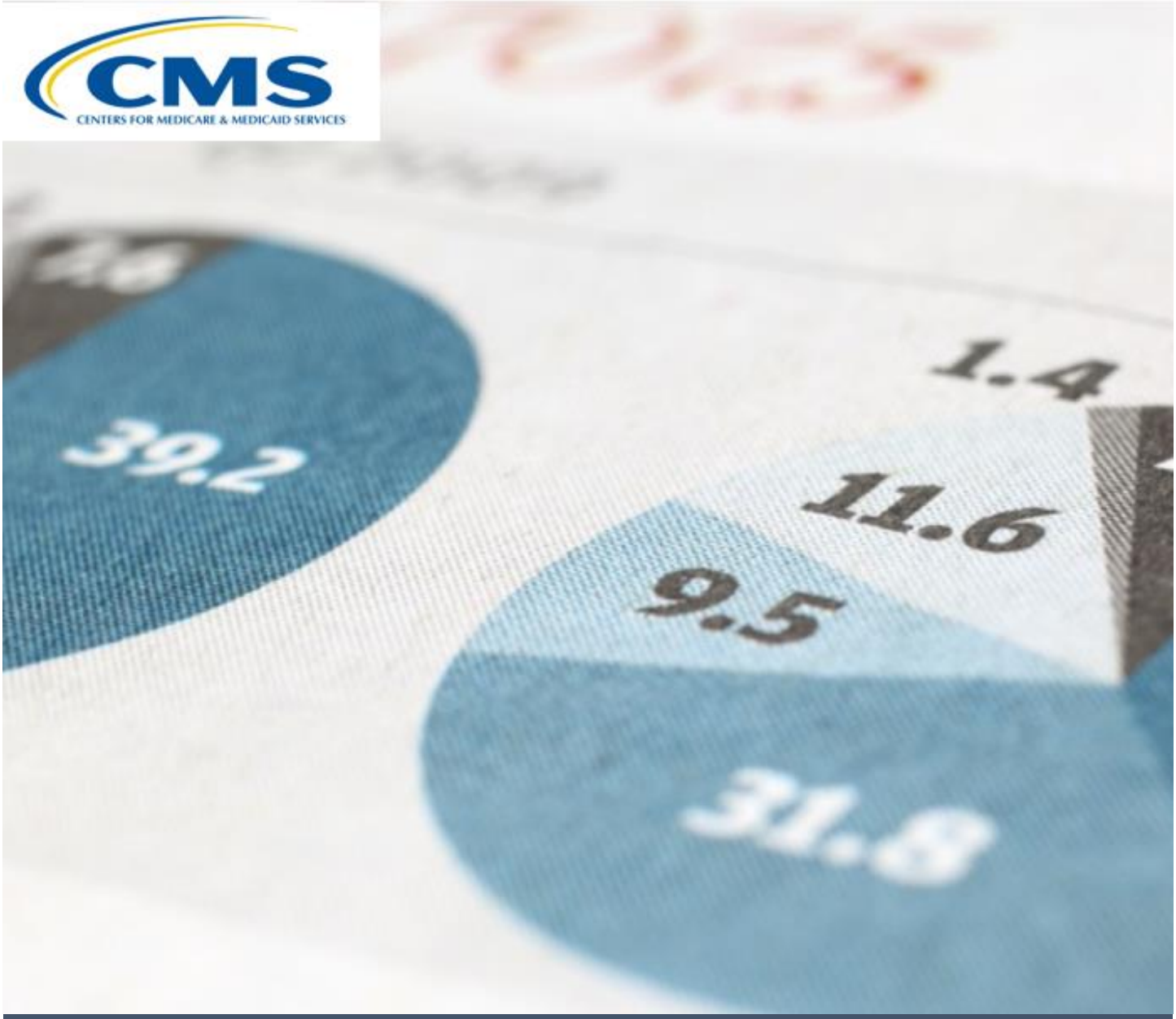

National Medicaid Fee-For-Service (FFS) FFY 2022 Drug Utilization Review (DUR) Annual Report

Executive Summary
National Medicaid Drug Utilization Review (DUR)
Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2022 Annual Report
(FFY 2022 Data: October 2021-September 2022)

Consistent with Section 1927(g)(3)(D) of the Social Security Act (the Act), the Centers for Medicare & 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]

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

Fifty States (this reference includes the District of Columbia hereafter) have submitted a FFY 2022 Medicaid DUR Annual Survey encompassing data from October 1, 2021-September 30, 2022.[2] The information in this report is focused on national Medicaid FFS DUR activities.

- FFY 2022 reported responses include 37,930,305 beneficiaries (36%) enrolled nationally in FFS Medicaid programs and 67,463,281 beneficiaries (64%) enrolled nationally in Medicaid Managed Care programs (MCP). This represents a 10% increase from FFY 2021 in national beneficiary enrollment in FFS Medicaid programs and a corresponding decrease in the national enrollment in Medicaid MCP.[3]

II. Prospective DUR (ProDUR)

Prospective DUR (ProDUR) is one component of the DUR process that is performed prior to dispensing of the prescription to the patient. It 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. ProDUR functions are performed at the point-of-sale (POS) when the prescription is being processed at the pharmacy.

FFY 2022 reported responses confirm all States set early prescription refill thresholds as a way of preventing prescriptions from being over utilized:

[1] All data presented within these reports originate from State responses to the FFY 2022 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 valid until September 2022.
[3] In FFY 2022, the California Medicaid program carved-out their pharmacy benefits from their managed care program and transitioned all pharmacy services to their fee-for-service (FFS) program accounting for the national 10% difference in beneficiary enrollment.

- Non-controlled Substances: State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 80% of the prescription being used before a subsequent prescription could be refilled, consistent with FFY 2021.
- Controlled Substances (CII)[4]: State reported thresholds range from 75% to 100% of a prescription being used, with a national average of 87% of the prescription being used before a subsequent prescription could be dispensed, a 1% increase from FFY 2021.
- Controlled Substances (CIII to CV)[5,6,7]: State reported thresholds range from 75% to 95% of a prescription being used, with a national average of 85% of the prescription being used before a subsequent prescription could be refilled, consistent with FFY 2021.

Additionally, 29 States (58%) utilize a system-accumulation edit as part of their ProDUR edits for preventing early prescription refills, a 4% increase from FFY 2021. Of the 21 States not having an accumulation edit, 8 States (38%) plan to implement this edit in the future.

III. Retrospective DUR (RetroDUR)

Retrospective DUR (RetroDUR) involves an ongoing periodic examination of claims data, when applicable, after a prescription has been dispensed to identify patterns of fraud, abuse, gross overuse, medically unnecessary care, and implementation of corrective action(s). 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 10 States (20%). The remainder of the States utilize a combination of resources. Additionally, all States 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. All States provided a summary of their DUR Board activities. Based on FFY 2022 reported responses, 14 States (28%) reported utilization of a Medication Therapy Management (MTM) program, a professional service provided by pharmacists, a 4% increase from FFY 2021.

V. Physician Administered Drugs

Physician-administered drugs (PAD) are drugs that are covered outpatient drugs under section 1927(k)(2) of the Act and are administered by a medical professional in a physician's office or other outpatient clinical setting. According to FFY 2022 reported responses, 19 States (38%) have incorporated PAD into DUR criteria for ProDUR reviews, a 10% increase from FFY 2021, and 9 States (29%) plan to incorporate these drugs in the future. Additionally, 22 States (44%) have incorporated PAD into their DUR criteria for RetroDUR reviews, a 4% increase from FFY 2021, while 8 States (29%) plan to incorporate these drugs in their RetroDUR reviews in the future.

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[4] Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. Additional drugs may be also considered Schedule II as defined by State specific law.
[5] Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Additional drugs may be also considered Schedule III as defined by State specific law.
[6] Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Additional drugs may be also considered Schedule IV as defined by State specific law.
[7] Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Additional drugs may be also considered Schedule V as defined by State specific law.

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 2022 national percent average for generic utilization rate was 86%, a 1% increase from FFY 2021.

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 2022 can be accessed under *State FFS Individual Reports* on Medicaid.gov.

VIII. Fraud, Waste and Abuse (FWA) Detection

A. Lock- In or Patient Review and Restriction Programs

Lock-In or Patient Review and Restriction Programs are often used to restrict beneficiaries to specific practitioners or pharmacies, when their utilization of medical services is documented as being potentially unsafe, excessive, or who 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 2022 State responses, all States reported having processes in place to identify potential fraud or abuse of controlled substances by beneficiaries. Additionally, 46 States (92%) have a Lock-In program for beneficiaries, consistent with FFY 2021. A total of 29 States (63%) reported restricting beneficiaries to a specific prescriber, a 2% increase from FFY 2021, and 40 States (87%) reported restricting beneficiaries to a specific pharmacy, a 7% increase from FFY 2021.

While the title of this subsection refers to Lock-In and Patient Review and Restriction Programs, the survey also includes questions related to the processes used by programs to identify potential fraud, waste and abuse. The FFY 2022 reported responses also identifies States with a process to identify possible fraudulent practices of health care providers. For example, all States have processes in place to identify potential fraudulent practices by prescribers, a 6% increase form FFY 2021, and 49 States have processes in place to identify potential fraudulent practices by pharmacies, a 6% increase from FFY 2021. These reviews initiate 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. State responses indicate:

- 23 States (46%) have the ability to query their States' PDMP database directly and 10 States (20%) receive PDMP data from their State upon request.
    - 18 (64%) of these 33 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, 17 States (34%) are unable to access their States' PDMP data in any form; however, this is a 14% improvement from FFY 2021 responses.
- All States require that prescribers access the patient history in the PDMP database prior to prescribing controlled substances, a 16% increase from FFY 2021.
- 35 States (70%) responded that they face a range of barriers that hinder their ability to fully

access and utilize the PDMP database, an 8% decrease from FFY 2021. Barriers included, based on State responses, lack of data, financial constraints for funding third party vendors, PDMPs being managed by a different agency, and/or State enacted legislation that prohibits their access.

C. Opioids

According to FFY 2022 responses, 48 States (96%) have POS safety edits in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients. Based on FFY 2022 reported responses, 38 States (76%) apply this POS edit to all opioid prescriptions, a 6% increase from FFY 2021, and 10 States (20%) apply this edit to some opioid prescriptions, a 6% decrease from FFY 2021. The median days' supply for an initial opioid prescription for an opioid naïve patient, based on FFY 2022 reported responses, is 7 days and the national range is between 5 and 34 days, consistent with FFY 2021. 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, but are not limited to, prescriber intervention letters and morphine milligram equivalent (MME) daily dose programs. 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, pursuant to FFY 2022 responses:

- 49 States (98%) have prospective edits in place to monitor duplicate therapy of opioid prescriptions, a 4% increase from FFY 2021.
- All States have prospective edits in place to monitor early refills of opioid prescriptions, consistent with FFY 2021.
- 49 States (98%) have an automated retrospective claims review process to monitor opioid prescriptions exceeding State limitations, a 34% increase from FFY 2021.
- All States have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently, a 2% increase from FFY 2021.
- 44 States (88%) have prospective edits or a retrospective claims review process to monitor opioids and sedatives being used concurrently, a 14% increase from FFY 2021.
- All States have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently, a 6% increase from FFY 2021.
- 40 States (80%) have prospective edits or a retrospective claims review process to monitor beneficiaries with a diagnosis or history of opioid use disorder or opioid poisoning.
- 37 States (74%) utilize abuse deterrent opioids to prevent misuse and abuse, an 8% increase from FFY 2021.
- 42 States (84%) develop and/or provide prescribers with pain management or opioid prescribing guidelines, a 2% increase from FFY 2021.

D. Morphine Milligram Equivalent (MME) Daily Dose

FFY 2022 responses confirm all States set recommended maximum MME daily doses to reduce potential patient harm, abuse and/or diversion, a 2% increase from FFY 2021. The median MME daily dose for FFY 2022 reported responses is 90 mg/day which includes a national range of 30 to 500 mg/day, each State having their specific methodology used for MME calculation, consistent with FFY 2021.

Additionally, FFY 2022 reported responses confirm:

- 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, consistent with FFY 2021.
- All States have an edit in their POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded, an 8% increase from FFY 2021.
- 43 States (86%) have an automated retrospective claims review process to monitor the total daily dose of MMEs for opioid prescriptions dispensed, a 26% increase from FFY 2021.

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 2022 reported responses, 47 States (94%) have utilization controls to monitor or manage prescribing of medication-assisted treatment drugs for OUD, a 2% increase from FFY 2021.

Further, FFY 2022 reported responses confirmed 43 States (86%) set total milligrams per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs. Additionally, 4 States (8%) also set limitations on allowable length of treatment for a beneficiary receiving buprenorphine and buprenorphine/ naloxone combination drugs while 46 States (92%) have no limits assessed, consistent with FFY 2021. FFY 2022 reported responses also confirm 46 States (92%) provide at least one buprenorphine and buprenorphine/naloxone combination drug without a prior authorization requirement, a 6% increase from FFY 2021. Additionally, 41 States (82%) have system edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of medication-assisted treatment (MAT), a 2% decrease from FFY 2021; however, 5 States do monitor retrospectively.

Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist and can reverse and block the effects of opioids. Currently, naloxone is available without prior authorization in all States and all States allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols. Additionally, 38 States (76%) retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose. Also, based on FFY 2022 reported responses, 49 States (98%) have at least 1 formulation of naltrexone for OUD available without a prior authorization.

F. Outpatient Treatment Programs (OTP)

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). The FDA has approved methadone as one of three drugs for treatment of OUD within an OTP. Based on FFY 2022 reported responses, 48 States (96%) provide coverage for methadone for OUD through an OTP.

G. Psychotropic Medication for Children

Antipsychotic Medication

According to FFY 2022 reported responses, all States have a program in place for managing or monitoring appropriate use of antipsychotic drugs in children. Additionally, all States monitor the use of these medications in children in foster care.

Stimulant Medication

According to FFY 2022 reported responses, 46 States (92%) have a program in place for managing or monitoring appropriate use of stimulant drugs in all children, including those in foster care, an 8% increase from FFY 2021. The 4 States without a stimulant medication monitoring program reported

they have plans for future implementation.

Antidepressant Medication

According to FFY 2022 reported responses, 41 States (82%) have a program in place for managing or monitoring appropriate use of antidepressant medication in children, a 12% increase from FFY 2021. Seven States reported they plan a future implementation of an antidepressant medication monitoring program.

Mood Stabilizer Medication

According to FFY 2022 reported responses, 34 States (68%) have a program in place for managing or monitoring appropriate use of mood stabilizing medication in children, a 12% increase from FFY 2021. Ten States reported they plan a future implementation of a mood stabilizer medication monitoring program.

Antianxiety/Sedative Medication

According to FFY 2022 reported responses, 40 States (80%) have a program in place for managing or monitoring appropriate use of antianxiety/sedative medication in children, a 12% increase from FFY 2021. Eight States reported they plan a future implementation of an anxiety/sedative medication monitoring program.

IX. Innovative Practices

Sharing of new ideas and best practices is an invaluable resource to all States. FFY 2022 reported responses include 43 State submissions for DUR innovative practices that can be accessed at the end of this report.

FFY 2022 reported responses also confirm 3 States (6%) currently participate in a demonstration or have a waiver to allow for drug importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries. This is a 4% increase from FFY 2021.

X. Managed Care Organizations (MCOs)

All MCOs have submitted the FFY 2021 DUR annual survey. Based on FFY 2022 reported responses, 40 States have active MCOs encompassing 251 managed care programs. Furthermore, 7 of these States (CA, MO, ND, OH (partial), TN, WI, and WV) carve out their drug benefit and submitted an abbreviated MCO survey for each of their programs. National, State and Abbreviated MCO reports can be accessed on Medicaid.gov.

XI. State Executive Summaries

All States have submitted Executive Summaries and can be accessed at the end of this report.

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

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Section I - Demographic Information

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 Pharmacy Benefit

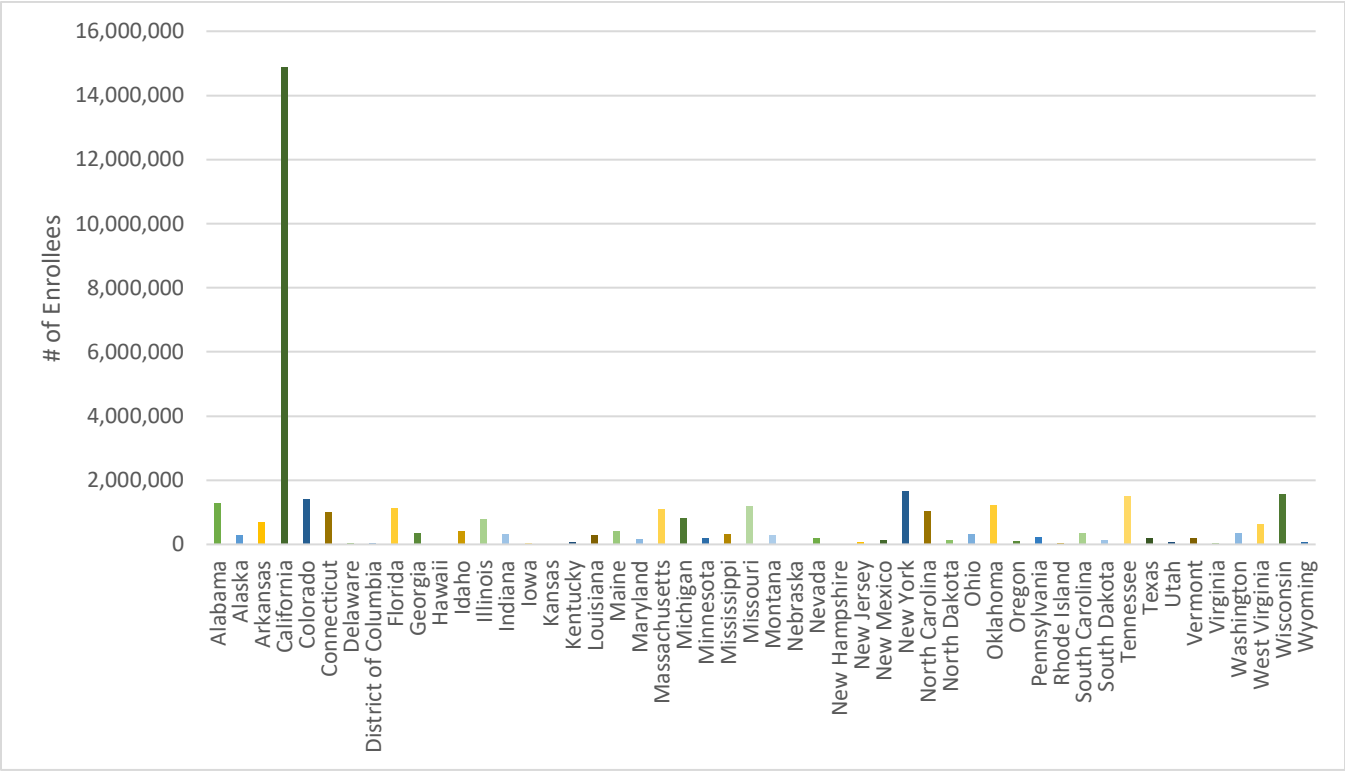

Table 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Alabama	1,291,932
Alaska	277,958
Arkansas	702,094
California	14,875,290
Colorado	1,399,988
Connecticut	995,878
Delaware	41,612
District of Columbia	52,151
Florida	1,118,649
Georgia	366,454
Hawaii	50
Idaho	430,325
Illinois	778,316
Indiana	333,918
Iowa	50,747

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Kansas	457
Kentucky	68,759
Louisiana	275,188
Maine	405,496
Maryland	168,096
Massachusetts	1,113,836
Michigan	829,346
Minnesota	203,537
Mississippi	311,608
Missouri	1,209,920
Montana	282,018
Nebraska	1,570
Nevada	202,435
New Hampshire	3,868
New Jersey	61,971
New Mexico	147,510
New York	1,670,000
North Carolina	1,038,445
North Dakota	120,500
Ohio	321,799
Oklahoma	1,234,462
Oregon	112,986
Pennsylvania	243,694
Rhode Island	56,271
South Carolina	350,000
South Dakota	145,000
Tennessee	1,502,804
Texas	194,237
Utah	86,915
Vermont	189,010
Virginia	32,544
Washington	338,443
West Virginia	644,656
Wisconsin	1,570,089
Wyoming	77,473
Total	37,930,305

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

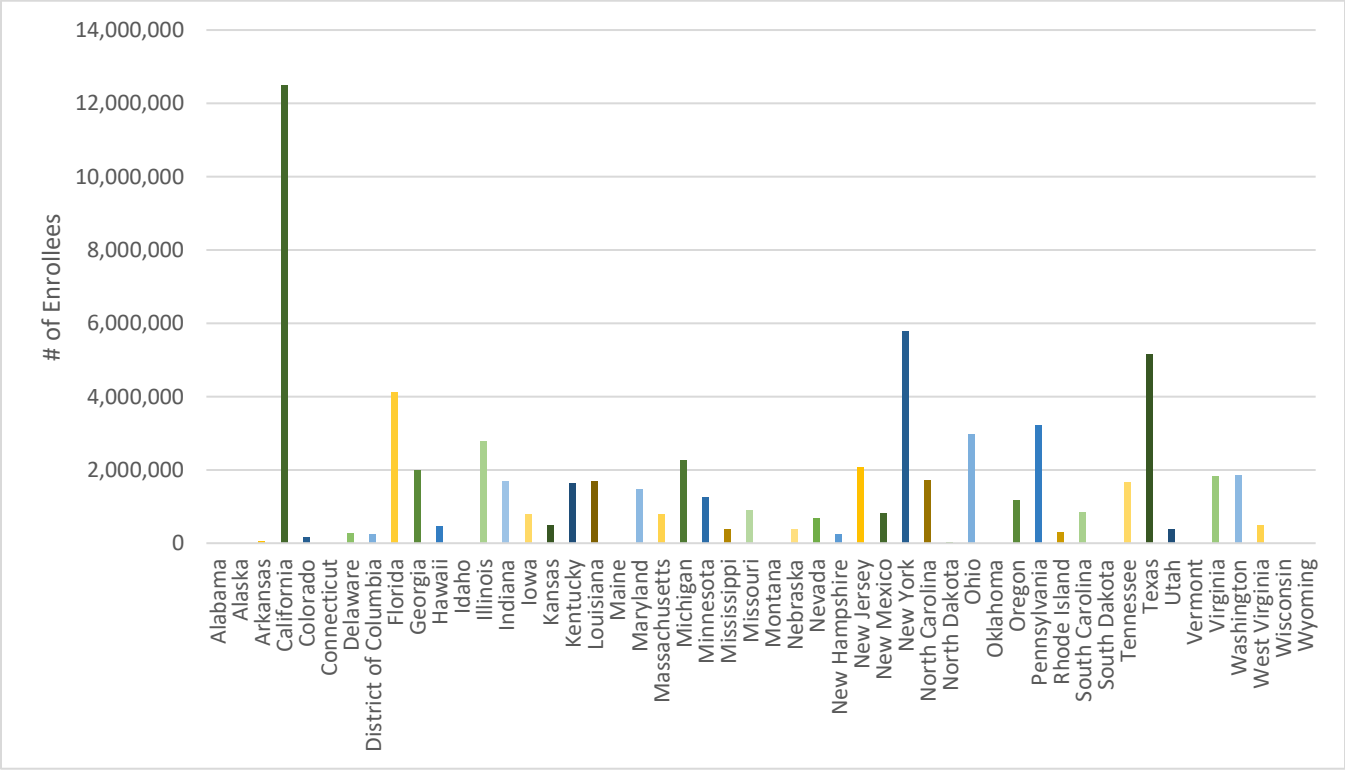

Table 2 - Medicaid Beneficiaries Enrolled in MCOs by State

State	Number of Beneficiaries Enrolled in MCO Plans
Alabama	0
Alaska	0
Arkansas	53,934
California	12,502,567
Colorado	159,074
Connecticut	0
Delaware	269,908
District of Columbia	249,241
Florida	4,108,013
Georgia	1,985,529
Hawaii	467,000
Idaho	0
Illinois	2,776,463
Indiana	1,698,951
Iowa	788,962
Kansas	480,566
Kentucky	1,628,682

State	Number of Beneficiaries Enrolled in MCO Plans
Louisiana	1,679,371
Maine	0
Maryland	1,471,670
Massachusetts	782,575
Michigan	2,263,426
Minnesota	1,240,055
Mississippi	389,536
Missouri	895,556
Montana	0
Nebraska	391,465
Nevada	690,454
New Hampshire	232,917
New Jersey	2,057,426
New Mexico	806,675
New York	5,781,000
North Carolina	1,708,402
North Dakota	32,275
Ohio	2,961,711
Oklahoma	0
Oregon	1,175,221
Pennsylvania	3,206,445
Rhode Island	310,640
South Carolina	850,000
South Dakota	0
Tennessee	1,669,322
Texas	5,167,075
Utah	378,621
Vermont	0
Virginia	1,813,559
Washington	1,854,062
West Virginia	484,932
Wisconsin	0
Wyoming	0
Total	67,463,281

Section II - Prospective DUR (ProDUR)

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

Figure 3 - Pharmacy POS Type of Vendor

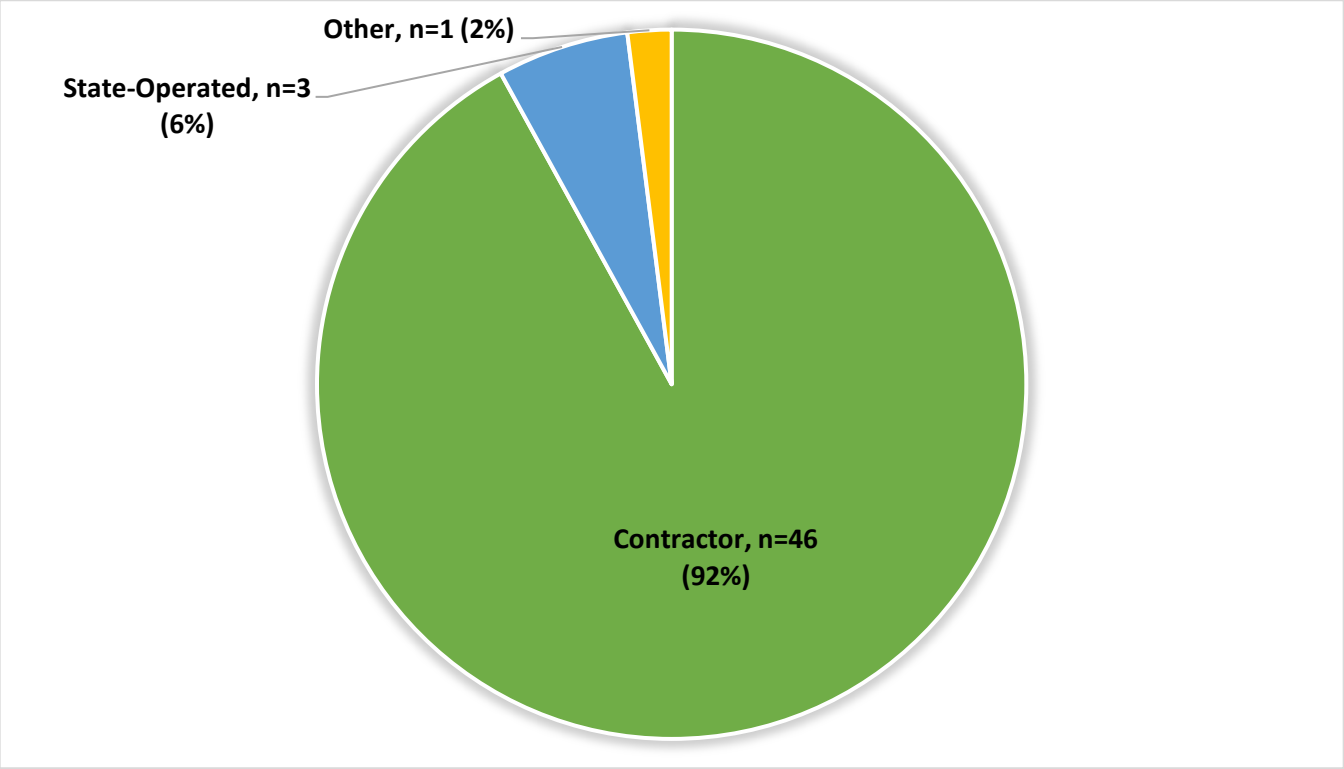

Table 3 - Pharmacy POS Type of Vendor

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, Connecticut, Delaware, Kansas, Louisiana, New Jersey, Oregon, Pennsylvania, Rhode Island, West Virginia, Wisconsin	11	23.40%

Response	States	Count	Percentage
Magellan	Alaska, Arkansas, California, Colorado, District of Columbia, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, South Carolina, Virginia	13	27.66%
OptumRx	Georgia, Tennessee	2	4.26%
Conduent	Hawaii, Maryland, Massachusetts, Mississippi, Montana, New Mexico	6	12.77%
State operated using Change Healthcare Pharmacy Benefits Management System (PBMS) to process claims.	Illinois	1	2.13%
Optum Rx Administrative Services, LLC. (Optum Rx)	Indiana	1	2.13%
Change Healthcare	Iowa, Maine, Ohio, Utah, Vermont, Wyoming	6	12.77%
Wipro and Conduent	Missouri	1	2.13%
OptumRx (Q1 FFY2022-Q3 FFY2022). Magellan Medicaid Administration (Q4 FFY2022)	Nevada	1	2.13%
General Dynamics Information Technology (GDIT)	New York	1	2.13%
CSRA/GDIT	North Carolina	1	2.13%
Gainwell	Oklahoma	1	2.13%
OptumRx (although they do not function as the fiscal agent or PBM despite the answer selected below)	South Dakota	1	2.13%
Conduent Public Health Solutions INC	Texas	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

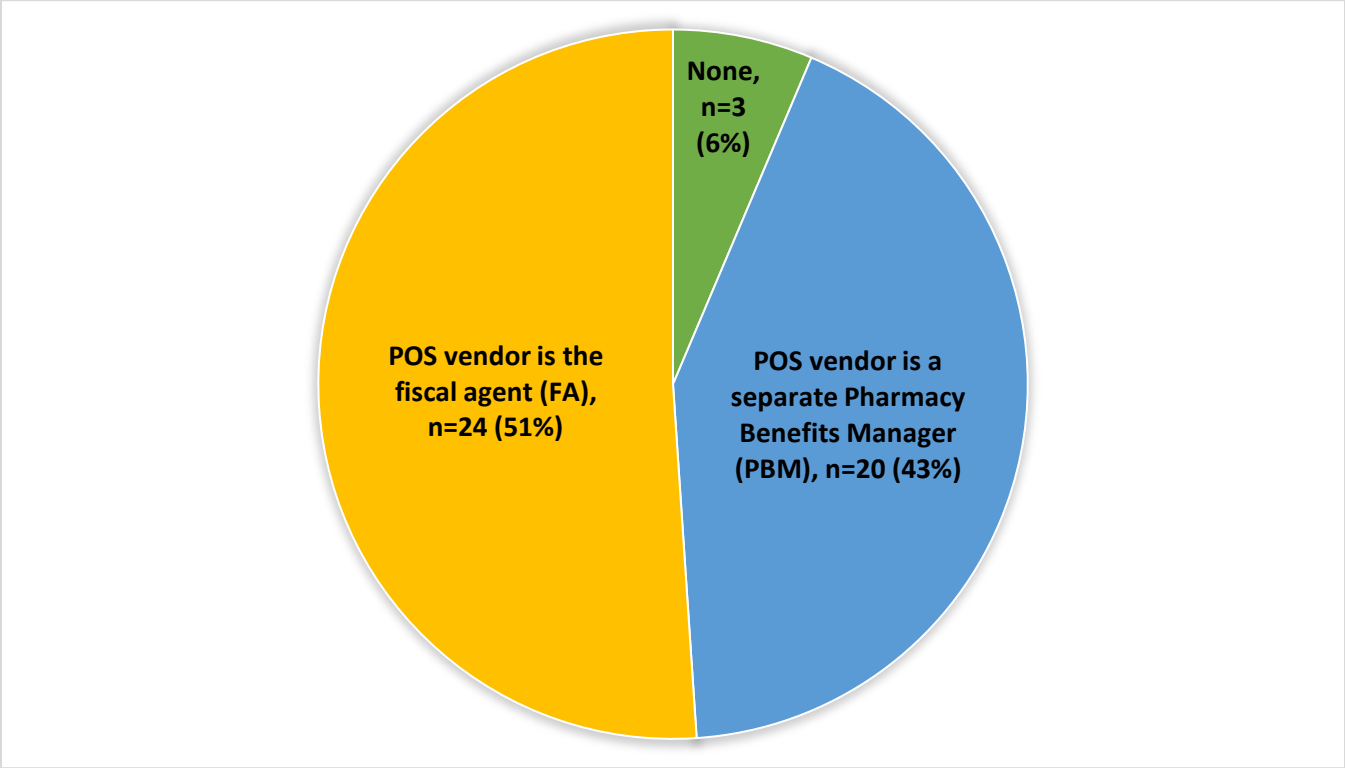

Table 5 - Who Processes the State's National Council for Prescription Drug Programs (NCPDP) transactions

Response	States	Count	Percentage
None	Arkansas, Florida, Indiana	3	6.38%
POS vendor is a separate Pharmacy Benefits Manager (PBM)	Alaska, Colorado, District of Columbia, Georgia, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Michigan, Nebraska, Nevada, New Hampshire, Ohio, South Carolina, Tennessee, Utah, Vermont, Wyoming	20	42.55%
POS vendor is the fiscal agent (FA)	Alabama, California, Connecticut, Delaware, Hawaii, Kansas, Louisiana, Massachusetts, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Virginia, West Virginia, Wisconsin	24	51.06%
Total		47	100.00%

2. Identify your ProDUR table driven criteria source (multiple responses allowed).

Figure 5 - ProDUR Criteria Source

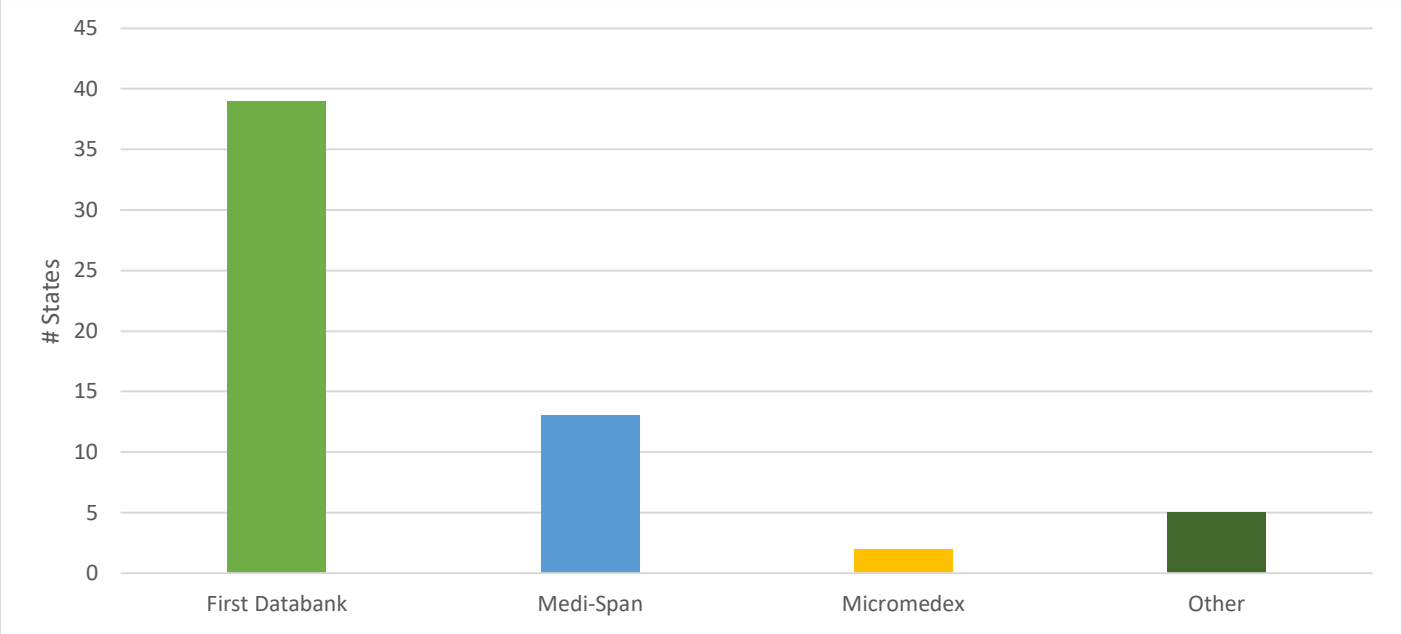

Table 6 - ProDUR Criteria Source

Response	States	Count	Percentage
First Databank	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Kansas, Kentucky, 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, Virginia, West Virginia, Wisconsin	39	66.10%
Medi-Span	Georgia, Illinois, Indiana, Iowa, Maine, Nevada, Ohio, South Dakota, Tennessee, Utah, Vermont, Washington, Wyoming	13	22.03%
Micromedex	Mississippi, Oregon	2	3.39%
Other	Illinois, Louisiana, Texas, Vermont, Washington	5	8.47%
Total		59	100.00%

If "Other," please specify.

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

State	Explanation
Illinois	Additional criteria are developed by HFS with input from the DUR Board. Some are also 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, Gainwell Technologies, and the University of Louisiana at Monroe.
Texas	Some criteria are developed in-house.
Vermont	Clinical literature and FDA safety alerts

State	Explanation
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 National Council for Prescription Drug Programs (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

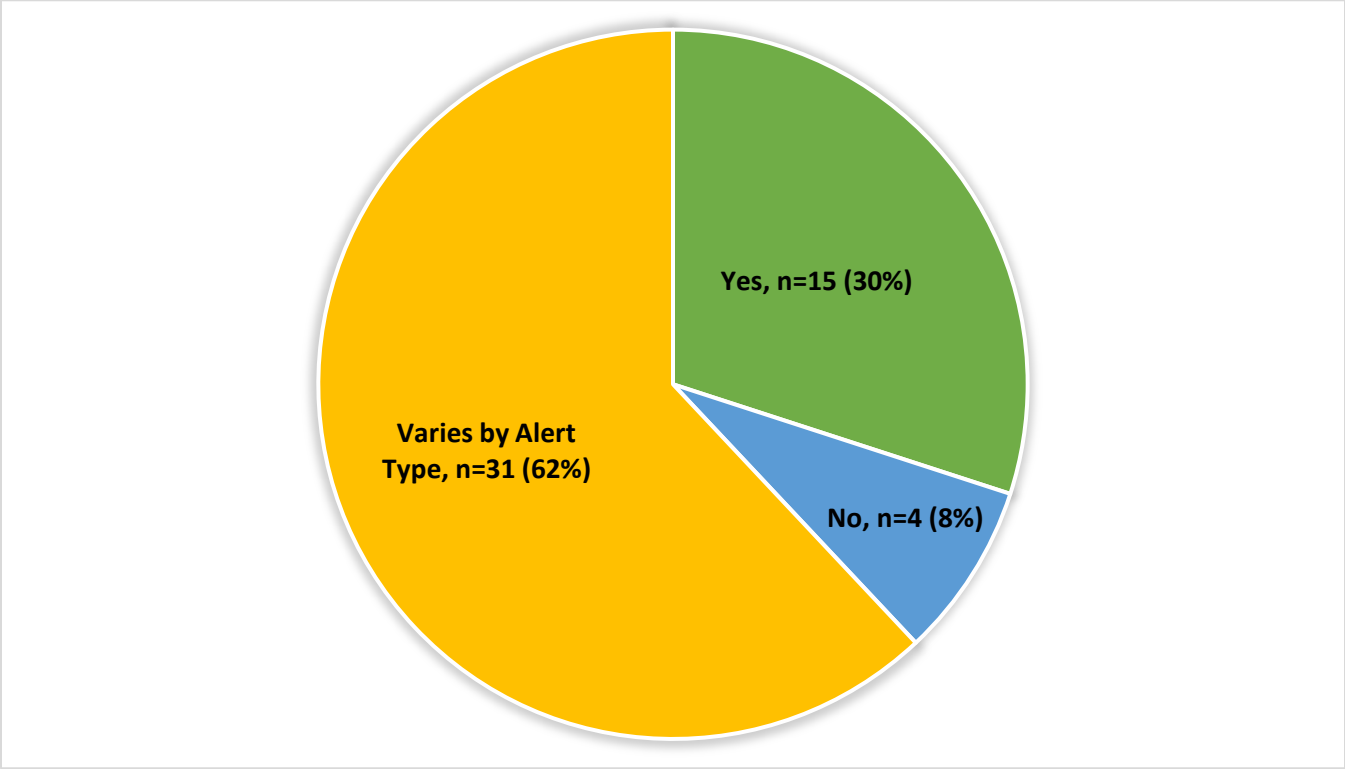

Table 8 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

Response	States	Count	Percentage
Yes	Alaska, Connecticut, District of Columbia, Florida, Kentucky, Maryland, Michigan, Mississippi, Missouri, New Mexico, Oregon, Rhode Island, Utah, Virginia, Wyoming	15	30.00%
No	Illinois, Iowa, Maine, New Jersey	4	8.00%
Varies by Alert Type	Alabama, Arkansas, California, Colorado, Delaware, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin	31	62.00%
Total		50	100.00%

If "Yes" or "Varies by Alert Type," check all that apply.

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	8.51%
Alerts can be overridden with standard professional codes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, 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	46	48.94%
Alerts need prior authorization (PA) to be overridden	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington, West Virginia, Wisconsin	31	32.98%
Other	Arkansas, Colorado, Indiana, New Hampshire, North Carolina, Ohio, Texas, Vermont, Wisconsin	9	9.57%
Total		94	100.00%

If “Other,” please explain.

Table 10 - Explanation for “Other” ProDUR Alert Message Override

State	Explanation
Arkansas	Most level-one alerts can be overridden by the pharmacist at POS using standard professional codes. 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 prior authorization review by the vendor's help desk.
Colorado	Selected ProDUR alerts may be overridden by pharmacists using standard professional codes.
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.
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.
Ohio	Some alerts may be overridden by NCPDP Professional Pharmacy Service (PPS) codes. Other alerts may require prior authorization completion by the prescriber.
Texas	Except for Med Synchronization purposes, all early refills will require an override by calling HHSC Help Desk. Early refill does not require a prior authorization request from prescriber.
Vermont	Some ProDUR messaging is only set to soft messaging to alert the pharmacist of potential interaction., so no override is necessary.
Wisconsin	There are Controlled Substance drugs in the early refill alert that require a call by the pharmacy to the Drug Authorization Policy Override (DAPO) Center to get an override (prior authorization) before dispensing of the medication. All other prospective DUR alerts allow the pharmacist to override the alert. During the public health emergency, all DAPO early refill alerts were moved to allow a pharmacist override, except for Schedule II drugs. As of December 1, 2022, our standard early refill alerts were reinstated.

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

Figure 8 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

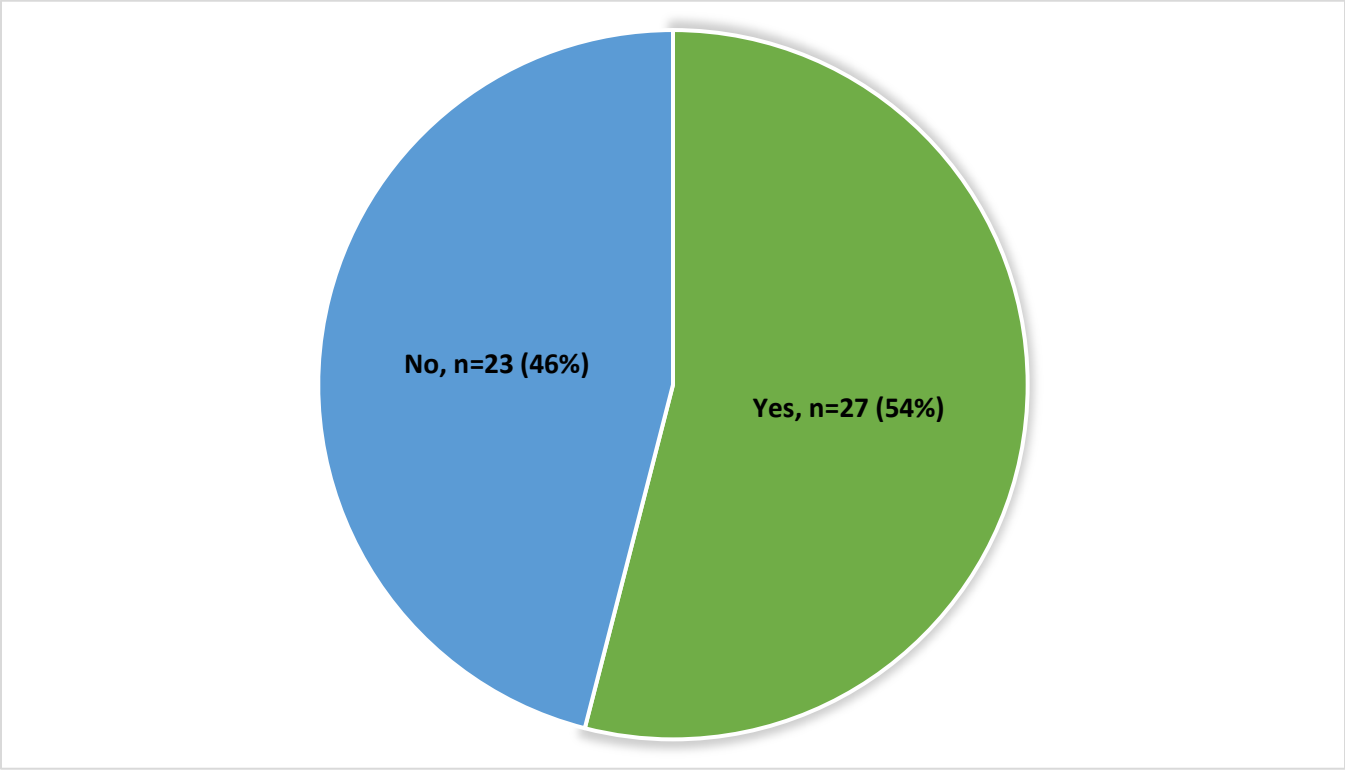

Table 11 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Kentucky, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Vermont, Virginia	27	54.00%
No	Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, Wyoming	23	46.00%
Total		50	100.00%

If "No," please explain.

Table 12 - "No" Explanation for Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

State	Explanation
Florida	ProDUR alerts are an indication of the edits previously established by the DUR Board. The DUR Board makes upfront decisions on whether edits should be overridden at the pharmacy level (based on clinical judgement). The programming is then implemented to reflect soft or hard edits. Therefore, a pharmacist is only able to override those alerts that the Board has pre-determined should be left to their discretion (as soft edits). ProDUR monitoring reports are not generated outside of the standard fiscal monitoring of Medicaid Program Integrity. The Bureau of Medicaid Program Integrity reviews the pharmacy provider activity, not Pharmacy section under the Policy Bureau.
Georgia	Can receive on an ad hoc basis if needed.
Idaho	No individual pharmacy reports are generated at this time.
Illinois	The State does not receive reports regarding pharmacy provider DUR alert override activity.
Indiana	The claims processing system has logic in place to determine appropriate pharmacy provider submission of conflict, intervention, and outcome codes. We continue to evaluate the utility of this type of reporting.
Iowa	Pharmacists are not able to override the alert.
Kansas	Our fiscal agent creates a summary-only report for this survey. The State is working to create a data query which will provide more details for this monitoring process. There are some system changes needed to allow for a more detailed report and we are working through that data system update with our fiscal agent.
Louisiana	Currently Louisiana does not receive periodic reports providing individual pharmacy providers DUR alert override activity.
Maine	Currently we do not allow pharmacies to override conflict codes/interventions. soft messaging is relayed back to the pharmacies
Maryland	Reports are generated and reviewed ad hoc or as necessary for individual pharmacy providers.
Minnesota	These reports can be produced when desired. The refill too soon edit requires a PA which is approved for less than 1% of prescriptions with the refill too rejection. Informational edits are not reviewed.
Missouri	We can request reports as needed, but do not do so on a scheduled basis.
Montana	The only edits pharmacists can override without a PA are FDB prompted edits such as high dose or duplicate therapy. The State trusts that pharmacists are utilizing these overrides appropriately and does not deem it necessary to utilize State staff to monitor this on a regular basis. However, utilization of override edits is reviewed in the course of pharmacy audits. We have not had reports of misuse from the audit team.
Nevada	Nevada has not developed a process to identify individual pharmacy provider DUR alert override activity in summary and/or detail.
New Jersey	Prospective DUR alerts cannot be overridden by the pharmacy provider.
South Carolina	No specific State requested reporting runs. Reports are available as ad hoc and at State's request and annually
Tennessee	At this time, we do not feel that this particular report is necessary for our pharmacy program. However, we do monitor the use of the 3-day emergency DUR override on a pharmacy level to ensure that pharmacies are utilizing this edit appropriately.
Texas	Ad-hoc reports are run as needed.

State	Explanation
Utah	Reports are received on an as needed basis from the point of sale contractor.
Washington	Washington Medicaid considers potential misuse of submitted DUR codes to be an issue of misuse and abuse, rather than a clinical issue, and defers review of submitted DUR codes to the Program Integrity team as permitted under 42 CFR 456.714 and limits the review activities of DUR staff to those that focus on what constitutes appropriate and medically necessary care. Use of DUR codes are reviewed for accuracy and appropriateness during individual pharmacy audits.
West Virginia	No we are not set up to however we can ask for that data to be provided.
Wisconsin	The Wisconsin DUR Board has previously reviewed pharmacy overrides and the Board members have cautioned the State on the validity on the answers received from the pharmacy. Pharmacies will often override a prospective DUR alert in order to move the prescription to the next phase of review; either outreach to the prescriber or counseling the patient. The responses may not accurately reflect the final decision of what occurred regarding the prescription dispensing.
Wyoming	Reports were reviewed for some time in the past and were not found to be informative or actionable.

a. If "Yes," how often does your State receive reports (multiple responses allowed)?

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

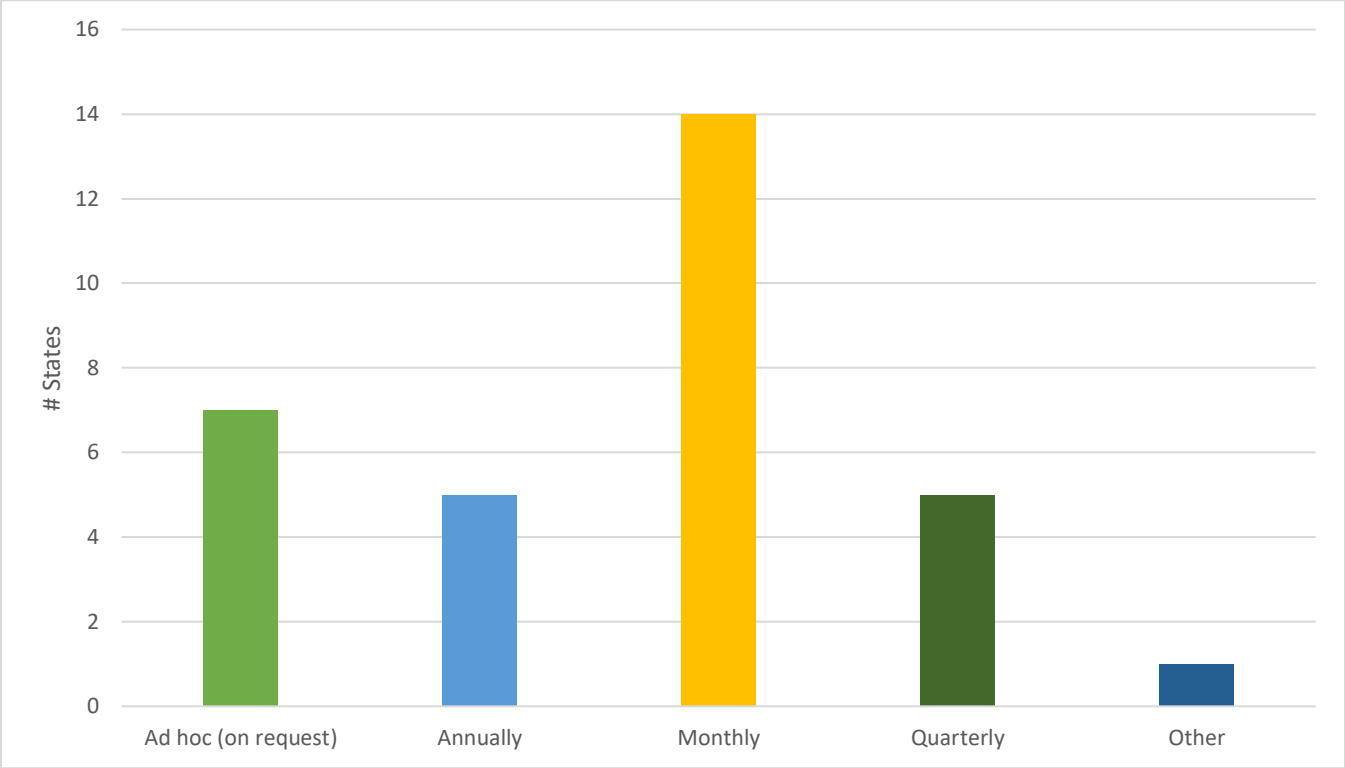

Table 13 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity

Response	States	Count	Percentage
Ad hoc (on request)	Alaska, Arkansas, California, Colorado, Hawaii, North Carolina, North Dakota	7	21.88%
Annually	Alaska, Kentucky, New York, Rhode Island, South Dakota	5	15.63%
Monthly	Alabama, California, Connecticut, Delaware, District of Columbia, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, Ohio, Pennsylvania, Virginia	14	43.75%
Quarterly	Michigan, North Carolina, Oklahoma, Oregon, Vermont	5	15.63%
Other	Arkansas	1	3.13%
Total		32	100.00%

If "Other," please explain.

Table 14 - "Other" Explanation for Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity

State	Explanation
Arkansas	Typically, the pharmacy providers DUR alert override activity report is a summary for all pharmacies together provided quarterly during the DUR Board meeting. However, ad hoc reports are possible for individual pharmacies.

b. If "Yes," does your State follow up with those providers who routinely override with interventions?

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

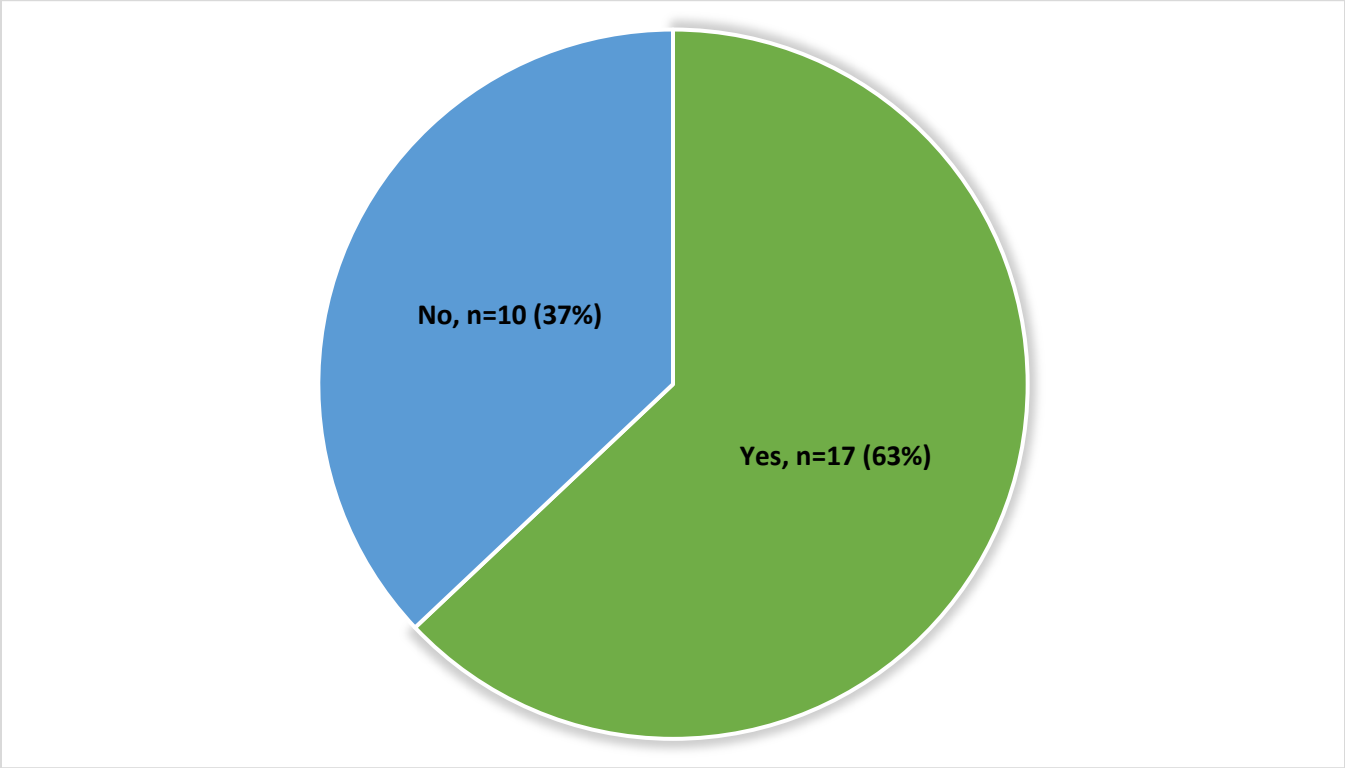

Table 15 – Follow up with Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Delaware, District of Columbia, Hawaii, Kentucky, Massachusetts, Michigan, Nebraska, New York, North Dakota, Oklahoma, South Dakota, Vermont, Virginia	17	62.96%
No	Arkansas, Connecticut, Mississippi, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island	10	37.04%
Total		27	100.00%

If "Yes," by what method does your State follow up (multiple responses allowed)?

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

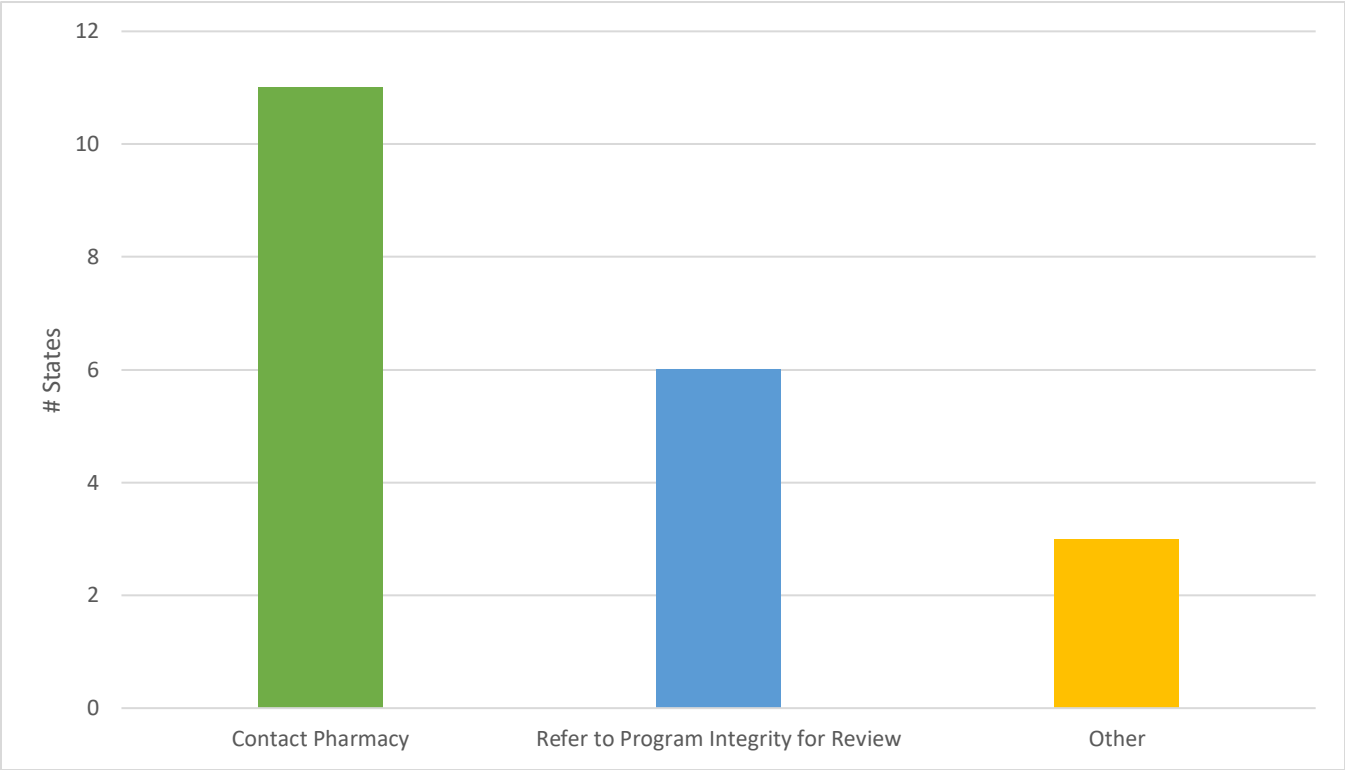

Table 16 - Follow-up Methods for Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Contact Pharmacy	Alaska, California, Delaware, District of Columbia, Hawaii, Massachusetts, Michigan, Nebraska, North Dakota, Oklahoma, South Dakota	11	55.00%
Refer to Program Integrity for Review	Colorado, District of Columbia, Kentucky, Michigan, North Dakota, Virginia	6	30.00%
Other	Alabama, New York, Vermont	3	15.00%
Total		20	100.00%

If "Other," please explain.

Table 17 - "Other" Explanations for Follow-up Methods for Providers who Routinely Override with Interventions

State	Explanation
Alabama	Alabama Medicaid has an Academic Detailing program that provides scheduled face-to-face visits to providers.
New York	Pharmacy provider interventions concerning potential drug related problems are communicated / addressed through the RetroDUR intervention therapeutic criteria exemption program/processes/reviews.
Vermont	Policy allows the pharmacist to 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 pharmacist 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

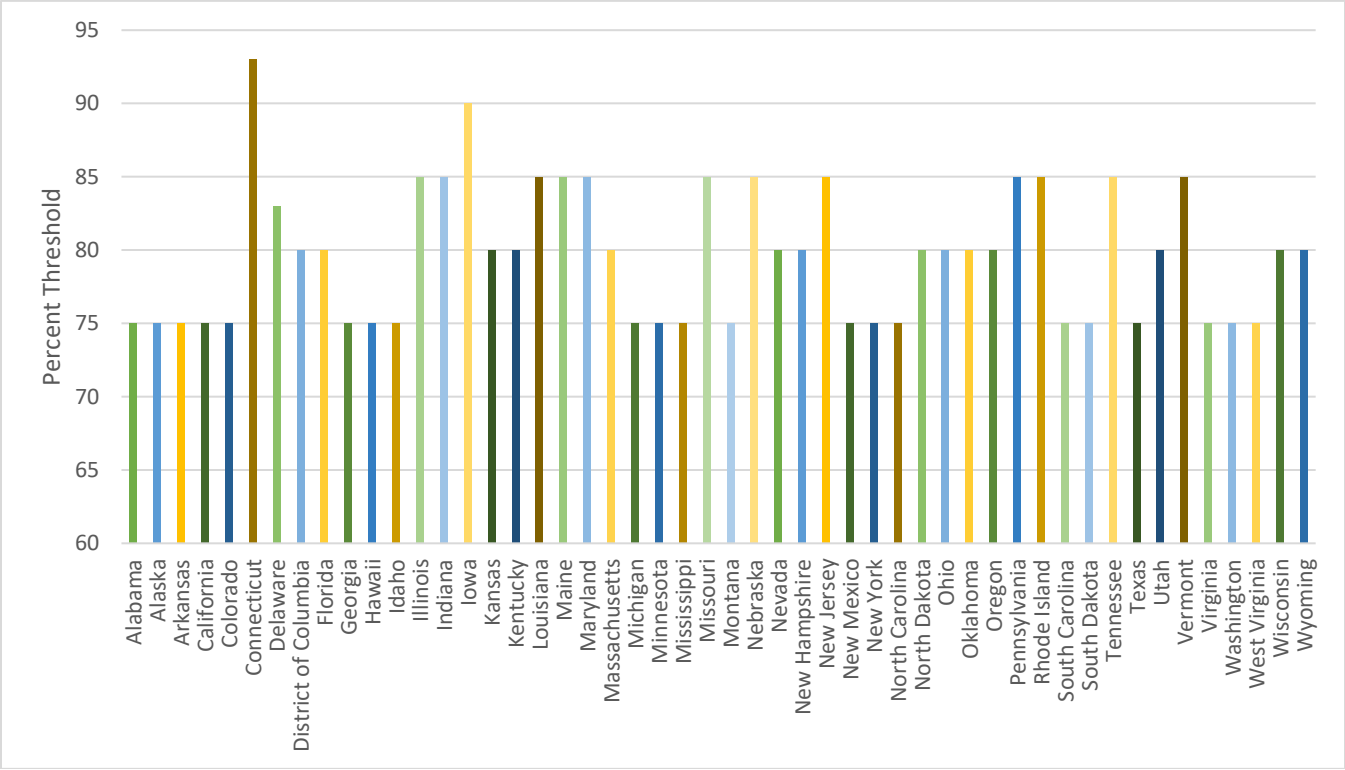

Figure 13 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold

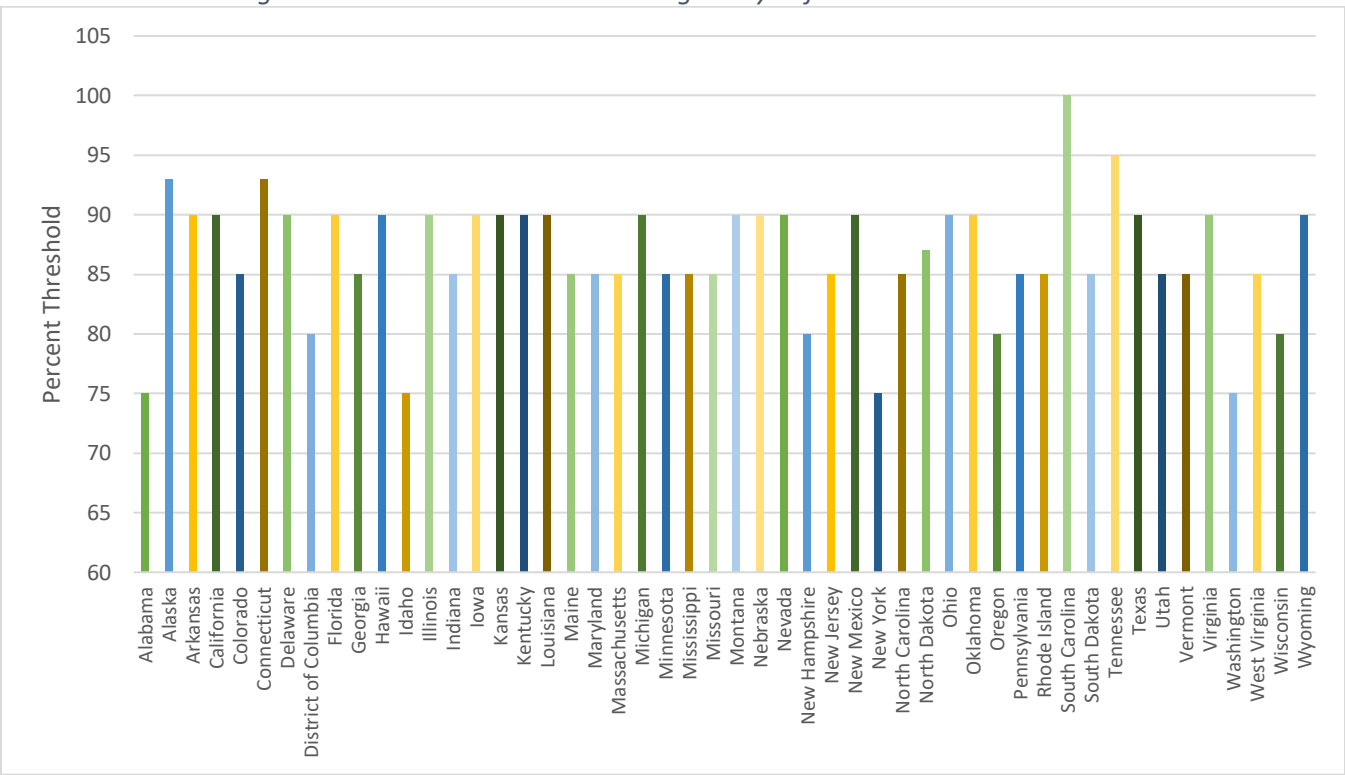

Figure 14 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold

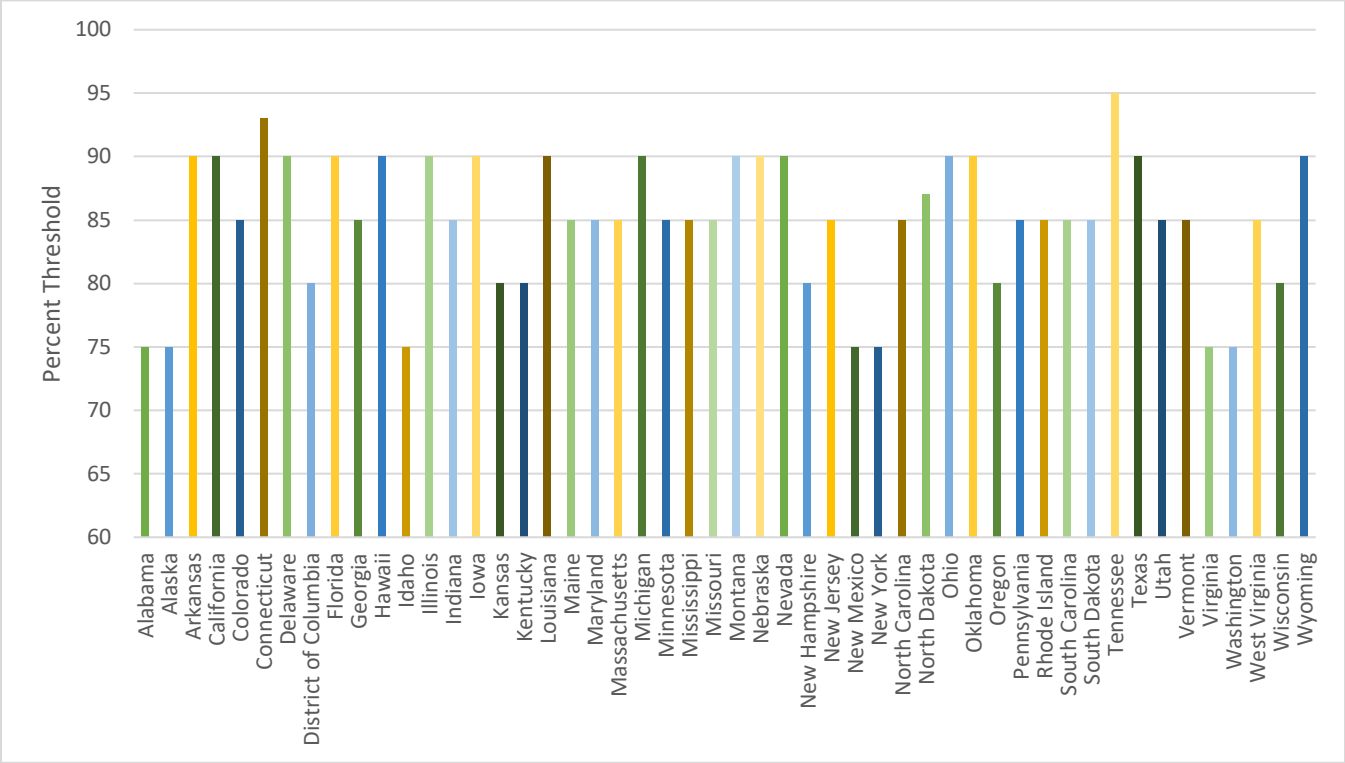

Table 18 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Alabama	75%	75%	75%
Alaska	75%	93%	75%
Arkansas	75%	90%	90%
California	75%	90%	90%
Colorado	75%	85%	85%
Connecticut	93%	93%	93%
Delaware	83%	90%	90%
District of Columbia	80%	80%	80%
Florida	80%	90%	90%
Georgia	75%	85%	85%
Hawaii	75%	90%	90%
Idaho	75%	75%	75%
Illinois	85%	90%	90%
Indiana	85%	85%	85%
Iowa	90%	90%	90%
Kansas	80%	90%	80%
Kentucky	80%	90%	80%
Louisiana	85%	90%	90%
Maine	85%	85%	85%
Maryland	85%	85%	85%
Massachusetts	80%	85%	85%
Michigan	75%	90%	90%
Minnesota	75%	85%	85%

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Mississippi	75%	85%	85%
Missouri	85%	85%	85%
Montana	75%	90%	90%
Nebraska	85%	90%	90%
Nevada	80%	90%	90%
New Hampshire	80%	80%	80%
New Jersey	85%	85%	85%
New Mexico	75%	90%	75%
New York	75%	75%	75%
North Carolina	75%	85%	85%
North Dakota	80%	87%	87%
Ohio	80%	90%	90%
Oklahoma	80%	90%	90%
Oregon	80%	80%	80%
Pennsylvania	85%	85%	85%
Rhode Island	85%	85%	85%
South Carolina	75%	100%	85%
South Dakota	75%	85%	85%
Tennessee	85%	95%	95%
Texas	75%	90%	90%
Utah	80%	85%	85%
Vermont	85%	85%	85%
Virginia	75%	90%	75%
Washington	75%	75%	75%
West Virginia	75%	85%	85%
Wisconsin	80%	80%	80%
Wyoming	80%	90%	90%

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

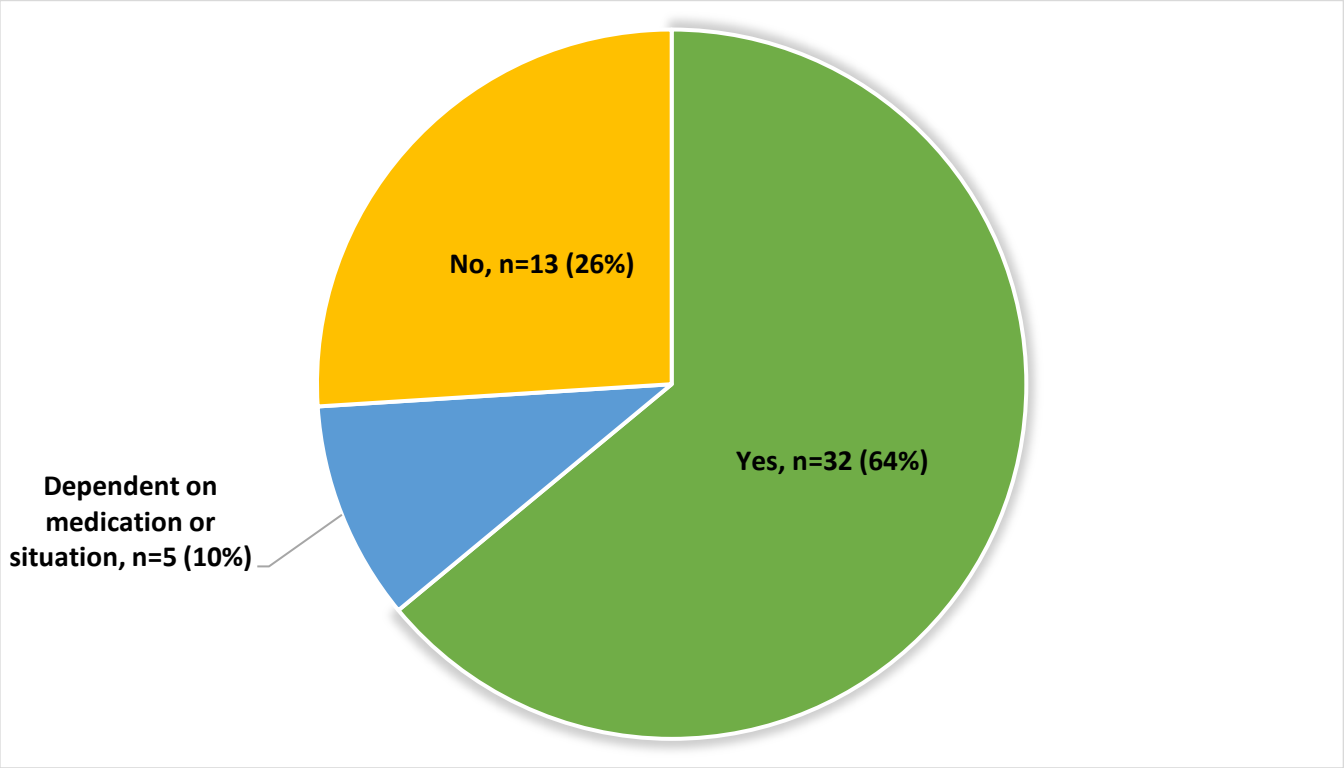

Table 19 - Non-Controlled Drugs Early Refill Requirement for Prior Authorization

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, Virginia, West Virginia, Wyoming	32	64.00%
Dependent on medication or situation	North Dakota, South Carolina, Utah, Vermont, Washington	5	10.00%
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

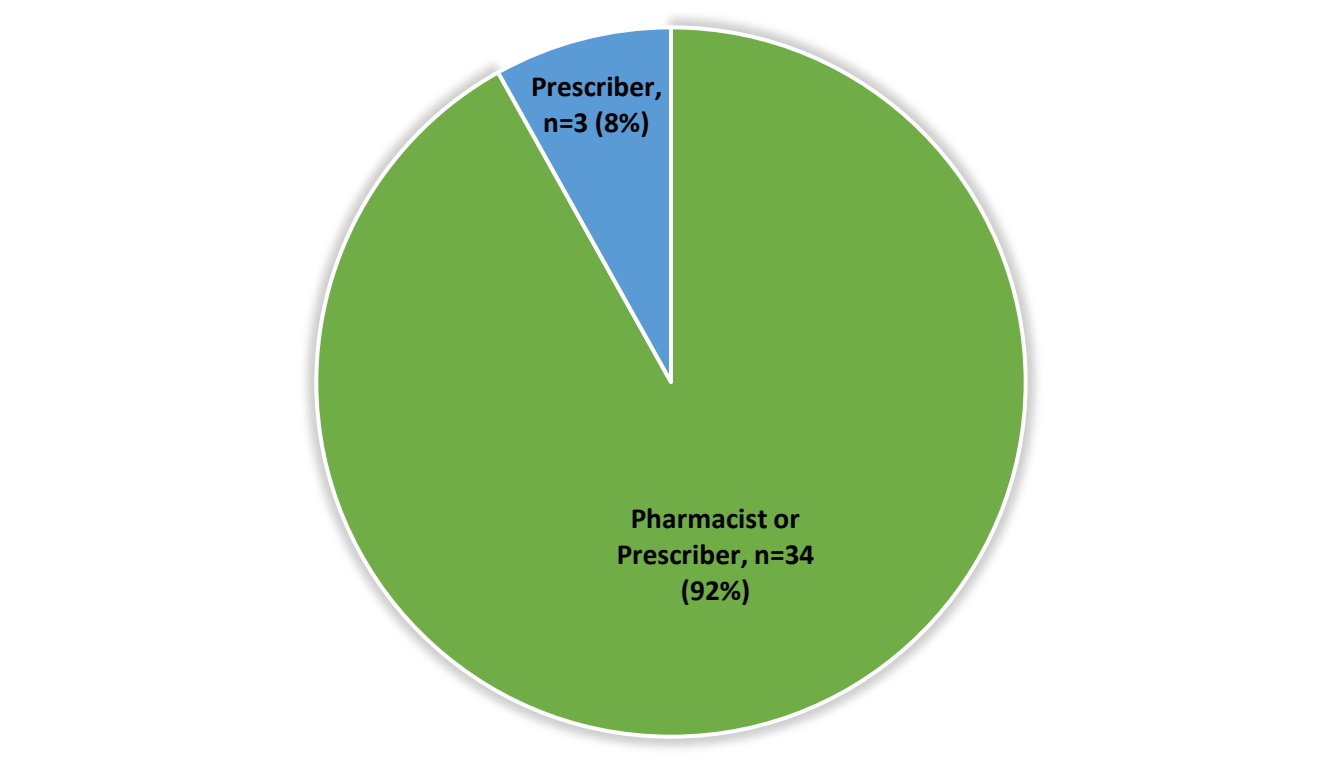

Table 20 - Non-Controlled Drugs Early Refill Authorization Sources

Response	States	Count	Percentage
Pharmacist or Prescriber	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	34	91.89%
Prescriber	Indiana, Iowa, New York	3	8.11%
Total		37	100.00%

If “No,” can the pharmacist override at the point of service?

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

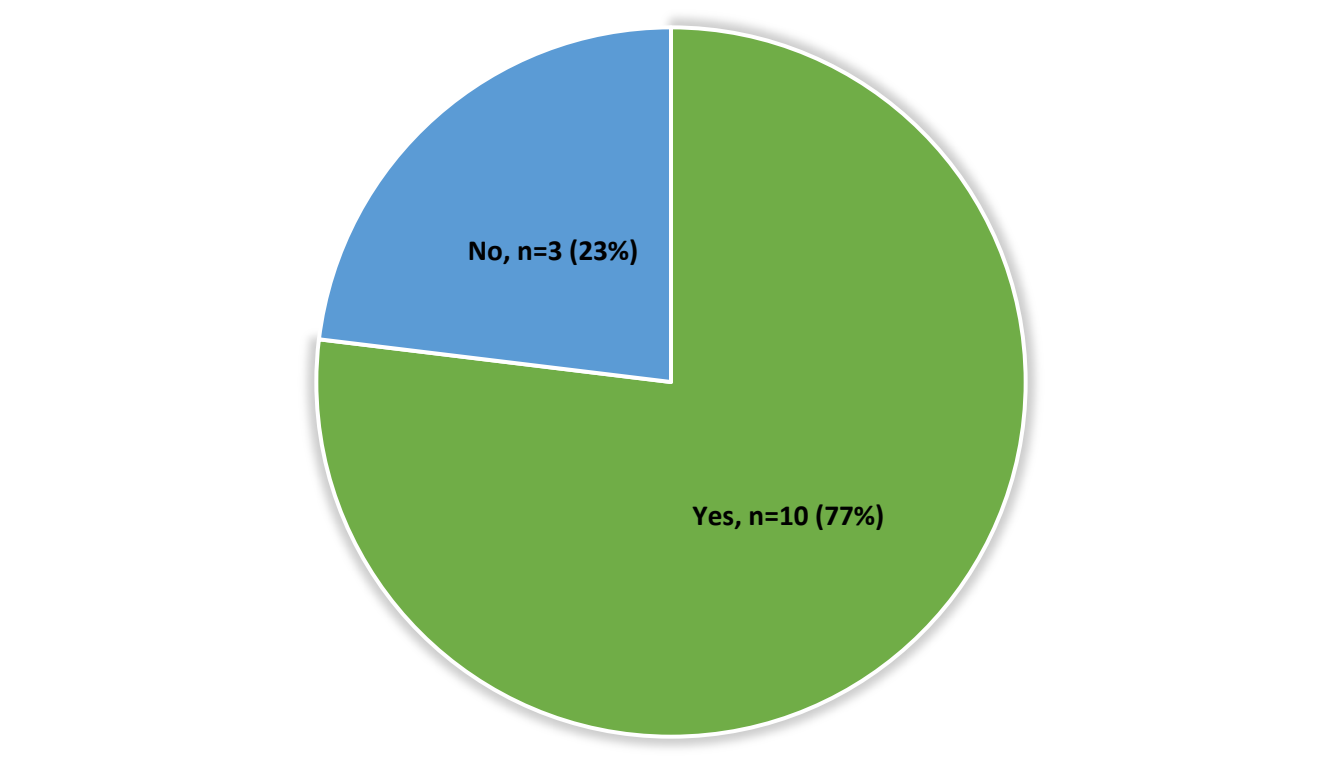

Table 21 - Non-Controlled Drugs, Pharmacist May Override at Point of Service

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 - Controlled Drugs Early Refill Requirement for Prior Authorization

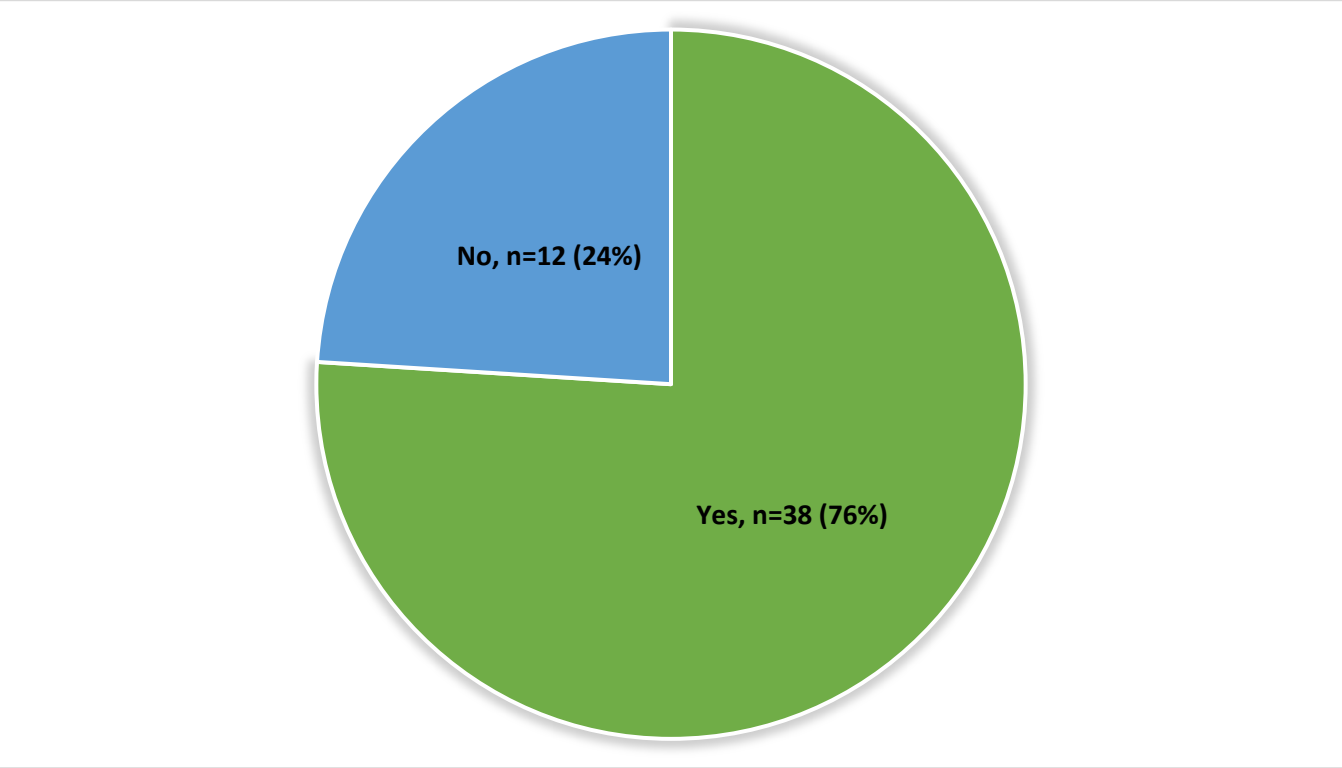

Table 22 - Controlled Drugs Early Refill Requirement for Prior Authorization

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

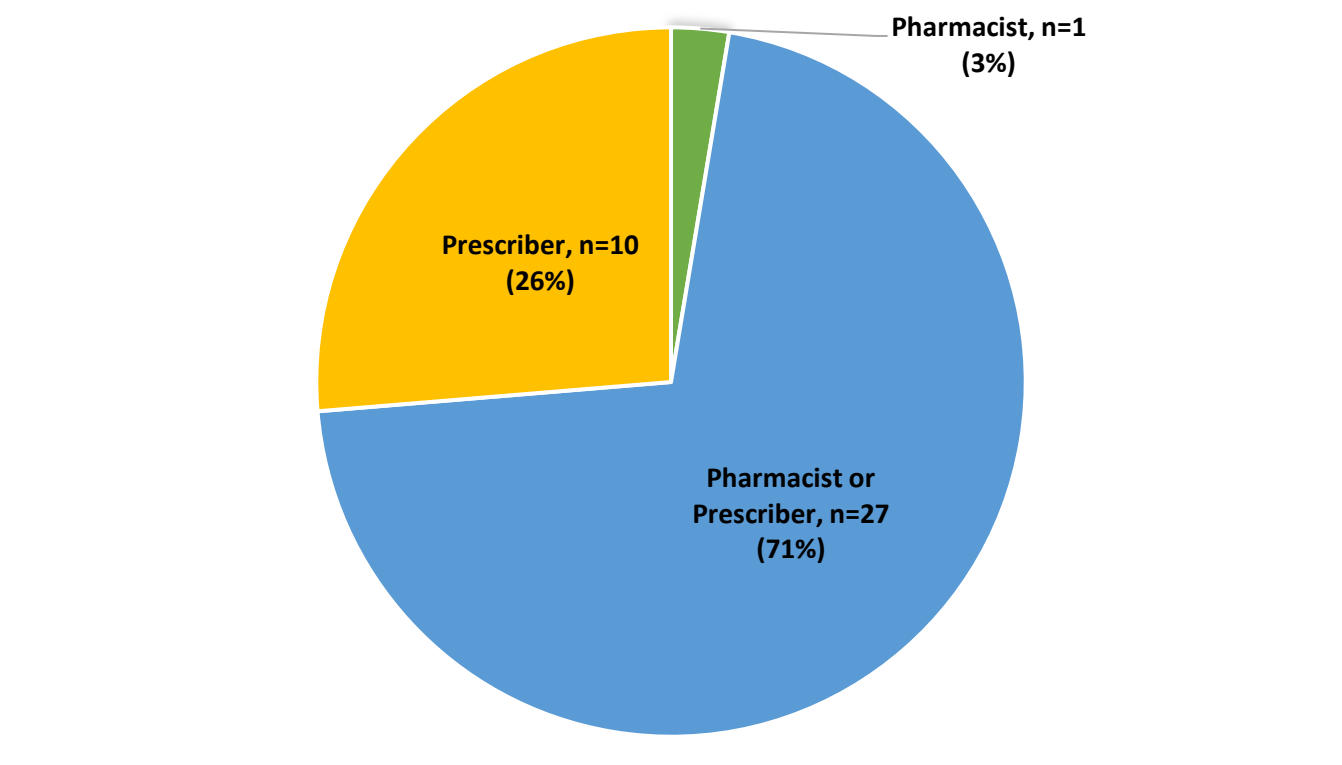

Table 23 - Controlled Drugs Early Refill Authorization Source

Response	States	Count	Percentage
Pharmacist	Wisconsin	1	2.63%
Pharmacist or Prescriber	Alabama, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wyoming	27	71.05%
Prescriber	Alaska, Connecticut, Florida, Hawaii, Idaho, Indiana, Iowa, New York, Pennsylvania, Utah	10	26.32%
Total		38	100.00%

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

Figure 20 - Controlled Drugs, Pharmacist May Override at Point of Service

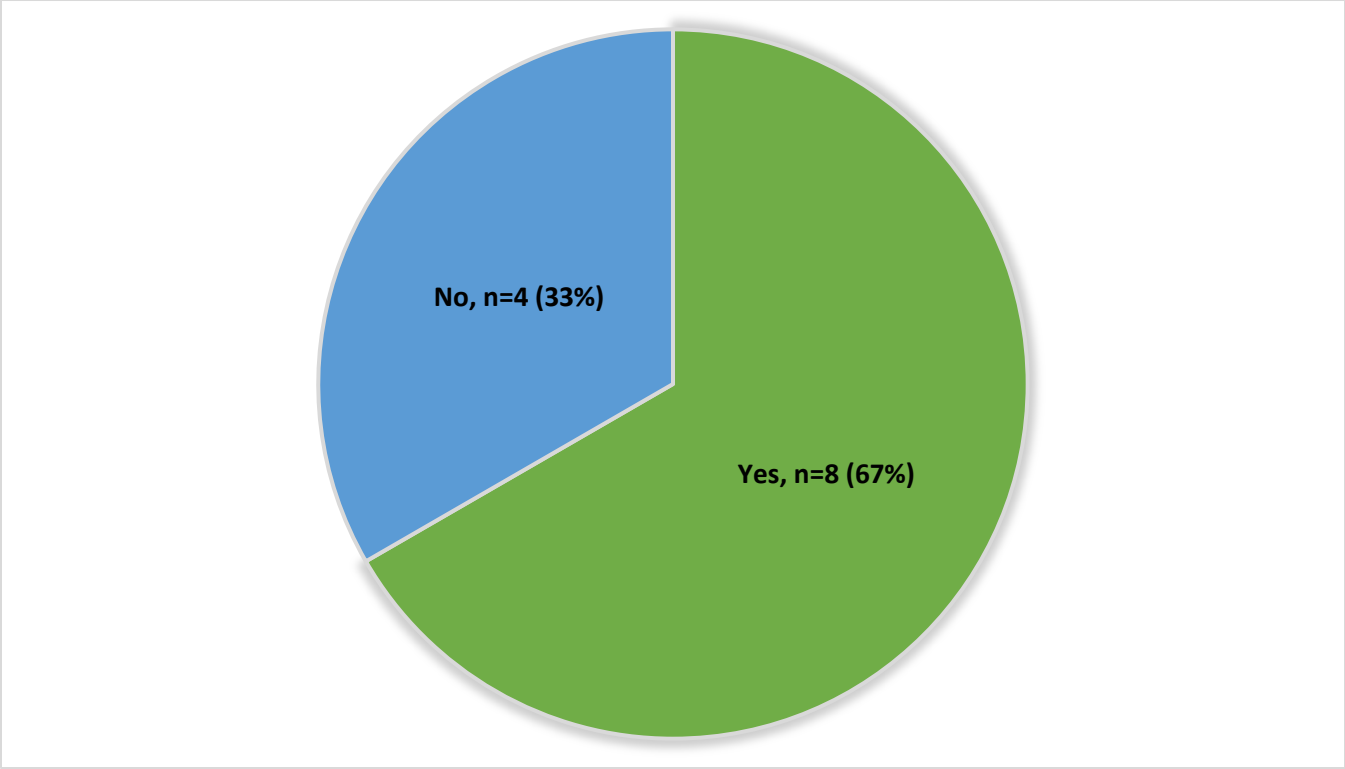

Table 24 - Controlled Drugs, Pharmacist May Override at Point of Service

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 (multiple responses allowed):

Figure 21- Allow Pharmacist Overrides for an Early Refill

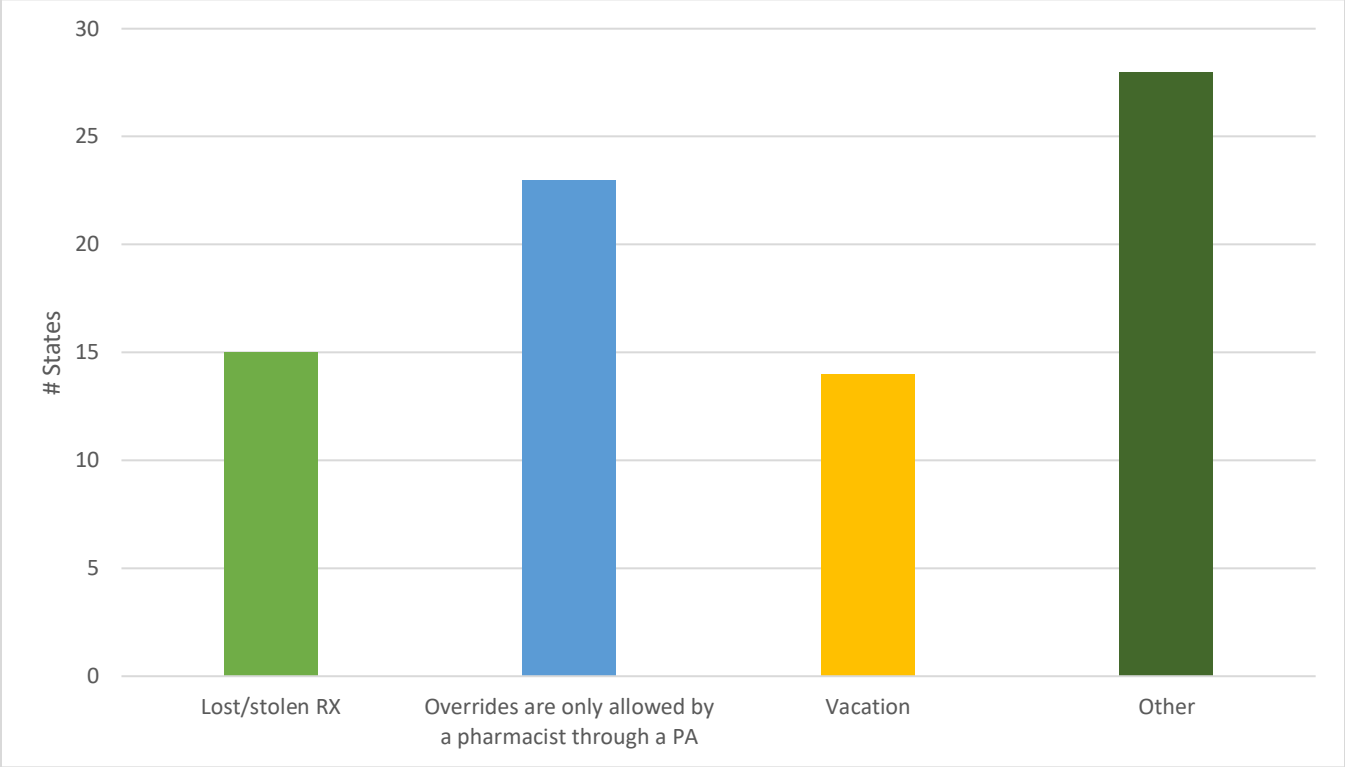

Table 25 - Allow Pharmacist Overrides for an Early Refill

Response	States	Count	Percentage
Lost/stolen RX	Kansas, Louisiana, Massachusetts, Missouri, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Virginia, Washington, Wisconsin	15	18.75%
Overrides are only allowed by a pharmacist through a PA	Alabama, Alaska, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, Tennessee, Washington, Wyoming	23	28.75%
Vacation	Louisiana, Massachusetts, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Vermont, Virginia, Washington, Wisconsin	14	17.50%
Other	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	28	35.00%
Total		80	100.00%

If "Other," please explain.

Table 26 - "Other" Explanations for Allowing Pharmacist Overrides for an Early Refill

State	Explanation
Arkansas	Pharmacists are not allowed to override an early refill DUR message at POS. Early refill overrides must be reviewed with a prior authorization request for all early refill POS denials including for lost/stolen RX and vacations.
California	The pharmacist can override the early refill DUR alert message for any situation if medically necessary.
Colorado	Pharmacist overrides at the point of sale are not allowed for lost or stolen prescriptions or for vacation requests. However, pharmacists may contact the pharmacy call center 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 a pharmacist are allowed for changes in dosage with a prior authorization, or entry of Submission Clarification code 5 and any required professional codes.
Florida	The overrides are not allowed.
Idaho	Overrides are allowed for change of dose only.
Indiana	Prescriber must obtain prior authorization for early refill validating lost/stolen med with police report. Vacation override and lost/stolen medication are only permitted one time per calendar year with prescriber approval.
Iowa	Pharmacists are not able to do any overrides at the POS. Any lost/stolen rx 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 18 years and younger qualify for the lost or spilled medication early refill override.
Louisiana	Lost/stolen RX, vacation, other situations may be overridden using the pharmacist's professional judgment.
Maine	Nursing home new admissions are allowed at the store level
Missouri	Will also provide a PA if there is a dosage change in the middle of the prescription.
Nevada	After the Magellan PBM system was implemented on July 1, 2022, early refill denials of non-controlled substances (for which the prescriber has authorized a vacation fill) may be overridden by the pharmacist. All other early refill overrides require a PA. Prior to Magellan takeover on July 1, 2022, overrides were only allowed by a pharmacist through a PA.
New Hampshire	NH allows for other early refill reasons such as increased/variable dose, transitions to a facility, school/daycare supply, and lost/destroyed medications. The pharmacist must contact the technical call center to request an override.
New Jersey	Prospective DUR alerts cannot be overridden by the pharmacy provider.
New York	Overrides are allowed by pharmacist in an emergency situation as noted in question #10.a. below.
North Carolina	For controlled substances, the only override allowed is for change of therapy.

State	Explanation
Ohio	Overrides are only allowed via a pharmacy phone call to the pharmacy benefit help desk. Pharmacies can override a Refill Too Soon early refill DUR message at Point-of-Sale (POS) under certain circumstances. The dosage (quantity/days supply) on the submitted claim must be greater than the previous claim it is rejecting against, and the original quantity must be used up. This override will not be available for controlled substances. Denials may be overridden by pharmacy benefit help desk for the following documented reasons: -Previous supply was lost, stolen, or destroyed. ODM may limit the number of instances denials may be overridden in cases of suspected fraud or abuse and may request additional documentation before an override is authorized. -Pharmacist entered previous wrong day supply. -Vacation or travel. -Multiple supplies of the same medication are needed, for example in a workshop or school setting. -Hospital or police retained the medication.
Oregon	As long as the pharmacist enter a valid Submission Clarification Code and the appropriate intervention and outcome codes, the pharmacist can use whichever ones apply. Oregon FFS do not limit which ones can be used.
South Carolina	State request that all Lost Stolen damaged spills destroyed and vacation overrides are routed to the State for their review approval for medications
South Dakota	Dose increase, recipient newly admitted to a care facility
Texas	In normal situations only for Medication Synchronization purposes, dispensing pharmacist may override by entering a PA code. For all other reasons pharmacists must call the HHSC Help Desk. Med. Sync. override does not apply to CIIs and controlled substances containing hydrocodone.
Utah	The pharmacies have to call Medicaid FFS to place overrides (authorized by Medicaid pharmacist) for lost/stolen Rx, and vacation.
Vermont	The pharmacist is allowed to provide a Submission Clarification Code / Description with the following guidance: 03/ vacation supply Allowable; use for vacations and LTC leave of absence (requires call to Pharmacy Help Desk at 844-679-5362) 04/ lost prescription Allowable (requires call to Pharmacy Help Desk at 844-679- 5362.) Not allowed for controlled substances.
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 also allows for the pharmacist to override the alert for natural disaster, a dosage change, or when the member misunderstood the directions. If the medication is a Controlled Substance in the early refill alert that require a call by the pharmacy to the Drug Authorization Policy Override (DAPO) Center to get an override (prior authorization), the pharmacist still needs to get the override (prior authorization) from the Drug Authorization Policy Override Center. During the public health emergency, all DAPO early refill alerts were moved to allow a pharmacist override, except for Schedule II drugs. As of December 1, 2022, our standard early refill alerts were reinstated.

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

Figure 22 - System Accumulation Edit for Prevention of Early Prescription Filling

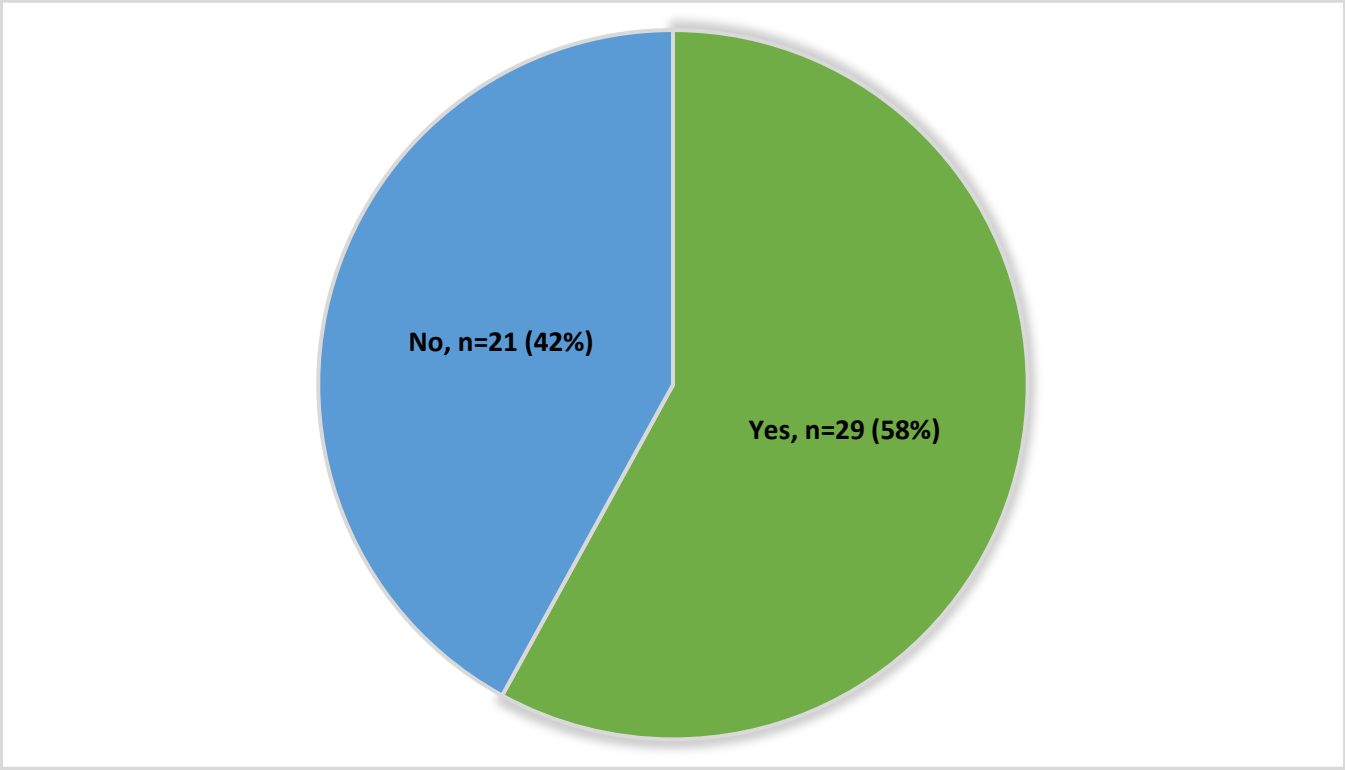

Table 27 - System Accumulation Edit for Prevention of Early Prescription Filling

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, Vermont, Virginia, Washington, West Virginia, Wyoming	29	58.00%
No	California, Connecticut, District of Columbia, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Wisconsin	21	42.00%
Total		50	100.00%

If "Yes," please explain your edit.

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

State	Explanation
Alabama	Claims that exceed, or result in, the accumulation of more than seven days' worth of medication in a 120-day period will deny at the point-of-sale (POS).
Alaska	Alaska Medicaid allows a 7 day accumulation over a 120 day look-back for controlled medications and a 21 day accumulation over 120 days for non-controlled medication filled for 90 days.

State	Explanation
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. Beneficiaries with non-controlled drugs are allowed 12 days' extra supply in the 180-day period, and beneficiaries with controlled drugs are allowed only 7 days' extra supply in the 180-day period.
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 accumulation refills are greater than 4 fills in a 120 day lookback 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	Due to the status of the transplant patient, a medical consultant reviews retrospectively to alert case managers proactively avoiding early refills. Thus, early refill programming is not utilized by our current patient population although it is turned on.
Idaho	The pharmacy claims system is set to look at a maximum quantity per day as well as a rolling accumulation 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 days supply on hand. HFS allows a maximum of 5 accumulated carry over days at any given time.
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.
Kansas	Yes, for certain medications, such as opioids.
Kentucky	Kentucky allows a three day tolerance per month.
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 and obtaining a medically indicated diagnosis code. 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	accumulation is set at 7 days of accumulation before hard stop that requires a PA for a refill to occur.
Michigan	MI has refill tolerance and dispensing fee accumulation edits to prevent patients from filling prescriptions early.
New Hampshire	There is a ProDUR early refill edit in place to include the early refill accumulation of 15 days when looking back over 180 days of fill history.
New Jersey	Resulting from approved legislation, limits have been put in place at 120 day accumulative day supply during the public health emergency. Additional limits were later implemented that were not specific to the public health emergency, allowing a total excess accumulation of medication of 30 days.

State	Explanation
New Mexico	An exception code posts to the pharmacy indicating the date when the medication can be filled.
New York	For non-controlled substances: no more than a 10 day supply (on hand) using a ninety day look back. For controlled substances: no more than a 7 day supply (on-hand) using a ninety day look back.
North Dakota	Non-controlled allows 15 days of accumulation in a rolling 180 day window. Controlled allows 10 days of accumulation in a rolling 180 day window.
Oklahoma	We have an accumulation edit for stimulants. The claim will deny for cumulative early refill when a member has received an early refill in the last 240 days and the combined days' supply is 110% of the days' supply on the current claim being submitted. Additionally, we have an accumulation edit for hydrocodone products. The claim will deny when the member has filled 13 hydrocodone prescriptions (13 claims) within 1 year, regardless of the days' supply.
Rhode Island	Only allows one original script and 5 refills per prescription.
South Carolina	75% of fill required for non controls and 85% for controls; CII medications excluded
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.
Washington	Example: 1st fill: Client fills a prescription 100 tabs for 100 days. 2nd fill: After 75 days, they can refill for another 100 tabs and now have a total of 125 days supply. 3rd fill: After 75 days, they can refill for another 100 tabs and now have a total of 150 days supply. 4th fill: If they try to fill again after 75 days, they will still have 75 days remaining and the system will reject for refill too soon.
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 h 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 23 - Plans to Implement a System Accumulation Edit

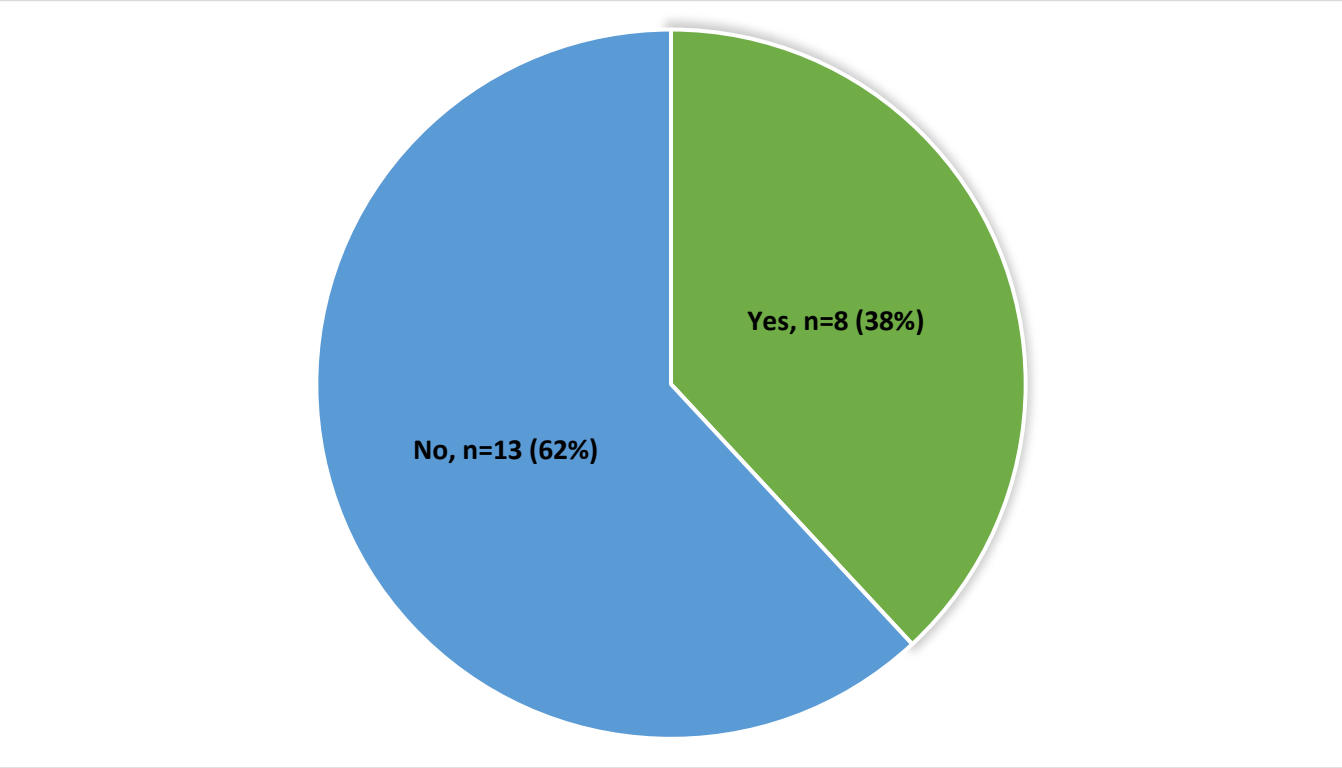

Table 29 - Plans to Implement a System Accumulation Edit

Response	States	Count	Percentage
Yes	District of Columbia, Iowa, Maryland, Massachusetts, Mississippi, Montana, North Carolina, Utah	8	38.10%
No	California, Connecticut, Minnesota, Missouri, Nebraska, Nevada, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Wisconsin	13	61.90%
Total		21	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 24 - State Policy Prohibiting Auto-Refill at the POS

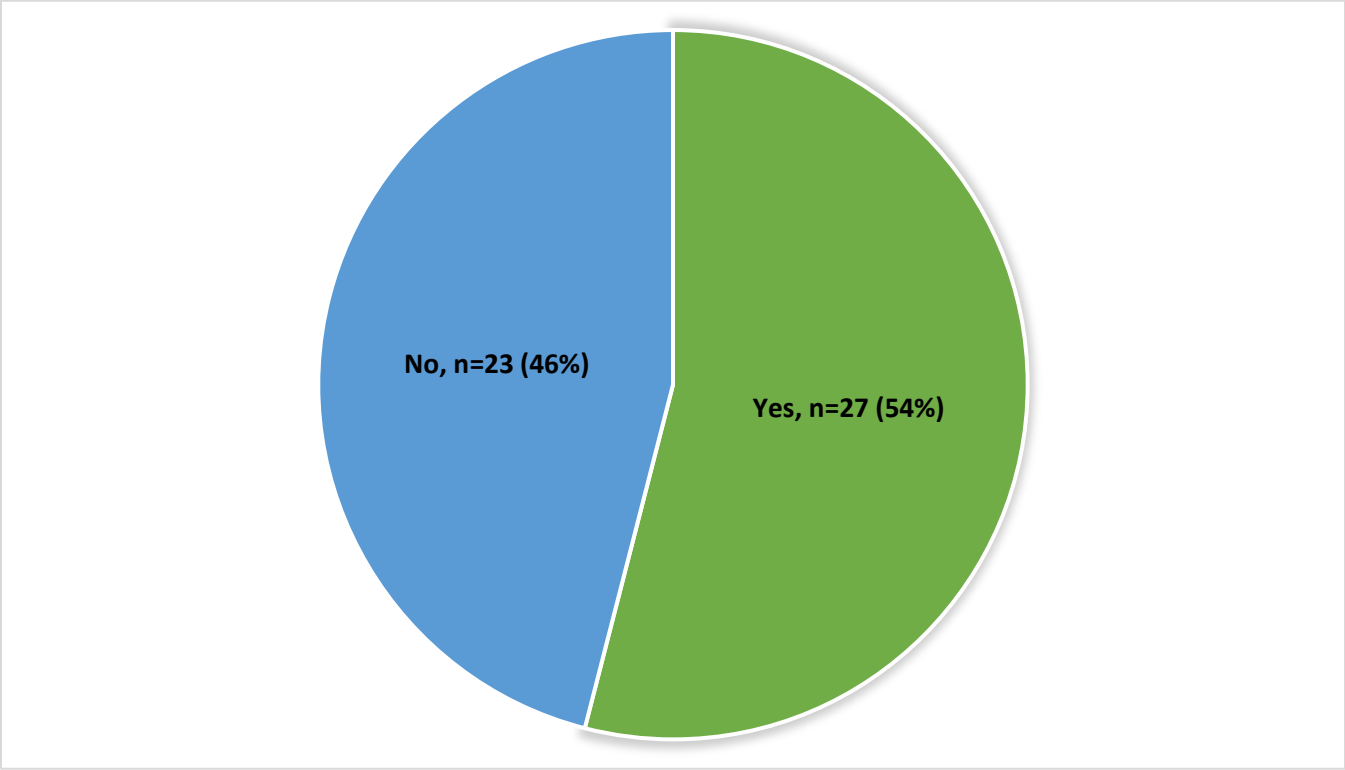

Table 30 - State Policy Prohibiting Auto-Refill at the POS

Response	States	Count	Percentage
Yes	Alabama, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, New Jersey, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, Wyoming	27	54.00%
No	Alaska, Arkansas, Colorado, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Utah, Vermont, Wisconsin	23	46.00%
Total		50	100.00%

9. Does your system have a diagnosis edit that can be utilized when processing a prescription?

Figure 25 - Diagnosis Edit Utilized When Processing Prescriptions

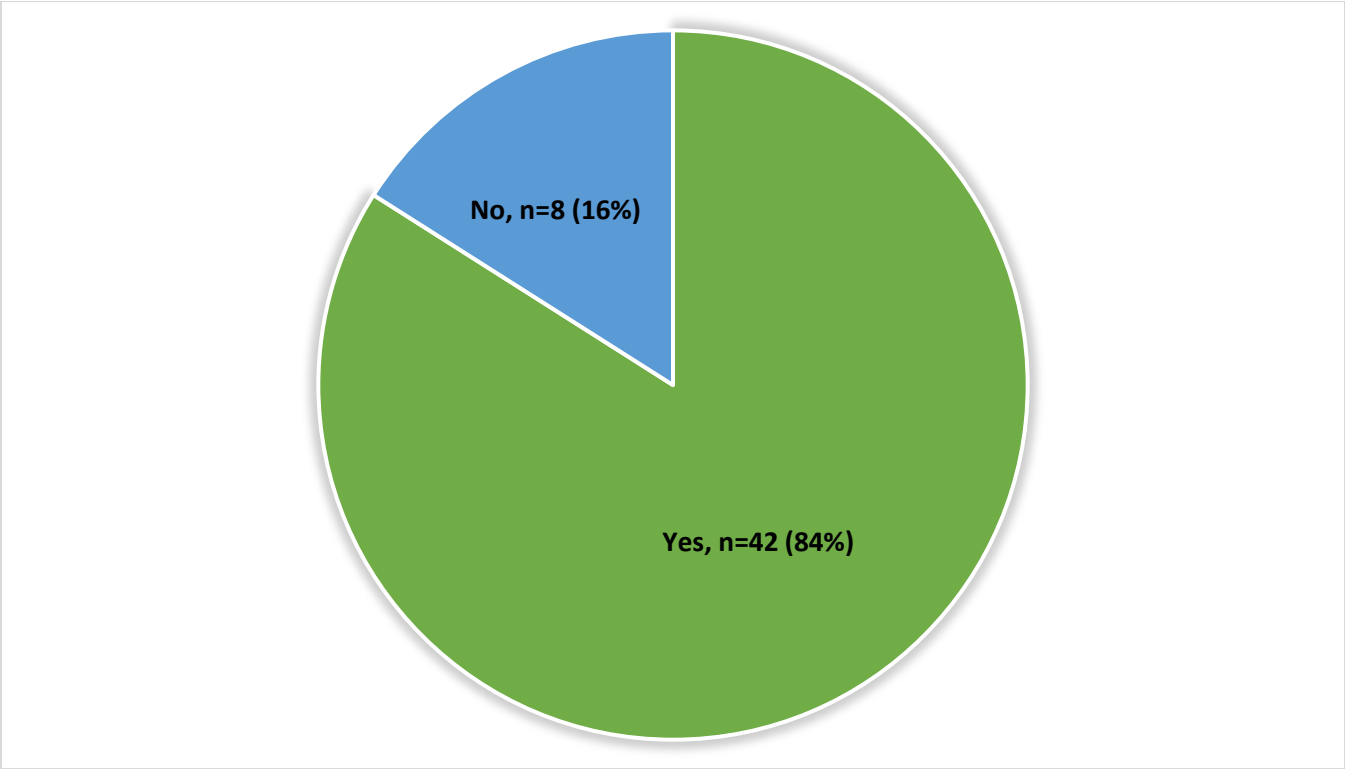

Table 31 - Diagnosis Edit Utilized When Processing Prescriptions

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

If "Yes," please explain.

Table 32 - Explanations for Diagnosis Edit Utilized When Processing Prescriptions

State	Explanation
Alabama	AL Medicaid does not have a diagnosis edit but the Smart PA system does check for diagnosis through claims processing. There is not an option for a pharmacist to enter a diagnosis through an edit.
Alaska	When appropriate, an ICD 10 code can be required at POS processing on a prescription. This information can be tied to an edit as necessary.

State	Explanation
Arkansas	AutoPA rules have the capability to be developed around specific diagnoses in history. The addition of this type of edit has relieved some of the burden from our clinical review team while ensuring continued proper use of medications that are many times prescribed off-label. An example for our program is the preferred SGLT-2 inhibitors which will process without a prior authorization with the any of the following found in the beneficiary's history: *Billed diagnosis of Type 2 Diabetes Mellitus AND ---Paid metformin claim in last 90 days OR ---Billed diagnosis of ASCVD OR *Billed diagnosis of heart failure OR *Billed diagnosis of CKD (Farxiga only) OR *Paid claim in the last 60 days for a SGLT-2 inhibitor
California	When processing a claim for Code 1 restricted products with a diagnosis/type of illness restriction, if the diagnosis is not found during the claim adjudication process the submitter may communicate the restriction has been met using a Submission Clarification Code (SCC) value of 7 (Medically Necessary).
Colorado	The pharmacy claims system can verify the presence of specific ICD-10 diagnosis codes contained within a member's electronic claims record as part of automated processing of pharmacy claims for designated drug products. The system is also capable of verifying specific ICD-10 diagnosis codes when manually entered in the POS system during pharmacy claims processing.
Connecticut	The capability to require a diagnosis code on a claim for a specific drug is available. Failure to put the diagnosis code on the claim will result in a denied claim. Additional edits are in place to deny claims when specific diagnosis code(s) is/are configured to a specific drug. When these specific diagnosis codes are not found on the claim, the claim will deny.
Delaware	This edit is utilized to by-pass PA requirements on certain drugs when an appropriate diagnosis code is transmitted by the pharmacy on the claim or to prevent a claim from paying on certain classes of drugs if no diagnosis code is supplied on the claim. For example, all oral contraceptives claims require an appropriate diagnosis code on the POS claim or the claim will deny.
District of Columbia	Diagnosis codes are used for automatic prior authorizations on multiple drug classes including controlled substances.
Florida	Certain classes and medications have diagnosis edits (e.g., alpha-1 protease inhibitors, anticonvulsants, lidocaine patches, Solaraze gel, Nurtec ODT, Qulipta, and Ubrelvy). The system will look back in medical claims history for a predetermined diagnosis.
Georgia	Drug-Diagnosis Caution Screening checks the member's health profile record for conflicts between listed diagnoses and the submitted drug. Also, Diagnosis codes lists can be used to determine drug coverage when diagnosis codes are assigned to a list and checked against a member's record during adjudication.
Hawaii	Programmed and turned on but not utilized by our current patient population.
Idaho	There are Automatic PAs that look for a diagnosis in beneficiary's history or submitted on the incoming claim.

State	Explanation
Illinois	Currently the two diagnosis edits are 1) seizures: pharmacy claims for antiepileptic medications are not subject to prior authorization or the Four Prescription Policy; 2) malignant cancer: pharmacy claims for opioids are not subject to the MME edit. The medical diagnosis must be in the patient's medical claims profile when the pharmacy claim is being processed, otherwise prior authorization is required.
Indiana	Diagnosis edit can be utilized when submitted on the prescription or via medical claims submission.
Kansas	For prenatal vitamins and certain other drugs, we require a diagnosis code for the claim to pay. Otherwise, requiring a diagnosis code at the point of sale for all drugs is too labor intensive on the back side. That would require manually putting diagnosis codes on every NDC and some drugs have many diagnoses.
Kentucky	Diagnosis codes may be entered on a claim to allow auto approval of certain medications if the diagnosis meets prior authorization criteria.
Louisiana	Prescriptions for select medications require a diagnosis code at POS for reimbursement. Claims submitted with the appropriate diagnosis code listed on the PDL for a particular medication in the required NCPDP field of the claim will bypass the edit. Claims will deny at POS if the diagnosis code field is not populated or invalid. A valid diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.
Maine	automatic PA based on diagnosis codes or systematic review
Massachusetts	If a member has specific diagnosis codes in claims history, a prescription will usually process at the pharmacy without requiring prior authorization.
Michigan	Our POS system can look back in medical claim history for a specific diagnosis coded for an edit. It can also accept a diagnosis code when submitted on the pharmacy claim.
Minnesota	Diagnosis codes used for stimulants to treat ADHD.
Mississippi	Stimulant prescriptions require entry of a diagnosis on the claim.
Missouri	The system is able to utilize the diagnosis code on the incoming claim to transparently process claims when needed. If the needed diagnosis code is not on the incoming claim the system is also able to evaluate the claim based on historical diagnosis codes in the participant's paid claim history. The diagnosis code is not required on the incoming claim at this time, instead it is an added benefit to decrease the number of manual prior authorizations required.
Montana	While our system allows for this, we currently only utilize it for our plan first members (family planning) to ensure the product is being used for a covered indication. Neither State law nor Montana Medicaid require diagnoses on all prescriptions.
Nebraska	Automatic PA based on diagnosis code or systematic review, trial and failure of first or second-line therapies, pharmacists or technician reviews, direct involvement with pharmacy and/or medical director.
Nevada	Specific PAs can be auto-approved if the appropriate ICD disease State or diagnosis code is submitted on the claim.
New York	The pharmacy system has the capability to validate diagnosis by the way of the patient's medical claim history.
North Carolina	Diagnosis codes are used in pharmacy claim processing in NCTracks for pregnancy and COVID copay exemptions as well as identifying Hospice beneficiaries. Diagnosis codes are also used in the autogeneration of Prior Approvals.

State	Explanation
North Dakota	Individual drugs can be set up in the system to require specific diagnoses which are based on FDA approval and compendia. If the pharmacy claim does not have an accepted diagnosis, it will deny requiring prior authorization to be paid.
Oklahoma	We have a diagnosis edit that can be utilized when processing a prescription and allow claims to pay at the pharmacy point of sale (PPOS) and not require submission of a manual prior authorization (PA) request if the member has the reported diagnosis in their claims history (e.g., preferred inhaled tobramycin products will pay at the PPOS for members who have a reported diagnosis of cystic fibrosis within the past 12 months of claims history, rifaximin 550mg tablets will pay at the PPOS for members who have a reported diagnosis of hepatic encephalopathy or hepatic failure within the past 12 months of claims history).
Pennsylvania	The claims processing system can require specific diagnosis codes for specified drugs based on the prior authorization guidelines, allowing for an automated prior authorization.
Rhode Island	There is an automated criteria system that looks back at the medical claims for a diagnosis for certain drugs. We do not have the ability to receive a diagnosis code from the pharmacy, on a pharmacy claim and then edit off of that.
South Carolina	Diagnosis codes are currently supported for various therapies including Family Planning Antibiotics
South Dakota	State supplies recipient diagnosis history for use during adjudication/PA processing.
Tennessee	For select medications, diagnosis codes can be entered to allow a paid claim at POS. Without this code, the claim will reject at point of sale for 75-PA Required.
Utah	POS requires ICD-10 for cancer pain in claims that exceeds MME limits, and for antipsychotics in kids
Vermont	Utilize member medical claims for diagnosis and create edit for auto adjudication of the claim
Virginia	We have access to medical claims and we can create AutoPA edits to look back for certain diagnosis codes (ICD-10 codes) within a certain time frame before the claim gets processed.
Washington	Our system is capable of using the diagnosis code submitted on a claim although we do not currently have this logic turned on.
West Virginia	We edit on diagnosis for naltrexone so as to distinguish when it is used for OUD or AUD.
Wisconsin	In some situations, Wisconsin uses diagnosis code edits to allow a claim to pay and not require a prior authorization or Wisconsin may require a diagnosis code with a prior authorization (i.e., non-preferred stimulants).
Wyoming	Wyoming uses automated diagnosis edits for some drugs which depend on the diagnosis being present in the medical claims file for the client. A diagnosis entered by a pharmacist on a pharmacy claim, however, is ignored for purposes of a diagnosis edit.

10. 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 for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

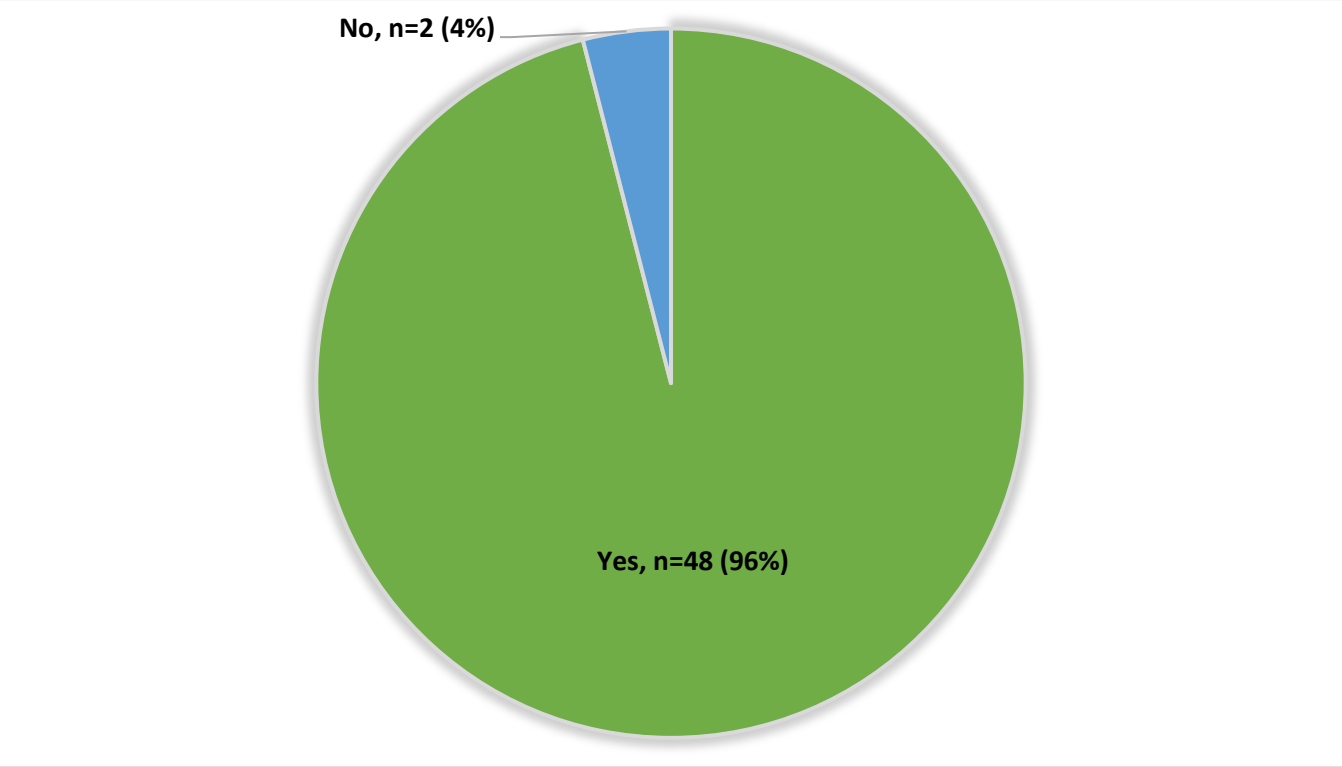

Table 33 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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	48	96.00%
No	New Jersey, South Dakota	2	4.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 27 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) when Medically Necessary

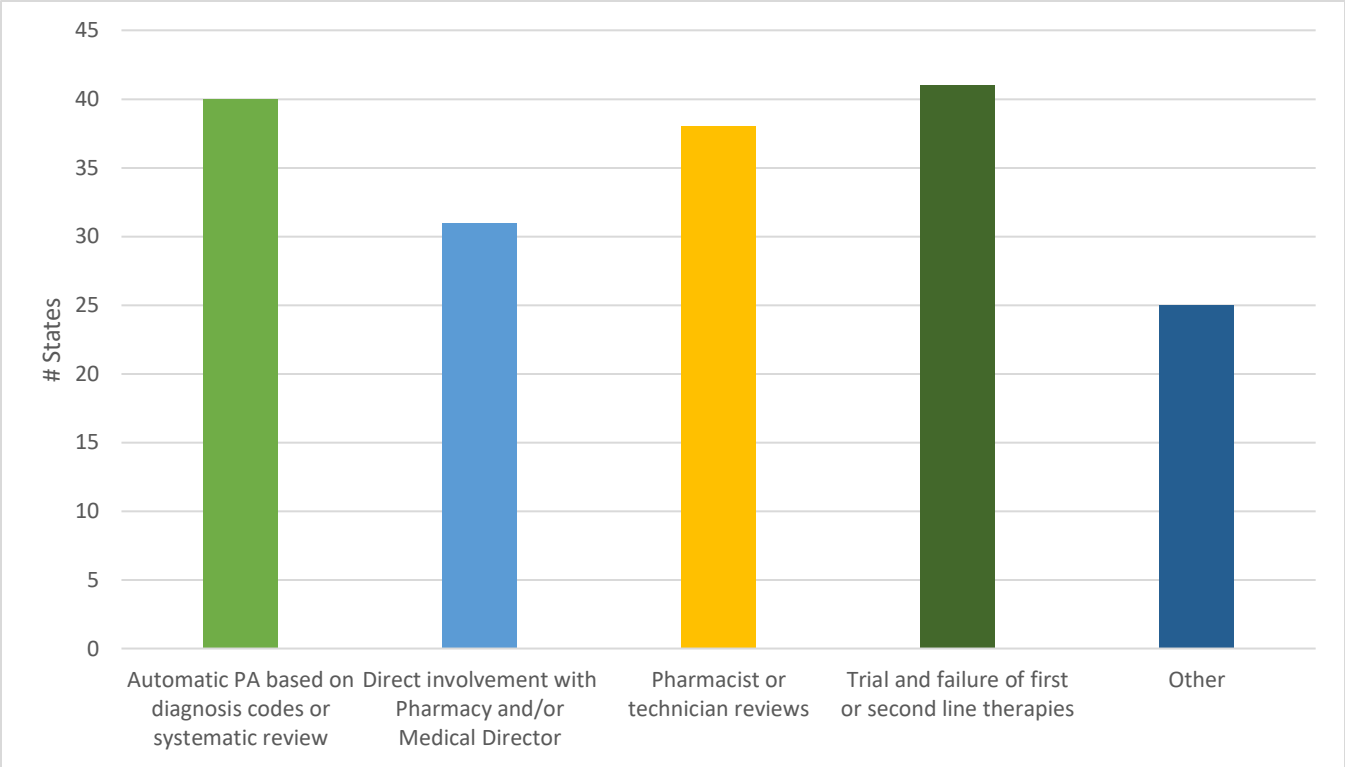

Table 34 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	States	Count	Percentage
Automatic PA based on diagnosis codes or systematic review	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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, Texas, Virginia, Washington, West Virginia, Wisconsin, Wyoming	40	22.86%
Direct involvement with Pharmacy and/or Medical Director	Alabama, Alaska, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	31	17.71%

Response	States	Count	Percentage
Pharmacist or technician reviews	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Virginia, Washington, West Virginia, Wisconsin, Wyoming	38	21.71%
Trial and failure of first or second line therapies	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	23.43%
Other	Arkansas, California, Colorado, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	25	14.29%
Total		175	100.00%

If “Other,” please explain.

Table 35 - Explanations for “Other” Processes in Place for Beneficiaries to Access Any Covered Outpatient Drug when it is Medically Necessary.

State	Explanation
Arkansas	Drugs not on the PDL will either process without a PA, process with POS edits with AutoPA rules based on diagnosis codes/lab values/medication in history, or require manual review with specific DUR Board approved criteria after PA request submission. Drugs requiring a prior authorization request must be submitted by the prescriber which includes a letter of medical necessity, completed PA form (if required), chart notes, and labs if warranted. PA requests are reviewed by clinical pharmacists and a psychiatrist (for antipsychotics) on a case-by-case basis with guidance from the DUR Board approved criteria, clinical guidelines, and support in the official Compendia. Our New-to-Market policy dictates coverage of all new products that are FDA approved and rebate eligible. Link to the policy-- https://ar.magellanrx.com/provider-documents?tag=evidence-based%20prescription%20drug%20program%20(pdl)&tag=evidence-based+prescription+drug+program+%28pdl%29 PA requests for new, novel drugs that have not been discussed by the DUR Board are reviewed by referring to the manufacturer package insert and clinical trials.
California	The Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug not on the Medi-Cal Rx Contract Drugs List (CDL) with an approved PA.

State	Explanation
Colorado	Prescribers may submit a pharmacy prior authorization (PA) request to the State's PBM, 24 hours a day/7 days a week by phone, fax, or electronically. PA 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. Medications that do not have set criteria can be submitted on the miscellaneous prior authorization form. The clinical reviewers have 24 hours to review the prior authorization request and provide a response.
Hawaii	Hawaii FFS does not have a PDL. If medically necessary the COD is covered with documentation by PA for high cost drugs to ensure patient safety and efficacy as this typically occurs for transplant recipients. A medical consultant or medical director will work with the prescriber. Dental formulary is generic, not brand COD. If brand is medically necessary, it is to be covered by the MCO under the MCO formulary and/or PDL.
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 Provider Portal, PBMS. 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.
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	Prescriber must submit PA for drugs with clinical PA or nonpreferred status.
Kansas	We cover all drugs deemed to be 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 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	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 products. All requests are reviewed on a case-by-case basis by the MDHHS physicians.
Minnesota	Some non-PDL drugs do not require any sort of PA and this would apply to them.

State	Explanation
Nevada	Drugs not on the PDL, but within drug classes reviewed by the Silver State Scripts Board, require prior authorization, unless exempt under NRS, 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 may request prior authorization from the PBM by calling, faxing, or submitting a prior authorization electronically. All prior authorization criteria and prior authorization request forms are available on the NH PBM website, https://nh.magellanrx.com.
New Mexico	The provider can contact the pharmacy department 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 Ohio Medicaid Website to assist in determining coverage of a specific product. If the Drug Lookup Tool indicates that the drug requires a prior authorization, there is a process in place to access a drug when medically necessary. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is taken into consideration when submitting prior authorizations for drugs not on the PDL. For non-PDL covered outpatient drugs, Ohio has a prior authorization process set up. All submitted prior authorizations are reviewed by clinical staff on a case-by-case basis.
Oregon	Claim would deny as a non-preferred drug that requires a prior authorization. Prescriber submits prior authorization request to vendor via phone, fax, mail, or provider web portal. Prior authorization request is reviewed and responded to within 24 hours.
South Carolina	Denial letter is also generated with the State's Appeals Process and or providers can be referred to the State's Appeals website
Texas	The non-preferred drugs are on the Texas Formulary and can be accessed via a prior authorization. The PA criteria are automated and will be approved if all criteria are met. If one or more PA criteria fail, the system will prompt a message to the dispensing pharmacy about PDL PA failure. Dispensing pharmacy is responsible for informing the prescriber about the PDL PA failure. The prescriber may either change the prescription to a preferred drug or contact the PA call center for approval.
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 for brand over generic, quantity limit, the prescriber may submit a Medication Coverage Exception Form.
Vermont	Requests for new drugs to market that have not been reviewed by the DUR board are handled on a case by case basis.
Washington	Not all drugs require authorization and are covered without limits. Some drugs have PA requirements that may be self-authorized by a pharmacist with use of an 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 reviewed by a pharmacist at BMS along with the medical director who makes a final decision.

State	Explanation
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 PA requirements, Wisconsin has a documented PA policy and procedures in place to obtain PA.

If "No," please explain why not.

Table 36 - Explanations for Lack of Documented Process for Beneficiaries to Access a Covered Outpatient Drug when it is Medically Necessary

State	Explanation
New Jersey	The NJ FFS Medicaid program has an open formulary. Medicaid FFS members have access to all medically necessary covered outpatient drugs.
South Dakota	No PDL in place during this reporting period.

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

Figure 28 - Program Provides for the Dispensing of at least a 72-Hour Supply of a COD in Emergency Situations

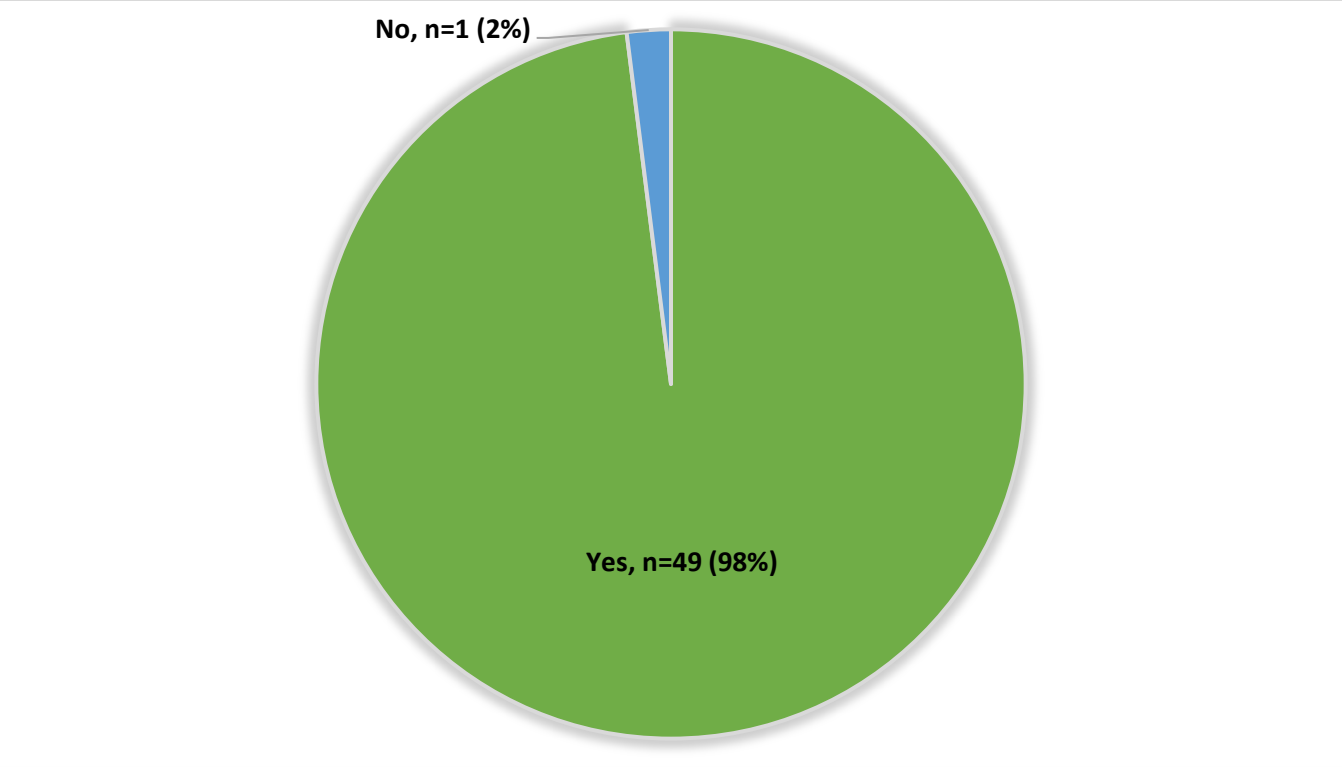

Table 37 - Program Provides for the Dispensing of at least a 72-Hour Supply of a COD in Emergency Situations

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 of CODs in Emergency Situations

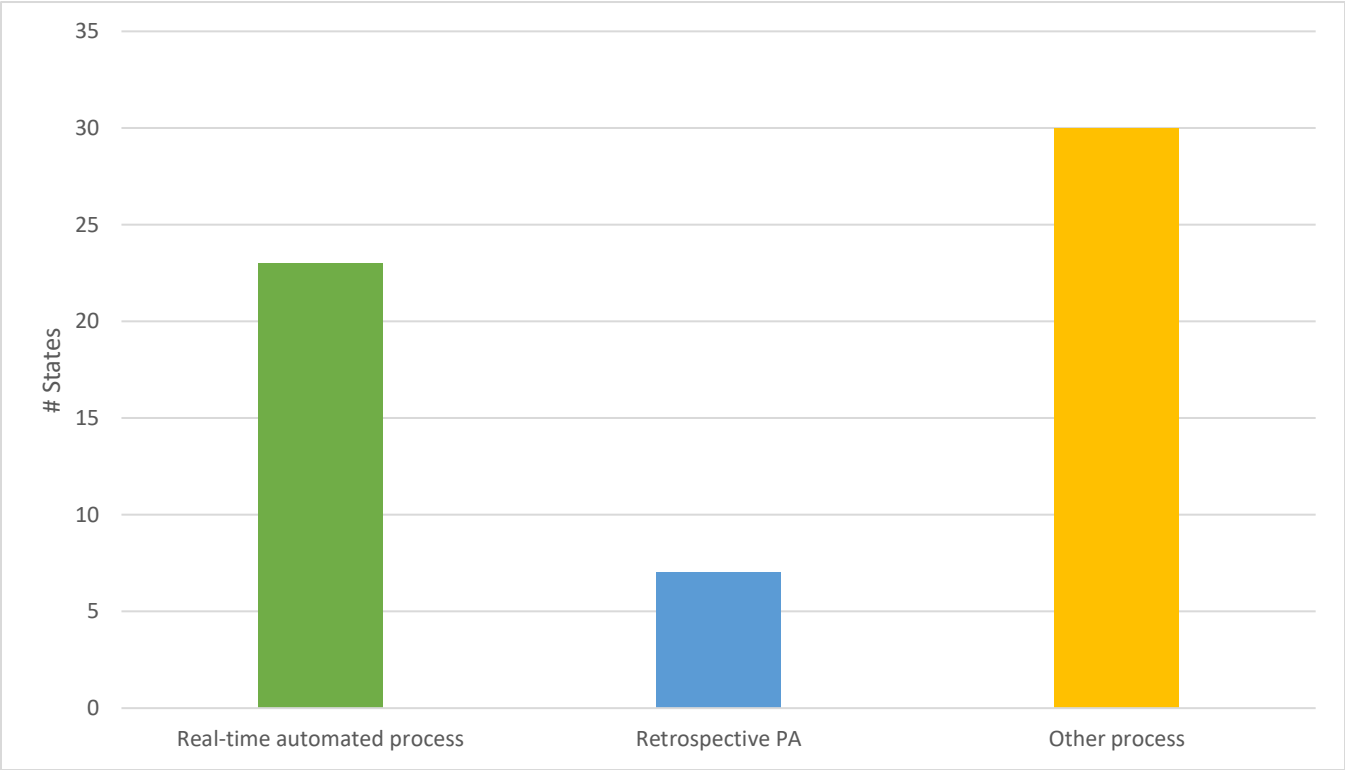

Table 38 - Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

Response	States	Count	Percentage
Real-time automated process	California, Delaware, Hawaii, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Jersey, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin, Wyoming	23	38.33%
Retrospective PA	Delaware, Illinois, Minnesota, Missouri, Montana, North Carolina, Oklahoma	7	11.67%
Other process	Alabama, Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Nebraska, Nevada, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Utah, Virginia, Washington, West Virginia, Wisconsin	30	50.00%
Total		60	100.00%

If "Other," please explain.

Table 39 - Explanations of "Other" Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

State	Explanation
Alabama	The emergency 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.

State	Explanation
Arkansas	In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy may dispense up to a five-day supply of a drug that requires prior authorization. This provision applies only in an emergency situation when the DHS Contracted Pharmacy Vendor 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-LTC beneficiaries and once per sixty (60) days per drug class for LTC beneficiaries. To file a claim using this emergency provision, the pharmacy provider will submit a '03' in the Level of Service (418 DI) field.
Colorado	Pharmacists or prescribers may call the Magellan pharmacy help desk to request an emergency override to dispense a 3-day supply of medication in an emergency situation.
Connecticut	The pharmacist has the ability to perform a onetime 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	Real-time automated process requires a verbal PA approval from the PA desk. Or manual billing is required for payment.
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 emergent during nonworking hours/days will be considered for reimbursement.
Kentucky	Providers may override PA requirements by entering LEVEL OF SERVICE (NCPDP Field 418-DI) 03 (emergency) under the following guidelines: -Overrides must be outside of normal business hours. -Overrides must be for a three (3)-day supply except where the package must be dispensed intact. -OTC medications cannot be overridden. -Drugs normally not covered cannot be overridden

State	Explanation
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 the support center staff. This protocol allows for override of all applicable drug coverage edits with the exception of plan-excluded products. The requester must attest to the MDHHS Statement of emergency care for medically necessary service.
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 clinical 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)).
New York	If a prior authorization number has not been obtained by the prescriber and the pharmacist is unable to reach the prescriber, the pharmacist may obtain a prior authorization for up to a 72-hour emergency supply. Once a 72-hour supply prior authorization number is given and a 72-hour supply is dispensed, the prescription is no longer valid for the remaining quantity and refills. The pharmacist is expected to follow-up with the prescriber to determine future needs.
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 if the prescription is changed to an alternative medication. A "3" in the Level of Service field (418-DI) should be used to indicate the transaction is an emergency fill. The claim will only allow a 72-hour supply. As part of our COVID flexibility, we implemented up to 14-day emergency supplies for non-controlled substances. There are no limits to the number of emergency fills while waiting for PA request determination.
Ohio	For controlled medications, the pharmacy must call the helpdesk. For non-controlled medications, the pharmacy may use a submission clarification code. Pharmacies can utilize a 72-hour emergency fill when a required prior authorization has not been secured, and the need to fill the prescription is determined to be an emergency. Pharmacies can submit the 72-hour supply via POS or call the vendor's help desk. Some limits do apply such as: the PA will not override other edits on the claim, controlled substances, partial claims and consumers assigned to a lock-in program are excluded from this process, and overrides are limited to one unique drug entity per consumer, per month. In order to process a claim for an emergency 3-day supply, the pharmacy must submit a Prior Authorization Type Code (NCPDP field #461-EU) = 2 and Prior Authorization Number Submitted (NCPDP field #462-EV) = 72.
Oklahoma	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

State	Explanation
	an emergency 3-day supply, and an authorization can be approved retroactively when the Help Desk reopens.
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. Emergency supplies permitted as long as the 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
Utah	The pharmacy 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 judgement to meet the 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 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 allows pharmacy providers to dispense a COD that is needed in an emergency, when the prescriber cannot be reached, and the pharmacist determines the member should begin taking the medication immediately. Wisconsin has two types of emergency medication dispensing policies, standard and expedited policy. If the medication is not included in the expedited emergency dispensing medication policy, the standard emergency medication dispensing policy applies. Pharmacy providers submit a manual/paper claim for payment. Pharmacy providers must include specific information about why the standard emergency supply is being requested. Pharmacy providers may provide up to a 14-day supply of medication. An 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 approved prior authorization response on the expedited emergency supply request. Pharmacy providers may provide up to a 14-day supply; some drugs are allowed to be provided up to a 34-day or 100-day supply. 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.

If "No," please explain why not.

Table 40 - Explanations for not Providing for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

State	Explanation
New Mexico	New Mexico has an open formulary with very few restricted medications. However, a pharmacist can use his or her professional judgement to dispense up to a five-day supply of a non-narcotic prescription in an emergency situation.

11. Top Drug Claims Data Reviewed by the DUR Board:

*Table 41 - Top Drug Claims Data Reviewed by the DUR Board**

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Column 2 Top 10 Prior Authorization (PA) Requests by Drug Class	Column 3 Top 5 DUR Claim Denial Reasons (i.e., Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level	Column 5 Top 10 Drug Names by Claim Count, report at generic ingredient level
Oxycodone	Diabetic Therapy	Prior Authorization Required	Adalimumab	Albuterol
Alprazolam	Analgesics, Narcotic Agents	Over Utilization Precaution	Bictegravir/ emtricitabine/ tenofovir	Gabapentin
Hydrocodone/acetaminophen	Psychostimulants-antidepressants	Product	Paliperidone	Ibuprofen
Tirzepatide	Ataractics - Tranquilizers	Non-matched Prescriber Id	Lurasidone	Atorvastatin
Cholecalciferol (vitamin D3)	Lipotropic Agents	Claim Not Processed	Dulaglutide	Metformin
Sacubitril/valsartan	Miscellaneous		Insulin Glargine	Aspirin
Icosapent Ethyl	Other Cardiovascular Preps		Elexacaftor/tezacaftor /ivacaftor	Lisinopril
Buprenorphine	Fat Soluble Vitamins		Semaglutide	Fluticasone
Omega-3 Acid Ethyl Esters	Other Antihypertensives		Empagliflozin	Loratadine
Semaglutide	Multivitamins		Etanercept	Cholecalciferol (vitamin D3)

* This table has been developed and formulated using weighted averages to reflect the relative beneficiary size of each reporting State. Drug names are reported at the generic ingredient level.

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

Figure 30 - Monitoring Oral Counseling Requirements

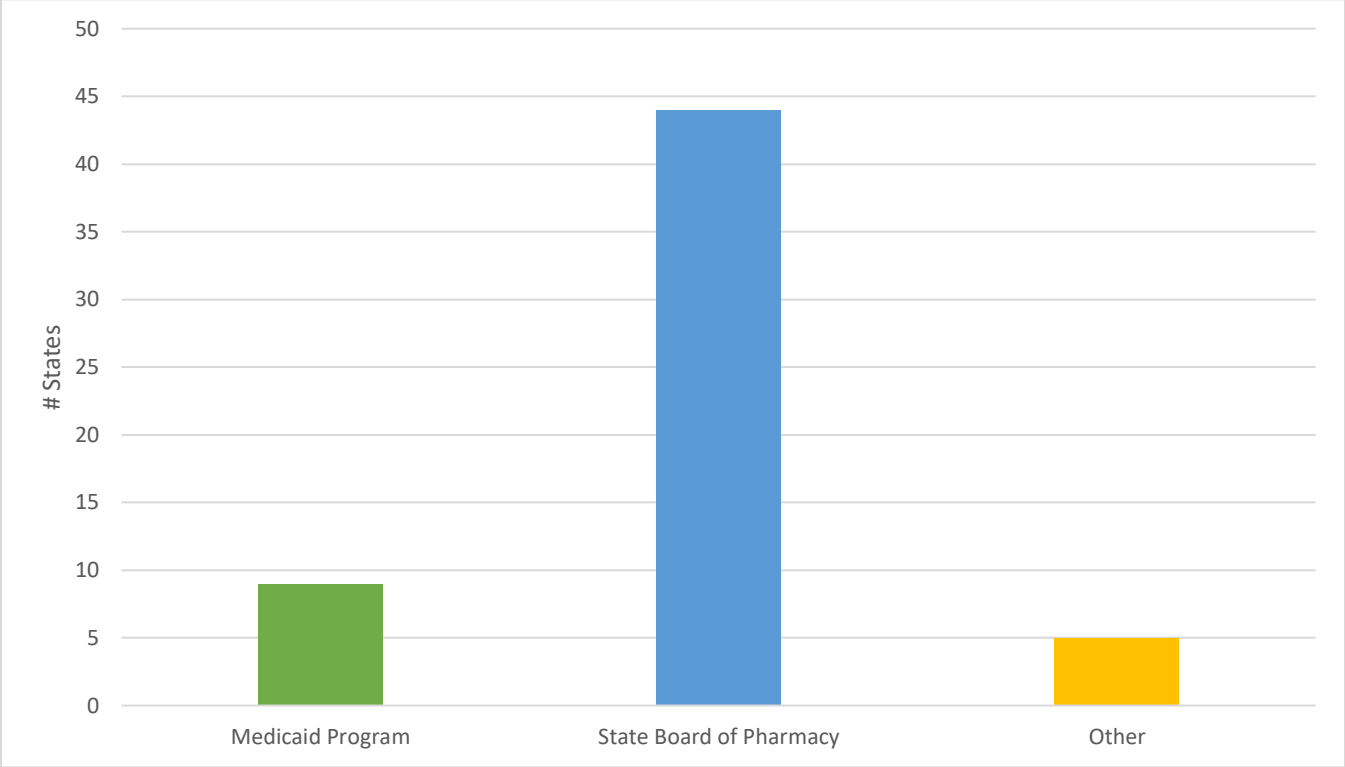

Table 42 - Monitoring Oral Counseling Requirements

Response	States	Count	Percentage
Medicaid Program	Colorado, Connecticut, Florida, Hawaii, Kansas, Minnesota, New York, South Carolina, Vermont	9	15.52%
State Board of Pharmacy	Alabama, Alaska, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Idaho, 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, West Virginia, Wisconsin, Wyoming	44	75.86%
Other	Hawaii, Illinois, Missouri, Utah, Washington	5	8.62%
Total		58	100.00%

If "Other," please explain

Table 43 - "Other" Explanations for Monitoring Oral Counseling Requirements

State	Explanation
Hawaii	Transplant case managers provide due to the nature of the transplant program and need for compliance.

State	Explanation
Illinois	The Illinois Department of Financial and Professional Regulation (IDFPR) licenses pharmacists in the State of Illinois. The IDFPR pharmacy inspectors during the course of pharmacy inspections evaluate compliance with the requirement for prospective drug regimen review and counseling. The IDFPR inspectors report findings to the State Board of Pharmacy which disciplines pharmacists and pharmacies.
Missouri	The Missouri Medicaid Audit and Compliance Unit monitors compliance with the oral counseling requirement.
Utah	Division of Occupational and Professional Licensing (DOPL) under the Pharmacy Act Rule.
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 that Performed RetroDUR Activities

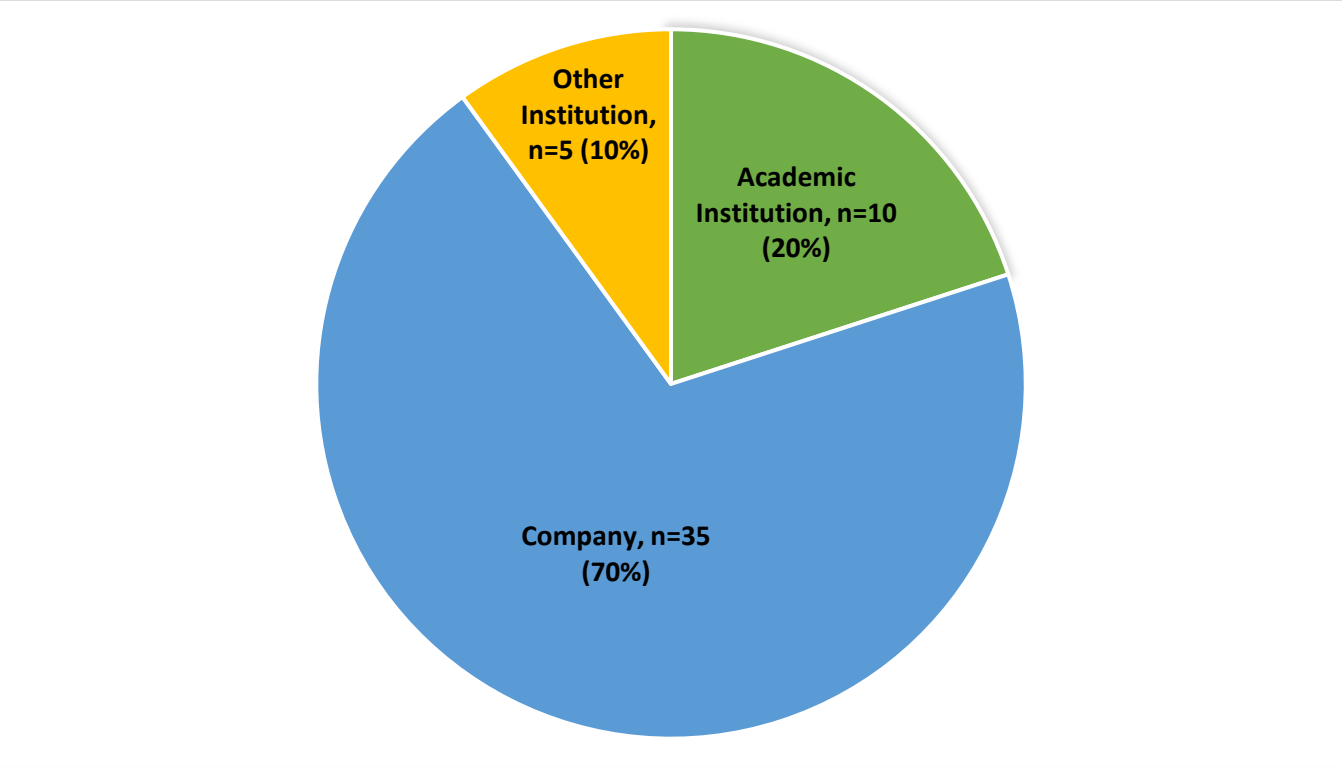

Table 44 - Type of Vendor that Performed RetroDUR Activities

Response	States	Count	Percentage
Academic Institution	California, Colorado, Illinois, Massachusetts, Mississippi, Oklahoma, Oregon, South Carolina, West Virginia, Wyoming	10	20.00%
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, Utah, Washington	5	10.00%
Total		50	100.00%

a. Identify, by name, your RetroDUR vendor

Table 45 - Vendor Names

Response	States	Count	Percentage
Kepro	Alabama, Connecticut, Kansas, Maryland, North Dakota, South Dakota, Wisconsin	7	20.00%
Magellan	Alaska, Arkansas, Florida, Idaho, Kentucky, Michigan, New Hampshire, Virginia	8	22.86%

Response	States	Count	Percentage
Gainwell Technologies	Delaware, Louisiana, New Jersey	3	8.57%
Conduent	District of Columbia, Missouri, New Mexico, Texas	4	11.43%
NorthStar Healthcare Consulting	Georgia	1	2.86%
Optum Rx Administrative Services, LLC.	Indiana	1	2.86%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	14.29%
Kepro, Inc.	Minnesota	1	2.86%
OptumRx (Q1 FFY2022-Q3 FFY2022). Magellan Medicaid Administration (Q4 FFY2022)	Nevada	1	2.86%
Kepro / Health Information Designs (HID)	New York	1	2.86%
Magellan Medicaid Administration, through subcontract with GDIT	North Carolina	1	2.86%
KEPRO	Rhode Island	1	2.86%
OptumRx	Tennessee	1	2.86%
Total		35	100.00%

Table 46 - Academic/Other Institution Names

State	Academic/Other Institution Name
California	University of California, San Francisco
Colorado	The Regents of the University of Colorado, Skaggs School of Pharmacy
Hawaii	State and Conduent Healthcare and Koan
Illinois	University of Illinois Chicago College of Pharmacy staff and Change Healthcare RetroDUR.
Massachusetts	University of Massachusetts Chan 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	The Medical University of South Carolina (MUSC) and Magellan
Utah	UT 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

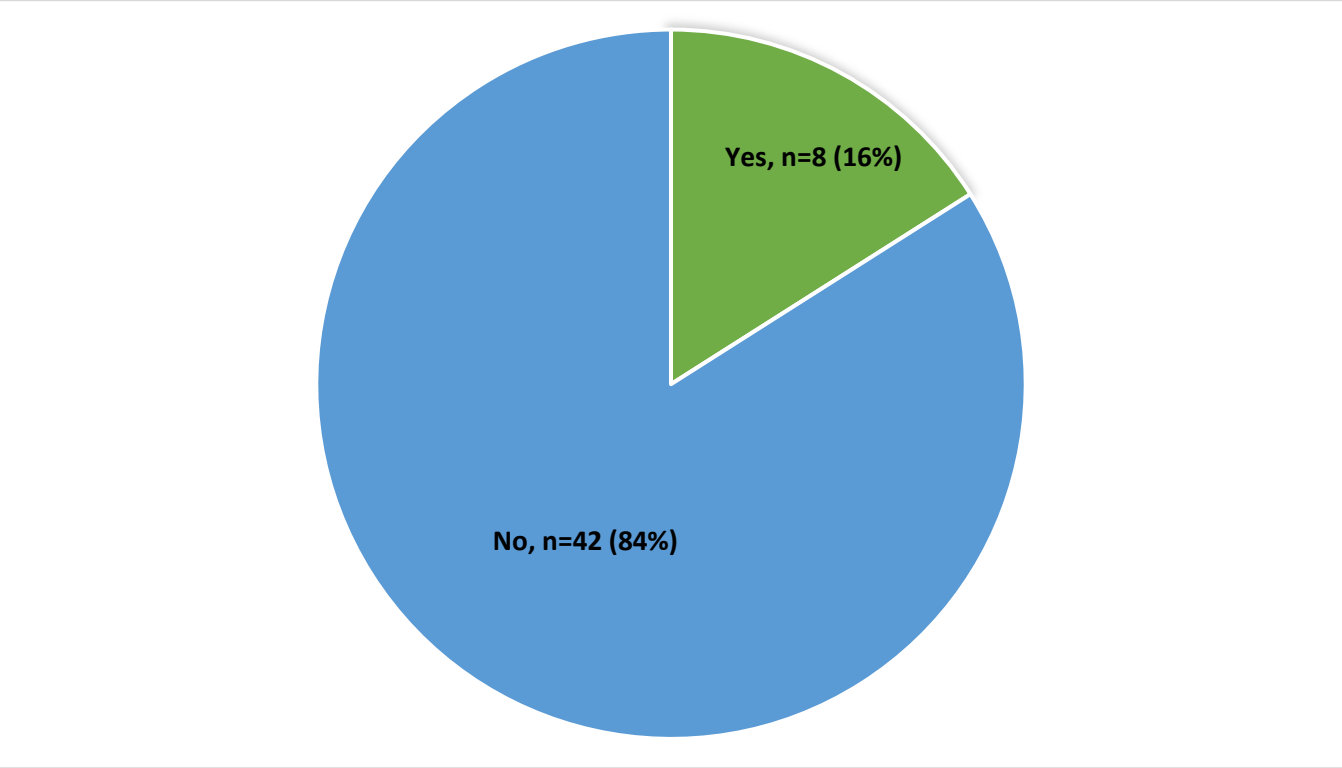

Table 47 - Is RetroDUR Vendor the State MMIS Fiscal Agent

Response	States	Count	Percentage
Yes	Delaware, District of Columbia, Hawaii, Louisiana, New Jersey, New Mexico, Virginia, Washington	8	16.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, 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, West Virginia, Wisconsin, Wyoming	42	84.00%
Total		50	100.00%

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

Figure 33 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

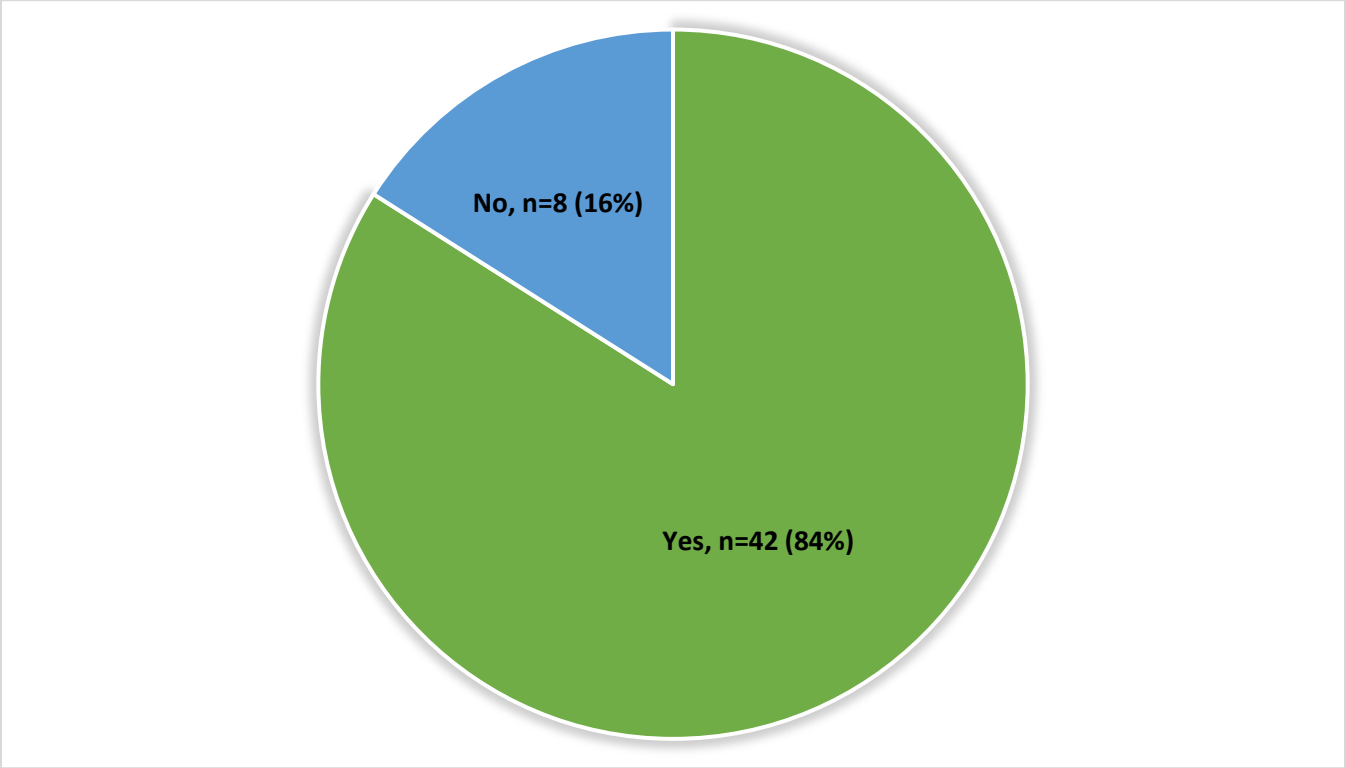

Table 48 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

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, Nebraska, 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	42	84.00%
No	California, Florida, Hawaii, Idaho, Louisiana, Pennsylvania, South Carolina, Utah	8	16.00%
Total		50	100.00%

If "Yes" or "No," please explain.

Table 49 - Explanations for why the RetroDUR Vendor is or is not the Developer/Supplier of Retrospective DUR Criteria

State	Explanation
Alabama	Kepro develops and maintains RDUR criteria for AL Medicaid.
Alaska	Magellan has both predefined and customizable reports for retrospective reviews.

State	Explanation
Arkansas	RetroDUR criteria are developed by the RDUR vendor. The vendor presents the possible intervention criteria and number of beneficiaries impacted to the DUR Board who reviews the presented options and approves a minimum of one criteria per month. The State and DUR Board can request ad hoc criteria in addition to those presented by the vendor.
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 by Kepro and reviewed by the DUR Board on a quarterly basis.
Delaware	Gainwell Technologies provides both services for the State of Delaware.
District of Columbia	Conduent develops rules for identifying individual beneficiary profiles for retrospective utilization review by the DHCF DUR Board. Conduent uses both pharmacy and medical claims history to select 300 profiles each month.
Florida	The developer of the retrospective DUR criteria is provided by the State DUR Board in collaboration with the Agency and Magellan Medicaid Administration.
Georgia	The RetroDUR vendor is the developer/supplier of the retrospective DUR criteria.
Hawaii	The State develops with the support of the vendors Conduent and Koan.
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	Change Healthcare 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 Chicago College of Pharmacy identify issues/criteria for drug-focused retrospective drug utilization review with input from the DUR Board.
Indiana	The retroDUR vendor presents proposed retroDUR 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	Yes, partially. The State supplies RDUR criteria as well.
Kentucky	Magellan develops the RetroDUR criteria and carries out the RetroDUR activity that is approved.
Louisiana	Retrospective DUR criteria are developed through the collaboration of pharmacists at LDH, Gainwell Technologies, 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.

State	Explanation
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.
Minnesota	Kepro'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 retroDUR criteria on behalf of the State.
Missouri	The vender creates the criteria and presents the 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	RetroDUR criteria is developed NE DHHS Medicaid and Long-term Care and either approved by either the State DUR Board or the program, . Some initiatives included as RetroDUR are initiated and completed by other units within the Division such as care gap analysis that include a pharmacy component plus overall health care interventions that result in provider education.
Nevada	The PBM vendors develop initiatives, provides presentations to the DUR Boards during quarterly meetings, and seeks input from the State.
New Hampshire	Magellan RX Management 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 RX Management. These activities are implemented over the proceeding 6 months. The letter and claims responses are summarized at the next DUR meeting.
New Jersey	Gainwell Technologies clinical staff assist with the development of DUR criteria, which is approved 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	Kepro updates and maintains the RetroDUR clinical criteria. The criteria is updated at least once a month in consideration of new clinical information.
North Carolina	The RetroDUR vendor supplies criteria, but the DUR Board and the Division of Health Benefits also recommend criteria.
North Dakota	Kepro proposes RetroDUR criteria quarterly and the DUR Board reviews the suggestions and approves. State staff also can propose criteria which will be implemented by Kepro.
Ohio	Change Healthcare, with the assistance and guidance of the State, DUR Committee, and Board members develops the RetroDUR criteria for each intervention. The State performs final review and approval of criteria.
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.

State	Explanation
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 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	The RetroDUR vendor is the developer/supplier of the retrospective DUR criteria.
South Carolina	The State continues to contract 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 review claims information for additional opportunities including: Hospice, Compound Claims and other drug classes which may provide opportunities around coding, policy language and processes.
South Dakota	The retroDUR vendor develops the retroDUR criteria. The DUR Review Committee reviews new criteria for inclusion in the review process.
Tennessee	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 is responsible for developing retrospective intervention criteria and the intervention letters to the prescribers. Conduent uses a web-based tool to conduct clinical analysis of drug therapy and disease States using both pharmacy and medical claims. This method allows clinical issues affecting thousands of members to be addressed without the need to individually review each profile. The retrospective criteria are presented to the Texas DUR Board for review and approval prior to being mailed out. An outcome report is submitted to the State and presented to the DUR Board. The outcome report shows the dollar amount of cost saving/cost avoidance by comparing the claims from 6-month before and after intervention. Additional clinical impact is also included.
Utah	The Retro-DUR criteria are developed by the Medicaid Pharmacy Team and implemented jointly by the Medicaid Pharmacy Team and the DUR Board
Vermont	The RetroDUR criteria is developed collaboratively by Change Healthcare, the Department of Vermont Health Access (State of Vermont), and the Drug Utilization Review (DUR) Board. The DUR Board votes on clinical criteria and DUR topics of interest, as well as makes suggestions for implementation and design.
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 is 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.

State	Explanation
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.
Wisconsin	Kepro is responsible for Wisconsin's retrospective DUR criteria. Each month Kepro evaluates pharmacy claims against criteria for several hundred potential drug therapy issues. Standard criteria are developed by Kepro with any customizable applications presented to the DUR Board.
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

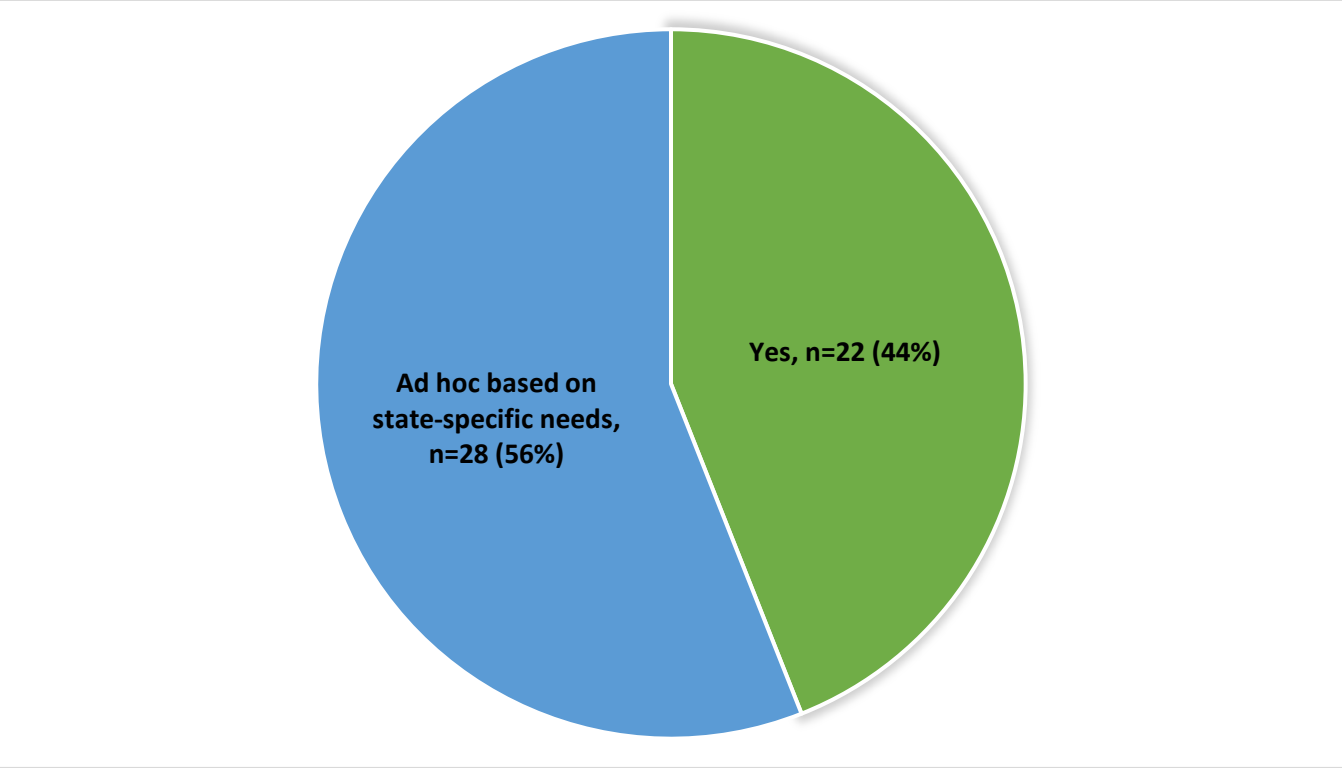

Table 50 - Does State Customize RetroDUR Vendor Criteria

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Indiana, Kentucky, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, West Virginia	22	44.00%
Ad hoc based on State-specific needs	Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, New Hampshire, New Mexico, New York, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, Wisconsin, Wyoming	28	56.00%
Total		50	100.00%

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

Figure 35 - Frequency of Retrospective Practitioner-Based Education

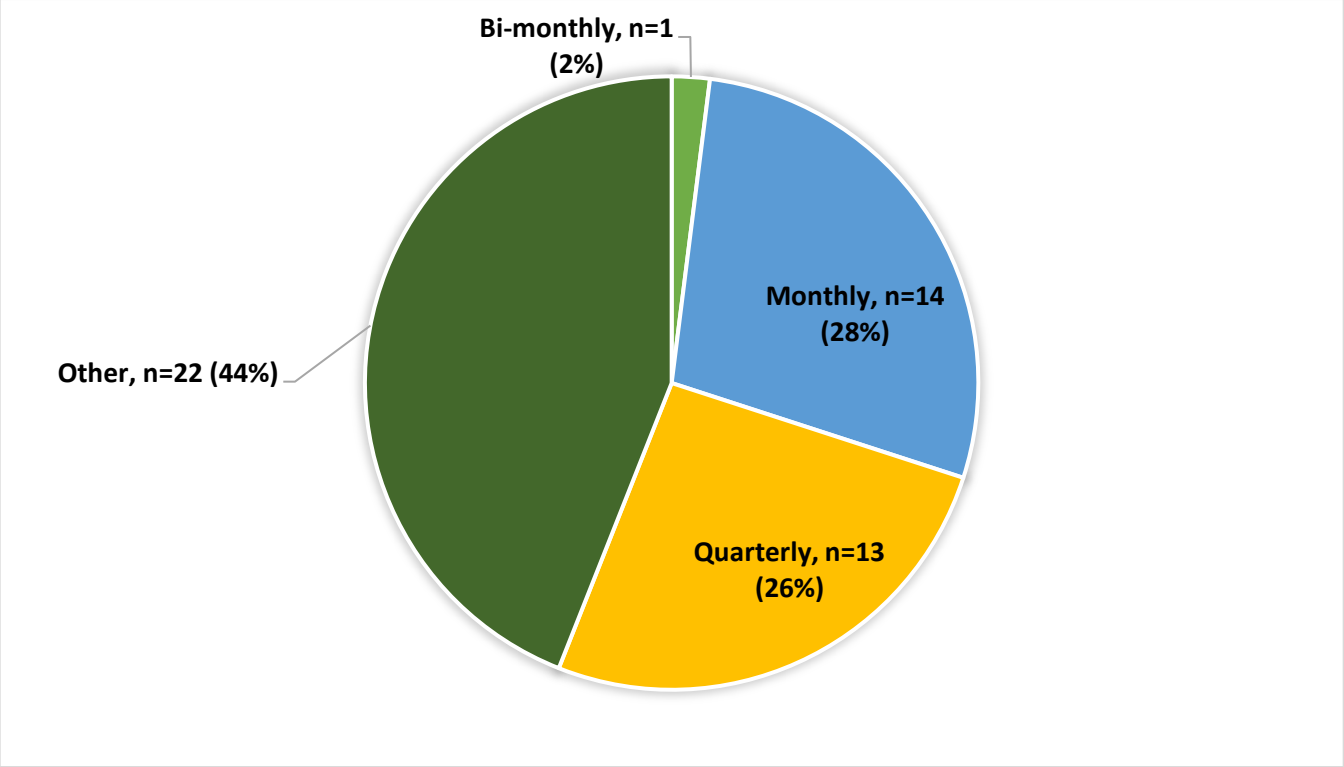

Table 51 - Frequency of Retrospective Practitioner-Based Education

Response	States	Count	Percentage
Bi-monthly	Oregon	1	2.00%
Monthly	Connecticut, Louisiana, Massachusetts, Mississippi, Montana, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Virginia	14	28.00%
Quarterly	Alabama, Alaska, Colorado, District of Columbia, Georgia, Kentucky, Maine, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Tennessee	13	26.00%
Other	Arkansas, California, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Nebraska, Nevada, New Jersey, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	22	44.00%
Total		50	100.00%

If "Other," please specify.

Table 52 - "Other" Frequency of Retrospective Practitioner-Based Education

State	Explanation
Arkansas	Retrospective practitioner-based education is performed monthly based on the DUR Board approved guidance. The State pharmacy program requests ad hoc education interventions, and quarterly education is provided by a provider newsletter.
California	Practitioner-based education is performed at least on a quarterly basis and more frequently as needed.

State	Explanation
Delaware	Delaware sends out retro DUR letters that are generated weekly based on DUR criteria that has been established by the DUR Board members. Additionally, blast faxes and prescriber notifications are sent out 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 s as a supplement if needed.
Idaho	Depending on the outreach, it may vary from monthly to quarterly.
Illinois	Practitioner-based education may occur as part of the prior authorization process. After completion of RetroDUR 300 evaluations and after a focused retrospective review, practitioner education may be done and is targeted to individual patients of the prescriber 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 and approved by the DUR Board or a link to pertinent publicly available materials is posted on the DUR Board Education page. The DUR Board approves links that are posted on the education page. The posted information may be shared with prescribers when pertinent during the PA process.
Indiana	The retroDUR vendor provides practitioner-based education at least twice per year and no more often than quarterly.
Iowa	Twice a year through the DUR digest and other provider specific education as issues are identified.
Kansas	The frequency varies, depending on specific RDUR requirements given in State policy and also requirements set in vendor contract. Not all RDUR analyses lead to individual practitioner lettering.
Maryland	The RetroDUR vendor performs retrospective practitioner based educational interventions depending on the criteria and direction from the DUR Board. For the reporting period, there were, monthly, quarterly, and bi-annually interventions performed.
Nebraska	RetroDUR provider education is determined by the DUR Board in collaboration with the Division and customized to the education topic. Not all RetroDUR activities result in individual providers letter and may be addressed through State-wide education campaigns.
Nevada	Ad hoc based
New Jersey	Practitioner-based education is performed on an ongoing basis based on member specific retrospective review.
South Carolina	Quarterly initiatives are planned which include mailings sometimes paired with Academic Detailing resources and CE via the tipSC website, as well as, presentations at academic meetings conferences
Texas	There is no set schedule for conducting R-DUR practitioner-based education. Per the State's requirement, vendor performs up to10 or 12 population-based interventions after which educational letters are sent to the flagged providers.
Utah	The practitioner-based education is an ongoing process. It is integrated to day-to-day Prior Authorization review work flow.
Vermont	Retrospective practitioner-based education is dependent on the specific outcomes of the retrospective DUR analysis and feedback from the DUR board.
Washington	Retrospective practitioner-based education occurs on an ad hoc basis based on State specific needs, as a result of provider oversight activities.

State	Explanation
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	The majority of retrospective practitioner-based educational letters are completed monthly. Some educational letters are quarterly and on an as needed basis. Newsletters are developed as needed.
Wyoming	Practitioner-based education occurs through a variety of programs that are published monthly, quarterly and up to weekly as needed depending on the project.

a. How often does your State perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)?

