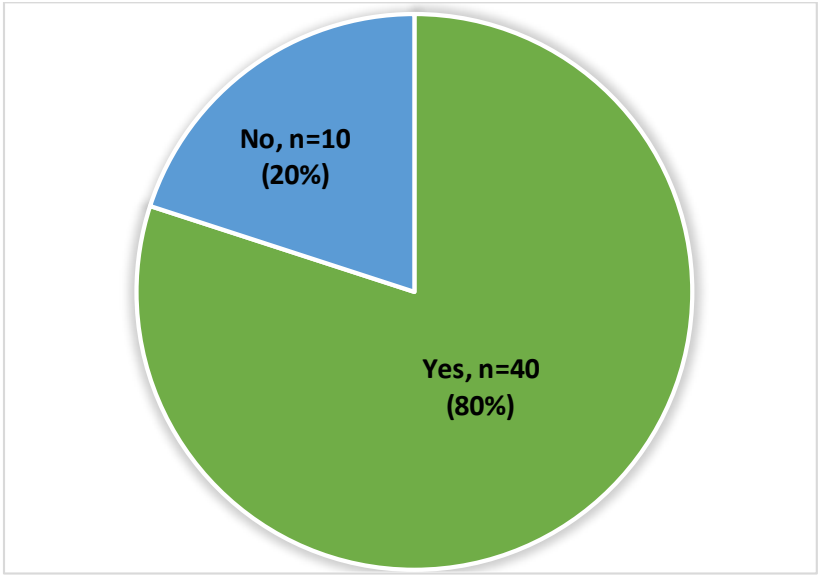

Table 223- Restrictions to Limit Quantity of Antipsychotics

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New	40	80.00%

Response	States	Count	Percentage
	Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wyoming		
No	California, Louisiana, Massachusetts, Michigan, New Mexico, North Carolina, Oregon, Rhode Island, West Virginia, Wisconsin	10	20.00%
Total		50	100.00%

Please explain restrictions or N/A

Table 224 - Explanations of Restrictions to Limit Quantity of Antipsychotics

State	Explanations
Alabama	PA is required for all antipsychotics. Prescriptions written by a psychiatrist and prescriptions for FDA-approved diagnoses are processed through electronic PA at the POS. Medical justification is required for polytherapy. Metabolic monitoring is required for children (,6 years of age) and must be documented on the PA request form.
Alaska	N/A
Arkansas	Oral antipsychotics have maximum dose edits (implemented by quantity edits at POS) for adults and children based on treatment guidelines and recommendations from the manufacturer's package insert for the specific drugs. Dose edits for children are based on age. A therapeutic duplication edit allows a maximum of two oral antipsychotic agents or one oral antipsychotic agent and one long-acting injection (LAI) without an additional TD prior authorization. All new starts for a long-acting injection require a prior authorization, and all LAIs have continuation criteria if the client remains stable and compliant. Oral and injection antipsychotics are both on our PDL.
California	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0-17 years of age. An approved Treatment Authorization Request is also required for beneficiaries residing in skilled nursing facilities (SNFs).
Colorado	Quantity and age limits are in place.
Connecticut	A quantity limit of 240 units is used for oral tablets. QL of 500 units for liquid, QL of 30 units for injectables.
Delaware	Prior authorization is required for all antipsychotics for patients under six (6) years of age and for any product being prescribed outside of FDA approved age ranges. We also edit for therapeutic duplication.
District of Columbia	Injectable antipsychotic medications are available at POS through pharmacies participating in the Mental Health Pharmacy Network.
Florida	There are limits according to FDA package inserts.
Georgia	Clinical prior authorization also in place for certain antipsychotics. Pediatric off-label use of antipsychotics reviewed on case-by-case basis.
Hawaii	30 day supply maximum
Idaho	Limit dose per day. Age limit per FDA approved labeling. Specifically do not allow for less than 6 years without a PA.
Illinois	Group accumulators on long-acting injectable antipsychotics and high dose override for some of the antipsychotics that overrides the Medispan programmed high dose. Also prior

State	Explanations
	authorization is required for use of antipsychotic medications for long-term care residents, for long acting atypical antipsychotics, and for all children less than 8 years of age.
Indiana	Age limits, duplicate therapy edits, low-dose edits, 15-day initial supply limits, and quantity limits.
Iowa	Quantity limits
Kansas	We have multiple concurrent use limits, dose limits, age limits, and provider type/or in consultation with a psychiatrist, neurologist, or developmental/behavioral pediatrician
Kentucky	There are quantity limits and dose accumulation limits on many of the second- generation and long-acting agents. Also, a PA is required for the member to receive more than 2 antipsychotics concurrently.
Louisiana	Selected antipsychotic agents have quantity limits. Additionally, safety edits are in place at POS and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for beneficiaries less than 6 years old.
Maine	Require prior authorization for use under age 5, for multiple anti-psychotic concurrently and routinely review metabolic monitoring during use.
Maryland	Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP) To support providers who prescribe this drug class, the Office of Pharmacy Services (OPS) has established two programs. These are the Peer Review Program (PRP) and the Tier 2 & Non Preferred (Tier 2 & NP) Antipsychotic Review Program. Non-preferred and Tier 2 clinical criteria. For additional information, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx. The Program also employs clinical criteria and dose optimization requirements.
Massachusetts	Prior authorization is required for polypharmacy with two or more antipsychotics. PA criteria requires documentation of treatment-resistant diagnoses, complete treatment plan including dose, frequency and indication for each antipsychotic, psychiatrist involvement (either as the prescriber or consult notes from the past year) and additional rational for use (cross-taper planned that will result in only one antipsychotic, discharged on polypharmacy after a recent psychiatric hospitalization, or failed trail with two antipsychotics as monotherapy). Dosing is generally managed and monitored with only quantity limits.
Michigan	Current state law prohibits the Fee-For-Service (FFS) pharmacy program from prior authorizing, delaying, or denying coverage of psychotropic medications that are not controlled substances. All psychotropic medications are carved-out of MCO pharmacy benefit and paid through FFS.
Minnesota	FDA max dose.
Mississippi	Electronic PA age edits, quantity limits for all beneficiaries, multiple antipsychotic edit for children, and manual PA criteria for multiple antipsychotic continued use in children.
Missouri	Missouri utilizes a Dose Optimization Fiscal Edit to help reduce the utilization of drug therapies that comprise of multiple units of lower strength dosage forms, when single units of higher strength dosage forms deliver the same drug therapy, with lower cost to the program. Dosing that exceeds the set limitation requires prior authorization. Additionally there are clinical criteria surrounding atypical antipsychotics that must be met including dosing limits.
Montana	For children 7 and under we require prior authorization including documentation of metabolic labs and parental notification of potential side effects. Case management is performed on all foster children on psychotropic medications. Dosages and quantities are reviewed for appropriateness
Nebraska	Daily dose units

State	Explanations
Nevada	Children under age 18 years-old are allowed one antipsychotic without prior authorization.
New Hampshire	Quantity is limited to a 90 day supply for beneficiaries on maintenance.
New Jersey	Maximum daily dose edits are in place for antipsychotics.
New Mexico	Only up to a 34-day maximum supply is allowed per prescriber dosing.
New York	Maximum daily limits have been placed on the following antipsychotics. paliperidone ER, quetiapine, quetiapine ER based upon tablet strength, lumateperone.
North Carolina	Antipsychotics have edits that require Prior Authorization, check for concomitant use, check for quantity limits, daily dose, and maximum quantity.
North Dakota	We follow FDA and compendia max and min limits.
Ohio	Restrictions include quantity and day supply limits.
Oklahoma	Quantity limits of antipsychotics are based on FDA approved dosing regimens.
Oregon	N/A
Pennsylvania	Prior authorization and quantity limits.
Rhode Island	No restrictions
South Carolina	Including, but not limited to: Prior authorization for indication and age, TD duplication edits, Overuse, etc.
South Dakota	Quantity limits in accordance with FDA approved dosages.
Tennessee	Tennessee has quantity limits for many psychotropic classes of drugs including anti-anxiety, antidepressants and atypical antipsychotics. The quantity limits for atypical antipsychotics are managed via a hard edit, and the limits may be surpassed via prior authorization. We would like to adhere strictly to quantity limits for APsy, however it would be extremely disruptive to the therapy of our enrollees, who are among the most vulnerable population served by our State. Many of our APsy are used for the worst of the worst cases, and doses have been necessarily and appropriately pushed higher than manufacturer's recommendations.
Texas	The POS PA criteria limits the number of antipsychotics prescribed concurrently. The criteria allows for up to two different antipsychotics (that are not the same in chemical formulations). combination of various strengths and dosage forms of the same drug is permitted.
Utah	Utah Medicaid monitors the use of antipsychotics for all children under 19 years of age: high dose, under 6 years of age, concurrent use of multiple antipsychotics.
Vermont	Limits are in conjunction with the FDA maximum recommended dose Listed on the PDL for example ARIPIPRAZOLE (compare to Abilify) QTY LIMIT: 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization. Also there are quantity limits.
Washington	For clients 17 years of age and younger WA Medicaid applies age/dose limits to second generation antipsychotics. These limits are set by the Pediatric Mental Health guidelines and all requests to exceed the established thresholds must have a Second Opinion (SON) Review by the Agency's contracted mental health specialist (Seattle Children's Hospital).
West Virginia	We use a therapeutic duplication edit to limit the use of multiple antipsychotics. Quantity limits are by FDA label.
Wisconsin	Wisconsin requires prior authorization for children less than nine years of age who are on antipsychotics.
Wyoming	Antipsychotics are limited to labeled maximum daily doses.

2. Does your state have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

Figure 134- Program in Place for Either Managing or Monitoring Appropriate Use of Antipsychotic Drugs in Children

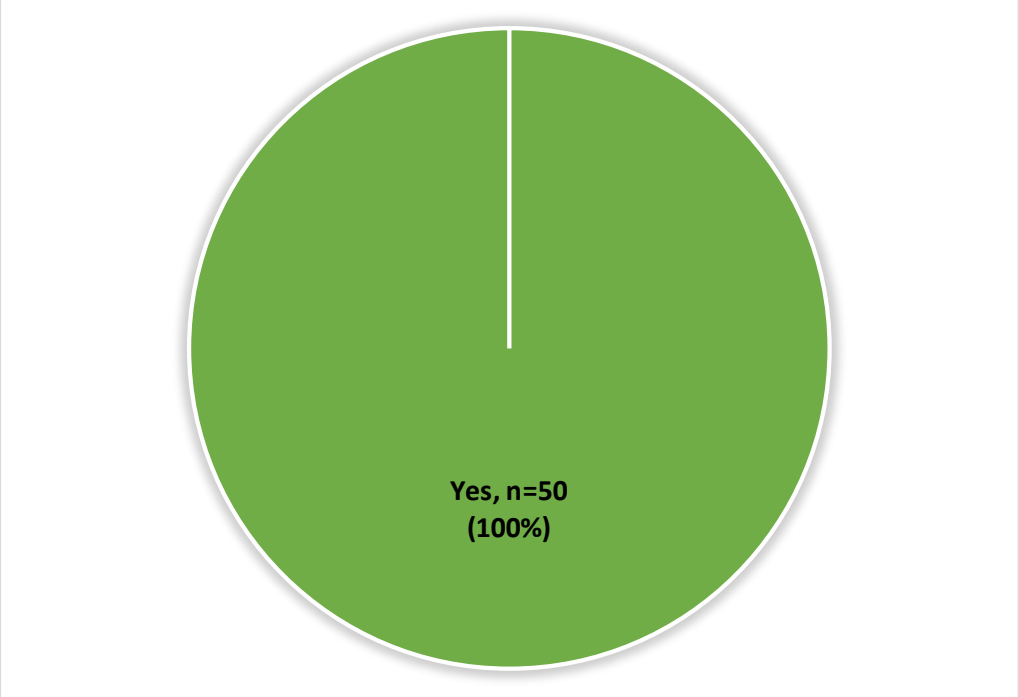

Table 225 - Monitoring Program in Place for Either Managing or Monitoring Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%
Total		50	100.00%

If "Yes," please continue.

a. Does your state either manage or monitor:

Figure 135- Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

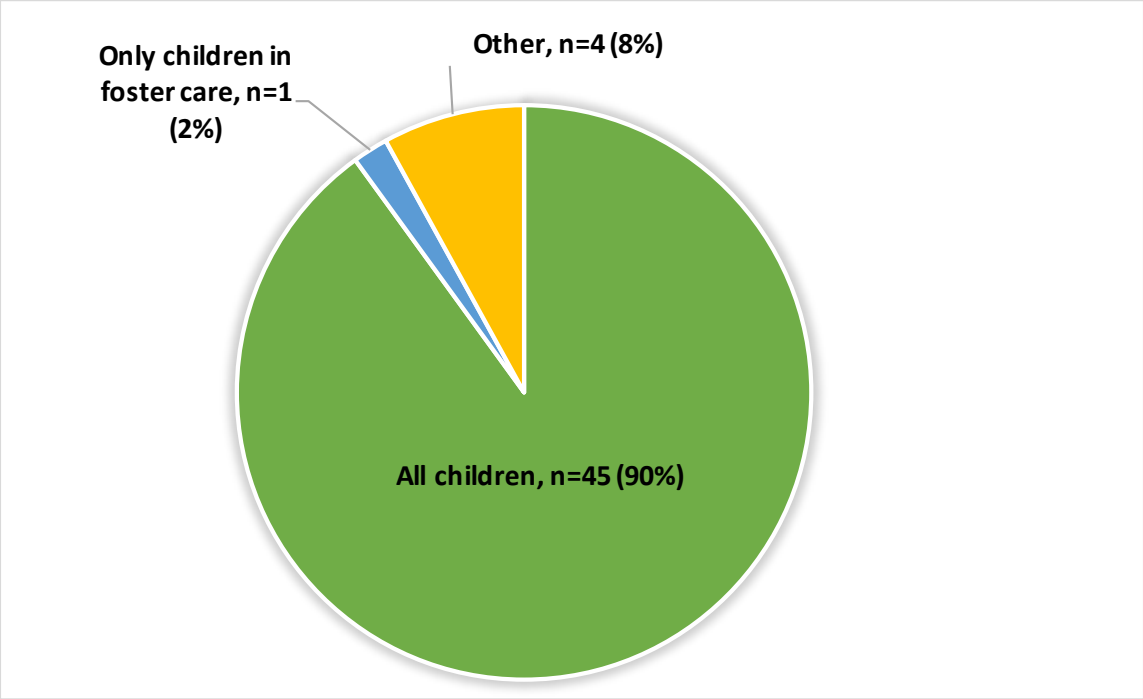

Table 226 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	States	Count	Percentage
All children	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	45	90.00%
Only children in foster care	Maine	1	2.00%
Other	Illinois, New Mexico, Oregon, Wisconsin	4	8.00%
Total		50	100.00%

If "Other," please explain.

Table 227 - "Other" Explanations for Either Managing or Monitoring Categories for Appropriate Use of Antipsychotic Drugs in Children

State	"Other" Explanations
Illinois	Prior authorization is required for all children under the Department of Child and Family Services (DCFS) Youth in Care; all children less than 8 years of age who are prescribed atypical antipsychotic medications; and all children prescribed long-acting atypical antipsychotics. Doc Assist review and peer-to-peer consultation are also available.
New Mexico	Children prescribed antipsychotics from non-IHS prescribers are identified as requiring metabolic monitoring. The IHS prescribers are notified by the State IHS liaison for follow-up.
Oregon	We monitor all foster care children yearly if prescribed an antipsychotic. For non-foster care children, higher risk children are identified for intervention based on a variety of prescribing characteristics. Specifically, in non-foster care, we're monitoring use in children less than 10 years of age prescribed long-term antipsychotics (>90 days) and we select the highest risk ones for intervention. Anyone who isn't in foster care and is over 10 years old isn't monitored.
Wisconsin	Wisconsin requires a prior authorization for children less than nine years of age, including those children in foster care.

b. Does your state have edits in place to monitor:

Figure 136 - Antipsychotic Edits in Place to Monitor for Appropriate Use in Children

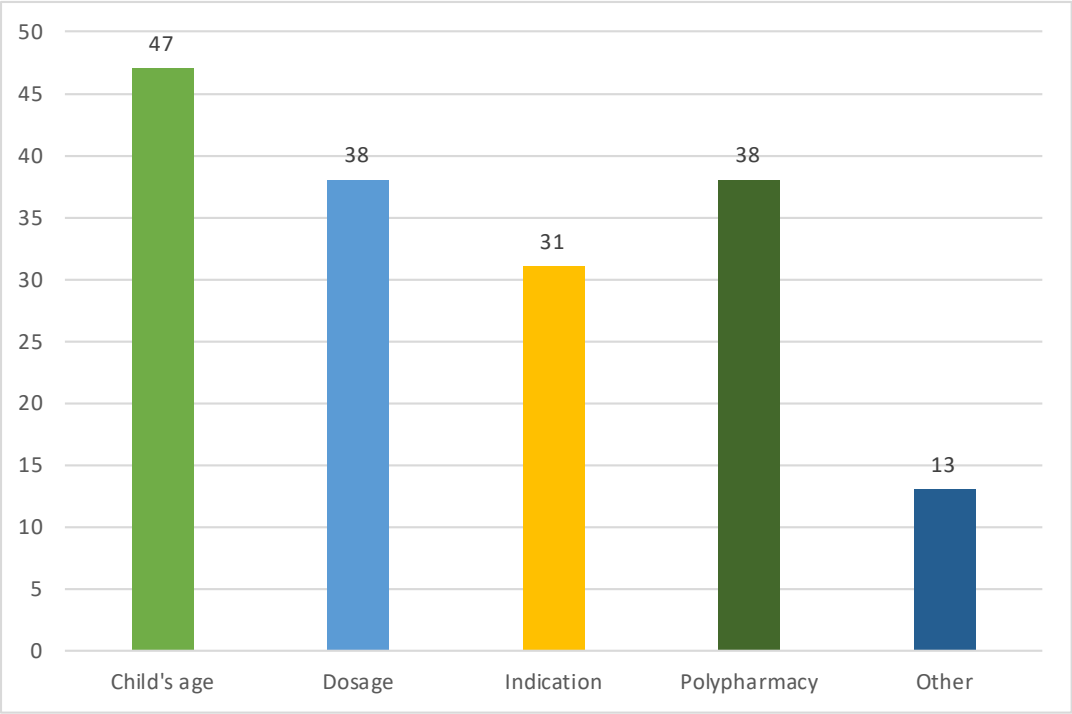

Table 228 - Antipsychotic Edits in Place to Monitor for Appropriate Use in Children

Response	States	Count	Percentage
Child's age	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	28.14%
Dosage	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	38	22.75%
Indication	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington	31	18.56%
Polypharmacy	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, Wyoming	38	22.75%
Other	Illinois, Kansas, Kentucky, Louisiana, Maine, Massachusetts, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Vermont, Washington	13	7.78%
Total		167	100.00%

If "Other," please explain.

Table 229 - "Other" Explanations for Antipsychotic Edits in Place to Monitor for Appropriate Use in Children

State	"Other" Explanations
Illinois	Prior authorization for atypical antipsychotics in children < 8 years of age reviews appropriate indication, non-pharmacologic therapy use, and step therapy pre-use of antipsychotics.
Kansas	Multiple concurrent drug use edits. Provider type edits- either at POS or via the PA process.
Kentucky	A diagnosis-drive PA is required for all second- generation antipsychotics and there is a therapeutic duplication limit of 2 antipsychotics at a time as well as maximum daily dosage accumulations. Some individual agents have an age limit in line with the FDA-approved indications.
Louisiana	Safety edits are in place at POS and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for beneficiaries less than 6 years old.

State	"Other" Explanations
Maine	metabolic monitoring is required and prior authorization if monitoring is not completed in the members medical claims data.
Massachusetts	Use of behavioral health medications in children, including antipsychotics, are managed through a comprehensive monitoring program. Prior authorization is required for members less than 18 years of age if there is polypharmacy with four or more behavioral health medications (including antipsychotics) across all behavioral health classes. Also for all children less than 18 years of age, PA is required for polypharmacy with two or more antipsychotics. Additionally, PA is required for antipsychotics for all children less than six years of age.
New Mexico	Retro DUR interventions identify children requiring metabolic monitoring.
North Carolina	Require Prior Authorization, check for concomitant use, and quantity limits.
Ohio	We have edits in place that monitor any medication that has a drug interaction with an antipsychotic. Additionally, we have a DUR edit in place that notifies a pharmacist when an opioid is prescribed in combination with an antipsychotic.
Oregon	duration of therapy, metabolic monitoring, and prescriber specialty
Tennessee	In addition to checking the age and indication, during the prior authorization process the drug product being selected is also checked for preferred status on the PDL.
Vermont	All antipsychotic atypical & combinations require the following clinical criteria to be met for children under 18 years old Criteria for approval : Medication is being requested for one of the target symptoms or diagnoses listed above AND the patient is started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient meets additional criteria outlined below. Note: all requests for patients < 5 years will be reviewed by the DVHA medical director. Target symptoms or Diagnosis that will be accepted for approval: Target Symptoms - Grandiosity/euphoria/mania; Obsessions/compulsions; Psychotic symptoms; Tics (motor or vocal). Diagnosis- Autism with Aggression and/or irritability; Disruptive Mood Dysregulation Disorder; Bipolar Disorder; Intellectual Disability with Aggression and/or Irritability; Major Depressive Disorder with psychotic features; Obsessive Compulsive Disorder; Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome.
Washington	For clients 17 years of age and younger WA Medicaid also applies edits for therapy duplication.

c. Please briefly explain the specifics of your antipsychotic monitoring program(s).

Table 230- Explanations of the specifics for the state Antipsychotic Monitoring Program for Appropriate Use in Children

State	Explanation of Antipsychotic Monitoring Program
Alabama	PA is required for all antipsychotics. Prescriptions written by a psychiatrist and prescriptions for FDA-approved diagnoses are processed through electronic PA at the POS. Medical justification is required for polytherapy. Metabolic monitoring is required for children (,6 years of age) and must be documented on the PA request form.

State	Explanation of Antipsychotic Monitoring Program
Alaska	Quantity limits and therapeutic duplication edits. Special edits for children under 5 years of age. Under contract with pediatric psychiatry specialists.
Arkansas	Reviews by the Medicaid Pharmacy Program clinical pharmacists and psychiatrist take into consideration the client's diagnosis and age, requested drug's indication, other concomitant therapy, and previous therapies tried when reviewing the PA requests. Oral antipsychotics have maximum dose edits for adults and children based on treatment guidelines and recommendations from the manufacturer's package insert for the specific drugs. Dose edits for children are based on age. Clients <18 years of age require a manual review prior authorization for new starts. Continuation criteria for clients 10-17 years of age require at least one paid claim for an oral antipsychotic in the past 45 days and monitoring for both glucose and lipid screening in the past 9 months. Clients <10 years of age require manual review prior authorization after each PA expires. Clients <18 years of age presenting as a new start or changing to a different chemical entity require a signed informed consent form by the guardian. One therapeutic duplication for a change in therapy between two antipsychotics (oral or injectable) with >25% remaining on the last fill on different dates of service is allowed per 93 days. Adults prescribed a preferred medication below the maximum therapeutic dose will have a claim process at POS without a PA. Claims will deny for therapeutic duplication (TD) when either the client is prescribed 3 or more oral antipsychotics OR 2 oral antipsychotics along with a LAI. Patients with a denied claim for TD require a prior authorization request to be submitted by the prescriber.
California	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0-17 years of age. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
Colorado	Edits are in place to identify doses exceeding maximum and off-label uses based on atypical antipsychotic indications for use and patient age, and require prior authorization potentially involving a child/adolescent psychiatrist consult. Retrospective DUR is conducted and letters are sent to providers regarding pediatric members' use of antipsychotic medications.
Connecticut	Connecticut currently has approximately 40 individual RDUR criteria used to monitor and manage antipsychotic medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, antipsychotic medication targeted review and intervention occur at least four times a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
Delaware	Delaware monitors all children but in addition, we do targeted intervention in the foster care population. Ages on the atypical antipsychotic agents are set to the FDA approved indications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies. Doses are edited based on FDA approved doses.
District of Columbia	Monthly reports monitors opioids and antipsychotics, including pediatric patients. Also POS DUE edits include: ANTICHOLINERGICS/SELECT ANTIPSYCHOTICS;SELECT PHENOTHIAZINES, SELECTED ANTIPSYCHOTICS;/TRAMADOL (IR), ANTIPSYCHOTICS; PHENOTHIAZINES/OPIOIDS, SELECTED ANTIPSYCHOTICS THAT PROLONG QT intervals
Florida	The clinical pharmacist is required to review submissions for all children under six and select children over six depending on antipsychotic selection and dosage. Retrospective reviews will be performed identifying all children (including foster care) receiving antipsychotics, at least annually, by the DUR Board. Education shall be provided to practitioners prescribing these medications as deemed appropriate.

State	Explanation of Antipsychotic Monitoring Program
Georgia	All pediatric use of antipsychotics requires submission for review using a Atypical Antipsychotic PA Form. The requests are reviewed on a case-by-case basis by a clinical pharmacist.
Hawaii	Annual review as a whole program with quarterly claim review for individual's at possible risk.
Idaho	Targeted DUR interventions for all children less than 6 years old. Currently in process of implementing a specific PA form for that age group which will include an attestation that informed consent has occurred.
Illinois	Atypical antipsychotics in children < 8 years of age: Ensures appropriate use in schizophrenia, bipolar disorder, and other requested conditions. Check indication and comorbidities. Behavioral/psychosocial interventions before or with drug therapy. Preferred mood stabilizer used alone or in combination before atypical is used. In some cases atypical may be first line therapy: Risperidone first-line, preferred. Polypharmacy.
Indiana	Antipsychotics require prior authorization when used in duplication, low dose, age outside of FDA-approved limits, or when a drug-specific quantity limit is exceeded.
Iowa	Age edit on risperidone for members less than five (5) years of age. Age edit on all other antipsychotics for members less than six (6) years of age. Duplicate therapy edit on all antipsychotics for members 0 through 17 years of age. A 30 day grace period is allowed to allow transition between antipsychotic medications.
Kansas	We have a clinical PA in place and have done claims reviews for this drug class as part of preparations for our Mental Health Medication Advisory Committee meetings.
Kentucky	Prospective review at point of sale which requires an indication submitted on the claim, in medical history or via PA process. There is a therapeutic duplication limit of 2 antipsychotics at a time as well as maximum daily dosage accumulations. Some individual agents have a minimum age limit in line with the FDA-approved indications.
Louisiana	Louisiana has safety edits in place at POS for children and for adults, and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Preauthorization is required for behavioral health agents for beneficiaries less than 6 years old. Antipsychotic agent utilization is reviewed retrospectively for adherence to therapy and for concurrent use with opioids.
Maine	This practice was suspended during the pandemic since the letters could not be generated and mailed from the work from home model. The DUR typically sent out over 1800 letters to providers in a FFY regarding the appropriate need for metabolic monitoring with the use of atypical antipsychotics. The communication included monitoring of weight and metabolic parameters including blood pressure, A1c, fasting glucose and fasting lipid profile in accordance with the ADA screening guidelines. The letters also described a process where baseline parameters would be obtained then at 12 weeks follow up labs would be required. Providers that were surveyed were given 20 weeks to obtain and submit the baseline and follow up numbers for review, if this information was not received than further antipsychotic use would require prior authorization to assure proper monitoring. In its review, 30% of members lack proper documentation of routine monitoring.
Maryland	In October 2011 Maryland Medicaid established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non-pharmacologic information for decision making and ensures the appropriate use while limiting adverse sequelae in the program's vulnerable pediatric population. The program initially addressed the use of antipsychotics in participants under the age of 5 years. During FFY 2013, the program was expanded to include all participants less than 10 years of age. As of January 2014, the program encompasses all participants less than 18 years of age.
Massachusetts	PA criteria varies by restriction but generally requires documentation of a complete treatment plan including the name dose and frequency of all behavioral health medications with associated diagnosis or target symptom, a comprehensive treatment plan including non-pharmacologic interventions,

State	Explanation of Antipsychotic Monitoring Program
	psychiatrist involvement (either as the prescriber or consult notes from the past year). For antipsychotic polypharmacy additional requirements include two failed trials with antipsychotic mono-therapy and if treatment beyond one year, rational for continued use of polypharmacy (e.g., previous efforts to reduce/simplify the antipsychotic regimen in the past 24 months resulted in symptom exacerbation, family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation, other significant barrier for antipsychotic therapy discontinuation. Dosing is generally managed and monitored through quantity limits. All member cases (PAs) evaluated through the initiative are evaluated on a case-by-case basis to determine if there are additional high-risk factors for additional, individualized case review by multidisciplinary team (psychiatrists, pharmacists, social worker). This comprehensive review evaluates all aspects of the child's case (diagnosis, medication regimen and indications, dosing, drug-drug and drug-disease interactions, nonpharmacologic and psycho social services, pharmacy and medical claims history, context of care, custody status, etc). For cases where the team identifies unnecessary or redundant medication use or if the team has other concerns, a peer-to-peer discussion may be required between the member's prescriber and a psychiatrist associated with the initiative.
Michigan	We utilize a program called WholeHealthRx which is operationalized through our Magellan contract. It is a monthly academic detailing mailing and face-to-face pharmacy consultation intervention with the most exceptional providers on specific educational topics. We also have a Foster Children Psychotropic Medication Oversight Unit that monitors informed consents, utilization trends and performs psychiatrist to prescriber education/outreach if any concerning utilization trends are identified (e.g. multiple concurrent antipsychotics).
Minnesota	Monthly, the DHS Children's Mental Health Division receives monthly reports that identifies children on multiple psychotropic drugs, lack of monitoring for those on antipsychotic drugs, and high dose antipsychotic and stimulant drugs using DHS retrospective criteria developed for this project. The Children's Mental Health Division uses this information in many ways one of which is to do outreach to the provider community especially to those in foster care. Additionally, there are two RetroDUR mailings per year regarding criteria regarding psychotropic drug use in youth.
Mississippi	Electronic PA age edits, quantity limits for all beneficiaries, multiple antipsychotic edit for children, and manual PA criteria for multiple antipsychotic continued use in children.
Missouri	For children 0 to 9 years old, atypical and typical antipsychotics deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 9 to 18 years old, atypical typical antipsychotics will approve as long as they are on no more than 1 antipsychotic, have appropriate diagnosis, and dose does not exceed recommended maximum doses.
Montana	We require metabolic monitoring and parental consent for antipsychotics for children 7 and under. Dose and indication are also reviewed. Case management is provided for all foster children taking psychotropics. These are reviewed for dosage, quantity, polypharmacy, etc.
Nebraska	Outside of limits will trigger at POS.
Nevada	Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant or benzodiazepine) without prior authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six years of age require prior authorization.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed an antipsychotic (or other psychotropic drug), a prior authorization is required. The criteria require that the patient is seen by a child psychiatrist, neurologist, or developmental pediatrician or that prescribing has been in consultation with one of these specialists. An additional consideration for use of an antipsychotic is for the diagnosis of Tourette's syndrome or tic disorder. For pediatric patients 6 years of age and older, a prior authorization is required if more than one antipsychotic is prescribed during a 60 day time frame. The criteria review that a patient has a DSM-V diagnosis and that the patient has received psychiatry, neurology, or care in consultation with a developmental pediatrician.
New Jersey	Maximum daily dose edits were updated to apply to antipsychotic drugs in children.
New Mexico	Require glucose and lipid monitoring for children on second generation antipsychotics.

State	Explanation of Antipsychotic Monitoring Program
New York	PA for cases where an oral SGA is used above the highest MDD per FDA labeling. PA where patients under 21 years are prescribed 2 or more different antipsychotics for greater than 90 days or when 3 or more oral SGA's are used for more than 180 days. Confirm diagnosis of FDA approved or compendia supported indications. PA required for initial prescription for beneficiaries younger that the drug specific minimum age. Require confirmation of diagnosis that supports the concurrent use of a SGA and CNS stimulant for beneficiaries under the age of 18 years.
North Carolina	The NC Medicaid Outpatient Pharmacy antipsychotic monitoring programs are A+KIDS, ASAP and select Behavioral Health (BH) Clinical Edits. A+KIDS - The objective of the A+KIDS program is improvement in adherence to recommended safety monitoring parameters when any antipsychotics is prescribed for beneficiaries aged 0 - 17. Documentation of safety monitoring measures is requested for any of the following occurrences: the antipsychotic is prescribed for an indication that is not approved by the FDA; the antipsychotic is prescribed at a higher dosage than approved by the FDA for a specific indication; or the prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents. A+KIDS targets metabolic adverse effects. ASAP - The objective of the ASAP program is improvement in adherence to recommended safety monitoring parameters when an antipsychotics is prescribed for beneficiaries aged 18 and over. Documentation of safety monitoring measures is requested for any of the following occurrences: the antipsychotic is prescribed for an indication that is not approved by the FDA; the antipsychotic is prescribed at a higher dosage than approved by the FDA for a specific indication; or the prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents. The ASAP program is implemented for atypical antipsychotics, targets metabolic adverse effects and is exempted for beneficiaries with any psychosis diagnosis. Behavioral Health Clinical Edits - These POS clinical edits include atypical antipsychotics triggers. For an atypical antipsychotic claim, if the dosage and quantity prescribed exceeds the FDA approved maximum dosage, dosage frequency or meets the definition of in class therapeutic duplication, the claim denies. To override the edit, the pharmacist can contact the prescriber to obtain clinical rationale for the therapy issue identified by the edit. These utilization management edits are implemented for pediatrics and adults.
North Dakota	North Dakota applies diagnosis, age, and quantity limits according to the FDA and compendia recommendations. Chart notes are reviewed and alternatives are discussed for requests outside of these limits. Therapeutic duplication edits prevent antipsychotic duplication and poly pharmacy as well as dose optimization. Chart notes and alternatives are reviewed for requests beyond one antipsychotic. The antipsychotics with the least evidence for off-label and combination use have had edits implemented first. These edits are applied equally across all populations.
Ohio	We utilize prospective edits to monitor dose, days supply, and polypharmacy. Soft DUR drug-drug interactions messaging is also utilized. In January 2020, our DUR committee reviewed profiles of members taking opioids in combination with antipsychotics. In July 2020, we distributed a RetroDUR communication to educate prescribers on the importance of pediatric metabolic monitoring in those taking atypical antipsychotic medications.
Oklahoma	All antipsychotics for members younger than five years of age require prior authorization and consultation by a child psychiatrist. Educational mailings are sent to prescribers of psychotropic drugs used in pediatric members, particularly when prescribers deviate from evidence-based norms in this patient population. The mailings are followed with academic detailing to the prescribers that deviate from evidence-based norms.
Oregon	For recipients in non-foster care periodic claims reviews for specialist consultation when concerning treatment is identified (e.g. long term antipsychotic use in patients <10 years of age). For recipients in foster care, yearly reviews of prescribed mental hearth medications are performed. If concerning

State	Explanation of Antipsychotic Monitoring Program
	treatment is identified, providers are referred for consultation with a specialist. Examples of concerning treatment may include patients < 18 years of age prescribed antipsychotics, prescriptions of an antipsychotic without diabetic screening, prescription of three or more psychotropics, patients with no documented age-appropriate indications for therapy, or children prescribed a psychotropic not FDA-indicated for children.
Pennsylvania	All prescriptions for antipsychotics for children under 18 years of age require prior authorization.
Rhode Island	Rhode Island currently has approximately 40 individual RDUR criteria used to monitor and manage antipsychotic medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
South Carolina	Claims edits, Prior Authorizations may include: age, indication, dose and quantity. Periodic Retro DUR "runs" have been done regarding polypharmacy.
South Dakota	All atypical antipsychotics require PA regardless of age. Children under 6 years of age must have a child psychiatrist involved with their care.
Tennessee	The State monitors and manages the utilization of antipsychotic medications for all children via prospective programs and retrospective programs. Prospective Programs for Monitoring and Managing Antipsychotic Medications for Children- Prior authorization is one prospective program used by the State to monitor and manage antipsychotic medications for children. Prescriptions for antipsychotic medications are rejected unless appropriate clinical action (such as including a diagnosis code that warrants use of the medication) has been taken. DUR edits at the point of sale are another prospective program utilized by the State. For instance, an age edit identifies instances in which dosage of an antipsychotic medication exceeds what is usually recommended for a child and issues a soft reject at the point of sale. Likewise, a duplicate therapy edit identifies instances of ingredient duplication, therapeutic duplication, and other potential problems and issues a soft reject at the point of sale. Claims rejected as a result of both of these edits may be resubmitted and considered for payment once the pharmacist inputs appropriate Professional Pharmacy Service (PPS) codes. A third prospective program employed by the State is a prescription review and consultation program for children in State custody. The program is operated by the Tennessee Department of Children's Services (DCS) in partnership with the Center of Excellence for Children in State Custody administered by Vanderbilt University Medical Center. Nurse consultants employed by DCS are responsible for consenting to or denying medication requests for children in State custody if the child's guardian cannot be reached or if the child is in full guardianship of the State. DCS identifies and flags medication requests that are indicative of potentially high-risk prescribing practices such as: Dosages that exceed the maximum recommended range, as defined by the State's Pharmacy Benefits Manager; Two or more overlapping prescriptions in the same drug class; Four or more concurrent psychotropic medications; and A medication prescribed for a child five years old or younger. Flagged requests trigger a protocol in which the nurse consultants confer with psychiatric providers from Vanderbilt's Center of Excellence who specialize in child and adolescent prescribing practices. Consultation between the nurse consultants and psychiatric providers is reflective of evidence-based practices for use of psychotropic medications in children and adolescents. Potential risks and benefits of such medications are weighed before a recommendation regarding the proposed regimen is made. As the custodial body responsible for decision-making on the child's behalf, DCS uses this consultation

State	Explanation of Antipsychotic Monitoring Program
	in conjunction with the child's health history and other relevant factors to determine whether psychotropic medications are appropriate. Retrospective Programs for Monitoring and Managing Antipsychotic Medications for Children: The State's DUR Committee performs periodic retrospective reviews in conjunction with the Pharmacy Benefits Manager. Claims data is examined to determine whether prescriptions for antipsychotic medications are appropriate, medically necessary, and unlikely to result in adverse medical outcomes. The DUR Committee then has the option to notify the prescriber in writing of the potential drawbacks to use of the medication, as well as steps that can be taken to address those risks. In addition, if the DUR Committee's review of the claims data identifies wider trends that need to be addressed, then recommendations may be made to the State on more comprehensive actions to be taken. A second retrospective program used by the State to monitor the utilization of antipsychotic medications for children involves data obtained from the State's managed care organizations (MCOs) on three HEDIS measures: Metabolic Monitoring for Children and Adolescents on Antipsychotics, Use of Multiple Concurrent Antipsychotics in Children and Adolescents, and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Data collected within Tennessee on these three measures may be compared with data collected on a regional and national basis to help inform decision-making by the State. The partnership between the Tennessee Department of Children's Services (DCS) and the Center of Excellence for Children in State Custody administered by Vanderbilt University Medical Center (described on the previous page) represents a third retrospective program for monitoring use of antipsychotic medications with children. This surveillance model was developed by Vanderbilt University Medical Center clinical experts and biostatisticians in partnership with a collaborative of psychiatric providers, insurers, and State stakeholders to monitor psychotropic prescriptions for youth in state's custody. The resulting model, which is based on approaches used by CMS for evaluation programs, compares an individual prescriber's red flag rate to the average risk-standardized red flag rate of all providers who wrote at least ten prescriptions to youth in DCS custody. The model includes risk-adjustments for acuity of case population using several variables.
Texas	children 3 years of age and older may receive certain atypical antipsychotics for the FDA approved indications (such as autism). Patients 6 years of age and older may receive up to two different antipsychotics for the appropriate indications. The prior authorization criteria will reject the antipsychotic claim if the only diagnosis found is insomnia. or if the diagnosis is major depression but without concurrent therapy with an antidepressants.
Utah	Utah Medicaid implemented a new policy on October 1, 2019, to monitor and manage antipsychotic (AP) medications prescribed to members 19 years of age and younger. Pharmacies are required to enter the diagnosis code into the point of sale system when processing a claim for an antipsychotic. Prior Authorization is required for children who are taking high-dose antipsychotics, multiple antipsychotics, or under 6 years of age. Also, Retrospective Drug Utilization Review peer to peer educational interventions addresses the following: a. Use of other first-line services such as psychosocial counseling and safer medications. Dosing should follow the start low and go slow approach. Identification of higher than recommended doses. Careful and frequent monitoring of side effects such as metabolic screening, Body Mass Index, weight gain, movement disorders. Use of AP in children younger than 6 years old.

State	Explanation of Antipsychotic Monitoring Program
Vermont	Vermont is one of six states participating in the Psychotropic Medications Quality Improvement Collaborative (PMQIC), with a goal of improving the use of psychotropic medication among children and youth in foster care. The workgroup developed a set of definitions and common measures related to psychotropic medication use among children in foster care. In an effort of evaluating the PMQIC common measures, Change Healthcare conducted this study. To evaluate the PMQIC common measures, the study estimated them by using pharmacy claims for psychotropic medications paid by the Department of Vermont Health Access (DVHA) reported on a semi-annual basis. The study estimated and evaluated the following nine PMQIC common measures: 1) Percentage of children in foster care on any psychotropic medication, 2) Percentage of children in foster care on a specific class of medication, 3) Percentage of children in foster care on more than one psychotropic medication from the same class simultaneously for 90 days or more (defined above as co-pharmacy), 4) Percentage of children in foster care on 2 psychotropic medications; 3 psychotropic medications and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more, 5) Percentage of children in foster care < 6 years old on any psychotropic medication, 6) Percentage of children in foster care < 6 years on 2; 3 and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more, 7) Percentage of children in foster care < 6 years old on any antipsychotic medication, 8) Percentage of children in foster care on more than one antipsychotic simultaneously for 45 days or more, 9) Percentage of children in foster care who are continuously on an antipsychotic for more than 1 year. The study also estimated the above-mentioned measures for non-foster care children as a comparison group. The study reviewed trends for both foster care and non-foster care groups of children over the mentioned time frames. The study also estimated the common measures for different age and gender groups.
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization.
Washington	In collaboration with The Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, HCA has established pediatric mental health guidelines to identify children who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers. For antipsychotics exceeding the established thresholds for age/dose, therapy duplications, or included in polypharmacy (defined as the use of five or more psychotropic medications) a SON review is required. Washington Medicaid has developed reports that allows us to monitor children's prescription claims for psychotropic medications. The data in the report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. If there seems to be misuse or abuse one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse. This data is also reviewed for potential prospective and retrospective DUR activities.

State	Explanation of Antipsychotic Monitoring Program
West Virginia	An edit will fire if the prescriber attempts to use multiple antipsychotics. We are in the process of changing this edit to prevent pharmacist-override. All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaids consultant psychiatrist.
Wisconsin	Wisconsin monitors the use of antipsychotic drugs in young children (less than nine years of age) through prior authorization (PA). The PA process is intended to scrutinize the prescribing of antipsychotic drugs for mood disorders and the monitoring of metabolic effects of this drug class. Child psychiatrists who are contracted with the State perform peer to peer outreach calls when needed. In addition, Wisconsin monitors the use of multiple antipsychotics in all children 18 years of age and younger. Contracted child psychiatrist reviews the doses the child is on and perform peer to peer outreach calls when needed to discuss a specific case with the prescriber. Wisconsin has retrospective DUR criteria to review antipsychotic drug prescribing that are not indicated for use in children.
Wyoming	Children aged 5 and under require prior authorization for all antipsychotics. Additionally, children under age 9 require prior authorization for Latuda and Saphris, and all children under age 18 require prior authorization for Fanapt. Dosage is limited to the maximum dose in FDA approved labeling. Prior authorization is required for use of an injectable and oral dosage form concurrently. A retrospective review of children is regularly completed for polypharmacy. Any child receiving 5 or more mental health drugs from any class is referred to Seattle Children's for independent review.

If “No,” does your state plan on implementing a program in the future?

Figure 137 - Future Monitoring Program for Appropriate Use of Antipsychotic Drugs in Children

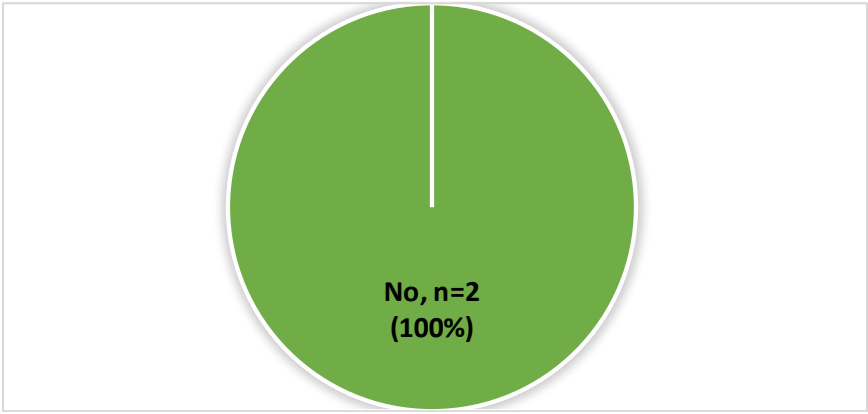

Table 231 - Future Monitoring Program for Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
No	Mississippi, Missouri	2	100.00%

If “Yes,” please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children?

Table 232 - Explanations for Implementing a Program to Monitor Appropriate use of Antipsychotic Drugs in Children

State	Explanations

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

Table 233 - Explanations for not Implementing a Program to Monitor Appropriate use of Antipsychotic Drugs in Children

State	Explanations
Mississippi	DRUG IN CHILDREN

Stimulants

3. Does your state currently have restrictions in place to limit the quantity of stimulants?

Figure 138 - Restrictions in Place to Limit the Quantity of Stimulants

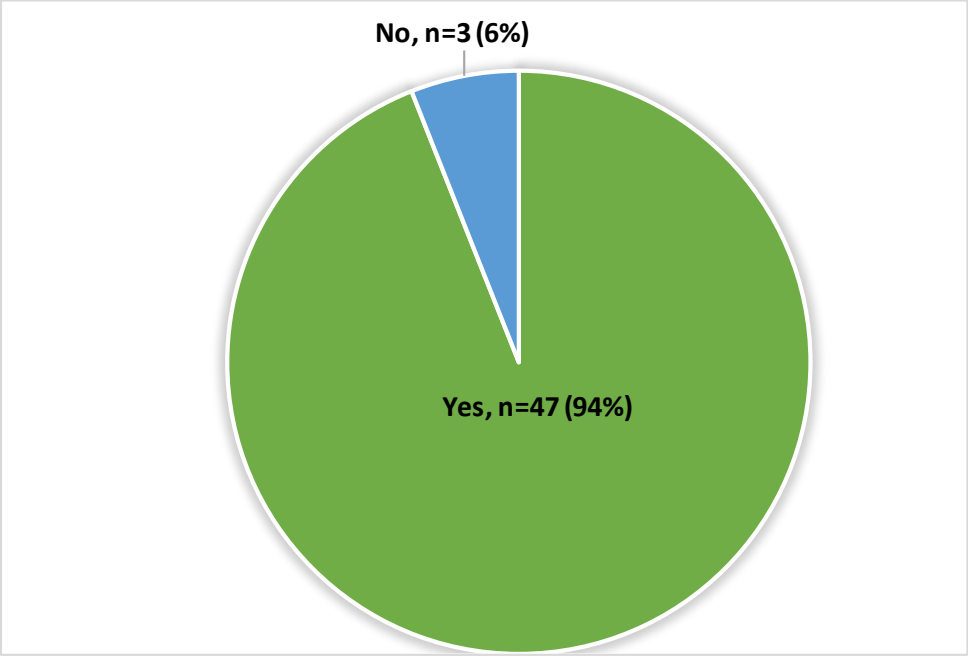

Table 234 - Restrictions in Place to Limit the Quantity of Stimulants

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	California, Louisiana, Maryland	3	6.00%
Total		50	100.00%

4. Does your state have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

Figure 139 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

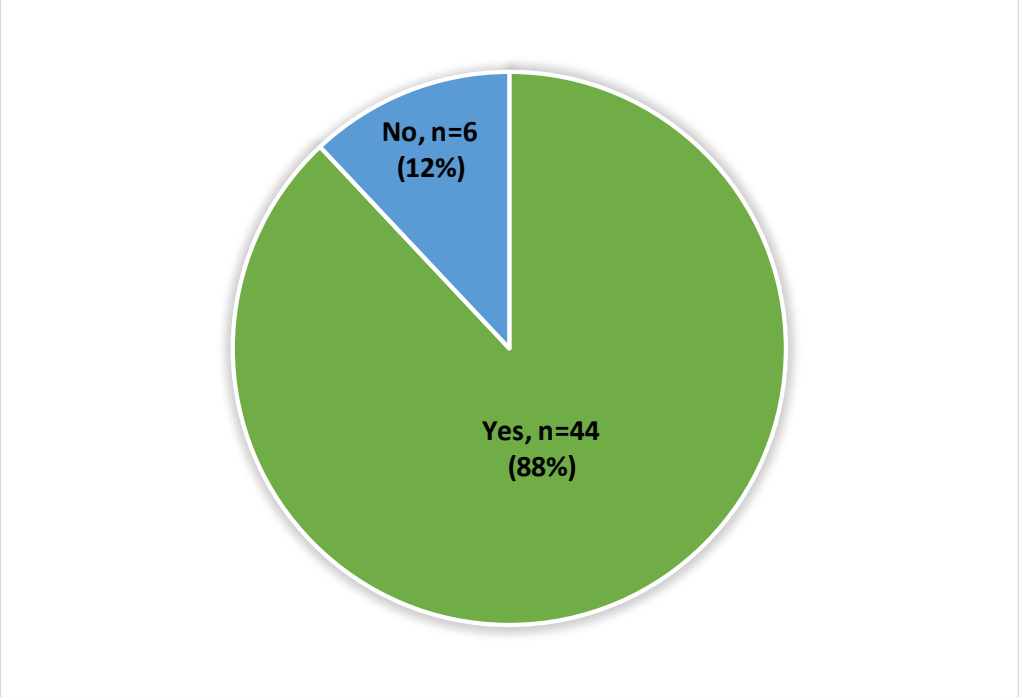

Table 235 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	88.00%
No	Alaska, District of Columbia, Maryland, New Mexico, Oregon, South Dakota	6	12.00%
Total		50	100.00%

If "Yes," please continue

a. Does your state either manage or monitor:

Figure 140 – Categories of Children Either Managing or Monitoring the Appropriate Use of Stimulant Drugs

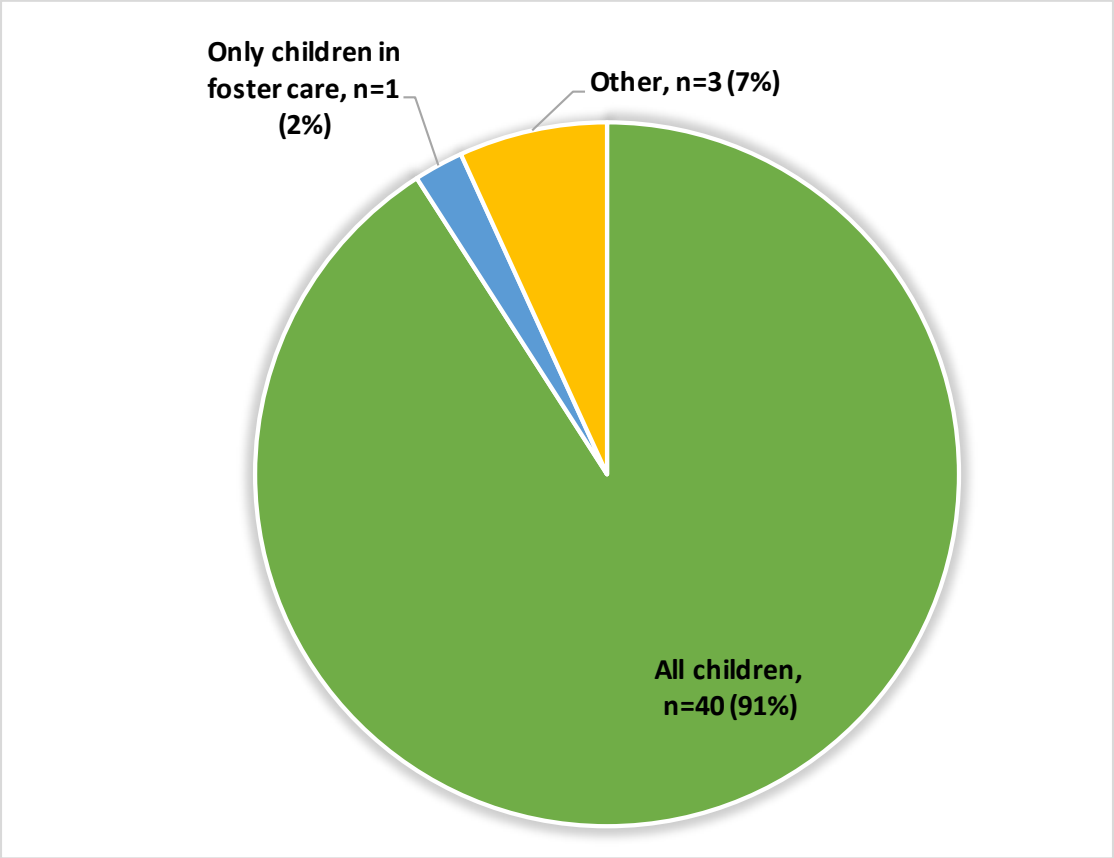

Table 236 - Categories of Children Either Managing or Monitoring the Appropriate Use of Stimulant Drugs

Response	States	Count	Percentage
All children	Alabama, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	40	90.91%
Only children in foster care	Montana	1	2.27%
Other	Colorado, Illinois, Wisconsin	3	6.82%
Total		44	100.00%

If "Other," please explain.

Table 237 - "Other" Explanations to Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

State	"Other" Explanation
Colorado	All children are managed/monitored. Additionally, edits are in place for maximum dose, off-label use, and patient age. Prior authorization may be required when exceeding limitations.
Illinois	All DCFS Youth in Care require Prior authorization. Stimulants require prior authorization for children less than 6 years of age. Atomoxetine is not preferred, requires prior authorization. Clonidine/guanfacine are on PDL Adults (19 years and older) require prior authorization for ADHD medications. DocAssist referral by prior authorization staff to address stimulant use in younger children. Child psychiatrists from DocAssist review specific cases and discuss cases with prescriber.
Wisconsin	Wisconsin has quantity limits and diagnosis restrictions for all stimulants for both children and adults.

b. Does your state have edits in place to monitor:

Figure 141 - Edits in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

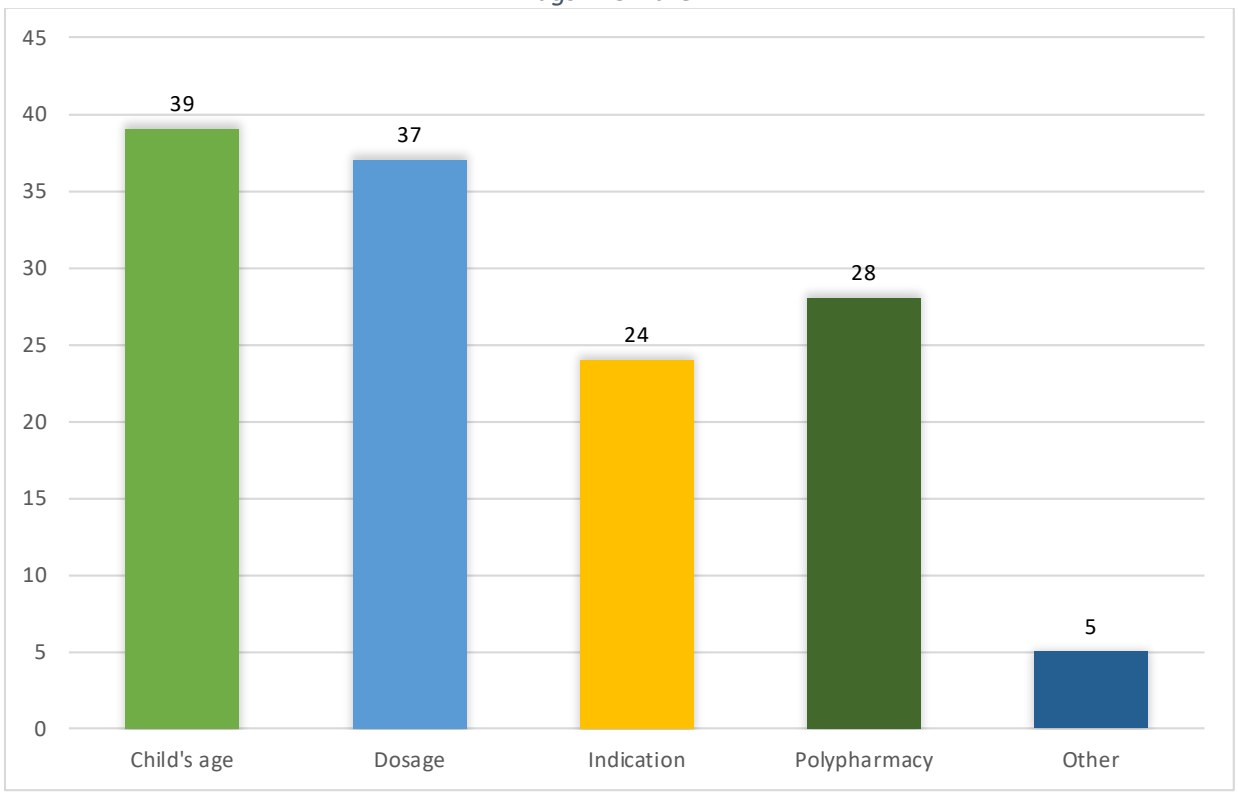

Table 238 - Edits in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	39	29.32%
Dosage	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wyoming	37	27.82%
Indication	Arkansas, California, Colorado, Connecticut, Florida, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Dakota, Rhode Island, South Carolina, Texas, Virginia, Washington, Wisconsin	24	18.05%
Polypharmacy	Arkansas, California, Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	28	21.05%
Other	Kansas, Louisiana, Massachusetts, Utah, Washington	5	3.76%
Total		133	100.00%

If "Other," please explain.

Table 239 - "Other" Explanations to Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

State	"Other" Explanation
Kansas	Must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician. Either an edit or via the PA process
Louisiana	Preauthorization is required for ADHD agents for beneficiaries less than 6 years old. POS edits for all ages include diagnosis requirement, therapeutic duplication of short acting ADHD agents, of long acting ADHD agents, and ADHD agents from different prescribers.
Massachusetts	PA criteria varies by restriction, but polypharmacy generally requires documentation of a complete treatment plan including the name dose and frequency of all behavioral health medications with associated diagnosis or target symptom, a comprehensive treatment plan including non-pharmacologic interventions, psychiatrist involvement (either as the prescriber or consult notes from the past year), trial with stimulant monotherapy and rationale for the

State	"Other" Explanation
	stimulant polypharmacy. PA criteria for children less than three years of age requires an appropriate diagnosis and clinical rationale for use of the stimulant in a very young child. Dosing is generally managed and monitored through quantity limits
Utah	Restriction on concomitant use of both methylphenidate class and amphetamine class, more than 2 stimulants, and quantity limit are implemented in 2021.
Washington	For client 17 years of age and younger WA Medicaid also applies edits for therapy duplication.

c. Please briefly explain the specifics of your documented stimulant monitoring program(s).

