National Medicaid Fee-For-Service (FFS) FFY 2021 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 2021 Data: October 2020-September 2021)

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

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

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

I. Enrollees

Fifty States (this reference includes the District of Columbia hereafter) have submitted a FFY 2021 Medicaid DUR Annual Survey encompassing data from October 1, 2020 -September 30, 2021 reported responses.[2] The information in this report is focused on national Medicaid FFS DUR activities.

- FFY 2021 reported responses include 22,561,578 beneficiaries (26%) enrolled in national FFS Medicaid programs and 62,887,720 beneficiaries (74%) enrolled in national Medicaid Managed Care programs (MCP). This represents a 2% decrease in beneficiary enrollment in the national FFS Medicaid program and a corresponding increase in the national Medicaid MCPs.

II. Prospective DUR (ProDUR)

ProDUR functions are performed at the point-of-sale (POS) when the prescription is being processed at the pharmacy. FFY 2021 reported responses show 47 states (94%) continue to contract with an outside vendor to process their POS claims, and that 3 states (6%) process their own claims, consistent with FFY 2020. Additionally:

- FFY 2021 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 2021 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.

- 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, a 1% decrease from FFY 2020.
- Controlled Substances (CII)[3]: State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 86% of the prescription being used before a subsequent prescription could be dispensed, consistent with FFY 2020.
- Controlled Substances (CIII to CV)[4,5,6]: State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 85% of the prescription being used before a subsequent prescription could be refilled, a 1% decrease from FFY 2020.

- In FFY 2021 reported responses, 27 states (54%) utilize a system-accumulation edit as part of their ProDUR edits for preventing early prescription refills, a 2% increase from FFY 2020. Of the 23 states not having an accumulation edit, 8 states (35%) plan to implement this edit in the future.

III. Retrospective DUR (RetroDUR)

The RetroDUR process allows states to use evidence-based literature, clinical data, and existing guidelines, to evaluate patients' prescription data to identify patterns of clinical concerns. These functions reside primarily with a state vendor in 35 states (70%) and with an academic institution in 11 states (22%), consistent with FFY 2020. 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. These boards on an average meet quarterly and are open to the public. All states provided a summary of their DUR Board activities. Based on FFY 2021 reported responses, 12 states (24%) reported utilization of a Medication Therapy Management (MTM) program, a professional service provided by pharmacists, a 4% increase from FFY 2020.

V. Physician Administered Drugs

Physician-administered drugs are drugs, other than vaccines, that are covered outpatient drugs under section 1927(k)(2) of the Social Security Act, and are typically administered by a medical professional in a physician's office or other outpatient clinical setting. According to FFY 2020 reported responses, 14 states (28%) have incorporated physician administered drugs into DUR criteria for ProDUR reviews, a 2% decrease from FFY 2020, and 14 states (39%) plan to incorporate these drugs in the future. Additionally, 20 states (40%) have incorporated physician administered drugs into their DUR criteria for RetroDUR reviews, a 4% decrease from FFY 2020, while 8 states (27%) plan to incorporate these drugs in their RetroDUR reviews in the future.

VI. Generic Policy and Utilization Data

In an ongoing effort to reduce spending on prescription drugs, states continue to encourage the use of

[3] 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.
[4] Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence.
[5] Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence.
[6] 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.

lower-cost generic drugs. The FFY 2021 national percent average for generic utilization rate was 85%, consistent with FFY 2020. FFY 2021 reported responses confirm that 45 states (90%) base decisions of "brand-versus-generic" product preferred status on the net cost of the drug to the state, taking into consideration federal and supplemental rebate dollars on brand and generics. The average number of preferred products is 81 in these states with a range between 9 and 392 products.

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 2021 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 restrict beneficiaries whose utilization of medical services is documented as being potentially unsafe, excessive or could benefit from increased coordination of care. In some instances, beneficiaries are restricted to specific provider(s) to monitor services being utilized and reduce unnecessary or inappropriate utilization. According to FFY 2021 state responses, 46 states (92%) have a Lock-In program for beneficiaries, consistent with FFY 2020. Additionally, 28 states (61%) restrict beneficiaries to a specific prescriber, a 2% increase from FFY 2020 and 37 states (80%) restrict beneficiaries to a specific pharmacy, a 5% decrease from FFY 2020.

FFY 2021 reported responses also recognize states with a process to identify possible fraudulent practices of health care providers. For example, 47 states (94%) have processes in place to identify potential fraudulent practices by prescribers, and 46 states (92%) have processes in place to identify potential fraudulent practices by pharmacies, both consistent with FFY 2020 reported responses.

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

B. Prescription Drug Monitoring Program (PDMP)

PDMPs are statewide electronic databases that collect designated data on controlled substances that are prescribed and dispensed in the state. Depending on the state, prescribers and pharmacists have access to these databases to identify patients that areengaging in potential fraud or misuse of controlled substances. State responses indicate:

- 18 states (36%) have the ability to query their states' PDMP database directly as opposed to 8 states (16%) that receive PDMP data from their state upon request.
    - 16 (62%) of these 26 states that have the ability to directly query or receive PDMP data from their state, also have access to border state PDMP information.
    - In contrast, 24 states (48%) are unable to access their states' PDMP data in any form.
- 42 states (84%) require that prescribers access the patient history in the PDMP database prior to prescribing controlled substances, an 8% increase from FFY 2020. Additionally, 21 states (42%) require pharmacists to check the PDMP prior to dispensing, an 8% increase

from FFY 2020.

- 39 states (78%) responded that they face a range of barriers that hinder their ability to fully access and utilize the PDMP database to curb fraud, waste and abuse, a 6% decrease from FFY 2020.

C. Opioids

States have POS safety edits in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients. Based on FFY 2021 reported responses, 35 states (70%) apply this POS edit to all opioid prescriptions and 15 states (30%) apply this edit to some opioid prescriptions. The median days' supply for an initial opioid prescription for an opioid naïve patient based on FFY 2021 reported responses is 7 days and the national range is between 5 and 34 days. 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 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:

- 47 states (94%) have prospective edits in place to monitor duplicate therapy of opioid prescriptions, consistent with FFY 2020.
- 50 states (100%) have prospective edits in place to monitor early refills of opioid prescriptions.
- 32 states (64%) have an automated retrospective claims review process to monitor opioid prescriptions exceeding state limitations, consistent with FFY 2020.
- 49 states (98%) have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently, consistent with FFY 2020.
- 37 states (74%) have prospective edits or a retrospective claims review process to monitor opioids and sedatives being used concurrently, a 6% increase from FFY 2020.
- 47 states (94%) have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently, a 2% increase from FFY 2020.
- 33 states (66%) utilize abuse deterrent opioids to prevent misuse and abuse, consistent with FFY 2020.
- 41 states (82%) develop and/or provide prescribers with pain management or opioid prescribing guidelines, a 2% decrease from FFY 2020.

D. Morphine Milligram Equivalent (MME) Daily Dose

MME is the amount of morphine, in milligrams, equivalent to the strength of the opioid dose prescribed. Using an MME approach allows comparison between the strength of different types of opioids. A total of 49 states (98%) set recommended maximum MME daily doses to reduce potential patient harm, abuse and/or diversion, a 1% increase from FFY 2020. The median MME daily dose for FFY 2021 reported responses is 90mg/day which includes a national range of 30 to 500mg/day, each state having their specific methodology used for MME calculation.

FFY 2021 reported responses confirm that 36 states (72%) provide information to their prescribers on how to calculate an MME or provide a calculator to determine a patient specific MME daily dose, consistent with FFY 2020. Additionally:

- 46 states (92%) have an edit in their POS system that alerts the pharmacy provider that the

MME daily dose prescribed has been exceeded, a 2% increase from FFY 2020.
- 30 states (60%) have an automated retrospective claims review process to monitor the total daily dose of MMEs for opioid prescriptions dispensed, consistent with FFY 2020.

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 2021 reported responses, 46 states (92%) have utilization controls to monitor or manage prescribing of medication-assisted treatment drugs for OUD, consistent with FFY 2020.

Further, FFY 2021 reported responses confirmed 44 states (88%) set total milligrams per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs, a 2% increase from FFY 2020. 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, a 2% increase from FFY 2020. FFY 2021 reported responses confirm 43 states (86%) provide at least one buprenorphine and buprenorphine/naloxone combination drug without a prior authorization requirement while 7 states (14%) require prior authorization for these products, consistent with FFY 2020. Additionally, 42 states (84%) have system edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of medication-assisted treatment (MAT), a 6% increase from FFY 2020.

Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist and can reverse and block the effects of opioids. Naloxone is available without prior authorization in all states. Additionally, all states allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols. Based on FFY 2021 reported responses, 48 states (96%) have at least 1 formulation of naltrexone for OUD available without a prior authorization. Additionally, 37 states (74%) retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose.

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). Due to methadone's potential opioid-related harms, CMS, in conjunction with the CDC recommends that states remove methadone for pain (outside of end of life care) from their preferred drug lists and not be considered a drug of first choice by prescribers for chronic non-cancer pain. However, the FDA has approved methadone as one of three drugs for treatment of OUD within an OTP. Based on FFY 2021 reported responses, 48 states (96%) provide coverage for methadone for OUD through an OTP, a 4% increase from FFY 2020 as two states (4%) provide no methadone coverage for OUD.

G. Psychotropic Medication (for Children)

Antipsychotic Medication

According to FFY 2021 reported responses, all states have a program in place for managing or monitoring appropriate use of antipsychotic drugs in children. Additionally, all states have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children. Additionally 45 states (90%) manage or monitor antipsychotic medication for all children under the age of 18, including those in foster care, consistent with FFY 2020.

Stimulant Medication

According to FFY 2021 reported responses, 42 states (93%) have a program in place for managing or monitoring appropriate use of stimulant drugs in all children, including those in foster care, a 2% increase from FFY 2020.

Antidepressant Medication

Antidepressant medication was an additional subsection added to the Psychotropic Medication section of the FFY 2021 DUR survey. According to FFY 2021 reported responses, 35 states (70%) have a program in place for managing or monitoring appropriate use of antidepressant medication in children. Nine states plan future implementation of an Antidepressant Monitoring Program.

Mood Stabilizer Medication

Mood Stabilizer medication was an additional subsection added to the Psychotropic Medication section of the FFY 2021 DUR survey. According to FFY 2021 reported responses, 28 states (56%) have a program in place for managing or monitoring appropriate use of mood stabilizing medication in children. Twelve states plan future implementation of a Mood Stabilizer Monitoring Program.

Antianxiety/Sedative Medication

Antianxiety/Sedative medication was an additional subsection added to the Psychotropic Medication section of the FFY 2021 DUR survey. According to FFY 2021 reported responses, 34 states (68%) have a program in place for managing or monitoring appropriate use of antianxiety/sedative medication in children. Eleven states plan future implementation of an Anxiety/Sedative Monitoring Program.

IX. Innovative Practices

Sharing of new ideas and best practices is an invaluable resource to all states. FFY 2021 reported responses include 43 state (86%) submissions for DUR innovative practices. Currently submitted state innovative practices can be found in this report. Previously submitted innovative practices from FFY 2014 to FFY 2021 can be accessed on Medicaid.gov.

FFY 2021 reported responses show only 1 state (2%) currently participating in a demonstration or having 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.

X. Managed Care Organizations (MCOs)

All MCOs have submitted the FFY 2021 DUR annual survey.[7] Based on FFY 2021 reported responses, 39 states (78%) have active MCOs encompassing 258 programs. Furthermore, 5 of the 39 states (13%) (MO, ND, TN, WI, and WV) carve out their drug benefit and submitted an abbreviated MCO survey for each of their programs. National MCO, State MCO and Abbreviated MCO reports can be accessed on Medicaid.gov.

XI. State Executive Summaries

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

[7] North Carolina did not submit a MCO survey in FFY 2021 for one of its MCOs. This MCO has only been in operation for 3 months and CMS requires 6 months of operation to report out on the DUR survey.

Table of Contents

Section I - Enrollees 1

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? 1

2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)? 3

Section II - Prospective DUR (ProDUR) 5

1. Indicate the type of your pharmacy point of service (POS) Vendor. 5

2. Identify your ProDUR table driven criteria source. 8

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? 9

4. Does your state receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail? 12

5. Early Refill 19

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. 28

7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early? 31

8. Does the state Medicaid program have any policy prohibiting the auto-refill process that occurs at the POS? 35

9. For drugs not on your Preferred Drug List (PDL), does your Medicaid program have a documented process in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary? 36

10. Top Drug Claims Data Reviewed by the DUR Board: 47

11. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? 48

Section III - Retrospective DUR (RetroDUR) 50

1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report. 50

2. How often does your state perform retrospective practitioner-based education? 58

3. Summary 1 - RetroDUR Educational Outreach 65

Section IV - DUR Board Activity 124

1. Does your state have an approved Medication Therapy Management (MTM) Program? 124

2. Summary 2 - DUR Board Activities 125

Section V - Physician Administered Drugs 207

1. ProDUR? 207

2. RetroDUR? 209

Section VI - Generic Policy and Utilization Data 211

1. Summary 3 - Generic Drug Substitution Policies 211

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? 244

3. Indicate the generic utilization percentage for all covered outpatient drugs (COD) paid during this reporting period. 254

4. How many innovator drugs are the preferred product on your state PDL when multi-source drugs are available based on net pricing and rebates? 256

5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period. 258

6. Does your state have any policies related to Biosimilars? 260

Section VII - Program Evaluation / Cost Savings / Cost Avoidance 264

1. Did your state conduct a DUR program evaluation of the estimated cost savings/cost avoidance? 264

2. ProDUR and RetroDUR program cost savings/cost avoidance. 267

3. The Estimated Percent Impact 267

4. Summary 4 - Cost Savings/Cost Avoidance Methodology 268

Section VIII - Fraud, Waste and Abuse (FWA) Detection 325

A. Lock-In or Patient Review and Restrictions Programs 325

1. Does your state have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries? 325

2. Does your state have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? 329

3. Does your state have a documented process in place that identifies possible FWA of controlled drugs by prescribers? 342

4. Does your state have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers? 347

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? 351

B. Prescription Drug Monitoring Program (PDMP) 356

1. Does your Medicaid program have the ability to query the state's PDMP database? 356

2. Does your state or your professional board require prescribers to access the PDMP patient history before prescribing controlled substances? 364

3. Does the State or professional board require pharmacists to check the PDMP prior to dispensing? 382

4. In the State's PDMP system, which of the following pieces of information with respect to a beneficiary is available to prescribers as close to real-time as possible? 389

5. Have you had any changes to your state's PDMP during this reporting period that have improved the Medicaid program's ability to access PDMP data? ... 396

6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data? ... 397

C. Opioids ... 398

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? ... 398

2. Does your state have POS edits in place to limit the quantity dispensed of short-acting opioids? ... 409

3. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids? ... 414

4. Does your state have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids? ... 418

5. Does your state have POS edits to monitor duplicate therapy of opioid prescriptions? ... 432

6. Does your state have POS edits to monitor early refills of opioid prescriptions dispensed? ... 437

7. Does your state have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these state limitations? ... 441

8. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently? ... 447

9. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently? ... 455

10. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently? ... 461

11. Does your state have POS safety edits or perform automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis? ... 468

12. Does your state Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines? ... 476

13. Does your state have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse? ... 481

14. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency? ... 484

D. Morphine Milligram Equivalent (MME) Daily Dose ... 487

1. Have you set recommended maximum MME daily dose measures? ... 487

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? ... 495

3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed? ... 497

4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere? ... 502

E. Opioid Use Disorder (OUD) Treatment ... 507

1. Does your state have utilization controls to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD? 507

2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs? 513

3. What are your limitations on the allowable length of this treatment? 516

4. Does your state require that the maximum mg per day allowable be reduced after a set period of time? 517

5. Does your state have at least one buprenorphine/naloxone combination product available without PA? 520

6. Does your state currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT? 521

7. Is there at least one formulation of naltrexone for OUD available without PA? 524

8. Does your state have at least one naloxone opioid overdose product available without PA? 525

9. Does your state retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose? 526

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? 529

F. Outpatient Treatment Programs (OTP) 530

1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services? 530

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? 536

3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan? 537

4. Does your state Medicaid program cover Methadone for a substance use disorder? 538

G. Psychotropic Medication 539

Antipsychotics 539

1. Does your state currently have restrictions in place to limit the quantity of antipsychotic drugs? 539

2. Does your state have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? 543

Stimulants 560

3. Does your state currently have restrictions in place to limit the quantity of stimulant drugs? 560

4. Does your state have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? 561

Antidepressants 576

5. Does your state have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? 576

Mood Stabilizers 587

6. Does your state have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children? 587

Antianxiety/Sedatives 596

7. Does your state have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children? 596

Section IX - Innovative Practices 608

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? 608

2. Summary 5 - Innovative Practices 609

Section X - Managed Care Organizations (MCOs) 677

1. How many MCOs are enrolled in your state Medicaid program? 677

2. Is your pharmacy program included in the capitation rate (carved in)? 679

3. If covered outpatient drugs are included in an MCO's covered benefit package, has the State updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act? 682

4. Does the state set requirements for the MCO's pharmacy benefit? 692

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? 700

6. Indicate how the State oversees the FFS and MCO RetroDUR programs? 701

7. How does the state ensure MCO compliance with DUR requirements described in Section 1927(g) of Act and 42 CFR part 456, subpart K? 709

8. Did all of your managed care plans submit their DUR reports? 716

Section XI - Executive Summary 717

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

List of Figures

Figure 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit 1
Figure 2 - Medicaid Beneficiaries Enrolled in MCOs by State 3
Figure 3 - Pharmacy POS Type of Vendor 5
Figure 4 - Who Processes the State's National Council for Prescription Drug Programs (NCPDP) transactions 7
Figure 5 - ProDUR Criteria Source 8
Figure 6 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes 9
Figure 7 - "Yes" or "Varies by Alert Type" Override 10
Figure 8 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity 12
Figure 9 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity 15
Figure 10 - Follow up with Providers who Routinely Override with Interventions 16
Figure 11 - Follow-up Methods for Providers who Routinely Override with Interventions 17
Figure 12 - Non-Controlled Drugs Early Refill Percent Edit Threshold 19
Figure 13 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold 19
Figure 14 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold 20
Figure 15 - Non-Controlled Drugs Early Refill Requirement for Prior Authorization 22
Figure 16 - Non-Controlled Drugs Early Refill Authorization Sources 23
Figure 17 - Non-Controlled Drugs, Pharmacist May Override at Point of Service 24
Figure 18 - Controlled Drugs Early Refill Requirement for Prior Authorization 25
Figure 19 - Controlled Drugs Early Refill Authorization Source 26
Figure 20 - Controlled Drugs, Pharmacist May Override at Point of Service 27
Figure 21- Allow Pharmacist Overrides for an Early Refill 28
Figure 22 - System Accumulation Edit for Prevention of Early Prescription Filling 31
Figure 23 - Plans to Implement a System Accumulation Edit 34
Figure 24 - State Policy Prohibiting Auto-Refill at the POS 35
Figure 25 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary 36
Figure 26 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) when Medically Necessary 37
Figure 27 - Program Provides for the Dispensing of at least a 72-Hour Supply of a COD in Emergency Situations 41
Figure 28 - Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations 42
Figure 29 - Monitoring Oral Counseling Requirements 48
Figure 30 - Type of Vendor that Performed RetroDUR Activities 50
Figure 31 - Is RetroDUR Vendor the State MMIS Fiscal Agent 52
Figure 32 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria 53
Figure 33 - Does State Customize RetroDUR Vendor Criteria 57
Figure 34 - Frequency of Retrospective Practitioner-Based Education 58
Figure 35 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners 61
Figure 36 - Preferred Mode of Communication When Performing RetroDUR Initiatives 63
Figure 37 - State has an Approved Medication Therapy Management Program 124
Figure 38 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR 207

Figure 39 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR 208
Figure 40 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR 209
Figure 41 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR 210
Figure 42 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting “Brand Medically Necessary” for a Brand Name Drug 244
Figure 43 - Additional Restrictive State Requirements for Dispensing a Brand Name Drug 245
Figure 44 - Single Source (S) Drugs Total Number of Claims by State 248
Figure 45 - Non-Innovator Source (N) Drugs Total Number of Claims by State 248
Figure 46 - Innovator Multi-Source (I) Drugs Total Number of Claims by State 249
Figure 47 - Single Source (S) Drugs Total Reimbursement Amount Less Co-Pay by State 251
Figure 48 - Non-Innovator Source (N) Drugs Total Reimbursement Amount Less Co-Pay by State 251
Figure 49 - Innovator Multi-Source (I) Drugs Total Reimbursement Amount Less Co-Pay by State 252
Figure 50 - Generic & Total Claims by State 254
Figure 51 - Multi-Source Drugs That Have the Innovator as the Preferred Drug Product Based on Net Pricing 256
Figure 52 - Generic/Total Amount Paid by State 258
Figure 53 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance 264
Figure 54 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation 265
Figure 55 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries 325
Figure 56 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected 326
Figure 57 - Lock-In Program 329
Figure 58 - Lock-In Program Candidate Identification Criteria 330
Figure 59 - Prescriber Only Restriction Capability 334
Figure 60 - Pharmacy Only Restriction Capability 335
Figure 61 - Prescriber and Pharmacy Restriction Capability 336
Figure 62 - Lock-In Time Period 337
Figure 63 - Percentage of FFS Population in Lock-In Status Annually 340
Figure 64 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers 342
Figure 65 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected 343
Figure 66 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers 347
Figure 67 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected 348
Figure 68 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers 351
Figure 69 - State has Ability to Query the State’s PDMP Database 356
Figure 70 - Frequency of PDMP Data Received 357
Figure 71 - State’s Direct Access to the PDMP Database 358
Figure 72 - Access to Border State PDMP Information 362
Figure 73 - PDMP Data Integration into POS Edits 363
Figure 74 - Prescribers Requirement to Access the PDMP Patient History Before Prescribing Controlled Substances 364
Figure 75 - Protocols Involved Checking the PDMP 366
Figure 76 - Providers Required to Have Protocols for Responses to Information from PDMP that is Contradictory to Direction Expected from Client 377
Figure 77 - State Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check 378
Figure 78 - State Requires Provider, on Request, to Submit Documentation 380

Figure 79 - State Requires Pharmacist to Check PDMP Prior to Dispensing 382
Figure 80 - State Has Protocols Involved in Checking PDMP 385
Figure 81 - Beneficiary Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible 389
Figure 82 - Barriers Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA 392
Figure 83 - Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data 396
Figure 84 - Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period 397
Figure 85 - POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients 398
Figure 86 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients 403
Figure 87 - POS Edits in Place to Limit Days' Supply of Subsequent Opioid Prescriptions 405
Figure 88 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids 409
Figure 89 - Limits for Quantity Dispensed of Short-Acting Opioids 410
Figure 90 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids 414
Figure 91 - Limits for Quantity Dispensed of Long-Acting Opioids 415
Figure 92 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids 418
Figure 93 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids 419
Figure 94 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions 432
Figure 95 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed 437
Figure 96 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions Exceeding State Limitations 441
Figure 97 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently 447
Figure 98 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently 455
Figure 99 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently 461
Figure 100 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis 468
Figure 101 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis 469
Figure 102 - 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 474
Figure 103 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines 476
Figure 104 - Pain Management / Opioid Prescribing Guidelines Provided 477
Figure 105 - Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse 481
Figure 106 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency 484
Figure 107 - State Recommended Maximum MME Daily Dose Measures 487
Figure 108 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams 488
Figure 109 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded 495
Figure 110 - Prior Authorization Required if MME Limit is Exceeded 496

Figure 111 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed 497
Figure 112 - Provide Information to Prescribers to Calculate MME Daily Dosage or Provide Calculator Elsewhere 502
Figure 113 - Developer of Calculator 503
Figure 114 - How Information is Disseminated 504
Figure 115 - State Has Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD 507
Figure 116 - Program Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs 513
Figure 117 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs 514
Figure 118 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs 516
Figure 119 - Maximum Milligrams per Day Reduction After a Set Period of Time 517
Figure 120 - Reduced (Maintenance) Dosage 518
Figure 121 - Limitations on the Allowable Length of the Reduced Dosage Treatment 519
Figure 122 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization 520
Figure 123 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT 521
Figure 124 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT 522
Figure 125 - Formulation of Naltrexone for OUD Available without Prior Authorization 524
Figure 126 -Naloxone Opioid Overdose Product Available without PA 525
Figure 127 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose 526
Figure 128 - State Allows Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols 529
Figure 129 - State Covers OTPs that Provide BH and MAT services 530
Figure 130 - Referral Needed for OUD Treatment Through OTPs 531
Figure 131 - Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs 536
Figure 132 - Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs 537
Figure 133 - State Program Covers Methadone for Substance Use Disorder 538
Figure 134 - Restrictions to Limit Quantity of Antipsychotics 539
Figure 135 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children 543
Figure 136 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs 544
Figure 137 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children 546
Figure 138 - Restrictions in Place to Limit the Quantity of Stimulant Drugs 560
Figure 139 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children 561
Figure 140 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs 562
Figure 141 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children 564
Figure 142 - Future Plans to Implement a Stimulant Monitoring Program 575
Figure 143 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children 576
Figure 144 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs 577
Figure 145 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children 578
Figure 146 - Future Plans to Implement an Antidepressant Monitoring Program 585

Figure 147 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 587
Figure 148 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs 588
Figure 149 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 589
Figure 150 - Future Plans to Implement a Mood Stabilizer Monitoring Program 594
Figure 151 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 596
Figure 152 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs 597
Figure 153 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 598
Figure 154 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program 605
Figure 155 - 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 608
Figure 156 - Number of MCOs Enrolled in State Medicaid Program 677
Figure 157 - Pharmacy Program Included in the Capitation Rate 679
Figure 158 - Have States Updated Their MCOs' Contracts for Section 1004 Compliance 682
Figure 159 - Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions 684
Figure 160 - State Mandating Requirements for the MCO's Pharmacy Benefit 692
Figure 161 - State Requirements for the MCO's Pharmacy Benefit 693
Figure 162 - Future Plans to Set MCO Pharmacy Benefit Standards 698
Figure 163 - RetroDUR Program Operated by State, MCO, or Combination of State and MCO 700
Figure 164 - Managed Care Plans Submission of DUR Reports 716

List of Tables

Table 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit 1
Table 2 - Medicaid Beneficiaries Enrolled in MCOs by State 3
Table 3 - Pharmacy POS Type of Vendor 5
Table 4 - POS Vendor Name 6
Table 5 - Who Processes the State's National Council for Prescription Drug Programs (NCPDP) transactions 7
Table 6 - ProDUR Criteria Source 8
Table 7 - "Other" State Explanations for ProDUR Criteria Source 9
Table 8 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes 10
Table 9 - "Yes" or "Varies by Alert Type" Override 11
Table 10 - Explanation for "Other" ProDUR Alert Message Override 11
Table 11 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity 13
Table 12 - "No" Explanation for Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity 13
Table 13 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity 15
Table 14 - "Other" Explanation for Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity 15
Table 15 – Follow up with Providers who Routinely Override with Interventions 16
Table 16 - Follow-up Methods for Providers who Routinely Override with Interventions 17
Table 17 - "Other" Explanations for Follow-up Methods for Providers who Routinely Override with Interventions 17
Table 18 - Explanations for No Follow-up Methods for Providers who Routinely Override with Interventions 18
Table 19 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs 20
Table 20 - Non-Controlled Drugs Early Refill Requirement for Prior Authorization 22
Table 21 - Non-Controlled Drugs Early Refill Authorization Sources 23
Table 22 - Non-Controlled Drugs, Pharmacist May Override at Point of Service 24
Table 23 - Controlled Drugs Early Refill Requirement for Prior Authorization 25
Table 24 - Controlled Drugs Early Refill Authorization Source 26
Table 25 - Controlled Drugs, Pharmacist May Override at Point of Service 27
Table 26 - Allow Pharmacist Overrides for an Early Refill 28
Table 27 - "Other" Explanations for Allowing Pharmacist Overrides for an Early Refill 29
Table 28 - System Accumulation Edit for Prevention of Early Prescription Filling 31
Table 29 - Explanations for System Accumulation Edit for Prevention of Early Prescription Filling 32
Table 30 - Plans to Implement a System Accumulation Edit 34
Table 31 - State Policy Prohibiting Auto-Refill at the POS 35
Table 32 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary 36
Table 33 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) when Medically Necessary 37
Table 34 - Explanations for "Other" Processes in Place for Beneficiaries to Access Any Covered Outpatient Drug when it is Medically Necessary. 38
Table 35 - Explanations for Lack of Documented Process for Beneficiaries to Access a Covered Outpatient Drug when it is Medically Necessary 40
Table 36 - Program Provides for the Dispensing of at least a 72-Hour Supply of a COD in Emergency Situations 41
Table 37 - Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations 42

Table 38 - Explanations of "Other" Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations 43
Table 39 - Explanations for not Providing for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations 46
Table 40 - Top Drug Claims Data Reviewed by the DUR Board* 47
Table 41 - Monitoring Oral Counseling Requirements 48
Table 42 - "Other" Explanations for Monitoring Oral Counseling Requirements 49
Table 43 - Type of Vendor that Performed RetroDUR Activities 50
Table 44 - Vendor Names 51
Table 45 - Academic/Other Institution Names 51
Table 46 - Is RetroDUR Vendor the State MMIS Fiscal Agent 52
Table 47 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria 53
Table 48 - Explanations for why the RetroDUR Vendor is or is not the Developer/Supplier of Retrospective DUR Criteria 54
Table 49 - Does State Customize RetroDUR Vendor Criteria 58
Table 50 - Frequency of Retrospective Practitioner-Based Education 59
Table 51 - "Other" Frequency of Retrospective Practitioner-Based Education 59
Table 52 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners 61
Table 53 - "Other" Explanations for Frequency of Retrospective Reviews that Involve Communication of Client-specific Information to Healthcare Practitioners 62
Table 54 - Preferred Mode of Communication When Performing RetroDUR Initiatives 64
Table 55 - "Other" Explanations for Preferred Mode of Communication When Performing RetroDUR Initiatives 64
Table 56 - RetroDUR Educational Outreach Summary 65
Table 57 - State has an Approved Medication Therapy Management Program 124
Table 58 - DUR Board Activities Summary 125
Table 59 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR 207
Table 60 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR 208
Table 61 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR 209
Table 62 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR 210
Table 63 - Generic Drug Substitution Policies Summary 211
Table 64 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug 244
Table 65 - Additional Restrictive State Requirements for Dispensing a Brand Name Drug 245
Table 66 - "Other" Explanations for Additional Restrictive State Requirements for Dispensing a Brand Name Drug 246
Table 67 - Drug Utilization Number of Claims by Drug Category 249
Table 68 - Drug Utilization Total Reimbursement Amount by Drug Category 252
Table 69 - Generic & Total Claims by State 254
Table 70 - Multi-Source Drugs That Have the Innovator as the Preferred Drug Product Based on Net Pricing 256
Table 71 - Generic/Total Amount Paid by State 258
Table 72 - Explanations for Policies Related to Biosimilars 260
Table 73 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance 264
Table 74 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation 265

Table 75 - Vendors by State that Conducted the Cost Savings/Avoidance Program Evaluation 266
Table 76 - Academic/Other Institutions that Conducted the Cost Savings/Avoidance Program Evaluation 267
Table 77 - Cost Savings/Cost Avoidance Methodology Summary 268
Table 78 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries 325
Table 79 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected 326
Table 80 - “Other” Explanations for Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected 327
Table 81 - Lock-In Program 329
Table 82 - Lock-In Program Candidate Identification Criteria 330
Table 83 - “Other” Explanations for Lock-In Program Candidate Identification Criteria 331
Table 84 - Prescriber Only Restriction Capability 334
Table 85 - Pharmacy Only Restriction Capability 335
Table 86 - Prescriber and Pharmacy Restriction Capability 336
Table 87 - Lock-In Time Period 337
Table 88 - "Other" Explanations for Lock-In Time Period 338
Table 89 - Percentage of FFS Population in Lock-In Status Annually 340
Table 90 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers 342
Table 91 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected 343
Table 92 - “Other” Explanations for Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected 344
Table 93 - Explanations for Lack of Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers 346
Table 94 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers 347
Table 95 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected 348
Table 96 - “Other” Explanations for Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected 349
Table 97 - Explanations for Lack of Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers 351
Table 98 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers 352
Table 99 - Explanations of Program for FWA of Non-Controlled Substances 352
Table 100 - Explanations for Lack of Documented Process to Identify and/or Prevent Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers 355
Table 101 - State has Ability to Query the State’s PDMP Database 356
Table 102 - Frequency of PDMP Data Received 357
Table 103 - “Other” Explanations of Frequency of PDMP Data Received 357
Table 104 - State’s Direct Access to the PDMP Database 358
Table 105 - Explanations for No Ability to Query PDMP Database 358
Table 106 - Explanation for How State Applies Information to Control FWA of Controlled Substances 360
Table 107 - Access to Border State PDMP Information 362
Table 108 - PDMP Data Integration into POS Edits 363
Table 109 - Prescribers Requirement to Access the PDMP Patient History Before Prescribing Controlled Substances 364
Table 110 - Explanations for Allowing Prescription of Controlled Substances without Accessing PDMP Patient History 365
Table 111 - Protocols Involved Checking the PDMP 366
Table 112 - Explanations of Protocols Involved in Checking the PDMP 367
Table 113 - Providers Required to Have Protocols for Responses to Information from PDMP that is Contradictory to Direction Expected from Client 377

Table 114 - State Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check 378
Table 115 - Explanations for not Requiring Prescribers to Document a Good Faith Effort 378
Table 116 - State Requires Provider, on Request, to Submit Documentation 380
Table 117 - Explanations for not Requiring Provider to Submit Documentation 380
Table 118 - State Requires Pharmacist to Check PDMP Prior to Dispensing 382
Table 119 - Explanations for not Requiring Pharmacists to Check PDMP Prior to Dispensing 383
Table 120 - State Has Protocols Involved in Checking PDMP 385
Table 121 - Explanations of Protocols Involved in Checking PDMP 386
Table 122 - Beneficiary Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible 390
Table 123 - “Other” Explanations for Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible 390
Table 124 - Barriers Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA 392
Table 125 - Explanations of Barriers That Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA 393
Table 126 - Changes to State PDMP That Have Improved Medicaid’s Ability to Access PDMP Data 396
Table 127 - Explanations of Changes to State PDMP That Have Improved Medicaid’s Ability to Access PDMP Data 397
Table 128 - Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period 397
Table 129 - Summary of Breach 398
Table 130 - POS Edit in Place to Limit the Days’ Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients 399
Table 131 - Explanations of POS Edit in Place to Limit the Days’ Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients 399
Table 132 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients 404
Table 133 - POS Edits in Place to Limit Days' Supply of Subsequent Opioid Prescriptions 405
Table 134 - “Other” Days' Supply Limit for Subsequent Opioid Prescriptions 406
Table 135 - Explanations of POS Edit in Place to Limit Days' Supply of Subsequent Opioid Prescriptions 406
Table 136 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids 409
Table 137 - Limits for Quantity Dispensed of Short-Acting Opioids 410
Table 138 - “No” Explanation for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids 411
Table 139 - “Other” Explanation for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids 411
Table 140 - POS Edits In Place to Limit the Quantity Dispensed of Long-Acting Opioids 414
Table 141 - Limits for Quantity Dispensed of Long-Acting Opioids 415
Table 142 - “No” Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids 416
Table 143 - “Other” Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids 416
Table 144 - Measures other than Restricted Quantities and Days’ Supply in Place to Either Monitor or Manage the Prescribing of Opioids 418
Table 145 - Measures other than Restricted Quantities and Days’ Supply in Place to Either Monitor or Manage the Prescribing of Opioids 419
Table 146 - “Other” Explanations for Measures other than Restricted Quantities and Days’ Supply in Place to Either Monitor or Manage the Prescribing of Opioids 421
Table 147 - Detail for Opioid Prescribing Controls in Place 422
Table 148 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions 432
Table 149 - Explanations of POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions 433
Table 150 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed 437
Table 151 - Explanation for Scope and Nature of Reviews and Edits in Place 438
Table 152 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions Exceeding State Limitations 441

Table 153 – Scope, Nature and Frequency of the Automated Retrospective Claim Reviews 442
Table 154 - Explanation of "No" Comprehensive Automated Retrospective Claim Reviews 445
Table 155 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently 447
Table 156 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Benzodiazepines Being Used Concurrently 448
Table 157 - Explanations for not Having POS Edits in Place or Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently 454
Table 158 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently 455
Table 159 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Sedatives Being Used Concurrently 456
Table 160 - Explanations for not Having POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently 459
Table 161 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently 461
Table 162 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Antipsychotics Being Used Concurrently 462
Table 163 - Explanations for not Having POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently 467
Table 164 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis 468
Table 165 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis 469
Table 166 - "Other" Explanations for Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis 470
Table 167 - Explanations of Nature and Scope of Edits, Reviews and/or Provider Education Reviews Performed Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis 470
Table 168 - 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 474
Table 169 - "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 474
Table 170 - "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 475
Table 171 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines 476
Table 172 - Pain Management / Opioid Prescribing Guidelines Provided 477
Table 173 - "Other" Explanations of Pain Management / Opioid Prescribing Guidelines Provided 478
Table 174 - Explanations for not Offering Pain Management/Opioid Prescribing Guidelines 480
Table 175 - Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse 481
Table 176 - Explanation of Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse 482
Table 177 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency 484
Table 178 - "Yes" Explanations for COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency 485

Table 179 - State Recommended Maximum MME Daily Dose Measures 487
Table 180 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams 488
Table 181 - Maximum Morphine Equivalent Daily Dose Limit Less Than 50 MME Per Day 489
Table 182 - Maximum Morphine Equivalent Daily Dose Limit More Than 200 MME Per Day 489
Table 183 - "Other" Maximum Morphine Equivalent Daily Dose Limit 489
Table 184 - Explanations for Nature and Scope of Maximum Morphine Equivalent Daily Dose Limit 489
Table 185 - Explanations of the Measure or Program Utilized for Maximum Morphine Equivalent Daily Dose Limit 495
Table 186 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded 496
Table 187 - Prior Authorization Required if MME Limit is Exceeded 497
Table 188 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed 498
Table 189 - Explanations for Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed 498
Table 190 - Provide Information to Prescribers to Calculate MME Daily Dosage or Provide Calculator Elsewhere 502
Table 191 - Developer of Calculator 503
Table 192 - Explanations for "Other" 504
Table 193 - How Information is Disseminated 505
Table 194 - Explanations for "Other" Dissemination Method 505
Table 195 - State Has Utilization Controls to Monitor or Manage Prescribing of MAT of Drugs for OUD 507
Table 196 - Explanations of Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD 508
Table 197 - Program Sets Total Milligrams per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs 513
Table 198 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs 514
Table 199 - "Other" Explanations for Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs 515
Table 200 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs 516
Table 201 - "Other" Explanations for Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs 517
Table 202 - Maximum Milligrams per Day Reduction After a Set Period of Time 518
Table 203 - Reduced (Maintenance) Dosage 518
Table 204 - "Other" Explanations for Reduced (Maintenance) Dosage 519
Table 205 - Limitations on the Allowable Length of the Reduced Dosage Treatment 519
Table 206 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization 520
Table 207 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT 521
Table 208 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT 522
Table 209 - "Other" Explanations for Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT 523
Table 210 - Formulation of Naltrexone for OUD Available without Prior Authorization 524
Table 211 - Naloxone Opioid Overdose Product Available without PA 525
Table 212 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose 526
Table 213 - Explanations for Not Retrospectively Monitoring and Managing Appropriate Use of Naloxone to Persons at Risk of Overdose 527

Table 214 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols 529
Table 215 - State Covers OTPs that Provide BH and MAT services 530
Table 216 - Referral Needed for OUD Treatment Through OTPs 531
Table 217 - Explanations Referral Needed for OUD Treatment Through OTPs 531
Table 218 - Explanations for Not Covering OTPs that Provide BH and MAT services 535
Table 219 - Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs 536
Table 220 - Explanations for State Not Covering Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs 537
Table 221 - Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs .. 537
Table 222 - Explanations for State Not Covering Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs 538
Table 223 - State Program Covers Methadone for Substance Use Disorder 538
Table 224 - Restrictions to Limit Quantity of Antipsychotics 539
Table 225 - Explanations of Restrictions to Limit Quantity of Antipsychotics 540
Table 226 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children 544
Table 227 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs 545
Table 228 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Antipsychotic Drugs in Children 545
Table 229 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children 546
Table 230 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children..... 547
Table 231 - “Other” Explanations for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children 548
Table 232 - Explanations of State’s Documented Antipsychotic Monitoring Program 550
Table 233 - Restrictions in Place to Limit the Quantity of Stimulant Drugs 561
Table 234 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children 562
Table 235 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs 563
Table 236 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Stimulant Drugs in Children 563
Table 237 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children 564
Table 238 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children 565
Table 239 - “Other” Explanations for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children 566
Table 240 - Explanations of Specifics of Documented Stimulant Monitoring Program(s) 567
Table 241 - Future Plans to Implement a Stimulant Monitoring Program 575
Table 242 - When States Plan to Implement a Program to Monitor the Appropriate Use of Stimulant Drugs in Children 575
Table 243 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children 576
Table 244 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children 576
Table 245 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs 577
Table 246 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Antidepressant Drugs in Children 578
Table 247 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children 578
Table 248 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children ... 579

Table 249 - “Other” Explanations for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children 580
Table 250 - Explanations of Specifics of Documented Antidepressant Monitoring Program(s) 580
Table 251 - Future Plans to Implement an Antidepressant Monitoring Program 585
Table 252 - When States Plan to Implement a Program to Monitor the Appropriate Use of Antidepressant Drugs in Children 585
Table 253 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Antidepressant Drugs in Children 586
Table 254 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 587
Table 255 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs 588
Table 256 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Mood Stabilizing Drugs in Children 588
Table 257 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 589
Table 258 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 590
Table 259 - “Other” Explanations for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 590
Table 260 - Explanations of Specifics of Documented Mood Stabilizer Monitoring Program(s) 591
Table 261 - Future Plans to Implement a Mood Stabilizer Monitoring Program 594
Table 262 - When States Plan to Implement a Program to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 594
Table 263 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children 595
Table 264 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 596
Table 265 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs 597
Table 266 - “Other” Explanations for Managing or Monitoring the Appropriate Use of Antianxiety/Sedative Drugs in Children 598
Table 267 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 599
Table 268 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 599
Table 269 - “Other” Explanations for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 600
Table 270 - Explanations of Specifics of Documented Antianxiety/Sedative Monitoring Program(s) 601
Table 271 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program 606
Table 272 - When States Plan to Implement a Program to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 606
Table 273 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children 607
Table 274 - 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 608
Table 275 - 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 609
Table 276 - Innovative Practices Summary 609
Table 277 - Number of MCOs Enrolled in State Medicaid Program 677
Table 278 - Pharmacy Program Included in the Capitation Rate (Carved In) 679

Table 279 - Drug Categories that are Carved Out of the Capitation Rate 680
Table 280 - Have States Updated Their MCO's Contracts for Section 1004 Compliance 682
Table 281 - Effective Dates for Updating MCO Contracts for Section 1004 Compliance 683
Table 282 - Explanations for States That Have Not Updated MCO Contracts for Section 1004 Compliance 684
Table 283 - Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions 685
Table 284 - Explanations for Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions . 685
Table 285 - Explanations for States Not Complying with Federal Law and Monitoring MCO Compliance is Support of the Patients and Communities Act Provision 692
Table 286 - State Mandating Requirements for the MCO's Pharmacy Benefit 692
Table 287 - State Requirements for the MCO's Pharmacy Benefit 693
Table 288 - Policy Explanations for State Requirements for the MCO's Pharmacy Benefit 694
Table 289 - Future Plans to Set MCO Pharmacy Benefit Standards 698
Table 290 - Explanations for not Setting MCO Pharmacy Benefit Standards in the Future 699
Table 291 - RetroDUR Program Operated by State, MCO, or Combination of State and MCO 700
Table 292 - Explanations for How the State Oversees the FFS and MCO RetroDUR programs 701
Table 293 - Explanations for How the State Ensures MCO Compliance with DUR Requirements 709
Table 294 - Managed Care Plans Submission of DUR Reports 716
Table 295 - Explanations for Managed Care Plans Not Submitting DUR Reports 716
Table 296 - State Executive Summary 717

Section I - Enrollees

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

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

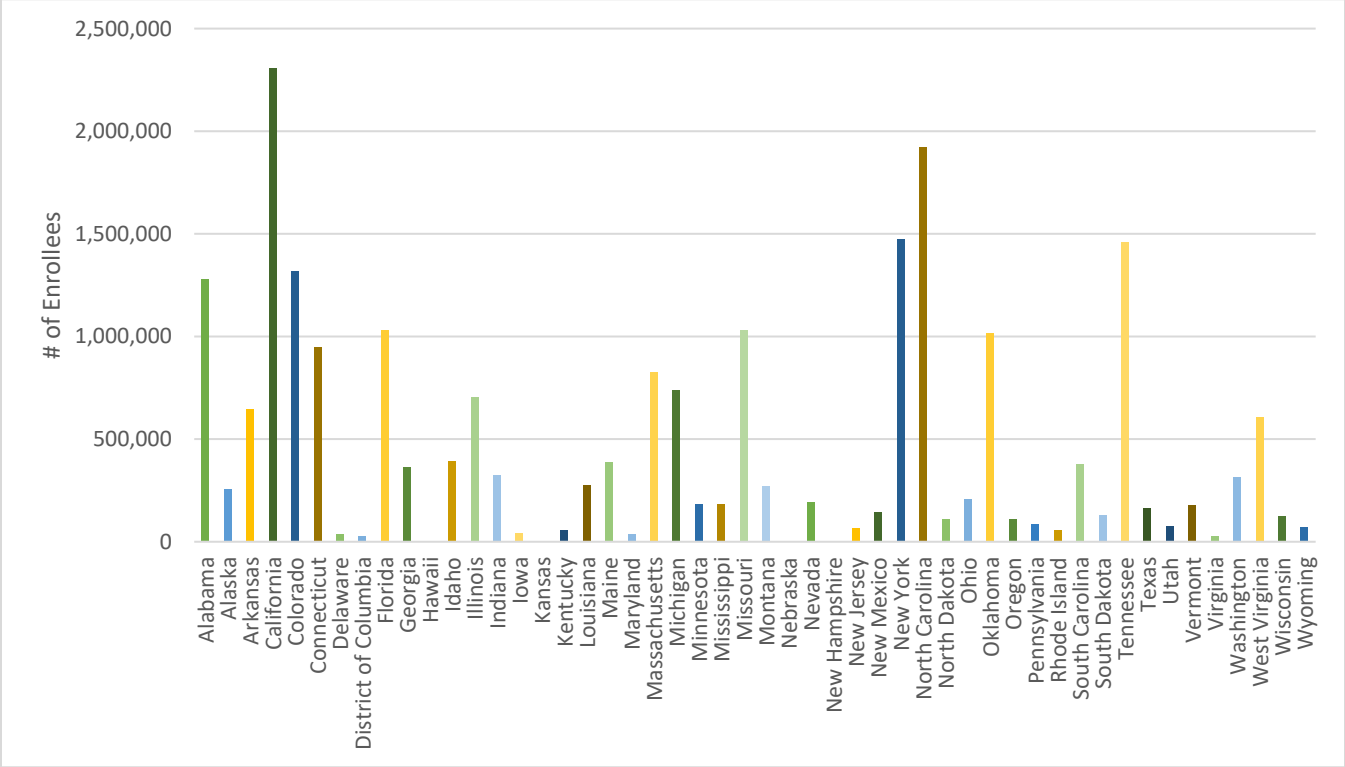

Table 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Alabama	1,280,872
Alaska	255,000
Arkansas	647,094
California	2,307,558
Colorado	1,316,106
Connecticut	947,000
Delaware	38,570
District of Columbia	25,000
Florida	1,028,967
Georgia	362,852
Hawaii	60
Idaho	390,000
Illinois	704,709

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Indiana	322,156
Iowa	41,975
Kansas	1,382
Kentucky	54,301
Louisiana	273,247
Maine	386,376
Maryland	35,909
Massachusetts	824,557
Michigan	737,047
Minnesota	182,013
Mississippi	181,281
Missouri	1,030,053
Montana	270,312
Nebraska	1,700
Nevada	192,107
New Hampshire	3,658
New Jersey	66,368
New Mexico	143,238
New York	1,474,000
North Carolina	1,924,214
North Dakota	110,448
Ohio	205,058
Oklahoma	1,016,399
Oregon	108,097
Pennsylvania	86,000
Rhode Island	56,841
South Carolina	380,000
South Dakota	130,000
Tennessee	1,460,000
Texas	165,221
Utah	75,282
Vermont	176,992
Virginia	25,838
Washington	314,024
West Virginia	607,326
Wisconsin	125,213
Wyoming	69,157
Total	22,561,578

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

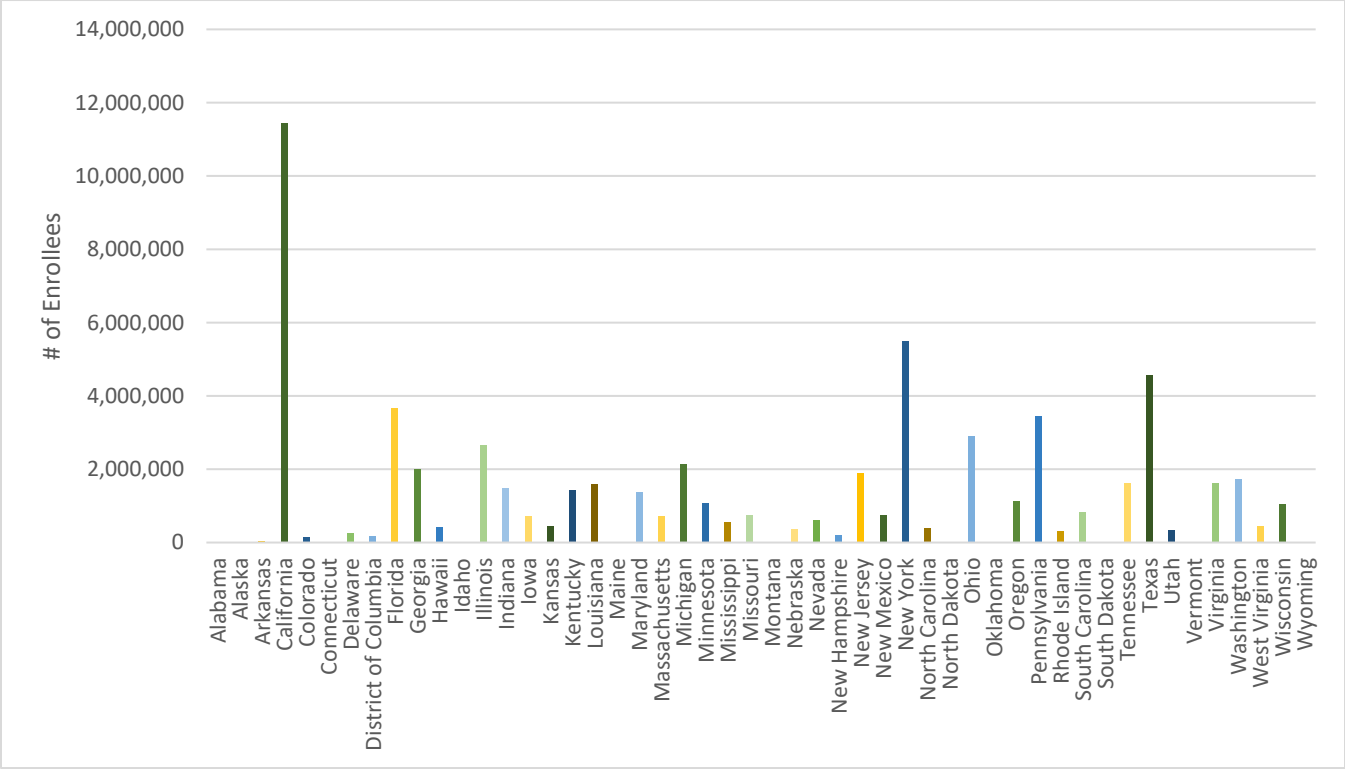

Table 2 - Medicaid Beneficiaries Enrolled in MCOs by State

State	Number of Beneficiaries Enrolled in MCO Plans
Alabama	0
Alaska	0
Arkansas	47,754
California	11,439,224
Colorado	143,251
Connecticut	0
Delaware	252,949
District of Columbia	190,000
Florida	3,677,584
Georgia	2,000,000
Hawaii	430,000
Idaho	0
Illinois	2,664,222
Indiana	1,497,103
Iowa	729,621

State	Number of Beneficiaries Enrolled in MCO Plans
Kansas	444,091
Kentucky	1,442,225
Louisiana	1,589,565
Maine	0
Maryland	1,366,686
Massachusetts	714,887
Michigan	2,150,667
Minnesota	1,086,078
Mississippi	557,560
Missouri	752,092
Montana	0
Nebraska	360,000
Nevada	607,359
New Hampshire	214,457
New Jersey	1,898,410
New Mexico	761,135
New York	5,492,000
North Carolina	391,032
North Dakota	0
Ohio	2,904,678
Oklahoma	0
Oregon	1,121,649
Pennsylvania	3,460,000
Rhode Island	302,390
South Carolina	820,000
South Dakota	0
Tennessee	1,615,000
Texas	4,574,465
Utah	330,365
Vermont	0
Virginia	1,628,319
Washington	1,735,355
West Virginia	446,815
Wisconsin	1,048,732
Wyoming	0
Total	62,887,720

Section II - Prospective DUR (ProDUR)

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

Figure 3 - Pharmacy POS Type of Vendor

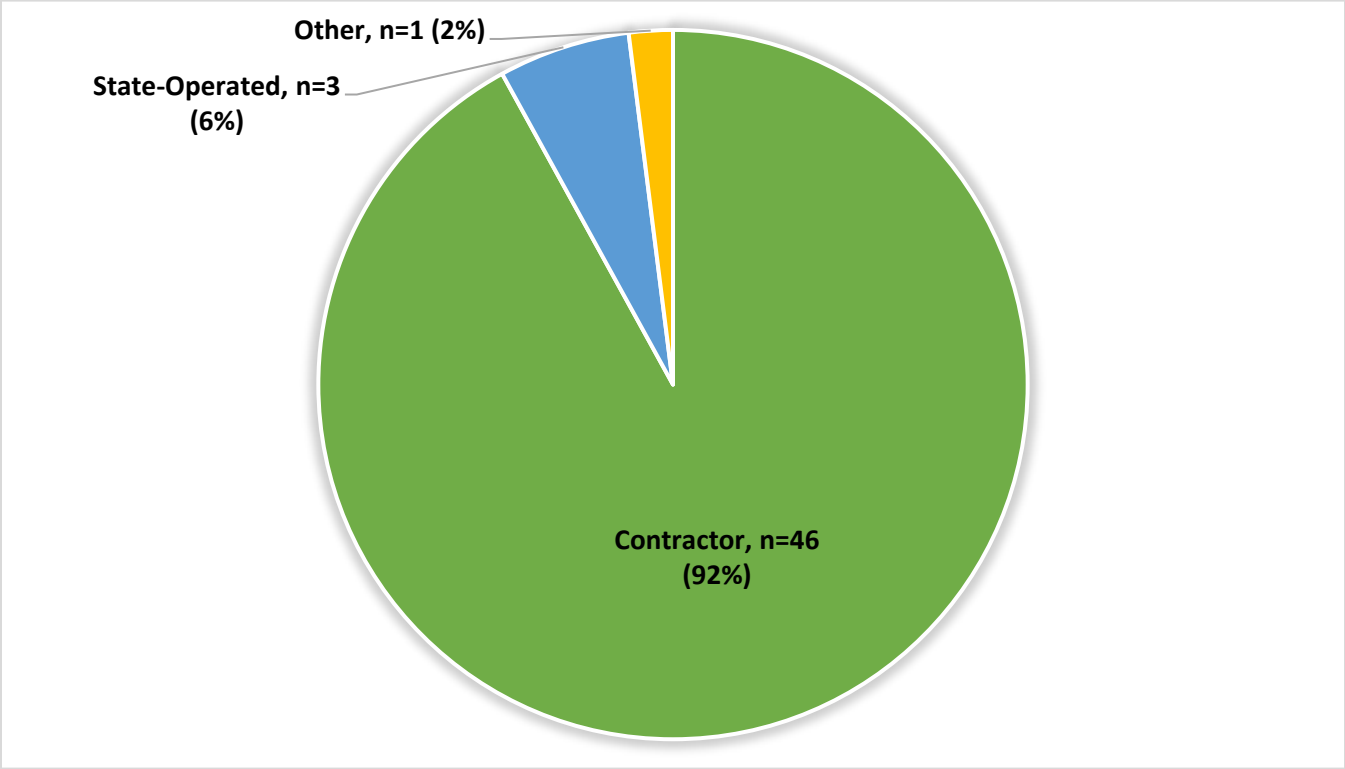

Table 3 - Pharmacy POS Type of Vendor

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, Kansas, Louisiana, New Jersey, Oregon, Pennsylvania, Rhode Island, West Virginia, Wisconsin	10	21.28%
Magellan	Alaska, Arkansas, District of Columbia, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, South Carolina, Virginia	11	23.40%
DXC Technology	California	1	2.13%
Magellan Health, Inc.	Colorado	1	2.13%
Gainwell Technology	Delaware	1	2.13%
OptumRx	Georgia, Nevada, Tennessee	3	6.38%
Conduent	Hawaii, Maryland, Massachusetts, Mississippi, Missouri, Montana, New Mexico	7	14.89%
State operated using Change Healthcare Pharmacy Benefits Management System (PBMS) to process claims.	Illinois	1	2.13%
OptumRx Administrative Services, LLC. (OptumRx)	Indiana	1	2.13%
Change Healthcare	Iowa, Maine, Ohio, Utah, Vermont, Wyoming	6	12.77%
General Dynamics Information Technology (GDIT)	New York	1	2.13%
GDIT	North Carolina	1	2.13%
Gainwell	Oklahoma	1	2.13%
OptumRx (but they are not the fiscal agent and do not function as a PBM as indicated in 1. b.)	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

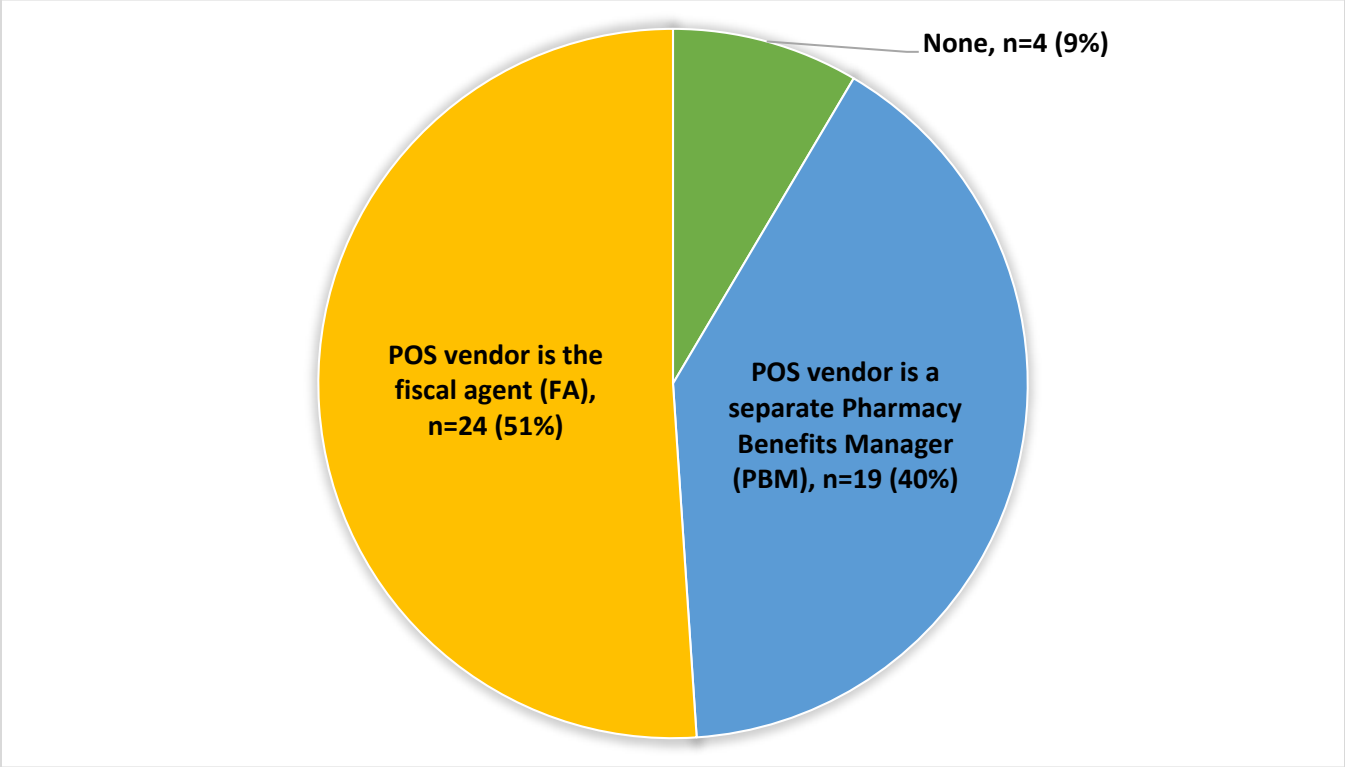

Table 5 - Who Processes the State's National Council for Prescription Drug Programs (NCPDP) transactions

Response	States	Count	Percentage
None	Arkansas, Florida, Indiana, Utah	4	8.51%
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, Vermont, Wyoming	19	40.43%
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

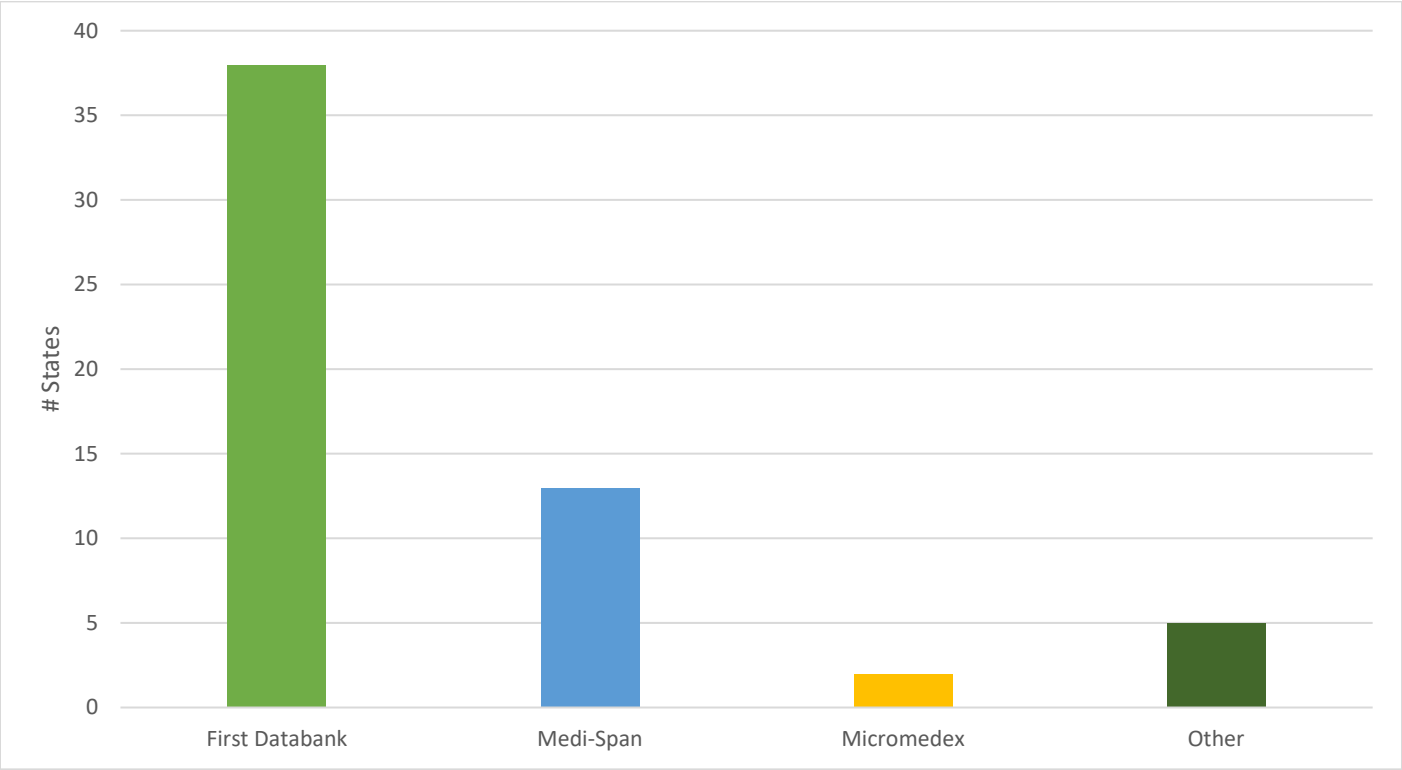

Table 6 - ProDUR Criteria Source

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, 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	38	65.52%
Medi-Span	Georgia, Illinois, Indiana, Iowa, Maine, Nevada, Ohio, South Dakota, Tennessee, Utah, Vermont, Washington, Wyoming	13	22.41%
Micromedex	Mississippi, Oregon	2	3.45%
Other	Illinois, Louisiana, Texas, Vermont, Washington	5	8.62%
Total		58	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-Monroe.
Texas	Some criteria are developed in-house.
Vermont	Clinical Literature and FDA safety alerts.
Washington	Pre-set DUR criteria and functionality are provided through the POS vendor's built in DUR module. Additional DUR criteria based on medically accepted indications/dosing are developed by state staff.

3. When the pharmacist receives a ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the 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

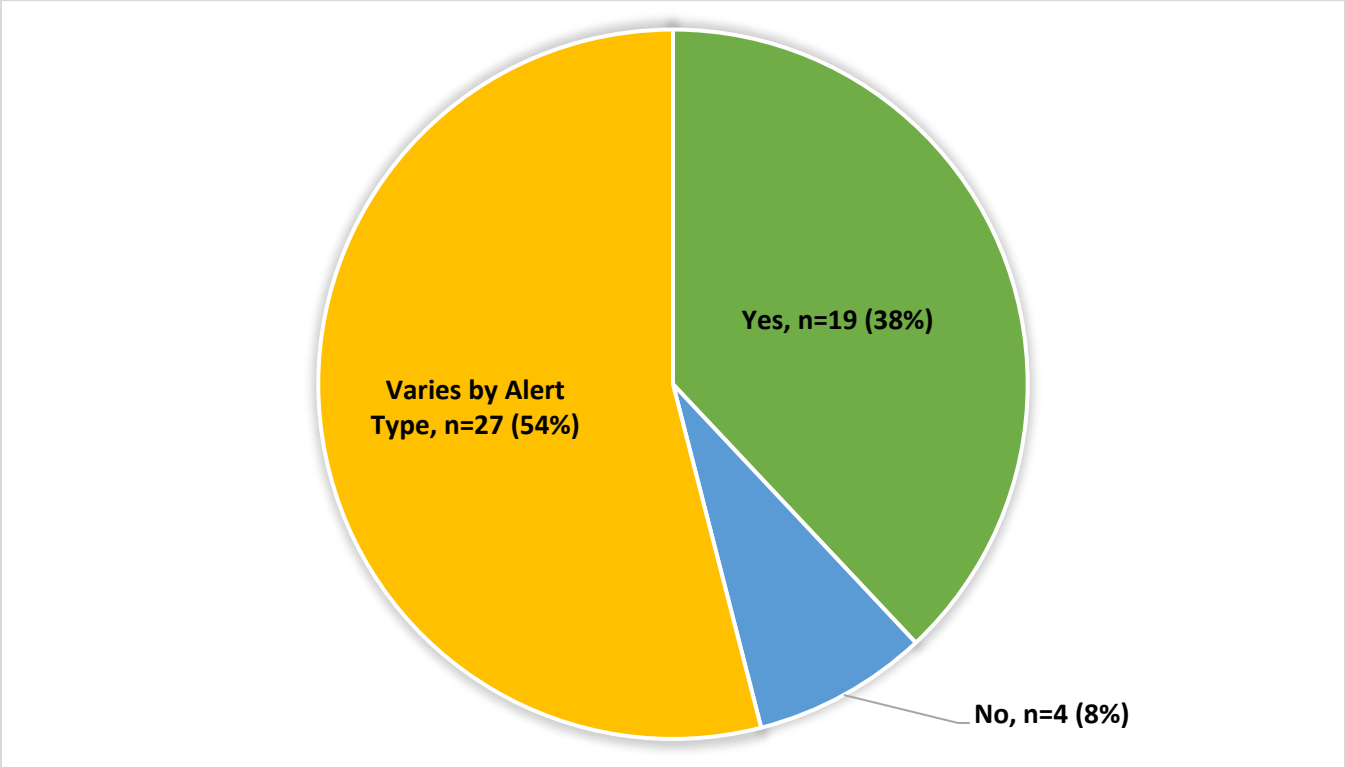

Table 8 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

Response	States	Count	Percentage
Yes	Alaska, California, Connecticut, District of Columbia, Florida, Kentucky, Maryland, Michigan, Mississippi, Missouri, Nebraska, New Mexico, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, Wyoming	19	38.00%
No	Illinois, Iowa, Maine, New Jersey	4	8.00%
Varies by Alert Type	Alabama, Arkansas, Colorado, Delaware, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Washington, West Virginia, Wisconsin	27	54.00%
Total		50	100.00%

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

Figure 7 - “Yes” or “Varies by Alert Type” Override

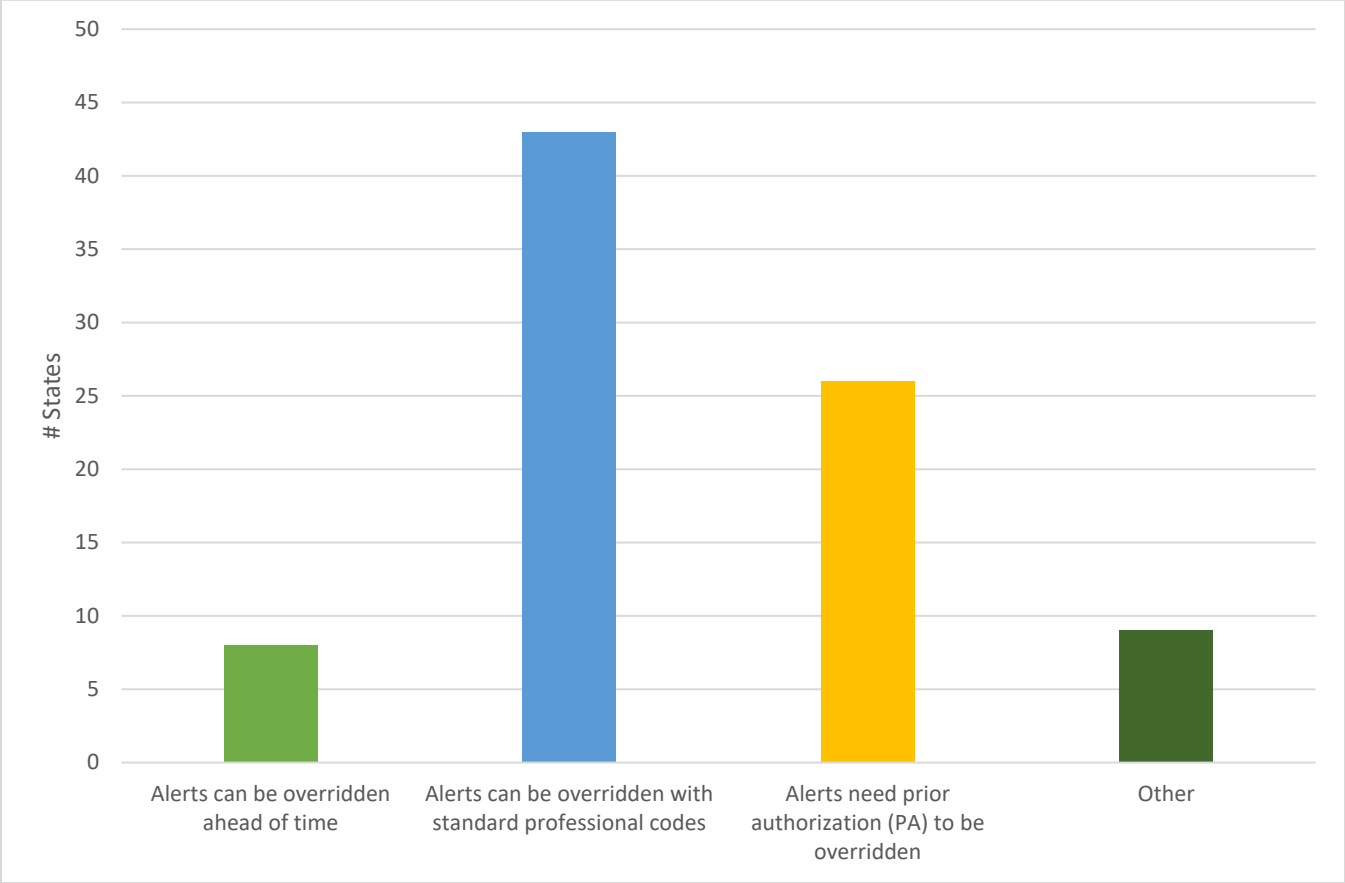

Table 9 - "Yes" or "Varies by Alert Type" Override

Response	States	Count	Percentage
Alerts can be overridden ahead of time	California, Hawaii, North Carolina, Oklahoma, South Carolina, Texas, West Virginia, Wisconsin	8	9.30%
Alerts can be overridden with standard professional codes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	43	50.00%
Alerts need prior authorization (PA) to be overridden	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Hawaii, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Montana, Nevada, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington, West Virginia, Wisconsin	26	30.23%
Other	Arkansas, Colorado, Idaho, Indiana, New Hampshire, North Carolina, Ohio, Texas, Wisconsin	9	10.47%
Total		86	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 manual review by the contractor's help desk.
Colorado	Selected ProDUR alerts may be overridden by pharmacists with standard professional codes.
Idaho	PA needed for override
Indiana	A pharmacist may override level-one drug-drug interactions only when the pharmacy has received direction to discontinue one of the drugs involved in the interaction. All other level-one drug-drug interactions will require prior authorization.
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 PPS codes. Other alerts may require prior authorization completion by the prescriber.
Texas	With the exception of Med Synchronization purposes, all early refills will require an override by calling HHSC Help Desk. Early refill does not require a prior authorization request by prescriber.

State	Explanation
Wisconsin	There are drugs in the ER alert that require a call to the Drug Authorization Policy Override Center that require an override (prior authorization) before dispensing the medication. All other prospective DUR alerts allow the pharmacist to override the alert. During the Public Health Emergency all early refill alerts have been moved to allow a pharmacist override, except for Schedule II drugs.

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

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

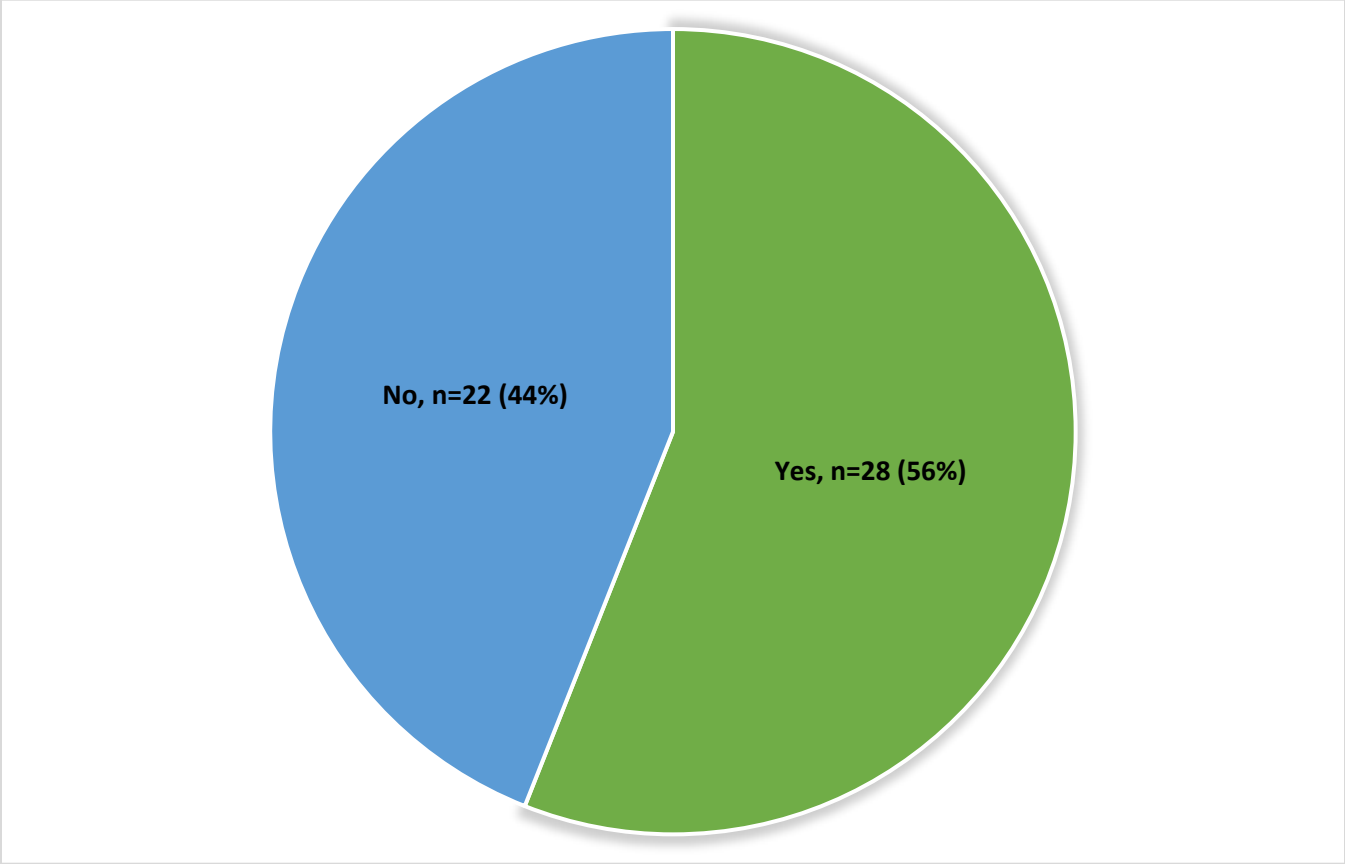

Table 11 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

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 Carolina, South Dakota, Vermont, Virginia	28	56.00%
No	Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, Wyoming	22	44.00%
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 providers 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	The vendor has created a summary for this survey but not in detail by the pharmacy provider.
Louisiana	Currently Louisiana does not receive periodic reports providing individual pharmacy providers DUR alert override activity.
Maine	n/a
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 soon rejection. Informational edits are not reviewed.

State	Explanation
Missouri	Reports can be requested on an as needed basis, but are not generated on a scheduled basis.
Montana	The only alerts that the pharmacy can override are more for informational purposes for the pharmacy and provider. The edits in place for concerns of inappropriate use require a PA.
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.
Tennessee	We have not considered this information to be a priority for our DUR Committee or small State staff to this point in time. We have required prior authorization when overrides, in our opinion need further clinical consideration to determine if the enrollee would qualify for coverage, or to determine if the override would be medically necessary.
Texas	Reports are run as needed (ad-hoc)
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	N/A
Wisconsin	The Wisconsin DUR Board has previously reviewed pharmacy overrides and the Board members have cautioned the State on the validity of 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 for the prescription. WI does not review individual pharmacy provider DUR alert information.
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

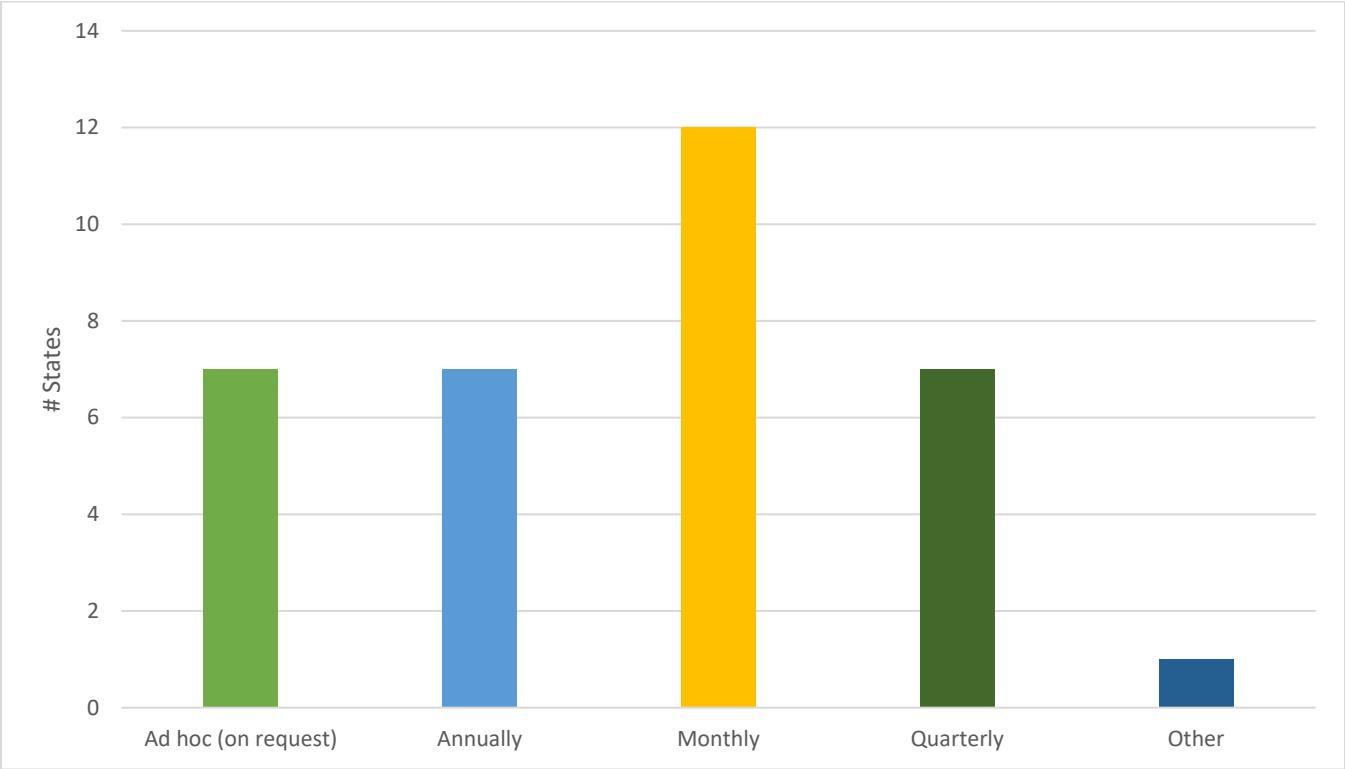

Table 13 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity

Response	States	Count	Percentage
Ad hoc (on request)	Alaska, Arkansas, California, Colorado, Hawaii, North Carolina, South Carolina	7	20.59%
Annually	Alaska, California, Kentucky, New York, Rhode Island, South Carolina, South Dakota	7	20.59%
Monthly	Connecticut, Delaware, District of Columbia, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, Ohio, Pennsylvania, Virginia	12	35.29%
Quarterly	Alabama, Michigan, North Carolina, North Dakota, Oklahoma, Oregon, Vermont	7	20.59%
Other	Arkansas	1	2.94%
Total		34	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	Quarterly, the pharmacy vendor provides a DUR alert report that is a summary for all pharmacies together. The report does not contain DUR activity for individual pharmacies. Ad hoc reports are possible.

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

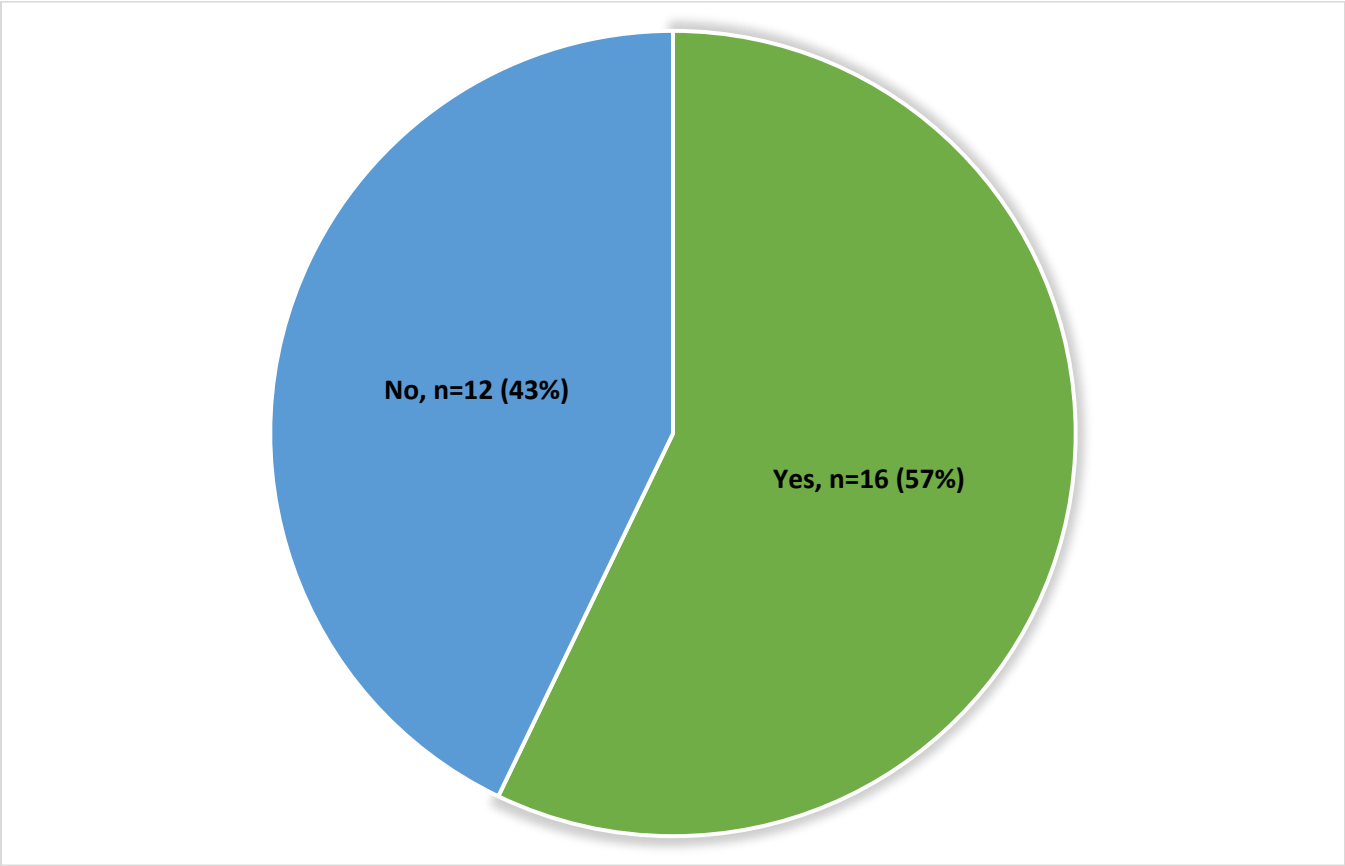

Table 15 – Follow up with Providers who Routinely Override with Interventions

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, Virginia	16	57.14%
No	Arkansas, Connecticut, Mississippi, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Vermont	12	42.86%
Total		28	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

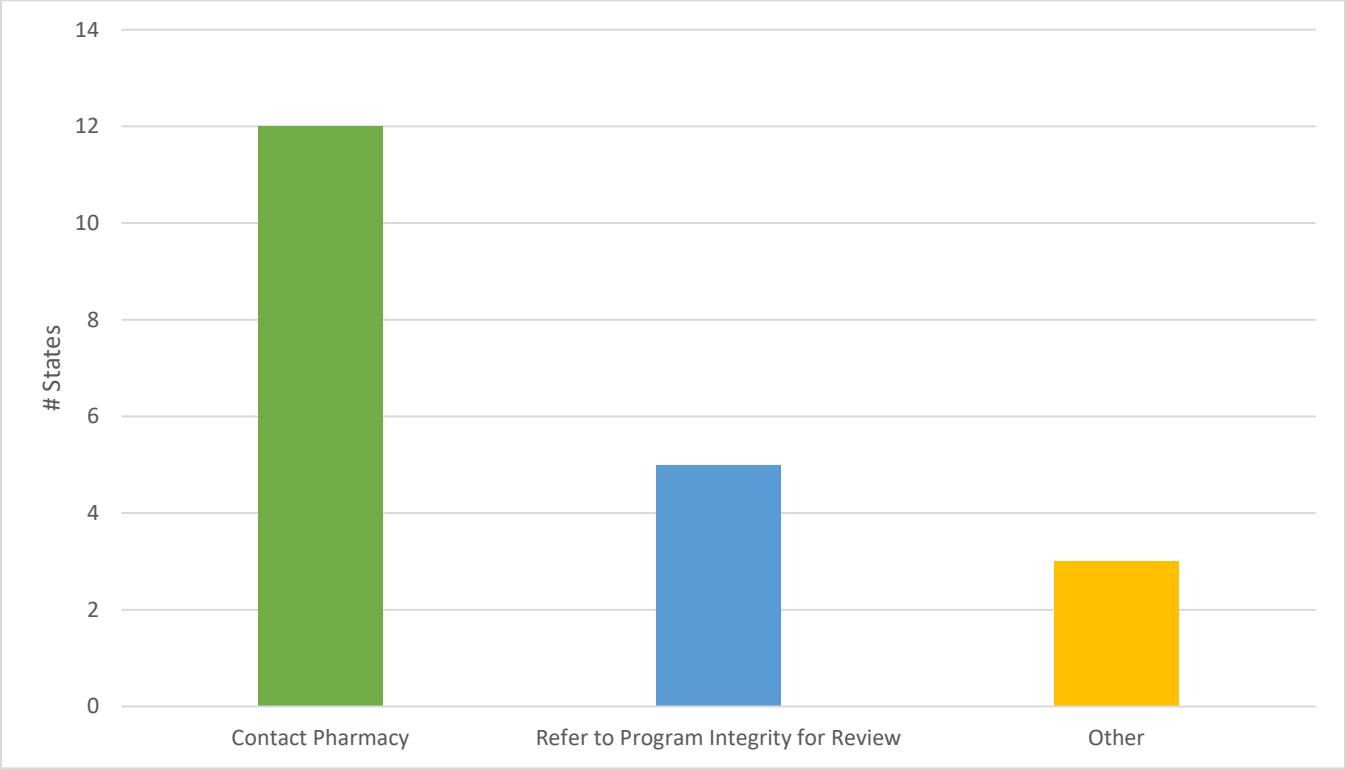

Table 16 - Follow-up Methods for Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Contact Pharmacy	Alaska, California, Delaware, District of Columbia, Hawaii, Kentucky, Massachusetts, Michigan, Nebraska, North Dakota, Oklahoma, South Dakota	12	60.00%
Refer to Program Integrity for Review	Colorado, District of Columbia, Kentucky, Michigan, Virginia	5	25.00%
Other	Alabama, Hawaii, New York	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.
Hawaii	Reviewed and have not had utilization from current population served.
New York	Pharmacy provider interventions concerning potential drug related problems are communicated / addressed through the RetroDUR intervention therapeutic criteria exemption program/processes/reviews.

If "No," please explain.

Table 18 - Explanations for No Follow-up Methods for Providers who Routinely Override with Interventions

State	Explanation
Arkansas	ProDUR response reports with overall activity by pharmacists are provided by our contractor quarterly and presented to the DUR Board. This same information is received from the MCOs quarterly. Currently, we do not request the contractor to provide routine ProDUR response reports on individual pharmacies, but ad hoc reports are an option. Individual pharmacies can be audited based on OMIG reporting.
Connecticut	No, we do not follow-up with providers who routinely override interventions.
Mississippi	Due to time-restriction of DOM staff, we are unable to perform real-time evaluation and intervention. We anticipate adding such interventions after our new fiscal agent goes live in late 2022.
New Hampshire	NH has not found any trend in this information requiring follow up with providers. There is a very low Fee-for-Service population to manage.
New Mexico	System edit overrides are allowed through the Conduent pharmacy helpdesk and state Pharmacists at this time. Follow-up is only on a case-by-case basis.
North Carolina	The DUR Board reviews the DUR Alert Overrides Report quarterly, but there is no follow up interventions with individual providers. The report is used to monitor and improve alert quality, to avoid alert fatigue and be clinically significant. The Board may suggest drug additions or deletions to the alerts when appropriate.
Ohio	The information collected may be used to guide other policy decisions.
Oregon	We do not specifically audit provider use of the intervention and outcome codes. We can identify if a provider seems to be overriding alerts to an unusual degree, but that has not been an issue in our state. Two ProDUR alerts are set to deny claims: Early Refill (ER) and Pregnancy-Drug Interaction (PG).
Pennsylvania	The most severe alerts require agency review for medical necessity.
Rhode Island	Fee for Service is routinely secondary payer.
South Carolina	Information is provided to assess/identify potential areas to address and/or opportunities for coding i.e. Prior Authorizations, coding opportunities and interventions
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

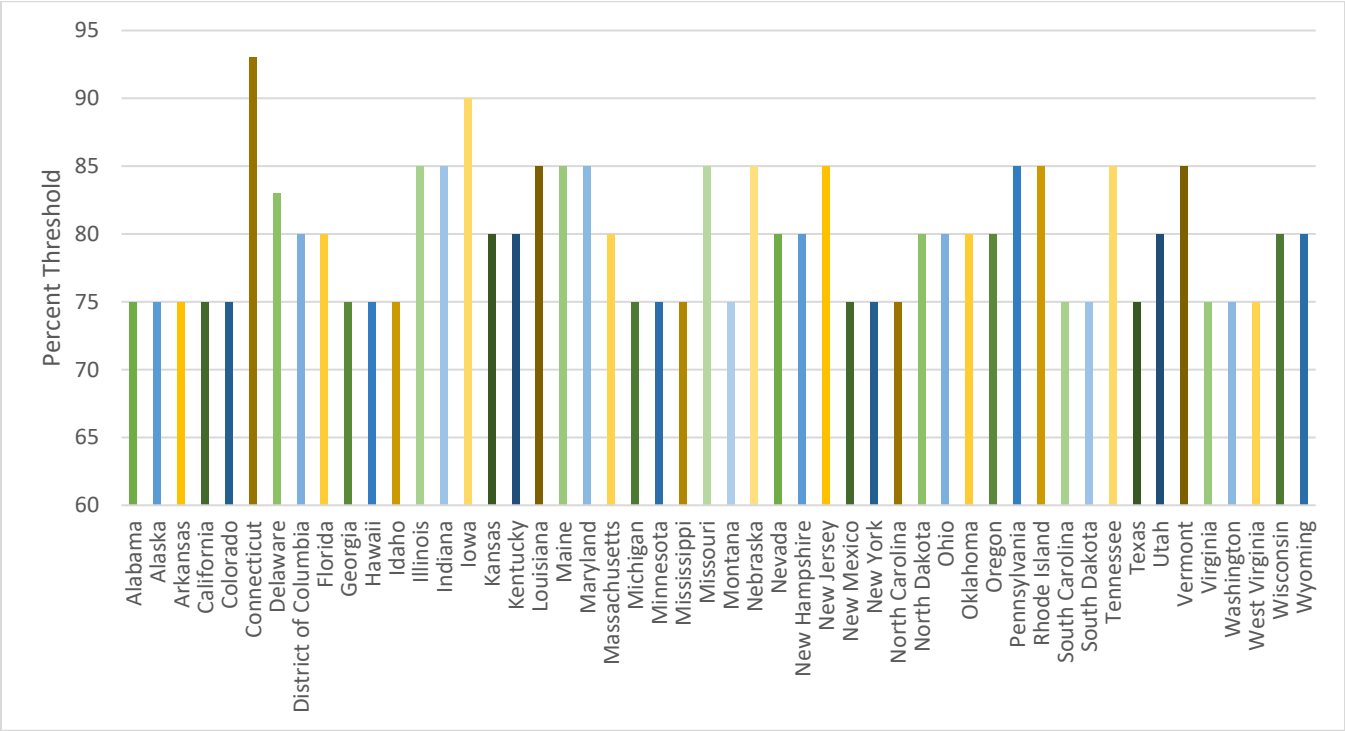

Figure 13 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold

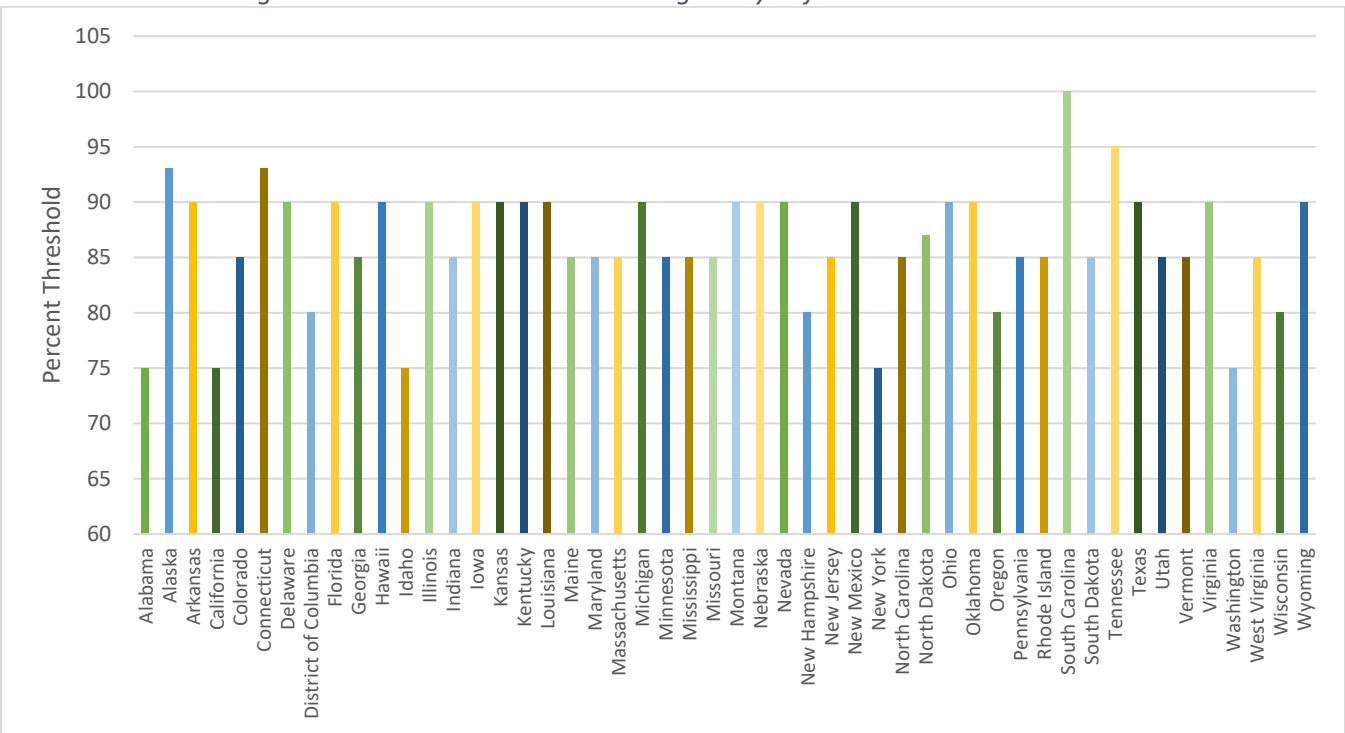

Figure 14 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold

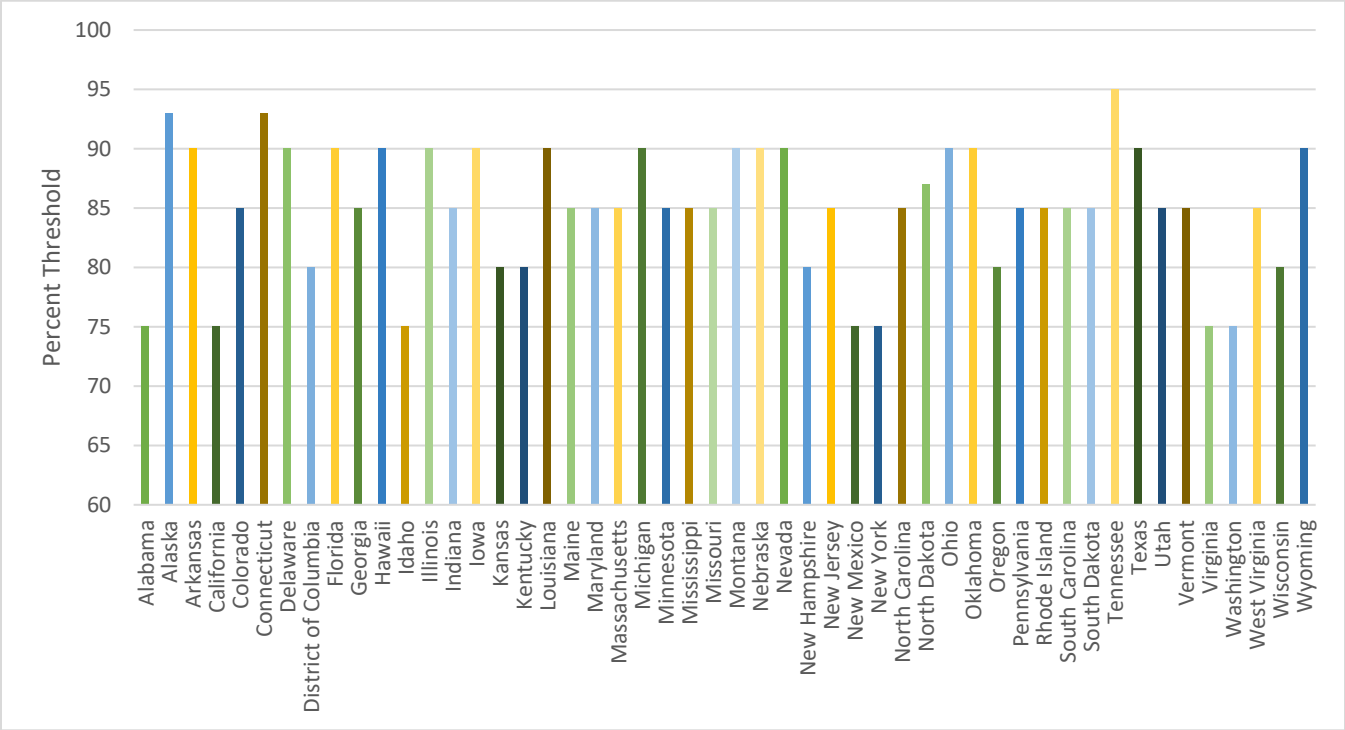

Table 19 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs

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

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

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

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

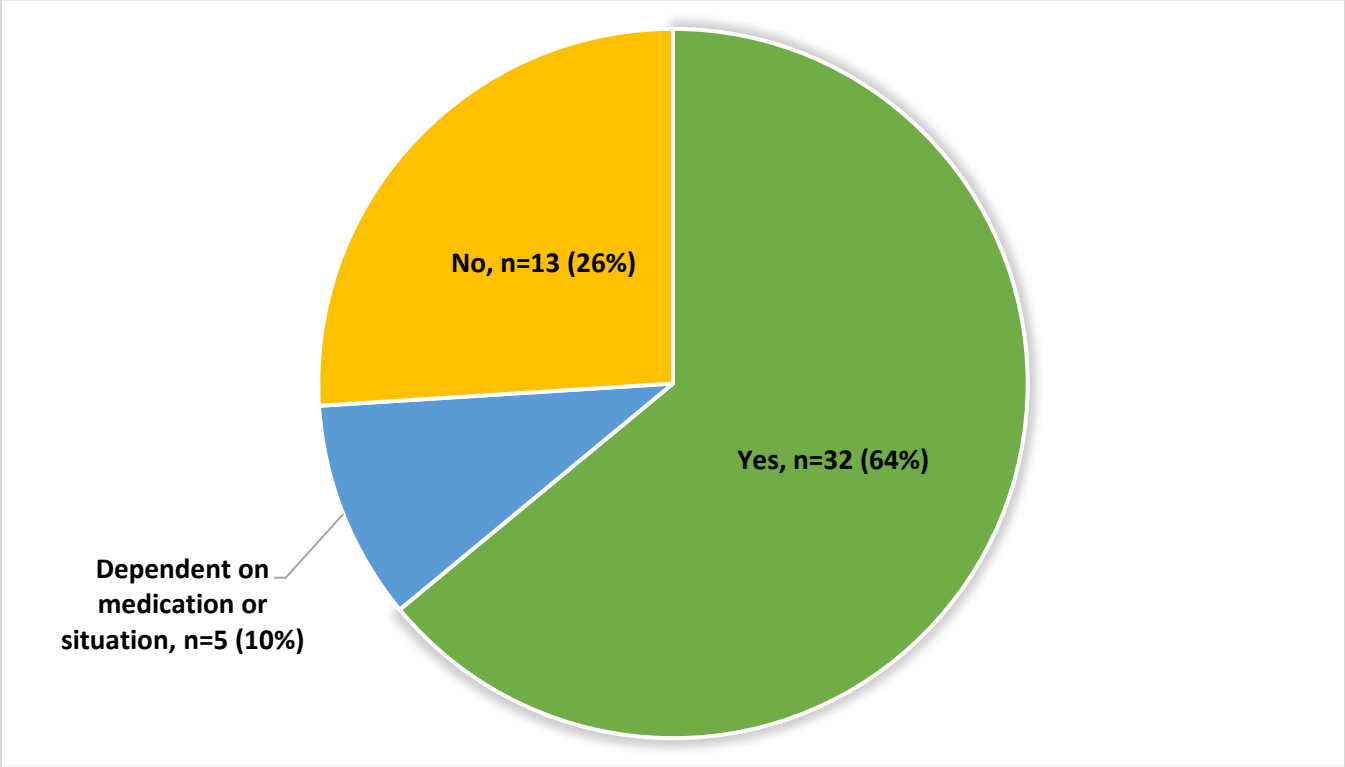

Table 20 - Non-Controlled Drugs Early Refill Requirement for Prior Authorization

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

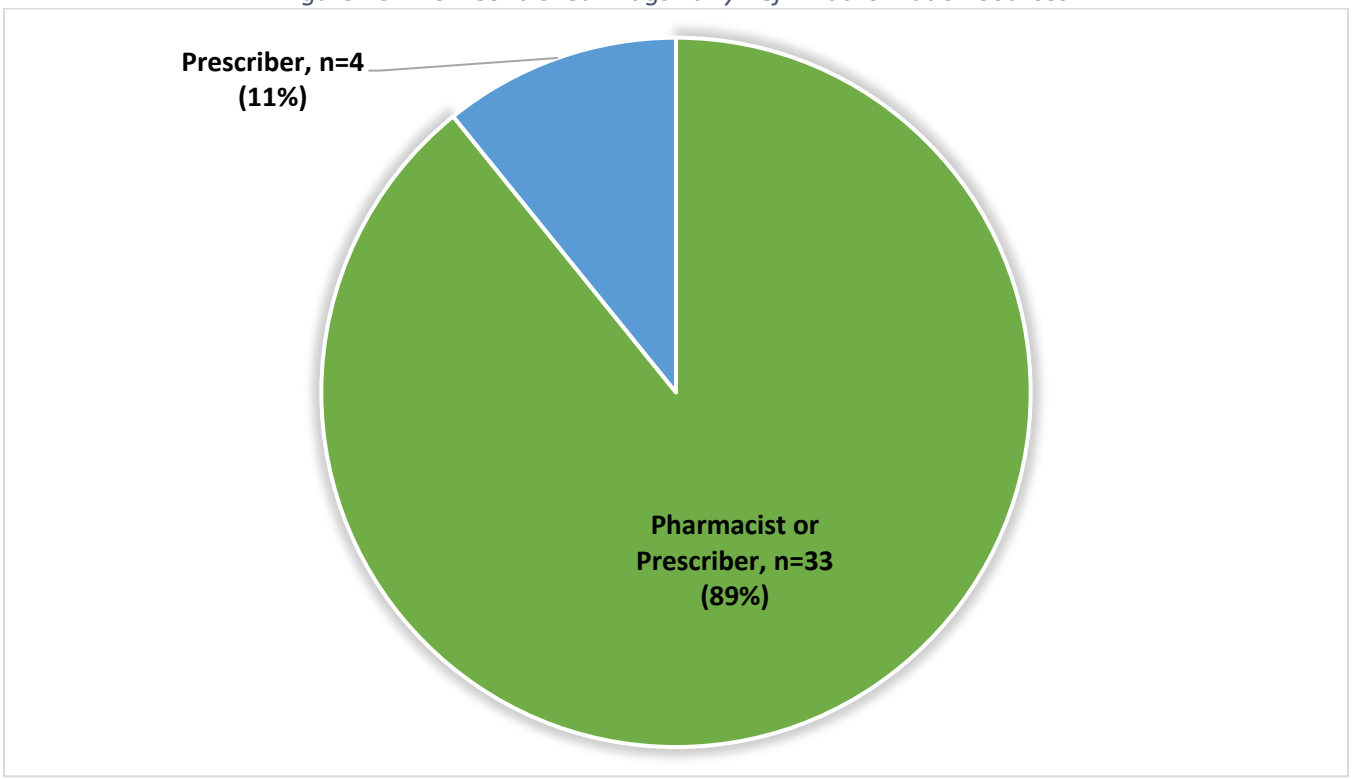

Table 21 - Non-Controlled Drugs Early Refill Authorization Sources

Response	States	Count	Percentage
Pharmacist or Prescriber	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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	33	89.19%
Prescriber	Idaho, Indiana, Iowa, New York	4	10.81%
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

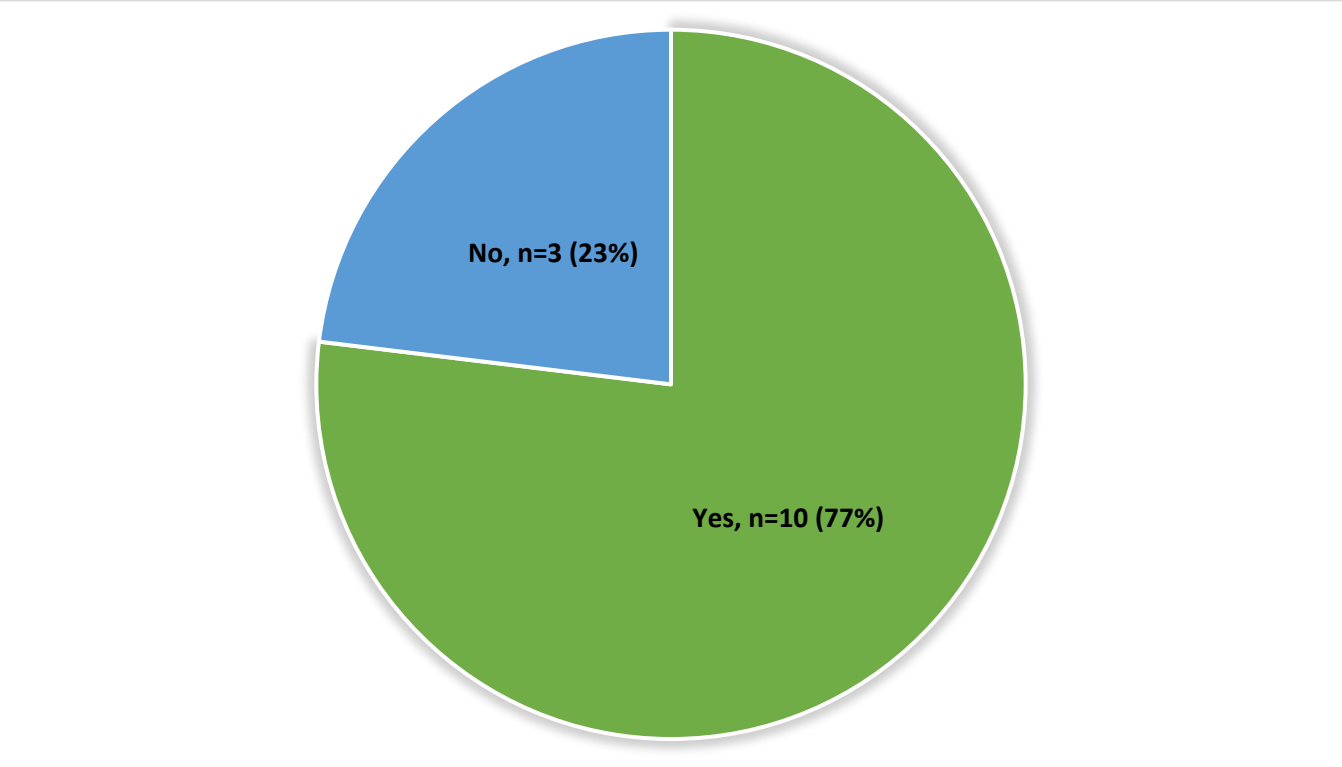

Table 22 - Non-Controlled Drugs, Pharmacist May Override at Point of Service

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

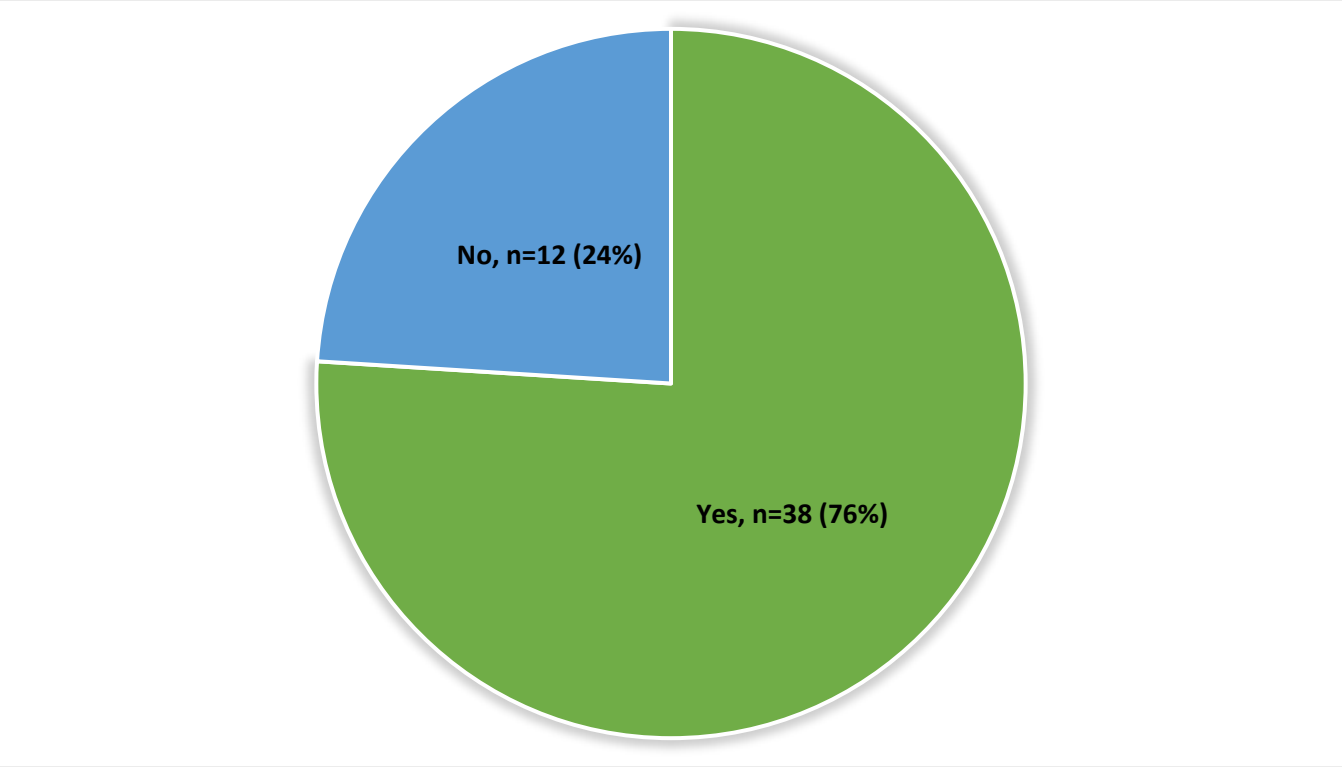

Table 23 - Controlled Drugs Early Refill Requirement for Prior Authorization

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

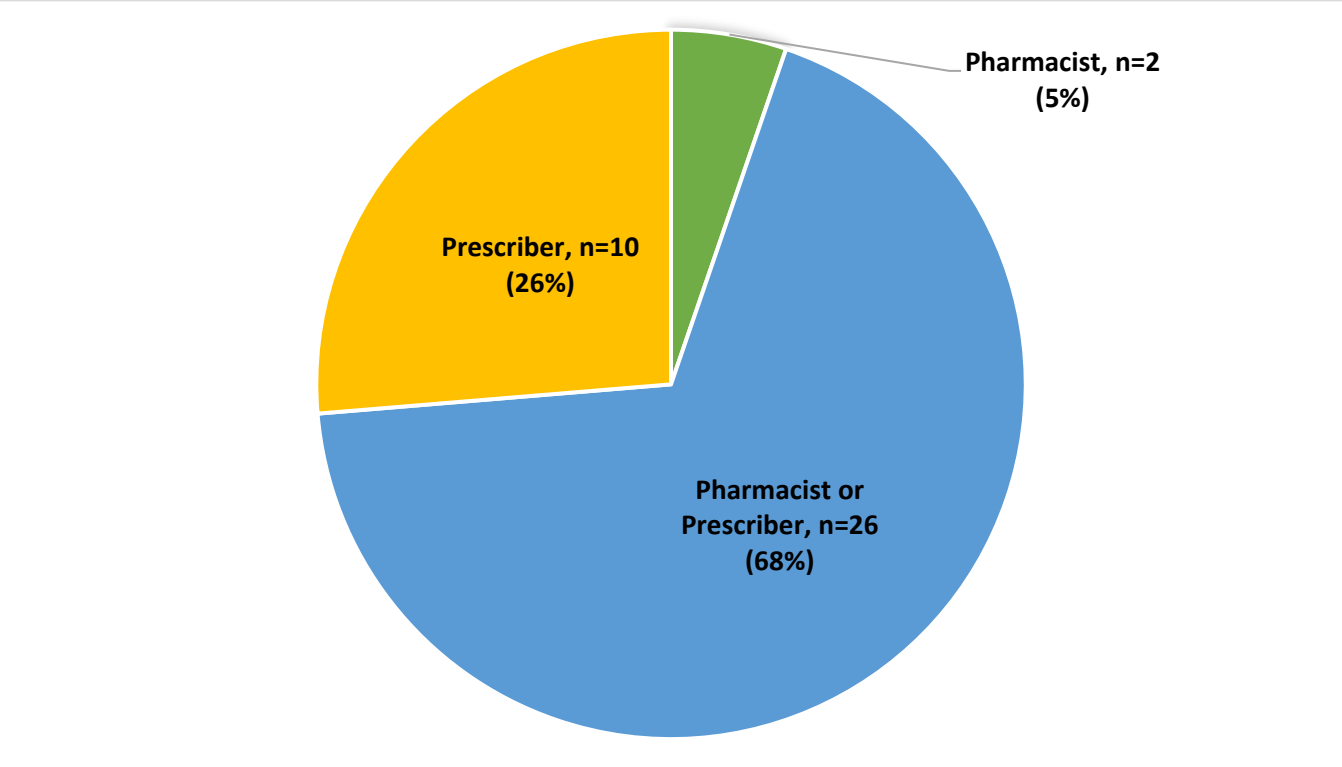

Table 24 - Controlled Drugs Early Refill Authorization Source

Response	States	Count	Percentage
Pharmacist	Minnesota, Wisconsin	2	5.26%
Pharmacist or Prescriber	Alabama, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, Wyoming	26	68.42%
Prescriber	Alaska, Connecticut, Florida, Hawaii, Idaho, Indiana, Iowa, New York, Pennsylvania, Vermont	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

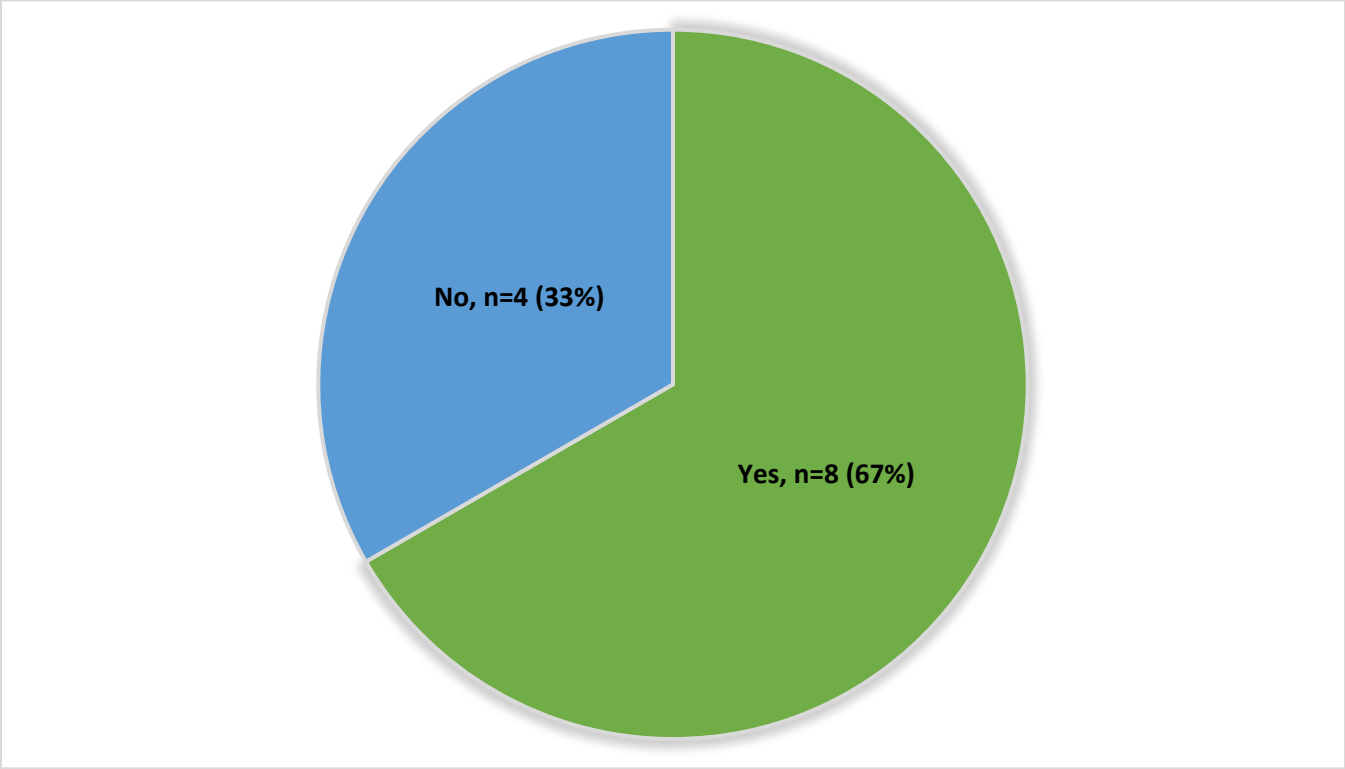

Table 25 - Controlled Drugs, Pharmacist May Override at Point of Service

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

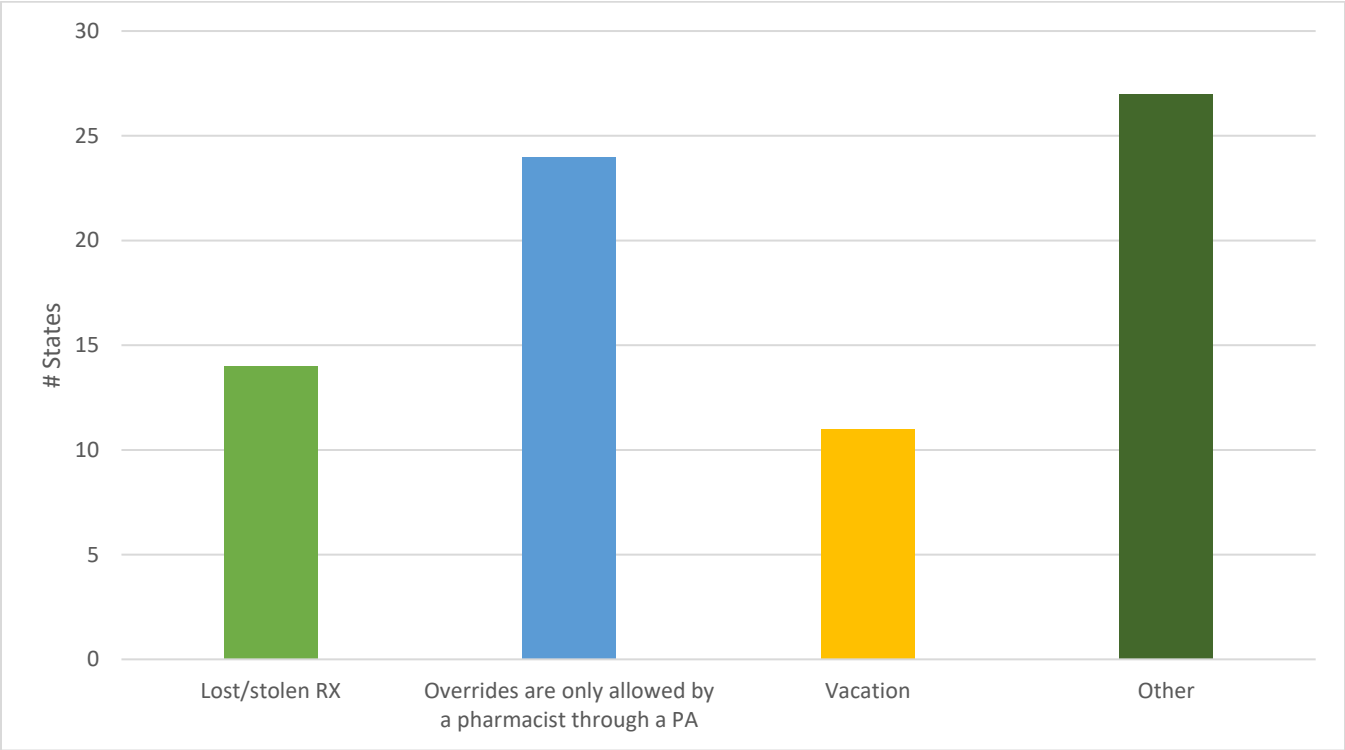

Table 26 - Allow Pharmacist Overrides for an Early Refill

Response	States	Count	Percentage
Lost/stolen RX	California, Kansas, Louisiana, Massachusetts, New Mexico, North Carolina, Ohio, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, Wisconsin	14	18.42%
Overrides are only allowed by a pharmacist through a PA	Alabama, Alaska, Arkansas, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, Tennessee, Washington, Wyoming	24	31.58%
Vacation	California, Louisiana, Massachusetts, Nebraska, New Mexico, North Carolina, Ohio, Vermont, Virginia, Washington, Wisconsin	11	14.47%
Other	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, South Carolina, South Dakota, Texas, Vermont, Washington, West Virginia, Wisconsin	27	35.53%
Total		76	100.00%

If “Other,” please explain.