Figure 36 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

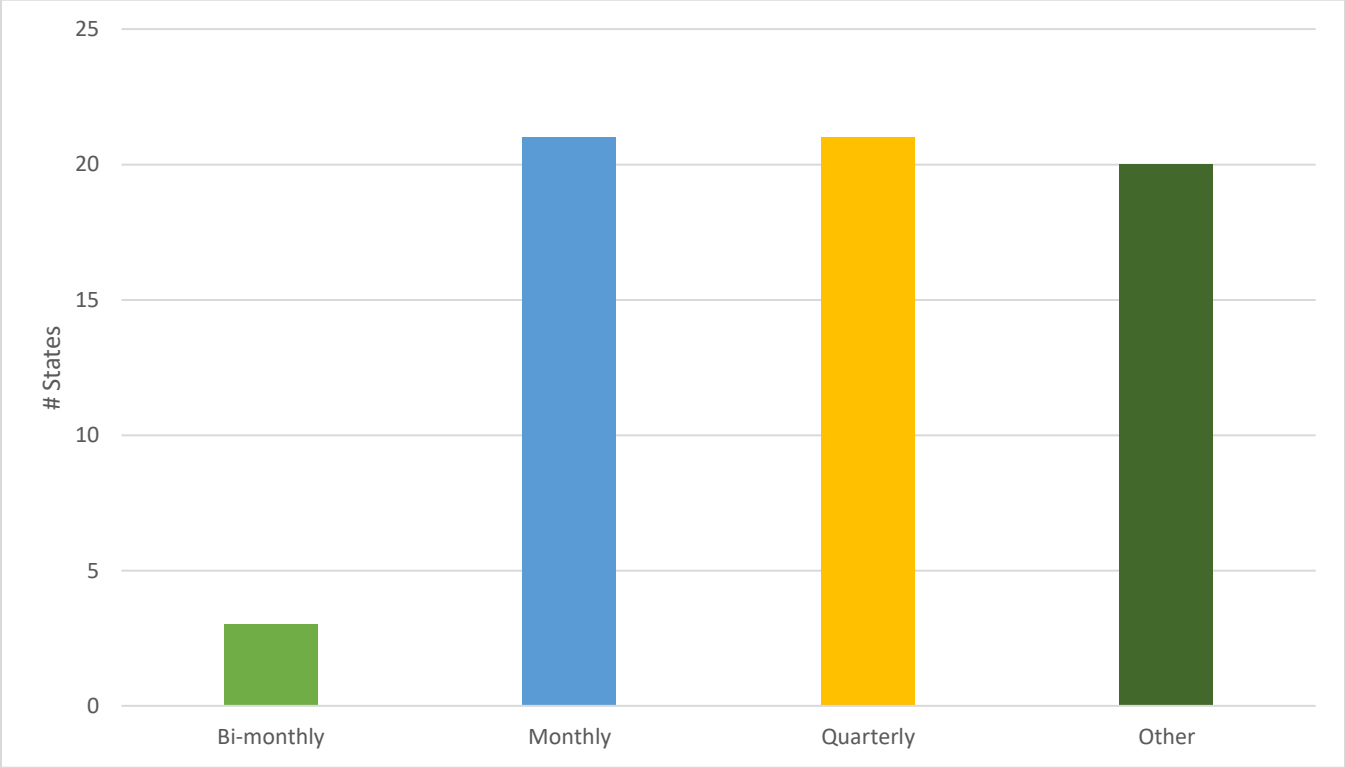

Table 53 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

Response	States	Count	Percentage
Bi-monthly	Illinois, Maine, Utah	3	4.62%
Monthly	Arkansas, Connecticut, District of Columbia, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, New Hampshire, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin	21	32.31%

Response	States	Count	Percentage
Quarterly	Alabama, Alaska, Colorado, District of Columbia, Georgia, Iowa, Kentucky, Maine, Maryland, Michigan, Missouri, Nevada, New Mexico, North Carolina, North Dakota, Oklahoma, South Carolina, Tennessee, Utah, Wisconsin, Wyoming	21	32.31%
Other	Arkansas, California, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Nebraska, New Jersey, New Mexico, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, Washington, Wisconsin	20	30.77%
Total		65	100.00%

If "Other," please specify.

Table 54 - "Other" Explanations for Frequency of Retrospective Reviews that Involve Communication of Client-specific Information to Healthcare Practitioners

State	Explanation
Arkansas	The DUR Board reviews multiple intervention criteria options during each quarterly board meeting provided by the RDUR vendor. Medicaid beneficiaries are analyzed with the DUR Board approved criteria with at least one Board approved criteria being analyzed monthly. Patient specific communication along with an educational letter is mailed to prescribers based on the specific beneficiaries that met Board approved criteria.
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 retro DUR letters that are generated weekly based on DUR criteria that has been established by the DUR Board members. We send out retro DUR letters and also do targeted calls to providers on an ad hoc basis when concerns arise regarding specific clients.
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 usually by phone call with the healthcare practitioner.
Idaho	Depending on the outreach, it may vary from monthly to quarterly.
Illinois	Client-specific information may be shared for issues identified at the claim level in RetroDUR 300 and other focused retrospective reviews. Pharmacist reviewers may determine that an issue identified by the automated RetroDUR 300 report is no longer a problem, for example drug therapy changed since the date of the claim in the report. In those cases, the prescriber outreach and sharing of client-specific information is not done.
Indiana	The retroDUR vendor 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. For FFY 2021, there were two provider RDUR reviews that led to communication of client specific information to healthcare practitioners, but those interventions were not impactful. We are reviewing how we might improve this area of the DUR Program.
Nebraska	Provider education that is client-specific occurs at varying intervals dependent upon the education needs of the specific initiative or retrospective review therapeutic class.
New Jersey	Practitioner-based education is performed on an ongoing basis based on member specific retrospective review.

State	Explanation
New Mexico	The goal is quarterly interventions, however there were limitations with education due to the COVID epidemic and limitations of the DURB members. Many of the DURB members had staffing issues and provided direct patient care limiting their involvement with the DUR board. Moving foward, we have recognized the limitations and returned to the quarterly education goals in FFY23.
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 website as well as presentations at academic meetings conferences
Texas	There is no set frequency for mailing educational letters to prescribers. Intervention packages are sent to targeted prescribers via mail after the DUR Board approval. Each package includes a letter to the prescriber, specific client claims information, and a clinical message page explaining the standard practices guidance.
Utah	It is an ongoing process, integrated to day-to-day Prior Authorization review work flow.
Vermont	Retrospective reviews that involve communication of client-specific information to healthcare practitioners (through messaging, fax, or mail) are developed on an as needed basis. Communications are dependent on specific PDL changes or Retrospective DURs reviewed by the DUR Board
Virginia	There are monthly reviews and discussions of clinical hot topics and trends and review of reports to see how the FFS Medicaid population is doing with these topics. These topics will get reviewed at DUR meetings and with the DUR Board and DMAS together; these topics are selected for lettering if necessary and if there is a valid concern.
Washington	Retrospective reviews that involve communication of client specific information to practitioners occurs on an ad hoc basis based on State specific needs as a result of provider oversight activities or care gap analysis.
Wisconsin	The majority of retrospective practitioner-based educational letters are completed monthly. Some educational letters are quarterly and on an as needed basis.

b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?

Figure 37 - Preferred Mode of Communication When Performing RetroDUR Initiatives

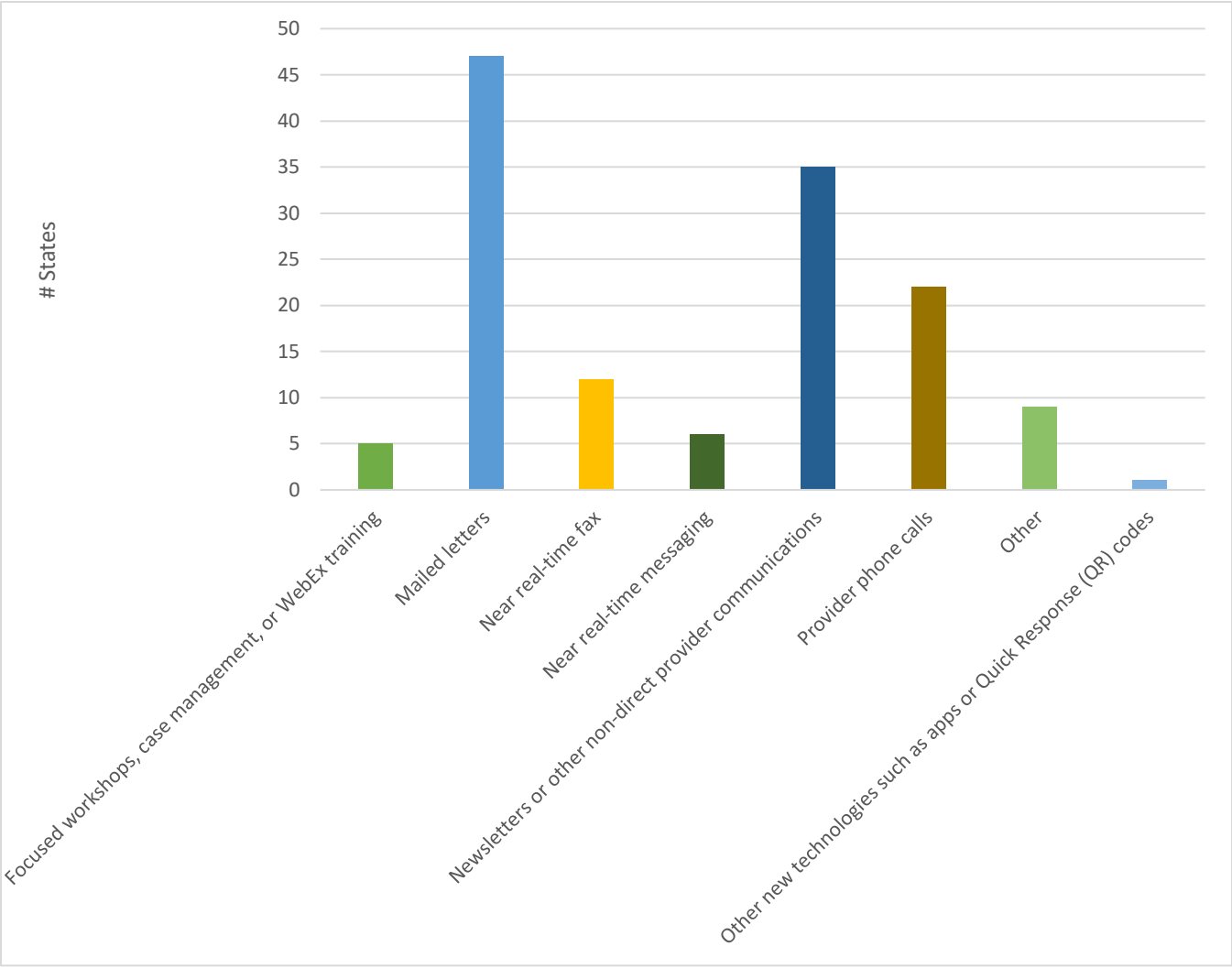

Table 55 - Preferred Mode of Communication When Performing RetroDUR Initiatives

Response	States	Count	Percentage
Focused workshops, case management, or WebEx training	District of Columbia, Florida, Oklahoma, South Carolina, Washington	5	3.65%
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, 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	47	34.31%

Response	States	Count	Percentage
Near real-time fax	Arkansas, Georgia, Illinois, Indiana, Maine, Massachusetts, Nebraska, New Jersey, Oklahoma, South Carolina, Washington, West Virginia	12	8.76%
Near real-time messaging	Florida, Massachusetts, Oregon, South Carolina, Vermont, Washington	6	4.38%
Newsletters or other non-direct provider communications	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, 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, Washington, West Virginia, Wisconsin, Wyoming	35	25.55%
Provider phone calls	Alaska, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Massachusetts, Michigan, Montana, Nebraska, New Jersey, Ohio, Oklahoma, South Carolina, Utah, Vermont, Washington, Wisconsin	22	16.06%
Other	Hawaii, Illinois, Michigan, New Mexico, North Carolina, Ohio, South Carolina, Vermont, Washington	9	6.57%
Other new technologies such as apps or Quick Response (QR) codes	South Carolina	1	0.73%
Total		137	100.00%

If "Other," please specify.

Table 56 - "Other" Explanations for Preferred Mode of Communication When Performing RetroDUR Initiatives

State	Explanation
Hawaii	The combination of phone calls and email are preferred.
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	Retrospective faxes
South Carolina	The mode of communication is assessed and evaluated independently every effort is made to align the most appropriate method of communication with the intervention taking into account limitations in some methods which may include cost resources and timeliness.
Vermont	Communications are also shared via FAX blast type messaging to providers.
Washington	Meetings and outreach with Washington State professional and quality assurance boards, commissions, and associations.

3. Summary 1 - RetroDUR Educational Outreach

RetroDUR Educational Outreach Summary should be a year-end report on retrospective screening and educational interventions. This 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 57 - RetroDUR Educational Outreach Summary

State	RetroDUR Educational Outreach Summary
Alabama	This report prepared for AL Medicaid Agency 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) 2022. Kepro identified recipients with drug therapy problems based upon each intervention topic and mailed educational letters to their prescribers. When more than one prescriber was attributed to pertinent claims on a patient profile, letters were mailed to all relevant prescribers. Informing prescribers of a patients' complete drug and diagnosis history, including medications prescribed by other providers, may reduce duplicate prescribing of medications. While the intervention letter itself only addressed the intervention topics, Kepro included a patient profile with up to two additional alert messages regarding drug therapy issues and a 6-month history of drug claims and diagnoses along with the letter. Prescribers had the opportunity to review the entire recipient drug and diagnoses history, including medications prescribed by other providers, and make changes to therapies based upon this information. Each month Kepro evaluates Alabama Medicaid pharmacy claims data against thousands of proprietary criteria. The criteria are developed and maintained by Kepro clinical pharmacists who review package insert updates as well as medical literature to develop the criteria. The following are the top ten criteria and problem types for which interventions were taken for Federal Fiscal Year 2022. Criteria Evaluated Respiratory Depression Drug-Drug Interaction: -The FDA is warning that serious, life-threatening, and fatal respiratory depression has been reported with the use of gabapentinoids (gabapentin and pregabalin). Most cases occurred in association with co-administration of central nervous system (CNS) depressants, especially opioids, in the setting of underlying respiratory impairment, or in the elderly. When co-prescribing gabapentinoids with another CNS depressant, particularly an opioid, or in patients with underlying respiratory impairment, initiate the gabapentinoid at the lowest dose and monitor for respiratory depression and sedation. Diabetes and Hypertension Therapeutic Appropriateness: -The patient has a history of diabetes and hypertension and may benefit from the addition of an antihypertensive agent to reduce cardiovascular morbidity and mortality. The recommended blood pressure goal for adults with both hypertension and diabetes is a blood pressure of less than 130/80 mmHg. All first-line classes of antihypertensive agents (i.e., diuretics, ACE inhibitors, ARBs, and CCBs) are useful and effective for the treatment of hypertension in patients

State	RetroDUR Educational Outreach Summary
	with diabetes. Combination antihypertensive therapy may be necessary as blood pressure control is more difficult in this patient population. SUPPORT Act of 2018 Drug-Drug Precaution: -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. Appropriate Use of Opioids Therapeutic Appropriateness: -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, 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). SUPPORT Act of 2018 Drug-Drug Precaution: -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. Risk of Serotonin Syndrome Drug-Drug Interaction: -Coadministration of triptans and SSRIs or SNRIs should be done with caution. Concomitant use may increase the risk of serotonin syndrome. Prescribers are advised to weigh the potential risk of serotonin syndrome. Stimulants and Anxiety Drug-Disease Precaution: -The stimulant is contraindicated in patients with agitated States as the drug may aggravate the condition. Polypsychopharmacy (Antipsychotics, Benzodiazepines, and Stimulants) Therapeutic Appropriateness: -The patient is receiving multi-class polypsychopharmacy. Review the patient's medication history for any unintended additional therapy and assess adherence

State	RetroDUR Educational Outreach Summary

to ensure efficacy. Complex drug regimens increase the risk of adverse effects, drug/drug interactions, and non-adherence which may result in the relapse of the disease State.

Potential Drug Abuse
Therapeutic Appropriateness:
-Due to the potential for abuse, misuse, addiction, physical dependence, and withdrawal reactions, benzodiazepines should be used with caution, and chronic therapy should be avoided if possible.

Black Box Warning
Drug-Disease Precaution:
-The triple drug combination involving an opioid agonist, a skeletal muscle relaxant (particularly carisoprodol), and a benzodiazepine can cause a heroin-like euphoria as well as lethal CNS depression. This polydrug combo is sought for illicit use and diversion. Use extreme caution when prescribing this drug combination especially in patients with a history of drug abuse/dependence.

Recipient Selection
A total of 3,465 recipients met the criteria for intervention letters. The drug history profile for each recipient was reviewed by a clinical pharmacist to determine if the recipient should be selected for intervention.
After recipients were selected for intervention, educational intervention letters, along with a complete drug and diagnosis history profile listing all pharmacy and available diagnosis claims data for the past 6 months, were mailed to the appropriate prescribers. Prior to mailing, generated letters undergo a quality assurance (QA) process. Some letters are not mailed due to various reasons, including missing or invalid prescriber addresses.

Recipients Selected for Intervention	Recipients Reviewed	Letters Generated	Letters Mailed
Respiratory Depression	1213	721	1461	1388
Diabetes and Hypertension	437	331	770	427
SUPPORT Act of 2018	416	242	484	464
Appropriate Use of Immediate Release Opioids	326	6	6	5
SUPPORT Act of 2018	303	175	281	281
Risk of Serotonin Syndrome	249	208	356	334
Stimulants and Anxiety	158	6	6	6
Polypsychopharmacy	139	2	2	2

State	RetroDUR Educational Outreach Summary
	Potential Drug Abuse 120 102 167 167 Black Box Warning 104 3 3 3 Totals 3465 1796 3536 3077
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 2022 are summarized below: Highlighted Activities Opioids in combination with benzodiazepines, z-drugs, and antipsychotics were continually reviewed by the DUR Board quarterly Pharmacies were contacted via a lettering campaign to educate on the opioid ICD requirement and importance thereof. 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	Our RDUR vendor, Magellan Rx Management, developed RetroDUR criteria 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

State	RetroDUR Educational Outreach Summary
	necessary, and are not at risk of adverse medical outcomes. The DUR Board approves intervention criteria for active and ongoing educational outreach programs to educate practitioners, with the aim of improving prescribing or dispensing practices. At least one new intervention criteria is reviewed monthly as determined by the DUR Board. The drug history and diagnosis profile for each beneficiary who meets the selected criteria are reviewed by the Magellan RDUR team to determine if the beneficiary should be selected for an intervention. Educational intervention letters include a description of the intervention, beneficiary's pharmacy claim history when appropriate for the intervention, and language to encourage the prescriber to have a discussion with their patient on the medication effectiveness, adverse effects, and importance of adherence. Once the specific criteria has been selected, the criteria will not be chosen for review again for at least 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, beneficiaries could be selected for additional interventions if they meet specific criteria. The results below contain more information than just the interventions that began in FFY2022, but the re-review period for interventions from FFY2021 fell within this report timeframe and warrant mentioning. Monthly RetroDUR Educational Outreach Summary 1. April 2021--Concurrent use of Opioids and Antipsychotics a. 1036 profiles reviewed, 552 beneficiaries required letters, 1097 prescribers were sent letters which were mailed 4/21/2021. b. This criterion was re-reviewed in October 2021 and 224 beneficiaries had the same issue; this calculates to approximately a 59% change in therapy. 2. May 2021--DPP4 and SGLT-2 inhibitors-FDA warnings a. 657 profiles reviewed, 657 beneficiaries required letters, 687 prescribers were sent letters which were mailed 5/20/2021. b. This criterion was re-reviewed in November 2021 and 371 beneficiaries had the same issue; this calculates to approximately a 44% change in therapy. 3. June 2021--CNS Polypharmacy (narcotic claim and psychiatric drug and muscle relaxer or sedative hypnotic in the previous 120 days) a. 2,253 profiles reviewed, 244 clients required letters, 655 prescribers were sent letters which were mailed 6/29/2021. b. This criterion was re-reviewed in December 2021 and 145 beneficiaries had the same issue; this calculates to approximately a 41% change in therapy. 4. August 2021--Females 15-50 with claims for opioid analgesics and no claims for birth control a. 817 profiles reviewed, 817 beneficiaries required letters,1129 prescribers were sent letters which were mailed 8/2/2021. b. This criterion was re-reviewed in February 2022 and 398 beneficiaries had the same issue; this calculates to approximately a 51% change in therapy. 5. October 2021--ADHD in females (CDC warning) and SABA with 2 or more in 90 days without a controller medication (2 separate interventions)

State	RetroDUR Educational Outreach Summary
	a. For the ADHD intervention--891 profiles reviewed, 891 beneficiaries required letters, 987 provider letters were sent 10/7/2021. b. For the SABA intervention--2730 beneficiaries required letters, 3147 provider letters were sent 10/21/2021. c. Re-review was performed in April 2022 for both interventions with total of 2752 beneficiaries with the same issue. Since they interventions were combined, the percent improvement is difficult to ascertain. 6. November 2021--FDA increased warning about complex sleep behaviors with zaleplon, zolpidem and eszopiclone a. 1439 beneficiaries required letters; 1739 provider letters were sent on 11/17/2021. b. Re-review was performed in May 2022 with 1163 beneficiaries having the same issue at that time; this calculates to approximately a 19% change in therapy. 7. December 2021--APAP with other meds which may have hepatotoxic side effects a. 580 beneficiaries required letters; 1003 provider letters were sent on 12/28/2021. b. Re-review was performed in June 2022 with 319 beneficiaries having the same issue at that time; this calculates to approximately a 45% change in therapy. 8. January 2022--Tramadol with SSRI or SNRI a. 516 profiles were reviewed; 167 beneficiaries required letters which were sent to providers on 1/26/2022. b. Re-review was performed in July 2022 with 71 beneficiaries having the same issue at that time; this calculates to approximately a 57% change in therapy. 9. February 2022--Non-compliance with anticonvulsant medications a. 2959 profiles were reviewed; 343 beneficiaries required letters which were sent to providers on 2/10/2022. b. Re-review was performed in August 2022 with 31 beneficiaries having the same issue at that time; this calculates to approximately a 91% change in therapy. 10. March 2022--Bipolar disorder with antidepressants and no mood stabilizer a. 806 profiles were reviewed; 743 beneficiaries required letters; 832 provider letters were sent on 3/10/2022. b. Re-review was performed in September 2022 with 537 beneficiaries having the same issue at that time, this calculates to approximately a 28% change in therapy. 11. April 2022--Members with 6 or more narcotic claims, with risk factors and no claims for naloxone in 180 days and concurrent uses of opioids and antipsychotics (2 separate interventions)

State	RetroDUR Educational Outreach Summary
	a. For the naloxone intervention--165 profiles were reviewed; 162 beneficiaries required letters mailed to their providers which were sent on 4/12/2022. b. For the opioid/psych intervention--776 profiles were reviewed, 405 beneficiaries required letters mailed to their providers which were sent on 4/12/2022. c. This intervention was scheduled to be re-reviewed in October 2022, so it will be available on the next FFY report. 12. May 2022--CNS Polypharmacy a. 523 profiles were reviewed; 255 beneficiaries required letters; 655 provider letters were sent on 5/25/2022 b. This intervention was scheduled to be re-reviewed in November 2022, so it will be available on the next FFY report. 13. June 2022--FDA Boxed warning--Chronic use of metoclopramide has been linked to tardive dyskinesia a. 553 profiles were reviewed; 216 beneficiaries required letters; 228 provider letters were sent on 6/17/2022. b. This intervention was scheduled to be re-reviewed in December 2022, so it will be available on the next FFY report. 14. July 2022--NSAIDs increase cardiac risk-patients with angina/coronary heart disease a. 752 profiles were reviewed; 328 beneficiaries required letters; 369 provider letters were sent on 7/19/2022. b. This intervention was scheduled to be re-reviewed in January 2023, so it will be available on the next FFY report. 15. August 2022--Metformin is contraindicated in patients with renal impairment AND concomitant use of opioids and benzodiazepines (2 separate interventions) a. For the metformin intervention--241 profiles were reviewed; 195 beneficiaries required letters; 213 provider letters were sent on 8/16/2022. b. For the opioid/benzo intervention--All beneficiaries identified qualified for letters to be sent, 1775 beneficiaries required letters, 2975 provider letters were sent on 8/26/2022. c. This intervention was scheduled to be re-reviewed in February 2023, so it will be available on the next FFY report. 16. September 2022--CNS stimulants may retard growth in pediatric patients ages 4-10 a. 6493 beneficiaries required letters to be sent; 1008 unique prescribers were sent letters that included a list of all impacted beneficiaries to minimize quantity of letters sent. Letters were mailed on 9/19/2022. b. This intervention was scheduled to be re-reviewed in March 2023, so it will be available on the next FFY report.

State	RetroDUR Educational Outreach Summary
	In summary for FFY2022, the RDUR program reviewed 25,536 profiles, determined that 16,722 beneficiaries met criteria warranting a letter to be sent to the prescriber, and 14,891 prescriber letters were mailed.
California	1. Clozapine o Educational outreach letter sent in October 2021: This letter aimed to inform prescribers of clozapine that on July 29, 2021, the FDA approved modifications to the Clozapine REMS that prescribers and patients will not have access to clozapine if they have not re-certified or re-enrolled in the program by November 15, 2021. The letter was sent to all 115 prescribers who prescribed clozapine to at least one FFS beneficiary in 2021. Letters included the Clozapine REMS fact sheet and a provider survey. 2. Naloxone o Educational alert published December 31, 2021 (and later updated March 31, 2022): This educational bulletin reviewed California legislation regarding naloxone and summarized best practices for responsible prescribing and furnishing of naloxone. o Retrospective Naloxone Study: A retrospective study was conducted by the DUR program based on research completed for the DUR educational article published in December 2021. This study focused on the impacts of the authorization for pharmacists to furnish naloxone and the mandate to offer naloxone under certain conditions. The study aimed to determine if there was an impact on total paid claims for naloxone among Medi-Cal beneficiaries and it revealed there was an uptick in total paid claims since legislation passed. The study results were presented at two clinical pharmacy conferences in 2022, including the 24th Annual UCSF Department of Clinical Pharmacy Spring Research Symposium and the 2022 American College of Clinical Pharmacy Virtual Poster Symposium. The abstract will also be presented at the upcoming American Drug Utilization Review Society (ADURS) symposium in 2023. o Prospective Naloxone Study: A prospective study was developed by the DUR program in response to a review of Medi-Cal pharmacy data review that found naloxone furnishing rates remain low, particularly in rural communities, despite rising mortality rates due to opioid overdose during the COVID-19 pandemic. The study was designed to assess the barriers and facilitators to furnishing naloxone from community pharmacies and focused on two rural counties in California with high mortality due to opioid overdose in 2020. The DUR program has completed data collection for the study, which included stakeholder interviews and surveys administer pharmacy visits o Naloxone Provider Letter: An educational outreach letter was sent in September 2022 that aimed to inform health care providers about the importance of prescribing naloxone to patients at high risk for overdose. Letters were mailed to 1,021 prescribers of opioids to at least four high-risk Medi-Cal FFS beneficiaries that did not have a paid claim for naloxone within the last year. Each prescriber was sent a letter that included the Medi-Cal DUR naloxone bulletin and a provider survey. o Naloxone Pharmacy Letter: An educational outreach letter was sent in September 2022 that aimed to inform pharmacies about the importance of furnishing naloxone to patients at high risk for overdose. Letters were mailed to the top pharmacies that had dispensed opioids to at least ten high-risk Medi-Cal

State	RetroDUR Educational Outreach Summary
	FFS beneficiaries that did not have a paid claim for naloxone within the last year. Each pharmacy was sent a letter that included the Medi-Cal DUR alert, the CDPH naloxone handout, and a pharmacy survey. 3. Buprenorphine o Educational alert published February 15, 2022: This alert summarized a letter from the American Society of Addiction Medicine (ASAM) and ten other health professional association to FDA, to retract a Drug Safety Communication issued in January on possible dental problems associated with transmucosal buprenorphine. o Provider letter sent August 2022: This educational outreach letter aimed to inform health care providers about a letter from ASAM and ten other health professional associations that called for the FDA to immediately and fully retract their Drug Safety Communication on dental problems associated with buprenorphine. Letters were mailed on August 10, 2022, to all 1,116 prescribers of transmucosal buprenorphine to Medi-Cal FFS beneficiaries during 2022. Each prescriber was sent a letter that included the Medi-Cal DUR alert and a provider survey. 4. California Immunization Registry (CAIR2) o Educational alert published May 2022: This alert highlighted steps that providers and pharmacies can take to ensure CAIR2 contains only high-quality data. 5. Bosentan o Educational outreach letter sent in June 2022: This letter aimed to inform health care providers about a modification to the Bosentan Risk Evaluation and Mitigation Strategy (REMS) Program that changed the pre-dispense authorization process for pharmacies. The letter was sent to all eleven pharmacies who had dispensed bosentan to at least one Medi-Cal patient during the previous 180 days. Each prescriber was sent a letter that included the Bosentan REMS Program fact sheet, a patient list, and a pharmacy survey.
Colorado	INTERVENTIONAL LETTERS Educational letters that contain patient-specific information are prepared and mailed to prescribers on a quarterly basis. These letters generally cover clinical topics such as high risk opioid prescribing, high risk benzodiazepine prescribing, and high risk psychotropic medication prescribing in children. During FFY 2022, nearly 3,800 interventional and educational letters were mailed to Colorado Medicaid prescribers. FFY 2022 Q1 (Oct 1 to Dec 31, 2021) - TOTAL 953 251 Adult members with claims for 2 or more BZD for 90/180 days using most recent data files 83 Members less than 18 years of age with claims for 2 or more antipsychotics for greater than 45 days of the measurement quarter 297 Concomitant claims for an opioid plus BZD plus muscle relaxant in adults 322 Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months

State	RetroDUR Educational Outreach Summary
	FFY 2022 Q2 (Jan 1 to Mar 31, 2022) - TOTAL 983 314 Adult members with claims for 2 or more BZD for 90/180 days using most recent data files 84 Members less than 18 years of age with claims for 2 or more antipsychotics for greater than 45 days of the measurement quarter 256 Concomitant claims for an opioid plus BZD plus muscle relaxant in adults 329 Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months FFY 2022 Q3 (Mar 31 to Jun 30, 2022) - TOTAL 849 259 Adult members with claims for 2 or more BZD for 90/180 days using most recent data files 100 Members less than 18 years of age with claims for 2 or more antipsychotics for greater than 45 days of the measurement quarter 223 Concomitant claims for an opioid plus BZD plus muscle relaxant in adults 267 Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months FFY 2022 Q4 (Jul 1 to Sep 30, 2022) - TOTAL 1002 230 Adult members with claims for 2 or more BZD for 90/180 days using most recent data files 311 *NEW* -- Members less than 18 years of age with claims for 3 or more psychotropic medications (antidepressants, antipsychotics, anxiolytics, mood stabilizers and stimulants) for 30/90 days of the measurement quarter 216 Concomitant claims for an opioid plus BZD plus muscle relaxant in adults 245 Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months OTHER RetroDUR MONITORING ACTIVITIES A new paragraph was added to specific RetroDUR educational outreach letters during the 4th quarter of 2021. The paragraph States 'Please note that information contained in this letter is intended to alert providers to potential pharmacotherapy issues and create opportunities for making medication adjustments when warranted. RDUR communications may represent situations in which a member has received medications from more than one prescriber.' The new text appears to have increased provider acceptance of RetroDUR mailings over time and also appears to have fostered a somewhat higher level of increased communication and collaboration among prescribers who are providing (or have provided) care to individual Medicaid members. A report summarizing members with multiple claims for opioid prescriptions that total > 200 MME calculated as a daily dose averaged over a 30-day period, along with the associated prescribers, is produced and reviewed quarterly. A report summarizing the number of children and adolescent beneficiaries receiving 3 or more stimulant medications for 30+ continuous days per quarter, along with the associated prescribers, is produced and reviewed quarterly (a new, recurring report as of July 2022).

State	RetroDUR Educational Outreach Summary
	DUR DIGITAL NEWSLETTERS DUR newsletters were developed, posted online, and distributed by email to DUR Board members and other key stakeholders in December 2021 and June 2022. The current Colorado DUR newsletter library is available online at https://hcpf.colorado.gov/drug-utilization-review-board. DUR Newsletter clinical topics during FFY 2022 included: Cardiovascular risks associated with ADHD drugs in adults; Colorado Medicaid hemophilia research module findings; Utilization management of physician administered drugs (PADs); New aspirin guidelines for primary prevention of cardiovascular disease; Cardiovascular risks associated with cannabis use; Involvement of gabapentin in fatal drug overdoses
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) 2022. 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 10,965 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 13% was achieved for the top 10 criteria reviewed and a response rate of 10% was achieved overall for all interventions performed during FFY 2022. Program Background Kepro currently provides RDUR services for the Connecticut fee-for-service Medicaid population as a subcontractor with Gainwell Technologies. In an effort to promote appropriate prescribing and utilization of medications, Kepro 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 Kepro evaluates Connecticut fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by Kepro and presented to the Connecticut 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 a Kepro 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.

State	RetroDUR Educational Outreach Summary
	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 2022. CRITERIA TYPE, CRITERIA DESCRIPTION, # OF CASES CREATED, # INTERVENTION LETTERS MAILED TO PRESCRIBERS, # PRESCRIBER RESPONSES LI, Connecticut lock-in (LI) criteria, 1274, 3593, 398 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. , 940, 1450, 215 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. , 1390, 1353, 296 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. , 682, 1334, 176 TA, Clinical trials have not shown Lyrica (pregabalin) to be superior to gabapentin for the treatment of neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia or partial-onset seizures in adults. If no contraindications are present consider prescribing the less expensive generic agent, gabapentin, as first-line therapy. , 666, 665, 76 TA, Females of reproductive potential should be informed to discontinue the use of Ozempic (semaglutide) at least 2 months before a planned pregnancy due to the long washout period for semaglutide. , 663, 663, 71 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. , 553, 553, 34 DD, The combination of first-generation antihistamines and CNS depressants should be done with caution due to potentiation of sedative action caused by CNS depressants. , 380, 475, 34

State	RetroDUR Educational Outreach Summary
	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)., 412, 450, 53 TA, Our records do not indicate an FDA-approved supporting diagnosis for the use of aripiprazole. Although evidence supports the use of antipsychotics in youth for certain narrowly defined conditions, the majority of children on antipsychotics do not have one of these conditions. The AHRQ CHIPRA Pediatric Quality Measures Program (PQMP) recommends psychosocial care as first-line treatment before utilizing antipsychotic medications in this population. Antipsychotics have serious, common adverse effects including weight gain, hyperprolactinemia, and metabolic disturbances. , 434, 429, 32 , Total Top 10, 7,394, 10,965, 1,385 , Total all letters for all criteria, 19,439, 24,423, 2,561 LI-Lock In, TA-Therapeutic Appropriateness, DD-Drug Drug Interaction 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 Kepro 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. Kepro tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 10,965 DUR educational intervention letters were mailed for the top 10 interventions to prescribers during FFY 2022, however, a total of 24,423 letters were mailed for all interventions performed during FFY 2022. 2,561 responses were received during FFY 2022 for a total response rate of 10%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response, Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS, 198 MD UNAWARE OF WHAT OTHER MD PRESCRIBING, 41 PT IS NO LONGER UNDER THIS MD's CARE, 139 MD SAYS PROB INSIGNIF NO CHG THX, 1,214 MD WILL REASSESS AND MODIFY DRUG THERAPY, 160 MD TRIED TO MODIFY THERAPY, PT NON-COOP, 70 PT UNDER MY CARE BUT NOT SEEN RECENTLY, 75 PATIENT DECEASED, 4 PATIENT WAS NEVER UNDER MD CARE, 20 HAS APPT TO DISCUSS THERAPY, 283

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	MD DID NOT RX DRUG ATTRIBUTED TO HIM, 125 TRIED TO MODIFY THERAPY,SYMPTOMS RECURRED, 73 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD, 158 BENEFIT OUTWEIGHS RISK,NO CHANGE RECOMMENDED, 1 Total responses for FFY 2022, 2,561 Response Rate, 10% Conclusion The top 10 interventions to prescribers were conducted for the Connecticut Medical Assistance Program population during FFY 2022 which resulted in 7,394 cases created, 10,965 prescriber letters mailed, and 1,385 responses received. The response rate for the top 10 interventions, was 13% during FFY 2022.
Delaware	Delaware continues to utilize Retro DUR tools to improve client health and fiscal responsibility through various targeted provider outreaches. Channels used include blast faxes to pharmacies, bulletins to providers, and notifications on our webpage. Specifically, in accordance with the DUR requirements of the SUPPORT Act, the State continues to closely monitor and prioritized outreach to assist in educating providers on safe opioid prescribing. Auto-generated letters are sent to alert providers of high dose warnings, prescribing over the threshold of 90 MME, and drug-drug interactions. Letters specifically targeting combinations of opioid-antipsychotic, opioid-muscle relaxant, opioid-benzodiazepine, as well as opioid-sedative combinations are designed to increase awareness of these interactions particularly when multiple prescribers are involved. A total of 263 letters were sent to providers to alert them of high doses, drug interactions or the need for dose optimization this year. Though increased provider awareness of these interactions and others, the State hopes to increase patient safety, increase coordination of care, and decrease adverse outcomes among the Medicaid population.
District of Columbia	Gabapentinoid Drug Use Evaluation Update to FY21 reporting DC is providing an update to the FY2021 Population based mailing intervention after the completion of the 6-month post intervention period. This evaluation was launched to determine opportunities for improving the safety and efficacy of drug therapy for patients prescribed gabapentinoids. Gabapentinoids (e.g., pregabalin and gabapentin) are widely used in neurology, psychiatry and primary healthcare but are increasingly being reported as possessing a potential for misuse. The U.S. Food and Drug Administration has found that the number of patients dispensed gabapentinoids concurrently with opioid analgesics has recently increased, with more than one half of patients concurrently dispensed both a gabapentinoids and an opioid analgesic. Gabapentinoids are CNS depressants and increase the risk for respiratory depression, coma, and death when combined with opioids. This population-based intervention was successful in helping providers identify patients with gabapentinoid drug-related issues and providing prescribers with educational tools to better communicate with their patients regarding appropriate treatment. This resulted in an economic impact on pharmacy program expenditures, with a six-month overall decrease in costs of $1,837.74

State	RetroDUR Educational Outreach Summary
	and a 29.5% decrease in clinical indicators e.g., unapproved indication, respiratory depression, concomitant use of other CNS depressants or concomitant use of opioids. FY2022 Educational Intervention: Anticonvulsant Drug Use Evaluation Purpose: To promote safe, cost-effective use of anticonvulsant medications Anticonvulsant medications are among the most prescribed classes of medications. Various anticonvulsants are associated with risks for drug-drug and drug-disease interactions as well as other potential toxicities. These variables have an impact on the cost/benefit ratio of the use of these medications. The following Clinical Indicators were used to identify potential risks: 1) Increased risk of adverse events with anticonvulsants and contraindications- 91 patients identified originally with 59 showing a 35.2% decrease in risk after the initial mailing intervention. 2) Anticonvulsant adherence: 362 patients were identified with 279 showing a post intervention increase in therapy adherence based on pharmacy claims for a 22.9% change. 3) Monitoring for potential anticonvulsant toxicities. Selected anticonvulsants are associated with box warnings relating to potential complications associated with their use. Official prescribing information for these agents suggests monitoring that should be employed to minimize the risk for complications. Hepatic monitoring for 191 identified patients increased with 147 beneficiaries having medical claims submitted for hepatic testing post intervention. This resulted in a 23.0% increase. Renal monitoring was completed for 20 of 29 identified patients resulting in a 31.0% increase. Platelet/Coagulation monitoring/CBC was completed for 24 of 31 patients identified for a 22.6% increase. Serum Bicarbonate monitoring was initiated for 50 of 69 identified patients. Ophthalmologic Exams were done for 61 or 83 identified patients as a result of the intervention.
Florida	1. Review utilization of antipsychotic medication in children. a. As required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, the DUR Board reviewed utilization of antipsychotic medication in children during the December 2021 DUR Board meeting. 2. Review trends in opiate recipients that received naloxone and had an emergency room visit for opiate overdose. a. During the December 2021 DUR Board meeting, the DUR Board reviewed safety outcomes for recipients that had an opiate overdose. 3. Review recipients receiving gabapentin without a supported indication for use in their health conditions.

State	RetroDUR Educational Outreach Summary
	a. During the December 2021 DUR Board meeting, the DUR Board reviewed recipients on gabapentin without a supported indication for use in their health conditions. 4. Review utilization trends for sickle cell therapy. a. During the December 2021 and March 2022 DUR Board meeting, the DUR Board discussed sickle cell therapy utilization related to hospital admissions and health outcomes. 5. Review the post-impact of the Lyrica automated prior authorization. a. During the December 2021 DUR Board meeting, the DUR Board reviewed the post impact of the Lyrica automated prior authorization (based on FDA approved indications). The edit deployed on 12/04/2020. 6. Review utilization of COVID-19 vaccines. a. During the December 2021 DUR Board meeting, the DUR Board reviewed utilization of COVID-19 vaccines. 7. Review Chantix utilization, claim denials, and retreatment. a. During the March 2022 DUR Board meeting, the DUR Board reviewed Chantix utilization over the last 5 years and agreed with the updated criteria. 8. Review opiates and antipsychotics overlap. a. During the March 2022 DUR Board meeting, the DUR Board reviewed recipients on opiates and antipsychotics concomitantly as required by the SUPPORT Act. There is currently a soft edit deployed to monitor/manage use of concomitant therapy. 9. Review long-acting opiates and benzodiazepine overlap. a. During the June 2022 DUR Board meeting, the DUR Board reviewed recipients on long-acting opiates and benzodiazepines concomitantly. There is currently an edit in place to monitor/manage use of concomitant therapy. 10. Review Hepatitis C treatment utilization over 7 years. a. During the September 2022 DUR Board meeting, the DUR Board reviewed Hepatitis C utilization over 7 years and reviewed retreatment trends.
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 updated guidelines for the use of opioids in chronic, non-cancer pain in 2022. 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) previously implemented a prior authorization program for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day in treatment-experienced patients. In 2021, the MME limit was reduced to 150 per day for treatment-experienced patients. In 2022, the MME limit was reduced to 120 per day for treatment-experienced patients. 372 total interventions. 2. Use of Naloxone in Patients with Increased Risk of Opioid-Related Harms -- In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published updated guidelines for the use of opioids in chronic, non-cancer pain in 2022. In the Guidelines for Prescribing Opioids for Chronic

State	RetroDUR Educational Outreach Summary
	Pain, the CDC recommends that clinicians should consider offering naloxone when prescribing opioids to patients at increased risk for overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients taking benzodiazepines with opioids, patients at risk for returning to a high dose to which they are no longer tolerant (e.g., patients recently released from prison), and patients taking higher dosages of opioids (greater than/equal to 50 MME/day). In an effort to reduce opioid-related harms, Georgia Fee-For-Service (FFS) identified patients at increased risk of opioid-related harm without a pharmacy claim for naloxone in the previous year and sent provider communication to the opioid prescribing physician to facilitate prescribing of naloxone. 411 total interventions. 4. Newsletter on Omicron Variant of SARS-CoV-2 5. Newsletter on Novel Nomenclature for Monoclonal Antibodies 6. Newsletter on New Vaccination Guidelines for the 2019 Novel Coronavirus (SARS-COV-2) 7. Newsletter on ICER Draft Report on Gene Therapy for Hemophilia A and B
Hawaii	Provider calls and educational interventions for claim denial of NDC not covered, prescriber not covered and no rebate per CMS are on-going. Most of these claims are incorrectly sent to the dental FFS for payment after denial by MCO for medical coverage.
Idaho	Quetiapine Use for Sleep in Pediatrics: Pediatric patients consistently (five fills during the six-month period) receiving less than 100 mg per day of quetiapine from 3/1/22 to 8/31/22 were identified. Thirty-four letters were mailed on 10/5/22. There were four responses (of these, three indicated they would encourage sleep hygiene). There was a limited response, it was resource intensive, and impacted few patients.
Illinois	Retrospective reviews and related educational efforts conducted in FFY22 are summarized below. One-on-one provider discussion and faxes continued as strategies to address appropriate medication use and adherence. First-line therapy in patients taking alprazolam. Use of first-line therapy (selective serotonin reuptake inhibitors [SSRI] or serotonin and norepinephrine reuptake inhibitors [SNRI]) in FFS and MCO patients filling alprazolam January to March 2021 was assessed. At least 25,364 participants filled an average of 2.2 alprazolam prescriptions each during the review period. Type of alprazolam (immediate-release vs extended-release (ER)), strengths, and quantity based on 14 days vs 15-31 days, and number of fills (duration of therapy) were reviewed. About 59% of participants filled alprazolam for 2-3 consecutive months. Up to 11% of these participants filled SSRI/SNRI therapy every month. No first-line therapy was filled during the review period in 66% of participants filling alprazolam for up to a 14 days supply, 64% of participants filling a 15-31 days supply, and 70% of participants filling more than a 32 days supply. In participants who filled both therapies monthly, dose titration (up and down) of the first line therapy, stable dosing, as well as changes to a different first line therapy within the 3-month review period were evident. To discourage long-term alprazolam monotherapy, use of alprazolam ER if ongoing alprazolam therapy is at a stable dose, prior authorization after 14-30 days of alprazolam, start of first line therapy by the second month of alprazolam monotherapy,

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	taper plans, an initial days supply hard edit for benzodiazepine-naive participants, prescriber outreach, and education were recommended. Dental patients filling multiple short days supply opioid prescriptions. Calendar year 2020 opioid fills from dental prescribers in FFS and MCO were reviewed for multiple up to 7 days supply fills. Number of prescribers and pharmacies for these fills were also assessed. At least 95% of prescriptions were for up to a 5 days supply; 84% were for up to a 3 days supply. Profiles of participants filling more than 15 prescriptions were reviewed with the DUR Board. Utilization review supported previous recommendations to decrease the opioid initial days supply edit to a max of 5 days for acute pain. Pharmacy review recommended when multiple short days supply prescriptions filled for the same participant. Internal pharmacy alerts for multiple opioid fills were recommended. Naloxone prescriber outreach for patients receiving high opioid MME prescriptions. Pharmacy claims for participants filling opioids 50 MME and greater from November 2020-November 2021 who had FFS coverage for at least part of that time were reviewed to determine presence of a naloxone fill and characterize opioid use. Only 26% of participants receiving a high MME opioid had ever filled naloxone. Range of naloxone fills was 1-3. The average daily MME was 117 (range 15-675) for chronic opioid users who had never filled naloxone. Not all prescribers with multiple participants provided naloxone for each high MME participant. Initial fax outreach was conducted with prescribers of 122 participants who had never filled naloxone. During Phase 1 (January-February 2022) three naloxone fills occurred. The DUR Board recommended continued outreach and use of the standing order by pharmacists. Naloxone fills were reviewed to determine use of the standing order. Pharmacy logistics impact use of the standing order (checking the MME, running a naloxone prescription, and 30-minute commitment to complete the required naloxone checklist and educate educate/counsel the patient regarding naloxone use per the standing order requirements). Although copay for naloxone is not required by Medicaid, other insurers' copay is a disincentive. Internal pharmacy system hard edit for high MME to remind to fill naloxone was suggested. Patient education should be done and naloxone offered, even if patient refuses to take the naloxone. During Phase 2 (March-May 2022), prescriber outreach increased to 2 more attempts and then the pharmacy was asked to implement the standing order. Overall, 33% of the prescribers returned faxes. For 20% of the participants, naloxone was not deemed applicable for patient, medication, prescriber, or pharmacy reasons. For example, tapered off opioids or naloxone refusal during prescriber discussions or at time of prescription pick-up. The intervention resulted in a 15% increase of naloxone receipt in high-risk participants for whom naloxone was deemed applicable. Time-intensive nature of the intervention yielded lower than anticipated results. Use of a hard edit and increased education and training of pharmacists were considered to increase naloxone co-prescribing. The intervention was repeated in FFY Q4 for a new group of naloxone naive participants. A continuing education presentation at the Illinois Pharmacists Association Annual Meeting was conducted to encourage use of the naloxone standing order.

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	Historic naloxone fills. Prescribers asked when it is appropriate to refill naloxone if not utilized. Other State requirements and FDA recommendations, which increased the expiration for naloxone from 2 to 3 years were reviewed. Annual review of naloxone fill in patients at high-risk for opioid overdose will be done. Outreach will focus on determining if opioid harm reduction discussions and naloxone co-prescribing occurred. Tramadol and codeine utilization. Tramadol and codeine utilization in FFS and MCO participants for calendar year 2021 were reviewed. The DUR Board was considering a prior authorization requirement due to metabolic-pharmacokinetic issues that can result in higher or lower concentrations, leading to adverse effects or lack of therapeutic effect. Preferred Drug List status and edits in 8 top Medicaid enrollment States were reviewed. Prescriber education as prior authorization requests are received and Academic Detailing regarding opioid use were recommended until reassessment after the 2022 CDC chronic pain guidelines are published. Antidiabetic medications and Type 2 diabetes mellitus (T2DM) comorbidities. Percent of Illinois Medicaid participants with T2DM and comorbid conditions such as atherosclerotic cardiovascular disease, chronic kidney disease, or heart failure parallel trends seen nationally. Usage of glucagon-like peptide-1 receptor agonists (GLP1-RA) and sodium-glucose co-transporter 2 inhibitors (SGLT2i) was reviewed in FFS and MCO participants for the July to December 2021 time frame. The GLP1-RA are being filled by 4% to 6% of participants with T2DM and a comorbid condition, while SGLT2is are filled by 6% to 7% of patients. Overall, up to 13% of participants are receiving guideline recommended therapies. Identification of patients with T2DM and the three comorbities who have not received recommended therapies and prescriber as well as patient outreach proposed. RetroDUR 300. The Change Healthcare RetroDUR 300 automated algorithm identifies participants for pharmacists to review to determine whether prescriber outreach or education is warranted. After pharmacist review, prescriber outreach recommended for 48 issues. Main problems were subtherapeutic doses and duplicate therapy. Duplicate therapy with incretin mimetics was identified outside of the algorithm-identified issues in several patients. Concomitant incretin mimetic therapy. Usage of GLP1-RA and DPP4-i alone and in combination was reviewed. About 7% of patients received both medications during the 6-month review period. Patients filling both drug classes for 3 or more months or those alternating medication fills every month were recommended for prescriber outreach. Benzodiazepines. Provider outreach continued to prescribers of chronic benzodiazepine therapy for the management of anxiety in the absence of first-line therapies. During FFY22, at least 482 benzodiazepine determination letters for 310 participants were sent to 320 prescribers from the HFS prior authorization system. Prescribers were asked to provide an anxiety

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	management plan and benzodiazepine taper plan. Additional benzodiazepine faxes citing evidence-based literature are sent if further prescriber education is needed. During FFY22, at least 11 additional benzodiazepine faxes were sent. Opioid pain management. During FFY22, at least 1,906 determination letters for 1,163 participants were sent to 1,084 prescribers for opioid medications requiring prior approval for days supply, exceeding the MME, dose, concomitant benzodiazepine use, duplicate therapy, quantity, or use of long-acting opioid dosage form. During FFY22, as part of the Chronic Pain Management Program, a total of 161 additional individualized letters were faxed to prescribers of opioids with recommendations for improving pain management using appropriate medications for specific pain conditions. The COVID pandemic-related temporary lift of the Four Prescription Policy edit that identified participants for benzodiazepine and chronic pain management program outreach impacted the number of interventions. Proactive medication adherence monitoring. The prior authorization staff continues to strictly monitor adherence for medications to treat cystic fibrosis and hepatitis C infection. Prescribers are contacted by fax or phone to discuss adherence issues. Website information. Educational information regarding new initiatives is placed on the DUR Website. HFS redesigned the website in the 4th quarter of FFY22. The DUR Board Web page informs about meetings. The DUR Web page provides educational materials or links for prescribers to help manage medication-related issues identified by the DUR Board in the HFS population. The Pharmacy Services Web page provides forms and criteria and the Preferred Drug List search engine facilitates appropriate therapy choices.
Indiana	The following information is an annualized analysis of retroDUR activities and outcomes that were approved by the DUR Board and performed by Optum Rx pharmacists through facsimile of retroDUR education materials. A savings summary and detailed outcomes report for each retroDUR program type is provided below. The detailed outcomes report for each retroDUR 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. November 2020 Caring for Your Patients with Hepatitis C Optum Rx proposed a follow-up retroDUR phase to track SVR in patients completing therapy after the removal of the prior authorization criteria from initial utilizers. The retroDUR was approved at the DUR Board meeting in October 2020 and the Newsletter was reviewed and approved November 2020. As part of this retro-DUR initiative, letters were sent to prescribers requesting SVRs 12 weeks after completion of hepatitis C DAA therapy. At the completion of this tracking period, 3,640 members were determined to be eligible for the achievement of SVR monitoring based on fill history that would constitute complete duration of hepatitis C treatment; a letter requesting

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	SVR follow-up was sent to the corresponding providers. Optum Rx received provider responses for 936 members (25.7%). Of those responses, 502 members (53.6%) were confirmed to have achieved SVR, 10 members (1.1%) were confirmed to have not achieved SVR, and 169 members (18.1%) had responses with indeterminable SVR achievement. Forty-four members (4.7%) did not finish therapy per provider response (due to therapy abandonment, discontinuation, loss of insurance coverage, etc.) and 36 members (3.8%) had future labs scheduled to determine SVR at the time of response. The remaining 175 members (18.7%) were lost to follow-up. April 2021 Caring for Your Patients with Diabetes Members utilizing insulin therapy that did not appear to be receiving claims for blood glucose testing supplies per claims history had a near real-time letter faxed to the prescriber. The goal of this program was to increase the utilization of blood glucose testing supplies, in alignment with guideline recommendations. Per the American Diabetes Association, glucose monitoring is the key to achieving glycemic targets, especially in patients utilizing insulin and prone to hypoglycemia. Monitoring blood glucose levels can help to guide medical management through diet, exercise, and medication therapy, and help to prevent hypoglycemic events. Patient-specific needs should be reviewed to determine the appropriate amount of testing. Better glycemic control leads to better overall patient outcomes and less patient mortality. Evaluation will be made to determine if members have blood glucose testing supplies added. Claims data for members with a claim for insulin therapy were reviewed from January 1, 2020, through December 31, 2020. During this period, 4,090 unique members were identified as utilizing insulin therapy. Of these members, 2,799 were not utilizing blood glucose testing supplies (only 32% of patients were utilizing testing supplies). During this time period, 3,464 claims for blood glucose testing supplies were processed, totaling $129,859.53. Optum Rx proposed this intervention at the March 2021 DUR Board meeting and obtained approval of this topic. The retro-DUR intervention began processing letters on July 1, 2021. At the one-year completion of this retro-DUR, 4,597 letters were faxed to prescribers. Of these letters, 3,236 were identified as eligible for outcomes. Of these patients, 1,879 had a positive outcome (58.07%) by obtaining diabetic testing supplies which resulted in an increased plan spend of $5,532,039.34 (plan spend does not take into account savings from medical due to better diabetic control or rebate contracts). Naloxone Utilization in Members Utilizing Opioid Therapy at 90MME or Greater Members utilizing an opioid at 90MME or higher that do not appear to have received a claim for rescue naloxone per claims history in the past year have a letter mailed to the prescriber. The goal of this program is to increase the utilization of rescue naloxone in patients that are at higher risk of opioid overdose. The SUPPORT Act requires tracking and monitoring of naloxone use in patients receiving opioid therapy. An analysis performed by the US Department of Health and Human Services Center for Disease Control and Prevention (CDC) determined the risk of harm to individuals increases as their opioid dose and therapy duration increases. Evaluation will be made to determine if the percentage of naloxone use in opioid utilizers with 90MME or greater increases.

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	National claims data demonstrates that less than 1% of patients at high risk receive a naloxone prescription. Naloxone does not lead to more or riskier drug use or prevent substance users from seeking treatment (ISDH Naloxone Myths Debunked). For all members in the Indiana Medicaid Program, naloxone claims totaled 13,359 while opioid claims totaled 934,310. Optum Rx proposed this intervention at the May 2021 DUR Board meeting and obtained approval of this topic. The retroDUR intervention began processing letters on July 1, 2021. At the one-year completion point, 659 members were identified for faxed intervention. Of those eligible, 73 (11.1%) had a claim for naloxone submitted for processing, leading to an increase in pharmacy benefit expenditure of $6,685.94. Medical benefit savings were not able to be calculated with this analysis. COVID-19 Vaccine 2nd Dose Members that received a single dose of the COVID-19 vaccine and had not received any subsequent doses (per CHIRP and claims history) had a letter faxed to their primary prescriber. The goal of this program was to increase the receipt of appropriate COVID-19 vaccine doses, as studies have shown the receipt of one dose of the mRNA vaccine will increase protection from COVID-19 infection related illnesses by 33% as compared to unvaccinated individuals; two doses of the mRNA vaccine increased protection by up to 90% when compared to unvaccinated individuals (Petri, W. How effective is the first shot of the Pfizer or Moderna vaccine?.ASBMBTODAY (April 2021). Retrieved March 2022 from https://www.asbmb.org/asbmb-today/science/040421/how-effective-is-the-first-shot-of-the-pfizer-or-m). COVID-19 vaccines were initially approved through an emergency use authorization (EUA) as a two-dose series (additional doses and boosters may apply, Janssen COVID-19 vaccine is recommended as a single dose followed by a single booster and was not included in this analysis). Evaluation will be made to determine if members receive a subsequent dose of the COVID-19 vaccine following provider outreach. Claims data for members with a claim for a COVID-19 vaccine were reviewed from December 15, 2020, through January 31, 2022. During this period, 48,794 unique members were identified as receiving a single COVID-19 vaccine dose without receiving additional doses (entire population). Of these members, 4,608 were identified in the FFS Medicaid population. During this time, 6,320 claims for first dose COVID-19 vaccine were processed, totaling $227,695.79 (up to $37.21 for administration fee). Optum Rx proposed this intervention at the March 2022 DUR Board meeting and obtained approval of this topic. The retro-DUR intervention began sending letters after approval of the DUR Board Newsletter at their May 2022 meeting. Further information will be provided at the one-year follow-up in the FFY2023 report. Dipeptidyl Peptidase-4 (DPP-4) Inhibitors and Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RA) Concurrent Therapy Members utilizing at least 35 days of concurrent DPP-4 Inhibitor therapy with GLP-1 RA therapy in the past 120 days will have a near real-time letter faxed to the prescriber. The goal of this program is to ensure members are receiving appropriate DDP-4 Inhibitor and GLP-1 RA therapy, as evidence suggests that no

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	additional benefit is gained with concurrent use. Evaluation will be made to determine if members have discontinued concurrent therapy. Claims data for members utilizing DPP-4 inhibitor therapy in combination with a GLP-1 RA were reviewed from January 1, 2021, to December 31, 2021. During this period, 65 unique utilizers of both agents were identified. A total of 925 claims were processed during the reporting period, totaling $646,272.73. Optum Rx proposed this intervention at the September 2022 DUR Board meeting and obtained approval of this topic. The retro-DUR intervention will begin processing letters on February 1, 2023. Further information will be provided at the one-year follow-up in the FFY2023 report.
Iowa	Type of Problem, Drug Class, Number of Exceptions, and % of Problem Type (all presented in this order separated by commas) Therapeutic Duplication, Dibenzapines, 14, 0.8% Therapeutic Duplication, Quinolinone Derivatives, 9, 0.68% Therapeutic Duplication, Benzisoxazoles, 7, 0.64% Therapeutic Duplication, Antiadrenergic Antihypertensives, 6, 0.19% Therapeutic Duplication, Antipsychotics Misc., 6, 1.54% Therapeutic Duplication, ADHD Agents, 3, 0.35% Therapeutic Duplication, Opioid Agonists, 2, 0.18% Therapeutic Duplication, Opioid Combinations, 2, 1.98% Therapeutic Duplication, Phenothiazines, 2, 1.98% Therapeutic Duplication, PPIs, 2, 0.07%
Kansas	We are still in discussion on a more effective approach for RDUR educational outreach. Our FFS population is very small and specific. For example, beneficiaries in LTC facilities. We have implemented the SUPPORT Act requirements and other RDUR requirements that require patient and provider education. We do not believe that lettering is an effective means for provider change and the current process to arrive at lettering is being reviewed. We are considering having webinars as a new method for provider education and provider interaction. We will continue to work towards this goal and report an update as able. Most of the State's Medicaid population are covered by our MCOs and the MCOs are required to implement all CMS and SUPPORT Act RDUR requirements as well as any additional RDUR requirements listed in State policy. Criteria Type Criteria Description Number of TCEs Reviewed Number of Cases Number of Letters Generated Number of Letters Sent Prescriber Responses Response Rate Therapeutic Appropriateness Beneficiaries with Chronic Opioid Use and No Naloxone 6 6 6 6 0 0% Therapeutic Appropriateness Diabetes and Reduction of Cardiovascular Risk 11 11 12 12 0 0% Summary 1 - Retrospective DUR Educational Outreach for FFY 2022 Criteria Type Criteria Description Number of TCEs Reviewed Number of Cases Number of Letters Generated Number of Letters Sent Prescriber Responses Response Rate Therapeutic Appropriateness Beneficiaries with Chronic Opioid Use and No Naloxone 6 6 6 6 0 0%

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	Therapeutic Appropriateness Diabetes and Reduction of Cardiovascular Risk 11 11 12 12 0 0% 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 2022, Kentucky performed the following RetroDUR activities: In FFY 4Q2021, Kentucky identified members who had received a second-generation antipsychotic (SGA) medication in the last 3 months and had no claims for a hemoglobin A1c or fasting glucose level in the last 6 months. Prescribers were sent letters identifying all patients who met this criteria asking them to assess whether monitoring was appropriate and should be added to the patient's drug regimen. In FFY 1Q2022, Kentucky identified members utilizing insulin who did not have any claims for blood glucose monitoring products. Prescribers were sent letters, asking the prescriber to discuss with the patient the ways their medications are being taken, the effectiveness of the current regimen, any adverse effects the patient may be experiencing, the importance of adherence, and the importance of blood glucose monitoring. In FFY 2Q2022, Kentucky identified members with evidence of non-adherence, defined as at least a 10 day gap in drug supply, with one or more oral medications prescribed for the treatment of cancer. Prescribers were sent letters with each patient's medical history to encourage discussing the importance of taking medications as prescribed to reduce progression of disease. In FFY 3Q2022, Kentucky identified members with a large number of medications from multiple prescribers and multiple pharmacies (polypharmacy). Prescribers were sent letters identifying all Kentucky FFS Medicaid members who fit that criteria asking them to review the medication history for any changes that may be appropriate.
Louisiana	1. Statin agent: Underutilization Recipient Profiles Screened: 265 Interventions: 139 2. Opioids & gabapentinoids: Concurrent use Recipient Profiles Screened: 236 Interventions: 200 3. A1C testing: Underutilization Recipient Profiles Screened: 130 Interventions: 57 4. Short acting opioid: Exceeds 15-day supply Recipient Profiles Screened: 107 Interventions: 10 5. Short acting opioid: Exceeds quantity limit Recipient Profiles Screened: 102 Interventions: 94 6. Hypertension agent: Underutilization

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	Recipient Profiles Screened: 85 Interventions: 38 7. Sleep agents: Duration Recipient Profiles Screened: 81 Interventions: 79 8. Albuterol inhaler: Overutilization Recipient Profiles Screened: 77 Interventions: 62 9. Opioids & benzodiazepines/sleep agents: Concurrent use Recipient Profiles Screened: 66 Interventions: 64 10. Opioids & antipsychotic agents: Concurrent use Recipient Profiles Screened: 62 Interventions: 60
Maine	Retrospective Drug Utilization Review (RetroDUR) and Educational Outreach Program FFY 2022 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 and Educational Outreach Summary (FFY 2022) Description RetroDUR Analyses : RetroDUR Zoster Vaccination rates Dec 2021 RetroDUR HPV vaccination rates Dec 2021 RetroDUR Codeine use in Pediatric Population Mar 2022 RetroDUR Concurrent use of glp-1 receptor agonists, dpp-4 inhibitors Jun 2022 RetroDUR Opioid Use from Multiple Providers Sep 2022 Provider Newsletter November 2021 PDL Update Pharmacy Benefit Update Winter 2021 Buprenorphine Pregnancy Memo Provider Newsletter January 14 2022 PDL Update Pharmacy Updates: Varenicline and NPH Newsletter

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	End of Atypical Inter-Season palivizumab coverage Provider Newsletter April 8 2022 PDL Update Provider Newsletter August 2 2022 PDL Update
Maryland	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) 2022. 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 2022: potentially inappropriate use of opioids (Corrective Managed Care Program), therapeutic duplication of sedative/hypnotic agents, concurrent use of an opioid and medium-high dose gabapentin, concurrent use of gabapentin and pregabalin, concurrent use of an opioid, benzodiazepine and carisoprodol-containing product, concurrent use of an opioid and benzodiazepine, concurrent use of an opioid and antipsychotic, CGRP medication overutilization, and use of opioid with a history of opioid misuse or overdose and no naloxone prescription. A total of 2,908 unique participants were selected for intervention, and 4,903 prescriber letters were mailed. Each letter included a response form soliciting feedback from the prescriber. Responses are voluntary, and a response rate of 11% was achieved. Prescribers were also asked to evaluate the usefulness of the intervention letters. Of those who responded 72% 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 3,701 pharmacy letters were mailed, and a response rate of 25% was achieved. Of those who responded, 76% of pharmacy providers found the letters to be useful. Program Background Kepro, currently provides RDUR services for the Maryland Medicaid fee-for-service population. In an effort to promote appropriate prescribing and utilization of medications, Kepro 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, Kepro evaluates Maryland Medicaid pharmacy claims data against criteria for potential overutilization and inappropriate use of opioids. Other criteria, developed in conjunction with Kepro, OPS, and the Maryland Drug Utilization Review Board are selected for DUR evaluation on a quarterly basis.

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	For FFY 2022, 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 3. Concurrent use of an opioid, benzodiazepine and carisoprodol-containing product 4. Concurrent use of gabapentin and pregabalin 5. Concurrent use of an opioid and medium-high dose gabapentin 6. Concurrent use of an opioid and benzodiazepine 7. Concurrent use of an opioid and antipsychotic 8. CGRP medication overutilization 9. Use of opioid with a history of opioid misuse or overdose and no naloxone prescription 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 Kepro 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

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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 2021. 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.

MARYLAND MEDICAID PHARMACY PROGRAM RETROSPECTIVE EDUCATIONAL OUTREACH SUMMARY REPORT FOR FFY 2022

Criteria	Participants who met criteria	Participants selected for intervention	Intervention letters prescribers	Intervention letters pharmacies
THERAPEUTIC DUPLICATION OF SEDATIVE HYNOTICS	562	158	225	187
APPROPRIATE USE OF METHADONE	15	11	11	11
OVERUTILIZATION OF NARCOTIC AGENTS (OPIOIDS) BASED ON DAYS SUPPLY	963	98	192	161
OVERUTILIZATION OF NARCOTIC AGENTS (OPIOIDS) BASED ON DOSE PER DAY	6	4	4	4
CONCURRENT USE OF AN OPIOID AND BENZODIAZEPINE	550	488	965	676
LONG-TERM THERAPY WITH SHORT-ACTING OPIOIDS IN ABSENCE OF LONG-ACTING AGENT	112	78	81	79
BUPRENORPHINE/NALOXONE CONTAINING PRODUCTS FOR OPIOID ABUSE/DEPENDENCE AND ANOTHER OPIOID	2,327	298	309	306
LACK OF CURRENT NALOXONE PRESCRIPTION IN A PATIENT WITH OPIOIDS AND A DIAGNOSIS OF SUBSTANCE ABUSE OR DEPENDANCE	116	93	99	93
LACK OF CURRENT NALOXONE PRESCRIPTION IN A PATIENT WITH OPIOIDS AND A DIAGNOSIS OF MEDICATION-RELATED POISONING	3	1	1	1
OPIOID AND A HISTORY OF SUBSTANCE USE DISORDER	268	180	191	183
CONCURRENT USE OF AN OPIOID AND MEDIUM-HIGH DOSE GABAPENTIN	1,014	590	1131	775
CONCURRENT USE OF GABAPENTIN AND PREGABALIN	732	415	713	515
CONCURRENT USE OF AN OPIOID AND ANTIPSYCHOTIC	550	494	982	710
OVERUTILIZATION OF TUSSIONEX	0	0	0	0
CONCURRENT USE OF OPIOID, CARISPRODOL, AND BENZODIAZEPINE	1	0	0	0

1. Not all participants are selected for intervention. Selection is based on review by a Clinical Pharmacist.

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	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 Kepro 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. 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 via fax. Kepro tracks all returned response forms. Information presented to the Maryland Drug Utilization Board is reported anonymously. Results Provider Responses to Intervention Letters A total of 4,903 DUR educational intervention letters were mailed to prescribers, and 547 responses were received for a response rate of 11%. A summary of all coded responses from prescribers is listed in the table below: Prescriber Response Number of Responses BENEFITS OF THE DRUG OUTWEIGH THE RISKS 97 MD UNAWARE OF WHAT OTHER MD PRESCRIBING 4 PATIENT HAS DIAGNOSIS THAT SUPPORTS TX 5 PT IS NO LONGER UNDER THIS MD's CARE 58 MD SAYS PROB INSIGNIF NO CHG THX 3 MD WILL REASSESS AND MODIFY DRUG THERAPY 40 PT HAS OR WILL DISCONTINUE DRUG 1 MD TRIED TO MODIFY THERAPY, PT NON-COOP 10 PT UNDER MY CARE BUT NOT SEEN RECENTLY 15 PATIENT DECEASED 4 PATIENT WAS NEVER UNDER MD CARE 5 HAS APPT TO DISCUSS THERAPY 74 MD DID NOT RX DRUG ATTRIBUTED TO HIM. 129 TRIED TO MODIFY THERAPY,SX RECURRED 19 MD DISCONTINUED MEDS 81 PHARMACY CAN'T PROVIDE MD INFORMATION 1 PT NO LONGER USES PHARM / OR SEES MD 1 TOTAL 547
Massachusetts	Retrospective Educational Outreach Summary Top 10 Problems By Number of Exceptions, With Number of Interventions NCPDP Reject Code 75, Prior Authorization Required

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	Date Range: 10/1/21 - 9/30/22 Problem Number of Exceptions Letters Sent Calls To Prescriber Drug requires prior authorization 514,002 66,185 3,673 Pediatric behavioral health initiative 78,179 7,983 1,158 Prior authorization required for quantity over limit 34,595 4,840 219 Age restriction 31,998 6,964 125 Polypharmacy/duplicate therapy 24,526 2,854 337 Polypharmacy restriction for drug that requires prior authorization 6,110 205 12 Brand name requires prior authorization 5,644 1,491 25 High dose 3,963 1,552 295 Quantity limit exceeded for drug that requires prior authorization 3,003 604 35 Inappropriate dose 2,066 120 4
Michigan	RetroDUR letters and prescriber consultations were performed on two algorithms involving 2,777 distinct prescribers and 9,065 distinct members. Below is a summary of each: 1. Behavioral Health (BH) Polypharmacy- 6 or More Medications - 1,098 prescribers; 1,365 members - Observed a 14% reduction in utilization of target BH medications, from 6.5 to 5.5 distinct claims (PEMPM) - At six months post initial identification of members, observed a 12% reduction in utilization of benzodiazepines and a 14% reduction in utilization of stimulants - 11% decrease in PEMPM pharmacy spend for target BH medications from $808.93 to $720.71 - At six months post intervention, 59% of the gaps in care were closed (807 members) 2. Low dose Seroquel - 2,548 prescribers; 7,577 members - 17% increase in average daily Seroquel dose per member, from 59mg to 69mg - Observed a 18% reduction in utilization of Seroquel (distinct claim count decreased from 38,882 to 31,825) - 1,233 members discontinued Seroquel, as defined as 0 claims in the post period - 14% decrease in the PEMPM pharmacy spend for target medication from $9.50 to $8.15

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	- At six months post intervention, 52% of the gaps in care were closed (3967 members)
Minnesota	CMS FFY 2022: Summary 1. RetroDUR Educational Outreach The top ten is based on the greatest number of exceptions. The order below is the intervention group, problem type, criteria description, total #exceptions, #cases reviewed, special mailing status Y/N, #prescriber letters, #pre recipients, #adjusted post recipients, #exceptions post period, % outcome improved. 1. Psychotropic drugs in Adults,TD,Polypsychopharmacy 3 or more psychotropic drugs,4417,500,N,738,437,395,331,16% 2. Psychotropic drugs in Adults,TA,SGA Monitoring of blood glucose levels,3245,0,Y,1306,3245,2669,1735,35% 3. Psychotropic drugs in Youth,TD,Polypsychopharmacy 3 or more psychotropic drugs,2367,619,N,362,226,217,141,35% 4. Diabetes Management,DB/MC,Drug-Disease interactions,2026,176,N,119,119,95,24,75% 5. Psychotropic drugs in Adults,TA,SGA Monitoring of lipid levels,1604,0,Y,946,1604,1174,544,54% 6. Psychotropic drugs in Youth,TA,SGA Monitoring of blood glucose levels,1602,0,Y,450,1602,1502,849,43% 7. Montelukast Black Box Warnings,MC,Montelukast BBWs,1516,0,Y,1028,1516,1297,727,44% 8. Psychotropic drugs in Adults,TD,Polypsychopharmacy 2 or more SGA drugs ,1119,450,N,29,27,25,18,28% 9. Psychotropic drugs in Youth,TA,SGA Monitoring of lipid levels,981,0,Y,366,981,918,430,53% 10. Diabetes Management,TA,Underutilization,Hyperlipidemia Guideline/Treatment,831,118,N,87,87,69,1,99%
Mississippi	RetroDUR Educational Outreach Summary for FFY 2022 During FFY2022, our retrospective DUR (retroDUR) program educational and intervention activities were targeted at improving adherence to safety recommendations, early notification of providers about policy changes in order to avoid disruptions in treatment, and improvement on national quality measures. The retroDUR vendor continued educational outreach efforts where most of our 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 months 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:

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	1. Opioid Provider Shopping 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 306,462 prescription claims were analyzed during FFY 2022. In FFY 2022, 79 mailings were sent to providers and pharmacies addressing 79 beneficiaries. 2. Concomitant Use of Opioids and Antipsychotics Objective: To identify beneficiaries that were prescribed antipsychotics and opioid therapy concurrently for > 14 days and to ensure the coordination of care for both pain management and mental health conditions is occurring and both conditions are being appropriately treated. Results: This ongoing monthly mailing to providers began in May 2021 and continues. A total of 359,337 prescription claims were analyzed during FFY 2022. In FFY 2022, 544 mailings were sent to providers addressing 656 beneficiaries. 3. Updated Asthma Guidelines: Best Practice Prescribing Objective: To educate providers on the updated recommendations by the Global Initiative for Asthma (GINA) and the National Asthma Education and Prevention Program (NAEPP) supporting symptom-driven or regular use of a single combination agent with low-dose ICS and the long-acting beta agonist formoterol for people with moderate to severe asthma. The mailing targeted prescribers who had treated Medicaid patients with persistent asthma that did not receive appropriate controller medications and experienced an asthma-related hospitalization or emergency department visit. The mailing also contained a flyer that could be displayed in office settings to guide conversations with patients. The mailing occurred in June 2022 and was sent to 284 providers addressing 181 beneficiaries.
Missouri	Concurrent Opioids and Benzodiazepines Intervention Overall, there was a 35.4% reduction in the clinical indicator for the Concurrent Opioids and Benzodiazepines intervention (e.g., increased risk of adverse event) over the six-month period. Additionally, there was a decrease in targeted drug costs of $79,560.00 for the six-month period. The total annualized decrease in costs would be expected to be $159,120.00. Improving Short-acting Beta Agonist Utilization Safety Intervention Overall, there was a 37.2% reduction in the clinical indicator for the Improving Short-acting Beta Agonist Utilization Safety intervention (e.g., overutilization) over the six-month intervention period. Additionally, there was a decrease in targeted drug costs of $937,280.28 for the six-month period. The total annualized decrease in costs would be expected to be $1,874,560.56. This RetroDUR intervention occurred simultaneously with a ProDUR change. The

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	synergy of the two interventions being implemented together resulted in more significant change than would otherwise have been expected. Hepatitis C Intervention Overall, there was an 11.1% reduction in the clinical indicator for the Hepatitis C intervention (e.g., underutilization) over the six-month period. There were 612 participants treated with a direct acting antiretroviral. The financial outcomes for this intervention were not calculated. Concurrent Opioids and CNS Stimulants Intervention Overall, there was a 30.9% reduction in the clinical indicator for the Concurrent Opioids and CNS Stimulants intervention (e.g., increased risk of adverse event) over the six-month period. Additionally, there was a decrease in targeted drug costs of $14,622.96 for the six-month period. The total annualized decrease in costs would be expected to be $29,245.92.
Montana	The following Retrospective DUR (RDUR) and Academic Detailing (AD) categories are used to identify member profiles with potential medication related issues. The initial report is run on all members with Medicaid and then risk stratification is used to target members at highest risk. If a potential issue is identified, the CM team provides prescriber education and makes a clinical recommendation for management of the drug issue identified. Some of these are further defined below. Atypical Antipsychotic Metabolic Monitoring: Provider alerted if member, regardless of age, has a diagnosis history which indicates potential or suspected adverse effect of prescribed antipsychotic Gabapentin/Lyrica: Provider alerted if member receives gabapentin or pregabalin and has presence of risk factor that could lead to respiratory depression. Naloxone: Provider alerted member is candidate for naloxone prescription and overdose education due to presence of one or more overdose risk factors outlined per CDC guidelines. Poisoning/Naloxone: Provider alerted if member receiving opioid has diagnosis of medication-related poisoning. Naloxone is recommended. Therapeutic Appropriateness: Provider alerted if disease State does not appear to be treated per current guidelines or if member is receiving medication that does not have a clear clinical indication RDUR reviews were performed (1st number below), and interventions/recommendations (2nd number) made for the following categories. Atypical Metabolic Monitoring: 2 / 1 Drug-Disease Contraindication: 26 / 4 Drug-Drug Interaction: 46 / 14 Duplicate Therapy: 6 / 3 Gabapentin/Lyrica: 11 / 1 Naloxone: 103 / 46 Overutilization: 16 / 6

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	Poisoning/Naloxone: 13 / 5 SUPPORT Act AP<18: 137 / 57 SUPPORT Act AP/Opioids: 85 / 12 SUPPORT Act Opioids/Bzd: 67 / 23 Therapeutic Appropriateness: 42 / 12 Tramadol/Codeine/Hydrocodone <18: 14 / 6 Underutilization: 10 / 6 149 letters sent for AD 47 letters sent for RDUR 196 Total Clinical Interventions/Recommendations to Providers: -Current Pending Cases: 22 -Member Gained Medicare D Eligibility: 2 -Member Lost Eligibility: 1 Complete Interventions: 171 --Positive Response Rate / Changes Implemented After Case Management (CM)Clinical Intervention or Recommendation: 69% (118/171) --No Response from Provider / No Changes Made After CM Clinical Intervention or Recommendation: 31% (53/171) In addition to the standard RDUR and AD activities listed above, CM performed additional RDUR and AD projects. Optimizing COPD Treatment-The project's goal was to ensure members with COPD exacerbations are on optimized medication therapies as directed by current COPD best practice treatment guidelines. Members with a diagnosis code for one or more COPD exacerbations who were also receiving one or more courses of prednisone within the previous six months were targeted for a CM pharmacist review. A white paper was developed to send to providers to educate them on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) report, which was updated in November of 2021. Interventions or recommendations included adding a Long-Acting Muscarinic Antagonist (LAMA), adding a Long-Acting Beta Agonist (LABA), adding an inhaled corticosteroid (ICS), increasing the dose of a LABA or LABA/ICS inhaler, recommending and educating providers to limit the use of generic DuoNeb to 15 days or less, decreasing utilization of albuterol, decreasing prednisone use, decreasing ER/hospital utilization, nicotine cessation counseling, medication adherence counseling, and recommending addition of Daliresp or daily azithromycin if clinically appropriate. Of the interventions/recommendations, 36% resulted in a change in therapy or the recommendation was accepted. Furthermore, the review discovered that sometimes LAMAs were denied due to a concurrent SAMA prescription. As this was not the intention of the therapeutic duplication edit, the issue was brought to the Board and resulted in discontinuation of the LAMA/SAMA TD edit. Gabapentin and Pregabalin Dose Limit Restriction -CM contacted providers about the plan to implement dose limits on gabapentin and pregabalin. Provider attestations were sent prior to implementation to allow providers to continue their members at their current dose, if clinically appropriate, but no escalation would be approved. A white paper was faxed explaining the decision to limit these medications as well as additional information on the risks involved with

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	high doses. Verbal feedback from providers and pharmacists throughout the program was very positive, and maximum dose limits were implemented. Of the members originally identified as being over the new limits, the majority (57%) had doses decreased to or below the limit of 3600mg of gabapentin or 600mg of pregabalin, while 43% continued at their prior dose above the FDA recommendation with written acknowledgement by their provider. Other CM Programs include the following. FRAUD AND ABUSE -The CM team uses clinical judgement to identify cases of potential or actual fraud and abuse through review of claims data and diagnosis information, then contacts providers to verify the problem and notifies DPHHS if the problem is verified. Examples include but are not limited to high utilization; multiple provider usage resulting in the receipt of unnecessary services wherein the professional opinion of the pharmacist represents abuse; member seeks medical services that are not medically necessary; repeated use of emergency rooms; unwarranted multiple pharmacy usage. TEAM CARE -The goal of the Team Care program is to provide consistent care for complex members at high risk for harm due to a complicated disease process and medication regimen. Referrals to this program are those members using multiple health care resources, including multiple providers and pharmacies. CM identifies and refers members who could benefit from medication management and treatment regimen to improve member experience, outcomes and efficiencies by reducing fragmented care. DRUG NOT COVERED-The Drug Not Covered (DNC) program is a Montana-specific program developed by Mountain-Pacific Quality Health in collaboration with the pharmacy program at DPHHS. Prescribers designated by Medicaid as the primary provider enter into an agreement with the member and the Medicaid program and restrict coverage of lock in medication(s) to these designated providers. MEDICATION FOR OPIOID USE DISORDER (MOUD) The MOUD program focuses primarily on providing education and outreach regarding the complex medication management of Sublocade, Vivitrol, buprenorphine, Zubsolv and Suboxone. This includes care planning for additional medications, including emergent pain management. The CM pharmacist discusses criteria, best practices, options for treatment covered in the program and treatment plans with appropriate providers. Additionally, providers receive assistance with complicated cases to resolve treatment problems in the best interest of the member FOSTER CARE REVIEW and PSYCHOTROPIC DRUG OVERSITE -This Foster Care monitoring program improves coordination of prescribing and management of psychotropic medications through educational and clinical interventions. Monthly claims are monitored to identify the number and type of psychotropic medications being prescribed in foster care children less than or equal to 18 years of age. The reviews utilize the following criteria: 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 Claims are reviewed for the following: Diagnosis/Indication, FDA Approved Dosing, Medication Compliance, Lowest Effective Dose, Appropriate Lab

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	Monitoring, Drug-Drug Interactions, Medication misuse/abuse, Polypharmacy, Multiple Pharmacies/Physicians ATYPICAL ANTIPSYCHOTICS FOR CHILDREN UNDER 8 YEARS OLD: By identifying children less than 8 years of age who are receiving antipsychotic medications and associated providers, we have been able to improve coordination of prescribing (often multiple different prescribers are involved) and reduce the number of and/or dose of atypical antipsychotic medications in this population. While the foster care psychotropic oversite program is retrospective, the atypical antipsychotics for children program requires prior authorization for use of these medications in children under 8 years old. Metabolic monitoring, guardian education and consent are required. In addition, claims are reviewed for appropriate indication, dose, etc.
Nebraska	DUR has seen a robust growth in topics reviewed and planning for the future of the DUR Board. Opioid use and abuse, MME maximums, naloxone use programs, Asthma and Diabetes medications and DUR project planning is ongoing. RetroDUR tools utilized to improve client health and appropriate drug utilization included bulletins to providers including pharmacies and prescribers, and notifications and education links posted on the Division webpage. The SUPPORT Act criteria is in place and the PDMP for Nebraska is working with Nebraska Medicaid to implement provider reports. The Health Information Exchange portal of the PDMP is being used to gather disease-State information and reports are in development that will present holistic view of disease-based treatment and interventions.
Nevada	The following information is an analysis of retro-DUR activities and outcomes that were reviewed by the DUR Board and performed by vendor pharmacists through letter mailings of retro-DUR education materials. The top retro-DUR activity for Fiscal Year 2022 were as follows: Patients prescribed combination Opioid, Antipsychotic, and Benzodiazepine: 235 letters were sent with response rate of 4.7% Patients who received 1 dose of COVID Vaccine primary series and are overdue for 2nd dose: 125 letters were sent with response rate of 12.8%
New Hampshire	Letters were mailed on 13 algorithms involving 203 distinct prescribers and 189 members. Below is a summary of each. 1. High Risk Medications in persons 65 or older a. 23 prescribers; 19 members b. No letter response c. 3 members with claim changes responsive to activity 2. Members age 18 and over with claims for Stimulant type ADHD treatments a. 24 prescribers; 17 members b. 4.17% of prescribers responded with changes in therapy or explanation of why continued therapy was necessary c. 3 members with claim changes responsive to activity 3. Short-Acting Beta Agonist_ 2 or more in 90 days without a controller medication a. 5 prescribers; 5 members

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	b. No letter response c. 1 member with claim change responsive to activity 4. Benzodiazepine; 2 or more claims in recent 90 days without an SSRI or SNRI in the last 6 months a. 4 prescribers; 4 members b. No letter response c. 1 member with claim change responsive to activity 5. FDA Drug Safety Communication: Dental Problems with Transmucosal Buprenorphine a. 61 prescribers; 37 members b. Educational activity 6. Polypharmacy a. 39 prescribers; 9 members b. No letter response c. 5 members with claim changes responsive to activity 7. Fluoroquinolones: Boxed Warning relating to the increased risk of tendon rupture and tendinitis a. 24 prescribers; 23 members b. Educational activity 8. Leukotriene inhibitor without asthma diagnosis a. 8 prescribers; 8 members b. 8.33% of prescribers responded with changes in therapy or explanation of why continued therapy was necessary c. 6 members with claim changes responsive to activity 9. Diabetics without an ACEI or ARB in history a. 20 prescribers; 19 members b. 5% of prescribers responded with changes in therapy or explanation of why continued therapy was necessary c. 1 member with claim changes responsive to activity 10. Medications that increase the risk of falls in the elderly a. 29 prescribers; 15 members b. 20.69% of prescribers responded with changes in therapy or explanation of why continued therapy was necessary c. 2 members with claim changes responsive to activity 11. Non-compliance with Inhaled Corticosteroids_10 day gap a. 2 prescribers; 2 members b. Educational activity 12. Diabetes medication claims and no claims for Blood Glucose Monitoring supplies a. 18 prescribers; 16 members b. 5.56% of prescribers responded with changes in therapy or explanation of why continued therapy was necessary 13. Atypical Antipsychotics without metabolic testing a. 32 prescribers; 27 members b. 6.25% of prescribers responded with changes in therapy or explanation of why continued therapy was necessary
New Jersey	(1) Retrospective review of claims exceeding $4000. During this reporting period, 1,640 claims and 1,349 members were reviewed. Outreaches were

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	made to confirm appropriateness, clinical drug-related issues, and/or billing corrections. This resulted in a reversal of 3 claims for a savings of $38,812. In addition, 2 lock-ins ("No-Pay-PA") were placed to prevent future requests for the medication in question, with a cost avoidance of $20,559. (2) Retrospective review of prescription threshold claims. This review included 6 reports: Members with 2 or more ER visits followed by prescriptions from ER physicians, members with claims from 4 or more pharmacies in any calendar month, members with claims from 6 or more prescribers in any calendar month, members with 8 or more claims in any day, members with 15 or more claims in any calendar month, and members with non-NJ pharmacy. During this reporting period a total of 10,192 claims and 822 profiles were reviewed. 54 outreaches were made resulting in 10 pharmacy claim reversals, 13 lock-ins ("No-Pay-PA") were placed on members' profiles and 13 pharmacies were advised to review and adjust the next fill date accordingly due to accumulation. In addition, 2 MCOs were forewarned regarding excessive accumulation because these members were transitioned to MCOs. (3) Retrospective review of opioid/benzodiazepine and opioid/antipsychotic utilization. The 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 10 profiles were reviewed, for a total of 120 profiles, and 29 RetroDUR letters were sent to prescribers. (4) Provider education newsletters. During this reporting period, there were outreaches made to providers through newsletters faxed and posted on the NJMMIS website about clinical information that the NJ DURB determined might be helpful to providers, including Volume 32 No. 25: Clinical News from the New Jersey Drug Utilization Review Board (DURB), regarding prescription drugs for Oral Covid therapy, and Volume 32 No. 11, regarding ivermectin use and Volume 32 No. 01: Medicaid/NJ FamilyCare Fee-For-Service (FFS) Coverage of at home SARS-CoV-2 test kits.
New Mexico	The Ivermectin Educational Newsletter was mailed to 1,258 physicians and 338 pharmacies. The educational newsletter provided guidelines on better understanding of ivermectin utilization during the COVID-19 pandemic and a State savings of $31,760.
New York	Drug to Drug Interaction - Concurrent gabapentinoids & CNS depressants: 608 members selected for intervention; 1,540 intervention letters mailed; 61 responses. Drug to Diagnosis - Antipsychotic use in convulsive disorders: 193 members selected for intervention; 405 intervention letters mailed; 14 responses. Therapeutic Appropriateness -Chronic use of proton pump inhibitors: 250 members selected for intervention; 279 intervention letters mailed; 9 responses. Drug to Drug Interaction - Concurrent opioids & benzodiazepines SUPPORT Act: 126 members selected for intervention; 262 intervention letters mailed; 13 responses. Therapeutic Duplication - Duplicate therapy of atypical antipsychotics: 166 members selected for intervention; 247 intervention letters mailed; 9 responses. Therapeutic Appropriateness - Asthma & lack of controller medication: 131 members selected for intervention; 240 intervention letters mailed; 0 responses. Drug to Drug Interaction - Concurrent opioids & antipsychotics SUPPORT Act: 105 members selected for intervention; 234 intervention letters mailed; 7 responses. Drug to Drug Interaction -

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	Concurrent duloxetine & other serotonergic drugs: 128 members selected for intervention; 225 intervention letters mailed; 11 responses. Therapeutic Appropriateness - Cholesterol guidelines in diabetic patients age 40-75: 146 members selected for intervention; 207 intervention letters mailed; 10 responses. Drug to Drug Interaction - Concurrent opioids & gabapentin (>900mg/day): 91 members selected for intervention; 181 intervention letters mailed; 6 responses.
North Carolina	During October 2021 through September 2022, the North Carolina Medicaid Drug Utilization Review (DUR) Board reviewed several therapeutics areas including concurrent use of opioids with other medications; patients diagnosed with substance abuse or opioid use disorder and their concurrent use of Board targeted medications; clozapine, Hepatitis C therapy, and emtricitabine/tenofovir alafenamide utilization; blood glucose monitoring compliance; and health disparities in the treatment of Hepatis C and opioid dependence treatment. Educational outreach primarily consisted of educational letters to prescribers and pharmacies identifying their impacted patients. 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 opioids, use of Board-targeted medications in patients with a diagnosis of substance abuse or opioid use disorder, clozapine utilization, blood glucose monitoring compliance, and health disparities. Large percent changes in the Fee-for-Service data was a result of a majority of lives shifting to Managed Care plans in July 2021. Patients using opioids concurrently with benzodiazepines, antipsychotics, or z-drugs (zolpidem, zaleplon, and eszopiclone) were reviewed each quarter. Since opioids and benzodiazepines are often misused and concurrent use may result in serious side effects the North Carolina DUR Board has continued to monitor each quarter. During the July 2022 DUR Board meeting data showed a ~-5% annual decrease in the number of users in Fee-for-Service (FFS) and Managed Care (MCO) combined and a ~-32% decrease in the FFS only population. The Board also monitored the use of patients using antipsychotics and opioids together. On average, ~7% of patients using antipsychotics were also taking opioids in the FFS population. When reviewing the annual trend there was <-1% decrease in the number of FFS and MCO population combined and a ~-9% decrease in the FFS only population. When reviewing the concurrent use of opioids and z-drugs in the FFS and MCO combined population the average number of opioid/z-drug concurrent users over 2 years was < 1,000 patients/ month and represented < ~3% opioid or z-drug population. The number of concurrent users decreased ~-21% over two years. The average number of concurrent opioid/z-drug users over 2 years was < ~ 400 patients/month and represented ~3% of the number of patients taking either an opioid or z-drug in FFS. The number of concurrent users decreased ~-45% over two years for the FFS population. The Board recommended continued monitoring on the use of opioids with benzodiazepines, antipsychotics, or z-drugs. Additionally, the Board requested the Department to consider point-of-sale edits to ensure clinically appropriate benzodiazepine use and point-of-sale messaging to encourage naloxone dispensing.

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	Patients with a diagnosis of substance abuse disorder and their utilization of gabapentin or benzodiazepines was reviewed by the Board. In April 2022, the DUR Board reviewed the use of gabapentin in patients without an FDA indication for gabapentin who had a history of substance abuse. In the FFS population, there were ~14K patients who received a gabapentin prescription. Of those patients ~80% (~11K patients) did not have an FDA approved indication for gabapentin and 39% had a diagnosis of past or present substance abuse. The Board also took the opportunity to examine the top 50 diagnoses for off-label gabapentin use, the top 50 gabapentin prescribers, and overall gabapentin utilization trends since March 2017. The use of gabapentin in the FFS and MCO combined population increased ~9% but use significantly declined in the FFS population (~-45%). When reviewing benzodiazepine use in patients with substance abuse disorder in the FFS population it was found that ~2K patients/month had a present or past diagnosis and had received a prescription. This represented ~23% of the general benzodiazepine user population. The most dispensed benzodiazepine was clonazepam followed by alprazolam and lorazepam. The Board also reviewed the number of prescribers patients receive their benzodiazepine prescription from. Data showed that ~87% of FFS patients received their benzodiazepine prescriptions from one prescriber. The Board also reviewed the use of short-acting opioids in patients with a past or present diagnosis of opioid use disorder (OUD). Data showed that ~1K FFS patients had a past or present OUD diagnosis who recently received a prescription(s) for a short-acting opioid(s). Of those patients, ~5% also had a prescription for buprenorphine. The Board requested routine monitoring on these topics. The North Carolina DUR Board had multiple discussions on the use, benefits, and challenges associated with clozapine use. The Board reviewed two-year utilization trend data for the combined FFS and MCO population by age (adult versus pediatric) and with and without a psychosis diagnosis. The percent of adults with no psychosis and with psychosis increased by ~4% and ~12%, respectively. However, the percent of pediatrics without and with psychosis had a ~-62% and ~-38% decrease, respectively. Next, the North Carolina DUR Board recognizes that blood glucose monitoring provides patients with valuable information and can improve lives and health outcomes. The Board reviewed the compliance rates of patients taking oral medications, insulin, other injectables, and inhaled products. The average rate of non-compliance in the FFS population was ~24%. When reviewing non-compliance rates for diabetic testing the rate of non-compliance decreased ~-36%. The Board requested continued monitoring of clozapine utilization and diabetic medication/supply compliance. Additionally, the Board requested the Department include diabetic medication/supply compliance information in a Medicaid newsletter encouraging the medical community to educate patients on the importance of taking medications as prescribed. Health disparities in the FFS population pertaining to access to care for Hepatitis C therapy and opioid dependence treatment was reviewed by the Board. Using Medicaid paid claims information only, a patient was considered having access to care with the presence of > or = 1 drug claim. Claim information was

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	examined to determine access to care based on patient demographics (e.g., American Indian, Asian, Black, Pacific Island, Unidentified, White) and geographical location. When examining access to Hepatitis C therapy in the FFS population, ~31K patients had a Hepatitis C diagnosis and a majority of the patients were White (~67%) followed by Black (~30%), American Indian (~2%), Unidentified (~1%), Asian (<1%), and Pacific Island (<1%). Of the ~31K patients, ~83% did not have a paid claim for a Hepatitis C drug (White 81%, Black 85%, American Indian 81%, Unidentified 93%, Asian 86%, Pacific Island 92%). The top zip codes for untreated patients in FFS with Hepatitis C were Charlotte, Wilmington, Gastonia, Raleigh, Lenoir, Greensboro, Winston Salem, Morganton, and Asheville. When examining access to care for opioid dependence therapy in the FFS population ~62K patients had a diagnosis of opioid dependence and a majority of the patients were White (~75%) followed by Black (~21%), American Indian (~3%), Unidentified (~1%), Asian (< 1%), and Pacific Island (< 1%). Of the ~62K patients, ~72% did not have a paid claim for buprenorphine (White 68%, Black 88%, American Indian 60%, Unidentified 87%, Asian 86%, Pacific Island 65%). The top zip codes for untreated patients in Medicaid Direct with opioid dependence were Lenoir, Wilmington, Thomasville, Mt. Airy, Morganton, Greensboro, Greenville, Charlotte, and Asheville. The Department continues to monitor health disparities.
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: Support Act Criteria - Therapeutic appropriateness (154, 136, 213, 13.6%, 149, 15.4%) 2: Underutilization of long-term asthma controllers - Underuse Precaution (86, 77, 85, 8.2%, 78, 26.9%) 3: Assessing hypertension medication use in members with diabetes - Therapeutic Appropriateness (73, 73, 80, 11.3%, 76, 9.2%) 4: Underutilization of Advair Diskus/Wixela - Underuse Precaution (76, 71, 76, 3.9%, 72, 15.3%) 5: Underutilization of fluoxetine - Underuse Precaution (73, 60, 61, 6.6%, 62, 16.1%) 6: Underutilization of escitalopram - Underuse Precaution (67, 58, 59, 8.5%, 58, 15.5%) 7: Underutilization of sertraline - Underuse Precaution (73, 56, 58, 13.8%, 57, 10.5%) 8: Support Act Criteria - Therapeutic Appropriateness (67, 46, 80, 21.3%, 49, 12.2%) 9: Utilizing statins in members with diabetes - Therapeutic appropriateness (67, 42, 50, 14%, 46, 30.4%)

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	10: Overutilization of sedative agents- Underuse Precaution (44, 40, 41, 12.2%, 41, 19.5%)
Ohio	MAT + Opioid/Benzodiazepine Outreach Every month, outreach is made to each pharmacy and prescriber whose patients are taking Medication Assisted Treatment (MAT) in combination with an opioid and/or a benzodiazepine 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. RetroDUR Interventions Adherence to Controller Inhalers In October 2021, a RetroDUR intervention letter was sent to notify prescribers that suboptimal adherence to pharmacological treatment of asthma and COPD has adverse effects on disease control and treatment costs. Eight hundred and seven members with adherence of less than 60% were identified for this intervention. Butalbital Overutilization In November 2021, a RetroDUR intervention letter was sent to prescribers whose patients were filling prescriptions for high-dose or long-term butalbital to present guidance which advises against this. Twenty-one members were identified for this intervention. Multiple Antipsychotics in Children In December 2021, a RetroDUR intervention letter was sent to notify prescribers that antipsychotic polypharmacy in the pediatric population is associated with a higher risk of diabetes, weight gain, and associated metabolic disturbances and to ask these prescribers to consider behavioral counseling in addition to pharmacological therapy. Thirty-five members were identified for this intervention. Insulin Without Glucose Monitoring In January 2022, a RetroDUR intervention letter was sent to prescribers whose patients were receiving insulin without claims for blood glucose strips or continuous glucose monitors and components. Six hundred and forty-one members were identified for this intervention. Coordinated Services Program (CSP) Members Without Naloxone In February 2022, a RetroDUR intervention letter was sent to prescribers of CSP members who did not have a pharmacy claim for naloxone. One hundred and ninety members were identified for this intervention. Asthma and Non-Selective Beta-Blocker In March 2022, a RetroDUR intervention letter was sent to prescribers whose patients have asthma and had pharmacy claims for a non-selective beta-blocker. Two hundred and three members were identified for this intervention. Atherosclerotic Cardiovascular Disease (ASCVD) Without Statin In April 2022, a RetroDUR intervention letter was sent to prescribers whose patients had a diagnosis of ASCVD and did not have a pharmacy claim for a statin. Three hundred and ninety-two members were identified for this intervention. Opioids from Multiple Prescribers In May 2022, a RetroDUR intervention letter was sent to prescribers whose patients had received overlapping opioid prescriptions from prescribers at different practice sites. Three hundred and thirty-three members were identified for this intervention. Benzodiazepine Monotherapy for Anxiety In June 2022, a RetroDUR intervention letter was sent to prescribers whose patients were taking benzodiazepine monotherapy for anxiety and had not previously taken a different anxiety medication. Five hundred and thirty-six members were identified for this intervention. Heart Failure With Reduced Ejection Fraction Without ACE-I/ARB/ARNI In July 2022, a RetroDUR intervention letter was sent to prescribers with patients having a diagnosis of heart failure with reduced ejection fraction who were not taking an ACE inhibitor, ARB, or ARNI. Five

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	hundred and eighty-nine members were identified for this intervention. Antipsychotic Opioid Overlap In August 2022, a RetroDUR intervention letter was sent to prescribers whose patients were taking antipsychotic and opioid medication concurrently for 60 days or longer. Two hundred and eighty-six members were identified for this intervention. Frequent Albuterol Use In September 2022, a RetroDUR intervention letter was sent to prescribers whose patients with an asthma or Chronic Obstructive Pulmonary Disease (COPD) diagnosis had filled six or more albuterol prescriptions in six months with no controller inhaler. Two hundred and ninety-four members were identified for this intervention. 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 initial intervention. Concurrent use of Multiple Antipsychotics In November 2020, 251 letters were mailed to prescribers whose patients were receiving multiple antipsychotics. One hundred thirty members were identified for this intervention. One year later in November 2021, claims were reviewed for these members. One member was no longer Medicaid eligible. One hundred twenty-nine members were available for re-review. Of the 129 members available at re-review, 83 members had a positive change, that is no longer taking multiple antipsychotics (64%). Adherence to HIV Medications In December 2020, 54 letters were mailed to prescribers with patients having an adherence rate of less than 95% (based on PDC) to their HIV medication. Forty-one members were identified for this intervention. One year later in February 2022, claims were reviewed for these members. Thirty members were available for re-review. Of the 30 members available at re-review, 15 members improved their adherence to their HIV medications (50%). Proton Pump Inhibitor (PPI) Deprescribing In February 2021, 878 letters were mailed to prescribers whose patients were taking a PPI for greater than 6 months. Seven hundred and three members were identified for this intervention. One year later in February 2022, claims were reviewed for these members. Six hundred and twenty-four members were available for re-review. Of the 624 members available at re-review, 17 members were no longer taking a PPI (2.7%). Opioids Greater Than 80 MED In March 2021, 296 letters were mailed to prescribers whose patients were taking opioids greater than 80 MED. One hundred and seventy-five members were identified for this intervention. One year later in March 2022, claims were reviewed for these members. One hundred and forty-four members were available for re-review. Of the 144 members available at re-review, 98 members had improved, either taking less than 80 MED or discontinued their opioid (68%). Triple Antithrombotic Therapy In March 2021, 51 members were initially identified for this intervention and letters were mailed to prescribers whose patients were taking prolonged triple antithrombotic therapy for greater than 30 days. One year later in March 2022, claims were reviewed for these members. There were 45 members available at re-review, with an overall reduction of 67% in triple antithrombotic therapy prescriptions (30 improved members). Children Taking Opioids In June 2021, 85 members were initially identified for the intervention where letters were mailed to prescribers whose patients were less than 18 years old and who were taking at least one opioid prescription from 1/1/2021 to 3/31/2021. One year later in June 2022, claims were reviewed for these members. There were 79 members available at re-review, with an overall

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	reduction of 82% (from 119 to 20) receiving opioid prescriptions. Multiple Anticholinergics In August 2021, 149 members were initially identified for this intervention where letters were mailed to prescribers whose patients were over 60 years old and taking multiple anticholinergic medications or seeing multiple prescribers who were issuing medication with anticholinergic action. The interventions goal was to mitigate the risks of undesired additive anticholinergic effects. One year later in August 2022, claims were reviewed for these members. There were 129 members available at re-review, with an overall reduction of 9% (from 9.9 to 9.0) in anticholinergic prescriptions and a $35 decrease (from $256 to $221) in anticholinergic spending per member. Opioids and Benzodiazepines In September 2021, 130 members were initially identified for the intervention where letters were mailed to prescribers whose patients were co-prescribed two or more opioids and one or more benzodiazepines. One year later in September 2022, claims were reviewed for these members. There were 96 members available at re-review, with an overall reduction of 30% (from 795 to 554) in opioid and 14% decrease (from 470 to 405) in benzodiazepine prescriptions, resulting in a decrease of $8 in opioid and benzodiazepine spend spend per member. 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 2021: 29 new members were identified for enrollment, February 2022: 33 new members were identified for enrollment, May 2022: 21 new members were identified for enrollment, August 2022: 38 members were identified for enrollment.
Oklahoma	Date|Medication Category|Educational Intervention Criteria|Cases Reviewed|Cases Intervened|Affected Members|Total Members|Total Claims|Minimum Cost Savings 10/2021|SP|ADMP|54,974|26,065|13,599|70,991|560,559|CO 01/2022|SP|ADMP|54,763|31,042|13,318|70,512|556,168|CO 04/2022|SP|ADMP|54,800|30,785|13,420|71,614|559,963|CO 07/2022|SP|ADMP|55,184|30,617|13,400|71,614|562,160|CO 11/2021|CMA|DM/CV|41,108|5,802|16,950|41,108|202,105|CO 02/2022|CMA|DM/CV|41,772|7,599|17,235|41,772|203,804|CO 05/2022|CMA|DM/CV|41,172|7,200|34,209|41,165|202,691|CO 08/2022|CMA|DM/CV|41,851|6,942|17,034|41,851|207,061|CO 12/2021|AP Pediatrics|ADMP|5,327|885|2,357|10,377|22,395|CO 06/2022|AP Pediatric Foster|ADMP|5,900|498|5,028|10,719|23,099|CO 08/2022|Statin use in Members with DM|NA|122|1676|NA|NA|CO 09/2022|T1DM|5,137|3,279|231|4,828|8,416|$408,207 ADMP: adherence/diagnosis/metabolic monitoring/polypharmacy; AP: Anti Psychotic CMA: chronic medication adherence; CO: clinical outcomes; DM: diabetes; N/A: not applicable; SP: SoonerPsych; T1DM: Type 1 Diabetes
Oregon	Change Forms:

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	Aripiprazole Rapid Dissolve Tabs to Oral Tabs: Faxes sent-18; Rx changed w/in six months-14; cumulative pharmacy payment reduction (12 months)-$94,537 Desvenlafaxine Salt Formulations: Faxes sent-197 Rx changed w/in six months-173; cumulative pharmacy payment reduction (12 months)-$244,506 Venlafaxine Tabs to Caps: Faxes sent-478; Rx changed w/in six months-318; cumulative pharmacy payment reduction (12 months)-$140,245 Dose Consolidation: Faxes sent-39; Rx changed to recommended dose within 3 Months-20; Rx changed to alternative dose within 3 Months-12; cumulative pharmacy payment reduction (12 months)-$41,973 Expert Consultation Referral: Long Term Antipsychotic Use in Children: high-risk patients identified-26; prescribers successfully notified-26; change in Rx within 90 days-1; no change w/in 90 days-23; discontinued within 90days-2 Non-Adherence: Antipsychotics in people w/schizophrenia: Prescribers successfully notified-233; Patients with claims for the same antipsychotic within the next 90 day-119; Patients with claims for a different antipsychotic within the next 90 day-10 Safety Net: PA Denials with no subsequent PA requested or dangerous drug combinations: Combination Opioid-Sedative: Prescribers successfully notified-374; Patients with discontinuation of therapy within next 90 days-93; Patients with new prescription for naloxone within next 90 days-21; Denied Claims due to Antipsychotic Dose Consolidation: Total patients identified-219; Patients with a paid claim for the drug (based on HSN) within 14 days-122; Patients without a paid claim within 14 days-97 ICS/LABA: Denials-80; Disqualified-21; Faxes sent 7: (combination inhaler-4; SABA-3); No subsequent pulmonary claims-4 Oncology Denials: Prescribers successfully notified-6; Patients with claims for the same drug within the next 90 days-4; Patients with claims for any oncology agent within the next 90 days-5 TCAs in Children: Total patients identified-49; Prescribers successfully notified-31; Patients with claims for a TCA w/in the next 90 days-8; Patients with claims for an alternate drug (SSRI, migraine prevention, or diabetic neuropathy) w/in the next 90 days-3
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

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	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 (FFY22). The activities of the RDUR program resulted in a calculated cost savings of $237,162.85*, equating to a savings of 28 cents* for every $1.00 of combined federal and State dollars spent administratively on the RDUR program. During this evaluation period, 6119 educational intervention letters were mailed to prescribers regarding medication therapy. Providers are invited to voluntarily respond to RDUR Program letters. Providers returned 588 responses to these letters, resulting in an overall response rate by the providers of 9.61 percent. In these 6,119 educational letters, the RDUR Program made 6,119 observations and subsequent education. The suggested change was implemented in 2,355 cases, resulting in an overall impact rate of 38.49 percent. Implementation of these therapeutic suggestions resulted in a cost savings of $237,162.85* for the 4535 patients evaluated, or a savings of $52.30* per patient. *Savings reported are pre-rebate, total dollars.
Rhode Island	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) 2022. 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 1,203 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 19% was achieved for the top 10 criteria and a response rate of 12% was achieved for total interventions during FFY 2022. Program Background Kepro currently provides RDUR services for the Rhode Island fee-for-service Medicaid population as a subcontractor with Gainwell Technologies. In an effort to promote appropriate prescribing and utilization of medications, Kepro 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 Kepro evaluates Rhode Island fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues.

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	Criteria are developed by Kepro and presented to the Rhode Island Drug Utilization Review Board and Gainwell Technologies for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by a Kepro 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 can 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 2022. CRITERIA TYPE CRITERIA NUMBER CRITERIA DESCRIPTION # RECIPIENTS SELECTED FOR INTERVENTION # INTERVENTION LETTERS MAILED TO PRESCRIBERS # PRESCRIBER RESPONSES TA 3006 Antidepressants may increase risk of suicidal thinking 240 242 48 TA 1335 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. 201 209 32 TA 4693 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. 163 163 23 TA 3178 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). All patients should receive baseline screenings for risk factors associated with metabolic syndrome before receiving an SGA and regular monitoring of metabolic parameters throughout therapy. If metabolic risk factors cannot be controlled, consider switching, if clinically possible, to an SGA with a more favorable metabolic profile. 150 147 29 TA 2813 Misuse of amphetamines and cardiovascular warning 104 104 32 LR 1606 The lipid lowering medication may be under-utilized. Non-adherence to the dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional medical costs. 76 76 10

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	LR 7448 Non-adherence to the prescribed once daily ADHD medication may result in decreased patient outcomes and additional health care costs. 70 70 22 TA 9237 The AHA/ACC Guideline on the Management of Blood Cholesterol recommends 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 unless contraindicated. If adult diabetic patients who have multiple ASCVD risk factors, it is reasonable to prescriber high-intensity statin therapy with the aim to reduce LDL-C levels by 50% or more. Refer to the AHA/ACC guidelines for agents and dosage. 62 65 7 TA 3179 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. 64 64 9 TA 541 Diabetic would benefit from addition of an ACE or ARB 60 63 11 Total Top 10 1,190 1,203 223 (19%) Total all letters 2,837 2,969 348 (12%) 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 Kepro 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. Kepro tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 1,203 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 223 responses were received for a response rate of 19%. A summary of all coded responses from prescribers is listed in the table below. Response Description Count BENEFITS OF THE DRUG OUTWEIGH THE RISKS 112 MD UNAWARE OF WHAT OTHER MD PRESCRIBING 1 MD SAYS PROB INSIGNIF NO CHG THX 22 MD WILL REASSESS AND MODIFY DRUG THERAPY 33 MD TRIED TO MODIFY THERAPY, PT NON-COOP 6 PT UNDER MY CARE BUT NOT SEEN RECENTLY 16 PATIENT DECEASED 2

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	PATIENT WAS NEVER UNDER MD CARE 9 HAS APPT TO DISCUSS THERAPY 123 MD DID NOT RX DRUG ATTRIBUTED TO HIM. 13 AWARE OF INTERACTION, MONITORING PATIENT 56 TRIED TO MODIFY THERAPY, SYMPTOMS RECURRED 16 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD34 I AM PROVIDING THE ICD-10 CODE ASSOCIATED WITH MEDICATION(S) BEING PRESCRIBED 17 Total of all responses 348 Results Discussion With respect to prescriber responses to all RDUR letters, a response rate of 12% 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 2022, a total of 1,203 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 19% was achieved for the top 10 criteria alerts.
South Carolina	Academic Detailing style visits to pharmacies by student pharmacists following mini training on topic and AD principles: Visits to pharmacists=6, Visits to pharmacy staff = 63. Topic selection is based on individualized needs of provider, Shared Support not Stigma handout with staff at all applicable visits, regardless of topic. AD visit counts include first visits to prescribers=34 AD follow-up visits to prescribers= 122. tipSC NOTES Summary 2022 (first issue) finalized and printed: Low-Dose Naltrexone Is there a role for ORAL LDN in chronic pain management? and tipSC Issue October 2022 Balancing Comfort and Safety in Post-Op Pain Management for surgeons finalized and printed. Continued efforts to promote safer opioid prescribing and expanded access to medications for OUD which includes innovative management of the Agency's MAT Guidelines. Future efforts will extend educational outreach under the behavioral health umbrella to include alcohol use disorder (AUD) and attention-deficit/hyperactivity disorder (ADHD).
South Dakota	In an effort to improve clinical outcomes the RDUR program evaluates pharmacy and medical claims data against a library of clinical criteria and mails educational letters to providers of identified recipients. The recipient claim histories 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. During FFY 2022, 897 recipients met the initial criteria for an educational letter. After review, 314 recipient profiles with potential drug therapy problems were found to require additional provider education. 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.

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	The intervention group had a decrease of 5.78% in pharmacy claims cost following the RDUR educational letters, whereas the comparison group had an increase of 11.79%. These changes resulted in an estimated cost savings of $975.93 per case requiring an educational letter during FFY 2022. The RDUR program provides an important educational service to providers enrolled in the South Dakota Medicaid Program. The RDUR educational 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.
Tennessee	Below is a list of TennCare's RetroDUR Initiatives: Concurrent Therapy: Concurrent Use of Opioids and Antipsychotics-- A RetroDUR initiative was conducted to identify TennCare members who were concurrently receiving opioids and antipsychotics for FFY2022. Claims data for members who were concurrently receiving opioids and antipsychotics between October 2021 through September 2022 were reviewed. 1,093 unique members were identified, and Retro-DUR interventions were initiated. Letters were sent to corresponding prescribers. A follow up claims data review was done after the intervention which resulted in a savings of $ 7,743.04. Morphine Equivalent Dose (MED): Exceeding 90 MME without appropriate diagnosis/Exceeding 50 MME and not on Narcan - - A RetroDUR initiative was conducted to identify TennCare members who were receiving opioids and exceeding 90 MME in patients without an appropriate diagnosis and TennCare members who were receiving opioids and exceeding 50 MME and not on Narcan in the last 180 days for FFY2022. Claims data for identified members were reviewed between November 2021 through February 2022. 2,667 unique members were identified, and Retro-DUR interventions were initiated. Letters were sent to corresponding prescribers. A follow up claims data review was done after the intervention which resulted in a savings of $2,836,198.52. Drug-Disease Interactions: Respiratory conditions and Opioids, Asthma/COPD and non-selective beta-blockers, and Cardiac abnormalities and stimulant medications -- A RetroDUR initiative was conducted to identify TennCare members with one of the following potential diagnosis/drug interaction: respiratory conditions and opioids, asthma/COPD and non-selective beta-blockers, and cardiac abnormalities and stimulant medications. Claims data for the identified members were reviewed between May 2022 through August 2022. 6,647 unique members were identified, and Retro-DUR interventions were initiated. Letters were sent to corresponding prescribers. A follow up claims data review was done after the intervention which resulted in a savings of $ 71,058.54. Conduct disorders and antipsychotics - - A RetroDUR initiative was conducted to identify TennCare members who had conduct disorders and antipsychotics. Claims data for members who were identified were reviewed between August 2022 through September 30, 2022.

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	242 unique members were identified, and Retro-DUR interventions were initiated. Letters were sent to corresponding prescribers. A follow up claims data review was done after the intervention which resulted in a savings of $510,221.75. Concurrent Therapy: Concurrent use of three antidepressants for >= 60 days - - A RetroDUR initiative was conducted to identify TennCare members who were concurrently using three antidepressants for >= 60 days. Claims data for members who were identified were reviewed between August 2022 through September 2022. 324 unique members were identified, and Retro-DUR interventions were initiated. Letters were sent to corresponding prescribers. A follow up claims data review was done after the intervention which resulted in a savings of $2,857.56. Educational Interventions - DUR Board educational letters were sent to notify prescribers of new FDA-safety updates for Janus kinase (JAK) inhibitors, tramadol products in pediatric patients, and NSAIDs use in pregnancy. The updated warnings for JAK inhibitors label included increased risks of cardiovascular events including heart attack or stroke. Additionally, JAK inhibitors are associated with an increased risk of cancer, blood clots, and death. A total of 2,406 educational letters were sent to prescribers to notify them of the JAK inhibitors FDA label update from Oct-Dec 2021. The updated FDA label updates for tramadol included contraindications in pediatric patients less than 12 years of age due to increased risk of slowed or difficulty breathing, and in patients ages 12-18 who meet the following: recent tonsillectomy or adenoidectomy, obese with BMI 30 or higher, or who have Obstructive Sleep Apnea, and severe lung disease (acute or severe Asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, Pneumonia, Pulmonary Hypertension, etc.). A total of 2,912 educational letters were sent to prescribers to notify them of the tramadol FDA label update from Dec 2021-April 2022. The updated FDA label updates for NSAIDs included updated warnings in women who are 20 weeks or later in pregnancy due to possible increased risk of rare but serious kidney problems in the unborn baby. A total of 5,019 educational letters were sent to prescribers to notify them of the NSAIDs in pregnancy FDA label update from May 2022-September 2022.
Texas	For the FFY 2022, 8 retour-DUR interventions were conducted: 1. Diabetes Disease Management was mailed to 2717 providers and targeted patients had average reductions in clinical indicators of 25.2%. However, there was an estimated increase of $384,309.60 in intervention-related drug expenditures on an annualized basis. 2. Bipolar Disorder Management intervention targeted 322 providers and had a reduction/improvement in clinical indicators by 31.9%. The amount expenditure for intervention-related drugs decreased by $1,385,350.20.

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	3. Hypertension Management targeted 1248 providers and had average reductions/improvement in clinical indicators of 32.0%. In terms of financial outcomes, an overall decrease by $13,894.80 in intervention-related drug was reported. 4. ADHD Medication Management targeted 171 providers and had an average improvement in the clinical indicators of 27.7%. An overall $590,144.94 decrease in intervention-related drug expenditures was reported 5. Combined Use of Opioids and CNS Depressants targeted 46 providers and had improved clinical indicators by an average of 33.3%. In terms of financial outcomes, an overall estimated decrease of $15,257.28 in intervention-related drug expenditures was reported. 6. Management of Psychotropic Drugs in Pediatric Patients targeted 154 providers and had average reductions in clinical indicators of 26.4%. The Dollar amount paid for intervention-related drugs decrease by $73,418.40. 7. Heart Failure Management targeted 148 providers and had average reductions in clinical indicators of 28.5%. However, there was an increase in intervention-related drugs expenditure by $24,727.68. 8. Migraine Disease Management targeted 16 providers and had average reductions in clinical indicators of 37.5%. In terms of financial outcomes, this intervention yielded an overall estimated decrease of $10,273.68 in intervention-related drug expenditures.
Utah	Retrospective DUR is performed primarily through the peer-to-peer program that aims to achieve quantitative improvements through direct and focused provider engagement delivered by the Utah State Medicaid Pharmacy. All peer-to-peer work is evaluated by and receives approval from the DUR Board. 1) An update on the opioid high-dose peer-to-peer program started in FFY 2019 and is ongoing. On January 1, 2019, a threshold of 90 MME was established for opioid-naive members and 180 MME for opioid-experienced members. Over time, the higher MME threshold was reduced to achieve a common 90 MME standard for all Utah Medicaid members. In Oct 2019, 64 FFS members were receiving opioids at 90 MME or greater. The MME limit was reduced to 90 MME during FFY 2020. In Oct 2022, the number of members receiving opioids at 90 MME or greater decreased to 42. The pharmacists continue to contact the prescribers when reviewing prior authorizations for members with opioids prescriptions higher than 90 MME. Overall, despite the growth of the UT Medicaid population by 74% since 2018, the number of members on high dose opioid above 90 MME continued to decline. 2) On October 1, 2019, the UT Medicaid Pharmacy team launched a peer-to-peer intervention to monitor and manage antipsychotic medications prescribed to members 19 years of age and younger. The program has continued throughout FFY 2022 with significant results. From October 2019 to September 2022, the number of children under 6 years of age receiving antipsychotics was reduced from 16 children to 1 child. The number of more than one antipsychotic from 16 children to 1 child, and children on high dose antipsychotics exceeding literature recommendations from 61 to 39 children. The rate of metabolic screening in all children receiving antipsychotics increased from 22% in 2019 to

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	27% in 2021. As of September 2022, the screening rate stood at 22%, with a higher rate of 35% observed among foster kids. The pharmacists continue to outreach to providers to discuss the appropriateness of using antipsychotics in children and encourage metabolic screening when reviewing prior authorization. The UT Medicaid Pharmacy Team also contracted with the University of Utah Department of Pediatrics to provide consultation to providers to manage the use of antipsychotics in complex children. The contract has been in place in May 2021. 3) In January 2020, the Utah Medicaid Pharmacy Team engaged in a peer-to-peer program for providers prescribing an opioid/benzodiazepine combination without naloxone. This program has continued through FFY 2022. A clinical pharmacist performs telephonic outreach to prescribers. During the call, the pharmacist engages the prescriber in the following topics from the CDC's Clinical Practice Guideline for Prescribing Opioids for Pain: a) Reviews with the provider cover the risks of concurrent use of opioids/benzodiazepines; b) Requests that the provider counsel patients on the risk; c) Encourages consideration of other, safer combinations; d) Encourages proactive naloxone prescribing and educates on appropriate use; e) Encourages routine use of the controlled substance database; f) Encourages the prescriber to coordinate with other co-prescribing providers. The baseline concurrent use among Medicaid Fee for Service (FFS) members is 15.38%, with 3.56% of these being prescribed naloxone. There was slight improvement at the end of September 2022: FFS members with concurrent use were 14.9%, and 3.8% of these were prescribed naloxone. 4) Beginning April 1, 2020, the UT Medicaid Pharmacy Team launched the Hepatitis C Adherence program to improve members' adherence to hepatitis C treatments. The program has continued through FFY 2022. The program's impact is reviewed per calendar year. For the calendar year of 2022, 304 prior authorizations for members enrolled in the program and the adherence rate was 84.2%, which is below the established goal of 90%. The pharmacists discussed the following points during outreach with members: Counseling members on medication direction, and adverse drug events The importance of adhering to Hepatitis C medications to "cure" hepatitis C Utilized motivational interviewing to motivate members to adhere to therapy 5) Beginning in March 2021, the UT Medicaid Pharmacy Team started an Antidepressant Medication Management (AMM) Program to improve members' adherence to antidepressant therapies. The National Committee for Quality Assurance (NCQA) AMM measure was used as the basis to identify members with newly diagnosed depression in the acute and continuation phases of treatment. Clinical pharmacists telephonically reach out to the Medicaid Fee for Service members 18 years of age or older, who have a diagnosis of major depression, and are newly treated with antidepressant medication. Clinical pharmacists use motivational interviewing to address medication non-adherence and create a strategy for change. The antidepressant medication adherence rate increased from 54.1% at baseline to 57.3% for newly treated members (acute phase) while the adherence rate dipped from a baseline of

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	33.4% to 32.5%, for members who had been on antidepressant medication for more than 6 months (continuation phase).
Vermont	Concomitant use of GLP-1 agonists and DPP-4 inhibitors in Type II DM Presented June 21, 2022 Treatment for Type 2 Diabetes Mellitus (DM) has improved substantially in the last decade. Several effective newer classes of medications are now available, including glucagon-like peptide-1 receptor agonists (GLP-1 agonists), sodium-glucose co-transporter 2 inhibitors (SGLT2 inhibitors) and dipeptidyl peptidase-4 inhibitors (DPP-4 inhibitors, also called gliptins), along with older medications, such as sulfonylureas and insulin. Recent guidelines from the American Diabetes Association and the American Society of Endocrinology incorporate these newer agents into treatment algorithms, often recommending considering these drugs before starting insulin therapy. Some of these agents have beneficial effects on other risks, such as heart failure and other cardiovascular diseases, and determining which drugs to use depends on an individual's health profile. GLP-1 receptor agonists work by stimulating insulin secretion and decreasing glucagon production. DPP-4 inhibitors prevent the degradation of GLP-1. Both have shown benefit in lowering blood glucose, however comparative trials have shown GLP-1 receptor agonists to be superior in improving glycemic control and inducing weight loss. Studies have shown that combining a GLP-1 agonist with a DPP-4 inhibitor provides minimal improvement in glycemic control and weight loss compared with either monotherapy, and combination therapy is not cost effective. Guidelines do not support combined therapy with these drugs. Change Healthcare used paid, non-reversed Medicaid pharmacy claims from January 2021 December 2021, excluding members with Part D or other insurance as primary coverage, VMAP, and Healthy Vermonters coverage. They looked at members to see if they were being prescribed both a DPP-4 inhibitor and GLP-1 receptor agonist to determine if the practice waswidespread or isolated among a few providers. The following GLP-1 Receptor Agonists were included in the analysis: Adlyxin(lixisenatide), Bydureon (exenatide extended-release), Bydureon BCise (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide), Soliqu (insulin glargine/lixisenatide), Trulicity (dulaglutide), and Victoza (liraglutide). The following DPP-4 Inhibitors and combinations were included in the analysis: Janumet (sitagliptin/metformin), Janumet XR (sitagliptin/metformin ER), Januvia (sitagliptin), Jentadueto (linagliptin/metformin), Jentadueto XR (linagliptin/metformin ER), Kazano (alogliptin/metformin), Kombiglyze XR (saxagliptin/metformin ER), Nesina (alogliptin), Onglyza (saxagliptin), Oseni (alogliptin/pioglitazone), and Tradjenta (linagliptin). There were 1,100 members taking only a GLP-1 RA and 281 member taking only a DPP-4 Inhibitor. 76 members had an overlapping claim with a medication from each class. 26 members had an overlap of more than 90 days, and 13 members had an overlap of more than 180 days. The most common combination of medications that overlapped were Trulicty and Januvia. Fortunately, there were few members (76) who were concurrently taking a GLP-1 receptor agonist and DPP-4 inhibitor to treat their diabetes. This overlap in some patients may have been because of a transition from one drug to another. However, there were still a total 26 patients who were on both for more than 90 days, and 13 whose overlap exceeded 180 days. Options for education include a general educational mailing to providers who prescribe

State	RetroDUR Educational Outreach Summary
	diabetic medications, but an intervention targeting the prescribers of these medications where overlap exceeds 90 or 180 days might be more effective. The DURB voted to send a targeted communication to the prescribers of the 13 members with claim overlap of greater than 180 days. Letrozole Prior Authorization Requirement Updates, Presented 05/10/2022 Introduction: Letrozole, an aromatase inhibitor, has indications for treatment in hormone receptor positive breast cancer, in the adjuvant, extended adjuvant, and advanced disease settings. The oral dosing in all these settings is 2.5 mg daily. In breast cancer, off-label indications include using in combination with other drugs in the advanced disease and metastatic settings, again at 2.5mg/day dosing. Other off-label indications include treatment of recurrent ovarian cancer (2.5mg/day) and infertility/ovulation stimulation in anovulatory females with polycystic ovarian syndrome. The doses in this case include 2.5 up to 7.5mg/day, starting day 3-5 of the cycle for 5 days. Treatment of infertility is not a covered benefit in members who receive Medicaid drug coverage in Vermont, therefore the decision was made to evaluate the use of letrozole in women of child-bearing age in this population. Methods: Change Healthcare used paid, non-reversed Medicaid pharmacy and medical claims from SFY 2021 excluding members with Part D, VMAP and Healthy Vermonters coverage. They identified women between the ages of 20 and 50 who were taking letrozole and identify the ordering provider to determine whether the medication may have been prescribed for fertility. Results: It appears possible that many, if not most, women being prescribed letrozole were taking it to improve the odds of getting pregnant, as most were younger women who were prescribed letrozole for 5 or fewer days. Most of the prescribers were OB/GYN providers, or providers who practiced both Endocrinology and OB/GYN. There were a few members (5) with a breast cancer diagnosis and a few members were on continuous therapy, supporting a diagnosis other than fertility, however that was not the majority of claims. Letrozole is not expensive, however its use for treatment of infertility is not consistent with Medicaid policy. Educational Outreach and interventions: A reminder to OB/GYN and Endocrinology providers of the policy to prevent inappropriate Medicaid billing. To ensure compliance with Medicaid policy, a prior authorization on letrozole for patients under the age of 50, effective 6/17/22, will be required to ensure the medication is being used for a covered diagnosis. Implementation of an auto-prior authorization for those with a cancer diagnosis on file. Use of Acute Migraine Medication in Members on CGRP medications, Presented 12/07/2021 Introduction: A newer class of medications, the calcium gene-related peptide receptor antagonists (CGRPs) arrived on the scene in 2018 for migraine prevention. With improvements in prevention, the expectation is that use of medications for acute treatment of migraines will decrease. Methods: Change Healthcare used paid, non-reversed Medicaid pharmacy and medical claims from SFY 2019-2020 (pre-COVID), excluding members with TPL, Part D, VMAP and Healthy Vermonters coverage. Only members with continuous eligibility were included. Using pharmacy and medical claims, they identified members who were taking a long-acting CGRP and identified the prescribing

State	RetroDUR Educational Outreach Summary
	patterns of acute migraine medications for these members as well as their compliance with the long-acting injectables. Although pediatric patients were not excluded from the analysis, CGRPs are not indicated in this population, and all patients were 18 years of age or older at the time of their first CGRP claim. Since medications such as NSAIDs and opioids can be used for many indications aside from migraine treatment, it was decided to limit the analysis of acute migraine medications to triptans. Change Healthcare specifically looked to see if use of acute migraine medication decreased in the 6-months after the initiation of the long-acting CGRP medication compared to the 6-months prior. Results: Total members with at least one CGRP claim between 7/1/18-6/30/20 = 79, Total members with CGRP claim and triptan claim 6 months before or after CGRP claim = 44, Total members with CGRP claim and NO triptan claim 6 months before or after CGRP claim=35. Of those with a Triptan claim (44 members), there were a total of 1,117 triptan tablets filled in the 6 months prior to starting the CGRP and 990 tablets in the 6 months after starting the CGRP, for a decrease in Triptan usage of 11.4%. 13 members (29.5%) had more Triptan doses filled after starting a CGRP, 10 members (22.7%) had an equal number of Triptan doses in both time frames, and 21 members (47.7%) had less Triptan doses after starting the CGRP. A prescription profile review of the 13 members who filled more Triptans after CGRP initiation revealed the following: 7 members changed to a different CGRP suggesting that the initial CGRP was either not tolerated or not effective. 5 members had either a change to their triptan dose or switched to a different triptan (one of these members also changed their CGRP and is included in the above total). 1 member discontinued injectable CGRP therapy. They are currently prescribed Nurtec ODT for acute migraine treatment as well as amlodipine and divalproex (indication for use is unknown). 1 member had nothing in claims history to explain the increase in triptan use. Educational Outreach and interventions: It appears that the initiation of CGRPs in members using Triptans for acute migraine treatment decreased overall usage of Triptans by about 11%, however the usage did not drop in all members. In fact, in some members the quantity of Triptans increased following the introduction of the CGRP medication. The current criteria for re-approval after 6 months requires that the patient have documentation of a decrease in the number of headache days per month or decreased use of acute migraine medications such as triptans. A requirement for renewal of prior authorizations, that providers explain increases in triptan use when requesting the same CGRP be renewed will be implemented.
Virginia	Profile Cycle Month-Year Profile/ Criteria Review Date Criteria Description Total Interventions (Excludes Returned Mail) Total Members (Excludes Returned Mail) Total Responses Average Response Oct-21 Nov-21 CNS Polypharmacy 258 123 5 1.9% Nov-21 Dec-21 High Risk Medications in the Elderly 139

State	RetroDUR Educational Outreach Summary
	120 1 0.7% Dec-21 Jan-22 Opioid Utilization and NO Naloxone Claims 681 449 34 5.0% Jan-22 Feb-22 Antipsychotics in Children 491 422 6 1.2% Feb-22 Mar-22 Aripiprazole without an FDA approved indication in history in the last 180 days 178 159 9 5.1% Mar-22 Apr-22 Nonadherence with Atypical Antipsychotics 75 57 2 2.7% Apr-22 May-22 Prescriber Letter to Enroll in VA Medicaid 103 103 0 0.0% May-22 Jun-22 N/A 0 0 0 0.0% Jun-22 Jul-22 N/A 0 0 0 0.0% Jul-22 Aug-22 N/A 0 0 0 0.0% Aug-22 Sep-22 N/A 0 0 0 0.0% Sep-22 Oct-22 N/A 0 0 0 0.0%
Washington	For FFY 2022 the Agency focused on updates to the single Apple Health Preferred Drug List (AHPDL), used by the fee-for-service (FFS) and all five Managed Care (MCO) pharmacy programs. The pharmacy program, in collaboration, with The Optimal PDL $olution (TOP$) supplemental rebate vendor reviewed utilization data (FFS claims and MCO encounters) and conducted quarterly analysis that resulted in 33 new drug classes being added to the AHPDL and 10 updates to existing AHPDL drug classes. Along with the AHPDL implementation, we developed 18 drug or drug class policies during FFY 2022 (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 open public meetings. The Agency

State	RetroDUR Educational Outreach Summary
	published all meeting materials, finalized AHPDLs and policies on our Pharmacy webpage and sent provider notices announcing the changes. Policies implemented or updated during FFY 2022: 1. ADHD/anti-narcolepsy: Armodafinil/Modafinil 2. Antidepressants: Serotonin Modulators 3. Antidiabetics- GLP-1 Agonists 4. Therapies for COVID-19 5. Dermatologics: Acne Products - Isotretinoin 6. Medication Treatment Guidelines for Substance Use Disorders (SUDs) - Transmucosal Buprenorphine 7. Agents for ALS - edaravone (Radicava) 8. Spinal Muscular Atrophy Agents - risdiplam (Evrysdi) 9. Antineoplastics and Adjunctive Therapies - Imidazotetrazines - Oral 10. Atopic Dermatitis Agents: Dupilumab (Dupixent) 11. Atopic Dermatitis Agents: Crisaborole (Eucrisa) 12. Antivirals: HIV - rilpivirine (Edurant) 13. Antivirals: HIV - Cabotegravir/rilpivirine (Cabenuva) 14. Antivirals : HIV - emtricitabine / tenofovir alafenamide (Descovy) 15. Antivirals- HIV Combinations 16. Cystic Fibrosis Agents (Oral) 17. Spinal Muscular Atrophy Agents - nusinersen (Spinraza) 18. Antihyperlipidemics: PCSK-9 Inhibitors
West Virginia	The RetroDUR Committee looks at prominent disease States (high numbers), most severe diseases (high cost), or ones experiencing the most growth (such as Hepatitis C) in West Virginia. The initiatives identified by the CMS are also incorporated into the review process, for example, antipsychotic use in pediatric patients. Collectively, we make an impact that will improve the health of West Virginians. The Marshall DUR Coalition collaborates with the WV DUR Board and WV DHHR pharmacists to determine criteria they would like to see evaluated. The Marshall DUR Coalition and the WV DUR Board and WV DHHR Pharmacists focus on the specific needs of our State, clinically and pharmacoeconomically. Additionally, we identify patients at risk for opioid abuse and/or overdose. This intervention identifies patients on high-dose opioids and/or concurrent medications which may increase the risk of serious respiratory depression. Concurrent medications of concern are the benzodiazepines and gabapentinoids. Patients on high-dose opioids are screened for concurrent naloxone prescriptions for safety. WV DHHR using CMS guidelines has developed a program to restrict certain patients to a single pharmacy, commonly known as the Lock-In program. This Lock-In program evaluates patients based on history of abuse, evidence of prescriber or pharmacy shopping, and other criteria. Clinicians determine on three courses of action; no letter, a warning letter, or restrict the patient to a single pharmacy, Locked In. Clinical Intervention Program and descriptions: Recognizing that West Virginia has unique health care needs, the Marshall DUR Coalition sought to identify specific clinical interventions that would have the most benefit for WV Medicaid clients as well as cost savings. The following

State	RetroDUR Educational Outreach Summary
	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. 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. 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. 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. 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. 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. 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.

State	RetroDUR Educational Outreach Summary
	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. 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. 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. 11. Diagnosis of Diabetes Mellitus (DM) and Heart Failure with Reduced Ejection Fraction (HFrEF) with a sodium-glucose contransporter-2 inhibitor (SGLT-2). SGLT-2 inhibitors have been clinically shown to reduce the risk of cardiovascular death as well as improve glycemic control in adults with type 2 DM. 12. Diagnosis of Diabetes Mellitus (DM) and Heart Failure without a statin. Patients with DM have a higher risk for Atherosclerotic Cardiovascular Disease (ASCVD) which increases risk for heart attack, stroke, and death. Statins decrease cholesterol to decrease ASCVD and therefore decrease risk for heart attack. 13. Morphine Milligram Equivalents (MME) greater than 50 without Naloxone. Patients using more than 50 MME of a narcotic are more likely to overdose. It is recommended to have naloxone readily available should this occur. 14. Diagnosis of Hepatitis C without treatment. It is recommended that patients testing positive for Hepatitis C should be provided treatment. CLINICAL INTERVENTION FEEDBACK SUMMARY A total of 220 feedback forms were received via fax over the course of the year. Of those 220 faxes, it was found that 114 were marked Useful, 42 were marked Made Changes, 84 were marked No Changes Made, 11 were marked No Longer a Patient, 3 were marked Never a Patient and 13 were marked Notice Not Useful (more than one selection could be made). Population Health Initiative Program Various practitioners, agencies, and institutions identified opportunities to educate health care providers in WV to improve care of the persons in these groups and to reduce costs if possible. The following is a list of the initiatives approved by the DUR Board: 1. Antipsychotics in pediatric patients, total, stratified by age groups <17 CY 2022, 97 members requiring either a letter or locked in and 3 members were locked in.

State	RetroDUR Educational Outreach Summary
	Clinical reviews letter sent= 2306
Wisconsin	Wisconsin Badger Care Plus, Medicaid and SeniorCare Centers for Medicare and Medicaid Services Medicaid Drug Utilization Review Annual Report Federal Fiscal Year 2022 Summary 1: Retrospective Educational Outreach Summary [SUM1-2022-WI-REOS] Prepared by Keystone Peer Review Organization Inc. (KEPRO) June 2023 Executive Summary 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) 2022. 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 Keystone Peer Review Organization Inc. (KEPRO) 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, KEPRO 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 KEPRO 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 KEPRO 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 KEPRO 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

State	RetroDUR Educational Outreach Summary

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 2022, Wisconsin reviewed at least one recipient in each of 490 different criteria. In addition to these standard KEPRO criteria, Wisconsin performs targeted interventions that 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 2022

CRITERIA TYPE	CRITERIA DESCRIPTION	# OF RECIPIENTS SELECTED FOR INTERVENTION	# OF LETTERS MAILED	# OF PRESCRIBER RESPONSES
LI	OVERUTILIZATION OF CONTROLLED SUBTANCES	996	1,643	215
DD	CONCURRENT GABAPENTENOID/CNS DEPRESSANT USE	223	412	42
TA	MULTI-CLASS POLYPSYCHOPHARMACY	169	188	24
DD	CONCURRENT OPIOID/ANTIPSYCHOTIC - SUPPORT ACT	700	1,456	182
ER	APPROPRIATE USE OF IMMEDIATE RELEASE OPIOIDS	103	114	18
TA	SECOND GEN ANTIPSYCHOTICS METABOLIC SCREENING	215	219	28
TA	ANTIDEPRESSANT BEHAVIOR CHANGES IN PEDS/YOUNG ADULTS	147	194	16
TA	MISUSE OF AMPHETAMINES	42	43	6
DD	CONCURRENT USE OF GABAPENTIN/PREGABALIN	903	1,418	187
TD	THERAPEUTIC DUPLICATION OF SKELETAL MUSCLE RELAXANTS	515	845	112

State	RetroDUR Educational Outreach Summary

TOTAL 4,013

6,531 830

RESPONSE RATE 13%

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 KEPRO 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. KEPRO tracks all returned response forms.

Results

Provider Responses to Intervention Letters

A total of 6,531 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 830 responses were received for a response rate of 13%. 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	153
AB	PHYSICIAN UNAWARE OF CONCURRENT USE	13
AE	PATIENT IS NO LONGER UNDER THIS PHYSICIAN'S CARE	55
AF	PHYSICIAN FEELS PROBLEM IS INSIGNIFICANT. NO CHANGE IN TX.	12
AG	PHYSICIAN WILL REASSESS AND MODIFY DRUG THERAPY	86
AI	PATIENT HAS DISCONTINUED OR WILL DISCONTINUE THE DRUG	120
AK	MD DOES NOT DISCUSS DRUG THERAPY CONFLICT	0
AP	PHYSICIAN TRIED TO MODIFY THERAPY; PATIENT NON-COOPERATIVE	18
AS	IS MY PATIENT BUT HAVE NOT SEEN IN MOST RECENT 6 MONTHS	40
AW	PATIENT DECEASED	3
BA	PATIENT NEVER UNDER THIS PHYSICIAN'S CARE	20
BB	PATIENT HAS APPT. TO DISCUSS DRUG THERAPY PROBLEM	107
BE	MD DID NOT PRESCRIBE DRUG ATTRIBUTED TO HIM/HER	62
BG	AWARE OF INTERACTION, MONITORING PATIENT	141
TOTAL RESPONSES		830

Results Discussion

With respect to prescriber responses to RDUR letters, a response rate of 13% was achieved. Approximately 58% of prescribers indicated that some positive

State	RetroDUR Educational Outreach Summary
	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 For FFY 2022, a total of 6,531 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 13% was achieved. In their responses, 58% 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 Board sent letters or comparative reports on the following topics in FFY22: Antipsychotic and opioid use (116) Concurrent use of gabapentin and opioids (22) PDMP Monitoring requirements (34) Hypertension guidelines (105) Diabetic receiving routine labs (16) Narcotic use during pregnancy (2) Statin use and diabetes progression (111) Benzodiazepine utilization (22) GI Side effects and metformin (110) Opioids and sedatives (22) Buprenorphine dental effects (75)

Section IV - DUR Board Activity

1. Does your State have an approved Medication Therapy Management (MTM) Program?

Figure 38 - State has an Approved Medication Therapy Management Program

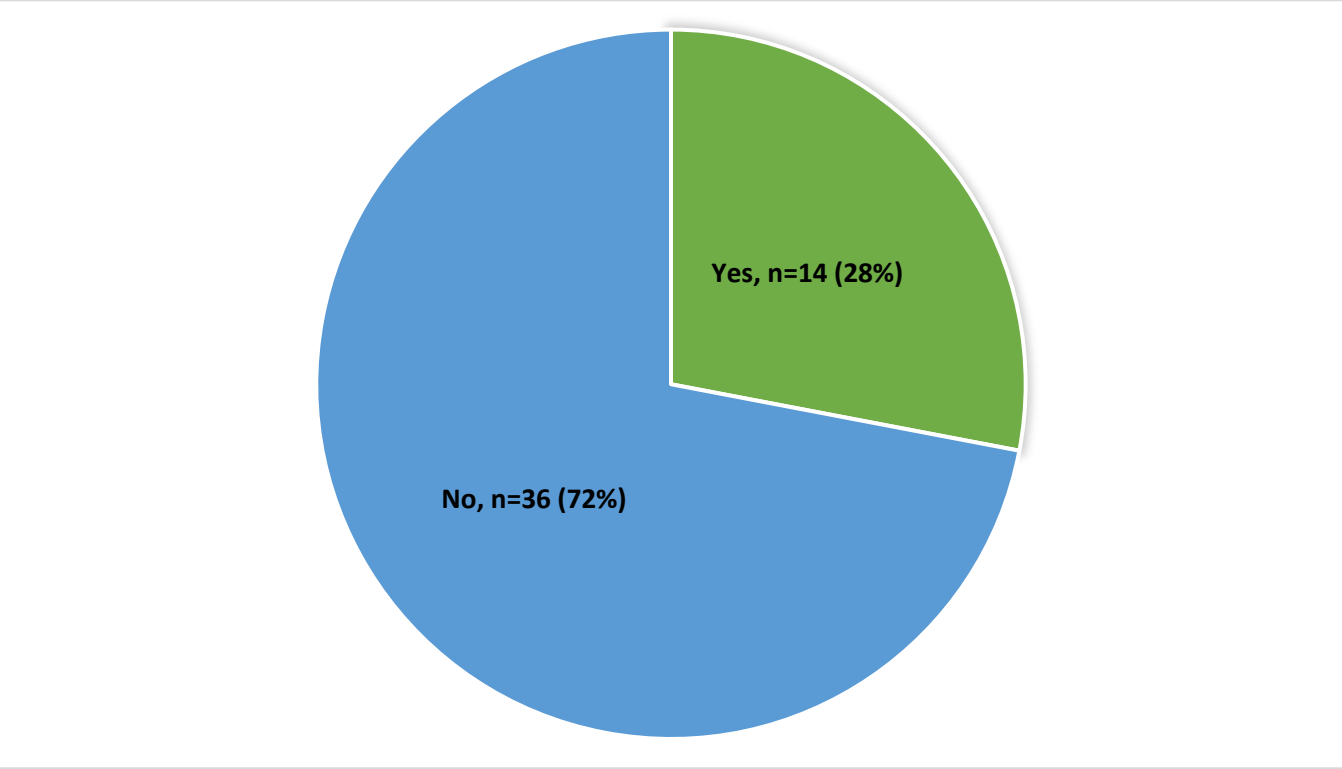

Table 58 - State has an Approved Medication Therapy Management Program

Response	States	Count	Percentage
Yes	California, Colorado, Florida, Idaho, Michigan, Minnesota, Mississippi, Missouri, North Dakota, Oklahoma, Tennessee, Utah, Vermont, Wisconsin	14	28.00%
No	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, 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, Virginia, Washington, West Virginia, Wyoming	36	72.00%
Total		50	100.00%

2. Summary 2 - DUR Board Activities

DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported. Please provide a summary below:

Table 59 - DUR Board Activities Summary

State	DUR Board Activities Report Summary
Alabama	The Alabama Medicaid Drug Utilization Review (DUR) Board held four meetings during the fiscal year 2022. Meetings were held in October 2021 and January, April, and July of 2022. 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 2022. 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 provide 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 2022, 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 Synagis criteria; the Global Initiative for Asthma (GINA) guideline update; American College of Cardiology (ACC) updates to the management of hypertriglyceridemia; updated guidance for the treatment of migraine headaches from the American Headache Society; pharmacy and DME updates related to COVID-19; COVID-19 vaccine billing information (pharmacy and non-pharmacy); COVID-19 monoclonal antibody infusion billing information; pharmacy billing information for COVID-19 over-the-counter tests; guidelines regarding the use of Dispense as Written (DAW) code of 9. During FFY 2022, the DUR Board reviewed prior authorization and override data; RDUR intervention activity summaries; palivizumab utilization. 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

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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 2022 the committee was comprised primarily of 3 physicians and 3 pharmacists, who were licensed and actively practicing health care professionals in the State of Alaska. The DUR committee met five times during FFY 2022 and discussed the following retrospective and prospective criteria: November 2021 Prospective DUR: Interim prior authorization 6 month review Lybolvi (review of criteria) Kerendia (review of criteria) Verquvo (review of criteria) Myalept (review of criteria) Hepatitis C (review of criteria) Lidoderm (review of criteria) Retrospective DUR: Opioids, utilization patterns with benzodiazepines, z-drugs, and antipsychotics, ICD-10 compliance and member MME's Ivermectin and Hydroxychloroquine use was reviewed January 2022 Prospective DUR: Interim prior authorization 6 month review Sphingosine1-Phosphate Receptor Modulator (review of criteria) Opzelura (review of criteria) Inhaled Prostacyclins (review of criteria) Benlysta (review of criteria) Reclast (review of criteria) Prolia, Xgeva (review of criteria) Zylresso (review of criteria) Eucrisa (review of criteria) Nucala (review of criteria) Retrospective DUR: Opioids, utilization patterns with benzodiazepines, z-drugs, and antipsychotics, ICD-10 compliance and member MME's ADHD drug utilization and stimulant criteria ICD-10 compliance March 2022 Prospective DUR: Interim prior authorization 6 month review Ocrevus (review of criteria) Infliximab (review of criteria) Hetlioz (review of criteria) Retrospective DUR: Opioids, utilization patterns with benzodiazepines, z-drugs, and antipsychotics, ICD-10 compliance and member MME's

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	Statin use among diabetics was reviewed. April 2022 Prospective DUR: Interim prior authorization 6 month review Soliris, Ultomiris (review of criteria) Exondus 51, Amondys 45, Vyvondys 53, Viltepso (review of criteria) Krystexxa (review of criteria) Zulresso (review of criteria) tolvaptan (review of criteria) Retrospective DUR: Opioids, utilization patterns with benzodiazepines, z-drugs, and antipsychotics, ICD-10 compliance and member MME's The potential role of Specialized Medication Counseling/Comprehensive Medication Review was reviewed. September 2022 Prospective DUR: Interim prior authorization 6 month review Evrysdi, Spinraza (review of criteria) Soliris, Ultomiris (review of criteria) Dupixent (review of criteria) Mayzent (review of criteria) Opzelura (review of criteria) Oxbryta (review of criteria) Xolair (review of criteria) Benlysta (review of criteria) Myfembree (review of criteria) PPI (criteria retired) Long acting beta agonist (criteria retired) Retrospective DUR: Opioids, utilization patterns with benzodiazepines, z-drugs, and antipsychotics, ICD-10 compliance and member MME's Prospective Drug Utilization Review (ProDUR) The DUR Committee has continued their attention on ProDUR issues during FFY 2022. 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 2022 revolved around COVID 19 and edits made to the POS system. Retrospective Drug Utilization Review (RetroDUR)

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	The DUR Committee conducted retrospective reviews during FFY 2022. 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 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 2022 can be found on the State Medicaid website.
Arkansas	ARKANSAS MEDICAID DUR BOARD ACTIVITIES SUMMARY FFY 2022 The Arkansas Medicaid DUR Board meets quarterly (January, April, July, and October) on the 3rd Wednesday of the month. The Arkansas Medicaid Drug Review Committee (DRC) meets quarterly (February, May, August, and November) on the 2nd Wednesday of the month to discuss preferred drug list changes. The DUR Board is comprised of 15 voting members with 8 pharmacists and 7 physicians. Per Arkansas Act 745 of 2021, 2 rare disease prescribers were added to the Board causing an increased need for pharmacists to keep the required pharmacist to prescriber ratio. Also, the DUR Board contains 6 non-voting members which includes 4 members that represent each MCO, the Department of Human Services Medical Director as an advisor, and a representative 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 4 non-voting members which represent each MCO. Both the DUR Board and DRC meetings are open to the public. During FFY 2022 (effective 10/1/2021 through 9/30/2022), the following therapeutic drug classes were added to the PDL: Alzheimer's agents, hemorrhoidal preparations, antiparkinson's agents, anticonvulsants, and immunoglobulins. During FFY 2022 (updates were effective 10/1/2021 through 9/30/2022), the DRC updated the following therapeutic drug classes on the PDL: benign prostatic hyperplasia, opiate dependence class, skeletal muscle relaxant, beta blockers, neuropathic pain agents, sedative hypnotics, antipsychotics, bowel prep agents, cystine depleting

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	agents/penicillamine agents, and proton pump inhibitors. PDL drug classes are not reviewed annually as supplemental rebate agreements are implemented as a three-year contract. 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 are provided by the contractor quarterly to the DUR Board which includes claims with ProDUR alert overrides along with percentages of claims overridden. MCO ProDUR reports are provided to the Board as well. The DUR Board reviews proposals for prior approval criteria algorithms for drugs covered by the Arkansas Medicaid Pharmacy Program and provides recommendations for approval. 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. The DUR Board approves POS edits based on billed diagnoses, lab values, and previous therapies tried through paid claims on the beneficiary's Medicaid profile. Updates to POS edits for FFY2022 include: --New POS edits for immunoglobulins (IVIG and SCIG) --Quantity edits for anticonvulsants --Dose optimization on various drug classes (diabetes, blood modifiers, blood pressure and cholesterol) --New POS edits for quetiapine (to decrease off-label use) --New POS edits for rescue seizure medications --New POS edits for Diclegis --Update for inhaled steroids including budesonide respules for eosinophilic esophagitis --New POS edits for preferred SGLT-2 inhibitors and GLP-1 receptor agonists --Maximum dose for targeted immunomodulators --Age edits for sedative hypnotics New and updated clinical criteria and edits for FFY2022: October 2021--criteria for hidradenitis suppurativa, update to Synagis criteria based on positivity rate, criteria for Brexafemme, criteria for Rezurock, criteria for Bylvay, criteria for Welireg and criteria for Aemcolo. January 2022--update criteria for Palforzia, criteria for Kerendia, criteria for Tavneos, criteria for Exkivity, criteria for Opzelura, criteria for Scemblix, criteria for Vuity, criteria for Carbaglu, and criteria for Voxzogo

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	April 2022--criteria for Livmarli, criteria for Livtencity, criteria for Tarpeyo, criteria for Apretude, criteria for Leqvio, criteria for Recorlev, criteria for Besremi, criteria for Vonjo, criteria for Pyrukynd, and criteria for Oxervate July 2022--criteria for acute and prophylaxis migraine treatment, updated criteria for Hemlibra, updated criteria for NovoSeven/Sevenfact, updated criteria for FEIBA, criteria for Camzyos, criteria for Vijoice, and criteria for Dupixent for EoE The DUR Board reviews data presented for RetroDUR screening to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. Many interventions include underutilization to ensure the beneficiaries optimize therapy. The RetroDUR program typically provides the following information to the DUR Board: RDUR education intervention topics (voted on by the Board), lock-in report, summary of recent interventions mailed to prescribers, top 25 products by total claims, top products by pharmacy reimbursement, top products by net net expenditures, program summary with cost PMPM, prescriber/pharmacy outliers overall, and opioid prescriber/pharmacy outliers. 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. Therapeutic categories based on SUPPORT Act requirements were reviewed in addition to the Board approved categories for educational intervention for FFY2022. Board approved RDUR criteria included: October 2021--FDA increased warning about complex sleep behaviors with zaleplon, zolpidem, and eszopiclone November 2021--APAP with other meds which may have hepatotoxic side effects December 2021--Tramadol with SSRIs or SNRIs January 2022--Non-compliance with anticonvulsant medications February 2022--Bipolar disorder with antidepressants and no mood stabilizer March 2022 (1)--Members with 6 or more narcotic claims, with risk factors and no claims for naloxone in 180 days March 2022 (2)--Concurrent use of opioids and antipsychotics April 2022--CNS polypharmacy May 2022--FDA Boxed Warning: chronic use of metoclopramide has been linked to tardive dyskinesia June 2022--NSAIDS increase cardiac risk--patients with angina/coronary heart disease July 2022--Metformin is contraindicated in patients with renal impairment August 2022--Concomitant use of opioids and benzodiazepines September 2022--CNS stimulants may retard growth in pediatric patients ages 4-10 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

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	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. Quarterly newsletters are also posted online the contractor website and emailed directly to prescribers and pharmacists. Newsletters contain information on status of new drugs on the market, policy updates, treatment recommendation for a selected disease State, and other general Medicaid information that is important at that time.
California	The DUR Board met four times during FFY 2022. Due to the coronavirus disease 2019 (COVID-19) pandemic, three meetings were abbreviated, and two meetings were webinar-only meetings. Prospective DUR Criteria Presented Review of new Generic Code Number (GCN) sequence numbers: The DUR Board recommended turning on additional alerts for 19 new GCNs that matched drugs appearing on the Medi-Cal target drug list for prospective DUR. Retrospective DUR Criteria Presented Review of Retrospective DUR Criteria: New Additions to the Medi-Cal List of Contract Drugs in FFY 2020. During the Federal Fiscal Year 2020 (between 10/1/19 and 9/30/20), there were a total of 42 new prescription medications added to the CDL. Utilization data (total number of paid claims and utilizing beneficiaries with at least one paid claim) were reviewed for each of these drugs during the period between 1/1/19 and 08/31/21. Twenty-four of these drugs had lower utilization (< 100 utilizing beneficiaries during all months reviewed and were not reported in detail. Utilization was reported over time for polyethylene glycol 3350 and electrolytes, polyethylene glycol 3350, methylprednisolone, lactulose, apixaban, benzonatate, lisinopril/hydrochlorothiazide, dulaglutide, cyclobenzaprine, methocarbamol, tizanidine HCl, glucagon (synthetic), atomoxetine HCl, rizatriptan, mycophenolate mofetil, sirolimus, tacrolimus, and pregabalin. Naloxone: A poster presentation summarizing the legislative impact on the utilization of naloxone was shared at both the 24th Annual UCSF Department of Clinical Pharmacy Spring Research Symposium and the 2022 American College of Clinical Pharmacy Virtual Poster Symposium. This study was based on research completed for the DUR educational article published in December 2021. The results of the study found that the highest percentage of pharmacist-furnished naloxone (22.8%) occurred during the 2nd quarter of 2020 early in the COVID-19 pandemic after the stay-at-home order was issued. Also, the number of counties in California with at least one paid claim for naloxone increased from only 29 in 2015 to almost all counties (56 out of 58) by 2019. While some beneficiaries did receive multiple paid claims for naloxone over time, the majority (82%) had only one paid claim for naloxone between January 1, 2015, and September 30, 2021. Anticholinergic Medications: An evaluation was conducted to determine if there has been an increase in long-term use of anticholinergic medications in the Medi-Cal population. The report found that between August 2019 and September 2021, over half of Medi-Cal beneficiaries (63%) taking anticholinergic medications were on anticholinergics for more than half the year, and 28% were on them for the entire measurement year. This was despite an 11% decrease in utilization of 1st-generation antipsychotic medications with a higher propensity for antipsychotic-induced extrapyramidal symptoms (EPS). It was

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	recommended to prioritize the retrospective DUR review of antipsychotic polypharmacy in adults and establish a comprehensive baseline of antipsychotic use in the Medi-Cal population, including an analysis of ProDUR therapeutic duplication (TD) alerts generated due to antipsychotic polypharmacy in adults. Childhood Vaccines: The COVID-19 pandemic has resulted in substantial disruptions to outpatient medical care and routine childhood vaccinations. In comparison to April 2019, in April 2020, the number of shots given to children 0 through 18 years old in California decreased by more than 40%. In response to this, the California Immunization Coalition (CIC) and CDPH started the #DontWaitVaccinate campaign, which includes social media messages, talking points, template letters and other tools to encourage patients to reconnect with their providers. The Board recommended continuous monitoring of Medi-Cal vaccination rates, especially among children and adolescents under 18 years of age and routine review of Medi-Cal vaccination policy, especially the ongoing administration and utilization of COVID-19 vaccines. Gabapentinoids: An evaluation was conducted to determine the total number of beneficiaries with at least one paid claim for gabapentin between December 2019 and December 2021. The report found that gabapentin prescribing increased by 13.4% in two years, compared with an overall increase in the eligible Medi-Cal population of 7.5% during this same time. The evaluation also found an 11.5% decrease in the percentage of continuously eligible FFS beneficiaries with concomitant use of gabapentin and any opioid medication, and a 2.7% decrease in the percentage of continuously eligible FFS beneficiaries with concomitant use of gabapentin, any opioid medication, and two additional CNS depressants. These data, in combination with data showing a 2.5% decrease in the percentage of continuously eligible FFS beneficiaries with an FDA-approved indication for gabapentin, indicate that gabapentin may be increasingly used off-label as a substitute for opioid pain medication instead of being prescribed concomitantly with opioid pain medication. Overall utilization of both gabapentin and pregabalin continues to increase without a corresponding increase in any conditions in which gabapentinoids are FDA-approved to treat. An additional evaluation was conducted to determine if there was a change in pregabalin use relative to the addition of pregabalin to the Contract Drugs List on September 1, 2020. a review of pharmacy claims data found that the total number of paid claims for both pregabalin and gabapentin through October 31, 2021, exceeded the total number of paid claims for all of 2020. It was recommended to continue to monitor CNS polypharmacy and use of gabapentinoids in the Medi-Cal population. Physician Administered Drugs (PADs): 2021. A retrospective review of paid claims for physician-administered drugs was presented for the calendar year of 2021. These data were presented in three tables: 1) the top 20 drugs by total reimbursement paid to pharmacies, 2) the top 20 drugs by utilizing beneficiaries, and 3) the top 20 drugs by reimbursement paid to pharmacies per utilizing beneficiary. Fluoroquinolones: An evaluation was conducted to determine if there has been a change in the appropriate use of fluoroquinolones among Medi-Cal beneficiaries. The evaluation found that between April 2020 and April 2022, there was a 30% decrease in community-dwelling FFS beneficiaries being prescribed a fluoroquinolone. Potentially inappropriate use of fluoroquinolones decreased from 57% to 8% in the FFS population and 13% in the MCO population. It was recommended to continue monitoring antibiotic use in the Medi-

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	Cal population (both FFS and MCO populations). Additionally, it was recommended that MCO plans review prescribing data for fluoroquinolones and provide educational interventions to prescribers when appropriate. Hepatitis C Virus (HCV) Diagnoses and Treatment: An evaluation was conducted to determine the prevalence of HCV infection in the Medi-Cal population and the percentage of beneficiaries with a diagnosis of HCV infection that initiate treatment, stratified by beneficiary region of residence in California. The study population included all Medi-Cal beneficiaries with a diagnosis code for chronic HCV with a date of service between October 1, 2020, and September 30, 2021. The evaluation found that glecaprevir/pibrentasvir and sofosbuvir/velpatasvir continue to be the top medications by total utilizing beneficiaries. While the total number of beneficiaries diagnosed with chronic HCV increased 30.6% from FFY2020 (78% among FFS [n = 4,973] and 27% increase among MCP enrollees [n = 47,927]), this was still 15.4% less than were diagnosed in FFY2019. This decrease was exclusive to beneficiaries enrolled in an MCP, as the number diagnosed among FFS beneficiaries was higher in FFY2021 in comparison with both FFY2020 and FFY 2019. These data were consistent across regions. Additionally, while the regional variation in treatment was similar to the prior year, ranging from a low of 3.2% (FFS in Fresno region) to high of 11.2% (MCP in San Francisco region), the overall rate of beneficiaries treated for chronic HCV infection was down 21.6% from FFY2020. For FFS enrollees there was a 6% decrease in treatment rate and for MCP enrollees there was a 23% decrease in treatment rate. It was recommended that additional review was completed to identify treatment barriers and solutions to low treatment rates. It was also suggested that the DUR program should create a DUR bulletin on new simplified algorithms from the AASLD-IDSA and/or provider mailing be drafted as an educational intervention to improve treatment initiation among Medi-Cal beneficiaries. 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: Improving the Quality of Care: Legislative Impact on the Use of Naloxone Professional Organizations Push for Recall of Buprenorphine Dental Warning Submitting Quality Data to the California Immunization Registry (CAIR2) Provider intervention letters: Clozapine REMS Bosentan Buprenorphine Dental Warning Naloxone Provider Letter Naloxone Pharmacy Letter Ongoing DUR Board projects: Advise DHCS on updates/additions to existing Drug Utilization Review reports through Medi-Cal Rx Promote dialogue and collaboration with MCOs Conduct DUR activities after full implementation of the SPA for the SUPPORT Act

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	Focus on the top three DUR priority areas established in 2018-2019, using the new capabilities available once Medi-Cal Rx is implemented Engage with DHCS on programs related to DUR activities
Colorado	Number of DUR Board meetings held: Four virtual DUR Board meetings were held during FFY 2022: November 9, 2021; February 11, 2022; May 10, 2022; August 9, 2022 Summary of additions/deletions to DUR Board reviewed criteria (including problem type/drug combinations added or deleted for ProDUR and therapeutic categories added or deleted for RetroDUR): November 9, 2021 Summary: -- New therapeutic classes added to the PDL: Oral Human Immunodeficiency Virus (HIV) Agents (although agents in this therapeutic class remain unmanaged); Systemic Juvenile Idiopathic Arthritis (sJIA) added to Targeted Immune Modulators class -- Criteria deleted: Hepatitis C requirements for HCV genotype/subtype testing, HCV RNA test post-Hepatitis C treatment, pregnancy testing, hepatitis A and B vaccination, specific therapeutic lab testing, and drug interaction screening -- New criteria were developed for the following medications: Ilaris (canakinumab); Infliximab (Remicade and biosimilar products); Entyvio (vedolizumab); Stelara (usetekinumab) IV injection; ACTEMRA (tocilizumab); Crysvita (burosumab); Brexafemme (ibrexafungerp); Afinitor Disperz (everolimus); Cystadrops (cysteamine hydrochloride) and Aemcolo (rifamycin) -- Criteria were updated for the following medications: Revatio (sildenafil) oral suspension, Stelara (ustekinumab) syringe for subcutaneous use, Spiriva Respimat (tiotropium) 2.5 mcg, Uceris (budesonide ER) tablet; Otrexup, Rasuvo and Xatmep (methotrexate) February 8, 2022 Summary: -- New therapeutic classes added to the PDL: None -- Criteria deleted: None -- New criteria were developed for the following medications: Eysuvis and Inveltys (loteprednol etabonate); Livtencity (maribavir); Nexviazyme-ngpt (avalglucosidase alpha); Voxzogo (vosoritide) and Saphnelo (anifrolumab) -- Criteria were updated for the following medications: Nucynta (tapentadol); Xolair (omalizumab); TYRVAYA (varenicline); calcitonin gene-related peptide inhibitors (CGRPIs); oral triptans and multiple sclerosis agents May 10, 2022 Summary: - New therapeutic classes added to the PDL: Other Agents (including podofilox and imiquimod) added to the Topical Immunomodulators class - Criteria deleted: Bevyxxa (betrixaban)

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	- New criteria were developed for the following medications: Opzelura (ruxolitinib); Veregen (sinecatechins); Zyclara (imiquimod); compounded products; Xarelto (rivaroxaban) oral Suspension; Besremi (ropeginterferon alfa-2b); Vyvgart (efgartigimod alfa); Leqvio (inclisiran); Adbry (tralokinumab-ldrm); Isturisa (osilodrostat); Recorlev (levoketoconazole) and Dojolvi (triheptanoin) - Criteria were updated for the following medications: Entresto (sacubitril/valsartan) and Brilinta (ticagrelor) August 9, 2022 Summary: - New therapeutic classes added to the PDL: None - Criteria deleted: None - New criteria were developed for the following medications: Baqsimi (glucagon); Zegalogue (dasiglucagon); Pyrukynd (mitapivat); Vijoice (alpelisib); Camzyos (mavacamten); Tepezza (teprotumumab); Ultomiris (ravulizumab); Nplate (romiplostim); Vyepti (eptinezumab); Lumizyme (alglucosidase alfa); Lemtrada (alemtuzumab); Eylea (aflibercept) - Criteria were updated for the following medications: Afrezza (human insulin); Steglatro (ertugliflozin); Benlysta (belimumab); Nexviazyme (avalglucosidase); Ocrevus (ocrelizumab); Tysabri (natalizumab) Description of policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens: 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/adolescent members). Description of 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, including the number of members with opioid claims resulting in a cumulative MME > 200. 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). Description of DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.): The DUR Board reviews metrics associated with RetroDUR educational interventions (member-specific educational letters mailed to providers) during each quarterly meeting. Two educational DUR newsletters were published online during FFY 2022 (December 2021 and June 2022). The DUR Board is not directly involved in the development of these newsletters, although individual Board members are often included in biographical Spotlight articles. Newsletters are also directly distributed to Board members and other key DUR stakeholders by email. A library of recent Colorado DUR Newsletters is available at https://hcpf.colorado.gov/drug-utilization-review-board.

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	Description of 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 prepared by the University of Colorado Skaggs School of Pharmacy (see Colorado Summary 5: Innovative practices). Recent educational letters mailed to providers have included high risk psychotropic prescribing in members less than 18 years of age, cumulative MMEs greater than 150 with no claim for naloxone within the past 12 months, concomitant claims for opioid/skeletal muscle relaxant/benzodiazepine combinations, and evidence of overlapping claims for two or more benzodiazepines.
Connecticut	Summary 2 is a brief descriptive report on DUR Board activities during FFY 2022. This summary should: - Indicate the number of DUR Board meetings held. Four DUR Board meetings were held during FFY 2022; December 2021, March 2022, June 2022, and September 2022. See link below for meeting minutes. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf DUR BOARD MEMBERSHIP - 10/01/2021 to 12/31/2021 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 DUR BOARD MEMBERSHIP - 1/01/2022 to 06/30/2022 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, Lacey Whitmire, M.D. DUR BOARD MEMBERSHIP - 7/1/2022 to 09/30/2022 Keith Lyke, R.Ph. (Interim-Chair), Dennis Chapron, M.S., R.Ph., Richard Gannon, Pharm.D., Bhupesh Mangla, M.D., MPH., Ram Illindala, M.D., Carol Drufva, R.Ph., Angela Boggs, Pharm.D. BCPP, Lacey Whitmire, 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 2022 by the DUR Board.

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	2. For retrospective DUR, list therapeutic categories added or deleted. See recommended criteria below. - 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, Kepro 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.

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	The criteria reviewed by the DUR Board during FFY 2022 are included in Summary 2 including which criteria were approved, tabled, or rejected. Four educational newsletters were mailed to targeted prescribers and pharmacies during FFY 2022. See link below for DUR newsletters. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Newsletters.pdf
Delaware	Delaware held its DUR Board meeting virtually again this year. 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 28, 2022. Both managed care organizations' pharmacy directors, which represent the majority of the Medicaid population in Delaware, participated in the DUR/P&T committee meeting. This year the DUR Board reviewed the criteria for Hepatitis C treatments that are preferred on the PDL and recommended removing the Prior Authorization requirement for those preferred agents with a quantity limit of one treatment course per year. Requests for multiple treatment courses within the same year will still require a Prior Authorization. This change will be effective on 1/1/2023 and provider education will take place to notify of the change and encourage increased treatment within this population. The Board also recommended removing clinical Prior Authorization requirements for some preferred Constipation Agents due to low utilization of these products. And in response to the SUPPORT Act requirements, the DUR board continues to discuss and ensure that FFS and managed care programs have continued with implementation of claims review requirements of safety edits, maximum daily morphine milligram equivalent safety edits, and concurrent utilization alerts.
District of Columbia	The District of Columbia Drug Utilization Review Board meets once monthly. All twelve (12) meetings were held virtually during FY22 due to COVID pandemic restrictions in place in the District and to maximize member participation. The DHCF MTM clinical pharmacist reviews and evaluates potential Lock-in candidates with the PBM pharmacy staff prior to presentation to the DUR Board members. Coordination of Lock-in program activities with the Medicaid managed care plans has evolved into an automated monthly file being distributed to each MCO to promote continuity of care and status for lock-in program participants. In accordance with District policy, the DUR Board offers recommendations for the development of drug specific prior authorization (PA) forms used by the Pharmacy Benefit Management team. The PA form will usually contain questions and information that address several retrospective DUR concerns: e.g., the collection of required laboratory value results to aid in the pre-screening of patients for appropriate dosage adjustments where warranted by abnormal hepatic or renal function. The DUR Board reviewed 300 patient profiles each month to determine if a provider should receive an educational mailing intended to update/remind prescribers of current medication therapy practice guidelines.

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	However, where available, some patient appropriate materials may be included with information mailed to physicians. Board members voted to model a new method to improve medication use disparities in healthcare. The Board pays close attention to published clinical studies that reflect and report on the proportion of demographic groups within the disease or condition that align with the District's Medication population mix. During FY22, the MCO Pharmacy Directors made three quarterly presentations to the DHCF DUR Board on the MCOs respective DUR activities including Paxlovid dispensing policy, sickle cell disease treatment protocol oversight, monitoring of oral oncology medications and adherence to SUPPORT Act DUR requirements. October 2021-The Board examined utilization reports prepared in response to SUPPORT Act requirements for FFS patients impacted by MME editing 1385 patients were impacted over the last fiscal year due to greater than 90 daily MME per day or greater than 7 days supply. Of those, only 315 received prior authorization. Of those 315, only 11% received daily dose over 90 MME. FFS naloxone claims review showed 216 paid claims for naloxone and of those only 86 have claims related to opioids. Of those, only 70 have prior authorizations for a medication that can be tied to the possible need for naloxone. The Board approved an update to the clinical criteria for Aristada (aripiprazole lauroxil) in response to a recommendation from the Clinical Call Center pharmacist manager. Existing language that required females of reproductive age to be using a contraceptive was changed to prescriber should advise pregnant woman of potential fetal risk since there is no reference to contraceptive use in the package insert. There is a screening question present on the PA form. November 2021 SUPPORT Act MME edits monitoring reported only 1 patient with concomitant opioid/amphetamines, 52 patients with concomitant opioids/antipsychotics, 31 patients with concomitant opioid/benzodiazepine, 11 patients with concomitant opioid/naloxone. December 2021 The Board reviewed utilization of Sickle Cell pharmacy and medical claims for the year 2021 identifying 30 unique beneficiaries with Sickle Cell Anemia related prescriptions. Of these 30 patients, 22 identified with medical claims for SCD. 29 patients (97%) with claims for Hydroxyurea which meets the standard of care. There were 2 patients (7%) with claims for Oxbryta -including one patient on both meds. January 2022- MCO Pharmacy Directors reported at the January DUR Board meeting on observed changes in Lock-in program candidate lists after implementation of the polypharmacy exclusion list updates. Each MCO shared their adherence rates for oral oncolytic treatment regimens (including methotrexate) measured over period 1-1-2021 to 12-31-2021. They also identified medications not captured at the pharmacy POS (e.g., HIV antiretrovirals, PAD specialty drugs covered under the medical benefit) that were not subjected to prospective utilization review. The Board co-sponsored a CE/CME program entitled New Era of Sickle Cell on January 24, 2022 that was open for participation by physicians, pharmacists, and nurses. February 2022- The Magellan PDL clinical pharmacy team provided Board members with an overview of the Rx Therapeutic Class Reviews (TCR) they present to the DHCF P&T Committee to provide recommendations for preferred drugs in each reviewed therapeutic class. The presentations include drug package insert and clinical trials data for special populations. Prevalence/incidence related to race or ethnicity is also included when data is available in the clinical trial information provided by the manufacturer.

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	Utilization of specialty drugs used to treat Rheumatoid Arthritis was reviewed by using 2021 medical claims for 23 FFS patients. Medical claims with ICD-10 codes M.05 and M.06 were selected for review with 3 beneficiaries using Enbrel and 4 using Humira. Hydroxychloroquine and methotrexate have the highest utilization as shown by pharmacy claims for this period. March 2022 One beneficiary was identified for inclusion into the pharmacy Lock-in program. The Board approved the Lock-in recommendation. April 2022 Benlysta clinical criteria language was updated to highlight the limitations of evidence of efficacy in African American females, and requiring acknowledgement that the prescriber has shared this information with appropriate patients. This recommendation was approved by the Board. May 2022 MME edits and SUPPORT Act reports review of opioid concomitant therapy utilizers Opioids and benzos: 65 claims for 28 patients Opioids and antipsychotics: 198 claims for patients Opioids and benzodiazepines: 4 claims for 2 unique patients Opioids and naloxone: 14 claims for 8 unique patients No pediatric patients identified. June 2022- Continuous Glucose Monitoring criteria was reviewed by the Board. Current utilization information was requested to see if grandfathering of some patients is necessary and send notification to prescribers that changes in coverage are occurring. Motion to approve grandfathering provision for existing patients. MME edits and SUPPORT Act reports review SUPPORT Act Summary Report Opioids and Benzos Concomitant Therapy: 95 claims for 33 unique members Opioids and Antipsychotics Concomitant Therapy: 190 claims for 47 unique members Amphetamines / Opioids concomitant use: 1 claim Naloxone / Opioids concomitant use: 25 claims for 16 unique members Pediatrics patients: None July 2022 Paxlovid prescribing protocol monitoring was a topic of discussion. An analysis of FFS utilization showed 33 paid claims since January 2022. MCO and FFS PA criteria is same for quantity limits with the claim only paying the dispensing fee. Claims analysis identified low utilization for mild to moderate COVID. There is an education gap for prescribers, hesitancy over drug adverse profile, and disparity. Concern was raised whether the pharmacy asks the appropriate questions regarding Drug-Drug interactions and renal function. August 2022 Prior authorization criteria and forms were approved for Apretude. Cabenuva clinical criteria was updated to remove an oral lead in requirement, and new indications were added to the Hetlioz criteria. September 2022 The Pharmacy Director of each Medicaid MCO presented to the Board on the following DUR related topics.

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	Describe benefit coverage of Paxlovid, including handling of prescribing by Pharmacist. What is your Provider Status policy? i.e., are Pharmacist recognized as providers, provided reimbursement for services, and if so, what services are reimbursed? Provide an update on Sickle Cell Treatment Utilization. Provide an update on Antiretroviral Utilization and are any patient interventions or outreaches performed from the use of the DHCF HIV File. James Taylor, MD, renowned hematologist, and Chair of the Sickle Cell Center of Excellence at Howard University joined the Board for the Sickle Cell treatment utilization discussion and provided feedback on MCO performance.
Florida	The Drug Utilization Review (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.

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	The Florida Medicaid DUR Board met four times during the Federal Fiscal Year 2022. 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: 1. Review the top 20 therapeutic classes by claims volume and expenditure to identify appropriate therapies and intervention opportunities including an in-depth review of the miscellaneous class. The DUR Board reviewed a year-to-year comparison to monitor therapeutic class trends. 2. Review utilization of antipsychotic medication in children. As required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, the DUR Board reviewed utilization of antipsychotic medication in children during the December 2021 DUR Board meeting. 3. Review trends in opiate recipients that received naloxone and had an emergency room visit for opiate overdose. During the December 2021 DUR Board meeting, the DUR Board reviewed safety outcomes for recipients that had an opiate overdose. 4. Review recipients receiving gabapentin without a supported indication for use in their health conditions. During the December 2021 DUR Board meeting, the DUR Board reviewed recipients on gabapentin without a supported indication for use in their health conditions. 5. Review utilization trends for sickle cell therapy. During the December 2021 and March 2022 DUR Board meeting, the DUR Board discussed sickle cell therapy utilization related to hospital admissions and health outcomes. 6. Review the post-impact of the Lyrica automated prior authorization. During the December 2021 DUR Board meeting, the DUR Board reviewed the post impact of the Lyrica automated prior authorization (based on FDA approved indications). The edit deployed on 12/04/2020. 7. Review utilization of COVID-19 vaccines. During the December 2021 DUR Board meeting, the DUR Board reviewed utilization of COVID-19 vaccines. 8. Review Chantix utilization, denials, and retreatment. During the March 2022 DUR Board meeting, the DUR Board reviewed Chantix utilization over the last 5 years and agreed with the updated criteria. 9. Review opiates and antipsychotics overlap. During the March 2022 DUR Board meeting, the DUR Board reviewed recipients on opiates and antipsychotics concomitantly as required by the SUPPORT Act. There is currently a soft edit deployed to monitor/manage use of concomitant therapy. 10. Review long-acting opiates and benzodiazepine overlap. During the June 2022 DUR Board meeting, the DUR Board reviewed recipients on long-acting opiates and benzodiazepines concomitantly. There is currently an edit in place to monitor/manage use of concomitant therapy.

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	11. Review Hepatitis C treatment utilization over 7 years. During the September 2022 DUR Board meeting, the DUR Board reviewed Hepatitis C utilization over 7 years and reviewed retreatment trends. 12. Review recipients that received more than one influenza vaccine per season. During the December 2021 DUR Board meeting, the DUR Board reviewed recipients than received more than one influenza vaccine per season. The DUR Board requested a review of pharmacy outliers. 13. Review glucocorticoids inhaled therapy. During the March 2022 DUR Board meeting, the DUR Board reviewed glucocorticoids inhaled therapy for utilization and expenditure trends. 14. Review therapeutic class utilization and expenditure. During the June 2022 DUR Board meeting, a guest speaker from the Pharmaceutical & Therapeutics (P&T) Committee spoke to the DUR Board regarding therapeutic class expenditure and PDL procedures. 15. Review utilization of Entresto. During the September 2022 DUR Board meeting, the DUR Board reviewed Entresto utilization by dosage. The DUR Board will continue to review topic. 16. Review utilization of systemic contraceptives. During the September 2022 DUR Board meeting, the DUR Board reviewed systemic contraceptive utilization including a review of utilization by age. Summary of additions/deletions to DUR Board approved criteria: The DUR Board reviewed Chantix utilization and agreed upon updated criteria. The DUR Board approved the proposed growth hormone criteria changes with the addition of the gastroenterologist is limited to adults with short bowel syndrome. The DUR Board reviewed the Hepatitis C criteria and voted to remove the sobriety requirements (urine drug screening) while adding Statement that the patient is referred to substance use disorder treatment or counseling within the retreatment criteria.
Georgia	4 DURB meetings were conducted on the following dates in 2022: Tuesday, February 1; Tuesday, May 3; Tuesday, August 2; Tuesday, November 1. -New drugs reviewed included: Brexafemme Kerendia Saphnelo Aduhelm Lybalvi Myfembree Opzelura Skytrofa Tyrvaya Apretude Leqvio Qulipta Tezspire Vabysmo Xipere Adbry Cibinqo Ibsrela

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	Winlevi 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/2022-durb-meeting-information
Hawaii	One teleconference DUR Board meeting was held in FFY 2022. For proDUR, controlled substance quantity limits for the dental FFS formulary was added. RetroDUR therapeutic categories reviewed were Hepatitis C, immunosuppressants, opioids, benzodiazepines and psychotropics. The DUR Board policies for proDUR are patient safety and access to medically necessary COD regarding changing guidance from FDA, CMS, CDC and Hawaii Law. For example, the dental FFS formulary narcotic proDUR screenings were sufficient for the population under 21 years of age. RetroDUR found quantities usually lower, and no PAs were requested. Hawaii law enacted in 2021 allows adult (21 years and older) dental care by Medicaid beginning January 2023. Planning for their inclusion into the dental FFS program an adjusted retroDUR screen for age 21 years and over, hydrocodone/acetaminophen use, in MCOs and for outliers >120 MME was used. Clinical standards and specific population outcomes in the diverse Hawaii demographics guide the DUR Board policy for retroDUR. For example, retroDUR screening for location of adult outliers with >120MME also finds less Medicaid participating dental providers in specific areas. Adjusting proDUR screenings for quantity limits was evaluated for the whole State with consideration of the specific areas, empowering dental providers to limit the drug seeking recipients access. The direction of DUR education is recommended by the DUR Board. Each member's involvement with the community and other providers is valuable for best practices and shared communications. Provider memorandums and provider bulletins are standards continued to be used. Specific program population determines patient (dental versus transplant) intervention type. Dental currently covers the population under 21 years of age for antibiotic, analgesic, inflammation and fluoride. Acute or annual care decreases patient contact. Provider intervention is preferred via provider memorandum, provider bulletin and phone calls. For the transplant program, case managers support with counseling the patient and monitoring of transplant drugs. With more patient contact, a greater number of interventions are possible with one-on-one interaction. Provider intervention by phone call is preferred.
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 14,2021 January 20,2022 April 21, 2022 During FFY22, the following RetroDUR activities were performed on behalf of the Idaho DUR Board: Hemophilia DUR Use of Anticonvulsants in Idaho Medicaid Children

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	COVID-19 Update Emicizumab-kxwh DUR Opioid Analgesics Impact of Opioid Prescription Duration Substance Use Disorders in Pregnancy Buprenorphine for OUD Prescribing Trends Esketamine Nasal Spray Concurrent Benzodiazepines with Sedative Hypnotics Benzodiazepine Prior Authorization Medications for Type 2 Diabetes: Discussion for Utilization Review Process COVID-19 Vaccinations COVID-19 Drug Treatment Utilization Quetiapine: Diagnosis, Use and Misuse, Dosing 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, 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 three meetings during FFY22. A fourth meeting was canceled due to lack of quorum. 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 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 FFY22, the following prospective edits were discussed or implemented:

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	- August Synagis start during atypical inter-seasonal respiratory syncytial virus (RSV) spread - Ivermectin prior authorization for all indications - Continuous glucose monitoring (CGM) - Pharmacy-based COVID-19 related services - Imported apo-varenicline during Chantix shortage - Pharmacist prescribed oral antivirals for COVID-19 - Opioid and benzodiazepine initial days supply edits. The Illinois DUR Board addressed the following drug classes and issues retrospectively during FFY22: - First-line therapy in patients taking alprazolam - Dental patients filling multiple short days supply opioid prescriptions - Naloxone prescriber outreach for patients receiving high opioid MME prescriptions - Tramadol and codeine utilization - Historic naloxone fills - Antidiabetic medications and Type 2 diabetes mellitus (T2DM) comorbidities - RetroDUR 300 - Concomitant incretin mimetic therapy. The DUR Board and Drug Utilization Review Web pages continued to be used as educational vehicles for providers during FFY22. Educational interventions and outreach are implemented based on what may be the most appropriate and most feasible to implement for a given drug utilization topic. The following educational topics were discussed and/or links approved for posting for providers on the Drug Utilization Review Web site: - FAQ- Can chronic opioid use cause endocrinopathies? - Prescriber letter: naloxone, high MME - Concomitant GLP1-RA and DPP4-i - Illinois ADVANCE: new resource for prescribers.
Indiana	DUR Board meetings are held monthly. Ten meetings were held during FFY 2022. Due to the COVID-19 pandemic, meetings have been held virtually. For prospective DUR, the DUR Board focuses on three major initiatives: SilentAuth applications, prior authorization criteria, and mental health medication utilization edits. During FFY 2021, 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, antiseizure agents, antipsychotic agents, SSRI/SNRIs, pulmonary antihypertensives, cystic fibrosis inhaled agents, hematinic agents, Sandostatin®, Soriatane®, topical immunomodulators, antimigraine, and sedative-hypnotics/benzodiazepine agents. The DUR Board reviewed and approved the following new and updated manual prior authorization criteria: hepatitis C agents, cystic fibrosis inhaled agents, hepatitis B agents, antimigraine agents, pulmonary antihypertensive agents, PCSK9 inhibitors and select lipotropics, miscellaneous cardiac agents, miscellaneous step therapy, spinal muscular atrophy agents, Sickle Cell agents, Cushing's Disease agents, growth hormone, allergy specific immunotherapy, Mepron®, narcolepsy agents, Oxervate®, testosterones, uterine disorder agents, Vyndaqel® and Vyndamax®, Aduhelm®, somatostatin analogs, Carafate® and Cytotec®, Fentanyl®, presbyopia agents,

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	treatments for dry eye disease or keratoconjunctivitis, and muscular dystrophy agents. 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 retroDUR were added or deleted during the reporting period. Analyses of both proDUR edits and retroDUR 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 Optum Rx 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), proDUR and retroDUR 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 retroDUR programs are reviewed and approved by the DUR Board. These documents are posted publicly online for review and referenced in retroDUR 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	Number of DUR Board Meetings held: 4 out of 4 scheduled 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. Retrospective DUR: Currently, the Board does not review the Retrospective DUR criteria used for patient profiles. Change Healthcare utilizes MediSpan for retrospective DUR criteria involving a complex screening process. Proposed retrospective problem-focused initiatives are brought to the Board for consideration, input, and review of proposed parameters. The Board can make a recommendation to proceed with the initiative, modify initiative, or not proceed with the initiative. 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. 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

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	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 Board develops and distributes a newsletter two times annually. The Board also maintains a web site, www.iadur.org.
Kansas	There were four DUR Board meetings in FFY 2022. OCTOBER 1, 2021 DUR BOARD MEETING: Agenda items and Key changes Ankylosing Spondylitis Agents - Addition of Taltz. Crohn's Disease Agents - Addition of Avsola, clarifications regarding dosing limitations, and an allowance for alternative dosing based on therapeutic drug monitoring. Ulcerative Colitis Agents - Review of all agents, addition of a warning for JAK inhibitors, plus an update to the criteria to allow for dose modifications based on therapeutic drug monitoring. Migraine Prophylaxis Agents- Addition of Qulipta and corrected dosing frequency for Vyepti. Synagis- Added language to allow for expanded coverage based on the Centers for Disease Control and Prevention (CDC) reports on respiratory syncytial virus (RSV) activity in the State. Multiple Sclerosis- Addition of Ponvory and clarification regarding the applicability of the PDL PA Statement due to Zeposia's lateral approval for ulcerative colitis (UC).