Table 240- Explanations of the specifics for the state Stimulant Monitoring Program for Children

State	Explanations
Alabama	All stimulants have quantity limits.
Arkansas	All stimulant requests for children <6 years of age require a manual review PA by the Medicaid Pharmacy Program psychiatrist and state clinical pharmacists. Clients <19 years of age with denied claims due to a POS edit will also require a PA. Reviewing a PA request requires review of the client's diagnosis, age, concomitant therapies, history of therapy, and psychosocial status. POS edits for stimulants include: *Therapeutic duplication edit--Criteria allows concurrent therapy for children <19 years of age with both a long-acting agent and a short-acting agent as a booster dose (one pill of short-acting per day). Atomoxetine is included in the therapeutic duplication edits with CII stimulants. If an incoming long-acting CII stimulant claim overlaps with a short-acting CII stimulant that was filled at a dose of at least 2 units per day, the long-acting product will require prior authorization. If an incoming short-acting CII stimulant claim overlaps with a long-acting CII stimulant, the short-acting product will only be approved for a dose of one unit per day. *Quantity edit--All stimulants and atomoxetine have quantity/dosing edits. *Edit for indication--All clients must have a billed diagnosis for ADHD/ADD in the last 2 years for a claim to process at POS. If there is not a diagnosis billed, a PA request is required by the prescriber with documentation of the client's diagnosis. Children with a current billed diagnosis of ADHD, prescribed preferred agent/agents, has no therapeutic duplication as defined above, and prescribed dosage within the POS quantity edits will process without a PA. All adults require a prior authorization for CII stimulants and must include a PA form, current chart notes, and documentation of medical necessity which usually includes impact on education or employment.
California	The stimulant monitoring program includes both ProDUR and RetroDUR components. During FFY 2020 there were documented restrictions to use for all stimulants. These restrictions varied by drug, and may have included age limits, indication restrictions (for attention deficit disorder), and/or ProDUR edits for both high and low dosage. In addition, retrospective utilization of all psychotherapeutic medications in children younger than 18 years of age is reviewed on at least an annual basis.

State	Explanations
Colorado	Edits are in place for maximum dose, off-label use, and patient age. Prior authorization and expanded clinical review by a pharmacist may be required when exceeding limitations.
Connecticut	Connecticut currently RDUR criteria used to monitor and manage stimulant medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, stimulant medication targeted review and intervention occur at least once a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
Delaware	Ages on stimulant agents are set to the FDA approved indications. Doses are edited based on FDA approved doses and Pro%u2010DUR edits are in place to monitor for therapeutic duplication within the stimulant class of medications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies
Florida	High dose limitations are placed on all stimulants. A close prior authorization review is performed on all children less than six.
Georgia	Quantity limits, clinical prior authorizations, age requirements in place for stimulants.
Hawaii	Annual review as a whole program with quarterly claim review for individual's at possible risk.
Idaho	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.
Illinois	Only one extended-release and one short-acting stimulant allowed at one time. All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require a special prior authorization request form. Form is available at https://www.illinois.gov/hfs/SiteCollectionDocuments/ADHDkids6122916HFSWEB007R416007.pdf
Indiana	Stimulants require prior authorization when used in duplication or when drug-specific quantity and age limits have been exceeded. Adults must have an FDA-approved or approved compendia diagnosis for use within medical profile; otherwise medical necessity prior authorization review is required.
Iowa	Age - ProDUR age edit on stimulants claim rejects for: amphetamines (excluding Adderall XR and Dexedrine ER) < 3 years of age; Dexmethylphenidate, methylphenidate, atomoxetine, Adderall XR and Dexedrine ER < 6 years of age. Dosage - Prior authorization is required for stimulants above the set quantity limit. Additionally, prescribers are required to check the Iowa PMP for any stimulant that requires PA.
Kansas	We have a mental health medication advisory committee (MHMAC) that meets quarterly. We review data, treatment guidelines, and address areas where prior authorization is needed for patient safety and cost-effective drug use.
Kentucky	Prospective review at point of sale which requires an indication submitted on claim, in medical history or via PA process. Edit which creates a hard stop/PA required when more than 1 short- and 1 long- acting stimulant are used concurrently based on pharmacy claims data. Dose accumulations for all stimulants and minimum age limits corresponding to the FDA approval on newer formulations.
Louisiana	Preauthorization is required for ADHD agents for beneficiaries less than 6 years old. POS edits for all ages include diagnosis requirement, therapeutic duplication of short acting ADHD agents, of long acting ADHD agents, and ADHD agents from different prescribers.
Maine	manage daily dosing requirements.

State	Explanations
Massachusetts	All member cases (PAs) evaluated through the initiative are evaluated on a case-by-case basis to determine if there are additional high-risk factors for additional, individualized case review by multidisciplinary team (psychiatrists, pharmacists, social worker). This comprehensive review evaluates all aspects of the child's case (diagnosis, medication regimen and indications, dosing, drug-drug and drug-disease interactions, nonpharmacologic and psychosocial services, pharmacy and medical claims history, context of care, custody status, etc.). For cases where the team identifies unnecessary or redundant medication use or if the team has other concerns, a peer-to-peer discussion may be required between the member's prescriber and a psychiatrist associated with the initiative.
Michigan	In addition to the WholeHealthRx academic detailing program and monthly interventions, prior authorization is required for members under the age of 6 years and those age of 18 years or older. Specific to Foster Children, our Psychotropic Medication Oversight Unit regularly monitors stimulant usage and performs additional education/outreach if warranted with prescribers via our contract psychiatrist.
Minnesota	Monthly, the DHS Children's Mental Health Division receives monthly reports that identifies children on multiple psychotropic drugs, lack of monitoring for those on antipsychotic drugs, and high dose antipsychotic and stimulant drugs using DHS retrospective criteria developed for this project. The Children's Mental Health Division uses this information in many ways one of which is to do outreach to the provider community especially to those in foster care. Additionally, there are two RetroDUR mailings per year regarding psychotropic drug use in youth.
Mississippi	Age edits and indication edits follow FDA approved or compendia supported diagnoses,
Missouri	For children 0 to 6 years old, stimulants deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 6 to 18 years old, stimulants will auto approve as long as they have an appropriate diagnosis on file and the dose does not exceed recommended maximum limitations.
Montana	Children in foster care taking more than one stimulant medication are reviewed for treatment appropriateness including indication, age, dosage, etc. Children in foster care are monitored for polypharmacy.
Nebraska	High dose limits in place at POS.
Nevada	Prior authorization is required for all stimulant use for children. More than one agent including more than one long-acting agent requires prior authorization and clinical justification.
New Hampshire	Dosage and quantity per day is reviewed on all claims.
New Jersey	Pharmacy claims exceeding the set maximum daily dosage deny at POS for all stimulant drugs in children and adults.
New York	Confirm diagnosis of FDA approved , compendia supported indications for beneficiaries less than 18 years. PA required for initial prescription for beneficiaries under the age of 3 years. Require confirmation of diagnosis that supports concurrent use of CMS stimulant and SGA agents. For patients older than 18 years confirm diagnosis of FDA approved, compendia supported indications. Dose optimization for CNS listed drugs and strengths. Quantity limits based upon FDA labeling
North Carolina	Edits are in place to limit quantities based on maximum daily dose approved by the FDA and FDA approved pediatric age ranges. ProDUR edits limit claims from multiple pharmacies and concurrent use of drugs from the same drug class.
North Dakota	North Dakota applies diagnosis for amphetamine stimulants, as well as age limits, and quantity limits for all stimulants according to FDA and compendia recommendations. Therapeutic duplication prevents multiple types of stimulants from being used together. Long acting and short acting stimulants of the same ingredient are allowed for some products. North Dakota has

State	Explanations
	proactively been driving utilization toward Vyvanse instead of other amphetamines due to lower abuse risk.
Ohio	We utilize edits that monitor any medication that has a drug interaction with a stimulant, prospective edits to monitor dose, day supply, and polypharmacy, and soft DUR drug-drug interactions messaging. In September 2020, we completed a RetroDUR educational outreach to prescribers whose patients were receiving opioid medications in combination with a stimulant. Stimulants are also part of our Coordinated Services Program.
Oklahoma	Children younger than 5 years of age require psychiatric consultation for any stimulant medication. Adults older than 21 years of age require a prior authorization for any stimulant medications to ensure appropriate use. Quantity limits are in place based on FDA approved dosing.
Pennsylvania	All prescriptions for Stimulants and Related Agents require prior authorization for children less than 4 years of age and adults age 18 and older.
Rhode Island	Rhode Island currently RDUR criteria used to monitor and manage stimulant medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
South Carolina	Claims edits, Prior Authorizations may include: age, indication, dose and quantity in children. In addition, there are criteria in place for products for narcolepsy in adults.

State	Explanations
Tennessee	A retrospective review of C-II stimulant use by children under age 21 was conducted in September 2020, based on claims during the period between June 1, 2020 and August 31, 2020. Enrollees chosen for this review review were based on the following criteria: Claims paid during the months of June through August of 2020 Chronic use- enrollees to have at least 90 count total units, 3 claims, and must have a claim in June, so it was possible to have claims in all 3 months. Selected those with at least 6 claims for C-II stimulants Selected those with at least 180 total unit count Selected those who had claims in June A total of 1926 enrollees fit the criteria above and were selected for the retrospective review. Of 1926 children chosen, 114 children under 21 used both amphetamine and methylphenidate products. 109 of 114 used both amphetamines and methylphenidate products concomitantly 5 of 114 discontinued either amphetamine or methylphenidate product and were switched to the other 114 were removed from the 1926 total enrollees to be looked at separately, however due to the combination, it was difficult to evaluate whether any individual doses were outliers. Amphetamine Claims Reviewed: Mean dose per day equaled 21.36mg with a Standard Deviation of 9.19mg. With 3 Standard Deviations over the mean being considered as an outlier, any dose higher than 48.91mg/day is an outlier. A total of only 6 enrollees were found to have an average daily dose over 48.91mg, with the highest daily dose equaling 65mg/day. Lisdexamfetamine has a 70mg dose available, and the highest average dose/day for children under 21 in this study did not reach the 70mg dosage form of Lisdexamfetamine. Methylphenidate products reviewed: Mean dose per day equaled 20.97mg with a Standard Deviation of 9.73mg. With 3 Standard Deviations over the mean being considered as an outlier, any dose higher than 50.16mg/day is an outlier. A total of 7 enrollees were found to have an average daily dose over 50.16mg, with the highest daily dose equaling 70.16mg/day. Methylphenidate has a 72mg dose available, and the highest average dose/day for children under 21 in this study did not reach the 70mg dosage form of Methylphenidate. Statistical outliers using greater than 50.16mg were still within the MAX dose of Methylphenidate at 60mg/day. Only 3 enrollees were found to use a dose higher than 60mg/day (70.16mg, 66mg, 63mg). In summarizing, doses of C-II stimulants for TennCare enrollees who are children under the age of 21 appeared to be within guidelines, with very few outliers. For children, prior authorization for C-II stimulants that are preferred products is not required. In the presenter's opinion, the data presented with this retrospective review supports TennCare in not requiring a prior authorization for these products, unless the product is non-preferred on TennCare's PDL. This review was presented to TennCare's DUR Board during FFY2021, and will be highlighted in next year's CMS Annual report

State	Explanations
Texas	The POS PA criteria allows children who are 3 years of age and older to receive prescriptions for amphetamine sulfate, amphetamine/dextroamphetamine, dextroamphetamine, dexmethylphenidate, Evekeo tablets, methylphenidate, Procentra, or Zenzedi, or non-stimulants or a combination of these two (two short acting stimulants are not allowed without a PA). Children who are 6 years of age alder may receive long-acting, short-acting, or a combination of the two (multiple short acting or long-acting prescriptions are not permitted without a PA). Adults may receive stimulants for up to 90-days without a documented diagnosis. After 90 days, the claim will require a PA if an appropriate diagnosis is not documented in the system. The maximum daily dose is either based on the FDA approved dosing regiment or based on the Texas Department of Family and Protective Services guideline.
Utah	Beginning July 2020, age edit limitations apply when a claim for an ADHD stimulant is processed through the pharmacy point of sale: 1) ADHD stimulant prescriptions for children under 4 years of age. 2) ADHD stimulant prescriptions for Adzenys ER suspension (susp.), Dyanavel XR, Desoxyn, Adhansia XR, Jornay PM, and Cotempla XR Orally Disintegrating Tablet (ODT) for children under 6 years of age.
Vermont	Vermont gathers statistics based on previous participation in the Psychotropic Medications Quality Improvement Collaborative (PMQIC) with a goal of improving the use of psychotropic medication among children and youth in foster care. PMQIC common measures in Vermont Medicaid pharmacy Program includes ADHD medications /stimulants in the analysis
Virginia	*All stimulants (preferred and non-preferred) require the submission of Clinical Service Authorization if prescribed for a child less than four or an adult eighteen years and older. Stimulants prescribed for children under the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician or in consultation with one of these specialists. The patient must have a diagnosis of ADHD. The prescriber must have reviewed the Virginia PMP on the date of the request. The prescriber has ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. (The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates). For maintenance: the practitioner must have checked the PMP at least every three months after the initiation of treatment. The practitioner has ordered and reviewed a random urine drug screen at least every six months. The practitioner has regularly evaluated the patient for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated.
Washington	For client 17 years of age and younger WA Medicaid also applies edits for therapy duplication.
West Virginia	We require a PA for all stimulants prescribed in patients older than the age of 18. We have set up edits to allow the use of one short acting and one-long acting stimulant. Limits are set to the FDA recommended maximum dosages and are designed to provide all available dosages with the fewest number of tablets/capsules dispensed.
Wisconsin	Wisconsin has both documented restrictions and special programs to monitor, manage or control the use of stimulants for adults and children on stimulants. This includes diagnosis restrictions (allowable diagnoses are ADHD and narcolepsy), a prior authorization requirement for non-preferred stimulants on the preferred drug list. A Children's Mental Health workgroup focuses on behavioral health medications and the contracted child psychiatrist reviews high dose stimulant use and performs peer to peer outreach calls on an as needed basis. Wisconsin also has a quantity limit for all stimulant drugs.

State	Explanations
Wyoming	Prior authorization is required for children under the age of 4. Dosages are limited to the maximum dose in FDA approved labeling.

If "No," do you plan on implementing a program in the future?

Figure 142 - Future Implementation of a Stimulant Monitoring Program for Children

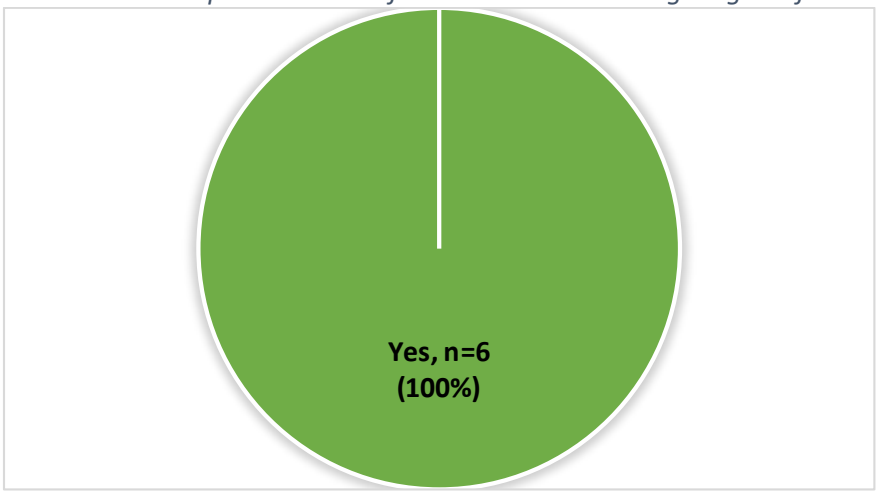

Table 241- Future Implementation of a Stimulant Monitoring Program for Children

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Maryland, New Mexico, Oregon, South Dakota	6	100.00%
Total		6	100.00%

If "Yes," when do you plan on implementing a program?

Table 242 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanations
Alaska	Yes actively working with the DUR committee.
District of Columbia	The DUR Board is developing a monitoring program and intends to implement during the upcoming FY.
Maryland	TBD
New Mexico	This will be part of the new MMIS replacement implementation in FFY22 or FFY23.
Oregon	Not in effect during reporting period, but currently implementing.
South Dakota	1-3 years

If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 243- Explanations for not Implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanations
Mississippi	PROGRAM TO MONITOR

Section IX - Innovative Practices

1. Does your state participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries?

Figure 143 – Does the State Participation in Demonstrations or Have Waivers to Allow Importation of Certain Drugs from Canada or Other Countries That Are Versions of FDA Approved Drugs for Dispensing to Medicaid Beneficiaries

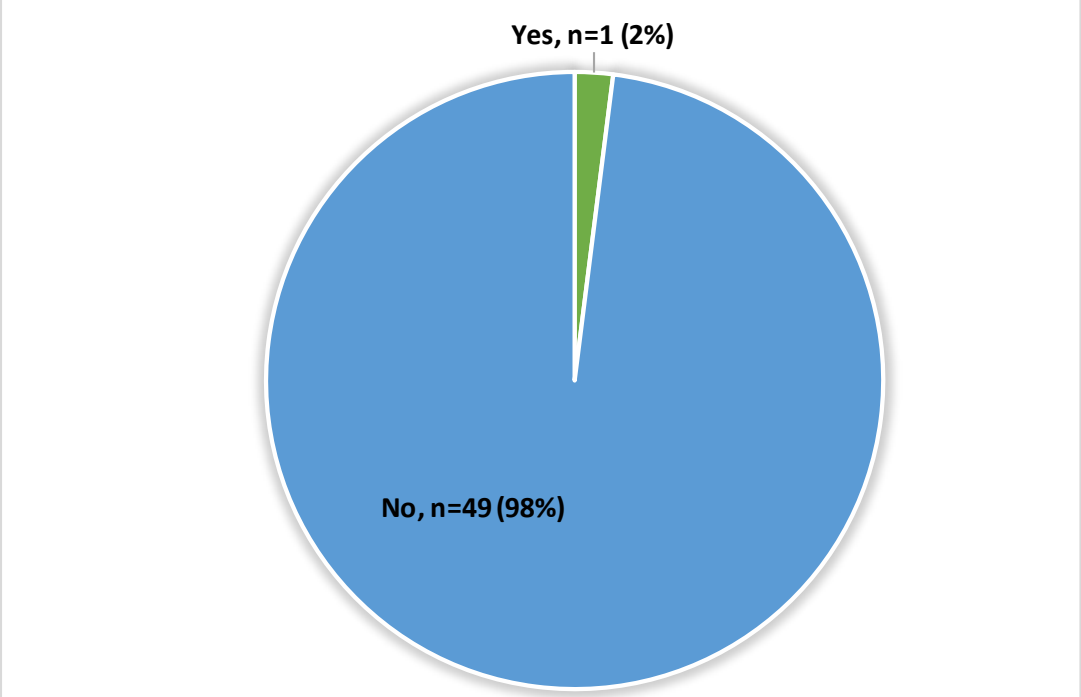

Table 244 - Does the State Participation in Demonstrations or Have Waivers to Allow Importation of Certain Drugs from Canada or Other Countries That Are Versions of FDA Approved Drugs for Dispensing to Medicaid Beneficiaries

Response	States	Count	Percentage
Yes	Colorado	1	2.00%
No	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
Total		50	100.00%

If "Yes," please explain.

Table 245 – Explanations for State Participation in Demonstrations or Have Waivers to Allow Importation of Certain Drugs from Canada or Other Countries That Are Versions of FDA Approved Drugs for Dispensing to Medicaid Beneficiaries

State	"Yes" Explanations
Colorado	The Colorado General Assembly passed legislation in 2019 authorizing the importation of certain drugs from eligible Canadian suppliers.

2. Summary 5 - Innovative Practices

Summary 5: Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing). Please describe in detailed narrative below any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e., disease management, academic detailing, automated PA, continuing education programs).

Table 246 - Summary 6 - Innovative Practices

State	Explanations
Alabama	Innovative Practices for Federal Fiscal Year 2020 The Alabama Medicaid Agency has several innovative practices that improve the administration of the Drug Utilization Review (DUR) program. In addition to a DUR program that consists of Prospective and Retrospective DUR, Academic Detailing and continuous education for providers, the following other practices were implemented during the FFY 2020. Include preferred fibric acid derivatives, alendronate tablets, amitriptyline tablets, azathioprine tablets, hydroxychloroquine tablets, methotrexate tablets, pioglitazone tablets, and trazodone tablets in the mandatory Three-Month Maintenance Supply program. Include the Antigout Agents in the Preferred Drug List (PDL) Require Prior Authorization (PA) for colchicine tablets Update pharmacy vaccine administration billing Implement hard edits on cumulative daily Morphine Milligram Equivalents (MME) claims exceeding 200 MME/day. Implement a phase in-period for claims exceeding 150 MME/day, but less than 200 MME/day Remove methotrexate from the mandatory Three-Month Maintenance Supply program Remove PA from tobramycin-dexamethasone ophthalmic solution (generic Tobradex); brand Tobradex will require PA In response to COVID-19, the following accommodations were made: A universal PA number may be used when claims deny for early refill (ER) and the pharmacist should use clincal judfement when determining if the universal PA number is utilized. Postpone the implementation of the cumulative daily MME edit decrease scheduled for April 1, 2020.

State	Explanations
	Changes to the PDL were made due to potential drug shortages. In conjunction with the Alabama Board of Pharmacy (ALBOP) guidance, overrides allowed for maintenance supply medications. Temporary exceptions allowed for prior authorization renewal requests for lab values or urine drug screens that require an in-person visit with a lab or provider. Temporarily waiving copayments for all services, including prescription drugs Remove PA from mometasone nasal spray (generic Nasonex) and modafinil (generic Provigil); brand Nasonex and Provigil will now require PA Allow the Insulins within the Three-Month Maintenance Supply program to be dispensed with a days' supply in a range from 80 days up to 90 days depending on the dosage of the medication prescribed Include dornase alfa (Pulmozyme), all oral formulations of mycophenalate, all oral formulations of tacrolimus, and all oral formulations of ursodiol in the mandatory Three-Month Maintenance Supply program In cases of cost-effectiveness, the Alabama Medicaid Agency sometimes allows for reimbursement of certain brand named medications while requiring prior authorization for the generic alternative. In these cases, a Dispense as Written (DAW) code of 9 must be utilized when dispensing the preferred brand named medication. A DAW Code of 9 indicates that substitution is allowed by the prescriber but Alabama Medicaid requests the brand product be dispensed.
Alaska	Innovative Practices for FFY 2020 Alaska Medicaid began to enroll pharmacists as rendering providers consistent with 42 CFR 455.400 et seq and enrolled Pharmacy Professional Groups in order to bill for non-dispensing pharmacist professional services in FFY 2020. This was extremely important to the COVID-19 efforts, allowing pharmacist to be reimbursed for professional services such as immunization administration and prescribing nasal naloxone. In FFY 2019, the Alaska Medicaid Drug Utilization Review (DUR) committee and the State of Alaska Medicaid program implemented a morphine milligram equivalent (MME) limit. The initial MME threshold was set at a cumulative 300 MME/day and a prospective edit was deployed in the pharmacy point-of-sale (POS) system. A threshold reduction of 50 MME/day has occurred every six months to 200 MME per day with a goal of reaching 90 MME/day or as set by the DUR Committee based on statewide rules. Regimens exceeding the set MME threshold required a prior authorization. Since the implementation of this edit, we have seen not only a reduction of total MME, but also a reduction in the number of opioids being prescribed. Alaska Medicaid developed a drug lookup tool and was implemented in FFY 2020. The tool allows members, providers, and pharmacies to enter a drug, which will then tells them if it is covered, if it's preferred or nonpreferred, whether there are any edits related to the drug, and alternatives to the medication. This combined with the ePA process, has reduced the amount of phone calls and faxes that the state and call center receives, thus decreasing admirative burden for providers, which reduces costs.
Arkansas	ARKANSAS INNOVATIVE PRACTICES FFY2020 DASHBOARDS Arkansas Medicaid has established a series of dashboards to allow real-time data reviews. All dashboards contain no HIPAA information and include non-client specific data. These dashboards can demonstrate trends that can be helpful in all aspects of the Medicaid program.

State	Explanations
	Dashboards with eligibility data are available for FFS, MCOs and ARWORKS (Affordable Care Act Expansion). Several pharmacy specific dashboards are available that include pharmacy claims, PASSE encounters (MCOs), J-code drug claims, 340B claims, pharmacy billing providers, and pharmacy prescribing providers. We can narrow searches in multiple ways (i.e., HIC3, specific drugs, specific prescribers/pharmacies, and by date, etc.). All of the data can be exported to Excel or other desired platforms for presentation. These platforms have been helpful in determining RetroDUR criteria, outlying prescribers, and drug classes that may need to be reviewed by the DUR Board. CYSTIC FIBROSIS STUDY With the addition of multiple new cystic fibrosis medications that have a significant impact to the overall budget, Arkansas has started a study spanning the last 10 years. This study will track overall expenditures for medical and pharmacy expenses for our cystic fibrosis population. We would expect that the addition of the CFTR modulators would correspond to a decrease in medical expenditures. Multiple factors are being taken into consideration. 1) Compliance with therapy 2) Accounting for patients not on Medicaid for the full 10 years 3) Clients with other third party insurance 4) COVID-19 impact An overview of the data does indicate a decrease in overall expenditures for calendar year 2020, but more research needs to be done on the patient level to get the full impact. If we determine that the addition of CFTR modulators has positively impacted the overall expenditures, case management may be our next step in the care of our cystic fibrosis clients. AUTOMATED PA (POINT-OF-SALE RULES) Clinical review on certain medications can be a lengthy process (e.g., oncology, hemophilia, hereditary angioedema) when taking into account the criteria needed based on the manufacturer's packet inserts, MicroMedex, and treatment guidelines. Therefore, automated PA's at POS can provide oversight to ensure medications are being used for FDA approved indications and following treatment guidelines but become less time consuming for our clinical team. Arkansas has the capability through Magellan as the processor to design POS rules with algorithms that utilize the client's medication history, billed diagnoses, billed procedure codes, and integrated lab values. Examples from FFY2020 include Lysteda, Lovaza, Entresto, and erythropoiesis stimulating agents. As an example, criteria for Lovaza includes: a billed diagnosis of hypertriglyceridemia in the last 3 years, triglyceride level greater than or equal to 500 mg/dL in the last 180 days, medication history indicates at least 3 claims of a fibric acid derivative in the last year, and a recent pharmacy claim of a statin or ezetimibe overlapping with the fibric acid derivative. If all criteria are met, the claim will process at POS and bypasses the prior authorization process. ANTIPSYCHOTIC MEDICATION REVIEW FOR CHILDREN Our program has been proactive in monitoring antipsychotic use in children well before the SUPPORT Act requirements. Arkansas Medicaid is fortunate to have a psychiatrist on staff to assist with case reviews for children and adults and to assist with monitoring of medication usage in all children. Currently, our psychiatrist and clinical team review all antipsychotic new starts for patients <18 years of age through a PA request. Antipsychotic PA renewals for children <10 years of age must be reviewed by our clinical team. Children 10-17 years of age

State	Explanations
	may qualify for continuation without a PA if there has been no change in therapy and the metabolic labs are current. This process has decreased the amount of off-label antipsychotic usage and decreased the use of medications outside of guidelines supported dosages.
California	Much of FFY 2020 was dedicated to the transition of pharmacy services from the 26 managed care plans to Medi-Cal Fee-for-Service, which will begin in FFY 2021. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system will be identified collectively as Medi-Cal Rx. The goals of this transition are as follows: 1. Standardize the Medi-Cal pharmacy benefit statewide, under one delivery system. 2. Improve access to pharmacy services with a network that includes approximately 94% of the state's pharmacies. 3. Apply statewide utilization management protocols to all outpatient drugs. 4. Strengthen California's ability to negotiate state supplemental drug rebates with pharmaceutical manufacturers. Medi-Cal Rx will include all pharmacy services billed as a pharmacy claim, including but not limited to outpatient drugs (prescription and over-the counter), including physician-administered drugs (PADs), enteral nutrition products, and medical supplies. Medi-Cal Rx will not include pharmacy services billed as a medical (professional) or institutional claim. In addition, during FFY 2020 the Board continued to collaborate with key state agencies and national experts, and actively worked to incorporate a variety of Medi-Cal MCP best practices across multiple plans into the Board meeting agenda. Presentations for FFY 2020 included: 1. Asthma Medication and Asthma Medication Ratio (AMR) 2. The Role of Managed Care Pharmacists in Improving Outcomes of Patients with Type 2 Diabetes 3. Opioid Stewardship 4. Asthma Population Health Project 5. Opioid-Benzodiazepine Edit and Provider Outreach 6. Smoking Cessation
Colorado	As part of the State's contract with the CU Skaggs School of Pharmacy and Pharmaceutical Sciences, clinical modules are conducted every quarter to provide a deeper granular evaluation of medication related issues and programmatic policies that are pertinent to our members. We use these data to make both policy changes as well as improve the medication safety and quality of life for our members. Below are the summaries of five evaluations conducted during FFY 2020. Detailed reports are available upon request. Consult Service Clinical Outcomes Investigation: Pain Management Specialty (Delivered 10/29/2019) Objectives: Describe members participating in the Opioid Consult Service OUTCOMES: The largest Consult Service group was opioid naive (n=268), followed by high dose opioid users (n=74) and provider-initiated (n=18). Slightly more than half of the high dose opioid users group (51.35%) was female while less than half of the opioid naive group (46.18%) was female. The majority of members in each Consult Service group reported being White or multiple race/ethnicities. The mean age was highest in the high dose opioid use group (49 years), and lowest in the opioid naive group (45 years). Estimate the effect of the Opioid Consult Service on opioid use

State	Explanations
	OUTCOMES: Among members who received a high dose opioid use consult, there were improvements in several outcomes when compared between the three months prior to the consult and the three months following the consult Fewer members had an average MME greater than/equal to 200 during the three months following their consult (80.9%) compared to the three months before (88.8%); 76% had an average MME greater than/equal to 200 both prior to and following their consult, while 7.9% had an average MME < 200 both prior to and following their consult. Over 11% improved, having an average MME greater than/equal to 200 prior to their consult and an average MME < 200 following their consult. Use of atypical opioids (defined as tapentedol, tramadol, or buprenorphine product formulations) and high risk medications (defined as an add-on muscle relaxant or benzodiazepine) decreased following the consult. Almost 13% of members discontinued use of high risk medications after their consult; 6% of members discontinued use of atypical opioids. However, all-cause hospital and ER visits increased slightly. Similar trends were seen when the pre and post periods were expanded to six months. Seventeen percent of members had an average MME greater than/equal to 200 during the six months prior to their consult and an average MME <200 following their consult. Use of atypical opioids and high risk medications decreased following the consult. Almost 11 percent of members discontinued use of high risk medications after their consult; 7 percent of members discontinued use of atypical opioids. All-cause hospital and ER visits stayed about the same. In the high dose opioid use group, there was a significant decrease in average MME for both the three month pre to post comparison and the six month pre to post comparison. Average MME decreased from a median of 286.61 during the three months prior to a consult to 268.94 during the three months following a consult (absolute change = -25.43, percent change = -7.48%). The decrease was more substantial when compared between the six months before a consult to the six months following a consult, with a median difference of -43.02 (percent change = -12.53%). The median total opioid doses decreased from three months pre consult to three months post consult, but the differences were not statistically significant. The change from six months pre consult to six months post consult was larger, but also not significant: the median total opioid dose decreased from 1020 during the six months prior to a consult to 865 during the six months following a consult (absolute median change = 1.00, median percent change = 0%). Use of high risk medications among the opioid naive consult group decreased from 34% during the three months prior to the consult to 26% during the three months following the consult; 16% discontinued use of high risk medications following their consult. Use of atypical opioids and long-acting opioids increased from the pre-period to post-period; it is important to note that use during the pre-period is indicative of the type of opioid the member was initiated on because by definition, the opioid naive group would not have used an opioid prior to the initiation that flagged the consult. More than half of the members did not use atypical opioids during the pre or post-period; 88% of members did not use long-acting opioids during the pre or post-period. All-cause hospital and ER visits decreased following consults; 34% of members had a hospital/ER visit during the three months prior to their consults but had no visits during the three months following their consult. Similar results were seen when the pre and post periods were expanded to six months. Of note, 18% discontinued use of high risk medications during the six months following their consult. Almost 14% discontinued use of an atypical opioid in the six months following their consults. All-cause hospitalizations and ER visits also decreased.

State	Explanations
	Among the cohort of opioid naive members who received a consult and had at least three months of enrollment following their consult (n=229), the percentage of members continuing opioid medication decreased from 36% during the 30 days following the consult to 26% during the first 90 days following the consult. In other words, 74% had discontinued the opioid by 90 days following their consult. In comparison, the historical opioid naive group with three months of follow-up (n=4,167) saw a similar downward trend in opioid continuation. However, the prevalence of opioid use was higher within each time period compared to the opioid naive consult cohort, starting at 41% of members using an opioid during the 30 days following their proxy consult and decreasing to 33% by 90 days following their proxy consult. In order to look further than three months, we considered the sub-cohorts with at least six months of enrollment following their consult. Opioid use continued to decrease in both the opioid naive consult group (n=185) and in the historical opioid naive group (n=3,092) through 180 days following their consults. Discussion: For this analysis, the CO-DUR team divided all of the consults that were conducted between February 2017 and April 2019 and split them into 3 groups depending on their type. The three groups identified are high dose, opioid naive, and provider requested. The largest group of consults was the opioid naive group with 268 total consults, followed by high dose opioids with 78 total consults, and 18 provider requested consults. Different sets of outcomes were measured in each opioid naive and high dose opioid group as the goals of the consult are different for each setting. Both outcome sets include concomitant high risk medication prescribing. A duration of opioid therapy was measured in the opioid naive group and a decrease of MME with total dosage count was measured in the high dose group. An outcome of atypical opioid proportion prescribed was also measured in the high dose group. The high dose group and the opioid naive groups were then used to conduct two separate investigations. One investigation looked at the outcome set six months before and six months after the consult index time. The other investigation looked at the outcome set 3 months before and 3 months after the consult index time. Our findings show a similar sex and other measured demographic breakdown amongst opioid naive and high dose opioid groups. The provider-requested consult group is small (n=18) and has slightly different demographic distributions. For the high dose group, the findings are positive for MME <200 and reduction of proportion of atypical opioid prescribed in both the 3 month and the 6 month test groups. As the consultant routinely recommends atypical opioids, we wrongly hypothesized that the proportion would go up. In both the 3 and 6 month high dose the number of ED visits remained about the same. A decrease in this number is a central goal of opioid policy as a surrogate marker of overdose visits. While there was an absolute decrease in the number of high-risk medications prescribed with the high dose group in the 3 and 6 month sub-groups, this did not approach statistical significance. With the nature of high risk concomitant prescribing with opioids, all reductions may be clinically significant. Our findings show absolute reductions in MME and total dose counts, with statistical findings in both groups. There is some heterogeneity of members who may have had a decrease in MME, but an increase in dosage forms prescribed. Those particular members are being prescribed more dosage forms of a lower dosage opioid and the percent change is positive for this reason. With some control for outliers, this would likely be negative as hypothesized. For the opioid naive portions of the module, our findings show a positive and statistically significant decrease in high risk concomitant prescribing at both 3 and 6 month sub-groups.

State	Explanations
	Policy limiting these high risk combinations are not yet implemented, but the RDUR program has been providing letters to providers regarding the 3 part combination of an opioid, a BZD, and a skeletal muscle relaxant for the past year. Strong warnings from the CDC and other entities plus our own local RDUR projects may influence some of these results. Hospital and ED visits significantly decreased in the opioid naive group for the 3 and 6 month tests. Many of the members included in the opioid naive group may have received their acute opioid prescription immediately following a hospitalization or ED visit, which could have influenced this reduction. Recommendations: Continue and, if possible, expand the pain management consult service. Future potential triggers include combination opioid and benzodiazepine prescribing as well as risk factor stratification. Outcomes analysis for Child Psychiatry Specialty Consult service (Delivered 12/19/19) Objectives: Describe members participating in the Child Psychiatry Consult Service Population OUTCOMES: The largest Child Psychiatry Consult Service group was flagged for off-label age for antipsychotic medications (n=192), followed by off-label dosing for psychostimulants (n=80) and provider-initiated (n=6). The majority of each group were not in foster care at the time of their index consult (78% - 87%). While the provider-initiated consult group was primarily female (83%), there were more males than females in the other two consult groups. The majority of members in each Child Psychiatry Consult Service group reported being White or multiple race/ethnicities. The mean age was highest in the provider-initiated group (mean = 13.8 years) and lowest in the off-label dosing for psychostimulants group (mean = 8 years). Age ranged from 3 to 17 years in each group. The most common mental health diagnoses received by members flagged for a consult because of off-label age for antipsychotic or off-label psychostimulant dosing during the three months prior to the consult were from the following categories: Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; pervasive and specific developmental disorders; anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders; and mood [affective] disorders. The most common diagnosis among members with a provider-initiated consult was a mood [affective] disorder Describe the effect of Child Psychiatry Consult Service on outcomes OUTCOMES: Among members who received a consult for off-label for age antipsychotic medications, there were improvements in some outcomes when compared between the three/six months prior to the consult and the three/six months following the consult. While more members used off-label antipsychotics during the three and six months following their consult compared to prior to their consult, use of multiple stimulants decreased from 12.6% in the three months prior to 9.6% in the three months post. Supramaximal use of antipsychotics and stimulants was very low prior to and following consults. Several discrete (i.e., count) outcomes significantly decreased from the three/six month prior to the consult to the three/six months following the consult. The number of distinct stimulants and outpatient visits (all-cause) significantly decreased from the three months pre to the three months post-consult. When the pre and post time periods were extended to six months, several more outcomes saw a significant improvement. Count of distinct drugs, distinct psychotropics, distinct stimulants, and outpatient visits (all-cause and mental health related) all significantly decreased from the six months prior to the consult to the six months following the consult.

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	Small changes were seen among members who received a consult for off-label dosing for psychostimulant medications. Use of multiple stimulants increased from the three/six months prior to the consult to the three/six months following the consult, while supramaximal stimulant use slightly decreased. No changes were statistically significant. Several discrete (i.e., count) outcomes significantly increased from the three/six month prior to the consult to the three/six months following the consult. The number of distinct stimulants and distinct psychotropics significantly increased from the three months pre to the three months post-consult. When the pre and post time periods were extended to six months, the count of distinct psychotropics, distinct stimulants, and inpatient visits (all-cause) significantly increased from the six months prior to the consult to the six months following the consult. Examine trends in receipt of antipsychotics in children younger than 5 OUTCOMES: The start of the Child Psychiatry Consult Service began in February 2017. When taking into account the number of antipsychotic medication fills in children less than 5 years of age, trends suggest a sharp drop of 7 fills in September 2016 to 3 fills one year later. While an increase in fills was demonstrated in January 2018 to 8, these have dropped to between 2-3 fills during the study period following implantation of the consult service. Discussion: Off-label age for antipsychotic medication was the largest consult group with 192 recorded consults, followed by off-label dosing of a stimulant medication with 80 recorded consults and lastly there were six recorded provider-initiated consults. Approximately two-thirds of all members consulted upon were male and approximately 40% identified as either white race or multiple race making the vast majority of reported race. Off-label age for antipsychotic has a very different age distribution for the consulted cases than the off-label dose for a stimulant group does with the smallest group being age range 0-5 years old. The off-label age for antipsychotic group also has a higher percentage of members identified as receiving foster care. There are not currently antipsychotic medications indicated for use by the FDA in patients 5 years of age or under, but about 12% of this consult cohort were in this age group. The foster care population representing a higher percentage of members receiving antipsychotics versus stimulants may be due to higher needs and much different mental health demographics of the foster population. In attempt to further define the population of who is being triggered for consult, the number of diagnoses in each consult group was collected and organized by groups of ICD-10 codes. Behavioral and emotional disorders with onset usually occurring in childhood and adolescence and pervasive and specific developmental disorders comprise the majority of mental health diagnoses that were given to the cohorts in the pre-phase. Behavioral and emotional disorders with onset usually occurring in childhood and adolescence includes diagnoses of attention deficit hyperactivity disorder (ADHD), conduct disorders, tics, stuttering, and many more. Pervasive and specific developmental disorders includes autism, Asperger's Syndrome disintegrative disorder, Rett's Syndrome, and many more. The off-label prescribing appears to increase significantly in both the three and six month cohorts. This is probably related to first time antipsychotic prescriptions being written in which a member was naive to the antipsychotics measured. The outcome of multiple stimulants was measured in this group and a significant decrease is found in both three and six month cohorts.

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	For discrete outcomes analyzed, multiple outcomes in the six month cohort showed significant decreases including Distinct Drugs (By name, Dose), Distinct Psychotropics (By Drug ID), Distinct Stimulants (By Drug ID), Outpatient visits (all cause), and Outpatient visits (mental health). Not all of these outcomes were found to be statistically significant in the three month cohort, suggesting that it may take a few months to realize the benefits of the consult. Psychotropic medication tapering and switching does take time depending on the situation and could take up to a couple months to titrate a new medication to therapeutic range safely. In terms of off-label dosing of a stimulant consult cohort, there was no impact on high dose prescribing or multiple stimulant use in both the three and six month cohorts. We theorized there would be downward trends with these outcomes. The multiple stimulant outcome required a 50% overlap and controlled for immediate release and extended release formulations of the same medication being taken (this would count as one stimulant). These results suggest further expansion of stimulant prescribing should be conducted to determine why the consult service has not had impact. For discrete outcomes analyzed, a notably significant increase was found in Distinct Psychotropics (By Drug ID), Distinct stimulants (By Drug ID), and inpatient hospital stays (all cause). For the increases in psychotropic medication and stimulants, the outcomes are likely measuring members who were previously naive to a stimulant. Also, in the psychotropic medication group, stimulants are included, which produces a duplicate measure but important outcome of total psychotropic medications, but for this reason both outcomes could trend in a similar manner. Some of the increase in all cause hospitalizations may be related to the recent increase in psychotropic medications and subsequent risk for adverse event. Our third objective quantified the outcome of antipsychotic fills for members younger than 5 years prior to and following implementation of the consult service in February 2017. However, the monthly count of fills (<10 each month) is too small to determine meaningful trends. Ideally, the members who were flagged for their provider to receive a consult through the Child Psychiatry Consult Service (i.e., the off-label age for antipsychotic medications group and off-label dosing for psychostimulants group) could be compared to a control group that was not flagged to receive a consult. In order to make such comparisons, the control group would need to be as similar as possible to the groups that were flagged to receive a consult. Creation of such a control group is not possible once the consult service was implemented because all members meeting the criteria to trigger the service (i.e., off-label age for antipsychotic medications and off-label dosing for psychostimulants) would inherently become one of the consult groups. Members who did not meet the criteria would be too different from those that did, particularly regarding antipsychotic use, making them an inappropriate control group. Upon review of consult notes for the multiple antipsychotics cohort. Intentional multiple antipsychotic prescribing was found to be very low and clinical notes show 1 of the 3 members receiving concomitant therapy had basal antipsychotic coverage in addition to as needed dosing for severe symptoms. Consultants approved all but 1 medication triggering consult (28 out of 29 reviewed). This population was found to have severe symptoms across the board with agitation, aggression, hallucinations, psychotics disorders, and severe symptoms with autism spectrum disorders found.

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	The six month off-label antipsychotic group shows some promising preliminary numbers with regard to impact of the consult service. The off-label dose for stimulant group likely requires expanding and adjusting the approach by which clinical outcomes are measured. Recommendations: Add more than one antipsychotic to list of consult triggers for pediatric members, more antipsychotics are gaining pediatric indications potentially resulting in multiple antipsychotic prescribing that is not triggering for below minimum age. Use a strict definition for more than one antipsychotic. Second, work with child and adolescent psychiatry consultants to determine continued appropriateness of current triggers. Finally, consider other patient factors such as developmental disorders when consulting specialist and include other health conditions in consult form. Calcitonin Gene-Related Peptide Antagonists Utilization Review (Delivered 3/31/20) Objectives: Describe members receiving CGRP antagonist OUTCOMES: Nearly half of the members who filled at least one CGRP antagonist from August 2018 through September 2019 (N=973) filled Aimovig (45%), while 44% filled Emgality and the remaining 11% filled Ajovy. The large majority of each group was female (84% - 88%) and white (51% - 58%). The mean age was about 40 years old in each group, with about half of the members (47%) in the 36 to 50 years age group. Nearly all members (approximately 96%) had a diagnosis of migraine at some point during the two years prior to their initial CGRP fill, while only about 1% had a prior diagnosis of episodic cluster headache. Members had similar lengths of prior enrollment (an average of 48 to 53 months), indicating adequate time prior to their first CGRP to consider related diagnoses, migraine-related medication use, and health service utilization use. Describe CGRP antagonist utilization OUTCOMES: The large majority of the CGRP antagonist cohort (90%) filled only one type of CGRP antagonist; 10% filled two and less than 1% filled all three. Duration of CGRP antagoinist use ranged from 28 days to 457 days (mean = 133 days). Adherence was fairly high (75%). About half of the cohort (50%) had concomitant use of an abortive agent, while 26% had concomitant use of a preventative agent. Thirty-percent used Botox concomitantly. Prior to filling the initial CGRP antagonist, the average number of fills of a preventative agent was 1.7 (range 0-9). Among members with at least one Emgality fill (N=427), the majority had no loading doses (70%); 29% had one loading dose; and less than 1% had two or three loading doses. The abortive agents most commonly used with a CGRP antagonist were sumatriptan (34%) and rizatriptan (23%). The Preventative agents most commonly used with a CGRP were topiramate (33%) and amitriptyline (21%). The total monthly counts of CGRP fills from June 2018 through September 2019 shows an upward trend until August 2019. It is likely that the slight decrease between August and September2019 is due to a lag in data availability for September 2019. October through December 2019 are not provided as they were not included in the analysis. Examine impact of CGRP antagonist use on migraine-related medication use and health services utilization OUTCOMES: Among a subcohort of members who filled a CGRP at least twice, fewer members filled an abortive agent after starting a CGRP; the same was true for preventative agents. However, days covered by abortive agents and preventative agents significantly increased from the pre-period to the post-period. Mean total days covered by abortive agents was about

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	4 days longer in the post-period compared to the pre-period; mean total days covered by preventative agents was about one week longer. Among this same subcohort, fewer patients had an emergency department (ED) visit and fewer had a hospital visit during the post-period compared to the pre-period. The mean number of ED visits and hospital visits was less than one in each period and did not significantly change from the pre-period to the post-period. Discussion: The members receiving CGRP inhibitors are majority female with age ranging from 16 years to 71 years of age. The age group 36-50 years appears to be receiving the most CGRP inhibitor prescriptions. The racial distribution does not differ in any of the different medication groups. 95% of members receiving a CGRP inhibitor have a diagnosis of migraine headaches, while 1% has a diagnosis of cluster headache. The remaining members likely were placed on Aimovig when it was available and unmanaged after the class initially came to market. Most members (~90%) taking a CGRP inhibitor have only taken one and approximately 10% have trialed two. Switching may be due to adverse effects, lack of efficacy, or criteria/preferred coverage changes. About 50% of members were found to be taking a concomitant abortive agent and ~26% taking another preventative agent. 70.5% of Emgality users have no evidence of receiving a loading dose. A loading dose is indicated in the labeling for Emgality and low adherence with loading may be a provider education issue. The members may also be receiving the loading dose in the provider's office, which would not show up in pharmacy claims. Also, if the provider was administering the loading dose from a sample provided by industry, this may not show up as a pharmacy claim or a j-code. A trend of increased CGRP inhibitor claims per month was observed, but this is not a surprising finding given that these medications are new and represent a new mechanism for a disease state that affects ~10% of the general population. Using current PDL PA criteria, we also determined the maximum number of Medicaid members who would be eligible to receive a CGRP antagonist for migraine headaches (since episodic cluster headaches represent a small portion of the population). There is an ICD-10 code for chronic migraines, but not for episodic migraine, thus limiting the strength of this approach. Our teams' approach chose the family ICD-10 for migraine headache and the sub-code for chronic migraine. Based on a large survey of patients experiencing migraines in 2006-200711, 7.7% of participants who had previous year history of migraine, met diagnostic criteria for chronic migraine. The portion of their population who had episodic migraine was higher than chronic migraine, but comparable numbers were not provided. Authors also noted that approximately 63% of survey responders had 1-4 migraines per month. Pulling the ICD-10 code for chronic migraine from the Medicaid dataset returned nearly 12 thousand unique members, suggesting a higher rate of chronic migraine diagnosis among those with a diagnosis of migraine headache. The limitation step of medication overuse headache with chronic migraine to determine CGRP antagonist eligibility is softening as literature evolves.

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	The PDL, effective 4/1/2020, contains language for the use of Aimovig for members with medication overuse headache. This step in the way we have counted CGRP eligibility limits about 48,000 members. Aimovig is the only CGRP with literature supporting efficacy in medication overuse headache at this time, and since this diagnosis was found in such a large portion of the population, one would expect Aimovig utilization to outpace the other CGRP antagonists. Piecing together the chronic migraine population, projected episodic migraine population, and adding in some tolerance for medication overuse headache, we predict the maximum utilization of CGRP antagonists with the current criteria to be somewhere around 10-12,000 members. That's 9-11,000 additional members taking a CGRP inhibitor. Regarding abortive and preventative medication utilization among members receiving a CGRP inhibitor, fewer members were found to be receiving either during the post measurement period. But with fewer members receiving either medications, it was found that more days-supply of both abortive and preventative medications were being provided. This may be resulting from an acute destabilization of migraine symptoms of some members with starting a new anti-migraine therapy resulting in the necessity for extra coverage. It may also be an artifact in the analysis showing that at the time of prescription of the CGRP inhibitor, other medications were also prescribed. No statistically significant difference was measured in the number of emergency department visits or hospital visits. Botox utilization stayed and remained relatively high prior to and after initiating a CGRP inhibitor. Members potentially had not had a chance to trial off of Botox after starting the CGRP inhibitor. Overall, a benefit measured in the outcomes of medication use and medical resource utilization found no positive impact. More outcomes may be conducted to investigate further and as time elapses, the measurement sample will grow, strengthening and potentially changing results. Recommendations: First, maintain criteria that requires migraine headache monthly counts. Could streamline reauthorization criteria after initial period to determine efficacy to same for all indications. Second, add educational information to PDL regarding loading dose of Emgality. Third, continue to monitor concomitant Botox and CGRP antagonist use, while not overtly inappropriate, there may be less appropriate circumstances for use. Potentially use RDUR to inform providers and/or suggest trial off of Botox while CGRP is being used. Finally, maintain familiarity with medication overuse headache and emerging literature investigating safety/efficacy of CGRP inhibitors. Proton Pump Inhibitor (PPI) therapy duration quality analysis: post policy change implemented 1/1/2019 (Delivered 6/30/2020) Objectives: Describe members receiving a PPI prior to and following the policy change in January 2019 OUTCOMES: The majority (61-62%) of members filling PPIs in 2018 and 2019 were female, and the average age was 41 years (median = 43 years). Nearly 70% of the members filling a PPI had a GERD diagnosis on or since January 1, 2016. Besides GERD, gastritis/duodenitis (ICD10 code K29) was the most common esophagus, stomach and duodenum diagnosis among members filling a PPI (22.65% in 2018, 21.44% in 2019), followed by other diseases of stomach and duodenum (ICD10 code K31), other disease of esophagus (ICD10 code K22), esophagitis (ICD10 code K20), and gastric ulcer (K25). The most common diagnoses of the esophagus, stomach and duodenum were the same among members with at least one PPI fill and no GERD

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	diagnosis, although with slightly lower prevalence of each diagnosis among the group of members with no GERD diagnosis. Investigate the impact of the January 1, 2019 policy change on PPI and H2RA utilization, therapy duration and associated outcomes OUTCOMES: The total number of members who filled an H2RA and the total number of H2RA claims decreased from 2018 to 2019, while the total number of members who filled a PPI and the total number of PPI claims increased from 2018 to 2019. Mean days supplied increased from 2018 to 2019 for both H2RAs and PPIs (more so for PPIs). Mean days supplied ranged from 44-44 days for H2RAs, and from 42-46 days for PPIs. Mean doses per day were approximately 1 per day for PPIs and 2 per day for H2RAs. Doses per day slightly increased from 2018 to 2019 for H2RAs and slightly decreased for PPIs. PPI twice-daily dosing decreased from 31.6% in 2018 to 25.8% in 2019. The number of PPI starts stayed stable from 2018 to 2019, with approximately 75% of members having only 1 start of a PPI, 21% with 2 PPI starts, and 4% having 3 or more starts. Note that nearly 60% of patients with a PPI in 2019 had no new starts; rather, they had a PPI fill late in 2018 that overlapped January 1, 2019. The percentage of members with continuous PPI use increased from 57% in 2018 to 67% in 2019. Average length of first continuous PPI use increased from 91 days in 2018 to 120 days in 2019; the average length of continuous PPI use increased from 91 days to 106 days. PPI days covered increased from 110 days in 2018 to 145 days in 209, while H2RA days covered decreased from 43 days to 38 days. H2RA step-down trials (i.e., H2RA post use) decreased from 8% in 2018 to 3% in 2019. Among members who discontinued a PPI and trialed an H2RA, 15% (2018) to 29% (2019) filled another PPI during the 56 day H2RA trial. The average length of H2RA trials slightly decreased from 33 days in 2018 to 30 days in 2019. Adverse events thought to correlate with long-term PPI use were not common and stayed fairly stable from 2018 to 2019. Adverse events associated with short-term PPI use also remained stable from 2018 to 2019 and were fairly uncommon: about 1% of members experienced C. Diff while 5% had CAP. Use of a PPI with a concomitant contraindicated medication increased slightly from 3% in 2018 to 3.5% in 2019. The average number of days with concomitant PPI and contraindicated drug was low but slightly increased from 3 days to 4 days. About 62% of members had at least one ED visit in 2018, and 60% had an ED visit in 2019. Inpatient stays were less common, with 22% of members having at least one inpatient stay in 2018 and 20% of members having at least one inpatient stay in 2019. Mean count of ED visits and inpatient stays (2 and <1 per year, respectively) were low and remained relatively stable from 2018 to 2019. The percentage of members each month with an H2RA step-down trial was generally decreasing before and after the interruption (i.e., the January 1, 2019 policy change). The slope of this line was -0.37 (i.e., a decrease of 0.37% each month) prior to the interruption. The change in slope from pre-to post-interruption was 0.11, indicating the slope post-interruption was not as steep as pre-interruption. The estimate of the pre-interruption slope can be added to the estimate of the change in slope from pre- to post-interruption to calculate the post-interruption slope as -0.26%. It is important to note the estimated change in slope was not statistically significant (p=0.35), while the slope prior to the interruption was significantly different from zero (p <0.001). The level change from just prior to the interruption compared to the month of the interruption was negative but not statistically significant (level change = -1.227%, p=0.09). Discussion:

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	PPI therapy continues to be a highly prescribed mainstay therapy for symptoms of GERD. In this module, we isolated the GERD population and investigated the difference a policy change has made on their utilization and the utilization of the recommended step-down therapy of H2RAs. The overall utilization of PPIs slightly increased from the calendar year of 2018 vs the calendar year of 2019, by about 1400 members who filled at least 1 claim of a PPI. Approximately 18 thousand of these members had claims in both calendar year 2018 and 2019. 70% of members filling a PPI during this measurement period had a diagnosis of GERD. Approximately 30 thousand members in each measurement year had the diagnosis of GERD. Twice daily dosing of a PPI decreased in 2019. This is likely resulting from added criteria for twice daily dosing requiring a step down from twice daily dosing to daily dosing. Continuous use, defined as 60 days of continuous use with a gap no greater than 30 days, of a PPI occurred in 57% of the GERD population in 2018 and 66% of the GERD population in 2019. This measurement served as an identification step to determine what portion of the GERD population would have to trial an H2RA (in 2018) or would be a part of the hypothetical H2RA step-down group in 2019. Of the PPI continuous use GERD population, H2RA step-down was found to decrease by more than half from 7.8% in 2018 to 3.2% in 2019. The interrupted time series analysis shows H2RA step-down was generally decreasing from March 2018 through December 2019, with no significant change in the slope when compared from pre-to post-policy change. One possible explanation for the down-trend in H2RA trial is that after members have trialed, they may be meeting criteria to skip the trial as described in the criteria. This was the hypothesized result since the criteria directly impacted this measurement. 7.8% of the GERD population who did step-down seems like a low number as it was written in policy to step-down. Presumably, some of the members who were not required to step down in 2018 met one or more of the exceptions or had previously trialed a step-down and were allowed to continue without step-down for clinical reasons. They may have also had a diagnosis in addition to GERD that was exceptional. Another result supported the policy change impacting our measurement was the near doubling of the PPI post-start result, this showed that more members were continuing to PPI therapy after trial of step-down H2RA therapy. All measured short-term and long-term adverse effects occurred at similar rates in 2018 compared to 2019. Long-term adverse effect change likely could not be accurately measured with this design, as the conditions in this group (i.e., hypomagnesemia, Vitamin B deficiency) take more time to reach a clinically relevant level. Case reports showing hypomagnesemia with continued use of PPI noted durations of PPI therapy for at least one year to be correlated with hypomagnesemia8. Vitamin B12 deficiency has been shown as an adverse effect of chronic use of greater than two years of a PPI, but notably, patients dispensed an H2RA were also found to have higher risk for vitamin B12 deficiency. Individual-level results found similar, but slightly decreased counts of ED visits and hospitalizations. Also, the PPI utilizations trend upwards on all measured metrics including length of first continuous PPI use, average continuous PPI use, and days covered of PPI. H2RA average days covered and post continuous PPI days of continuous use both decreased. This is well in-line with what one would hypothesize the effect of the policy may be. With the

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	increased use of PPI and more continuous use of PPIs, more drug-drug interactions were measured. Recommendations: First, maintain twice daily dosing criteria - a reduction of BID dosing is noted. Second, maintain softer step-down language - more PPIs with less H2RA step-down are being utilized; however, it is not affecting adverse events. Characterization of gabapentinoid use within Colorado Medicaid beneficiaries. (Delivered 9/30/2020) Objectives: Identify and describe members using gabapentin and pregabalin OUTCOMES: Gabapentin was used by approximately five times more members than pregabalin, with about 3.5% of gabapentin users having an overlapping fill of pregabalin at some point. The mean age of members ranged from 44 years for gabapentin users to 47 years for pregabalin users. A small percentage of each drug group were pediatric members (age <18 years). More women filled these drugs than men, and nearly half of the members were White. Demographic characteristics of members with concomitant use were similar to those of gabapentin and pregabalin users and were similar across strata of varying durations of concomitant use Members were followed after their earliest gabapentin or pregabalin fill in the study period in order to measure drug and health service utilization. More than half of members had more than one year of follow-up after their first gabapentin or pregabalin fill, meaning their earliest fill of gabapentin or pregabalin was during the first year of the study. From the list of on-label indications for gabapentin and pregabalin, the most common diagnosis among gabapentin users was partial seizure (0.8%) and among pregabalin users was fibromyalgia (19.7%). The next most common diagnosis among pregabalin users was diabetic peripheral neuropathy, followed by partial seizure and spinal neuropathic pain. Diagnoses associated with on-label indications for gabapentin occurred rarely. Among off-label uses for gabapentin and pregabalin, the most common diagnosis was anxiety disorder (34.5% and 38.0%, respectively). The next most common diagnosis for both gabapentin and pregabalin was chronic pain, followed by acute postoperative pain. Of note, certain indications or uses occur both on and off label as approved indications vary by specific drug formulations. The total percentage of on and off label indications is less than 100, reflecting some potential diagnoses not reflected in the analysis. Describe gabapentin and pregabalin utilization and health service utilization OUTCOMES: For the 58,256 members with at least one fill of gabapentin, the mean number of fills per member was 5.62 (standard deviation = 6.27, median = 3, range 1-82). Pregabalin was filled slightly more often; for the 11,011 members with at least one fill of pregabalin, the mean number of fills was 7.24 (standard deviation = 7.41, median = 4, range = 1-101). Supramaximal dosing was very rare for both gabapentin (n=181, 0.3%) and pregabalin (n=16, 0.1%). The mean refill tolerance for gabapentin and pregabalin was 91% and 95%, respectively. The majority of members had refill tolerance greater than/equal to 92%, with more members being in the highest tolerance category in the pregabalin group than the gabapentin group.