Table 27 - “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 those for lost/stolen RX and vacation.
California	The pharmacist can override the early refill DUR alert message for any situation if medically necessary.
Colorado	Pharmacist overrides at the POS are not allowed for lost/stolen Rx's or vacation requests. However, pharmacists may contact the pharmacy call center help desk to request authorization to override these edits.
Connecticut	For non-CS for lost or stolen or vacation, either the pharmacist or prescriber can override with a PA. For CS for lost or stolen or vacation, only the prescriber can request a PA.
Delaware	Overrides by 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.
Hawaii	Not utilized by current covered population, but available for other reasons for early refill: change in dose, additional therapy authorized, member was readmitted to a long term care facility and discharged from hospital without medication.
Idaho	Overrides are allowed for change of dose only
Indiana	Prescriber must obtain prior authorization for early refill validating lost/stolen medication with police report. Vacation override and lost/stolen medication are only permitted one time per calendar year with prescriber approval.
Iowa	Other; 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 18yo and younger qualify for the lost or spilled medication early refill override.
Louisiana	Other situations may be overridden using the pharmacist's professional judgement.
Mississippi	For a lost or stolen prescription, the prescriber may request a PA to override the early refill alert. Such requests are reviewed on a case-by-case basis.
New Hampshire	The pharmacist is required to call the technical call center for an override for all early refills.
New Jersey	Prospective DUR alerts cannot be overridden by the pharmacy provider.
New Mexico	The pharmacy must contact the State of New Mexico or Conduent helpdesk for approval prior to overriding refill too soon requests.
New York	Overrides are allowed by pharmacist in an emergency situation as noted in question #9.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 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 setting. -Hospital or police kept the medication.
Oregon	As long as they enter a valid Submission Clarification Code and the appropriate intervention and outcome codes, they can use whichever ones apply to the situation. We do not limit which ones can be used.
South Carolina	Lost/Stolen required documentation (police report/documentation) and notification/approval by prescriber if Control Rx and forwarded to the State for their review/consideration. Spills/Stability (meds left in car/unrefrigerated/heat, etc.) are forwarded to the State for review/consideration Vacation override requests are referred to the State for their review.
South Dakota	Dose increase, recipient newly admitted to a care facility
Texas	For Med Synchronization purposes, the dispensing pharmacist may override by entering a PA code. For all the other reasons, pharmacist must call the HHSC Help Desk.
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 the pharmacist to override the alert for natural disaster, a dosage change, or when the member has misunderstood directions. Schedule II drugs still require an override (PA) from the Drug Authorization Policy Override Center.

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

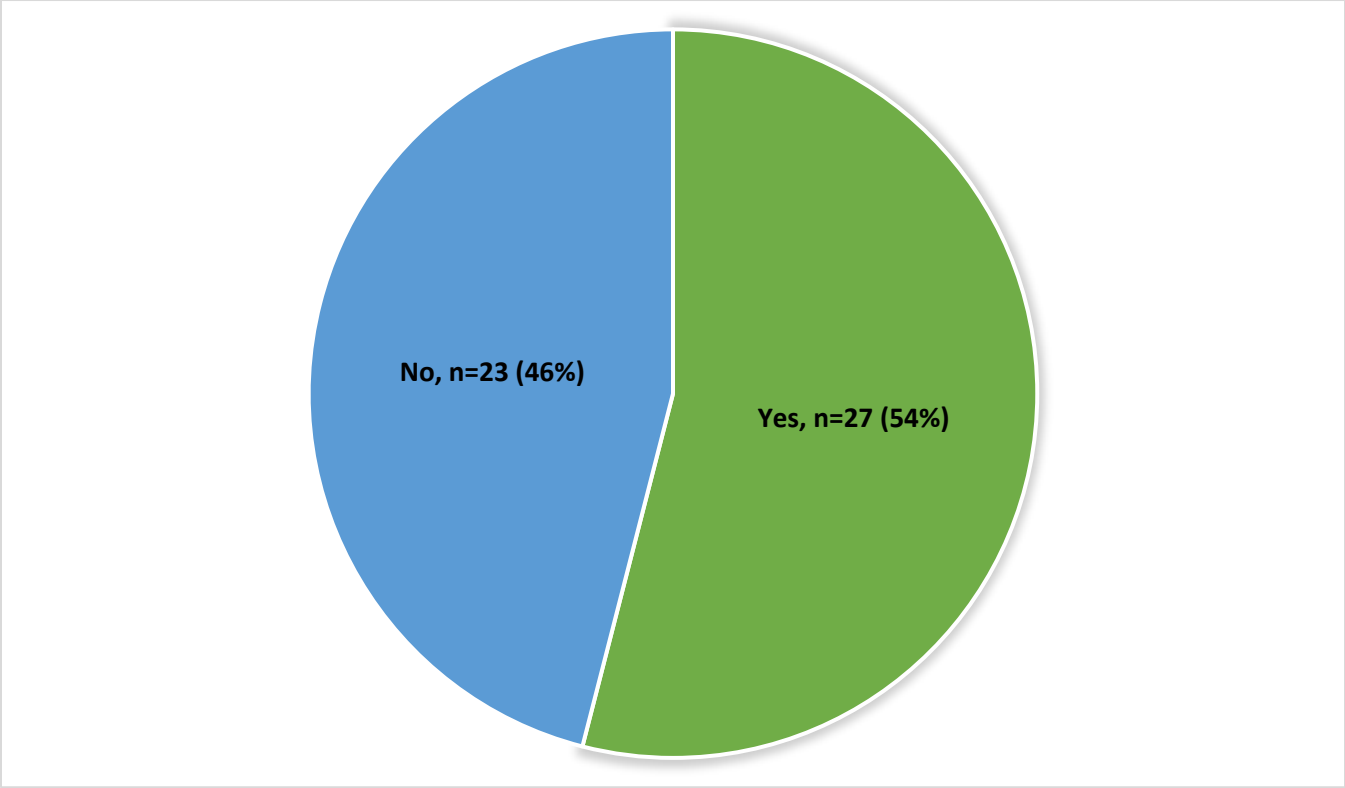

Table 28 - System Accumulation Edit for Prevention of Early Prescription Filling

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

If “Yes,” please explain your edit.

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

State	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 control medications and a 21 day accumulation over 120 days for non-controlled medication filled for 90 days.
Arkansas	The early refill accumulation limit allows a maximum accumulation in a 180-day look-back period identifying the same drug/same strength/same dosage form. Clients with non-controlled drugs are allowed 12 days' extra supply in the 180-day period, and clients 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	A medical consultant reviews retrospectively to alert case managers to proactively work with patients to avoid continuously filling prescriptions early.
Idaho	The pharmacy claims system is set to look at a maximum quantity per day as well as a rolling accumulation edit to not allow for early refill.
Illinois	Refill too soon edit where early refill days accumulate from month to month and refill tolerance must be met based on days supply on hand.
Indiana	The claims processing system will evaluate the days' supply for historical claims against the days' supply of new claims. If the new claim's daily dose has increased, the system will calculate the next date of fill automatically based on remaining supply. If the new daily dose has not increased, the system will calculate the next date of fill based on the remaining supply from all historical claims.
Kentucky	Kentucky allows a three (3) day tolerance per month.
Louisiana	Proton pump inhibitor (PPI) duration of therapy edit: PPIs are limited to a maximum 180-day duration of therapy in a rolling 365-day period. The pharmacist may override the maximum duration of therapy after consultation with the prescribing provider. Morphine milligram equivalent (MME) edit: The MME per day for all active opioid prescriptions for that beneficiary is calculated each time an opioid prescription is submitted and limited to a maximum of 90 MME per day. There are exemptions for certain conditions. If the conditions do not exist, authorization is required to override this edit.
Maine	The accumulation allows for refill accumulation up to 7 days of additional medications then stops the next early refill and requires a prior authorization or override with clinical rationale.

State	Explanation
Michigan	MI has refill tolerance and dispensing fee accumulation edits to prevent patients from continuously filling prescriptions early.
New Jersey	Resulting from approved legislation, limits were in place on accumulative day supply to be no more than 120 days on hand 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 to be no more than a maximum 30 days supply.
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	For non-controlled drugs, we allow up to 15 days accumulation in a rolling 180 day lookback period. For controlled drugs, we allow up to 10 days accumulation in a rolling 180 day lookback period.
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.
Rhode Island	Only allows one original prescription and five refills per prescription.
South Carolina	75% of fill required for non controls and 85% for controls (excluding CII)
Vermont	Control substance allow for a rolling accumulation of 7 days of medication and then a PA is required once the accumulation threshold is achieved.
Virginia	If the patient accumulates more than 15 days early in a 183 day period the claim will deny.
Washington	HCA system calculates how many days early for each fill over time and utilizes that calculation to the current fill to prevent continuous early fills. For 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 they have a total of 125 days supply. 3rd fill: After 75 days, they can refill for another 100 tabs and now they 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

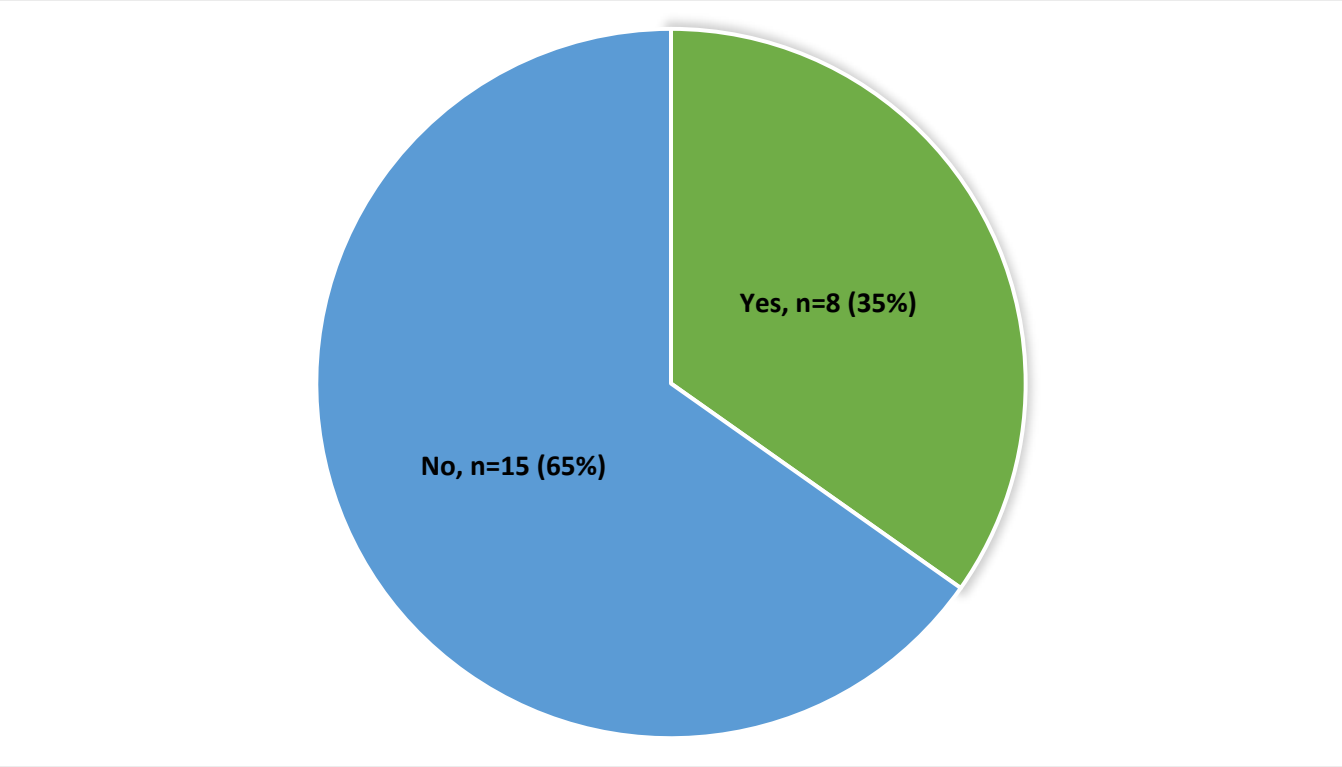

Table 30 - Plans to Implement a System Accumulation Edit

Response	States	Count	Percentage
Yes	District of Columbia, Iowa, Maryland, Massachusetts, Mississippi, New Hampshire, North Carolina, Utah	8	34.78%
No	California, Connecticut, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Wisconsin	15	65.22%
Total		23	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

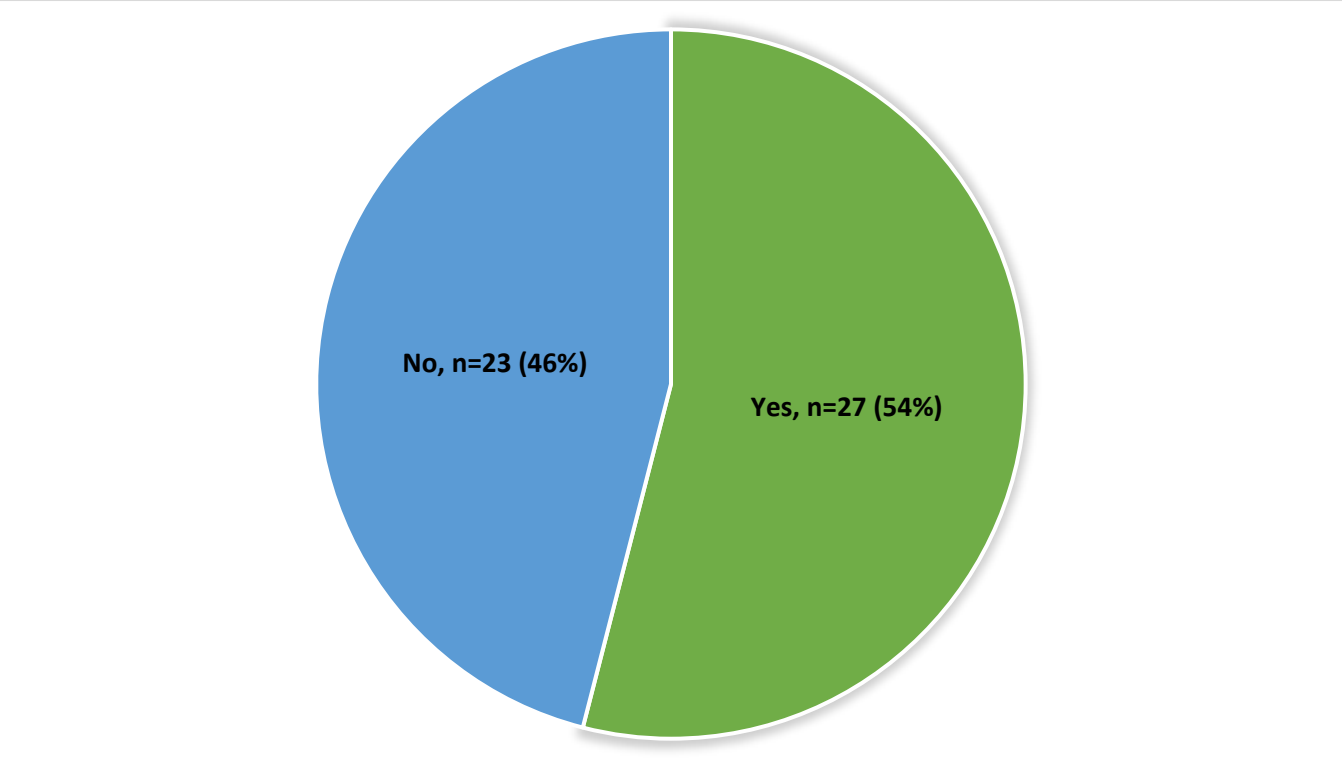

Table 31 - State Policy Prohibiting Auto-Refill at the POS

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

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

Figure 25 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

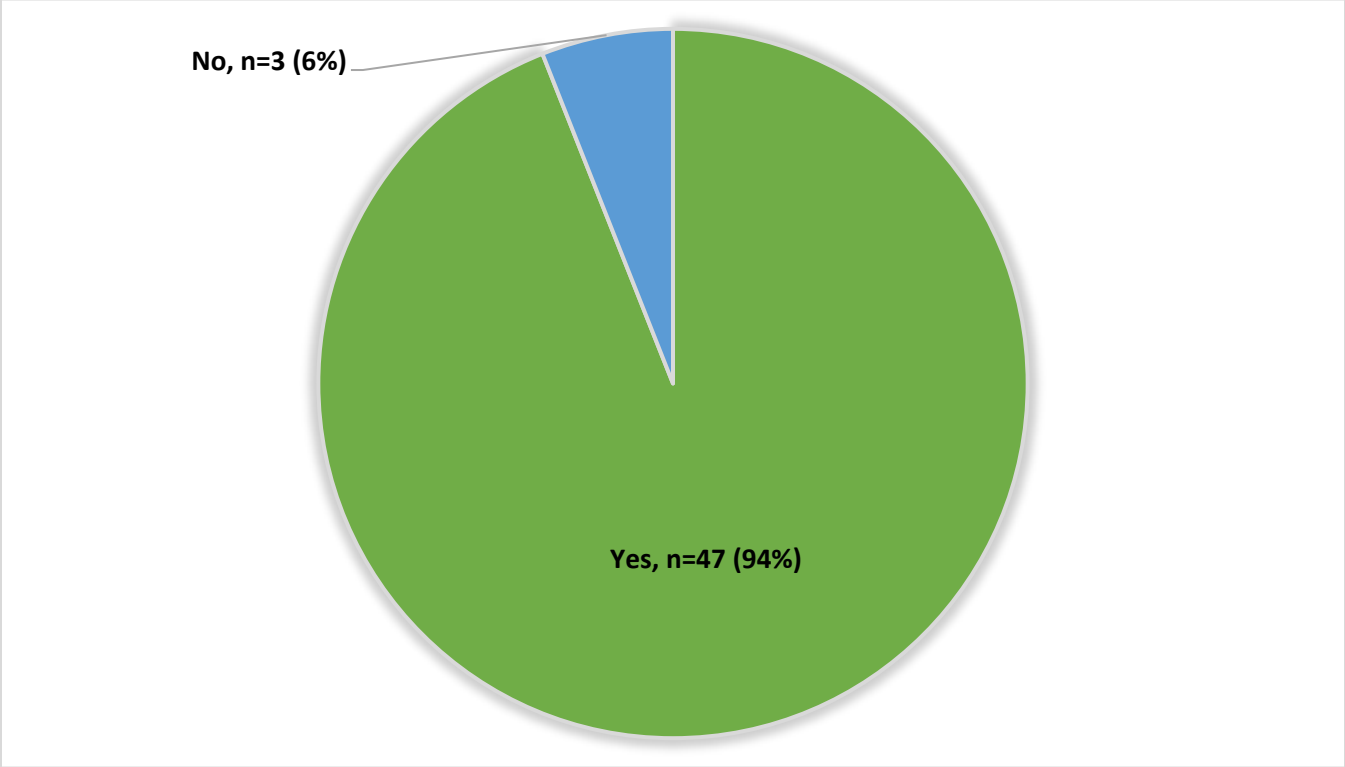

Table 32 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

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

If "Yes," please check all that apply.

Figure 26 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) when Medically Necessary

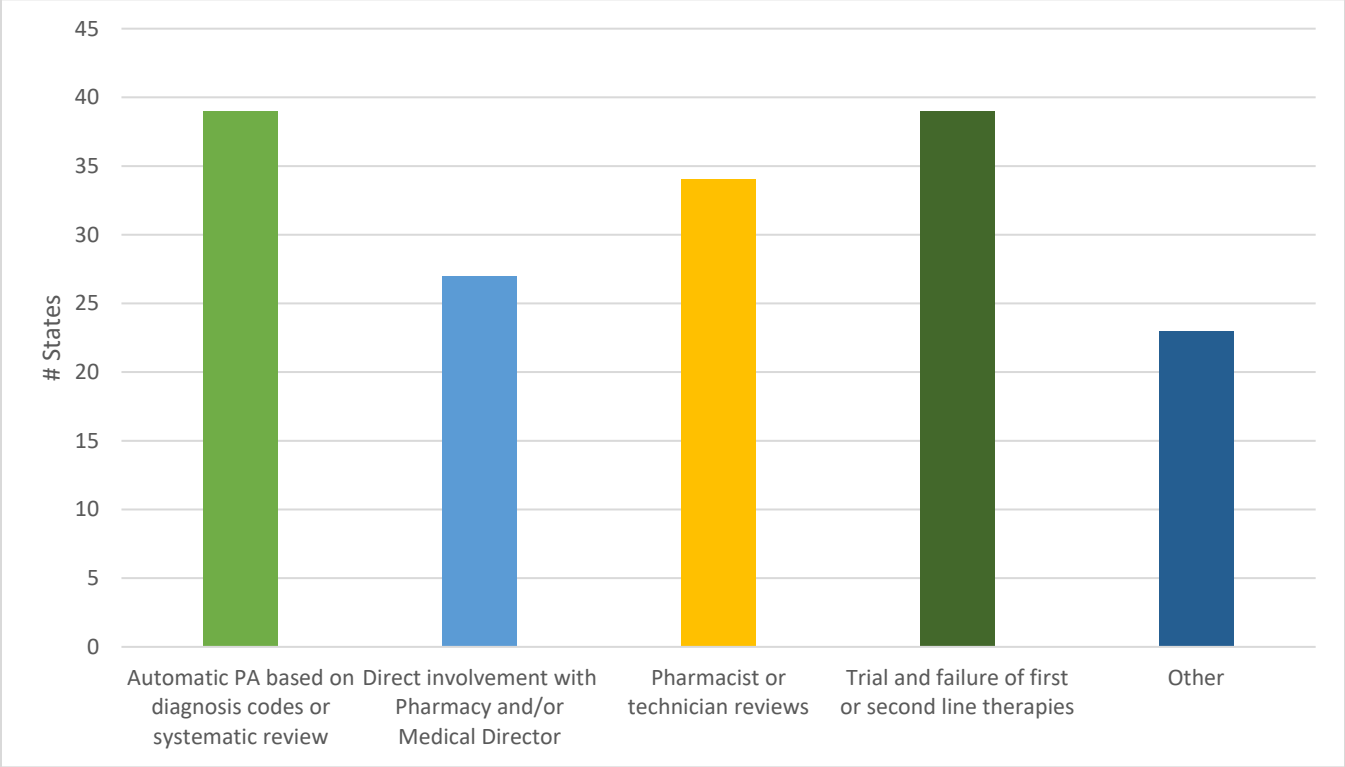

Table 33 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	States	Count	Percentage
Automatic PA based on diagnosis codes or systematic review	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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	39	24.07%
Direct involvement with Pharmacy and/or Medical Director	Alaska, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wyoming	27	16.67%

Response	States	Count	Percentage
Pharmacist or technician reviews	Alaska, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Virginia, Washington, West Virginia, Wisconsin, Wyoming	34	20.99%
Trial and failure of first or second line therapies	Alabama, Alaska, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	39	24.07%
Other	Arkansas, California, Colorado, Florida, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Texas, Utah, Washington, West Virginia, Wisconsin	23	14.20%
Total		162	100.00%

If “Other,” please explain.

Table 34 - 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 based on diagnosis codes/lab values/medication in history, or require manual review by PA with specific DUR Board approved criteria. 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 MicroMedex. PA requests for new drugs not yet 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 Fee-for-Service List of Contract Drugs (CDL) with an approved Treatment Authorization Request.
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 or fax. 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.

State	Explanation
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.
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 Covered Outpatient Drugs (CODs) by CMS standards. For drugs with a prior authorization requirement, our process is as follows: Soft edit for some drugs by NCPDP override code approval. Hard stop PA at the point-of-sale (and via medical claims request) followed by manual/automated review of submitted provider information and prior authorization criteria approved by the DUR Board. We provide a 72 hours supply of drugs for emergent situations.
Louisiana	Some drugs not on the PDL do not require PA, but may have safety edits at POS.
Maryland	Maryland Medicaid utilizes a prior authorization process to provide coverage for all non-preferred covered outpatient drug products. When a claim is rejected for prior authorization, a message is provided through the POS system that alerts the pharmacy provider. The prescriber is then contacted with the prior authorization rejection information as well as any contact information provided. Prescribers must then contact the appropriate party to resolve the claim denial. This may include diagnostic or laboratory data, attestation of baseline and subsequent evaluations, or patient specific past medical history required to assure the safe and appropriate use of the requested drug product. Additionally, prior authorization forms are available online at https://mmcp.health.maryland.gov/pap/Pages/Pharmacy-Program-Forms.aspx
Michigan	Not all medications are included in the MI PDL. For those medications that are not included in the overall MI formulary of covered products, MI has a non-formulary prior authorization process. Prescribers must submit a request stating the clinical necessity of the non-formulary medication over similar covered formulary products. All requests are reviewed on a case-by-case basis by the MDHHS physicians.
Minnesota	Some non-PDL drugs do not require any sort of PA and this would not apply to them.
Nevada	Drugs not on the PDL, but within drug classes reviewed by the Silver State Scripts Board, require prior authorization, unless exempt under NRS or federal law or excluded through recommendations of the Silver State Scripts Board or excluded by DHCFP. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard Preferred Drug List Criteria.
New Hampshire	The Medicaid beneficiary's prescriber may request prior authorization from the State's PBM by calling, faxing, or submitting a prior authorization request electronically. All prior authorization criteria and prior authorization request forms are available on the New Hampshire's PBM website, https://newhampshire.magellanmedicaid.com.
New Mexico	The provider can contact a Pharmacist at New Mexico Human Services Department when a drug has a prior authorization requirement.

State	Explanation
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 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. 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.
Texas	The non-preferred drugs are on Texas Formulary and can be accessed via a prior authorization. The PA criteria are automated and will approve 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 in turn must inform the Prescriber who may either decide to change prescription to a preferred drug, or contact the PA call center for approval. In other situations, when a drug is CMS rebatable but is not yet on Texas formulary, the claim will be denied and pharmacy will receive a "NDC Not Covered" message. If prescriber still wants coverage due to medical necessity, Medicaid program staff will quickly act to provide access.
Utah	There are drugs that are not listed on the PDL and do not require PA. For drugs that require PA, there are two pathways. The first pathway is identified by the PDL. For these drugs, prior authorization is available for non-drug specific (Medication Coverage Exception PA Form) and drug specific. The second pathway is when a prior authorization requirement is identified at the point of sale for drugs that are not listed on the PDL, the prescriber may submit a Medication Coverage Exception Form.
Washington	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 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.
Wisconsin	Wisconsin's PDL has a limited number of drugs and drug classes. Many covered outpatient drugs that are not part of the Wisconsin PDL are covered without prior authorization (PA) requirements. When a covered outpatient drug does have a PA requirement, Wisconsin has a documented PA policy and procedures in place to obtain a PA.

If “No,” please explain.

Table 35 - Explanations for Lack of Documented Process for Beneficiaries to Access a Covered Outpatient Drug when it is Medically Necessary

State	Explanation
Hawaii	FFS program does not have a PDL

State	Explanation
New Jersey	NJ FFS has an open formulary. Medicaid FFS beneficiaries have access to all covered outpatient drugs when deemed necessary.
South Dakota	No PDL

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

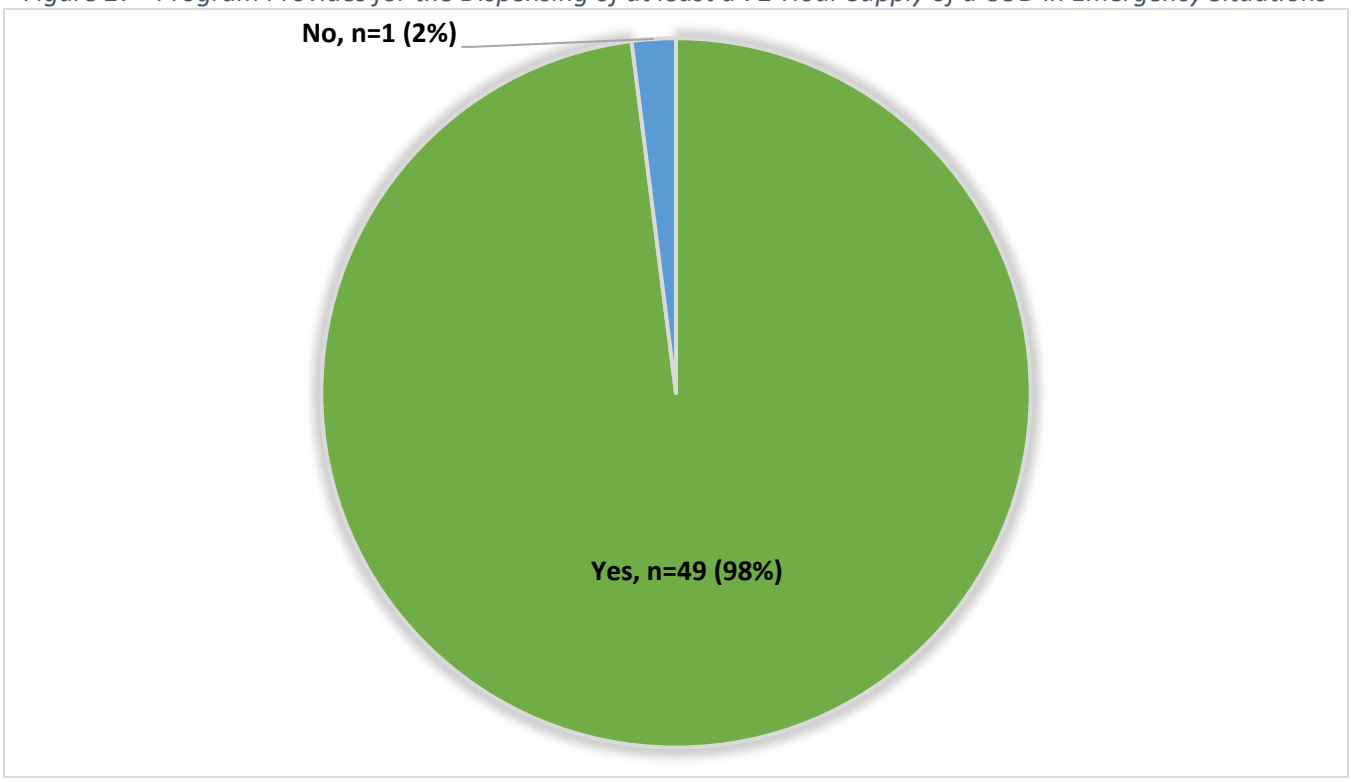

Table 36 - Program Provides for the Dispensing of at least a 72-Hour Supply of a COD in Emergency Situations

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

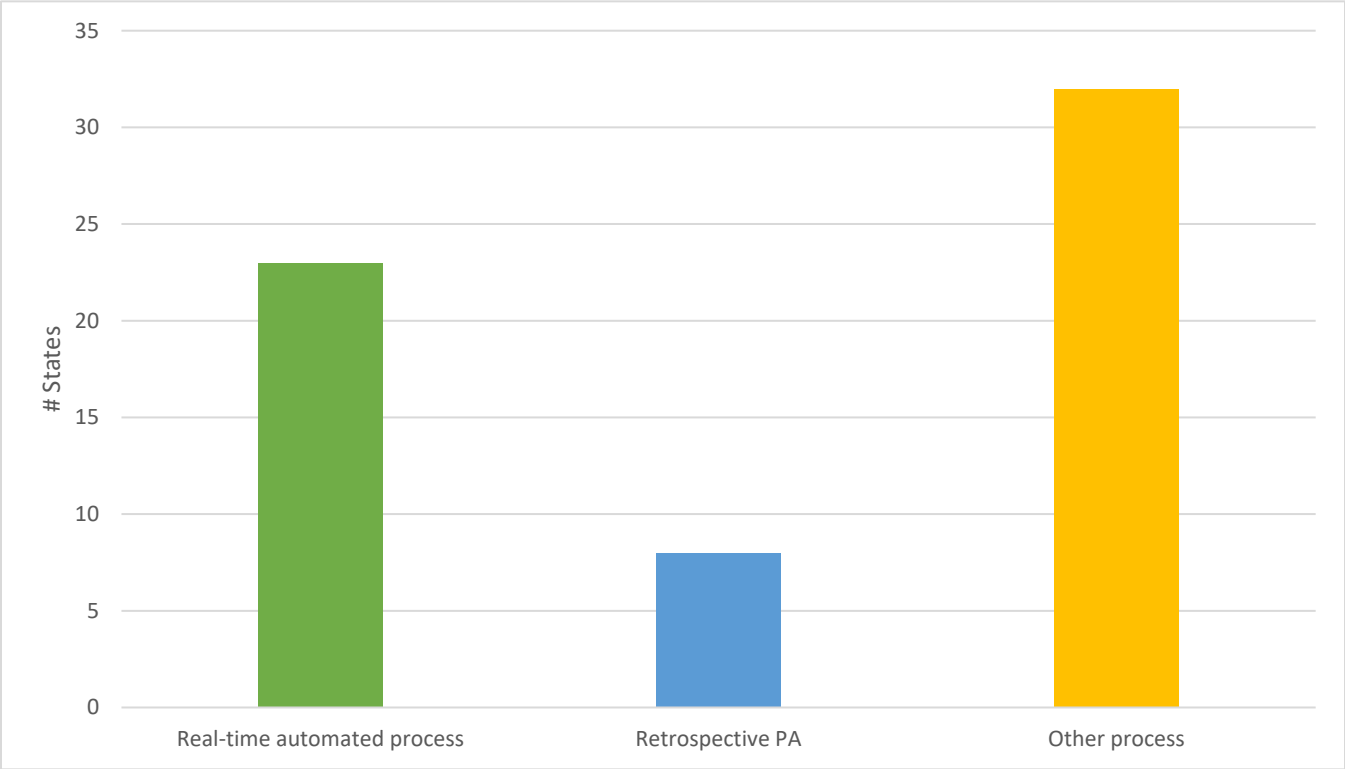

Table 37 - Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

Response	States	Count	Percentage
Real-time automated process	Delaware, Florida, 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	36.51%
Retrospective PA	Delaware, Illinois, Minnesota, Missouri, Montana, North Carolina, Oklahoma, South Carolina	8	12.70%
Other process	Alabama, Alaska, Arkansas, California, 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, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	32	50.79%
Total		63	100.00%

If "Other," please explain.

Table 38 - 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.
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 clients and once per sixty (60) days per drug class for LTC clients. To file a claim using this emergency provision, the pharmacy provider will submit a '03' in the Level of Service (418 DI) field.
California	The pharmacy may manually bill a 72-hour supply of a covered outpatient prescription drug in an emergency situation.
Colorado	Pharmacists or prescribers may call the Magellan pharmacy help desk to request an emergency override to dispense a 3-day supply of a medication in an emergency situation.
Connecticut	The pharmacist has the ability to perform a onetime override at POS.
District of Columbia	Pharmacy providers can override the PA requirement for a non-preferred drug by entering 3 (indicating an emergency supply dispensing) in the Level of Service field (NCPDP Field 418-D1).
Florida	In the event of a natural disaster, the Bureau Chief will selectively open payment to counties under threat. In the event of a fire or catastrophic loss, one early refill per year may be granted for certain non-controlled substances.
Georgia	If a pharmacist deems it necessary to dispense a 72 hour supply of medication, they may provide the medication, then contact the State for billing and reimbursement approval.
Hawaii	Manual billing or real-time automated process after verbal PA approval from PA desk of pharmacy fiscal agent.
Idaho	Pharmacy can submit the appropriate ProDUR fields that allow the emergency supply to pay at POS.
Illinois	Pharmacist can dispense a 72-hour fill and submit for prior authorization and reimbursement for a 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.

State	Explanation
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. -OTCs cannot be overridden. -Drugs normally not covered cannot be overridden.
Maryland	In the event that a participant requires a 72 hour supply of a covered outpatient drug in an emergency situation, the dispensing pharmacy must contact the POS vendor and request an override to fill an emergency supply.
Michigan	A Medical Emergency override requires that the Registered Pharmacist's or Licensed Prescriber's first and last names be documented by support center staff. This protocol allows for override of all applicable drug coverage edits with the exception of plan-excluded products. The 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 OptumRx call center to request emergency situation coverage.
New Hampshire	Pharmacies must request payment for the 72-hour supply from the member's prescription plan, either Fee-For-Service or the appropriate Medicaid MCO. On each provider notice we include the following: Emergency Drug Coverage Pharmacies are reminded that federal statute requires Medicaid programs (Fee-for-Service and managed care) provide payment for dispensing of at least a 72-hour supply for any drugs requiring prior authorizations if prior authorization cannot be obtained outside of Medicaid business hours. (Section 1927 of the Social Security Act. Codified as Section 1396r-8 of Title 42.(d)(5) (B))
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.

State	Explanation
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 with only allow a 72-hour supply. As part of our COVID flexibility, we implemented up to 14-day emergency supplies for non-controlled substances. Co-payments will apply and only the drug cost will be reimbursed.
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 point-of-sale 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 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.
Texas	The 72-hours supply can be dispensed when a prior authorization is required and the provider cannot be reached. Providing 72-hours emergency supply is based on the dispensing pharmacist's professional discretion. The 72-hour supply may be repeated on the same claim if the prescriber is not reachable after the first 72-hrs but it should not be used for routine and continuous overrides of the drug prior-approval process. A 72-hour emergency supply does not count towards pharmacies 3 RX limit for adults enrolled in Texas FFS program.
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 judgment to meet a client's urgent medical need 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.

State	Explanation
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 has two types of emergency medication dispensing, standard and expedited. Wisconsin allows pharmacy providers to submit claims for standard emergency medication drugs that are not included in the expedited emergency dispensing medication process when the prescriber cannot be reached and the pharmacist determines the member should begin taking their medication immediately. Pharmacy providers must include specific information about why the standard emergency supply is being requested. The pharmacy providers may provide up to a 14-day supply of medication. For medications that are in an unbreakable package the pharmacy provider is directed to use the smallest package size and dispense up to a 34-day supply. Expedited emergency supply is available for certain drugs on the PDL and is available through the specialized transmission approval technology- prior authorization system. Pharmacy providers are given a real-time response on the expedited emergency supply request. Pharmacy providers may provider up to a 14-day supply; some drugs are allowed to be provided up to a 34-day or 100-day supply.

If “No,” please explain

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

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

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

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

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
Hydrocodone/ acetaminophen	Anticonvulsant Agents	Prior Authorization Required	Adalimumab	Albuterol
Aripiprazole	Antipsychotic Agents	Therapeutic Duplication	Bictegravir/ emtricitabine/ tenofovir	Gabapentin
Methylphenidate	Analgesics, Narcotic Agents	Plan Limitations Exceeded	Lurasidone	Cetirizine
Dextroamphetamine/ amphetamine	Stimulants And Related Agents	Product/service Not Covered - Plan/benefit Exclusion	Paliperidone	Covid-19 Vaccine (pfizer)
Buprenorphine	Hypoglycemic Agents	Refill Too Soon	Elexacaftor/ tezacaftor/ivacaftor	Sertraline
Oxycodone	Proton Pump Inhibitor Agents		Buprenorphine/ naloxone	Fluticasone
Buprenorphine/ naloxone	Antimigraine Agents		Lisdexamfetamine	Ergocalciferol
Oxycodone/ acetaminophen	Opiate Dependence Agents		Insulin Glargine	Omeprazole
Risperidone	Bronchodilator Agents		Sofosbuvir/velpatasvir	Quetiapine
Omeprazole	Antidepressant Agents		Glecaprevir/ pibrentasvir	Atorvastatin

* 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.

11. 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 29 - Monitoring Oral Counseling Requirements

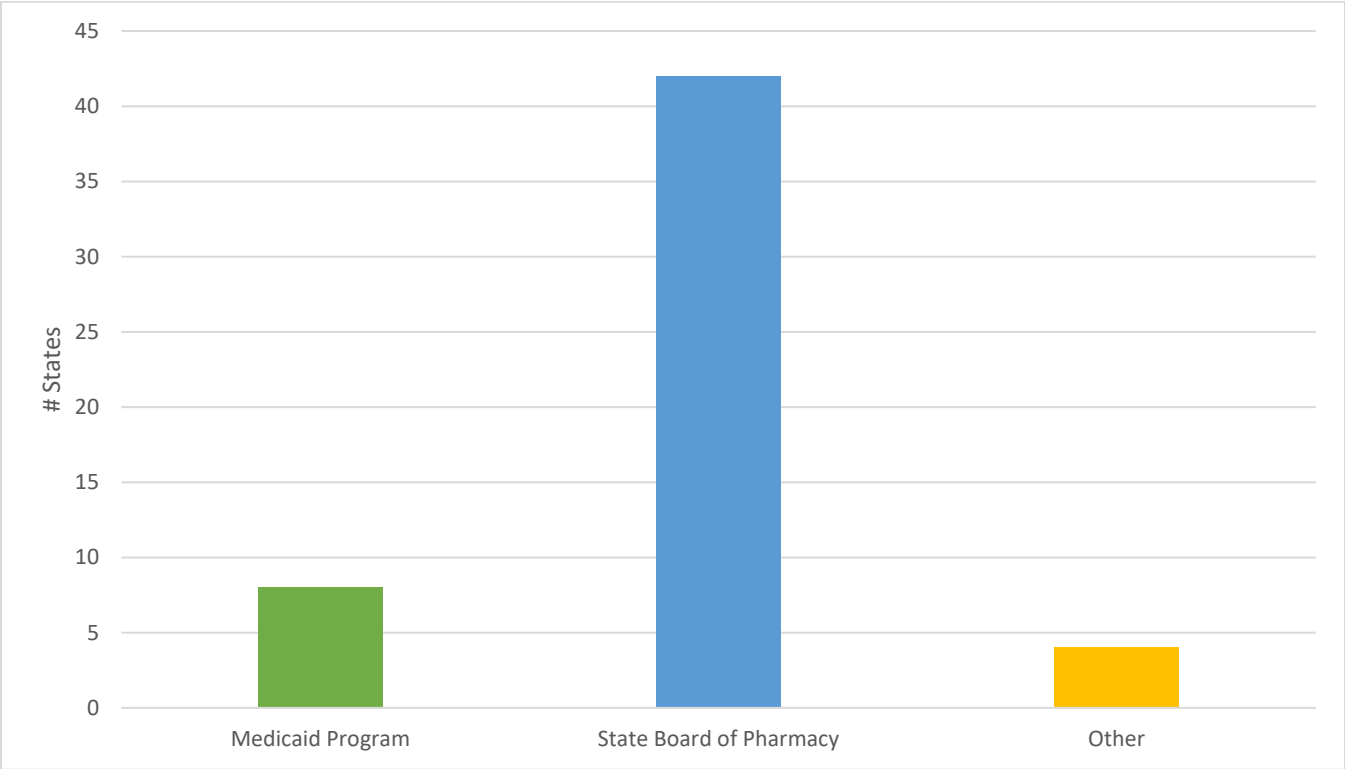

Table 41 - Monitoring Oral Counseling Requirements

Response	States	Count	Percentage
Medicaid Program	Alaska, Colorado, Connecticut, Florida, Hawaii, Kansas, Minnesota, South Carolina	8	14.81%
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, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	42	77.78%
Other	Illinois, Missouri, Utah, Washington	4	7.41%
Total		54	100.00%

If “Other,” please explain

Table 42 - “Other” Explanations for Monitoring Oral Counseling Requirements

State	Explanation
Illinois	The Illinois Department of Financial and Professional Regulation (IDFPR) licenses pharmacists in the State of Illinois and the IDFPR pharmacy inspectors during the course of pharmacy inspections evaluate compliance with the requirement for prospective drug regimen review and counseling. IDFPR inspectors report findings to the State Board of Pharmacy which disciplines pharmacists and pharmacies.
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 30 - Type of Vendor that Performed RetroDUR Activities

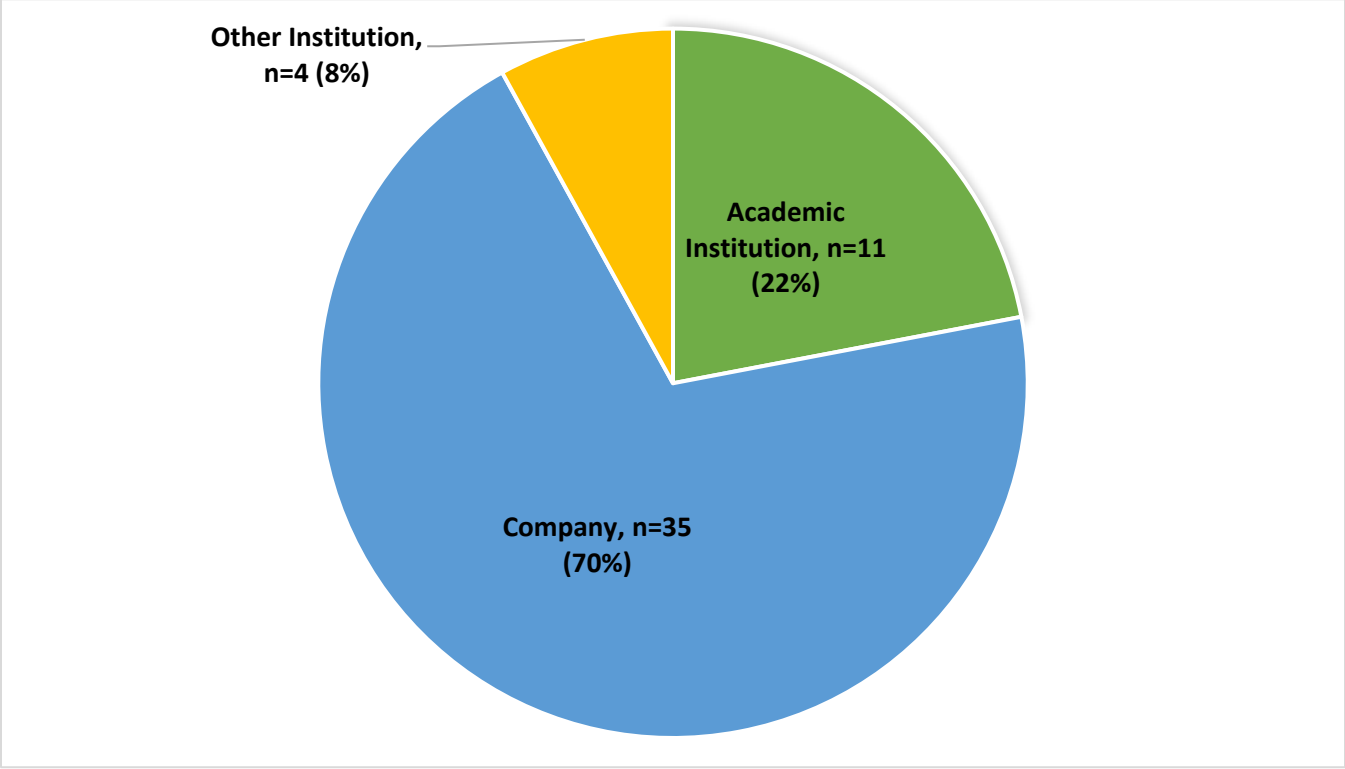

Table 43 - Type of Vendor that Performed RetroDUR Activities

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

a. Identify, by name, your RetroDUR vendor

Table 44 - Vendor Names

Response	States	Count	Percentage
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%
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%
OptumRx	Indiana, Nevada, Tennessee	3	8.57%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	14.29%
Kepro, Inc.	Minnesota	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%
Total		35	100.00%

Table 45 - Academic/Other Institution Names

State	Academic/Other Institution Name
California	University of California, San Francisco (UCSF)
Colorado	The Regents of the University of Colorado, Skaggs School of Pharmacy
Hawaii	State and Conduent State Healthcare LLC
Illinois	University of Illinois Chicago College of Pharmacy staff; Change Healthcare RetroDUR 300.
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)
South Carolina	MUSC/Magellan
Utah	University of Utah Drug Regimen Review Center (DRRC) and 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 31 - Is RetroDUR Vendor the State MMIS Fiscal Agent

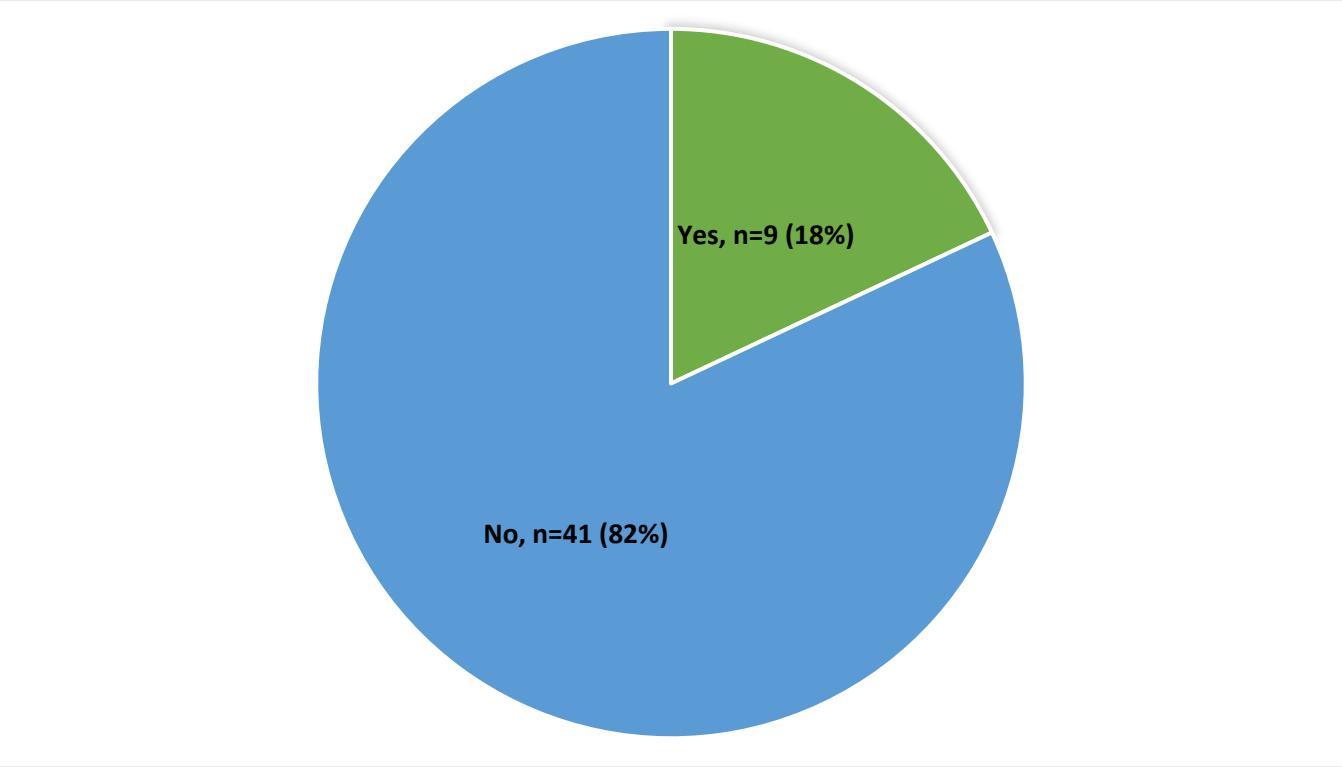

Table 46 - Is RetroDUR Vendor the State MMIS Fiscal Agent

Response	States	Count	Percentage
Yes	Delaware, District of Columbia, Florida, Hawaii, Louisiana, Nebraska, New Jersey, New Mexico, Virginia	9	18.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, 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, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	41	82.00%
Total		50	100.00%

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

Figure 32 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

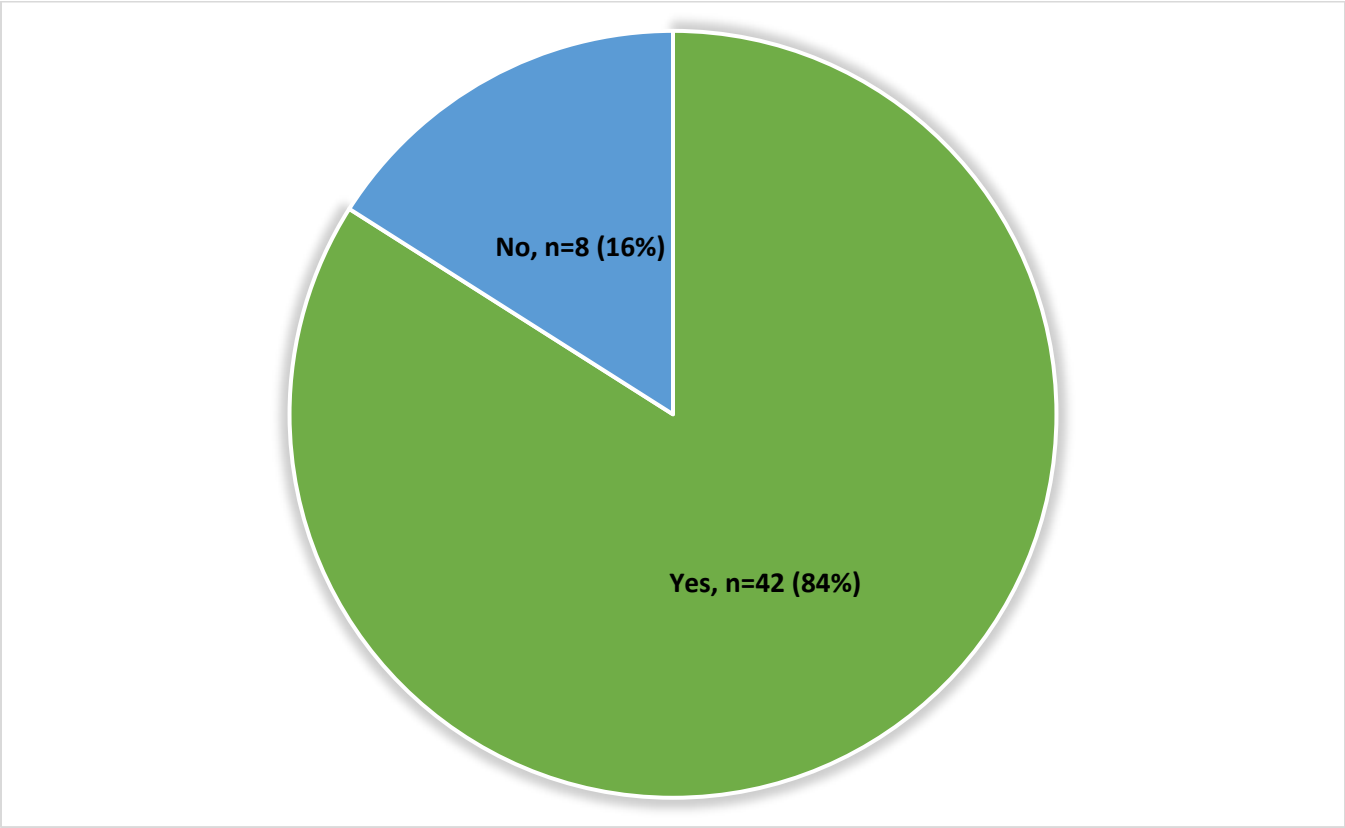

Table 47 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

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 48 - 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.
Arkansas	RetroDUR criteria are developed by the RDUR vendor. The vendor presents the possible intervention criteria and number of clients 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 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 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	In conjunction with the State, the retro DUR program is tailored to the current covered population.
Idaho	The Medicaid Pharmacy Staff Clinical Pharmacists develop the retrospective DUR criteria with input from the DUR Board and P&T Committee as necessary.
Illinois	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 collaboration of pharmacists at LDH, Gainwell Technologies, and the University of Louisiana-Monroe.

State	Explanation
Maine	This is discussed as part of the RetroDUR process with the DUR committee to get consensus on initiatives and parameters around the RetroDUR.
Maryland	The RetroDUR vendor presents new criteria to the DUR Board at quarterly meetings for the Board to review and vote if it should be added to the monthly monitoring cycle. Additionally, the DUR Board must approve any educational interventions proposed by the RetroDUR vendor.
Massachusetts	The RetroDUR vendor develops, implements and maintains the DUR criteria.
Michigan	Magellan has a catalog of RetroDUR criteria from which the DUR Board can select as needed for various topics.
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 retro-DUR criteria on behalf of the State.
Missouri	The vendor 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	Nebraska DHHS is their own developer/supplier of their retrospective DUR criteria.
Nevada	The DUR Board provides topics and reviews but does not approve final initiatives.
New Hampshire	Magellan maintains an extensive database of retrospective DUR activities that may be implemented for the NH FFS population. Approximately 200 activities are summarized and presented with an estimate of impacted members, impacted prescribers, and total payment amount for medications within the intervention. The DUR board selects activities from the list or recommends topics for development and implementation by Magellan. These activities are implemented over the preceding 6 months and are summarized at the next DUR meeting.
New Jersey	Gainwell Technologies clinical staff assist with the development of DUR criteria, which is recommended by the DURB/State prior to implementation.
New Mexico	Conduent develops and supplies the retrospective DUR criteria based on state-specific needs and DUR Board member requests.
New York	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 provides quarterly updates of DUR criteria which are reviewed and approved by the state and the DUR Board.
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	KEPRO runs the DUR Board meetings and develops the Retro DUR criteria.
South Carolina	Currently the State is contracted with MUSC (Medical University of South Carolina) for initiatives which focus primarily on opioids, while the State continues efforts to restructure the DUR board. Magellan continues to focus on Compound Claims, which has identified opportunities regarding coding, policy/language and processes (ketogenic diets/coordination with prescribers).
South Dakota	The RetroDUR vendor develops the retrospective DUR 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 for 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 data. This method allows clinical issues affecting thousands of members to be addressed without the need to individually review each profile. The retrospective criteria are developed and are submitted to the Texas DUR Board for review and approval prior to deployment. To allow for development of physician outlier profiles based on the number of beneficiaries who are receiving sub-optimal therapy, the Prescribing physicians who treat only one or two members are not flagged for intervention. Physicians who are flagged will receive an intervention letter along with patient specific information and an intervention message page which includes helpful clinical information and resources. On the letter there is also vendor's contact information if physician wishes to further discuss the issue. These letters are for educational purposes and do not affect any future prescribing abilities for the FFS clients. Vendor
Utah	The Retro-DUR criteria are developed by the Medicaid Pharmacy Team and implemented jointly by the Medicaid Pharmacy Team and the University of Utah DRRC
Vermont	The RetroDUR criteria is developed collaboratively with the State of Vermont, The DUR Board and Change Healthcare. DUR Board votes on topic of interest as well as makes suggestions to the design and implementation of the Retro DUR topics.
Virginia	The Magellan Clinical Team develops new clinical criteria for all new DUR drugs. The clinical criteria then gets discussed and reviewed at the Virginia DUR Board meetings. After discussion at the DUR Board meetings the Board will make updates if needed and then approve for implementation.

State	Explanation
Washington	RetroDUR criteria is developed by the Health Care Authority and approved by both the State DUR Board and the Health Care Authority. Some activities included as RetroDUR are initiated and completed by other program sections within the Health Care Authority and are not approved by the State DUR Board; examples of these activities include Program Integrity activities and provider oversight resulting in provider education or care gap analysis that include a pharmacy component but are not solely pharmacy based.
West Virginia	The vendor offers suggestions for RetroDUR interventions that are presented at our DUR board meetings. The members will vote and rank the offered suggestions and the vendor will implement the top choices and create criteria by working with the RetroDUR board and BMS clinical staff.
Wisconsin	Kepro is responsible for Wisconsin's retrospective DUR criteria. Each month Kepro evaluates pharmacy claims data against criteria for several hundred potential drug therapy issues. Standard criteria are developed by Kepro with any customizable applications presented to the DUR Board for approval and implementation.
Wyoming	Retrospective criteria is developed by the DUR Manager.

d. Does your state customize your RetroDUR vendor criteria?

Figure 33 - Does State Customize RetroDUR Vendor Criteria

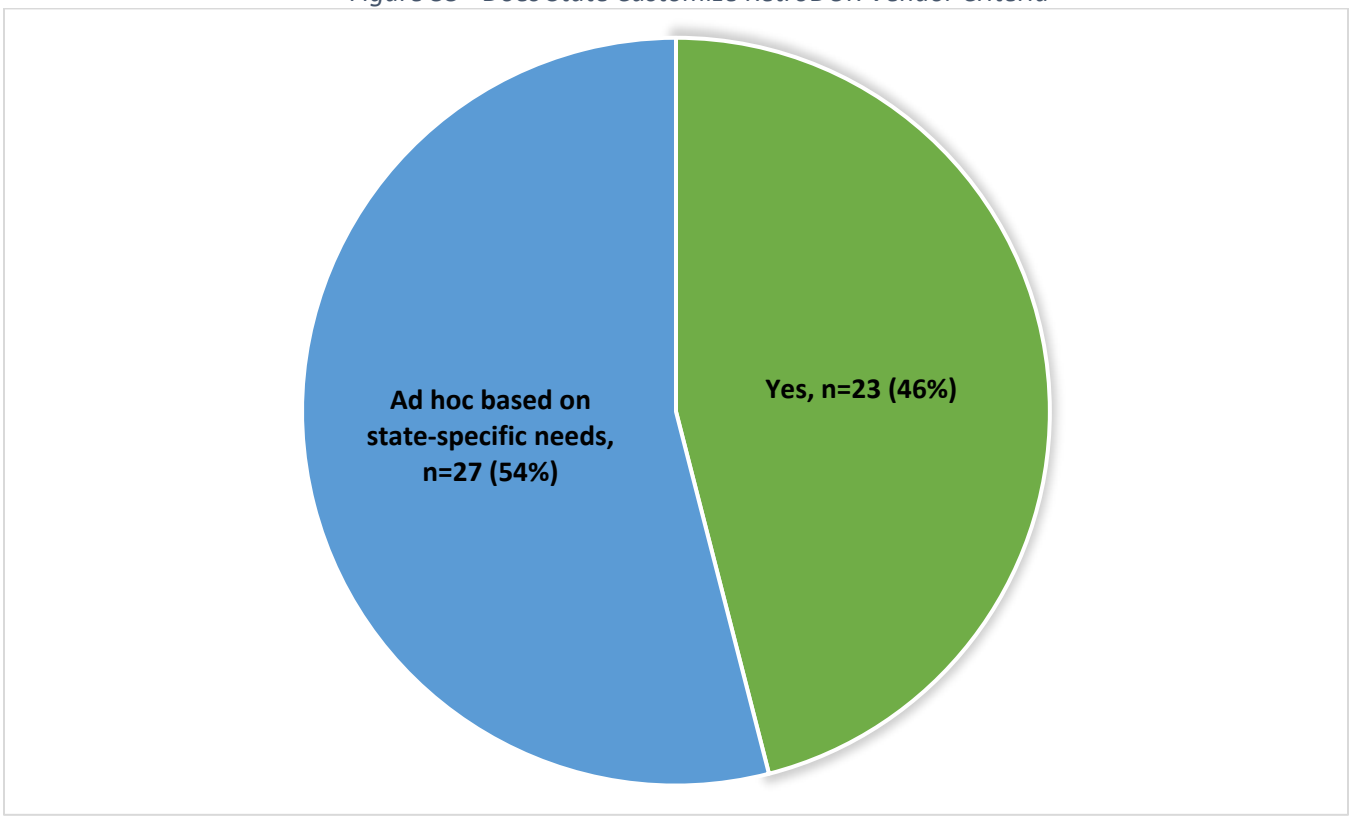

Table 49 - Does State Customize RetroDUR Vendor Criteria

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Indiana, Kentucky, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, West Virginia	23	46.00%
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 Mexico, New York, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, Wisconsin, Wyoming	27	54.00%
Total		50	100.00%

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

Figure 34 - Frequency of Retrospective Practitioner-Based Education

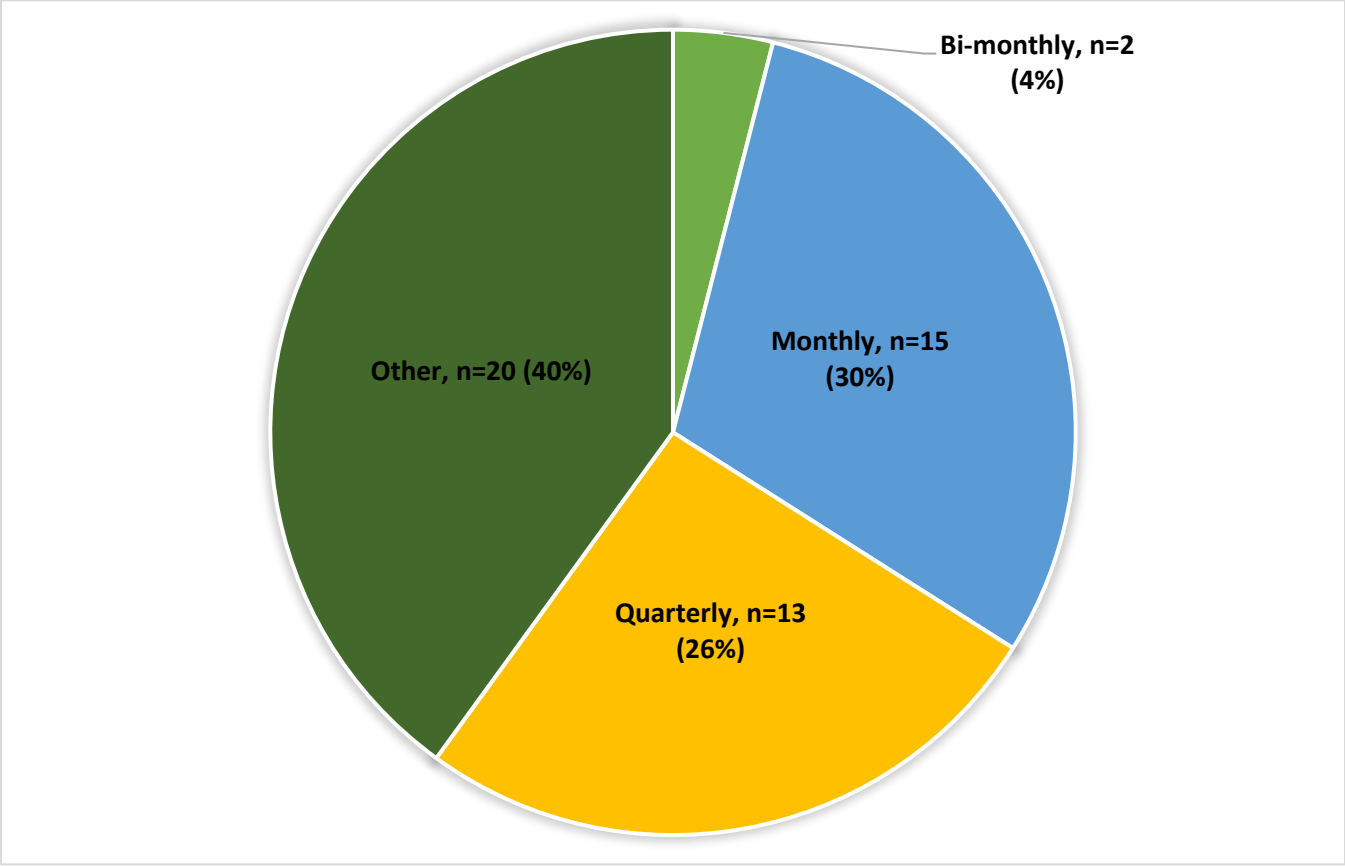

Table 50 - Frequency of Retrospective Practitioner-Based Education

Response	States	Count	Percentage
Bi-monthly	Nebraska, Oregon	2	4.00%
Monthly	Connecticut, Louisiana, Massachusetts, Mississippi, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Virginia	15	30.00%
Quarterly	Alabama, Alaska, Colorado, District of Columbia, Georgia, Kentucky, Maine, Michigan, Minnesota, Missouri, New Mexico, Tennessee, Wyoming	13	26.00%
Other	Arkansas, California, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Nevada, New Jersey, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	20	40.00%
Total		50	100.00%

If "Other," please specify.

Table 51 - "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 educational 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.
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 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 provider memorandums per current retro DUR project with quarterly provider bulletin available for medical providers as a supplemental education.
Idaho	Depending on the outreach, it can vary from monthly to quarterly.
Illinois	Practitioner-based education may occur as part of the prior authorization process. After completion of RetroDUR 300 evaluation and after a focused retrospective review practitioner education may be done and is targeted to individual patients or an individual drug issue. Retrospective review may identify need for an educational item that would benefit all prescribers. That educational item is either prepared or a link to pertinent publicly available materials is posted on the DUR Board Education page. The posted information may be shared with prescribers when pertinent during the PA process.
Indiana	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(s). Not all RDUR analyses lead to individual practitioner lettering.

State	Explanation
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 one-time, monthly and quarterly interventions performed.
Nevada	Ad hoc based
New Jersey	Practitioner based education is performed on an ongoing basis based on patient specific retrospective review.
South Carolina	Varies by intervention, typically quarterly- at a minimum .
Texas	There is no set frequency for mailing educational letters to prescribers. Per the program requirement, vendor must perform seven to ten population-based retrospective interventions per year. Proposed intervention criteria and the educational letters are mailed out within 1-3 months from the DUR Board's approval.
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 or as a result of provider oversight activities.
West Virginia	We hold monthly meeting where the RetroDUR board reviews patient profiles and sends letters to physicians when appropriate. The RetroDUR vendor also puts out a quarterly educational newsletters that is posted on our site for clinicians to view.
Wisconsin	Some retrospective practitioner-based educational letters are completed monthly. quarterly and on an as needed basis (i.e., development of newsletters).

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

Figure 35 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

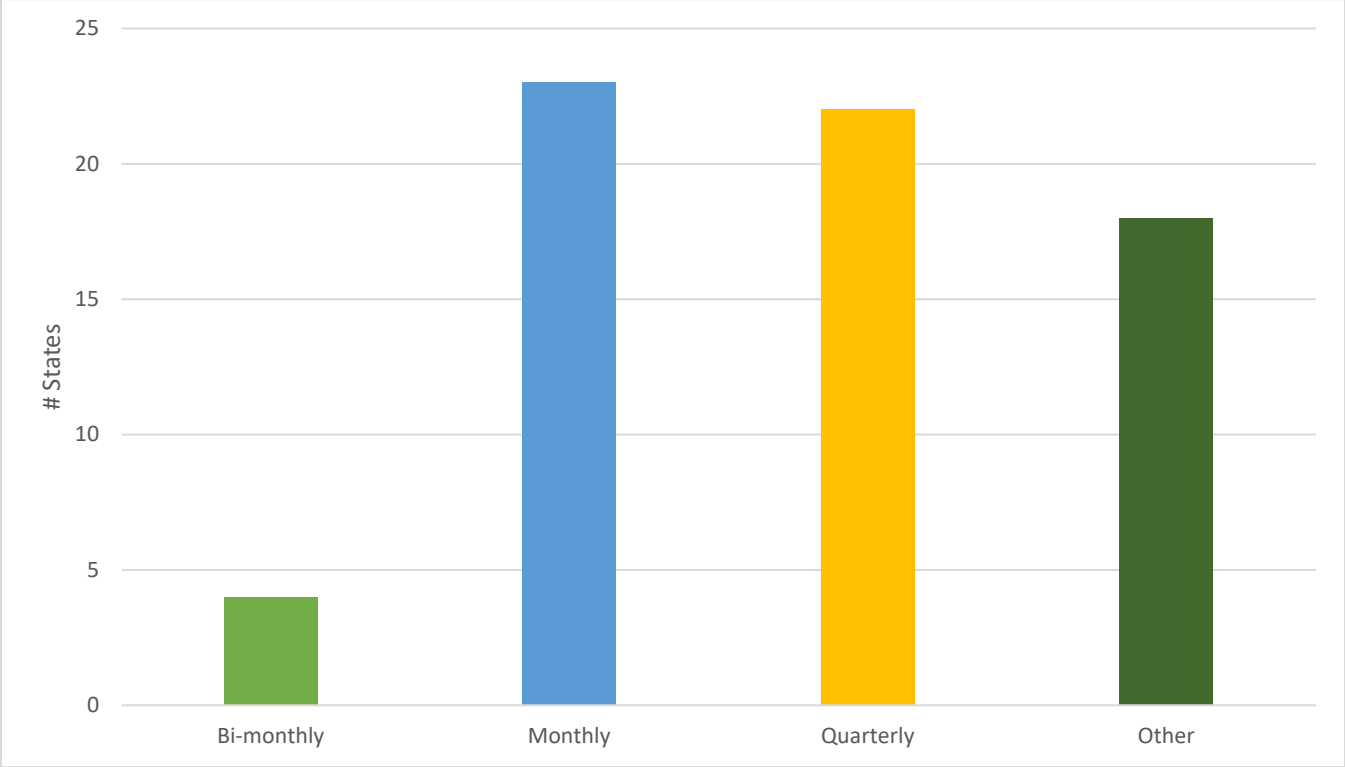

Table 52 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

Response	States	Count	Percentage
Bi-monthly	Illinois, Maine, Nebraska, Utah	4	5.97%
Monthly	Arkansas, Connecticut, District of Columbia, Louisiana, Maryland, Massachusetts, Mississippi, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, Wyoming	23	34.33%
Quarterly	Alabama, Alaska, Colorado, District of Columbia, Georgia, Idaho, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Nevada, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Utah, Wisconsin, Wyoming	22	32.84%
Other	Arkansas, California, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, New Jersey, North Carolina, Oregon, South Carolina, Texas, Utah, Vermont, Washington, Wyoming	18	26.87%
Total		67	100.00%

If "Other," please specify.

Table 53 - "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 clients 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 clients 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. Additionally, blast faxes and prescriber notifications are sent 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 retro DUR project
Idaho	Depending on the outreach, it can vary from monthly to quarterly.
Illinois	Client-specific information may be shared for issues identified at the claim level in RetroDUR 300 and other 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 client-specific information is not shared with the prescriber.
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(s). 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.
New Jersey	Practitioner based education is performed on an ongoing basis based on patient specific retrospective review.
North Carolina	While DUR Board meetings are held quarterly, lettering initiatives may occur at any time after approval by the Board and DHB. Multiple topics may be addressed in one month or it may be that letters are sent quarterly. This is dependent on the Board and DHB deciding that there is sufficient evidence in the claims data to support a clinical initiative.
Oregon	Retrospective reviews that involve communication of client specific information to healthcare practitioners are faxed weekly.
South Carolina	Quarterly initiatives are planned, which include mailings, sometimes paired with Academic Detailing, resources and CE via the tipSC webiste, as well as presentations at academic meetings/conferences.
Texas	There is no set frequency for mailing educational letters. Intervention packages are sent to targeted prescribers every 1-3 months after the DUR Board approval and will include the letter to the prescriber, specific client's claims information, and a clinical message sheet explaining the standard treatment practices.

State	Explanation
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.
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.
Wyoming	Prescription Drug Monitoring Program letters are sent weekly as required.

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

Figure 36 - Preferred Mode of Communication When Performing RetroDUR Initiatives

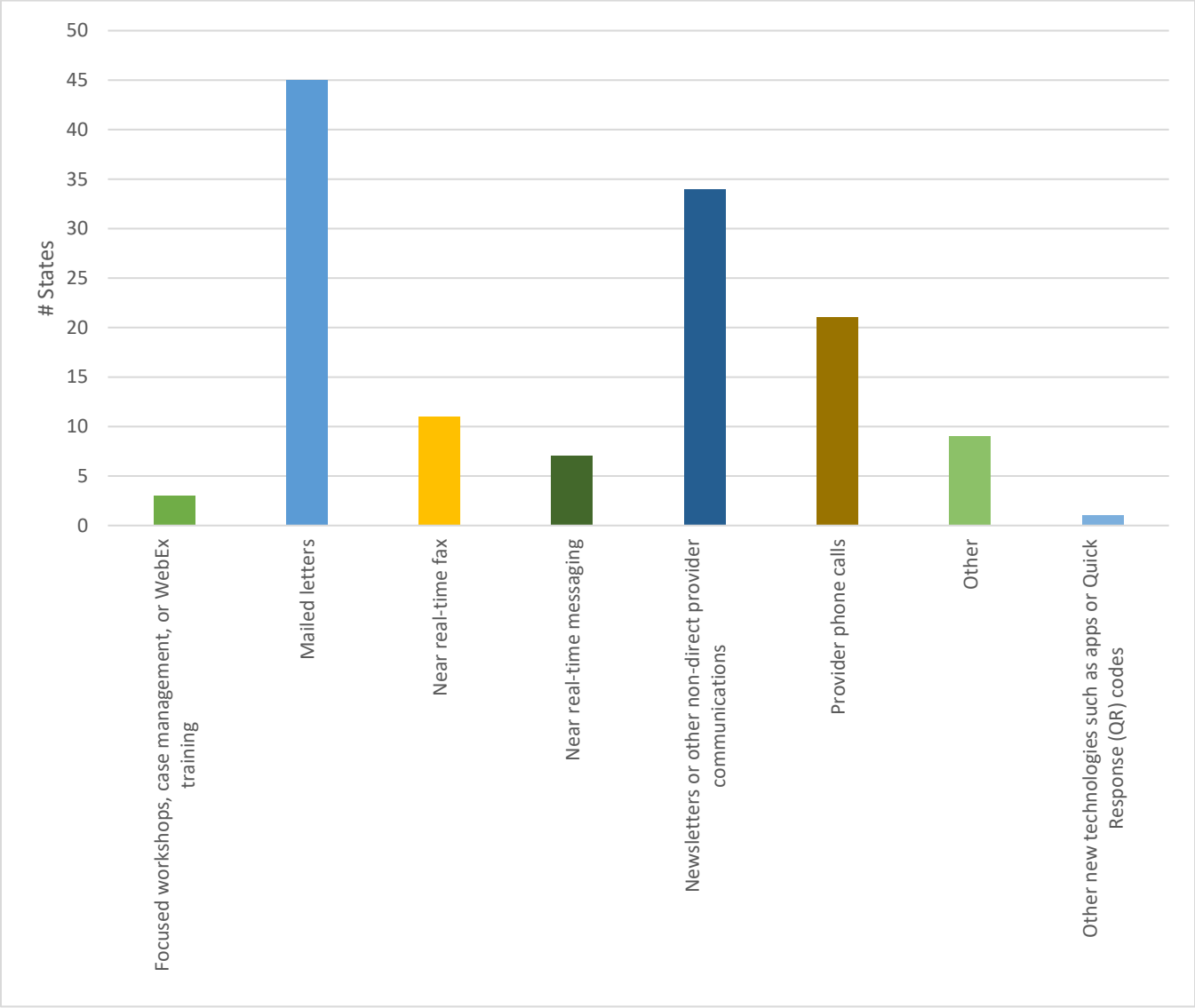

Table 54 - Preferred Mode of Communication When Performing RetroDUR Initiatives

Response	States	Count	Percentage
Focused workshops, case management, or WebEx training	Florida, Oklahoma, South Carolina	3	2.29%
Mailed letters	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	34.35%
Near real-time fax	Arkansas, Georgia, Illinois, Indiana, Maine, Massachusetts, New Jersey, Oklahoma, South Carolina, Washington, West Virginia	11	8.40%
Near real-time messaging	Florida, Massachusetts, Missouri, Oregon, Rhode Island, Vermont, Washington	7	5.34%
Newsletters or other non-direct provider communications	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	34	25.95%
Provider phone calls	Alaska, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Massachusetts, Michigan, Montana, New Jersey, Ohio, Oklahoma, South Carolina, Utah, Vermont, Washington, Wisconsin	21	16.03%
Other	Hawaii, Illinois, Michigan, New Mexico, North Carolina, Ohio, South Carolina, Vermont, Washington	9	6.87%
Other new technologies such as apps or Quick Response (QR) codes	Alabama	1	0.76%
Total		131	100.00%

If "Other," please specify.

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

State	Explanation
Hawaii	email
Illinois	For educational materials- posting on DUR Board Education page.
Michigan	Office visits.
New Mexico	Email and/or Fax
North Carolina	Mailed letters are our primary mode of communications for RetroDUR activities, but we also use the Medicaid monthly newsletter as well as direct communications through the NCTracks provider portal.

State	Explanation
Ohio	Retrospective faxes
South Carolina	The mode of communication is assessed/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 56 - RetroDUR Educational Outreach Summary

State	RetroDUR Educational Outreach Summary			
Alabama	1. Drug-Drug Precaution - SUPPORT Act of 2018 2. Drug-Drug Interaction - Respiratory Depression 3. Therapeutic Appropriateness - Appropriate Use of Opioids 4. Drug-Drug Precaution - SUPPORT Act of 2018 5. Therapeutic Appropriateness - Potential Drug Abuse 6. Therapeutic Appropriateness - Adverse Metabolic Effects 7. Drug-Disease Precaution - Black Box Warning 8. Drug-Drug Interaction - Cytochrome-related Drug Interaction 9. Drug-Disease Precaution - Stimulants and Hypertension 10. Appropriate Use - Appropriate Use of Buprenorphine-containing Products			
	Recipients Reviewed	Recipients Selected for Intervention	Letters Generated	Letters Mailed
	1. 704	454	769	748
	2. 674	2	4	4
	3. 663	14	14	13
	4. 644	384	511	505
	5. 432	298	456	445
	6. 305	205	210	196
	7. 161	115	115	111
	8. 129	84	146	143
	9. 62	7	13	11
	10. 61	45	83	81
	Total 3835	1608	2321	2257

State	RetroDUR Educational Outreach Summary
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 2021 are summarized below: Highlighted Activities Opioid Morphine Equivalent Dose Prescriber education; letters sent to providers; patient outreach; ongoing MME was reduced to 150 education runs concurrent with long-acting opioid PA requests and letters sent to providers with patients in excess of the established MME Opioids in combination with benzodiazepines, z-drugs, and antipsychotics were continually reviewed by the DUR Board quarterly Pharmacist level overrides were made available after consultation with the prescriber Antipsychotic drugs and metabolic monitoring Letters sent to prescribers identifying recipients that had not received metabolic testing while taking antipsychotic drugs Use of Makena Letters sent to prescribers regarding FDA recommendations 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	Magellan 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 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

State	RetroDUR Educational Outreach Summary
	is reviewed monthly as determined by the DUR Board. The drug history and diagnosis profile for each client who meets the selected criteria are reviewed by the Magellan RDUR team to determine if the client should be selected for an intervention. Educational intervention letters include a description of the intervention, client'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, clients could be selected for additional interventions if they meet specific criteria. Monthly RetroDUR Educational Outreach Summary 1. October 2020--Aripiprazole without an FDA approved indication in history in the last 365 days a. 348 profiles reviewed, 248 clients required letters, 249 prescribers were sent letters b. Letters mailed 11/23/2020 and re-mailed 2/17/2021 c. 195 clients had the same issue at re-review; this calculates to approximately a 21% change in therapy 2. November 2020--Member under 18 with stimulant type ADHD meds and no ADHD diagnosis a. 1336 profiles reviewed, 1336 clients required letters, 1383 prescribers were sent letters b. Letters mailed 12/16/2020 and re-mailed 2/18/2021 c. 717 clients had the same issue at re-review; this calculates to approximately a 46% change in therapy 3. December 2020--Statin non-compliance looking for a 20-day gap in refill a. 638 profiles reviewed, 190 clients required letters, 198 prescribers were sent letters b. Letters mailed 2/29/2021 c. 16 clients had the same issue at re-review; this calculates to approximately a 92% change in therapy 4. January 2021--Use of triptan without a migraine prevention medication a. 1671 profiles reviewed, 1106 clients required letters, 1146 prescribers were sent letters b. Letters mailed 2/22/2021 c. 294 clients had the same issue at re-review; this calculates to approximately a 73% change in therapy 5. February 2021--Diabetics ages 40-75 with no statins a. 2419 profiles reviewed, 2125 clients required letters, 2055 prescribers were sent letters b. Letters mailed 3/26/2021 c. 759 clients had the same issue at re-review; this calculates to approximately a 60% change in therapy 6. March 2021--Concurrent use of opioids and antipsychotics a. 1036 profiles reviewed, 552 clients required letters, 1097 prescribers were sent letters b. Letters mailed 4/21/2021

State	RetroDUR Educational Outreach Summary
	c. 224 clients had the same issue at re-review; this calculates to approximately a 60% change in therapy 7. April 2021--DPP-4 and SGLT-2 inhibitors--FDA warnings a. 657 profiles reviewed, 657 clients required letters, 687 prescribers were sent letters b. Letters mailed 5/20/2021 c. 371 clients had the same issue at re-review; this calculates to approximately a 43% change in therapy 8. May 2021--CNS polypharmacy a. 2253 profiles reviewed, 272 clients required letters, 655 prescribers were sent letters b. Letters mailed 6/29/2021 c. 145 clients had the same issue at re-review; this calculates to approximately a 40% change in therapy 9. June 2021--Use of antibiotics for URI--antibiotic overutilization and resistance a. 14,134 profiles reviewed, 14,134 clients required letters, 16,684 prescribers were sent letters b. Letters mailed 7/15/2021 c. Nothing to monitor for follow-up since antibiotics are one time treatment 10. July 2021--Females 15-50, claims for narcotics without birth control a. 1352 profiles reviewed, 817 clients required letters, 1129 prescribers were sent letters b. Letters mailed 8/2/2021 c. 398 clients had the same issue at re-review; this calculates to approximately a 51% change in therapy 11. August 2021--ADHD medication in women ages 15-44--CDC reports concerns a. 1687 profiles reviewed, 891 clients required letters, 987 prescribers were sent letters b. Letters mailed 10/7/2021 c. Nothing to monitor as was an educational letter only 12. September 2021--SABA use of 2 or more in 90 days without a controller medication a. 3624 profiles reviewed, 2719 clients required letters, 3147 prescribers were sent letters b. Letters mailed 10/21/2021 c. 2752 clients had the same issue at re-review; No improvement as response calculated as a -0.8% change In summary for FFY2021, the RDUR program reviewed 31,155 profiles, determined that 25,047 clients met criteria warranting a letter to be sent to the prescriber, and 29,597 prescriber letters were mailed.
California	1. Benzodiazepines o Educational alert published October 2020: This alert was published in response to a U.S. Food and Drug Administration (FDA) announcement that required the Boxed Warning for all benzodiazepines to be updated to reflect the serious risks of abuse, misuse, addiction, physical dependence, and withdrawal reactions. o Clinical Review: Recommendations for the Tapering of Benzodiazepines published March 2021: This bulletin reviewed the risks of dependence and withdrawal during benzodiazepine therapy and discussed strategies for designing a safe taper. o Provider letter sent April 2021: The objective was to inform health care providers about safety issues associated with benzodiazepine tapering. A total of 153 letters were mailed on April 18, 2021, to the top prescribers of benzodiazepines (by total paid claims) in

State	RetroDUR Educational Outreach Summary
	the Medi-Cal program. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on benzodiazepine tapering and a provider survey. 2. Management of Acute Dental Pain o Educational bulletin published January 2021: This bulletin reviewed recommendations from the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD) regarding routine management for acute dental pain, including the recommendations for non-opioid analgesics as first line agents. o Provider letter sent February 2021: The objective was to inform dentists about the updated American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD) recommendations for the management of acute dental pain. Letters were mailed on February 16, 2021, to the top 153 dentists by total paid claims for opioid medication exceeding a three-day supply between March 1, 2019, and February 29, 2020. Each prescriber was sent a letter that included the Medi-Cal DUR bulletin on management of acute dental pain and a provider survey. 3. Potential Increased Arrhythmia Risk from Lamotrigine o Educational alert published April 2021: This alert was published in response to the FDA's Drug Safety Communication that discussed the potential for Increased risk of arrythmias with use of lamotrigine and summarized recommendations for patients that are continued on lamotrigine therapy. 4. Pregnancy Contraindication Removed for Statins o Educational alert published August 2021: This alert was published in response to the FDA's request to remove the contraindication against using statin medications in people who are pregnant and recommendation to continue therapy in pregnant patients at very high risk of cardiovascular events. o Provider letter sent September 2021: The objective was to inform health care providers about the FDA announcement that it is requesting removal of its strongest warning against using cholesterol-lowering statin medicines in pregnant patients. Letters were mailed on September 20, 2021, to the top 200 prescribers of statins to female Medi-Cal FFS beneficiaries between 15 and 49 years of age during 2021. Each prescriber was sent a letter that included the Medi-Cal DUR alert and a provider survey. 5. Voluntary Recall of Varenicline (Chantix) Due to Nitrosamine o Educational alert published August 2021 and updated September 2021: This alert was published in response to the FDA's Drug Safety Communication that announced a voluntary manufacturer recall of varenicline tablets due to levels of nitrosamine impurity above the FDA's acceptable limit and recommended patients continue taking recalled varenicline until a replacement is provided. o Provider letter sent October 2021: The objective was to inform health care providers about a voluntary manufacturer recall of all lots of varenicline (Chantix) 0.5 mg and 1 mg tablets due to unacceptable levels of a nitrosamine impurity, called N-nitroso-varenicline. The letter was sent to the top 200 prescribers of varenicline to Medi-Cal beneficiaries since January 1, 2021. Each prescriber received a letter that includes the updated Medi-Cal DUR alert on the varenicline recall and a provider survey. 6. 2020 Immunization Updates: Vaccination during COVID-19, Flu, HepA, and Tdap

State	RetroDUR Educational Outreach Summary
	o Educational bulletin published September 2021: This bulletin is an annual publication provided by the DUR program to provide updates on immunization guidelines, products, policy and/or research each year. Links to recommended immunization schedules for 2021 in the United States were also provided. The summary for 2021 included updates for COVID-19 vaccines, influenza vaccine, Hepatitis A (HepA) vaccine, tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine, as well as a review of strategies to improve COVID-19 vaccination rates.
Colorado	Interventional letters that contain patient-specific information are prepared and mailed to prescribers on a quarterly basis. During FFY 2021, these letters contained information about high risk opioid prescribing, high risk benzodiazepine prescribing, high risk psychotropic prescribing in children/adolescents, and high opioid MME (> 150) without a pharmacy claim for naloxone during the prior 12 months. During FFY 2021 over 3,300 interventional letters were mailed to Colorado Medicaid providers. Individual letters mailed to prescribers may include an intervention for more than one member. FFY Q1 (Oct 1 to Dec 31, 2020): 672 provider letters 96 Children and adolescents receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 272 Receiving 2 or more BZDs for 90/180 days using most recent data 304 Opioid plus BZD plus skeletal muscle relaxant FFY Q2 (Jan 1 to Mar 31, 2021): 740 provider letters 104 Children and adolescents receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 274 Receiving 2 or more BZDs for 90/180 days using most recent data 362 Opioid plus BZD plus skeletal muscle relaxant FFY Q3 (Apr 1 to Jun 30, 2021): 982 provider letters 94 Children and adolescents receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 267 Receiving 2 or more BZDs for 90/180 days using most recent data 315 Opioid plus BZD plus skeletal muscle relaxant 306 Opioid Claims > 150 MME and no naloxone fill during the 12 months prior (new intervention this quarter) FFY Q4 (Jul 1 to Sep 30, 2021): 968 provider letters 107 Children and adolescents receiving 2 or more antipsychotics for greater than 45 days of the measurement quarter 254 Receiving 2 or more BZDs for 90/180 days using most recent data 292 Opioid plus BZD plus skeletal muscle relaxant 315 Opioid Claims > 150 MME and no naloxone fill during the 12 months prior
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) 2021. 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.

State	RetroDUR Educational Outreach Summary
	A total of 12,895 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 11% was achieved for the top 10 criteria reviewed and a response rate of 11% was achieved overall for all interventions performed during FFY 2021. 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. 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 2021. CRITERIA TYPE, CRITERIA DESCRIPTION, # OF CASES CREATED, # INTERVENTION LETTERS MAILED TO PRESCRIBERS, # PRESCRIBER RESPONSES LI, Connecticut lock-in (LI) criteria, 1311, 3773, 415 DB, Epidemiological studies suggest atypical antipsychotics may exacerbate pre-existing diabetes. A dose adjustment in the patient's current diabetic medication(s) may be necessary for optimal blood glucose levels. Blood glucose and HgA1c monitoring should be conducted in conjunction with monitoring for weight gain and signs of hyperglycemia. All patients should be advised to report signs of ketoacidosis or glycosuria., 1919, 2757, 225 TA, The effects of prolonged use of atypical antipsychotics in pediatric patients are unknown. Preliminary evidence suggests that pediatric patients experience more prevalent and severe adverse effects than those reported in adults (e.g., weight gain, extrapyramidal side effects, and insulin resistance). If therapy with these agents is clinically necessary, use the lowest effective dose and observe patients closely for adverse events. If adverse effects cannot be controlled, consider switching, if clinically possible, to a second-generation antipsychotic with a more favorable adverse effect profile. The SUPPORT Act of 2018 requires that Medicaid monitor antipsychotic prescribing for children., 1855, 1828, 153

State	RetroDUR Educational Outreach Summary
	ER, Cyclobenzaprine should be used only for short periods (up to two or three weeks) because adequate evidence for more prolonged use is not available. Muscle spasm associated with acute painful musculoskeletal conditions is generally of short duration and specific therapy for longer periods is seldom warranted., 961, 990, 122 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. , 836, 816, 142 TD, This patient may be receiving concurrent therapy with multiple antipsychotic agents., 535, 730, 37 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)., 472, 535, 66 TA, The Connecticut DCF Psychotropic Medication Monitoring Guidelines recommend that all children and adolescents on an SSRI should have follow-up every 3 months for height, weight, BMI/BMI percentile, blood pressure and pulse., 521, 513, 97 TD, Therapeutic duplication of antihistamine agents may be occurring., 309, 486, 91 DB, The stimulant is contraindicated in patients with agitated states as the drug may aggravate the condition., 473, 467, 76 , Total Top 10, 9,192, 12,895, 1,424 , Total all letters for all criteria, 20,893, 25,968, 2,838 LI-Lock In, DB- Drug-Drug Marker and/or Diagnosis, TA-Therapeutic Appropriateness, ER-Early Refill, TD-Therapeutic Duplication 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 12,895 DUR educational intervention letters were mailed for the top 10 interventions to prescribers during FFY 2021, however, a total of 25,968 letters were mailed for all interventions performed during FFY 2021. 2,838 responses were received during FFY 2021 for a total response rate of 11%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response, Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS, 141 MD UNAWARE OF WHAT OTHER MD PRESCRIBING, 17 PT IS NO LONGER UNDER THIS MD's CARE, 156 MD SAYS PROB INSIGNIF NO CHG THX, 1,368 MD WILL REASSESS AND MODIFY DRUG THERAPY, 184 MD TRIED TO MODIFY THERAPY, PT NON-COOP, 60

State	RetroDUR Educational Outreach Summary
	PT UNDER MY CARE BUT NOT SEEN RECENTLY, 103 PATIENT DECEASED, 6 PATIENT WAS NEVER UNDER MD CARE, 31 HAS APPT TO DISCUSS THERAPY, 385 MD DID NOT RX DRUG ATTRIBUTED TO HIM., 155 TRIED TO MODIFY THERAPY,SX RECURRED, 44 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD, 188 Total responses for FFY 2021, 2,838 Response Rate, 11% Conclusion The top 10 interventions to prescribers were conducted for the Connecticut Medical Assistance Program population during FFY 2021 which resulted in 9,192 cases created, 12,895 prescriber letters mailed, and 2,838 responses received. The response rate for the top 10 interventions, was 11% during FFY 2021.
Delaware	For FFY 2021, much of the focus of provider education was on Covid vaccine administration, testing and treatments. Delaware utilized RetroDUR 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. For example, Delaware sent out a blast fax to pharmacies providing them with the list of OTC Covid home test kits that would be covered at the pharmacy. Similar information was also provided to non-pharmacy providers on the webpage and in the quarterly provider bulletin. 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 256 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, the State hopes to increase patient safety, increase coordination of care, and decrease adverse outcomes among the Medicaid population.

State	RetroDUR Educational Outreach Summary
District of Columbia	Gabapentinoid Drug Use Evaluation Educational RetroDUR Mailing Initial Study Follow up /Restudy Executive Summary Purpose: To determine opportunities for improving the safety and efficacy of drug therapy for patients with gabapentinoids. Why Issue was Selected: 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. Program Specific Information: Performance Indicators Exceptions Gabapentinoid and opioid use concomitantly. 150 Multiple prescribers of opioids or CNS depressants and gabapentinoids. 141 Gabapentinoid use with other CNS depressants 532 Gabapentinoid use in patients with respiratory impairment 305 Use of a gabapentinoid without an approved indication. 2031 Setting & Population: All patients with a history of gabapentinoid use. Types of Intervention: Cover letter and individual patient profiles. Main Outcome Measures: Re-measure of performance indicators Anticipated Results: Reduce the use of gabapentinoids in individuals with an unapproved indication, respiratory depression, concomitant use of other CNS depressants or concomitant use of opioids. Please note that Conduent has not yet submitted its outcomes metrics or cost impact analysis for this FY21 population-level intervention.
Florida	1. Review pre and post implementation impact of the cumulative Morphine Milligram Equivalent (MME) > 50 soft edit a. The DUR Board moved to amend and expand the soft edit from targeting recipients on > 300 MME to recipients on > 50 MME based on a single or accumulation of opiate claims. During the March 2021 DUR Board meeting, the DUR Board reviewed the post impact of the soft edit. 2. To review the post implementation impact of Eucrisa changing from preferred to an automated prior authorization a. During the June 2021 DUR Board meeting, the DUR Board reviewed the impact of changing Eucrisa from preferred to an automated prior authorization. The DUR Board was satisfied with the impact of the edit. 3. To review the post implementation impact of the anticonvulsant multiple therapy soft edit a. The DUR Board voted to implement a soft edit for recipients on multiple anticonvulsants (>2 unique anticonvulsants per 30 days). DUR intervention codes are required at the Point-of-Sale (POS) to allow for claim processing. Products to treat acute increased seizure activity are excluded. The edit deployed 01/09/20. During the June 2021 DUR Board meeting, the DUR Board reviewed the impact of the anticonvulsant multiple therapy soft edit. The DUR Board was satisfied with the impact of the edit.

State	RetroDUR Educational Outreach Summary
	4. To review trends in opiate prescribing as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act a. The DUR Board reviewed opioid claims, concomitant use of opiates and Medication Assisted Treatment (MAT), claims exceeding the recommended 90 MME limits, top opioid prescribers including specialty, top opioid recipients, average MME, Narcan/naloxone utilization, and overdose data. The DUR Board will continue to review this topic. 5. To review utilization, cost, and safety of Proton Pump Inhibitor (PPI) therapy a. The DUR Board reviewed the recipient count, claims, financial impact, and discussed safety with long term PPI therapy. 6. To review the pre and post impact of the revised soft edit for asthma medication management a. During the June 2021 DUR Board meeting, the DUR Board reviewed the revised soft edit for asthma medication management and no further action was warranted. 7. To review the pre and post impact of the Lyrica automated prior authorization edit a. During the June 2021 DUR Board meeting, the DUR Board reviewed the impact of the Lyrica automated prior authorization edit and will continue to monitor the edit. 8. Review concomitant utilization of long-acting opiates and benzodiazepines (yearly review required by the SUPPORT Act) a. During the June 2021 DUR Board meeting, the DUR Board reviewed the utilization of long-acting opiates and benzodiazepines and will review yearly. 9. To review trends in the antiviral utilization and influenza vaccine over the last 4 influenza seasons a. During the September 2021 DUR Board meeting, the DUR Board reviewed trends in influenza vaccine and antiviral utilization. 10. To review the post impact of the gabapentin daily milligram limit and concomitant therapy soft edit a. During the September 2021 DUR Board meeting, the DUR Board reviewed the post implementation impact of the gabapentin edit. The DUR Board will continue to review this edit.
Georgia	1. Use of High Dose Opioids and Alert of Change in Opioid Quantity Limits -In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published guidelines for the use of opioids in chronic, non-cancer pain in 2016. In the Guidelines for Prescribing Opioids for Chronic Pain, the CDC recommends careful justification for titrating opioid doses above an average of 90 morphine milligram equivalents (MME) per day to avoid potential overdose. In an effort to reduce the risk of opioid-related harms while preserving access to appropriate pain treatment, Georgia Medicaid Fee-For-Service (FFS) previously implemented a prior authorization program for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day. In 2021, the MME limit was reduced to 150 per day. -Opioid prescribing continues to decrease quarter-over-quarter. 2. Newsletter on Variants of SARS-COV-2. 3. Newsletter on Psilocybin for Major Depressive Order. 4. Newsletter on Post Exposure Prophylaxis of SARS-CoV-2. 5. Newsletter on Omicron Variant of SARS-CoV-2.

State	RetroDUR Educational Outreach Summary
Hawaii	An expensive drug DUR identified a third party billing error for Ravicti. The patient left FFS and transitioned into MCO. Outreach to the dispensing pharmacy and billing agents by phone and email was successful.
Idaho	Naloxone Prescribing Trends: 34 educational letters were sent out to pharmacies asking for naloxone prescribing for patients between 2/14/2020 and 3/12/2020. 13 of 34 (37%) participants filled a naloxone prescription. There was a decent response, it was resource intensive, and reached few patients.
Illinois	Retrospective reviews and related educational efforts conducted throughout FFY21 are summarized below. One-on-one provider discussion and faxes continued as strategies to address appropriate medication use. Antipsychotic use in children. Oral antipsychotic use in 7,754 children 8 to 17 years of age who had one insurer for the period of April 1, 2020 through July 31, 2020 was reviewed. Number of prescriptions filled by children ranged from 1 to 17, with 93% of the prescriptions filled for a 1-month supply. Approximately 60% of children filled 3 or more prescriptions during the review period. Thirteen different antipsychotics were filled. The top 5 medications were risperidone, quetiapine, aripiprazole, ziprasidone, and olanzapine. First-generation antipsychotics comprised less than 2% of all prescriptions filled (chlorpromazine, haloperidol, and perphenazine). Case examples of 5 fills in a month during the review period were discussed. Dose titration and multiple prescribers were reasons for numerous fills. Approximately 9.9% of children filled 2-5 medications during the review period. At least 21% of the children filled the same therapy monthly, 6% of children clearly added a second therapy during the review period, and the rest switched therapies during the 4-month review period. Switch of therapies over 4 months showed no overlap between therapies (32% of switches), a 1-month overlap of therapies (19% of switches), a 2-month therapy overlap (2.5% of switches), and 3% switched therapies 2 to 4 times during the review period. Case review of a child filling 3 medications concomitantly demonstrated fills of olanzapine, quetiapine, and ziprasidone at near or max daily doses for age. The DUR Board members discussed further review that may be indicated, including medication and dosing appropriateness for age and indication, as well as prescriber type, required DocAssist referral, and opportunities for prescriber education. Utility of prior authorization regarding identifying multiple strengths was discussed. The DUR Board recommended prescriber outreach in situations of two or more antipsychotics filled concomitantly for more than 1 month, since a 1-month overlap deemed sufficient for switching. Prescriber education may be warranted. Dental opioid therapy duration. Dental opioid prescribing for calendar year 2020 for HFS was reviewed. The majority of the 28,502 claims were for Medicaid MCO covered participants. The most common medications were acetaminophen with codeine and hydrocodone with acetaminophen. About 97.5% of claims were for less than 50 MME (average MME was 23.2). The majority of claims were for < 7 days of therapy, commonly 3-day supply or less. Only 192 claims (0.67%) were for more than a 7-day supply from 85 dentists. The majority of dentists did not prescribe for more than 7 days supply more than 1-2 times. A quantity of 30 was present in almost 77% of the greater than 7-day supply group. Eleven claims exceeding an MME of 50 in 7 participants were reviewed. Outreach recommended for one participant who continued to get opioids (5 times in the last 6 months). Five participants continue to receive chronic opioid therapy from a dentist for an average MME of 38 daily. Current opioid safety edits and mandatory opioid education for

State	RetroDUR Educational Outreach Summary
	license renewal were deemed to sufficiently limit dental opioid prescribing to < 7 days supply. The Center for Opioid Research and Education Dental Opioid Guidelines for common dental procedures and the CDC patient information resource about opioid use for acute pain were recommended for posting even though the utilization review did not identify a problem at this time. Naloxone in patients with high opioid MME. Naloxone-related Illinois and federal legislation/guidance was reviewed. Claims for naloxone January 2010 through April 2021 were reviewed. Increased usage parallels legislative actions to expand naloxone availability. Naloxone prescribers by type were reviewed. Top prescribers were the chief medical officers on standing orders from the Illinois Department of Public Health and Walgreens. Addiction medicine, Psychiatry, Family Medicine, and Emergency Medicine specialties prescribed naloxone frequently. Naloxone prescribing was highest in the Chicagoland area, Springfield, and Alton. Walgreens was the top pharmacy dispensing naloxone in the state. Profiles of participants with high opioid MME of 50 and 90 identified via Change Healthcare reports were reviewed for naloxone prescription claims. Between 26% to 40% of participants in these MME categories (50 and 90 MME, respectively) have filled naloxone in either FFS or MCO Medicaid. Standing orders accounted for 12% to 31% of the naloxone claims. Participants filled 1-3 naloxone prescriptions primarily, although a few patients had up to 12 refills. Diagnoses for the 90 MME with 9 or more naloxone fills were trauma, sickle cell, chronic back pain, and one history of substance abuse with a current cancer diagnosis. The DUR Board members suggested potential ways to improve naloxone prescribing/availability for patients who may have a safety risk due to high opioid MME. Academic detailing regarding naloxone recommended for prescribers whose patients fill opioids at 90 MME or greater. Continuous glucose monitoring (CGM) utilization. Staff reviewed CGM utilization across the HFS population (MCO and Fee-for-Service [FFS]) from September 2020 through September 2021 to gain an understanding of CGM uptake. The majority of claims for CGM transmitters, receivers, and sensors were from the Medicaid MCO participants. Final determinations for FFS prior authorization requests for 844 participants for CGM supplies were also reviewed. The information was useful information to consider when updating FFS CGM prior authorization criteria. Montelukast monotherapy/steroid-containing inhaler and spacer devices letters to prescribers. The Four Prescription Policy edit identifies participants filling montelukast monotherapy for asthma who could potentially benefit from steroid inhaler therapy. Since the Four Prescription Policy edit was turned off temporarily during the COVID-19 pandemic, no faxes were sent to prescribers regarding this topic during FFY21. Benzodiazepines. Provider outreach continued to prescribers of chronic benzodiazepine therapy for the management of anxiety in the absence of first-line therapies, such as selective serotonin reuptake inhibitors (SSRIs). The adjudicating pharmacist noted recommendations regarding benzodiazepine therapy and/or tapers in the determination letters sent from the HFS prior authorization system. Prescribers were asked to provide an anxiety management plan and benzodiazepine taper plan. During FFY21, at least 666 benzodiazepine determination letters for 453 participants were sent to 420 prescribers. This was approximately a 67.5% decrease in the number of benzodiazepine prior

State	RetroDUR Educational Outreach Summary
	authorization requests compared to FFY20. The decrease was a result of COVID pandemic-related temporary lift of the Four Prescription Policy that generated the majority of benzodiazepine prior authorization requests in the past. Additional benzodiazepine faxes citing evidence-based literature are only sent if further prescriber education is needed. During FFY21, at least 9 additional benzodiazepine faxes were sent to prescribers. Opioid pain management. During FFY21, at least 2,456 determination letters for 1,516 participants were sent to 1,360 prescribers for opioid medications requiring prior approval for days supply, exceeding the MME, dose, concomitant benzodiazepine use, or use of long-acting opioid dosage form. During FFY21, as part of the Chronic Pain Management Program, a total of 247 additional individualized letters were faxed to prescribers of opioids (6 for methadone) 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 the majority of participants for the chronic pain management program impacted the numbers of participants for whom outreach was conducted regarding opioid use. RetroDUR 300. During FFY21, 248 patients identified via the Change Healthcare RetroDUR 300 automated algorithm who had FFS coverage underwent pharmacist review to determine whether prescriber outreach was warranted. Prescriber outreach recommended for 46 participants. Medication adherence. The prior authorization staff continues to monitor adherence for medications to treat cystic fibrosis, direct-acting oral anticoagulant therapy (DOAC), and hepatitis C infection. Prescribers are contacted by fax or phone to discuss adherence issues Website information. Educational information regarding new initiatives is posted on the DUR Website. The DUR Board Web page provides information about the DUR Board, while the Drug Utilization Review Web page provides educational materials or links for prescribers to help manage medication-related issues identified by the DUR Board in the HFS population. During FFY21, the main DUR Board Web page was accessed 880 times and the Drug Utilization Review Web page was accessed 1279, both a slight decrease over FFY20. The Pharmacy Services Web page providing forms and prior authorization criteria was accessed 9,112 times - almost 5 times greater than in FFY20. The Preferred Drug List (PDL) search engine page was accessed 14,222 times. The increase in use of these pages is reflective of a single HFS PDL across FFS and MCO Medicaid, restart of Pharmacy and Therapeutics Committee meetings virtually, as well as state legislation regarding prior authorization.
Indiana	The following information is an annualized analysis of retroDUR activities and outcomes that were approved by the DUR Board and performed by OptumRx 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. 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 2019 Caring for your Patients with Potential Off-Label Gabapentin Use

State	RetroDUR Educational Outreach Summary
	Members utilizing at least 30 days of gabapentin without an FDA-labeled or approved compendia diagnosis found in their medical claims data will have a near real-time letter faxed to the prescriber. The goal of this program is to ensure members are receiving appropriate gabapentin therapy, especially considering recent overdose deaths with concurrent opioids and benzodiazepines. Evaluation will be made to determine if members have the gabapentin therapy discontinued. Claims data for members utilizing gabapentin therapy were reviewed from August 1, 2018 to August 1, 2019. During this period, 7,590 unique utilizers of gabapentin for at least 30 days were identified. A total of 2,869 claims were processed (38%) during the reporting period that did not have an FDA-labeled or approved compendia diagnosis found in their medical profile, totaling $99,519.18. OptumRx proposed this intervention at the September 2019 DUR Board meeting. The retroDUR intervention began processing letters on January 6, 2020. At the one-year completion, 3,403 members were identified for a near real-time fax intervention. Of those eligible, 532 (15.63%) had discontinued gabapentin therapy, resulting in a savings of $83,638.34. August 2020 Caring for your Patients with Sickle Cell Disease Members diagnosed with sickle cell disease that have not received hydroxyurea therapy based on a review of claims history will have a near real-time letter faxed to the prescriber. The goal of this program is to increase the utilization of hydroxyurea therapy due to guideline recommendations. Per the Management of Sickle Cell Disease: Recommendations from the 2014 Expert Panel Report, hydroxyurea works primarily by increasing levels of fetal hemoglobin, which does not sickle. Hydroxyurea is indicated in patients 2 years of age and older (use in children nine months and older is recommended) to reduce sickle cell symptoms, such as frequency of painful episodes, acute chest syndrome (ACS) events, blood transfusion requirements, and sickle cell-related hospitalizations. Discontinuation of hydroxyurea is recommended for pregnant women, those planning to become pregnant, and those that are breastfeeding. Long-term observational studies demonstrate that the use of hydroxyurea has long-term beneficial effects across all age groups with limited side effects. Evaluation will be made to determine if members have hydroxyurea therapy added. Claims data for members with a diagnosis of sickle cell disease were reviewed from June 1, 2019 to May 31, 2020. During this period, 467 unique members were identified as having sickle cell disease. Of these members, 445 were not utilizing hydroxyurea (only 4.7% of patients utilize hydroxyurea). During this time period, 100 claims for hydroxyurea were processed for 22 members, totaling $3,937.86. OptumRx proposed this intervention at the July 2020 DUR Board meeting. The retroDUR intervention began processing letters on October 5, 2020. At the one-year completion of this retroDUR, 47 interventions have been faxed to the prescriber for review. Of the 47 interventions submitted, 42 are eligible for outcomes at this time. Five (11.9%) interventions had positive outcome resulting in an increase in expenditure of $21,765.46 (due to increased utilization of hydroxyurea). November 2020 Caring for Your Patients with Hepatitis C Members utilizing hepatitis C therapy were monitored for compliance during therapy and SVR measurement at the end of therapy. When a prior authorization was approved and a claim was submitted, OptumRx monitored fill dates for the member to ensure they

State	RetroDUR Educational Outreach Summary
	received claims in a timely manner. For claims that were up to three days late from the previous fill, outreach was potentially made to the member, pharmacy, and/or prescriber to help ensure adherence to therapy. In addition, at the completion of therapy, a letter was submitted to the prescriber requesting documentation regarding achievement of SVR for the treated member. The goal of this program was to ensure members were adhering to and completing hepatitis C therapy. Adherence to this therapy is known to increase SVR and prevent the need for future retreatment due to treatment failures. Evaluation will be made to determine if members were more adherent and achieved SVR at the end of therapy. Claims data for members utilizing hepatitis C therapy were reviewed from October 1, 2016 to January 31, 2017. During this time period, 539 unique utilizers of hepatitis C agents were identified, totaling 1,493 claims. These claims totaled $31,796,504.81. Of these members, 14.8% were not adherent to therapy, as defined by a late subsequent fill of 5 days or greater. OptumRx proposed this intervention at the March 2017 DUR Board meeting and obtained approval of this topic. OptumRx began tracking and contacting appropriate individuals regarding compliance with therapy on June 1, 2017. At the completion of this tracking period on June 1, 2018, 807 members had completed hepatitis C therapy and 129 members (13.8%) either did not begin or finish therapy (due to either abandonment of therapy or loss of insurance coverage). Fifty-three members had at least one instance of late subsequent fill of 5 days or greater (6.6%). Being unable to reach members to schedule refills is the most common reason for late refills. Of the 807 members that completed therapy, OptumRx received 465 (57.6%) SVR responses from prescribers. SVR was achieved in 355 members (76.3%) after completion of therapy, while 110 (23.7%) did not achieve SVR. Since the completion of this retroDUR, fibrosis requirements have been removed from the prior authorization criteria. OptumRx proposed a follow-up retroDUR 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. This retroDUR will send letters to prescribers requesting SVRs 12 weeks after completion of hepatitis C DAA therapy. Further data will be provided at the one-year follow-up in the FFY2022 report (one year of claims + time for completion of therapy + time to receive mailed letters). April 2021 Caring for Your Patients with Diabetes Members utilizing insulin therapy that do not appear to be receiving claims for blood glucose testing supplies per claims history will have a near real-time letter faxed to the prescriber. The goal of this program is 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 hypoglycemia. 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

State	RetroDUR Educational Outreach Summary
	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. OptumRx proposed this intervention at the March 2021 DUR Board meeting. The retroDUR intervention began processing letters on July 1, 2021. Further data will be provided at the one-year follow-up in the FFY2022 report. 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 will 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. 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 increases and as their length of opioid therapy increases. Evaluation will be made to determine if the percentage of naloxone use in opioid utilizers with 90MME or greater increases. 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. OptumRx proposed this intervention at the May 2021 DUR Board meeting. Letters began processing letters on July 1, 2021. Further data will be provided at the one-year follow-up in the FFY2022 report.
Iowa	Type of Problem, Drug Class, Number of Exceptions, and % of Problem Type (all presented in this order separated by commas) Therapeutic Duplication, Antiadrenergic Antihypertensives, 4, 0.1131% Therapeutic Duplication, Benzisoxazoles, 4, 0.3040% Therapeutic Duplication, Quinolinone Derivatives, 4, 0.3108% Therapeutic Duplication, Dibenzapines, 3, 0.1592% Therapeutic Duplication, SSRIs, 3, 0.0470% Therapeutic Duplication, Antipsychotics Misc., 2, 0.4357% Therapeutic Duplication, ADHD Agents, 2, 0.2172% Therapeutic Duplication, Non-Barbiturate Hypnotics, 2, 0.4107% Therapeutic Duplication, Anti-Inflammatory Agents Topical, 1, 0.7092% Unnecessary Drug Therapy, DPP-4 Inhibitors, 1, 0.3968%

State	RetroDUR Educational Outreach Summary
Kansas	The state is working on better methods to analyze the FFS population, which is very small and specific. For example, beneficiaries in LTC facilities. We have implemented the SUPPORT Act requirements and other DUR 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 needs is being reviewed. We are considering provider webinars as a new method for provider education and provider interaction. We will continue to work towards this goal and report an update in next year's survey. 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.
Kentucky	During FFY 2021, Kentucky performed the following RetroDUR activities: In FFY 4Q2020, Kentucky identified members with at least a 10 day gap in drug supply with one or more medications prescribed for the treatment of hypertension. Prescribers were sent letters identifying all patients who met this criteria asking them to assess whether the patient is adherent with therapy and discuss the importance of taking medications as prescribed. In FFY 1Q2021, Kentucky identified members with at least a 10 day gap in drug supply with one or more medications prescribed for the treatment of seizure disorder. Prescribers were sent letters, which included medication and medical claims history, asking the prescriber to assess whether the patient is adherent with therapy. In FFY 2Q2021, Kentucky identified members who were less than 18 years old with prescriptions for one or more antipsychotic drugs. Prescribers were sent letters with recent guidance regarding the utilization of psychotropic medications in this population and the related health care quality measures. In FFY 3Q2021, Kentucky identified members with at least 3 claims for a short-acting beta agonists in the past 90 days and without any claims for an associated controller medication. Prescribers were sent letters identifying all Kentucky FFS Medicaid members who fit that criteria asking them to consider adding a controller medication to their patients' asthma regimen.

State	RetroDUR Educational Outreach Summary
Louisiana	Summary 1. Retrospective DUR Educational Outreach. Top Ten Problems. 1. Antipsychotic agents: Concurrent use Recipient Profiles Screened: 1,030 Interventions: 1,076 2. Statin agent: Underutilization Recipient Profiles Screened: 304 Interventions: 146 3. A1C testing: Underutilization Recipient Profiles Screened: 201 Interventions: 100 4. Hypertension agent: Underutilization Recipient Profiles Screened: 176 Interventions: 92 5. Opioids & antipsychotic agents: Concurrent use Recipient Profiles Screened: 139 Interventions: 113 6. Opioids & gabapentinoids: Concurrent use Recipient Profiles Screened: 131 Interventions: 138 7. Sleep agents: Duration Recipient Profiles Screened: 131 Interventions: 117 8. Opioids & benzodiazepines/sleep agents: Concurrent use Recipient Profiles Screened: 118 Interventions: 115 9. Short-acting opioid exceeds 15 days supply Recipient Profiles Screened: 89 Interventions: 83 10. Short-acting opioid exceeds quantity limit Recipient Profiles Screened: 77 Interventions: 74

State	RetroDUR Educational Outreach Summary
Maine	Retrospective Drug Utilization Review (RetroDUR) and Educational Outreach Program FFY 2021 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, 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 2021) Description Provider Newsletter October 2020 PDL Changes Pharmacy Benefit Update Winter 2020 Provider Newsletter January 2021 PDL Update Important Billing Information for COVID Provider Newsletter- Pharmacy NPI Provider Newsletter- April 2021 PDL Update Important Billing Information for COVID-19 Vaccines- ages 12/15 Prior Authorization Criteria for Buprenorphine Provider Newsletter July 2021 PDL Update Important 3rd dose Billing Information for COVID-19 Vaccines RetroDUR Chantix Utilization and Compliance Dec 2020 RetroDUR Influenza Vaccination Rates/Compliance with CDC Guidelines Mar 2021 RetroDUR Hydroxychloroquine Use Pre and Post Covid June 2021 RetroDUR Long Acting Injectable Antipsychotics Sept 2021
Maryland	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) 2021. It 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 will prevent possible adverse drug reactions and improve patient outcomes in the targeted participant population. The following educational interventions were conducted during FFY2021: 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 product, concurrent use of a stimulant and sedative, potentially inappropriate dose of quetiapine, 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

State	RetroDUR Educational Outreach Summary
	naloxone prescription. A total of 1,810 participants were selected for intervention, and 3,467 prescriber letters were mailed. Each letter included a response form soliciting feedback from the prescriber. Responses are voluntary. A response rate of 12% was achieved. Prescribers were also asked to evaluate the usefulness of the intervention letters. Of those who responded 67% of prescribers found the letters to be either useful or extremely useful. Copies of intervention letters were also sent to each dispensing pharmacy. A total of 2,723 pharmacy letters were mailed and a response rate of 23% was achieved. Of those who responded 76% of pharmacy providers found the letters to be useful. Program Background Kepro 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 dispensing pharmacies. A copy of the participant's complete drug and diagnosis history, which also lists all medications prescribed by other providers, is included. Based on this information, prescribers have the opportunity to review the entire drug and diagnosis history and make changes to the participant's drug therapy. 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 DUR Board are selected for DUR evaluation on a quarterly basis. For FFY2021, 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 a stimulant and a sedative 7. Potentially inappropriate dose of quetiapine 8. Concurrent use of an opioid and benzodiazepine 9. Concurrent use of an opioid and antipsychotic 10. CGRP medication overutilization 11. 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

State	RetroDUR Educational Outreach Summary

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 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. Participants could be selected for additional criteria exceptions later in the year. Participants may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle.

Criteria Exception and Intervention Summary
The table below provides a summary of criteria exceptions and educational outreach letters mailed for all retrospective DUR interventions for FFY2021. 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 2021

CRITERIA DESCRIPTION	PARTICIPANTS WHO MET CRITERIA	PARTICIPANTS SELECTED FOR INTERVENTION	INTERVENTION LETTERS PRESCRIBERS	INTERVENTION LETTERS PHARMACIES
THERAPEUTIC DUPLICATION OF SEDATIVE HYNOTICS	1,149	146	235	196
OVERUTILIZATION OF TUSSIONEX	10	6	7	7
SEDATIVE USE IN ADHD	250	209	256	233
APPROPRIATE USE OF METHADONE	61	7	8	7
APPROPRIATE USE OF SEROQUEL	316	219	226	227
OVERUTILIZATION OF OPIOIDS BASED ON DAYS SUPPLY	1,192	86	205	172
OVERUTILIZATION OF OPIOIDS BASED ON DOSE PER DAY		11	5	5	5
CONCURRENT USE OF AN OPIOID AND BENZODIAZEPINE		150	116	241	167
LONG-TERM THERAPY WITH SHORT-ACTING OPIOIDS IN ABSENCE OF LONG-ACTING AGENT		157	60	82	75

State	RetroDUR Educational Outreach Summary
	BUPRENORPHINE/NALOXONE CONTAINING PRODUCTS FOR OPIOID ABUSE/DEPENDENCE AND ANOTHER OPIOID 1,688 174 213 213 LACK OF CURRENT NALOXONE PRESCRIPTION IN A PATIENT WITH OPIOIDS AND A DIAGNOSIS OF SUBSTANCE ABUSE OR DEPENDANCE 67 47 52 48 LACK OF CURRENT NALOXONE PRESCRIPTION IN A PATIENT WITH OPIOIDS AND A DIAGNOSIS OF MEDICATION-RELATED POISONING 4 3 4 4 OPIOID AND A HISTORY OF SUBSTANCE USE DISORDER 412 144 204 191 CONCURRENT USE OF AN OPIOID AND MEDIUM-HIGH DOSE GABAPENTIN 700 222 881 581 CONCURRENT USE OF GABAPENTIN AND PREGABALIN 711 251 611 435 CONCURRENT USE OF AN OPIOID AND ANTIPSYCHOTIC 150 113 234 160 CONCURRENT USE OF OPIOID, CARISPRODOL, AND BENZODIAZEPINE 2 2 3 2 TOTALS 7,030 1810 3467 2723 1. Not all participants are selected for intervention. Selection is based on review by a Clinical Pharmacist. 2. Letters mailed are noted in this table. Copies of intervention letters are also mailed to the dispensing pharmacy. Some letters cannot be mailed due to inaccurate/missing address information. Participants may also use multiple prescribers 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 also provides space for handwritten comments. The form also includes an evaluation question asking providers to indicate if the letter was useful. 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. Information presented to the DUR Board is reported anonymously. Results Provider Responses to Intervention Letters A total of 3,467 DUR educational intervention letters were mailed to prescribers, and 431 responses were received for a response rate of 12.4%. A summary of all coded responses from prescribers is listed in the table: Prescriber Response Number of Responses BENEFITS OUTWEIGH THE RISKS 52 MD UNAWARE OF WHAT OTHER MD PRESCRIBING 1 PATIENT HAS DIAGNOSIS THAT SUPPORTS TX 13 PT NO LONGER UNDER THIS MD CARE 47 MD WILL REASSESS AND MODIFY DRUG THERAPY 25 PATIENT NEVER UNDER MD CARE 11 PT NOT SEEN RECENTLY 15 HAS APPT TO DISCUSS THERAPY 62

State	RetroDUR Educational Outreach Summary
	MD DID NOT RX DRUG ATTRIBUTED TO HIM 81 TRIED TO MODIFY THERAPY,SX RECURRED 23 MD DISCONTINUED MEDS 83 PT NO LONGER USES PHARM/OR SEES MD 2 MD TRIED TO MODIFY THERAPY, PT NON-COOP 11 MD SAW PATIENT ONCE IN ER/ON-CALL MD 1 PATIENT DECEASED 4 TOTAL 431
Massachusetts	CMS Report FFY 2021 Summary 1 Report Date: 5/6/2022 Retrospective Educational Outreach Summary Top 10 Problems By Number of Exceptions, With Number of Interventions NCPDP Reject Code 75, Prior Authorization Required Date Range: 10/1/20 - 9/30/21 Problem Number of Exceptions Letters Sent Calls To Prescriber Drug requires prior authorization 493,511 69,552 5,016 Pediatric behavioral health initiative 131,474 12,803 1,954 Prior authorization required for quantity over limit 36,301 5,181 253 Age restriction 34,358 7,075 351 Polypharmacy/duplicate therapy 24,625 2,495 267 Brand name requires prior authorization 5,322 1,616 40 Polypharmacy restriction for drug that requires prior authorization 5,142 209 6 High dose 4,135 1,599 304 Quantity limit exceeded for drug that requires prior authorization 2,968 652 38 Inappropriate dose 2,453 105 3

State	RetroDUR Educational Outreach Summary
Michigan	RetroDUR letters and prescriber visits were performed on five algorithms involving 1,841 distinct prescribers and 2,437 distinct members. Below is a summary of each. 1. Pediatric Behavioral Health (BH) Polypharmacy- 5 or More Medications 364 prescribers; 411 members Observed a 11.4% reduction in utilization of BH medications At six months post initial identification of members, observed a 13% reduction in utilization of benzodiazepines and a 10% reduction in utilization of stimulants 13% reduction in BH medication spend where the PEMPM pharmacy spend decreased from $572.90 to $498.61 At six months post initial identification of members, 62% of the gaps in care were closed (253 members) 2. Pediatric Antipsychotic Polypharmacy 784 prescribers; 779 members Observed a 14% reduction in utilization of atypical antipsychotics 10% reduction in atypical antipsychotic spend where the PEMPM pharmacy spend decreased from $325.06 to $291.95 3. Dose optimization Fluoxetine 20 mg 2/day 1,007 prescribers; 935 members Observed a 29% reduction in utilization of fluoxetine 20mg at 2 caps or tabs/day At six months post initial identification of members, 48% of the gaps in care were closed (452 members) 22% reduction in fluoxetine 20 mg at 2 caps or tabs/day spend where the PEMPM pharmacy spend decreased from $17.57 to $13.73 4. Doctor/Pharmacy Shopping (3 or more) 384 prescribers; 220 members Observed a 38% reduction in the number of prescribers per member Observed a 44% reduction in the number of pharmacies per member Observed a 22% decrease in PEMPM pharmacy spend for target medications, from $23.49 to $18.40 5. High Morphine Milligram Equivalents (>=90) 148 prescribers; 95 members Observed a 21% reduction in utilization of opioids Observed a22% reduction in average daily MME per member, which decreased from 112 to 87 Observed a 28% reduction in PEMPM pharmacy spend for target medications, from $70.28 to $50.71 At six months post initial identification of members, 56% of the gaps in care were closed (53 members) 6. High Morphine Milligram Equivalents (>=90) with Concomitant Benzodiazepine Use 67 prescribers; 33 members Observed a 16% reduction in utilization of opioids, where the PEMPM clam count decreased from 1.7 to 1.4 12.2% reduction in average daily MME per member, which decreased from 93 to 82 At six months post initial identification of members, 67% of the gaps in care were closed (22 members)

State	RetroDUR Educational Outreach Summary
Minnesota	The top ten is based on the largest number of exceptions. The order below is the intervention group, problem type, criteria description, total #exceptions, #cases reviewed, special mailing Y/N, #prescriber letters, #pre recipients, #adjusted post recipients, #exceptions post, % outcome improved. 1. Psychotropic drugs in Youth,TD,Polypsychopharmacy 3 or more psychotropic drugs,1988,548,N,462,367,344,189,45% 2. Psychotropic drugs in Youth,TA,SGA Monitoring of blood glucose levels,1798,0,Y,444,1798,1698,888,48% 3. Overuse of PPIs,TA,Long Term with no indication,1311,0,Y,1201,1311,919,559,39% 4. Psychotropic drugs in Youth,TA,SGA Monitoring of lipid levels,1113,0,Y,361,1113,970,463,52% 5. Respiratory Management,TA,SABA inhaler w/o SAMA in COPD,824,0,Y,751,824,620,371,40% 6. Respiratory Management,LR,Underutilization of ICS in Patients with Asthma,520,0,Y,544,520,420,123,71% 7. Diabetes Management,TA,Underutilization - Hyperlipidemia Guideline/Treatment,511,90,N,99,79,66,0,100% 8. Gabapentinoids,DD/MC,Respiratory Depression Risk ,444,383,N,704,314,251,154,39% 9. Psychotropic drugs in Youth,TD,Polypsychopharmacy 2 or more SGA drugs ,421,104,N,20,19,16,5,69% 10. Diabetes Management,TA,Underutilization - Hypertensive Guideline/Treatment,479,390,N,302,189,169,69,59%

State	RetroDUR Educational Outreach Summary
Mississippi	RetroDUR Educational Outreach Summary During FFY2021, 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: 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 316,824 prescription claims were analyzed during FFY 2021. In FFY 2021, 109 mailings were sent to providers and pharmacies addressing 111 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 152,623 prescription claims were analyzed during FFY 2021. In FFY 2021, 269 mailings were sent to providers addressing 319 beneficiaries. 3: Proton Pump Inhibitors - Best Practice Prescribing Objective: To educate providers on the growing evidence linking long-term PPI use with several negative health-related consequences and alert them to prescribing recommendations from the DUR Board. This article not only contained details about the new prescribing recommendations but also included strategies for transitioning patients off of long-term PPIs.