State	DUR Board Activities Report Summary
	Non-Preferred PDL PA Criteria - Addition of a list of PDL drug classes no longer requiring annual PDL PA renewal. Oncology Agents - Addition of several drugs to the list of agents requiring prior authorization. Oncology - Auxiliary Treatment Agents - Addition of several drugs. Enzyme Replacement Therapy- Addition of Elaprase and adjustments to the criteria. Minimum Requirements Prior Authorization - Addition of Hetlioz, Hetlioz LQ, Nplate and Promacta. Aduhelm - PA to ensure appropriate use based upon the FDA-approved labeling information and clinical guidelines. Blanket Statements - A summary of changes to specific criteria were presented. Fee-for-Service Annual Program Assessment-The annual program assessment for the Medicaid fee-for-service population will be presented to show drug trends over the past State fiscal year. Managed Care Annual Program Assessment - Aetna Better Health of Kansas, Sunflower State Health Plan, and UnitedHealthcare Community Plan will present reports detailing utilization trends and provider education efforts for 2020. JANUARY 19, 2022 DUR BOARD MEETING: Agenda items and Key changes Adult Rheumatoid Arthritis Agents - Addition of Avsola, Ruxience, and Truxima plus additional criteria for the use of JAK inhibitors. Asthma Agents- Addition of Tezspire. Updated the indicated age groups and dosing information for Dupixent. Atopic Dermatitis Agents - Addition of Opzelura and Adbry to the list of agents and updated the initial and renewal criteria. Enzyme Replacement Agents - Addition of Lumizyme and Nexviazyme to the list of agents. Hepatitis C Agents- Updates to the indicated age groups and dosing information and the addition of new formulations of Epclusa and Mavyret. Oncology Agents- Addition and/or removal of several drugs. Oncology - Auxiliary Treatment Agents - Addition and/or removal of several drugs. Opioid Products Indicated for Pain Management - Addition of Seglentis.

State	DUR Board Activities Report Summary
	Systemic Lupus Erythematosus Agents New class PA. ADHD Medications Safe Use for All Ages -Clarification of PDMP requirements. Antipsychotic Medications Safe Use for All Ages -Revisit the diagnosis requirement. Revisit management of current drugs with new indications. New PDL Classes - Dry Eye Disease: Cequa, Restasis, Tyrvaya, Xiidra and Immunomodulation Agents- Atopic Dermatitis: Adbry, Dupixent APRIL 20, 2022 DUR BOARD MEETING: Agenda items and Key changes High Cost Compound PA - This PA will be used to increase oversight of APIs used in compounded products. Ankylosing Spondylitis Agents - Addition of Xeljanz/Xeljanz XR and updates to the table of conventional oral agents. Atopic Dermatitis Agents - Addition of Cibinqo and Rinvoq and updates to initial and renewal criteria. Hypercholesterolemia Agents - Updates to the age groups and dosing information for Repatha, updates to dosing information for Praluent and the addition of Leqvio. Minimum Requirements Prior Authorization- Updates to several agents and the removal of Onfi. Psoriatic Arthritis Agents- An update to the indicated age groups and dosing information for Cosentyx and addition of Skyrizi and Rinvoq. ADHD Medications Safe Use for All Ages -Revisit PDMP criteria and management of Qelbree. Antipsychotic Medications Safe Use for All Ages -Revisit management of Caplyta. Benzodiazepine Medications Safe Use for All Ages -Revisit PDMP criteria and management of Loreev XR. JULY 20, 2022 DUR BOARD MEETING: Agenda items and Key changes Atopic Dermatitis (AD) Agents -Updates to the dosing of Dupixent and to step therapy. Chimeric Antigen Receptor T-Cell (CAR-T) Agents -Addition of Carvykti and updates to indications, dosing limits and/or diagnoses for Kymriah, Tecartus, Breyanzi and Yescarta. Crohn's Disease Agents - Addition of Skyrizi and addition of another reference for Therapeutic Drug Monitoring.

State	DUR Board Activities Report Summary
	Ulcerative Colitis Agents- Addition of Rinvoq and addition of another reference for Therapeutic Drug Monitoring. Growth Hormone Agents (Somatropin Products) - Addition of Skytrofa, consolidation of the initial and renewal criteria. Minimum Requirements Prior Authorization - Addition of Demser capsules. Oncology - Auxiliary Agents - Addition of Releuko. High Cost Compounds -Clarification of prior authorization criteria. Opioid Use Discussion - Long-Term Care Setting Discussion on opioid use for pain management in Long-Term Care settings. ADHD Medications - Safe Use for All Ages -Addition of the adult dosage of Qelbree. New PDL Classes- Imiquimods: (Aldara , Zyclara), Prenatal Vitamins: (Various Products), Thyroid Hormones: (Levoxyl, Synthroid , Tirosint , Unithroid , Thyquidity)
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 FFY2022. During FFY2022, the following RetroDUR activities were performed on behalf of the DMRAB: Prescriber-lettering activities: Polypharmacy: patients with eight or more medications from three or more prescribers and two or more pharmacies, non-adherence with oral oncology, patients with claims for insulin who lacked pharmacy claims for blood glucose monitoring products, and non- adherence with hypertensive medications. 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. 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. Newsletter features for FFY2022: Drug product recalls and discontinuations, FDA Alerts Regarding Montelukast and Lamotrigine, and Heart Failure Treatment Guidelines Update.

State	DUR Board Activities Report Summary
Louisiana	The Louisiana Drug Utilization Review Board held four meetings during federal fiscal year 2022. Addressing the COVID pandemic, two of the meetings were held virtually in October 2021 and January 2022. In-person meetings were resumed in April 2022. The DUR Board reviewed the recommendations. As a component of quality improvement in the DUR program, existing POS edits were modified or inactivated. Examples are the removal of diagnosis requirements for Descovy (emtricitabine & tenofovir alafenamide) and Truvada (emtricitabine/tenofovir disoproxil fumarate), the removal of the quantity limit for Oxbryta (voxelotor) and Nuplazid 17 mg (pimavanserin), and the modification of a prior use requirement for long-acting injectable antipsychotics. POS edits were implemented for new drug products. Examples included Besremi (ropeginterferon alfa-2b-njft) and Lybalvi (olanzapine/samidorphan). Retrospective DUR criteria: Criteria focused on opioid safety, statin recommendations in diabetes in individuals with and without ASCVD, diabetic, hypertensive, and antipsychotic agent adherence, albuterol overutilization, NSAID precaution in heart failure, beta-blocker precaution in asthma, medication-assisted treatment in opioid use disorder, and sedative-hypnotic agent duration. Clinical authorization: criteria were defined for a wide range of drug categories. Examples included cytokine and CAM antagonists and lupus immunomodulators. Medically necessary criteria: clinical criteria were defined for overriding POS diagnosis requirements and quantity limit safety edits. Prospective DUR Approvals by the DUR Board: ADDED AGE LIMIT: Tramadol and tramadol combination products ADDED AGE LIMIT: Loreev XR (lorazepam) ADDED AGE LIMIT: Twyneo (benzoyl peroxide and tretinoin) ADDED AGE LIMIT: Winlevi (clascoterone) ADDED AGE LIMIT: Seglentis (celecoxib/tramadol) ADDED CONCURRENT USE: Loreev XR (lorazepam) ADDED CONCURRENT USE: Seglentis (celecoxib/tramadol) ADDED DIAGNOSIS BYPASS: Qdolo (tramadol) oral solution ADDED DIAGNOSIS BYPASS: Jardiance (empagliflozin) ADDED DIAGNOSIS BYPASS: Seglentis (celecoxib/tramadol) ADDED DIAGNOSIS REQUIREMENT: Ferriprox (deferiprone) ADDED DIAGNOSIS REQUIREMENT: Nexviazyme (avalglucosidase alfa-ngpt) ADDED DIAGNOSIS REQUIREMENT: Exservan (riluzole) ADDED DIAGNOSIS REQUIREMENT: Invega Hafyera (paliperidone palmitate) ADDED DIAGNOSIS REQUIREMENT: Lybalvi (olanzapine/samidorphan) ADDED DIAGNOSIS REQUIREMENT: Azstarys (serdexmethylphenidate/dexmethylphenidate) ADDED DIAGNOSIS REQUIREMENT: Empaveli (pegcetacoplan) ADDED DIAGNOSIS REQUIREMENT: Pyrukynd (mitapivat) ADDED DIAGNOSIS REQUIREMENT: Radicava ORS (edaravone) ADDED DIAGNOSIS REQUIREMENT: Besremi (ropeginterferon alfa-2b-njft) ADDED DIAGNOSIS REQUIREMENT: Camcevi (leuprolide)

State	DUR Board Activities Report Summary
	ADDED DOSE LIMIT: Qdolo (tramadol) oral solution ADDED DOSE LIMIT: Onfi, Sympazan (clobazam) ADDED DOSE LIMIT: Aptiom (eslicarbazepine) ADDED DOSE LIMIT: Seglentis (celecoxib/tramadol) ADDED QUANTITY LIMIT: Juxtapid (lomitapide) ADDED QUANTITY LIMIT: Repatha (evolucumab) ADDED QUANTITY LIMIT: Praluent (alirocumab) ADDED QUANTITY LIMIT: Qdolo (tramadol) oral solution ADDED QUANTITY LIMIT: Nuplazid 10 mg (pimavanserin) ADDED QUANTITY LIMIT: Invega Hafyera (paliperidone palmitate) ADDED QUANTITY LIMIT: Lybalvi (olanzapine/samidorphan) ADDED QUANTITY LIMIT: Loreev XR (lorazepam) ADDED QUANTITY LIMIT: Mavyret (glecaprevir/pibrentasvir) ADDED QUANTITY LIMIT: Epclusa (sofosbuvir/velpatasvir) ADDED QUANTITY LIMIT: Opzelura (ruxolitinib) ADDED QUANTITY LIMIT: Amphetamine / Dextroamphentamine XR formulations ADDED QUANTITY LIMIT: Qulipta (atogepant) ADDED QUANTITY LIMIT: Latuda (lurasidone) ADDED QUANTITY LIMIT: Nayzilam (midazolam) ADDED QUANTITY LIMIT: Leqvio (inclisiran) ADDED QUANTITY LIMIT: Mounjaro (tirzepatide) ADDED QUANTITY LIMIT: Twyneo (benzoyl peroxide and tretinoin) ADDED QUANTITY LIMIT: Winlevi (clascoterone) ADDED QUANTITY LIMIT: Zimhi, Kloxxado (naloxone) ADDED QUANTITY LIMIT: Seglentis (celecoxib/tramadol) ADDED QUANTITY LIMIT: Humira (adalimumab) ADDED QUANTITY LIMIT: Enbrel (etanercept) ADDED QUANTITY LIMIT: Xarelto (rivaroxaban) suspension ADDED PRIOR USE REQUIREMENT: Loreev XR (lorazepam) ADDED PRIOR USE REQUIREMENT: Invega Hafyera (paliperidone palmitate) ADDED PRIOR USE REQUIREMENT: Opzelura (ruxolitinib) ADDED THERAPEUTIC DUPLICATION: Invega Hafyera (paliperidone palmitate) ADDED THERAPEUTIC DUPLICATION: Lybalvi (olanzapine/samidorphan) ADDED THERAPEUTIC DUPLICATION: Azstarys (serdexmethylphenidate/dexmethylphenidate) ADDED THERAPEUTIC DUPLICATION: Loreev XR (lorazepam) ADDED THERAPEUTIC DUPLICATION: Mounjaro (tirzepatide) ADDED THERAPEUTIC DUPLICATION: Norliqva (amlodipine) oral solution ADDED THERAPEUTIC DUPLICATION: Seglentis (celecoxib/tramadol) ADDED DRUG-DRUG INTERACTION: Seglentis (celecoxib/tramadol) ADDED DURATION OVERRIDE: Authorized generic Epclusa (sofosbuvir/velpatasvir) MODIFIED/EXPANDED DIAGNOSIS REQUIREMENTS: Caplyta (lumateperone) MODIFIED PRIOR USE REQUIREMENT: Long-acting injectable antipsychotics MODIFIED DOSE LIMIT: Aspirin MODIFIED DOSE LIMIT: Ozempic (semaglutide) MODIFIED QUANTITY LIMIT: Dayvigo (lemborexant) MODIFIED QUANTITY LIMIT: Nurtec ODT (rimegepant) MODIFIED QUANTITY LIMIT: Sublocade (buprenorphine extended-release injection) MODIFIED DOSE LIMIT OVERRIDE OPTION: Tramadol

State	DUR Board Activities Report Summary
	MODIFIED DOSE LIMIT OVERRIDE OPTION: Tapentadol MODIFIED CONCURRENT USE: Opioid-benzodiazepine REMOVED DIAGNOSIS REQUIREMENT: Descovy (emtricitabine & tenofovir alafenamide) REMOVED DIAGNOSIS REQUIREMENT: Truvada (emtricitabine/tenofovir disoproxil fumarate) REMOVED DIAGNOSIS REQUIREMENT: Apretude (cabotegravir) REMOVED QUANTITY LIMIT: Oxbryta (voxelotor) REMOVED QUANTITY LIMIT: Nuplazid 17 mg (pimavanserin) REMOVED PRIOR USE REQUIREMENT: SGLT2 inhibitors and incretin mimetics REMOVED DURATION OF THERAPY EDIT WITH ASSOCIATED BYPASS: H2 blockers REMOVED DURATION OF THERAPY EDIT WITH ASSOCIATED BYPASS: Carafate (sucralfate) REMOVED HANDWRITTEN RX REQUIREMENT/ALLOW REFILLS: Xenical (orlistat) REMOVED HANDWRITTEN RX REQUIREMENT/ALLOW REFILLS: Isotretinoin MCO ALIGNMENT, AGE LIMIT: Codeine MCO ALIGNMENT, DOSE LIMIT: Tramadol and tramadol combination products MCO ALIGNMENT, DOSE LIMIT: Tapentadol MCO ALIGNMENT, DIAGNOSIS REQUIREMENT: Butrans (buprenorphine transdermal) New educational alerts Therapeutic Duplication, Level One Educational Alerts: H1H, AMYLOID DIRECTED MONOCLONAL ANTIBODY M0Q, COMPLEMENT (C3) INHIBITORS M4Y, ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR N1J, HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH. Drug Interactions, Level One Educational Alerts: CABOTEGRAVIR-RILPIVIRINE/CYP3A4 & UGT1A1 INDUCERS CABOTEGRAVIR/UGT1A1 INDUCERS RANOLAZINE/STRONG CYP3A4 INHIBITORS THAT PROLONG QT VOCLOSPORIN/STRONG CYP3A4 INHIBITORS CYCLOPHOSPHAMIDE/VOCLOSPORIN DOFETILIDE/TRILACICLIB SELECTED CYP1A2 SUBSTRATES/VILOXAZINE TIZANIDINE/VILOXAZINE INTRAMUSCULAR RILPIVIRINE/RIFABUTIN ARTEMETHER; LUMEFANTRINE/STRONG CYP3A4 INDUCERS PROLONG QT CYP3A4 SUBSTRATES THAT PROLONG QT/POSACONAZOLE FINERENONE/STRONG CYP3A4 INHIBITORS ALFUZOSIN/SELECTED STRONG CYP3A4 INHIBITORS ALFUZOSIN/STRONG CYP3A4 INHIBITORS THAT PROLONG QT CONIVAPTAN/SELECTED STRONG CYP3A4 INHIBITORS THIORIDAZINE/DACOMITINIB OZANIMOD/PROCARBAZINE MOBOCERTINIB/DRONEDARONE Retrospective DUR category modifications: Added underutilization: MAT recommendation in opioid use disorder Added underutilization: Naloxone recommendation in high dose opioid therapy Added underutilization: MAT agent adherence Added overutilization: Beta blocker precaution in asthma

State	DUR Board Activities Report Summary
	Removed overutilization: Antipsychotic agent therapeutic duplication 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. 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	The ME Medicaid (MaineCare) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met (5) five times in FFY2022. 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 that the adopted clinical criteria are appropriate and result in patterns of utilization that are appropriate and cost-effective. In FFY 2022, the ME DUR Board activities included: 63 New Drug Reviews 6 Revised Clinical Coverage Criteria 51 Therapeutic Class Reviews 0 Quantity Limits established for new or previously reviewed drugs

State	DUR Board Activities Report Summary
	1 FDA Safety Alerts reviewed RetroDUR Analyses o HPV vaccination rates o Codeine use in Pediatric Population o Concurrent use of glp-1 receptor agonists, dpp-4 inhibitors o Opioid use from multiple provider o Appropriate use of asthma controller medications 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 12, 2021 Time: 1:00PM to 2:30PM Closed Session, 2:30PM to 5:30PM Public Session Location: Virtual: Microsoft Teams Meeting Call in (audio only): 1-207-209-4724 Conference ID: 644404396# 1) Closed Session (1pm- 2:30pm) Drug Financial Information Review 2) MaineCare Updates 3) Public Comments 4) Old Business Approve June Meeting Minutes Approve September Meeting Minutes Vote on September New Drug Reviews:

State	DUR Board Activities Report Summary
	o Exservan (riluzole oral film)- ALS Drugs o Aduhelm (aducanumab-avwa)- Alzheimer- Cholinomimetics/Other o Elepsia XR (levetiracetam extended-release tablets)- Anticonvulsants o Jemperli (dostarlimab-gxly)- Cancer o Lumakras (sotorasib)- Cancer o Rybrevant (amivantamab-vmjw)- Cancer o Rylaze (asparaginase erwinia chrysanthemi(recombinant)-rywn)- Cancer o Truseltiq (infigratinib)- Cancer o Zynlonta (loncastuximab tesirine)- Cancer o Kerendia (finerenone)- Diurectics o Zegalogue (dasiglucagon)- Glucose Elevating Agents o Empaveli (pegcetacoplan)- Monoclonal Antibody o Ozobax (baclofen oral solution)- Muscle Relaxants o Kloxxado (naloxone hydrochloride)- Narcotic- Antagonists o Myfembree (relugolix, estradiol, and norethindrone acetate)- Pituitary Suppressive Agents, LHRH o Brexafemme (ibrexafungerp)- Antifungals- Assorted Present Retro-DUR Results: Use of Long-acting Injectable Antipsychotics 5) Revised clinical criteria . None at this time 6) New Business (open session) Present 2022 Meeting Schedule Open session to review and vote categories subject to potential changes Alzheimer/Antidementia Agents Analgesics, Narcotics, Short- Acting Analgesics/Anesthetics (Topical) Angiotensin Modulators Antiasthmatic - Antiinflammatory Agents Antibiotic- Cystic Fibrosis Anticoagulants Anticonvulsants Antihyperlipidemic/PCSK 9 Inhibitors Antineoplastics Antipsychotics Antiretrovirals Beta-Blockers Bronchodilators, Beta Agonists Colony Stimulating Factors Contraceptives COPD Agents Cytokine and CAM Antagonists Dermatologic- Scabicides/Ped/Atopic/Corticosteriods DME- Diabetic Supplies Endometriosis Erythropoiesis Stimulating Proteins GI- IBS/ OIC/CIC/ Antiemetics Growth Hormones Hematopoietics Hemophilia

State	DUR Board Activities Report Summary
	Hepatitis C Agents Hyperuricemia and Gout Hypoglycemics, Incretin Memetics Hypoglycemics, Insulins & Related Agents Hypoglycemics, Misc Agents Idiopathic Pulmonary Fibrosis Migraine Movement Disorders Multiple Sclerosis Agents Neurotoxins Ophthalmic Antibiotics Ophthalmic Anti-inflammatories Ophthalmic Modulators Ophthalmics Antiallergics Opiate Dependence & Overdose Treatments Otic Anti Infectives Pancreatic Enzymes Platelet Aggregation Inhibitors Platelet Stimulating Agents Resp. Steriod/Anticholinergic/Misc Sickle Cell Disease Agents Neurologics-Spinal Muscular Atrophy (SMA) Agents Stimulants & Related Agents Urinary Antispasmodic Vaginal Anti-Infectives 7) FDA Safety Alerts 8) Next Meeting (Tuesday, December 14, 2021 (from 5:30pm to 8:30pm) DUR COMMITTEE AGENDA Date: Tuesday, December 14, 2021 Time: 6:00PM to 8:30PM Location: Virtual: Teams Link (please see live Teams link in the Agenda that is posted at mainecarepdl.org/durfiles) To Dial in: 1-207-209-4724 Phone Conference ID: 629 771 71# 1) Closed Session: 5:30PM- 6:00PM- Board members only (a separate invitation to be sent) 2) MaineCare Updates- Anne-Marie Toderico 3) Public Comments 4) Old Business . Approve October Meeting Minutes 5) Revised clinical criteria None at this time. 6) New Business (open session) Retro DUR o Introduce: 2022 Potential RetroDUR Initiatives o Data Presentation: Herpes Zoster Vaccination Rates o Data Presentation: HPV Vaccination Rates

State	DUR Board Activities Report Summary
	New Drug Review (http://www.mainecarepdl.org/) DUR COMMITTEE AGENDA Date: Tuesday, March 8, 2022 Time: 6:00PM to 8:30PM Location: Virtual: Teams Meeting Link To Dial in: 207-209-4724 Phone Conference ID: 964 521 86# 8) Closed Session: 5:30PM- 6:00PM- Board members only (a separate invitation to be sent) 9) MaineCare Updates- Anne-Marie Toderico 10) Public Comments 11) Old Business . Approve December Meeting Minutes 12) Revised clinical criteria Muscular Dystrophy clinical criteria update Biosimilar preferred agent update 13) New Business (open session) Retro DUR o Introduce: Concurrent use of glp-1 receptor agonists, dpp-4 inhibitors o Data Presentation: Codeine use in Pediatric Population New Drug Review (http://www.mainecarepdl.org/) Adbry (tralokinumab- Idrm)- Topical- Atopic Dermatitis Apretude (cabotegravir)- Antiretroviral Agents Besremi (ropeginterferon alfa-2b-njft)- Polycythemia Vera Treatments Elyxyb (celecoxib oral solution)- Migraine, Misc. Eprontia soln (topiramate)- Anticonvulsants Leqvio (inclisiran)- Familial Hypercholesterolemia Livtencity (maribavir)- Cytomegalovirus Agents Lofena (diclofenac potassium)- NSAIDs Recorlev (leoketoconazole)- Cushing Disease Agents Scemblix (asciminib)- Cancer Skytrofa (lonapegsomatropin- tcgd)- Growth Hormone Susvimo implant (ranibizumab injection)- Op. -Of Interest Tyrvaya (varenicline solution)- Op. -Of Interest Tezspire (Tezepelumab-ekko)- Antiasthmatic- Anti Inflammatory Agents Tavneos (avacopan)- Complement Receptor Antagonist Voxzogo (vosoritide)- Achondroplasia Treatments Vyvgart (efgartigimod alfa-fcab)- Myasthenia Gravis Treatments 14) Other Considerations 15) FDA Safety Alerts- None at this time 8) Next Meeting (Tuesday, June 14, 202 Aemcolo (rifamycin delayed-release)- Antibiotics, Misc. Invega Hafyera (paliperidone palmitate)- Antipsychotics- Atypicals Lybalvi (olanzapine and samidorphan)- Antipsychotics- Atypicals Loreev XR (lorazepam)- Anxiolytics- Benzodiazepines Exkivity (mobovertinib)- Cancer

State	DUR Board Activities Report Summary
	Welireg (belzutifan)- Cancer Bylvay (odevixibat)- GI- IBAT Inhibitors Livmarli (maralixibat)- GI- IBAT Inhibitors Rezurock (belumosudil)- Immunosuppressants Trudhesa (dihydroergotamine mesylate)- Migraine- Ergotamine Derivatives Qulipta (atogepant)- Migraine, Misc. Nexviazyme (avalglucosidase alfa-ngpt)- Pompe Disease Agents Saphnelo (anifrolumab-fnia)- SLE Azstarys (serdexmthylphenidate and dexmethylphenidate)- Stimulant- Methylphenidate, Long-Acting Winlevi (clascoterone)- Topical- Acne Preparations Opzelura (ruxolitinib)- Topical- Atopic Dermatitis Thyquidity (levothyroxine sodium)- Thyroid Hormones 7) FDA Safety Alerts- None at this time 8) Next Meeting (Tuesday, March 8, 2021) 9) Adjournment: 8:30PM
Maryland	Indicate the number of DUR Board meetings held The Maryland Medicaid Drug Utilization Review Board met four (4) times during FFY 2022. 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

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	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 2022, retrospective DUR interventions were performed to identify participants with potentially inappropriate use of opioids (Corrective Managed Care Program), therapeutic duplication of sedative/hypnotic agents, concurrent use of an opioid and medium-high dose gabapentin, concurrent use of gabapentin and pregabalin, concurrent use of an opioid, benzodiazepine and carisoprodol-containing product, concurrent use of an opioid and benzodiazepine, concurrent use of an opioid and antipsychotic, CGRP medication overutilization, and use of opioid with a history of opioid misuse or overdose and no naloxone prescription. 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 potential future interventions. Criteria added during FFY2022 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. Beginning in 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

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	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 FFY2022. 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 2022, OPS sponsored two live programs for Maryland Medicaid healthcare providers. The program titled 'Challenges in the Management of Post-COVID Syndrome' was held in October 2021 and the program titled 'Substance Use Disorders and Treatment' was held in April 2022. 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 Four Quarterly meetings of the MassHealth DUR Board were held for the Federal Fiscal Year period October 1, 2021 to September 30, 2022. The DUR Board also participated in

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	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-three were reviewed for changes to prospective DUR criteria. Of which, 131 had additions to criteria and 22 had deletions of criteria. A retrospective DUR review was performed for 75 therapeutic classes. Of which, 56 had additions to criteria and 19 had deletions of criteria. In addition, 63 criteria were related to underutilization, 54 related to appropriate use of generics, 35 related to overutilization, 28 criteria related to insufficient dose, 20 related to incorrect duration, 13 related to drug/disease contraindication, and13 related to therapeutic duplication. All classes were related to at least one 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. All meetings during FFY 2022 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 2022, 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 continued to monitor utilization patterns as a result of the COVID-19 pandemic and the emergency measures enacted to ensure access to medications. The Board also reviewed appropriate use of incretin mimetics as well as concurrent use of short-acting beta agonist (SABA) inhalers with inhaled corticosteroids related to GINA guideline changes.

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	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	Four Minnesota FFS Medicaid DUR Board meetings were held during FFY 2022. These meetings occurred December 8, 2021; February 9, 2022; April 13, 2022; and August 10, 2022. First Data Bank (FDB) continues to be the source of drug information including FFS prospective DUR edits. Quantity limits per prescription are based on a 34-day supply using FDA max dose. When a drug is on prior authorization (PA), criteria may be more specific as to maximum quantity, duration of therapy, and specific clinical parameters. The RetroDUR contract provides for a quarterly population-based mailing and for biannual SUPPORT Act and psychotropic drugs in youth mailings. Proposed RetroDUR interventions, including criteria, provider messages, and provider letters are reviewed and may be modified by the DUR Board. The contractor also uses FDB as their drug information source. The DUR Board determines which mailing format is used, either the individual patient profile which includes a patient's medication and diagnosis or a special mailing where providers receive only a list of their patients meeting criteria. RetroDUR intervention outcomes are also presented to the DUR Board. New business topics per meeting are listed. December 8, 2021 DUR Board Meeting New Business: 1. Central Nervous System (CNS) Effects RetroDUR intervention. Criteria for muscle relaxant and sedative drug class was presented separately. Included was duplicate therapy within the same class, drug-drug interactions FDB level 1 and 2, drug-disease interactions using FDB level 1 and 2, high dose defined as exceed FDA-approved maximum daily dose, minimum FDA age requirement, and appropriate duration of treatment. For duration of treatment, zolpidem had over 90% of the occurrences. For zolpidem, the provider message recommendations were a) a patient should be re-evaluated, as these agents are not to be used long-term and b) there is a disclaimer Statement that alerts the provider there is still room to make a patient-centered decision. Format will be to include the patient's entire profile. The DUR Board commented that

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	prescribers might not be fully aware how often their patient is filling zolpidem. The sixth and last criterion was Additive CNS Sedation which is a claim for an agent that has a risk of CNS depression and another interacting CNS depressant for 30 days within 28 days of each other. Most prevalent was first-generation antihistamines combined with a CNS depressants (n=314). 2. High Risk Score. Patient Profile Reviews using the Kepro's proprietary High Risk Score was presented. The DUR Board recommendation was not to be used solely as an automated process but would be useful if those identified as high risk were subsequently reviewed by the Kepro clinical pharmacist. February 9, 2022 DUR Board Meeting New Business: 1. Adult Polypsychopharmacy Drug classes include antipsychotics, antidepressants, mood stabilizers, benzodiazepines, and stimulants. Two methodologies were proposed either use existing criteria in Kepro's RxExplorer (n=2,179) or use the Minnesota psychotropic drugs in youth criteria changing the age criteria to greater than eighteen years (n=4,987). The existing Minnesota criteria was chosen. Approved was: A. Three or more psychotropic drug for 30 days in the last 90 days of each other. Profile review will be for the Top 500 based on High Risk Score. This corresponds with patients on six or more psychotropic drugs. B. Multiple (two or more) oral second generation antipsychotics (SGA). (n=802), profile review C. SGA Blood Glucose Monitoring (n=3,067), special mailing format. D. SGA Lipid Monitoring (n=1,450), special mailing format. April 13, 2022 DUR Board Meeting New Business: 1. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) are common medications that are commercially available as a legend and OTC medication. Six indicators were approved for profile review. A. Duplicate Therapy (n=88). B. Drug-Drug Interactions included FDB level 1 and 2 (n=248). C. Drug-Disease Interactions included FDB level 1 and 2 (n=323). D. High-Dose (n=1) E. Age (n=163) F. Therapeutic Appropriateness refers to longer than the FDA specified timeframe (n=65). 2. Non-Adherence of Select Drug Treatment Categories (n=696). This will be a profile review. A. Hyperlipidemia: includes bempedoic acids, fenofibrates, and juxtapid (n=145) B. Cardiovascular: includes ACE inhibitors, antiarrhythmics, antiplatelets, ARBs, beta-blockers, calcium-channel blockers, and diuretics (thiazide, loop, potassium-sparing) (n=200). C. Antipsychotics: includes first-generation and second-generation antipsychotics (n=179) D. Antidepressants: includes SSRIs, SNRIs, MAOIs, tetracyclics, and bupropion (n=167).

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	E. Lithium: there were five occurrences. 3. Montelukast - Black Box Warning (BBW) A. Criteria: patients with a montelukast claim for 30 days in the last 30 days and a diagnosis of adverse neuropsychiatric events in the last 90 days. (n=302) This will be a profile review. B. Criteria: patients with a montelukast claim for 53 days in the last 60 days and a diagnosis of allergic rhinitis in the last 60 days. Patients with an asthma diagnosis in the last 180 days were excluded. (n=1,841) This will be a special mailing. August 10, 2022 DUR Board Meeting New Business: 1. Intervention Outcomes for FFY 2021 (October 1, 2020 to September 30, 2021) Outcome methodology was explained. Outcome timelines was defined as a pre-period, a null-period (14 days), and the post-period (180 days post null-period). Targeted providers and targeted patients are those in the pre-period whereas adjusted targeted providers and adjusted targeted patients are those in the post-period. Patients must have FFS eligibility and drug claims during the post-intervention period to be included in the analysis. Prescribers must have received an intervention letter. Changes in clinical criteria counts are reported pre-period compared to post-period. Overall clinical improvement per intervention was Overuse of PPI showed (40%), Respiratory Management (54%) SUPPORT Act#1 (79%), SUPPORT Act#2 (48%), Psychotropic in Youth #1 (49%), Psychotropic in Youth #2 (52%), Gabapentinoids Evaluation (43%), and Diabetes Management Evaluation (77%). The six-month economic outcome for the eight interventions was an estimated $862,731. The economic impact is determined using the all drug costs, not just targeted drug costs, in the pre-intervention period compared to the post-intervention period. This is based on difference in average drug cost paid per month for the patients in the pre-period compared to the average paid per month for patients in post-period. The percent change is determined as well as the average savings per recipient per month. The average savings per recipient per month is multiplied by the number of patients in the post-period and the number of months in the post-period to calculate the economic outcome. 2. Diabetes Management 2022 This intervention is recommended again for FFY 2022. Clinical indicators were updated using the American Diabetes Association (ADA) 2022 clinical practice recommendations. Only minimal changes were found, in the drug-drug interactions section. The largest number of occurrences was the underutilization area with 936 occurrences. Underuse of antihypertensive therapy was n=499, underuse of antihyperlipidemic therapy was n=111, and underuse of metformin was n=326. 3. Recommended Change in Current Psychotropic Drugs in Youth Process Currently, a profile review process is used for the clinical indicators whereas a special mailing is used for the second-generation antipsychotic (SGA) monitoring of blood glucose and the SGA monitoring of lipids. Going forward the special mailing format and process be used for both the clinical indicators and the SGA monitoring which will ensure that all youth will be included in both mailings.
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	There were 4 meetings held during FFY 2022. On December 9, 2021, a quorum of 7 members were present. This was the first in-person meeting in 2 years. The DUR vendor presented a summary of interventional/educational mailings that were performed during the 3 months preceding the meeting, to include Opioid Provider Shopping (total of 14 letters to prescribers, 8 letters to pharmacies representing claims for 22 beneficiaries) and Concomitant Use of Opioids and Antipsychotics (total of 140 letters to prescribers representing claims for 187 beneficiaries. MS-DUR presented a report detailing performance on the Health Effectiveness Data and Information Set (HEDIS) Statin Therapy for Patients with Diabetes (SPD) quality measure among Medicaid beneficiaries for calendar year (CY) 2020. The HEDIS-SPD measure reports the percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD). Two rates are reported: 1. Received a Statin Therapy. Members who were dispensed at least one statin of any intensity during the measurement year. 2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period. It was noted that while the overall rates for both measures were the same (45.8%), performance was different across pharmacy plans. Beneficiaries enrolled in the coordinated care organizations (CCOs) had higher rates for Received Statin Therapy compared to FFS. The 3 rates for Statin Adherence varied across plans with Magnolia having the highest. It was noted that each of the CCOs have Gaps in Care programs addressing the utilization of statins among individuals with diabetes. The following recommendations were presented and unanimously approved: 1. MS-DUR should work with DOM to develop and implement a Gaps in Care program for the FFS population aimed at improving the rate of beneficiaries with diabetes prescribed statin therapy. 2. DOM should work with CCOs and FFS programs to develop plans for improving adherence rates for beneficiaries with diabetes prescribed statin therapy. Asthma Guideline Update and UPDL Implications At the March 2019 DUR Board Meeting, an overview of asthma, along with performance on related quality measures, was presented. The board recommended MS-DUR design and implement an educational intervention program to educate providers about performance on asthma quality measures. Prior to implementing any provider education, an updated report from the Global Initiative for Asthma (GINA) was released in April 2019 and recommended significant changes in asthma management. The landmark changes involved the recommendation that all adults and adolescents with asthma receive symptom-driven or regular low-dose inhaled corticosteroid (ICS) containing controller treatment, specifically low dose ICS-formoterol. The Division of Medicaid (DOM) requested MS-DUR conduct an updated analysis and review the Universal Preferred Drug List (UPDL) for any issues that may limit providers from prescribing in accordance with the updated guidelines MS-DUR presented a report on performance on the Asthma Medication Ratio (AMR) quality measure, healthcare utilization costs associated with asthma, and potential UPDL issues that may limit providers from prescribing in accordance with the updated guidelines. The following recommendations were presented and unanimously approved: 1. The UPDL quantity limit for Symbicort should be updated to allow for its prescribing in both as needed and maintenance therapy concurrently.

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	2. MS-DUR should design and implement an educational intervention program to educate providers on the updated asthma guidelines, performance on asthma medication management quality measures, and any asthma related UPDL updates. On March 3, 2022, a quorum of 9 members were present. The DUR vendor presented a summary of interventional/educational mailings that were performed during the 3 months preceding the meeting, to include Opioid Provider Shopping (total of 14 letters to prescribers, 9 letters to pharmacies representing 23 beneficiaries) and Concomitant Use of Opioids and Antipsychotics (total of 145 letters to prescribers representing 171 beneficiaries). MS-DUR presented a series of reports focusing on maternal health and drug utilization issues. This report included 4 projects: prenatal vitamin use among pregnant women, opioid use among pregnant women, low-dose aspirin use among pregnant women at high risk of preeclampsia, and angiotensin-converting enzyme (ACE) inhibitor and angiotensin receptor blocker (ARB) use among women of childbearing age. Prenatal Vitamin Use Among Pregnant Women Claims data analysis showed that prenatal vitamins were utilized in only 30.9% of pregnancy events between 2018 and 2021. Prenatal vitamin use may have been negatively impacted by supply-chain issues related to prenatal vitamins. Supply chain issues potentially pushed more beneficiaries to use over-the-counter vitamins in prenatal care. To increase access to prenatal vitamins, DOM recently expanded the number of prenatal vitamins included in their preferred drug list (PDL). The following recommendations were presented and approved: 1. DOM should initiate educational activities to increase awareness of their expanded PDL list of prenatal vitamins. 2. DOM should explore innovative approaches to increase prenatal vitamin use among beneficiaries. A robust discussion around various ways of increasing prenatal vitamin use occurred among the Board. Some of the ideas discussed included: encouraging prenatal vitamin use among teens of childbearing age; engaging pharmacists in initiating prenatal vitamin use among women of childbearing age by incentivizing pharmacists and pursuing prescriptive authority of pharmacists to prescribe prenatal vitamins; and removing obstacles that delay Medicaid enrollment of pregnant women. Opioid Use Among Pregnant Women The rates of opioid use among pregnant women in Mississippi Medicaid appear to be in line with rates published in the literature. Reductions in maximum MEDD levels, chronic use, and concomitant use with psychotropic medications all occurred following the implementation of Medicaid's opioid initiatives in 2019. Use of Low-dose Aspirin Among Pregnant Women at High-Risk for Preeclampsia Low-dose aspirin is recommended for use among pregnant women at high risk for developing

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	preeclampsia. Claims data analysis revealed a low rate of low-dose aspirin use among this high-risk population. However, limitations in claims data likely prohibit capturing the true rate of low-dose aspirin use among high-risk Medicaid beneficiaries. Board members engaged in a healthy discussion around ways to improve the use of low-dose aspirin among pregnant beneficiaries at high-risk for preeclampsia. The board noted that part of the issue may be a lack of knowledge of this recommendation among prescribers and pharmacists. The following recommendations were presented and approved: 1. MS-DUR recommends that DOM explore and implement policies that encourage the prescribing and coverage of daily low-dose aspirin for women at high risk for preeclampsia as recommended by ACOG. 2. DOM should develop an educational piece to be included in an upcoming provider bulletin and distributed to professional member associations. Use of ACE Inhibitors and ARBs Among Women of Childbearing Age Despite well-documented risks of teratogenic effects associated with the use of ACE inhibitors and ARBs during pregnancy, there is significant use of these agents to treat hypertension among women of childbearing age. Our analysis indicated that among female Medicaid beneficiaries of childbearing age diagnosed with hypertension and treated with ACE inhibitors or ARBs, only 23.26% had concomitant use of contraception documented in claims data. This rate is well below other published rates of contraception use in women of childbearing age. Results from this analysis present great opportunities for future education and intervention activities. The Board reiterated the idea of DOM developing mechanisms that would enable and encourage pharmacists to be more actively involved in patient management. Pharmacists could directly impact the provision of care related to maternal health and improve outcomes. Following a robust discussion, the below recommendation was presented and approved: 1. DOM should include results from this analysis in future provider communications and should explore opportunities to increase contraception use rates among female beneficiaries of childbearing age prescribed ACE inhibitors or ARBs. Use of Long-acting Injectable (LAI) Antipsychotics (APs) Among Medicaid Beneficiaries The creation of the Clinician-Administered Drugs and Implantable Drug System Devices (CADD) List in 2018 was intended to increase beneficiary access to needed Medicaid services. Since their addition to the CADD List, utilization of atypical LAI APs has consistently increased. Our

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	analysis also found that when comparing outcomes in the 12-month period prior to and after LAI AP initiation, ED visits, hospitalizations, and continuity of care all improved. The below recommendation was presented and approved: 1. MS-DUR recommends DOM continue its current policies supporting access to long acting injectable antipsychotic medications On June 9, 2022, a quorum of 7 members were present. The DUR vendor presented a summary of interventional/educational mailings that were performed during the 3 months preceding the meeting, to include Opioid Provider Shopping (total of 13 letters to prescribers, 9 letters to pharmacies representing 22 beneficiaries) and Concomitant Use of Opioids and Antipsychotics (total of 123 letters to prescribers representing 136 beneficiaries). In addition, as recommended by the DUR Board on December 9, 2021, a one-time ma
Missouri	At the October 2021 meeting, the DUR board reviewed and approved the following edits: Emsam Clinical Edit; Immunoglobulin Clinical Edit; Lambert-Eaton Myasthenic Syndrome (LEMS) Clinical Edit; Neuromyelitis Optica Spectrum Disorder (NMOSD) Clinical Edit; Nuedexta Clinical Edit; Oxandrin Clinical Edit; Palforzia Clinical Edit; Ranexa Clinical Edit; Xcopri Clinical Edit; Aduhelm Clinical Edit; Botulinum Toxin Clinical Edit; Equetro Clinical Edit; Narcolepsy Inhibitors Clinical Edit; Psychotropic Medications Polypharmacy Clinical Edit; Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) Clinical Edit; Selective Serotonin Reuptake Inhibitor (SSRI) Clinical Edit; Transthyretin-Mediated Amyloidosis (ATTR) Clinical Edit; ARBs and ARBs/Diuretic Combinations; ARBs/CCB Combinations; Calcium Channel Blockers, Dihydropyridine; Calcium Channel Blockers, Non-Dihydropyridine; Direct Renin Inhibitors and Combinations; Dry Eye Disease Agents; Niacin Derivatives; PAH, ETRAs; PAH, Prostacyclins Inhaled; PAH, Prostacyclins Oral; Sympatholytics; ACE Inhibitors and ACE Inhibitors/Diuretic Combinations; ACE Inhibitors/Calcium Channel Blocker Combinations; ADHD, Methylphenidate Short Acting; ADHD, Amphetamines Short Acting; ADHD, Methylphenidate Long Acting; ADHD, Amphetamines Long Acting; ADHD, Non-Stimulants; Anticoagulants; Anticonvulsants, Rescue Agents; Antiplatelets; Beta Blockers and Beta Blockers/Diuretic Combinations; Homozygous Familial Hypercholesterolemia (HoFH) Agents; PAH, PDE5/SGC Stimulators; PAH, Prostacyclins Injectable; PCSK9 Inhibitors; Proton Pump Inhibitors; Statins (HMG-CoA Reductase Inhibitors) and Combinations; Triglyceride Lowering Agents. At the January 2022 meeting, the DUR board reviewed and approved the following edits: High Risk Therapies Clinical Edit; Morphine Milligram Equivalent (MME) Accumulation Clinical Edit; Opioid Dependence Agents PDL Edit; Opioid Emergency Reversal Agents PDL Edit; Opioids, Long Acting PDL Edit; Opioids, Short Acting Clinical Edit; Transmucosal Immediate Release Fentanyl (TIRF) Clinical Edit; Tramadol-Like Agents PDL Edit; 15 Day Supply Fiscal Edit; Acetaminophen Cumulative Dose Clinical Edit; Antipsychotics, 1st Generation (Typical) Clinical Edit; Antipsychotics, 2nd Generation (Atypical) Clinical Edit; Benzodiazepine, Select Oral Clinical Edit; BiDil Clinical Edit; Biosimilar vs. Reference Products Fiscal Edit; Corlanor Clinical Edit; Empaveli Clinical Edit; Extended Supply Fiscal Edit; High Cost Medications Fiscal Edit; Kerendia Clinical Edit; Non-Oral Contraceptives Fiscal Edit; Pompe Disease Clinical Edit; Spinal Muscular Atrophy (SMA) Clinical Edit; o Alzheimer's Agents, AChEIs and NMDA Receptor Antagonists; Anticonvulsants, Dravet Syndrome; Antiemetics, THC Derivatives; Anti-Parkinsonism, MAO-B Inhibitors; Anti-Parkinsonism, Non-Ergot Dopamine Agonists; GI Motility Agents, Chronic; Somatostatin Analogs; Antiandrogenic

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	Agents; Antiemetics, 5-HT3 and NK1 Injectables; Antiemetics, 5-HT3, NK1 and Other Select Non-Injectables; Anti-Migraine, Alternative Oral Agents; Anti-Migraine, Serotonin (5-HT1) Receptor Agonists; Antiretroviral Therapy (ART); Bile Salt Agents; Calcitonin Gene-Related Peptide (CGRP) Inhibitors; Cyclin-Dependent Kinase (CDK) 4/6 Inhibitors; Fibromyalgia Agents; Glucagon Agents; Hereditary Angioedema Agents; Homozygous Familial Hypercholesterolemia (HoFH); Neuropathic Pain Agents; NSAIDs; Sedative Hypnotics; Skeletal Muscle Relaxants; Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors. At the April 2022 meeting, the DUR board reviewed and approved the following edits: Imcivree Clinical Edit; Megestrol Clinical Edit; Nulibry Clinical Edit; Oxervate Clinical Edit; Oxlumo Clinical Edit; Spravato Clinical Edit; Zokinvy Clinical Edit; Zulresso Clinical Edit; Acne or Rosacea, Select Topical Agents Step Therapy Edit; C5 Complement Inhibitors Clinical Edit; Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators Clinical Edit; Fabry Disease Clinical Edit; Givlaari Clinical Edit; Isturisa Clinical Edit; Scenesse Clinical Edit; Sickle Cell Disease Clinical Edit; Systemic Antifungals Clinical Edit; Tavneos Clinical Edit; Voxzogo Clinical Edit; Actinic Keratosis Agents, Topical; Androgenic Agents; Antibiotics, Inhaled; Antifungals, Oral; Antifungals, Topical; Antihistamines & Antihistamines/Decongestant Combinations, 2nd Generation; Antihistamines, Intranasal; Antivirals, Herpes Oral; Antivirals, Topical; Benzoyl Peroxide/Antibiotic Combinations; Corticosteroids, Oral Inhaled; Corticosteroids, Topical; Corticosteroids and Rhinitis Agents, Intranasal; Cough/Cold Preparations; Epinephrine Agents, Self-Injectable; Fluoroquinolones, Ophthalmic; Fluoroquinolones, Otic; Glaucoma Agents; Mast Cell Stabilizers, Ophthalmic; NSAIDs, Ophthalmic; Psoriasis Agents, Oral; Psoriasis Agents, Topical; Retinoids, Topical; Ulcerative Colitis Agents, Oral; Ulcerative Colitis Agents, Rectal; Asthma Policy Updates; Beta Adrenergic Agents, Nebulized; Beta Adrenergic Agents, Short Acting; Leukotriene Receptor Modifiers; Anticholinergics, LABAs/ICS Combinations and PDE4 Inhibitors; Anticholinergics, Long Acting Inhaled; Anticholinergics, Short Acting and Combinations Inhaled; Anticholinergics, LABA Combinations; Antihistamines, Ophthalmic; Antiparasitics, Topical; Atopic Dermatitis Agents, Immunomodulators; Beta Adrenergic Agents, Long Acting; Corticosteroids, Ophthalmic Soft; Hepatitis C Agents; Pancreatic Enzymes; Respiratory Monoclonal Antibodies. At the July 2022 meeting, the DUR board reviewed and approved the following edits: Ampyra; Botulinum Toxin; Duchenne Muscular Dystrophy (DMD); Emsam; Gamifant; Immunoglobulin; Koselugo; Luxturna; Narcolepsy Inhibitors; Neuromyelitis Optica Spectrum Disorder (NMOSD); Nuedexta; Oxandrin; Palforzia; Palynziq; Ranexa; Reblozyl; Selective Serotonin Reuptake Inhibitors (SSRI); Synagis; Tepezza; Tolvaptan; Transthyretin-Mediated Amyloidosis (ATTR); Xcopri; Zometa; Besremi Clinical Edit; CAR-T Cell Clinical Edit; Crysvita Clinical Edit; Enjaymo Clinical Edit; Enzyme Deficiency, Select Agents Clinical Edit; Iron, Injectable Clinical Edit; Lambert-Eaton Myasthenic Syndrome (LEMS) Clinical Edit; Manufacturers Requiring Prior Authorization Fiscal Edit; Psychotropic Medications Polypharmacy Clinical Edit; Parathyroid Hormone (PTH) and Bone Resorption Suppression Related Agents Clinical Edit; Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) Clinical Edit; Targeted Immune Modulators, Small Molecule Janus Kinase (JAK) Inhibitors Clinical Edit; Vyvgart Clinical Edit.
Montana	-Number of DUR Board Meetings Held --Seven (7) DUR Board meetings were held in FFY 2022, 3 of which were focused solely on Preferred Drug List (PDL) decisions

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	-Deletions or Additions to Prospective DUR Criteria --New Criteria was developed for the following 22 Drugs: Adbry, Aduhelm, Cibinqo, Dartisla, Dupixent, Emgality, Entadfi, Evkeeza, Ibsrela, Invega Hafyera, Leqvio, Lybalvi, Opzelura, Perseris, Qelbree, Qulipta, Quviviq, Rinvoq, Seglentis, Tezspire, Vtama, and Zoryve --Criteria was updated for the following 14 drugs: Amondys 45, Belbuca, Belsomra, Daliresp, Dayvigo, Exondys 51, Juxtapid, Lemtrada, Nuedexta, Viltepso, Vyepti, Vyondys 53, Xyrem, and Xywav --Criteria was removed for the following drugs or drug classes: TZD class, Ondansetron, Iron products, SGLT2, and LAMA/SAMA therapeutic duplication edits. -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. -Describe Board policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens 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. 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. For example, sometimes ProDUR screening shows that almost all PAs are being approved, which indicates that there is little inappropriate use. In this situation, the DUR Board may choose to remove the ProDUR criteria. Conversely, RetroDUR might show inappropriate use or monitoring, and the Board might add ProDUR criteria to correct these issues, as they did with excessive gabapentinoid dosing and lack of metabolic monitoring with antipsychotic use in children. -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 FFY2022. A link to on-

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	line quarterly newsletters are distributed to nearly 1000 pharmacies and providers with timely drug utilization review topics and newly developed criteria information. Newsletter topics from FFY2022 included gabapentin utilization, Team Care program, migraine prevalence, diagnosis and treatment, COPD, sleep disorders, fentanyl in Montana, COVID vaccine age expansions, and PHE information.
Nebraska	The DUR Board met six times during the FFY on the second Tuesday of the odd number month. DUR Board policy establishes the DUR Board as the authority to identify and develop topics of education for providers as needed to improve prescribing or dispensing practices, or utilization of medication therapy. Activities of note during the DUR Board meetings: Annual review of the Human Growth Hormone criteria and prior authorization form along with utilization trends. Review of national trends in MME utilization in other States compared to NE and any differences in those States FFS programs compared to MCO MME limits. Criteria for prescribing and prior authorization requirements were reviewed for Xolair and a Board Certified physician in Adult and Pediatric Asthma and Allergy provided education to the board regarding self-administration of Xolair and necessary physician oversight from the transition from physician-administered to self-administered. Utilization review of the immunomodulator drug class occurred along with criteria from the Global Initiative for Asthma-GINA guidelines, American Gastroenterological Association, and the Joint Task Force on Practice Parameters. Data was analyzed and discussed regarding clients with a long-acting inhaler that did not have a prescriptions dispensed for a short-acting inhaler and the action for provider review. Naloxone dispensing trends were reviewed and evaluated in the context of the expanded adult population. Nebraska continues to review SUPPORT ACT medications every six months. For example, reviews of SUPPORT Act utilization of opioids concurrently with benzodiazepines, antipsychotics, and gabapentin/pregabalin data was presented. Data was presented on members who were prescribed Lithium and had a claim for a lithium serum level within the last six months. Antipsychotic use in children continues to be an important category for review in the SUPPORT Act. DHHS prepares the data from the categories to be reviewed and send out to the DUR Board members prior to the meeting. The Board members agree that data utilizing PDMP information may be combined with Medicaid prescription data to catch any missing prescriptions that were billed outside of Medicaid claims. The State uses this information to adopt policies, improve prior authorization criteria, and provide education and monitoring as needed.
Nevada	The DUR Board convenes on a quarterly basis to oversee the appropriateness of therapeutic drugs, address issues of over or under-utilization, prevent therapeutic duplications, consider drug-disease contraindications, and ensure quality care. This is accomplished through the establishment of prior authorization and quantity limits for specific drugs and drug classes, informed by utilization data, expert knowledge, and testimony presented during the DUR Board meetings. The process includes retrospective evaluation of interventions and prospective electronic drug review at the Point of Sale (POS) for each prescription filled.

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	For the Federal Fiscal Year 2022, the DUR Board consisted of five physicians and five pharmacists with diverse backgrounds and locations across Nevada. Other non-voting members, including DHCFP employees, a Deputy Attorney General, and representatives from the MMIS and PBM service contractors, contribute to the Board discussions. The four managed care organizations also participate, with non-voting representation on the Board. The public is welcome to provide testimony before the Board's decision-making process. OptumRx supplies clinical reviews and proposed prior authorization criteria to the Board. Additional input is received from pharmaceutical manufacturers, members of the public, and the DUR Board's own expertise and research. All DUR Board meeting information, including clinical drug reviews, meeting materials, and proposed criteria, is made available to the public on the fiscal agent's website prior to each meeting. During the October 2021 meeting, updates were made to the prior authorization (PA) criteria for Entresto, Humira, and Nurtec, while new PA requirements were introduced for Skyrizi, Gimoti, and Aduhelm. The Growth Hormones criteria were reviewed but remained unchanged. Additionally, the meeting included a comprehensive evaluation of opioid and benzodiazepine utilization, with a focus on identifying the top prescribers and members involved in their usage. Similarly, the January 2022 meeting introduced new prior authorization (PA) criteria for Cabenuva, Amondys 45, and Opzelura. PA criteria were also updated for Qulipta, Cystic Fibrosis agents, Zeposia, Dupixent, Fasenra, and Qutenza. Additionally, opioid and benzodiazepine utilization was comprehensively evaluated during this meeting. In the April 2022 meeting, new PA criteria were established for Xolair (for Nala Polyps indication), Hetlioz (for nighttime sleep disturbances in Smith Mageniz Syndrome), Ingrezza (for tardive Dyskinesia), and Vuity. The meeting also included an assessment of opioid and benzodiazepine utilization to identify top prescribers and members involved in their usage. During the July 2021 meeting, new PA criteria were implemented for Invega Hafyera, Brexafemme, Ponvory, Bylvay, Livmarli, Opzelura, Skytrofa, and Trudhesa. Updates were also made to the PA criteria for Antifungals (for onychomycosis) and Immediate-Release Fentanyl Products. Similar to other meetings, opioid and benzodiazepine utilization were thoroughly evaluated, aiming to identify the top prescribers and members associated with their usage.
New Hampshire	The NH Medicaid DUR Board met twice during FFY 2022 on December 2, 2021 and June 2, 2022 where drug utilization patterns for prospective and retrospective activity were discussed. During the hybrid meetings, 34 current clinical criteria updates and 9 new clinical criteria were approved. During FFY 2022, the following clinical criteria were updated with new medications, new indications, and guideline changes: 1. Adenosine Triphosphate Citrate Lyase Inhibitor 2. Anti-Fungal Medications for Onychomycosis 3. Asthma/Allergy Immunomodulator 4. Atopic Dermatitis 5. Brand Name Multiple Source Prescription Drug Product 6. Buprenorphine/Naloxone and Buprenorphine (Oral) 7. Calcitonin Gene-Related Peptide (CGRP) Inhibitor 8. Carisoprodol and Combination Criteria

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	9. CNS Stimulants and ADHD/ADD Medications 10. Duloxetine 11. Dupixent 12. Hepatitis C Agents 13. Human Growth Hormone 14. Hyaluronic Acid Derivatives 15. Inhaled Insulin 16. Long-Acting Opioid Analgesic 17. Lyrica 18. Methadone 19. Morphine Milligram Equivalent 20. Movement Disorders 21. New Drug Product 22. Oral Isotretinoin 23. Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) 24. Psychoactive Medication for Children (5 years and younger) 25. Psychotropic Medication Duplicate Therapy (Patients 6 years and older) 26. Pulmonary Arterial Hypertension 27. Restless Leg Syndrome 28. Rho Kinase Inhibitors 29. Spinraza 30. Symlin 31. Synagis 32. Systemic Immunomodulators 33. Weight Management 34. Zolgensma The following were new clinical criteria approved during FFY 2022: 1. Codeine for Pediatric Use 2. Convenience Kits 3. Hetlioz/Hetlioz LQ 4. Juxtapid 5. Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease 6. Second-Line Antifungal 7. Stromectol 8. Verquvo 9. Vuity The NH DUR Board removed the criteria for Oral NSAIDs and Combinations Legend and Topical NSAIDs Legend to eliminate disruptions in access for non-opioid analgesic medications. NH DUR Board continues to monitor Therapeutic Duplications, Drug-Drug interactions, Duplicate Ingredients and Early Refills. NH Medicaid continues to utilize First Databank 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

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	interventions that will be performed until the next DUR Board meeting. Profiles are reviewed and letters are mailed to prescribers when the prescriber is identified to be involved in care for a specific member pertaining to the topic or when an educational alert is necessary. In addition to the offerings suggested by the RetroDUR vendor, a DUR member requested review of clozapine co-prescribing with benzodiazepines based on a trend noted at their community practice site highlighting the ongoing DUR member engagement in selecting RetroDUR activities.
New Jersey	The DUR Board held four meetings on October 20, 2021, January 19, 2022, April 20, 2022, and July 13, 2022. October 2021: 1. Addendum to the Duchenne Muscular Dystrophy (DMD) drugs protocol: The Board reviewed and recommended an addendum to add a recently FDA-approved product, Amondys 45 (casimersen), and to change the name from Vyondys 53 Protocol to Duchenne Muscular Dystrophy Products. 2. Protocol for Aduhelm (aducanumab-avwa): The Board approved the protocol for Aduhelm, a product which was recently approved by the FDA for the treatment of early-stage Alzheimer's disease. 3. Protocol for Bronchitol (mannitol): The Board approved the protocol for Bronchitol to be used as add-on treatment for cystic fibrosis. 4. Protocol for Imcivree (setmelanotide): The Board approved the protocol for Imcivree for the treatment of obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency. The protocol requires confirmation of this type of obesity prior to treatment. 5. Exclusion Protocol for Stromectol (ivermectin): The Board recommended that only the quantity of ivermectin required for the treatment of FDA-approved indications will be authorized. The Board also recommended a Dear Prescriber letter to ensure that prescribers are aware of these limits and the reason for the recommending this limit. January 2022: 1. Addendum to the protein convertase subtilisin/kexin type 9 (PCSK9) inhibitors protocol: The Board reviewed and approved an addendum to the PCSK9 protocol, adding recently FDA-approved indications for both products, Praluent, and Repatha. The update also adjusted the eligibility age for Repatha to pediatric patients ages 10 and older for approved indications. 2. Addendum to the Spravato (esketamine) protocol: The Board reviewed and approved an addendum to the Spravato protocol adding the new FDA approved indication for depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior. 3. Protocol for Gamifant (emapalumab-lzsg): The Board approved the protocol for Gamifant, an interferon gamma blocking antibody, to be used for the treatment of primary hemophagocytic lymphohistiocytosis (HLH). 4. Protocol for Nitisinone products (Nityr and Orfadin): The Board approved the protocol for Nityr and Orfadin for the treatment of hereditary tyrosinemia type 1 (HT-1). 5. Protocol for Lucemyra (lofexidine): The Board approved the protocol for Lucemyra for use in medically supervised opioid withdrawal therapy. 6. Protocol for Paxlovid (nirmatrelvir/ritonavir): The Board approved the protocol for Paxlovid for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients

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	aged >12 years and weight > 40 kg under the FDA's emergency use authorization (EUA) guidelines. 7. Protocol for molnupiravir: The Board approved the protocol for molnupiravir for the treatment of mild-to-moderate COVID-19 in adults under the FDA's EUA guidelines. April 2022: 1. Protocol for Hetlioz (tasimelteon): The Board approved the protocol for Heltioz for the treatment of non-24-hour sleep-wake disorder. 2. Protocol for cysteamine products (Cystagon and Procysbi): The Board approved the protocol for Cystagon and Procysbi for the treatment of nephropathic cystinosis. 3. Protocol for Revcovi (elapegademase-lvlr): The Board approved the protocol for Revcovi for the treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients. 4. Protocol for Luxturna (voretigene neparvovec-rzyl): The Board approved the protocol for Luxturna for patients with a diagnosis of confirmed biallelic RPE65 mutation-associated retinal dystrophy. July 2022: 1. Protocol for Vuity (pilocarpine ophthalmic): The Board approved the protocol for Vuity for the treatment of presbyopia, a gradual loss of the eyes' ability to focus on nearby objects. 2. Protocol for paroxysmal nocturnal hemoglobinuria (PNH) products (Empaveli, Soliris, Ultomiris): The Board approved the protocol for Empaveli (pegcetacoplan), Soliris (eculizumab) and Ultomiris (ravulizumab) for the treatment of PNH. 3. Protocol for Bylvay (odevixibat): The Board approved the protocol for Bylvay for the treatment of pruritus in patients with progressive familial intrahepatic cholestasis (PFIC). The DUR Board reviewed COVID-19 vaccine information at every meeting. In January 2022, a prescriber newsletter on ivermectin was approved and distributed. The DUR Board also reviewed utilization of drugs and products with DURB-recommended protocols for CY 2020. In July 2022, the Board discussed an educational newsletter on oral COVID-19 medications. Various medication information resources were also presented, including the New Jersey COVID-19 Information Hub.
New Mexico	The DUR Board met four times in FFY 2022. The DUR board did not approve, delete, or change any NCPDP ProDUR criteria or RetroDUR therapeutic categories. There were no changes in DUR Board Policies for RetroDUR screenings adjusting ProDUR screenings. The Board reviewed existing edits and current utilization data for interventions and strategies in accordance with the SUPPORT act which included usage of opioids with benzodiazepines, antipsychotics, skeletal muscle relaxants and/or gabapentin. Data reviewed to assess intervention and edit needs also included MME limits, early refills, and quantity limits. The monitoring of second-generation antipsychotics in youth also continued. The DUR Board evaluated the utilization and need for Epidiolex and Aduhelm and discussed future interventions for Tumor Necrosis Factors, ADHD, and further diabetes education. However, DUR Board members limitations resulted in delays of direct patient interventions and provider.
New York	There were three DUR Board meetings held during the reporting period. Meeting dates and activities are as follows:

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	November 18, 2021 The DUR Board reviewed the utilization of Central Nervous System (CNS) stimulants use concurrently with other controlled substances, specifically, benzodiazepines and opioids. The DUR Board was provided updates on the following topics: 1. Statewide Formulary for Opioid Dependence Agents and Opioid Antagonists 2. Respiratory Synctical Virus (RSV) Season and palivizumab 3. Direct Acting Antivirals (DAA) for Hepatitis C Virus (HCV) 4. Supplemental Rebate Initiatives May 12, 2022 The DUR Board reviewed information regarding esketamine nasal spray (Spravato) and recommended clinical criteria to ensure appropriate drug utilization. The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred or non-preferred in the following therapeutic classes: 1. Cholesterol Absorption Inhibitors 2. Antimigraine Agents-Other 3. Movement Disorders Agents 4. Acne Agents-Topical 5. Antifungals-Topical 6. Dipeptidyl Peptidase-4 (DPP-4) Inhibitors 7. Glucagon-like Peptide-1 (GLP-1) Agonists 8. Growth Hormones 9. Antihyperuricemics 10. Anticholinergics/COPD Agents The DUR Board was presented information regarding asthma guidelines and the use of inhaled corticosteroids / long-acting beta agonist combinations for maintenance and reliever therapy. July 14, 2022 The DUR board was presented information regarding the management of physician/practitioner administered drugs (PADs). The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred or non-preferred in the following therapeutic classes: 1. Antipsychotics-Injectable 2. Antipsychotics-Second Generation 3. Other Agents for Attention Deficit Hyperactivity Disorder 4. Immunomodulators-Systemic 5. Glucagon Agents The DUR Board reviewed the drugs/drug classes listed below and recommend clinical criteria to ensure appropriate drug utilization:

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	1. aduncanumab (Aduhlem) 2. Botulinum Toxins onabotulinumtoxinA (Botox), abobotulinumtoxinA (Dysport), rimabotulinumtoxinB (Myobloc), inobotulinumtoxinA (Xeomin) 3. infliximab (Remicade), infliximab-abda (Renflexis), infliximab-axxq (Avsola), infliximab-dyyb (Inflectra) 4. vedolizumab (entyvio) Additional DUR Board Meeting information can be found at: https://www.health.ny.gov/health_care/medicaid/program/dur/index.htm
North Carolina	The North Carolina Drug Utilization Review (DUR) Board meets quarterly in January, April, July, and October of each year. Starting July 2021 North Carolina transitioned to Managed Care. The Board reviewed drug utilization data and trends for both the Fee-for-Service (FFS) and managed care (MCO) population. 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 and/or retrospective interventions such as DUR lettering to pharmacies and/or prescribers and newsletters. 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), treatment for ADHD/narcolepsy (H2V), and antipsychotics, dopamine antagonist, butyrophenones (H7O). Anticonvulsants (H4B), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), and SSRIs (H2S) ranked the top in drug-drug interaction alerts. The top overuse alerts consisted of antipsychotic, atypical, dopamine, serotonin antagonist (H7T), treatment for ADHD/narcolepsy (H2V), and adrenergics, aromatic, non-catecholamine (J5B). The top high dose alerts were antipsychotic, atypical, dopamine, serotonin antagonist (H7T), antihistamines- 2nd generation (Z2Q), treatment for ADHD/narcolepsy (H2V), and SSRIs (H2S). Antipsychotic, atypical, dopamine, serotonin antagonist (H7T), anticonvulsants (H4B), and treatment for ADHD/narcolepsy (H2V) were the top categories in the ingredient duplication alerts. The top low dose alerts were linosamide antibiotics (W1K), macrolide antibiotics (W1D), penicillin antibiotics (W1A), Covid-19 vaccines (Z0L), anticonvulsant-BZD Type (H4A), beta-adrenergic-anticholinergic-glucocort, inhaled (B64), and anti-anxiety-benzodiazepines (H20). The highest ranked drug underuse alerts were anticonvulsants (H4B), SSRIs (H2S), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), and treatment for ADHD/narcolepsy (H2V). The top drug age alerts included antihistamines- 1st generation (Z2P), absorbable sulfonamide antibacterial agents (W2A), and antiparkinsonism drugs, anticholinergic (H6B). The top pregnancy alerts were anticonvulsants (H4B), SSRIs (H2S), and opioid withdrawal therapy agents, opioid-type (H3W). Anticonvulsants (H4B), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), and SSRIs (H2S) were the top therapeutic duplication alerts.

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	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 15 Drugs (GSN) by total claims were ProAir HFA (average ~25K claims/quarter), cetirizine 10 mg tab (average ~20K claims/quarter), cetirizine 1 mg/mL (average ~23K claims/quarter), fluticasone nasal (average ~16K claims/quarter), and vitamin D 50,000-unit caps (average ~5K claims/quarter). Humira CF Pen 40 mg/0.4 ml (average ~$6M/quarter), Biktarvy 50-200-25 tab (average ~$3.3M/quarter), Suboxone Film (average ~$3.6M/quarter), and Invega Sustenna (average ~$2.3M/quarter) were in the top 15 Drugs (GSN) by total amount paid. The top 15 drugs (GSN) by total amount paid (all strengths) included Humira (average ~$8.8M/quarter), Invega (average ~$4.9M/quarter), Concerta (average ~$5.4M/quarter), Vyvanse (average ~$5.4M/quarter), and Latuda (average ~$2.6M/quarter). The Top 15 GC3 classes by payment amount included anti-inflammatory tumor necrosis fac (S2J; average ~$14.3M/quarter), anticonvulsants (H4B; average ~$9.5M/quarter), atypical, dopamine, serotonin antagonist (H7T; average ~$10.4M/quarter), and anti-narcolepsy/anti-hyperkinesis (H2V; average ~$3.5/quarter). In 2021 and 2022 the retrospective drug utilization categories included the examination of opioids used in combination with select medications that have synergistic effects. The Board also focused their attention on health disparities in the treatment of Hepatitis C and access to opioid dependence treatment medication based on patient demographics and geographic location. Compliance rates of medications and ways to promote appropriate use are always at the forefront and this year North Carolina reviewed trends in diabetic medication use and blood glucose testing. The Board also reviewed the use of benzodiazepines and gabapentin in patients who have been diagnosed with substance abuse disorder and the use of short-acting opioids in patients with opioid use disorder. Use and trending of clozapine, emtricitabine/tenofovir alafenamide, and Hepatitis C therapy were also examined by the North Carolina DUR Board.
North Dakota	Four North Dakota Medicaid DUR Board meetings were held during FFY 2022. The meetings were held on December 1, 2021, March 2, 2022, June 1, 2022, and September 7, 2022. For prospective DUR, prior authorization criteria was put in place for the following problem types/drugs by the DUR Board: chronic kidney disease (Kerendia), lupus (Benlysta, Lupkynis, Saphnelo), familial cholestasis pruritis (Bylvay, Livmarli), Wilson's disease (Cuvrior), Cushing's syndrome (Recorlev), presbyopia (Vuity), vernal keratoconjunctivitis (Verkazia), amyloidosis (Tegsedi, Vyndaqel, Vyndamax), amyotrophic lateral sclerosis (riluzole and edaravone agents), and chelating agents. No deletions of DUR Board approved prospective DUR criteria occurred in FFY 2022. For retrospective DUR (RDUR), the DUR Board voted to approve and add a total of 360 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 cancer, multiple sclerosis, ADHD, cystic fibrosis, seizure disorder, Crohn's

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	disease, migraine, mood disorder, peptic ulcer, proteinuria, atopic dermatitis, HIV, insomnia, rheumatoid arthritis, and osteoporosis. No deletions of DUR Board approved retrospective DUR criteria occurred in FFY 2022. The RDUR vendor for the North Dakota Medicaid program, KEPRO 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 are 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 electronic/remote 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 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 and on the intervention topic.
Ohio	November 9, 2021 DUR Board Meeting Five RetroDUR interventions were reviewed at this quarterly meeting. Refer to previous section for summaries of interventions. The Board reviewed and approved interventions and communication. After reviewing the interventions, the Board was updated on a monthly outreach program, which contacts prescribers and pharmacists whose patients were concomitantly taking medication assisted therapy (MAT) with opioids or benzodiazepines in the previous month. A quarterly update on Coordinated Services Program (CSP) membership was provided to the Board. To close out the meeting, the Board then reviewed the 2022 calendar of RetroDUR interventions. February 8, 2022 DUR Board Meeting Six RetroDUR interventions were reviewed at this quarterly meeting. Refer to previous section for summaries of interventions. The Board reviewed and approved interventions and communication. After reviewing the interventions, the Board was updated on a monthly outreach program, which contacts prescribers and pharmacists whose patients were concomitantly taking (MAT) with opioids or benzodiazepines in the previous month. Then a quarterly update on CSP membership was provided to the Board. There was an update to ensure access to the COVID-19 vaccine and boosters, COVID-19 home diagnostic tests in line with federal guidance, and oral COVID-19 treatments as they gain emergency use authorization. Next, an overview of the Fee-for-Service (FFS) member demographics and claims data was presented. Following this, the January 1, 2022 Unified Preferred Drug List (UPDL) update was presented. The Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents, Endocrine Agents: Diabetes-Insulin and Non-Insulin, and Respiratory Agents: Inhaled Agents categories were presented, along with the revised prior authorization form for Hepatitis C and highlighting the removal of the specialty prescriber requirement. After receiving continued input from the provider community regarding prior authorization requirements for (MAT), ODM recommended removal of clinical prior

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	authorization from long-acting forms of buprenorphine to allow prescribers to initiate immediate treatment to eligible patients as soon as possible. After a robust discussion about lifting the requirements of prior authorization for Sublocade, the DUR Board voted unanimously in approval of removing prior authorization. An update on past recommendations made by the Board regarding sending reminder intervention letters to providers in 14 days rather than 30 days, redesign of the prescriber letter to decrease provider fatigue, and an online response option for intervention surveys was presented. The new Chair and Co-Chair were voted in for 2022. To close out the meeting, the Board then reviewed the 2022 calendar of RetroDUR interventions. May 10, 2022 DUR Board Meeting Six RetroDUR interventions were reviewed at this quarterly meeting. First, three re-reviews were presented. The first re-review results of the RetroDUR intervention directed at prescribers whose patients were taking a PPI for greater than 6 months were presented. The second re-review results of the RetroDUR intervention directed at prescribers whose patients were taking opioids greater than 80 Morphine Equivalent Daily Doses (MED) were presented. The third re-review results presented were from the intervention directed at prescribers whose patients were taking prolonged triple antithrombotic therapy for greater than 30 days. Next, the prescriber responses and an overview of two recent interventions were presented. The first intervention was to prescribers of CSP members who did not have a pharmacy claim for naloxone. Prescribers were encouraged to ensure that their patient has access to naloxone if they are currently taking an opioid, have a history of addiction or dependence to opioids, history of illicit drug use, current or past medication assisted treatment for opioid use disorder, or history of poisoning involving an opioid. The second intervention was to prescribers whose patients have asthma and had pharmacy claims for a non-selective beta-blocker. Prescribers were educated on the potential for non-selective beta-blockers to exacerbate asthma symptoms in patients with asthma and encouraged to weigh the risk/benefit and to change the non-selective beta-blockers to a selective beta-blocker where appropriate. Lastly, an overview of the newest intervention targeting members with atherosclerotic cardiovascular disease (ASCVD) but not taking a statin and the member demographics were presented. After reviewing the interventions, the Board was updated on the monthly outreach program for prescribers and pharmacists whose patients are taking either MAT and opioids or MAT and benzodiazepines concomitantly the previous month and some of the prescribers' and pharmacists' responses were presented. Then a quarterly update on CSP membership was provided to the Board. The DUR Board's decision to remove Sublocade prior authorization criteria was announced during the P&T meeting held on April 6,2022. The P&T committee voted to remove prior authorizations on sublingual buprenorphine products, replacing them with a safety edit for buprenorphine doses greater than 24mg per day. ODM announced that the State of Ohio Board of Pharmacy Ohio Automated RX Reporting System (OARRS) 2021 Annual Report had been published and that opioid and benzodiazepine prescribing continue to fall in both Ohio and Medicaid FFS populations. Following this, the April 1, 2022 UPDL update was presented. New medications in the Central Nervous System (CNS) Agents: Atypical Antipsychotics class were presented as well as changes in criteria for this class. The revised therapeutic category criteria for Cardiovascular Agents: Lipotropics was also presented with the changes being highlighted. To close out the meeting, the Board then reviewed the 2022 calendar of RetroDUR interventions. September 20, 2022 DUR Board Meeting Eight RetroDUR interventions were reviewed at this quarterly meeting. First, three re-reviews were presented. The first re-review results of the RetroDUR intervention directed at prescribers whose patients were less than 18 years old and taking at least one opioid prescription were presented. The

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	second re-review results of the RetroDUR intervention directed at prescribers whose patients were taking multiple anticholinergic medications or seeing multiple prescribers who were issuing medication with anticholinergic action were presented. The third re-review results presented were from the intervention directed at prescribers whose patients were taking antipsychotic and opioid medication concurrently for 60 days or longer. Next, the prescriber responses and an overview of four recent interventions were presented. The first intervention was to prescribers whose patients had a diagnosis of ASCVD and did not have a pharmacy claim for a statin. Prescribers were encouraged to prescribe a high intensity statin for their patients, and if adverse effects have occurred from a statin in the past, to consider a re-trial with a different statin or a lower dose and titrate up as tolerated. The second intervention was to prescribers whose patients had received overlapping opioid prescriptions from prescribers at different practice sites. Prescribers were made aware their patients received opioids from prescribers at different practice sites, encouraged to communicate between patients and their opioid prescribers, and encouraged to check OARRS before prescribing controlled substances. Both patients and prescribers were encouraged to enter into a pain management agreement. The third intervention was to prescribers whose patients were taking benzodiazepine monotherapy for anxiety and have not previously taken a different anxiety medication. Prescribers were encouraged to prescribe first line anxiety medications, such as SSRIs or SNRIs, to their patients when pharmacologic treatment for anxiety is indicated and to weigh the risks and benefits of long-term benzodiazepine use. The fourth recent intervention was to prescribers with patients having a diagnosis of HFrEF who were not taking an ACE-I, ARB, or ARNI. Prescribers were encouraged to follow guideline-directed medical therapy by prescribing an ACE-I, ARB, or ARNI and ensure continued adherence for their patients with heart failure with reduced ejection fraction. Lastly, an overview of the newest intervention targeting members with asthma COPD who had filled six or more albuterol prescriptions in six months with no controller inhaler. The prescriber letter was presented, and edits were taken from the Board. Then a quarterly update on CSP membership was provided to the Board. ODM initiated the start of an atypical Synagis season effective August 25, 2022. Doses given during the atypical season will not count towards the five doses of Synagis allowed on or after November 1, 2022. To close out the meeting, the Board then reviewed the 2022 calendar of RetroDUR interventions.
Oklahoma	During FFY 2022 the DUR Board met 11 times. Meetings were held in October, November, and December 2021, and January, February, April, May, June, July, August, and September 2022. In accordance with State legislative mandate, 23 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 2022: CBPA Categories/Products Added:

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	Margenza, Orgovyx, Jakafi, Rezurock, Bylvay, Lupkynis, Saphnelo, Opzelura, Abecma, Farydak, Pepaxto, Jemperli, Livmarli, Myfembree, Tyrvaya, Byooviz, Susvimo, Empaveli, Evkeeza, Leqvio, Elepsia, Eprontia, Winlevi, Dojolvi, Qulipta, Erwinase, Erwinaze, Oncaspar, Rylaze, Scemblix, Releuko, Lampit, Voxzogo, Ponvory, Brexafemme, Zynlonta, Nexviazyme, Kerendia, Rezvoglar, Semglee, Exkivity, Lumakras, Rybrevant, Livtencity, Ryplazim, Fleqsuvy, Loreev XR, Sutab, Tarpeyo, Vuity, Xipere, Camcevi, Pluvicto, Tivdak, Welireg CBPA Categories/Products Modified: Breast Cancer Medications, Evrysdi, Botulinum Toxins, Dupixent, Nucala, Xolair, Carbaglu, Multiple Myeloma Medications, Keytruda, Lenvima, Skin Cancer Medications, Crohn's Disease and Ulcerative Colitis Medications, Anticoagulants and Platelet Aggregation Inhibitors, Dry Eye Disease Medications, Arcalyst, Leukemia Medications, Hemophilia Medications, Granulocyte Colony-Stimulating Factors (G-CSFs), Systemic Antifungal Medications, Lymphoma Medications, Lung Cancer Medications, Genitourinary and Cervical/Endometrial Cancer Medications PBPA Categories/Products Added: Sertraline Capsule, Trudhesa, Skytrofa, Ryaltris, Xelstrym, Quviviq, Invega Hafyera, Citalopram Capsule, Dartisla ODT, Lofena, Norliqva, Seglentis PBPA Categories/Products Modified: Targeted Immunomodulator Agents, Antidepressants, Glaucoma Medications, Antihyperlipidemics, Anti-Migraine Medications, Growth Hormone Products, Multiple Sclerosis Medications, Nasal Allergy Medications, Anti-Diabetic Medications, Attention-Deficit/Hyperactivity Disorder (ADHD) and Narcolepsy Medications, Insomnia Medications, Atypical Antipsychotic Medications 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 includes 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.

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	Academic Detailing (AD) Program: This program provides educational, evidence-based, in-person meetings to prescribers of targeted medication categories including ADHD medications, atypical antipsychotics, and treatment of diabetes and is intended to encourage evidence-based prescribing practices among SoonerCare prescribers. 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 2022: Fall 2021 Pipeline Update, FDA Safety Alerts, AD Program Update, Maintenance Drug List, Opioid Initiative Update, Use of Glucagon-Like Peptide-1 Agonists or Sodium-Glucose Co-Transporter-2 Inhibitors with Cardiovascular (CV) Benefit in Members with Type 2 Diabetes and High CV Risk or Established Atherosclerotic CV Disease Mailing Update, Narrow Therapeutic Index Drug List, 2022 Spring Pipeline Report, MTM Calendar Year 2021 Review, Prenatal Vitamin Utilization Update, SoonerPsych and Pediatric Antipsychotic Monitoring Program Update, Annual Review of the SoonerCare Pharmacy Benefit, CMA Program Update, Use of Statins in Members with Diabetes Mellitus, Nonalcoholic Fatty Liver Disease Overview ProDUR Edits Implemented during FFY 2022: Added coverage of COVID-19 vaccine booster doses as pharmacy benefit per EUA, reviewed and updated the list of covered diabetic testing supplies, added coverage of OTC COVID-19 tests and coverage of pediatric COVID-19 vaccines as pharmacy benefit per EUA, 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 2022. 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 2022: CBPA Drugs/Categories: Spinal Muscular Atrophy Medications, Hepatitis C Medications, Ovarian Cancer Medications, Beta Thalassemia and Sickle Cell Disease Medications, Botulinum Toxins, Carbaglu, Multiple Myeloma Medications, Lenvima, Atopic Dermatitis Medications, Mycapssa, Signifor LAR, Skin Cancer Medications, Crohn's Disease and Ulcerative Colitis Medications, Anticoagulants and Platelet Aggregation Inhibitors, Enspryng, Soliris, Ultomiris, Uplizna, Alpha1-Proteinase Inhibitors, Amyloidosis Medications, Amyotrophic Lateral Sclerosis Medications, Chorionic Gonadotropin Medications, Constipation and Diarrhea Medications, Corticosteroid Special Formulations, Crysvita, Erythropoietin Stimulating Agents, Fabry Disease Medications, Gaucher Disease Medications, Givlaari and Scenesse, Hyperkalemia Medications, Lambert-Eaton Myasthenic Syndrome Medications, Northera, Ocaliva, Pancreatic Enzymes, Parathyroid Medications, Qbrexza, Revcovi, Tepezza, Thrombocytopenia Medications, Oxlumo, Dry Eye Disease Medications, Imcivree, Elzonris and Inrebic, Turalio, Arcalyst, Leukemia Medications, Azedra, Anticonvulsants, Zokinvy, Topical Acne and Rosacea Products, Actinic Keratosis Medications, Allergen

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	Immunotherapies, Anti-Emetic Medications, Hereditary Angioedema Medications, Inhaled Anti-Infective Medications, Injectable and Vaginal Progesterone Products, Iron Chelating Agents, Korlym, Parkinson's Disease Medications, Phenylketonuria Medications, Procysbi, Strensiq, Xgeva, Xiaflex, Hemophilia Medications, Lymphoma Medications, Lutathera, Vitrakvi, G-CSFs, Anti-Parasitic Medications, Systemic Antifungal Medications, Lung Cancer Medications, Ayvakit and Bynfezia Pen, Heart Failure Medications, Muscular Dystrophy Medications, Lumizyme, Genitourinary and Cervical/Endometrial Cancer Medications, Antiviral Medications, Various Special Formulations, Benzodiazepine Medications, Bowel Preparation Medications, Butalbital Medications, Gout Medications, Idiopathic Pulmonary Fibrosis Medications, Leukotriene Modulators, Mozobil, Naloxone Medications, Nuedexta, Phosphate Binders, Prenatal Vitamins, Pulmonary Hypertension Medications, Qutenza, Ravicti, Smoking Cessation Products, Vasomotor Symptom Medications, Vesicular Monoamine Transporter 2 Inhibitor Medications, Colorectal Cancer Medications, Danelza, Koselugo, Pemazyre, Qinlock, Truseltiq, Alzheimer's Disease Medications, Various Systemic Antibiotics, Isturisa, Intravenous Iron Products, Cystic Fibrosis Transmembrane Conductance Regulator Modulators, Breast Cancer Medications, Synagis, Nulibry, Cholbam, Cystadrops and Cystaran, Defitelio, Gamifant, Jynarque, Keveyis, Lidocaine Topical Products, Oxlumo, Vimizim, Zinplava PBPA Categories: Targeted Immunomodulator Agents, Asthma and Chronic Obstructive Pulmonary Disease Maintenance Medications, Antidepressants, Benign Prostatic Hyperplasia Medications, Fibromyalgia Medications, Pediculicide Medications, Antihyperlipidemics, Glaucoma Medications, Gonadotropin-Releasing Hormone Medications, Anti-Migraine Medications, Antihistamine Medications (Oral), Antihypertensive Medications, Anti-Ulcer Medications, Bladder Control Medications, Ophthalmic Allergy Medications, Ophthalmic Antibiotic Medications, Osteoporosis Medications, Short-Acting Beta2 Agonists, Growth Hormone Products, Multiple Sclerosis Medications, Nasal Allergy Medications, Anti-Diabetic Medications, ADHD and Narcolepsy Medications, Insomnia Medications, Atypical Antipsychotic Medications, Muscle Relaxant Medications, Non-Steroidal Anti-Inflammatory Drugs (systemic), Otic Anti-Infective Medications, Topical Antibiotic Products, Topical Antifungal Products, Testosterone Products, Ophthalmic Anti-Inflammatory Products, Opioid Analgesics and Opioid Medication Assisted Treatment Medications, Topical Corticosteroids
Oregon	DUR Board meetings held: 6 Additions/deletions to DUR Board approved criteria: Added new FDA-approved antineoplastic agents to Table 1 in the Oncology Agents PA criteria. Updated Table 1 in the Orphan Drugs PA criteria to support medically appropriate use new orphan drugs or expanded indications based on FDA-approved labeling. Renamed the Biologics for Autoimmune Disease to Targeted Immune Modulators and modified the PA criteria to include expanded ages and indications. Modified the Multiple Sclerosis Oral Agents PA criteria to include the expanded indication for ozanimod in adults with moderate-to severe ulcerative colitis. Updated the CGRP Inhibitor PA criteria to clarify the difference between acute (abortive) and prophylactic (preventative) treatment, updated the recommended drugs for cluster

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	headache, and added a question to require providers assess for uncontrolled hypertension prior to initiation of therapy for applicable agents, including Aimovig. Updated the DAA PA criteria and treatment table to include new pediatric indications. Updated the PAH PA criteria to include expanded indications. Implemented Alzheimer's Disease PA criteria and modified renewal criteria to prevent continuation of therapy in patients with any evidence of microhemorrhage to ensure appropriate use. Updated the evinacumab initial approval PA criteria to require 12 weeks of maximally tolerated therapy and added renewal PA criteria with a question to evaluate pregnancy risk. Updated the safety edit for esketamine to clarify appropriate maintenance dose and use in patients with a history of substance use disorder. Recommended development of an educational retrospective DUR program to improve provider knowledge of PrEP for patients with a recent sexually transmitted infection, diagnosis of high-risk sexual behavior, or potential viral exposure. Revised the ravulizumab PA criteria to reflect an expanded indication for use in pediatric patients aged one month and older with PNH or atypical hemolytic uremic syndrome (aHUS) and revised the accompanying dosing table. Added pegcetacoplan to the Biologics for Rare Diseases drug class and to implemented PA criteria for pegcetacoplan to limit use to FDA-approved indications funded by the OHP. Implemented new PA criterion for GnRH modifiers to evaluate GnRH antagonists separately from GnRH agonists. Updated the Growth Hormone PA criteria to include lonapegsomatropin. Modified the obeticholic acid PA criteria to include recommended dosing parameters and safety precautions. Updated the RSV PA criteria to correlate with State guidance on season onset. Updated the PA criteria for Pompe Disease drugs to include avalglucosidase alfa and require provider assessment of risk factors for adverse events and whether baseline tests have been performed. Updated the belimumab PA criteria; implemented the PA for voclosporin; and implement the anifrolumab-fnia PA criteria to ensure appropriate use. Implemented PA criteria for emergency drug coverage of drugs prescribed for patients with the CWM benefit. Updated the botulinum toxins PA criteria. Updated the non-preferred drugs and drugs for non-funded conditions PA criterion to align with the final version of Statement of Intent 4 (SOI4) from the Health Evidence Review Commission's Prioritized List of Health Services. Removed DAA PA criteria and required case management for preferred DAA regimens for treatment-naive patients with hepatitis C virus, but to continue to require PA for: re-treatment of HCV; non-preferred DAAs; and for uses not FDA-approved. Updated sickle cell disease PA criteria for expanded age indication for voxelotor; removed requirement for documentation of baseline pain crises for voxelotor; clarified hydroxyurea use; and clarified documentation of benefit required for renewal. Revised the fabry disease PA criteria to reflect the expanded indication for agalsidase beta. Implemented vosoritide PA criteria to ensure appropriate use. Implemented efgartigimod PA criteria to ensure appropriate use. Implemented the tetracyclines PA criteria to support the approved quantity limits. Updated the ADHD PA criteria with maximum doses for extended release versions.

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	Implemented finerenone PA criteria to limit use to patients with chronic kidney disease and type 2 diabetes on background therapy with an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker. Updated the PA criteria for drugs used to manage atopic dermatitis (AD) to reflect an update to Guideline Note 21 from the Health Evidence Review Commission's Prioritized List of Health Services to include facial involvement in the severity assessment of inflammatory skin conditions and add severe vitiligo as a funded condition. Renamed the AD and psoriasis PA criteria the Topical Agents for Inflammatory Skin Conditions and apply to topical ruxolitinib. Renamed the Monoclonal Antibodies for Severe Asthma PA criteria the TIMs for Severe Asthma and Atopic Dermatitis and apply to: abrocitnib; tralokinumab; and tezepelumab. Included severe AD as an FDA-approved diagnosis for upadacitinib in the TIMs for Autoimmune Conditions PA criteria and: reduce the threshold for blood eosinophils to 150 cells/microL for monoclonal antibodies prescribed for eosinophilic asthma; updated the definition of severe asthma exacerbation; and included the use of oral corticosteroids in asthma exacerbation criteria. Removed the PA requirement and PMPDP coding for bedaquiline and to keep open access for all agents. Renamed the PCSK9 modulators class and included inclisiran to limit use to its FDA indication and require trial of agents with evidence of cardiovascular risk reduction. Removed the PA requirement for preferred intranasal allergy products for children up to their 21st birthday. ProDUR reports are presented quarterly and results inform potential changes to PA criteria and RetroDUR initiatives. RetroDUR reviews and Drug Use Evaluations inform changes to PA criteria and ProDUR edits. DUR Board involvement in education (e.g. Newsletters): Anti-SARS-CoV-2 Therapeutics can Effectively Treat, Prevent COVID-19 Infection A PEP Talk on PrEP-ing for HIV Prevention Second-Generation Antipsychotic Use in Children and Adolescents Updated 2021 Treatment Guidelines for Sexually Transmitted Infections Asthma Guidance Update with a Focus on Changes for Managing Patients with Mild Asthma Population Trends in the Use of Migraine Preventative Treatments Antimicrobial Stewardship An Update in Lipid Lowering Therapies COVID-19 Vaccine Bivalent Boosters
Pennsylvania	The DUR Board met once in FFY 2022 on the following dates: 1. November 3, 2021 The DUR Board recommends prospective hard edits and develops prior authorization guidelines to help ensure that the medications are used appropriately with respect to indications, duration, dosage and avoidance of potential drug or disease interactions. The

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	following topics were identified during FFY 2022 as focus areas for the DUR Board to assess and promote appropriate utilization: 1. New clinical prior authorization of the following: a. Aduhelm (aducanumab) 2. Revisions to the following prior authorization guidelines: a. Growth Hormones b. Immunosuppressives, Oral [Lupkynis (voclosporin)] c. Xywav (calcium, magnesium, potassium, and sodium oxybates) 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 the prospective claims edits and develops the prior authorization guidelines used by the Department's clinical reviewers to determine medical necessity. 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 (4) times during FFY 2022. 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 2022, the top 10 alerts are noted in Summary 1. 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

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	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. 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	The State continues the restructuring of the DUR Board. The Agreement between SCDHHS and MUSC (The Medical University of South Carolina) for the provision of drug utilization review (DUR) services has supported educational outreach focused on safer opioid prescribing and expanded access to treatment for opioid use disorder (OUD); data analysis of unidentified Medicaid claims data for eight mutually agreed upon index surgeries performed between 2014 and 2017 to identify the trajectory of opioid dependence and chronic use post-surgery; and management of the Agency's Medication Assisted Treatment (MAT) coverage guidelines. This reporting period, the use of information derived from data analyses to help tailor educational outreach and print materials on post-surgical pain management became a reality with the launch of the topic Balancing Comfort and Safety in Post-Op Pain Management at the October meeting of the South Carolina Surgical Quality Collaborative (SC SQC). The collective expertise of the analytics team and the tipSC writing group has undoubtedly strengthened this intervention and its potential to impact the practice behavior of both surgeons and primary care providers around surgical pain management and care coordination and alter the chronic opioid use trajectory, enhance patient satisfaction, and lower healthcare utilization. The following highlight some of the efforts within the fiscal year Academic Detailing AD style visits to pharmacies by student pharmacists following mini training on topic and AD principles Visits to pharmacists: Total count: 69, Visits to pharmacy staff : Total count: 63; AD visits to primary care providers Topic selected based on individualized needs of provider 'Shared Support not Stigma,' handout with staff at all applicable visits, regardless of topic, Academic detailing visits to prescribers= 34, AD follow-up visits to prescribers=122. August 2022 MAT Guidelines-Policy Advisory Committee Meeting to elicit input for guidelines Educational Outreach Content Development: Low-Dose Naltrexone Is there a role for ORAL LDN in chronic pain management? and Balancing Comfort and Safety in Post-Op Pain Management for surgeons finalized and printed (October 2022).

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South Dakota	Patient profiles were generated eleven times during the October 1, 2021 through the September 30, 2022 fiscal year. Attached are the background material on the reviews conducted during the fiscal year. Note that the term DEEP refers to the South Dakota Drug Evaluation and Education Program the long time name for the State's retrospective DUR program. The term ICER refers to the Initial Criteria Exception Report which is used to determine which cases require additional review. The RDUR committee consisting of 2 physicians and 4 pharmacists retrospectively screen and review patient profiles identified by the ICER. A determination is then made by the committee members whether to send a letter to the prescriber and pharmacists alerting them to potential therapy modification or suggested monitoring as an educational intervention. Patient profile reviews and letters are generated on a monthly basis. All DUR committee members participated in patient reviews for the eleven months that patient profiles were generated during this fiscal year. DUR committee members help identify specific criteria to focus on during the monthly reviews. During select months, the committee targeted specific criteria for a focused review. These specific criteria included: Use of atypical antipsychotics in patients with attention deficit/hyperactivity disorder (ADHD) Underutilization of thiazide medications Utilization of statin medications in patients with diabetes Underutilization of amlodipine and apixaban Co-administration of opioid analgesics and benzodiazepines Utilization of dual anti-anxiety agents Overutilization of suvorexant and zolpidem The committee also reviewed and approved new drug interaction criteria and updates as needed. ProDUR and RetroDUR screenings are adjusted on an ad hoc basis. Both ProDUR and RetroDUR may trigger an adjustment of the other area's criteria or screening focus. October 6th, 2021 This was a general review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 129 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee also reviewed and approved updated drug interaction and alert criteria. November 4th, 2021 This was a general review of the 80 most at risk cases as determined by the ICER.

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	The committee sent letters to 128 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee also reviewed and approved updated drug interaction and alert criteria. December 2021 No patient profiles reviews were completed in December 2021. The committee did review and approve updated drug interaction and alert criteria. January 5th, 2022 This was a general review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 129 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee completed a targeted review focused on: Underutilization of amlodipine Underutilization of apixaban February 3rd, 2022 This was a review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 137 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. March 8th, 2022. This was a general review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 111 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee completed a targeted review focused on: Appropriate use of atypical antipsychotics in patients with attention deficit/hyperactivity disorder (ADHD) The committee also reviewed and approved updated drug interaction and alert criteria. April 8th, 2022 This was a general review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 79 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter.

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	The committee completed a targeted review focused on: Underutilization of beta-blocker medications Underutilization of thiazide medications Underutilization of statins therapy in patients with diabetes The committee reviewed and approved updated drug interaction and alert criteria. May 10th, 2022 This was a general review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 127 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee reviewed and approved updated drug interaction and alert criteria. The committee also completed a targeted review focused on: Co-administration of opioids and benzodiazepines. June 8, 202 This was a general review of the 100 most at risk cases as determined by the ICER. The committee sent letters to 155 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee completed a targeted review focused on: Co-administration of opioid analgesics and benzodiazepines The committee reviewed and approved updated drug interaction and alert criteria. July 12, 2022 This was a general review of the 100 most at risk cases as determined by the ICER. The committee sent letters to 149 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee reviewed and approved updated drug interaction and alert criteria. August 5th, 2022 This was a general review of the 100 most at risk cases as determined by the ICER. The committee sent letters to 124 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee reviewed and approved updated drug interaction and alert criteria. September 8th, 2022

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	This was a review of the 80 most at risk cases as determined by the ICER. The committee sent letters to 132 providers (prescribers and pharmacies) for the cases determined to meet the criteria for receiving an educational letter. The committee completed a targeted review focused on: Utilization of dual anti-anxiety agents Overutilization of suvorexant and zolpidem The committee reviewed and approved updated drug interaction and alert criteria.
Tennessee	The operation of the DUR program is a shared responsibility of the Division of TennCare and OptumRx. TennCare DUR Board met quarterly for FFY22. Board meetings were held October 2021, January 2022, April 2022, and July 2022. TennCare's pharmacy program includes the Pharmacy Advisory Committee (PAC) which is responsible for the PDL and criteria and the DUR Board reviews trends in drug use and overutilization. The DUR Board meets with OptumRx quarterly to review ProDUR edits which identify potential drug therapy problems prior to dispensing the medication. The DUR Board can recommend changes to ProDUR edits. These edits include Therapeutic Duplication, Early Refill, Max Dose, Drug to Drug, Drug to Inferred Disease, Drug to Gender, and Geriatric and Pediatric warnings. There were no ProDUR edits added or deleted. The DUR Board may also recommend prior authorization criteria and quantity limits restrictions to the Pharmacy Advisory Committee. The DUR Board recommended to add supplemental denial messages on requests for 3-day supply for non-emergency drugs; updated PA criteria for tramadol-containing products for pediatric patients; and implemented a letter campaign for members at or above 200 MME without a diagnosis of cancer or palliative care. OptumRx presents a retrospective class review at each quarterly DUR meeting. The DUR Board reviews member profiles and refers the profile to the member's respective MCO if needed. The DUR Board makes recommendations on RetroDUR initiatives, and future initiatives are based on their requests. RetroDUR activities are based on FDA updates, industry trends, and topics requested by the DUR Vendor and State Agency. RetroDUR initiatives recommended by the Board were exceeding 90 MME in patients without appropriate diagnosis; concurrent use of opioid and antipsychotics; exceeding 50 MME without claim for Narcan; respiratory conditions and opioids; conduct disorders and antipsychotics; concurrent use of three antidepressants for over 60 days; cardiac abnormalities and stimulant medications; and Asthma/COPD and non-selective beta-blockers.
Texas	During FFY 2022, the Texas DUR Board held four quarterly meetings. Each meeting consisted of several functions: On Oct 22, 2021, the board reviewed the following drug classes for the PDL purposes: a. Androgenic agents b. Antibiotics, gastrointestinal (GI) c. Antibiotics, topical d. Antibiotics, vaginal e. Anticonvulsants

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	f. Antiemetics/Antivertigo agents g. Antifungals, oral h. Antifungals, topical i. Antihistamines - first generation j. Antiparasitics, topical k. Antipsychotics l. Antivirals, topical m. Bone resorption suppression and related agents n. Colony stimulating factors o. Epinephrine, self-injected p. GI Motility, chronic q. Growth hormone r. Hepatitis C s. HIV / AIDS t. Hypoglycemics, insulin and related agents u. Hypoglycemics, meglitinides v. Hypoglycemics, metformin w. Hypoglycemics, sodium-glucose cotransporter-2 (SGLT2) inhibitors x. Hypoglycemics, thiazolidinediones (TZDs) y. Macrolides-Ketolides z. Opiate dependence treatments The following new products were reviewed off cycle: Benlysta Autoinjector (subcutaneous) / Immunosuppressives Benlysta Syringe (subcutaneous) / Immunosuppressives Lumakras (oral) / Oncology, oral for lung cancer Lupkynis (oral) / Immunosuppressives Truseltiq (oral) / Oncology, oral - other Zegalogue Autoinjector (subcutaneous) / Glucagon agents Zegalogue Syringe (subcutaneous) / Glucagon agents The Board voted on these proposed retro-DUR intervention criteria, and interventional letters. ADD/ADHD Management Opioid and CNS depressants Drug Use Evaluation. The clinical prior authorization criteria proposals included the followings: a. Topical antifungal for treatment of onychomycosis new criteria b. Antipsychotic agents -Lybalvi new criteria c. Cytokine and cell-adhesion molecule (CAM) -Enspryng new criteria d. Lupus, new criteria- Benslysta (safety checks) and Lupknis (safety checks) e. SGLT2- Farxiga (revised criteria) and Jardiance (revised criteria) Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Atypical antipsychotics (long-acting injectable) b. Atypical antipsychotics (oral) c. Exogenous insulin products d. Nitazoxanide (Alinia)

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	e. Promethazine use in children less than 2 years of age f. Quetiapine (low dose) On January 21,2022, the Board reviewed these PDL therapeutic classes a. Acne agents, oral b. Acne agents, topical c. Analgesics, narcotics long d. Analgesics, narcotics short e. Angiotensin modulator combinations f. Angiotensin modulators g. Antiparkinsons agents h. Antimigraine agents, other i. Antimigraine agents, triptans j. Bladder relaxant preparations k. Glucagon agents l. H. pylori treatment m. Immunomodulators, atopic dermatitis n. Intranasal rhinitis agents o. Movement disorders p. Neuropathic pain q. Oncology, oral - breast r. Oncology, oral - hematologic s. Oncology, oral - lung t. Oncology, oral - other u. Oncology, oral - proState v. Oncology, oral - renal cell w. Oncology, oral - skin x. Phosphate binders y. Platelet aggregation inhibitors z. Potassium binders aa. Progestins for cachexia bb. Proton pump inhibitors cc. Smoking cessation dd. Stimulants and related agents Th following new brand name drugs were reviewed off cycle: a. Bylvay capsule (oral) / Bile salts b. Bylvay pellet (oral) / Bile salts c. Invega Hafyera (intramusc) / Antipsychotics d. Livmarli (oral) / Bile salts e. Loreev XR capsule ER 24H (oral) / Anxiolytics f. Lybalvi (oral) / Antipsychotics g. Miconatate OTC (topical) / Antifungals, topical h. Mucinex instasoothe cough OTC (oral) / Cough and Cold, non-narcotic i. Rezurock (oral) / Immunosupressives, oral The following retrospective intervention proposals were reviewed: i. Attention-deficit/hyperactivity disorder management ii. Management of psychotropic drugs in pediatrics iii. Opioids and central nervous system depressants DUE

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	The following clinical prior authorization proposals were reviewed: a. Antimigraine agents, triptans- new criteria b. Bile salts i. Add Bylvay- new criteria c. Calcitonin gene-related peptide (CGRP) agents, chronic i. Add Quilpta- new criteria d. Immunomodulators, atopic dermatitis i. Add Opzelura e. Phosphate binders - revised criteria f. Pulmozyme- new criteria Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Fentanyl b. Gabapentin c. Hydrocodone Bitartrate/Hydrocodone Polistirex d. Ivacaftpor (Kalydeco) and combination therapy e. Topical Calcineurin Ihibitors- Pimecrolimus (Elidel) and Tacrolimus (Protopic) f. Tramadol On April 22, 2022, the following drug classes were reviewed for PDL purposes: a. Analgesics, narcotics long acting b. Anti-Allergens, oral c. Antibiotics, inhaled d. Anticoagulants e. Antidepressants, other f. Antidepressants, selective serotonin reuptake inhibitors (SSRIs) g. Antidepressants, tricyclic h. Antihyperuricemics i. Antivirals, oral j. Anxiolytics k. Benign prostatic hyperplasia treatments l. Beta-blockers m. Bile salts n. Bronchodilators, beta-agonists o. Chronic obstructive pulmonary disease (COPD) agents p. Cough and cold, cold q. Cough and cold, narcotic r. Cough and cold, non-narcotic s. Erythropoiesis stimulating proteins t. Glucocorticoids, inhaled u. Hemophilia treatment v. Hereditary angioedema (HAE) treatments w. Immune globulins, intravenous x. Immunomodulators, asthma y. Lincosamides/oxazolidinones/streptogramins z. Lipotropics, other aa. Lipotropics, statins

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	bb. Multiple sclerosis agents cc. Pancreatic enzymes dd. Pediatric vitamin preparations ee. Prenatal vitamins ff. Pulmonary arterial hypertension agents, oral and inhaled gg. Sedative hypnotics hh. Sickle cell anemia treatments ii. Thrombopoiesis stimulating proteins jj. Urea cycle disorder, oral Additionally, the following new drugs were reviewed off cycle a. Dhivy tablet (oral) / Antiparkinson agents b. Eprontia solution (oral) / Anticonvulsants c. Skytrofa cartridge (subcutaneous) / Growth hormone d. Adbry (subcutaneous) / Immunomodulators, atopic dermatitis e. Tyrvaya spray (nasal) / Ophthalmics, anti-inflammatory/immunomodulators f. Vuity (ophthalmic) / Ophthalmics, glaucoma agents There were two proposals for retroDUR interventions: i. Heart failure management ii. Migraine disease management The following clinical prior authorization criteria proposals were reviewed: a. Atopic Dermatitis- add Cibinqo and Adbry b. Livmarli- new criteria for cholestatic pruritis due to Alagille syndrome c. Recorlev oral tablets- new criteria for Cushing Disease d. Tyrvaya nasal- new criteria for dry eye e. Voxzogo- new criteria for achondroplasia Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Benzodiazepines (nonsedative/hypnotics) b. Complement Inhibitor and Enzyme/ Protein Replacement Therapy c. Direct oral anticoagulants d. Hydroxy-Methylglutaryl Coenzyme A Reductase Inhibitors e. Ivacaftor (Kalydeco) and Combination Therapy (Resubmission from the January Meeting) f. Low Molecular-Weight Heparins g. Nebulized Bronchodilators On July 22, 2022, The DUR Board Reviewed the following PDL therapeutic classes a. Alzheimer's agents b. Antihistamines, minimally sedating c. Antihypertensives, sympatholytics d. Calcium channel blockers e. Cephalosporins and related antibiotics f. Cytokine and cell adhesion module (CAM) antagonists g. Fluoroquinolones, oral h. Glucocorticoids, oral i. Immunomodulators, Lupus j. Immunosuppressives, oral k. Iron, oral

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	l. Leukotriene modifiers m. Nonsteroidal anti-inflammatory drugs (NSAIDs) n. Ophthalmic antibiotics o. Ophthalmic antibiotic-steroid combinations p. Ophthalmics for allergic conjunctivitis q. Ophthalmics, anti-inflammatories r. Ophthalmics, anti-inflammatory/immunomodulator s. Ophthalmics, glaucoma agents t. Otic antibiotics u. Otic anti-infectives and anesthetics v. Penicillins w. Progestational agents x. Rosacea agents, topical y. Skeletal muscle relaxants z. Steroids, topical high aa. Steroids, topical low bb. Steroids, topical medium cc. Steroids, topical very high dd. Ulcerative colitis agents ee. Uterine disorder treatments As well as the following brand name drugs were reviewed off cycle: a. Twyneo, cream (topical)/ Acne Agents, topical b. Seglentis (oral) / Analgesics, narcotics short c. Livtencity (oral)/ Antivirals, orals d. Releuko, syringe (subcutaneous)/ Colony Stimulating Factors e. Releuko, vial (injection) / Colony Stimulating Factors f. Ibsrela, tablet (oral) / Gastrointestinal(GI) Motility, chronic g. Takhzyro, syringe (subcutaneous)/ Heridatry Angioedema (HAE) Treatments h. Triumeq Pediatric (PD), tablet, suspension (oral) / HIV / AIDs i. Zimhi (injection) / Opiate Dependence Treatments Potential RetroDUR interventions was reviewed i. Influenza Prevention: vaccination and education Clinical Prior authorization proposals: a. Allergen Extracts- Oralair revised criteria b. Fintepla (fenfluramine)- new criteria c. Gastrointesinal Mobility- new criteria for Ibsrela d. Monoclonal Antibody Agents- new criteria for Xolair e. Sodium-glucose cotransporter-2 (SGLT2) - Farxiga and Jardiance revised criteria Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Fluoroquinolones (oral) b. Hepatitis C (new criteria) c. Immune globulins d. Non-sedating antihistamines e. Non-steroidal anti-inflammatory drugs

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	f. Rifaximin (Xifaxan) g. Sickle cell disease products h. Skeletal muscle relaxants
Utah	In FFY 2022, the Utah Medicaid DUR Board met 10 times in a rolling 12 months period. The following topics and policies were discussed at the meetings: October 2021: The DUR Board reviewed topical Lidocaine and approved removing Lidoderm prior authorization requirements, aiming to improve access to non-opioid pain treatment. The DUR Board also reviewed Rukobia for the treatment of HIV and approved to place Rukobia as a non-preferred product on the Preferred Drug List and require clinical prior authorization. November 2021: The DUR Board met to discuss the experience with newer Cystic Fibrosis treatment (particularly the Trikafta). The pharmacy team updated the DUR Board on the Early Refill Policy. With this policy, early refill requests will be evaluated based on Medicaid's definition of medical necessity as defined in the Utah Medicaid Provider Manual to expand access to medications that fall under broader circumstances. The DUR Board reviewed Acute Hereditary Angioedema (HAE) and approved utilizing the Rare Disease prior authorization to review requests for acute HAE treatments. December 2021: The DUR Board reviewed Prophylaxis Hereditary Angioedema (HAE) and approved utilizing the Rare Disease prior authorization to review requests for prophylaxis HAE treatments. The DUR Board reviewed and approved the updated Parathyroid Hormone Analogs Prior Authorization. January 2022: . The DUR Board reviewed Benlysta, and Lupkynis and approved to not place clinical prior authorization requirements for these drugs as utilization is low. The DUR Board approved changes to the PCSK9 Prior Authorization to remove requirements for ABCL-certified specialists. February 2022: The DUR Board approved restricting antitussive codeine products to adults 18 years and up and analgesics codeine products to children over 12 years of age. April 2022: The DUR Board reviewed the Guideline Treatment Recommendations for Nonspecific Low Back Pain with or without Radiculopathy. May 2022: The DUR Board approved the revised Anti-Asthmatic Monoclonal Antibodies Prior Authorization to accommodate newly approved and upcoming monoclonal antibodies. The DUR Board approved the revised Hetlioz Prior Authorization. June & July 2022:

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	The DUR Board reviewed insomnia treatments in pediatric and adult patients, and approved the proposal to have coverage for OTC melatonins. The DUR Board approved the revised Intravitreal Implants & Ophthalmic Injections. August 2022: The DUR Board reviewed the drafted CDC Clinical Practice Guideline for Prescribing Opioids 2022 and the results of Utah Medicaid's high-dose opioid intervention. September 2022: The DUR Board reviewed Mounjaro (tirzepatide) and approved to place Mounjaro as a non-preferred GLP-1 product on the Preferred Drug List. The DUR Board approved the revised Calcitonin Gene-Related Peptide (CGRP) Antagonists Prior Authorization and Botox Prior Authorization. The revision allowed concurrent uses of prophylaxis CGRP and Botox. A comprehensive list of PRO-DUR edits is below: 10/13/2021 - Nayzilam (midazolam) was added to the cumulative quantity limit of benzodiazepine limit of 120 units per 30 days. 10/27/2021 - Implemented age restriction of older than 12 years of age on certain codeine products. 11/1/2021 - Removed prior authorization requirement for Lidoderm. 11/1/2021 - Added Rukobia to non-preferred on the Preferred Drug List and required clinical prior authorization. 2/3/2022 - Updated quantity limit of Vivitrol to 1 injection every 22 days. 3/1/2022 - Remove quantity limit on naltrexone tablets to improve access. 4/1/2022 - Increased quantity limit of tramadol and tramadol/acetaminophen from 6 tablets/day to 8 tablets/day. 4/1/2022 - Updated Antipsychotic Use in Children policy to only reject claims for two or more concurrent antipsychotic medications used for 45 days consecutive days or more for members 17 years of age or younger. Members 18 to 19 years of age or older will no longer be subject to concurrent use of multiple antipsychotic use restrictions. 5/25/2022 - Increased quantity limit of oxycodone, oxycodone combinations, hydrocodone, hydrocodone combinations drugs from 4 tablets/day to 6 tablets/day. The 90 MME limit remains.
Vermont	The Vermont Medicaid/Department of Vermont Health Access (DVHA) DUR Board, acting as the program's Pharmacy and Therapeutics (P&T) Committee, met 7 (seven) times in FFY2022. 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 manages these medications in a manner that will result in appropriate prescribing, prospectively, prior to the start of treatment. This results in the early adoption of quantity limits, step therapy, safety edits for age or indication, and promotion of lowest net-cost drugs. 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. The DUR Board will recommend that follow-up RetroDUR be performed of relatively new drugs to ensure that the adopted clinical criteria and result in patterns of utilization are appropriate and cost-effective. In FFY2022, the DUR Board activities included: 49 Therapeutic Drug Class reviews, 33 Full New Drug Reviews, 2 FDA Safety Alerts, 6 RetroDUR/ProDUR reviews, 1 Biosimilar new

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	Drug Review, 24 revised clinical coverage criteria, and 38 quantity limits established for new or previously review drugs. RetroDUR Analyses Completed: Use of Acute Migraine Medications in Members on CGRPs (12/07/2021), Immunologic Therapies for Asthma (02/15/2022), Blood Glucose Test Strips in CGM Users (04/05/2022), Letrozole Use for Infertility (05/10/2022), Concurrent Use of GLP-1 Receptor Agonists and DPP-4 Inhibitors (06/21/2022), Opioid Use from Multiple Providers (09/13/2022). 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 outcomes, 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 performed prior to dispensing assists pharmacists in ensuring that patients receive appropriate medications in a safe manner. 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 outcomes. 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 and ProDUR Edits, of which the denial 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 guideline recommendations. 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 including prospective edits in the Point-of-Sale System, educational mailings, new utilization controls such as prior authorization or quantity limits and other edits 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 examination 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. The Drug Utilization Review (DUR) Board will advise DVHA on how best to educate providers and address the impact of pharmacy manufacturers' advertising, academic detailing opportunities are considered as a possible response. 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

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	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 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. 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 informational instructions and alerts. Sample DUR Board Meeting Agenda for SFY2022 Department of Vermont Health Access Pharmacy Benefits Management Program October 19, 2021: 5:00 p.m. - 8:30 p.m. Executive Session 5:00 p.m. - 6:00 p.m. Introductions and Approval of DUR Board Minutes 6:00 p.m. - 6:05 p.m. (Public Comment Prior to Board Action) DVHA Pharmacy Administration Updates 6:05 p.m. - 6:10 p.m. Medical Director Update 6:10 p.m. - 6:15 p.m. Follow-up Items from Previous Meetings 6:15 p.m. - 6:20 p.m. RetroDUR/ProDUR 6:20 p.m.- 6:45 p.m. Clinical Update: Drug Reviews 6:45 p.m. -6:45 p.m. (Public comment prior to Board action) Biosimilar Drug Reviews Full New Drug Reviews New Managed Therapeutic Drug Classes 6:45 p.m. - 6:45 p.m. (Public comment prior to Board action) Therapeutic Drug Classes Periodic Review 6:45 p.m.- 6:45 p.m. (Public comment prior to Board action) Review of Newly-Developed/Revised Criteria 6:45 p.m. - 8:20 p.m. (Public comment prior to Board action) General Announcements 8:20 p.m. - 8:30 p.m. Selected FDA Safety Alerts Adjourn 8:30 p.m.
Virginia	Virginia Medicaid DUR Board quarterly meetings were held on December 1, 2021, March 10, June 2 and September 8, 2022 for FFY 2022 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 2022 RetroDUR intervention activities are reported in Summary 1: RetroDUR Educational Outreach Summary. For FFY 2022, 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. The DUR Board continued to address and review topics in reference to the SUPPORT Act. During FFY 2022, the DUR board continued to review and address concurrent use of opioids and benzodiazepines as well as concurrent use of opioids and antipsychotics

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	utilization reports. DMAS also reviewed 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 naive, which was implemented on April 6, 2020. DMAS has also decreased the MME further down to 90 MME in addition to the existing quantity limits on all short and long-acting opioids. 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 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. Magellan Rx Management provides a quarterly MRx Pipeline Report at each DUR Board Meeting. The summary of the minutes for each of the FFY 2022 DUR Board meetings are included below. Minutes Summary - December 1, 2021 New Drugs: The DUR Board reviewed Fotivda (tivozanib), Lumakras (sotorasib), Myfembree (relugolix, estradiol, and norethindrone acetate), Truseltiq (infigratinib), Wegovy (semaglutide), Exkivity (mobocertinib), Kerendia (finerenone) and Welireg (belzutifan). The Impact Reports and the reports for utilization of these new DUR drugs for FFS and MCOs were reviewed. Utilization Management for Movement Disorder Drugs were discussed and reviewed. This class was recently added to the PDL as a Closed Class. Clinical criteria and quantity limits were reviewed for this class. Utilization Management for HIV Drugs were discussed as this class was recently added to the PDL as a Closed Class. Quantity limits were added to the HIV drugs. Hepatitis C Class - The final decision was to remove the service authorization criteria from the preferred Hepatitis C Agents (Mavyret and sofosbuvir/velpatasvir (generic Epclusa)). Also, they will be limited to 3 one-month fills (total 84 days supply) without service authorization. Oral Hypoglycemic Class - The Board discussed the current metformin step edit that is required before use of all oral hypoglycemics and the barriers this can cause. The Board decided to remove the metformin step edit for all oral hypoglycemics.

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	New Class criteria was discussed and approved for Oral Oncology - Lung Cancer Drugs and Oral Oncology - Renal Cell Carcinoma Drugs. The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines, Concurrent Use of Opioids and Antipsychotics, Antipsychotic Medications in Children, and Opioid Use with Risk Factors with and without Naloxone reports for FFS and MCOs. The DUR Board also reviewed the following reports: ProDUR, Recent RetroDUR Activity, Utilization Analysis, and Hemoglobin A1c Lab Value Over 9 and On Diabetic Meds for 6 Months Reports. 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. Minutes Summary - March 10, 2022 The DUR Board reviewed molnupiravir and Paxlovid (nirmatrelvir + ritonavir). The molnupiravir and Paxlovid clinical criteria were presented and reviewed with the DUR Board. New Drugs: The DUR Board reviewed Besremi (ropeginterferon alfa-2b-njft), Livtencity (maribavir), Scemblix (asciminib), Tavneos (avacopan) and Voxzogo (vosoritide). The Impact Reports and the reports for utilization of these new DUR drugs for FFS and MCOs were reviewed. New Class criteria was discussed and approved for Oral Oncology - Hematologic Cancer Drugs. The DUR Board also reviewed the following reports: ProDUR, Recent RetroDUR Activity, Utilization Analysis, and Hemoglobin A1c Lab Value Over 9 and On Diabetic Meds for 6 Months Reports. 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. Minutes Summary - June 2, 2022 New Drugs: The DUR Board reviewed Rezurock (belumosudil). The Impact Report and the report for utilization of this new DUR drug for FFS and MCOs was reviewed. DMAS is in the process of developing a Physician Administered Drugs (PADs) program which will be followed by the DUR Board. The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines, Concurrent Use of Opioids and Antipsychotics, and Antipsychotic Medications in Children reports for FFS and MCOs.

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	The DUR Board also reviewed the following reports: ProDUR, Recent RetroDUR Activity, and Utilization Analysis Reports. 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. Minutes Summary - September 8, 2022 New Drugs: The DUR Board reviewed Camzyos (mavacamten), Vijoice (alpelisib) and Vonjo (pacritinib). The Impact Reports and the reports for utilization of these new DUR drugs for FFS and MCOs were reviewed. The DUR Board reviewed Antidepressant Medications in Children and Mood Stabilizer Medications in Children reports for FFS and MCOs. The DUR Board reviewed the Synagis Utilization Report for last season. The DUR Board also reviewed the following reports: ProDUR, Recent RetroDUR Activity, and Utilization Analysis Reports. 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.
Washington	During FFY 2022, the DUR Board met four times with meetings focused on reviewing Apple Health Preferred Drug List (AHPDL) classes and clinical policies. There were four clinical policies reviewed by the DUR board: PCSK-9, Spinraza, Evrysdi and Cabenuva, all of which were approved. The DUR Board agreed to make both the Evrysdi and Spinraza policies identical. The criteria 'Patient demonstrated ability to maintain meaningful function including breathing independently of permanent mechanical ventilation or either ambulatory or can independently operate wheelchair' was added to the policy and approved by the DUR Board. HIV drug utilization was presented to the DUR Board and touched upon the following topics: current evidence available around antiretroviral therapies, differences between single versus multi-tablet regimens, HIV drug authorization approval and denial rates, and current Apple Health utilization of single tablet vs. multi- tablet regimens. Due to the rising costs of single tablet regimens on the Apple Health program, the goal of the utilization presentation was to show the DUR Board that the current management strategy to have multi-tablet HIV drug regimens preferred on the AHPDL versus the expensive single tablet counterparts is both fiscally responsible for State resources but most importantly provides a less costly, equally effective product available to Apple Health patients. Two pharmacist DUR Board members transitioned off however those positions were quickly filled with two new pharmacist board members. A new chair and co-chair were also elected for the year. To help acclimate the new DUR Board members, a brief presentation was given explaining the purpose of the board, their roles and responsibilities, and the Apple Health Preferred Drug List (AHPDL) process. For both prospective and retrospective DUR interventions, the DUR board does not have set policies on what types of

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	interventions need to be adopted. However, if interventions are identified they are determined on a topic-by-topic basis. The following 78 AHPDL drug classes were reviewed by the DUR Board during FFY 2022. 1) October 20, 2021 Meeting a. AHPDL Classes Reviewed i. Multiple Sclerosis Agents ii. Antihyperlipidemics: MTP Inhibitors iii. Antihyperlipidemics: PCSK-9 Inhibitors iv. Antivirals: Influenza Agents v. Cardiovascular Agents: Sinus Node Inhibitors vi. Endocrine and Metabolic Agents: Pituitary Suppressants vii. Oncology Agents: LHRH Analogs- Injectable viii. Gastrointestinal Agents- Inflammatory Bowel Agents ix. Gastrointestinal Agents- IBS Agents/GI Motility x. Gastrointestinal Agents- Phosphate Binder Agents xi. Genitourinary Agents: Overactive Bladder Agents xii. Hematological Agents: Hereditary Angioedema Agents xiii. Miscellaneous Therapeutic Classes: Potassium Removing Agents xiv. Substance Use Disorder: Agents for Opioid Withdrawal xv. Substance Use Disorder: Opioid Antagonists xvi. Substance Use Disorder: Opioid Partial Agonists- Subcutaneous xvii. Substance Use Disorder: Opioid Partial Agonists- Transmucosal b. Policies Reviewed i. 39.35.00- Antihyperlipidemics- PCSK-9 Inhibitors (Approved by DUR Board) 2) December 15, 2021 Meeting a. AHPDL Classes Reviewed i. Analgesics: Opioid Agonists- Long Acting ii. Antiemetics/Antivertigo Agents: 5-HT3 Receptor Antagonists iii. Antiemetics/Antivertigo Agents: Substance P/Neruokinin 1 (NK1) Receptor Antagonists iv. Antiemetics/Antivertigo Agents: Substance P/Neruokinin 1 (NK1) Receptor Antagonists Combinations v. Antihypertensives: Direct Renin Inhibitor Combinations vi. Antihypertensives: Direct Renin Inhibitor vii. Antihypertensives: Neprilsyn Inhibitors (ARNI)- Angiotensive II Receptor Antagonist Combinations viii. Antivirals: Hepatitis C Agents ix. Antivirals: HIV x. Antivirals: HIV Combinations xi. Endocrine and Metabolic Agents: Androgens- Testosterone xii. Endocrine and Metabolic Agents: Bone Density Regulators- Sclerostin Inhibitors xiii. Migraine Agents: Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists xiv. Migraine Agents: Selective Serotonin Agonists 5-HT(1) xv. Pulmonary Hypertension Agents: Endothelin Receptor Antagonists xvi. Pulmonary Hypertension Agents: Prostacyclin Receptor Agonists xvii. Pulmonary Hypertension Agents: Prostaglandin Vasodilators xviii. Pulmonary Hypertension Agents: SGC Stimulator xix. Pulmonary Hypertension Agents: Phosphodiesterase Inhibitors (PDEI) b. HIV Utilization Presentation

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	c. Policies Reviewed i. 12.10.99.AB- Cabenuva (Approved by DUR Board) ii. 74.70.00.AA- Spinraza (Approved by DUR Board) iii. 74.70.65.AA- Evrysdi (Approved by DUR Board) 3) February 16, 2022 Meeting a. AHPDL Classes Reviewed i. Antibiotics: Aminoglycosides- Inhaled ii. Antibiotics: Monobactams- Inhaled iii. Respiratory Agents: Cystic Fibrosis Agents iv. Anticoagulants: Factor Xa and Thrombin Inhibitors- Oral v. Antidiabetics: Amylin Analogs vi. Antidiabetics: DPP4 Inhibitor/SGLT2 Inhibitor Combinations vii. Antidiabetics: DPP4 Inhibitor/TZD Combinations viii. Antidiabetics: DPP4 Inhibitors ix. Antidiabetics: GLP-1 Agonist/Insulin Combinations x. Antidiabetics: GLP-1 Agonists xi. Antidiabetics: Insulin- Intermediate Acting xii. Antidiabetics: Insulin- Long Acting xiii. Antidiabetics: Insulin- Pre-Mixed xiv. Antidiabetics: Insulin-Rapid Acting xv. Antidiabetics: Insulin- Short Acting xvi. Antidiabetics: Insulin- SGLT2 Inhibitors b. P&T/DUR Board Process Overview 4) April 2022- No meeting 5) June 15, 2022 Meeting a. AHPDL Classes Reviewed i. Asthma and COPD Agents: Anticholinergics ii. Asthma and COPD Agents: Phosphodiesterase 4 Inhibitors iii. Asthma and COPD Agents: Long-Acting Muscarinic Agents/Long Acting Beta Agonist Combinations iv. Asthma and COPD Agents: Long-Acting Muscarinic Agents v. Asthma and COPD Agents: Inhaled Corticosteroid Combinations vi. Asthma and COPD Agents: Inhaled Corticosteroids vii. Asthma and COPD Agents: Monoclonal Antibodies viii. Hematopoietic Agents: Gaucher Disease ix. Hematopoietic Agents: Sickle Cell Anemia x. Hematopoietic Agents: Granulocyte Colony-Stimulating Factors (G-CSF) xi. Hematopoietic Agents: Erythropoiesis- Stimulating Agents (ESAS) xii. Immune Modulators: Thalidomide Analogues xiii. Oncology Agents: Alkylating Agents- Oral xiv. Oncology Agents: Antimetabolites- Oral xv. Oncology Agents: Antineoplastic Misc- Oral xvi. Oncology Agents: BCL-2 Inhibitors- Oral xvii. Oncology Agents: Histone Deacetylase Inhibitors- Oral xviii. Oncology Agents: Isocitrate Dehydrogenase-1 (IDH1) Inhibitors- Oral xix. Oncology Agents: Isocitrate Dehydrogenase-2 (IDH2) Inhibitors- Oral xx. Oncology Agents: Janus Associated Kinase (JAK) Inhibitors- Oral xxi. Oncology Agents: Phosphatidylinositol 3-Kinase (PI3K) Inhibitors- Oral xxii. Oncology Agents: Proteasome Inhibitors- Oral

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	xxiii. Oncology Agents: XPO1 Inhibitors- Oral xxiv. Hematopoietic Agents: Thrombopoiesis (TPO) Stimulating Proteins xxv. Endocrine and Metabolic Agents: Growth Hormone releasing Hormones (GHRH) xxvi. Endocrine and Metabolic Agents: Growth Hormones b. P&T/DUR Board Process Overview 6) August 2022- No meeting
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 2022 the DUR Board met a total of four times. The first DUR Board meeting of the 2022 Federal Fiscal Year was held on November 17, 2021. 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 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 November 17, 2021 and Sept 28, 2022. The following indicates clinical criteria which were added or altered during these meetings. November 17, 2021 Prospective DUR topics covered included: Myfembree, Hemangeol, MABS, ANTI- IL/ IgE, Cytokine/CAM Antagonists, Hypoglycemia treatments- Baqsimi, Zegalogue, Aemcolo, Epidiolex, Rezurock, Ozobax February 16, 2022 Prospective DUR topics covered included: Hetlioz, Opzelura cream, Austedo, Nuzyra, Invega Hafyera, Ergot alkaloids, Lybalvi, Kerendia, Analgesics, Narcotic Long-Acting- Fentanyl May 25, 2022 Prospective DUR topics covered included: Adbry, Eprontia, Oral and Topical contraceptives, Atypical Antipsychotics, Hepatitis C September 28, 2022 Prospective DUR topics covered included: celecoxib, Seglentis, Cibinqo, Rinvoq- atopic dermatitis, Fleqsuvy/baclofen solution, Voxzogo, Ibsrela, Norliqva, Vaginal ring contraceptives

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	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. Below is a list of newsletter topics, a list of targeted RDUR interventions, population health initiatives reviewed from 10/1/21 to 9/30/2022. Information about our lock-in program is also described below. A total of 3 Newsletters containing 15 articles were posted during this time,. The topics of the articles are listed below: 1. Janus Kinase (JAK) Inhibitors Used in the Treatment of Rheumatoid Arthritis (RA) 2. CDC Immunization Updates 3. Tedizolid and Serotonin Syndrome: Understudied or Non-existent? 4. Semglee, the Face of Biosimilar Interchange 5. Paxlovid (nirmatrelvir/ritonavir) Now Available Directly from Pharmacist 6. New Novel Agent for the Management of Heart Failure 7. Inclisiran 8. FDA approves treatments for both Smallpox and Ebola 9. Sexually Transmitted Infections 2021 Updates 10. Substitution of Biological Pharmaceuticals: 11. What prescribers can expect from pharmacists 12. The Inflation Reduction Act Lowers the Cost of Prescription Drugs 13. Where are my Patient's Drugs 14. Adverse Drug Events Associated with Proton Pump Inhibitors 15. Summary of Select Innovative Drugs Approved by the FDA as of September 2022 Lock-In Program: 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.

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	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. During 2021, working closely with the DHHR team, the criteria were adjusted over the prior years to provide a scope of patients that were most in need of intervention. For CY 2022, 97 members requiring either a letter or locked in and 3 members were locked in.
Wisconsin	Summary of Wisconsin Drug Utilization Review Board Activities Summary_2CMS FFY 2022 The Wisconsin DUR Board convened virtually for four regularly scheduled quarterly meetings. A quorum of members was present at each meeting. Below are the DUR activities: For Prospective DUR: - New and updated groupings for the Therapeutic Duplication and Late Refill alerts are still in place. - System enhancement is still in place, requiring pharmacies to respond to all unique prospective DUR alerts. - The high cumulative dose alert changed from an informational alert to a soft alert. The alert triggers when a single claim has a daily MME that is greater than or equal to 90. The alert was modified from an informational alert to a soft alert which requires the pharmacy to respond to the alert for claim payment. For Retrospective DUR: - Continued addition of RDUR criteria based on established guidelines with subcontractor KEPRO as new criteria were created. - Reviewed Quarterly Reports of RDUR activity. - Targeted intervention letters sent to dental providers prescribing opioids for both pediatric and adult members. In October 2021 letters were sent regarding pediatric members. In August 2022 letters were revised and sent regarding both adults and children. - Targeted intervention to review use of duplicate sedative hypnotics and benzodiazepines. This intervention targeted members receiving at least two or more sedative hypnotics and/or benzodiazepines on a regular basis. The initial cycle of intervention letters sent in December 2021. - Updated the high MME intervention, redefining high MME as 180 MME or greater rather than the previous 250 MME or greater. Kepro began reviewing members using the new criteria in March 2022.

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	- Targeted intervention for polypharmacy sedating medications in children. Provider letters were sent and peer to peer outreach calls were made for high-risk members identified for intervention. - Ongoing intervention for high dose stimulant use in children 14 years of age and younger. Dose thresholds are used for this intervention that were developed by our psychiatrist consultant. These individuals are reviewed on a quarterly basis. For children exceeding the set dose per day thresholds, the psychiatrist consultant, reviews and makes phone calls as necessary. - Ongoing opioid/benzodiazepine intervention. This intervention identifies members receiving 50 morphine milligram equivalents (MME) or more of any non-medication-assisted therapy (MAT) opioid and a daily benzodiazepine for at least 90 days or more. - Focused intervention to review the overuse of butalbital. This intervention focused on members using butalbital more than three times per week. Initial letters sent in April 2022. - Focused intervention to review the concurrent use of gabapentin and pregabalin. Initial letters were sent beginning April 2022. - Updated lock-in criteria to determine if lowering the days' supply could have a positive impact and improve overall efficiency of the program. In April 2022 the days' supply was lowered from 240 to 210 days in a 90-day period. - Continued focused quarterly intervention to address the risks associated with the chronic use of multiple CNS depressants. The methodology for this intervention was updated in first quarter 2022. Intervention letters sent on members identified who are concurrently receiving at least one medication from each of the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants, and are receiving 45 or more actual days' supply of each of the four medications during the quarter. Letters sent to prescribers annually or when there is a change of prescriber. - Continued focused quarterly intervention for members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members receiving drugs from all five classes are reviewed for possible inclusion in the Lock-In program. DUR Activities for SUPPORT Act - Prospective DUR o 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.

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	- Morphine milligram equivalents (MME): Alerts the pharmacy when the MME on a claim exceeds the 90 MME limit identified by the State. - Retrospective DUR o Retrospective Lock-In/High Utilization criteria: Review of MMEs, multiple high dose short-acting opioids, receiving more narcotics than intended or 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. o Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. o Retrospective review of members at high-risk for opioid overdose who may benefit from co-prescribing naloxone. - Program to Monitor Antipsychotic Use in Children o Antipsychotic agents are reviewed in all children including children in foster care. 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. A psychiatrist consultant contracted with the State performs peer to peer outreach calls when needed. Children over eight years of age are monitored for polypharmacy of antipsychotics by the psychiatrist consultant and peer outreach calls are conducted as needed. o 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 o 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, 2,680 member profiles are reviewed for regular RDUR and up to 1,080 member profiles are reviewed for the Pharmacy Services Lock-In program.

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Wyoming	Number of P&T Committee meetings held Four P&T Committee meetings were held. The meetings were convened quarterly in Cheyenne or via Zoom. 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. Criteria additions/deletions Prospective criteria additions/changes are listed below: Drug/indication limits: Bylvay Livmarli Voxzogo Livtencity Paxlovid Zavesca Aduhelm Dartisla Adbry Apretude Cabenuva Leqvio Tlando Camzyos Voquezna Ztalmy Radicava Drug/age limits: ADHD medications (upper age limits) Drug/dose limits: Synagis Albuterol Concurrent therapy: Lybalvi and opioids Drug/Pregnancy limits: Brexafemme Other PA criteria/step therapy: Antipsychotics for major depressive disorder Karendia Brexafemme

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	Opzelura Qulipta Skytrofa Tyrvaya Vuity Elyxyb Molnupravir Dupixent Nucala Oxcarbazepine Carbamazepine Tezspire Adbry Cibinqo Ibsrela Stelara Vyepti Tlando Quviviq Vtamo Mounjaro Lyvispah Voquezna In-depth Clinical or utilization Reviews Off-label use of ivermectin Use of more than 2 albuterol inhalers per month Oxcarbazepine and carbamazepine for neuropathic pain 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 The following topics were included in provider education letters sent from the DUR Program during FFY 2022: Concurrent use of antipsychotics and opioids (quarterly) Narcotic use and pregnancy (monthly) Prescription Drug Monitoring Program (weekly) Statin use and diabetic progression

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	GI side effects and metformin Hypertension guidelines Buprenorphine dental effects The following topics were included in comparative prescriber reports sent from the DUR Program during FFY 2022: Routine labs in diabetic patients Benzodiazepine utilization Concurrent gabapentin and opioid utilization Concurrent use of opioids and sedatives DUR Newsletters Four quarterly WY-DUR Newsletters were sent during FFY2022. Newsletters are sent to approximately 3300 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.

Section V - Physician Administered Drugs

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

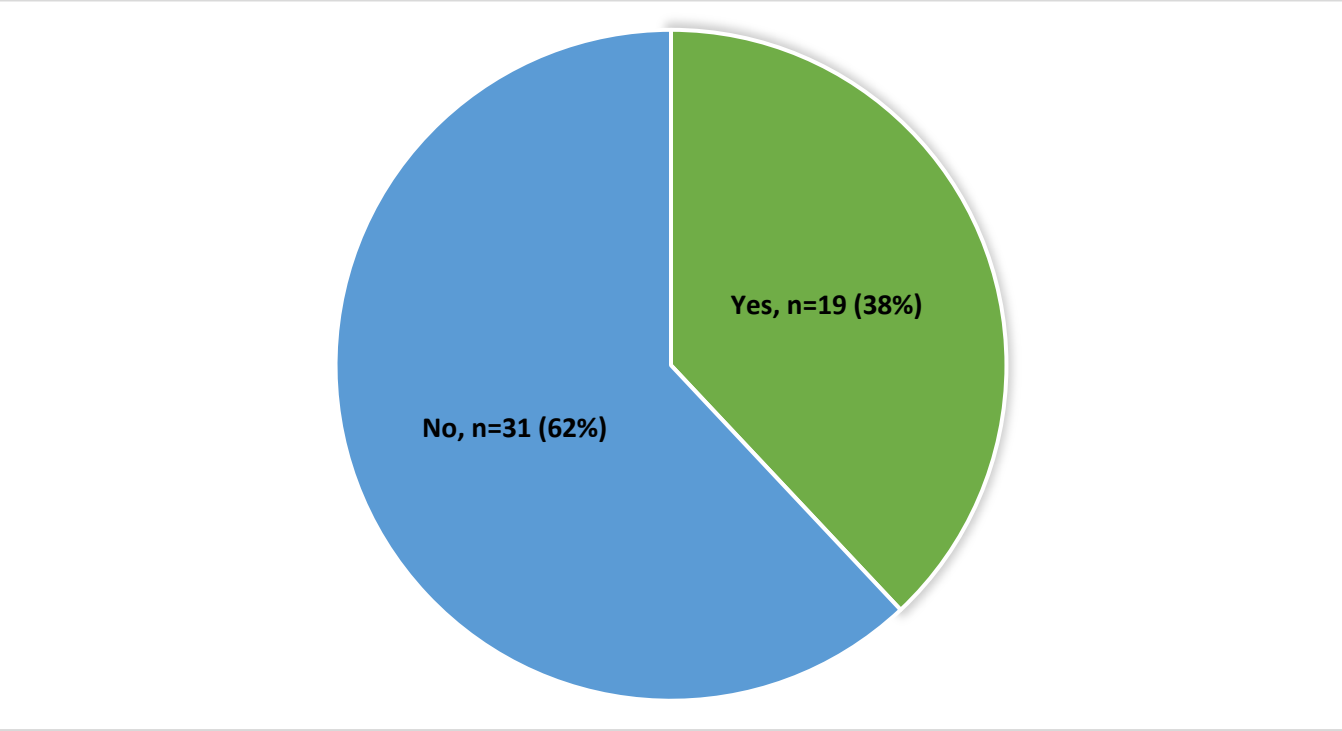

Table 60 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Alaska, Colorado, Delaware, Georgia, Hawaii, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, North Dakota, Pennsylvania, South Carolina, Utah, Vermont, Virginia, Washington, Wyoming	19	38.00%
No	Alabama, Arkansas, California, 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, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin	31	62.00%
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

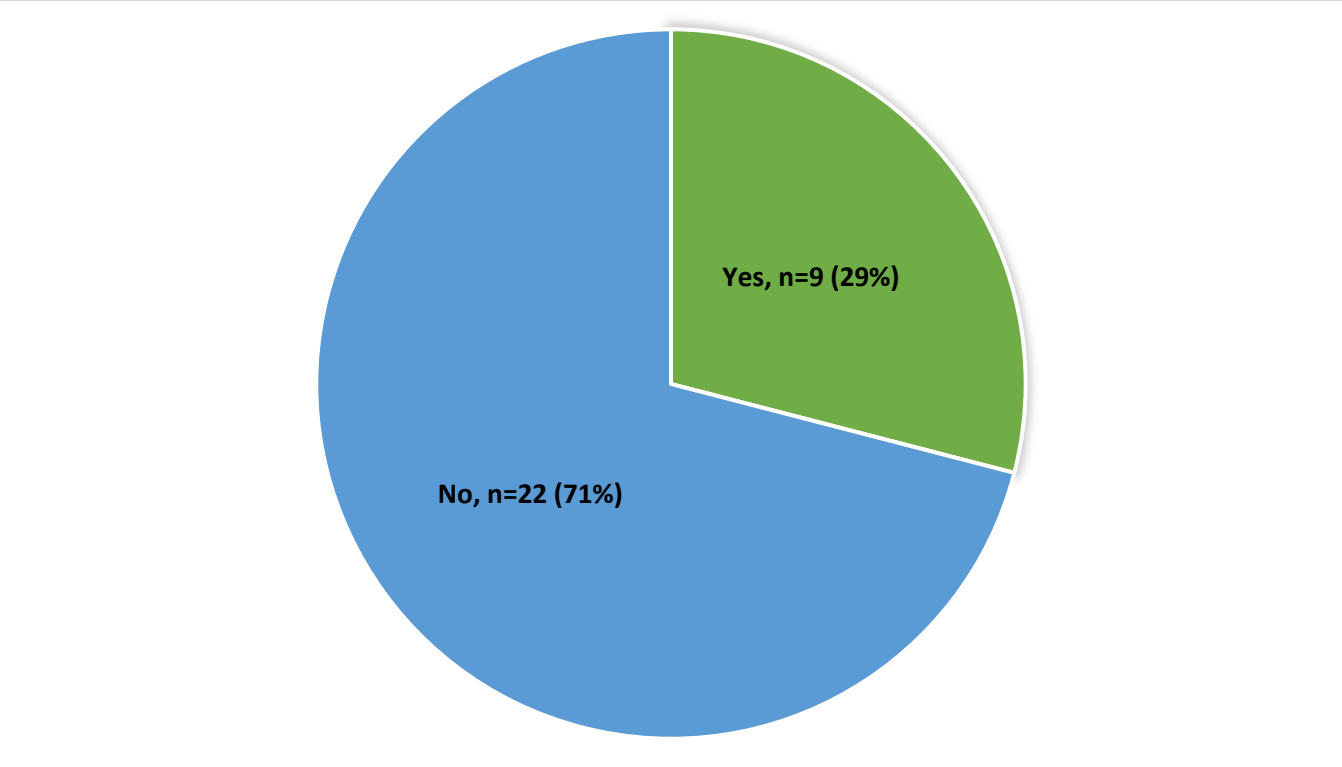

Table 61 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Arkansas, District of Columbia, Florida, Illinois, Maryland, Mississippi, New Jersey, New York, Oregon	9	29.03%
No	Alabama, California, Connecticut, Idaho, Indiana, Iowa, Kansas, Louisiana, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin	22	70.97%
Total		31	100.00%

2. RetroDUR?

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

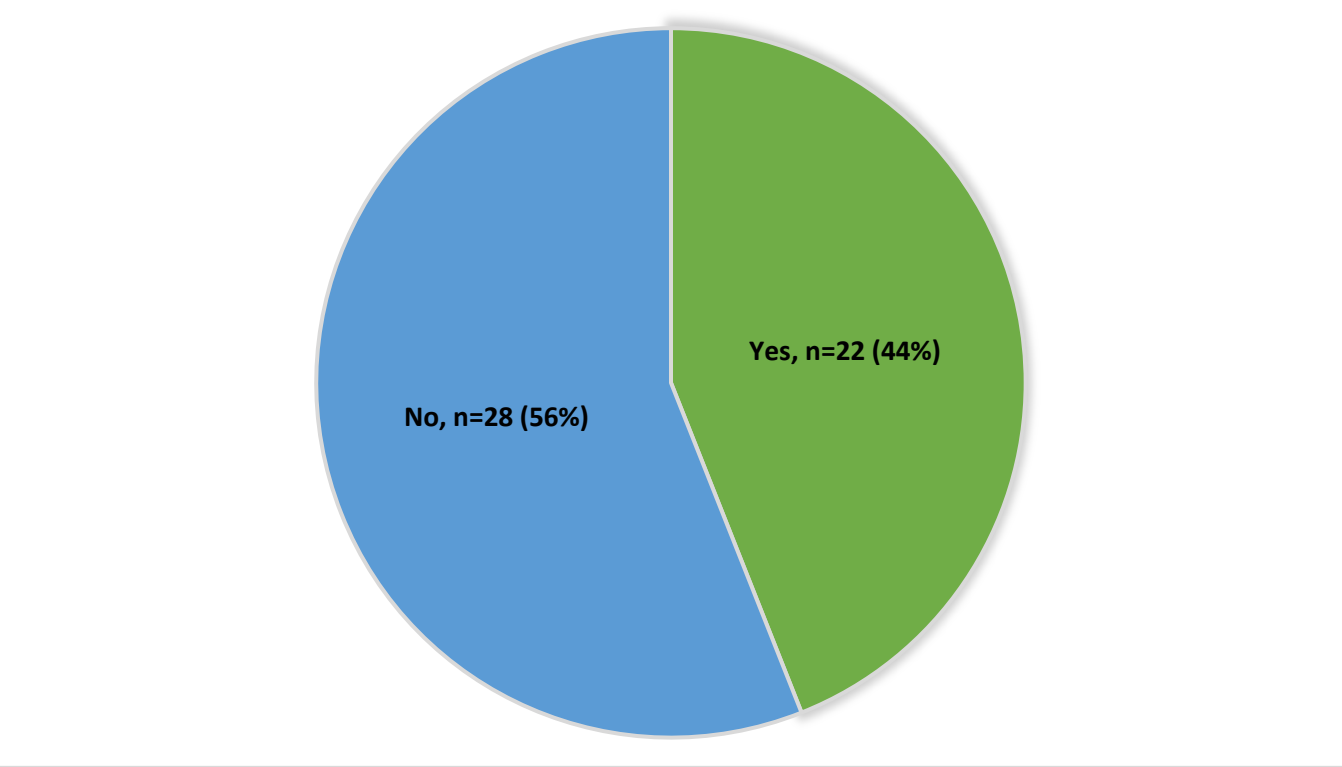

Table 62 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

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

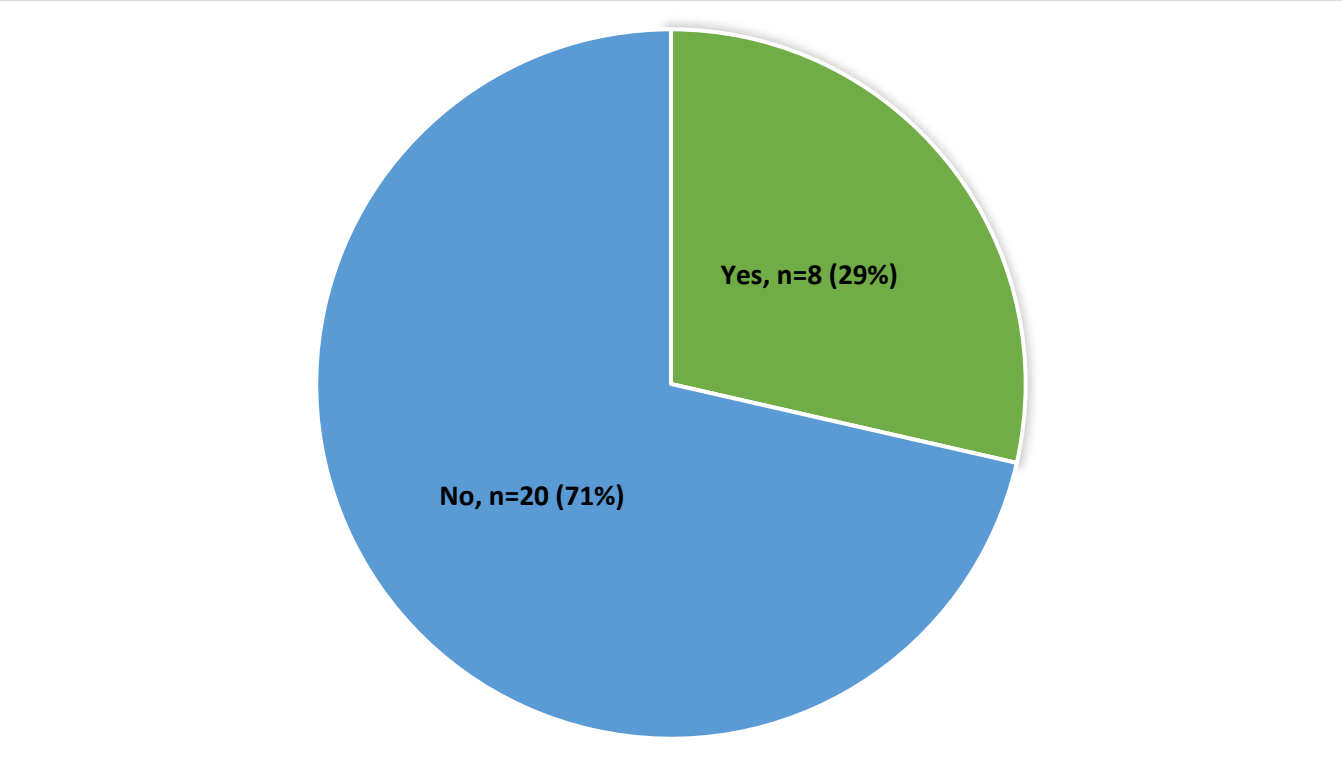

Table 63 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Arkansas, District of Columbia, Idaho, Maryland, Mississippi, New Jersey, New York, North Carolina	8	28.57%
No	Alabama, Connecticut, Delaware, Illinois, Indiana, Iowa, Kansas, Minnesota, Montana, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming	20	71.43%
Total		28	100.00%

Section VI - Generic Policy and Utilization Data

1. Summary 3 - Generic Drug Substitution Policies

Generic Drug Substitution Policies Summary should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, preferred drug list (PDL) policies, educational initiatives, technology or promotional factors, or other State-specific factors that affect your generic utilization rate.

Table 64 - Generic Drug Substitution Policies Summary

State	Generic Drug Substitution Policies Summary
Alabama	Alabama Medicaid Policies On Use of Therapeutically Equivalent Generic Drugs Alabama Medicaid mandates generic substitution of therapeutically equivalent drugs. If the prescriber 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 2022. 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

State	Generic Drug Substitution Policies Summary
	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 (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	ARKANSAS MEDICAID GENERIC DRUG SUBSTITUTION POLICIES-FFY2022 The Arkansas Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: Brand medically necessary edit: This edit requires physicians to indicate that a multi-source brand drug is required for their patient. Claims for multi-source brand drugs will be paid at the MAC, generic NADAC, or FUL price (lesser of methodology) unless the prescriber requests a prior authorization (PA) for the brand multi-source product, and the request is deemed medically necessary. 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). 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 or NADAC allowing for the shift to generic usage. Enhanced dispensing fee: There is an incentive for the pharmacy to dispense the generic or State preferred brands as the dispensing fee is higher than for single source brand or non-preferred brand products. 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: Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. 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.

State	Generic Drug Substitution Policies Summary
	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 85.34% for all outpatient claims comprising 14.89% of total drug expenditures for FFY2022.
California	Among possible factors contributing to the Medi-Cal fee-for-service generic utilization percentage, the most impactful are supplemental rebate contracts with manufacturers and 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 After the implementation of Medi-Cal Rx in January 2022, most components of the pharmacy benefit transitioned from managed care to fee-for-service. 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), Maximum Allowable Ingredient Cost (MAIC), or 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

State	Generic Drug Substitution Policies Summary
	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. The objective of the MAIC program is to establish upper limit generic ingredient reimbursement rates that encourage efficient purchasing while being responsive to drug pricing fluctuations. The California Department of Health Care Services (DHCS) has contracted with Magellan Medicaid Administration, Inc. (MMA) , who has contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to establish and maintain a Maximum Allowable Ingredient Cost (MAIC) program for generic drugs. Mercer will update the MAIC rate list at least quarterly, with the effective date of the change posted on the rate list at least 30 days prior to the effective date of the new rate. 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 policy): Brand name drug products that have generic equivalent product formulations (multi-source innovator products) require a prior authorization. Exceptions to this include cases where the brand name drug has been exempted from the generic mandate policy based on 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 (designated brand favored products are listed on the 'Brand Favored Product List' for reference on the Department's Pharmacy Resources webpage). - 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.

State	Generic Drug Substitution Policies Summary
	- 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. - The medication is being prescribed for the treatment of any of the following disease States (which are exempt from the generic mandate policy): Biologically based mental illness (as defined in 10-16-104 (5.5) C.R.S.), cancer, epilepsy, or 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 recommendations, the program provides advantage to products that are most cost effective. Using these methods, we have been able to enhance generic utilization 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 made 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

State	Generic Drug Substitution Policies Summary
	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 net-net cost to the State.
Delaware	During federal fiscal year 2022, DMMA policy continued to encourage 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. Leveraging this policy has resulted in an 79.89 percent 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 and expedite access to these particular brand name products. Claims being submitted with a DAW code of 2, Patient Requests Brand, will be 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 sourced medications. Med Watch forms are detailed descriptions of the generic product that failed and the type of failure that occurred. By requiring submission of this form, Delaware helps ensure that a generic product be tried prior to the request for a brand name product. A minimum of a two week trial period is required unless an objective adverse event occurs that necessitates the medication being stopped. The Med Watch form must be completely filled out to include the National Drug Code (NDC) and the lot number. Documentation by the physician of a valid side effect or lack of efficacy that occurred with the member utilizing a generic must

State	Generic Drug Substitution Policies Summary
	also be provided in sufficient detail. Many of the 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 source drugs for many years and continues to find it to be effective method of decreasing unnecessary and costly use of brand name products.
District of Columbia	There are several marketplace factors that could potentially influence the generic utilization percentage. 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 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 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 practice, however, may negatively influence the generic utilization rate.
Florida	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 85% for Federal Fiscal Year 2022.

State	Generic Drug Substitution Policies Summary
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	Generic is mandatory by Hawaii law with a few exceptions: narrow therapeutic index drugs. Dental FFS formulary is generic and 8 of the top 10 drug claim count are dental, driving the generic rate high. Hawaii providers are compliant with prescribing and filling generic drugs whenever available. The transplant drugs are usually brand, low in claims count and high in cost as single source brands. There is not PDL and the MCOs manage their own formularies and PDL.
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 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 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. These policy changes remained in effect during FFY22. Illinois Medicaid uses State Maximum Allowable Cost (SMAC) pricing on generic drugs. The lesser of the Estimated Acquisition Cost (AEC), Federal Upper Limit (FUL), National Average Drug Acquisition Cost (NADAC) or billed charges is used to establish the reimbursement rate for generic products. The SMAC and Specialty medication SMAC lists are available at http://www.ilsmac.com/list.

State	Generic Drug Substitution Policies Summary
	Effective July 15, 2019, the Fee-for-Service professional dispensing fee for brand and generic products for non-critical access pharmacies is the same at $8.85. There are different dispensing fees for 340B claims ($12) and Critical Access Pharmacies (CAP). The CAP self-attested for State fiscal year 2022 (SFY22) to receive enhanced professional dispensing fees of $15.55. Illinois Medicaid uses tiered copayments to encourage utilization of generic products. During FFY22, 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. These copays may be waived for certain participants and medications as detailed at https://www.dhs.State.il.us/page.aspx?Item=17633. Copayments for medications and other Medicaid benefits were waived in the second half of FFY20 due to the COVID-19 pandemic for all participants. This policy change remained in effect during FFY22. 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 as well as the national Chantix shortage during FY22. 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. This policy change remained in effect during FFY22. 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. The expanded list of drugs covered in 90-day supplies during the COVID-19 emergency is available at https://www2.illinois.gov/hfs/SiteCollectionDocuments/05202020DrugsCovered90DaySuppliesCOVID19Final.pdf. The expanded 90-day supply list remained in effect during FFY22. In FFY22, the Illinois Medicaid generic utilization rate was 90.20% of total paid claims, essentially unchanged compared to the FFY21 generic utilization rate of 90.43%. In FFY22, brand name single-source drugs accounted for 5.78% of the total paid claims, which was 0.67% higher than in FFY21. In FFY22 innovator multiple source drugs accounted for 4.02% of the total paid claims, at least 0.44% percent lower than in FFY21. 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 “Brand

State	Generic Drug Substitution Policies Summary
	Medically Necessary" on the prescription and obtains prior authorization. Excluded from the prior authorization requirement are those claims for Coumadin®, Provera®, Synthroid®, Tegretol®, Lanoxin®, Premarin®, and Dilantin®, as well as claims with a dispense as written (DAW)/product selection code 01 indicating "Brand Medically Necessary." In addition, brand name agents that are preferred by the plan due to cost savings do not require prior authorization or a prescription indicating "Brand Medically Necessary." 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: o the words "Brand Medically Necessary" are written in the practitioner's own writing on the form; or o the 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 "Brand Medically Necessary" 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 rebates 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: 1. 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. 2. A note stating dispense as written on an electronically sent prescription. 3. Verbally request was made when phoning in a prescription order. 4. The FDA has determined that a drug is not bioequivalent to the prescribed drug.

State	Generic Drug Substitution Policies Summary
	Kansas Medicaid has Brand Medical Necessity PA criteria for when a provider requests brand drugs and there is a substitutable/interchangeable product available.
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 copayment 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. 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: 02/16/23, Page 16 of 208 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 and the Pharmacy Benefits Management Services Manual: 4.2.2 Federal Upper Limits (FUL). Claim payments are adjusted in accordance with the Maximum Allowable Reimbursement Methodology for drugs with FUL.

State	Generic Drug Substitution Policies Summary
	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 in the prescriber's handwriting and signed unless the prescription is submitted electronically.
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 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.
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").

State	Generic Drug Substitution Policies Summary
	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 92%.
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 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.

State	Generic Drug Substitution Policies Summary
	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 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	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:

State	Generic Drug Substitution Policies Summary
	- 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 - 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 results 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 brands. Preferred brands do not count toward the two brand monthly prescription limit. There are some situations where a more expensive generic drug is co-preferred with the branded agent in order for beneficiary access.
Missouri	Missouri encourages providers to utilize generics by utilizing NADAC-G and MAC pricing, which reimburses pharmacies at the lower generic rate. Providers may request an override to utilize the brand name product. If the override request is approved the pharmacy is reimbursed at the applicable brand name rate. In order to be considered for an override the participant must have tried the required generic agents previously. Missouri has also implemented a brand over generic list for products where the brand name agent has a lower net cost than the generics available on the market.
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	Nebraska Medicaid and Long-Term Care has a drug utilization program that includes a State-wide single PDL for therapeutic drug classes reviewed by the P&T Committee. The single PDL is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee along with criteria when generic utilization may be

State	Generic Drug Substitution Policies Summary
	non-preferred for. Generic utilization is supported through point of sale edits and managed care contract generic utilization requirements. Formulary management tools include: State-wide Single Preferred Drug List Bi-annual PDL review via P&T meetings in May and November Bi-monthly DUR meetings Cost determination of brand and generic drugs by analyzing supplemental and federal rebate review for branded products
Nevada	Nevada Revised Statute (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 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. New Hampshire Medicaid policy requires a Prior Authorization for all multi-source brand legend medications to determine the medical necessity of the request based on the following parameters: 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. New Hampshire regulation requires that generic formulations of drugs within Medicaid PDL classes are covered as preferred drugs independent of the PDL status of the brand reference product. New Hampshire Medicaid continues to enhance the maximum allowable cost (MAC) program to further encourage generic utilization.

State	Generic Drug Substitution Policies Summary
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 more cost-effective than multi-source drugs; - the dispensing of a ten (10) day supply of a 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. On October 21, 2011, the New Jersey Drug Utilization Review Board reviewed and approved an updated State Mandatory Generic Substitution Exempt List. Changes were as follows: atypical antipsychotics would now be referred to as behavioral health drugs, hormone replacement therapy drugs would no longer be exempt, and transplant or anti-rejection drugs would become exempt.
New Mexico	New Mexico 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 for 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, antidepressants, cancer chemotherapy items, and thyroid hormones, and oral birth control. Brand name medications are not covered for acne and cough and cold medications.
New York	The Brand Less than Generic Program is a cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent. Generic drugs included in this program require prior authorization. Once it is determined that the generic drug is more cost-effective than the brand name equivalent, the prior authorization requirement is removed for the generic drug.
North Carolina	Generic Substitution Policies NC Medicaid and Health Choice Outpatient Pharmacy Clinical Coverage Policy No: 9 Revised Date: July 1, 2021 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

State	Generic Drug Substitution Policies Summary
	drug by its generic 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. B.1 Vaccines

State	Generic Drug Substitution Policies Summary
	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 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

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	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 174 Preferred Brands with Non-Preferred Generics on the Preferred Drug List (PDL) as of September 30, 2022 (brand use required unless prior approval for generic). Averaged over the fiscal year, there were 167 Preferred Brands with Non-Preferred Generics on the PDL.
North Dakota	State prefers brand over generic when rebates make brand the net cost effective option. Brand is also allowed in cases where TPL is requiring brand when it is cost effective for the State with TPL and rebates. In some cases brand and generic are equally preferred either by not putting generic pricing on the brand or allowing (but not requiring) bypass of the generic pricing of the brand. In cases where the generic is preferred, the provider must submit a prior authorization to be approved for the brand name, including trialing available generic manufacturers.
Ohio	While the Ohio Department of Medicaid (ODM) encourages generic drug use, drugs included in the ODM Drug File are considered reimbursable, regardless of their brand or generic designation. When generic substitution is being performed, pharmacists should practice in accordance with Ohio Revised Code (ORC) 4729.38. This includes only substituting when the prescriber has not indicated that the brand drug should be dispense as written (DAW). ODM will reimburse participating pharmacies only when accepted DAW Codes are submitted. Only DAW codes 0, 1, 4, 5, 7, 8, and 9 should be submitted by pharmacy providers. DAW codes 2, 3, and 6 are not accepted values and will cause the claim to reject for inactive DAW code. Incorrect use of these codes may result in recoupment. To appropriately use DAW code 1, the pharmacy must submit the claim in compliance with ORC 4729.38 and 4729.40. Pharmacies must submit the claim with the appropriate DAW Code in the Dispense as Written (DAW)/Product Selection Code field (408-D8). Ohio Medicaid also promotes generic substitution through point-of-sale edits such as requiring a prior authorization for any brand name drug for which there is a generic available. Ohio Medicaid continues to encourage generic substitution when possible. This

State	Generic Drug Substitution Policies Summary
	is demonstrated by Ohio Medicaid's generic utilization rate of 88.9% for Federal Fiscal Year 2022.
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 the generic form unless the practitioner requests 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 prices and rebates, is equal to or less than 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	When the net cost of a mutli-source brand drug, after rebates, is less than the net cost of the equivalent generic, the Department may list the multi-source brand on the Statewide Preferred Drug List. Pharmaceutical Services Prior Authorization Requirement Multisource Brand Name Drugs Medical Assistance Bulletin 01-94-17, 03-94-04, 04-94-05, 19-94-11, 1121-94-02 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 Department's requiring all Medical Assistance recipients to obtain prior authorization with respect to all brand name drugs for which

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	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.
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

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	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 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 Carolina continues to participate in the National Medicaid Pooling Initiative (NMPI) for assistance with Preferred Drug List recommendations, supplemental rebates opportunities.
South Dakota	South Dakota law provides that prescriptions written for brand-name drugs are substitutable with therapeutically equivalent generic drugs unless prescribers write 'Do Not Substitute' or an equivalent Statement in their own handwriting on the face of the prescription or specifically State such on an oral order. Through the South Dakota Medicaid Prior Authorization Program, any brand-name drug with an FDA approved generic will require prior authorization. South Dakota Medicaid also encourages generic utilization by limiting payment of substitutable brand drugs without a PA to the federal upper limit price or the State maximum allowable cost, whichever is less.
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) - 2 claims. For DAW-1 claims, if the prescriber marks that 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

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	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	Generic utilization percentage is affected by the preferred brand name drugs. Due to the Federal and State rebate policies, the brand names that are less costly when compared to their generic formulations, are moved to preferred list. Texas has a single-PDL policy and the MCOs are required to implement the same preferred drug and PDL PA criteria. Therefore, the MCOs generic utilization is directly impacted by the State's PDL 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 generic.
Vermont	Title 18 : Health Chapter 091 : Prescription Drug Cost Containment Subchapter 001 : Generic Drugs (Cite as: 18 V.S.A. 4605) 4605. Alternative drug or biological product 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 brandname 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

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	allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher-priced drug or biological product. National Medicaid FFS DUR FFY 2021 Annual Report 239 | Page State Generic Drug Substitution Policies Summary (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 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 or more of the electronic systems described in subdivision (1) of this subsection (e), the pharmacist or designee shall communicate to the prescriber the information regarding the biological product dispensed using telephone, facsimile, electronic transmission, or other prevailing means. (B) If a prescription is communicated to the pharmacy by means other than electronic prescribing technology, the pharmacist or designee shall communicate to the prescriber the information regarding the biological product dispensed using the electronic process described in subdivision (1) of this subsection (e) unless the prescriber requests a different means of communication on the prescription. (4) Notwithstanding any provision of this subsection to the contrary, a pharmacist shall not be required to communicate information regarding the biological product dispensed in the following circumstances: (A) the U.S. Food and Drug Administration has not approved any interchangeable biological products for the product prescribed; or (B) the pharmacist dispensed a refill prescription in which the product dispensed was unchanged from the product dispensed at the prior filling of the prescription. (f) The Board of Pharmacy shall maintain a link on its website to the current lists of all biological products that the U.S. Food and Drug Administration has determined to be interchangeable biological products. (Added 1977, No. 127 (Adj. Sess.), 1; amended 2001, No. 63, 124; 2005, No. 71, 306, eff. June 21, 2005; 2009, No. 35, 3; 2017, No. 193 (Adj. Sess.), 2.) National Medicaid FFS DUR FFY 2021 Annual Report 240 | Page State Generic Drug Substitution Policies Summary Generic and Biosimilar Substitution Policy Vermont law requires that when available, the lowest-cost equivalent generic or interchangeable biologic product should be dispensed. However, when a pharmacist receives a prescription for a Medicaid member, the pharmacist shall select the preferred brand, generic, biological or interchangeable biological product from the Department of Vermont Health Access's preferred drug list. The Preferred Drug List (PDL) may require a branded product or biological product to be dispensed in lieu of a generic or interchangeable biological product in limited circumstances when net cost to the State is lower.
Virginia	The Virginia Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: - Brand 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

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	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-eight percent (88%) for FFY 2022. - 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. - Tiered 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: - Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. - 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. - 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, Virginia Medicaid has a generic utilization of 88% for all outpatient claims comprising 21% of total drug expenditures for FFY 2022.
Washington	Washington Apple Health (Medicaid) applies various strategies to increase and maintain generic utilization rates. The following strategies could influence 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. Generic substitution is permitted and mandatory unless the prescriber notes 'Dispense as written' on the prescription. 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, safety, potential for misuse and abuse, drugs with a narrow therapeutic index, and cost

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	and outcome data demonstrating the cost effectiveness of the drug versus alternatives on the market. 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 as well as select medically administered injectable drugs. 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 considers product-by-product comparisons based on quality evidence reviews, utilization trends, cost net of rebate and if applicable, supplemental rebate offers. The drugs which are indicated as preferred have been selected for their clinical significance, medical efficacy, and are least costly to the State. All non-preferred products require a trial of at least 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. 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 substitutions 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. State law requiring mandatory generic substitution.
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:

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	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. 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 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. As of December 1, 2022, the standard three-month policy was reinStated.
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

State	Generic Drug Substitution Policies Summary
	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

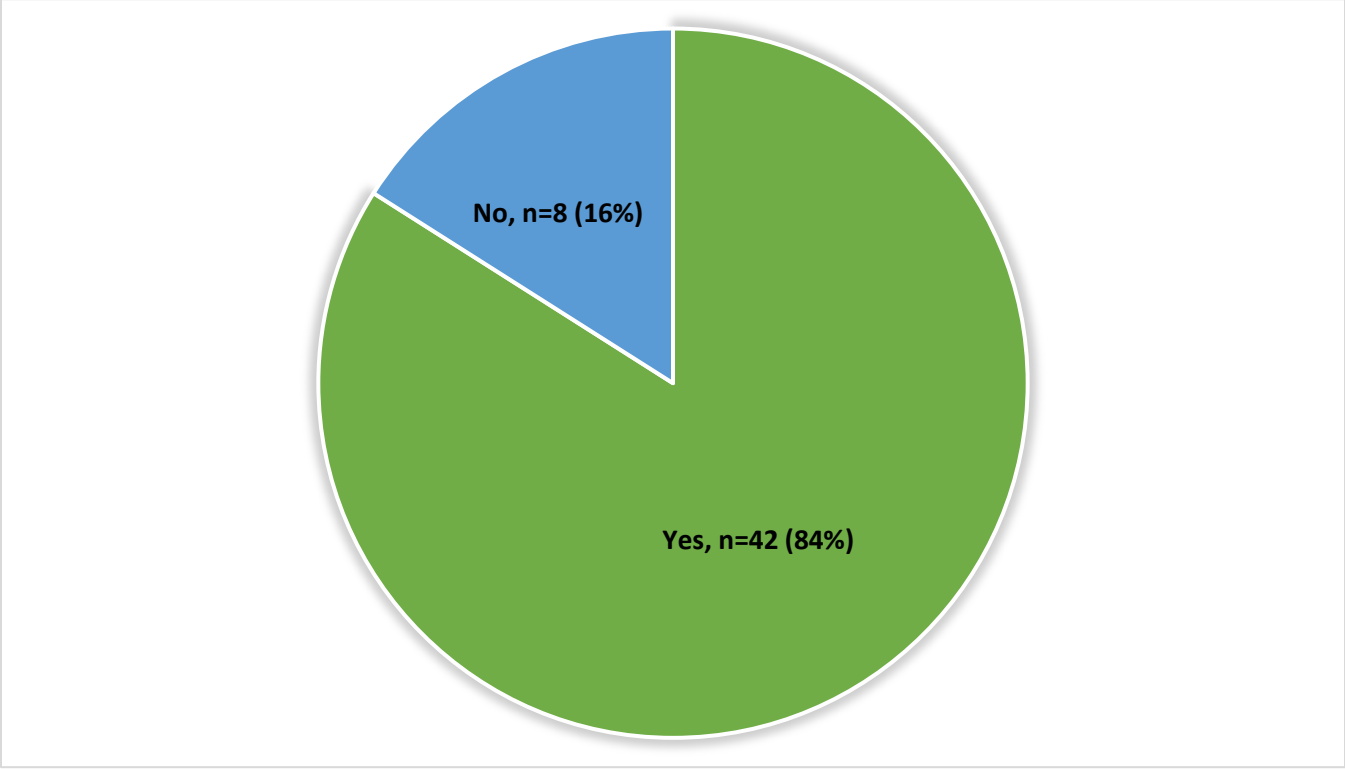

Table 65 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, 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	42	84.00%
No	Florida, Hawaii, Kentucky, Louisiana, Mississippi, New Mexico, Rhode Island, Virginia	8	16.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 44 - Additional Restrictive State Requirements for Dispensing a Brand Name Drug

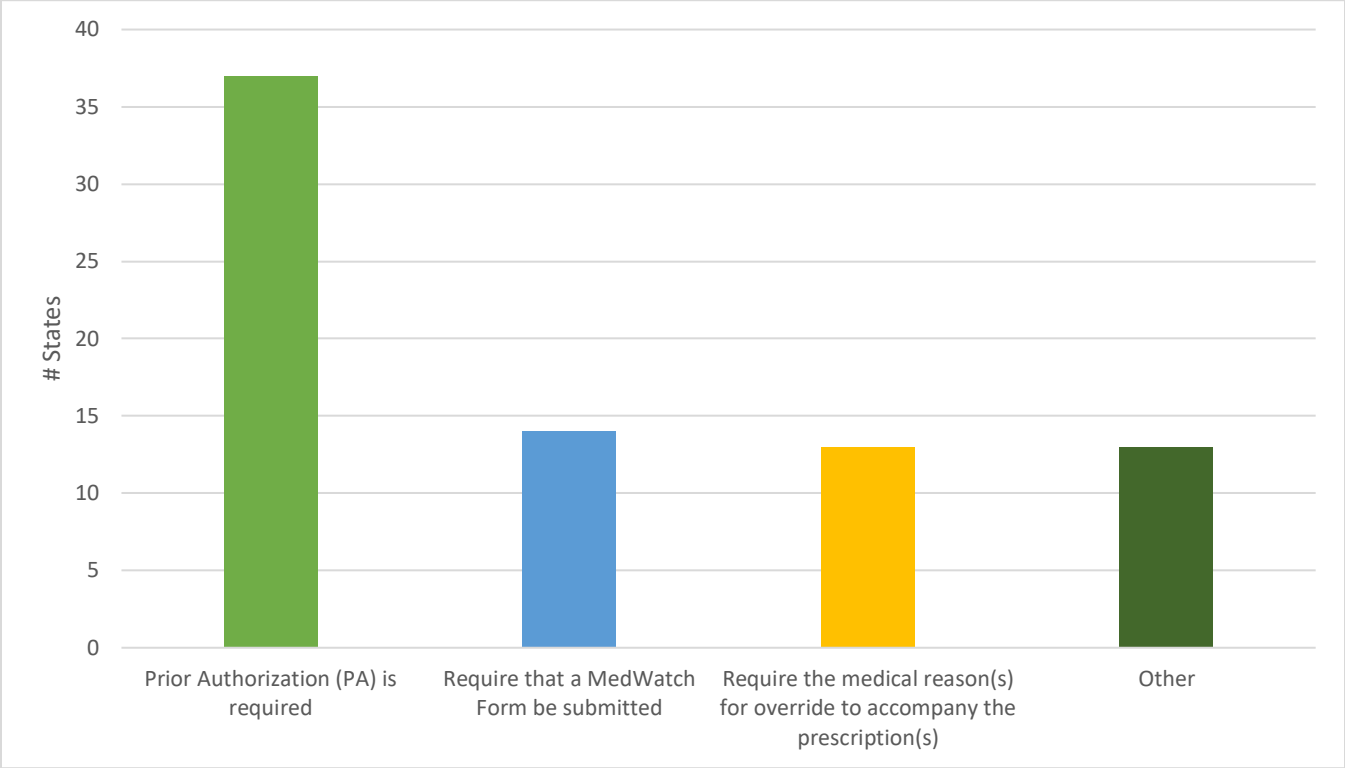

Table 66 - Additional Restrictive State Requirements for Dispensing a Brand Name Drug

Response	States	Count	Percentage
Prior Authorization (PA) is required	Alabama, Alaska, Arkansas, California, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	37	48.05%
Require that a MedWatch Form be submitted	Alabama, Arkansas, Connecticut, Delaware, Indiana, Iowa, Maine, Maryland, Nevada, North Dakota, South Carolina, Tennessee, West Virginia, Wyoming	14	18.18%
Require the medical reason(s) for override to accompany the prescription(s)	Alabama, Delaware, Idaho, Missouri, Montana, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, West Virginia	13	16.88%
Other	Colorado, Connecticut, Delaware, Idaho, Michigan, Missouri, Nebraska, Nevada, North Carolina, Texas, Utah, Washington, Wisconsin	13	16.88%
Total		77	100.00%

If “Other,” please explain.

Table 67 - “Other” Explanations for Additional Restrictive State Requirements for Dispensing a Brand Name Drug

State	Explanation
Colorado	Prescriptions for multi-source 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 is used to determine to the reason why a brand drug is required.
Idaho	Must fail two separate (different) manufacturer generic products
Michigan	Select drug classes determined by the State Legislature are exempt from prior authorization.
Missouri	Missouri has also implemented a brand over generic list for products where the brand name agent has a lower net cost than the generics available on the market.
Nebraska	Prescriber = Must complete a MC-6 Prescriber Certification - Brand Medically Necessary form, which declares the brand name medication is medically necessary. This form can be found for prescribers on https://nebraska.fhsc.com/Downloads/mc6-20120817.pdf
Nevada	Trial/Failure of two generics (if available)
North Carolina	Several drug classes on the Preferred Drug List (PDL) have brand name drugs as non-preferred, thus requiring the try and failure of preferred drugs before using these non-preferred brands. If trial and failure of preferred drugs is not medically appropriate, the prescriber must complete a PA detailing why the brand name drug is medically necessary.
Texas	If brand name drug has a preferred status, the prescriber does not need to write "Brand name Necessary".
Utah	DAW-1 only override for mental health medications. Other meds require prior authorization
Washington	Washington Medicaid may require prior authorization to justify medical necessity of the brand over the generic in order to get paid at the branded rate.
Wisconsin	Wisconsin has identified select Brand Medically Necessary drugs that do not require a prior authorization (e.g., anticonvulsants, thyroid replacement drugs), but these drugs do still require the prescriber to write in his own handwriting "Brand Medically Necessary".