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	These high refill tolerances indicate members are waiting to refill their gabapentin and pregabalin until they have used the majority of their current supply; this is also consistent with gabapentin and pregabalin refill tolerances observed within a national claims database (IQVIA). Note refill tolerance was very similar whether calculated at the claim level or member level. Demographic characteristics of those users who filled prescriptions early (refill tolerance <75%) were similar to characteristics observed in the overall cohort. Concomitant use of opioids was more common than concomitant use of benzodiazepines and muscle relaxants for both gabapentin and pregabalin. Over forty percent of gabapentin users had at least some concomitant use of an opioid, with 18% having at least 33% of their gabapentin use overlap with an opioid. More than half of pregabalin users (58%) had concomitant use of an opioid, with 35% having at least 33% of their pregabalin use overlap with an opioid. In general, pregabalin users were more likely to have concomitant use of opioids, benzodiazepines, and muscle relaxants. Of note, 27% of pregabalin users had at least 33% of their pregabalin use overlap with a muscle relaxant. Emergency department visits were common, with nearly three-quarters of gabapentin and pregabalin users having at least one all-cause ED visit. The mean number of all cause ED visits was 3-4 per member. Inpatient stays were less common (28%-30% of members). ED visits and inpatient stays due to poisonings were rare (less than 3% of members). Discussion: Gabapentin and pregabalin are commonly prescribed in the Health First Colorado population, with over400,000 claims paid for over 68,000 members in the study period of April 1, 2018 through March 31, 2020. Gabapentin was prescribed far more commonly than pregabalin, accounting for approximately 330,000 claims for 57,000 members. White and multiple races account for the majority of members receiving either drug. The vast majority of gabapentinoids are prescribed for adults, for which both agents are indicated (gabapentin is indicated for use down to 3 years of age for seizure disorder). There is a small amount of pediatric use, and concomitant use of both gabapentin and pregabalin. Receiving both gabapentin and pregabalin at the same time is a duplication of therapy and was hypothesized to be uncommonly found in claims data. The definition for concomitant use of these two drugs in this report was met if the member has >1 day overlap of days' supply for both claims. This is an easy target definition to meet for concomitant use; many of the members who met this definition may be transitioning from one drug to the other (most likely gabapentin to pregabalin). Diagnoses amongst the population of members receiving gabapentin or pregabalin are varied. The list the DUR team used comes from clinically known off label indications, off-label indications described in Micromedex, and the FDA-approved indications with a primary focus on gabapentin. Using these indications, we found that nearly half of individuals receiving either gabapentin or pregabalin had an anxiety disorder. This does not mean these members were being prescribed either medication for an anxiety disorder, but rather that they had the diagnosis in medical claims history and were also receiving either medication. That said, gabapentin is commonly used for anxiety disorders and particularly those that do not respond to traditional therapies. Chronic pain and other pain disorders (many neuropathic) are also listed as commonly found diagnoses amongst the population receiving either medication.

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	There are several off-label indications for which gabapentin or pregabalin may be prescribed, many of which are mental health disorders. Mental health disorders were not included due to lacking or controversial evidence without consensus support for use. The mean days supplied used prior to refilling a medication is greater than 90% for both medications and both methods of analysis. The median for all groups in the refill tolerance analysis is greater than 95%, which enforces the claim that the vast majority of members are adherent to gabapentin or pregabalin. This analysis rests on the hypothesis that if the member was either non-adherent or exhibiting behaviors consistent with misuse, they would have fewer days elapsed prior to requesting a refill, indicating potential overuse or possible diversion. Widespread misuse or non-adherence is not found at the population level. Many of the lower % days-supplied that are used (i.e., <75% days-supplied used prior to refill request) may be resulting from titrating or tapering regimens. Gabapentin has a higher refill rate at 85% or less of days-supplied used, somewhere in between 5-10%. This group may require more investigation to determine if this is a signal to non-adherence to their regimen or higher risk medication misuse. Policies applying controlled substance refill tolerance rules (i.e., >85% days-supplied used) to gabapentin would affect this population and could reduce the number of people filling early. We additionally found a moderate degree of other high-risk substances that are concomitantly prescribed including opioids, benzodiazepines, and skeletal muscle relaxants. All of these substances may increase CNS depression and may theoretically have a pharmacodynamic interaction with gabapentin or pregabalin. Our data suggest providers may feel more comfortable prescribing pregabalin long-term than gabapentin as the rates of greater than/equal to 33% overlapping use are higher with all three higher risk substances compared to gabapentin. Although these numbers show a high degree of concomitant higher risk use, they should be added to the clinical context of each individual patient when considering overall risk. The retrospective letters could be used in this case to identify higher risk individuals and communicate risks to providers. A much smaller group of members had any ED visit for a poisoning code, which is being used as a proxy code for overdose for this analysis. A sub-group analysis could be used to correlate ED visits/hospital stays due to poisonings with refill tolerance. If at risk individuals are identified, the RDUR letter program or consult service may be used to provide an intervention with providers on behalf of members. Recommendations: First, consider further investigation of gabapentin group who refilled at <85% days-supplied used to determine if this group is at higher risk. Second, pending analysis in recommendation one, consider policy applying controlled substance refill tolerance to gabapentin (greater than/equal to 85% days supplied used). Third, consider RDUR letters for concomitant use high risk scenarios. Fourth, consider subgroup analysis of early fill population and ED visits/hospital stays (with all-cause and poisoning). Fifth, if findings from above recommendations allow for interventions to be made, consider RDUR letter program. Sixth, given there are large amounts of off-label prescribing for these medications and minimal population level information suggesting large scale early refill misuse, consider avoiding prescription limitations by indication.
Connecticut	Retrospective DUR Innovative Practices Pediatric Reviews

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	There are approximately 800,000 patients enrolled in the Connecticut Medical Assistance Program and approximately half of those patients are under the age of eighteen. Beginning July 2010, the Connecticut Medical Assistance Program began performing Retrospective Drug Utilization Review (RDUR) on the Pediatric population in addition to the reviews performed on the adult population. 1,000 monthly reviews are performed on the adult population and 1,000 monthly reviews are performed on the pediatric population. Pediatric Reviews Examples of pediatric reviews performed during FFY 2020 include; Inappropriate pediatric therapy, stimulants contraindicated in anxiety, opioid use in the pediatric population, patients who are diagnosed with poisoning or overdose and continue to receive controlled substance prescriptions, use of antibiotics in patients with uncomplicated otitis media, medications that when used concurrently cause additive sedation, pediatric psychotropic medication maximum dosing, risks associated with chronic use of proton pump inhibitors (patients receiving > 12 weeks without appropriate diagnosis), use of PPIs without trial of H-2 blocker, NCQA/HEDIS criteria for use of atypical antipsychotics in the pediatric population, and long term risks with atypical antipsychotics in the pediatric population. Adult Reviews Adult drug utilization review has been the foundation of the RDUR program in Connecticut. Select topics of review during FFY 2020 for the adult population included; Underutilization of antidepressants, SUPPORT Act criteria - concurrent opioids and antipsychotics, underutilization of antihypertensives, medications contraindicated during pregnancy, inappropriate therapy in the elderly, patients who are diagnosed with poisoning or overdose and continue to receive controlled substance prescriptions, overutilization of narcotics, concurrent use of pure opioid agonists with opioid antagonists/partial agonists, risks associated with chronic use of proton pump inhibitors (patients receiving > 12 weeks without appropriate diagnosis), and appropriate use of migraine medications. Lock-In Program Approximately 5,000 patients are flagged by the lock-in criteria for review each month and 800 patients are reviewed during each monthly cycle. The goal of restricting a patient to a single pharmacy is to ensure that patients have access to medication they need while reducing the harm associated with over utilizing controlled substances. Fraud Hotline The Fraud Hotline at the Department of Social Services (DSS) is a proactive approach to handling complaints regarding fraud and abuse from the community. Complaints received by the fraud hotline are sent to the pharmacy unit at DSS to determine if patients should be placed into selected review for further action. Retrospective DUR Innovative Practices Established during FFY 2020 During the first quarter of FFY 2019, review and discussion of information related to the SUPPORT Act with a heavy focus on DUR requirements occurred. Retrospective criteria targeting concurrent therapy for opioids and benzodiazepines, as well as opioids and antipsychotics were reviewed and approved by the DUR Board during September 2019 and reviewed as part of the targeted monthly intervention on the adult population during November 2019. Earlier in the year, antipsychotic oversight in the pediatric population was

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	bolstered by additional criteria focusing on NCQA/HEDIS recommendations for use of atypical antipsychotics in the pediatric population, and the process for identifying fraud and abuse of controlled substances by pharmacies and prescribers continues to be a focus for the DUR program. During December 2019, the DUR Board approved a newsletter covering the history of opioid use in the U.S., actions leading up to the current opioid epidemic, and the measures taken to combat opioid use in our country. A second newsletter will be release in March 2020 that will focus on the treatment of opioid withdrawal and management of opioid use disorder (OUD) with current FDA approved medication assisted treatment (MAT) options. During March 2020, the DUR Board approved a newsletter focusing on the treatment of opioid withdrawal and management of opioid use disorder (OUD) with current FDA approved medication assisted treatment (MAT) options. This newsletter was the second part in a two part newsletter series on the opioid epidemic in our country; past, present, and future. During February 2020, a targeted RDUR intervention was performed on the adult population which reviewed the SUPPORT Act criteria for concurrent use of opioids and antipsychotics. During this intervention 796 unique recipients were targeted, and their prescribers received intervention letters. 7 months post intervention, 277 of the 796 recipients intervened on continued to receive concurrent therapy, resulting in 65% of patient intervened on stopping concurrent therapy. During April and May 2020, criteria to meet the claims review requirements for the SUPPORT Act were finalized on the retrospective DUR side. Criteria addressing days' supply, early refill, duplicate therapy, quantity limits and MME for opioid claims were reviewed and finalized with the Department. Other SUPPORT Act criteria, such as concurrent therapy for opioids and benzodiazepines, concurrent therapy for opioids and antipsychotics, and a multitude of criteria to address and monitor the use of antipsychotics in children were already in place. During June 2020, the DUR Board approved a newsletter covering the topic of cytokine storm detailing an overview of innate and adaptive immunity. During August 2020, a targeted RDUR intervention was performed on the adult population which reviewed patients who were diagnosed with poisoning or overdose and continue to receive controlled substance prescriptions, despite the poisoning diagnosis. During this intervention 146 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 7 of the 146 recipients intervened on continued to receive concurrent therapy, resulting in 95% positive outcome of patient intervened on. During September 2020, the DUR Board approved a newsletter covering the utilization, overutilization, and deprescribing of proton pump inhibitors (PPIs). The newsletter focused on appropriate treatment timeframes for specific diagnoses and the risks associated with chronic long term use of PPIs such as impaired absorption of micronutrients, bone fractures, acute kidney injury, chronic interstitial nephritis, increased risk of infection, and gastric neoplasia. In tandem with the newsletter a targeted intervention was performed in both the adult and pediatric populations specifically reviewing chronic use of any PPI (> 12 weeks) without an appropriate diagnosis for use. Intervention letters were sent to prescribers detailing the risks associated with chronic use of PPIs. The newsletter provided information regarding effective measures to deprescribe these medications. Prospective DUR Innovative Practices Established during FFY 2020 During FFY 2020, the COVID-19 Pandemic required multiple changes both systemically and operationally. From a pharmacy systems perspective, the Connecticut Medical Assistance

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	Program implemented changes to allow for larger days supplies on non-controlled medications that had previously limited to a 30 day supply. Additionally, changes were made to remove copay requirements for dual eligibiles as well as removing copay requirements for Husky B (CHIP) beneficiaries. Additionally, prescription pickup signature requirements acknowledging OBRA 90 and the patient's right for counseling was also waived during the public health emergency. The Connecticut Medical Assistance program also made changes to support the requirements of quantity prescribed and claim auditing for schedule II controlled substance prescriptions as required by CMS. These changes allow for pharmacies who short fill schedule II controlled substance to do so and to ensure that schedule II prescriptions that are short filled are not dispensed beyond the total of the original prescribed quantity. During calendar year 2020 there were challenges around in person meetings such as semiannual P&T committee meetings, the quarterly DUR Board meetings, and Fair Hearings for the pharmacy lock-in program. At the close of FFY 2020 we successfully conducted all contractually required meetings using platforms such as skype, Microsoft teams, zoom, and conference calls. The COVID-19 pandemic and Operation Warp Speed made it difficult to implement system changes due to unknown/undefined requirements. Additionally, the timelines to implement changes were aggressive. Despite these challenges the State of Connecticut was able to meet timelines to support activities during the pandemic.
Delaware	Much of Delaware's innovative practices centered around COVID-19 responses. Delaware responded quickly to any needed changes to policies and coverage related to COVID-10: %u2022Temporarily added PA requirement for Hydroxychloroquine and Chloroquine to avoid shortage for patients with chronic conditions, such as Lupus. %u2022Waived Pharmacy copays to ensure access for our all of our members who might have been affected by the financial downturn related to COVID-19 %u2022Expanded the PDL for rescue inhalers to remove any barriers patients could face in getting their much-needed breathing treatments %u2022Removed the POS edit for early refills on non-controlled substances to allow members to consolidate their trips to the pharmacy and make sure necessary chronic medications were on hand when needed %u2022Strategized on how to adapt system changes and reimbursement policy for the anticipated COVID-19 vaccines that were eventually released mid December 2020: o *Built a framework for future in advance of vaccine release that ensured consistent reimbursement with CMS on COVID-19 vaccinations o Worked quickly to ensure providers were able to submit claims for COVID-19 vaccinations %u2022DE enacted mandatory e-prescribing law with limited exceptions for providers. Delaware Medicaid provided information to our enrolled providers.
District of Columbia	PHARMACY LOCK IN REVIEW This innovative practice implemented in 2017 continues to provide great value to the District as we prepare for the transition of 17,000 FFS beneficiaries into the managed care environment at the start of FY20. Feedback from prescribers, pharmacists and beneficiaries has been mostly positive with the recognition of the extensive preliminary review and mitigation process that precedes a pharmacy lock-in decision. The DUR Board engages in an in depth review of Lock in program candidates presented during monthly meetings as grand round case studies. Prior to each meeting individual candidate profiles are thoroughly reviewed and vetted by the by the Medicaid pharmacy staff led by the MTM clinical

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	pharmacist and FFS PBM contractor who provides detailed reporting on pharmacy and medical claims, diagnoses, and any mitigating circumstances that might influence the decision to restrict a beneficiary to a single pharmacy provider. The proactive outreach efforts and meticulous documentation of patient and provider encounters by the MTM pharmacist allow the DUR Board members to confidently approve and recommend candidates to the Lock in program knowing that those FFS beneficiaries who simply require reengagement with their care providers and/or additional counseling from a pharmacist on drug dosing or avoidance of adverse effects had received the help they needed instead of assignment to a nonproductive punitive lock in period. SUBOXONE PRESCRIBER PANEL In response to the growing opioid epidemic legislation was passed in the District in 2018 mandating the removal of prior authorization requirements for access to Medication Assisted Therapy (MAT) including medications. Because only DATA waivered providers may prescribe buprenorphine containing products, a pharmacy POS solution to accurately identifying these providers was needed. Working with the FFS PBM contractor and Medicaid pharmacy staff, the Board explored possible solutions to satisfy both the new District legislative mandate as well as the existing federal DEA requirements. A special subpanel of pre screened and verified DATA waivered providers was created within the POS adjudication system which allowed claims from these empaneled providers to pay without the prior authorization requirement previously established to verify DATA waivered status.
Florida	Innovative Practices Narrative The point-of-sale (POS)/prospective drug utilization review (ProDUR) system provides the Florida Agency for Health Care Administration (Agency) with the ability to meet an important objective; that is, to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations, or additional drug therapy. Magellan Medicaid Administration has brought this technology to the Drug Utilization Review (DUR) Board which allows the Board to make recommendations for edits to address the therapeutic appropriateness of drug regimens to the Agency for implementation via the POS system. These system edits encourage providers to prescribe medications appropriately, which is the primary goal of this Board. The Agency continues to automate many prior authorizations. Automated prior authorizations (AutoPA's) look for information in the patient's clinical record such as historic ICD-9 codes or current ICD-10 codes or CPT codes that may be a diagnosis marker and provides the ability to systematically make a decision whether to deny or pay claims during adjudication. AutoPA's may also look for a drug or a drug combination in the patient's clinical records/drug history to pay or deny claims. In addition, AutoPA's may also include a review of submitted claims data, pharmacy information, prescriber information, number of pharmacies in a patient history or number of prescribers in history, accumulated drug days supply, accumulated dose and accumulated drug quantities. The DUR Board works collaboratively with the Pharmaceutical and Therapeutics (P&T) Committee to ensure Florida Medicaid recipients receive optimized drug therapy. The DUR Board makes recommendations for the P&T Committee to consider and the P&T Committee

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	will frequently refer utilization questions to the DUR Board for follow up. A report from the other Committee is a standing agenda item at each of these meetings.
Georgia	-Continued to establish a more robust prospective drug utilization review (ProDUR) process for drugs covered under the Provider Administered Drug List (PADL). Previously, drug products were added to the PADL by individual requests which made formulary decisions driven by clinical and cost-related factors more burdensome due to an imminent need of the requested product by one or more plan participants at the time of request. To ensure clinically appropriate costcontainment strategies were applied to provider administered drugs, DCH began proactively evaluating drugs that met criteria for inclusion on the PADL. This ongoing comprehensive evaluation incorporates data provided by clinical and financial vendors regarding cost-effective strategies which may include prior authorization criteria creation/implementation and solicitation of supplemental rebates. Representatives for the state presented the program's progress at the twenty-ninth annual American Drug Utilization Review Symposium (ADURS) on February 23, 2018, providing an overview of program details and offering ideas and solutions to other state Medicaid programs wishing to implement similar ProDUR programs for provider administered drugs. -Continued to strengthen measures for curbing opioid abuse and misuse, the details for which have been provided in previous sections.
Hawaii	N/A
Idaho	Innovative Practices Idaho's most innovative practices for the year centered around Idaho Medicaid Expansion. Idaho as background has a 100% fee-for-service pharmacy benefit and we manage our own on-site, within the Department prior authorization pharmacy call center rather than contracting to a third-party. In addition to POS pharmacy prior authorizations, our clinical staff also sets up criteria and performs prior authorizations on many physician-administered drugs in the medical benefit. Idaho implemented Medicaid Expansion in January 2020. Although Medicaid Expansion increased our drug utilizers by approximately 33%, the Idaho Legislature did not approve any additional staff to handle the increase in prior authorization load. We saw significant increases in the number of participants utilizing Hepatitis C drugs, HIV drugs, and opioids. Prior to Medicaid Expansion, one pharmacist focused on Hepatitis C treatment and addressed all Hepatitis C PAs utilizing a case management approach, including direct communication with

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	providers. This set the groundwork to allow us to case manage new Hepatitis C patients in the Expansion population. The fact that our clinical pharmacist had already established relationships with most of the providers prescribing hepatitis C drugs made the increase in workload associated with Medicaid Expansion more manageable. This case management approach also allowed us to facilitate access to these expensive but extremely effective treatments, while avoiding clinically inappropriate costs and poor outcomes from incorrectly prescribed hepatitis C drugs. Leading up to Medicaid Expansion, the Medicaid pharmacy team worked closely with the state's AIDS Drug Assistance Program (ADAP) to identify utilization patterns of their current patients and add the HIV drugs as a PDL class for review by the P&T Committee. We were able to negotiate some supplemental rebate agreements and capitalize on drugs with high federal rebates to put together a workable and sustainable preferred drug list for this class of drugs. Probably our most innovative practice for Idaho though this year was to use SUPPORT Act grant money to contract with an additional clinical pharmacist to improve opioid use and prescribing. The Idaho Medicaid pharmacy program had made significant strides in improving opioid use prior to adding the Expansion population. Between January of 2017 and December 2019, the pharmacy program had decreased the percent of participants on opioids by 37% and the number of participants receiving high daily doses (over 90 MME) by 39%. Unfortunately, Medicaid Expansion in early 2020 resulted in those percentages increasing back to 2017 values. The additional clinical pharmacist hired with SUPPORT Act funding was able to focus on participants receiving opioids and begin interacting and educating providers directly, freeing up our other clinical pharmacy staff to focus on other initiatives. A standardized prior authorization form with prompts to guide best practice opioid prescribing was probably the most significant accomplishment of this dedicated pharmacist. This form is educational and includes guidelines outlining the place of opioids in therapy and provides links to resources for safe opioid prescribing and tapering guidelines. This standardized form also prompts the co-prescribing of naloxone and includes a provider attestation form and signature field. The attestation form asks prescribers to confirm that the PDMP has been accessed, an opioid treatment agreement is in place, concurrent non-opioid and non-drug pain treatment is part of the treatment plan, and that urine drug screens are being done and evaluated. Idaho Medicaid's innovative pharmacy program has facilitated significantly better pharmaceutical care for our participants as well as ensured the appropriate use of state financial resources. It has provided a model which can be used for other programs in the future.
Illinois	Illinois Medicaid continues to focus on controlling Medicaid drug spending while ensuring Medicaid participants have access to the most cost-effective, clinically appropriate therapies. Illinois Medicaid routinely reviews processes to improve the care of Medicaid patients, maximize cost containment, and streamline operations. Provider education is also a key part of facilitating appropriate therapeutic care. The following innovative practices are highlighted for FFY20. In the second half of FFY20 COVID-19 pandemic medication changes were implemented to facilitate access to medication, support social distancing by decreasing need for frequent pharmacy visits, and decrease prior-authorization paperwork for prescribers. Changes included:

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	Preferred drug list and OTC coverage changes as well as a temporary lift of edits related to the Four Prescription Policy, 3-Brand limit, days' supply, quantity for diabetes medication administration and monitoring supplies. Edits to facilitate use of FDA Emergency Use Authorized medications, for example hydroxychloroquine, while also ensuring patients receiving these medications chronically for non-COVID-19 indications maintained medication access. Expansion of the 90-day allowed medication fill list. Encouragement of increased use of refill synchronization. Illinois Public Act 100-138 amended the Illinois Insurance Code to allow all providers of prescription coverage to provide synchronization of prescription medication refills. Effective August 8, 2019, Fee-for-Service permits synchronization of prescription drug refills one time per maintenance medication per year. A specific clarification code is required on the prescription claim. No participant copay is required for the synchronized prescriptions. Compound drugs, partial fill/completions and controlled substances are not eligible for medication synchronization. Illinois HFS implemented the following opioid-related prospective edits based on SUPPORT for Patients and Communities Act (SUPPORT Act): 7-day initial opioid fill, 90 MME edit for opioid naive participants, 120 MME edit for chronic opioid users, drug interaction edit for concomitant opioid and benzodiazepine use, and an informational edit regarding concomitant opioid and antipsychotic use. Prescriber peer consultation for mental health medication use in children via University of Illinois Department of Child and Adolescent Psychiatry DocAssist program continued. Provider outreach to prescribers continued for Chronic benzodiazepine medication use for the management of anxiety in the absence of first-line therapies, such as selective serotonin re-uptake inhibitors (SSRIs). Appropriate pain management with opioids. Montelukast monotherapy in adults with asthma to facilitate start of first-line therapy (steroid-containing inhaler) Adherence with hepatitis C, cystic fibrosis, and direct-acting anticoagulant therapy Illinois ADVANCE (Academic Detailing Visits And New evidence CEnter) initiative. Illinois Public Act 101 0278 required establishment of an evidence based, non-commercial education program for Medicaid prescribers consisting of web based curriculum and academic educator outreach. This resulted in an HFS collaboration with the University of Illinois at Chicago College of Pharmacy to provide academic detailing services in Illinois. During academic detailing clinical pharmacists meet one on one with prescribers for 15 to 20 minutes at their offices or via online video conferencing to provide unbiased, non-commercial, and current drug information while offering new tools, solutions, and support for Illinois Medicaid prescribers. The Illinois Advance Website provides continuing medical education (CME), frequently asked questions, for example regarding various opioid prescribing issues, as well as opportunities to make an academic detailing appointment or have a drug information request answered. The academic detailing visits also allow providers to obtain CME. During FFY20, FFS MRAD (Medication Review and Academic Detailing) and PA (Prior authorization) staff pivoted from in-person academic detailing sessions to virtual televisits. Staff authored and edited materials used for prescriber education and conducted outreach to

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	inform professional prescriber associations of Illinois ADVANCE services. During FFY20 academic detailing sessions addressed the CDC Guideline for Prescribing Opioids for Chronic Pain, opioid alternatives, Illinois Prescription Monitoring Program's MyPMP feature, and opioid use disorder. Illinois ADVANCE has also established a social media presence on LinkedIn, Facebook, and Twitter to encourage appropriate prescribing.
Indiana	On November 1, 2009, the fee-for-service (FFS) pharmacy program implemented an automated prior authorization (PA) tool known as SmartPA. On May 24, 2013, OptumRx (previously known as Catamaran) became the pharmacy benefit manager and implemented SilentAuth. SilentAuth is an automated PA tool that executes real-time prior authorization decisions by utilizing highly sophisticated clinical PA edits supported by the member's medical profiles and pharmacy claims data. This results in quicker PA determinations for Medicaid members, with less intervention on the part of both the pharmacy and the prescribing provider. On April 1, 2020, the FFS pharmacy program removed prior authorization criteria from buprenorphine/naloxone and maintained a day supply limit for buprenorphine. On September 1, 2020, the day supply limit from buprenorphine was removed. At this time, only preference, quantity limits, and age are reviewed for the use of buprenorphine and buprenorphine/naloxone for medication assisted treatment (MAT). On May 24, 2013, OptumRx implemented near real-time faxed retro-DUR interventions. These retro-DUR interventions evaluate claims as they happen and send DUR Board-approved interventions to prescribers to address as the potential concern occurs. During the reporting period, two new interventions were implemented to address the utilization of gabapentin and the use of hydroxyurea in sickle cell disease. OMPP collaborated with OptumRx and managed care to implement several temporary changes to assist members during the COVID-19 pandemic. A few of these changes are still currently in operation, while others have returned to the original configuration. Copays were removed to aid in members obtaining necessary medications. Early refills were permitted and 100-day supply for all maintenance meds were permitted. Prior authorizations for non-controlled drugs were extended as members were often unable to be seen by a prescriber. All short-acting inhaled beta agonists, inhaled corticosteroids, and inhaled anticholinergics were considered preferred to prevent additional prior authorization burden for potentially urgent therapy.
Iowa	N/A
Kansas	2020 INNOVATIVE PRACTICE NARRATIVE Below are the two key updates to the drug program for the 2020 Federal Fiscal Year: We further expanded our Advanced Medical Hold Manual Review (AMHMR) prior authorization criteria, as approved by our DUR Board. The criteria are listed in the link below. https://www.kdheks.gov/hcf/pharmacy/download/Advanced_Medical_Hold_Manual_Review_APPROVED_PA_Criteria.pdf The PDL Program has a pre-approval management tool, called the Consent Agenda Item, as mentioned in last year's DUR survey. The Consent Agenda Item criteria were further expanded in FFY 2020 to include pre-approval to add a biosimilar with the same indication as the reference product on the PDL.

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Kentucky	During Federal Fiscal Year 2020, the Kentucky Medicaid Program made the following programmatic changes. 1. Due to the COVID19 pandemic the following edits were modified: a. early refill edits were bypassed b. dispense fee limits were bypassed c. days' supply edits were relaxed on all medications except opioids d. copays were waived d. quantity limits were removed from short-acting beta-agonists 2. The P&T committee reviewed new drugs to market in various classes, such as oral oncology, narcolepsy, immunomodulators, spinal muscular atrophy, anticonvulsants, Parkinson's Disease, pleuromutulins, and HIV/AIDS and DMS developed utilization management measures to ensure appropriate use. 3. We converted prior authorization criteria for preferred multiple sclerosis agents to an automated, diagnosis driven PA.
Louisiana	Louisiana did not initiate innovative practices in FFY 2020.
Maine	COVID-19 Pandemic Initiative To ensure MaineCare members had access to the medications they needed, for the duration of the COVID-19 emergency, MaineCare in collaboration with the DUR committee instituted the following changes to provide access during a difficult and uncertain time. Waiving copays for prescriptions (excluding Maine Rx Plus and DEL programs). MaineCare co-pays are set at the plan level for the various programs within MaineCare. Claims adjudicated during the pandemic calculates the claim and sends $0.00 back as the member's co-pay and the full payment to the pharmacy rather than requiring the member to pay that portion to the pharmacy. Payment is now covered by MaineCare in full. Early refill Currently, MaineCare members can get up to a 34-day supply of brand medications. MaineCare is now allowing one additional refill of the days' supply for which the brand name Rx is prescribed. Generic Drugs: MaineCare members can already receive up to a 90-day supply of generic medications through prescription. Submission Clarification Code 13 (SCC 13): MaineCare is allowing pharmacies to use SCC 13, which is the Natural Disaster Emergency Override Code that pharmacies can use in the adjudication of pharmacy claims. This code indicates that an override is needed based on an emergency/disaster situation recognized for patients in response to COVID-19. To utilize SCC 13, the dispensing pharmacist must add the code when processing an early refill for a patient. The use of SCC13 will override a Reject 79 (Refill too soon). Controlled Substances: Maine law (Chapter 488) limits the prescribing of controlled substances for chronic pain to 30 days; MaineCare recognizes those limits and has not made changes to Maine's existing controlled substance statues. Given that, please note that the SCC 13 override noted above is not intended and should not be used for overriding prescribing amounts or refill limits for controlled substances (including both opioid pain medications and buprenorphine), although; Prescribers may exercise professional judgement regarding the

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	dispensing of early refills for controlled substances and must document the reason for the early refill. Encouraging naloxone prescribing for opioid overdose rescue: MaineCare recognizes the potential risk for increases in drug overdose and overdose deaths during this high-stress time and continues to encourage providers and pharmacists to prescribe and dispense naloxone to all patients receiving prescriptions for opioid medications and/or buprenorphine for treatment of Opioid Use Disorder. For all patients without an existing provider prescription for naloxone, MaineCare encourages pharmacists to leverage their ability under existing Maine law to prescribe and dispense naloxone, or to access a standing order for naloxone available from Maine DHHS medical leadership. Extending Prior Authorization (PA) periods for prescriptions: MaineCare will proactively review all existing PAs due to expire at the end of March and will extend them out to the end of April. This process will be reviewed on a month to month basis. All initial PA requirements on the MaineCare Preferred Drug List (PDL) remain in effect. Waiving initial PA requirements for asthma and immune-related drugs (e.g.Neupogen). MaineCare moved all acute albuterol inhalers to preferred on the PDL since these medications were needed for any rescue breathing related effects of the virus. We also have many other products already covered, without prior authorization, in the longer acting beta agonist category and multiple options for corticosteroids as well. Immune drugs: MaineCare has added Neupogen and Granix to the PDL and will handle any other requests through the Pharmacy Helpdesk (1-888-445-0497). We expect that these drugs would more than likely come through the medical benefit, but the Helpdesk will aid in any requests as they come in. For a listing of MaineCare's PDL, visit: http://www.mainecarepdl.org/pdl Testing for COVID-19 by Medicaid Pharmacies: On July 10, 2020, MaineCare will begin implementing the guidelines from the Federal Health and Human Services Department to allow pharmacists to order and administer tests for COVID-19. Change Healthcare is working on system modifications that will allow pharmacies to submit claims for COVID-19 specimen collection testing through the POS.Starting July 10, 2020, the POS will be ready to process these claims. The Payer Specific instructions on how to submit a claim for the collection of the specimen will be available at: http://www.mainecarepdl.org/payer_sheets_system_info Metabolic Monitoring This practice was suspended during the pandemic since the letters could not be generated and mailed from the work from home model. The DUR typically sent out over 1800 letters to providers in a FFY regarding the appropriate need for metabolic monitoring with the use of atypical antipsychotics. The communication included monitoring of weight and metabolic parameters including blood pressure, A1c, fasting glucose and fasting lipid profile in accordance with the ADA screening guidelines. The letters also described a process where baseline parameters would be obtained then at 12 weeks follow up labs would be required. Providers that were surveyed were given 20 weeks to obtain and submit the baseline and follow up numbers for review, if this information was not received than further antipsychotic use would require prior authorization to assure proper monitoring. In its review, 30% of members lack proper documentation of routine monitoring.

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	Opiate Limits MaineCare members are allowed over a rolling 12-month period up to a 15-day supply of an opiate without prior authorization after an initial 7-day limit on short acting opiates. Members requiring longer than 15 days require a PA for continuation of therapy and providers may provide medical necessity. Members may be eligible for up to three prior authorizations of up to 14-day supplies of opiates during the 12-month period. MaineCare members that are in Hospice care or are being treated for a diagnosis of cancer will be exempt from these limits. Providers are required to indicate on the prescription these exceptions and the pharmacies utilize the CA or HO diagnosis code when transmitting the claims for processing. Post-surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon. Members that require additional opiates after the initial 8 week limits listed above are considered chronic users and further communications will be sent to providers on developing criteria requiring other potential treatment options or monitoring programs PCM Program The MaineCare Pharmacy Care Management (PCM) program for Fiscal Year 2020, enrolled an additional 1,033 members to total 4,692 members since program initiation (including Pilot). Our program has been designed to assure that the right patients are receiving the right medication for the right condition. We confirm that medication prescribing comports with FDA approval for the condition it is being used for as well as that it is being taken by the correct type of patient. Our program educates patients on new medications so that they are aware of how to take their medications, the importance of being compliant with the dosing schedule, and what they can expect in terms of outcomes and adverse reactions. This program tracks patient adherence to medication regimens by measuring Medication Possession Ratio. At the conclusions of Fiscal Year 2020, the PCM program included 1,524 members being actively followed (others have stopped medications, lost eligibility or required no further monitoring for various reasons). Looking at the 4th quarter alone, after an in-depth initial review for each new member (assessing prescription claims history along with previous prior authorization requests), an additional 880 follow-up reviews were completed on existing PCM patients. All follow-up reviews begin by researching all prescription fills and prior authorization requests since the previous review to determine what, if any, contact and follow-up is needed with the patient and/or provider. Resultant of these reviews, MaineCare PCM contacted providers (prescribers and pharmacies) via telephone or fax a total of 207 times and contacted patients via telephone 59 times during the 4th quarter alone. Medication cost abatement readily occurs when a lower cost regimen is selected, a dose decrease occurs, or medication discontinuation ensues following a consult with our pharmacist. Treatment adherence is tracked in real time using established methods and also include assessment of medication possession ratio. We strive to achieve the highest treatment medication adherence to ensure maximal benefit from the treatment selected. Utilization information is continually monitored to assess the impact of the PCM program on all aspects of the patient's care including aggregate spend. This not only includes the direct cost of medications but other utilization measures such as emergency room visits, hospital stays, and laboratory services, amongst others. Hepatitis C Value-based Authorizations Hepatitis C is a serious illness that can lead to cirrhosis, liver cancer and death. It is the leading indication for liver transplants in the United States. Once again, further medication

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	development and release occurred throughout Fiscal Year 2020 to further advance this field. Cures are possible with oral regimens that range from 8-24 weeks for most patients. However, the cost for treating this disease is staggering with hepatitis C drugs rising quickly to one of the top 5 categories in cost for almost every state Medicaid program. Despite the release now of multiple therapies and some relief in the form of cost competition and supplemental rebates, the cost remains high. Maine has taken a multi-pronged approach to managing these medications--balancing evidence-based science with cost to try to allow as many as possible to access this important category of medications. In addition to being expensive, the clinical care of Hepatitis C is complex. There are now over 25 regimens recommended by the AASLD/IDSA guidelines for the treatment of hepatitis C. The choice is based on the genotype of the virus as well as patient factors, such as prior treatments and the presence of cirrhosis. Given the continued high cost of treatment, it is critical that the correct therapy is chosen and that adherence be monitored. An incorrect choice of regimen or lack of adherence that results in an unsuccessful treatment course is not only costly, it makes the next attempt at cure potentially both less likely and more expensive. The most cost effective, clinically correct choice is to make sure the patient is cured with the first treatment course by ensuring that the correct treatment is chosen, the patient is ready for treatment and likely to be compliant and then monitoring for that compliance. Finally, it is critical that Maine ensures it pays the lowest net cost for the correct therapeutic regimen. The introduction of multiple new therapies has created options for treatment and options for price negotiation. In many circumstances, the guidelines offer as many as 4 clinically acceptable, equally efficacious regimens. Through its membership in the SSDC drug pool, Maine has been able to consider offers from all of the labelers of the major hepatitis C direct-acting antivirals. However, sorting through these offers and making sure the best overall value is obtained for this category has required complex modelling and consideration of the prevalence of the various genotypes and clinical scenarios to arrive at the most clinically effective as well as the most cost effective regimen for each of the various clinical circumstances. Using the AASLD/IDSA guidelines as a source of evidence-based practice and considering the various offers available via complex clinical/fiscal models allowed determination of the best value for each unique clinical situation and helped to determine which agents would be placed in a preferred position on the preferred drug list and in which circumstance each was the best value (considering both efficacy and cost). The next hurdle was providing information to providers in an easy to use format so that they could see which choice of drug regimen in each unique clinical circumstance was the most cost effective. It is not as simple as choosing only preferred drugs. There are some complex situations where the use of a non-preferred drug is the most cost-effective choice for MaineCare as well as the right choice for the member. In this type of circumstance, the occasional use of a non-preferred drug to meet a specific clinical need is authorized. To meet this complex challenge, Maine worked with its DUR Board to develop a prior authorization form that helps lead the provider to the most clinically effective, cost-effective choice based on net pricing to the State of Maine. Considering the genotype, prior therapy and level of cirrhosis, a provider can work through the form to determine the clinically appropriate choice as well as the choice that represents the best value to the State. For cases that don't fall easily into the choices provided, MaineCare also offers expert oversight of the hepatitis therapies, when needed. This form was again updated during Fiscal Year 2020 to include the newest therapy options and changes to preferred regimens. Finally, the Pharmacy Care Management Program allows a pharmacist to interact with the member and provider on an ongoing basis to help ensure the medication is taken, monitored

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	appropriately and to collect follow-up information on outcomes. The PCM program has continued to track adherence (at the end of Fiscal Year 2020, Hepatitis C adherence was measured at 96% based on a medication possession ratio of 0.8 or higher), as well as cure rates by receiving post-treatment viral loads from providers. During Fiscal Year 2020, cure rates based on Genotype and Fibrosis Level (degree of liver damage) ranged from 83% in the most diseased/difficult to treat members to 100% in the more common and less diseased groups. By synthesizing complex clinical and fiscal data into an easy to follow authorization form, Maine has made it easier for providers to choose the most cost-effective, clinically appropriate therapy the first time rather than asking for a therapy only to be told no and that another therapy is more cost-effective. By making the right choice easy to find, Maine is helping providers to navigate a complex therapeutic landscape to enable members access to these breakthrough therapies.
Maryland	Summary 5 - Innovative Practices Live Continuing Education Programs Annually, the Maryland Department of Health Office of Pharmacy Services (OPS) has sponsored a live continuing education program. In FFY 2020, OPS sponsored two live programs for Maryland Medicaid healthcare providers. The first program, Treatment of Hepatitis C and Comorbid Conditions was held in December 2019, and the second program, Stimulants: A therapeutic review was held in July 2020. Members of the DUR Board have actively participated as speakers at these events in past years, provided recommendations for potential speakers, and attended the presentations. Continuing education program details are available at www.mmppi.com/previous_seminars.htm. Response to the program was overwhelmingly positive. The Department plans to continue this service to the healthcare community. Clinical Criteria Expansion In FFY 2020, OPS continued to update its website to include clinical criteria for additional medications. The clinical criteria are based on FDA approved indications and exist to ensure appropriate utilization of medications with limited indications. The list of medications for which prior authorization is required is updated regularly and can be found at: https://mmcp.health.maryland.gov/pap/Pages/Clinical-Criteria.aspx Dose Optimization and Quantity Limits Many drugs have flat pricing across dosage strengths; however, there are products with significant price disparities between dosage forms. In an effort to reduce waste and improve prescribing practices, dose optimization and quantity limits continue to be utilized. Medical necessity overrides are available with prior authorization. The most recent list of dose optimization quantity limits can be found at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf Online Formulary hosting for Maryland Medicaid and HealthChoice MCOs

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	The OPS has maintained an electronic database with FFS and MCO formulary information since 2007. This program, which is free for providers and participants, provides updated information on the formulary status of medications. During FFY 2020, the use of Formulary Navigator allowed real time access to information for Maryland Medicaid providers for all nine MCO and FFS formulary information. This user-friendly platform allows searches by drug name (brand or generic), therapeutic class or alphabetical listing. Additionally, products are now displayed with drug strength/formulation, and multiple flags (prior authorization, quantity limits, criteria for use) are available to guide prescribing and facilitate access to medications for patients. Corrective Managed Care Program The Corrective Managed Care (CMC) Program has been instituted by the OPS to monitor and promote appropriate use of controlled substances. Through a monthly review, the state identifies Maryland Medicaid participants who appear to be on duplicate drug therapy, visit multiple prescribers writing for similar medications, and/or patronize multiple pharmacies. Intervention letters are mailed to prescribers and pharmacy providers in an effort to alert them to potential drug therapy concerns. If there continues to be overutilization of a substance by a participant after intervention letters are mailed, a participant can be locked-in to a single pharmacy. Under a Lock-In pharmacy agreement, the participant will be required to fill the related medications at one mutually agreed upon pharmacy. The CMC Program utilizes the Corrective Managed Care Advisory Committee, which is a sub-committee of the DUR Board, to assist with the review of individual participants and help set policy regarding efforts to reduce the potential misuse of controlled substances. The Committee meets just prior to the regular quarterly DUR Board meeting and includes all members of the DUR Board. For those participants where contact with prescribers through means of intervention letters has not changed behavior, the CMC Advisory Committee reviews each participant's drug and diagnosis history profile. The Committee then advises the OPS on recommended corrective action, which may include lock-in, further provider education or continued follow-up. Specific criteria have been approved by the CMC Advisory Committee, which allow some participants to be automatically restricted to a single pharmacy without prior CMC review. Criteria are based on the number of claims for controlled substances in their recent history and the number of prescribers and pharmacies utilized. In addition, some criteria used to screen patients for potential misuse have been modified to allow for follow-up 3 months after initial letters are mailed to providers. In the past, follow-up was not performed until 6 months after letters were initially mailed to providers. On April 1, 2016 (FFY 2016), a Unified CMC program was initiated that expanded CMC lock-in participation to all Medicaid participants included in the MCO programs. The program was expanded to create a minimum standard for monitoring of controlled substances by participants. The pharmacy program and MCO programs provided input on the final criteria that will be utilized by all parties when reviewing participant prescription claims. In addition to providing optimal care for all Medicaid participants, the unified program prevents the enrollment into a program that may not provide this oversight and allow potential fraud or abuse of controlled substances to occur without any corrective actions. Under the new program, if a lock-in participant switches between any Medicaid program, the lock-in information is maintained for the full lock-in term of 24 months.

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	The goal of the CMC program is to educate providers when patients appear to be over-utilizing controlled substances while ensuring that participants have access to appropriate medications they need and reducing adverse outcomes associated with over-utilizing controlled substances. Automated Prior Authorization System The Prospective DUR vendor, Conduent State Healthcare, LLC, utilizes an automated prior authorization program for selected medications which require prior authorizations. Pharmacy claims can be automatically authorized if specific criteria are met at the point of service. This eliminates the need for the provider to call for an authorization if the participant meets the criteria for approval. The Conduent automated prior authorization system is made up of two components known as SmartPA and SmartFusion. A brief description is below. SmartPA - A clinical rules-based system that allows flexibility when determining prior authorization acceptance or denial. It produces the prior authorization that can be saved within the system. It has help desk tracking, support, and reporting capabilities. SmartFusion - The call center solution for providing call center representatives access to the SmartPA rules engine via a window on certain claim processing screens. This system is used to determine pre-authorizations for rules based in SmartPA. Hepatitis C Peer Review Program While coverage of Hepatitis C agents is provided by MCOs and the Medicaid FFS program, during FFY 2015, the OPS partnered with the MCOs in the State of Maryland to standardize treatment options for this disease state. Through a joint program, managed through the University of Maryland School of Pharmacy (UMSOP), clinical guidelines have been developed to address the growing use of Hepatitis C agents. These guidelines are updated as new information becomes available and serve as a guide for the FFS program and all nine MCOs. During FFY2019, the Department expanded coverage to include fibrosis scores of F1 (mild/portal or periportal fibrosis w/o septa) and greater; patients < 21 years were approved with a status F0; patients > 21 years old with a score of F0 was approved for treatment if they presented with a viral condition (e.g. HIV) which was known to accelerate hepatic disease progression. Additionally, drugs such as daclatasvir/sofosbuvir, Technivie and Viekira XR were removed from the criteria as they were discontinued due to low utilization. Full program details, including recommended treatment plans, medication guidelines and prior authorization forms, are available at: https://mmcp.health.maryland.gov/pap/pages/Hepatitis-C-Therapy.aspx Substance Use Disorder Carve-Out program Beginning January 1, 2015, the Maryland Department of Health initiated a carve-out program to provide all substance use disorder medications to Medicaid participants. Through this program, the OPS standardized coverage and criteria for use of medication assisted treatment, including buprenorphine-containing products, disulfiram, acamprosate, naltrexone (oral and injectable), varenicline, bupropion SR and nicotine replacement products. Effective October 1, 2018, Lucemyra (lofexidine) was added to the program. Criteria for use, quantity limits/dose

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	optimization and copayment for participants were implemented with this program. Treatment guidelines are based off of the FDA-approved indications as well as CMS recommendations for comprehensive patient-care. In addition to medication assisted treatment for substance use disorders, the OPS also provided coverage of naloxone for opioid overdose/reversal for all Medicaid participants and community members who were certified to administer the medication. Program details are available at: https://mmcp.health.maryland.gov/pap/docs/Substance%20Use%20Disorder%20%20Medication%20Clinical%20Criteria%20Final%20updated%20Aug2018.pdf SUPPORT Act Effective October 1, 2019, the OPS implemented reporting and monitoring practices to be compliant with updated Federal regulations regarding the SUPPORT Act. These measures included prospective safety edits alerts and automated claims review processes that monitor when a participant is concurrently prescribed opioids and a benzodiazepine or an opioid and antipsychotic. Additionally, continued monitoring of those received medication assisted treatment for an opioid use disorder and also receiving an opioid, and monitoring of opioid claims. Because benzodiazepines and antipsychotics are carved out of the MCO benefit and paid FFS, the Department implemented these changes through the Coordinated drug utilization review program, while MCOs were encouraged to report on reporting and monitoring practices for opioid prescriptions, including initial and subsequent fills, quantity limits, therapeutic duplications, early refills and total morphine equivalent dosing. Carve in HIV Antiretrovirals for the treatment of HIV/AIDS were carved back in to the MCO benefit beginning January 1, 2020. This update and change in coverage included a thorough review of anticipated MCO coverage and clinical criteria for use, if appropriate. Additionally, a six-month soothing period was implemented to maintain coverage for all participants receiving these therapies. COVID-19 initiatives Due to the novel Coronavirus pandemic, the Maryland Department of Health implemented multiple measures to facilitate the continued safe and appropriate use of medications for members. These measures included a waiver of early refills edits allowing a one time 30 day early refill supply and up to a 90 day supply on maintenance medications, a 14 day emergency supply of medications if a prescriber is unable to obtain a preauthorization, signature less deliveries of medications, and non-enforcement of certain preauthorization requirements. Additionally, pharmacies were authorized to collect specimens for COVID-19 testing. The Department has maintained a separate website with COVID-19 related information for public use to stay up to date on any changes and available resources. These initiatives are temporary and only in effect during the State of Emergency or designated timeframe.
Massachusetts	MASSHEALTH INNOVATIVE PRACTICES FFY2020 COVID-19 response

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	Following the public health emergency in response to the spread of COVID-19, the MassHealth pharmacy program Implemented a plan response in March 2020. This strategy included developing accommodations to the claims processing system (e.g., early refill leniencies, 90 day supply allowances, select PA removal), proactively monitoring the COVID-19 treatment and vaccination pipeline and implementing proactive management strategies (where appropriate) and developing a messaging strategy to communicate virus response to stakeholders. Unified Preferred Pharmacy Product List In July 2020, the preferred uniform product list was expanded to a total of approximately 200 drugs for which PA status and approval criteria was coordinated amongst the Fee For Service/Primary Care Clinical/Accountable Care Organization type B plans were and coordinated with Managed Care Organization (MCO) plans. Efforts were taken to evaluate impacts on plan members and share clinical guidelines with MCO plans to facilitate this process. Provider Outreach Programs The goal of this program is to identify high cost medications / disease states that are also associated with considerable nonadherence. The measure utilized within the programs will be the medication possession ration (MPR). Examples of such programs include the following: Synagis/RSV Prophylaxis, Hepatitis C Agents Each individual program follows a similar model whereby a consultant pharmacist or pharmacy associate monitors medication claims/MPR for the select members. If a lapse or potential lapse in medication claims is identified, a consultant pharmacist conducts telephonic outreach to the prescriber. Prior Authorization determinations are adjusted on a case by case basis when indicated. These interactions are monitored, and outcomes of the interventions are reviewed periodically. CAR-T Monitoring Program Following the initial approval of CAR-T therapies in late 2017, a monitoring program was created with several aims. First, the manufacturer of one agent Kymriah (tisagenlecleucel) offered to reimburse the provider for the cost of the drug if treatment was unsuccessful at 30 days post-treatment. A mechanism was needed to ensure that the plan would not pay for medication is this scenario. In addition, the monitoring program follows plan members at specified points post-treatment to verify treatment response and better understand the long-term impact of therapy. Vitrakvi (larotrectinib) Monitoring Program Following approval of Vitrakvi (larotrectinib) in November of 2018, a monitoring program was created with several aims. First, the manufacturer offered to reimburse the provider for the cost of 60 days of treatment with the drug if the intervention was unsuccessful. In addition, the monitoring program follows plan members at specified points post-treatment to verify treatment response and better understand the long-term impact of therapy. Zolgensma (onasemnogene abeparvovecxioi) Monitoring Program Following approval of Zolgensma (onasemnogene abeparvovec-xioi) in May of 2019 a monitoring program was created with the aim of following plan members at specified points

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	post-treatment to verify treatment response and better understand the long-term impact of therapy. voretigene neparvovec-rzyl Monitoring Program Following approval of voretigene neparvovec-rzyl in December of 2017, a monitoring program was created with the aim of following plan members at specified points post-treatment to verify treatment response and better understand the long-term impact of therapy. Complex Opioid / Therapeutic Case Management Workgroup A biweekly meeting occurs with a multidisciplinary team involving clinical consultant pharmacists, a primary care physician specialized in pain control and addiction medicine and psychiatry consultant. The intent of these meetings is to discuss and develop action plans for members on complex opioid regimes including high dose and duplicative therapies. Polypharmacy with other classes associated with abuse and diversion (e.g., benzodiazepines, stimulants) are considered in the evaluation. Opioid Dose Accumulator In 2019, point of sale coding was developed to identify and monitor members receiving multiple opioids and accumulate those different products into a cumulative daily dose. Monitoring of average opioid doses will guide further interventions included reassessing the morphine milligram equivalent (MME) limits for high dose opioid use. Concomitant Opioid Benzodiazepine initiatives In 2019, coding was developed to monitor members receiving opioids in combination with benzodiazepines. A claims edit was established in November 2019, which resulted in prior authorization applying to members receiving concomitant therapy starting in January 2020. The prior authorization process was aimed as identifying appropriate tapers of the benzodiazepine component of the regimen. An algorithm that evaluated concomitant polypharmacy classes with a risk of abuse and diversion and other medical conditions was created to triage highest risk members to case review at the complex Opioid therapeutic case management workgroup. Compounding Program and Monitoring Periodic monitoring of high cost compounding ingredients is performed to ensure clinically appropriate and lowest cost ingredients are used. If an ingredient has been identified and determined not to be medically necessary, it may be subject to prior authorization. Hepatitis C Medications Following the Food and Drug Administration (FDA) -approval of Sovaldi (sofosbuvir) in late 2013, all prior authorization (PA) requests for hepatitis C regimens have been reviewed by Drug Utilization Review (DUR) to promote selection of the most cost -effective regimen. Several other products, Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Daklinza (daclatasvir), Epclusa (velpatasvir/sofosbuvir), Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir) , Vosevi (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier (elbasvir/grazoprevir) were also included in the prescriber outreach to discuss treatment alternatives following their FDA - approvals. At the time a PA request for one of the above products is received by the DUR, a DUR clinical pharmacist may contact the prescriber to discuss an alternative, more clinically appropriate and/or more cost - effective regimen. If the

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	prescriber agrees to switch the member to the suggested regimen, prescriber may resubmit the PA request for that regimen and receive an approval. Pediatric Behavioral Health Medication Initiative / Therapeutic Case Management Workgroup A multidisciplinary Pediatric Behavioral Health Medication Initiative (PBHMI) Therapeutic Class Management (TCM) workgroup was created consisting of pharmacists, psychopharmacology consultant, child psychiatrists, and a social worker. Retrospective case review is conducted daily, and cases are discussed weekly among workgroup members to provide an increased level of clinical expertise and prescriber outreach as appropriate. Member cases reviewed by the workgroup include those with a recent psychiatric hospitalization, age less than three years, behavioral health regimens with six or more medications, and use of select high -risk agents in certain age groups (e.g., antipsychotics in children less eight years). Workgroup responsibilities include clinical discussions regarding treatment plans, prescriber outreach to encourage evidence - based prescribing practices, and referral of members to a behavioral health program that assists in integrating care and providing psychosocial interventions. Pharmaceutical Pipeline Monitoring and Budget Impact Forecasting Prospective monitoring of the pharmaceutical pipeline is essential to anticipate new medications and their impact on pharmacy programs from both a formulary perspective and a budgetary perspective. The pipeline pharmacist continuously tracks agents in development, reporting on the potential place in therapy, the anticipated FDA approval date, and potential impact to the plan membership. In 2019 this process evolved to consider pipeline agents within therapeutic classes to project the impact of competing products coming to market. In addition, the pipeline pharmacist uses available clinical and economic data to predict the cost of the new agent, adoption by providers and patients, and the potential budgetary impact to the plan. Based on this information, the program can successfully organize, prioritize, and determine appropriate management strategies for emerging therapies, as well as allocate budgetary resources appropriately. Accountable Care Organization Care Referrals In 2018, MassHealth enrolled most plan members into Accountable Care Organizations with the goal of providing coordinated high-quality care. To support the success of this model efforts were taken to identify at risk members for the ACO to facilitate intervention. Members referred to ACO case managers included those with diabetes (low adherence to medications and a recent emergency room visit or hospitalization), respiratory disorders (patients using frequent as-needed bronchodilators without a controller medication) and pediatric members receiving psychiatric medications (those may be candidates for care coordination). Special Populations Extended Scope and Services Community Case Management (CCM) The special populations pharmacist maintains a direct means of expedited communication between MassHealth DUR and CCM. The CCM pharmacist tracks PA denials and approvals, reports trends and provide recommendations to MassHealth based on findings. Provider outreach involving medication related consultations, discharge consultations, and medication reconciliation ensure continuity of care among this at-risk population. Division of Children and Families (DCF) The special populations pharmacist maintains a direct means of expedited communication between MassHealth and DCF nurse case managers and social workers for medication related

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	inquiries. The special populations pharmacist also facilitates procurement and appropriate utilization of medications through collaboration with DCF providers. Enhanced Coordination of Benefits (ECOB) The special populations pharmacist maintains a direct means of expedited communication between MassHealth DUR and ECOB health benefits coordinators to ensure appropriate use of third-party liability and pharmacy billing for members. Automated PA -Point of Sale (POS) Rules As the Drug Utilization Review (DUR) program reviews new medications, performs evidence -based medicine reviews and executes quality assurance analyses, updates to the PA process are required. These updates require the creation or update of a clinical guideline used for reviewing PA requests. Each clinical guideline that is created requires the development of a point of sale (POS) rule. These POS rules are decision algorithms designed to evaluate clinical criteria at the time the prescription is processed at the pharmacy level and bypassing the PA submission process. When a prescription is processed through the MassHealth Pharmacy Online Processing System (POPS), the software automatically searches medication history, diagnosis, or procedure codes from the MassHealth medical and pharmacy claims database. If all criteria are met, the medication will adjudicate at the pharmacy without a requirement for PA submission. Special Projects Uptake of direct acting antivirals for hepatitis C virus in a New England Medicaid population. This project has led to a better understanding of the hepatitis use trends in the state. Evaluating the Effect of Proactive Interventions for Prior Authorization Recertifications on Continuity of Care in a Specialized Medicaid Population. This project has led to a better understanding of the impacts of interventions to promote PA recertification in the MassHealth Community Case Management population. Cost-Benefit Analysis of Sacubitril/Valsartan Among Patients with Heart Failure with Reduced Ejection Fraction in a Medicaid Population. This project has led to a better understanding of the value of Sacubitril/Valsartan in the MassHealth population. Budget Impact Forecast of Emerging Agents for the Treatment of Sickle Cell Disease and Beta-Thalassemia in a State Medicaid Plan. This project has led to a better understanding of the emerging sickle cell disease and beta-thalassemia therapies and their impact on the pharmacy program budget. Reduction in Pharmacy Cost Following a Pharmaceutical Compounding Retrospective Utilization Management Strategy Targeting Topical Pain Compounds in a Medicaid Program. This project has led to a better understanding of the impact of managing topical pain compounds. MassHealth Acute Hospital Carve-Out Drugs List This MassHealth Acute Hospital Carve-Out Drugs List section of the MassHealth Drug List (MHDL) applies to participating in-state MassHealth Acute Hospital providers, and as applicable to out-of-state MassHealth acute hospital providers pursuant to 130 CMR 450.233(D). This List identifies the current list of Adjudicated Payment Amount per Discharge

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	(APAD) Carve-Out Drugs and Adjudicated Payment per Episode of Care (APEC) Carve-Out Drugs for purposes of Sections 5.B.8.b and 5.C.9 of the current MassHealth Acute Hospital Request for Applications for in-state acute hospitals (Acute Hospital RFA), and regulations at 130 CMR 450.233(D) for out-of-state acute hospitals. The hospital must obtain prior authorization (PA) from MassHealth for the APAD Carve Out Drugs and APEC Carve-Out Drugs on this list, and the associated treatment will be subject to monitoring, as indicated below. Other requirements also apply. This list, and the PA and other requirements, may be updated from time to time. APAD and APEC drugs include Car-T Therapies, Spinal Muscular Atrophy Gene Therapy, and FDA-Approved New to Market Drugs and Biologics that are not listed on the MassHealth Drug List are evaluated on a case by case basis.
Michigan	Throughout FFY 2020, Michigan Department of Health and Human Services (MDHHS) worked diligently to combat the opioid crisis; improve access to MAT and hepatitis C medications; and to manage spending through implementation of a single preferred drug list (PDL) and outcomes-based contracting. In December 2019, MDHHS lowered the morphine milligram equivalent threshold to 120 MME per day. This has been a gradual tapering process that began in 2018. That same month, MDHHS removed the clinical prior authorization (PA) and prescriber restrictions on MAT medications. Dosages exceeding FDA approved labeling and those medications that are PDL non-preferred still require prior authorization. With the removal of this clinical PA, there has been a 28% increase in the number of beneficiaries on MAT medications. As a result of the DUR Board's input on the SUPPORT Act, MDHHS developed a new process with the managed MCOs to perform concurrent utilization reviews on opioids with antipsychotics and with benzodiazepines. MCO aggregate utilization trends along with those for FFS are presented to the Board each quarter starting at the March 2020 meeting. Over the past few years, MDHHS has worked to reduce the barriers to hepatitis C treatments. In October 2019, we expanded the coverage of hepatitis C medications to patients with F0 liver scarring. Prior to that date, coverage had been limited to more advanced liver scarring of stages F1-F4. The MDHHS Public Health Administration set a goal to eliminate hepatitis C virus (HCV) in Michigan. It is leading a steering committee with stakeholders, clinicians and community leaders to develop a state plan that includes data and strategic planning, community-based interventions, and adult and pediatric interventions. They entitled this initiative We Treat Hep C. MDHHS and the Michigan Department of Corrections (MDOC) drafted a collaborative RFP to secure lower pricing on hepatitis C agents to treat as many Michiganders as possible. The goal is to select one hepatitis C medication as preferred on the PDL. MDHHS entered into an agreement with the manufacturer AbbVie to expand access to Mavyret (glecaprevir/pibrentasvir). Effective April 2021, clinical prior authorization (PA) is no longer required for Mavyret. This includes removal of the requirement that HCV medications must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist. All providers who have prescriptive authority will be able to prescribe this treatment to beneficiaries with HCV. PA will still be required for the PDL Non-Preferred agents. Much of FFY 2020 was also devoted to developing a single Medicaid PDL to maximize drug manufacturer rebates to generate savings. MDHHS also coordinated the adoption of the FFS PDL PA criteria by the MCOs. Both FFS and the MCOs utilize the same criteria to ensure consistency across the entire Medicaid population for the PDL drug classes. Also, to support