State	RetroDUR Educational Outreach Summary
Missouri	POPULATION-BASED INTERVENTION SUMMARY Conduent completed three population-based interventions in the FFY 2021. Table 1 includes a summary of the outcomes reports for the Influenza Intervention, Post-Traumatic Stress Disorder Intervention, and Glucagon Intervention. Influenza Intervention Overall, there was a 21.2% reduction in the clinical indicators for the Influenza intervention (e.g., increase risk of ADE) over the six-month intervention period. Additionally, there was an increase in targeted drug costs of $22,178.18 for the six-month period. The total annualized increase in costs would be expected to be $44,356.36. Post Traumatic Stress Disorder Intervention Overall, there was a 21.7% reduction in the clinical indicators for the Naloxone intervention (e.g., increased risk of ADE) over the six-month period. Additionally, there was a decrease in targeted drug costs of $83,108.63 for the six-month period. The total annualized decrease in costs would be expected to be $166,217.26. Glucagon Intervention Overall, there was a 23.2% reduction in the clinical indicators for the Glucagon intervention (e.g., increased risk of ADE) over the six-month period. Additionally, there was an increase in targeted drug costs of $17,112.03 for the six-month period. The total annualized increase in costs would be expected to be $34,224.06
Montana	RDUR Intervention Letters and Education Provided for the following: Clinical appropriateness Clinical-general Drug-Disease Contraindication Drug-Drug Interaction Duplicate Therapy Naloxone Overutilization Poisoning/Naloxone Support Act (AP<18) Support Act (AP/Opioids) Support Act (Opioids/BZD) Therapeutic Appropriateness Therapeutic Duplication Tramadol/Codeine/Hydro<18y/o A more in depth overview of select interventions is described below. ATYPICAL ANTIPSYCHOTICS FOR CHILDREN UNDER 8 YEARS OLD:

State	RetroDUR Educational Outreach Summary
	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. -130 clinical reviews were performed on 89 individual children --42 PA requests were received for new start atypical antipsychotic medications for children under 8 years of age. ---Baseline metabolic labs were obtained in 38 of the requests ---3 prescriptions were withdrawn after discussion with provider ---2 providers changed medication after discussion with case management staff. FOSTER CARE PSYCHOTROPICS: 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 to18 years of age. The reviews utilize the following criteria, (*indicates criteria which prompts further review/intervention): 1 or more Antipsychotic* 2 or more Atypical Antipsychotics* 3 or more Psychotropic Medications* Less than 8 Years of Age on an Atypical Antipsychotic* Greater than 1 ADHD Treatment* No Well Child Check Within 365 Days* 2 or more Prescribers of Psychotropic Medications* Diagnosis/Indication FDA Approved Dosing Medication Compliance Lowest Effective Dose Appropriate Lab Monitoring Drug-Drug Interactions Medication misuse/abuse Polypharmacy Multiple Pharmacies/Physicians -460 clinical reviews were performed on 251 individual children. -Some of the interventions are still pending response. Of the completed data at the time of review, 198 individual children were reviewed, requiring 139 interventions. --28% (55/198) of the children who were taking a medication that required metabolic monitoring did not have current metabolic syndrome lab monitoring in claims databases. ---After CM intervention, 71% (39/55) of the children obtained metabolic labs or drug discontinuation. This testing may lead to decreased long term risks (i.e., diabetes, heart disease, obesity and joint problems) associated with these medications. --19% (37/198) of the children did not have any current psychotherapy claims in databases upon review. ---65% (24/37) began psychotherapy after working with individual providers. One provider indicated that therapy was not appropriate for member. -69% (96/139) provider response rate

State	RetroDUR Educational Outreach Summary
	FRAUD/WASTE/ABUSE: Members or providers identified by either a pharmacy or Mountain-Pacific staff that may be engaging in activity resulting in unnecessary cost. -52 patients were reviewed by case management for potential abuse or misuse of medications. Prescribers were reviewed in the case of higher than usual prescribing, however if they did not demonstrate problems in multiple patients they were not referred. 5 prescribers and 1 pharmacy were reviewed. --14 members and prescribers were referred to the Department for Fraud or Abuse ---6 members were referred for Fraud ---7 members and 1 prescriber were referred for Abuse ---1 pharmacy was reported to the Pharmacy Program Officer for sending Sublocade without a refill request from provider MOVEMENT DISORDER: Using DUR Board approved protocols, our CM team evaluates diagnosis and patient need to initiate therapy. This utilization effort supports appropriate use and reduces costs in situations where the medication is not indicated or does not provide a benefit for a patient. -71 clinical reviews were performed on 43 individual members --Initial requests: 50% denial rate after extensive clinical review. HEART FAILURE WITH REDUCED EJECTION FRACTION ACADEMIC DETAILING: Evidence-based prescribing guidelines were shared with providers regarding the American College of Cardiology (ACC) update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment. The purpose was to provide guidance in managing patients with chronic HFrEF. -CM interventions addressed any of the following: Guideline-Directed Medical Therapy (GDMT), Target doses, Compliance, Duplicate therapy, Medications exacerbating HF --34 individual members reviewed for potential clinical intervention --16 individual members required Case Management intervention (academic detailing sheet, provider letter, and prescription fill history all mailed to provider) ---56% of the case managed members received changes to therapy in response to the intervention recommended by Case Management. HEPATITIS C TREATMENT: Since 2/3/20, all Hepatitis C prior authorizations have been reviewed by PA staff. All non-preferred, re-treatment, or decompensated cirrhosis cases of Hepatitis C, however, are referred to CM for review. Many of these patients are complicated in that they have had treatment failures, been re-infected, or have other co-morbidities that need to be considered when selecting the appropriate treatment plan. -64 clinical reviews were performed on 51 individual members --18% denial rate --of the 82% of requests that were approved, CM recommended a more cost-effective treatment 19% of the time.

State	RetroDUR Educational Outreach Summary
	REDUCTION IN CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING: Evidence-based prescribing guidelines were shared with providers (often multiple) who have prescribed this combination and education provided regarding risks. DRUG NOT COVERED: Provider driven agreements between a specific prescriber and Montana Medicaid to restrict coverage for a specific drug or class of drug for a specific member. This is based on said member's documented history of misuse, and need to be followed more closely than the general population. -7 patients were updated to new contracted providers -1 new patient was placed on DRUG NOT COVERED for gabapentin -1 new patient was placed on DRUG NOT COVERED for opioids MEDICATION ASSISTED TREATMENT/OPIOID USE DISORDER: Education and outreach involving review and discussion of complex medication management of buprenorphine-containing products and Vivitrol. This is done in collaboration with Prior Authorization staff and involves care planning for additional medications like benzodiazepines, and tramadol. The case management pharmacist discusses criteria, best practice, options for treatment covered in the program and treatment plans. Combining our CM efforts with the prior authorization of both agents, we have been able to decrease the number of concomitant opioids, benzodiazepines, and tramadol medication use in Medicaid members receiving MAT therapy. This has also diminished the risk of overdose in this population by restricting their access to other opioid medications while receiving MAT therapy. Medication Assisted Treatment Provider outreach involved: -123 interventions with MAT providers aimed at addressing complex medication authorization requests. -Contact came from CM outreach to providers, providers contacting CM directly or referrals from the PA unit. TEAM CARE: Referrals to this program provide better care management to patients using multiple health care resources including multiple providers and pharmacies. Potential referrals are identified through claims history as well as provider concerns/complaints. A clinical pharmacist does a thorough review of claims history to identify members who would benefit from the program; the goal being to provide better patient experiences and health outcomes by reducing fragmented care and also lower cost. -112 patients were reviewed, but no intervention was required as they were already in team care, were not appropriate candidates for team care, or had lost eligibility -53 clinical interventions were performed on members filling prescriptions at multiple pharmacies and/or with multiple prescribers. --15 were evaluated, but did not meet criteria for team care or clinical judgement determined they would not benefit from team care --38 resulted in a referral to the Department for Team Care Lock-in ---Of these, 8 patients were not locked in by the Department. These patients are listed in reserve, reviewed again, and re-referred later if they meet criteria.

State	RetroDUR Educational Outreach Summary
	---Of the 30 patients admitted to Team Care, benefit is shown by the following changes in pharmacies and medical provider visits after the restriction was put in place. ----50% reduction in the average number of total prescribers ----76% reduction in the average number of total pharmacies REDUCTION IN CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING: -Evidence-based prescribing guidelines were shared with providers (often multiple) who have prescribed this combination and education provided regarding risks.
Nebraska	This past year the 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 on going. The SUPPORT Act criteria is in place and the PDMP for Nebraska is working with Nebraska Medicaid to implement reports and the monitoring parameters. The HIE portion of the PDMP is being used to gather disease-state information and we are creating reports based upon the medications needed to treat the disease-states.
Nevada	The following information is an annualized analysis of retro-DUR activities and outcomes that were reviewed by the DUR Board and performed by OptumRx pharmacists through letter mailings of retro-DUR education materials. The top retro-DUR activities for Fiscal Year 2021 were as follows: Recipients with long term use of proton-pump inhibitors (PPI) sent March 2020. Letters were sent to 139 recipients and 121 prescribers. Of those mailed, 17 (12.23%) responses were received. Gabapentin utilization without appropriate indication sent May 2020. Letters were sent to 94 recipients and 85 prescribers. Of those mailed, 12 (12.77%) responses were received.

State	RetroDUR Educational Outreach Summary
New Hampshire	Letters were mailed on twelve algorithms involving 415 distinct prescribers and 332 distinct members. Below is a summary of each. 1. Proton Pump Inhibitor duplication with H2 Receptor Antagonist a. 21 prescribers; 12 members b. 1% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 2. Short-Acting Beta Agonist_ 2 or more in 90 days without a controller medication a. 5 prescribers; 5 members b. No response 3. Diabetic patients without an ACEI or ARB in history a. 17 prescribers; 15 members b. 11.76% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 4. Polypharmacy a. 30 prescribers; 13 members b. No response 5. Atypical antipsychotics without metabolic testing a. 66 prescribers; 58 members b. 4.55% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 6. Benzodiazepines; increased FDA warnings for abuse and misuse a. 46 prescribers; 35 members b. 2.17% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 7. Medications that increase the risk of falls in the elderly a. 25 prescribers; 18 members b. 8% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 8. Non-adherence to antidepressants a. 8 prescribers; 8 members b. No response 9. FDA Alert: Antiepileptic drugs and the increased risk of suicidal thoughts and behaviors a. 132 prescribers; 112 members b. 3.03% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary 10. Diabetes medication claims and no claims for Blood Glucose Monitoring supplies a. 47 prescribers; 39 members b. No response 11. Concomitant use of opioids and benzodiazepines a. 6 prescribers; 5 members b. No response 12. Use of antipsychotics in children < 18 without metabolic testing a. 12 prescribers; 12 members b. 8.33% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary

State	RetroDUR Educational Outreach Summary
New Jersey	1. Retrospective Compliance of HIV drugs - Goal is to improve adherence to HIV drug treatment. During this reporting period, a monthly average of 9 profiles were reviewed, for a total of 107 profiles. 2. Retrospective Compliance of Oral Diabetes Medications - Goal is to improve adherence to oral hypoglycemic medications. During this reporting period, a monthly average of 34 profiles were reviewed, for a total of 408 profiles, and 1 retroDUR letter was sent to the prescriber. 3. Retrospective Review of claims exceeding claim payment >$4000 - FFS and Encounter claims were reviewed for appropriateness, clinical drug related issues, and correct billing. 8 claims required intervention yielding a cost-savings of $97,915. 4. Retrospective Review of Opioid/Benzodiazepine and Opioid/Antipsychotic utilization - Goal is to notify prescribers of drug-drug interactions involving the concurrent use of opioids with benzodiazepines, sedatives, hypnotics, and/or antipsychotics. During this reporting period, a monthly average of 11 profiles were reviewed, for a total of 137 profiles, and 29 retroDUR letters were sent to prescribers.
New Mexico	Intervention Date of Intervention Recipients Targeted Pharmacies Targeted Physicians Targeted Opioid 90 MME Prescribing Limit #1 02/13/2020 27 N/A 28 Opioid 90 MME Prescribing Limit #2 04/17/2020 10 N/A 11 Monitoring of Second Generation Antipsychotics in Youth Patients 07/01/2020 26 N/A 29 Receiving Opioids and Gabapentinoids Concurrently 09/24/2020 147 N/A 230 Influenza Vaccination 2020-2021 Newsletter 12/14/2020 N/A 320 N/A Patients Receiving Opioids and Benzodiazepines and/or Antipsychotics Concurrently 23 N/A 34 Treatment with Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) 05/14/2021 30 N/A 40
New York	Drug to Drug Interaction - Concurrent gabapentinoids & CNS depressants: 567 members selected for intervention; 1,252 intervention letters mailed; 32 responses. Therapeutic Appropriateness -Chronic use of proton pump inhibitors: 556 members selected for intervention; 694 intervention letters mailed; 22 responses. Drug to Drug Interaction - Concurrent opioids & gabapentin (>900mg/day): 231 members selected for intervention; 481 intervention letters mailed; 17 responses. Drug to Diagnosis - Antipsychotic use in convulsive disorders: 160 members selected for intervention; 361 intervention letters mailed; 11 responses. Therapeutic Appropriateness -Multi-class polypsychopharmacy: 162 members selected for intervention; 311 intervention letters mailed; 10 responses. Drug to Drug Interaction - Concurrent opioids & benzodiazepines SUPPORT Act: 142 members selected for intervention; 307 intervention letters mailed; 9 responses. Therapeutic Duplication - Duplicate therapy of atypical antipsychotics: 159 members selected for intervention; 265 intervention letters mailed; 14 responses. Therapeutic Appropriateness - Immediate-release opioids for pain management: 170 members selected for intervention; 263 intervention letters mailed; 11 responses. Drug to Drug Interaction - Concurrent opioids & antipsychotics SUPPORT Act: 116 members selected for intervention; 253 intervention letters mailed; 1 response. Therapeutic Appropriateness - Cholesterol guidelines in diabetic patients age 40-75: 157 members selected for intervention; 236 intervention letters mailed; 7 responses.

State	RetroDUR Educational Outreach Summary
North Carolina	During October 2020 through September 2021, the North Carolina Medicaid Drug Utilization Review (DUR) Board reviewed several therapeutics areas including benzodiazepines, stimulants, opioids, antipsychotics, blood glucose monitoring, naloxone, oral oncology agents, and z-drugs. Educational outreach primarily consisted of educational letters to prescribers and pharmacies identifying their patients impacted. Educational outreach was also provided by pharmacy newsletters that are auto-generated and electronically mailed to subscribers; the newsletter is also posted on North Carolina Medicaid's website. The most prominent areas addressed were related to benzodiazepine, naloxone, and opioids. The North Carolina Medicaid DUR Board reviewed characteristics of benzodiazepine use throughout the year including 2-year prescribing trends, chronic use, concurrent use with stimulants, and concurrent use with z-drugs. Two year prescribing trends in all patients and patients with a >= 7 days' supply were reviewed by the Board. Overall, the prescribing trend was flat with an average of 20K beneficiaries using the medicine. The North Carolina DUR Board also examined chronic use of benzodiazepines, 60-day supply within 90 days and 90-day supply within 180 days, in the adult and pediatric populations. Data showed that on average 55% of adults and 12% of pediatrics were chronic users. The Board reviewed the percent of beneficiaries who have a schizophrenic diagnosis and found the incidence to be low (9% of adults and 4% pediatrics). The concurrent use of benzodiazepines and stimulants were examined. Approximately 4K patients had claims for both. Of those patients, 54% of adults and 17% of pediatrics were chronic users. Data showed that most patients received their medications from 1 prescriber. The 2-year prescribing trend for concurrent prescribing of benzodiazepines and z-drugs was reviewed. The average number of benzodiazepine/z-drug concurrent users over 2 years was approximately 1,300. Use decreased approximately 7% over the 2 years. Most patients received their prescription from 1 prescriber. North Carolina reviewed opioid utilization throughout 2020 and 2021 including general use, concurrent use with antipsychotics, duplication of therapy, and morphine milligram equivalents (MME). Each quarter the Board reviewed the concurrent (>= 1 day overlap) use of opioids and antipsychotics by month. On average, there were 36K patients who were concurrent users and the trend has remained flat. The North Carolina DUR Board observed a decrease (~28%) in the number of patients receiving opioid claims with MME > 90 daily and a decrease (~20%) in the number of prescribers writing for high-dose opioid prescriptions. Patients diagnosed with cancer or sickle cell disease were excluded. Patients with rheumatoid arthritis, osteoarthritis of the hip or spine, ankylosing spondylitis, and psoriatic arthritis using high dose opioid prescriptions also decreased. The top 25 prescribers of high dose opioid prescriptions were reviewed along with their specialties. Additionally, the Board reviewed top opioids prescribed. Duplication of short-acting opioid therapy trends were monitored over several quarters and the Board observed a downward trend. For example, when comparing 2Q2016 to 1Q2021 the number of short acting opioid users decreased from 11,818 patients to 2,729 patients. Furthermore, North Carolina reviewed MME trends in beneficiaries. Data omitted cancer patients and reviewed data with and without sickle cell disease. Data showed claims >90 MME daily have decreased approximately 40% over the 2 years examined. The Board also reviewed prescribers who were top prescribers of high dose opioid claims. The state continues to monitor. Using the North Carolina State Health Director's Standing Order for Naloxone Protocol for the Dispensing Pharmacist, North Carolina Medicaid claims were examined for patients who may be at risk for an opioid related adverse event and who may benefit from having naloxone on hand. Data showed that approximately 8% of opioid users received a naloxone prescription within the last year. The protocol identifies the following as an increased risk for opioid related

State	RetroDUR Educational Outreach Summary
	adverse events: history of opioid abuse, intoxication, overdose, or poisoning; > 50 MME daily; diagnosis of alcohol use; diagnosis of smoking or respiratory diagnosis; diagnosis of renal dysfunction, cardiac disease, or HIV; or enrollment in the North Carolina Medicaid Lock-In Program. The number of patients meeting those qualifications and their receipt of naloxone were reviewed by the Board. The Board reviewed 2-year naloxone and opioid prescribing trends. For patients who received opioids the distribution of a naloxone prescription in the previous 12 months was reviewed. On average the number of patients who received an opioid prescription during the time examined decreased 11%. The average number of patients receiving a naloxone prescription was 545 and represented a 36% increase in 2 years. The number of patients on opioids who received a naloxone prescription in the 12 months prior averaged ~3K which was 8 to 11% of the overall opioid population. Naloxone refill statistics were reviewed, and data showed over 90% of patients who filled the mediation received 1 prescription within 12 months. Pharmacies dispensing a higher percentage of opioids and a lower percentage of naloxone were lettered and reminded of the state's Standing Order for naloxone. Additionally, a newsletter article was published reminding pharmacy providers of the importance of using the standing orders for beneficiaries who meet the criteria. Non-compliance to oral oncology products and diabetic testing supplies was reviewed. The Board reviewed 12 months of data for oral oncology. Data showed there was ~4K patients who received a prescription. Of those patients, data indicated approximately 16% of patients were potentially non-compliant to their oral oncology medication. Non-compliance to diabetic testing was analyzed using 12 months of information and categorized by route of administration. Data showed that 24%, 37%, and 40%, of patients were non-compliant to their oral, injectable, and inhaled medications, respectively, and that the overall non-compliance rate was 28%.

State	RetroDUR Educational Outreach Summary
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: Concurrent Use of an ACE-I with a NSAID in Patients with Renal Impairment Drug/Disease Interaction (188, 139, 173, 10.98%, 145, 29.66%) 2: NSAID Use with an ACE-I - Therapeutic Appropriateness (175, 30, 40, 7.50%, 32, 40.63%) 3: Support Act Criteria - Therapeutic Appropriateness (169, 106, 156, 21.79%, 112, 31.25%) 4: Use of Stimulants in Patients With Hypertension - Drug/Disease Interaction (163, 110, 182, 10.99%, 118, 26.27%) 5: BBW for Benzodiazepines in Patients with h/o Substance Abuse/Use Disorders - Therapeutic Appropriateness (100, 15, 14, 57.14%, 15, 13.33%) 6: BBW for Using Benzodiazepines in Patients for Chronic Therapy - Therapeutic Appropriateness (100, 58, 57, 28.07%, 60, 23.33%) 7: Use of Tizanidine With Other Alpha2-Adrenergic Agonists/Antihypertensive Therapy - Drug/Drug Conflicts (94, 14, 21, 4.76%, 14, 28.57%) 8: Overutilization of Sedative Agents in Patients With Depression - Therapeutic Appropriateness (93, 45, 44, 13.64%, 45, 28.89%) 9: ACE-I May Cause a Persistent, Non-Productive Cough - Drug Side Effects (83, 9, 11, 9.09%, 9, 11.11%) 10: Additive CNS Effects From Coadministration of Oxycodone-Containing Products and Benzodiazepines - Drug/Drug Conflicts (78, 32, 55, 20%, 35, 31.43%)
Ohio	MAT + Opioid/Benzodiazepine Outreach Every month, outreach is made to each prescriber whose patients are taking MAT in combination with an opioid and/or a benzodiazepine. The outreach is made to determine if the prescriber has knowledge of the medication combination and to ensure that Ohio Automated RX Reporting System (OARRS), Ohio's Prescription Drug Monitoring Program (PDMP), is utilized. An outreach is also made to each pharmacy to determine if they contacted the prescriber and checked OARRS before dispensing these medications. Concurrent use of Multiple Antipsychotics In October 2020, a RetroDUR intervention was performed. The purpose of this intervention was to inform prescribers that their patients were taking multiple antipsychotics. One hundred thirty-two members were identified for this intervention. The goal of this intervention was to ask prescribers to consider previous use of a maximum tolerable dose of an atypical antipsychotic, ensuring that continuation of symptoms is not due to non-adherence to monotherapy, a trial of three or more monotherapy antipsychotics prior to prescribing multiple agents, cross-titrating antipsychotic medications to work toward monotherapy, or a plan to taper to monotherapy. One hundred thirty-two members were identified for this intervention. HIV Adherence In December 2020, a RetroDUR intervention letter was sent to prescribers whose patients were not filling HIV medication prescriptions at a rate sufficient to ensure adherence, defined as Proportion of Days Covered (PDC) less than 95%. Forty-one members were identified for this intervention. The goal of this intervention was to remind prescribers that

State	RetroDUR Educational Outreach Summary
	strict adherence to antiretroviral therapy is key to sustained viral load suppression and that their patients might not be taking their HIV medication as prescribed. Proton Pump Inhibitor (PPI) Deprescribing In January 2021, a RetroDUR educational mailing was performed for prescribers whose patients were taking PPIs for greater than six months. Seven-hundred thirty members were identified for this intervention. The goal was to remind prescribers that while long term PPI therapy is appropriate in certain conditions, it is necessary to re-evaluate the need for continuation of therapy due to increased risk of fractures, hypomagnesemia, C. diff, and vitamin B12 deficiency. Opioids Greater than 80 Morphine Equivalent Doses (MED) In February 2021, a RetroDUR intervention was carried out for prescribers whose patients received opioid medications exceeding 80 MED per day. One-hundred seventy-five members were identified for this intervention. The goal was to remind prescribers that prior to increasing the opioid dosage to a daily average of 80 MED or greater, the State Medical Board of Ohio requires Ohio prescribers to complete a written pain treatment agreement with their patient and to obtain a consultation with a specialist in pain management, addiction medicine, addiction psychiatry, or the area of the body affected by the pain. Additionally, prescribers were reminded to offer a prescription for naloxone to the patient. Triple Antithrombotic Therapy (TT) In March 2021, a RetroDUR intervention was performed by mailing letters to prescribers whose patients were taking TT, defined as dual antiplatelet therapy in addition to an anticoagulant such as apixaban, rivaroxaban, or warfarin, for longer than 30 days. Fifty-one members were identified for this intervention. The goal was to remind prescribers that TT carries an elevated bleeding risk, and the risk of bleeding increases with continued use. Therefore, triple antithrombotic therapy should be limited to the shortest possible period. Correct Inhaler Technique In April 2021, a fax was sent to all Ohio Medicaid pharmacies to serve as a reminder to request that patients picking up inhaler prescriptions demonstrate their inhaler technique. The goal was to encourage pharmacists to reinforce proper inhaler technique and adherence to controller inhalers. Children Taking Opioids In May 2021, a RetroDUR mailing intervention was performed for prescribers whose patients were less than 18 years old and receiving an opioid medication. Prescribers were informed that there is an association between legitimate opioid use before high school completion and an increased risk of subsequent misuse after high school. The goal was to remind prescribers were asked to weigh the risk/benefit when prescribing opioids to children, considering the risk of future opioid misuse. Eighty-five members were identified for this intervention. High Triptan Use without Migraine Prophylaxis In June 2021, a RetroDUR intervention was performed by contacting prescribers whose patients were receiving nine or more doses of triptans per month, but not receiving any prophylactic migraine medications. The goal of the intervention was to encourage prescribers to add prophylactic therapy to reduce the frequency and/or severity of migraine attacks. Twenty-three members were identified for this intervention.

	Multiple Anticholinergics In August 2021, a RetroDUR intervention was performed for prescribers whose patients were over 60 years old and taking more than three anticholinergic medications. Prescribers were informed that the cumulative effect of taking multiple medicines with anticholinergic properties termed as anticholinergic burden can adversely impact cognition, physical function and increase the risk of mortality. The goals of this intervention were to alert prescribers if their patients were receiving additional anticholinergic medications from other prescribers, to encourage prescribers to continually weigh the risks and benefits of anticholinergic medications, and to encourage prescribing alternative, non-anticholinergic medications where clinically appropriate. One hundred forty-nine members were identified for this intervention. Opioids and Benzodiazepines In September 2021, a RetroDUR letter was mailed to prescribers whose patients were receiving opioids in combination with benzodiazepines. The goals of the intervention were to remind prescribers that adults who received prescriptions for both opioids and benzodiazepines, compared to opioids alone, are more likely to visit the emergency department or have an inpatient admission for opioid overdose, to maximize the use of non-pharmacologic treatments, to prescriber alternate medications when clinically appropriate, and to consider tapering opioids to the lowest effective dose. One-hundred thirty 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. Opioids and Benzodiazepines In December 2019, 311 members were enrolled in a RetroDUR intervention for taking an opioid together with a benzodiazepine. In December 2020, 166 of these members remained in Fee-For-Service. 131 members were either were taking fewer or no opioids or benzodiazepines (79%). Thirty-eight members were no longer taking an opioid (23%) and 42 were members no longer taking a benzodiazepine (25%). Adherence to Antiepileptic Medications In January 2020, 82 members were enrolled in a RetroDUR intervention for adherence rates (proportion of days covered) to their antiepileptic medications being < 70% based on pharmacy claims. In January 2021, 64 of these members remained in Fee-For-Service. Thirty out of the 64 members improved their adherence rate (47%). Influenza Vaccine Fax In September 2020, a fax was sent to all participating Ohio Medicaid pharmacies asking them to counsel on and offer to administer an influenza vaccine to their Ohio Medicaid patients. In February 2021, the results were reviewed. 3,220 members received an influenza vaccine between 9/1/2020 and 2/28/2021. Of those 3,220 members, 1,418 members did not receive an influenza vaccine during the previous influenza season (44%). Opioids and Gabapentin In July 2020, 118 members were enrolled in a RetroDUR intervention because they were receiving opioid medications in combination with > 2,400mg of gabapentin per day. In July 2021, 95 of these members remained in Fee-For-Service. Nineteen members were using fewer than 2,400mg of gabapentin (32%), 10 members were no longer taking gabapentin (17%), 16 members were no longer taking an opioid (27%), and 14 members were using less gabapentin and opioids (24%).

State	RetroDUR Educational Outreach Summary
	Opioids and Stimulants In September 2020, 62 members were originally enrolled in a RetroDUR intervention while receiving opioid medications in combination with a stimulant. In September 2021, 49 of these members remained in Fee-For-Service. Three members (6%) were no longer taking opioids. Three members (6%) were no longer taking stimulants. Eight members (16%) had stopped taking both opioids and stimulants. Twenty-one members (43%) had decreased either their opioid or stimulant use, but were still taking both an opioid and stimulant. In total, 35 of the 49 members who remained in Fee-For-Service (71%) had either reduced their opioid or stimulant use or stopped taking an opioid or stimulant. 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 2020: 13 members were identified for enrollment, February 2021: 27 members were identified for enrollment, May 2021: 62 members were identified for enrollment, August 2021: 30 members were identified for enrollment.
Oklahoma	RetroDUR Educational Outreach Summary: Federal Fiscal Year 2020 (10/01/2020 - 09/30/2021) Date|Medication Category|Educational Intervention Criteria|Cases Reviewed|Cases Intervened|Affected Members|Total Members|Total Claims|Minimum Cost Savings 10/2020|SP|ADMP|53,432|28,100|13,473|69,428|563,173|CO 01/2021|SP|ADMP|54,785|27,500|13,586|71,296|568,006|CO 04/2021|SP|ADMP|55,597|27,727|14,007|72,755|573,698|CO 07/2021|SP|ADMP|56,812|28,246|14,134|73,590|575,080|CO 11/2020|CMA|DM/CV|37,286|7,145|16,087|37,286|192,766|CO 02/2021|CMA|DM/CV|38,546|6,470|16,846|38,546|196,372|CO 05/2021|CMA|DM/CV|39,720|6,311|17,199|39,720|199,440|CO 08/2021|CMA|DM/CV|40,681|6,182|17,033|40,681|202,396|CO 12/2020|AP Pediatrics|ADMP|6,114|569|5,087|10,339|22,338|CO 07/2021|AP Pediatric Foster|ADMP|6,078|468|5,090|10,309|22,317|CO 02/2021|N/A|GLP-1/SGLT-2 with CV Benefit in Members with T2D and CV Risk or ASCVD|N/A|120|944|N/A|N/A|CO 12/2020|AD|Asthma|N/A|195|4,455|933|3,181|$1,587,612 ADMP: adherence/diagnosis/metabolic monitoring/polypharmacy; AP: Anti Psychotic CMA: chronic medication adherence; CO: clinical outcomes; DM/CV: diabetes/cardiovascular; N/A: not applicable; SP: SoonerPsych; T2D: Type 2 Diabetes

State	RetroDUR Educational Outreach Summary
Oregon	Change forms: Fluoxetine tabs to caps: Faxes sent-15; Rx changed w/in six months-7; cumulative pharmacy payment reduction (12 months)-$783 Venlafaxine tabs to caps: Faxes sent-541 ; Rx changed w/in six months-420; cumulative pharmacy payment reduction (12 months)-$430,753 Desvenlafaxine salt formulations: Faxes sent-132; Rx changed w/in six months-100; cumulative pharmacy payment reduction (12 months)-$135,463 Dose Consolidation: Faxes sent-47; Rx changed to recommended dose within 3 Months-23; Rx changed to alternative dose within 3 Months-20; cumulative pharmacy payment reduction (12 months)-$88,808 Expert Consultation Referral: Long Term Antipsychotic Use in Children: high-risk patients identified-29; prescribers successfully notified-29; change in Rx within 90 days-2; no change w/in 90 days-23; discontinued within 90days-3 Non-Adherence: Antipsychotics in people w/schizophrenia: Prescribers successfully notified-234; Patients with claims for the same antipsychotic within the next 90 day -123; Patients with claims for a different antipsychotic within the next 90 day-16 Safety Net: PA Denials with no subsequent PA requested or dangerous drug combinations: Combination Opioid-Sedative: Prescribers successfully notified-414; Patients with discontinuation of therapy within next 90 days-98; Patients with new prescription for naloxone within next 90 days-13; Denied Claims due to Antipsychotic Dose Consolidation: Total patients identified-193; Patients with a paid claim for the drug (based on HSN) within 14 days-127; Patients without a paid claim within 14 days-66 ICS/LABA: Denials-109; Disqualified-32; Faxes sent 4: (combination inhaler-2; SABA-2) Oncology Denials: Prescribers successfully notified-3; Patients with claims for the same drug within the next 90 days-3; Patients with claims for any oncology agent within the next 90 days-4 TCAs in Children: Total patients identified-38; Prescribers successfully notified-19; Patients with claims for a TCA w/in the next 90 days-9; Patients with claims for an alternate drug (SSRI, migraine prevention, or diabetic neuropathy) w/in the next 90 days-1

State	RetroDUR Educational Outreach Summary
Pennsylvania	The Pennsylvania Medicaid RDUR Program performs retroDUR and educational outreach through problem-focused reviews. Problem-focused reviews narrow the emphasis of review to a specific issue that has been determined to be an area where a targeted educational effort to providers may be valuable. Topics for review are selected from reviews of medical literature, emerging trends in local or national news, or suggestions by DUR Board members, as well as other avenues. Criteria are developed to identify the members who may benefit from an intervention and educational materials are disseminated to their providers. Providers are encouraged to voluntarily respond. The member profile is generated again in an appropriate amount of time (typically 6 months) to determine the impact rate of the intervention, along with any fiscal considerations. Activities of the RDUR Program were evaluated for interventions performed in the previous fiscal year (FFY21). The activities of the RDUR program resulted in a calculated cost savings of $356,416.02*, equating to a savings of 43 cents* for every $1.00 of combined federal and state dollars spent administratively on the RDUR program. During this evaluation period, 9909 educational intervention letters were mailed to prescribers regarding medication therapy. Providers are invited to voluntarily respond to RDUR Program letters. Providers returned 865 responses to these letters, resulting in an overall response rate by the providers of 8.73 percent. In these 9909 educational letters, the RDUR Program made 9,099 observations and subsequent education. The suggested change was implemented in 3,562 cases, resulting in an overall impact rate of 35.95 percent. Implementation of these therapeutic suggestions resulted in a cost savings of $356,416.02* for the 7047 patients evaluated, or a savings of $50.58* per patient.
Rhode Island	Executive Summary This report prepared for the Rhode Island Medial Assistance Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2021. 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 1,450 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 18% was achieved for the top 10 criteria and a response rate of 16% was achieved for total interventions during FFY 2021. 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. Criteria are developed by

State	RetroDUR Educational Outreach Summary
	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 2021. 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 284 289 50 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. 232 234 37 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. 163 171 36 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. 163 166 17 TA 3362 NSAIDs can increase the risk of heart attack or stroke in patients with or without heart disease or risk factors for heart disease. 125 125 13 TA 2813 Misuse of amphetamines and cardiovascular warning 103 103 43 TA 3093 Diabetic would benefit from addition of an ACE or ARB 89 100 27 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. 92 92 17 TA 541 Diabetic would benefit from addition of an ACE or ARB 87 89 11 TD 1073 Therapeutic duplication of antihistamine agents may be occurring. 57 81 13 Total Top 10 1,395 1,450 264 (18%)

State	RetroDUR Educational Outreach Summary
	Total all letters 3,657 3,885 631 (16%) Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs 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 1,450 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 264 responses were received for a response rate of 18%. A summary of all coded responses from prescribers is listed in the table below. Response Description Count BENEFITS OF THE DRUG OUTWEIGH THE RISKS 131 MD SAYS PROB INSIGNIF NO CHG THX 47 MD WILL REASSESS AND MODIFY DRUG THERAPY 38 MD TRIED TO MODIFY THERAPY, PT NON-COOP 11 PT UNDER MY CARE BUT NOT SEEN RECENTLY 16 PATIENT DECEASED 2 PATIENT WAS NEVER UNDER MD CARE 14 HAS APPT TO DISCUSS THERAPY 169 MD DID NOT RX DRUG ATTRIBUTED TO HIM. 15 AWARE OF INTERACTION, MONITORING PATIENT 85 TRIED TO MODIFY THERAPY, SYMPTOMS RECURRED 34 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD 34 I AM PROVIDING THE ICD-10 CODE ASSOCIATED WITH MEDICATION(S) BEING PRESCRIBED 35 Total of all responses 631 Results Discussion With respect to prescriber responses to all RDUR letters, a response rate of 16% 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 2021, a total of 1,450 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 18% was achieved for the top 10 criteria alerts.
South Carolina	Pull from MUSC reporting

South Dakota	OCTOBER 2020 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 115 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on November 2, 2020. The committee also reviewed and approved updated drug interaction and alert criteria. DEEP MEETING MINUTES NOVEMBER 2020 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 86 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on December 7, 2020. The committee also reviewed and approved updated drug interaction and alert criteria. The committee also conducted a targeted review of alerts including: use of gabapentoids and respiratory depression, overuse of beta-agonists possibly signaling worsening asthma, and life-threatening respiratory depression with gabapentoids. DECEMBER 2020 No patient profiles reviews were completed in December 2020. JANUARY 2021 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 114 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on February 1, 2021. The committee transitioned to a fully electronic review process during January 2021. This new system allows reviewers to access and evaluate patient profiles fully electronically. FEBRUARY 2021 This was a review of the 80 most at risk (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 108 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on March 3, 2021. The committee also conducted targeted reviews on the use of statins in patients with diabetes as well as the use of tramadol in patients with renal insufficicency. MARCH 2021 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 86 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on March 31, 2021. APRIL 2021 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 86 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on May 3, 2021. MAY 2021

State	RetroDUR Educational Outreach Summary
	This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 86 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on June 3, 2021. The committee also reviewed and approved updated drug interaction and alert criteria as well as a targeted review of co-administration of opioids and benzodiazepines. JUNE 2021 A total of 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 122 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on July 6, 2021. JULY 2021 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 137 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on August 3, 2021. AUGUST 2021 This was a general review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 115 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on September 3, 2021. The committee also reviewed and approved updated drug interaction and alert criteria as well as a targeted review of co-administration of opioids and benzodiazepines. SEPTEMBER 2021 This was a review of the 80 most at risk cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 126 providers (prescribers and pharmacies) for the cases deemed worthy of intervention and were created on October 11, 2021. The committee also completed a targeted review of statin use in patients with diabetes.

State	RetroDUR Educational Outreach Summary
Tennessee	Concurrent Use of Opioids and Benzodiazepines/Antipsychotics--A RetroDUR initiative was conducted to identify members who were concurrently receiving opioids and antipsychotics and opioids and benzodiazepines for FFY2021. Concurrent use of opioids and antipsychotics may result in an increased risk of respiratory and Central Nervous System (CNS) depression. Coordination of care for members taking both antipsychotics and opioids are recommended. Concurrent use of opioids and benzodiazepines might place patients at a greater risk for potentially fatal opioid overdose. This combination should be avoided unless the benefits outweigh the risks. Claims data for members who were concurrently receiving opioids and antipsychotics and opioids and benzodiazepines between April 2021 through September 30, 2021 were reviewed. 1,155 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 $25,496.96. Drug Age Pediatric for Behavioral Health Medications--A RetroDUR initiative was conducted to identify pediatric patients who were placed on medications not indicated for patients less than 18 years of age. The FDA has not established safety and effectiveness for these agents in this patient population; therefore, they should be avoided unless the benefits outweigh the risks. Claims data for pediatric patients who were placed on medications not indicated for patients less than 18 years of age between April 2021 through September 30, 2021 were reviewed. 8,277 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 $185,005.68. Educational Interventions FDA Safety Warning Updates for JAK Inhibitors-- DUR Board educational letters were sent to notify prescribers of a new FDA update on JAK inhibitors. The updated warnings for Janus kinase (JAK) inhibitors label included increased risks of cardiovascular events including heart attack or stroke. Additionally, Janus kinase (JAK) inhibitors are associated with an increased risk of cancer, blood clots, and death. A total of 2400 educational letters were sent to prescribers to notify them of this FDA label update.
Texas	1. Appropriate Use of Antibiotics letters were mailed on 11/17/2020 to 1,288 prescribers Outcome summary- This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in clinical indicators by 23.4%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.57 in the post-intervention period. This yielded an overall estimated decrease of $228,465.12 in intervention-related drug expenditures on an annualized basis. 2. Anticonvulsant Drug Use Evaluation (DUE) intervention letters were mailed on 01/28/2021 to 320 prescribers impacting 531 FFS recipients. Outcome Summary- This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in clinical indicators by 31.1%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $12.58 in the post-intervention period. This yielded an overall estimated decrease of $1,022,386.56 in intervention-related drug expenditures on an annualized basis.

State	RetroDUR Educational Outreach Summary
	3. Benzodiazepine Anxiolytics and Controlled Sedative Hypnotics intervention letters were mailed on 06/15/2021 to 38 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 35.3%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $1.77 in the post-intervention period. This yielded an overall estimated decrease of $38,529.36 in intervention-related drug expenditures on an annualized basis. 4. Contraceptive DUE intervention letters were mailed on 11/19/2020 to 1158 prescribers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 28.1%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $4.12 in the post-intervention period. This yielded an overall estimated decrease of $921,075.44 in intervention-related drug expenditures on an annualized basis 5. Depression Disease Management intervention letters were mailed on to 635 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 27.8%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.10 in the post-intervention period. This yielded an overall estimated decrease of $19,291.80 in intervention-related drug expenditures on an annualized basis. 6. Gabapentinoids DUE intervention letters were mailed on 10/23/2020 to 334 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 23.0%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.65 in the post-intervention period. This yielded an overall estimated decrease of $82,303.06 in intervention-related drug expenditures on an annualized basis. 7. Hyperlipidemia Disease Management intervention letters were mailed on 08/31/2021 to 1224 providers. Outcome Summery: During the intervention, targeted patients saw average reductions in clinical indicators by 27.3%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.68 in the post-intervention period. This yielded an overall estimated decrease of $133,362.12 in intervention-related drug expenditures on an annualized basis. 8. influenza Prevention intervention letters were mailed on 01/08/2020. Outcome Summery: During the intervention, targeted patients saw average reductions in clinical indicators by 41.4%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $5.23 in the post-intervention period. This yielded an overall estimated increase of $9,006.06 in intervention-related drug expenditures on an annualized basis. 9. Opioid Management intervention letters were mailed to 64 providers. During the intervention, targeted patients saw average reductions in clinical indicators by 43.1%. Outcome Summery: In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.72 in the post-intervention period. This yielded an overall estimated decrease of $5,595.84 in intervention-related drug expenditures on an annualized basis.

State	RetroDUR Educational Outreach Summary
	10. Psychotropic Drugs in Youth intervention letters were mailed on 03/18/2021 to 154 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 27.5%.. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $3.16 in the post-intervention period. This yielded an overall estimated decrease of $719,759.52 in intervention-related drug expenditures on an annualized basis.
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 Department. 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. The peer-to-peer pharmacists continued to contact the prescribers of these members for educational outreach. In Oct 2021, the number of members receiving opioids at 90 MME or greater decreased to 29. 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 2021 with significant results. From October 2019 to September 2021, the number of children under 6 years of age receiving antipsychotics was reduced from 16 children to 4 children, the number on more than one antipsychotic from 16 children to 2 children, and children on high dose antipsychotics exceeding literature recommendations from 61 to 30 children. Regarding the metabolic screening in all children receiving antipsychotics, the rate increased from 22% to 27%, with higher rates of 33% in foster kids. The peer-to-peer pharmacists sent 33 letters to providers who had pediatric members that fall in Medicaid's antipsychotic program. Beginning in May 2021, the UT Medicaid Pharmacy Team contracted with the Utah Psychotropic Oversight Program (UPOP) to ensure children served by UT Medicaid receive appropriate evidence-based mental health and medication therapy. Specifically, this 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. This collaboration with UPOP, together with the peer-to-peer antipsychotic program, focuses on educational interventions which follow the American Academy of Child and Adolescent Psychiatry's recommendations and addresses: Use other first-line available services (psychosocial counseling and safer medication alternatives) before initiating antipsychotic medication. Dosing of antipsychotic medication following the "start low and go slow" approach Careful and frequent monitoring of side effects related to antipsychotic medication use Metabolic screening, Body Mass Index (weight gain) calculation, and movement disorder assessments Use of multiple concurrent antipsychotic medications

State	RetroDUR Educational Outreach Summary
	3) Another peer-to-peer program started in July 2020 and continued through FFY 2021 monitoring ADHD stimulant medication used in children under 4 or 6 years of age for some specific ADHD stimulant medications. The intervention reduced the number of members under 4 and 6 years of age on ADHD stimulant medications in July 2020 from 7 to only 2 members in September 2021. To strengthen the ADHD stimulant policy, in April 2021, the UT Medicaid Pharmacy Team started a peer-to-peer program and implemented point-of-sale restrictions on concurrent use of the amphetamine class and the methylphenidate stimulants class for children under 18 years of age. In addition, the peer-to-peer program and restriction also restrict the use of three or more unique ADHD stimulant medications for both children and adult members. In a short period, the program demonstrated impactful results: the number of Medicaid members under 18 years of age who were receiving stimulants from both amphetamine class with methylphenidate class reduced from 19 to 0 members in September 2021 and no members received 3 or more unique stimulants in October 2021. The following education points were reviewed during outreach calls and follow-up letters with ADHD stimulant prescribers: Use of behavioral parent training behavioral management or behavioral classroom intervention as first-line treatments for children with ADHD. Literature supports the use of methylphenidate at least 4 years of age, and there is insufficient evidence for treatment for children under 4 years of age. More than 2 stimulant medications have not been discussed in literature and practice. Inappropriate use can increase the risk of adverse drug events, misuse, and abuse. Concurrent use of two different stimulant therapeutic classes is not recommended for children under 18 years of age. 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 2021. By September 2021, 329 prior authorizations enrolled in the program and the adherence rate increased from 80.9% to 90.2%. The clinical pharmacists discussed the following points during outreach with members: Counseling members on expected adverse drug events, medication directions The importance of adhering to Hepatitis C medications to "cure" hepatitis C Utilized motivational interviewing to motivate members to adhere to therapy 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, have a diagnosis of major depression, and are newly treated with antidepressant medication. The clinical pharmacists use motivational interviewing to address medication non-adherence and create a strategy for change. 828 initial and follow-up calls were made, and 58 initial call summary letters were sent from March to September 2021. The antidepressant medication adherence rate increased from 54% at baseline to 56.3% for newly treated members (acute phase) while the adherence rate remained the same, at 33%, for members who had been on antidepressant medication for more than 6 months (continuation phase).

State	RetroDUR Educational Outreach Summary
Vermont	February 16, 2021, Data presentation: Use of Chantix for Smoking Cessation Change Healthcare looked at all members who were prescribed Chantix and evaluated the duration of therapy per member. Additionally, they looked to see which members were also simultaneously prescribed a short acting nicotine replacement product (gum, lozenges, inhaler, nasal spray). They evaluated if there were any members taking either bupropion or the long[1]acting nicotine patches, which is not common practice or recommended. Note: Only the smoking deterrent formulation of bupropion (150mg SR 12H) was included in the analysis. 3,356 distinct members had at least one prescription for a smoking cessation product in SFY 2020. 73% (2,435 members) had a prescription for nicotine replacement therapy or bupropion. Only 27% (921 members) had a prescription for Chantix. Of the members receiving Chantix, 26% (237 members) also had a prescription for nicotine replacement therapy (NRT) or bupropion. Of these 237 members, 90 appeared to be using Chantix concurrently with NRT or bupropion. 147 members had a prescription for NRT or bupropion, but the dates of service did not overlap with Chantix. There were 407 distinct prescribers of Chantix, 619 prescribers of short acting NRT, and 844 prescribers of long acting NRT or bupropion. Recommendation: It is difficult to ascertain from this data the reasons why members did not complete 12-weeks of Chantix. It is possible that Chantix was ineffective, or the member could have experienced side effects. Some members could also have filled a Chantix prescription outside of the date frame for this analysis. Vermont Medicaid provides broad coverage of smoking cessation products without a co-pay, and most are available without prior authorization including nicotine patches, gum, lozenges, bupropion SR, and Chantix. This data was shared with the Tobacco Medicaid Benefit and Promotion Initiative in order to develop and coordinate outreach and education. DVHA also collaborated with the Department of Health and the Board of pharmacy to implement a protocol that expanded pharmacists' prescribing authority for smoking cessation products. https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Pharmacist-provided%20tobacco%20cessation_Pharmacy%20Communication.pdf April 6,2021 Review of Newly Developed/Revised Criteria -Cumulative Daily Maximum Morphine Milligram Equivalent (MME) Limits Any new patient will be limited to 90 MME per day, and existing patients will be limited to 120 MME per day. MME per day (applies to any combination of short and/or long acting opiates). In addition to a provider notice indicating the change, targeted provider outreach was sent to prescribers that had members exceeding the threshold along with the required safety checklist (ie PA form) to be filled out and faxed to CHC. https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Cumulative%20MME%20Limits.pdf May 11, 2021: Data presentation: Codeine Use in the Pediatric Population Prior Authorization implemented 7/30/21 for patients 12 years of age and younger. Communication sent to pharmacies and prescribers 7/15/21 A review of pharmacy dispensing data from 2019-2020 identified that codeine pain and cough medications continue to be prescribed in a small but significant percentage of patients 12 and under. As a result of this analysis, the Board recommended additional edits be placed on the use of codeine in children 12 and under https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/RetroDUR_Codeine%20Age%20Edit.pdf

State	RetroDUR Educational Outreach Summary
Virginia	Profile Cycle Month-Year (Excludes Returned Mail) | Profile/ Criteria Review Date | Criteria Description | Total Interventions (Excludes Returned Mail) | Total Members | Total Responses | Average Responses Oct-20 | Nov-20 | Diabetic Patients on Insulin without Claims for Blood Glucose Monitoring Products | 331 | 306 | 2 | 0.6% Nov-20 | Dec-20 | Nonadherence with Antihypertensive Agents | 75 | 62 | 0 | 0.0% Dec-20 | Jan-21 | Opioid Utilization and NO Naloxone Claims | 566 | 436 | 1 | 0.2% Jan-21 | Feb-21 | Diabetics Ages 40 through 75 with No Statins | 129 | 119 | 1 | 0.8% Feb-21 | Mar-21 | Atypical Antipsychotics without Metabolic Testing | 825 | 739 | 18 | 2.2% Mar-21 | Apr-21 | Anti-anxiety Benzodiazepine without an SSRI or SNRI | 139 | 117 | 3 | 2.2% Apr-21 | May-21 | Use NSAIDs Cautiously in Patients with Hypertension | 213 | 201 | 12 | 5.6% May-21 | Jun-21 | Nonadherence with Antidepressants | 123 | 104 | 2 | 1.6% Jun-21 | Jul-21 | Benzodiazepines, Increased FDA Warnings for Abuse and Misuse | 390 | 299 | 0 | 0.0% Jul-21 | Aug-21 | ACE Inhibitors & ARBs in Diabetes and Hypertension | 173 | 150 | 0 | 0.0% Aug-21 | Sep-21 | Nonadherence with Anticonvulsants | 143 | 110 | 0 | 0.0% Sep-21 | Oct-21 | Cyclobenzaprine, Duration of Therapy > 3 Weeks | 110 | 93 | 1 | 0.9%

State	RetroDUR Educational Outreach Summary
Washington	For FFY 2021 the Agency focused efforts on updates to the single Apple Health Preferred Drug List (AHPDL) used by the fee-for-service (FFS) and all five Managed Care (MCOs) pharmacy programs. The pharmacy program in collaboration with The Optimal PDL Solution (TOP$) supplemental rebate vendor reviewed utilization data (FFS claims and MCO encounters) and conducted quarterly analysis that resulted in 15 drug classes being added to the AHPDL and 25 updates to existing AHPDL drug classes. Along with the AHPDL implementation, we developed 18 drug or drug class policies during FFY 2021 (see list below). These policies are used as part of our prospective DUR prior authorization review to determine medical necessity, safety and efficacy, or less costly alternatives. The policies and drug classes were reviewed and approved by the State DUR board during the open public meetings held throughout FFY 2021. The Agency published all meeting materials and finalized AHPDLs and policies on our Pharmacy webpage and sent provider notices announcing the changes. Policies implemented or updated during FFY 2021: 1. Acute Migraine Treatment: Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist 2. Androgenic Agents - Testosterone Replacement Therapy (TRT) 3. Antihyperlipidemics - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK-9) Inhibitors 4. Antineoplastics and Adjunctive Therapies - Tyrosine Kinase Inhibitors - Oral 5. Antipsychotics - 2nd Generation: Vraylar 6. Antivirals - HIV : emtricitabine alafenamide-tenofovir (Descovy) 7. Antivirals - HIV Combinations 8. Antivirals: HIV - Cabotegravir/rilpivirine (Cabenuva) 9. Chronic GI Motility Agents 10. Cystic Fibrosis Agents (Oral) 11. Cytokine & CAM Antagonists 12. Gout Agents 13. Hormone Therapy for Gender Dysphoria 14. Medication Treatment Guidelines for Substance Use Disorders (SUDs) - Transmucosal Buprenorphine 15. Preventive Migraine Products: Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist 16. Proton Pump Inhibitors (PPI) 17. Pulmonary Hypertension (PH) Agents (Oral/Inhalation) 18. Substance Use Disorders (SUDs) - Buprenorphine extended-release injection (Sublocade)
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.

State	RetroDUR Educational Outreach Summary
	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 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

State	RetroDUR Educational Outreach Summary
	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. 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 243 feedback forms were received via fax over the course of the year. Of those 243 faxes, it was found that 93 (45%) were marked Useful, 12 (5.9%) were marked Made Changes, 89 (43%) were marked No Changes Made, 16 (7.8%) were marked No Longer a Patient, 10 (4.9%) were marked Never a Patient and 23 (11.3%) were marked Notice Not Useful. After assessing the issue with Not Useful, it was found subsequently that it is a non-compliance issue on part of the patient more than a prescriber issue. 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

State	RetroDUR Educational Outreach Summary
	Pediatric patients were reviewed by stratification of age groups. Group 1 represented those under the age of 12 years, Group 2 represented those between the ages of 12 to 14 years, and Group 3 represented those between the ages of 15 to 17 years. Overall, there is a trend towards a decrease in the use of antipsychotics in pediatric patients has been observed. In Group 3, a decline in the percentage of 15- to 17-year-olds receiving an antipsychotic use declined from 3.2% in 2020 to 1.8 percent so far in 2022. In Group 2, the percentage of 12- to 14-year-old has declined from 2.6% to 1.4% from 2020 to 2022 to date. In Group 3, those patients under the age of 12, the rate has declined from 0.6% to 0.3% from 2020 to 2022 to date. Risperidone and Aripiprazole continue to dominate the antipsychotics prescribed in pediatric patients accounting for 76% of all antipsychotic agents used. 2. COVID vaccines either not received or documented 3. Number of patients on more than 5 prescriptions and more than 10 prescriptions 4. Patients on two antiplatelets plus an anticoagulant 5. Patients who have Hepatitis C and have not received treatment 6. Total number of patients on insulin For CY 2021, 101 patients were reviewed, with 66 requiring either a letter or locked in. 55 required letters to providers and letters, and 11 were locked in. Clinical reviews= 4059 Letters sent= 3048
Wisconsin	Wisconsin Badger Care Plus, Medicaid and SeniorCare Centers for Medicare and Medicaid Services Medicaid Drug Utilization Review Annual Report Federal Fiscal Year 2021 Summary 1: Retrospective Educational Outreach Summary [SUM1-2021-WI-REOS] Prepared by Kepro June 2022 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) 2021. 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 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.

State	RetroDUR Educational Outreach Summary
	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 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 2021, Wisconsin reviewed at least one recipient in each of 468 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 2021 CRITERIA TYPE CRITERIA DESCRIPTION # OF RECIPIENTS SELECTED FOR INTERVENTION # OF LETTERS MAILED # OF PRESCRIBER RESPONSES LI OVERUTILIZATION OF CONTROLLED SUBTANCES 865 1,180 199 DD CONCURRENT GABAPENTENOID/CNS DEPRESSANT USE 185 375 39

State	RetroDUR Educational Outreach Summary

TA MULTI-CLASS POLYPSYCHOPHARMACY 58
67 9
DD CONCURRENT OPIOID/ANTIPSYCHOTIC - SUPPORT ACT 686
1,753 215
ER APPROPRIATE USE OF IMMEDIATE RELEASE OPIOIDS 52
69 19
TA SECOND GEN ANTIPSYCHOTICS METABOLIC SCREENING 95
98 13
LI OVERUTILIZATION OF CONTROLLED SUBTANCES W/ POISIONING 397
657 124
TA ANTIDEPRESSANT BEHAVIOR CHANGES IN PEDS/YOUNG ADULTS 187
262 30
DD CONCURRENT USE QUETIAPINE AND QT PROLONGING AGENTS 87
105 6
DB STIMULANTS CONTRAINDICATED IN AGITATED STATES 345
415 53
TOTAL 2,957
4,981 707
RESPONSE RATE 14%

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 4,981 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 707 responses were received for a response rate of 14%. 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 67
AB PHYSICIAN UNAWARE OF CONCURRENT USE 10
AE PATIENT IS NO LONGER UNDER THIS PHYSICIAN'S CARE 108
AF PHYSICIAN FEELS PROBLEM IS INSIGNIFICANT. NO CHANGE IN TX. 4
AG PHYSICIAN WILL REASSESS AND MODIFY DRUG THERAPY 49
AI PATIENT HAS DISCONTINUED OR WILL DISCONTINUE THE DRUG 42
AK MD DOES NOT DISCUSS DRUG THERAPY CONFLICT 0

State	RetroDUR Educational Outreach Summary
	AP PHYSICIAN TRIED TO MODIFY THERAPY; PATIENT NON-COOPERATIVE 18 AS IS MY PATIENT BUT HAVE NOT SEEN IN MOST RECENT 6 MONTHS 50 AW PATIENT DECEASED 0 BA PATIENT NEVER UNDER THIS PHYSICIAN'S CARE 35 BB PATIENT HAS APPT. TO DISCUSS DRUG THERAPY PROBLEM 207 BE MD DID NOT PRESCRIBE DRUG ATTRIBUTED TO HIM/HER 51 BG AWARE OF INTERACTION, MONITORING PATIENT 66 TOTAL RESPONSES 707 Results Discussion With respect to prescriber responses to RDUR letters, a response rate of 14% was achieved. Approximately 55% of prescribers indicated that some positive action resulted from the intervention letter. These actions include: prescriber was alerted to unknown concurrent use, patient has an appointment to discuss therapy, will reassess and modify drug therapy, therapy was discontinued, tried to modify therapy, currently monitoring patient. All standard, and most customized, intervention letters include the recipient's drug claims data within the previous 12 months and any available diagnosis data to provide as complete of a drug and diagnosis history as possible. This approach provides prescribers with the information needed to fully review and evaluate each recipient's drug history. Conclusion For FFY 2021, a total of 4,981 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 14% was achieved. In their responses, 55% 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 FFY21: Opioid abuse or dependence (87) Pediatric opioid use (15) Dyslipidemia guidelines (365) High dose montelukast (41) Concurrent opioid, stimulant and gabapentin (8) Use of NSAIDs during pregnancy (80) Concurrent opioids and sedative hypnotics (11) Delayed Antibiotic prescribing (211) Albuterol utilization (29) Xeljanz black box warning (56) Antipsychotic and opioid use (174) Narcotic use during pregnancy (16) Prescription drug monitoring program (51)

Section IV - DUR Board Activity

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

Figure 37 - State has an Approved Medication Therapy Management Program

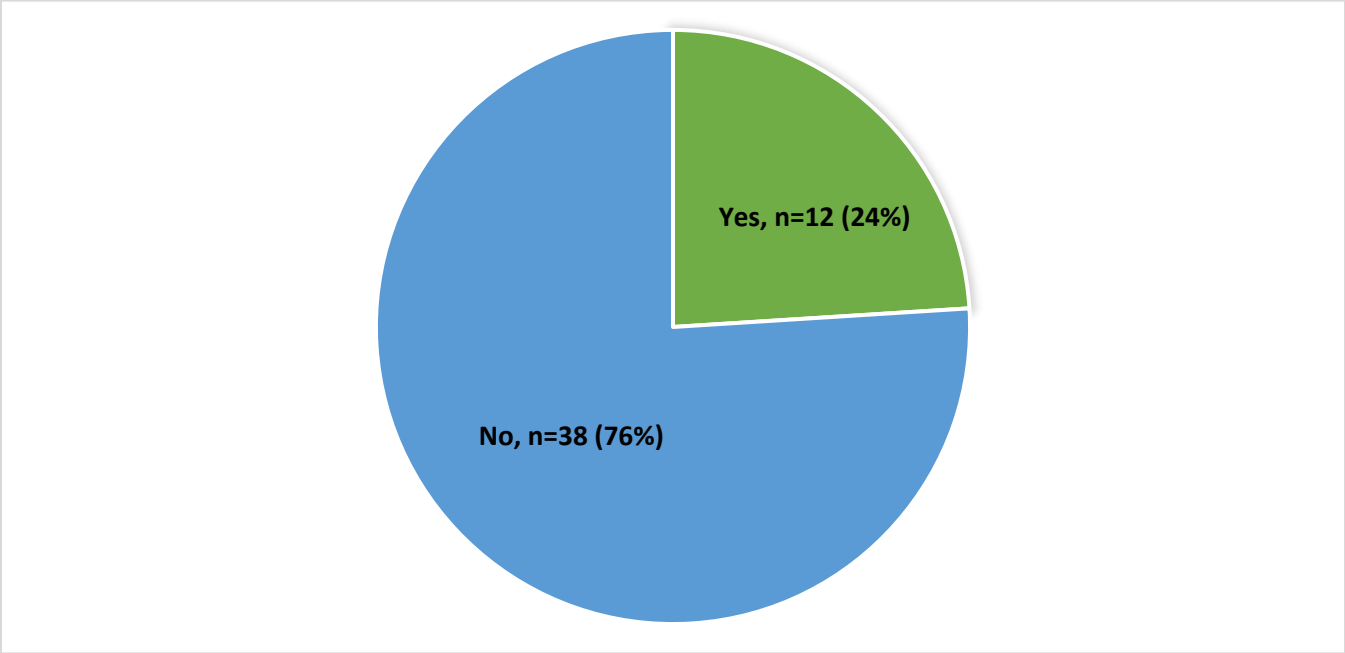

Table 57 - State has an Approved Medication Therapy Management Program

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

State	DUR Board Activities Report Summary
Alabama	The Alabama Medicaid Drug Utilization Review (DUR) Board held four meetings during fiscal year 2020. Meetings were held in October 2019 and January, April, and July of 2020. The following retrospective DUR (RDUR) therapeutic categories were added: RDUR Therapeutic Categories Added Therapeutic Appropriateness Overutilization Drug-Disease Interaction Drug-Drug Interaction High Dose Non-Adherence Therapeutic Effectiveness Therapeutic Duplication Appropriate Use There were no RDUR therapeutic categories deleted during fiscal year 2020. Retrospective DUR and Prospective DUR (ProDUR) are both utilization review techniques; however, the methods used in each type of review differ. ProDUR is an online review that assists the pharmacist in screening drugs for potential drug therapy problems before the prescription is ever delivered to the patient. Reports generated from prospective DUR can show trends and patterns to focus on during a manual review using Retro DUR techniques and provides valuable targeting for educational intervention. DUR Board policy establishes activities of the DUR Board and states that the DUR Board shall identify and develop topics of education for practitioners based on common identified drug therapy problems as needed to improve prescribing or dispensing practices. During FFY 2020, the DUR Board recommended articles for the quarterly newsletter, as well as verbiage for electronic based intervention letters to providers that contain patient specific information. Articles included information regarding the 2019 Global Initiative for Asthma (GINA) guidelines; changes to pharmacy vaccine administration billing; Summary of the 2019 American College of Cardiology/American Heart Association (ACC/AHA) guidelines; information regarding the Cumulative Daily MME limit decrease; updated treatment guidelines for attention deficit/hyperactivity disorder (ADHD); pharmacy updates related to COVID-19; updated American Gastrological Association (AGA) guidelines for the treatment of ulcerative colitis; and guidelines regarding the use of Dispense as Written (DAW) code of 9. During FFY 2020, the DUR Board reviewed palivizumab utilization and reviewed the short-acting opioid naive and MME edits that were implemented. DUR minutes can be located at the following link: http://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.3_DUR_Board.aspx
Alaska	General Information The Alaska Medicaid Drug Utilization Review (DUR) Committee was established to comply with Sec. 1927 (g) of the Social Security Act, Title 42 CFR 456 and Alaska Administrative Code 7 AAC 120.120. During FFY 2021 the committee was comprised primarily of 4 physicians and 4 pharmacists, who

State	DUR Board Activities Report Summary
	were licensed and actively practicing health care professionals in the State of Alaska. The DUR committee met four times during FFY 2021 and discussed the following retrospective and prospective criteria: November 2020 Prospective DUR Interim prior authorization 6 month review Reyvow (review of criteria) Palforzia (review of criteria) Apokyn_Kynmobi (review of criteria) Dojolvi (review of criteria) Xyrem/Xywav (review of criteria) Interleukin-5 inhibitors (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 Reviewed guidance for Makena utilization January 2021 Prospective DUR Interim prior authorization 6 month review Ofev (review of criteria) Fintepla (review of criteria) Kesimpta (review of criteria) Xcopri (review of criteria) Vascepa/ Lovaza (review of criteria) Eucrisa (review of criteria) Retrospective DUR Opioids, utilization patterns with benzodiazepines and antipsychotics, ICD-10 compliance and member MME's Reviewed potential specialty drug class classifications April 2021 Prospective DUR Interim prior authorization 6 month review Imcivree (review of criteria) Esbriet (review of criteria) Wakix (review of criteria) Mytesi (review of criteria) Evkeeza(review of criteria) Retrospective DUR Opioids, utilization patterns with benzodiazepines and antipsychotics, ICD-10 compliance and member MME's Introduced brand over generic utilization and POS messaging Antipsychotic use without metabolic screening letter sent Sept 2021 Prospective DUR Interim prior authorization 6 month review Lupkynis (review of criteria)

State	DUR Board Activities Report Summary
	Isturisa (review of criteria) Aduhelm (review of criteria) Orilissa/Oriahnn/Myfembree (review of criteria) Vancocin (review of criteria) Reviewed max units list 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 2021. 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 2021 revolved around COVID 19 and edits made to the POS system. Retrospective Drug Utilization Review (RetroDUR) The DUR Committee conducted retrospective reviews during FFY 2021. 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 2021 can be found on the State Medicaid website.
Arkansas	ARKANSAS MEDICAID DUR BOARD ACTIVITIES SUMMARY FFY2021 The Arkansas Medicaid DUR Board meets quarterly (January, April, July, and October) on the 3rd Wednesday of the meeting month. The Arkansas Medicaid Drug Review Committee (DRC) meets quarterly (February, May, August, and November) on the 2nd Wednesday of the meeting month to

State	DUR Board Activities Report Summary
	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 5 non-voting members which includes 3 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 3 non-voting members which represent each MCO. Both the DUR Board and DRC meetings are open to the public. During FFY2021 (effective 10/1/2020 through 9/30/2021), the DRC added the following therapeutic drug classes to the PDL: thrombopoiesis stimulating proteins and PCSK9 inhibitors During FFY2021, the DRC updated the following therapeutic drug classes in the PDL: angiotensin modulators, calcium channel blockers, cytokine and CAM antagonists, asthma immunomodulators, stimulants and related agents, antidiabetic agents (oral, inhaled, injection, and insulin), long-acting antipsychotic injections, colony stimulating factors, lipotropic agents, narcolepsy agents, platelet aggregation inhibitors, anticoagulants, hyperuricemia agents, estrogen agents, GI motility agents, and hepatitis C agents. 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 included 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 provide 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 client's Medicaid profile. Updates to POS edits for FFY2021 include: *Added CII stimulant POS criteria *Increased the early refill threshold for controlled drugs from 75% to 90% *Added POS criteria for Otezla *Added POS criteria for GI motility agents *Updated edit for asthma treatment with ICS-LABA based on new GINA guidelines *Updated POS Lyrica criteria (moved to preferred) *Approved implementation of soft polypharmacy edits requiring pharmacists to review a ProDUR alert and override if medically appropriate with NCPDP drug use evaluation codes for the following: --opioid with benzodiazepines --opioid with antipsychotics --opioid with muscle relaxers --opioid with sedative hypnotics --opioid with gabapentin New and updated clinical criteria and edits for FFY2021:

State	DUR Board Activities Report Summary
	1st Quarter--Palforzia, Fasenra, Qinlock, Kynmobi, Fintepla, Evrysdi, Ensprying, Inqovi, oral CGRP antagonists, and Dojolvi 2nd Quarter--Isotretinoin, GnRH receptor antagonists, thrombopoiesis stimulating proteins, immunomodulators for asthma, Xpovio, Gavreto, Ongentys, Onureg, and Zokinvy 3rd Quarter--SGLT-2 inhibitors for heart failure, antipsychotics for 10-17 years of age, Ukoniq, Nexletol, Cabenuva, Bronchitol, Tepmetko, Lupkynis, Benlysta, Orgovyx, and Orladeyo 4th Quarter--Hetlioz, general criteria policy for new-to-market products or products with label expansions, removal of fibromyalgia class, Verquvo, Fotivda, Lumakras, Empaveli, and Truseltiq 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 clients 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 FFY2021. Board approved RDUR criteria included: October 2020--Aripiprazole without an FDA approved indication in history for the last 365 days November 2020--Member under 18 with stimulant type ADHD meds and no ADHD diagnosis December 2020--Statin non-compliance looking for a 20 day gap in refill January 2021--Use of Triptans without a migraine prevention medication February 2021--Diabetics ages 40-75 with no statins March 2021--Concurrent use of opioids and antipsychotics April 2021--DPP-4 and SGLT-2 inhibitors FDA warning May 2021--CNS polypharmacy June 2021--Use of antibiotics for URI (overutilization and resistance) July 2021--Females 15-50, claims for narcotics without birth control August 2021--ADHD medication in women ages 15-44 September 2021--SABA overutilization with 2 or more in 90 days without a controller medication Providing education to prescribers and pharmacies is an important part of our DUR program. Quarterly, a provider memo is posted on the contractor website and Medicaid website with new information approved during the DUR and DRC meetings. The provider memo also contains useful links and tips on various topics (i.e., MAT treatment, billing vaccines, emergency overrides, early refill thresholds, and opioid information). The contractor tracks changes made during the DUR Board meeting and DRC meeting by updating a PA criteria document with links to memos and criteria that is posted on their website. Prescribers and pharmacy providers are emailed the link to the new memos when posted.
California	The DUR Board met four times during FFY 2021. Due to the coronavirus disease 2019 (COVID-19) pandemic, the meetings were abbreviated, webinar-only meetings. Prospective DUR Criteria Presented:

State	DUR Board Activities Report Summary
	Review of new Generic Code Number (GCN) sequence numbers. The DUR Board recommended turning on additional alerts for 31 new GCNs that matched drugs appearing on the Medi-Cal target drug list for prospective DUR. Retrospective DUR Criteria Presented New Additions to the Medi-Cal List of Contract Drugs in FFY 2019: During FFY 2019 there were a total of 26 new prescription medications added to the Medi-Cal List of Contract Drugs. Utilization data (total number of paid claims and utilizing beneficiaries with at least one paid claim) were reviewed for each of these drugs. Twenty drugs had low utilization (< 20 utilizing beneficiaries during all of the months reviewed) and were not reported in detail. The Board did not suggest additional evaluation for any of these drugs. Psychotropic Medication Use in Children and Adolescents: An evaluation was conducted that reviewed all psychotropic medication use over time among children and adolescents under 18 years of age, not just antipsychotic medications. In addition, this evaluation aimed to determine if use of psychotropic medications in children and adolescents is different when stratified by children in foster care compared with children not in foster care and those enrolled in the Medi-Cal FFS program compared with children enrolled in a Medi-Cal managed care plan. Utilizing beneficiaries with a paid claim for any psychotropic medication has been in decline since 2013Q1. All classes of psychotropic medications continue to decrease over time and there appears to be no replacement with other medication classes after an initial decrease in paid claims for antipsychotic medications and no curve back to pre-policy use levels of antipsychotic medications was observed. It was noted that COVID-19 may have decreased paid claims for stimulants due to distance learning. Continued monitoring of the use of psychotropic medications within the Medi-Cal population younger than 18 years of age was recommended, with particular attention to stimulants as distance learning continues. Additionally, it was recommended to assess the impact of the transition on utilization of these drugs (and similar classes) that had been previously carved out after implementation of Medi-Cal Rx on January 1, 2022. Hepatitis C Virus (HCV) Drugs: Paid claims for HCV medications with dates of service between October 1, 2019, and September 30, 2020 (FFY 2020), in both the Medi-Cal FFS and MCP population, were reviewed. This evaluation included the number of beneficiaries with a diagnosis code indicating HCV infection, the total number of beneficiaries initiating treatment for HCV infection, and regional stratification of these data to identify potential areas in the state that may benefit from additional outreach. The results showed that regional variation in treatment ranged from low of 4.9% (FFS in Fresno region) to high of 17.6% (FFS in San Diego region). In addition, a total of 7,111 beneficiaries were identified as having a paid claim for an HCV medication, which was a decrease from 2019 in both FFS (decrease of 15%) and managed care (27%). There were not any obvious areas requiring intervention and glecaprevir/pibrentasvir and sofosbuvir/velpatasvir continue to be the top medications by total utilizing beneficiaries. As baseline HCV-RNA level and comprehensive metabolic panel are required before initiating treatment, prescribing trends remain in line with guidelines, and there is continued limited evidence of retreatment over time. The Board requested this stratified analysis be completed for one additional year. Opioid use in Emergency Departments: An evaluation was conducted on opioid prescribing practices in the emergency department (ED). All paid outpatient pharmacy claims for opioids were reviewed with dates of service between January 1, 2021, and June 30, 2021. Any pharmacy claims were included if prescribers had taxonomy codes, specialty codes, or practice locations indicating

State	DUR Board Activities Report Summary
	emergency medicine. Primary outcomes included the percentage of patients receiving greater than a 3-day supply of opioids (33.5%) and the percentage of patients receiving greater than a 7-day supply of opioids (10.3%). Less than ten beneficiaries had cumulative paid claims for opioids greater than 80 morphine milligram equivalent (MME)/day and that most beneficiaries (82%) had only one opioid paid claim from an ED prescriber during the 6-month period. Most claims (93%) were for 7 days' supply or less, although a small percentage of beneficiaries had more than one claim for 7 days or fewer. Among children and adolescents, of the 118 beneficiaries under 18 years of age with a paid claim for an opioid medication, only 36% of beneficiaries had greater than a 3-day supply of opioids and only 8% had greater than a 7-day supply of opioids. Opioid use among Dentists: Current opioid prescribing practices by dentists and oral surgeons were evaluated in the Medi-Cal program. All paid outpatient pharmacy claims for opioids were reviewed with dates of service between January 1, 2021, and June 30, 2021. Any pharmacy claims were included if prescribers had taxonomy codes or specialty codes indicating they were dentists or oral surgeons. Primary outcomes included the percentage of patients receiving greater than a 3-day supply of opioids (66.2%) and the percentage of patients receiving greater than a 7-day supply of opioids (13.8%). Approximately 63% of paid claims were for acetaminophen w/codeine, with the majority (97%) for 7 days' supply or fewer and the most common paid claim for a 5 days' supply (26%) or 20 tablets (29%). In addition, 32% of paid claims were for hydrocodone w/acetaminophen, with the majority (97%) for 7 days' supply or fewer and the most common paid claim was for a 3 days' supply (25%) or 20 tablets (27%). There were no paid claims for greater than 80 MME/day and 82% of utilizing beneficiaries had only one paid claim for an opioid during the measurement period. Opioid use in Outpatient Surgical Settings: Current opioid prescribing practices for acute pain management following common, low-risk outpatient surgical procedures were evaluated. All paid outpatient pharmacy claims for opioids were reviewed for eligible beneficiaries between 18 and 64 years of age with dates of service between January 1, 2021, and June 30, 2021. Any pharmacy claims were included if prescribed up to three days after one of the following low-risk outpatient procedures where opioids are typically prescribed as a first-line therapy for acute pain: Laparoscopic cholecystectomy (CPTs: 47562, 47563, and 47564) Laparoscopic inguinal hernia (CPTs: 49650 and 49651) Laparoscopic appendectomy (CPT: 44970) Knee arthroscopy with meniscectomy (CPTs: 29880 and 29881) Partial excision of breast (CPTs: 19301, 19302, and 19120) Outcomes included the proportion of patients with a paid claim for an opioid prescription within three days following procedure date (ranged from 51.6% to 60.2%), the percentage of patients with a daily opioid dose prescribed greater than 80 morphine milligram equivalents (ranged from 0% to < 1.0%), the percentage of patients receiving greater than a 3-day supply of opioids (ranged from 29.4% to 81.1%), and the percentage of patients receiving greater than a 7-day supply of opioids (ranged from 1.1% to 13.2%). Paid claims for opioids prescribed after common outpatient surgeries appeared appropriate and followed prescribing guidelines for acute pain and found no differences in prescribing or outcomes between FFS and MCP enrollees. Further, all procedures evaluated averaged less than 30 MME/day and that data limitations on OTC paid claims make it difficult to evaluate utilization and prescribing patterns of other treatment options for acute pain management.

State	DUR Board Activities Report Summary
	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: Drug Safety Communication: Stronger Warning Labels for Benzodiazepines Clinical Review: Recommendations for the Management of Acute Dental Pain Clinical Review: Recommendations for the Tapering of Benzodiazepines Drug Safety Communication: Potential Increased Arrhythmia Risk from Lamotrigine Drug Safety Communication: FDA Requests Removal of Pregnancy Contraindication for Statins UPDATED: Drug Safety Communication: Voluntary Recall of Varenicline (Chantix) Due to Nitrosamine 2021 Immunization Updates: COVID-19, Influenza, and Meningococcal Disease Provider intervention letters: Dentists and Opioids Letter: February 2021 Benzodiazepine Letter: April 2021 Statins in Pregnancy Letter: September 2021 Varenicline Recall Letter: September 2021 Ongoing DUR Board projects: The DUR Board goals for FFY 2021 were as follows: Support DHCS Medi-Cal Rx initiative Continue to promote dialogue, collaboration among MCOs Present innovative practices and projects Share approaches and lessons learned Disseminate DUR educational bulletins to MCPs Integrate/align FFS and MCO DUR action items Align goals with DHCS Comprehensive Quality Strategy Align goals with California Advancing and Innovating Medi-Cal (CalAIM) Revisit Healthcare Effectiveness Data and Information Set (HEDIS) measures Continue to use the Vital Directions Framework to focus on the three DUR priority areas: Optimizing drug prescribing and dispensing, including specialty drugs Optimizing pain management and opioid use Optimizing medication management, prevention, and wellness for chronic conditions, with a special focus on diabetes, hypertensio
Colorado	Five DUR Board meetings held in FFY 2021: November 10, 2020 (virtual) February 9, 2021 (virtual) March 23, 2021 (virtual, for PAD products only) May 11, 2021 (virtual) August 10, 2021 (virtual) November 10, 2020: Call to Order: The meeting was officially called to order at 1:00 PM. All board members except one, HCPF staff, and CO DUR team members were present. There were sufficient members for a quorum with nine voting members participating. Quorum is five members. Department updates,

State	DUR Board Activities Report Summary
	FDA new drug updates, retrospective DUR reports, and quarterly clinical modules were presented and reviewed by the board. Drug Classes Reviewed: The following drug classes were reviewed: NSAIDS (oral), NSAIDS (non-oral), inhaled antibiotics, Hepatitis C Virus treatment-Directing Acting Antivirals, Pulmonary Arterial Hypertension Therapies, Triptans and Other Migraine Treatments (Oral and Non-oral), Antipsoriatics (oral), Antipsoriatics (topical), Anti-emetics (oral and non-oral), H Pylori Treatments, Methotrexate Products, Targeted Immune Modulators, Antihyperuricemics, Antiherpetic Agents (oral and topical), Fluoroquinolones (oral), Hepatitis C Virus Treatments, Ribavirin Products, Newer Generation Antidepressants, Monoamine Oxidase Inhibitors (MAOIs), Tricyclic Antidepressants, Pancreatic Enzymes, Proton Pump Inhibitors, Non-Biologic Ulcerative Colitis Agents (oral and rectal), Antiplatelet Agents, Epinephrine (self-administered) Products, and Antiherpetic Agents (oral and topical). The following proposed ProDUR and physician administered medications were reviewed: Evrysdi (risdiplam) and Enspryng (satralizumab-mwge). February 9, 2021: Call to Order: The meeting was officially called to order at 1:03 PM. All board members except one, HCPF staff, and CO DUR team members were present. There were sufficient members for a quorum with nine voting members participating. Quorum is five members. Department updates, FDA new drug updates, and retrospective DUR reports, were presented and reviewed by the board. A new Board Chair and Vice Chair were elected. Drug Classes Reviewed: The following drug classes were reviewed: Diabetes Management Class-Insulins; Lipotropics; Cardiovascular Agents (alpha-blockers, beta-blocker and combinations, beta-blockers-antiarrhythmic, calcium channel blockers and combinations); Multiple Sclerosis Agents (disease modifying therapies, symptom management therapies, dopamine agonists); Antimigraine Agents- Calcitonin Gene-Related Peptide inhibitors; Atypical Antipsychotics; Anxiolytics (benzodiazepines, non-benzodiazepines); Ophthalmics, Anti-Inflammatory; Glucagon, Self-administered; Statins and Stain Combinations; Lithium Agents; Neurocognitive Disorder Agents; Topical Steroids; Growth Hormone; Bile Salts; Immune Globulins; Intranasal Rhinitis Agents; Ophthalmic Agents, Allergy; Leukotriene Modifiers; Anti-Parkinson's Agents, Dopa Decarboxylase Inhibitors & Combinations; Multiple Sclerosis, MAO-B Inhibitors; Sedative Hypnotics, Non-Benzodiazepines; Sedative Hypnotics, Benzodiazepines; Hemorrhoidal and Related Anorectal Agents; and Ophthalmics, Glaucoma Agents (beta-blockers, carbonic anhydrase inhibitors, prostaglandin analogue, alpha-2 adrenergic agonists, other ophthalmic-glaucoma and combinations). The following proposed ProDUR were reviewed: Lampit (nifurtimox); Bynfezia Pen (octreotide acetate injection); Xywav (calcium, magnesium, potassium, sodium oxybates); and Jynargue (tolvaptan). The planned review of criteria for physician administered drugs was deferred to a future date due to time limitations. March 23, 2021 (interim meeting for PAD products only): Call to Order: The meeting was officially called to order at 3:31 PM. All board members, HCPF staff, and CO DUR team members were present. There were sufficient members for a quorum with seven voting members participating. Quorum is five members. The following PAD products were reviewed: Botox, Myobloc, Dysport, Xeomin, Prolia, Xgeva, Xolair, Nucala, Fasenra, Cinqair, Remicade, Soliris, Entyvio, Ocrevus, Tysabri, Gammaked, Gamunex-C, Gamunex, Octagam 5% and 10%, Gammagard Liquid, Privigen, Asceniv, Gammaplex, Panzyga, Bivigam, Flebogamma DIF, Gammagard S/D and Gammaplex. May 11, 2021:

State	DUR Board Activities Report Summary
	Call to Order: The meeting was officially called to order at 1:03 PM. All board members, HCPF staff, and CO DUR team members were present. There were sufficient members for a quorum with eight voting members participating. Quorum is five members. Department updates, FDA new drug updates, and retrospective DUR reports, and quarterly clinical modules were presented and reviewed by the board. Drug Classes Reviewed: The following drug classes were reviewed: Non-opioid Analgesics (oral and topical); Opioids (short-acting); Angiotensin Modulators and Angiotensin Modulator combinations (ACE-inhibitors and combinations, ARBs and combinations, ARNIs, and Renin inhibitors and combinations); Acne Agents (topical); Acne Agents (oral isotretinoins); Antineoplastics (topical); Rosacea Agents (topical and oral); Phosphate binders; Respiratory Inhalants (inhaled anticholinergics and anticholinergic combinations, inhaled beta2 agonists (short-acting/SABA), inhaled beta2 agonists (long-acting/LABA), inhaled corticosteroids and combinations, and phosphodiesterase inhibitors); Tetracyclines; Skeletal Muscle Relaxants; Topical Immunomodulators; Androgenic Agents (topical, injectables, oral); Antihistamines, Newer Generation and combinations; and BPH Agents. The following proposed ProDUR and physician administered drugs were reviewed: Uplizna (inebilizumab-cdon), Viltepso (viltolarsen), Hemady (dexamethasone), Mycapssa (octreotide), Amondys 45 (casimersen), Bronchitol (mannitol), and Gimoti (metoclopramide). A discussion was had regarding the pharmacy claims system edit for concomitant opioid and oral buprenorphine-containing products. August 10, 2021: Call to Order: The meeting was officially called to order at 1:03 PM. All board members, HCPF staff, and CO DUR team members were present. There were sufficient members for a quorum with eight voting members participating. Quorum is five members. Department updates, FDA new drug updates, and retrospective DUR reports, and quarterly clinical modules were presented and reviewed by the board. Drug Classes Reviewed: The following drug classes were reviewed: Ophthalmics (Immunomodulators); Anticonvulsants (oral); Stimulants and Related Agents; Estrogen Agents (injectable, oral/transdermal, oral contraception, contraceptives non-oral); Diabetes Management Classes (GLP-1 Analogues, Amylin, Biguanides, DPP-4 inhibitors and combinations, SGLT-2 inhibitors and combinations, Meglitinides and combinations, and TZDs and combinations); Glucagon Agents; Antiplatelet Agents; Colony Stimulating Factors; Newer Hereditary Angioedema Products; Overactive Bladder Agents; Bone Resorption Suppression and Related Agents; GI Motility (chronic); Anticoagulants (oral and intravenous); Erythropoiesis Stimulating Agents; and Prenatal Vitamins/Minerals. The following proposed ProDUR and physician administered drugs were reviewed: Aduhelm (aducanumab-avwa); Cablivi (caplacizumab-yhdp); Ingrezza (valbenazine); Myfembree (relugolix, estradiol hemihydrate, norethindrone acetate); Empaveli (pegcetacoplan); Xolair (omalizumab); Zokinvy (lonafarnib); and Verquvo (vericiguat). Therapeutic categories added to the Preferred Drug List in FFY 2021: Antibiotics, Inhaled Antineoplastics, Topical Anxiolytics Cardiovascular Agents (single agent alpha blockers, beta blockers, calcium channel blockers and combination products) Contraceptives, Non-Oral Estrogen Agents Methotrexate Products

State	DUR Board Activities Report Summary
	Therapeutic categories deleted from the Preferred Drug List in FFY 2021: None ProDUR screening used to adjust RetroDUR 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). One example is an analysis conducted in September 2021 to evaluate new starts of older anticonvulsant agents that occurred between 7/1/19 and 6/30/21. This report was requested by the DUR Board during their August 2021 meeting. Inversely, ProDUR criteria can influence RDUR activity when there are utilization trends for a specific drug product or within a specific therapeutic class. This drug use activity may lead to further investigation of the impact of ProDUR changes on prescribing patterns (such as for opioids, benzodiazepines, or psychotropic medications in pediatric/adolescent members). Involvement in the DUR education program: The DUR Board reviews metrics associated with RetroDUR educational interventions (member-specific educational letters mailed to providers) during each quarterly meeting. Two DUR newsletters were published during the reporting period (December 2020 and June 2021). Board members receive newsletters by email and recent editions are also posted on the DUR Board web page at https://hcpf.colorado.gov/drug-utilization-review-board. Policies adopted to determine patient or provider specific intervention types: 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, FDA Drug Safety Communications, and clinical module analyses. The letters tend to include rotating clinical topics such as high risk opioid prescribing, high risk benzodiazepine prescribing, and high risk psychotropic prescribing in children and adolescents.
Connecticut	Summary 2 is a brief descriptive report on DUR Board activities during FFY 2021. This summary should: Indicate the number of DUR Board meetings held. Four DUR Board meetings were held during FFY 2021; December 2020, March 2021, June 2021, and September 2021. See link below for meeting minutes. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf DUR BOARD MEMBERSHIP - 10/01/2020 to 06/30/2021 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, Damian Dos Santos, M.D. DUR BOARD MEMBERSHIP - 7/01/2021 to 09/30/2021

State	DUR Board Activities Report Summary
	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 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 2021 by the DUR Board. 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

State	DUR Board Activities Report Summary
	review 800 patient profiles per month. The contractor is required to conduct educational interventions with prescribers based upon criteria involving overuse of drugs with potential for abuse, doctor shopping, and pharmacy shopping. Patients are warned and if their excessive use does not change within 90 days, the recipients are locked-in to one pharmacy for one year, at which time their drug usage is re-evaluated. The criteria reviewed by the DUR Board during FFY 2021 are included in Summary 3 including which criteria were approved, tabled, or rejected. Four educational newsletters were mailed to targeted prescribers and pharmacies during FFY 2021. 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 due to Covid concerns. 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 30, 2021. Both managed care organizations' pharmacy directors, which represent 87% of the Medicaid population in Delaware, participated in the DUR/P&T committee meeting. In response to the SUPPORT Act requirements, the DUR board discussed and ensured that FFS and managed care programs have worked towards the implementation of claims review requirements of safety edits, maximum daily morphine milligram equivalent safety edits, and concurrent utilization alerts. The DUR board examined utilization trends in the year 2019 and 2020 of unique members who filled at least 1 naloxone with > 50 MME using RetroDUR data. While FFS and MCO plans have an average of <50 MME per member, RetroDUR data shows an increase in unique members with >50 MME that have filled at least 1 naloxone rescue prescription from 2019 to 2020. The DUR board examined concomitant use of opioid and benzodiazepine use and edits in place for both FFS and MCO organizations. FFS has an overridable soft edit in place that targets opioid-benzodiazepine concurrent usage with overlapping day supply. A letter is sent to both providers if the pharmacist overrides the edit. RetroDUR data show a decrease in both FFS and MCO members who filled both an opioid and benzodiazepine script within the same year during the 2019 to 2020 timeframe. The DUR board also examined concomitant use of MAT and opioid use and edits in place for both FFS and MCO organizations. For FFS, a letter is sent to both the provider who prescribed the MAT product and the provider who prescribed the opioid if the pharmacist overrides the edit. A review of RetroDUR data showed no FFS members with concomitant Opioid and MAT products in 2019 or 2020. Finally, the DUR board reviewed stimulant utilization and management strategies for stimulant and benzodiazepine use. FFS strategies include all stimulants for adult members requiring prior authorization and a soft edit for concurrent day supply of stimulant and benzodiazepine use. A DUR letter is sent to both providers if the pharmacist chooses to override this edit.

State	DUR Board Activities Report Summary
District of Columbia	The District of Columbia's Drug Utilization Review Board meets once monthly. There was a total of twelve (12) meetings held virtually during FY21 due to COVID pandemic restrictions. The Board reviewed several new therapeutic categories to recommend clinical criteria guidelines including CGRP antagonist Ubrelvy. Also recommendations were made for Trogarzo, Spravato, Evrysdai, Aduhelm and Cabenuva clinical criteria. The Board developed a written Guideline titled A Collaborative Approach to Safe Use of Opioids that was distributed to all providers and is available on the DHCF website. A Continuing Education program for opioid prescribers and dispensers is planned for FY22. Monthly reviews of potential pharmacy lock-in candidates were conducted and appropriate beneficiaries were selected for inclusion in the program for a one-year length of time. 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 were 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. Based on provider feedback, prescribers find these mailings to be useful and informative in their management of and dialogue with patients. 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 appropriate, 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 will pay closer 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. The Board devoted a great deal of time and effort to review and approve the Polypharmacy Exclusion criteria that are currently in effect to include otic, vaginal, rectal, ophthalmic, nasal, and some topical products. During FY21, the MCO Pharmacy Directors made three quarterly presenations to the DHCF DUR Board on the MCOs respective DUR activities including Lock-in policy, specialty pharmacy network enrollment and oversight, monitoring of oral oncology medications and adherence to SUPPORT Act DUR requirements.
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

State	DUR Board Activities Report Summary
	against each member's summary. Claims history includes current, historical, paid, and denied claims data, regardless of the media source of the claims submission. The real-time evaluation of POS claims permits identification of drug therapy problems prior to dispensing. The RetroDUR utilization analyses, as described below, provides information which assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians to potential drug therapy problems, identifies opportunities to improve drug therapy and makes recommendations to avoid drug therapy problems. The ongoing operation of the RetroDUR program is a shared responsibility of Magellan Medicaid Administration, a Magellan Medicaid Administration Company, and the Agency for Health Care Administration (Agency). Each quarter, specific therapeutic areas that have been approved by the DUR Board are targeted for focused review under the RetroDUR program. Magellan Medicaid Administration applies the specified criteria established by the Board to the prescription and health claims files and identifies medication regimens that violate the criteria. Results of analyses are provided to the Board during quarterly meetings. Electronic educational letters are created by Magellan Medicaid Administration, regarding targeted criteria. Letters are reviewed and approved by the DUR Board and the Agency. The electronic letters are posted to a designated provider alert area of the Agency's website for the provider community. (http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml). With enhanced technology, Magellan Medicaid Administration offered the DUR Board the ability to provide recommendations to the Agency for POS edits to assist in the mission of the Board, which include educating physicians and positively impacting prescribing for Florida Medicaid recipients. The DUR Board reviews the potential edits and makes recommendations based on their clinical expertise and knowledge. DUR Board members frequently collaborate with colleagues regarding drug utilization issues and bring the results of those discussions back to the DUR Board for consideration. The Florida Medicaid DUR Board met four times during the Federal Fiscal Year 2021. During this timeframe, Magellan Medicaid Administration recommended RetroDUR criteria associated with drug to drug interactions, inappropriate dosing, therapeutic duplication, polypharmacy, safety precautions and overutilization of medications. Magellan Medicaid Administration produces a monthly newsletter/Clinical Alert to educate the provider community about the most recent issues in the pharmaceutical industry and new drug information. These newsletters are available on the Magellan Medicaid Administration website and can be accessed at: https://www1.magellanrx.com/magellan-rx/publications/pharmacy-clinical-alerts.aspx Summary of DUR Board activities: Review the top 20 therapeutic classes by claims volume and expenditure to identify appropriate therapies and intervention opportunities. Review impact of the soft edit for cumulative quantity limit of Morphine Milligram Equivalent (MME) > 50. The DUR Board moved to amend and expand the soft edit from targeting recipients on > 300 MME to recipients on > 50 MME based on a single or accumulation of opiate claims. During the March 2021 DUR Board meeting, the DUR Board reviewed the post impact of the soft edit. Determine Trikafta utilization and hospital avoidance. The DUR Board reviewed Trikafta utilization and criteria during the December 2020 DUR Board meeting. Determine Eucrisa utilization, review for use based on FDA approved indication, age, and quantity limits. During the May 2020 P&T Committee meeting, Eucrisa was voted from preferred with quantity limits (60 grams per 30 days) to an automated prior authorization. The automated prior authorization

State	DUR Board Activities Report Summary
	includes a 180 day look back for a topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI). If the patient was previously on Eucrisa they will bypass the automated prior authorization requirements. The edit deployed on 07/15/20. The P&T Committee requested the DUR Board complete a 90-day post implementation impact review to determine any barriers to treatment. The DUR Board reviewed the post implementation impact data during the December 2020 DUR Board meeting. Review high utilizing members to determine polypharmacy and uncoordinated care. The DUR Board reviewed high utilizing members during the December 2020 DUR Board meeting. Utilization of antipsychotic medication in children. The DUR Board reviewed utilization of antipsychotic medication in children during the December 2020 DUR Board meeting. Review utilization of Spinal Muscular Atrophy (SMA) products. The DUR Board continues to review utilization and criteria for Zolgensma, Spinraza, and Evrysdi. Further review of the post impact of the anticonvulsant multiple therapy soft edit. The DUR Board voted to implement a soft edit for recipients on multiple anticonvulsants (>2 unique anticonvulsants per 30 days). DUR intervention codes are required at the POS to allow for claim processing. Products to treat acute increased seizure activity are excluded. The edit deployed 01/09/20. During the June 2021 DUR Board meeting, the DUR Board reviewed the impact of the anticonvulsant multiple therapy soft edit. The DUR Board was satisfied with the impact of the edit. To further review gabapentin utilization. The DUR Board reviewed the average milligram per day utilized, utilization based on indication, and provider specialty. The DUR Board voted for a 3,600 mg per day quantity limit and a concomitant use edit for gabapentinoids with benzodiazepines, opiates, and skeletal muscle relaxants. The edit deployed on 02/03/21. Review the pre and post impact of the updated long-acting injectable antipsychotic (LAI AP) automated prior authorization logic. The oral tolerability requirement of the LAI AP Auto-PA was removed to increase access to treatment. The DUR Board reviewed the post implementation impact during the December 2020 DUR Board meeting. Review trends in opiate prescribing as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The DUR Board reviewed opioid claims, concomitant use of opiates and Medication Assisted Treatment (MAT), claims exceeding the recommended 90 MME limits, top opioid prescribers including specialty, top opioid recipients, average MME, Narcan/naloxone utilization, and overdose data during the December 2020 DUR Board meeting. The DUR Board will continue to review topic. Review utilization trends of insulin and Glucagon-like Peptide (GLP)-1 Agonists. The DUR Board reviewed recipients switching from GLP-1 agonists to insulin, from insulin to GLP-1 agonists, and on concomitant therapy. The DUR Board reviewed recipients on combination long-acting insulin and intermediate insulin. The DUR Board requested an endocrinologist's input. Following the input from a specialist, the DUR Board voted to implement an edit that will allow one month of overlapping therapy (long acting plus intermediate/pre-mixed insulin) prior to a hard stop. Review utilization, cost, and safety of Proton Pump Inhibitor (PPI) therapy. The DUR Board reviewed the number of recipients, claims and cost for PPI therapy and discussed safety with long term therapy. The DUR Board reviewed PPI therapy in children. Review the pre and post implementation impact of the 30-day Suboxone induction. During the March 2021 DUR Board meeting, the DUR Board reviewing the impact of expanding the Suboxone induction period from 14 days to 30 days. Review the pre and post implementation impact of the revised soft edit for asthma medication management. During the June 2021 DUR Board meeting, the DUR Board reviewed the revised soft edit for asthma medication management and no further action was warranted. Review the pre and post implementation impact of the Lyrica automated prior authorization edit. During the June 2021 DUR Board meeting, the DUR Board reviewed the post implementation impact and will continue to monitor the edit.

State	DUR Board Activities Report Summary
	Review concomitant utilization of long-acting opiates and benzodiazepines. During the June 2021 DUR Board meeting, the DUR Board reviewed the utilization of long-acting opiates and benzodiazepines and will review yearly. Review trends in the antiviral utilization over the last few years. During the June 2021 DUR Board meeting, the DUR Board revied antiviral influenza trends over the last 4 years. Review trends in opiate prescribing with a focus on naloxone and a subset review for pregnant women. During the September 2021 DUR Board meeting, the DUR Board reviewed current opiate trends. Review trends in antiviral utilization and influenza vaccine use over the last 4 influenza seasons. Review utilization trends for Hepatitis C therapy. Review utilization trends for sickle cell therapy. Review utilization trends for selected novel therapy. Review utilization trends for smoking cessation therapy. Summary of additions/deletions to DUR Board approved criteria: Hepatitis C Growth Hormone Aduhelm Spinal Muscular Atrophy - Zolgensma, Spinraza, and Evrysdi
Georgia	-4 meetings were conducted on the following dates in 2021: Tuesday, February 2; Tuesday, May 4; Tuesday, August 3; Tuesday, November 9. -New drugs reviewed included: Dayvigo Enspryng Evrysdi Fintepla Rukobia Uplizna Zeposia Kesimpta Ongentys Verquvo Viltepso Cabenuva/Vocabria Evkeeza Lupkynis Olinvyk Sevenfact Amondys 45 Cosela Gemtesa Ponvory Qelbree 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/2021-durb-meeting-information

State	DUR Board Activities Report Summary
Hawaii	Four DUR Board meetings were held, on a quarterly basis. Prospective DUR is driven by FirstDataBank edits without any changes needed at this time. Retrospective DUR monitors for quantity prescribing outliers and ingredient outliers with changes to prospective edits. For example, dental opioids outliers analysis will be lowering quantity limits, days supply and MME as adult dental drugs are only for acute and emergency use. Higher strength opioids and single ingredient opioids will be deleted for dental pain treatment. Medically necessary policy looks at prospective DUR cost of drugs. A ceiling cost will trigger a soft edit for review by medical and pharmacy consultants for medical necessity. Prior authorization hard edits are avoided for patient access meeting the needs of our transplant population. Otherwise, a prior authorization will be required prospectively. Billing discrepancies are also minimized at point of sale. Continuous monitoring for drugs of national interest but less of a problem in Hawaii is a retrospective DUR policy. Quarterly reviews of data will continue with reporting to the DUR Board on an annual basis while utilization is under control: hepatitis C and dental narcotic usage. Prospective screens will change as clinical guidelines change. Provider phone calls, website and memorandums have been the basis for the DUR education program this FFY. Quarterly provider bulletins will be utilized in the future as well. A medical and pharmacy consultant are available for phone calls with specific individual interventions. The size of the population served allows this. Working with case managers to proactively discuss with patients also occurs.

State	DUR Board Activities Report Summary
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 15, 2020 April 15, 2021 July 15, 2021 During FFY21, the following RetroDUR activities were performed on behalf of the Idaho DUR Board: Treatment of Spinal Muscular Atrophy (SMA) Extended-Release Naltrexone Implementation of a Prescriber Attestation Process for High Dose Opioid Use Naloxone Prescribing Trends Benzodiazepine Limitation to 14 Days Supply per Six Months Benzodiazepine Rescue Agents Clonazepam Gabapentin Utilization Hepatitis C Update Foster Children and Behavioral Health Drugs Overview of Benzodiazepine Use and Areas of Concern Benzodiazepines Focus on Alprazolam Retrospective Review of High-Cost Drug Claims Overview of the Medicaid Institutions for Mental Disease/Behavioral Health Transformation Waiver and Pharmacy Related Measures Overview of the Drug Overdose Prevention Program and Medicaid Pharmacy Partnership Opportunities 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 when 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.

State	DUR Board Activities Report Summary
Illinois	The Illinois Drug Utilization Review (DUR) Board conducted three meetings during FFY21. 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 FFY21, the following prospective edits were discussed or implemented: - Extended-release alprazolam - Final CMS-2482 rule that establishes minimum standards for state Medicaid DUR in part based on Support for Patients and Communities Act. Discussion centered on opioid use and medication-assisted treatment (MAT) for opioid used disorder and naloxone co-prescribing/co-dispensing. - Order standardization for opioid prescribing - Initial opioid days supply - Removal of prior authorization requirement for topical lidocaine 5% patch since it became a preferred product. The Illinois DUR Board addressed the following drug classes and issues retrospectively during FFY21: - Antipsychotic polypharmacy in children 8 to 17 years of age - Dental opioid therapy duration - Naloxone utilization The DUR Board and Drug Utilization Review Web pages continued to be used as educational vehicles for providers during FFY21. 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: - Benzodiazepine black box warnings that address risk of abuse, misuse, addiction, physical dependence, and withdrawal reactions - Non-steroidal anti-inflammatory drug (NSAID) use in pregnancy - Sodium glucose cotransporter-2 inhibitor (SGLT2i) warnings - Educational outreach to reduce dental opioid prescribing - Opioid-induced endocrinopathies - Illinois opioid data dashboard - Center for Opioid Research and Education Dental Opioid Guidelines for common dental procedures - CDC patient information resource about opioid use for acute pain

State	DUR Board Activities Report Summary
Indiana	DUR Board meetings are held monthly. Twelve meetings were held during FFY 2021. 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, COX II inhibitors and select non-steroidal anti-inflammatory agents (NSAIDs), antiseizure agents, SGLT2 inhibitors and combinations, antipsychotic agents, SSRI/SNRIs, pulmonary antihypertensives, proton pump inhibitors, 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 agents, antimigraine agents, pulmonary antihypertensive agents, PCSK9 inhibitors and select lipotropics, miscellaneous cardiac agents, miscellaneous step therapy, spinal muscular atrophy agents, Lucemyra®, compound criteria, bone formation stimulating agents, Reblozyl®, Dificid®, Sickle Cell agents, Cushing's Disease agents, Hetlioz®, growth hormone, ophthalmic anti-inflammatory agents/immunomodulator type, allergy specific immunotherapy, Cipro® suspension & Levaquin® solution, 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 OptumRx will develop and present innovative ideas on cost containment & therapeutic appropriateness through DUR program efforts. The DUR Board advises on the Preferred Drug List (PDL), 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

State	DUR Board Activities Report Summary
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 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.

State	DUR Board Activities Report Summary
Kansas	1. Four DUR Board meetings. 2. Additions/Changes/Deletions to DUR Board approved prior authorization medical necessity criteria are listed below. 2a. Currently, we edit with PAs to ensure drug use follows clinical guidelines and cost effective drug use. 2b. The RDUR activities added were implemented mainly through policy and were primarily those required by CMS and the SUPPORT Act. 3. Combining the results of ProDUR to guide RDUR is a program area that needs improvement. 4. Mainly the RDUR activities added were those required by CMS and The SUPPORT Act. There were two other DUR Board RDURs that were implemented but the results were limited in impact. 5. The DUR pharmacist creates quarterly newsletters for the providers, to explain updates to the program and other impactful information. We use provider bulletin notices, global messaging, and website postings regarding drug-related management changes. We are considering a webinar for DUR education updates and for dialogue with the providers. This is still being vetted. OCTOBER 14, 2020 DUR BOARD MEETING: Agenda items and Key changes. Narcolepsy Agents- Step Therapy requirement added. Monoamine Depletors- Safety clarification reviewed. Duchenne Muscular Dystrophy Agents- Addition of new agent. Acute Migraine Agents- Provider type and scoring assessment review. Chemotherapy Agents- Addition of new agents. Botulinum Toxins- Labeling changes update. Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents- New PA. Fee-for-Service Annual Program Assessment. Managed Care Annual Program Assessment. JANUARY 20, 2021 DUR BOARD MEETING: Agenda items and Key changes. Spinal Muscular Atrophy (SMA) Agents- Consolidation of individual PAs & update to criteria. Oncology Agents (formerly Chemotherapy Agents)- Addition of new agents. Asthma Agents- Step Therapy and dosing limit updates. Multiple Sclerosis (MS) Agents- Fumaric acid derivative use parameters added. Neuromyelitis Optica Spectrum Disorder (NMOSD) Agents- Clarifications made. Juvenile Idiopathic Arthritis (JIA) Agents- Addition of new agents. Psoriatic Arthritis Agent- Age/dose limits update. Minimum Requirements Prior Authorization- Changes made to several agents. Diabetes Mellitus-Type2 Agents (formerly Type 2 Diabetes Mellitus Agents)-Several changes. Narcolepsy Agents- Indication update and clarification of renewal criteria. Opioid Use Dependence Agents- SUPPORT Act updates. Oncology - Auxiliary Treatment Agent- New PA. Brand Medical Necessity Prior Authorization- New PA. APRIL 21, 2021 DUR BOARD MEETING: Agenda items and Key changes. Preferred Drug List- Removal of annual PA renewal requirement for certain PDL classes. Duchenne Muscular Dystrophy (DMD) Agents- Addition of new agent. Ulcerative Colitis (UC) Agents- Clinical guideline and safety updates.

State	DUR Board Activities Report Summary
	Weight Loss Agents- Minor updates. Hepatitis C Agents- Removal of sobriety requirement. CAR-T Therapy Agents- Consolidation of individual PAs & addition of new agents. Hypercholesterolemia Agents- Consolidation of individual PAs & addition of new agents. Consent Agenda- Tabled by State. Fee-for-Service Retrospective Drug Utilization Review- Topic Selections. JULY 21, 2021 DUR BOARD MEETING: Agenda items and Key changes. ADHD Medications Safe Use for All Ages- Criteria and dosing updates. Antidepressant Medications Safe Use for All Ages- Spravato labeling changes. Antipsychotic Medications Safe Use for All Ages- Step Therapy for Secuado . Crohn's Disease Agents- Renewal requirement update. Oncology Agents- Addition of new agents. Oncology Auxiliary Agents- Consolidation of individual PAs & addition of new agents. Migraine Prophylaxis Agents- Step Therapy requirement added. Weight Loss Agents- Initial and renewal criteria changes. Ulcerative Colitis (UC) Agents- Many changes made. Minimum Requirements Prior Authorization- Age update to Trikafta . Opioid Products Indicated for Pain Management- Addition of new agent. Atopic Dermatitis Agents- Initial and renewal criteria changes.
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 FFY2021. During FFY2021, the following RetroDUR activities were performed on behalf of the DMRAB: Prescriber-lettering activities: Patients with a 10 day gap in hypertension medications, patients with a 10 day gap in seizure medications, Psych Meds in Children, Short-acting bronchodilator without a controller medication. 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 FFY2021: HIV Medications for Post Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP), Drug product recalls and discontinuations, and Single-dose Vaccine Coverage for Medicaid Recipients.
Louisiana	Summary 2. DUR Board Activity

State	DUR Board Activities Report Summary
	The Louisiana Drug Utilization Review Board held four meetings during federal fiscal year 2021. Addressing the COVID pandemic, the meetings were held virtually. 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 Celebrex (celecoxib) and somatropin. POS edits were implemented for new drug products. Examples include Qelbree (viloxazine) and Verquvo (vericiguat). Retrospective DUR criteria: Criteria focused on diabetes management and updating criteria for MCO implementation. CMS required criteria were established to address opioid safety and opioid use disorder. Clinical authorization: Criteria were defined for a wide range of drug categories. Examples include agents to treat multiple sclerosis and behavioral health. Medically necessary criteria: Clinical criteria were defined for overriding POS diagnosis requirements and quantity limit safety edits. Indicate the number of meetings held 4 For prospective DUR, list problem type/drug combinations approved by the DUR Board, added or deleted. AGE LIMIT Lucemyra (lofexidine) AGE LIMIT Naltrexone tablets AGE LIMIT Xywav (oxybate salts) AGE LIMIT Xyrem (sodium oxybate) CONCURRENT USE (BUPRENORPHINE) Naltrexone tablets DAYS SUPPLY Lucemyra (lofexidine) DIAGNOSIS BYPASS Generic cefixime DIAGNOSIS REQUIREMENT Glucose strips & lancets DIAGNOSIS REQUIREMENT Hemophilia agents DIAGNOSIS REQUIREMENT Enzyme replacement therapy agents DIAGNOSIS REQUIREMENT Lucemyra (lofexidine) DIAGNOSIS REQUIREMENT Naltrexone tablets DIAGNOSIS REQUIREMENT Entresto (sacubitril/valsartan) DIAGNOSIS REQUIREMENT Qelbree (viloxazine) DIAGNOSIS REQUIREMENT, BYPASS QL EDIT, MCO ALIGNMENT Short-acting beta agonists DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Botulinum agents DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Pulmonary Arterial Hypertension agents DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Miscellaneous agents DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Other interferons DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Hormones DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Topicals DIAGNOSIS REQUIREMENT, MCO ALIGNMENT Triptans DIAGNOSIS REQUIREMENT, RISK FACTORS, MCO ALIGNMENT Orlistat

State	DUR Board Activities Report Summary
	DOSE LIMIT Lucemyra (lofexidine) DOSE LIMIT, EDUCATIONAL ALERT Opioid MME DRUG-DRUG INTERACTION (OPIOIDS) Naltrexone tablets DURATION OF THERAPY Generic Epclusa preferred agent PRIOR DRUG USE REQUIREMENT Epidiolex (cannabidiol) PRIOR DRUG USE REQUIREMENT Eucrisa (crisaborole) QUANTITY LIMIT Sedative-hypnotic agents QUANTITY LIMIT Nocdurna (desmopressin) QUANTITY LIMIT Acne agents QUANTITY LIMIT Glucose strips & lancets QUANTITY LIMIT Selective anti-infective, anti-fungal, and corticosteroid medications (foot bath products) QUANTITY LIMIT Evrysdi (risdiplam) QUANTITY LIMIT Muscle relaxants QUANTITY LIMIT Short-acting beta agonists QUANTITY LIMIT Lucemyra (lofexidine) QUANTITY LIMIT Acne agents QUANTITY LIMIT Trulicity (dulaglutide) QUANTITY LIMIT Proton pump inhibitors QUANTITY LIMIT Pulmonary arterial hypertension agents QUANTITY LIMIT Bronchodilators, anticholinergics (COPD) inhalation agents QUANTITY LIMIT Hetlioz LQ (tasimelteon) QUANTITY LIMIT Verquvo (vericiguat) REMOVE AUTO-INJECTABLE EPINEPHRINE Oralair (grass pollen allergen extract), Odactra (house dust mite allergen extract), Palforzia (peanut allergen powder) REMOVE BYPASS OVERRIDE DIAGNOSIS Celebrex (celecoxib) REMOVE DIAGNOSIS REQUIREMENT Celebrex (celecoxib) REMOVE DIAGNOSIS REQUIREMENT Somatropin REMOVE PROVIDER SPECIALTY REQUIREMENT Oralair (grass pollen allergen extract), Odactra (house dust mite allergen extract), Palforzia (peanut allergen powder) THERAPEUTIC DUPLICATION Fabrazyme (agalsidase beta) & Galafold (migalastat) THERAPEUTIC DUPLICATION Naltrexone tablets THERAPEUTIC DUPLICATION Xywav (oxybate salts) THERAPEUTIC DUPLICATION HIV agents THERAPEUTIC DUPLICATION Qelbree (viloxazine) UPDATE: DIAGNOSIS BYPASS Farxiga (dapagliflozin) UPDATE: DIAGNOSIS BYPASS Farxiga (dapagliflozin) UPDATE: DIAGNOSIS REQUIREMENT Rexulti (brexpiprazole) UPDATE: PRIOR DRUG USE REQUIREMENT Vraylar (cariprazine), Latuda (lurasidone) UPDATE: REMOVAL OF DIAGNOSIS REQUIREMENT Exondys (eteplirsen), Spinraza (nusinersen) New educational alerts Therapeutic Duplication, Level One Educational Alerts (FFS) A2E, BETA-BLOCKER-SA NODE SELECTIVE I(F) CURRENT INHIB A4P, ACE INHIBITOR AND BETA-ADRENERGIC BLOCKER COMB. B67, DECONGESTANT-ANALGESIC;NSAID AND NON-SALICYLATE CB D42, ANTIDIARRHEAL MICROORGANISMS AGENTS (CONTINUED 3)

State	DUR Board Activities Report Summary
	D6O, INFLAMMATORY BOWEL AGENTS - MESENCHYMAL STEM CELLS E0P, MULTIVITAMIN PREPARATIONS (CONTINUED 6) F3A, ANDROGENIC RECEPTOR INHIBITORS H25, SELECTIVE SEROTONIN 5-HT1F RECEPTOR AGONISTS H80, BENZODIAZEPINES (CONTINUED 1) J8F, ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS M4V, ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR M4W, ANTIHYPERLIPIDEMIC-ACLY AND CHOLES ABSORP INHIB P1R, LHRH (GNRH) ANTAGONIST;ESTROGEN AND PROGESTIN COMB Drug Interactions, Level One Educational Alerts (FFS) DICHLORPHENAMIDE/ASPIRIN (> 325 MG); SALICYLATES PIMOZIDE/NILOTINIB PROTEASE INHIBITORS/APALUTAMIDE DABIGATRAN/COBICISTAT PRAVASTATIN (> 40 MG); SIMVASTATIN (> 20 MG)/BEMPEDOIC ACID METHADONE FOR MAT/SELECTED ANTIPSYCHOTICS THAT PROLONG QT METHADONE (NON MAT)/SELECTED ANTIPSYCHOTICS THAT PROLONG QT LEVOMETHADYL (IR)/SELECTED ANTIPSYCHOTICS THAT PROLONG QT OZANIMOD/MAOIS PIMOZIDE/LONAFARNIB; TUCATINIB LOVASTATIN; SIMVASTATIN/TUCATINIB IVABRADINE/DRONEDARONE IVABRADINE/STRONG CYP3A4 INHIBITORS THAT PROLONG QT ROSUVASTATIN (> 5 MG)/DAROLUTAMIDE ROSUVASTATIN (>10 MG)/REGORAFENIB SLT HMG-COA REDUCTASE INHIBITORS/KETOCONAZOLE; POSACONAZOLE ETHINYL ESTRADIOL (> 30 MCG)/FOSTEMSAVIR FOSTEMSAVIR/STRONG CYP3A4 INDUCERS RASAGILINE; ORAL SELEGILINE/SELECTED MAOIS ST. JOHN'S WORT/MAOIS ETHYL ALCOHOL/NIFURTIMOX TICAGRELOR/TIPRANAVIR LEVOMETHADONE; METHADONE/POSACONAZOLE ATORVASTATIN; LOVASTATIN; SIMVASTATIN/LONAFARNIB MIDAZOLAM/LONAFARNIB LONAFARNIB/STRONG AND MODERATE CYP3A4 INHIBITORS LONAFARNIB/STRONG AND MODERATE CYP3A4 INDUCERS CILOSTAZOL (>50MG)/LONAFARNIB SELECTED NEPHROTOXIC AGENTS/BACITRACIN METHADONE/SELECTED MAOIS For retrospective DUR, list therapeutic categories added or deleted. Underutilization: Antipsychotic agent adherence (new for MCOs) Duration of therapy: Sedative-hypnotics agent > 90 days (new for MCOs) Underutilization: Diabetes agent adherence (modified) Underutilization: Statin agent for individuals with diabetes (new) Underutilization: Statin agent recommendation for individuals with diabetes (new) Underutilization: Statin agent recommendation for individuals with diabetes and ASCVD (new)

State	DUR Board Activities Report Summary
	Drug-to-drug: Concurrent use of MAT and opioids (new) Underutilization: MAT recommendation for individuals with opioid dependency (new) Underutilization: MAT agent adherence (new) Underutilization: Naloxone availability for individuals at high risk of opioid overdose (new) Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. Discussions at the Louisiana DUR Board meetings include prospective DUR and its impact on established retrospective DUR criteria. Policies are not written for global implementation; rather, criteria or drug classes are reviewed for effectiveness in prospective DUR and applicable modifications in retrospective criteria. For example, the prospective duration of therapy edit for high-dose anti-ulcer drugs have reduced the need for examining this issue retrospectively. The Board has recommended implementation of prospective DUR criteria based on exception reports from retrospective reviews. Again, criteria or drug classes are reviewed individually. For example, retrospective reviews targeting therapeutic duplication of non-steroidal anti-inflammatory agents led to the implementation of a prospective DUR edit. Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). The DUR Board recommends topics for educational articles to be included in the "Provider Update" newsletter targeting Louisiana Medicaid providers. Educational efforts by individual DUR Board members may include writing articles for the "Provider Update" newsletter or sharing the DUR Annual Report with interested parties. DUR Board-initiated criteria recommendations for prospective and retrospective DUR supply providers with additional educational information. In the prospective DUR process, pharmacy providers receive educational alerts or "deny" edits on selected medication-related issues. In the retrospective DUR process, recipient-specific profiles along with therapeutic criteria are sent to physician and pharmacy providers. Additional educational information is included for selected criteria topics.
Maine	Drug Utilization Review Board Activity Summary FFY2021 The ME Medicaid (MaineCare) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met (5) five times in FFY2021. 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 2021, the ME DUR Board activities included: 76 New Drug Reviews 1 Revised Clinical Coverage Criteria 49 Therapeutic Class Reviews

State	DUR Board Activities Report Summary
	1 Quantity Limits established for new or previously reviewed drugs 12 FDA Safety Alerts reviewed RetroDUR Analyses o Chantix Use o Influenza Vaccination Rates o Hydroxychloroquine use Pre and Post Covid-19 o Long-acting Injectable Antipsychotics 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, communications are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. The topics are generally complimentary so that pharmacies understand the communications that have been sent to prescribers. These communications 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 13, 2020 Time:1:00PM to 2:30PM Closed Session, 2:30PM to 5PM Public Session Location: Virtual: Join Zoom Meeting https://us02web.zoom.us/j/88328708018?pwd=QSswVitZUk5BbmswUVdUdTFsbzhrUT09 Meeting ID: 883 2870 8018 Passcode: fny76L Closed Session (1pm- 2:30pm) Drug Financial Information Review MaineCare Updates Public Comments Old Business Review of Minutes Revised clinical criteria/ preferred products New Business (open session) Present Retro-DUR Initiatives for 2021 Present 2021 Meeting Schedule A. Open session to review and vote categories subject to potential changes Analgesics, Narcotics, Long-Acting

State	DUR Board Activities Report Summary
	Analgesics, Narcotics, Short- Acting Analgesics, NSAIDS Topical Antiasthmatic - Antiinflammatory Agents Alzheimer/Antidementia Agents Antibiotic- Cystic Fibrosis Anticoagulants Anticonvulsants Antihyperlipidemic/PCSK 9 Inhibitors Antipsychotics Antiretrovirals Bronchodilators, Beta Agonists Cardiovascular- Misc COPD Agents Cytokine and CAM Antagonists Dermatologic- Atopic Dermatitis Dermatologic- Lidocaine Dermatologic- Scabicides/Ped DME- Diabetic Supplies Endometriosis Estrogens GI- IBS/ OIC/CIC GI- Ulcerative Colitis Growth Hormones Hematopoietics Hemophilia Hepatitis C Agents Hereditary Angioedema Hypoglycemics, Incretin Memetics Hypoglycemics, Insulins & Related Agents Hypoglycemics, Misc Agents Migraine Movement Disorders Multiple Sclerosis Agents Neurotoxins Ophthalmics Antiallergics Ophthalmic Antibiotics Ophthalmic Anti-inflammatories Ophthalmic Modulators Opiate Dependence & Overdose Treatments Otic Anti Infectives Pancreatic Enzymes Platelet Aggregation Inhibitors Pulmonary Hypertension Resp. Steriod/Anticholinergic/Misc Sickle Cell Stimulants & Related Agents Urinary Antispasmodic Vaginal Anti-Infectives

State	DUR Board Activities Report Summary
	B. FDA Safety Alerts Benadryl (diphenhydramine): Drug Safety Communication - Serious Problems with High Doses of the Allergy Medicine https://www.fda.gov/safety/medical-product-safety-information/benadryl-diphenhydramine-drug-safety-communication-serious-problems-high-doses-allergy-medicine?utm_medium=email&utm_source=govdelivery FDA Requiring Labeling Changes for Benzodiazepines https://www.fda.gov/drugs/drug-safety-and-availability/fda-requiring-boxed-warning-updated-improve-safe-use-benzodiazepine-drug-class Invokana, Invokamet, Invokamet XR (canagliflozin): MedWatch Safety Alert - Boxed Warning about Risk of Leg and Foot Amputations Removed https://www.fda.gov/safety/medical-product-safety-information/invokana-invokamet-invokamet-xr-canagliflozin-medwatch-safety-alert-boxed-warning-about-risk-leg-and?utm_campaign=FDA%20MedWatch%20-%20Invokana%2C%20Invokamet%2C%20Invokamet%20XR%20%28canagliflozin%29%3A%20MedWatch%20Safety%20Alert&utm_medium=email&utm_source=Eloqua C. Next Meeting (Tuesday, December 8, 2020 (from 5:30pm to 8:30pm) D. Adjournment: 5:00PM DUR COMMITTEE AGENDA Date: Tuesday, December 8, 2020 Time: 6:00PM to 8:30PM Location: Virtual: Join Zoom Meeting https://us02web.zoom.us/j/83746725612?pwd=SDVwbE0wUjB1bFo2VmR4dTIzSGdpZz09 Meeting ID: 837 4672 5612 Passcode: zmHN9D Closed Session: 5:30PM- 6:00PM- Board members only (a separate invitation to be sent) MaineCare Updates Public Comments Old Business . Approve October Meeting Minutes Revised clinical criteria None at this time New Business (open session) Retro DUR o Introduce: Influenza Vaccination Rates o Data Presentation: Chantix Use New Drug Review (http://www.mainecarepdl.org/) AirDuo Digihaler (antiasthmatic - adrenergic combinations) Alkindi (glucocorticoids/ mineralocorticoids) Armonair Digihaler (antiasthmatic - steroid inhalants) Bafiertam (multiple sclerosis - non-interferons) Blenrep (cancer) Breztri (antiasthmatic - adrenergic combinations) Cystadrops (ophthalmic) Cystaran (ophthalmic) Dojolvi (electrolytes/ nutritionals)

State	DUR Board Activities Report Summary
	Enspryng (monoclonal antibody) Evrysdi (neurologics- SMA) Gavreto (cancer) Hemady (glucocorticoids/ mineralocorticoids) Inqovi (cancer) Kesimpta (multiple sclerosis - non-interferons) Lampit (antiprotozoals) Licart (NSAIDS) Mycapssa (somatostatic agents) Ongentys (parkinsons - COMT inhibitors) Onureg (cancer) Polivy (cancer) Tecartus (cancer) Uplizna (monoclonal antibody) Viltepso (muscular dystrophy agents) Xywav (stimulant - stimulant like) FDA Safety Alerts CDER proposes withdrawal of approval for Makena https://www.fda.gov/drugs/drug-safety-and-availability/cder-proposes-withdrawal-approval-makena?utm_medium=email&utm_source=govdelivery FDA advises health care professionals and patients about insulin pen packaging and dispensing https://www.fda.gov/drugs/drug-safety-and-availability/fda-advises-health-care-professionals-and-patients-about-insulin-pen-packaging-and-dispensing?utm_medium=email&utm_source=govdelivery FDA Warns that Using a Type of Pain and Fever Medication in Second Half of Pregnancy Could Lead to Complications https://www.fda.gov/news-events/press-announcements/fda-warns-using-type-pain-and-fever-medication-second-half-pregnancy-could-lead-complications?utm_medium=email&utm_source=govdelivery Next Meeting (Tuesday, March 9, 2021 (from 5:30pm to 8:30pm) Adjournment: 8:30PM DUR COMMITTEE AGENDA Date: Tuesday, March 9, 2021 Time: 6:00PM to 8:30PM Location: Virtual: Join Zoom Meeting https://mainestate.zoom.us/j/87994369540?pwd=bFk5L0xUMExZd3NaSFJ1b28yNnlEQT09 Meeting ID: 879 9436 9540 Passcode: RgAN931% Closed Session: 5:30PM- 6:00PM- Board members only (a separate invitation to be sent) MaineCare Updates- Jan Wright Public Comments Old Business Approve December Meeting Minutes Revised clinical criteria Biosimilars o Nyvepria (pegfilgrastim- apgf injection) - Biosimilar to Neulasta o Riabni (rituximab-arrx) - Biosimilar to Rituxan

State	DUR Board Activities Report Summary
	New Business (open session) Retro DUR o Introduce: Hydroxychloroquine use Pre and Post Covid-19 o Data Presentation: Influenza Vaccination Rates New Drug Review (http://www.mainecarepdl.org/) Barhemsys (amisulpride injection) - Antiemetic- Anticholinergic/Dopaminergic Eysuvis drops (loteprednol etabonate) - Op. Of Interest Fyavolv (norethindrone acetate & ethinyl estradiol) - Estrogen Combos Impeklo Lotion (clobetasol propionate lotion) Topical - Corticosteroids, Very High Potency Monjuvi (tafasitamab-cxix) - Cancer Orladeyo (berotralstat) - Hereditary Angioedema- Prophylaxis Oxlumo (lumasiran) - Cancer Phexxi (lactic acid, citric acid, potassium bitartrate) - Contraceptives- Non
Maryland	Indicate the number of DUR Board meetings held The Maryland Medicaid Drug Utilization Review Board met four (4) times during FFY 2021. Meetings were held on the first Thursday of the months of March, June, September and December. List additions/deletions to DUR Board approved criteria. a) For prospective DUR, list problem type/drug combinations added or deleted. Prospective DUR screening criteria utilized by the current vendor (Conduent State Healthcare, LLC) are based on First Data Bank criteria. All First Data Bank severity level 1 drug-drug interaction alerts are activated by the ProDUR vendor on an ongoing basis. At each DUR Board meeting a review of the top 20 prospective DUR alerts is presented by the prospective DUR vendor for the following types of alerts: -Drug-Drug Interactions -Early Refill -Therapeutic Duplication Early refill alerts require a prior authorization (PA). Calls requesting a PA can be made by the pharmacist or prescriber. Therapeutic duplication alerts can be overridden at point of service by the pharmacy by entering the appropriate NCPDP conflict, intervention and outcome codes. A summary of conflict, intervention and outcome codes entered by the pharmacy to override therapeutic duplication claims is reviewed by the DUR Board at each meeting. A summary of other edits that include low dose, high dose, drug age and drug gender alerts is also reviewed at each meeting. Estimated cost savings/cost avoidance and the number of calls taken by the call center help desk is reviewed at each meeting as well. During FFY 2013, the DUR Board requested a therapeutic duplication alert be developed for the concurrent use of clonazepam and another benzodiazepine. This particular alert is not included in the standard therapeutic duplication alert for benzodiazepines since clonazepam is classified as an anticonvulsant. The alert was implemented in FFY 2014 and continues to be presented to the DUR Board on a quarterly basis. b) For retrospective DUR, list therapeutic categories added or deleted. During FFY 2021, retrospective DUR interventions were performed to identify participants with potentially inappropriate use of controlled substances, 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 a stimulant and a sedative, potentially inappropriate dose of quetiapine, 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.