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:

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

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

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

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 2021 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

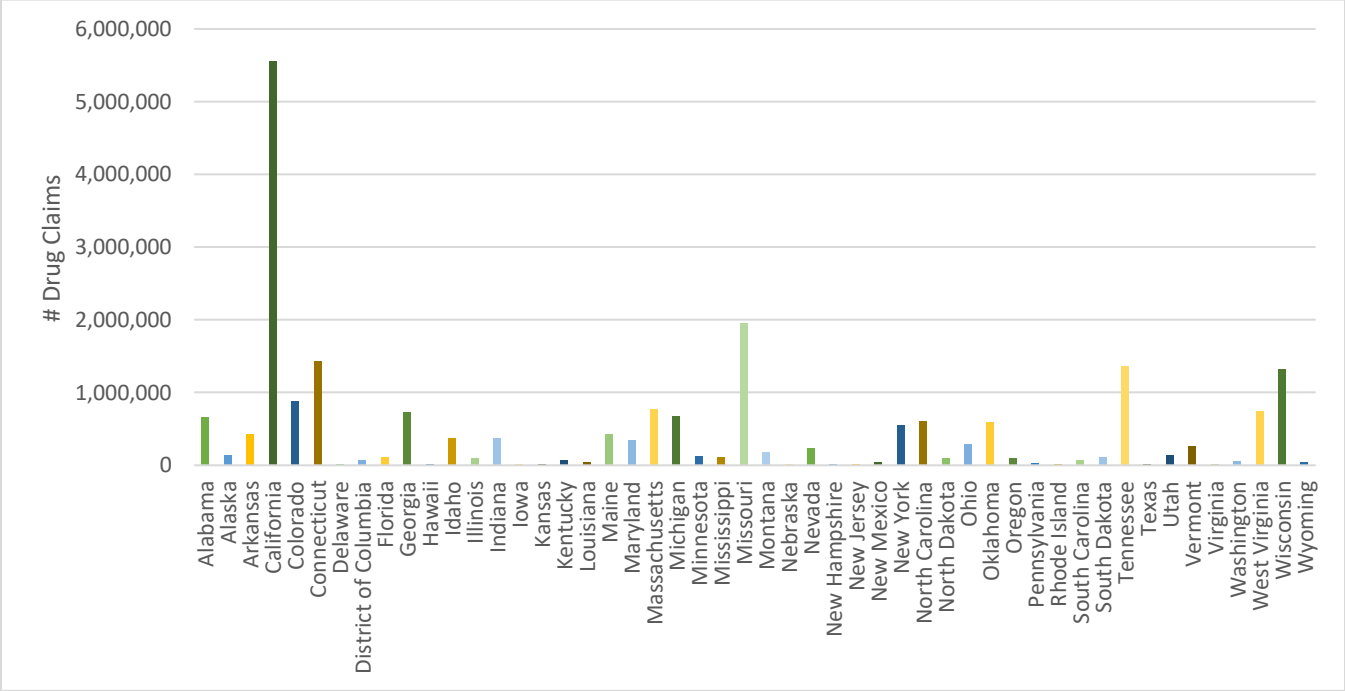

Figure 46 - Non-Innovator Source (N) Drugs Total Number of Claims by State

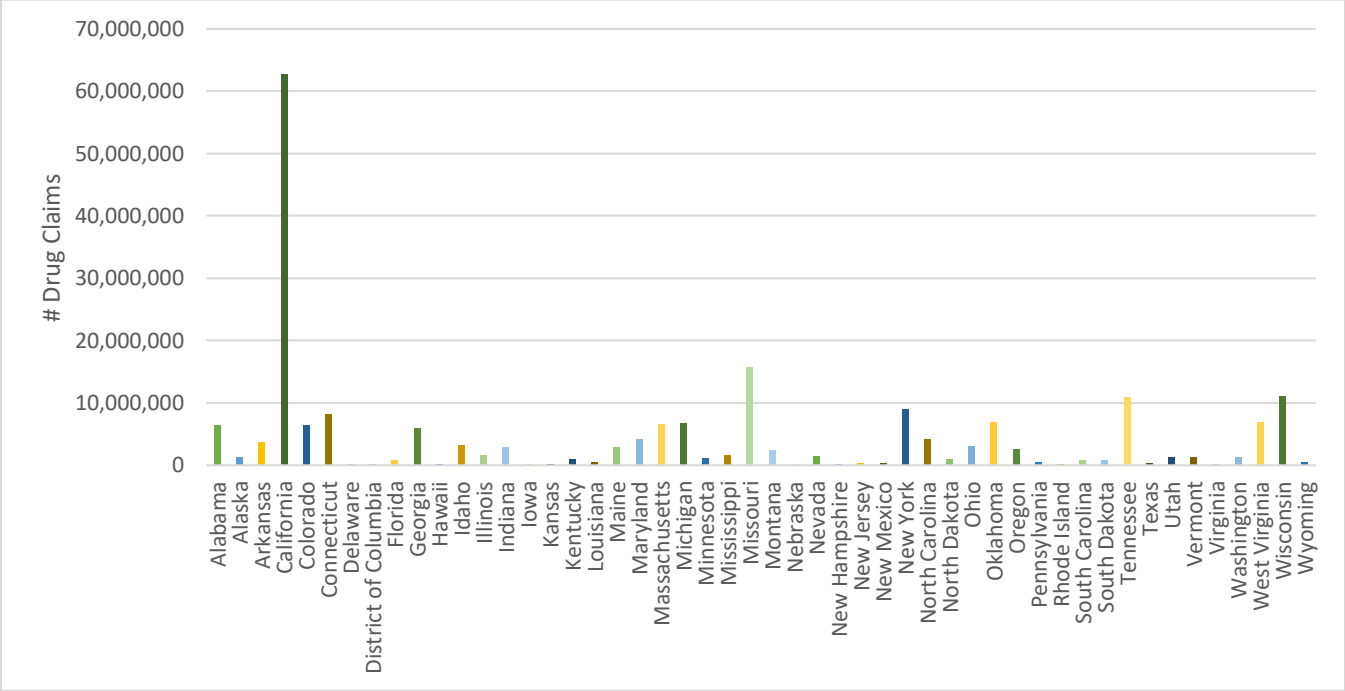

Figure 47 - Innovator Multi-Source (I) Drugs Total Number of Claims by State

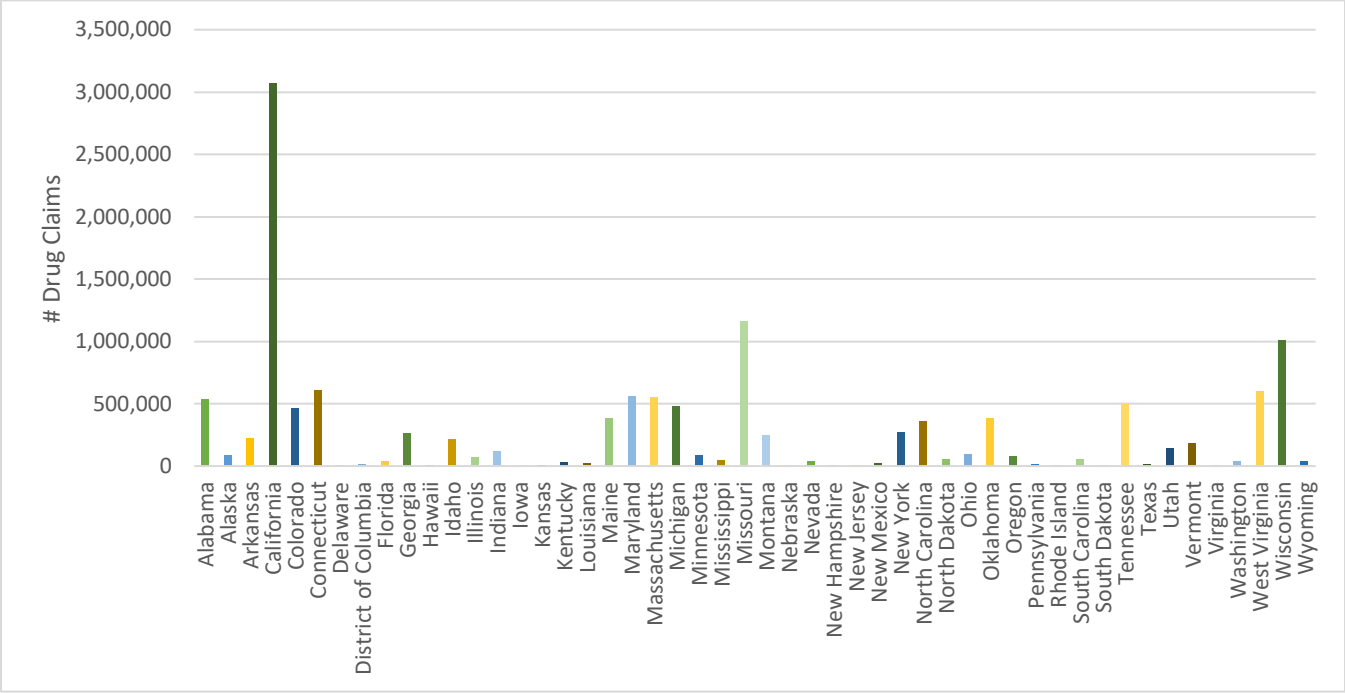

Table 68 - Drug Utilization Number of Claims by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	662,641	6,359,666	532,387
Alaska	137,541	1,208,590	82,951
Arkansas	423,197	3,763,913	223,181
California	5,559,603	62,794,992	3,068,458
Colorado	885,433	6,480,450	459,047
Connecticut	1,430,383	8,146,558	608,523
Delaware	9,193	45,069	2,153
District of Columbia	63,683	211,862	13,649
Florida	106,664	847,673	40,254
Georgia	725,476	5,944,034	260,474
Hawaii	229	8,737	64
Idaho	374,021	3,176,347	216,131
Illinois	98,598	1,537,828	68,534
Indiana	377,360	2,943,429	114,448
Iowa	11,640	102,158	5,361
Kansas	1,752	27,275	887
Kentucky	76,221	909,755	28,393
Louisiana	49,251	551,454	20,958
Maine	424,960	2,833,996	385,446
Maryland	343,987	4,169,282	556,985
Massachusetts	768,974	6,578,288	553,717

State	"S" Drugs	"N" Drugs	"I" Drugs
Michigan	673,430	6,672,014	481,228
Minnesota	123,960	1,194,326	86,274
Mississippi	112,065	1,636,614	48,185
Missouri	1,947,365	15,726,934	1,159,579
Montana	184,713	2,455,548	241,766
Nebraska	76	983	20
Nevada	234,506	1,458,301	40,673
New Hampshire	937	6,886	342
New Jersey	20,124	266,030	7,288
New Mexico	45,632	269,547	17,509
New York	555,790	8,985,655	266,129
North Carolina	601,296	4,184,997	356,792
North Dakota	101,637	896,196	54,789
Ohio	286,135	3,028,734	91,889
Oklahoma	595,317	6,898,841	381,757
Oregon	94,211	2,555,746	79,261
Pennsylvania	31,220	551,995	15,314
Rhode Island	7,279	111,400	2,749
South Carolina	74,576	817,097	49,363
South Dakota	114,989	782,939	611
Tennessee	1,357,623	10,957,392	503,567
Texas	19,919	291,236	10,137
Utah	137,837	1,328,548	142,686
Vermont	262,951	1,320,407	177,961
Virginia	10,846	134,379	8,218
Washington	50,945	1,229,016	38,775
West Virginia	743,803	6,832,786	596,511
Wisconsin	1,325,171	11,059,922	1,006,227
Wyoming	36,294	442,530	33,916
Total	22,281,454	210,738,355	13,141,517

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

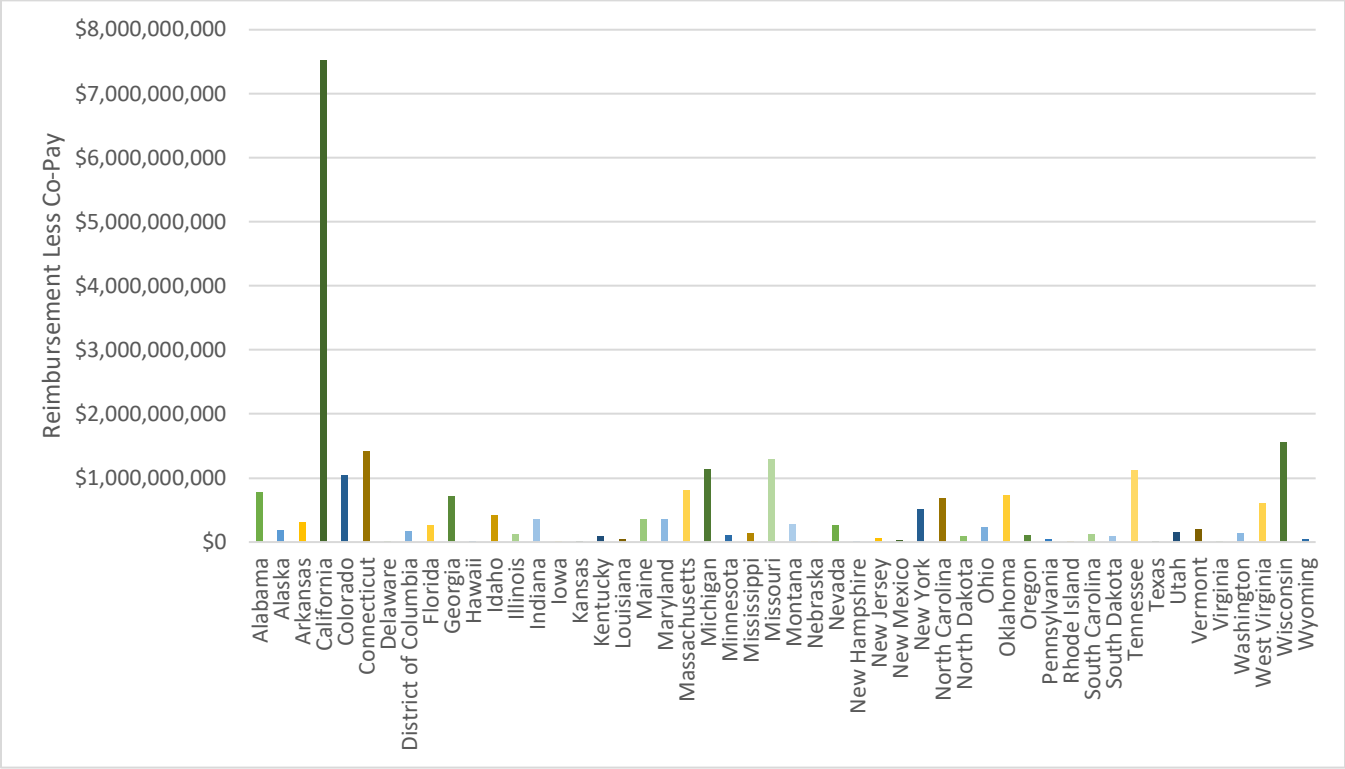

Figure 49 - Non-Innovator Source (N) Drugs Total Reimbursement Amount Less Co-Pay by State

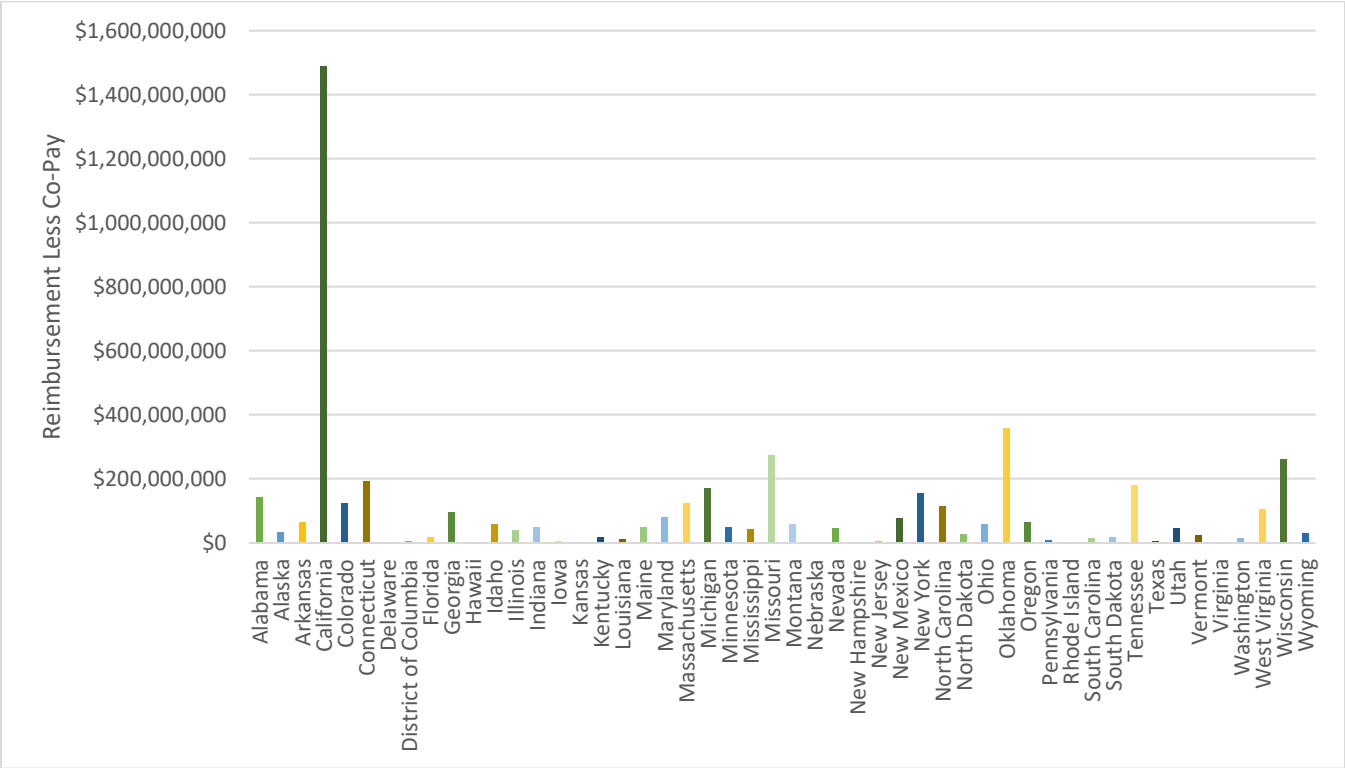

Figure 50 - Innovator Multi-Source (I) Drugs Total Reimbursement Amount Less Co-Pay by State

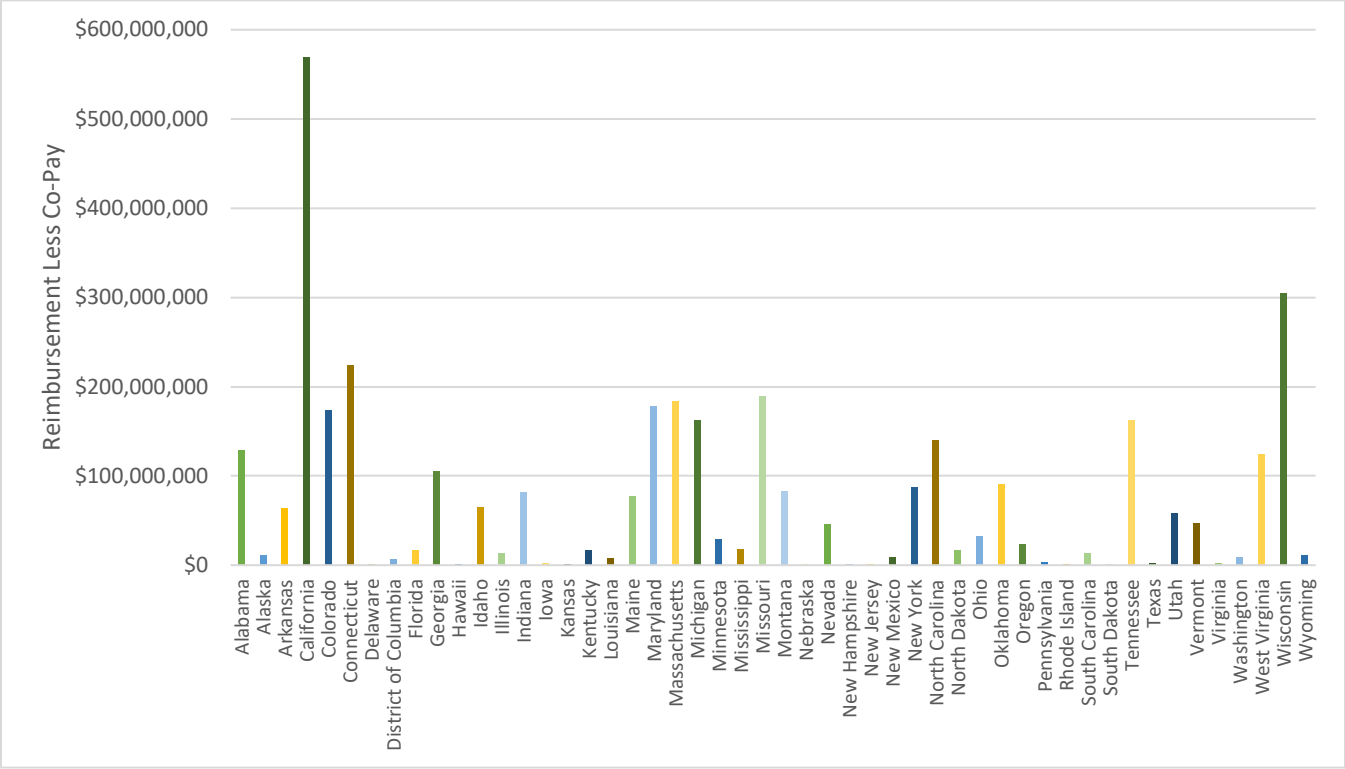

Table 69 - Drug Utilization Total Reimbursement Amount by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	$779,157,855	$141,463,292	$128,794,239
Alaska	$182,329,017	$31,987,369	$11,532,888
Arkansas	$302,543,481	$64,047,975	$63,636,974
California	$7,517,703,921	$1,488,222,889	$568,629,876
Colorado	$1,045,267,717	$123,783,996	$173,504,635
Connecticut	$1,420,440,983	$193,153,174	$224,054,126
Delaware	$2,239,004	$684,018	$127,985
District of Columbia	$158,775,768	$4,222,613	$6,350,326
Florida	$258,690,531	$18,697,295	$16,667,120
Georgia	$718,080,321	$94,964,589	$105,057,418
Hawaii	$872,269	$289,733	$62,026
Idaho	$413,760,255	$58,788,986	$64,947,532
Illinois	$118,252,490	$39,665,687	$13,450,631
Indiana	$361,143,716	$50,186,812	$81,635,482
Iowa	$7,295,932	$3,805,969	$1,656,295
Kansas	$2,571,000	$486,000	$50,000
Kentucky	$80,291,440	$17,990,309	$17,218,277
Louisiana	$47,853,879	$12,122,454	$8,030,027
Maine	$348,104,985	$47,411,283	$77,414,826

State	"S" Drugs	"N" Drugs	"I" Drugs
Maryland	$347,848,414	$78,798,646	$178,509,743
Massachusetts	$811,693,906	$122,158,104	$183,658,215
Michigan	$1,132,168,030	$169,438,550	$162,103,132
Minnesota	$109,382,263	$49,346,044	$28,643,981
Mississippi	$138,653,856	$41,839,286	$18,031,613
Missouri	$1,284,838,702	$273,168,481	$189,456,497
Montana	$272,505,049	$59,524,241	$83,184,052
Nebraska	$40,559	$16,123	$4,106
Nevada	$260,228,080	$45,270,874	$45,766,241
New Hampshire	$11,693,589	$140,982	$57,593
New Jersey	$64,272,014	$4,502,368	$866,790
New Mexico	$29,994,707	$77,964,646	$8,503,543
New York	$507,493,293	$153,714,354	$86,788,107
North Carolina	$676,773,497	$114,670,500	$140,051,590
North Dakota	$83,496,096	$27,838,430	$16,113,580
Ohio	$234,023,007	$59,486,675	$32,412,775
Oklahoma	$726,181,396	$356,732,465	$90,579,237
Oregon	$104,526,445	$65,079,652	$23,943,258
Pennsylvania	$46,104,825	$8,805,321	$2,829,797
Rhode Island	$6,107,361	$1,408,407	$597,038
South Carolina	$114,507,822	$15,856,286	$13,347,226
South Dakota	$86,751,132	$17,857,811	$804,016
Tennessee	$1,120,439,925	$179,582,201	$161,780,855
Texas	$16,773,952	$6,164,261	$2,193,661
Utah	$152,962,955	$44,372,381	$58,326,812
Vermont	$190,514,544	$25,129,507	$47,173,289
Virginia	$8,812,377	$2,783,762	$1,593,811
Washington	$134,867,478	$12,910,313	$8,361,704
West Virginia	$605,074,678	$105,916,307	$124,378,469
Wisconsin	$1,549,191,501	$261,731,870	$304,608,276
Wyoming	$41,844,106	$30,162,201	$10,899,112
Total	$24,635,140,123	$4,804,345,492	$3,588,388,802

3. Indicate the generic utilization percentage for all covered outpatient drugs (COD) paid during this reporting period.

Figure 51 - Generic & Total Claims by State

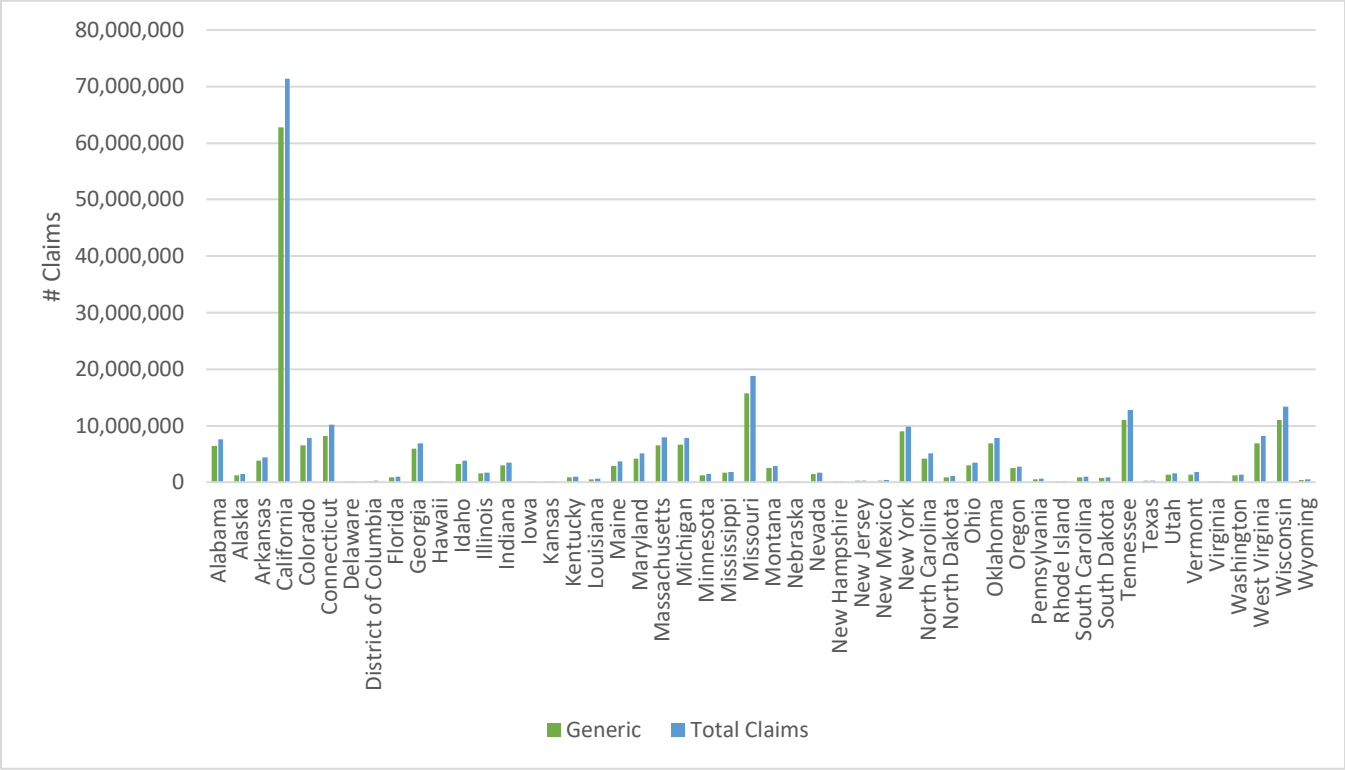

Table 70 - Generic & Total Claims by State

State	Generic Claim Count	Total Claim Count	Percentage
Alabama	6,359,666	7,554,694	84.18%
Alaska	1,208,590	1,429,082	84.57%
Arkansas	3,763,913	4,410,291	85.34%
California	62,794,992	71,423,053	87.92%
Colorado	6,480,450	7,824,930	82.82%
Connecticut	8,146,558	10,185,464	79.98%
Delaware	45,069	56,415	79.89%
District of Columbia	211,862	289,194	73.26%
Florida	847,673	994,591	85.23%
Georgia	5,944,034	6,929,984	85.77%
Hawaii	8,737	9,030	96.76%
Idaho	3,176,347	3,766,499	84.33%
Illinois	1,537,828	1,704,960	90.20%
Indiana	2,943,429	3,435,237	85.68%
Iowa	102,158	119,159	85.73%
Kansas	27,275	29,914	91.18%
Kentucky	909,755	1,014,369	89.69%

State	Generic Claim Count	Total Claim Count	Percentage
Louisiana	551,454	621,663	88.71%
Maine	2,833,996	3,644,402	77.76%
Maryland	4,169,282	5,070,254	82.23%
Massachusetts	6,578,288	7,900,979	83.26%
Michigan	6,672,014	7,826,672	85.25%
Minnesota	1,194,326	1,404,560	85.03%
Mississippi	1,636,614	1,796,864	91.08%
Missouri	15,726,934	18,833,878	83.50%
Montana	2,455,548	2,882,027	85.20%
Nebraska	983	1,079	91.10%
Nevada	1,458,301	1,733,480	84.13%
New Hampshire	6,886	8,165	84.34%
New Jersey	266,030	293,442	90.66%
New Mexico	269,547	332,688	81.02%
New York	8,985,655	9,807,574	91.62%
North Carolina	4,184,997	5,143,085	81.37%
North Dakota	896,196	1,052,622	85.14%
Ohio	3,028,734	3,406,758	88.90%
Oklahoma	6,898,841	7,875,915	87.59%
Oregon	2,555,746	2,729,218	93.64%
Pennsylvania	551,995	598,529	92.23%
Rhode Island	111,400	121,428	91.74%
South Carolina	817,097	941,036	86.83%
South Dakota	782,939	898,539	87.13%
Tennessee	10,957,392	12,818,582	85.48%
Texas	291,236	321,292	90.65%
Utah	1,328,548	1,609,071	82.57%
Vermont	1,320,407	1,761,319	74.97%
Virginia	134,379	153,443	87.58%
Washington	1,229,016	1,318,736	93.20%
West Virginia	6,832,786	8,173,100	83.60%
Wisconsin	11,059,922	13,391,320	82.59%
Wyoming	442,530	512,740	86.31%

4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing (i.e. brand name drug is preferred over equivalent generic product on the PDL)?

Figure 52 - Innovator Drugs that are the Preferred Product Based on Net Pricing

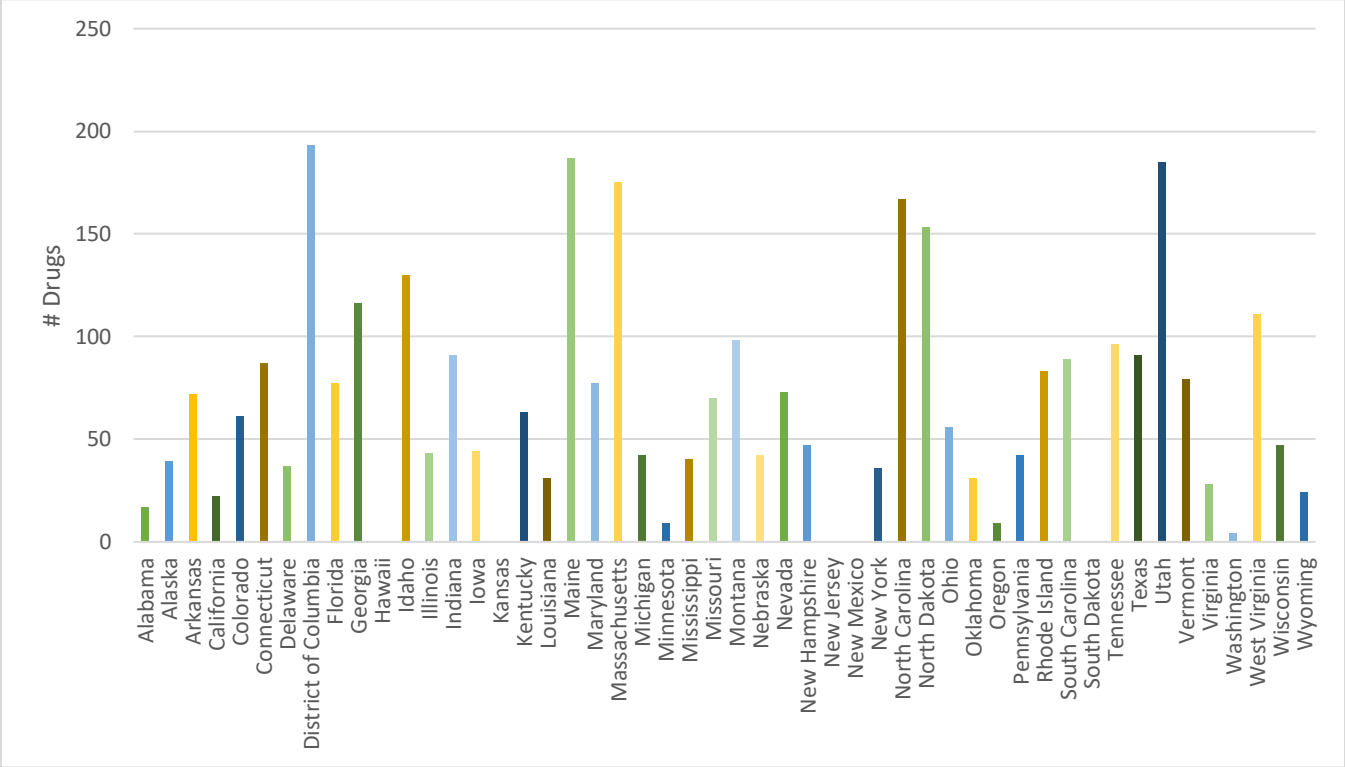

Table 71 - Innovator Drugs that are the Preferred Product Based on Net Pricing

State	Drug Count
Alabama	17
Alaska	39
Arkansas	72
California	22
Colorado	61
Connecticut	87
Delaware	37
District of Columbia	193
Florida	77
Georgia	116
Hawaii	0
Idaho	130
Illinois	43
Indiana	91
Iowa	44
Kansas	0

State	Drug Count
Kentucky	63
Louisiana	31
Maine	187
Maryland	77
Massachusetts	175
Michigan	42
Minnesota	9
Mississippi	40
Missouri	70
Montana	98
Nebraska	42
Nevada	73
New Hampshire	47
New Jersey	0
New Mexico	0
New York	36
North Carolina	167
North Dakota	153
Ohio	56
Oklahoma	31
Oregon	9
Pennsylvania	42
Rhode Island	83
South Carolina	89
South Dakota	0
Tennessee	96
Texas	91
Utah	185
Vermont	79
Virginia	28
Washington	4
West Virginia	111
Wisconsin	47
Wyoming	24

5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period.

Figure 53 - Generic/Total Amount Paid by State

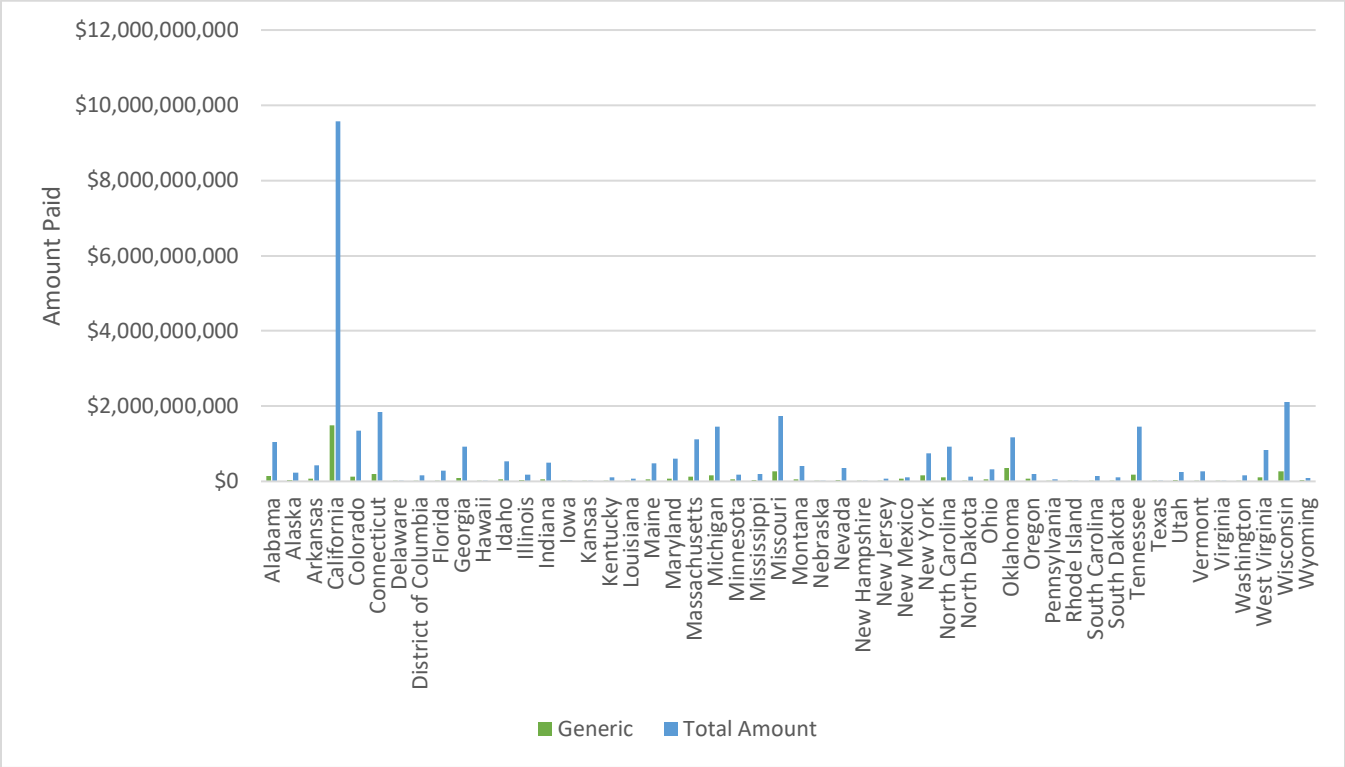

Table 72 - Generic/Total Amount Paid by State

State	Generic Claim Amount	Total Claim Amount	Percentage
Alabama	$141,463,292	$1,049,415,386	13.48%
Alaska	$31,987,369	$225,849,274	14.16%
Arkansas	$64,047,975	$430,228,431	14.89%
California	$1,488,222,889	$9,574,556,686	15.54%
Colorado	$123,783,996	$1,342,556,348	9.22%
Connecticut	$193,153,174	$1,837,648,283	10.51%
Delaware	$684,018	$3,051,007	22.42%
District of Columbia	$4,222,613	$169,348,706	2.49%
Florida	$18,697,295	$294,054,945	6.36%
Georgia	$94,964,589	$918,102,328	10.34%
Hawaii	$289,733	$1,224,028	23.67%
Idaho	$58,788,986	$537,496,773	10.94%
Illinois	$39,665,687	$171,368,808	23.15%
Indiana	$50,186,812	$492,966,010	10.18%
Iowa	$3,805,969	$12,758,195	29.83%
Kansas	$486,000	$3,107,000	15.64%

State	Generic Claim Amount	Total Claim Amount	Percentage
Kentucky	$17,990,309	$115,500,025	15.58%
Louisiana	$12,122,454	$68,006,360	17.83%
Maine	$47,411,283	$472,931,094	10.02%
Maryland	$78,798,646	$605,156,803	13.02%
Massachusetts	$122,158,104	$1,117,510,225	10.93%
Michigan	$169,438,550	$1,463,709,712	11.58%
Minnesota	$49,346,044	$187,372,288	26.34%
Mississippi	$41,839,286	$198,524,755	21.08%
Missouri	$273,168,481	$1,747,463,680	15.63%
Montana	$59,524,241	$415,213,342	14.34%
Nebraska	$16,123	$60,787	26.52%
Nevada	$45,270,874	$351,265,195	12.89%
New Hampshire	$140,982	$11,892,164	1.19%
New Jersey	$4,502,368	$69,641,172	6.47%
New Mexico	$77,964,646	$116,462,896	66.94%
New York	$153,714,354	$747,995,754	20.55%
North Carolina	$114,670,500	$931,495,587	12.31%
North Dakota	$27,838,430	$127,448,106	21.84%
Ohio	$59,486,675	$325,922,457	18.25%
Oklahoma	$356,732,465	$1,173,493,098	30.40%
Oregon	$65,079,652	$193,549,355	33.62%
Pennsylvania	$8,805,321	$57,739,943	15.25%
Rhode Island	$1,408,407	$8,112,806	17.36%
South Carolina	$15,856,286	$143,711,334	11.03%
South Dakota	$17,857,811	$105,412,959	16.94%
Tennessee	$179,582,201	$1,461,802,981	12.28%
Texas	$6,164,261	$25,131,874	24.53%
Utah	$44,372,381	$255,662,147	17.36%
Vermont	$25,129,507	$262,817,341	9.56%
Virginia	$2,783,762	$13,189,951	21.11%
Washington	$12,910,313	$156,139,496	8.27%
West Virginia	$105,916,307	$835,369,453	12.68%
Wisconsin	$261,731,870	$2,115,531,647	12.37%
Wyoming	$30,162,201	$82,905,419	36.38%

6. Does your State have any policies related to Biosimilars? Please explain.

Table 73 - Explanations for Policies Related to Biosimilars

State	Explanation
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; biosimilars have parity with branded preferred products.
Arkansas	Arkansas has no policies specific to biosimilars. When a new product becomes available and there is a PDL class for the product, the biosimilar is considered like any other new product and designated a non-preferred medication.
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 prescriber 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 with the same policies as the reference product.
District of Columbia	There was no biosimilar policy in effect during this time period.
Florida	Biosimilar products are reviewed during the therapeutic class review quarterly at the Pharmaceutical and Therapeutics (P&T) Committee meetings.
Georgia	No, not at this time.
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	Depending on the drug class, biosimilars may be included on the PDL.
Iowa	No
Kansas	Both the Kansas Medicaid PDL Committee and DUR Board members approve addition of biosimilars to the same PDL class whereby the biosimilar has the same indication as the Reference Product in that PDL class.
Kentucky	Per KRS 217.822. (2) When a pharmacist receives a prescription for a brand name biological product which is not listed by name in the nonequivalent drug product formulary prepared by the board, the pharmacist shall dispense a lower-priced interchangeable biological product, if there is one in stock, unless otherwise instructed by the patient at the point of purchase or by the patient's prescribing practitioner. If an interchangeable product is selected, the label on the container shall show the name of the biological product dispensed. (3) When an equivalent drug product or interchangeable biological product is dispensed in lieu of a brand name drug prescribed, the price of the equivalent drug or interchangeable biological product dispensed shall be lower in price to the purchaser than

State	Explanation
	the drug product prescribed. (5) The selection of any drug or interchangeable biological product by a pharmacist under the provisions of this section shall not constitute the practice of medicine. (8) When a pharmacist receives a prescription for a biological product written by nonbrand or proper name, he or she shall dispense an interchangeable biological product in accordance with the provisions of KRS 217.814 to 217.826, provided that the interchangeable product has been deemed by the United States Food and Drug Administration to be interchangeable with that specific reference product as identified by the nonbrand or proper name. (9) A pharmacist shall not substitute a biological product for a prescribed biological product unless the substituted product is an interchangeable biological product for the prescribed biological product.
Louisiana	Currently we do not have any policies specifically relating to biosimilars. Biosimilars are included on the PDL. However, a Statement is listed that ensures the use of a preferred biosimilar over a non-preferred reference product, if the preferred product has the same indications as the non-preferred.
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. 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 when the reference product is less expensive than the biosimilar net of rebate. In cases where a PDL exists for the class the policy is decided by PDL class for preferred/non-preferred status.
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	Preferred agents will be approved with FDA-approved indication ICD-10 diagnosis code is required. Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of ONE preferred agent within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.
Nevada	Biosimilars are considered new drugs that are highly similar to originator products in-terms of safety and effectiveness. They are reviewed by the Silver State Scripts Board and DUR board as separate products and are not interchangeable to the originator.
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. When there are Biosimilars present in PDL classes, the Biosimilars are reviewed alongside reference products in consideration of PDL placement .

State	Explanation
New Jersey	No policies related to biosimilars are currently in place.
New Mexico	No, this is in development with a PDL implementation in 2024 or 2025.
New York	None during this reporting period.
North Carolina	Biosimilars are added to the Preferred Drug List (PDL) as applicable. All biosimilars are covered if rebate eligible.
North Dakota	All biosimilars are reviewed for their placement on the preferred drug list, and their position on the PDL depends on safety, efficacy, and net cost. Just being a biosimilar or being a brand with biosimilars available in the market does not impact our payment or selection process for the PDL. 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 preferreed 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 new product will be designated a nonpreferred drug until the P&T Committee reviews the product.
Pennsylvania	No specific biosimilar policy. Medicaid covered biosimilars are included in the Statewide Preferred Drug List.
Rhode Island	No, not at this time.
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	State is currently exploring options in regards to biosimilars.
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	Biosimilars are reviewed for the PDL purposes.
Utah	UT Medicaid uses the FDA's Purple Book as a reference and unless otherwise limited through the prior authorization process, the State does not mandate interchange of biosimilar, 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 within the PDL category. Once evaluated they are placed as preferred or non-preferred the therapeutic category based on cost effectiveness to the program.

State	Explanation
Virginia	Section 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 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. If a brand biosimilar requires prior authorization, the biosimilar will require authorization as well.
West Virginia	We do not have any general Biosimilar policies at this time. However in our Cytokines and CAM antagonist criteria we do specify that "Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication AND a more cost-effective biosimilar product is not available). In cases where a biosimilar exists but is also non-preferred, the PA vendor shall advise the provider which product is the most cost-effective agent."
Wisconsin	Wisconsin does not have specific policies related to Biosimilars. If there are Biosimilars that are included on the PDL, decision on preferred or non-preferred status are made on an individual basis. Effective May 1, 2023, Wisconsin Medicaid prefers Humira over its Biosimilars. Humira does not require a prior authorization, but the Biosimilar products do require a prior authorization.
Wyoming	Biosimilars are included in cost analysis and will be placed on the PDL when appropriate.

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

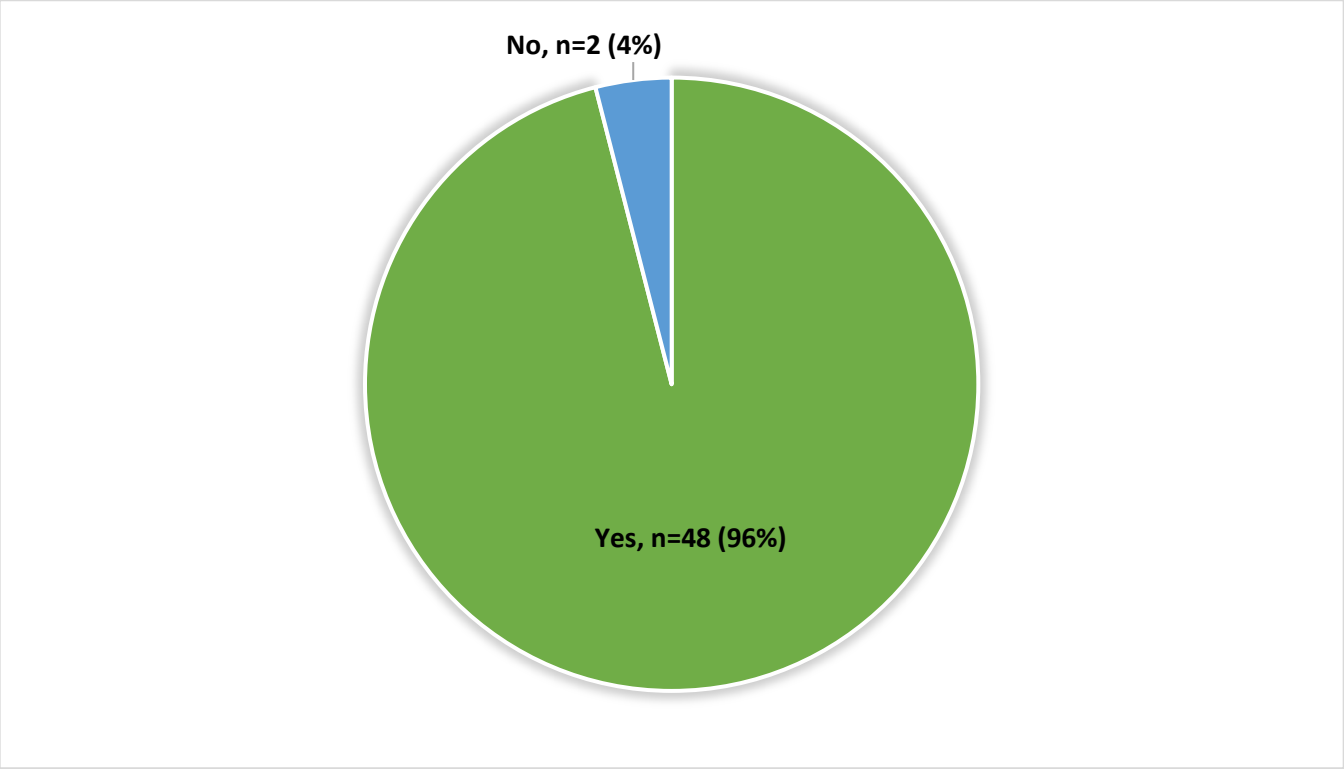

Table 74 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	Hawaii, Nebraska	2	4.00%
Total		50	100.00%

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

Figure 55 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

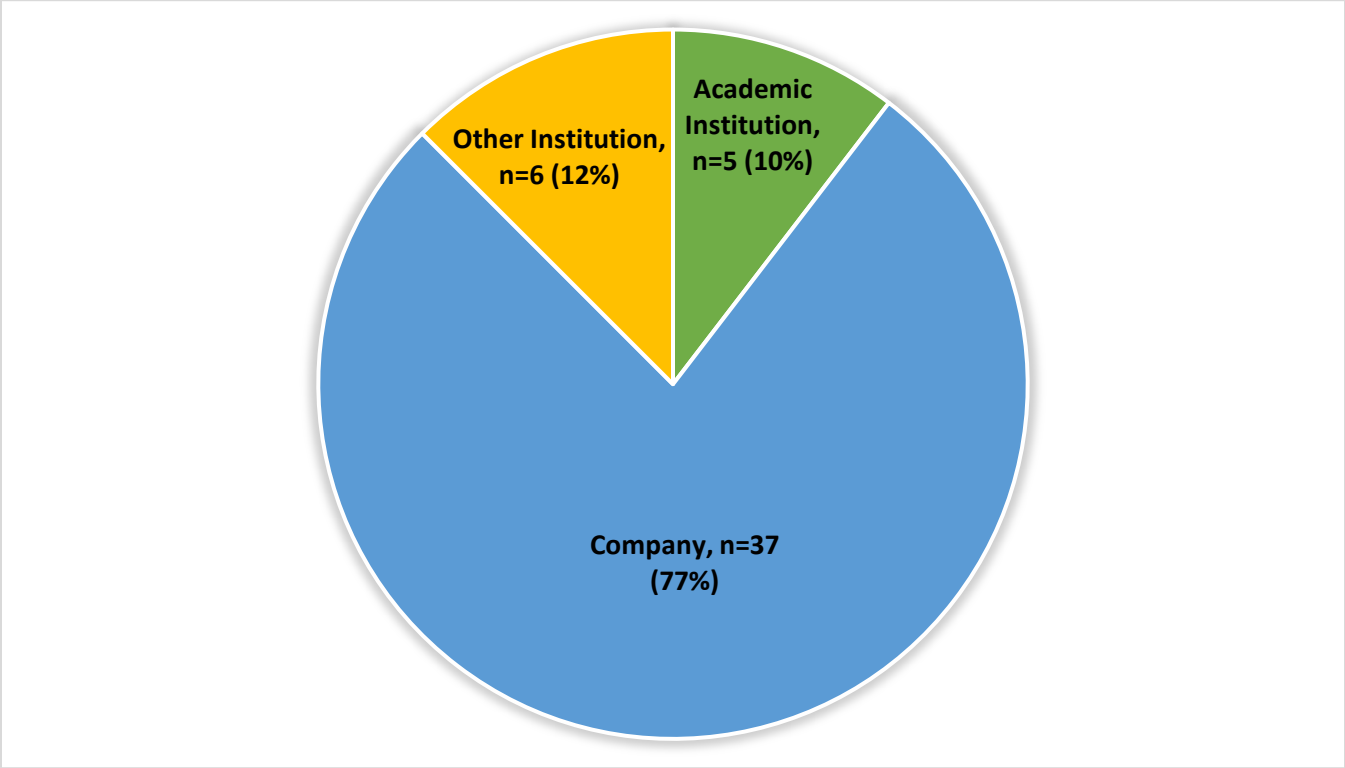

Table 75 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Academic Institution	Massachusetts, Oklahoma, Oregon, Utah, Wyoming	5	10.42%
Company	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Wisconsin	37	77.08%
Other Institution	Illinois, Minnesota, Mississippi, Montana, Washington, West Virginia	6	12.50%
Total		48	100.00%

Table 76 - Vendors by State that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
KEPRO	Alabama, Kansas, North Dakota, Wisconsin	4	10.81%
Magellan	Alaska, Arkansas, California, Florida, Idaho, Kentucky, Michigan, New Hampshire, South Carolina, Virginia	10	27.03%
Magellan Health, Inc.	Colorado	1	2.70%

Response	States	Count	Percentage
Prospective cost savings by Gainwell Technologies. Retro DUR cost savings by Kepro.	Connecticut	1	2.70%
Gainwell Technologies	Delaware, Louisiana, New Jersey	3	8.11%
Magellan for proDUR and Conduent for retroDUR	District of Columbia	1	2.70%
OptumRx	Georgia, Tennessee	2	5.41%
Optum Rx Administrative Services, LLC.	Indiana	1	2.70%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	13.51%
Conduent State Healthcare, LLC and Kepro	Maryland	1	2.70%
Conduent	Missouri, New Mexico	2	5.41%
OptumRx/Magellan Medicaid Administration	Nevada	1	2.70%
ProDUR: State. RetroDUR: Kepro. Other Cost Avoidance: Magellan Medicaid Administration	New York	1	2.70%
Myers and Stauffer	North Carolina	1	2.70%
Gainwell Technologies and KEPRO	Rhode Island	1	2.70%
Kepro - retroDUR, OptumRx - proDUR	South Dakota	1	2.70%
KePro for the Pro-DUR and Conduent for Retro-DUR, Lock-in for the other cost avoidance	Texas	1	2.70%
Total		37	100.00%

Table 77 - Academic/Other Institutions that Conducted the Cost Savings/Avoidance Program Evaluation

State	Academic/Other Institution Name
Illinois	Illinois HFS Bureau of Professional and Ancillary Services and Change Healthcare for SMAC.
Massachusetts	University of Massachusetts Chan Medical School
Minnesota	Minnesota does internally except for the RetroDUR Savings which is completed by Kepro, Inc.
Mississippi	MS Division of Medicaid, Office of Pharmacy
Montana	Mountain Pacific Quality Health Foundation
Oklahoma	University of Oklahoma College of Pharmacy: Pharmacy Management Consultants (PMC)
Oregon	OSU College of Pharmacy, Drug Use Research & Management Program, and Gainwell Technologies

State	Academic/Other Institution Name
Utah	University of Utah Drug Regimen Review Center / Utah Medicaid Pharmacy
Washington	Health Care Authority
West Virginia	Gainwell Technologies and Marshall DUR Coalition
Wyoming	University of Wyoming, School of Pharmacy (retrospective) and Change Healthcare (prospective)

2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.

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

3. 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. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?

Figure 56 - Provide Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

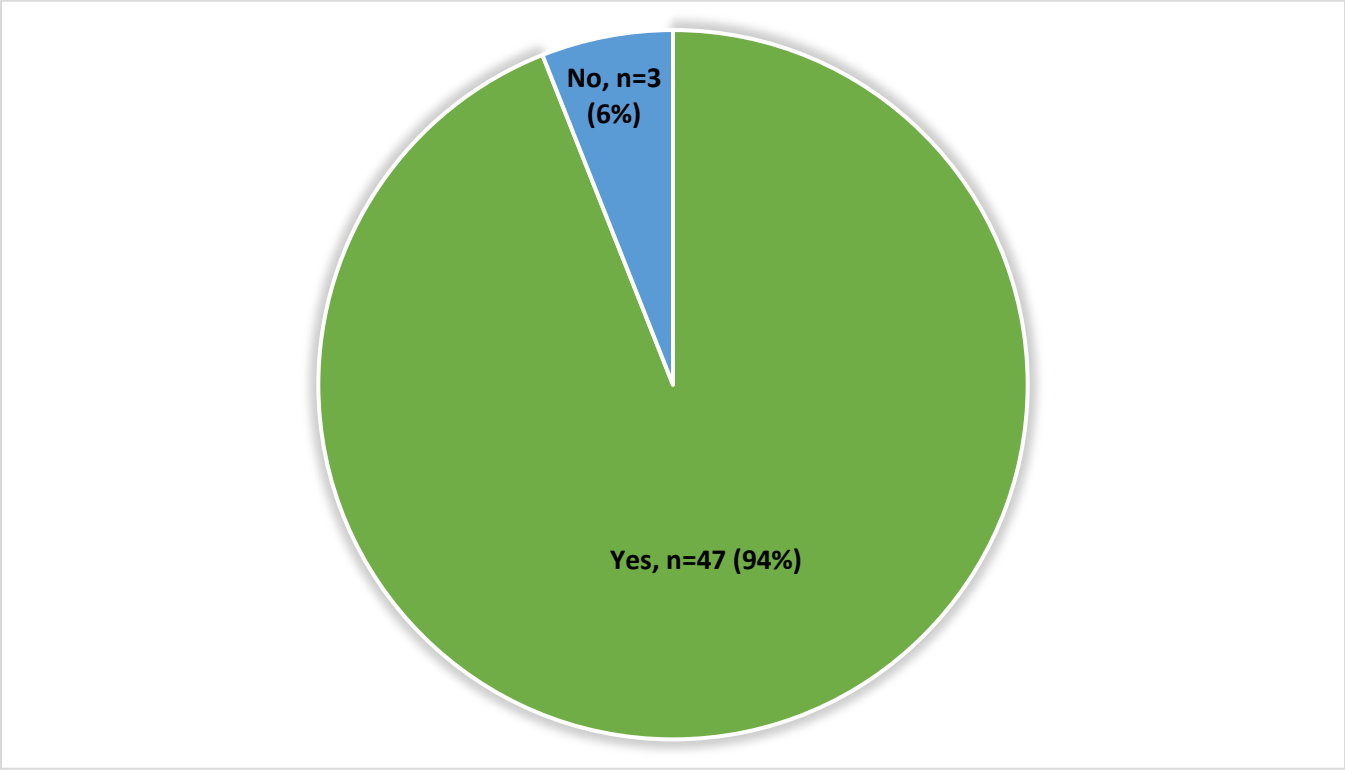

Table 78 - Provide Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, 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, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	47	94.00%
No	Illinois, South Dakota, Wisconsin	3	6.00%
Total		50	100.00%

If "No," please explain why not.

Table 79 - Explanations for not Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

State	Explanation
Illinois	For the standard Medicaid patient, some OTC medications prescribed by an authorized prescriber are covered, for example, ferrous sulfate, nicotine replacement products, emergency contraception. Select OTC medications may be covered for CILA/SLF, LTC, pediatric participants through 20 years of age, or patients with cystic fibrosis. The LTC

State	Explanation
	provides some OTC products as a medicine chest item so HFS does not cover them. During the COVID public health emergency, a portion of which occurred during FFY22, select OTC products were covered for all patients (acetaminophen and cough suppressants containing guaifenesin, dextromethorphan or their combinations).
South Dakota	Select OTC's are covered.
Wisconsin	Wisconsin does provide limited coverage of over-the-counter medications when prescriber by an authorized prescriber. Wisconsin has a list of covered OTC drugs for all members and an expanded list of covered OTC drugs for children. Additionally, children less than 21 years of age have access to OTC drugs through the EPSDT benefit.

5. Summary 4 - Cost Savings/Cost Avoidance Methodology

Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the State or contractor.

Table 80 - Cost Savings/Cost Avoidance Methodology Summary

State	Cost Savings/Cost Avoidance Methodology Summary
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 2022 (FFY 2022). 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, 2021 and September 30, 2022, there was an estimated cost savings of $656,092. Table 1 - Estimated Cost Savings for FFY 2022 - 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 $531,508 (-$124,584) $656,092 During FFY 2022, Kepro reviewed 1,808 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

State	Cost Savings/Cost Avoidance Methodology Summary
	Each month, Kepro 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, Kepro 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 4,411 recipients met the criteria for intervention letters during FFY 2022. 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. Kepro 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 2022). 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, Kepro evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed. Table 2 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 2022. Table 2 - Estimated Cost Savings for FFY 2022 Intervention Group Comparison Group Estimated Cost Savings Change between 6 Month Pre- and Post- Change between 6 Month Pre- and Post-

State	Cost Savings/Cost Avoidance Methodology Summary
	Single Intervention $648,144 $8,330 $639,814 Multiple Intervention (-$116,637) (-$132,915) $16,278 Total Estimated Cost Savings $656,092 Kepro found the intervention group had a decrease of 3.87% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 5.76%. These changes resulted in an estimated cost savings of $379.24 per recipient who received an intervention during FFY 2022. 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 Alabama Medicaid Program. During FFY 2022, 1,808 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 $656,092 for FFY 2022.
Alaska	Prospective Drug Utilization Review (ProDUR) A cost savings estimate was prepared for the State of Alaska by Magellan Medicaid Administration. The cost savings estimate was calculated by identifying claims with ProDUR messages that were either reversed and resubmitted or reversed but not resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the allowable payment amounts of the resubmitted claim. During FFY 2022 Covid-19 edits were in place, such as continuity of prior authorizations if the patient had the medication within a 90 day lookback, which would have reduced the amount of typically expected ProDUR savings. Day supply dispensed was also increased to 68 days, potentially decreasing the number of edits being hit. Summary (ProDUR Paid Claims Savings Report, Severity Level 1) Total # of Reversed Claims 25,456 Allowable Amount ($) of Reversed Claims $8,967,337.45 Total # of Resubmitted Claims 12,643 Allowable Amount ($) of Resubmitted Claims $3,883,796.26 Net Cost Savings $5,083,541.19

State	Cost Savings/Cost Avoidance Methodology Summary
	Summary (ProDUR Denied Claims Savings Report, Severity Level 1) Total # of Claims 44,289 Allowable Amount ($) of Claims $15,966,617.41 Total # of Resubmitted Claims 22,010 Allowable Amount ($) of Resubmitted Claims $3,719,587.88 Net Cost Savings $12,247,029.53 Retrospective Drug Utilization Review (RetroDUR) A cost savings estimate was not computable by Magellan Medicaid Administration. Summary The total cost savings estimate for ProDUR and RetroDUR interventions for FFY 2022 was $17,330,570.72
Arkansas	RETROSPECTIVE DRUG UTILIZATION REVIEW METHODOLOGY The First IQ (FIQ) RetroDur cost savings is based on interventions (letter, telephone call, or face-to-face) to a provider (physician and/or pharmacy) concerning a beneficiary identified through a RetroDur profile cycle. The intervention moves the case to the cost savings tracking system. The Therapeutic Class(s) related to the criteria involved in the exception, is captured and tracked. The average cost per day of the Therapeutic Class for the intervened beneficiary is calculated based on the three-month intervention period. This figure is used as a comparative baseline figure in the monthly cost savings calculation. There is then a six-month waiting period before cost savings begin to be calculated. This waiting period allows time for the intervened provider to make the appropriate changes in therapy. Once the waiting period has elapsed, the average cost per day for the original therapeutic class is calculated based on the current utilization. This figure is then compared with the baseline figure and the difference is the cost savings (or cost increase, as the case may be). This comparative calculation is systematically performed each month and the case is tracked for twelve months. Each month a cumulative RetroDur cost savings is reported based on the active cases in the tracking system. This cost savings methodology provides reasonable cost savings data as it relates to the Magellan RetroDur program. Based on the criteria that impacted the total cost avoidance amount for FFY2022, the estimated cost avoidance was $778,739. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 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 beneficiary 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) $23,658,873.23 Denied claim savings (Denied claims not resubmitted) $310,551,969.48 TOTAL ESTIMATED ProDUR SAVINGS $334,210,842.71 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

State	Cost Savings/Cost Avoidance Methodology Summary
	drugs on the preferred drug list will deny at POS and require a 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. TOTAL FFY2022 COST AVOIDANCE DUE TO PA REQUIRED, PLAN LIMITS EXCEEDED, AND DUR REJECT ERROR: $31,858,341 TOTAL ESTIMATED COST AVOIDANCE FOR FFY2022: $366,847,922.71
California	The Medi-Cal DUR program has saved money by encouraging appropriate drug therapy in order to reduce total healthcare expenditures. A report detailing ProDUR total estimated avoided costs was prepared for the State of California by Magellan. In this report, ProDUR total estimated avoided costs ($2,555,416,372) were computed by adding cost avoidance due to both paid claims ($1,084,645,326) and denied claims ($1,470,771,046). Paid claim cost avoidance is calculated by taking the paid dollar amount of claims with a ProDUR alert or message that paid but were subsequently reversed and subtracting the paid amount for the claims resubmitted within 72 hours (claim paid amount - reversal amount + resubmit amount). Denied claim cost avoidance is calculated by taking the submitted dollar value of the claims that were initially denied and had a ProDUR alert or message and subtracting any of those claims that were then resubmitted within the same calendar month and then paid (claim paid amount - resubmit amount). There are several limitations to this analysis and cost avoidance should not be interpreted as true cost savings. While ProDUR alerts 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 alert. 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 a single prescription, which would result in an inflated number of claims and ProDUR alerts. If the provider fails to reverse all duplicate claims submitted, the calculations would be inflated. Finally, all cost calculations do not include any adjustment for supplemental rebates, which would also reduce both the total dollars paid and estimated cost savings.
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 minus 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 minus Resubmit Amount)

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2022 (FFY 2022). 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, 2021 and September 30, 2022, there was an estimated cost savings of $3,964,587. Table 1 Estimated Cost Savings for FFY 2022 All Interventions Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings All Interventions $1,077,638 ($2,886,949) $3,964,587 During FFY 2022, KEPRO reviewed 17,418 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, KEPRO 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, KEPRO 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 33,123 recipients met the criteria for intervention letters during FFY 2022. 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. KEPRO 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.

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2022). 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, KEPRO 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 2022. Table 3 - Estimated Cost Savings for FFY 2022 Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings Single Intervention $2,301,556 ($2,442,324) $4,743,880 Multiple Intervention ($1,223,918) ($444,625) (779,293) Total Estimated Cost Savings $3,964,587 KEPRO found the intervention group had a decrease of 1.13% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 13.34%. These changes resulted in an estimated cost savings of $266.26 per recipient who received an intervention during FFY 2022. 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 Connecticut Medical Assistance. During FFY 2022, 17,418 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 $3,964,587 for FFY 2022.

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	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 Gainwell Technologies calculated the ProDUR savings is either Gainwell Technologies multiplied the number of cancelled & no response prescriptions by the average cost per prescription for each ProDUR Alert type; or, Gainwell Technologies 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 2022, as calculated by the claims processor and fiscal agent Gainwell Technologies , was estimated to be a total of $156,524,513 on 4,470,977 prescriptions for patients. ALERT TYPE, # of Claims Cost Savings, Reporting the year of 10/01/2021 09/30/2022, Reporting the year of 10/01/2021 09/30/2022 , , , , , Total # of Claims, Total Cost Savings Drug-Drug, Rx, 137,540, DD, $, , $1,387,183 Early Refill, Rx, 2,817,393, ER, $, , $134,888,657 High Dose, Rx, 13,638, HD, $, , $94,338 Ingredient Duplication, Rx, 1,135,711, ID, $, , $16,923,294 Drug-Age, Rx, 4,072, PA, $, , $11,916 Drug-Pregnancy, Rx, 35,075, PG, $, , $189,761 Therapeutic Duplication, Rx, 327,548, TD, $, , $3,029,364 , , ,

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	TOTALS, Rx, 4,470,977, , $, , $156,524,513
Delaware	Delaware has continued to take a conservative approach in estimating our cost savings due to pro DUR. While early refill denials could be considered, Delaware has always deemed these savings to be more of cost deferral rather than cost avoidance. The refill percentage in Delaware is normally set at 83% for non-controlled drugs and for prior authorization claims we can 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 by decreasing any dispensing of additional products or more units of medication per day than is necessary to achieve treatment goals. Additionally, therapeutic duplication edits at point of sale within drug classes helps to proactively prevent duplicate therapy and related unnecessary expenditures. Fee for service comprises about 13% of the Medicaid population. In addition, most newly eligible Medicaid members ultimately transition to an MCO administered benefit. In FFY 2022, the estimated therapeutic duplication alerts for FFS deferred the dispensing of 3401 units with an estimated savings of $654,872. Delaware has a long standing 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 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 additional clinical benefit from more than once daily dosing. For FFY 2022, the drug classes of proton pump inhibitors, blood pressure medications and antipsychotics were the predominant classes that triggered the edit for quantity units billed outside the limits. 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. During FFY 2022, Delaware's dose optimization edits set on over 28,555 units of medication. By optimizing dosing for these medications, Delaware estimated savings of $18,467 for the year. Delaware continues to review each drug as it enters the market and add it to the dose optimization list when appropriat
District of Columbia	ProDUR 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 Step 3: Denied and replacement claims are matched by patient ID and the AHFS 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)

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	The denied and replacement claims will lastly be matched by the HIC3, GSN, BRAND NAME, GENERIC NAME , NDC, and STANDARD THERAPEUTIC CLASS CODE RetroDUR Methodology Clinical Paragraphs Conduent develops rules for identifying individual beneficiary profiles for retrospective utilization review by the DUR Board. Conduent uses both pharmacy and medical claims history to select profiles each month for review and possible intervention. The DUR Board reviews 300 patient profiles each month to determine if a provider should receive an educational mailing intended to update/remind prescribers of current medication therapy practice guidelines. The DUR Board sends out intervention notices to targeted prescribers based on monthly patient profile reviews of pharmacy and medical claims. Individual patients do not receive direct educational information from the DUR Board. However, where available, some patient appropriate materials may be included with information mailed to providers. Population-Based Intervention Summary Conduent did not complete population-based interventions in the FFY 2022. As such, Table 1 for a summary of the intervention outcomes reports and Table 2 for a summary of the intervention cost savings are blank but are included for completeness. Conclusion Monthly clinical paragraph reviews were utilized by the DUR Board to retrospectively identify prescribers who might benefit from a targeted educational mailing/intervention based on their patient profiles and prescribing patterns. There were no population-based interventions completed in FFY 2022, hence, no FFY 2022 projected cost savings are reported.
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 2022, the MAC program provided savings of $2,658,329.91. 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 2022 was $7,842,170. 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

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	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 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 FFY2022 was $13,631.40. 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 2022 was $237,599,811. The following table summarizes the FFY 2022 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 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	For proDUR reimbursement of the ingredient costs utilizes the least of NADAC, SMAC, WAC, FUL or U&C (submitted). NADAC was implemented in 2020 and costs savings continue. SMAC (-19.17%) and WAC (-36.86%) have decreased versus NADAC for brand (+15.24%) and NADAC for generic (+21.14%) have increased rates of change while expenditures increased 9.05%. The Total Estimated Avoided Costs was not calculated. In retroDUR of high cost drugs and post payment review, one drug claim was identified as incorrectly billed to FFS and paid in FFY 2021. Recovery was over several FFYs and reported in FFY 2022 when completed. Total Estimated Avoided Costs was $90,000.00.
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

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	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. 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. No pharmacy claims rejected due to the Four Prescription Policy edit in FFY22 since the Four Prescription Policy edit was still not active. 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 308,036 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 that remained in place during FFY22 included the following: - Encouragement of medicine fill synchronization, a process that was introduced August 2019 - Reduction of RTS tolerances on all medications - Allowing pharmacies to submit Submission Clarification Code (420-DK) of 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 fill for a 90-day supply. - Preferred Drug List was updated and adjusted as needed based on shortages of preferred medications. For example, all albuterol HFA inahlers, 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 and remained in effect for FFY22: - 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 FFY22, HFS rejected approximately 154,392 unique claims as a result of DUR edits addressing duplicate therapy, duration of therapy, daily dose, excess quantity, excess accumulated quantity, age, gender, high dose, initial opioid days supply, and morphine milligram equivalents. Some participants had more than one claim impacted by a DUR edit. In FFY22, Illinois reimbursed pharmacies $91.47 per prescription on average. Based on the average cost of a claim, Illinois rejected approximately $14.1 M in pharmacy claims as a result of DUR editing in FY22. 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 some edits due to the COVID-19 pandemic.

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	Generic Product Utilization. During FFY22, Illinois Fee-for-Service Medicaid's generic dispensing ratio essentially remained the same (a 0.2% decrease compared to FFY21). During FFY22, the average brand name/innovator prescription was reimbursed at $788.02, while the average generic prescription was reimbursed at $25.79. Illinois Medicaid reimbursed providers for approximately 1.7 M prescriptions. Each percentage point shift from brand/innovator to generic utilization would result in about 12.99 M in savings. Three Brand Name Drug Limit. The Department limits the number of brand name drugs participants age 21 and older may receive 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 and remained lifted during FFY22. 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 - Drugs in the following classes: antiretroviral agents, antineoplastic agents, immunosuppressive agents. 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 (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%. For brand name drugs it was WAC minus 4.4%. The FUL price is determined by the Centers for Medicare and Medicaid Services (CMS). During FFY22, the SMAC pricing program saved Illinois Medicaid $7,566,073 (State and federal dollars). 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 FFY22, the PDL generated approximately $7.6 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.

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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 “Guidelines for Estimating the Impact of Medicaid DUR.”%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. ProDUR savings estimates should specifically track results relative to individual cases affected by proDUR alerts. One cannot sum dollar amounts associated with all denials and/or reversals and claim these as the total proDUR cost savings, either. The reason being: one cannot assume that all denials of prescriptions through on-line proDUR 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 proDUR edit alerts have always been difficult at best. Comparison group designs are normally recommended; however, with on-line proDUR, comparison populations who are not receiving an alert are not possible. 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 The outcomes measured by Optum Rx's regarding 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 retroDUR initiatives were measured by the claims 180 days before and after interventions.

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	To analyze recipients' drug use, Optum Rx followed the 1994 CMS "Guidelines for Estimating the Impact of Medicaid DUR." Optum Rx 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 "the substitution effect." 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, the analysis performed by Optum Rx also included the cost of other drugs in the same therapeutic class. Optum Rx 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 retroDUR and proDUR programs.
Iowa	Patient Focused Review Summary - FFS Profiles Reviewed - 44 Number of Suggestions Made - 46 Number of Changes Made - 14 Total Dollars Saved on Medication - $16,689.93 Problem Focused Review Summary - FFS Concurrent Gabapentin & Pregabalin: members evaluated - 0 (MCO identified members) Duplicate Muscle Relaxants: members evaluated - 3; positive impact - 0 (0%) Concurrent SSRI & SNRI: members evaluated - 2; positive impact - 1 (50%); cost savings $168.84 Concurrent Gabapentinoid & Opioid: members evaluated - 6; positive impact 0 (0%) Duplicate Anxiolytic Benzodiazepines: members evaluated - 4; positive impact 0 (0%) Duplicate Sedative/Hypnotic Benzodiazepines: members evaluated - 0 (MCO identified members) Single Ingredient Buprenorphine: members evaluated - 0 (MCO identified members) Montelukast without Asthma Diagnosis: members evaluated - 112; positive impact - 33 (29%); cost savings $10,682.09 Two Short-Acting Opioids: members evaluated - 2; positive impact - 1 (50%); cost savings $129.24 Two Long-Acting Opioids: members evaluated - 0 (MCO identified members) Concurrent GLP1 RA and DPP4i: members evaluated - 0 (MCO identified members) High Dose Glucocorticoids without Bisphosphonate: members evaluated - 3; positive impact - 0 (0%) 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.

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	*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 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

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	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. 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

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	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
Kansas	Once recipients have been identified and RDUR letters have been mailed to their providers, the RDUR vendor 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 difference between the two groups is the estimated cost savings.
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 FFY2022 was $88,967,933.89. However, cost avoidance should not be interpreted as 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 repricing 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 2022, the MAC program provided an estimated cost avoidance of $2,075,902.00. 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, nonpreferred products, to less expensive, preferred products. The estimated savings provided by the PDL program during FFY 2022 was $4,163,202.00. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 $ $52,607,013.00 during FFY 2022. 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 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 $5,796,598.00 during FFY 2022. 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, nonpreferred products, to less expensive, preferred products. During FFY 2022, the KY FFS program invoiced for $1,386,948 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 Medicaid Drug Programs 2/2 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 2022 is estimated to be $263,397.58. 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 follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2022 will not be known until after the end of FFY 2023.

State	Cost Savings/Cost Avoidance Methodology Summary
	Overall Cost Avoidance and/or Savings: During FFY 2022 the combined cost avoidance or savings generated by all of the above initiatives was estimated to be $155,260,994
Louisiana	Prospective DUR methodology: Cost avoidance attributed to prospective DUR in FFY22 is $39,782,223.04. 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 FFY22 is $77,788.92. 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.
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

State	Cost Savings/Cost Avoidance Methodology Summary
	is included in the estimates above
Maryland	Summary 4 Cost Savings and Cost Avoidance Methodology AS OF 2022-09-30 CONDUENT PRESCRIPTION BENEFIT MANAGEMENT RUN DATE 02/03/2023 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 2021-10-01 - 2022-09-30 GROUP:CAID MARYLAND - DIVISION OF MEDICAID DUR ALERTS SUMMARY CC DESCRIPTION PAID CLM PAID AMT DENIED CLM DENIED AMT REVERSE CLM REVERSE AMT TOTAL SAVINGS DD DRUG-DRUG INTERACTION 2,062,984 $182,993,494 0 $0 213,096 $28,910,346 $28,910,346 TD THERAPEUTIC DUPLICATION 793,163 $106,620,521 0 $0 91,269 $16,956,906 $16,956,906 ID INGREDIENT DUPLICATION 739,292 $40,873,532 0 $0 71,432 $6,573,713 $6,573,713 LD LOW DOSE 98,380 $5,356,386 0 $0 12,747 $1,034,780 $1,034,780 ER OVERUSE 54,728 $7,214,744 157,300 $20,736,720 0 $0 $20,736,720 HD HIGH DOSE 50,638 $1,427,830 0 $0 2,717 $331,234 $331,234 PA DRUG-AGE 14,061 $304,088 0 $0 1,426 $53,048 $53,048 SX DRUG-GENDER 114 $29,683 0 $0 25 $1,941 $1,941 3,813,360 $344,820,278 157,300 $20,736,720 392,712 $53,861,968 $74,598,688 SUMMARY LINE ALL CONFLICTS 2,835,285 $277,229,981 157,300 $15,380,562 297,883 $43,458,809 $58,839,371 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. 4. SAVINGS ATTRIBUTABLE TO EARLY REFILL (ER) ARE PRIMARILY COSTS DELAYED. IN OTHER WORDS, APPROXIMATELY 80% OF ER CLAIMS GO ON TO BE

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2022 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 $196,339 (-$223,788) $420,127 Multiple Intervention (-$26,570) ($-4,014) $22,556 Total Estimated Cost Savings $397,571 KEPRO found the intervention group had a decrease of 2.58% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 11.83%. These changes resulted in an estimated cost savings of $162.81 per recipient who received an intervention during FFY 2022. 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 Maryland Medicaid Program. During FFY 2022, 2,363 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 $397,571for FFY 2022.
Massachusetts	Cost Avoidance Methodology To calculate cost avoidance, prescription denials for FFY2022 were analyzed. Because a prescription can be denied multiple times at the point of service (POS), unique MassHealth

State	Cost Savings/Cost Avoidance Methodology Summary
	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. 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 2022. 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 2022. 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 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.

State	Cost Savings/Cost Avoidance Methodology Summary
	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.
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. 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. A total of 2,777 distinct prescribers of 9,065 distinct beneficiaries were targeted. The program measures the success in closing gaps in care for the targeted intervention. The estimated cost savings generated from these interventions was $783,798.
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) and Specialty Pharmaceutical Reimbursement Rate program, prior authorization of brand name drugs, and the retrospective drug utilization review (RetroDUR) program. Savings from uniform Preferred Drug List (PDL) is not included. 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 2022, the gross calculated allowable reimbursement amount for claims denied by ProDUR edits minus amounts that would have been paid by third party liability was $6,859,342. However, the gross amount does not consider 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 $18,736,331 to $50,111,237. 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 must call the provider help desk to obtain an override where

State	Cost Savings/Cost Avoidance Methodology Summary
	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-too-soon edit was $50,499,317. This savings is reduced by the amount of refill-too-soon overrides issued by the provider helpdesk. Out of 301,440 denied claims, only 1,573 (0.5%) were given overrides by the provider help desk which reduced savings by $829,990. Therefore, estimated savings is in the range of $12,392,497 to $33,144,342 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. The Minnesota SMAC and Specialty Pharmaceutical Reimbursement Rate programs total cost avoidance was $7,325,026. Effective July 1, 2019, ingredient cost reimbursement was changed to 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% (WAC is the wholesaler acquisition cost). Specialty Pharmaceutical and Hemophilia Treatment Drug Reimbursement Rates are included in the cost avoidance computation. Prior authorization of brand name drugs To further encourage the use of generics, legend, brand name drug prescriptions require prior authorization in addition to the prescriber writing DAW-brand name necessary to pay at the brand name price when a generic is available. This requirement became effective January 1, 2004. Administratively, this edit is tied to the NADAC-generic and Minnesota State Maximum Allowable Cost Program (SMAC). If the drug has a NADAC-generic or SMAC price, a brand name drug claim will adjudicate paying at the NADAC-generic price or SMAC level. A prior authorization for DAW-brand name necessary is required to pay at the NADAC-brand price level. Therefore, using prior authorization along with the NADAC-generic price and SMAC program continues to provide a high rate of generic utilization of 99%. Retrospective DUR During FFY 2022, there were six population-based DUR mailings. The contract with Kepro, Inc for retrospective drug utilization was effective October 1, 2020. The DUR Board reviewed Kepro's RetroDUR proposals and provided their recommendations about the criteria, message content, letter educational content, and mailing format. To determine cost savings, only those patients are who still eligible in the post intervention period are included. FFY 2022: Annualized cost savings for quarterly RetroDUR population-based mailings are $63,942 for Muscle Relaxers/Sedative Hypnotics/CNS Depressants (1/2022), $891,855 for Psychotropics in Adults, (4/2022), $183,239 for Montelukast Black Box Warnings (6/2022), and $275,114 for Management of Diabetes Mellitus (10/2022). There are two mailings per year regarding psychotropic drugs in children with combined savings of $50,057. There are two mailings per year regarding the SUPPORT Act with a combined savings of $108,434.

State	Cost Savings/Cost Avoidance Methodology Summary
	Therefore, the total net effect of RetroDUR was a decrease of $1,463,080 after reduced by the amount of $109,560 per year contract cost. Estimated RetroDUR savings is in the range of $365,038 to $976,313.
Mississippi	The Prospective DUR Total Estimated Avoided Cost was obtained by the following method, based on Reports On Line (ROL) reports: 1. Total claims with ProDUR alerts that were denied (ROL report MSMC2800-RC001) $ 32,423,425.95 2. Total claims with ProDUR alerts that were overridden (ROL report MSMC2800-RC002) $ 8,860,902.53 3. Subtracted overridden claims from denied claims = $ 23,562,523.42
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. ProDUR avoided cost estimates are based on denied claims at point of sales for ProDUR edits. If the patient fills an alternative product within 7 days the estimated avoided cost is the difference between the initial denied claim and the subsequent processed claim. If the patient never fills an alternative product in the drug class the total cost of the claim is estimated to have been avoided.
Montana	ProDUR--Prior Authorizations Total PA Requests 72,269 (including 11,178 non-clinical) / Approved 31,129 Clinical / Denied 29,962 Clinical / Approval Rate 51% / Denial Rate 49% /Non-Clinical Rate 15% / Total savings $36,260,855 Case Management--Other Cost Avoidance Total Cases Reviewed 2521 Total Clinical Interventions 2498 cost savings assigned 128 cost savings unable to determine 2370 Selection Method PA 71 CM 2422 Other 5 Contact Type MD 866 RN 298 RX 94

State	Cost Savings/Cost Avoidance Methodology Summary

PA 195
NP 544
Other 556

Outcome
Compliance Noted 1
Dose Changed 0
Drug Changed 0
Drug Discontinued 2
Labs Completed 6
Pending Response 297
No Change 2
Other Change 38
Per Plan 2583
Not specified 2

Criteria Selection
Abuse Refer to DPHHS 5
Academic Detailing 644
Atypical Antipsych PA Required 215
Atypical High Cost 14
CF 136
Clinical- General 62
Drug Dosage 39
Drug Not Covered 58
Drug Recommendation Request 2
Drug -Disease Contraindication 26
Drug-Drug Interaction 51
Duration of Treatment 0
Eosinophilic Asthma 5
Foster Care Psychotropics 440
Fraud Refer to DPHHS 2
HAE 46
Hep C 67
ITP/Severe Aplastic Anemia 11
MAT 104
Medication Overutilization 0
Medication History Review 1
Movement Disorders 85
Multiple Medications 2
Multiple Pharmacies/MDs 86
Overutilization 79
PA Requests Higher Level Clinical Review 70
PA Required (Old) 0
PBA 4
Potential Clinical Abuse or Misuse 22
Team Care 58
Therapeutic Appropriateness 75
Therapeutic Duplication 79

State	Cost Savings/Cost Avoidance Methodology Summary

Underutilization 10

Total in Progress 722
Total Completed 1799

Operational Monthly Cost Savings* $- 0

CM Monthly Cost Savings $507,565
Annualized CM Cost Savings $6,090,800
Total YTD Cost Savings (=YTD Operational Cost Savings + Annualized CM Cost Savings) $6,090,800
*Operational Cost-Savings: Identified by inappropriately paid claim and not attributable to a standard CM intervention

RDUR 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, Kepro 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 186 members met the criteria for intervention letters during FFY 2022.
RDUR 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. Kepro 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 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 2022). 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.
RDUR Estimated Cost Savings Analyses Results

State	Cost Savings/Cost Avoidance Methodology Summary
	For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, Kepro 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 2022. 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. 2022: 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, 2021, and September 30, 2022, there was an estimated cost savings of $73,798. Intervention Group. Change between 6 Month Pre and Post: $77,703 Comparison Group. Change between 6 Month Pre and Post: $3,905 Estimated Cost Savings: $73,798
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. 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.

State	Cost Savings/Cost Avoidance Methodology Summary
	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 methodology (FFY2022 Q1-Q3): OptumRx calculates the ProDUR savings by summing the amounts on claims either reversed or denied due to a ProDUR edit. These numbers may 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. Due to transition to a new PBM for the State, FFY2022 Q3 ProDUR savings were unavailable. The amount of savings available was pro-rated to account for the unreported quarter. Magellan Medicaid Administration (FFY2022 Q4): ProDUR cost avoidance 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.
New Hampshire	Magellan RX Management 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 2022 cost savings for ProDUR $1,037,161. 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 2022 was $26,871. The cumulative cost savings for the RetroDUR program are described below:

State	Cost Savings/Cost Avoidance Methodology Summary
	Activity Description; Cost Savings Antidepressant Adherence $385.12 Antiepileptic warning $31,600.02 Opioid and benzodiazepines co-administration $116.00 Pediatric antipsychotic utilization ($115.93) High Risk Medications in Elderly $21.87 ADHD medications in adults ($446.62) Buprenorphine Dental warning ($13,777.64) Polypharmacy $9,065.00 Fluoroquinolone warning $21.31 Total Savings $26,894.08 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 2022 will not be known until the end of FFY 2023. 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 2022 was $392,897. 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 2022 was $9,189.
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 member 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 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 PRODUR SAVINGS* Total Denied Claims (Nursing Home and Retail Combined) from report ID Q2862R01 Quarter and FFY Total Amount 4th quarter 2021: $657,288 1st quarter 2022: $532,864 2nd quarter 2022: $677,470 3rd quarter 2022: $475,955 ProDUR Total: $2,343,577 Additional RetroDUR Estimated Avoided Costs of $38,812, RetroDUR Estimated Cost Avoidance of $20,559 and Other Cost Avoidance of $2,544 result in a Grand Total Estimated Avoided Costs of $2,405,492. *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 takin in response to a ProDUR alert or a RetroDUR intervention. Appropriate actions include discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, switching to safer drug therapies, and avoiding inappropriate medication therapies. Savings for DUR are calculated from the analysis of claim submitted where DUR interventions were completed using the following data for final calculations: number of paid claims: paid amount, number of denied claims (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) denied amount paid, reversed claims (a claim is counted as reversed only if it has been reversed within 24 hours), and reversed amount. The total ProDUR savings of $7,357,622 is a sum of the total ProDUR savings as follows: Drug-Age: $3,329 Drug-Drug: $1,505,514 Drug-Gender: $1,758 Drug-Pregnancy: $3,089 High Dose: $612,926 Ingredient Duplication: $674,998 Low Dose: $897,784

State	Cost Savings/Cost Avoidance Methodology Summary
	Overuse: $829,755 Therapeutic Duplication: $2,828,469 The RetroDUR savings of $31,760 were calculated from ivermectin utilization before and after the educational mailing.
New York	ProDUR: To estimate the impact of ProDUR, the total number of ProDUR claim alerts/conflicts not overridden (i.e. number of alerts/conflicts minus the number of overrides) was multiplied by the average cost per claim (without factoring in any federal or supplemental rebates). RetroDUR: 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. Kepro 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 2022). 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. Other Cost Avoidance: Attributed to the Preferred Drugs Program (i.e. Preferred Drug List and promoting the most cost effective products in a class in consideration of supplemental rebates and market share savings) and the Brand Less than Generic Program (i.e., promoting the utilization of a multisource brand name product when less expensive than the generic [net of all rebates]). Estimates based on State Fiscal Year 2021 - 2022 (April 1, 2021 - March 31, 2022). Lock In Program: New York State's Office of the Medicaid Inspector General (OMIG) provides savings estimate amount attributed to the restricted recipient program. OMIG's Lock-In program data encompasses statistics from both Managed Care and Fee-For-Service (FFS). A FFS only savings estimate is difficult to ascertain as beneficiaries often move between Managed Care and FFS (see VIII. Fraud, Waste and Abuse Detection, Lock-in or Patient Review and Restriction Programs section for cost savings estimate which is not included here).
North Carolina	October 1, 2021 to September 30, 2022 Estimated Savings: ProDUR $ 304 million RetoDUR $ 3.12 million PA $ 17.5 million

State	Cost Savings/Cost Avoidance Methodology Summary
	PDL $ 153 million Lock-In $ 4.92 million TOTAL $ 483 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) Lock-In = NC Medicaid Beneficiary Management Lock-In Program 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-Oct 2021 to Sept 2022, Reversals-719,877, Non-responses-994,113, Cost Saving-$304,473,183.28 The RetroDUR Savings are calculated from the Retro-DUR activities described in Section III of the Annual Report. Oct 2021 to Sept 2022, Cost Savings- $3,118,749.93 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 2020 Q4- $35,791,873 2021 Q1- $34,205,512 2021 Q2- $38,835,644 2021 Q3- $44,202,236 Oct 2021 to Sept 2022- $153,035,265 The PA Cost Avoidance is calculated by the cost of drugs requiring Prior Approval when the requests were denied for not meeting PA criteria. The savings calculated were for drugs not on the PDL. Period- Cost Savings Oct 2021 to Sept 2022- $17,492,903.76 Lock-In The Lock-In Cost Avoidance is calculated by the cost of drugs for pharmacy claims that denied for lock-in beneficiaries not using the required pharmacy or prescriber for their lock-in drugs. Oct 2021 to Sept 2022- $4,923,670.63
North Dakota	This report prepared for the North Dakota 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. 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 2022 (FFY 2022). 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.

State	Cost Savings/Cost Avoidance Methodology Summary
	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, 2021, and September 30, 2022, there was an estimated cost savings of $334,306. During FFY 2022, Kepro reviewed 1,865 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, Kepro 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, Kepro 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. 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. Kepro 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 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 2022). 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, Kepro evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed. Kepro found the intervention group had a decrease of 2.92% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 16.97%. These changes resulted in an estimated cost savings of $329.37 per recipient who received an intervention during FFY 2022. Results Discussion:

State	Cost Savings/Cost Avoidance Methodology Summary
	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 North Dakota Medicaid Program. During FFY 2022, 1,865 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 $334,306 for FFY 2022.
Ohio	The Ohio Medicaid DUR program has saved money by encouraging appropriate drug therapy to reduce total healthcare expenditures. In FFY22, ODM rejected approximately 155,912 unique claims because of ProDUR edits addressing duplicate therapy, drug interactions, low dose, and high dose. Savings are tracked when claims are reversed or reversed and then resubmitted following ProDUR edits. Estimated prescription drug savings as a direct result of these ProDUR edits is $39,439,849. Additionally, 87,291 claims rejected by DUR Code 88 resulted in $2,965,326 in savings. In total 243,203 claims rejected by ProDUR edits resulted in $42,405,175 in avoided drug spending. For the RetroDUR program, a year after the intervention takes place, a post-analysis is performed to determine the success of the intervention including the number of claims affected, number of recipients affected, and change in prescription spending between periods before and after the intervention. The cost savings is the difference in the total amount paid during periods before and after the intervention. These figures are annualized to calculate the RetroDUR cost savings. Seven interventions accounted for this cost savings. Concurrent use of Multiple Antipsychotics saved $334,407, PPI Deprescribing saved $6,289, Opioids Greater Than 80 MED saved $136,766, Triple Antithrombotic Therapy saved $26,244, Children Taking Opioids saved $5,240, Multiple Anticholinergics saved $18,060, and Opioids and Benzodiazepines saved $2,223. The total savings measured at the time of report submission for RetroDUR edits in FFY2022 was $529,229.
Oklahoma	ProDUR Methodology The ProDUR savings calculation included for the 2022 Federal Fiscal Year (FFY) focused on the four ProDUR system edits and twenty-one additional edits that have been identified within the scope of ProDUR but are not accounted for in our ProDUR system. Examples of these edits are Refill Too Soon, Age Restrictions, and Day Supply Restrictions. Claims resulting from these edits were filtered to only include denied single, unique prescription numbers. This was to prevent multiple denied claims for one prescription number from falsely inflating the cost avoidance. Denied prescription numbers give 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. The ProDUR cost avoidance was calculated by multiplying the total number of denied prescriptions by the average cost per prescription (split into brand and generic cost). The average costs per prescription were calculated to be $667.04 and $52.20, respectively. The brand and generic average cost per

State	Cost Savings/Cost Avoidance Methodology Summary
	prescription was multiplied by the number of prescriptions 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 45% to account for the 55% rebate recovery percentage (Rebate Recovery percentage is based on the SFY 2021 Annual Report). Therefore, the total estimated ProDUR cost avoidance is $143,248,715.47 for FFY 2022. 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 prescription count was still included in the total prescriptions and cost for these were also calculated based on brand or generic status as Stated above. Academic Detailing Outcomes are reported as a 9-month average per provider during the pre-AD period and post-AD period. Non-drug cost comparisons were assessed by examining paid medical claims for non-ambulatory health care service utilization. In total, 44 providers received T1DM-AD services. These prescribers cared for a total of 231 members with T1DM. An average of $56,717 per month was spent to provide diabetes related emergency department and hospital services for these members before detailing. After detailing the monthly cost decreased to $34,568 per month for these diabetes related services. An average of $127,429 was spent to provide all cause emergency department and hospital services for these members before detailing. After detailing the monthly cost decreased to $82,073 for all cause emergency and hospital services. Thus, AD resulted in a 36-39% decrease in healthcare costs. During the same time period, diabetes related emergency department and hospital services costs for pediatric patients of non-detailed providers increased by more than 16%. Overall, there was nearly $410,000 saved, or more than $9,000 per provider detailed. Cost savings are based on paid claims for Medicaid patients receiving ambulatory care services from detailed prescribers. Other cost avoidance methodology Other Cost Avoidance savings includes the savings generated from our State maximum allowable costs (SMAC) and our 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 is subtracted from the potential Wholesale Acquisition Cost (WAC) for each claim to establish the SMAC savings per claim. The total savings is calculated by summing each claim's SMAC savings and is estimated to be $36,352,989.56 for FFY 2022. For the Product Based Prior Authorization (PBPA) report savings, FFY 2022 PAs are used to identify the total number of members that had a denied PA based on drugs' National Drug Code (NDC). 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

State	Cost Savings/Cost Avoidance Methodology Summary
	avoidance for the PBPA report. This is estimated to be $17,781,490.45 for the FFY 2022. 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 savings of $49,929,760.39.
Oregon	ProDUR Methodology: Claims that trigger ProDUR alerts are not always denied. The pharmacist will receive a denial for Early Refill (ER) or Pregnancy-Drug Interaction (PG) 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. RetroDUR and Cost Avoidance 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-preferred status, all subsequent claims (paid and denied) for the member within the drug class are monitored. Cost Avoidance is calculated based on the initial claim (index event) and the final disposition of therapy within the drug class for a member. The types of cost avoidance are: deferred, therapeutic duplication, switched, add-on, discontinued, and other. 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. Deferred cost avoidance includes claims for which the requested therapy is eventually approved and savings are calculated based on the time from the initial request to the first paid claim. Therapeutic duplication cost avoidance is calculated 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. The difference in cost between the initial drug requested and the actual drug dispensed is the cost avoided. Add on therapy is calculated when a drug is denied when there are already paid claims for an alternative that treats the same condition. There are limitations to the cost avoidance methodology. The method is dependent upon detecting a denied claim. Members new to the Medicaid program or newly marketed medications are examples of situations that make it more difficult to adequately track and model potential savings. However, providers who have learned the FFS Medicaid PDL (or have learned to consult it) will prescribe preferred and unrestricted medications without

State	Cost Savings/Cost Avoidance Methodology Summary
	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 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 summarized 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 included. Significant savings go undetected with the methodology in the interest of conservative reporting. The methodology may also potentially inflate savings. For example, assuming a denied claim for a chronic medication would have continued to be filled throughout the reporting period, or until the member dis-enrolled could overestimate savings resulting from the intervention. Brand over Generic: Select brand name medications are preferred over their generic alternatives when the net cost has been determined to provide substantial Cost Savings to the program.
Pennsylvania	During this evaluation period, 6119 educational intervention letters were mailed to prescribers regarding medication therapy. Providers are invited to voluntarily respond to RDUR Program letters. Providers returned 588 responses to these letters, resulting in an overall response rate by the providers of 9.61 percent. In these 6,119 educational letters, the RDUR Program made 6,119 observations and subsequent education. The suggested change was implemented in 2,355 cases, resulting in an overall impact rate of 38.49 percent. Implementation of these therapeutic suggestions resulted in a cost savings of $237,162.85* for the 4535 patients evaluated, or a savings of $52.30* per patient. *Savings reported are pre-rebate, total dollars.
Rhode Island	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 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 1,901 $1,291,500 $963,374 $328,126 Multiple Interventions 800 $1,096,138 $1,073,020 $23,119 Totals 2,701 $2,387,638 $2,036,394 $351,245 * Total drug cost reimbursed to pharmacy does not include any rebates.
South Carolina	Cost avoidance calculated from ProDUR claims Paid and Denied claims, Additional savings calculated utilizing, MAC savings, PDL Savings and TPL cost avoidance (Patient Responsibility)
South Dakota	ProDUR - 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. 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. Kepro 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.
Tennessee	RetroDUR Cost Savings/Cost Avoidance methodology-- OptumRx's RetroDUR cost savings were measured based on a review of the claims data for members on concurrent therapy of opioids and benzodiazepines as well as opioids and antipsychotics. The goal of the intervention was to recommend against the concurrent use of opioids and benzodiazepines (unless benefits outweigh risks) due to increased risk of opioid overdose. The goal of the intervention for opioids and antipsychotics was to ensure coordination of care, and to increase awareness of the risk of respiratory depression. OptumRx initiated an intervention for pediatrics to reduce the number of drugs being used without a pediatric indication. Cost savings estimates were measured by claims 180 days before and after the intervention which resulted in a savings of $210,502.64. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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. 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	For the Pro-DUR - we only consider the cost savings/avoidance associated with the clinical and PDL prior authorizations. The data used for this analysis was sourced by the RxPert prior authorization processing system and the PCRA vendor. The total cost savings =Total Cost Savings for Unique Denials with Substitute Therapy + Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy. Total Cost Savings for Unique Denials with Substitute Therapy= Total number of non-duplicate denied prior authorization requests for the time frame, where the client had a paid claim within 7 days of the original denied request for a drug within the same HIC3 category Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy= Total number of non-duplicate denied prior authorization requests for the time frame, where the client did not have a prior authorization approval within 7 days of the original denied request and the client did not have a paid claim within 7 days of the original denied request for a drug within the same HIC3 category. For the RDUR savings The Sourse Data: The Conduent RetroDUR program receives outpatient pharmacy claims data from Conduent Pharmacy PBM daily. Accenture provides eligibility data daily and medical data weekly. Further, updated Texas Medical Board Provider files are received from Conduent Pharmacy PBM monthly. Target Prescribers are those that were identified and received intervention materials. Control prescribers are those prescribers that prescribed the intervention drugs but did not receive intervention materials. When seven months of data have been received post-intervention, Conduent prepares an outcome report. The analysis identifies all patients who had a prescription for an intervention drug for either the target or control group of prescribers. The number of patients treated and the total cost for intervention drugs are determined for the 6-month pre-intervention period and for a 6-month post-intervention period. Total drug costs can be defined as the total amount of paid intervention drug claims for the above time periods for the prescribers in the control and target groups. The number of

State	Cost Savings/Cost Avoidance Methodology Summary
	panel patients is calculated by counting the distinct number of patients per month prescribed an intervention drug. Medicaid patients that did not have an intervention drug claim were not counted in the prescriber's panel. Average cost per patient per month (PPPM) is calculated by dividing the total dollars paid for drug claims during the analysis period by the total number of Medicaid panel patients during the respective time period. The change in the control group is calculated by comparing the post-intervention per patient per month cost by the pre-intervention. This provides the expected change in costs for all patients for the intervention drugs. This amount represents the estimated amount paid per targeted provider per patient in the absence of the intervention (i.e., estimated paid amount). The estimated paid amount PPPM is then subtracted from the actual Intervention target group average cost PPPM to estimate the average cost savings PPPM. 6-Month Total Savings = the Intervention Average Cost Savings PPPM x total number of targeted patients served over the 6-month time frame. 6-Month State General Revenue Funds Savings = the 6-Month Total State Savings x by 0.400 Total State Savings = 6-Month State General Revenue Funds Savings x 2. Lock-in did not provide cost saving methodology for the lock-in savings.
Utah	PLAN ID CONFLICT DUR MSG DESC PAID CLAIMS PAID AMT OVERRIDE CT DENIED CLAIMS DENIED AMT REV COUNT REV AMT TOTAL SAVINGS NONTRAD HD HIGH DOSE 1832 $195,097.10 21 34 $7,311.34 537 $198,855.36 $206,166.70 NONTRAD DD DRUG DRUG 24890 $773,449.89 161 937 $40,126.28 5276 $292,418.12 $332,544.40 NONTRAD LD LOW DOSE 9996 $1,439,698.74 58 1 $219.67 2337 $756,077.22 $756,296.89 NONTRAD TD THER DUP 122072 $11,287,470.41 1582 45 $5,841.12 27962 $4,557,716.21 $4,563,557.33 NONTRAD SUMMARY $19,500,897.61 1822 0 $- 36112 $5,805,066.91 $5,805,066.91 TRAD HD HIGH DOSE 9172 $2,110,185.02 181 104 $38,489.20 2390 $1,284,266.75 $1,322,755.95 TRAD DD DRUG DRUG 105824 $4,453,359.50 2369 2530 $145,700.42 20258 $1,640,942.56 $1,786,642.98 TRAD LD LOW DOSE 44499 $6,100,716.83 288 0 $- 9742 $2,723,026.25 $2,723,026.25 TRAD TD THER DUP 564153 $61,480,030.65 10269 241 $35,470.14 116584 $21,551,420.52 $21,586,890.66 TRAD SUMMARY $101,343,989.48 13107 0 $- 148974 $27,199,656.08 $27,199,656.08 TRADNH HD HIGH DOSE 1198 $92,975.77 5 5 $1,166.99 151 $186,636.07 $187,803.06 TRADNH LD LOW DOSE 3559 $475,079.70 5 0 $- 386 $112,636.02 $112,636.02 TRADNH DD DRUG DRUG 8850 $583,158.33 104 219 $18,718.17 725 $173,261.75 $191,979.92

State	Cost Savings/Cost Avoidance Methodology Summary
	TRADNH TD THER DUP 44290 $2,636,929.23 484 31 $2,248.67 3416 $575,776.55 $578,025.22 TRADNH SUMMARY $4,836,453.42 598 0 $- 4678 $1,048,310.39 $1,048,310.39 SUMMARY HD HIGH DOSE 12202 $2,398,257.89 207 143 $46,967.54 3078 $1,669,758.18 $1,716,725.72 SUMMARY DD DRUG DRUG 139564 $5,809,967.72 2634 3686 $204,544.87 26259 $2,106,622.43 $2,311,167.30 SUMMARY LD LOW DOSE 58054 $8,015,495.27 351 1 $219.67 12465 $3,591,739.49 $3,591,959.16 SUMMARY TD THER DUP 730515 $75,404,430.29 12335 317 $43,559.93 147962 $26,684,913.28 $26,728,473.21 SUMMARY SUMMARY $125,681,340.51 15527 0 $- 189764 $34,053,033.38 $34,053,033.38 PLAN ID CLAIM COUNT PAID AMT REV CLAIM AMT REV AMT NONTRAD 77,802 $9,416,967.00 22,433 $3,911,452.34 TRAD 336,757 $50,515,907.58 87,631 $18,342,035.20 TRADNH 27,689 $2,736,748.21 2,535 $744,631.42
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 assume it did not result in a paid claim and therefore we count it as cost avoidance. Other cost savings are based on aggressive management of the Vermont Medicaid preferred drug lists, 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 2022 was $70,410,378.33. The following table summarizes the FFY 2022 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 Denied Claims Savings Paid Claims Saving Total

State	Cost Savings/Cost Avoidance Methodology Summary

Not Resubmitted | | Reversed and Not Resubmitted

$68,958,111.13 + $1,452,267.20
= $70,410,378.33

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 2022 was $40,534,785.73.

Monthly cost avoidance may vary due to a variety of factors, including:

. the class selection and problem type chosen for review
. the lag time before the next physician visit when changes in drug therapy may be made
. the 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 2022 will not be known until the end of FFY 2023.

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

State	Cost Savings/Cost Avoidance Methodology Summary
	certain time period. These limits are based upon the drug manufacturer's recommendations and FDA guidelines. For FFY 2022, the savings for the dose optimization edit was $343,424.60 and for the quantity limits edit was $140,626.21. The combined savings for both edits was $484,050.81.
Washington	For FFY 2022, Washington Medicaid's cost savings/cost avoidance analysis includes savings based on prospective drug utilization review (ProDUR) and cost avoidance from prior authorization. For FFY 2022 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 party payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings of $10286132. The estimated savings do 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 $30501260. The estimated cost avoidance savings do 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 $90,041,018.78 for FFY2022. The methodology used by Gainwell to calculate these savings is as outlined below. Following this DUR Savings report is the cost savings analysis for the West Virginia RetroDUR program, as calculated by Health Information Designs (HID). Annual FY2022 DUR Cost Save Report Data Gathering 1. Set date range for fiscal year 2022 (FY2022) a. Start Date = 10/01/2021 b. End Date = 09/30/2022 2. Calculate average total paid amount per claim for FY2022 a. Exclude claims with ADAP/LPS planID b. Claim start date must fall within the Start Date and End Date of FY2022 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 FY2022 which denied due to a DUR edit a. Claim start date must fall within the Start Date and End Date of FY2022 b. Claim must have a status of DENY in the claimedit table

State	Cost Savings/Cost Avoidance Methodology Summary
	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 FY2022 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 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: $51,959,780.20 Override Dollars: $33,676,053.11 Cost savings: $18,283,727.09 Percent savings: 20.3% ER, Early Refill: Denied Dollars: $68,738,617.55 Override Dollars: $1,838,305.22 Cost savings: $66,900,312.33 Percent savings: 74.29% HD, High Dose Denied Dollars: $3,540,548.50 Override Dollars: $11,620,255.86 Cost savings: $0.00 Percent savings: 0.00% ID, Ingredient Duplication Denied Dollars: $7,401,498.50 Override Dollars: $2,662,812.13 Cost savings:$4,738,686.37

State	Cost Savings/Cost Avoidance Methodology Summary
	Percent savings: 5.26% TD, Therapeutic Duplication Denied Dollars: $18,772,767.89 Override Dollars: $36,849,473.01 Cost savings: $0.00 Percent savings: 0.00% PG, Pregnancy Precaution Denied Dollars: $1,653,014.39 Override Dollars: $1,828,734.65 Cost savings: $0.00 Percent savings: 0.00% LR, Late Refill Denied Dollars: $471,650.41 Override Dollars: $353,357.42 Cost savings: $118,292.99 Percent savings: 0.13%
Wisconsin	Wisconsin Medicaid Program Centers for Medicare and Medicaid Services Medicaid Drug Utilization Review Annual Report Federal Fiscal Year 2022 Attachment 4: Wisconsin RDUR Estimated Cost Savings [ATT4-2022-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 2022 (FFY 2022). 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, 2021 and September 30, 2022, there was an estimated cost savings of $2,766,794. Table 1 - Estimated Cost Savings for FFY 2022 - All Interventions Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings All Interventions $1,964,768 (-$802,026) $2,766,794

State	Cost Savings/Cost Avoidance Methodology Summary

Table 2 - Estimated Cost Savings for FFY 2022 - Lock-Ins only

FFY 2022	Intervention Group Change between 6 Month Pre- and Post-	Comparison Group Change between 6 Month Pre- and Post-	Estimated Cost Savings
Lock-Ins Only	$233,455	$222,038	$11,417

During FFY 2022, Kepro reviewed 13,231 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 2022, 11,394 members were included in the intervention group.

Table 3 - Drug Therapy Problem Distribution

- Drug-Drug Interactions 31%
- Therapeutic Appropriateness 18%
- Under-Utilization 16%
- Drug-Disease Interactions 12%

Analysis Methodology

Each month Kepro 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, Kepro 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 42,481 members met the criteria for intervention letters during FFY 2022.

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. Kepro 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

State	Cost Savings/Cost Avoidance Methodology Summary

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 2022). 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, Kepro 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 2022.

Table 4 - Estimated Cost Savings for FFY 2022 - 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	$1,549,353	(-$839,393)	$2,388,746
Multiple Intervention	$415,415	$37,367	$378,048
Total Estimated Cost Savings	$2,766,794		

Kepro found the intervention group had a decrease of 2.89% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 5.54%. These changes resulted in an estimated cost savings of $242.83 per member who received an intervention during FFY 2022. The intervention group utilized for the cost savings calculation included 11,394 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	10,292	10,292
Average Cost/Member	$5,709	$5,558
Total Claims Cost	$58,757,371	$57,208,018

Comparison Group (Single Intervention)

	Pre 6 Months	Post 6 Months
Members	10,292	10,292
Average Cost/Member	$1,296	$1,378
Total Claims Cost	$13,342,268	$14,181,661

Single Intervention Outcomes

Total Prescription Claims Saved	38,556

State	Cost Savings/Cost Avoidance Methodology Summary
	Percent Change in Claims Cost -2.64% Change in Claims Cost $1,549,353 Single Intervention Outcomes Comparison Group Claims Cost Change (-$839,393) Total Savings for Single Interventions $2,388,746 Table 6- Cost Savings of Recipients' Total Prescription Medications for the Pre-and Post-Intervention Periods - Multiple Interventions Multiple Interventions Pre 6 Months Post 6 Months Recipients 1,102 1,102 Average Cost/Recipient $8,411 $8,034 Total Claims Cost $9,268,400 $8,852,984 Comparison Multiple Interventions Pre 6 Months Post 6 Months Recipients 1,102 1,102 Average Cost/Recipient $1,030 $996 Total Claims Cost $1,135,428 $1,098,060 Multiple Intervention Outcomes Total Prescription Claims Saved 520 Percent Change in Claims Cost - 4.48% Change in Claims Cost $415,415 Comparison Group Claims Cost Change -$37,367 Total Savings for Multiple Interventions $378,048 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 2022, 13,231 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 $2,766,794 for FFY 2022.
Wyoming	For prospective cost avoidance:

State	Cost Savings/Cost Avoidance Methodology Summary
	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.

Section VIII - Fraud, Waste and Abuse (FWA) 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 57 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

Table 81 - Documented Process in Place to Identify Potential FWA 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 (multiple responses allowed)?

Figure 58 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

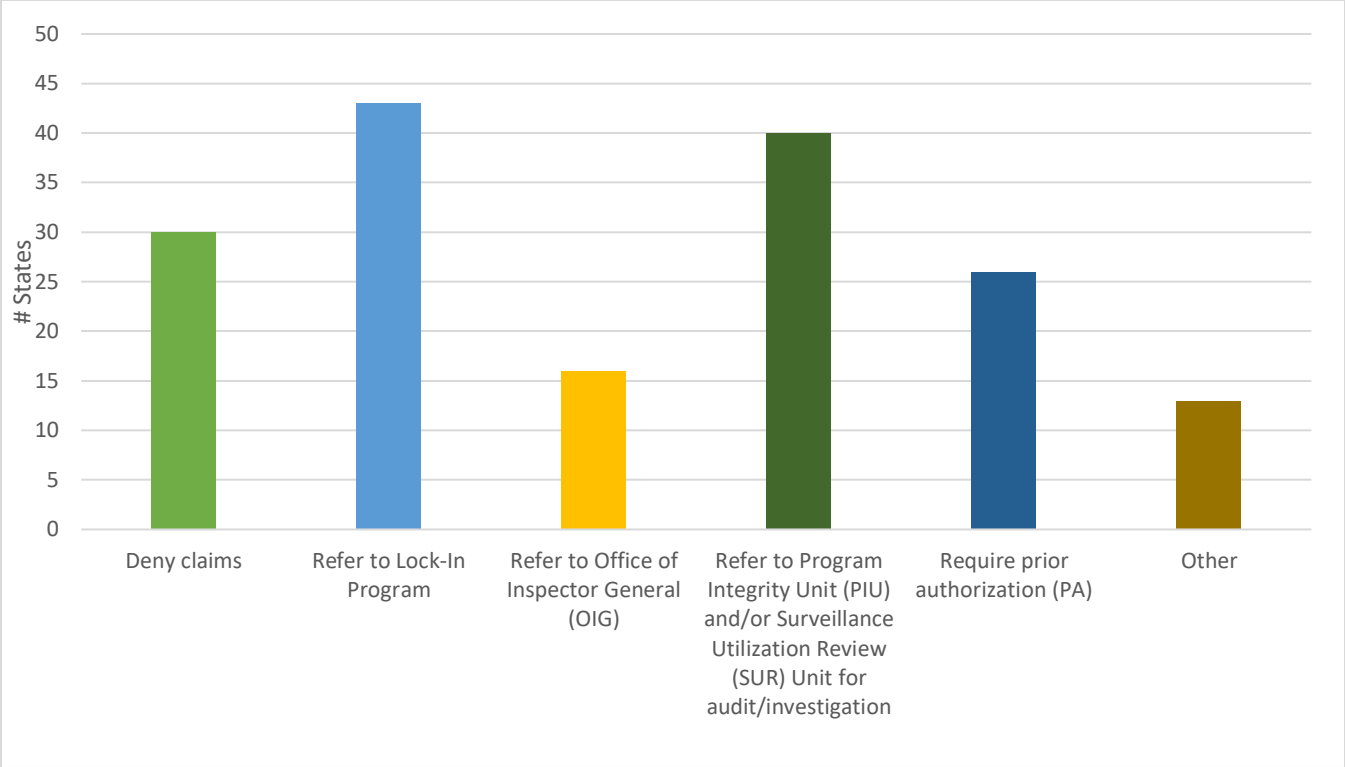

Table 82 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

Response	States	Count	Percentage
Deny claims	Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia	30	17.86%
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, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	43	25.60%
Refer to Office of Inspector General (OIG)	Arkansas, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, New Mexico, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Wisconsin	16	9.52%
Refer to Program Integrity Unit (PIU)	Alabama, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas,	40	23.81%

Response	States	Count	Percentage
and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	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, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, Wyoming		
Require prior authorization (PA)	Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Dakota, Oregon, South Carolina, Tennessee, Vermont, Virginia, West Virginia	26	15.48%
Other	Alaska, California, Connecticut, Florida, Indiana, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, Utah, Vermont, Virginia	13	7.74%
Total		168	100.00%

If "Other," please explain.

Table 83 - "Other" Explanations for Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

State	Explanation
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 (A&I), Contract and Enrollment Review Division (CERD) and Investigations Division (ID are responsible for working potential fraud or abuse of controlled drugs by beneficiaries. A&I has an intake process for complaints which entails an initial case review and if warranted, assignment of a case for investigation or audit. 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); local law enforcement, or other entities such as federal/State task forces.
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.

State	Explanation
New Hampshire	Beneficiaries may be referred to the Program Integrity Unit. This unit performs the review function and manages the Lock-In Program when the service is necessary. 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. These individuals may also be referred to the OIG by the PIU. Claims are denied for lock-in beneficiaries if not using designated providers.
Utah	Management of Medicaid member's case in coordination with providers to bring utilization in line with Lock-in Program guidelines and criteria
Vermont	Internally the quality unit utilizes a process that reviews data -mined claims information. The process screens for claims that meet the criteria: multiple prescribers of controlled substances, multiple ED visits, and/ or use of multiple pharmacies. Outreach to 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 59 - Lock-In Program

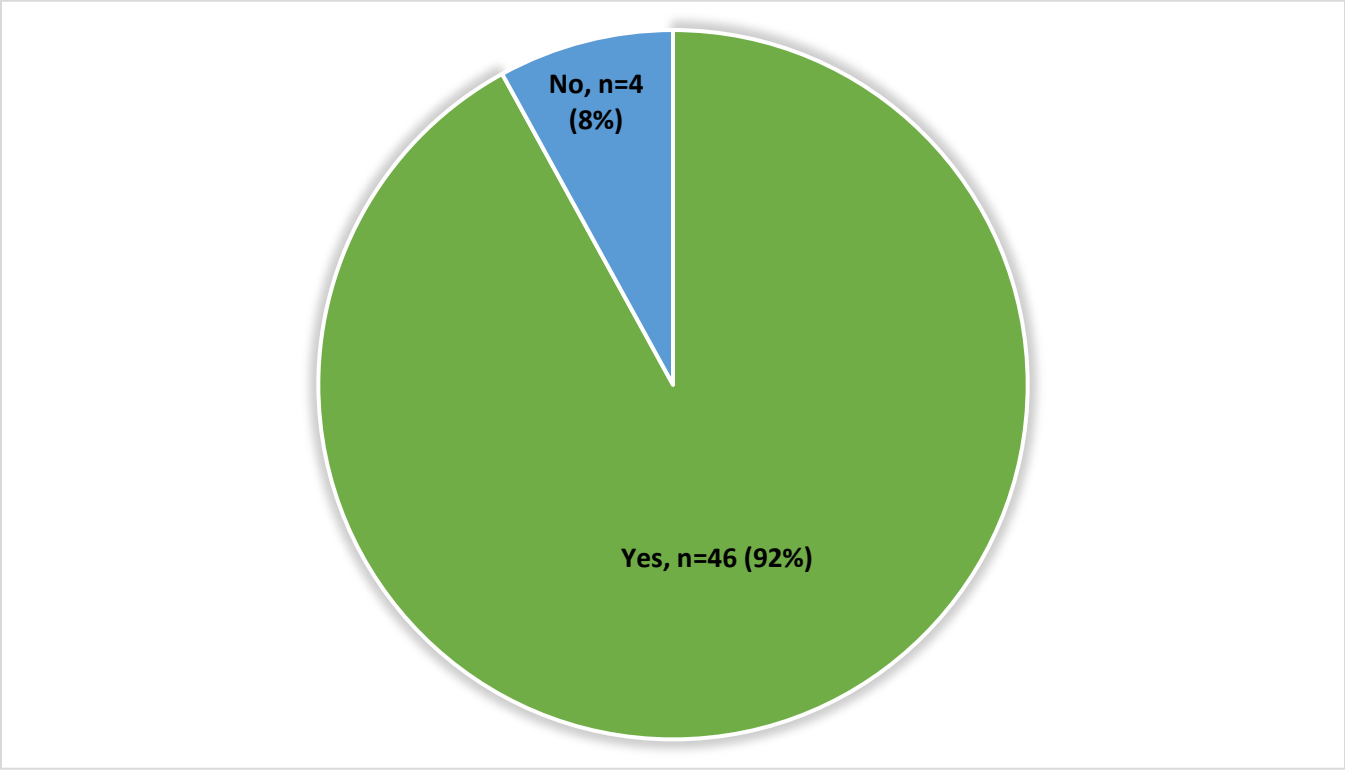

Table 84 - Lock-In Program

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%

a. If "Yes," what criteria does your State use to identify candidates for lock-in (multiple responses allowed)?

Figure 60 - Lock-In Program Candidate Identification Criteria

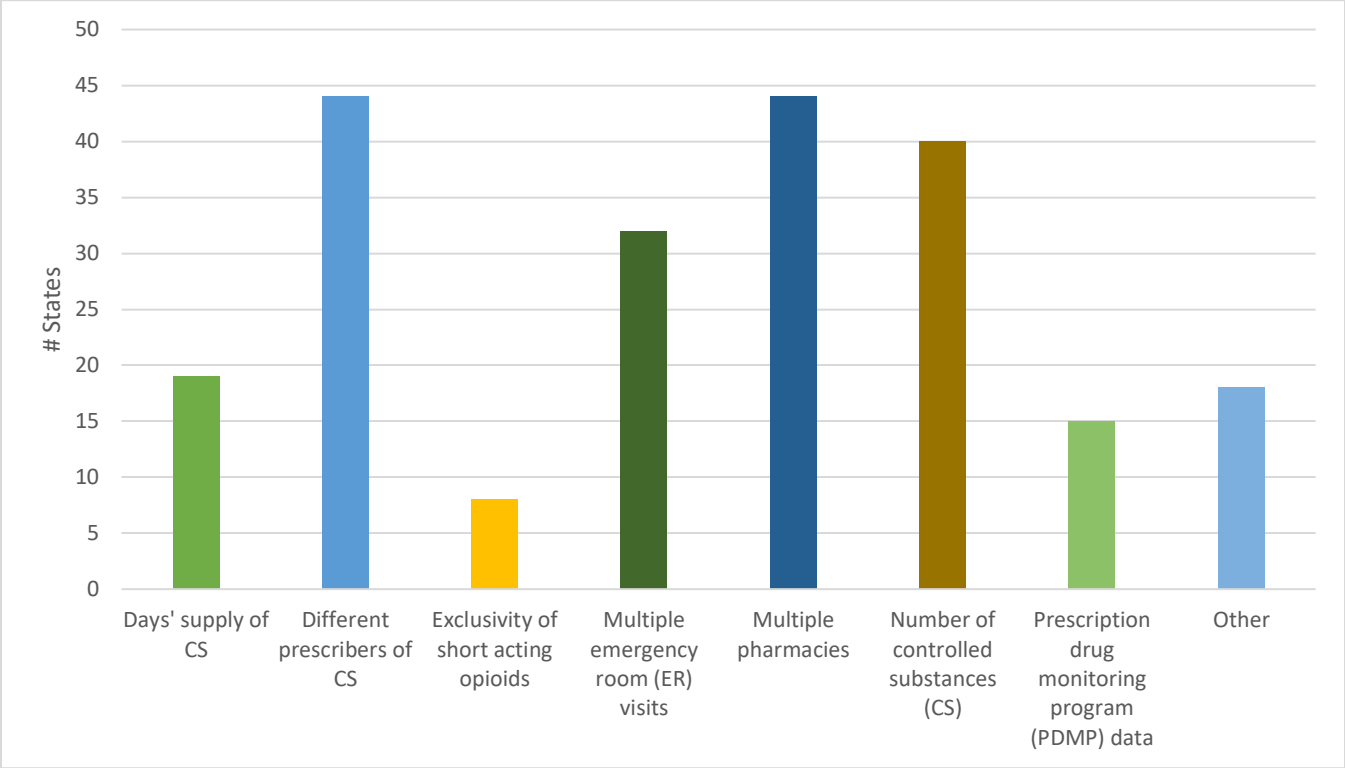

Table 85 - Lock-In Program Candidate Identification Criteria

Response	States	Count	Percentage
Days' supply of CS	Alabama, Arkansas, Connecticut, Delaware, Georgia, Kansas, Louisiana, Maryland, Michigan, Missouri, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, Utah, Virginia, West Virginia, Wisconsin	19	8.64%
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, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	20.00%
Exclusivity of short acting opioids	Arkansas, Delaware, Georgia, Maryland, Michigan, New York, Pennsylvania, Utah	8	3.64%
Multiple emergency room (ER) visits	Alabama, Alaska, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	32	14.55%
Multiple pharmacies	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas,	44	20.00%

Response	States	Count	Percentage
	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		
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	18.18%
Prescription drug monitoring program (PDMP) data	Alabama, Alaska, Arkansas, Georgia, Idaho, Indiana, Kansas, Michigan, Mississippi, Montana, Nevada, North Dakota, Utah, Virginia, West Virginia	15	6.82%
Other	Arkansas, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Maine, Mississippi, Montana, Nebraska, Nevada, Ohio, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin	18	8.18%
Total		220	100.00%

If “Other,” please explain.

Table 86 - “Other” Explanations for Lock-In Program Candidate Identification Criteria

State	Explanation
Arkansas	The beneficiary lock-in algorithm requires the following scenario to be flagged for lock-in review. Beneficiary must have all of the following: 1) >= 3 prescribers; AND 2) >= 3 pharmacies in the last 90 days; AND 3) >= 3 GSNs out of the following list--opioids, controlled ADHD stimulants, benzodiazepines, gabapentin, muscle relaxants, buprenorphine containing agents, sedative hypnotics, narcolepsy agents, or Xyrem; AND 4) Beneficiary must be >= 18 years of age 5) Exclusions include cancer patients, long-term care patients and patients with recent surgery Beneficiaries with the diagnosis of poisoning or overdose are monitored monthly. Beneficiaries are monitored for a billed diagnosis consistent with poisoning or with an overdose of opioids, narcotics, barbiturates, benzodiazepines or unspecified drug or substances. Beneficiaries on this report may be flagged for further review of lock-in necessity.
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 in place for beneficiaries with greater than or equal to ten prescriptions per month.

State	Explanation
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, pharmacy and State)
Mississippi	Additional criteria that can be used to determine individuals for lock-in also include: - When an individual utilized cash payments to purchase controlled substances - When any written prescription is stolen, forges, 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	Refer to OAC rule 5160-20-01 located at: https://codes.ohio.gov/ohio-administrative-code/rule-5160-20-01 Additional criteria: In accordance with OAC Rule 5160-20-01, when three or more criteria are met an individual will be enrolled in CSP -Individual received four or more abuse potential drugs. Defined as during a 90-day period within the last 12 months, an individual received four of more of any combination of any Ohio Automated RX Reporting System (OARRS) reportable drugs or any muscle relaxants. -Individual has an indefinite history of addiction or drug dependence with abuse potential drugs. Defined as the individual was diagnosed with or treated for addiction, and the individual received any combination of any OARRS reportable drugs or any muscle relaxants. National diagnosis codes are used to identify addiction and drug dependence. -Individual obtained prescriptions for abuse potential drugs from four of more prescribers. Defined as during a 90-day period within the last 12 months, an individual obtained prescribed drugs from four or more prescribers for any combination of any OARRS reportable drugs or any muscle relaxants. Affiliated prescribers with a shared business structure such as those at an RHC, FQHC, and group practices are considered a single prescriber. Prescriber identification numbers are used for the determination of multiple prescriber use. -Individual has a poisoning overdose with a benzodiazepine, prescription opioid, or abuse potential drug. Defined as an individual diagnosed or treated for poisoning overdose within 365 days, and during a 90-day period within the last 12 months, the individual received of any combination of any OARRS reportable drugs or any muscle relaxants. National diagnosis codes are used to identify poisoning and/or overdose. -Individual utilized three or more pharmacies. Defined as during a 90-day period within the last 12 months, an individual utilized three or more Pharmacies to fill abuse potential drugs as determined by national provider identification (NPI) number. -Individual received one narcotic analgesic, one benzodiazepine, and one muscle relaxant. Defined as during a 90-day period within the last 12 months, an individual concurrently received all of the following: any benzodiazepine, any muscle relaxant, any opioid. -Individual received Medication Assisted Treatment. Defined as during a 90-day period within the last 12 months, an individual received Medication Assisted Treatment concurrently with an opioid.

State	Explanation
Tennessee	Enrollees are also subject to the Lock-In Program if: - Arrested for one of the following reasons: drug offense, TennCare doctor shopping, drug sales or fraud, - Convicted for one of the following reasons: TennCare drug sales, doctor shopping or fraud - Has diagnosis of poisoning due to an illicit substance
Texas	- Opioid therapy that exceeds MME daily dose - Any prescription combination with abuse potential - Member had two or more occurrences of violating a pain contract with the same prescriber or with different prescribers - Member had conviction due to crime related to restricted medications within the past year (forgery, theft, distribution, or Medicaid fraud)
Utah	multiple different providers
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; 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	Wisconsin also identifies for lock-in reviews: Members with several recent prescriptions for controlled substances and has a diagnosis of medication-related poisoning (opioid or benzodiazepine). Members with concurrent opioid and buprenorphine use.

b. If "Yes," does your State have the capability to restrict the beneficiary to:

i. Prescriber only

Figure 61 - Prescriber Only Restriction Capability

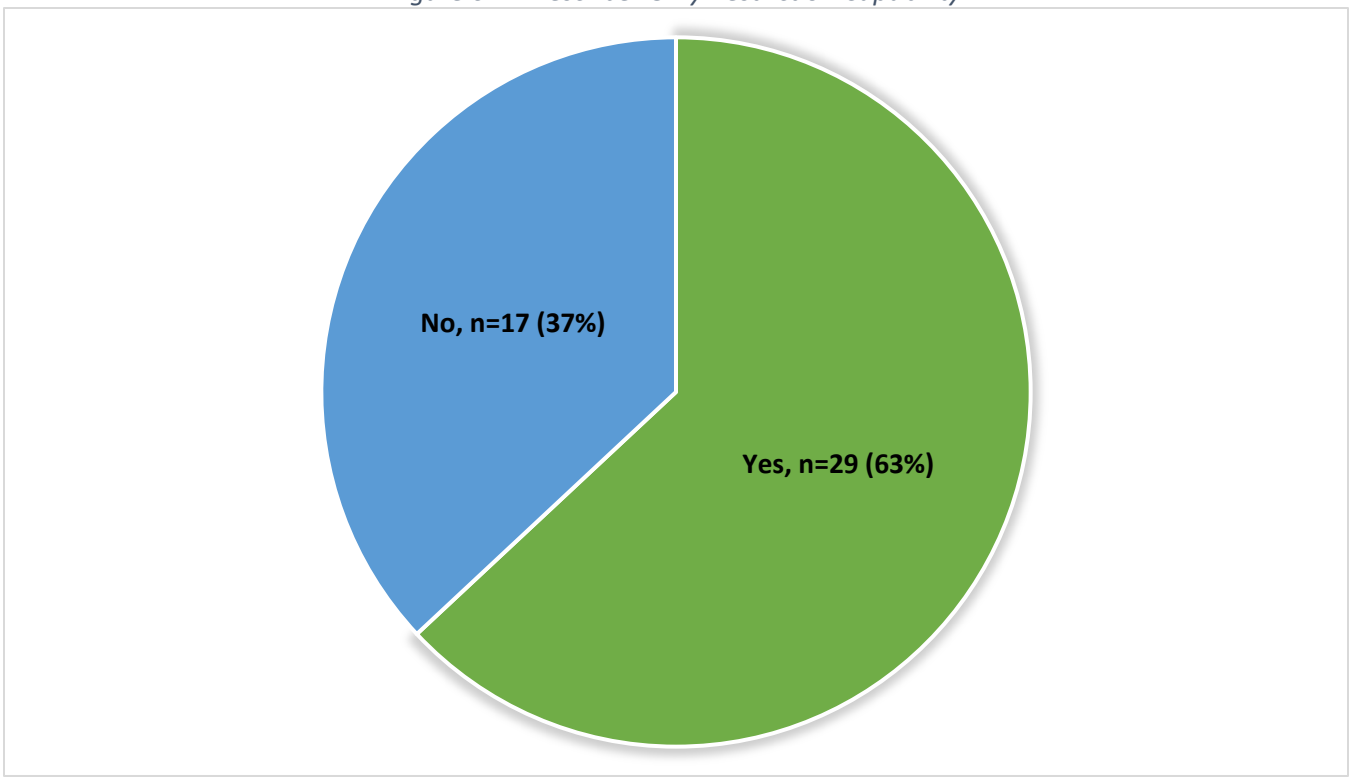

Table 87 - Prescriber Only Restriction Capability

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, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	29	63.04%
No	Alabama, Alaska, Arkansas, Connecticut, District of Columbia, Louisiana, Maryland, Massachusetts, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Wisconsin, Wyoming	17	36.96%
Total		46	100.00%

ii. Pharmacy only

Figure 62 - Pharmacy Only Restriction Capability

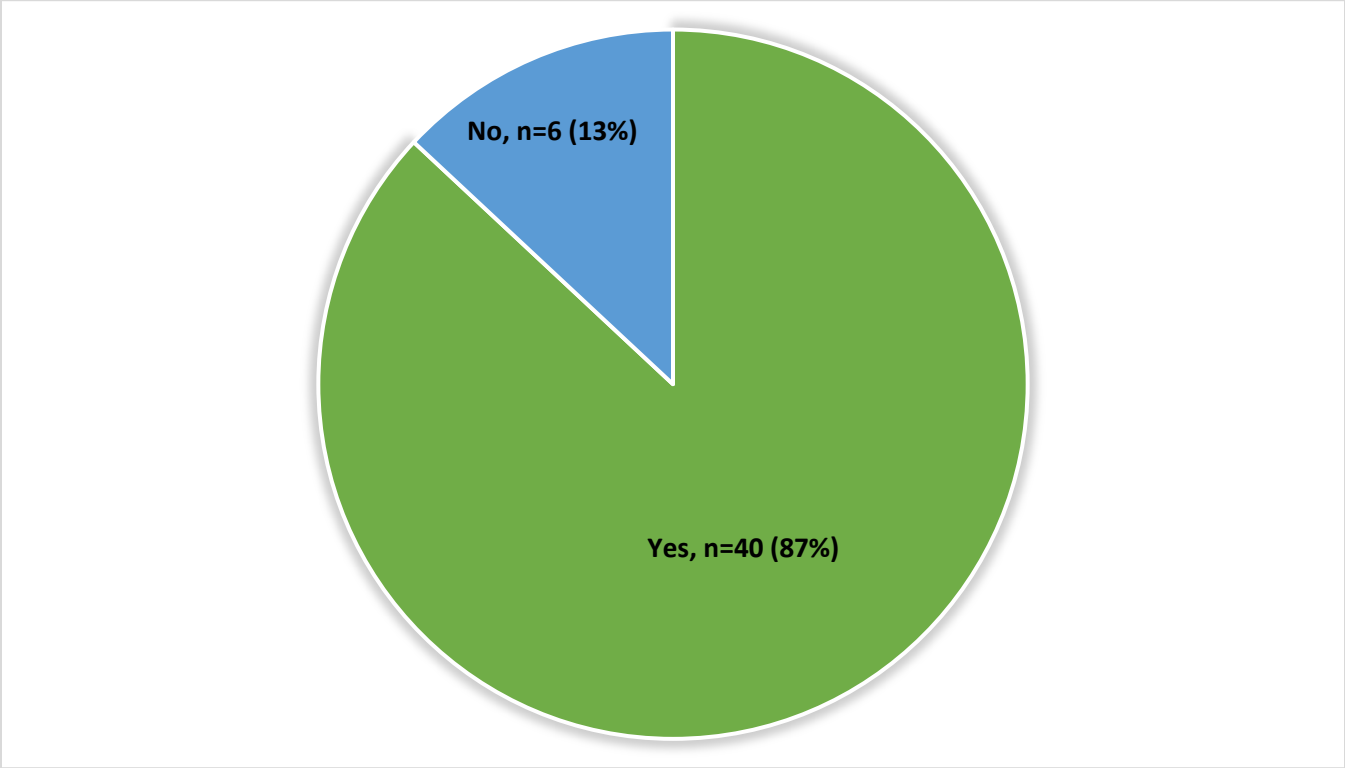

Table 88 - Pharmacy Only Restriction Capability

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, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	40	86.96%
No	Alabama, Alaska, Nebraska, North Carolina, Oklahoma, Wisconsin	6	13.04%
Total		46	100.00%

iii. Prescriber and pharmacy

Figure 63 - Prescriber and Pharmacy Restriction Capability

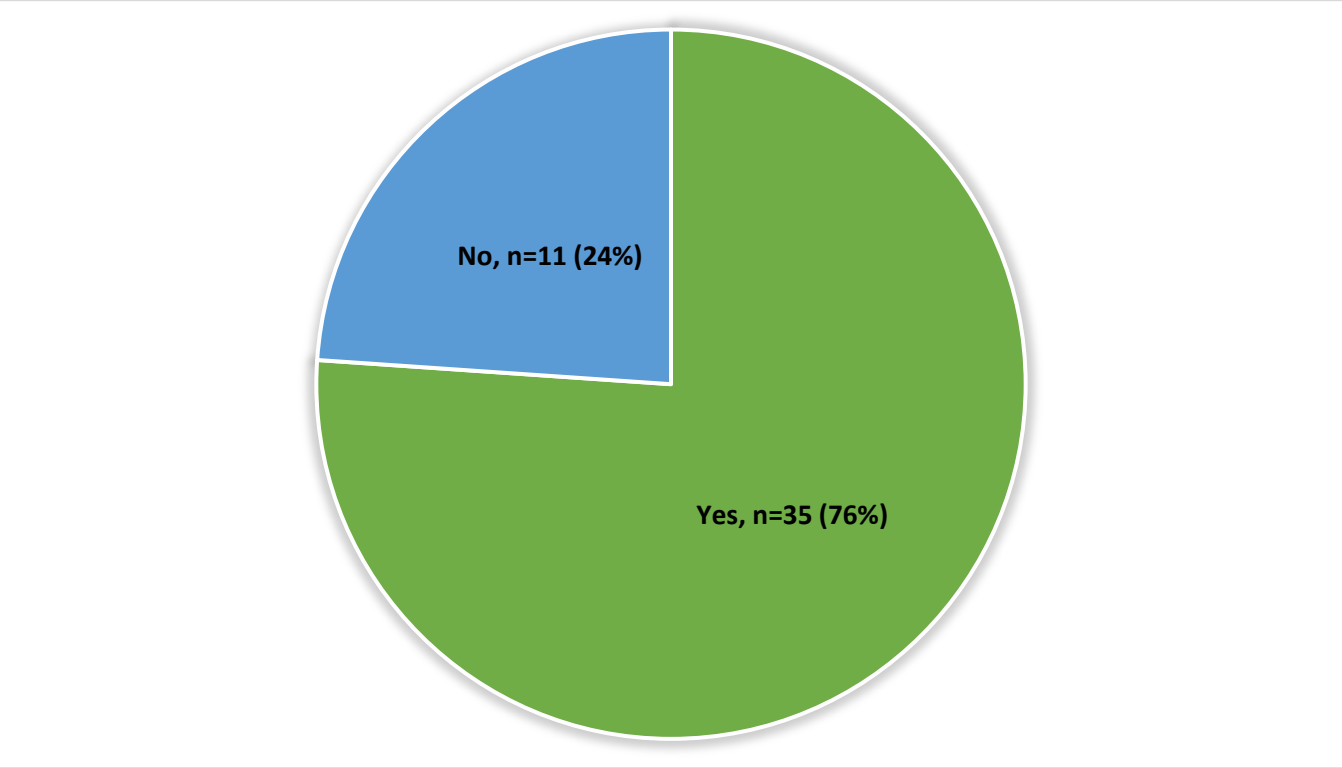

Table 89 - Prescriber and Pharmacy Restriction Capability

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, Tennessee, 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, Texas, Wyoming	11	23.91%
Total		46	100.00%

c. If "Yes," what is the usual lock-in time period?

Figure 64 - Lock-In Time Period

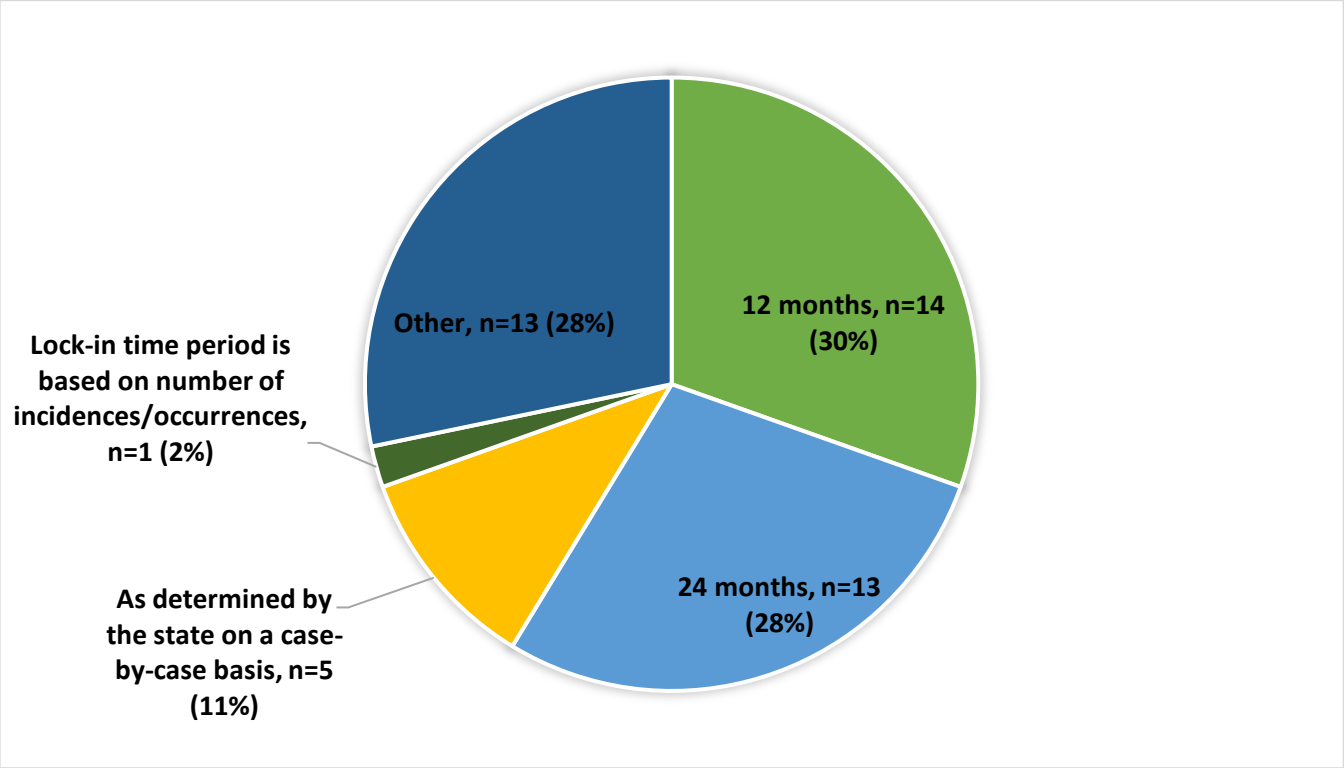

Table 90 - Lock-In Time Period

Response	States	Count	Percentage
12 months	Alabama, Alaska, Colorado, Connecticut, District of Columbia, Georgia, Mississippi, Montana, New Hampshire, Oregon, Rhode Island, Utah, Virginia, West Virginia	14	30.43%
24 months	Hawaii, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, North Carolina, Ohio, South Carolina, Washington, Wisconsin	13	28.26%
As determined by the State on a case-by-case basis	Idaho, New Jersey, New Mexico, New York, North Dakota	5	10.87%
Lock-in time period is based on number of incidences/occurrences	Wyoming	1	2.17%
Other	Arkansas, Delaware, Illinois, Indiana, Maine, Massachusetts, Minnesota, Nevada, Oklahoma, Pennsylvania, Tennessee, Texas, Vermont	13	28.26%
Total		46	100.00%

If "Other," please explain.

Table 91 - "Other" Explanations for Lock-In Time Period

State	Explanation
Arkansas	Lock-in beneficiaries are initially locked into a pharmacy for one year, and their status is re-reviewed by the lock-in committee annually. The restriction will be removed after

State	Explanation
	demonstration by the beneficiary that the potential for fraud, waste, or abuse has been corrected.
Delaware	Lock in period does not have an end date but can be reviewed at a member's request.
Illinois	The department can currently restrict a participant to up to three providers at a time, one Pharmacy, one Physician and one Clinic. The initial FFS participant lock-in is for 12 months. All subsequent lock-ins for the same participant 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 36-month review.
Nevada	36-months or as determined by the State on a case-by-case basis
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	Pennsylvania's Lock-In is for five (5) years.
Tennessee	It depends. 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 on PA status until acquitted. If the enrollee is convicted, they are subject to Lock-In and PA Status as long as they have the benefit at any time.
Texas	The Lock-In Program time periods are cumulative eligibility time frames of 36-months, 60-months, and lifetime depending 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 disenrollment.

d. If "Yes," on average, what percentage of the FFS population is in lock-in status annually?

Figure 65 - Percentage of FFS Population in Lock-In Status Annually

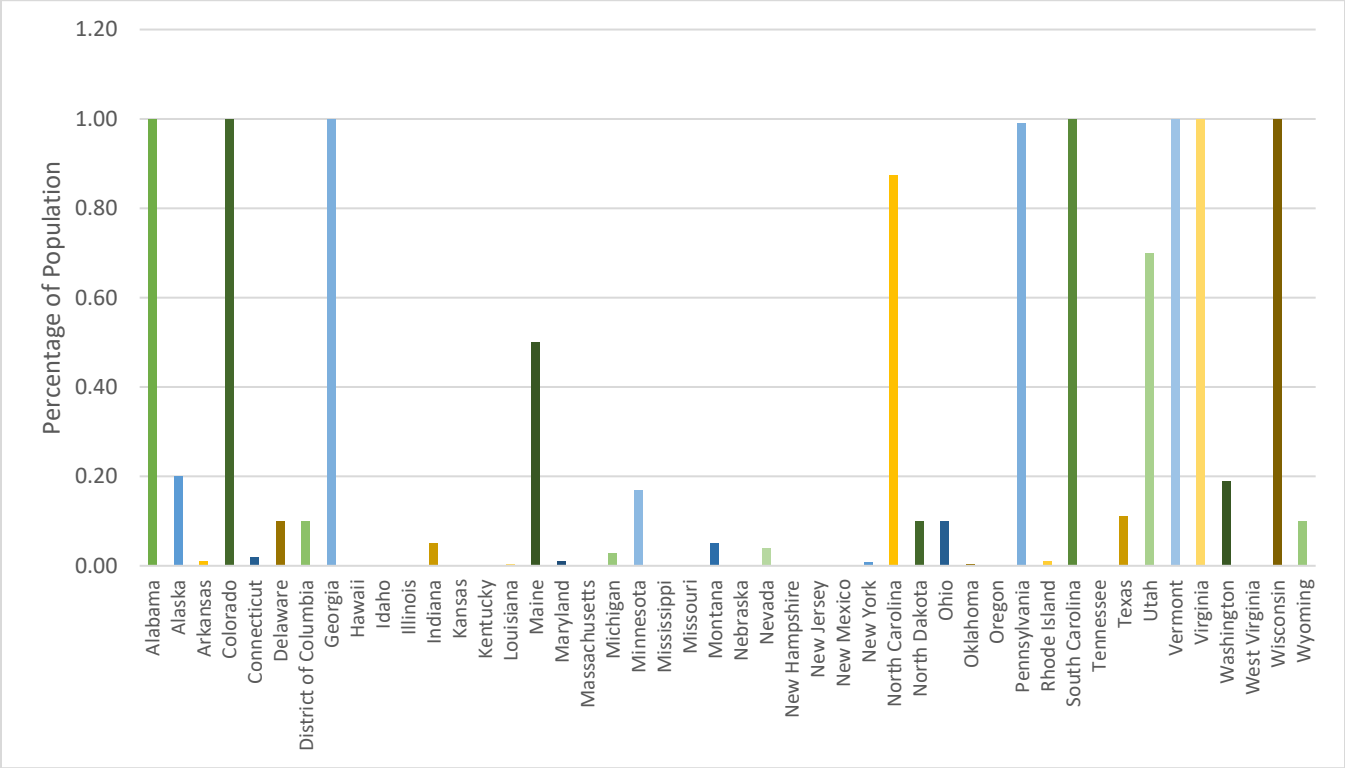

Table 92 - Percentage of FFS Population in Lock-In Status Annually

State	Percent
Alabama	1.0000%
Alaska	0.2000%
Arkansas	0.0090%
Colorado	1.0000%
Connecticut	0.0200%
Delaware	0.1000%
District of Columbia	0.1000%
Georgia	1.0000%
Hawaii	0.0000%
Idaho	0.0010%
Illinois	0.0002%
Indiana	0.0500%
Kansas	0.0000%
Kentucky	0.0000%
Louisiana	0.0030%
Maine	0.5000%
Maryland	0.0100%
Massachusetts	0.0010%
Michigan	0.0280%
Minnesota	0.1700%
Mississippi	0.0000%
Missouri	0.0011%

State	Percent
Montana	0.0500%
Nebraska	0.0000%
Nevada	0.0400%
New Hampshire	0.0000%
New Jersey	0.0000%
New Mexico	0.0000%
New York	0.0080%
North Carolina	0.8740%
North Dakota	0.1000%
Ohio	0.1000%
Oklahoma	0.0030%
Oregon	0.0000%
Pennsylvania	0.9900%
Rhode Island	0.0100%
South Carolina	1.0000%
Tennessee	0.0020%
Texas	0.1100%
Utah	0.7000%
Vermont	1.0000%
Virginia	1.0000%
Washington	0.1900%
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 66 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

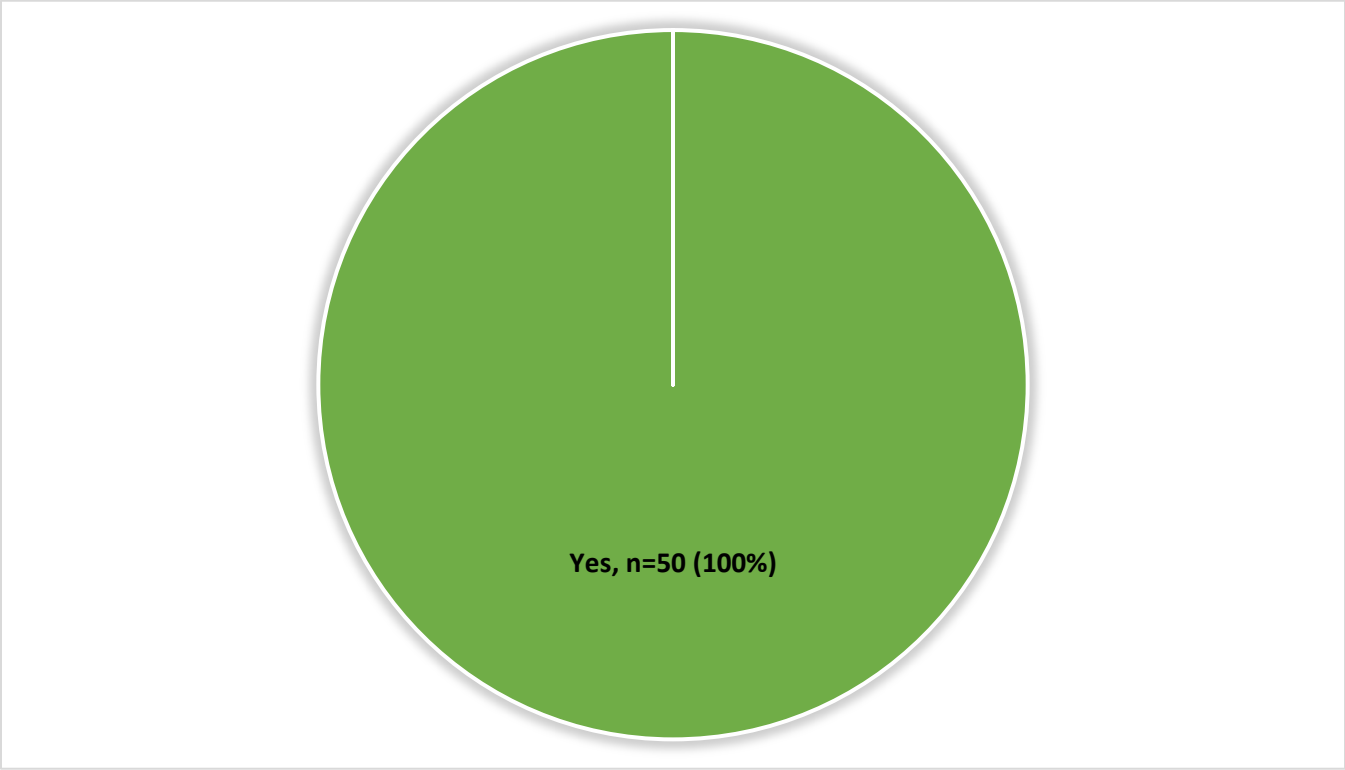

Table 93 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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 (multiple responses allowed)?

Figure 67 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

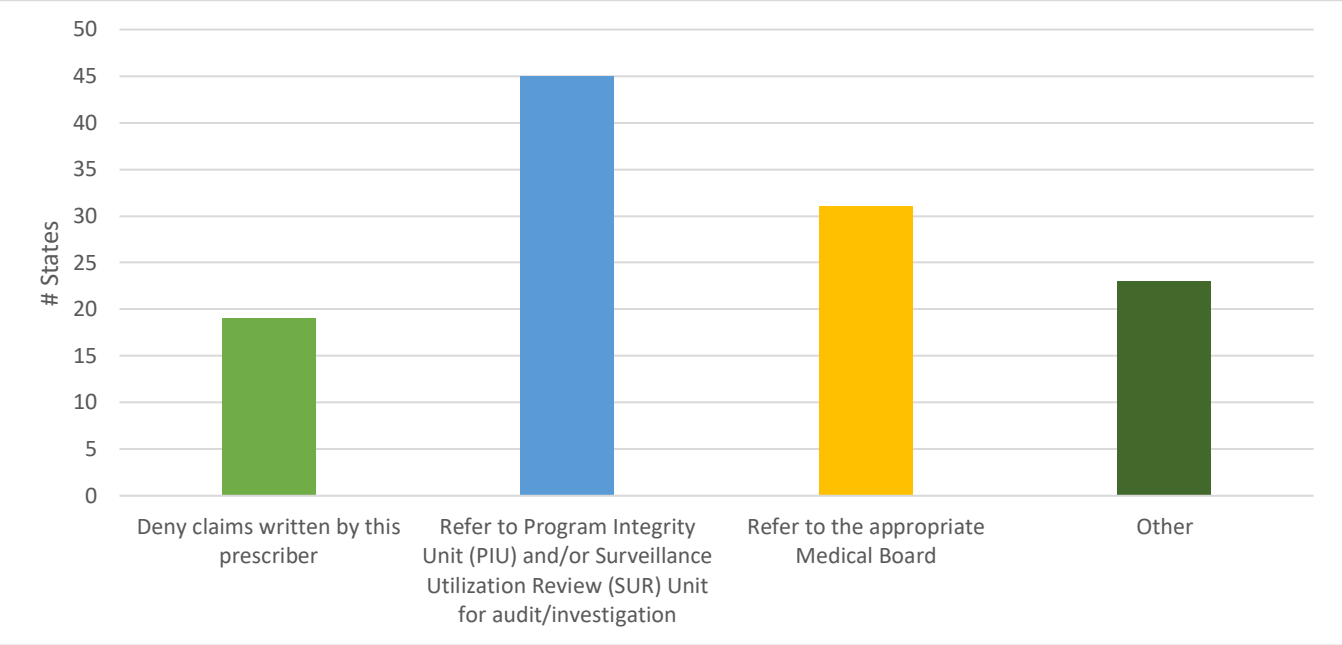

Table 94 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

Response	States	Count	Percentage
Deny claims written by this prescriber	California, Connecticut, Florida, Georgia, Illinois, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oregon, South Carolina, Texas, Utah, Vermont, West Virginia	19	16.10%
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, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, 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, Wyoming	45	38.14%
Refer to the appropriate Medical Board	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wyoming	31	26.27%
Other	Alaska, Arkansas, California, Connecticut, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Vermont, Washington, Wisconsin	23	19.49%
Total		118	100.00%

If "Other," please explain.

Table 95 - "Other" Explanations for Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers 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	The Arkansas Medicaid RDUR program identifies prescribing outliers which are presented to the DUR Board for consideration. Depending on the situation, a peer-to-peer outreach may be recommended or referral to Arkansas OMIG. Also, Arkansas OMIG performs sampling for adherence to State/federal policies and procedures and for claim integrity. If Arkansas OMIG identifies possible fraudulent behavior of a prescriber, the Medicaid Fraud Control Unit is notified.
California	Audit & Investigations (A&I), Contract and Enrollment Review Division (CERD) and the Investigations Division (ID) are responsible for working cases involving possible fraud or abuse of controlled drugs by prescribers. A&I has an intake process for complaints that entails an initial case review and if warranted assignment of a case for investigation or audit. 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.
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	Program Integrity audit process identifies possible fraud or abuse by prescribers.
Maryland	This process may result in a referral to Office of Inspector General. Kepro, through the RxExplorer software, is able to produce various reports to identify the top prescribers of controlled substances or non-controlled substances with abuse potential, and provide the average prescribing rate for a specified period of time. Using this information, Kepro 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, and prescriptions written by these prescribers would then be denied at point-of-sale.
Minnesota	Refer to the 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.

State	Explanation
Montana	Previously, prescriber review was not automated. Prescribers identified by the State to have concerning prescribing practices were referred to SURS or the medical board. We have established an automated process to identify providers with concerning prescribing patterns. The actions initiated by this process beyond those already in place are yet to be determined. This process was implemented ahead of the 6/30/2023 estimated implementation date.
Nevada	The State has a process to identify potential fraud or abuse of controlled substances by health care providers prescribing drugs through regular reports presented to the DUR Board. Any anomalies are reported to the SUR Unit for investigation. Board members were educated regarding their ability to refer providers to the Surveillance Utilization Review (SUR) Unit for investigation during FF2022. However, the process lacked clear documentation which was addressed when CMS reached out in February 2023 and the State immediately documented the process in newly drafted DUR Bylaws.
New Hampshire	Prescribers may be suspended or sanctioned by the Medical Board. Prescriptions written by suspended or sanctioned prescribers would be denied at point-of-sale.
New Jersey	Restriction of medications by utilizing no-pay PA. No pay PA will block payment of a prescription service. Number of referrals are low due to transition of members to Medicaid Managed Care.
North Carolina	An audit of specific claims may be performed. If fraud is suspected, a referral is made to the NC DOJ.
Ohio	If a credible allegation of fraud exists, at the direction of ODM, all payments to the provider will be suspended and the provider will be suspended in accordance with ORC section 5164.36. If a provider is indicted for fraud, the provider will be suspended and Medicaid payments to the provider for Medicaid services rendered will be terminated in accordance with ORC section 5164.37(D).
Pennsylvania	Refer to the MFCU if a credible allegation of fraud is determined.
Tennessee	Additional actions include: -- Provider is referred to the MCO's Medical Director for peer review, since the MCO's hold the provider contracts. -- Providers may also be referred to TennCare's DUR Board for a vote of referral to TennCare'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 prescriber to the OIG for a preliminary investigation. If findings merit a full-scale investigation, an initial notification is made to the Medicaid Fraud Control Unit (MIFU). 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.
Vermont	They may also be referred to the Medicaid Fraud Waste and Abuse Unit. There is also an internal Quality of Care process that a provider may be referred to. There are also operational reports that look at pharmacy and provider utilization: including opiates, MAT and stimulants to evaluate % of total rxs compared to controlled prescriptions.
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

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

Figure 68 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

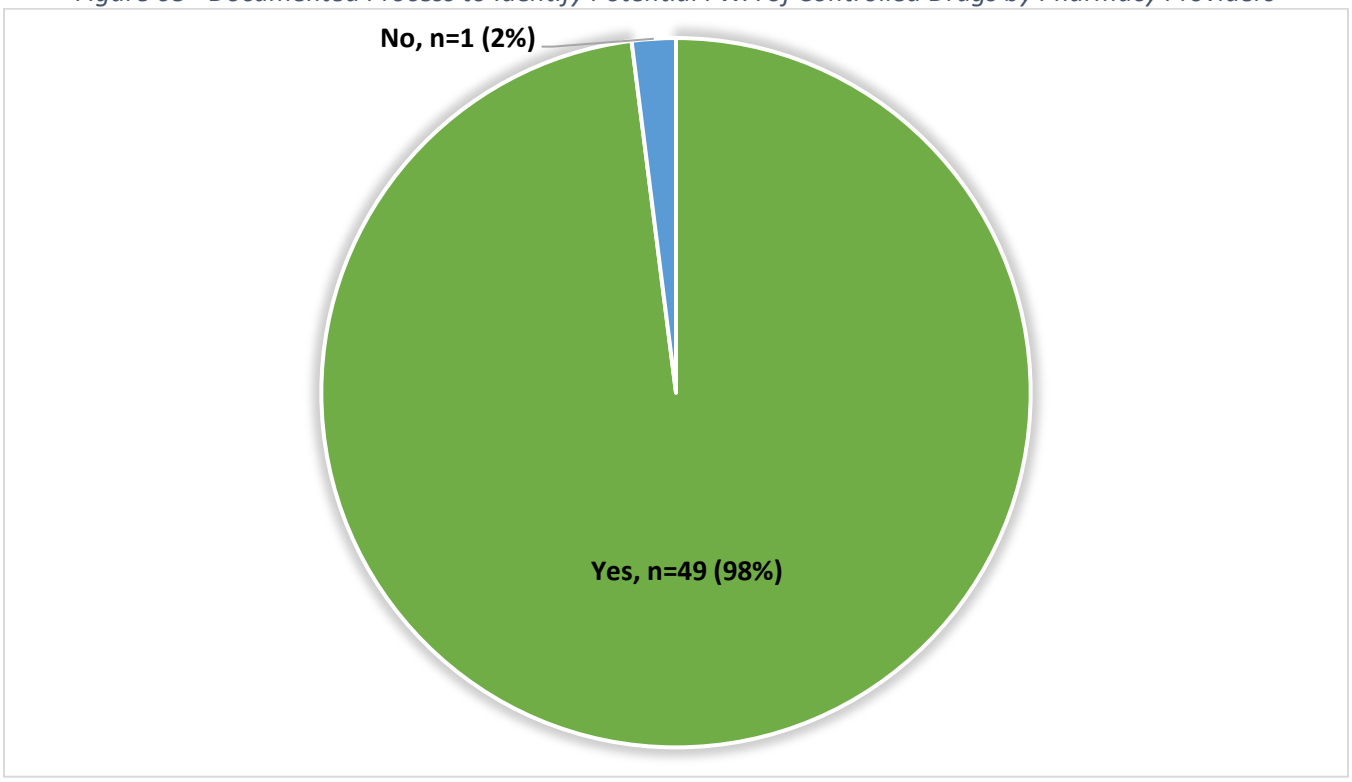

Table 96 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

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, 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%
No	Nevada	1	2.00%
Total		50	100.00%

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 69 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

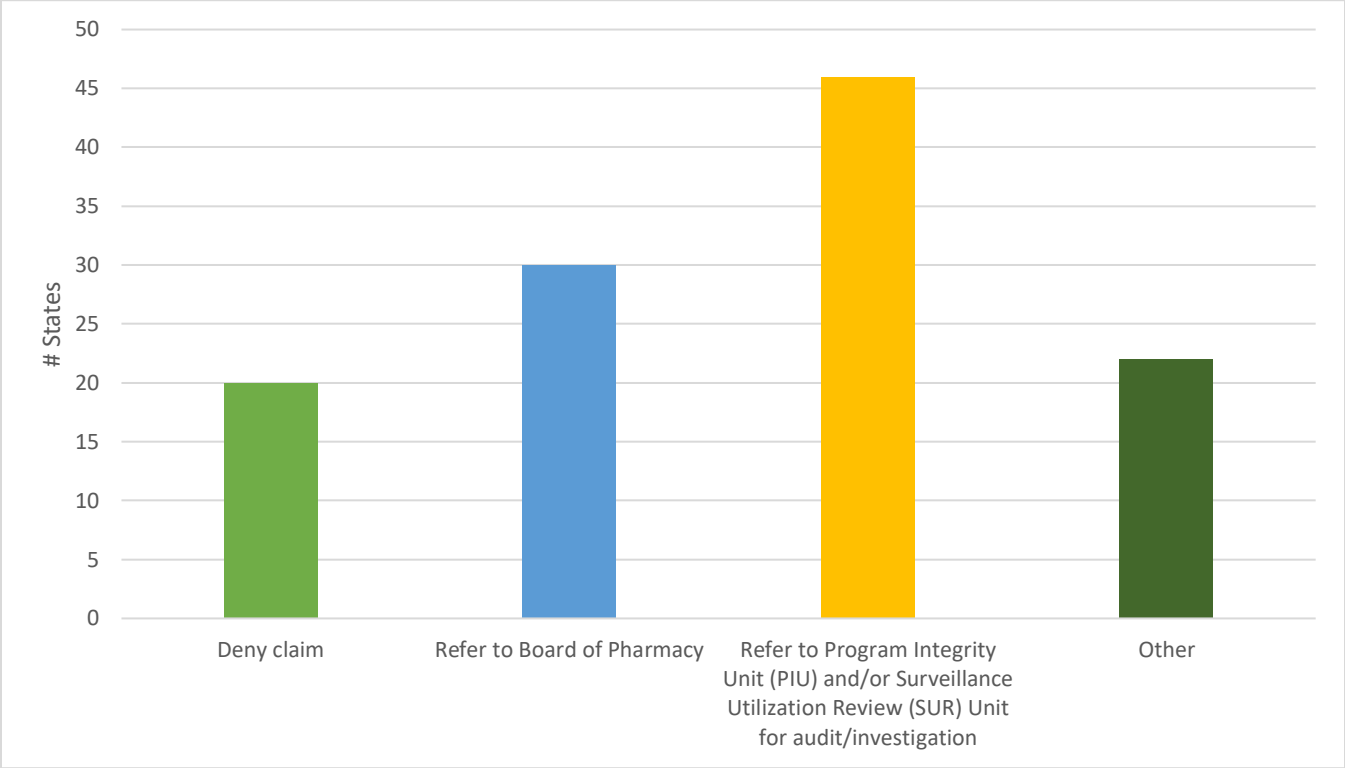

Table 97 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

Response	States	Count	Percentage
Deny claim	California, Connecticut, Delaware, Florida, Georgia, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oregon, South Carolina, Texas, Vermont, West Virginia	20	16.95%
Refer to Board of Pharmacy	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wyoming	30	25.42%
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, 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, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	46	38.98%
Other	Alaska, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, North	22	18.64%

Response	States	Count	Percentage
	Carolina, Pennsylvania, Tennessee, Texas, Washington, Wisconsin		
Total		118	100.00%

If "Other," please explain.

Table 98 - "Other" Explanations for Actions Process Initiates when Potential FWA 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	The Arkansas Medicaid RDUR program identifies pharmacy outliers which are presented to the DUR Board for consideration. Depending on the situation, a peer-to-peer outreach may be recommended or referral to Arkansas OMIG. Also, Arkansas OMIG performs sampling for adherence to State/federal policies and procedures and for claim integrity. Arkansas OMIG performs pharmacy audits twice a year on all AR Medicaid enrolled pharmacies.
California	Audit & Investigations (A&I), Contract and Enrollment Review Division (CERD and the Investigations Division (ID) are responsible for working cases involving potential fraud or abuse of controlled drugs by pharmacy providers. A&I has an intake process for complaints that entails an initial case review and if warranted assignment of a case for investigation or audit. 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.
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
Kansas	Referrals can be made to the Attorney General's office.
Maryland	A compliance pharmacist performs desktop audits to identify potential fraud, waste and abuse by pharmacies. Additionally, Kepro, through the RxExplorer software, is able to produce various reports to identify the top dispensing pharmacies of controlled substances and non-controlled substances with abuse potential. Using this information, Kepro 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

State	Explanation
	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 the denial of claims submitted by the pharmacy at point-of-sale.
Minnesota	Refer to the 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.
Montana	Previously, pharmacy provider review was not automated. Pharmacies identified by the State to be miss utilizing edit overrides, such as emergency fill or TPL edits, were contacted for correction. If the behavior continued, they were referred to SURS for potential recoupment. We have established an automated process to identify providers with concerning dispensing and/or edit override patterns. The actions initiated by this process beyond those already in place are yet to be determined. However, we feel that our edits regarding duplicate fills, early fills, quantity limits, MME limits etc., and the inability of pharmacists to override these edits, prevents pharmacy providers from most forms of fraud or abuse of controlled drugs. This process was implemented ahead of the 6/30/2023 estimated implementation date.
New Hampshire	Pharmacies may be suspended or sanctioned which results in in the denial of claims submitted by the pharmacy at point-of-sale.
New Jersey	Restriction of medications by utilizing no-pay PA. No pay PA will block payment of a prescription service. Number of referrals are low due to transition of members to Medicaid Managed Care.
North Carolina	An audit of specific claims may be performed. If fraud is suspected, a referral is made to the NC DOJ.
Pennsylvania	Refer to the MFCU if a credible allegation of fraud is determined.
Tennessee	Additional actions include: --Pharmacy is referred to the PBM's Director of Audit, and pharmacy is investigated to the point where the PBM decides to make a formal referral to OPI (Office Provider Integrity), or because we have the PBM hold the pharmacy agreements, the PBM could make a decision to terminate without cause. --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 will be a preliminary investigation. If findings merit a full-scale investigation, an initial notification will be 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.
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 why not.

Table 99 - Explanations for Lack of Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

State	Explanation
Nevada	A new report has been created for the purpose of identifying potential fraud or abuse of controlled substances by pharmacies when CMS reached out in February 2023. The State drafted updated DUR Board Bylaws to document the new process as a result of this communication. However, implementation occurred on April 20, 2023, at the next scheduled DUR Board Meeting in FFY2023. The DUR Board now reviews potential fraud or abuse of controlled drugs by pharmacy providers and the DUR Board refers SUR Unit for investigation as appropriate. In the future we anticipate, Nevada will report "yes" to this question.

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

Figure 70 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers

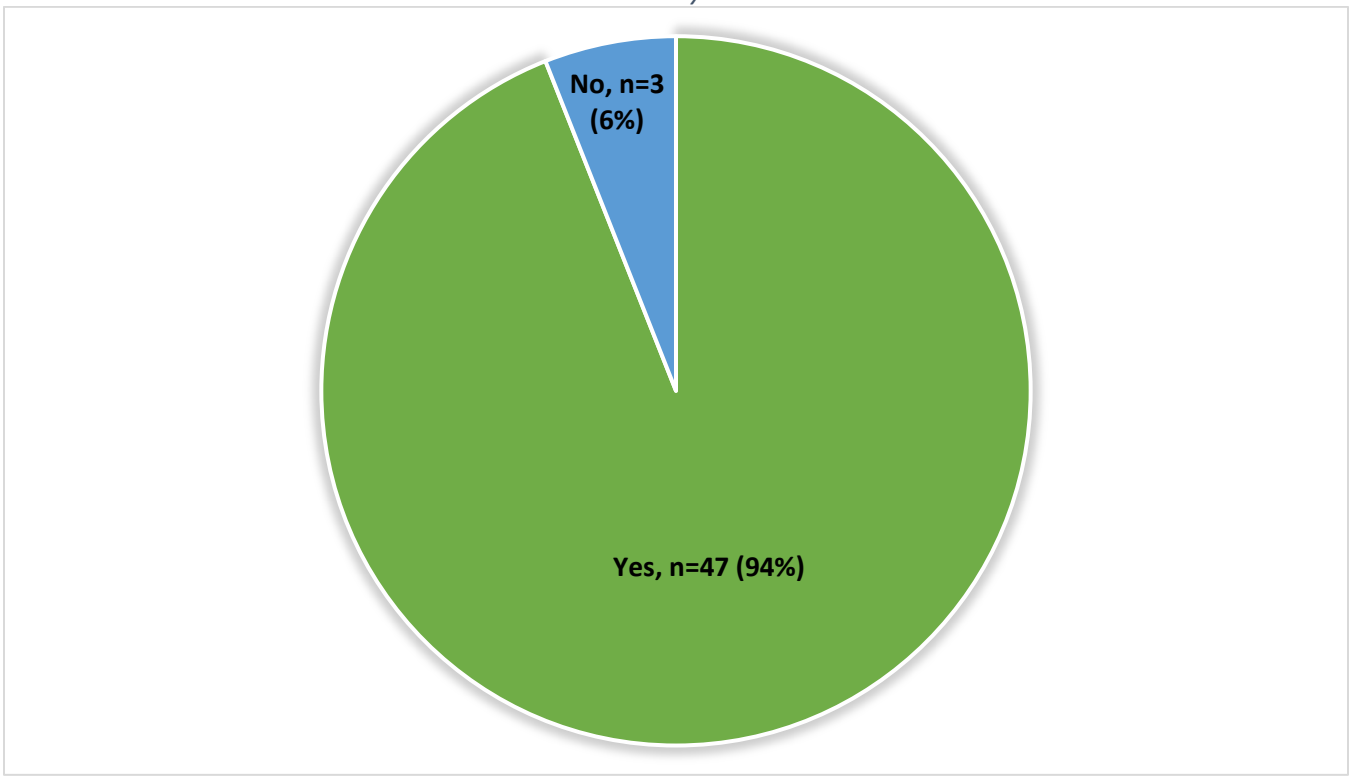

Table 100 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, 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, Wisconsin, Wyoming	47	94.00%
No	Delaware, Montana, West Virginia	3	6.00%
Total		50	100.00%

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

Table 101 - Explanations of Program for FWA of Non-Controlled Substances

State	Explanation
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 the manufacturers' package inserts. Refill too soon edits, ProDUR alerts, accumulation edits, and prior authorization criteria help prevent fraud, waste, and abuse by beneficiaries, prescribers, and pharmacy providers. To identify FWA by beneficiaries, the RDUR lock-in program 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 beneficiaries and forwards the information to the local prosecutor. If Arkansas OMIG identifies potential fraud and abuse by beneficiaries during random sampling, information gathered is forwarded to the local prosecutor. Arkansas OMIG performs pharmacy audits twice a year on all AR Medicaid enrolled pharmacies which may catch fraudulent habits. Also, a fraud hotline and integrity reporting form are available for concerned citizens to bring attention to possible FWA by a beneficiary.
California	Audit & Investigations (A&I), Contract and Enrollment Review Division (CERD) and Investigation Division (ID) are responsible for working potential fraud or abuse of non-controlled drugs by beneficiaries. A&I 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 District's Lock-in polypharmacy review includes non-controlled substances in the screening process.

State	Explanation
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	Currently manual quarterly retroDUR (also post payment review) for expensive claims finds no beneficiary, prescriber or pharmacy provider potential for fraud, waste or abuse. Previously an automated documented process (when a larger population was in FFS) was utilized; the current population is not large enough for automation but same fields are reviewed.
Idaho	Quarterly reports to identify participants with high numbers of prescribers or who utilize high numbers of pharmacies and ad hoc reports to identify pharmacies that fill prescriptions for Medicaid participants who have no physician/midlevel practitioner services.
Illinois	For prescribers and pharmacy providers it is the same as for controlled substances. For beneficiaries, Recipient and Provider Analysis Units look at correlating diagnoses to support use of all medications and medical benefits by participants. The Units also look to see if alternative services to drug therapy are ordered for participants such as physical therapy, specialty providers, assistive devices etc. that would indicate standards of care being provided. The Units will also contact the 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, the Units worked with Pharmacy Services to adjust quantity limit and obtain lower cost for topical lidocaine 5%.
Indiana	Pharmacies are able to supply tips on members and prescribers to the fraud control line if member fraud and abuse is suspected. Audit evaluates all pharmacy providers.
Iowa	Retrospective review, prior authorization and claims review may identify issues which would be further evaluated through specific claims data and taken to the DUR for further discussion as needed. The Program has increased the refill tolerance over time, currently at 90% for all drugs, to limit waste and quantity limits are established.
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.
Louisiana	FFS has multiple point of sale edits such as quantity limits, age limits, therapeutic duplication, early refill, etc. to control FWA.
Maine	referral process to identify over use and internal clinical review for placement in the lock-in (IBM) Intensive Benefit Program
Maryland	After monitoring prescribing trends in FFY2022 and research indicating growing misuse of noncontrolled substances, noncontrolled medications with abuse potential have been added to our program's quarterly reporting and monitoring. In addition, at point of sale quantity limits, day supply limits, and duplication of therapy edits continue to provide our pharmacy providers with a more complete picture to determine appropriate use.
Massachusetts	MassHealth monitors through age limits, dose limits, quantity limits and case reviews at a therapeutic class management workgroup.
Michigan	Beneficiaries with high utilization of emergency room prescribers and including those that paid with cash are subject to review.

State	Explanation
Minnesota	Questionable utilization is referred to the SURS program and they determine the action from there.
Mississippi	Medicaid utilized a maximum daily dose edit to prevent potential fraud or abuse of non-controlled drugs.
Missouri	Missouri utilizes point-of-sale prescribing limits via utilization management edits (e.g., quantity limits, days supply, therapeutic duplications, early refill) to prevent potential FWA of non-controlled drugs. To further ensure program integrity, our team also utilizes a pharmacist to retrospectively analyze patterns of potential fraud, waste, and abuse related to non-controlled substances. If a MO HealthNet participant is found to be misusing their benefits, they may be recommended for placement in our Lock-In program operated by Missouri Medicaid Audit and Compliance.
Nebraska	Early refill limits and daily quantity limits.
Nevada	The State examines pharmacy reports on a monthly basis. During this review process, the data is carefully analyzed in collaboration with the Pharmacy Benefit Manager (PBM) to detect any possible instances of fraud, waste, and abuse. If any irregularities or suspicious activities are identified, they are reported to the internal SUR unit for investigation. This thorough evaluation helps to ensure the integrity of the pharmacy system and protect against fraudulent or inefficient practices.
New Hampshire	Beneficiaries with high utilization of emergency room prescribers and pharmacies are subject to review.
New Jersey	Lock into a pharmacy and utilize no-pay PA. No-pay PA will block payment of a prescription service. Number of referrals are low due to transition of members 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	ProDUR editing and RetroDUR case reviews (i.e. therapeutic duplication and over utilization).
North Carolina	NC Medicaid has a manual review of all claims over $9999.99. Early refill edits check every pharmacy claim processed. All providers are verified as Medicaid enrolled providers before claims will pay or prior approval requests approved. Program Integrity will refer any potential provider fraud to the Medicaid Investigations Unit.
North Dakota	ND Medicaid identifies non-controlled medications that have the potential for fraud, waste, or abuse, and puts proper edits into place to limit FWA potential including quantity limits, therapeutic duplication, diagnosis requirements, prior authorization, electronic lookback, and other edits.
Ohio	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	The Bureau of Program Integrity completes retrospective reviews of both enrolled providers and beneficiaries to identify and prevent potential fraud, waste and abuse of the MA program.
Rhode Island	Refer to Program Integrity Unit and/or SUR unit for investigation.
South Carolina	Managed by Program Integrity

State	Explanation
South Dakota	The Medicaid agency conducts monthly RDUR reviews and works closely with the Program Integrity Unit to identify and/or prevent FWA of drugs by beneficiaries, prescribers, and pharmacy providers.
Tennessee	Tennessee combats potential FWA for both controlled and non-controlled substances, in several different ways: 1. We utilize a robust list of ProDUR edits that help prevent problems from occurring. In some situations, we discovered that ProDUR edits like Max Quantity are not effective (e.g., topicals, ophthalmics and otics); therefore, we have established quantity limits to prevent TennCare from paying for inappropriately large quantities. 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 corrected 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	Texas Administrative Code (TAC) 370.502 describes managed care organizations (MCOs) responsibilities in developing a plan to prevent and reduce waste, abuse, and fraud (WAF) and submit that plan annually to the Health and Human Services Commission (HHSC), Office of Inspector General (OIG) for approval. The plan must include information about the procedures for detection and investigation of possible acts of WAF by providers and recipients and the follow up process once the detection is made. FFS uses the same process to identify or report FWA of non-controlled drugs by providers or beneficiaries.
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	Pharmacy claims are subject to quantity limits and early refill limits. Replacement fills for lost or stolen medication require a call to the help desk for appropriate documentation (possible PA) and override. There are also operational reports that look at pharmacy and provider utilization: including opiates, MAT and stimulants to evaluate % of total rxs compared to controlled prescriptions.
Virginia	Refer to Program Integrity Unit
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Fraud, waste, and abuse must be reported regardless if the drug is a controlled or non-controlled drug. Fraud, waste, and abuse may be reported by going to the Office of the Inspector General's 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, prescribers or pharmacy providers are referred to the program integrity unit for further review.

If “No,” please explain why not.

Table 102 - Explanations for Lack of Documented Process to Identify and/or Prevent Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers

State	Explanation
Delaware	Delaware does not have a structured plan in place to identify FWA but currently works with the SURs Investigation Team when FWA is suspected or reported. Delaware may develop a more structured program in the future.

State	Explanation
Montana	We 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. Pharmacies are not able to override these without a prior authorization. We do not have a retrospective review process.
West Virginia	NA

B. Prescription Drug Monitoring Program (PDMP)

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

Figure 71 - State has Ability to Query the State's PDMP Database

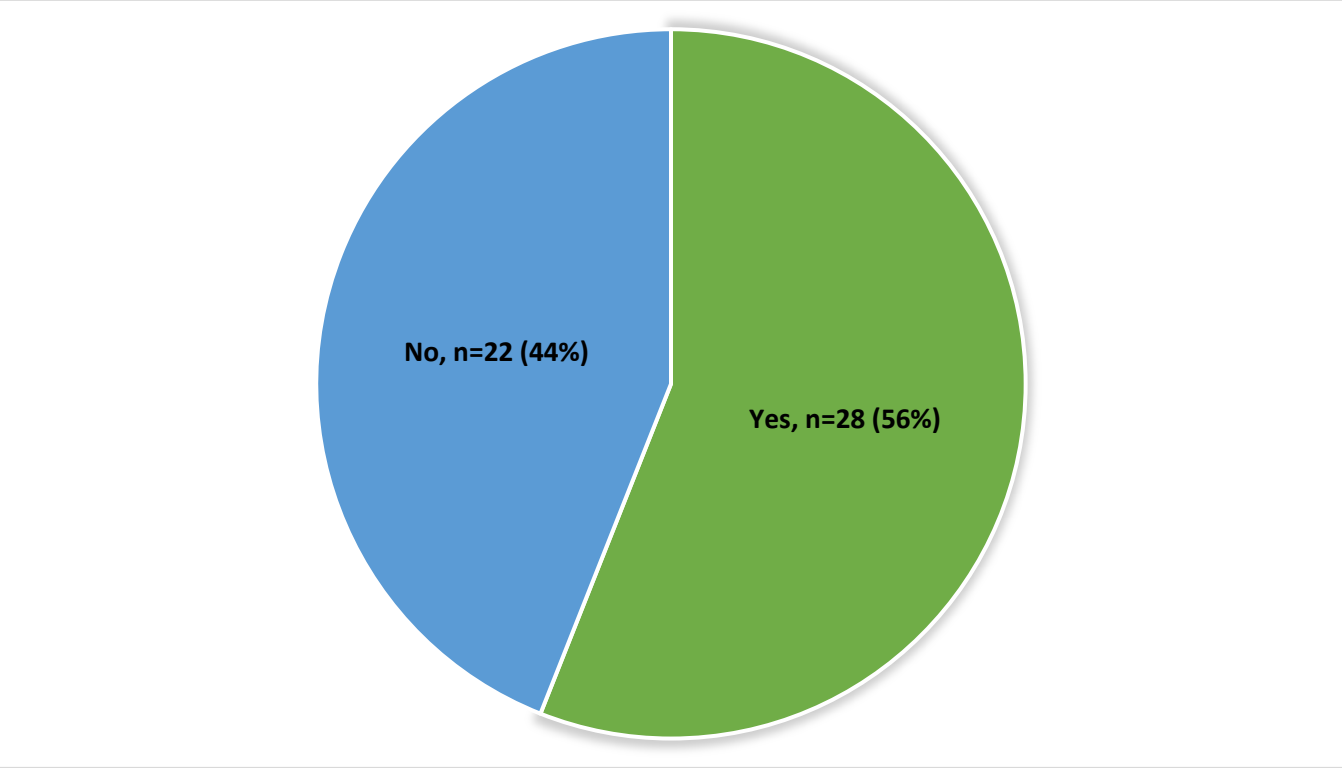

Table 103 - State has Ability to Query the State's PDMP Database

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

If "No," please explain.

Table 104 - Explanations for No Ability to Query PDMP Database

State	Explanation
California	California State law does not allow direct access to client data for this type of analysis. For FFY 2023, there will be a process established for requesting data that meets the needs of the Medicaid program while still following State law. For example, there is a pathway for a public or private entity and a Bona Fide Researcher to access CURES data for educational purposes, Peer Review purposes, statistical purposes, or Research Purposes. This is described in detail at California Code of Regulations (CCR) Title 11, Division 1, Article 3. Additionally, an employee of the California Division of Medi-Cal Fraud and Elder Abuse (DMFEA) may access CURES data under certain circumstances, subject to the requirements of CCR Title 11, Division 1, Section 827.4 (m)(4). In this case, the DMFEA employee qualifies for access to CURES data as a Law Enforcement Official (defined in CCR Title 11, Division 1, Section 820(rr)).
Colorado	The State is prohibited by law from accessing the PDMP.
Delaware	The Medicaid program does not have access to the Delaware PDMP at this time.
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 implemented.
Indiana	In accordance with IC 25-26-24-19, INSPECT provides PDMP accounts and query capabilities to Medicaid Fraud Investigators and certified representatives of the Medicaid retrospective and prospective drug utilization review program.
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.
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.
Michigan	Medicaid program staff can request Third Party Benefits Reviewer access. This access role allows for submission of a request for a 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 turnaround 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 individual recipient to determine if the individual should be placed in the Restricted program.
Missouri	Missouri does not have a Statewide PDMP.
New Hampshire	The Medicaid program is prohibited by New Hampshire statute from accessing and querying 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 are considered unauthorized users since they are not directly delivering healthcare.

State	Explanation
New Mexico	Information is obtained on a case-by-case basis by a State pharmacist's personal access to confirm inappropriate behaviors.
New York	N/A
Oregon	Legislatively prohibited.
Rhode Island	State law does not permit RI Medicaid access to the PDMP.
South Carolina	PDMP access is restricted to those with a 'valid prescriber-patient or pharmacist-patient relationship.'
Texas	Texas law does not permit Texas Medicaid Program to access the PDMP portal.
Virginia	Not allowed to access by State law
Wisconsin	Wisconsin receives a monthly data file from the PDMP and we are able to query the data received in the file.
Wyoming	The Wyoming Department of Health is not allowed access by the Wyoming Board of Pharmacy due to current interpretation of the statute creating the PDMP.

If *"Yes,"* please continue.

a. Please check all applicable ways the State accesses the PDMP database.

Figure 72 - Applicable Ways the State Accesses the PDMP database

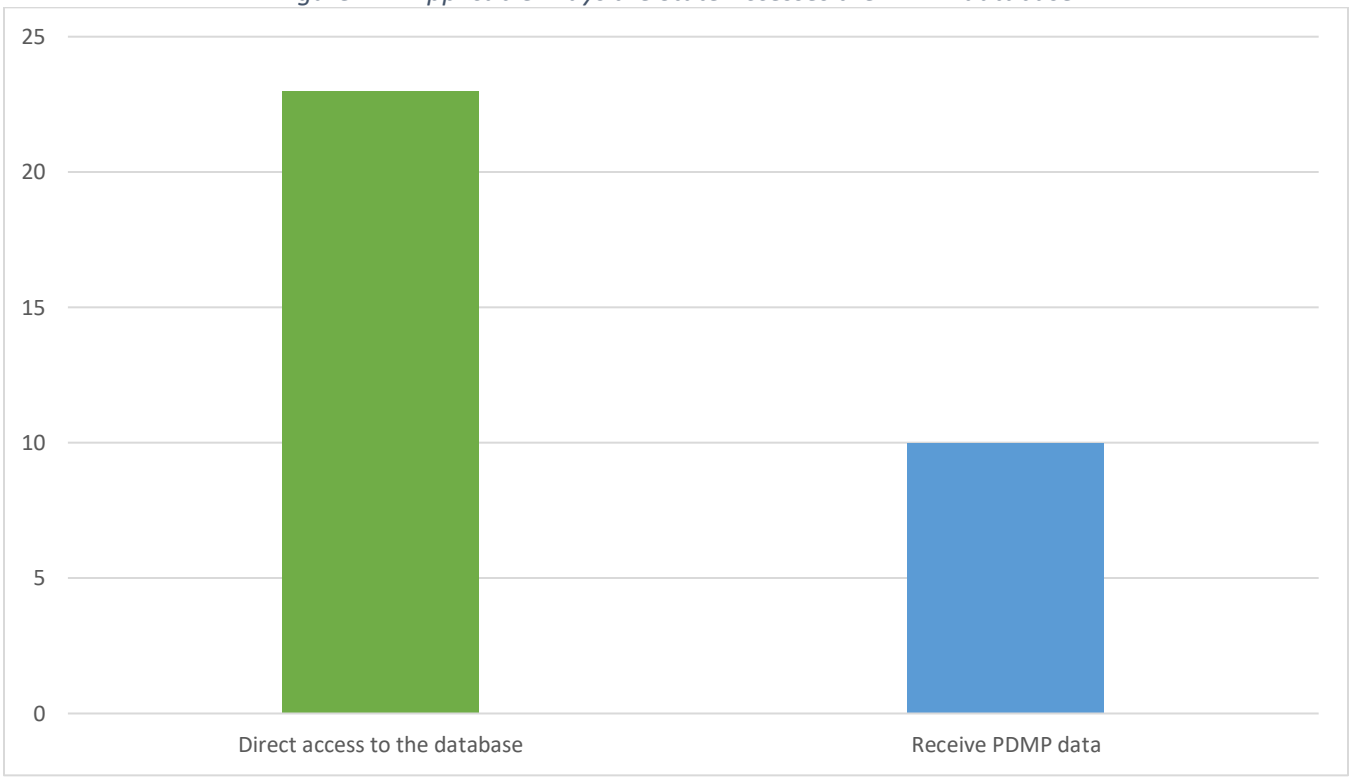

Table 105 - Applicable Ways the State Accesses the PDMP database

Response	States	Count	Percentage
Direct access to the database	Alabama, Alaska, Arkansas, Connecticut, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Pennsylvania, South Dakota, Utah, Vermont, Washington, West Virginia	23	69.70%

Response	States	Count	Percentage
Receive PDMP data	District of Columbia, Kansas, Maryland, Mississippi, North Carolina, North Dakota, Oklahoma, Tennessee, Vermont, Washington	10	30.30%
Total		33	100.00%

i. If "Receive PDMP data," please indicate how often (multiple responses allowed).