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	the financial sustainability of Michigan's independent pharmacies, MDHHS proposed raising the Medicaid Health Plan dispensing fee for independent pharmacies to $3. The single PDL and related changes were implemented on October 1, 2020. To further address the high cost of medications, MDHHS received CMS approval in October 2018 to pursue Outcomes-Based Contracts with drug manufacturers. In August 2020, the first contract was executed with Novartis Gene Therapies for the gene therapy medication, Zolgensma.
Minnesota	There are no innovative practices.
Mississippi	DOM submitted a SPA that was approved by CMS on December 23, 2020, with an effective date. Prior to this change, only a few vaccines were open for coverage and billing via the pharmacy venue. This SPA allows licensed pharmacists employed by DOM pharmacy providers to administer all vaccines listed on CDC vaccine schedules. administrators that receive payment for services to beneficiaries age 10 and above. Instead of professional dispensing fees, providers will receive vaccine administration fees calculated at 100% of the Medicare rates. The allowable ingredient cost per vaccine will equal the Wholesale Acquisition Cost (WAC) plus 0% per NDC#. Vaccines billed via pharmacy claims will not count toward the monthly prescription limit and no copayments will be required. Pharmacy providers must be enrolled in the Vaccines for Children (VFC) program to administer vaccines to children age 10 through 18.
Missouri	Atypical Antipsychotic Usage in Children - MO HealthNet (MHD) in partnership with the Department of Mental Health and the Children's Division within the Department of Social Services, implemented revised clinical criteria for use of the atypical antipsychotics in children in January 2016. We are using a combination of prior authorization and clinical review, along with retrospective case review to ensure appropriate utilization among our youth participants. Our initial focus was on children under 9 years of age in foster care, but our criteria changes and reviews apply to therapy for all children covered by MO HealthNet. In April 2017, MHD began reminding ALL prescribers of atypical antipsychotics in children of the need for metabolic monitoring, and that the division would require documentation in the near future, prior to authorizing continued therapy. This initiative was anticipated to be fully in place by August 2017, however MHD ran into issues being able to check for metabolic monitoring transparently. The issues involved FQHCs being able to bundle bill and MHD being unable to distinguish metabolic monitoring claims within the bundle bill and that there were some providers who did finger sticks in their offices but MHD does not cover a claim for finger stick metabolic monitoring. Discussions are ongoing around these issues. The Children Division under the Department of Social Services, The Department of Mental Health and MHD have had ongoing meetings regarding Psychotropic Prescribing for children under the age of 9 which has led to the establishment of a Center of Excellence to provide additional review specifically for our foster children. High Quality and Cost-Effective Health Care (Direct Care Pro) Direct Care Pro is a highly innovative Medication Therapy Management (MTM) tool. This application utilizes the pharmacist-patient relationship, focusing on quality of care, wellness initiatives and cost containment. This web-based system assists pharmacists and other appropriate healthcare providers to maintain standards of care for participants' multiple chronic diseases and co-morbidities by utilizing nationally recognized, evidence-based treatment standards. The statewide rollout of this tool started in summer 2010 by delivering actionable clinical information at the point-of-service, empowering pharmacists to provide clinical education to their patients. As of August 2016, there were over 150 pharmacy sites with over 200

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	pharmacists set up with MTM access to perform encounters. To date, over 8,600 encounters have been performed. Clinical Editing/Prior Authorization (SmartPATM) - SmartPATM employs a highly sophisticated clinical rules engine that uses algorithmic criteria derived from best practices and evidence-based medical information to allow transparent approval of service and product requests. It streamlines the prior authorization process for all stakeholders - physicians, allied health professionals and participants - as it adjudicates prior authorizations in real time. All providers who participate in MO HealthNet's fee-for-service program are subject to clinical editing and prior authorization requirements. Smart MedPATM technology was implemented in July 2006 utilizing the same clinical rules engine used for SmartPATM. SmartPATM and Smart MedPATM process precertifications for pharmacy, durable medical equipment, radiology and optical services. MHD has started including behavioral health services in the Smart MedPA TM rules engine to ensure appropriate utilization and efficient use of funds. As of August 2019 there are over 300 Pharmacy edits and 38 Durable Medical Equipment Rules. In the pharmacy program transparency rates exceed 90% for certain rules with an overall transparency average of 82%. Long Acting Reversible Contraceptives (LARCs) - The 2017 Missouri legislative session passed legislation in the attempt to deal with the high number of MHD abandoned non-oral Long Acting Reversible Contraceptives (LARCs) in provider's offices. If the LARC was dispensed from a pharmacy, it cannot be returned to the pharmacy. The legislation allowed for a MHD participant abandoned unit to be utilized for another MHD participant. A prescription paid under one MHD participant being utilized by another MHD participant would create an audit nightmare and have incorrect information or no information regarding the LARC in MHD medical profiles. MHD changed its policy where LARCs were no longer allowed to be dispensed by a pharmacy and medical providers needed to obtain the LARC from the pharmaceutical company or wholesaler and bill MHD the LARC as a pharmacy claim. Should the unit become abandoned the provider has 90 days to return it to the manufacturer or wholesaler for credit. Advisory Council on Rare Diseases and Personalized Medicine - The 2018 Missouri legislative session passed legislation that established an Advisory Council on Rare Diseases and Personalized Medicine within the MO HealthNet Division. The advisory council shall serve as an expert advisory committee to the drug utilization review board, providing necessary consultation to the board when the board makes recommendations or determinations regarding beneficiary access to drugs or biological products for rare diseases, or when the board itself determines that it lacks the specific scientific, medical, or technical expertise necessary for the proper performance of its responsibilities and such necessary expertise can be provided by experts outside the board. The advisory council meets quarterly and has reviewed a number of rare disease medications including unique insight into the treatment and care of these rare and ultra-rare diseases that would not be available to state staff without the council. Alternative Pain Management Therapies - In 2019 MO HealthNet implemented the coverage of alternative pain management therapies, including acupuncture, chiropractic services, and physical therapy. These services are covered as an alternative to opioids for chronic pain. While the program is still in its infancy, the goals of the program are to reduce the need for chronic opioids when participants are suffering from chronic pain. The services are available to FFS and MCO participants.
Montana	Pharmacy Case Management Program The primary goal of the pharmacy case management program is to share information with all providers of care to enable individual /multiple providers the opportunity to manage drug

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	therapy based on all the information available. The Medicaid program allows for this sharing of information by virtue of the benefit and that all the data resides in mostly one repository. By having first-hand knowledge of all the medications, providers, pharmacies, and other medical services that have been provided to the member, a more goal-oriented approach can be made for each member. After a case is chosen for review, a case management pharmacist then makes phone appointments with the providers involved to discuss utilization issues, counter-detailing, and cost appropriateness. This program also defines a mechanism for reimbursement of the provider's participation in the telephone conference by virtue of a CPT code. Cases are chosen for review by several methods: Selection by the Pharmacy Case Management Clinician via retrospective DUR, referral from the Drug Prior Authorization Unit during prospective DUR, or referral from outside sources including the Team Care (lock-in) program director, Medicaid Pharmacy Program Officer, case workers, or other members of the patient's health care team (i.e. retail pharmacist or physician). Medicaid drug claims data in conjunction with diagnoses information is then reviewed by a pharmacist. Medication review may include any/all of the following parameters: Possible medication over-usage, medication duplication, potential drug-drug interactions, drug-disease indications, identification of multiple pharmacies or providers, and potential cost savings recommendations. If an intervention is deemed appropriate, a copy of the patient's medication profile, diagnosis profile, and letter requesting a telephone conference is mailed to the prescribing physician(s). This information indicates all medications, physicians, pharmacies, and diagnoses that have been documented through Montana Medicaid within a selected time period. It also indicates the reason for patient selection. A telephone conference is scheduled to discuss recommendations with the physician. Often times, a physician will fax documentation resulting in a positive outcome for the patient in lieu of a telephone conference. If necessary, cases may be referred to the DUR Board for further review and recommendations. Information on how to bill for the telephone conference is sent to the provider after the interface, and all patients involved in the case management are tracked within the internal MARS database tracking system. These cases are also viewable by drug PA staff for cross-referencing relevant data with the prior authorization process. Pharmacy case management was expanded in FFY 2008 to include academic detailing of selected topics (i.e. Suboxone best-practice guidelines.) Face-to-face education of prescribers has been effective in changing prescribing practices of targeted drugs to be consistent with the medical evidence, support patient safety, and to be cost-effective choices. The process has been extremely successful in engaging providers to be part of the solution in dealing with the increasing complexity and cost associated with current drug therapies. Psychotropic Medication Usage Oversight among Children in Foster Care The pharmacy case management program continues to assist in the oversight of psychotropic medication use in the Montana Medicaid foster care population. Clinical case management staff has met with stakeholders for input including the medical directors of child and adolescent psychiatric treatment facilities and community-based psychiatric services in Montana. Based on current psychiatric treatment guidelines and input from the profession,

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	foster care members meeting specific clinical criteria undergo case review by a clinical pharmacist, who works with providers following the same protocols established by the pharmacy case management program previously described. Case management staff are currently working with stakeholders and providing educational presentations at various Montana conferences such as the Foster Resource Conference, Child Abuse and Neglect Conference, MSFAPA Conference, and the upcoming Youth Summit. The development of an educational brochure for CPS Workers, Foster Parents and children, and psychotropic medication education packet for foster parents has also been accomplished. Various successes have been realized; including increased laboratory monitoring and appropriate indication for atypical antipsychotic medication, medication dose decrease and/or discontinuation, and increased continuity of care between providers of care for the foster care population. Development of a Prior Authorization Required Process for Medications without prospective DUR edits In an effort to combat significant medication overuse/abuse and support patient safety, the pharmacy case management program worked with the department to develop and implement a process for a provider-driven PA required process managed through the point-of-sale system. This process is for medications normally not requiring prior authorization and members for this program are referred on a case-by-case basis. Implementation of a Drug Not Covered Status in the Medicaid POS system prevents a member from receiving a selected medication or complete therapeutic class of medications each time a claim is submitted, unless a prior authorization is granted per instructions developed by the provider and the case management pharmacist. Currently approximately 300 members are enrolled and managed through this program. This has been an effective means to provide a higher level of management for those members for who even the lock-in program cannot prevent overuse and misuse of medications. Case Management for Hepatitis C Medications The pharmacy case management program has been intimately responsible for managing the approval process for the new generation of medications to treat Hepatitis C. This has promoted the utilization of appropriate therapy through telephonic prescriber outreach by a clinical case management pharmacist and resulted in considerable cost savings to the Medicaid program. In coordination with the state, the criteria for treatment has changed and our staff has been able to help guide providers to better treatment outcomes for the increased population receiving antivirals treating/curing Hepatitis C. Case Management for Hereditary Angioedema (HAE) Medications Significant cost savings were found by working with patients and providers to increase use of attack logs, awareness of acute vs prophylactic medication need, and utilization management by the CM pharmacist that promoted better patient understanding of their disease. This effort reduced the anticipated amount of emergency department visits by coordinating care between the patient and their providers in addition to helping patients and their families understand the nature and progression of HAE. Case Management of Idiopathic Thrombocytopenic Purpura (ITP)

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	By correctly identifying the need/indication for drug therapy with providers and then working out appropriate dosing with them for their patients, significant cost savings were found in addition to enhanced management of chronic therapy needs. Case Management of Cystic Fibrosis (CF) Working with providers and their CF patients, we have been able to reduce disease exacerbations, increase drug compliance, potentially lower drug resistance rates with appropriate antibiotic use, and lower overall treatment costs related to all these efforts. Case Management of Opioid Use Disorder (OUD) Our pharmacy team has worked with almost all providers of Medication Assisted Treatment (MAT) in Montana that use Suboxone or Sublocade for their patients. Combining our CM efforts with the prior authorization of both agents, we have been able to decrease the number of concomitant opioids, benzodiazepines, and tramadol medication use in Medicaid members receiving MAT therapy. This has also diminished the risk of overdose in this population by restricting their access to other opioid medications while receiving MAT therapy. The teams are also actively involved in both state and local taskforces working to help manage opioid use disorder and to be active within our communities as a resource to help manage patient care. Case Management of Pseudobulbar Affect (PBA) Diagnosis of this condition and its treatment can often be difficult, the medications are not highly effective, and patients are often left on therapy without evidence of success. Our CM team, using DUR Board approved protocols, evaluates diagnosis and patient need to start therapy and then follows up with providers to establish continued efficacy in relation to baseline metrics. This utilization effort not only sets up appropriate use but reduces costs in situations where the medication is not indicated or does not provide a benefit for a patient. Automated Prior Authorizations Our PA staff continues to work with the State and their contracted vendor to improve automatic prior authorizations where appropriate and the appropriate algorithms can be managed. Through weekly meetings and constant communication, any issues with these are resolved almost immediately, and without disruption to patient care.
Nebraska	Hepatitis C staging from F2 to F0. SUPPORT Act documentation and education. MME down to 90 mg MME daily.
Nevada	The Nevada Medicaid Drug Use Review Board (DUR) continually evolves in order to meet the needs of Nevada Medicaid recipients while making the practice of medicine fair and efficient for providers and to ensure that Nevada's resources are utilized in fiscally appropriate fashion. In order to optimize time and the effectiveness of the board, the following innovative practices were employed by Nevada Medicaid Drug Use Review Board and listed below. To ease the effort required for prior authorization submission, Nevada Medicaid began implementing electronic prior authorization (ePA). When fully implemented in the first quarter of 2021, prescribers will be able to submit prior authorization requests via their electronic medical record system or utilizing a web portal. Some prior authorization decisions will be made in real time, while others that require a clinical review will still meet the 24-hour turn-around time.

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	COVID-19 presented many challenges to State's in terms of drug coverage, meetings, and program monitoring. Nevada Medicaid reduced the refill threshold for non-controlled substances from 80% usage to 50% usage. This allowed more leeway for members to access medications during shelter in place mandates or other restrictions. Nevada Medicaid developed several reports to enhance monitoring of potentially inappropriate or unproven treatments for COVID-19. Weekly reports were updated as needed based on information from the Food and Drug Administration (FDA), the Center for Medicare and Medicaid Services (CMS), clinical literature and the lay press. As a result, utilization of unapproved therapies for COVID-19 treatment was kept at a minimum. Nevada Medicaid was able to dynamically shift all Silver State Scripts Board (SSSB) meetings and Drug Use Review (DUR) meetings to a virtual setting. Board members called in from their home or place of work to participate. No meetings were missed due to COVID-19 travel or meeting restrictions.
New Hampshire	New Hampshire FFS Medicaid program continuously monitors Hepatitis C medication guidelines and recommendations to allow coverage for additional Hepatitis C patients to be eligible for coverage. Specialty medications for oncology and HIV are covered without restriction but are monitored for potential cost saving initiatives. New Hampshire continues to review current programs such as: Maximum Allowable Cost (MAC) program, dose optimization, quantity limits, clinical edits and RetroDUR programs for potential cost savings. New Hampshire continues to address the opioid epidemic with a cumulative Morphine Milligram Equivalent (MME) program. All claims for members over a cumulative MME of 100 require prior authorization. Hospice, cancer, end-of-life and sickle cell patients are exempt from the prior authorization requirement. Continuous Monthly monitoring of members who exceed the MME limit is conducted. The prior authorization criteria require step therapy through non-opioid pain relievers, diagnosis information, justification for higher dosing, and multiple prescriber attestations targeting pain management contract, PDMP review, risk/benefit discussions with the patient, and naloxone prescribing. Continuous monitoring of members who exceed the MME limit is conducted and reviewed at each monthly meeting with the PBM. To improve access for treatment of Substance Use Disorder, New Hampshire does not require prior authorization for medication-assisted treatment (MAT) with brand and generic buprenorphine/naloxone SL tablets and film if the daily dose is 16mg or less. To ensure appropriate use of single agent buprenorphine SL, a prior authorization is required for all doses. In FFY 2020, New Hampshire implemented criteria for review of very young pediatric patients with prescriptions for psychotropic drugs and for pediatric patients receiving 2 or more psychotropic drugs in the same therapeutic class. These criteria include antipsychotics, antidepressants, anti-anxiety, sedative hypnotics, mood stabilizers, and anti-mania agents. For pediatric patients 5 years of age and younger who are prescribed a psychotropic drug, a prior authorization is required. The criteria require that the patient is seen by a child psychiatrist, neurologist, or developmental pediatrician or that prescribing has been in consultation with one of these specialists. An additional consideration for use of an antipsychotic is for the

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	diagnosis of Tourette's syndrome or tic disorder or use of medications for seizure disorders. For pediatric patients 6 years of age and older, a prior authorization is required if more than one drug from the same class is prescribed during a 60-day time frame. The criteria review that a patient has a DSM-V diagnosis and that the patient has received psychiatry, neurology, or care in consultation with a developmental pediatrician.
New Jersey	In FFY 2020, the State continued its focus on managing the opioid epidemic. In addition to having a real-time Medical Exception Process (MEP) in place that prospectively monitors Opioid Use Disorders (OUDs), the Division of Medical Assistance and Health Services (DMAHS) also continued to reevaluate its Morphine Milligram Equivalency (MME) protocol for its pharmacy provider community, both in FFS and managed care. The MME protocol was implemented in October 2019. In FFY 2020, the DMAHS also turned its focus to the issue of auto-refills and their suspected negative fiscal impact on the NJFC Medicaid program. The DMAHS is familiar with difficulties encountered when attempting to identify auto-refills that are not medically necessary. The DMAHS worked closely with its managed care partners to communicate auto-refill guidelines in October 2019. In FFY 2020, the DMAHS continued to evaluate a retrospective DUR activity to evaluate the cost effectiveness of encouraging utilization of metformin as first-line treatment for Type 2 diabetes after diet and exercise. A NJDURB educational Newsletter highlighting the clinical and fiscal benefits of prescribing metformin was communicated to prescribers in November 2018 to encourage changes to treatment plans developed to treat Type 2 diabetes. The State will continue its monitoring effort to report any subsequent changes in utilization. In June 2020, as part of Governor Murphy's initiatives to strengthen New Jersey's fight against the opioid epidemic, the Governor required residential treatment facilities that receive NJFC Medicaid payments to provide access to Medication Assistive Treatment (MAT). To help meet the goals of assuring compliance with this requirement, DMAHS increased the per diem Long Term Residential rate and added two potential bonus payments to encourage providing MAT. In addition, DMAHS offered an improved method of medication reimbursement to ensure broader access to available MAT products. Incentives were designed to create the capacity to prescribe and administer MAT. Providers were required, at a minimum, to provide buprenorphine and/or provide (or arrange for) methadone. In an effort to remove barriers to MAT treatment outpatient, DMAHS also updated the Medicaid Managed Care contract to require coverage of all generic MAT medications without prior authorization or formulary restrictions.
New Mexico	No innovative practices were implemented to improve the administration of the DUR program, appropriateness of prescription drug uses, or to help control costs for FFY 2020.
New York	2020 Jan thru Sept 1 Claim edits in place to assure appropriate Medicare D billing of OTC insulin and legend drugs with OTC alternatives. 2 System edits affecting coordination of benefit claims implemented to ensure simultaneously submitted copay or coinsurance values secondary to Medicaid are not permitted. 3 Establishment of billing guidance for COVID19 testing and specimen collection for pharmacy providers.

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	4 Public notification of DURB Preferred Drug program recommendations affecting the following categories NSAIDs CNS stimulants high potency steroids GLP1 agonists sulfasalazine derivatives oral immunosuppressive agents phosphate binder regulators. 5 Removal of PA criteria except for identified retreatment and instances in a members claim history where absence of an approved FDA or compendia supported diagnosis is noted for nonpreferred Hepatitis C agents. 6 System changes were implemented to allow provider bypass for agents requiring PA prescribed for domiciled residents in specific facilities when Medicaid eligibility is obtained within 90 days from the prescription date of service or fill date for claims not included in the rate. 7 Medicaid pharmacy provider COVID19 guidance in the form of relaxed editing for formulary adherence for payment of lab testing and specimen collection and for vaccine administration in the pharmacy. Guidance in accord with State and Federal laws addressed 90 day supplies where indicated and medication delivery authorizations as well as prescription transfers allowing more convenient medication access and changes in formulary listing due to drug supply availability in addition to changes in select prior authorization requirements and permissible pharmacy provider overrides in select early fill situations. 8 Dose Optimization Program updates. 9 Brand Less than Generic change updates. There were two for the period. 10 Reimbursement for FFS providers enrolled in National Diabetes Prevention Program. 2019 Oct thru Dec 1 Allowance for family planning contraception prescriptions to be filled 12 times in one year provided the prescription is for a one month supply. 2 DUR Board educational letter to prescribers highlighting the SUPPORT ACT requirements addressing the concurrent use of antipsychotic and opioid medications and the importance of mental health treatment and the coordination of care. 3 DUR Board educational letter to prescribers found in a retrodur review to be prescribing multiple antipsychotics to children under 21 years of age. Prior authorization will be required for children under 21 years of age prescribed two or more different antipsychotics for greater than 90 days. 4 DUR Board educational letter to prescribers addressing the need to monitor metabolic requirements in children less than 21 years of age prescribed antipsychotic as addressed in the SUPPORT ACT. 5 DUR Board educational letter the subject of a retroDUR review on the treatment of asthma to prescribers of Leukotriene Modifiers and Their Use in the Treatment of Asthma. 6 DUR Board educational letter to prescribers highlighting the establishment of a PA requirement in opioid naive recipients receiving greater than 90 morphine milligram per day. 7 Brand Less than Generic Program change updates one for the period.
North Carolina	These are some of the articles from our North Carolina Medicaid Pharmacy Newsletter to describe innovative practices that have improved the administration of the DUR program, the appropriateness of prescription drug use, or have helped to control costs. November 2019 Pharmacy Newsletter-- New Drug Look Up Tool on NCTracks A drug search page is now available on NCTracks to find drugs currently manufactured and other useful information. Drugs can be searched by name or NDC (National Drug Code). Please note that this tool is not to be used to verify payment of a particular product by North Carolina

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	Medicaid; coverage should be based on the response received from the pharmacy claims processor and not solely on the information on this site. To access the site, visit NCTracks.nc.gov, click on the provider portal tab, and look for the "Drug Search Page" on the right under Quick Links. December 2019 Pharmacy Newsletter-- Pharmacy Point of Sale Override Code 18 Effective Nov. 10, 2019, NC Medicaid now accepts code "18" in the Submission Clarification Code field (420-DK) for early refill alerts related to long term care patient admissions/readmissions. By entering this code, the pharmacy is indicating that the transaction is for new dispensing of medication due to the patient's admission or readmission status. Pharmacies should ensure the code is used only when appropriate and make sure that supportive documentation is maintained as part of the pharmacy record. February 2020 Pharmacy Newsletter-- Reminder Regarding the Naloxone Standing Order North Carolina's standing order for naloxone, signed by the State Health Director in 2016, authorizes any pharmacist practicing in the state of North Carolina and licensed by the North Carolina Board of Pharmacy to dispense naloxone to any person who meets set criteria. Narcan nasal spray and naloxone (ampule/syringe/vial) are listed as preferred on the North Carolina Medicaid Preferred Drug List for beneficiaries who are at risk of an opioid overdose. NC Medicaid covers Narcan/naloxone through the outpatient pharmacy benefit using either the Naloxone Standing Order or a prescription issued to a beneficiary. Pharmacies are encouraged to dispense naloxone when medically appropriate. For more information on the use of naloxone, including information on the North Carolina standing order, visit www.naloxonesaves.org. February 2020 Pharmacy Newsletter-- Outpatient Pharmacy Clinical Coverage Policy No: 9 The NC Medicaid Outpatient Pharmacy Clinical Coverage Policy No: 9, along with several other policies, dictates how providers are to interact with NC Medicaid when providing medication services to our beneficiaries. Occasionally, changes to Policy 9 are necessary. Prior to implementation, any proposed change to the policy is posted for a 45-day public comment period. All changes that are approved are chronologically documented in Section 8.0 of Policy 9 with the section that was revised listed and a description of the change. Many policy changes directly impact individual pharmacy operations. For example, Policy 9 was amended in July 2019 to make Dispense as Written (DAW) codes 2, 3, 4, 6 and 9 acceptable when billing Medicaid and NC Health Choice claims. March 2020 Special Bulletin-- Pharmacy Claims Flexibility Available to Prevent Spread of Coronavirus Disease (COVID-19) Given the presence of the COVID-19 virus in North Carolina, claims processing flexibility has been instituted to help reduce the administrative burden of providing appropriate medications in a timely fashion to NC Medicaid and NC Health Choice beneficiaries. We encourage prescribers and pharmacies to utilize these flexible options as we assist our beneficiaries in preparing for this public health issue. Preparations related to the COVID-19 virus could present situations where NC Medicaid and Health Choice beneficiaries may require an early refill or expanded quantity of their prescription medications. In these situations, NC Medicaid enrolled pharmacy providers should resubmit these claims with "09" (Emergency Preparedness) in the PA Type Code field and a valid value for an E.R. override in the Reason for Service, Professional Service and Result of

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	Service fields to override a denial for an early refill. Do not place any values in the Submission Clarification Code field. This override code will allow for early refills and will also allow for coverage of up to a 90-day supply of the medication. Be aware that NC Medicaid policy allows 90-day supply to be filled when the prescription is either written for 90-day supply or has enough refills remaining to fill for 90 days. Please be aware that these edit changes do not apply to controlled substances. Additionally, we encourage providers to follow all applicable state and federal laws and regulations for controlled substances. If necessary, up to a 14-day emergency supply can be billed for any pharmacy claim requiring prior approval when no active prior approval is showing in NC Tracks. The pharmacy provider should resubmit these claims with "09" (Emergency Preparedness) in the PA Type Code field and "03" in the Level of Service Field. For beneficiaries in the Pharmacy Lock-in Program needing emergency supplies of Lock-In program related medications, up to a 14-day emergency supply can be billed with "09" (Emergency Preparedness) in the PA Type Code field and "03" in the Level of Service Field. This override is only valid once per beneficiary per year. Beneficiaries and providers may also contact the NC Tracks call center to change either the preferred Lock-In pharmacy or preferred Lock-In prescriber on an emergency basis. Co-pay requirements are still applicable to these pharmacy claims. Providers may submit any information related to market shortages of medications directly to DHB staff at Medicaid.PDL@dhhs.nc.gov. These overrides are in effect beginning effective 03/13/2020 and ending date TBD. NC Medicaid Contact Center, (888) 245-0179 GDIT, (800) 688-6696 March 2020 Pharmacy Newsletter-- NCCARE360 There is growing recognition that better coordination and investment in the non-medical drivers of health, like access to healthy food, safe and affordable housing and well-paying jobs, can improve health and decrease health care costs. NCCARE360 is the first statewide coordinated care network to electronically connect those with identified needs to community resources. It also allows for a feedback loop on the outcome of that connection. Often times, people face a fragmented system of health and human services that can be hard to navigate. Providers often operate in silos, are disconnected and have no meaningful way of coordinating services for local residents. NCCARE360 is collaborative solution to this problem by providing a coordinated, community-oriented, person-centered approach to delivering care in North Carolina. Through NCCARE360, community partners will have access to: A robust statewide resource directory that will include a call center with dedicated navigators, a data team verifying resources and text and chat capabilities. A data repository to integrate resource directories across the state to share resource data. A shared technology platform that enables health care and human service providers to send and receive secure electronic referrals, seamlessly communicate in real-time, securely share client information and track outcomes. A community engagement team working with community-based organizations, social service agencies, health systems, independent providers and more to create a statewide coordinated care network. This solution ensures accountability around services delivered, provides a "no wrong door" approach and closes the loop on every referral made.

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	NCCARE360 implementation started in January 2019. NCCARE360 will be available in every county in North Carolina with full statewide implementation by end of 2020. NCCARE360 is a result of a public-private partnership between the NC Department of Health and Human Services and the Foundation for Health Leadership and Innovation (FHLI). The NCCARE360 implementation partners are United Way of NC/211, Expound Decision Systems and Unite Us Additional information is available at https://nccare360.org. March 2020 Pharmacy Newsletter-- Suspension of Pharmacy POS Adult and Pediatric Behavioral Health Clinical Edits The Outpatient Pharmacy point of sale (POS) adult and pediatric clinical edits for behavioral health medications will temporarily suspend effective 03/23/2020. These point of sale edits target dosages exceeding the FDA approved maximum limit and in class therapeutic duplication. Claims meeting the edit criteria deny and a message about the issue is returned to the pharmacy. After the pharmacist contacts the prescriber for clinical justification, the claim, resubmitted with the override submission clarification code (SCC) 10, pays. During the period of suspension, claims will not deny for the adult and pediatric behavioral health clinical edits and the pharmacy will not have to use override SCC 10 for the claim to pay. Pharmacy Clinical Policy also wants to remind medical and pharmacy providers that effective 03/13/2020 NC Medicaid extended the day supply allowed for most non-controlled substance outpatient prescription medications to 90 day. NC Medicaid strongly encourages medical providers to write prescriptions for up to a 90 day supply, where clinically appropriate, and for pharmacies to fill these prescriptions for up to a 90 day supply, where appropriate. April 2020 Special Bulletin-- Pharmacy Claims Flexibility Available to Prevent Spread of Coronavirus Disease (COVID-19) Given the presence of the COVID-19 virus in North Carolina, point of sale pharmacy claims processing flexibility has been instituted to help reduce the administrative burden of providing appropriate medications in a timely fashion to NC Medicaid and NC Health Choice beneficiaries. In addition, these measures can help accommodate appropriate social distancing measures. We encourage prescribers and pharmacies to utilize these flexible options as we assist our beneficiaries in managing their drug therapies during this public health issue. Beginning April 6, 2020, NC Medicaid and NC Health Choice beneficiaries may fill prescriptions for up to 90 days supply for: Schedule 2 medications typically prescribed for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder (i.e. Adderall XR, amphetamine combo, methylphenidate, Vyvanse, etc.) Medications prescribed for Opioid Use Disorder Medication Assisted Treatment and paid for via the point of sale outpatient pharmacy program (i.e. Suboxone, etc.) Medical providers are encouraged to write prescriptions for up to 90 days supply of these medications where clinically appropriate so beneficiaries may utilize this important benefit Please be aware that these edit changes do not apply to any other controlled substances. Additionally, we encourage providers to follow all applicable state and federal laws and regulations for controlled substances. Refer to the Special Pharmacy Newsletter dated March 13, 2020, for a listing of other flexibilities initiated, including allowing up to 90 days supply of most non-controlled substance medications

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	Co-pay requirements are still applicable to these pharmacy claims. We are monitoring potential drug shortages daily. Providers may submit any information related to market shortages of medications directly to DHB staff at Medicaid.PDL@dhhs.nc.gov. These flexibilities are in effect beginning April 6, 2020, and will end the earlier of the cancellation of the North Carolina state of emergency declaration or when the policy modification is rescinded. Addition of Mailing and Delivery Fees to Retail Pharmacy Claims Effective April 27, 2020, prescriptions for NC Medicaid and NC Health Choice beneficiaries are eligible for the addition of a mailing or delivery fee via the guidelines below. NC Medicaid encourages beneficiaries to request, and pharmacy providers to mail or deliver prescriptions to beneficiaries, during the COVID-19 pandemic to achieve better social distancing within their community. This measure should be considered for all beneficiaries but especially those that are considered at higher risk for severe COVID-19 illness (CDC definition of people considered higher risk: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higherrisk.html). Pharmacies must input a Level of Service (Field 418-DI) indicator equal to 02 on the POS pharmacy claim for prescriptions that are requested by the beneficiary to be mailed. The rate of payment for this mailing fee is $1.50. Mailing of prescriptions includes those that are sent via the US Postal Service, UPS, FedEx, or other similar service. Pharmacies must input a Level of Service (Field 418-DI) indicator equal to 06 on the POS pharmacy claim for prescriptions that are requested by the beneficiary to be hand delivered by the pharmacy provider. The rate of payment for this delivery fee is $3.00. Delivery of prescriptions includes via courier or other person-to-person delivery method to the beneficiary or their designee. Please note: Providers are limited to one mail or delivery fee, per beneficiary, per Pharmacy NPI, per day No more than one delivery fee will be paid on a single claim Pharmacies cannot request an emergency supply and a delivery fee on the same claim Mailing and Delivery fees will be reported on the POS pharmacy response transaction in the Other Amount Paid (565-J4) Field Denied pharmacy claims will not pay a mail or delivery fee NC Medicaid will monitor this fee usage and may update these guidelines at any time These changes are effective April 27, 2020 and will end the earlier of the cancellation of the North Carolina state of emergency declaration or when the policy modification is rescinded by NC Medicaid. May 2020 Pharmacy Newsletter-- Continuous Glucose Monitoring Systems Coverage Transition Effective July 1, 2020, coverage of therapeutic Continuous Glucose Monitoring (CGM) products will transition from the Durable Medical Equipment (DME) Program to the Outpatient Pharmacy Point of Sale Program. The products will be included on the NC Medicaid and Health Choice Preferred Drug List (PDL). To help ensure a smooth transition, prior authorizations (PAs) obtained through the DME program for therapeutic CGM products that are active at the time of transition will be converted to pharmacy PAs in NCTracks. Coverage of non-therapeutic CGM products will not

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	transition and will remain under the DME program and billing for these supplies should continue through the DME program. Beginning July 1, 2020, new and existing therapeutic CGM users must obtain their CGM supplies from an enrolled NC Medicaid pharmacy provider of their choice. All claims for therapeutic CGM products will be processed through pharmacy Point of Sale (POS) billing. Therefore, all CGM products will require an active and valid prescription at the filling pharmacy on file. The PDL Preferred therapeutic CGM products will be the Dexcom G5 and G6. The Freestyle Libre will be Non-Preferred. Pharmacies are encouraged to order sufficient inventory of the CGM products to satisfy beneficiary demand during this transition. As NC Medicaid was in the process of moving forward with future implementation of Managed Care, the pharmacy section was meeting with the PHPs to ensure they were building the same flexibilities into their systems we recently implemented as a result of COVID 19, as their program is to mirror Medicaid Direct.
North Dakota	Improving appropriate dosing of montelukast products by implementing claims processing edits checking for dosing based on patient age Reducing overutilization of sedative/hypnotic agents via provider profiling and directed provider educational letters Reduce diversion of glucagon and identifying patients in need of intervention by implementing prior authorization requirements on any fill for glucagon that exceeds 2 doses in a 180 day period Improving appropriate utilization of antipsychotic agents by implementing claims processing edits that evaluate utilization based on drug quantity, patient diagnosis, patient age, and therapeutic duplication Improving medication adherence with select high-cost medications by implementing claims processing edits checking for medication adherence
Ohio	Unified Preferred Drug List (UPDL) On January 1, 2020, ODM, in partnership with the Manage Care Plans (MCPs), moved toward a Unified Preferred Drug List (UPDL). All ODM MCPs prefer the same medications and use the same prior authorization criteria for drug categories. This was created to streamline access to the pharmacy benefit and reduce administrative burden for members, prescribers, and pharmacies. Adherence to the UPDL is monitored. Several updates were made to the UPDL throughout the year. Reorganization was done within two sections of the UPDL. Anti-migraine agents are now reorganized into three categories: acute, cluster, and prophylaxis. The inhaled respiratory agents are also now reorganized into short acting inhaled beta-adrenergic agonists, long acting inhaled beta-adrenergic agonists, inhaled glucocorticoid agents, and newly added Cystic Fibrosis. Additionally, a new therapeutic category of tetracyclines was added to the infectious disease agents. COVID-19 Edits In an effort to remove potential barriers to the access of medications during the COVID-19 pandemic several changes were implemented at point of sale (POS). These efforts included lifting prior authorization on many medications, extending the length of prior authorizations on several medications, allowing a 90 day supply of durable medical equipment, permitting early refills on prescriptions, waiving copays, allowing dispensing of an over the counter

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	medication without a prescription, allowing non-Ohio Medicaid enrolled prescribers to prescribe, and waiving the signature requirement for medication pickup. Pharmacists as Providers ODM began work to implement Ohio Senate Bill 265 which conferred provider status to pharmacists within the state and permits ODM to enroll and reimburse pharmacists for clinical services. The proposed rule allows pharmacists to enroll in ODM as a billing provider and receive reimbursement for administering immunizations, administering limited injectable drug products (as permitted by state law), and managing drug therapy pursuant to a consult agreement with an authorized prescriber (physician, APRN, PA). This initiative is expected to help ODM optimize member health outcomes while realizing potential cost savings in the pharmacy program. Prescription Drug Transparency and Affordability Council ODM participated in the state's Prescription Drug Transparency and Affordability Council, established in Ohio House Bill 166. The Council was tasked with providing recommendations to the General Assembly, Governor's Office, and the Joint Medicaid Oversight Committee regarding state initiatives to ensure prescription drug price transparency, affordable payment models, and healthcare efficiency. Six meetings total were held during FFY 2020. National Governors Association Workgroups ODM participated in several workgroups organized by the National Governors Association which focused on prescription drug purchasing and affordability trends. These workgroups spanned a wide array of potential opportunities for state governments, including inter-agency purchasing, value-based reimbursement models, 340B, and pharmacy benefit redesign. Episode Based Payments Program ODM pharmacy also provided subject matter expertise to the Department's Episode Based Payments program. This model seeks to reduce healthcare costs and improve quality of care by providing transparency on spend and quality across an entire episode of care. This gives providers enhanced visibility into their performance and how they compare to their peers. COVID-19 Testing ODM's pharmacy program additionally drove innovation during the pandemic by developing payment mechanisms for COVID-19 specimen collection in the pharmacy setting. ODM worked during the initial months of the pandemic to configure reimbursement methodology into the pharmacy POS system, collaborated with the state's MCPs to ensure alignment and uniformity, actively communicated with the provider community and pharmacy stakeholders, and monitored COVID-19 testing activity in the pharmacy setting through claims surveillance.
Oklahoma	Innovative Practices: Academic Detailing Program Oklahoma Health Care Authority (OHCA), Federal Fiscal Year 2020 Introduction Academic Detailing (AD) combines evidence-based guidelines with standards of care in practice and presents them in a non-biased manner. AD programs provide a link between prescribers and an educator resulting in positive health and cost outcomes.

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	The AD-pharmacist prepares educational materials in consultation with the National Resource Center for Academic Detailing (NaRCAD), and offers the program to selected prescribers. Educational materials include: - Clinical treatment guidelines - Provider resources - Patient and parent resources - Diagnostic and treatment tools - Topic-specific Continuing Medical Education (CME) course listings - Drug alerts and statements from the U.S. Food and Drug Administration - National quality measures (e.g. Healthcare Effectiveness Data and Information Set, HEDIS) - OHCA Product Based Prior Authorization (PBPA) coverage criteria Research Method The state's AD program involves educational outreach to providers on a chosen topic impacting pediatric members covered through SoonerCare. The program has addressed Attention-deficit/hyperactivity disorder (ADHD), use of atypical antipsychotic medications, and most recently, antibiotic (ABX) usage. When considering medical necessity, choice of ABX agent, dose, and duration, current publications estimate at least 30% of all outpatient antibiotics are clinically unnecessary, and up to 50% are being used inappropriately. The College of Pharmacy analyzed Oklahoma SoonerCare claims to investigate antibiotic prescribing trends. Providers were identified to receive AD if three or more of the following were true: - Having a 50% or more increase in number of ABX claims from 2016 to 2017 - Having 50% more ABX claims than the average for their prescriber specialty - Being 1 of the top 50 prescribers of ABX across the entire state - Being 1 of the top 200 prescribers of ABX for both 2016 and 2017 Academic Detailing Data Data is continuously compiled for review and educational opportunities for improvement. Collected data for FFY 2019 focused on changes in prescribing patterns, utilization, and use of specific therapeutic agents. During FFY 2019, 150 providers received ABX-AD visits and the program impacted 29,251 members. Specific educational focus was given to treatment of upper respiratory infections, as this is the area with the highest degree of inappropriate antibiotic prescribing for pediatric patients. Detailed providers reduced their ABX prescribing by 17.13% and the non-first line ABX prescribing by 16.34%. AD providers had large-scale improvements in hospitalizations and length of stays, occurring up to 14 days after the initial antibiotic medication, compared to their own previous 5-year averages, representing a significant clinical improvement. Changes in Academic Detailing Outcomes: Healthcare Utilization Pre-AD Post-AD Change % Change Hospitalizations 0.95 0.47 -0.48 -50.5% Length of Stay (days) 5.15 2.42 -2.73 -53.0% ED visits 15.7 1.6 -14.1 -89.8% *negative indicates improvement Academic Detailing Analysis Summary

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	Providers continue to express a high degree of satisfaction with the AD program as evidenced by cumulative satisfaction survey results. More than 97% of providers describe the program as easily understood, clearly presented, and evidence-based. When asked about the impact on their practice, more than 84% say they will make practice changes as a result, recommend the program to colleagues, and participate in future topics. With the clinical success of the program to date, associated prescription cost savings of $834,021 for this fiscal year, and recently demonstrated reductions in hospital utilization, further program material for additional drug categories will be created with more providers being reached.
Oregon	New Oncology Agent Policy: Require PA for any new start of an antineoplastic agent approved within the past 12 years. New oncology agents are coded to require PA to ensure appropriate use for oncology medications based on FDA-approved and compendia-recommended (i.e., National Comprehensive Cancer Network [NCCN]) indications. Drugs with an original FDA-approval date prior to January 2008, or subsequently approved new formulations of these older agents, are exempted from this criteria given the increased clinical experience with these agents. Orphan Drug Policy: Require PA for all agents with an Orphan Drug designation (as designated by the FDA) which are indicated for rare conditions - to support medically appropriate use and to limit off-label use. New orphan drugs are coded to require PA when they come to market.
Pennsylvania	FFS does not have specific innovative practices to report during the FFY2020 time period. FFS Pharmacy Program clinicians stay abreast of new clinical information and develop strategies as opportunities are identified to ensure the health and safety of Pennsylvania's MA beneficiaries.
Rhode Island	Retrospective DUR Innovative Practices Established during FFY 2020 During FFY 2020, targeted and specialty mailings for the FFS population included concurrent use of an atypical antipsychotic and a stimulant, concurrent use of benzodiazepines and opiates, atypical antipsychotic use and risk of metabolic syndrome, patients receiving > 90 morphine milligram equivalents (MME) per day, as well as methadone maintenance and concurrent prescription opioid utilization. Specific to the identification of recipients receiving methadone maintenance with concurrent opioid prescription(s), a specialty mailer was developed and mailed to the opioid treatment programs (OTPs) of the recipients identified to inform the OTPs of the concurrent use. Over the course of 3 quarters, we saw a decline in the number of recipients receiving methadone maintenance with concurrent opioid prescriptions. 48 new criteria were developed during FFY 2020 to target recipients exceeding the FDA recommended maximum doses of stimulant medications. These new criteria were activated in June 2020 and are continually reviewed for intervention each month. Additionally, during FFY 2020, the DUR Board tracked naloxone utilization, biologic agent utilization, top prescribers of controlled substances, short and long acting opioid utilization, and atypical antipsychotic use under the indicated age in the pediatric population on a quarterly basis. Prospective DUR Innovative Practices Established during FFY 2019
South Carolina	The following are some of the issues which were targeted by scTIPS : Acute Non-Cancer Pain Treatment: January 2020 - Issue No. 9: Acute Non-Cancer Pain Treatment (CME Credit available)

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	Naloxone Can Save a Life- April 2020: Naloxone Can Save a Life, Steps to Respond to an Opioid Overdose,Medication Disposal Patient Handout (CME Credit available) Monitoring Practices to Promote Safer Opioid Use: August 2020 - S.O.S for Safer Opioid Prescribing (online view) S.O.S for Safer Opioid Prescribing (print view) Selected Resources for Safer Opioid Prescribing, SCRIPTS (PDMP or DHEC Reports) Tips and Tricks, Patient Provider Agreement (CME Credit available) The State continues review and address codes/policy in regard to Compound claims. i
South Dakota	In response to Covid the patient profile review process and subsequent letter selection process was updated to be an online procedure. IHS claims now process through the POS system. This allows for those claims to be included in Pro-DUR and RDUR reviews. Select generic maintenance medications are now eligible for 90 day fills.
Tennessee	Although this summary has been technically implemented in FFY2021, the Public Notice for announcing changes to our MAT program was released within FFY2020 on September 25, 2020, and we wanted to include this information in our Annual DUR Report. Also, this is a TennCare non-DUR-specific program, but affects many areas within our Agency and membership, and is very appropriate for reporting as an Innovative Practice. TennCare has implemented the BESMART (Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment) program, and has included this program to TennCare Rules, which are approved by the Tennessee Legislature. This is a treatment model comprised of a coordinated set of services consisting of psychosocial assessment and development of a treatment plan, individual and group counseling, peer recovery services, and care coordination in addition to opioid-agonist therapy. Opioid agonist therapy used will be buprenorphine products that have been FDA-approved for opioid use disorder treatment. Each participant will have an individual treatment plan comprising those services designed to meet the participant's identified needs. BESMART services will be administered as part of the managed care program, and providers of BESMART services will be reimbursed by affected members' managed care organizations. (1) BESMART treatment is a component of covered outpatient substance abuse benefits and consists of a set of coordinated medically necessary covered services which includes: (a) Psychosocial assessment and development of a treatment plan (b) Individual or group counseling (c) Peer recovery services (d) Care coordination (e) Opioid agonist therapy consisting of buprenorphine products that have been FDA approved for OUD treatment and may be prescribed in excess of the previously established limits, when determined to be medically necessary by a treating provider in an MCO's network of BESMART providers and under the participant's plan of care. 1. Participants may receive up to sixteen (16) mg of buprenorphine containing products daily; however, providers shall initiate and lead a discussion regarding a participant's readiness to taper down or off treatment at any time upon a participant's request, but no later than one (1) year after initiating treatment and every six (6) months thereafter. 2. Under the best practices for treatment of OUD, the BESMART provider shall utilize the lowest effective dose of Medication Assisted Treatment (MAT). 3. The following adult populations shall be eligible to receive a maximum daily dosage of twenty four (24) mg of buprenorphine, not to exceed one (1) year in duration:

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	(i) Pregnant participants confirmed by provider attestation. (ii) Postpartum participants for a period of twelve (12) months from delivery date as shown by medical records or insurance claim. (iii) Recent intravenous (IV) drug users confirmed by prescriber attestation and a positive urine drug screen. (iv) Current users receiving greater than fifty (50) mg of methadone for OUD treatment transitioning to buprenorphine agonist therapy demonstrated by paid claims data from the participant's health insurer, provider attestation, or medical records. (v) Current users of sixteen (16) mg to twenty-four (24) mg per day of buprenorphine demonstrated by paid claims data from the participant's previous health insurer. (vi) For one (1) year from the effective date of this rule, a member who does not qualify under the criteria of this part but receives greater than sixteen (16) mg per day of buprenorphine as demonstrated by the controlled substance monitoring database (PDMP) shall be eligible to receive a maximum daily dose of twenty-four (24) mg. (2) BESMART treatment requires physician office visits at least weekly for participants in the induction and stabilization phase of treatment; at least every two (2) to four (4) weeks for participants in the maintenance phase of treatment; and at least every two (2) months for participants who have been in the maintenance phase of treatment for one (1) year or longer. (3) To be reimbursed for a BESMART covered service, treating providers must demonstrate an ability to provide all BESMART services in a coordinated, person-centric way, including the ability to facilitate access to all related treatment modalities and provider types, and must participate in at least one (1) MCO's network of BESMART providers. (4) Nurse practitioners and physician assistants must participate in at least one (1) MCO's network of BESMART providers in order to be reimbursed for the prescription of buprenorphine containing products to TennCare enrollees. Per the Public Notice, this is not a program that is intended to control cost, but instead intended to increase treatment options and to increase access to MAT care for members with OUD and opioid addiction issues. Per the Public Notice, this program is expected to result in an increase of approximately $8.3 million in annual aggregate expenditures under the TennCare program.
Texas	Dental Managed Care Organization (DMO)-This project is to establish a mechanism to provide DMOs with the necessary data to perform retrospective reviews. Dental managed care organizations (DMOs) will be required to adhere to the uniform Opioid Policy for Medicaid. One of the requirement is to perform retrospective drug utilization reviews to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. If outlier prescribing patterns are identified, a review must be conducted and, if necessary, an intervention, such as a letter or phone call to the prescriber or a peer-to-peer review. Texas Medicaid continues to implement retrospective claims review on various drugs or drug classes in order to improve on the providers' prescribing behaviors. Retrospective DUR Interventions for the FFY 2020 were as follows.

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	1. Influenza Prevention was mailed out on 10/18/2019 to 3,411 physicians. This intervention focused on improving prescribing practices and increased flu vaccination. 2. Cough and Cold Remedies was delivered on 10/22/2019 to 485 physicians. This intervention focused on improving prescribing practices and reducing overutilization of these products in pediatrics. 3. Anticonvulsants was delivered on 10/14/2019 to 337 physicians and impacted 342 clients. This intervention focused on improving prescribing practices and educing the overall cost of care for patients through improved treatment adherence. 4. Post-Traumatic Stress Disorder (PTSD) was a newly developed R-DUR intervention. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. 5. Pain Management was mailed out on 02/28/2020. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in clinical indicators by 39.6%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.64 in the post-intervention period. This yielded an overall estimated decrease of $3,728.64 in intervention-related drug expenditures on an annualized basis. 6. Opioid/Benzo/ Antipsychotics was mailed on 01/08/2020. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. Several formulary coverage restrictions were removed to accommodate issues related to the COVID-19 drug shortage. In FFY 2020, four new therapeutic classes were reviewed by the DUR Board: Glucagon Agents, Immunomodulators, Asthma, Sickle Cell Agents, and Rosacea Agents, Topical.
Utah	In FFY 2020, the Utah Medicaid Pharmacy Program launched multiple peer-to-peer programs aimed at improving the safe and effective use of medications. The first peer-to-peer program was launched on October 1, 2020 to monitor and manage antipsychotic medications prescribed to members 19 years of age and younger in alignment with the American Academy of Child and Adolescent Psychiatry recommendations. The intervention includes 102 phone conversations and 58 provider-specific letters addressing the use of other first-line psychosocial counseling and safer medication alternatives, dosing of antipsychotic medication following the start low and go slow approach, the use of multiple concurrent antipsychotic medications, and careful and frequent monitoring of side-effects related to antipsychotic medication use such as metabolic screening, weight gain and movement disorder assessments. After 1 year of this intervention, the number of children under the age of 6 receiving an antipsychotic went from 16 to 11, the number of children on more than one antipsychotic decreased from 16 to 12, and the number of doses of antipsychotics that exceeded literature recommendations declined from 61 to 34. Metabolic screening rate changed from 22% (out of 1,972 children) to 19% (out of 1,815 children). The second peer-to-peer program was launched on November 1, 2020 to 9 local pharmacies. The peer-to-peer pharmacist educated these pharmacists about UT Medicaid's restriction on the concurrent use of opioids and benzodiazepines, encouraged pharmacists to routinely check the controlled substance database, to counsel members on respiratory risk depression, and to dispense naloxone to high-risk members. To complement this work, a DUR hard edit was implemented at the POS, triggered when a claim for an opioid is dispensed within 45 days of a claim for a benzodiazepine or vice versa. This edit requires interventions from the dispensing

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	pharmacist to ensure appropriate proactive counseling occurs. This combined approach has shown great results. In 2019, 628 members were receiving both benzodiazepines and opioids from 702 providers; in October 2020 this declined to 343 members receiving both benzodiazepines and opioid from 333 providers. The third peer-to-peer program, launched on January 1, 2020, focused on reducing the misuse and abuse of gabapentin and pregabalin. 82 member-specific letters were sent to providers to inform these providers about the FDA warning that concurrent use of gabapentin or pregabalin with opioids increases the risks of misuse, abuse and respiratory depression. After one year of implementation, the number of members receiving concurrent gabapentin and pregabalin fell from 186 to 4 and the number of members obtaining high dose gabapentin and pregabalin dropped from 87 to 2. The fourth peer-to-peer program started in June of 2020, monitoring ADHD stimulants medication use in children under 4 years of age (or 6 years of age for those ADHD medications not indicated for children under 6). Phone outreach and provider-specific letters were sent to 7 providers to suggest the use of behavioral parent training and/or classroom behavioral interventions as first-line treatments for children with ADHD, and that the current evidence does not support treatment for children under 4 years of age. This intervention reduced the number of members under 4 years of age (or 6 for specific ADHD medications not indicated for younger children) on ADHD stimulant medications from 7 in June 2020 to only 1 member in October 2020. In addition to the above peer-to-peer outreach interventions the UT FFS pharmacy team also does patient outreaches to improve medication adherence: Beginning October 1, 2020, the Pharmacy Team personnel assumed the role of Care Manager to all FFS members diagnosed with hemophilia and receiving blood factor products. The team worked closely with the Division of Workforce Services, Bureau of Financial Services, Bureau of Managed Health Care, and Bureau of Eligibility Policy to ensure successful transition of care management services for these high acuity patients. The Pharmacy Team Care Manager contacts each FFS Medicaid hemophilia member via telephone once monthly to verify eligibility, review medication adherence to factors, provide clinical service, and refer and coordinate with the Hemophilia Treatment Center as necessary. Beginning April 1, 2020, the Hepatitis C Adherence program was launched to improve members adherence to hepatitis C treatments. Pharmacists counseled members on expected adverse drug events, answered medication questions, stressed the importance of adhering to Hepatitis C treatment, and used motivational interviewing to motivate members to adhere to therapy. By November, 2021, with 179 members enrolled in the program, the adherence rate increased from 80.9% at baseline to 84.36%.
Vermont	INNOVATIVE PRACTICES Expanding Access to Continuous Glucose Monitors: Effective October 1, 2019 Policy Summary: The Agency of Human Services (AHS) has made continuous glucose monitors (CGMs) available through pharmacies. CGMs previously were available only through durable medical equipment providers. This change has been made to not only allow for faster and easier access for patients, but also will lower DVHAs net cost for these products. Pharmacies

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	will be reimbursed for CGMs using the established reimbursement methodology for prescribed drugs. With this expansion, AHS has also streamlined the prior authorization (PA) process through its pharmacy benefits manager, Change Healthcare. Criteria and prior authorization forms are available on the Department of Vermont Health Access website. Prior authorization is required for both new and existing patients and applies to all CGM supplies including transmitters, receivers, and sensors. Medication Therapy Management at Federally Qualified Health Centers and Rural Health Centers Effective April 1, 2020 Policy Summary: MTM provided by a clinical pharmacist is a valuable addition to a health care team and can contribute medication expertise to improve patient compliance and adherence, reduce medication-related adverse events, and improve health outcomes. SPA 20-0001 has been approved by CMS. Vermont Medicaid now covers medication therapy management (MTM) services when provided by an office-based clinical pharmacist operating under their scope of practice at a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC). Coverage is limited to individuals with alcohol/substance use disorder or a mental health diagnosis. Pharmacists providing this service must have a nationally recognized MTM certification. FQHCs and RHCs which have validated with Vermont Medicaid that MTM costs are not included in their cost reporting for prospective payment system (PPS) reimbursement will receive fee-for-service reimbursement. Facilities may also request a PPS change in scope to be reimbursed for this service. The fee-for-service rate for an initial visit will not exceed $80, and follow-up visits will not exceed $55. COVID-19 Dashboard The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities in which staff have engaged. Currently an internal evaluation tool, the dashboard is updated weekly and made available to all DVHA staff via our intranet. Currently the Pharmacy Unit reports on 3 Topics: Percent(%) of claims using the overrides allowing early refills and waiving the mandatory 90 day-supply program; Number of claims and the financial impact of waived co-pays for medications that treat COVID-19 symptoms and; dispensing fee savings attributed to Buprenorphine products being allowed for more than a 14 day-supply. DVHA's Management Team highlights certain metrics within the dashboard at its regular meetings. This work was maintained throughout 2020 and continues into 2021. Changes to Refill Tolerance for Controlled Substances To minimize the risk of misuse, abuse and diversion of controlled substances, Vermont Medicaid periodically reviews the prospective safety edits in place in the Pharmacy Point-of-Sale System. To support ongoing efforts to lower the risk to Medicaid members, DVHA implemented a more restrictive refill tolerance edit. Previously, the refill too soon calculation was based only on the most recent fill date. Over time, however, a succession of early refills could allow the member to accumulate additional units (tabs, caps, milliliters, etc.), leading to members having significantly more medication on hand than medically needed. This new edit cumulatively counts early refills beginning in January 2020, and a maximum accumulation of seven (7) extra days of medication is allowed at any given time. This change is an important step in reducing the availability of unused or unnecessary controlled substance medication and preventing medication misuse.

State	Explanations
Virginia	In order to align with the Virginia Board of Medicine Regulations governing prescribing of opioids, DMAS made the following changes effective July 1, 2017: Service Authorizations are required for all long acting opioids, service authorizations are required for all short acting opioids prescribed for greater than 7 days' supply or two prescriptions for a 7 day supply in a 60 day period. Virginia Board of Medicine requires limit of treatment for acute pain with opioids to a 7-day supply and all post-op pain to no more than a 14 days' supply. In addition, DMAS has further lowered the morphine milligram equivalents (MME) from 120 to 90 MME. Service authorizations are required for any cumulative opioid prescriptions exceeding 90 MME per day. Quantity limits apply to each drug. DMAS has implemented new edits and reports to meet the requirements for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act. The DUR Board reviews each quarter concurrent use of opioids and benzodiazepines, concurrent use of opioids and antipsychotics, and opioid use with high risk factors and no naloxone use or with naloxone use. DMAS also has ProDUR edits in place that sends the pharmacist a soft message in reference to the potential risk of concurrent opioids with benzodiazepines and concurrent opioids with antipsychotics. Moreover, DMAS has implemented an edit to notify the pharmacist when an opioid na%u00efve member is trying to fill an opioid prescription and sends a message back alerting of the potential risk and to offer naloxone. DMAS continued the CNS behavioral pharmacy program which the DUR Board began in 2007. In 2008 and 2009 the CNS contract was renewed for one additional year. In 2009, the DUR Board reviewed the percentage of all patients on behavioral health medications; children taking atypical antipsychotics; and, antipsychotic medication utilization in children ages 0 to 5. During FFY 2010, the DUR Board decided to monitor all children under age 6 who are new to atypical antipsychotic therapy on a quarterly basis, which was later changed to a monthly basis. During FFY 2011, the DUR Board decided to implement a Service Authorization (SA) requirement for the use of atypical antipsychotics in children under the age of six years of age based on the following criteria: a. The drug must be prescribed by a pediatric psychiatrist or pediatric neurologist or the prescriber must supply proof of a psychiatric consultation AND, b. The recipient must have an appropriate diagnosis AND, c. The recipient must be participating in a behavioral management program AND, d. Written, informed consent for the medication must be obtained from the parent or guardian. A pediatric psychiatrist was contracted to review service authorization requests for the antipsychotics in children under the age of six that do not meet the approved criteria and provide peer to peer consultations with the prescribing providers. For requests that do not meet the criteria, the SA contractor will authorize a SA for a period of 30 days so that the child will receive the medication while requests are reviewed. This program was implemented on December 1, 2011. In FFY 2014, the program was expanded to require prior authorization requests for children ages 0 to 12 years. The program continued in FFY 2020 to include all children ages 0 to 17 years and the board continues to monitor.