State	DUR Board Activities Report Summary
	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 FFY2021 may be found in the DUR Board meeting minutes available at https://mmcp.health.maryland.gov/pap/Pages/dur-minutes.aspx Describe Board policies that establish whether and how results of prospective DUR screenings are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. The Maryland DUR Board meets quarterly to review Prospective and Retrospective DUR information. If information is presented that is concerning to Board members, such as overutilization of high risk medications, inappropriate therapeutic use of medications, or high rates of drug interactions with common medications, a request may be made to retrospectively analyze the claims information to determine if a true issue exists within the participant population. In some instances, an intervention may become a recurring intervention that is performed continuously due to the findings from the initial intervention. Conversely, when retrospective DUR interventions are performed, if the outcomes show an unacceptable improvement in practice, the Board may create a Prospective alert, when possible, to further prevent adverse drug events for the participant population and ensure safe and effective use of medications. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring). Information regarding newsletters and upcoming continuing education events are discussed with the DUR Board at each meeting. The DUR Board members routinely offer recommendations for topics in the newsletter as well as continuing education programs. Board members also attend continuing education events in support of the Program. During FFY2017, the DUR Board recommended further review of provider responses that may indicate fraudulent activity. Educational intervention letters include a voluntary response form that the provider may use to indicate follow-up actions in response to the information provided. Some responses include that the provider was incorrectly identified as the prescriber or that the participant was never under the provider's care. In those instances, the RDUR vendor was instructed to contact the provider directly to further investigate the prescription claim and determine if fraud or abuse by the participant was occurring. In some instances, copies of the prescription(s) were obtained for evaluation. This practice continued into FFY2021. 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 2021, OPS sponsored a live program for Maryland Medicaid healthcare providers. The program, “COVID-19: Prevention to Protection” was held in February 2021. 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.

State	DUR Board Activities Report Summary
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, 2020 to September 30, 2021. The DUR Board also participated in seven monthly Clinical Workgroup meetings to address ongoing clinical updates and issues. Clinical Work groups are held during the months between DUR Board Meetings. DUR presentations to the Board include New Drug Reviews, Drugs in Development, Guidelines Quality Assurance, and Performance Metrics. The Guideline Quality Assurance presentations include utilization trends, prior authorization volume and trends and the most recently published evidenced based medical information for a particular guideline. These reviews lead to the expansion of the scope of retrospective DUR screens and guide future prospective DUR criteria development and implementation strategies. DUR Board Educational Activities The DUR Board also approves changes to the MassHealth Drug List website where educational materials are posted, such as Hepatitis C Clinical Information, MassHealth Pain Initiative, and MassHealth ADHD Initiative. The MassHealth Website posts the Prescriber e-Letter, also available by web mail. One hundred fifty-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.

State	DUR Board Activities Report Summary
Michigan	The Michigan Medicaid DUR Board meets quarterly in March, June, September and December of each year. All meetings during FFY 2021 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 2021, 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 atenolol utilization as well as seasonal and non-seasonal vaccination utilization. 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	Summary 2. DUR Board Activities The Minnesota Department of Human Services (DHS) Drug Utilization Board met for four quarterly meetings during Federal Fiscal Year 2021. Highlights of each DUR Board meeting below reflect criteria discussions. December 9, 2020 DUR Board Meeting New Business: The new Retrospective Drug Utilization Review (RetroDUR) contract, with Keystone Peer Review Organization (Kepro), is from October 1, 2020 through September 30, 2022. Kepro's RxExplorer software capabilities were explained. Two mail intervention formats are available: individual

State	DUR Board Activities Report Summary
	patient profile reviews or special mailings where providers receive their patient lists pertaining to criteria. 1. Proton Pump Inhibitors (PPI) Intervention: an extended duration of therapy with no indication for long-term use or extended duration in patients with PUD but without test or treatment for H.pylori. The special mailing format was selected. The DUR Board recommended including PPI tapering educational information. 2. Respiratory Drug Management Intervention: asthma and COPD guidelines were used to create DUR indicators. Three asthma criteria included overutilization of SABA inhalers, underutilization of ICS, and use of LABA inhaler without a SABA inhaler and/or ICS. Three COPD criteria included use of LABA inhaler with LAMA inhaler with chronic stable COPD, use of SABA inhaler without SAMA inhaler, use of ICS without LABA inhaler, and last is duplicate ingredient inhalers with includes asthma and/or COPD. The DUR Board recommended modifying the educational provider messages to include a call-to-action for provider(s). The special mailing format was selected. March 10, 2021 DUR Board Meeting New Business: Kepro is contracted for two SUPPORT Act RetroDUR mailings per contract year in addition to quarterly RetroDUR mailings. For Part I, five criteria were approved. The individual profile review format was chosen. The DUR Board recommended that the alert messages include the specific SUPPORT Act monitoring requirement per criteria. 1. Opioid and Benzodiazepine Concurrent Use (n=189). Patients with a claim for a 30-day supply for a benzodiazepine and 30-day supply of an opioid within 28 days of each other in the last 90 days and criteria for exclusion: any patient with a diagnosis of cancer, a claim for an antineoplastic agent, or diagnosis of palliative care in the last 180 days 2. Opioid and Antipsychotic Concurrent Use (n=130). Same criteria parameters as above with antipsychotic instead of benzodiazepine. 3. Duplicative Short-Acting Opioids (n=242). Patients with at least a 2-day supply for two or more different short-acting opioids within 25 days of each other in the last 90 days. Exclude patient if a diagnosis of malignant neoplasms or sickle cell in the last 180 days. 4. Duplicative Long-Acting Opioids (n=3). Patients with at least a 21-day supply for two or more different long-acting opioids within 28 days of each other in the last 90 days. Exclude patient if a diagnosis of malignant neoplasms in the last 180 days. 5. Maximum Daily Morphine Milligram Equivalent (MME) (n=108). Patients with at least a 30-day supply for 2 or more different opioids in the last 90 days that cumulatively exceeds more than 90 MME per day. May 12, 2021 DUR Board Meeting New Business: SUPPORT for Patients and Communities Act. Part II Discussion. 1. Opioid Use with a History of MAT/OUD. (n=376) Inclusion criteria was an opioid within last 90 days and a MAT drug within the last 730 days or a diagnosis of drug abuse and dependence in the last 365 days without a new indication to support utilization of opioids. Exclusion criteria: (1) a diagnosis of cancer, hospice, or diagnosis of palliative care in the last 90 days and/or (2) seven or less days supply. DUR Board recommendation was to include a call to action in the prescriber letter. Include information about the Minnesota Prescription Drug Monitoring Program, in particular, the coordination of care if there are multiple providers. Include educational information about planning for tapering.

State	DUR Board Activities Report Summary
	2. High Risk of Opioid Overdose and Should Be Considered for Co-Prescription or Co-Dispensing of Naloxone (N=218). Include patients with a claim for an opioid for 30 or greater days in the last 45 days with at least one of the following: claim for one or more drug(s) considered high risk in the last 30 days or a diagnosis of high risk of opioid overdose in the last 365 days. Drug(s) considered high risk are benzodiazepines. Diagnosis of high risk of opioid overdose include drug overdose/poisoning or drug/substance abuse/dependence. Exclude if a claim for naloxone in the last 365 days or a diagnosis of cancer or a diagnosis of palliative care in the last 90 days. While the SUPPORT Act is two separate mailing initially, there will be a combined mailing after that. The Gabapentionoids Intervention consists of three criteria. 1. Gabapentinoid Risk of Respiratory Depression for Those on CNS Depressant Medications and/or with Underlying Respiratory Impairment (n=551). Gabapentinoid and a CNS depressant within 28 days of each other, with or without a diagnosis of underlying respiratory impairment in the last 90 days. 2. High-Dose Gabapentin (N=31). Exceeding 2400mg/day of gabapentin immediate release. 3. Gabapentin in Those with a History of Drug Abuse (n=48). Gabapentin and a diagnosis of drug abuse was within the last 180 days. The Psychotropic Drugs in Youth Intervention continues to be two mailings per contract year. The Minnesota legislature enacted legislation in 2010 that authorized the Department of Human Services to develop a Collaborative Psychiatric Consultation Service. Laws of Minnesota 2010, chapter 200, article 1, section 5, subdivision 13j. 245.4862, subdivision 4. and 256B.0625, subdivision 13j. are referenced. Individual profile review format will be used for the six criteria below. The reviewer will select the most important criteria if a patient meets more than one criteria. Age less than eighteen years applies. Information about Psychiatric Assistance Line (PAL) will be part of alert messages. http://www.mnpsychconsult.com 1. Polypsychopharmacy with Greater than 3 psychotropic drugs concurrently for at least 30 days in the last 60 days. (n=1,530). 2. Polypsychopharmacy with Greater than 2 second generation antipsychotic (SGA) drugs concurrently for at least 30 days in the last 60 days. (n=110) 3. Second-Generation Antipsychotic (SGA) Inappropriate Age (n=166). Age less than the approved age with a claim for a psychotropic medication for at least a 28-day supply in the last 90 days 4. Second-Generation Antipsychotic (SGA) High Dose for Age Range (n=10). Exceeds the maximum FDA dose for at least a 28-day supply in the last 90 days. 5. Attention Deficit Hyperactivity Disorder (ADHD) Inappropriate Age (n=142). Age less than the approved FDA age for an ADHD medication for at least a 28-day supply in the last 90 days. 6. ADHD - High Dose for Age Range (n=357). Exceeds the maximum FDA daily dose per age for at least a 28-day supply in the last 90 days. The SGA blood glucose and lipid monitoring criteria will use a special mailing format. 1. SGA blood glucose monitoring (n=1,167). An SGA in the last 30 days and no blood glucose measurement CPT code in the past year (365 days). 2. SGA lipid monitoring (n=1,891). An SGA in the last 30 days and no lipid panel CPT code performed in the past two years (730 days). September 15, 2021 DUR Board Meeting

State	DUR Board Activities Report Summary
	New Business: Diabetes Mellitus Management Intervention contains nine criteria. The patient profile review format will be used. 1. Duplicate Therapy within the Same Class (n=46). More than one diabetic medication in the same class for 30 days in the last 90 days within 25 days of each other. 2. Drug-Drug Interactions (n=13). An antidiabetic agent and an interacting medication for 30 days using First Data Base (FDB) Level 1 drug-drug interactions. 3. Drug-Disease Interactions (n=105). An antidiabetic agent for 30 days in the last 90 days with an interacting disease condition in the last 180 days or on drugs suggesting the disease state in the last 90 days using FDB Level 1 drug-disease interactions. 4. High Dose (N=15). Exceeds the FDA maximum daily dose for 30 days in the last 90 days. 5. Minimum FDA Age Requirements (n=4). Age less than FDA approved age for 30 days in the last 90 days. 6. Non-Adherence (n=114). Drug claim for more than 60 days in the past 6 months but with less than or equal to 70 days or less in the last 90 days. 7. Underutilization - Hypertensive Guideline/Treatment (n=479). Adult patients with a claim for an antidiabetic agent for 30 days in the last 90 days, with a diagnosis of hypertension or diabetic nephritis in the last 90 days. Exclude patients with a claim for an ACEI/ARB. Messages are based on the ADA 2021 guidelines, Standards of Medical Care in Diabetes. 8. Underutilization - Hyperlipidemia Guideline/Treatment (n=537). Patients aged 20 to 75 years with a claim for an antidiabetic agent for 30 days in the last 90 days within the specified age range. For those 20 to 39 years of age, identification requires a diagnosis of family history of atherosclerotic cardiovascular disease (ASCVD). Exclude patients with a claim for a statin and/or ASCVD drug in the last 90 days. Messages are based on the AHA/ACC Guideline on the Management of Blood Cholesterol. 9. Underutilization - Use of Metformin (n=225). Include patients with a claim for a non-metformin hypoglycemic for 30 days in the last 90 days. Exclude if a claim for metformin in the last 90 days and/or a contraindication in the last 180 days. Message: Use of metformin as first-line therapy initially and continuing with augmentation of therapy to maintain glycemic control. Metformin effectively decreases HbA1c levels, is associated with weight loss and improvement in lipid profile.
Mississippi	FFY 2021 DUR Board Activities Summary Mississippi Division of Medicaid uses two provider boards to provide review and input on prospective and retrospective DUR efforts. The Pharmacy and Therapeutics (P&T) Committee reviews selected drug classes on a regular basis and makes recommendations regarding the PDL and clinical edits for specific products and/or classes. The DUR Board reviews utilization reports and retrospective studies conducted by the DUR vendor and makes recommendations about prospective and retrospective utilization management interventions that should be taken for specific drugs and/or therapeutic classes and what items should be included or deleted from the retrospective exceptions monitoring program. The two groups are closely coordinated with prospective DUR vendor representatives and retrospective DUR vendor representatives attending both meetings. During P&T Committee meetings, issues are frequently identified for retrospective review for potential further action by the DUR Board. Four virtual DUR Board meetings were held during the fiscal year on the following dates: December 3, 2020; March 4, 2021; June 10, 2021; September 16, 2021 Two virtual P&T Committee meetings were held during the fiscal year on the following dates: October 27, 2020; August 20, 2021

State	DUR Board Activities Report Summary
	The following is a summary of initiatives reviewed and recommendations made by the DUR Board during FFY 2021: December 3, 2020 In response to a report describing the use of naloxone among beneficiaries at high risk of experiencing adverse opioid events or overdose, the Board recommended that DOM distribute educational reminders to prescribers and pharmacists regarding the FDA's recent recommendation for naloxone, the covered status of naloxone products on the PDL, and the MS Dept of Health's naloxone standing order. MS-DUR presented a report on the administration of adult vaccines to Medicaid beneficiaries during calendar year 2019. At that time, DOM had submitted to CMS a SPA to expand adult vaccine services offered through pharmacies (SPA was subsequently approved by CMS). The Board recommended an educational initiative targeting pharmacists to highlight the expanded opportunities granted to pharmacists to actively engage in adult immunizations. March 4, 2021 After an overview of HIV PrEP and a review of PrEP utilization between 2014 and 2020, the board recommended provider education on PrEP therapy. Another recommendation by the board was to conduct future research related to PrEP utilization focused on disparities and barriers to treatment. The board reviewed Epidiolex prescribing trends that seemed to indicate consistent dosage increases since its approval in 2018. No dosing limits were recommended to DOM. The board reviewed growth hormone utilization trends during calendar years 2018 to 2020 and recommended extending diagnosis requirements to beneficiaries of all ages, whereas diagnosis had previously been required only for ages 18 and above. Subsequently, the SmartPA criteria was updated with this change effective October 1, 2021. June 10, 2021 This meeting was focused primarily on the treatment of migraine. The board was presented with three reports on various aspects of migraine treatment: Overall trends in the utilization of migraine medications, CGRP inhibitor utilization trends and outcomes assessment, utilization of preventive therapy for migraine. As a result of these reports, the Board recommended that DOM prohibit concurrent use of oral CGRP inhibitor agents with another CGRP inhibitor agent by defining parameters for concurrent use such as a minimum length of trial of a preventive CGRP inhibitor agent prior to adding a second agent, doses maximization of preventive agent prior to adding a second agent trial of a different preventive agent prior to adding a second agent, or verification of adherence to preventive agent prior to adding a second agent. In addition, the Board recommended that DOM tighten manual PA reauthorization criteria to incorporate measurable thresholds based on evidence in literature. The Board also recommended that DOM consider strategies to improve the rates of preventive migraine diagnosis and treatment among Medicaid beneficiaries, especially targeting those in the FFS program. September 16, 2021 Utilization data of immune globulin (IG) products during calendars 2017 through 2020 was reviewed. While the number of beneficiaries treated during the timeframe increased only slightly, there was a significant increase in costs for IG. The board approved a recommendation to implement manual PA for all IG products.
Missouri	At the October 2020 meeting, the DUR board reviewed and approved the following edits: Transthyretin-Mediated Amyloidosis (ATTR) Clinical Edit, Botulinum Toxin Clinical Edit, Elagolix Clinical Edit (formerly Orilissa Clinical Edit), Emsam Clinical Edit, Equetro Clinical Edit, Fintepla Clinical Edit, Immunoglobulins (IVIG and SCIG) Clinical Edit, Lambert-Eaton Myasthenic Syndrome

State	DUR Board Activities Report Summary
	(LEMS) Clinical Edit, Narcolepsy Inhibitors Clinical Edit, Nuedexta Clinical Edit, Oxandrin Clinical Edit, Palforzia Clinical Edit, Ranexa Clinical Edit, Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) Clinical Edit, Uplizna Clinical Edit, Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors Clinical Edit, Xcopri Clinical Edit, Zometa Clinical Edit, ACE Inhibitors and ACE inhibitors/ Diuretic Combinations PDL, ACE Inhibitor/ Calcium Channel Blocker Combinations PDL Edit, ADHD: Amphetamines, Long Acting PDL Edit, ADHD: Amphetamines, Short Acting PDL Edit, ADHD: Methylphenidate, Long Acting PDL Edit, ADHD: Methylphenidate, Short Acting PDL Edit, ADHD Non-Stimulant Agents PDL Edit, Anticoagulant Agents, Oral and Subcutaneous PDL Edit, Anticonvulsants, Rescue Agents PDL Edit, Antiplatelet Agents PDL Edit, Angiotensin Receptor Blockers and Angiotensin Receptor Blocker/ Diuretic Combinations PDL Edit, Angiotensin Receptor Blocker/ Calcium Channel Blocker Combinations PDL Edit, Beta Adrenergic Blockers and Beta Adrenergic Blockers/ Diuretic Combinations PDL Edit, Calcium Channel Blockers (Dihydropyridines) PDL Edit, Calcium Channel Blockers (Non- Dihydropyridine) PDL Edit, Direct Renin Inhibitors and Combinations PDL Edit, Dry Eye Disease Agents PDL Edit, Homozygous Familial Hypercholesterolemia (HFHC) Products PDL Edit, Niacin Derivatives PDL Edit, Pulmonary Arterial Hypertension (PAH) Agents: Endothelin Receptor Antagonists (ETRAs) PDL Edit, Pulmonary Arterial Hypertension (PAH) Agents: Phosphodiesterase-5 (PDE5) and Soluble Guanylate Cyclase (SGC) Stimulators PDL Edit, Pulmonary Arterial Hypertension (PAH) Agents: Prostacyclin Pathway Agonists, Inhaled PDL Edit, Pulmonary Arterial Hypertension (PAH) Agents: Prostacyclin Pathway Agonists, Injectable PDL Edit, Pulmonary Arterial Hypertension (PAH) Agents: Prostacyclin Pathway Agonists, Oral PDL Edit, Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Binders PDL Edit, Proton Pump Inhibitors (PPIs) PDL Edit, Statins (HMG-CoA Reductase Inhibitors) and Combinations PDL Edit, Sympatholytic Agents PDL Edit, Triglyceride Lowering Agents PDL Edit. At the January 2021 meeting, the DUR board reviewed and approved the following edits: 15 Day Supply Fiscal Edit, Antipsychotics-1st Generation (Typical) Clinical Edit, Antipsychotics-2nd Generation (Atypical) Clinical Edit and Reference List, Benzodiazepines (Select Oral) Clinical Edit, Biosimilar vs Reference Products Fiscal Edit, CAR T-Cell Therapy Clinical Edit, Diabetic Supply Quantity Limit Fiscal Edit, Duchenne Muscular Dystrophy (DMD) Clinical Edit, High Cost Medication Kits Fiscal Edit, High Risk Therapies Clinical Edit, Isturisa Clinical Edit, Morphine Milligram Equivalent Accumulation Clinical Edit, Neuromyelitis Optica Spectrum Disorder (NMOSD) Clinical Edit, Non-Oral Contraceptives Fiscal Edit, Opioids- Short-Acting Combinations Clinical Edit, Opioids-Short-Acting Single Agents Clinical Edit, Out-of-State, Non-Bordering Pharmacies Fiscal Edit, Psychotropic Medications Polypharmacy Clinical Edit, PrEP Fiscal Edit, Spinal Muscular Atrophy (SMA) Clinical Edit, Transmucosal Immediate Release Fentanyl (TIRF) Clinical Edit, Preferred Drug List Edits With No Annual Changes, Anticonvulsants, Dravet Syndrome PDL Edit, Antiemetic 5HT3 and NK1 Agents, Injectables PDL Edit, Anti-Migraine Agents, Alternative Oral Agents PDL Edit, Anti-Migraine, Serotonin (5-HT1) Receptor Agonists PDL Edit, Antiretrovirals, Treatment Products Reference List, Anti-Parkinsonism Non-Ergot Dopamine Agonists PDL Edit, Calcitonin Gene-Related Peptide (CGRP) Inhibitors PDL Edit, Cyclin-Dependent Kinase (CDK) 4/6 Inhibitors PDL Edit, Fibromyalgia Agents PDL Edit, GI Motility Agents PDL Edit, Glucagon Agents PDL Edit, Neuropathic Pain Agents PDL Edit, NSAID Agents PDL Edit, Opiate Dependence Agents PDL Edit, Opioids, Long Acting PDL Edit, Sedative Hypnotic Agents PDL Edit, Skeletal Muscle Relaxants PDL Edit, Somatostatic Agents PDL Edit, Tramadol-Like Agents PDL Edit, Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors PDL Edit. At the April 2021 meeting, the DUR board reviewed and approved the following edits: Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators Clinical Edit, Clobazam Agents Clinical Edit, Fabry Disease Clinical Edit, Nocturnal Polyuria Clinical Edit, Opioids, Single Agents Short Acting Clinical Edit, Oxlumo Clinical Edit, Spravato Clinical Edit, Androgenic Agents PDL Edit, Antibiotics, Inhaled PDL Edit, Antifungals, Topical PDL Edit, Antihistamines, Ophthalmic PDL Edit,

State	DUR Board Activities Report Summary
	Antiparasitics, Topical PDL Edit, Atopic Dermatitis Agents, Immunomodulators, PDL Edit, Beta Adrenergics Agents, Short Acting PDL Edit, COPD Agents PDL Edit, Corticosteroids Inhaled PDL Edit, Corticosteroids Intranasal PDL Edit, Corticosteroids Ophthalmic Soft PDL Edit, Corticosteroids Topical PDL Edit, Epinephrine Agents Self-Injectable PDL Edit, Fluoroquinolones Otic PDL Edit, Glaucoma Agents PDL Edit, Hepatitis C Agents PDL Edit, Hereditary Angioedema (HAE) Agents PDL Edit, Leukotriene Receptor Modifiers PDL Edit, Respiratory Monoclonal Antibodies PDL Edit, Ulcerative Colitis Oral PDL Edit. At the July 2021 meeting, the DUR board reviewed and approved the following edits: CAR-T Cell Clinical Edit, Crysvita Clinical Edit, Duchenne Muscular Dystrophy Clinical Edit, Entresto Clinical Edit, Extended Supply Fiscal Edit, HBV Nucleotide Analog Clinical Edit, Imcivree Clinical Edit, Iron Injectable Clinical Edit, Nulibry Clinical Edit, Oxazolidinone Fiscal Edit, Palynziq Clinical Edit, PTH Agents Clinical Edit, Verquvo Clinical Edit, Zokinvy Clinical Edit, Alpha-Glucosidase Inhibitors PDL Edit, Antibiotics GI Oral PDL Edit, Antibiotics Mupirocin Topical PDL Edit, Antihyperuricemic Agents PDL Edit, Benign Prostatic Hyperplasia (BPH) Agents PDL Edit, Biguanides & Combinations PDL Edit, Bone Ossification Agents PDL Edit, Colony Stimulating Factors PDL Edit, Cryopyrin-Associated Periodic Syndrome Agents PDL Edit, DPP-IV Inhibitors & Combinations PDL Edit, Erythropoiesis Stimulating Agents PDL Edit, GLP-1 Receptor Agonists & Combinations PDL Edit, Growth Hormone Agents, Somatropin PDL Edit, Growth Hormone & Growth Hormone Releasing Factors Select Agents PDL Edit, Insulin Long Acting PDL Edit, Insulin Rapid Acting PDL Edit, LHRH/GnRH Agents Non-Oral PDL Edit, Macrolides PDL Edit, Meglitinides PDL Edit, Methotrexate Agents PDL Edit, Multiple Sclerosis Agents Injectable PDL Edit, Multiple Sclerosis Agents Oral PDL Edit, SGLT2 Inhibitors & Combinations PDL Edit, Targeted Immune Modulators IL17 Antibody/IL17 Receptor Antagonists PDL Edit, Targeted Immune Modulators IL23 Inhibitors & IL23/IL12 Inhibitors PDL Edit, Targeted Immune Modulators JAK Inhibitors PDL Edit, Targeted Immune Modulators Select Agents PDL Edit, Targeted Immune Modulators TNF Inhibitors PDL Edit, Tetracycline Agents PDL Edit, Thiazolidinediones & Combinations PDL Edit, Urinary Tract Antispasmodics PDL Edit.

State	DUR Board Activities Report Summary
Montana	-Number of DUR Board Meetings Held --Six (8) DUR Board meetings were held in FFY 2021. -Deletions or Additions to Prospective DUR Criteria --New Criteria was developed for the following Drugs: Amondys, Apokyn, Dayvigo, Entyvio, Evenity, Evrysdi, Fasenra, Fintepla, Hetlioz, Kerendia, Kynmobi, Lemtrada, Lupkynis, Nexletol, Nexlizet, Ocrevus, Prolia, Simponi Aria, Spinraza, Spravato, Supprelin LA, Verquvo, Xgeva, Xywav, Zinplava, Zolgensma, Zulresso --Criteria was updated for the following drugs: Cinqair, Clonidine ER, Entresto, Epidiolex, Exondys, Growth Hormone, Invega Trinza, Krystexxa, Lemtrada, Linezolid, Modafinil/armodafinil, Namenda, Nucala, Nurtec, Ofev, Sublocade, Vivitrol, Xofluza, Xolair, Zeposia -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 Retrospective DUR Criteria that resulted in changes to prospective DUR and vice-versa Prospective DUR criteria are provided by a different vendor than the Retrospective criteria. The DUR Board recognized the need for consistency between criteria sets and attempts to align them as closely as possible. In all cases, prospective criteria are more selective and refined because of internal access to the criteria development process. 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. -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 FFY2021. A link to on-line quarterly newsletters are distributed to nearly 1000 pharmacies and providers with timely drug utilization review topics and newly developed criteria information.

State	DUR Board Activities Report Summary
Nebraska	The DUR Board meetings occur six times per year. They are currently set up for the second Tuesday of odd numbered months. They were primarily virtual due to the pandemic. They were switched to a combination of virtual and in-person. This is allowed twice per calendar year. We are now in an in-person only format. As far as problem types, we continue to review SUPPORT Act medications every 6 months. We are just starting the review of naloxone prescribing and use, along with a robust review of patients that obtain multiple refills of short-acting inhalers without a prescription for a long-acting agent. Once we obtain the data, we will propose ways we can get the prescribers to add/consider the addition of a long-acting agent. Pain management continues a topic of review and discussion. With the data we get from any of these topics, we will use the MCO's and the professional associations to assist in the distribution of teaching materials.
Nevada	The DUR Board meets quarterly to monitor drugs for: therapeutic appropriateness, over or under-utilization, therapeutic duplications, drug-disease contraindications, and quality care. The DUR Board does this by establishing prior authorization and quantity limits to certain drugs/drug classes based on utilization data, experience, and testimony presented at the DUR Board meetings. This includes retrospective evaluation of interventions, and prospective drug review that is done electronically for each prescription filled at the Point of Sale (POS). During the Federal Fiscal Year 2021, the DUR Board was comprised of five physician and five pharmacists from various backgrounds and locations around the State of Nevada. Other non-voting members who contribute to Board discussions include employees from DHCFP, a Deputy Attorney General and representatives from the contractors for MMIS and PBM services. The three managed care organizations also participate, and each have non-voting representation on the Board. The public is welcome to provide testimony to the Board before the Board vote on topics. Clinical reviews and proposed prior authorization criteria for the Board are supplied by OptumRx. Additional input is provided by pharmaceutical manufacturers, members of the public, and the DUR Boards unique experiences and research. All DUR Board meeting information is posted before each meeting on the fiscal agent's website for the public. This includes all clinical drug reviews, meeting materials and proposed criteria. At the October 2020 meeting, prior authorization (PA) criteria were added for topical doxepin, Zeposia, GNRH/LHRH antagonists, and bone density regulators. During this meeting opioid and benzodiazepine utilization was reviewed regarding top prescribers and members. In addition, benzodiazepine utilization was reviewed. At the January 2021 meeting, PA criteria were added for Fintepla, Evrysdi, Viltepso, Vyondys 53 and Qutenza. During this meeting opioid utilization was reviewed regarding top prescribers and members. At the April 2021 meeting, PA criteria was added For Kesimpta and Xywav. Criteria was updated for hereditary angioedema agents, platelet inhibitors, hepatitis C agents, and anticonvulsants. During this meeting reports regarding opioid utilization were reviewed. At the July 2021 meeting, PA criteria was added to ergot derivates and Viltepso. In addition, reporting regarding top opioid prescribers and members was reviewed.
New Hampshire	The NH Medicaid DUR Board met twice during FFY2021 on December 15, 2020 and June 8, 2021 where drug utilization patterns for prospective and retrospective activity were discussed as well as 38 current clinical criteria updates and 4 new clinical criteria were approved. During FFY 2021, the following clinical criteria were updated with new medications, new indications, and guideline changes: 1. Allergen Extracts 2. Anti-Fungal Medication for Onychomycosis 3. Anti-Obesity

State	DUR Board Activities Report Summary
	4. Asthma/Allergy Immunomodulators 5. Atopic Dermatitis 6. Benign Prostatic Hyperplasia 7. Brand Name Multiple Source Prescription Drug Product 8. Buprenorphine/Naloxone and Buprenorphine (Oral) 9. Calcitonin Gene-Related Peptide (CGRP) Inhibitor 10. Carisoprodol and Combination Medication 11. Direct Renin Inhibitor and Combination 12. Drugs for Bowel Disorders/GI Motility, Chronic 13. Duchenne Muscular Dystrophy Agents 14. Duloxetine 15. Dupixent 16. Fibromyalgia 17. Hematopoietic Agents 18. Human Growth Hormones 19. Hyaluronic Acid Derivatives Injection 20. Inhaled Insulin 21. Long-Acting Opioid Analgesics 22. Lyrica 23. Methadone (Pain Management Only) 24. Morphine Milligram Equivalent 25. Movement Disorders 26. New Drug Product 27. Oral Isotretinoin 28. Oral NSAIDs and Combinations Legend (Rx Required) Systemic 29. Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) 30. Psychoactive Medication for Children (5 Years of Age or Younger) 31. Psychotropic Medication Duplicate Therapy (Patients 6 Years and Older) 32. Restless Leg Syndrome 33. Short-Acting Fentanyl Analgesic 34. Symlin 35. Synagis 36. Systemic Immunomodulators 37. Topical NSAIDs Legend (Rx Required) 38. Zolgensma The following were new clinical criterion approved during FFY 2021: 1. Adenosine triphosphate-citrate lyase (ACL) inhibitor Criteria 2. Duchenne Muscular Dystrophy Criteria 3. Evyrsdi Criteria 4. Spravato Criteria The NH DUR Board removed the criteria for Syndros (dronabinol) as the manufacturer does not participate in the Medicaid Drug Rebate Program. NH DUR Board continues to monitor Therapeutic Duplications, Drug Drug interactions, Duplicate Ingredients and Early Refills. NH Medicaid continues to utilize First Data Bank for Prospective DUR Criteria. The NH DUR Board reviews the summary of potential impacts to prescribers and members for over 200 RetroDUR activities at each meeting. The NH DUR Board selects the interventions that will be performed until the next DUR Board meeting. These interventions include letters to prescribers and may contain a request for response depending on the topics selected.

State	DUR Board Activities Report Summary
New Jersey	The DUR Board held four meetings on October 2020, January 2021, April 2021, and July 2021. October 2020 1. Protocol for Vimizim (elosulfase alfa). The Board reviewed and approved the use of Vimizim for the treatment of Mucopolysaccharidosis IVA or Morquio A syndrome. 2. Protocol for Naglazyme (galsulfase). The Board reviewed and approved a protocol for Naglazyme for the treatment of Mucopolysaccharidosis VI or Maroteaux-Lamy syndrome. 3. Protocol for Mepsevii (vestronidase alfa-vjbk). The Board reviewed and recommended the use of Mepsevii for the treatment of Mucopolysaccharidosis VII or Sly syndrome. January 2021 1. Protocol for Daraprim (pyrimethamine). The Board reviewed and approved the use of Daraprim for the treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis. 2. Protocol for Increlex (mecasermin). The Board recommended Increlex for patients diagnosed with growth hormone (GH) gene deletion, with neutralizing antibodies to GH, or severe primary insulin-like growth factor-1 deficiency. 3. Protocol for exclusion for Victoza (liraglutide). The Board recommended the exclusion of Victoza doses greater than 1.8mg per day and for use with weight loss as recommended by the manufacturer. The Board approved use for all FDA listed indications. April 2021 1. Protocol for Korlym (mifepristone). The Board recommended the use of Korlym for the treatment of hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery. 2. Protocol for Juxtapid (lomitapide). The Board reviewed and approved Juxtapid as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH). 3. Protocol for Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) products. The Board reviewed and approved the use of Kalydeco, Orkambi, Symdeko, and Trikafta for management of cystic fibrosis (CF) when appropriate. July 2021 1. An addendum to direct acting antiretrovirals (DAAs) for HCV protocol. The Board reviewed and recommended an addendum to the direct acting antiretrovirals (DAAs) for Hepatitis C virus (HCV) protocol. The update included removing restrictions on prescribers, thereby increasing access to treatment. 2. An addendum to Dupixent (dupilumab) protocol. The Board reviewed and recommended an addendum to the protocol for dupilumab, an interleukin4 receptor alpha antagonist indicated for the treatment of moderate-to-severe atopic dermatitis. The update included adjusting eligibility age from 12 to 6 years of age per new guidelines. The requirement to provide dates of trial for step therapy drugs was also removed. 3. Addendum for Vyondys (golodirsen) protocol. The Board reviewed and recommended an addendum to the golodirsen protocol. The update included the addition of a new drug in this class, Viltepso (Viltolarsen). The addendum also included a change of name for the protocol to 'Duchenne Muscular Dystrophy Products' to accommodate any future FDA approvals in this category. 4. Addendum for Epidiolex (cannabidiol) protocol. The Board reviewed and approved an addendum to the cannabidiol protocol. The update included a new indication for 'Tuberous Sclerosis Complex' or TSC. The eligibility age was also changed from 2 years to 1 year of age and older.

State	DUR Board Activities Report Summary
	5. Addendum for Cablivi (caplacizumab) protocol. The Board reviewed and approved an addendum to the protocol for caplacizumab, a von Willebrand factor (vWF)-directed antibody fragment. The protocol was updated to include a new indication for 'Thrombotic Microangiopathy' or TMA. 6. Protocol for Cabenuva (cabotegravir/rilpivirine) injectable. The Board reviewed and recommended Cabenuva, a long-acting injection approved for the treatment of HIV-1 infection. 7. Protocol for biologic response modifier products. The Board reviewed and made recommendations for the use of the products Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Humira (adalimumab), Ilumya (tildrakizumab), Otezla (apremilast), Remicade (infliximab), Siliq (bradalumab), Skyrizi (risankizimab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab) and Tremfya (guselkumab) for use in plaque psoriasis. 8. Protocol for Lumizyme (alglucosidase alfa). The Board reviewed and approved Lumizyme, an enzyme replacement therapy, for the treatment of Pompe disease. 9. Protocol for Myalept (metreleptin). The Board reviewed and approved Myalept as an adjunct to diet as replacement therapy for patients with congenital or acquired generalized lipodystrophy. The DUR Board reviewed COVID-19 drug utilization and provided various medication information resources to board members and attendees, including the New Jersey COVID-19 Information Hub.
New Mexico	SUMMARY OF DUR BOARD ACTIVITIES A. Number of DUR Board meetings held. Four meetings were held in FFY 2021. B. Additions/deletions to DUR Board approved criteria. 1. For prospective DUR, problem type/drug combinations added or deleted. The DUR Board did not approve, delete, or change any NCPDP ProDUR criteria. 2. For retrospective DUR, therapeutic categories added or deleted. The DUR Board approved and completed two educational newsletters and five interventions for Federal Fiscal Year 2021. C. Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. There are no written DUR Board policies per se. D. Policies used to encourage the use of therapeutically equivalent generic drugs. Include relevant documentation, if available. New Mexico Medicaid reimburses for the generic cost only if a brand drug is dispensed when a generic is available. E. DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). One educational outreach newsletter was delivered to fee-for-service providers and three patient-focused interventions were delivered to selected providers in FFY 2021. The newsletter contained information regarding influenza treatment and prevention, a clinical topic approved by the New Mexico DUR Board. The first intervention focused on Opioids/Benzodiazepines/Antipsychotics final outcome in FFY22, the second intervention was surrounding NSAIDs final outcome in FFY22, and the third intervention was surrounding second-generation antipsychotics and metabolic monitoring in children <18 years. Three interventions from FFY20 were completed to determine the FFY 2021 retrospective DUR cost savings, two focused on Morphine Milligram Equivalents, and one focused on Gabapentinoids and Opioids.
New York	There were four DUR Board meetings held during the reporting period. Meeting dates and activities are as follows: November 5, 2020

State	DUR Board Activities Report Summary
	The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred or non-preferred in the following therapeutic classes: 1. ARBs Combinations 2. Antimigraine Agents - Acute Treatment 3. Antipsychotics - Second Generation 4. Multiple Sclerosis Agents 5. Gastrointestinal Antibiotics 6. Immunomodulators - Systemic The DUR Board reviewed the following topics and recommended clinical criteria and/or interventions to ensure appropriate drug utilization: 1. Opioids used for the treatment of acute pain and morphine milligram equivalent (MME) parameters. The DUR Board recommendation: Prior authorization required when initiating therapy with a short-acting opioid (SAO) at equal to or greater than 50 morphine milligram equivalents (MME) per day. Note: This was a reduction from greater than 90 MME per day. Exceptions for patients with cancer, sickle cell disease or receiving hospice care 2. Long-Acting Injectable Antipsychotic utilization as related to the SUPPORT Act. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The outcome of the DUR as to continue to monitor the use of oral and injectable antipsychotics across the entire Medicaid population. February 11, 2021 The DUR Board reviewed the following drugs/drug classes currently subject to the Clinical Drug Review Program (CDRP) and recommended changes to the clinical criteria or other drug utilization review interventions to ensure appropriate utilization: 1. Palivizumab (Synagis) 2. Sodium Oxybate (Xyrem) 3. Somatropin (Serostim) 4. Anabolic Steroids 5. Fentanyl Mucosal Agents 6. Growth Hormones For all but one of the therapeutic classes / drugs reviewed, the DUR Board determined that the existing clinical criteria was appropriate, and the products would remain subject to the CDRP. The one change to the existing clinical criteria was for growth hormone class as follows: Prior authorization required when prescribed for members 18 years of age or older. Note: This was a reduction of age from 21 years or older. The DUR Board was provided updates on the following topics: 1. Drug Cap Initiative 2. Pharmacy Benefit Carve-Out from Managed Care May 13, 2021

State	DUR Board Activities Report Summary
	The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred and non-preferred drugs in the following therapeutic classes: 1. Non-Steroidal Anti-inflammatory Drugs (NSAIDs) 2. Antibiotics, Inhaled 3. Triglyceride Lowering Agents 4. Antimigraine Agents, Other 5. Colony Stimulating Factors 6. Anti-inflammatories/Immunomodulators, Ophthalmic 7. Fluoroquinolones, Otic 8. Antihyperuricemics July 15, 2021 The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred and non-preferred drugs in the following therapeutic classes: 1. Anticonvulsants, Other 2. Antipsychotics, Injectable 3. Multiple Sclerosis Agents 4. Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) 5. Actinic Keratosis Agents 6. Glucocorticoids, Oral 7. Phosphate Binders/Regulators 8. Anticholinergics/COPD Agents More information regarding DUR Board Meetings can be found at: https://www.health.ny.gov/health_care/medicaid/program/dur/index.htm New RetroDUR criteria (e.g., drug interactions, diagnosis alerts, contraindications, therapeutic appropriateness, overutilization, underutilization, adherence, etc.) was added to the program for the drugs listed: October 2020: alpelisib, upadacitinib, binimetinib, cobimetinib, selumetinib, capmatinib, enasidenib, everolimus, fedratinib, gilteritinib, midostaurin, regorafenib, sorafenib, idelalisib, duvelisib, November 2020: istradefylline, diroximel, diroximel/dimethyl fumarate, apalutamide, darolutamide, entrectinib, ivosidenib, vorinostat, trifluridine/tipiracil, selinexor, tazemetostat, venetoclax, topotecan, celecoxib oral solution, forfivo XL December 2020: cenobamate, ibrutinib, enasidenib, Panobinostat, capecitabine, abiraterone, abiraterone micronized, bicalutamide, enzalutamide, flutamide, nilutamide, fluticasone/umeclidinium/vilanterol January 2021: duloxetine, pexidartinib, fostemsavir, pralsetinib, rucaparib, temozolomide, gabapentin IR, gabapentin/pregabalin February 2021: osilodrostat, budesonide/glycopyrrolate/formoterol, procarbazine, mitotane, olaparib, talazoparib, ixazomib, bexarotene, hydroxyurea, decitabine/cedazuridine, March 2021: amifampridine, acalabrutinib, afatinib, alectinib, avapritinib, axitinib, bosutinib, brigatinib, cabozantinib, ceritinib, crizotinib, dasatinib, rosuvastatin sprinkle April 2021: brigatinib, opicapone, guselkumab

State	DUR Board Activities Report Summary
	May 2021: viloxazine, seckinumab, erlotinib, gefitinib, ibrutinib, imatinib, lapatinib, lenvatinib, lorlatinib, neratinib, nilotinib, erdafitinib June 2021: vibegron, pralsetinib, monetelukast, budesonide inhalation powder, ciclesonide, fluticasone HFA, fluticasone diskus, mometasone inhalation, budesonide/formoteol, mometasone inhalantion aerosol, fluticasone/salmeterol July 2021: rosuvastatin/ezetimibe, capmatinib, ivosidenib August 2021: ozanimod, ponesimod September 2021: vorinostat, serdexmethylphenidate/dexmethylphenidate, elexacaftor/tezacaftor/ivacaftor, exenatide/exenatide ER, fesoterodine
North Carolina	The North Carolina Drug Utilization Review (DUR) Board meets quarterly in January, April, July, and October of each year. During each DUR Board meeting the DUR Board is presented prospective and retrospective DUR information. The DUR Board uses prospective screenings to identify areas for additional retrospective research. The research findings are then presented at a future DUR Board meeting. During each quarterly meeting, the DUR Board is presented with several retrospective topics. After discussion, the DUR Board may recommend to the Department of Health Benefits the addition of prospective point-of-sale edits or prior authorizations, as well as recommend a lettering initiative or newsletter articles. The Board also reviews reports on concurrent use of opioids and benzodiazepines and antipsychotics In recent years, the Board has recommended lettering campaigns and newsletter articles as the primary method of interventions. Using these processes, the state is able to reach many providers. Letters have response forms for the provider to return to the state's RetroDUR vendor in order to collect feedback. The Board will often monitor the interventions to see if provider habits changed after lettering. Board members also share pertinent information with their respective organizations. For example, in NC, there are initiatives to increase clozapine utilization which is spearheaded by the NC Psychiatric Association in conjunction with other projects across the state.. Topics where the Board recommended lettering are listed below. The following prospective DUR categories are reviewed with the DUR Board during each meeting: drug disease contraindication alerts, drug-drug interaction alerts, overuse alerts, high dose alerts, ingredient duplication alerts, low dose alerts, drug underuse alerts, drug age alerts, pregnancy alerts, and therapeutic duplication alerts. The top drug disease contraindication alerts were antihyperglycemic, biguanide type (C4L), skeletal muscle relaxants (H6H), and treatment for ADHD/narcolepsy (H2V). Opioid analgesics (H3A), narcotic, analgesic and non-salicylate analgesic (H3U), and anticonvulsants (H4B) were the top drug-drug interaction alerts. The top overuse alerts consisted of antipsychotic, atypical, dopamine, serotonin antagonist (H7T), adrenergics, aromatic, non-catecholamine (J5B), and treatment for ADHD/narcolepsy (H2V). The top high dose alerts were antipsychotic, atypical, dopamine, serotonin antagonist (H7T), antihistamines- 2nd generation (Z2Q), adrenergics, aromatic, non-catecholamine (J5B), and SSRIs (H2S). Adrenergics, aromatic, non-catecholamine (J5B), treatment for ADHD/narcolepsy (H2V), anticonvulsants (H4B), and antipsychotic, atypical, dopamine, serotonin antagonist (H7T) were the top ingredient duplication alerts. The top low dose alerts were lincosamide antibiotics (W1K), penicillins (W1A), nitrofuran derivatives antibacterial agents (W2F), and macrolide antibiotics (W1D). The highest ranked drug underuse alerts were anticonvulsants (H4B), SSRIs (H2S), and treatment for ADHD/narcolepsy (H2V). The top drug age alerts included antihistamines- 1st generation (Z2P), absorbable sulfonamide antibacterial agents (W2A), and topical immunosuppressive agents (Q5K). The top pregnancy alerts were anticonvulsants (H4B), SSRIs (H2S), and contraceptives, oral (G8A). Anticonvulsants (H4B), SSRIs (H2S), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), and antihistamines, 2nd generation (Z2Q) were the top therapeutic duplication alerts.

State	DUR Board Activities Report Summary
	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 cetirizine 10 mg tab (~21K to ~ 29K claims), albuterol HFA (~27K to ~33K claims), fluticasone nasal (~22K claims), and cetirizine 1 mg/mL (~18K to ~26K claims). Humira CF Pen (~$4.8M to ~$7M), Suboxone Film (~$3.1M to ~$3.9M), and Biktarvy 50-200-25 tab (~$2.9M to ~$4.3M) were in the top 15 Drugs (GSN) by total amount paid. The top 15 drugs (GSN) by total amount paid (all strengths) included Humira (~$7.3M to ~$9.7M), Concerta (~$4.5M to ~$4.9M), Invega (~$4M to 4.3M), and Vyvanse (~$4.1M). The Top 15 GC3 classes by payment amount included atypical, dopamine, serotonin antagonist (H7T; ~$9.4M to ~$9.7M), anti-inflammatory tumor necrosis factor (S2J; ~$9.2M to ~$11.9M), and insulins (C4G; ~$8.4M to ~$8.9M). In 2020 and 2021 the retrospective drug utilization categories included the examination of the following benzodiazepine topics: 2-year trend, general utilization, chronic use, concurrent use with stimulants, and concurrent use with z-drugs. Additionally, the Board focused considerable attention to safe and clinically appropriate use of opioids including high dose prescribing trends, top prescribers, top opioids, concurrent use with antipsychotics, duplication of therapy, and conditions which may warrant higher daily MME. Naloxone use was reviewed and increased utilization was observed in the Medicaid population. Finally, the Board reviewed non-compliance of diabetic testing supplies and oral oncology medications. Other reviews included use of Puretek products, use of hydroxyurea in sickle cell disease, non-compliance to immunosuppressive medications, opioids for the treatment of fibromyalgia, and clozapine utilization. Data comparing drug utilization from one quarter to the next is also reviewed by the Board. Unexplained seasonal increases leads to a drill down of the data to see if there has been a shift in utilization or price increase.

State	DUR Board Activities Report Summary
North Dakota	North Dakota Summary of DUR Board Activities FFY 2021 Four North Dakota Medicaid DUR Board meetings were held during FFY 2021. The meetings were held on January 13, 2021, March 03, 2021, June 02, 2021, and September 01, 2021. For prospective DUR, prior authorization criteria was put in place for the following problem types/drugs by the DUR Board: diabetic gastroparesis agents, Ohriahnn, Dojolvi, Evrysdi, Sickle cell disease agents, Fabry disease agents, Imcivree, Bowel prep agents, Heart Failure agents, and Non-stimulant agents for ADHD. No deletions of DUR Board approved prospective DUR criteria occurred in FFY 2021. For retrospective DUR (RDUR), the DUR Board voted to approve and add a total of 346 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 pain, Type-2 diabetes, inherited hyperlipidemia, certain types of cancer, plaque psoriasis, migraine treatment, seizure disorder, COPD, eczema/atopic dermatitis, Parkinson's disease, hyperlipidemia, ADHD, and over-active bladder. No deletions of DUR Board approved retrospective DUR criteria occurred in FFY 2021. 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 is brought to the DUR Board for review and approval before being implemented. If information from RDUR screens indicates an issue that could be prevented via new prospective DUR edits, the state implements those edits. The ND DUR Board is directly involved in the DUR educational program. All new outpatient pharmacy prior authorization criteria and RDUR criteria are reviewed by the DUR Board at the quarterly meetings, and all criteria and prior authorization request forms are re-reviewed annually. The Board offers suggestions for educational endeavors and provides input on the quarterly newsletters that are developed. North Dakota also participates in Academic Detailing with quarterly visits with pharmacies and prescribers to discuss PDL changes, new edits, targeted provider interventions and education, and other pertinent information important in supporting the provider community. Drug utilization information and provider prescribing rates are used to determine candidates for in-person targeted educational interventions, which are conducted during the same time as academic detailing visits. Targeted education letters are sent out based on provider drug utilization, based on the intervention topic.
Ohio	The Ohio Department of Medicaid (ODM) Drug Utilization Review (DUR) Board met four times during FFY 2021: November 10, 2020, February 9, 2021, May 11, 2021, and September 21, 2021. Interventions and results listed in Summary 2 were presented to the DUR Board. Results of ProDUR screenings are used to adjust retrospective DUR screenings and vice versa. November 10, 2020 DUR Board Meeting Two RetroDUR interventions were reviewed at this quarterly meeting. First, a sample of prescriber survey responses from the previous intervention targeting patients who were taking opioids in

State	DUR Board Activities Report Summary
	combination with a stimulant were presented. Then the Board reviewed the prescriber letter for the new intervention that informed prescribers that their patients were taking multiple antipsychotics. After reviewing the interventions, a quarterly update on CSP membership was provided to the Board. Next, the meeting switched to covering more administrative topics. It included an overview of ODM's COVID-19 Point of Care Testing strategies in pharmacies, U.S. Department of Health and Human Services guidelines for Naloxone prescribing, and the Ohio Administrative Code 4731-11-14 Prescribing for subacute and chronic pain. Next, a draft of the 102-day supply list of maintenance medications and a draft list of Bulk powders and excipients were presented. To close out the meeting, the Board then reviewed the 2021 calendar of RetroDUR interventions. February 9, 2021 DUR Board Meeting Four RetroDUR interventions were reviewed at this quarterly meeting. First, a rereview of the RetroDUR intervention directed at prescribers whose patients were less than 70% adherent to their antiepileptic medication was presented. Then two recent interventions were reviewed. The first invention was to prescribers whose patients were not filling HIV medication prescriptions at a rate sufficient to ensure adherence, defined as Proportion of Days Covered (PDC) less than 95%. The second intervention was an educational mailing where a letter was sent to prescribers whose patients were taking proton pump inhibitors (PPIs) for greater than six months. Prescribers were asked to reassess the indication for and duration of therapy. Finally, the newest intervention directed at prescribers whose patients were receiving opioid medications exceeding 80 Morphine Equivalent Doses (MED) per day was presented. The Board reviewed the prescriber letter and made recommendations. A quarterly update on the CSP membership was provided along with an update to the new CSP rule that began on January 1, 2021. May 11, 2021 DUR Board Meeting First, the re-review results from the influenza vaccine fax sent to pharmacies was presented. The intervention resulted in an additional 44% of members receiving an influenza vaccine. Then responses from prescribers whose patients were receiving opioid medications exceeding 80 Morphine Equivalent Doses (MED) per day were presented. Prescribers were educated on pain treatment agreement requirements, asked to consider multimodal treatment strategies, and reminded to offer a prescription for naloxone. Next, the Board reviewed responses from prescribers whose patients were taking triple antithrombotic therapy (TT), defined as dual antiplatelet therapy in addition to an anticoagulant such as apixaban, rivaroxaban, or warfarin, for greater than 30 days. An overview of an educational intervention faxed to pharmacies requesting pharmacists ask patients to demonstrate correct inhaler technique when picking up an inhaler was presented. 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 CSP membership was provided to the Board. Lastly, there was an update on the reimbursement rate to pharmacies for the COVID-19 vaccine and a discussion on methods to proactively increase the rates of vaccination in the community. September 21, 2021 DUR Board Meeting First, two re-reviews of previous RetroDUR interventions were presented to the Board. The first review re-review presented results from the intervention directed at the prescribers of patients who were taking opioid medications in combination with > 2,400mg of gabapentin per day. The intervention resulted in sixty two percent of members in the intervention using less opioids or

State	DUR Board Activities Report Summary
	gabapentin. The second re-review looked at results from the intervention directed at the prescribers of patients who were taking opioids and stimulants. Next, the intervention and responses from prescribers whose patients were taking chronic triptan therapy without prophylactic medication were presented. Finally, an overview of an intervention where prescribers were alerted if their patients were taking multiple anticholinergic medications was presented. Prescribers were informed that the cumulative effect of taking multiple medicines with anticholinergic properties, termed as anticholinergic burden, can adversely impact cognition and physical function and increase the risk of mortality. The Board was informed that the most recent 2021 Vol 16 DUR Digest had been posted to the Ohio Medicaid Pharmacy Website and the contents of the Digest were presented. Then Board was updated on the monthly outreach program which contacts prescribers and pharmacists whose patients are concomitantly taking medication assisted therapy (MAT) with opioids or benzodiazepines in the previous month. A quarterly update on CSP membership was provided to the Board.
Oklahoma	During FFY 2021 the DUR Board met 11 times. Meetings were held in October, November, and December 2020, and January, February, March, April, May, June, July, and September 2021. In accordance with state legislative mandate, 18 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 2021: CBPA Categories/Products Added: Cystadrops, Cystaran, Mycapssa, Lenvima, Imcivree, Oxlumo, Zokinvy, Nyvepria, Barhemsys, Orladeyo, Verquvo, Zilxi, Kimyrsa, Fetroja, Alkindi Sprinkle, Eysuvis, Gimoti, Nextstellis, Ozobax, Phexxi, RediTrex, Reltone, Thyquidity, Nulibry, Danyelza, Truseltiq CBPA Categories/Products Modified: Crysvita, Qutenza, Ziextenzo, Granix, Zarxio, Aczone, Tazorac, Amzeeq PBPA Categories/Products Added: Adakveo, Oxbryta, Reblozyl, Enhertu, Phesgo, Trodelvy, Tukysa, Rubraca, Evrysdi, Trikafta, Zejula, AirDuo Digihaler, ArmonAir Digihaler, Breztri Aerosphere, Blenrep, Darzalex, Darzalex Faspro, Empliciti, Hemady, Ninlaro, Sarclisa, Xpovio, Enspryng, Uplizna, Abrilada, Avsola, Hulio, Ortikos, Pizensy, Nexletol, Nexlizet, Fensolvi, Oriahnn, Durysta, Anjeso, Licart, Fintepla, Teriparatide, Nurtec ODT, Vyepti, Inqovi, Onureg, Riabni, Bafiertam, Kesimpta, Zeposia, Sevenfact, Sogroya, Monjuvi, Lyumjev, Amondys 45, Viltepso, Vyondys 53, Breyanzi, Cosela, Gavreto, Retevmo, Tabrecta, Tepmetko, Zepzelca, Gemtesa, Kynmobi, Ogentys, Lybalvi, Azstarys, Qelbree, Xywav, Helidac, Pylera, Qdolo, Impeklo PBPA Categories/Products Modified: Herzuma, Lynparza, Nerlynx, Perjeta, Tecentriq, Xtandi, Spinraza, Zolgensma, Kalydeco, Epclusa, Harvoni, Vosevi, Mekinist, Eucrisa, Dupixent, Trelegy Ellipta, Nucala, Asmanex, Dulera, Soliris, Entyvio, Benlysta, Ilaris, Spravato, Bavencio, Braftovi, Keytruda, Opdivo, Yervoy, Omega-3 Fatty

State	DUR Board Activities Report Summary
	Acids, Epidiolex, Ajovy, Iclusig, Venclexta, Tecartus, Ukoniq, Romidepsin 27.5mg/5.5mL, Tazverik, Xalkori, Anti-Diabetic Medications, Alunbrig, Cyramza, Imfinzi, Libtayo, Lorbrena, Tagrisso, Cabometyx, Fotivda, Jelmyto, Padcev, Kapvay, Axid, Tagamet 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. Academic Detailing Program: This program provides educational, evidence-based, in-person meetings to prescribers of targeted medication categories including Attention-Deficit/Hyperactivity Disorder (ADHD) medications, atypical antipsychotics, and treatment of persistent asthma 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 2021: Fall 2020 Pipeline Update, FDA safety alerts, Pediatric Antipsychotic Monitoring Program Update, Opioid MME Review, Montelukast RetroDUR, MTM Program Update, 2021 Spring Pipeline Report, SoonerPsych Program Update, Prenatal Vitamins RetroDUR, GLP-1 SGLT-2 with CV benefit in patients with High CV risk or ASCVD, Annual Review of the SoonerCare Pharmacy Benefit, Chronic Medication Adherence Program Update, Pediatric Antipsychotic Monitoring Program Update, SFY MTM Review ProDUR Edits Implemented during FFY 2021: Added coverage of COVID-19 vaccine as pharmacy benefit per EUA, reviewed and updated the Maintenance Drug List, reviewed and updated the Narrow Therapeutic Index List, reviewed and

State	DUR Board Activities Report Summary
	updated the Brand Preferred List, 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 2021. 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 2021: CBPA Drugs/Categories: Ovarian Cancer Medications, Signifor LAR, Firdapse, Ruzurgi, Cystaran, Cystadrops, Multiple Myeloma Medications, Lenvima, Tepezza, Skin Cancer Medications, Thrombocytopenia, Soliris, Ultomiris, Imcivree, Turalio, Inrebic, Elzonris, Korlym, Fensolvi, Oriahnn, Zokinvy, Oxlumo, Leukemia Medications, Crysvita, Azedra, Vitrakvi, Lutathera, Lymphoma Medications, Qutenza, Hemophilia Medications, Tazverik, Ayvakit, Bynfezia Pen, Lung Cancer Medications, Balversa, Phexxi, Gimoti, RediTrex, Ozobax, Thyquidity, Nextstellis, Reltone, Alkindi Sprinkle, Eysuvis, Koselugo, Isturisa, Pemazyre, Qinlock, Nulibry, Breast Cancer Medications, Synagis, Prostate Cancer Medications PBPA Categories: Cystic Fibrosis Medications, Hepatitis C Medications, Spinal Muscular Atrophy, Maintenance Asthma and COPD, Atopic Dermatitis, Anticoagulants and Platelet Aggregation Inhibitors, Targeted Immunomodulator, Antidepressants, Ulcerative Colitis (UC) and Crohn's Disease, Constipation and Diarrhea, Gonadotropin Release Hormone (GnRH), Glaucoma Medications, Antiviral Medications, Hyperlipidemia Medications, Anticonvulsants , Anti-Migraine, Osteoporosis Medications, Non-Steroidal Anti-Inflammatory Drugs, Multiple Sclerosis, Hereditary Angioedema, Anti-Emetic, Growth Hormone, Granulocyte Colony-Stimulating Factors (G-CSFs), Anti-Diabetic Medications, Muscular Dystrophy, Antihypertensive Medications, Heart Failure Medications, Allergen Immunotherapies, Parkinson's Disease Medications, Alzheimer's Disease Medications, Topical Acne and Rosacea Products, Bladder Control Medications, Systemic Antibiotics, ADHD and Narcolepsy Medications, Atypical Antipsychotic Medications, Anti-Ulcer Medications, Opioid Analgesics and MAT Medications, Topical Corticosteroids, Ophthalmic Anti-Inflammatories
Oregon	DUR Board meetings held: 6 Additions/deletions to DUR Board approved criteria: Revised the prior authorization (PA) criteria for Atopic Dermatitis (AD) and topical antipsoriatics to reflect the expanded indication for crisaborole in children aged 3 months and older with moderate AD. The Committee also recommended revising the PA criteria for dupilumab to reflect expanded indication for management of moderate-to severe AD not well controlled by topical prescription medications in children older than 6 years of age. Updated the clinical definition of severe and very severe COPD, require a specialist in the roflumilast PA criteria and clarify the age recommendations for use of monoclonal antibodies. Implement the proposed fenfluramine PA criteria to ensure medically appropriate utilization and revise the PA criteria for cannabidiol to reflect the expanded indication and appropriate dosing for tuberous sclerosis complex (TSC) in patients 1 year of age and older and to rename Antiepileptics class name from Oral and Rectal to Non-injectable to account for nasal formulations. Modify the PPI PA criteria to clarify durations of therapy. Update the Anti-Parkinson's Agents PA criteria to ensure safe and appropriate use of the new agents. Modify the PA criteria to reflect updated indications for the Targeted Immune Modulator agents. Implement a targeted profile review of patients with bipolar disorder who have frequent hospitalizations or ED visits for psychiatric reasons, to identify areas for optimization of

State	DUR Board Activities Report Summary
	medications and to then notify prescribers if opportunities to improve care. Priority was given to patients with 3 or more hospitalizations or ED visits over 6 months for psychiatric reasons and who: 1) appear non-adherent to current therapy; or 2) are prescribed regimens not recommended by the OHA and Mental Health Clinical Advisory Group. Non-recommended regimens may include patients with 3 or more bipolar medications, patients prescribed antidepressant monotherapy, or patients who use aripiprazole for bipolar depression. 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. Modify the modafinil/armodafinil PA criteria to prevent inappropriate use during pregnancy and in women of childbearing age. Make melatonin open access for children up to 18 years old and update the clinical PA criteria as proposed. Implement the teprotumumab clinical PA criteria. Update the Agents for Gout PA criteria to allow for colchicine use in patients with pericarditis and Behcet's Syndrome BS and implement a quantity limit to permit an initial fill without requiring PA. Implement the risdiplam clinical PA criteria. Implement the cenegermin clinical PA criteria. Update the ICS/LABA/LAMA PA criteria with the updated indication for Trelegy Ellipta (fluticasone furoate, umeclidinium & vilanterol). Revise the PA criteria for biologic therapies, dupilumab, atopic dermatitis, and topical antipsoriatics to include an assessment of severe disease using a validated scoring tool such as the Dermatology Life Quality Index or Children's Dermatology Life Quality Index per HERC guidance. Implement the proposed case management referral program for patients with gaps in therapy for high-risk maintenance medications. Update the Duchenne Muscular Dystrophy PA criteria to include viltolarsen to ensure medically appropriate use. Update the Smoking Cessation PA criteria and only apply it to non-preferred drugs. Update the esketamine safety edit to accommodate the new indication and amend the proposed renewal criteria to include an assessment of adherence to oral antidepressant therapy. Update the current opioid policy to include two newly approved opioid formulations and to add an assessment for opioid use disorder (OUD) in the renewal criteria for both short-acting and long-acting PA criteria. Modify the high-risk opioid RetroDUR program criteria to include patients who may be paying cash for chronic opioid prescriptions and patients with a diagnosis of substance abuse or history of overdose and to notify providers about risk mitigation strategies and opportunities to improve care. Implement the alglucosidase alfa, satralizumab, inebilizumab, ravulizumab, and eculizumab PA criterion. Implement the antipsychotic safety edit to ensure appropriate in children 5 years of age or younger and to implement retrospective provider outreach program to facilitate access to medications for appropriate children. Perform provider education to increase migraine prophylaxis use in patients taking chronic triptans. Remove the requirement for manual review by the medical director for use of lumacaftor/ivacaftor in patients less than 12 years of age- consistent with FDA labeling and standard of care - and to add

State	DUR Board Activities Report Summary
	a link to FDA labeling in the Oral CF Modulators PA criteria to ensure all approved CFTR mutations are current. Add somapacitan-beco to the Growth Hormone class, designate non-preferred and limit use to OHP-covered conditions and update the PA criteria to align with HERC coverage guidance and FDA-approved indications. Update the Hereditary Angioedema PA criteria to include berotralstat. Implement the PA criteria for ofatumumab for both physician administered and point of sale pharmacy claims, limit use to conditions funded by the OHA for patients with a history of inadequate response to at least two disease-modifying drugs approved for MS, and when prescribed by a neurologist. Update the Oral MS Drug PA criteria to add ponesimod and recommended modifying the language regarding pregnancy to address all populations of childbearing potential. Rename the "ACEIs, ARBs and DRIs" PMPDP class to "Inhibitors of the Renin-Angiotensin-Aldosterone System (RAAS)," including Entresto (sacubitril/valsartan) and update the dedicated PA criteria to include the expanded FDA approved indications Require PA for vericiguat to ensure appropriate use in patients on goal-directed therapy with advanced symptomatic HFrEF (heart failure with reduced ejection fraction), add a pregnancy question to the PA criteria, and adding an assessment of adherence to the renewal criteria for both sacubitril/valsartan and vericiguat. Updating the Platelet Inhibitor PA criteria to include new indications for ticagrelor. Update the PA criteria for belimumab to include the expanded FDA indication for adults with active lupus nephritis Updatie the SGLT-2 Inhibitor PA criteria as proposed and no longer require PA for preferred SGLT-2 inhibitors Make evinacumab non-preferred and require PA to limit use to patients with homozygous familial hypercholesterolemia (HoFH) requiring additional LDL-lowering on maximally tolerated lipid-lowering therapies. Create a PMPDP class entitled "Biologics for Severe Asthma" encompassing: benralizumab, dupilumab, mepolizumab, omalizumab and reslizumab. Modify the "Monoclonal Antibodies for Severe Asthma" PA criteria to include expanded indications, to apply to all drugs in the new class including dupilumab and practitioner-administered claims, and retiring the current dupilumab PA criteria Remove the PA requirement for preferred non-calcium phosphate binders 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): COVID-19 Viral Testing 2019-2020 Food and Drug Administration Drug Safety Communications Update Coronavirus Disease-2019 Vaccine Update Antidepressant Review Bipolar Disorder: Resources for Primary Care Providers COVID-19 Vaccine Update Deprescribing Techniques to Minimize Safety Issues Associated with Inappropriate Polypharmacy Therapeutic Uses for Cannabinoids Updates in Heart Failure Therapy: New Drugs and Indications

State	DUR Board Activities Report Summary
Pennsylvania	The DUR Board met once in FFY 2021 on October 21, 2020. The DUR Board recommends prospective hard edits and develops prior authorization guidelines to help to ensure that the medications are used appropriately with respect to indications, duration, dosage and avoidance of potential drug or disease interactions. The following topics were identified during FFY 2021 as focus areas for the DUR Board to assess and promote appropriate utilization: 1. New clinical prior authorization of the following: a. Crysvita (burosumab-twza) b. Evrysdi (risdiplam) c. Palforzia [Peanut(Arachis hypogaea) Allergen Powder-dnfp] d. Tepezza (teprotumumab-trbw) e. Xywav (calcium, magnesium, potassium, and sodium oxybates) 2. Revisions to the following prior authorization guidelines: a. Complement Inhibitors b. Corlanor (ivabradine) c. Cystic Fibrosis Transmembrane Regulator (CFTR) Modulator Therapies d. Cytokine and CAM Antagonists e. Duchenne Muscular Dystrophy Antisense Oligonucleotides f. Spinraza (nusinersen) g. Tysabri (natalizumab) 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.

State	DUR Board Activities Report Summary
Rhode Island	Indicate the number of DUR Board meetings held The Rhode Island Medicaid Drug Utilization Review Board met four (3) times during FFY 2021. The September 2021 DUR meeting was canceled due to COVID and information from the canceled meeting was presented during the December 2021 DUR meeting. List additions/deletions to DUR Board approved criteria. For prospective DUR, list problem type/drug combinations added or deleted. For retrospective DUR, list therapeutic categories added or deleted. Prospective DUR Prospective DUR criteria are not routinely reviewed by the DUR Board. However, specific criteria may be brought up for discussion. All severity level 1 First Databank criteria are active in the prospective DUR system. Retrospective DUR Rhode Island Medicaid uses a comprehensive list of retrospective DUR criteria, which include alerts for drug interaction, overuse, therapeutic duplication, black box warnings, and underuse (non-adherence). Each month, claims data are run against criteria and approximately 1,000 recipient drug profiles are selected for review and evaluation by a clinical pharmacist. Many different types of criteria may be selected for review each month. For FFY 2021, the top 10 alerts are noted in attachment 2. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. For the most part, prospective screening operates independently from retrospective screening. However, the Board has recommended that drug interactions that are black box warnings in the product labeling also be alerted as retrospective interventions, even though these alerts are included in the prospective DUR screening. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring). For retrospective DUR, list therapeutic categories added or deleted. Currently, educational efforts include mailing of alert letters to prescribers based on criteria exceptions and further review by a clinical pharmacist. Therapeutic duplication, drug interaction, and underuse (non-adherence) retrospective and prospective DUR criteria are in place. In addition, drug interaction and therapeutic duplication alerts were mailed. These alerts included patients with specific diseases not found to have claims for drugs that are recommended as part of national guidelines. Specific examples include diabetic patients not taking lipid lowering therapy or ACE inhibitors. There continues to be a focus on appropriate use of opioids. Patients identified as possibly misusing opioids can be restricted to a single pharmacy as part of the State's Lock-In program. Individual outreach was also made to prescribers who did not respond to any DUR letters mailed. 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

State	DUR Board Activities Report Summary
South Carolina	The restructuring of the DUR Board remains in process. COVID, transition of both internal (State) and external contacts (MCO Pharmacy Directors) resulted in multiple challenges in identifying potential members and meeting dates. The primary focus has remained to center around opioid use disorder, until such time as the structure of the Board is finalized. July 2020 through December 2020 tip SC deliveries included AD visits from SCORXE clinical pharmacy consultants (i.e., academic detailers), student pharmacists utilizing AD principles for outreach to pharmacists, presentations that incorporated multiple tip SC issues, and visits to the tip SC webpages. Unlike all previous reporting periods, US mail was not included in our outreach strategies, as the tip SC issue finalized the last half of the year is primarily intended for AD visits that offer live CME credit. The novel student pharmacist led AD outreach to the pharmacy community on naloxone expansion started last reporting period with students from the Medical University of South Carolina added students from Presbyterian College and extended tip SC AD reach to 3 new counties. Two important points about this initiative, the support of SCDHHS and the braiding of quality initiatives from SCDHHS and SC DAODAS, were included in the presentation Academic Detailers, Pharmacy Students, and Community Pharmacists in South Carolina Expanding Access to Naloxone at the virtual National Resource Center on Academic Detailing (Na RCAD) International Annual Meeting in November. Our academic detailer clinical pharmacists continued to disseminate tip SC content through meeting presentations. In keeping with a primary focus for 2020, these presentations focused on outreach to the pharmacy community to promote increased naloxone distribution and to reduce stigma. Content from the tip SC issue Naloxone Can Save a Life was incorporated into both presentations: Opioid Use Disorder Treatment Principles was provided during the10/9/2020 South Carolina Health Systems Pharmacist Meeting (111 pharmacists/35 students); and Naloxone Can Save a Life: Naloxone Training was provided at the Medical University of South Carolina College of Pharmacy (Rho Chi Chapter) on 11/18/2020 (29 pharmacists and 49 students from multiple healthcare disciplines. 2021 meetings focused on outreach to the pharmacy community to promote increased naloxone distribution and opioid overdose education and to reduce stigma. These key messages were delivered indirectly by sharing student pharmacists' learning together experiences on the tip SC topic Naloxone Can Save a Life or more directly as part of a continuing education conference: Naloxone Advocate: Utilizing Academic Detailing and Student Pharmacists to Expand Access to Naloxone was presented at the SC Society of Health Systems Pharmacists meeting 3/15/2021 and on 5/13/2021, Naloxone Can Save a Life training was provided during the Continuing Education Conference at Presbyterian College School of Pharmacy. In addition MUSC group continued efforts on the Non-Drug Strategies for Non-Cancer Acute and Chronic Pain which centered on promoting patient engagement in non-drug strategies to help patients reach treatment goals with fewer interventions. Educational materials include a table on the utility and clinical benefit of select behavioral and physical non-drug strategies for acute pain (low back, sprains or strains, and post-operative) and chronic pain. CME credit continues to be available for providers for many of these topics, during the period of January 2020- June 2020 33 physicians or doctors of osteopathy, 10 nurse practitioners, and 3 physician assistants completed a CME assessment form at the end of the visit and cumulatively earned 46 live Category 1 AMA PRA Category I Credit(s).

State	DUR Board Activities Report Summary
South Dakota	Patient profiles were generated eleven times during the October 1, 2020 through the September 30, 2021 fiscal year. Profiles were reviewed and letters were created to be sent to prescribers of the problematic therapy as well as the pharmacies, which dispensed the involved drugs for each of those eleven months of reviews. During a couple select months, the committee examined specific criteria for a focused review. These specific criteria included: Use of gabapentoids and respiratory depression Overuse of beta-agonists possibly signaling worsening asthma Life-threatening respiration depression with gabapentoids Underutilization of statin medications in diabetes Use of tramadol in patients with renal insufficiency Co-administration of opioids and benzodiazepines The committee also reviewed and approved new drug interaction criteria and updates during 4 months. Attached are the background material on the reviews conducted. 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 HID's Initial Criteria Exception Report. The ICER lists categories of exceptions to the clinical criteria appropriate for patient care. The cases to be reviewed can come from making specific case selection from the ICER. DEEP OVERVIEW FOR 2020-2021 FISCAL YEAR Total number of letters sent out was 1,274 for the year with an approximate average of 116 letters per month when the committee reviewed patient profiles. Month Number of letters sent Specific criteria reviewed (if any) October 2020 115 New criteria reviewed/approved November 2020 86 New criteria reviewed/approved December 2020 -- Committee did not review patient profiles January 2021 114 Transitioned to electronic review system February 2021 130 Use of statins in diabetic patients Use of tramadol in renal insufficiency March 2021 93 April 2021 129 May 2021 125 Co-administration of opioids and benzodiazepines New criteria reviewed/approved June 2021 93 July 2021 128 August 2021 142 Co-administration of opioids and benzodiazepines New criteria reviewed/approved September 2021 119 Use of statins in diabetic patients

State	DUR Board Activities Report Summary
Tennessee	The operation of the DUR program is a shared responsibility of the Division of TennCare and OptumRx. TennCare DUR Board met quarterly for FFY21. Board meetings were held October 2020, January 2021, April 2021, and July 2021. 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 TennCare and OptumRx quarterly to review ProDUR edits which identifies 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. During FFY21, 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 an update to the criteria for all tramadol containing product due to 2017 FDA safety update. OptumRx or TennCare 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.
Texas	In FFY 2021, four scheduled meetings were held. These meetings are opened to the public. The board's activities are typically consisting of the following: 1. Hearing public testimonies on drugs scheduled for review. 2. Making recommendations for preferred drug list. 3. Review and approval of prospective clinical prior authorizations on drugs or drug classes. 3. Review and approval of retrospective DUR criteria on drug or drug classes. These criteria may be used as the basis for future prospective and retrospective DUR proposals. 4. Review of the proposed retrospective DUR intervention criteria and letters. On October 23, 2020, meeting, the Board's activities included: Review of the following therapeutic categories and single drugs for PDL recommendations: Androgenic agents, Antibiotics (gastrointestinal), Antibiotics (topical), Antibiotics (vaginal, Antiemetics or Antivertigo agents, Antifungals (oral); Antifungals (topical), Antihistamines (first generation), Antiparasitics (topical), Antipsychotics, Antivirals (topical), Bone resorption suppression and related agents, Colony stimulating factors, Epinephrine (self-injected), GI motility (chronic), Growth hormone, Hepatitis C agents, Hypoglycemics (incretin mimetics or enhancers), Hypoglycemics (insulin and related), Hypoglycemics (meglitinides), Hypoglycemics (metformin), Hypoglycemics (SLGT2), Hypoglycemics (TZD), Macrolides and Ketolides, Opiate dependence treatments, Tetracyclines, Benzefoam foam, Dupixent pen, Nexlizet, Voltaren gel, and Dayvigo Retrospective intervention proposals on the following topics: Anticonvulsants Drug Use Evaluation (DUE); Comprehensive opioid management; Management of psychotropic drugs in youth

State	DUR Board Activities Report Summary
	Prospective prior authorization proposals (clinical edits) included: new criteria for Evrysdi (oral solution); Calcitonin gene related peptide receptor (CRGP) antagonists, acute; new criteria for Nurtec and Ubrelvy; New criteria for Oriahnn (capsules); revised criteria for Vyvanse capsules and chewable tablets; new criteria for Wakix (tablets); new criteria for Xywav (oral solution) Retrospective drug use criteria for outpatient use included: document updates on anti-diabetic agents (oral); document updates on attention deficit disorder/attention deficit hyperactivity disorder; document updates on glucagon peptide like 1 receptor agonists; document updates on pramlintide; document updates on serotonin 5HT3 receptor antagonists for nausea and vomiting (oral); document update on substance P/neurokinin1 receptor antagonists. On the January 22, 2021 meeting, the board reviewed the following therapeutic categories and single drugs for PDL recommendations: Acne agents, oral, Acne agents, topical, Analgesics, narcotics long, Analgesics, narcotics short, Angiotensin modulator combinations, Angiotensin modulators, Antimigraine agents, other, Antimigraine agents, triptans, Antiparkinson agents, Bladder relaxant preparations, Glucagon agents, H. pylori treatment, Immunomodulators, atopic dermatitis, Intranasal rhinitis agents, Movement disorders, Neuropathic pain, Oncology (oral) for Breast cancer, Oncology (oral) for Hematologic; Oncology (oral) for Lung, Oncology (oral) for Other, Oncology (oral) for prostate, Oncology (oral) for Renal cell, Oncology (oral) for Skin, Phosphate binders, Platelet aggregation inhibitors, Progestins for cachexia, Proton pump inhibitors, Smoking cessation, Stimulants and related agents, Airduo Digihaler, inhaled, Armonair Digihaler, Bafiertam Capsule Dr, Breztri Aerosphere HFA AER AD, Diclotrex Kit, Enbrel Vial , Enspryng, Hemady , Kesimpta , Semglee Retrospective intervention criteria included the followings: Benzodiazepine anxiolytics and controlled sedative/hypnotics DUE; Major depressive disorder (MDD) management Prospective prior authorization (clinical edits) proposals included: New criteria for Apokyn and Kynmobi (dopamine agonists); new criteria for Evrysdi (oral solution); New criteria for Govovri and Osmolex (Amantadine extended-release agents); New criteria for Hemady (Dexamethsone)new criteria Retrospective drug use criteria for outpatient use included the followings: document updates on angiotensin converting enzyme (ACE) inhibitors; document updates on angiotensin II receptor blockers; document updates on platelet aggregation inhibitors; document updates on proton pump inhibitors; document updates on sedative and hypnotics; document updates on serotonin 5 HT1B1D receptor agonists On the April 23, 2021 meeting, the board reviewed the following therapeutic categories and single drugs for DPL recommendations: Anti-allergens, oral, Antibiotics (inhaled), Anticoagulants, Antidepressants, other, Antidepressants, selective serotonin reuptake inhibitors (SSRIs), Antidepressants, tricyclic, Antihyperuricemics, Antivirals (oral), Anxiolytics, Benign prostatic hyperplasia treatments, Beta blockers, Bile salts, Bronchodilators, beta agonist, Chronic obstructive pulmonary disease agents, Cough and cold, Erythropoiesis stimulating proteins, Glucocorticoids, inhaled, Hemophilia treatment, Hereditary angioedema (HAE) treatments, Hypoglycemics, incretin mimetics and enhancers, Immune globulins, intravenous, Immunomodulators, asthma, Lincosamides and oxazolidinones and streptogramins, Lipotropics, other, Lipotropics, statins, Multiple sclerosis agents, Pancreatic

State	DUR Board Activities Report Summary
	enzymes, Pediatric vitamin preparations, Prenatal vitamins, Pulmonary arterial hypertension agents, oral and inhaled, Sedative hypnotics, Sickle cell anemia treatments, Thrombopoiesis stimulating proteins, Urea cycle disorder (oral), Dificid suspension Antibiotics, gastrointestinal, Nyvepria, Ibupak kit, Venngel one Kit, Pataday extra strength, Eysuvis (ophthalmic), Impeklo lotion, Retrospective intervention proposals on the following topics: Diabetes disease management; Dyslipidemia disease management; Influenza prevention: vaccination and education Prospective prior authorization (clinical edits) Proposals included the followings: Anxiolytic and sedative and hypnotics; Criteria revision for sedative and hypnotics for adults (added PA criteria for Belsomra and Dayvigo to the existing document); HAE agents criteria revision (added PA criteria for Orladeyo); Hyperlipidemia agents, Formerly was titled as Protein Convertase Subtilisin Kexin type 9 agents (added Juxtapid to the criteria guide document); Multiple sclerosis agents criteria for safety checks. Retrospective drug use criteria for outpatient use review: aerosolized agents metered dose inhalers (MDIs) criteria document updated: anticholinergic drugs criteria document update; aerosolized agents MDIs criteria document update: anti-inflammatory drugs criteria document update; Aerosolized agents MDIs: beta2 agonists (long acting) criteria document update; aerosolized agents MDIs: beta2 agonists (short acting) criteria document updated; Antidepressant drugs, other criteria document updated; Antidepressant drugs (SSRIs) criteria document update On July 23, 2021, the board reviewed the following therapeutic categories and single drugs for PDL recommendations: Alzheimers agents, Antihistamines, minimally sedating, Antihypertensives, sympatholytic, Calcium channel blockers, Cephalosporins and related antibiotics, Cytokine and cell adhesion module antagonists and related agents, Fluoroquinolones, oral, Glucocorticoids, oral, Immunosuppressives, oral, Iron, oral, Leukotriene modifiers, Nonsteroidal anti-inflammatory drugs (NSAIDs), Ophthalmic antibiotics, Ophthalmic antibiotic and steroid combinations, Ophthalmics for allergic conjunctivitis, Ophthalmics, anti inflammatories, Ophthalmic, anti inflammatories and immunomodulators, Ophthalmics, glaucoma agents, Otic antibiotics, Otic anti-infectives and anesthetics, Penicillins, Platelet aggregation inhibitors, Progestational agents, Rosacea agents, topical, Skeletal muscle relaxants, Steroids, topical, Ulcerative colitis agents, Hetlioz liquid (oral), Ponvory starter pack (oral), Ponvory tablet, Qelbree, Tepmetko tablet, Trilociclo kit, Ukoniq, Vesicare LS (oral) Retrospective DUR intervention proposals: Bipolar disorder disease management; Hypertension disease management. Prospective prior authorization (clinical edits) proposals: Addition of Qelbree to the Attention Deficit and Attention Deficit Hyperactivity Disorder criteria guide; addition of Ponvoy to the Multiple sclerosis agents for safety checks; Phosphate Binders criteria revisions; Sedative and Hypnotics criteria revisions on Hetlioz Retrospective drug use criteria for outpatient use document review and updates for the followings: Acetylcholinesterase inhibitors; Cyclooxygenase 2 inhibitors; Histamine H2 receptor antagonists; Ketorolac (oral); Leukotriene receptor antagonists; Mecasermin; Memantine

State	DUR Board Activities Report Summary
Utah	October 2020 - The DUR Board reviewed Truvada and Descovy for Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). The Board approved making Truvada and Descovy preferred products on the Medicaid Preferred Drug List. November 2020 - The DUR Board reviewed the spinal muscular atrophy (SMA) drugs and approved the Evrysdi (risdiplam), Spinraza (nusinersen) prior authorization criteria. The Board also approved the HER-2 Positive Targeted Therapy prior authorization criteria. December 2020 - The DUR Board reviewed newer oral antipsychotics, including brexpiprazole, cariprazine, and lumateperone. The discussion included places in therapy, off-label use in specific populations, and each medication's safety profile. January 2021 - The DUR Board reviewed and discussed long-acting injectable and orally-disintegrating tablet second-generation antipsychotics. The discussion included places in therapy, off-label use in specific populations, and their safety profiles. The Board also approved the Trodelvy prior authorization criteria. February 2021 - The DUR Board discussed and approved the proposed ADHD stimulant intervention to limit cross-class concurrent use of amphetamine and methylphenidate in children eighteen years of age and younger, and to limit to three or more unique ADHD Stimulants prescribed concurrently for all ages. The Board also approved the Anti-Vascular Endothelial Growth Factor Therapy prior authorization criteria and Epidiolex prior authorization criteria. March 2021 - The DUR Board reviewed and approved to cover Continuous Glucose Monitoring (CGM) for Medicaid members as a pharmacy benefit dispensed at point-of-sale. The CGM products are managed by prior authorization and as a drug class on the Preferred Drug List. April 2021 - The DUR Board reviewed Verquvo (vericiguat) and approved the proposed prior authorization criteria. The Pharmacy team informed the DUR Board about the Continuation of Care policy that ensures member access to non-preferred medications for members who are new to Medicaid or who had a recent change in coverage and that have been stable on the requested medication for a minimum of sixty out of the last ninety days. May 2021 - The DUR Board reviewed and approved the proposed Chorionic Gonadotropin prior authorization criteria. June 2021 - The Pharmacy Team proposed to the DUR Board new soft-messaging edits at point-of-sale to be applied when Medicaid opioid-naive members fill initial opioid prescriptions for seven days (3 days for dentists) for more than 50 MME. The Pharmacy Team also informed the DUR Board of the new retrospective Antidepressant Medication Management Program. The program targets non-adherence to medication Medicaid members. The clinical pharmacists telephonically reach out to Medicaid Fee for Service members 18 years of age or older, have a diagnosis of major depression, and are newly treated with antidepressant medication. The pharmacists used motivational interviewing to address medication non-adherence. July 2021 - The DUR Board received annual training on the Utah Open Public Meeting Act from the Assistant Attorney General. The DUR Board also approved the Evkeeza (evinacumab-dgnb) Injection prior authorization criteria.

State	DUR Board Activities Report Summary
	September 2021 - The DUR Board approved updated Anti-asthmatic Monoclonal Antibodies prior authorization criteria and the Humulin U-500 prior authorization criteria. The DUR Board also approved the proposed Aduhelm (aducanumab) prior authorization criteria which aligns with the Accountable Care Organizations' criteria. A comprehensive list of PRO-DUR edits is below: 1/1/2021 - Truvada and Descovy are preferred products on the Preferred Drug List. 1/1/ 2021 - Limited the use of opioid medications in members who are also receiving MAT for opioid use disorder. When a claim for opioids is submitted at POS, the system will look back 45 days to find any MAT claims. The system will limit the opioid to 7 days supply or less only. 3/1/2021 - Developed and started an Antidepressant Medication Management(AMM) with pharmacists callingMedicaid Fee-For-Service members 18 years of age or older, have a diagnosis of major depression, and are newly treated with antidepressant medication. 4/1/2021 - Allowed coverage for Continuous Glucose Monitor for type 1 and type 2 diabetes that meet prior authorization criteria via the point-of-sale system. 4/1/2021 - Limited 3 or more unique ADHD stimulants to reduce abuse and diversion; look-back period is 45 days 4/1/2021 - Restricted the use of cross-class ADHD stimulant (amphetamine and methylphenidate) medications with a look-back period of 45 days 4/1/2021 - Developed and implemented continuation of care policy to allow the use of non-preferred products without trial of failure preferred products when there is evidence the member has been stable on the product for a minimum of 60 days 4/1/2021 - Allowed insulin pens to be billed up to 140 days supply to accommodate pharmacy not to break insulin pen packaging 6/1/2021 - Pharmacy point-of-sale opioid claims (paid/rejected) started receiving a DUR soft edit/message for opioid naive members that said, "Max limit of 50 MME for opioid-naive patients is recommended by the CDC." 9/1/2021 - Waived Copay for HIV PREP medications.
Vermont	The VT Medicaid (DVHA) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met 7(seven) times in FFY2021. 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 from the time of introduction of the drug (prospectively) rather than in a retrospective. This results in the early adoption of quantity limits, step therapy and promotion of lowest net cost drug choices. At the same time, as new drugs are evaluated, patterns of prescribing for alternative drugs may become apparent and lead the Board to undertake retrospective DUR activities for those other medications. Additionally, the DUR Board will recommend that follow-up RetroDUR be performed of relatively new drugs to ensure that the adopted clinical criteria are appropriate and result in patterns of utilization that are appropriate and cost-effective. In FFY 2021, the DUR Board activities included: 59 Therapeutic Drug Class reviews, 56 Full New Drug Reviews, 2 FDA Safety Alerts, 7 New/Updated Clinical Guidelines, 4 RetroDUR/ProDUR reviews,1 New Managed Therapeutic Drug Class, 1 Bio Similar Drug Review. RetroDUR Analyses: Prescriber PDL Compliance, Use of Chantix for Smoking Cessation, Sublocade Adherence, Codeine Use in the Pediatric Population, Influenza Vaccination Rates, Long-Acting Injectable Antipsychotics

State	DUR Board Activities Report Summary
	ProDUR is an integral part of the Vermont Medicaid claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed; reviewing the available medical history; focusing on those patients at the highest severity of risk for harmful outcome; and intervening and/or counseling when appropriate. ProDUR encompasses the detection, evaluation and counseling components of pre-dispensing drug therapy screening. The ProDUR system addresses situations where potential drug problems may exist. ProDUR performed prior to dispensing assists pharmacists in ensuring that patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available. We have implemented Pro-DUR edits to members at the highest severity of risk for harmful outcome. Severity levels are applied utilizing the Medispan DUR module. The following ProDUR Reason of Service types will deny for the Vermont Medicaid program: Drug-to-Drug Interaction (Highest Severity Levels) Therapeutic Duplication. ProDUR Edits that deny may be overridden at POS using the interactive NCPDP DUR override codes. Pharmacies may override the denial bysubmitting the appropriate Professional Service and Result of Service codes. Below details the Professional Service and Result of Service codes that will override a claim that has been denied for drug-to-drug interaction and/or therapeutic duplication. Note: that the designated Professional Service code must accompany the appropriate Result of Service code as indicated in the chart to allow the override. The valid DUR Reason for Service Codes for Vermont Medicaid are: DD Drug-Drug Interaction TD Therapeutic Duplication The only acceptable Professional Service Codes are: MR Medication Review M0 Prescriber Consulted R0 Pharmacist Consulted Other The goal of the Vermont RetroDUR Program is to promote the safe and appropriate prescribing and use of medications. RetroDUR identifies prescribing, dispensing, and utilization patterns which may be clinically and therapeutically inappropriate and may not meet the established clinical practice guidelines. Data is collected and reviewed in detail and presented to the Board. Further analysis is conducted as needed. Depending on the specific issue identified, various interventions are then employed to correct these situations. Prospective edits in the Point-of-Sale System, educational mailings or new utilization controls such as prior authorization or quantity limits, among others are employed as appropriate. The DVHA RetroDUR program takes an individualized approach to identifying, evaluating and developing improvements specific to each intervention. The cornerstone of the RetroDUR process is based on a review of peer-reviewed evidence as well as considerations of recognized guidelines and best practices. This information is evaluated in the context of the claims reviewed and then reviewed with the DUR Board for input and then interventions, as appropriate are implemented. As appropriate, academic detailing opportunities are considered. DVHA partners with The Vermont Academic Detailing Program which is a university-based prescriber education and support program that operates out of AHEC (Area Health Education Center Programs) to identify mutual areas of interest. The goal of the Vermont Academic Detailing Program is to promote high quality, evidence-based, patient-centered, and cost-effective treatment decisions by healthcare professionals. AHEC staff visit prescriber offices for

State	DUR Board Activities Report Summary
	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 at http://dvha.vermont.gov/for-providers. These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions and alerts. Sample DUR Board Meeting Agenda for SFY 2021 Department of Vermont Health Access Pharmacy Benefits Management Program October 22, 2019: 5:30 8:30 p.m. Executive Session 5:00 6:00 Introductions and Approval of DUR Board Minutes 6:00-6:05 (Public Comment Prior to Board Action) DVHA Pharmacy Administration Updates 6:05-6:10 Medical Director Update 6:10-6:15 Follow-up Items from Previous Meetings 6:15-6:15 RetroDUR/ProDUR 6:15-6:15 Clinical Update: Drug Reviews 6:15-6:15 (Public comment prior to Board action) Biosimilar Drug Reviews None at this time Full New Drug Reviews New Managed Therapeutic Drug Classes 6:15-6:15 (Public comment prior to Board action) Therapeutic Drug Classes Periodic Review 6:15-6:15 (Public comment prior to Board action) Review of Newly-Developed/Revised Criteria 6:15- 8:15 (Public comment prior to Board action) General Announcements 8:15 - 8:30 Selected FDA Safety Alerts Adjourn 8:30

State	DUR Board Activities Report Summary
Virginia	Virginia Medicaid DUR Board quarterly meetings were held on December 10, 2020, June 10 and September 9, 2021 for FFY 2021 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 2021 RetroDUR intervention activities are reported in Summary 1: RetroDUR Educational Outreach Summary. For FFY 2021, 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 2021, the DUR board continued to review and address concurrent use of opioids and benzodiazepines as well as concurrent use of opioids and antipsychotics utilization reports. DMAS also continues to review reports looking at members utilizing opioids with risk factors and without a claim for naloxone. DMAS has also implemented two soft edits for the SUPPORT Act. The first edit triggers a soft message to the pharmacist when opioid and antipsychotic claims overlap, which was implemented on March 10, 2020. The second edit triggers a soft message to the pharmacist when the member is getting an opioid prescription filled and the member is opioid niave, which was implemented on April 6, 2020. DMAS has also recently decreased the MME further down to 90 MME in addition to the existing quantity limits on all short and long-acting opioids. Also, Magellan Rx Management has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. DUR Quarterly Newsletters were created and posted on VA Medicaid website. Magellan Rx Management provides a quarterly MRx Pipeline Report at each DUR Board Meeting. The summary of the minutes for each of the FFY 2021 DUR Board meetings are included below. Minutes Summary - December 10, 2020 (Electronic Meeting) RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Reports and the Criteria Exception Estimates Report for Lab Values, which includes MCO data. The DUR Board reviewed the Hemoglobin A1c Lab Value Over 9 and On Diabetic Meds for 6 Months Report. New Drugs: The DUR Board reviewed Evrysdi (risdiplam), Gavreto (pralsetinib), Inqovi (decitabine and cedazuridine), Lampit (nifurtimox), Mycapssa (octreotide), Ongentys (opicapone), Onureg (azacitidine), and Rukobia (fostemsavir).

State	DUR Board Activities Report Summary
	Minutes Summary - June 10, 2021 (Electronic Meeting) New Drugs: The DUR Board reviewed Bronchitol (mannitol), Eysuvis (loteprednol etabonate), Imcivree (setmelanotide), Lupkynis (voclosporin), Orgovyx (relugolix), Phexxi (lactic acid, citric acid, and potassium bitartrate), Tepmetko (tepotinib), Ukoniq (umbralisib), Verquvo (vericiguat), Xyrem (sodium oxybate), Xywav (calcium, magnesium, potassium, and sodium oxybates) and Zokinvy (lonafarnib). The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines utilization reports for FFS and MCOs. The DUR Board reviewed Concurrent Use of Opioids and Antipsychotics utilization reports for FFS and MCOs. The DUR Board reviewed the Antipsychotic Medications in Children reports for FFS and MCOs. The DUR Board reviewed the Respiratory Drugs (excludes ICS and SABAs) in Members Less than 4 Years of Age reports for FFS and MCOs. The DUR Board reviewed the Utilization of Anticoagulant Reversals When Using the Novel Oral Anticoagulants reports for FFS and MCOs. The DUR Board reviewed Opioid Use with Risk Factors with and without Naloxone reports for FFS and MCOs. ProDUR, Recent RetroDUR Activity, Hemoglobin A1c Lab Value Over 9 and On Diabetic Meds for 6 Months Report, and Utilization Analysis reports were provided to the Board members for review. 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. The DUR Board reviewed recent updates to the American Society of Addiction Medicine (ASAM) guidelines in reference to Lucemyra. Minutes Summary - September 9, 2021 (Electronic Meeting) New Drugs: The DUR Board reviewed Empaveli (pegcetacoplan), Fotivda (tivozanib), Lumakras (sotorasib), Myfembree (relugolix, estradiol, and norethindrone acetate), Nextstellis (drospirenone and estetrol), Truseltiq (infigratinib), Wegovy (semaglutide) and Zegalogue (dasiglucagon). Hepatitis C: The DUR Board discussed the hepatitis C epidemic in Virginia and access to treatment. Acute and chronic hepatitis C cases worsened between 2013 and 2017. The DUR Board discussed removing barriers, such as removing the service authorization criteria on preferred hepatitis C drugs, to increase access to hepatitis C treatment. The hepatitis C criteria for preferred hepatitis C drugs were removed.

State	DUR Board Activities Report Summary
	Oral hypoglycemics: The DUR Board discussed the consideration of removal or amendment of the metformin step edit for oral hypoglycemic medications to enhance the ability to efficiently provide evidence-based and tailored diabetic therapies. This is to remove the metformin step edit on all oral hypoglycemics, which prevents prescription of any other oral hypoglycemic agent without completing a 90-day trial of metformin, except in select narrowly defined scenarios (i.e., A1c > 7.5, history of intolerance, severe renal impairment, known metformin intolerance, metabolic/acidosis/DKA). The metformin step edit for oral hypoglycemic medications have been removed. The DUR Board reviewed the Oral Oncology, Lung Cancer service authorization class criteria. The DUR Board reviewed the Oral Oncology, Renal Cell Carcinoma service authorization class criteria. The DUR Board reviewed Opioid Use with Risk Factors with and without Naloxone reports for FFS and MCOs. The DUR Board reviewed the Synagis Utilization Report for last season. DMAS has opened the service authorization Synagis season criteria to start earlier due to a sharp increase in RSV infection starting early this year in Virginia. The Synagis service authorization season started on August 15, 2021. The DUR Board reviewed the ProDUR, Recent RetroDUR Activity and Utilization Analysis reports. The Hemoglobin A1c Lab Value Over 9 and On Diabetic Meds for 6 Months Report was provided to the DUR Board for review. 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. The DUR Board reviewed a new pipeline drug, teplizumab.
Washington	During the FFY 2021, the DUR Board met six times with meetings focused on reviewing Apple Health Preferred Drug List (AHPDL) classes and clinical policies. There were 22 clinical policies reviewed by the DUR board and 14 were approved. Draft policies for Spinraza and Evrysdi were presented to the DUR Board however they were not approved as the DUR board recommended to consult with a spinal muscular atrophy specialist to review the proposed invasive ventilation criteria. The clinical policies reviewed by the DUR Board go through an extensive review process that includes review from internal agency clinicians and the Managed Care Organization (MCO) clinicians. After the DUR Board approves the policies, they go through a 2-3 month review process until the final draft is created. Once the final draft is completed, we are required to give the MCOs a 90-day notice for implementation. Due to the 90-day notice we are required to give the MCOs, 9 out of the 14 DUR Board approved policies were implemented in FFY 2021. For both prospective and retrospective DUR interventions, the DUR board does not have set policies on what types of interventions need to be adopted however if interventions are identified they are determined on a topic-by-topic basis. Select AHPDL drug classes were reviewed by the DUR Board for archiving. For a drug class to be eligible for archiving the following criteria must be met: 95% of the products in the drug class are generic and no new brand name products were added to the drug class. The following 404 drug classes and 22 clinical policies were reviewed by the DUR Board:

State	DUR Board Activities Report Summary
	1) October 21, 2020 Meeting a) AHPDL Classes Reviewed (drug class names shortened) i) 17 classes Reviewed and approved by DUR Board (1) Antihyperlipidemics (2 subclasses) (2) Antivirals (3 sublcasses) (3) Cardiovascular Agents (1 subclass) (4) Pituitary Suppressants (1 subclass) (5) GI Agents (2 subclasses) (6) Genitourinary Agents (1 subclass) (7) Hematological Agents (1 subclass) (8) Potassium Removing Agents (1 subclass) (9) Multiple Sclerosis Agents (1 subclass) (10) Oncology Agents (1 subclass) (11) Substance Use Disorder Agents (3 subclasses) b) AHPDL Classes Archived i) 55 Classes Reviewed and Approved by DUR Board (1) Largely generic classes with no new brand name products added (antibiotics, analgesics, anticoagulants, anticonvulsants) c) Policies Reviewed- All approved by DUR Board i) 65.20.00.10-Substane Use Disorders: Transmucosal Buprenorphine ii) 65.20.00.E5- Substance Use Disorders: Sublocade iii) 39.35.00- Antihyperlipidemics: PCSK-9 Inhibitors iv) 52.55.00- Chronic GI Motility Agents 2) December 16, 2020 Meeting a) Drug Classes Reviewed i) 17 classes Reviewed and approved by DUR Board (1) Analgesics (1 subclass) (2) Antiemetics (3 subclasses) (3) Antihypertensives (3 subclasses) (4) Hepatitis C Agents (1 subclass) (5) Endocrine and Metabolic Agents (2 subclasses) (6) Migraine Agents (2 subclasses) (7) Pulmonary Hypertension Agents (5 subclasses) b) Policies Reviewed i) 12.10.99- Antivirals: HIV Combinations (Approved by DUR Board) (1) Recommendations from DUR Board (a) DUR Board recommended adding criteria addressing renal function decline by 25% (b) Add clarification for mental illness poorly controlled ii) 12.10.99.02- Antivirals: Descovy (Approved by DUR Board) (1) Recommendations from DUR Board (a) DUR Board recommended adding criteria addressing renal function decline by 25% (b) Add clarification for mental illness poorly controlled iii) 74.50.90- Agents for ALS: Radicava (1) Not approved by DUR Board (2) Recommendations from DUR Board (a) Removed forced vital capacity criteria iv) 40.12.00- Pulmonary Hypertension Agents

State	DUR Board Activities Report Summary
	(1) Not approved by DUR Board (2) Recommendations from DUR Board (a) Add language referencing preferred product pathway v) 45.30.00- Cystic Fibrosis Agents (Approved by DUR Board) (1) Recommendations from DUR Board (a) Remove lung transplant criteria vi) 65.10.00- Analgesics: Opioid Agonists (Approved by DUR Board) 3) February 17, 2021 Meeting a) Drug Classes Reviewed i) 19 classes reviewed and approved by DUR Board (1) Antibiotics (2 subclasses) (2) Anticoagulants (1 subclass) (3) Antidiabetics (12 subclasses) (4) Endocrine and Metabolic Agents (2 subclasses) (5) Gastrointestinal Agents: Inflammatory Bowel Agents (1 subclass) (6) Cystic Fibrosis Agents (1 subclass) b) AHPDL Classes Archived i) 223 classes reviewed and approved by DUR Board ii) Largely generic classes with no new brand name products added (Antidepressants, antidiabetics, antihyperlipidiemics, antihypertensives, etc.) c) Policies Reviewed - All approved by DUR Board i) 40.12.00- Pulmonary Hypertension Agents 4) April 21, 2021 Meeting a) Drug Classes Reviewed i) 23 classes reviewed and approved by DUR Board (1) ADHD (6 subclasses) (2) Allergy (1 subclass) (3) Anticonvulsants (4 subclasses) (4) Antidementia (1 subclass) (5) Antidepressants (1 subclass) (6) Antiparkinsons (3 subclasses) (7) Atopic Dermatitis (3 subclasses) (8) Spinal Muscular Atrophy (2 subclasses) (9) Sleep Disorder Agents (2 subclasses) b) Policies Reviewed i) 74.50.90- Agents for ALS: Radicava (1) Approved by DUR Board ii) 74.70.00- SMA Agents: Spinraza (1) Not approved by DUR Board (2) DUR board recommendations (a) Get specialist feedback to review the invasive ventilation criteria and consider adding language for pre-symptomatic criteria iii) 74.70.65- SMA Agents: Evrysdi (1) Not approved by DUR Board (2) DUR board recommendations

State	DUR Board Activities Report Summary
	(a) Get specialist feedback to review the invasive ventilation criteria and consider adding language for pre-symptomatic criteria iv) 21.10.40- Antineoplastics: Imidazotetrazines- Oral (1) Approved by DUR Board 5) June 16, 2021 Meeting a) Drug Classes Reviewed i) 24 classes reviewed and approved by DUR Board (1) Asthma and COPD Agents (7 subclasses) (2) Hematopoetic Agents (5 subclasses) (3) Immune Modulators (1 subclass) (4) Oncology Agents (11 subclasses) b) Policies Reviewed - All approved by DUR Board i) 12.10.99.AA- Antivirals: HIV- Rilpivirine (1) DUR Board Recommendations (a) Update criteria 1d to have OR at the end ii) 90.05.00.AA- Dermatologics: Acne Products- Isotretinoin iii) 90.23.00.AA- Atopic Dermatitis: Eucrisa iv) 90.27.30.AA- Atopic Dermatitis: Dupixent (1) DUR Board Recommendations (a) Add link to website on the form 6) August 18, 2021 Meeting a) Drug Classes Reviewed i) 24 classes reviewed and approved by DUR Board (1) Antipsychotics (3 subclasses) (2) Cytokine and CAM (1 subclass) (3) Movement Disorders (1 subclass) (4) Oncology Agents (15 subclasses) (5) Ophthalmic Agents (2 subclasses) (6) Pulmonary Fibrosing Agents (1 subclass) (7) Smoking Deterrents (1 subclass) b) Policies Reviewed - All approved by DUR Board i) 27.17.00- Antidiabetics: GLP-1 Agonists (1) DUR Board recommendations (a) Remove DPP-4 inhibitor criteria (b) Consider adding age appropriate indications criteria for pediatric approved GLP-1 agonists ii) 52.12.00- Antidepressants: Serotonin Modulators (1) DUR Board recommendations (a) Updated reauthorization criteria language (b) Removed trial duration language from form iii) 61.40.00.AA- ADHD: Stimulants- Armodafinil/Modafinil (1) DUR Board recommendations (a) Consider adding BiPaP and non positive airway pressure devices if covered by Apple Health
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 2021 the DUR Board met a total of four times. The first DUR Board meeting of the 2021 Federal Fiscal Year was held on November 18, 2020. The Pharmacy Services calendar is structured so that the P&T

State	DUR Board Activities Report Summary
	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 18, 2020 and Sept 30, 2021. The following indicates clinical criteria which were added or altered during these meetings. November 18, 2020 Prospective DUR topics covered included: Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI agents- Linzess 72mcg, Zelnorm, Spravato, Epidiolex, VMAT 2 Inhibitors, Benlysta, Cytokine/CAM antagonists- Xeljanz, MABS/ Anti-IL/IgE, Onfi/Diacomit, Farxiga, Nexletol & Nexlizet, and CGRP receptor antagonists (prophylaxis). February 24, 2021 Prospective DUR topics covered included: Evrysdi, Breztri, Palforzia, Entocort EC & Ortikos, Lubiprostone, Oriahnn, Enspryng, Analgesics, Narcotics Long-Acting, and Suboxone policy. May 26, 2021 Prospective DUR topics covered included: Dojolvi, Omnipod, Fintepla, Xywav/Xyrem, Emflaza, Multiple Sclerosis Agents, Amondys 45, Verquvo, Lupkynis and Benlysta, Oxlumo, and Analgesics, Narcotic Long Acting. September 22, 2021 Prospective DUR topics covered included: Cabenuva, Antimigraine Agents, Prophylaxis- removal of grandfathering, Nurtec ODT- prophylaxis, Hepatitis C, Infliximab and biosimilars, Continuous Glucose Monitors, Qelbree, Orilissa, and Gemtesa. 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

State	DUR Board Activities Report Summary
	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 10/1/20 to 9/30/2021. Information about our lock-in program is also described below. A total of 4 Newsletters containing 13 articles were posted during this time,. The topics of the articles are listed below: 1. AMERICAN HEART MONTH Focus on Spontaneous Coronary Artery Dissection (SCAD) 2. Gabapentinoids and the Risk of Respiratory Depression 3. Prescribers Suggestions to Avoid ePrescribing Errors for Medicaid Patients 4. First Extended-Release Injectable HIV Medication 5. Statin-induced rhabdomyolysis: to restart or discontinue permanently? 6. Long-Term Benzodiazepine Use Considerations for the Busy Practitioner 7.Naloxone Prescription for Opioid Prescriptions 8. Fibrates and Drug-Induced Liver Injury 9. Managing Resistant Hypertension 10.FDA Approval of Novel Alzheimer's Disease Medication 11. SGLT2'S in Heart Failure 12. Aducanumab (Aduhelm) Controversy and Appropriate Use Guidance 13.The Who, What, When, How of Linezolid induced Thrombocytopenia 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. 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 2021, 101 patients were reviewed, with 66 requiring either a letter or locked in. 55 required letters to providers and letters, and 11 were locked in.
Wisconsin	Summary of Wisconsin Drug Utilization Review Board Activities Summary_2CMS FFY 2021

State	DUR Board Activities Report Summary
	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: - Implemented system enhancement requiring pharmacies to respond to all unique prospective DUR alerts. Providers were notified of the response change on February 15, 2021, and as of March 1, 2021, pharmacy providers were required to respond to each alert type. Previously providers only needed to respond to one unique alert type on a claim. - Reviewed Quarterly Reports of Prospective activity. - A benzodiazepine newsletter was released to providers and pharmacies to address benzodiazepine prescribing, appropriate indications, and challenges associated with deprescribing these medications. 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. - Focused intervention on underutilization of three antipsychotic medications was completed during the February 2021 cycle. The drugs included were cariprazine, lurasidone, and brexpiprazole. - Focused intervention for three inhaled asthma controller medications was also completed during the February 2021 cycle. The drugs included were fluticasone propionate HFA, budesonide/formoterol, and fluticasone propionate/salmeterol. - 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. The Phase I letter, which includes naloxone information, is currently being used. A mailing for newly identified members was completed in February 2021. - The additional SUPPORT Act requirements identifying members at high-risk for opioid overdose who may benefit from co-prescribing naloxone were implemented and as a result of this requirement, two new retrospective review criteria were operationalized in March 2021 to allow intervention on these high-risk members. Alert letters were sent to providers. - Focused intervention was conducted to identify members receiving duplicate sedatives/hypnotics. - Continued focused quarterly intervention to address the risks associated with the chronic use of multiple CNS depressants. Intervention letters are sent on members who have claims for all four of the following drug classes: opioids, benzodiazepines, sedative hypnotics, and skeletal muscle relaxants. Initial letters were sent December 2020. It was determined that future letters will only be mailed on newly identified members. - Continued focused quarterly interventions on members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed for possible inclusion in the Lock-In program. DUR Activities for SUPPORT Act - Prospective DUR

State	DUR Board Activities Report Summary
	- Prospective Safety edits on opioid prescriptions include: -Opioid script limit: Limits the number of opioid claims allowed in a calendar month. -Opioid quantity limits: Limits the amount of short-acting and/or select long-acting opioids dispensed in a rolling calendar month. -Early refill: Limits when a subsequent opioid prescription can be filled. -Therapeutic Duplication: Limits duplicate fills of select drug classes (i.e., opioids, benzodiazepines, etc.) per DUR Board recommendations. -Morphine milligram equivalents (MME): Alerts the pharmacy when the MME on a claim exceeds the 90 MME limit identified by the state. - Retrospective DUR - Retrospective Lock-In/High Utilization criteria: Review of MMEs, multiple high dose short-acting opioids, receiving more narcotics than intended or is using short-acting opioids when a long-acting formulation is available. -Outreach calls are being made to prescribers after intervention letters are sent. Prescribers are selected for intervention based on continued high MME or an MME increase after the intervention letter was sent. -Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. -Implementation of the new SUPPORT Act requirement identifying members at high-risk for opioid overdose who may benefit from co-prescribing naloxone. - Program to Monitor Antipsychotic Use in Children - Antipsychotic agents are reviewed for appropriateness in all children including foster children based on approved indications and clinical guidelines. -Peer to peer outreach calls are being made to prescribers on children identified as being on two or more antipsychotic medications, focusing specifically on children with higher doses of both medications. -Retrospective letters are sent to prescribers when a child is on an antipsychotic medication that does not have an indication for use in children. - Fraud and Abuse Identification -The DUR program utilizes the Pharmacy Services Lock-In program to identify potential fraud or abuse of controlled substances by enrolled members. Members are identified and reviewed for possible inclusion in the program via a systematic algorithm or referral by a prescriber or other agency. Yearly results of the Lock-In program are reported to the DUR Board. There are no specific policies of this Board which establish whether or how results of prospective DUR screens are used to adjust retrospective DUR screens. Likewise, there are no specific policies that establish whether or how results of retrospective DUR screening are used to adjust prospective DUR screens. The Board considers issues related to screenings on a case-by-case basis. The Wisconsin DUR Board takes an active advisory role in determining all aspects of the DUR education program. There are no specific policies of this Board which establish which intervention type should be utilized for patient or prescriber outreach. The Board considers the method of outreach on a case-by-case basis. The Board reviews criteria for and results of monthly prescriber intervention lettering. Monthly, 2,680 member profiles are reviewed for regular RDUR and an additional 1,080 member profiles are reviewed for the Pharmacy Services Lock-In program.

State	DUR Board Activities Report Summary
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: Vyondys 53 Viltepso Evrysdi Enspryng Ongentys Oxlumo Orladeyo Zokinvy Verkuvo Evkeeza Lupkynis Amondys-45 Xolair Fasenra Nucala Dupixent Myfembree Kerendia Drug/age limits: CGRP agents for migraine Drug/dose limits: Guanfacine Montelukast Suboxone (amended) Concurrent therapy: Vyondys/Viltepso Duration of therapy: Suboxone (amended) Myfembree Other PA criteria/step therapy: Vyondys 53 Viltepso

State	DUR Board Activities Report Summary
	Entresto Bafiertam Kesimpta Conjupri Sunosi Gemtasa Klisyri Amondys-45 Ponvory Qelbree Xolair Fasenra Nucala Dupixent Exservan Myfembree Azstarys Kloxxado Gender transition medications Protopic (amended) Elidel (amended) In-depth Utilization Reviews Parkinson's disease Suboxone Gabapentin and pregabalin for post-operative pain Eosinophilic asthma agents Policies regarding the interaction between prospective DUR and retrospective DUR criteria and utilization reviews Utilization issues identified during prospective review of claims are presented to the P&T Committee as necessary to determine if prior authorization criteria should be added, changed or deleted. When needed, in-depth retrospective review is completed to determine the type of problem and most reasonable solution. Similarly, retrospective reviews often identify utilization issues that require prospective criteria to be added. Both prospective and retrospective reviews drive the selection of education projects. P&T Committee involvement in the education program The following topics were included in provider education letters sent from the DUR Program during FFY 2021: Concurrent use of antipsychotics and opioids (quarterly) Narcotic use and pregnancy (monthly) Prescription Drug Monitoring Program (weekly) Dyslipidemia guidelines Opioid abuse or dependence

State	DUR Board Activities Report Summary
	High dose montelukast utilization Use of NSAIDs during pregnancy Delayed antibiotic prescribing Xeljanz black box warning The following topics were included in comparative prescriber reports sent from the DUR Program during FFY 2021: Pediatric opioid use Concurrent use of opioids, stimulants and gabapentin Concurrent use of opioids and sedative hypnotics Albuterol utilization DUR Newsletters Four quarterly WY-DUR Newsletters were sent during FFY2020. Newsletters are sent to approximately 3000 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 38 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

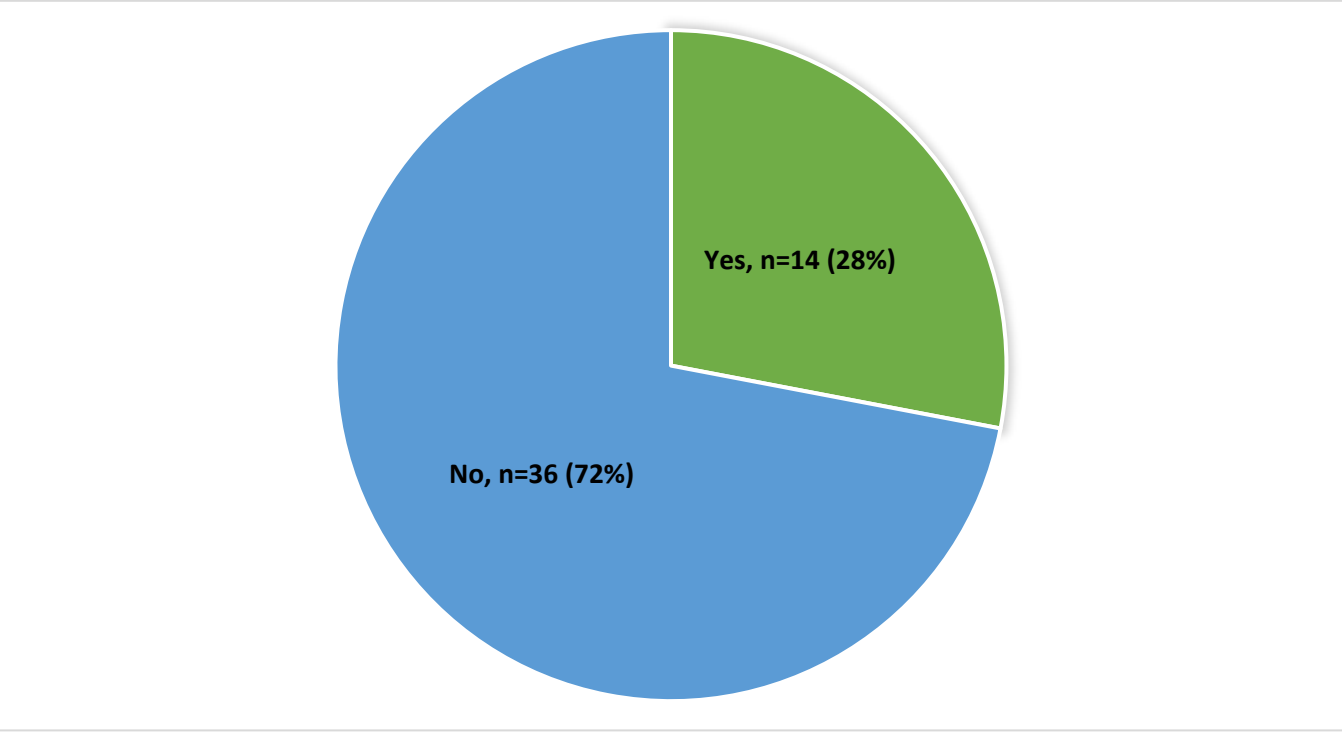

Table 59 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Alaska, Delaware, Georgia, Hawaii, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Pennsylvania, Utah, Virginia, Washington	14	28.00%
No	Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin, Wyoming	36	72.00%
Total		50	100.00%

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

Figure 39 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

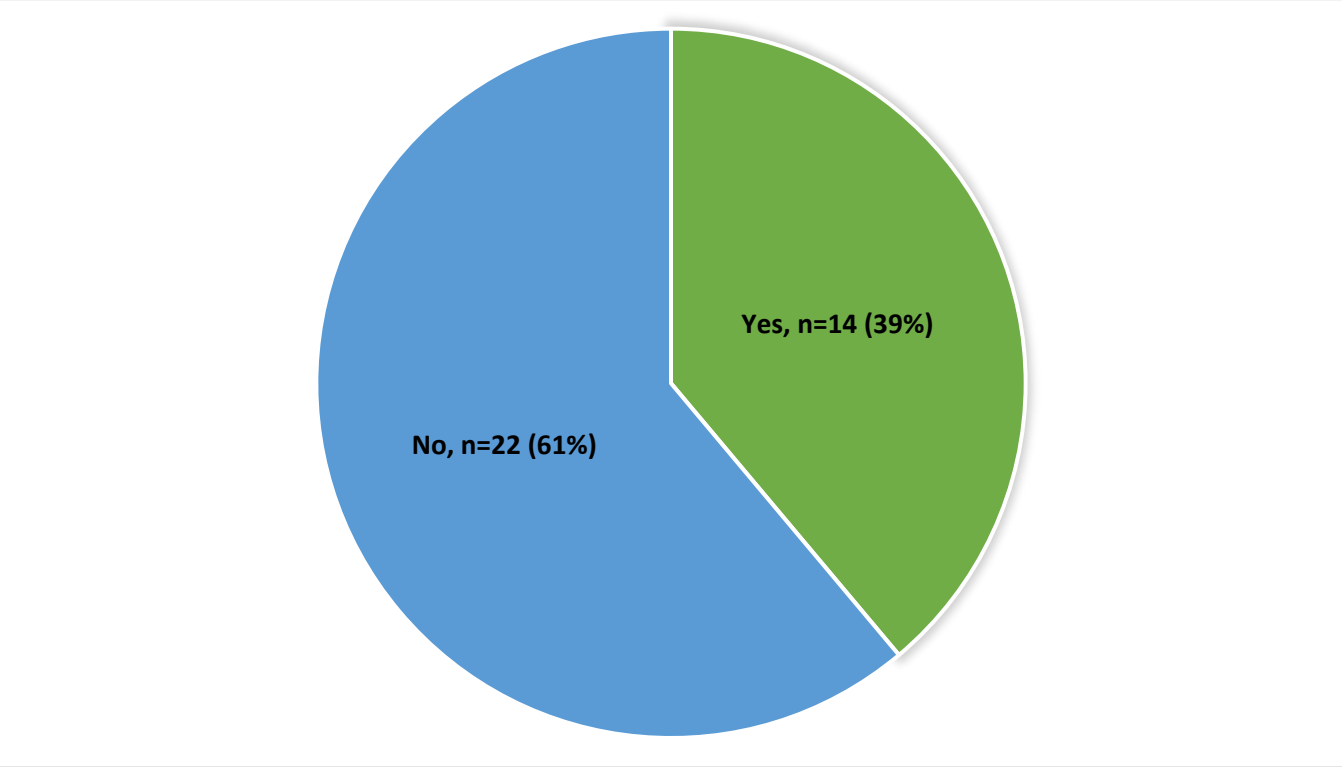

Table 60 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Florida, Illinois, Maryland, Mississippi, Nevada, New Jersey, New York, North Carolina, North Dakota, Oregon, South Carolina, Vermont	14	38.89%
No	Alabama, Arkansas, California, Connecticut, Idaho, Indiana, Iowa, Kansas, Louisiana, Minnesota, Nebraska, New Hampshire, New Mexico, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming	22	61.11%
Total		36	100.00%

2. RetroDUR?

Figure 40 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

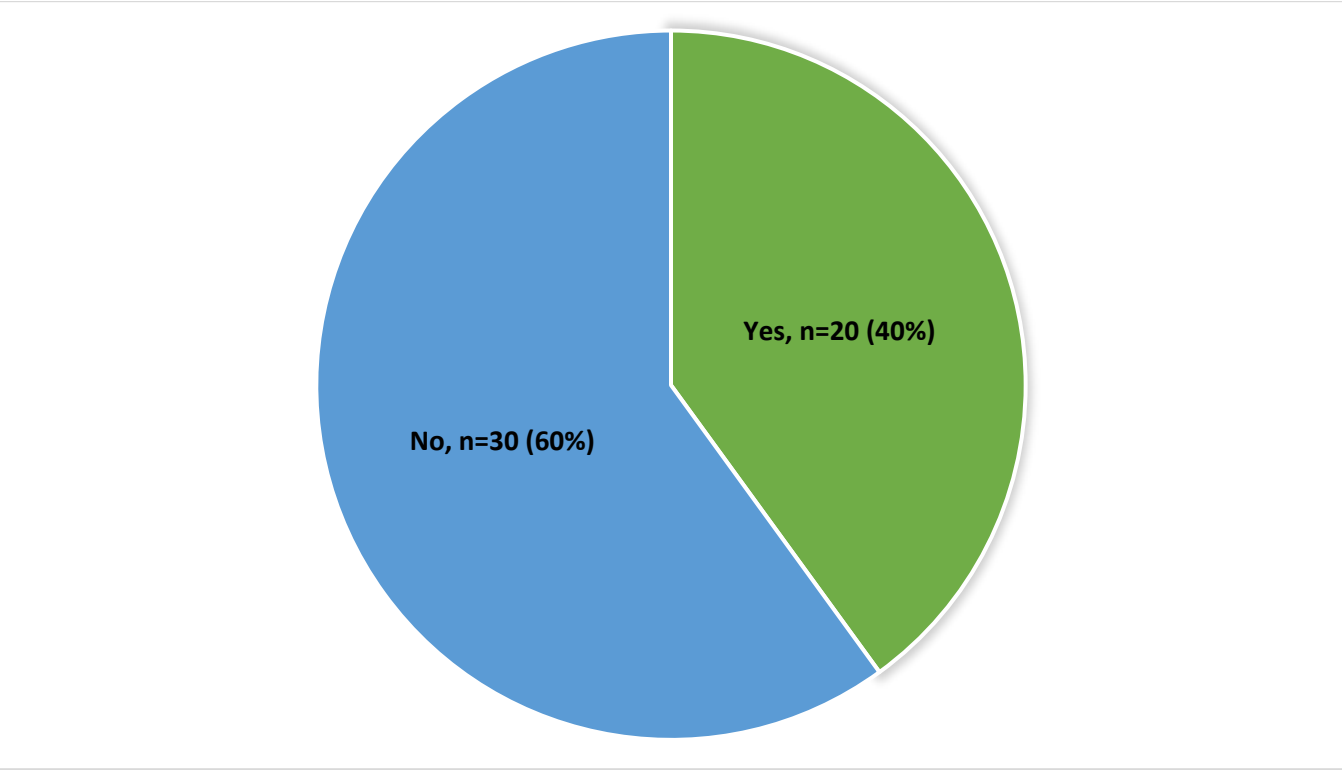

Table 61 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Alaska, California, Florida, Georgia, Hawaii, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, North Dakota, Oregon, Pennsylvania, South Carolina, Utah, Virginia, Washington	20	40.00%
No	Alabama, Arkansas, Colorado, 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, Vermont, West Virginia, Wisconsin, Wyoming	30	60.00%
Total		50	100.00%

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

Figure 41 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

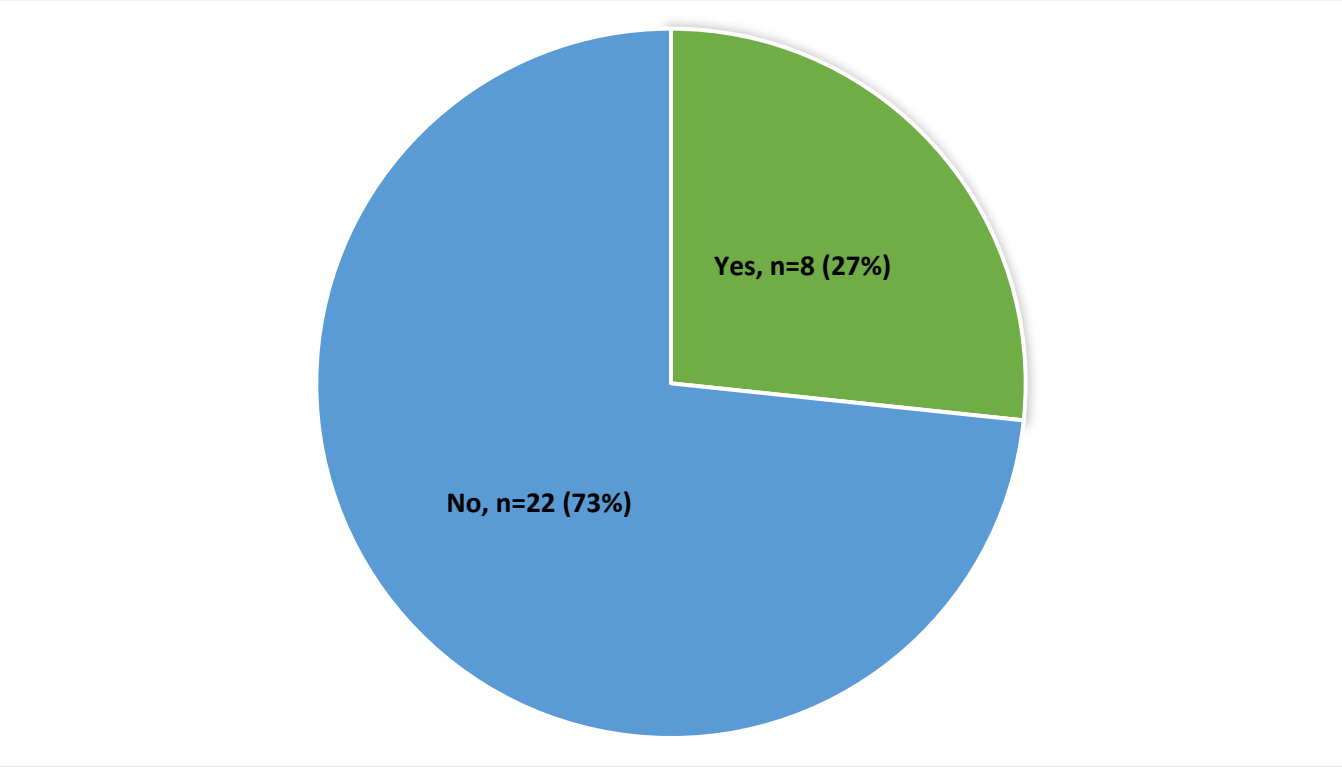

Table 62 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Idaho, Mississippi, New Jersey, New York, North Carolina, Vermont	8	26.67%
No	Alabama, Arkansas, Connecticut, Delaware, Illinois, Indiana, Iowa, Kansas, Maryland, Minnesota, Montana, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming	22	73.33%
Total		30	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 63 - Generic Drug Substitution Policies Summary

State	Generic Drug Substitution Policies Summary
Alabama	Alabama Medicaid mandates generic substitution of therapeutically equivalent drugs. If the doctor requests that brand name be dispensed, he/she must submit an override request, including medical justification for the use of the brand name medication over the generic and a completed FDA MedWatch form; exclusions exist for certain drugs. The Alabama Medicaid program encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. As another way to encourage the substitution of therapeutically equivalent generic drugs, the Alabama Medicaid Agency has implemented a maintenance supply program. This program allows for the dispensing of a 3-month supply of certain medications for Medicaid recipients. Medications included in the maintenance supply program are primarily generic medications used to treat chronic conditions. Alabama Medicaid also makes use of a Preferred Drug List (PDL) as a way to promote use of generic products. The majority of generic drugs are preferred and providers are urged to utilize the PDL through provider education and academic detailing. Alabama Medicaid's academic detailing program utilizes a team of Medicaid Pharmacy Specialists (MPS) who live in and travel throughout their specific area making prescheduled visits to pharmacists and providers. The MPSs provide education regarding the preferred drug list, new edits, and other priority initiatives designated by the Alabama Medicaid Agency.
Alaska	The use of generic medications is encouraged through regulation 7 AAC 120.112(7). Additional initiatives to encourage the use of generic medications were continued by the Department in FFY 2021. This includes continuation of a point of sale edit which requires a prior authorization for brand name drug claims submitted with a DAW = 1. To the extent possible, and considering the net-net cost of therapeutic equivalents, PDL preferred drug selection encourages generic drug utilization. Educating providers and recipients that generic medications are therapeutically equivalent to the brand name product can be challenging due to periodically held perceptions that generic products are not as effective or potent as the brand product. Patients must trial a minimum of two generic products prior to utilization of a branded product to minimize selection bias. 7 AAC 120.112 Non-covered drugs Notwithstanding 7 AAC 120.110, the department will not pay for:

State	Generic Drug Substitution Policies Summary
	(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-FFY2021 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 that 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. * 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. 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, Arkansas Medicaid has a generic utilization of 85% for all outpatient claims comprising 15% of total drug expenditures for FFY2021.
California	Among possible factors contributing to the Medi-Cal fee-for-service generic utilization percentage, the most impactful are the following: 1) supplemental rebate contracts with manufacturers; 2) carve-out drugs; and 3) generic drug pricing policies.