Figure 73 - Frequency of PDMP Data Received

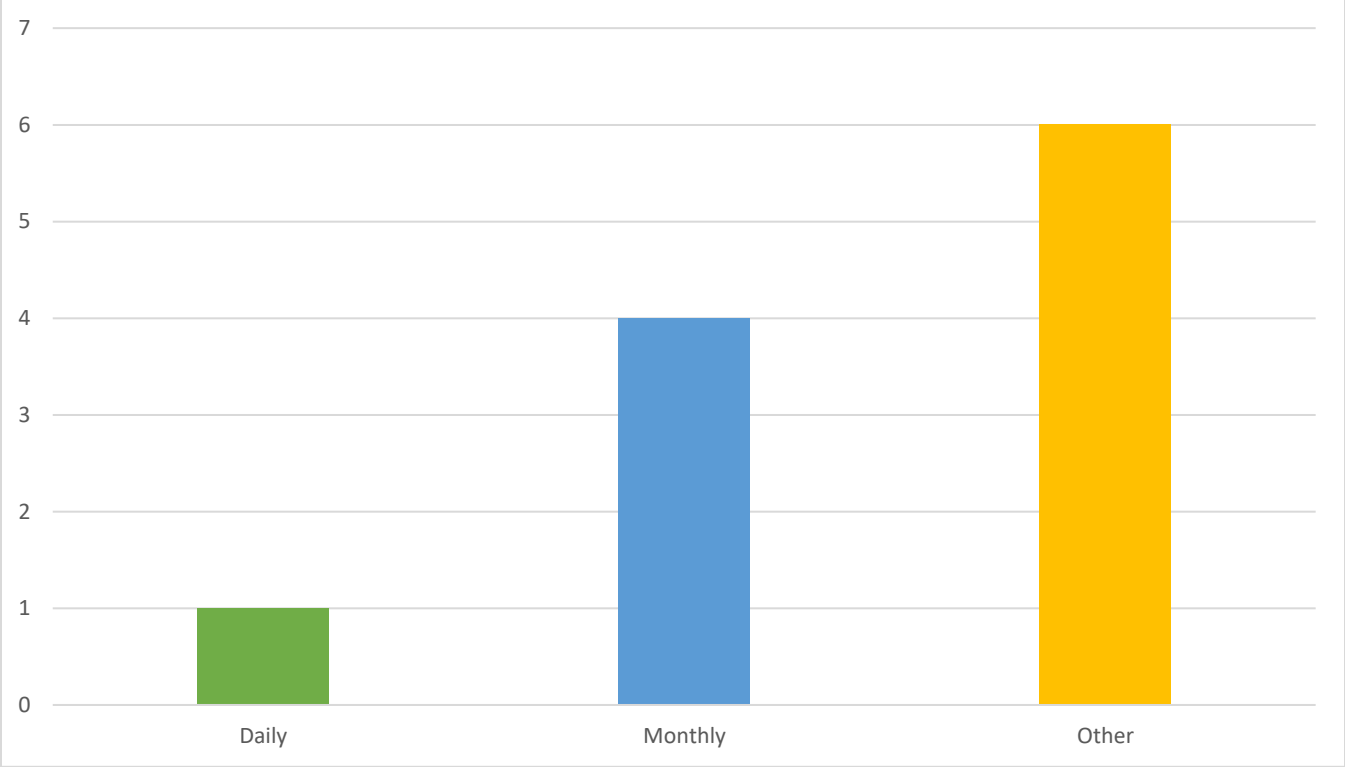

Table 106 - Frequency of PDMP Data Received

Response	States	Count	Percentage
Daily	North Dakota	1	9.09%
Monthly	Mississippi, North Dakota, Tennessee, Washington	4	36.36%
Other	District of Columbia, Kansas, Maryland, North Carolina, Oklahoma, Vermont	6	54.55%
Total		11	100.00%

If "Other," please explain.

Table 107 - "Other" Explanations of Frequency of PDMP Data Received

State	Explanation
District of Columbia	PDMP information is made available to the Medicaid agency by the Department of Health only as part of an active investigation of a Medicaid beneficiary, prescriber or dispenser on an as needed basis.
Kansas	As necessary for FWA case review.

State	Explanation
Maryland	Maryland Medicaid administrative staff cannot query the PDMP database unless the FFS program provides a bona fide formal investigation to obtain the data from the PDMP. Ad hoc requests must be approved by the Secretary of the Maryland Department of Health (MDH). Information is obtained through the MDH's PDMP.
North Carolina	Some individuals have direct access to the database, but the most common exchange of information is upon request.
Oklahoma	As needed
Vermont	Upon request from the PDMP program

ii. If "Direct access to the database," please specify (multiple responses allowed).

Figure 74 - State's Direct Access to the PDMP Database

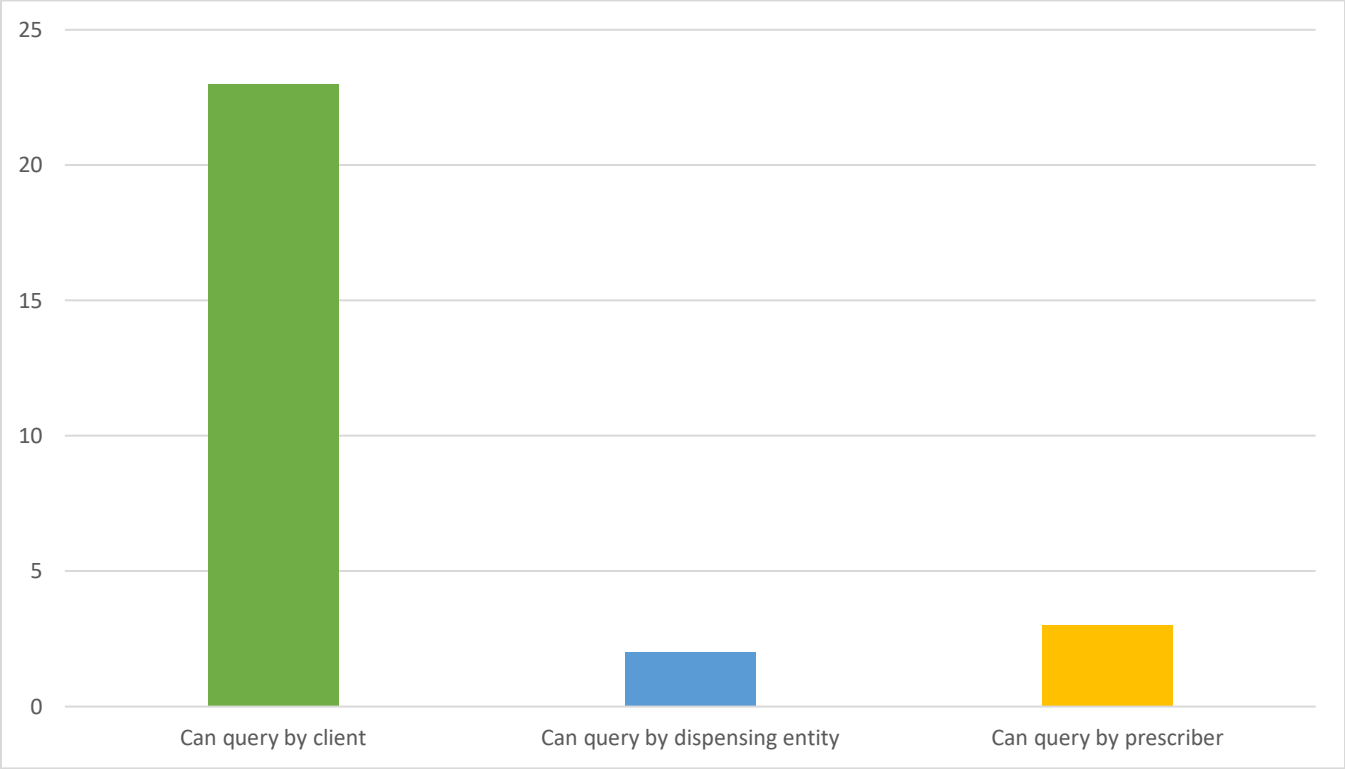

Table 108 - State's Direct Access to the PDMP Database

Response	States	Count	Percentage
Can query by client	Alabama, Alaska, Arkansas, Connecticut, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Pennsylvania, South Dakota, Utah, Vermont, Washington, West Virginia	23	82.14%
Can query by dispensing entity	Nebraska, North Carolina	2	7.14%
Can query by prescriber	Idaho, Nebraska, North Carolina	3	10.71%
Total		28	100.00%

b. If "Yes," please explain how the State applies this information to control FWA of controlled substances.

Table 109 - Explanation for How State Applies Information to Control FWA of Controlled Substances

State	Explanation
Alabama	Used in conjunction with Lock-in reviews.
Alaska	PDMP is utilized during prior authorization reviews and case reviews for suspected fraud or abuse.
Arkansas	The RDUR Medicaid program is responsible for monitoring the lock-in program. When reviewing potential lock-in beneficaries, the PDMP is used to ascertain that controlled substances were used by the beneficiary in addition to what has been billed and found on the beneficiary'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. Some Board approved criteria require a full review of controlled substances used, and the PDMP is useful in this situation. 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. In cases where FWA is suspected the QA department can query the database and open cases for investigations.
District of Columbia	The Director of the Department of Health may disclose to designated employees of the Department of Health Care Finance, or to the Medicaid Fraud Control Unit of the Office of the Inspector General, as appropriate, the following: (a) Information relevant to an investigation relating to a specific dispenser or prescriber who is a participating provider in the District Medicaid program, DC Health Care Alliance, or any other public health care program; (b) Information relating to an investigation concerning a specific patient who is currently eligible for and receiving, or who has been eligible for and has received, medical assistance services; or (c) Other information relevant to the Medicaid Fraud Control Unit of the Office of the Inspector General related to a specific prescriber, dispenser, or patient
Georgia	Assessment for Lock-In Program
Idaho	As part of the prior authorization process for opioids, the evaluating pharmacist may access the PDMP to review claims (allows access to claims that may not have been covered under Medicaid - before eligible or fully covered by a primary insurance).
Illinois	Recipient Analysis Unit staff use the PDMP as a reference only during their review of the participant. 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 regarding controlled substances and naloxone administration.
Kansas	The State Fiscal Agent SURS team has this access and reviews preliminary information and requests additional information as needed when reviewing for potential FWA cases. For the FFY 2022, query by prescriber and pharmacy was allowed by statute, but the State did not utilize this access as it was still to be further developed for easy access. For the current FFY, access to prescriber and dispensing entity is allowed and those listings will be checked in the next DUR survey.

State	Explanation
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.
Maryland	Based on information found in the automated retrospective DUR process, in cases where FWA is suspected, the PDMP data is obtained based on bona fide formal investigation request as mentioned above and once analyzed, and compiled with other necessary info. /Data, if it is deemed appropriate and necessary, it is brought to the Corrective Managed Care Committee for lock-in consideration.
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 cast-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. This may result in the State contacting the provider and/or locking the member into one pharmacy and one provider.
Nebraska	Assessment for lock-in program.
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 data is available. Additionally, the PDMP staff and tool resides under the direction of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. They have reporting metrics to identify outliers in the data and will report providers of concern to their respective licensing agency. They also have the ability to make referrals to regulatory agencies such as the OIG and Medicaid Investigations Unit.
North Dakota	A query is run on members that request early fill and therapeutic duplication overrides before the override is authorized. These members may also be referred to program integrity (PI) or lock-in program based on findings in the PDMP query.
Ohio	Used for data mining projects with SURS.
Oklahoma	The information is applied to substantiate rather than identify concerns due to limited access.
Pennsylvania	State Medicaid Program Clinicians can query the PDMP if necessary during the prior authorization process for controlled substances.
South Dakota	On a case by case basis when FWA is suspected or has been reported.
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 program uses the PDMP to review controlled substance use in individuals who are under prior authorization review for an opioid.
Vermont	The Vermont Prescription Monitoring System Rule allows the Medical Director of the Department of Vermont Health Access to query the system directly relating to a Medicaid

State	Explanation
	recipient for whom a claim for a Schedule II, III, or IV was submitted. This access is for Medicaid quality assurance, utilization, and federal monitoring purposes
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 pharmacist 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.

c. If "Yes," does your State also have access to contiguous States' PDMP information?

Figure 75 - Access to Contiguous State PDMP Information

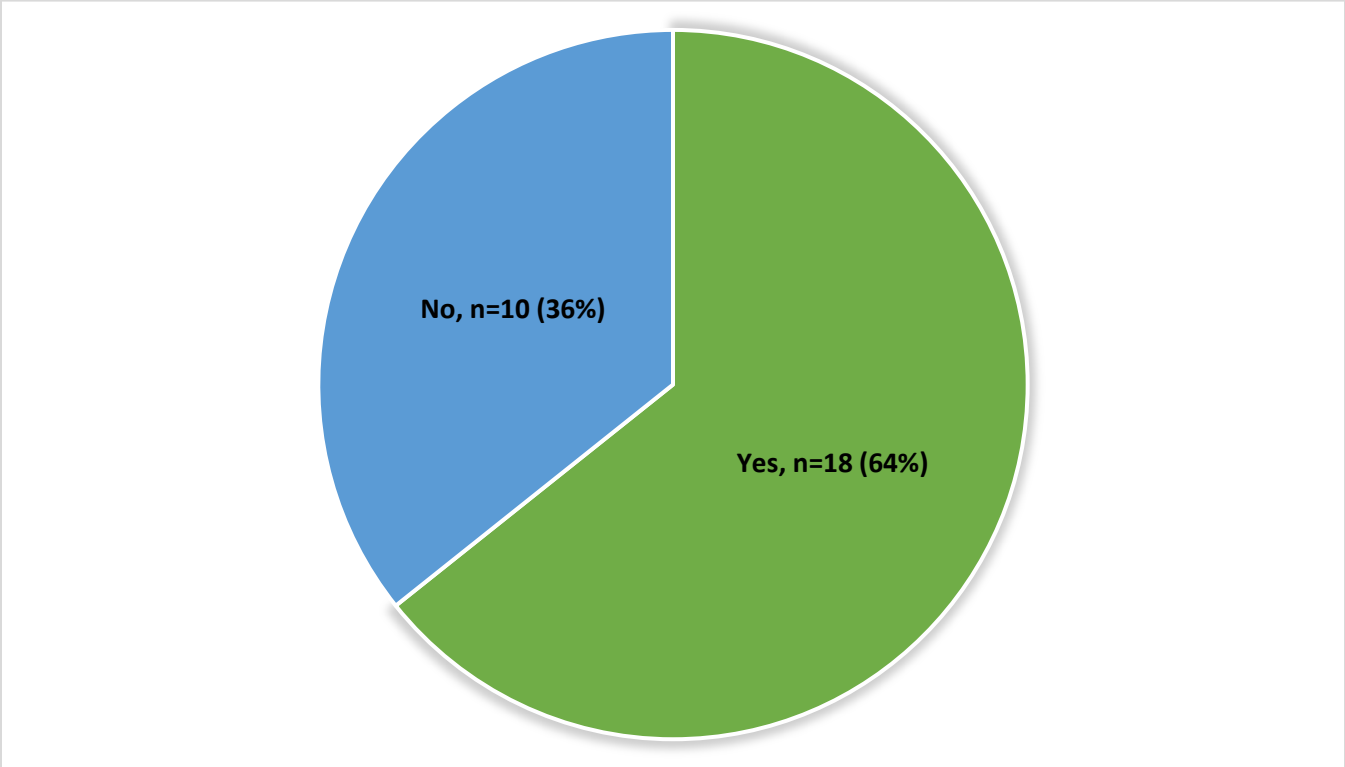

Table 110 - Access to Contiguous State PDMP Information

Response	States	Count	Percentage
Yes	Alaska, Connecticut, District of Columbia, Idaho, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Utah, Vermont	18	64.29%

Response	States	Count	Percentage
No	Alabama, Arkansas, Georgia, Louisiana, Nevada, North Carolina, Pennsylvania, Tennessee, Washington, West Virginia	10	35.71%
Total		28	100.00%

d. If "Yes," does your State also have PDMP data integrated into your point of sale (POS) edits?

Figure 76 - PDMP Data Integration into POS Edits

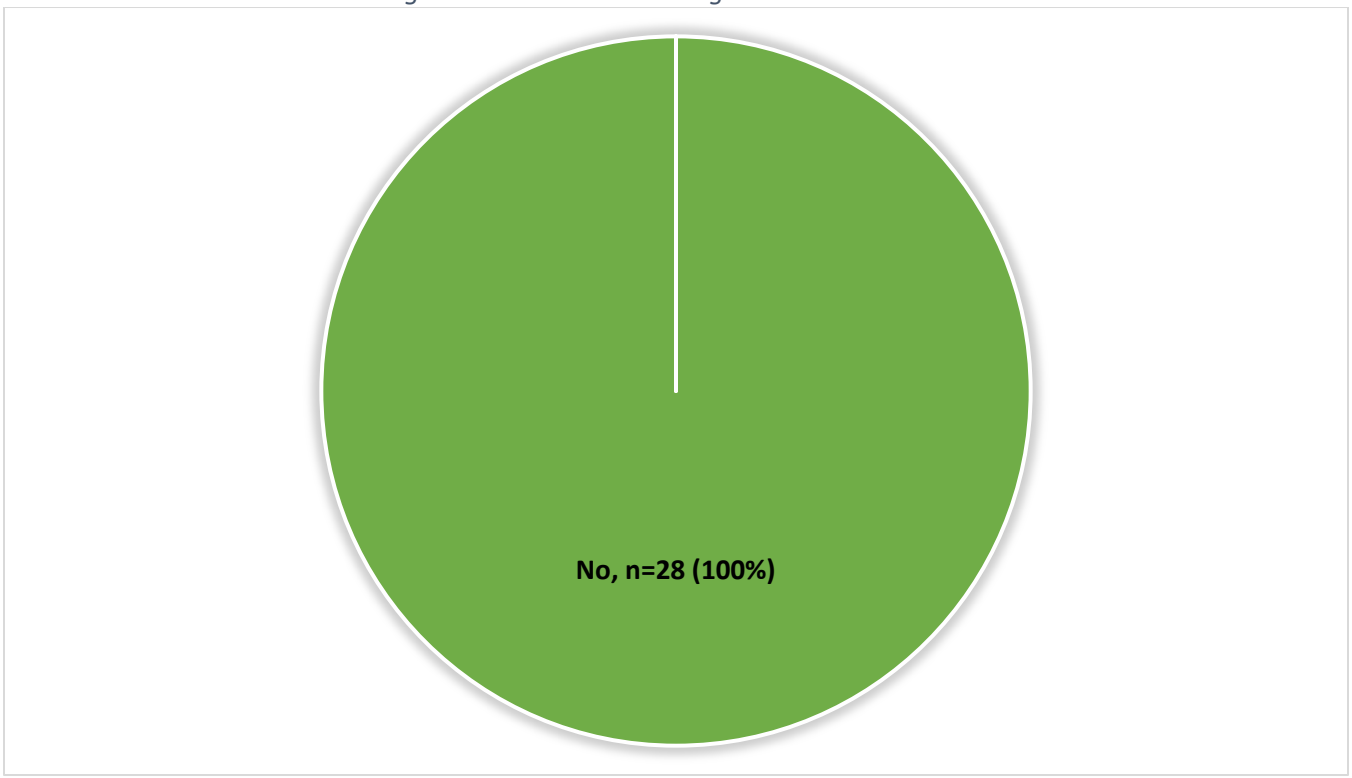

Table 111 - PDMP Data Integration into POS Edits

Response	States	Count	Percentage
No	Alabama, Alaska, Arkansas, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia	28	100.00%
Total		28	100.00%

2. Have you communicated to prescribers who are covered providers that as of October 1, 2021, they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals?

Figure 77 - Communicated Prescribers' Requirement to Check the PDMP Before Prescribing Controlled Substances

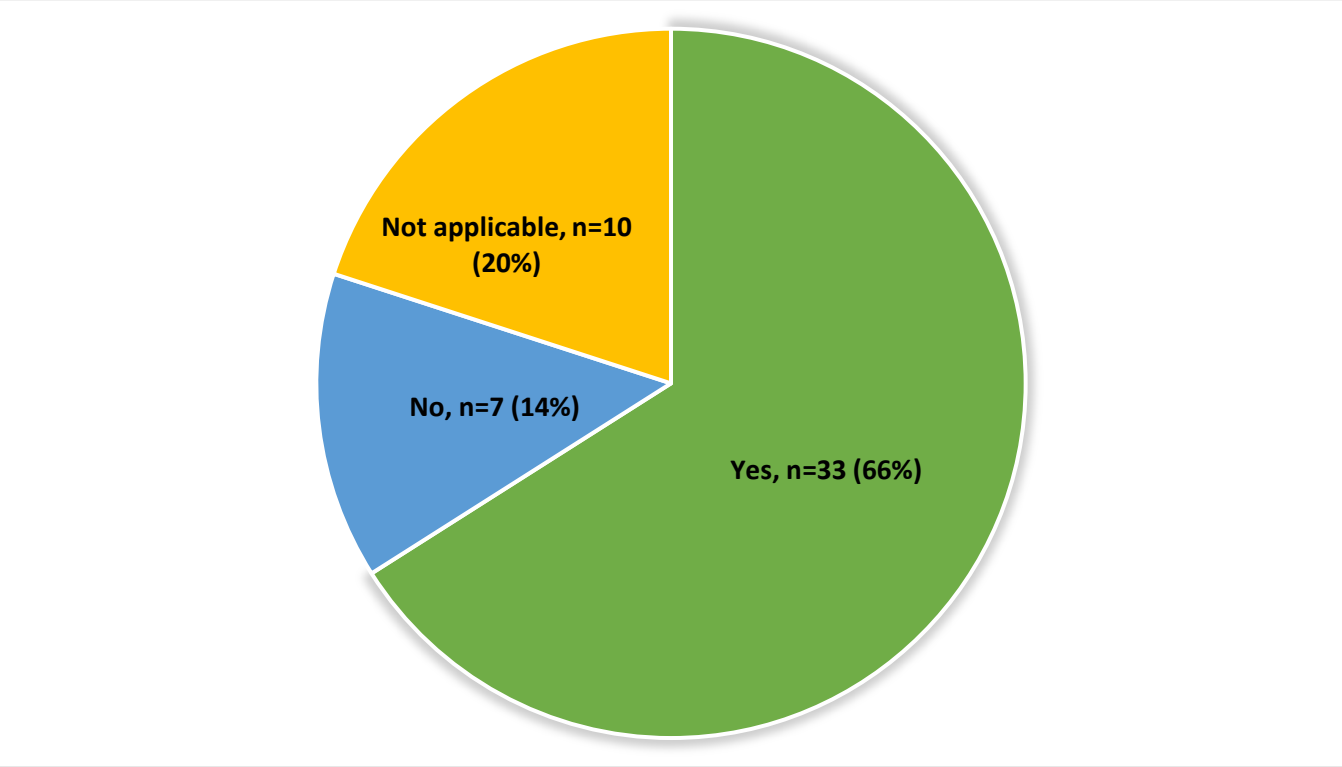

Table 112 - Communicated Prescribers' Requirement to Check the PDMP Before Prescribing Controlled Substances

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Virginia, Washington, Wyoming	33	66.00%
No	Georgia, Illinois, Nevada, New Jersey, New Mexico, Rhode Island, Texas	7	14.00%
Not applicable	Hawaii, Indiana, Louisiana, Maryland, New York, Pennsylvania, Tennessee, Vermont, West Virginia, Wisconsin	10	20.00%
Total		50	100.00%

If "Yes," check all that apply.

Figure 78 - Ways State Has Communicated Requirement

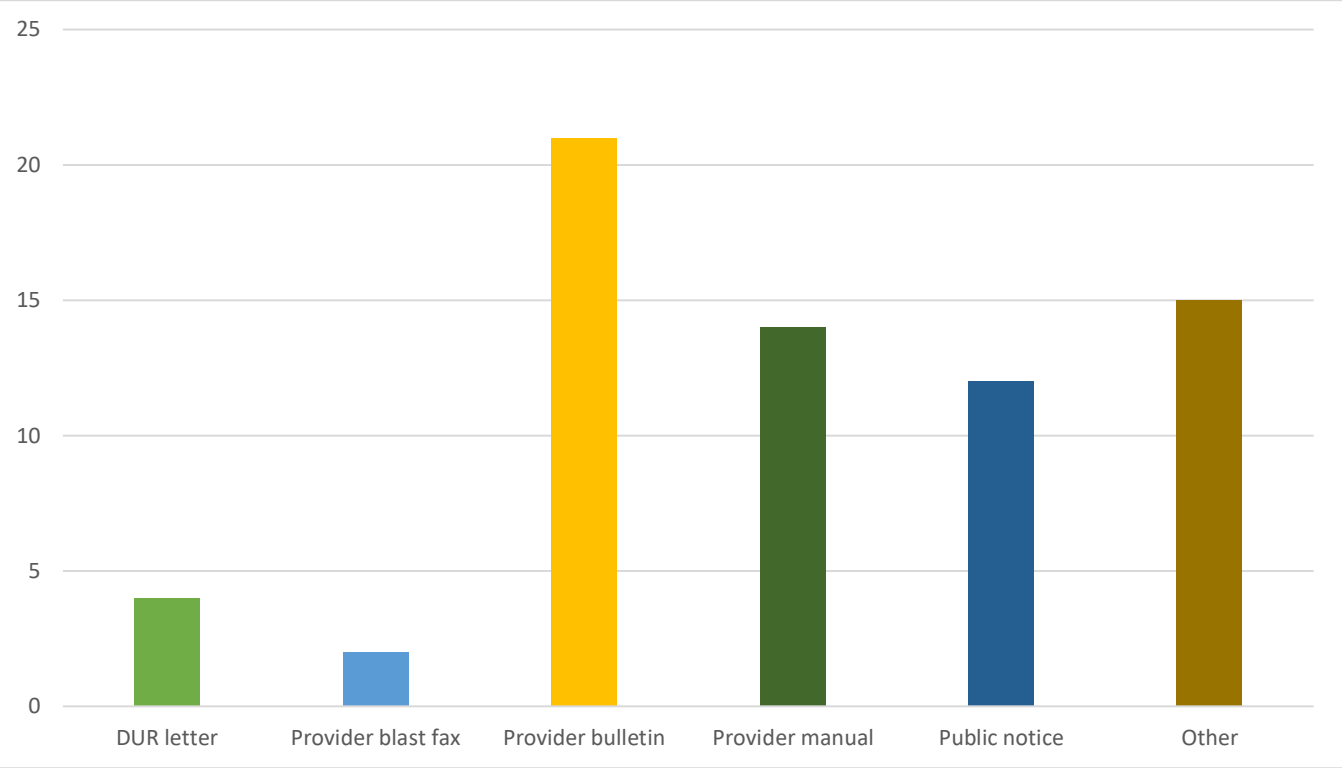

Table 113 - Ways State Has Communicated Requirement

Response	States	Count	Percentage
DUR letter	Arkansas, Connecticut, Oregon, Wyoming	4	5.88%
Provider blast fax	Kentucky, Washington	2	2.94%
Provider bulletin	Alabama, California, Connecticut, District of Columbia, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Washington	21	30.88%
Provider manual	Alabama, Colorado, Delaware, District of Columbia, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, South Carolina, South Dakota, Virginia, Washington	14	20.59%
Public notice	Alaska, California, Colorado, Florida, Iowa, Massachusetts, New Hampshire, North Carolina, South Carolina, Utah, Virginia, Washington	12	17.65%
Other	Alaska, California, Connecticut, District of Columbia, Idaho, Iowa, Michigan, Nebraska, New Hampshire, North Carolina, Ohio, Oregon, South Carolina, Washington, Wyoming	15	22.06%
Total		68	100.00%

If "Other," please explain.

Table 114 - "Other" Explanations for Ways State Has Communicated Requirement

State	Explanation
Alaska	RA messaging
California	Per State law, this has been a requirement in California since October 2, 2018. All communications, including a provider bulletin and public notice, took place prior to the law becoming effective in 2018.
Connecticut	It is required by State law that providers check the PDMP prior to prescribing more than a 72 hour supply of a controlled substance.
District of Columbia	Pharmacy Provider Forum announcements
Idaho	Notification from Board of Pharmacy (Idaho Code 37-2722(f) effective October 1, 2020)
Iowa	Administrative rule change
Michigan	Pharmacy Provider liaison meeting discussion and Web Announcement via designated Fee-For-Service pharmacy website.
Nebraska	Provider webex sessions and notices in provider association newsletters.
New Hampshire	The New Hampshire Office of Professional Licensure and Certification (OPLC) Board of Medicine website contains a link for tools and resources for opioid prescribing. This website details the requirements for prescriber reviews of the PDMP prior to prescribing all opioids for the treatment of pain within the Checklist for the Prescribing of Opioids for the Management or Treatment of Pain. The website also contains the direct link to the NH PDMP for ease of access. Additionally, the prior authorization criteria for Methadone, Morphine Milligram Equivalent (>100 MME), Short-Acting Fentanyl, and Long-Acting Opioid Analgesic contain the additional attestation requirement that the PDMP has been reviewed by the prescriber.
North Carolina	This information was included in the NC Medicaid Pharmacy Bulletin, on the Provider Portal and posted for public comment..
Ohio	See Ohio Administrative Code 4731-11-11: Standards and procedures for review of "Ohio Automated Rx Reporting System" (OARRS).
Oregon	OAR 410-120-1260 (13) requires enrolled providers to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A,655 before prescribing a schedule II-controlled substance pursuant to 42 U.S.C 1396w-3a.
South Carolina	The Medical University of South Carolina (RetroDUR contractor) has also provided provider training and handouts 'PDMP Reports Quick Tips and Tricks' d/on how to access/utilize the PDMP as part of their provider outreach, additional information is also provided at http://southcarolina.pmpaware.net
Washington	This information is included on our website and WAC 182-530-1080.
Wyoming	Prior authorization forms for opioids ask if the prescriber has checked the PDMP. If the prescriber checks "no" or leaves this line blank, a follow up DUR letter is sent notifying them of the requirement.

If "Not applicable," please explain.

Table 115 - "Not Applicable" Explanations for Communicating Prescribers' Requirement to Check the PDMP Before Prescribing Controlled Substances

State	Explanation
Hawaii	State law has required this prior to October 1, 2021. It has been communicated to all prescribers to check the PDMP before prescribing controlled substances to any individual, not only covered individuals.

State	Explanation
Indiana	Prescribers have received communications via their medical licensing boards on their specific requirements.
Louisiana	Under Act 76 (LA SB55) of the 2017 Legislative Session, 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.
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 in certain clinical situations. Exceptions can be found here: https://health.maryland.gov/pdmp/Pages/pdmp-use-mandate-information.aspx
New York	Practitioners are required to check the PDMP database prior to prescribing any controlled substance listed on schedule II, III or IV. Communication to prescribers is done by the New York State Department of Health Bureau of Narcotic Enforcement. https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/
Pennsylvania	Pennsylvania State law already required prescribers to check the PDMP prior to prescribing controlled substances to all Pennsylvania citizens.
Tennessee	Providers agree to operate within the scope of their license and abide by State and federal laws.
Vermont	The Vermont Department of Health has done extensive provider outreach and communication in conjunction with the implementation of the VPMS rule (implemented in 2017) and the Opioid prescribing rule. These Vermont rules outline the requirements for querying the PDMP.
West Virginia	This is already required by State statute.
Wisconsin	In Wisconsin, State law requires prescribers to check the PDMP before prescribing controlled substances.

If “No,” please explain.

Table 116 - Explanations for not Communicating Prescribers’ Requirement to Check the PDMP Before Prescribing Controlled Substances

State	Explanation
Georgia	Medicaid has not required the prescribers to check, but the State of Georgia has.
Illinois	Public Act 100-0564 amended the Illinois Controlled Substances Act to mandate that effective January 1, 2018 all prescribers with a State of Illinois issued controlled substance license must register with the ILPMP regardless of practice type. It is mandatory to search the PMP upon prescribing schedule 2 narcotics. 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. The attempt to access must be documented in the patient's medical record.

State	Explanation
	HFS requires prescribers to comply with the laws of the State of Illinois and applicable federal law.
Nevada	Nevada implemented legislation requiring prescribers to check the State's Prescription Drug Monitoring Program (PDMP) database before prescribing controlled substances. No specific communication to Nevada Medicaid prescribers has been issued.
New Jersey	Providers are required to comply with all State and federal laws which in the State of New Jersey includes the checking of the PDMP before prescribing of controlled substances.
New Mexico	Communication for checking the PDMP before prescribing controlled substances was communicated by the State Medical Board and the State Board of Pharmacy.
Rhode Island	State law requires it.
Texas	The Agency did not send notification to the prescribers. The State Board of Pharmacy oversaw managing the regulation and published information regarding PDMP.

a. Has the State specified protocols for prescribers checking the PDMP?

Figure 79 - Protocols Involved Checking the PDMP

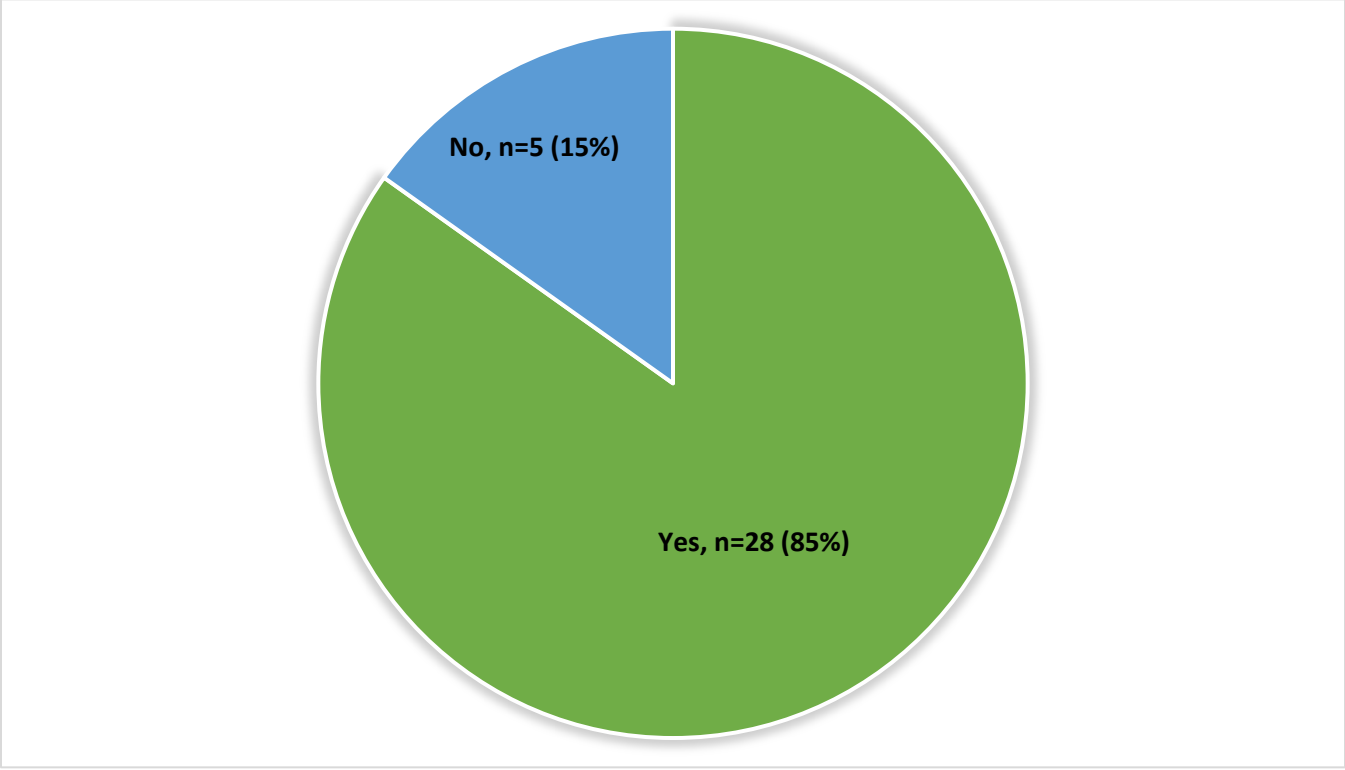

Table 117 - Protocols Involved Checking the PDMP

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Virginia, Washington, Wyoming	28	84.85%
No	District of Columbia, Minnesota, Mississippi, Montana, North Dakota	5	15.15%
Total		33	100.00%

If "Yes," please explain.

Table 118 - Explanations of Protocols Involved in Checking the PDMP

State	Explanation
Alabama	Prescribers of Medicaid eligible recipients are required to check the Alabama PDMP prior to prescribing a Schedule II controlled substance. If the prescriber does not check the PDMP, the prescriber is required to document the reason in the medical record. Exclusions to this requirement include prescriptions written for hospice patients, patients with an active cancer diagnosis, residents of a long-term care nursing facility, and children under the age of 18 (Schedule II prescriptions for ADHD only).
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. These protocols are governed by the individual provider licensing boards and not by Medicaid.
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: o Licensed Clinic, or o Outpatient Setting, or o Health Facility, or o 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: o Licensed Clinic, or o Outpatient Setting, or o Health Facility, or o County Medical Facility, or o Place of Practice (defined as a Dental Office pursuant to Business and Professions Code 1658) 4. The patient is receiving hospice care.

State	Explanation
Colorado	Colorado law requires that prescribers query the PDMP prior to prescribing any opioid or benzodiazepine prescription unless the patient receiving the prescription meets specific exceptions to this requirement as defined in statute (Colorado Revised Statutes Title 12 Professions and Occupations). Department policy States that Colorado Medicaid providers permitted to prescribe controlled substances must query the Colorado Drug Monitoring Program (PDMP) before prescribing controlled substances to Medicaid members, in accordance with Section 5042 of the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and the Communities Act (SUPPORT Act)"; and the requirement to check the PDMP does not apply when a member: Is receiving the controlled substance in a hospital, skilled nursing facility, residential facility, or correctional facility Has been diagnosed with cancer and is experiencing cancer-related pain Is undergoing palliative care or hospice care Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days Is receiving treatment during a natural disaster or during an incident where mass casualties have taken place Has received only a single dose to relieve pain for a single test or procedure
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	Per Delaware's Medicaid provider manual 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 surrounding States, New Jersey, Pennsylvania and Maryland. For medications that are DEA Schedule III to V, the PMP website should be queried at least every six months. For Schedule II medications that are prescribed for chronic conditions, the PMP website should be queried every 3 months. DMAP requires

State	Explanation
	providers to document in the patient record all controlled substances that have been prescribed and filed inside and outside of the provider's practice. Providers must document all actions taken in collaboration 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.
Idaho	Prior to issuing a patient a prescription for outpatient use for an opioid analgesic or benzodiazepine listed in schedule II, III, or IV, the prescriber or the prescriber's delegate shall review the patient's prescription drug history from the preceding twelve (12) months from the prescription drug monitoring program and evaluate the data for indicators of prescription drug diversion or misuse. Exceptions The review is not required: (1) For patients: (i) Receiving treatment in an inpatient setting: (ii) At the scene of an emergency or in an ambulance: (iii) In hospice care: or (iv) In a skilled nursing home care facility: or (2) For a prescription in a quantity intended to last no more than three (3) days.
Iowa	Recommended prescribers follow licensing board requirements and rules. 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. Effective October 2021 Medicaid promulgated Rules requiring those who participate in Medicaid to query qualified PMP before prescribing controlled substances to most Medicaid beneficiaries consistent with Section 5042 of the SUPPORT Act.
Kansas	We require checking our PDMP for patients above 13 years of age, unless the patient is excluded for other reasons listed later in this section. We determine the frequency of PDMP check based upon if the prescription is new or a renewed Rx and whether it is a new or current patient. We exclude patients with cancer or sickle cell diagnosis, those who receive hospice or palliative care, and those residing in an assisted or custodial care environment. We require notation in the medical chart when the PDMP is down or when the provider's electronic system is down, which prevents the provider from checking the PDMP in a timely manner. Additionally, if there is a natural disaster or emergency service that is declared by the State department of health and environment, this requirement would be temporarily waived.
Kentucky	Kentucky statute and regulation describe frequency and method of querying, and ultimately prescribing controlled substances.
Maine	1. Prescribers must perform a thorough history and physical examination, including an opioid therapy risk assessment, at the initial visit for pain management 2. Prescribers must review the Prescription Monitoring Program database as medically indicated and required by 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid

State	Explanation
	Medications, to verify that no concomitant narcotic use by the member is occurring, and the reviews must be evidenced in the medical documentation
Massachusetts	The State requires provider to check the PDMP before each prescription of a controlled substance. https://www.mass.gov/doc/policy-15-05-prescribing-practices-policy-and-guidelines-amended-january-14-2021/download
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.
Missouri	In the provider bulletin, prescribers are provided a link to the PDMP Registration tutorial.
Nebraska	PDMP Check Requirements- Nebraska Medicaid providers are required to check the prescription drug history in the Statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries. (Exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request. PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C.1396w-3a], beginning October 1, 2021.
New Hampshire	New Hampshire law requires all prescribers and dispensers who are authorized to prescribe or dispense schedule II-IV controlled substances within NH to be registered with the PDMP. Every dispenser is required to submit information to the PDMP regarding each prescription dispensed for a schedule II-IV controlled substance per NH law.
North Carolina	The NC Stop Act is a legislative mandate that sets the requirements for checking the PDMP for both prescribers and pharmacies.
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 PDMP 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 PDMP are recommended.
Oregon	Provider guide best practices Statement encourages clinicians to review the patient's history of controlled substance prescriptions using the PDMP before prescribing when starting, and periodically during, therapy for all controlled substances.
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

State	Explanation
	requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide patient 2. an individual who requests the individuals 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
South Dakota	The Board of Medicine requires through State administrative rule that prescribers access the PDMP or document why access was not completed.
Utah	Starting October 1, 2021 Medicaid providers must check each patient's fill history for any controlled substance through the Utah Department of Commerce Controlled Substance Database before prescribing any new controlled substances. If the provider is unable to access the patient's-controlled substance fill history they must document a reason as to why they were unable to meet this requirement. Providers must be able to provide this information to the State upon request.
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	HCA requires prescribers to query the PMP no more than ten days prior to prescribing a controlled substance.
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. If "Yes," do providers have protocols for responses to information from the PDMP that are contradictory to information that the practitioner expects to receive, based on information from the client (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?

Figure 80 - Providers Have Protocols for Responses to Information from the PDMP that Contradicts Information the Practitioner Expects to Receive

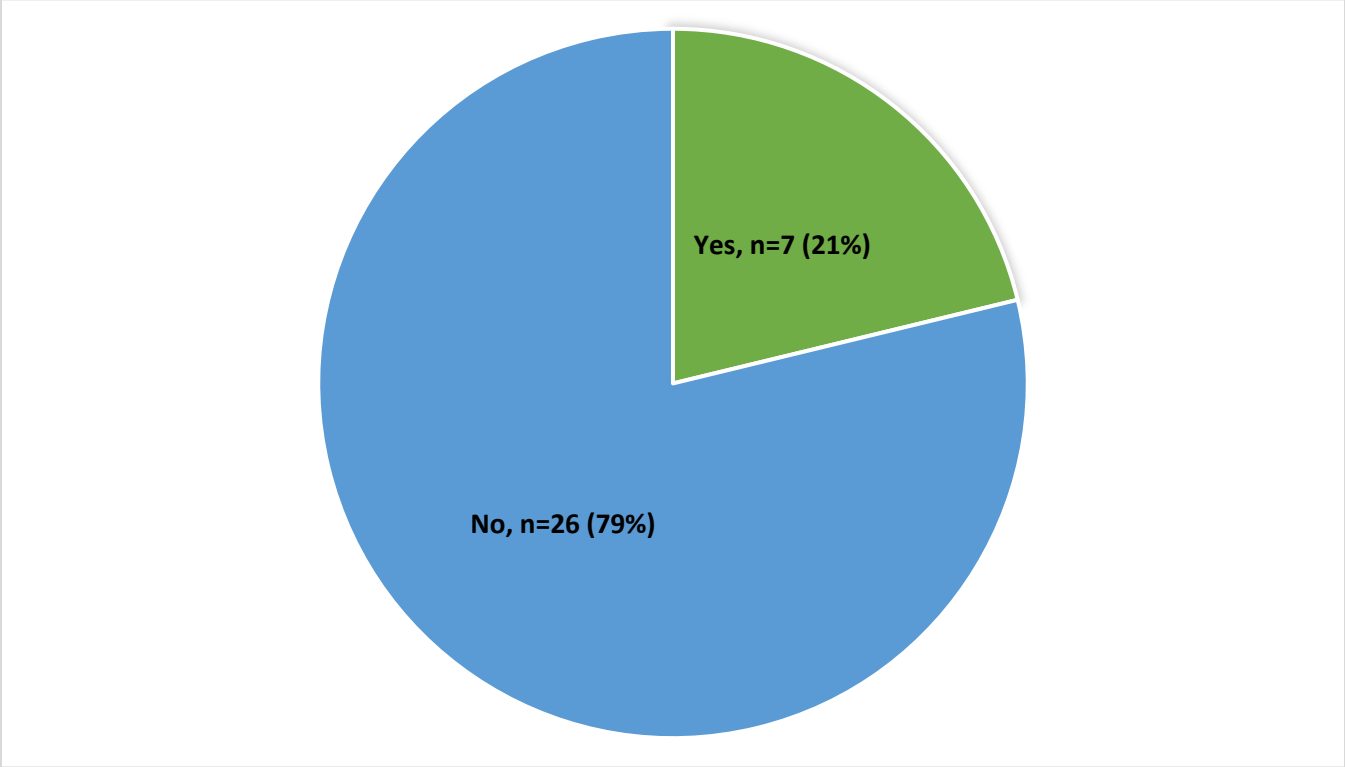

Table 119 - Providers Have Protocols for Responses to Information from the PDMP that Contradicts Information the Practitioner Expects to Receive

Response	States	Count	Percentage
Yes	Kentucky, Maine, Michigan, Missouri, Oregon, South Carolina, Virginia	7	21.21%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Iowa, Kansas, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Utah, Washington, Wyoming	26	78.79%
Total		33	100.00%

c. If "Yes," if a provider is not able to conduct PDMP checks, 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 81 - State Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

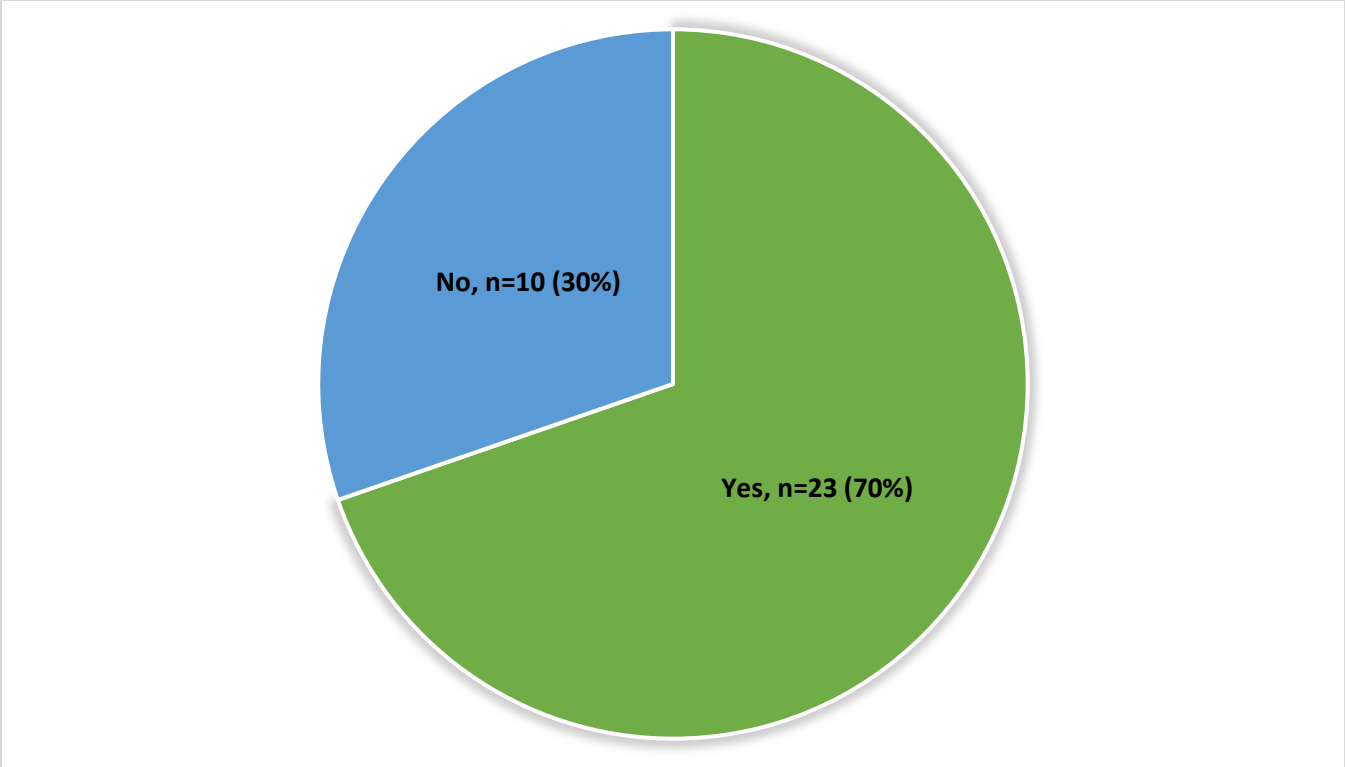

Table 120 - State Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Iowa, Kansas, Kentucky, Maine, Michigan, Missouri, Montana, Nebraska, New Hampshire, Ohio, Oregon, South Carolina, South Dakota, Utah, Washington	23	69.70%
No	California, Idaho, Massachusetts, Minnesota, Mississippi, North Carolina, North Dakota, Oklahoma, Virginia, Wyoming	10	30.30%
Total		33	100.00%

If "No," please explain why not.

Table 121 - Explanations for not Requiring Prescribers to Document a Good Faith Effort

State	Explanation
California	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
Idaho	This was not an exception not included in Idaho Code 37-2722(f). Exceptions listed above in response to 2a.
Massachusetts	Not currently in State law or regulation.

State	Explanation
Minnesota	This is not a requirement.
Mississippi	The State Board of Medical Licensure is responsible for establishing and enforcing PDMP requirements for prescribers.
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 as a condition of issuing PA approval. (https://northcarolina.pmpaware.net/login).
North Dakota	The requirement is for the provider to check the PDMP - there is no option to not check the PDMP.
Oklahoma	In instances that a provider is not able to conduct a PDMP 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 PDMP check is one step in a multilevel prescribing guideline that is not intended to replace clinical judgment in the appropriate care of patients.
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.
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 82 - State Requires Provider, on Request, to Submit Documentation

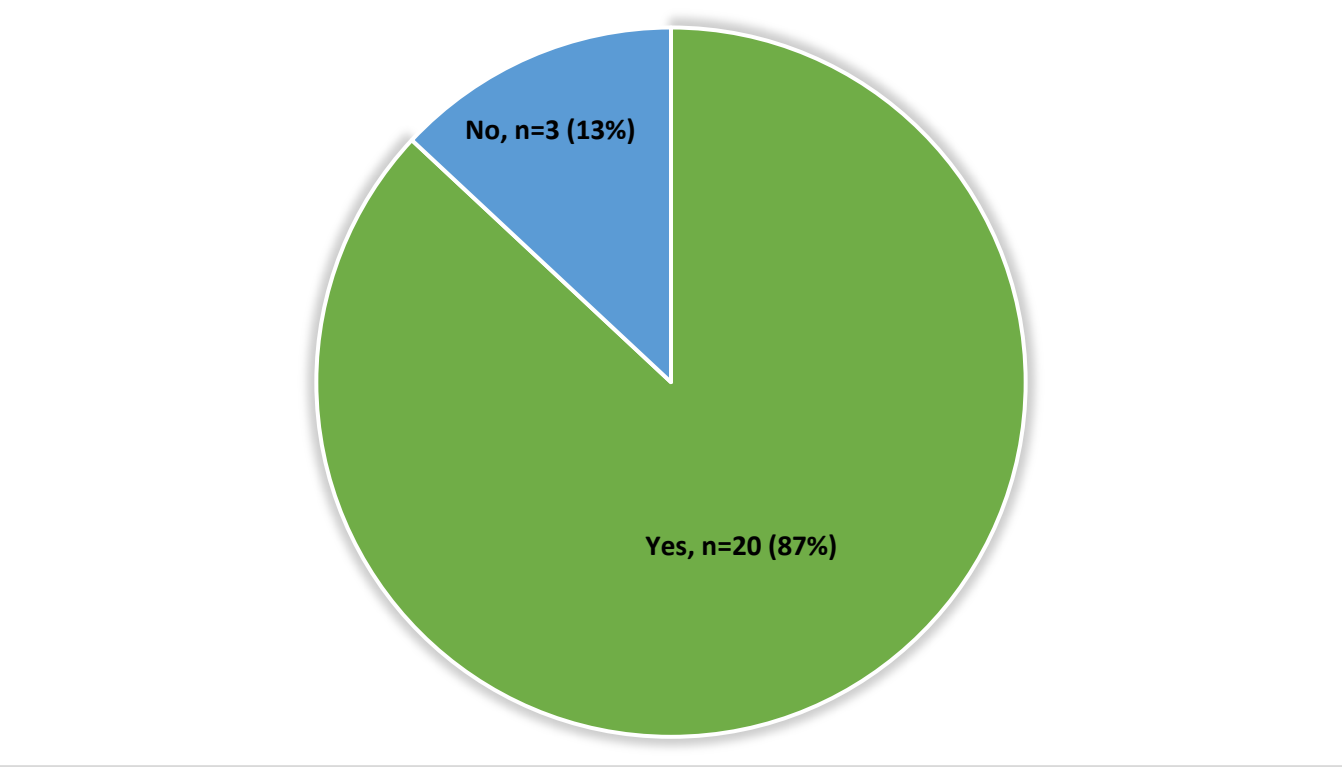

Table 122 - State Requires Provider, on Request, to Submit Documentation

Response	States	Count	Percentage
Yes	Alabama, Alaska, Colorado, Connecticut, District of Columbia, Iowa, Kansas, Kentucky, Maine, Michigan, Missouri, Montana, Nebraska, New Hampshire, Ohio, Oregon, South Carolina, South Dakota, Utah, Washington	20	86.96%
No	Arkansas, Delaware, Florida	3	13.04%
Total		23	100.00%

If "No," please explain.

Table 123 - Explanations for not Requiring Provider to Submit Documentation

State	Explanation
Arkansas	This documentation is not required by the Medicaid program. Per Arkansas Medical Practices Act and Regulations as ordered by Act 820 of 2017, a healthcare provider must document in the patient record that the PDMP was checked. A healthcare provider who purposely fails to access the PDMP is subject to disciplinary action by the Arkansas State Medical Board. Similar requirements are noted by the nursing board.
Delaware	As the Medicaid program does not have access to the PDMP, nothing can be verified and Medicaid 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 a patient.

3. In the State's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible (multiple responses allowed)?

Figure 83 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

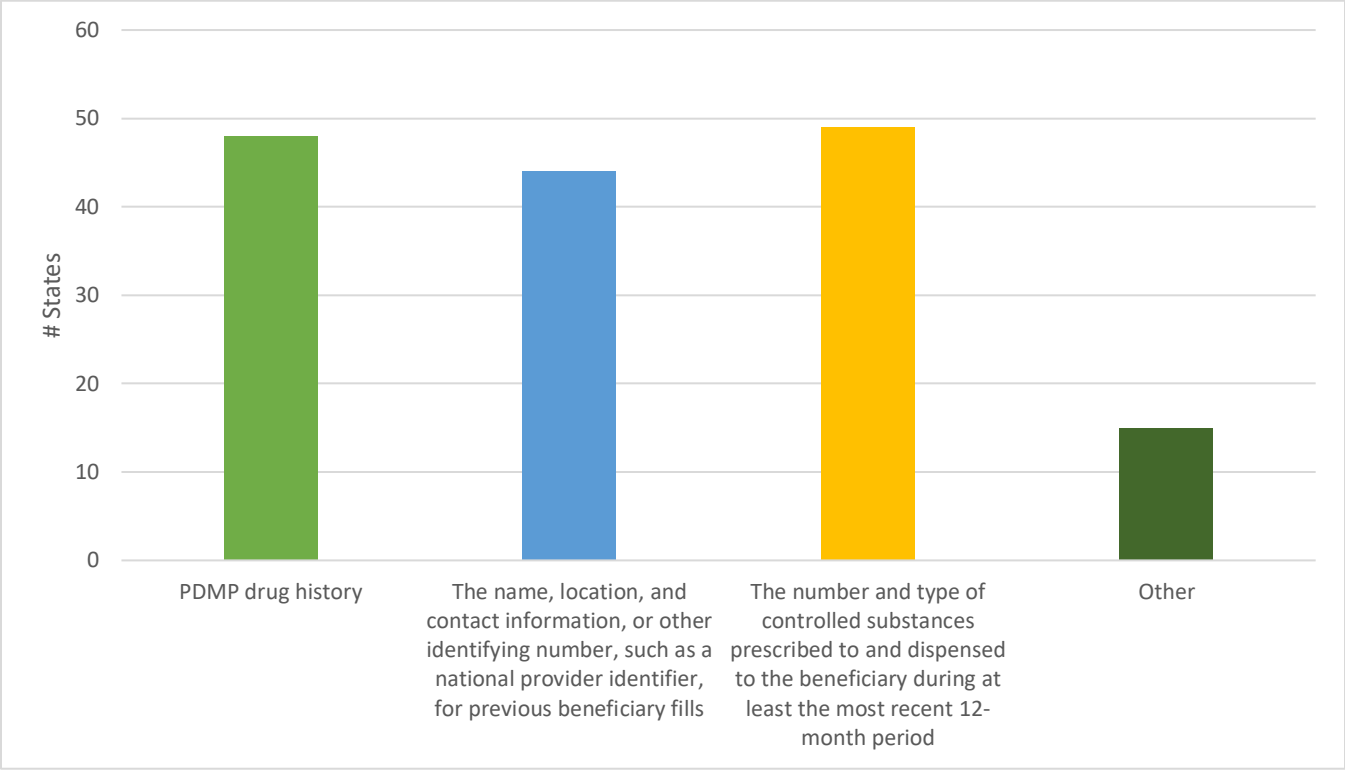

Table 124 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

Response	States	Count	Percentage
PDMP drug history	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, 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, Wyoming	48	30.77%
The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills	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, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	44	28.21%
The number and type of controlled substances prescribed to and	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas,	49	31.41%

Response	States	Count	Percentage
dispensed to the beneficiary during at least the most recent 12-month period	Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, 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		
Other	Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Kansas, Maine, Massachusetts, Minnesota, Missouri, Tennessee, Utah, Washington	15	9.62%
Total		156	100.00%

If "Other," please explain.

Table 125 - "Other" Explanations for Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

State	Explanation
Colorado	Beneficiary's current calculated daily or average MME Description of payment method used for controlled substance prescriptions dispensed to the beneficiary
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.
Delaware	Narx scores for narcotics, sedative and stimulants: overdose risk score: average daily MME and payment type.
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/day.
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, naloxone and Suboxone fills, medical marijuana card. Prescribers also have section MyPMP where can create and monitor designees and see list of their patients for whom controlled substances have been prescribed.
Indiana	Beginning in 2021, patient INSPECT reports also contained Narx Score. Each patient is assigned an overdose score (from 000-999) that indicates how likely they are to experience an overdose, based on the information in their PDMP report. Explanations and guidance on this score are provided to practitioners. The score may change periodically based on new information in the patient's report.
Kansas	Both the Prescriber and the Pharmacy Name and Payor.
Maine	PMP provides a alerts based on co-occuring, prescriber/dipenser 5x5, over 100MME
Massachusetts	Payment type, current total MME, 30 day average MME, buprenorphine claims are also available fields.
Minnesota	Minnesota also collects information on gabapentin and all formulations of butalbital.

State	Explanation
Missouri	Missouri does not have a Statewide 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) Unique in Tennessee: FLAG DENOTING IF PATIENT IS LOCKED INTO A PHARMACY BY TENNCARE. This was made possible with a CDC grant to the CSMD (Tennessee's Title for the PDMP, The Controlled Substance Monitoring Database) in 2015.
Utah	Pharmacy, and dosing
Washington	Pharmacy and demographic details of the pharmacy that filled the controlled substance.

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

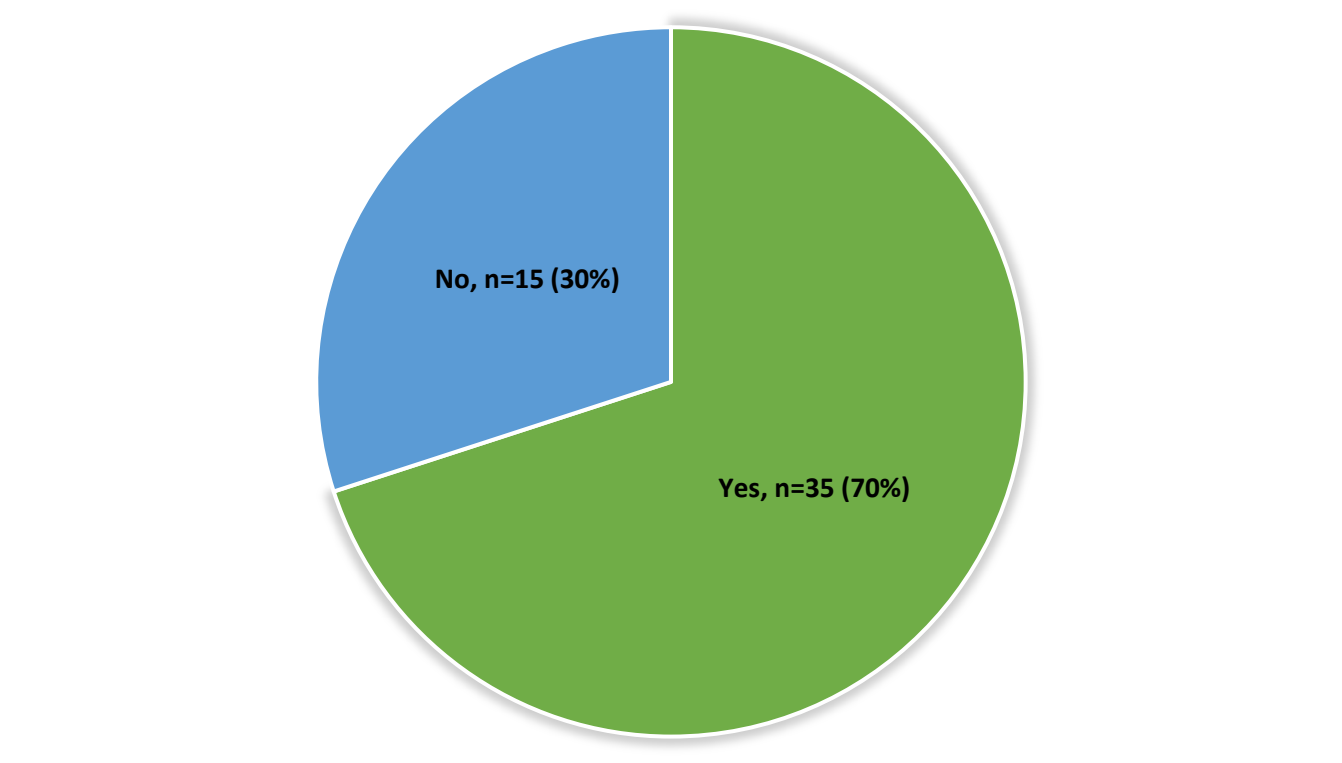

Table 126 - Barriers Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oregon,	35	70.00%

Response	States	Count	Percentage
	Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
No	Alaska, Georgia, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, Nevada, New Mexico, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah	15	30.00%
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 127 - Explanations of Barriers That Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA

State	Explanation
Alabama	AL Medicaid has limited access to PDMP as the oversight is with another State agency. Pharmacists are not required to check the PDMP prior to dispensing a controlled substance.
Arkansas	Arkansas Medicaid has the following barriers: 1) Arkansas Medicaid pharmacy program clinical pharmacists have access to the PDMP, but we have no access to neighboring States. 2) The PDMP is managed by a different agency. Getting data to answer the questions in this survey will be difficult. 3) At this point, the PDMP data is not incorporated into the Medicaid data system for use in ProDUR edits, RDUR review, or clinical POS edits.
California	Inability to access border States' PDMP information and lag time for prescription data being submitted.
Colorado	The State is prohibited by legislation from accessing the PDMP. The requirement for prescribers to check the PDMP prior to prescribing controlled substances to Medicaid members in accordance with Section 5042 of the 'SUPPORT for Patients and Communities Act' is reflected in posted Department policy.
Connecticut	Access is restricted to our Medicaid Fraud Unit only.
Delaware	The current barrier is that there is no direct access to PDMP by the Medicaid agency. Any request must go through the PDMP agency.
District of Columbia	The Medicaid agency cannot access PDMP information for a beneficiary in the absence of an active investigation of fraud or abuse as so called data mining is prohibited. An additional concern is not being able to determine the number of prescribers who may not be accessing the PDMP before prescribing controlled substances despite the implementation of a mandatory query law.
Florida	Sections 893.055 and 893.0551, Florida Statutes does not authorize the release of PDMP information to the Agency for Health Care Administration.
Hawaii	Medicaid cannot access PDMP yet. Time lag of up to 7 days in prescription data being submitted is allowed by State law. Less than or equal to 3 days supply does not require entry by the prescriber into PDMP. If the PDMP is not functioning, i.e. power outage, entry is not required. Negotiating with vendor to obtain cash prescription data.
Idaho	Data may only be accessed/viewed by individual patient.

State	Explanation
Illinois	- Currently only one patient at a time can be viewed. HFS is working on obtaining ILPMP data to look at the whole HFS population. - HFS has no way to verify if prescriber checked ILPMP prior to writing a prescription. - One of the border States, Missouri, passed legislation for a State PDMP in June 2021. That was not yet implemented during FFY22 so data was not available.
Indiana	Privacy concerns for both prescribers and members to provide data to the agency, financial constraints for funding third party vendor to collect and provide the needed information.
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.
Maine	Medicaid has access to the data through a data request, but not direct access as described in the statute.
Maryland	The FFS program must have a bona fide 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.
Massachusetts	DUR program does not have access to MassPAT. No aggregate data, 42CFR part 2, Methadone maintenance is not uploaded into 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.
Montana	The State's PDMP program by Bamboo Health 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 by even a letter. Furthermore, Medicaid cannot review by prescriber to limit abuse by prescribers. While we can review prescribers by our claims data, this doesn't include cash pay prescriptions.
New Hampshire	The Medicaid program is prohibited by New Hampshire statute from accessing and querying the PDMP.
New Jersey	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. Licensed pharmacy staff conducting DUR are considered unauthorized users since they are not directly delivering healthcare.
New York	Data sharing or access to information for Medicaid members only.
North Carolina	Some barriers are that some pharmacies have restricted internet access, there is some delay in processing data submitted, and prescribers complain of time required to log in. However, this issue seems to have exponentially improved over time. There are some navigation and security access issues with department when trying to access the PDMP system. Additionally, PDMP limits access to specific users within the agency to certain aspects of the PDMP data. However, we do have a good working relationship with the division that houses the PDMP system and they are receptive to our needs
North Dakota	Restrictions exist for payers not being able to access border State data.

State	Explanation
Oregon	Oregon State law greatly limits payer access to the PDMP. State Medicaid agency (OHA) does not have direct access.
Rhode Island	State law requires a DEA number to access the PDMP
South Carolina	Potential lag time in capturing data/Restricted access from PDMP (State and MCOs)
Tennessee	The real barrier is matching CSMD (Tennessee's Title for the PDMP, The Controlled Substance Monitoring Database) 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	Access to the prescription data is statutorily restricted. The information is available to practitioners and pharmacies who are inquiring about their own prescribing or dispensing history on their patients. State regulatory boards have access as well. A person who knowingly gives, permits or obtains unauthorized access to this information, is subject to criminal penalty.
Vermont	Direct access to the PDMP is limited to only the Medical Director of DHVA by statute. In addition, this role is not allowed interState data sharing privileges and is unable to see prescriptions in the surrounding States with whom VPMS shares data.
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. Washington State allowed facilities to obtain a single sign on which prevents the State from being able to determine who at the facility checked the PMP.
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 and there is a delay in receiving the data. Also, our retrospective DUR contractor does not have a system developed to incorporate the claims data into their claim review process.
Wyoming	Current interpretation of Wyoming State Law does not allow Medicaid to access the PDMP.

4. Have any changes to your State's PDMP during this reporting period improved the Medicaid program's ability to access PDMP data?

Figure 85 - Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

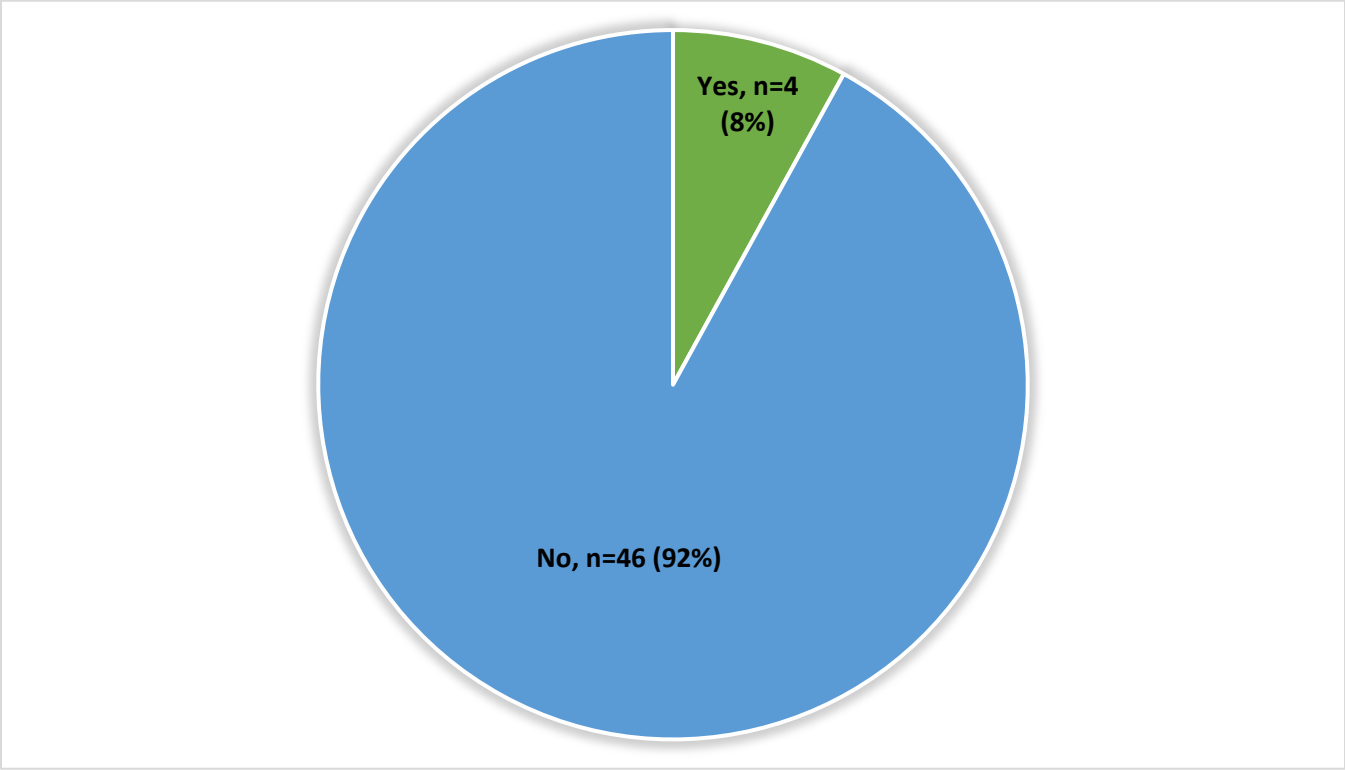

Table 128 - Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

Response	States	Count	Percentage
Yes	Colorado, Kansas, Nebraska, Vermont	4	8.00%
No	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, 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, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
Total		50	100.00%

If "Yes," please explain.

Table 129 - Explanations of Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

State	Explanation
Colorado	The Department has made progress with exploring strategies for obtaining the PDMP data needed for the mandatory reporting submitted to CMS with the FFY 2023 DUR survey.

State	Explanation
Kansas	Access to the provider and pharmacy level data is now available due to State statute update.
Nebraska	Dual CMS certification with the HIE.
Vermont	The Department of Vermont Health Access and the Vermont Department of Health have signed an MOU that allows for the transfer of information required to complete this report.

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

Figure 86 - Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period

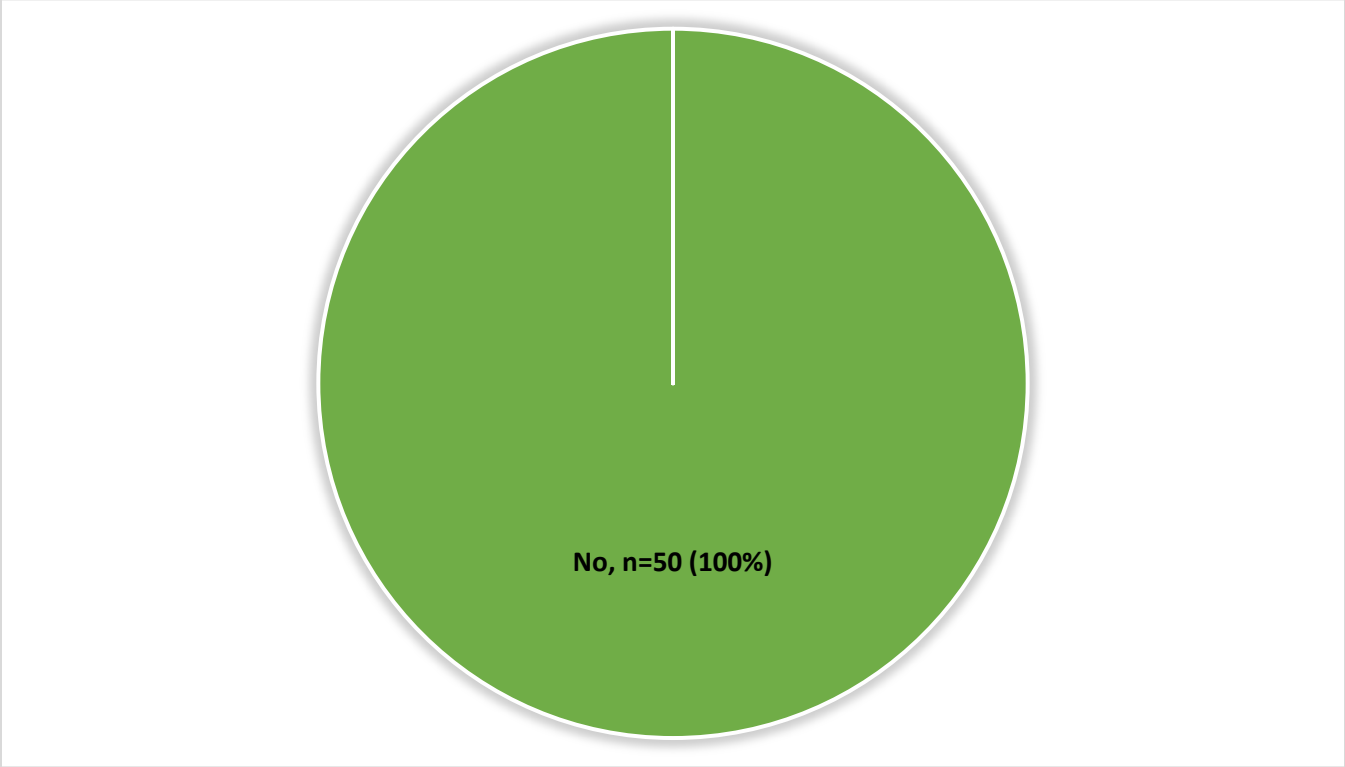

Table 130 - Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period

Response	States	Count	Percentage
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, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%
Total		50	100.00%

C. Opioids

1. Does your State currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?

Figure 87 - POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

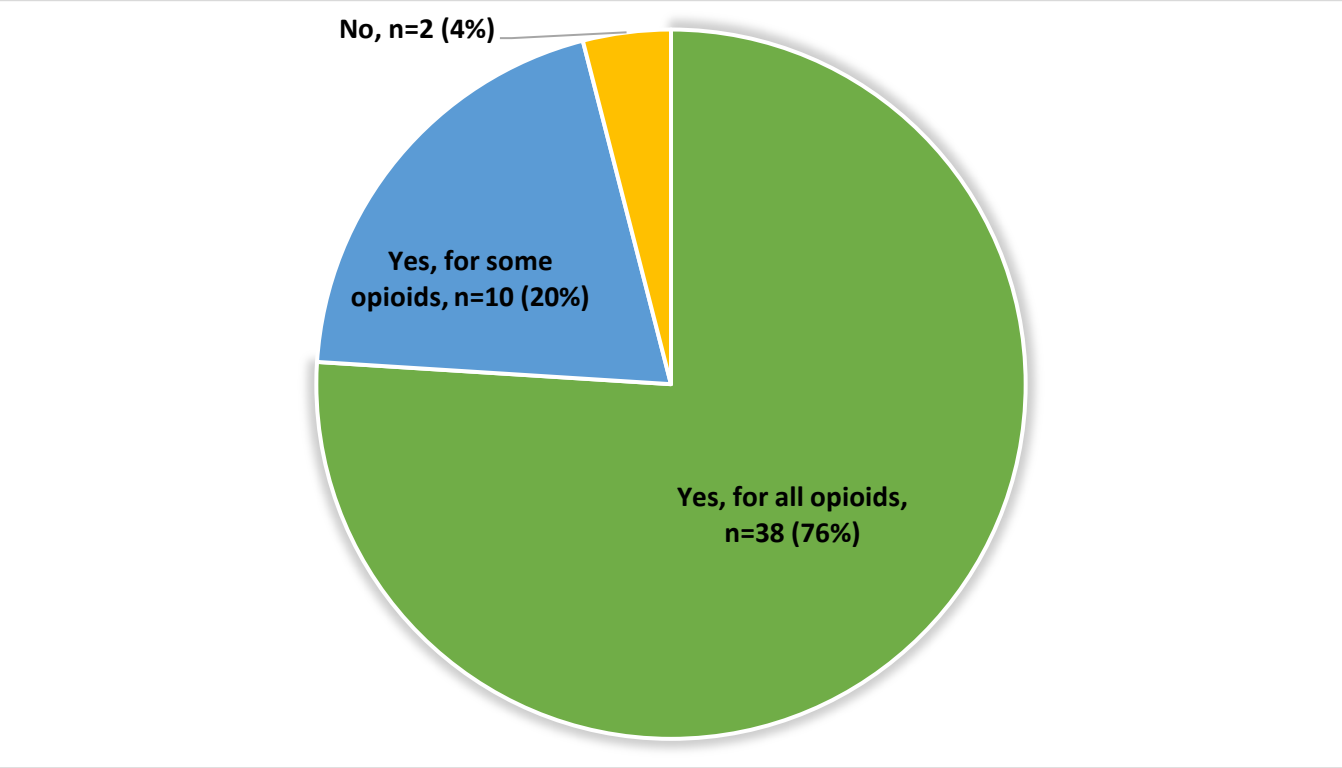

Table 131 - POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

Response	States	Count	Percentage
Yes, for all opioids	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, Wyoming	38	76.00%
Yes, for some opioids	Hawaii, Kansas, Louisiana, Michigan, Montana, New Mexico, New York, Oklahoma, Rhode Island, Utah	10	20.00%
No	North Carolina, West Virginia	2	4.00%
Total		50	100.00%

If "No," please explain why not.

Table 132 - Explanations for not Having a POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

State	Explanation
North Carolina	We do for drugs other than Schedule V. Opioid claims are limited by daily dose, quantity dispensed, days supply, and morphine equivalency limits. All opioid prescriptions for more than a 7-day supply require prior approval.
West Virginia	We do not limit the days' supply dispensed on an initial opioid prescription. However we do limit the quantity dispensed. Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.

a. If "Yes," what is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?

Figure 88 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients

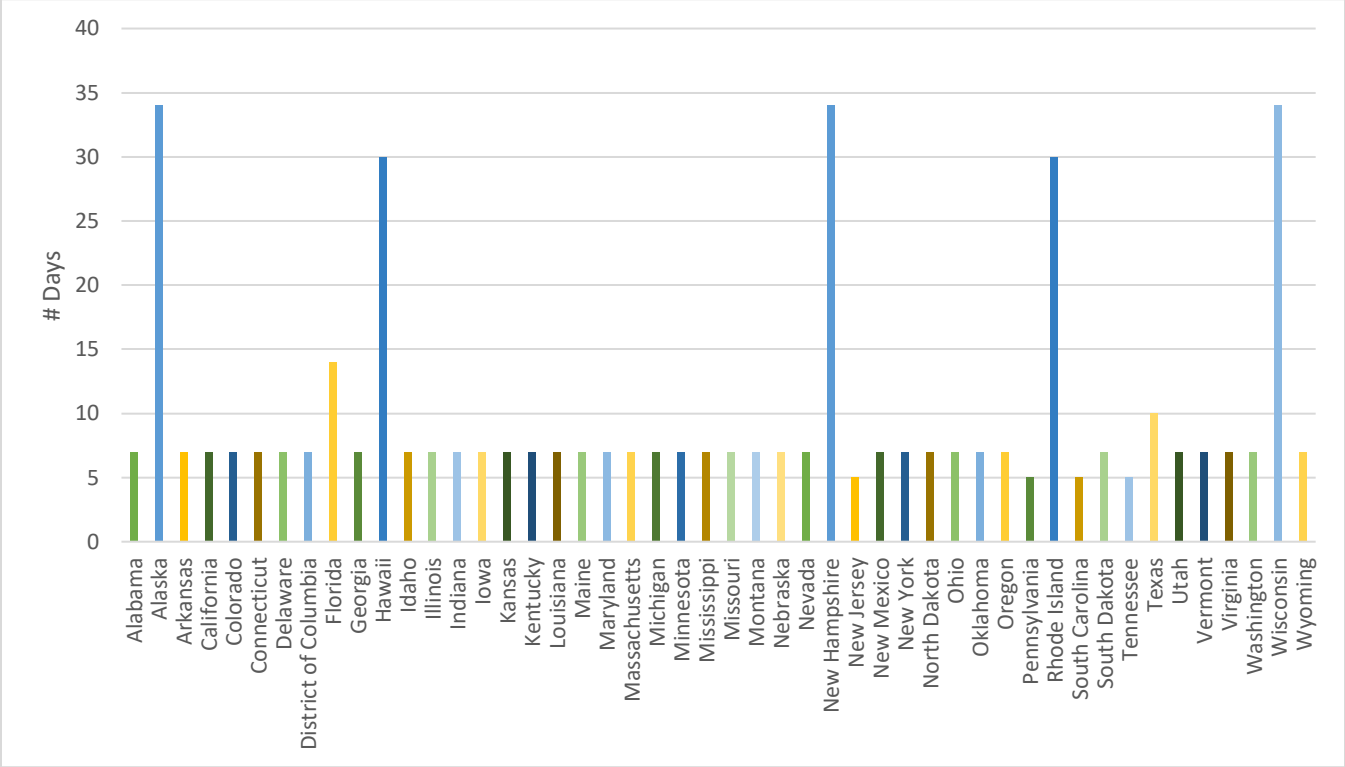

Table 133 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients

State	Maximum Days
Alabama	7
Alaska	34
Arkansas	7
California	7
Colorado	7
Connecticut	7
Delaware	7
District of Columbia	7

State	Maximum Days
Florida	14
Georgia	7
Hawaii	30
Idaho	7
Illinois	7
Indiana	7
Iowa	7
Kansas	7
Kentucky	7
Louisiana	7
Maine	7
Maryland	7
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 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
Wisconsin	34
Wyoming	7

b. Does your State have POS edits in place to limit days' supply of subsequent opioid prescriptions? If "Yes," please indicate your days' supply limit.

Figure 89 - POS Edits in Place to Limit Days' Supply of Subsequent Opioid Prescriptions

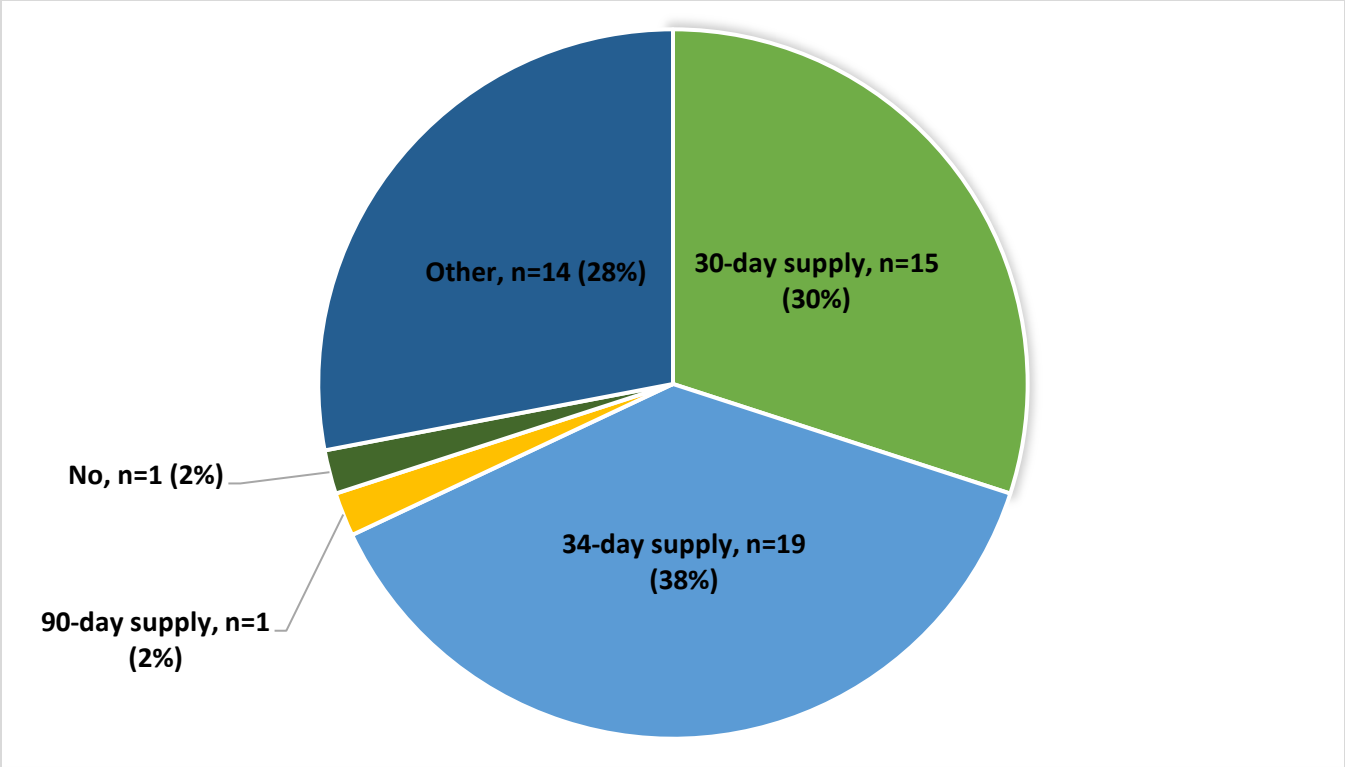

Table 134 - POS Edits in Place to Limit Days' Supply of Subsequent Opioid Prescriptions

Response	States	Count	Percentage
30-day supply	Connecticut, District of Columbia, Georgia, Hawaii, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Nebraska, New York, Oklahoma, Rhode Island, South Carolina, Utah	15	30.00%
34-day supply	Alabama, Alaska, Delaware, Idaho, Kentucky, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, South Dakota, West Virginia, Wisconsin, Wyoming	19	38.00%
90-day supply	Pennsylvania	1	2.00%
No	Texas	1	2.00%
Other	Arkansas, California, Colorado, Florida, Illinois, Indiana, Iowa, Kansas, Nevada, Oregon, Tennessee, Vermont, Virginia, Washington	14	28.00%
Total		50	100.00%

If "Other," please specify.

Table 135 - "Other" Days' Supply Limit for Subsequent Opioid Prescriptions

State	Limit in Units
Arkansas	31
California	35
Colorado	7

State	Limit in Units
Florida	14
Illinois	31
Indiana	14
Iowa	31
Kansas	7
Nevada	7
Oregon	7
Tennessee	10
Vermont	102
Virginia	7
Washington	42

If "No," please explain.

Table 136 - Explanations for not Having a POS Edit in Place to Limit the Days' Supply of Subsequent Opioid Prescriptions

State	Explanation
Texas	The days' supply limit on the subsequent opioid prescriptions or refills will be based on the maximum quantity per prescription set in the claims system for each opioid product.

2. Does your State have POS edits in place to limit the quantity dispensed of opioids?

Figure 90 - POS Edits in Place to Limit the Quantity Dispensed of Opioids

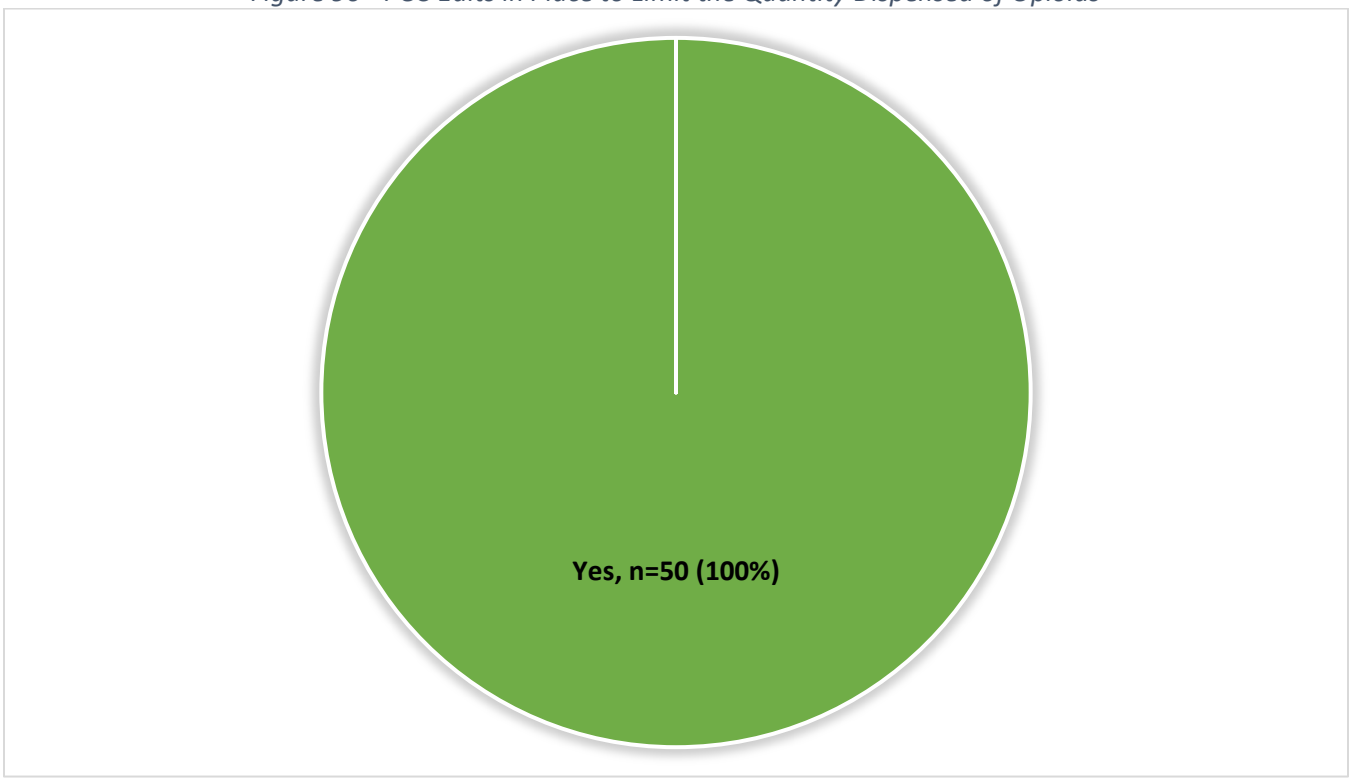

Table 137 - POS Edits in Place to Limit the Quantity Dispensed of Opioids

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%

a. If "Yes," does your State have POS edits in place to limit the quantity dispensed of short-acting opioids?

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

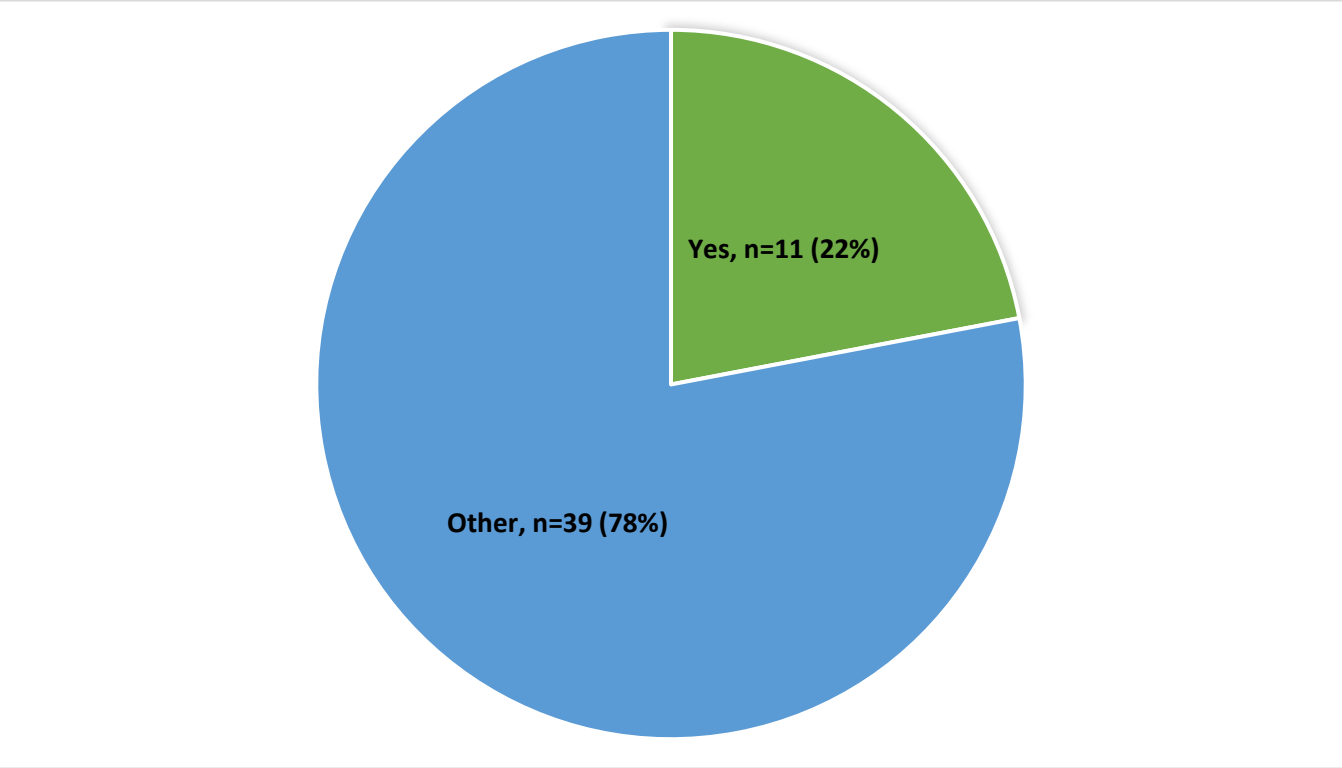

Table 138 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States	Count	Percentage
Yes	California, Indiana, Louisiana, Mississippi, Nebraska, Oklahoma, Rhode Island, South Carolina, Utah, West Virginia, Wisconsin	11	22.00%
Other	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon,	39	78.00%

Response	States	Count	Percentage
	Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wyoming		
Total		50	100.00%

If "Yes," please specify limit as # of units.

Figure 92 - Limits for Quantity Dispensed of Short-Acting Opioids

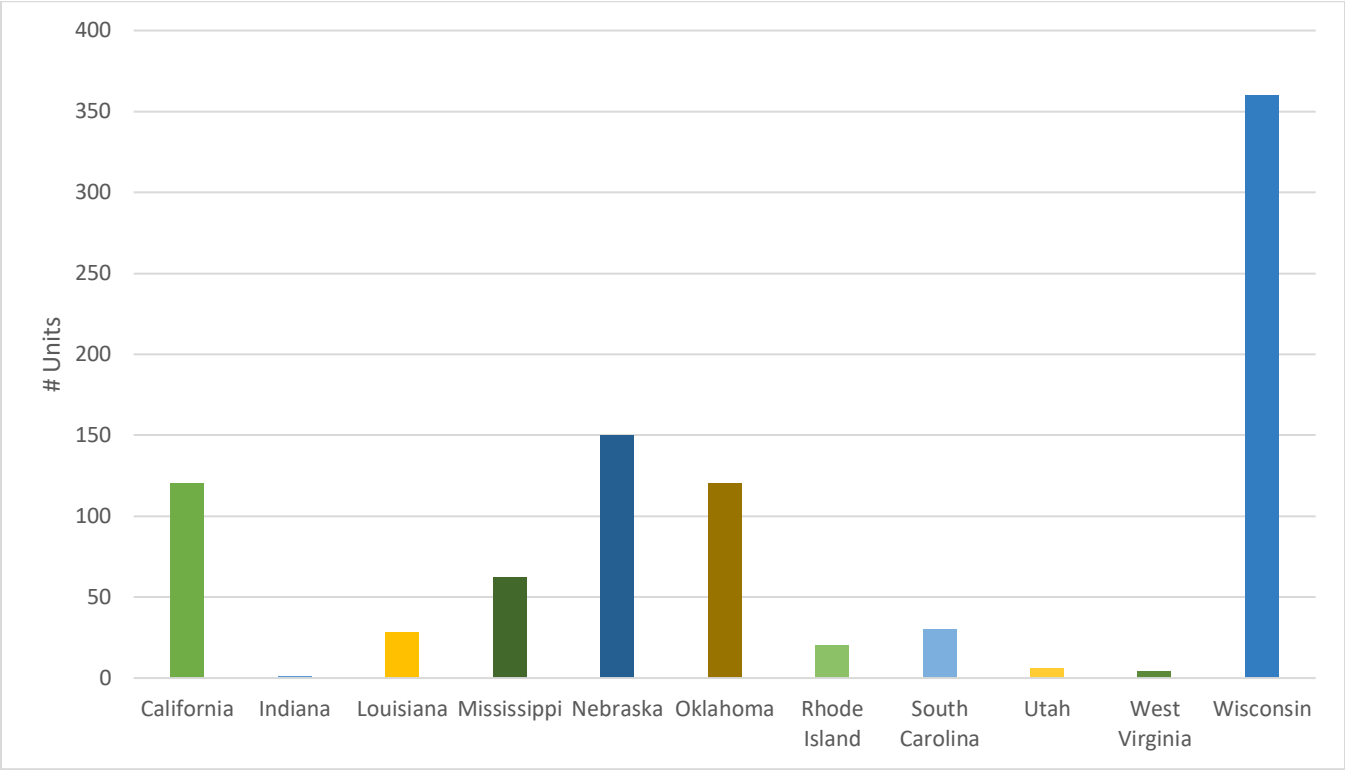

Table 139 - Limits for Quantity Dispensed of Short-Acting Opioids

State	Units
California	120
Indiana	1
Louisiana	28
Mississippi	62
Nebraska	150
Oklahoma	120
Rhode Island	20
South Carolina	30
Utah	6
West Virginia	4
Wisconsin	360

If "Other" please explain.

Table 140 - "Other" Explanation for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

State	Explanation
Alabama	AL Medicaid has POS edits in place to limit the quantity dispensed of short-acting opioids. The quantity limit is dependent on the particular product.
Alaska	Quantity limits are based on unit dosage, not to exceed a 30 day supply.
Arkansas	Beyond an initial claim for short-acting opioids for treatment naive beneficiaries, the maximum monthly quantity is #93/31 days. Cancer patients may receive up to #124/31 days of short acting opioids. Quantities above these limits require a PA.
Colorado	Opioid naive members are limited to a quantity of 8 pills per day. For members that are not opioid naive, short-acting opioids are limited to a quantity of 120 pills per 30 days, with exception of tapentadol IR, which is limited to 180 tablets per 30 days.
Connecticut	If a patient has a diagnosis of cancer or sickle cell, no quantity restrictions are applicable however, a maximum of a 30-day supply applies. For all other patients, a maximum of 630 MME every 120 days applies. If a patient exceeds 630 MME in a 120 day period, or > 7 day supply, a short acting opioid PA is required. If prior authorization is granted up to a 30 day supply is imposed.
Delaware	The total dose of opioid cannot exceed 90 mg MME per 24 hours. The total quantity of short acting opioids may not exceed 120 units per 30 days with a total of 720 units per year.
District of Columbia	Patients that are considered acute (having less than 120 days of history of opioids in the last 180 days) are limited to a seven days supply for a total of 30 days.
Florida	Yes, 7-day supply limit.
Georgia	30-day supply. # of units dispensed depends on PI/guideline-recommended dosing frequency.
Hawaii	Unit limits vary by the program. Dental has a 5 day limit and transplant has a 30 day limit. Dental is acute and initial care without subsequent fills. Transplant is not limited and can have subsequent fills due to the nature of transplant needs.
Idaho	There are quantity per day limitations, MME edit and fills are limited to a 34 day supply.
Illinois	186 Units/rolling 31 days

State	Explanation
Iowa	Maximum days' supply is up to a 31 day supply and up to 6 units per day, unless otherwise indicated on the Quantity Limit Chart.
Kansas	The quantity limit is based upon the days supply and MME limits.
Kentucky	Quantity limits are specific to each drug based on total MME and day supply
Maine	After initial fill of opioid prescription the requirement is for 30 day supply until 60 days of continuous use then the member is considered a chronic utilizer and the requirement of a prior authorization for continued opioid use.
Maryland	Quantity limits are in place for specific short acting opioids. Quantity limit information is available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	Quantity limits are based on maximum of 120 MME specific to the opioid prescribed.
Michigan	Drug-specific quantity limits on short-acting opioids that vary by drug strength such that the daily dose would not exceed 90 MME.
Minnesota	There is a 7-day supply limit for the first opioid naive prescription. The maximum quantity is based on a daily 90 mg MME per short-acting (SA) opioid.
Missouri	The quantity and units are variable based on the dose and dosage form.
Montana	Short acting opioids are limited to 8 per day.
Nevada	7 days / 60 MME for initial prescriptions
New Hampshire	POS edits for short-acting opioids are driven by maximum days supply of 34 and the MME edit.
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 member shall not be provided with more than a 30-day supply of a Schedule II medication at one time.
New Mexico	Quantity limits for opioid naive (no history of opioids in last 60 days) is limited to a 7-day supply with a maximum of 90MME/day and a 34 days supply for opioids.
New York	Initial prescription for opioid-naive patients limited to a 7-day supply. Prior Authorization (PA) required for initiation of opioid therapy for patients on established opioid dependence therapy. PA required for use if greater than or equal to 90 MME of opioid per day for management of non acute pain (greater than 7 days). PA is required for opioid-naive patients for prescription requests if greater than or equal to 50 MME per day.
North Carolina	Other than Schedule V, opioid claims are limited by daily dose, quantity dispensed, days supply, and morphine equivalency limits. All opioid prescriptions for more than a 7-day supply require prior approval. For subsequent fills, the days supply is limited to 34 days. We have a edit that requires PA for opioid claims over 90 MME.
North Dakota	Different products and different strengths of different products have varying limits based on MME as well as likely frequency. Only one short acting agent is allowed at a time. So the answer to this question is yes, but the units cannot be specified as the limit is product and strength specific.
Ohio	30 MED
Oregon	POS edit to limit days' supply. Quantity varies depending on the agent and MME in the SAO PA criteria table: https://www.orpdl.org/durm/PA_Docs/opioids_short_acting.pdf

State	Explanation
Pennsylvania	An Analgesic, Opioid Short-Acting that contains codeine or tramadol when prescribed for a beneficiary 18-20 years of age and at least one of the following: a. More than a 3-day supply is prescribed b. The beneficiary has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 365 days. An Analgesic, Opioid Short-Acting that does not contain codeine or tramadol when prescribed for a beneficiary under 21 years of age and at least one of the following: a. More than a 3-day supply is prescribed b. The beneficiary has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 365 days. An Analgesic, Opioid Short-Acting when prescribed for a beneficiary 21 years of age or older and at least one of the following: a. More than a 5-day supply is prescribed b. The beneficiary has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 180 days.
South Dakota	Opioid naive patients are limited to an initial fill of a 7 day supply with a maximum MME of 60. Daily quantity limits also apply and vary by product.
Tennessee	Yes, TennCare has quantity limit edits in place for short acting opioids. Our QL edits vary per medication and the limit is based on our daily MME limit (Non-Chronic patients: 60 MME; Chronic Patients: 200 MME).
Texas	The quantity limit for a short acting opioid, if written for an opioid naive patient, will be calculated at a 10-day supply limit and 90 MME level. The quantity for subsequent short-acting opioid (for non-native patient) will be based on the 90 MME per day levels and the maximum quantity for that NDC set in the claims system.
Vermont	Yes, 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 17 years of age or younger. Otherwise refer to the PDL for details. https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria
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	19 years of age and younger 18 units and 20 years of age and above 42 units
Wyoming	After 42 days of acute therapy, short-acting medications are limited to a maximum of four units per day.

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

Figure 93 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

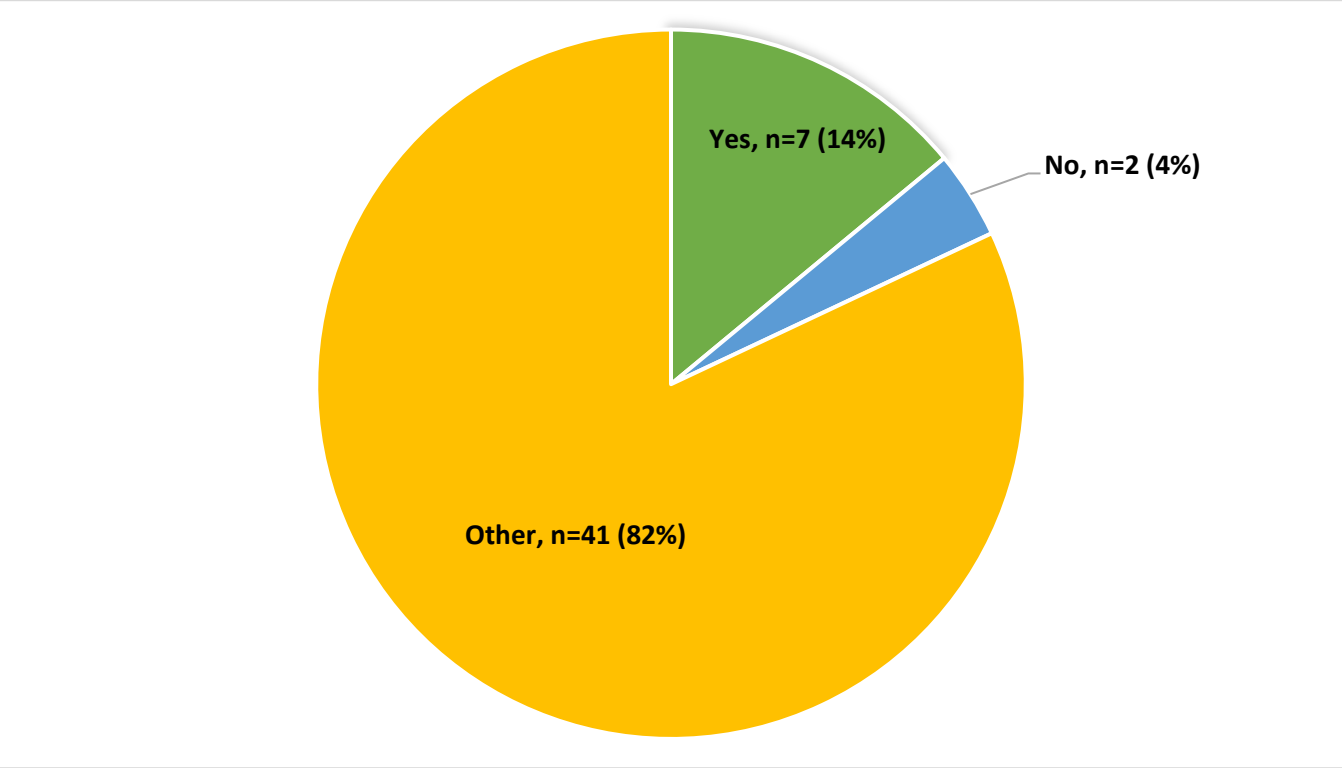

Table 141 - POS Edits In Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States	Count	Percentage
Yes	California, Indiana, Louisiana, Mississippi, South Carolina, South Dakota, West Virginia	7	14.00%
No	Rhode Island, Washington	2	4.00%
Other	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, 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, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming	41	82.00%
Total		50	100.00%

If "Yes," please specify limit as # of units.

Figure 94 - Limits for Quantity Dispensed of Long-Acting Opioids

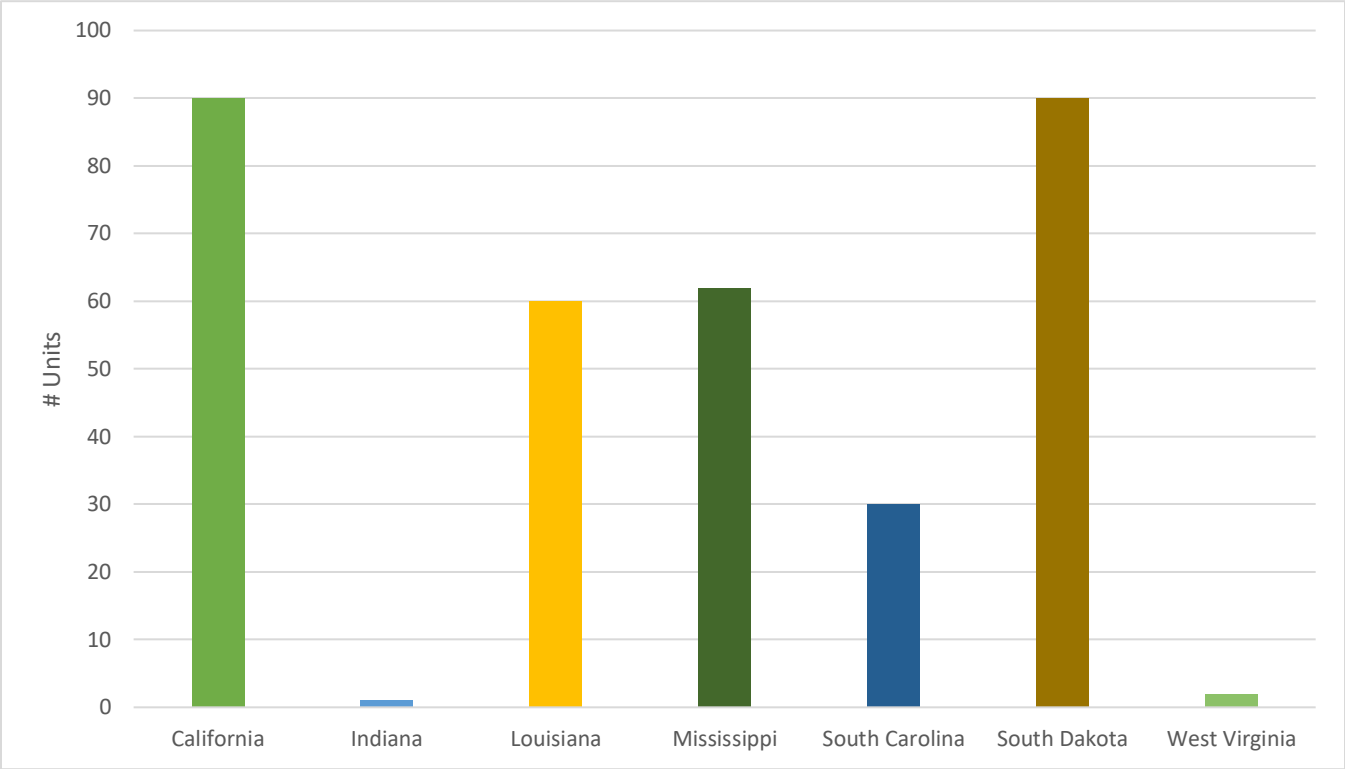

Table 142 - Limits for Quantity Dispensed of Long-Acting Opioids

State	Units
California	90
Indiana	1
Louisiana	60
Mississippi	62
South Carolina	30
South Dakota	90
West Virginia	2

If "No," please explain.

Table 143 - "No" Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

State	Explanation
Rhode Island	Limited by MME - PA required for all Long Acting Opioids.
Washington	No long-acting opioids are allowed during the acute phase which WA defines as the initial 42 calendar days within a 90 day period

If "Other" please explain.

Table 144 - "Other" Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

State	Explanation
Alabama	AL Medicaid has POS edits in place to limit the quantity dispensed of long-acting opioids. The quantity limit is dependent on the particular product.

State	Explanation
Alaska	Quantity limits are based on unit dosage, not to exceed a 30 day supply.
Arkansas	Long-acting opioids require a prior authorization and/or documentation of opioid tolerance with a long-acting opioid on the Medicaid profile in the previous 60 days before a claim will process. Claims are limited to a 31-day supply, but quantity edits are specific to the individual medication based on typical dosing guidelines. Cancer patients do not require a PA for preferred long-acting opioids.
Colorado	Long-acting opioids are subject to quantity limits listed for specific products on the preferred drug list.
Connecticut	If a patient has a diagnosis of cancer or sickle cell, no quantity restrictions are applicable however, a maximum of a 30-day supply applies. For all other patients, a prior authorization is required. If prior authorization is granted up to a 30-day supply is imposed.
Delaware	The total dose of Long Acting Opioids cannot exceed 90 mg MME per 24 hours.
District of Columbia	Patients that are considered acute (having less than 120 days of history of opioids in the last 180 days) are limited to a seven days supply for a total of 30 days.
Florida	30-day supply limit and product specific quantity limits.
Georgia	30-day supply. # of units dispensed depends on PI/guideline-recommended dosing frequency.
Hawaii	POS edits of unit limits vary by the program. Dental is acute and initial care without subsequent fills and no long-acting opioids. Transplant is not limited and can have subsequent fills due to the nature of transplant needs. Currently we have no utilization.
Idaho	There are quantity per day limitations, MME edit, PA edit to limit to one LA opioid at a time, and fills are limited to a 34 day supply.
Illinois	124 Units/rolling 31 days
Iowa	Maximum days' 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 with a 31 day supply limit per fill.
Kentucky	Quantity limits are specific to each drug based on total MME and day supply
Maine	30 days supply
Maryland	Quantity limits are in place for specific short acting opioids. Quantity limit information is available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	Quantity limits are based on maximum of 120 MME specific to the opioid prescribed.
Michigan	Drug-specific quantity limits on select long-acting opioids that vary by drug strength such that the daily dose would not exceed 90 MME.
Minnesota	There is a 7-day supply limit for the first opioid naive prescription. The maximum quantity is based on a daily 90 mg MME per long-acting (LA) opioid.
Missouri	Quantity limits are in place based on the strength of the medication and alternative strengths available on the market.
Montana	We have a limit of 2 long-acting opioids at a time (to allow for multiple strengths of the same opioids). Quantity limits differ depending on product.
Nebraska	Quantity limits are in place based upon dosage units not to exceed a 30 day supply.
Nevada	7 days / 60 MME for initial prescriptions
New Hampshire	POS edits for long-acting opioids are driven by maximum days supply of 34 and the MME edit in addition to a clinical prior authorization. Additionally, there are quantity limits for long-acting opioids aligned with FDA labeling for maximum dosing per day.
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

State	Explanation
	manufacturer's package insert. New Jersey regulations also dictate that a member shall not be provided with more than a 30-day supply of a Schedule II medication at one time.
New Mexico	Maximum of 90MME/day and 34 day supply maximum per dispense.
New York	Yes. Quantity limits are based on FDA maximum daily doses in the product labeling extended to a thirty day supply.
North Carolina	Other than Schedule V, opioid claims are limited by daily dose, quantity dispensed, days supply, and morphine equivalency limits. All opioid prescriptions for more than a 7-day supply require prior approval. For subsequent fills, the days supply limited to 34 days. We have a edit that requires PA for opioid claims over 90 MME.
North Dakota	Different products and different strengths of different products have varying limits based on MME as well as likely frequency. Only one long acting agent is allowed at a time. So the answer to this question is yes, but the units cannot be specified as the limit is product and strength specific.
Ohio	Yes, 80 MED
Oklahoma	Long-acting opioids are limited to a 30-day supply with a quantity limit specific to product's FDA approved dosing regimen.
Oregon	All LAOs require PA and in addition to the daily MME limit are subject to frequency limits per FDA-approved labeling detailed in Table 2: https://www.orpdl.org/durm/PA_Docs/opioids_long_acting.pdf
Pennsylvania	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.
Tennessee	Yes, TennCare has quantity limit edits in place for long-acting opioids. Our QL edits vary per medication and the limit is based on our daily MME limit (Non-Chronic patients: 60 MME; Chronic Patients: 200 MME).
Texas	Per the Opioid Clinical Policy, long-acting opioids prescriptions are only approved for subsequent prescribing or for non-native patients. The quantity limit would be based on the maximum quantity set in the claims system. However, the 90 MME per day limit will be applied.
Utah	Morphine Milligrams Equivalent (90 MME), daily quantity limit (1 to 3 units, depends on the medication), and maximum 30 days-supply
Vermont	Yes this is based on a daily MME edit. members new to opioid therapy with a daily MME over 90 per day will require the completion of an opioid safety checklist as prior authorization. Most Long acting opioids are limited to a 30 day supply. Refer to PDL https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria
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.
Wisconsin	All long-acting opioids have either an early refill edit or a quantity limit.
Wyoming	After 42 days of acute therapy, long-acting medications are limited to a maximum of 120 MME per day.

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

Figure 95 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

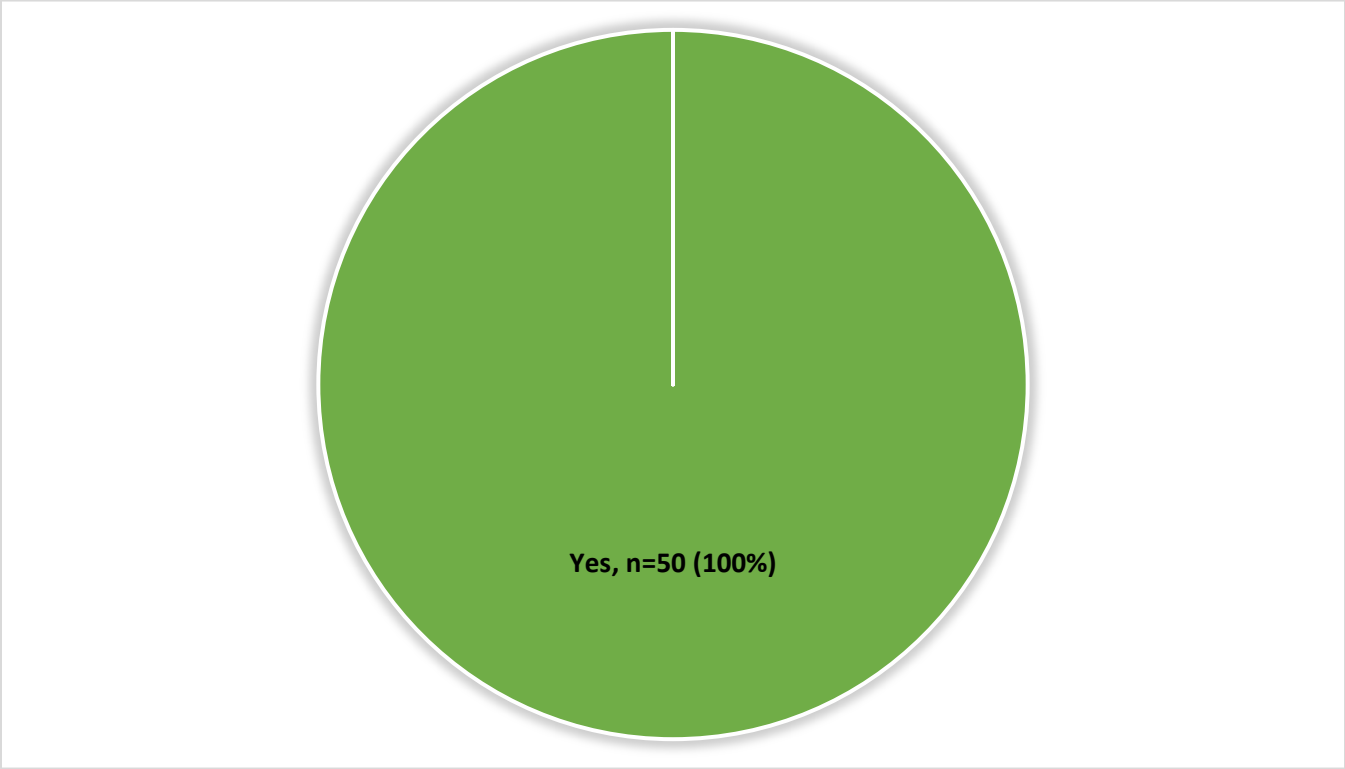

Table 145 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
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," check all that apply.

Figure 96 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

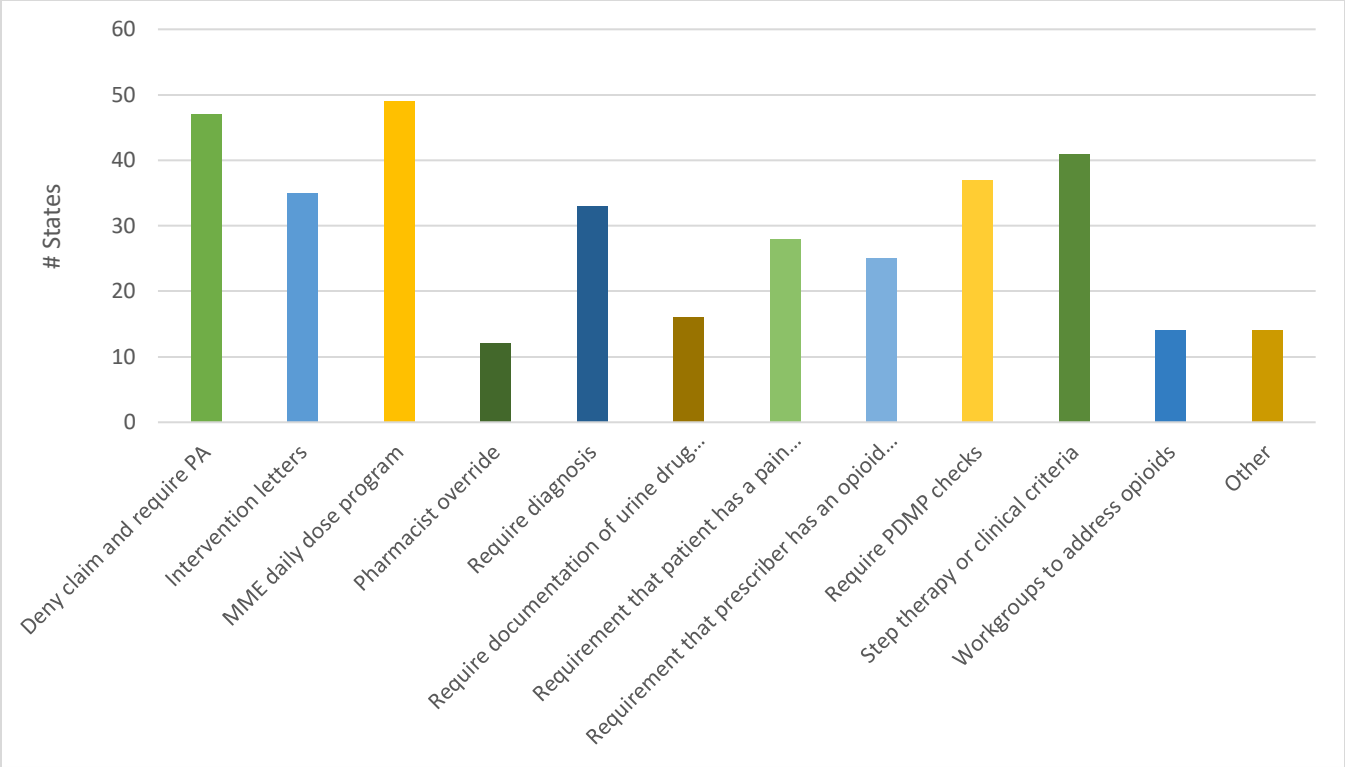

Table 146 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

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, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	47	13.39%
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, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Wisconsin, Wyoming	35	9.97%

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	13.96%
Pharmacist override	Alabama, Georgia, Idaho, Louisiana, Massachusetts, Mississippi, Nebraska, North Carolina, South Carolina, Utah, West Virginia, Wisconsin	12	3.42%
Require diagnosis	Alabama, Alaska, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington	33	9.40%
Require documentation of urine drug screening results	Alabama, Alaska, Delaware, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, Ohio, Oregon, Pennsylvania, Virginia, Washington	16	4.56%
Requirement that patient has a pain management contract or Patient-Provider agreement	Alabama, Alaska, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia	28	7.98%
Requirement that prescriber has an opioid treatment plan for patients	Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Kansas, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Utah, Virginia, Washington, West Virginia	25	7.12%
Require PDMP checks	Alabama, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	37	10.54%

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, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	41	11.68%
Workgroups to address opioids	Alabama, Alaska, California, Delaware, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Missouri, South Carolina, South Dakota, Utah	14	3.99%
Other	Colorado, District of Columbia, Idaho, Illinois, Indiana, Kansas, Louisiana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, West Virginia	14	3.99%
Total		351	100.00%

If "Other," please specify.

Table 147 - "Other" Explanations for Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

State	Explanation
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.
District of Columbia	The DUR Board published a document entitled Guidelines for Collaborative Management of Opioid Use which addressed the opioid epidemic in the District of Columbia and offered recommendations for opioid treatment clinical criteria and best practices.
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 of long-acting opioids, and non-preferred medications. Intervention letters are done through the DUR Board on focused topics. The MME program is an automated edit that totals 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 GSN 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 Misuse and Overdose Strategic Plan Working Group and 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 Abuse Disorder Advisory Board Worked with Magellan to develop and implement an Opioid Geo Mapping program. Pharmacists at the State may select any quarter of 2022 and filter by age, duration of initial prescription, duration of use, and MME. Results are presented by healthcare region and/or zip code. There is an adjacent display for naloxone utilization. A table presents the patients on potentiator medications (displays number of benzodiazepines and number of other potentiator medications) and if naloxone has been prescribed. The table includes a drill down to display patient details (specific medication(s)/dose, prescriber, pharmacy).

State	Explanation
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. 4. Pain management program for patients flagged via the Four Prescription Policy who are filling opioids 3 or more months. If the patient is filling methadone for pain, additional safety monitoring, including submission of recent urine drug screen, certain laboratory values, and completion of an EKG are required. The prescriber notes date PDMP checked. After pain management program forms with medical justification submitted by prescriber are reviewed, intervention letters (response with evidence-based recommendations) are sent to the prescriber. All chronic opioid use requires use of short-acting opioids and/or preferred long-acting opioids first. 5. Only one short and one long-acting opioid are allowed at a time. Exceptions can be made for cancer diagnoses.
Indiana	System edits are utilized to identify the number of prescribers; restrictions for concurrent use with benzodiazepines, carisoprodol-containing products, buprenorphine, or buprenorphine/naloxone; current utilizers limited to one long-acting and one short-acting opioid product concurrently.
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 screen 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 we also sent provider bulletins about this policy and PA criteria. The bulletin links are below: https://www.kmapStateks.us/Documents/Content/Bulletins/18027%2 0-%20General%20-%20Opioid_2.pdf https://www.kmapStateks.us/Documents/Content/Bulletins/18101%2 0-%20General%20-%20Opioid_2.1.pdf https://www.kmapStateks.us
Louisiana	Age limit, maximum dose limit, therapeutic duplication, concurrent use, bypass diagnosis
Nebraska	Non-preferred opioids require a prior authorization. Some medications also have quantity limits.
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, a 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, 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. These limits are in place for opioid naive and opioid tolerant members. Initial fills of high dose opioids require a PA to confirm diagnosis and titration of dosage. Members on short-acting opioids for 90 days or more require prior authorization to obtain justification of continued use.
New Mexico	Quarterly automated retrospective claim reviews to monitor prescribing of opioids.
North Carolina	Prior approval is required for greater than 5-day supplies for acute pain and 7-day supplies for postoperative pain. Prior approval requests should include the beneficiary's diagnosis and reason for exceeding dose per day limits and duration (day supply) limits. 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-rulespositionStatements/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

State	Explanation
	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). The DUR Board and the State monitor the trend line for opioids.
Ohio	Initial short-acting opioid prescriptions are limited to 30 MED per day for a 7 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 nonpharmacological 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.
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.

4. 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 97 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

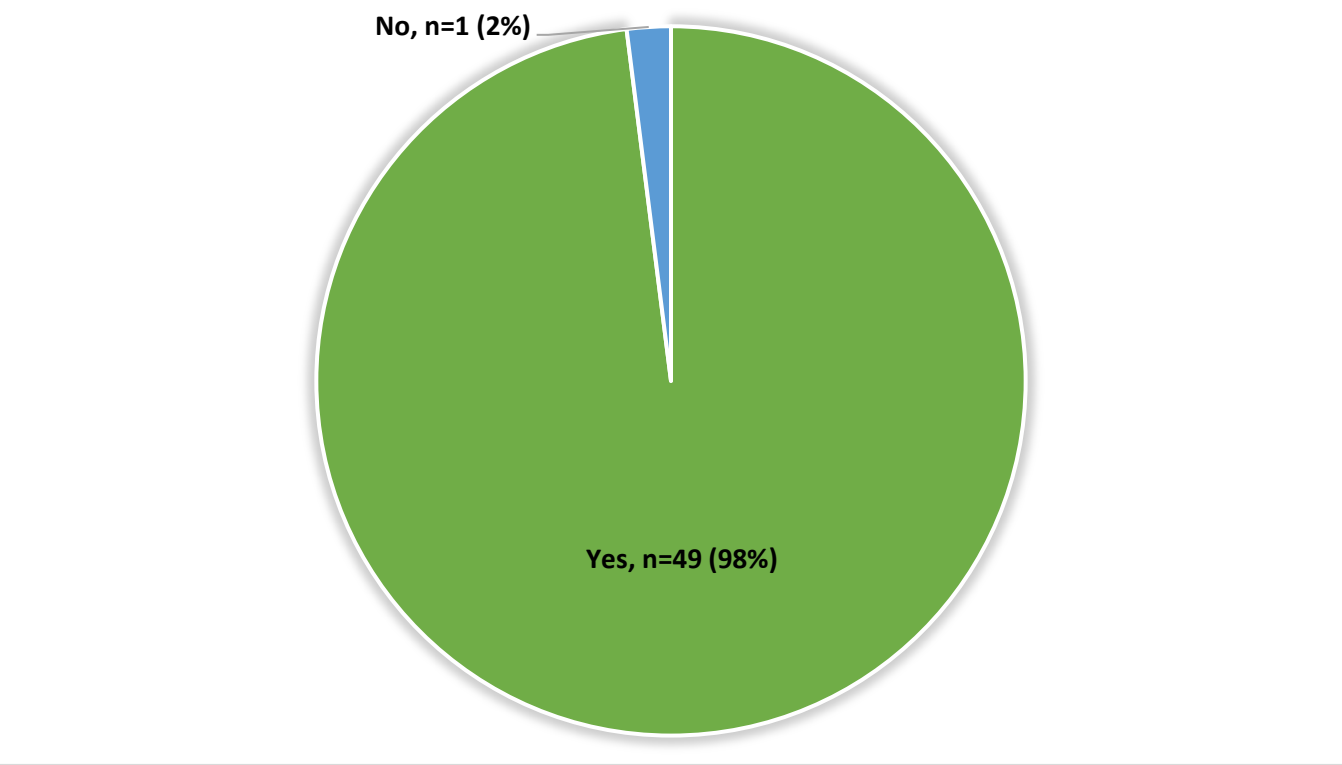

Table 148 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas,	49	98.00%

Response	States	Count	Percentage
	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		
No	New Mexico	1	2.00%
Total		50	100.00%

If "No," please explain why not.

Table 149 - Explanations for not Having POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

State	Explanation
New Mexico	There is not a therapeutic duplication edit for opioids, but there is a therapeutic duplication edit at POS that will capture opioid duplication.

5. Does your State have POS edits to monitor early refills of opioid prescriptions dispensed?

Figure 98 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

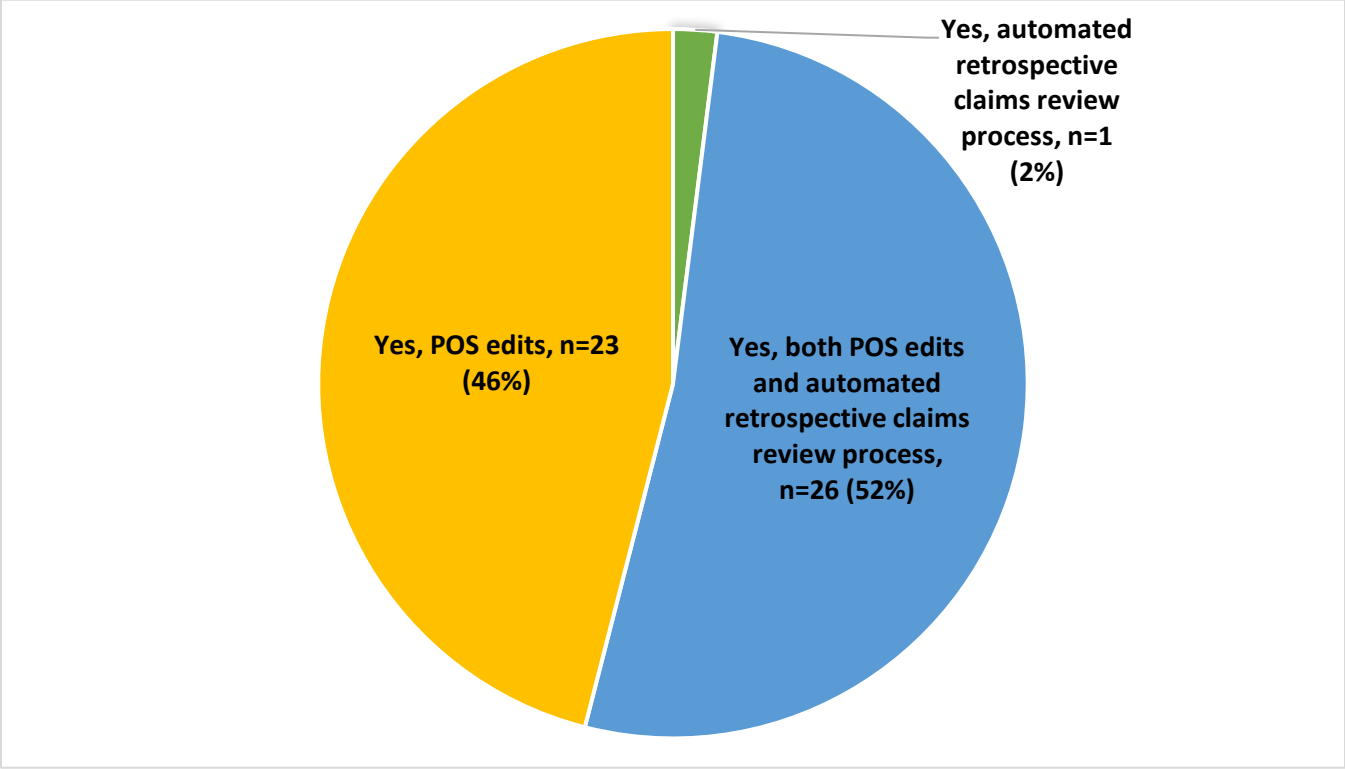

Table 150 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	States	Count	Percentage
Yes, automated retrospective claims review process	Tennessee	1	2.00%
Yes, both POS edits and automated	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Iowa,	26	52.00%

Response	States	Count	Percentage
retrospective claims review process	Kansas, Louisiana, Maryland, Mississippi, Nebraska, New York, North Carolina, North Dakota, Oregon, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin		
Yes, POS edits	Arkansas, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Virginia, Wyoming	23	46.00%
Total		50	100.00%

6. Does your State have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these State limitations (early refills, duplicate fills, quantity limits and days' supply)?

Figure 99 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions Exceeding State Limitations

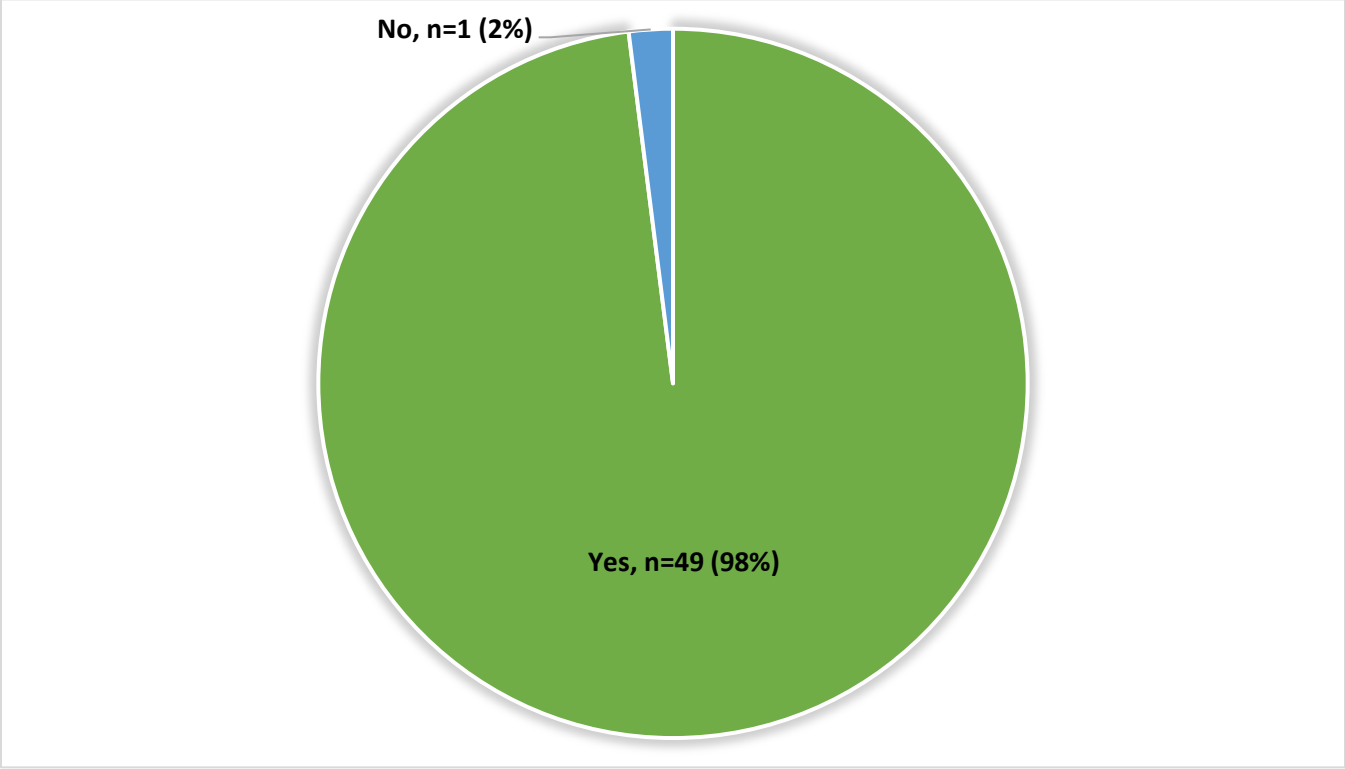

Table 151 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions Exceeding State Limitations

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, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New	49	98.00%

Response	States	Count	Percentage
	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		
No	Massachusetts	1	2.00%
Total		50	100.00%

If "Yes," please explain in detail scope, nature and frequency of these retrospective reviews.

Table 152 – Scope, Nature and Frequency of the Automated Retrospective Claim Reviews

State	Explanation
Alabama	AL Medicaid performs an automated RDUR review on prescription refills of opioids in excess of the prospective safety edit limitations to provide for ongoing review of opioids as specified in the SUPPORT Act. These include: early refills, duplicate fills, quantity limits, accumulation edit and days' supply. In addition, AL Medicaid has retrospective lock-in reviews, as well as weekly, monthly, and quarterly override reports.
Alaska	The opioid report generated is reviewed by the State and with the DUR committee quarterly.
Arkansas	The RetroDUR vendor is monitoring for overutilization of opioids with an automated process for lock-in reviews. 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. High quantity, early refill, and high MME/day retrospective reviews are rare due to very strict POS edits that require a PA to exceed quantity, accumulation and MME limits.
California	Each month all opioid claims are flagged and reviewed in aggregate for excess MME/day, early refills, duplicate fills, quantity limits and days' supply that were approved via Prior Authorization (PA).
Colorado	Retrospective claims review of member opioid utilization is conducted as part of pharmacy call center procedures for processing automated prior authorizations requiring provider-to-provider telephone consultation with the State's contracted pain management physician for cases where member opioid claims exceed a cumulative MME of 200, the fourth fill of an opioid occurs for a previously opioid-naive member, or the fourth fill occurs for an opioid prescribed by a dental provider. Retrospective DUR analysis is also conducted on an ongoing basis for monitoring of overall opioid utilization and MME among beneficiaries.
Connecticut	The automated retrospective claims review 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 or exceeding days supply. CT has automated retrospective claims reviews for identifying recipients receiving duplicate therapy with long acting opioids and short acting opioids. Duplicate therapy criteria negate for malignancy and sickle cell disease. Automated retrospective claims reviews for identifying recipients exceeding quantity limits for solid oral opioids (>240 units per 30 days), liquid oral opioids (>500 ml per 30 days), and injectable opioids (>30 units per 30 days). Quantity limit criteria negate for malignancy and sickle cell disease. These reviews occur monthly during the regular profile review process.
Delaware	Delaware has prospective edits to prevent opioid claims that exceed limitations on duplicate fills, early fills, drug quantity limitations and days supply limits from being dispensed so a retrospective claims review would not capture claims exceeding those

State	Explanation
	limits. When opioid claims are denied due to these clinical edits and are subsequently overridden, they are flagged for manual review through an automated process.
District of Columbia	Monthly retrospective claims review includes opioid prescriptions and these reports are used to monitor aberrant prescribing and dispensing patterns.
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 prescriber's including specialty, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Georgia	The State has access to automated retrospective claim reports that delineate the utilization of opioid prescriptions.
Hawaii	All opioids are manually reviewed for the transplant program and have little to no utilization of this therapeutic class. Transplant patients come from the MCO and managed under the specific MCO formulary. FFS grandfathers any existing PAs and a medical consultant also monitors. Dental use is acute and initial without subsequent fills for patients under the age of 21 years. Reviews for both are done quarterly.
Idaho	Early refills, duplicate fills, quantity limits and day's supply are all part of the Idaho Pharmacy POS edits. These look backs are performed for every opioid claim that is entered at POS and will deny if present in the case of early refill or duplicate fill or if a threshold such as quantity limit or days' supply is exceeded. All claims that exceed MME> 90, quantity per day limitations, > 1 long-acting opioid being used concurrently, or > 7 days' supply for an opioid naive patient deny at POS for prior authorization. Any patient currently exceeding any of these limitations would have been approved through our clinical pharmacy prior authorization program and have been deemed to meet appropriate criteria. In addition, a quarterly report is provided to Idaho Medicaid by our vendor Magellan to identify potential opioid over-utilization. This report includes high MME, opioids used with drugs that potentiate overdose, including antipsychotics, benzodiazepines, gabapentin, and sedative hypnotics and any change in dosage. Top prescribers and pharmacies are also included in this report.
Illinois	HFS periodically reviews impact of opioid edits to determine whether edit changes are needed. The PBM provides monthly automated retrospective reports of participants who filled opioid prescriptions that were over 50 MME and over 90 MME. These reports are used to identify candidates for naloxone prescriber/pharmacy outreach as well as include patients into the chronic pain management program as appropriate. At least annually HFS runs a retrospective report of medication claims for which error codes (edits) were applied for duplicate therapy, quantity, early refills, days supply, drug interactions (DUR), etc. Opioid claims that hit for these edits initially underwent retrospective claims review within the POS edit process and when a prior authorization request was received. Authorization is needed if a claim exceeds State opioid limitations. Further analysis of the opioid-related error codes report will be conducted to determine need for additional prescriber education.
Indiana	Opioid claims are reviewed monthly for MME limits, quantity, number of utilizers, age of utilizers, new starts, and concomitant conditions. Claims exceeding early refill, duplicate fill, quantity limits, and days' supply must be approved through a PA approval process. Additional retrospective review for these types of edits is unnecessary as they are thoroughly reviewed prospectively prior to dispensing.
Iowa	State PDL has quantity limits, duplicate therapy and MME edits. Reports for those members exceeding limits are reviewed quarterly. Reports for those members exceeding limits are reviewed quarterly between FFS and MCOs with referral to the DUR when

State	Explanation
	needed. Early Refill: 3 months of pharmacy claims for early refill override in cases of lost, stolen or destroyed drugs as well as any allowed vacation supply. Controlled substances are excluded from lost, stolen, or destroyed allowance; Duplicate Fills: 3 months of pharmacy claims for members on 2 or more opioids for a minimum of 30 days; Quantity Limits: 3 months of pharmacy claims for members who have been prescribed an opioid medication that exceeds the established daily quantity limit; Days' Supply: 3 months of pharmacy claims for members with a claim for an opioid where the days supplied is greater than 31 days. Opioid Naive: 3 months period of pharmacy claims for members with greater than a 1 day supply of an opioid with no prior claim in prior 60 days from DOS.
Kansas	The State has built data queries to perform this review. Ongoing updating of the queries has been done to improve information populated from the query, which has further helped us in doing these analyses.
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	Louisiana Medicaid reviews claims retrospectively for opioid prescriptions exceeding POS edits every September. Results from September 2022 are as follows: 1. Early refills (before 2 days early) - one intervention was made, 2. Duplicate fills - four interventions were made, 3. Quantity limits - ninety-five interventions were made, 4. Days' supply - ten interventions were made, 5. Greater than 90 MME - twenty-four interventions were made.
Maine	The State utilizes automated retrospective claim reports, generated monthly, that indicate prescription fills of opioids in excess of prospective safety edit limitations and indicate the necessity for prior authorization as part of our ongoing review of opioids as specified in the SUPPORT Act.
Maryland	The Retrospective DUR (RDUR) vendor, Kepro, monitors criteria to look at over-utilization of opioids as part of the Corrective Managed Care program, and performs interventions monthly. Additionally, Kepro 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. Kepro 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, Kepro 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.
Minnesota	SUPPORT Act specific mailings occur two times a year to prescribers regarding their specific patients and corresponding SUPPORT Act drug issue.
Mississippi	We are in the process of developing a system to monitor for opioid prescription exceptions.
Missouri	Missouri does perform an automated retroDUR review on prescription fills of opioids in excess of the prospective safety edit limitations to provide for the ongoing review of opioids as specified in the Support Act. These include but are not limited to: early refills, duplicate fills, quantity limits and days' supply.

State	Explanation
Montana	We deny claims that exceed these limitations at point of sale and require prior authorization. Therefore, claims that exceed our limitations have been authorized by the State or it's PA vendor. Our retroDUR vendor has recently implemented an automated retrospective claims review to ensure these ProDUR edits are working as expected. This process was implemented ahead of the 6/30/2023 estimated implementation date.
Nebraska	Claims review utilizes the lock-in criteria to identify patients and the early refill edits at point of sale to identify patient receiving early refills or exceeding days supply. Drug alert is sent to the pharmacies with each fill.
Nevada	Point-of-sale (POS) edits are in place for early refills and duplicate of opioid prescriptions.
New Hampshire	All opioid claims are automatically reviewed monthly. The daily MME for combined and overlapping opioid prescription fills is calculated and a report is generated and reviewed monthly. The report identifies utilization above the prospective 100 MME daily limit for the month under review, as well as retrospectively over the preceding 3-month and 6-month time frames.
New Jersey	Ad hoc quarterly reports are generated for claims review and provider follow up as needed.
New Mexico	Obtained quarterly reports concerning patients using opioids greater than 90 MME per day are reviewed and monitored. Edits for early refills and ingredient duplication are also monitored.
New York	The RetroDUR program maintains criteria to identify the incidence of therapeutic duplications. If inappropriate drug therapy is identified, an intervention letter is sent to prescribers and/or pharmacists detailing the potential drug therapy problem. In addition to the RetroDUR process, targeted educational letters can also be used for select clinical issues through the actions of the DUR Board.
North Carolina	NC has automated reports on drugs hitting the Early Refill Edit. Early refills are only allowed for opioids when there is a change in therapy. Additionally, the DUR Board reviews the top drugs that hit the POS DUR edits quarterly, periodically review profiles for members receiving more than the 90 MME limit, and look for drug combinations that increase patient risk for adverse events.
North Dakota	Retrospective letter generation is automated by matching criteria against medical and drug claims. Opioid criteria is selected by a pharmacist on a cyclical basis (quarterly). These matches are loaded into an electronic queue to be reviewed by a pharmacist prior to being distributed to pharmacies and prescribers. The State also reviews claims that exceed State limitations prospectively to determine whether an override is medically necessary.
Ohio	We have an automatic retrospective review built into our daily concurrent claim review process which identifies opioid prescriptions that exceeded the MDD limit, quantity limit, high quantity per day supply, duplicate fills, early refills. These are all identified through our daily algorithms. This is reported in the program integrity report for the next day for auditor review.
Oklahoma	Oklahoma does perform an automated retroDUR review on prescription fills of opioids that exceed the prospective safety edit limitations to provide for the ongoing review of opioids as specified in the Support Act. These include but are not limited to: early refills, duplicate fills, quantity limits and days' supply.
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

State	Explanation
	inclusion criteria met (see list below). Those meeting the greatest number of inclusion criteria are reviewed manually each quarter. Prescription and at least one of the following criteria: 90 Morphine Milligram Equivalents (MMEs) cumulative daily dose Concurrent paid claims for short- and long-acting opioids Concurrent paid claims for > 2 unique opioids Multiple paid claims for early opioid fills 3 unique denied claims for opioid prescriptions Patients are prioritized based on the number of inclusion criteria met. Higher priority patients meet more inclusion criteria. Individual patient profiles are reviewed, and the prescriber is lettered with a clinical recommendation. Patients excluded from the report: Patients with a malignant cancer diagnosis or claim for palliative care. Patients with a diagnosis of sickle cell disease in the past year Patients with currently active TPL or Medicare coverage Patients previously reviewed with this initiative in the last 6 months.
Pennsylvania	Prior authorization is required through POS edits for all long acting opioids and for first prescriptions for short acting opioids where the days supply is exceeded. For all subsequent short acting opioid prescriptions, prior authorization is required. The medical necessity review encompasses the beneficiary's history of early refills, duplicate fills, quantities and day supplies filled and requested. The RetroDUR program is leveraged for identifying concomitant use of opioids and other CNS depressants.
Rhode Island	The automated retrospective claims review 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 or exceeding days supply. RI has automated retrospective claims reviews for identifying recipients receiving duplicate therapy with long acting opioids and short acting opioids. Duplicate therapy criteria negate for malignancy and sickle cell disease. Automated retrospective claims reviews for identifying recipients exceeding quantity limits for solid oral opioids, liquid oral opioids, and injectable opioids. Quantity limit criteria negate for malignancy and sickle cell disease. These reviews occur monthly during the regular profile review process.
South Carolina	Ad hoc reporting is available
South Dakota	The RDUR system monitors for prescriptions exceeding State limitations.
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	Texas conducts periodic retrospective claim review and interventions which include the criteria for opioid overutilization. Prescribers whose opioid prescribing appears to exceed the set parameters will be flagged. and will receive educational intervention letters. The criteria parameters may differ for members depending on the patient's disease condition. For example, those with diagnosis of cancer, sickle cell, or hospice and palliative care may be allowed to have access to more prescriptions and higher quantities.
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	Explanation
	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.
Vermont	The claim will not pay if exceeding these limitations. Prior Authorization would be required. The State also utilizes automated retrospective claim reports, generated monthly, to monitor opioid prescriptions, as part of our ongoing review of opioids as specified in the SUPPORT Act. The State also applies a cumulative days supply edit.
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) has hired 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
West Virginia	We have automated reports from the claims processor that generate quarterly that mirror the edits on quantity limits, days' supply, duplicate therapy, and early refill. This report is provided to the RetroDUR vendor for regular review.
Wisconsin	Wisconsin has comprehensive automated retrospective claim reviews monthly of opioid prescription dispensing. This includes overutilization criteria, days' supply, units dispensed, frequency of fills, etc., and lock-in reviews. Wisconsin also monitors the average opioid MMEs for members.
Wyoming	An automated report is produced by Change Healthcare including MME levels on a quarterly basis. These reports are reviewed regularly. As all prescriptions exceeding limitations require prior authorization, these clients are followed very closely by the PA Help Desk team.

If “No,” please explain why not.

Table 153 - Explanation of “No” Comprehensive Automated Retrospective Claim Reviews

State	Explanation
Massachusetts	As of 6/2023, our DUR program will set up an automatically run report to monitor for how many opioid claims have been overridden early, approved for duplication, and exceeding quantity limits.

7. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?

Figure 100 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently

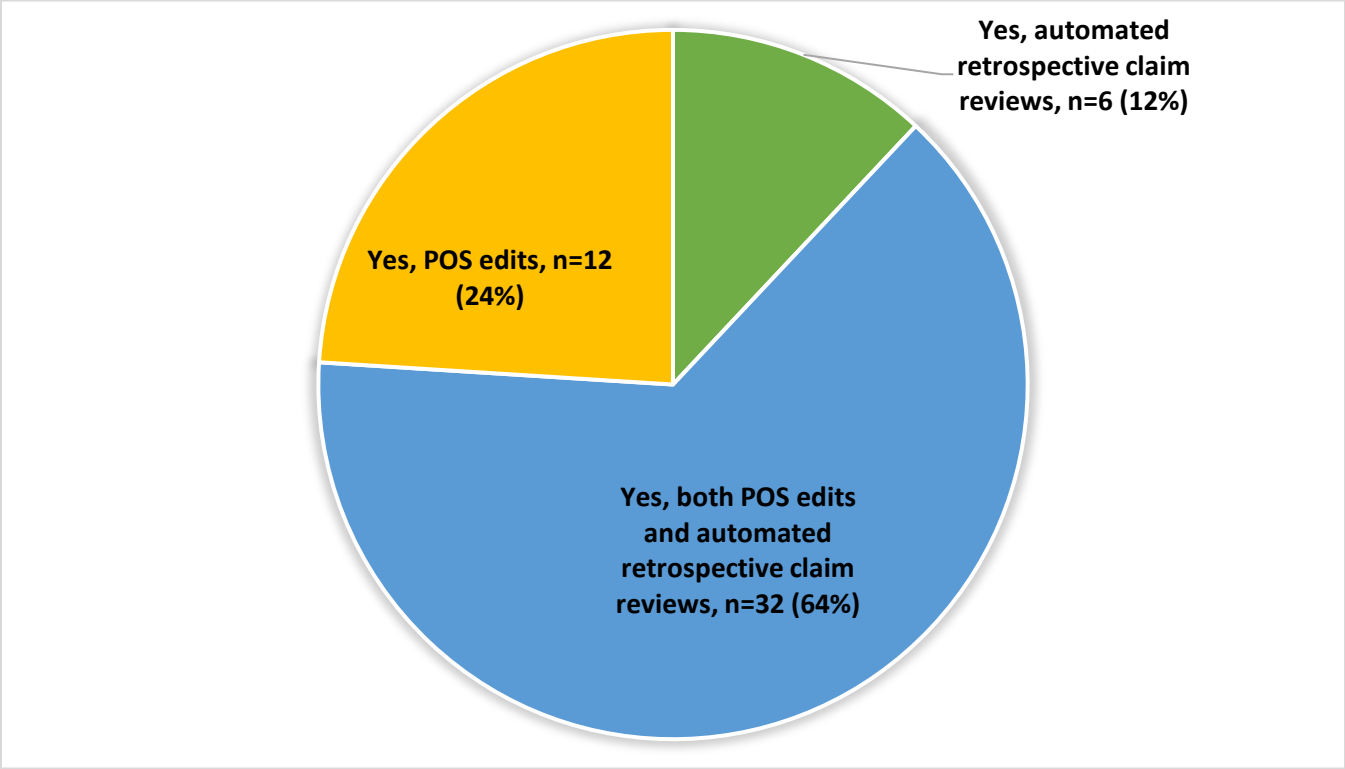

Table 154 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	Alabama, Hawaii, Michigan, New Mexico, Washington, Wisconsin	6	12.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia	32	64.00%
Yes, POS edits	Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Jersey, Oklahoma, South Carolina, Tennessee, Wyoming	12	24.00%
Total		50	100.00%

If "Yes," please explain above and detail scope and nature of reviews and edits for opioids and benzodiazepines being used concurrently.

Table 155 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Benzodiazepines Being Used Concurrently

State	Explanation
Alabama	SUPPORT Act of 2018 RDUR criteria: 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.
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 beneficiaries with poisoning/overdose diagnoses billed in the previous year. Any beneficiary 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. During the July 20, 2021 DUR Board meeting, the Board voted to implement a drug-to-drug interaction message at POS for concomitant fills for an opioid with any of the following: benzodiazepine, muscle relaxer, gabapentin, sedative hypnotic, or antipsychotic requiring the pharmacy to override the DUR rejection with approved DUR codes. This educational edit requires the pharmacist to review the medical necessity for concomitant therapy and enter a DUR override to dispense the combination therapy.
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. Several provider and pharmacy mailings on this topic have been initiated after retrospective reviews showed areas that could be improved. In addition, the total number of Medi-Cal beneficiaries with concomitant use of opioids and benzodiazepines during each calendar month has been tracked on a monthly basis since October 1, 2019.
Colorado	ProDUR alert system 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 claims review of member concomitant long-term use of a benzodiazepine with a prescribed opioid is evaluated as part of provider-to-provider telephone consultation with the State's contracted pain management physician, and titration processes may be evaluated as part of the consult based on the individualized treatment

State	Explanation
	plan and with consideration for a specific member's needs. Retrospective DUR is also conducted and letters are sent to providers regarding members' 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 will generally only be approved if the member is not receiving a concurrent benzodiazepine or if a taper plan for the benzodiazepine is provided. 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	The POS contractor produces monthly automated reports that track utilization of opioids and benzodiazepines concurrently. Patients chronically utilizing benzodiazepines who are identified through the prior authorization process and who require opioid medications for breakthrough pain, acute dental or surgical procedures are able to obtain needed medications without jeopardizing patient care.
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 opioids and BZDs will trigger POS message that this combination is not recommended.
Hawaii	Annual reviews are done as there is no history of opioid and benzodiazepine use in the transplant program. Patients are effectively managed in the MCO prior to entering the FFS transplant program and while remaining in it. The dental program is for initial and acute care; there is no history of opioid and benzodiazepine use in the dental program.
Idaho	ProDUR edits and RetroDUR reviews. The opioid prior authorization form includes an attestation that the patient will not be using opioids concurrently with benzodiazepines, sedative-hypnotics or barbiturates or a taper plan to discontinue the concurrent agent is submitted with the PA request. Date of last taper attempt is requested. The form includes a link to a guide to assist with opioid tapering. The Geo Mapping program discussed in #3 above includes information on patients receiving an opioid concurrently with a benzodiazepine. Patients on concurrent therapy would have been evaluated and approved through our clinical pharmacy prior authorization program and been deemed to meet appropriate criteria (such as short-term use of an opioid or an approval to allow an appropriate taper to occur)
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

State	Explanation
	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 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. HFS will work with prescribers who desire to taper participants off benzodiazepines or opioids by assuring appropriate prior approvals are in place as needed. Opioids, if approved in patients taking chronic benzodiazepine therapy, are subject to current opioid edits. Similarly, approved benzodiazepines are subject to current benzodiazepine quantity limits.
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 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	The RDUR queries were not easy to build and had to be modified several times to make the data easier to evaluate. We address the concerns of opioids and other medications such as benzos in our opioid PA criteria and guidance. PA reviewers use all of this information in their PA reviews.
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: 57 interventions were mailed to prescribers regarding individuals who had concurrent prescriptions for opioids and benzodiazepines in FFY22. 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. Kepro 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.

State	Explanation
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. For RetroDUR, there are two RetroDUR mailings per year for the SUPPORT Act which includes opioids and benzodiazepines being used concurrently.
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	With the implementation of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, State Medicaid programs have new requirements regarding prescription drug utilization reviews. MO HealthNet is introducing new processes to monitor concurrent prescribing of opioids, benzodiazepines, and antipsychotics to meet the above requirements. The combination of opioids and CNS depressants (i.e., benzodiazepines, sedative hypnotics, and gabapentinoids) is considered a high risk therapy as both may cause sedation, impaired cognitive function, and respiratory depression potentially leading to an overdose fatality. Unfortunately, many patients are still prescribed these high risk therapy combinations. In 2016, the CDC released their Guideline for Prescribing Opioids for Chronic Pain; further clarification of these guidelines was published in 2019. These guidelines recommend avoiding the prescribing of benzodiazepines concurrently with opioids whenever possible. Also, both opioids and benzodiazepine prescription products now carry a boxed warning from the FDA highlighting the danger of using these agents together. In 2019, the FDA also added a boxed warning to gabapentinoid agents on the risk of respiratory depression when used alone or with opioids. Recently, several studies have pointed to an increased risk of overdose when combining non-benzodiazepine sedative hypnotics with opioid therapy, especially the (z-drugs) zolpidem, zaleplon, and eszopiclone. Naloxone is an opioid antagonist indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression. Pharmacists in Missouri are able to dispense naloxone according to protocol upon request or upon presentation of a valid prescription. A Statewide Standing Order issued by the Missouri Department of Health and Senior Services is available at https://pr.mo.gov/boards/pharmacy/NaloxoneStandingOrder.pdf. As part of the efforts to protect participants from the possible adverse effects of combining opioid and CNS depressant medications, MO HealthNet will impose clinical criteria to require the presence of an opioid emergency reversal agent, such as naloxone, when these agents are used concomitantly.
Montana	We prospectively limit benzodiazepines when used with methadone. We retrospectively outreach to providers who prescribe benzodiazepines and/or opioids to members who receive both.
Nebraska	ProDUR Drug/Drug alert safety edit is in place and point of sale and is sent to the pharmacies with each fill.

State	Explanation
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 opioids 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 reporting, the State performs monthly retrospective reviews. These encompass an outreach to the prescriber to determine medical necessity, as well as alerting 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 Mexico	Quarterly automated retrospective claims reviews are used to monitor opioids and benzodiazepines being used concurrently.
New York	POS: Prior authorization required. RetroDUR: The Retro DUR program maintains criteria to identify co-administration of opioids and benzodiazepines. If inappropriate drug therapy is identified, an intervention letter is sent to prescribers and/or pharmacists detailing the potential drug therapy problem. In addition to the RetroDUR process, targeted educational letters can also be used for select clinical issues through the actions of the DUR Board.
North Carolina	NC has an edit for concurrent use of opioids and benzodiazepines. NC also does retrospective DUR reviews of concurrent use.
North Dakota	To prevent disruption of patient care, long acting opioids < 90 MME/day and short acting opioids < 15 MME/dose are allowed with benzodiazepines. These claims are matched against criteria to generate retrospective letters to pharmacies and prescribers in an automated process. POS edits require prior authorization for benzodiazepines used concurrently with long acting opioids exceeding 90 MME/day or short acting opioids exceeding 15 MME/day. Criteria for concurrent use include access to Narcan and routine drug screens, providing a prescriber led taper plan or oncology or pain management specialist involvement.
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 by calling the help desk. 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

State	Explanation
	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 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 excluded 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	Monthly RetroDUR letters are sent to prescribers for patients on opioids and benzodiazepines. During the prior authorization process for opioids, benzodiazepine utilization is assessed using the following guideline: In evaluating a request for prior authorization of a prescription for an Analgesic, Opioid Short-Acting, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary.
Rhode Island	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	At the State's direction and request, Ad hoc reporting is available. Additionally, the State's Program Integrity Department continues to monitor/review individuals for the Lock-In program. MUSC (The Medical University of South Carolina) continues to provide outreach and education for providers via their tipSC (Timely Information for Providers in South Carolina) website, academic detailing and presentations/public meetings.
South Dakota	The POS monitors for concomitant use of an opioid and benzodiazepine and messages the pharmacist during adjudication. The RDUR system alerts to the concomitant use of an opioid and a benzodiazepine and an intervention letter is generated if the review committee member feels it is clinically relevant.
Tennessee	Prior to 2014, Tennessee did not cover benzodiazepines (BZO) for adults. When mandated in 2014, our prior authorization criteria was so stringent that we covered around 1% of our enrollees' total use of BZO (found from data from the PDMP). Our BZO criteria has always included a denial if the enrollee was using opioids. Opioids are also denied if the enrollee

State	Explanation
	is using BZO, unless the BZO is being prescribed by a mental health provider, per Tennessee's Chronic Opioid (non-cancer) Prescribing Guidelines. Additionally, 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 (excluding clonazepam and rectal dosage form of diazepam) with a 14-day overlap. In response to a part of the Federal Support Act, the retro-DUR review and intervention for opioid-benzodiazepine combination as well as antipsychotics- opioid combination are conducted regularly.
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	There is soft messaging that alerts the pharmacist of this combination. This is also on a routine schedule for retrospective DUR analysis in conjunction with the DUR Board.
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 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

State	Explanation
	patients receiving opioids and benzodiazepine concurrently. Prescriber phone calls are conducted when the prescriber continues to remain an outlier. Wisconsin has developed educational letters to inform prescribers when a member is receiving multiple CNS depressants (opioids, benzodiazepines, sedative hypnotics, and skeletal muscle relaxants). Wisconsin has developed educational letters to inform prescribers when a member is receiving multiple benzodiazepines or high dose chronic benzodiazepines.
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.

8. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?

Figure 101 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

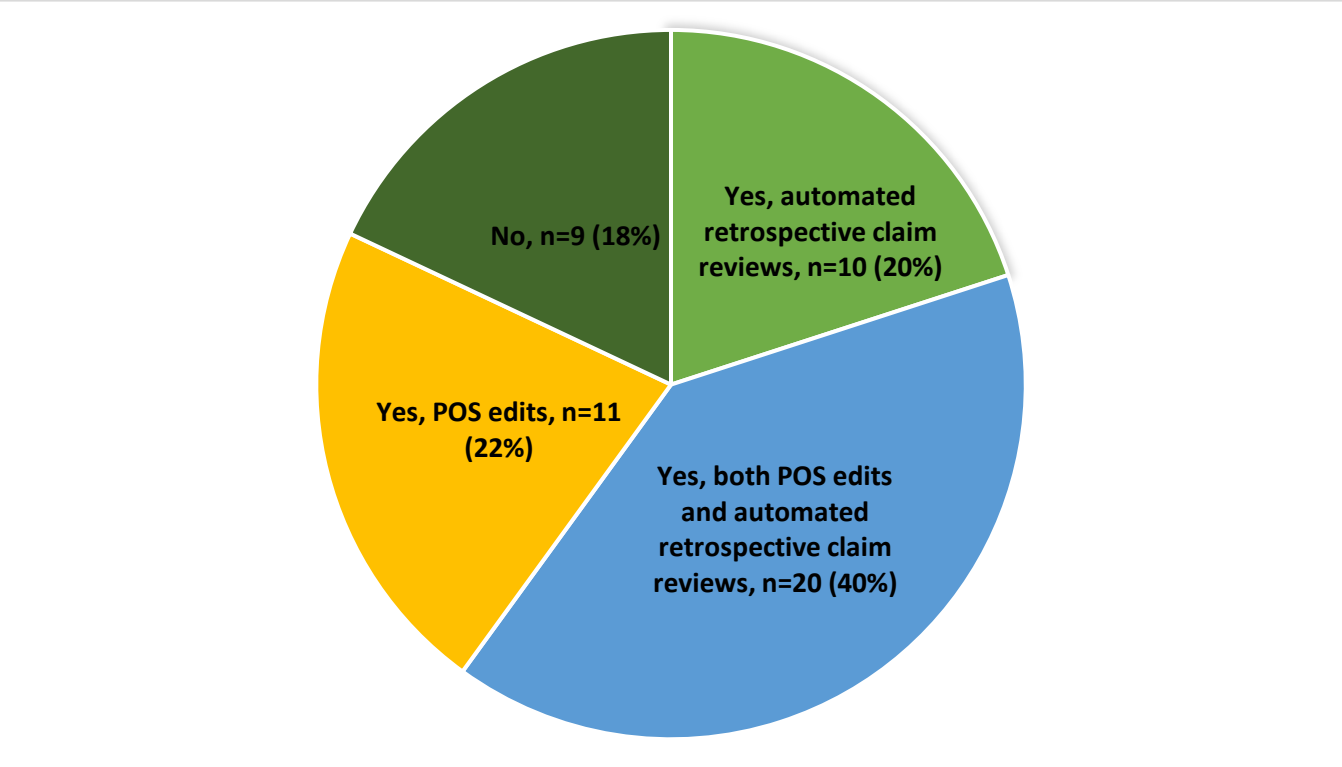

Table 156 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	Alabama, Colorado, Connecticut, Hawaii, Louisiana, Maryland, Michigan, Washington, Wisconsin, Wyoming	10	20.00%
Yes, both POS edits and automated	Alaska, Arkansas, California, Delaware, Florida, Idaho, Kansas, Minnesota, Mississippi, Missouri, Nevada, New	20	40.00%

Response	States	Count	Percentage
retrospective claim reviews	York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas		
Yes, POS edits	District of Columbia, Maine, Massachusetts, Nebraska, New Hampshire, New Jersey, Oklahoma, South Carolina, Vermont, Virginia, West Virginia	11	22.00%
No	Georgia, Illinois, Indiana, Iowa, Kentucky, Montana, New Mexico, Tennessee, Utah	9	18.00%
Total		50	100.00%

If "No," please explain why not.

Table 157 - Explanations for not Having POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

State	Explanation
Georgia	POS edits are currently under review.
Illinois	No current POS edits address concomitant sedative and opioid therapy. Fee-for-Service only allows 8 sedative units per month. The automated RetroDUR 300 identifies patients based on Medispan criteria, not just patients filling 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	It is a DUR meeting topic currently under discussion for consideration of appropriate initiatives.
Kentucky	These types of issues are addressed with RetroDUR lettering campaigns.
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 Mexico	Current monitoring systems are in place for opioids and benzodiazepine derivatives. Plan to expand edits to include all medications utilized as a sedative.
Tennessee	We are not aware of a standard ProDUR edit addressing the concomitant use of opioids and sedatives. We do address this issue with retrospective claim reviews that include the concomitant use of opioids with BZD, sedatives, and/or antipsychotics.
Utah	Will implement in the future

9. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?

Figure 102 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

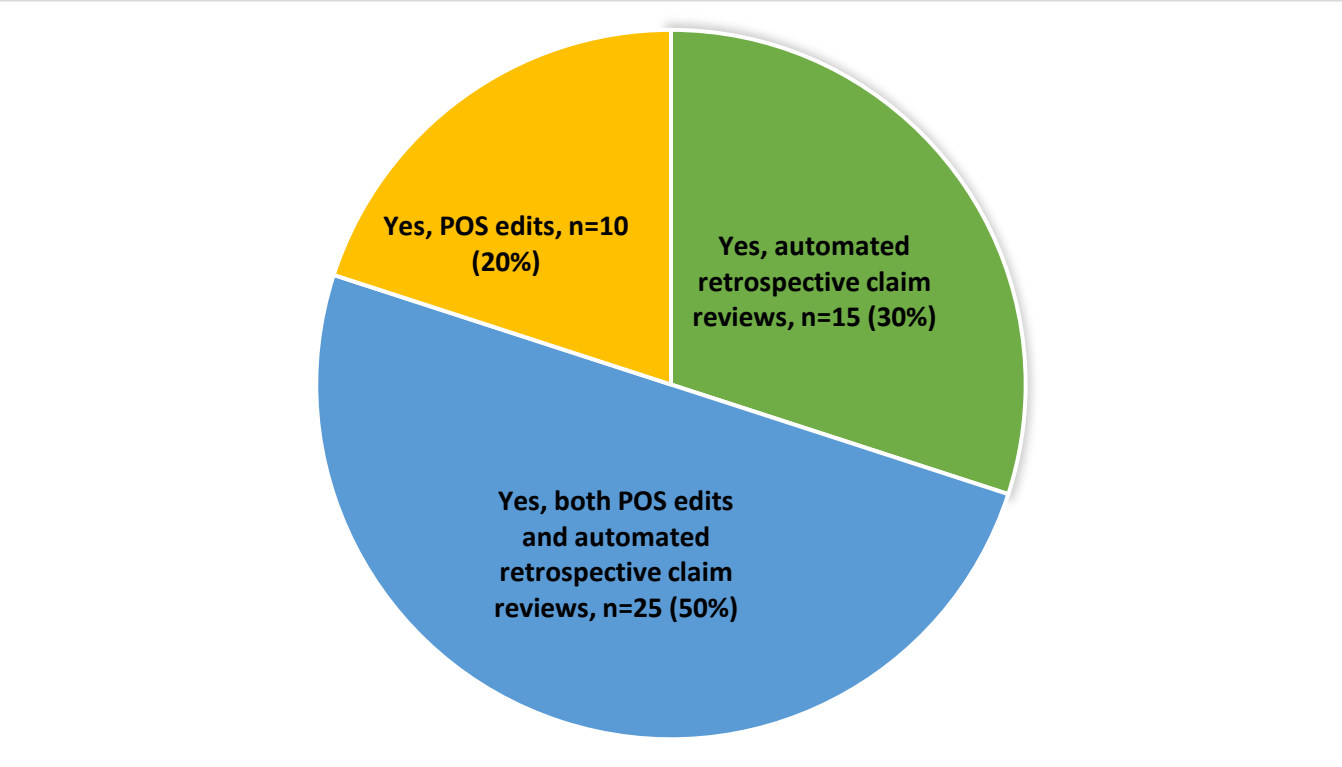

Table 158 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	Alabama, Hawaii, Louisiana, Michigan, Montana, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Washington, Wisconsin, Wyoming	15	30.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Nevada, New York, North Carolina, North Dakota, Oklahoma, South Dakota, Vermont, Virginia, West Virginia	25	50.00%
Yes, POS edits	Colorado, Georgia, Illinois, Maine, Massachusetts, Nebraska, New Hampshire, New Jersey, South Carolina, Tennessee	10	20.00%
Total		50	100.00%

10. Does your State have POS safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

Figure 103 - State Has POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

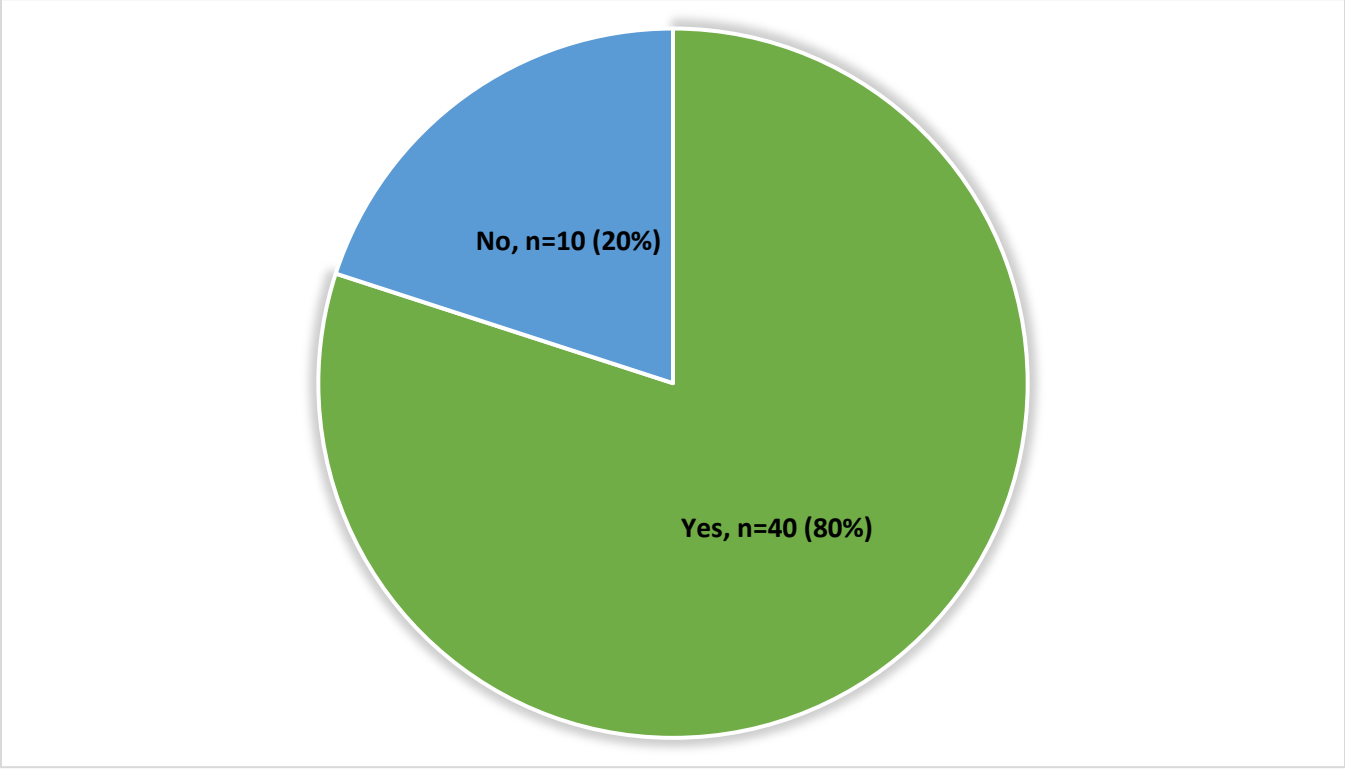

Table 159 - State Has POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

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

If "No," please explain why not.

Table 160 - Explanation for not having POS safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis

State	Explanation
Alaska	Alaska Medicaid is exploring data capabilities with our SURS team.
Delaware	Pharmacy claims do not required a diagnosis code to be entered on OUD prescriptions. Pharmacy claims are not cross referenced with diagnosis codes on medical claims to determine if a member has a history or OUD or opioid poisoning.
Indiana	POS edits, retroDUR disclosures, and/or provider education 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.
Massachusetts	Ad hoc retrospective reviews including direct outreach to prescribers bi-weekly for members who exceed clinical thresholds.
Nevada	Due to system limitations with the contracted Pharmacy Benefit Manager (PBM), the State currently does not have Point-of-Service (POS) safety edits or automated retrospective claims reviews in place for beneficiaries with a history of opioid use disorder (OUD) or opioid poisoning diagnosis is not currently being conducted. The State has procured a new vendor and is currently in the process of implementing one of these enhancements to the system.
New Mexico	Plans for implementation in 2024 or 2025.
North Carolina	NC has engaged in discussions with DHB legal team regarding the addition of new claims edits to identify beneficiaries who have a history of OUD or opioid poisoning diagnosis. Implementation is pending. The DUR Board has reviewed this topic.
Utah	Will implement in the future
Wyoming	Data is reviewed approximately annually, however, it is not an automated process. Utilization has been minor in this population, however, it will be monitored regularly.

If "Yes," please check all that apply.

Figure 104 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

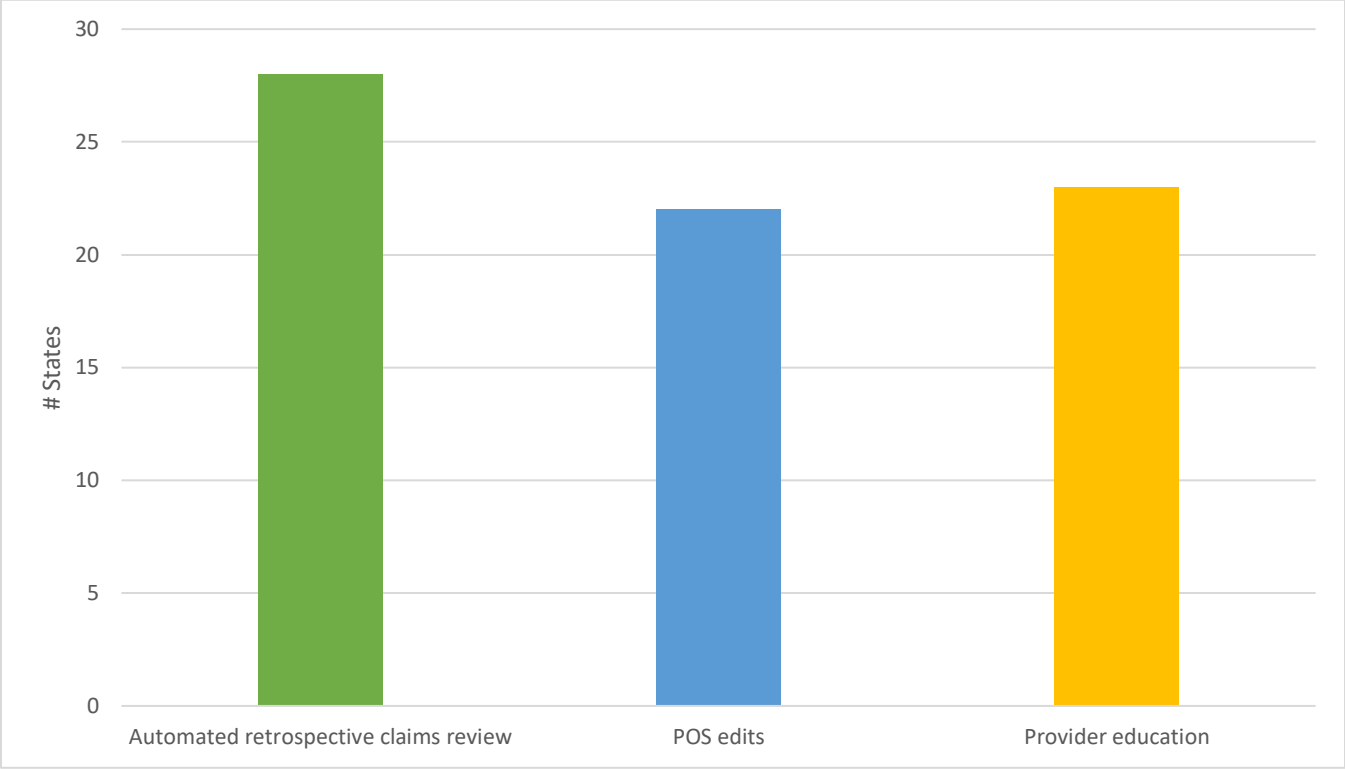

Table 161 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Automated retrospective claims review	Alabama, California, Connecticut, District of Columbia, Florida, Hawaii, Idaho, Kansas, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin	28	38.36%
POS edits	Arkansas, Colorado, District of Columbia, Georgia, Idaho, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, Washington	22	30.14%
Provider education	California, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Kansas, Louisiana, Maine, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington	23	31.51%
Total		73	100.00%

If "Automated retrospective claim reviews" and/or "Provider education," please indicate how often.

Figure 105 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

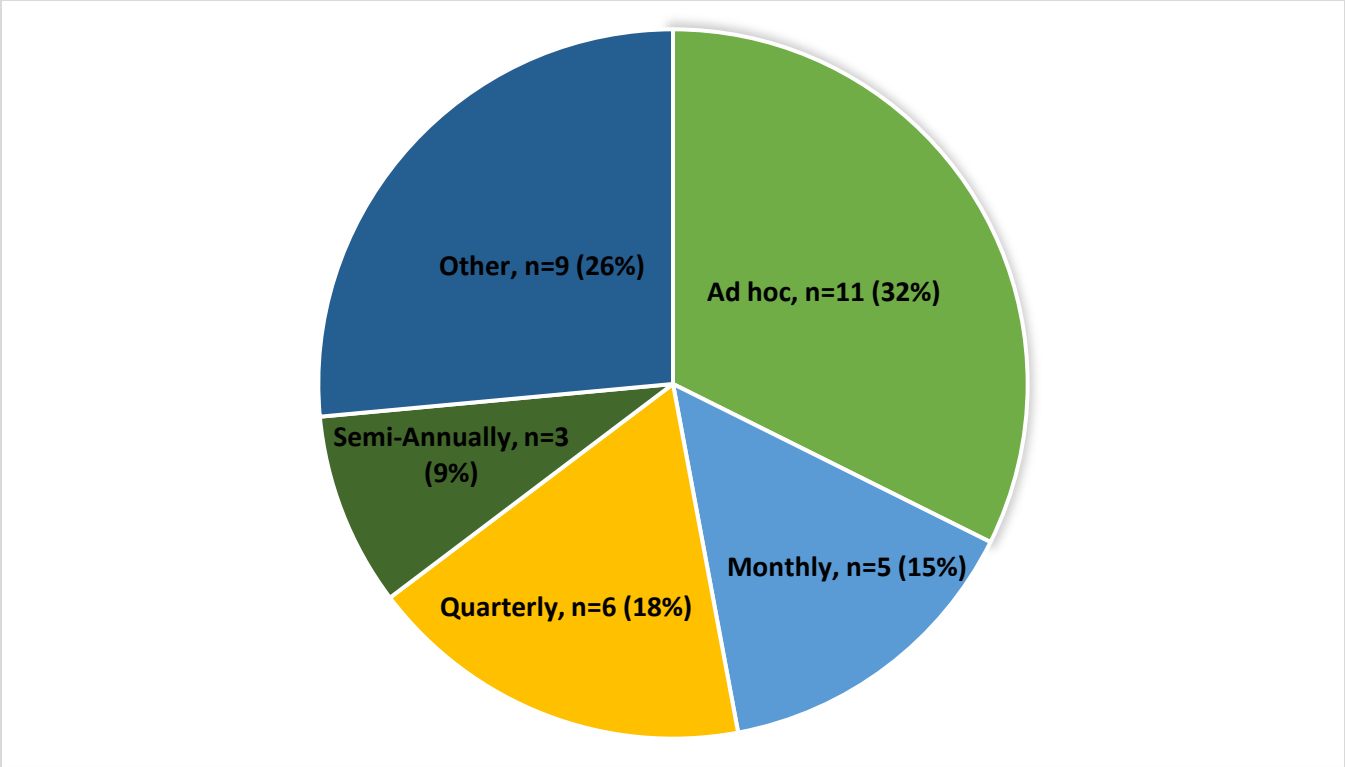

Table 162 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Ad hoc	Georgia, Illinois, Louisiana, Michigan, Mississippi, Nebraska, New Hampshire, New Jersey, New York, Oregon, Rhode Island	11	32.35%
Monthly	Alabama, Pennsylvania, South Dakota, West Virginia, Wisconsin	5	14.71%
Quarterly	Florida, Hawaii, Missouri, North Dakota, Ohio, Virginia	6	17.65%
Semi-Annually	Idaho, Maine, Minnesota	3	8.82%
Other	California, Connecticut, District of Columbia, Kansas, Montana, South Carolina, Texas, Vermont, Washington	9	26.47%
Total		34	100.00%

If "Other," please specify.