State	Explanations
	The DUR Board reviewed some physician administered drugs as well as some specialty drugs during FFY 2020. Magellan Rx Management along with DMAS work together to create clinical service authorization criteria for several of these drugs which get reviewed at the DUR Board Meetings. Clinical criteria for physician administered drugs reviewed during FFY 2020 DUR Board meetings were: %u2022Adakveo%u00ae (crizanlizumab IV) %u2022Luxturna%u00ae (voretigene neparvovec-rzyl) %u2022Zolgensma%u00ae (onasemnogene abeparvovec-xioi) Also, Magellan Rx Management has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. The DUR Board has been focused on compounded prescriptions in terms of safety, efficacy and effectiveness as well as cost. At the May 10, 2018 meeting the Board made the recommendation to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. In order for the service authorization to be approved, the prescriber would be required to submit peer review studies of the compounded products safety and effectiveness. Compound claims over these limits will be forwarded to the DMAS physicians for review and approval/denial. This change to the compounded prescription edit was implemented on November 26, 2018 and the DUR Board continues to monitor the results. The compound prescription edit has caused a significant decrease in the number of compounded claims and the total cost on compounded prescriptions per quarter. The DUR Board actively monitors new drugs to the market and evaluates the need for utilization management through Service Authorizations (SA). During FFY 2020, the DUR Board recommended that DMAS require prescribing providers to submit an SA for the use of the following drugs based on FDA approved labeling effective for: %u2022Ayvakit%u2122 (avapritinib) %u2022Brukinsa%u2122 (zanubrutinib) %u2022Fasenra%u00ae Pen (benralizumab) %u2022Inrebic%u00ae (fedratinib) %u2022Koselugo%u2122 (selumetinib) %u2022Nubeqa%u00ae (darolutamide) %u2022Oriahnn%u2122 (elagolix, estradiol, and norethindrone acetate; elagolix) %u2022Oxbryta%u2122 (voxelotor) %u2022Pemazyre%u2122 (pemigatinib) %u2022Pretomanid (pretomanid) %u2022Qinlock%u2122 (ripretinib) %u2022Retevmo%u2122 (selpercatinib) %u2022Rozlytrek%u2122 (entrectinib)

State	Explanations
	%u2022Tabrecta%u2122 (capmatinib) %u2022Tazverik%u2122 (tazemetostat) %u2022Temixys%u2122 (lamivudine/ tenofovir disoproxil fumarate) %u2022Trikafta%u2122 (elexacaftor/tezacaftor/ivacaftor) %u2022Tukysa%u2122 (tucatinib) %u2022Xenleta%u2122 (lefamulin) %u2022Xpovio%u2122 (selinexor)
Washington	- Hepatitis C Elimination Strategy The Governor of Washington State issued a directive to eliminate Hepatitis C in Washington by 2030. This directive was a public health effort led by the Washington State Department of Health (DOH) to work together with the Washington State Health Care Authority (HCA) to create an elimination strategy around Hepatitis C. HCA explored an innovative purchasing strategy primarily focused on a 'subscription model' and negotiated with Abbvie as the chosen manufacturer. This modified subscription type model helps the State control costs while also increasing access to care for Hepatitis C patients. Details of the Hepatitis C elimination strategy include Mavyret chosen as the preferred product without any prior authorization restrictions, all antiretroviral Hepatitis C medications being carved out of MCO responsibility, and a hepatitis C elimination awareness bus which traveled around Washington State for education campaigns and testing. The Elimination Awareness Bus went out three times during FFY 2020 and tested a total of 349 people with 14 patients identified as positive for Hepatitis C. MCOs also received data from HCA which identified patients diagnosed with Hepatitis C who have not been initiated on treatment. Once that data was received patients were connected to care by the MCO case managers. This data was sent out twice in FFY 2020, in December and October. - Implemented Single PDL In FFY 2020, Washington Apple Health (Medicaid) fully implemented the single Apple Health Preferred Drug List (AHPDL). The goal of the AHPDL was to align the fee-for-service and Managed Care Organizations (MCOs) providing guidance on which drugs are preferred and non-preferred as well as help provide cost savings for the State. MCOs who administer managed Medicaid benefits are no longer allowed to negotiate supplemental rebate agreements and must adhere to those processes and procedures set forth by the Washington State Health Care Authority (HCA). Washington Apple Health (Medicaid) participates in The Optimal PDL $olution (TOP$) purchasing pool to help manage and negotiate rebates. Through the TOP$ program, Washington Apple Health (Medicaid) is able to make decisions on which drugs will be the most cost effective for the State. Washington Apple Health (Medicaid) works collaboratively with the MCOs in creating clinical policies for the AHPDL through an extensive review process that allows for feedback from the MCOs that may include clinical appropriateness and configuration of various pharmacy processing systems. The clinical criteria created applies to the fee-for-service (FFS) and all contracted Managed Care pharmacy programs. - HIV Policies Starting on August 1, 2020, Washington Apple Health (Medicaid) managed HIV products on the Apple Health Preferred Drug List (AHPDL) by choosing Preferred and Non-Preferred products as well as implemented clinical policies surrounding single tablet antiretroviral HIV medications (ex: Biktarvy, Descovy, Cimduo, Temixys, etc.) to help mitigate the high cost of these regimens. Many of the available single tablet regimens are available as once daily two tablet regimens

State	Explanations
	which are more cost effective than their counterparts. The non-preferred status and prior authorization requirements only applies to patients who are new starts for antiretroviral therapy and does not apply to those patients who are already established. Washington Apple Health (Medicaid) has implemented an expedited authorization for continuation of therapy which bypasses the prior authorization requirements at the point-of-sale if the dispensing pharmacist has knowledge the prescription is being filled as a continuation fill. Patients who are new starts will need to meet prior authorization criteria which includes justification of why the patient needs a single tablet formulation and documentation stating if the patient has any allergies or contraindications to the preferred HIV products listed on the AHPDL. The clinical policy was created in collaboration with the Department of Health HIV Advisory Committee, Managed Care Organizations, and clinicians at HCA. - Pharmacy Safe Storage Program The HCA piloted a pharmacy based program to test whether making a personal commitment to lock up medications would influence consumer behavior. Two community pharmacies participated in the pilot program by asking patients who received an opioid prescription if they had a way to lock it up, asking for their commitment to do so and offering a free locking bag if the customer needed one. 270 locking bags were distributed over a three-month period, 352 people pledged to lock up their medications, and 383 people were talked to about the Safe Storage program. The number one reason patients pledged to lock up their medication was because 'I personally feel locking up medication is important' followed by 'my pharmacist encouraged me to.' The pilot program highlights the leadership role pharmacists play in advising people about preventing opioid misuse. The HCA is looking to expand the program to more pharmacies and those who participate will receive a supply of free locking bags to provide to patients, promotional materials, pharmacy promotion through media relations and social media and ongoing support to ensure a smooth implementation of the program.
West Virginia	We implemented an uninsured COVID-19 benefit- for which we created a specific formulary it is limited to albuterol inhalers acetaminophen, guaifenesin, dextromethorphan and its combinations. There are no copays required for this benefit. Other changes we made included: 1-90 days supply on non-controlled maintenance meds. 2- We changed the Early Refill edit to 50% on maintenance meds. Originally it is 75% for non-controlled and 85% for controlled substances). This has now gone back to the original levels. 3- We removed the PA requirement for non-preferred albuterol inhalers. PA has now been turned back on 4- There was an waiver issued for patient signatures for dispensing of non-controlled medications 6- The advanced registered nurse practitioners are allowed to write for C-2 medications as long as they have authorization from the Board of Nursing and have updated their DEA. WV did a terrific job getting our population vaccinated. Our Office of pharmacy services was set up to reimburse ahead of the first day of vaccinations to ensure no system issues for members attempting to get vaccinated. In addition, with the collaboration of the medical and pharmacy administration the pharmacy claims system is set up to be able to see both the POS and medical administration of the vaccines. Workflow changed quite a bit since mid-march 2020. The entire Bureau of Medical Services had been operating 100% virtually. This included all our large scale meetings such as DUR, P &T as well as all our other meetings. In 2019 the Pharmacy Director for Medicaid retired and the DUR Coordinator moved up to the position of director. The Office of Pharmacy Services hired and onboarded a new Drug Utilization Review Coordinator to fill the vacant position. This change came just a few weeks prior to the star of

State	Explanations
	the pandemic, however our telework capacity allowed for a seamless transition and training and communication were handled remotely. WV Medicaid continued our efforts to better manage Hepatitis C in our State both from a clinical and financial standpoint. In combination with various stakeholders throughout the State we have encouraged development of consulting programs, such as WVHAMP, with the goal of expanding access to skilled practitioners and adherence to treatment guidelines. We are also working with the Hep C affinity group along with public health.
Wisconsin	Attachment 6 - Innovative Practices CMS FFY 2020 High Volume Prescribers of Opioid plus Benzodiazepines The Wisconsin Drug Utilization Review (DUR) Board developed a letter intervention targeting prescribers with a high volume of patients taking both a daily benzodiazepine and at least 50 morphine milligram equivalents (MME) of opioids per day. The intervention letter was directed at outliers who are identified as top prescribers of this high-risk drug combination. The intervention criteria were based off Wisconsin Medical Examining Board Opioid Prescribing Guidelines that strongly discourage the concomitant prescribing of benzodiazepines and opioids due to increased risk of respiratory depression and mortality. The intervention letter included a list of patients taking the high-risk drug combination and reference information for prescribers regarding appropriate prescribing of benzodiazepines. Several cycles of this letter have been sent to outlier prescribers. The Wisconsin DUR Board has reviewed post- intervention analysis to evaluate effectiveness of this intervention. Future changes to the letter intervention may be made based on results of post intervention analysis. This is an ongoing intervention. SUPPORT Act Several changes were implemented by the Wisconsin Drug Utilization Review (DUR) Board to address requirements of the federal SUPPORT Act legislation. - A high MME prospective DUR alert was implemented in June 2020. The alert sets when a single claim has a daily MME greater than or equal to 90. The alert was implemented as an informational only and does not require a response from the pharmacy to override. The informational only status of the alert may be modified in the future. - A retrospective DUR letter intervention targeting members with a cumulative daily MME of 250 or greater was implemented. Letters are sent to prescribers who have a member that meets criteria. Letters are sent out monthly as part of the standard retrospective DUR process. Post-intervention analysis was conducted to evaluate letter effectiveness. Members were flagged if they had no change or an increase in their daily MME. Prescribers for members who were flagged were contacted via telephone call by a pharmacist consultant. This intervention is ongoing. - Child psychiatrist consultants review all members between the ages of 9 and 18 who are taking two or more antipsychotic medications, focusing specifically on children taking higher doses. The psychiatrist consultants place phone to prescribers of the highest risk members. Phone calls often include discussions of diagnosis, target symptoms, therapy options, and antipsychotic dosing. This is an ongoing intervention. Gabapentinoid Intervention In December 2019 the FDA issued a warning that stated the use of gabapentinoids in combination with CNS depressants can result in serious and potentially fatal respiratory depression. To address the FDA warning, the Wisconsin DUR Board implemented three new retrospective alerts with the following criterion:

State	Explanations
	1. Gabapentinoid + CNS depressant 2. Gabapentinoid + respiratory diagnosis 3. High dose gabapentin (>3,600 mg per day) A pharmacy consultant reviewed high-risk members who met the criterion for a possible retrospective letter intervention to their prescribers. The criterion was adopted into the standard retrospective DUR criteria set for Wisconsin. This is an ongoing intervention. Multiple CNS Depressant Intervention The Wisconsin DUR Board implemented a quarterly prescriber letter intervention targeting members who are on multiple CNS depressant drugs. Members who received at least one medication from each of the following drug classes on a daily basis were flagged for review: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants. A pharmacy consultant reviewed the members and sent
Wyoming	Wyoming now provides Continuing Education Credits to P&T Committee members, ex-officio members and Department of Health staff for review of meeting materials prior to the meeting. Two hours of accredited CME are provided per meeting. Accreditation is being provided for a small fee through a local hospital.

Section X - Managed Care Organizations (MCOs)

1. How many MCOs are enrolled in your state Medicaid program?

Figure 144- Number of MCOs Enrolled in State Medicaid Program

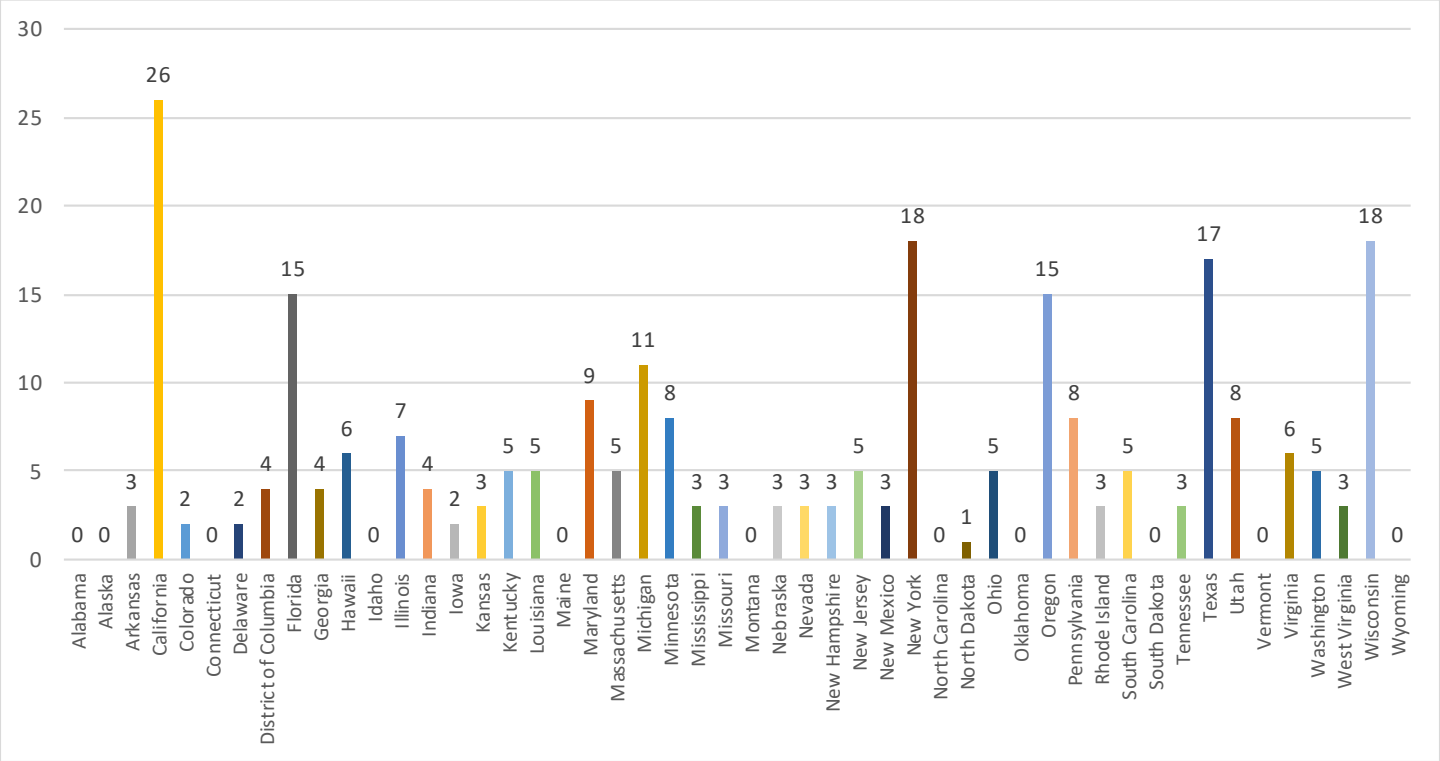

Table 247 - Number of MCOs Enrolled in State Medicaid Program

State	Number of MCOs
Alabama	0
Alaska	0
Arkansas	3
California	26
Colorado	2
Connecticut	0
Delaware	2
District of Columbia	4
Florida	15
Georgia	4
Hawaii	6
Idaho	0
Illinois	7
Indiana	4
Iowa	2
Kansas	3

State	Number of MCOs
Kentucky	5
Louisiana	5
Maine	0
Maryland	9
Massachusetts	5
Michigan	11
Minnesota	8
Mississippi	3
Missouri	3
Montana	0
Nebraska	3
Nevada	3
New Hampshire	3
New Jersey	5
New Mexico	3
New York	18
North Carolina	0
North Dakota	1
Ohio	5
Oklahoma	0
Oregon	15
Pennsylvania	8
Rhode Island	3
South Carolina	5
South Dakota	0
Tennessee	3
Texas	17
Utah	8
Vermont	0
Virginia	6
Washington	5
West Virginia	3
Wisconsin	18
Wyoming	0
Total	259

2. Is your pharmacy program included in the capitation rate (carved in)?

Figure 145- Pharmacy Program Included in the Capitation Rate (Carved In)

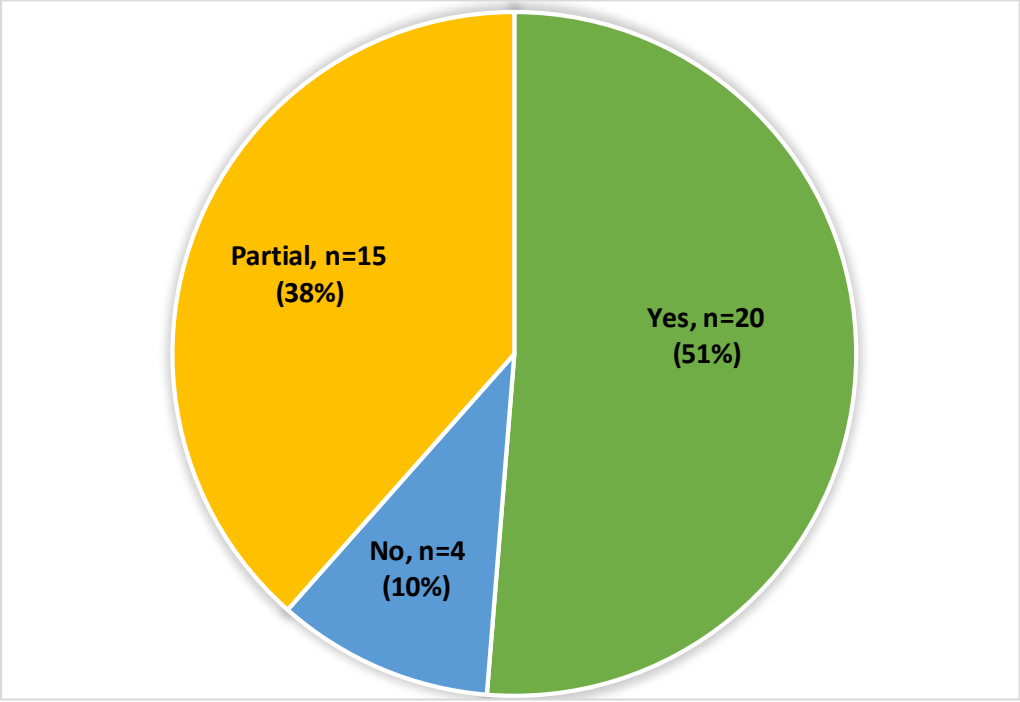

Table 248 - Pharmacy Program Included in the Capitation Rate (Carved In)

Response	States	Count	Percentage
Yes	Arkansas, Delaware, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Nebraska, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Texas, Virginia	20	51.28%
No	Missouri, Tennessee, West Virginia, Wisconsin	4	10.26%
Partial	California, Colorado, District of Columbia, Florida, Indiana, Iowa, Maryland, Michigan, Mississippi, New Hampshire, North Dakota, Oregon, Rhode Island, Utah, Washington	15	38.46%
Total		39	100.00%

Please specify the drug categories that are carved out.

Table 249 - Drug Categories that are Carved Out of the Capitation Rate

State	Drug Categories
California	1. Selected HIV/AIDS/Hepatitis B treatment drugs; 2. Selected alcohol and heroin detoxification and dependency treatment drugs; 3. Selected coagulation factors; and 4. Selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)

State	Drug Categories
Colorado	Certain outpatient hospital specialty drugs are carved out from Enhanced Ambulatory Patient Group (EAPG) payment. These drugs include Brineura, Spinraza, Kymriah, Yescarta, Danyelza, and Zolgensma.
District of Columbia	HIV antiretrovirals
Florida	Hemophilia.
Indiana	Hepatitis C agents, cystic fibrosis agents, clotting factor agents, muscular dystrophy agents, and spinal muscular atrophy agents are carved-out.
Iowa	Zolgensma
Maryland	During FFY2020, the following drug categories were carved out of the MCO benefit and paid FFS: mental health medications, substance use disorder products. Antiretrovirals for the treatment of HIV/AIDS were carved in to the MCO benefit effective 1/1/2020.
Michigan	Mental health drugs/psychotropics, substance abuse treatment, hemophilia clotting factors, HIV antivirals, Hepatitis C treatments and drugs used to treat rare metabolic diseases.
Mississippi	Beneficiaries diagnosed with hemophilia are carved out and enrolled in FFS. A member must be disenrolled from the Contractor (MCO) and enrolled in FFS if the member is diagnosed with hemophilia. The category of hemophilia products are not included in the MCO capitation rate. Long-term Care beneficiaries are also carved out and enrolled in FFS.
New Hampshire	Hemophilia treatments billed through the pharmacy POS system , Carbaglu, Ravicti and Zolgensma are carved out.
North Dakota	For this FFY, the three months in 2019 were 100% carve in, and starting in 2020, pharmacy services were 100% carved out.
Oregon	Mental health drugs carved out to FFS only.
Rhode Island	Stop loss arrangement for Hepatitis C drugs
Utah	Transplant Immunosuppressive Drugs, Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Drugs, Anti-psychotic Drugs, Anti-depressant Drugs, Anti-anxiety Drugs, Anti-convulsant Drugs, Hemophilia Drugs, Opioid Use Disorder Treatments
Washington	As of July 2018 all prescriptions paid through the pharmacy point-of-sale (POS) systems were carved out of the capitated rate and paid to the MCO on a monthly basis based on the total paid from the MCOs submitted and accepted pharmacy encounters. In addition to POS claims the following drugs are excluded from the MCO rate when administered in a physician or outpatient hospital setting: 1. Hemophiliac Products - Blood factors VII, VIII and IX, anti-inhibitor, and all FDA approved products labeled with an indication for use in treatment of hemophilia and von

State	Drug Categories
	Willebrand disease when distributed for administration in the Enrollee's home or other outpatient setting; 2. axicabtagene ciloleucel, as marketed under the brand name Yescarta; 3. brexucabtagene autoleucel, as marketed under the brand name Tecartus; 4. burosumab-twza, as marketed under the brand name Crysvita; 5. cerliponase alfa, as marketed under the brand name Brineura; 6. crizanlizumab alfa, as marketed under the brand name Adakveo; 7. edaravone, as marketed under the brand name Radicava; 8. elapegademase-lvlr, as marketed under the brand name Revcovi; 9. emapalumab-lzsg, as marketed under the brand name Gamifant; 10. eteplirsen, as marketed under the brand name Exondys 51; 11. givosiran sodium, as marketed under the brand name Givlaari; 12. golodirsen, as marketed under the brand name Vyondys 53; 13. luspatercept-aamt, as marketed under the brand name Reblozyl; 14. lutetium lu 177 dotatate, as marketed under the brand name Lutathera; 15. nusinersen, as marketed under the brand name Spinraza; 16. onasemnogene abeparvovec-xioi, as marketed under the brand name Zolgensma; 17. pegvaliase-pqpz, as marketed under the brand name Palynziq; 18. tisagenlecleucel-t, as marketed under the brand name Kymriah; and 19. viltolarsen, as marketed under the brand name Viltepso; 20. voretigene neparvovec-rzyl, as marketed under the brand name Luxturna

Contract updates between state and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo).

3. If covered outpatient drugs are included in an MCO's covered benefit package, has the State updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?

Figure 152 – Have States Updated Their MCO's Contracts for Section 1004 Compliance

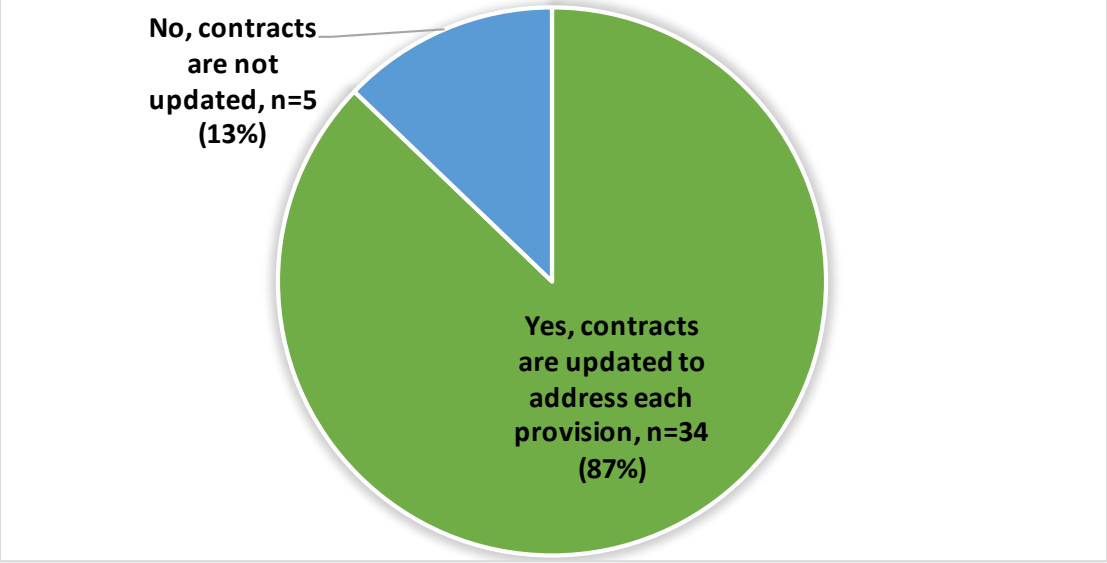

Table 250- Have States Updated Their MCO's Contracts for Section 1004 Compliance

Response	States	Count	Percentage
Yes, contracts are updated to address each provision	Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia	34	87.18%
No, contracts are not updated	Colorado, Mississippi, Missouri, New York, Wisconsin	5	12.82%
Total		39	100.00%

If "Yes," contracts have been updated to address each provision, please specify effective date.

Table 251- Have States Updated Their MCO's Contracts for Section 1004 Compliance

State	Effective Date
Arkansas	09/19/2019
California	10/01/2019
Delaware	01/01/2019
District of Columbia	10/01/2019
Florida	10/01/2020
Georgia	10/01/2019
Hawaii	06/05/2020
Illinois	12/18/2019
Indiana	10/01/2019
Iowa	07/02/2020
Kansas	12/04/2020
Kentucky	01/01/2021
Louisiana	07/01/2019
Maryland	10/01/2019
Massachusetts	01/01/2020
Michigan	10/01/2019
Minnesota	01/01/2020
Nebraska	02/02/2020
Nevada	10/01/2019
New Hampshire	09/01/2019
New Jersey	10/01/2019
New Mexico	10/01/2018
North Dakota	01/01/2019
Ohio	07/01/2019
Oregon	01/01/2020
Pennsylvania	01/01/2020
Rhode Island	07/01/2021
South Carolina	01/01/2021
Tennessee	07/01/2020
Texas	08/14/2020

State	Effective Date
Utah	07/01/2019
Virginia	10/24/2018
Washington	01/01/2020
West Virginia	07/01/2020

If "No," contracts have not been updated, please explain.

Table 252 – Explanations for States That Have Not Updated Their MCO's Contracts for Section 1004 Compliance

State	"No" Explanations
Colorado	Contractual updates related to rates will occur 07/01/21 followed by programmatic updates occurring by the end of August 2021.
Mississippi	We are in contract extension with MCOs at this time. New contracts effective 2022 will be updated to reflect this provision.
Missouri	Pharmacy benefits are carved out of Managed Care
New York	The March 1, 2019 model contract was sent into CMS. CMS sent a returned guidance response with language documenting the need for an attestation or changes to the contract since it was learned that the State was unable to update their MMCO contracts during the SPA review process due to work on amendments required to address the COVID crisis. In response to the CMS request to provide an attestation regarding compliance with requirements of the SUPPORT ACT New York sent the following attestation: Under the requirements of Section 35.1 of the existing MMCO model contract MMCO's are required to follow all applicable legal and regulatory requirements which would include the requirements of the SUPPORT ACT, information to contracted MMCOs were disseminated regarding requirements of the SUPPORT ACT. In the fall of 2019, all MMCO's were surveyed by the Department to confirm compliance with the SUPPOR ACT. MMCO's are regularly survey for compliance with the model contract. The State will all requirements of Section 1004 as described in section 1927(g) of the Act and 42CFR part 456, subpart K to the next Model Contract amendment which will be drafted once CMS has approved the 3-1-19 Model Contract which has been with CMS since April 2019.
Wisconsin	Covered outpatient drugs are carved-out of the managed care benefit packages and are covered fee-for-service. As a result, managed care entities do not process covered outpatient drug claims.

a. Is the state complying with Federal law and monitoring MCO compliance on the SUPPORT for Patients and Communities Act provisions?

Figure 146 – Are States Complying with Federal Law and Monitoring MCO Compliance is Support of the Patients and Communities Act Provision

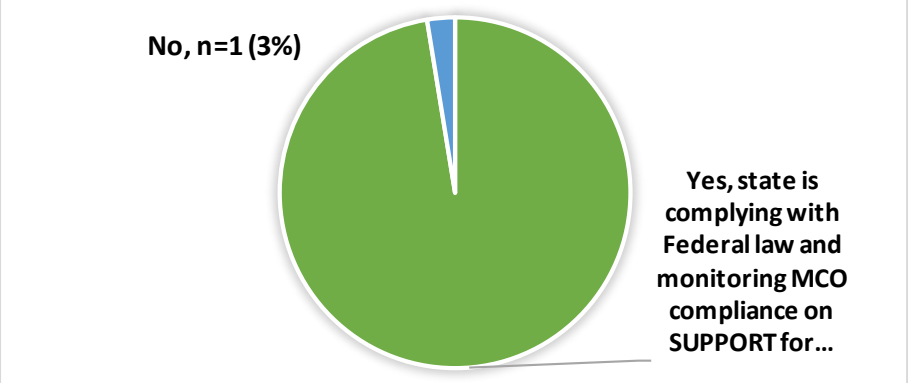

Table 253 - Are States Complying with Federal Law and Monitoring MCO Compliance is Support of the Patients and Communities Act Provision

Response	States	Count	Percentage
Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	38	97.44%
No	Missouri	1	2.56%
Total		39	100.00%

If "Yes," state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.

Table 254 – Explanations for States Complying with Federal Law and Monitoring MCO Compliance is Support of the Patients and Communities Act Provision

State	"Monitoring Activities" Explanations
Arkansas	Arkansas Medicaid MCOs are referred to as Provider-Led Arkansas Shared Savings Entity (PASSE). Per the MCO contract pursuant to the requirements of Section 1004 of the SUPPORT Act, each MCO shall implement minimum opioid standards to include: 1. Prospective safety edits and claims review automated process for opioids for early fills, therapeutic duplication, and quantity limits. 2. Prospective safety edits and for a claims review automated process for MME for treatment of chronic pain and for when the recipient exceeds maximum MME doses. 3. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. 4. Program to monitor and manage the appropriate us of antipsychotic medication by Medicaid children 5. Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies. The PASSEs are required to submit quarterly reports to the State for review. Ad hoc reports are often requested as well. Each PASSE is required to have a minimum of two DUR meetings per year, and the committee must include a voting representative from the State. This requirement allows for additional monitoring of ProDUR and RDUR processes which includes SUPPORT Act criteria.
California	Per All Plan Letter 19-012, all MCO policies and procedures addressing the requirements of the SUPPORT Act have been submitted by each MCO and reviewed for compliance.
Colorado	The State DUR Contact and other members of the State's Pharmacy Office team work directly with designated MCO DUR program pharmacist contacts (for each of the State's two MCOs) to coordinate DUR program activities and verify compliance with these provisions.
Delaware	Delaware has managed care operations oversight in place in Delaware including monthly operational meetings with the MCOs to discuss operational issues, annual External Quality

State	"Monitoring Activities" Explanations
	Review processes, and corrective action plan remediation activities. The SUPPORT Act compliance is being incorporated into those operations. To increase oversight operations, Delaware added a contract compliance officer position in October of 2019. This position participates in the MCO oversight activities and also attends monthly leadership meetings to discuss issues that are larger in scope with MCO leaders.
District of Columbia	The DUR Board actively incorporates involvement of the Pharmacy and Medical Directors of the MCOs into quarterly DUR Board meetings. Each MCO presents a thorough review of its SUPPORT act mandated initiatives and receives detailed feedback on areas of concern from the Board. Collaborative discussion to provide parity across FFS and MCOs addresses MCO compliance as well. In addition, DHCF conducts monthly MCO Pharmacy oversight meetings that always include review and assessment of MCO DUR activities, trends and initiatives required by the SUPPORT Act.
Florida	Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-49 sent on August 31, 2020 with the requirements of the Support Act: https://ahca.myflorida.com/medicaid/statewide_mc/mcp_plan_comunications_archive.shtml
Georgia	Antipsychotic use in children, walk-in programs, and use of PDMP, concurrent reviews, etc.
Hawaii	The FFS DUR Board discusses MCO program compliance. The State is preparing monitoring of MCO compliance on SUPPORT for Patients and Communities Act provisions for FFY2021.
Illinois	Evaluation of information reported in the DUR Annual report. In the future, the Bureau of Managed Care will require the MCO to provide annual attestation regarding compliance with Support Act requirements.
Indiana	Managed care organizations are required to present to the DUR Board and OMPP representatives are present at these meetings.
Iowa	The MCO is required to follow the fee-for-service (FFS) preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits. This includes all requirements of Section 1004 provisions of the SUPPORT Act. The state was provided confirmation from each MCO that all safety edits (prospective drug review - proDUR) were in place. Additionally FFS and the MCO pharmacy staff collaboratively developed and provide reports to the Drug Utilization Review (DUR) Commission based on a claims review automated process (retroDUR) for all opioid related claims review limitations, antipsychotic medication use in children and identification of fraud or abuse for controlled substances. The DUR Commission makes recommendations for further action based on the review of these reports. The state is also able to utilize these reports for comparison among the MCOs to ensure edits are in place and functioning correctly.
Kansas	In addition to our annual MCO oversight reviews, we have the following processes/supports in place. These requirements are included in state policies, which also apply to the MCOs. Provider bulletins are used to notify the providers of program changes. Providers do make the state aware if they come across inconsistencies between the provider bulletin sent/posted by the state and provider experience. The state researches provider complaints for validity and to find resolutions for any valid concerns. The state also reviews claims data, which assists in finding any potential non-compliance by the MCOs. The MCOs are required to have provider education and marketing materials peer reviewed by the state before use.
Kentucky	Kentucky DMS monitors MCO compliance with the SUPPORT Act via quarterly reports from each of the MCOs.

State	"Monitoring Activities" Explanations
Louisiana	To comply with the SUPPORT Act, MCOs must: - follow safety edits and claims review requirements as specified by the state. - follow the state specifications for permitted exclusions from all opioid review activities. - include review of Mental Health drugs in their prospective, retrospective and educational DUR program. - follow prospective safety edits for opioids including early, duplicate and quantity limits, as specified by the state. - follow maximum daily morphine milligram equivalents (MME) prospective safety edits, as specified by the state. - follow the state clinical authorization criteria for monitoring and managing the appropriate use of antipsychotic medications by children enrolled under the State plan.
Maryland	Maryland Medicaid carves out benzodiazepines, antipsychotics, and substance use disorder products and pays Fee For Service (FFS). Monitoring of these claims is handled by the FFS program. Current activities include prospective edits that occur at the Point of Sale (POS) to alert providers of issues related to appropriate days supply of prescriptions, early refills, therapeutic duplications, quantity limits, morphine milligram equivalents, concurrent therapy of an opioid with a benzodiazepine or antipsychotic, as well as opioid use with an approved medication assisted treatment product for opioid use disorder. A retrospective claims review process is in place for all of the above criteria and is monitored on a monthly/quarterly basis in addition to maintain a lock in program. Additionally the Peer Review Program has been in place in Maryland that reviews the use of antipsychotics in children. Regarding Fraud, Waste and Abuse, claims data is evaluated to identify potentially inappropriate therapy based on medication claims as well as reviewing top prescribers, dispensers and utilizers of controlled substances. MCOs that provide services to Maryland Medicaid patients participate in a Unified Corrective Managed Care program.
Massachusetts	We confirm with the MCOs that they have monitoring edits in place that comply with Federal law and the SUPPORT for Patients and Communities Act provisions.
Michigan	MCOs are required to submit quarterly reports showing opioid utilization including MME data and concurrent utilization with benzodiazepines and antipsychotics.
Minnesota	MCO compliance is monitored with the contract and rule both through the CMS annual report and quarterly reports with regards to prior authorizations that are responded to within the 24 hour requirement as part of the contracts.
Mississippi	SUPPORT Act requirements have been communicated to and discussed with the MCOs. The MCOs are reporting on the provisions.
Nebraska	Audits
Nevada	The MCOs report on opioid utilization data. Nevada Medicaid is building a plan to improve its monitoring of MCO compliance through the sharing of existing reports and data as well reviewing the need for additional monitoring activities.
New Hampshire	The Medicaid Quality Unit requires and monitors routine reporting for compliance.
New Jersey	The State confirms required coverage of OUD treatment medication in Medicaid, with some allowable exceptions, by requesting quarterly formulary submissions from each MCO. PA requirements for MAT services were removed effective April 1, 2019 for both the MCOs and FFS. Formulary submissions confirm no PA indicators exist on these products. Any changes to policies regarding the MCO outpatient DUR program, including prospective drug review, retrospective drug use review, and an educational programs, must be approved by the State prior to implementation.
New Mexico	MCO Pharmacy Quarterly reports are submitted to the state that includes compliance on the Support Act provisions.

State	"Monitoring Activities" Explanations
New York	Under the requirements of Section 35.1 of the existing MMCO model contract MMCO's are required to follow all applicable legal and regulatory requirements which would include the requirements of the SUPPORT ACT, information to contracted MMCOs were disseminated regarding requirements of the SUPPORT ACT. In the fall of 2019 all MMCO's were surveyed by the Department to confirm compliance with the SUPPOR ACT. MMCO's are regularly survey for compliance with the model contract. The State will include all requirements of Section 1004 as described in section 1927(g) of the Act and 42CFR part 456, subpart K to the next Model Contract amendment which will be drafted once CMS has approved the 3-1-19 Model Contract.
North Dakota	We have been in communication with the MCO to ensure they are complying.
Ohio	ODM developed a minimum standards for SUPPORT Act compliance document and required all of the MCPs to submit to the state how they are currently meeting the standards and/or how they intend to meet the standards by no later than October 1, 2019. The document is available at: Letterhead | Administration (ohio.gov)
Oregon	Oregon reviews all completed CMS annual surveys from MCOs and compares responses to state and federal expectations. If a response raises a compliance concern, Oregon's Medicaid agency (the Oregon Health Authority, or "OHA") investigates and requires corrective action as appropriate. OHA also meets with MCO pharmacy Directors and representatives in even-numbered months to discuss DUR and other topics relevant to pharmacy program operations and policies. This is often a good opportunity to share best practices and operational challenges. While implementing the initial minimum standards requirement from the SUPPORT Act and during implementation of the related CMS final rules, CCOs completed surveys that detail their practices. Finally, OHA reviews all member letter templates drafted by MCOs. These are routed to subject matter experts for policy review.
Pennsylvania	Effective 1/1/2020, the State implemented a Statewide Preferred Drug List (PDL) including the short and long acting opioids. The MCOs are required to utilize the State's prior authorization guidelines for drugs included on the Statewide PDL. The State Pharmacy Program clinicians monitor MCO compliance with the Statewide PDL and prior authorization guidelines through quarterly denial and approval decision reviews. The State's clinicians also review and approve all MCO quantity limits prior to MCO implementation. Monitoring is also conducted through the State's RetroDUR program which includes both the FFS and MCO delivery systems.
Rhode Island	The DUR program will provide for various reports to be submitted to EOHHS in a specified format on a quarterly basis, to include: Data that is necessary for EOHHS to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than forty-five (45) calendar days after the end of each quarterly rebate period, pursuant to 42 CFR 438.3(s)(2). Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor. The Contractor will establish procedures to clearly identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from these reports to enable EOHHS to accurately bill for the rebate.
South Carolina	As these are contractual items, compliance falls under the State's Contract Monitoring Entity

State	"Monitoring Activities" Explanations
	Several different monitoring activities are performed. Contract Reference From the MCO Contracts: 2.9.10.4.2 Intervening with contract providers whose prescribing practices appear to be operating outside industry or peer norms as defined by TENNCARE, are non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns, and/or who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices among the identified contract providers, as appropriate. Interventions shall be personal and one-on-one; 2.9.10.4.3 Support drug utilization review program that meets the requirements of Section 1902(oo) of the Social Security Act. Support of drug utilization review program shall include: 1. Pharmacy claims review relating to subsequent fills of opioid prescriptions and a claims review automated process that indicates when a member is prescribed a subsequent fill of opioids in excess of limits specified by the State; 2. Pharmacy claims review relating to the maximum daily morphine equivalent that can be prescribed for treatment of chronic pain and a claims review automated process that indicates when a member is prescribed MME in excess of limitations specified by the State; and 3. Pharmacy claims review automated process that monitors concurrent prescribing of opioids and benzodiazepines and concurrent prescribing of opioids and antipsychotics.
Tennessee	Additional clauses in the MCO contract regarding the Lock-In program showing monitoring of the MCO's compliance: 2.30.6.7 The CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section A.2.9.10.3.2) twice a year on June 1 and December 1, according to the following parameters: 1. Members with at least 3 controlled substances in a three-month period, and 2. at least 3 different pharmacies, and 3. at least 3 different emergency room prescribers. 2.30.6.8 The CONTRACTOR shall submit a quarterly Pharmacy Services Report on the prescribing of selected medications mutually agreed-upon by TENNCARE and the CONTRACTOR and includes a list of the providers who appear to be operating outside industry or peer norms as defined by TENNCARE or have been identified as non-compliant as it relates to adherence to accepted treatment guidelines for use of said medications and the steps the CONTRACTOR has taken to personally intervene with each one of the identified providers as well as the outcome of these personal contacts. 2.30.6.9 The CONTRACTOR shall submit a Pharmacy Services Report, On Request when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

State	"Monitoring Activities" Explanations
Texas	The MCO DUR programs are initially assessed through a Readiness Review. Once operational, the MCO must submit an annual report to HHSC Vendor Drug Program (VDP) providing a detailed description of its DUR program activities, as provided for under 42 C.F.R. 438.3(s).
Utah	Monitoring activities include holding quarterly meetings with MCO pharmacy leadership to review policy updates including but not limited to the SUPPORT Act, MME/MED standards, coverage and PA changes, among other things. In these meetings the MCOs will share progress and best practices and the State inquires about specific areas of the SUPPORT Act. In the previous two years, great strides have been taken to reduce the MME/MED utilization of Medicaid members and align the MCO and FFS opioid utilization to the same MME/MED standards.
Virginia	The DMAS DUR pharmacist attends all FFS and MCO DUR Meetings and ensures that the MCOs are in compliance with the SUPPORT for Patients and Communities Act provisions. Several reports are run and reviewed quarterly for both FFS and MCOs to make sure all are in compliance.
Washington	HCA has developed reports related to the SUPPORT Act for opioid MME, co-prescribing and psychotropic use in children. These reports will be used to conduct analysis and make recommendations for follow-up oversight activities to one of the following: HCA Program Integrity, HCA Quality Management Team, Managed Care Review and Analytics Team, Patient Review and Coordination Team, or to the Pharmacy Team for a DUR activity.
West Virginia	The MCO shall comply with Section 1004 of the SUPPORT for Patients and Communities Act and the Drug Utilization Review (DUR) regulations as described in section 1927(g) of the Act and 42 CFR part %u00a7456, subpart K. The MCO shall be subject to both prospective and retrospective requirements, as applicable, dependent on whether the medication is administered via point of sale or clinically. The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point of sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services. The MCO shall be subject to following provisions of Section 1004 of the SUPPORT for Patient and Communities Act: 1. Claim Reviews: a. Retrospective reviews on opioid prescriptions exceeding state defined limitations on an ongoing basis. b. Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. 2. Programs to monitor antipsychotic medications to children: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines. 3. Fraud and abuse identification: The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.
Wisconsin	Wisconsin has implemented monitoring activities in its State Plan to review outpatient drugs claims for numerous safety issues. These include limiting the number of opioids permitted in a calendar month, limiting the amount of short-acting and/or select long-acting opioids in a rolling calendar month, limiting early refills, limiting duplicate fills of select drug classes (i.e. opioids, benzodiazepines, etc.).. Also conducting lock-in reviews, and reviewing concurrent utilization of opioids and benzodiazepines, opioids and antipsychotics, and monitoring of

State	"Monitoring Activities" Explanations
	morphine milligram equivalents (MME). The State also monitors antipsychotic medications to children, and identifying potential fraud and abuse. However, as indicated in the response to question two, covered outpatient drugs have been carved-out of the managed care benefit packages and are covered fee-for-service. As a result, managed care entities do not process covered outpatient drug claims and there are no managed care organization activities for the state to monitor in this regard. However, all Medicaid members are subject to the safety monitoring activities listed above.

If "No," please explain.

Table 255 – Explanations for States Not Complying with Federal Law and Monitoring MCO Compliance is Support of the Patients and Communities Act Provision

State	"No" Explanations
Missouri	The state agency monitors DUR provisions on behalf of the MCOs since pharmacy is carved out of Managed Care benefit package.

4. Does the state set requirements for the MCO's pharmacy benefit (i.e. same PDL, same ProDUR/RetroDUR)?

Figure 147 - State Mandating Requirements for the MCO's Pharmacy Benefit

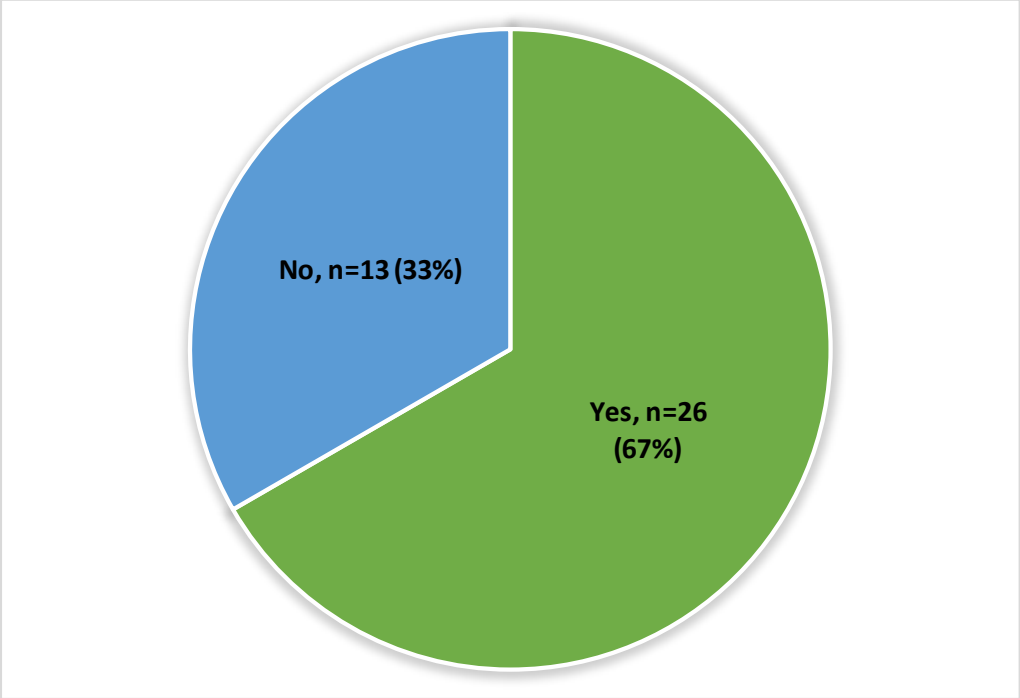

Table 256 - State Mandating Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Illinois, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia	26	66.67%
No	Georgia, Hawaii, Indiana, Kentucky, Missouri, Nevada, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin	13	33.33%
Total		39	100.00%

If "Yes," please continue.

a. State Requirements

Figure 148 - State Requirements for the MCO's Pharmacy Benefit

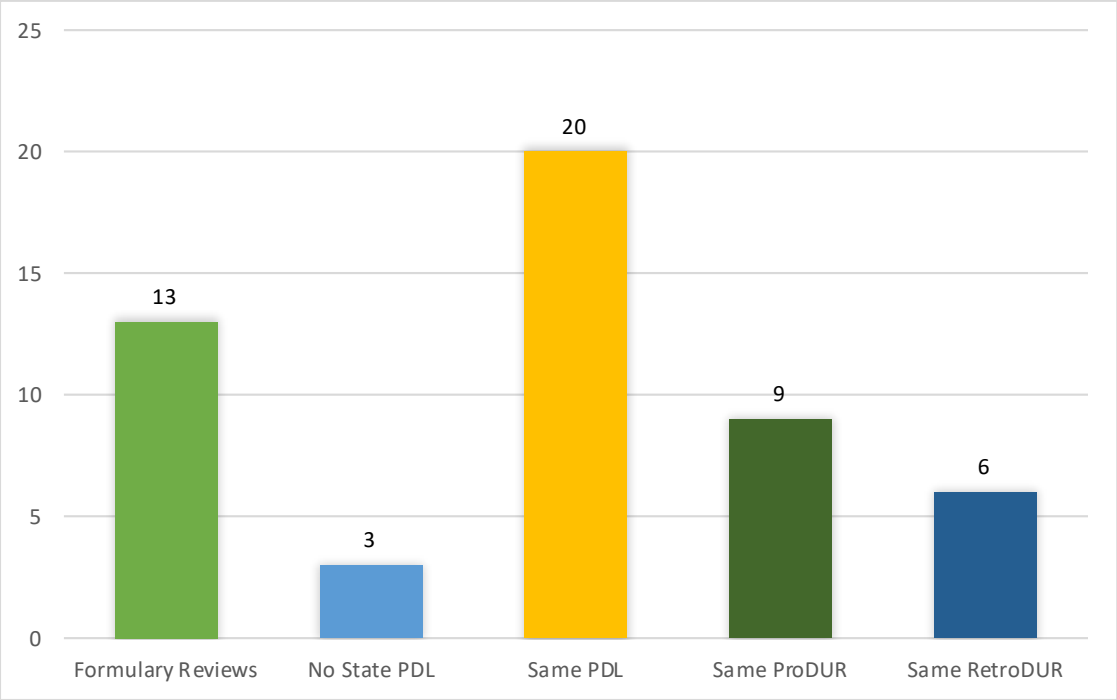

Table 257 - State Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Formulary Reviews	California, Colorado, District of Columbia, Florida, Kansas, Maryland, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Washington	13	25.49%
No State PDL	District of Columbia, Mississippi, New Jersey	3	5.88%
Same PDL	Arkansas, Delaware, Florida, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska,	20	39.22%

Response	States	Count	Percentage
	New Hampshire, North Dakota, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia		
Same ProDUR	Arkansas, Florida, Iowa, Kansas, Louisiana, Massachusetts, Mississippi, Nebraska, New Jersey	9	17.65%
Same RetroDUR	Florida, Iowa, Kansas, Louisiana, Nebraska, New Jersey	6	11.76%
Total		51	100.00%

b. Please briefly explain your policy.

Table 258 - Policy Explanations for State Requirements for the MCO's Pharmacy Benefit

State	Explanations
Arkansas	The PASSEs are required to cover all therapeutic classes of drugs covered by the Arkansas Medicaid pharmacy program and must follow the Arkansas Medicaid Preferred Drug List. The State provides the PASSEs a weekly Custom Drug File, delegating the preferred or non-preferred status of each NDC. The PASSEs must update their pharmacy claims system within one business day of receipt of the Custom Drug File or for any off-cycle updates. The PASSEs are required to maintain a drug formulary that must be developed and reviewed at least annually by an appropriate P&T or DUR Committee. The reviewed formulary must be submitted to the State for input at least 30 days prior to implementation. Drugs on the PDL must be covered without prior authorization unless they are subject to clinical or utilization edits as defined by the State. For drugs not on the Arkansas PDL but that are covered outpatient drugs, the PASSEs may require prior authorization. Prior authorization criteria and PDL formulary cannot be more restrictive than the Arkansas Medicaid Fee For Service Program. The PASSEs are not authorized to negotiate rebates with manufacturers for products on the PDL, and the State collects all rebates for outpatient drugs dispensed to enrolled clients. Drug utilization encounter data must be provided by the PASSEs for all claims including paid, denied, voided, and rejected no later than 45 calendar days after the end of each quarterly rebate period. Also, the PASSEs must identify encounter claims administered under the 340B program.
California	Medi-Cal MCOs are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program and their preferred drug lists (PDLs) are required to be comparable to the Medi-Cal List of Contract Drugs. While all drugs included on the Medi-Cal List of Contract Drugs do not need to be included on the MCOs' PDLs, comparable means that the drugs on the PDLs must have the same mechanism of action sub-class within all major therapeutic categories of drugs included in the Medi-Cal List of Contract Drugs. Starting in FFY 2018, the DUR Board expanded to become the Global Medi-Cal DUR Board, with MCO representatives now included as Board members. MCOs utilize the Global Medi-Cal DUR Board and educational components of the Medi-Cal DUR program. However, MCOs maintain their current proprietary claims processing procedures and protocols and MCOs individually administer the systematic components related to the prospective and retrospective DUR processes. As is the case with the Fee-For-Service (FFS) program, MCOs are not required to implement all DUR Board recommended actions, nor are they required to mirror the Medi-Cal DUR activities.

State	Explanations
Colorado	The State's policy is that MCO medication coverage and utilization limitations cannot be more stringent than current limitations in place for FFS. If a drug is carved out, then MCOs must follow the State's FFS PDL and associated prior authorization criteria.
Delaware	Delaware has a unified PDL between FFS and the MCOs to ensure consistency for our providers and members. Although MCOs may adopt different clinical review requirements, any such deviation from FFS standards are approved by the state
District of Columbia	All formulary changes proposed by each MCO must be approved by DHCF prior to implementation. This approval is usually done on a quarterly basis but can be requested on an adhoc basis if the deletion or addition to the formulary can not be postponed until the next scheduled review date. There is currently no District wide single PDL, however, there is a proposal under consideration for future budget years.
Florida	MCO plans criteria, edits, etc. cannot be more restrictive than the Agency.
Illinois	Effecive January 1, 2020, there is one Medicaid Preferred Drug List (PDL) for MCOs and Fee-for-Service. The MCO must follow FFS age limits and days' supply for those drugs listed on the PDL, but may determine their own clinical prior authorization criteria unless otherwise stipulated by the Department.
Iowa	The MCO is required to follow the fee-for-service (FFS) preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits.
Kansas	The MCOs are to have the same drug coverage and DUR program as FFS, with few exceptions. The MCOs can set different quantity or day supply limits, if there is not a limit already set in state policy. The state requires some specific RetroDURs to be done, but the MCOs are also required in their contract to review their claims data, prospectively and retrospectively, per CMS requirements. Drug prior authorization requirements are the same as FFS and are approved by the state DUR Board. The state requires the MCOs to use the state FFS prior authorization criteria and prior authorization forms.
Louisiana	DUR is directed by a DUR Board comprised of participating Medicaid physicians and pharmacy providers, one MCO Medical Director, one MCO Behavioral Health Medical Director, and one MCO Pharmacy Director, to align initiatives and criteria. PDL: A single PDL was implemented across FFS and MCOs on May 1, 2019. Prior Authorization criteria has been aligned over time. ProDUR: Each plan follows DUR Board directives for prospective criteria. However, safety edits such as quantity limits are allowed to be implemented by the MCO if they are in accordance with FDA guidelines. RetroDUR: FFS and MCOs adhere to an annual schedule of retrospective reviews. MCOs are allowed to implement additional retrospective reviews when approved by Medicaid pharmacy staff. Educational objectives are supported by the University of Louisiana at Monroe College of Pharmacy. MCOs are allowed to bring additional educational initiatives to the DUR Board and Medicaid pharmacy staff for consideration.
Maryland	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefit including P &T Committee management and procedures, formulary content/management, prior authorization procedures and criteria, generic substitution, drug utilization reviews and disease management programs. A review and assessment of each MCO Drug Use Management Program is conducted annually.

State	Explanations
Massachusetts	MassHealth ACPP/MCO Uniform Preferred Drug List In order to provide the most cost effective, sustainable pharmacy benefit, MassHealth has designated preferred drugs within certain therapeutic classes. Preferred drugs are either subject to supplemental rebate agreements between the manufacturer and the State or brand name drugs preferred over their generic equivalents based on net costs to the State. This Uniform Preferred Drug List identifies the therapeutic classes for which preferred drugs have been designated and the obligations of MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) with respect to those classes. This list is subject to change at any time and may be updated frequently. Please consider modifying this question to account for partial Preferred Drug Lists.
Michigan	The MCO contract requires that the plan's formulary include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List (MPPL). In addition, the MCOs can only be less restrictive than the MDHHS approved MCO Common Formulary. Effective October 1, 2020, a single PDL for both FFS and the MCOs was implemented.
Minnesota	DHS has developed a uniform nonpreferred PDL drug prior authorization used by both FFS and MCOs. If the MCO chooses, they can develop their own PA criteria but the criteria cannot disadvantage the preferred drug
Mississippi	MCOs have been required to reimburse at the same amount as or higher than FFS on pharmacy claims. Since January 2015, MCOs have been required to use Universal Preferred Drug List and same clinical criteria.
Nebraska	MCO's act just like FFS.
New Hampshire	The MCOs can set their own coverage criteria for therapeutic classes not managed by the Medicaid FFS PDL.
New Jersey	Each MCO submits proposed formulary and drug coverage changes to Division for review and approval on a quarterly basis. The prospective and retrospective DUR standards established by the MCO must be consistent with those same standards established by the Medicaid Drug Utilization Review Board (DURB). The State approves the effective date for implementation of any DUR standards by the MCO.
New York	MCOs mimic the therapeutic categories on the FFS formulary but are not required to make available the exact same drugs that are covered by the Medicaid program. Rules and regulations of each MCO plan regarding elements for PA requirements appeals etc. remain with each individual plan.
North Dakota	While pharmacy was carved in, ND required the MCO to follow our PDL.
Ohio	On 1/1/2020, the Unified Preferred Drug List (UPDL) was implemented. MCP adherence to the UPDL and prior authorization denials are monitored. We also have consistent utilization management and prior authorization approach for all opioids as well as Medication Assisted Treatment (MAT). Additionally, the minimum standards for the SUPPORT Act compliance has been enacted and MCPs have followed these standards beginning October 1, 2019. The Minimum standards for SUPPORT Act compliance for the Managed Care Plans is available at: Letterhead | Administration (ohio.gov)
Pennsylvania	The MCOs are required to utilize the State's prior authorization guidelines for drugs included on the Statewide PDL. The State Pharmacy Program clinicians monitor MCO compliance with the Statewide PDL and prior authorization guidelines through quarterly denial and approval decision reviews. The State's clinicians also review and approve all MCO quantity limits prior to MCO implementation.