State	Generic Drug Substitution Policies Summary
	1) Restrictions to the Medi-Cal List of Contract Drugs The Medi-Cal Drug Rebate program negotiates supplemental rebate contracts with pharmaceutical manufacturers and collects rebates greater than rebates obtainable through federal contracts alone. As a result, the net cost to the State for some brand name drugs can be lower than the therapeutically equivalent generic drug. In some cases, contracted drugs are payable at the point of service, while their generic equivalents require prior authorization. On the Medi-Cal List of Contract Drugs, these drugs can be identified through restrictions to the NDC labeler code. 2) Carve-out Pharmacy Benefits The Medi-Cal fee-for-service program pays for certain carved-out therapeutic classes of drugs for beneficiaries in both the Medi-Cal fee-for-service program and the Medi-Cal managed care program. Most notably, this applies to selected psychiatric drugs, alcohol and heroin detoxification and dependency treatment drugs, coagulation factors, and drugs used in treatment of Human Immunodeficiency Virus (HIV) and AIDS. These classes of drugs are largely single-source innovator products and consistently account for a large portion of Medi-Cal drug benefit expenditures in the Medi-Cal fee-for-service population. 3) Policies encouraging generic equivalent substitution for drugs dispensed through the Medi-Cal program. In cases where generic drugs are more cost-effective, Medi-Cal encourages use of generic drugs. The providers, to the extent permitted by law, shall dispense the lowest cost drug product within the generic drug type in stock, which meets the medical needs of the beneficiary. Reimbursement for any legend and non-legend drug covered under the Medi- Cal program is the lowest of: 1. Actual acquisition cost (AAC) plus a professional dispensing fee. The AAC is equal to the lowest of the following: National Average Drug Acquisition Cost (NADAC), or when no NADAC is available, the wholesale acquisition cost (WAC) Maximum Allowable Ingredient Cost (MAIC) Federal Upper Limit (FUL) 2. The pharmacy's usual and customary charge. Among these, whenever available, MAIC and FUL promote the use of generic equivalents unless restricted on the Medi-Cal List of Contract Drugs. The rates established by MAIC or FUL are generally much lower than the cost of branded products, which discourages providers from filling prescriptions with name brand drugs. Full reimbursement of prescription ingredient cost requires use of a brand of a multiple source drug, which costs no more than the program specified price limits. When medically necessary for a specific recipient, approval of reimbursement may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting authorization from a Medi-Cal consultant. National Average Drug Acquisition Cost (NADAC) The National Average Drug Acquisition Cost (NADAC) is used as the basis for the actual acquisition cost-based ingredient cost reimbursement for covered outpatient drugs. The NADAC is a national drug-pricing benchmark determined by a federal survey, representing

State	Generic Drug Substitution Policies Summary
	the national average invoice price for drug products based on invoices from wholesalers and manufacturers submitted by retail community pharmacies. Wholesale acquisition cost (WAC) plus 0 percent is used as the basis for reimbursement when a NADAC is not available. The methodology reimburses the lower of the NADAC, WAC, federal upper limit (FUL), maximum allowable ingredient cost (MAIC) or the pharmacy's usual and customary charge. Maximum Allowable Ingredient Cost (MAIC) The Maximum Allowable Ingredient Cost (MAIC) program establishes maximum ingredient cost limits for generically equivalent drugs. Each cost limit is established only when there are three or more generically equivalent drugs available for purchase and dispensing by retail pharmacies within California. Federal Upper Limit (FUL) Federal Upper Limit (FUL) is an upper limit of reimbursement for certain multiple source drugs established independently from the California MAIC Program by the United States Department of Health and Human Services (DHHS). The federally required FUL is administered by the Medi-Cal program in a similar manner as the MAIC program. The major difference is that changes to the FUL list of drugs and respective price limits are issued periodically by DHHS and then implemented by Medi-Cal. When a drug is listed on both the MAIC and FUL price lists, the reimbursement rate is the lower of the MAIC or FUL.
Colorado	Policy for mandated use of generic product formulations (generic mandate 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. -The physician is of the opinion that a transition to the generic equivalent of a brand drug product would be unacceptably disruptive to the patient's stabilized drug regimen. -The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician. -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.

State	Generic Drug Substitution Policies Summary
	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 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).

State	Generic Drug Substitution Policies Summary
	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 2021, 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 80.5% 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 drugs. 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 multisourced 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%u2010week 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 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%u2010source 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 a prior authorization before submitting the claim with DAW 1.

State	Generic Drug Substitution Policies Summary
	Additionally, the District utilizes a Preferred Drug List to manage selected classes of drugs that are vetted for efficacy, safety and therapeutic equivalency. Preferred brand drugs are subject to a manufacturer supplemental rebate payable to the District based on utilization of the product. At times the net cost to the District for a brand product is more advantageous than if a generic product is preferred mainly due to high federal and supplemental rebates on the brand product. In these instances, the District will make a brand product preferred over a generic. This fiscally sound practice however may negatively influence the generic utilization rate.
Florida	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 74% for Federal Fiscal Year 2021.
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	State law requires generic mandatory. Two generic anti-depressants or anti-anxiety drugs must be tried and failed before a brand is approved. When a generic is available, a brand will be paid with dispense as written (DAW) 1 or by a prior authorization for all other drugs. Anti-seizure drugs if written as a brand, is to be dispensed as a brand by state law. If documented prescriber approval is obtained, a generic can be substituted.
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

State	Generic Drug Substitution Policies Summary
	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 FFY21. Illinois Medicaid uses State Maximum Allowable Cost (SMAC) pricing on generic drugs. The lesser of FUL, NADAC, SMAC, WAC-minus 17.5% 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. 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 2021 (SFY21) to receive enhanced professional dispensing fees of $15.55. Illinois Medicaid uses tiered copayments to encourage utilization of generic products. During FFY21, 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 FFY21. 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.

State	Generic Drug Substitution Policies Summary
	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 FFY21. 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 FFY21. In FFY21, the Illinois Medicaid generic utilization rate was 90.43% of total paid claims, an increase of 1.87 percentage points compared to the FFY20 generic utilization rate of 88.56%. In FFY21, brand name single-source drugs accounted for 5.11% of the total paid claims, which was 1.24% lower than in FFY20. In FFY21 innovator multiple source drugs accounted for 4.46% of the total paid claims, at least 0.6% percent lower than in FFY20. 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 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: • the words “Brand Medically Necessary” are written in the practitioner's own writing on the form; or • 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

State	Generic Drug Substitution Policies Summary
	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 rebate to the state. A list of current brand preferred agents can be found on the pharmacy services website on the pharmacy criteria and forms page at: https://inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp. Pharmacy providers need not obtain a brand medically necessary prior authorization or prescription for agents in which the state prefers the brand product. For these claims submissions, a dispense as written code of 9 is utilized.
Iowa	While use of therapeutically equivalent generic drugs is encouraged, there are instances where a brand name drug is preferred over the generic equivalent. The Pharmaceutical & Therapeutics Committee (P&T) determines placement of drugs on the Preferred Drug List (PDL), taking into consideration the therapeutics and the cost of the drug. The overall cost determination of brand and generic drugs are based on a review of the net cost to the program, subtracting out all CMS and supplemental rebates. Because of varying rebates for brand name drugs, it is not uncommon for the net cost of brand name drug to be less than that of its generic counterparts thus making it preferred for Medicaid programs.
Kansas	Kansas State Board of Pharmacy allows for pharmacist substitution of generic drugs unless: If the physician insists that brand name be dispensed, he/she must write dispense as written on the face of the prescription in his/her own handwriting. A note stating dispense as written on an electronically sent prescription. Verbally request was made when phoning in a prescription order. The FDA has determined that a drug is not bioequivalent to the prescribed drug. Kansas Medicaid has a Brand Medical Necessity PA requiring generic drug use and medical necessity criteria for when a provider requests brand drugs.
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. For patients that have a copay, a higher copayment for branded products is assessed unless the plan prefers a brand when a generic of that same product is available. As discussed above, generic utilization is encouraged whenever possible; however, generics must be cost effective as well. There are

State	Generic Drug Substitution Policies Summary
	times when a branded product, after all rebates have been considered, proves to be more cost-effective to the Commonwealth. In those instances, the claims adjudication system is coded to require pharmacies to dispense the more cost-effective (brand) product and generic utilization numbers are negatively impacted.
Louisiana	1. When Brand name drugs are preferred on the PDL and the generic requires prior authorization. From the POS Manual: 4.2.3 Drugs with PA Criteria. Claim payments for Brand Name drugs at Brand reimbursement are allowed when the Brand drug is on the PDL and the generic drug requires Prior Authorization. Edits. The generic reimbursement of a Brand Name drug can be overridden when the Brand drug is on the PDL and the generic drug requires Prior Authorization. Louisiana Medicaid POS User Manual Revised Date: 08/11/14, Page 15 of 73 Override. Enter a value of 9 which is substitution allowed by prescriber but plan requests brand in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Documentation. When 9 is entered in NCPDP field #408-D8, it will not be necessary for the Brand Medically Necessary to be handwritten on the prescription by the prescriber. 2. When the physician requests the Brand for medical necessity. From the POS Manual: 4.2.2 Federal Upper Limits (FUL). Claim payments are adjusted in accordance with the Maximum Allowable Reimbursement Methodology for drugs with FUL. Edits. The FUL can be overridden when the prescribing practitioner utilizing his/her medical judgment certifies in his/her own handwriting that a specific brand name drug is medically necessary for a specific patient. Override. Enter a value of 1 which is substitution not allowed in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Please consult the pharmacy system vendor manual or your pharmacy system documentation or contact your software vendor on what codes need to be entered in this field. If a code is entered in this field, it could affect the amount received. Documentation. The certification must be written either directly on or must be a signed and dated attachment (which may be faxed) to the prescription. The certification must be in the prescriber's handwriting.
Maine	Generic Drug Substitution Policy The state encourages generic prescribing by virtue of a mandatory generic law, a Preferred Drug List that prefers all costeffective generics and a rigorous prior

State	Generic Drug Substitution Policies Summary
	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 Maine Medicaid FFS DUR FFY 2020 Individual State Annual Report 20 Question Response generic and therapeutically equivalent drug or an interchangeable biological product only when the Department of Health and Human Services has determined that the substitute

State	Generic Drug Substitution Policies Summary
	drug or interchangeable biological product would be a more cost-effective alternative than the drug or biological product prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug or biological product with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug or for either the prescribed biological product or interchangeable biological product and dispense the drug or biological product that the patient prefers. [PL 2019, c. 34, 4 (AMD).] Except with regard to a patient who is paying for a drug or biological product with the patient's own resources, if a written prescription issued by a practitioner in this State does not contain the box described in this section, a pharmacist shall substitute a generic and therapeutically equivalent drug for the drug or an interchangeable biological product for the biological product specified on the prescription if the substituted drug or interchangeable biological product is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug or interchangeable biological product does not exceed the price of the drug or biological product specified by the practitioner, unless a practitioner has handwritten on the prescription form, along with the practitioner's signature, "dispense as written," "DAW," "brand," "brand necessary" or "brand medically necessary"; except that, when the cost of a prescription is to be reimbursed under the MaineCare Maine Medicaid FFS DUR FFY 2020 Individual State Annual Report 21 Question Response program pursuant to Title 22, chapter 855,

State	Generic Drug Substitution Policies Summary
	the pharmacist shall substitute a generic and therapeutically equivalent drug or an interchangeable biological product only when the Department of Health and Human Services has determined that the substitute drug or interchangeable biological product would be a more cost-effective alternative than the drug or biological product prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug or biological product with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug or for either the prescribed biological product or interchangeable biological product and dispense the drug or biological product that the patient prefers. [PL 2019, c. 34, 4 (AMD).] Any pharmacist who substitutes a generic and therapeutically equivalent drug or an interchangeable biological product under this section shall inform the person to whom the drug or interchangeable biological product is dispensed of the substitution. When any substitution is made under this section, the pharmacist shall cause all information as required by section 13794, the name of the generic and therapeutically equivalent drug and the name or abbreviation of the drug manufacturer or distributor of that substitute drug or, in the case of an interchangeable biological product, the proper name and the name of the manufacturer of the interchangeable biological product, to appear on the container label of the drug or interchangeable biological product dispensed. [PL 2019, c. 34, 4 (AMD).] This section does not apply to prescriptions ordered by practitioners for patients in hospitals when those prescriptions are filled by a hospital pharmacy or in any institution Maine Medicaid FFS DUR FFY 2020 Individual State Annual Report

State	Generic Drug Substitution Policies Summary
	22 Question Response where a formulary system is established. [PL 1987, c. 710, 5 (NEW).] Within 5 business days after a pharmacist dispenses a biological product, the dispensing pharmacist or the pharmacist's designee shall enter in an electronic records system that is electronically accessible to the practitioner who prescribed the biological product the specific biological product dispensed, including the name of the biological product and the manufacturer. For purposes of this paragraph, "electronic records system" means an interoperable electronic medical records system, an electronic prescribing technology, a pharmacist benefit management system or an electronic pharmacy record. Entry into an electronic records system as described in this paragraph is presumed to provide notice to the practitioner. If a pharmacist cannot make an entry in an electronic records system, the pharmacist shall notify the practitioner of the specific biological product dispensed by facsimile, telephone, electronic transmission or other similar means. Notice to a practitioner under this paragraph is not required if the federal Food and Drug Administration has not approved an interchangeable biological product for the product prescribed or a refill prescription is not changed from the biological product dispensed on the prior filling of the prescription. [PL 2019, c. 34, 4 (NEW).] The board shall maintain a link on the board's publicly accessible website to the current list of all biological products determined by the federal Food and Drug Administration to be an interchangeable biological product. [PL 2019, c. 34, 4 (NEW).] For the purposes of this section, "drug" does not include biological products. [PL 2019, c.
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

State	Generic Drug Substitution Policies Summary
	drug. Generics include drugs that have been rated AB (product meets necessary bioequivalence requirements) by the Food and Drug Administration. These ratings are published in the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (the "Orange Book"). Current Maryland Medicaid policy is to require the approval of a prior authorization, supported by the submission of an FDA Medwatch form, for a brand name drug to be dispensed for which there is an FDA approved equivalent generic agent on the market. The exception to this policy is that, in some instances, the multisource brand name drug is preferred on the Preferred Drug List (PDL) because the branded drug is more cost-effective than its generic counterpart. In the survey question VI. Generic Policy and Utilization Data, sub question 3, we have reported generic utilization percentage of 82%. However, due to the reason stated above, recalculated generic use rate would be 89%.
Massachusetts	Within the MassHealth Pharmacy Program, generic utilization is part of an evidence-based approach to clinical decisions and program design. Generic utilization is also encouraged and mandated by several Massachusetts regulations. Less Costly Alternatives: Massachusetts regulation 130 CMR 450.204 states that The Division will not pay a provider for services that are not medically necessary. (A) A service is "medically necessary" if ... (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the Division. Preferred Copayment for generic medications: Massachusetts regulation 130 CMR 450.130 states that "MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 450.130(D) or (E). The copayment for pharmacy services is (a) $1 for each prescription and refill for each generic drug, and non-legend drug covered by MassHealth in 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

State	Generic Drug Substitution Policies Summary
	authorization (PA) for clinical reasons. Drugs that require additional PA requirements are noted with "PA" on this list and are subject to 130CMR 406.000 and other MassHealth regulations. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent. MassHealth Supplemental Rebate/Preferred Drug List - A list of drugs for which MassHealth has entered into a supplemental rebate agreement with drug manufacturers, allowing MassHealth the ability to provide medications at the lowest possible costs. The items are listed alphabetically by therapeutic class, then by the name of the drug or drug ingredients. MassHealth may still require prior authorization for clinical reasons. Drugs that require additional prior authorization requirements are noted with PA on this list and are subject to 130CMR 406.000 and other MassHealth regulations. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.
Michigan	The Michigan Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include a brand medically necessary edit, maximum allowable cost (MAC) pricing, National Average Drug Acquisition Cost (NADAC) pricing, preferred drug list (PDL) and tiered copays for brand and generic drugs.
Minnesota	The Minnesota Department of Human Service's Pharmacy Program encourages the use of therapeutically equivalent generic drugs when appropriate. Pursuant to Minnesota Statutes, section 151.21, subdivision 3: When a pharmacist receives a written prescription on which the prescriber has not personally written in handwriting dispense as written or D.A.W., or an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated, and there is available in the pharmacist's stock a less expensive generically equivalent drug that, in the pharmacist's professional judgment, is safely interchangeable with 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.

State	Generic Drug Substitution Policies Summary
	There are select brand name preferred drugs if the net cost is less for the brand name drug.
Mississippi	DOM mandates generic substitution of therapeutically equivalent drugs. The following is an excerpt from our 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: 1. Observed allergy to a component of the generic drug; or 2. An attributable adverse event; or 3. 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 equivalents excepts NTI drugs. If a beneficiary requires a brand name multisource drug, the prescriber must request a prior authorization by seeking approval from DOM's PA unit. NTI drugs: Coumadin, Dilantin, Lanoxin, Synthroid, Tegretol. DOM does not have a MAC program for multisource generic drugs; please refer to Westlaw system 20 So.3d 1236 (Miss. 2009). DOM has a robust PDL with associated supplemental rebates. For some agents, the combination of federal and supplemental rebates result in the branded agents being the least expensive to both the state and the federal government. State law limits the adult non-institutionalized beneficiary to 6 drugs monthly of which no more than 2 may be branded - preferred brands do not count toward the two brand monthly prescription limit (eff. 1/12/12). There are some situations where a more expensive generic drug is co-preferred with the branded agent in 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	Single PDL Bi-annual PDL review via P&T meetings in May and November Bi-monthly DUR meetings TOP$ supplemental rebate program reviews

State	Generic Drug Substitution Policies Summary
Nevada	NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand name; and d) is of the same generic type as the drug prescribed by brand name. If the pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are available to him or her for substitution. Before a pharmacist dispenses a drug in substitution for a drug prescribed by brand name, the pharmacist shall: a) advise the person who presents the prescription that the pharmacist intends to dispense a drug in substitution; and b) advise the person that he or she may refuse to accept the drug that the pharmacist intends to dispense in substitution, unless the pharmacist is being paid for the drug by a governmental agency. If a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense the drug in substitution.
New Hampshire	New Hampshire law requires pharmacists to substitute an FDA A rated generic equivalent (AA, AN, AO, AP, AT or AB) listed in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) for a multi-source legend medication product. New Hampshire Medicaid policy requires a Prior Authorization for all multi-source legend medications unless: A. Patient must have experienced a therapeutic failure (inadequate response) to the A rated generic or the patient must have experienced an adverse reaction to the A rated generic OR B. In the prescriber's opinion, transition to another generic in the same therapeutic category would represent an unacceptable risk to the patient OR C. The patient has a documented allergy to one of the components of the generic (i.e. dye). If multiple generics are available, the patient must try another generic AND D. In accordance with FDA regulations, the prescriber must submit a MedWatch form to the FDA to verify a documented failure and/or adverse reaction on an A-B rated generic product. To further encourage generic utilization, New Hampshire Medicaid continues to enhance the maximum allowable cost (MAC) program. New Hampshire Medicaid participates in the National Medicaid Pooling Initiative (NMPI), a multi-state purchasing pool that allow states to aggregate their eligible lives thereby leveraging pharmaceutical purchasing power as a group to achieve more supplemental rebates than could be achieved on their own. By being part of this initiative, it lowers the net cost of brand drugs and the overall pharmacy spend through a competitive bidding process.
New Jersey	The New Jersey Division of Medical Assistance and Health Services (DMAHS) implemented a Mandatory Generic Substitution Program on July 8, 2003. New Jersey FamilyCare/Medicaid fee-for-service payments for brand-name multi-source drugs require prior authorization, with exceptions for: - brand name drugs determined more cost-effective than multi-source drugs;

State	Generic Drug Substitution Policies Summary
	- the dispensing of a ten (10) days supply of the brand-name multi-source drug without prior authorization to allow the practitioner the opportunity to request prior authorization; and - Narrow Therapeutic Index (NTI) drugs, including: behavioral health meds, 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's Mandatory Generic Substitution Exempt List. Changes were as follows: atypical antipsychotics would now be referred to as Behavioral Health Drugs, hormone replacement therapy drugs will no longer be exempt, and transplant or anti-rejection drugs will be exempt.
New Mexico	GENERIC DRUG SUBSTITUTION POLICIES New Mexico Medicaid works to ensure that whenever possible therapeutically equivalent generic drugs are used in place of more expensive brand name alternatives. Covered drugs are subject to generic-first coverage provisions. The recipient must first use one or more generic items available to treat a condition before the Medical Assistance Division (MAD) covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD or its designee, based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items. The generic-first provision does not apply to Indian Health Service (IHS) facilities and PL 93-638 operated hospitals and clinics. The following categories of drug items are exempt from the generic-first requirements: Anti-asthmatic and other respiratory drugs Anticoagulants Anticonvulsants Antipsychotics and antidepressants Cancer chemotherapy items, and Thyroid hormones Some categories of drugs, brand names will not be covered. The following categories of drug items, only generic items will be covered: Acne medications Cough and cold medication
New York	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

State	Generic Drug Substitution Policies Summary
	The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available is considered an order for the drug by its generic 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.

State	Generic Drug Substitution Policies Summary
	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 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

State	Generic Drug Substitution Policies Summary
	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 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 154 Preferred Brands with Non-Preferred Generics on the Preferred Drug List (PDL) as of September 24, 2021 (brand use required unless prior approval for generic).
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 where 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 approve for the brand name including trialing available generic manufacturers.
Ohio	While 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 ORC

State	Generic Drug Substitution Policies Summary
	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. 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 is demonstrated by Ohio Medicaid's generic utilization rate of 88.7% for Federal Fiscal Year 2020. At the beginning of the COVID-19 pandemic, copays were waived for all prescription medications. On 12/14/2020, copays were reinstated at rates of $3 for prescription drugs requiring prior authorization (non-pregnant and non-institutionalized individuals over age 21); $2 copay for most name-brand drugs (non-pregnant and non-institutionalized individuals over age 21); $0 copay for hospice consumers and medications for emergency services and family planning services.
Oklahoma	OHCA requires the use of generic drugs when available. Dispensing a branded medication that is available generically requires a brand override prior authorization. Approval of a brand override request requires a documented clinically significant reason to dispense the branded product. Exceptions are made to this rule for select drugs with a narrow therapeutic index or for those branded agents that are preferred over the generic due to net cost. Adult members who do not reside in long-term care facilities are limited to two brand medications per month with limited exceptions. Generic medications typically occupy the first tier in Product Based Prior Authorization categories and are commonly available without prior authorization.
Oregon	By Administrative rule OAR 410-121-0030 (5)(a)&(b) pharmacy providers dispense prescriptions in generic form unless requested by practitioner request otherwise pursuant to OAR 410-121-0155 and/or OAR 410-121-0040. Providers shall obtain prior authorization (PA) for the brand drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060. If the cost of the brand name drug, after receiving discounted process and rebates, is equal to or less that the cost of the generic version of the drug, then the Division may prefer the brand product over the generic after notifying pharmacies of the policy change. Mental health drugs are carved out of CCO budgets and are reimbursed directly by FFS. Because mental health drug utilization is very strongly skewed toward generics, the overall FFS generic percentage is also skewed more toward generics than the percentages reported by CCOs.
Pennsylvania	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

State	Generic Drug Substitution Policies Summary
	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 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.

State	Generic Drug Substitution Policies Summary
	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 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

State	Generic Drug Substitution Policies Summary
	brand name products (traditionally categorized as Narrow Therapeutic Index [NTI] drugs): digoxin, warfarin, theophylline (controlled release), levothyroxine, pancrelipase, phenytoin and carbamazepine. In addition, continuity of care (beneficiary moves from MCO to FFS) where established on a Brand/clinical rationale.
South Dakota	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 handwritting 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 drug available will require prior authorization. The exception to this policy is drugs on South Dakota's list of Narrow Therapeutic Index drugs. The South Dakota Medicaid program encourages generic utilization by limiting reimbursement to the upper limit payment unless the physician certifies that the brand name products is medically necessary.
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 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	Texas Government Code Sec 531.303, Generic Equivalent Authorized, requires that, unless the practitioner's signature on the prescription clearly indicates that the prescription must be dispensed as written, the dispensing pharmacies may select a generic equivalent of the prescribed drug. However, if a brand name drug is preferred on Texas formulary, the pharmacy does not have to ask for prescriber to certify medically necessary. In this case, Texas Medicaid reimburses pharmacy for the brand name product without requiring a PDL prior authorization.

State	Generic Drug Substitution Policies Summary
	The single formulary and PDL policy is in effect in Texas Medicaid. Medicaid outpatient drug formulary includes covered generic drugs. The factors that may potentially affect generic utilization include the PDL decisions within a therapeutic class. HHSC requires the MCOs to cover the same preferred brands as was approved by HHSC.
Utah	As a result of the Pharmacy Practice Act, Medicaid has placed all name brand products on prior approval if a generic is available, except when allowed rebates bring the cost of the brand name products lower than generic.
Vermont	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 brand-name or generic drug or biological product from the Department of Vermont Health Access's preferred drug list. (b) The purchaser shall be informed by the pharmacist or his or her representative that an alternative selection as provided under subsection (a) of this section will be made unless the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher-priced drug or biological product. (c) When refilling a prescription, pharmacists shall receive the consent of the prescriber to dispense a drug or biological product different from that originally dispensed, and shall inform the purchaser that a substitution shall be made pursuant to this section unless the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, or otherwise to pay the full cost for the higher-priced drug or biological product.

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.)

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 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 2021. • 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.

State	Generic Drug Substitution Policies Summary
	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 24% of total drug expenditures for FFY 2021.
Washington	Washington Apple Health (Medicaid) utilizes various strategies to increase and maintain generic utilization rates. The following strategies employed could affect Washington State Medicaid's generic utilization percentage: Coverage of less costly generic over-the-counter (OTC) products Washington Apple Health (Medicaid) covers many OTC products in various drug classes as less costly alternatives to prescription medications. Standard generic substitution Washington Apple Health (Medicaid) follows generic substitution rules as authorized under State law. 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 and safety, cost comparisons of drugs with similar existing drugs, potential for misuse and abuse, drugs with a narrow therapeutic index, and cost and outcome data demonstrating the cost effectiveness of the drug. Clinical policies are created by Washington State Medicaid staff, which may include step-through less costly generic drugs with the same indication first before another drug product may be authorized . Use of single PDL and PDL selection process Drugs listed on the Apple Health Preferred Drug List (AHPDL) reflect all pharmacy point-of-sale drugs covered under Washington State Medicaid. The AHPDL is used by both Fee-for-Service and Managed Care Organizations (MCOs) and governs those organizations to use brand and generic drugs that are preferred or non-preferred. The PDL selection process 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

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

State	Generic Drug Substitution Policies Summary
	- 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.
Wyoming	On 11/1/05, the Wyoming Medicaid program mandated generic substitution by implementing a generic mandatory policy. This policy requires a prior authorization for any brand name medication for which there are two or more A-rated generic equivalents available. Clients may receive the brand name following trial and failure of a generic equivalent in the specific class of drugs, or with a documented adverse effect caused by the generic formulation. Copays are lower for generic medications at $0.65 per prescription vs. $3.65 per prescription for brand-name medications. In addition, the Wyoming Medicaid Pharmacy Program encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. Federal and State MAC lists for pricing also help to enforce generic substitution

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

Figure 42 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

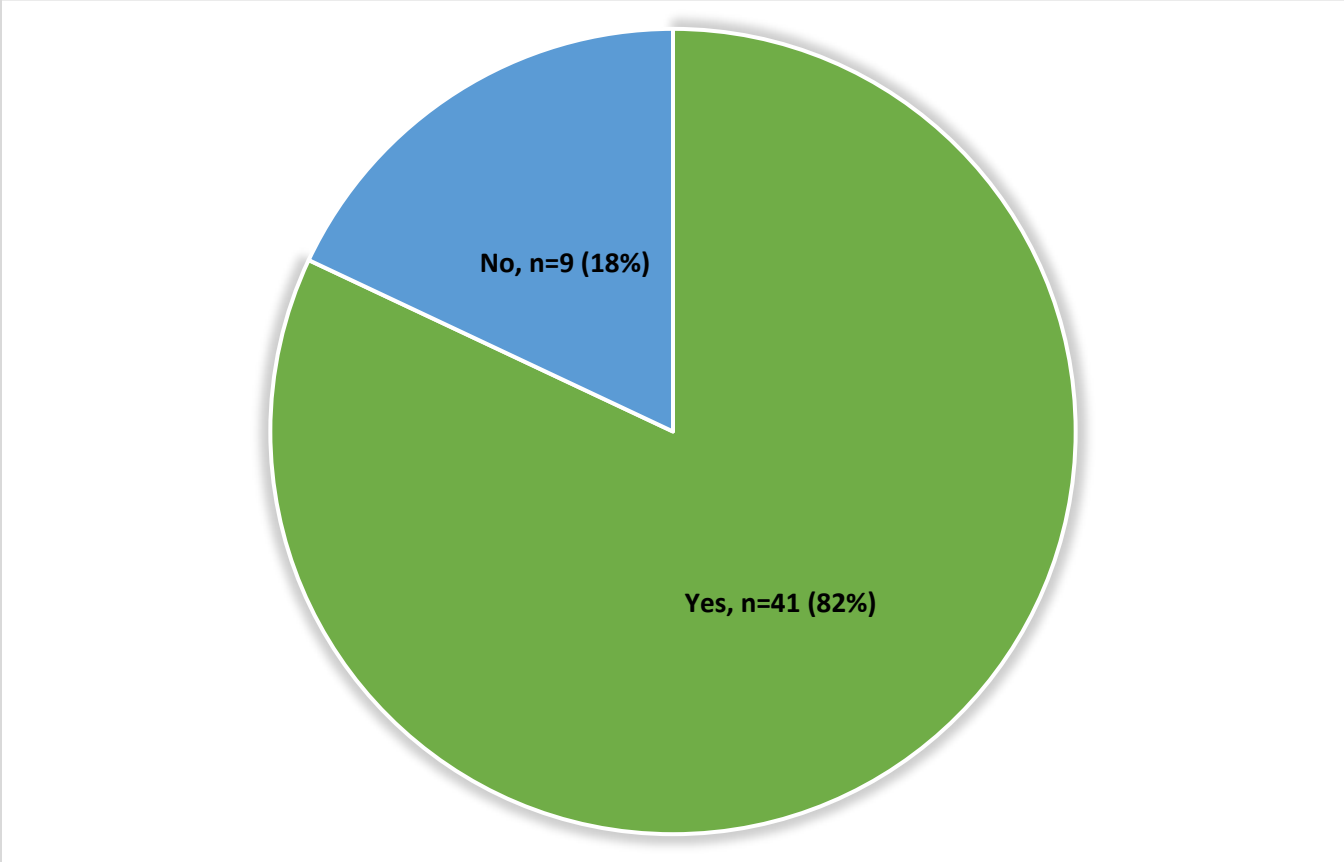

Table 64 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, 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	41	82.00%
No	Alabama, Florida, Hawaii, Kentucky, Louisiana, Mississippi, New Mexico, Rhode Island, Virginia	9	18.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 43 - Additional Restrictive State Requirements for Dispensing a Brand Name Drug

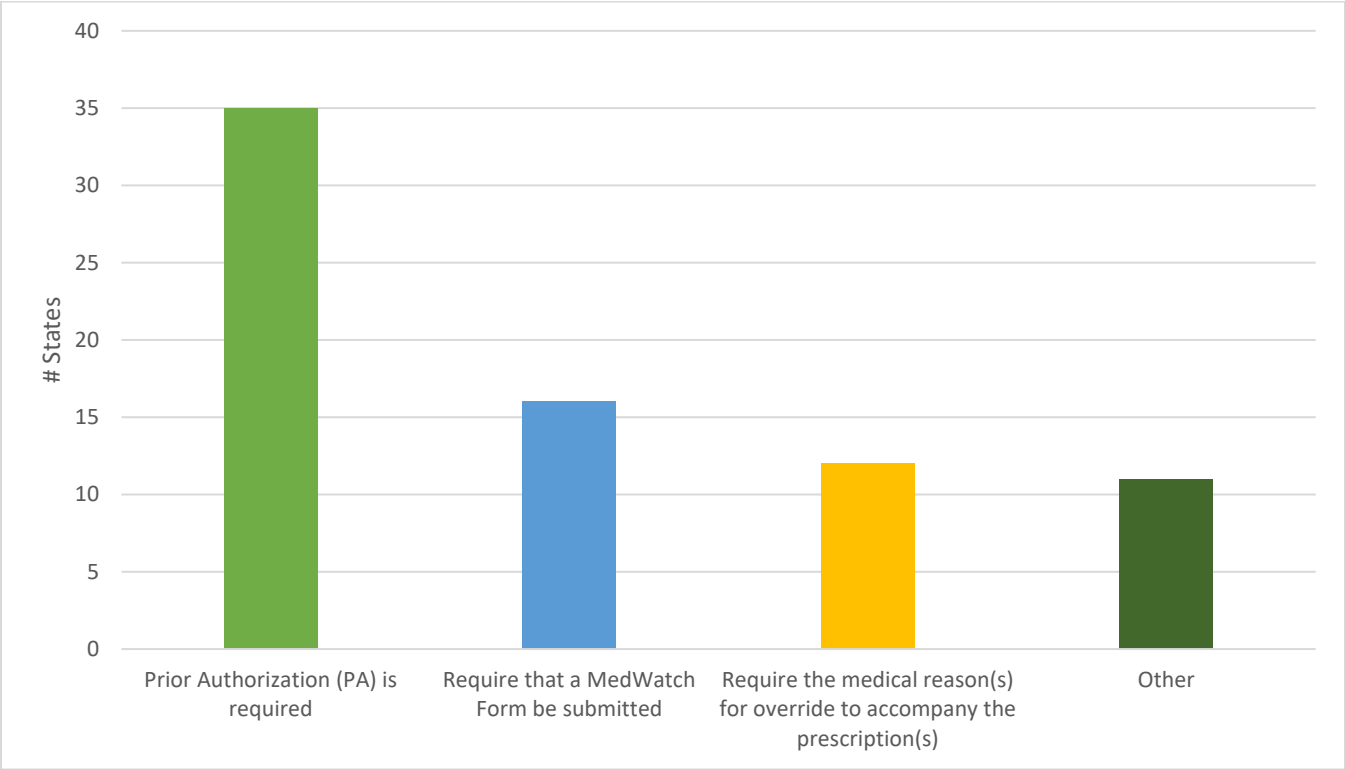

Table 65 - Additional Restrictive State Requirements for Dispensing a Brand Name Drug

Response	States	Count	Percentage
Prior Authorization (PA) is required	Alaska, Arkansas, 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	35	47.30%
Require that a MedWatch Form be submitted	Arkansas, Connecticut, Delaware, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Missouri, Nevada, North Dakota, South Carolina, Tennessee, West Virginia, Wyoming	16	21.62%
Require the medical reason(s) for override to accompany the prescription(s)	Delaware, Idaho, Missouri, Montana, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, West Virginia	12	16.22%
Other	California, Colorado, Connecticut, Idaho, Michigan, Nebraska, Nevada, North Carolina, Texas, Vermont, Wisconsin	11	14.86%
Total		74	100.00%

If “Other,” please explain.

Table 66 - “Other” Explanations for Additional Restrictive State Requirements for Dispensing a Brand Name Drug

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

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

Computation Instructions

KEY

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

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

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

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

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

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 44 - Single Source (S) Drugs Total Number of Claims by State

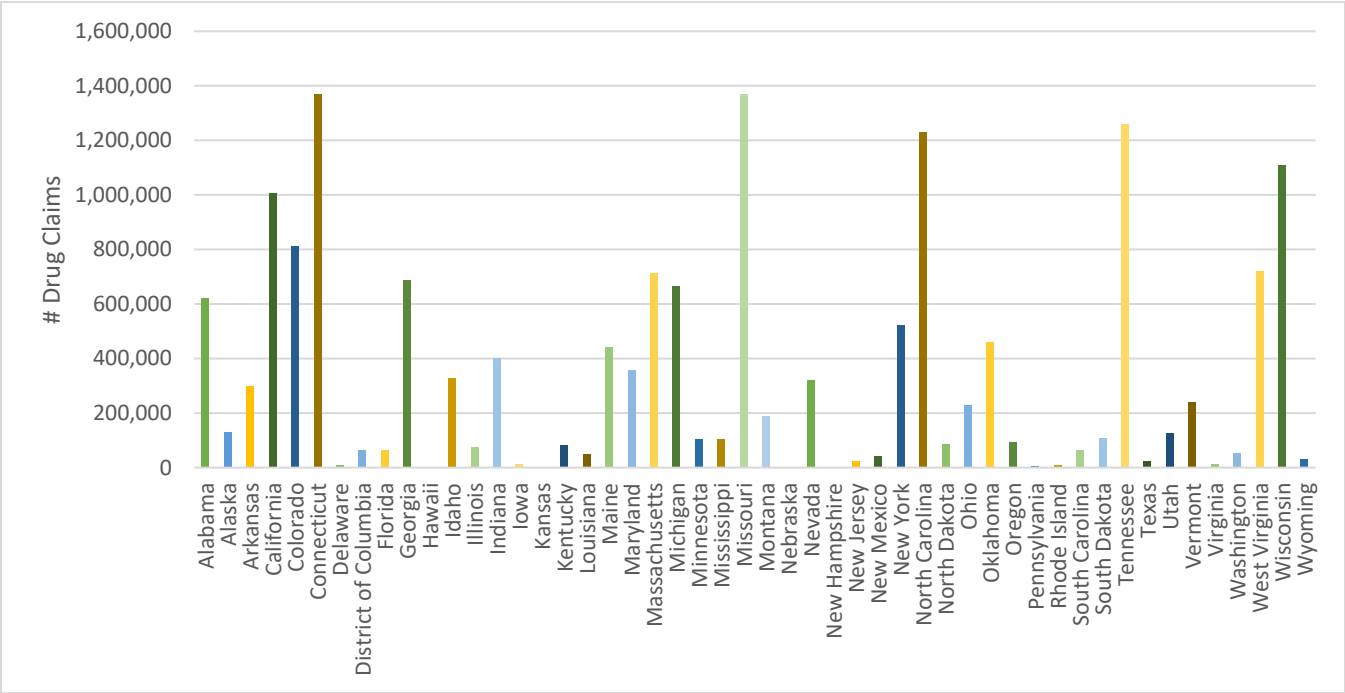

Figure 45 - Non-Innovator Source (N) Drugs Total Number of Claims by State

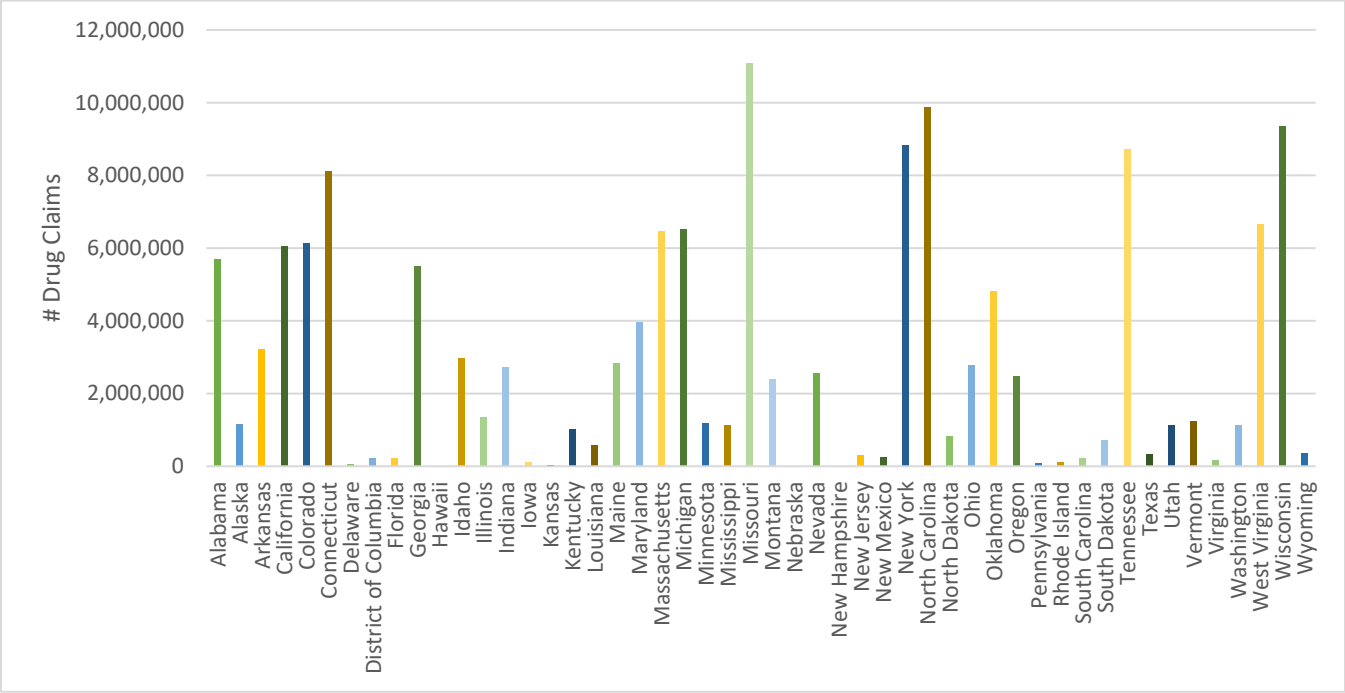

Figure 46 - Innovator Multi-Source (I) Drugs Total Number of Claims by State

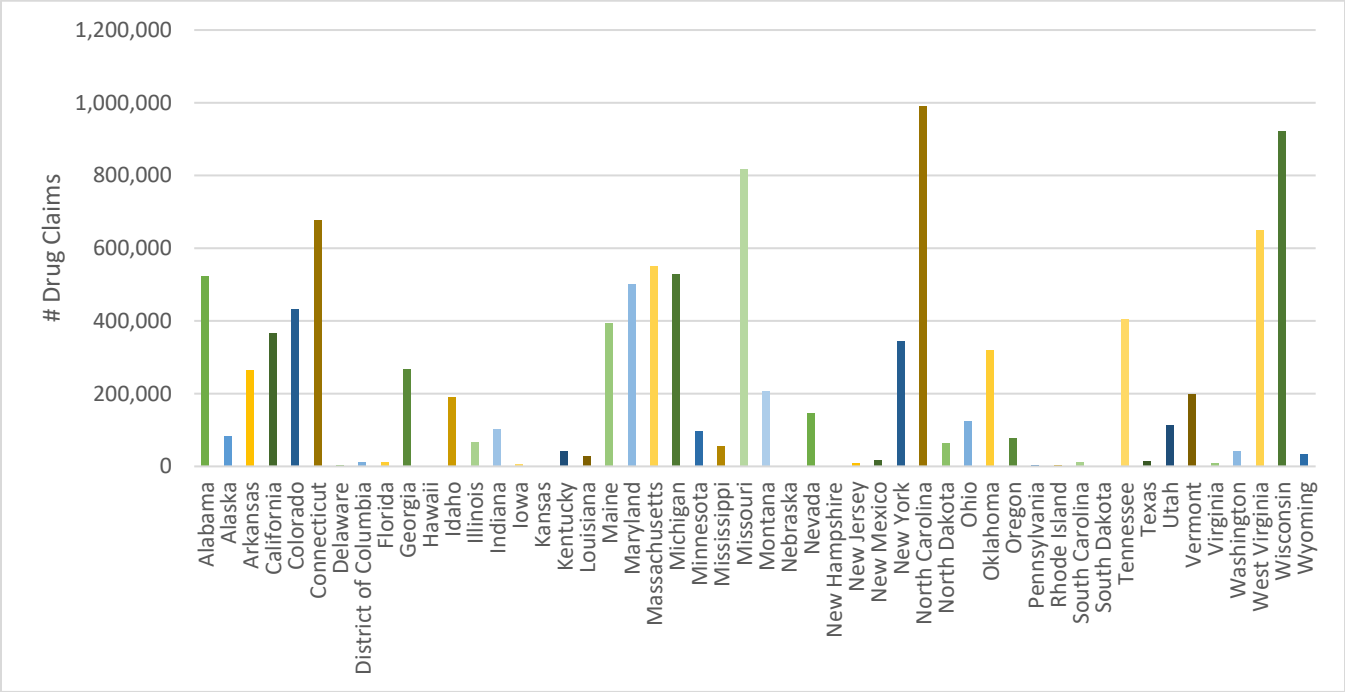

Table 67 - Drug Utilization Number of Claims by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	622,076	5,698,874	524,302
Alaska	129,636	1,154,577	83,367
Arkansas	297,870	3,213,296	264,585
California	1,005,206	6,040,489	366,635
Colorado	813,394	6,130,181	432,708
Connecticut	1,370,105	8,118,204	677,960
Delaware	9,295	49,517	2,733
District of Columbia	65,711	217,731	12,666
Florida	65,711	217,731	12,666
Georgia	686,237	5,500,357	268,146
Hawaii	188	5,646	41
Idaho	328,008	2,965,908	189,631
Illinois	76,785	1,357,591	66,945
Indiana	401,240	2,720,965	103,116
Iowa	11,409	109,144	7,307
Kansas	1,627	24,443	682
Kentucky	83,473	1,017,319	40,741
Louisiana	49,355	568,352	26,962
Maine	441,954	2,846,009	394,846
Maryland	355,955	3,959,785	500,912

State	"S" Drugs	"N" Drugs	"I" Drugs
Massachusetts	713,398	6,463,720	550,507
Michigan	666,043	6,506,517	528,127
Minnesota	104,232	1,195,802	96,765
Mississippi	106,094	1,119,388	54,635
Missouri	1,371,089	11,072,923	816,429
Montana	188,152	2,387,364	206,408
Nebraska	146	3,049	95
Nevada	320,862	2,555,642	145,923
New Hampshire	1,282	9,210	503
New Jersey	25,123	305,003	10,018
New Mexico	43,135	255,698	17,952
New York	523,896	8,841,499	343,907
North Carolina	1,229,414	9,884,966	991,477
North Dakota	86,283	838,268	63,109
Ohio	228,178	2,775,006	123,914
Oklahoma	460,649	4,819,175	318,611
Oregon	91,867	2,467,161	77,558
Pennsylvania	4,403	79,552	2,559
Rhode Island	7,828	119,565	3,490
South Carolina	65,711	217,731	12,666
South Dakota	108,344	713,422	604
Tennessee	1,261,189	8,721,680	404,957
Texas	23,929	331,529	15,188
Utah	125,912	1,125,946	114,878
Vermont	239,340	1,236,537	198,830
Virginia	11,975	152,183	9,390
Washington	53,060	1,125,890	41,321
West Virginia	722,331	6,653,553	650,280
Wisconsin	1,110,195	9,354,334	921,839
Wyoming	30,301	360,751	34,918
Total	16,739,596	143,609,183	10,733,809

Figure 47 - Single Source (S) Drugs Total Reimbursement Amount Less Co-Pay by State

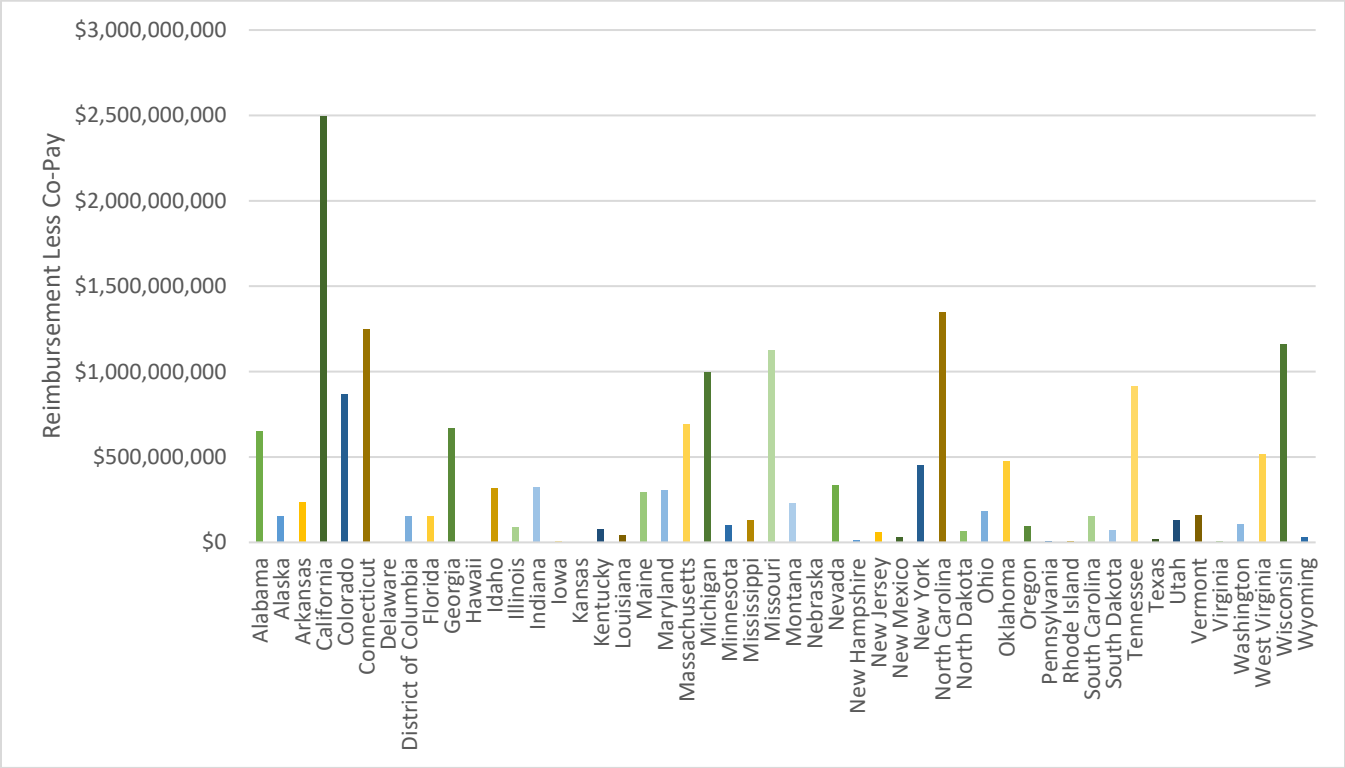

Figure 48 - Non-Innovator Source (N) Drugs Total Reimbursement Amount Less Co-Pay by State

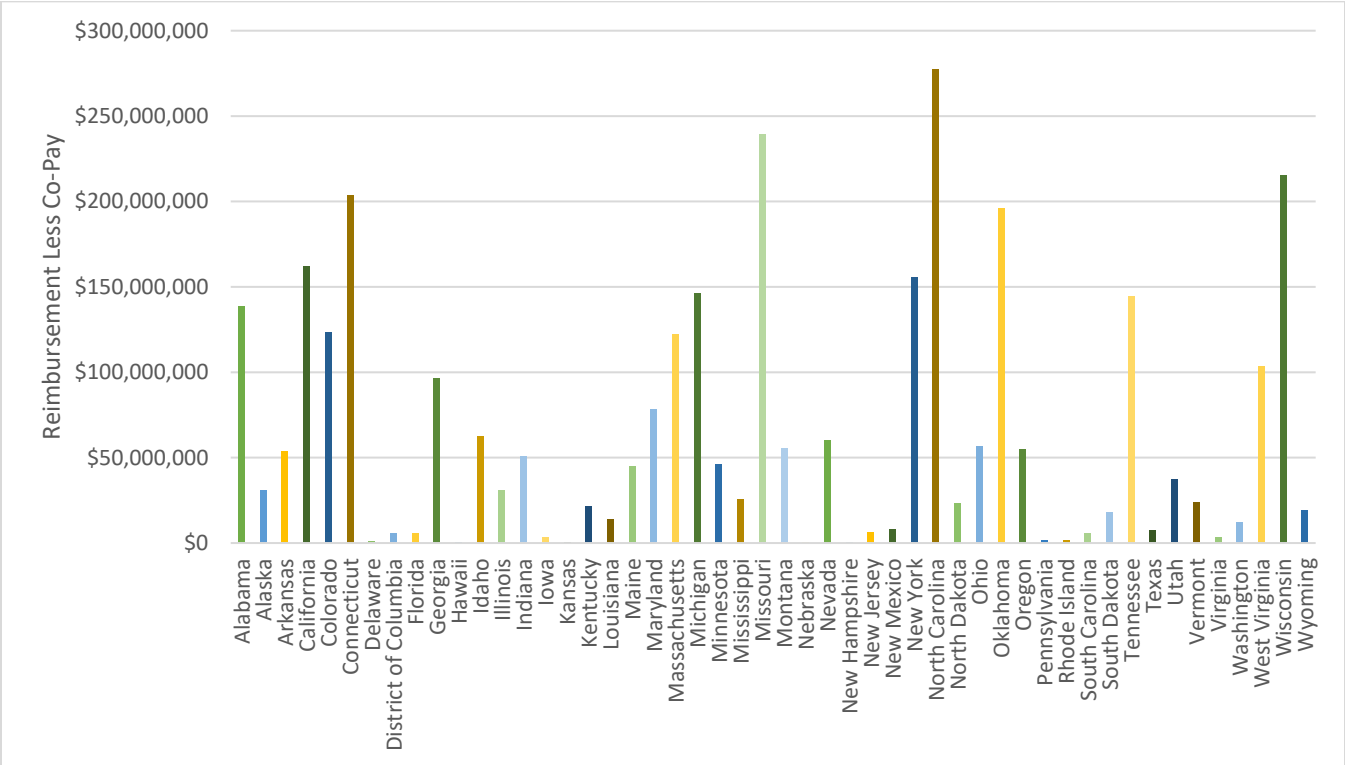

Figure 49 - Innovator Multi-Source (I) Drugs Total Reimbursement Amount Less Co-Pay by State

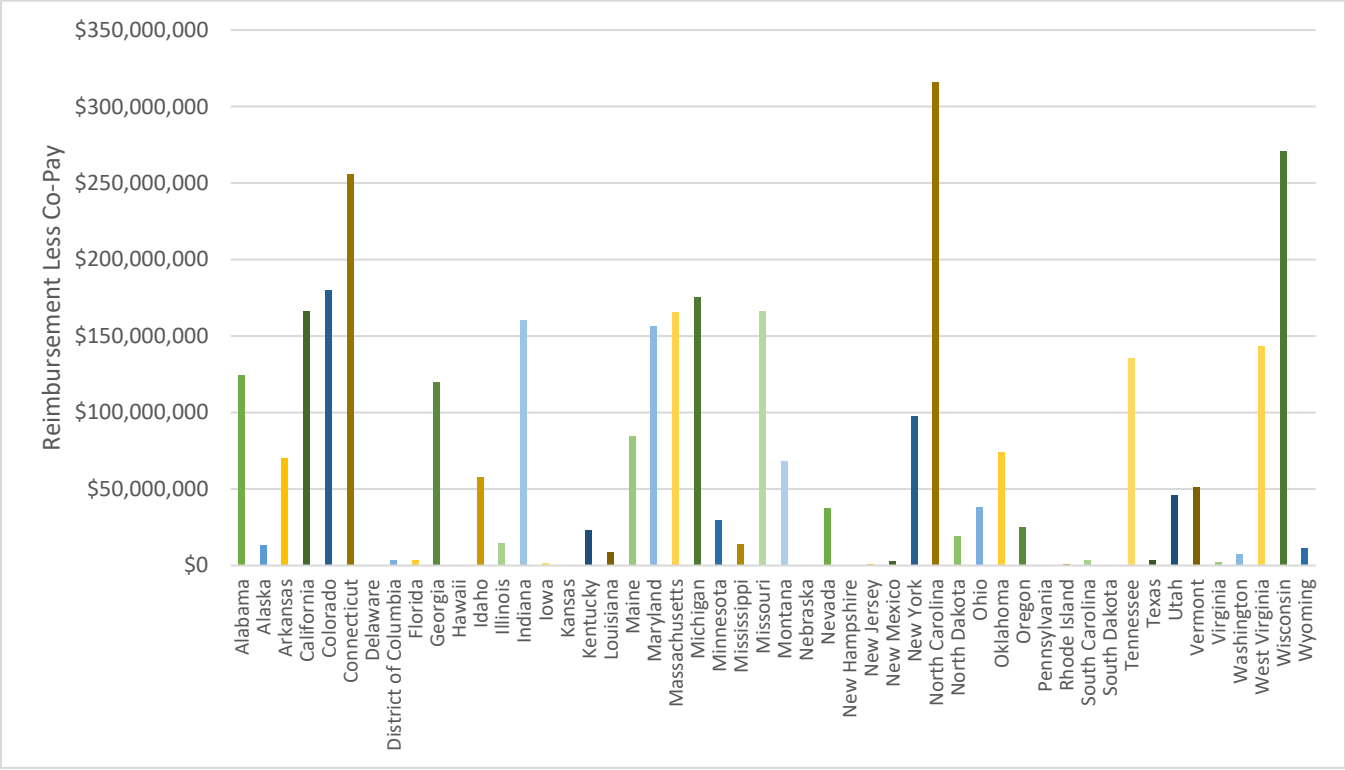

Table 68 - Drug Utilization Total Reimbursement Amount by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	$649,979,665	$138,550,470	$124,639,721
Alaska	$151,417,726	$30,864,043	$13,520,932
Arkansas	$234,704,101	$53,607,070	$69,972,998
California	$2,496,227,995	$161,891,085	$166,304,379
Colorado	$870,822,170	$123,087,129	$180,161,124
Connecticut	$1,251,404,065	$203,642,924	$256,212,700
Delaware	$2,526,543	$826,107	$201,217
District of Columbia	$153,527,413	$5,363,809	$3,667,381
Florida	$153,527,414	$5,363,809	$3,667,382
Georgia	$671,430,525	$96,266,970	$120,014,315
Hawaii	$775,283	$234,323	$1,161
Idaho	$320,640,577	$62,403,719	$58,026,548
Illinois	$87,112,809	$31,042,498	$14,521,541
Indiana	$326,104,916	$50,623,841	$160,278,272
Iowa	$6,840,887	$3,539,446	$1,754,547
Kansas	$2,378,000	$548,000	$78,000
Kentucky	$80,083,935	$21,329,567	$22,895,854
Louisiana	$43,739,785	$13,718,991	$8,557,921

State	"S" Drugs	"N" Drugs	"I" Drugs
Maine	$291,740,390	$44,692,644	$84,640,532
Maryland	$303,448,717	$78,273,794	$156,285,379
Massachusetts	$693,816,828	$122,089,676	$165,969,316
Michigan	$996,079,806	$146,409,554	$175,346,063
Minnesota	$101,617,731	$46,250,167	$29,547,600
Mississippi	$131,600,204	$25,629,490	$14,039,536
Missouri	$1,125,928,470	$239,382,710	$166,024,313
Montana	$231,674,415	$55,573,752	$68,240,265
Nebraska	$44,532	$51,075	$8,178
Nevada	$337,559,969	$60,309,795	$37,444,990
New Hampshire	$10,978,875	$191,783	$68,484
New Jersey	$61,322,242	$5,906,802	$986,607
New Mexico	$32,028,791	$7,911,421	$2,977,891
New York	$453,441,024	$155,584,883	$97,604,816
North Carolina	$1,349,194,376	$277,521,014	$316,231,997
North Dakota	$66,365,121	$23,170,217	$19,498,479
Ohio	$184,331,869	$56,520,992	$38,486,188
Oklahoma	$475,790,074	$196,126,572	$74,190,406
Oregon	$96,909,189	$55,080,730	$25,109,202
Pennsylvania	$5,666,197	$1,427,973	$261,169
Rhode Island	$5,611,985	$1,629,290	$754,937
South Carolina	$153,527,414	$5,363,809	$3,667,382
South Dakota	$74,113,120	$17,927,303	$507,939
Tennessee	$916,848,019	$144,399,083	$135,670,926
Texas	$19,080,300	$7,274,933	$3,605,234
Utah	$128,553,754	$37,363,362	$46,250,496
Vermont	$157,745,931	$23,518,404	$51,426,043
Virginia	$8,732,269	$3,302,546	$1,980,482
Washington	$105,004,659	$12,145,315	$7,753,471
West Virginia	$518,779,168	$103,379,244	$143,742,897
Wisconsin	$1,163,287,463	$215,189,780	$270,747,569
Wyoming	$28,392,461	$19,252,504	$11,160,346
Total	$17,732,459,172	$3,191,754,418	$3,354,705,126

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

Figure 50 - Generic & Total Claims by State

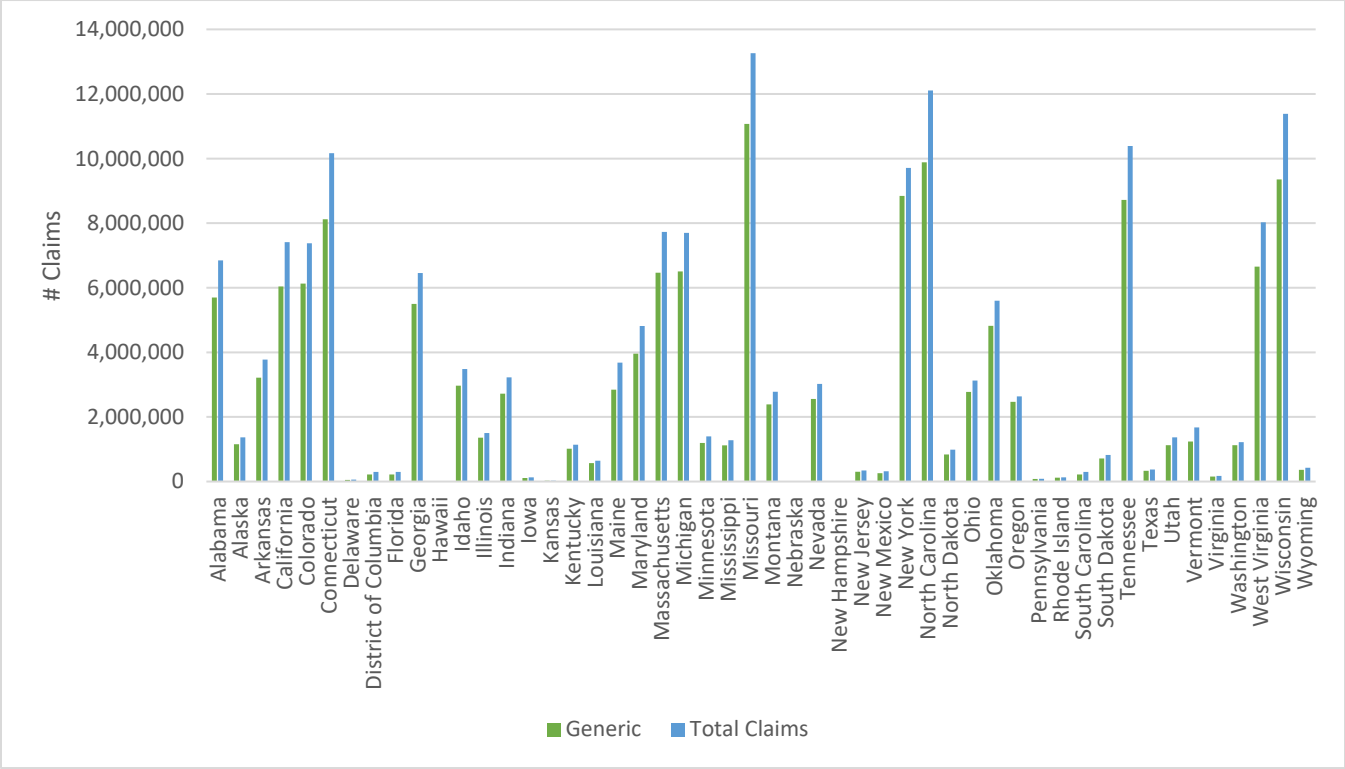

Table 69 - Generic & Total Claims by State

State	Generic Claim Count	Total Claim Count	Percentage
Alabama	5,698,874	6,845,252	83.25%
Alaska	1,154,577	1,367,580	84.42%
Arkansas	3,213,296	3,775,751	85.10%
California	6,040,489	7,412,330	81.49%
Colorado	6,130,181	7,376,283	83.11%
Connecticut	8,118,204	10,166,269	79.85%
Delaware	49,517	61,545	80.46%
District of Columbia	217,731	296,108	73.53%
Florida	217,731	296,108	73.53%
Georgia	5,500,357	6,454,740	85.21%
Hawaii	5,646	5,875	96.10%
Idaho	2,965,908	3,483,547	85.14%
Illinois	1,357,591	1,501,321	90.43%
Indiana	2,720,965	3,225,321	84.36%
Iowa	109,144	127,860	85.36%

State	Generic Claim Count	Total Claim Count	Percentage
Kansas	24,443	26,752	91.37%
Kentucky	1,017,319	1,141,533	89.12%
Louisiana	568,352	644,669	88.16%
Maine	2,846,009	3,682,809	77.28%
Maryland	3,959,785	4,816,652	82.21%
Massachusetts	6,463,720	7,727,625	83.64%
Michigan	6,506,517	7,700,687	84.49%
Minnesota	1,195,802	1,396,799	85.61%
Mississippi	1,119,388	1,280,117	87.44%
Missouri	11,072,923	13,260,441	83.50%
Montana	2,387,364	2,781,924	85.82%
Nebraska	3,049	3,290	92.67%
Nevada	2,555,642	3,022,427	84.56%
New Hampshire	9,210	10,995	83.77%
New Jersey	305,003	340,144	89.67%
New Mexico	255,698	316,785	80.72%
New York	8,841,499	9,709,302	91.06%
North Carolina	9,884,966	12,105,857	81.65%
North Dakota	838,268	987,660	84.87%
Ohio	2,775,006	3,127,098	88.74%
Oklahoma	4,819,175	5,598,435	86.08%
Oregon	2,467,161	2,636,586	93.57%
Pennsylvania	79,552	86,514	91.95%
Rhode Island	119,565	130,883	91.35%
South Carolina	217,731	296,108	73.53%
South Dakota	713,422	822,370	86.75%
Tennessee	8,721,680	10,387,826	83.96%
Texas	331,529	370,646	89.45%
Utah	1,125,946	1,366,736	82.38%
Vermont	1,236,537	1,674,707	73.84%
Virginia	152,183	173,548	87.69%
Washington	1,125,890	1,220,271	92.27%
West Virginia	6,653,553	8,026,164	82.90%
Wisconsin	9,354,334	11,386,368	82.15%
Wyoming	360,751	425,970	84.69%

4. How many innovator drugs are the preferred product on your state PDL when multi-source drugs are available based on net pricing and rebates (i.e. brand preferred over generic)?

Figure 51 - Multi-Source Drugs That Have the Innovator as the Preferred Drug Product Based on Net Pricing

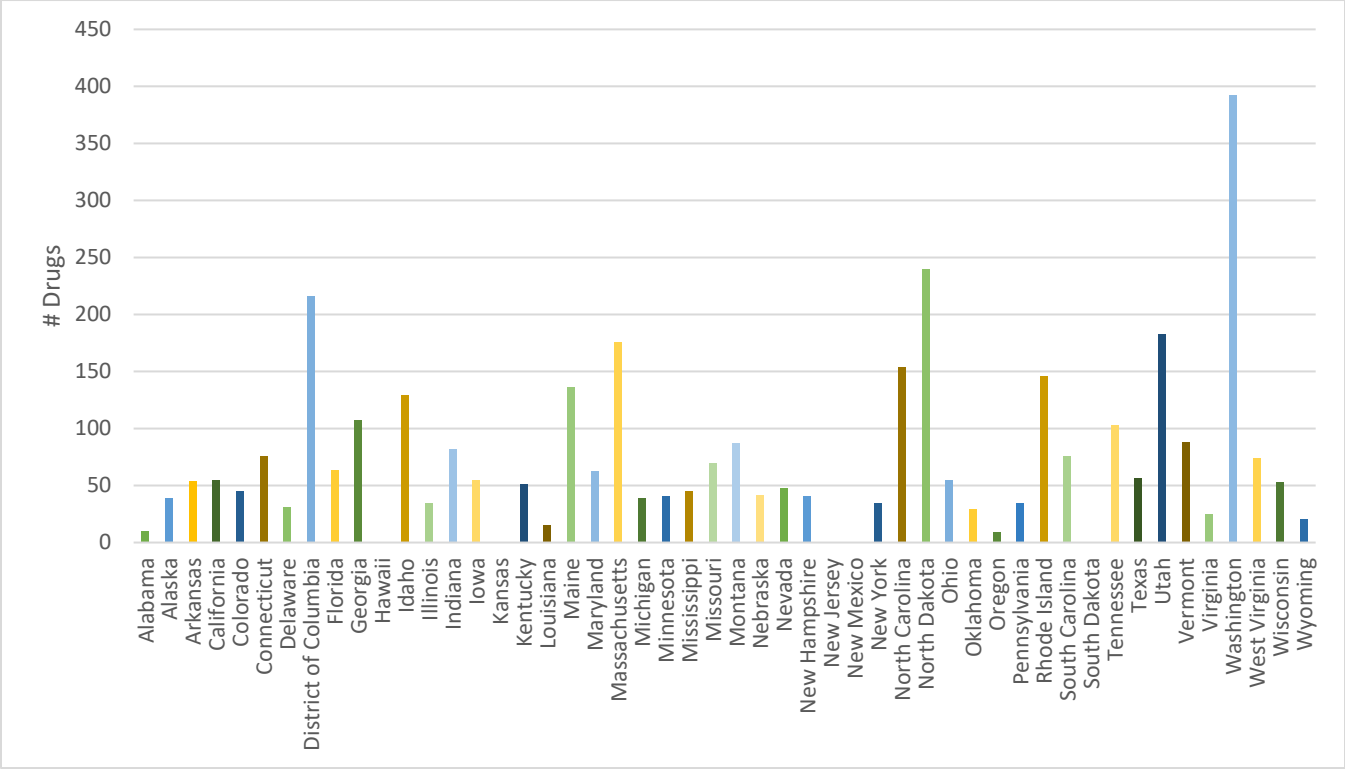

Table 70 - Multi-Source Drugs That Have the Innovator as the Preferred Drug Product Based on Net Pricing

State	Preferred Drug Count
Alabama	10
Alaska	39
Arkansas	54
California	55
Colorado	45
Connecticut	76
Delaware	31
District of Columbia	216
Florida	64
Georgia	107
Hawaii	0
Idaho	129
Illinois	35
Indiana	82

State	Preferred Drug Count
Iowa	55
Kansas	0
Kentucky	51
Louisiana	15
Maine	136
Maryland	63
Massachusetts	176
Michigan	39
Minnesota	41
Mississippi	45
Missouri	70
Montana	87
Nebraska	42
Nevada	48
New Hampshire	41
New Jersey	0
New Mexico	0
New York	35
North Carolina	154
North Dakota	240
Ohio	55
Oklahoma	29
Oregon	9
Pennsylvania	35
Rhode Island	146
South Carolina	76
South Dakota	0
Tennessee	103
Texas	57
Utah	183
Vermont	88
Virginia	25
Washington	392
West Virginia	74
Wisconsin	53
Wyoming	21

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

Figure 52 - Generic/Total Amount Paid by State

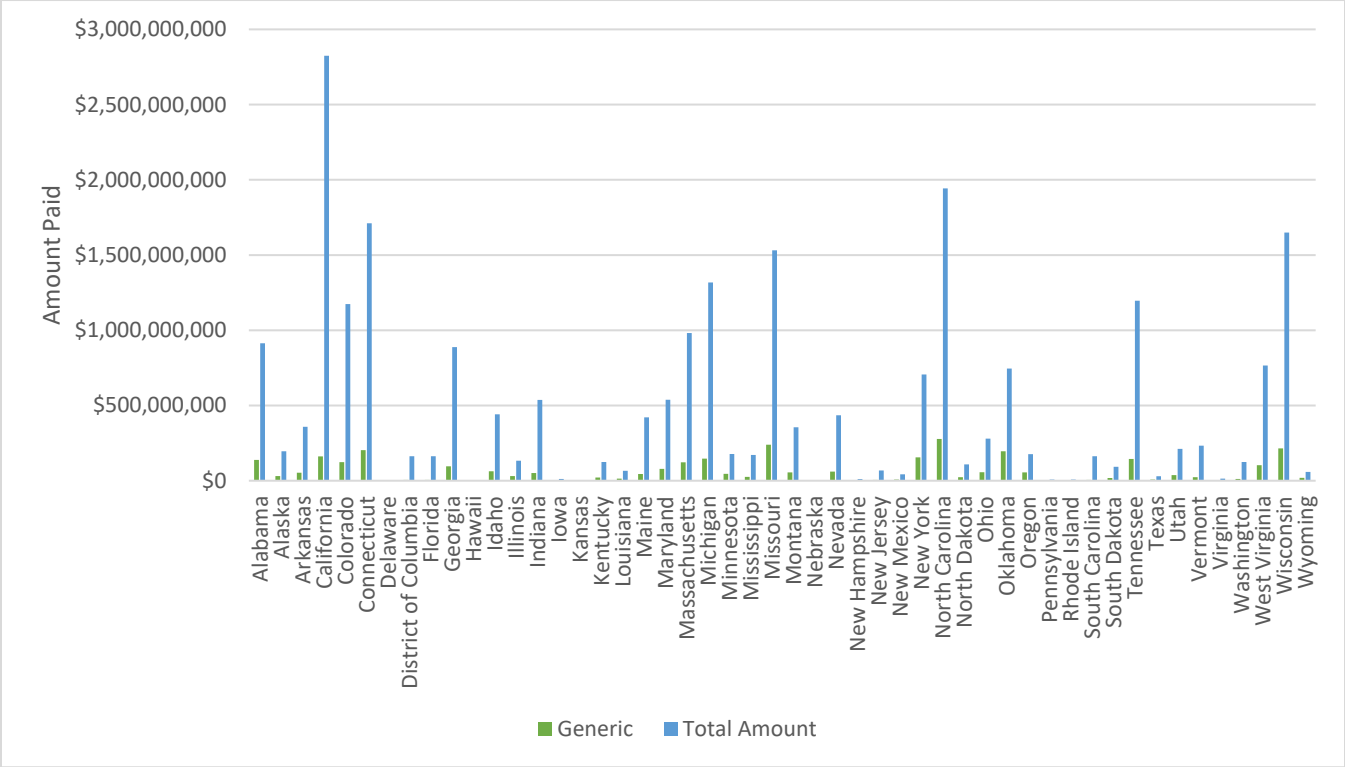

Table 71 - Generic/Total Amount Paid by State

State	Generic Claim Amount	Total Claim Amount	Percentage
Alabama	$138,550,470	$913,169,855	15.17%
Alaska	$30,864,043	$195,802,702	15.76%
Arkansas	$53,607,070	$358,284,169	14.96%
California	$161,891,085	$2,824,423,459	5.73%
Colorado	$123,087,129	$1,174,070,423	10.48%
Connecticut	$203,642,924	$1,711,259,689	11.90%
Delaware	$826,107	$3,553,867	23.25%
District of Columbia	$5,363,809	$162,558,603	3.30%
Florida	$5,363,809	$162,558,605	3.30%
Georgia	$96,266,970	$887,711,810	10.84%
Hawaii	$234,323	$1,010,767	23.18%
Idaho	$62,403,719	$441,070,844	14.15%
Illinois	$31,042,498	$132,676,848	23.40%
Indiana	$50,623,841	$537,007,028	9.43%
Iowa	$3,539,446	$12,134,880	29.17%

State	Generic Claim Amount	Total Claim Amount	Percentage
Kansas	$548,000	$3,004,000	18.24%
Kentucky	$21,329,567	$124,309,356	17.16%
Louisiana	$13,718,991	$66,016,697	20.78%
Maine	$44,692,644	$421,073,566	10.61%
Maryland	$78,273,794	$538,007,890	14.55%
Massachusetts	$122,089,676	$981,875,820	12.43%
Michigan	$146,409,554	$1,317,835,423	11.11%
Minnesota	$46,250,167	$177,415,498	26.07%
Mississippi	$25,629,490	$171,269,229	14.96%
Missouri	$239,382,710	$1,531,335,493	15.63%
Montana	$55,573,752	$355,488,432	15.63%
Nebraska	$51,075	$103,785	49.21%
Nevada	$60,309,795	$435,314,754	13.85%
New Hampshire	$191,783	$11,239,142	1.71%
New Jersey	$5,906,802	$68,215,651	8.66%
New Mexico	$7,911,421	$42,918,103	18.43%
New York	$155,584,883	$706,630,723	22.02%
North Carolina	$277,521,014	$1,942,947,387	14.28%
North Dakota	$23,170,217	$109,033,817	21.25%
Ohio	$56,520,992	$279,339,049	20.23%
Oklahoma	$196,126,572	$746,107,052	26.29%
Oregon	$55,080,730	$177,099,121	31.10%
Pennsylvania	$1,427,973	$7,355,339	19.41%
Rhode Island	$1,629,290	$7,996,212	20.38%
South Carolina	$5,363,809	$162,558,605	3.30%
South Dakota	$17,927,303	$92,548,362	19.37%
Tennessee	$144,399,083	$1,196,918,028	12.06%
Texas	$7,274,933	$29,960,466	24.28%
Utah	$37,363,362	$212,167,612	17.61%
Vermont	$23,518,404	$232,690,378	10.11%
Virginia	$3,302,546	$14,015,297	23.56%
Washington	$12,145,315	$124,903,444	9.72%
West Virginia	$103,379,244	$765,901,309	13.50%
Wisconsin	$215,189,780	$1,649,224,812	13.05%
Wyoming	$19,252,504	$58,805,311	32.74%

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

Table 72 - 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 substitution of FDA approved, interchangeable biosimilar biologic product for prescribed biological reference products with certain safeguards. To substitute a biosimilar product, pharmacists must notify the patient and prescriber in writing, record information on the label and dispensing record, and maintain a 3-year record of such substitutions. This bill also provided liability protections for pharmacists who substitute biosimilars. In the Medicaid program, biosimilars are covered with same clinical criteria as the reference product and are addressed within the same policies as the reference product. The MCOs have language within all policies to ensure compliance to the FFS Preferred Drug List (PDL) and the placement and preference of biosimilars according to the PDL.
District of Columbia	Not at this time.
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	no
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	The Kansas Medicaid PDL Committee and DUR Board members allow addition of biosimilars to the same PDL class whereby the biosimilar has the same indication as the Reference Product in that PDL class.
Kentucky	Per KRS 217.822. 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

State	Explanation
	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 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.
Louisiana	Currently we do not have any policies specifically relating to biosimilars. Biosimilars are included in Louisiana's PDL.
Maine	Biosimilars are incorporated into the overall Preferred Drug List and evaluated to the brand product currently on the PDL as we would for a generic; clinically and cost effectively.
Maryland	For the reporting period, there were no policies related to the use of biosimilars for the State of Maryland.
Massachusetts	Biosimilars are evaluated class by class, including net cost, to determine if the biosimilar or innovator product is preferred and/or requires prior authorization
Michigan	None at this time.
Minnesota	With respect to the MN Uniform Preferred Drug List, either the referenced biologic product or the biosimilar may be selected as preferred. In order to obtain the nonpreferred product, the member must have an allergic or adverse reaction to inactive ingredients of the preferred product or have therapeutic success while taking a nonpreferred product and therapeutic failure with the preferred product; or the patient has a diagnosis not included in the FDA-approved indications of the preferred product but is included in the FDA-approved indications of the non-preferred product.
Mississippi	Not at this time.
Missouri	Yes, Missouri utilizes a Biosimilar vs Reference Products Fiscal Edit to ensure appropriate utilization and control of biosimilar agents and their reference products 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	No current policies in place.

State	Explanation
New Hampshire	No. In drug classes that do not undergo review for status on the Preferred Drug List, there is no policy regarding Biosimilar coverage. Biosimilars are reviewed alongside reference products in consideration of PDL placement when there are biosimilars present in PDL classes.
New Jersey	No policies related to Biosimilars are in place.
New Mexico	Not at this time. Under review to determine diagnosis related treatments in FFY22 or FFY23.
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	North Dakota Medicaid requires prior authorization on non-preferred biosimilar agents. The criteria requires that the patient must have an FDA-approved indication for use (must meet label recommendations for age and diagnosis, and the requesting provider must submit clinical justification explaining why the patient is unable to use the preferred agents (justification is subject to review by clinical pharmacist).
Ohio	No
Oklahoma	Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.
Oregon	When a product becomes available that is a biosimilar for one or more drugs that have been reviewed for the PDL, where applicable, the product will be designated a nonpreferred drug until the P&T Committee reviews the product.
Pennsylvania	No
Rhode Island	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 subject to the same PDL and clinical policies and criteria as the original single source products.
Utah	UT Medicaid uses the FDA "Purple Book" as a reference and unless otherwise limited through the prior authorization process, the State does not mandate interchange of biosimilars unless they are listed interchangeable.
Vermont	Biosimilars are controlled as part of the preferred drug list and looked at by comparison to the branded drug 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 any specific policies related to Biosimilars. If there are Biosimilars that are included on the PDL, decisions on preferred or non-preferred status are made on an individual basis.
Wyoming	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 53 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

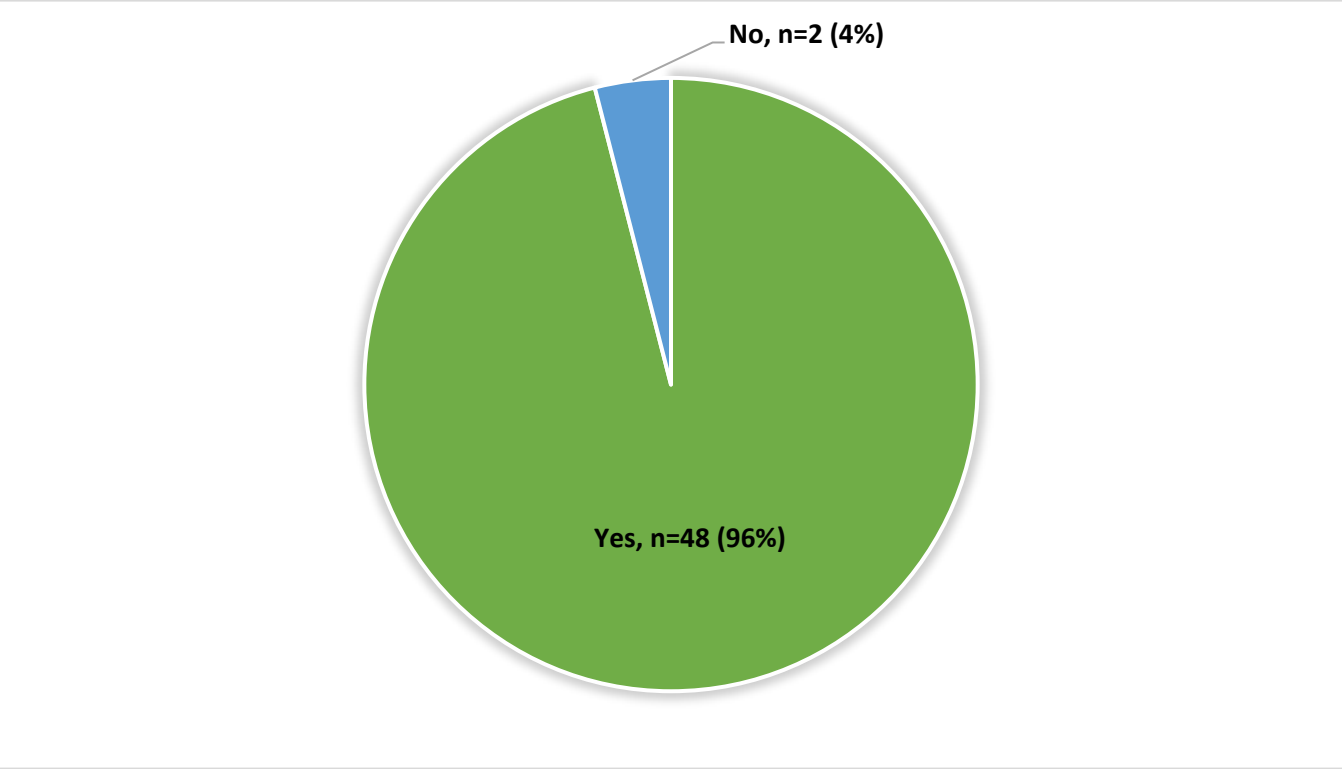

Table 73 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	Nebraska, South Carolina	2	4.00%
Total		50	100.00%

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

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

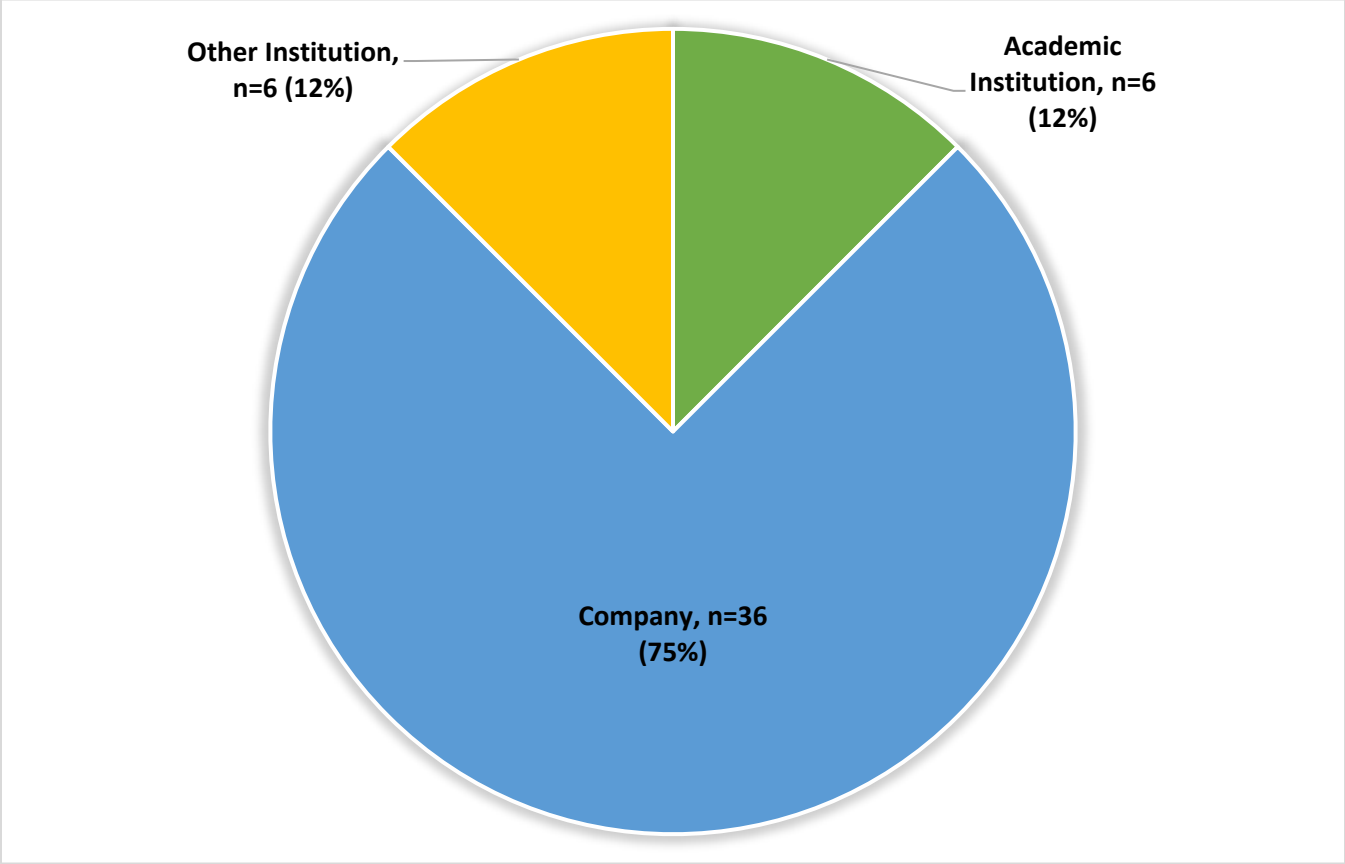

Table 74 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Academic Institution	California, Massachusetts, Oklahoma, Oregon, Utah, Wyoming	6	12.50%
Company	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Wisconsin	36	75.00%
Other Institution	Hawaii, Illinois, Minnesota, Montana, Washington, West Virginia	6	12.50%
Total		48	100.00%

Table 75 - Vendors by State that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
KEPRO	Alabama, Kansas, North Dakota, Wisconsin	4	11.11%
Magellan	Alaska, Arkansas, Florida, Idaho, Kentucky, Michigan, New Hampshire, Virginia	8	22.22%
Magellan Health, Inc.	Colorado	1	2.78%
Gainwell for ProDUR, Kepro for RetroDUR	Connecticut	1	2.78%
Gainwell Technologies	Delaware, Louisiana, New Jersey	3	8.33%
Magellan for proDUR and Conduent for retroDUR	District of Columbia	1	2.78%
OptumRx	Georgia, Indiana, Nevada, Tennessee	4	11.11%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	13.89%
Conduent State Healthcare, LLC and Kepro	Maryland	1	2.78%
Conduent, Change Healthcare	Mississippi	1	2.78%
Conduent	Missouri, New Mexico	2	5.56%
ProDUR: State. RetroDUR: Kepro. Other Cost Avoidance: Magellan Medicaid Administration	New York	1	2.78%
Myers and Stauffer	North Carolina	1	2.78%
FDB - Pro-DUR and KEPRO - Retro DUR	Rhode Island	1	2.78%
KEPRO (RDUR), OptumRx (Pro DUR)	South Dakota	1	2.78%
Conduent for RDUR interventions cost savings; KePro for PDL and clinical PA cost savings	Texas	1	2.78%
Total		36	100.00%

Table 76 - Academic/Other Institutions that Conducted the Cost Savings/Avoidance Program Evaluation

State	Academic/Other Institution Name
California	University of California, San Francisco (UCSF)
Hawaii	State Medicaid pharmacist
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.
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
Utah	University of Utah Drug Regiment Review Center / Utah Medicaid Pharmacy
Washington	Health Care Authority
West Virginia	Gainwell Technologies and Marshall DUR Coalition
Wyoming	University of Wyoming School of Pharmacy

2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance 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. 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 77 - 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 2021 (FFY 2021). 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, 2020 and September 30, 2021, there was an estimated cost savings of $604,296. Table 1 Estimated Cost Savings for FFY 2021 All Interventions Intervention Group Change between 6 Month Pre- and Post- Change between 6 Month Pre- and Post- Comparison Group Estimated Cost Savings All Interventions $570,320 (-$33,976) $604,296 During FFY 2021, Kepro reviewed 1,592 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. Table 2 Drug Therapy Problem Distribution 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

State	Cost Savings/Cost Avoidance Methodology Summary
	within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 4,419 recipients met the criteria for intervention letters during FFY 2021. 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 2021). 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 2021. Table 3 - Estimated Cost Savings for FFY 2021 Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings Single Intervention $577,655 (-$35,230) $612,885 Multiple Intervention (-$7,335) $1,254 (-$8,589) Total Estimated Cost Savings $604,296 Kepro found the intervention group had a decrease of 32.81% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 1.89%. These changes resulted in an estimated cost savings of $379.11 per recipient who received an intervention during FFY 2021. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2021, 1,592 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 $604,296 for FFY 2021.
Alaska	Prospective Drug Utilization Review (ProDUR) A cost savings estimate was prepared for the State of Alaska by Magellan Medicaid Administration. The cost savings estimate was calculated by identifying claims with ProDUR messages that were either reversed and resubmitted or reversed but not resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the allowable payment amounts of the resubmitted claim. During FFY 2021 Covid-19 edits were in place, such as continuity of prior authorizations if the patient had the medication within a 90 day lookback, which would have reduced the amount of typically expected ProDUR savings. Day supply dispensed was also increased to 68 days, potentially decreasing the number of edits being hit. Summary (ProDUR Paid Claims Savings Report, Severity Level 1) Total # of Reversed Claims 24,375 Allowable Amount ($) of Reversed Claims $9,078,040.98 Total # of Resubmitted Claims 12,933 Allowable Amount ($) of Resubmitted Claims $3,376,155.64 Net Cost Savings $5,701,885.04 Summary (ProDUR Denied Claims Savings Report, Severity Level 1) Total # of Claims 39,117 Allowable Amount ($) of Claims $19,113,335.50 Total # of Resubmitted Claims 19,519 Allowable Amount ($) of Resubmitted Claims $3,796,326.34 Net Cost Savings $15,317,009.16 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 2021 was $21,018,894.20.

State	Cost Savings/Cost Avoidance Methodology Summary
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 client 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 client 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 FFY2021, the estimated cost avoidance was $207,883.60. 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 clients. The codes 1A, 1B, and 1G are override codes and would not produce any program savings since no changes in the dispensed prescription took place. The pharmacist determines to his best professional judgment, with or without the communicated judgment of the prescriber, that the benefits of dispensing the medication outweigh the potential risks associated with the alert. Codes 1C, 1D, 1E, and 1F are adjustments made to the prescription in response by the pharmacist to the ProDUR alert which could produce program savings or increase in program costs depending on the response. Magellan's system has the ability to identify what alert was sent and when the response codes 1C, 1D, 1E, and 1F were used. The codes 2A and 2B are outcome codes for a cancellation response to a ProDUR alert and no claim was processed. A non-response to an alert indicates that the pharmacist did not respond to the soft alert. If a pharmacist does not respond to a ProDUR alert within seven days, the claim is denied, and no program funds are expended.

State	Cost Savings/Cost Avoidance Methodology Summary
	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 client 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) $18,089,238.80 Denied claim savings (Denied claims not resubmitted) $242,803,492.47 TOTAL ESTIMATED ProDUR SAVINGS $260,892,731.27 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 client does not meet the established prior approval criteria, the prescriber may submit a request in writing to provide additional documentation to substantiate the medical necessity of the client receiving the drug in question, or the prescriber may change the drug to an alternative drug that does not require prior approval. Drug claim edits (DUR reject error) are limitations placed on drugs or drug classes using gender, age, daily dose, monthly quantity allowed, quantity allowed per claim, or accumulation quantity edits that allow up to a certain quantity over a period of time. In addition to clinical edits and claim edits, AR Medicaid Pharmacy Program has a preferred drug list (PDL), and the drugs may be listed as preferred status, preferred status with criteria, non-preferred status, or non-preferred status with criteria. The non-preferred drugs on the preferred drug list will deny at POS and require 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 client to receive the non-preferred drug over the preferred drug(s), or the prescriber can change the prescription to a preferred drug as an alternative 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.

State	Cost Savings/Cost Avoidance Methodology Summary
	TOTAL FFY2021 COST AVOIDANCE DUE TO PA REQUIRED, PLAN LIMITS EXCEEDED, AND DUR REJECT ERROR: $71,430,345 TOTAL ESTIMATED COST AVOIDANCE FOR FFY2021: $332,530,959.87
California	Prospective DUR alerts and educational bulletins provide health care providers and pharmacists with specific, focused, and comprehensive drug information. If DUR alerts and educational bulletins are reviewed as intended, then notification of a potential drug therapy problem through a DUR alert or the knowledge gained from educational bulletins will lead to appropriate action, including: 1. Discontinuing unnecessary prescriptions 2. Reducing quantities of medications prescribed 3. Switching to safer drug therapies 4. Adding a drug therapy recommended in evidence-based guidelines 5. Appropriate monitoring of patients taking prescription drugs The Medi-Cal DUR program has saved money by encouraging appropriate drug therapy in order to reduce total healthcare expenditures. Estimated prescription drug savings as a direct result of the prospective DUR system for FFY 2021 were calculated by taking each individual prospective DUR alert and multiplying the total claims cancelled or not overridden by the average reimbursement dollars paid to pharmacies per claim and a multiplier (allows for an adjustment of estimated costs using a conservative estimate that 90% of early refill claims are resubmitted and paid and that 20% of the remaining alerts are duplicate alerts for the same claim) in order to get the total estimated costs avoided through prospective DUR. Of note, multiple alerts can be generated per claim, so there may be duplicate alerts cancelled or overridden and the average reimbursement dollars paid to pharmacies per claim was calculated for each alert by looking at the total number of paid claims (including overrides) and total reimbursement dollars paid to pharmacies per claim (does not include adjustment for any rebates) for all drugs that generated that particular alert in FFY 2021.
Colorado	Paid Claims Cost Avoidance is calculated by taking the paid dollar amount of claims with a ProDUR message that paid, but were subsequently reversed and subtracting the paid amount the claims resubmitted within 72 hours. (Claim Amount - Reversal Amount + Resubmit Amount) Denied Claims Cost Avoidance is calculated by taking the submitted dollar value of the claims that were initially denied and had a ProDUR message and subtracting any of those claims that were then resubmitted within the same calendar month and then paid. (Claim Amount - Resubmit Amount) ProDUR Total Estimated Avoided Costs = Denied Claims Cost Avoidance + Paid Claims Cost Avoidance
Connecticut	This report prepared for the Connecticut Medical Assistance shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during

State	Cost Savings/Cost Avoidance Methodology Summary
	federal fiscal year 2021 (FFY 2021). 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, 2020 and September 30, 2021, there was an estimated cost savings of $2,558,118. Table 1 Estimated Cost Savings for FFY 2021 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, $580,780, ($1,977,338), $2,558,118 During FFY 2021, KEPRO reviewed 18,844 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 32,913 recipients met the criteria for intervention letters during FFY 2021. 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 2021). 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2021. Table 3 - Estimated Cost Savings for FFY 2021 , Intervention Group Change between 6 Month Pre- and Post-, Comparison Group Change between 6 Month Pre- and Post-, Estimated Cost Savings Single Intervention, $1,198,796, ($1,751,536), $2,950,332 Multiple Intervention, ($618,016), ($225,802), (392,214) Total Estimated Cost Savings, $2,558,118 KEPRO found the intervention group had a decrease of 0.73% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 10.18%. These changes resulted in an estimated cost savings of $162.25 per recipient who received an intervention during FFY 2021. 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 2021, 18,844 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 $2,558,118 for FFY 2021.

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2021, as calculated by the claims processor and fiscal agent Gainwell Technologies , was estimated to be a total of $105,000,531 on 3,247,777 prescriptions for patients.
Delaware	Delaware has continued to take a conservative approach in estimating our cost savings due to pro%u2010DUR. While early refill denials could be considered, Delaware has always deemed these savings to be more of cost deferral rather than cost avoidance. The refill percentage in Delaware is normally set at 83% for non-controlled drugs and for prior authorization claims we even tighten this percentage more by the date range and quantity for which the drug is approved. The two edits that Delaware uses to calculate cost savings/cost avoidance are therapeutic duplication and dose optimization. The list of medications that hit for these two edits are extensive and have produced cost savings by decreasing any unnecessary 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 unnecessary expenditures.

State	Cost Savings/Cost Avoidance Methodology Summary
	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 federal fiscal year 2021, the estimated therapeutic duplication alerts for FFS deferred the dispensing of 3792 units with an estimated savings of $686,872 Delaware has a long%u2010standing history of maximizing dose optimization since its implementation in February 2005. Setting optimal dose edits ensures that the member receives a dose that maximizes compliance and therapeutic appropriateness, and as a result, decreases expenditures for the state by dispensing the minimum units and beneficial healthcare outcomes which drive future cost savings. One current trend that continues to be identified in Delaware by the dose optimization audit, are those healthcare providers who prescribe an FDA approved drug for once daily dosing to be dosed multiple times per day. Research has continued to indicate that there is no additional benefit from more than once daily dosing. For federal fiscal year 2021, 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 federal fiscal year 2021, Delaware's dose optimization edits set on over 34671 units of medication. By optimizing dosing for these medications, Delaware estimated savings of $49063 for the year. Delaware continues to review each drug as it enters the market and add it to the dose optimization list when appropriate.
District of Columbia	Step 1- Denied claims are extracted from the study quarter's data and linked to the external NCPDP error codes Step 2- Paid claims that do not fall into a refill designation are extracted and matched to the respective denied claims becoming replacement claims Paid claims that have been filled with the same GSN within 90 days from the member's fill date are excluded Step 3- Denied and replacement claims are matched by patient ID and the GPI6 Code to ensure that the replacement claim is for the same therapy The replacement claim should have a service date on or after the denial claim date The window between the service date for the denial claim and the paid claim should be 14 days (denied date lesser than or equal to paid date The denied and replacement claims will lastly be matched by the HIC3, GSN, BRAND NAME, GENERIC NAME , NDC, and STANDARD THERAPEUTIC CLASS CODE
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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2021, the MAC program provided savings of $2,856,510. 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 2021 was $7,014,009. Retrospective DUR For all edits or criteria approved by the DUR Board, a pre-implementation analysis is conducted demonstrating the number of claims, number of recipients, and total amount paid that would be impacted by such an edit or criteria. At a reasonable amount of time after implementation of the edit or criteria, a post-implementation analysis is performed demonstrating the number of claims, number of recipients and total amount paid for a similar period of time. The standard post implementation analysis is conducted three months after deployment of the edit but may vary depending on the nature of the edit and the time needed to measure an impact. For example, if an edit allows for a six-month window before claims denial, the impact of the edit 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 FFY2021 was $1,149,390.52. 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 2021 was $219,489,966. The following table summarizes the FFY 2021 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. ProDUR Cost Avoidance Calculation = Paid claims reversed and not resubmitted + Denied claims not resubmitted

State	Cost Savings/Cost Avoidance Methodology Summary
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	An expensive drug retrospective DUR identified a third party billing error for Ravicti. Recovery of the claim cost saved the program $90,000.
Idaho	ProDUR cost savings estimate was calculated by identifying claims with ProDUR messages that were reversed and those that were reversed but resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the amounts of the resubmitted claim. RetroDUR savings were calculated by looking at expenditures prior to intervention for included drugs minus expenditures after intervention.
Illinois	Four Prescription Policy The Department requires adults to obtain a prior authorization to fill a prescription beyond four in a 30-day period. Medications that do not count toward or require prior authorization due to the Four Prescription Policy included antineoplastic agents, antiretroviral agents, antipsychotics, immunosuppressive agents, and anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder in Department records. As pharmacies and prescribers learn what requires prior authorization, requests for prior authorization for the Four Prescription Policy are submitted prospectively to resolve issues before claims are processed. 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 FFY21 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 277,852 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 FFY21 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 inhalers and levalbuterol inhalers and generic levalbuterol nebulizer solutions were changed to preferred.

State	Cost Savings/Cost Avoidance Methodology Summary
	- 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 FFY21: - 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 FFY21, HFS rejected approximately 132,590 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, and initial opioid days supply. Some participants had more than one claim impacted by a DUR edit. In FFY21, Illinois reimbursed pharmacies $80.18 per prescription on average. Based on the average cost of a claim, Illinois rejected approximately $10.63 M in pharmacy claims as a result of DUR editing in FY21. 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. Generic Product Utilization During FFY21, Illinois Fee-for-Service Medicaid's generic dispensing ratio increased by 2.07%. During FFY21, the average brand name/innovator prescription was reimbursed at $707.12, while the average generic prescription was reimbursed at $22.87. Illinois Medicaid reimbursed providers for approximately 1.5 M prescriptions. Each percentage point shift from brand/innovator to generic utilization would result in about 10.27 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 FFY21. The three brand limit does not impact the following drug categories: - Drugs for which there are no alternative generic therapies for the condition being treated. - Drugs for which the generic alternatives are deemed clinically inappropriate for the majority of participants. - Brand name drugs that are less expensive to the Department than their generic alternatives. - Drugs in the following classes: antiretroviral agents, antineoplastic agents, immunosuppressive agents. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	7/15/2019 the EAC for generic drugs changed from WAC to WAC minus 17.5%. The FUL price is determined by the Centers for Medicare and Medicaid Services (CMS). During FFY21, the SMAC pricing program saved Illinois Medicaid $7,031,712 (state and federal dollars). Illinois Pharmaceutical State Maximum Allowable Cost Savings FFY21 Q1 FFY2021 October 2020 Actual SMAC Savings (Difference between [Lesser of EAC, FUL, and NADAC] and SMAC) x Total Units with SMAC (7,946,492) = $518,278 November 2020 Actual SMAC Savings x Total Units with SMAC (7,717,807) = $486,847 December 2020 Actual SMAC Savings x Total Units with SMAC (7,798,620) = $526,953 Q1 FFY2021 Actual SMAC savings = $1,532,078 Q2 FFY2021 January 2021 Actual SMAC Savings x Total Units with SMAC (8,069,778) =$575,828 February 2021 Actual SMAC Savings x Total Units with SMAC (7,758,279) = $646,952 March 2021 Actual SMAC Savings x Total Units with SMAC (8,756,152) = $659,767 Q2 FFY2021 Actual SMAC savings = $1,882,547 Q3 FFY2021 April 2021 Actual SMAC Savings x Total Units with SMAC (8,431,025) = $615,373 May 2021 Actual SMAC Savings x Total Units with SMAC (8,273,621) = $602,373 June 2021 Actual SMAC Savings x Total Units with SMAC (8,562,863)= $614,298 Q3 FFY2021 Actual SMAC savings = $1,832,044 Q4 FFY2021 July 2021 Actual SMAC Savings x Total Units with SMAC (8,204,817)= $578,824 August 2021 Actual SMAC Savings x Total Units with SMAC (8,576,230) = $663,704 September 2021 Actual SMAC Savings x Total Units with SMAC (8.335.433) = $542,515 Q4 FFY2021 Actual SMAC savings = $1,785,043 Total FFY2021 Actual SMAC savings = $7,031,712 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 FFY21, the PDL generated approximately $4.76 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 are achieved by using the PDL to encourage the use of lower cost generic alternative drugs. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 OptumRx'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 were measured by the claims 180 days before and after interventions. To analyze recipients' drug use, OptumRx followed the 1994 CMS "Guidelines for Estimating the Impact of Medicaid DUR." OptumRx compared the cost of all prescription drugs for each recipient before and after physicians received faxed alert letters. By following CMS' guidelines, our analysis measured "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 OptumRx also included the cost of other drugs in the same therapeutic class. OptumRx calculated each period's costs using the exact quantities of each drug dispensed and the cost of the claims (defined as reimbursement formula specified in the plan). Cases were analyzed using 180 days of claims data before and after the faxed letter/intervention. The number of prescriptions and cost of drug therapy were then compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was evaluated compared to a control group. Any savings that occurred can then be attributed to the DUR intervention and not some other effect. The Indiana Medicaid DUR program has been shown to be beneficial to the state, provider community, and beneficiary population served. OMPP will continue to monitor and improve the retroDUR and proDUR programs.
Iowa	Patient Focused Review Summary Profiles Reviewed - 17 Number of Suggestions Made - 26 Number of Changes Made - 8 Total Dollars Saved on Medication - $5,457.72 Problem Focused Review Summary - FFS Duplicate SNRIs: members evaluated - 1; positive impact - 1 (100%); Cost Savings - $317.04 Concurrent Use of Baclofen and Opioid: members evaluated - 5; positive impact - 0 (0%) Baclofen Dose > 80mg per Day: members evaluated - 2; positive impact - 0 (0%) High Dose Gabapentin: members evaluated - 0 (MCOs identified members) 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

State	Cost Savings/Cost Avoidance Methodology Summary
	pharmacy medical program at the Iowa Medicaid Enterprise to contribute to the overall success of the program. The Drug Utilization program: *Evaluates three areas of activity including Patient-focused Drug Utilization Reviews, Problem-focused Drug Utilization Reviews, and Administrative Activities. *Examines only direct drug costs. DUR evaluation does not have the ability to quantify its impact on other health services such as hospitalizations, ER visits, and physician visits. *Reports pre-rebate savings since access to supplemental rebates is not within the scope of the DUR program. *Often provides recommendations that are qualitative, such as improved health outcomes, rather than quantitative in nature. As a general principle, evaluations are based upon an observed change in the targeted prescribing or dispensing pattern, as well as changes seen in therapy of the individual patients. One evaluation approach is to observe and quantify changes in prescribing due to a given intervention compared to a control group of providers who do not receive the intervention. The intervention's impact on prescribing may be more readily detectable by this method and could be measured by comparing the two groups of patients or prescribers. However, it is very difficult to design a scientifically sound control group given the many variables surrounding 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

State	Cost Savings/Cost Avoidance Methodology Summary
	subtracting the total amount paid from the initial profile with the total amount paid from the re-review profile. This calculation is then annualized multiplying the number by 2 to get the pre-rebate annualized savings. All savings for patient-focused review are based on annualized savings for one year only. Reporting on patient-focused interventions will provide the following information: Total number of templates mentioned Number of templates that were therapeutic in nature Number of templates that were cost-saving in nature Total number of changes implemented Number of changes that were therapeutic in nature Number of changes with positive impact without savings Number of changes that were cost-saving in nature Total dollars saved from therapeutic changes Total dollars saved from cost-saving changes Total dollars saved Impact of interventions expressed as a percentage All templates are described by one of sixteen classifications. These classifications indicate the general type of intervention addressed by the template. Reports will also include a breakdown by classification (therapeutic or cost-saving) of the templates used in the patient-focused letters. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	process ensures that each intervention is unique due to the subject matter and may differ in steps of evaluation. Reporting for problem-focused interventions will include the types of intervention done and the resulting savings. Savings are always calculated based on one year of therapy only and are calculated in the same manner as explained in the patient-focused DUR section. Administrative Review The Drug Utilization Review (DUR) program is a component of the Pharmacy Medical Division of the Iowa Medicaid Enterprise (IME). DUR contributes expertise and information that leads to implementation in other programmatic areas including, but not limited to: Prospective Drug Utilization Review, Prior Authorization, Preferred Drug List, Disease Management, and Supplemental Rebates. Although the DUR program impacts all of the different pharmacy programs it is difficult to determine where its impact begins and ends. Therefore, the savings associated with DUR contribution in other pharmacy areas cannot be determined.
Kansas	Due to the variability of drugs within each PA assignment code, like drugs are grouped together. Then an average PA timespan, average price per unit (PPU), and average utilization (units per day) were determined and multiplied. Then, the above PA price per grouped drugs was averaged for an assignment code price per PA.
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 FFY2021 was $85,799,975.87. 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 2021, the MAC program provided an estimated cost avoidance of $ $1,567,995.60. PDL: Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings is generated by shifting the

State	Cost Savings/Cost Avoidance Methodology Summary
	market from more expensive, nonpreferred products, to less expensive, preferred products. The estimated savings provided by the PDL program during FFY 2021 was $ $3,932,642.86. Preferring Brand Products over Generics: When a new generic comes to market, often times it is granted a six (6) month exclusivity period to allow the generic manufacturer time to recoup some of the monetary investment required to get that generic to market. During this time, there are no competitors; therefore, the price is not driven down by competition in the market. In order to maintain their current position in the market space, manufacturers of the branded product will continue to pay supplemental rebates as long as their branded drug is preferred over the new generic product. This results in the branded product being less costly to the Commonwealth; net of federal and supplemental rebates. As more generic products enter the market and the price is driven down by competition, the branded product, net of federal and supplemental rebates, eventually will become more costly than the generic product; and at this time, the generic will be preferred over the brand. By preferring more cost-effective branded products over generics the Commonwealth has experienced an estimated cost avoidance of $ $25,214,837.00 during FFY 2021. 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 $ $6,655,657.81 during FFY 2021. 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 2021, the KY FFS program invoiced for $ $1,157,799.92 in supplemental rebates for preferred diabetic supplies. Retro DUR: Magellan Medicaid Administration uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. Indirect effects arise when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2021 is estimated to be $ $15,492.59. 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 2021 will not be known until after the end of FFY 2022. Overall Cost Avoidance and/or Savings: During FFY 2021 the combined cost avoidance or savings generated by all of the above initiatives was estimated to be $124,344,401.65.
Louisiana	Prospective DUR methodology: Cost avoidance attributed to prospective DUR in FFY21 is $46,371,429. 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 FFY21 is $424,644. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	prescription ingredient costs, utilization of high-priced new drugs or changes in drug mix to more expensive products in the follow-up review period. Data indicates that significant drug utilization pattern changes and reductions universally occur in prescribing and utilization patterns within six months following drug utilization review intervention. The cost avoidance methodology used in this report measured two periods. Period one: each recipient's drug cost per day was calculated in a three-month period prior to the LADUR review. Period two: each recipient's drug cost per day was calculated in a three-month period following the LADUR review. This interval allows time for physician intervention and follow-up claim data to appear on the history file. Lock-in Program methodology: Cost avoidance attributed to the Lock-in Program in FFY21 is $5,000. The estimated cost savings attributable to the FFS Lock-in Program was based on a review of Medicaid claims pre and post Lock-in enrollment. An estimated member month savings was determined based on a cohort of beneficiaries and multiplied by the number of Lock-in member months during FFY 21.
Maine	Total cost savings are based off of aggressive management of the MaineCare Preferred Drug list through careful management of SMAC savings, lower of cost pricing of pharmacy claims, timely PDL management and strong SR negotiations to maximize lower program cost and maintaining excellent quality care choices. Savings include AWP savings from a calculated claim level and rather than looking at ProDUR or RetroDUR as reflections of cost avoidance since these claims may come in through prior authorization or changed to another medication of choice and captured through PDL savings estimates. We look at true cost avoidance through TPL cost avoidance which is included in the estimates above
Maryland	1 PDMU1000-RC002 MARYLAND MEDICAID PAGE 1 AS OF 2021-09-30 ACS PRESCRIPTION BENEFIT MANAGEMENT RUN DATE 12/30/2021 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 2020-10-01 - 2021-09-30 GROUP:CAID MARYLAND - DIVISION OF ME DUR ALERTS SUMMARY 0 CC DESCRIPTION PAID CLM PAID AMT DENIED CLM DENIED AMT REVERSE CLM REVERSE AMT TOTAL SAVINGS DD DRUG-DRUG INTERACTION 1,998,975 164,710,325 0 0 201,421 23,370,226 $23,370,226

State	Cost Savings/Cost Avoidance Methodology Summary
	TD THERAPEUTIC DUP (NOT D.0 USE) 752,659 101,901,069 0 0 81,015 15,338,385 $15,338,385 ID INGREDIENT DUPLICATION 712,150 39,257,234 0 0 69,378 5,881,449 $5,881,449 ER OVERUSE 53,805 6,624,428 149,395 18,392,018 3 34 $18,392,053 LD LOW DOSE 94,155 4,640,987 0 0 12,175 984,362 $984,362 HD HIGH DOSE 54,029 1,814,752 0 0 2,955 349,310 $349,310 PA DRUG-AGE 12,995 298,980 0 0 1,157 37,448 $37,448 SX DRUG-GENDER (NOT D.0 USE) 161 79,525 0 0 18 2,685 $2,685 0 3,678,929 319,327,304 149,395 18,392,018 368,122 45,963,903 $64,355,921 0 SUMMARY LINE ALL CONFLICTS 2,731,289 254,045,660 149,395 13,895,228 277,555 36,562,278 $50,457,507 0 PLEASE NOTE: 1. A CLAIM IS COUNTED AS DENIED ONLY IF IT IS NOT FOLLOWED BY A PAID CLAIM FOR THE SAME INDIVIDUAL/DATE OF SERVICE/DRUG COMBINATION. 2. A CLAIM IS COUNTED AS REVERSED ONLY IF IT HAS BEEN REVERSED WITHIN 24 HOURS (A SAME DAY REVERSAL). 3. A DENIED CLAIM IS COUNTED AS DENIED ONLY ONCE IF FOLLOWED BY MULTIPLE DENIES FOR THE SAME INDIVIDUAL/D O S/DRUG COMBINATION. 4. SAVINGS ATTRIBUTABLE TO EARLY REFILL (ER) ARE PRIMARILY COSTS DELAYED. IN OTHER WORDS, APPROXIMATELY 80% OF ER CLAIMS GO ON TO BE FILLED AFTER WAITING A FEW DAYS. THEREFORE, ER SAVINGS ARE CONSERVATIVELY CALCULATED AS 20% OF THE CLAIMS THAT HIT ER (AND DO NOT GO ON TO BE FILLED LATER). 5. A CLAIM REVERSED FOR LOW DOSE (LD) WAS CONSIDERED SAVINGS, BECAUSE THE PRESCRIPTION WAS NOT DISPENSED IN AN INEFFECTIVE DOSE. 6. THIS REPORT ONLY USES CONFLICT CODES ASSOCIATED WITH ACTUAL SAVINGS. CONFLICT CODES INCLUDED IN SAVINGS CALCULATIONS ARE: --DC, DD, ER, GA, HD, ID, LD, LI, MC, MX, PA, PG, SX, TD-- Table 3 - Estimated Cost Savings for FFY 2021 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 $386,515 ($-92,735) $479,250 Multiple Intervention $121,522 ($-48,219) $169,741 Total Estimated Cost Savings $648,991 Kepro found the intervention group had a decrease of 14.43% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of

State	Cost Savings/Cost Avoidance Methodology Summary
	11.13%. These changes resulted in an estimated cost savings of $463.15 per recipient who received an intervention during FFY 2021. Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions or other medically associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Maryland Medicaid Program. During FFY 2021, 1,810 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 $648,991 for FFY 2021.
Massachusetts	Cost Avoidance Methodology To calculate cost avoidance, prescription denials for FFY2021 were analyzed. Because a prescription can be denied multiple times at the point of service (POS), unique MassHealth utilizers rather than claims were used to count claim denials. MassHealth has a prescription duration limit of 30 days for most drugs, and most prescriptions are for 30 days. Therefore, every member with a claim in a month for any drug was counted as one denial for that drug in that month. 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 2019. 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 2019.