Table 163 - "Other" Explanations for Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

State	Explanation
California	Retrospective reviews of beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis are performed at least monthly and on an ad-hoc basis.

State	Explanation
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 specialty intervention annually with more specific parameters that target recipients who receive any controlled substance with a diagnosis of poisoning, who also have specific risk factors for overdose including opioid use disorder.
District of Columbia	Automated retrospective claims reviews are performed monthly. Provider education is offered on an adhoc basis.
Kansas	Our RDUR query can be run quarterly. Due to the potential for violation of 42 CFR Part 2 SUD HIPPA requirements, we have policy guidance as provider education for OUD patients, requiring this PDMP monitoring as the responsibility of the OBOT and OPT providers. A minimum of every two weeks, the OBOT and OPT providers are to check our State PDMP for their patient's use of opioids for pain. These providers are to reach out to the provider who prescribed the pain meds.
Montana	Prior authorization is required for MOUD and for any opioid for a member with a history of OUD. We review the member history and discuss/educate the provider each time a member with a history of opioid use disorder receives a prescription for an opioid. We educate providers prior to paying for buprenorphine products for MOUD. This education follows SAMHSA guidelines for MOUD prescribing.
South Carolina	Ad hoc reports as requested. The State also partners with MUSC (The Medical University of South Carolina), additional information/resources are located at schealthviz.sc.edu
Texas	The POS clinical PA criteria will reject claims for opioids if diagnosis of OUD is found. Also, the retro-DUR interventions on Opioids include performance indicators to target providers writing opioid prescriptions for clients with OUD diagnosis.
Vermont	One example of this, if a member has filled Sublocade within the prior 60 days a prescription for any dose of Suboxone will reject. Additionally, a safety checklist has been developed for prior authorization. There are also operational reports reviewed regularly available monthly that pulls in members using MAT and opioids concurrently.
Washington	Both Quarterly and Ad Hoc.

If "No," does your State plan on implementing automated retrospective claim reviews and/or provider education regarding beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

Figure 106 - Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

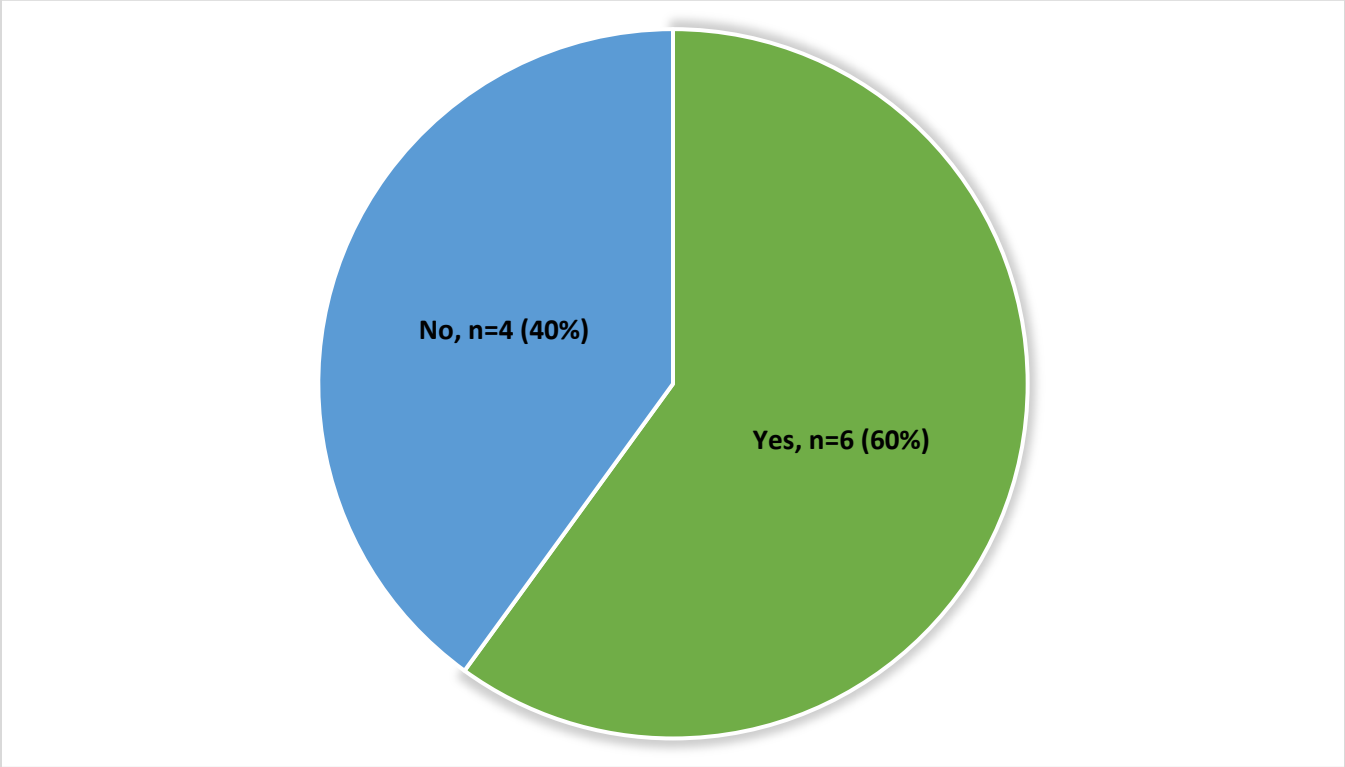

Table 164 - Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Response	States	Count	Percentage
Yes	Alaska, Delaware, Nevada, New Mexico, North Carolina, Utah	6	60.00%
No	Indiana, Kentucky, Massachusetts, Wyoming	4	40.00%
Total		10	100.00%

If "Yes," when does your State plan on implementing?

Table 165 - "Yes" Explanations for Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

State	Explanation
Alaska	Alaska Medicaid is exploring data capabilities with our SURS team.
Delaware	Delaware has safety edits in place for participants actively receiving MAT, this is based on prescription claims instead of diagnosis codes, which may be incomplete. POS system does not access diagnosis codes from medical claims.
Nevada	The integration of one of these enhancements is planned to be completed within the next two years.
New Mexico	Implementation planned for 2024 or 2025.
North Carolina	Implementation is pending.
Utah	2024

If "No," please explain why not.

Table 166 - "No" Explanations for Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

State	Explanation
Indiana	POS edits, retroDUR disclosures, and/or provider education 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.
Massachusetts	Ad hoc retrospective reviews including direct outreach to prescribers bi-weekly for members who exceed clinical thresholds.
Wyoming	Based on low utilization, an increase in review intensity is not necessary at this time.

11. Does your State Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?

Figure 107 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

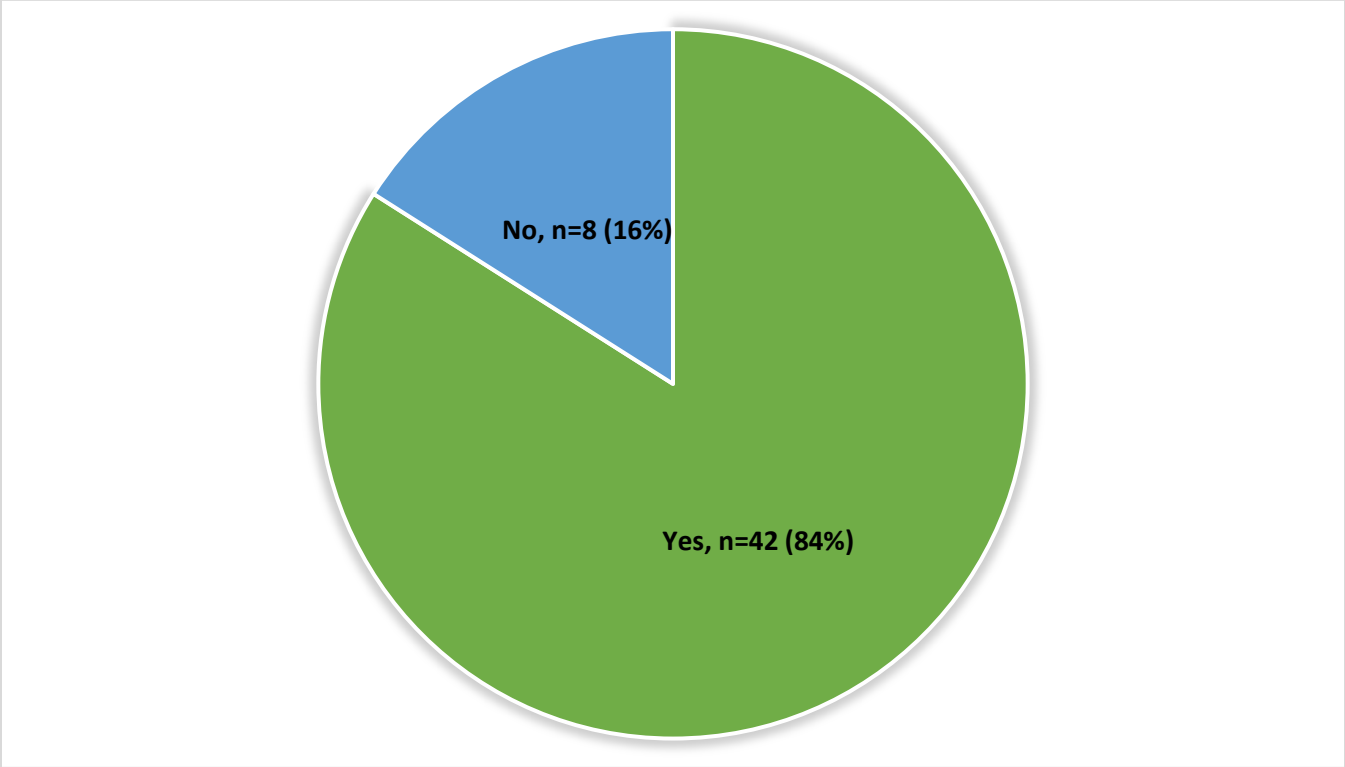

Table 167 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

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, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina,	42	84.00%

Response	States	Count	Percentage
	Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia		
No	Louisiana, Maryland, Missouri, New Hampshire, Pennsylvania, South Dakota, Wisconsin, Wyoming	8	16.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 108 - Pain Management / Opioid Prescribing Guidelines Provided

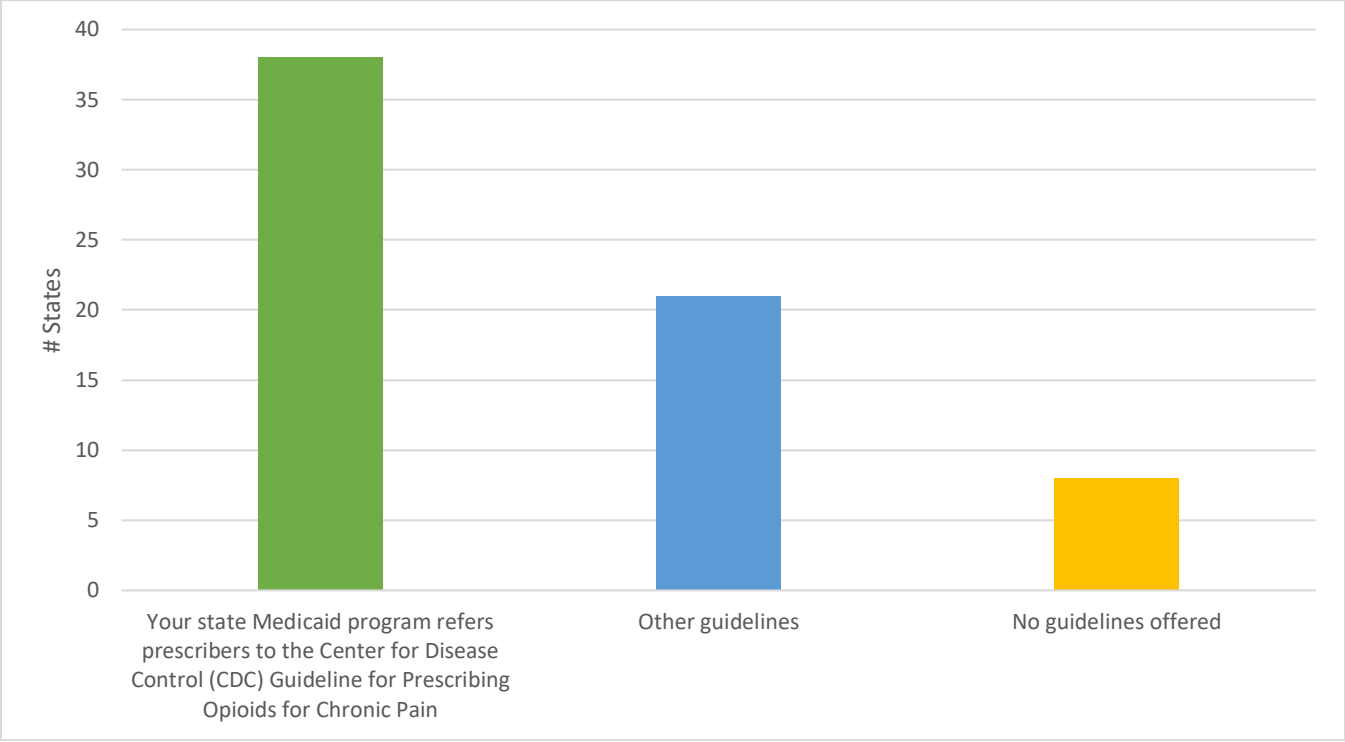

Table 168 - Pain Management / Opioid Prescribing Guidelines Provided

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, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia	38	56.71%
Other guidelines	Alabama, Alaska, Arkansas, California, Colorado, District of Columbia, Idaho, Illinois, Kansas, Minnesota, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Utah, Vermont, Virginia, Washington, West Virginia	21	31.34%
No guidelines offered	Louisiana, Maryland, Missouri, New Hampshire, Pennsylvania, South Dakota, Wisconsin, Wyoming	8	11.95%
Total		67	100.00%

If "No," please explain why no guidelines are offered.

Table 169 - Explanations for not Offering Pain Management/Opioid Prescribing Guidelines

State	Explanation
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	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.
New Hampshire	The Office of Professional Licensure and Certification (OPLC) Board of Medicine has opioid prescribing guidelines for their licensees to follow on their website.
Pennsylvania	The Pennsylvania Department of Health has developed opioid prescribing guidelines for prescribers in Pennsylvania.
South Dakota	Medicaid agency defers to established guidelines prepared by professional organizations.
Wisconsin	Wisconsin refers prescribers to the Wisconsin Medical Examining Board opioid guidelines.
Wyoming	These guidelines are offered by the Board of Medicine. On occasion, targeted education letters are sent regarding updates to the CDC Opioid Prescribing guidelines.

12. 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 109 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

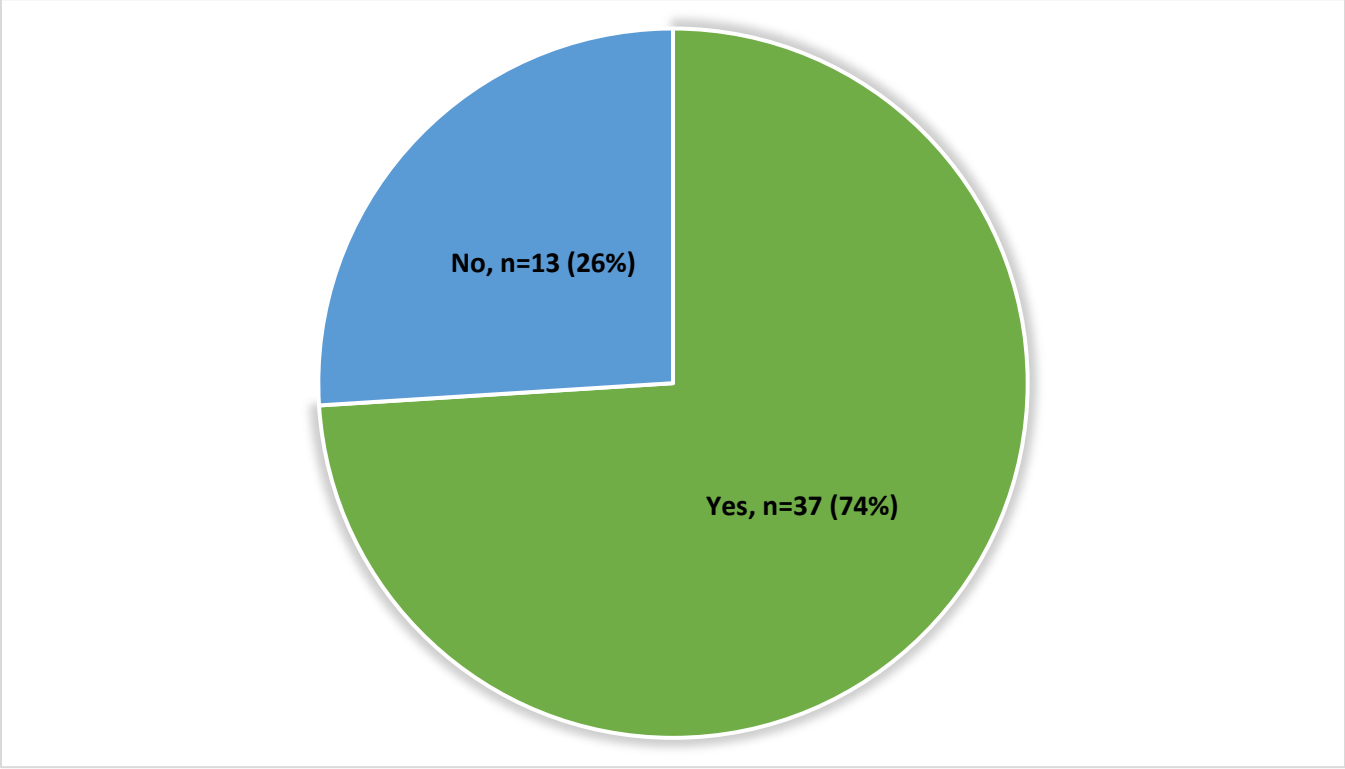

Table 170 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	37	74.00%
No	Arkansas, Georgia, Idaho, Iowa, Kentucky, Massachusetts, New Jersey, New Mexico, Ohio, South Dakota, Tennessee, Virginia, Wyoming	13	26.00%
Total		50	100.00%

If "Yes," please explain.

Table 171 - Explanation of Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

State	Explanation
Alabama	According to the FDA, the opioids with FDA-approved labeling with abuse deterrent labeling are extended-release products. Alabama Medicaid requires prior authorization for all extended-release opioids for medical necessity.
Alaska	We currently have at least 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 Rx Contract Drugs List.
Colorado	Availability and access for abuse deterrent opioid products managed on the Preferred Drug List is evaluated at least annually through the State's Pharmacy and Therapeutics (P&T) Committee and DUR Board review processes with consideration for safety, efficacy, and utilization of abuse deterrent product formulations.
Connecticut	Abuse deterrent opioids are included on the PDL.
Delaware	Abuse deterrent medications on the preferred drug list do not require prior authorization if the medications are prescribed within the FDA approved dosage limits. A select list of abuse deterrent medications are preferred in Delaware with at least one product preferred at all times.
District of Columbia	All opioid abuse deterrent products have preferred status on the DC Medicaid Preferred Drug List.
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	No PDL for FFS and all abuse deterrent opioid use to prevent opioid misuse and abuse are covered,
Illinois	Embeda, which has been discontinued, while still on the market was a preferred long-acting opioid. The currently available FDA-labeled abuse deterrent opioids include OxyContin, Hysingla ER. Xtampza ER, RoxyBond. All of the long-acting opioids require prior approval, thus are labeled non-preferred on the Preferred Drug List. Of the long-acting opioids, morphine ER is preferred, but requires PA. Abuse-deterrent opioids may be approved during the PA process if criteria are met.
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 morphine sulfate ER, Nucynta ER, and Xtampza XR that were available as a preferred agent during the reporting period.
Michigan	The abuse deterrent agents are covered as preferred on the PDL without prior authorization.
Minnesota	Preferred drugs without prior authorization include naloxone syringe (injectable), naloxone vial (injectable), Narcan spray (nasal), Suboxone film (sublingual), and buprenorphine/naloxone tablets (sublingual).

State	Explanation
Mississippi	Medication Assisted Treatment (MAT) agents are available and included as preferred agents on our PDL.
Missouri	MHN has an abuse deterrent opioid with preferred status on our PDL.
Montana	Butrans is a preferred product on our preferred drug list.
Nebraska	Butrans, Oxycotin (oxycodone er) is listed on the PDL as preferred agents.
Nevada	The Medicaid preferred drug list includes a drug class dedicated to abuse deterrent opioids, which emphasizes the importance of addressing opioid abuse effectively. Unlike traditional protocols, Medicaid members are not required to undergo a trial with a non-abuse deterrent opioid before being granted access to abuse deterrent opioids. This streamlined approach prioritizes the well-being of the members by allowing them direct access to medications with abuse deterrent properties, promoting safer and more responsible opioid utilization.
New Hampshire	The generic equivalent of Hysingla ER (hydrocodone bitartrate ER) is an abuse deterrent formulation and is preferred on the NH Medicaid FFS PDL.
New York	Abuse Deterrent agents listed as preferred on preferred drug list.
North Carolina	Xtampza ER and OxyContin, abuse deterrent products, are the long-acting oxycodone preferred drugs 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	Abuse deterrent formulations are listed separately from non-abuse deterrent formulations on the PDL. Partial agonist opioids are available without prior authorization and at least one full agonist agent with an abuse deterrent formulation is preferred.
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.
Oregon	Abuse deterrent opioid medications are available and authorized when appropriate.
Pennsylvania	Abuse deterrent opioids are included in the Statewide PDL.
Rhode Island	Abuse deterrent opioids are included on the preferred drug list.
South Carolina	The Preferred Drug List has continues to provide at least one abuse deterrent formulation as preferred (e.g. Embeda (prior to discontinuation), Butrans, and effective July 1, 2023 Xtampza will also be added)
Texas	Currently, the out-patient pharmacy formulary includes Xtampza ER (extended-release oxycodone) as a preferred agent.
Utah	Abuse deterrent formulations have preferred status on the PDL..
Vermont	the Preferred Drug List has abuse deterrent formulations in a preferred status on the VT PDL for example, Xtampza ER is preferred.
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 abuse deterrent opioid agents that are preferred products on the preferred drug list.

If "No," please explain.

Table 172 - Explanations for not Having a Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

State	Explanation
Arkansas	We currently do not have an abuse deterrent opioid as preferred on our PDL.
Georgia	Abuse-deterrent opioids have historically been cost-prohibitive to the State. We continue to work with manufacturers to make these products more affordable for our patients.
Idaho	The low utilization and high net prices of abuse-deterrent formulations, combined with their lack of credible evidence for deterring opioid abuse has led to the decision to not preferring any of these agents. Our overall strategies to focus on decreasing use of opioids in general makes a strategy of preferring abuse-deterrent agents of minimal additional impact.
Iowa	Abuse deterrent opioids may be considered dependent on the patient specific need.
Kentucky	The FDA designated abuse deterrent products are listed as non-preferred on the PDL.
Massachusetts	Abuse deterrent opioids are on the formulary requiring prior authorization and can be approved if medically necessary.
New Jersey	NJ FFS has an open formulary. Medicaid FFS members have access to all covered outpatient drugs when deemed necessary.
New Mexico	In consideration for implementation in 2024 or 2025.
Ohio	Although no abuse deterrent medications are preferred on our PDL, to obtain coverage of a non-preferred abuse deterrent medication, a prescriber may bypass the trial of two preferred medications, by providing documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug.
South Dakota	State agency does not utilize a PDL.
Tennessee	While TennCare supports the use of abuse deterrent opioids and offers a pathway to access, these medications are not listed as preferred on the TennCare preferred drug list.
Virginia	Currently, there is no drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse. There are several strong measures currently to prevent opioid misuse and abuse such as clinical opioid criteria, MME limits, quantity limits, and PDMP checks.
Wyoming	Currently, no DUR strategy is in place. Prior authorizations for abuse deterrent opioids are reviewed for appropriateness.

13. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?

Figure 110 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

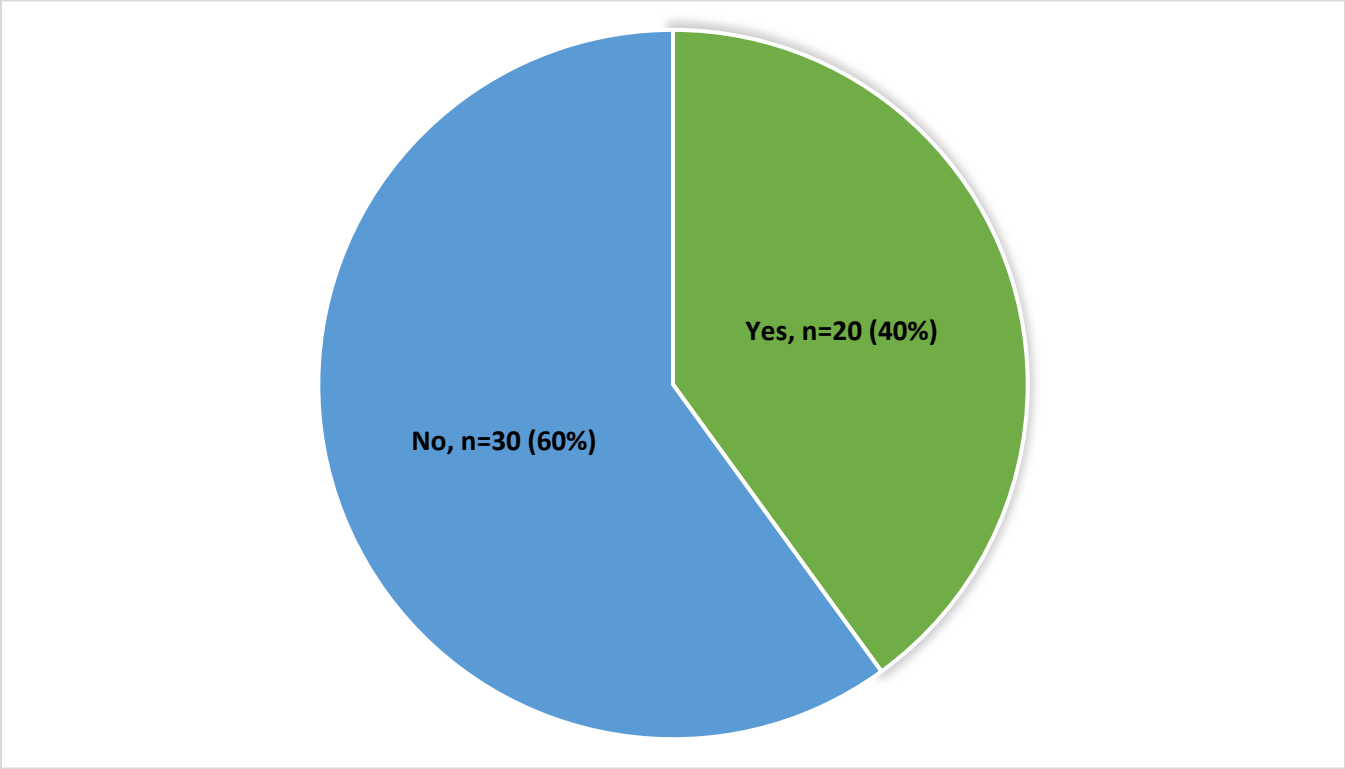

Table 173 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

Response	States	Count	Percentage
Yes	Alabama, Alaska, Colorado, Connecticut, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Montana, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, Wisconsin	20	40.00%
No	Arkansas, California, Delaware, Florida, Hawaii, Idaho, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wyoming	30	60.00%
Total		50	100.00%

If "Yes," please explain.

Table 174 - "Yes" Explanations for COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

State	Explanation
Alabama	MME edit phase down was put on hold during the public health emergency.
Alaska	Refill tolerances were impacted due to transportation and patient access considerations.

State	Explanation
Colorado	Retrospective DUR analyses were conducted in October 2020 and January 2021 (and also subsequent to the FFY22 reporting period) to evaluate opioid utilization trends among beneficiaries during the course of the COVID-19 public health emergency. An ad hoc claims review analysis conducted in October 2020 for the time period 10/1/2019 to 9/30/2020 (6 months pre- and post-onset of the COVID-19 pandemic) showed that prescribed utilization of both shorting-acting and long-acting opioids remained stable in the Colorado Medicaid population.
Connecticut	For a portion of the public health emergency, early refill thresholds on controlled substances, including opioids, was relaxed from 93% to 80%.
District of Columbia	Prior Authorization was not required for non-opioids and Schedule III-V Controlled Substances during the COVID-19 PHE. Additionally, early refills on these medications were allowed.
Georgia	We delayed further tapering our MME limit due to the pandemic. This tapering plan has resumed now.
Illinois	Refill tolerances were temporarily reduced during the COVID-19 pandemic for all medications, including controlled substances. The Four Prescription Policy edit was temporarily lifted. This resulted in fewer patients identified for the chronic opioid pain management program. SUPPORT Act edits identified new issues related to opioids and patients were incorporated into the pain program as appropriate. Fewer patients filling benzodiazepine monotherapy were identified.
Indiana	Early refills were permitted for patients with COVID-19 related illness in a prior authorization process. Access to prescribers and other care were diminished and additional grace periods were provided in prior authorization 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	A 90-day extension was given on State specified drugs for chronic conditions when the PA expired during the disaster period in 2020. Opioids were not considered maintenance medications. ADHD products were considered maintenance medications.
Kentucky	Early refill edits were suspended for all medications. Day supply limitations were increased to 92 day supply for any controlled substance and any non-maintenance drug.
Maine	Many edits were softened to allow early refills of medications including control substances so that members could obtain during pandemic. Reports were monitored to review proper utilization of the COVID changes to edits.
Montana	Day supply limits for all medications, including CIII-CV, but excluding CII, were extended to 90 days during the PHE. All other edits and reviews remained the same.
North Carolina	Emergency fill for prior approval overrides were increased from a 3 day supply to up to 14-day supplies. The days supply allowed was increased to 90 days for opioid withdrawal therapy agents (e.g. buprenorphine) and Attention-Deficit Hyperactivity Disorder agents.
Ohio	During the period of 3/13/20 - 4/25/21 all refill thresholds were relaxed to 50% for both controlled and non-controlled substances. Also, during the period of 3/20/20 - 1/29/21 acute opioids prescriptions were allowed to be filled for up to 14 days to allow adequate supply for individuals that may be quarantined.
Oregon	We did not enforce the PDL for a short period of time and extended some PAs.
Pennsylvania	Early refill edits were turned off during the public health emergency.

State	Explanation
Rhode Island	Some controlled agents established PAs were extended for stimulants for children. Opioids were reviewed case by case.
Washington	Apple Health FFS and MCOs removed refill too soon edits and allowed up to a 90-day supply of maintenance medications, this may have included opioids during the public health emergency. MME limits from 120 MME to 199 MME were changed to a soft DUR edit, overridable by the pharmacist.
Wisconsin	Some controlled substance early refill prospective alerts were changed from a hard stop alert that require a call to the Drug Authorization Policy Override (DAPO) Center to get an override (prior authorization) instead to an alert the pharmacist can override. As of December 1, 2022, our standard early refill alerts were reinStated.

D. Morphine Milligram Equivalent (MME) Daily Dose

1. Have you set recommended maximum MME daily dose measures?

Figure 111 - State Recommended Maximum MME Daily Dose Measures

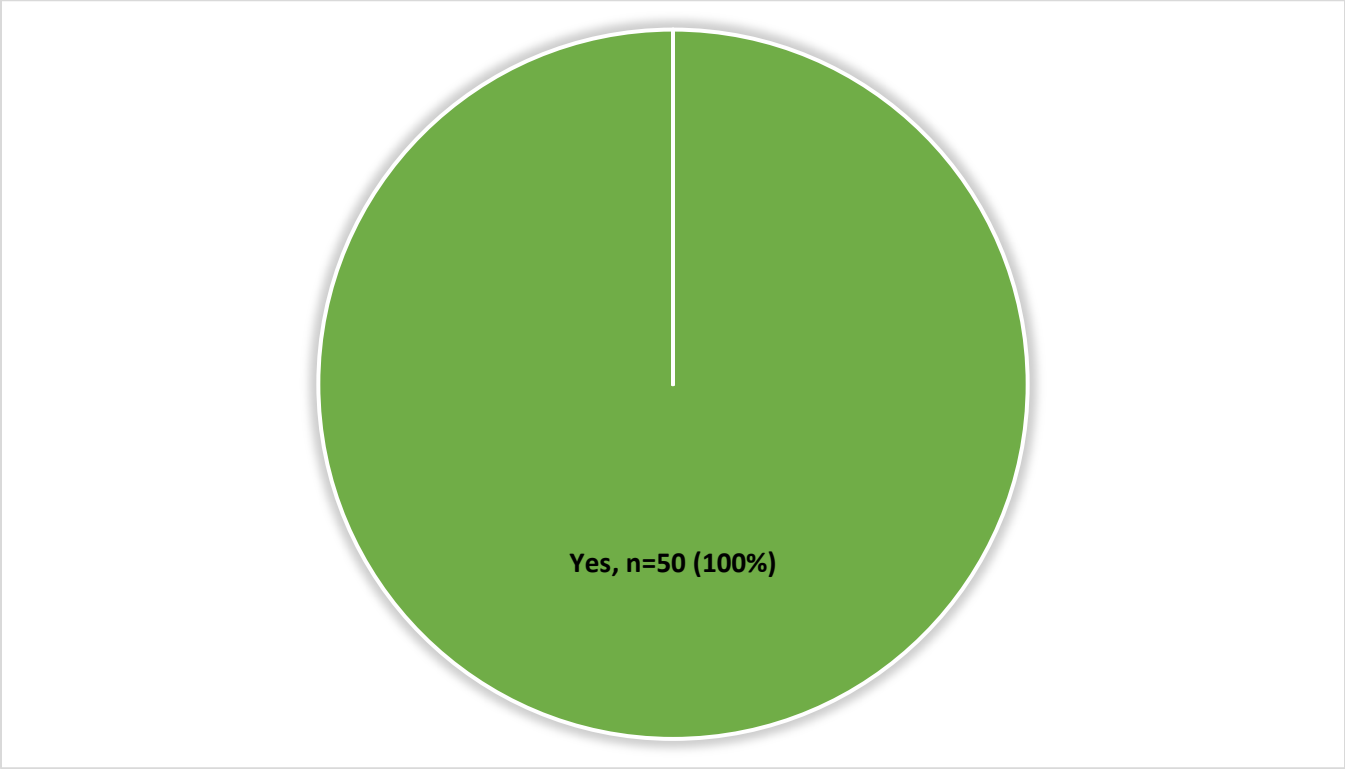

Table 175 - State Recommended Maximum MME Daily Dose Measures

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, Rhode Island, South	50	100.00%

Response	States	Count	Percentage
	Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
Total		50	100.00%

a. If "Yes," what is your maximum morphine equivalent daily dose limit in milligrams?

Figure 112 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

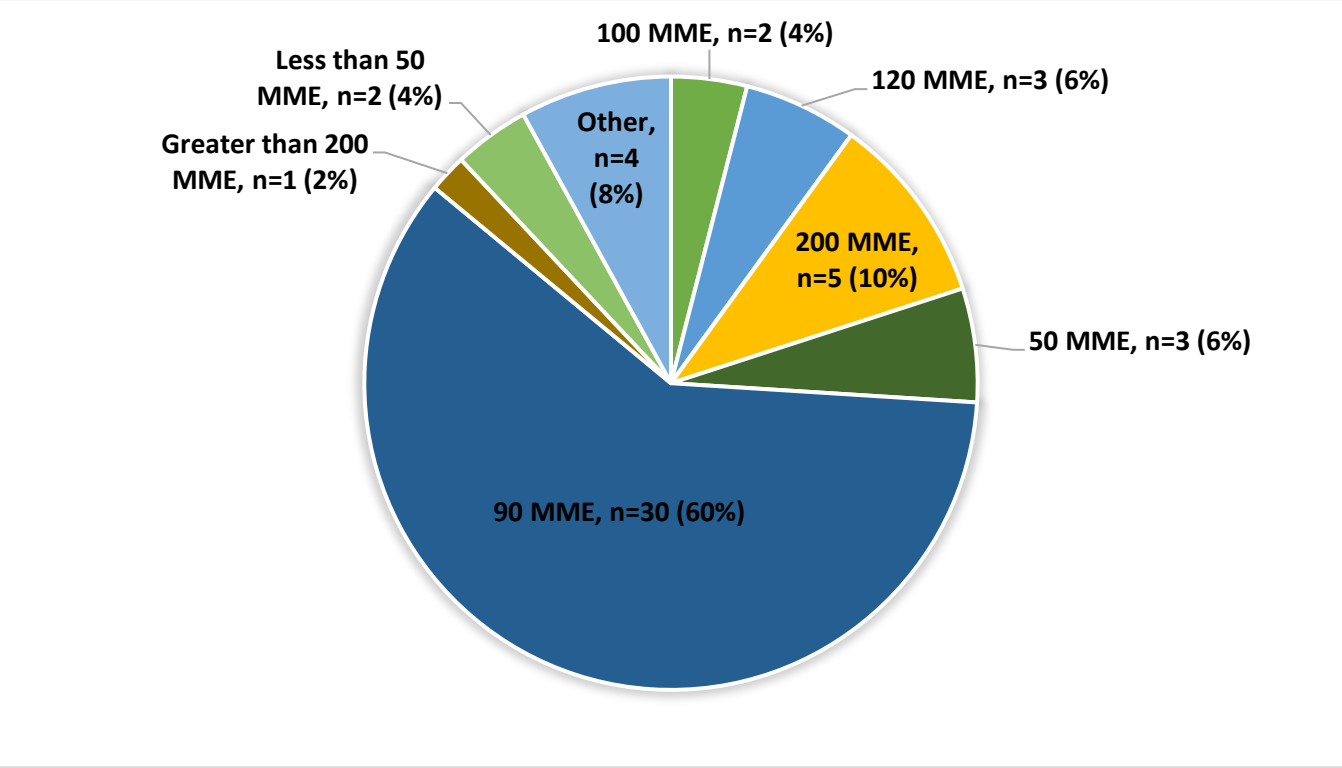

Table 176 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

Response	States	Count	Percentage
100 MME	Mississippi, New Hampshire	2	4.00%
120 MME	Hawaii, Massachusetts, Wyoming	3	6.00%
200 MME	Alabama, Colorado, Kentucky, Tennessee, Washington	5	10.00%
50 MME	Georgia, Pennsylvania, West Virginia	3	6.00%
90 MME	Arkansas, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia	30	60.00%
Greater than 200 MME	California	1	2.00%
Less than 50 MME	Maine, Ohio	2	4.00%
Other	Alaska, Indiana, Nevada, Wisconsin	4	8.00%
Total		50	100.00%

If “Less than 50 MME”, please specify amount in mg per day.

Table 177 - Maximum Morphine Equivalent Daily Dose Limit Less Than 50 MME Per Day

State	Less Than 50 MME
Maine	30
Ohio	30

If “Greater than 200 MME”, please specify in mg per day.

Table 178 - Maximum Morphine Equivalent Daily Dose Limit More Than 200 MME Per Day

State	Greater Than 50 MME
California	500

If “Other”, please specify in mg per day.

Table 179 - “Other” Maximum Morphine Equivalent Daily Dose Limit

State	Other Limit
Alaska	150
Indiana	60
Nevada	60
Wisconsin	180

b. If “Yes,” 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 180 - Explanations for Nature and Scope of Maximum Morphine Equivalent Daily Dose Limit

State	Explanation
Alabama	AL Medicaid began with a cumulative MME edit "phase-in" period for 3 months. Currently claims that exceed the cumulative daily MME limit of 200 MME/day will hit a hard edit and deny at the POS. A Maximum Cumulative MME Override must be submitted to Kepro. Claims that exceed the cumulative daily MME limit of 150 MME/day will hit a soft edit and deny at the POS, but can be overridden by the pharmacist. The Agency will continue to phase down to a goal of 90 MME/day, but the phase down was placed on hold due to the public health emergency.
Alaska	This edit applies to all patients receiving any prescribed opioid. Members in excess of 150MME require a prior authorization which includes a requirement for a treatment/taper plan.
Arkansas	The maximum MME/day for opioid naive beneficiaries is 50 MME/day and limited to #42 pills for a 7 days' supply of short acting opioids. The maximum daily MME limit for opioid experienced beneficiaries is 90 MME with quantity limited to #93 in 31 days for short acting opioids. Beneficiaries with certain cancer diagnoses have a maximum quantity of #124/31 days for short acting opioids. The MME edit is additive for all opioid drug claims with overlapping days' supply including long and short acting opioids. Beneficiaries prescribed opioids with calculated MME >90/day will require a prior authorization.
California	For the treatment of chronic pain, dose is to not exceed 500 MME/daily without an approved Prior Authorization (PA). This safety edit assists in identifying members at potentially-high clinical risk who may benefit from close monitoring and care coordination. This alert accounts for both individual and cumulative claims that exceed 500 MME/daily.

State	Explanation
Colorado	Prior authorization involving a prescriber-to-prescriber consult is required for beneficiary claims for long-acting or short-acting opioids that exceed the cumulative 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 continuation or tapering. Exceptions apply when opioids are prescribed to treat sickle cell anemia, pain associated with cancer, or in association with hospice or end of life care.
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 cancer, sickle cell, or if their prescriber is in a hematology/oncology taxonomy. This limit applies to short acting opioid only. All long acting opioids require prior authorization unless their diagnosis is cancer or if their prescriber is in a hematology/oncology taxonomy.
Delaware	Delaware follows the most recent CDC recommendations. When the dose is above the current recommended dose, physicians receiver retroactive written notification in order to reduce patient risk by encouraging reevaluation of the necessity of higher dose. The 90 MME limit is also part of the clinical criteria for approval of the PA. The 90 MME limit has been in place since July 1, 2018, however, Delaware would further reevaluate this limit if new recommendations for lower doses are released.
District of Columbia	This 90 daily MME dose limit applies to all opioids. Prior authorization is given for beneficiaries in active cancer treatment, in palliative care, residing in a long term care facility or diagnosed with sickle cell disease.
Florida	For opioid treatment naive recipients, the limit is 90 MME. For treatment experienced recipients there is a soft edit at 50 MME.
Georgia	The dose limit is 50 MME mg per day for treatment-naive patients and 120 MME mg per day for treatment-experienced patients. The limits apply to all opioids. We may consider further tapering this limit in the future if clinically appropriate.
Hawaii	The limit applies to all opioids. FFS dental program is acute and initial care and more restrictive in nature for the population under 21 years of age. Currently there is no chronic use patient in the transplant program, nor is one >120MME in need of tapering. (The stability of the transplant is the priority if tapering was a consideration.)
Idaho	Edit implemented in July 2017. When a new prescription is submitted the edit looks at the cumulative daily MME of currently received opioid prescriptions plus the new prescription and will deny claim if all drugs and doses added together exceed 90 MME at that point in time. A prior authorization is required for override to allow dispensing.
Illinois	Prior authorization is required if the opioid claim exceeds 90 MME. This applies to all opioid claims for chronic, non-cancer pain. If the participant has been taking opioids chronically, 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, HFS will work with the prescriber to ensure prior approvals are in place as needed to accommodate the planned taper schedule.
Indiana	Current limits apply to initial therapy. Indiana Medicaid introduced an opioid taper iniative, with a goal limit of 90 MME per day. Current limit for long-term opioid utilizers is 675MME. Indiana Medicaid will taper by 10% each quarter until goal is reached.
Iowa	90 MME per day went into effect October 2020. Applies to all members and all opioids. Prescribers can submit the High Dose Opioids PA form for exceptions.

State	Explanation
Kansas	First, I thought that I put 90MME last year, but 120MME shows up on the online survey. 90 MME is correct. There was a titration period started back in 2018 but that time period is long over. Opioid product exceptions: Cough and cold products, compound ingredients, and injectable meds are not included in the opioid edits. Population Exceptions: patients with cancer, sickle cell anemia, palliative care, and patients whom reside in an assisted or custodial care environment.
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): 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 or corrosions. Authorization to increase the maximum prescribed MME limit for a recipient may be requested by the prescriber for approval by the PA unit prior to 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.
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

State	Explanation
	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 120/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. The edit threshold was gradually lowered over the course of 3 years until the CDC recommended threshold of 90 MEDD was reached in July 2021. The MEDD threshold edit applies to all opioids. Prescribers are referred to the CDC tapering tools for assistance.
Minnesota	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	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 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 >/=90MME 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 are at our MME limit goal of 90MME and have been for years. It applies to all opioids. This limit 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 Opioid Use Disorder (OUD), that they have been unsuccessful in tapering the member, that they will not further escalate the dose, etc.
Nebraska	Cumulative of all long-acting and short-acting products, and cough and cold medications were tapered down to a max of 90 MME per day by December 2020.
Nevada	The MME limit applies to all oral opioid products.
New Hampshire	New Hampshire Medicaid set the daily limit at 100 MME 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 and require prior authorization.
New Jersey	For short-acting opioids (SAO), daily dosing is limited to 50 MME for an opioid naive member or 90 MME for an opioid tolerant member. Opioid naive members are defined as those receiving no opioid therapy in the previous 90 days. For long-acting opioids (LAO), a member must currently be on a short-acting opioid and daily dosing is limited to 90 MME.

State	Explanation
	These limitations do not apply to cancer members, sickle cell members, or those on hospice, palliative or end of life care.
New Mexico	Limited to opioids in the State therapeutic class H3A-Analgesic Narcotics, H3N-Analgesics, Narcotic Agonist and NSAID Combination, and H3U-Narcotic Analgesic and non-salicylate analgesic. No prior authorization requests received to assist with tapering patients to 90MME/day
New York	Prior authorization required in opioid-naive patients for prescription requests equal to or greater than 50 MME per day. Prior authorization required for the management of non acute pain (greater than 7 days) if the dose is equal to or greater than 90 MME of opioid per day. Exceptions for diagnosis of cancer or sickle cell disease, or hospice program.
North Carolina	Beneficiaries requiring more than 90 MME (cumulative for all opioids) are required to meet prior approval requirements. We monitor opioid utilization trends. Overall, the number of beneficiaries exceeding the 90 MME limit has decreased over time as has the number of beneficiaries receiving opioid prescriptions.
North Dakota	Limit is currently in place. Limit applies to all opioids and prior authorization is required to exceed. Authorizations are allowed for prescribers that provide a tapering plan and timeline or when prescribed by an oncologist or pain management specialist.
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 disease, and/or hemophilia and MAT drugs for OUD 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	Prior authorization is required for opioids when the prescribed dose is greater than 50MME/day. Approvals are issued through the prior authorization process to allow for tapering and to avoid abrupt discontinuation.
Rhode Island	Support the State's prescribing limitations for 20 doses/30 mme for opioid naive patients. 90 mme accumulator edit is in place also.
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 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	Doses exceeding 90 MME require prior authorization.
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

State	Explanation
	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 claims system does a retrospective review to check for cumulative 90 MME level. The daily 90 MME level is applied to all opioids and is calculated for both initial therapies as well as subsequent therapies. For those who may require a daily dose tapering plan, provider may develop and manage patient-specific course of therapy. Prescriber may request for a tapering plan through prior authorization process on a case-by-case basis. Prior authorization approval lasts for 6 months. Clients with documented diagnosis of cancer, sickle cell disease, or hospice/palliative care are exempt from opioid criteria.
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 has been reduced over time, every 6 months to achieve one common MME standard, 90 MME, for all UT Medicaid members. The MME already be reduced for opioid experience based on the timeline: January 1, 2020: MME 120; July 1, 2020: MME 90. Current MME limits are 90 for both opioid-naive and opioid-experienced.
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 17 years of age or younger Opioid safety checklist prior authorization required for new patients with a cumulative daily MME over 90. https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Cumulative%20Daily%20MME%202021.03.pdf
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. 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 (< 20 years of age) and 42 dosages per prescription for adults (>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)

State	Explanation
	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	We currently have a daily dose limit of 180MME. We are reducing that limit to 150MME in July 2023. We have a monthly comprehensive retrospective claims review of members greater than 180MME per day. The member's medication profile is reviewed by a pharmacist to determine if a prescriber intervention letter should be sent. If a member has a hospice designation or other type of medical situation like cancer, the pharmacist will pull that letter. Phone calls are made to the prescribers after an appropriate follow-up period if the member's MME has not decreased or has increased.
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.

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 113 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded

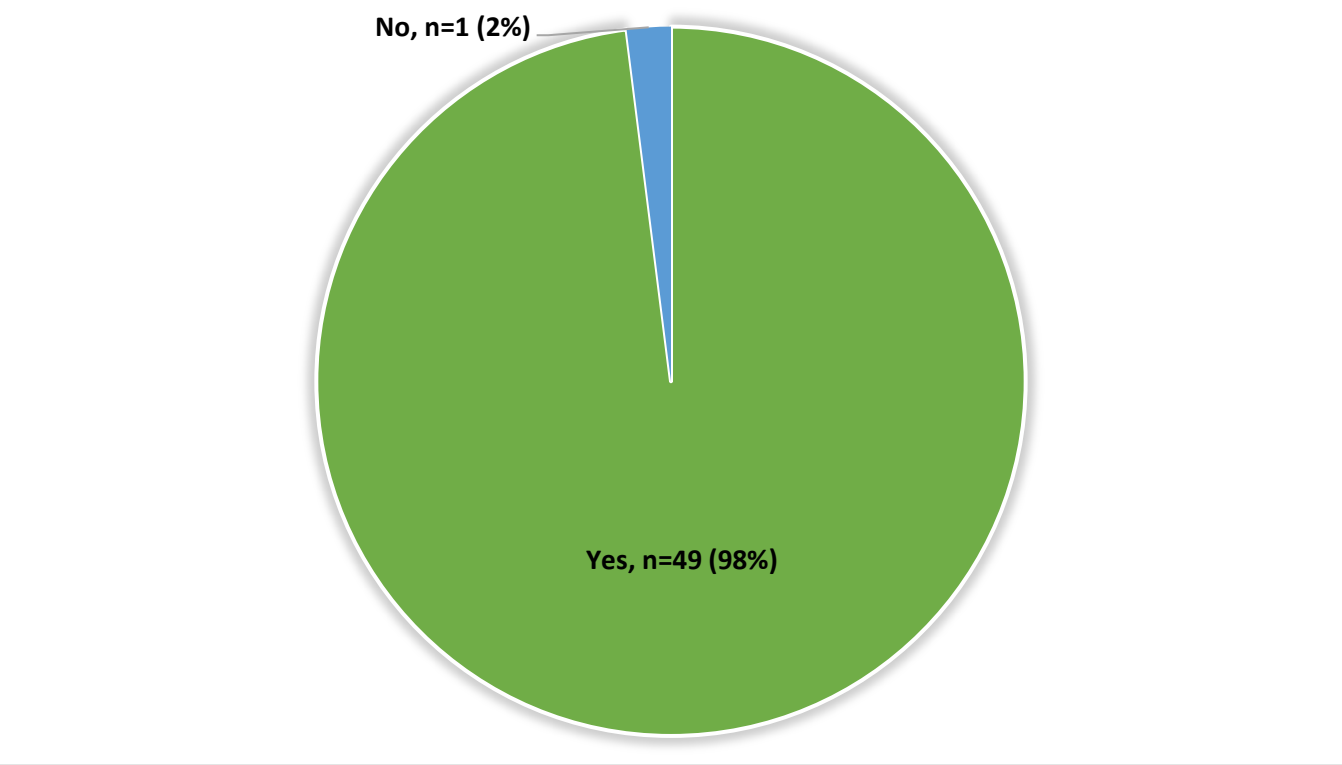

Table 181 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded

Response	State	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,	49	98.00%

Response	State	Count	Percentage
	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		
No	Wisconsin	1	2.00%
Total		50	100.00%

If "Yes," does your State require PA if the MME limit is exceeded?

Figure 114 - Prior Authorization Required if MME Limit is Exceeded

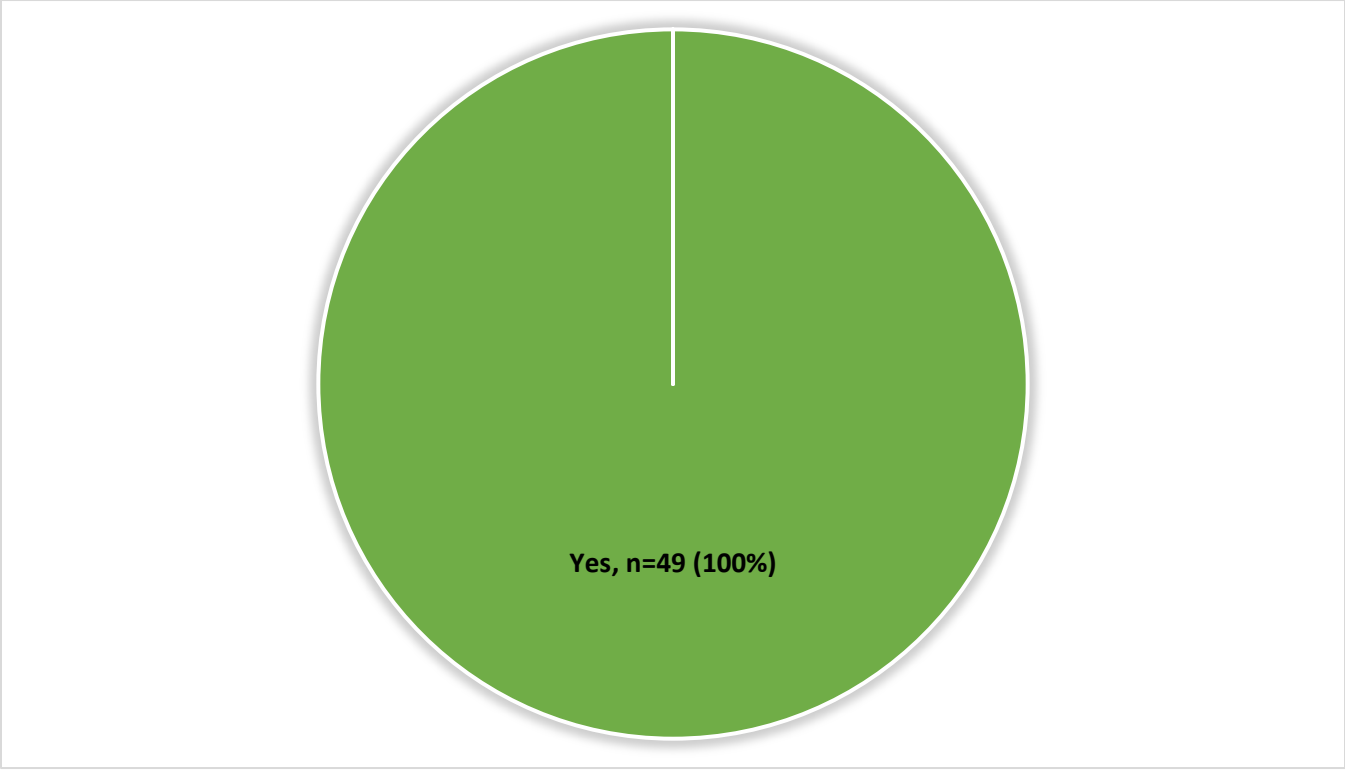

Table 182 - Prior Authorization Required if MME Limit is Exceeded

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, Wyoming	49	100.00%
Total		49	100.00%

If "No," please explain why not.

Table 183 - Explanations for not Having an Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded

State	Explanation
Wisconsin	Wisconsin does not have a prospective alert to the pharmacy provider regarding a daily MME dose. 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 opioids in the prospective system and alerts the pharmacy provider regarding quantity limits, early refill, therapeutic duplication, etc.

3. Does your State have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?

Figure 115 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

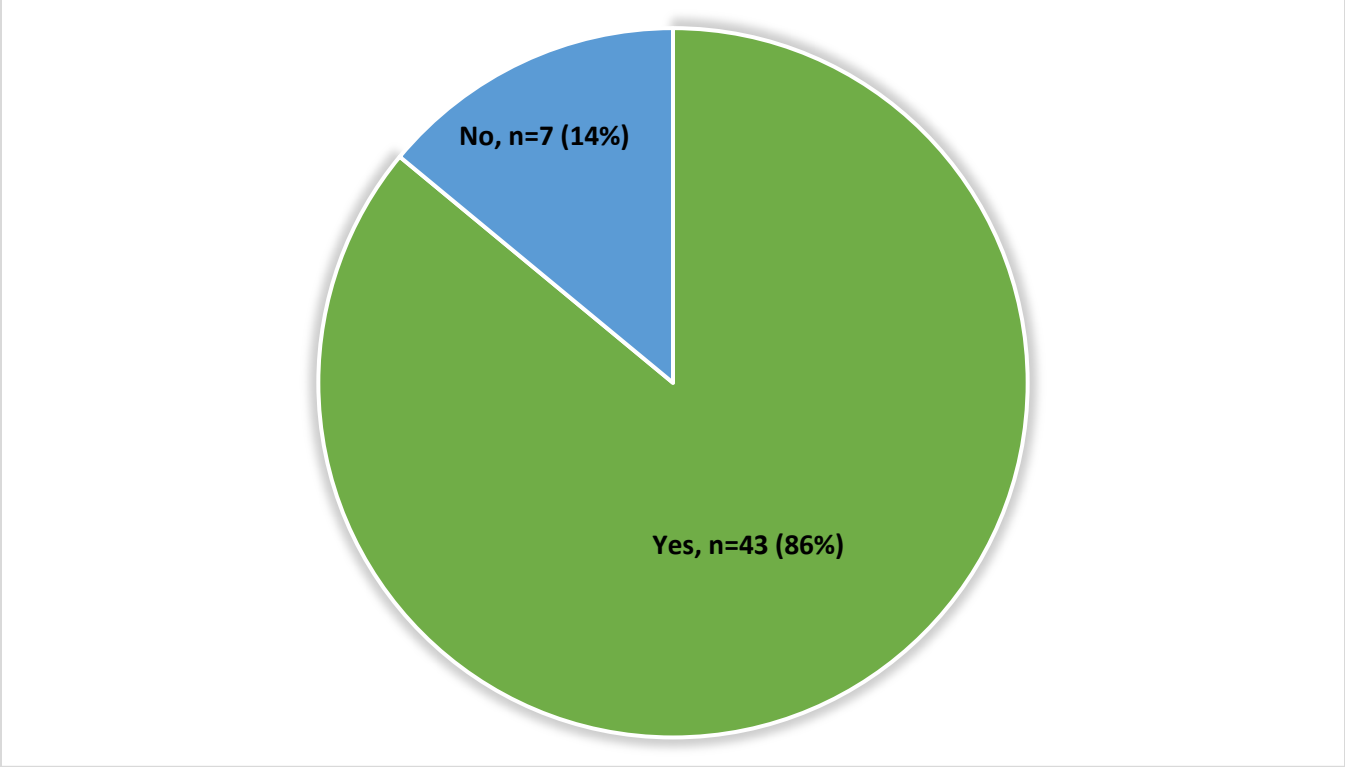

Table 184 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	43	86.00%

Response	State	Count	Percentage
No	Kentucky, Massachusetts, Nebraska, New Jersey, New York, Pennsylvania, West Virginia	7	14.00%
Total		50	100.00%

If "No," please explain why not.

Table 185 - Explanations for not Having Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

State	Explanation
Kentucky	MME edits are prospective through the PA process.
Massachusetts	We use claim edits to monitor daily MME, however no automated review. Reports are produced ad-hoc.
Nebraska	Automated prospective PA edits/lookbacks are in place to monitor daily dose limits of 90 MMEs along with PA required for any dose exceeding the daily dose limit.
New Jersey	Retrospective reviews to monitor MME are currently manually reviewed based on routine, quarterly ad hoc reporting.
New York	The RetroDUR criteria identifies doses > 100 mg morphine equivalents per day and includes information indicating that higher doses of opioids may increase risk for opioid-related adverse effects and overdose, members may benefit from a change of opioid regimen or substitution with non-opioid analgesics, discontinuation or opioid tapering may decrease risks and guidelines recommend tapering when risks outweigh benefits.
Pennsylvania	The RetroDUR system is not able to calculate MME's.
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.

4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere?

Figure 116 - Provide Information to Prescribers to Calculate MME Daily Dosage or Provide Calculator Elsewhere

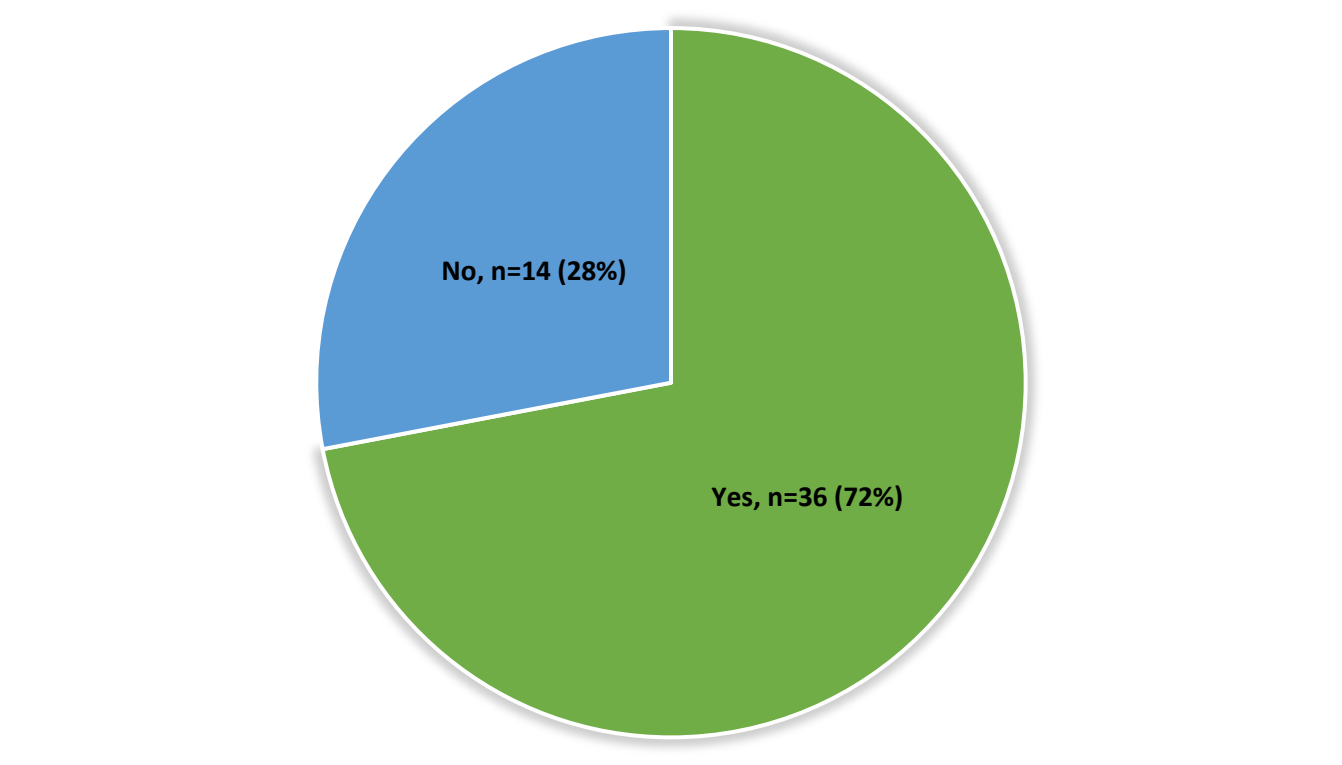

Table 186 - Provide Information to Prescribers to Calculate MME Daily Dosage or Provide Calculator Elsewhere

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	36	72.00%
No	California, Delaware, Georgia, Idaho, Kentucky, Louisiana, Minnesota, Missouri, New York, Oklahoma, Pennsylvania, South Dakota, Wisconsin, Wyoming	14	28.00%
Total		50	100.00%

a. If "Yes," please name the developer of the calculator.

Figure 117 - Developer of Calculator

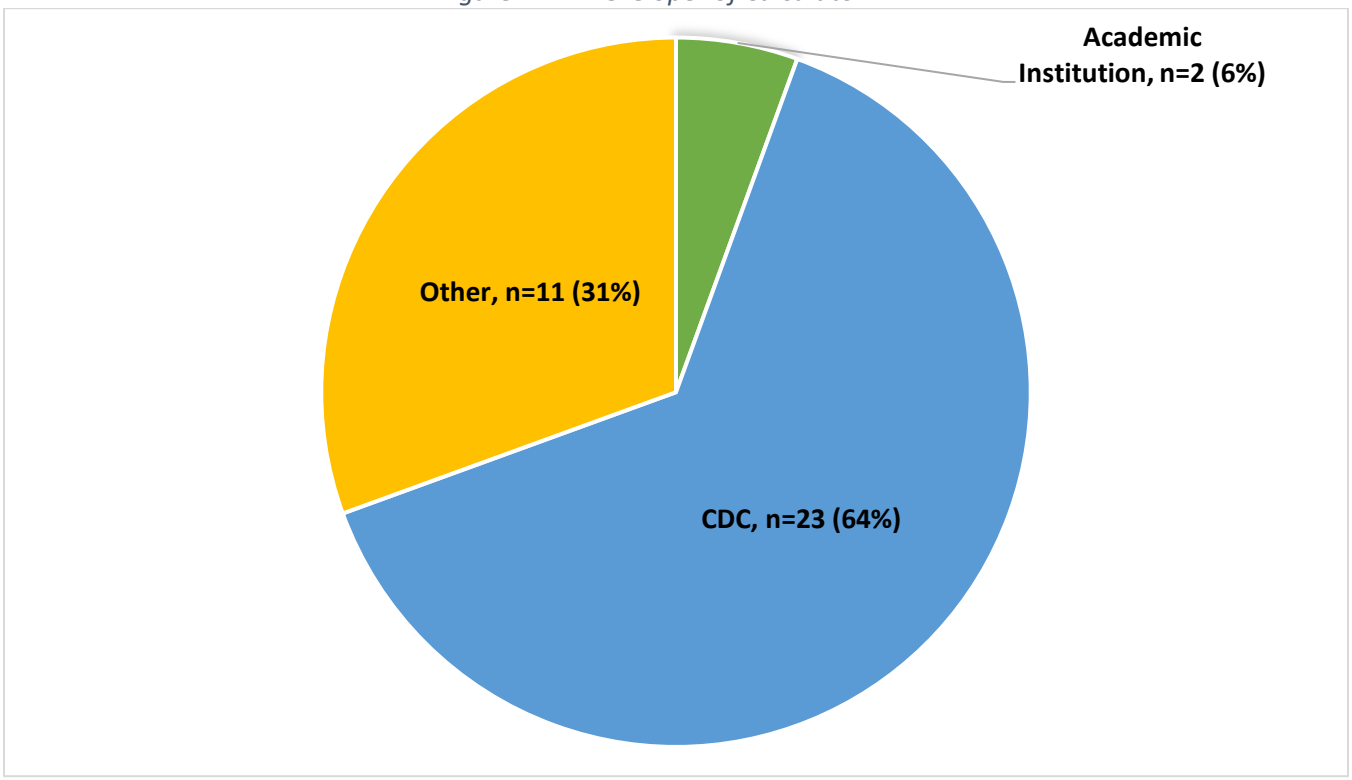

Table 187 - Developer of Calculator

Response	State	Count	Percentage
Academic Institution	North Dakota, Oregon	2	5.56%
CDC	Alabama, Arkansas, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Iowa, Maine, Maryland, Michigan, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, Utah, Vermont, West Virginia	23	63.89%
Other	Alaska, Colorado, Indiana, Kansas, Massachusetts, New Hampshire, North Carolina, Ohio, South Carolina, Virginia, Washington	11	30.56%
Total		36	100.00%

If "Other," please specify.

Table 188 - Explanations for "Other"

State	Explanation
Alaska	Washington AMDG and the Alaska State PDMP website
Colorado	Washington State Agency Medical Directors' Group (AMDG)
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.
Massachusetts	MassHealth distributed a prescriber letter re Updated Opioid High Dose Limits with an MEDD table.
New Hampshire	Washington State Agency Medical Directors' Group

State	Explanation
North Carolina	NC has a table, not a calculator.
Ohio	Take Charge Ohio, Ohio Automated Rx Reporting System (OARRS)
South Carolina	PDMP (Bamboo), Magellan (Contractor) for Call Center
Virginia	SA form States for prescriber to provide pts Daily MME from PMP (http://virginia.pmpaware.net/login)
Washington	Combination of CDC, AMDG, and HCA self created calculator

b. If "Yes," how is the information disseminated (multiple responses allowed)?

Figure 118 - How Information is Disseminated

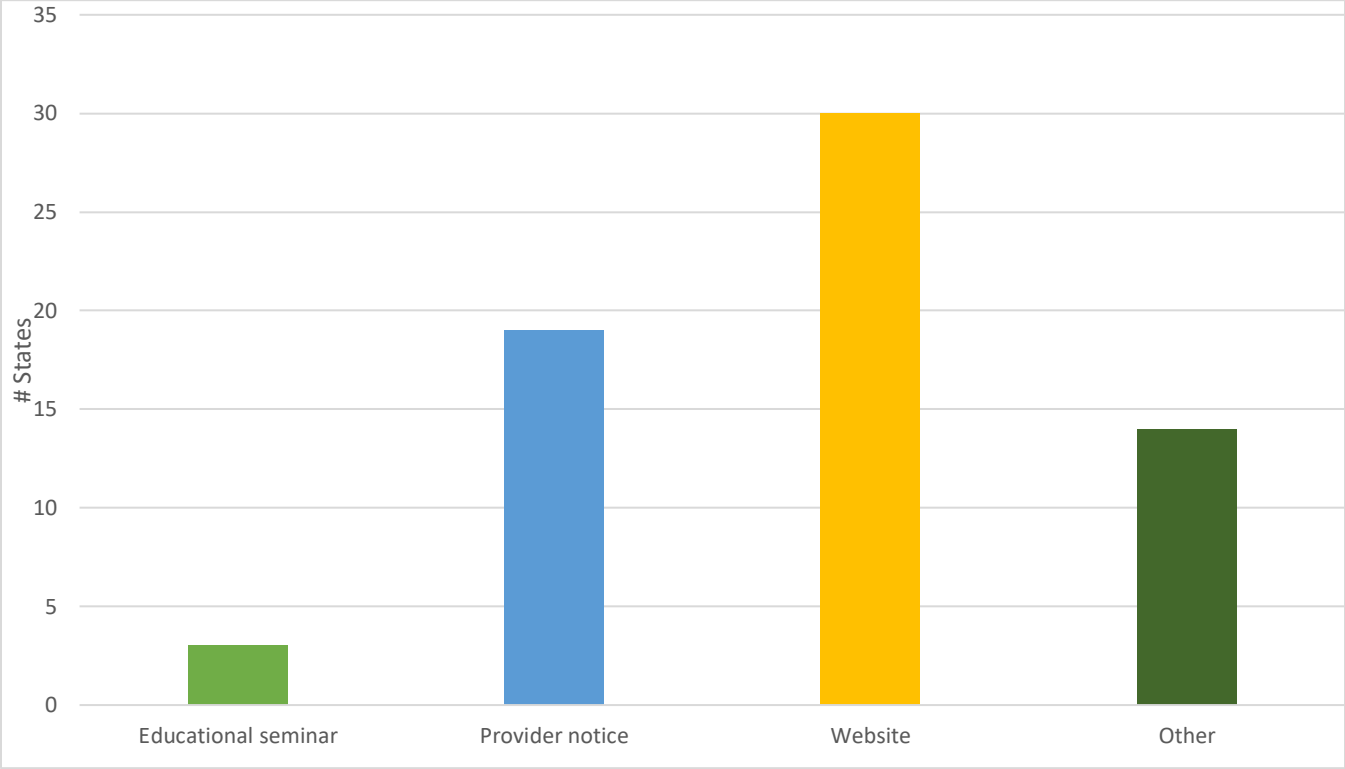

Table 189 - How Information is Disseminated

Information Type	State	Count	Percentage
Educational seminar	District of Columbia, South Carolina, Washington	3	4.55%
Provider notice	Alabama, Arkansas, District of Columbia, Florida, Hawaii, Kansas, Maine, Massachusetts, Montana, Nebraska, New Jersey, New Mexico, Ohio, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia	19	28.79%
Website	Alabama, Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, South Carolina, Tennessee, Utah, Virginia, Washington	30	45.45%
Other	Alabama, Alaska, Arkansas, District of Columbia, Massachusetts, Michigan, Montana, Nevada, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia	14	21.21%
Total		66	100.00%

If "Other," please explain.

Table 190 - Explanations for "Other" Dissemination Method

State	Explanation
Alabama	Academic Detailers distribute information to prescribers and providers.
Alaska	Website, prior authorization form, and criteria documents.
Arkansas	Arkansas shares a link for the MME calculator through a quarterly provider newsletter, provider memorandum which summarizes the DUR Board activities and opioid information tab on the pharmacy vendor website.
District of Columbia	Quarterly Provider Forums and a quarterly provider newsletter are other sources of information.
Massachusetts	Direct mail to prescribers.
Michigan	Information is 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.
Nevada	Nevada Medicaid Services Manual, Chapter 1200, Section Z.
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
South Carolina	Providers can utilize PDMP site, MUSC provides information/training on PDMP and additional resources at their tipSC website, Providers can contact Magellan's Call Center for information/submit Clinical information for MME overrides 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 prescriptions can be added together (Active Daily MME) to help assess cumulative risk in addition to assessing the risk associated with a single opioid Rx.
Tennessee	We list the MME calculations on our website and on all opioid prior authorization forms.
Texas	A link to the CDC's calculation page is included on the Opioid policy criteria guide document.
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.

E. Opioid Use Disorder (OUD) Treatment

1. Does your State have utilization controls (i.e., preferred drug list (PDL), prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

Figure 119 - State Has Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD

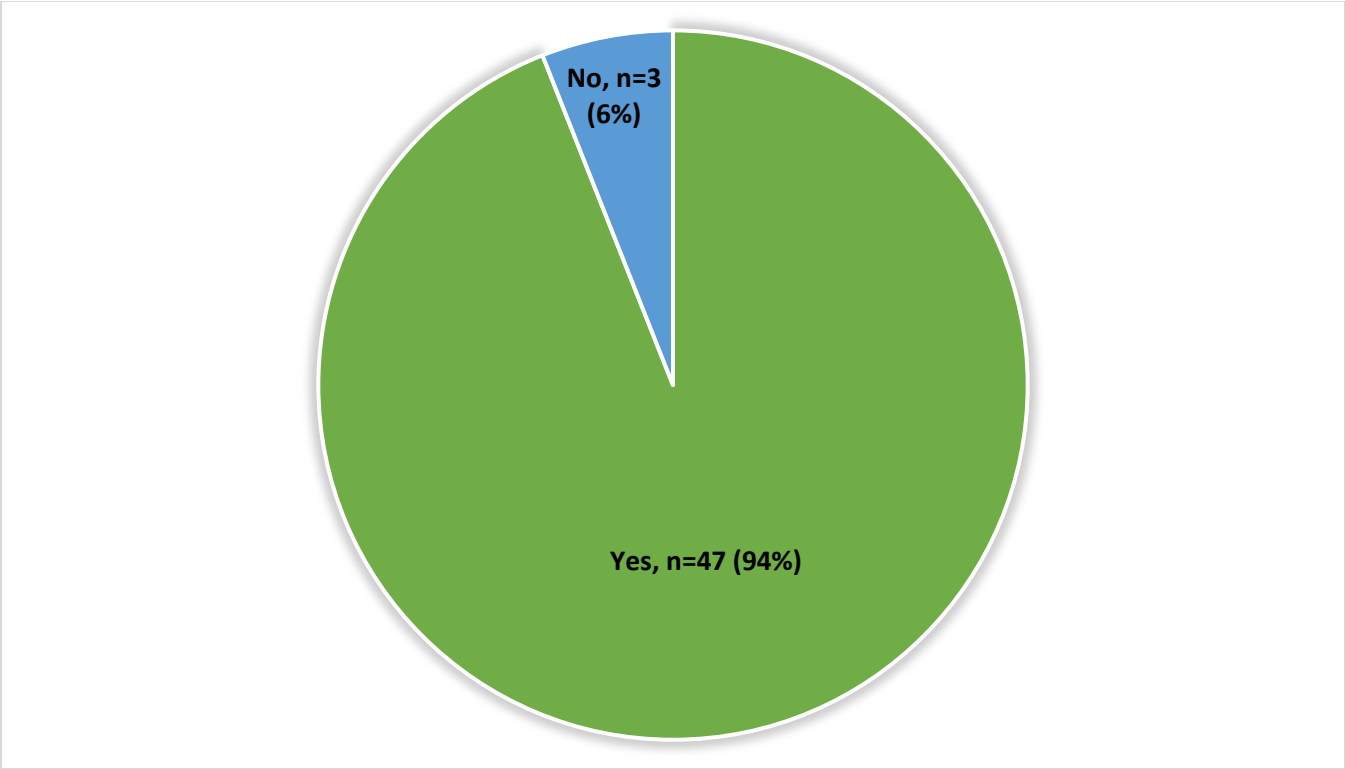

Table 191 - State Has Utilization Controls to Monitor or Manage Prescribing of MAT of Drugs for OUD

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, 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	47	94.00%
No	California, Hawaii, South Dakota	3	6.00%
Total		50	100.00%

If "Yes," please explain.

Table 192 - Explanations of Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD

State	Explanation
Alabama	Buprenorphine products are included in the PDL and they also have quantity limits.
Alaska	PDL, PA, QL

State	Explanation
Arkansas	Per Act 964 of the 2021 Arkansas legislative session, a health insurer (including Medicaid) shall not require prior authorization in order for a patient to obtain coverage of buprenorphine, naloxone, naltrexone, methadone and their various formulations/combinations (excluding injectables) for the treatment of opioid addiction. Therefore, the oral MAT class had been placed on the PDL with 3 preferred oral buprenorphine containing products (currently Suboxone films, buprenorphine SL tablets, and Zubsolv SL tablets) that do not require a PA. Oral naltrexone does not require a PA either. Non-preferred buprenorphine products will require a PA with documentation of the medical necessity over the preferred products. Quantity limits exist for all MAT products with maximum doses based on the manufacturer's package insert recommendations. Vivitrol is the preferred injectable MAT drug, and claims are payable as a pharmacy or medical claim after an approved PA request. Sublocade requires a PA and is payable as a medical claim only. PA requirements for the injectable medications are minimal.
Colorado	During the reporting period, prior authorization requirements were removed for Suboxone (buprenorphine/naloxone) sublingual film. All other oral buprenorphine-containing medications used to treat OUD require prior authorization verifying appropriate use. A quantity limit of 24 mg buprenorphine per day is applied to all oral buprenorphine-containing medications used to treat OUD. Pharmacy benefit place of service prior authorization requirements were also removed for Vivitrol (naltrexone ER) injection during the reporting period . Other injectable formulations of medications used to treat OUD require prior authorization for cases where eligible for billing under the pharmacy benefit.
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	DC Medicaid has all approved MAT drugs in preferred status on the Preferred Drug List. Quantity limits and daily dose limits are utilized to manage the prescribing of MAT drugs for OUD.
Florida	The DUR Board reviews MAT access and utilization. Prescribers initiating patients on MAT can prescribe buprenorphine sublingual tablets, buprenorphine/naloxone sublingual tablets, Suboxone film, or Zubsolv sublingual tablets via an automated prior authorization. The claim will process as paid if a recipient has a diagnosis of OUD within the past 365 days of the incoming claim.
Georgia	Utilization controls include PDL, PA criteria and use of QLLs to manage prescribing of MATs for OUD.
Idaho	We utilize maximum daily quantity limits and conduct retrospective reviews on the medication
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	Subutex and non-rebate eligible MAT NDCs require a PA. All other MAT drugs do not require a PA.

State	Explanation
Kentucky	Please explain. We have PDL edits, quantity limit, and therapeutic duplication edits in place. Senate Bill 51 required that PDL edits and prior authorization be removed from OUD treatments. Those edits were 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, remained in place.
Louisiana	Buprenorphine, buprenorphine/naloxone, and naltrexone are on the preferred drug list. POS edits: age limit, diagnosis requirement, and quantity limit for selected agents, dose limits for buprenorphine agents, and concurrent use of (1) an opioid, benzodiazepine, and/or any buprenorphine-containing agent and (2) buprenorphine-containing agent or opioid with naltrexone.
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 dosage limits.
Minnesota	QL per FDA max dose. Nonpreferred drugs need a PA.
Mississippi	Our PDL includes opiate dependence treatments (buprenorphine/naloxone, naltrexone, etc.) with a range of preferred products available without prior authorization. Non-preferred products in these categories (dependence and treatment) require prior authorization for coverage.
Missouri	MO HealthNet utilizes a PDL edit which includes clinical criteria and dosing limits.
Montana	We utilize PDL controls, max daily dose, and 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	Medications in the medication assisted therapy classification have some or all of the following: criteria on the preferred drug list (PDL), prior authorization (PA), and quantity limit (QL).
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 exists on some MAT products.
New Mexico	Reports are generated by Conduent on the utilization of MAT drugs for State review.

State	Explanation
New York	Quantity Limits for all products based units per day extended to a thirty days supply. For buprenorphine sublingual (SL): six tablets dispensed as a two-day supply; not to exceed 24 mg per day. Prior authorization required for initiation of opioid therapy for members on established opioid dependence therapy. Prior Authorization required for initiation of a central nervous system stimulant for members established on opioid dependence therapy.
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 24 mg; limited to maximum of 32 mg.
North Dakota	Quantity limits are in place for FDA and compendia max dosing recommendations. Therapeutic duplication edits are in place for dose consolidation and to prevent concurrent opioid use. Prior authorization is required for single agent buprenorphine oral therapy allowing use for pregnancy and breastfeeding. PA is not required for the combination buprenorphine/naloxone SL tablets or long acting injectable buprenorphine. An underutilization edit is implemented to address adherence barriers, long acting injectable buprenorphine eligibility, and counseling on overdose risk during relapse.
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 (i.e., no claim for oral short acting buprenorphine in the prior 90 calendar days) per the following: a. Individuals who are 15 years of age or younger; or b. Individuals who are male and receiving short acting buprenorphine without naloxone; or c. Individuals who are female and 45 years of age or older and receiving short acting buprenorphine without naloxone d. Dosages that are greater than 24 mg/day; or e. Dosages over 16 mg/day beginning 90 days after the initial fill. f. Long-acting or injectable buprenorphine. In addition, ODM has removed clinical prior authorization requirements on the long-acting injectable buprenorphine product, Sublocade.
Oklahoma	The utilization controls (PDL, PA, QL) to monitor or manage the prescribing of MAT drugs for OUD are available on our website.
Oregon	QL - 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	Prescriptions for Opioid Dependence Treatments that meet any of the following conditions must be prior authorized: 1. An oral buprenorphine Opioid Dependence Treatment without naloxone. 2. A non-preferred Opioid Dependence Treatment. See the Preferred Drug List (PDL) for the list of preferred Opioid Dependence Treatments at: https://papdl.com/preferred-drug-list. 3. An Opioid Dependence Treatment with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/QuantityLimits-and-Daily-Dose-Limits.aspx. REMINDER: A prescription for a benzodiazepine, opioid analgesic, controlled substance sedative hypnotic, or carisoprodol requires prior authorization when a beneficiary has a concurrent prescription for a buprenorphine Opioid Dependence Treatment. Refer to the specific individual handbook chapters (e.g., Analgesics, Opioid Long-Acting, Analgesics,

State	Explanation
	Opioid Short-Acting, Anticonvulsants, Anxiolytics, Skeletal Muscle Relaxants, Sedative Hypnotics) for corresponding prior authorization guidelines. REMINDER: A prescription for an opioid analgesic requires prior authorization when a beneficiary has a concurrent prescription for Vivitrol.
Rhode Island	Suboxone is accessible as a preferred agent on the preferred drug list.
South Carolina	The State developed MAT (Medication Assisted Treatment Guidelines) which is utilized by FFS and MCO
Tennessee	TennCare uses all of the above tools to control utilization for MAT drugs.
Texas	There is a clinical prior authorization for buprenorphine agents with the following checks: age, diagnosis of opioid dependency, concurrent therapy with opioids. For single-ingredient buprenorphine drugs PA will approve if the client is pregnant or is intolerant to naloxone. All MAT therapy drugs are given a preferred status on the PDL.
Utah	Preferred Drug List, Prior Authorization for buprenorphine single products that exceed the quantity limit of 24 mg/day. Prior Authorization is also required for concurrent use of opioids exceeding 7 days supply when POS identifies MAT therapy in profile with 45 days look back.
Vermont	The preferred drug list has preferred drugs for OUD. There is a PA required for doses over 16 mg of preferred buprenorphine/naloxone combinations. The Maximum days' supply is for Suboxone films, buprenorphine naloxone tabs is 30 days.
Virginia	The following criteria must ALL be met for approval: * Patient is at least 16 years of age and older with a diagnosis of Opioid Use Disorder; AND * Requests for non-preferred medications will require submission of a completed FDA MedWatch form for adverse reactions to combination products; AND * Buprenorphine monotherapy 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 * Maximum of 24 mg per day. Doses greater than 24 mg per day will not be approved * Concurrent Drugs: - 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.
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

State	Explanation
	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	The State does have a PDL which includes MAT products which are preferred without a PA requirement. Additionally there is a suboxone policy which limits the total mg/day however exceptions are reviewed on a case-by-case basis by the medical director. Policy can be found on our PA page.
Wisconsin	Wisconsin has diagnosis restrictions on drugs used for MAT and most prescribed drugs for MAT are preferred on the preferred drug list and do not require prior authorization.
Wyoming	Buprenorphine products are on the PDL. Claims over 24 mg per day require a prior authorization.

If “No,” please explain.

Table 193 - Explanations for not Having Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD

State	Explanation
California	We do not have utilization controls on MAT for OUD in order to improve beneficiary access to these important medications.
Hawaii	No PDL and no PA. No utilization in FFY 2022. Suboxone 24mg triggers a review.
South Dakota	The State developed MAT (Medication Assisted Treatment Guidelines) which is utilized by FFS and MCO No PDL or PA for MAT for OUD

2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

Figure 120 - Program Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

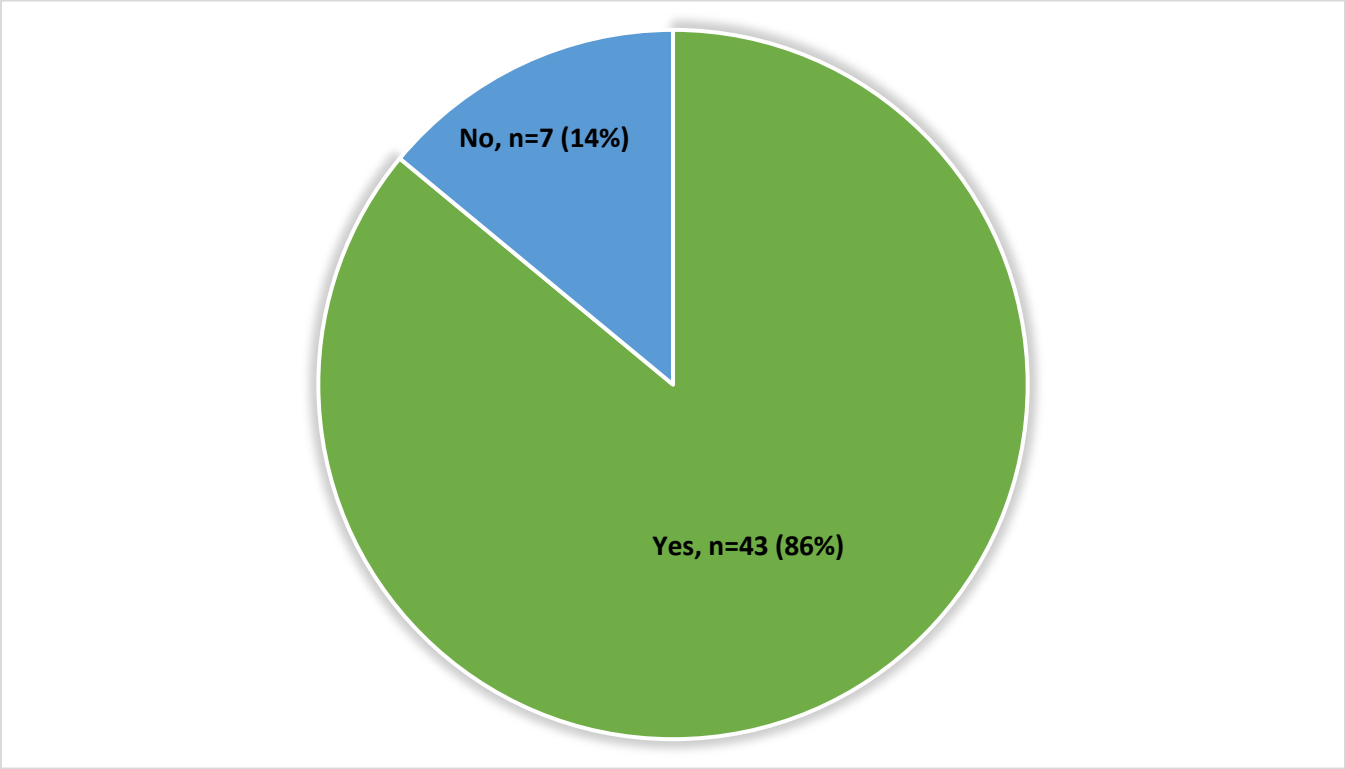

Table 194 - Program Sets Total Milligrams per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	43	86.00%
No	California, New Mexico, Rhode Island, South Carolina, South Dakota, Texas, Wisconsin	7	14.00%
Total		50	100.00%

If "Yes," please specify the total mg/day.

Figure 121 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

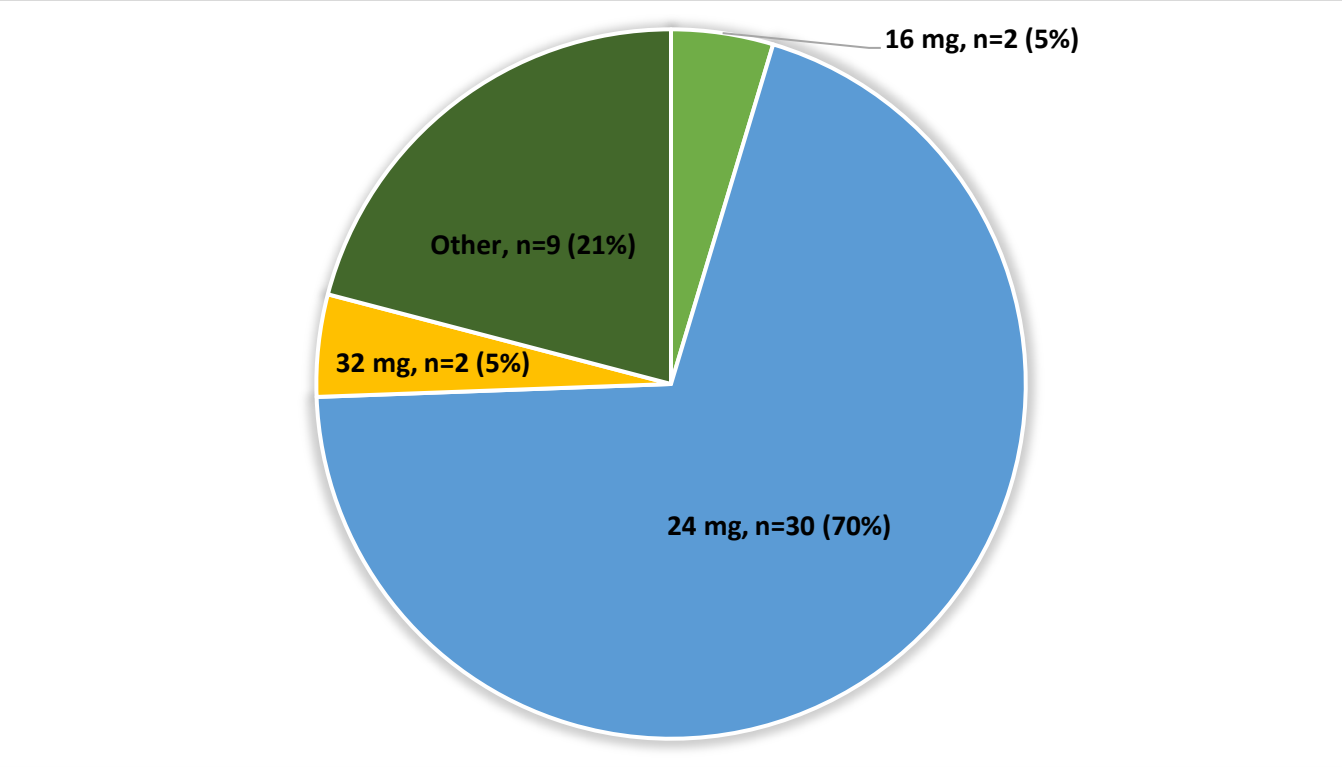

Table 195 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
16 mg	Oklahoma, Vermont	2	4.65%
24 mg	Alaska, Arkansas, Colorado, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New York, North Dakota, Ohio, Oregon, Utah, Virginia, West Virginia, Wyoming	30	69.77%
32 mg	New Jersey, Washington	2	4.65%
Other	Alabama, Connecticut, Delaware, Illinois, Maryland, Montana, North Carolina, Pennsylvania, Tennessee	9	20.93%
Total		43	100.00%

If "Other," please explain.

Table 196 - "Other" Explanations for Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

State	Explanation
Alabama	Per CMS Guidelines, the Agency sets the total mg/day for buprenorphine and buprenorphine-naloxone combination products at 24 mg/day. Bunavail is not approved for > 12.6mg/day, and Zubsolv is not approved for > 17.1mg/day.

State	Explanation
Connecticut	An informational ProDUR high dose alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
Delaware	2 dosage units per day are allowed of any formulation without a Prior Authorization, which allows for dosages up to 24 mg per day.
Illinois	Buprenorphine tablets total mg/day is 24mg. Prior to the COVID pandemic, the group accumulator edit allowed up to 93 units per rolling month of any buprenorphine and/or buprenorphine/naloxone combination claims. This policy was suspended during the pandemic. During FFY22 participants were allowed up to 186 units per rolling month of any short-acting buprenorphine-containing product. 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
Montana	The limit is set at 24 mg/day. However, with increasing fentanyl use, we will do individual prior authorizations of up to 32 mg/day if necessary.
North Carolina	Pharmacist override is needed to exceed 24 mg. However, doses above 32mg are not allowed,
Pennsylvania	Doses exceeding 24mg/day require prior authorization. When medically necessary, higher doses are available through the prior authorization process.
Tennessee	We have different limits dependent upon whether the enrollee is using one of TennCare's "BESMART" MAT providers or not. BESMART was developed in 2019 to be a specialized provider network focused on contracting with high quality medication assisted treatment (MAT) providers to provide comprehensive care to TennCare members with opioid use disorder (OUD). A major reason for needing this program was that in East Tennessee, where we had the highest concentration of abuse and addiction amongst our enrollee population, there were very few if any MAT providers that accepted insurance of any kind, and accepted only cash payments. With BESMART, the office visits for qualifying MAT providers are reimbursed by the MCO's higher than other visits, and in turn the BESMART providers agree to a standard of care with their practice of MAT. Enrollees using BESMART providers have no limit on the length of treatment at 16 mg per day, where enrollees who choose to see non-BESMART providers, have a 6-month limit of 16 mg per day, and must reduce to 8 mg/day thereafter with no limit on length of treatment at 8mg/day. Enrollees using BESMART providers are also eligible for up to 24mg/day for up to 1 year with prior authorization and with medical necessity.

3. What are your limitations on the allowable length of this treatment?

Figure 122 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

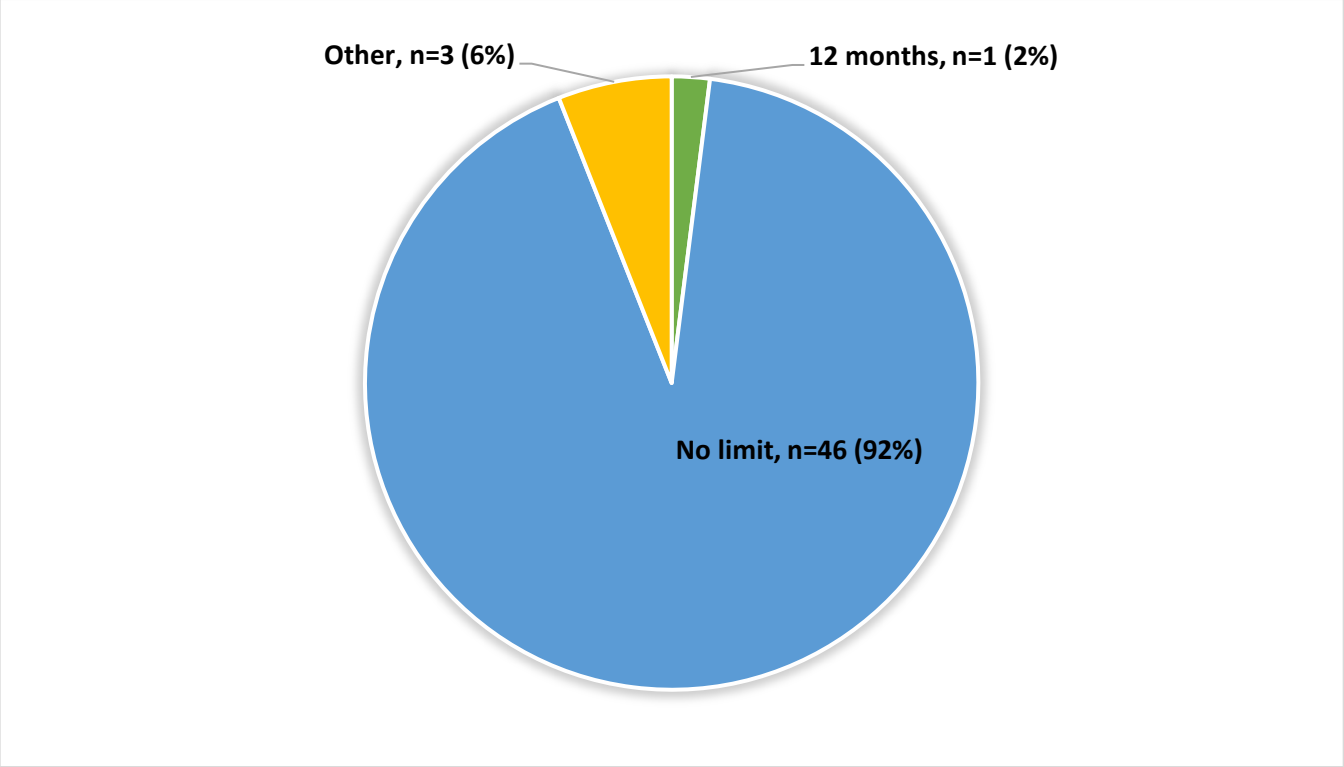

Table 197 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
12 months	Nebraska	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, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming	46	92.00%
Other	Tennessee, Virginia, West Virginia	3	6.00%
Total		50	100.00%

If "Other," please explain.

Table 198 - "Other" Explanations for Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

State	Explanation
Tennessee	Enrollees using BESMART providers have no limit on the length of treatment at 16 mg per day, where enrollees who choose to see non-BESMART providers, have a 6-month limit of

State	Explanation
	16 mg per day, and must reduce to 8 mg/day thereafter with no limit on length of treatment at 8mg/day. Enrollees using BESMART providers are also eligible for up to 24mg/day for up to 1 year with prior authorization and with medical necessity.
Virginia	Length of Authorization: 3 Months (Initial SA), 6 months (Maintenance SA)
West Virginia	3 months or less. However exceptions may be possible and are reviewed on a case-by-case basis by the medical director.

4. Does your State require that the maximum mg per day allowable be reduced after a set period of time?

Figure 123 - Maximum Milligrams per Day Reduction After a Set Period of Time

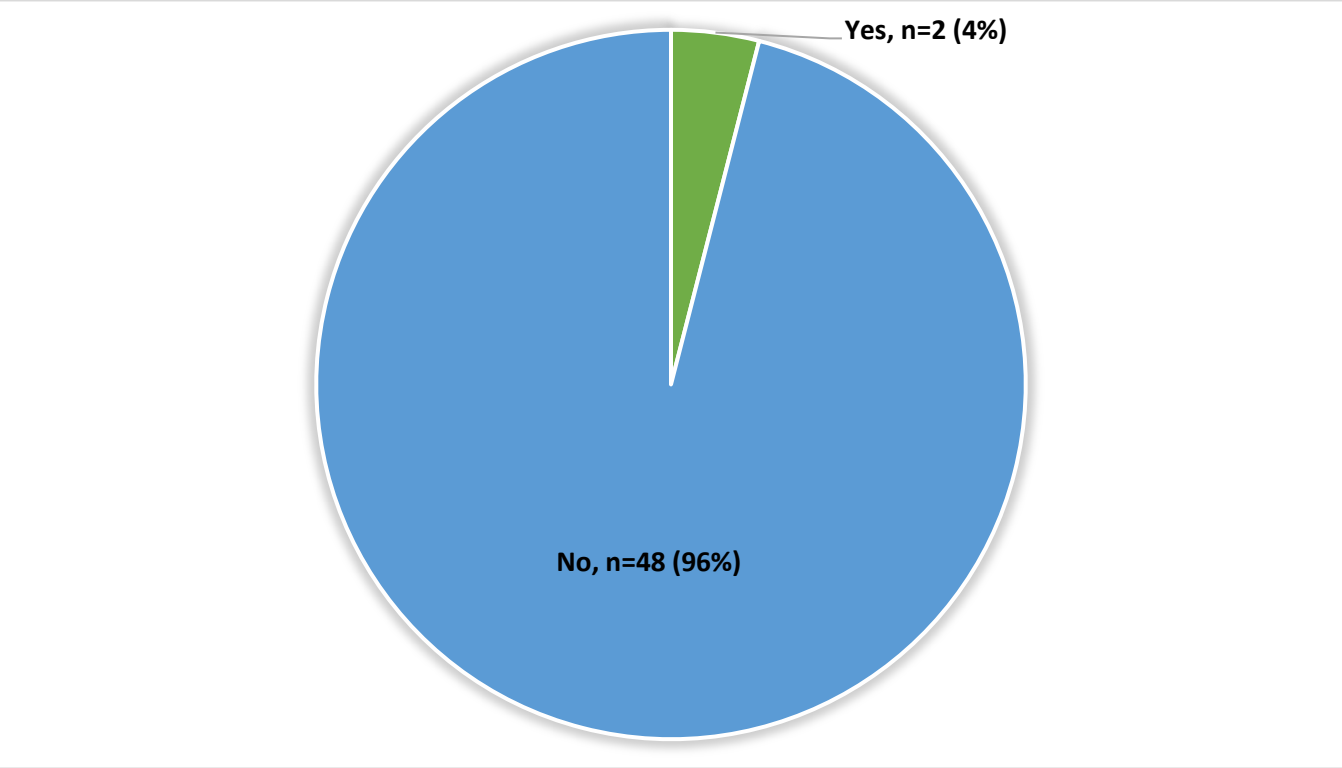

Table 199 - Maximum Milligrams per Day Reduction After a Set Period of Time

Response	States	Count	Percentage
Yes	Tennessee, West Virginia	2	4.00%
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	48	96.00%

Response	States	Count	Percentage
	Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming		
Total		50	100.00%

a. If "Yes," what is your reduced (maintenance) dosage?

Figure 124 - Reduced (Maintenance) Dosage

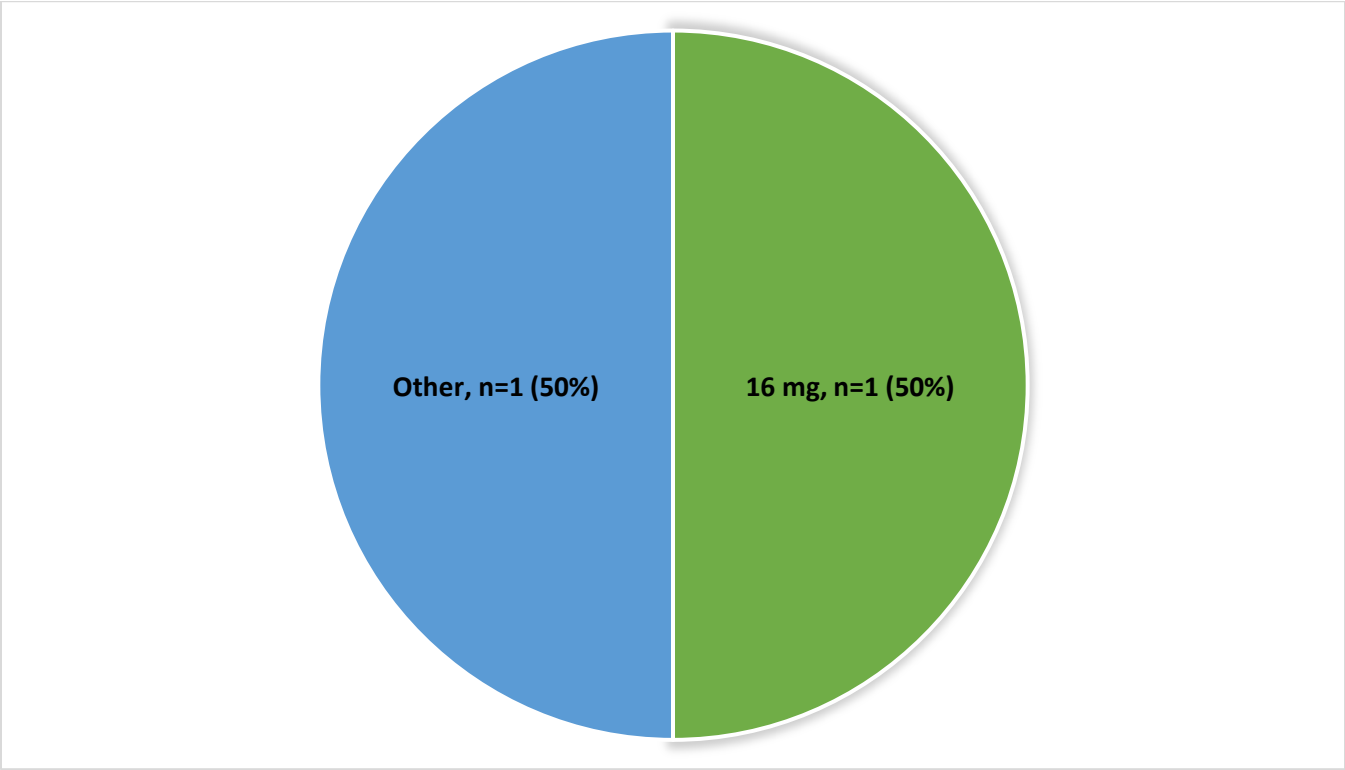

Table 200 - Reduced (Maintenance) Dosage

Response	States	Count	Percentage
16 mg	West Virginia	1	50.00%
Other	Tennessee	1	50.00%
Total		2	100.00%

If "Other," please explain.

Table 201 - "Other" Explanations for Reduced (Maintenance) Dosage

State	Explanation
Tennessee	Enrollees of non-BESMART providers, have a 6-month limit of 16 mg per day; thereafter, TennCare only covers up to 8 mg/day. Enrollees of BESMART providers, have access to up to 24 mg/day (if certain conditions are met) for up to 1 year; however, enrollees do not have to reduce their dosage below 16 mg/day.

b. If "Yes," what are your limitations on the allowable length of the reduced dosage treatment?

Figure 125 - Limitations on the Allowable Length of the Reduced Dosage Treatment

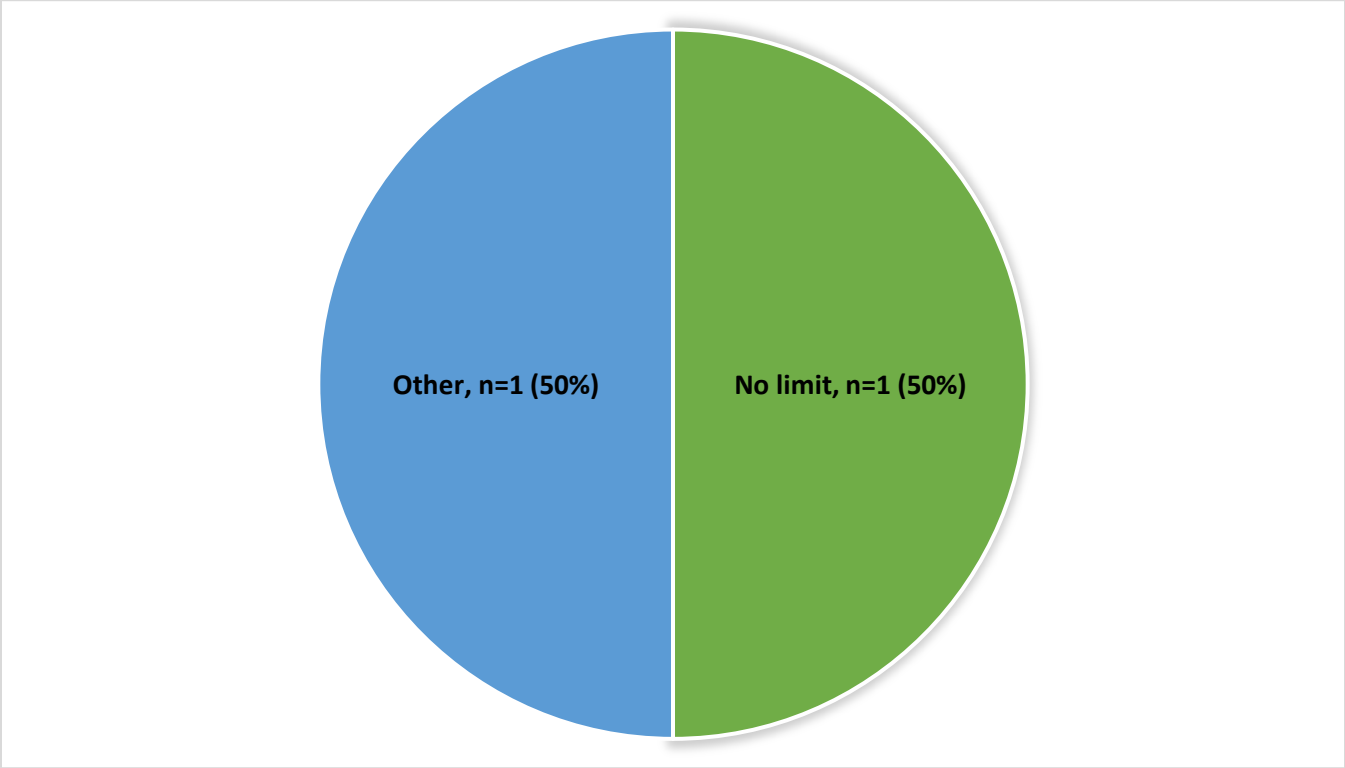

Table 202 - Limitations on the Allowable Length of the Reduced Dosage Treatment

Response	States	Count	Percentage
No limit	West Virginia	1	50.00%
Other	Tennessee	1	50.00%
Total		2	100.00%

If "Other," please explain.

Table 203 - "Other" Explanations for Limitations on the Allowable Length of the Reduced Dosage Treatment

State	Explanation
Tennessee	There are no limitations on the allowable length of the REDUCED dosage. Enrollees of non-BESMART providers, have a 6-month limit of 16 mg per day; thereafter, TennCare only covers up to 8 mg/day. Enrollees do not have to reduce their dosage below 8 mg/day. Enrollees of BESMART providers, have access to up to 24 mg/day (if certain conditions are met) for up to 1 year; however, enrollees do not have to reduce their dosage below 16 mg/day.

5. Does your State have at least one buprenorphine/naloxone combination product available without PA?

Figure 126 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

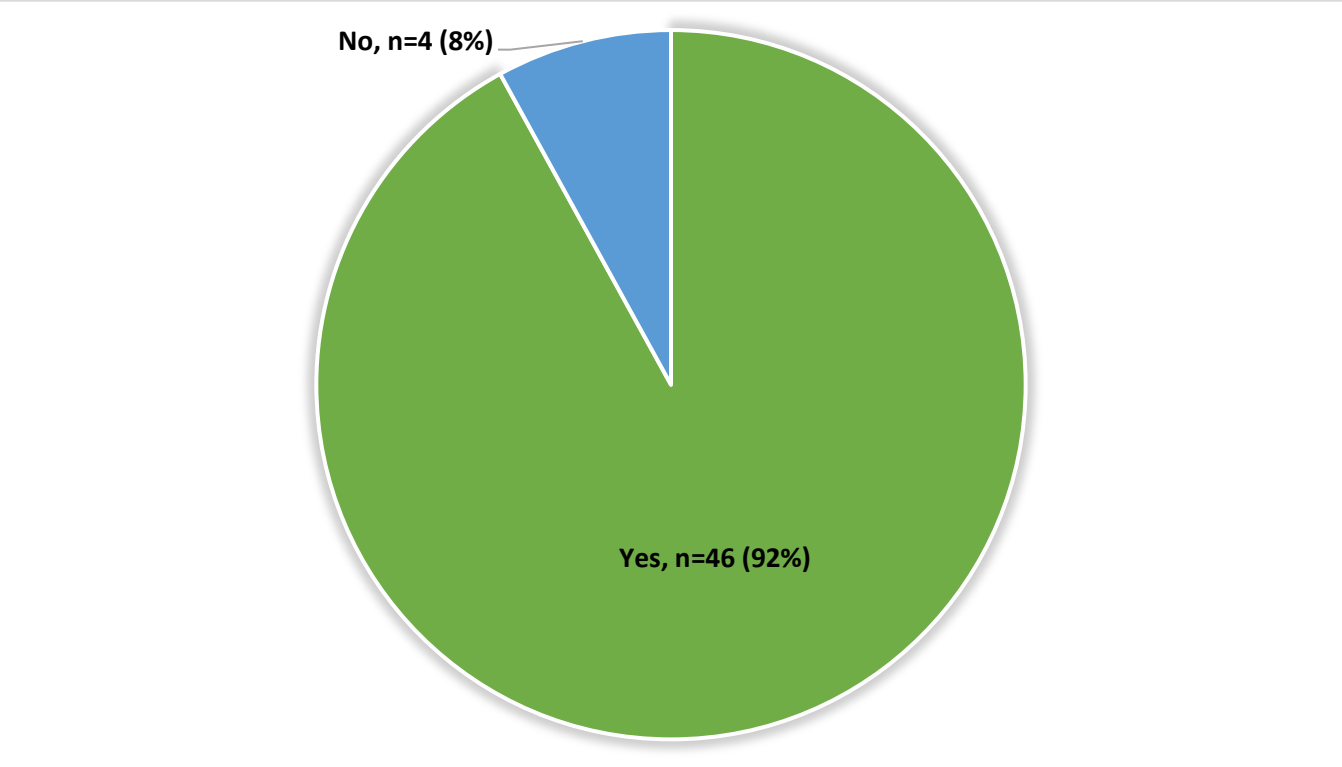

Table 204 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

Response	States	Count	Percentage
Yes	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, Nebraska, Nevada, 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, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Alabama, Montana, Tennessee, Texas	4	8.00%
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 127 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

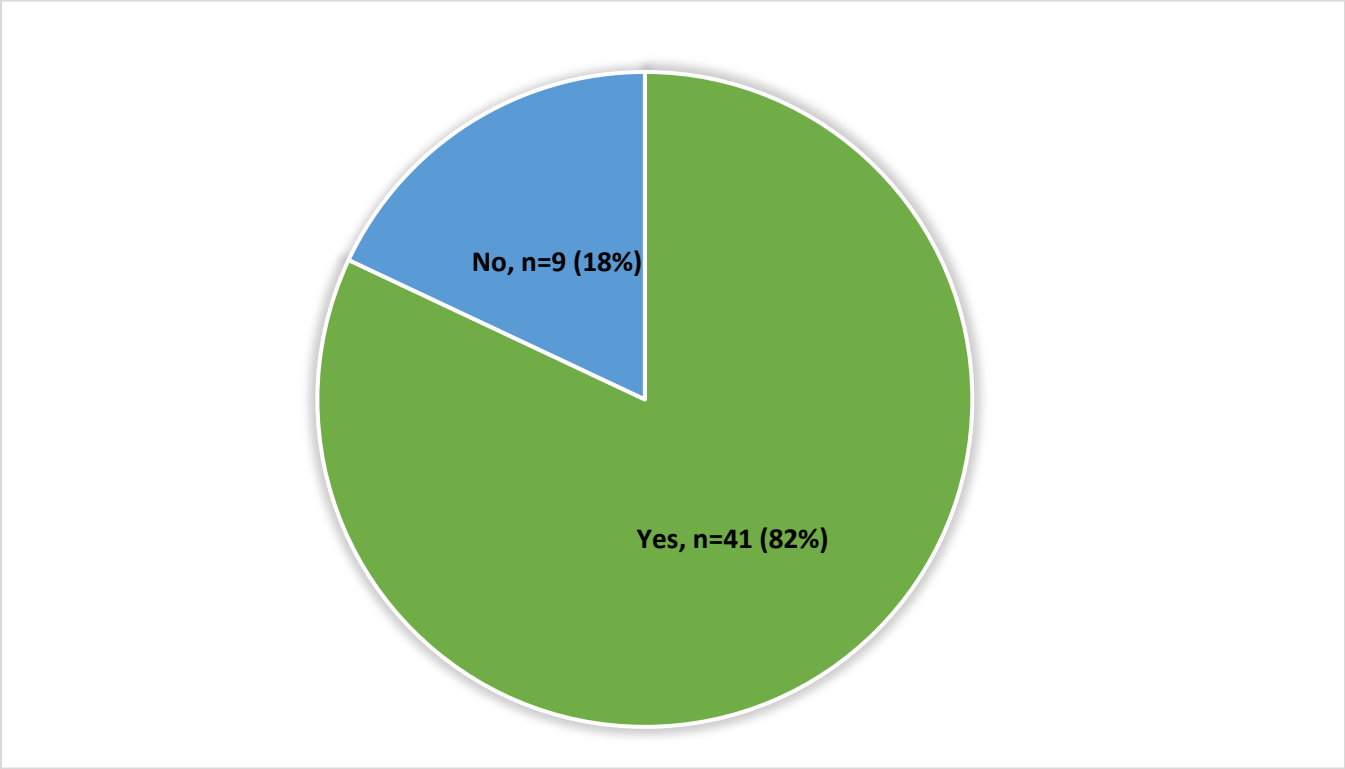

Table 205 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, 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, West Virginia, Wyoming	41	82.00%
No	Connecticut, Hawaii, Illinois, Iowa, Kansas, Maine, New Mexico, Washington, Wisconsin	9	18.00%
Total		50	100.00%

If "Yes," can the POS pharmacist override the edit?

Figure 128 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

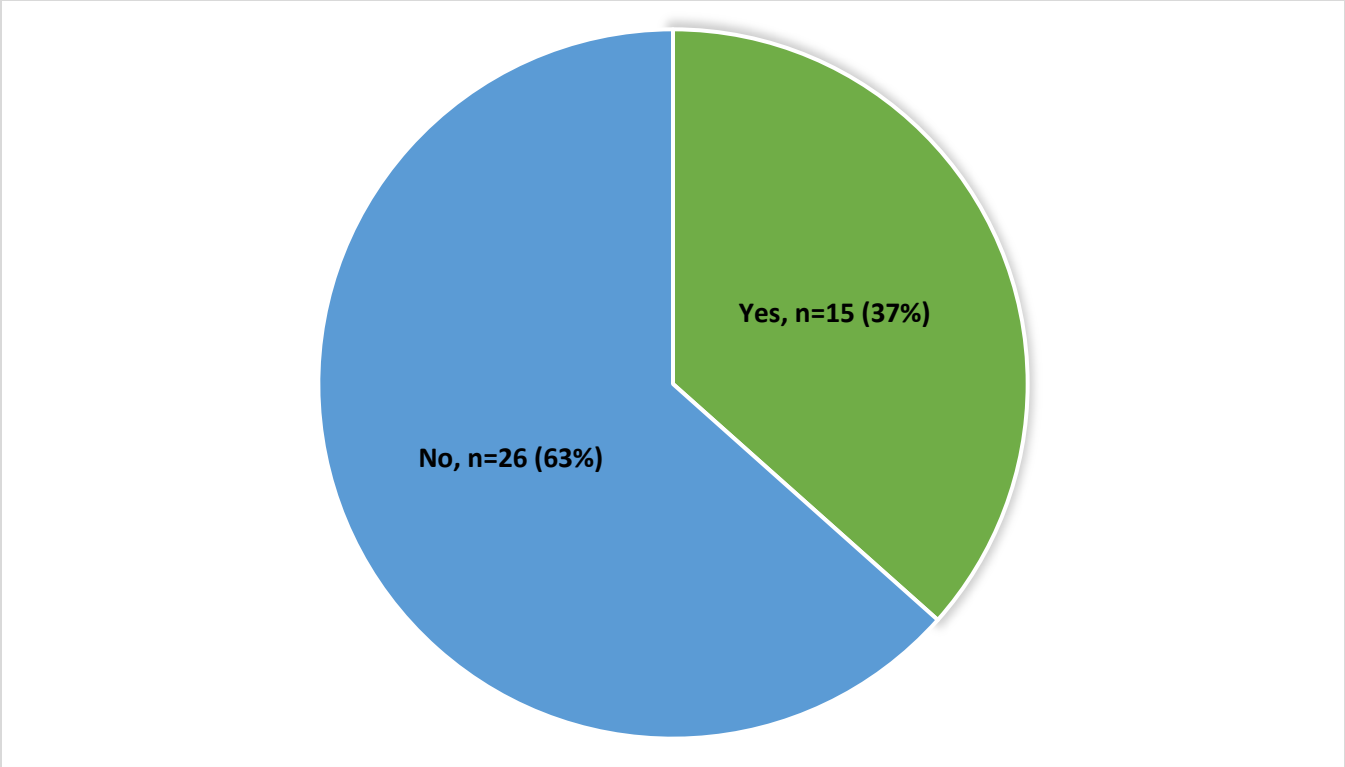

Table 206 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

Response	States	Count	Percentage
Yes	California, Colorado, Delaware, Florida, Louisiana, Maryland, Minnesota, Nebraska, Nevada, North Carolina, Ohio, Rhode Island, South Carolina, Vermont, Virginia	15	36.59%
No	Alabama, Alaska, Arkansas, District of Columbia, Georgia, Idaho, Indiana, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, West Virginia, Wyoming	26	63.41%
Total		41	100.00%

If "No," please explain why not.

Table 207 - Explanations for not Having Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

State	Explanation
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.
Hawaii	In the transplant program no opioids are being used concurrently with any buprenorphine drug or any form of MAT. The dental program only provides dental.

State	Explanation
Illinois	HFS Administration directed removal of edits regarding opioid and buprenorphine concomitant therapy in June 2021.
Iowa	There is a soft edit in place for the pharmacist to review and consult the prescriber as needed.
Kansas	We don't have a POS edit due to 42CFR Part 2 confidentiality but we do require the SUD providers to monitor the PDMP for their patients med use and reach out to the opioid provider if a patient receives an opioid for pain med.
Maine	These opioid prescriptions are subject to the same safety edits and retro drug utilization reviews as all opioid prescriptions. The State in partnership with the Maine Opioid Response Clinical Advisory Committee, MaineCare updated our coverage criteria and Prior Authorization (PA) process for buprenorphine for the treatment of Opioid Use Disorder (OUD). The Maine Opioid Response Clinical Advisory Committee is a group of approximately 30 leaders in Substance Use Disorder (SUD) prevention, treatment and harm reduction in Maine and includes both prescribers and pharmacists. With their input, MaineCare has made these updates to its coverage criteria to reflect best clinical practice in the use of Medications for Addiction Treatment (MAT) for OUD and to further its efforts to reduce barriers to care and increase access to life-saving medications for the treatment of OUD. Key changes to the MaineCare coverage criteria and PA processes include the following: Buprenorphine induction period changes: o Induction period is now considered to be 30 days (previously was 60 days) o Max buprenorphine dose is 24 mg/day for up to 30 days of induction period (previously was 32 mg/day) o Buprenorphine induction doses of up to 24mg/day will be allowed for multiple induction periods per year, during which prescribers can write for a maximum of 24 mg daily for up to 30 days without requiring a PA. For members who are pregnant, a Prior Authorization (PA) will not be required for buprenorphine monotherapy in doses up to 16 mg/day when the prescriber notes a pregnancy diagnosis noted on the prescription PAs for buprenorphine will no longer be required when a provider prescribes a concomitant opioid medication for the treatment of acute pain. The SC (Strength Change) override code can be used with an active PA to titrate a member's dose from once daily to twice daily dosing. This new override eliminates the need to submit a new PA request.
New Mexico	Considering edits for monitoring opioids being used concurrently with any buprenorphine products or any form of MAT in 2024 or 2025.
Washington	This is monitored on our monthly reports and is being considered for a future DUR activity.
Wisconsin	Wisconsin believes it is better to have a comprehensive retrospective claims review process and lock-in reviews to monitor concurrent use of opioids and MAT treatment. Frequently the concurrent use occurs as a member is switching from opioid use to MAT treatment. It can delay a MAT treatment start if this is handled as a prospective edit.

7. Is there at least one formulation of naltrexone for OUD available without PA?

Figure 129 - Formulation of Naltrexone for OUD Available without Prior Authorization

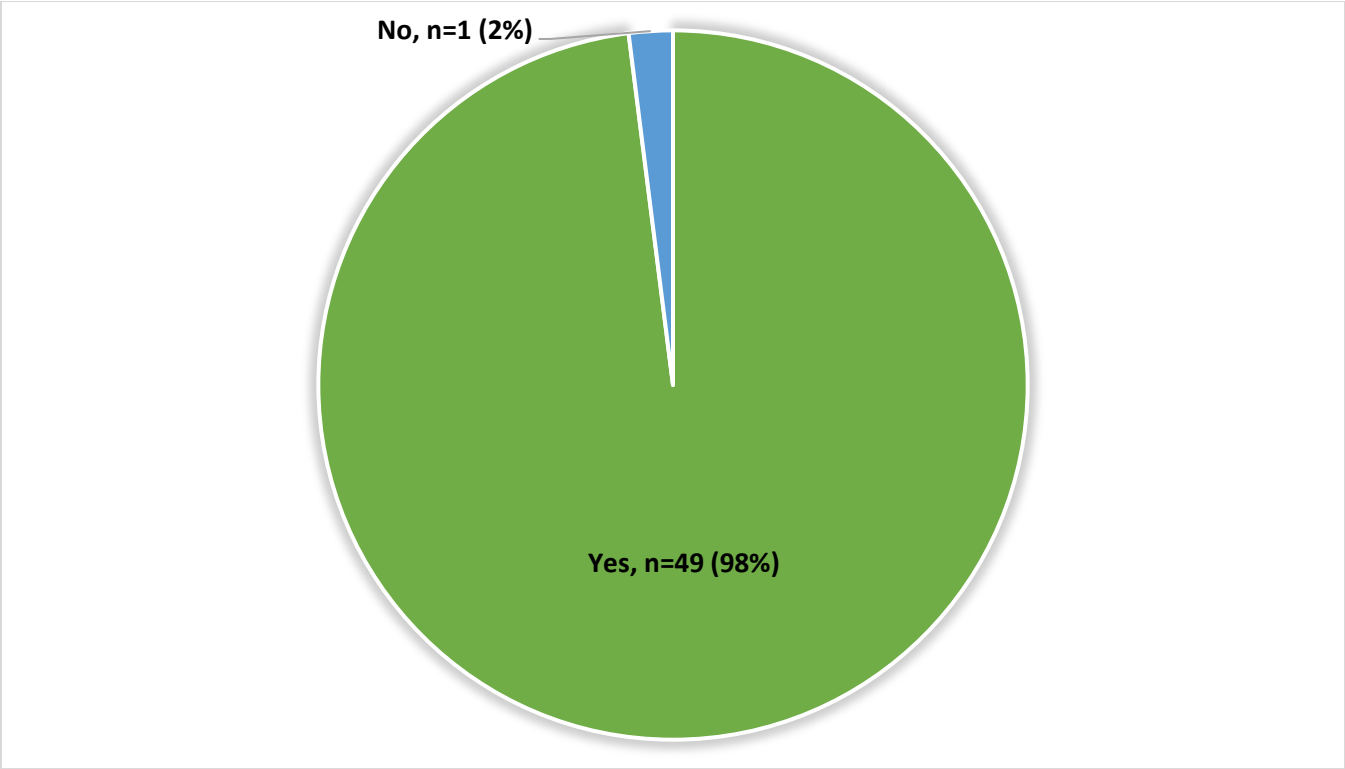

Table 208 - Formulation of Naltrexone for OUD Available without Prior Authorization

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	49	98.00%
No	Wyoming	1	2.00%
Total		50	100.00%

8. Does your State have at least one naloxone opioid overdose product available without PA?

Figure 130 -Naloxone Opioid Overdose Product Available without PA

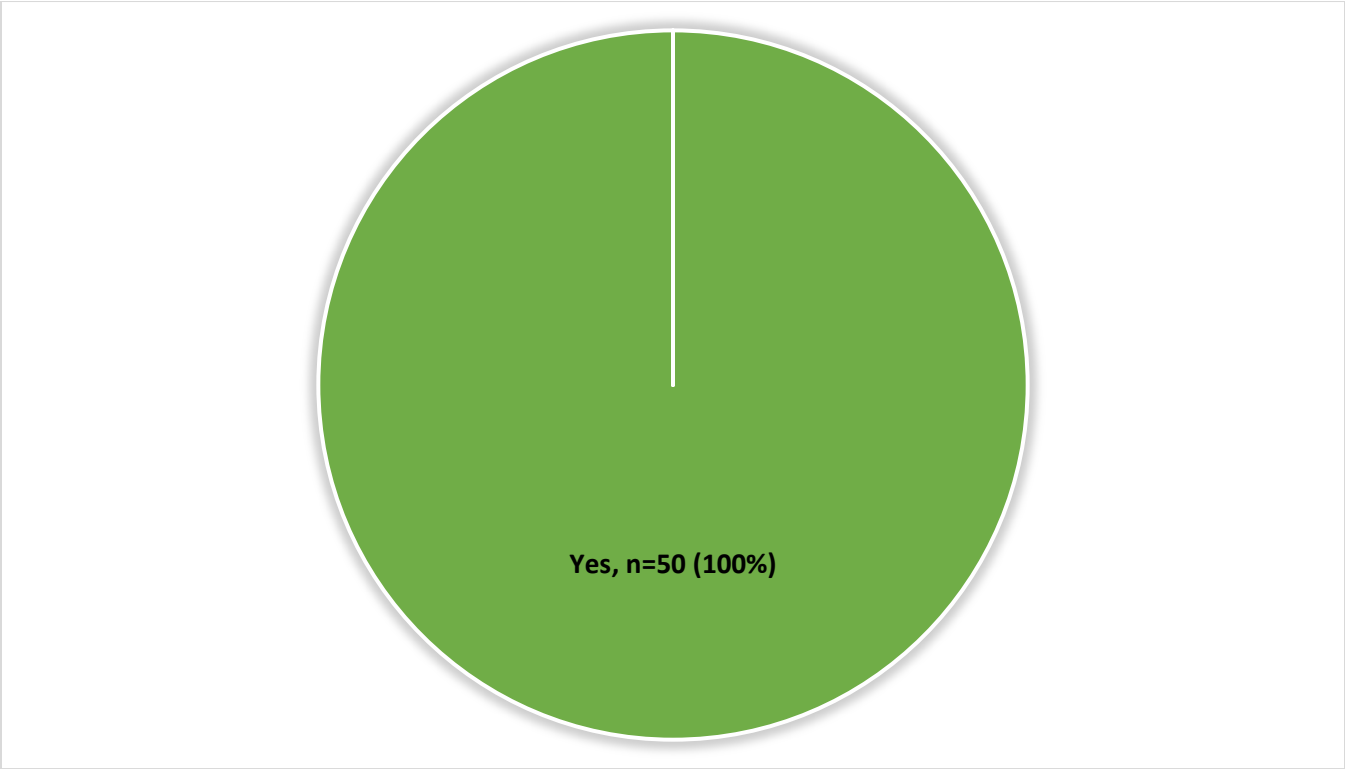

Table 209 - Naloxone Opioid Overdose Product Available without PA

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 monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 131 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

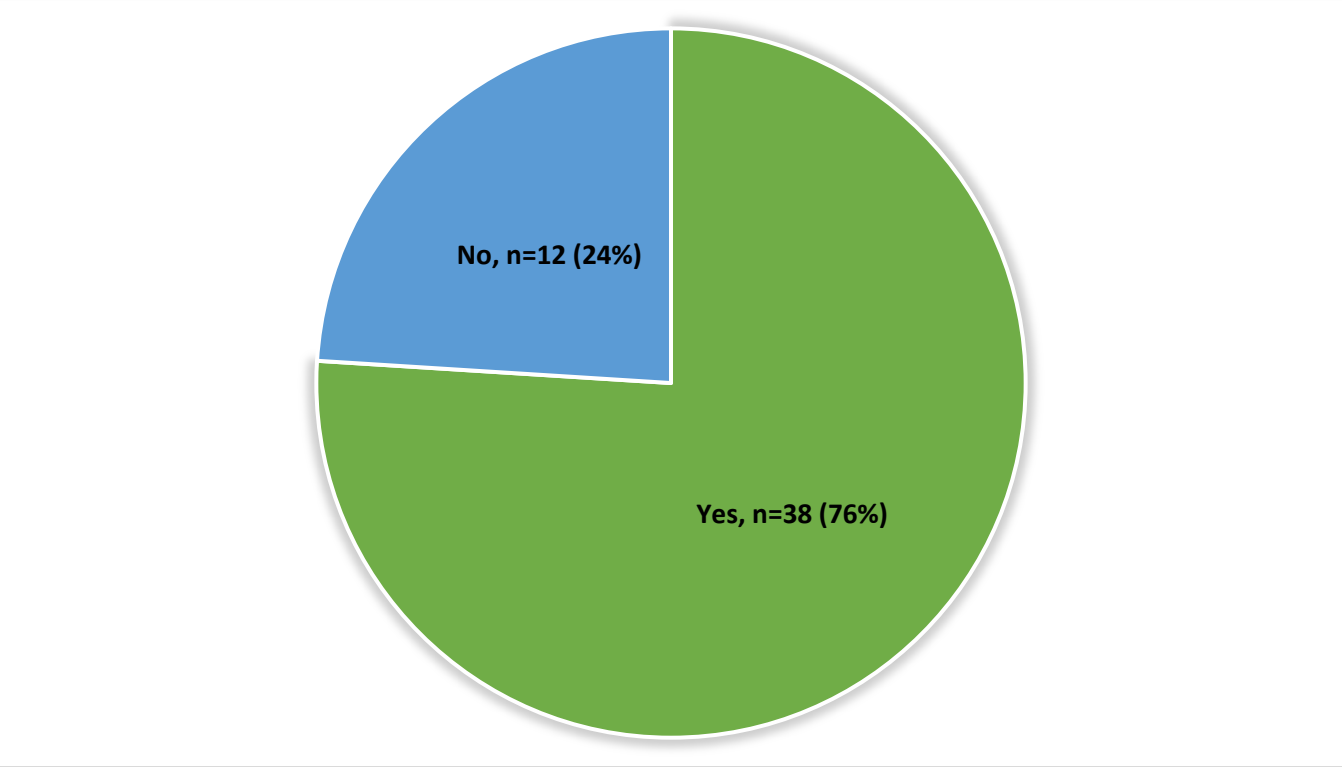

Table 210 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

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, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, Wyoming	38	76.00%
No	Maine, Massachusetts, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, South Dakota, Utah, Vermont	12	24.00%
Total		50	100.00%

If "No," please explain why not.

Table 211 - Explanations for Not Retrospectively Monitoring and Managing Appropriate Use of Naloxone to Persons at Risk of Overdose

State	Explanation
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.
Massachusetts	Naloxone is available without prior authorization.
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. Case management staff will outreach providers of members with a history of an overdose (accidental or otherwise, on retrospective review) to recommend naloxone.
Nebraska	Appropriate use of naloxone and opioids is addressed at time of dispensing through patient counseling being offered.
New Hampshire	Prior authorizations for buprenorphine and opioid products require attestation by the prescriber that a prescription for naloxone is provided.
New Jersey	The New Jersey Division of Consumer Affairs requires that naloxone be co-prescribed with continued use of opioids.
New Mexico	Plan for intervention in 2024 or 2025. New Mexico prescriptive authority allows for pharmacists to prescribe and dispense at POS.
Ohio	Currently, we do not retrospectively monitor naloxone. However, in February 2022, an RDUR intervention was performed to identify CSP members who did not have a pharmacy claim for naloxone. The goal of this intervention was to encourage prescribers to ensure that their patient has access to naloxone if they are currently taking an opioid, has a history of addiction or dependence to opioids, history of illicit drug use, current or past medication assisted treatment for opioid use disorder, or history of poisoning involving an opioid and to encourage prescribers to counsel their patients on the importance of filling their prescription for naloxone, carry it with them in the event of an emergency, and address patient concerns or stigmas surrounding naloxone. Naloxone prescribing guidelines are referenced in all pertinent RetroDUR interventions.
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.
South Dakota	Not at this time.
Utah	Retrospective review and peer-to-peer education on high dose opioid and concurrent opioid/benzo monthly. Naloxone products don't require prior authorization.
Vermont	The Vermont Department of Health has an extensive program for access to naloxone without a prescription required, therefore retrospective review would not be helpful or accurate because there are many ways a patient could obtain this outside of the pharmacy benefit. The Health Department provides naloxone (Narcan) and training through collaborations with community-based organizations. These partners distribute naloxone and provide overdose response training, opioid misuse prevention training and referrals to treatment across Vermont https://www.healthvermont.gov/emergency/injury/opioid-overdose-prevention

10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or State Medicaid program allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

Figure 132 - State Allows Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

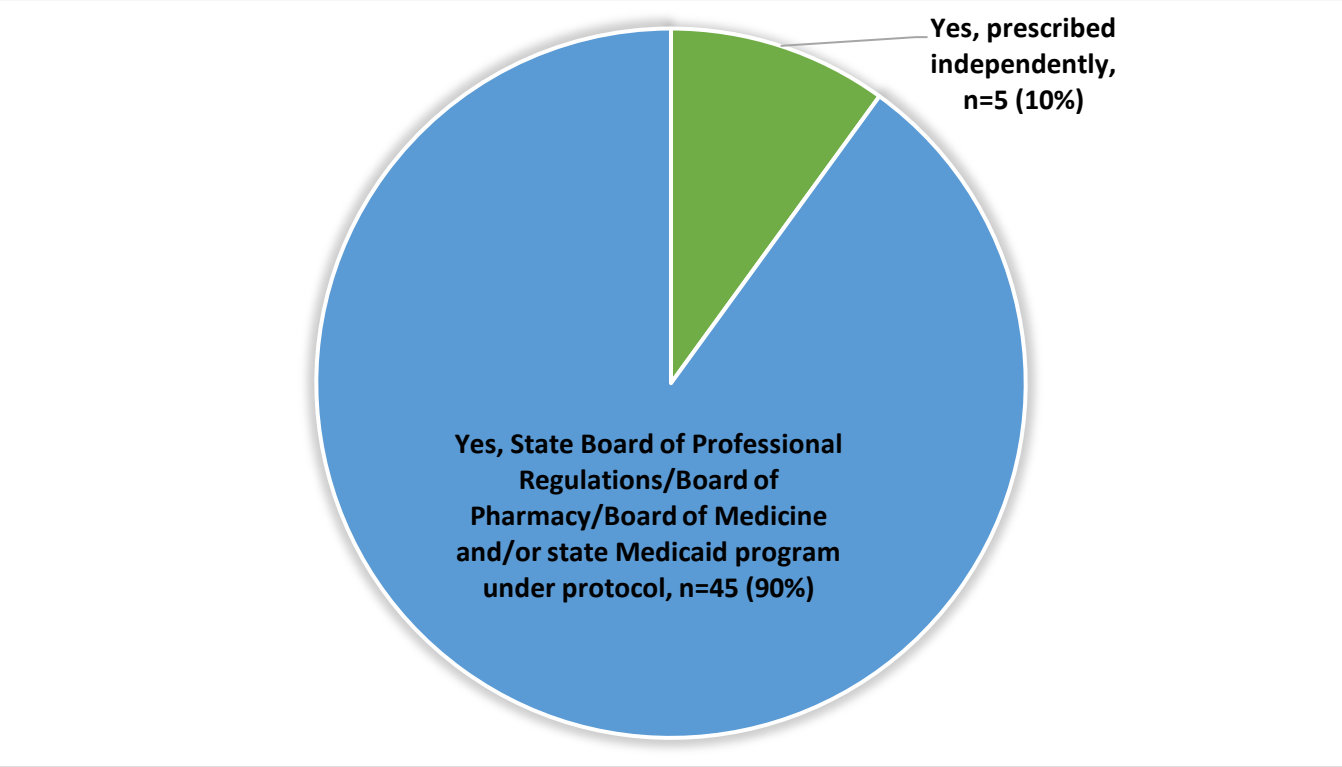

Table 212 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

Response	States	Count	Percentage
Yes, prescribed independently	Alaska, Connecticut, Idaho, Oregon, Wyoming	5	10.00%
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 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	45	90.00%
Total		50	100.00%

F. Outpatient Treatment Programs (OTP)

1. Does your State cover OTPs that provide Behavioral Health (BH) and MAT services?

Figure 133 - State Covers OTPs that Provide BH and MAT services

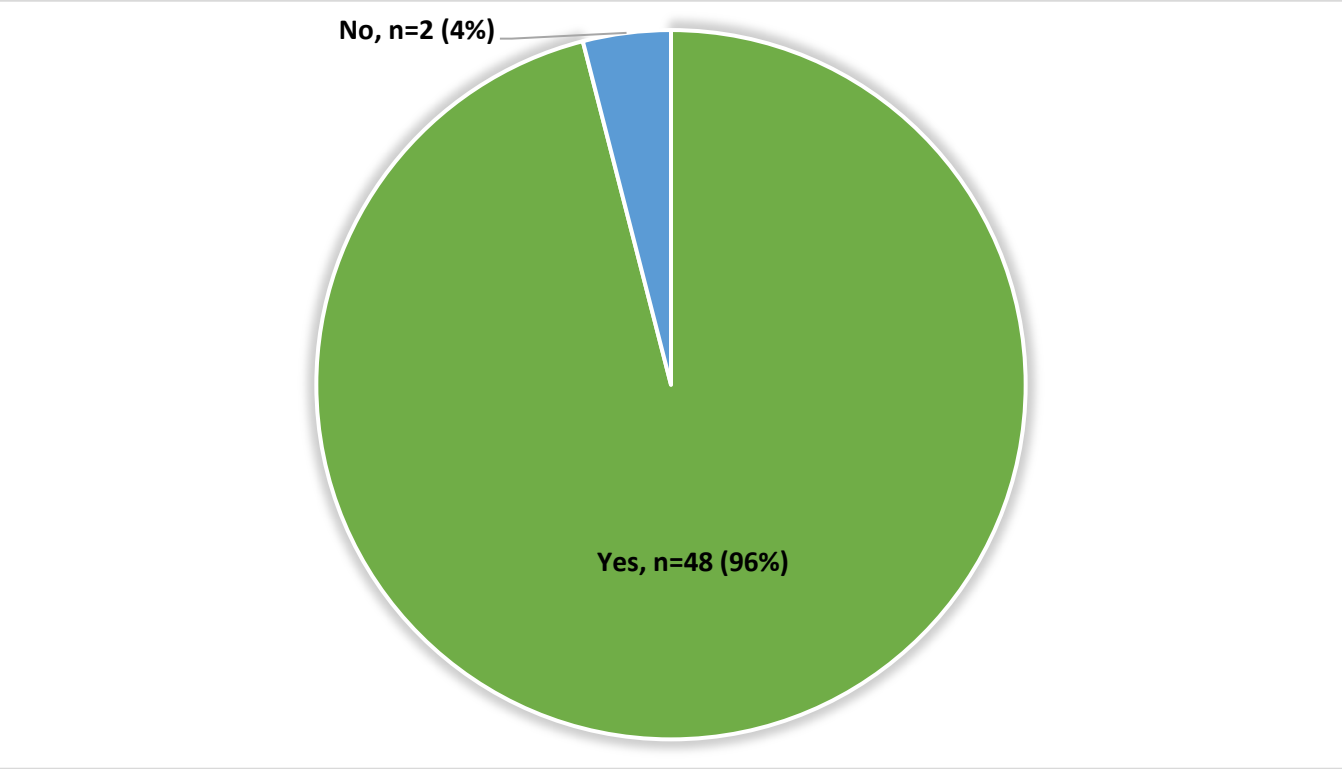

Table 213 - State Covers OTPs that Provide BH and MAT services

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, 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 why not.

Table 214 - Explanations for Not Covering OTPs that Provide BH and MAT services

State	Explanation
Hawaii	In the transplant program behavioral health and MAT have not been needed. The dental program only provides dental.
Wyoming	Wyoming does not have any outpatient treatment programs.

If "Yes," is a referral needed for OUD treatment through OTPs?

Figure 134 - Referral Needed for OUD Treatment Through OTPs

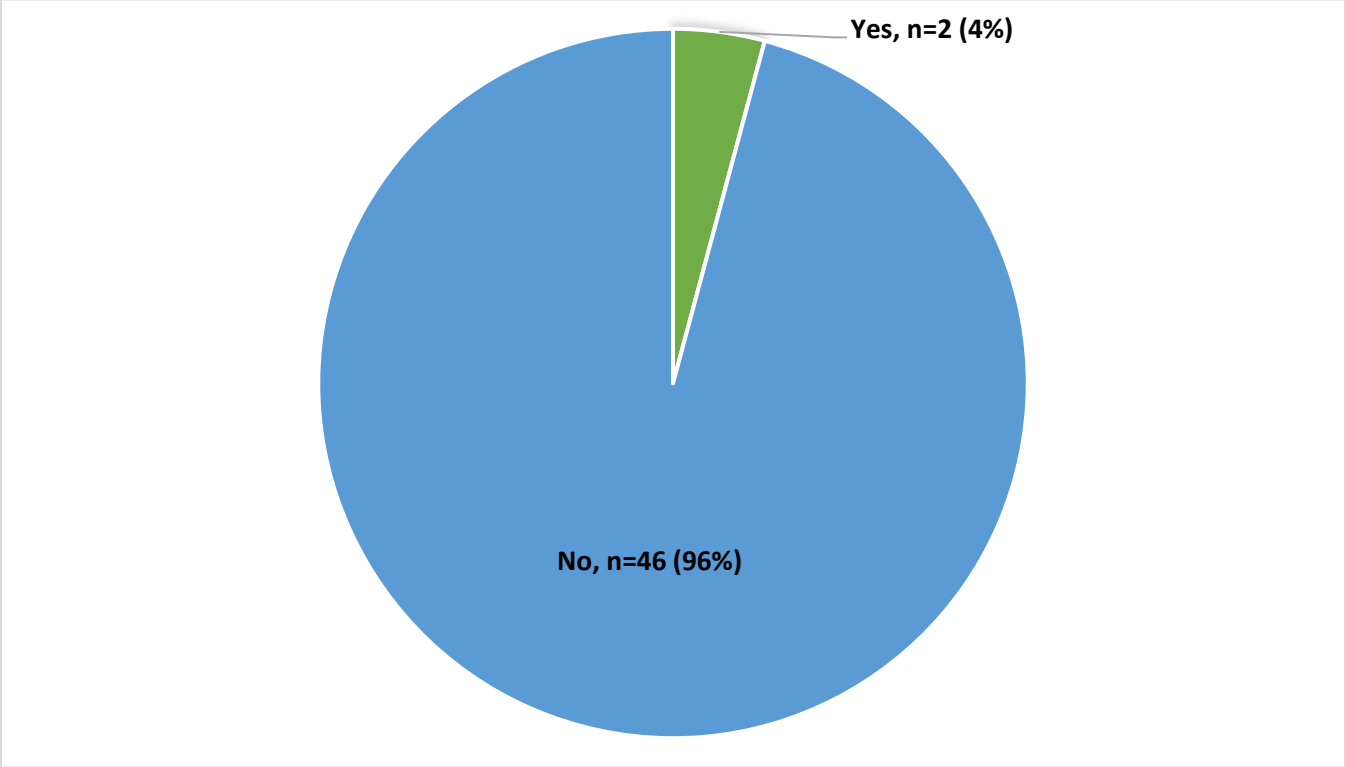

Table 215 - Referral Needed for OUD Treatment Through OTPs

Response	States	Count	Percentage
Yes	Maine, Michigan	2	4.17%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, 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, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	46	95.83%
Total		48	100.00%

Please explain.

Table 216 - Explanations Referral Needed for OUD Treatment Through OTPs

State	Explanation
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.

State	Explanation
Colorado	Behavioral health services including SUD treatment are available to all members without the need for a referral or copay.
Connecticut	A referral is not needed for OUD treatment through OTPs.
Delaware	A referral is not required.
District of Columbia	No referral is required.
Florida	No referral is needed for OUD treatment through OTPs.
Georgia	n/a
Idaho	X
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	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 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;

State	Explanation
	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 drugfree 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.
Minnesota	A referral is not needed. All clients can go directly to the OTP for evaluation and possible admission as of July 1, 2022.
Mississippi	No referral is required, but OTP services are subject to prior authorization.
Missouri	MO HealthNet utilizes a PDL edit which includes clinical criteria and dosing limits.

State	Explanation
Montana	Medication Assisted Treatment does not require a referral either through an OTP or OBOT.
Nebraska	A referral is not needed for OUD treatment through OTPs.
Nevada	No referral is needed.
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 referral is needed for OUD treatment through an OTP.
New York	Members have open access to outpatient services / outpatient treatment programs. State law prohibits prior approval for these services across public and commercial insurance programs that are regulated by New York State.
North Carolina	Beneficiaries can seek treatment and admittance to OUD treatment programs without a referral.
North Dakota	No referral is needed.
Ohio	On January 1, 2017 Ohio Medicaid began paying for opioid treatment services including counseling and therapy and medication assisted treatment provided at facilities certified by the Ohio Department of Mental Health and Addiction Services (OMHAS).
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 Medicaid program, and if applicable, the Coordinated Care Organization (Oregon's MCO).
Pennsylvania	Does OMHSAS require referrals?
Rhode Island	MAT services are available.
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	Referral not needed.
Tennessee	Enrollees can self-refer, and a formal referral from a provider is not required.
Texas	There are no prior authorizations or referrals required for Opioid Use Disorder (OUD) treatment.
Utah	N/A
Vermont	Patients may self-refer. They are also able to get same day treatment in the ER and be seen by an OTP within 3 days. People can also get connected to the services they need via VT helplink https://vthelplink.org/
Virginia	A referral is not needed.
Washington	Clients can 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.

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 135 - Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

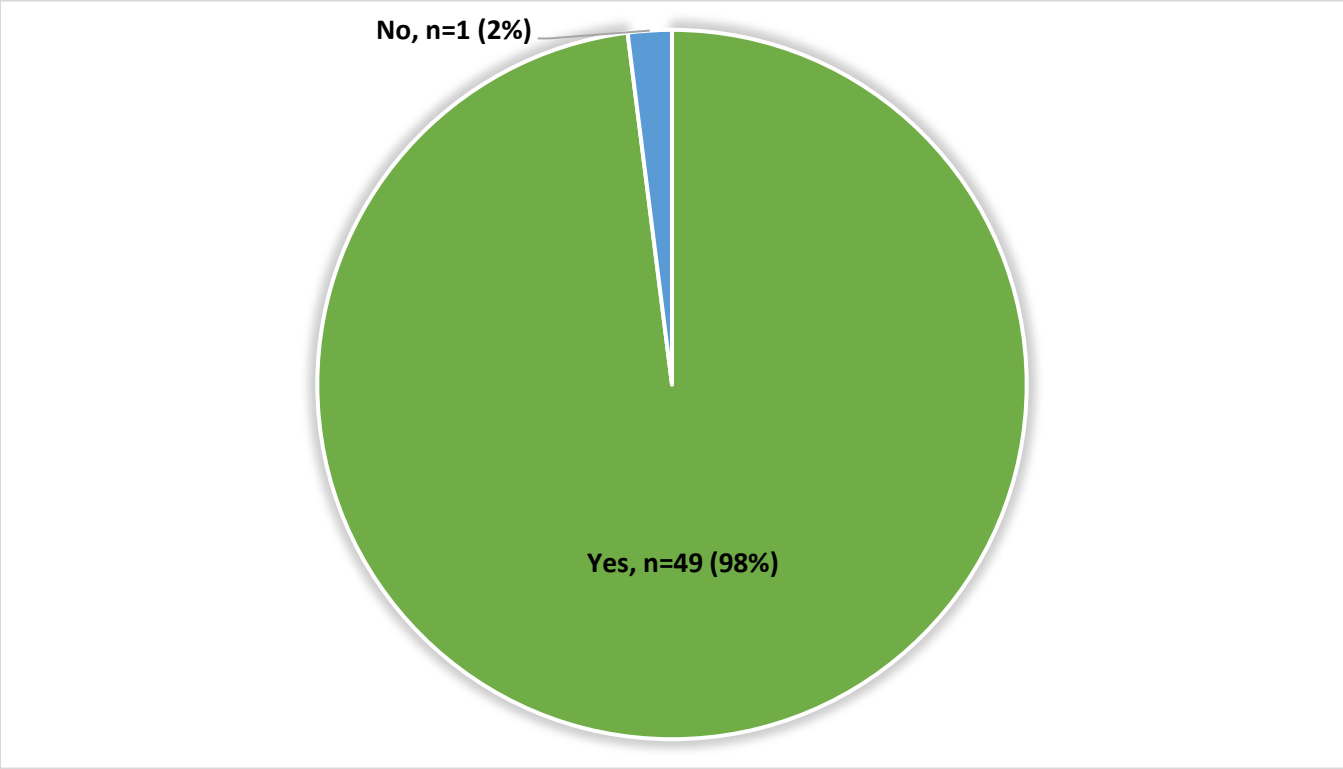

Table 217 - Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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	49	98.00%
No	Wyoming	1	2.00%
Total		50	100.00%

If “No,” please explain.

Table 218 - Explanations for State Not Covering Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

State	Explanation
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 136 - Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

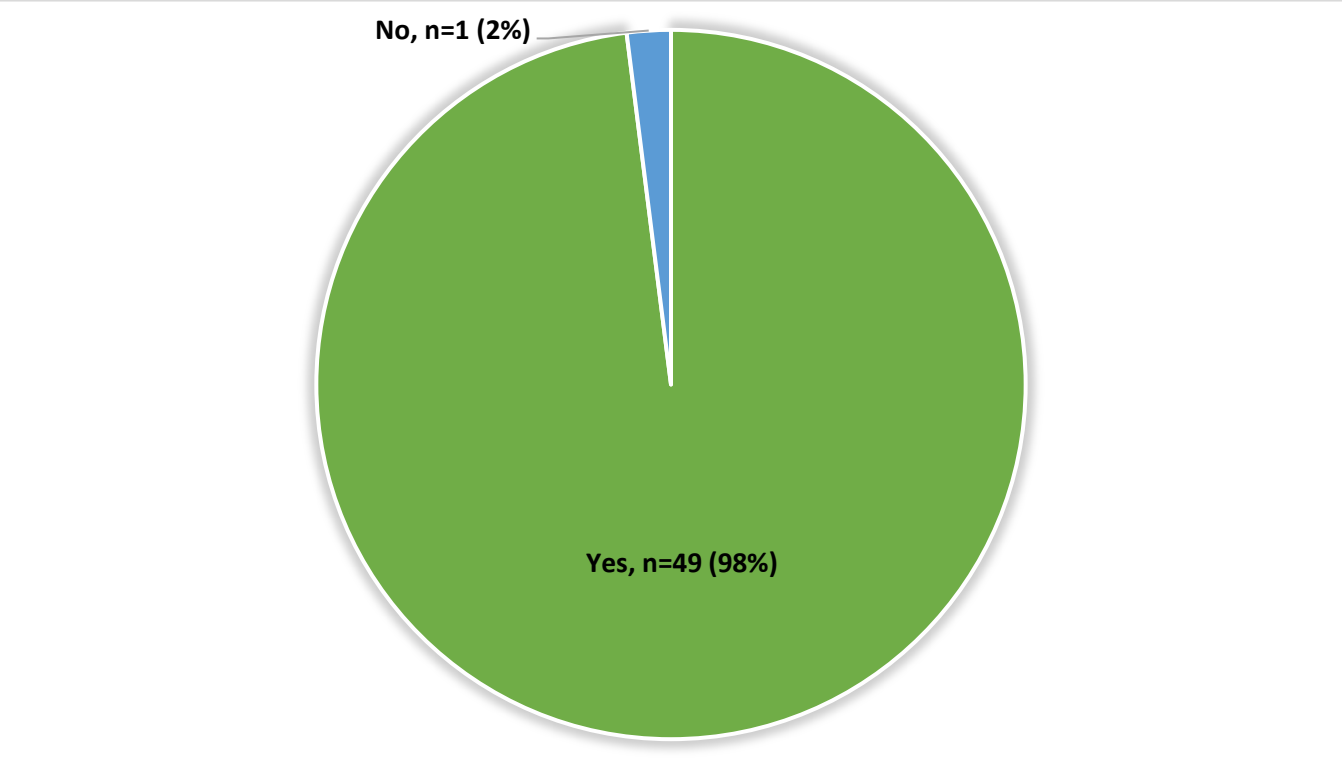

Table 219 - Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Wyoming	49	98.00%
No	Louisiana	1	2.00%
Total		50	100.00%

If “No,” please explain.

Table 220 - Explanations for State Not Covering Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

State	Explanation
Louisiana	Naltrexone is available as a pharmacy benefit, but not in the OTP setting.

4. Does your State Medicaid program cover Methadone for a substance use disorder (i.e., OTPs, Methadone Clinics)?

Figure 137 - State Program Covers Methadone for Substance Use Disorder

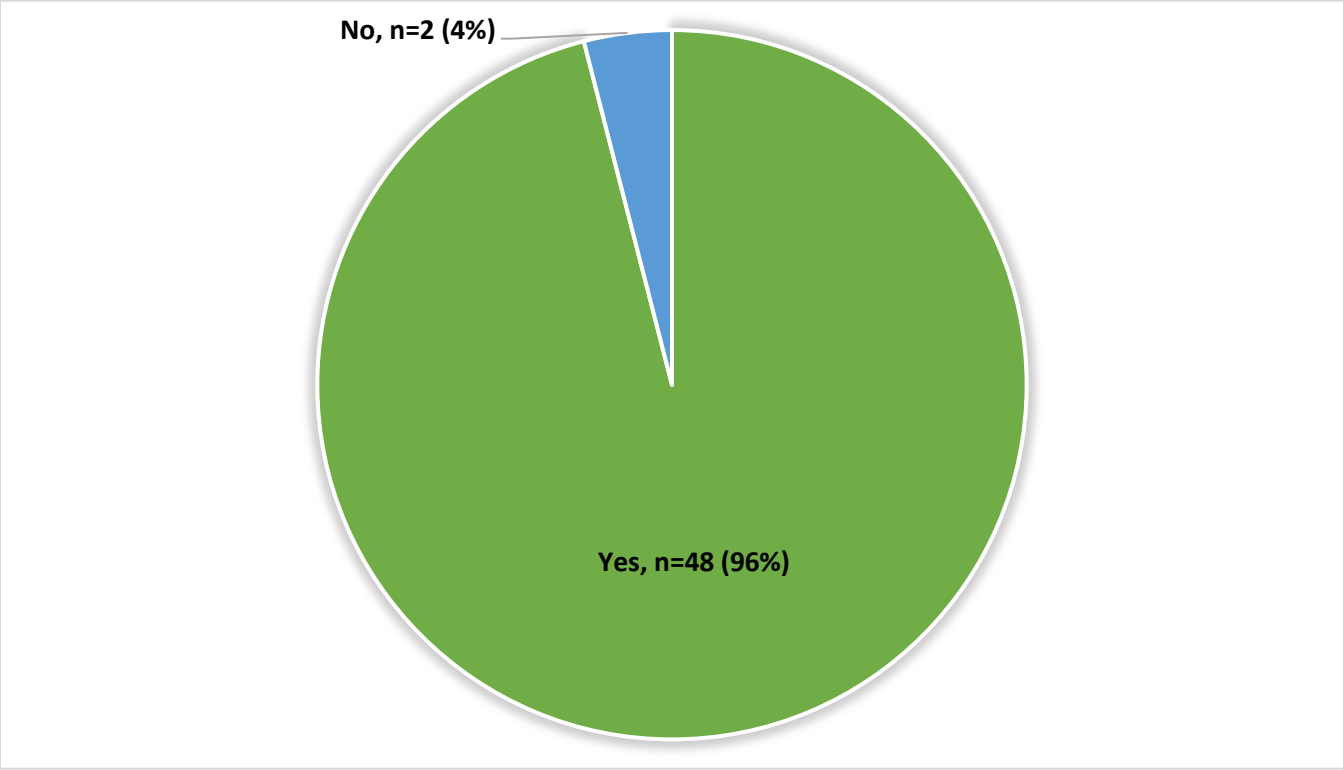

Table 221 - State Program Covers Methadone for Substance Use Disorder

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, 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	Kentucky, Wyoming	2	4.00%
Total		50	100.00%

If "No," please explain why not.

Table 222 - Explanations for State not Covering Methadone for a Substance Use Disorder

State	Explanation
Kentucky	Methadone for substance abuse is not covered under FFS pharmacy benefit.
Wyoming	Wyoming does not have any outpatient treatment programs.

G. Psychotropic Medication for Children

Antipsychotics

1. Does your State currently have restrictions in place to limit the quantity of antipsychotic drugs?

Figure 138 - Restrictions to Limit Quantity of Antipsychotics

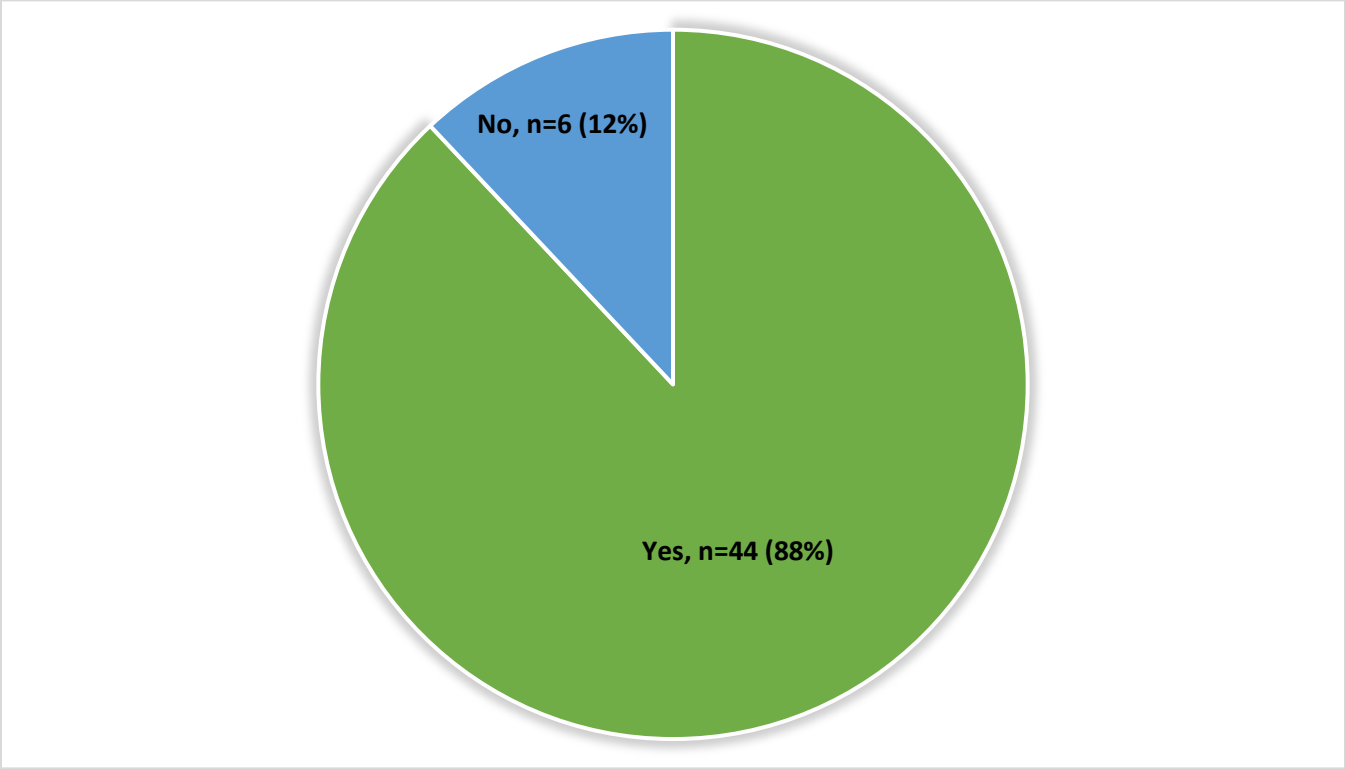

Table 223 - Restrictions to Limit Quantity of Antipsychotics

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, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wyoming	44	88.00%
No	Massachusetts, Michigan, Oregon, Rhode Island, West Virginia, Wisconsin	6	12.00%
Total		50	100.00%

Please explain restrictions or N/A.

Table 224 - Explanations of Restrictions to Limit Quantity of Antipsychotics

State	Explanation
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.

State	Explanation
	Medical justification is required for polytherapy. Metabolic monitoring is required for children less than 6 years of age and must be documented.
Alaska	Quantity limits in place consistent with standard doses.
Arkansas	Oral antipsychotics have maximum dose edits implemented by quantity edits at POS for adults and children based on treatment guidelines and FDA approved dosing for each product from the package insert. Dose edits for children are further differentiated based on age. A therapeutic duplication edit allows a maximum of two oral antipsychotics OR one oral and one long-acting injectable (LAI) without an additional therapeutic duplication PA which limits beneficiaries to no more than two antipsychotics at one time. All new starts for an LAI require a prior authorization, and all LAIs have continuation criteria if the beneficiary remains stable and compliant. Oral and injectable antipsychotics are on our PDL.
California	An approved Prior Authorization (PA) is 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 if medication is prescriber outside of FDA labeling. We also edit for therapeutic duplication and dose optimization.
District of Columbia	Injectable antipsychotic medications are available at the POS through pharmacies participating in the DHCF Specialty Mental Health Network. Selected injectable products require prior authorization based on clinical criteria.
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 a case-by-case basis.
Hawaii	30 days supply
Idaho	Limit dose per day. Age limit per FDA approved labeling.
Illinois	Group accumulators on long-acting injectable antipsychotics and high dose overrides for some of the antipsychotics are in place which override the Medispan programmed high dose. Prior authorization is required for use of antipsychotic medications for long-term care residents, for long-acting injectable atypical antipsychotics, and for all children less than 8 years of age.
Indiana	Age limits, duplicate therapy edits, low-dose edits, metabolic monitoring requirements, 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. Prior authorization is required for the member to receive more than 2 antipsychotics concurrently.
Louisiana	Selected antipsychotic agents have quantity limits. Additional POS safety edits include age-specific maximum dose limits, diagnosis requirements, and therapeutic duplication. Preauthorization is also required for behavioral health agents for beneficiaries less than 7 years of age.
Maine	Require prior authorization for use under age 5, for multiple anti-psychotic concurrently and routinely review metabolic monitoring during use.

State	Explanation
Maryland	To support providers who prescribe this drug class, the Office of Pharmacy Services (OPS) has established two programs: Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP). The OPS also has established prior authorization requirements and clinical review process for the Tier 2 & Non Preferred (Tier 2 & NP) Antipsychotics including dose optimization requirements. For additional information, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx.
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	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, FFS Medicaid performs two RetroDUR mailings per year regarding criteria regarding psychotropic drug use in youth.
Mississippi	Electronic PA age edites, quantity limits for all beneficiaries, multiple antipsychotic edits 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	There are limits according to FDA package inserts.
Nevada	Children under age 18 years-old are allowed one antipsychotic without prior authorization.
New Hampshire	There are daily day supply limits for antipsychotic drugs that vary based on the FDA Package insert daily dosing interval. Quantity is also limited to a 90 day supply for beneficiaries on maintenance regimens.
New Jersey	Maximum daily dose edits are in place for antipsychotics. No more than two antipsychotics are to be taken concomitantly by a member.
New Mexico	Up to a 34 day maximum supply is allowed per prescriber dosing.
New York	Frequency and quantity limits in place for the following products: asenapine, lumateperone, paliperidone, paliperidone, quetiapine, and quetiapine ER.

State	Explanation
North Carolina	Antipsychotics have edits that require Prior Authorization, check for concomitant use, check for quantity limits, daily dose, and maximum quantity.
North Dakota	Quantity limits are in place for FDA and compendia max dosing recommendations.
Ohio	The State allows up to 102-day supply for antipsychotic drugs. Quantity limit specifics may be found here: https://pharmacy.medicaid.ohio.gov/drug-coverage
Oklahoma	Quantity limits of antipsychotics are based on FDA approved dosing regimens. Authorization of medications are based on FDA approved age limits.
Oregon	N/A
Pennsylvania	The prior authorization guidelines for the Statewide PDL class Antipsychotics require prior authorization for an atypical Antipsychotic when there is a record of a recent paid claim for another atypical Antipsychotic in the Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication). Prior authorization is also required for a typical Antipsychotic when there is a record of a recent paid claim for another typical Antipsychotic in the Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication). These therapeutic duplication guidelines assure that the beneficiary has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines OR that the beneficiary is being titrated to or tapered from another atypical/typical Antipsychotic.
Rhode Island	n/a
South Carolina	Including, but not limited to: Prior authorization for indication and age, TD duplication edits, Overuse, etc.
South Dakota	Quantity limits apply and vary by product.
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.
Texas	The quantity limit on the antipsychotic prescriptions is based on the maximum quantity per claim set in the claims system. The clinical prior authorization limits the number of antipsychotics prescribed to 2 different antipsychotics (chemically different drugs) at any given time. Prior authorization is required for more than two antipsychotics prescribed concurrently.
Utah	UT 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 based on FDA maximum recommended dose Refer to the PDL for specific details. https://dvha.vermont.gov/sites/dvha/files/doc_library/VERMONT%20PDL_July2022.pdf
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 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

State	Explanation
	effects of this drug class. A psychiatrist consultant makes peer outreach calls as needed. Children over eight years of age are monitored for polypharmacy of antipsychotics by the psychiatrist consultant and peer outreach calls are conducted as needed. Wisconsin has also an intervention letter that identifies children who are currently taking at least three of more sedating medications drug classes including antipsychotics. The letter offers prescribers the opportunity to discuss specific cases with the psychiatrist consultant. The psychiatrist consultant reviews the medications for the members identified. Peer outreach calls are conducted as needed.
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 139 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

Table 225 - Documented Program in Place to Either Manage or Monitor the 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%

a. If "Yes," does your State either manage or monitor:

Figure 140 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

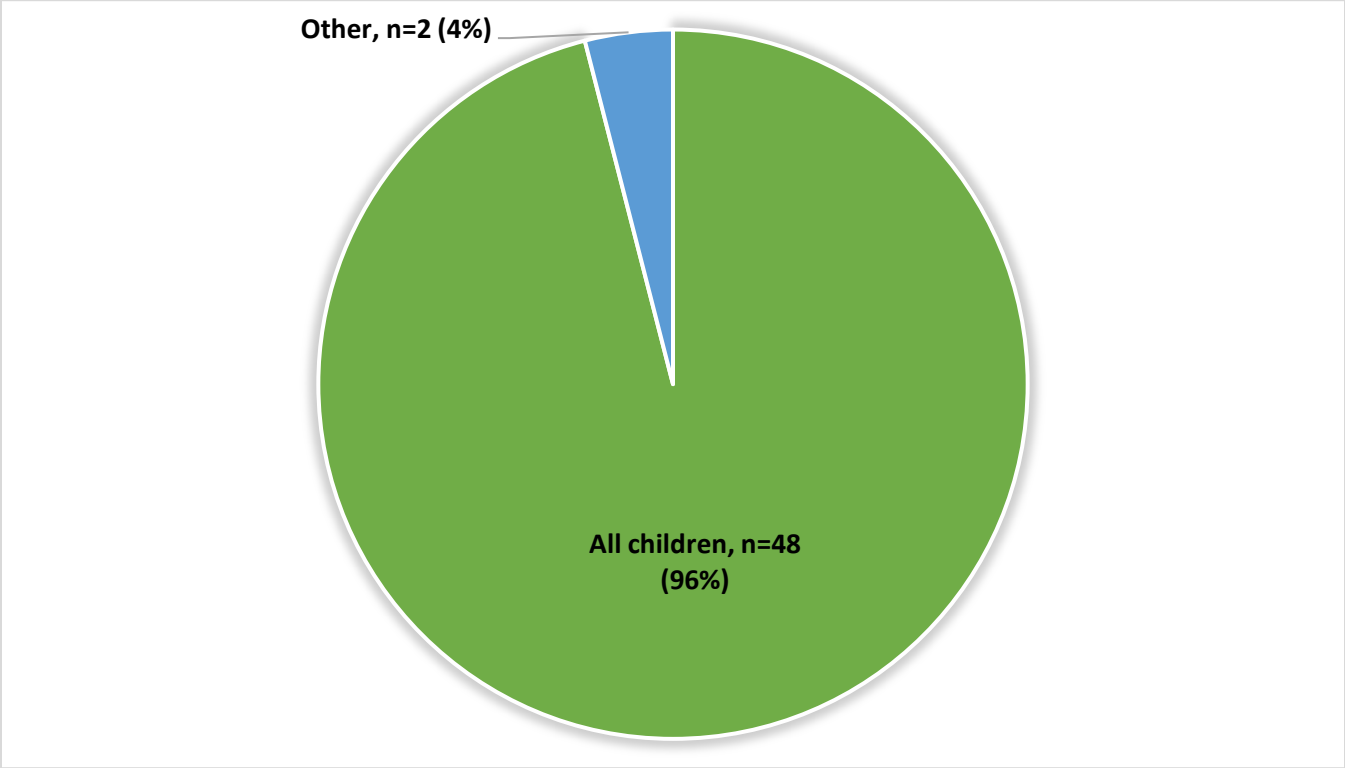

Table 226 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

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, 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	48	96.00%
Other	Illinois, Oregon	2	4.00%
Total		50	100.00%

If "Other," please explain.

Table 227 - "Other" Explanations for Managing or Monitoring the Appropriate Use of Antipsychotic Drugs in Children

State	Explanation
Illinois	In FFS, prior authorization is required for all children covered under the Department of Child and Family Services (DCFS) Youth in Care program. The majority of Youth in Care children are now covered by the YouthCare MCO. In addition, prior authorization is required for all other children less than 8 years of age who are prescribed atypical antipsychotic medications (age edit). Prior authorization is required if a prescriber requests

State	Explanation
	a long-acting atypical antipsychotic for anyone. A group accumulator edit applies, if a long-acting injectable antipsychotic is approved. Prior authorization is required for high dose use of all antipsychotics. Doc Assist review and peer-to-peer consultation are available for mental health medications in children.
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.

b. If "Yes," does your State have edits in place to monitor (multiple responses allowed):

Figure 141 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

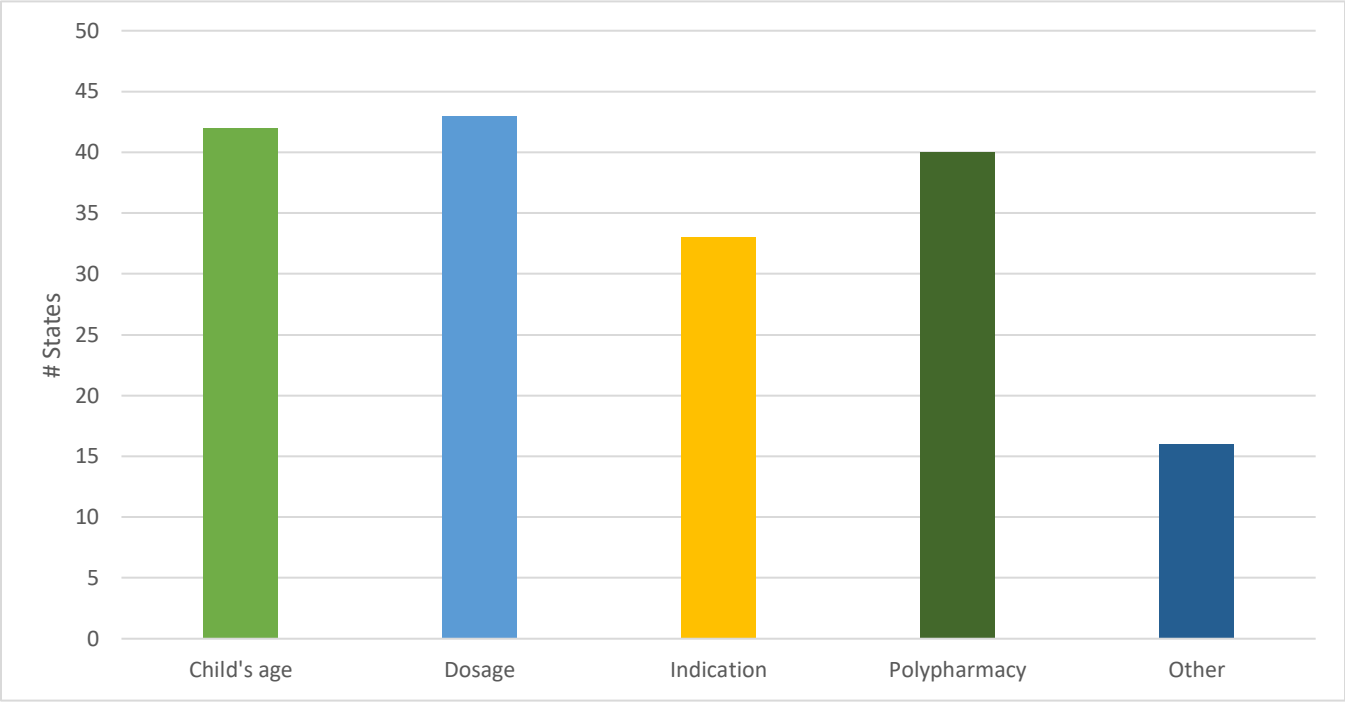

Table 228 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Child's age	Alabama, Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	42	24.14%
Dosage	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota,	43	24.71%

Response	States	Count	Percentage
	Mississippi, Missouri, Montana, Nebraska, 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		
Indication	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington	33	18.97%
Polypharmacy	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, 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 Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	40	22.99%
Other	Arkansas, Delaware, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Mississippi, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Washington	16	9.20%
Total		174	100.00%

If “Child’s age,” please specify age limit in years.

Table 229 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

State	Age Limit in Years
Alabama	0
Alaska	5
Arkansas	17
Colorado	5
Connecticut	18
District of Columbia	18
Florida	6
Georgia	17
Hawaii	21
Idaho	6
Illinois	8
Indiana	18
Iowa	3
Kansas	17
Kentucky	18
Louisiana	6
Maine	5
Maryland	18

State	Age Limit in Years
Massachusetts	6
Michigan	17
Missouri	9
Montana	7
Nebraska	18
Nevada	18
New Hampshire	18
New York	5
North Carolina	17
North Dakota	5
Oklahoma	4
Oregon	5
Pennsylvania	18
Rhode Island	18
South Carolina	6
South Dakota	18
Tennessee	12
Texas	6
Utah	6
Vermont	18
Virginia	18
West Virginia	6
Wisconsin	18
Wyoming	5

If "Other," please explain.

Table 230 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

State	Explanation
Arkansas	Edits for beneficiaries <10 years of age and those 10-17 years of age are explained in the next question. To monitor potential metabolic effects of antipsychotics, children are required to have lipids and glucose labs at least every 9 months.
Delaware	Age limit varies depending on FDA approved indications.
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.
Indiana	Metabolic monitoring performed annually.
Kansas	multiple concurrent drug use and provider type- either at POS or via the PA process
Louisiana	Louisiana has specific POS safety edits in place for children including age-specific maximum dose limits, diagnosis requirements, and therapeutic duplication. Preauthorization is also required for behavioral health agents for beneficiaries less than 7 years of age. Antipsychotic agent utilization is also reviewed retrospectively for adherence and concurrent use with opioids.
Maine	metabolic monitoring is required and prior authorization if monitoring is not completed in the members medical claims data.

State	Explanation
Massachusetts	Use of behavioral health medications in children 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.
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.
Mississippi	Age edits vary by antipsychotic agents. electronic PA age edits, quantity limits for all beneficiaries, multiple antipsychotic eds for children, and manual PA criteria for multiple antipsychotic continued use for children.
New Mexico	RetroDUR interventions are performed to identify children requiring metabolic monitoring.
North Carolina	Require prior approval, check for concomitant use, and quantity limits.
Ohio	We have additional edits in place which 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.
Washington	Washington Medicaid applies age/dose limits, therapeutic duplication edits, and polypharmacy edits (5 or more mental health drugs) to claims submitted for antipsychotics used by children ages 17 years or younger for a second opinion review with are contracted metal health specialist. Our age limitations are determined by our pediatric mental health workgroup and structure as age bands with different dosing restrictions for the individual bands and drugs. For example our age dosing for aripiprazole is full PA ages 0-3, 5mg per day for ages 4-5, 20mg per day for ages 6-12, and 30mg per day ages 13-17 compared to lurasidone requires full PA ages 0-6, 40mg per day ages 6-12, 80mg per day for ages 13-17. For our comprehensive list of our limits can be found at https://www.hca.wa.gov/billers-providers-partners/program-information-providers/apple-health-second-opinion-program

C. If "Yes," please briefly explain the specifics of your documented antipsychotic monitoring program(s).

Table 231 - Explanations of State's Documented Antipsychotic Monitoring Program

State	Explanation
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 less than 6 years of age and must be documented.
Alaska	Quantity limits and therapeutic duplication edits. Special edits for children under 5 years of age. Under contract with pediatric psychiatry specialists for case review.
Arkansas	Reviews by the Medicaid Pharmacy Program clinical pharmacists and psychiatrist take into consideration the beneficiary'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

State	Explanation
	drugs. Dose edits for children are further differentiated based on age. Beneficiaries<18 years of age require a manual review prior authorization for new starts or change in chemical entity along with a signed informed consent form by the guardian. Continuation criteria for beneficiaries 10-17 years of age require at least one paid claim for the approved oral antipsychotic in the past 45 days and monitoring for both glucose and lipid screening in the past 9 months. Beneficiaries <10 years of age require manual review prior authorization after each PA expires. 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 beneficiary is prescribed 3 or more oral antipsychotics OR 2 oral antipsychotics along with a LAI. Beneficiaries with a denied claim for TD require a prior authorization request to be submitted by the prescriber. Also, we run monthly reports for reviewing psychotropic drugs for children separated into multiple age groups and foster care status. We also review the same data for our MCOs. Presence of behavioral health therapy in history is noted. Drug classes reviewed on this report include antipsychotics, CII stimulants, alpha blockers, metformin, and mood stabilizers.
California	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 multiple psychotropic medications (including antipsychotic medications). Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
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. All antipsychotic agents are set to require a prior authorization for children under 18 and must follow the FDA approved indications. Synergy is also achieved

State	Explanation
	in Delaware by the Department of Family Services (DSCYF) working with Medicaid on foster children to reduce unnecessary therapies.
District of Columbia	The PBM contractor produces monthly reports that monitor the use of opioids and antipsychotics including for pediatric patients. Point of sale DUE edits capture concomitant use with opioids, phenothiazines and other drugs that may prolong QT. The addition of a child and adolescent Psychiatrist to the Board membership continues to enhance the Board's ability to monitor antipsychotic, antidepressant, and stimulant use more closely in the Medicaid child population. The psychiatrist member 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.
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.
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	Quarterly and annual review done manually. Transplant program has less than 10 patients per quarter. Patient status, location, provider and medical necessity are all reviewed. The dental program does not include anti-psychotic medication.
Idaho	Targeted DUR interventions for all children less than 6 years old.
Illinois	- All Fee-for-Service (FFS) children not in the DCFS Youth in Care program who are < 8 years of age require Prior Authorization for antipsychotic therapy. - 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, lack of metabolic monitoring performed in the past year, 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 do a claims review 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 specific POS safety edits in place for children including age-specific maximum dose limits, diagnosis requirements, and therapeutic duplication. Preauthorization is also required for behavioral health agents for beneficiaries less than 7 years of age.