State	Explanations
Texas	The state sets some requirement for the MCO's pharmacy benefits: Single PDL Single Formulary POS clinical PA criteria must not be more stringent than the what the Board has approved.
Virginia	All preferred drugs on the DMAS PDL will be included on the CCC Plus plans formularies. With the Common Core Formulary (CCF), health plans may add drugs to most drug classes but cannot remove drugs or place additional utilization management criteria on the CCF drugs. The Virginia Medicaid preferred drug list has 13 closed classes for which only the drugs listed within the classes are covered. For the closed classes, the plans will NOT be able to add or delete any drugs to these classes. DMAS will collect supplemental drug rebates for the drugs in these closed classes. The primary focus of this is for the ease of the providers and the members. It will decrease the administrative burden for prescribers while ensuring continuity of care for the members.
Washington	In January 2018 Washington Medicaid began implementing a single Apple Health Preferred Drug List (AHPDL) to be used by the fee-for-service (FFS) program and all five contracted Managed Care plans (MCO). The AHPDL initially included approximately 25 drug class with additional classes being added overtime (2018-2020). The AHPDL was fully implemented June 2020. The FFS and MCO programs are required to use the AHPDL drug statuses, prior authorization requirements, and drug policies. The MCOs may continue to apply their own quantity limits and corporate drug policies when a shared policy has not been developed. For all drugs paid through the pharmacy benefit and not included on the AHPDL, MCOs must have a wrap-around formulary and submit any requested changes to Washington Medicaid for review and approval.
West Virginia	All pharmacy is carved out. Previously the MCOs were required to use the same PDL.

If "No," does your state plan to set standards in the future?

Figure 149 - State Plan to Set MCO Pharmacy Benefit Standards in the Future

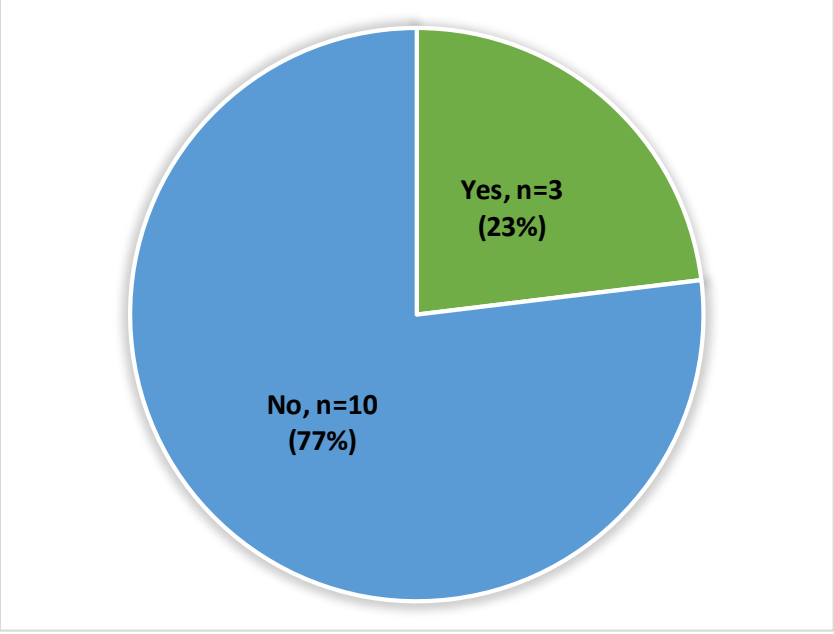

Table 259 - State Plan to Set MCO Pharmacy Benefit Standards in the Future

Response	States	Count	Percentage
Yes	Kentucky, Nevada, Oregon	3	23.08%
No	Georgia, Hawaii, Indiana, Missouri, New Mexico, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin	10	76.92%
Total		13	100.00%

If "No," please explain.

Table 260 - Explanations for State Plan to Set MCO Pharmacy Benefit Standards in the Future

State	Explanations
Georgia	Not planning on doing so in the future.
Hawaii	Currently ad hoc and selective legislated programs by the State set requirements for the MCOs pharmacy benefit.
Indiana	Establishing requirements such as these would require substantial contract changes and negotiations.
Missouri	Pharmacy benefits are carved out of Managed Care.
New Mexico	N/A
Rhode Island	Not at this time.
South Carolina	4.2.21.2 Preferred Drug List Elect to implement a Preferred Drug List (PDL) to encourage the use of the most cost-effective medication within a drug class. 4.2.21.2.1. The CONTRACTOR's Pharmacy & Therapeutics (P&T) Committee must approve the PDL prior to implementation. 4.2.21.2.2. The current PDL shall be provided to the Department upon execution of the contract and any PDL changes shall be communicated to the Department prior to implementation. 4.2.21.2.3. Negative PDL changes must be published on the CONTRACTORs website at least thirty (30) Days prior to implementation. 4.2.21.2.4. While the CONTRACTOR may employ a PDL and other mechanisms to promote cost-effective, clinically appropriate medication utilization, all Food and Drug Administration (FDA)-approved medications must ultimately be covered except for those listed in the Managed Care Policy and Procedure Guide. 4.2.21.2.5. The Department may elect to restrict the CONTRACTORs ability to make PDL changes. https://msp.scdhhs.gov/managedcare/sites/default/files/2018%20MCO%20Contract%20Boilerplate%20-%20Amendment%20VII%20Final.pdf
Tennessee	Tennessee is a 100% managed care state, with pharmacy carved out, so the MCO's only manage and cover physician administered drugs from the office and outpatient settings. However, all members regardless of which MCO they are enrolled with, are under the same TennCare PDL, ProDUR, RetroDUR, and all products and categories are subject to formulary reviews by TennCare's PAC (Professional Advisory Committee), which is TennCare's P&T Committee.
Utah	Not at this time.
Wisconsin	The drug benefit is carved-out from the MCO to fee-for-service.

5. Is the RetroDUR program operated by the state or by the MCOs or does your state use a combination of state interventions as well as individual MCO interventions?

Figure 150 – RetroDUR Program Operated by State, MCO, or Combination of State and MCO

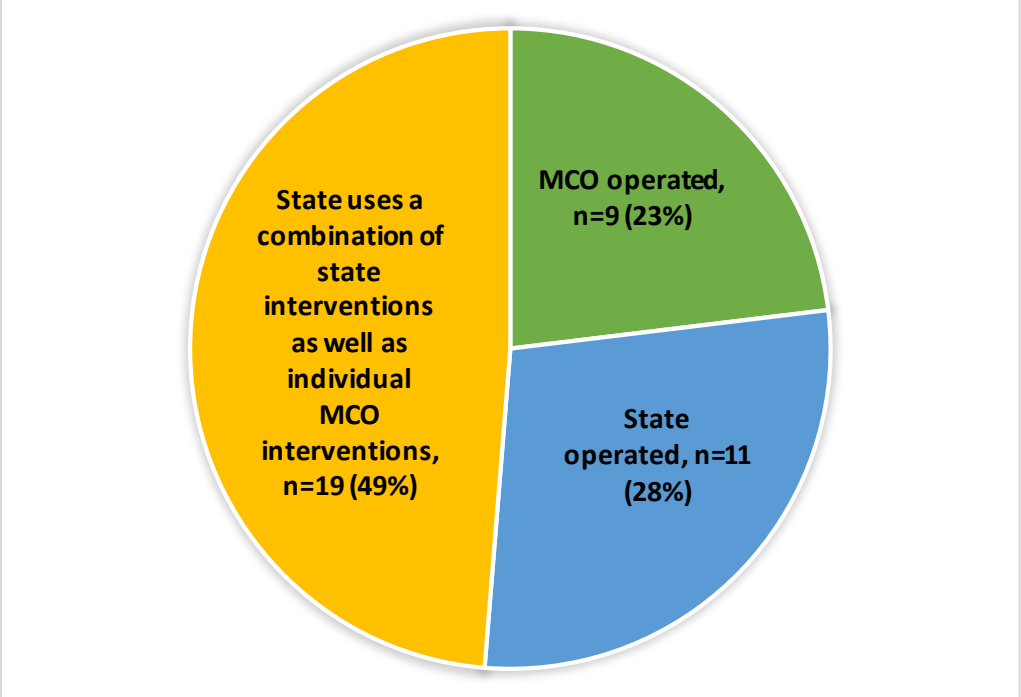

Table 261- RetroDUR Program Operated by State, MCO, or Combination of State and MCO

Response	States	Count	Percentage
MCO operated	Arkansas, Maryland, Michigan, Minnesota, Nevada, New Hampshire, Ohio, Oregon, Rhode Island	9	23.08%
State operated	Florida, Georgia, Indiana, Iowa, Mississippi, Missouri, Nebraska, North Dakota, Texas, West Virginia, Wisconsin	11	28.21%
State uses a combination of state interventions as well as individual MCO interventions	California, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, New Jersey, New Mexico, New York, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington	19	48.72%
Total		39	100.00%

6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.

Table 262 - Explanations for How the State Oversees the FFS and MCO RetroDUR programs

State	Explanations
Arkansas	Per the PASSE contract, the PASSEs must develop and maintain a DUR program that complies with the DUR program standards as described in SSA 1927 which includes prospective DUR, retrospective DUR, educational programs, and the DUR Board. The State oversees the MCO programs by requiring quarterly and CMS annual reports pertaining to DUR activities, Lock-in programs, and prospective utilization data. Each PASSE DUR Board must include a State representative as a voting member, and each PASSE must appoint a non-voting member to the fee-for-service DUR Board. The PASSEs create and determine their own intervention criteria. RetroDUR programs are discussed in each PASSE DUR Board meeting. The FFS RetroDUR program is managed by the point of service vendor, Magellan. Prior to 7/1/2020, Health Information Designs was the RetroDUR vendor. The State pharmacy program works closely with the RetroDUR program on a monthly basis (sometimes even weekly). Magellan provides a monthly summary report in addition to the quarterly report summary for the DUR Board. Magellan analyzes the potential intervention criteria for review by the DUR Board. Ultimately, the DUR Board determines the intervention criteria for the following quarter. Once the timeframe of review for a specific intervention has elapsed, the outcomes data is submitted to the DUR Board as well.
California	The oversight process includes evaluating MCO annual report surveys, reviewing MCO policies and procedures, and requiring MCO participation in Global Medi-Cal DUR Board meetings and dissemination of FFS RetroDUR educational bulletins and alerts.
Colorado	The State's two MCOs each have designated DUR program pharmacist contacts that collaborate with the State DUR Contact and other members of the State's Pharmacy Office team regarding MCO RetroDUR program activities. MCO DUR contractual obligations are also managed through coordinated efforts involving the MCO contract management team within the State's Health Programs Office.
Delaware	Prospective and retrospective DUR alerts and edits are put into place for MCO and FFS only with approval from the state. Educational programs, such as blast faxes, provider newsletters, and other provider outreach modalities all require approval by the state.
District of Columbia	The DUR Board actively incorporates involvement of the Pharmacy and Medical Directors of the MCOs into quarterly DUR Board meetings. Individual MCO SUPPORT Act initiatives are thoroughly vetted by the DUR Board for compliance. DHCF conducts monthly MCO Pharmacy oversight meetings that always include review and assessment of MCO DUR activities, trends and initiatives required by the SUPPORT Act. The DUR Board recommends and/or approves POS edits and prior authorization clinical criteria for the FFS pharmacy program to ensure medication safety, efficacy and clinical necessity.
Florida	The State oversees the DUR program which includes prospective and retrospective reviews. The State meets with the DUR Board quarterly to review drug utilization including pre and post impact analysis of edits, review of drug criteria, prior authorizations requirements, and pipeline drugs. The MCOs participate on the State DUR Board and also may operate their own internal DUR program. MCOs submit an annual report to Medicaid describing their DUR program activities.
Georgia	The State reviews each of the MCO's annual DUR report and approves prior to submission.

State	Explanations
Hawaii	The FFS DUR Board supports the FFS RetroDUR programs oversight by the state. Quarterly and annual MCO reports provide an example of MCO RetroDUR programs.
Illinois	The RetroDUR contractor in cooperation with HFS Pharmacy Services conducts FFS retrospective DUR and presents the information to the FFS DUR Board. In August 2020, the FFS and MCO pharmacy representatives met to discuss DUR for Medicaid participants for the first time. Pharmacy Services reviews information the MCOs provide in their DUR annual reports to determine activities conducted related to ProDUR and RetroDUR.
Indiana	FFS receives review and approval by the DUR Board for all RetroDUR programs. The managed care organizations submit documents to OMPP for approval and they also collaborate with OMPP on retroDUR projects to be submitted to the DUR Board.
Iowa	MCO's participate in the State DUR Commission meetings and activities, as well as adhere to DUR oversight conducted on the Medicaid population and initiatives recommended. No DUR initiatives can be implemented without review and recommendation from the DUR Commission. The MCOs participate and collaborate with the State DUR Commission in regards to Retro DUR. Existing and newly proposed RetroDUR initiatives must be reviewed and recommended by the DUR Commission.
Kansas	These requirements are included in vendor contracts. The vendor contracts also require following state policy. In addition to our annual MCO oversight reviews, we have the following processes/supports in place for FFS and the MCOs. All provider education and marketing materials are to be peer reviewed by the state before use. These reviews reveal provider education and interventions that will be taking place. The FFS vendor and MCOs present their DUR programs to the state DUR Board annually. Provider bulletins are used to notify the providers of program changes. Providers do make the state aware if they come across inconsistencies between the provider bulletin sent/posted by the state and provider experience. The state reviews claims data, which assists in finding potential non-compliance. The state works collaboratively with FFS and the MCOs. This promotes sharing of findings needing follow up, as well as an evaluation of current program activities in place.
Kentucky	The state is contracted with Magellan Medicaid Administration (MMA) for the FFS RetroDUR program. The state reviews and approves all RDUR criteria and interventions before they are sent. MMA provides the state with follow up stats on interventions and cost savings associated with interventions. Kentucky DMS utilizes quarterly reports to monitor the MCO's RetroDUR programs. Kentucky DMS monitors the following types of information: Retrospective drug utilization review activities and outcomes of initiatives performed during the calendar year. New or removed MCO RDUR initiatives for the calendar year. List the Opioid Retrospective Automated Process Initiatives in alignment with the SUPPORT ACT
Louisiana	FFS and MCOs adhere to an annual schedule of retrospective reviews. MCOs are allowed to implement additional retrospective reviews when approved by Medicaid pharmacy staff.
Maryland	Part of the annual review of each MCO drug use management program includes a review of RetroDUR policies and processes as well as any interventions that have been conducted during

State	Explanations
	the assessment period. The FFS RetroDUR program is closely monitored by the State, who works directly with the vendor who provides services.
Massachusetts	Representatives from the DUR programs attend DUR board meetings. Contract managers ensure FFS and MCO programs are meeting contract requirements including alignment with state's DUR program and RetroDUR process. In addition, the state meets regularly with representatives of the programs to address any changes and updates.
Michigan	MDHHS and the DUR Board oversee the FFS RetroDUR activities and review the results and utilization patterns at each quarterly meeting. The MCO contract requires a DUR Board and the state's Health Plan Division oversees compliance with all MCO contract requirements via ad hoc inquiries, site visits and focus studies.
Minnesota	MCO compliance is monitored with the contract and rule both through the CMS annual report and quarterly reports with regards to prior authorizations that are responded to within the 24 hour requirement as part of the contracts.
Mississippi	The MCOs are contractually required to operate a DUR program that complies with the requirements described in section 1927(g) of the Act and 42 C.F.R. Part 456, subpart K and to provide a detailed description of its drug utilization review program activities to DOM on an annual basis.
Missouri	The Retrospective DUR system applies to all MO HealthNet Division (MHD) participants and focuses on drug regimen reviews after the patient has received a prescription. It targets potential therapy problems that result after a period of time, possibly characterized by an exacerbated medical condition or the appearance of a drug side effect. The MHD has entered into an outside contract for the production of computerized patient reports or 'patient profiles.' These patient profiles are generated by applying therapeutic criteria to paid MHD claims data. Therapeutic criteria are reviewed and approved by the DUR Board.
Nebraska	Through audits and DUR Board meeting agenda items.
Nevada	MCOs present quarterly at state DUR Board Meetings. Any changes due to their RetroDUR programs are to be shared at these meetings to ensure they align with the approved recommendations from the DUR Board. At least annually, the MCOs are required to present RetroDUR activities.
New Hampshire	The State oversees the FFS RetroDUR program with input from the Medicaid DUR Board. The MCO RetroDUR programs are monitored by reports submitted to the Quality Unit.
New Jersey	Each MCO submits proposed RetroDUR programs to Division for review and approval on an ongoing basis. The State approves the effective date for implementation of any DUR standards by the MCO and FFS.
New Mexico	The MCO health plans report their Retro DUR interventions in a quarterly pharmacy report. The state meets with the FFS vendor every other week to discuss the Retro DUR program and develop interventions. These interventions are presented at the quarterly DUR Board Meeting.
New York	In accordance with NYS Social Services Law 369bb the DUR board is responsible for collaborating with MCOs to address drug utilization concerns and implementing consistent management strategies across the FFS and managed care pharmacy benefits. This is done through an ongoing evaluation of retrospective pharmacy claims data (FFS and MCO) for which the data is included as DUR Board meeting agenda items as needed. MCO data (specific to their member population) are provided to each MCO upon DUR Board evaluation. The DUR Board's recommendations and associated RetroDUR programmatic improvements are communicated to the MCO to necessitate any drug related interventions as needed.

State	Explanations
North Dakota	ND contracts with Kepro for retrospective drug use review and all MCO data is also loaded into the system. RetroDUR activities then occur on the population as a whole without regard to what program they are in.
Ohio	ODM oversees MCP RetroDUR programs via provider agreement requirements, monitoring DUR reports, quarterly MTM report submissions, and weekly MCP Pharmacy Director meetings. ODM oversees the FFS RetroDUR program by attending all DUR Committee and DUR Board meetings and by approving all DUR materials.
Oregon	Oregon reviews all completed CMS annual surveys from FFS and MCOs and compares responses to state and federal expectations. If a response raises a compliance concern, OHA investigates and requires corrective action as appropriate. In addition, OHA meets with MCO pharmacy Directors and representatives in even-numbered months to discuss DUR and other topics relevant to pharmacy program operations and policies. Finally, OHA and the Oregon FFS Pharmacy & Therapeutics Committee review quarterly DUR reports for the FFS program. The Committee discusses the reports and recommends changes or follow-up reporting when appropriate.
Pennsylvania	RetroDUR requirements are included in the MCO agreement. RetroDUR requirements include the following: a. The MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Members. b. The MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care. c. The MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices. The MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program. Monitoring is conducted through the State's RetroDUR program which includes both the FFS and MCO delivery systems.
Rhode Island	1. The State plan must provide for a retrospective DUR program review quarterly of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. 2. This examination must involve pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. 3. This program must be provided through the State's MMIS or an electronic drug claims processing system that is integrated with MMIS

State	Explanations
South Carolina	RetroDUR is a specific contract requirement, which is monitored by the State's Contract Monitoring Entity
Tennessee	Regarding Oversight of the MCO RetroDUR program, TennCare's Office of Program Integrity (OPI) requires MCC oversite of prospective drug review, retrospective drug use review, data assessment of drug use against predetermined standards, outlier reviews, are appropriate and medically necessary, and requires educational outreach activities to ensure compliance with medical and pharmaceutical standards. Additionally, the MCCs Compliance Programs: 1. Have edits in place to alert them of any suspicious medical or pharmaceutical billing activities 2. Provide several venues to report suspicious activities or perceived violations of medical or drug usage 3. Several MCCs have specific triage procedures for prescription drug matters, for example prescription drug matters are sent directly to their Special Investigation Unit 4. Algorithms based on billing patterns and peer norms In addition, OPI monitors TennCare's MCCs oversight for medical, dental, and pharmaceutical suspicious claims activity through monthly and quarterly reports and meetings. All activities that require a closer inspection to determine if the billing is an administration error or possible fraud activities is monitored from the inception of the questionable billing to the determination of fraud or administrative error. Regarding FFS RetroDUR programs, listed are clauses in the PBM Vendor's Contract between TennCare and the PBM: A.45.a. TennCare Retrospective Drug Utilization Review (Retro-DUR) The Contractor shall provide to the State all necessary components of a TennCare Retro-DUR program as required in 42 CFR 456.709: for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. The Contractor's Retro-DUR system's intervention processes shall include, at a minimum, letter-based information to providers and a system for tracking provider response to the interventions. The Contractor shall prepare, for the State's approval, provider letters containing information related to the operation of the TennCare pharmacy program. The Contractor shall also implement a complete Retro-DUR program to be coordinated and maintained by the full-time DUR Clinical Pharmacist dedicated to TennCare and supported by

	the Provider Liaison Pharmacists who are Tennessee-licensed pharmacists, and additional clinical reviewers who are also Tennessee-licensed pharmacists. 1. Description of the Operation of the TennCare Retro-DUR Program -The Contractor shall provide to the State all necessary components of a Retro-DUR program and shall operationalize those as specified in 42 CFR 456.716: (b) Recruit, maintain, and reimburse a panel of clinical pharmacists sufficient to review member profiles as noted in subsection e. below. The clinical pharmacists shall recommend appropriate interventions related to each profile reviewed. (c) With input from the State and the DUR Board, the Contractor shall determine the focus of and generate data above for each of four (4) quarterly provider profile runs and each of twelve (12) monthly member profile runs. Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter. Monthly member profile reviews shall be completed and results/interventions distributed to prescribers within sixty (60) days of the end of the month. (d) After approval by the State of the focus of, and methodology to be used in, the member profile reviews, the Contractor shall produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per calendar quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken. Any summaries, correspondence or other documents produced as a result of the review process shall be approved by the State prior to their distribution. (e) After approval by the State of the focus of, and the methodology to be used in, the provider profile reviews, the Contractor shall produce two thousand four hundred (2,400) provider profiles per calendar quarter and determine appropriate interventions to address any potential problems identified during profile review. Unlike member profiling, provider profiles need not reviewed by clinical reviewers, as they simply detail members for whom a prescriber or pharmacy provider has prescribed or dispensed a medication under review for the calendar quarter. (f) Implement interventions designed to address problems identified during profile review. These interventions shall include, at a minimum, mailings sent to prescribers or pharmacy providers, but phone calls or visits may also be conducted if appropriate and/or upon the direction of the State. Mailings shall consist of an intervention letter to the prescriber or pharmacy provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included, along with a provider response form seeking input for the value of the intervention. Interventions regarding possible fraud and abuse shall be reported to the State. (g) Maintain a system that complies with all requirements of Section A.45.b below, capable of tracking all interventions, both letters and direct communication, and determining cost savings related to the specific interventions. This system shall also record input received from providers regarding the value of the intervention. A.45.b. TennCare Retro DUR Reporting System 1. The Contractor shall provide a reporting system that tracks the outcomes of the Retro DUR initiatives. TennCare's Retro DUR initiatives are mainly focused on improving care quality. The Contractor's system shall be able to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. The data elements tracked will vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to:

State	Explanations
	(a) Drug change within a sixty (60) or ninety (90) day period of the intervention; (b) Total number of drugs pre- and post- intervention; (c) Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention; (d) Daily dose of drug in question pre- and post- intervention; (e) Assessment of various interactions (as relevant to the activity) pre- and post-intervention which may include drug-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems; (f) Compliance with national guidelines (e.g.., percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the RetroDUR initiative; (g) Semi-annual Top Controlled Substance Prescribers report card; (h) Patient compliance; (i) Hospitalizations and/or doctor visits pre and post intervention; and (j) Prescription and/or medical costs pre and post intervention. (k) Cost savings resulting directly from DUR interventions to be reported to the State on a twice-yearly basis, and included in the Annual CMS report.
Texas	The FFS retro-DUR vendor provides periodic reports on their activities. The topics and the criteria for these retro-DUR interventions are developed by the vendor and upon approval by the DUR Board, the vendor will implement. The outcome report for each intervention is submitted to the state for approval. For the MCO retro-DUR activities, periodic reports from individual MCOs are submitted to the HHSC MCO Contract Oversight team.
Utah	The State utilizes a data-driven approach to outreach to prescribers on trends or concerns about drug utilization through the review of FFS claims data and MCO encounter data. The MCOs are contracted to have a RetroDUR program. Because the pharmacy benefits are both carved in and carved out simultaneously, the State has set up a daily file containing pharmacy claims to allow the MCOs to perform a more reliable RetroDUR process with the latest claim data. The State also holds quarterly meetings between the State and the MCO pharmacy leadership to review policy updates including but not limited to the SUPPORT Act, MME/MED standards, coverage and PA changes, among other things.
Virginia	The DMAS DUR pharmacist attends all FFS and MCO DUR Meetings and ensures that both the FFS and the MCOs are in compliance with all the RetroDUR programs. Several reports are run quarterly and reviewed for both FFS and MCOs to make sure all are in compliance.

State	Explanations
Washington	HCA requires several deliverables from our contracted MCOs that assist us with monitoring RetroDUR. These include: 1. Quarterly AHPDL Compliance report 2. Quarterly MCO drug rebate report 3. Quarterly MCO MAC List 4. Quarterly Network Pharmacy Reimbursement Reconciliation report 5. Quarterly Prescription Drug Authorization report 6. Annual List of drugs allowed through Specialty pharmacies 7. Quarterly Underpaid Pharmacy Claims The deliverables in combination with MCO encounter data are used to conduct retro-DUR analysis of drug spend, utilization, as well as over all program compliance. HCA uses the results of our analysis to inform us of potential pro-DUR opportunities, changes to drug status on our AHPDL, clinical policies development, and potential MCO contract changes. Examples of the retro-DUR activities conducted in FFY 2020 can be found in section III. HCA's Medicaid Compliance Review and Analytics team in collaboration with the Prescription Drug Program conducts annual reviews called TeamMonitor (42 CFR, part 438.66 State monitoring requirements) which includes verification of the following: 1. Evidence that providers are informed about Partnership Access Line resources, including the Washington Partnership Access Line (PAL) and PAL for Moms. 2. Contraceptives are allowed up to a 12-month supply at a time and process or system coding in place to allow less than a 12-month supply if necessary. 3. Compliance of the single preferred drug list, Apple Health PDL (AHDPL), by providing examples of system coding and claims adjudication for 10 NDCs within 5 separate drug classes. 4. Proper AHPDL clinical policy implementation by providing decision processes for determining authorization requests, training materials and examples of an adverse benefit determination, approval and appeal for each of the following AHPDL policies: a. 65.00.00 - Opioids b. 66.27.00 - CAM Antagonists c. 45.55.00 - Pulmonary Fibrosis Agents 5. Documentation demonstrating consideration of EPSDT requirements by providing three examples of either an approval or denial. HCA's Program Integrity team requires Program Integrity Activities (PIA) monthly deliverable from each managed care plan. For FFY 2020, the following number of Audits, Reviews, Investigations were reported by the managed care plans for the PIA deliverable: 1. Amerigroup: 2 2. Coordinated Care of Washington: 1 3. Community Health plan of Washington: 1 4. Molina Healthcare of Washington: 0 5. United Health plan of Washington: 4 HCA created a provider enrollment and disenrollment processes to verify that terminated providers are no longer providing services to our clients. This is verified by using claims data, including encounters, to verify if any MCOs may have paid claims to terminated providers.

State	Explanations
West Virginia	West Virginia is a pharmacy carve-out state. The state oversees the FFS RetroDUR program. Aetna Better health: RetroDUR criteria approved by MCO DUR Board and Combination of medical and pharmacy directors Educational outreach is further explained in the MCO abbreviated survey The Health Plan: RetroDUR criteria approved by MCO and P & T board Unicare: Not applicable
Wisconsin	The drug benefit is carved-out from the MCO to fee-for-service. Fee-for-service is responsible for management of the DUR program for Wisconsin.

7. How does the state ensure MCO compliance with DUR requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K?

Table 263 - Explanations for How the State Ensures MCO Compliance with DUR Requirements

State	Explanations
Arkansas	The MCOs must submit quarterly reports to the State which include the same information required for the CMS annual survey. Any compliance issues would be addressed at that time. Each MCO (PASSE) is required to have a State representative as a voting member for their individual DUR Boards. Compliance is monitored through the MCO DUR Board meetings, and MCO ProDUR reports are presented during the FFS DUR Board meeting.
California	MCO compliance with DUR requirements is ensured through a detailed review of each MCO's annual report survey.
Colorado	Designated DUR program pharmacist contacts for the State's two MCOs collaborate with the State DUR Contact and other members of the State's Pharmacy Office team regarding DUR activities. MCO DUR contractual obligations are also managed through coordinated efforts involving the MCO contract management team within the State's Health Programs Office. Verification and monitoring of MCO compliance with DUR requirements is conducted by direct communication from the State to the MCO DUR program pharmacist contacts.
Delaware	Delaware ensures MCO compliance with DUR requirements of the act by requiring that MCOs employ a prospective and retrospective DUR program, provide education to enlisted providers, and comply with DUR board requirements.
District of Columbia	An amendment to the existing MCO contracts was made in October 2019 to add language requiring compliance with DUR requirements described in Section 1927 (g) of the act and 42 CFR part 456, subpart K. These same contractual requirements were incorporated into the new MCO contracts awarded in October 2020. In addition, DHCF conducts monthly MCO Pharmacy oversight meetings that always include review and assessment of MCO DUR activities, trends and initiatives required by the SUPPORT Act.

State	Explanations
Florida	MCO plans participate with the State DUR Board. The State complies with all provisions by having a DUR program that includes: Prospective drug review Retrospective drug review Education to providers on common drug therapy problems Claims reviews to identify medications trends, misuse, overutilization, underutilization, therapeutic or ingredient duplications, appropriateness, medical necessity, fraud, etc. The State conducts DUR Board meetings on a quarterly basis and applies all of the above aspects in its detailed analyses and documentation and on an annual basis reports to CMS on the details and compliance of the program. MCO plan data is reviewed during the DUR meeting along with fee-for-service data.
Georgia	The State monitors MCO's quarterly submissions of proDUR/rDUR reports.
Hawaii	Surveys and provider input have identified multiple issues. A meeting of all MCOs has been welcomed and a corrective action plan for compliance is in place for FFY2020, with expansion of the corrective action plan in FFY2021. State direction is documented in MCO memorandums. Follow up on the OIG's audit of Hawaii continues.
Illinois	HFS monitors information submitted in the annual DUR report to ensure compliance. HFS plans to require MCO attestation for FFY21.
Indiana	Managed care organizations are required to present to the DUR Board and OMPP representatives are present at these meetings.
Iowa	The MCOs are required to follow the fee-for-service (FFS) preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits. The state and MCOs work collaboratively to establish the DUR Board (Commission) meeting agendas and activities. Additionally one MCO representative is non-voting member of the DUR Board (Commission). The DUR Board (Commission) provides recommendations for new and revised PA criteria, utilization edits or prospective drug utilization review (proDUR) edits, retrospective drug utilization review (retroDUR) initiatives and provider educational initiatives. The MCOS must enforce the Iowa Medicaid FFS proDUR (hard and soft) edits through their pharmacy POS claims processing system. MCOs must also participate and collaborate in carrying out all aspects of retroDUR initiatives and provider educational program/interventions. The MCOs also participate in the Pharmaceutical and Therapeutics (P&T) Committee meetings, who make recommendations on PDL status of drugs. For monitoring compliance, various reports, including prevalence reports and proDUR/retroDUR initiative reporting, are shared by each MCO and FFS at the quarterly DUR Board (Commission) meetings. Additionally regular quarterly meetings (and as needed) meetings are conducted between the FFS pharmacy staff and MCO Pharmacy Directors to ensure compliance, address questions and provide clarifications on expectations.

State	Explanations
Kansas	In addition to our annual MCO oversight reviews, we have the following processes/supports in place. These requirements are included in a state policy, which also applies to the MCOs. Provider bulletins are used to notify the providers of program changes. Providers do make the state aware if they come across inconsistencies between the provider bulletin sent/posted by the state and provider experience. The state also reviews claims data, which assists in finding any potential non-compliance by the MCOs. The MCOs are required to have all provider education and marketing materials peer reviewed by the state before use.
Kentucky	As part of its DUR activities, the Contractor shall work collaboratively with the Department on related pharmacy initiatives such as the universal policy implementations, the pharmacy lock-in program, buprenorphine provider programs, and other initiatives as identified by DMS. The Contractor shall provide a detailed description of its drug utilization review program activities to the Department on an annual basis. The actual date shall be determined by the Department and in sufficient time to gather the information necessary to comply with and time submit the CMS Annual DUR report. The Contractor shall provide all data necessary for appropriate CMS Annual DUR Report submissions including, but not limited to, completing the Contractor's portion of the actual annual report template furnished by CMS and within the requested timeframe. At the request of DMS, quarterly written reports of DUR activities shall be provided to the Department. All Managed Care Organizations (MCOs) contracted with the Kentucky Department for Medicaid Services will have drug utilization review provisions as outlined in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. These provisions will include utilizing safety edits related to duplicate and early fills, quantity limits, dosage limits, and morphine milligram equivalents (MME). All MCOs will utilize safety edits for concurrent prescribing of opioids and benzodiazepines and opioids and antipsychotics. Additionally, all MCOs must have a program in place to monitor antipsychotic medications by children and document the appropriate actions taken based on the program.
Louisiana	The state reviews monthly MCO DUR reports.
Maryland	Maryland Medicaid has had a comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefit. A review of the Standards for drug use management programs occurs annually and Standards were updated to be in compliance with updated Federal regulations regarding DUR programs for both FFS and MCOs. These Standards are used for the internal annual review of the drug use management programs. This assessment occurs annually and is required under Maryland regulations for all who participate in the Medicaid program. Additionally, the Department has been proactive in providing guidance to MCOs regarding updated requirements for DUR programs.
Massachusetts	Contract managers ensure MCOs are meeting contract requirements including alignment with state's DUR program. in addition, the state meets monthly with representatives of the MCOs to address any changes and updates.
Michigan	MCO contracts were updated to require compliance with the DUR requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K. The state's Health Plan Division oversees compliance with all MCO contract requirements via ad hoc inquiries, site visits and focus studies. Additionally, the MCOs are required to provide reports to the State

State	Explanations
	demonstrating compliance. Lastly, there is an established process for the state to investigate any reported compliance concerns.
Minnesota	MCO compliance is monitored with the contract and rule both through the CMS annual report and quarterly reports with regards to prior authorizations that are responded to within the 24 hour requirement as part of the contracts.
Mississippi	DOM oversees one common drug utilization review board for MCO and FFS beneficiaries. Each MCO's pharmacy account manager is required to attend all drug utilization review board meetings and to participate with DOM in implementing drug utilization review board initiatives. Each MCO is contractually obliged to have a drug utilization review program to conduct prospective and retrospective utilization review of prescriptions.
Missouri	Pharmacy benefits are carved out of Managed Care
Nebraska	Audits
Nevada	MCOs must operate a drug utilization review program for covered outpatient drugs that includes prospective drug review, retrospective drug use review, application of standards and an education program in compliance with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR part 456, subpart K. Each MCO must provide a detailed description and information about its drug utilization review program activities by December 31 of each calendar year for the prior federal fiscal year..
New Hampshire	The contract requires compliance and this is monitored by the Quality Unit and Contract Management.
New Jersey	MCOs are required to submit prior authorization policies annually to the State for review and approval. These policies are required to meet all CMS guidelines, NJ Medicaid Managed Care contract requirements, applicable state and Federal guidelines, and national accreditation standards. The State, assisted by an actuarial vendor, review the MCOs' utilization of these policies annually through encounter data to confirm DUR requirements are being managed efficiently and appropriately. Any changes to policies regarding the MCO outpatient DUR program, including prospective drug review, retrospective drug use review, and an educational programs, must be approved by the State prior to implementation. See responses above for additional information.
New Mexico	MCO compliance and DUR requirements are monitored through the quarterly pharmacy reporting that is submitted to the state.
New York	The NYS Medicaid Managed Care Model contract requires MCOs provide coverage of outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act, in alignment with standards for such coverage imposed by Section 1927 of the Social Security Act. Additionally, in accordance with 42 CFR 438.3(s)(4), MCOs are required to operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR 456, Subpart K. The NYS Medicaid Pharmacy Program monitors the MCOs using encounter data to ensure compliance of the above provisions. https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
North Dakota	The MCO has reviewed their processes with the state staff to ensure compliance.
Ohio	There is language for the requirements in the provider agreement with the MCPs. Also, ODM published the Minimum standards for SUPPORT Act compliance available at: Letterhead | Administration (ohio.gov). MCPs were required to submit to the department how they were currently meeting or how they plan on meeting the minimum standards within the SUPPORT Act guidance by the stated deadline.

State	Explanations
Oregon	Oregon reviews each completed CMS annual survey and compares responses to state and federal expectations. If a response raises a compliance concern, OHA investigates and requires corrective action as appropriate. MCO contracts require implementation of a DUR program as described in Section 1927(g), 42 CFR 438.2(s)(4)-(5) and 42 CFR Part 456, Subpart K. MCOs are required to maintain policies and procedures for their DUR programs and provide these policies and procedures when requested. In addition, OHA meets with MCO pharmacy Directors and representatives in even-numbered months to discuss DUR and other topics relevant to pharmacy program operations and policies.
Pennsylvania	The State includes the requirement for a DUR program in the MCO agreements, approved by CMS. The MCOs submit annual DUR Reports as required by the Act. MCOs are monitored for compliance with the MCO agreement. DHS receives and reviews the DUR reports submitted by the MCO. DHS also reviews and approves DUR policies submitted to the Department.
Rhode Island	The Contractor is required to be submit the following reports to EOHHS 1. Report information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor. 2. In accordance with 42 C.F.R. 438.3(s)(5), the Contractor will establish procedures to clearly identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing 3. A detailed description of its drug utilization review program activities to EOHHS on an annual basis. The Contractor must have Contractor must have automated drug utilization review safety edits for opioid refills Automated claims review process to identify refills in excess of State limits Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics) Maximum daily morphine equivalent (MME) safety edits; and Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.
South Carolina	8.2.1. At a minimum, establish Policies and Procedures consistent with 42 CFR 456 and 42 CFR 438.3(s)These Policies and Procedures must address the following provisions: 8.2.1.7. Operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Act and 42 CFR 456, subpart K, as if such requirement applied to the CONTRACTOR instead of the Department. 8.3.2. In accordance with 438.3(s)(5) provide the Department a detailed description of its drug utilization review program activities annually. https://msp.scdhhs.gov/managedcare/sites/default/files/2018%20MCO%20Contract%20Boilerplate%20-%20Amendment%20VII%20Final.pdf
Tennessee	First of all, when discussing ProDUR, since the MCO's provide only physician administered covered outpatient drugs, it isn't possible to have online, real-time ProDUR as in pharmacy

State	Explanations
	claims via a PBM, where all ProDUR is instantaneous. However, we feel that the best two examples that we can offer would be: 1. diagnosis information that is provided by the MCO's are used as SmartPA in the PBM's system, allowing PA's to be approved when diagnosis is the primary criterion, and 2. The MCO's prospectively do approve many medications with pre-certification, similar to prior authorization with a PBM. During pre-certification the MCO determines that the product is safe, effective and medically necessary for the member. 3. Because the physician administered drugs are not reviewed by TennCare's P&T, known as PAC (Professional Advisory Committee), they are instead reviewed by each MCOs P&T, which reviews products and categories of drug to ensure safety, efficacy and pharmacoeconomic value. Regarding RetroDUR as found in Section 2(B) of the Act, and regarding identifications of patterns of fraud, abuse, gross overuse, etc., we noted in the previous answer number 6., that the MCO's are required under their contracts to have edits in place to alert them of suspicious behaviors, and to report found behaviors to their respective SIU's. Some details are available in the Abbreviated MCO reports attached to this submission. Regarding Section 3 of the Act, 2 out of the 3 MCO's are present on TennCare's DUR Board, as 2 of the medical directors are TennCare DUR Board members. Both of these providers are not only medical directors with our MCO's but they both still have practices, and provide patient care, and are therefore meeting the membership requirements of the Board being comprised of at least 1/3 actively practicing physicians. Our opinion is that although the MCO's do not have their own DUR Boards for TennCare's business, that the MCO's are satisfying this requirement with representation in TennCare's DUR Program via two Medical Directors being contributing members on TennCare's Board. With regard to FWA, the MCO's and their auditors and surveillance units are active in many different aspects in combating FWA, however the DUR Board is not privy to this type of activity as the MCO's work through TennCare's Office of Provider Integrity in combating FWA from providers and with the State of Tennessee's Office of Inspector General, an agency that was created purely for the detection and investigation of FWA from TennCare members. Some details surrounding FWA activities are found in the MCO Abbreviated DUR reports submitted with this report.
Texas	In addition to the assessment of MCO DUR programs during a Readiness Review and each MCO's annual submission of a detailed report of their DUR activities, MCO DUR programs are evaluated every two years during through an Operational Review
Utah	The State ensures compliance through the inclusion of contract provisions of the specific DUR requirements as well as via regular meetings between the State and the MCO pharmacy leadership.
Virginia	The DMAS DUR pharmacist attends all FFS and MCO DUR Meetings and ensures that both the FFS and the MCOs are in compliance with all the RetroDUR programs. Several reports are run quarterly and reviewed for both FFS and MCOs to make sure all are in compliance.
Washington	HCA has developed the following to ensure MCO compliance of DUR requirements: 1. A utilization dashboard, including both FFS and MCO claims/encounter. This data is used to conduct retro-DUR analysis of drug spend, utilization, as well as overall program

State	Explanations
	compliance. HCA uses the results of our analysis to inform us of potential pro-DUR, identify clinical policies development or other interventions. 2. Reports related to the SUPPORT Act for opioid MME, co-prescribing and psychotropic use in children. These reports will be used to conduct analysis and make recommendations for follow-up oversight activities to one of the following: HCA Program Integrity, HCA Quality Management Team, Managed Care Review and Analytics Team, Patient Review and Coordination Team, or to the Pharmacy Team for a DUR activity. 3. HCA's Prescription Drug Program, in collaboration with HCA's Medicaid Compliance Review and Analytics team, conducts annual reviews called TeamMonitor (42 CFR, part 438.66 State monitoring requirements). Part of this review is to ensure proper implementation and compliance of AHPDL and clinical policies approved by the Washington State DUR board.
West Virginia	WV is a pharmacy carve-out state. The MCO shall comply with Section 1004 of the SUPPORT for Patients and Communities Act and the Drug Utilization Review (DUR) regulations as described in section 1927(g) of the Act and 42 CFR part %u00a7456, subpart K. The MCO shall be subject to both prospective and retrospective requirements, as applicable, dependent on whether the medication is administered via point of sale or clinically. The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point of sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services. The MCO shall be subject to following provisions of Section 1004 of the SUPPORT for Patient and Communities Act: 1. Claim Reviews: a. Retrospective reviews on opioid prescriptions exceeding state defined limitations on an ongoing basis. b. Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. 2. Programs to monitor antipsychotic medications to children: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines. 3. Fraud and abuse identification: The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.
Wisconsin	The drug benefit is carved-out from the MCO to fee-for-service. Fee-for-service is responsible for management of the DUR program for Wisconsin.

8. Did all of your managed care plans submit their DUR reports?

Figure 151 - Managed Care Plans Submission of DUR Reports

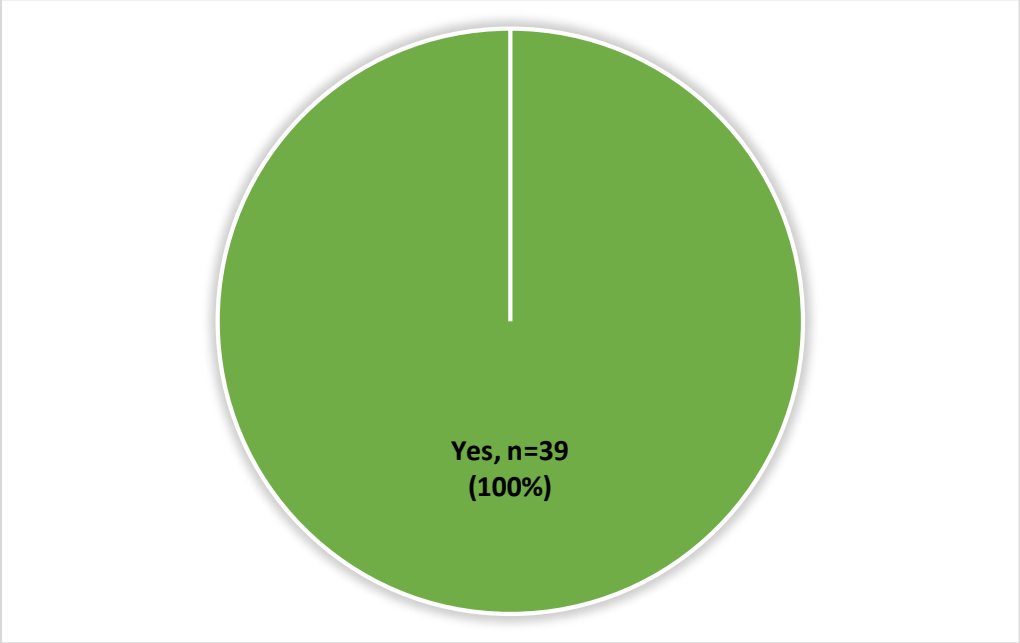

Table 264 - Managed Care Plans Submission of DUR Reports

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	39	100.00%
Total		39	100.00%

If "No," please explain.

Table 265 - Explanations for Managed Care Plans Not Submitting DUR Reports

State	Explanations
N/A	N/A

Section XI - Executive Summary

1. Summary 6 – Executive Summary

Summary 6 - Executive Summary should provide a brief overview of your program. It should describe 2020 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives

Table 266 - State Executive Summaries

State	Executive Summaries
Alabama	The AL Medicaid Drug Utilization Review (RDUR) report in its entirety serves as the summary for the RDUR Program for the AL Medicaid Agency covering Federal Fiscal Year (FFY) 2020.
Alaska	Executive Summary for Annual DUR report for FFY 2020 The Alaska Medicaid Drug Utilization Review (DUR) committee met for four scheduled meetings in FFY 2020. The committee strives to ensure recipients have access to medically necessary pharmaceutical therapies to yield the best clinical outcomes while concomitantly considering the fiscal and time impact on the users of the system. The interdisciplinary nature of the DUR committee provides for consideration of a breadth of perspectives, as does the members' varied practice locations around the state. Prescription drug costs have steadily risen over the past several years despite many older medications now having generic equivalents in the market place. The committee is dedicated to help promote safe and effective use of medications by approving prospective claims processing edits that are reasonable and sensible. Reaching out to providers by varied means and educating them of the edits has been a challenge. Advances in FFY 2020 will aid in solving these challenges. The committee continues to utilize and explore expanded opportunities for electronic educational communication avenues as alternatives to paper mailings. Prospective Drug Utilization Review (ProDUR) The generic utilization from FFY 2019 (81.9%) to FFY 2020 (82.96%) experienced a 1.06% increase, which contributes to a grand total of an 10.56% increase since FFY 2012. The generic expenditure for FFY 2019, as a percent of total costs, was 17.9%. In FFY 2020, this number decreased to 16.9%. The influencing factors can be attributed to the constant focus on new clinical edits and diligence to promote the utilization of equally effective generic therapies while maintaining a high standard of care. Coupled to this, however, is the dilution of generic drug cost savings from steadily rising branded drug costs with no generic equivalent. Maintaining the stability of the program without negatively impacting patient care, or outcomes, is primarily addressed by incorporating new edits at the point of sale. Therapeutic duplication, refill too soon, drug disease interaction, drug/drug interaction, drug/pregnancy interaction, drug to age, quantity limit, and prior authorization edits are valuable tools that aided in safety, appropriate utilization, and cost containment successes during FFY 2020. High cost specialty medications for infectious disease, oncology, hematology, and immunology in particular continue to increase the criticality of the DUR committee's decisions. In light of increasing costs, ensuring rational, evidence-based utilization of medications across the spectrum is imperative. Resource consideration coupled with sound clinical decisions is essential to the sustainability of Medicaid pharmacy programs in this new pharmaceutical era.

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	Retrospective Drug Utilization (RetroDUR) The RetroDUR portion of the committee meetings during FFY 2020 relied primarily on the review of aggregate claims data. Various educational means were employed, including sending informational letters to prescribers. The committee members are very passionate about sharing information within the medical community; communicating meaningful information can be a challenge when the reviews are limited to the Medicaid claims. The committee continues to explore other communication channels to provide meaningful education to prescribers and providers around the state. Conclusion In FFY 2020 the DUR committee reviewed issues with respect to therapeutic appropriateness, overutilization, therapeutic duplication, drug-disease and drug-drug interactions, inappropriate dosing and duration. The committee addressed these issues through the utilization of quantity limits, prior authorization, point-of-sale edits, and educational materials. These initiatives have translated into an increase in appropriate drug utilization, prevention of waste, and promotion of cost saving options while maintaining positive outcomes. The committee will continue to focus on appropriate drug utilization, safety and efficacy issues, maintaining accessibility, diversion control, and use their professional knowledge of unique Alaskan healthcare delivery challenges when applying standards and interventions on behalf of the Alaska Medicaid Pharmacy program for the delivery of quality care to beneficiaries.
Arkansas	ARKANSAS EXECUTIVE SUMMARY FFY2020 The purpose of Drug Utilization Review (DUR) Board is to improve the quality of care for Arkansas Medicaid clients receiving prescription drug benefits by assuring that prescriptions are therapeutically and medically appropriate while conserving program funds. The Arkansas Medicaid DUR Board is governed by the Arkansas Department of Human Services and includes prospective drug utilization review, retrospective drug utilization review, and education for prescribers and pharmacists to reduce fraud, abuse, gross overuse, excessive utilization, or inappropriate or medically unnecessary care. The DUR Board composition includes five (5) physicians with varied specialties and six (6) pharmacists from various fields that are voting members. Arkansas has three MCOs (Provider-Led Arkansas Shared Savings Entity (PASSE)) that are represented by one non-voting member each. The Board has 2 ex-officio advisors- Department of Human Services medical director and the Secretary of Health from the Department of Health. The chairperson is a pharmacist from the Medicaid Pharmacy Program. The DUR Board meets quarterly in January, April, July, and October. Multiple meetings during FFY2020 were held virtually due to COVID-19. TYPES OF EDITS The clinical criteria edits may use either point of sale (POS) clinical approval algorithms or a clinical manual review PA for approval of a particular drug. If a client does not meet the established prior approval criteria, the prescriber may submit a request in writing to provide additional documentation to substantiate the medical necessity of the client receiving the drug in question, or the prescriber may change the drug to an alternative drug that does not require prior approval. Drug claim edits are limitations placed on drugs or drug classes using gender, age, daily dose, monthly quantity allowed, quantity allowed per claim, or accumulation quantity edits that allow up to a certain quantity over a period of time.

State	Executive Summaries
	In addition to clinical edits and claim edits, AR Medicaid Pharmacy Program has a preferred drug list (PDL). The drugs may be listed as preferred status, preferred status with criteria, non-preferred status, and non-preferred status with criteria. The non-preferred drugs on the Preferred Drug List will deny at point of sale and require an approved manual review authorization in order for the claim to pay. The prescribing provider must submit a request in writing explaining the medical necessity for the client to receive the non-preferred drug over the preferred drug(s), or the prescriber can change the prescription to a preferred drug as an alternative drug that does not require a prior approval. The Pharmacy Program staff use an evidence-based approach for developing proposals for the DUR Board to review and approve at the quarterly meetings, including clinical PA criteria algorithms and drug claim edits (quantity edits, dose edits, cumulative quantity edits, age, or gender edits) that will support appropriate and safe prescription drug use. Although it is important for the AR Medicaid Pharmacy Program to conserve program funds using these types of drug claim edits and prior authorization criteria, the success of the AR Medicaid Pharmacy Program is not measured by cost savings or cost avoidance alone. The evidence-based approach to safe and clinically appropriate use of prescription drugs is a strong foundation on which we have built our pharmacy program so that we may protect the vulnerable, promote better health, and provide improved outcomes in a cost-effective manner. FFY2020 HIGHLIGHTS: COVID-19 Much of our accomplishments during FFY2020 were overshadowed by the impact of COVID-19. Some programs and policies were delayed due to ensuring our clients were taken care of during this pandemic. To assist with social distancing, early refill edits and accumulation edits were temporarily removed. The short-acting beta agonist inhalers were all made available without a PA despite being on the PDL. And quantity edits on aerochambers were removed. Our clinical team would approve prior authorizations for an extended period of time due to patients not going to their doctors. MEDICATION ASSISTED TREATMENT Beginning January 1, 2020, Arkansas Medicaid removed prior authorization requirements for preferred buprenorphine products on the Arkansas Medicaid evidence-based preferred drug list. With a valid prescription for opioid use disorder, the preferred MAT medications do not require a PA. Prescriptions for MAT medications do not take up a Medicaid slot and do not require a copay for the client. Quantity edits based on FDA approved dosing recommendations and therapeutic duplication edits still apply DUR BOARD ACTION The DUR Board created POS criteria edits for multiple medications to help decrease the burden on our clinical review team. Medications included Lovaza, Lysteda, Entresto, Sensipar, Epogen and Procrit. Also POS edits and manual review requirements were removed for Truvada for HIV PrEP.

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	The DUR Board reviewed and approved manual review criteria for 33 new medications, and the Board updated criteria and claim edits for 11 drugs/drug classes including gabapentin, targeted immune modulators, Hemlibra, Ingrezza, and Austedo. The DUR Board has always contributed to RDUR intervention criteria selection, but the Board has taken a more hands-on approach to choosing the actual intervention criteria. RDUR and ProDUR presentations during the Board meetings are an important component of the meetings to provide feedback to our Board members. DRUG REVIEW COMMITTEE (DRC) The DRC reviews placement of drug classes on our preferred drug list (PDL) and meets quarterly in February, May, August, and November. The committee is comprised of 3 physicians and 4 pharmacists that are voting members with a representative from each PASSE as a non-voting member. The chairperson is a pharmacist from the Medicaid Pharmacy Program. The committee composition is varied in experience to ensure knowledge in many aspects of medicine. The Committee votes on placement of preferred and nonpreferred agents based on safety and efficacy data provided by a Magellan clinical pharmacist. Arkansas Medicaid has a private cost committee that discusses rebates and final net cost. The recommendations from both committees are taken into consideration when determining the final PDL. Several new PDL classes were added in FFY2020 which included CGRP-receptor blockers, bone resorption suppression and related agents, Opiate Dependence Treatments (injectable only), Glucagon Agents, and Immunomodulator Ophthalmic Agents. FFY2021 GOALS FFY2021 goals are an extension of our last year's goals which include tracking response and expenditures for cystic fibrosis and implementing edits to decrease polypharmacy. Another goal is filling all DUR Board and DRC open positions which has been a challenge.
California	The purpose of Drug Utilization Review (DUR) is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. California's Medi-Cal DUR program is the responsibility of the Department of Health Care Services (DHCS), and includes prospective DUR reviews, retrospective DUR reviews, and educational interventions for providers and pharmacies. During federal fiscal year (FFY) 2020, California's Global Medi-Cal DUR Board (the Board) included nine pharmacists and five physicians, meeting OBRA 1990 requirements. The Board held four meetings in FFY 2020, with each meeting divided up into two distinct sections: 1) old business and follow-ups; and 2) new business that included placeholders for updates from DHCS and the DUR Board, drug utilization reports, prospective and retrospective DUR reviews, and descriptions of educational bulletins and/or alerts. The Board is responsible for advising and making recommendations to DHCS for the Medi-Cal population. Over the course of FFY 2020 the Board reviewed prospective DUR criteria for 49 drugs. In addition, retrospective DUR criteria were reviewed for antihyperglycemic medications, fluoroquinolones, ADHD medications, hepatitis C virus (HCV) medications, Beers criteria drugs, and all medications that became available on the Medi-Cal Contract Drugs List in FFY 2018. A total of eight educational bulletins and alerts were published on the Medi-Cal website in order to educate and inform Medi-Cal providers and beneficiaries on timely and relevant topics related to medication use. A total of seven educational mailings were sent to

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	selected prescribers to improve the quality of care for Medi-Cal beneficiaries. Finally, in FFY 2020, the Board continued to collaborate with key state agencies and national experts, and actively worked to incorporate a variety of Medi-Cal MCO best practices across multiple plans into the Board meeting agenda. This Annual Report was prepared through a collaborative effort between the California Department of Health Care Services, the Global Medi-Cal Drug Use Review Board, DXC Technology, Inc., and the University of California, San Francisco.
Colorado	The Health First Colorado (Colorado Medicaid) FFS DUR program is now in its eighth year of collaboration with the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Science (SSPPS). The DUR program continues to contract with a pain management specialist and a child and adolescent psychiatrist for teleconsultation services. In addition to the sub-contracted specialists, there are two clinical faculty members, an administrative faculty member, an analyst, and a pharmacy outcomes researcher involved in conducting DUR-related analyses and performing other DUR program activities. One clinical faculty member serves as a contracted clinical consultant and SSPPS liaison to the State, working directly with the State DUR Contact and other members of the Department's Pharmacy Office team. During the time period of the reporting fiscal year, Colorado's FFS DUR program added upon work performed previously related to the SUPPORT for Patients and Communities Act with development of a RetroDUR-generated provider educational outreach letter promoting use of naloxone in high-risk patients and a pharmacy claims systems edit for concomitant use of opioid and MAT medications. Collaborative work has continued with MCO DUR programs to ensure compliance with SUPPORT Act DUR provisions. In response to the COVID-19 pandemic, changes were made to pharmacy policies and systems edits for early refill, mail-order prescriptions, and prior authorization requirements for cough and cold medications. The DUR team also conducted an analysis to identify trends or potential changes in opioid utilization during the pandemic and with respect to issuance of stay-at-home orders. Additional DUR and policy-related medication management changes made during the reporting fiscal year included incorporation of patient-specific clinical lab data into pharmacy claims systems edits, implementation of a claims systems edit for automated PA approval of oral MAT medications, and expansion of vaccine coverage to include pharmacist-administered influenza vaccines. DUR Board meeting agendas have continued to be very full as additional drug classes have been added to the State's FFS pharmacy PDL. New PDL classes added during FFY 2020 included ophthalmic anti-inflammatory agents, self-administered glucagon agents, lithium products, and hemorrhoidal and related anorectal agents. The DUR Board continues to have high quality discussion leading to high quality recommendations made to the Department. Though changes were made to accommodate for the need to conduct public DUR Board meetings virtually, meetings continue to occur at a quarterly frequency and last approximately 4-5 hours.
Connecticut	Objectives for the operations of the Connecticut Medical Assistance Drug Utilization Review (DUR) Board during federal fiscal year 2020 include: (1) maintain a DUR Board with membership that meets OBRA 1990 requirements; (2) continue prospective DUR criteria review and evaluation, (3) conduct focused retrospective analyses of claims data to study drug utilization in the Connecticut Medical Assistance Program including the fee-for-service population and to (4) guide the development and implementation of educational interventions to improve drug use in this population.