State	Cost Savings/Cost Avoidance Methodology Summary
	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. 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2,139 distinct prescribers of 3,527 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 $312,103.
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. This does not include savings from uniform Preferred Drug List (PDL). 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 2021, the gross calculated allowable reimbursement amount for claims denied by ProDUR edits minus amounts that would have been paid by third party liability was $7,688,009. However, the gross amount does not take into account factors such as claim resubmissions and changes in the drug prescribed. In 1996, the Reports and Forecasts Division developed a method to estimate actual savings attributable to the ProDUR Program. Using this method estimated actual savings is in the range of $18,678,438 to $49,956,400. Refill-too-soon hard edit On January 22, 2004, there was a significant change in ProDUR edits. The refill-too-soon edit became a hard edit where claims are stopped if less than 75% of the previous prescription was utilized for non-controlled substances and 85% for controlled substances. Pharmacy providers now have to call the provider help desk in order to obtain an override where previously, the pharmacy providers only needed to enter an online DUR reason code and resend the claim. Reasons to allow the provider help desk to override the refill-too-soon were developed by the pharmacy policy area. The gross calculated allowable reimbursement amount for claims less TPL (third party liability) denied with the refill-too-soon edit was $44,202,946. This savings is reduced by the amount of refill-too-soon overrides issued by the provider helpdesk. Out of 277,822 denied claims, only 1,618 (0.6%) were given overrides by the provider help desk which reduced savings by $1,104,980. Therefore, estimated savings is in the range of $10,752,942 to $28,759,272 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

State	Cost Savings/Cost Avoidance Methodology Summary
	and Specialty Pharmaceutical Reimbursement Rate programs total cost avoidance was $(2,393,766). The value for FFY 2021 is negative because of the legislative change in FFS reimbursement methodology 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). NADAC pricing is significantly lower the previous SMAC pricing. Specialty Pharmaceutical 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 in order 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 2021, 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 2021: Annualized cost savings are as follows: (1) Overuse of PPIs showed decreased costs of $90,395 (2) Respiratory Disease Management decreased by $662,802 (3) Gabapentinoids decreased by $293,170, and (4) Management of Diabetes Mellitus decreased by $282,748. There are two mailings per year regarding psychotropic drugs in children. Savings for the first mailing was $107,467 and for the second mailing was $167,070. There are two mailings per year regarding the SUPPORT Act. Savings for the first mailing was $43,396 and for the second mailing was $78,424. Therefore, the total net effect of RetroDUR was a decrease of $1,078,298 reduced by the amount of $109,560 per year contract cost. Estimated savings is in the range of $403,170 to $1,078,298.
Mississippi	The prospective DUR cost savings estimate provided by Conduent was generated by summing all claims that post a DUR reject error, NCPDP reject code 88, during the 2021 Federal Fiscal Year (October 1, 2020 - September 30, 2021), then subtracting the alerts that were over-ridden.
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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 58,800 / Approved 30,049 / Denied 28,751 / Approval Rate 51.1% / Denial Rate 48.9% / Total savings $31,341,324 Case Management--Other Cost Avoidance Total Cases Reviewed 2375 Total Clinical Interventions 2087 cost savings assigned 125 cost savings unable to determine 1962 Selection Method PA 134 CM 1951 Other 2 Contact Type MD 662 RN 298 RX 86 PA 106 NP 353 Other 616 Outcome Compliance Noted 1 Dose Changed 3 Drug Changed 0 Drug Discontinued 9 Labs Completed 5 Pending Response 326 No Change 140

State	Cost Savings/Cost Avoidance Methodology Summary

Other Change 104
Per Plan 1882
Not specified 2

Criteria Selection
Abuse Refer to DPHHS 8
Academic Detailing 382
Atypical Antipsych PA Required 126
Atypical High Cost 12
CF 81
Clinical- General 189
Drug Dosage 17
Drug Not Covered 85
Drug Recommendation Request 0
Drug -Disease Contraindication 30
Drug-Drug Interaction 34
Duration of Treatment 0
Eosinophilic Asthma 23
Foster Care Psychotropics 484
Fraud Refer to DPHHS 6
HAE 6
Hep C 64
ITP/Severe Aplastic Anemia 12
MAT 104
Medication Overutilization 0
Movement Disorders 67
Multiple Medications 7
Multiple Pharmacies/MDs 53
Overutilization 22
PA Requests Higher Level Clinical Review 47
PA Required (Old) 0
PBA 17
Potential Clinical Abuse or Misuse 52
Team Care 75
Therapeutic Appropriateness 63
Therapeutic Duplication 19
Underutilization 1

Total in Progress 531
Total Completed 1844

Operational Monthly Cost Savings* $N/A

CM Monthly Cost Savings $255,063
Annualized CM Cost Savings $3,060,763
Total YTD Cost Savings (=YTD Operational Cost Savings + Annualized CM Cost Savings)
$3,060,763

State	Cost Savings/Cost Avoidance Methodology Summary
	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 143 members met the criteria for intervention letters during FFY 2021. 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 2021). 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 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 2021. The drug claims for the selected members were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RetroDUR interventions. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2020 and September 30, 2021, there was an estimated cost savings of $210,314. Intervention Group. Change between 6 Month Pre and Post: $153,791

State	Cost Savings/Cost Avoidance Methodology Summary
	Comparison Group. Change between 6 Month Pre and Post: -$56,523 Estimated Cost Savings: $210,314
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. 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:

State	Cost Savings/Cost Avoidance Methodology Summary
	Cost Avoidance = Unmatched Denied Payment + (Matched Denied Amount Replacement Paid Amount) PMPM = (Cost Avoidance /Membership per time period)/# of Months % Total Cost=Cost Avoidance/(Total Paid Amount + Total Denied Paid Amount)
Nevada	OptumRx calculates the ProDUR savings by summing the amounts on claims either reversed or denied due to a ProDUR edit. We understand these numbers will be inflated as there is no way to track if the medication was later filled again after consulting with the prescriber or patient or taken to a different pharmacy.
New Hampshire	Magellan Health Services uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. This indirect effect arises when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. ProDUR Cost Savings The cost saving for Prospective Drug Utilization is based on cost avoidance when claims are reversed and not resubmitted. For FFY 2021, cost savings for ProDUR was $3,081,314. 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 2021 was $115,219. The cumulative cost savings for the RetroDUR program are described below: New Hampshire Medicaid Program RetroDURand Polypharmacy Cost Savings FFY 2021 Activity Description: Cost Savings Polypharmacy; $176,324 ADHD medications and cardiac risk: $3,810 Acetaminophen and SJS: $734 Antidepressants and suicide risk: ($427) NSAIDs and cardiac risk: $238 High Risk medications and elderly: $95 PPI and H2A: $925 BZD safety: $91 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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 2021 will not be known until the end of FFY 2022. 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 2021 was $565,869. 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 2021 was $111,563.
New Jersey	The New Jersey Division of Medical Assistance and Health Services conducts an on-going analysis of cost savings resulting from the PDUR program. Contributing to this analysis is output from a denied claims report that assesses pharmacy claim activities after PDUR edits have denied initial payments. PDUR interventions manifest themselves in two ways. The first is through PDUR responses returned to pharmacies by the point-of-sale system. In these situations, the pharmacist makes a decision to intervene with the patient and/or practitioner to resolve the PDUR issue. These types of interventions are referred to as having a sentinel effect. Typically these types of interventions result in a PDUR service continuing to be denied or a change in medication or dosage. The second type of PDUR intervention involves the Medical Exception Process (MEP). Certain PDUR edits are set to deny payments without prior authorization. In either situation, the PDUR edits have identified reasons for denying payment without some type of intervention. In order to appreciate the cost savings from these PDUR interventions, a production report (see below) is in place that analyzes claim activities sixty (60) days after a pharmacy service has been denied payment due to a PDUR edit. Cost savings identified in the report reflect costs for PDUR claims denied by a PDUR Edit for which no future paid claims were identified for the 60-day period following the date of denial. The reported cost savings is limited to the absence of a payment for a single PDUR claim. Extrapolated savings are not reflected in this report. The analysis is also performed at the Generic Code Number (GCN) level to capture claim information for all drugs with the same description, strength and route of administration. MEDICAID PDUR SAVINGS* - Total Denied Claims (Nursing Home and Retail Combined) from reruns of report ID Q2862R01 Quarter/FFY Year Total Amount 4th quarter 2020 $645,889 1st quarter 2021 $938,238

State	Cost Savings/Cost Avoidance Methodology Summary
	2nd quarter 2021 $829,744 3rd quarter 2021 $579,500 ProDUR Total $2,993,371 Additional RetroDUR Total Estimated Avoided Costs of $97,915 result in a Grand Total Estimated Avoided Costs of $3,091,286. *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	COST SAVINGS/COST AVOIDANCE METHODOLOGY DUR serves a vital monitoring purpose. Prospective DUR (ProDUR) and Retrospective DUR (RetroDUR) each serve a unique purpose in alerting practitioners and pharmacists with specific, focused and comprehensive drug information available from no other source. If practitioners and pharmacists use DUR as intended, then notification of a potential drug therapy problem will lead to appropriate action taken in response to a ProDUR alert or Retro-DUR intervention. Appropriate actions include discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, switching to safer drug therapies, or even adding a therapy recommended in published (evidence-based) guidelines from an expert panel. ProDUR Savings Ranked by Amount Saved for Paid Date Range October 1, 2020 through September 30, 2021 Conflict Code Description # of Paid Claims Paid Amount # of Denied Claims Denied Amount Paid Reversed Claims Reversed Amount Total Savings TD THER DUP 21,251 $4,011,079 1,486 $283,083 3,580 $1,035,973 $1,319,063 DD DRG-DRG INT 35,143 $2,967,997 0 $0 4,457 $735,398 $735,398 HD HIGH DOSE 2,282 $972,003 102 $40,815 484 $415,119 $455,943 LD LOW DOSE 4,990 $1,427,976 0 $0 628 $380,494 $380,494 ER OVERUSE 4,408 $620,049 2,691 $380,158 3 $70 $380,230 ID INGRED DUP 15,831 $1,501,947 0 $0 2,225 $348,025 $348,025 PG DRG-PREG 69 $2,977 0 $0 7 $1,547 $1,547 PA DRG-AGE 199 $3,407 0 $0 22 $377 $377 SX DRG-GEN 40 $2,138 75 $0 3 $110 $110 Summary Line 84,213 $11,509,573 4,354 $704,056 11,409 $2,917,113 $3,621,187 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.

State	Cost Savings/Cost Avoidance Methodology Summary
	2. A claim is counted as reversed only if it has been reversed within 24 hours (a same day reversal). 3. A denied claim is counted as denied only once if followed by multiple denials for the same individual/D O S/drug combination. 4. Savings attributable to early refill (ER) are primarily costs delayed. In other words, approximately 80% of ER claims go on to be filled after waiting a few days. Therefore, ER savings are conservatively calculated as 20% of the claims that hit ER (and do not go on to be filled later). 5. A claim reversed for low dose (LD) was considered savings, because the prescription was not dispensed in an ineffective dose. 6. This report only uses conflict codes associated with actual savings. Conflict codes included in savings calculations are: DC, DD, ER, GA, HD, ID, LD, LI, MC, MX, PA, PG Summary for October 1, 2020 through September 30, 2021 Intervention Savings per Targeted Projected FFFY21 Savings Opioid 90 MME Prescribing Limit #1 N/A $1,604.54 Opioid 90 MME Prescribing Limit #2 N/A $366.29 Monitoring of Second Generation Antipsychotics in Youth N/A $8,525.45 Patients Receiving Opioids and Gabapentinoids Concurrently N/A $8,736.94 Influenza Vaccination 2020-2021 Newsletter N/A N/A Patients Receiving Opioids and Benzodiazepines and/or Antipsychotics Concurrently N/A N/A Treatment with Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) N/A N/A Total N/A $19,233.22 In conclusion for FFY 2021, the total estimated new savings for ProDUR and RetroDUR programs for New Mexico was $3,601,953.78. The RetroDUR estimated savings were $19,233.22 while the ProDUR estimated savings were $3,621,187.00.
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 estimate the impact of RetroDUR, the total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention

State	Cost Savings/Cost Avoidance Methodology Summary
	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 Retro DUR 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 RetroDUR 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 2021). 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 multi-source brand name product when less expensive than the generic [net of all rebates]). Estimates based on State Fiscal Year 2020 - 20201 (April 1, 2020 - March 31, 2021). 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, 2020 to September 30, 2021 Estimated Savings: ProDUR $ 559 million RetoDUR $ 351 thousand PA $ 16.7 million PDL $ 109.4 million Lock-In $ 8.83 million TOTAL $ 694 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

State	Cost Savings/Cost Avoidance Methodology Summary
	The ProDUR Cost Avoidance is calculated from the saving of not dispensing prescriptions that denied due to a Pro-DUR edit being applied to the claim. Period Cost Saving Reversals Non-responses Oct 2020 to Sep 2021 $559,083,988 1,664,398 1,836,450 The RetroDUR Savings are calculated from the Retro-DUR activities described in Section III of the Annual Report. Period Cost Savings Oct 2020 to Sep 2021 $350,983.94 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 $23,057,117 2021 Q1 $28,089,484 2021 Q2 $29,523,968 2021 Q3 $28,754,317 Oct 2020 to Sep 2021 $109,424,886 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 2020 to Sep 2021 $16,696,503 Lock-In The Lock-In Cost Avoidance is calculated by the cost of drugs for pharmacy claims that denied for the lock-in beneficiary not using the required pharmacy or prescriber for their lock-in drugs. Period Cost Savings Oct 2020 to Sep 2021 $8,830,837 The State of North Carolina contracts with Myers and Stauffer to provide reports on DUR Program Evaluation and Cost Savings/Avoidance. However, at the time of this Annual Report, the reports were not complete.
North Dakota	Summary: The cost savings report was prepared by Kepro for the North Dakota Medicaid Program to illustrate the expected estimated cost savings from their retrospective drug utilization review (RDUR) program and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2021 (FFY 2021). The drug claims for the selected recipients were

State	Cost Savings/Cost Avoidance Methodology Summary
	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, 2020, and September 30, 2021, there was an estimated cost savings of $1,295,794. During FFY 2021, Kepro reviewed 2,372 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. The methodology is validated by independent third party. Estimated Cost Savings Methodology: To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. 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 2021). 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. During this time, the intervention group consisting of single interventions and the intervention group with multiple interventions experienced an estimated cost savings of $996,345 and $299,449 respectively. During this period, the 2 comparison groups experienced a total cost increase of $255,592 (-$255,592 in cost savings).

State	Cost Savings/Cost Avoidance Methodology Summary
	Subtracting the estimated cost savings of the comparison groups (-$255,592) from the estimated cost savings from the intervention groups ($1,040,202) resulted in a total estimated cost savings of $1,295,794. Further analysis found the intervention group had a decrease of 9.91% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 12.06%. These changes resulted in an estimated cost savings of $558.29 per recipient who received an RDUR intervention during FFY 2021. Results Discussion: All drug claims and some medical claims or diagnosis data is available for analysis, and all medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions, other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion: The RDUR program provides an important educational service to providers enrolled in the North Dakota Medicaid Program. During FFY 2021, 2,372 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,295,794 for FFY 2021.
Ohio	The Ohio Medicaid DUR program has saved money by encouraging appropriate drug therapy to reduce total healthcare expenditures. In FFY21, ODM rejected approximately 131,196 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 $29,629,283. Additionally, 60,954 claims rejected by DUR Code 88 resulted in $2,640,883 in savings. In total 192,780 claims rejected by ProDUR edits resulted in $32,270,166 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 impact. Three interventions accounted for this cost savings. Opioids and benzodiazepines saved $99,259, Opioids and Gabapentin saved $30,746, and Opioids and Stimulants saved $18,518. The total savings measured at the time of report submission for RetroDUR edits in FFY2021 was $148,523.
Oklahoma	ProDUR Methodology: The ProDUR savings calculation included for the 2021 Federal Fiscal Year (FFY) focused on the four ProDUR system edits and twenty-one additional edits that have been identified

State	Cost Savings/Cost Avoidance Methodology Summary
	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 claims by prescription number giving a true cost avoidance from the ProDUR program. Voided claims and claims with products classified as non-drug items by First Data Bank (FDB) were excluded. The ProDUR cost avoidance was calculated by multiplying the total number of denied claims by the average cost per prescription (split into brand and generic cost). The average costs per prescription were calculated to be $551.56 and $40.51, respectively. The brand and generic average cost per prescription was multiplied by the number of claims for brand and generic, respectively, for each edit. These were summed to give a total cost avoidance for ProDUR. Then, this total cost avoidance was multiplied by 42.3% to account for the 57.7% rebate recovery percentage (Rebate Recovery percentage is based on the SFY 2021 Annual Report). Therefore, the total estimated ProDUR cost avoidance is $72,228,618.79 for FFY 2021. Notes: 1. This cost avoidance does not take into consideration subsequent paid claims related to changes in pharmacotherapy resulting in the pharmacy alert edits. 2. The average cost per prescription calculation was based on traditional drug spend and excluded specialty drug spend from the calculation to prevent cost avoidance inflation. However, the specialty drug claim count was still included in the total claims and cost for these claims were also calculated based on brand or generic status as stated above. Academic Detailing: Treatment Persistent Asthma Outcomes are reported as an annual average per provider during the 5-year Pre-AD period and as a 1-year average per provider during the Post-AD period. Non-drug cost comparisons were assessed by examining non-ambulatory health care service utilization. Changes in Academic Detailing Outcomes Healthcare Utilization Pre-AD Post-AD Change % Change Hospitalization and ED visit costs $4,083,760 $2,496,148 -$1,587,612 -38.88% *negative indicates improvement Total drug costs were expected to increase as a result of aligning prescribing practices with published guidelines. Drug costs increased by 14% and 21% respectively for rescue medications and controller medications as a result of Asthma-AD. In the Pre-AD period, these 195 prescribers cared for a total of 4,455 members with persistent asthma. Of these total members, 1,584 had an average of 13,453 hospital and ED paid claims per year, with a 5-year average annual cost of $4,083,760. In the Post-AD period, 933 of the total members had a total of 3,181 hospital and ED paid claims per year, with a total annual cost of $2,496,148. Total hospital and ED annual cost savings of $1,587,612 resulted from Asthma-AD. Cost savings are based on paid claims for Medicaid patients receiving ambulatory care services from detailed prescriber. Across all parameters, Asthma-AD providers improved their prescribing of rescue medications by 14% and their prescribing of controller medications by 21%. They improved

State	Cost Savings/Cost Avoidance Methodology Summary
	their patients' health care utilization by nearly 40%. Total annual cost savings of $1,587,612 or more than $8,000 per provider, resulted from Asthma-AD. 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 $29,107,840.52 for FFY 2021. For the Product Based Prior Authorization (PBPA) report savings, FFY 2021 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 avoidance for the PBPA report. This is estimated to be $11,534,634.53 for the FFY 2021. 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 $36,390,090.68.
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

State	Cost Savings/Cost Avoidance Methodology Summary
	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 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	Activities of the RDUR Program were evaluated for interventions performed in FFY21. The activities of the RDUR program resulted in a calculated cost savings of $356,416.02*, equating to a savings of 43 cents* for every $1.00 of combined federal and state dollars spent administratively on the RDUR program. *Savings reported are pre-rebate, total dollars
Rhode Island	Retrospective DUR Cost Savings Methodology

State	Cost Savings/Cost Avoidance Methodology Summary
	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 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	Pro DUR Paid Claims Savings/Denied- Cost avoidance claims denied/alternate therapy (switch therapy), reversals and resubmissions. Other cost avoidance: MAC pricing/PDL management, PA Criteria, Medical Directors review/guidance of criteria and review of initial/renewal for specific therapies/cases (SMA, DMD, etc.) Retro DUR: SCDHHS has engaged in an aggressive provider education campaign to promote opioid risk reduction strategies and expand access to MAT, named tip SC. 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. These educational programs offer continuing education credit for providers. As a result, the ability to place a cost saving/avoidance for the program for impact on cost avoidance

State	Cost Savings/Cost Avoidance Methodology Summary
	from overdose/accidental exposure, prescribing practices, education and potential lives saved/linkage to care/MAT services make it difficult to quantify in terms of a dollar amount. South Carolina incorporated NADAC 7/2020, transitioning to AAC November 2021, the cost savings associated with those changes were not available at time of submission, and are therefore not included in the cost savings methodology.
South Dakota	Pro-DUR: 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. Retro-DUR: 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.
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 the 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 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

State	Cost Savings/Cost Avoidance Methodology Summary
Texas	Retro-DUR Cost saving Methodology Pharmacy claims data is mapped to allow R-DUR data management system to analyze and interpret data. The medical claims data is mapped to evaluate up to two years of patient medical history for the Retro-DUR interventions. Vendor delivers interventions to prescribers based on clinical performance indicators. Prescribers are mailed intervention letters based on the number of patients with identified clinical indicators. 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, vendor 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 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 time 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 is the Intervention Average Cost Savings PPPM multiplied by the total number of targeted patients served over the 6-month time frame. 6-Month State General Revenue Funds Savings equals the 6-Month Total State Savings multiplied by 0.400 Total State Savings equals 6-Month State General Revenue Funds Savings multiplied 2. Pro-DUR Cost Saving Methodology Vendor provides the prior authorization services for the Vendor Drug Program (VDP). Prescribers must obtain PA for all non-preferred drugs. In addition to the PDL PAs, some drugs may be subject to one or more clinical PAs or edits. The PA system permits for automated processing of PAs and a large percentage of PAs are obtained at point-of-sale (POS) without requiring a phone call. The overall cost saving is calculated by adding the cost savings for unique denials with subsequent substitution to a preferred drug to the cost savings for unique denial without subsequent follow up approval or substitution therapy. Total cost savings for unique denial with subsequent substitution therapy is estimated by calculating total dollar amount for all unique denied prior authorization requests with a substitute therapy within 7 days of the original denial for a drug within the same HIC3 category.

State	Cost Savings/Cost Avoidance Methodology Summary
	Total cost savings for unique denial without subsequent follow up approval or substitution is estimated by calculating total dollar amount for all unique denied prior authorization requests without a prior authorization approval or a substitute therapy within 7 days of the original denial for a drug within the same HIC3 category. Lock-In Program Methodology The Lock-In program receives referrals from the public, providers, managed care organizations (MCOs) and the law enforcement officials. The Waste, Abuse, Fraud Electronic Referral System (WAFER) is available to the public for this purpose. Each referral is reviewed for lock-in criteria match. The estimated cost savings are based on the dollar amount would have been spent For the FFY 2021, there were 4 FFS members in the lock-in program with an estimated savings of $9,011.04. A cost saving methodology was not provider by the reporting party.
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 1,757 216,324.04 40 3 960.65 460 346,293.84 347,254.49 NONTRAD DD DRUG DRUG 24,973 644,051.39 262 945 35,779.40 5,125 301,472.57 337,251.97 NONTRAD LD LOW DOSE 9,623 1,512,406.40 127 0 0.00 2,162 822,514.46 822,514.46 NONTRAD TD THER DUP 101,334 7,322,545.89 1,969 90 9,144.72 22,281 2,973,806.97 2,982,951.69 NONTRAD SUMMARY 14,139,415.56 2,398 0 0 30,028 4,444,087.84 4,444,087.84 TRAD HD HIGH DOSE 9,403 1,752,931.75 239 39 13,089.59 2,405 1,403,001.61 1,416,091.20 TRAD DD DRUG DRUG 106,642 3,883,212.15 2,538 2,261 109,447.32 19,699 1,278,971.23 1,388,418.55 TRAD LD LOW DOSE 44,132 6,880,068.08 315 2 456.43 9,290 3,191,406.11 3,191,862.54 TRAD TD THER DUP 509,354 47,781,445.61 10,599 179 22,349.39 100,581 15,814,932.85 15,837,282.24 TRAD SUMMARY 81,985,969.39 13,691 0 0 131,975 21,688,311.80 21,688,311.80 TRADNH HD HIGH DOSE 1,308 71,485.49 4 7 561.09 123 33,357.37 33,918.46 TRADNH DD DRUG DRUG 9,565 378,249.31 71 330 17,156.21 811 119,021.00 136,177.21 TRADNH LD LOW DOSE 3,861 465,145.91 3 2 326.55 392 165,257.90 165,584.45 TRADNH TD THER DUP 48,195 2,730,998.19 803 61 4,123.02 3,771 526,527.80 530,650.82

State	Cost Savings/Cost Avoidance Methodology Summary
	TRADNH SUMMARY 4,490,042.97 881 0 0 5,097 844,164.07 844,164.07 SUMMARY HD HIGH DOSE 12,468 2,040,741.28 283 49 14,611.32 2,988 1,782,652.82 1,797,264.14 SUMMARY DD DRUG DRUG 141,180 4,905,512.85 2,871 3,536 162,382.93 25,635 1,699,464.80 1,861,847.73 SUMMARY LD LOW DOSE 57,616 8,857,620.39 445 4 782.97 11,844 4,179,178.47 4,179,961.44 SUMMARY TD THER DUP 658,883 57,834,989.69 13,371 330 35,617.13 126,633 19,315,267.62 19,350,884.75 SUMMARY SUMMARY 100,615,427.92 16,970 0 0 167,100 26,976,563.71 26,976,563.71 PLAN_ID CLAIM_COUNT PAID_AMOUNT REV_CLAIM_COUNT REV_AMOUNT NONTRAD 69594 $ 7,061,214.79 19163 $ 3,297,601.25 TRAD 320027 $ 42,762,424.79 79003 $ 15,285,233.43 TRADNH 29914 $ 2,540,100.12 2585 $ 551,476.42
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 2021 was $4,816,781. The following table summarizes the FFY 2021 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

State	Cost Savings/Cost Avoidance Methodology Summary

Paid Claims - Reversed and Not Resubmitted Denied Claims - Not Resubmitted

$3,309,043.68 +

$1,507,737.80 = $4,816,781.48

Month-Year	Total # Paid ProDUR # Claims	Total Payment Savings From ProDUR	PAID ProDUR # Savings From PRODUR Drug Claims Not Overridden	Amount Total PAID ProDUR Cost Savings	Alerts Reversals	Reversals Not Overridden
October-20	15,142	$1,149,494.94	2,035	$540,509.85	$340,439.38	1,216
November-20	13,584	$1,085,027.16	1,870	$395,778.90	$271,024.82	1,138
December-20	14,467	$1,145,223.14	2,011	$401,578.05	$283,203.34	1,176
January-21	13,511	$1,147,439.71	1,708	$430,853.94	$302,912.22	947
February-21	13,725	$1,124,985.60	1,657	$416,377.61	$289,455.89	877
March-21	15,035	$1,202,895.56	1,788	$362,386.94	$271,852.76	917
April-21	13,879	$1,236,878.49	1,570	$307,047.06	783	$111,984.18
May-21	14,389	$1,132,220.54	1,763	$256,313.25	926	$93,732.00
June-21	14,786	$1,120,667.16	1,797	$198,825.91	984	$92,877.49
July-21	14,760	$1,180,764.52	1,721	$283,959.59	904	$154,982.67
August-21	15,844	$1,174,167.01	2,027	$406,941.62	$266,963.49	1,044
September-21	14,124	$1,116,114.89	1,759	$362,632.42	$237,045.97	921
FFY 21 Averages	14,437	$1,151,323.23	1,809	$401,398.46	$275,753.64	986

State	Cost Savings/Cost Avoidance Methodology Summary
	FFY 21 Totals 173,246 $13,815,878.72 21,706 $3,309,043.68 11,833 $1,507,737.80 $4,816,781.48 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 2021 was $131,480.00. 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 2021 will not be known until the end of FFY 2022. Dose Optimization and Maximum Quantity Limits Analysis In January 2008, Virginia Medicaid implemented dose optimization and quantity limits on selected medications. The purpose of a dose optimization program is to change multiple dose medications to a single daily dose where appropriate. Quantity limits provide a baseline for the recommended amount of medication that should be dispensed over a certain time period. These limits are based upon the drug manufacturer's

State	Cost Savings/Cost Avoidance Methodology Summary
	recommendations and FDA guidelines. For FFY 2021, the savings for the dose optimization edit was $559,611.40 and for the quantity limits edit was $162,379.32. The combined savings for both edits was $721,990.72.
Washington	For FFY 2021, 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 2021 Washington Medicaid has not included any direct savings based on retrospective drug utilization review (RetroDUR) activities. Savings based on ProDUR looked at unique prescription occurrences for payable claims that rejected for NCPDP reject 88 DUR and never resulted in a paid claim (i.e., not overridden by a pharmacy with DUR codes). All other NCPDP rejections and third part payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings of $11,480,599. The estimated savings does not reflect medication changes that may have occurred based on the reject 88 and may have resulted in separately payable claims that would reduce this savings. Savings based on cost avoidance from prior authorization looked at payable claims (claims for eligible clients, no missing or invalid data, all NDCs were rebate eligible, etc.) that rejected for NCPDP reject 75 and did not result in a paid claim. All other NCPDP rejections and third part payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings or cost avoidance of $13,320,876. The estimated cost avoidance savings does not reflect medication changes that may have occurred based on the need for prior authorization and would result in separately payable claims that would reduce this savings.
West Virginia	Total estimated costs savings for the West Virginia Medicaid Pro-DUR program were estimated by our POS vendor, Gainwell Technologies, to be $50,056,597.71 for FFY2021. The methodology used by Gainwell to calculate these savings is as outlined below. Annual FFY2020 DUR Cost Save Report Data Gathering 1. Set date range for fiscal year 2021 (FY2021) a. Start Date = 10/01/2020 b. End Date = 09/30/2021 2. Calculate average total paid amount per claim for FY2021 a. Exclude claims with ADAP/LPS planID b. Claim start date must fall within the Start Date and End Date of FY2021 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 FY2021 which denied due to a DUR edit a. Claim start date must fall within the Start Date and End Date of FY2021 b. Claim must have a status of DENY in the claim edit table c. DENY edit must be one of the following DUR edits: 7067, 7069, 7071, 7073, 7075, 7079, 7202, 7203, 7204, 7205, 7206, 7170, 7171, 7172, 7173, 7175, 7250, 7251, 7252, 7077, 7245 d. Exclude claims with ADAP/LPS planID

State	Cost Savings/Cost Avoidance Methodology Summary
	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 FY2021 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: $51,950,045.27 Override Dollars: $33,690,424.21 Cost savings: $18,259,621.06 Percent savings: 20.28% ER, Early Refill: Denied Dollars: $68,730,502.06 Override Dollars: $1,838,305.22 Cost savings: $66,892,196.84 Percent savings: 74.31% HD, High Dose Denied Dollars: $3,539,867.99 Override Dollars: $11,622,100.41 Cost savings: $0.00 Percent savings: 0.00% ID, Ingredient Duplication Denied Dollars: $7,399,736.69 Override Dollars: $2,662,812.13 Cost savings: $4,736,924.56 Percent savings: 5.26% TD, Therapeutic Duplication

State	Cost Savings/Cost Avoidance Methodology Summary
	Denied Dollars: $18,770,391.27 Override Dollars: $36,852,826.76 Cost savings: $0.00 Percent savings: 0.00% PG, Pregnancy Precaution Denied Dollars: $1,652,870.80 Override Dollars: $1,828,734.65 Cost savings: $0.00 Percent savings: 0.00% LR, Late Refill Denied Dollars: $471,609.44 Override Dollars: $353,357.42 Cost savings: $118,252.02 Percent savings: 0.13% Annual DUR Coalition cost avoidance estimates are $6,558,878. Breaking out the Lock-In and Clinical components of the RDUR Program, conservative estimates are an increase in charges of $228,748 for the Lock-In program, and a reduction of $6,787,626 for the Clinical component. Analysis of claims for patients receiving a letter saw a 13% reduction in office visits, a 21% reduction in ED visits and a 25% reduction in patients being admitted. Admissions represented the majority of savings at 70% with ED visits and office visits being 26% and 4% respectively. The phenomena of increased costs after Lock in or Warning letters sent is consistent with the literature surrounding lock-in programs where it was revealed that there can be a four-fold increase in out-of-pocket opioid expenditure and seeking illegal opioids, resulting in increased ED and hospital visits associated with this behavior. The extent to which program restrictions may influence enrollees to obtain substances outside of the health care system is unknown and could also affect overdose risk across these periods. Ideally, lock-in programs improve care coordination, connection to appropriate opioid use disorder treatment as needed and thus reduce the incidence in overdose. Estimated Cost Avoidance Methodology (Proprietary) For each program and metric, a retrospective pre-post evaluation was done to evaluate financial impact. The evaluation was based on presence of Common Procedural Technology (CPT codes) signifying either patient office visits, Emergency Department (ED) visits or hospital admissions relevant to the metric. Charges for office and ED visits were extracted from the Medicaid data for the claims associated with the same Dates of Service (DoS) where the primary diagnosis (PDx) was within the scope of the metrics. For the admissions, as the admission data and Diagnosis-related Group (DRG) are not available, the PDx were mapped to appropriate Medicare Severity-Diagnosis Related Group (MS-DRG) cluster, with severity of the admission CPT designating the position of the DRG within the cluster (e.g., a higher severity CPT would result in a higher weighted DRG within the appropriate DRG cluster.) DRG weights were taken from the Content Management System (CMS) 2020 List of Medicare Severity Diagnosis-Related Groups (MS-DRGS), Relative Weighting Factors. The Base rate used was the CMS Operating Base Rate 2020 with no modifiers. While it is well known that the predicted compared to the final DRGs often

State	Cost Savings/Cost Avoidance Methodology Summary
	change, this method allows for cost of care to be conservatively estimated based on the PDx at the time of admission. In addition, where a sentinel PDx was identified in a metric, the visit may be excluded due to the visit being primarily attributed to another condition. For example, gastrointestinal (GI) bleeding associated with myocardial infarction (MI) often presents as a distinct syndrome that differs from either disease alone. GI bleeding, particularly when massive, may precipitate MI from hypovolemia, hemodynamic compromise, and myocardial hypoperfusion. For a metric where MI is indicated, and GI bleeding, hypovolemia, etc., were present, the patient would be excluded. Methodology for financial estimation is intentionally conservative. For all Lock-In Review visit types (OP, IP, ED), the severity was reduced as indicated by a population shift from a lower severity visit to a higher severity visit. An example of this is indicated by the increase in severity of High-level ED visits in the post test population while there was an overall reduction in ED visits (40 & 16 visits respectively). All visits post intervention were high severity whereas all priors were low (36) or moderate/high (4). This same pattern was also present in IP visits where we saw a 120% increase. In the clinical population, we saw an overall 76% reduction of related ED visits, a 74% reduction in IP visits, and a 40% reduction in OP (office) visits related to the Metric. For clinical visits overall, the severity was reduced as indicated by a population shift from a higher severity visit to a lower severity visit indicated by the CPT visit code.
Wisconsin	Wisconsin Medicaid Program Centers for Medicare and Medicaid Services Medicaid Drug Utilization Review Annual Report Federal Fiscal Year 2021 Attachment 4: Wisconsin RDUR Estimated Cost Savings [ATT4-2021-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 2021 (FFY 2021). 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

State	Cost Savings/Cost Avoidance Methodology Summary
	and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2020 and September 30, 2021, there was an estimated cost savings of $891,804. Table 1: Estimated Cost Savings for FFY 2021 _ 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 $207,762 (-$684,042) $891,804 Table 2 : Estimated Cost Savings for FFY 2021 _ Lock-Ins only Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings Lock-Ins Only (-$7,447) (-$90,483) $83,036 During FFY 2021, Kepro reviewed 7,487 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 2021, 6,318 members were included in the intervention group. Table 3 : Drug Therapy Problem Distribution Drug-Drug Interaction: 26% Over Utilization: 25% Therapeutic Appropriateness: 22% Under Utilization: 16% Drug-Disease Interactions: 11% 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 22,721 members met the criteria for intervention letters during FFY 2021. 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-

State	Cost Savings/Cost Avoidance Methodology Summary

intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters.
The comparison group consisted of a random group of members who were not chosen for RDUR intervention letters. For a member to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre- and post-intervention periods.
For the purpose of this report, members were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Members were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same member within FFY 2021). 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 2021.
Table 4 - Estimated Cost Savings for FFY 2021 _ 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	$170,550	(-$629,645)	$800,195
Multiple Intervention	$37,212	(-$54,397)	$91,609
Total Estimated Cost Savings	$891,804		

Kepro found the intervention group had a decrease of 0.60% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 8.99%. These changes resulted in an estimated cost savings of $141.15 per member who received an intervention during FFY 2021. The intervention group utilized for the cost savings calculation included 6,293 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	6,017	6,017
Average Cost/Member	$5,417	$5,389
Total Claims Cost	$32,596,474	$32,425,924

State	Cost Savings/Cost Avoidance Methodology Summary

Comparison Group (Single Intervention)

	Pre 6 Months	Post 6 Months
Members	6,017	6,017
Average Cost/Member	$1,231	$1,336
Total Claims Cost	$7,409,377	$8,039,022

Single Intervention Outcomes

Total Prescription Claims Saved	27,301
Percent Change in Claims Cost	-0.52%
Change in Claims Cost	$170,550

Single Intervention Outcomes

Comparison Group Claims Cost Change	(-$629,645)
Total Savings for Single Interventions	$800,195

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	301	301
Average Cost/Recipient	$6,275	$6,152
Total Claims Cost	$1,888,894	$1,851,681

Comparison Multiple Interventions

	Pre 6 Months	Post 6 Months
Recipients	301	301
Average Cost/Recipients	$672	$853
Total Claims Cost	$202,277	$256,674

Multiple Intervention Outcomes

Total Prescription Claims Saved	650
Percent Change in Claims Cost	- 1.97%
Change in Claims Cost	$37,212
Comparison Group Claims Cost Change	-$54,397
Total Savings for Multiple Interventions	$91,609

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.

State	Cost Savings/Cost Avoidance Methodology Summary
	Conclusion The RDUR program provides an important educational service to providers enrolled in the Wisconsin Medicaid program. During FFY 2021, 7,487 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 $891,804 for FFY 2021.
Wyoming	For prospective cost avoidance: Total savings = Denied amount + reversed amount Denied amount is based on the average paid amount for accepted claims, grouped by conflict code. Reversed amount is the total amount paid for reversed claims that generated DUR messages (sum of absolute values since this amount is negative for reversed claims), grouped by conflict code. For retrospective cost avoidance: Total cost (medical + pharmacy) is calculated for the quarter prior to intervention and a quarter at least six months after intervention. The difference between cost before and cost after is converted to cost/eligible claimant and multiplied by eligible claimants in the post period. This quarterly amount is then multiplied by 4 to estimate annualized cost avoidance. For prescriber reports looking solely at prescribing trends, only pharmacy costs are included.

Section VIII - Fraud, Waste and Abuse (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 55 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

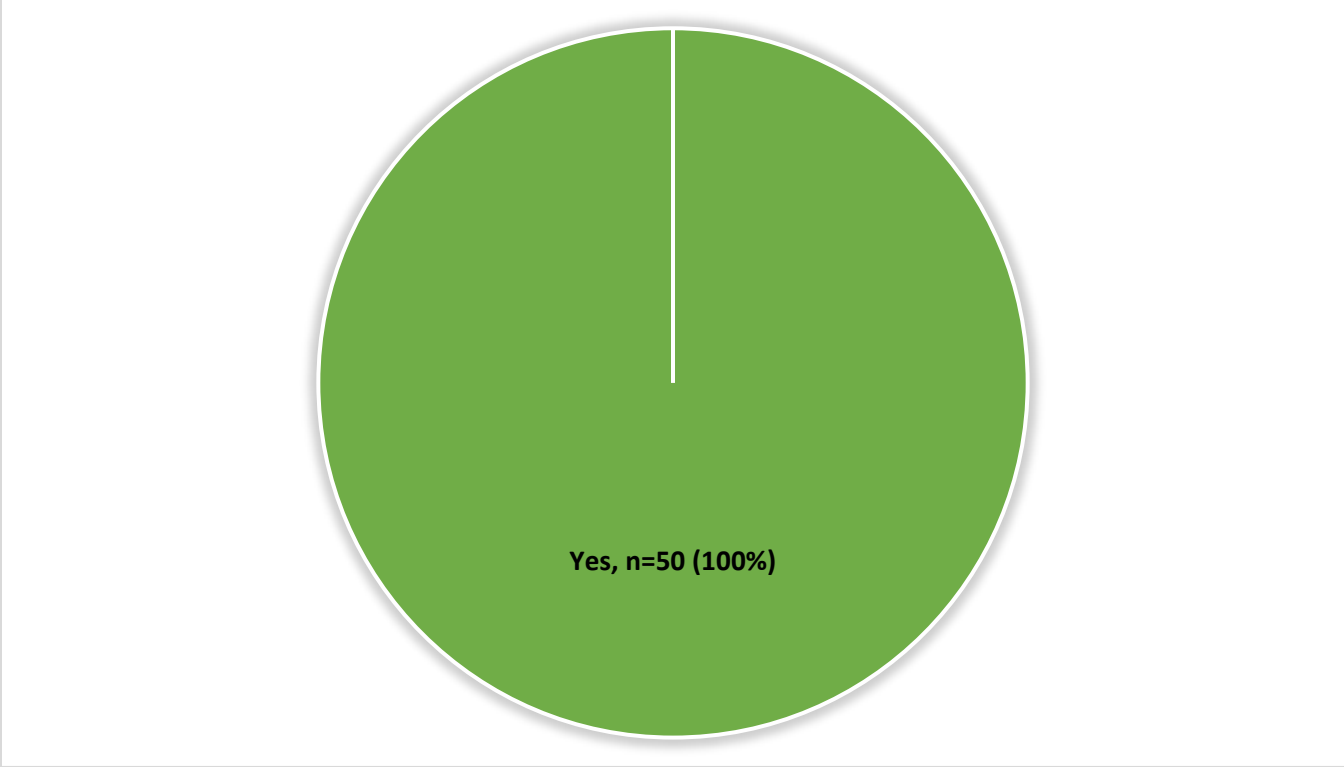

Table 78 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

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

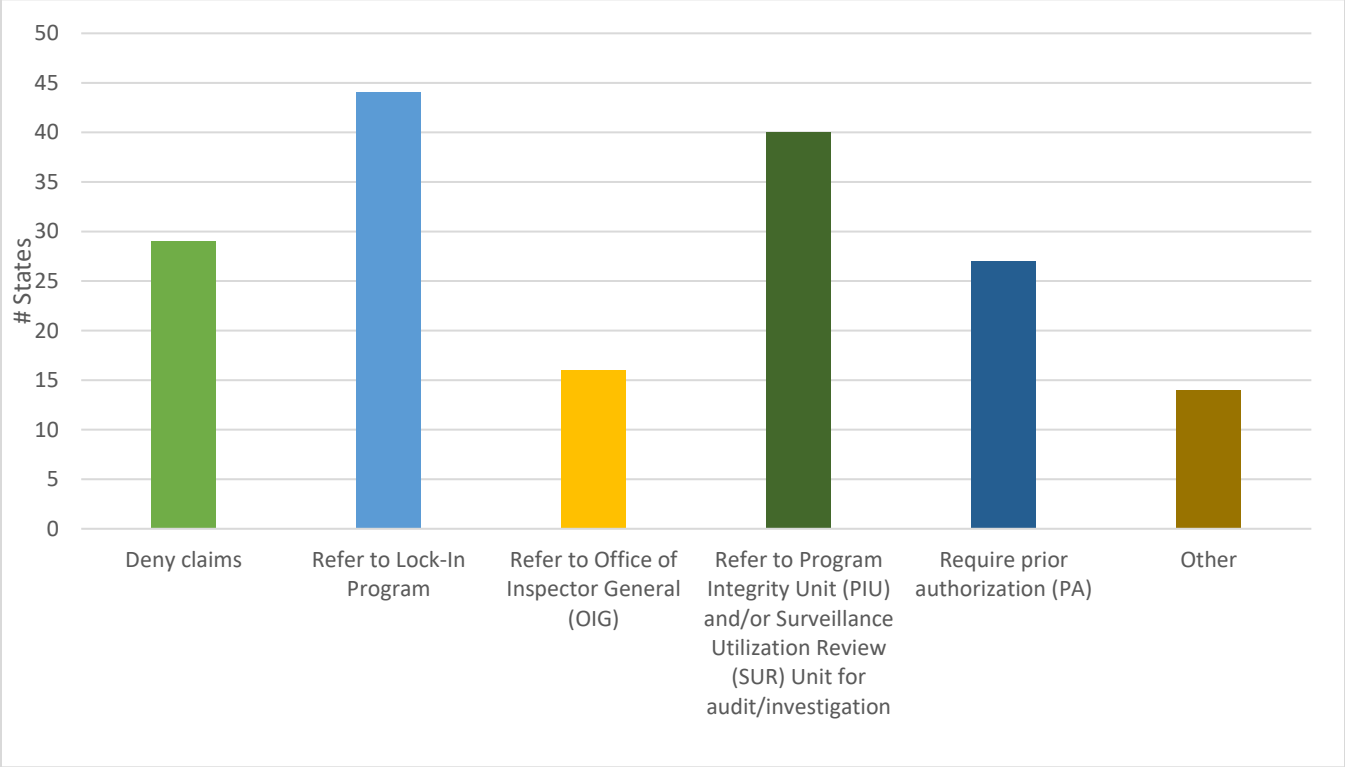

Table 79 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

Response	States	Count	Percentage
Deny claims	Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia	29	17.06%
Refer to Lock-In Program	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	25.88%
Refer to Office of Inspector General (OIG)	Arkansas, Indiana, Kentucky, Maryland, Michigan, Minnesota, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Wisconsin	16	9.41%

Response	States	Count	Percentage
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Alabama, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, Wyoming	40	23.53%
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 Carolina, North Dakota, Oregon, South Carolina, Tennessee, Vermont, Virginia, West Virginia	27	15.88%
Other	Alabama, Alaska, California, Connecticut, Florida, Indiana, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, Utah, Vermont, Virginia	14	8.24%
Total		170	100.00%

If “Other,” please explain.

Table 80 - “Other” Explanations for Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

State	Explanation
Alabama	Refer to MFCU if necessary.
Alaska	SURS, MFCU
California	22CCR 50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits, including being subjected to one or more of the following forms of utilization restriction: (1) Prior authorization for all Medi-Cal services. (2) Prior authorization for specific Medi-Cal services. (3) Restriction to utilization of a specific, beneficiary- or Department-selected pharmacy. (4) Restriction to a specific, beneficiary- or Department-selected primary provider of medical services. Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.
Connecticut	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
Florida	Deny claims and require a prospective drug utilization review by the pharmacist at the point of sale.

State	Explanation
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
New Hampshire	Members can be referred to the Program Integrity Unit. However, the Program Integrity Unit performs the review function and manages the Lock-In Program. Program Integrity may also refer cases to the Medicaid Fraud Control Unit and/or the Office of the Inspector General. Providers may also be reported to the Office of Professional Licensure and Certification (OPLC).
New Jersey	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Office of the State Comptroller's, Medicaid Fraud Division to look for unusual patterns in claim reimbursement from providers.
North Carolina	All potential beneficiary fraud and abuse leads are referred by Program Integrity to the beneficiary's county Department of Social Services for further investigation and disposition. Claims are denied for lock-in beneficiaries if not using designated providers. Some controlled substances require a PA which may decrease prescription fraud.
Utah	Management of Medicaid member's case in coordination with providers to bring utilization in line with Lock-in Program (Lock-in) guidelines and criteria.
Vermont	There is an internal process that outlines the process for review of data-mined claims information, screening for claims indicating a high number of prescribers, multiple ED visits, and/or use of multiple pharmacies. Team members outreach providers, pharmacies, and EDs describing the Team Care program criteria, guidelines and referral process. Provider notification through banner and mailing.
Virginia	Java- Server Utilization Review System (JSURS) identified members to review for enrollment in DMAS Client Medical Management Program (Lock- In program).

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

Figure 57 - Lock-In Program

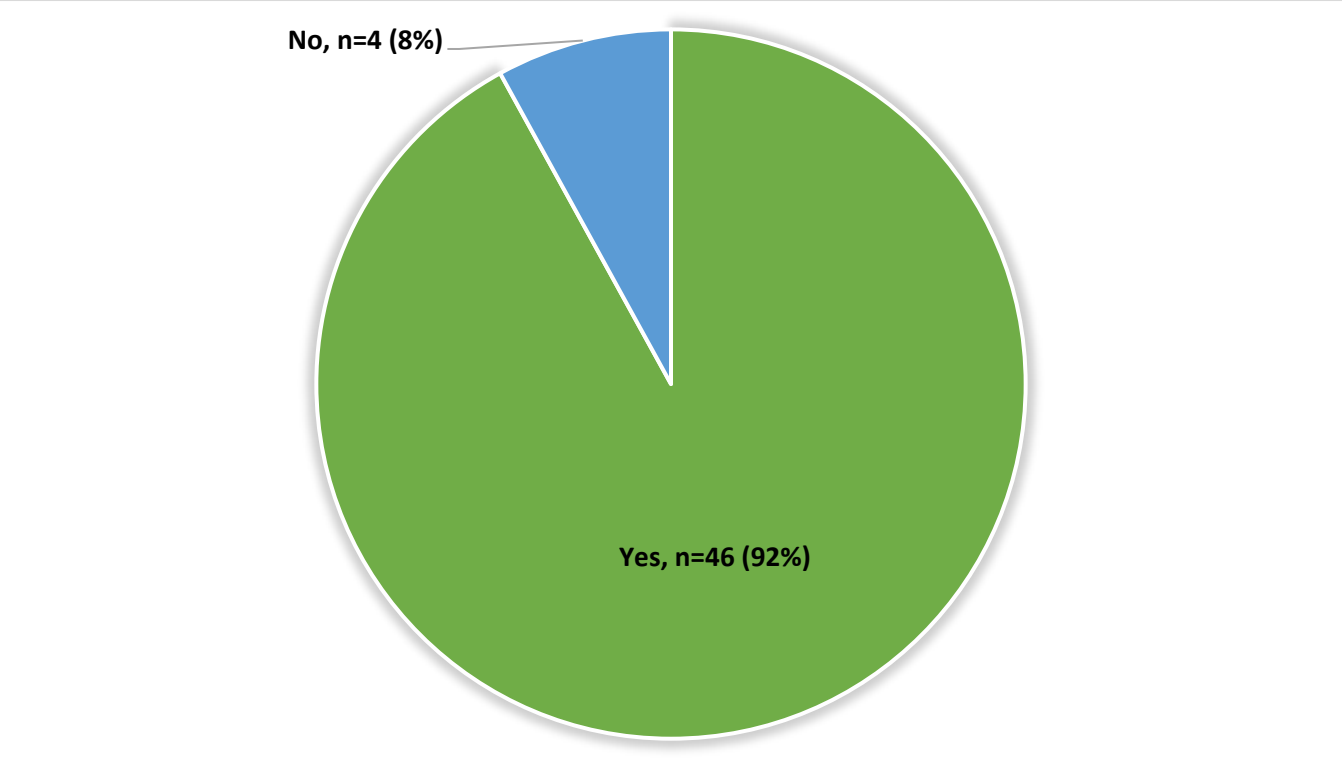

Table 81 - Lock-In Program

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 58 - Lock-In Program Candidate Identification Criteria

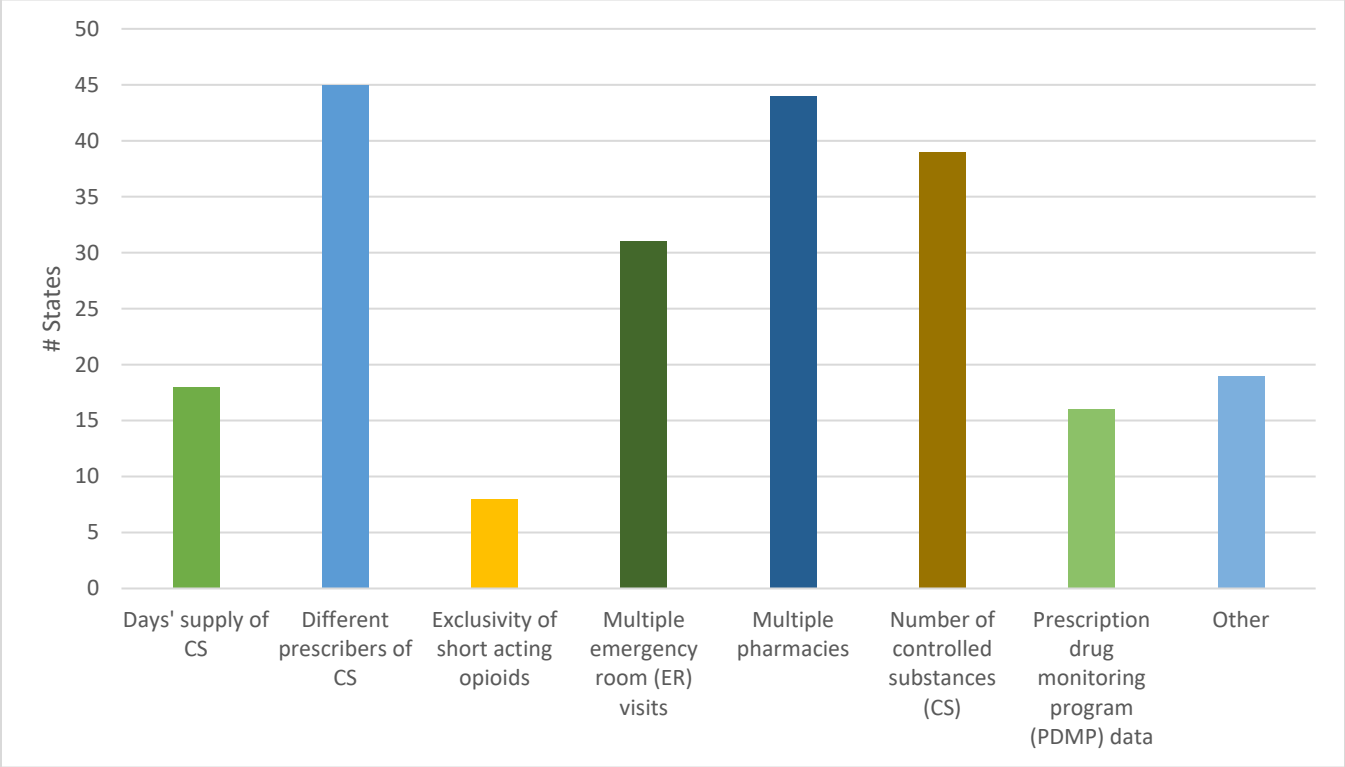

Table 82 - Lock-In Program Candidate Identification Criteria

Response	States	Count	Percentage
Days' supply of CS	Alabama, Arkansas, Connecticut, Delaware, Georgia, Kansas, Louisiana, Maryland, Michigan, Missouri, New York, Oklahoma, Oregon, South Carolina, Utah, Virginia, West Virginia, Wisconsin	18	8.18%
Different prescribers of CS	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	20.45%
Exclusivity of short acting opioids	Arkansas, Delaware, Georgia, Maryland, Michigan, New York, North Dakota, 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 York, North Dakota, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	31	14.09%

Response	States	Count	Percentage
Multiple pharmacies	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	20.00%
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, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	39	17.73%
Prescription drug monitoring program (PDMP) data	Alabama, Alaska, Arkansas, Georgia, Idaho, Indiana, Michigan, Mississippi, Montana, Nevada, North Dakota, Pennsylvania, Tennessee, Utah, Virginia, West Virginia	16	7.27%
Other	Arkansas, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Maine, Mississippi, Montana, Nebraska, Nevada, Ohio, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin	19	8.64%
Total		220	100.00%

If “Other,” please explain.

Table 83 - “Other” Explanations for Lock-In Program Candidate Identification Criteria

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

State	Explanation
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 for greater than or equal to 10 prescriptions per month
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 control substances -When any written prescription is stolen, forged, or altered -When DOM 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 Additional criteria: In accordance with OAC Rule 5160-20-01, when three or more criteria are met the individual is enrolled in CSP -Individual received four or more abuse potential drugs in a 90-day period -Individual has a history of addiction or drug dependence with abuse potential drugs within 365 days -Individual obtained prescriptions for abuse potential drugs from four of more prescribers in a 90-day period -Individual has a poisoning overdose with a benzodiazepine, prescription opioid, or abuse potential drug with 365 days -Individual utilized four or more pharmacies in a 90-day period -Individual received one narcotic analgesic, one benzodiazepine, and one muscle relaxant in a 90-day period -Individual received medication assisted treatment concurrently with an opioid in a 90-day period
Pennsylvania	Other criteria that warrants placement in the Lock-In program includes beneficiaries with an identified pattern of obtaining early refills in addition to one or more of the above listed criteria, have forged or altered prescriptions, using another beneficiaries card or sharing a card with an ineligible individual to obtain medical services.
Tennessee	Enrollees are also subject to Lock-In and Prior Authorization Status if arrested for a drug offense, arrested for TennCare doctor shopping, drug sales or TennCare fraud, Convicted of TennCare drug sales, doctor shopping or fraud, or if they have been found with a diagnosis of poisoning due to an illicit substance.

State	Explanation
Texas	-Treatment that exceeds therapeutic daily Morphine equivalent dose (MED) -Any prescription combination with abuse potential -Member had two of more occurrences of violating a pain contact with the same prescriber or with different prescribers -Member had conviction due to crime related to restricted medications within the past year (theft, distribution, or Medicaid Fraud) -The member required emergency room visit or hospitalization due to a suicide attempt, poisoning or overdose of drugs or medications, or there was a diagnosis of alcohol or drug abuse (including non-therapeutic, recreational, or illegal drug use).
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	Medicaid claims are reviewed for recent emergency department visits and if there is a diagnosis of medication poisoning.

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

i. Prescriber only

Figure 59 - Prescriber Only Restriction Capability

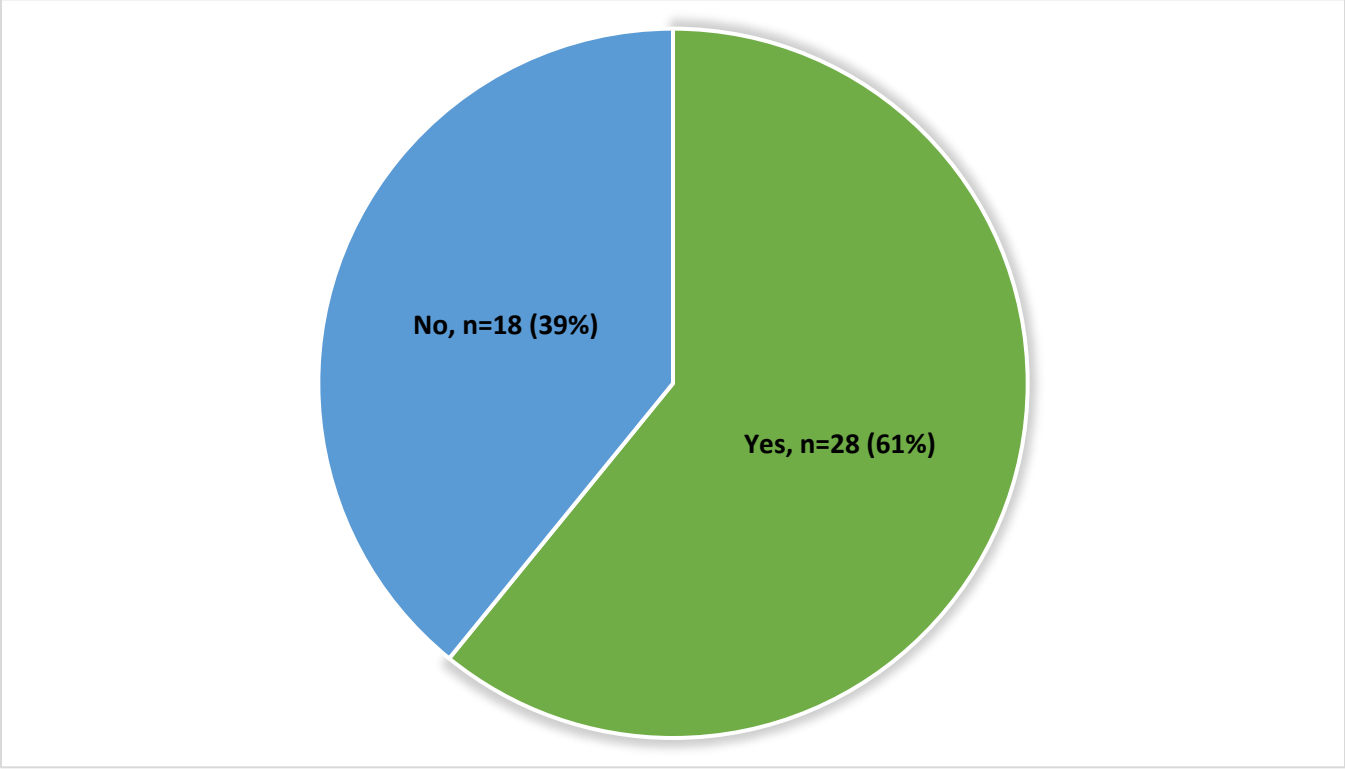

Table 84 - Prescriber Only Restriction Capability

Response	States	Count	Percentage
Yes	Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Texas, Vermont, Virginia, Washington, West Virginia	28	60.87%
No	Alabama, Alaska, Arkansas, District of Columbia, Louisiana, Maryland, Massachusetts, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin, Wyoming	18	39.13%
Total		46	100.00%

ii. Pharmacy only

Figure 60 - Pharmacy Only Restriction Capability

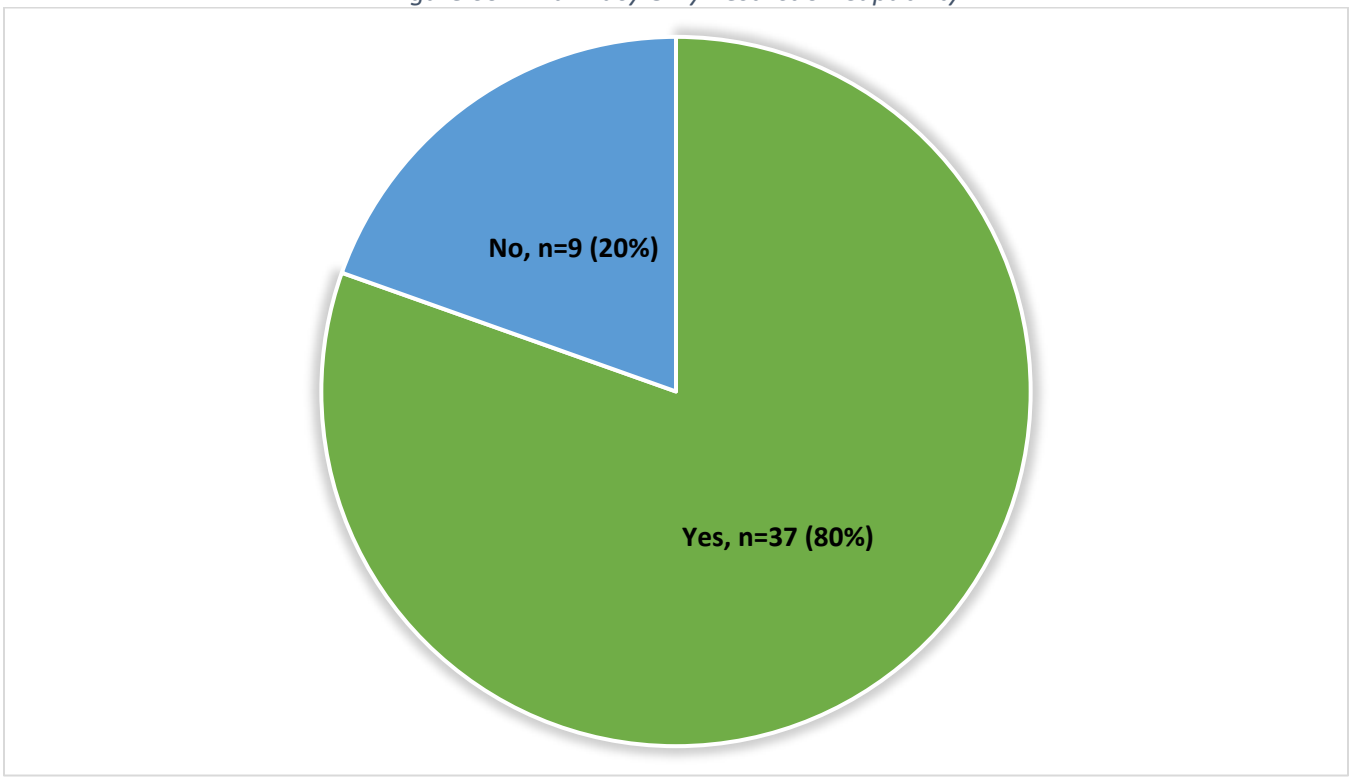

Table 85 - Pharmacy Only Restriction Capability

Response	States	Count	Percentage
Yes	Arkansas, Colorado, 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, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	37	80.43%
No	Alabama, Alaska, Connecticut, Nebraska, North Carolina, Oklahoma, South Carolina, Utah, Wisconsin	9	19.57%
Total		46	100.00%

iii. Prescriber and pharmacy

Figure 61 - Prescriber and Pharmacy Restriction Capability

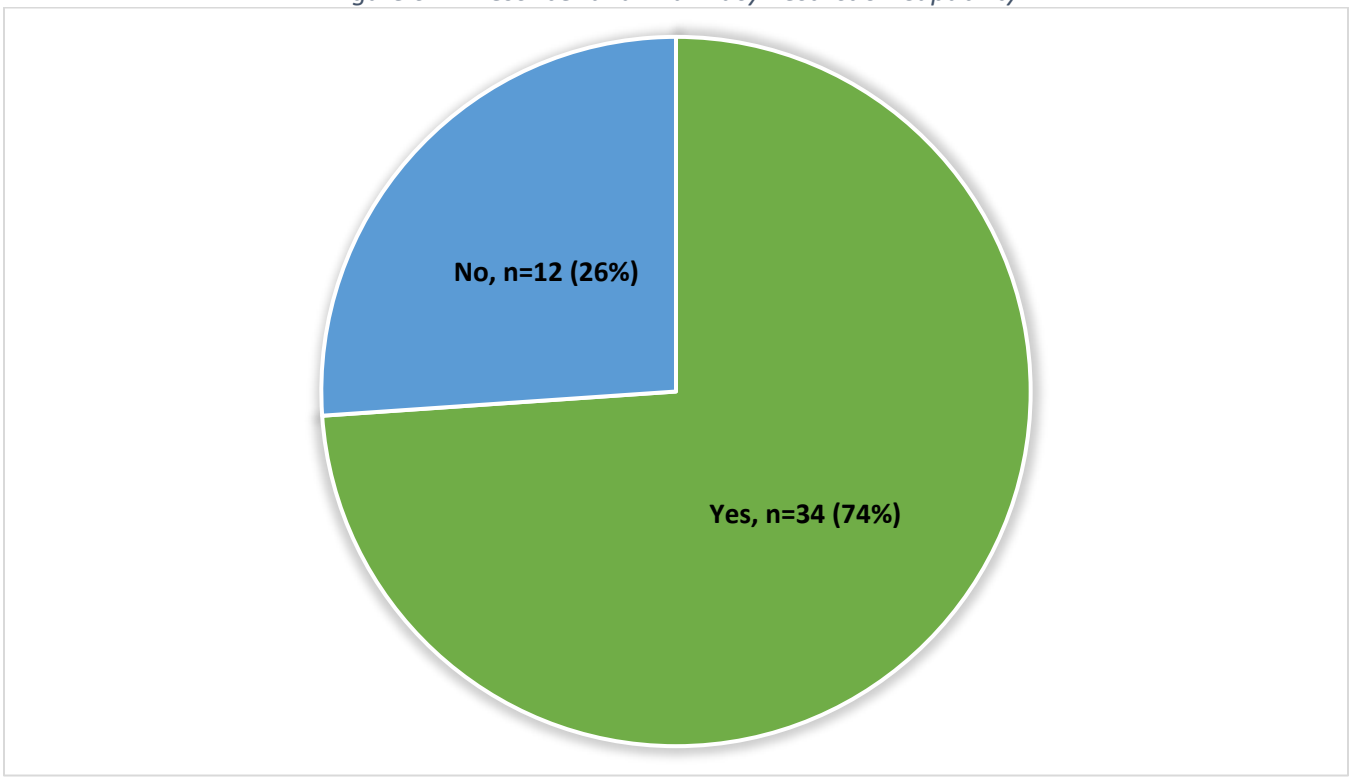

Table 86 - Prescriber and Pharmacy Restriction Capability

Response	States	Count	Percentage
Yes	Alabama, Alaska, Colorado, Delaware, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	34	73.91%
No	Arkansas, Connecticut, District of Columbia, Illinois, Maryland, Massachusetts, New Hampshire, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming	12	26.09%
Total		46	100.00%

c. If "Yes," what is the usual Lock-In time period?

Figure 62 - Lock-In Time Period

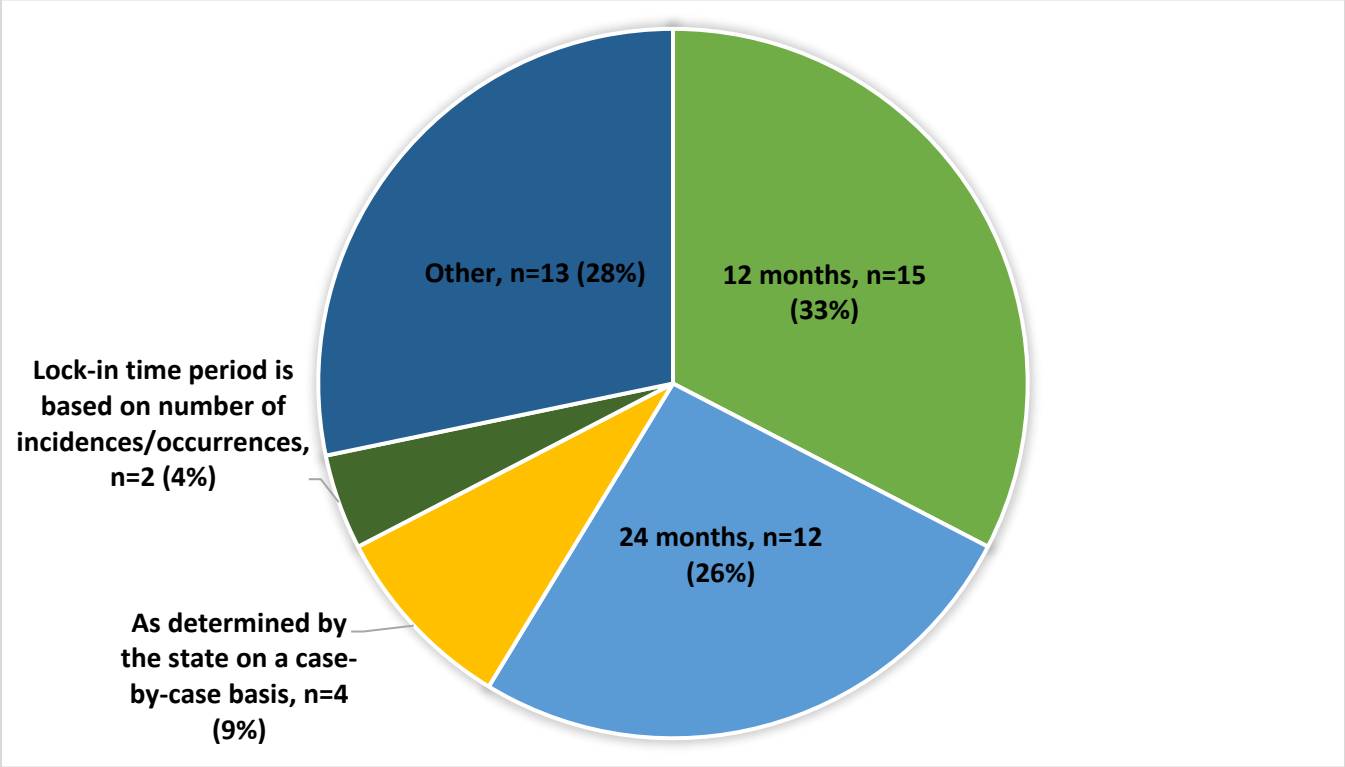

Table 87 - Lock-In Time Period

Response	States	Count	Percentage
12 months	Alabama, Alaska, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Mississippi, Montana, New Hampshire, Oregon, Rhode Island, Utah, Virginia, West Virginia	15	32.61%
24 months	Hawaii, Kansas, Kentucky, Louisiana, Maryland, Michigan, Nebraska, North Carolina, Ohio, South Carolina, Washington, Wisconsin	12	26.09%
As determined by the state on a case-by-case basis	New Jersey, New Mexico, New York, North Dakota	4	8.70%
Lock-in time period is based on number of incidences/occurrences	Missouri, Wyoming	2	4.35%
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 88 - "Other" Explanations for Lock-In Time Period

State	Explanation
Arkansas	Lock-in clients are initially locked in to a pharmacy for one year, and their status is re-reviewed by the lock-in committee annually. The restriction will be removed after demonstration by the client 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 the request of the member.
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 a 36 month renewal.
Nevada	Initially, a recipient remains in lock-in status for period lasting 36 months.
Oklahoma	The initial lock-in time period is 24 months. After the initial 24 months, members in the lock-in program are reviewed at least every 12 months for the continued need of lock-in status.
Pennsylvania	Restrictions are lifted after a period of five years if improvement in use of services is demonstrated. An additional five-year Lock-In period is implemented if the beneficiary continues to abuse medical services including medications.
Tennessee	There is no time limitation. Members are re-reviewed at least yearly, and are not unlocked or removed from PA Status until they qualify according to our Rules. If Arrested for TennCare doctor shopping, drug sales or fraud there is no re-review and they remain until convicted or acquitted, nolled or dismissed, and if convicted, they are subject to Lock-In and PA Status as long as they have the benefit at any time.
Texas	The lock-in time periods are cumulative eligibility time frames of 36-months, 60-months, and lifetime depending on a case by case basis.

State	Explanation
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 63 - Percentage of FFS Population in Lock-In Status Annually

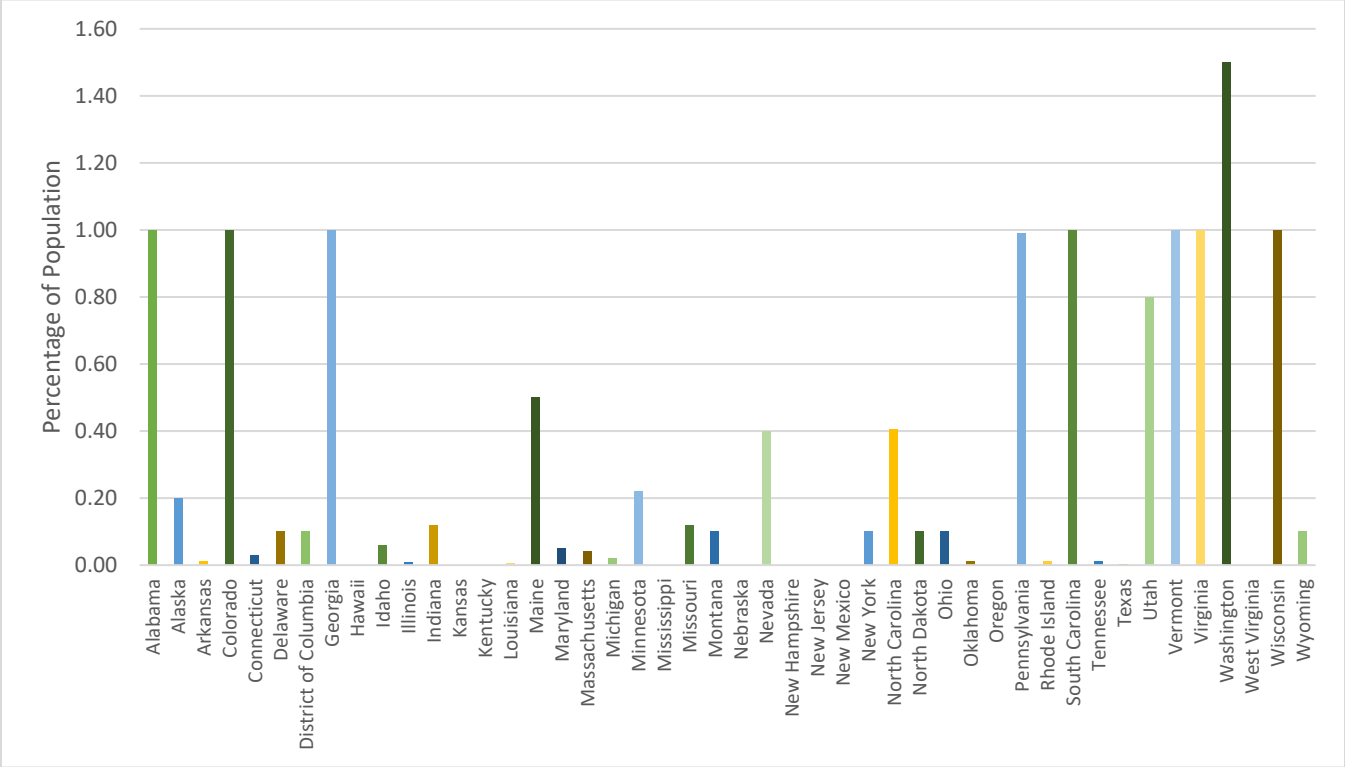

Table 89 - Percentage of FFS Population in Lock-In Status Annually

State	Percent
Alabama	1.0000%
Alaska	0.2000%
Arkansas	0.0100%
Colorado	1.0000%
Connecticut	0.0300%
Delaware	0.1000%
District of Columbia	0.1000%
Georgia	1.0000%
Hawaii	0.0000%
Idaho	0.0600%
Illinois	0.0080%
Indiana	0.1200%
Kansas	0.0000%
Kentucky	0.0000%
Louisiana	0.0040%
Maine	0.5000%
Maryland	0.0500%
Massachusetts	0.0400%
Michigan	0.0200%
Minnesota	0.2200%

State	Percent
Mississippi	0.0000%
Missouri	0.1200%
Montana	0.1000%
Nebraska	0.0000%
Nevada	0.4000%
New Hampshire	0.0000%
New Jersey	0.0000%
New Mexico	0.0000%
New York	0.1000%
North Carolina	0.4040%
North Dakota	0.1000%
Ohio	0.1000%
Oklahoma	0.0100%
Oregon	0.0006%
Pennsylvania	0.9900%
Rhode Island	0.0100%
South Carolina	1.0000%
Tennessee	0.0100%
Texas	0.0020%
Utah	0.8000%
Vermont	1.0000%
Virginia	1.0000%
Washington	1.5000%
West Virginia	0.0000%
Wisconsin	1.0000%
Wyoming	0.1000%

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

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

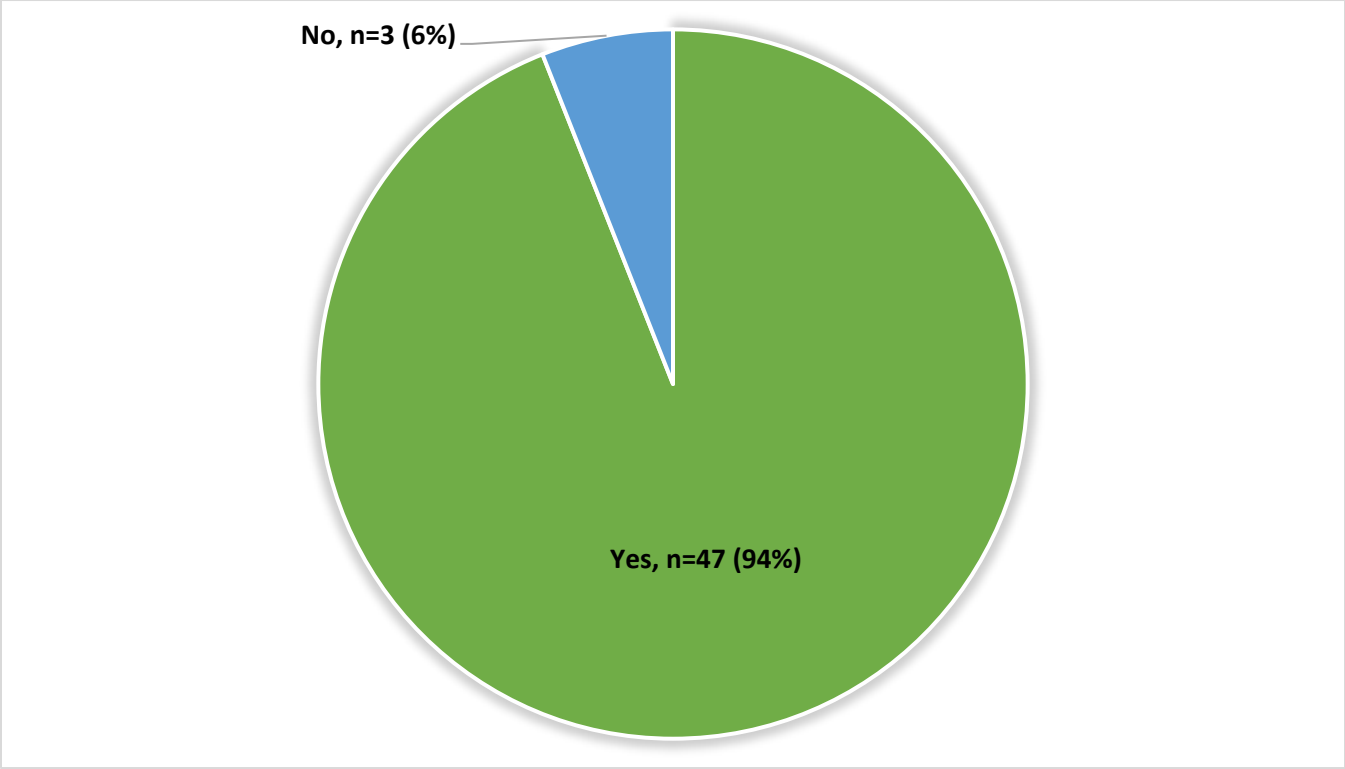

Table 90 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

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

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

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

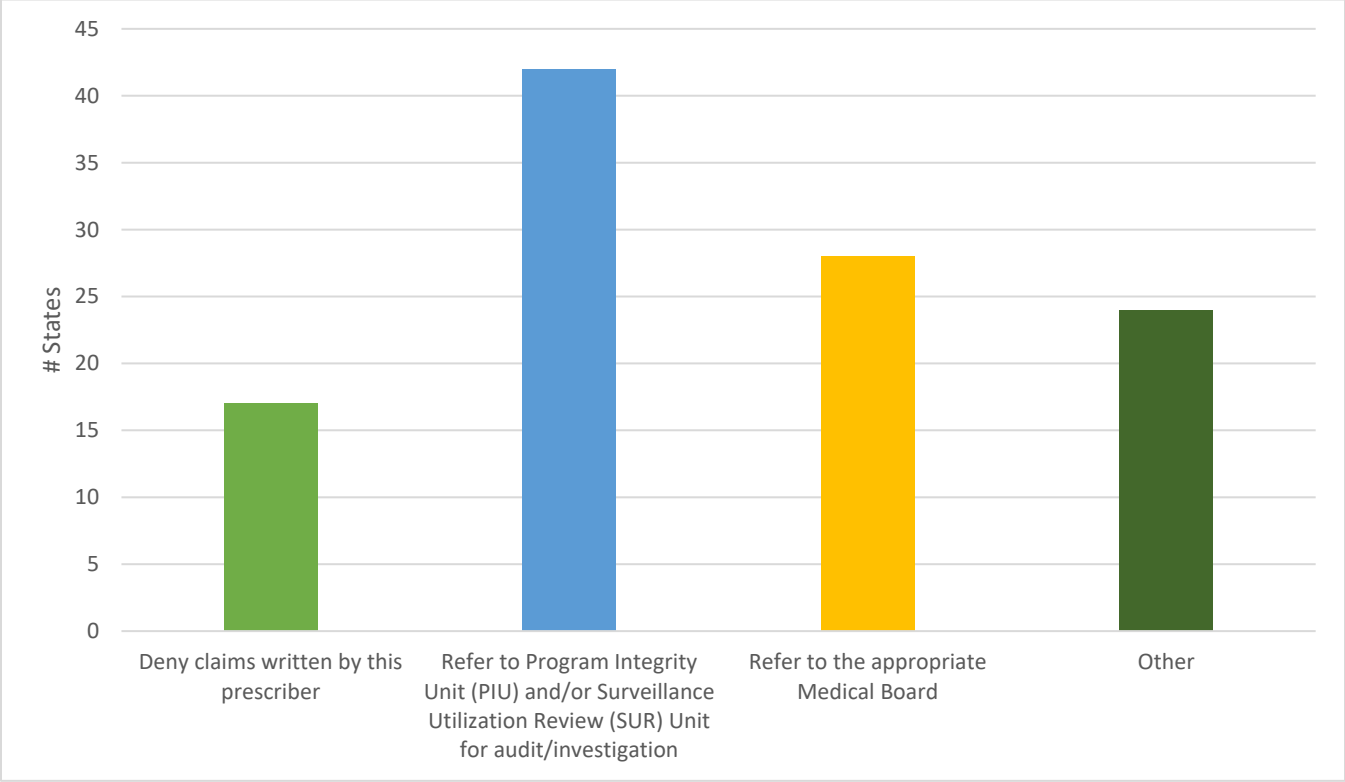

Table 91 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

Response	States	Count	Percentage
Deny claims written by this prescriber	California, Connecticut, Florida, Georgia, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oregon, Texas, Utah, Vermont, West Virginia	17	15.32%
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	42	37.84%
Refer to the appropriate Medical Board	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wyoming	28	25.23%

Response	States	Count	Percentage
Other	Alaska, Arkansas, California, Connecticut, Georgia, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Vermont, Washington, Wisconsin	24	21.62%
Total		111	100.00%

If "Other," please explain.

Table 92 - "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, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving possible fraud or abuse of controlled drugs by prescribers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and, if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and prescribing trends. Current utilization controls include suspended provider lists, provider sanctions for a specified time period, provider sanctions from prescribing select medications, contracted drug list compliance, code 1 restrictions, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.
Connecticut	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
Georgia	Deny claims written by this prescriber, Refer to Program Integrity Unit, Refer to the appropriate Medical Board
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.

State	Explanation
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, as well as 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 or sanctioned and prescription written by these prescribers would then be denied at point-of-sale.
Minnesota	These can be referred to DHS's Office of Inspector General based on hotline tips. There are also direct referrals from anyone including law enforcement, state agencies, and local advocates.
Mississippi	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit.
Nebraska	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
New Hampshire	Prescribers may be suspended or sanctioned and prescriptions written by these prescribers would then be denied at point-of-sale.
New 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 beneficiaries to Medicaid Managed Care.
New Mexico	There is a threshold for refilling controlled prescriptions where 90% of the original days' supply must be used prior to dispensing a refill.
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	The Bureau of Program Integrity (BPI) monitors prescribers for possible fraud, waste and abuse of controlled substances. BPI reviews the prescriber's medical and fiscal records, paid claims and historical allegations or complaints. If it is determined there is a credible allegation of fraud, BPI refers the prescriber to the Office of Attorney General's Medicaid Fraud Control Section and evaluates for possible payment suspension. A referral is sent to the Medical Board for concerns of quality of care following the completion of any criminal investigation. For reviews that are identified as possible abuse only, the BPI process is to notify the provider of the violation of PA MA regulations in a two-step process resulting in possible recovery of restitution of the medications reimbursement amount.

State	Explanation
Tennessee	2 additional possibilities: Provider is referred to the MCO's Medical Director for peer review, since the MCO's hold the provider contracts. 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 (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.
Vermont	Refer to Medicaid Fraud and Residential Abuse Unit
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

If “No,” please explain

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

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

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

Figure 66 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

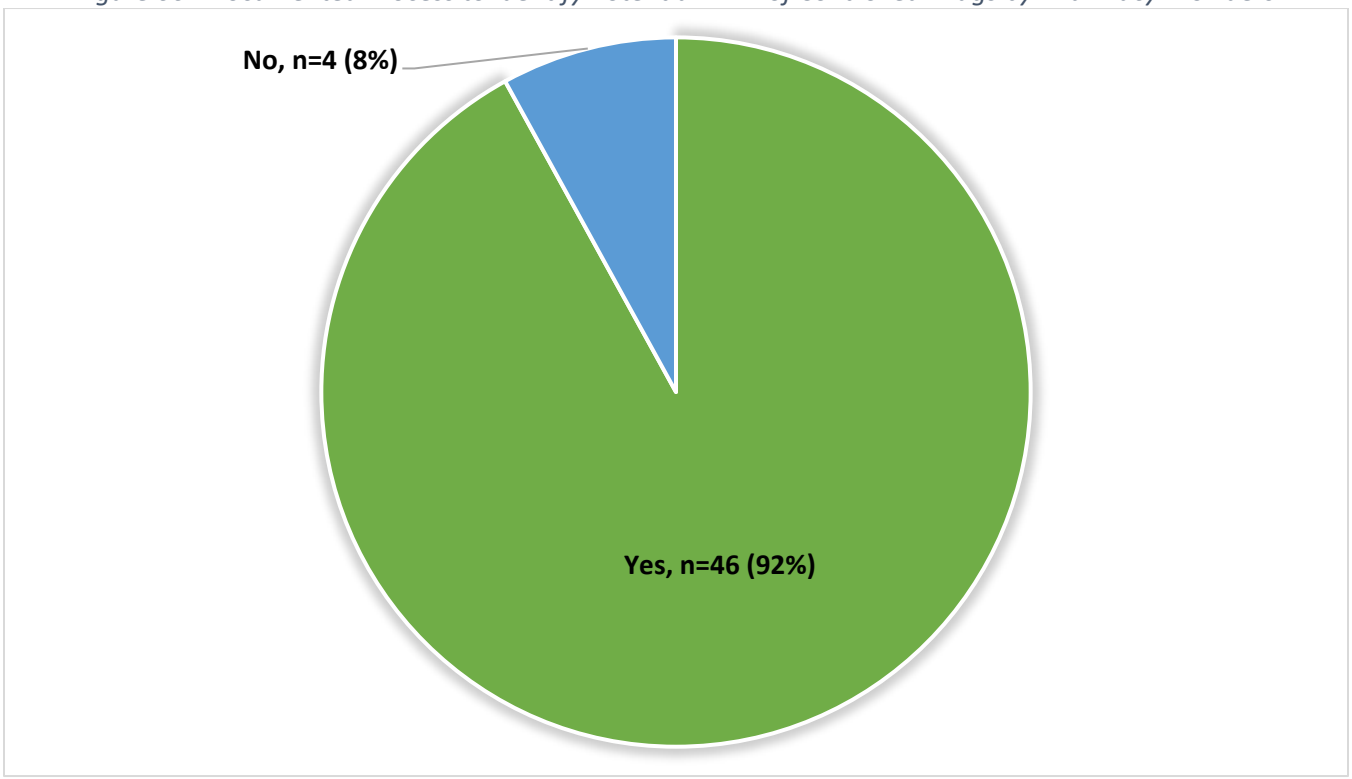

Table 94 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

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

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

Figure 67 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

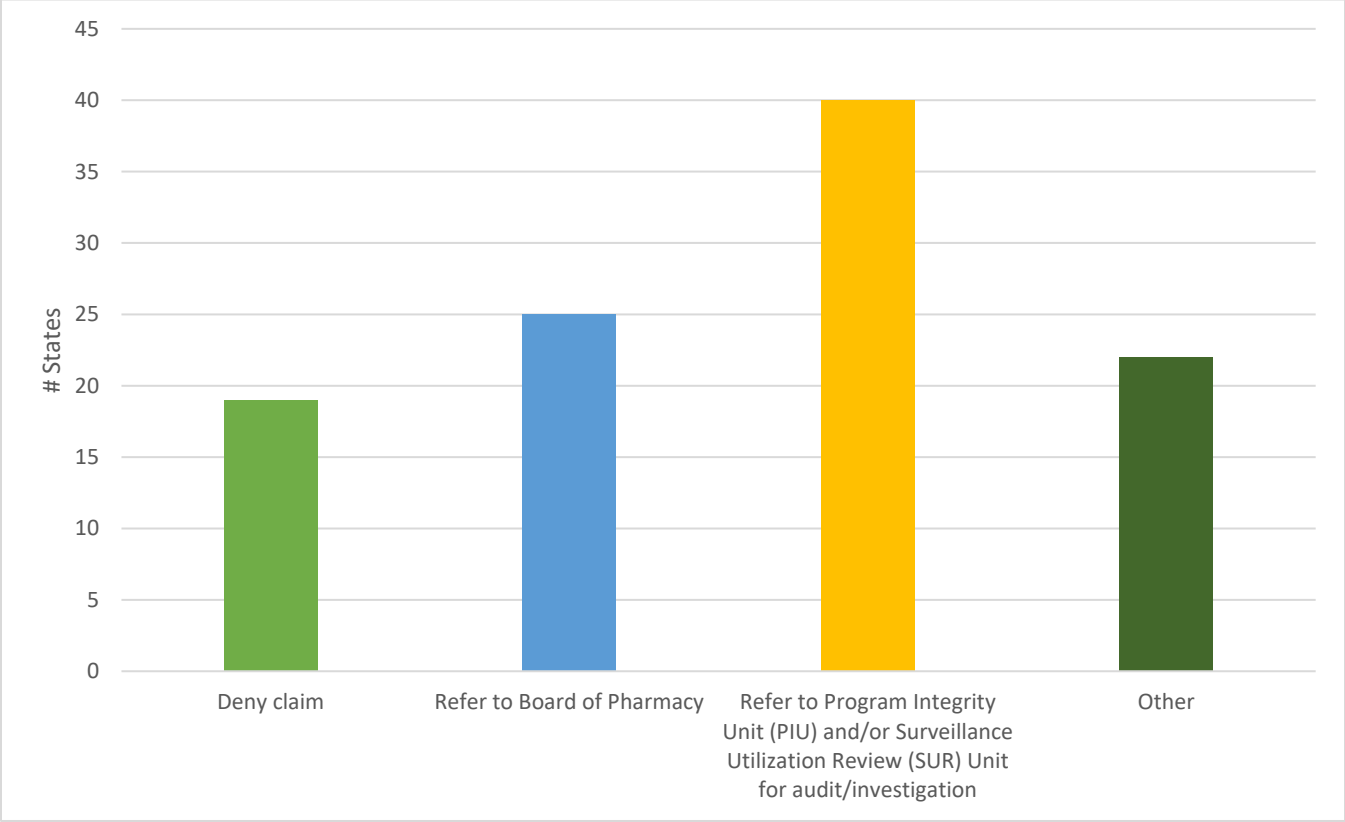

Table 95 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

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, Texas, Vermont, West Virginia	19	17.92%
Refer to Board of Pharmacy	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wyoming	25	23.58%
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	40	37.74%

Response	States	Count	Percentage
Other	Alaska, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, North Carolina, Pennsylvania, Tennessee, Texas, Utah, Washington, Wisconsin	22	20.75%
Total		106	100.00%

If "Other," please explain.

Table 96 - "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, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving potential fraud or abuse of controlled drugs by pharmacy providers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and, if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and pharmacy dispensing trends. Current utilization controls include suspended pharmacy provider lists, restrictions placed upon individual pharmacist licenses by the State Board of Pharmacy, contracted drug list compliance, code 1 restrictions documentation, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.
Connecticut	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
Florida	Claims will deny that exceed the limits set by the Agency (i.e., Morphine Milligram Equivalent (MME), quantity limits, and day supply limits).
Georgia	Pharmacy will be referred for audit; we have an active pharmacy audit program; explanation of benefit surveys to patients regarding pharmacy claims.
Illinois	Refer to Provider Analysis Unit for evaluation. Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
Indiana	Audit recoupment, Prepayment review program
Maryland	A compliance pharmacist performs desktop audits to identify potential fraud, waste and abuse by pharmacies. Additionally, Kepro, through the RxExplorer software, is able to produce various reports to identify the top dispensing pharmacies of controlled substances. 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,

State	Explanation
	claims data reports can be pulled for any opioid claim for a specified timeframe. This information will identify the Participant, Prescriber and Dispensing pharmacy in one report. Review of this information for concerning trends or red flags will identify those participants, prescribers or pharmacies that may require a more focused review. These reports can be submitted to the Department.
Michigan	Pharmacies may be suspended or sanctioned which results in the denial of claims submitted by the pharmacy at point-of-sale.
Minnesota	These can be referred to DHS's Office of Inspector General based on hotline tips. There are also direct referrals from anyone including law enforcement, state agencies, and local advocates.
Mississippi	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit.
Nebraska	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
New Hampshire	Pharmacies may be suspended or sanctioned which results in in the denial of claims submitted by the pharmacy at point-of-sale.
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 beneficiaries 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	BPI refers to the PA Attorney General, Medicaid Fraud Control Section (MFCS).
Tennessee	2 additional possibilities: --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 with our 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 referral 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 merits 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 coordinated on the case. The OIG may also close and refer a case to a board/licensing body.
Utah	Peer to peer outreach.
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

If "No," please explain.

Table 97 - Explanations for Lack of Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

State	Explanation
Idaho	Although we do not have a documented process, questions and potential fraud and abuse are referred to the Board of Pharmacy when deemed appropriate.
Kansas	Many of the FFS beneficiaries reside in the nursing home or are in smaller subgroups of care, which are not seen as likely to have this type of fraud.
Montana	We feel that our edits regarding duplicate fills, early fills, quantity limits, MME limits, etc. and not allowing pharmacists to override these edits prevents pharmacy providers from most forms of fraud or abuse of controlled drugs.
Nevada	Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR Unit for investigation.

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

Figure 68 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers

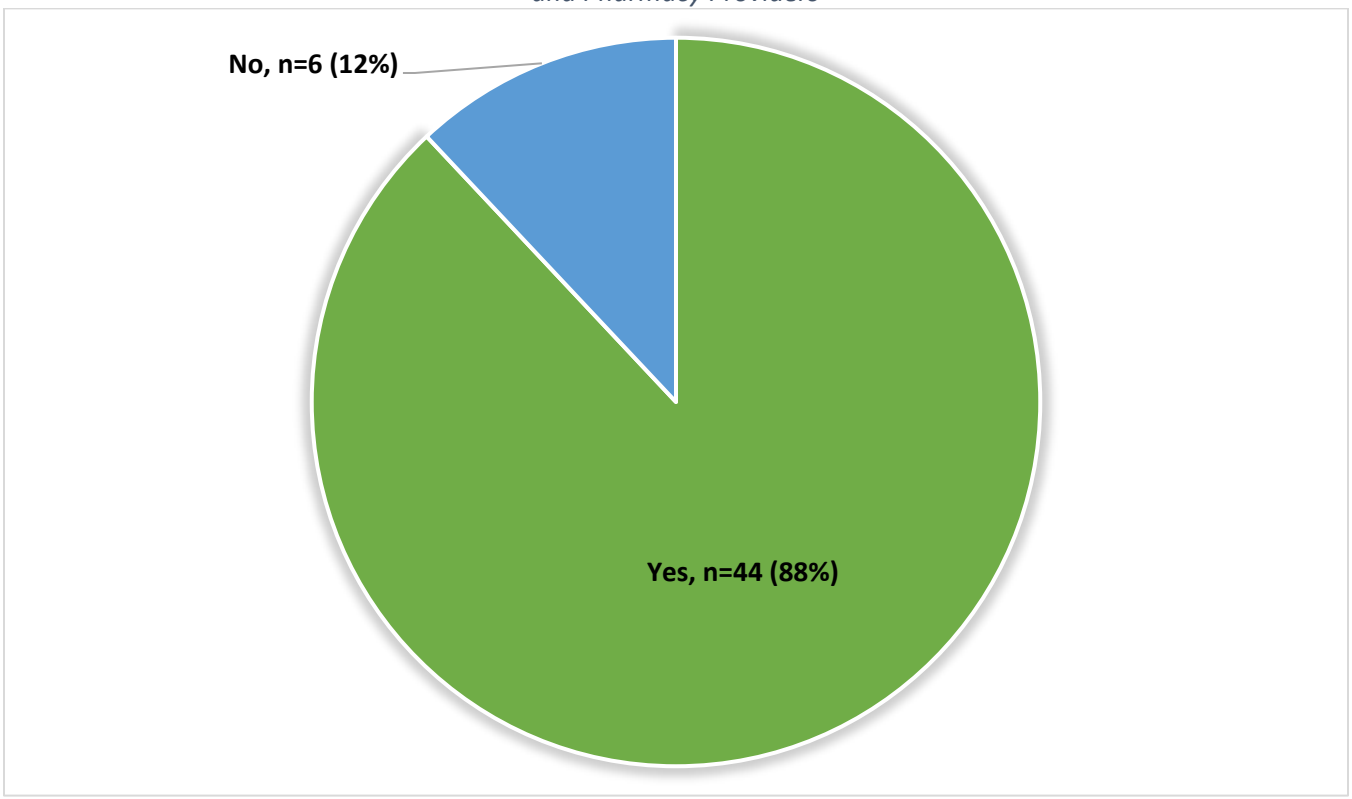

Table 98 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers and Pharmacy Providers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	44	88.00%
No	Delaware, Idaho, Montana, Nevada, Rhode Island, West Virginia	6	12.00%
Total		50	100.00%

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

Table 99 - 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 clients, prescribers, and pharmacy providers. To identify FWA by clients, 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 clients and forwards the information to the local prosecutor. If Arkansas OMIG identifies potential fraud and abuse by clients during random sampling, information gathered is forwarded to the local prosecutor. Also, a fraud hotline and integrity reporting form are available for concerned citizens to bring attention to possible FWA by a client.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of non-controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and, if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.
Colorado	Retrospective DUR analyses and prior authorization are used to identify these issues. Beneficiaries are referred to the Program Integrity Unit that works with individual counties.
Connecticut	A referral form exists to allow the clinical pharmacist to document suspected fraud and abuse of controlled and non-controlled drugs by beneficiaries, pharmacies and prescribers and send the referral form to the DSS program integrity unit for referral or further review.
District of Columbia	Lock-in review process includes non-controlled substances polypharmacy

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, post payment review (retro DUR) for expensive claims is done quarterly and manually and finds no beneficiary, prescriber or pharmacy provider nor potential for FWA. Previously documented processes (when a larger population was in FFS) were utilized; the current population is not large enough.
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 ordering provider to validate need. If fraud or abuse of non-narcotics are suspected Units work together with appropriate unit(s) to implement cost avoidance measures such as quantity limits and product cost reduction, for example worked with Pharmacy Services to adjust quantity limit and obtain lower cost for 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	Although the Maryland Department of Health (MDH) did not have a specific process in place that identifies and/or prevents potential fraud or abuse of non-controlled medications, the MDH Compliance Pharmacist conducts the desktop audits on a regular basis for all medications, COB, TPL claims.
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 cash are subject to review.
Minnesota	Questionable utilization is referred to the SURS program and they determine the action from there.
Mississippi	Medicaid utilizes a maximum daily dose edit to prevent potential fraud or abuse of non-controlled drugs.

State	Explanation
Missouri	Monitoring of trends, change in prescribing and fill habits among providers and pharmacies. Outlier claims and trends are further researched for potential action. MO HealthNet utilizes multiple methods to detect potential FWA.
Nebraska	Early refill limits and daily quantity limits.
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 beneficiaries to Medicaid Managed Care.
New Mexico	A threshold for filling or refilling non-controlled prescriptions exists where 75% of the original days' supply must be used prior to dispensing the medication.
New York	ProDUR editing and RetroDUR case reviews (i.e. therapeutic duplication and over utilization).
North Carolina	We have 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.
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	Beneficiaries are placed in the Lock-In program when a pattern of fraud, waste or abuse of any medication is identified.
South Carolina	Managed by Program Integrity
South Dakota	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. Our ProDUR edits are strong and prevent some problems from occurring on the front end. Where we have found that ProDUR edits like Max Quantity have not worked in the case of topicals, ophthalmics and otics, we have established strong quantity limits to prevent inappropriately large quantities from being paid for. 2. Our PBM vendor looks at inappropriately large quantities of all paid claims on a daily basis, and contacts pharmacy providers the same day or the following day, when it appears that an extra zero has been added to a quantity. This type of problematic claim is stopped prior to the claim ever being paid for by the State. 3. Our Office of Provider Integrity analyzes claims for outliers for controlled substances, non-controlled substances and all other types of claims from pharmacies and from MCO medical claims, in order to combat FWA.
Texas	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)

State	Explanation
	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. Also, a description of MCO's internal procedure for referring possible acts of WAF to MCO's Special Investigative Unit (SIU) and the mandatory reporting of possible acts of WAF by providers or recipients to the HHSC-OIG. Further more, the plan must include a description of the MCOs procedures for educating recipients and providers and training personnel to prevent WAF, as well as, a process flow diagram, or chart outlining the organizational arrangement of the MCO's personnel responsible for investigation and reporting of WAF, and any advertising and marketing materials utilized by the MCOs must be completed and accurately reflect the information about the MCO.
Utah	To prevent fraud, waste, or abuse of non-controlled substances utilization management edits are in place. These edits vary depending on the medication, include but are not limited to: quantity limits, day supply limits, and prior authorization.
Vermont	Quantity limits and early refill limits. Additional replacement fills for lost or stolen medication require a call to the help desk for appropriate documentation (possible PA) and override.
Virginia	Refer to Program Integrity Unit
Washington	A referral would be made to the Lock-In (Patient Review and Coordination) program for assessment.
Wisconsin	Fraud and abuse must be reported regardless if the drug is a controlled or non-controlled drug. Fraud and abuse may be reported by going to the Office of the Inspector General fraud and abuse website or by calling the fraud and abuse hotline.
Wyoming	The DUR Manager may identify patterns of fraud, waste or abuse of non-controlled substances during retrospective analysis. When this occurs, beneficiaries are referred to the program integrity unit for further review.

If “No,” please explain.

Table 100 - 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 closely with the SUR Investigative Team when FWA is suspected or reported. Delaware may develop a more structured plan in the future.
Idaho	Presently we do not have a documented process. We work very closely with Board of Pharmacy with referral going both ways (from them to us or us to them). The Board of Pharmacy also will work with the licensing agency for the prescriber if necessary.
Montana	We only have duplicate fill, early fill, and some quantity limit or criteria POS edits to prevent potential fraud or abuse of non-controlled drugs by beneficiaries. We do not have a retrospective review process.
Nevada	Currently, the program does not include regular reviews to identify pharmacy providers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board

State	Explanation
	and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR Unit for investigation.
Rhode Island	Fee for Service is routinely secondary payer.
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 69 - State has Ability to Query the State's PDMP Database

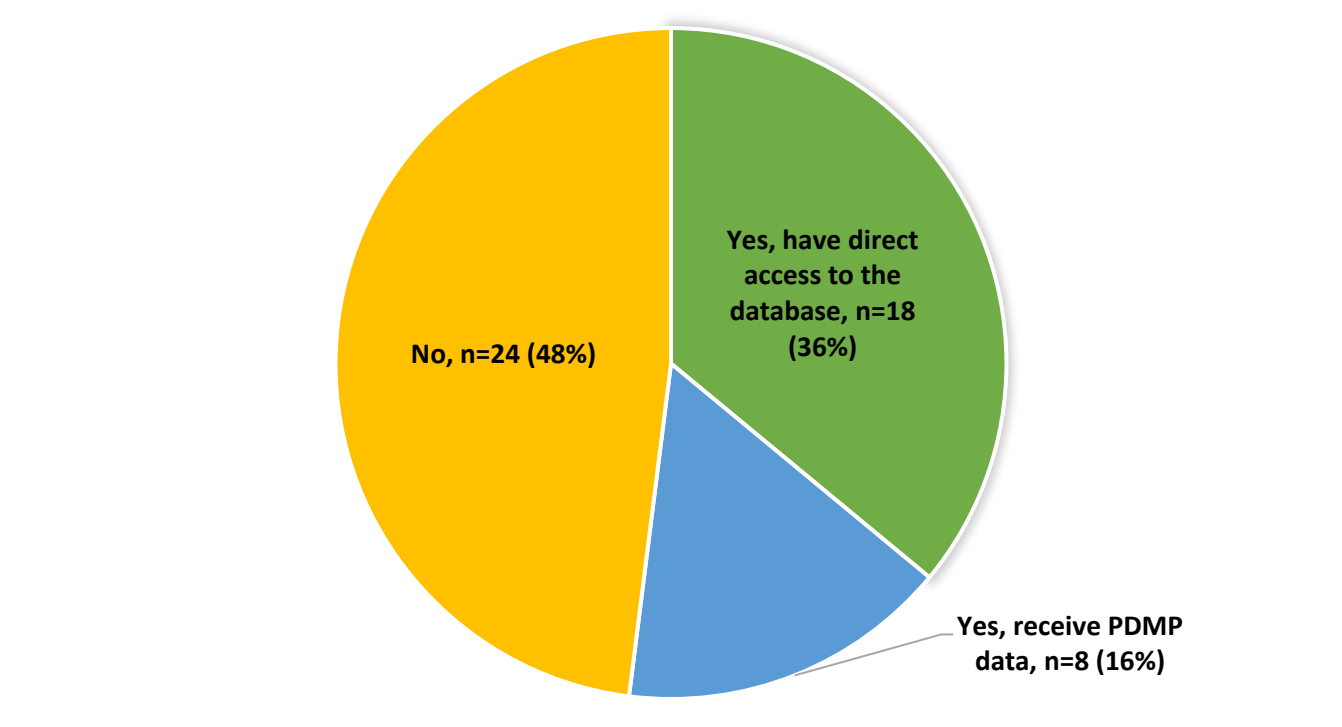

Table 101 - State has Ability to Query the State's PDMP Database

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

If "Yes, receive PDMP data," please indicate how often.

Figure 70 - Frequency of PDMP Data Received

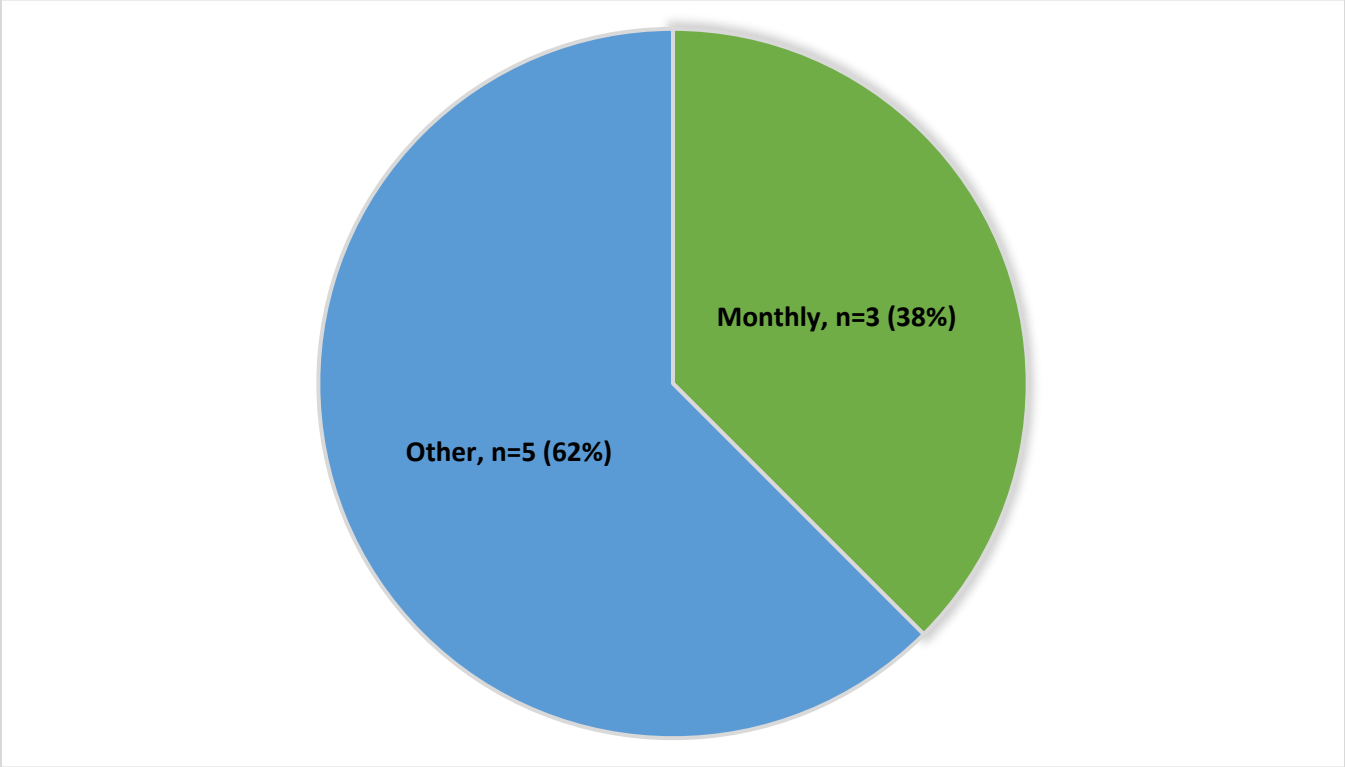

Table 102 - Frequency of PDMP Data Received

Response	States	Count	Percentage
Monthly	Mississippi, Tennessee, Wisconsin	3	37.50%
Other	Kentucky, Nebraska, Oklahoma, Washington, West Virginia	5	62.50%
Total		8	100.00%

If "Other," please explain.

Table 103 - "Other" Explanations of Frequency of PDMP Data Received

State	Explanation
Kentucky	The Medicaid program has direct access to the database and has to ability to query by client, prescriber or dispensing quantity.
Nebraska	ADHOC / As requested.
Oklahoma	On the legal and medical side, OHCA has limited access to the Oklahoma Prescription Monitoring Program (PMP) (PDMP = PMP in Oklahoma) database. The pharmacy side does not have direct access to query or retrieve PMP information due to Oklahoma laws.
Washington	HCA receives PMP transactional data monthly. HCA may also query the database directly for specific patients/clients.
West Virginia	We are allowed to delegate authority to our PA vendor so that they may also review patient's before granting overrides and PAs.

If "Yes, have access to the database," please specify.

Figure 71 - State's Direct Access to the PDMP Database

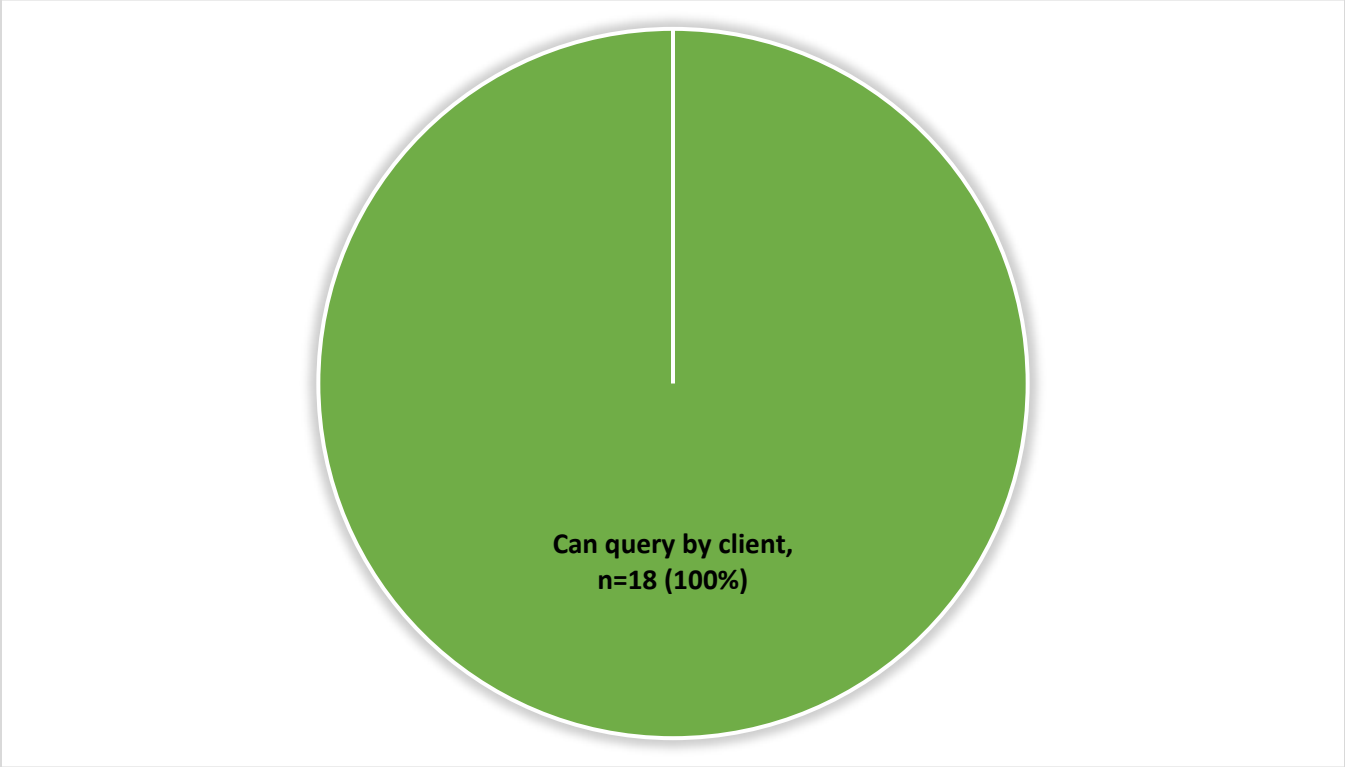

Table 104 - State's Direct Access to the PDMP Database

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

If "No," please explain.

Table 105 - Explanations for No Ability to Query PDMP Database

State	Explanation
California	California state law does not allow access to client data for this type of analysis.
Colorado	The State is prohibited by law from accessing the PDMP.
Delaware	The Medicaid program does not have access to the Delaware PDMP at this time.
District of Columbia	Per DC Department of Health who adminsters the PDMP, the PDMP is not to be used by the Department of Health Care Finance (DC Medicaid) for efforts of its Pharmacy Lock-in Program or other pharmacy related programs.
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.

State	Explanation
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.
Kansas	The State Medicaid agency does not have access, but the Kansas pharmacies/pharmacists have access. FFS and MCO Pharmacy Directors have limited access; mainly can request for individual data.
Maine	According to AG interpretation of the State PDMP data, the State agency is not entitled to non de-identified personal data within the PDMP for management of member benefits.
Maryland	Maryland Medicaid administrative staff cannot query the PDMP database unless the FFS program provides a bonafide formal investigation to obtain the data from the PDMP. Requests must be approved by the Secretary of the Maryland Department of Health (MDH). Information is obtained through the MDH's PDMP. Only healthcare providers with a treatment relationship with the patient can query the PDMP or investigators with authority designated by statute.
Michigan	Medicaid program staff can request Third Party Benefits Reviewer access. This access role allows for submission of a request for PDMP report on a particular client. The report is not autogenerated. Instead, the State Agency responsible for the PDMP has staff review and manually generate the requested report during regular business days/hours only. The turn around time varies on volume of requests and staffing resources at the State Agency responsible for the PDMP.
Minnesota	Administrative use of PDMP is not permitted by law. The exception is the SURS program who can query on an individual recipient to determine if the individual should be placed in the Restricted Program.
Missouri	Missouri does not have a state wide PDMP.
New Hampshire	The Department is prohibited by NH statute from accessing the PDMP.
New Jersey	NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and are in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR are considered unauthorized users since they are not directly delivering healthcare.
New Mexico	Information is obtained on a case-by-case situation by a state Pharmacist's personal access to confirm inappropriate behaviors.
New York	n/a
Oregon	Legislatively prohibited
Rhode Island	State law requires users of the PDMP to have a DEA number.
South Carolina	No
Texas	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
Virginia	Not allowed to access by state law
Wyoming	The Wyoming Department of Health is not allowed access by the Wyoming Board of Pharmacy due to interpretation of the statute creating the PDMP.

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

Table 106 - Explanation for How State Applies Information to Control FWA of Controlled Substances

State	Explanation
Alabama	This information is 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 clients, the PDMP is used to ascertain that controlled substances were used by the client in addition to what has been billed and found on the client's Medicaid profile. Arkansas has a poisoning/overdose edit that requires a prior authorization for opioids and benzodiazepines if the beneficiary has a billed diagnosis of poisoning or overdose on their profile. Some Board approved criteria requires 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.
Georgia	Assessment for Lock-In Program
Idaho	The clinical pharmacy staff at IDHW will access the PDMP in cases where it is brought to their attention that possible fraud and/or abuse is occurring. The PDMP is also used to identify patients who are paying cash (private pay) for controlled substance outside of the Idaho Medicaid benefit. The PDMP gives us a more complete picture of what controlled substances a beneficiary may be receiving.
Illinois	Recipient Analysis Unit staff use the PDMP as a reference only during their review of the 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.
Kentucky	PDMP Data may be obtained as needed and appropriate per regulation. Prescribers must attest to the fact that the PDMP report was reviewed in order for certain PAs to be approved.
Louisiana	PMP queries are pulled on Medicaid recipients only to help determine lock-in recommendations.
Massachusetts	MassHealth checks MassPAT for outlier behavior episodically and develops corrective action.
Mississippi	State's program integrity unit can audit the PDMP to verify suspected fraud and abuse. DUR vendor has access to both claims and cash-pay data to analyze claims for suspected fraud and abuse based on prescriber and pharmacy providers.
Montana	We review utilization between FlexibleRx and the PDMP looking for cash pay on the PDMP that are not found in FlexibleRx.
Nebraska	Information is shared via DUR meetings and Provider Bulletins. The state uses this data to continuously monitor to see if any ProDUR edits or changes are needed.

State	Explanation
Nevada	A query may be used during a Lock-In evaluation of a recipient.
North Carolina	If supporting information is needed for an investigation, the PDMP is available.
North Dakota	A query is ran on clients that request early fill and therapeutic duplication overrides before the override is authorized. These clients may also be referred to program integrity (PI) or lock-in programs 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 fraud, waste, or abuse 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	Only the Medical Director can access on a case by case basis 18 V.S.A. 4284 (b)(1) The Department shall provide only the following persons with access to query the VPMS: (C) the Medical Director of the Department of Vermont Health Access, for the purposes of Medicaid quality assurance, utilization, and federal monitoring requirements with respect to Medicaid recipients for whom a Medicaid claim for a Schedule II, III, or IV controlled substance has been submitted;
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.
Wisconsin	The State of Wisconsin is working on incorporating the PDMP data into DUR activities.

b. If "Yes," does your state also have access to border states' PDMP information?

Figure 72 - Access to Border State PDMP Information

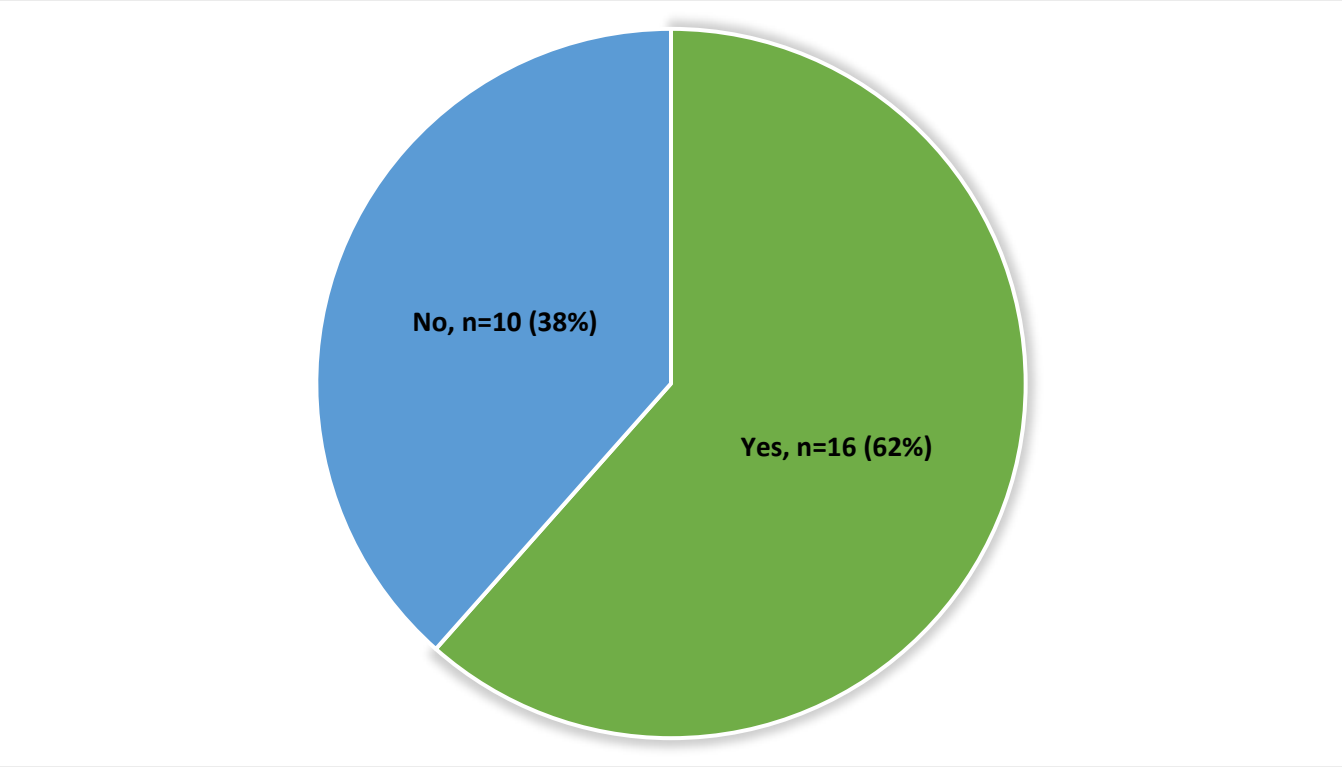

Table 107 - Access to Border State PDMP Information

Response	States	Count	Percentage
Yes	Alaska, Connecticut, Idaho, Illinois, Kentucky, Massachusetts, Mississippi, Montana, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Wisconsin	16	61.54%
No	Alabama, Arkansas, Georgia, Louisiana, Nebraska, Nevada, North Carolina, North Dakota, Washington, West Virginia	10	38.46%
Total		26	100.00%

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

Figure 73 - PDMP Data Integration into POS Edits

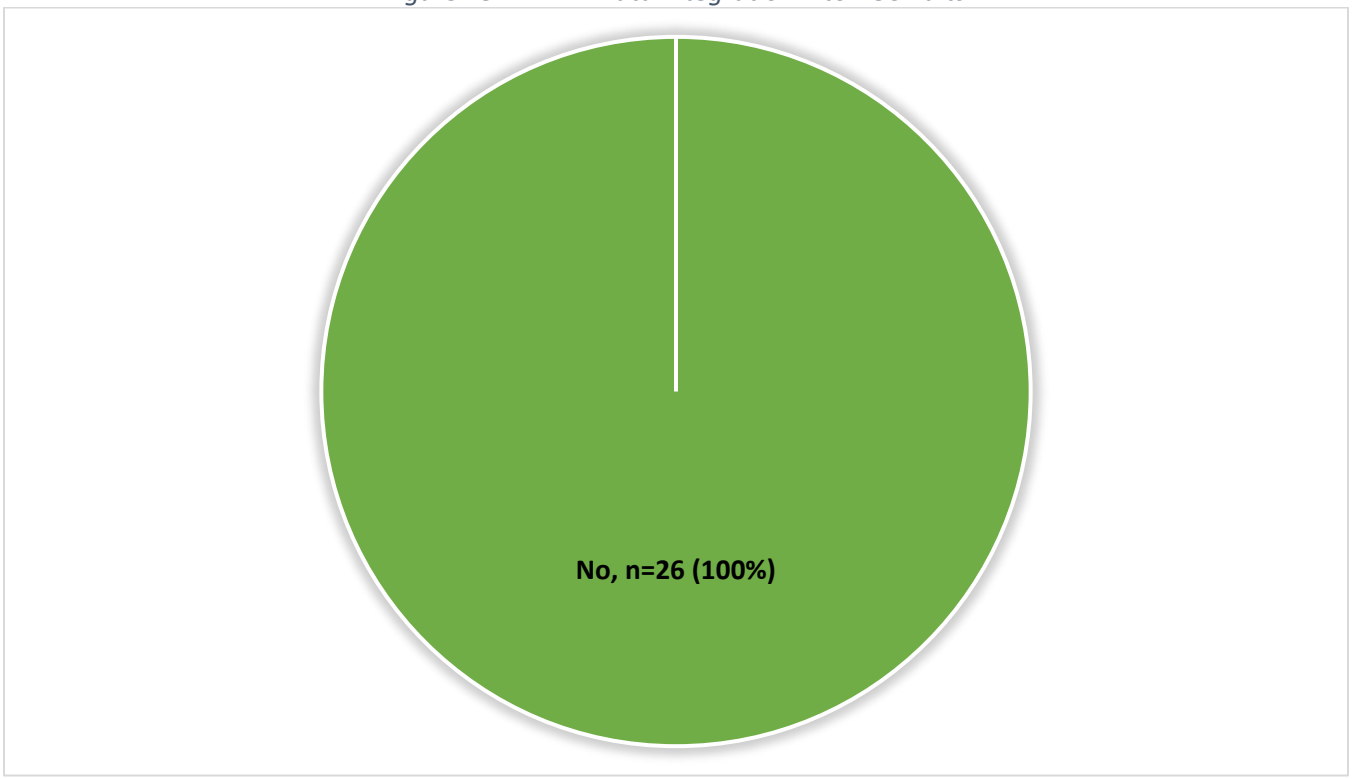

Table 108 - PDMP Data Integration into POS Edits

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

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

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

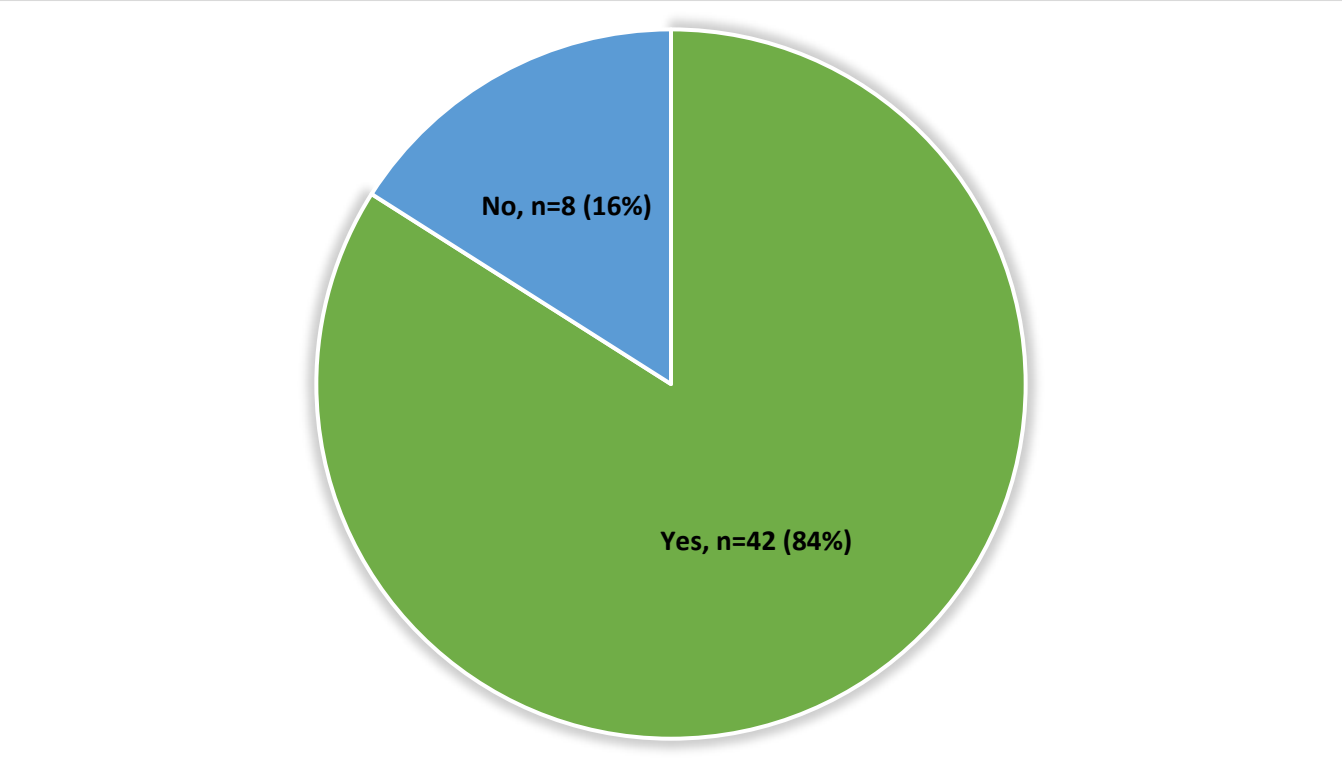

Table 109 - Prescribers Requirement to Access the PDMP Patient History Before Prescribing Controlled Substances

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

If “No,” please explain.