State	Explanation
	Antipsychotic agent utilization is also reviewed retrospectively for adherence and concurrent use with opioids.
Maine	Re-inStated after the pandemic. The State and DUR vendor typically sent out over 1500 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. 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, psychiatrist involvement (either as the prescriber or consult notes from the past year). For antipsychotic polypharmacy additional requirements include two failed trials with antipsychotic monotherapy 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, non-pharmacologic 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	We utilize a program called WholeHealthRx which is operationalized through our Magellan contract. It is a monthly RetroDUR academic detailing program which includes 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

State	Explanation
	identified (e.g. multiple concurrent antipsychotics). In particular, the monitoring program reviews monthly reports of antipsychotics in children under 6, in children under 2, and any children with 2 or more agents in the same therapeutic class, or those with 5 or more psychotropic medications.
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, FFS Medicaid performs two RetroDUR mailings per year regarding criteria regarding psychotropic drug use in youth.
Mississippi	Our electronic PA criteria include age check, indication check and check for use of multiple antipsychotic medications.
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	Minimum age limits, quantity limits, daily dose limits, and a review by a board-certified child and adolescent psychiatrist is required for request outside of these limits.
Nevada	Prior authorization is required for all children under 18 years of age. In order to obtain authorization, certain documentation must be present in the medical record. For psychotropics (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) medications prescribed to this age group, it is preferred that they are prescribed by a child psychiatrist or in consultation with one. Additionally, the use of psychotropics medication should be part of a comprehensive treatment plan that includes education, behavioral management, the home environment, and psychotherapy. Furthermore, while the recipient is using any of the classes mentioned above, monitoring by the physician or prescriber is necessary. The frequency of visits depends on the recipient's treatment status and stability. Those in initial treatment or considered unstable require monthly or more frequent visits, while stable recipients must see their treating physician at least every three months. For polypharmacy, where multiple psychotropic medications are prescribed, each medication should be independently targeting a specific symptom or diagnosis. Prior authorization is required for two or more drugs within the same therapeutic class within a 60-day period (intra-class). Additionally, prior authorization is required for four or more drugs across all psychotropic therapeutic classes listed in the policy within a 60-day period (inter-class). However, there are situations in which approval for polypharmacy may be granted. This includes cases where the requested medication(s) will be used for cross tapering or when the recipient will be discontinuing a previously prescribed agent. A 30-day cross-taper is allowed in these cases. Furthermore, approval for polypharmacy may be given if the purpose is to augment the effect of another psychotropic medication and if

State	Explanation
	each agent is supported by individual authorizations clearly documented in the recipient's medical record. To ensure appropriate medication selection, the recipient must have a trial of each individual medication alone, and reasons for an inadequate response should be documented. Both intra-class and inter-class polypharmacy must adhere to the criteria that all psychotropic medications used must be for medically accepted indications as established by the FDA and/or peer-reviewed literature. Exceptions to the polypharmacy rules are made for antidepressants, antipsychotics, anticonvulsants, and mood stabilizers if prescribed by a board-certified child psychiatrist.
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 in place for antipsychotics. Based on routine reporting, the State performs quarterly retrospective reviews. Review process includes but is not limited to the review of appropriate therapy, dosage, indication and polypharmacy.
New Mexico	Recommend glucose and lipid monitoring for children on second generation antipsychotics. Direct patient intervention planned for 2024 to target patients who are not being monitored.
New York	Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days. Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days. Confirm diagnosis of FDA-approved or compendia-supported indication PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age. Require confirmation of diagnosis that supports the concurrent use of a Second-Generation Antipsychotic and a CNS Stimulant for patients <18 years of age. For all Second-Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required. For Example PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below: aripiprazole (Abilify) 6 years aripiprazole (Abilify MyCite) 18 years asenapine (Saphris) 10 years Asenapine (Secuado) 18 years brexpiprazole (Rexulti) 13 years cariprazine (Vraylar) 18 years clozapine (Clozaril, Versacloz) 12 years iloperidone (Fanapt) 18 years lumateperone (Caplyta) 18 years lurasidone HCl (Latuda) 10 years olanzapine (Zyprexa) 10 years paliperidone ER (Invega) 12 years pimavanserin (Nuplazid) 18 years quetiapine fum. (Seroquel, Seroquel XR) 10 years risperidone (Risperdal) 5 years ziprasidone HCl (Geodon) 10 years.

State	Explanation
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	ND Medicaid applies diagnosis, age, and quantity limits according to the FDA and compendia recommendations and to ensure dose consolidation. Therapeutic duplication edits are in place to prevent poly pharmacy of antipsychotics. Chart notes are reviewed and alternatives are discussed for requests outside of these limits as part of a review for an override request beyond State limits. Retrospective DUR criteria (e.g., utilization of high doses, combinations which increase adverse effects) is matched with claim data to automate lettering to providers and pharmacies. Pharmacokinetic, pharmacodynamic, and other pertinent information and recommendations are available to prescribers on the State website.
Ohio	We utilize prospective edits to monitor dose, days' supply, and polypharmacy. Soft DUR drug-drug interactions messaging is also utilized. We performed a RetroDUR intervention in December 2021 directed at children taking multiple antipsychotics and in August 2022 directed at patients taking antipsychotic and opioid medication concurrently for 60 days or longer. Ohio plans to begin a performance improvement project (PIP) regarding metabolic monitoring of children taking antipsychotics and will take a multidisciplinary approach by including OhioRISE and the pharmacy benefit program. This project will begin in FFY23, use quality improvement science from IHI, and will be reported to CMS. OhioRISE will also work to address utilization concerns including overprescribing of psychotropic medications when non-medical clinical interventions are appropriate, gaps in prescriptions for children and adolescents with conditions in need of continuity of psychotropic medications when placement transitions occur, and lack of appropriate metabolic monitoring for certain psychotropic medications. These concerns will be addressed with interventions including identification of at-risk enrollees through an internal polypharmacy report, a thorough care management approach for identified enrollees that includes a comprehensive medication

State	Explanation
	review, comprehensive assessments, referrals to appropriate resources, coordination and collaborative care planning with MCO's, MCE's and SPBM, and monthly polypharmacy rounds with care management staff, quality staff, utilization management staff, pharmacy staff, Aetna medical directors, and State partners in attendance to discuss individual enrollees and provide collaborative recommendations to resolve medication-related issues
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. antipsychotic use beyond 30 days in children 3-5 years of age; all antipsychotic use in children 2 years of age or younger; long term antipsychotic use in patients <10 years of age). For recipients in foster care, yearly reviews of prescribed mental health medications are performed. If concerning 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	Prescriptions for Antipsychotics that meet any of the following conditions must be prior authorized: 1. A non-preferred Antipsychotic. See the Preferred Drug List (PDL) for the list of preferred Antipsychotics at: https://papdl.com/preferred-drug-list. 2. An Antipsychotic with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-DailyDose-Limits.aspx. 3. An Antipsychotic when prescribed for a child under 18 years of age. 4. An atypical Antipsychotic when there is a record of a recent paid claim for another atypical Antipsychotic in the Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication). 5. A typical Antipsychotic when there is a record of a recent paid claim for another typical Antipsychotic in the Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).
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 occur 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	Atypical antipsychotics require PA for all children.

State	Explanation
Tennessee	The age in the age limit box above varies based on drug indication and FDA approval. 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 --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 in

State	Explanation
	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 only for the FDA approved indications, such as autism. For antipsychotic therapy, 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 only given for insomnia, or for major depressive disorder treatment without concurrent antidepressant therapy.
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

State	Explanation
	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.
Vermont	Prior Authorization is required for every prescription for all antipsychotic prescriptions for children under 18 years of age. Criteria for approval of ALL drugs: 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 on the PDL. All requests for patients younger than 5 years will be reviewed by the DVHA medical director
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 allow 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.
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 the Medicaid 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. A psychiatrist consultant makes peer outreach calls as needed. Children over eight years of age are monitored for polypharmacy of antipsychotics by the psychiatrist consultant and peer outreach calls are conducted as needed. Wisconsin has also an intervention letter that identifies children who are currently taking at least three of more sedating medications drug classes including antipsychotics. The letter offers

State	Explanation
	prescribers the opportunity to discuss specific cases with the psychiatrist consultant. The psychiatrist consultant reviews the medications for the members identified. Peer outreach calls are conducted as needed.
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.

Stimulants

3. Does your State currently have restrictions in place to limit the quantity of stimulant drugs?

Figure 142 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

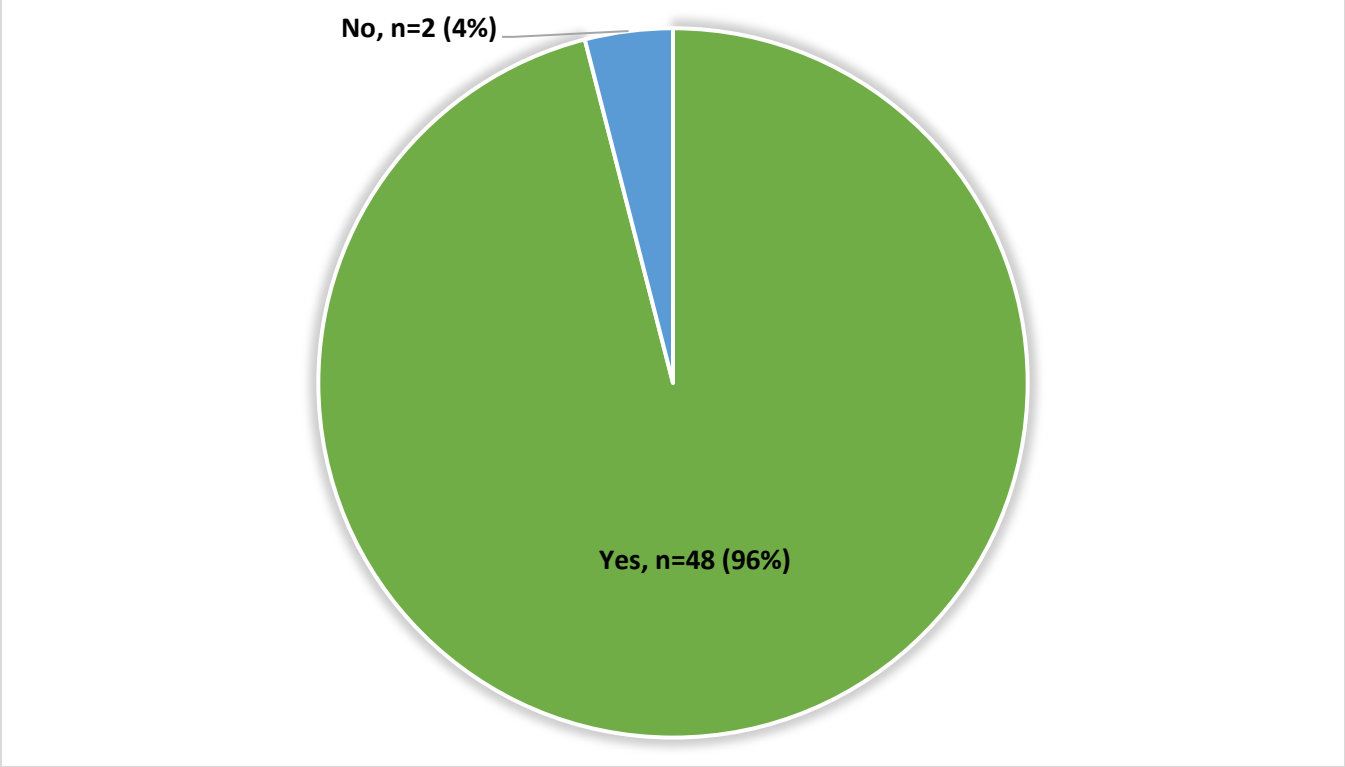

Table 232 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, 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,	48	96.00%

Response	States	Count	Percentage
	Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
No	California, Maryland	2	4.00%
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 143 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

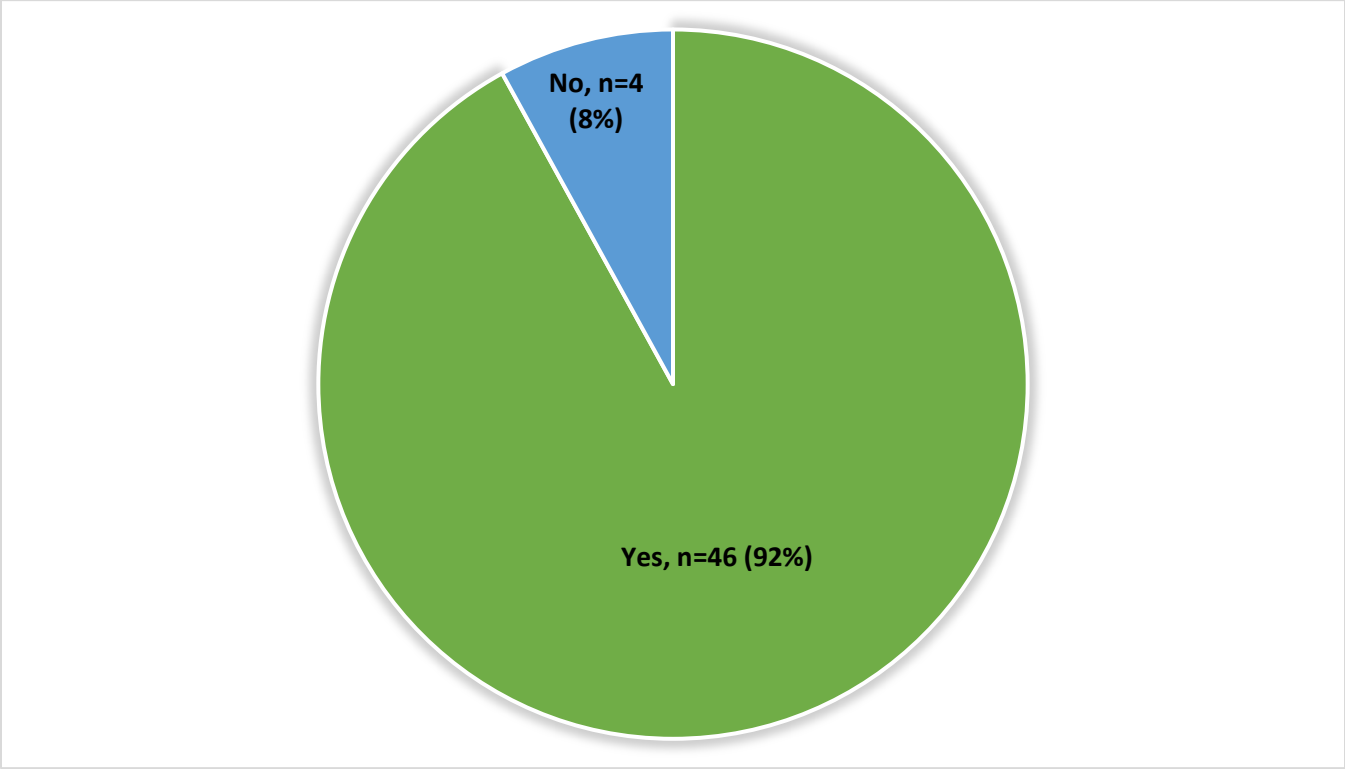

Table 233 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, 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, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Alaska, Maryland, New Mexico, South Dakota	4	8.00%
Total		50	100.00%

a. If "Yes," does your State either manage or monitor:

Figure 144 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

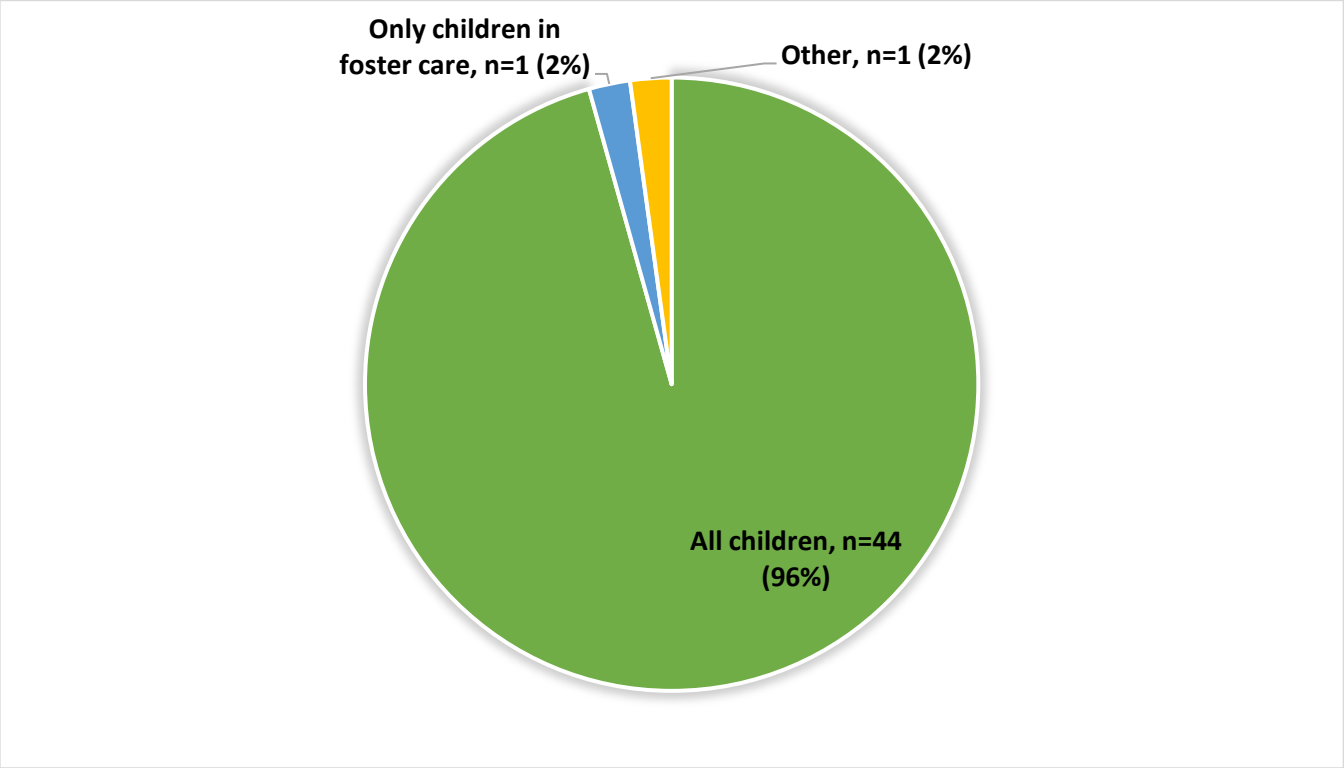

Table 234 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

Response	States	Count	Percentage
All children	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, 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, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	95.65%
Only children in foster care	Montana	1	2.17%
Other	Illinois	1	2.17%
Total		46	100.00%

If "Other," please explain.

Table 235 - "Other" Explanations for Managing or Monitoring the Appropriate Use of Stimulant Drugs in Children

State	Explanation
Illinois	- Adderall XR, Focalin XR, Concerta, and Relexxi have a 1 per day high dose edit. - Ritalin: SR 10mg has a 6 per day high dose edit and SR 20 has a 3 per day high dose edit. - All DCFS Youth in Care require Prior authorization. - All Fee-for-Service (FFS) children not in the DCFS Youth in Care program who are < 6 years of age require Prior Authorization for stimulants. - 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.

b. If "Yes," does your State have edits in place to monitor (multiple responses allowed):

Figure 145 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

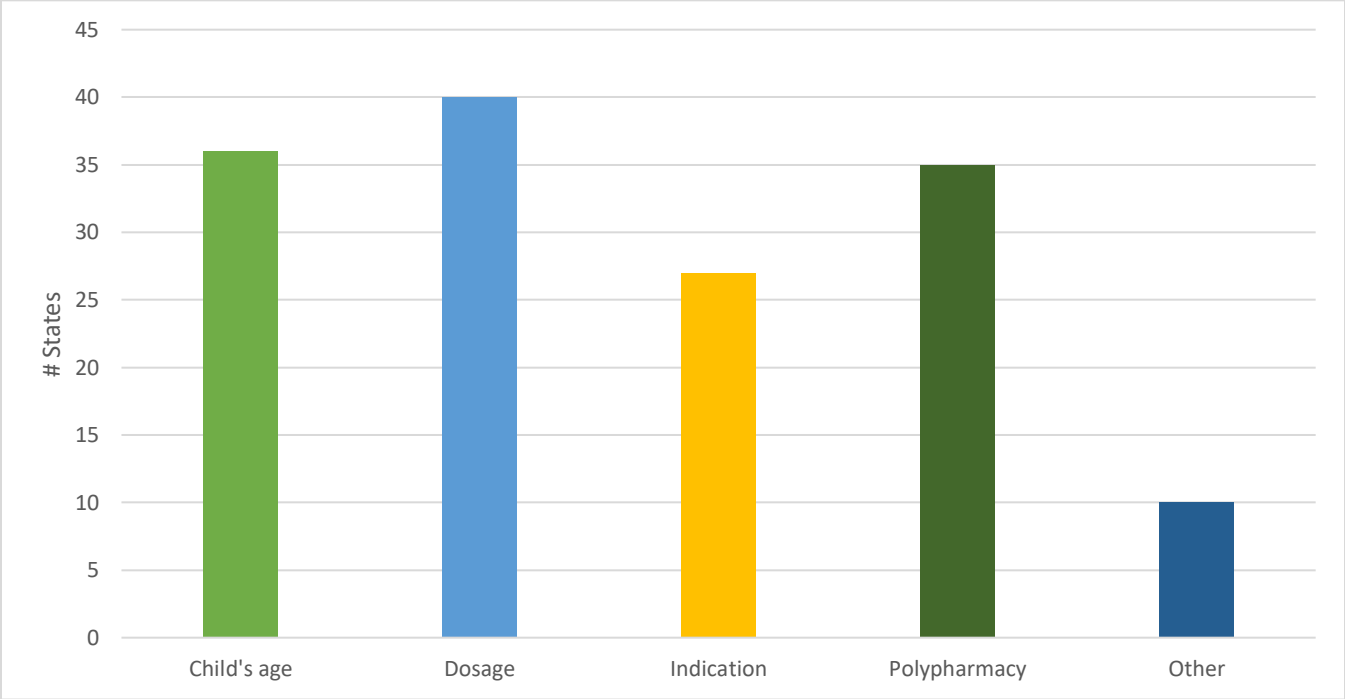

Table 236 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, West Virginia, Wyoming	36	24.32%
Dosage	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii,	40	27.03%

Response	States	Count	Percentage
	Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming		
Indication	Alabama, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Wisconsin	27	18.24%
Polypharmacy	Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	35	23.65%
Other	Arkansas, Colorado, Delaware, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Ohio, Washington	10	6.76%
Total		148	100.00%

If “Child’s age,” please specify age limit in years.

Table 237 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Age Limit in Years
Arkansas	18
Connecticut	18
District of Columbia	18
Florida	6
Georgia	17
Hawaii	21
Idaho	6
Illinois	6
Indiana	6
Iowa	3
Kansas	3
Kentucky	0
Louisiana	6
Maine	6
Massachusetts	3
Michigan	17
Missouri	6
Montana	0
Nebraska	18
Nevada	18

State	Age Limit in Years
New Hampshire	18
New York	3
North Carolina	17
North Dakota	3
Ohio	12
Oklahoma	4
Oregon	6
Pennsylvania	4
Rhode Island	18
South Carolina	6
Texas	3
Utah	4
Virginia	18
Washington	17
West Virginia	18
Wyoming	4

If "Other," please explain.

Table 238 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanation
Arkansas	A therapeutic duplication edit allows one claim for a short-acting stimulant and one claim of a long-acting stimulant per month. The therapeutic duplication edit will prevent the patient from getting either two short-acting stimulants or two long-acting stimulants without a PA.
Colorado	Age limit edits are in place and applied to individual stimulant medications based on FDA labeling or clinical compendia supported use.
Delaware	Age limit varies depending on FDA approved indications.
Illinois	- All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization. - Stimulants require prior authorization for children less than 6 years of age and adults greater than 18 years of age. - DocAssist referral by prior authorization staff to address stimulant use in younger children. Pediatric psychiatrists from DocAssist review specific cases and discuss cases with prescriber.
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.
Kansas	Must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician for children < 3 years old. Dose edits for all ages.
Louisiana	Preauthorization is required for ADHD agents for beneficiaries less than 7 years of age. POS edits for all ages include diagnosis requirements, therapeutic duplication of short-acting ADHD agents, of long-acting ADHD agents, and ADHD agents from different prescribers.
Massachusetts	Use of behavioral health medications in children 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 across all behavioral health classes. Also for all children less than 18 years of age, PA is required for

State	Explanation
	polypharmacy with two or more stimulants. Additionally, PA is required for stimulants for all children less than three years of age.
Ohio	We have prospective edits in place which monitor any medication that has a drug interaction with a stimulant. Stimulants are included in the controlled substances that we count as enrollment criteria for our Coordinated Services (lock-in) Program.
Washington	Washington Medicaid applies age/dose limits, therapeutic duplication edits, and polypharmacy edits (5 or more mental health drugs) to claims submitted for stimulants used by children ages 17 years or younger for a second opinion review with are contracted metal health specialist.

c. If "Yes," please briefly explain the specifics of your documented stimulant monitoring program(s).

Table 239 - Explanations of Specifics of Documented Stimulant Monitoring Program(s)

State	Explanation
Alabama	Stimulants are included in the PDL. All stimulants have quantity limits. A PA is required for all non-preferred stimulants. A max quantity override is required for all preferred stimulants exceeding the monthly max quantity limit.
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. Beneficiaries <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 beneficiary's diagnosis, age, concomitant therapies, history of therapy, and psychosocial status. POS edits for stimulants include: 1) Therapeutic duplication edit--Criteria allows concurrent therapy for beneficiaries <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. 2) Quantity edit--All stimulants and atomoxetine have quantity/dosing edits. 3) 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. 4) Both long-acting and short-acting stimulants are on the PDL. Also, we run monthly reports for reviewing psychotropic drugs for children separated into multiple age groups and foster care status. We also review the same data for our MCOs. Presence of behavioral health therapy in history is noted. Drug classes reviewed on this report include antipsychotics, CII stimulants, alpha blockers, metformin, and mood stabilizers.
California	The stimulant monitoring program includes both ProDUR and RetroDUR components. During FFY 2022 there were documented restrictions to use for all stimulants. These

State	Explanation
	restrictions included indication restrictions (for attention deficit hyperactivity disorder) and labeler restrictions for certain medications. In addition, there are ProDUR edits that vary by drug for high dosage, therapeutic duplication, and ingredient duplication. In addition, retrospective utilization of all psychotherapeutic medications in children younger than 18 years of age is reviewed on at least an annual basis.
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 any of these limitations are exceeded. Retrospective DUR is conducted and letters are sent to providers regarding pediatric members' use of multiple stimulant medications or use of multiple psychotropic medications (including stimulants). Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
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-DUR edits are in place to monitor for therapeutic duplication within the stimulant class of medications. Synergy is also achieved in Delaware by DSCYF working with Medicaid on foster children to reduce unnecessary therapies.
District of Columbia	The POS contractor generates monthly DUR reports to monitor concomitant use of stimulants and opioids use in the pediatric population. The addition of a child and adolescent Psychiatrist to the Board membership continues to enhance the Board's ability to monitor antipsychotic, antidepressant, and stimulant use more closely in the Medicaid child population. The psychiatrist member 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.
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
Hawaii	Quarterly and annual review done manually. Transplant program has less than 10 patients per quarter. Patient status, location, provider and medical necessity are all reviewed. The dental program does not include stimulant medication.
Idaho	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.

State	Explanation
Illinois	- Only one extended-release and one short-acting stimulant allowed at a time without prior authorization. - All attention-deficit/hyperactivity disorder (ADHD) stimulants in children less than 6 years of age require a special prior authorization request form. Form is available at https://hfs.illinois.gov/medicalproviders/pharmacy/criteriaandforms.html - DocAssist referral by prior authorization staff to address stimulant use in younger children. Pediatric psychiatrists from DocAssist review specific cases and discuss cases with prescriber.
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 Limits- 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 Limits - 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. The are no POS age limit edits for stimulant medications.
Louisiana	Preauthorization is required for ADHD agents for beneficiaries less than 7 years of age. POS edits for all ages include diagnosis requirements, therapeutic duplication of short-acting ADHD agents, of long-acting ADHD agents, and ADHD agents from different prescribers.
Maine	Currently manage daily dosing requirements, PMQIC reporting and RetroDUR analysis on an ad-hoc basis.
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, psychiatrist involvement (either as the prescriber or consult notes from the past year). For stimulant polypharmacy additional requirements include two failed trials with stimulant monotherapy. 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, non-pharmacologic 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

State	Explanation
	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, FFS Medicaid performs two RetroDUR mailings per year regarding criteria regarding psychotropic drug use in youth.
Mississippi	Age limit varies by agent. 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	Non-preferred drugs require review for compliance and doses are monitored. Claim edits in place for methylphenidate type stimulants include a maximum accumulated dose.
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 are reviewed on all claims for stimulants in pediatric beneficiaries.
New Jersey	A retrospective review process began on 7/1/22. Based on routine reporting, the State performs these quarterly retrospective reviews. Review process includes, but is not limited to, the review of appropriate therapy, dosage, indication and polypharmacy.
New York	Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries less than 18 years of age. Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries less than 3 years of age. Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent. For Example, short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) and long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotempla XR-ODT 25.9 mg; not to exceed 2 units daily. Azstarys; not to exceed 1 dosage unit per day. Pitolisant (Wakix): not to exceed 2 dosage units daily of the 17.8 mg tablets or 3 dosage units daily of the 4.45 mg tablets.
North Carolina	Claims edits 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.

State	Explanation
North Dakota	ND Medicaid applies diagnosis on amphetamine stimulants. Age and quantity limits apply to all stimulants according to the FDA and compendia recommendations and to ensure dose consolidation. Therapeutic duplication edits are in place to allow use of one type of stimulant at a time. Long and short acting stimulants of the same ingredient are allowed for some products. Alternatives are discussed for requests outside of these limits as part of a review for an override request beyond State limits. ND Medicaid proactively drives utilization to Vyvanse instead of other amphetamines with higher abuse potential. Retrospective DUR criteria (e.g., utilization of high doses, combinations which increase adverse effects) is matched with claim data to automate lettering to providers and pharmacies. Pharmacokinetic, pharmacodynamic, and other pertinent information and recommendations are available to prescribers on the State website.
Ohio	We utilize prospective edits to monitor dose, day supply, and polypharmacy. Soft DUR drug-drug interactions messaging is also utilized.
Oklahoma	Children younger than 5 years of age require psychiatric consultation for any stimulant medication. Quantity limits are in place based on FDA approved dosing.
Oregon	Cover ADHD medications only for diagnoses funded by the OHP and medications consistent with current best practices. Promote care by a psychiatrist for patients requiring therapy outside of best-practice guidelines. Regimens prescribed outside of standard doses and age range and non-standard polypharmacy. https://www.orpdl.org/durm/PA_Docs/AttentionDeficitHyperactivityDisorder.pdf
Pennsylvania	Prescriptions for Stimulants and Related Agents that meet the following conditions must be prior authorized. 1. A non-preferred Stimulants and Related Agent. See the Preferred Drug List (PDL) for the list of preferred Stimulants and Related Agents at: https://papdl.com/preferred-drug-list. 2. A Stimulants and Related Agent with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limitsand-Daily-Dose-Limits.aspx. 3. A Stimulants and Related Agent for a beneficiary under 4 years of age. 4. A prescription for an analeptic Stimulants and Related Agent (e.g., armodafinil, modafinil, etc.). 5. A Stimulants and Related Agent when there is a record of a recent paid claim for another Stimulants and Related Agent with the same duration of action (i.e., short-acting or long-acting) in the Point-of-Sale Online Claims Adjudication System (therapeutic duplication). EXCEPTIONS: Intuniv (guanfacine ER), Kapvay (clonidine ER), an analeptic Stimulants and Related Agent. 6. A Stimulants and Related Agent when prescribed for a beneficiary 18 years of age or older. EXCEPTION: an analeptic Stimulants and Related Agent.
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.
Tennessee	Prior authorizations for preferred C-II stimulants are not required in children; however, prior authorizations are required for dosages that exceed 80 mg/day of total amphetamine.

State	Explanation
Texas	The POS automated PA process approves claims for FDA approved diagnosis, for children older than 3 years of age. For dosing, VDP uses either the FDA approved dosing or the Texas Health and Human Services (HHS) Psychotropic Medication Utilization Parameters maximum recommended daily dose. Additionally, the system checks for concurrent therapy of two or more immediate release (IR) or extended release (ER) formulations. Combination of an IR and an ER stimulant, as well as any combination of IR or ER stimulants with one or more non-stimulants are approved. For clients aged 19 or older, a diagnosis of ADD/ADHD must be documented for approval after the initial approval for the first 90-days therapy.
Utah	Effective July 2020, age edit limitations apply when a claim for an ADHD stimulant is processed through the pharmacy point of sale: - ADHD stimulant prescriptions for children under 4 years of age. - 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. Also, effective April 2021, a multiple agent edits, and a cross-class edit limitation will apply when claims for ADHD stimulants are processed through the pharmacy point of sale: - Three or more unique ADHD stimulant medications were prescribed concurrently for at least 30 days in the last 45 days across all ages. - Cross-class prescribing of ADHD stimulant medications from the amphetamine class and the methylphenidate class for at least 30 days in the last 45 days for children under 18 years of age.
Vermont	Vermont has a Psychotropic Medications Quality Improvement Collaborative (PMQIC) common measures in Vermont Medicaid pharmacy program analysis. The goal of PMQIC is to improve the use of psychotropic medication among children and youth in foster care. This analysis was derived from a set of definitions and common medications use among children in foster care. The common measures were originally developed by a work group that Vt was one of 6 States participating, The study examines common measures on a semiannual basis over the most 3 recent years for 6-month periods of time. 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.

State	Explanation
	Pharmacy claims for the following psychotropic medications are included into the analysis: Antipsychotics, Antidepressants, ADHD medications, Mood Stabilizers, Anxiolytics 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 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 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 clients 17 years of age and younger WA Medicaid applies age/dose limits. 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). For clients 17 years of age and younger WA Medicaid applies therapy duplication logic which looks across stimulants at an ingredient level and rejects for PA and a Second Opinion review if using more than one stimulant ingredient. Example: methylphenidate IR and amphetamine salts ER would stop for PA where methylphenidate IR and ER would not. For clients 17 years of age and younger WA Medicaid applies a polypharmacy edit across all psychotropics including stimulants. This edit looks for 5 or more different psychotropic ingredients and requires authorization and a Second Opinion review.
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. If PDL placement for stimulants change and patient is under 18 years of age we allow for continuation of use at the discretion of the prescriber.
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 psychiatrist consultant reviews high dose stimulant use. Peer outreach calls are conducted as needed. Wisconsin also has a quantity limit for all stimulant drugs.

State	Explanation
Wyoming	Prior authorization is required for children under the age of 4. Dosages are limited to the maximum dose in FDA approved labeling. Stimulants are included in the overall review for polypharmacy in children.

d. If "No," does your State plan on implementing a stimulant monitoring program in the future?

Figure 146 - Future Plans to Implement a Stimulant Monitoring Program

Table 240 - Future Plans to Implement a Stimulant Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, Maryland, New Mexico, South Dakota	4	100.00%
Total		4	100.00%

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 241 - When States Plan to Implement a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanation
Alaska	Yes, actively working with the DUR committee.
Maryland	Maryland Medicaid currently has two well documented programs, the Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP), to support providers who prescribe this drug class. For additional information on these programs, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx. The program has plans to be expanded to include stimulants in the future.
New Mexico	This will be part of the new MMIS replacement implementation in 2024 or 2025.
South Dakota	The State is considering relevant clinical requirements through ongoing discussions with the P&T Committee.

Antidepressants

5. Does your State have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children?

Figure 147 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children

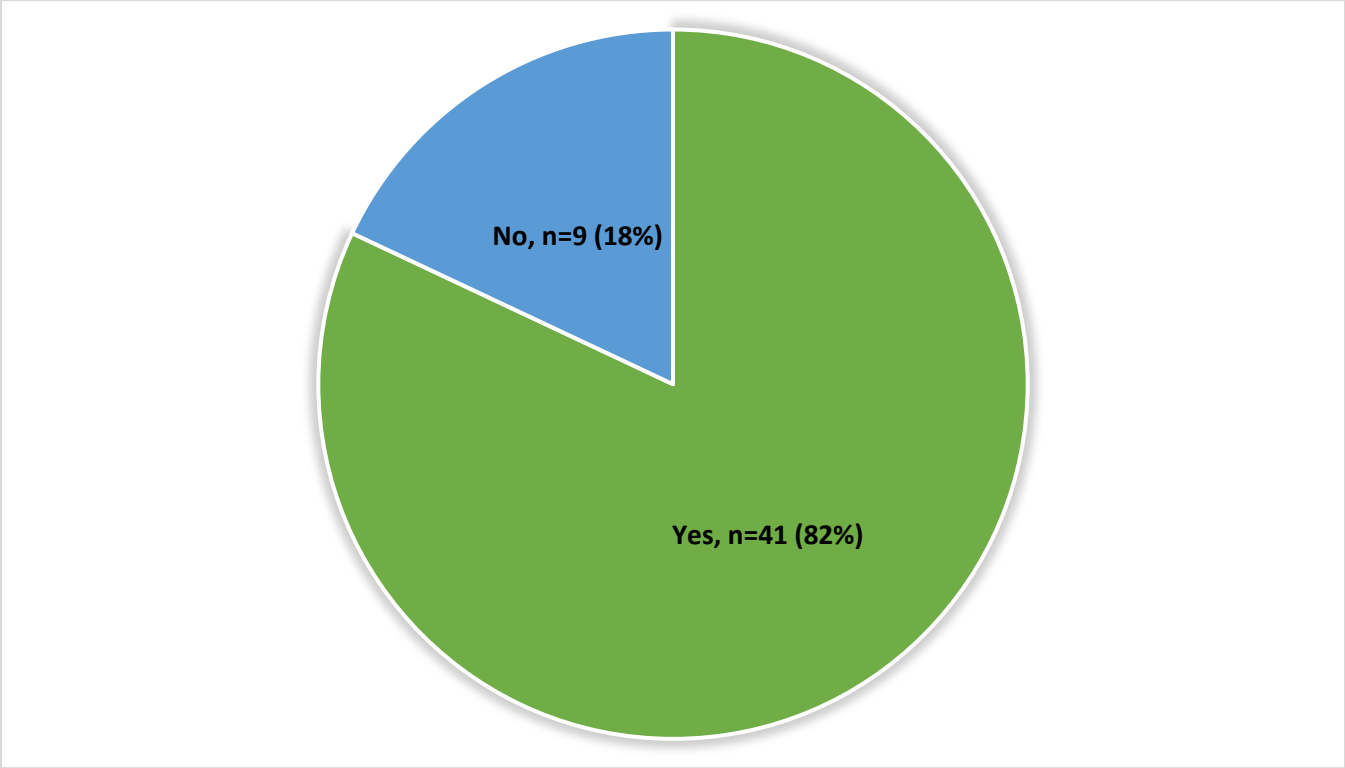

Table 242 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, 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, Vermont, Virginia, Washington, Wyoming	41	82.00%
No	Alaska, District of Columbia, Georgia, Iowa, Maryland, New Mexico, Utah, West Virginia, Wisconsin	9	18.00%
Total		50	100.00%

a. If "Yes," does your State either manage or monitor:

Figure 148 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

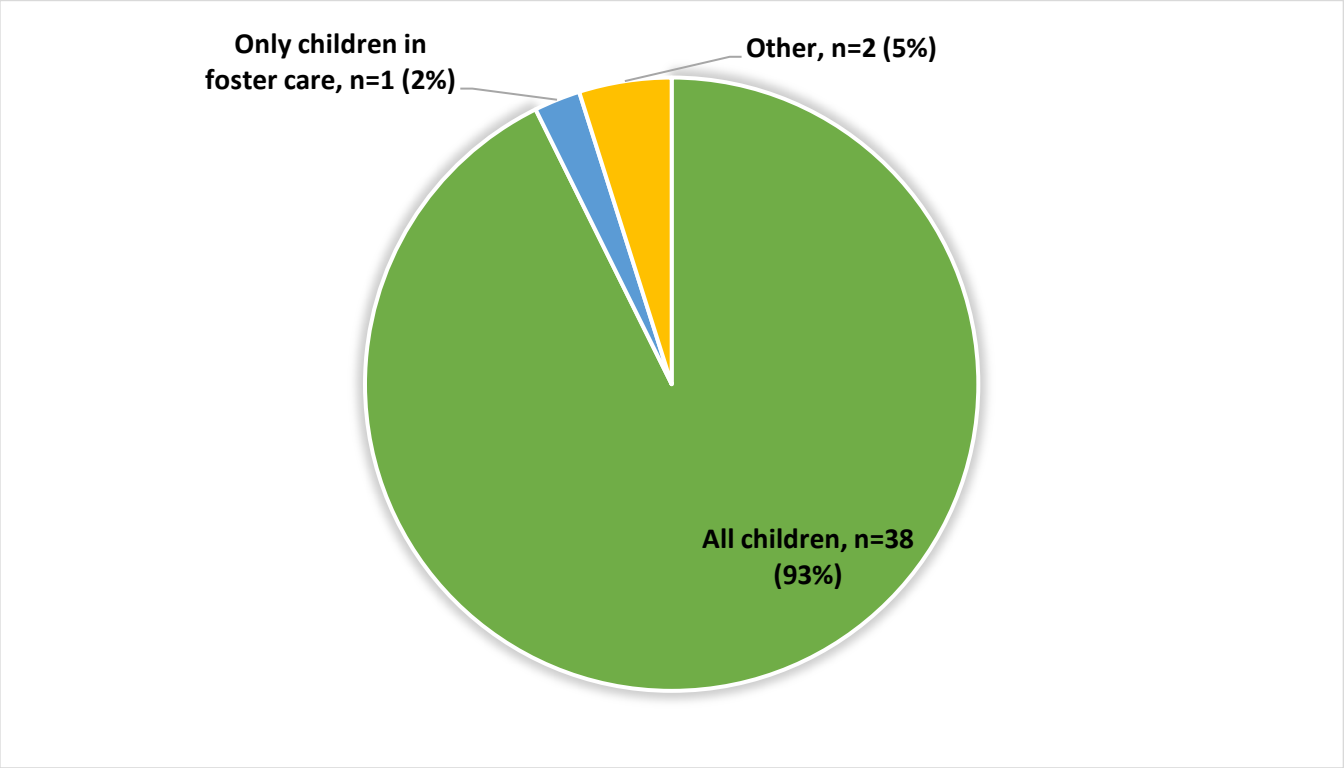

Table 243 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

Response	States	Count	Percentage
All children	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wyoming	38	92.68%
Only children in foster care	Montana	1	2.44%
Other	Illinois, New York	2	4.88%
Total		41	100.00%

If "Other," please explain.

Table 244 - "Other" Explanations for Managing or Monitoring the Appropriate Use of Antidepressant Drugs in Children

State	Explanation
Illinois	DCFS Youth in Care.
New York	The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. See additional information in "c." below.

b. If "Yes," does your State have edits in place to monitor (multiple responses allowed):

Figure 149 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

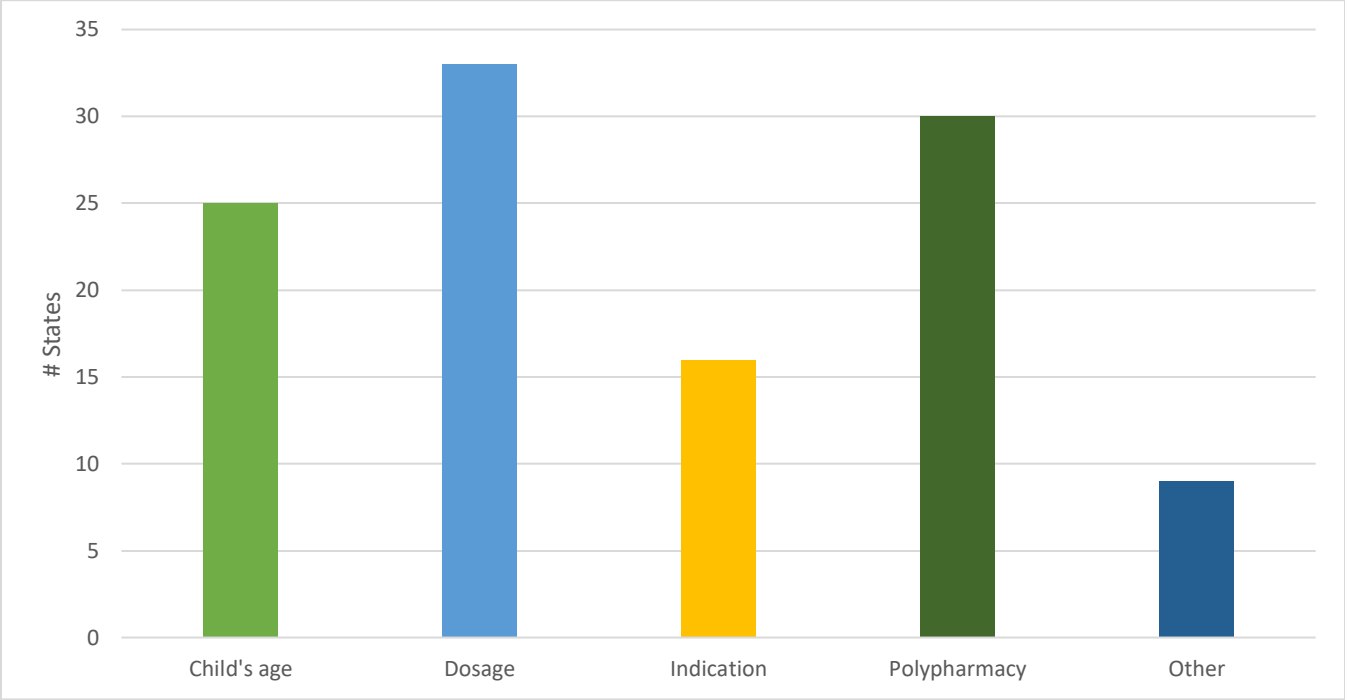

Table 245 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, Connecticut, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming	25	22.12%
Dosage	Alabama, Arkansas, California, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Wyoming	33	29.20%
Indication	Alabama, Connecticut, Florida, Hawaii, Indiana, Massachusetts, Michigan, Missouri, Montana, Nevada, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Texas	16	14.16%
Polypharmacy	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Washington, Wyoming	30	26.55%
Other	Arkansas, Delaware, Illinois, Kansas, Louisiana, Massachusetts, Ohio, Virginia, Washington	9	7.96%
Total		113	100.00%

If "Child's age," please specify age limit in years.

Table 246 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	Age Limit in Years
Arkansas	4
Connecticut	18
Florida	6
Hawaii	21
Idaho	6
Indiana	12
Kansas	17
Kentucky	18
Louisiana	6
Maine	18
Massachusetts	6
Michigan	17
Missouri	5
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	0
North Carolina	17
Oklahoma	18
Oregon	12
Rhode Island	18
South Carolina	6
Tennessee	18
Wyoming	5

If "Other," please explain.

Table 247 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	Explanation
Arkansas	Beneficiaries <4 years of age require a prior authorization. Antidepressants are on the PDL. Therapeutic duplication edits are in place for multiple antidepressants prescribed concomitantly.
Delaware	The age limit used for children using antidepressants varies based on a medication's FDA approved indication.
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization.
Kansas	Age appropriate use and dosing based upon FDA approved age limits per drug. Multiple concurrent use allowance is based upon age.
Louisiana	Preauthorization is required for antidepressant agents for beneficiaries less than 7 years of age. SSRIs are subject to POS therapeutic duplication edits. Tricyclic antidepressants are also subject to POS therapeutic duplication edits.
Massachusetts	Use of behavioral health medications in children 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 across all

State	Explanation
	behavioral health classes. Also for all children less than 18 years of age, PA is required for polypharmacy with two or more antidepressants. Additionally, PA is required for antidepressants for all children less than six years of age.
Ohio	We have additional edits in place which monitor any medication that has a drug interaction with an antidepressant.
Virginia	DMAS is currently reviewing and monitoring antidepressant use in children twice a year during the DUR Meetings for both FFS and the MCOs.
Washington	WA Medicaid applies therapy duplication logic which looks across antidepressants classifications and rejects for PA when using drugs from multiple classes. For clients 17 years of age and younger WA Medicaid applies a polypharmacy edit across all psychotropics including antidepressants. This edit looks for 5 or more different psychotropic ingredients and requires authorization and a Second Opinion review.

c. If "Yes," please briefly explain the specifics of your documented antidepressant monitoring program(s).

Table 248 - Explanations of Specifics of Documented Antidepressant Monitoring Program(s)

State	Explanation
Alabama	Antidepressants are included in the PDL. All antidepressants have quantity limits. A PA is required for all non-preferred antidepressants. A max quantity override is required for all preferred antidepressants exceeding the monthly max quantity limit.
Arkansas	Second generation antidepressants are on the PDL with preferred agents. All antidepressant requests for children <4 years of age require a manual review PA by the Medicaid Pharmacy Program psychiatrist and State clinical pharmacists. For beneficiaries 4 years of age and older, claims for preferred medications at doses that do not exceed the maximum daily allowed dose and do not have a therapeutic duplication issue will process at POS without a PA. For a new medication or dose change to process at POS, the minimum daily therapeutic dose of the previous medication must be taken for at least 4 weeks before a change in therapy or addition of a second agent is allowed without PA. Maximum daily doses are in place based on treatment guidelines and the manufacturer's package insert recommendations. There are continuation criteria for non-preferred medications which ensures the prescriber is aware if their patient has a lack of adherence to prescription therapy. The beneficiary must have >90 days of therapy in the previous 120 days for the same drug, strength, and daily dose of the non-preferred agent. Also, we run monthly reports for reviewing psychotropic drugs for children separated into multiple age groups and foster care status. We also review the same data for our MCOs. Presence of behavioral health therapy in history is noted. Drug classes reviewed on this report include antipsychotics, CII stimulants, alpha blockers, metformin, and mood stabilizers.
California	The antidepressant monitoring program includes ProDUR components. During FFY 2022 there were ProDUR edits for therapeutic and ingredient duplication and both high and low dosage for most antidepressants. In addition, retrospective utilization of all psychotherapeutic medications in children younger than 18 years of age is reviewed on at least an annual basis.
Colorado	Interventional letters that contain patient-specific information identifying use of multiple psychotropic medications (including antidepressants) in children/adolescents are prepared

State	Explanation
	and mailed to prescribers periodically. Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
Connecticut	Connecticut currently RDUR criteria used to monitor and manage antidepressant 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, antidepressant 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	Perform retrospective DUR for all medications (e.g. drug-drug interactions, drug-disease interactions) for children in DSCYF program and perform any monitoring necessary based on the medication's therapeutic class especially if member is concurrently on an antipsychotic
Florida	Quantity and age limitations are placed on antidepressants based on FDA package inserts. A close prior authorization review is performed on all children less than six.
Hawaii	Quarterly and annual review done manually. Transplant program has less than 10 patients per quarter. Patient status, location, provider and medical necessity are all reviewed. The dental program does not include antidepressant medication.
Idaho	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization. Clinical consent is granted by the DCFS Guardian's Office following psychiatric review and recommendation.
Indiana	Antidepressants (SSRIs/SNRIs/NRIs) require prior authorization when used in duplication or when drug-specific quantity and age limits have been exceeded.
Kansas	We have a clinical PA in place and do a claims review 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 claim, in medical history or via PA process. Edit which creates a hard stop/PA required when a high dose or age limit has been exceeded. Minimum age limits corresponding to the FDA approval are added on newer formulations.
Louisiana	Preauthorization is required for antidepressant agents for beneficiaries less than 7 years of age. SSRIs are subject to POS therapeutic duplication edits. Tricyclic antidepressants are also subject to POS therapeutic duplication edits.
Maine	the State utilizes edits with the POS and ProDUR module to monitor for age appropriate utilization and dosing with children. PMQIC reporting looks at utilization and is shared with other agencies within the State for appropriate utilization.
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, psychiatrist involvement (either as the prescriber or consult notes from the past year). For polypharmacy additional requirements include two failed trials with monotherapy. Dosing is generally managed and monitored through quantity limits. All member cases (PAs) evaluated through the initiative are

State	Explanation
	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, non-pharmacologic 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	We utilize our WholeHealthRx academic detailing program to provide monthly mailings and face-to-face pharmacy consultation interventions 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 antidepressants).
Minnesota	Antidepressants are part of the two times per year RetroDUR Intervention that includes criteria of three or greater polypsychotropic drugs in youth or psychotropic drug polypharmacy. Antidepressants are included in the monthly reports provided to DHS Children's Mental Health (CMH) Division. All psychotropic drugs are part of these CMH reports whether the drug flagged on one of the criteria or not.
Mississippi	Age limits vary by agent as indicated. These limits are evaluated by an electronic PA criteria. For citalopram, she electronic PA limits dose based on age.
Missouri	For children 0 to 5 years old, antidepressants deny at point of sale and must be reviewed by a clinical consultant for approval or denial.
Montana	Children in foster care taking more than 2 psychotropic medications are reviewed for treatment appropriateness including indication, age, dosage, etc. Children in foster care are monitored for polypharmacy.
Nebraska	Non-preferred drugs require review for compliance and doses are monitored. Edits are in place to prevent use of more than one stimulant and high doses in children.
Nevada	Prior authorization is required for all children under 18 years of age. In order to obtain authorization, certain documentation must be present in the medical record. For psychotropics (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) medications prescribed to this age group, it is preferred that they are prescribed by a child psychiatrist or in consultation with one. Additionally, the use of psychotropics medication should be part of a comprehensive treatment plan that includes education, behavioral management, the home environment, and psychotherapy. Furthermore, while the recipient is using any of the classes mentioned above, monitoring by the physician or prescriber is necessary. The frequency of visits depends on the recipient's treatment status and stability. Those in initial treatment or considered unstable require monthly or more frequent visits, while stable recipients must see their treating physician at least every three months. For polypharmacy, where multiple psychotropic medications are prescribed, each medication should be independently targeting a specific symptom or diagnosis. Prior authorization is required for two or more drugs within the same therapeutic class within a 60-day period (intra-class). Additionally, prior authorization is required for four or more drugs across all psychotropic therapeutic classes listed in the policy within a 60-day period (inter-class). However, there are situations in which approval for polypharmacy may be

State	Explanation
	granted. This includes cases where the requested medication(s) will be used for cross tapering or when the recipient will be discontinuing a previously prescribed agent. A 30-day cross-taper is allowed in these cases. Furthermore, approval for polypharmacy may be given if the purpose is to augment the effect of another psychotropic medication and if each agent is supported by individual authorizations clearly documented in the recipient's medical record. To ensure appropriate medication selection, the recipient must have a trial of each individual medication alone, and reasons for an inadequate response should be documented. Both intra-class and inter-class polypharmacy must adhere to the criteria that all psychotropic medications used must be for medically accepted indications as established by the FDA and/or peer-reviewed literature. Exceptions to the polypharmacy rules are made for antidepressants, antipsychotics, anticonvulsants, and mood stabilizers if prescribed by a board-certified child psychiatrist.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed an antidepressant (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. For pediatric patients 6 years of age and older, a prior authorization is required if more than one antidepressant 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	A retrospective review process began on 7/1/22. Based on routine reporting, the State performs these quarterly retrospective reviews. Review process includes, but is not limited to, the review of appropriate therapy, dosage, indication and polypharmacy.
New York	The RetroDUR process monitors for appropriate use of antidepressants. The criteria addresses drug-drug, drugdisease interactions, under over utilization, and therapeutic duplication. Some criteria include references to children including that antidepressant-containing medications may increase the risk of suicidal thinking and behaviors (suicidality) in children, adolescents, and young adults. Patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior especially during the initial months of drug therapy, or at times of dose changes.
North Carolina	Behavioral health (BH) clinical edits alert for claim quantities that exceed the pediatric dose recommended by the FDA. Dose is determined by the quantity and day supply. BH edits alert for concomitant use of antidepressants. Concomitant use is defined as 60 or more days of overlapping therapy. The pharmacist must contact the prescriber for therapy justification and enter an override for the claim to pay.
North Dakota	Quantity limits are in place according to FDA and compendia recommendations to ensure dose consolidation. Therapeutic duplication prevent more than one antidepressant in the same class to be utilized at the same time. Retrospective DUR criteria (e.g., utilization of high doses, combinations which increase adverse effects) is matched with claim data to automate lettering to providers and pharmacies.
Ohio	We utilize prospective edits to monitor dose, day supply, and polypharmacy. Soft DUR drug-drug interactions messaging is also utilized.

State	Explanation
Oklahoma	Point of sale edits are in place to identify antidepressant use outside FDA approved indications based on both age and dosage. Requests for use beyond these approved ages and dosages are evaluated by a clinical pharmacist.
Oregon	Require PA for tricyclic antidepressants in children younger than the FDA approved minimum age. Ensure safe and appropriate use of tricyclic antidepressants in children less than 12 years of age and discourage off label use not supported by compendia: https://www.orpdl.org/durm/PA_Docs/TCAs.pdf
Pennsylvania	POS edits are in place to require prior authorization when therapeutic duplication is identified or when quantity limits are exceeded.
Rhode Island	Rhode Island currently RDUR criteria used to monitor and manage antidepressant 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	The maximum daily dosage is monitored during claim adjudication. Claims exceeding the products maximum dosage are denied .
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.
Texas	At this time, the antidepressants are subject to the PDL prior authorization but there are no clinical prior authorizations criteria set up in the automated PA system. Texas FFS also conducts retro-DUR intervention on the topic of appropriate use of antidepressants for all age groups and will include performance indicators such as appropriate age, diagnosis, polypharmacy, etc. In the FFY 2022, Texas FFS did not conduct an intervention on this topic.
Vermont	Vermont has a Psychotropic Medications Quality Improvement Collaborative (PMQIC) common measures in Vermont Medicaid pharmacy program analysis. The goal of PMQIC is to improve the use of psychotropic medication among children and youth in foster care. This analysis was derived from a set of definitions and common medications use among children in foster care. The common measures were originally developed by a work group that Vt was one of 6 States participating, The study examines common measures on a semiannual basis over the most 3 recent years for 6-month periods of time. 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,

State	Explanation
	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. Pharmacy claims for the following psychotropic medications are included into the analysis: Antipsychotics, Antidepressants, ADHD medications, Mood Stabilizers, Anxiolytics 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	Looking for members on any antidepressant and under the age of 18. Then looking at the 5 youngest members on antidepressants and looking at their diagnosis history and the specialty of the prescribing physician.
Washington	In collaboration with the Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, WA Medicaid 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 clients 17 years of age and younger WA Medicaid requires a review by an agency-designated mental health specialist from the Second Opinion Network when drugs used to treat mental health conditions are prescribed outside of the established guidelines set by the pediatric children's mental health workgroup. The guidelines applicable to antidepressants includes therapy duplication and polypharmacy; the process is outlined on our website and can be found at https://www.hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-second-opinion-program.
Wyoming	Prior authorization is required for children under age 5 for the use of an antidepressant. Dosage is limited to FDA labeled maximum. Antidepressants are included in the overall review for polypharmacy in children.

d. If "No," does your State plan on implementing an antidepressant monitoring program in the future?

Figure 150 - Future Plans to Implement an Antidepressant Monitoring Program

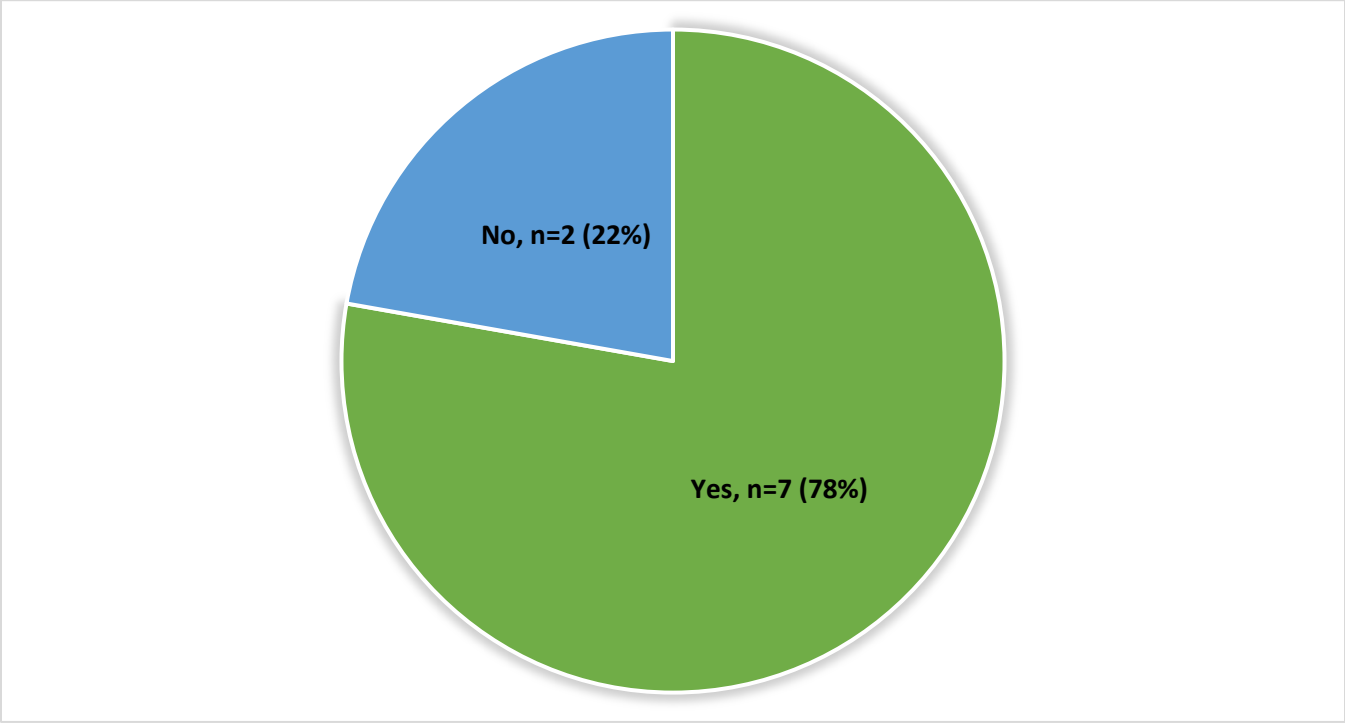

Table 249 - Future Plans to Implement an Antidepressant Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Georgia, Iowa, Maryland, New Mexico, Utah	7	77.78%
No	West Virginia, Wisconsin	2	22.22%
Total		9	100.00%

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 250 - When States Plan to Implement a Program to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	Explanation
Alaska	Yes actively working with the DUR committee and the Alaska pediatric psychotropic utilization and quality team.
District of Columbia	The monthly antidepressant monitoring reporting is scheduled to be implemented in FY23 as recommended by the Board's child and adolescent Psychiatrist member.
Georgia	Unsure at this time.
Iowa	Can look at as a future topic for the DUR Commission, date to be determined.
Maryland	Maryland Medicaid currently has two well documented programs, the Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP), to support providers who prescribe this drug class. For additional information on these programs, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx. The program has plans to be expanded to include antidepressants in the future.
New Mexico	This will be part of the new MMIS replacement implementation in 2024 or 2025.
Utah	2024

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 251 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	Explanation
West Virginia	Currently there is no plan however it may be a possibility in the future.
Wisconsin	At this time, Wisconsin does not plan to implement monitoring of antidepressants.

Mood Stabilizers

6. Does your State have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children?

Figure 151 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

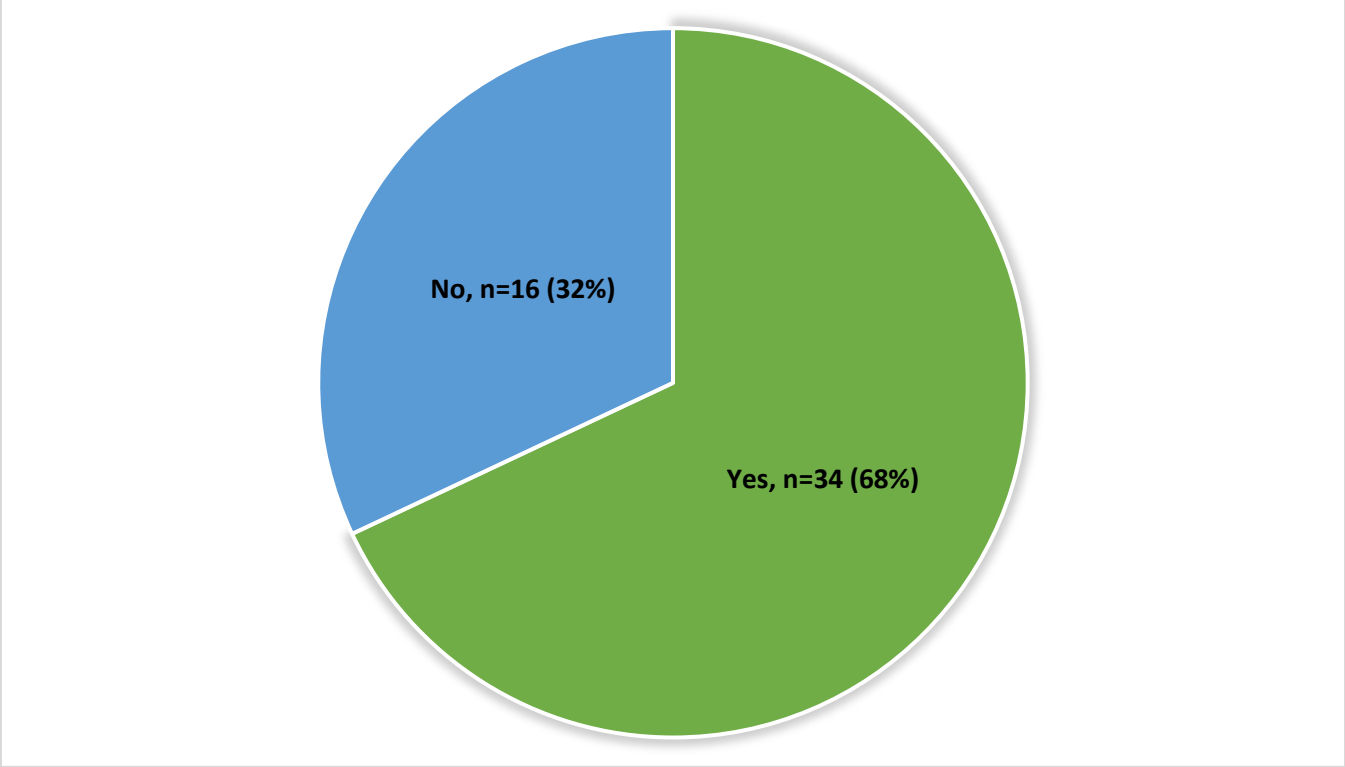

Table 252 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wyoming	34	68.00%

Response	States	Count	Percentage
No	Alaska, Arkansas, District of Columbia, Georgia, Iowa, Kansas, Maine, Maryland, Mississippi, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, West Virginia, Wisconsin	16	32.00%
Total		50	100.00%

a. If "Yes," does your State either manage or monitor:

Figure 152 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

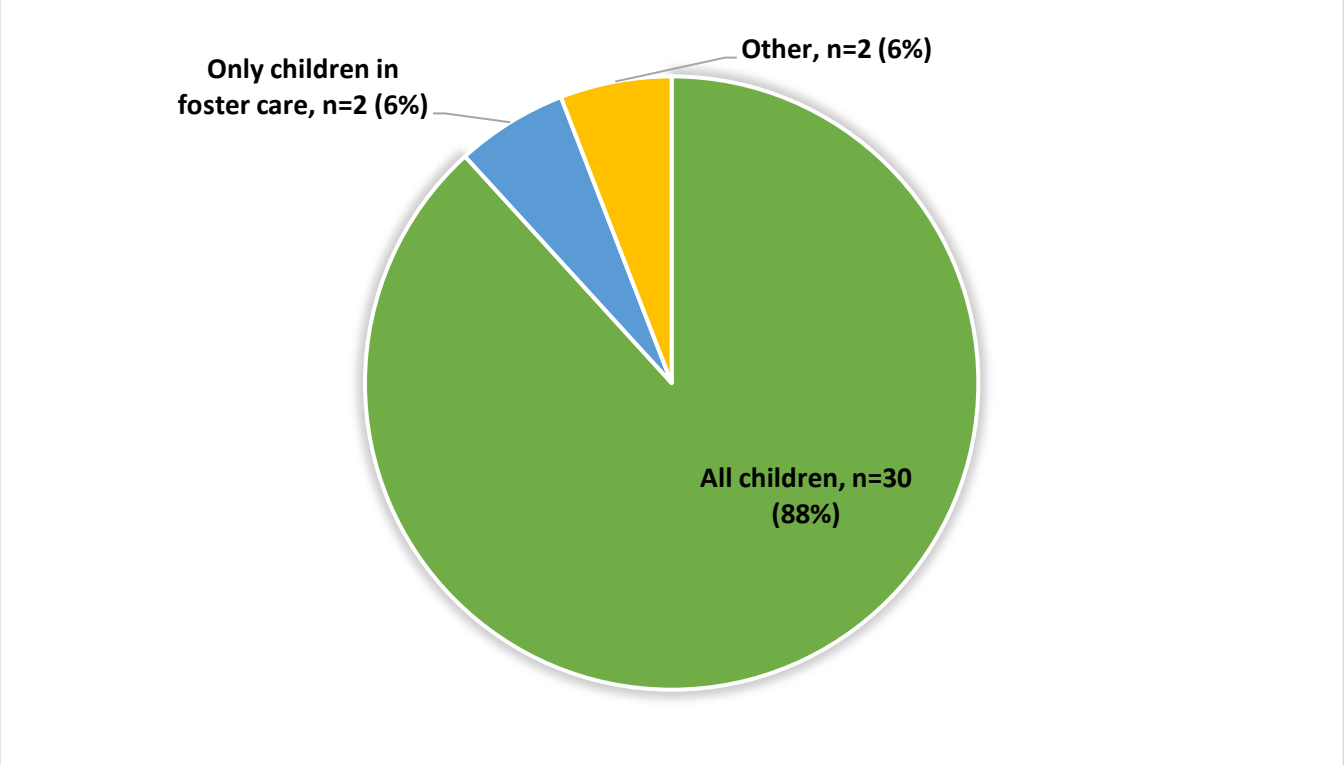

Table 253 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

Response	States	Count	Percentage
All children	Alabama, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wyoming	30	88.24%
Only children in foster care	Missouri, Montana	2	5.88%
Other	Illinois, New York	2	5.88%
Total		34	100.00%

If “Other,” please explain.

Table 254 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Mood Stabilizing Drugs in Children

State	Explanation
Illinois	DCFS Youth in Care.
New York	The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. See additional information in "c." below.

b. If “Yes,” does your State have edits in place to monitor (multiple responses allowed):

Figure 153 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

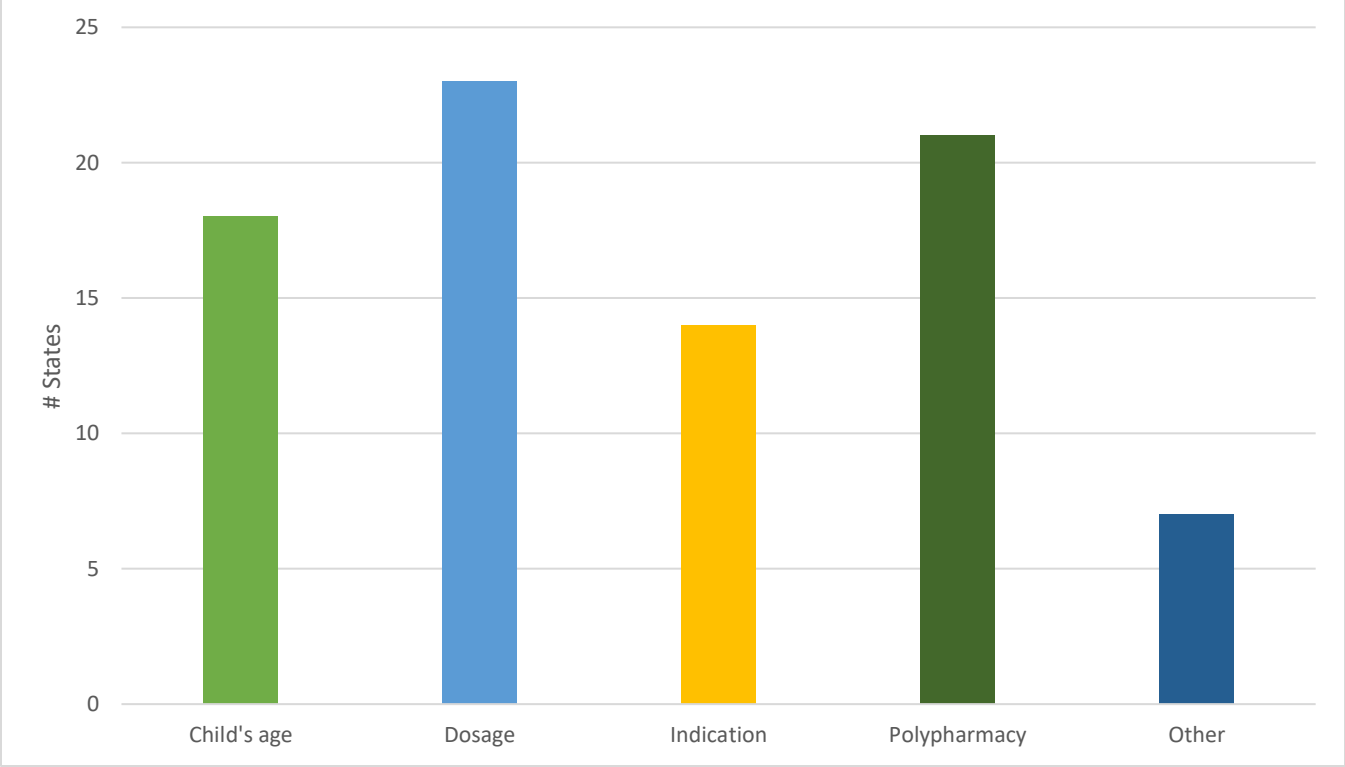

Table 255 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Response	States	Count	Percentage
Child's age	Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, Rhode Island, South Carolina, Tennessee	18	21.69%
Dosage	Alabama, California, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee	23	27.71%
Indication	Alabama, Connecticut, Florida, Hawaii, Massachusetts, Michigan, Missouri, Montana, Nevada, New York, Rhode Island, South Carolina, Tennessee, Wyoming	14	16.87%
Polypharmacy	California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kentucky, Massachusetts, Michigan, Minnesota,	21	25.30%

Response	States	Count	Percentage
	Missouri, Montana, New Hampshire, New York, Ohio, Rhode Island, South Carolina, Vermont, Washington, Wyoming		
Other	Delaware, Illinois, Louisiana, Massachusetts, Ohio, Texas, Virginia	7	8.43%
Total		83	100.00%

If "Child's age," please specify age limit in years.

Table 256 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Age Limit in Years
Connecticut	18
Florida	6
Hawaii	21
Idaho	6
Indiana	
Kentucky	18
Louisiana	6
Massachusetts	6
Michigan	17
Missouri	21
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	0
Rhode Island	18
South Carolina	6
Tennessee	18

If "Other," please explain.

Table 257 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Explanation
Delaware	The age limit used for children using mood stabilizers varies based on a medication's FDA approved indication.
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization.
Louisiana	Preauthorization is required for mood stabilizer agents for beneficiaries less than 7 years of age.
Massachusetts	Use of behavioral health medications in children 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 across all behavioral health classes. Also for all children less than 18 years of age, PA is required for polypharmacy with three or more mood stabilizers. Additionally, PA is required for mood stabilizers for all children less than six years of age.
Ohio	We have additional edits in place which monitor any medication that has a drug interaction with a mood stabilizer.

State	Explanation
Texas	All the above options may be included for consideration for the retro-DUR criteria and interventions.
Virginia	DMAS is currently reviewing and monitoring mood stabilizer use in children twice a year during the DUR Meetings for both FFS and the MCOs.

c. If "Yes," please briefly explain the specifics of your documented mood stabilizer monitoring program(s).

Table 258 - Explanations of Specifics of Documented Mood Stabilizer Monitoring Program(s)

State	Explanation
Alabama	A 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 less than 6 years of age and must be documented.
California	The mood stabilizer monitoring program includes ProDUR components. During FFY 2022 there were 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.
Colorado	Interventional letters that contain patient-specific information identifying use of multiple psychotropic medications (including mood stabilizers) in children/adolescents are prepared and mailed to prescribers periodically. Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
Connecticut	Connecticut currently RDUR criteria used to monitor and manage mood stabilizing 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, mood stabilizing 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	Perform retrospective DUR for all medications (e.g. drug-drug interactions, drug-disease interactions) for children in DSCYF program and perform any monitoring necessary based on the medication's therapeutic class especially if member is concurrently on an antipsychotic.
Florida	Quantity and age limitations are placed on mood stabilizers based on FDA package inserts. A close prior authorization review is performed on all children less than six.
Hawaii	Quarterly and annual review done manually. Transplant program has less than 10 patients per quarter. Patient status, location, provider and medical necessity are all reviewed. The dental program does not include mood stabilizer medication.
Idaho	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization. Clinical consent is granted by the DCFS Guardian's Office following psychiatric review and recommendation.
Indiana	Mood stabilizers require prior authorization when drug-specific quantity and age limits have been exceeded.
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 a high

State	Explanation
	dose or age limit has been exceeded. Minimum age limits corresponding to the FDA approval are added on newer formulations.
Louisiana	Preauthorization is required for mood stabilizer agents for beneficiaries less than 7 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, psychiatrist involvement (either as the prescriber or consult notes from the past year). For polypharmacy additional requirements include two failed trials with monotherapy. 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, non-pharmacologic 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	We utilize our WholeHealthRx 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.
Minnesota	Mood stabilizers are part of the two times per year RetroDUR Intervention that includes criteria of three or greater polypsychotropic drugs in youth or psychotropic drug polypharmacy. Mood stabilizers are included in the monthly reports provided to DHS Children's Mental Health (CMH) Division. All psychotropic drugs are part of these CMH reports whether the drug flagged on one of the criteria or not. Antiseizure medications used as mood stabilizers are not counted when there is the presence of seizure diagnosis in medical claims.
Missouri	Foster children who newly start mood stabilizing drugs are reviewed by the Center of Excellence. The Center of Excellence consists of provider specialists.
Montana	Children in foster care taking more than 2 psychotropic medications are reviewed for treatment appropriateness including indication, age, dosage, etc. Children in foster care are monitored for polypharmacy.
Nebraska	Non-preferred drugs require review for compliance and doses are monitored. Edits are in place to prevent use of more than one stimulant and high doses in children.
Nevada	Prior authorization is required for all children under 18 years of age. In order to obtain authorization, certain documentation must be present in the medical record. For psychotropics (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) medications prescribed to this age group, it is preferred that they are prescribed by a child psychiatrist or in consultation with one. Additionally, the use of psychotropics medication should be part of a comprehensive treatment plan that includes education, behavioral management, the home environment, and psychotherapy. Furthermore, while the recipient is using any of the classes mentioned above, monitoring

State	Explanation
	by the physician or prescriber is necessary. The frequency of visits depends on the recipient's treatment status and stability. Those in initial treatment or considered unstable require monthly or more frequent visits, while stable recipients must see their treating physician at least every three months. For polypharmacy, where multiple psychotropic medications are prescribed, each medication should be independently targeting a specific symptom or diagnosis. Prior authorization is required for two or more drugs within the same therapeutic class within a 60-day period (intra-class). Additionally, prior authorization is required for four or more drugs across all psychotropic therapeutic classes listed in the policy within a 60-day period (inter-class). However, there are situations in which approval for polypharmacy may be granted. This includes cases where the requested medication(s) will be used for cross tapering or when the recipient will be discontinuing a previously prescribed agent. A 30-day cross-taper is allowed in these cases. Furthermore, approval for polypharmacy may be given if the purpose is to augment the effect of another psychotropic medication and if each agent is supported by individual authorizations clearly documented in the recipient's medical record. To ensure appropriate medication selection, the recipient must have a trial of each individual medication alone, and reasons for an inadequate response should be documented. Both intra-class and inter-class polypharmacy must adhere to the criteria that all psychotropic medications used must be for medically accepted indications as established by the FDA and/or peer-reviewed literature. Exceptions to the polypharmacy rules are made for antidepressants, antipsychotics, anticonvulsants, and mood stabilizers if prescribed by a board-certified child psychiatrist.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed a mood stabilizer (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. For pediatric patients 6 years of age and older, a prior authorization is required if more than one mood stabilizer 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	A retrospective review process began on 7/1/22. Based on routine reporting, the State performs these quarterly retrospective reviews. Review process includes, but is not limited to, the review of appropriate therapy, dosage, indication and polypharmacy.
New York	The RetroDUR process monitors for appropriate use of antidepressant drugs. The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. The criteria addresses drug-drug, drug-disease interactions, under utilization, over utilization, and therapeutic duplication.
North Dakota	Quantity limits are in place according to FDA and compendia recommendations to ensure dose consolidation.
Ohio	We utilize prospective edits to monitor dose, day supply, and polypharmacy. Soft DUR drug-drug interactions messaging is also utilized.

State	Explanation
Oklahoma	Point of sale edits are in place to identify mood stabilizer use outside FDA approved indications based on dosage. Requests for use beyond these approved dosages are evaluated by a clinical pharmacist.
Rhode Island	Rhode Island currently RDUR criteria used to monitor and manage mood stabilizing 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	The maximum daily dosage is monitored during claim adjudication. Claims exceeding the products maximum dosage are denied .
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.
Texas	As a part of the retrospective DUR program, multiple safety criteria are included, such as, Lithium monitoring (serum levels, renal function, and thyroid function), use of an antidepressant in the absence of a mood stabilizer/atypical antipsychotic, medication non-adherence with antipsychotics or mood stabilizers.
Vermont	Vermont has a Psychotropic Medications Quality Improvement Collaborative (PMQIC) common measures in Vermont Medicaid pharmacy program analysis. The goal of PMQIC is to improve the use of psychotropic medication among children and youth in foster care. This analysis was derived from a set of definitions and common medications use among children in foster care. The common measures were originally developed by a work group that Vt was one of 6 States participating, The study examines common measures on a semiannual basis over the most 3 recent years for 6-month periods of time. 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. Pharmacy claims for the following psychotropic medications are included into the analysis:

State	Explanation
	Antipsychotics, Antidepressants, ADHD medications, Mood Stabilizers, Anxiolytics 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	Looking for members on any mood stabilizer and under the age of 18. Then looking at the 5 youngest members on mood stabilizers and looking at their diagnosis history and the specialty of the prescribing physician.
Washington	For clients 17 years of age and younger WA Medicaid applies a polypharmacy edit across all psychotropics including mood stabilizers. This edit looks for 5 or more different psychotropic ingredients and requires authorization and a Second Opinion review. WA Medicaid plans to supplement the current Second Opinion program with retrospective reviews and conduct oversight activities focused on clients, prescribers, and pharmacies.
Wyoming	Mood stabilizers are included in the overall review for polypharmacy in children.

d. If "No," does your State plan on implementing a mood stabilizer monitoring program in the future?

Figure 154 - Future Plans to Implement a Mood Stabilizer Monitoring Program

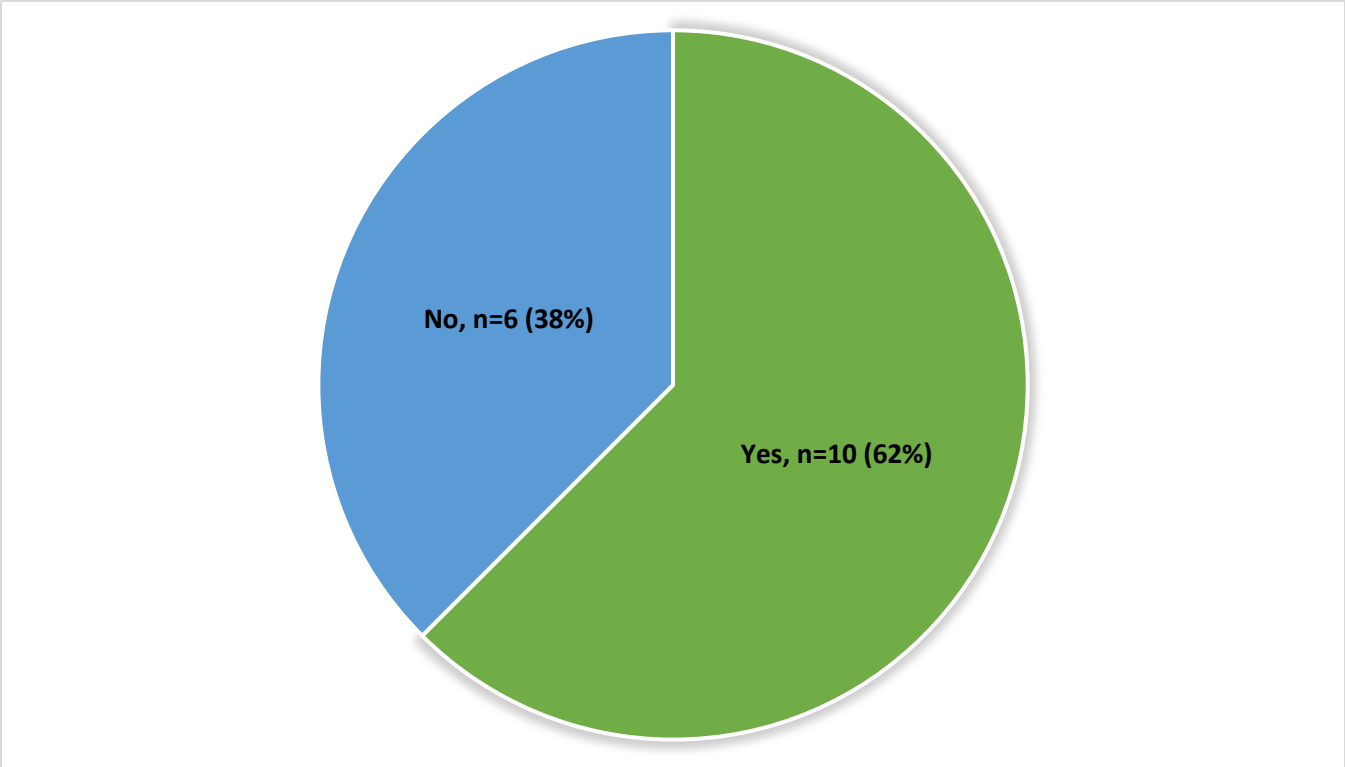

Table 259 - Future Plans to Implement a Mood Stabilizer Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, Arkansas, District of Columbia, Georgia, Iowa, Maine, Maryland, Mississippi, New Mexico, Utah	10	62.50%
No	Kansas, North Carolina, Oregon, Pennsylvania, West Virginia, Wisconsin	6	37.50%
Total		16	100.00%

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

Table 260 - When States Plan to Implement a Program to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Explanation
Alaska	Yes, actively working with the DUR committee and the Alaska pediatric psychotropic utilization and quality team.
Arkansas	We are considering the addition of edits similar to the antipsychotics over the next year. Monitoring mood stabilizers is complicated by the multiple uses of the mood stabilizer medications outside of this indication. We include lithium and divalproex on our monthly pediatric psychotropic report, but no action is taken with that information at this point.
District of Columbia	The monthly mood stablizer monitoring reporting is scheduled to be implemented in FY23 as recommended by the Board's child and adolescent Psychiatrist member.
Georgia	Unsure at this time.
Iowa	Can look at as a future topic for the DUR Commission, date to be determined.
Maine	The DUR will be looking at this drug class in a future RetroDUR in SFY 2023 to review utilzation across the medicaid population and potential edits or provider communications in the future related to the analysis.
Maryland	Maryland Medicaid currently has two well documented programs, the Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP), to support providers who prescribe this drug class. For additional information on these programs, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx. The program has plans to be expanded to include mood stabilizers in the future.
Mississippi	We plan to implement age limits on mood stabilizers via our electronic PA system.
New Mexico	This will be part of the new MMIS replacement implementation in 2024 or 2025.
Utah	2024

If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

Table 261 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Explanation
Kansas	Our MCOs have the majority of the population and we require them to do a quarterly RDUR analysis for multiple concurrent use of mood stabilizers. Many of the drugs used in mood stabilization are also drugs used for patients with seizure disorder. Requiring a diagnosis at POS is labor intensive to manage. We do not have a timeline for a policy specific to the use of these drugs in children.

State	Explanation
North Carolina	The State does not have plans, within current operations timeline, to expand BH edits to include mood stabilizers beyond antipsychotics and antidepressants.
Oregon	We are evaluating.
Pennsylvania	It is unclear how CMS is defining mood stabilizing drugs. Antidepressants, anticonvulsants, and antipsychotics are monitored.
West Virginia	Currently there is no plan however it may be a possibility in the future.
Wisconsin	Wisconsin does not plan to implement monitoring of mood stabilizers at this time.

Antianxiety/Sedatives

7. Does your State have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children?

Figure 155 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

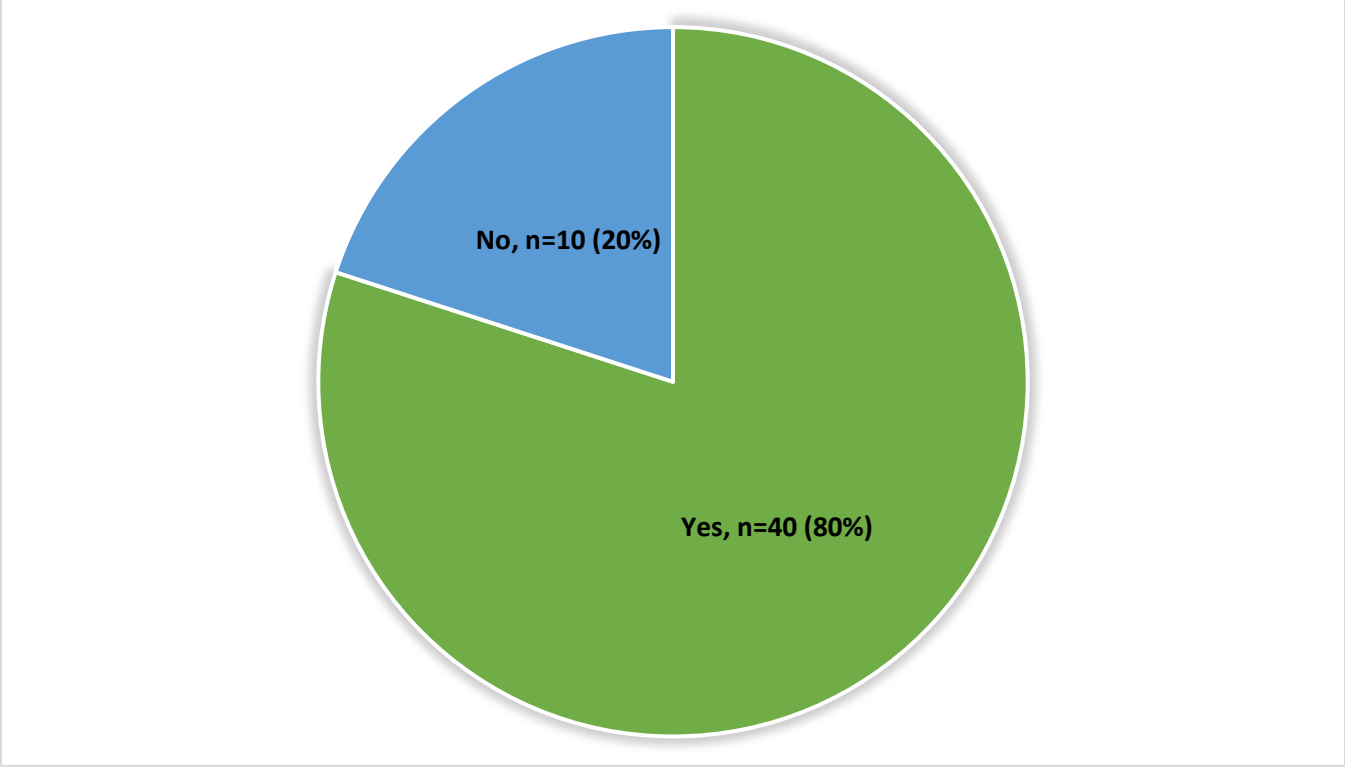

Table 262 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode	40	80.00%

Response	States	Count	Percentage
	Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, Wisconsin, Wyoming		
No	Alaska, District of Columbia, Georgia, Iowa, Maine, Maryland, New Mexico, Utah, Virginia, West Virginia	10	20.00%
Total		50	100.00%

a. If "Yes," does your State either manage or monitor:

Figure 156 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

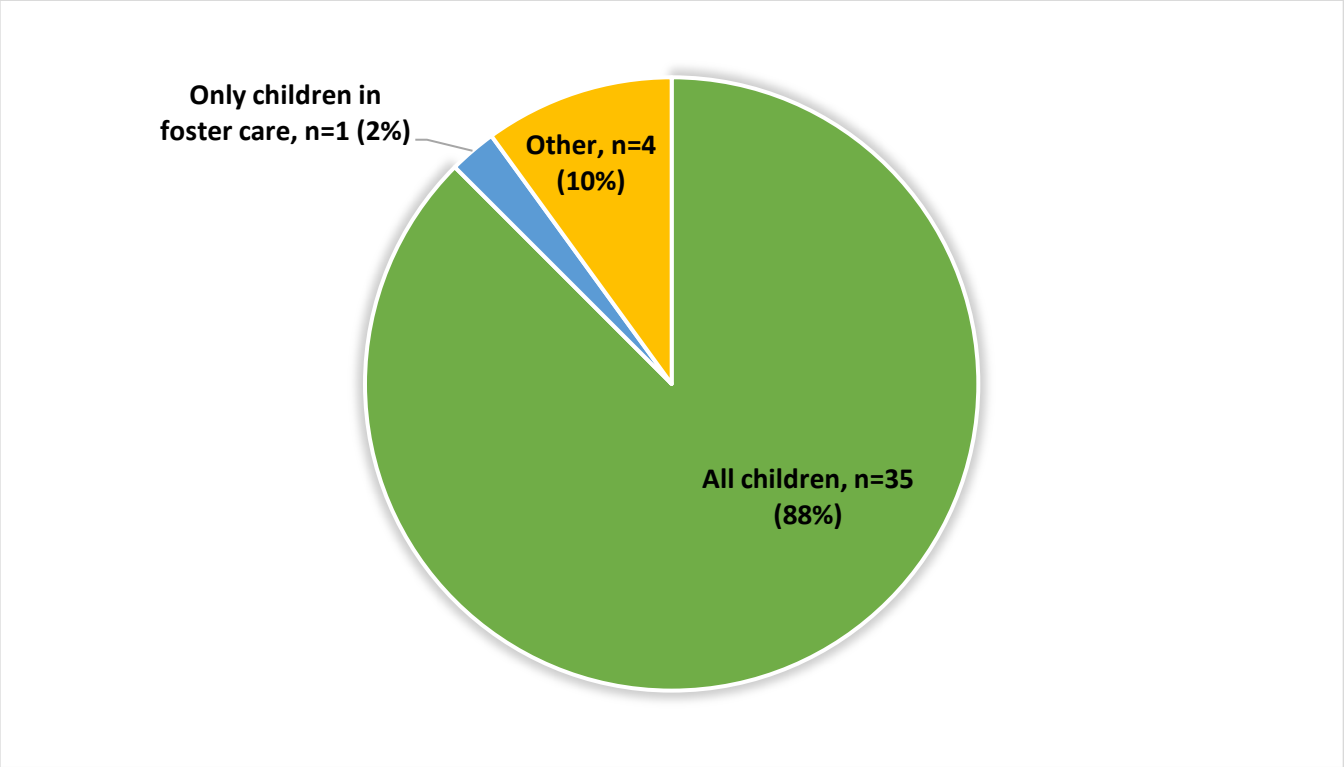

Table 263 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

Response	States	Count	Percentage
All children	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, Wisconsin, Wyoming	35	87.50%
Only children in foster care	Montana	1	2.50%
Other	Illinois, Kansas, New York, Texas	4	10.00%
Total		40	100.00%

If “Other,” please explain.

Table 264 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Explanation
Illinois	DCFS Youth in Care.
Kansas	We have a benzodiazepine PA with criteria that is general in implementation. We will consider possible changes to our PA criteria to give more attention to adolescent use. We do not monitor sedatives specifically for children.
New York	The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. See additional information in "c." below.
Texas	Managing/monitoring is not specific to just for children. Antianxiety and sedatives are managed through claims edits such as 90% early refill threshold, Anxiolytics/Sedative and Hypnotics clinical prior authorizations, as well as retrospective DUR education intervention letters sent to the prescribers.

b. If “Yes,” does your State have edits in place to monitor (multiple responses allowed):

Figure 157 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

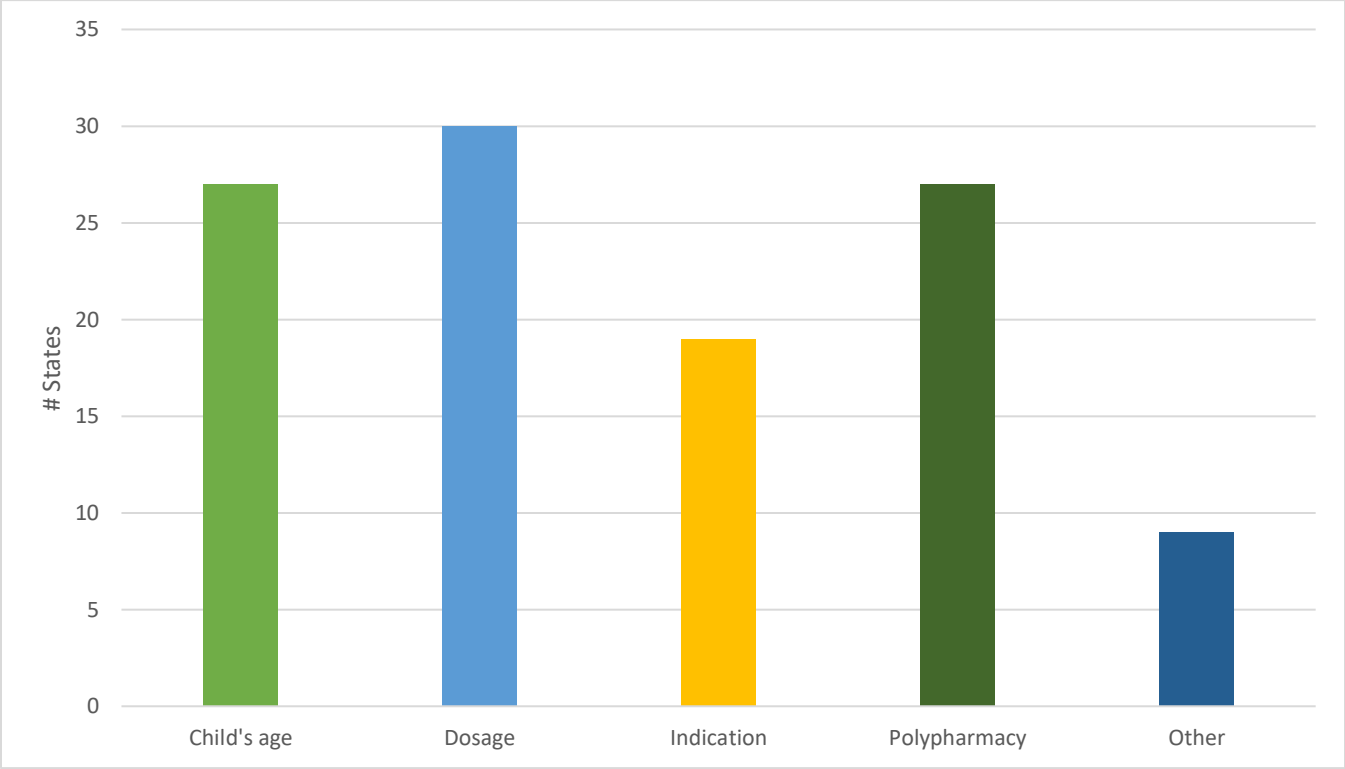

Table 265 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, Colorado, Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Washington, Wyoming	27	24.11%

Response	States	Count	Percentage
Dosage	Alabama, Arkansas, California, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Wyoming	30	26.79%
Indication	Alabama, California, Connecticut, Florida, Hawaii, Indiana, Massachusetts, Michigan, Missouri, Montana, Nevada, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Washington	19	16.96%
Polypharmacy	California, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Washington, Wisconsin, Wyoming	27	24.11%
Other	Arkansas, Delaware, Illinois, Indiana, Louisiana, Massachusetts, Ohio, Texas, Washington	9	8.04%
Total		112	100.00%

If “Child’s age,” please specify age limit in years.

Table 266 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Age Limit in Years
Arkansas	17
Colorado	18
Connecticut	18
Florida	6
Hawaii	21
Idaho	6
Indiana	18
Kentucky	18
Louisiana	6
Massachusetts	6
Michigan	17
Missouri	18
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	0
North Carolina	17
North Dakota	18
Oklahoma	17
Oregon	18
Pennsylvania	21
Rhode Island	18

State	Age Limit in Years
South Carolina	6
Tennessee	18
Washington	17
Wyoming	18

If "Other," please explain.

Table 267 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Explanation
Arkansas	Quantity edits are in place for benzodiazepines and non-benzodiazepine sedatives. Therapeutic duplication edits are in place for multiple benzodiazepine prescriptions or benzodiazepine and sedative hypnotics. Benzodiazepines and sedative hypnotics are on the PDL.
Delaware	The age limit used for children using antianxiety/sedatives varies based on a medication's FDA approved indication.
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization.
Indiana	Duration of therapy is restricted to 30 days in new starts. Diagnosis of seizure disorder is excluded.
Louisiana	Anxiolytics: Preauthorization is required for anxiolytics (except meprobamate) for beneficiaries less than 7 years of age. Selected anxiolytic agents have quantity limits. Selected alprazolam dosage forms have age limits, diagnosis requirements, and prior drug use requirements. Concurrent pharmacy claims for benzodiazepines and buprenorphine will deny, and benzodiazepine claims will deny when the recipient has an active opioid prescription. Selected anxiolytics may bypass certain POS requirements with submission of a seizure, cancer, or pallative-care related diagnosis. Selected agents for narcolepsy have POS therapeutic duplication edits. Sedatives: Preauthorization is required for doxepin for beneficiaries less than 7 years of age. Sedatives also have POS dose limits and therapeutic duplication edits. Selected sedatives have additional clinical requirements and quantity limits.
Massachusetts	Use of behavioral health medications in children 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 across all behavioral health classes. Also for all children less than 18 years of age, PA is required for polypharmacy with two or more benzodiazepines. Additionally, PA is required for benzodiazepines for all children less than six years of age.
Ohio	We have additional edits in place which monitor any medication that has a drug interaction with antianxiety/sedatives.
Texas	All the above are included in the monitoring of anxiolytics/sedative/Hypnotics but not just for children.
Washington	Washington Medicaid applies prior authorization for medical necessity to some sedative hypnotics and other anti-anxiety medications when used in children 17 years of age and younger.

c. If "Yes," please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).

Table 268 - Explanations of Specifics of Documented Antianxiety/Sedative Monitoring Program(s)

State	Explanation
Alabama	Sedatives are included in the PDL. All sedatives have quantity limits. A PA is required for all non-preferred sedatives. A max quantity override is required for all preferred sedatives exceeding the monthly max quantity limit.
Arkansas	Quantity edits are in place for benzodiazepines and non-benzodiazepine sedatives. Therapeutic duplication edits are in place for multiple overlapping benzodiazepine prescriptions or overlapping benzodiazepine and non-benzodiazepine sedatives. Benzodiazepines and non-benzodiazepine sedatives are on the PDL. Effective 9/1/2022, age edits were added to certain benzodiazepines (temazepam, triazolam, estazolam, and flurazepam) and non-benzodiazepine (eszopiclone, zaleplon, zolpidem, suvorexant, lemborexant, doxepin, daridorexant, and ramelteon) sedative hypnotics preventing children from receiving these medications without an approved prior authorization.
California	The antianxiety/sedative monitoring program includes both ProDUR and RetroDUR components. During FFY 2022 there were documented restrictions to use for most antianxiety/sedative medications. These restrictions included indication restrictions (for acute epilepsy, for example), and and/or ProDUR edits for therapeutic and ingredient duplication and 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.
Colorado	Edits are in place for maximum dose, duplicate sedative hypnotic use, and patient age. Prior authorization and expanded clinical review by a pharmacist may be required when any of these limitations are exceeded. Retrospective DUR is conducted and letters are periodically sent to providers regarding pediatric members' use of multiple psychotropic medications (including antianxiety/sedative medications). Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
Connecticut	Connecticut currently RDUR criteria used to monitor and manage anti-anxiety/sedative 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, anti-anxiety/sedative 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	Perform retrospective DUR for all medications (e.g. drug-drug interactions, drug-disease interactions) for children in DSCYF program and perform any monitoring necessary based on the medication's therapeutic class especially if member is concurrently on an antipsychotic.
Florida	Quantity and age limitations are placed on anti-anxiety medications based on FDA package inserts. A close prior authorization review is performed on all children less than six.
Hawaii	Quarterly and annual review done manually. Transplant program has less than 10 patients per quarter. Patient status, location, provider and medical necessity are all reviewed. The dental program does not include anti-anxiety/ sedative medication.
Idaho	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.

State	Explanation
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization. Clinical consent is granted by the DCFS Guardian's Office following psychiatric review and recommendation.
Indiana	Antianxiety agents and sedatives require prior authorization when used in duplication and when drug-specific quantity and age limits have been exceeded. In addition, new starts of benzodiazepines are limited to a 30-day supply total in a rolling 90-day period (excluding seizure diagnosis). Benzodiazepines are also restricted when used in combination with carisoprodol and opioid therapy.
Kansas	We have max dosing limits and limitations for multiple concurrent 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 a high dose or age limit has been exceeded. Minimum age limits corresponding to the FDA approval are added on newer formulations.
Louisiana	Anxiolytics: Preauthorization is required for anxiolytics (except meprobamate) for beneficiaries less than 7 years of age. Selected anxiolytic agents have quantity limits. Selected alprazolam dosage forms have age limits, diagnosis requirements, and prior drug use requirements. Concurrent pharmacy claims for benzodiazepines and buprenorphine will deny, and benzodiazepine claims will deny when the recipient has an active opioid prescription. Selected anxiolytics may bypass certain POS requirements with submission of a seizure, cancer, or pallative-care related diagnosis. Selected agents for narcolepsy have POS therapeutic duplication edits. Sedatives: Preauthorization is required for doxepin for beneficiaries less than 7 years of age. Sedatives also have POS dose limits and therapeutic duplication edits. Selected sedatives have additional clinical requirements and quantity limits.
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, psychiatrist involvement (either as the prescriber or consult notes from the past year). For polypharmacy additional requirements include two failed trials with monotherapy. 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, non-pharmacologic 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	We utilize our WholeHealthRx 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.
Minnesota	Antianxiety/sedative are part of the two times per year RetroDUR Intervention that includes criteria of three or greater polypsychotropic drugs in youth or psychotropic drug

State	Explanation
	polypharmacy. Antianxiety/sedative are included in the monthly reports provided to DHS Children's Mental Health (CMH) Division. All psychotropic drugs are part of these CMH reports whether the drug flagged on one of the criteria or not.
Mississippi	Our POS system has quantity limit edits for both standard and extended-release benzodiazepines.
Missouri	Patients who newly start on antianxiety/sedative agents must first try less addictive medications. Sedative hypnotics have an initial fill limit. Both classes require an appropriate diagnosis to be on file.
Montana	Children in foster care taking more than 2 psychotropic medications are reviewed for treatment appropriateness including indication, age, dosage, etc. Children in foster care are monitored for polypharmacy.
Nebraska	Non-preferred drugs require review for compliance and doses are monitored. Edits are in place to prevent use of more than one stimulant and high doses in children.
Nevada	Prior authorization is required for all children under 18 years of age. In order to obtain authorization, certain documentation must be present in the medical record. For psychotropics (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) medications prescribed to this age group, it is preferred that they are prescribed by a child psychiatrist or in consultation with one. Additionally, the use of psychotropics medication should be part of a comprehensive treatment plan that includes education, behavioral management, the home environment, and psychotherapy. Furthermore, while the recipient is using any of the classes mentioned above, monitoring by the physician or prescriber is necessary. The frequency of visits depends on the recipient's treatment status and stability. Those in initial treatment or considered unstable require monthly or more frequent visits, while stable recipients must see their treating physician at least every three months. For polypharmacy, where multiple psychotropic medications are prescribed, each medication should be independently targeting a specific symptom or diagnosis. Prior authorization is required for two or more drugs within the same therapeutic class within a 60-day period (intra-class). Additionally, prior authorization is required for four or more drugs across all psychotropic therapeutic classes listed in the policy within a 60-day period (inter-class). However, there are situations in which approval for polypharmacy may be granted. This includes cases where the requested medication(s) will be used for cross tapering or when the recipient will be discontinuing a previously prescribed agent. A 30-day cross-taper is allowed in these cases. Furthermore, approval for polypharmacy may be given if the purpose is to augment the effect of another psychotropic medication and if each agent is supported by individual authorizations clearly documented in the recipient's medical record. To ensure appropriate medication selection, the recipient must have a trial of each individual medication alone, and reasons for an inadequate response should be documented. Both intra-class and inter-class polypharmacy must adhere to the criteria that all psychotropic medications used must be for medically accepted indications as established by the FDA and/or peer-reviewed literature. Exceptions to the polypharmacy rules are made for antidepressants, antipsychotics, anticonvulsants, and mood stabilizers if prescribed by a board-certified child psychiatrist.

State	Explanation
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed an antianxiety/sedative (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. For pediatric patients 6 years of age and older, a prior authorization is required if more than one antianxiety/sedative 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	A retrospective review process began on 7/1/22. Based on routine reporting, the State performs these quarterly retrospective reviews. Review process includes, but is not limited to, the review of appropriate therapy, dosage, indication and polypharmacy.
New York	The RetroDUR process monitors for appropriate use of antianxiety/sedatives. The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. The criteria addresses drug-drug, drug-disease interactions, under utilization, over utilization, and therapeutic duplication. Benzodiazepines: For Example, Benzodiazepines used in Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD) require trial with a Selective Serotonin Reuptake Inhibitor (SSRI) or a Serotonin Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription. Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). Skeletal muscle spasms, require trial with a skeletal muscle relaxant prior to a benzodiazepine DURATION LIMIT: For Insomnia: 30 consecutive days For Panic Disorder: 30 consecutive days Require confirmation of FDA approved or compendia supported use PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant Sedative Hypnotics/Sleep Agents For Example, Zolpidem products: Confirm dosage is consistent with FDA labeling for initial prescriptions. Benzodiazepine Agents (estazolam, Halcion, Restoril, temazepam, triazolam): confirm diagnosis of FDA-approved or compendia-supported indication; PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy; PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy; PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant. Frequency and duration limits for the following products: -For non-zaleplon and non-benzodiazepine containing products: 30 dosage units per fill/1 dosage unit per day/30 days -For zaleplon-containing products: 60 dosage units per fill/2 dosage units per day/30 days -Duration limit equivalent to the maximum recommended duration: 180 days for immediate-release zolpidem (Ambien, Edluar) products

State	Explanation
North Carolina	Behavioral health (BH) edits alert for the use of two or more anxiolytics. The pharmacist must contact the prescriber for therapy justification and enter an override for the claim to pay.
North Dakota	Age and quantity limits are utilized according to FDA and compendia recommendations and to ensure dose consolidations. Therapeutic duplications allow use of one short acting benzodiazepine and one long acting benzodiazepine at a time. Long acting benzodiazepines are not allowed with sedatives, such as z-sleepers. ODT benzodiazepine preparations require prior authorization to be used for those above age 9 except for when prescribed by a pediatric sleep specialist.
Ohio	We utilize prospective edits to monitor dose, day supply, and polypharmacy. Soft DUR drug-drug interactions messaging is also utilized.
Oklahoma	Point of sale edits are in place to identify antianxiety/sedative use outside FDA approved indications based on both age and dosage. Requests for use beyond these approved ages and dosages are evaluated by a clinical pharmacist. Lorazepam and diazepam are required to be prescribed by a psychiatrist or neurologist. Insomnia medications require a prior authorization for members age 18 and younger. Less sedating pharmacological therapies and non-pharmacological therapies must have failed for authorization to be considered for members age 18 and younger.
Oregon	Require PA for all sedatives (e.g. sedative hypnotics, hypnotics-melatonin agonists) except melatonin in children and adolescents. Melatonin is not covered for adults over 18 years of age.
Pennsylvania	Prescriptions for Anxiolytics that meet any of the following conditions must be prior authorized: 1. A non-preferred Anxiolytic. See the Preferred Drug List (PDL) for the list of preferred Anxiolytics at: https://papdl.com/preferred-drug-list. 2. An Anxiolytic with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-DailyDose-Limits.aspx. 3. An Anxiolytic benzodiazepine when prescribed for a beneficiary under 21 years of age. 4. An Anxiolytic benzodiazepine when a beneficiary has a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder. 5. An Anxiolytic benzodiazepine when there is a record of a recent paid claim for another benzodiazepine (excluding clobazam and benzodiazepines indicated for the acute treatment of increased seizure activity [e.g., rectal and nasal formulations]) in the Point-of-Sale Online Claims Adjudication System (therapeutic duplication). 6. A prescription for an Anxiolytic benzodiazepine when there is a record of 2 or more paid claims for any benzodiazepine (excluding clobazam and benzodiazepines indicated for the acute treatment of increased seizure activity [e.g., rectal and nasal formulations]) in the Point-of-Sale Online Claims Adjudication System within the past 30 days.
Rhode Island	Rhode Island currently RDUR criteria used to monitor and manage anti anxiety/sedative 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.

State	Explanation
South Dakota	The maximum daily dosage is monitored during claim adjudication. Claims exceeding the products maximum dosage are denied .
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.
Texas	All the anxiolytic and sedative/hypnotics that are classified as controlled substances are subject to 90% refill threshold; benzodiazepines that are approved for epilepsy, or certain muscle disorders are exempt from this restriction. Refill claim will be denied if submitted prior to 90% of the previous claim's day supply. The clinical prior authorization criteria include age check, diagnosis check, and diagnosis of substance use disorder (SUD) safety check. The duration of PA for diagnosis of anxiety is short termed to give the providers the opportunity to reevaluate continued therapy.
Vermont	Vermont has a Psychotropic Medications Quality Improvement Collaborative (PMQIC) common measures in Vermont Medicaid pharmacy program analysis. The goal of PMQIC is to improve the use of psychotropic medication among children and youth in foster care. This analysis was derived from a set of definitions and common medications use among children in foster care. The common measures were originally developed by a work group that Vt was one of 6 States participating, The study examines common measures on a semiannual basis over the most 3 recent years for 6-month periods of time. 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. Pharmacy claims for the following psychotropic medications are included into the analysis: Antipsychotics, Antidepressants, ADHD medications, Mood Stabilizers, Anxiolytics 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

State	Explanation
	groups of children over the mentioned time frames. The study also estimated the common measures for different age and gender groups.
Washington	In collaboration with the Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, WA Medicaid 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 clients 17 years of age and younger WA Medicaid requires a review by an agency-designated mental health specialist from the Second Opinion Network when drugs used to treat mental health conditions are prescribed outside of the established guidelines set by the pediatric children's mental health workgroup. The guidelines applicable to antianxiety/sedatives include age limit and polypharmacy; the process is outlined on our website and can be found at https://www.hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-second-opinion-program. WA Medicaid plans to supplement the current Second Opinion program with retrospective reviews and conduct oversight activities focused on clients, prescribers, and pharmacies.
Wisconsin	Wisconsin has developed an intervention letter, under the guidance of a psychiatrist consultant, that identifies children who are currently taking at least three of more sedating medications drug classes (sedative hypnotics, benzodiazepines, antipsychotics, melatonin, antidepressants (mirtazapine, tricyclics and trazadone), antihistamines (hydroxyzine and diphenhydramine), in the last quarter. The letter, which is sent every six months, alerts prescribers to a clinical concern. In addition, the letter offers prescribers the opportunity to discuss specific cases with the psychiatrist consultant. The psychiatrist consultant reviews the medications for the members identified. Peer outreach calls are conducted as needed.
Wyoming	Prior authorization is required for use of sedatives in children under 18. Dosages are limited to FDA labeled maximum. Anxiety medications are included in the overall review for polypharmacy in children.

d. If "No," does your State plan on implementing an antianxiety/sedative monitoring program in the future?

Figure 158 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

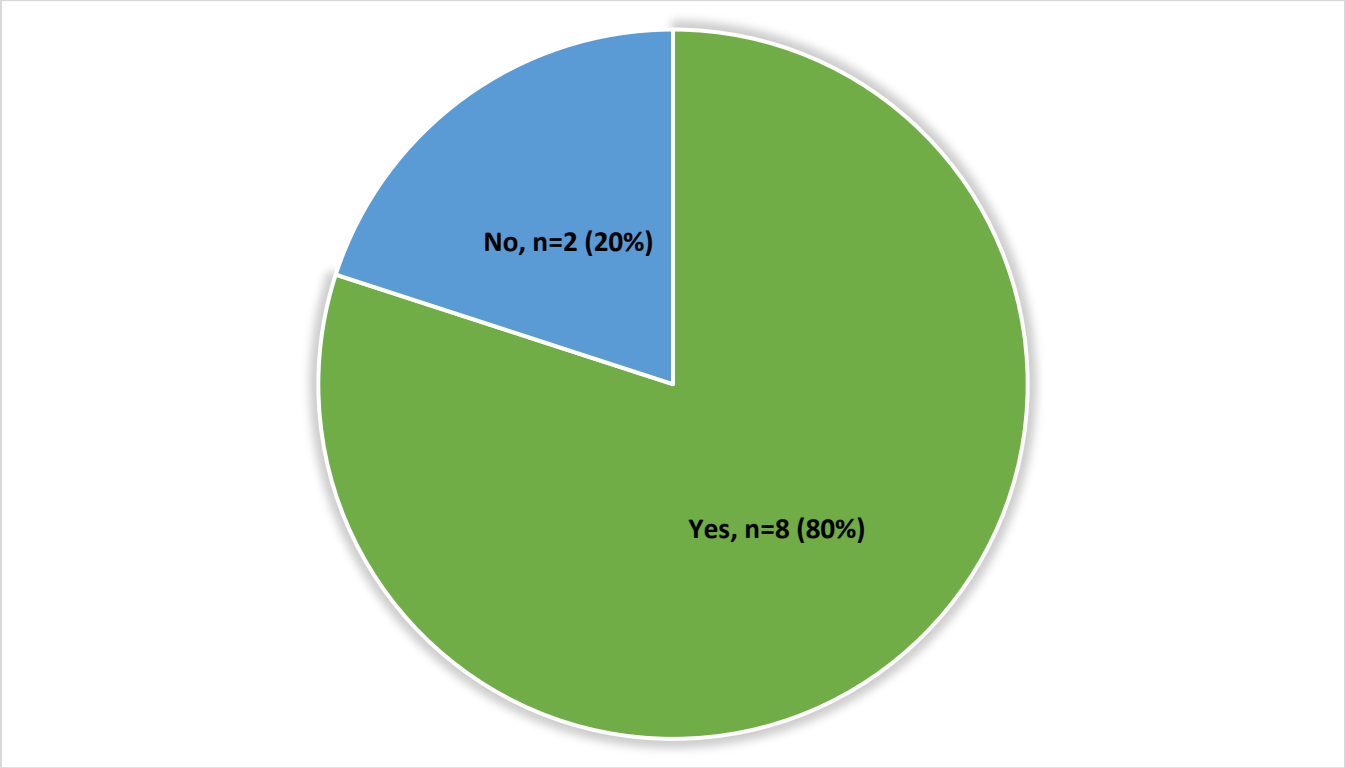

Table 269 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Georgia, Iowa, Maine, Maryland, New Mexico, Utah	8	80.00%
No	Virginia, West Virginia	2	20.00%
Total		10	100.00%

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

Table 270 - When States Plan to Implement a Program to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Explanation
Alaska	Yes, actively working with the DUR committee and the Alaska pediatric psychotropic utilization and quality team.
District of Columbia	The monthly antianxiety/sedative monitoring reporting is scheduled to be implemented in FY23 as recommended by the Board's child and adolescent Psychiatrist member.
Georgia	Unsure at this time.
Iowa	Can look at as a future topic for the DUR Commission, date to be determined.
Maine	The State of Maine is currently running a RetroDUR looking at the the use of antianxiety and sedatives in Children, the results are expected at the end of the summer 2023. We will report on the results and any implementation of future edits or monitoring depending on the results of the analysis once complete.
Maryland	Maryland Medicaid currently has two well documented programs, the Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP), to support providers who

State	Explanation
	prescribe this drug class. For additional information on these programs, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx. The program has plans to be expanded to include antianxiety/sedatives in the future.
New Mexico	This will be part of the new MMIS replacement implementation in 2024 or 2025.
Utah	2024

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

Table 271 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Explanation
Virginia	This topic has not been brought up or discussed yet.
West Virginia	Currently there is no plan however it may be a possibility in the future.

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 159 - Demonstrations or Waivers to Allow Importation of Certain Drugs from Canada or Other Countries that are Versions of FDA Approved Drugs for Dispensing to Medicaid Beneficiaries

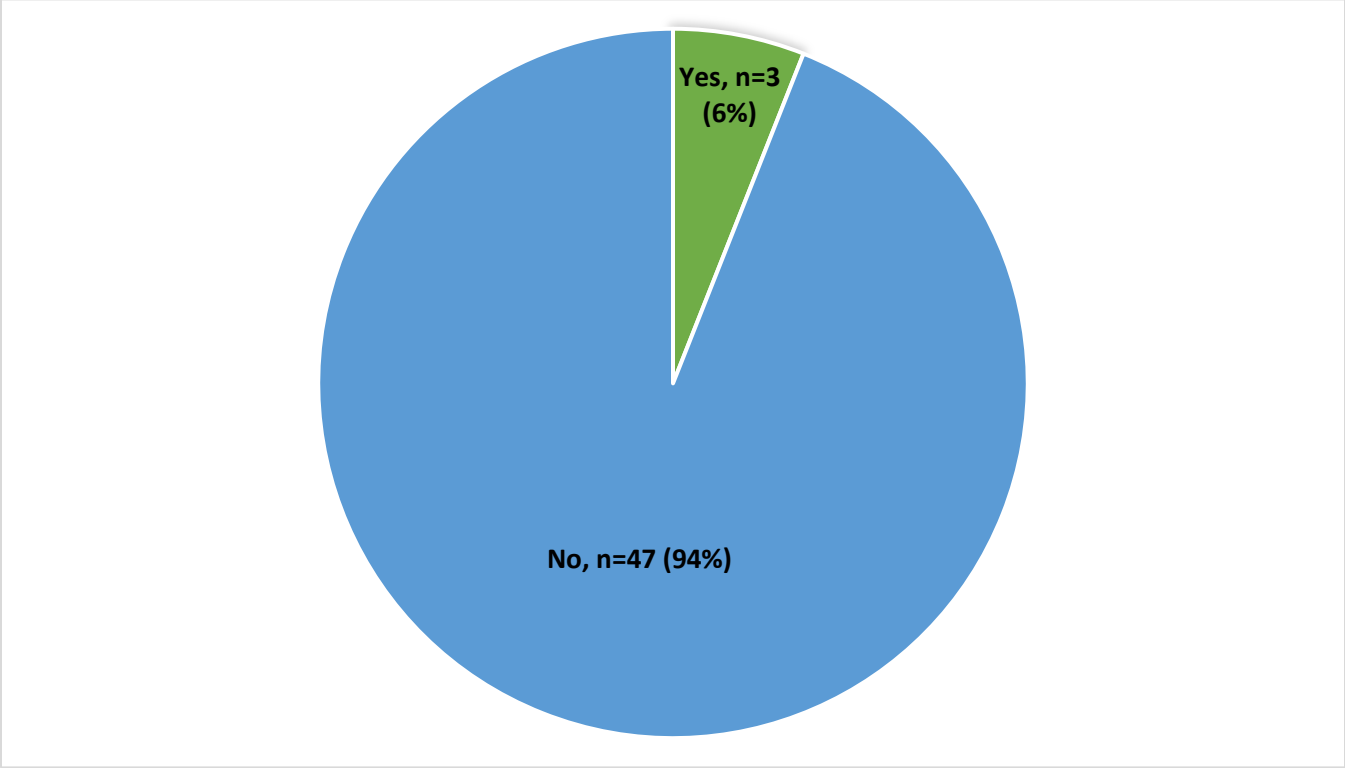

Table 272 - Demonstrations or Waivers to Allow Importation of Certain Drugs from Canada or Other Countries that are Versions of FDA Approved Drugs for Dispensing to Medicaid Beneficiaries

Response	States	Count	Percentage
Yes	Colorado, Illinois, Ohio	3	6.00%
No	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, 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, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
Total		50	100.00%

If "Yes," please explain.

Table 273 - Explanations for Demonstrations or 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	Explanation
Colorado	The Colorado General Assembly passed legislation in 2019 authorizing the importation of certain drugs from eligible Canadian suppliers.
Illinois	HFS allowed coverage of imported Apo-Varenicline from Canada from September 2021 through February 2022. https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn210903b.aspx
Ohio	Yes, ODM has a State plan amendment addressing the coverage of prescribed drugs in cases of a drug shortage. Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the FDA) are covered when medically necessary during drug shortages as identified by at least one of the following: US FDA, ASHP.

2. Summary 5 - Innovative Practices

Innovative Practices Summary 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 274 - Innovative Practices Summary

State	Innovative Practices Summary
Alabama	Alabama Medicaid Innovative Practices for Federal Fiscal Year 2022 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, automated PA, and continuous education for providers, the following other practices were implemented during the FFY 2022. -Require Prior Authorization (PA) for azelastine/fluticasone nasal spray (generic Dymista). Brand Dymista will be added as preferred. -Require Dymista to be billed with a Dispense as Written (DAW) Code of 9. -Remove Prior Authorization (PA) from dexmethylphenidate ER (generic Focalin XR). Brand Focalin XR will require PA. 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 2022 Alaska Medicaid continued to enroll pharmacists as rendering providers consistent with 42 CFR 455.400 et seq in order to bill for non-dispensing pharmacist professional services in FFY 2022. This supported COVID-19 efforts by allowing pharmacists to be reimbursed for professional services such as immunization administration, testing, and prescribing nasal

State	Innovative Practices Summary
	naloxone. This improved community access to naloxone, as well as vaccination and testing services, including COVID 19 vaccine. Alaska Medicaid removed the requirement for prior authorization for 2 Direct Acting Antivirals (Hepatitis C).
Arkansas	ARKANSAS INNOVATIVE PRACTICES FFY2022 AUTO-PA UPDATES Our goal is to get the right medication to the right patient at the right time. Over the years, our program has performed manual clinical review on many medications (especially rare disease and new to market novel medications) with a clinical pharmacist review team. 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. While our program has thrived on this practice, the process can be lengthy as DUR Board criteria, manufacturers' packet inserts, MicroMedex, and treatment guidelines are used for these reviews. To assist our clinical team and relieve some burden, we have begun adding more AutoPA POS edits for medications that can be monitored using POS algorithms that utilize the client's medication history, billed medical diagnoses, billed procedure codes, and integrated lab values. During FFY2022, we added POS edits for immunoglobulins, quetiapine to decrease off-label use, rescue seizure medications, Diclegis, budesonide respules for eosinophilic esophagitis and preferred SGLT-2 inhibitors/GLP-1 agonists. DOSE OPTIMIZATION Effective January 1, 2022 in response to Act 758 of the 2021 Arkansas legislative session, the following drug classes no longer take up a Medicaid slot for the fee-for-service beneficiaries: high blood pressure agents, high cholesterol agents, bleeding disorder agents, diabetes drugs, and inhalers for breathing disorders. Dose optimization can reduce pill burden, simplify therapeutic regimens, improve treatment compliance, and reduce pharmacy spend. Effective the same date, dose optimization was implemented for diabetes products, blood modifiers, blood pressure agents, and cholesterol medications. VALUE BASED PURCHASING CMS approved our State to enter into Value-Based Purchasing (VBP) rebate agreements with drug manufacturers for drugs provided under the Medicaid program with an effective date of 5/1/2022. We are in discussions with multiple manufacturers for potential agreements. PHARMACISTS AS PRESCRIBERS Arkansas Medicaid began enrolling pharmacists with a new provider type 95, RX specialty, beginning April 1st, 2022, with billing rules allowed beginning 6/1/2022. Pharmacists are now able to be ordering, rendering, and prescribing providers (ORP). Pharmacists enrolled may now be pharmacy claims prescribers within the established scope of practice, as well as be the ordering and rendering provider on various types of medical professional claims in place of service pharmacy.
California	Much of FFY 2022 was dedicated to the transition of pharmacy services from the 25 managed care plans to Medi-Cal Fee-for-Service, which began on January 1, 2022. The

State	Innovative Practices Summary
	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 Medi-Cal Rx 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 encompasses 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 does not include pharmacy services billed as a medical (professional) or institutional claim. In addition, during FFY 2022 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 2022 included: 1. Persistence of beta-blocker treatment after a heart attack 2. Statin therapy for patients with cardiovascular disease 3. Statin therapy for patients with diabetes 4. Post-myocardial Infarction (MI) medication review 5. Clinical pharmacy adherence program focused on controlling blood pressure and comprehensive diabetes care 6. Identifying and informing high-risk members prior to the Medi-Cal Rx transition 7. Enhanced care management program 8. Asthma affinity workgroup 9. Biosimilar optimization program 10. COVID-19 vaccine program 11. California Advancing and Innovating Medi-Cal (CalAIM) Presentation 12. Opioid DUR program Finally, Medication Therapy Management (MTM) was added as a new benefit during the last few weeks of FFY 2021 (SPA was approved by CMS on September 15, 2021), but the rollout and approval of applications began in FFY 2022. Initially, DHCS contracted for MTM services related to: 1. HIV/AIDS 2. Serious Mental Health conditions (psychotic disorders such as schizophrenia/schizoaffective disorder, bipolar disorder, etc.) 3. Cancer 4. Hemophilia 5. Diabetes On August 01, 2022, the following new categories were added as additional eligible qualifying conditions for MTM services: autoimmune disorders (e.g., rheumatoid arthritis), asthma/chronic obstructive pulmonary disease (COPD), cystic fibrosis, and multiple sclerosis.
Colorado	VALUE BASED CONTRACTING

State	Innovative Practices Summary
	The Department entered into two value based contracts (VBCs) during the reporting period. Activity continues to expand in this space and additional VBC contracts will be reported in future annual survey reports. PROVIDER EDUCATIONAL INTERVENTION FOR NALOXONE AND OPIOID USE SAFETY As part of a don't forget the naloxone campaign, an educational letter for providers was specifically developed and implemented in June 2021 and has continued through FFY 2022. This interventional letter, based in part on the July 2020 FDA Drug Safety Communication, alerts prescribers to patients are taking opioids at a cumulative dose of MME greater than 150 and also do not have a naloxone claim administratively identified in the previous 12 months. Members may obtain naloxone from other sources; however, the new letter prompted conversations between prescribers and patients to promote opioid safety at home. HEALTH FIRST COLORADO PRESCRIBER TOOL The Health First Colorado Prescriber Tool is a platform accessible to prescribers through most electronic health record (EHR) systems. The goals of the Prescriber Tool project are to (1) help improve health outcomes, (2) reduce administrative burdens for prescribers, and (3) better manage prescription drug costs .The Prescriber Tool provides patient-specific information to prescribers at the point of care. The opioid risk mitigation module was originally implemented January 1, 2021 in collaboration with OpiSafe. This module provides easy access to PDMP data, tools for evidence-based treatment and overdose prevention, and identification of Opioid Use Disorder (OUD). Each prescriber must have an individual license to access the opioid risk module. Each license will provide prescribers with access to information for all their patients, including those not covered by Health First Colorado. The affordability module implemented on June 1, 2021 allows for electronic submission of prescriptions and prior authorization requests, plus real time patient-specific pharmacy benefit information. HEALTH FIRST COLORADO Rx REVIEW MTM PROGRAM Colorado's Rx Review MTM program identifies cohorts of Medicaid members most likely to benefit from a detailed medication review. Cohorts are identified through the diagnosis of a specific chronic disease State (such as asthma, heart failure, migraine or hypertension) plus a polypharmacy component based on quarterly prescription medication claims data. Pharmacists and pharmacy interns conduct telephone medication reviews with individual members to identify therapeutic duplications, drug interactions, untreated or undertreated medical conditions, adverse drug effects, COVID-19 vaccination status, medication non-adherence, and therapeutic drug monitoring requirements. Detailed summary letters are mailed to both members and their providers. UNIVERSITY OF COLORADO SKAGGS SCHOOL OF PHARMACY DUR INTERN PROGRAM Faculty at the University of Colorado Skaggs School of Pharmacy oversee a unique DUR Intern Program to support the contractual agreement between the Department and the university. DUR Interns assist with drug information research through winter and summer assigned projects, prepare and present FDA New Approval and Safety Report at quarterly DUR Board meetings, verbally present selected proposed DUR criteria to the Board, prepare RetroDUR provider education letters for mailing each quarter, contribute articles to DUR Newsletters, and manage the technical aspects of virtual DUR Board meetings.

State	Innovative Practices Summary
	PEER-REVIEWED PUBLICATIONS The Department collaborates with the DUR team at the University Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences to occasionally publish peer-reviewed papers. An in-depth evaluation of the Health First Colorado Pain Management Teleconsultation Service was undertaken during FFY 2022 and was subsequently published. More details about this analysis and other peer-reviewed publications will be included in next year's report. UNIVERSITY OF COLORADO QUARTERLY CLINICAL RESEARCH MODULES As part of the Department's contract with the CU Skaggs School of Pharmacy and Pharmaceutical Sciences, quarterly clinical research modules are produced each quarter to provide more granular evaluations of medication related issues and drug use policies that are pertinent to Health First Colorado members. The Department uses these data to make policy changes and improve medication safety and quality of care for our members. The four quarterly research module evaluations conducted during FFY 2022 are summarized below. CLINICAL MODULE 1: Utilization of Antiretroviral Therapy for treatment of HIV Among Health First Colorado Members (Delivered 12/31/2021) Objective 1: Identify and describe members with HIV (Type 1 and Type 2) who are receiving ART Objective 2: Describe ART utilization and adherence among members with HIV who are receiving ART Objective 3: Describe initiation of HIV regimens for members newly diagnosed with HIV CLINICAL MODULE 2: Consult Service Clinical Outcomes Investigation: An Updated Assessment of Pain Management Specialty (Delivered 3/31/22) Objective 1: Describe members participating in the Opioid Consult Service Objective 2: Estimate the effect of the Opioid Consult Service on opioid use CLINICAL MODULE 3: Targeted Immune Modulators: Analysis of Select Biological Products (Delivered 6/30/2022) Objective 1: Identify and describe members receiving select biologic agents Objective 2: Describe history of FDA-indicated diagnoses and utilization of select biologic agents Objective 3: Describe the utilization and cost of select biologic agents CLINICAL MODULE 4: Psychotropic Medication Use among Pediatric and Adolescent Members of Health First Colorado (Delivered 9/30/2022) (psychotropic medications analyzed included stimulants, antipsychotics, anti-anxiety agents, mood stabilizers, and antidepressants) Objective 1: Identify and describe pediatric and adolescent members receiving psychotropic medications Objective 2: Describe psychotropic medication use by therapeutic class Objective 3: Describe psychotropic medication use and enrollment in Colorado's child welfare system
Connecticut	Retrospective DUR Innovative Practices Pediatric Reviews

State	Innovative Practices Summary
	There are approximately 1,000,000 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 2022 include; stimulant use in patients with comorbid anxiety, risks associated with use of atypical antipsychotics in the pediatric population, therapeutic duplication of antidepressants, pediatric psychotropic medication monitoring for stimulants, NCQA/HEDIS criteria, proton pump inhibitor (PPI) review, additive sedation, pediatric psychotropic medication monitoring for benzodiazepines, pediatric psychotropic medication max dosing, monitoring recommendations for anticonvulsant medications, and antihistamine and steroid criteria review. Adult Reviews Adult drug utilization review has been the foundation of the RDUR program in Connecticut. Select topics of review during FFY 2022 for the adult population included; medication use in renal impairment, atypical antipsychotic use in diabetic patients, SUPPORT Act criteria concurrent opioids and benzodiazepines, utilization of pregabalin over gabapentin for neuropathic pain, underutilization of antipsychotics, underutilization of anticonvulsant medications, concurrent use of opioid agonists with partial agonists or antagonists, SUPPORT Act criteria concurrent use of opioids and antipsychotics. Inappropriate therapy in the elderly, Specialty mailer - patients who are receiving chronic opioid therapy without naloxone who have at least 1 risk factor for overdose, and drugs cautioned or contraindicated during pregnancy. 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 2022 During December 2021, the DUR Board approved a newsletter titled Hitting a Nerve with the Gabapentinoids. In tandem with the newsletter a targeted intervention was performed in the adult population for utilization of pregabalin over gabapentin for neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia or partial-onset seizures in adults.

State	Innovative Practices Summary
	During February and March 2022, targeted RDUR interventions were performed on the pediatric population which reviewed NCQA/HEDIS recommendations for use of antipsychotics in the pediatric population. In line with the SUPPORT Act requirements to have a program in place to monitor the use of antipsychotics in this population, the DUR Board proactively approved these criteria as additions to the criteria library used to review and send educational interventions for all recipients in the pediatric population, including foster care children. During this intervention 866 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 352 of the 866 recipients intervened on continued to be flagged by the criteria, resulting in 60% positive response to the intervention. During March 2022, the DUR Board approved a newsletter focusing on Alzheimer's Disease, diagnosis, treatment, and future outlook. This newsletter was sent to all enrolled CT Medicaid providers. During April 2022 a targeted intervention was performed on the adult population for the underutilization of antipsychotics. During this intervention 505 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 27 of the 505 recipients intervened on continued to underutilize their antipsychotic, resulting in 95% of patients responding positively to the intervention. During June 2022, the DUR Board approved a two-part newsletter titled Affirming Gender Through Clinical Pharmacology. The first part of this newsletter series covered historical aspects, diagnostic criteria, barriers to healthcare that transgender people are faced with, and a review of guideline based pharmacological treatment with Gonadotropin Releasing Hormone analogues (GnRHa). The newsletter was sent to all enrolled CT Medicaid providers. During July 2022, a specialty mailer was performed targeting prescribers of patients receiving greater than or equal to 90 morphine milligram equivalents (MME) per day chronically, without evidence of a current naloxone prescription (within the past six months) and are considered at risk for experiencing an overdose. During this intervention 667 unique recipients were targeted, and their prescribers received intervention letters. During September 2022, the DUR Board approved part two of Affirming Gender Through Clinical Pharmacology. This newsletter focused on guideline-based gender affirming hormone therapy used in the transgender population. The newsletter was sent to all enrolled CT Medicaid providers. Prospective DUR Innovative Practices Established during FFY 2022 During March 2022, Tubeless Insulin Pumps (V-Go and Omnipod) were added as covered items with prior authorization under the pharmacy benefit. Additionally, in April 2022, Coverage of Outpatient Dialysis Services under Emergency Medicaid for Non-Citizens was implemented. This coverage included select pharmacy services. Pharmacy point of sales claims submitted require a diagnosis code for patients in this coverage group indicating the drug or product is being dispensed for dialysis or renal disease implications.

State	Innovative Practices Summary
	Additionally, in July 2022, Medically Necessary Prior Authorization was implemented for Dupixent. Dupixent, a costly biologic agent, currently is indicated for Eosinophilic Esophagitis, Uncontrolled Moderate-to-Severe Atopic Dermatitis (Patients aged 6+ months), Moderate-to-Severe Asthma (Patients 6+ years), Inadequately Controlled Chronic Rhinosinusitis with Nasal Polyposis (Patients 18+ years), and Prurigo Nodularis (Patients 18+ years). As such, patients must meet the clinical criteria based on the approved indication for Dupixent to obtain an approved prior authorization. During August 2022, CT Medicaid implemented changes to support pharmacist prescribing and coverage of paxlovid for patients. Pharmacists prescribing paxlovid must follow guidelines as documented in FDA's emergency use authorization. Pharmacists who have an NPI are permitted to submit either their own personal NPI or that NPI of the pharmacy to receive a paid claim.
Delaware	Delaware removed the diagnosis code requirements on anticoagulants and increased the duration of treatment allowed without a prior authorization to facilitate timely access to these critical medications based on input from providers. Due to the ongoing Opioid Epidemic, Delaware continues to look at ways to expand access to treatments for Opioid Use Disorder. Medication assisted treatment and naloxone are now both available without a copay to members and reminders that naloxone is available at local pharmacies without co-pay have been sent to providers to encourage dispensing these products to anyone at risk of opioid overdose. And, in compliance with the Support Act, Delaware continues to expand monitoring and management of the appropriate use of antipsychotics, stimulants, antianxiety medications/sedatives, antidepressants and mood stabilizer medications by children enrolled under the State plan. DMMA collaborates with Department of Services for Children, Youth, and their Families (DSCYF) to ensure these member receive appropriate treatment. A Clinical Pharmacist reviews patient medication protocols for these drug classes to screen for appropriateness of dose and usage.
District of Columbia	PHARMACY LOCK IN REVIEW 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 pharmacist and the FFS PBM contractor's dedicated clinical pharmacists 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 re-engagement with their care providers and/or additional counseling from a pharmacist on drug dosing or avoidance of adverse effects have received the help they needed instead of assignment to a nonproductive punitive lock in period.

State	Innovative Practices Summary
	Feedback from prescribers, pharmacists and beneficiaries has been mostly positive with the recognition of and appreciation for the extensive preliminary review and mitigation process that precedes a pharmacy lock-in decision. OPIOID PRESCRIBING GUIDELINES The Drug Utilization Review Board published a newsletter entitled A Collaborative Approach for Safe Use of Opioids. This effort was coordinated by a DHCF clinical pharmacist who reached out to approximately 20 identified community-based stakeholders including prescribers, professional associations, teaching institutions, the Boards of Medicine, Nursing and Pharmacy, respectively, to gather their professional input on appropriate opioid prescribing, use, and management strategies in the District of Columbia. The DUR Board recommended that all providers adopt the DC Health and CDC guidelines when prescribing and dispensing opioids. The newsletter was made available on the respective websites of the PBMs, MCOs and Department of Health Care Financing (DHCF). In addition, the DUR Board plans to organize continuing education programs on appropriate opioid prescribing and dispensing during the upcoming fiscal year in collaboration with the Medicaid managed care plans. INDIVIDUAL PATIENT PROFILE REVIEW Each month DUR Board members collectively review three hundred (300) individual patient profiles generated by the DUR contractor based on clinical rules approved by the Board. The retrospective rules engine incorporates the current guidelines for specific therapeutic classes and reviews pharmacy and medical claims history to identify beneficiaries and prescribers who might require educational outreach or follow-up. This intensive retrospective review process provides a vital insight into and oversight of the effectiveness of the prospective POS system edit configuration.
Florida	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 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.

State	Innovative Practices Summary
	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 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	Not available.
Idaho	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 with a third party. Prior to the Covid-19 pandemic we were 100% office-based. During the pandemic we moved to a remote model with pharmacists and technician teams working from home. In Spring of 2022 we moved to a hybrid model so that we have two teams of pharmacists and technicians that rotate between 2 days per week in the physical pharmacy call center and 3 days per week remotely. We have maintained a daily morning check-in meeting for everyone including our non-pharmacy staff to review work-load and other issues. This has been vital for communication and maintaining a cohesive team environment. We are fortunate to have a very stable team that adds to the success of our program. This year we have continued to partner with our Public Health colleagues and use funding from a DOPP (Drug Overdose and Prevention Program) grant to fund two clinical pharmacists to focus on opioids, opioid use disorder treatment and benzodiazepine use and abuse. These pharmacists are responsible for all prior authorizations for these drug classes and work one on one with prescribers to ensure the best treatment options for our beneficiaries. A big part of their efforts involves provider outreach and education, which in a rural State with a high percentage of nurse practitioners and physician assistants as primary care givers, is a useful service. They have also improved our prior authorization forms as tools to guide best prescribing and monitoring. The forms provide links to resources for safe opioid prescribing and tapering guidelines. The opioid 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

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	treatment is part of the treatment plan, and that urine drug screens are being done and evaluated. In the next grant cycle, we have budgeted for an additional pharmacist plus funds for these pharmacists to receive formalized academic detailing training so that one on one and group practice training for best practice can be implemented. In addition to the grant funding of pharmacists to focus on opioid and benzodiazepine usage we have also worked with local physician addiction fellowship programs to include Idaho Medicaid as a rotation site for several of the fellows for 1-4 days per month. This has added another layer of patient centered appropriate care. We have also partnered with our Magellan colleagues to develop and implement an Opioid Geo- Mapping program. This has been well received as valuable information by the members of both the DUR Board and Pharmacy and Therapeutics Committee. Our staff pharmacists and contract pharmacists may select any quarter of the year and filter by age, duration of initial prescription, duration of use, and MME. Results are presented by healthcare region and/or zip code. There is an adjacent display for naloxone utilization. A table presents the patients on potentiator medications (displays number of benzodiazepines and number of other potentiator medications) and if naloxone has been prescribed. The table includes a drill down to display patient details (specific medication(s)/dose, prescriber, pharmacy). With Idaho being a large State geographically with a few pockets of larger population areas and many rural areas this is useful for identifying areas of concern as well as focus areas for education and intervention. This is a program that Magellan will probably make available and expand to other Medicaid State clients in the future. Aside from opioid and benzodiazepine focused programs, we have also this year developed a beneficial service relationship with our Foster Children program. We have been able to facilitate medication availability for children new to the Foster Children program emergently without medications or children currently on the program emergently moved to a different facility or home without their current medications. In 2018 the Idaho Legislature passed updates to the Idaho Practice of Pharmacy Act to allow pharmacists additional prescriptive authority. Pharmacists are now considered practitioners in the same classification as physician assistants and nurse practitioners. Prescriptive authority is independent and broad without the need for collaborative practice agreements. Idaho Medicaid now enrolls pharmacists as providers and this year the Medicaid Pharmacy Program was able to present to the DUR Board an analysis of prescribing practices and patterns. In addition, pharmacists may now bill for the same CPT codes for patient evaluation and management as other Ordering and Referring Providers with the addition of unique codes for Medication Therapy Management (MTM). Implementation of these additional services has demonstrated the benefit of pharmacists working at the top of their licenses to expand the care in a rural State with a shortage of primary care providers. Idaho Medicaid's innovative pharmacy program has facilitated significantly better pharmaceutical care for our participants as well as ensuring the appropriate use of State financial resources. It has provided a model which can be used for other internal and external programs in the future.
Illinois	Illinois Fee-for-Service (FFS) Medicaid continues to focus on controlling Medicaid drug spending while ensuring Medicaid participants have access to the most cost effective,

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	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 FFY22. Illinois HFS opioid-related prospective edits based on SUPPORT for Patients and Communities Act (SUPPORT Act) were maintained during FFY22 with no changes due to the COVID-19 pandemic. The December 2020 CMS 2482-2 final regulation regarding SUPPORT Act and DUR opioid safety edits further recommended that participants at high risk of opioid overdose should be considered for co-prescription or co-dispensing of FDA-approved opioid antagonist/reversal agents. Change Healthcare's high opioid MME reports for HFS continued to be used to identify high-risk patients that would benefit from naloxone availability. When multiple prescriber outreach attempts did not result in feedback or a naloxone fill, pharmacies were asked to implement the standing order for the patient. Overall, the intervention resulted in a 15% increase of naloxone receipt in high-risk participants for whom naloxone was deemed applicable. Time-intensive nature of the intervention yielded lower than anticipated results. Prescribers need more time to do their prescriber patient education about the importance of this issue. Pharmacists need to proactively apply the standing order without waiting for a prescriber's prescription since that is not a requirement of the standing order. A continuing education presentation at the Illinois Pharmacists Association Annual Meeting was conducted to encourage implementation of the naloxone standing order. Annual review of naloxone fill in patients at high-risk for opioid overdose will be done and outreach for other high-risk groups besides high MME opioid use is planned. Outreach will focus on prescriber education and determining if opioid harm reduction discussions and naloxone co-prescribing occurred as well as pharmacist education and standing order implementation. During FFY22 prescriber peer consultation for mental health medication use in children via University of Illinois Chicago, Clinical Services in Psychopharmacology Program continued as needed. Provider outreach to individual prescribers continued for chronic benzodiazepine monotherapy for the management of anxiety in the absence of first-line therapies, such as selective serotonin re-uptake inhibitors (SSRIs), as well as for appropriate chronic pain management with opioids. The COVID pandemic-related temporary lift of the Four Prescription Policy edit that identified participants for benzodiazepine and chronic pain management program outreach impacted the number of interventions. Use of first-line therapy SSRI or serotonin and norepinephrine reuptake inhibitors [SNRI]) was assessed in the overall FFS and MCO population. Work on implementation of an initial days supply hard edit for benzodiazepine-naive participants was initiated as one method to improve appropriate utilization and minimize chronic benzodiazepine monotherapy as appropriate. Starting summer 2021 pediatric hospitals serving Illinois children and HFS worked cooperatively to monitor changes in RSV prevalence in Illinois. Prior approval processes were adjusted to facilitate early doses of Synagis outside of the traditional RSV season on a month-by-month basis. This facilitated appropriate, timely care of HFS participants in a dynamically changing environment. The RSV season in FFY22 ended in March 2022.

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	Need for continued responsiveness included medication coverage for special populations and drug shortages. Due to the Chantix shortage, at the end of FFY21, HFS allowed coverage of imported apo-varenicline from Apotex for smoking cessation. Provision of the imported product continued until February 2022. Pharmacies and providers were reminded of the post-kidney transplant preferred drugs available to participants who received a kidney transplant under the Emergency Medical Program. This FFS program provides coverage for persons aged 19 and older who do not meet immigration status. HFS also confirmed coverage of treatment for port-wine stains, not limited to children and not solely for cosmetic purposes, including topical, intralesional, or systemic medical therapy and surgery, and laser treatments. 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. The changes highlighted in the FFY20 and FFY21 reports were maintained through FFY22 as the pandemic continued. During FFY22, HFS continued to address COVID vaccination and treatment coverage and related rates as new age groups and immigrant patient groups became candidates for initial and additional vaccine doses and booster vaccination or antiviral and monoclonal treatments. Illinois pharmacies were able to be reimbursed for administration or dispensing of these medications. COVID-19 home rapid test kits were billable if ordered by pharmacists. There was continued use of the HFS COVID Portal, an online portal for reimbursement of COVID-19 testing services for uninsured individuals who have been tested for COVID-19, regardless of income, citizenship, or immigration status. HFS and Pharmacy Services addressed diabetes in FFY22. Coverage and reimbursement for participation in two nationally recognized programs for diabetes prevention and management was available for all HFS participants. The covered programs were the Diabetes Prevention Program (DPP) and Diabetes Self-Management Education and Support (DSMES). Coverage for continuous glucose monitors (CGMs) was available for FFS and MCO participants who met criteria. Pharmacy services retrospectively evaluated usage of glucagon-like peptide-1 receptor agonists (GLP1-RA) and sodium-glucose co-transporter 2 inhibitors (SGLT2i) in FFS and MCO participants for the July to December 2021 time frame. Overall, up to 13% of participants were filling guideline recommended therapies. Identification of patients with T2DM and concomitant atherosclerotic cardiovascular disease, chronic kidney disease, and heart failure who have not received recommended therapies and prescriber as well as potential patient outreach is planned. The HFS collaboration continued with the University of Illinois Chicago College of Pharmacy to provide academic detailing services via the Illinois ADVANCE (Academic Detailing Visits And New evidence CEnter) initiative. 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) and frequently asked questions, 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 further encourages appropriate prescribing with social media posts on LinkedIn, Facebook, and Twitter. During FFY22, Academic Detailing via

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	virtual televisits continued. In addition to the opioid and diabetes offerings, new topics launched in FFY22 included neonatal opioid withdrawal syndrome, smoking cessation, sexually transmitted infections, Human Papilloma Virus vaccination, and SMART therapy for asthma. Outreach to inform individual prescribers and State and county prescriber associations of Illinois ADVANCE services continued in FFY22. During FFY21, HFS began researching implementation of Value Based Agreements. HFS is looking into creating new reimbursement pathways and negotiating outcomes-based agreements to assure access to new highly expensive gene therapies and orphan drugs expected to come to market. During FFY22, HFS continued working on this initiative.
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, Optum Rx (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 May 24, 2013, Optum Rx implemented near real-time faxed retroDUR interventions. These retroDUR 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 receipt of the second dose of the COVID-19 vaccine and concurrent therapy of dipeptidyl peptidase-4 (DPP-4) inhibitors and glucagon-like peptide-1 receptor agonists (GLP-1 RA). In the beginning of FFY 2022, the FFS pharmacy benefit implemented Pre-Check My Script® (PCMS). PCMS is a real-time benefit check tool that is embedded within the electronic health record (EHR) system. Prescribers can find patient-specific medication coverage information, compare alternative medications based on the patient's FFS pharmacy benefit, and receive alerts when a prior authorization is needed. When a prescriber prescribes a medication through the patient's EHR, the Optum Rx tool will run a trial claim through the pharmacy claims system to determine the drug benefit status, alternatives, and if any prior authorization is required. The PCMS tool will provide additional transparency to the FFS pharmacy benefit status, allow for streamlined prescribing potentially less administrative tasks, and may enable patients to receive their medications faster (when compared to waiting on prior authorization if preferred alternative is appropriate). The PCMS program is automatically integrated in the prescriber's EHR through Optum Rx. Beginning in FFY 2023, Indiana Medicaid will move to a unified Preferred Drug List (PDL) with its' five managed care organizations. During FFY 2022, the Office of Medicaid Policy and Planning, Optum Rx, and the State managed care organizations have been diligently driving towards a unified PDL goal that not only reflects unified preference status, but also unified prior authorization criteria for PDL agents. It is believed that this will simplify the benefit and ease member, prescriber, and pharmacy burden.
Iowa	N/A
Kansas	In FFY 2022 Kansas received CMS approval for a revised supplemental drug rebate contract. This contract revision ensured that all Covered Outpatient Drugs, which by

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	default includes physician administered drugs, that are included on the PDL are allowed to have supplemental drug rebate agreements. The State changed its supplemental rebate contract date range and bid rotation to start on a CMS rebate quarter, so as to improve invoicing efficiency for both the Labelers and the State. This revision also allowed for any late interest rate calculations to be done at the same time for both the mandatory and the supplemental rebates. The State moved all of its clinical meetings (DUR, MHMAC, and PDL) to be in the same month each quarter, for improved tracking of needed program changes and policy processes. We also changed our Synagis coverage to mirror the RSV viral activity in our State, which was earlier in the year, than the long-standing RSV viral activity time period. We updated our clinical PA criteria for some drugs, to allow for dose modifications based upon therapeutic drug monitoring. We removed the annual PA renewal request for non-preferred PDL drugs, when there was no additional clinical criteria to meet. We added prior authorization to high dollar compounds to increase oversight of active pharmaceutical ingredients that may be used inappropriately.
Kentucky	During Federal Fiscal Year 2022, the Kentucky Medicaid Program made the following programmatic changes: 1. Medications which require health care provider administration, based on the route of administration, were excluded from pharmacy coverage and referred to the medical plan. Prior authorization criteria were created to allow coverage if the medication is being self-administered; AND self-administration is allowed per DOSAGE AND ADMINISTRATION section of the prescribing information; OR the medication is being administered by a home infusion provider; OR the medication is being used for a compound in compliance with USP 795 standards for non-sterile compounding. 2. Prior authorization criteria were added to IVIG and SCIG products to ensure appropriate use. 3. Due to the spike in respiratory syncytial virus cases, the Kentucky Medicaid Program extended the 2022 Synagis season to start in October to allow for early access. 4. To ensure that members had access to COVID-19 treatment and testing, a provider protocol was put in place to allow pharmacists to initiate the dispensing of Paxlovid and administration of COVID-19 test kits. 5. Clinical criteria and quantity limits were added to continuous glucose monitors to ensure appropriate utilization. 6. In response to the emergency in areas impacted by tornadoes, the Kentucky Medicaid Program allowed a submission code indicating Payer-Recognized Emergency/Disaster Assistance Request to bypass the NCPDP 88 early refill rejection. 7. The P&T committee reviewed new drugs to market in various classes, such as Immunomodulators, Atopic Dermatitis; Cytokine and CAM Antagonists; Oral Immunosuppressants; CGRP antagonists; Bile Salts; and Growth Hormones. Immunomodulators, Asthma and Uterine Disorder Treatments were added as new PDL drug classes.
Louisiana	Louisiana did not initiate innovative practices in FFY 2022.
Maine	Authorized (EUA) over the counter (OTC), direct to consumer (DTC), and prescription COVID-19 at-home tests and the OTC, DTC, and prescription COVID-19 home collection kits through a Standing Order for MaineCare beneficiaries. This Standing Order authorizes licensed pharmacists to create a prescription for the OTC, DTC, or prescription COVID-19 at home tests and the OTC, DTC, or prescription COVID-19 home collection kits for eligible MaineCare members. MaineCare members with proper identification who meet the age

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	requirements of the OTC, DTC, or prescription COVID-19 at home tests and the OTC, DTC, or prescription COVID-19 home collection kits. Tobacco program Expansion: The Maine Tobacco and Substance Use Prevention and Control Program expanded the use of the Nicotine Replacement Therapy (NRT) voucher program to MaineCare members. With the expansion to MaineCare members, Medicaid recipients will now have additional resources available to obtain NRT's outside their primary care provider and through the tobacco voucher support line. As part of the expansion of coverage, Mainecare allowed the use of a Standing Order which authorized licensed pharmacists to create a prescription for the OTC NRT products. These NRT vouchers will work similarly with regards to medication coverage as with the current Tobacco program, but it will be billed through the MaineCare system. Suboxone PA Criteria Changes: The State in partnership with the Maine Opioid Response Clinical Advisory Committee, MaineCare updated our coverage criteria and Prior Authorization (PA) process for buprenorphine for the treatment of Opioid Use Disorder (OUD). The Maine Opioid Response Clinical Advisory Committee is a group of approximately 30 leaders in Substance Use Disorder (SUD) prevention, treatment and harm reduction in Maine and includes both prescribers and pharmacists. With their input, MaineCare has made these updates to its coverage criteria to reflect best clinical practice in the use of Medications for Addiction Treatment (MAT) for OUD and to further its efforts to reduce barriers to care and increase access to life-saving medications for the treatment of OUD. Key changes to the MaineCare coverage criteria and PA processes include the following: Buprenorphine induction period changes: o Induction period is now considered to be 30 days (previously was 60 days) o Max buprenorphine dose is 24 mg/day for up to 30 days of induction period (previously was 32 mg/day) o Buprenorphine induction doses of up to 24mg/day will be allowed for multiple induction periods per year, during which prescribers can write for a maximum of 24 mg daily for up to 30 days without requiring a PA. For members who are pregnant, a Prior Authorization (PA) will not be required for buprenorphine monotherapy in doses up to 16 mg/day when the prescriber notes a pregnancy diagnosis noted on the prescription PAs for buprenorphine will no longer be required when a provider prescribes a concomitant opioid medication for the treatment of acute pain. The SC (Strength Change) override code can be used with an active PA to titrate a member's dose from once daily to twice daily dosing. This new override eliminates the need to submit a new PA request. . 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 sent out over 438 letters to providers in FFY22 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

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	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. 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 2022 enrolled an additional 1,122 members to total 6,919 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 2022, the PCM program included 1,715 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 991 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. As a result of these reviews, MaineCare PCM contacted providers (prescribers and pharmacies) via telephone or fax a total of 226 times and contacted patients via telephone 61 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.

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	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 development and release occurred throughout Fiscal Year 2022 to further advance this field more pellet formulations and strides made in pediatric treatment regimens. 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
Maryland	Live Continuing Education Programs Annually, the Maryland Department of Health Office of Pharmacy Services (OPS) has sponsored 2 live continuing education programs for Maryland Medicaid healthcare providers. In FFY 2022, the first program, 'Challenges in the Management of Post-COVID Syndrome' was held in October 2021. The second program, 'Substance Use Disorders and Treatments' was held in April 2022. Continuing education program details are available on the MDH website, and sent out via mail. Clinical Criteria and Dose Optimization In FFY 2022, OPS continued to update its website to include clinical criteria and dose optimization for new medications in an effort to reduce waste and improve prescribing practices. Clinical criteria and quantity limits are based on FDA approved indications and exist to ensure appropriate use of medications, however medical necessity overrides are available with prior authorization. The list of medications included in this program is updated regularly and can be easily accessed on the MDH website. Online Formulary hosting for Maryland Medicaid and HealthChoice MCOs The OPS has maintained a free to use electronic database with FFS and MCO formulary information since 2007. During FFY 2022, the use of Formulary Navigator offered Maryland

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	Medicaid providers real time access to all 9 MCO and FFS formularies. This user-friendly platform allows searches by drug name, therapeutic class or alphabetical listing and displays drug strength/formulation, and multiple flags (prior authorization, quantity limits, criteria for use) to guide prescribing and facilitate medication access. Corrective Managed Care Program: The Corrective Managed Care (CMC) Program monitors and promotes appropriate use of controlled substances. The CMC program aims to educate providers when patients appear to be over-utilizing controlled substances, ensure safe participant access to medications and reduce adverse outcomes associated with overutilization. Monthly review identifies Medicaid participants who appear to be on duplicate drug therapy, have multiple prescribers of similar medications, and/or fill at multiple pharmacies. Intervention letters are mailed to prescribers and pharmacy providers to alert them to potential drug therapy concerns. If there continues to be overutilization by a participant after intervention letters are mailed, a participant can be locked-in to a single pharmacy or presented to the Corrective Managed Care Advisory Committee, a sub-committee of the DUR Board. This committee assists with the review of individual participants and helps set policy regarding efforts to reduce the potential misuse of controlled substances. The Committee includes all members of the DUR board and meets quarterly prior to the DUR Board meeting to review the drug and diagnosis history profile of previously identified participants before advising the OPS on recommended corrective action. 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 as opposed to waiting 6 months as in the past. Since creation in 2016, the Unified CMC program has set a minimum standard for monitoring of controlled substance use that includes all Medicaid participants enrolled in an MCO. Collaborative development of this program ensures uniform oversight, continued corrective actions, and optimal care if a lock-in participant switches between any Medicaid program over the 24 month lock-in term. Opioid Drug Utilization Review The OPS worked with Maryland HealthChoice MCOs to create a minimum standard prior authorization criteria for opioids as part of the Maryland Department of Health's initiative to combat the national opioid epidemic and 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 (MME) per day. In addition, a standard 30-day quantity limit for all opioids is set at or below 90 MME per day. Exceptions to these standards include participants with a diagnosis of cancer (treatment within the past 2 years), sickle cell anemia, those receiving palliative care or in hospice care. These minimum standards continued to be utilized and monitoring of the program has shown improved prescribing of opioids without restricting access for recipients. Automated Prior Authorizations The Prospective DUR vendor, Conduent State Healthcare, LLC, utilizes an automated prior authorization (PA) program for selected medications which require PA. Pharmacy claims

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	can be automatically authorized if specific criteria are met at the point of service, eliminating the need for the provider to call if the participant meets the criteria for approval. The Conduent automated PA system is made up of two components, described 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 - Provides call center representatives view access to the SmartPA rules engine. This system is used to determine pre-authorizations for rules based in SmartPA. Antipsychotic Review Programs Increased use of antipsychotic agents in children and adolescents, increased controversy, and the lack of long-term data for these medications in pediatric populations has led the OPS to establish two new programs. Since 2011, the Peer Review Program for Mental Health Drugs has addressed the use of antipsychotics in Medicaid patients under five years of age, with expansions in 2013 and 2014 to now require prior authorization for all patients less than 18 years of age. The program partners with the Behavioral Health Administration (BHA) and the University of Maryland (UMD) Division of Child and Adolescent Psychiatry and School of Pharmacy, to ensure that members of this vulnerable population receive optimal treatment along with appropriate non-pharmacologic measures. With the assistance of UMD, the OPS also established the Antipsychotic Prescription Review Program (APRP) in 2013 as another avenue to promote evidenced based, cost-effective prescribing. The APRP retrospectively reviews paid antipsychotic claims to identify outlying prescribing patterns, then contact the associated prescribers with the goal of improving their prescribing practices. Substance Use Disorder Carve-Out program The Maryland Department of Health initiated a carve-out program in 2015 to standardize coverage and criteria for use of substance use disorder medications including buprenorphine products, disulfiram, acamprosate, naltrexone products, varenicline, bupropion SR, nicotine replacement products, and naloxone for opioid overdose reversal. Treatment guidelines are based off of FDA-approved indications as well as CMS recommendations for comprehensive patient-care and new medications are continuously reviewed for carve-out inclusion. SUPPORT Act Following updated federal regulations from the SUPPORT act, in 2019 the OPS implemented coordinated prospective safety edits and automated claims review processes that monitor when a participant is concurrently prescribed opioid + benzodiazepine or opioid + antipsychotic. Monitoring for concurrent prescriptions of an opioid + MAT for an opioid use disorder and opioid claims in general has continued. Although mental health medications such as antipsychotics are carved out of the MCO benefit and paid FFS, MCOs are encouraged to continue reporting and monitoring practices for these opioids along with these medications. Further SUPPORT Act updates in October 2021 include ensuring patient access to MAT regardless of a history of or current therapy with an opioid, however opioid claims greater than 7 days will require PA. New POSECMS System

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	On October 30, 2022 the Maryland Department of Health went live with a new Point of Sale Electronic Claims Management System. The system added new e-prescribing capabilities and an enhanced web portal with prior authorization functionality. COVID-19 initiatives Due to the ongoing COVID-19 pandemic, the Maryland Department of Health continues to allow pharmacies 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.
Massachusetts	COVID-19 response Following the public health emergency in response to the spread of COVID-19, the MassHealth pharmacy program Implemented a plan response in March 2020. Select ones have been maintained through Fiscal Year 22 during the Public Health Emergency. Including proactively monitoring the COVID-19 treatment and vaccination pipeline and implementing proactive management strategies, paying for delivery of prescription medications, expansion of DME coverage of select products to process at the point of sale and coverage of COVID-19 testing kits through the pharmacy program. Fully Unified Pharmacy Product List In July 2020, the unified pharmacy product list was expanded to 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. Planning for full unification in April 2023 was started. Impacts on plan members and differences between the benefits of plans was evaluated as part of an evaluation of all currently managed therapeutic classes. Sharing clinical guidelines with MCO plans to facilitate this process continued. Estimated savings with the partial unified formulary was $120 million in calendar year 2021. Outcomes Monitoring Program An outcomes monitoring program was created to follow plan members at specified points post-treatment to verify treatment response and better understand the long-term impact of therapy as well as monitor specific outcomes based on manufacturer reimbursement. 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 a psychiatry consultant. The intent 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 also considered. Opioid Dose Accumulator In 2019, point of sale coding was developed to identify and monitor members receiving multiple opioids and accumulate those 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. Starting in January 2020, prior authorization was implemented applying to members receiving concomitant therapy. The aim was to identify 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

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	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 All prior authorization (PA) requests for hepatitis C regimens are reviewed by Drug Utilization Review (DUR) to promote selection of the most cost -effective regimen. A DUR clinical pharmacist may contact the prescriber to discuss an alternative, more clinically appropriate and/or more cost - effective regimen.. In addition, in 2021 point of sale rules were implemented to allow most claims for sofosbuvir/velpatasvir and Mavyret to pay within age and quantity limit for members for most members with comorbidities (e.g., those without pharmacy history for hepatitis C medications, claims suggestive of decompensated cirrhosis, or claims for a medication with a drug-drug interaction with the regimen). Pediatric Behavioral Health Medication Initiative / Therapeutic Case Management Workgroup A multidisciplinary Pediatric Behavioral Health Medication Initiative (PBHMI) Therapeutic Class Management (TCM) workgroup consists of pharmacists, psychopharmacology consultant, child psychiatrists, and a social worker. Retrospective case review is conducted daily, and cases are discussed weekly among workgroup members. Member cases reviewed by the workgroup may include those with a recent psychiatric hospitalization, age less than 3 years, behavioral health regimens with 6 or more medications, and use of select high -risk agents in certain age groups (e.g., antipsychotics in children less 8 years). Workgroup responsibilities include clinical discussions regarding treatment plans, prescriber outreach to encourage evidence - based prescribing practices (e.g., dose reduction/consolidation of the regimen, appropriate laboratory monitoring), 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. The pipeline pharmacist tracks agents in development, the potential place in therapy, the anticipated FDA approval date, and potential impact to the 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, available clinical and economic data is used 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

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	pediatric members receiving psychiatric medications (those may be candidates for care coordination). Community Case Management (CCM) The clinical pharmacist maintains a direct means of expedited communication between MassHealth DUR and CCM. The CCM pharmacist tracks PA denials and approvals, reports trends and provides recommendations. Provider outreach involving medication related consultations, discharge consultations, and medication reconciliation ensure continuity of care among this at-risk population. A proactive outreach program was created to help outreach to members with expiring prior authorizations to ensure continued adherence to medication. Automated PA -Point of Sale (POS) Rules As the DUR program creates clinical guidelines using evidence -based medicine reviews to review prior authorizations. Each clinical guideline that is created requires the development of a 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), medication history, diagnosis, or procedure codes from the MassHealth medical and pharmacy claims database are searched automatically. If all criteria are met, the medication will adjudicate at the pharmacy without a requirement for PA submission. Special Projects A State's Collaborative Response to Address Health Disparities and Treatment Access During the COVID-19 Pandemic. This project led to a better understanding of and reflection on the State responses to the COVID-19 pandemic. Not Yet Eliminated: The Current State of Hepatitis C Treatment and Policy. This project led to a better understanding of the current State of Hepatitis C virus management in the State. A Practical Framework in Managing Value-Based Contracts. This project led to a reflection on the best practices of developing and implementing value-based contract models. 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. This List identifies the current list of Adjudicated Payment Amount per Discharge (APAD) Carve-Out Drugs and Adjudicated Payment per Episode of Care (APEC) Carve-Out Drugs. The hospital must obtain prior authorization (PA) from MassHealth for the drugs on this list, and the associated treatment will be subject to monitoring. Other requirements also apply. Direct Negotiations MassHealth has been working to lower drug costs to manage the program's spending while ensuring access for members. With approval from the Legislature, in July 2019, MassHealth received the authority to directly and more effectively negotiate with drug manufacturers for supplemental and value-based rebate agreements. Since receiving his authority, MassHealth has signed supplemental rebate contracts on 63 drugs with 22 manufacturers (as of February 2023), including 8 value-based agreements, with a total annual rebate value of approximately $349 million. Direct negotiations have not had any negative impact on consumer access.
Michigan	Throughout FFY 2022, Michigan Department of Health and Human Services (MDHHS) worked diligently to combat the opioid crisis; improve access to MAT and hepatitis C

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	medications; and to manage spending through implementation of a single preferred drug list (PDL) and outcomes-based contracting. MDHHS implemented the Medicaid Preferred Drug List (sPDL) to maximize drug manufacturer rebates (both Federal and PDL supplemental) to generate savings starting October 1, 2020. The P&T Committee makes clinical recommendations for both the Michigan Pharmaceutical Product List (MPPL) and the subset of drugs on the PDL. The MCO Common Formulary workgroup will provide input and recommendations on Single PDL coverage for P&T Workgroup consideration before each full P&T Committee meeting. Drugs not on the PDL will continue to be managed by the MCO Common Formulary for Medicaid Health Plan enrollees. Over the past few years, MDHHS has worked to reduce the barriers to hepatitis C treatments. The MDHHS Public Health Administration set a goal to eliminate hepatitis C virus (HCV) in Michigan. They developed an initiative entitled 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 was 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. As part of an ongoing effort to inform the medical community about the program, MDHHS enlisted the assistance of the DUR Board with an academic detailing outreach targeting practitioners with relationship to individuals showing a Hepatitis C diagnosis in their medical history, but no record of treatment based on review of prescription drug utilization. Obesity is a growing concern in the United States and around the world. The CMS Medicaid State Plan excludes coverage of agents when used for anorexia, weight loss and weight gain. In recent years, there has been an increasing number of non-formulary prior authorization requests for anti-obesity drugs that have been approved by MDHHS for medical necessity. MDHHS received CMS approval of a State Plan Amendment (SPA) to allow coverage of the anti-obesity medications. On February 1, 2022, the anti-obesity agents were added to the PDL. Coverage of these products aligns with current standards of practice and supports recognized treatments of comorbid conditions. 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. The April 2021 contract with Abbvie for the drug Mavyret was the second agreement. MDHHS recently executed a third agreement with Janssen for their long-acting injectable antipsychotics (LAIs) Invega Sustenna, Invega Trinza and Invega Hafyera. MDHHS continues to review potential agreements with a couple drug manufacturers nearing finalization. Agreements that allow MDHHS staff to track outcomes instead of by a third-party data aggregator are preferred. MDHHS also prefers contracts where the outcomes can be easily tracked using claims data. Outcomes-Based Contracts/Value-Based

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	Agreements are encouraged by the Department of Health and Human Services to help address high drug costs.
Minnesota	There are no innovative practices this year.
Mississippi	DOM is currently designing and implementing pharmacist administered Medication Management within our Elderly and Disabled (E&D) Waiver population. Individuals with one or more chronic health conditions who are prescribed a daily regimen of at least five (5) prescription medications may elect to receive consultations and follow up visits with a licensed pharmacist. As a core component of the service, the pharmacy provider will review all prescription and over-the-counter medications taken by the individual on at least a monthly basis in order to support the individual's adherence with the therapeutic regimen and minimize potentially preventable decline in condition or hospitalizations/institutionalization resulting from medication errors. Reviews may occur more frequently, on an as needed basis, upon significant change in the individual's condition or immediately following discharge from an acute hospital stay. The service will include two components: a comprehensive initial/annual consultation and subsequent follow-up consultations. The provider will be responsible for collecting a complete medical history and list of prescribed and over-the-counter medications in order to assess whether the individual's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications are assessed and prevented. If issues with the above are identified, the provider will take necessary steps to implement necessary interventions, including but not limited to, medication counseling and disease education, referral to a primary care physician, consultation with a physician regarding recommended laboratory tests, and medication delivery/reminder services. The service is limited to one initial/annual consultation and fifteen (15) follow-up visits per waiver year. These services are limited to additional services not otherwise covered under the State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
Missouri	MO HealthNet has implemented several program practices during FFY 2022, including revising the Opioid policies to open up access to additional non-opioid products, decrease the accumulated MME allowed without prior authorization from 150 to 90 MME/day, and removing additional prior authorization burdens from the substance use disorder products. MO HealthNet expanded the requirement to receive naloxone to include additional participants who are receiving opioids and another medication that causes respiratory depression. In August of 2022 MO HealthNet implemented a limit on short acting beta agonist prescriptions to 3 inhalers per 6 months for adults in order to reduce the overuse of rescue agents and improve maintenance inhaler adherence. MO HealthNet continues to promote and see value from Project Hep Cure, the multi-agency purchasing initiative for the elimination of hepatitis c.
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 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

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	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, 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 work with stakeholders and provide educational presentations at various Montana conferences when opportunities arise. An educational brochure for CPS Workers, Foster Parents and children, and psychotropic medication education packet for foster parents has been developed. Various successes have been realized; including increased laboratory monitoring and appropriate indication for atypical antipsychotic medication, medication dose decrease

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	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. 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 have 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) 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

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	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	Division of Medicaid and Long-Term Care continues to develop the Population Health unit that incorporates all claims review with medication utilization to identify gaps in care for chronic diseases. Dashboards were in development during the FFY covered by this survey that will help to identify opportunities for intervention to close those gaps in care and optimize medication therapy. The pharmacy unit partners with health services (physical health, ancillary services and long-term care services) to create a multi-disciplinary team that identifies high-risk patient populations. The multi-disciplinary team engages with the Division of Behavioral Health and the Division of Public Health to work with community stakeholders on health care programs that are holistic and optimize clinical interventions focused on health outcomes and effective and efficient use of health care resources, including medication spend.
Nevada	As of 7/1/22, Nevada Medicaid has incorporated an automated prior authorization (PA) system for certain drugs. This allows for real-time approval of the PA upon submission of the claim from the pharmacy if the necessary clinical information (such as prescriber specialty code, medication history, diagnosis codes) is on-file or submitted with the claim.
New Hampshire	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 FFS Medicaid accessed MCO Align, a dynamic reporting tool, to review compliance with the single PDL and trending over time across the 3 managed care organizations in NH. New Hampshire FFS Medicaid program continuously monitors Hepatitis C medication guidelines and recommendations. In FFY 2022, coverage without prior authorization was expanded to treatment naive members accessing a preferred drug administered through an automated PA at POS. Specialty medications for oncology and HIV are covered without

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	restriction but are monitored for potential cost saving initiatives. New Hampshire Medicaid supports the treatment of chronic obesity through weight management pharmacotherapy options on the Preferred Drug List (PDL) and through clinical criteria. In order to prevent stockpiling of medications, NH updated the refill allowance to include an accumulation edit limiting the refill tolerance to an addition 15 days supply over the preceding 180 days. In a continued effort to address the opioid epidemic, quantity limits were added to long-acting opioid medications to align with FDA package labeling. The prescriber may request an override for the quantity limit if clinically warranted. The cumulative MME program and additional clinical PA for long-acting opioids remains in effect. All claims for members over a cumulative MME of 100 require prior authorization for any opioid and long-acting opioids require an additional prior authorization. Additional drug-to-drug ProDUR edits have been implemented for concurrent benzodiazepines and long-acting opioids and also concurrent sedative hypnotics and long-acting opioids. These edits allow a pharmacist to override the first 2 overlapping fills but will require a prescriber prior authorization for continuation beyond 60 days. Continuous monitoring of members who exceed the MME limit is conducted and reviewed at each monthly meeting with the PBA. NH also implemented an automated PA to review the age of the member with a claim for a codeine containing drug for pain management. There are restrictions on members < 12 years of age and the ability to access codeine after clinical review for adolescents 12 to 18 years of age. 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. NDCs for buprenorphine-containing medications that are not eligible for rebate are available through prior authorization. In FFY 2022, New Hampshire covered COVID-19 vaccines through point of sale for all Medicaid eligible beneficiaries. Adjustments were made in response to federal guidance for incentive fees, vaccine dosing intervals for various patient factors including additional and booster doses, and expanded age recommendations. Additionally, coverage of COVID-19 treatments and symptom management drugs required active management due to changes throughout FFY 2022. In addition to supporting the vaccination efforts during the pandemic, NH Medicaid also covered 8 over-the-counter COVID home testing kits every 30 days for all Medicaid eligible beneficiaries at no cost.
New Jersey	In FFY 22, 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) implemented its Morphine Milligram Equivalency (MME) protocol in October 2018 consisting of a MME daily dosage not to exceed 50 MME for an opioid naive member and a MME daily dosage not to exceed 120 MMEs for an opioid tolerant member. In January 2021, the Division adjusted its MME protocol for an opioid tolerant member not to exceed 90 MMEs. Exclusions from the protocol continued to include members diagnosed with cancer or sickle cell anemia, as well as hospice members and those members

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	receiving palliative end of life care. The protocol also requires prior authorization for the concomitant use of opioids and benzodiazepines. The Division adopted additional National Council for Prescription Drug Program (NCPDP) Telecommunication Standards which included enhanced prospective monitoring of a prescription's dispensing status (partial vs. complete), the prescription quantity intended to be dispensed, the fill number for schedule II drugs, the date written for schedule II - V drugs, and the quantity filled and prescribed for schedule II drugs. In addition, the Division implemented system changes in response to pharmacy claims for a Schedule II-V controlled drug being denied payment when a prescription written date was greater than thirty (30) days prior to the current claim service date for the controlled drug. Due to prescribing practices that allow Schedule II-V prescriptions with the same prescription written date to be dispensed with a future dispense date(s) that may exceed the 30-day dispensing rule, claim payments for these controlled drugs were being inappropriately denied. To accommodate this issue, the Division requested that pharmacies report the Submissions Clarification Code (SCC) value of 10 in the NCPDP field 414-DE. In response to the needs of the Public Health Emergency, the Division made available reimbursement for Pharmacist-Administered SARS-CoV-2 Vaccine Immunizations and at-home SARS-CoV2 test kits. In addition, the Division adopted changes to the claims processing system to recognize pharmacies as independent laboratories to allow pharmacies to receive reimbursement for COVID-19 Specimen Collection and Testing. In FFY22, DMAHS continued to perform retrospective DUR activities including: - Confirmation of a HIV diagnosis - Confirmation of diabetes compliance - Claims exceeding $4000 to monitor FWA/duplication of therapy - Concurrent utilization of opioids/benzodiazepines - Concurrent utilization of opioids/antipsychotics - Prescription thresholds claim reviews
New Mexico	No new innovative practices were implemented in the DUR program to improve the administration of the DUR program, appropriateness of prescription drug uses, or help control costs for FFY 2022.
New York	As part of an administrative budget initiative, uniform clinical standards for coverage of Physician/Practitioner-Administered Drugs (PADs) are being developed to modernize the process for the review of drugs covered under the medical benefit. Clinical criteria for PADs may be established through actions of the DUR board and subsequent approval by the Commissioner of Health. https://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2022/07/attachment.pdf Beginning April 1, 2023, all Medicaid members enrolled in Mainstream Managed Care will receive their prescription drugs through NYRx, the Medicaid Pharmacy Program. NYRx allows New York State to pay pharmacies directly for the drugs and supplies of Medicaid members. Prior to April 1, 2023, Mainstream Medicaid members accessed their pharmacy benefits through a health plan, rather than Medicaid Fee-For Service (NYRx). This includes anyone in Managed Care (MC) plans, Health and Recovery Plans (HARPs) and HIV Special

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	Needs Plans (HIV-SNPs). In this case, the State reimburses the health plan rather than the pharmacy. Moving all Medicaid members under the NYRx Program allows for a single, uniform list of covered drugs and standardized, consistent rules and regulations. Thus, New York State is able to offer an improved, simplified process for Medicaid members to get the medicines and supplies they need. Medicaid members have comprehensive drug coverage and equitable access to an extensive network of over 5,000 pharmacy providers. High Cost Drug initiative which allows the negotiation for supplemental rebates across the fee-for-service and managed care populations on newly launched drugs meeting certain criteria: 1) a brand name drug or biologic that has a launch wholesale acquisition cost of thirty thousand dollars or more per year or course of treatment, or 2) a biosimilar drug that has a launch wholesale acquisition cost that is not at least fifteen percent lower than the referenced brand biologic at the time the biosimilar is launched, or 3) a generic drug that has a wholesale acquisition cost of one hundred dollars or more for a thirty day supply or recommended dosage approved for labeling by the federal Food and Drug Administration, or 4) a brand name drug or biologic that has a wholesale acquisition cost increase of three thousand dollars or more in any twelve-month period, or course of treatment if less than twelve months. CMS has authorized the State of New York to enter into outcomes-based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries. These contracts will be executed on the contract template titled 'Outcome-Based Supplemental Rebate Agreement' submitted to CMS and authorized for use beginning April 1, 2022. Effective April 1, 2022, for New York State (NYS) Medicaid is reimbursing providers for pediatric vaccine counseling visits as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program when provided to Medicaid members ages 18 years of age or younger. Vaccine counseling visits align with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP).
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. 9th Amendment to the Public Readiness and Emergency Preparedness (PREP) Act Effective Sept. 13, 2021 the NC DHHS issued a NC State Health Director's Statewide Standing Order for Subcutaneous Administration of Casirivimab/Imdevimab (REGEN-COV) Monoclonal Antibodies to meet the goal of the 9th Amendment to the PREP Act. This standing order authorizes any NC Medicaid licensed pharmacist to order and administer REGEN-COV and for pharmacy technicians/interns to administer it, in accordance with the conditions of their licensure and/or scope of practice to include subcutaneous injections. Prior Approval for Stromectol (ivermectin) tablets Ivermectin is a U.S. FDA-approved prescription medication used to treat certain infections caused by internal and external parasites. When used as prescribed for approved indications, it is generally safe and well tolerated. During the COVID-19 pandemic, ivermectin dispensing by retail pharmacies has increased, as has use of veterinary formulations available over the counter but not intended for human use. FDA has cautioned about the potential risks of use for prevention or treatment of COVID-19. Ivermectin is not authorized or approved by FDA for prevention or treatment of COVID-19.