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	From 10/01/2019 to 9/30/2020 the DUR Board was comprised of six pharmacists and three physicians. Four DUR Board meetings were held during FFY 2020. Twenty-four targeted retrospective analyses were reviewed and approved by the DUR Board and conducted during FFY 2020. All the retrospective evaluations included mailing of recipient specific educational intervention letters to prescribers. Recipient specific educational intervention letters highlight a drug therapy concern and are sent to prescribers with a complete recipient drug and diagnosis history profile along with a response form. An additional 12 retrospective analyses for the pharmacy lock-in program were conducted during FFY 2020. The Pharmacy Lock-In Program is ongoing and HID was required to review 800 lock-in profiles monthly. A summary report of the activities of the regular DUR and Lock-In Program during FFY 2020 is included within the report. For the future, the DUR Board aims to accomplish the following: (1) provide recommendations to help improve drug therapy in the Connecticut Medical Assistance Program population, (2) analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service, (3) recommend and review prescriber interventions and educational programs and (4) serve in an advisory role for the development and management of a Pharmacy Lock-In Program. Cost Savings analyses of both prospective and retrospective DUR are reported and can be found in Summary 4 of the CMS Report. The reported cost savings for Retrospective DUR during FFY 2020 from HID was $6,028,169. The reported cost savings for Prospective DUR during FFY 2020 was $112,215,597.
Delaware	Federal Fiscal Year 2020 brought the novel challenge of responding the COVID-19 public health emergency but also the opportunity to show resiliency and demonstrate flexibility. For example: %u2022Added PA requirement for Hydroxychloroquine and Chloroquine to avoid shortage for patients with chronic conditions, such as Lupus. %u2022Waived Pharmacy copays to ensure access for our all of our members who might have been affected by the financial downturn related to COVID-19 %u2022Expanded the PDL for rescue inhalers to remove any barriers patients could face in getting their much-needed breathing treatments %u2022Removed the POS edit for early refills on non-controlled substances to allow members to consolidate their trips to the pharmacy %u2022Strategized on how to adapt system changes and reimbursement policy for the anticipated COVID-19 vaccines that were eventually released mid December 2020: o Ensured consistent reimbursement with CMS on COVID-19 vaccinations o Worked quickly to ensure providers were able to submit claims for COVID-19 vaccinations %u2022In all of these endeavors, Delaware FFS and MCOs remained aligned to avoid provider confusion and ensure consistency for our members. Although the COVID-19 public health emergency occupied a significant focus for Delaware, we can reflect back on other wins for Federal Fiscal Year 2020. In line with the SUPPORT ACT we accomplished the following: %u2022Added real time and retroactive provider notifications for patients on concurrent use of opioids with the following

State	Executive Summaries
	o Antipsychotics o Sedatives o Benzodiazepines o Muscle relaxants %u2022Reminded providers through blast fax that naloxone rescue medications are available in Delaware under a state standing order and at no charge to the patient. In addition, Delaware continues to utilize MMIS to automatically generating Retro%u2010DUR alerts to prescribers utilizing Pharmacy and medical information within the system. Provider specific letters with a compilation of clients is generated for portal retrieval, copies of the letters generated are data stored in document repository available for retrieval for faxing upon provider request. This system has served as a cost saving for the state through elimination of returned mail due to wrong addresses when an office relocation has occurred. It also guarantees the providers have access and receive these alerts. Delaware has continued to run all drug encounters through established edit/audit rules to track the MCO's management of the drug benefit aligned with Delaware State policies. MMIS generates a monthly report that tracks submitted encounter acceptance rate of our two MCOs. This report is utilized to analyze both MCO efficiency and compliance with all existing state policies and to identify potential modification In Federal Fiscal Year 2020 Delaware FFS served approximately 15% of the Delaware Medicaid population. This population continues to be a transient group where the majority will transition into one of our two Managed Care Organizations. To provide consistency for our members and providers, Delaware uses a unified PDL which optimizes cost savings across the entire program.
District of Columbia	The Drug Utilization Review Board focused on several areas of clinical concern for the District during FY2020. The opioid epidemic in the District of Columbia has been fueled in part by prescribed opioid drug misuse and abuse. The recent implementation of a Prescription Drug Monitoring Program (PDMP) did not include a legislative mandate for prescribers to query the PDMP for previous or current opioid utilization before writing a prescription. The DUR Board members recognizing that some opioid prescribers may not have specialized training in pain management decided to address this presumed knowledge gap. Led by the efforts of a DHCF staff clinical pharmacist, the Board worked with community-based thought leaders and Medicaid providers to prepare a working document entitled Guidelines for Collaborative Management of Opioid Use which addressed the opioid epidemic in the District. Discussion with these providers assisted the Board members in drafting recommendations for opioid treatment clinical criteria and best practices. Pending final approval by DHCF, the guidelines will be made available to stakeholders during FY21. The DUR Board worked with the DHCF MTM pharmacist to identify a list of OTC and prescribed medications that could safely be excluded from the calculation of polypharmacy limits under the Pharmacy Lock-in Program. Working in collaboration with the managed care plans, a uniform exclusion list was developed that would be implemented across the FFS program and each MCO to assure parity in the beneficiary lock-in criteria. Early in 2020 the Board was made aware that on October 1, 2020, approximately 17,000 FFS beneficiaries would be transitioned into managed care. Plans were made to actively incorporate involvement of the Pharmacy and Medical Directors of the MCOs into quarterly

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	DUR Board meetings throughout FY20 to mitigate the effects of the transition by proactively seeking common ground and identifying areas where DUR initiatives might be addressed collaboratively. This regular interaction has fostered an open dialogue that will positively impact the pharmacy benefit of all Medicaid members whether enrolled in FFS or managed care. The addition of a child and adolescent Psychiatrist to the Board membership has augmented the Board's ability to monitor antipsychotic, antidepressant, and stimulant use more closely in the Medicaid child population. The psychiatrist has been able to identify gaps in POS edits that did not adequately address prescribing parameters for different age ranges for some of these medications. Her recommendations led to added soft messaging on screen for pharmacists as well as several new edits that require professional code input to successfully adjudicate the claim. A targeted prescriber outreach education awareness program is being developed. The Board looks forward to future challenges and is committed to carrying out its oversight responsibilities for assuring that medications provided under the Medicaid program are safe, effective, and clinically necessary.
Florida	Drug Utilization Review Program Overview Magellan Medicaid Administration provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Florida Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients by reducing the potential for drug interactions as well as adverse drug reactions. Additional goals include conserving program funds and expenditures, as well as maintaining program integrity by controlling problems of fraud and benefit abuse. The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration (AHCA). The goal of the RetroDUR program is to promote appropriate medication prescribing by identifying patterns of potentially inappropriate prescribing or medication use. Once these patterns are reviewed and studied, potential interventions to address the issue are presented to the DUR Board for consideration. An analysis of the impact of planned interventions is created and agreed upon interventions are then communicated to physicians and/or pharmacists to improve prescribing and patient outcomes. Prospective Drug Utilization Review Program (ProDUR) ProDUR encompasses the detection, evaluation, and counseling components of pre dispensing drug therapy screening. The ProDUR system of Magellan Medicaid Administration assists the pharmacist in these functions by addressing nine different situations in which potential drug problems may exist. ProDUR is performed prior to dispensing and helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may have been previously unavailable. Because Magellan Medicaid Administration's ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. ProDUR recognizes that pharmacists utilize their education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid pharmacists in their professional duties. For certain edits, as determined by the DUR Board, ProDUR edits may be overridden by the pharmacist in such cases where the pharmacist, either

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	alone, or in consultation with prescriber has determined the accuracy and safety of the prescription. To accomplish the override, the provider must input the Reason for Service, Professional Service and Result of Service Codes in the appropriate fields. In other situations, as deemed appropriate by the DUR Board, no override of the ProDUR edit can be accomplished at the POS and a prior authorization must be obtained before the medication can be dispensed. This action adds an extra layer of safety in situations where the risks are known to be substantial or the prescribed therapy falls outside of nationally accepted standards of care. Magellan Medicaid Administration's ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing nine drug therapy problem types in which potential medication problems may exist. The screening types identified by Florida Medicaid's FFS ProDUR criteria are: Excessive Daily Dose (HD) - Alert occurs when the calculated dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific. Insufficient Daily Dose (LD) - Alert occurs when the calculated dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. Early Refill (ER) - Alert occurs when a prescription is refilled before 80 percent of the previously filled prescription's days' supply has elapsed. Therapeutic Duplication (TD) - Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous six weeks. Drug-Drug Interactions (DD) - Alert occurs when a drug that is to be dispensed may interact with a previously filled drug (within the previous six weeks) from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions. Ingredient Duplication (ID) Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy. Drug-Age Contraindication (PA) - alerts occur when a drug is dispensed that is not recommended for use in the age group of the patient. Underutilization (LR) - alerts occur when patients have waited to refill their maintenance medications beyond the specified days' supply of the previous fill. ProDUR Cost Savings ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden. Retrospective Drug Utilization Review (RetroDUR) The goal of the Florida Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug therapy problems, identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems. The operation of the RetroDUR program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration (AHCA). The RetroDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or

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	to examine prescribing patterns that are outside the established standard of care based on national guidelines or accepted standards of practice. The RetroDUR review process emphasizes medication classes where there is high utilization and/or high risk associated with those classes of medications. Recent updates to standards of practice, in the form of published peer-reviewed guidelines, as well as important safety communications from the US Food and Drug Administration (FDA) service are utilized to ensure timely reviews of important therapeutic issues affecting Florida Medicaid FFS recipients. Utilizing pharmacy claims history, medical claims history and diagnostic information captured on medical claims, Magellan Medicaid Administration is able to provide a robust analysis of utilization and identify areas of concern. These analyses are presented to the DUR Board quarterly, along with background information and details of currently accepted medical guidelines, to help guide recommendations for specific interventions or edits that may be appropriate to implement based on the RetroDUR findings. Impact analyses are performed regarding specific recommendations and the DUR Board is informed prior to the implementation of any such edits. A follow-up post edit implementation analysis is performed after a specified time interval and these results are presented to the DUR Board as well to ensure the intended outcomes of the edit are being met and resulting in improved quality of care for Florida Medicaid FFS recipients. Depending on the clinical situation, communication to prescribers and/or pharmacies may be accomplished through posting a banner message on the AHCA website or by direct mailings to specific providers who were identified as part of the RetroDUR process. Specific drug classes that will be reviewed at upcoming quarterly Pharmacy & Therapeutics (P & T) meetings are examined for recommendations by the DUR Board to serve the state collaboratively along with the members of the P & T committee. In this capacity, the DUR Board serves to provide advisory input to the P & T committee based on drug utilization patterns that are examined and reviewed as part of the RetroDUR process. RetroDUR Cost Analysis The provision of high quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. Magellan Medicaid Administration performs a post-edit implementation analysis for all RetroDUR interventions. This analysis examines any changes in number of claims, number of recipients or potential cost savings that may have occurred as a result of the intervention. Cost savings may vary due to a variety of factors including the particular class of medication, the intervention selected, the lag time before the recipient's next physician visit when changes in drug therapy may occur or changing patient demographics. Some interventions based on RetroDUR review emphasize the need to increase spending on a particular class of medications in order to improve adherence. Improved adherence for many classes of medications has been shown to improve outcomes and lessen other, long-term medical expenditures. Post implementation analyses of RetroDUR initiative in FFY 2020 demonstrated cost savings (per year) as documented below: Opiate and benzodiazepine concomitant therapy - $103.92 Stimulant and benzodiazepine concomitant therapy - $367,973.04 DPP-4 and GLP-1 concomitant therapy - $118,594.40 Antipsychotic polypharmacy - $153,937.72 Opiate and non-benzodiazepine sedative concomitant therapy - $44.80

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	Auto-PA Doxepin and Calcipotriene - $293,439.54 Opiate and Antipsychotic concomitant therapy edit - $51,567.76 Auto-PA Pancreatic Enzymes - $154,802.20 Short Acting Opiates Edits - $1,162,329.80
Georgia	The Drug Utilization Review Board (DUR Board, DURB or Board) continued its service to the Georgia Department of Community of Health (GDCH or DCH) in an advisory capacity. In this role, the DUR Board made recommendations related to the safe and effective use of medications for Medicaid Fee-for-Service members to the Department. During Federal Fiscal Year 2020 (FFY2020), the DUR Board was comprised of physicians and pharmacists from a variety of backgrounds located throughout the State of Georgia. The primary responsibility and charge to the Board was the continuing development and modification of the State of Georgia's Preferred Drug List (PDL) and Providers' Administered Drug List (PADL) for the Medicaid Fee for Service (FFS) program. Additionally, the Board offered its expertise to assist the State with development of prior authorization criteria, drug utilization reviews, increasing generic utilization, and advising on conditions for claims processing. Board Meetings follow parliamentary procedures and have a standing order of business, specifically: Call to Order Comments from the Department Approval of Minutes External Comments Session Executive Session New Drug Reviews Class Reviews Clinical Utilization Reviews Utilization Trend Review Drug Information Review Future Agenda Items Future Meeting Dates Boards' Recommendations Adjournment The clinical review of information includes input from several sources: NorthStar HealthCare Consulting (NHC) (review of medical literature including controlled clinical trials as well as clinical guidelines, drug safety alerts, generic availability report, new medication pipeline report); the pharmaceutical manufacturers (verbal presentations via the manufacturers' forum and written materials via electronic submission); external comments at the meetings; and the DUR Board members through their independent research and clinical expertise. Additionally, the Board sought clinical input from practicing clinical experts when supplemental information was needed. Drug classes previously reviewed by the Board are reconsidered on an annual basis. New market entrants that are subject to the outpatient drug benefit are reviewed after 6 months of market availability. During FFY2020, the DURB researched, reviewed and made PDL/PADL recommendations for the following drugs: Adakveo Oxbryta

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	Aklief Annovera Beovu Nourianz Rinvoq Vumerity Xenleta Nurtec ODT Reyvow Ubrelvy Vyepti Vyondys 53 Wakix Caplyta Esperoct Nexletol Palforzia Xcopri Xepi In addition to the drug classes which the new drugs above belonged to, the DURB also researched, reviewed and made PDL/PADL recommendations on several therapeutic classes.
Hawaii	Executive Summary Hawaii Medicaid provides 1/4 of the State of Hawaii's population with health care; the diverse demographics and extensive rural areas are major factors when considering DUR. FFS has less than 1% of the Medicaid population in the non-dental program: organ and tissue transplant, foster children out-of-state, breast and cervical cancer and intentional termination of pregnancy drug coverage. Program demographics result in 400 claims per month in FFY 2020 and enables manual review of random claims sampling as needed, quarterly or at least annually for the majority of DUR. By Hawaii law, Medicaid is not allowed to prior authorize any medications to treat the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or who is a patient in need of transplant immunosuppressives, approved by the United States Food and Drug Administration and that are eligible for Omnibus Budget Reconciliation Rebates Act (OBRA), that are necessary to treat the condition. Annual DUR reviews on patient drug profiles for the transplant program identified appropriate prescribing and utilization at the transplant centers, as well as foster children out-of-state profiles for medical necessity. Psychotropic use remains low due to the population served; DUR found no outlier on the few claims. All SUPPORT Act standards are done annually as no intervention has been necessary to date. Quarterly DUR of expensive drugs identified one claim with an eligibility issue; the claim was not reversed when retroactive to a MCO. Working with the dispenser, $90,500 will be recovered in FFY2021. DUR on amended reimbursement methodology to include national average drug acquisition cost has found cost savings on brand and generic drugs. The FFS dental program can service 340,000 but 1/5 of the eligibles utilize it: children have full dental care and adults have only emergency care. The dental formulary DUR highlights are as follows: outlier review found an off-island DDS filling a service gap for a community that lost an

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	oral surgeon. Dental providers are working with formulary with quantity limits. Fraud, waste and abuse are under control. Slowly MCOs are shifting their dental to FFS drug coverage. Quantity limits will be reviewed for adjustment to a recent Hawaii prescription drug monitoring program amendment. Virtual meetings with the MCO local pharmacists have begun on the SUPPORT Act and selected topics: educational and monitoring purposes are accomplished. Increasing compliance with CMS and Hawaii policies is the goal. Managed care plans have been included in the Hepatitis C, naloxone and Synagis reviews. Hepatitis C DUR showed continued decrease of need and it will be shifted to an annual review. Naloxone DUR found 0 FFS claims and a slowly increasing number of claims for managed care (which is extremely low) and will be also shifted to an annual review. Shared Synagis updates were from an annual state initiative by local pediatricians tailored to our Hawaii population and longer season. Collaboration within the medical community continues to be outstanding. Utilization has dropped and it will be shifted to an annual review. No end of life treatment has been requested by any Medicaid patient.
Idaho	During Federal Fiscal Year 2020, the activities of the Idaho Drug Utilization Review (DUR) Board were coordinated by Magellan Rx Management. Idaho Medicaid has developed and over the last decade continuously improved upon a successful DUR model that is different from that of most state Medicaid DUR programs. The model is a partnership between Magellan and the Idaho Medicaid program's staff clinical pharmacists. Medicaid's clinical pharmacists identify specific areas of concern and quality improvement opportunities. Magellan then pulls the specific data needed, including individual patient profiles, which are then analyzed by Medicaid clinical pharmacy staff. Both Magellan staff and Medicaid staff present study findings at our quarterly DUR meetings. The Division operates its own internal call center to manage the prior authorization (PA) program. Criteria are developed by our clinical staff and are operationalized through the Magellan automated PA system. The DUR Board is involved in outcome studies to review the impact of PA criteria and the preferred drug list (PDL) on utilization. They also identify problematic drug utilization issues for further DUR Board study. The DUR Board and P&T Committee work closely together to identify areas for improvement and evaluate interventions. Idaho Medicaid uniquely includes physician-administered drugs in our PDL evaluations, PA processes, and DUR studies to ensure appropriate use of drugs across the Medicaid program. This allows our clinical pharmacists to weigh in on the use of high-cost, physician-administered specialty drugs and ensure that Medicaid participants receive high quality and cost-effective care. During the time interval for this report, sixteen unique RetroDUR Studies (with follow up) were completed. These studies included educational interventions to prescribers and pharmacists, and strongly correlated with the P&T Committee's current areas of focus, including long term opioid analgesics for chronic non-malignant pain, treatment of opioid use disorder, and benzodiazepine use. Several of these studies are ongoing and are updated at each quarterly DUR meeting. All DUR studies have included insufficient dose, high dose, incorrect duration, overutilization, underutilization, therapeutic duplication, drug-drug interactions and drug-disease contraindications. Generic utilization for the Idaho Pharmacy Program is currently at 85%. We prefer brand drugs over generics in many instances until the generic is more cost effective which results in

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	cost avoidance of approximately $ 1.5 million per quarter. Net cost savings for Prospective DUR was $ 18,997,476 and for Retrospective DUR was $ 101,160. Innovative practices by the program this year were centered around activities that maintained cost savings and appropriate use in the new Medicaid Expansion population, especially regarding long-term opioid therapy for non-malignant pain as well as treatment of hepatitis C and HIV. This year Idaho State rules expanded pharmacist independent prescriber roles to many more drug classes to increase medical access particularly in rural areas. New rules also listed pharmacists in the same provider category as nurse practitioners and physician assistants. Based on these new designations, Idaho Medicaid enrolled pharmacists with NPI numbers as ordering, referring, prescribing providers (ORP) and added Medication Therapy Management codes to the fee schedule. Having pharmacists enrolled as ORPs ended up being a significant advantage for facilitating COVID testing and vaccination. Idaho Medicaid ensures appropriate drug utilization through the DUR Board, the P&T Committee, and an extensive PA system, including an automated PA system at point of sale. The Department puts emphasis on evidence-based drug information to develop and regularly review its 80 drug-class PDL and to create therapeutic prior authorization criteria. The pharmacy program is well respected within the Division of Medicaid and the Department of Health and Welfare. It continuously engages in quality improvement work to ensure our participants have access to the best drugs at the right price to facilitate good health outcomes.
Illinois	Throughout FFY20, the Illinois Department of Healthcare and Family Services (HFS) continued to strive to ensure the efficient operation of the Pharmacy Program, in part, by protecting against reimbursement for unnecessary or inappropriate services. During FFY20 the HFS Bureau of Professional and Ancillary Services, which includes Pharmacy Services, underwent several interim Bureau Chief transitions. A new Bureau Chief was appointed at the end of FFY20 third quarter. During FFY20 staff continued to adjust processes in the Pharmacy Benefit Management System (PBMS) for claims processing, in particular adding opioid-related edits in line with the SUPPORT for Patients and Communities Act (SUPPORT Act). In third quarter FFY20 HFS temporarily lifted some edits (for example, Four Prescription Policy, 3-Brand limit), relaxed refill-too-soon tolerances, enhanced the 90-day allowed maintenance drug list, and adjusted the Preferred Drug List and OTC coverage to help prescribers and participants weather the impact of the COVID-19 pandemic. In the second half of FFY20, staff pivoted to virtual direct-one-on-one academic detailing of prescribers about opioid use for chronic pain, the Illinois Prescription Monitoring Program, opioid alternatives for pain management, and opioid use disorder. The University of Illinois Department of Child and Adolescent Psychiatry DocAssist program continued to serve as a resource for review of stimulant use in children and for peer-to-peer consultation with prescribers to improve prescribing of mental health medications. During FFY20, focus continued on reduction of overutilization of narcotic agents and benzodiazepines, medication adherence, as well as appropriate use of medications for mental health issues, specialty medications, immunosuppressant medications, antiviral medications, and biological products. Cost savings have been realized as a result of improved utilization management of covered medications (after see numbers, this statement may need to be adjusted or removed). Retrospective review of steroid inhaler fills after the Inhaled Corticosteroid Prescription Request Form was sent to prescribers of montelukast monotherapy for asthma from April 2018 through February 2020 demonstrated a 41% to 47% increase in steroid inhaler fills for steroid-naive and steroid-experienced participants, respectively. Review of antipsychotic use in children led to recommendations to verify presence of antipsychotic polypharmacy in children 8 to 18 years of age. Other retrospective review focused on

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	concomitant opioid therapy with sedative-hypnotics, benzodiazepines, or antipsychotics and continued theophylline use. During FFY20, the DUR Board approved the educational items, Improving safety of ketorolac use and Call for pharmacists to help patients with asthma. Additionally, the link for the HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long term opioid analgesics was posted. Other educational initiatives addressed montelukast safety. Web sites continue to be maintained to provide information about DUR Board activities, DUR educational materials, as well as prior authorization criteria and forms. Illinois Public Act 101 0278 required establishment of an evidence based, non commercial education program for Medicaid prescribers consisting of a web based curriculum and academic educator outreach. This resulted in an HFS collaboration with the University of Illinois at Chicago College of Pharmacy to provide academic detailing services in Illinois. The Illinois Advance Website provides continuing medical education (CME), frequently asked questions, for example regarding various opioid prescribing issues, as well as opportunities to make an academic detailing appointment or have a drug information request answered. The academic detailing visits also allow providers to obtain CME. Illinois ADVANCE can be followed on LinkedIn, Facebook, and Twitter. At the end of FFY20, Fee-for-Service and Medicaid Managed Care pharmacy representatives met for the first time as a group to discuss potential collaboration for statewide initiatives regarding drug utilization.
Indiana	The State of Indiana is committed to operating a Medicaid DUR program that has a positive impact upon quality of care as well as upon pharmacy and medical expenditures. Prospective DUR (pro-DUR) and retrospective DUR (retro-DUR) each serve a unique purpose in providing practitioners and pharmacists with specific, focused, and comprehensive drug information available from no other source. For FFY 2020, the total estimated savings for the Indiana Medicaid pro-DUR program was approximately $53.96 million. The retro-DUR estimated savings were $3,102 in FFY 2020 due to only one retro-DUR finalizing financial savings in FFY2020. Two retro-DUR initiatives are not yet complete, and savings will be provided in FFY 2021. The total savings was estimated at approximately $53.96 million. The cost to administer both programs is $0.30 million, which results in a net savings of approximately $53.66 million. In FFY 2013, the State of Indiana transferred the management of the pharmacy benefit to OptumRx (previously Catamaran). OptumRx manages both the pro-DUR and retro-DUR programs, which were previously split between two contractors. OptumRx began the first real-time faxed prescriber retro-DUR intervention on August 1, 2014. Additional information regarding the specifics of the implemented retro-DUR programs is in Summary 1. The Indiana Medicaid Pharmacy program initiated several updates to prior authorization criteria as well as new utilization edits during FFY 2020. The Mental Health Quality Advisory Committee advised the DUR Board in regard to updates involving all mental health prior authorization criteria to provide streamlined, guideline-centered requirements. New and updated SilentAuth prior authorization criteria were implemented for the targeted immunomodulators, opiates, stimulants, monoclonal antibodies for the treatment of respiratory conditions, multiple sclerosis agents, COX II inhibitors and select non-steroidal anti-inflammatory agents (NSAIDs), and aromatase inhibitors. The DUR Board reviewed and approved the following new and updated manual prior authorization criteria: hepatitis C agents, cystic fibrosis agents, testosterones, narcolepsy agents, antimigraine agents, movement disorder agents, pulmonary antihypertensive agents, PCSK9 inhibitors,

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	Spinraza%u00ae, and muscular dystrophy agents. The DUR Board removed prior authorization criteria for buprenorphine and buprenorphine naloxone and gonadotropin-releasing hormone (GnRH) analogs. The Indiana Medicaid DUR program remains beneficial to the state, the provider community, and the beneficiary population served. OMPP continues to utilize and improve the retro-DUR and pro-DUR program through review of guideline-based care with the DUR Board.
Iowa	On April 1, 2016, Iowa Medicaid transitioned from 100 percent fee-for-service (FFS) to providing coverage through Managed Care Organizations (MCOs) for roughly 90 percent of its population. While this transition occurred over five years ago, the DUR program continues to evolve with the addition of Managed Care (MC). The MCOs are required to follow the FFS preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits. The state and MCOs work collaboratively to establish the DUR Board (Commission) meeting agendas and activities. Additionally, one MCO representative is a non-voting member of the DUR Commission, rotating every two years amongst the MCOs. The DUR Commission provides recommendations for new and revised PA criteria, utilization edits or prospective drug utilization review (ProDUR) edits, retrospective drug utilization review (retroDUR) initiatives and provider educational initiatives. The MCOs must enforce the Iowa Medicaid FFS ProDUR (hard and soft) edits through their pharmacy POS claims processing system. MCOs must also participate and collaborate in carrying out all aspects of retroDUR initiatives and provider educational program/interventions. The FFS program produced an estimated total cost savings of $10,412.04 versus an estimated total cost savings of $7,913.23 in FFYE 2019. While there was a slight increase in total savings over the prior FFY, savings continue to be nominal given the small population remaining in the FFS program. Patient-focused review saw a savings of $10,173.48 versus a savings of $1,317.31 in FFYE 2019. This increase in savings is due to the cost of the particular drug(s) involved in the therapeutic or cost-saving interventions. FFS member profiles are reviewed four times per year, coinciding with the four scheduled DUR meetings. Cost savings for the FFS problem-focused studies for FFYE 2020 is $238.56 versus $6,595.92 in FFYE 2019. The decrease in savings is due to the cost of the particular drug(s) involved in the intervention. The FFS program conducted a small problem-focused study based on claims review and as recommended by the DUR Commission. The FFS and MCOs collaborated on multiple retroDUR initiatives during FFYE 2020. Topics include High Dose Gabapentin; Duplicate SSRIs; Duplicate SNRIs; Baclofen Dose Exceeding 80mg per Day; and Opioid plus Baclofen.
Kansas	KANSAS MEDICAID (Executive Summary) Kansas Medicaid continues to monitor for patient safety and cost-effective drug use. Two common management tools used are the Preferred Drug List (PDL) Program, which includes a Consent Agenda Item Process and the Drug Utilization Review (DUR) Program which includes Step Therapy and Advanced Medical Hold Manual Review components. We continue to update clinical prior authorization criteria to be compatible with disease state clinical guidelines. The criteria also includes adherence to the PDL, where applicable. Disease activity scales/scores are incorporated into the criteria to evaluate the effectiveness of drug therapy. We continue to work with providers and PhRMA representatives for a better patient and provider experience. The DUR portion of the 2018

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	SUPPORT Act involved increased communication with many stakeholders, particularly Opioid Use Disorder specialty providers. We maintain quarterly meetings with the state pharmacy associations. The NADAC lesser of reimbursement methodology continues to be a well-received change to the program. In general, FFS and the Managed Care Organizations (MCOs) are both under the direction of the State, so this provides greater consistency throughout the drug program. The result is a better patient and provider experience. Additionally, we continue to improve and expand our website content for greater use and benefit to providers, the MCOs, and the public. http://www.kdheks.gov/hcf/pharmacy/default.htm We conducted our annual oversight review of some key program areas and made recommendations for any areas that needed improvements. We have a strong drug program because the MCOs, FFS, and State work closely together on common goals. Weekly and monthly, joint and individual entity, conference calls and emails, help to keep an open line of communication, which provides for a better program overall.
Kentucky	This DUR program annual report encompasses the drug utilization review activities and outcomes that have occurred during FFY 2020. Included are ProDUR alerts and intervention statistics, and RetroDUR alerts and intervention statistics. I. Drug Utilization Review Program Overview Magellan Medicaid Administration (MMA) provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Kentucky Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients, to conserve program funds and expenditures, and to maintain program integrity by controlling problems of fraud and benefit abuse. On March 1, 2009 MMA began providing retrospective drug utilization review (RetroDUR) for the Commonwealth of Kentucky Medicaid FFS Pharmacy Program. The goal of this program is to promote appropriate medication prescribing by: Identifying patterns of potential inappropriate prescribing or medication use, Alerting physicians and/or pharmacists to potential drug therapy problems, and Recommending future corrective actions to avoid identified problems. Prospective Drug Utilization Review Program (ProDUR) The POS/ProDUR system provides Kentucky Medicaid with the ability to meet an important objective: to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. The POS/ProDUR system provides the dispensing pharmacist with access to a comprehensive patient/drug incompatibility database. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations or additional drug therapy. ProDUR achieves this objective by: Reviewing all claims for therapeutic appropriateness before a medication is dispensed, Reviewing eight (8) weeks of the recipient's available drug claims and medical histories for incompatible or duplicative therapy, and Focusing on those recipients at the highest level of risk for harmful outcome.

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	The primary focus of the Kentucky Medicaid FFS ProDUR program is to enhance the quality of patient care through appropriate drug therapy. The ProDUR system provides information that may have been previously unavailable, enabling the dispensing pharmacist to review comprehensive medical and drug histories. The system identifies potentially severe adverse consequences of drug therapy prior to dispensing. The dispensing pharmacist can use the therapeutic situations identified by the system to intervene via patient counseling and consultation with the prescribing physician. ProDUR messages are presented to the pharmacist as an informational tool that can enhance the pharmacist's ability to assure rational, effective and safe drug therapy. The ProDUR system was designed to function as an adjunct to the pharmacist's education and professional judgment and not to overwhelm the pharmacist with excessive alerts. Kentucky Medicaid's FFS ProDUR criteria are designed to be clear, concise, and clinically significant. Kentucky Medicaid's FFS ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing six drug therapy problem types in which potential medication problems may exist. The screening types identified by Kentucky Medicaid's FFS ProDUR criteria are: Excessive Drug-Dosage (HD) - Alert occurs when the calculated milligram dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific. This alert is also referred to as Min-Max Dose. Insufficient Daily Dose (LD) - Alert occurs when the calculated milligram dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. This alert is also referred to as Min-Max Dose. Early Refill (ER) - Alert occurs when a prescription is refilled before 90% of the previously filled prescription's days' supply has elapsed. Therapeutic Duplication (TD) - Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous eight weeks. Drug-Drug Interactions (DD) - Alert occurs when a drug that is to be dispensed may interact with a previously filled drug from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions. Ingredient Duplication (ID) - Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy. ProDUR Cost Savings ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden. Exact duplicate paid claims (DPC) are not included in ProDUR cost savings, because the Kentucky Medicaid FFS program denies these claims outside of the ProDUR environment. IV. Retrospective Drug Utilization Review (RetroDUR) The goal of the Kentucky Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug therapy problems,

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	identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems. Utilization Analysis MMA began providing RetroDUR services to Kentucky Medicaid on March 1, 2009. The operation of the RetroDUR program is a shared responsibility of MMA, the Kentucky Cabinet for Health and Family Services and the Drug Management Review Advisory Board (DMRAB). Specific drug classes that have been reviewed are targeted for focused review under the RetroDUR program at least quarterly. MMA then applies the specified criteria established to the prescription drug and health claims files and identifies medication regimens that are not congruent to the criteria established. Copies of individual medication profiles that are not consistent with the criteria are generated by MMA and sent to clinical reviewers for in-depth review. If, based on the professional judgment of the clinical reviewers or the MMA Kentucky Medicaid Clinical Manager, an aberrant pattern of prescribing and/or utilization is indeed present, an educational letter is sent to the prescribing physician and/or the dispensing pharmacist informing the provider of the suspected problem. MMA produces and mails provider letters documenting the therapeutic effects of the RetroDUR program and tracks provider responses and cost savings associated with the interventions. RetroDUR Cost Analysis The provision of high quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. MMA uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. Indirect effects arise when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a twelve (12) month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. Monthly cost savings may vary due to a variety of factors, including: the class selection and problem type chosen for review, intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system, the lag time before the next physician visit when changes in drug therapy may be made, and/or the incremental educational and familiarity impact on the prescriber after receiving intervention letters. Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve (12) consecutive months of review/tracking) vary with intensity of

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	intervention activity. Intervention letters sent during the past fiscal year have not all completed follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2020 will not be known until the end of FFY 2021.
Louisiana	This annual report represents a summary of the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program's drug utilization review (DUR) activities under the direction of the Louisiana Department of Health (LDH). A commitment to improving the quality of patient health care was demonstrated during the federal fiscal year 2020. Background. In February 2015 approximately 90 percent of Louisiana Medicaid lives moved to managed care. Those lives remain in the managed care as do the lives of the Medicaid expansion population. Louisiana expanded Medicaid beginning July 1, 2016. Beginning in FFY17 through the current time, Louisiana has included five managed care organizations (MCOs) in the Medicaid arena. In FFY19 LDH established a Single Preferred Drug List across all MCOs and Medicaid Fee for Service (FFS). COVID-10. Beginning March 17, 2020, LMPBM began addressing the COVID-19 pandemic with policy adjustments including early refills, days supplies, prescription deliveries and pick-up services, copays, prior authorization approvals, and retrospective DUR activities. DUR. FFS continues to review incoming claims for appropriateness at the Point of Sale and has updated prior authorization criteria. Louisiana has modified existing retrospective drug utilization review (DUR) criteria to address the shift in population demographics. Education. Under the direction of the LDH, the University of Louisiana at Monroe (ULM) College of Pharmacy published monthly educational articles in the Provider Update newsletters which are available for viewing on the lamedicaid.com webpage. Prospective DUR interventions. Clinical alerts and edits address current disease-focused categories such as behavioral health and opioid use. Pharmacy cost avoidance of $33,108,585 is attributed to the use of the prospective interventions during FFY20. Retrospective DUR interventions. Retrospective interventions in the form of mailings to providers make accessible current pertinent information concerning the beneficiary and are often derived from nationally recognized disease management guidelines. In FFY20, LADUR interventions addressed issues in the following categories: diabetes management, sleep disorders, opioid safety, asthma management, sickle cell disorder, behavioral health, and heart failure management Pharmacy cost avoidance attributed to LADUR interventions during FFY20 projected to $18,633 in the targeted drug classes. Drug expenditure reductions averaged 24 percent in the drug classes in which discontinuation or reduction of drug use was recommended. Drug expenditure increases were reflected for several disease management drug initiation recommendations, indicating successful clinical interventions. The cost analysis does not include potential savings in other categories such as hospitalizations or physician visits. LADUR program acceptance and approval by the provider community is evident by numerous positive responses along with a response rate of 11 percent.
Maine	The Maine Medicaid program, known as MaineCare, oversees the pharmacy benefit program and the Drug Utilization Review Committee (DUR). The DUR was formed in accordance with the Omnibus Budget Reconciliation Act of 1990. The purpose is to review drugs that will

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	become part of the preferred drug list (PDL) and assist the Department to make decisions on the structure of the PDL based on clinical and financial reviews. For FFY 2020, the DUR reviewed 102 New Drugs, 11 revised clinical criteria, looked at 47 Therapeutic Class reviews, 5 Quantity Limits on new or established drugs, in determining placement of medications on the State's Preferred Drug List. Overall, 19 FDA safety alerts were reviewed and recommendations were made when appropriate. The DUR continued its review of narcotic utilization and co-prescribing, substance abuse prescribing, assessed the use of appropriate use of antipsychotics in children and adolescents, the use of statins in diabetic patients, continuous use and adherence of prescribers to the preferred drug list (PDL) across a variety of PDL categories to reassess criteria and placement, the DUR looked at PrEP HIV therapy prescribing rate and overall use of buprenorphine doses with MAT treatment. The DUR did a variety of educational outreach to providers or review of prescriber activity with the Department in which the collected information provided multiple analysis for the DUR to review. As a result of the reviews mentioned above the DUR has recommended changes to PA requirements for these categories of drugs and in some cases has implemented new PA requirements. The DUR will continue to monitor these categories of drugs and provide recommendations to the Department to improve patient care and educate prescribers. The Department continues to work with the DUR on retro and prospective reviews and analysis to continue to improve the pharmacy program for MaineCare, including its new Pharmacy Care Management Program (PCM) as described in the Innovative Practices section of the Report.
Maryland	Executive Summary FFY 2020 The objectives for the operation of the Maryland Medicaid Drug Utilization Review (DUR) Board during Federal Fiscal Year (FFY) 2020 include: 1. Continue to review and evaluate prospective DUR criteria alerts; 2. Conduct focused retrospective analyses of claims data to study drug utilization in the Maryland Medicaid fee-for-service population; 3. Guide the development and implementation of educational interventions to improve drug use in this population; and 4. Maintain a DUR Board with membership that meets OBRA 1990 requirements. During FFY 2020, the DUR Board was comprised of six (6) pharmacists and five (5) physicians. Four (4) DUR Board meetings were held during FFY 2020. The meetings were held on the first Thursday of the months of March, June, September and December. Approximately 97% of Maryland Medicaid participants were enrolled in the managed care program known as HealthChoice during FFY 2020. There were nine (9) managed care organizations who participated in the HealthChoice Program during this timeframe. Mental health drugs, including many anticonvulsant agents, and substance use disorder medications are carved out of the managed care pharmacy benefits and are paid fee-for-service. As a result of this, the transition to managed care resulted in the need to integrate all prescription claims through a common source. The Department of Health (MDH) implemented and continues to maintain an electronic claims management pharmacy processing system which includes Coordinated Prospective Drug Utilization Review (ProDUR). The Coordinated ProDUR system transmits an alert to the pharmacy submitting the claim at the time of claim adjudication regarding any identified drug therapy issue.

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	The contract for maintaining the electronic claims management pharmacy processing system, along with Coordinated ProDUR, is administered by Conduent Government Healthcare Solutions. Conduent continues to enhance and maintain Coordinated ProDUR and provides the DUR Board with quarterly prospective DUR message summary reports for prescription claims reimbursed by the Maryland Medicaid Pharmacy Program. For FFY 2020, these reports include all claims for fee-for-service participants and claims for medications included on the Mental health drugs and substance use disorder medications.. The Maryland Department of Health Office of Pharmacy Services (OPS) conducts focused retrospective DUR analyses. Data evaluations, educational interventions and clinical support services are provided by Health Information Designs, LLC. (HID), a Kepro company. The OPS, with recommendations from the DUR Board, implements educational and administrative interventions with the objectives of encouraging appropriate medication use and improving clinical outcomes among Maryland Medicaid participants. Twelve (12) retrospective analyses were conducted during FFY 2020. All of these retrospective evaluations included the mailing of participant specific educational intervention letters to prescribers and pharmacy providers. Participant specific educational intervention letters highlight a drug therapy concern and are sent to prescribers and pharmacy providers with a complete participant drug and diagnosis history profile along with a response form. In the survey Section VI. Generic policy and utilization data, sub question 3, we have reported generic utilization percentage of 82%, however several brand drugs are preferred over their generic counterparts due to the availability of supplemental rebates and lower net cost. Taking into account the preferred brands, a generic use rate of 89% was calculated. There has been increased public scrutiny, controversy and debate regarding the increasing use of antipsychotic agents in children. As a response to this, OPS established a new program, The Peer Review Program for Mental Health Drugs. The program began in October 2011 and initially addressed the use of antipsychotics in Medicaid patients under five years of age. In partnership with the Behavioral Health Administration (BHA) and the University of Maryland (UMD) Division of Child and Adolescent Psychiatry and School of Pharmacy, the program's goal is to ensure that members of this vulnerable population receive optimal treatment in concert with appropriate non-pharmacologic measures in the safest manner possible. During FFY 2014, the program expanded to include all patients under 18 years of age. This program continues to benefit all covered participants. In 2013, the OPS, with the assistance of the University of Maryland, established the Antipsychotic Prescription Review Program (APRP) as another avenue to promote evidenced based, cost-effective prescribing. Through this program, the APRP retrospectively reviews paid antipsychotic claims and identifies outlying prescribing patterns. Subsequently, APRP contacts the prescribers associated with the above claims with the goal of improving their prescribing practices. Beginning in FFY2016, a Unified Corrective Managed Care Lock-In Program was initiated. This program sets minimum standards across all HealthChoice MCO programs, as well as the fee-for-service program, regarding monitoring for potential fraud and/or inappropriate use of controlled substances.

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	During FFY 2017, the Office of Pharmacy Services worked with the Maryland HealthChoice MCOs to create prior authorization criteria for opioids as part of the Maryland Department of Health's initiative to combat the national opioid epidemic. The criteria is part of a minimum standard across all plans to assure safe and appropriate use of opioids in the Medicaid population. Prior authorization is required for all long-acting opioids, fentanyl, methadone for pain and any opioid prescription that results in a dose exceeding 90 morphine milligram equivalents per day. In addition, a standard 30-day quantity limit for all opioids is set at or below 90 morphine milligram equivalents per day. Exceptions to these standards include participants with a diagnosis of cancer (treatment within the past 2 years), sickle cell anemia or those receiving palliative care or in hospice care. Program details, forms and educational resources are available at: https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/medicaid-opioid-response.aspx In the future, the DUR Board aims to accomplish the following: 1. Provide recommendations to OPS to improve drug therapy in the Maryland Medicaid population; 2. Analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service; 3. Recommend and review prescriber interventions and educational programs; and 4. Serve in an advisory role for OPS in the continued management of a Participant Corrective Managed Care (Pharmacy Lock-In) Program.
Massachusetts	The University of Massachusetts Medical School administers the Massachusetts Drug Utilization Review Program for MassHealth (Massachusetts Medicaid). The Massachusetts Drug Utilization Review (DUR) program was established in response to the requirements of the Omnibus Budget and Reconciliation Act of 1990 (OBRA90). The main goal of the DUR program is to ensure that Medicaid recipients are receiving appropriate, medically necessary, prescription drug therapy. To achieve this goal, three programs have been implemented. Prospective DUR (proDUR): Prior to dispensing prescription medication, the pharmacist is required to screen for possible drug therapy problems including incorrect dosing, over/under utilization, drug- drug interactions, drug- disease interactions, duplicate therapy, and possible abuse. The process of a drug requiring a prior authorization approval prior to dispensing of the drug is also part of proDUR. Retrospective DUR (retroDUR): This program occurs after the prescription is dispensed and targets patterns involving the prescriber, pharmacists, and Medicaid recipients. Under the advice of the DUR Board and MassHealth, educational interventions are executed to promote proper use of prescription medications. Such interventions include providing education material to pharmacists, providers, and members. The Drug Utilization Review (DUR) Board: The Massachusetts DUR Board was established in response to OBRA90 regulations. Its responsibilities include advising MassHealth on clinical

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	guidelines for medications and case reviews. The DUR Board is made up of physicians and pharmacists currently practicing in Massachusetts. MassHealth has required representatives of all MCOs to attend Quarterly Board Meetings and monthly Clinical Workgroup Meetings. Conduent is the claims processor for the MassHealth FFS/PCC plans and administers the Point of Sale rules (SmartPA) and internal prior authorization evaluation tools (SmartFusion) for the MassHealth Pharmacy Program. In order to provide the most cost effective, sustainable pharmacy benefit, MassHealth has designated preferred drugs within certain therapeutic classes (MassHealth ACPP/MCO Uniform Preferred Drug List.) Preferred drugs are either subject to supplemental rebate agreements between the manufacturer and the State or brand name drugs preferred over their generic equivalents based on net costs to the State. This Uniform Preferred Drug List identifies the therapeutic classes for which preferred drugs have been designated and the obligations of MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) with respect to those classes.
Michigan	Michigan Medicaid ensures appropriate drug utilization through the Drug Utilization Review Board, the Pharmacy and Therapeutics Committee and an extensive prior authorization system including an automated PA system at point of sale. The Department puts emphasis on evidence-based drug information for the development of therapeutic prior authorization criteria. Much of FFY 2020 was focused on programs that will reduce or eliminate barriers to care as well as programs to maximize rebates and generate increased savings. The Medicaid enrollment remained fairly constant during FFY 2020 with an average total enrollment of 2,579,634, a slight increase of 0.12% from FFY 2019. Approximately 72% of the Medicaid beneficiaries are enrolled in Managed Care Organizations (MCOs). The remaining 28% are in Fee-for-Service (FFS). The DUR Board reviews prescribing patterns for both the FFS patient population as well as for the therapeutic classes covered through a carve-out program for the Managed Care population. Michigan, like all states, was faced with the challenges brought on by the COVID-19 pandemic. On March 10, 2020, the State of Michigan issued an Emergency Declaration. MDHHS enacted measures to ensure access to essential medications and promote social distancing as permitted by law. These steps included overrides to bypass quantity limits and day supplies, lowered the early refill tolerance to 50% of non-controlled medications, bypass prescriber network requirements, waived signature requirements to promote mailing medications and copays waived on COVID-19 related prescriptions. The DUR Board monitored utilization patterns as a result of the COVID-19 pandemic and these emergency measures. The DUR Board continued to focus heavily on opioid and MAT medication prescribing trends. Concurrent utilization of opioids with benzodiazepines and with antipsychotics was reviewed at each meeting for both FFS and MCO populations. The WholeHealthRx RetroDUR academic detailing program has been very successful at targeting trends in opioid prescribing for interventions. Significant steps were taken to reduce barriers to MAT treatments with the removal of the clinical PA and prescriber requirements which led to a 28% increase in the number of beneficiaries receiving these medications.

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	FFY 2020 saw the continued expansion of hepatitis C virus (HCV) treatment coverage with the removal of the metavir scores for liver scarring requirement in October 2019 and the development of Michigan's HCV elimination program, called We Treat Hep C. While this new program was not implemented until April 2021, most of the work was performed during 2020. The impact will be reported in the FFY 2021 annual survey. A great deal of time was devoted to the development of the single Medicaid PDL to maximize drug manufacturer rebates to generate savings. Coordination of the PDL PA criteria with the MCOs and FFS will ensure consistency across the entire Medicaid population for the PDL drug classes. To further address the high cost of medications, MDHHS received CMS approval in October 2018 to pursue Outcomes-Based Contracts with drug manufacturers. In August 2020, the first contract was executed with Novartis Gene Therapies for the gene therapy medication, Zolgensma.
Minnesota	There are 1.2 million average monthly enrollees. Minnesota Medicaid enrollment mix is approximately twenty percent in Fee-for Service (FFS) and eighty percent in Prepaid Health Plan (PPHP) or managed care organizations (MCO). There are no PPHP carve-out of drugs. A uniform preferred drug list (PDL) became effective July 2019. MCO criteria for nonpreferred drugs cannot disadvantage preferred drugs. MCO may also use the same criteria as FFS Medicaid. Managed Care Organizations (MCO): This is the third federal fiscal year (FFY) where Minnesota Medicaid MCOs, BluePlus, HealthPartners, HennepinHealth, IMCare, Medica, PrimeWest, SouthCountry, and UCare will be included in the Medicaid State report to CMS. Pharmacy representatives from each MCO meet routinely with the Medicaid pharmacy staff. The Annual DUR Survey requirement has been included in the agendas. Changes in the uniform POS DUR opioid edits in the past included the max morphine equivalent per day, currently set at 90 MME, and the initial opioid prescription limit of a 7-day supply edit. This group was initially formed years ago so that the same parameters/limits for opioids were used across FFS and all MCOs to eliminate patients choosing one MCO over another because of their opioid benefit management. The main agenda item for these meetings are upcoming changes in the uniform PDL. Fee-for-Service (FFS): The FFS DUR Board met quarterly where a meeting's agenda consisted of (1) ProDUR criteria (performed in-house through DHS MMIS claims adjudication) and (2) RetroDUR criteria for retrospective population based mailing proposals (contracted with Conduent Government Health Care Solution) and (3) post intervention outcome assessments. The contract with Conduent ended September 30, 2020. Kepro, Inc. is the RetroDUR contractor as of October 1, 2020. RetroDUR interventions were generally selected where they offer the greatest potential for clinical indicator changes usually because of the large number of occurrences per clinical indictors. During FFY 2020, there were a total of 7,035 provider letters mailed regarding 14,313

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	patients. Quarterly RetroDUR population-based mailings for FFY 2020 included Opioid/ Benzodiazepines/Antipsychotics (10/2019), Psychotropic Drugs in Adults, (4/2020), Polypharmacy (5/2020), and Management of Diabetes Mellitus (8/2020). Time did not allow all outcome reports, Polypharmacy and Management of Diabetes, to be completed six months post intervention mailing as the contract ended. Improvement in clinical indicators outcomes were Opioid, Benzodiazepines/Antipsychotics 42%, Psychotropic Drugs in Adults 19%, Polypharmacy 11% (based on four months of data instead of six months), and Management of Diabetes Mellitus 2.5% (based on 1.5 months instead of six months of data). Psychotropic Drugs in Children: Two additional mailings during FFY 2020 were completed to address the use of psychotropic drugs in children (mailed 3/2020 and 9/2020). The criteria included (I) monitoring of second generation antipsychotics (SGA) for changes in lipids and glucose as well as (II) multiple (2 or more) oral SGAs and (III) polypharmacy defined as greater than 2 psychotropic medications. The average number of prescribers mailed a letter was 708 and average patient count per mailing was 2,366. Improvement in clinical indicators for 3/2020 was 27%. Opioids: There were no new ProDUR edits nor RetroDUR opioid specific mailings for FFY 2020. There was a quarterly RetroDUR interventions was about the SUPPORT Act. The Opioid Prescribing Improvement Program (OPIP) which was established by the Minnesota Legislature in 2015 to reduce opioid dependency and misuse in Minnesota related to opioid prescriptions continues. https://mn.gov/dhs/opip/opioid-guidelines/ and http://mn.gov/dhs/opioid-guidelines. The most recent reports regarding prescribers and their opioid prescribing occurred April of 2021. These April of 2021 reports will determine whether providers are required to engage in mandatory quality improvement (QI) with DHS. https://mn.gov/dhs/opip/quality-improvement-program/reports/. Information about the Prescription Drug Monitoring Program (PDMP) in Minnesota is found at https://pmp.pharmacy.state.mn.us/ Administrative use of PDMP information is not permitted in Minnesota. Subd.6. https://www.revisor.mn.gov/statutes/cite/152.126. It is stated that a prescriber must access the PDMP data submitted (1) before the prescriber issues an initial prescription order for a Schedules II through IV opiate controlled substance to the patient; and (2) at least once every three months for patients receiving an opiate for treatment of chronic pain or participating in medically assisted treatment for an opioid addiction. For FFY 2021, there will a continued focus on criteria developed around the SUPPORT Act.
Mississippi	As for every state, the COVID-10 pandemic consumed the second half of FY2020. DOM was successful in quickly adjusting to the pandemic to continue providing services as seamlessly as possible. Most DOM employees began working remotely in March 2020 and policies were adjusted to prohibit cost-sharing, including prescription copays for the duration of the public health emergency. Public meetings, such as DUR Board meetings were held virtually to allow for continuation of important work. The other major event occurring within DOM during the fiscal year and continuing still is the transition to a new fiscal agent. After many years with Conduent, a new system is being developed by Gainwell for implementation in 2022. DOM employees have been involved in every step of this important process to ensure a successful transition at go-live. Testing is

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	beginning imminently to verify that services to beneficiaries and providers will continue when the switch to the new vendor occurs.
Missouri	Incorporating increasing levels of technology throughout Missouri's health care system increases efficiency, coordination and transparency; decreases errors and reduces administrative costs. CyberAccessSM is a web-based HIPAA-compliant tool providing health care providers with access to MO HealthNet patient data. It is the first step toward a comprehensive electronic health record for MO HealthNet participants and allows access to medical, procedural and pharmacy paid claims data for participants for the past two years. In addition to the participant health information, a health care provider with prescribing privileges can submit an electronic prescription and access the clinical rules engine to request precertification of medical procedures and prior authorization for prescription drugs when needed. CyberAccessSM allows providers to view the MO HealthNet participant's claims history from all providers to determine the most appropriate course of treatment. MO HealthNet participants, health care providers, Missourians and the state of Missouri benefit from the use of this tool. More than 22,000 MO HealthNet providers and allied health professionals use this web-based portal to access electronic health records for MO HealthNet patients. Treating providers can view a patient's medical history including diagnoses, procedures and prescribed medications. Providers can electronically submit prescriptions, request pre-certification for imaging procedures, durable medical equipment, inpatient hospital stays and optical services within the tool. CyberAccessSM improves the efficiency of health care delivery by using a rules-based engine to determine if a requested drug or procedure meets the appropriate clinical criteria. All of these tasks are performed in a secure environment and the entire system is Health Insurance Portability and Accountability Act (HIPAA) compliant. The tool now includes lab and clinical trait data imported from provider medical records, as well as increased functionality to allow physicians to input notes and E-prescribe. MO HealthNet maintains active provider outreach activities to encourage providers to sign up for and utilize the CyberAccessSM tools. Numerous pharmacy program initiatives include protecting patient safety by assessing utilization of psychotropic medications. A number of psychotropic clinic edits are inplace to reduce the inappropriate use of these medications and to improve patient outcomes and quality of care. An initiative specifically to address potentially inappropriate 'off-label' usage of atypical antipsychotics in pediatric participants, is entering its second year. Next steps for MO HealthNet are to require prescribers to submit diagnosis codes for pediatric psychotropic medications. In December 2016, the Pharmacy Program implemented updated criteria to provide greater access to the full range of Opiate Dependence Agents, as well as access to Narcan (Naloxone) for opioid reversal. Missouri has also opened up access to alternative pain management therapies, including acupuncture, chiropractic services, and physical therapy, along with reducing burdens for participants to receive non-opioid analgesics. Additionally, since February 2011, MO HealthNet Division has covered smoking cessation for all eligible participants, and all products are Open Access without restrictions. The MO HealthNet Pharmacy Program's goal is the continued provision of quality, cost-effective health care for Missouri's most vulnerable citizens.
Montana	Refer to sections 3.3 and 9.2 for detailed descriptions of Case Management activities including disease state management and educational outreach. In addition, we made the following changes: Eliminated Copays for all prescriptions COVID exceptions: allowed early fills on non-controlled substances, allowed 90 day fills on all but CII, auto-extended PAs, opened PDL for albuterol and other drug shortages

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	Increased day supply allowance for insulin to enable pharmacies to bill correct day supply and not break boxes of pens Enacted limits for sedative-hypnotics to be in line with FDA dosage recommendations Hepatitis C PA changes. Removed Fibrosis score limitation, specialist provider requirements, and readiness requirements. Providers still required to sign an attestation that they have performed a psychosocial readiness evaluation and worked with the member to remove barriers to treatment. Increase age for PA for antipsychotics in children from 6 to 7. Will continue to increase as resources permit. Enacted 7day opioid initial fill limit for opioid naive members Finished max allowed MME taper to 90MME
Nebraska	MME down to 90 mg MME daily. Hepatitis C treatment initiated at F0 instead of F2. Budgetary concerns alleviated with this change. Will be monitoring prescription / cost increases. Will address increase with new DUR project. SUPPORT Act being monitored and reported every two months at DUR Board meetings. New DUR Board members onboarded and more to be added. Policies of DUR Board updated.
Nevada	The Drug Use Review Board (DUR) is a requirement of the Social Security Act, Section 1927 and operates in accordance with Nevada Medicaid Services Manual, Chapter 1200, Prescribed Drugs, and Nevada Medicaid Operations Manual Chapter 1200. The DUR Board consists of no less than five members and no more than ten members appointed by the Director of Health and Human Resources. The quarterly public DUR meetings are facilitated by a licensed clinical pharmacist from OptumRx, the Pharmacy Benefit Manager for Fee-for-Service Medicaid. The DUR Board meets to monitor drugs for: therapeutic appropriateness, over or under-utilization, therapeutic duplications, drug-disease contraindications, and quality care. The DUR Board does this by establishing prior authorization and quantity limits to certain drugs/drug classes based on utilization data, experience, and testimony presented at the DUR Board meetings. This includes retrospective evaluation of interventions, and prospective drug review that is done electronically for each prescription filled at the Point of Sale (POS). During the Federal Fiscal Year 2020, the DUR Board was comprised of five physicians (1 pain specialist, 1 psychiatrist, 1 internal medicine, and 2 family practice physicians) and five pharmacists (2 hospital pharmacists and 3 ambulatory care pharmacists) from various backgrounds and locations around the State of Nevada. Other non-voting members who contribute to Board discussions include employees from the Division of Health Care Financing and Policy, a Deputy Attorney General, and representatives from the contractors for MMIS and PBM services. The three managed care organizations also participate, and each have non-voting representation on the Board. The public is welcome to provide testimony to the board before they vote on topics. Clinical reviews and proposed prior authorization criteria for the Board are supplied by OptumRx and the pharmacy directors from each managed care organization. Additional input is provided by pharmaceutical manufacturers, members of the public, and the DUR Boards unique experiences and research. All DUR Board meeting information is posted on the fiscal agent's website for the public before each meeting. This includes all clinical drug reviews, meeting materials and proposed criteria.

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	During the 2020 reporting period, FFS initiatives included the starting the implementation of an electronic prior authorization (ePA) system and exploring a specialty pharmacy program to address the high cost of hemophilia medications, Hepatitis C drugs, and intravenous immunoglobulin. When the ePA is fully implemented, prescribers will be able to submit prior authorization requests via their electronic medical record system or utilizing a web portal. Some prior authorization decisions will be made in real time, while others that require a clinical review will still be resolved within the 24-hour turn-around time. State budget concerns prompted a special session which resulted in a mandate for the program to implement a specialty pharmacy program to generate a savings on high-cost drugs. The program began the process to seek a waiver for a specialty pharmacy program. Due to legislative and contractual restraints the timeline was delayed for another year. The program was able to become more familiar with the steps needed to implement a specialty pharmacy program and now has the framework to build on in the upcoming year. Additionally, statewide initiatives centered around developing new reporting to track COVID-related spending and drug use as well as making system changes to allow for early refills of non-controlled medications during the public health emergency.
New Hampshire	During FFY 2020 the New Hampshire Medicaid population was managed under 3 managed care organizations and the Fee-for-Service program. In the first quarter of FFY 2020, the New Hampshire Fee-for-Service program implemented a prior authorization program for concurrent opioid and benzodiazepine therapy that extends beyond 2 months. ProDUR overrides regarding the interaction and potential risks to the patient are required by the pharmacist for the initial 2 fills of the benzodiazepine. New Hampshire Fee-for-Service implemented a ProDUR drug to drug edit recommending naloxone for patients receiving an antipsychotic drug and an opioid. The remainder of FFY 2020 focused on the response to the COVID pandemic to promote continued access to medications. The drugs used to treat the symptoms of COVID were updated with a $0 co-pay. Extensions to clinical prior authorizations and early refills were permitted if COVID was cited as the justification. The remaining effort was to provide continuous, exceptional care to New Hampshire Fee-for-Service recipients during the pandemic. In developing DUR programs for the Fee-for-Service program, the criteria is built on maintaining quality of care, effective provider outreach and upholding standards of care while managing cost. The development of therapeutic prior authorization criteria is based on evidence-based drug information. The ProDUR program is updated, as new medications are available, to monitor duplicate therapy, drug-drug, proper dosing and drug-disease initiatives to assist pharmacy providers in reducing negative patient outcomes. The RetroDUR program continues to develop clinically relevant programs to educate providers on the most up to date information. New Hampshire reviews all therapeutic classes, including non-control substance classes, for fraud and abuse. New Hampshire Medicaid's DUR program ensures appropriate access to medications while providing clinically sound interventions.