Table 110 - Explanations for Allowing Prescription of Controlled Substances without Accessing PDMP Patient History

State	Explanation
Alabama	Accessing the PDMP is not required for all controlled substances. Prescribers must check for opioids per Board of Medical Examiners (BME) guidelines. The BME requires prescribers to query the PDMP for certain morphine milligram equivalent (MME) levels per day.
Colorado	After the first opioid prescription is written by a prescriber, Colorado legislation requires the prescriber to check the PDMP database before prescribing any additional opioids for the same patient. This second fill requirement to check the PDMP does not apply when a patient: - Is receiving the opioid 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 or has received only a single dose to relieve pain for a single test or procedure. During the reporting period, there were no additional requirements for prescribers to access the PDMP patient history before prescribing controlled substances, though use is highly encouraged.
Idaho	not at this time
Kansas	Effective 10.01.2021, Medicaid prescribers were required to check the state PDMP prior to writing prescriptions for controlled substances, per Medicaid policy guidelines.
Minnesota	It is required in some cases but not across the board. https://www.revisor.mn.gov/statutes/cite/152.126.
Missouri	Missouri does not have a state wide PDMP.
Oregon	Not required
Rhode Island	State laws set prescriber requirements for checking PDMP.

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

Figure 75 - Protocols Involved Checking the PDMP

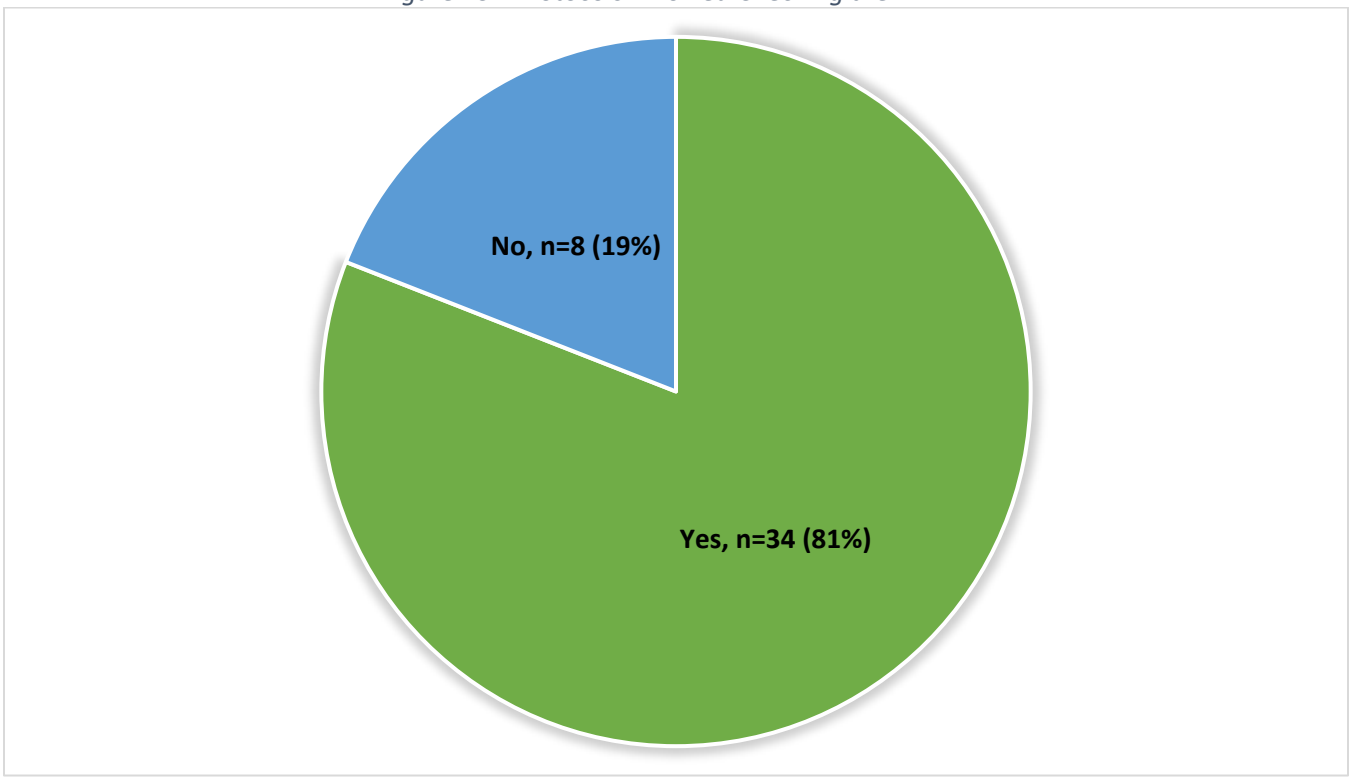

Table 111 - Protocols Involved Checking the PDMP

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	34	80.95%
No	District of Columbia, Hawaii, Massachusetts, Montana, New Mexico, North Dakota, Pennsylvania, South Dakota	8	19.05%
Total		42	100.00%

If "Yes," please explain.

Table 112 - Explanations of Protocols Involved in Checking the PDMP

State	Explanation
Alaska	The state requires that a prescriber or their agent check the PDMP prior to prescribing controlled substances.
Arkansas	Per Act 820 from 2017, a prescriber should check the PDMP every time a schedule II or Schedule III opioid is prescribed and the first time a benzodiazepine is prescribed. The Act does document exceptions to the requirement including palliative care patients, residents in a licensed nursing home, and for those doses actually administered by the prescriber. Act 820 verbiage: (d) (1) Except as required in subdivision (d)(2) of this section, practitioners are encouraged to access or check the information in the controlled substance database created under this subchapter before prescribing, dispensing, or administering medications. (2) (A) A prescriber shall check the information in the program when prescribing: (i) An opioid from Schedule II or Schedule III for every time prescribing the medication to a patient; and (ii) A benzodiazepine medication for the first time prescribing the medication to a patient. (B) A licensing board that licenses practitioners who have the authority to prescribe shall adopt rules requiring the practitioners to check the information in the program as described in subdivision (d)(2)(A) of this section. (C) This subdivision (d)(2) does not apply to: (i) A practitioner administering a controlled substance: (a) Immediately before or during surgery; (b) During recovery from a surgery while in a healthcare facility; (c) In a healthcare facility; or (d) Necessary to treat the patient in an emergency situation at the scene of an emergency, in a licensed ground ambulance or air ambulance, or in the intensive care unit of a licensed hospital; (ii) A practitioner prescribing or administering a controlled substance to: (a) A palliative care or hospice patient; or (b) A resident in a licensed nursing home facility; or (iii) Situations in which the program is not accessible due to technological or electrical failure. (D) The State Board of Health may amend, by rule, the exemptions listed in subdivision (d)(2)(C) of this section upon a recommendation from the Secretary of the Department of Health and a showing that the exemption or lack of exemption is unnecessarily burdensome or has created a hardship. (3) A licensed oncologist shall check the program when prescribing to a patient on an initial malignant episodic diagnosis and every three (3) months following the diagnosis while continuing treatment. In addition to the above, advanced nursing practitioners must recheck the PDMP for patients receiving a benzodiazepine every 6 months. Prescribers must document in the patient record that the PDMP was checked or face possible disciplinary action by their respective boards. The Medical Board and Nursing Board are responsible for ensuring prescribers are following this legislation.

State	Explanation
California	Prescribers are required to check the PDMP under the following circumstances: The first time a patient is prescribed, ordered, administered, or furnished a controlled substance, unless an exemption applies. Within the twenty-four hour period, or the previous business day, before prescribing, ordering, administering, or furnishing a controlled substance, unless an exemption applies. Before subsequently prescribing a controlled substance, if previously exempt. At least once every six months if the controlled substance remains a part of the patient's treatment plan. Exemptions include: 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 In the emergency department of a general acute care hospital, and the controlled substance does not exceed a non-refillable seven-day supply. 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) The patient is receiving hospice care.
Connecticut	Public Act 16-43 became effective 7/1/2016. Whenever a prescribing practitioner prescribes greater than a 72-hour supply of any Schedule V controlled substance for the treatment of any patient, such prescriber, or such prescriber's authorized agent, shall review, not less than annually, the patient's records in the CPMRS. Public Act 15-198 became effective 10/1/2015. MANDATORY USAGE Prior to prescribing greater than a 72-hour supply of any controlled substance (Schedule II - V) to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the CPMRS at https://connecticut.pmpaware.net. Whenever a prescribing practitioner prescribes controlled substances for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent shall review not less than once every 90 days, the patient's records in the CPMRS. If the CPMRS is not operational, prescriber may prescribe greater than a 72-hour supply of a controlled substance to a patient during the time that the system is down as long as the prescriber or prescriber's authorized agent reviews the records of the patient in the CPMRS not more than twenty-four hours after regaining access to the system. Public Act 13-172 was signed into law on June 21, 2013 and became effective immediately. This Public Act will have two direct effects on prescribers in the state of Connecticut. MANDATORY REGISTRATION All prescribers in possession of a Connecticut Controlled Substance Registration issued by the State of Connecticut, Department of Consumer Protection, will be required to register

State	Explanation
	as a user with the Connecticut Prescription Monitoring and Reporting System (CPMRS) at https://connecticut.pmpaware.net.
Delaware	In accordance with the Delaware Prescription Monitoring Act, all DMAP providers must comply with the Delaware Prescription Monitoring Program (PMP) when generating a prescription for a controlled substance for a DMAP member. Providers are required to review the member's patient utilization report. The query should include Delaware and all of the surrounding states; New Jersey, Pennsylvania and Maryland. For medications that are Drug Enforcement Agency (DEA) Schedule III-V, the PMP website should be queried at least every six months. For Schedule II medications that are prescribed for chronic conditions, the PMP website should be queried every three months. DMAP requires providers to document in the patient record all controlled substances that have been prescribed and filled inside and outside of the provider's practice. Providers must document all actions taken to collaborate with other clinicians prescribing controlled substances in the patient record in regards to mutual patients.
Florida	Section 893.055, Florida Statutes and Rules 64K-1.003, Florida Administrative Code, includes guidance related to the PDMP.
Georgia	There are protocols involved in checking the PDMP. Must have an NPI to access PDMP. The State checks the PDMP on an ad-hoc basis for the Lock-In Program as well as MME opioid edits.
Illinois	Illinois state law requires that all prescribers (or their designees) attempt to check the PDMP before writing an initial prescription for a Schedule II opioid; that attempt must be documented in the patient's medical record. Exceptions to this requirement include prescriptions for oncology treatment; palliative care; and acute traumatic medical conditions, when a supply of seven days or less is prescribed in the emergency department.
Indiana	Practitioners may only query a patient PDMP report if they are treating the patient. Law enforcement users may only query a patient if the patient is involved in an active investigation for a drug related offense. The case number must be submitted with each query. Additional details regarding confidentiality, disclosure or release of information, requirements to obtain information and immunity can be found under IC 35-48-7-11.1
Iowa	In CY 2020 Iowa licensing boards adopted rules requiring their respective licensees to utilize the PMP database prior to issuing an opioid prescription. PMP Program rules and protocols are in Iowa Administrative Code 657 Chapter 37 under the purview of the Board of Pharmacy. Providers are not obligated to take any action in response to reports or alerts from the PMP program but should use their professional judgment in determining any subsequent action based on the information. 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.
Kentucky	Kentucky statute and regulation describe frequency and method of querying, and ultimately prescribing controlled substances.

State	Explanation
Louisiana	A prescriber or his delegate shall access and review the patient's record in the PMP prior to initially prescribing any opioid to a patient and shall access the PMP and review the patient's record at least every ninety days if the patient's course of treatment continues for more than ninety days. The requirement established shall not apply in the following instances: (a) The drug is prescribed or administered to a hospice patient or to any other patient who has been diagnosed as terminally ill. (b) The drug is prescribed or administered for the treatment of cancer-related chronic or intractable pain. (c) The drug is ordered or administered to a patient being treated in a hospital. (d) The PMP is inaccessible or not functioning properly due to an internal or external electronic issue. However, the prescriber or his delegate shall check the prescription monitoring program once electronic accessibility has been restored and note the cause for the delay in the patient's chart. (e) No more than a single seven-day supply of the drug is prescribed or administered to a patient.
Maine	Prescribers and dispensers required to check prescription monitoring information 1. Prescribers. On or after January 1, 2017, upon initial prescription of a benzodiazepine or an opioid medication to a person and every 90 days for as long as that prescription is renewed, a prescriber shall check prescription monitoring information for records related to that person.
Maryland	Since 2018 the Maryland PDMP use mandate requires providers to query a patient's dispense history when beginning a new course of opioids or benzodiazepines (as opposed to the wording in the question regarding "controlled substances") in certain clinical situations. Exceptions can be found here: https://health.maryland.gov/pdmp/Pages/pdmp-use-mandate-information.aspx
Michigan	State legislation, professional medical and pharmacy boards, and the Department of Licensing and Regulatory Affairs (LARA) establish protocols for checking Michigan's PDMP called Michigan Automated Prescription System (MAPS) for prescribers of controlled substances.
Mississippi	The following are prescriber requirements for PMP usage from the MS Board of Medical Licensure: Pain management providers/practices must review PMP before a Rx for a controlled substance is authorized. All licensees must review the PMP at each encounter wherein an opioid is prescribed for acute or chronic non-cancer/non-terminal pain. All licensees must review the PMP before prescribing a benzodiazepine for non-cancer/non-terminal, chronic medical or psychiatric conditions. Essentially, if you prescribe a benzodiazepine, you must check the PMP first. All non-pain provider/practice licensees must review the PMP upon initial contact with new patients and every 3 months thereafter before prescribing controlled substances other than opioids. This rule pertains to those patients treated for chronic conditions requiring controlled substances who are seen outside a registered pain practice setting. Documentation evidencing a licensee has run the PMP as required must be recorded in the patient record (Rule 1.3). An example of this would be printing a copy of the PMP and placing it into the record. Simply making a note it was reviewed and was appropriate (or inappropriate) satisfies this requirement as well. PMP review is not required when issuing

State	Explanation
	prescriptions for Lomotil, Lyrica, testosterone, pseudoephedrine, or amphetamines prescribed to pediatric patients under age 16 for the treatment of ADHD. PMP use is not required when treating patients in an inpatient setting. However, PMP review is required before a patient is discharged if the decision is made to issue a prescription for a controlled substance.
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.
Nevada	The Nevada State Board of Pharmacy has specific protocols and guidance to access the PDMP.
New Hampshire	The Office of Professional Licensure and Certification (OPLC) has administrative rules that prescribing providers must follow.
New Jersey	Prescribers are required to access the NJPMP for a patient the first time that they prescribe any Schedule II medication or opioid for acute or chronic pain, any Schedule III, or IV benzodiazepine; every 3 months thereafter, if continuing to prescribe one of the above; and any time the patient appears to be seeking CDS for any purpose other than the treatment of an existing medical condition (misuse, abuse, or diversion).
New York	Practitioners are required to check the PDMP database prior to prescribing any controlled substance listed on schedule II, II or IV.
North Carolina	The NC Stop Act (legislative mandate) 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.
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

State	Explanation
	appropriate law enforcement or professional licensure, certification, or regulatory agency or entity and shall provide prescription information required for an investigation. (D) Drug control may provide data in the prescription monitoring program to the following persons: (1) a practitioner or pharmacist or authorized delegate who requests information and certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide patient; (2) an individual who requests the individual's own prescription monitoring information in accordance with procedures established pursuant to state law; (3) a designated representative of the South Carolina Department of Labor, Licensing and Regulation responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons authorized to prescribe, administer, or dispense controlled substances and who is involved in a bona fide specific investigation involving a designated person; (4) a local, state, or federal law enforcement or prosecutorial official engaged in the administration, investigation, or enforcement of the laws governing licit drugs and who is involved in a bona fide specific drug related investigation involving a designated person; (5) the South Carolina Department of Health and Human Services regarding Medicaid program recipients; (6) a properly convened grand jury pursuant to a subpoena properly issued for the records; (7) personnel of drug control for purposes of administration and enforcement of this article; (8) qualified personnel for the purpose of bona fide research or education; however, data elements that would reasonably identify a specific recipient, prescriber, or dispenser must be deleted or redacted from such information prior to disclosure. Further, release of the information only may be made pursuant to a written agreement between qualified personnel and the department in order to ensure compliance with this subsection. https://scdhec.gov/laws-regulations/prescription-monitoring
Tennessee	Registration: Prescribers who provide direct care and prescribe controlled substances to patients in Tennessee for more than 15 days per year or dispense in practice providing direct care to patients in Tennessee for more than 15 days per year, are required to register with the CSMD. Required Checks: All healthcare practitioners are required to check before prescribing an opioid or benzodiazepine to a human patient as a new episode of treatment and every six (6) months thereafter when said controlled substance remains a part of the treatment. A new episode of treatment means a prescription for a controlled substance that has not been prescribed by that healthcare practitioner within the previous six (6) months. A new episode of treatment includes not only changes to specific drugs, but all changes to the strength of the drug prescribed, and the frequency with which the drug is taken. All healthcare practitioners are also required to check before dispensing an opioid or benzodiazepine as a new episode of treatment to a human patient the first time at that practice site and every six (6) months thereafter when said controlled substance remains a part of the treatment for that human patient after the initial dispensing. However, healthcare practitioners are not required to check, pursuant to statute, if: (a) the controlled substance is prescribed or dispensed for a patient who is currently receiving

State	Explanation
	hospice care; (b) the committee has determined that healthcare practitioners in a particular medical specialty do not have to check as a result of the low potential for abuse by patients receiving treatment in that medical specialty; (c) the quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, three-day treatment period and does not allow a refill; or (d) the controlled substance is prescribed for administration directly to a patient during the course of inpatient or residential treatment in a hospital or nursing home licensed under title 68. Before prescribing or dispensing, a healthcare practitioner is also required to check the database if the healthcare practitioner is aware or reasonably certain that a person is attempting to obtain a Schedule II-V controlled substance, identified by the committee or commissioner as demonstrating a potential for abuse, for fraudulent, illegal, or medically inappropriate purposes, in violation of 53-11-402. An authorized healthcare practitioner's delegate may check the database on behalf of the healthcare practitioner. Licensed veterinarians are not required to check the database before prescribing a controlled substance to a non-human patient. However, changes to the scheduling of certain drugs, most pertinently Gabapentin, may affect the requirements related to the treatment of non-human patients.
Texas	Per House Bill 3285, 86th Legislature, prescribers are required to check the Texas Prescription Monitoring Program (PMP) before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. Practitioners are not required to check the PMP before ordering controlled substances in the inpatient setting. The mandate applies to outpatient and discharge prescriptions. Patients diagnosed with cancer and terminally ill under hospice care are exempt. The prescriber must clearly note in the prescription record that the patient has this diagnosis or that the patient is receiving hospice care. Prescribers are not subject to the mandate if unique circumstances outside of the prescriber's control prohibit access to the PMP after a good faith attempt to comply.
Utah	According to Utah Code 58-37f-304 (2), prescriber must check the PDMP before the first time the prescriber issues a Schedule II or III opioid. The prescriber is also required to periodically check the database or similar records if the prescriber is repeatedly prescribing Schedule II or III opioids to a patient.

State	Explanation
Vermont	Vermont Prescription Monitoring System Rule 6.2 Prescriber-Required Querying of VPMS Prior to prescribing a controlled substance for a patient, Vermont licensed prescribers and/or their delegates must query the VPMS system in the following circumstances: 6.2.1 The first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat pain when such a prescription exceeds 10 pills or the equivalent; 6.2.2 When starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more; 6.2.3 Prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance; 6.2.4 At least annually for patients who are receiving ongoing treatment (treatment without meaningful interruption) with an opioid Schedule II, III, or IV controlled substance; 6.2.5 The first time a provider prescribes a benzodiazepine; 6.2.6 When a patient requests an opioid prescription or a renewal of an existing prescription for pain from an Emergency Department or Urgent Care prescriber if the prescriber intends to write a prescription for an opioid; 6.2.7 With the exception of prescriptions written from an OTP, prior to prescribing buprenorphine or a drug containing buprenorphine to a Vermont patient for the first time and at regular intervals thereafter, and: 6.2.7.1 At regular intervals thereafter, but no less than twice annually; and 6.2.7.2 No fewer than two times annually thereafter; and 6.2.7.3 Prior to writing a replacement prescription. 6.2.8 In the case of an OTP, prior to prescribing buprenorphine, methadone, or a drug containing buprenorphine to a Vermont patient for the first time, and: 6.2.8.1 Annually thereafter; and 6.2.8.2 Any other time that is clinically warranted. 6.2.9 Prior to prescribing buprenorphine or a drug containing buprenorphine that exceeds the dosage threshold approved by the Vermont Medicaid Drug Utilization Review Board and published in its Preferred Drug List [1], prescribers must receive prior approval from

State	Explanation
	the Chief Medical Officer or Medical Director of the Department of Vermont Health Access or designee. 6.3 Prescriber Delegates Prescribers may designate a delegate or delegates to access and query the VPMS system subject to Section 7.2 of this rule. 6.4 Exemptions Patients experiencing chronic pain in the following categories are exempt from the requirements found in this section: Chronic pain associated with cancer or cancer treatment; Palliative care; End-of-life and hospice care; and Patients in skilled and intermediate care nursing facilities.
Virginia	The prescriber checks the PDMP to get the member's last fill date of an opioid prescription, get the member's active daily MME, and to check to see if the member got a prescription filled for a benzodiazepine in the past 30 days.
Washington	Washington Administrative Code (WAC) 182-530-1080 requires prescribers to query the PMP no more than ten days prior to prescribing a controlled substance and pharmacists no more than two days after dispensing a controlled substance. This new WAC goes into effect October 1, 2021. Prescribers and pharmacists are required to document the date and time they reviewed the PMP.
West Virginia	CHAPTER 60A. UNIFORM CONTROLLED SUBSTANCES ACT. ARTICLE 9. CONTROLLED SUBSTANCES MONITORING. 60A-9-5a. Practitioner requirements to access database and conduct annual search of the database; required rulemaking. (a) All practitioners, as that term is defined in 60A-2-201 of this code who prescribe or dispense Schedule II, III, IV or V controlled substances shall register with the West Virginia Controlled Substances Monitoring Program and obtain and maintain online or other electronic access to the program database: Provided, That compliance with the provisions of this subsection must be accomplished within 30 days of the practitioner obtaining a new license: Provided, however, That the Board of Pharmacy may renew a practitioner's license without proof that the practitioner meet the requirements of this subsection. (b) All persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and who are licensed by the Board of Medicine as set forth in 30-3-1 et seq. of this code, the Board of Registered Professional Nurses as set forth in 30-7-1 et seq. of this code, the Board of Dental Examiners as set forth in 30-4-1 et seq. of this code, the Board of Osteopathic Medicine as set forth in 30-14-1 et seq. of this code, the West Virginia Board of Optometrists as set forth in 30-8-1 et seq. of this code, and a pharmacist licensed by the West Virginia Board of Pharmacy as set forth in 30-5-1 et seq. upon initially prescribing or dispensing any Schedule II controlled substance, any opioid or any benzodiazepine to a patient who is not suffering from a terminal illness, and at least annually thereafter should the practitioner or dispenser continue to treat the patient with a controlled substance, shall access the West Virginia Controlled Substances Monitoring Program Database for information regarding specific patients. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program Database for the patient shall be documented in the

State	Explanation
	patient's medical record maintained by a private prescriber or any inpatient facility licensed pursuant to the provisions of chapter 16 of this code. A pain-relieving controlled substance shall be defined as set forth in 30-3A-1 of this code. (c) The various boards mentioned in 60A-9-5(b) of this code shall amend its legislative rules pursuant to the provisions of 29A-3-1 et seq. of this code to effectuate the provisions of this article.
Wisconsin	1. Yes. A practitioner, or a practitioner delegate assisting the practitioner in accordance with the standards of practice for the practitioner's profession, shall review the monitored prescription drug history report about a patient before the practitioner issues a prescription order for the patient unless any of the following conditions are met: a. The patient is receiving hospice care, as defined in s. 50.94 (1) (a). b. The prescription order is for a number of doses that is intended to last the patient 3 days or less and is not subject to refill. c. The monitored prescription drug is lawfully administered to the patient. d. The practitioner is unable to review the patient's monitored prescription drug history reports before issuing a prescription order for the patient due to an emergency. e. The practitioner is unable to review the patient's records under their program because the PDMP system is not operational or due to other technological failure that the practitioner reports to the board. 2. Reviews of reports or other information not provided by the board as part of the program that summarize or analyze PDMP data do not satisfy the requirement to review a monitored prescription drug history report under sub. (1). 3. The board may refer a practitioner that fails to review a monitored prescription drug history report about a patient prior to issuing a prescription order for that patient to the appropriate licensing or regulatory board for discipline.
Wyoming	Effective July 1, 2019, per Wyoming Statute 35-7-1060, the practitioner, or his delegate, is required to check the PDMP before issuing the first controlled substance prescription and every three months thereafter as long as the controlled substance is being prescribed.

b. If "Yes," are providers required to have protocols for responses to information from the PDMP that are contradictory to the direction that the practitioner expects from the client?

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

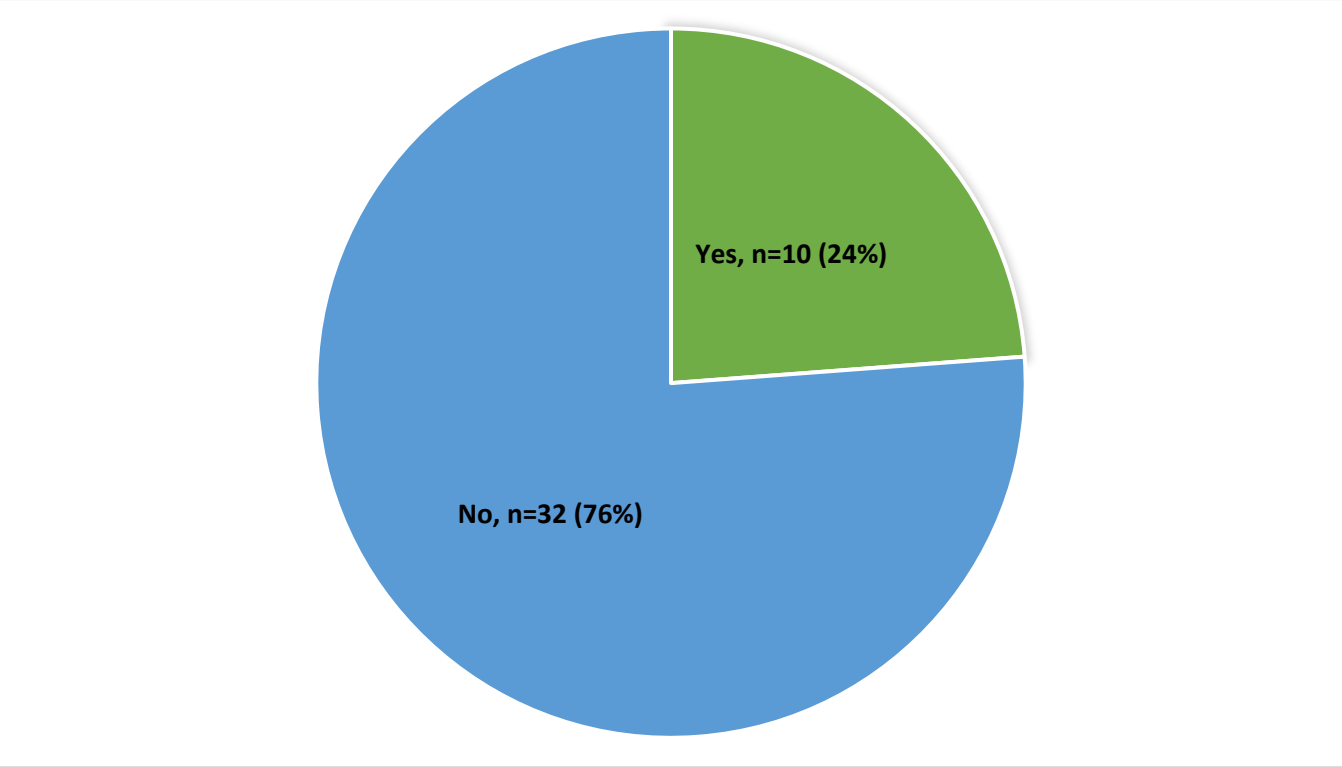

Table 113 - Providers Required to Have Protocols for Responses to Information from PDMP that is Contradictory to Direction Expected from Client

Response	States	Count	Percentage
Yes	Delaware, Georgia, Maine, Maryland, Michigan, Nevada, New York, South Carolina, Virginia, West Virginia	10	23.81%
No	Alaska, Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming	32	76.19%
Total		42	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 77 - State Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

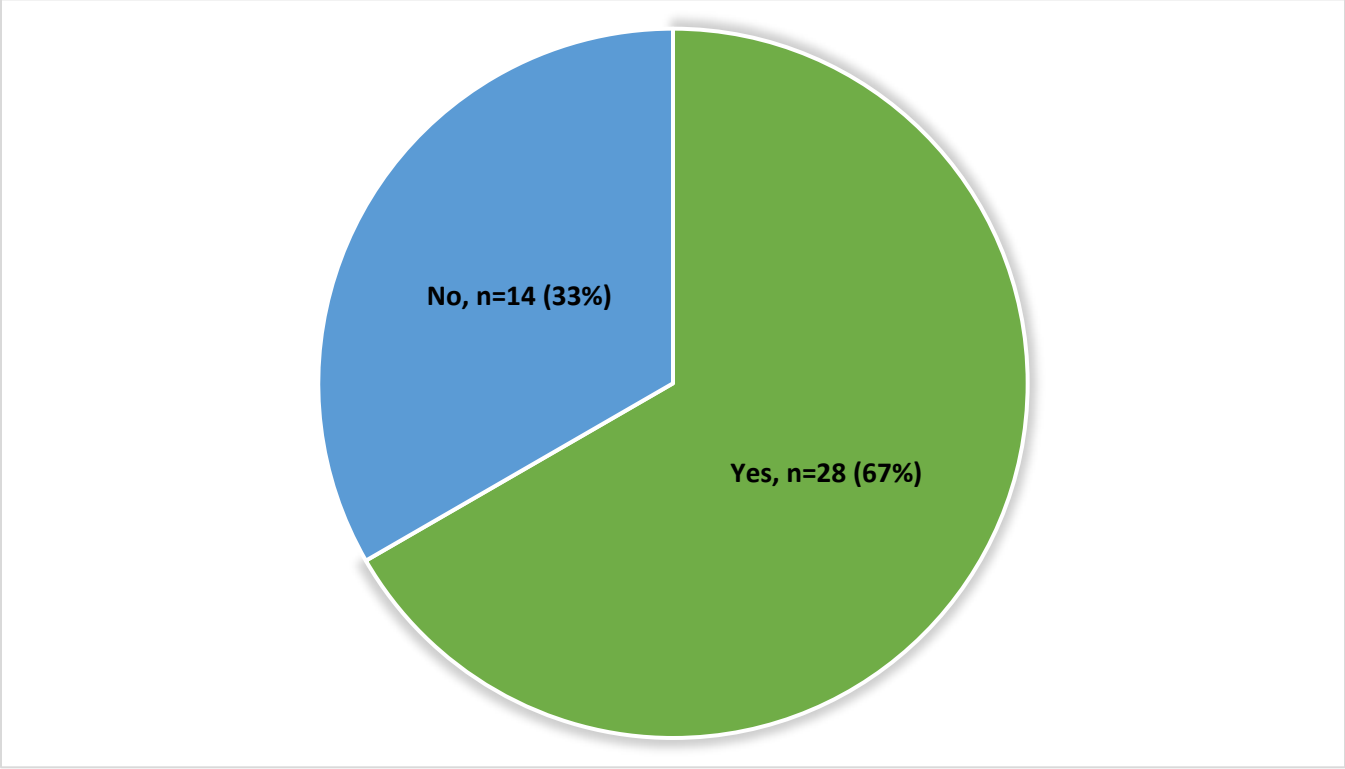

Table 114 - State Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Nebraska, Nevada, New Jersey, New York, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Washington, West Virginia	28	66.67%
No	Indiana, Massachusetts, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Tennessee, Utah, Vermont, Virginia, Wisconsin, Wyoming	14	33.33%
Total		42	100.00%

If "No," please explain.

Table 115 - Explanations for not Requiring Prescribers to Document a Good Faith Effort

State	Explanation
Indiana	The statute provides exceptions to this rule only for the following circumstance: the practitioner has obtained a waiver from the board because they do not have access to the internet at their place of business. Otherwise, the system must be checked before a practitioner can issue a prescription for an opioid or benzodiazepine.

State	Explanation
Massachusetts	The state requires provider to check the PDMP before each prescription of a controlled substance but does not have any additional requirements.
Montana	Currently, state legislation requires providers to access the PDMP patient history before prescribing opioids or benzodiazepines. State law does not address this issue. Montana Medicaid is still working on adding this requirement to rule. Once approved, providers will be required to document the reason they were unable to check the PDMP and provide this documentation upon request.
New Hampshire	Oversight and monitoring is performed by the PDMP.
New Mexico	PDMP checks are required and monitored by the state Medical Board.
North Carolina	The prior approval criteria for opioid analgesics requires the prescribing clinician to check the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System. (https://northcarolina.pmpaware.net/login).
North Dakota	Not applicable as all ND providers can access the ND 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.
Tennessee	The law requires that each person or entity operating a practice site where a controlled substance is prescribed or dispensed to a human patient shall provide for electronic access to the database at all times when a healthcare practitioner provides healthcare services to a human patient potentially receiving a controlled substance. A violation of this requirement is punishable by a civil penalty not to exceed one hundred dollars per day assessed against the person or entity operating the practice site; the penalty shall only be imposed when there is a continued pattern or practice of not providing electronic access to the database.
Utah	According to Utah Code 58-37f-340(2) prescriber is not required to check PDMP in these situations 1) in an emergency situation 2) when the CSD is not working or 3) when the internet is not working. However, the prescriber is not required to document reason why the prescriber was not able to conduct the check.
Vermont	There is no requirement, but it is recommended that prescribers document any issues they encounter in performing a VPMS query. In addition, some practices require checking a box about the VPMS query on their EHR prior to prescribing.
Virginia	The long and short acting clinical criteria for opioids states the provider must check the PMP to gather the member's active daily MME, check for last fill date of an opioid prescription, and to check if the member has had a benzodiazepine prescription filled in the past 30 days.
Wisconsin	There is no statute in place requiring provider to perform this action.
Wyoming	This is not included in state statute, rule or policy.

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

Figure 78 - State Requires Provider, on Request, to Submit Documentation

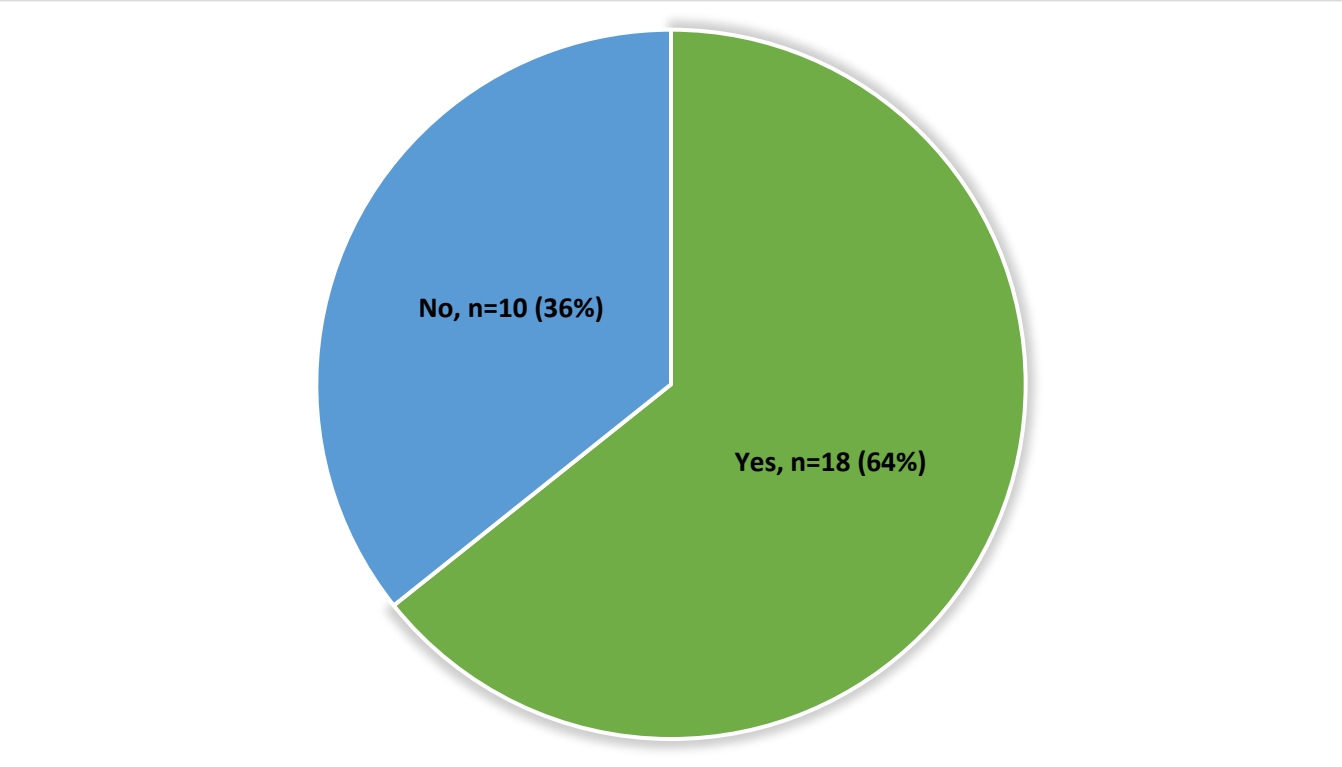

Table 116 - State Requires Provider, on Request, to Submit Documentation

Response	States	Count	Percentage
Yes	Alaska, Connecticut, District of Columbia, Georgia, Iowa, Kentucky, Maine, Maryland, Michigan, Mississippi, Nebraska, Nevada, New York, Ohio, Pennsylvania, South Carolina, South Dakota, Washington	18	64.29%
No	Arkansas, California, Delaware, Florida, Hawaii, Illinois, Louisiana, New Jersey, Texas, West Virginia	10	35.71%
Total		28	100.00%

If "No," please explain.

Table 117 - 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.
California	The prescriber must document the reason for not consulting the PDMP in the patient's medical record.
Delaware	The Medicaid program does not require submission of the documentation.

State	Explanation
Florida	A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system shall document the reason he or she did not consult the system in the patient's medical record or prescription record and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to the patient.
Hawaii	If the PDMP is not functional, entry is not required. It is in the best interest of the prescriber to document but it is not required.
Illinois	It is up to the prescribers and the health care organizations to develop internal policies to ensure compliance with the documentation portion set forth in Public Act 100-0564.
Louisiana	If the PMP is inaccessible or not functioning properly due to an internal or external electronic issue. However, the prescriber or his delegate shall check the prescription monitoring program once electronic accessibility has been restored and note the cause for the delay in the patient's chart.
New Jersey	NJPMP statutes and regulations do not explicitly state that providers are required to submit documentation regarding a good faith effort to access the NJPMP. It would be expected, however, if necessary for a disciplinary hearing that the provider would be able to provide this information to the respective state Board as explanatory proof as to why the PMP was not accessed as required by law at the time of prescribing.
Texas	Texas law requires the prescriber to make and document a good faith attempt to comply but is unable to access the PMP because of circumstances outside the control of the prescriber. HHSC does not require provider's document submission.
West Virginia	For SEMPP (which would be for those using >= 50 MME over the last 90 days, we require that the prescriber report via the form to have reviewed the PDMP. If they state that they have not, we only do a short term approval until they attest that they have. We, at this time, do not ask for a reason they have not checked. However, that is very rare. In 2021 so far, the % of prescribers reporting to have checked is 98- 99% each month. Some do submit documentation, but at this time, we do not require they print and fax.

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

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

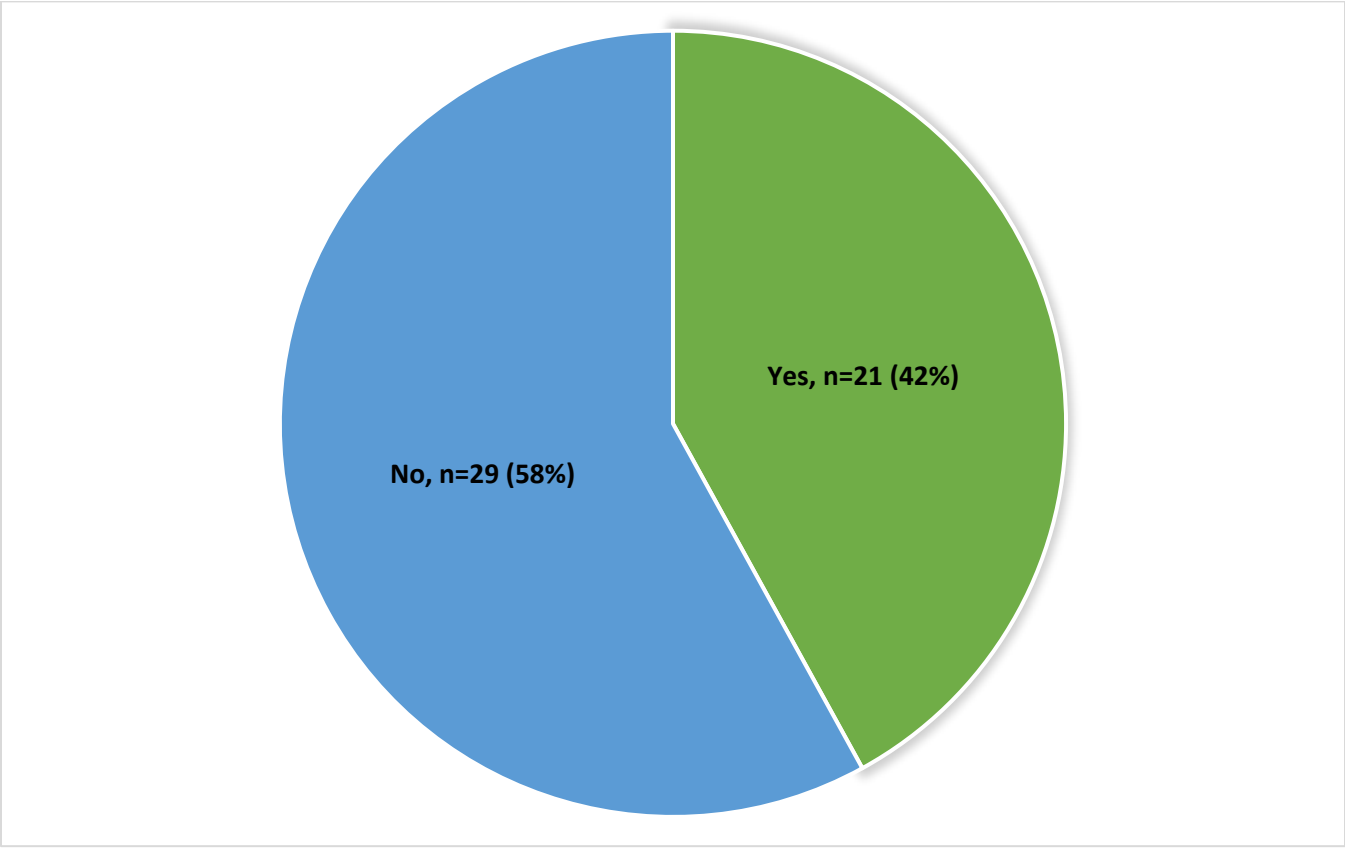

Table 118 - State Requires Pharmacist to Check PDMP Prior to Dispensing

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

If “No,” please explain.

Table 119 - Explanations for not Requiring Pharmacists to Check PDMP Prior to Dispensing

State	Explanation
Alabama	Pharmacists are not required to check.
Alaska	The state recommends the pharmacist check the PDMP prior to dispensing, but is not required under current law.
Arkansas	Pharmacists have access to the PDMP through the Department of Health. Currently, there is no legislation, Board of Pharmacy requirements, or Medicaid policies/procedures that require pharmacists to check the PDMP prior to dispensing.
California	The mandatory PDMP consultation requirement does not apply to dispensing pharmacists.
Colorado	State statute does not require pharmacists to check the PDMP prior to dispensing, although this practice is highly encouraged and may be required by specific pharmacist employers in the State.
Connecticut	Prior to any dispensation, a pharmacist may choose to review a patients PDMP and make a professional decision based on that information to not dispense at all, without reason if decided. Typically, the pharmacist will first discuss the prescription(s) in question with the patient's prescriber and/or the patient before any other decision is made by the pharmacist to dispense.
Hawaii	Although not required to check, pharmacists are required to submit information.
Idaho	not at this time
Illinois	The state does not require pharmacists to check the PDMP prior to dispensing. If PDMP access is available, it is good clinical practice to evaluate PDMP data prior to dispensing the prescription.
Indiana	The Board of Pharmacy does not currently require review of the PDMP prior to dispensing a controlled substance. The PDMP is integrated into several pharmacy point-of-sale systems within the state to permit easier review.
Iowa	FFS follows the Board of Pharmacy requirements relative to pharmacists checking the PMP prior to "dispensing" which states "A pharmacist may access a patient's or client's prescription history report; proactive alerts or system user notes, such as peer-to-peer communication; and NarxCare reports rule 657 - 37.16(2) . A pharmacist shall review a patient's or client's prescription history report prior to dispensing a Schedule V controlled substance without a prescription pursuant to rule 657-10.33.
Kansas	This is optional at this time.
Kentucky	Although pharmacists have the authority to query KASPER, and several large chains have automated mechanisms that auto-query all dispenses, there isn't a legal requirement to do so.
Louisiana	Pharmacists are required to enter dispensed prescriptions for controlled substances into the PMP database, including information about the patient, the prescribing doctor, the medication, and the dispensing pharmacy.
Minnesota	It is not required.
Missouri	Missouri does not have a state wide PDMP.
Montana	Only prescribers are required to access the PDMP prior to prescribing. Neither state law nor Medicaid rule address pharmacists checking the PDMP prior to dispensing.
Nevada	No, Nevada does not require currently.
Oklahoma	Oklahoma law does not require pharmacists to check the PDMP prior to dispensing. 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.

State	Explanation
Oregon	Not required
Pennsylvania	Pharmacists are not required to check the PDMP prior to dispensing.
Rhode Island	. When required, the healthcare provider who dispenses medication pursuant to the waiver authorized by 1.4.1 of this Part shall be responsible for ensuring that all necessary data is entered into the Department's Prescription Monitoring Program (PMP) database in accordance with the Rules and Regulations for the Prescription Drug Monitoring Program (Part 20-20-3 of this Title).
South Carolina	SECTION 44-53-1680. Violations and penalties. (E) Nothing in this chapter requires a pharmacist to obtain information about a patient from the prescription monitoring program. A practitioner or authorized delegate of a practitioner who knowingly fails to review a patient's controlled substance prescription history, as maintained in the prescription monitoring program, or a practitioner who knowingly fails to consult with his authorized delegate regarding a patient's controlled substance prescription history before issuing a prescription for a Schedule II controlled substance, as required by this article, must be reported to his respective board for disciplinary action. https://scdhec.gov/laws-regulations/prescription-monitoring
South Dakota	This is not yet a state requirement.
Utah	No State Code requiring this.
Virginia	The provider prescribing the opioid must check the PDMP.
Washington	HCA allows the pharmacist to check the PMP up to two days after dispensing a controlled substance. This is to account for the impact to workflow.
Wisconsin	There is no statute in place requiring pharmacists to check the PDMP before dispensing.
Wyoming	Pharmacists were not included in the state statute creating requirements to check the PDMP.

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

Figure 80 - State Has Protocols Involved in Checking PDMP

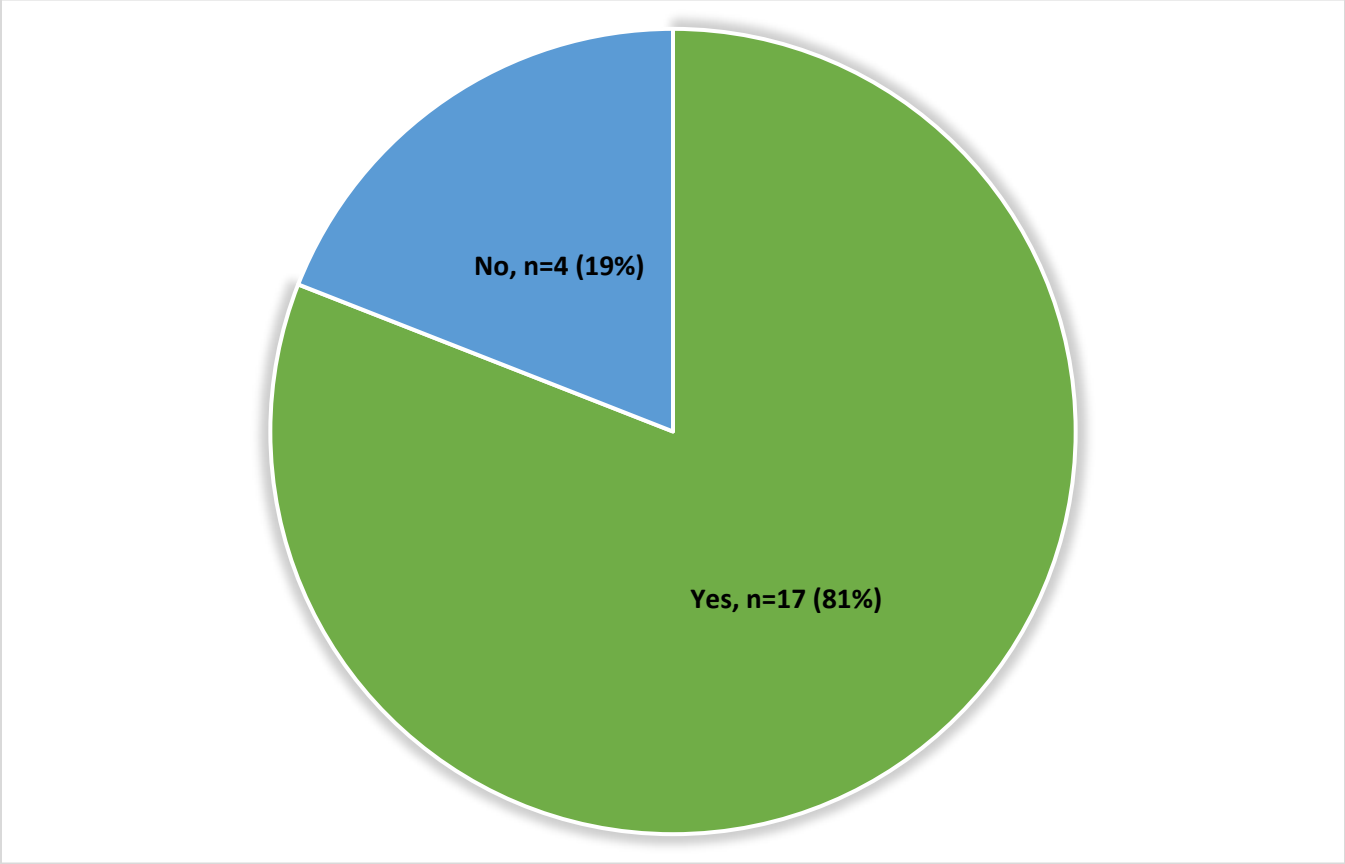

Table 120 - State Has Protocols Involved in Checking PDMP

Response	States	Count	Percentage
Yes	District of Columbia, Florida, Georgia, Maine, Maryland, Michigan, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Tennessee, Texas, Vermont, West Virginia	17	80.95%
No	Delaware, Massachusetts, New York, North Dakota	4	19.05%
Total		21	100.00%

If "Yes," please explain.

Table 121 - Explanations of Protocols Involved in Checking PDMP

State	Explanation
District of Columbia	Pharmacies must report dispensing of controlled substances to the PDMP within 24 hours of dispensing
Florida	Each dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is dispensed to a patient age 16 or older unless a statutory exemption applies. Statutory exemptions include prescribing or dispensing a nonopioid controlled substance listed in schedule V; if the system is nonoperational; if the prescriber cannot access the system because there is a temporary technological or electrical failure. If the system was not consulted only a 3-day supply may be prescribed, and the prescriber must document in the prescription record the reason the system was not consulted.
Georgia	Yes, there are protocols involved in checking the PDMP.
Maine	Dispensers. A dispenser shall check prescription monitoring information prior to dispensing a benzodiazepine or an opioid medication to a person under any of the following circumstances: A. The person is not a resident of this State; [PL 2015, c. 488, 9 (NEW).] B. The prescription is from a prescriber with an address outside of this State; [PL 2015, c. 488, 9 (NEW).] C. The person is paying cash when the person has prescription insurance on file; or [PL 2015, c. 488, 9 (NEW).] D. According to the pharmacy prescription record, the person has not had a prescription for a benzodiazepine or an opioid medication in the previous 12-month period. [PL 2015, c. 488, 9 (NEW).] A dispenser shall withhold a prescription until the dispenser is able to contact the prescriber of that prescription if the dispenser has reason to believe that the prescription is fraudulent or duplicative
Maryland	Since 2018 the Maryland PDMP use mandate requires providers to query a patient's dispense history when beginning a new course of opioids or benzodiazepines (as opposed to the wording in the question regarding "controlled substances") in certain clinical situations. Exceptions can be found here: https://health.maryland.gov/pdmp/Pages/pdmp-use-mandate-information.aspx
Michigan	State legislation, professional medical and pharmacy boards, and the Department of Licensing and Regulatory Affairs (LARA) establish protocols for checking Michigan's PDMP called Michigan Automated Prescription System (MAPS) for pharmacists prior to dispensing controlled substances.
Mississippi	Prior to dispensing a prescription for a schedule II opiate, a pharmacist shall review the prescription monitoring program based on any of the following circumstances: a. The patients is a new customer to that pharmacy; or b. The patient has not had an opioid prescription filled at that pharmacy within six (6) months; c. The prescription monitoring program shall be reviewed at least once every six (6) months for any patient receiving controlled substances.
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

State	Explanation
	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	The PDMP has administrative rules that dispensing providers must follow.
New Jersey	Pharmacists are required to access the NJPMP if they have a reasonable belief that the patient may be seeking a controlled dangerous substance, in whole or in part, for any purpose other than the treatment of an existing medical condition, such as for purposes of misuse, abuse, or diversion.
New Mexico	A Pharmacist has to enter a professional service code (M0) into the POS system stating that the PDMP was checked prior to dispensing. This exception code posts every 90 days.
North Carolina	Yes, in some circumstances. The STOP Act provides that a dispenser "shall review" a CSRS report on a patient "for the preceding 12-month period and document this review" when any of the following circumstances exist: (1) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user's existing medical condition. (2) The prescriber is located outside of the usual geographic area served by the dispenser. (3) The ultimate user resides outside of the usual geographic area served by the dispenser. (4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser. (5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following: (a) Over-utilization of the controlled substance. (b) Requests for early refills. (c) Utilization of multiple prescribers. (d) An appearance of being overly sedated or intoxicated upon presenting a prescription. (e) A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks. Each of these circumstances is a typical "red flag" indicating potential misuse or abuse of a controlled substance. Additional resources are available here: http://www.ncbop.org/faqs/Pharmacist/faq_RedFlagsCS.html and http://www.ncbop.org/faqs/DrugDiversionPocketcard.pdf The STOP Act also provides that if a pharmacist "has reason to believe that a prescription for a targeted controlled substance is fraudulent or duplicative," then the pharmacist "shall withhold delivery of the prescription until the [pharmacist] is able to contact the prescriber and verify that the prescription is medically appropriate."
Ohio	See OAC 4729-5-20: Prospective drug utilization review.
Tennessee	When dispensing a controlled substance, all healthcare practitioners, unless otherwise exempted under this part, shall check the controlled substance database prior to dispensing one (1) of the controlled substances identified in subdivision (e)(4) to a human patient the first time that patient is dispensed a controlled substance at that practice site. The dispenser shall check the controlled substance database again at least once every twelve (12) months for that human patient after the initial dispensing. The initial dispensing check fulfills the first annual check. An authorized healthcare practitioner's delegate may check the controlled substance database on behalf of the healthcare practitioner.
Texas	Pharmacists must report every controlled substance dispensed to an outpatient, including occasional or sporadic dispensing. Reporting must be done within one day of dispensing.

State	Explanation
	On days when there is no dispensing of any reportable drug, the pharmacy will file a 'zero report'.
Vermont	Vermont Prescription Monitoring System Rule 5.2 Pharmacist Required Querying of the VPMS All dispensers, with the exception of hospital-based dispensers dispensing a quantity of a Schedule II, III, or IV opioid controlled substance that is sufficient to treat a patient for fewer than 48 hours shall query the Vermont Prescription Monitoring System in the following circumstances: 5.2.1 Prior to dispensing a prescription for a Schedule II, III, or IV opioid controlled substance to a patient who is new to the pharmacy; 5.2.2 When an individual pays cash for a prescription for a Schedule II, III, or IV opioid controlled substance and the individual has prescription drug coverage on file; 5.2.3 When a patient requests a refill of a prescription for a Schedule II, III, or IV opioid controlled substance substantially in advance of when a refill would ordinarily be due; and 5.2.4 When the dispenser is aware that the patient is being prescribed Schedule II, III, or IV opioid controlled substances by more than one prescriber. 5.3 Pharmacist Delegates Pharmacists may designate a delegate or delegates to access and query the VPMS system subject to Section 7.2 of this rule.
West Virginia	CHAPTER 60A. UNIFORM CONTROLLED SUBSTANCES ACT. ARTICLE 9. CONTROLLED SUBSTANCES MONITORING. 60A-9-5a. Practitioner requirements to access database and conduct annual search of the database; required rulemaking. (a) All practitioners, as that term is defined in 60A-2-201 of this code who prescribe or dispense Schedule II, III, IV or V controlled substances shall register with the West Virginia Controlled Substances Monitoring Program and obtain and maintain online or other electronic access to the program database: Provided, That compliance with the provisions of this subsection must be accomplished within 30 days of the practitioner obtaining a new license: Provided, however, That the Board of Pharmacy may renew a practitioner's license without proof that the practitioner meet the requirements of this subsection. (b) All persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and who are licensed by the Board of Medicine as set forth in 30-3-1 et seq. of this code, the Board of Registered Professional Nurses as set forth in 30-7-1 et seq. of this code, the Board of Dental Examiners as set forth in 30-4-1 et seq. of this code, the Board of Osteopathic Medicine as set forth in 30-14-1 et seq. of this code, the West Virginia Board of Optometrists as set forth in 30-8-1 et seq. of this code, and a pharmacist licensed by the West Virginia Board of Pharmacy as set forth in 30-5-1 et seq. upon initially prescribing or dispensing any

State	Explanation
	Schedule II controlled substance, any opioid or any benzodiazepine to a patient who is not suffering from a terminal illness, and at least annually thereafter should the practitioner or dispenser continue to treat the patient with a controlled substance, shall access the West Virginia Controlled Substances Monitoring Program Database for information regarding specific patients. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program Database for the patient shall be documented in the patient's medical record maintained by a private prescriber or any inpatient facility licensed pursuant to the provisions of chapter 16 of this code. A pain-relieving controlled substance shall be defined as set forth in 30-3A-1 of this code. (c) The various boards mentioned in 60A-9-5(b) of this code shall amend its legislative rules pursuant to the provisions of 29A-3-1 et seq. of this code to effectuate the provisions of this article.

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

Figure 81 - Beneficiary Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible

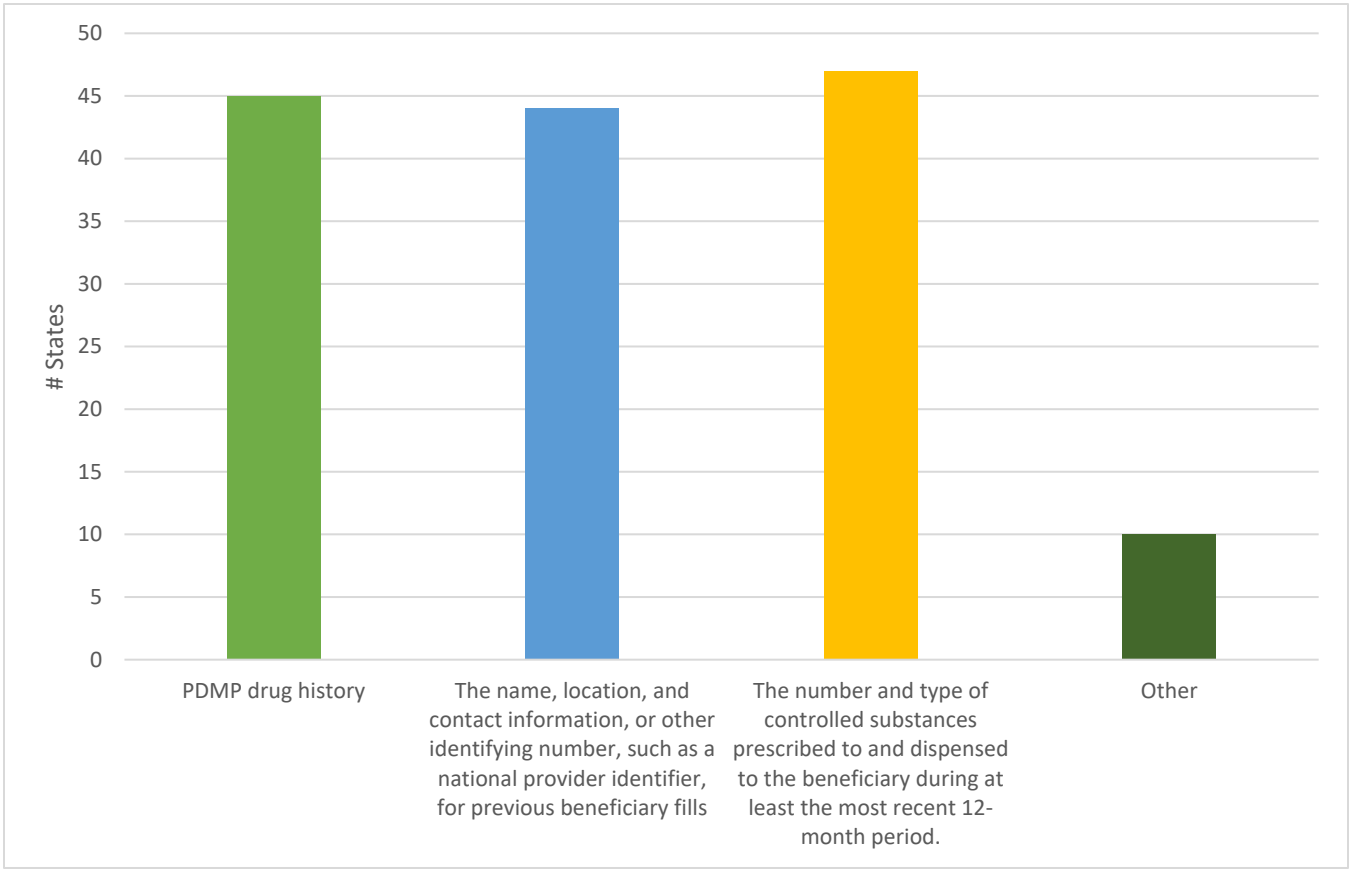

Table 122 - Beneficiary Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible

Response	States	Count	Percentage
PDMP drug history	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, 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	45	30.82%
The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	44	30.14%
The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period.	Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	32.19%
Other	Colorado, Connecticut, Florida, Illinois, Indiana, Kansas, Massachusetts, Minnesota, Missouri, Tennessee	10	6.85%
Total		146	100.00%

If “Other,” please explain.

Table 123 - “Other” Explanations for Information Available to Prescribers with Respect to a Beneficiary 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.

State	Explanation
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.
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	Pharmacy Name.
Massachusetts	Payment type, current total MME, 30 day average MME, buprenorphine claims are also available fields.
Minnesota	Details regarding the prescription, prescriber, and dispenser are available for the most recent 12 month period. This include names, location, and contact information. As well as controlled substances, Minnesota also collects gabapentin and all formulations of butalbital.
Missouri	Missouri does not have a state wide PDMP.
Tennessee	Name/Location of both the prescriber and the pharmacy for previous fills All addresses for the patient on file Payment method for all past prescriptions (although this is based on pharmacy input and is not reliable information) Clinical flags denoting: = 4 or > 5 practitioners in the last 90 days Clinical flags denoting: = 4 or > 5 pharmacies in the last 90 days Clinical flag denoting if patient has >= 120 active cumulative MME per day Clinical flag denoting if patient is a female of child bearing age (15-45 y/o) 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.

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

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

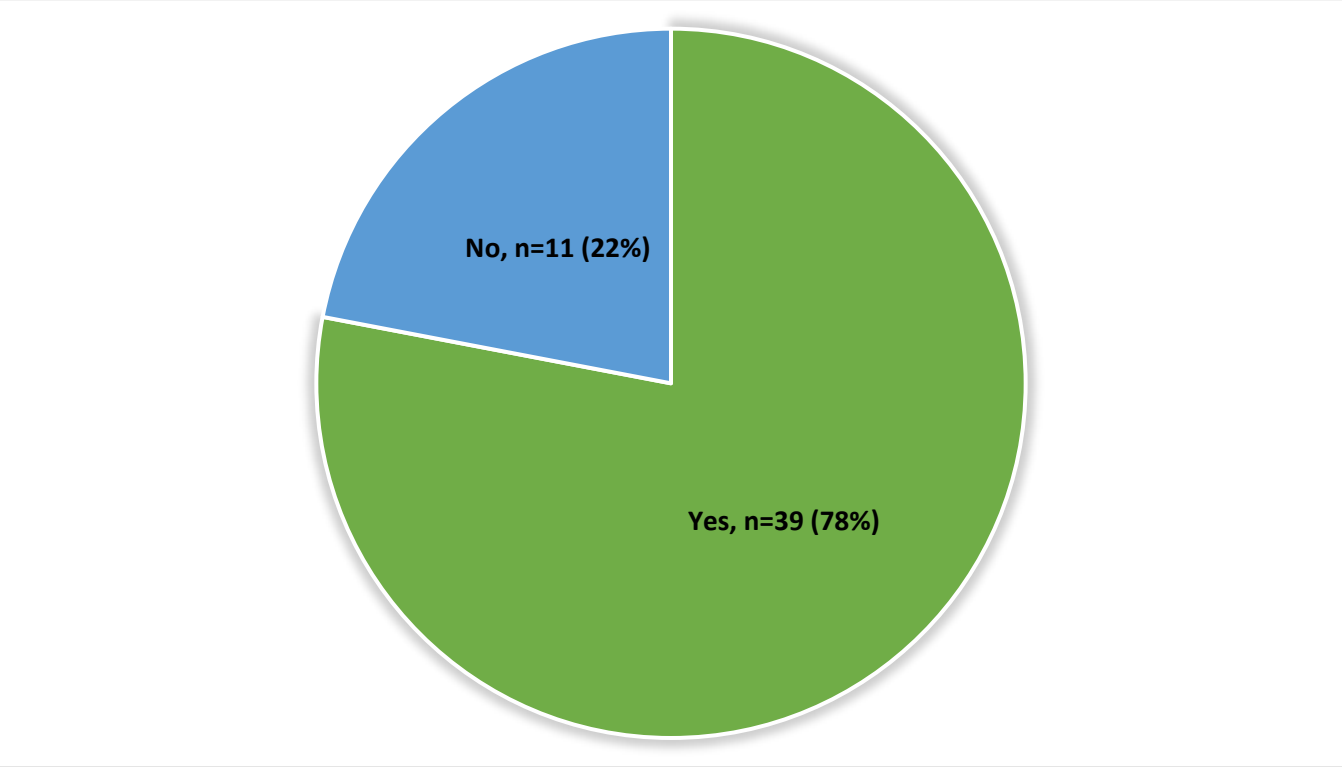

Table 124 - Barriers Hinder Medicaid Agency from Fully Accessing the PDMP to Curb FWA

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, 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, Oregon, Rhode Island, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	39	78.00%
No	Delaware, Indiana, Louisiana, Mississippi, Nebraska, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Utah	11	22.00%
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 125 - 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. Prescribers and pharmacists are not required to access prior to writing or dispensing prescriptions.
Alaska	The PDMP is not currently integrated into the Point-of-Sale system, limiting the efficiency of the pharmacist when checking previous prescription history.
Arkansas	Arkansas Medicaid has the following barriers: 1) Act 820 requires prescribers to access the PDMP each time an opioid is prescribed and for each new benzodiazepine. There is no requirements for other controls, and prescribers do not access 100% of the time. 2) Arkansas Medicaid pharmacy program clinical pharmacists have access to the PDMP, but we have no access to neighboring states. 3) The PDMP is managed by a different agency. Getting data to answer the questions in this survey will be difficult. 4) At this point, the PDMP data is not incorporated into the Medicaid data system for use in Pro/DUR edits, RDUR review, or clinical POS edits.
California	Inability to access border states' PDMP information Lag time for prescription data being submitted Ambiguous regulations governing access to PDMP data
Colorado	The State is prohibited by legislation from accessing the PDMP. In our DUR criteria we highly encourage providers to access the PDMP prior to prescribing controlled substances.
Connecticut	Access is restricted to our Medicaid Fraud Unit only.
District of Columbia	The Medicaid agency cannot access PDMP information for a beneficiary without an active investigation of fraud or abuse - so-called data mining is not allowed. Another concern is that some prescribers are not accessing the PDMP before prescribing controlled substances despite the implementation of a mandatory query law in 2020.
Florida	Sections 893.055 and 893.0551, Florida Statutes does not authorize the release of PDMP information to the Agency for Health Care Administration.
Georgia	Limited to claim-level detail (cannot query by prescriber) and must have an NPI to access PDMP
Hawaii	Currently Medicaid is unable to access the PDMP database. There up to a 7 days lag time for submission of prescription data permitted. If less than 3 days supply is dispensed, PDMP submission is not required entry by the prescriber.
Idaho	Can only access by specific patient and not able to look for patterns by patient, prescriber or pharmacy. There is a lag time in information available from the 6 border states. We are not able to generate aggregate reports such as cash (private pay) payments by the beneficiary or total MME over a set amount from all sources. We do not have the ability to see Outpatient Drug Treatment clinics (methadone).
Illinois	- Currently we can only view one patient at a time. Working on obtaining data to look at HFS population in ILPMP. - HFS has no way to verify if prescriber checked ILPMP prior to writing prescription.

State	Explanation
Iowa	No access to the PMP by Medicaid as only authorized prescribers and pharmacists may to obtain information regarding their patients' use of controlled substances when actively engaged in the patient's healthcare.
Kansas	The request has to be sent to the State Board of Pharmacy PDMP and then they send back a report. We cannot access the PDMP database and query in real time.
Kentucky	While OIG conducts investigations into Medicaid prescribers, currently the data is not being proactively analyzes due to structural changes at CHFS.
Maine	Lag time in prescription data being submitted and the fact that PDMP data is not available in a non de-identified format.
Maryland	The FFS program must have a bonafide formal investigation to access the PDMP. Requests must be approved by the Secretary of the Maryland Department of Health (MDH). Information is obtained through the MDH's PDMP. This may lead to a lag time between requests and the receipt of information. Additionally, technical issues including system downtime maintenance and delay of claims submission by providers.
Massachusetts	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.
Missouri	Missouri does not have a state wide PDMP.
Montana	The State's PDMP program by Bamboo Health dose 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.
Nevada	Access is limited to State employees. PBM vendor is not able to view the information.
New Hampshire	The Department is prohibited by NH statute from accessing the PDMP.
New Jersey	As intended, the NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and are in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR are considered unauthorized users since they are not directly delivering healthcare.
New Mexico	Currently unable to directly link Medicaid electronic health records with the PDMP.
New York	Data sharing or access to information for Medicaid members only.
North Carolina	Some pharmacies have restricted internet access, delays in processing data submitted, prescribers complain of time required to log in. There are some security issues with department access to the PDMP. PDMP limits access to specific users within the agency to the PDMP data.
North Dakota	Other state information (e.g. border states), Loading information into our claims system.
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 number to access the PDMP.
Tennessee	Yes and No. The real barrier is matching CSMD records to Medicaid eligibility records. There are mathematical formulae used, but the basic issue is that the members record in

State	Explanation
	the CSMD is identified only by Name and DOB, and this information is dependent upon pharmacy input.
Texas	Access to PMP is statutory restricted. Texas Medicaid does not have access to PMP
Vermont	Currently, only the Medical Director of Medicaid is allowed to perform a search, and these searches must be run one at a time. Additionally there is no provision for a delegate or alternate way to run a search if the position of the medical director is vacant.
Virginia	Not allowed to access by state law
Washington	Many prescribers do not have the PMP integrated into their electronic medical record system and therefore checking does have a significant impact on their current workflow.
West Virginia	Access to the PDMP is limited to one person at our department and queries are capable of only pulling up one member at a time. We are also unable to access information outside our borders even though we enroll pharmacies as far as 30 miles from the border.
Wisconsin	The PDMP is managed by a different agency and there is a delay in receiving the data. Also our retro DUR contractor does not have a system developed to incorporate this claims data into their claim review process.
Wyoming	Current interpretation of Wyoming State Law does not allow Medicaid to access the PDMP.

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

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

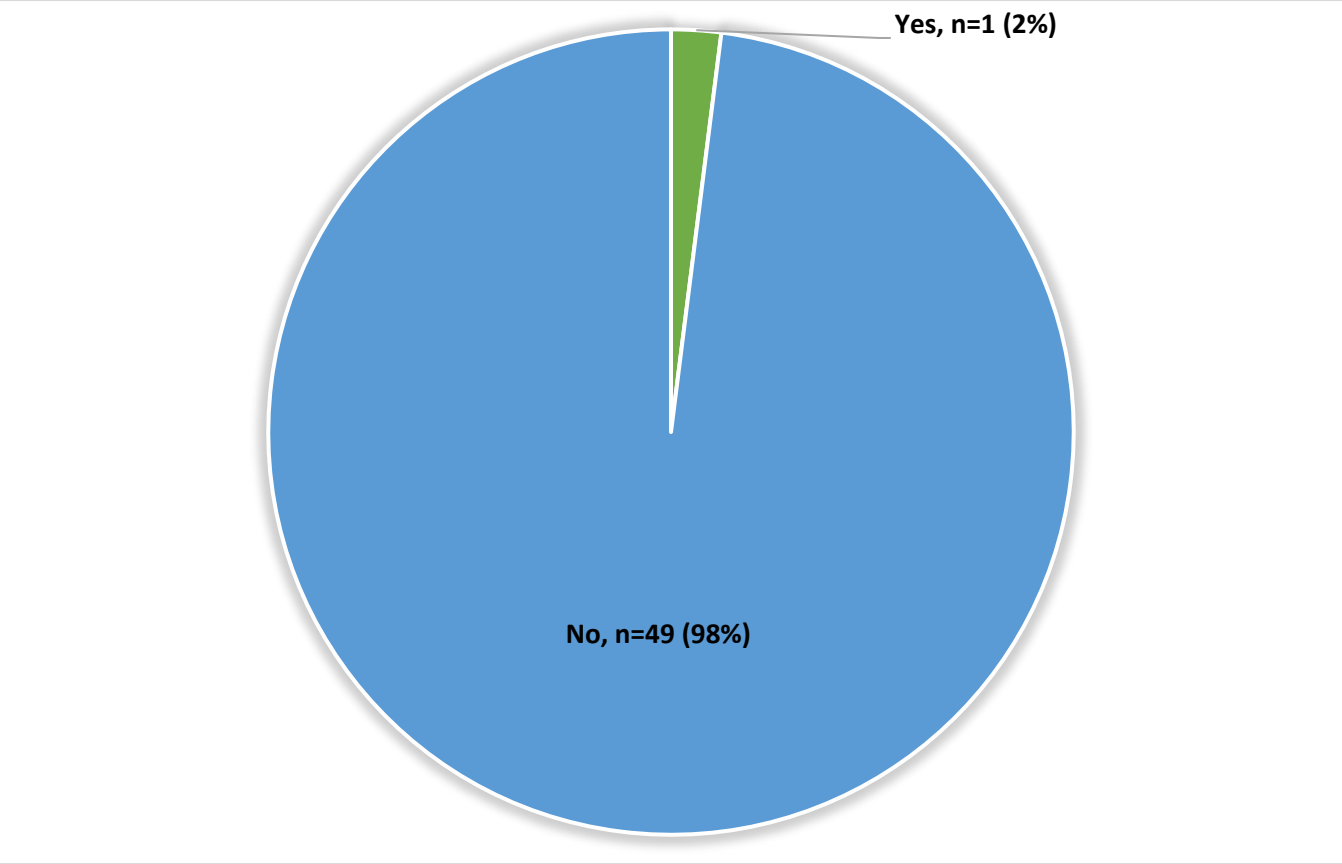

Table 126 - Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

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

If "Yes," please explain.

Table 127 - Explanations of Changes to State PDMP That Have Improved Medicaid's Ability to Access PDMP Data

State	Explanation
Nebraska	CyncHealth, in collaboration with NIC, administers the Nebraska Prescription Drug Monitoring Program (PDMP).

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

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

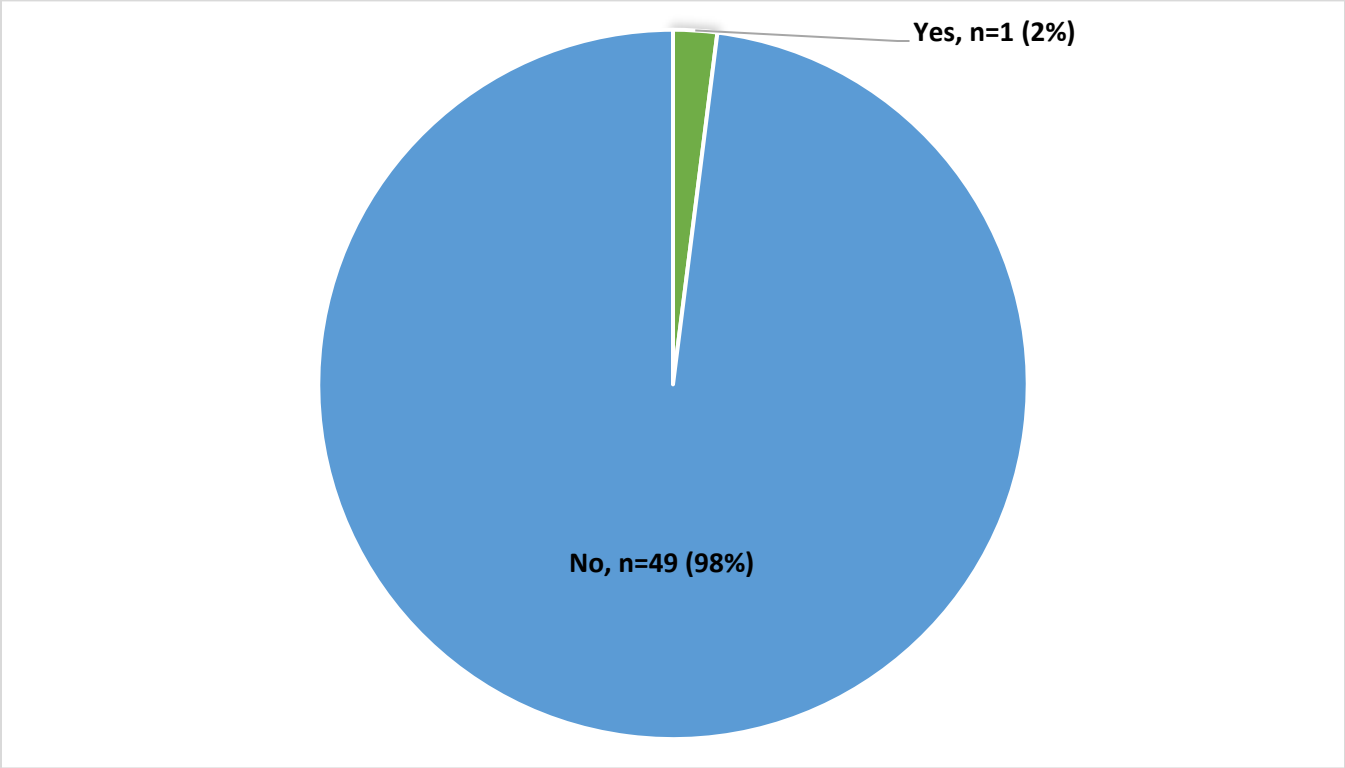

Table 128 - Data or Privacy Breaches of the PDMP or PDMP Data This Reporting Period

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

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

Table 129 - Summary of Breach

State	Explanation
Oregon	There were two unauthorized disclosures during this period. Both incidents were reported to the information security office and appropriate action was taken.

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

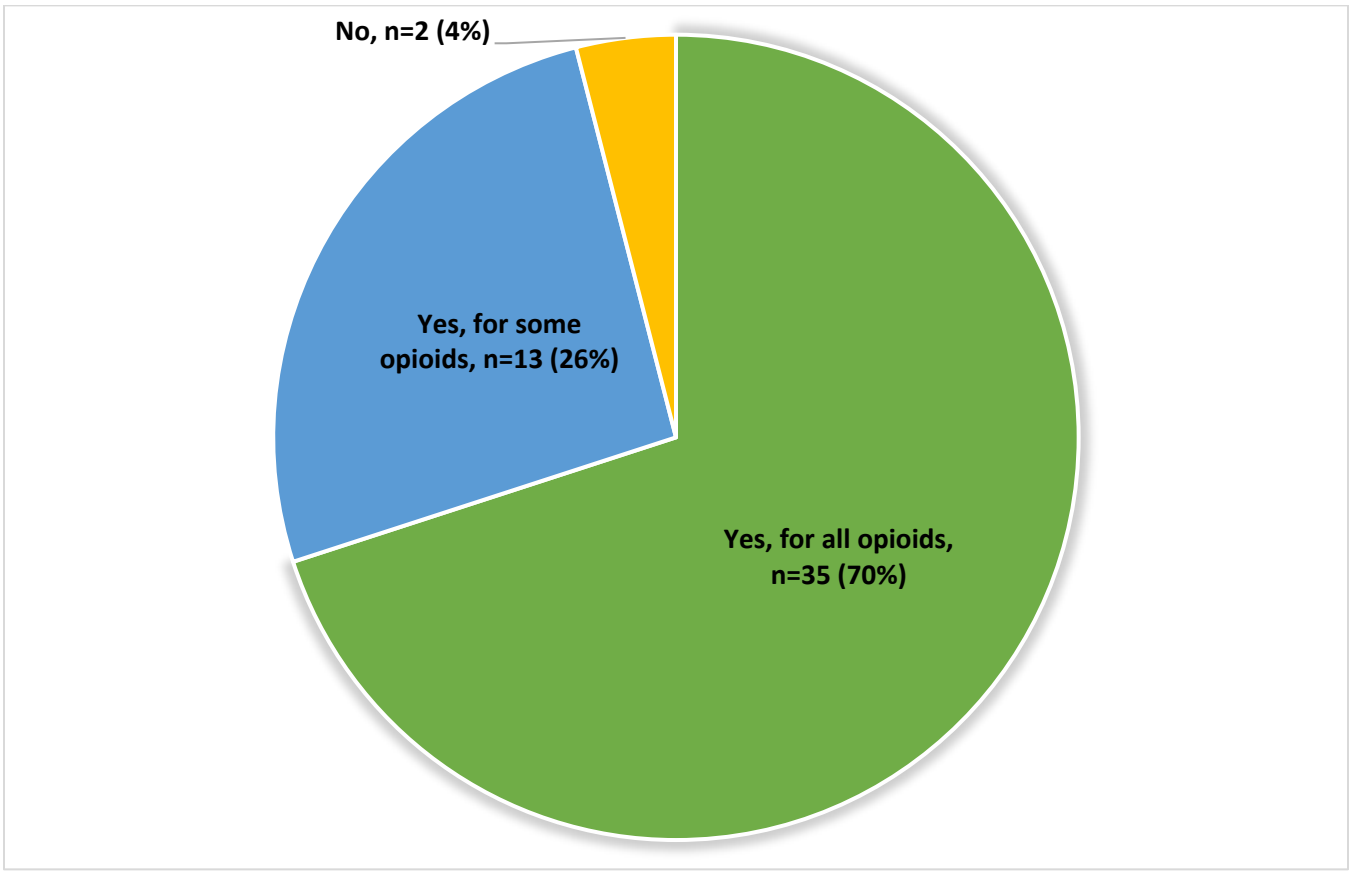

Table 130 - POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

Response	States	Count	Percentage
Yes, for all opioids	Alabama, 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 Carolina, Ohio, Oregon, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, Wisconsin, Wyoming	35	70.00%
Yes, for some opioids	Hawaii, Kansas, Louisiana, Michigan, Montana, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Utah, Vermont, West Virginia	13	26.00%
No	Alaska, Oklahoma	2	4.00%
Total		50	100.00%

Please explain response above.

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

State	Explanation
Alabama	AL Medicaid has short-acting opioid naive days' supply edit. Quantity limits are also in place for opioids.
Alaska	For state laws regarding maximum dosage for opioid prescriptions, refer to AS.08.64.363, AS.08.68.705, AS.08.36.355, AS.08.72.276
Arkansas	Opioid naive is defined as no claims for any opioid drugs for pain in the client's Medicaid drug profile in the previous 60 days. Opioid naive clients may receive a maximum of 50 MME/day. The initial prescription for the treatment naive client for the short-acting opioid is limited to a 7-day supply with the corresponding quantity limit of up to 6 tablets or capsules per day. The opioid naive limitation does not apply to clients with a cancer diagnosis. All new starts for long-acting opioids require a prior authorization or documentation of opioid tolerance with a paid claim for a long-acting opioid in the previous 60 days unless the client is LTC eligible, has cancer, or has an NPO diagnosis.
California	Claims for all controlled drug products, including opioids (DEA schedule 2-5) have a maximum days' supply of 35 days. Prior authorization is required for claims submitted greater than 35 days. This limit does not apply to initial opioid prescriptions for opioid naive patients or buprenorphine products.
Colorado	The first, second, and third prescription fills for an opioid naive member are limited to 7 days' supply.
Connecticut	CT state law requires that prescribers limit initial opioid prescriptions for patients to a 7 days' supply.
Delaware	the first fill of any short-acting opioid cannot exceed a 7 day supply. The first fill of any long-acting opioid cannot exceed a 15 day supply
District of Columbia	Claims are limited to a 7 day initial supply of opioids after a look back of the previous 120 days of dispensing
Florida	For short acting opioids CII, there is a max of 2 fills per month of a 3 day supply or 7 day supply with "acute pain exemption" written on the prescription. For CIII-CV there is a max of 14 day supply per month. There are also product specific limits per FDA package inserts.

State	Explanation
Georgia	Quantity level limits in place. MEDLIMIT 50 MME: For treatment naive members, edit check for a cumulative SAO & LAO dose check for >50 MME/day. MEDLIMIT 7 DAY SUPPLY: For treatment-naive members: Edit check for SAO prescriptions for >7 day supply
Hawaii	For dental use, otherwise 30 days supply due to the nature of the population served in FFS.
Idaho	Idaho Medicaid does not currently have a 3-7 day initial limit for opioid naive recipients. The drug specific daily and monthly quantity limit plus cumulative MME edit with all other opioids is applied.
Illinois	Yes, a 7-day initial opioid quantity for opioid naive individuals.
Indiana	There is a quantity limit of 60 MME for new opioid utilizers of short-acting opioids only, quantity limits applied to all long-acting agents if approved via PA for new starts or for those that are current utilizers. Patients with cancer, sickle cell, and other terminal diagnoses associated with significant pain are not subject to the initial quantity limits for new utilizers.
Iowa	Initial 7 days supply
Kansas	We have an initial fill limit of a 7 day supply for short-acting opioids. Patients with cancer, sickle cell anemia, palliative-hospice care, and those whom reside in an assisted or custodial care facility are exempt from this requirement. Cough/cold products, compounding ingredients, and injectables which contain opioids are not included in our initial quantity limit edit. Opioid Use Disorder medications do not have an initial quantity limit with the exception of Subutex. No prior authorization is required for prescriptions equal to or for no more than a cumulative 14 day supply of opioids in the last 60 days within allowed limits. o Maximum of 7 day supply is allowed per fill. o Cumulative opioid dose must not exceed 90 MME per day. o Drug must not exceed maximum FDA approved dosage. o Drug requested must not be a long-acting opioid.
Kentucky	Short-acting opioids are subject to days' supply limit. Most long- and short-acting opioids also have daily quantity limits. Members aged <18 are allowed up to an initial 3 days' supply, if opioid naive. Members aged 18 and over are allowed up to an initial 7 days' supply, if opioid naive.
Louisiana	Opioid policy, naive: Short-acting opioid, 28 units / 7 days. Exceptions: Short-acting fentanyl (not addressed); oxycodone/ibuprofen, 14 units / 7 days; liquid opioid, lesser of 180ml or a 7-day supply There are exemptions for certain medical conditions.
Maine	initial quantity limits are in place as adjudication edits
Maryland	Quantity limits are in place and are expressed as a cap of 90MME/day. All opioids have quantity limits in place regardless of the patient's length of treatment or history of use of the medication. Quantity limit information is available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	Massachusetts law established a maximum seven-day supply on prescriptions for opioids when issued to an adult for the first time. The law also sets a maximum seven-day supply on all opioid prescriptions for minors. A prescriber may issue a prescription for more than a seven-day supply of an opioid to adult or minor patients if, in the prescriber's medical judgment, a greater supply is necessary to treat an acute medical condition, chronic pain, pain associated with a cancer diagnosis or for palliative care. In such a case, the condition must be documented in the patient's medical record and the prescriber must indicate that a non-opioid alternative was not appropriate to address the medical condition. This law

State	Explanation
	does not apply to opioid medications that are designed for the treatment of substance abuse or opioid dependence.
Michigan	Prescriptions for short acting narcotics in opioid naive patients are limited to a 7 days supply unless a prior authorization is requested with attestation that the prescription is for chronic pain.
Minnesota	Yes, all opioids.
Mississippi	Patients who have not routinely filled an opioid prescription (i.e. 1 claim per month for the past 3 consecutive months) will be considered as new to opioids or opioid naive. Patients who have routinely filled any opioid prescriptions (i.e. 1 claim per month for the past 3 consecutive months) will be considered chronic opioid users. The claims system will allow opioid-naive patients to fill 2 x 7 day supplies in a rolling 30 days for a total of three months without prior authorization. After three months of filling these prescriptions the patient would then be considered to have chronic pain.
Missouri	Short-acting opioids and combination products are limited to less than or equal to a 7 days supply and less than or equal to 50 MME per day for an initial fill.
Montana	Our system limits initial opioid fills for opioid naive patient to a 7 day supply. The opioid lookback period is 90 days.
Nebraska	-prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day
Nevada	All opioids are limited to 60 morphine equivalents, a max of seven-day supply and a maximum of 13 fills per rolling 12 months for adults. For children under 18 years of age, the day supply is limited to three.
New Hampshire	NH Medicaid limits all opioid prescriptions to a 34 day supply. There is not a lower limit for initial prescriptions.
New Jersey	State regulations limit all initial opioid prescriptions to a 5 day supply. These limitations do not apply to cancer patients, sickle cell patients, or those on hospice, palliative or end of life care.
New Mexico	If an opioid prescription is not on file in the past 60 days, they are restricted to a 7 day supply.
New York	Initial prescription for short acting opioid for a opioid-naive patient is limited to a 7 day supply. Prior authorization (PA) is required for initiation of long-acting opioid therapy for an opioid-naive patient.
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, not just for opioid naive beneficiaries.
North Dakota	Immediate release products are limited to an initial 7 day supply. Extended release products require prior authorization.
Ohio	Initial prescriptions for short-acting opioids are limited to a seven days' supply. All prescriptions for long-acting opioids require prior authorization and then are limited to a 34 days' supply.
Oklahoma	Oklahoma state law limits the day's supply of initial opioid prescriptions to 7 days. Additionally there are POS edits in place related to QL and MME.

State	Explanation
Oregon	All long-acting opioids (LAO) require PA and short-acting opioids (SAO) are limited to two 7-day supplies every 90 days without PA .All opioids have quantity limit at 90 morphine ME.
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.
Rhode Island	Based on 30 MME and 20 doses. Different depending on the short acting medication.
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	Opioid naive patients are limited to a 7 day supply
Tennessee	For treatment naive patients, Opioids are limited to not more than 15 days supply per 180 days, at no greater than 60MME per day. The first prescription can be filled for 5 days supply without Prior Authorization. After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required.
Texas	Yes, the Opioid Clinical Policy is applied to opioid prescriptions for opioid naive patients to limit the days-supply, the type of opioid prescribed for opioid navie patient (short acting vs. long-acting), and the exemption criteria.
Utah	The initial edit applies only to short-acting opioid. The initial fill of a short-acting opioid is restricted to a maximum 7-day supply for non-dental prescribes and a maximum 3-days' supply for dental prescribes. The system will now allow the fill of a long-acting opioid without at least a 7-day trial of a short-acting opioid within the last 60 days. UT Medicaid

State	Explanation
	also restricts 7 days' supply of opioid for pregnant women and children under 18 years of age.
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
Virginia	There is a quantity limit currently in place to limit the quantity dispensed for all short and long acting opioids. Each opioid has a specific quantity limit on it.
Washington	FFS and MCOs apply a quantity limit of 18 dosages per prescription for children less than or equal to 20 years of age and 42 dosages per prescription for adults 21 years of age or older.
West Virginia	Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.
Wisconsin	Wisconsin has a standard 34 days' supply for opioids, unless there is quantity limit in place that allows less.
Wyoming	Initial fills are limited to a seven day supply. After 42 days of acute therapy, long-acting medications are limited to a maximum of 120 MME per day and short-acting are limited to four tablets per day.

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

Figure 86 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients

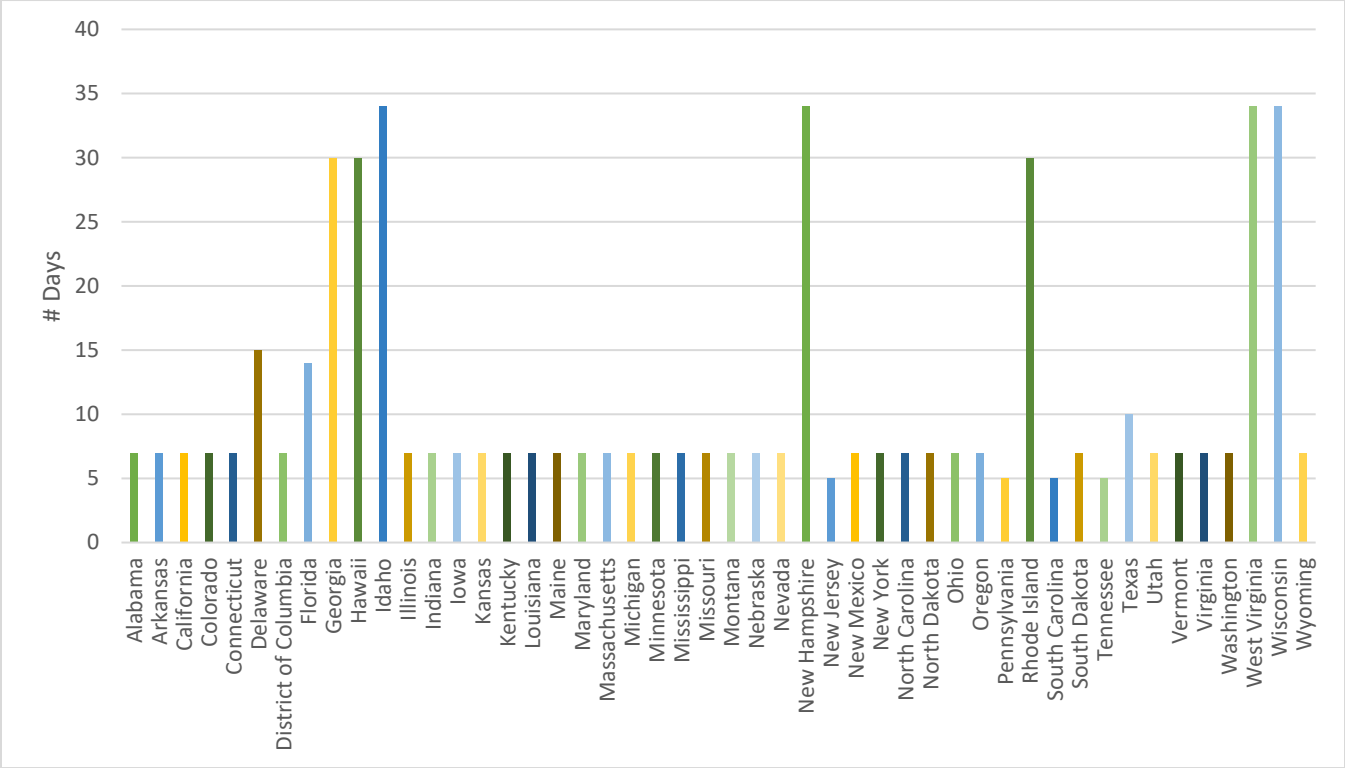

Table 132 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients

State	Maximum Days
Alabama	7
Arkansas	7
California	7
Colorado	7
Connecticut	7
Delaware	15
District of Columbia	7
Florida	14
Georgia	30
Hawaii	30
Idaho	34
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 Carolina	7
North Dakota	7
Ohio	7
Oregon	7
Pennsylvania	5
Rhode Island	30
South Carolina	5
South Dakota	7
Tennessee	5
Texas	10
Utah	7
Vermont	7
Virginia	7

State	Maximum Days
Washington	7
West Virginia	34
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 87 - POS Edits in Place to Limit Days' Supply of Subsequent Opioid Prescriptions

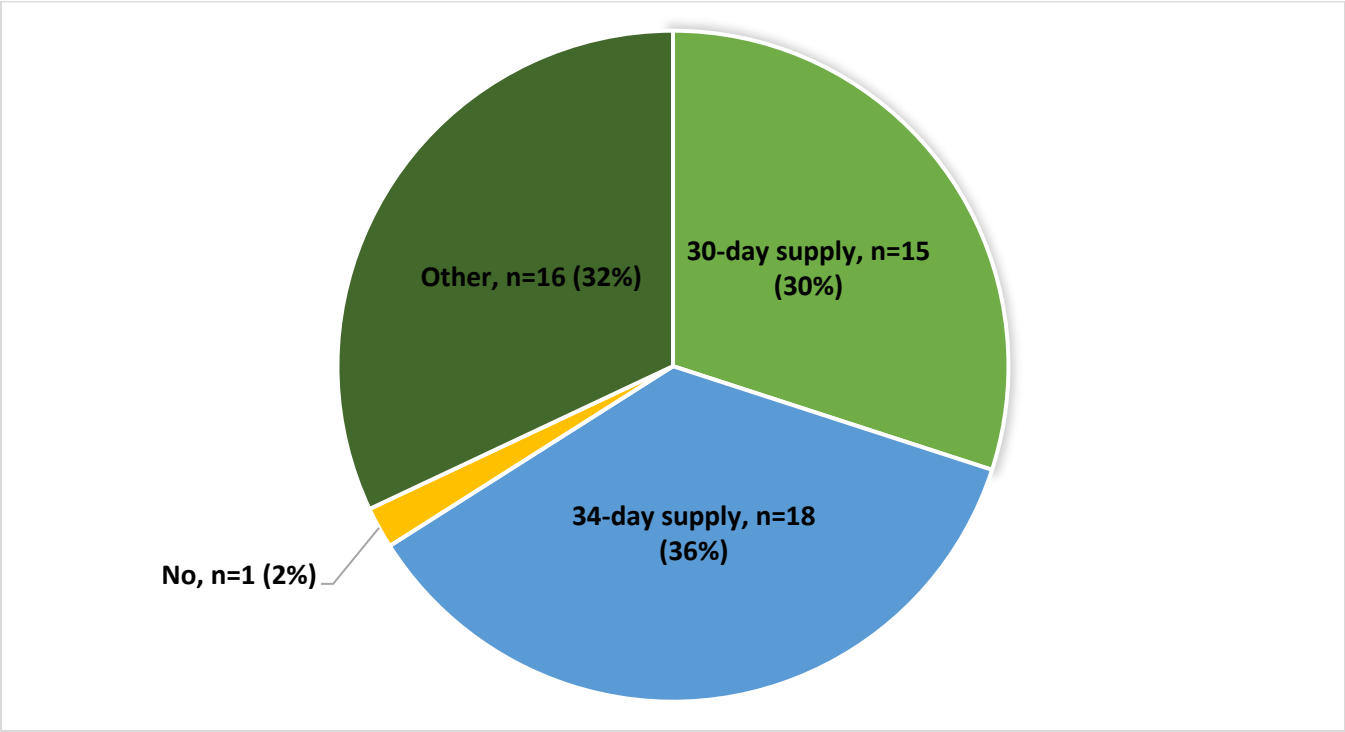

Table 133 - POS Edits in Place to Limit Days' Supply of Subsequent Opioid Prescriptions

Response	States	Count	Percentage
30-day supply	Connecticut, District of Columbia, Georgia, Hawaii, Louisiana, Maryland, Massachusetts, Mississippi, Nebraska, New York, Oklahoma, Rhode Island, South Carolina, Utah, Vermont	15	30.00%
34-day supply	Alabama, Alaska, Idaho, Kentucky, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Pennsylvania, South Dakota, West Virginia, Wisconsin, Wyoming	18	36.00%
No	Texas	1	2.00%
Other	Arkansas, California, Colorado, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Missouri, Nevada, Oregon, Tennessee, Virginia, Washington	16	32.00%
Total		50	100.00%

If “Other,” please specify.

Table 134 - “Other” Days' Supply Limit for Subsequent Opioid Prescriptions

State	Limit in Units
Arkansas	31
California	35
Colorado	7
Delaware	34
Florida	14
Illinois	31
Indiana	14
Iowa	31
Kansas	7
Maine	30
Missouri	31
Nevada	7
Oregon	7
Tennessee	10
Virginia	7
Washington	42

c. Please explain above response, or add N/A if not applicable.

Table 135 - Explanations of POS Edit in Place to Limit Days' Supply of Subsequent Opioid Prescriptions

State	Explanation
Alabama	Days' supply limit is 34 days.
Alaska	accumulation edits in place.
Arkansas	Initial prescriptions for short-acting opioids have a quantity limit of #42 capsules/tablets for a 7-day supply with a maximum of 50 MME/day. Beyond an initial claim for short-acting opioids, the maximum monthly quantity is #93/31 days and 90 MME/day. Cancer patients may receive up to #124/31 days of a short acting opioids. Quantities above these limits require a PA.
California	N/A
Colorado	The first, second, and third prescription fills for an opioid naive member are limited to a 7 days' supply; and the fourth fill requires prior authorization. Members who are not opioid naive are limited to a 30 days' supply of short-acting or long-acting opioids. Dental prescriptions are limited to a 3 days' supply of a short-acting opioid for up to three fills.
Connecticut	For subsequent opioid prescriptions, if a patient has received more than 630 MMEs within the past 120 days, claims will deny and require an opioid prior authorization. If a prior authorization is granted, a maximum days' supply of 30 will be imposed on the claim. For any clients with a diagnosis of cancer or sickle cell, all opioid prescriptions including initial fills will only be subject to a 30-day maximum per claim.
Delaware	Dependent on the specific opioid medication. DMMA limits the quantity allowed based on number of units and respective days supply (100 units or 34 days, whichever is greater), MME per day, as well as global number of units per year. For example, oxycodone 15 mg, 20 mg, and 30 mg have monthly, quarterly, and yearly limits in place

State	Explanation
District of Columbia	After the initial 7 day supply of an opioid prescription, subsequent fills are limited to maximum of a 30 day dispening at a single fill.
Florida	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" on prescription Max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 Long Acting (LA) Narcotic every 30 days.
Georgia	n/a
Hawaii	All dental use is considered naive and limited to 3 days.
Idaho	We apply drug specific drug quantity limits plus MME limits for all concurrent opioid prescriptions.
Illinois	After an initial 7-day opioid fill, subsequent prescriptions may be filled for a 31-day supply.
Indiana	There is a 14-day supply limitation. A 7-day supply followed by an additional 7-day supply is permitted for new utilizers.
Iowa	N/A
Kansas	After the first 7 days supply, prior authorization is required to exceed 14 day supply of opioid medication in last 60 days. If continued opioid use is needed, a PA will be required and the day supply limit going forward is 31 days per fill.
Kentucky	N/A
Louisiana	Opioid policy, naive: Short-acting opioid, 28 units / 7 days. Exceptions: Short-acting fentanyl (not addressed); oxycodone/ibuprofen, 14 units / 7 days; liquid opioid, lesser of 180ml or a 7-day supply There are exemptions for certain medical conditions.
Maine	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	All opioid prescriptions have a days supply limit of 30 days regardless of product.
Massachusetts	After the initial opioid prescription, all opioids have a limit of 30 days supply.
Michigan	After the initial 7-day supply of the opioid prescription, the remaining quantity may be filled. Subsequent opioid prescriptions may not be for quantities greater than a 34-day supply.
Minnesota	After the initial 7 day supply, then 34-day maximum supply applies.
Mississippi	N/A
Missouri	This applies to short-acting opioids and combination products
Montana	All controlled substance fills are limited to a maximum of 34 days supply.
Nebraska	N/A
Nevada	All fills are limited to seven-day supply without obtaining prior authorization.
New Hampshire	NH Medicaid limits all opioid prescriptions to a 34 day supply. There is not a lower limit for initial prescriptions.
New Jersey	On subsequent prescriptions, the limit is a 34 days supply or a maximum quantity of 100 units, whichever is greater. Quantity is dependent upon the FDA approved dosing per the manufacturer's package insert. New Jersey regulations also dictate that a patient shall not be provided with more than a 30-day supply of a Schedule II medication at one time.
New Mexico	Limited to opioids in the State Therapeutic Class H3A: Analgesics, Narcotics; H3N: Analgesics, Narcotic Agonist and NSAID Combination; and H3U: Narcotic Analgesic and Non-Salicylate Analgesic.

State	Explanation
New York	Yes. Quantity limits are based on FDA maximum daily doses in the product labeling extended to a thirty day supply.
North Carolina	All opioid prescriptions for more than a 7-day supply require prior approval.
North Dakota	Medicaid only claims are limited to 34 days in this situation. If other insurance is involved, and other insurances allows a larger day supply, ND Medicaid defers to the primary insurance limit for days supply.
Ohio	Short acting opioid therapy is limited to 30 MED per prescription and a maximum of 7 days per prescription. Prior authorization is required to exceed these limits. Opioid days' supply is limited to 34 days.
Oklahoma	We have an acute vs. chronic opioid edit in place that allows up to 8 units per day for 7 days on short acting opioids (acute use) and 4 units per day for 30 days for short acting opioids (chronic use). Quantity limits on long acting opioids are based on FDA approved dosing regimens and are limited to a 30-day supply.
Oregon	All LAO require PA and all SAO are limited to two 7-day supplies every 90 days without PA.
Pennsylvania	Subsequent supplies are approved via the prior authorization process and day supplies are at the discretion of the medical reviewers.
Rhode Island	N/A
South Carolina	N/A
South Dakota	Opioid naive patients are restricted to two 7 day supplies. After two fills the regular opioid edits apply.
Tennessee	See the answer to C.1.-- For treatment naive patients, Opioids are limited to not more than 15 days supply per 180 days, at no greater than 60MME per day. The first prescription can be filled for 5 days supply without Prior Authorization. After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required.
Texas	The day's supply limit on the subsequent opioid prescriptions or refills will be based on the maximum quantity per prescription set in the claims system and it may vary for each drug.
Utah	Initial prescriptions for over a 7-day supply of the cumulative 90 MME limit require prior authorization. A prescription is considered initial if the drug has not been filled for the patient in the past 60 days. Subsequent prescriptions maybe for a 30-days' supply and do not require prior authorization if the quantities prescribed is less than or equal to the cumulative 90 MME limit.
Vermont	Quantity limits may apply and are listed on the PDL . Example MORPHINE SULFATE CR 12 hr tablet (compare to MS Contin) QTY LIMIT: 90 tablets/strength/30 days
Virginia	Any Short-Acting Opioid prescribed for > 7 days or two (2) 7 day supplies in a 60-day period will require a service authorization. The Virginia Board of Medicine Regulations limit the treatment of acute pain with opioids to 7 days and post-op pain to no more than 14 days.
Washington	Limited to 42 calendar days within a rolling 90-day period
West Virginia	34 days is the days' supply limit for all opioid prescriptions
Wisconsin	Wisconsin has a standard 34 days' supply for opioids unless there is a quantity limit in place that allows less.
Wyoming	After the initial 7 day fill, opioid prescriptions are limited by quantity (short acting) or MME (long-acting). The standard days supply limit for all prescriptions is 34 days.

2. Does your state have POS edits in place to limit the quantity dispensed of short-acting opioids?

Figure 88 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

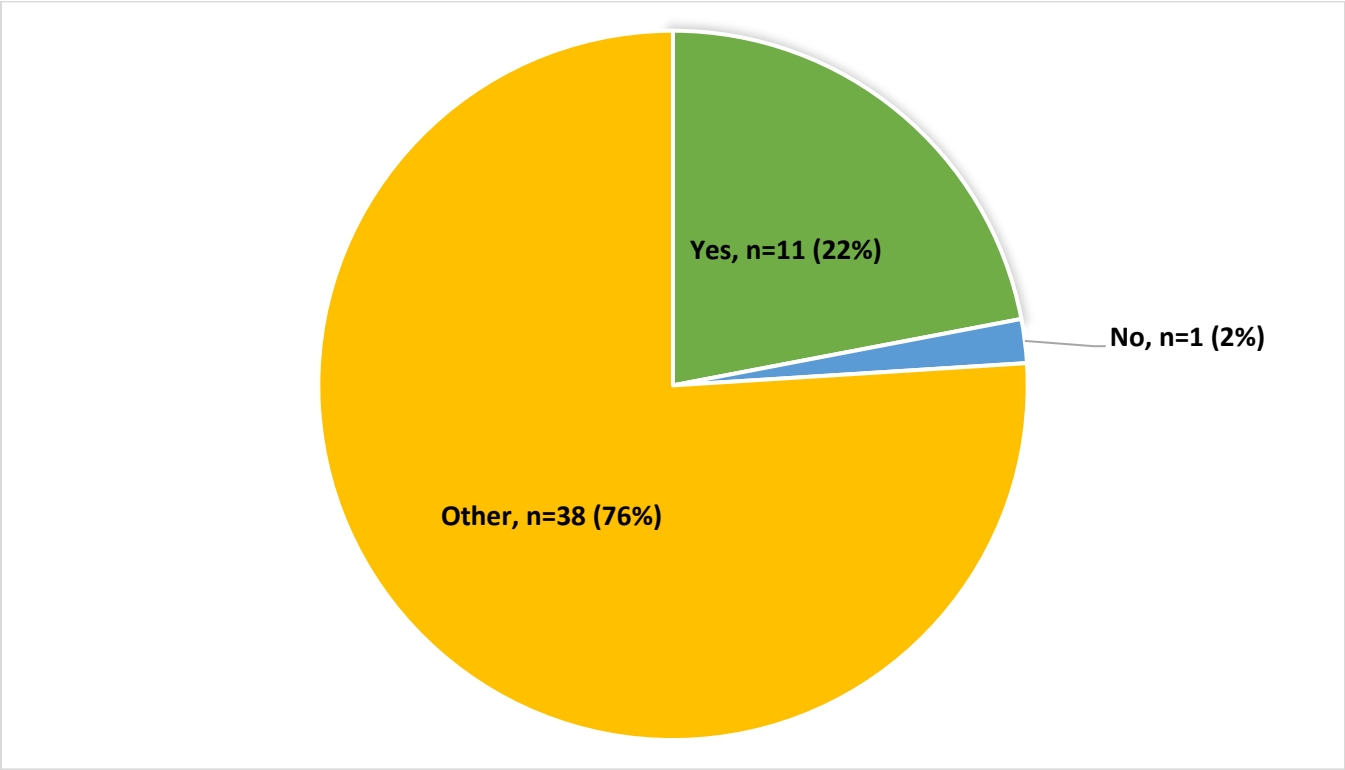

Table 136 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States	Count	Percentage
Yes	Arkansas, California, Georgia, Idaho, Louisiana, Mississippi, Nebraska, Oklahoma, Rhode Island, South Carolina, West Virginia	11	22.00%
No	Minnesota	1	2.00%
Other	Alabama, Alaska, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	38	76.00%
Total		50	100.00%

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

Figure 89 - Limits for Quantity Dispensed of Short-Acting Opioids

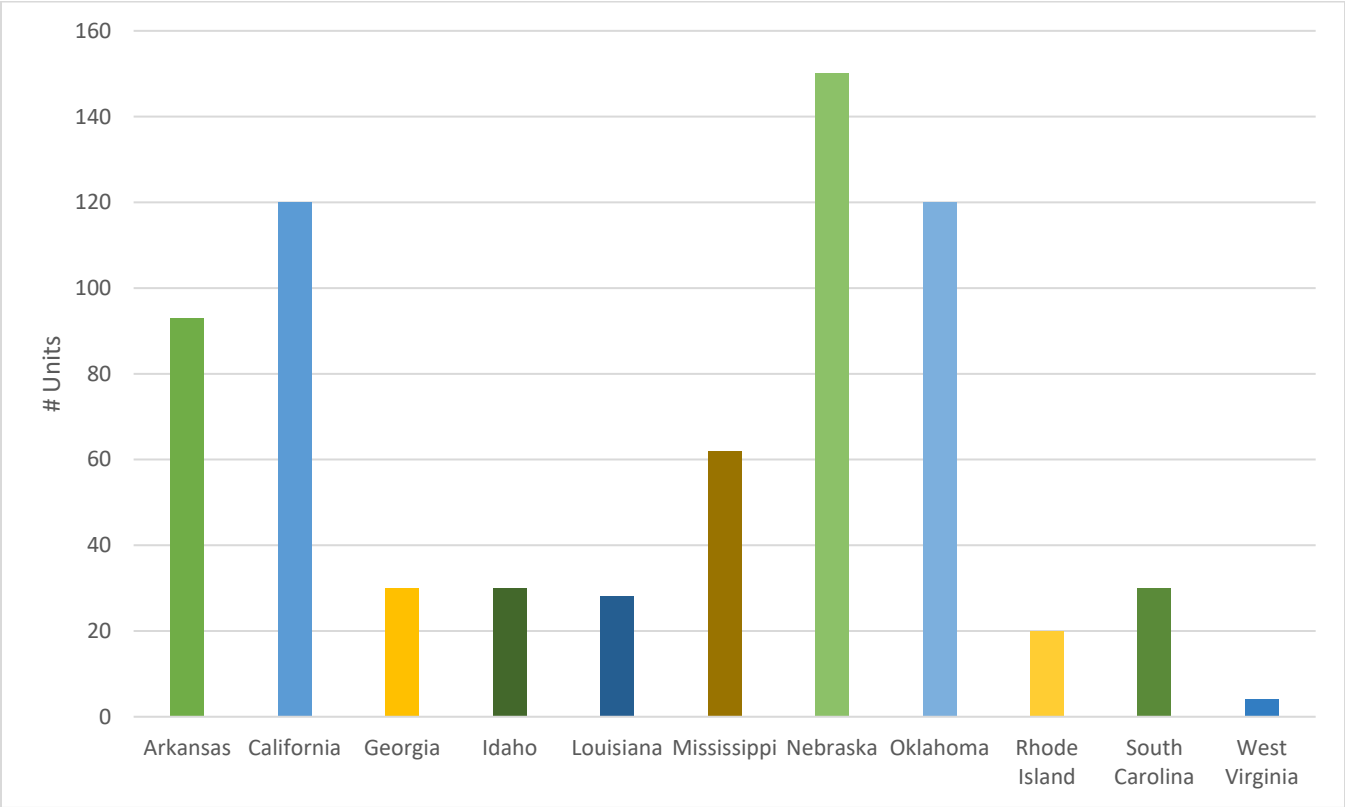

Table 137 - Limits for Quantity Dispensed of Short-Acting Opioids

State	Units
Arkansas	93
California	120
Georgia	30
Idaho	30
Louisiana	28
Mississippi	62
Nebraska	150
Oklahoma	120
Rhode Island	20
South Carolina	30
West Virginia	4

If "No" please explain.

Table 138 - "No" Explanation for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

State	Explanation
Minnesota	There is no set number of units across the board as quantity is based on MME.

If "Other" please explain.

Table 139 - "Other" Explanation for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

State	Explanation
Alabama	AL Medicaid has quantity limits in place and they are dependent on the particular product.
Alaska	Quantity limits are based on unit dosage, not to exceed a 30 day supply.
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, an opioid prior authorization is required. If prior authorization is granted up to a 30 day supply is imposed.
Delaware	The total does of opioid cannot exceed 90 MME per 24 hours. The total quantity of short-acting opioids cannot 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 opioid history in the last 180 days are limited to a 7 day supply
Florida	Yes, 7 day supply limit.
Hawaii	Unit limits vary by drug for dental narcotics.
Illinois	186 Units/rolling 31 days
Indiana	For initial utilizers of opioids, a 7-day supply followed by an additional 7-day supply in a rolling 45-day period is permitted without prior authorization.
Iowa	Maximum days' supply is up to a 31 day supply.
Kansas	The quantity limit is based upon the days supply limit.
Kentucky	Quantity limits are calculated based on total MME. Days supply limited to 34 days.
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 short-acting opioids that vary by drug strength such that the daily dose would not exceed 90 MME.
Missouri	Quantity limits are in place based on the strength of the medication and alternative strengths available on the market.
Montana	short acting opioids are limited to 8 per day
Nevada	All fills are limited to seven-day supply without obtaining prior authorization.
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 patient shall not be provided with more than a 30-day supply of a Schedule II medication at one time.

State	Explanation
New Mexico	Quantity limits are set at a maximum of 90 MME daily dosing up to a 34 day supply.
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. Days Supply limited to 34 days.
North Dakota	Individual products have limits to restrict to 6 units per day or < 90 MME per day for higher potency products.
Ohio	Yes, 30 MED per day.
Oregon	POS edit to limit days supply. Quantity varies depending on the agent and MME in the SAO PA criteria table.
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 7 days for the first two fills. Daily quantity limits vary by product.
Tennessee	After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required, all at no more than 60MME per day. There are exceptions to this rule if the enrollee has burns or corrosion damage over a large percent of body area, the limit is 45 days per 90 days with a limit of 60MME per day, and this same exception is in place for those in LTC facilities, and those with sickle cell disease.
Texas	The quantity limit for a short-acting opioid, if written for an opioid naive patient, will be the calculated at a10-days supply limit and a 90-days MME level. The quantity for subsequent short-acting opioid (for non-naive patient) will be based on the 90 MME per day levels and the maximum quantity for that drug/NDC set in the claims system.
Utah	Morphine Milligrams Equivalent (90 MME), daily quantity limit (4 tablets/day) and maximum 30 days supply. Also, restricts to 7 days supply for pregnant women and children under 18 years of age.

State	Explanation
Vermont	YES QTY limits are listed on the PDL and there are Also limits are based on the MME limitations 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 Completed Safety checklist must be completed for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opiates)**
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	Limited to 42 calendar days within a rolling 90-day period
Wisconsin	The state has a quantity limit or early refill limit on all SA opioids. For the SA products with a quantity limit the limit is 360 units.
Wyoming	After 42 days of acute therapy, short-acting medications are limited to a maximum of four units per day.