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	To ensure appropriate use, effective Sept. 10, 2021, North Carolina Medicaid will require prior approval for Stromectol (ivermectin) tablets. Long Acting Injectable (LAI) Medications Effective Oct. 1, 2021, Session Law 2021 - 110 House Bill 96 authorizes immunizing pharmacists to administer Long Acting Injectable (LAI) medications to persons at least 18 years of age pursuant to a specific prescription order initiated by a prescriber. Usage of Preferred Brands North Carolina Medicaid utilizes a preferred drug list (PDL) and encourages use of generics whenever possible. There are a few exceptions on the PDL where a branded product is preferred and the generic equivalent is non-preferred. A list of these products is published in the monthly pharmacy newsletters. Attention: Physicians, Nurse Practitioners, Physician Assistants, and Pharmacists Booster Dose of Moderna and Janssen COVID-19 Vaccine On Oct. 20, 2021, the Federal Drug Administration (FDA) recommended for individuals who received a Pfizer-BioNTech or Moderna COVID-19 vaccine, in the following groups, are eligible for a booster shot at 6 months or more after their initial series. Attention: Physicians, Physician's Assistants, Nurse Practitioners, and Pharmacists PFIZER PEDIATRIC COVID-19 Vaccine HCPCS code 91307: Billing Guidelines Pfizer PEDIATRIC COVID-19 vaccine is authorized for use under an Emergency Use Authorization (EUA) for active immunization to prevent coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in individuals 5 year through 11 years of age and older. Booster Dose of Moderna and Pfizer COVID -19 Vaccine for all Adults (including information about Janssen) The Food and Drug Administration and the Advisory Committee on Immunization Practices authorized COVID-19 boosters for all adults (18 years of age and older) at least six months after initial shots with the Moderna or Pfizer-BioNTech COVID-19 vaccines on Nov 19, 2021. Change in Age for Pfizer-BioNTech COVID-19 Booster Vaccine On Dec 9, 2021, the U.S. Food and Drug Administration amended the emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 vaccine, authorizing the use of a single booster dose for administration to individuals 16 and 17 years of age at least six months after completion of primary vaccination with the Pfizer-BioNTech COVID-19 Vaccine. Attention: Physicians, Physician's Assistants, and Nurse Practitioners COVID-19 MONOCLONAL ANTIBODIES - An Update to Minimum Age for HCPCS Code Q0245 - Bamlanivimab and Etesevimab, for Intravenous Infusion On Dec 3, 2021 the U.S. Food and Drug Administration revised the emergency use authorization (EUA) of bamlanivimab and etesevimab, to additionally authorize bamlanivimab and etesevimab administered together for the treatment of mild to moderate COVID-19 in all younger pediatric patients, including newborns, who have a positive COVID-19 test and are at high risk for progression to severe COVID-19, including hospitalization or death. This revision also authorizes bamlanivimab and etesevimab, to be administered together, for post-exposure prophylaxis for prevention of COVID-19 in all pediatric patients, including newborns, at high risk of progression to severe COVID-19, including hospitalization or death. OTC COVID-19 Tests for Home Use Effective Jan. 10, 2022, NC Medicaid enrolled pharmacy providers may bill POS for FDA approved OTC COVID-19 tests dispensed for use by NC Medicaid beneficiaries in a home

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	setting. The test can be dispensed with or without a prescription issued by an active NC Medicaid enrolled provider. The implementation date for POS claims submission is Jan. 10, 2022, for NC Medicaid Direct. Attention: Clinical Pharmacist Practitioners Billing Information for Continuous Glucose Monitoring for CPPs Effective Feb. 1, 2022, Clinical Pharmacist Practitioner (CPP) taxonomy code 1835P0018X will be allowed to bill and be reimbursed for: -CPT code 95249 - Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training and printout of recording. -CPT code 95250 - Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording. SPECIAL BULLETIN COVID-19 #216: Pharmacies Will Cover Oral Tablets (Paxlovid and Molnupiravir) Oral tablets covered for those in a home setting Effective Jan. 1, 2022, NC Medicaid-enrolled pharmacies may bill for FDA/EUA-approved COVID-19 oral tablets (Paxlovid and/or Molnupiravir) dispensed for use to NC Medicaid beneficiaries in a home setting. Synagis Coverage Season Ends March 31, 2022 The NC Medicaid coverage season for Synagis will end March 31, 2022. Pharmacy providers should not submit point of sale claims with date of service after March 31, 2022, for any prior authorization granted during the eight month extended coverage season from Aug. 15, 2021, to March 31, 2022. Second Booster Dose Authorization for Pfizer-BioNTech COVID-19 and Moderna COVID-19 Vaccine On March 29, 2022, the Food and Drug Administration approved a second booster dose of the Pfizer-BioNTech COVID-19 and Moderna COVID-19 Vaccine. SPECIAL BULLETIN COVID-19 #249: Pfizer-BioNTech Vaccine Booster Dose for Children Age 5 through 11 Effective May 19, 2022, Medicaid and NC Health Choice will cover the use of a single booster dose for administration to children age 5 through 11 at least five months after completion of a primary series with the Pfizer Pediatric COVID-19 Vaccine. SPECIAL BULLETIN COVID-19 #254: Pfizer-BioNTech COVID-19 Vaccine: Primary Series for Children Ages 6 Months to Under 5 Years Effective June 18, 2022, North Carolina Medicaid and NC Health Choice will cover the administration of the primary series of the Pfizer-BioNTech COVID-19 pediatric vaccine for administration to children ages 6 months to under 5 years. The Pfizer-BioNTech COVID-19 Vaccine is a preservative-free suspension for injection in a multiple dose vial. It is administered intramuscularly as a single dose (0.2 mL). See full prescribing information for further detail. The Pfizer-BioNTech COVID-19 Vaccine is administered as a primary series of three doses in which the initial two doses are administered three weeks apart followed by a third dose administered at least eight weeks after the second dose in individuals ages 6 months to under 5 years. SPECIAL BULLETIN COVID-19 #257: Moderna Pediatric Vaccine Primary Series for Children Ages 6 Through 11 Years

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	Effective June 24, 2022, NC Medicaid and NC Health Choice will cover the administration of the primary series of the Moderna COVID-19 pediatric vaccine for administration to children ages 6 through 11 years. The Statewide Standing Order (SWSO) FDA EUA Moderna for ages 6 through 11 and Moderna ages 12 and older are now published online and available. Influenza Vaccine and Reimbursement Guidelines for 2022-2023 for NC Medicaid and NC Health Choice Vaccine strains for the 2022-2023 influenza vaccines were selected by the FDA's Vaccines and Related Biologic Products Advisory Committee, based on the World Health Organization's recommended Northern Hemisphere 2022-2023 influenza vaccine composition. ProAir Manufacturer Discontinuation On Oct. 1, 2022, ProAir HFA inhalation aerosol was discontinued by the manufacturer. Ventolin HFA shifted from non-preferred to preferred on the preferred Drug List (PDL) effective Sept. 23, 2022. SPECIAL BULLETIN COVID-19 #264: Pfizer & Moderna Bivalent COVID-19 Booster Vaccines Effective with date of service Aug. 31, 2022, the NC Medicaid and NC Health Choice programs cover Pfizer-BioNTech COVID-19 Vaccine, Bivalent (Original and Omicron BA.4/BA.5) - 12 years of age and older (N/A) for use in the Physician Administered Drug Program (PADP). Attention: Physicians, Physician's Assistants, and Nurse Practitioners Monkeypox Vaccine (Jynneos) HCPCS code 90611: Billing Guidelines Effective Oct. 3, 2022 the Medicaid and NC Health Choice programs cover monkeypox vaccine, live, non-replicating suspension for subcutaneous and intradermal injection (Jynneos) for use in the Physician Administered Drug Program (PADP).
North Dakota	Prior authorization with clinical and step criteria were implemented on J-codes. The J-code criteria is listed on the same PDL as pharmacy dispensed drugs. A data-driven season was implemented for Synagis coverage rather than a date-driven season to match Synagis coverage at the time RSV is circulating in our region. System changes were implemented to define utilization for 351-NP and 338-5C to ensure the correct copayment was being reported to ND Medicaid. Pharmacists are able to enroll as providers and provide various medical services within their scope of practice and guidance for doing so is posted on the State website.
Ohio	Four new therapeutic categories were added to the Unified Preferred Drug List (UPDL) throughout 2022: Gastrointestinal Agents: Hepatic Encephalopathy; Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea; Gastrointestinal Agents: Unspecified GI; Dermatological: Oral Acne Products. Discontinued Submission Clarification Code (SCC) 13 Effective 11/19/2021, ODM discontinued the use of Submission Clarification Code (13) in NCPDP vD.0 field 420-DK (Submission Clarification Code) for members who were allowed early refills of prescriptions in response to the COVID-19 emergency when claims reject with NCPDP Reject 79 (Refill Too Soon). COVID-19 Vaccine ODM's pharmacy program additionally drove innovation by reimbursing Medicaid participating pharmacies an administration fee for a third/additional dose of COVID-19 vaccine to eligible members when medically necessary, the bivalent COVID booster vaccines, the prescribing of Paxlovid by pharmacists as outlined under its emergency use authorization (EUA), and COVID-19 home diagnostic tests without a prescription for up to a quantity of 8 tests per member in a 30-day period. Expanded Access to Continuous Glucose Monitoring Systems Effective July 1, 2021, ODM lifted prior authorization requirements on continuous glucose

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	monitoring systems. Early Synagis Access In response to an increase in summer Respiratory syncytial virus (RSV) activity, ODM initiated the start of an atypical Synagis season effective August 25, 2022. Doses given during the atypical season did not count towards the five doses of Synagis allowed on or after November 1, 2022. Hepatitis C Prior Authorization Requirement Changes ODM lifted the specialist consultation requirement for Hepatitis C therapy in January 2022, with the exception of complicated cases in which referral to a specialist should take place. Expanded Access to MAT ODM removed Sublocade prior authorization requirements in April 2022 to allow prescribers to initiate immediate treatment to eligible patients as soon as possible. In an effort to further increase access to care, ODM removed prior authorization requirements on sublingual buprenorphine products in July, replacing them with a safety edit for buprenorphine doses greater than 24mg per day. Next Generation The Next Generation of Managed Care Medicaid program launched on July 1st, 2022, with the start of OhioRISE (Resilience through Integrated Systems and Excellence), a coordinated care program for children with complex behavioral health needs. Ohio Department of Medicaid worked in FFY 2022 to design, develop, and implement a Single Pharmacy Benefit Manager (SPBM) that would go live October 1st, 2022, providing pharmacy services across all managed care plans and members. ODM worked with its Pharmacy Pricing and Audit Consultant (PPAC) to develop the Ohio Average Acquisition Cost (OAAC) survey. Rates developed by this survey will be used to determine pharmacy reimbursement. Specialty Drug List Ohio Department of Medicaid worked with its Pharmacy Pricing and Audit Consultant (PPAC) to develop a specialty drug list. The specialty drug list will ensure that medications requiring more complex dispensing and monitoring requirements will be filled at specialty credentialed pharmacies and that a specialty dispensing fee will be applied to appropriately reimburse these pharmacies. State of Ohio Board of Pharmacy OARRS 2021 Annual Report The State of Ohio Board of Pharmacy OARRS 2021 Annual Report was published. ODM created reporting to understand changes in Ohio Medicaid Fee-For-Service's average prescribing for number of solid opioid doses dispensed, opioid prescriptions dispensed, benzodiazepine solid doses dispensed, and benzodiazepine prescriptions dispensed compared to Ohio as a whole.
Oklahoma	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. 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

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	Attention-deficit/hyperactivity disorder (ADHD), use of atypical antipsychotic medications, antibiotic (ABX) usage, asthma, and most recently, type 1 diabetes mellitus (T1DM). Data from SoonerCare paid claims and member diagnoses were used to identify providers who stood to benefit from receiving AD services. Paid claims and diagnosis data for pediatric members were compared across the following criteria, with Diabetes Mellitus-AD (DM-AD) offered to SoonerCare providers meeting 3 or more of the following criteria: 1. Having greater than or equal to 50% increase in the number of DM claims from 2020 to 2021 2. Having greater than or equal to 50% increase in the number of claims for any DM medication from 2020 to 2021 3. Having hospital claims for any member with a diagnosis of diabetes during 2020 or 2021 4. Having >100 members in their practice with claims for any DM medication (excluding specialty providers) 5. Having greater than or equal to 50% more DM claims than their same specialty peers (e.g., general practitioner, physician assistant) 6. Having greater than or equal to 50% more claims for any DM medication than their same specialty peers (e.g., general practitioner, physician assistant) Providers received education focusing on the most recent guideline updates. Guidelines recommend assessing the following as they impact treatment decisions: - Food security - Housing stability/homelessness - Health literacy - Financial barriers - Social/community support - Use of real time continuous glucose monitors (CGMs) - Time-specific use of other CGM metrics - Specific amounts and types of physical activity - Management of new-onset diabetes in youth who are overweight or obese Changes and reinforced messaging from these guidelines served as the source material for the most recent AD topic. The College of Pharmacy analyzed Oklahoma SoonerCare claims during a nine-month pre- and post-AD period to investigate resultant health care utilization. Collected data for FFY 2022 focused on diabetes related and all-cause hospitalizations and emergency department admissions. During FFY 2022, 44 providers received T1DM-AD visits, and the program impacted 231 members. During FFY 2022, T1DM-AD resulted in total savings of $408,207. 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. Academic Detailing Analysis Summary Providers continue to express a high degree of satisfaction with the AD program as evidenced by cumulative satisfaction survey results. More than 95% of providers describe the program as easily understood, clearly presented, and evidence-based. When asked

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	about the impact on their practice, more than 83% 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 and associated reductions in hospital and ED utilization, further program materials for additional drug categories will be created with more providers being reached.
Oregon	The Oregon Medicaid P&T Committee recommended development of an educational retrospective DUR program to improve provider knowledge of PrEP for patients with a recent sexually transmitted infection, diagnosis of high-risk sexual behavior, or potential viral exposure and an informational newsletter was published in December 2021 entitled "A PEP Talk on PrEP-ing for HIV Prevention". The Committee recommended updating the Respiratory Syncytial Virus PA criteria to correlate with State guidance on season onset. The Committee recommended implementing PA criteria to allow for emergency drug coverage of drugs prescribed for the newly covered Citizenship Waived Medical (CWM) population and supported updating the PA criteria with relevant diagnoses if emergency drug coverage is expanded to other conditions in the future. The Committee recommended updating the "Non-Preferred Drugs in Select PDL Classes" and "Drugs for Non-Funded Conditions" prior authorization criteria as to align with the final version of Statement of Intent 4 (SOI4) from the Health Evidence Review Commission's Prioritized List of Health Services which included consideration of a child's individual circumstances and to provide coverage of the unfunded service when it is determined that it would improve the child's ability to grow, develop or participate in school - consistent with federal requirements for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The Committee recommended removing the PA requirement for preferred intranasal allergy products for children up to their 21st birthday. The Committee recommended removing PA criteria and required case management for preferred DAA regimens for treatment-naive patients with hepatitis C virus. The Committee recommended: continue monitoring for the use of combination therapies; evaluate any changes in drug-use trends over time; and consider provider education about the need for appropriate treatment of mental health disorders in those with ADHD. Based on guidance from and treatment algorithms developed by the Mental Health Clinical Advisory Group (MHCAG) the P&T Committee recommended updating PA criteria to facilitate benzodiazepine tapers. A provider education initiative took effect on July 1, 2022, with faxes being sent to providers notifying them when children aged 5 and under encounter a denied PA for an antipsychotic. Oregon Medicaid renegotiated the sole-source contract with our Hemophilia Treatment Center (HTC) which helps promote accurate dosing, minimizes waste with factor products, and provides funds to support wrap-around services for patients with hemophilia.
Pennsylvania	The Pharmacy & Therapeutics Committee met in September 2022 and reviewed the prior authorization guidelines for Hepatitis C agents. Revisions to the prior authorization guidelines were subsequently implemented to streamline the prior authorization process, limiting guidelines to those aimed at ensuring approval of the appropriate drug, dose, and duration for beneficiaries' clinical situations. The goal of the prior authorization is to approve requests for Hepatitis C Agents and address quality of care concerns when the incorrect drug/duration is prescribed. The use of a standardized prior authorization request fax form for Hepatitis C Agents was also implemented by Fee-for-Service (FFS) and all of the managed care organizations (MCOs). The goal of this form was to improve

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	efficiency for providers by identifying the necessary information for prior authorization and utilizing a standard form for all Medical Assistance payers.
Rhode Island	Retrospective DUR Innovative Practices Established during FFY 2021 During FFY 2021, targeted and specialty mailings for the FFS population included concurrent use of benzodiazepines and opiates, patients receiving > 90 morphine milligram equivalents (MME) per day, stimulants exceeding the maximum recommended dose, patients receiving chronic opioid therapy without a naloxone prescription, use of opioid induced constipation medications without appropriate need, and tramadol utilization criteria. Additionally, during FFY 2021, the DUR Board tracked naloxone utilization, HIV medication utilization, newer movement disorder/Tardive Dyskinesia medication utilization, SGLT-2 and GLP-1 medication utilization for diabetes versus cardiovascular disorder, and chronic proton pump inhibitor (PPI) utilization without appropriate diagnosis. Other quarterly topics that were discussed included high volume prescribers of controlled substances, short and long acting opioid utilization, and atypical antipsychotic use under the indicated age in the pediatric population. It should be noted that early during FFY 2021, the Board requested to review concurrent anxiolytics/sedative hypnotics and atypical antipsychotic use in patients less than 18 years of age. Criteria was created and reviewed against the RI FFS Medicaid population and did not identify any recipients between October 2020 and March 2021.
South Carolina	The traditional 'Synagis season' (Oct-March) was expanded to accommodate interseasonal doses of palivizumab (Synagis) to align with AAP recommendations and HPV vaccination via pharmacy (and medical) for ages >/=19 to </=26. The State began review/drafting Hepatitis C (HCV) prior authorization form/criteria for potential revisions to align with AASLD (American Association for the The Study of Liver Diseases) guidance. The South Carolina Department of Health and Human Services (SCDHHS) is formally launched its school-based mental health services initiative effective July 1, 2022. The SCDHHS policy changes announced in this bulletin are consistent with the recommendations made by SCDHHS to improve access to school-based mental health services for children across the State. Maximum Age for MCCW (Medically Complex Childrens Waiver) Participation Increased to Age twenty-one. The change in maximum age allows current participants meeting MCCW eligibility criteria to receive services through age twenty-one, previously the age range for eligibility was zero to eighteen years. Increasing the maximum age allows for continuity of care during the transition from pediatric to adult care systems and aligns with State plan services such as children's personal care and children's private duty nursing that are available up to age 21 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.
South Dakota	IHS outpatient prescription claims process through the POS allowing for DUR functions on these claims.
Tennessee	Tenncare and OptumRx implemented a non-clinical performance improvement plan that that sought to decrease the delay of member access to their prescribed preferred atypical antipsychotics (AP) by increasing prescriber and pharmacy awareness (with targeted provider communications) of the option to use diagnosis code overrides which processes

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	immediately at point of sale (POS) rather than following the standard clinical PA process which takes up to 72 hours. Study participants included enrollees with at least one claim for a preferred atypical AP and a diagnosis with an applicable ICD-10 code as identified by TennCare. The performance measure was defined as the total percentage of all preferred atypical AP claims that processed with an appropriate diagnosis code override for the baseline year (6.06%) and the remeasurement years, with a goal of 12%. Based on our results, we found that immediately following each intervention, utilization of the diagnosis code override peaked briefly, before beginning another decline without the level returning to baseline. Despite these increases, the intervention was not successful at achieving the overall goal of 12% at the conclusion of remeasurement year 2021 (6.64%). A statistical test and p-value assessment were conducted and found the p value to be <0.05 (0.0000339414), which demonstrates that the provider education interventions deployed had a statistically significant impact on the diagnosis code utilization from the baseline to the remeasurement Year even though the overall goal was not met. Our strategy for the next remeasurement year is to increase the frequency of provider communications due to the observed peak in diagnosis code overrides following each provider educational.
Texas	1. The antipsychotic prior authorization was automated in Texas Medicaid, fee-for-service and managed care. 2. In December 2021, Texas conducted a competitive procurement and issued a Request for Proposals (RFP) seeking a pharmaceutical manufacturer, through a Value Based Rebate Subscription Model, to provide an unlimited supply of one DAA medication to improve awareness, screening, diagnosis, and treatment of the Hepatitis C Virus for Texas Medicaid clients.
Utah	Beginning July 1, 2022, the UT Medicaid and our ACO partners begin to reimburse for Medication Therapy Management (MTM) services, which pharmacists provide to adults and children at outpatient pharmacies. The initial 15 minutes for new patients is reimbursed for $53.48 or $32.94 for established patients, and $16.68 for each additional 15 minutes of service. The program requires members to be Medicaid eligible and enrolled, that the assessment is performed face to face, that the member is not eligible for Medicare part D, and that the member is taking three or more medications to prevent one or more chronic conditions. In addition to the new MTM reimbursement to outpatient pharmacists, the Utah Medicaid Pharmacy Program continued to deliver impactful results with the continued peer-to-peer programs, and the medication adherence program that were started in 2019 and 2020: The Pharmacy Team continued the “antipsychotics in children” peer-to-peer intervention from 2019 to monitor and manage antipsychotic medications prescribed to members 19 years of age and younger. The number of children under 6 years of age receiving antipsychotics decreased from 16 in October 2019 to 1 in September 2022. The number of children on more than one antipsychotic declined from 16 children to 1 child, and the number of children on high dose antipsychotics (including exceeding literature

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	recommendations) reduced from 61 to 39 children in this same period. Regarding the metabolic screening, in all children (foster and non-foster) receiving antipsychotics from October 2019 to September 2022, the rate of metabolic screening increased from 22% to 27% in 2021, and to 22% by 2022, with higher rates of 35% in foster kids. Beginning in May 2021, the UT Medicaid Pharmacy Team contracted with the University of Utah Department of Pediatrics (UPP) to provide consultation on certain members' cases and situations to ensure children served by UT Medicaid receive appropriate evidence-based mental health and medication therapy. The collaboration's goal is to align Medicaid's pediatric mental health care with all necessary consultation, oversight, and review as per UT Medicaid, Division of Child and Family Services, the federal SUPPORT Act, and other policies, procedures, rules, and guidance. Continued from January 2020, the UT Medicaid Pharmacy Team provided education and encouragement to prescribers with Medicaid members on concurrent use of an opioid and a benzodiazepine without naloxone. The baseline concurrent use for Medicaid Fee for Service (FFS) members is 15.38%, with 3.56% of these being prescribed naloxone. There was improvement at the end of September 2022: FFS members with concurrent use decreased to 14.9%, and 3.8% of these were prescribed naloxone. Continuing from April 1, 2020, the Hepatitis C Medication Adherence program demonstrated impactful results. In the calendar year of 2022, with 304 members enrolled in the program, the adherence rate was 84.2%, a slight decrease from 90.2% in the 2021 calendar year. The pharmacists continue to outreach to members to improve the medication adherence to hepatitis C patients. Continued from FFY 2021, the Antidepressant Medication Management outreach to non-adherent members to address and improve medication adherence . The antidepressant medication adherence rate increased from 54.1% at baseline to 57.3% for newly treated members (acute phase) while the adherence rate dipped from a baseline of 33.4% to 32.5%, for members who had been on antidepressant medication for more than 6 months (continuation phase).
Vermont	Continuous Glucose Monitors Effective 10/1/21, Continuous Glucose Monitoring (CGM) systems and supplies are available ONLY through retail pharmacy channels and no longer be accepted via DME provider channels. Prior authorization requirements that had been waived temporarily because of the COVID-19 Public Health Emergency was reinStated. Prescribers may send prescriptions electronically to the pharmacy or hand write prescriptions for patients. Claims will adjudicate in real time through the Pharmacy Point of Sale (POS) system which will allow for faster and easier access for patients. CGM Changes.pdf (vermont.gov) Blood Glucose Test Strip Quantity Limits: A review of pharmacy dispensing data identified multiple patients using a significant number of test strips, some upwards of 10 strips per day while utilizing a continuous glucose monitor. Vermont Medicaid implemented quantity limits on test strips to ensure medical necessity when more than 6 test strips per day are being dispensed. This will apply to all members regardless of concurrent CGM use. Effective 6/10/22, prior authorization is required for members using more than 200 blood glucose test strips per 30 days. https://dvha.vermont.gov/sites/dvha/files/doc_library/Blood%20Glucose%20Test%20Strip%20Qty%20Limit.pdf

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	Hypertension Management Initiative Pharmacy collaboration with the Hypertension Performance Improvement Project with a goal of improving the Scorecard Measure Controlling High Blood Pressure. You can view the current this targeted measure here https://app.resultsscorecard.com/Measure/Embed/100093207. One of the first activities the Pharmacy Unit supported was to improve access to blood pressure cuffs. This included communicating with pharmacies on how to bill a prescription for a digital blood pressure monitor as DME claim. DVHA currently allows the purchase of an automatic blood pressure (BP) monitor for the following additional diagnoses: essential hypertension, benign hypertension, nonspecific hypertension, elevated blood pressure without the diagnosis of hypertension, hypertensive heart disease without heart failure and the pregnancy related hypertension diagnoses. A prescription for the digital BP monitor, along with diagnosis is needed and claims are processed as a DME claim. We are continuing to ask pharmacies to consider stocking blood pressure monitors to fulfill potential demand that may be generated by this program. The manual sphygmomanometer/blood pressure apparatus with cuff and stethoscope will no longer be allowed for purchase. The criteria for coverage can be found on the Department of Vermont Access (DVHA) website at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment Pharmacy Care Management The Vermont Medicaid Pharmacy Care Management (PCM) program for Fiscal Year 2022, enrolled an additional 562 members to total 3,028 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 2022, the PCM program included 480 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 405 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, Vermont Medicaid PCM contacted providers (prescribers and pharmacies) via telephone or fax a total of 144 times and contacted patients via telephone 199 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 include assessment of medication possession ratio. We strive to achieve the highest treatment medication adherence to ensure maximal benefit from the treatment selected.

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	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.
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 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 continues to review 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 naive 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

State	Innovative Practices Summary
	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 today. DMAS and the DUR Board have recently started to review and monitor children taking antidepressants and mood stabilizers. DMAS will continue to monitor this for both FFS and the MCOs. 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. Moreover, DMAS is in the process of developing a Physician Administered Drugs (PADs) program which will be followed by the DUR Board. The DUR Board actively monitors new drugs to the market and evaluates the need for utilization management through Service Authorizations (SA). During FFY 2022, 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: - Myfembree (relugolix, estradiol, and norethindrone acetate) - Truseltiq (infigratinib) - Wegovy (semaglutide) - Class SA Criteria for Oral Oncology - Lung Cancer and Other Neoplasms Drugs - Class SA Criteria for Oral Oncology - Renal Cell Carcinoma and Other Neoplasms Drugs - Besremi (ropeginterferon alfa2b-njft) - Livtencity (maribavir) - Tavneos (avacopan) - Voxzogo (vosoritide) - Class SA Criteria for Oral Oncology - Hematologic Cancers and Other Neoplasms Drugs - Rezurock (belumosudil) - Vijoice (alpelisib) - Vonjo (pacritinib)

State	Innovative Practices Summary
Washington	Creation of a Specialty Drug List Washington (Apple Health) continues to develop a specialty drug list which will be used to align coverage of specialty drugs for both Fee-For-Service (FFS) and the Managed Care Organizations (MCOs). The specialty drug list includes both provider-administered and outpatient drugs. Another purpose of the specialty drug list is for reporting to internal and external stakeholders which drugs HCA classifies as specialty, specialty drugs that are limited to be dispensed to a specialty pharmacy, and how much HCA spends on specialty drugs annually. Limitation of automatic refills Starting in FFY 2021 Washington (Apple Health) limited automatic refills which continues to present day. Automatic refills are not permitted for clients enrolled in an agency contracted Apple Health Managed Care (MCO) or FFS plan. Clients must request a prescription refill before the pharmacy submits a claim and fills the prescription. An automatic refill is defined as any prescription refill the pharmacy initiates without a request from the client. The intent of implementing this policy is to prevent excessive refills, stockpiling, and to address potential adherence issues. Hepatitis C Elimination Strategy The Hepatitis C Free Washington public health effort is ongoing and Mavyret continues to be the preferred product without any prior authorization restrictions. Washington (Apple Health) continues to maintain the value-based purchasing agreement with Abbvie. All other antiretroviral Hepatitis C medications are carved out of MCO responsibility. MCOs continue to receive data from HCA which identifies patients diagnosed with Hepatitis C who have not been initiated on treatment. The data received by MCOs helps connect patients to care by MCO case managers. Designing Smart PA for future POS system Washington (Apple Health) developed Smart PA criteria and workflows which will be used with our new POS vendor. Washington (Apple Health) was able to utilize existing expedited authorization (EA) codes and translate them to smart PA workflows and process. At the point of sale, pharmacists can enter specific EA codes which will override the PA and result in a paid claim. Embedding EA codes in the smart PA workflows and processes allow Washington (Apple Health) the ability to still implement drug utilization management strategies while also allowing access to care for patients who meet the specified criteria and urgently need medications. Developing smart PA criteria also allows HCA to streamline PA processes and differentiate between drugs that require a full clinician review or utilize system edits that can pull diagnosis and perform retrospective claims reviews to evaluate PAs.
West Virginia	We noticed that we had a few inconsistencies between our PDL and our claims system. So we had our PDL vendor work with our claims processor to do a PDL sync and cleanup. New to our PDL: Added: contraceptive classes and VMAT inhibitors Significant Prior Authorization Changes:

State	Innovative Practices Summary
	Hep C PA- relaxed criteria by removing sobriety and removal of specialist requirement for treatment naive patients. Testosterone PA - Streamlined Testosterone PA but added PA to the topical products Vyvanse- was moved to NP status and prior to the change sent out lots of communications (faxblasts, mailing to Vyvanse prescribers). However we received pushback after school year end (which is when it's expected to transition to preferred product). We re-evaluated this and worked with the DUR Board to change criteria to allow for grandfathering. Sumatriptan injection- PA removal Celecoxib- PA removal Adjusted PDL to deal with shortages (mainly with albuterol) - ProAir and Ventolin are already preferred therefore added Proventil to the preferred side. Plans in place for future shortages. New iPAs created: GLPs Vyvanse New warning edits 7375 - Exceeds 5 Opioid Claim in 30 Days 7386 - UNSAFE COMBO(OPIATE+BENZO+MUSC REL)
Wisconsin	Attachment 6 - Innovative Practices Intervention to Address Dental Providers Prescribing Opioids The Wisconsin Drug Utilization Review Board initiated a retrospective letter intervention targeting dental providers who prescribe opioids to children and adults. The intervention was originally developed in 2017 and has been modified several times since then. The original criteria focused on children under the age 18 with more than 10 pills of opioids in a six-month period. Two mailings occurred using the original criteria, once in December 2017 to 128 dental prescribers and once in September 2018 to 30 dental prescribers. Of note, the 2018 letter only focused on prescribers who were not previously identified as part of the 2017 mailing. Post intervention data analysis demonstrated a reduction in total number of members and prescribers identified as meeting criteria. Timeframe April-Sept 2017 Jan-June 2018 Number of Prescribers 128 98 (30 new)* Total Members 1,001 544 Letter Sent December 2017 September 2018 The intervention was revised in 2021 to include both adults and children aged eighteen years or younger. The criteria were modified to include all dental prescribers who had five or more members receiving more than 10 opioid pills from the dental prescriber in a six-month period. Two letters were developed, one for children and another for adults. In October 2021, 164 letters were sent dental prescribers who met criteria. A post intervention analysis conducted six months after the letter was sent showed a decline in total prescribers and total members (both adult and children) who met criteria. Post intervention data analysis demonstrated a reduction in total number of members and prescribers identified as meeting criteria.

State	Innovative Practices Summary

Timeframe	April-Sept 2021	Oct 2021- Mar 2022
Total Prescribers	164	150
Number of Total Members	4,020	3,238
Number of Children	312	225
Letter Sent	October 2021	NA

The dental intervention was revised a third time in August 2022 based on input from the Wisconsin Drug Utilization Board. Two updated criteria were used to identify members. One criterion identified prescribers who had three or more members under the age of 16 who received more than 10 opioid pills in a six-month period. The other criterion identified prescribers who had three or more members 16 years of age or older who received 12 or more opioid pills in a six-month period. Updated intervention letters were created by the State dental consultant. Letters were sent to 107 total dental prescribers in August 2022. Additional impact analysis of these interventions is scheduled for future board meetings.

Timeframe	Jan-June 2022
Total Prescribers	107
Number of Total Members	1,483
Number of Children	37
Letter Sent	August 2022

Naloxone Intervention

To address requirements of the SUPPORT Act, the Wisconsin Drug Utilization Board implemented retrospective intervention letters targeting high risk members who may benefit from receiving naloxone. Prescribers were identified for letters if they had a member who either: 1) Had a 30-days' supply of an opioid and an opioid or benzodiazepine poisoning diagnosis. 2) Had a 90 days' supply of an opioid and an opioid dependency diagnosis. The initial run of letters was sent in March 2021 and monthly thereafter. A review of naloxone data was conducted to evaluate overall trends in naloxone utilization, and impact of the intervention letters on naloxone utilization. The data demonstrated a significant increase (85%) in naloxone prescribing between the fourth quarter of 2020 (quarter prior to sending letter) to second quarter 2022. Additional data was pulled to evaluate opioid utilization for members taking naloxone. Analysis post intervention data indicated 245 members who met the intervention criteria, and their prescriber received a letter between March 2021 to December 2021. Approximately 50% of the identified members filled naloxone at least one time by the end of first quarter 2023. Naloxone intervention letters have continued to be sent monthly.

Adult Sedative Hypnotic and Benzodiazepine Intervention

The Wisconsin Drug Utilization Review Board initiated a retrospective letter intervention to address the overuse of sedative hypnotics and benzodiazepines. Members nineteen years or older receiving at least two hundred days' supply of sedative hypnotics and/or benzodiazepines in a three-month period were identified for the intervention. A total of 563 total members were identified. A targeted intervention letter was developed and signed by the Wisconsin Medicaid child psychiatry consultant. The letter informed prescribers of the risks associated with polypharmacy of CNS depressants. The letter was sent to prescribers involved in the prescribing of sedative hypnotics and/or

State	Innovative Practices Summary
	benzodiazepines in December of 2021. An impact analysis of the intervention may be reviewed at a future Board meeting. Polypharmacy Children's Multiple Sedative Hypnotic Intervention The Wisconsin Drug Utilization Review Board initiated a retrospective phone call/letter intervention to address polypharmacy of sedating medications in children. An initial list of CNS depressant drugs was developed with input from the Wisconsin Medicaid child psychiatry consultant. Drug groups included: sedative hypnotics, benzodiazepines, certain antipsychotics (quetiapine and olanzapine), melatonin, certain antidepressants (mirtazapine, trazodone, and tricyclics), certain antihistamines (hydroxyzine and diphenhydramine). Members 18 years of age and younger taking drugs in three or more of the sedating drug groups in a 90-day period were identified. A total of 55 members met those criteria. Exploratory peer to peer phone calls were conducted by the Wisconsin Medicaid child psychiatry consultant on six select cases to evaluate the scope of this issue. Discussions revealed that many prescribers were utilizing sedating medications to treat multiple conditions and improve sleep. Polypharmacy was more common with treatment resistant mood and anxiety disorders for which polypharmacy can be considered standard of care in complex cases. It was also determined that polypharmacy is more likely to occur in cases where multiple prescribers are involved. After the exploratory phone calls were conducted, the drug list was expanded and modified to include all antipsychotics, cyproheptadine, and all opioids except MAT drugs. A second data set was run using the updated drug list. A retrospective intervention letter was developed to address the issue. The letter informed prescribers of the risks associated with polypharmacy of CNS depressants. A total of 110 members and 267 prescribers were identified for a letter intervention. Additionally, members involved in the exploratory phone calls were analyzed to determine if changes in prescribing occurred. Four of the six cases showed a reduction in sedating medications with none showing an increase. This is an ongoing intervention for the Wisconsin Medicaid DUR Board. Review and improvement of the drug list and criteria have continued.
Wyoming	No innovative practices were implemented in FFY 2022.

Section X - Managed Care Organizations (MCOs)

1. How many MCOs are enrolled in your State Medicaid program?

Figure 160 - Number of MCOs Enrolled in State Medicaid Program

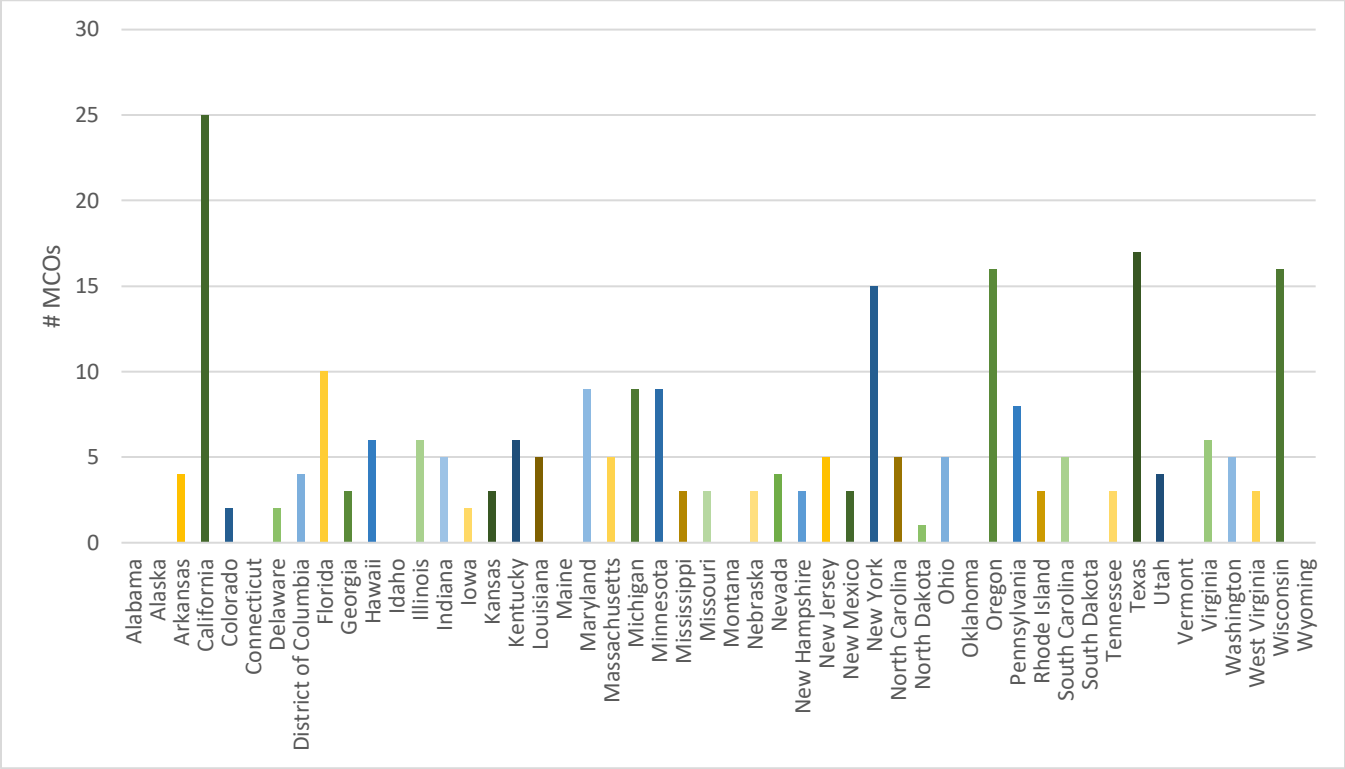

Table 275 - Number of MCOs Enrolled in State Medicaid Program

State	Number of MCOs
Alabama	0
Alaska	0
Arkansas	4
California	25
Colorado	2
Connecticut	0
Delaware	2
District of Columbia	4
Florida	10
Georgia	3
Hawaii	6
Idaho	0
Illinois	6
Indiana	5
Iowa	2
Kansas	3
Kentucky	6
Louisiana	5
Maine	0
Maryland	9

State	Number of MCOs
Massachusetts	5
Michigan	9
Minnesota	9
Mississippi	3
Missouri	3
Montana	0
Nebraska	3
Nevada	4
New Hampshire	3
New Jersey	5
New Mexico	3
New York	15
North Carolina	5
North Dakota	1
Ohio	5
Oklahoma	0
Oregon	16
Pennsylvania	8
Rhode Island	3
South Carolina	5
South Dakota	0
Tennessee	3
Texas	17
Utah	4
Vermont	0
Virginia	6
Washington	5
West Virginia	3
Wisconsin	16
Wyoming	0
Total	251

2. Is your pharmacy program included in the capitation rate (carved in)?

Figure 161 - Pharmacy Program Included in the Capitation Rate (Carved In)

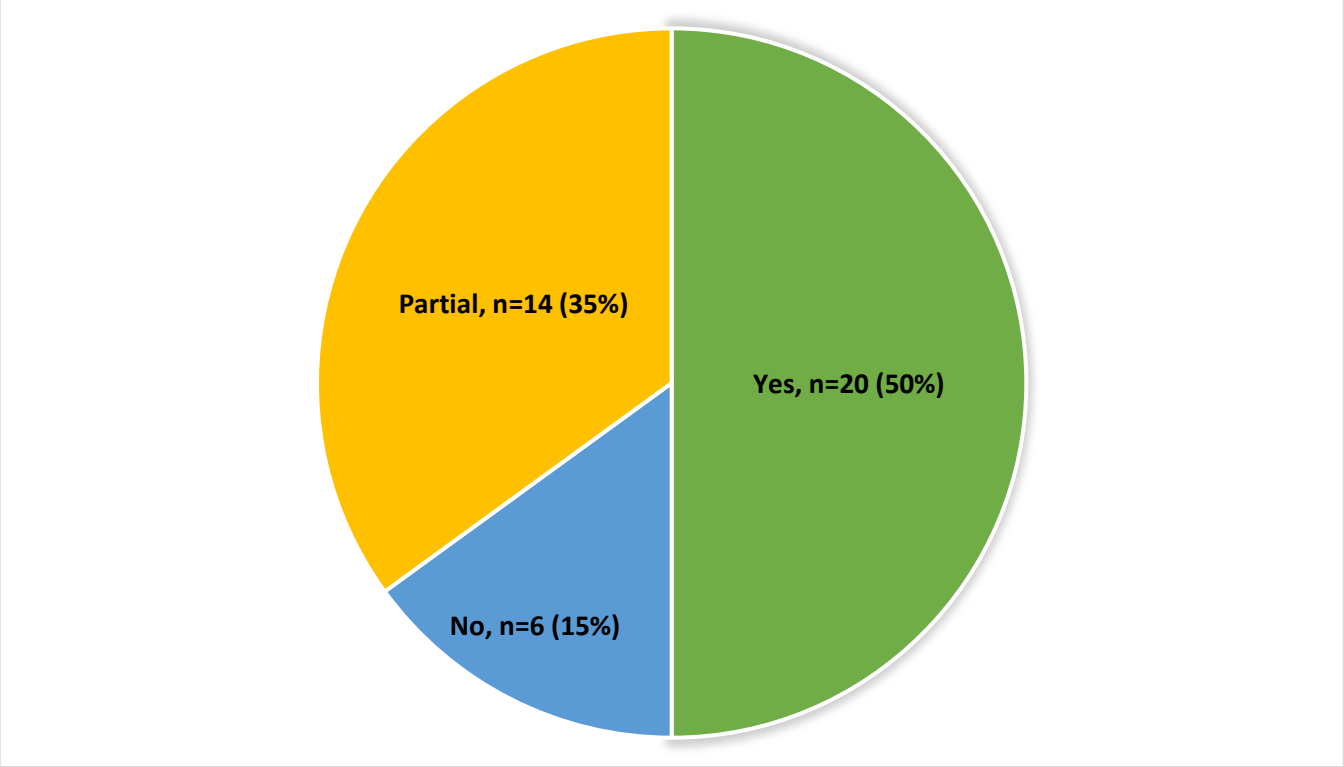

Table 276 - Pharmacy Program Included in the Capitation Rate (Carved In)

Response	States	Count	Percentage
Yes	Arkansas, Delaware, Georgia, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, Virginia, West Virginia	20	50.00%
No	California, Minnesota, Missouri, North Dakota, Tennessee, Wisconsin	6	15.00%
Partial	Colorado, District of Columbia, Florida, Hawaii, Indiana, Iowa, Maryland, Michigan, Mississippi, New Hampshire, Oregon, Rhode Island, Utah, Washington	14	35.00%
Total		40	100.00%

If “Partial,” what categories of medications are carved out and handled by your FFS program (multiple responses allowed)?

Figure 162 - Categories of Medications Carved Out and Handled by State FFS Program

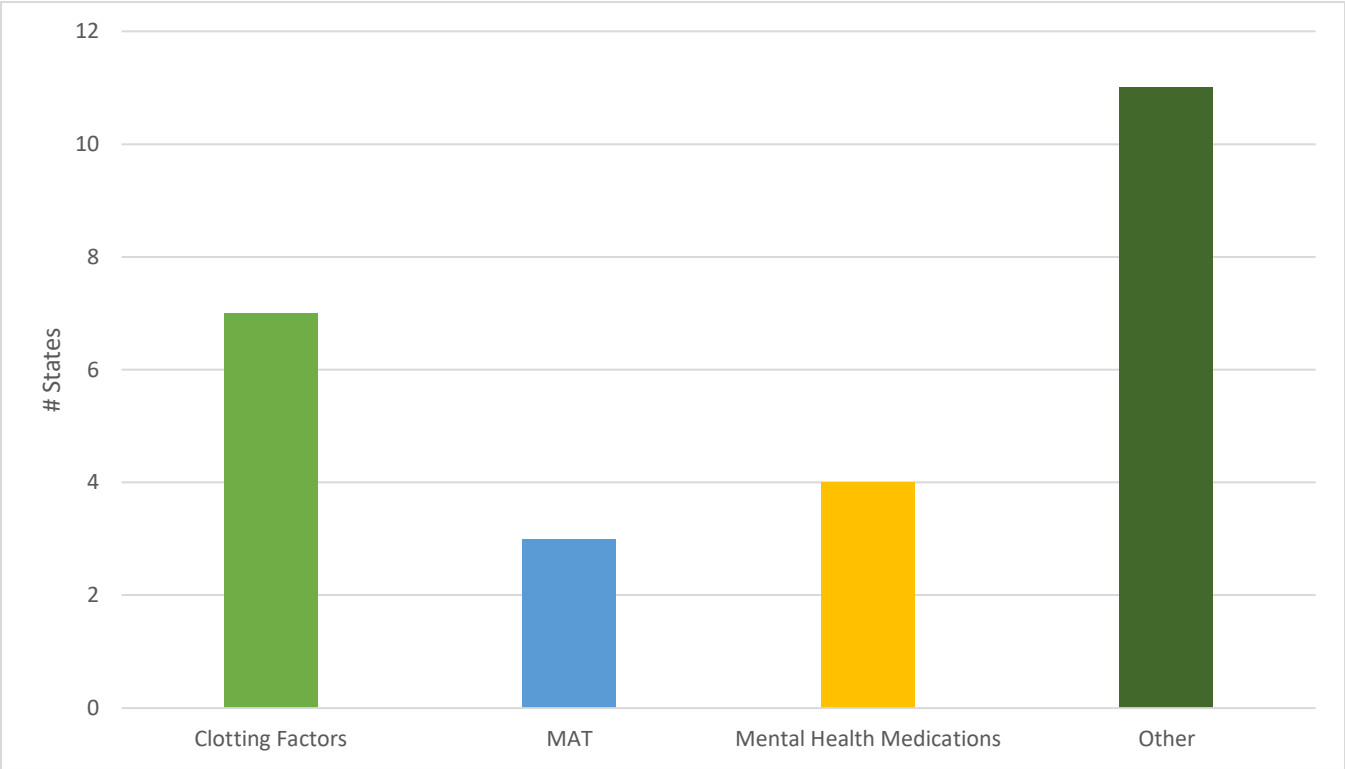

Table 277 - Categories of Medications Carved Out and Handled by State FFS Program

Response	States	Count	Percentage
Clotting Factors	Florida, Indiana, Michigan, Mississippi, New Hampshire, Utah, Washington	7	28.00%
MAT	Maryland, Michigan, Utah	3	12.00%
Mental Health Medications	Maryland, Michigan, Oregon, Utah	4	16.00%
Other	Colorado, District of Columbia, Hawaii, Indiana, Iowa, Michigan, Mississippi, New Hampshire, Rhode Island, Utah, Washington	11	44.00%
Total		25	100.00%

If “Other,” please specify the drug categories

Table 278 - Drug Categories that are Carved Out

State	Response
Colorado	Certain outpatient hospital specialty drugs are carved out from Enhanced Ambulatory Patient Group (EAPG) payment. These drugs include Brineura, Carvykti, Tecartus, Spinraza, Kymriah, Yescarta, Danyelza, and Zolgensma.
District of Columbia	HIV antiretroviral medications
Hawaii	Dental, transplant, breast and cervical cancer, "risk" extremely high cost drugs,
Indiana	Hepatitis C agents, cystic fibrosis agents, muscular dystrophy agents, non-hydroxyurea Sickle Cell agents, and spinal muscular atrophy agents are carved-out.

State	Response
Iowa	Zolgensma
Michigan	Mental Health medications, substance abuse treatments, hemophilia clotting factors, HIV antivirals, hepatitis C treatments and drugs used to treat rare conditions.
Mississippi	1. Beneficiaries diagnosed with hemophilia are carved out and enrolled in fee-for-service. A member must be disenrolled from the contractor (MCO) and enrolled in FFS if the member is diagnosed with hemophilia. Hemophilia products are not included in the MCO capitation rate. For SFY 2024 (beginning July 1, 2023), hemophilia patients will no longer be disenrolled in MCOs and these drugs will be included in capitation rate calculations. 2. Long-term care beneficiaries are also carved out and enrolled in FFS. 3. Zolgensma claims are not included in the capitation rate calculations. These claims are paid by the MCO and the Division of Medicaid pays the MCO directly for the claim. For SFY 2024 (beginning July 1, 2023), Zolgensma will be included in the capitation calculation and a high-cost drug risk corridor is being implemented with MCOs.
New Hampshire	Carbaglu Ravicti Zolgensma COVID Vaccine and COVID at Home test kits
Rhode Island	Stop gap arrangement in place 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	The following drug categories are carved out: ANTIDEMENTIA AGENTS : ANTI-AMYLOID ANTIBODIES ANTIHYPERLIPIDEMICS : ANGIOPOIETIN-LIKE PROTEIN INHIBITORS ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS CARDIOVASCULAR AGENTS : TRANSTHYRETIN STABILIZERS DERMATOLOGICS : MELANOCORTIN RECEPTOR AGONISTS (UV PROTECTIVE) ENDOCRINE AND METABOLIC AGENTS : ADENOSINE DEAMINASE SCID TREATMENT AGENTS - INJECTABLE ENDOCRINE AND METABOLIC AGENTS : ADRENAL STEROID INHIBITORS ENDOCRINE AND METABOLIC AGENTS : CORTISOL SYNTHESIS INHIBITORS ENDOCRINE AND METABOLIC AGENTS : FABRY DISEASE AGENTS - INJECTABLE ENDOCRINE AND METABOLIC AGENTS : FABRY DISEASE AGENTS - ORAL ENDOCRINE AND METABOLIC AGENTS : GAA DEFICIENCY AGENTS ENDOCRINE AND METABOLIC AGENTS : HEREDITARY TYROSINEMIA TYPE 1 (HT-1) AGENTS - ORAL ENDOCRINE AND METABOLIC AGENTS : HYPOPHOSPHATASIA AGENTS - INJECTABLE ENDOCRINE AND METABOLIC AGENTS : INSULIN-LIKE GROWTH FACTORS - INTRAVENOUS ENDOCRINE AND METABOLIC AGENTS : LEPTIN ANALOGUES ENDOCRINE AND METABOLIC AGENTS : LYSOSMAL ACID LIPASE DEFICIENCY AGENTS ENDOCRINE AND METABOLIC AGENTS : MOLYBDENUM COFACTOR DEFICIENCY (MOCD) AGENTS ENDOCRINE AND METABOLIC AGENTS : MUCOPOLYSACCHARIDOSIS AGENTS ENDOCRINE AND METABOLIC AGENTS : NATRIURETIC PEPTIDES ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - INJECTABLE ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - ORAL ENDOCRINE AND METABOLIC AGENTS : TRIPEPTIDYL PEPTIDASE 1 DEFICIENCY AGENTS ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL ENDOCRINE AND METABOLIC AGENTS : X-LINKED HYPOPHOSPHATEMIA (XLH) AGENTS GASTROINTESTINAL AGENTS : ILEAL BILE ACID TRANSPORTER INHIBITORS GENITOURINARY AGENTS - MISC : HYPEROXALURIA AGENTS GENITOURINARY AGENTS : CYSTINOSIS AGENTS

State	Response
	HEMATOLOGICAL AGENTS - MISC : AMINOLEVULINATE SYNTHASE 1-DIRECTED SIRNA HEMATOLOGICAL AGENTS - MISC : ANTIHEMOPHILIC PRODUCTS HEMATOLOGICAL AGENTS - MISC : COMPLIMENT INHIBITORS HEMATOLOGICAL AGENTS - MISC : COMPLIMENT INHIBITORS - INJECTABLE HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS HEMATOLOGICAL AGENTS : PLASMA PROTEINS HEMATOLOGICAL AGENTS : PYRUVATE KINASE ACTIVATORS HEMATOPOEITIC AGENTS : AUTOLOGOUS CELLULAR GENE THERAPY HEMATOPOIETIC AGENTS : ERYTHROID MATURATION AGENTS HEMATOPOIETIC AGENTS : SICKLE CELL ANEMIA - SELECTIN BLOCKERS IMMUNOSUPPRESSIVE AGENTS : MONOCLONAL ANTIBODIES MISCELLANEOUS THERAPEUTIC CLASSES : ALLOGENEIC TISSUE MISCELLANEOUS THERAPEUTIC CLASSES : PIK3CA-RELATED AGENTS MISCELLANEOUS THERAPEUTIC CLASSES : PROGERIA TREATMENT AGENTS NEUROLOGICAL AGENTS : TRANSTHYRETIN AMYLOIDOSIS AGENTS NEUROMUSCULAR AGENTS : ALS AGENTS - MISC NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY - GENE THERAPY AGENTS NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY AGENTS - ANTISENSE OLIGONUCLEOTIDES NUTRIENTS : LIPIDS ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T) ONCOLOGY AGENTS : INTERFERONS ONCOLOGY AGENTS : RADIOPHARMACEUTICALS OPHTHALMIC AGENTS : GENE THERAPY OPHTHALMIC AGENTS : NERVE GROWTH FACTORS

3. Contract updates between State and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). 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 163 - Have States Updated Their MCOs' Contracts for Section 1004 Compliance

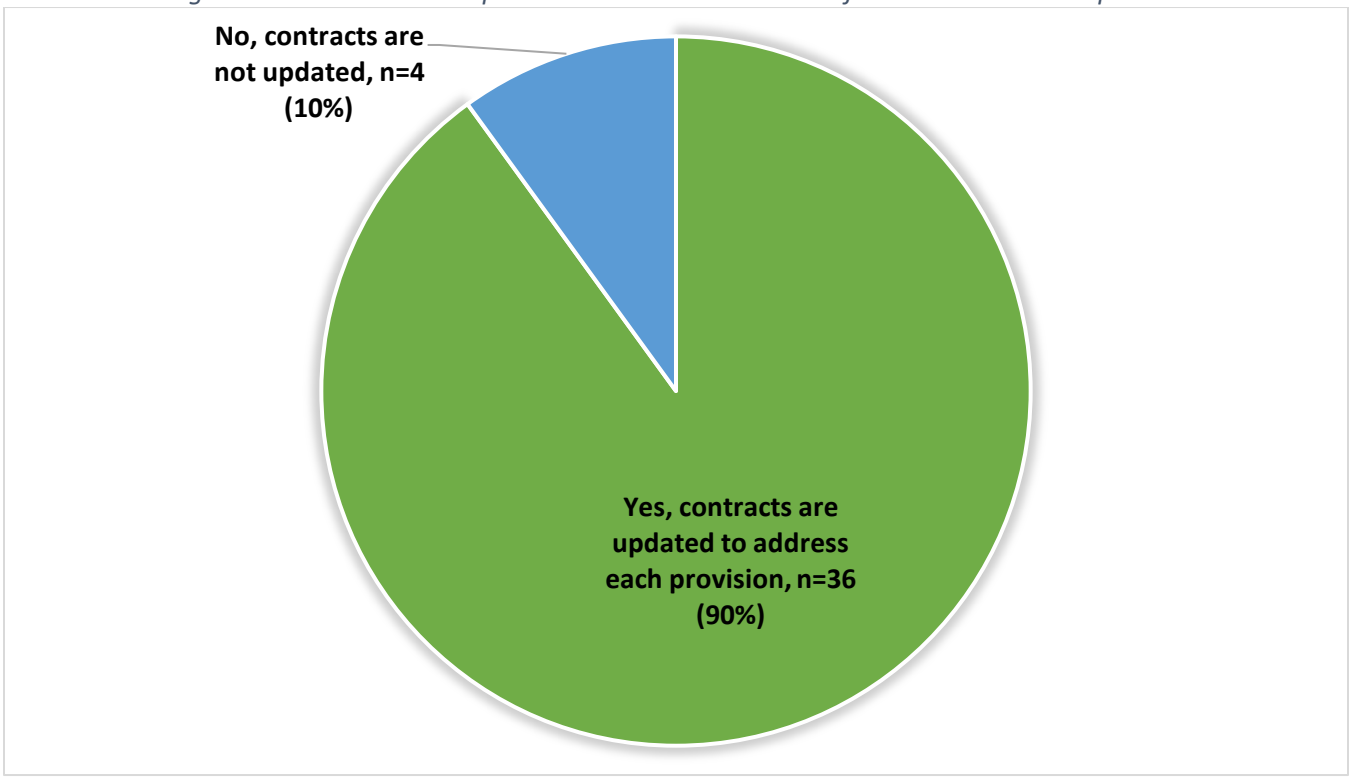

Table 279 - Have States Updated Their MCO's Contracts for Section 1004 Compliance

Response	States	Count	Percentage
Yes, contracts are updated to address each provision	Arkansas, California, 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, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia	36	90.00%
No, contracts are not updated	Missouri, New York, North Carolina, Wisconsin	4	10.00%
Total		40	100.00%

If "Yes," please specify effective date.

Table 280 - Effective Dates for Updating MCO Contracts for Section 1004 Compliance

State	Effective Date
Arkansas	9/19/2019
California	10/01/2019
Colorado	07/01/2021

State	Effective Date
Delaware	01/01/2019
District of Columbia	10/01/2022
Florida	10/01/2020
Georgia	10/1/2019
Hawaii	07/01/2021
Illinois	12/18/2019
Indiana	10/01/2019
Iowa	7/2/2020
Kansas	12/04/2020
Kentucky	01/01/2021
Louisiana	10/01/2019
Maryland	10/1/2019
Massachusetts	01/01/2020
Michigan	10/01/2020
Minnesota	1/1/2020
Mississippi	07/01/2022
Nebraska	10/1/2019
Nevada	10/01/2019
New Hampshire	12 18 2019
New Jersey	10/01/2019
New Mexico	10/01/2018
North Dakota	01/01/2019
Ohio	07/01/2022
Oregon	01/01/2020
Pennsylvania	10/1/2019
Rhode Island	07/01/2022
South Carolina	7/1/2022
Tennessee	7/1/2020
Texas	08/14/2020
Utah	7/1/2019
Virginia	10/24/2018
Washington	07/01/2022
West Virginia	7/1/2020

If contracts are not updated, please explain why not.

Table 281 - Explanations for States That Have Not Updated MCO Contracts for Section 1004 Compliance

State	Explanation
Missouri	Pharmacy benefits are carved out of managed care.
New York	Medicaid Managed Organizations (MCOs) are required to comply with all applicable State and federal laws and regulations under the provisions of Section 35.1 of the contract, which would include compliance with the SUPPORT Act. We have surveyed our contracted MCOs and have verified that all are in compliance with the SUPPORT Act. Specific SUPPORT ACT contract language will be amended to the contract in a forthcoming amendment.
North Carolina	The contracts do not have specific language regarding the SUPPORT Act. However, it does require that the plans follow all CMS guidance, SSA, and other federal and State laws and

State	Explanation
	regulations. Additionally, the plans are required to follow the State FFS Outpatient Pharmacy Policy 100%.
Wisconsin	Covered outpatient drugs are carved-out of the managed care benefit packages and are covered by 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 SUPPORT for Patients and Communities Act provisions?

Figure 164 - Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions

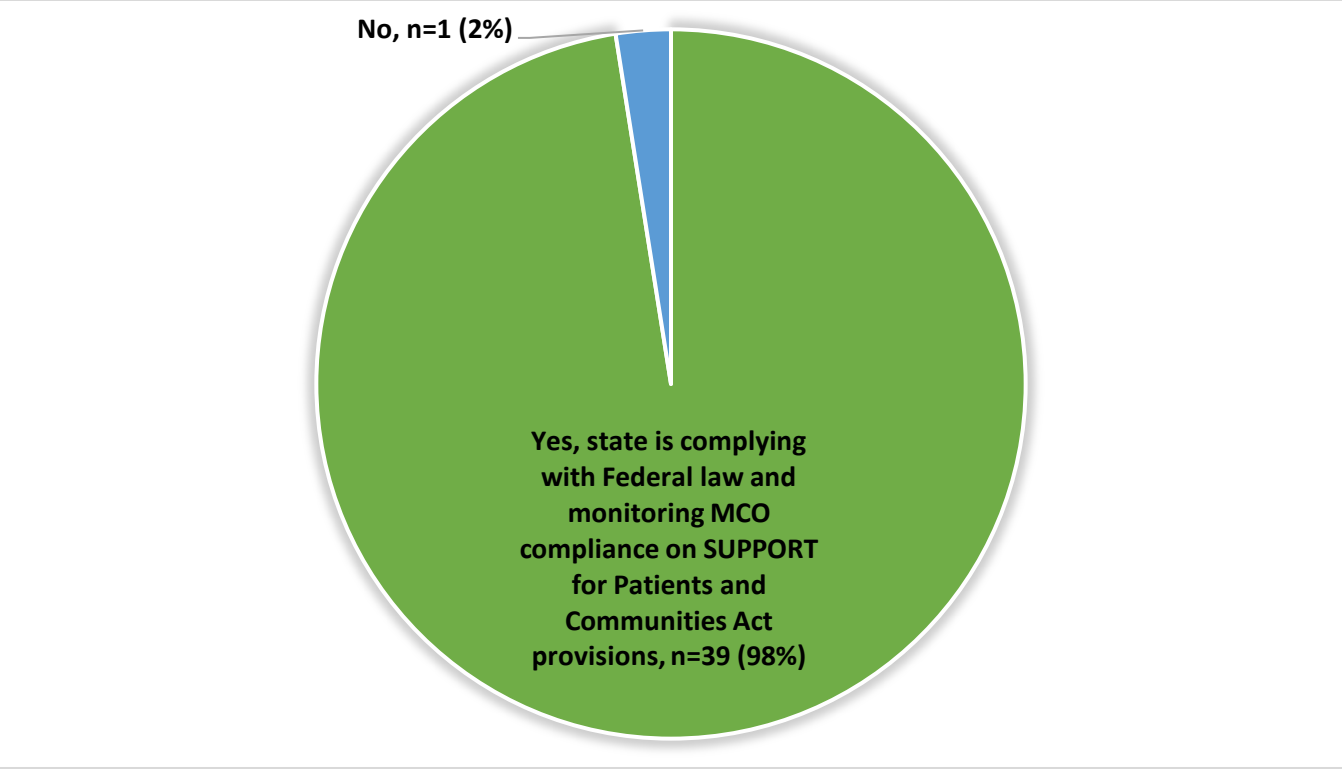

Table 282 - Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions

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 Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	39	97.50%
No	Missouri	1	2.50%
Total		40	100.00%

If "Yes," please explain monitoring activities.

Table 283 - Explanations for Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions

State	Explanation
Arkansas	Arkansas Medicaid MCOs are referred to as Provider-Led Arkansas Shared Savings Entity (PASSE). Per the PASSE contracts pursuant to the requirements of Section 1004 of the SUPPORT Act, each PASSE 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 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 beneficiary 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 beneficiaries, 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 operational meetings with the MCOs to discuss operational issues, annual External Quality 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	DC added specific language to the MCO contracts that addresses compliance with DUR requirements. The Contractor shall comply with all provisions of 1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The Contractor shall have the following in place: Prospective system safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness. Prospective system safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines). Retrospective review process on opioid prescriptions exceeding these above limitations on an ongoing basis.

State	Explanation
	Prospective and retrospective review process on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. The Contractor shall have programs to monitor and manage antipsychotic medications use in children. Antipsychotic agents shall be reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines to be reported annually in the CMS DUR Annual Report. Monthly oversight meetings are held with each MCO Pharmacy Director and SUPPORT Act required reporting on opioid concurrent use is reviewed. Additionally, MCOs prepare detailed summaries of SUPPORT Act mandated reporting for presentation at quarterly DHCF DUR Board meetings. Board members provided feedback and suggestions on areas where improvement in program performance might be warranted and requested follow-up assessments by the MCOs.
Florida	Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-49 sent on August 31, 2020, with the requirements of the Support Act:
Georgia	Antipsychotic use in children, walk-in programs, and use of PDMP, concurrent reviews, etc.
Hawaii	State pharmacist has monthly meetings with the MCO pharmacists to discuss implementation, review and improve of the MCO compliance of the SUPPORT Act provisions.
Illinois	The MCOs must attest they are conducting DUR. The DUR Annual reports are reviewed and comments are made to the MCO reminding them that they need to do activities, adhere to HFS policies, and that they attest to doing the activities. The Bureau of Managed Care and HFS implement penalties as needed.
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 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.

State	Explanation
Kentucky	Kentucky DMS monitors MCO compliance with the SUPPORT Act via quarterly reports from each of the MCOs.
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	State Medicaid MCOs are required to submit quarterly reports showing opioid utilization including MME data and concurrent utilizations with benzodiazepines and antipsychotics.
Minnesota	MCO compliance is monitored with the contract. Both through CMS annual reports and quarterly reports with regards to prior authorizations that are responded to within the 24-hour requirement as part of their contracts.
Mississippi	SUPPORT Act requirements have been communicated to and discussed with the MCOs. The MCOs are reporting on the provisions.
Nebraska	Nebraska Medicaid and Long-Term Care is in constant contact with each of their MCO vendors and FFS vendors in sharing SUPPORT ACT data. Reports are shared with the DUR board every six months. MCOs are required to follow the single State-wide preferred drug list (PDL) which includes all requirements of Section 1004 provisions of the SUPPORT Act. The State was provided confirmation from each MCO that all prospective safety edits were in place. The MCOs are required to have provider education and marketing materials peer reviewed by the State before use and the State reviews for compliance with all SUPPORT Act requirements.
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	MCOs are required to submit quality reports to the State The Bureau of Program Quality and the Pharmacy Program monitor reports for compliance

State	Explanation
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 educational programs, must be approved by the State prior to implementation.
New Mexico	MCO Pharmacy Quarterly reports are submitted to the State that include data supporting compliance on the SUPPORT Act provisions.
New York	The State staff monitor activities (i.e. ProDUR editing and/or RetroDUR interventions) and verify /confirm compliance with SUPPORT Act provisions.
North Carolina	MCOs are required to follow the NC Medicaid Outpatient Pharmacy policy.
North Dakota	Pharmacy is carved out and SUD and OTP services are required parts of the benefit plan for the MCO.
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: https://medicaid.ohio.gov/static/Providers/ManagedCare/PolicyGuidance/SUPPORT-Act.pdf?adlt=strict
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	All MCOs are required to use the FFS prior authorization guidelines for opioids, opioid dependence agents, and opioid overdose agents. MCO approvals and denials are reviewed for compliance. The FFS RetroDUR Program includes MCO utilization for additional compliance monitoring.
Rhode Island	Section 2.12.03.02.01 Drug Utilization Review MCO is required to comply with H.R. 6 The SUPPORT Act Title 1; Section 1004, which mandates the following: 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 o The DUR program will provide for various reports to be submitted to EOHHS in a specified format, 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

State	Explanation
	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. A detailed description of its drug utilization review program activities to EOHHS on an annual basis. The Contractor must respond to requests for prior authorization for a covered outpatient drug by telephone or other telecommunication device within twenty-four (24) hours of the request. In addition, the Contractor must ensure a seventy-two (72) hour supply of the requested covered outpatient drug is dispensed in an emergency situation Contractor is required to comply with RI General Assembly H-8313 Relating to Food and Drugs Naloxone Access (2) Ensuring that opioid antagonists that are distributed in a non-pharmacy setting are eligible for reimbursement from any health insurance carrier, as defined under chapters 18, 19, 20, and 41 of title 27, and the Rhode Island medical assistance program, as defined under chapter 7.2 of title 42
South Carolina	As these are contractual items compliance falls under the State' s Contract Monitoring Entity
Tennessee	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. 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

State	Explanation
	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 timeframe prescribed by TENNCARE.
Texas	The MCOs 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 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 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 7456, 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

State	Explanation
	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 is in compliance with the SUPPORT Act. Wisconsin has implemented monitoring activities in its State Plan to review outpatient drugs claims for numerous safety issues. These include limiting the number of opioid prescriptions dispensed in a calendar month, limiting the quantity 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 morphine milligram equivalents. The State also monitors antipsychotic medications prescribed to children. The State also monitors for 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 by 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 why not.

Table 284 - Explanations for States Not Complying with Federal Law and Monitoring MCO Compliance is Support of the Patients and Communities Act Provision

State	Explanation
Missouri	N/A

4. Does the State set requirements for the MCO's pharmacy benefit (i.e., same preferred drug list, same ProDUR/RetroDUR)?

Figure 165 - State Mandating Requirements for the MCO's Pharmacy Benefit

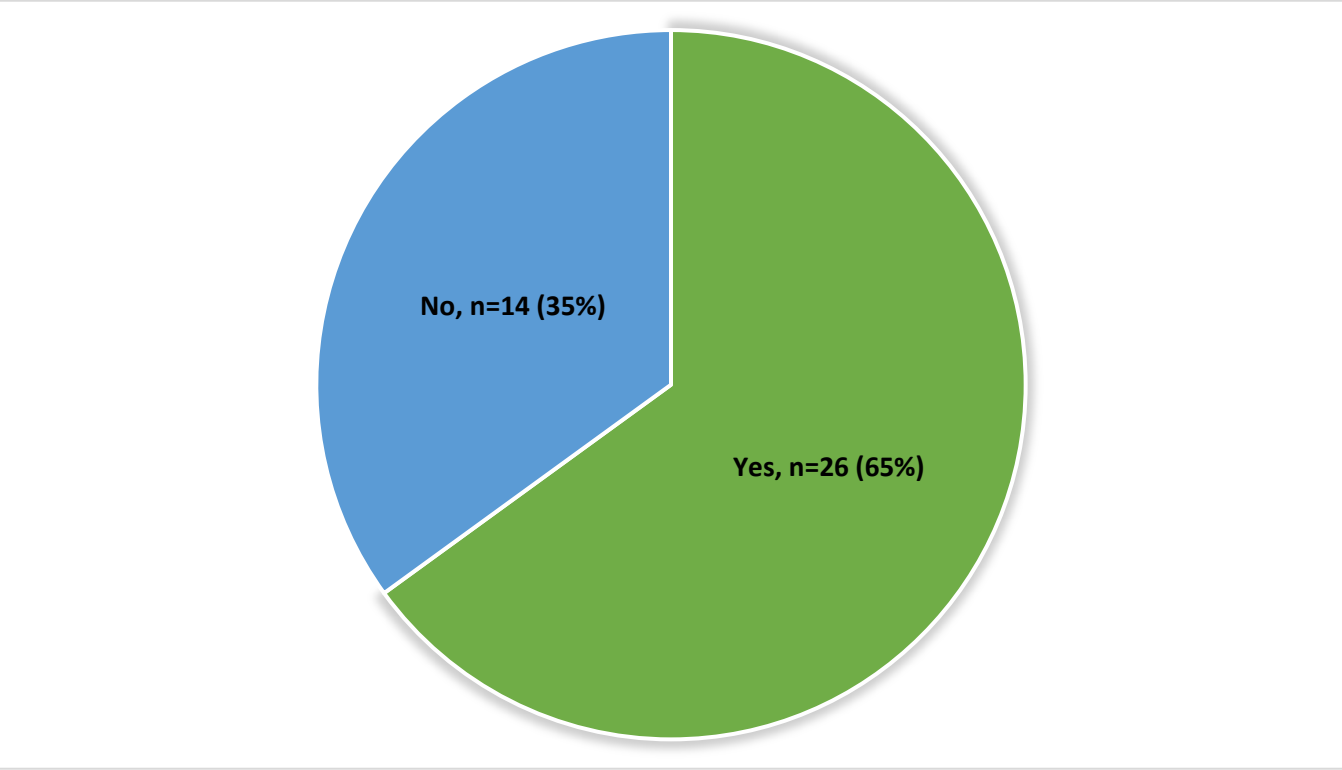

Table 285 - State Mandating Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Yes	Arkansas, Colorado, Delaware, District of Columbia, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia	26	65.00%
No	California, Georgia, Hawaii, Indiana, Missouri, Nevada, New Mexico, North Dakota, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin	14	35.00%
Total		40	100.00%

a. If "Yes," please check all that apply.

Figure 166 - State Requirements for the MCO's Pharmacy Benefit

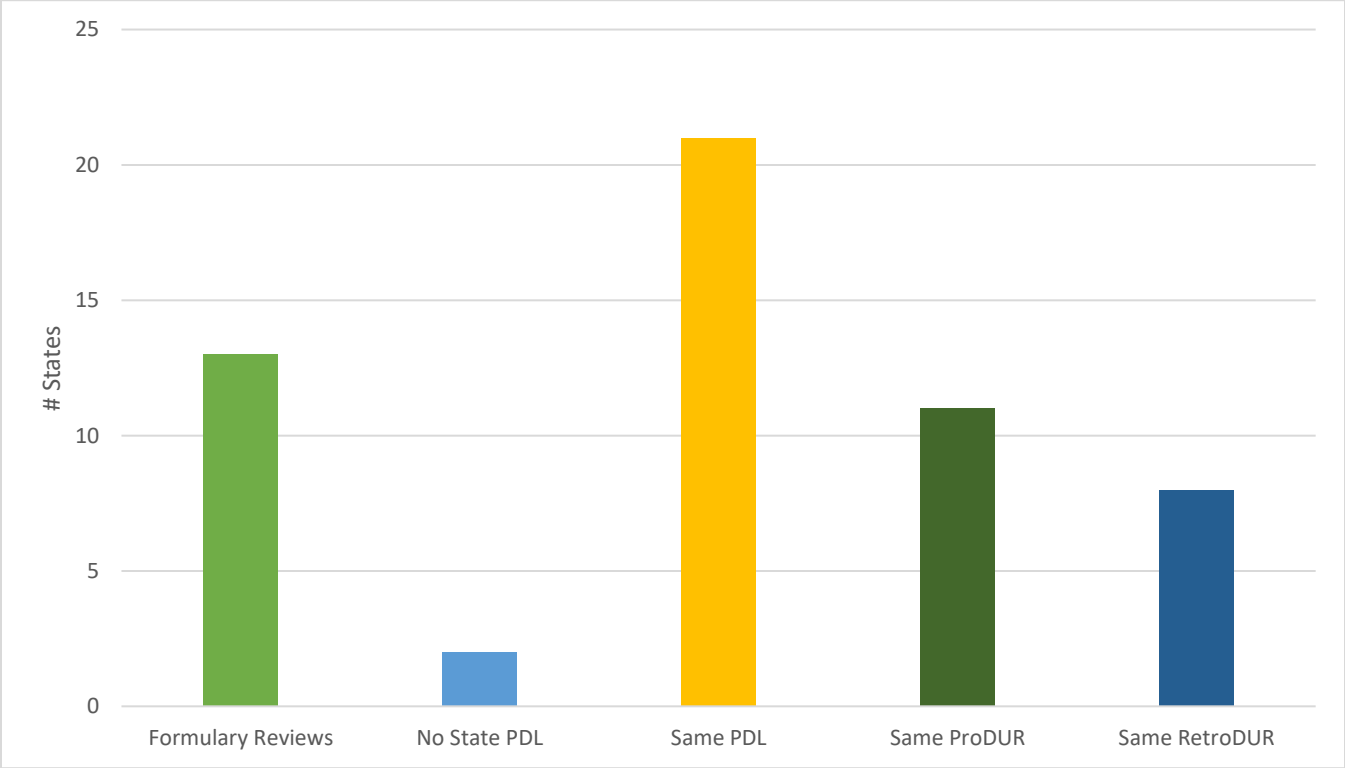

Table 286 - State Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Formulary Reviews	Colorado, District of Columbia, Florida, Kansas, Kentucky, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Washington	13	23.64%
No State PDL	New Jersey, New York	2	3.64%
Same PDL	Arkansas, Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia	21	38.18%
Same ProDUR	Arkansas, Florida, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Nebraska, New Jersey, North Carolina	11	20.00%
Same RetroDUR	Iowa, Kansas, Louisiana, Massachusetts, Mississippi, Nebraska, New Jersey, North Carolina	8	14.55%
Total		55	100.00%

b. If "Yes," please briefly explain your policy.

Table 287 - Policy Explanations for State Requirements for the MCO's Pharmacy Benefit

State	Explanation
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-

State	Explanation
	preferred status of each NDC. The PASSEs must update their pharmacy claims system within three business days 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.
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	The initial formulary for each MCO must be submitted to DHCF for approval within 30 days of contract award. Post award, all scheduled quarterly updates to the formulary and any ad hoc changes must be reviewed and approved by DHCF prior to MCO addition to its formulary.
Florida	MCO plans criteria, edits, etc. cannot be more restrictive than the Agency.
Illinois	Effective January 1, 2020 Illinois Medicaid has a single Preferred Drug List (PDL). The Drugs and Therapeutics Committee reviews medications requested for inclusion to the PDL and conducts periodic class reviews. Clinical reviews are provided by the UIC College of Pharmacy Drug Information Group. The MCOs must have the same age and days supply edits for all drugs on the PDL. Illinois does not require identical prior authorization criteria, only that the MCO is not stricter than FFS. The MCOs must also have the same stipulated criteria prior authorization language on supplemental rebate agreements for drugs on that are on the PDL.
Iowa	The MCO is required to follow the fee-for service (FFS) preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits.

State	Explanation
Kansas	The MCOs are to have the same drug coverage and DUR program as FFS, with few exceptions. For example, 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 RDURs 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.
Kentucky	The State has a single PDL for FFS and MCO pharmacy plans. The same prior authorization and ProDUR criteria are implemented across FFS and MCO.
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 was 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.
Massachusetts	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 MCOs was implemented.
Minnesota	DHS has developed a uniform nonpreferred PD drug prior authorization used by both FFS and MCOs. If the MCO chooses, they can develop their own PA criteria, but the PA criteria cannot disadvantage the preferred drug.

State	Explanation
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 the Universal PDL (UPDL) and same clinical criteria.
Nebraska	Nebraska has a single PDL and MCOs are required to follow per contractual obligation. Additionally the State DUR Board sets any initiatives, projects, or utilization reviews that apply to both FFS and MCOs that are in addition to any DUR activities each of the MCOs conduct through their own independent DUR Boards.
New Hampshire	The MCOs are required to follow the State PDL The MCOs are allowed to establish their own PDL for therapeutic classes not managed by the State 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 establish their own formularies and prior authorization processes. MCO formularies must include all categories of medications on the FFS list of reimbursable drugs. MCO formulary reviews, by the State staff, occur at least twice a year.
North Carolina	NC sets the requirements for the MCOs pharmacy benefits. MCOs are required to follow our pharmacy policy, PAs, and 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 have 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: https://medicaid.ohio.gov/static/Providers/ManagedCare/PolicyGuidance/SUPPORT-Act.pdf?adlt=strict
Pennsylvania	The MCO Agreements require the MCOs to utilize the Statewide PDL and prior authorization guidelines developed by the Department's P&T Committee. All of the MCOs have representation on the P&T Committee. The MCO Agreement requires all MCOs to submit to the Department for approval any supplemental formularies for drugs outside the scope of the Statewide PDL whenever changes are made and annually.
Texas	The State sets requirements for the MCOs pharmacy benefits: Single PDL Single Formulary POS clinical PA criteria must not be more stringent than what the HHSC DUR 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 26 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.

State	Explanation
Washington	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 167 - Future Plans to Set MCO Pharmacy Benefit Standards

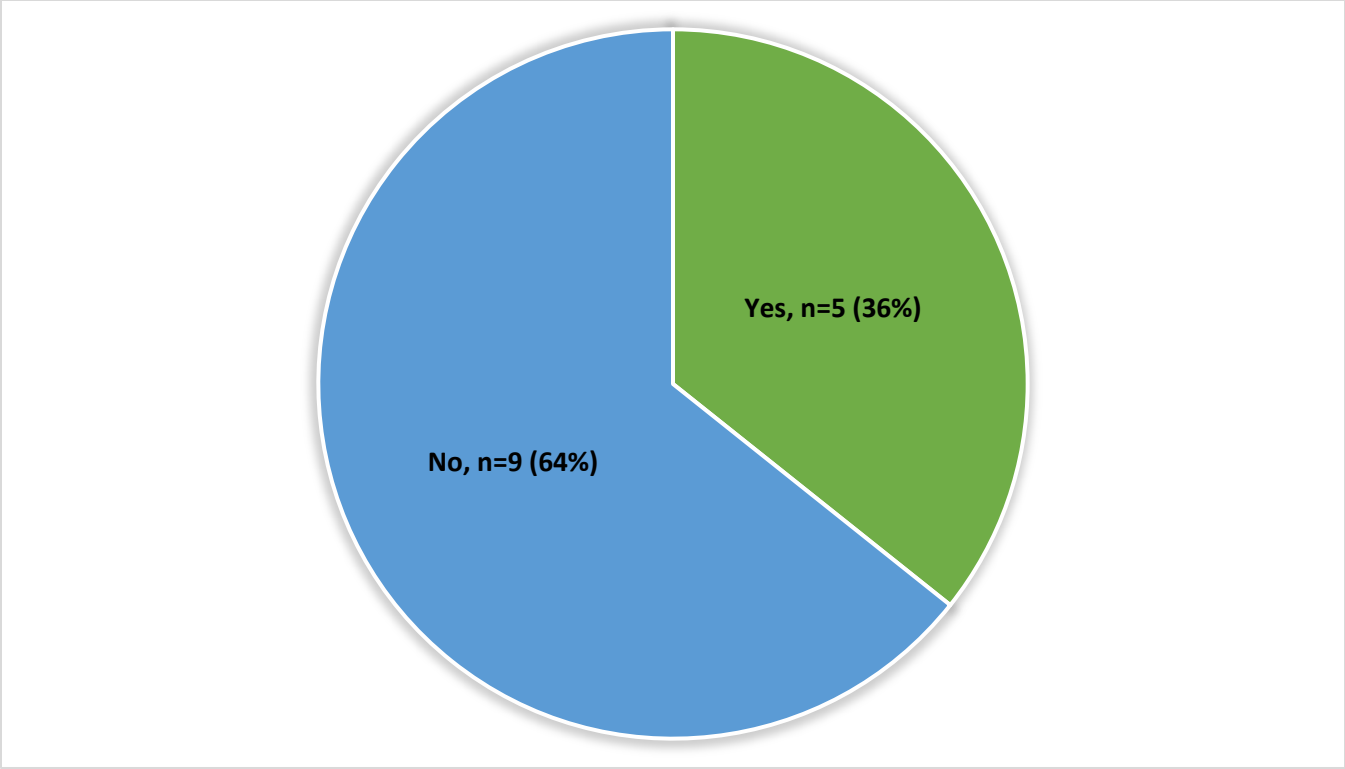

Table 288 - Future Plans to Set MCO Pharmacy Benefit Standards

Response	States	Count	Percentage
Yes	Indiana, Nevada, New Mexico, South Carolina, Utah	5	35.71%
No	California, Georgia, Hawaii, Missouri, North Dakota, Oregon, Rhode Island, Tennessee, Wisconsin	9	64.29%
Total		14	100.00%

If "No," please explain.

Table 289 - Explanations for not Setting MCO Pharmacy Benefit Standards in the Future

State	Explanation
California	The pharmacy benefit is carved out of managed care.
Georgia	Not planning on doing so in the future.
Hawaii	Currently ad hoc and selective legislated programs set requirements for the MCOs pharmacy benefit.
Missouri	Pharmacy benefits are carved out of Managed Care.

State	Explanation
North Dakota	Pharmacy is carved out.
Oregon	Oregon sets Statewide minimum standards that all MCOs must meet, but these allow some flexibility in specifically how standards are met. However, Oregon is evaluating options for greater uniformity.
Rhode Island	Discussions are ongoing.
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 (Pharmacy Advisory Committee), which is TennCare's P&T Committee.
Wisconsin	The drug benefit is carved-out from the MCOs 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 168 - RetroDUR Program Operated by State, MCO, or Combination of State and MCO

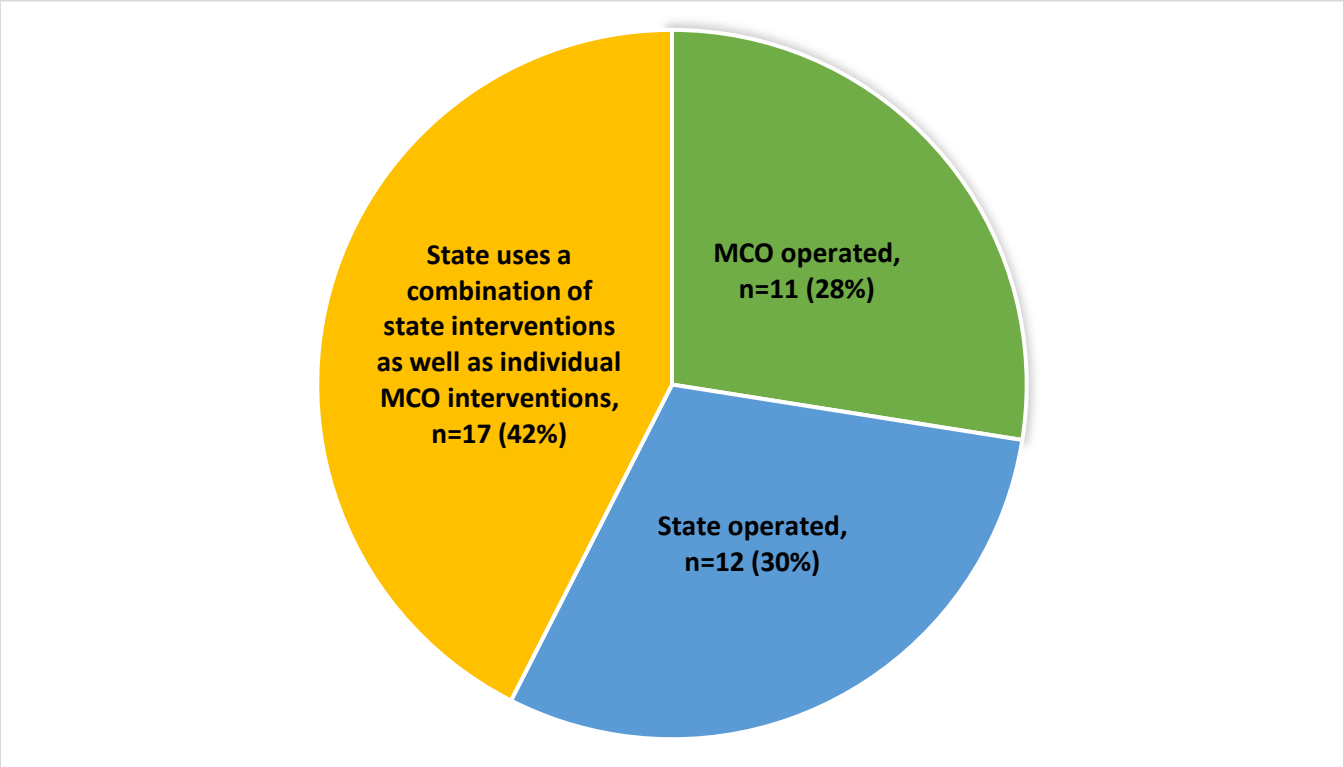

Table 290 - RetroDUR Program Operated by State, MCO, or Combination of State and MCO

Response	States	Count	Percentage
MCO operated	Arkansas, Illinois, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island	11	27.50%
State operated	District of Columbia, Florida, Georgia, Indiana, Iowa, Mississippi, Missouri, North Dakota, Tennessee, Texas, West Virginia, Wisconsin	12	30.00%

Response	States	Count	Percentage
State uses a combination of State interventions as well as individual MCO interventions	California, Colorado, Delaware, Hawaii, Kansas, Kentucky, Louisiana, Massachusetts, Nebraska, New Jersey, New York, Oregon, Pennsylvania, South Carolina, Utah, Virginia, Washington	17	42.50%
Total		40	100.00%

6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.

Table 291 - Explanations for How the State Oversees the FFS and MCO RetroDUR programs

State	Explanation
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 reports 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. 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 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 MCO Pharmacy and Medical Directors prepare quarterly presentations on DUR topics selected by the FFS Drug Utilization Review Board. Each MCO shares detailed information on its drug utilization initiatives and outcomes, members' disease State management and provider outreach assessments. DUR Board members make recommendations and request MCO follow-up reporting on selected topics of interest.

State	Explanation
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.
Hawaii	The FFS DUR Board supports the FFS retroDUR with the State pharmacist and Conduent. The State pharmacist oversees the Annual DUR report provided by the MCOs which includes examples of the MCO retroDUR programs as well as discussion in the monthly MCO pharmacist meetings.
Illinois	For FFS, the Bureau of Pharmacy and Ancillary Services participates as a non-voting member of the DUR Board and provides data to the contractor for identified retrospective reviews. The MCOs attest they are conducting DUR.
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 RDUR 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.

State	Explanation
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 RetroDUR initiatives for the calendar year, and 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 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 the 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 through quarterly reports with regards to prior authorizations that are responded to within the 24-hour requirement as part of the MCO 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	Nebraska Medicaid and Long-Term Care oversees the State DUR Program that applies to both FFS and MCO DUR activities. The MCOs provide to the State annual reports on their independent MCO DUR Board activities along with any identified opportunities for provider education and medication therapy optimization. The State reviews routine MCO medication utilization reports including generic utilization.
Nevada	MCOs are actively engaged in the State DUR Board Meetings on a quarterly basis, providing updates on their RetroDUR programs. These meetings serve as a platform for the MCOs to share any changes or modifications made to their programs, ensuring that they align with the approved recommendations from the DUR Board. Additionally, as part of their ongoing accountability, the MCOs are mandated to present a comprehensive overview of their

State	Explanation
	RetroDUR activities at least once a year. This regular reporting and collaboration between the MCOs and the DUR Board help to promote transparency, compliance, and the delivery of quality healthcare services.
New Hampshire	State Oversight of FFS RetroDUR The State DUR Board selects RetroDUR topics to be run each month at the DUR Board meetings The States Medicaid Pharmacy Team reviews and approves the RetroDur Letter each month before the letters are generated Magellan RX Management sends the RetroDUR letters and tracks responses that are reported back to the State The MCOs manage their own RetroDur program There are requirements in the MCO contracts that they must comply with all DUR requirements described in Section 1927 g of the Act and 42 CFR part 456 subpart K The State reviews all DUR annual reporting prior to submitting the reports to CMS
New Jersey	Each MCO submits proposed RetroDUR programs to the Division for review and approval on an ongoing basis. If approved, the State specifies an effective date for implementation of any DUR standards by the MCO and FFS.
New Mexico	The MCO health plans report their RetroDUR interventions in a quarterly pharmacy report. The State meets with the FFS vendor every other week to discuss the RetroDUR program which includes developing new interventions and evaluate data of existing interventions. These interventions are presented at the quarterly FFS DUR Board meetings for Board member approval.
New York	State staff continually evaluate of retrospective pharmacy claims data (FFS and MCO) by State staff. MCO data is included in retrospective review of pharmacy and medical claims information. MCO data / information, specific to each MCO's member population, is provided to the MCO upon DUR Board review inclusive of any DUR Board clinical criteria recommendations.
North Carolina	NC oversees the FFS RetroDUR program and monitors the MCO RetroDUR program. Our RetroDUR vendor will include MCO encounters as a measure when reviewing topics. However, each MCO has their own DUR Board and are responsible for determining topics used in interventions and for performing those interventions. Each MCO prepares a slide and presents their activities at the quarterly DUR Board meeting for State awareness. Each MCO is also required to submit Pro-DUR and RetroDUR reports to the State quarterly. The State monitors MCOs using a dyad model. Each plan has a nurse and pharmacist from the State assigned specifically to that plan. The dyad team works to provide guidance to the MCOs, monitors the MCO progress on resolving complaints filed through the Ombudsman for members and providers, and evaluates compliance with policies and contracts.
North Dakota	The State operates a fully compliant RetroDUR program for the entirety of the Medicaid population. The MCO is notified of any findings which can be impacted by the services the MCO provides. The MCO is compliant in providing encounter data to the State which is fully loaded into State operated RetroDUR programs.
Ohio	ODM oversees MCP RetroDUR programs via provider agreement requirements, monitoring DUR reports, quarterly MTM report submissions, and ongoing 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

State	Explanation
	the FFS program. The Committee discusses the reports and recommends changes or follow-up reporting when appropriate.
Pennsylvania	DHS performs RetroDUR on the MCO utilization as well as the FFS utilization. Each MCO has their own DHS-approved policies for their RetroDUR programs as required in the MCO Agreements.
Rhode Island	A State representative attends the FFS DUR Board meetings.
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 administrative 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: (a) Drug change within a sixty (60) or ninety (90) day period of the intervention;

State	Explanation
	(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 by mailing the educational letters. The outcome reports for these interventions are submitted to the State for approval. The MCOs the 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.
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. Quarterly Underpaid Pharmacy Claims 7. Annual List of drugs allowed though specialty pharmacies The deliverables in combination with MCO encounter data are used to conduct RetroDUR analysis of drug spend, utilization, as well as overall program compliance. HCA uses the results of our analyses to inform us of potential ProDUR opportunities, changes to drug

State	Explanation
	status on our AHPDL, clinical policy development and potential MCO contract change. Examples of RetroDUR activities conducted in FFY 2022 can be found in Section III. HCA's Medicaid Compliance Review and Analytics team in collaboration with the Prescription Drug Program conducted annual reviews called TEAMonitor (42 CFR, part 438.66 State monitoring requirements) which included verification of the following for FFY 2022: 1. Evidence the MCOs have system edits in place that ensure claims reject for drugs that are not rebate eligible. for non-rebatable drugs reject. Including any scripts used by call center staff to address questions from pharmacies regarding why a drug is not rebate eligible. 2. The mechanism in place that ensures pharmacy claims reject when the prescriber is excluded. 3. The process for updating the system and providing education to line staff and clinician for carve-out drugs. Include how the claims are redirected when billed to the MCO. 4. The process used for reviewing adjustment requests for underpaid claims. 5. The SON system edits for ADHD therapy duplications. If identified manually and no system edits are available, detail what edits are not built into the system. 6. Proper implementation of information below as it relates to AHPDL clinical policies. a. The process for implementing HCA clinical policies, including system edits, communication to staff (call center, authorization staff, clinical reviewers, etc.), providers, and clients. b. Steps taken on an annual basis to ensure clinical policies are updated and complete in accordance with HCA clinical policy and directives. c. Describe how the MCO internal policy was utilized to implement the PPI policy. 7. The continuation of care for opioids by providing policy and procedures for approving a one-month continuation of care period and initiating the PA process for opioids for newly enrolled members. 8. Documentation detailing how the MCO identifies and provides continuity of care (transition fill) and continuation of therapy for prescriptions for new enrollees. 9. The continuity of care for prescriptions by providing policy and procedures for approving payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication. HCA's Program Integrity team requires Program Integrity Activities (PIA) be delivered monthly by each managed care plan. For FFY 2022 the following number of Audits, Reviews, Investigations were reported by the managed care plans for the PIA deliverable: 1. Amerigroup: 5 2. Coordinated Care of Washington: 11 3. Community Health Plan of Washington: 4 4. Molina Healthcare of Washington: 12 5. United Healthcare of Washington: 11

State	Explanation
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 Act and 42 C.F.R. § 456, subpart K?

Table 292 - Explanations for How the State Ensures MCO Compliance with DUR Requirements

State	Explanation
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	MCO Contract language States that the Contractor shall operate a drug utilization program that complies with the requirements of Section 1927(g) of the Act. The Contractor shall conduct drug utilization review (DUR) activities, as these activities promote the delivery of quality care in a cost effective and responsible manner and assure that prescriptions are appropriate and Medically Necessary; and are not likely to result in adverse medical events. The District of Columbia may impose fines, sanctions and/or other penalties if non-compliance with these requirements occurs.
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, and claims reviews to identify medication 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

State	Explanation
	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	Guidance is released and meetings to monitor compliance are occurring for drug rebate, 340B, PAD and use of NDC.
Illinois	Evaluation of information reported in the DUR Annual report helps determine compliance. The Bureau of Managed Care requires 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 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.
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

State	Explanation
	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. As of October 1, 2019 all MCOs are compliant with DUR requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K, as well as included in each MCO contract.
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 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 through quarterly reports with regards to prior authorizations that are responded to within the 24-hour requirement as part of the MCO contracts.
Mississippi	DOM oversees one common DUR board for MCO and FFS beneficiaries. Each MCO's pharmacy account manager is required to attend all DUR board meetings and to participate with DOM in implementing DUR board initiatives. Each MCO is contractually obliged to have a DUR program to conduct prospective and retrospective utilization review of prescriptions.

State	Explanation
Missouri	Pharmacy benefits are carved out of Managed Care.
Nebraska	MCOs are required to conduct a prospective and retrospective DUR program and submit quarterly reports to the State for review. MCO compliance with DUR requirements is also ensured through a review of each MCO's annual report.
Nevada	MCOs are required to establish and maintain a comprehensive drug utilization review program for covered outpatient drugs. This program encompasses various essential components, including prospective drug review, retrospective drug use review, application of standards, and an education program. These requirements are in accordance with the guidelines outlined in Section 1927(g) of the Social Security Act and 42 CFR part 456, subpart K. To ensure transparency and accountability, each MCO is obligated to furnish a detailed report regarding its drug utilization review program activities by December 31 of each calendar year, covering the previous federal fiscal year. By adhering to these reporting obligations, MCOs contribute to the effective implementation and oversight of drug utilization review programs, fostering safe and appropriate utilization of outpatient drugs for covered individuals.
New Hampshire	The State has requirements in the MCO contracts that they must comply with all DUR requirements described in Section 1927 g of the Act and 42 CFR part 456 subpart K The State reviews all DUR reporting prior to submitting the reports to CMS
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, reviews 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 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	State staff monitor MCO drug utilization data, policies and coverage parameters. The MCOs submitted formulary coverage and prior authorization information on a quarterly basis. MCO drug utilization is compared to fee-for-service data to identify areas for which each drug utilization could be improved across the MCO and FFS programs / benefits.
North Carolina	NC ensures MCO compliance with DUR requirements in various ways. The Division of Health Benefits (DHB) determines covered drugs and the plans are expected to have the same designation, PAs and applicable edits. The MCOs receive various files from the State to use in the administration of the pharmacy program. The plans will approach the State with any question they may have regarding coverage. The SLA for following our PDL is 95%. The plans can receive liquidated damages for not meeting SLAs. We have a standard process we go through to evaluate the plan's compliance with policy to ensure they are not more restrictive and are covering all CODs. They have signed attestations along with contracts. PA approval/denial rates are provided for review and the State has developed dashboards for review to assist in monitoring the plans.
North Dakota	The State ensures compliance by choosing to be the entity that operates the DUR program.
Ohio	The following language in the MCP provider agreement outlines requirements for Social Security Act Section 1927(g) and 42 CFR part 456, subpart K compliance: The MCP will

State	Explanation
	coordinate Prospective and Retrospective Drug Utilization Review strategies with ODM as specified. Drug Utilization Management: The MCP shall operate a drug utilization review (DUR) program and DUR Board designed to promote the appropriate clinical prescribing of covered drugs that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR Part 456 subpart K. As specified by ODM, the MCP shall submit information to fulfill the requirements of the annual report detailed in 42 CFR 456.712 of subpart K, including a detailed description of the program as required by 42 CFR 438.3(s)(5). Pursuant to ORC section 5167.12, the MCP may implement strategies for the management of drug utilization. ODM may request details of drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. and require changes to such programs, if they cause barriers to care. The MCP is required to have a claims review process or program that: i. Has safety edits regarding subsequent fills for opioids prescribed in excess of any limitation identified by the State; ii. Has safety edits on the maximum daily morphine equivalents able to be prescribed to an individual enrolled in MCP for the treatment of chronic pain; iii. Monitors individuals enrolled in the MCP that are concurrently prescribed opioids and benzodiazepines or antipsychotics; iv. Monitors and manages the appropriate use of antipsychotic medications by children enrolled in the MCP and submits information to the Secretary activities under programs for individuals under the age of 18 years and children in foster care as requested annually; and v. Identifies potential fraud or abuse of controlled substances by individuals enrolled in the MCP.
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 DUR requirements in the Social Security Act are included in the MCO Agreements with DHS to ensure compliance with the Act.
Rhode Island	RI has State liaisons that have oversight of the MCOs.
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	The TennCare-contracted MCO's only provide coverage of physician-administered-outpatient drugs; therefore, ProDUR edits are unable to occur as it is with pharmacy claims

State	Explanation
	via a PBM, where all ProDUR edits occur in real-time. Despite this, the following examples outlines our efforts to ensure compliance occurs: 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 the 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 (Pharmacy 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, all of the 3 MCO's are present on TennCare's DUR Board, as each MCO provides one of their medical directors to TennCare to serve DUR Board members. All of these providers are not only medical directors with our MCO's but they also 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 their DUR programs during a Readiness Review and MCOs annual submission of detailed reports, their DUR activities are evaluated every two years through an Operation 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	Washington Medicaid uses the deliverables, in combination with MCO encounter data, to conduct RetroDUR analysis of drug spend and utilization, as well as overall program compliance. HCA uses results of analyses to inform us of potential ProDUR opportunities, changes to drug status on our AHPDL, clinical policy development, and potential MCO contract changes. Unless warranted to focus on a single entity, we review and consider all

State	Explanation
	pharmacy claims across all Medicaid pharmacy programs. The reports, provider/client complaints, and PDL/policy developments help identify issues or areas of concern and are addressed monthly in MCO pharmacy director meetings. Issues or areas of concern are also escalated to our internal HCA-MCO partners for their attention in addressing or to our Program Integrity team for audit. If neither team chooses to pursue the issue, we conduct our own DUR activity to ensure alignment across all programs. If an immediate access issue is identified, it is addressed directly with the MCO for resolution and internal HCA-MCO partners are included so will have all information should they choose to conduct a larger review.
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 7456, 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 169 - Managed Care Plans Submission of DUR Reports

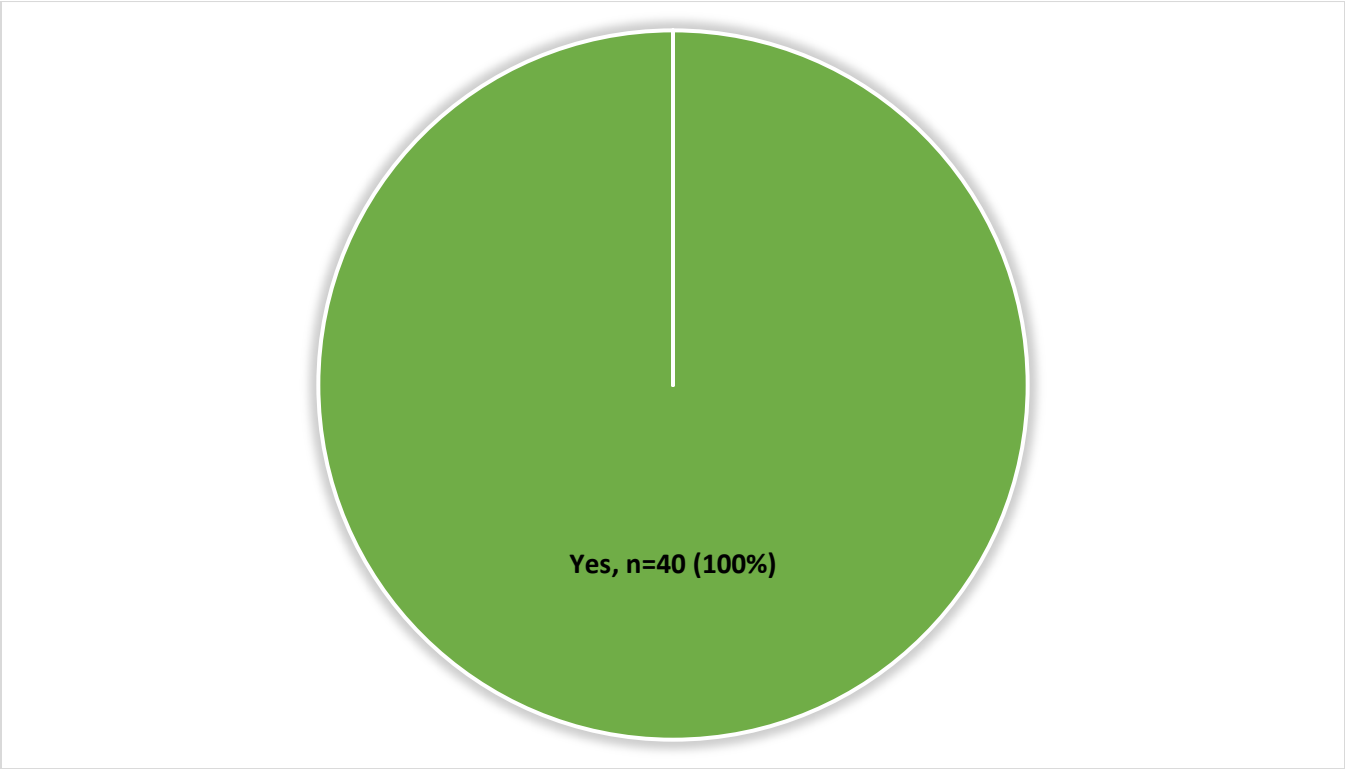

Table 293 - Managed Care Plans Submission of DUR Reports

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 Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	40	100.00%
Total		40	100.00%

Section XI - Executive Summary

Executive Summary should provide a brief overview of your program. It should describe FFY 2021 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and Statewide (FFS and MCO) initiatives.

Table 294 - State Executive Summary

State	Executive Summary
Alabama	In accordance with the Medicaid Drug Amendments contained in the Omnibus Budget Reconciliation Act of 1990, (Public Law 101-508), the Medicaid Agency provides a Drug Utilization Review (DUR) Program for covered outpatient drugs to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. The DUR Program is made up of the following components: Prospective Drug Utilization Review, Retrospective Drug Utilization Review, and an educational program. The Alabama Medicaid Agency has established a DUR Board. Board membership shall be composed of four practicing physicians, four practicing pharmacists, two representatives from the State's pharmacy schools, two representatives from the State's medical schools, and two representatives from the Alabama Medicaid Agency. The DUR Board has knowledge and experience in clinically appropriate prescribing and dispensing of covered outpatient drugs, monitoring of covered outpatient drugs, drug use review, evaluation and intervention, and medical quality assurance. Physician and pharmacist DUR Board members must be licensed in Alabama. The DUR Board meets quarterly. The activities of the DUR Board include retrospective DUR, prospective DUR, application of prescribing standards, and ongoing interventions for physicians and pharmacists. Interventions include information dissemination, written/oral/electronic reminders, face to face discussions, and intensified monitoring/review of providers/dispensers. The DUR Program is designed to educate physicians and pharmacists to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients associated with specific drugs. The DUR Program is also designed to monitory potential and actual drug reactions, therapeutic appropriateness, over-utilization, under-utilization, appropriate use of generic products, therapeutic duplication, drug/disease contraindications, drug interactions, incorrect drug dosage or duration, drug allergy interactions and clinical abuse/misuse. The DUR Board played an instrumental role in reviewing and implementing the SUPPORT Act of 2018 criteria. The DUR Program also reviews and approves new Point of Sale (POS) edits. The DUR Program is enhanced by an Academic Detailing program. The Academic Detailing program consists of full time provider representatives and one scheduler dedicated to educate providers on appropriate and cost-effective utilization of medications, Pharmacy ALERTS and other Medicaid-approved topics. The detailers develop an in-depth understanding of Medicaid prescribing patterns and work closely with Medicaid staff to educate providers on appropriate prescribing and dispensing patterns. The Alabama Medicaid Academic Detailers have been instrumental in dissemination related to the SUPPORT Act education and mandated DUR edits. Lastly, the DUR program includes the Pharmacy Lock-In Program. A dedicated clinical pharmacist reviews pharmacy and medical utilization of recipients to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The Lock-In Program restricts recipients found to be misusing services to one physician, pharmacy, or combination of these providers. With the

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	implementation of many SUPPORT Act mandates, the Pharmacy Lock-In Program is identifying less recipients for inclusion. Sources: 1) https://medicaid.alabama.gov/documents/9.0_Resources/9.2_Administrative_Code/9.2_Adm_Code_Chap_16_Pharmaceutical_Services_10-18-22.pdf 2) https://medicaid.alabama.gov/documents/2.0_Newsroom/2.4_Procurement/2.4_Active_Procurements/2.4_2023_PAS_01_RFP_2-21-23.pdf
Alaska	Executive Summary for Annual DUR report for FFY 2022 The Alaska Medicaid Drug Utilization Review (DUR) committee met for five scheduled meetings in FFY 2022. 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 2022 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 2021 (84.4%) to FFY 2022 (84.57) was relatively stable, which contributes to a grand total of a 12% increase since FFY 2012. The generic expenditure for FFY 2021, as a percent of total costs, was 15.7%. In FFY 2022, this number decreased to 14.2%. 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 2022. High cost specialty medications for rare orphan genetic conditions, 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. Retrospective Drug Utilization (RetroDUR) The RetroDUR portion of the committee meetings during FFY 2022 relied primarily on the review of aggregate claims data. Various educational means were employed, including sending informational

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	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 2022 the DUR committee continued their mission to review clinical 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 FFY2022 DRUG UTILIZATION REVIEW (DUR) BOARD The purpose of the DUR Board is to improve the quality of care for Arkansas Medicaid beneficiaries 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. The ProDUR program includes screening each claim in the POS system through the pharmacy vendor to monitor for potential drug therapy problems and assist the pharmacist in making sound clinical decisions for our Medicaid beneficiaries with focus on high dose warnings, drug-drug interactions, therapeutic duplications, early refills and incorrect duration. The RetroDUR program uses intervention criteria based on predetermined standards to monitor prescribing and dispensing patterns retrospectively focusing on overutilization/underutilization, clinical abuse and misuse, and patterns of fraud and abuse. The education component of the DUR Board provides for active and ongoing educational outreach programs to educate providers on common drug therapy problems. The DUR Board composition includes seven (7) physicians with varied specialties and eight (8) pharmacists from various fields that are voting members. Arkansas has four 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 a designee 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. Meetings have been held virtually since April 2020. 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

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	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. The FFS program has oversight of the managed care partners. The MCOs are required to have a representative attend all DUR Board meetings as a non-voting member to ensure they are kept abreast of any required updates. Each MCO must utilize the fee-for-service PDL. The MCOs are required to facilitate their own DUR Board meeting at least twice a year with a State representative attending as a voting member. The individual MCO's ProDUR and RDUR programs are discussed during those meetings. The MCOs provide a quarterly ProDUR report that mimics the required information on the CMS annual survey which is presented to the State DUR Board. The Pharmacy Program staff use an evidence-based approach for developing proposed criteria 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. DUR BOARD ACTION In addition to reviewing FFS and MCO ProDUR reports and determining RDUR intervention criteria, the Board voted on POS criteria edits, manual review criteria for new to market medications, and updated criteria/claim edits. The DUR Board created POS criteria edits for multiple medications/classes to help decrease the burden on our clinical review team and improve access to beneficiaries. The medications/classes included immunoglobulins, quetiapine, rescue seizure medications, Diclegis, preferred SGLT-2 inhibitors/GLP-1 agonists, and budesonide respules for eosinophilic esophagitis (EoE). The DUR Board reviewed and approved manual review criteria for 25 new medications, and the Board updated criteria and claim edits for 11 drugs/drug classes including quantity edits for anticonvulsants, dose optimization for multiple drug classes, age edits for sedative hypnotics, criteria for new Humira indication (hidradenitis suppurativa), update to Synagis policy, update to Palforzia criteria, migraine treatment criteria, update to multiple hemophilia medications, and update for new Dupixent indication (EoE).
California	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) 2021, California's Global Medi-Cal DUR Board (the Board) included eight pharmacists and five physicians, meeting OBRA 1990 requirements. The Board held four meetings in FFY 2021, 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, utilization reports, prospective and retrospective DUR reviews, and descriptions of educational articles.

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	The Board is responsible for advising and making recommendations to DHCS for the Medi-Cal population. Over the course of FFY 2021 the Board reviewed prospective DUR criteria for 17 drugs. In addition, retrospective DUR criteria were reviewed for all physician administered drugs (PADs), naloxone, anticholinergic medications, childhood vaccines, gabapentinoids, fluoroquinolones, hepatitis C virus (HCV) medications, and all medications that became available on the Medi-Cal Contract Drugs List in FFY 2020. A total of three educational articles were published on the Medi-Cal website to educate and inform Medi-Cal providers and beneficiaries on timely and relevant topics related to medication use. A poster on the legislative impact of naloxone prescribing in the Medi-Cal population was accepted for presentation at the American College of Clinical Pharmacy annual meeting. A total of five educational mailings were sent to selected prescribers to improve the quality of care for Medi-Cal beneficiaries. The Board provided a forum for dialogue and collaboration between FFS and MCOs, with five MCOs presenting their innovative practices and projects during Board meetings and all MCOs disseminating the DUR educational articles. The Board also continued to collaborate with key State agencies and national experts in FFY 2021, aligning their goals with the California Advancing and Innovating Medi-Cal (CalAIM) program and the DHCS Comprehensive Quality Strategy. Finally, the Board advised DHCS on updates and additions to existing DUR reports through Medi-Cal Rx, collaborating with Magellan to explore new system capabilities and focusing on medication safety and effective use. This report was prepared through a collaborative effort between DHCS, the Board, Magellan, and the University of California, San Francisco.
Colorado	The Health First Colorado (Colorado Medicaid) DUR program is in its tenth year of collaboration with the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences (SSPPS). The DUR program continues to contract with a pain management physician specialist and a child and adolescent psychiatrist for teleconsultation services. In addition to the subcontracted specialists, there are two clinical faculty members, an administrative faculty member, a biostatistician/analyst, a pharmacy outcomes researcher, and a pharmacy outcomes PhD student involved in conducting quarterly 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 Pharmacist and other members of the Department's Pharmacy Office team. During the time period of the reporting fiscal year, the Department observed a significant increase in electronic prior authorization (PA) request submissions when compared to traditional phone and fax requests. This increasing trend has been ongoing since implementation of the electronic prior authorization functionality in FFY21 as a component module of the Health First Colorado Prescriber Tool platform. The Department made changes to allow pharmacists enrolled as prescribers with Health First Colorado to prescribe opioid antagonists indicated for treating drug overdose in alignment with implementation of changes to Colorado Revised Statues C.R.S. 12-30-110 and C.R.S 12-280-123. In conjunction with the signing of Colorado SB21-009, the Department implemented changes to coverage and utilization management for medications provided in conjunction with family planning related services and made changes to allow $0 copay for these medications. The Department also removed place of service PA requirements for long-acting injectable antipsychotic medications filled through the pharmacy benefit, allowing pharmacy claims for these medications to pay with no PA required. Other noteworthy changes made to pharmacy benefit coverage during

State	Executive Summary
	the reporting period included removal of PA requirements for brand Suboxone (buprenorphine/naloxone) sublingual films, removal of place of service PA requirements for Vivitrol (naltrexone ER), removal of PA requirements for medications used for initial treatment of hepatitis C. The Department also implemented new value based contractual agreements and expanded the number of physician-administered drugs managed with PA under the medical benefit. Colorado's DUR program sent out provider educational outreach letters encouraging naloxone prescribing for high-risk beneficiaries receiving opioids; identifying beneficiaries receiving multiple benzodiazepine medications or opioid, benzodiazepine, and muscle relaxant medications concomitantly; and identifying children and adolescents receiving multiple antipsychotic medications. The DUR team worked collaboratively with the contracted opioid prescriber consult pain management physician to implement a more comprehensive data tracking system for Health First Colorado members and providers who interact with pain management consultation service. Based on feedback received from other State DUR programs, Colorado's DUR team conducted a reporting analysis of lorazepam oral liquid formulation utilization to rule out misuse or abuse of this product within the Health First Colorado population. The SSPSS DUR program team produced pharmacy intern projects to summarize the details of REMS program additions in 2020 and 2021 and also conduct literature searches to evaluate efficacy and safety of the clinical use of stimulant medications (such as 'basal-bolus' dosing, use in combination with buprenorphine, and concomitant use of two chemically distinct stimulant medications). DUR Board meeting agendas have continued to be very full as additional drug classes were added to the State's FFS pharmacy PDL and new PA criteria were developed and reviewed by the Board for selected non-PDL medications and physician administered drugs covered under the pharmacy and/or medical benefit. New Preferred Drug List classes added during FFY 2022 included oral Human Immunodeficiency Virus (HIV) agents (though all medications in this class remain preferred with no coverage or PA limitations), systemic juvenile idiopathic arthritis (added to the 'Targeted Immune Modulators' drug class), and topical immunomodulators and related agents. The DUR Board continues to have high quality discussions leading to high quality recommendations made to the Department. DUR Board meetings continue to be held virtually, occurring at a quarterly frequency and lasting around 5 hours.
Connecticut	Objectives for the operations of the Connecticut Medical Assistance Drug Utilization Review (DUR) Board during federal fiscal year 2022 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. From 10/01/2021 to 9/30/2022 the DUR Board was comprised of six pharmacists and three physicians. Four DUR Board meetings were held during FFY 2022. Twenty-four targeted retrospective analyses were reviewed and approved by the DUR Board and conducted during FFY 2022. 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 2022. The Pharmacy Lock-In Program is ongoing and Kepro is required to review 800 lock-in profiles monthly.

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	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 2022 from Kepro was $3,964,587. The reported cost savings for Prospective DUR during FFY 2022 was $156,524,513.
Delaware	In Federal Fiscal year 2022, eighty-seven percent of the population resided in two managed care organizations while 13% of the population remained in fee-for-service. Most of the FFS clients were transitioned into a managed care plan within 60 days. In order to streamline consistent drug status across both MCO plans and FFS and to reduce costs, Delaware has continued to maintain a unified PDL. Claims editing on encounters mirrors that of FFS claims which helps keep both MCO and FFS drug programs aligned and provides consistent care across the plans. As with previous years, the Covid 19 public health emergency continued to present on-going challenges. New treatments, testing and vaccines were added to the system as they became available, and care was taken to ensure consistency of coverage between MCO and FFS. Changes to comply with the Prep Act and amendments were implemented as necessary. Additionally, multiple methods of provider notification were utilized to keep providers informed of changes and updates. Delaware also continues to address the opioid epidemic by focusing on prescribing trends, opioid utilization, and provider outreach and education. Both the FFS and the MCO programs have implemented claims review requirements of safety edits, maximum daily morphine milligram equivalent safety edits and concurrent utilization alerts as required by the Support Act. The DUR board continues to review utilization trends to see where additional measures may be needed in the future. This utilization data continues to shed light onto areas of possible improvement through collaboration with Substance Abuse and Mental Health divisions, Department of Public Health and other State organizations. Ultimately, the goal is to ensure Delaware's most vulnerable population is provided with the level of care that they both need and deserve in an efficient and timely manner
District of Columbia	The Drug Utilization Review Board continued to focus on responding to the opioid epidemic in the District of Columbia which has been fueled in part by prescribed opioid drug misuse and abuse. Thankfully recent changes to the District's Prescription Drug Monitoring Program (PDMP) now include a legislative mandate for prescribers to query the PDMP for previous or current opioid utilization before writing a prescription. The Board published a document entitled Guidelines for Collaborative Management of Opioid Use which addressed the opioid epidemic in the District of Columbia and offered recommendations for opioid treatment clinical criteria and best practices. The Board actively incorporated involvement of the Pharmacy and Medical Directors of the MCOs into quarterly DHCF DUR Board meetings throughout FY22 to proactively seek 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. MCOs reported on their individual DUR initiatives and provided detailed information on utilization of hydroxyurea in the treatment of Sickle Cell Disease for their members. The Board engaged the professional services of a local hematologist and SCD expert to review the MCO reporting and to suggest strategies to promote increased use of

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	hydroxyurea where appropriate. An accredited continuing education program on new and emerging treatments for sickle cell disease sponsored by the DUR Board was made available to physicians, pharmacists and nurses providing care to patients living with SCD. The DUR Board receives and reviews monthly reports on SUPPORT Act DUR mandated oversight areas. Particular attention was given to concomitant prescribing of opioids and antidepressants, opioids and benzodiazepines and opioids and gabapentanoids since these are therapeutic categories with the greatest number of claims for the FFS program. The addition of a child and adolescent Psychiatrist to the Board membership continues to enhance the Board's ability to monitor antipsychotic, antidepressant, and stimulant use more closely in the Medicaid child population. The psychiatrist member 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 using a provider newsletter and website postings. The Board is pleased that its recommendations that several of the temporary pharmacy program enhancements made during the COVID-19 public health emergency PHE to promote maximal access to prescribed medications were considered for permanent adoption by District Medicaid. Specifically, the provision of a 90-day supply of maintenance medications and the elimination of the pharmacy copay were proposals that the Board members felt were vital to ensuring that unnecessary barriers be removed for the fee for service beneficiaries. The DC Medicaid program is following up with State Plan Amendment requests to be submitted to CMS for approval. MCO case management coordination of beneficiaries living with HIV remains a challenge as the coverage of HIV antiretroviral medications is carved out from managed care into Fee for Service. DHCF, Board members and the MCOs continue to explore technological solutions that might prove effective and practical in addressing these gaps in coordination of care. 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 medically necessary.
Florida	I. 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. II. Prospective Drug Utilization Review Program (ProDUR)

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	Prospective Drug Utilization Review (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 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 eight drug therapy problem types in which potential medication problems may exist. The screening types identified by Florida Medicaid's FFS ProDUR criteria are: 1. 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. 2. 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. 3. Early Refill (ER) - Alert occurs when a prescription is refilled before 80 percent of the previously filled prescription's days' supply has elapsed. 4. 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. 5. 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. 6. 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. 7. Drug-Age Contraindication (PA) - Drug-Age Contraindication alerts occur when a drug is dispensed that is not recommended for use in the age group of the patient. Age alerts can occur

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	when the patient is too old for the given medication, is too young for the given medication, or is not within the recommended age range for this medication. 8. Underutilization (LR) - Underutilization alerts occur when patients have waited to refill their maintenance medications beyond the specified days' supply of the previous fill. III. 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. IV. 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 retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration. The RetroDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or 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 can 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 provider alert on the Agency website. 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.

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	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 because of the intervention. Cost savings may vary due to a variety of factors including the 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 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 initiatives in FFY 2022 demonstrated cost savings as documented below: The Lyrica automated prior authorization produced a $13,527.48 savings. The long-acting opiate and benzodiazepine concomitant therapy soft edit produced a $103.92 savings.
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 2022 (FFY2022), 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 FFY2022, the DURB researched, reviewed and made PDL/PADL recommendations for the following drugs: Brexafemme Kerendia

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	Saphnelo Aduhelm Lybalvi Myfembree Opzelura Skytrofa Tyrvaya Apretude Leqvio Qulipta Tezspire Vabysmo Xipere Adbry Cibinqo Ibsrela Winlevi In addition to the drug classes which the new drugs above belonged to, the Department, in collaboration with the DURB, also researched, reviewed and made PDL/PADL recommendations and updates to several therapeutic classes to ensure cost-effective, clinically appropriate patient care.
Hawaii	FFS has a dental and a transplant program. The dental covers all under 21 years of age; has a generic formulary for dental necessity; initial and acute care. Only emergency dental care is covered for adults. The nature of the program defines the type of proDUR and retroDUR. The transplant program accepts recipients from the MCOs and their medication profile is grandfathered into the FFS. One year after the transplant and stabilization, the recipient returns to their original MCO. Their immunosuppressant medications will be covered by the MCO by State law. The nature of the program defines the type of proDUR and retroDUR. Beginning January 2023 all adults will be included in the dental plan by State law. A review of the formulary and retroDUR by the DUR Board were initiated for the quantity limits of the narcotics. Several MCO will grow to all MCOs using POS edits to direct their MCO recipients to the FFS dental program. Monthly meetings with the MCO pharmacists are providing DUR oversight and discussion of State initiatives: dental expansion, COVID, Hepatitis C, MAT, etc. The past DUR Board activities supported a judgment in FFY 2022 against Bristol Myers Squibb, et al. with $834,023,000 in civil penalties for unfair and deceptive practices in marketing and distributing the prescription drug Plavix. A smaller settlement of $19 million was secured for Neupogen and incorrect billing units.
Idaho	During Federal Fiscal Year 2022, the activities of the Idaho Drug Utilization Review (DUR) Board were coordinated by Magellan Rx Management. Idaho Medicaid has developed over the last decade and continuously improved upon a successful DUR model that is different from that of many State Medicaid DUR programs. The model is a partnership between Magellan and the Idaho Medicaid program's clinical pharmacists. Idaho Medicaid's clinical pharmacists and the Idaho Medicaid DUR Board identify specific areas of concern and quality improvement opportunities. Magellan then pulls the data needed, including individual patient profiles, which are then analyzed

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	by Idaho Medicaid clinical pharmacy staff. Both Magellan staff and Idaho Medicaid staff present findings at our quarterly DUR meetings. The Division operates its own internal pharmacy call center to manage the prior authorization (PA) program. Criteria are developed by our clinical pharmacy 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. The Board also identifies problematic drug utilization issues for further DUR Board studies. The DUR Board and P&T Committee work closely together to identify areas for improvement and evaluate interventions as well as evaluating the impact of preferred agent changes on quality of care. 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. Many of these drugs fall under the classification of specialty drugs and are of significant high cost to the program. By including these drugs in pharmacy processes, we ensure that Medicaid participants receive high quality, equivalent and cost-effective pharmaceutical care regardless of where the drug is administered. During the time interval for this report, twelve 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 during the time period of this report averaged 84% We prefer brand drugs over generics in many instances because of favorable net net cost after rebate. This results in significant cost avoidance each quarter. Cost savings for Prospective DUR, based on claims reversed and not resubmitted was $60,684,021 with no actual saving realized for Retrospective DUR. Innovative practices for the program this year were centered around appropriate opioid use and pain control, treatment of opioid use disorder, decreasing benzodiazepines use in the treatment of anxiety, appropriate and fiscally responsible use of new and high-cost therapies, particularly biologics, as well as expanding pharmacist practice as Ordering, Referring and Prescribing Providers. 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 the point-of-sale. The Department utilizes evidence-based drug information to develop and regularly review its 88 drug-class PDL and to create therapeutic criteria. The pharmacy program is well respected within the Division 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 positive health outcomes.
Illinois	Throughout FFY22, 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. A new universal Pharmacy Prior Authorization Form was created for Fee-for-Service (FFS) Medicaid. HFS also worked on overall efficiencies. The HFS Web site was updated and coverage groups adjusted. For example, all children previously in the State's All Kids Share, Premium Level 1, and Premium Level 2 Medical Assistance programs moved into the State's All KidsAssist Medicaid program (Title 19), effective July 1, 2022. Certain sexual assault survivors received coverage under the HFS Sexual Assault Emergency Treatment Program even if they had private insurance.

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	The COVID-19 policy and edit changes enacted in third quarter FFY20 remained in effect to facilitate access to medications and decrease prior-authorization paperwork for prescribers. These included the temporarily lifted edits such as Four Prescription Policy, 3-Brand limit, relaxed refill-too-soon tolerances, enhanced 90-day allowed maintenance drug list, and adjustments to the Preferred Drug List and OTC drug coverage. During FFY22, HFS continued to address COVID vaccination and treatment coverage and related rates as new age groups and immigrant patient groups became candidates for initial and additional vaccine doses and booster vaccination or antiviral and monoclonal treatments. Illinois pharmacies were able to be reimbursed for administration or dispensing of these products. COVID-19 home rapid test kits were billable if ordered by pharmacists. Emergency medical coverage was extended for persons aged 19 and older who do not meet immigration status and had a COVID-19 diagnosis or suspected diagnosis. In planning for the end of the COVID-19 Public Health Emergency (PHE), HFS released communication toolkits in 10 languages for prescribers and pharmacists to inform patients of the need to update addresses so that coverage did not cease with Medicaid eligibility redetermination upon PHE end. During FFY22, 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, immunosuppressants, antivirals, and biological products. Illinois HFS opioid-related prospective edits based on the SUPPORT for Patients and Communities Act (SUPPORT Act) were maintained during FFY22 with no changes due to the COVID-19 PHE. Retrospectively reviewed topics included first-line therapy in patients filling alprazolam monotherapy and in patients with Type 2 diabetes mellitus (T2DM) and comorbid atherosclerotic cardiovascular disease, chronic kidney disease, or heart failure; multiple short days supply opioid prescriptions in dental patients; tramadol and codeine utilization; and incretin mimetic duplicate therapy. Outreach was conducted with prescribers and pharmacy providers of patients receiving high opioid MME prescriptions to increase provision of naloxone. A continuing education presentation at the Illinois Pharmacists Association Annual Meeting was conducted to encourage use of the naloxone standing order. Increased naloxone education and provision by prescribers and pharmacists is anticipated due to Illinois legislation passed in June 2022. During FFY22 HFS continued to respond to participant and prescriber needs. Availability of Synagis earlier than the typical RSV season facilitated timely care of pediatric participants. During FFY22 HFS continued to allow coverage of imported apo-varenicline from Apotex for smoking cessation due to the Chantix shortage. Post-kidney transplant preferred drugs were available to participants who received a kidney transplant under the Emergency Medical Program. HFS provided coverage for treatment for port-wine stains, not limited to children and not solely for cosmetic purposes. Patients with diabetes benefited from coverage for participation in the Diabetes Prevention Program (DPP) and Diabetes Self-Management Education and Support (DSMES) as well as from coverage for continuous glucose monitors. Screening, Brief Intervention, and Referral to Treatment (SBIRT) services were covered and reimbursement rates were increased for Substance Use Prevention and Recovery (SUPR). Cost savings have been realized as a result of improved utilization management of covered medications. Web sites continue to be maintained to provide information about DUR Board activities, DUR educational materials, as well as prior authorization criteria and forms. The HFS collaboration continued with the University of Illinois Chicago College of Pharmacy to provide Academic Detailing services and continuing medical education via the Illinois ADVANCE (Academic Detailing Visits And New evidence CEnter) initiative. Available topics expanded beyond opioid-related topics and

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	cardiorenal benefits of anti-diabetic medications for the treatment of T2DM to sexually transmitted infections, asthma, and smoking cessation. For 2023 planned initiatives include ongoing outreach to prescribers of participants at high-risk for opioid overdose who may benefit from naloxone and those without first-line therapy for targeted conditions; implementation of initial days supply edit for benzodiazepine naive participants and adjustment of the initial days supply opioid edit; and utilization related to medications addressed by the Pharmacy & Therapeutics Committee.
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 (proDUR) and retrospective DUR (retroDUR) each serve a unique purpose in providing practitioners and pharmacists with specific, focused, and comprehensive drug information available from no other source. For FFY 2022, the total estimated savings for the Indiana Medicaid proDUR program was approximately $68.13 million. The retroDUR estimated savings were -$5,538,725 in FFY 2022 with additional retroDUR savings to be demonstrated in the FFY 2023 report. The negative estimated savings for the retroDUR in FFY 2022 is attributed to the increased dispensing of blood glucose testing supplies and naloxone in patients with opioid doses 90 MME or greater. Medical savings from these initiatives could not be determined. The total savings was estimated at approximately $62.59 million. The cost to administer both programs is $0.30 million, which results in a net savings of approximately $62.29 million. In FFY 2013, the State of Indiana transferred the management of the pharmacy benefit to Optum Rx (previously Catamaran). Optum Rx manages both the proDUR and retroDUR programs, which were previously split between two contractors. Optum Rx began the first real-time faxed prescriber retroDUR intervention on August 1, 2014. Additional information regarding the specifics of the implemented retroDUR 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 2022. The Mental Health Quality Advisory Committee advised the DUR Board regarding 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, antiseizure agents, antipsychotic agents, SSRI/SNRIs, pulmonary antihypertensives, cystic fibrosis inhaled agents, hematinic agents, Sandostatin®, Soriatane®, topical immunomodulators, antimigraine, and sedative-hypnotics/benzodiazepine agents. The DUR Board reviewed and approved the following new and updated manual prior authorization criteria: hepatitis C agents, cystic fibrosis inhaled agents, hepatitis B agents, antimigraine agents, pulmonary antihypertensive agents, PCSK9 inhibitors and select lipotropics, miscellaneous cardiac agents, miscellaneous step therapy, spinal muscular atrophy agents, Sickle Cell agents, Cushing's Disease agents, growth hormone, allergy specific immunotherapy, Mepron®, narcolepsy agents, Oxervate®, testosterones, uterine disorder agents, Vyndaqel® and Vyndamax®, Aduhelm®, somatostatin analogs, Carafate® and Cytotec®, cystic fibrosis inhaled agents, Fentanyl®, presbyopia agents, treatments for dry eye disease or keratoconjunctivitis, and muscular dystrophy agents. 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 retroDUR and proDUR program through review of guideline-based care with the DUR Board.

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Iowa	On April 1, 2016, Iowa Medicaid transitioned from 100 percent fee for-service (FFS) to providing coverage through Managed Care Organizations (MCOs) for over 90 percent of its population. While this transition occurred over six 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 $27,670.10 versus an estimated total cost savings of $5,774.76 in FFY 2021. While there was an 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 $16,689.93 versus a savings of $5,457.72 in FFY 2021. 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 evaluated in FFYE 2022 is $10,980.17 versus $317.04 in FFY 2021. The increase in savings is due to the cost of the particular drug(s) involved in the intervention. The FFS and MCOs collaborated on multiple retroDUR initiatives during FFY 2022. Topics include two short-acting opioids, two long-acting opioids, concurrent GLP1 RA and DPP4i, high dose glucocorticoids without bisphosphonate, duplicate therapy with stimulants, SABA overutilization, duplicate antipsychotics in adults, high dose opioids without reversal agent, and LABA without ICS.
Kansas	The State is learning our new Kansas Medicaid Modular System. The high percent of new drugs indicated for rare diseases requires additional time to evaluate management needs and possibly expanded program needs, including potential VBCs. The State legislature approved for another pharmacist and a pharmacy technician to the Medicaid drug team. We did not get a new pharmacist hired until 8 months after the position was approved due to the processes involved and finding a pharmacist that was willing to take a cut in pay to work for the State. We still do not have a candidate for the pharmacy technician position. Our efforts to decrease provider burden and re-evaluate program needs and work load to improve overall results is a constant process. On a brighter note, we now have a Medical Director and a new Nursing Supervisor, so our medical team at the State collectively is getting more support to do the work needed.
Kentucky	This DUR program annual report encompasses the drug utilization review activities and outcomes that have occurred during FFY 2022. 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

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	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. II. 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. 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 a defined time period. 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

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	(DPC) are not included in ProDUR cost savings, because the Kentucky Medicaid FFS program denies these claims outside of the ProDUR environment. III. 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, 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. IV. 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 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 2022 will not be known until the end of FFY 2023.
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

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	Louisiana Department of Health (LDH). A commitment to improving the quality of patient health care was demonstrated during the FFY22. 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 pharmacy program arena. In FFY19 LDH established a Single Preferred Drug List across all MCOs and Medicaid Fee for Service (FFS). 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. 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 develops a series of educational articles that are published in the Provider Update newsletters. The monthly newsletters are available for viewing on the lamedicaid.com webpage. Prospective DUR interventions: Prospective DUR screening occurs every time a pharmacist processes a prescription, before the prescription is dispensed to the patient, to assure safe and medically necessary drug use. Clinical alerts and edits address current disease-focused categories such as behavioral health and pain disorders. Pharmacy cost avoidance of $ $39,782,223.04 is attributed to the use of the prospective interventions during FFY22. Retrospective DUR interventions. The Louisiana Drug Utilization Review (LADUR) program provides retrospective clinical interventions in the form of mailings to prescribers and pharmacists and occur after prescriptions are dispensed. These interventions make accessible current pertinent information to the provider concerning the patient and are often derived from nationally recognized disease management guidelines, potentially improving the beneficiary's disease management and quality of life. In FFY22, LADUR interventions addressed issues in the following categories: opioid safety, sleep disorders, behavioral health, muscle relaxants, opioid use disorder, hypertension management, heart failure management, diabetes management, and asthma management. Pharmacy cost avoidance attributed to LADUR interventions during FFY22 projected to $77,788.92 in the targeted drug classes. Drug expenditure reductions averaged 26 percent in the drug classes in which discontinuation or reduction of drug use was recommended. Drug expenditure increases were reflected for 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.
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 become part

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	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 2022, the DUR reviewed 63 New Drugs, 6 revised clinical criteria, looked at 51 Therapeutic Class reviews, 5 Quantity Limits on new or established drugs, in determining placement of medications on the State's Preferred Drug List. Overall, 1 FDA safety alert was reviewed and recommendations were made when appropriate. The DUR continued its review of a variety of analyses to better advise The MaineCare program on how best to educate providers and address the impact of pharmacy manufacturer advertising. In it's review during the survey period the Board looked at HPV vaccination rates, the use of codeine medications in the pediatric population as a direct correlation to Safety Alerts from the the FDA. The DUR looked at overlapping or current use of GLP-1 and DPP-4 inhibitors for opportunities to educate providers on appropriate diabetic therapies. The review of appropriate Asthma controller medications and review of hospital or ER admission with inappropriate use. And lastly, the Board reviewed opioid use from multiple providers to see if any educational opportunities were apparent. 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 continue 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 2022 The objectives for the operation of the Maryland Medicaid Drug Utilization Review (DUR) Board during Federal Fiscal Year (FFY) 2022 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 2022, the DUR Board was comprised of seven (7) pharmacists and four (4) physicians. Four (4) DUR Board meetings were held during FFY 2022. The meetings were held on the first Thursday of the months of March, June, September and December. Approximately 90% of Maryland Medicaid participants were enrolled in the managed care program known as HealthChoice during FFY 2022. There were nine (9) managed care organizations who participated in the HealthChoice Program during this timeframe. Mental health drugs, including

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	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. 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 2022, 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 Kepro. 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. Fourteen (14) retrospective analyses were conducted during FFY 2022, including those directly related to the Corrective Managed Care Program. 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 92% 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 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.

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	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. 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. New POSECMS System On October 30, 2022 the Maryland Department of Health went live with a new Point of Sale Electronic Claims Management System. The system added new e-prescribing capabilities and an enhanced web portal with prior authorization functionality. 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 Chan 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 program s have been implemented. Prospective DUR (proDUR): Prior to dispensing prescription medication, the pharmacist is required to screen for possible drug therapy problem s 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

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	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 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 Pharmacy Product 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 Pharmacy Product 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 2022 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 increased during FFY 2022 with an average total enrollment of 3,092,772, an increase of 7% from FFY 2021. Approximately 73% of the Medicaid beneficiaries are enrolled in Managed Care Organizations (MCOs). The remaining 27% 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. During 2021, MDHHS added coverage of the COVID-19 vaccines, antivirals and home test kits. 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.

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	FFY 2022 saw the continued expansion of hepatitis C virus (HCV) treatment coverage with the implementation of Michigan's HCV elimination program, called We Treat Hep C, implemented in April 2021. This program removed barriers by eliminating the clinical prior authorization and prescriber specialty requirements. The DUR Board continued to monitor the academic detailing outreach that targeted practitioners with relationship to individuals with no record of treatment for their Hepatitis C infections. A great deal of time was devoted to the management of the single Medicaid PDL that was implemented in 2020 to maximize drug manufacturer rebates to generate savings. Coordination of the PDL PA criteria with the MCOs and FFS ensures consistency across the entire Medicaid population for the PDL drug classes. MDHHS received CMS approval of a State Amendment Plan (SPA) to allow the coverage of anti-obesity medications. Effective February 1, 2022, the anti-obesity medications were added to the PDL. Coverage of these products aligns with the current standards of practice and supports the recognized treatments of comorbid conditions. 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. The April 2021 contract with Abbvie for the HCV drug Mavyret was the second agreement. MDHHS recently executed a third agreement with Janssen for their long-acting injectable antipsychotics (LAIs) Invega Sustenna, Invega Trinza and Invega Hafyera. Outcomes-Based Contracts/Value-Based Agreements are encouraged by the Department of Health and Human Services to help address high drug costs.
Minnesota	There are 1.3 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 prior authorization criteria for nonpreferred drugs cannot disadvantage preferred drugs. MCO may also use the same prior authorization criteria as FFS Medicaid. Managed Care Organizations (MCO): This is the fourth federal fiscal year (FFY) where Minnesota Medicaid MCOs, BluePlus, HealthPartners, HennepinHealth, IMCare, Medica, PrimeWest, SouthCountry, UCare, and UnitedHealthcare will be included in the Medicaid State report to CMS. Oversight includes pharmacy representatives from each MCO meeting routinely with the Medicaid pharmacy staff regarding the uniform Preferred Drug List (PDL) changes and respective prior authorization criteria. The CMS Annual DUR Survey requirement is included in the agenda as needed. Fee-for-Service (FFS): The FFS DUR Board met quarterly. A meeting's agenda consisted of (1) ProDUR criteria (performed in-house through DHS MMIS claims adjudication) and (2) RetroDUR interventions including criteria and associated message(s), educational content, selection of intervention format (individual profile reviews or special mailings) and (3) post intervention outcome assessments. Kepro, Inc. became the RetroDUR contractor beginning October 1, 2020.

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	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 2022, there were a total of 10,424 provider letters mailed regarding 11,314 targeted patients. Quarterly RetroDUR population-based mailings for FFY 2022 included Muscle Relaxers/Sedative Hypnotics/CNS Depressants (1/2022), Psychotropics in Adults, (4/2022), Montelukast Black Box Warnings (6/2022), and Management of Diabetes Mellitus (10/2022). Improvement in clinical indicators outcomes were Muscle Relaxers/Sedative Hypnotics/CNS Depressants 50%, Psychotropics in Adults 38%, Montelukast Black Box Warnings 47%, and Management of Diabetes Mellitus 95%. Psychotropic Drugs in Children: Two additional mailings were completed to address the use of psychotropic drugs in children. Eight clinical indicators are used: 1) psychotropic drug polypharmacy defined as 3 or greater psychotropic medications., 2) multiple (two or more) oral second-generation antipsychotics (SGA), 3) SGA inappropriate age, 4) SGA high dose for age range, 5) inappropriate age for drugs used to treat Attention-deficit/Hyperactivity Disorder (ADHD), 6) high dose ADHD drugs for age range, 7) SGA blood glucose monitoring, and 8) SGA lipid monitoring. 1. The first mailing (3/2022) consisted of 1,259 prescriber letters regarding 1,792 patients. The outcome adjusted patient count was 1,682. Clinical indicator improvement was 47%. 2. The second mailing (9/2022) consisted of 1,886 prescriber letters regarding 2,558 patients. The outcome adjusted patient count was 2,450. Clinical indicator improvement was 47%. Opioids: SUPPORT Act RetroDUR mailings occur biannually. Criteria included current use of opioid and benzodiazepine, concurrent use of opioid and antipsychotic drugs, duplicative short-acting opioids, duplicative long-acting opioids, exceeding a 90 mg cumulative maximum daily morphine milligram equivalent (MME), new opioid use without a new indication after being prescribed drugs for MAT and/or OUD diagnosis, and lastly, consider co-dispensing naloxone in patients with high risk of opioid overdose, 1. The first mailing (02/2022) consisted of 934 provider letters regarding 498 patients. Improvement in clinical indicators was 46%. 2. The second mailing (08/2022) consisted of 750 provider letters regarding 421 patients. Improvement in clinical indicators was 52%.
Mississippi	During FFY 2022, the agency was focused on design and implementation of a new fiscal agent/MMIS vendor, Gainwell Technologies, after almost 20 years with the previous vendor and system. Although the new vendor implemented at the beginning of FFY 2023 on October 1, 2022, the run-up to implementation was extremely busy for DOM staff. Obviously, all of the every day responsibilities to our beneficiaries and providers continued, while an increasing number of meetings were necessary to work through design and testing of the new system. From a DUR perspective, this was an innovative year because we began a focus on severe maternal morbidity (SMM) that carried throughout the year. After beginning this focus with a look at medication and supplement utilization during pregnancy, we followed the data into a deep study of various factors associated with maternal morbidity among women of our beneficiary population. Our DUR initiatives resulted in several published articles and clinical poster presentations. These examinations of the relationship between risk factors and severe maternal morbidity events among Medicaid beneficiaries will help inform DOM on which risk factors are most closely associated with

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	SMM events and can help guide the development of future interventions aimed at improving overall maternal health. From this model, the Maternal Comorbidity Index (MCI), distance from the delivery center, age, and race were found to be significantly associated with SMM events. Another innovative DUR effort that we undertook was the design and distribution of an educational intervention program to educate providers on updated asthma guideline and performance on asthma management quality measures. The result of this effort was a Smart Therapy flyer designed to capture the attention of beneficiaries and convey the changes to asthma management treatment guidelines in relatively few words. This flyer was distributed with an informational letter to targeted providers who have prescribed inhalers (rescue or controller) to beneficiaries with AMR less than 0.5 AND at least 1 asthma-related hospitalization and/or ED visit in the past 12 months. In addition, the flyer was distributed through email and social media of State professional medical and pharmacy organizations, as well as DOM agency social media accounts.
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, increasing access of opioid overdose reversal agents, and decreasing barriers to hepatitis C treatment. A number of psychotropic clinic edits are in place 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 mature and has reduced utilization significantly. Next steps for MO HealthNet are to encourage prescribers to submit diagnosis codes on prescriptions 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. In April 2021 began requiring participants who are high risk combinations of opioids with other products to have a claim for naloxone in the past 2 years. Missouri has also opened up access to alternative pain management therapies, including acupuncture, chiropractic services, and physical therapy, along with reducing burdens for

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	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. MO HealthNet has removed prior authorization requirements for it's preferred Hepatitis C Therapy, recently receiving an A+ for Medicaid access to HCV treatments. The MO HealthNet Pharmacy Program's goal is the continued provision of quality, cost-effective health care for Missouri's most vulnerable citizens.
Montana	Due to components of our Disaster SPA, Montana has been unable to perform many of our prior authorization continuation follow-up reviews as these would require additional documentation from the provider. Our DUR contractor's case management team has continued to perform in-depth reviews for new medication starts as well as RDUR outreach. They did an in-depth review of COPD inhaler usage which resulted in a report to the Board and criteria change. A review of SGLT-2 prior authorization reviews, as well as new indications, led the Board to remove criteria for that class as well. They added Heart Failure Management to their RDUR academic detailing outreach. While their case reviews and RDUR has not waivered, they have not been able to capture as many outcome measures as in previous years and have relied on claim details to assess efficacy of outreach. Please see previous sections for more detailed descriptions of case management programs. The Department has not implemented new programs during the PHE. All PHE Disaster SPA pharmacy exceptions were in place until 5/12/2023.
Nebraska	The Nebraska Medicaid DUR Board has returned to in-person meetings along with virtual option for up to 50% of the meetings. The purpose of the Drug Utilization Review (DUR) Board is to improve the quality of care for Nebraska Medicaid members receiving prescription drug benefits by making sure prescriptions are therapeutically appropriate and cost effective. Each MCO vendor and Magellan Medicaid Administration for FFS are required to have a representative attend all DUR Board meetings as a non-voting member to ensure they are kept up to date on drug utilization changes. Each MCO also utilizes the same single PDL. 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 Nebraska Medicaid Fee-for-Service (FFS) Program. The PDMP is provided by CyncHealth. This vendor provides Nebraska with data resources and gives the ability to run reports through their Health Information Exchange portal. Nebraska opioid-related prospective edits for the SUPPORT ACT were maintained with no changes due to the ongoing PHE.
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 200. The DUR Board consists of no less than five members and no more than ten members appointed by the State Director of Health and Human Resources. During Federal Fiscal Year 2022, the quarterly public DUR meetings were facilitated by a licensed pharmacist from OptumRx (10/1/21 - 6/30/22) or Magellan Medicaid Administration (7/1/22 - present), the Pharmacy Benefit Manager (PBM) for Fee-for-Service Medicaid. The DUR Board meets to monitor drugs for clinical appropriateness, drug utilization, therapeutic duplications, drug-disease contraindications, and quality of care. The DUR Board accomplishes this by establishing prior authorization (PA) criteria and quantity limits to certain drugs/drug classes based on clinical presentations and recommendations from the PBM, utilization data, experience, and testimony presented at the DUR Board meetings. This includes retrospective evaluation of

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	interventions, and prospective drug review that is done electronically for each prescription filled at the Point of Sale (POS). For FFY 2022, the DUR Board was comprised of four physicians (1 pain specialist, two family medicine specialists, and one pediatrician), one physician assistant, and five clinical pharmacists. All members practiced in various locations in 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 PBM services. The four managed care organizations (MCOs) 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 PA criteria for the Board are supplied by the PBM vendor and each MCO. Additional input is provided by the DUR Board's unique experiences and research, as well as public testimony from clinicians, pharmaceutical companies, and members of the public. All DUR Board meeting information is posted on the PBM web portal for the public before each meeting. This includes all clinical drug reviews, meeting materials and proposed criteria. During the 2022 reporting period, FFS initiatives included the implementation of a new auto PA system for certain drugs. This allows for real-time approval of the PA upon submission of the claim from the pharmacy if the necessary clinical information (such as prescriber specialty, medication history, diagnosis code) is on-file or submitted with the claim. Additionally, progress towards development of a new physician administered drug (PAD) PA program began during FFY 2022. This new program will add PA requirements to 33 medical specialty drug classes. PA criteria will be reviewed and voted on by the DUR board during quarterly meetings. The program will go-live on 7/1/23. Providers will be able to request PA via web or phone.
New Hampshire	During FFY 2022 the New Hampshire Medicaid population was managed under 3 managed care organizations and the Fee-for-Service program. Single PDL oversight was supported by MCO Align, a dynamic reporting tool. Efforts in FFY 2022 continued to focus on the response to the COVID pandemic to promote access to vaccines and test kits for the entire New Hampshire Medicaid population through the POS system for the FFS program to ensure timely and consistent access. Adjustments were continuously made to support access to vaccines for new pediatric populations and to meet the needs for additional booster doses and the bivalent booster shots. The OTC COVID test kits were covered at no cost for all Medicaid eligible members for 8 kits per 30 days. Additionally, drugs used to treat the symptoms of COVID and drugs to treat COVID were maintained with a $0 co-pay. The remaining effort was to provide continuous, exceptional care to New Hampshire Fee-for-Service recipients during the pandemic. The New Hampshire Medicaid FFS DUR board continued to have high quality discussion during the 2 hybrid (in person and virtual) public meetings held in FFY 2022. 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. In addition to updating 34 clinical criteria, 9 new criteria were approved, 2 criteria were retired, and 3 new PDL classes were added to the Medicaid PDL. These new PDL classes included weight management agents, colony stimulating factors, and asthma immunomodulators.

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	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-controlled substance classes, for fraud and abuse. New Hampshire Medicaid's DUR program ensures appropriate access to medications while providing clinically sound interventions. 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 Medicaid/NJ FamilyCare (NJFC) Drug Utilization Review Annual Report for Federal Fiscal Year (FFY) 22. 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 Gainwell Technologies, the State's fiscal agent. Managed Care Organizations (MCOs) participating in the Medicaid/NJFC 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 22 for Medicaid/NJFC members transitioning from FFS to managed care, and those transitioning between managed care organizations. Effective July 1, 2022, pharmacy benefits for any members residing in long-term-care or receiving institutional care that were previously in FFS were transitioned to managed care. Since July 1, 2019, DMAHS continues to utilize 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 is included in the State's Medicaid/NJFC 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, but may not be limited to, 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

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	utilization managements are reviewed and approved by the State Commissioners of Human Services and Health. During FFY 2022, Gainwell Technologies paid 443,934 Medicaid/NJFC FFS pharmacy claims totaling $71,354,589, and 26,940,719 pharmacy encounter claims were reported by MCOs during this period totaling $1,827,517,747. Combined, 27,384,653 paid FFS and MCO encounter pharmacy claims were processed totaling $1,898,872,336. 91% of FFS claims or 6% of FFS pharmacy payments were for non-innovator drugs while 90% of reported encounter claims or 15% of MCO payments were for non-innovator drugs. Regardless of payer, 90% of paid claims or 14% 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 2022, the FFS ProDUR savings totaled $2,343,577. 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, staffed by NJ licensed pharmacists, 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 fifteen (15) member 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 FFY22, the NJDURB recommended the following DUR protocols, inclusive of Risk Corridor drugs managed by managed care: Addendum for Duchenne Muscular Dystrophy drugs protocol Protocol for Aduhelm (aducanumab-avwa) Protocol for Bronchitol (mannitol) Protocol for Imcivree (setmelanotide) Exclusion protocol for Stromectol (ivermectin) Addendum for PCSK9 Inhibitors protocol Addendum for Spravato (esketamine) protocol Protocol for Gamifant (emapalumab-lzsg) Protocol for Nitisinone products Protocol for Lucemyra (lofexidine) Protocol for Paxlovid (nirmatrelvir/ritonavir) Protocol for molnupiravir Protocol for Hetlioz (tasimelteon) Protocol for cysteamine products Protocol for Revcovi (elapegademase) Protocol for Luxturna (voretigene neparvovec-rzyl) Protocol for Vuity (pilocarpine ophthalmic) Protocol for Paroxysmal Nocturnal Hemoglobinuria (PNH) products (Soliris, Empaveli, Ultomiris) Protocol for Bylvay (odevixibat)

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	Retrospective DUR activities conducted in FFY22 included: -Claims greater than $4000 -HIV compliance -Diabetes compliance -Opioid claims with duplicate therapy edits -Opioid claims above MME threshold -Opioid claims with early refill edits -Opioid claims for members with GCN total quantity over 360 -Opioid claims for members with total days' supply over 90 -Members with 2 or more ER visits followed by prescriptions from ER physicians -Members with claims from 4 or more pharmacies in any month -Members with claims from 6 or more prescribers in any month -Members with 8 or more claims in any day -Members with 15 or more claims in any month -Members with non-NJ pharmacy -Opioid/benzodiazepine/Antipsychotic use -HIV retrospective DUR -Stimulants for children -Antianxiety and sedatives for children -Antidepressants for children -Mood stabilizers for children The State's Morphine Milligram Equivalents (MME) protocol includes a MME daily dosage not to exceed 50 MMEs for an opioid naive member and a MME daily dosage not to exceed 90 MMEs for an opioid tolerant member. Exclusions from the protocol continue to include members diagnosed with cancer or sickle cell anemia, as well as hospice members and those members receiving palliative end of life care. The protocol also requires prior authorization for the concomitant use of opioids and benzodiazepines. During FFY 22, the Division continued to provide coverage for SARS-CoV-2 related services, including Medicaid/NJFC coverage of at home SARS-CoV-2 test kits, and pharmacist administration of SARS-CoV-2 vaccines. The Board has taken opportunities to distribute educational materials to providers, including information shared individually with providers during the Medical Exception Process. Three (3) NJDURB Newsletters were also approved and distributed to providers during FFY 2022, These Newsletters may be viewed at www.njmmis.com under Newsletters and Alerts. -Newsletter Volume 32, No. 25: Clinical News from the New Jersey Drug Utilization Review Board (DURB) providing practitioners useful clinical information that the DURB determined helpful for prescribing oral COVID therapy. -Newsletter Volume 32, No. 11: Clinical News from the New Jersey Drug Utilization Review Board (DURB) providing useful clinical information regarding ivermectin use. -Newsletter Volume 32, No. 01: Medicaid/NJ FamilyCare Fee-For-Service (FFS) Coverage of at-home SARS-CoV-2 test kits. New Jersey continues to hold quarterly virtual public meetings of the New Jersey Drug Utilization Review Board. Routine activities of the Board have been conducted successfully.
New Mexico	The State of New Mexico is committed to operating Medicaid DUR program that has a positive impact upon quality of care as well upon pharmacy and medical expenditures. ProDUR and Retro

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	DUR each serve a unique purpose in alerting practitioners and pharmacists with specific, focused, and comprehensive drug information. The total estimated cost savings for the DUR program was $7,357,622 with an estimated percent impact of 6.34%. The generic utilization rate is 81.02%. The focus of DUR interventions and safety correlated to the COVID-19 Pandemic with provider education and guidance on treatment, including avoiding Ivermectin. The State continued monitoring and reporting in accordance with the SUPPORT ACT. The New Mexico DUR program remains beneficial to the State, provider community, and the population served.
New York	Beginning April 1, 2023, all Medicaid members enrolled in Mainstream Managed Care will receive their prescription drugs through NYRx, the Medicaid Pharmacy Program. NYRx allows New York State to pay pharmacies directly for the drugs and supplies of Medicaid members. Prior to April 1, 2023, Mainstream Medicaid members accessed their pharmacy benefits through a health plan, rather than Medicaid Fee-For Service (NYRx). This includes anyone in Managed Care (MC) plans, Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV-SNPs). In this case, the State reimburses the health plan rather than the pharmacy. Moving all Medicaid members under the NYRx Program allows for a single, uniform list of covered drugs and standardized, consistent rules and regulations. Thus, New York State is able to offer an improved, simplified process for Medicaid members to get the medicines and supplies they need. Medicaid members have comprehensive drug coverage and equitable access to an extensive network of over 5,000 pharmacy providers. The DUR Program is composed of three main components, Prospective Drug Utilization Review (ProDUR) Program, Retrospective Drug Utilization Review (RetroDUR) Program and the DUR Board. The ProDUR Program is a point-of-service monitoring system that analyzes pharmacy claims during the claims adjudication process. The system can identify drug related problems such as therapeutic duplication, drug-disease contraindications, drug interactions, incorrect dosage or duration of treatment, drug allergy, overutilization, and underutilization. The RetroDUR Program is designed to improve prescribing trends by alerting providers through provider education. The Program uses predetermined clinical criteria to generate case reviews of select members using claims data. The NYS Medicaid DUR Board is comprised of health care professionals and financial experts appointed by the Commissioner and their responsibilities include: The establishment and implementation of medical standards and criteria for the retrospective and prospective DUR Program. The development, selection, application, and assessment of educational interventions for prescribers and pharmacists to improve care. The collaboration with managed care organizations to address drug utilization concerns and to implement consistent management strategies across the fee-for-service and managed care pharmacy benefits.

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	The review of therapeutic classes subject to the Preferred Drug Program. The DUR Program continues to help to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical consequences. The DUR Program continues to focus innovate practices including the development of a physician/practitioner administered drug (PAD) management program and the transition of the pharmacy benefit for managed care members into the fee-for-service program. The DUR Program continues to protect and improve the health and improve the health of New York State Medicaid members. The Department will continue to enhance the ProDUR and RetroDUR Programs and work cooperatively with the DUR Board to develop and implement medication management processes that improve patient outcomes and reduce unnecessary medication costs.
North Carolina	North Carolina has historically been a FFS Medicaid program. Our most notable highlight since the last Annual Survey would be the transition to MCOs. In July 2021, in response to legislation, NC partnered with 5 MCOs to administer the NC Medicaid program. The 5 MCOs are AmeriHealth Caritas, Carolina Complete Health, Healthy Blue, UnitedHealthcare, and WellCare. Contractually, the MCOs are required to follow all NC Medicaid FFS Pharmacy policies, including PA criteria, PDL, and pricing. Additionally they are required to follow all State and federal laws and regulations. Those policies can be found here: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies. This is the first year our survey has included MCO reporting. NC uses a dyad model to monitor the plans. Each plan is assigned a Medicaid nurse and pharmacist who is responsible for assisting the plan, providers and members. The State receives reports monthly and quarterly, depending on the report, to monitor the plans for compliance. Additionally, the Medicaid Ombudsman and Medicaid call center uses Service Now to create tickets to efficiently assign issues reported to the plan and dyad team. This tool tracks cases, resolution and time to resolution. The Division of Health Benefits (DHB-NC Medicaid) also has created dashboards. Having a single PDL and Policy for the pharmacy benefit has assisted in the oversight of the plans and has aided in streamlining and simplifying the provider and member experience. Plans are required to have a 95% compliance rate to the PDL and can be assessed liquidated damages if not meeting this SLA. It is noted that the plans and FFS all listed a different number of brand drugs preferred over generics due to net costs. For the next FFY, the State will define the point in time and version of the PDL to use for this calculation. One other area that warrants explanation is the buprenorphine limit. The limit was up to 16mg with pharmacist override up to 24mg. After reviewing studies, it was brought to the State that there is compelling evidence that some patients will be more successful on 32mg(or product equivalent). Therefore, we now allow up to 24mg with a pharmacist override up to 32mg. Additionally, DHB collects and invoices for all the rebates for the FFS claims and MCO encounters. Each MCO has their own DUR Board. Please note that HB indicated on their survey that they used the State's DUR Board in lieu of having their own. However, they State, "DUR program functions are reviewed by the Pharmacy Quality Programs (PQP) committee. PQP provides feedback and approves newly proposed pharmacy quality interventions or changes to existing interventions upon request. Meet monthly and interventions noted." MCOs do attend the State's DUR Board meeting and prepare a slide for presentation by their Director of Pharmacy to summarize activities since the previous meeting. While the State's DUR Board is responsible for only the FFS interventions, this collaborative practice provides the opportunity for further monitoring of the plans and for further engagement between the DUR Board, the State and the plans.

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	During the FFY22, the DUR Board has used trending and viewing quantities as a percentage as a way to enhance the relevance of the data. As members were transitioning from FFS to MCO, and for some a transition back to FFS, there were fluctuations in the data based on the period of time being reviewed. One notable future NC Medicaid program change is that North Carolina will launch the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan on Oct. 1, 2023. There will be six additional MCOs added via the Tailor Plan implementation. This is an integrated health plan for individuals with behavioral health needs and intellectual/developmental disabilities (I/DDs). These plans will also help other populations such as those suffering from Traumatic Brain Injury. Additionally, NC Medicaid will become an Expansion State upon the legislative budget approval. During the last FFY, a few of the topics reviewed by the DUR Board are: Concurrent use of opioids and Z-drugs, Oral Oncology Non-Compliance, Naloxone Utilization, Benzodiazepine Utilization, Fibromyalgia and Opioid Utilization, Duplication of Therapy: Short-Acting Opioids, and Clozapine Utilization. We continue to monitor trends in opioid utilization and SUD treatment. We continue to search for ways to address health inequities. During the last FFY, NC Medicaid put out an RFP for a new PBM. We are currently in the silent period and are preparing for future work in this area. As NC Medicaid transitions further into the MCO space, Medicaid Expansion, and the implementation of a new PBM, we will find the opportunity for growth through the challenges.
North Dakota	In FY 2022, we have encouraged communication between prescribers, pharmacies, and members by expanding medical services that are available for pharmacists to provide. Our Medication Therapy Management program completed new patient visits increased from 42 to 127 for the federal fiscal year. Other services that pharmacists are eligible to provide are outlined in our pharmacist medical billing manual and include anticoagulation management, analysis for continuous glucose monitoring, drug administration, and tobacco cessation to improve the quality of drug utilization of our members. Diabetes care was in the forefront during this FFY as we worked with stake holders to develop policy for coverage for tubeless insulin pumps and optimize CGM coverage on the pharmacy benefit. We minimized disruption to health care delivery by improving our claims processing system messaging and accuracy of claims payment. Point of sale messages return detailed information about therapeutic duplication rejections, indicating the duplicate drug and when the duplication will no longer result in a rejected claim. Instructional documents are provided to providers on our website on how to manage rejected claims. The preferred drug list includes medical and pharmacy drugs, prior authorization criteria, and several other point of sale edits to create a consolidated reference document for providers and to facilitate communication with our MCO on medical drug coverage criteria. The MCO for medical claims changed to BCBSND, while pharmacy drugs remain carved out of managed care. Our comprehensive therapeutic duplication edits and quantity limits facilitate conversations with providers on opportunities to optimize treatment regimens to increase compliance and positive outcomes for our members.
Ohio	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 eight pharmacists who meet monthly. The Committee reviews member profiles and makes

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	recommendations to the DUR Board. In FFY22, the DUR Committee met eleven times and the DUR Board met four times. RetroDUR interventions were implemented pertaining to members with asthma and COPD with non-adherence to controller inhalers, members with high dose or long term butalbital use, children taking multiple antipsychotic medications, members using insulin without monitoring glucose, members in CSP without any naloxone claims, members with asthma taking non-selective beta blockers, members with atherosclerotic cardiovascular disease (ASCVD) not taking a statin, members receiving opioids from multiple prescribers, members with benzodiazepine monotherapy being used to treat anxiety, members with heart failure with reduced ejection fraction not taking an Angiotensin-converting enzyme (ACE) inhibitor; Angiotensin II receptor blocker (ARB); Angiotensin receptor/neprilysin inhibitor (ARNI), members taking antipsychotics and opioids, and members filling albuterol frequently without having a controller inhaler. In FFY22, DUR savings totaled approximately $43 million. ODM maintained compliance with Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271). RetroDUR interventions were performed to address multiple antipsychotics in children, CSP members without naloxone, duplicate prescribers of opioids, and antipsychotic and opioid overlap. Additionally, prescribers and pharmacies were contacted to address patients taking medication assisted treatment concurrently with opioids and/or benzodiazepines. 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 2022 and lists the most prominent problems with the largest number of exceptions. In FFY 2022, RetroDUR Educational Outreach activities included: Quarterly SoonerPsych Antipsychotic Monitoring Program Mailings (4 separate mailings in October of 2021 and January, April, and July of 2022); Quarterly Chronic Medication Adherence Program Mailings (4 separate mailings in November of 2021 and February, May, and August of 2022); Pediatric Antipsychotic Monitoring Program Mailing in December 2021; Statin Use in Members with Diabetes Mellitus Mailing in August 2022; Pediatric Antipsychotic Monitoring Program Mailing in June 2022; and Academic Detailing Program: Treatment of Pediatric Type 1 Diabetes with analysis period beginning in February 2022. DUR Board Activities: During FFY 2022 the DUR Board met 11 times. Meetings were held in October, November, and December 2021, and in January, February, April, May, June, July, August, and September of 2022. In accordance with State legislative mandate, 23 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 55 additions to the CBPA program and 22 changes in FFY 2022. There were 12 additions to the PBPA program and 12 additional categories updated. RetroDUR activities included: Fall 2021 Pipeline Update, FDA Safety Alerts, Academic Detailing Program Update, Maintenance Drug List, Opioid Initiative Update, Use of Glucagon-Like Peptide-1 Agonists or Sodium-Glucose Co-Transporter-2 Inhibitors with Cardiovascular (CV) Benefit in Members with Type 2 Diabetes and High CV Risk or Established Atherosclerotic CV Disease Mailing Update, Narrow Therapeutic Index Drug List, 2022

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	Spring Pipeline Report, MTM Calendar Year 2021 Review, Prenatal Vitamin Utilization Update, SoonerPsych and Pediatric Antipsychotic Monitoring Program Update, Annual Review of the SoonerCare Pharmacy Benefit, CMA Program Update, Use of Statins in Members with Diabetes Mellitus, and Nonalcoholic Fatty Liver Disease Overview. Annual Reviews were presented or made available to the DUR Board for 129 CBPA categories or products and 35 PBPA categories. Innovative Practices: Academic Detailing: 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, antibiotic (ABX) usage, asthma, and most recently, pediatric type 1 diabetes mellitus. Considering the most recent guideline updates, there is agreement across multiple areas impacting the treatment of both type 1 and type 2 pediatric diabetes mellitus (T1DM and T2DM). Guidelines recommend assessing the following as they impact treatment decisions: - Food security - Housing stability/homelessness - Health literacy - Financial barriers - Social/community support Recommendations also address the use of real time continuous glucose monitors (CGMs), time-specific use of other CGM metrics, and specific amounts and types of physical activity. Lastly, there is additional guidance in the management of new-onset diabetes in youth who are overweight or obese. Changes and reinforced messaging from these guidelines served as the source material for the most recent AD topic. The College of Pharmacy analyzed Oklahoma SoonerCare claims during a nine-month pre- and post-AD period to investigate resultant health care utilization. Collected data for FFY 2022 focused on diabetes related and all-cause hospitalizations and emergency department admissions. During FFY 2022, 44 providers received T1DM-AD visits, and the program impacted 231 members. During FFY 2022, T1DM-AD resulted in total savings of $408,207. 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. Cost Savings Estimates: Cost savings/cost avoidance are provided within the ProDUR and RetroDUR tables attached. Cost savings for FFY 2022 represented 16.4968% of the grand total. - State Maximum Allowable Cost Savings: $ 36,352,989.56 - Prior Authorization Program Savings: $ 17,781,490.45 - ProDUR Savings: $ 143,248,715.47 - RetroDUR Savings: $410,000 Total DUR Program Savings: $197,793,195.48 - O.U. College of Pharmacy: -$4,204,719.62 Annual Savings FFY 2022: $193,588,475.86

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Oregon	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 implementation and modification of prior authorization criteria in the fee-for-service (FFS) program to ensure medically appropriate use, drug use evaluations, and targeted strategies to: improve provider knowledge of PrEP for patients with a recent sexually transmitted infection, diagnosis of high-risk sexual behavior, or potential viral exposure through an educational newsletter; emergency drug coverage of drugs prescribed for patients with the CWM benefit; updating the "Non-preferred Drugs" and "Drugs for Non-funded Conditions" PA criterion to align with the final version of Statement of Intent 4 (SOI4) from the Health Evidence Review Commission's Prioritized List of Health Services which supported coverage under EPSDT; and removal of DAA PA criteria and required case management for preferred DAA regimens for treatment-naive patients with hepatitis C virus. The Oregon Health Authority (OHA) worked closely with contracted managed care entities (Coordinated Care Organizations, or "CCOs") to continue to coordinate the State's COVID-19 response (vaccination efforts and monoclonal antibodies) and share FFS initiatives focused on carveout mental health medications that would include CCO members. The OHA convened regular meetings with CCO Pharmacy Directors, with standing topics including: health equity & COVID-19 and pharmacy access in light of pharmacy closures and staffing challenges. Some of the specific COVID-19 topics included: COVID-19 home tests; COVID-19 therapeutics and pharmacy guidance for testing and referral for care; monoclonal antibody treatment in the pharmacy setting; COVID-19 emergency edits; Omicron and federally supplied products; and Paxlovid barriers. Additional topics of collaboration with the CCOs included: the Hepatitis C Risk Corridor; ivermectin and FFS PA strategy; vaccination distribution generally & updates from health systems/clinics; coordinating for disaster preparedness and response; 1115 Waiver renewal update; PDMP check requirements and access; vaccination transition planning as local pharmacies small independent provider practices do not participate in VFC program; telehealth for MAT; how CCOs use the mental health carve out "Push List"; and ending prior authorization criteria and required case management for preferred DAA regimens for treatment-naive patients with hepatitis C virus.
Pennsylvania	The emphasis of Pennsylvania's drug utilization review (DUR) program is to promote patient safety through an increased review and awareness of 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

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	effective prescribing practices in a factual and unobtrusive manner. Through the RetroDUR program, 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 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

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	concern with regard to recipient drug therapy. For Federal Fiscal Year 2021 (FFY 2021), 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 2021.
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. 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, tip SC develops and disseminates targeted, practical information to help prescribers make safer prescribing decisions. Many of those targets/interventions have been referenced within this survey. Educational outreach focused on safer opioid prescribing and expanded access to treatment for opioid use disorder (OUD); data analysis of unidentified Medicaid claims data for eight mutually agreed upon index surgeries performed between 2014 and 2017 to identify the trajectory of opioid dependence and chronic use post-surgery; and management of the Agency's Medication Assisted Treatment (MAT) coverage guidelines. Due to ongoing issues with availability/manufacturing the State relaxed edits around the Preferred Drug List (PDL) for several groups of medications (Diazepam Rectal Devices, Albuterol Inhalers, ADHD Medications) until resolution.
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. During the reporting period the RDUR program mailed over 1,400 educational letters to prescribers and pharmacists. This represented a 9% increase over the previous reporting period. Patient profiles are reviewed by a committee of pharmacists and physicians. These profiles are created using a vendor (Kepro) RDUR system. An Initial Criteria Exception Report (ICER) 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 requiring provider education. If any potentially problematic therapy is identified, the committee will send educational letters to the prescribing practitioners as well as the individual pharmacies involved highlighting the concern of the identified potentially inappropriate therapy. The DUR Review Committee meets virtually to discuss concerning cases or criteria issues with each other.

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	The committee will focus on specific criteria on an ad hoc basis. Focus on opioid and concomitant therapies will continue to be an area of focus. The review process has transitioned away from a paper-based process to a fully electronic review process.
Tennessee	Throughout FFY22, TennCare's DUR board continued to have success with meeting quorum due to the previous year's decision to include the medical director from each MCO to the board. Although membership has been an issue in the past, this change has greatly impacted our ability to have regularly scheduled meetings to discuss meaningful topics. This trend continues into FFY23 as well. The DUR program. Tennessee's PBM, OptumRx, and their DUR pharmacist Kimberly Barnes held the responsibility for planning the DUR Board meetings, including the provider education activities and enrollee profile reviews. Oversight of these activities was provided by Dr. Raymond McIntire (until July 1, 2022) and Dr. Lora Underwood who worked closely with OptumRx and Dr. Barnes to ensure that each meeting delivered relevant information that impacted our member population. During FFY22, the DUR Board continued to meet quarterly to review drug classes and make recommendations to our P&T committee, known in Tennessee as PAC (Pharmacy Advisory Committee). Meetings follow parliamentary procedures and have a standing order of business. Meeting highlights include a focus on new business, drug class reviews, TennCare population and drug utilization trend reviews, and an overview of pharmacy lock-program re-reviewers. To comply with the Support Act, TennCare assigned one-half of the PBM Vendor's chart reviews per month (at least 400 of the 800 profile reviews per month) to review the concomitant use of opioids and antipsychotics. TennCare also presented 2 case studies per quarterly meeting to DUR Board members, showing prescription claims history from the PBM and PDMP, along with medical claims history (diagnosis/procedure data), for those enrollees' profiles that exhibited prescribing habits that were outside of norms or standards of care in the reviewer's opinion. All data was blinded with respect to the identity of any of the enrollee, pharmacy, or provider. The board was granted the ability to vote on whether the case should be referred to the enrollee's MCO for further review. By the end of FFY 22 (Mid-September 2023), OptumRx implemented a ProDUR edit that would notify pharmacists of enrollees who are using opioids and antipsychotics concomitantly. The DUR Board was responsible for multiple initiatives and educational interventions for FFY22 such as: - Concurrent Therapy: Concurrent Use of Opioids and Antipsychotics - Morphine Equivalent Dose (MED): Exceeding 90 MME without appropriate diagnosis/Exceeding 50 MME and not on Narcan - Drug-Disease Interactions: Respiratory conditions and Opioids, Asthma/COPD and non-selective beta-blockers, and Cardiac abnormalities and stimulant medications - Conduct disorders and antipsychotics - - Concurrent Therapy: Concurrent use of three antidepressants for >= 60 days - - FDA-safety updates for Janus Kinase Inhibitors - Tramadol products in pediatric patients - NSAID use in pregnancy
Texas	Texas Medicaid implements single formulary and PDL. Vendor Drug Program (VDP) is responsible for managing the out-patient pharmacy formulary for Medicaid and CHIP and some of the State-operated programs such as Children with Special Healthcare Needs (CSHCN) Program, The Healthy

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	Texas Women Program, and Kidney Health Program. Managed Care Organizations (MCOs) are required to cover the same formulary for their Medicaid and CHIP members. In addition to formulary management, VDP maintains the Preferred Drug List (PDL) and Specialty Drug List (SDL). MCOs may ask their providers to send prescriptions from the SDL to the MCO's specialty pharmacy network. HHSC typically publishes the SDL in March and Sept which is intended for use by MCOs and their contracted PBMs. VDP publishes the preferred drug list (PDL) twice per year. The PDL therapeutic classes are reviewed by the Texas DUR Board. The Board holds four quarterly meetings each year and makes recommendations on the PDL drugs. The PDL review decisions from January and April are implemented in July and the decisions from July and October are implemented in January of the following year. PDL and criteria for PDL PAs are mandatory for all the MCOs. VDP also manages prospective clinical prior authorization criteria, and retrospective DUR intervention criteria and policies. VDP solicits the MCOs for the clinical PA criteria. The criteria proposals are submitted to the DUR Board for approval during the Board's regular meetings. Most of these PAs are not mandated for the MCOs and once approved by the Board, the MCOs and their PBMs may choose to implement as approved by the Board or a less stringent version. In FFY 2022, there were no significant changes to the PDL policies and therapeutic classes. Any COVID-19 pandemic related PDL exemptions were removed in Late summer in 2021 however, the program continued with removing non-preferred status in response to any drug shortages afterward. VDP also remained vigilant against any intersessional RSV outbreaks and granted access to prophylaxis therapy in any regions reported with an uptick in viral activity. The total estimated cost savings/cost avoidance reported for FFY 2022 is associated with the PDL and clinical PA implementations and the retro-DUR interventions. In FFY 2022, the total cost saving was $7,894,678. Regarding Opioids over utilization and Opioid Use Disorder (OUD) therapies, VDP has implemented several prospective and retrospective DUR policies and criteria for managing prescriptions for opioids and psychotropic medications. These edits and interventions are intended to target overutilization, duplicative therapies, doctor/pharmacy shoppers, and medication treatment adherence. VDP continually uses innovative practices to improve and enhance access to care issues. Below are some instances: 1. The antipsychotic prior authorization was automated in Texas Medicaid, fee-for-service and managed care. 2. In December 2021, Texas conducted a competitive procurement and issued a Request for Proposals (RFP) seeking a pharmaceutical manufacturer, through a Value Based Rebate Subscription Model, to provide an unlimited supply of one DAA medication to improve awareness, screening, diagnosis, and treatment of the Hepatitis C Virus for Texas Medicaid clients.
Utah	Utah Medicaid has been continuously implementing new pharmacy activities to improve efficiencies in cost and care for Medicaid members. Areas of focus have been improving access to COVID vaccines and treatment, improving access to care through removing certain prior authorizations, increased quantity edit in certain medications, adherence to antidepressant medications, hepatitis C therapies, and positive clinical therapy alternatives on the Preferred Drug List. The pharmacy team also continues our effort to reduce inappropriate use of opioid medications, reduce concurrent use of opioids and benzodiazepines, increase naloxone prescribing in patients on concurrent use of opioids and benzodiazepines, and antipsychotic medication use in children and adolescents. The UT Medicaid began reimbursing for MTM service performed by outpatient pharmacists.

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	Peer-to-peer programs were continued with the primary goals of educating and providing resources to health care providers in the areas previously mentioned. For the interventions concerning inappropriate opioid use, decreasing the number of members on an opioid and a benzodiazepine combination, increasing the number of members prescribed naloxone who take a concurrent opioid/benzodiazepine, ADHD stimulants used in children under 4 years of age, concurrent use of cross-class amphetamine and methylphenidate stimulants, 3 or more inappropriate concurrent stimulants use, and antipsychotic medication use in children and adolescents, phone calls were made to providers throughout the prior authorization review process to have patient-focused discussions and educate them on Medicaid policies and procedures. Nearly all interactions were positive and well-received, and providers collaborate to improve care for the members. For adherence programs on Antidepressant Medication Adherence and hepatitis C, phone calls were made to members to counsel on treatments, provide clinical care, answer questions, and refer care to the appropriate resources if necessary. Utah Medicaid continues to enhance the prior authorization program with regular updates of all pharmacy prior authorization forms, ensuring each is supported with current and robust clinical and operational criteria and is followed by our Accountable Care Organizations. These continued efforts have improved the efficiency of the prior authorization program and team.
Vermont	The Department of Vermont Health Access (DVHA) Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits programs and for assuring that members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible. In addition, the Pharmacy unit is focused on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations, and other efforts to simplify administration for the Department and for providers. The primary role of the Pharmacy Unit is oversight for the contract with the Department's pharmacy benefits manager (PBM), Change Healthcare. Change Healthcare provides operations and clinical services for the Department, its providers, and members. Change Healthcare is responsible for processing all pharmacy claims, assuring correct pricing and coordination of benefits, operating a provider-focused clinical call center that makes drug coverage determinations for pharmacy claims and physician-administered drugs, managing the federal, State, and supplemental drug rebate programs, assisting the Department with performing both prospective and retrospective drug utilization review analyses and procedures, and managing the Preferred Drug List (PDL). These activities are accomplished through participation by the Drug Utilization Drug Review Board (DURB) and by operating a suite of software programs that support clinical, operational, and financial reporting suites. In addition to providing monitoring and oversight for all aspects of the PBM contract, the Pharmacy unit also assists with drug appeals and exception requests, manages all pharmacy provider communications, oversees all rebate contracts, and programs, resolves drug-related pharmacy provider issues, oversees, and manages the Drug Utilization Review Board policies and membership, and assures compliance with all State and federal pharmacy and pharmacy benefits reporting and regulations. DVHA's Pharmacy Unit managed $266 million in total gross drug spend in State fiscal year (SFY) 2022, an increase of 15% over the previous fiscal year. Gross drug spend includes what DVHA paid to pharmacies for all publicly funded pharmacy benefit programs, including Medicaid for Children and Adults, those dually eligible for Medicare and Medicaid, and Vermont's Pharmaceutical

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	Assistance Program (VPharm). This figure does not include physician administered drugs processed though the medical benefit. 2,150,667 claims were processed across all programs. The significant spending increase was driven largely by three factors: increases in caseload and utilization, changes in drug mix, and increased costs per claim. COVID-19 vaccinations also played a role, albeit a lesser one. Federal law passed during the early days of the pandemic prevented States from disenrolling Medicaid members. The Consolidated Appropriations Act of 2022 ended this provision and required States to begin Medicaid redeterminations in the spring of 2023. As anticipated, Prior Authorizations rose in SFY 2022 due to increases in Medicaid enrollment and increased use of specialty medications. Increases in expensive specialty medications also drove up the average cost per claim. Effective July 1, 2022, VPharm - which allows enrollees to pay $1 or $2 copays for additional drugs through VPharm, including maintenance drugs - expanded the drug coverage available under two of the program's three levels. The Department continues to see the highest spending on drugs used to treat substance use disorder, diabetes, attention deficit hyperactivity disorder (ADHD), and inflammatory conditions such as rheumatoid arthritis, psoriasis, and Crohn's disease. During SFY 2022, the number of members using short-acting opioids decreased by 0.93% and the number of members using long-acting opioids decreased by 5%. The number of prescriptions for short-acting and long-acting opioids decreased by 4.9% and 4.6%, respectively. However, when the data is normalized to account for the increase in Medicaid eligibility during SFY 2022, short-acting opioid use per 1,000 members declined by 11.4% and long-acting opioid use declined by 11% during this time. These results indicate Vermont's continued commitment to implementing and maintaining initiatives that address the opioid crisis. Vermont recognizes and treats opioid use disorder as a chronic, relapsing medical condition, resulting in expanded access for those who seek treatment and, in most counties, greatly decreased wait times for those patients. The Hub and Spoke programs continue to be a nationally recognized system of care for improving access to medication for opioid use disorder.
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. 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 2022, the DUR Board approved clinical edits for Myfembree, Truseltiq, Wegovy, Class SA Criteria for Oral Oncology - Lung Cancer and Other Neoplasms Drugs, Class SA Criteria for Oral Oncology - Renal Cell Carcinoma and Other Neoplasms Drugs, Besremi, Livtencity, Tavneos, Voxzogo, Class SA Criteria for Oral Oncology - Hematologic Cancers and Other Neoplasms Drugs, Rezurock, Vijoice and Vonjo. The most recent significant achievement for Virginia Medicaid 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

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	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 naive 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. Furthermore, DMAS and the DUR Board have recently started to review and monitor children taking antidepressants and children taking mood stabilizers. DMAS will continue to monitor this for both FFS and the MCOs. 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 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 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 $70,410,378.33 in FFY 2022. Virginia Medicaid also administers dose optimization and quantity limit programs that saved $484,050.81. The total cost avoidance, attributed to RetroDUR, during FFY 2022 was $40,534,785.73. Virginia Medicaid's overall DUR Program savings in FFY 2022 was $111,429,214.87.
Washington	Pharmacy Services The Washington State Health Care Authority (HCA) is the designated State agency for administration of Medicaid in Washington State, 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

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	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) maintains the AHPDL which is used to align drug coverage both for Fee-For-Service (FFS) and the Managed Care Organizations (MCOs). Additionally, the Pharmacy Services section at HCA creates clinical policies in-house which are also used by FFS and the MCOs. Hepatitis C Elimination 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 the MCOs 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. 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 can 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 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

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	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. COVID-19 Response and Program Updates Washington Apple Health (Medicaid) updated the Washington Medicaid State Plan Amendment (SPA) to allow pharmacists and pharmacy technicians to administer COVID-19 vaccines which was approved by the Centers for Medicare and Medicaid Services (CMS). Washington Apple Health (Medicaid) created a Monoclonal Antibody Treatment for COVID-19 clinical guideline which applies to FFS and MCOs. The policy describes the requirements that facilities, providers and pharmacies must abide by to receive and use monoclonal antibodies for the treatment of COVID-19. A testing clinical guideline was also created explaining what tests pharmacists can perform and reimbursement information for administering and interpreting COVID-19 tests. Additional information including the maximum number of tests allowed per month and how to bill for COVID-19 tests is also Stated in the testing clinical guideline. To ensure access to care, HCA and the MCOs allowed the use of a variety of telehealth technologies to meet the healthcare needs of providers, clients, and families. The pharmacy services unit also made program updates in response to the pandemic by allowing 90-day supply for maintenance medications, allowing approval of Non-Preferred medications if Preferred medications were in shortage, and implementing quantity limits on hydroxychloroquine, azithromycin, and ivermectin to ensure appropriate and safe use of these medications.
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 $545,596,816.15 in rebates in FFY2022, of which $81,043,806.93 were from negotiated supplemental rebates. An additional $9,390,182.17 was saved through our SMAC program.

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	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 92.37 % 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. OBRA '90 mandates an outpatient DUR program including: a prospective drug review, retrospective drug use review and an educational program; the establishment composition and functions of the State DUR Board; and a point-of- sale electronic claims management system for processing claims for covered outpatient drugs. The goal of the State's DUR program must be to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individual drug therapy. The agency has the authority to accept or reject the recommendations or decision of the DUR Board. 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 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 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 is responsible for benefits administration in 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 Gainwell Technologies (formerly, DXC Technology). From July 1, 2009, Gainwell Technologies administered the Wisconsin retrospective DUR activities through a subcontract with Kepro (formerly 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 Kepro. Standard criteria are developed by Kepro. Kepro and DMS jointly develop Wisconsin specific criteria. Wisconsin specific criteria are reviewed

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	with the DUR Board for approval. If a potential drug problem is discovered, intervention letters are sent to 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 from 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 Summary 4 prepared by Kepro. 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. The SUPPORT Act requirements have been integrated into the prospective, retrospective and educational DUR activities.
Wyoming	In FFY2022, the Wyoming Drug Utilization Review (DUR) program conducted prospective and retrospective reviews resulting in a total estimated cost avoidance of more than $51 Million, an estimated impact of 62%. Generic medications accounted for 86% of claims and 36% of expenditures. Appropriate utilization of opioids continues to be a focus, specifically when used concurrently with other sedating medications. Physician administered drugs were added to P&T agendas for review in FFY2022, expanding the prior authorization and Preferred Drug List programs into the medical side. In addition to ongoing education programs, comparative prescriber reports were completed detailing completion of routine labs in diabetic patients, benzodiazepine utilization, concurrent use of gabapentin and opioids and concurrent use of opioids and sedatives.