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	While the DUR Program addresses patient safety, New Hampshire believes safe and effective pharmaceutical prescribing results in cost effective medicine. The New Hampshire Medicaid program aggressively addresses pharmacy expenditures through the Maximum Allowable Cost (MAC) and NADAC pricing algorithms, use of quantity limits, e-prescribing and the supplemental rebate contracting.
New Jersey	The New Jersey Division of Medical Assistance and Health Services (DMAHS) is pleased to provide this NJ FamilyCare (NJFC) Medicaid Drug Utilization Review Annual Report for Federal Fiscal Year 2020. This Summary details the activities and accomplishments of the New Jersey Drug Utilization Review Board (NJDURB), as well as the outcome of Prospective Drug Utilization Review (PDUR) and Retrospective Drug Utilization Review (RDUR) activities conducted by DXC Technology, the State's fiscal agent. Managed Care Organizations (MCOs) participating in the NJFC Medicaid Program are responsible for coverage and payment of all pharmacy claims, including those for members enrolled in Managed Long-Term Services and Supports (MLTSS). The DUR activities of the Board pertain to fee-for-service (FFS) pharmacy activities in FFY 2020 for NJFC Medicaid beneficiaries not transitioned to MLTSS and residing in long-term-care or receiving institutional care, and those transitioning from FFS to managed care. Prior to July 1, 2019, certain pharmacy encounters were carved out of MCO capitation payments, including high-cost drugs prescribed for the treatment of hemophilia, HIV, angioedema, Pompe disease, cystic fibrosis, Duchenne muscular dystrophy, Spinal Muscular Atrophy (SMA) and Gaucher's disease. Effective July 1, 2019, DMAHS amended the State's managed care contract to introduce a Risk Corridor Program for a predefined list of high cost drugs provided to the non-dual eligible/non-Managed Long-Term Services and Supports (MLTSS) population to mitigate their unpredictable catastrophic claim risks, excluding hemophilia drugs. A risk corridor payment or recoupment amount is determined by DMAHS and paid to or recouped from the MCO by DMAHS in a lump sum, based on the difference between actual incurred costs and predetermined benchmarks for risk corridor eligible claims. Additional information regarding the terms of the risk corridor payment provision are included in the State's NJ FamilyCare/Medicaid contract found at: https://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf The Medicaid/NJFC managed care contract requires that MCOs establish and maintain a DUR program that satisfies the minimum requirements for PDUR and RDUR described in Section 1927(g) of the SSA, as amended by OBRA 1990. The MCOs are required to submit to DMAHS an annual DUR report, similar to that required by CMS for the FFS program. The PDUR and RDUR standards established by the MCO are consistent with the standards established by the NJDURB for the FFS program. These standards include therapeutic duplication, drug-drug interactions, maximum daily dosage and therapy duration. In addition, the Board works to develop measures to ensure consistency in the drug protocols used by the MCOs when prior authorizing prescription drugs. The recommendations made by the Board pertaining to both FFS and MCO drug utilization managements are reviewed and approved by the State Commissioners of Health and Human Services. During FFY 2020, DXC Technology paid 672,271 NJFC Medicaid FFS pharmacy claims totaling $72,625,703 and 23,504,480 pharmacy encounter claims were reported by MCOs during this period totaling $1,465,310,428. Combined, 24,176,751 paid FFS and MCO encounter pharmacy claims were processed totaling $1,537,936,131. 89% of FFS claims or 12% of FFS pharmacy

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	payments were for non-innovator drugs while 87% of reported encounter claims or 16% of MCO payments were for non-innovator drugs. Regardless of payer, 87% of paid claims or 16% of claim payments were for non-innovator drugs. The FFS Point-of-Sale (POS) system monitors PDUR conflicts including, but not limited to severe drug-drug interactions, therapeutic duplication, duration of therapy and maximum daily dosage. For FFY 2020, the estimated FFS DUR savings was $5,086,563 ($5,066,804 ProDUR and $19,759 RetroDUR). Critical to our FFS PDUR program is the State's Medical Exception Process (MEP). The MEP is a prior authorization process which functions within the framework of DUR standards recommended by the NJDURB and approved by the New Jersey Departments of Health and Human Services. The MEP is a clinically based DUR process not influencing, in any way product selection by prescribers. Instead, the MEP prior authorizes certain FFS claims and is an effective tool for determining if drugs are being properly prescribed, providing cost savings by ensuring that prescriptions are clinically appropriate. The NJDURB is a board consisting of practicing practitioners and pharmacists representing several major specialties. The Board meets quarterly in an open public forum. Updated information regarding Board membership, meeting schedules, NJDURB educational newsletters and annual reports may be found at https://www.nj.gov/humanservices/dmahs/boards/durb/. In FFY2020, Board's focus was to recommend DUR protocols for risk corridor drugs introduced to managed care in 2019. The Board recommended the following DUR protocols: - Cablivi (caplacizumab-yhdp) - Cryopyrin-associated periodic syndromes (CAPS) products - Dupixent (dupilumab) protocol (addendum) - Elaprase (idursulfase) - Emflaza (deflazacort) protocol (addendum) - Fabry disease products - Gaucher disease products - Hereditary transthyretin-mediated amyloidosis (hATTR) products - Lambert-Eaton Myasthenic Syndrome products - Nicotine Replacement Therapy Utilization - PCSK9 Inhibitors protocol (amended) - Strensiq (asfotase) - Spravato (esketamine) - Varubi (rolapitant) - Vyondys 53 (golodirsen) Five (5) retrospective DUR activities were conducted in FFY20. These included: - Confirmation of a HIV diagnosis - Metformin utilization for diabetes management - Claims exceeding $4000 - Concurrent utilization of opioids/benzodiazepines - Concurrent utilization of opioids/antipsychotics

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	The New Jersey Division of Medical Assistance and Health Services (DMAHS) outreached other State Medicaid Agencies requesting information regarding participation of Medicaid beneficiaries in commercially sponsored auto-refill (also referred to as auto-shipment) programs. Concerns related to established auto-refill programs included on-line member enrollment authorization procedures, inappropriate refilling of former medically necessary prescriptions, failures to reverse State pharmacy benefit payments for prescriptions not dispensed and clinical concerns related to the administration of prescription drugs by enrolled members. In response to these concerns, DMAHS developed guidelines in October 2019 intended to ensure the integrity of auto-refill programs. These guidelines enforce the need for beneficiaries, pharmacies, and Managed Care Organizations (MCOs) to assume responsibility for ensuring the safe and cost-effective use of prescription drugs dispensed under these programs. The guidelines included the dispensing of prescriptions when explicitly requested by a beneficiary, responsible party or a prescriber; limiting participation to twelve (12) months subject to verification by a prescriber; retaining written authorizations on file for no less than ten (10) years, and limiting participation to only prescriptions for maintenance drugs. Verification of the continued use of a prescription drug during the authorized period is required to ensure beneficiaries are appropriately dispensed prescribed medications. Pharmacies with an auto-refill program are also required to reverse any payments for prescriptions not received by a beneficiary or responsible party within fourteen (14) days of the dispense date. The State continues to evaluate the Morphine Milligram Equivalent (MME) protocols implemented in July 2018. The State's MME protocol includes a MME daily dosage not to exceed 50 MMEs for an opioid naive patient and a MME daily dosage not to exceed 120 MMEs for an opioid tolerant patient. Exclusions from the protocol continue to include patients diagnosed with cancer or sickle cell anemia, as well as hospice patients and those patients receiving palliative end of life care. The protocol also requires prior authorization for the concomitant use of opioids and benzodiazepines. Since March 2020, the State has held quarterly virtual public meetings of the New Jersey Drug Utilization Review Board due to COVID 19 restrictions. Routine activities of the Board have been conducted successfully. The pandemic has, however, impacted opportunities for the Board to distribute educational materials to providers, outside of information shared individually with providers during the Medical Exception Process.
New Mexico	The State of New Mexico is committed to operating a Medicaid DUR program that has a positive impact upon quality of care as well as upon pharmacy and medical expenditures. Pro DUR and RetroDUR each serve a unique purpose in alerting practitioners and pharmacists with specific, focused, and comprehensive drug information. For FFY 2020, the total estimated new savings for Pro DUR and RetroDUR programs for New Mexico was $3,365,904.86. The RetroDUR estimated savings were $37,775.86 while the Pro DUR estimated savings were $3,328,129. The New Mexico DUR program remains beneficial to the State, provider community, and the population it served.
New York	Prospective and Retrospective Review Programs

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	Management of the ProDUR program is a function of the Department of Health's (DOH) Medicaid pharmacy support staff with the assistance from Medicaid Administration vendors (Magellan Medicaid Administration, State University of New York at Buffalo, HID/KEPRO and the DURB). ProDUR edits allow for online claim rejections and can instill savings within the Medicaid program while at the same time promoting safe medication use for program beneficiaries. During the reporting period for Federal Fiscal Year (FFY) 2020, there were 1.8 million on-line claim rejections where pharmacists encountered dispensing issues that were avoided due to ProDUR safety edits. On-line claim rejections encountered during the review period encompassed early fill, drug-drug interactions, therapeutic duplication, prescriber consult, drug-disease concerns, and high-low dose complications. The over-all cost per prescription as determined by cost (net of rebates)over prescription volume was $46.94 dollars. Calculated savings from the ProDUR Program amounted to approximately $84.5 million dollars in savings as determined by multiplying the number of on-line claim rejections by the average cost per prescription. The RetroDUR Program is designed to improve prescribing trends. Claims are screened using DURB adopted criteria and reviews are carried out using the combined efforts of clinical pharmacists from the State University of New York at Buffalo and the State's RetroDUR vendor, Kepro Health Information Design (HID). During FFY 2020 the computer-based clinical criteria identified approximately 3,477 claims for recipients meeting criteria for intervention letters. The types of drug therapy issues were divided into five general categories:drug-disease interactions (12%), drug-drug-interactions (40%), over-utilization (3%), under-utilization (2%) and therapeutic appropriateness (43%). During the review period 3,673 alert letters were mailed to prescribers for the top 10 criteria evaluated (7,642 letters for all instances). Approximately 5% of the prescribers voluntarily replied to the program intervention letters with 29% responding that positive steps were taken to address the drug therapy issues identified in the alert letter. HID found that the intervention group had a decrease of 12.46% in pharmacy claims cost following the RetroDUR intervention letters, whereas, the comparison group had a decrease of 4.61%. The total RetroDUR cost avoidance, calculated by the RetroDUR vendor was estimated at $3,873,000 ($3.9)million dollars. The RetroDUR program also tracks potentially fraudulent controlled substance claims forwarding them to the Office of the Inspector General (OMIG) for final review and action. For the period of this survey 66 findings were found and sent to OMIG for review and possible action. DUR Educational Program. In addition to the monthly RetroDUR intervention letters under the directions of the State's retrodur vendor, targeted educational letters may also be sent to providers for select clinical issues by the DURB. For FFY 2020, DURB educational letters sent out addressed the following:Use of Antipsychotic Medication in Children related to the Substance Use-Disorder Prevention that promotes Opioid Recovery and Therapy (SUPPORT) for Patients and Communities Act, Antipsychotic Use in Children as related to the Support ACT, Concurrent Use of Opioids and Antipsychotics as related to the SUPPORT ACT, Leukotriene Modifiers and Their Use in the Treatment of Asthma. A retrodur program update was presented to the DURB demonstrating the effectiveness of a previous educational letter sent to prescribers outlining the newly discovered adverse events attributed to fluoroquinolones. PDP and Brand Less Than Generic (BLTG)Programs, New York Medicaid belongs to a multi-state Medicaid pharmaceutical purchasing pool administered by the vendor, Magellan Medicaid Administration Inc (MMAI). Based upon clinical drug updates and/or financial information provided by the MMAI, the DURB manages the PDP. For State Fiscal Year (SFY) 2020 (April 1, 2019 to March 31, 2020) program savings amounting to $3,261,769 ($3.3) million dollars. An additional cost containment program is the BLTG Program. Managed by the State's Medicaid Administrator along with Department of Health staff, the BLTG program estimated savings was

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	$9,640,501 ($9.6) million dollars for SFY 2020. $39.9 million in cost avoidance (includes MCO data reported by OMIG) was obtained from the Lock-In Program during the initial 5 month period October 2019 to February 2020. The pandemic saw lifting of restrictions after February 2020. DUR Board Activities: There were 2 meetings held during FFY 2020:February 23 and July 23. February 23 Meeting Drug Utilization Reviews (DUR) 1. Management of Non-Acute Pain, Utilization of Opioids and Morphine Milligram Equivalent Parameters: Board recommended prior authorization is required when utilizing greater than or equal to 90 MME per day. 2. Management of Eosinophilic Asthma (EA):The Board recommended prior authorization is required when there is a)no history of corticosteroid utilization and b) no concurrent use of a corticosteroid. 3. Management of Oral Second-Generation Antipsychotics (SGAs):Utilization of SGAs and Maximum Daily Dosages (MDD):The Board Recommended prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. Prior authorization will not be required for members established on a dose greater than the highest MDD. Clinical Editing Updates 1. Utilization Trends for Products Used for the Treatment of Opioid Use Disorder. The DUR Board agreed that the current quantity limits and duration edits established for most of the products used for OUD in the Medicaid program remain in effect. Quantity limits were adjusted for the product having recently introduced package size changes 2. Utilization Trends for Long-Acting Opioids Used for the Management of Pain:The Board recommended to continue with current LAO quantity limits. General Program Updates 1. Medicaid Retrospective Drug Utilization Review (RetroDUR): Fluoroquinolone Project. The update was an assessment of a mailed letter intervention to promote appropriate use of the fluoroquinolone class and concluded that the letter appeared to have had a modest effect (15.1%) on decreasing potentially inappropriate fluoroquinolone prescribing. 2. Medicaid Prescriber Education Program:Antibiotic Stewardship. The presentation provided an overview to the Board of the New York State Medicaid Prescriber Education Program activities, including the newest educational module, Antibiotic Stewardship. The goal of the NYSMPEP program is to optimize the quality of care for NYS Medicaid members by providing the most current, unbiased, evidence-based information on best practices in pharmacotherapy. July 23, 2020 DURB Meeting 1. PDP Clinical Review. 10 therapeutic drug categories were reviewed for additions and/or changes to the preferred and non-preferred status of the drug categories being presented. The DUR Board recommended changes to those therapeutic categories based upon clinical and financial information. 2. Drug Cap Review, Spinraza (nusinersen) Drugs piercing the State Medicaid's Drug Cap and having no consensus on a negotiated drug rebate value are, by State law, sent to the State's DURB to determine a calculated target rebate value. The Board agreed to a supplemental rebate target amount for Spinraza as required by law. Innovative changes addressing the COVID Pandemic, Medicaid pharmacy provider COVID19 guidance relaxed editing of formulary adherence for payment of lab testing and specimen collection and for vaccine administration in the pharmacy. Provider guidance issued in accord with State and Federal laws addressed 90 day supplies where indicated and medication delivery authorizations as well as prescription transfers allowing more convenient medication access and changes in formulary listing due to drug supply availability in addition to changes in select prior authorization requirements and permissible pharmacy provider overrides in select early fill situations.

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	Declared Executive Orders, effective for the extent of the pandemic, modified the laws of New York designating licensed pharmacists as qualified healthcare representatives for the purpose of directing a limited service laboratory for patient COVID 19 testing. In addition, pharmacists were approved for COVID 19 vaccine administration after receiving proper training. Managed Care Oversight As of 10-24-2019 New York was awaiting approval of the 3-1-19 model Managed Care Contract. Once approved work on specific language to an amendment addressing specific requirements of the SUPPORT ACT will begin. Contract language follows the SUPPORT ACT as evidenced by section 35.1 of the current 3-1-10 model contract. A compliance attestation was sent to CMS addressing current contract compliance with the following addition; New York State will include all requirements of Section 1004 of the SUPPORT for Patients and Communities Act to the next model contract amendment which will commence once approval of the 3-1-2019 model contract has been receive from CMS. Medicaid Managed Care plans meet quarterly with the Medicaid Formulary and Operation Systems Implementation Unit to discuss statewide initiatives and major program changes. Discussion of returning the pharmacy program back to Medicaid from the Managed Care plans is being pursued. Routine meetings are held to discuss each plans adherence to NY Medicaid's formulary requirements for beneficiaries. Medicaid Managed Care formularies are reviewed for agents that are not considered Covered Outpatient Drugs. In addition, new pipeline drugs are introduced for discussion.
North Carolina	North Carolina Medicaid is currently 100% FFS. We are in the process of moving approximately 1.6 million beneficiaries over to Managed Care effective July 1, 2021. Some of our efforts during the last FFY have been to develop partnerships with the contracted PHPs and ensure a thorough understanding of NC's Medicaid Pharmacy Policy. Contractually, they are required to align with the state and there will be a single PDL. NC Medicaid has also been in the process of developing an RFP for a PBM for the MMIS replacement project. This is a combined effort with many other departments within Medicaid and DHHS. Additionally, NC put forth much effort in protecting NC's most vulnerable population during the COVID crisis by improving access to medications and enhancing services. These changes included: allowing up to 90 days' supply fills or refills of most non-controlled substances; allowing early refills of most non-controlled substances, subject to pharmacist and prescriber clinical judgement; allowing up to 14 days' supply of a medication waiting on prior authorization; allowing up to 14 days' supply of an emergency lock-in prescription (with limitations); suspending behavioral health edits to lessen administrative burdens on pharmacies and prescribers; updating the beta agonist inhaler category due to shortages in the marketplace; allowing up to 90 days' supply of certain Schedule II stimulant medications; allowing up to 90 days' supply of certain medication assisted treatment (MAT) medications; adding a mailing fee of $1.50 (with restrictions) to retail pharmacy claims; adding a delivery fee of $3.00 (with restrictions) to retail pharmacy claims; and increasing traditional dispensing fees and diabetic supply rates by 5%. These were efforts to combat compliance issues due to the fear of being in public spaces and decrease risk of disease transmission. In addition to the above, NC began work on developing tools and reports for monitoring the PHPs who will be providing services to Medicaid beneficiaries beginning July 1, 2021. Assuring compliance to contracts, state policy, and state and federal regulations is a top priority, as is

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	ensuring the PHPs continue to do business in such a way that NC Medicaid beneficiaries continue to receive high quality healthcare.
North Dakota	The North Dakota Medicaid FFS program continued to improve its prior authorization program by adding 14 new prior authorization criteria for drugs/drug classes. These criteria were added for reasons such as ensuring clinically appropriate/safe use, and for medications/classes that are high cost and/or had more affordable alternatives with comparable or equivalent efficacy available. During FFY2020, the DUR Board voted to approve and add 372 new RetroDUR criteria spanning 20 different therapeutic drug categories that are now a part of North Dakota Medicaid's RDUR criteria library. The state, with their RetroDUR vendor, reviewed a total of 4,965 patient profiles for RetroDUR, resulting in 3,690 cases where prescribers and pharmacies were alerted to a potential drug utilization issue. During FFY2020, North Dakota continued to work towards maximum efficiencies in our pharmacy program, working within the restrictions of no prior authorization allowed for six of the highest cost categories (antipsychotics, stimulants for ADHD, anticonvulsants, anti-neoplastics, anti-retrovirals, and antidepressants).
Ohio	During FFY20, there were several enhancements made to the ODM pharmacy program including innovative initiatives (see Summary 5), improvements, and increased oversight of managed care partners. As an overview, ODM's Drug Utilization Review (DUR) Board is made up of four pharmacists and four physicians who meet on a quarterly basis. ODM also has a DUR Committee made up of seven pharmacists who meet monthly. The Committee reviews member profiles and makes recommendations to the DUR Board. In FFY20, the DUR Committee met eight times (due to COVID-19) and the DUR Board met four times. RetroDUR interventions were implemented pertaining to members taking opioids with a benzodiazepine, members taking opioids with gabapentin, members taking opioids with stimulants, members not adherent to antiepileptic medications, prescriber education regarding pediatric metabolic monitoring in atypical antipsychotics, and pharmacy education regarding administration of the influenza vaccine. In FFY20, ProDUR savings totaled approximately $30 million. On January 1, 2020, ODM, in partnership with the MCPs, moved towards a Unified Preferred Drug List (UPDL). The goals of this initiative included: reduce administrative burden for providers by simplifying and streamlining the prescribing and prior authorization processes, allow for a standard process across ODM Fee-for-Service and MCPs to support population health initiatives, clinical coordination of care for Ohio's Medicaid population, and minimize member movement across MCPs. Of note this year, there were several updates made to the DUR program due to the implementation of the Medicaid DUR provisions included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271). A ProDUR edit was put in place for members taking opioids concurrently with antipsychotics. RetroDUR interventions were performed to address members taking opioids and benzodiazepines, opioids and gabapentin, and opioids and stimulants. An educational outreach was performed to educate prescribers to complete pediatric metabolic monitoring when prescribing atypical antipsychotics. Additionally,

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	prescribers and pharmacies were contacted to address patients taking Medication Assisted Treatment and opioids or benzodiazepines. Finally, ODM developed a minimum standards for SUPPORT Act compliance document and required all of the MCPs to submit to the state how they are currently meeting the standards and/or how they intend to meet the standards by no later than October 1, 2019. The DUR program continues to safeguard the health of Medicaid members, to assess the appropriateness of drug therapy, and to reduce the frequency of fraud, abuse, and gross overuse.
Oklahoma	Prospective Drug Utilization Review (DUR) Monitoring: Monitoring of prospective DUR is done by the clinical staff of Pharmacy Management Consultants in the form of issuing overrides for early refills and review of alert information generated by the fiscal agent. Retrospective Drug Utilization Review (RetroDUR) Screening and Educational Interventions: The retrospective educational outreach summary data is provided in Section III and includes the RetroDUR screening and educational interventions for FFY 2020 and lists the most prominent problems with the largest number of exceptions. In FFY 2020, RetroDUR Educational Outreach activities included: Quarterly SoonerPsych Program Mailings (4 separate mailings in October of 2019 and January, April, and July of 2020); Quarterly Chronic Medication Adherence Program Mailings (4 separate mailings in November of 2019 and February, May, and August of 2020); Pediatric Antipsychotic Monitoring Program Mailing in December 2019; Angiotensin Converting Enzyme Inhibitor (ACEI)/Angiotensin Receptor Blocker (ARB)/ Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy in Patients with Chronic Heart Failure (HF) Mailing in January 2020; Prenatal Vitamin Utilization Mailing in June 2020; Montelukast in Allergic Rhinitis Safety Mailing in June 2020; Pediatric Antipsychotic Monitoring Program Mailing in July 2020; and Academic Detailing Program Update: Treatment of Upper Respiratory Infections (URI) in September 2020. DUR Board Activities: During FFY 2020 the DUR Board met 11 times. Meetings were held in October, November, and December 2019, and in January, February, March, April, May, June, July, and September of 2020. In accordance with state legislative mandate, 20 speakers addressed the DUR board during public comment. DUR Board topics include Product-Based Prior Authorization (PBPA) and Criteria-Based Prior Authorization (CBPA) categories and or product additions, changes, and reviews. There were 75 additions to the CBPA program and 47 changes in FFY 2020. There were 30 additions to the Product Based Prior Authorization (PBPA) program and 8 additional categories or products updated. RetroDUR activities included: Overview of U.S. Food and Drug Administration (FDA) Safety Alerts, Maintenance Drug List, Atopic Dermatitis Prescriber Specialty Analysis, SoonerCare Opioid Initiative Update, Narrow Therapeutic Index (NTI) Drug List, Attention-Deficit/Hyperactivity Disorder (ADHD) Prescription Use in Reproductive-Aged Women, SoonerPsych Program Update: Atypical Antipsychotic Medications - Appropriate Diagnosis, Polypharmacy, Metabolic Monitoring, and Adherence, Prenatal Vitamin (PV) Utilization Update, Annual Review of the SoonerCare Pharmacy Benefit, Use of Angiotensin Converting Enzyme Inhibitor (ACEI)/Angiotensin Receptor Blocker (ARB)/Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy in Patients with Chronic Heart Failure (HF) Mailing Update, Chronic Medication Adherence Program: Maintenance Diabetes and Cardiovascular Medication Prescriber Mailing Update, and Academic Detailing Program Update. Annual

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	Reviews were presented or made available to the DUR Board for 107 CBPA categories or products and 34 PBPA categories. Cost Savings Estimates: Cost savings/cost avoidance are provided within the ProDUR and RetroDUR tables attached. Cost savings for FFY 2020 represented 16.08% of the grand total. - State Maximum Allowable Cost Savings: $41,765,521.24 - Prior Authorization Program Savings: $9,840,069.16 - ProDUR Savings: $56,568,560.68 - RetroDUR Savings: $834,021.00 Total DUR Program Savings: $109,008,172.08 - O.U. College of Pharmacy: -$4,299,317.56 Annual Savings FFY 2020: $104,708,854.52 Innovative Practices: Academic Detailing: Educational outreach to providers in the field promoting appropriate treatment options, identifying barriers to guideline implementation, and educating on prior authorization processes are the Academic Detailing (AD) program objectives. This program started with targeted intervention aimed at improving evidence-based prescribing of attention-deficit/hyperactivity disorder (ADHD) medications then progressed to include atypical antipsychotic medications and the treatment of upper respiratory tract infections. The College of Pharmacy analyzed Oklahoma SoonerCare claims to investigate antibiotic (ABX) prescribing trends, with a specific focus on the treatment of upper respiratory infections, as this is the area with the highest degree of inappropriate ABX prescribing for pediatric patients. Data collected focused on changes in prescribing patterns, utilization, and use of specific therapeutic agents. During FFY 2020, ABX-AD resulted in total savings of $834,021. Data is continuously compiled to bring to the DUR Board for review and educational opportunities for improvement. Recommendations presented have included comprehensive communication with providers, pharmacy level communication if needed, and goals for future drug categories to explore. Interventions have shown a trend toward meaningful benchmarks in costs, prior authorizations, and program application. With the success of the program, further program material for additional drug categories will be created with more providers being reached.
Oregon	Oregon implemented prior authorization criteria in the fee-for-service program to ensure medically appropriate use of new Orphan drugs and antineoplastic drugs originally approved by the FDA on January 1, 2008 or later. The criteria support medically appropriate use based on compendia-supported indications and FDA labeling. Drug Use Review (DUR) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program includes, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse. The DUR Board's priorities this reporting period focused on prior authorization criteria, drug use evaluations, and COVID-19 FFS Pharmacy strategies employed during the initial stages of pandemic to encourage social distancing and address access issues. The Oregon Health Authority (OHA) worked closely with contracted managed care entities (Coordinated Care Organizations, or 'CCOs') to coordinate the state's COVID-19 response. This included virtual meetings with CCO Pharmacy Directors (initially scheduled weekly), email

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	updates and data sharing. CCO Pharmacy Directors and OHA also continued regular meetings, with topics including hepatitis C, best practices to reduce waste of practitioner administered drugs (PADs), medication therapy management (MTM) and naloxone access during the COVID-19 emergency.
Pennsylvania	The emphasis of Pennsylvania's drug utilization review (DUR) program is to promote patient safety through an increased review and awareness of outpatient prescribed drugs to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. Pennsylvania employs a combination of prospective and retrospective DUR initiatives for a comprehensive approach to pharmacy utilization management.The prospective DUR component includes a combination of alerts transmitted to the dispensing pharmacist at the point of sale and clinical prior authorization required at the point of sale which is reviewed by the Pennsylvania clinical staff for medical necessity determination.The retrospective DUR component supports the overarching goal of patient health and safety by focusing on a retrospective review of patients' drug claims against specific criteria, identifying common drug therapy concerns such as inappropriate use of drugs, medically unnecessary care, and increased risk for drug interactions, and providing for educational interventions that promote effective prescribing practices in a factual and unobtrusive manner. Through the RetroDUR, the Department provides prescribing providers with a comprehensive drug history profile for their patient and specific recommendations which enable them to consider medically appropriate actions such as identifying and discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, or switching to safer drug therapies.Outcomes include enhanced therapy compliance and reductions in utilization of other medical services like emergency rooms and hospital stays, combined with reductions in drug abuse and diversions, all of which contribute to cost savings without compromising access or quality of care.
Rhode Island	Introduction Retrospective Drug Utilization Review (RDUR) seeks to assist prescribers by calling their attention to potential concerns with an individual recipient's drug therapy that could lead to possible adverse effects or undesirable outcomes. Pharmacy claims data are evaluated on an ongoing basis and run against criteria to generate educational intervention letters that are then sent to prescribers. The specific potential therapy issue is noted in the letter and the letter is sent, along with a complete drug history and available diagnosis history, to the prescriber for review. Rhode Island DUR Program Description Rhode Island has an active RDUR program that alerts prescribers of potential drug therapy issues for the Medical Assistance (Medicaid) population. The Rhode Island RDUR program alerts prescribers to potential issues related to the following: Drug-disease conflicts Drug-drug interactions Overutilization Underutilization (non-adherence) Clinical or therapeutic appropriateness Therapeutic duplication Each month, pharmacy claims data and available diagnosis data are evaluated against a database of several thousand criteria that look for potential drug therapy concerns. Approximately 1,000 drug and diagnosis history profiles for individual recipients are reviewed by a clinical pharmacist. In addition, approximately 200 recipients are screened each month

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	specifically to evaluate for potential overutilization of controlled substances. Specific recipients are selected for intervention based on the clinical review. Educational intervention letters are then generated and mailed to their prescribers along with a complete drug history and a response form that asks the prescriber to indicate any action taken in response to the letter. Responses to the letters are voluntary and give feedback to the program as to how prescribers may be adjusting therapy, if required, based on the intervention letters. A response rate of approximately 18% has been observed from prescribers who have received educational intervention letters. If a prescriber receives a letter addressing a specific drug therapy issue for a recipient, the same letter for that prescriber will not be sent again for an additional 6 months. However, prescribers may receive additional letters within that 6-month time period for the same recipient if other drug therapy concerns are noted. After the 6-month period, the same criteria may be evaluated against the recipient's data and a second letter may be mailed. Changes in utilization and criteria exceptions are evaluated on an ongoing basis and are discussed at DUR Board meetings. For example, for those recipients who are selected for overuse of controlled substances, each case is reviewed again after 6 months to determine if the initial letter had an impact on reducing overutilization. The Rhode Island Drug Utilization Review Board works closely with the Rhode Island Department of Human Services and their contracted vendors to develop criteria and focus on specific areas of concern with regard to recipient drug therapy. For Federal Fiscal Year 2020 (FFY 2020), the DUR Board continues to monitor recipient adherence to maintenance drug therapy and to alert prescribers to potential drug interactions. In addition, overutilization of controlled substances and therapeutic duplication are other areas that were targeted by the DUR program during FFY 2020.
South Carolina	The South Carolina Department of Health & Human Services strives to provide beneficiaries with access to medications necessary to achieve an optimum level of health, while concurrently managing both the utilization and clinically appropriate pharmaceutical products. The State continues to identify opportunities to purchase the most health for the citizens in need at the least cost possible to the taxpayer. The Prescription Preferred Drug List is a cornerstone of managing the pharmacy program, by driving utilization to clinically viable cost savings alternatives, as well as by garnering supplemental rebate revenues. Utilization control measures have been incorporated to ensure processes are in place to steer providers to evidence- based, cost effective and outcomes based pharmaceutical use. In addition to the methods listed above, the Prospective and Retrospective DUR Interventions programs assist in a more active role in the management of beneficiaries' medication regimens. SCDHHS added coverage for OTPs in January 2019, effectively providing access to all formulations of MAT to Medicaid beneficiaries in South Carolina. Since then, the Centers for Medicare and Medicaid Services (CMS) has introduced a series of Healthcare Common Procedure Coding System (HCPCS) codes to designate services provided by an OTP. SCDHHS transitioned to the CMS code set July 1, 2020. Expanded coverage of telehealth was employed for the duration of the current declared public health emergency, which was expanded to include MAT. SCDHHS continues to partner with tipSC in an aggressive provider education campaign to promote opioid risk reduction strategies and expand access to MAT. Working with physicians, pharmacists and other experts from the Medical University of South Carolina, tipSC develops and disseminates targeted, practical information to help prescribers make safer prescribing decisions. Many of those targets/interventions have been referenced within this survey.

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	The South Carolina Department of Health and Human Services (SCDHHS) has begun the transition to a new Medicaid Management Information System (MMIS). The project includes various system and services modules that will replace the current MMIS. The modules in the replacement MMIS (RMMIS) are the accounting and finance module, administrative services organization (ASO), business intelligence system (BIS), dental administrative services organization (DASO), electronic visit verification (EVV) module, pharmacy benefits administrator (PBA) and the third-party liability (TPL) module.
South Dakota	The aim of the South Dakota Drug Evaluation and Education Program Review Committee (RDUR program) is to evaluate patient profiles on a monthly basis with the goal to identify areas of potentially problematic therapy. This report outlines the fiscal year of October 1st, 2019 through September 30th, 2020. Patient profiles are reviewed by a committee of pharmacists and physicians. These profiles are created using the vendor Health Information Designs (HID) RDUR system. An Initial Criteria Exception Report is generated that lists categories of exceptions to the clinical criteria appropriate for patient care. The patients reviewed are identified through this report and can be chosen by a total risk score assigned to individual patients or through specified criteria. The committee will then evaluate individual patient profiles to identify any areas of potentially problematic therapy. If any potentially problematic therapy is identified, the committee will send letters to the prescribing practitioners as well as the individual pharmacies involved highlighting the concern of the identified potentially inappropriate therapy. For the fiscal year stated above, the committee reviewed patient profiles and delivered letters during eight of the twelve months. The RDUR committee were unable to complete this monthly process due to logistical issues in March, April, and May 2020 related to COVID-19. No patient profiles were reviewed and no accompanying letters were mailed during this time period. We were able to restart the RDUR program in June 2020 and have continued the monthly review ever since. The DUR Review Committee had discussions concerning cases or criteria issues with each other by phone or email over the year. During select months, the committee selected specific criteria for a focused review. These specific criteria included underutilization of hypertensive therapy in diabetic patients, underutilization of statin' medications in diabetic patients, and patients receiving co-administration of opioids and benzodiazepines.
Tennessee	Throughout FFY20, TennCare's DUR Board was not as active as in the past due to quorum issues, and two of the four quarterly meetings were cancelled due to lack of attendance, and one was non-official due to not reaching quorum. We feel that the role of the DUR Board and Tennessee's DUR program is to review prescription claims and member profiles both prospectively and retroactively, and upon seeing trends, make recommendations related to the safe and effective use of medications for our citizens to the Division of TennCare. During FFY20, the DUR Board was not able to meet quorum for 3 quarterly meetings (2 of which were cancelled), mostly due to the inability to identify and retain physician providers to serve as Board members. The 11-member DUR Board officially had 5 actively practicing physicians, 5 actively practicing pharmacists and one actively practicing mid-level nurse practitioner, however, during FFY20, a physician, who specializes in psychiatry did not show up

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	for meetings, and also a physician who with a neurology specialty in a pain management practice did not show up, and never responded to emails and meeting announcements. We don't know if COVID was partially responsible for the reason for non-attendance. We were able to solve our problem by reducing the number of Board members, and by requesting that our MCO's provide a medical director for our DUR Board, and we did add 2 physicians. Since the 3Q2020 meeting, the Board has met quarterly and has met quorum. The mid-level nurse practitioner, from a large teaching hospital was at one time working in the hospital's pain management area and is now working with patients who have undergone a bone marrow transplant, and this person was not active with the Board in FFY19. After asking all members about interest in serving, the mid-level nurse practitioner resigned. We have added a new pharmacist to the Board, from a community pharmacy practice in a rural East Tennessee setting. This person has until recently, served TennCare as a member of our Pharmacy Advisory Committee, which is TennCare's P&T Committee. When his term was ended, he was excited to be a part of the DUR Board. On January 1, 2020, Tennessee implemented a new PBM and DUR Vendor, and we are not working with OptumRx. Dr. April Bolden was our DUR Pharmacist for OptumRx, and prepared and presented for all meetings, and the individual at TennCare with overall DUR responsibility was Ray McIntire, D.Ph., and Director of Pharmacy Operations. These individuals worked collaboratively with Dr. Victor Wu, TennCare's Chief Medical Officer, Dr. David Collier, M.D., TennCare's Associate Medical Director, and Dr. Renee Williams-Clark, PharmD, TennCare's Chief Pharmacy Officer. As stated previously past yearly CMS report, the DUR Board has been involved in several aspects of fraud and abuse monitoring of TennCare enrollees and prescribers and are of great importance in assisting the TennCare Pharmacy team with our program integrity efforts. During the quarterly meeting that we were able to make quorum, we continued to review drug classes and make recommendations to our P&T, known in Tennessee as PAC (Pharmacy Advisory Committee), and these class reviews are retrospective reviews based on pharmacy claims data, merged with medical data and including data from the State of Tennessee's PDMP. In July 2020, we presented the Board members with a retrospective study of some specific products that had been filled in appropriately large quantities, and we found were being used by compounding pharmacies for foot baths and nasal lavages. The Board recommended that a letter go to prescribers of these prescriptions with information and recommendations from TennCare's DUR Board, evidencing that these treatments were not medically sound, were not standards of care, and potentially fraudulent. Board Meetings are held quarterly, follow parliamentary procedures and have a standing order of business, specifically: 1. Call to Order 2. Approval of Minutes 3. TennCare Update presented by Dr. Wu or Dr. Collier 4. TennCare Pharmacy Update presented by Dr. Williams-Clark 5. Follow Up on Old Business 6. Class Review (if presented) 6. New Business

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	7. Review of TennCare Population Trends 8. Review of TennCare Drug Utilization Trends 9. Review of Pharmacy Lock-In 10. Review of DUR Activities 11. Review of Provider Practice Activities 12. Future Meeting Dates 13. Adjournment The Division of TennCare continues to appreciate the time and efforts of the DUR Board members. The Bureau appreciates their support, and in our FY21 report next year, Tennessee will report with more DUR reviews, examples of how the DUR Board has been involved with reviewing profiles and providers in support of the SUPPORT Act, and we will be able to once again be successful in helping TennCare and our MCO's in ensuring cost-effective medically necessary health care and drug therapies for our beneficiaries. We expect to see much more success from their support and efforts in the years to come.
Texas	Texas Vendor Drug Program (VDP) manages coverage of outpatient drugs for members enrolled in Medicaid, CHIP, CHSCN Program, Health Texas Women Program, and Kidney Health Program. VDP manages the drug formulary and the preferred drug list (PDL) for Medicaid program, as well as, the Specialty Drug List (SDL). Texas Medicaid implements and shares a single formulary and PDL policy with all the contracted MCOs. Currently, there are 17 MCOs contracted with Texas Medicaid. Texas Medicaid has over 90% of the members enrolled in one of the managed care organizations. VDP works with the MCOs in developing proposals for clinical prior authorization criteria. The proposals are presented at the quarterly DUR Board meetings for approval. VDP, also develops retrospective-DUR programs for the FFS members, however, the MCOs are not required to follow the same Retro-DUR interventional topics. In FFY 2020, The Board approved the clinical PA criteria for the following drugs: Benjesta/Diclegis, Cytokine and CAM Antagonists- Rinvoq; Diacomet; Sunosi; Trikafta; Oxbryta; PAH Agents- addition of oral and inhaled agents to the existing inj. agents; Fasenra and Nucalal, Cequa; Restasis, Xiidra; Vyndamax, Vyndaqel, Tegsedi; Acthar gel (revision)- removed the non-FDA approved indications; Oxervate; Palforzia; Spravato Nasal Solution. In FFY 2020, the Board reviewed retrospective Criteria for the following drugs: Atypical Antipsychotics-long-acting injectable; Atypical Antipsychotics (oral); Exogenous Insulin Products; Nitazoxanide (Alinia); Promethazine Use in Children < 2 Years of Age; Quetiapine (low-dose); fentanyl Inhalation/oral/transdermal; Gabapentin; Hydrocodone Bitartrate/ Hydrocodone Polistirex; Ivacaftor (Kalydeco) and Combination Therapy; Topical Calcineurin Inhibitors Pimecrolimus (Elidel) Tacrolimus (Protopic) ; Tramadol (Ultram); Direct Oral Anticoagulants; Complement Inhibitor and Enzyme/Protein Replacement Therapy; Low-Molecular-Weight Heparins (LMWHs); Nebulized Bronchodilators; Hydroxy-Methylglutaryl Coenzyme A (HMG-CoA) Reductase Inhibitors (Statins); Benzodiazepines (Nonsedative/ Hypnotics); Immune Globulins; Oral/Rectal Nonsteroidal Anti-Inflammatory Drugs (NSAIDs); Non-sedating Antihistamines; Oral Fluoroquinolones; Rifaximin (Xifaxan); Skeletal Muscle Relaxants; Sickle Cell Disease Products In FFY 2020, the following retrospective intervention topics were reviewed: Opioids, Benzodiazepines, and Antipsychotics; Pain Management with Opioids; Diabetes Disease Management; Monitoring of Psychotropic Drugs in Youth; Postpartum Depression; Caring for

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	Your Patients with Asthma; NSAID Drug Usage Evaluation (DUE); Pharmacotherapy of Post-Traumatic Stress Disorder; Appropriate Use of Antibiotics; Contraception: Drug Use Evaluation; Gabapentinoid Drug Use Evaluation. There were a few innovative practices initiated in FFY 2020 including the monitoring of opioid claims prescribed by dentists. The program also, added PDL review of several new therapeutic categories for the first time. Those included the Anticonvulsants, the Glucagon Agents, the Immunomodulators for Asthma the Sickle Cell Anemia Treatments, and the Rosacea Agents, Topical. The total cost savings/cost avoidance was $8, 673, 837. 85.
Utah	Utah Medicaid has been continuously implementing new pharmacy system edits to improve efficiencies in cost and care for Medicaid recipients. Areas of concentration have been reducing inappropriate use of opioid medications, concurrent utilization of opioids and benzodiazepines, concurrent use of gabapentin and pregabalin, inappropriate use of ADHD stimulants, and antipsychotic medication use in children and adolescents. Also, focus on improving access to MATs, adherence to hepatitis C therapies, and adherence to hemophilia factors. Peer-to-peer programs were launched with the primary goals of educating and providing resources to health care providers in the focus areas previously mentioned. For the interventions concerning inappropriate opioid use, concurrent use of gabapentin and pregabalin, ADHD stimulants used in children under 4 years of age, and antipsychotic medication use in children and adolescents, telephonic outreaches were conducted to provide patient-focused discussions and education around Medicaid policies and procedures. That conversation was followed with a prescriber letter which summarized the points of the conversation. Nearly all interactions were positive and well-received and providers thanked us for the outreach. For the peer-to-peer concurrent utilization of opioid and benzodiazepine program, outreaches were conducted to dispensing pharmacists. Once again, these phone calls were focused on providing resources and educating around Medicaid policies and procedures. For adherence programs on hepatitis C and hemophilia, telephone calls were conducted to members to counsel on treatments, provide clinical care, answer questions, and refer and coordinate with the Hemophilia Treatment Center if necessary. Utah Medicaid continues to enhance the prior authorization program by standardizing the pharmacy prior authorization form format, using uniform concepts and terms across all forms, and developing a Rare Disease prior authorization form to simplify and streamline medications indicated for rare diseases. With annual reviews each prior authorization form is supported with current and robust clinical and operational criteria. These continued efforts have improved the efficiency of the prior authorization program and team.
Vermont	The Department of Vermont Health Access (DVHA) assists members in accessing clinically appropriate health services efficiently and effectively and collaborates with other health care system entities in applying evidence-based practices to the Medicaid program. In support of Department goals, the pharmacy benefits program goal is to ensure that members receive medically necessary medications in the most efficient and cost-effective manner possible. With ongoing fiscal challenges facing the state, at stake is preserving, to the greatest extent possible, the benefits that have evolved in Vermont's programs.

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	The DVHA Pharmacy Unit is responsible for managing and overseeing the pharmacy benefits programs for members enrolled in the Medicaid program. This encompasses but is not limited to processing pharmacy claims, making drug coverage determinations, managing drug appeals and exception requests, managing federal, state and supplemental drug rebate programs, resolving drug-related pharmacy and medical provider issues, overseeing and managing the Drug Utilization Review Board (DURB) and the Preferred Drug List (PDL), and assuring compliance with state and federal pharmacy and pharmacy-benefits regulations. In addition, the pharmacy program staff manages drug spend and routinely analyzes national and DVHA-specific drug trends and drug utilization. The pharmacy benefits program strives to deliver high-quality customer service, optimal drug therapy for DVHA members, and successful management of drug utilization and costs. Change Healthcare (CHC), DVHA's contracted Prescription Benefit Manager (PBM) since January 1, 2015, provides many clinical and operational support services, in addition to managing a provider call center in South Burlington, Vermont. In FFY2020 total gross drug spend was $205 million and paid prescription claims totaled 1,965,592 for all programs. Specialty drugs represented approximately 26% of DVHA's overall drug spend and the average specialty drugs cost was approximately $7,000 per prescription. This Federal Fiscal Year (10/1/2019-9/30/2020) we reacted swiftly to the COVID-19 Public Health Emergency by assuring that our members and pharmacies had the tools needed to continue to dispense and receive medically necessary medications. DVHA lifted refill restrictions allowing pharmacies to override early refills through a submission clarification code. In addition, we published a list of pharmacies who home deliver medications, waived copays for COVID symptomatic and antiviral treatments, lifted our 90-day requirement for maintenance medications, and opened up testing and COVID vaccinations for pharmacist administration. Lastly, we opened the Vaccine for Children program to pharmacy enrollment to assure better access for children's vaccines. In addition to multiple COVID accommodations, other areas of focus this FFY2020 included: - Enrollment of pharmacists as providers and DVHA's inclusion of pharmacists as a provider type in the new Provider Management Module which allowed pharmacists to order and bill for COVID vaccines under the PHE. This also positions pharmacists for performing other clinical services within their scope of practice. -Launched a Medication Therapy Management program for FQHC/RHCs provided by office-based pharmacists focused on Substance Use Disorder and Mental Health diagnoses. -Collaboration with Vermont's Department of Health on tobacco cessation efforts by pharmacists including a planned launch in FFY2021 of pharmacist tobacco cessation counseling and prescribing of all tobacco cessation products. -Opened continuous glucose monitors in the pharmacy benefit to improve member access and benefit from lower net cost pricing. More changes are expected in FFY21.
Virginia	The Medicaid Drug Utilization Review (DUR) Annual Report Survey reports on each State's operation of its Medicaid DUR program. Areas include prospective DUR (ProDUR) and retrospective DUR programs (RetroDUR), retrospective DUR intervention summary, educational program assessment, DUR Board activities, impact on quality of care, and program cost savings. DUR programs assist health care providers to evaluate drug therapies and ensure the appropriate prescribing of drugs while improving the health of their patients and preventing disease. The systematic review of drug therapy is essential to improving drug safety and reducing issues such as polypharmacy.

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	While the DUR Program addresses patient safety, Virginia believes safe and effective pharmaceutical prescribing results in cost effective medicine. The Virginia Medicaid program aggressively addresses pharmacy expenditures through the use of quantity limits and dose optimization (dose consolidation). The incorporation of service authorizations and step therapy has further guided prescribing practices to control drug spending. During federal fiscal year 2020, the DUR Board approved clinical edits for Ayvakit%u2122, Brukinsa%u2122, Fasenra%u00ae Pen, Inrebic%u00ae, Koselugo%u2122, Nubeqa%u00ae, Oriahnn%u2122, Oxbryta%u2122, Pemazyre%u2122, Pretomanid, Qinlock%u2122, Retevmo%u2122, Rozlytrek%u2122, Tabrecta%u2122, Tazverik%u2122, Temixys%u2122, Trikafta%u2122, Tukysa%u2122, Xenleta%u2122 and Xpovio%u2122. The DUR Board has also reviewed more closely some physician administered drugs as well as the specialty drugs. Magellan Rx Management along with DMAS work together to create clinical service authorization criteria for several of these drugs which get reviewed at the DUR Board Meetings. Clinical criteria for physician administered drugs reviewed during FFY 2020 DUR Board meetings were Adakveo%u00ae, Luxturna%u00ae and Zolgensma%u00ae. The most significant achievement for Virginia Medicaid during FFY 2020 is that DMAS has implemented several new edits and reports to meet the requirements for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act. The DUR Board reviews each quarter concurrent use of opioids and benzodiazepines, concurrent use of opioids and antipsychotics, and opioid use with high risk factors and no naloxone use or with naloxone use. DMAS also has ProDUR edits in place that sends the pharmacist a soft message in reference to the potential risk of concurrent opioids with benzodiazepines and concurrent opioids with antipsychotics. Moreover, DMAS has implemented an edit to notify the pharmacist when an opioid na%u00efve member is trying to fill an opioid prescription and sends a message back alerting of the potential risk and to offer naloxone. DMAS has further lowered the morphine milligram equivalents (MME) from 120 to 90 MME with quantity limits that apply to each opioid drug. DMAS also has several edits already in place to monitor and limit antipsychotic medication use in children. In addition, DMAS has sent out several RetroDUR letters to prescribers in reference to the SUPPORT Act. Virginia Medicaid has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. The DUR Board has been focused on compounded prescriptions in terms of safety, efficacy and effectiveness as well as cost. At the May 10, 2018 meeting the Board made the recommendation to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. In order for the service authorization to be approved, the prescriber would be required to submit peer review studies of the compounded products safety and effectiveness. Compound claims over these

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	limits will be forwarded to the DMAS physicians for review and approval/denial. This change to the compounded prescriptions edit was implemented on November 26, 2018 and the DUR Board continues to monitor the results. The compound prescription edit has caused a significant decrease in the number of compounded claims and the total cost on compounded prescriptions per quarter. Virginia Medicaid first implemented e-prescribing on February 1, 2018. Electronic prescribing (e-Prescribing) is the use of an automated data entry system to generate a prescription, replacing the use of handwritten prescriptions. Automation of the outpatient prescribing process benefits different healthcare stakeholders, especially members, physicians, health plans, pharmacy benefit managers, and employers. Virginia Medicaid realized cost avoidance related to prospective DUR alerts totaling $7,901,042 in FFY 2020. Virginia Medicaid also administers dose optimization and quantity limit programs that saved $980,080. The total cost avoidance, attributed to RetroDUR, during FFY 2020 was $502,960. Virginia Medicaid's overall DUR Program savings in FFY 2020 was $9,384,082.
Washington	- Pharmacy Services The Washington State Health Care Authority (HCA) is the designated state agency for administration of Medicaid in Washington State, otherwise known as Washington Apple Health (Medicaid). The Pharmacy Services section at HCA manages the pharmacy benefit using a multi-component integrated system of utilization management and utilization review activities. Washington Apple Health (Medicaid) receives advisory support in prospective and retrospective drug utilization review through the P&T Committee and DUR Board. The P&T Committee provides advisory support for three state agencies regarding the administration of the Washington State Preferred Drug List (WA-PDL). The same members of the P&T Committee serve as the DUR Board for Medicaid and provide advisory support for administration of the Apple Health Preferred Drug List (AHPDL). The DUR board does not have set policies on what types of interventions need to be adopted however if identified they are determined on a topic-by-topic basis. Washington Apple Health (Medicaid) has completely shifted to a single Preferred Drug List called the AHPDL. - Implementation of AHPDL Implementation of the AHPDL was completed in FFY 2020 with 95 new drug classes added and 10 existing drug classes that were updated. Products on the AHPDL are designated as either preferred or non-preferred, with or without the addition of prior authorization and quantity limits. Some drugs on the AHPDL have PA requirements that may be authorized by the pharmacist at the point of sale with use of expedited authorization (EA) codes. Clinical criteria for drug products listed on the AHPDL are created in-house by Washington State Medicaid staff and go through an extensive review process that involves collaboration with the Managed Care Organizations (MCOs) and clinicians at HCA. Clinical criteria are presented to the DUR board for input, guidance, and approval. Medicaid staff routinely perform retrospective DUR data analysis to determine areas that may need intervention. Possible interventions may include: changing drugs that are preferred or non-preferred, creation of new and updating clinical policies, or adding prior authorization or quantity limits. An annual schedule has been created for drug classes to be reviewed by the DUR board. MCOs that administer Managed Medicaid benefits are required to follow the coverage of drugs in classes included on the AHPDL. -Hepatitis C Elimination

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	The directive ordered by the Governor of Washington State for Eliminating Hepatitis C made Washington the first state in the nation to have a public health and purchasing approach to eliminating Hepatitis C. This innovative approach hopes to eliminate Hepatitis C by 2030 but also lower pharmacy costs for the State. It is a multi-agency effort that includes collaboration with various state agencies and stakeholders such as the Department of Health, Department of Labor and Industries, Department of Corrections, Department of Social and Health Services, MagellanRx, Center of Evidence Based Policy, Oregon Health Sciences University, Moda Health and Abbvie. HCA negotiated a subscription model approach with Abbvie which hopes to control costs but also increase access to care. Elimination efforts that have been implemented are making Mavyret the preferred Hepatitis C regimen, carving out antiretroviral Hepatitis C treatments from MCO responsibility, travel of the Hepatitis C elimination bus around the state and providing data to the MCOs to help identify patients diagnosed with Hepatitis C to connect them with care. - Opioid Monitoring Washington Apple Health (Medicaid) began efforts to address the opioid epidemic in April 2019 before passage of the SUPPORT Act. Quantity limits of 18 dosages per prescription for children (less than or equal to 20 years of age) and 42 dosages per prescription for adults (greater than or equal to 21 years of age) were applied to Fee-for-Service and the MCOs. FFS and MCOs require an attestation form for anyone receiving chronic opioid therapy defined as opioids exceeding 42 calendar days within a rolling 90-day period. Measures that are in place to monitor or manage the prescribing of opioids includes prior authorization, patient-provider agreements, requirement for prescriber to have an opioid treatment plan for patients, documentation of urine drug screening results, and PDMP checks. In November 2019, Washington Apple Health (Medicaid) implemented an updated opioid policy aligned with requirements of the SUPPORT Act, which included retrospective reporting and MME limits. - Program Integrity Program integrity is an integrated system of activities designed to ensure compliance with federal, state, and agency statutes, rules, regulations, and policies. It includes reasonable and consistent oversight of the Washington Apple Health program (Medicaid). Through teamwork within HCA and with its partners, program integrity: 1. Supports awareness and responsibility for administering public funds. 2. Encourages compliance where providers and managed care entities are able to self-disclose improper payments. 3. Holds managed care entities accountable to have systems in place to prevent improper billing and payments. 4. Recognizes areas of vulnerabilities that adversely affect Apple Health programs. 5. Ensures providers meet program participation requirements. 6. Ensures clients meet program eligibility requirements. 7. Ensures Apple Health is the payor of last resort, except for an eligible client covered under Indian Health Service (IHS), IHS is the payor of last resort. 8. Investigates all leads and referrals to determine evidence of potential fraud, waste or abuse. 9. Conducts activities to detect and prevent fraud, waste and abuse, and identify any associated improper payments. Activities include but are not limited to: a. Running data analytics and algorithms b. Creating provider utilization profiles

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	c. Conducting audits and clinical reviews d. Investigating potential credible allegations of fraud e. Applying payment suspensions f. Performing provider terminations g. Reporting individual and entity exclusions h. Invoking managed care entity sanctions i. Conducting provider outreach and education j. Implementing payment system edits k. Maintaining program policies and rules l. Complying with federal initiatives - Patient Review and Coordination Program The Patient Review and Coordination (PRC) Program is a federal and state requirement of Medicaid that focuses on the health and safety of clients. It is used by both Fee-For-Service and the MCOs to control the overutilization and inappropriate use of medical services by clients, by allowing restrictions of clients to certain providers. Many of the clients are seen by several different providers, have a high number of duplicative medications, use several different pharmacies, and have high emergency room usage. Based on clinical and utilization findings, clients are placed in the PRC program for at least two years. Clients can be assigned to one primary care provider, one pharmacy, one hospital for nonemergency care, one narcotic prescriber or any combination of these providers. The assigned provider will coordinate the client's medical needs, and monitor and educate clients about the appropriate use of services. - Office of Professional Rates (Pharmacy Rates, 340B Administration, and Federal Rebate) Management of costs within the pharmacy benefit are handled by fiscal staff who develop, apply and enforce policies such as the State Maximum Allowable Cost program to ensure the agency pays for prescriptions in the most cost effective manner as well as maintain 340B purchasing strategies and collection of federal rebates.
West Virginia	Cost Savings: The Pharmaceutical and Therapeutics Committee (P&T) and the Drug Utilization Review Board work closely together to curb rising pharmaceutical costs. Their efforts helped to generate a total of $530,788,524.94 in rebates in FFY2020, of which $53,628,272.30 were from negotiated supplemental rebates. An additional $11,715,464 was saved through our SMAC program. PDL Compliance: The P&T Committee reviewed all available rebates and worked diligently to prefer drugs which possessed favorable therapeutic profiles at the lowest Guaranteed Net Unit Price (GNUP). In addition, the DUR Board developed prior authorization criteria that was meant to encourage clinically appropriate prescribing, and which resulted in an overall 91.9% compliance rate to the PDL.
Wisconsin	BACKGROUND The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that, effective January 1, 1993, each State establishes a Medicaid Drug Utilization Review (DUR) Program. The program must include both prospective and retrospective DUR to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. To accomplish this objective, the law requires Medicaid DUR programs to screen, based upon explicit criteria, for therapeutic problems specified in the law (for example, drug-drug interactions, incorrect dosage and duration of therapy, therapeutic duplication), to develop

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	and implement interventions to change drug use behavior, and to assess the outcome of the intervention. Section 1927 (g) (3) (D) of the Social Security Act requires each State to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care as well as any cost savings generated by the program. HISTORY OF WISCONSIN DRUG UTILIZATION REVIEW PROGRAM The state agency in the Wisconsin Department of Health Services responsible for benefits administration is the Division of Medicaid Services (DMS), which established a Medicaid Evaluation and Decision Support Drug Utilization Review (DUR) Project. Since September 1996, the primary contractor for the DUR Project has been DXC Technology (formerly, Hewlett Packard Enterprise (HPE)). From July 1, 2009, DXC administered the Wisconsin retrospective DUR activities through a subcontract Health information Designs (HID). SUMMARY OF PROSPECTIVE DUR ACTIVITIES The State of Wisconsin utilizes an on-line, real-time, prospective DUR program that began in FFY 2002. Prior to that, Wisconsin relied on pharmacists to provide these services. SUMMARY OF RETROSPECTIVE DUR ACTIVITIES Monthly DUR reviews are performed following receipt of paid claims tape. Interrogation of drug claims against DUR Board-approved criteria generates patient profiles that are individually reviewed for clinical significance by the pharmacy staff of HID. Criteria are developed jointly by HID and are reviewed and approved by the DUR Board and recommended DMS for approval. If a potential drug problem is discovered, intervention letters are sent to all providers who prescribed a drug relevant to the identified problem. DUR BOARD ACTIVITIES The DUR Board meets quarterly. Materials are sent to Board members between meetings for review and action. Activities of the DUR Board include review and approval of DUR criteria, review and approval of educational material and interventions, and review of other recommendations to the DMS on drug-related issues. COST SAVINGS A cost savings analysis of member's drug costs before and after a retrospective DUR letter intervention are reflected in Attachment 5 prepared by HID. CONCLUSION The State of Wisconsin is in compliance with the DUR program requirements specified in OBRA '90 and the reporting requirements established by CMS. In FFY 2019, the opioid SUPPORT Act requirements was a significant focus for Wisconsin's DUR activity and submission of the State Plan Amendment regarding these requirements.
Wyoming	In FFY2020, the Wyoming Drug Utilization Review (DUR) program conducted prospective and retrospective reviews resulting in a total estimated cost avoidance of more than $30 Million,

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	an estimated impact of 52%. Generic medications accounted for 85% of claims and 33% of expenditures. Appropriate utilization of narcotics continued to be a major focus of discussion and education. In addition to ongoing education programs, comparative prescriber reports were completed detailing use of opioids in combination with antipsychotics, off-label use of gabapentin, prevalence of mental health disorders in patients on montelukast, and opioid use in clients with a history of substance use disorder. In addition, a 7-day initial fill limit was implemented for all opioids.