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

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

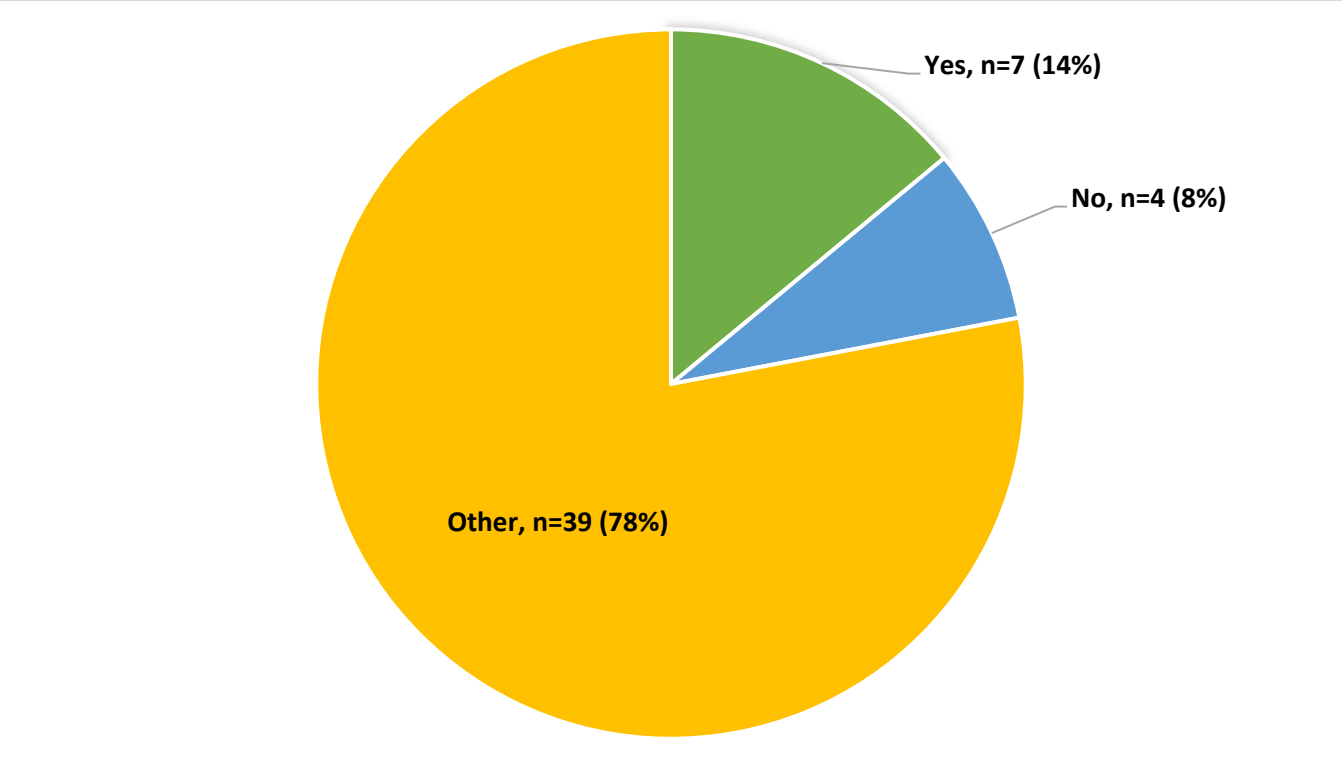

Table 140 - POS Edits In Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States	Count	Percentage
Yes	California, Georgia, Idaho, Louisiana, Mississippi, South Carolina, West Virginia	7	14.00%
No	Minnesota, New York, Rhode Island, Tennessee	4	8.00%
Other	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	39	78.00%
Total		50	100.00%

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

Figure 91 - Limits for Quantity Dispensed of Long-Acting Opioids

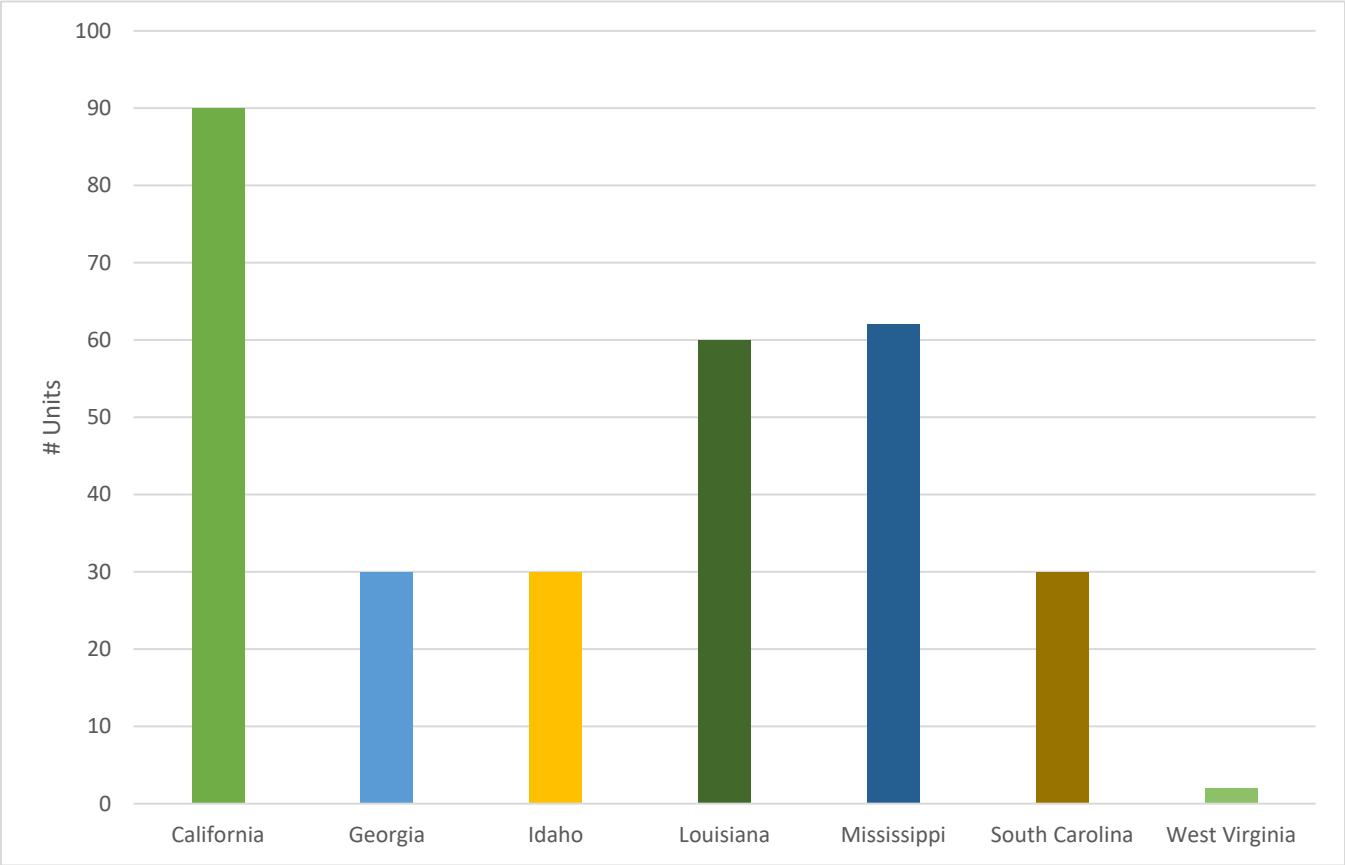

Table 141 - Limits for Quantity Dispensed of Long-Acting Opioids

State	Units
California	90
Georgia	30
Idaho	30
Louisiana	60
Mississippi	62
South Carolina	30
West Virginia	2

If “No,” please explain.

Table 142 - “No” Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

State	Explanation
Minnesota	There is no set number of units across the board. All long-acting opioids are on PA. These are limited to an initial 7 day supply for the first opioid naive prescription.
New York	Yes. Quantity limits are based on FDA maximum daily doses in the product labeling extended to a thirty day supply.
Rhode Island	Limited by MME
Tennessee	For chronic use the limit is in MME per month, with no greater than 30 days supply dispensed. The total limit is 200 MME per month, for all LAO and SAO combined. For non-chronic users, LAO are not approved.

If “Other” please explain.

Table 143 - “Other” Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

State	Explanation
Alabama	AL Medicaid has quantity limits in place and they are dependent on the particular product.
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 does of opioid cannot exceed 90 MME per 24 hours
District of Columbia	After an initial opioid fill, subsequent fills are limited to a 30 day supply per single fill.
Florida	30 day supply limit and product specific limits
Hawaii	Not used for population served at this time.
Illinois	124 Units/rolling 31 days
Indiana	For initial utilizers, PA is required. For current opioid utilizers, days' supply is limited to 34 as a non-maintenance medication, along with applicable quantity limits.
Iowa	Maximum 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 calculated based on total MME. Days supply limited to 34 days.
Maine	30 days supply
Maryland	Quantity limits are in place for specific long 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 long-acting opioids that vary by drug strength such that the daily dose would not exceed 90 MME.

State	Explanation
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 same opioid). Quantity limits differ depending on product
Nebraska	Limited to 30 day supply fills.
Nevada	Recipients can get up-to 34-day supply with an approved PA. A recipient limited to a seven-day supply without a PA.
New Hampshire	POS edits for long-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 patient shall not be provided with more than a 30-day supply of a Schedule II medication at one time.
New Mexico	Quantity limits are set at a maximum of 90 MME daily dosing up to a 34 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. Days Supply limited to 34 days.
North Dakota	All LA opioids have quantity limits in place (set to FDA or compendia supported dosages).
Ohio	Yes, 80 MED per day.
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.
Pennsylvania	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.
South Dakota	Daily quantity limits are in effect but vary by product.
Texas	Per the Opioid Clinical Policy, long-acting opioids prescriptions are approved for subsequent prescribing (for non-naive patients) . The only limit to subsequent prescriptions would be based on the 90 MME per day limit and the maximum quantity for that drug/NDC set in the claims system.
Utah	Morphine Milligrams Equivalent (90MME), daily quantity limit (depends on medication) and maximum 30 days supply.
Vermont	Quantity limits are listed on the PDL. MME limits also apply *NOTE: As of 5/1/21, a completed safety checklist must be submitted for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opiates)**
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	Yes we have POS edits in place to limit the quantity dispensed of long-acting opioids. It is limited to 34-day supply and limited to 42 calendar days within a rolling 90-day period.
Wisconsin	The state has a quantity limit or early refill limit on all LA opioids. For the LA products with a quantity limit the limit varies by product.
Wyoming	After 42 days of acute therapy, long-acting medications are limited to a maximum of 120 MME per day.

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

Figure 92 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Table 144 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

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

If "Yes," check all that apply.

Figure 93 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

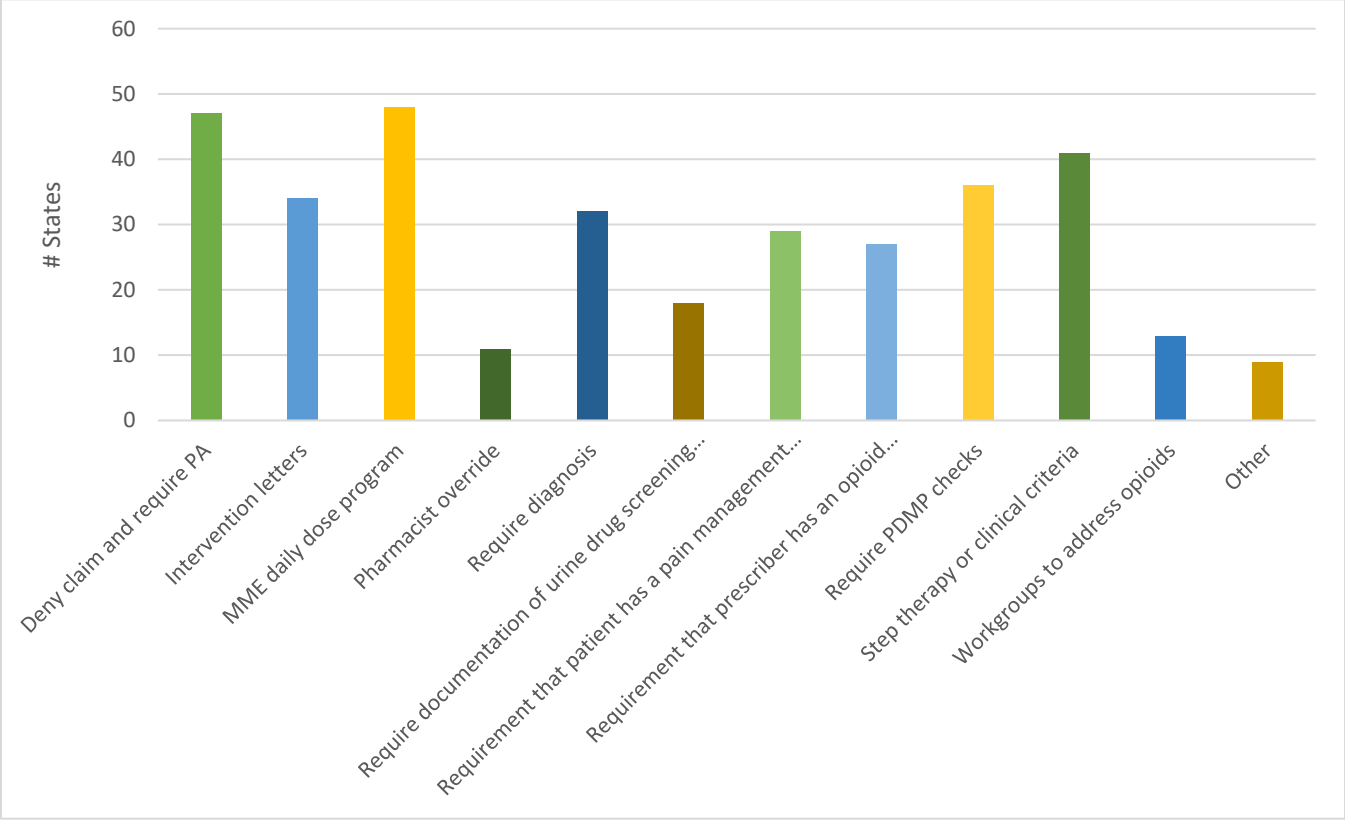

Table 145 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Deny claim and require PA	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, 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	47	13.62%
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 Dakota, Texas, Utah, Virginia, Wisconsin, Wyoming	34	9.86%

Response	States	Count	Percentage
MME daily dose program	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, 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	48	13.91%
Pharmacist override	Alabama, Georgia, Idaho, Louisiana, Mississippi, Nebraska, North Carolina, South Carolina, Utah, West Virginia, Wisconsin	11	3.19%
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, Virginia, Washington	32	9.28%
Require documentation of urine drug screening results	Alabama, Alaska, Delaware, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, North Dakota, Ohio, Oregon, Pennsylvania, Utah, Virginia, Washington	18	5.22%
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, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia	29	8.41%
Requirement that prescriber has an opioid treatment plan for patients	Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia	27	7.83%
Require PDMP checks	Alabama, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin	36	10.43%
Step therapy or clinical criteria	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska,	41	11.88%

Response	States	Count	Percentage
	Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming		
Workgroups to address opioids	Alabama, Alaska, California, Delaware, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Missouri, Utah, Vermont	13	3.77%
Other	Colorado, Idaho, Illinois, Indiana, Kansas, Louisiana, Nebraska, Vermont, West Virginia	9	2.61%
Total		345	100.00%

If "Other," please specify.

Table 146 - "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 and one short-acting opioid. Opioid-naive members are limited to short-acting opioids only.
Idaho	n/a
Illinois	1. Benzodiazepine and opioid drug interaction hard edit. 2. Antipsychotic and opioids drug interaction soft/informational edit. 3. All long-acting opioids require prior authorization.
Indiana	System edits are utilized to identify the number of prescribers; restrictions for concurrent use with benzodiazepines, carisoprodol products, buprenorphine, or buprenorphine/naloxone; current utilizers limited to one long-acting and one short-acting opioid product.
Kansas	We have a clinical prior authorization (PA) in place for opioids products used for pain management. This PA includes many other factors. The website link for this PA is https://www.kdheks.gov/hcf/pharmacy/PA_Criteria/Opioid_PA_Criteria.pdf 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.kmap-stateks.us/Documents/Content/Bulletins/18027%2 0-%20General%20-%20Opioid_2.pdf https://www.kmap-stateks.us/Documents/Content/Bulletins/18101%2 0-%20General%20-%20Opioid_2.1.pdf https://www.kmap-stateks.us
Louisiana	Other: Age limit Maximum dose limit Therapeutic duplication Concurrent use Bypass diagnosis
Nebraska	Non-preferred opioids require PA. Some medications also have quantity limits.

State	Explanation
Vermont	Cumulative Days Supply edit This new edit began 01/09/2021 to cumulatively count early refills and a maximum accumulation of seven (7) extra days of medication will be allowed at any given time
West Virginia	NA see below

Please provide details on these opioid prescribing controls in place.

Table 147 - Detail for Opioid Prescribing Controls in Place

State	Explanation
Alabama	AL Medicaid has max quantity limits; therapeutic duplication edit; short acting opioid naive edit; MME edit. PA is required for non-preferred agents.
Alaska	The opioid prescribing controls are integrated into the point-sale-system and reviewed by the state and DUR committee.
Arkansas	The initial prescription for an opioid naive client must not exceed 50 MME/day. Subsequent prescriptions must not exceed 90 MME/day. Prescriptions outside of these limits will require a prior authorization request from the prescriber. Both short-acting and long-acting opioids are on the PDL with preferred agents. Opioid naive patients may receive short-acting opioids only. Long-acting opioids require a PA with the exception of LTC clients, cancer patients, or clients identified as NPO as they may need patches. Continuation coverage for long-acting opioids without an additional PA request requires a paid claim for an opioid on the client's profile in the previous 60 days. Early refill threshold has been set at 90% utilization, and an accumulation edit allows only an extra 7 days of a controlled substance in 180 day period. PA would be required for an opioid claim when a client has a paid claim for a buprenorphine product in the previous 90 days. If the client has a billed diagnosis of overdose or poisoning in the previous 365 days, a prior authorization request would be required for an opioid.
California	Deny claim and require PA: Restrictions that may deny claim and require PA include, but are not limited to, age restrictions and duration of therapy restrictions. Intervention letters: In FFY 2021, intervention letters were sent to prescribers for the following topics: Dentists and oral surgeons with the highest percentage of paid claims for opioids with a days' supply greater than three days Tapering guidelines for patients with concomitant use of opioids and benzodiazepines. Morphine Milligram Equivalent (MME) daily dose program: For the treatment of chronic pain, dose is to not exceed 500 MME/daily without an approved Treatment Authorization

State	Explanation
	Request. This safety edit assists in identifying members at potentially high-clinical risk who may benefit from close monitoring and care coordination. Require PDMP checks: Assembly Bill 2760 (Wood, Chapter 324) was signed into law in 2018 and became effective on January 1, 2019. California prescribers are now required to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication when one or more of the following conditions are present: The prescription dosage for the patient is 90 mg or fewer MME/day. An opioid medication is prescribed concurrently with a prescription for a benzodiazepine. The patient presents with an increased risk for overdose, including a history of overdose, a history of substance use disorder, or a risk for returning to a high dose of opioid medication to which the patient is no longer tolerant. The bill also requires a prescriber, consistent with the existing standard of care, to provide education on overdose prevention and the use of naloxone or other similar drug approved by the FDA to a patient and his or her designee or, if the patient is a minor, to the patient's parent or guardian. Workgroups to address opioids: California has a Prescription Drug Overdose Prevention Initiative. The goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD.
Colorado	Prescriptions are limited to one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for opioid prior authorization approvals. Opioid-naive members are limited to short-acting opioids only. Prescriber opioid treatment plans are documented as part of provider-to-provider telephone consultations that are required for certain opioid prior authorizations.
Connecticut	Deny claim and require a PA Connecticut Medicaid requires a PA for all new LAO and SAO prescriptions (for prescriptions that are in excess of 7 days and/or 630 MMEs within the past 120 days). Intervention letters Retrospective DUR Intervention letters are mailed on a monthly basis to assist with monitoring and managing opioid utilization. MME LAO require PA. SAO claims in which the days' supply exceeds 7 days and/or the patient's cumulative morphine milligram equivalence (MME) exceeds 630 over the past 120-day window require PA. Require PDMP checks - Prior to prescribing greater than a 72-hour supply of any controlled substance (Schedule II - V) to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the CPMRS at https://connecticut.pmpaware.net.
Delaware	Prior authorization criteria contain the following requirements: verification that the prescriber verified the PDMP, verification of first line drug therapies used for treatment base on diagnosis provided, pain assessment and pain contract, and urine drug screeen.

State	Explanation
District of Columbia	Prospective monitoring occurs during the claims adjudication process to alert the pharmacist to daily MME limits and potential overus. Retrospective monitoring involves the DHCF clinical pharmacist who conducts MTM outreach to identified beneficiaries and prescribers in instances where questionable prescribing or utilization patterns are detected.
Florida	Any opioid claim outside of the established quantity limits, MME limits, or daily supply limits will deny for a prior authorization. In addition, there are various concomitant therapy edits for opioid and other agents.
Georgia	See above
Hawaii	Dental narcotics are limited to acute and naive. The transplant population enters FFS with existing MCO utilization of narcotics and usually grandfathered.
Idaho	Pharmacist override exists only for edits not involving doses, quantities or MME limits. For example general edits like a drug interaction override is allowed. Claims are denied at POS and a PA is required for quantities, MME, therapy duplication and non-preferred drugs. Intervention letters are done through the DUR Board on focused topics. The Morphine Milligram Equivalent (MME) daily program is an automated edit that adds up all opioid MME for all drugs and doses and denies for a cumulative MME exceeding 90 MME. Step therapy or clinical criteria are done at each drug 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 Use Disorder Advisory Group.
Illinois	Participants flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If patient has used opioids 3 or more months, the prescriber must fill out a pain management program form with medical justification. If approved, at approval expiration, must justify medical need for continued therapy. The methadone pain management program requires additional safety monitoring, including submission of recent urine drug screen, certain laboratory values, and completion of an EKG. All chronic opioid use requires use of short acting narcotics and/or preferred long-acting opioids first. Only one short and one long-acting opioid are allowed at a time. Exceptions can be made for patients with cancer. All patients in the pain management program must have a patient-prescriber pain contract and a pain diagnosis for which opioid therapy is appropriate. State law requires PDMP check before the first Schedule II prescription. The prescriber notes date PDMP checked on the Four Prescription Policy pain management program forms. All prescribers of participants within the pain program receive an intervention letter/response with recommendations after review of submitted pain management program forms.
Indiana	See above.
Iowa	Limited initial days' supply of 7 days for opioid naive. Prior authorization (PA) in required for non-preferred opioids, allowing the pharmacist to review and determine if therapy is appropriate and for an age edit override for codeine or tramadol for patients under 18 years of age. MME is in place, requiring PA for MME > 90 mg/day. Step therapy and clinical criteria is embedded as part of the overall PDL/PA process. Any opioid requiring PA must document patient has a pain management contract with the provider in addition, the prescriber must document the PMP has been reviewed.
Kansas	Same as above.

State	Explanation
Kentucky	Please see opioid criteria available at https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KYRx_PDL_prior_authorization_criteria.pdf
Louisiana	There are exemptions for certain medical conditions. 1. Diagnosis code requirement. Pharmacy claims for all Schedule II opioid prescriptions must be submitted with a valid diagnosis code. Pharmacy claims for fentanyl buccal and sublingual agents must be submitted with a cancer-related diagnosis code. 2. MME. The cumulative daily morphine milligram equivalent (MME) for all active opioid prescriptions will be limited to a maximum of 90 MME per day. 3. Clinical monitoring is required for methadone. 4. Long-acting opioid prescriptions require prior use of a short or long-acting opioid within the previous 90 days. 5. Age limit. Codeine single-ingredient products, 18 years or older; codeine combination products, 12 years or older; tramadol and tramadol/acetaminophen, 17 years or older. 6. Maximum dose limit. Tapentadol, 700mg per day; tramadol IR, 400mg/day for 75 years or younger; tramadol IR, 300mg/day for 76 years or older; tramadol/acetaminophen, 8 tablets/day; buprenorphine buccal film, 1800mcg/24hr; buprenorphine transdermal, 480mcg/24hr (20mcg/hr); morphine sulfate ER (Avinza), 1600mg/day. 7. Therapeutic duplication for opioid prescriptions written by different prescribers; Therapeutic duplication of short-acting opiates; Therapeutic duplication of long-acting opiates; Special POS edits to monitor the use of opioids with buprenorphine-containing agents. 8. Concurrent use. Opioids with benzodiazepines. 9. Intervention letters. The retrospective DUR program addresses opioid safety with interventions for concurrent use of opioids with antipsychotic agents, benzodiazepines, and sleep agents. Overrides of the opioid POS edits are addressed with interventions for >90MME, >quantity limit, >2 days early, duplication of therapy, and > days' supply.
Maine	see above responses listed above, these are all used in some fashion on controls on the prescribing of opiates
Maryland	Providers must obtain a prior authorization every six months to prescribe long-acting opioids, fentanyl products, methadone for pain, and opioids greater than 90milligram equivalents per day. This includes: Attestation of a patient-provider agreement; A medical justification for high-dose and/or long-acting opioid prescription; Attestation of screen patient with random drug screen(s) before and during treatment; and Attestation that a naloxone prescription was given or offered to the patient/patient's household member. The prior authorization form with more information is available at https://health.maryland.gov/mmcp/pap/docs/PA%20Forms/Universal%20Opioid%20PA%20Form%20%2810.2017%29.pdf
Massachusetts	https://mhdl.pharmacy.services.conduent.com/MHDL/pubtheradetail.do?id=8
Michigan	These point-of-sale edits prevent claims hitting these additional safety edits from processing. In essence they trigger a comprehensive medical necessity prior authorization review to occur to further evaluate the opioid treatment plan for safety and

State	Explanation
	appropriateness and provide an opportunity to recommend a naloxone prescription for individuals at risk for opioid overdose. The prior authorization reviews provide opportunity for State staff to acquire additional details on utilization and prescribing trends to further monitor and manage the prescribing of opioids in our program. The Medicaid Opioid Workgroup reviews other State Best Practices, utilization trends, and policies and evaluates opportunities for modification of the program to better monitor and manage the prescribing of opioids. Our comprehensive RetroDUR opioid review monitors for trends and targets prescribers of the highest risk Medicaid beneficiaries with additional education and resources to manage the safe and appropriate prescribing of opioids and referral options for MAT and additional behavioral health support services.
Minnesota	If the opioid claim is greater than 90mg MME, then the claims rejects at POS. Prior authorization is required which includes a Clinic Tool for the Assessment and Management of Persistent Pain which is completed and signed by both prescriber and patient. The prescriber must also complete the High Dose Opioid Drug Authorization found at High Dose Opioid Drug Authorization (PDF) (DHS-7072). This includes a PDMP attestation signature.
Mississippi	DOM implemented opioid prescribing criteria that sets cumulative MME limits to 90 and prohibits concomitant use with benzodiazepines.
Missouri	MO HealthNet utilizes clinical edits. These edits look for appropriate diagnosis, duplicate therapy, quantity and day supply limits, and accumulative MME limits. When participants do not meet the clinical criteria, claims are denied and require a clinical review.
Montana	Quantity per day limits on IR oxycodone. Limits on # of prescribers of opioids. Limit on # LA opioid prescriptions. 90MME limit. Provider attestation of risk vs benefit analysis, OUD analysis, failure of taper, failure of alternate therapy, offer of Narcan, etc to keep legacy patient on greater than 90mme.
Nebraska	Non-preferred opioids require PA. Some medications also have quantity limits.
Nevada	All of the following criteria must be met in order for a recipient to exceed the number of seven-day prescriptions, to exceed the seven-day limit or to exceed the 60 mg morphine equivalents or less per day: 1) the recipient has chronic pain or requires extended opioid therapy and is under the supervision of a licensed prescriber; 2) the pain cannot be controlled through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants, anti-seizure medications, physical therapy, etc.); and 3) the lowest effective dose is being requested and a pain contract is on file.
New Hampshire	All long-acting opioid prescriptions require prior authorization. In addition, NH has a daily MME edit of 100mg. When a beneficiary exceeds 100mg MME, 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, prior PDMP review, risk/benefit discussions with the patient, and naloxone prescribing. Patients with diagnoses of cancer or sickle cell anemia are exempt in addition to hospice and end-of-life patients.
New Jersey	MME daily dosing is calculated via an automated prospective review and will be denied at POS if exceeding the maximum allowed by DURB protocols. These limits are in place for opioid naive and opioid tolerant patients. Initial fills of high dose opioids require a PA to confirm diagnosis and titration of dosage. Beneficiaries on short-acting opioids for 90 days or more require prior authorization to obtain justification of continued use.

State	Explanation
New Mexico	Opioid naive claims require an initial 7-day supply of an immediate release (IR) opioid, extended release (ER) not initially covered. Additional fills of IR and ER after a 7-day IR supply can be filled at a 90% threshold up to a 34 day supply not to exceed 90 MME dosage per day with a claim on file within the last 60 days. Exceptions are cancer treatment, hospice or palliative care, and residents in a long-term care facility or facility where such drugs are dispensed to a resident. Pharmacy point-of-Sale PDMP check verification edit on opioids required on initial fill and every 90 days.
New York	Four prescription limit every thirty days. Initial prescription for opioid naive members limited to a seven day supply and equal to or less than 50 morphine milligram equivalents per day. Morphine milligram equivalent maximum equal to or greater than 90 morphine milligram equivalents .
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 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). Intervention letters have been used to increase the use of the state's naloxone standing order.
North Dakota	North Dakota has quantity limits applied to all opioid medications consistent with FDA labeling or 90 MME per day, whichever is less. Opioid naive patients are limited to a 7 day supply on their first fill. Long acting opioids require prior authorization and clinical criteria requires 90 day of previous opioid therapy, access to Narcan, counselling on overdose risk, review of the PDMP, trials of non-narcotic medication and/or therapies, pain management or oncology involvement when exceeding 90 MME per day (exception for LTC residents and tapering requests). Highly abused short acting medications require prior authorization and clinical criteria requires that a short acting dose be 10% or less of the total daily dose of a concurrent long acting opioid. Therapeutic duplication measures are also in place limiting to one short acting and one long acting opioid at a time. We also have an underutilization edit on long acting opioids which will reject for review to verify proper dosing directions and consistent adherence so a predictable opioid tolerance is maintained.
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 non-pharmacological treatment tried, non-opioid analgesics tried, and concurrent therapies. Prescribers must review the PDMP. The prescriber must discuss benefits and risks of opioid therapy with the patient and

State	Explanation
	provide documentation of a current treatment plan and demonstrated adherence to the treatment plan.
Oklahoma	MME is limited to 90 MME per day. PA/override requests for MME quantities greater than the 90 MME limit require documentation that prescriber has a tapering plan in place. Cancer, hemophilia, and sickle cell diagnoses are excluded from the MME limit. Quantity limits for short acting opioids are 8 units per day for 7 days for acute use and 4 units per day for 30 days for chronic use.
Oregon	Limit SAO to 7 day supply and require PA for all LAO Prescriber must attest they are enrolled in the Oregon PDMP and that they have reviewed at least once in the past 3 months the scheduled substances the patient has recently been prescribed from other providers. SAO Criteria: https://www.orpdl.org/durm/PA_Docs/short_acting_opioid_analgesics.pdf LAO Criteria: https://www.orpdl.org/durm/PA_Docs/opioids_long_acting.pdf
Pennsylvania	Prior authorization guidelines can be found at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx.
Rhode Island	State law requirements.
South Carolina	Timely Information for Providers in South Carolina (tipSC) SCDHHS has engaged in an aggressive provider education campaign to promote opioid risk reduction strategies and expand access to MAT, named tipSC. Working with physicians, pharmacists and other experts from the Medical University of South Carolina, tipSC develops and disseminates targeted, practical information to help prescribers make safer prescribing decisions. These educational programs offer continuing education credit for providers. These materials are available at https://msp.scdhhs.gov/tipsc/. Though corresponding liability rests with pharmacists who fill and ultimately dispense the prescription, pharmacists are not obligated to verify compliance. However, pharmacies may choose to implement their own verification procedures for prescriptions in accordance with the requirements of S.C. Pharmacy Practice Act. Pharmacists continue to have the authority under state law to refuse to fill a prescription if they are concerned about the legitimate nature of the prescription. S.918, in addition to establishing the above mentioned limitations for initial opioid prescriptions, requires DHEC to develop and maintain as part of the PMP a system to provide prescription report cards to practitioners to inform the practitioner about certain prescribing trends. Although DHEC currently provides prescription report cards to practitioners, the new law requires the report cards to provide a different set of metrics to practitioners beginning November 15, 2018. H.4117 authorizes DHEC's Drug Control to provide data in the PMP to the presiding judge of a drug court pertaining to a specific case involving a designated person.
South Dakota	State has implemented the measures as indicated above.
Tennessee	In addition to the information described above for non-chronic use, those who are chronic users are limited to 200MME per day

State	Explanation
Texas	HHSC implements multiple prior authorization criteria to manage the opioid prescriptions. The purpose of these PAs is to reduce opioid overutilization as well as to monitor inappropriate behaviors such as doctor shopping/pharmacy shopping, etc. Also, a number of population-based retro-DUR interventions are performed annually. These are intended to fulfill the requirement for federal SUPORT Act and to reduced inappropriate prescribing. Educational letters along with patient's specific claim information are mailed to prescribes identified through these RDUR monitoring. In addition, the Opioid Clinical Policy is in place to monitor daily cumulative MME levels. A daily MME level above 90 will trigger the system to stop the claim and require a prior authorization. For clients with certain diagnosis, including cancer, sickle cell, hospice care, the daily MME level does not apply.
Utah	All edits above are in place.

State	Explanation
Vermont	In 2017, DVHA implemented prescription limits on initial short-acting opiate prescriptions. Patients 18 years and older are limited to 50 MME per day and a maximum of 7 days' supply. Patients 17 years of age and younger are limited to 24 MME per day and a maximum of 3 days' supply. These limits remain unchanged. Effective 05/01/2021, additional edits apply that include any combination of short and long-acting opioids and members on chronic therapy for non-cancer pain. Members new to opioid therapy (no opioid in claims history after 2/1/21) with a daily MME > 90 per day will require the completion of an opioid safety checklist as a prior authorization. Members with existing claims history in the past 90 days for opioids will require a safety checklist if the daily MME > 120 per day. Morphine Milligram Equivalent (MME) Safety Checklist Non-Opioid alternatives (up to a maximum dose recommended by the FDA) have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: NSAIDs, Acetaminophen. YES NO Non-Pharmacological Treatments have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: Acupuncture, Chiropractic, Physical Therapy. YES NO Vermont Prescription Monitoring System (VPMS) has been queried. YES NO Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record. YES NO A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen is completed no less than once every 90 days. YES NO Patient has a valid prescription for or states they are in possession of naloxone YES NO
Virginia	* The prescriber has checked the Virginia's Prescription Monitoring Program (PMP) database on the date of the request to rule out use of other opioids or dangerous combinations (such as opioids and benzodiazepines). Document the date of the last opioid Rx, the date of the last benzodiazepine Rx. If benzodiazepine filled in past 30 days, prescriber attests that patient has been counseled on warnings associated with combined use and Naloxone has been prescribed; AND * Document the Morphine Milligram Equivalents (MME) per day from the PMP site. If MME is greater than or equal to 90, prescriber attests to the following: patient's long term opioid therapy will be managed, VA BOM Regulations for Opioid Prescribing has been reviewed, Naloxone has been prescribed and acknowledges the warnings associated

State	Explanation
	with high dose opioid therapy including fatal overdose and that therapy is medically necessary for the patient; AND * For female patients between 18-45 years of age, the prescriber has discussed risk of neonatal abstinence syndrome and provided counseling on contraceptives options; AND * Attestation from the prescriber that a signed physician/patient treatment plan/agreement with goals addressing the benefits and harm of opioids has been established; AND * The prescriber has ordered and reviewed a urine drug screen (UDS) or serum blood medication level prior to initiating opioid treatment. For renewals - Prescriber has ordered and reviewed a UDS or serum blood medication level at least every 3 months for the 1st year of treatment and at least every 6 months thereafter to ensure adherence.
Washington	Prescriber must attest that the client meets the following: A. on-going clinical need for chronic opioid use B. non-pharmacologic therapies have been used C. tried a short-acting opioid for at least 42 days D. conduct periodic pain assessments E. screened for mental health disorders, substance use disorder, naloxone use F. conduct periodic urine drug screens G. checked the PDMP to determine if the patient is receiving other opioid therapy H. discussed with my patient the realistic goals of pain management therapy I. confirmed that my patient understands and accepts these conditions
West Virginia	Patients who are receiving more than 50 MME/day for at least the last 90 days are required to receive a PA through our SEMP (Safe and Effective Management of Pain) Program. The PA process requires identification of previous therapies, a plan of care and encourages providers to titrate to the lowest effective dose whenever possible.
Wisconsin	Wisconsin has an Early Refill hard alert for certain opioid prescriptions dispensing that requires a prior authorization from a specialized call center. Wisconsin has a monthly opioid script limit that limits the dispensing of opioids to five scripts per month. Wisconsin has a Therapeutic Duplication alert for opioids, a High MME alert, and a Patient Age alert for tramadol, codeine, and hydrocodone or codeine cough syrups that a dispensing pharmacist may override. In addition, Wisconsin has a number of retrospective intervention letters addressing opioid prescribing issues, including the pharmacy Lock-In program. Wisconsin has a PDMP and requires prescribers to check the PDMP for most controlled substance prescribing.
Wyoming	Intervention letters are sent regarding pregnant patients who have filled 14+ days of opioids on a monthly basis. Quarterly letters are sent to mental health providers for patients who are on antipsychotic medications and opioids. Letters are sent as needed for providers who indicate on a PA form that they did not check the PDMP prior to prescribing a controlled substance. Following a 42-day acute treatment period, long-acting medications are limited to a maximum of 120 MME per day and short-acting medications are limited to a maximum of four tablets per day. Step therapy is required for fentanyl and buprenorphine.

5. Does your state have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent.

Figure 94 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

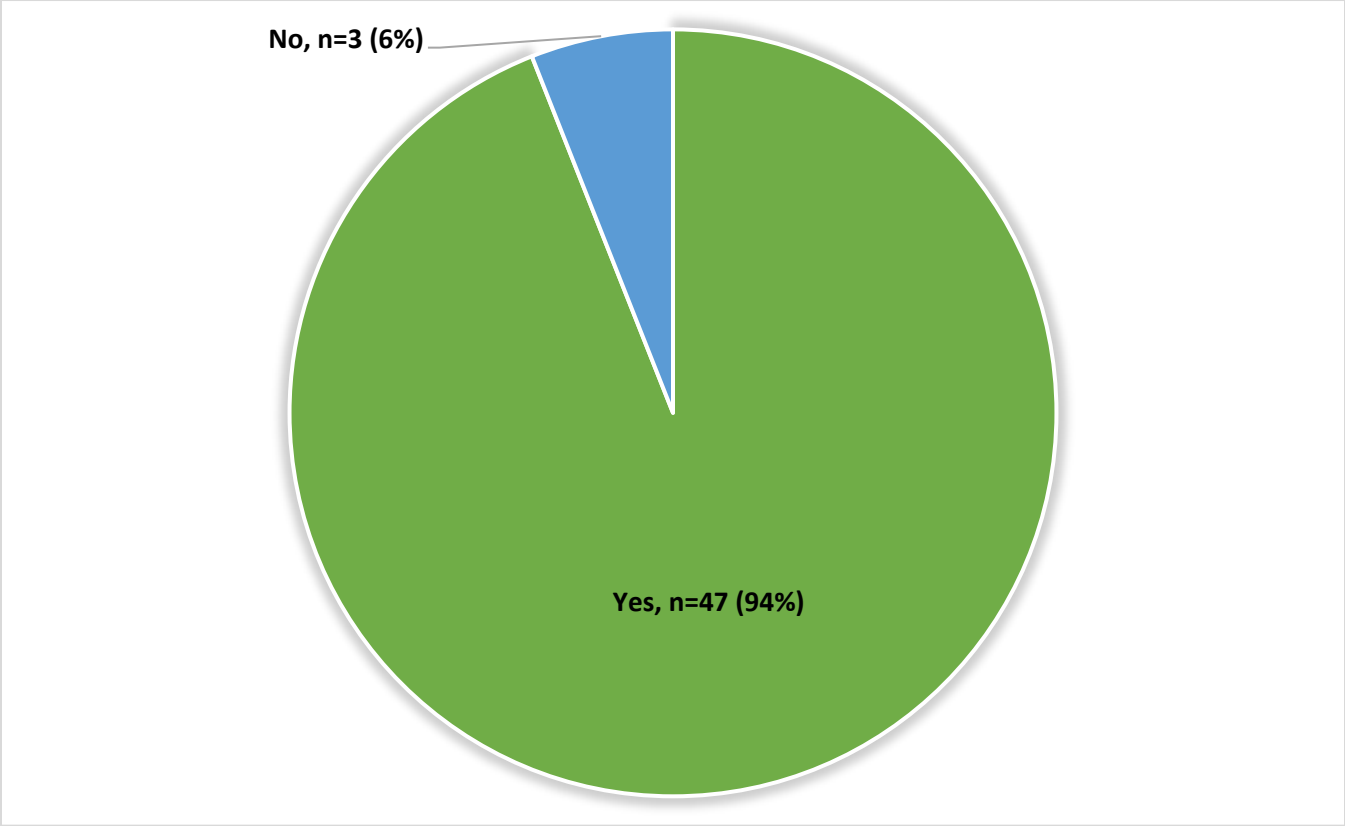

Table 148 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

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

Please explain.

Table 149 - Explanations of POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

State	Explanation
Alabama	Therapeutic duplication edit
Alaska	There is a point-of-sale prescription lookback and produr edits identify duplicate therapy.
Arkansas	There is a maximum quantity edit for short-acting opioids of #93 over a rolling 31 days. This edit would allow multiple short-acting opioids to be billed, but a total for all claims cannot exceed 93 pills in a 31 day rolling timeframe. Early refill thresholds apply to each fill. Therapeutic duplication edit exists between short-acting opioids with more than 25% of the days' supply remaining on the previous claim. Patients who have a diagnosis of malignant cancer in the past 12 months are exempt from the therapeutic duplication requirement. Opioid claims will deny at POS if the client has a billed claim of a buprenorphine product in the previous 90 days.
California	POS edits are in place to monitor duplicate therapy of opioid prescriptions that do not have an approved Treatment Authorization Request.
Colorado	Duplicate therapy limitations, including limit of one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for concomitant use, are managed by limiting PA approval on file for opioid medications prescribed. For members that are not opioid naive, the short-acting opioid quantity limit of 120 pills per 30 days applies cumulatively across multiple short-acting opioid agents when dispensed.
Connecticut	Same day/duplicate fills are not allowed and will trigger early refill notifications. Additionally, there are ProDUR alerts triggered by duplication of ingredients within the same therapeutic class.
Delaware	Duplicate claims are identified by comparing the current drug claim to drugs in claim history having the same generic sequence number or the same therapeutic class with overlapping day supply date ranges. Claim is flagged for Pharmacy verification and a prior authorization is required to override duplicate therapy or the use of submission clarification code of 5 to override in the case of a therapeutic change by prescriber.
District of Columbia	There are POS edits in place to identify duplicate therapy of opioid medications by requiring prior authorization and or prescribing contact and verification by the pharmacist.
Florida	Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 long-acting narcotic every 30 days.
Georgia	Members are limited to 5 narcotic (opioid pain relievers) fills per 30 days. Treatment naive members: Edit checks for a LAO with no paid claim for a SAO. Purpose is to verify patient receives IR prior to ER use. MME limits in place for overall opioid use.
Hawaii	Duplicative therapy edit by First Data Bank will deny.
Idaho	ProDUR edit plus cumulative MME total for all opioids.
Illinois	Duplicate therapy edit for short-acting narcotics. For long-acting opioids, which all currently require prior authorization, the adjudicating pharmacist manually checks for duplicate therapy.
Indiana	System monitors for more than one long-acting and one short-acting agent in current utilizers and requires PA if more are present.
Iowa	Softs edits are used to message pharmacy.
Kansas	Concurrent opioid use is limited to one short acting opioid and one long-acting opioid, with the exception of the following scenario: We allow for the main opioid prescriber plus an intermittent prescriber for a surgical/trauma type situation where increased opioid use would be needed. *The prescriber has to have reviewed controlled substance prescriptions

State	Explanation
	in the Prescription Drug Monitoring Program (PDMP) a.k.a K-TRACS. *Prescriber must attest that the patient has been counseled on potential respiratory depression. *Cumulative opioid dose must not exceed 90 MME per day. *Total day supply for the requested medication must not exceed 21 days (3 weeks).
Kentucky	An NCPDP 88 duplicate therapy denial will present when there are overlapping days' supply of 2 short-acting or 2 long-acting opioids. An NCPDP ProDUR denial will also present when there are overlapping days' supply of an opioid and a buprenorphine containing product. Prior authorization is required for all of the above instances.
Louisiana	Long-acting opioid prescriptions require the prior use of a short- or long-acting opioid within the previous 90 days. Therapeutic duplication for opioid prescriptions written by different prescribers. Therapeutic duplication of short-acting opiates. Therapeutic duplication of long-acting opiates. Special POS edits to monitor the use of opioids with buprenorphine-containing agents.
Maine	ProDUR messaging sent to the pharmacies during adjudication
Maryland	Prospective DUR edits are in place to identify therapeutic duplication of opioids and can be overridden at the point of sale (POS) after review by a pharmacist.
Massachusetts	1. Claims for any combination of the following long-acting agents: Belbuca, buprenorphine transdermal, fentanyl transdermal system, hydrocodone ER capsule, hydromorphone ER, levorphanol tablet, methadone injection, methadone oral, MorphaBond ER, morphine ER, Nucynta ER, oxycodone ER tablet, oxymorphone ER oral, tramadol ER, or Xtampza ER, and there is greater than 2 months of duplicate claims in POPS history, the claim will usually reject at the pharmacy as prior authorization required. 2. Claims for any combination of the following short-acting, opioid powders, and combination product agents: Abstral, acetaminophen/codeine, apomorphine powder, benzhydrocodone/acetaminophen, Buprenex, buprenorphine powder, butalbital/acetaminophen/caffeine/codeine, butalbital/aspirin/caffeine/codeine, butorphanol nasal spray, carisoprodol/aspirin/codeine, cocaine powder, codeine, codeine powder, dihydrocodeine/acetaminophen/caffeine, dihydrocodeine/aspirin/caffeine, fentanyl buccal tablet, fentanyl nasal spray, fentanyl powder, fentanyl transmucosal system, hydrocodone powder, hydrocodone/acetaminophen, hydrocodone/ibuprofen, hydromorphone, hydromorphone powder, levorphanol powder, meperidine, methadone powder, morphine IR, morphine sulfate powder, Nucynta, Oxaydo, oxycodone IR, oxycodone powder, oxycodone/acetaminophen, oxycodone/aspirin, oxycodone/ibuprofen, oxymorphone IR oral, pentazocine/naloxone, Prialt, Qdolo, Subsys, sufentanil powder, tramadol IR, tramadol/acetaminophen or Xartemis XR and there is greater than 2 months of duplicate claims in POPS history, the claim will usually reject at the pharmacy as prior authorization required.
Michigan	The POS therapeutic duplication edit denies claims and requires a call center override. Provider level overrides are not permitted on this edit.
Minnesota	If it is the same drug, strength, and dose form of the opioid, then the claim rejects as a duplicate claim.
Mississippi	POS edits capture duplicate opioid prescriptions.
Missouri	Missouri allows one short acting opioid at a time. We also have an accumulative MME edit and evaluate the total therapy when the MME limit is exceeded.

State	Explanation
Montana	Rx system will recognize same drug and strength and deny for duplicate.
Nebraska	Drug-drug alerts are sent to pharmacies with each fill.
Nevada	Pro-DUR edits are in place to monitor duplicate therapy.
New Hampshire	POS edits will deny opioid prescriptions for therapeutic duplication. If the prescription is medically necessary and clinically appropriate, the pharmacy can request an override.
New Jersey	DUR edits deny a claim if 2 or more short-acting or long-acting opioid prescriptions are requested.
New Mexico	Monthly reports are generated by Conduent for state staff review of opioid overutilization.
New York	The pharmacy would receive a therapeutic duplication (TD) warning. The therapeutic duplication edit checks the therapeutic class of the new drug against the classes of the member's current, active drugs already dispensed.
North Carolina	DUR Alerts for Therapeutic Duplication and Ingredient Duplication. The MME limit is cumulative for all opioid prescriptions.
North Dakota	We limit all to only one extended release product at a time and one short acting product at a time.
Ohio	DUR edits are in place to monitor duplicate therapy.
Oklahoma	POS edits are in place to limit opioid prescriptions to one short acting and one long acting opioid.
Oregon	Morphine equivalents and quantity limits are per opioid drug claim and do not look across multiple agents. All LAOs require PA, so manual review precludes the need for POS edits.
Pennsylvania	The following require prior authorization: 1. An Analgesic, Opioid Short-Acting when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in the Point-of-Sale Online Claims Adjudication System (therapeutic duplication). 2. An Analgesic, Opioid Long-Acting when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in the Point-of-Sale Online Claims Adjudication System (therapeutic duplication).
Rhode Island	Pro-DUR edits in place supplied by First Data Bank
South Carolina	Yes, First DataBank (FDB) edits for TD/DDI, 90 MME edits across all opioids are integrated via the Point of Sale System.
South Dakota	The POS edits for duplicate therapy. Multiple strengths of the same product are not considered duplicates.
Tennessee	Yes, duplicate therapy ProDUR edits will trigger with multiple opioids, and the use of multiple opioids is also controlled via the benefit limit for non-chronic users and PA's required. For chronic users, ProDUR edits would be triggered, however the enrollees benefit allows up to 200MME, so with the hard duplicate therapy edit, if the enrollee is below 200MME, the enrollee/practitioner can acquire coverage with PA submitted via CoverMyMeds or a call to the call center.
Texas	Per the Opioid Clinical Policy cumulative opioid dosing for any combinations of opioids must be less than 90 MME. In addition, the Opioid Overutilization PA criteria checks for doctor/pharmacy shopping, and for the number prescriptions/claims during a set time period (i.e. for clients with diagnosis of cancer, sickle cell, or palliative/hospice care, the client can receive no more than 3 prescriptions (of different opioids), or no more than 4 claims in the last 60 days. For any other conditions, the client can receive no more than 2 different prescriptions or no more than 3 claims in the last 60 days.)

State	Explanation
Utah	Opioid prescriptions of the same medication and dose will hit a refill too soon edit if filled before 85% is exhausted. The system will allow opioid in the same class or dose to fill concurrently if accumulative MME is less than 90.
Vermont	Duplicate fill edits are in place. NCPDP Reject Code 88/DUR REJECT ERROR. Must be overridden by the dispensing pharmacy by submitting the appropriate Professional Service and Result of Service Codes. Allowable professional service codes (intervention) are: "MR" Medication Review, "M0" Prescriber Consulted, "R0" Pharmacist Consulted Other Allowable Result of Service Code (Outcome) are: "1B" Filled Prescription as is, "1C" Filled with Different Dose, "1D" Filled with Different Directions, "3E" Therapy Changed
Virginia	There are ProDUR edits for duplication of therapy for opioids
Washington	For acute use POS adds the prescriptions to verify if they exceed the allowed number of doses based on the client's age. For chronic use (exceeding 42 days in a rolling 90-day period) only the opioids approved through the attestation prior authorization process will pay; all others will reject 75 for prior authorization required.
West Virginia	We allow long-acting to be used with short-acting but cannot have multiple of either. Edit will fire that requires override by the pa vendor RDTP (SEV 1 EDIT).
Wisconsin	Wisconsin has a prospective DUR alert for therapeutic duplication in certain therapeutic classes, including opioid analgesics.
Wyoming	Medicaid clients are allowed one long-acting and one short-acting medication at a time.

6. Does your state have POS edits to monitor early refills of opioid prescriptions dispensed?

Figure 95 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

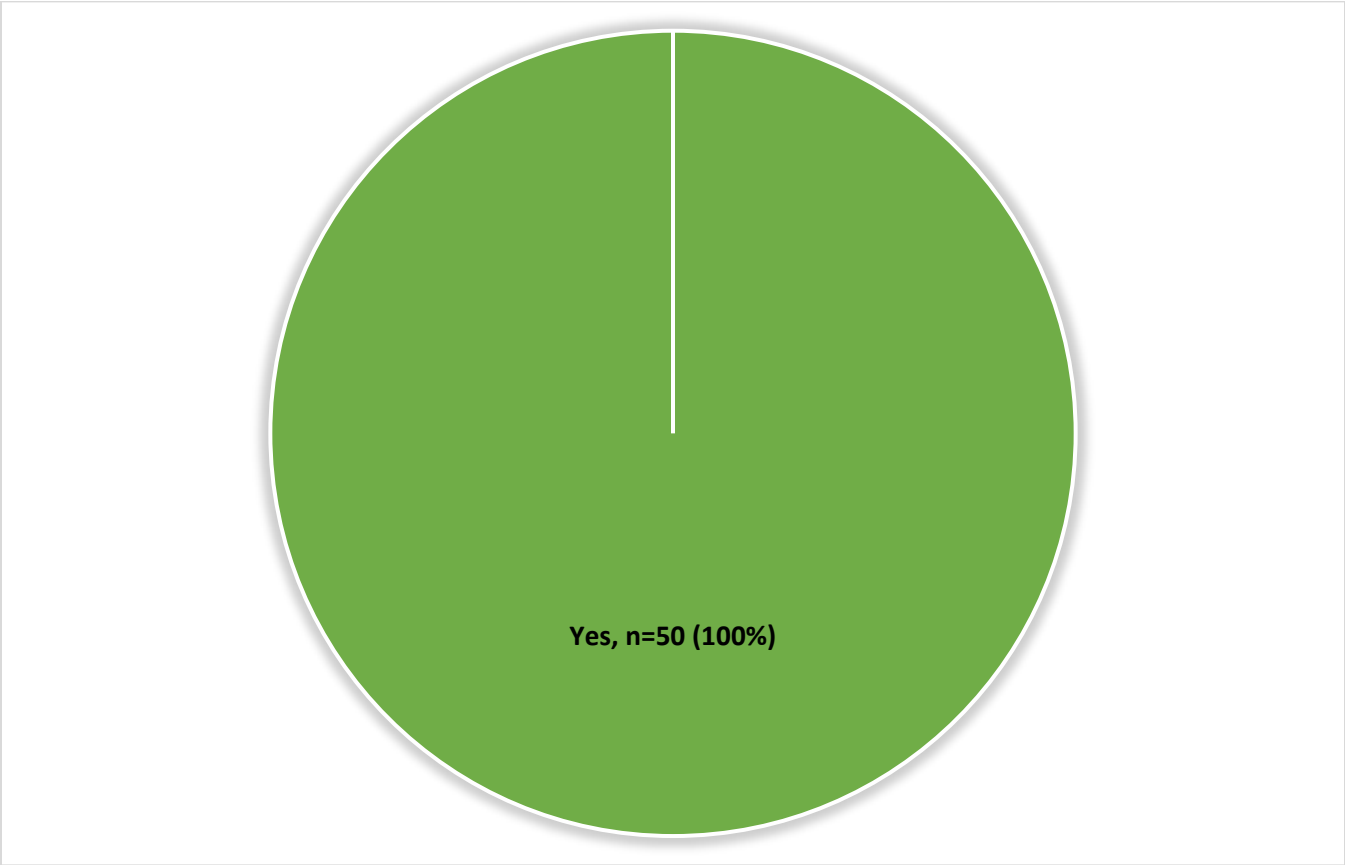

Table 150 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	States	Count	Percentage
Yes	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%

Please explain.

Table 151 - Explanation for Scope and Nature of Reviews and Edits in Place

State	Explanation
Alabama	Early refill edits: 75% threshold for Schedule II control drugs; 85% threshold for opioid agonists and partial agonists.
Alaska	Requires prior authorization.
Arkansas	POS edits for all controlled medications include an early refill threshold that requires at least 90% of dispensed medications to be utilized before a refill would be allowed. Also an accumulation edit for controlled drugs will allow an extra 7-days' supply accumulation through early fills in the previous 180 day period. POS edits include maximum quantities and MME restrictions for opioids which are so strict that very few clients will have claims that exceed our limitations which mirror the CDC recommendations. Behind the scenes, the RetroDUR vendor is monitoring for overutilization of opioids. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics.
California	POS edits are in place to monitor early refills of opioid prescriptions that do not have an approved Treatment Authorization Request.
Colorado	All opioid claims are subject to 85% early refill tolerance and a cumulative total of 20 early refill days over a 180 day period.
Connecticut	POS - Claims < 15 Day Supply, or if the pharmacy is out of state, require that 85 % of the days' supply on the previous prescription be used before allowing the current claim to pay. Claims > or =15 Days of supply require that 93 % of the days' supply on the previous prescription be used before allowing the current claim to pay.
Delaware	Early refill for opioid claims are denied if less than 90% of the day's supply has been used.
District of Columbia	Automated First Data Bank system early refill edits are used to monitor early refills of opioid prescriptions dispensing.
Florida	The early refill percent threshold is set at 90% for opioid prescriptions.
Georgia	Early refill edits are in place and members are limited to 5 narcotic fills per 30 days.
Hawaii	Must be outside of the 90% grace period for early refills else it will be denied. No refills on dental.
Idaho	ProDUR edit for early refill. Also the MME edit is set up so if early refill then both original fill and refill will count toward cumulative MME limit. If over 90 then will deny.
Illinois	HFS has a refill-too-soon threshold of 90% for Schedule II-V controlled substances. Prior authorization is required for all early refills.
Indiana	Early refill is monitored, and PA is required if 85% of supply is not exhausted.
Iowa	All prescriptions have refill threshold of 90%. Hard edits are in place for early refill and early refill reports are reviewed quarterly.
Kansas	We have all required federal edits and additional state hard and soft edits at the Point of Sale, which were in place within this FFY time frame.
Kentucky	Early refill edits are in place at POS. PA is required before the medication can be dispensed.
Louisiana	Refills are not allowed until 90% of the previous fill is used.
Maine	Accumulator edits are in place to minimize early refill use and require prior authorization
Maryland	POS edits were in place to identify early refills of opioids (85% threshold or claim will deny). Additionally, the automated retrospective claims review process identifies participants who may be receiving early refills of opioid prescriptions through the Corrective Managed Care Lock-In program.

State	Explanation
Massachusetts	POS rules will not allow less than 85% of days supply utilized. Prior authorization is required to override
Michigan	The POS system requires 90% of the opioid claim to be utilized otherwise the claim will deny. No provider level overrides are allowed. The call center must review and approve. For beneficiaries enrolled in our Benefits Monitoring Program (BMP), the POS system requires 95% of the opioid claim to be utilized before a refill is allowed.
Minnesota	Controlled substances are set at 85% refill too soon threshold.
Mississippi	POS edit limits claims to 85% threshold for subsequent/next fill.
Missouri	Missouri's early refill edit limits opioids to be filled at 85% and is not overridable by the pharmacist though the POS system.
Montana	Our system monitors early refills on all medications. Controlled substances will deny for early fill if more than 10% of the previous fill's day supply remains.
Nebraska	Drug alert is sent to pharmacies with each fill.
Nevada	Point-of-sale edits are in place for early refills and duplicate of opioid prescriptions.
New Hampshire	Early refills for opioid prescriptions are set at an 80% threshold and require prior authorization for an override.
New Jersey	Early refill edits deny claims for opioid prescriptions that have not exceeded 85% completion. Ad hoc quarterly reports are generated for claims review and provider follow up as needed.
New Mexico	All prescriptions are subject to early refill POS edits.
New York	Prior authorization required for an early refill. The decision to honor a member's request for authorization of a replacement supply is based on the professional judgement of the prescriber. An early refill (if granted) may be approved for up to a 30-day supply of medication.
North Carolina	Early Refill Edit hits for claims with less than 85% consumption. This can only be overridden if there is a change in therapy.
North Dakota	Early refill edits are set to 87% and accumulation edits are in place to limit to a max accumulation of 10 days of supply in a 180 day lookback.
Ohio	We utilize early refill edits at POS. The refill threshold for all controlled substances, including opioids, is set at 90%. The pharmacy cannot override the edit and must call the help desk if an override is required.
Oklahoma	The early refill threshold for opioids is set to 90%.
Oregon	All LAO require PA and all SAO are limited to two 7-day supplies every 90 days without PA.
Pennsylvania	Claims for opioids deny at the point of sale for prior authorization when the system calculates that the beneficiary has more than 15% of the previously filled day supply remaining. The prescriber must request medical necessity review for early fills.
Rhode Island	Pro-DUR edits in place
South Carolina	Yes, Prescription edits limit refill of Control Medications - 85% of control medications must be exhausted prior to a prescription refill. Claim will reject/deny NCPDP early refill and cannot be overridden by Pharmacy (Federal/State laws apply example: Authorization for Emergency Dispensing
South Dakota	The early refill threshold for controlled substances is 85%
Tennessee	The early refill edit is not only for opioids, but is for all controlled substances. The refill percent threshold for non-controlled substances is 85%, so for a 30-day supply, the prescription cannot be refilled until the 26th day. For all controlled substances, the refill

State	Explanation
	percent threshold is 95%, so any additional fills cannot be filled until the 30th day for a 30-day supply.
Texas	An early refill is triggered if client did not complete 90% refill threshold for opioids. It will trigger the system to reject that claim and message the dispensing pharmacy to contact HHSC Help Desk and provide justification for early refill.
Utah	Opioid prescriptions have a refill tolerance of 85%.
Vermont	In addition to the standard early refill edits, Cumulative Days Supply edit for controlled substances have been implemented. This new edit began 01/09/2021 to cumulatively count early refills and a maximum accumulation of seven (7) extra days of medication will be allowed at any given time
Virginia	There is an early refill edit with a percent threshold for schedule II controlled drugs of 90%.
Washington	Our point-of-sale system has been programmed to require eighty percent of an opioid medication to be used based on the prescriptions day supply before another fill will pay. This edit cannot be overridden by the pharmacy and requires a PA. Washington Apple Health (Medicaid) has developed reports to measure the SUPPORT Act requirements and is hiring an Oversight Specialist to help monitor opioid use. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects.
West Virginia	Early refill edit is set at 85% which can be overridden by rational drug therapy program (prior authorization vendor).
Wisconsin	Wisconsin has a prospective early refill, duplicative fills, quantity limits and days' supply requirements.
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.

7. 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 96 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions Exceeding State Limitations

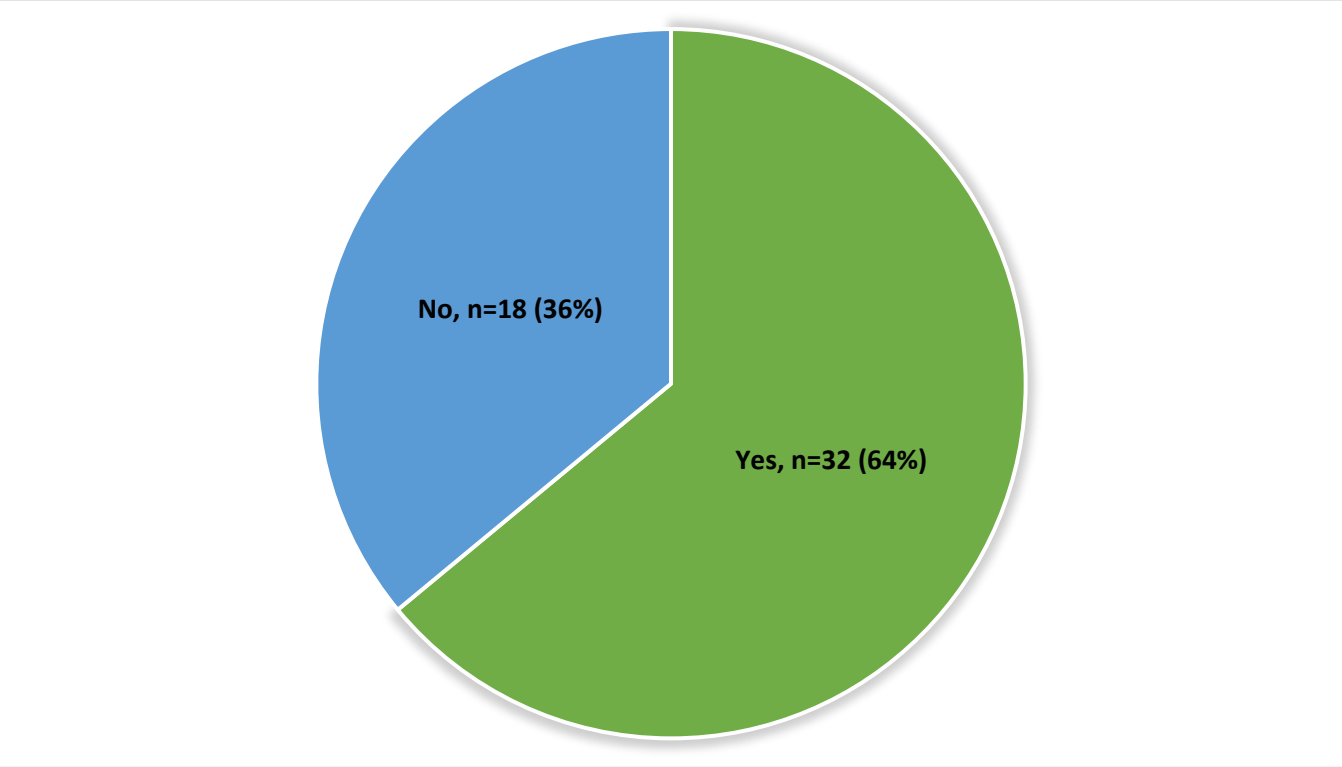

Table 152 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions Exceeding State Limitations

Response	States	Count	Percentage
Yes	Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington	32	64.00%
No	Alabama, California, Delaware, Idaho, Illinois, Maine, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, North Dakota, Oklahoma, Vermont, West Virginia, Wisconsin, Wyoming	18	36.00%
Total		50	100.00%

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

Table 153 – Scope, Nature and Frequency of the Automated Retrospective Claim Reviews

State	Explanation
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. Due to very strict POS edits that require a PA to exceed quantity and MME limits, high quantities and high MMEs/day retrospective reviews are rare.
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. Ad hoc 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.
District of Columbia	The retroDUR contractor has an extensive list of rules that generate 300 individual profiles per month that flag for potential patterns of prescribing or beneficiary utilization aberrations. The profiles contain both pharmacy and medical claims history and are reviewed by the DUR Board members who authorize the mailing of letters alerting prescribers to a potential problem.
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	We have the ability to retrospectively monitor opioid use in patients.
Hawaii	All transplant population claims are monitored by a medical consultant weekly. Quantity limits and days supply are reviewed quarterly for dental.
Indiana	Opioid claims are reviewed monthly for MME limits, quantity, number of utilizers, age of utilizers, and concomitant conditions.
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 needed. Early Refill: 3 months of pharmacy claims for early refill override n cases of lost,

State	Explanation
	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.
Kansas	We have real time POS soft and hard edits that meet opioid SUPPORT Act requirements. We have RDUR requirements per policy that meet this SUPPORT Act requirement. The FFS population is small. All of these requirements have also been put in place by our MCOs.
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. September 2021: Early refills (before 2 days early): Zero interventions were required. Duplicate fills: One intervention was made. Quantity limits: 74 interventions were made. Days' supply: 83 interventions were made. Greater than 90 MME: 3 interventions were made.
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.
Mississippi	We are in the process of developing a system to monitor for opioid prescription exceptions.
Nebraska	Drug alert is sent to the pharmacies with each fill.
New Jersey	Ad hoc quarterly reports are generated for claims review and provider follow up as needed.
New Mexico	The system searches for claims in the past 60 days to allow greater than a 7-day supply, 90 MME max dosage per day is calculated, and a PDMP initial fill and every 90 day confirmation is required.
New York	The RetroDUR program maintains criteria to identify the incidence of therapeutic duplications. If inappropriate drug therapy is identified, an intervention letter is sent to

State	Explanation
	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, days' supply edits, MME >90 edit and PA required edit. The state uses review of these edits, along with trending, to monitor opioid utilization. Additionally, the Board regularly reviews topics pertaining to opioid utilization in a variety of ways.
Ohio	We utilize a high quantity/day supply algorithm that identifies opioids where the quantity per day's supply ratio is not within appropriate clinical criteria. . This is monitored daily and the pharmacy is contacted if a claim exceeds prespecified thresholds. If the maximum daily dose or quantity is exceeded, the claim must go through prior authorization.
Oregon	RetroDUR Program for High-Risk Opioid Patients: We conduct quarterly manual utilization review for FFS patients who are determined to be highest risk. This program applies to non-excluded FFS patients with a paid or denied opioid claim in the past quarter. Patients are automatically included in the program and are prioritized based on the number of inclusion 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	Claims reviewed regularly by an automated retrospective process that was established during FFY 2020 to monitor opioid prescriptions exceeding the states limitations set prospectively.
South Carolina	Yes, POS edits apply to medications, with a 90days lookback in history (opioid naive).
South Dakota	The POS edits for all the above examples.
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

State	Explanation
	authorization. The only way for an enrollee to pass the benefit limits would be via appeal and this would include a hearing in front of an Administrative Law Judge.
Texas	The retrospective claim reviews are in place to monitor opioid claims. Periodic retroDUR intervention topics on the opioid utilization include the criteria for opioid overutilization and will flag prescribers whose opioid prescribing appears to exceed the set parameters. The parameters may differ depending on the patient's disease condition. For example those with diagnoses of cancer, sickle cell, or hospice or 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 evaluated by member prescription profile and provider prescribing patterns for opioid. Next, peer-to-peer outreach is done to encourage a decrease in prescribing of high dose opioid with the following goals: 1) educate healthcare providers on the availability of non-pharmacology and non-opioid pain options and selected opioid use disorder treatment 2) Provide healthcare providers with resources on both Medicaid and CDC website 3) Educate providers on Utah Medicaid opioid policies.
Virginia	Every quarter we review members utilizing opioids chronically and that have high risk activity (e.g., opioid/substance abuse, high MME, ER visits) and see if they are getting naloxone along with the opioid. We also review quarterly as part of the SUPPORT Act members on concurrent opioids and benzodiazepine therapy and concurrent opioids and antipsychotics.
Washington	Washington Apple Health (Medicaid) is hiring an Oversight Specialist to help monitor opioid use exceeding all state limits. The reports developed to monitor the thresholds established by the SUPPORT Act include MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. The reports are automatically updated each week with new claims data and monitored frequently to address concerns.

If “No,” please explain.

Table 154 - Explanation of “No” Comprehensive Automated Retrospective Claim Reviews

State	Explanation
Alabama	AL Medicaid has prospective edits.
California	While there is a regular, comprehensive claims review to monitor opioid prescriptions exceeding these state limitations, the review process is not automated.
Delaware	Claims that are denied and subsequently over ridden are flagged for review. This review may be used for a potential prescriber scorecard and ongoing provider education. Since the FFS population is largely comprised of dual eligible individuals with Medicaid as secondary payor, this poses a challenge in creating an automated, comprehensive retrospective claims review.
Idaho	The State does not have an automated retrospective process, but has employed a quarterly retrospective reporting package to look at all members exceeding limitations.
Illinois	The automated retrospective process to date from Change Healthcare selects 300 patients based on Medispan criteria, not just opioid prescriptions and not just Fee-for-Service. HFS

State	Explanation
	periodically reviews impact of opioid edits to determine whether edit changes are needed. The PBM provides reports of participants who filled opioid prescriptions that were over 50 MME and over 90 MME. The PBM and data warehouse group are working on reports to provide HFS retrospective feedback on implemented SUPPORT Act edits.
Maine	Claims exceeding State limitations are evaluated through the PA process with clinical review. Those found to be in excess or abusing the process are entered into the Intensive Benefit Management program (IBM).
Massachusetts	Process is not automated, however opioid prescriptions exceeding state limitations under specific conditions require prior authorization and review by a Therapeutic Class Management Group
Minnesota	All drugs that exceed state opioid prescription limits which is 90mg MME require prior authorization so these prescriptions have already gone through the prior authorization review process.
Missouri	All claims that exceed the ProDUR limits for opioid prescriptions are thoroughly reviewed in the prospective process. Claims are reviewed in aggregate semi-annually to detect and address potential utilization issues and the ProDUR edits are updated accordingly.
Montana	As we deny claims that exceed these limitations at point of sale and require prior authorization, all claims that exceed these limitations have been authorized. We run ad hoc reports to ensure any members exceeding 90 MME have a prior authorization provider attestation on file and that the provider has not increased the MME above the approved amount.
Nevada	RetroDUR is a manual review process and opioid reports are presented to the DUR Board.
New Hampshire	The state has an MME limit implemented that requires prior authorization for all claims above an MME of 100 daily. Patients with average daily MME > 100 are reviewed monthly.
North Dakota	Claims reject prospectively and are reviewed on a one on one basis to exceed state limitations. Retrospective letters are sent for high risk combinations and dosages that do not exceed state limitations or do exceed state limitations but have been authorized prospectively.
Oklahoma	We did not have an automated retrospective review during this federal fiscal year.
Vermont	Claims would deny for early refill edit.
West Virginia	We have prospective edits in place that prevent members from exceeding state limitations. Retrospective review cannot access PDMP.
Wisconsin	Wisconsin has a prospective early refill, duplicative fills, quantity limits and days' supply requirements, so this is not separately monitored on a retrospective basis. Wisconsin monitors opioid prescriptions with overutilization and lock-in retrospective reviews.
Wyoming	Retrospective reviews are done approximately annually, however, the process is not automated. As all prescriptions exceeding state limitations require prior authorization, and PDMP data is not available, regular retrospective review is not necessary

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

Figure 97 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently

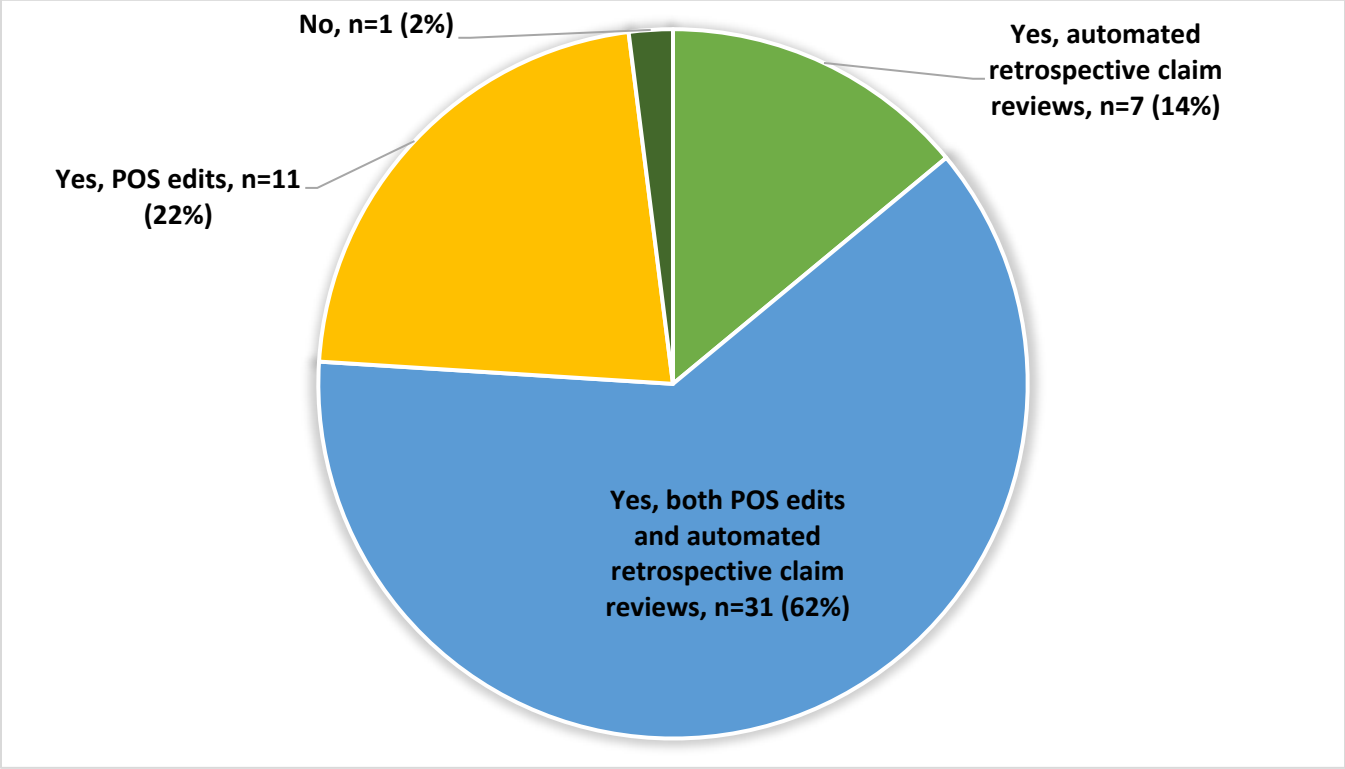

Table 155 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	Alabama, Hawaii, Massachusetts, Michigan, Rhode Island, Washington, Wisconsin	7	14.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia	31	62.00%
Yes, POS edits	Illinois, Kentucky, Maine, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, Oklahoma, Tennessee, Wyoming	11	22.00%
No	New Mexico	1	2.00%
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 156 - 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
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 clients with poisoning/overdose diagnoses billed in the previous year. Any client with these billed diagnoses will need a prior authorization for using benzodiazepines or opioids excluding patients with a billed diagnosis of cancer in the last year. Behind the scenes, the RetroDUR vendor is monitoring for concomitant use of opioids and benzodiazepines per the SUPPORT Act. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics. 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. These POS soft edits were implemented in FFY2022.
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. Two mailings on this topic have been initiated after retrospective reviews showed beneficiaries with concurrent use of opioids, benzodiazepines, and two additional medications with CNS depressant properties. In addition, the total number of Medi-Cal FFS beneficiaries with concomitant use of opioids and benzodiazepines during each calendar month has been tracked each calendar month 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 DUR is also conducted and letters are sent to providers regarding member concomitant use of these medications.
Connecticut	RDUR criteria is designed to target recipients who receive any benzodiazepine (30-day supply in 90 days) concurrently with any opioid (30-day supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating

State	Explanation
	them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
Delaware	Prior authorization for all opiates can only be approved if the member is not receiving a concurrent benzodiazepine. In addition, providers are notified retroactively via a provider letter when the drug-drug interaction alert flags for one of their patients for opioid-benzodiazepine combinations
District of Columbia	Claims review process includes monthly reports to identify trends on concomitant use of benzodiazepines and opioids. DUE edits at the POS include opioid-benzodiazepine, opioid-methadone and MAT-benzodiazepine pharmacy alerts being generated and displayed. Additionally, the comprehensive Lock-in review process conducted by DHCF includes MTM and individuala provider education.
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. See RDUR section previously for more details on retrospective claims.
Hawaii	Reviewed quarterly and annually for dental claims which are only acute and naive quantities. All transplant population claims are monitored by a medical consultant weekly. No patients were found.
Idaho	FDB ProDUR edits and RetroDUR reviews.
Illinois	HFS instituted a drug interaction edit that requires prior authorization if a participant is taking an opioid and tries to fill a benzodiazepine or if a participant who is taking a benzodiazepine tries to fill an opioid prescription. Prescriber must provide medical justification for concomitant therapy. Prescribers are reminded of the FDA black box warning regarding potentially fatal respiratory depression with concomitant use and encouraged to consider tapering of one of the agents and/or prescribing naloxone since the patient is at higher risk for potentially fatal respiratory depression. Benzodiazepine taper regimens and 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 absolutely necessary, the minimum effective dose for the shortest duration of time is utilized in the PA review.
Iowa	Soft edits are in place, messaging pharmacies. Additionally, a retrospective report is generated identifying members with concurrent use of an opioid and benzodiazepine and reviewed.

State	Explanation
Kansas	We have a real time POS soft edit that meets this SUPPORT Act requirement. We have this RDUR requirement in place. Our opioid PA criteria requires a PDMP check attestation from the provider. The FFS population is small. These requirements are also being implemented by our MCOs.
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. 107 interventions were mailed to prescribers regarding individuals who had concurrent prescriptions for opioids and benzodiazepines in FFY21. The retrospective intervention provides a statement to remind prescribers not to abruptly discontinue benzodiazepines.
Maine	ProDUR soft messaging back to the pharmacies and RetroDUR analysis are done
Maryland	The POS system has pay and report messaging on claims to monitor opioids and benzodiazepines when used concurrently since Oct. 1, 2019 as part of the SUPPORT ACT (HR-6) mandates. HID has RDUR claims review criteria to identify and monitor opioids and benzodiazepines in both populations, Fee-for-Service (FFS) and MCOs since Oct. 1, 2019. as part of the SUPPORT ACT (HR-6) mandates. Since antipsychotics and benzodiazepines are carved out of the MCO benefit and paid FFS, this program covers all Medicaid beneficiaries.
Massachusetts	All benzodiazepines (with the exception of clobazam, diazepam rectal gel, diazepam nasal spray, midazolam nasal spray and injectable products) require prior authorization if use concomitantly with an opioid for 60 out if the past 90 days under the Concomitant Opioid and Benzodiazepine Initiative. A taper plan for either the benzodiazepine or opioid is required for prior authorization approval.
Michigan	Concurrent utilization reports of opioids and benzodiazepines are reviewed regularly. In addition, our WholeHealthRx program performs academic detailing outreach to prescribers of members taking opioids in doses greater than or equal to 90 MME concurrently with benzodiazepines.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. For RetroDUR, there are two RetroDUR mailings per year 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

State	Explanation
	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 benzodiazepine and/or opioids to members who receive both.
Nebraska	Drug-drug alert is sent to the pharmacies with each fill.
Nevada	ProDUR edits are in place to warn of combination of opioids and benzodiazepines. The RetroDUR program includes initiatives to address the combination of opioids and benzodiazepines.
New Hampshire	POS edits will deny overlapping claims for benzodiazepines and long-acting 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, ad hoc reporting, the State performs monthly retrospective reviews. This encompasses an outreach to the prescriber to determine medical necessity, as well as alert the prescriber of the potential complications with continued concurrent use with opioids. Based on the information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	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 interference with patient care, long acting opioids < 90 MME/day and short acting opioids < 15 MME/dose are allowed at point of sale and retrospectively a letter is sent to the prescriber and pharmacy. POS edits are in place to require prior authorization for

State	Explanation
	benzodiazepines being used with long acting opioids that exceed 90 MME/day or short acting opioids that exceed 15 MME/dose. Clinical criteria include review of the PDMP, access to Narcan, counselling on overdose risk, opioid prescriber requirements of oncologist, palliative care specialist or pain management with a pain contract with urine and/or blood screens or request must be for a taper regimen, trials with non-opioid alternatives. Both prescribers must authorize combination. Titration requests are prescriber managed. The state requests a tapering plan and timeline for follow up be provided. If progress is not being made, clinical justification is reviewed. Requests to maintain on current combinations are also reviewable with clinical justification, and those approved often are palliative care, oncology patients, or those with long term therapy with failed attempts with a taper plan.
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 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

State	Explanation
	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. We perform this review as a targeted intervention each month.
South Carolina	Yes, both POS edits and automated retrospective claim reviews.
South Dakota	The POS edits for this drug combination. A message is returned to the pharmacist indicating the concurrent therapy. The retrospective DUR program monitors for this concurrent therapy and alert letters are mailed to the prescribers and pharmacies identified by the Review Committee.
Tennessee	Prior to 2014, Tennessee did not cover BZO for adults. When mandated in 2014, our criteria for approval was so stringent, that we cover around 1% of our enrollees' total use of BZO (found from data from the PDMP). BZO criteria has always included a denial if the enrollee was using opioids. Opioids are not also denied if the enrollee is using BZO, unless the BZO is being prescribed by a mental health provider, per Tennessee's Chronic Opioid (non-cancer) Prescribing Guidelines. We are not allowed as mentioned earlier to use the PDMP data for the purposes of enforcement with individuals, but the retrospective review from the PDMP showed us that we have very little BZO coverage, and even less for BZO and Opioid concomitant usage.
Texas	The POS edit checks for concurrent claims for opioid and benzodiazepine (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 -benzodiazepines combination, as well as, antipsychotics-opioids 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	The DURB Board reviews this data periodically as part of a Retrospective DUR. This is also a prospective DUR for drug-drug interaction via Medispan ProDUR module which provides soft messaging back to dispensing pharmacist. Note: this does not require to pharmacy to use professional service codes like the DUR reject 88 we have on other drug combinations
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

State	Explanation
	counseled the patient on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations? Also we run reports twice a year looking at concurrent use of opioids and benzodiazepines and review/discuss them at the DUR Board Meetings. Also: First Data Bank's ProDUR edits
Washington	Washington Apple Health (Medicaid) has developed a co-prescribing report that allows us to monitor opioids and ten drug classes with psychotropic effects (ADHD, anticonvulsants, antidepressants, antipsychotics, barbiturates, benzodiazepines, gabapentinoid, muscle relaxers, sedative hypnotics, and other psychotropics). The data in the co-prescribing report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	Yes we have both. For POS a warning fired but does not stop a claim from going through. Retrospectively there is a flag which prompts review by the RetroDur Board.
Wisconsin	Wisconsin has developed educational letters to inform prescribers when a member is receiving opioids and benzodiazepines concurrently. The letter discusses the clinical concern as well as recommending consideration of naloxone prescribing. Wisconsin has an additional retrospective educational letter that focuses on prescribers with multiple patients receiving opioids and benzodiazepine concurrently. Prescriber phone calls are conducted when the prescriber continues to remain an outlier.
Wyoming	Concurrent use of an opioid and a benzodiazepine is not allowed. Claims are denied at point of sale. As we do not have access to the PDMP, no retrospective claims review is completed.

If “No,” please explain.

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

State	Explanation
New Mexico	Development in process for FFY22 or FFY23.

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

Figure 98 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

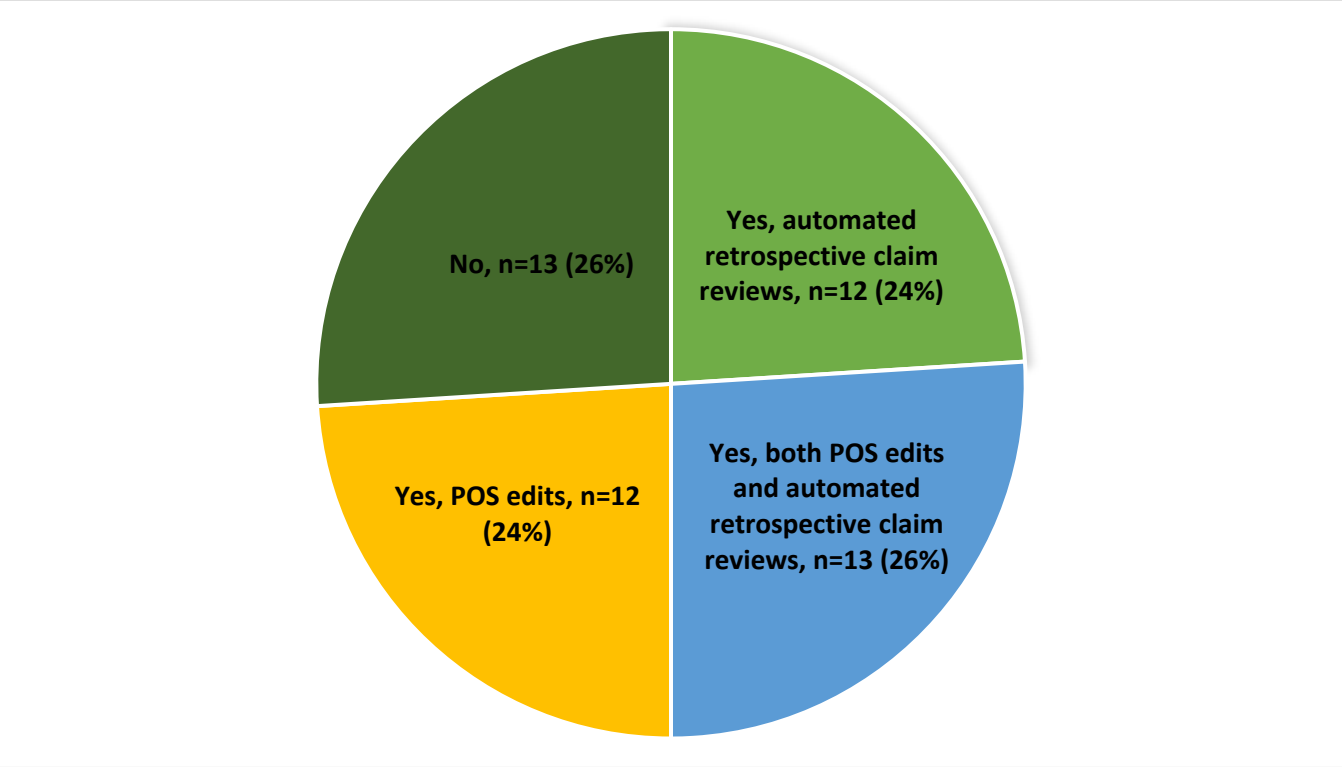

Table 158 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	Alabama, Arkansas, Connecticut, Georgia, Hawaii, Louisiana, Maryland, Michigan, North Dakota, Rhode Island, Washington, Wisconsin	12	24.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, Delaware, Florida, Idaho, Kansas, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Texas	13	26.00%
Yes, POS edits	California, District of Columbia, Maine, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, Oklahoma, Vermont, Virginia, West Virginia	12	24.00%
No	Colorado, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Missouri, Montana, New Hampshire, New Mexico, Tennessee, Utah, Wyoming	13	26.00%
Total		50	100.00%

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

Table 159 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Sedatives Being Used Concurrently

State	Explanation
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Reviewed quarterly at the DUR committee meetings.
Arkansas	In FFY2021, there were no POS edits for the concomitant use of opioids and sedatives. 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. These POS soft edits were implemented in FFY2022.
California	Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties.
Connecticut	RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any sedative/hypnotic (1-day supply in 90 days). During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention periodically.
Delaware	POS alerts and retrospective provider notification letters are activated for high and medium severity Drug-Drug interactions between opioid and sedative combinations. High and medium severity combinations were chosen to avoid alert fatigue.
District of Columbia	DUE edits at the pharmacy POS alert the phamcists to potential interactions with opioids and sedatives including sleep drugs, tranquilizers-opioids, antipsychotics, phenothiazine-opioids, muscle relaxant-opioid combinations. Pharmacists may use professional codes to process the claim after reviewing and or contacting the prescriber.
Florida	The DUR Board voted to create a hard edit for recipients on concomitant therapy. The edit will start with the Non-BZD sedative treatment naive recipients. Treatment naive is defined by the recipient having no paid claims for Non-BZD in the prior 60 days. An additional 2 month soft edit will be provided for Non-BZD sedative treatment experienced recipients with POS messaging advising the third fill of concomitant therapy will deny for a prior authorization. The prior authorization would be required for the Non-BZD sedative only. The hard edit includes long acting opiates only to allow for acute treatment of pain with short acting opiates. Seizure recipients, cancer/palliative care, Sickle Cell and Long-Term Care Facility (LTCF) recipients are excluded from the hard edit.
Georgia	We have the ability to monitor retrospectively and take action as needed.

State	Explanation
Hawaii	Reviewed quarterly and annually for dental claims which are only acute and naive quantities. All transplant population claims are monitored by a medical consultant weekly. No patients were found.
Idaho	FDB ProDUR edits and RetroDUR reviews.
Kansas	We have a real time POS soft edit that meets this SUPPORT Act requirement. We have this RDUR requirement in place. The FFS population is small. These requirements are also being implemented by our MCOs.
Louisiana	Retrospective review. 28 interventions were mailed to prescribers regarding individuals who had concurrent prescriptions for opioids and sedatives in FFY21.
Maine	ProDUR messaging is sent to the Pharmacies during the adjudication of the claims
Maryland	RDUR vendor, Kepro, has criteria which they monitor on an ongoing basis.
Michigan	Routine utilization reviews are performed to look at concurrent use of opioids and all potentiators which includes sedatives.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. For RetroDUR, DHS performs two RetroDUR mailings per year regarding the SUPPORT Act criteria which specifies benzodiazepines.
Mississippi	When we initiated hard edits for such concurrent utilization, we discontinued the automated retrospective claims reviews. We are in the process of developing a system to monitor for opioid prescription exceptions.
Nebraska	Drug-drug alert is sent to the pharmacies with each fill.
Nevada	ProDUR edits are in place to warn of the combination of opioids and sedatives being used concurrently.
New Jersey	POS safety edits are in place including, but not limited to, drug conflicts with concurrent use of opioids and sedatives. Based on routine, ad hoc reporting, the State performs monthly retrospective reviews. This encompasses an outreach to the prescriber to determine medical necessity, as well as alert the prescriber of the potential complications with continued concurrent use with opioids. Based on the information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	POS: The pharmacy would receive a drug-drug interaction (DD) warning. The drug-drug interaction edit matches the new drug against the member's current, active drugs to identify clinically relevant interactions. RetroDUR: The Retro DUR program maintains criteria to identify co-administration of opioids and sedative. 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. The Board has also reviewed the use of opiates and Z-drugs as an initiative.
North Dakota	Retrospective letters are sent for concerning concurrent use.
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with a sedative. Also, these medications are reviewed in our Coordinated Services Program.

State	Explanation
Oklahoma	ProDUR edits are in place at the point-of-sale (POS) for the concurrent use of opioids and sedatives to alert the pharmacist to review; this ProDUR edit does not currently require prior authorization.
Oregon	A POS edit evaluates for history of opioid use of more than 7 days within the last 90-day period. Opioid claims of more than 7 days stop for review and utilization of concurrent sedatives is evaluated before approval. A POS edit evaluated utilization of sedatives for more than 30 days. Utilization of benzodiazepines or sedatives for insomnia beyond 30 days stops for review and utilization of concurrent opioids is evaluated before the claim can be paid. In addition, we identify patients who have been prescribed both an opioid and another sedating medication within the past 120 days and an informational/educational letter is sent to prescribers notifying them of at least one the following circumstances: Prescriptions were written for opioids and sedatives (including benzodiazepines or antipsychotics) which overlap by at least 7 days written by more than a single unique provider Prescriptions were written for opioids and sedatives (including benzodiazepines or antipsychotics) from 3 or more unique providers in the past 120 days Prescriptions were written for members with a history of sedative poisoning or adverse events within the past 2 years The following individuals are excluded from the review if they meet any of the following criteria: They are a patient not currently enrolled in Medicaid They are a provider who has been messaged for the same patient within the past 6 months The prescriber of the most recent sedative or opioid prescription will receive the provider letter.
Pennsylvania	Prior authorization is required on all opioids and concurrent use with sedatives is evaluated during the medical necessity review. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any sedative/hypnotic (1-day supply in 90 days). During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention periodically.
South Carolina	POS edits identify concomitant therapy - Pharmacies may override duplication of therapy edits/clinical discretion SC requires prescribers review PDMP prior to prescribing opioids. F) A pharmacist or practitioner does not have a duty and must not be held liable in damages to any person in any civil or derivative criminal or administrative action for injury, death, or loss to person or property on the basis that the pharmacist or practitioner did or did not seek or obtain information from the prescription monitoring program. A pharmacist or practitioner acting in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting or receiving information from the prescription monitoring program. https://scdhec.gov/sites/default/files/media/document/PMPLaw_0.pdf

State	Explanation
South Dakota	The POS edits for this drug combination. A message is returned to the pharmacist indication the concurrent therapy. The retrospective DUR program monitors for this concurrent therapy and alert letters are mailed to the prescribers and pharmacies identified by the Review Committee.
Texas	The program uses a POS edit to deny sedative claim to those with diagnosis of SUD, but it does not deny concurrent use with opioids if diagnosis of SUD is not found. For the FFY 2021, also, a retrospective DUR intervention was completed that included concurrent prescribing of sedatives and opioids.
Vermont	This is also a prospective DUR for drug-drug interaction via Medispan which provides soft messaging back to dispensing pharmacist
Virginia	First Data Bank's ProDUR edits
Washington	Washington Apple Health (Medicaid) has developed a co-prescribing report that allows us to monitor opioids and ten drug classes with psychotropic effects (ADHD, anticonvulsants, antidepressants, antipsychotics, barbiturates, benzodiazepines, gabapentinoid, muscle relaxers, sedative hypnotics, and other psychotropics). The data in the co-prescribing report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	At the POS level there is a SEV 2 which can be overridden at the retail level. There is no retrospective review for this currently.
Wisconsin	Wisconsin has developed educational letters to inform prescribers when a member is receiving opioids and benzodiazepines concurrently. A number of sedatives are benzodiazepines. Wisconsin also has developed educational letters to inform prescribers when a member is receiving multiple CNS depressants (opioids, benzodiazepines, skeletal muscle relaxants and sedative hypnotics).

If “No,” please explain.

Table 160 - Explanations for not Having POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

State	Explanation
Colorado	There are no POS edits or automated retrospective claims reviews in place for opioids used in combination with non-benzodiazepine sedatives for the reporting period.
Illinois	No current POS edits address concomitant sedative and opioid therapy. Fee-for-Service only allows 8 sedative units per month. The automated retrospective process to date selects 300 patients based on Medispan criteria, not just sedatives and opioids.

State	Explanation
Indiana	The current focus is around concurrent opioid and benzodiazepine utilization. OMPP continues to review edits for opioids and the potential for edits around other sedatives.
Iowa	Will be a future DUR meeting topic for discussion and consideration of appropriate initiatives.
Kentucky	These types of issues are addressed with RetroDUR lettering campaigns.
Massachusetts	Hypnotic benzodiazepines are included in the Concomitant Opioid Benzodiazepine Initiative.
Missouri	MO HealthNet implemented this policy in 2022.
Montana	Currently we are only doing provider outreach for members receiving opioids and benzodiazepines or sedating antipsychotics. No other sedatives are being monitored for use with opioids.
New Hampshire	A POS edit to begin denying overlapping claims at point of sale (POS) for Sedative Hypnotics and Opioid therapy (excluding acute therapy), as a hard edit, Prior Authorization (PA) required, when the recipient is Sedative Hypnotic/ Opioid treatment naive is in the process of being implemented. If the recipient is Sedative Hypnotic/Opioid experienced the edit will allow an additional two-month soft edit, which allows pharmacist to enter appropriate DUR codes via POS with messaging. The third fill of concomitant therapy will deny for a hard edit, PA required. Please note that the prior authorization logic will impact non-benzodiazepine Sedative Hypnotic therapy only. There is a separate edit in place for overlapping Benzodiazepine/Opioid therapy.
New Mexico	A quarterly retrospective report is in progress for state review.
Tennessee	Retrospective reviews only. We are not aware of a standard ProDUR edit addressing the concomitant use of opioids and sedatives (we are having to assume that "sedatives" could be referring to hypnotic drugs, carisoprodol, and other CNS depressants). We do address this issue in retrospective reviews of controlled substance prescribing of practitioners in an algorithm that takes into account not only opioids + BZO, but also opioids + carisoprodol, opioids + stimulants, opioids + hypnotics and combinations of these, for example the "Trinity" of opioids + BZO + carisoprodol.
Utah	May implement in the future.
Wyoming	Retrospective review is completed on occasion, however, the process is not automated.

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

Figure 99 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

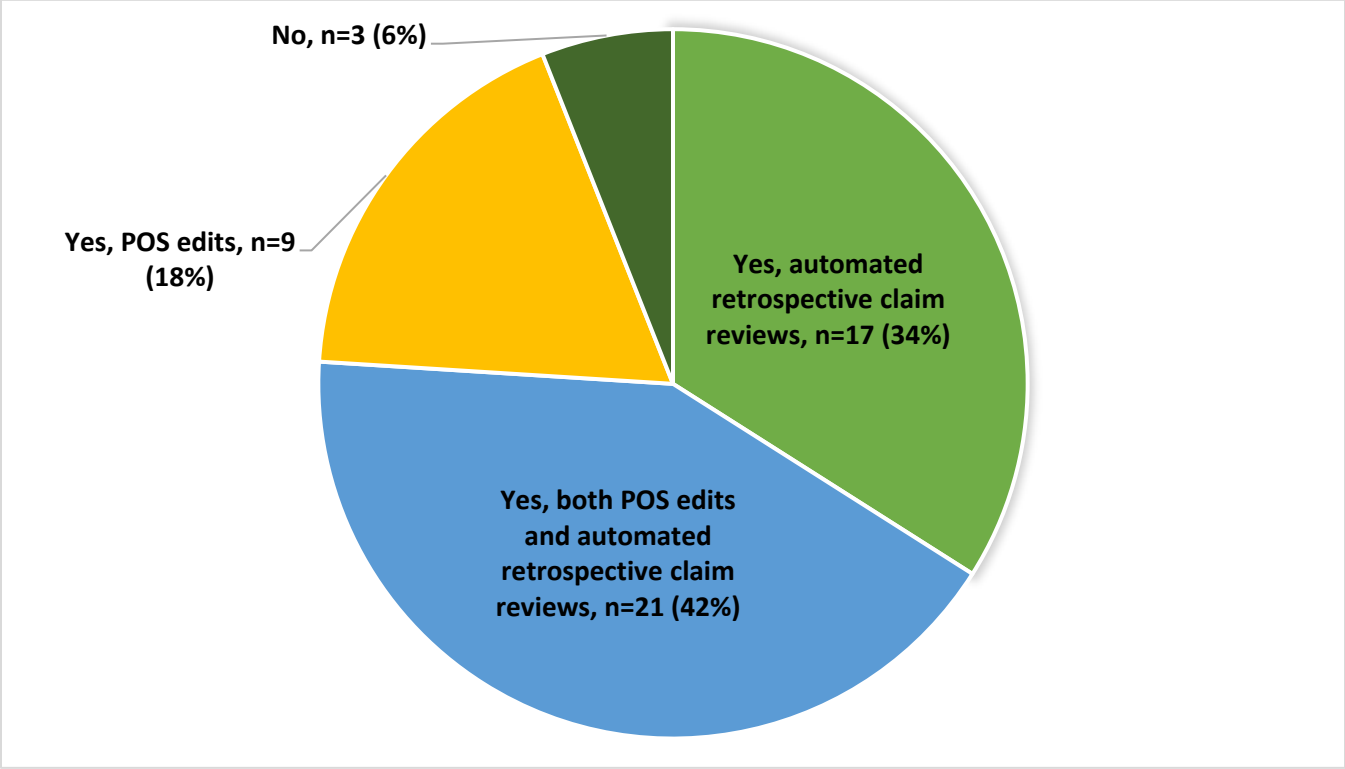

Table 161 - POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	Alabama, Arkansas, Hawaii, Idaho, Louisiana, Michigan, Montana, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Washington, Wisconsin, Wyoming	17	34.00%
Yes, both POS edits and automated retrospective claim reviews	Alaska, California, Connecticut, Delaware, Florida, Indiana, Iowa, Kansas, Maryland, Minnesota, Mississippi, Missouri, New Hampshire, New York, North Carolina, Oklahoma, South Carolina, South Dakota, Vermont, Virginia, West Virginia	21	42.00%
Yes, POS edits	Colorado, District of Columbia, Georgia, Illinois, Maine, Massachusetts, Nebraska, Nevada, New Jersey	9	18.00%
No	Kentucky, New Mexico, Tennessee	3	6.00%
Total		50	100.00%

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

Table 162 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Antipsychotics Being Used Concurrently

State	Explanation
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Point-of-Sale overrides are available when the pharmacist contacts the prescriber to discuss potential interactions. A report with concurrent use is reviewed by the DUR committee.
Arkansas	In FFY2021, there were no POS edits for the concomitant us of opioids and antipsychotics. The RetroDUR vendor is monitoring for concomitant us of opioids and antipsychotics per the SUPPORT Act. The RDUR program does monitor for over-utilization, multiple physicians/pharmacies, opioids with benzodiazepines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics. Additionally, the State receives monthly reports on antipsychotic usage. 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. These POS soft edits were implemented in FFY2022.
California	Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties. In addition, the total number of Medi-Cal FFS beneficiaries with concomitant use of opioids and antipsychotics during each calendar month has been tracked retrospectively each calendar month since October 1, 2019.
Colorado	Due to the risk of increased sedation with concomitant use, pharmacy claims for members receiving an opioid and quetiapine in combination require entry of POS DUR service codes (Reason for Service, Professional Service, Result of Service) in order to override an opioid-quetiapine drug-drug interaction.
Connecticut	RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any antipsychotic (30 days' supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
Delaware	POS alerts and retrospective provider notification letters are activated for high and medium severity Drug-Drug interactions between opioid and antipsychotic combinations. High and medium severity combinations were chosen to avoid alert fatigue.
District of Columbia	Although not automated, the claims review process includes monthly reports to identify trends on concomitant use of antipsychotics and opioids. DUE edits include

State	Explanation
	antipsychoticsopioids, antipsychotics-phenothiazines and selected antipsychotic cominations that prolong QT intervals.
Florida	In response to the SUPPORT Act, the Agency proceeded with deployment of a soft edit for individuals prescribed opioid and anti-psychotics concomitantly. The pharmacist has the capability to enter approved DUR intervention codes to allow claim payment. The edit excludes cancer, sickle cell, and LTCF recipients. The DUR Board reviews the impact of the edit yearly.
Georgia	Member filling an opioid and an antipsychotic will trigger POS message "Antipsych + Opioid- monitor use."
Hawaii	All transplant population claims are monitored by a medical consultant weekly. No patients were found. Antipsychotics are not on the dental formulary.
Idaho	The DUR Board has an annual review that includes * the number of beneficiaries receiving both drug classes concurrently * number of days of combination therapy * number of pediatric vs adult patients * drugs from both classes with highest incidence in combination use * evaluation of whether the same or different prescribers are prescribing component of combinations An Educational Letter with response request is sent to both the prescriber and dispensing pharmacy.
Illinois	An informational (soft) drug interaction edit is in place for concomitant antipsychotic and opioid therapy.
Indiana	Claims for concurrent opioids and antipsychotics prompt a message to pharmacies notifying them of the concurrent utilization. Reports are reviewed annually of claims with concurrent utilization.
Iowa	Soft edits are in place, messaging pharmacies. Additionally, a retrospective report is generated identifying members with concurrent use of an opioid and antipsychotic and reviewed.
Kansas	This is a correction from last year's answer. The correct answer then and now is that we do a soft edit at POS and do a quarterly RDUR analysis for this requirement.
Louisiana	Retrospective reviews. 113 interventions were mailed to prescribers regarding individuals who had concurrent prescriptions for opioids and antipsychotic agents in FFY21.
Maine	ProDUR messaging is sent to the Pharmacies during the adjudication of the claims
Maryland	The POS system has pay and report messaging on claims to monitor opioids and antipsychotics when used concurrently since Oct. 1, 2019 as part of the SUPPORT ACT (HR-6) mandates. HID has RDUR claims review criteria to identify and monitor opioids and antipsychotics in both populations, Fee-for-Service (FFS) and MCOs since Oct. 1, 2019. as part of the SUPPORT ACT (HR-6) mandates. Since antipsychotics and benzodiazepines are carved out of the MCO benefit and paid FFS, this program covers all Medicaid beneficiaries.
Massachusetts	HR6 coding is in place to capture opioids and antipsychotics being used concurrently when there are paid claims for at least 60 days of concurrent therapy out of the last 90 days of an opioid agent with an antipsychotic agent.
Michigan	Concurrent use of opioids and antipsychotics is included in our comprehensive review of opioids each quarter.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. For RetroDUR, DHS performs two RetroDUR mailings per year regarding the SUPPORT Act criteria.

State	Explanation
Mississippi	We have a process in place that approved by our DUR Board to monitor such concurrent utilization.
Missouri	Our retrospective intervention, in compliance with the SUPPORT act, identifies all patients with current drug claims for an opioid in the past 30 days and then flags and sends educational material to providers of those patients who are using antipsychotics concurrently for at least 7 of those days. We also send drug-drug interactions between antipsychotics and opioids from FDB to the pharmacy for review at POS along with a POS edit to monitor concurrent utilization of antipsychotics and opioids.
Montana	We are doing educational outreach to providers who are prescribing either an opioid or a sedating antipsychotic for a member who is receiving both. This education details the risks of prescribing multiple sedating medications as well as the increased risk of OUD in patients with other mental health issues.
Nebraska	Drug-drug alert is sent to the pharmacies with each fill.
Nevada	POS claims are edited with ProDUR edits set to warn pharmacists of the combination of opioids and antipsychotics. RetroDUR activities include letters and information to prescribers for the combination of opioids and antipsychotics.
New Hampshire	Concurrent use of opioids and antipsychotics is included in our comprehensive review of opioids each month. A ProDUR drug to drug edit was implemented recommending naloxone for patients receiving an antipsychotic drug and an opioid. This safety ProDUR edit is intended to alert dispensing pharmacists of the risks with concurrent prescribing and dispense naloxone using the state standing order after review with the patient.
New Jersey	POS safety edits are in place including, but not limited to, drug conflicts with concurrent use of opioids and antipsychotics. Based on routine, ad hoc reporting, the State performs monthly retrospective reviews. This encompasses an outreach to the prescriber to determine medical necessity, as well as alert the prescriber of the potential complications with continued concurrent use with opioids. Based on the information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New York	POS: The pharmacy may receive a drug-drug interaction (DD) warning. The drug-drug interaction edit matches the new drug against the member's current, active drugs to identify clinically relevant interactions. RetroDUR: The Retro DUR program maintains criteria to identify co-administration of opioids and antipsychotics. 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 antipsychotics. NC also does retrospective DUR reviews of concurrent use.
North Dakota	Retrospective letters are sent for concerning concurrent use.
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with an antipsychotic.
Oklahoma	ProDUR edits are in place at the point-of-sale (POS) for the concurrent use of opioids and antipsychotics to alert the pharmacist to review; this ProDUR edit does not currently require prior authorization. Retrospective review of claims is performed to identify outliers in regards to concurrent use of opioids and antipsychotics.
Oregon	The RetroDUR lettering process includes antipsychotics. A POS edit evaluates for history of opioid use of more than 7 days within the last 90-day period. Opioid claims of more than 7

State	Explanation
	days stop for review and utilization of concurrent sedatives is evaluated before approval. A POS edit evaluated utilization of sedatives for more than 30 days. Utilization of benzodiazepines or sedatives for insomnia beyond 30 days stops for review and utilization of concurrent opioids is evaluated before the claim can be paid. In addition, we identify patients who have been prescribed both an opioid and another sedating medication within the past 120 days and an informational/educational letter is sent to prescribers notifying them of at least one the following circumstances: Prescriptions were written for opioids and sedatives (including benzodiazepines or antipsychotics) which overlap by at least 7 days written by more than a single unique provider Prescriptions were written for opioids and sedatives (including benzodiazepines or antipsychotics) from 3 or more unique providers in the past 120 days Prescriptions were written for members with a history of sedative poisoning or adverse events within the past 2 years The following individuals are excluded from the review if they meet any of the following criteria: They are a patient not currently enrolled in Medicaid They are a provider who has been messaged for the same patient within the past 6 months The prescriber of the most recent sedative or opioid prescription will receive the provider letter.
Pennsylvania	Prior authorization is required on all opioids. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any anti-psychotic (1-day supply in 90 days). During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention periodically.
South Carolina	Yes, both POS edits and automated retrospective claim reviews.
South Dakota	The POS edits for this drug combination. A message is returned to the pharmacist indication the concurrent therapy. The retrospective DUR program monitors for this concurrent therapy and alert letters are mailed to the prescribers and pharmacies identified by the Review Committee.
Texas	A retrospective intervention is performed annually which monitors for concurrent use of opioids and antipsychotics.
Utah	Automated review with a peer to peer outreach to providers.
Vermont	DVHA DUR program currently has a retrospective DUR to periodically review concurrent use of opioids and antipsychotics. Pro DUR edit was added 1/13/21. A claim submitted for drugs tagged as ANTI_PSYCH will trigger a DUR soft message if the claim overlaps with a current active RX for any product tagged OPIOID and a claim submitted for drugs tagged as OPIOID will trigger a DUR soft message if the claim overlaps with a current active RX for any product tagged ANTI_PSYCH.

State	Explanation
Virginia	DMAS has a ProDUR edit that soft messages the pharmacy when concurrent opioid and antipsychotic therapy are being used and mentions to offer naloxone. There are also several FDB ProDUR edits looking at opioids and antipsychotics concurrently. DMAS also runs a report twice a year to monitor opioids and antipsychotics being used concurrently and gets reviewed/discussed at the DUR Board Meetings.
Washington	Washington Apple Health (Medicaid) has developed a co-prescribing report that allows us to monitor opioids and ten drug classes with psychotropic effects (ADHD, anticonvulsants, antidepressants, antipsychotics, barbiturates, benzodiazepines, gabapentinoid, muscle relaxers, sedative hypnotics, and other psychotropics). The data in the co-prescribing report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	At the POS level there is a SEV 2 which can be overridden at the retail level. There is no retrospective review for this currently. However, we are in the process of developing this to flag in order to allow for review by the RetroDUR board.
Wisconsin	Wisconsin performs retrospective reviews of concurrent utilization of opioids and antipsychotics on an ongoing basis.
Wyoming	Claims are reviewed on a quarterly basis and intervention letters are sent to the mental health provider.

If “No,” please explain.

Table 163 - Explanations for not Having POS Edits in Place or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

State	Explanation
Kentucky	These types of issues are addressed with RetroDUR lettering campaigns. Effective July 1, 2021, pharmacists will be notified at the POS when a claim is submitted for an opioid or antipsychotic if there is a claim for an opioid or antipsychotic in history.
New Mexico	Have a quarterly retrospective report developed for state review.
Tennessee	Retrospective Reviews only. There is not a standard POS ProDUR edit yet for concurrent use of opioids and antipsychotics (APsy). We did present a retrospective study to the DUR Board each quarter where we looked at the types of prescribers who were prescribing the antipsychotic to those adult enrollees who were also chronic opioid users. Our main focus during the review was the possibility of the APsy being prescribed by a practitioner not in the same practice as the opioid prescriber, and not knowing about the opioid, as the APsy prescriber would not be legally bound to check the PDMP prior to writing for an APsy. We did not find significant results about any specific provider type or practice type and found that polypharmacy was existing in all types. We did find that 11.6% of all adult chronic APsy users were also found to be concomitant chronic opioid users. We plan to follow up with looking specifically at quetiapine, also by looking at children under 21. We have also instituted in FFY21 a minimum of 200 retrospective chart reviews per month which will be 1/4th of our DUR Vendor's standard requirement of 800 chart reviews per month, dedicated to concomitant opioids and antipsychotics, with concentration on quetiapine, especially when not prescribed by a mental health provider, or if prescribed by the same provider that is prescribing the opioid.

11. Does your state have POS safety edits or perform automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis (multiple responses allowed)?

Figure 100 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

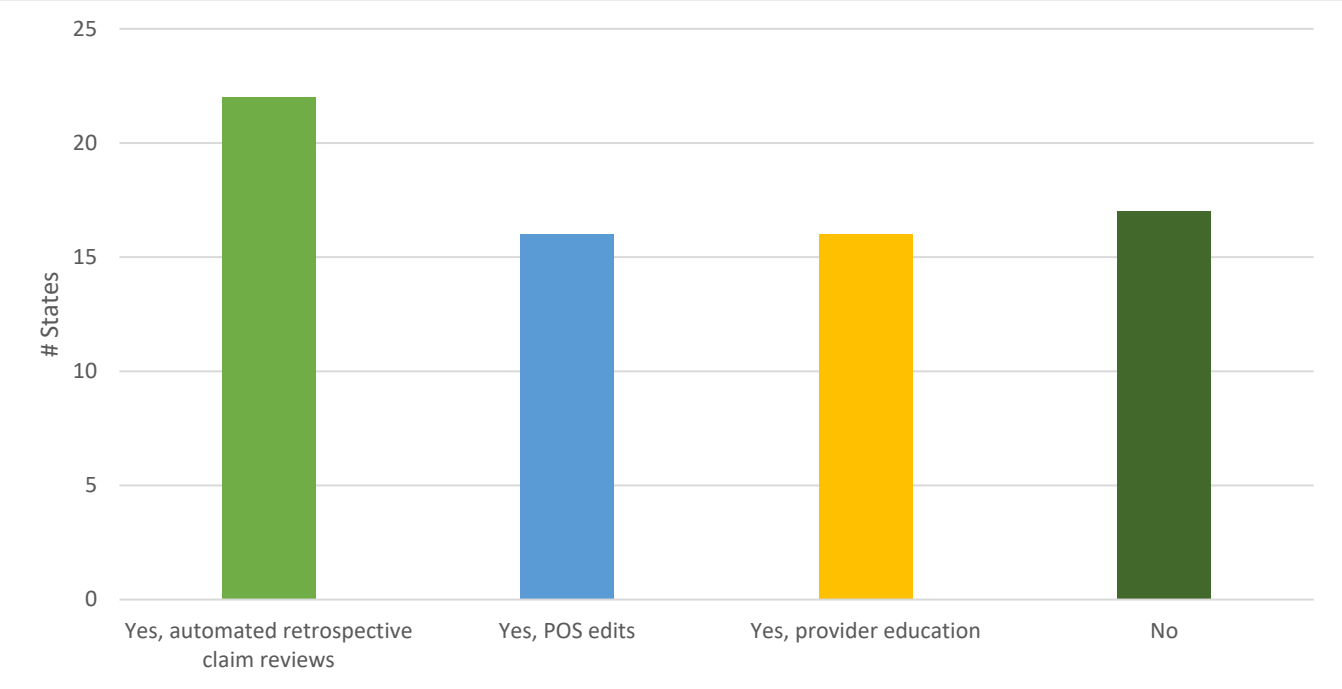

Table 164 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Yes, automated retrospective claim reviews	California, Connecticut, Florida, Idaho, Kansas, Michigan, Minnesota, Mississippi, Montana, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Virginia, Washington, West Virginia, Wisconsin	22	30.99%
Yes, POS edits	Arkansas, Colorado, District of Columbia, Iowa, Maine, Maryland, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, South Carolina, Tennessee, Texas, Washington	16	22.54%
Yes, provider education	Arkansas, Connecticut, District of Columbia, Idaho, Kansas, Louisiana, Maine, Montana, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Virginia, Washington	16	22.54%
No	Alabama, Alaska, Delaware, Georgia, Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Nebraska, Nevada, North Carolina, Oklahoma, Rhode Island, Utah, Vermont, Wyoming	17	23.94%
Total		71	100.00%

If "Yes, automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.

Figure 101 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

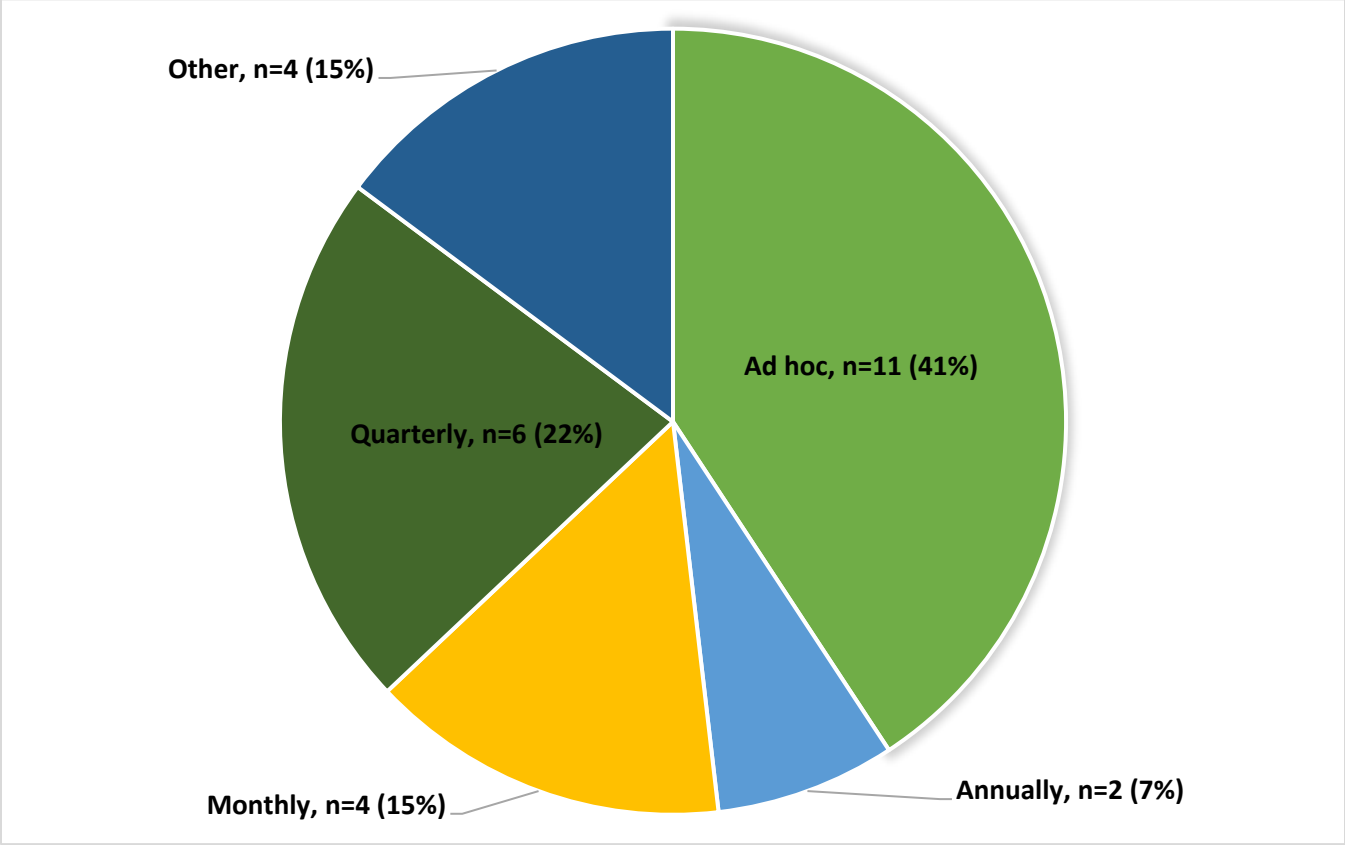

Table 165 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Ad hoc	Arkansas, District of Columbia, Idaho, Louisiana, Michigan, New Hampshire, New Jersey, New Mexico, New York, Oregon, South Carolina	11	40.74%
Annually	Maine, Minnesota	2	7.41%
Monthly	Pennsylvania, South Dakota, West Virginia, Wisconsin	4	14.81%
Quarterly	Florida, Mississippi, North Dakota, Ohio, Virginia, Washington	6	22.22%
Other	California, Connecticut, Kansas, Montana	4	14.81%
Total		27	100.00%

If "Other," please specify.

Table 166 - "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	Reviews are performed at least monthly and ad-hoc as needed.
Connecticut	Annually and Ad Hoc.
Kansas	Due to the potential for violation of 42 CFR Part 2 SUD HIPPA requirements, we have only policy guidance as provider education for OUD patients, requiring this PDMP monitoring as the responsibility of the OBOT and OPT providers.
Montana	Prior authorization is required for MAT and for any opioid for a member with a history of OUD. We review the member history and discuss/educate the provider each time a member with a history of opioid use disorder receives a prescription for an opioid.

If "Yes," please explain nature and scope of edits, reviews and/or provider education reviews performed for beneficiaries with a diagnosis history of OUD or opioid poisoning diagnosis.

Table 167 - Explanations of Nature and Scope of Edits, Reviews and/or Provider Education Reviews Performed Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

State	Explanation
Arkansas	Arkansas Medicaid has POS edits in place that manage the use of benzodiazepines and opioids in patients with poisoning/overdose diagnoses billed in the previous year. Any client with these billed diagnoses will need a prior authorization for using benzodiazepines or opioids excluding patients with a billed diagnosis of cancer in the last year. An opioid education panel was added to the Magellan website in December 2020 which includes links to SAMHSA, articles about polypharmacy, CDC recommendations, and ASAM guidelines.
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.
Colorado	Opioid claims submitted for members currently receiving buprenorphine-containing medications indicated for use for treating OUD require entry of point-of-sale DUR service codes (Reason for Service, Professional Service, Result of Service) in order to override the drug-drug interaction involved with use of these drug combinations.
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	POS edits lookback on a 180 day history of mediacl claims for a diagnosis of opioid use disorder or opioid poisoning to alert the dispensing pharmacist and prompt for naloxone counseling. Provider education is offered on an as needed basis to individual prescribers who have been identified with patientswho are not receiving naloxone.

State	Explanation
Florida	Opioid prescribing trends and potential fraud and/or abuse will be identified via automated claims review by the DUR Board. Additional topics that will be reviewed include opioid claims utilization, concomitant use of opiates with MAT, claims exceeding the recommended limits, top opioid prescriber's, top opioid recipients, average MME, Narcan/naloxone utilization, and overdose data.
Idaho	Focused reviews have been done to review the number of patients with OUD diagnoses receiving buprenorphine-based therapy.
Iowa	Soft Edit in POS if member is on MAT and prescribed an Opioid
Kansas	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.
Louisiana	Educational articles were published in the monthly Provider Update newsletter: April 2021: Life-Saving Naloxone Available through Standing Order in Louisiana Pharmacies July 2021: Naloxone for Patients Taking > 50 Morphine Milligram Equivalent (MME) per Day
Maine	During FFY21 enhanced edits were implemented to ensure member safety with OUD. Creation of these new enhanced edits allowed members with OUD and the providers the ability to titrate doses and manage their diagnosis more adeptly ensuring patient access yet monitoring changes through clinical PA if needed.
Maryland	POS edits were in place to identify a diagnosis of OUD or opioid poisoning.
Michigan	Our DUR Board has been monitoring MAT utilization trends each quarter for several years, including review of patient demographics, (e.g. ages, gender, race) to identify disparities along with diagnoses and concurrent utilization. Any concerning utilization trends are reviewed further by our contracted academic detailing pharmacist and additional education is performed to the prescriber for cases where naloxone education may be warranted.
Minnesota	This is part of the SUPPORT Act mailings. For FFY 2021, this criteria was approved at a DURB meeting and mailed once. It is then planned to be a part of the semi-annual SUPPORT Act mailings.
Mississippi	This information is included in a quarterly retro-DUR report for beneficiaries at high risk for opioid overdose and/or misuse.
Missouri	MO HealthNet currently has safety edits in place for participants actively receiving MAT, this is based on prescription claims instead of diagnosis codes, which may be incomplete.
Montana	We educate providers prior to paying for buprenorphine products for members they are treating for OUD. This education follows SMAHSA guidelines for MAT prescribing. We also educate providers and discuss member OUD history and treatment plan prior to authorizing opioids for members with OUD.
New Hampshire	RetroDUR education letters to prescribing physicians may include members with a diagnosis of opioid use disorder (OUD) or opioid poisoning when selected by the DUR Board or when requested by the Department. Additionally, there are POS edits in place to require prior authorization for high dose (> 16 mg daily) prescriptions for buprenorphine-containing oral products for OUD to review for safety, substance use disorder counseling, and PDMP monitoring. Diagnosis information is not captured in the POS system limiting the real-time edits for patients with a history of these diagnoses.
New Jersey	The State performs a retrospective review. This encompasses an outreach to the prescriber to provide medical necessity as well as alert the prescriber of the potential complications

State	Explanation
	with continued concurrent use with opioid. Based on information provided by prescriber, we will work with the prescriber to either titrate, discontinue or continue combination therapy.
New Mexico	Ad hoc requests for DUR therapeutic duplication edits.
New York	POS: The pharmacy would receive a drug-disease contraindication (DC) warning. The drug-disease contraindications edit determines whether the new drug is potentially harmful to the individual's disease condition. The active drugs on drug history determine the member's disease condition(s). RetroDUR: The Retro DUR program maintains criteria to associated with a history of substance abuse or dependence or substance use disorder. If inappropriate drug therapy is identified, an intervention letter can be sent to prescribers and/or pharmacists detailing the potential drug therapy problem.
North Dakota	Opioid claims reject at POS for members that have had services for opioid use disorder to have both the opioid use disorder therapy provider and opioid prescriber authorize and provide justification for an override, typically the override requests that are authorized are for a surgery. Quarterly, members with an opioid poisoning diagnosis have a letter sent to any provider that has prescribed an opioid and/or an identifiable primary care provider as well as the pharmacy that dispensed the opioid.
Ohio	We have a Coordinated Services Program (CSP) that identifies members with a diagnosis of a history of opioid use disorder or opioid poisoning diagnosis for potential enrollment in the program.
Oregon	Some of these patients may be included in initiative described in #7 but don't have any specific initiative targeting these patients. RetroDUR process - Anyone with a substance use diagnosis (including opioid use disorder or opioid poisoning) and who is prescribed an opioid or medication assisted treatment is included for evaluation in the pharmacy lock-in program if they visit multiple pharmacies.
Pennsylvania	Through the RetroDUR Program prescribers are encouraged to prescribe naloxone for beneficiaries treated for OUD.
South Carolina	Yes, both POS edits and automated retrospective claim reviews.
South Dakota	All claims are retrospectively reviewed on a monthly basis. Providers identified during profile review conducted by the Review Committee are mailed intervention letters.
Tennessee	Ongoing since 2014, Per our TennCare Rules (approved via the Legislative process), and as voted on and approved by the DUR Board, any TennCare enrollee who has a diagnosis of poisoning by an illicit substance is enrolled in the Pharmacy Lock-In program and is also subjected to "PA Status", where every fill of every controlled substance requires Prior Authorization. We have conducted the diagnosis searches for the past several years about every 9 months. 522 enrollees were added in in FFY21 to Lock-In and PA Status for poisoning by an illicit substance.
Texas	All the POS clinical PA criteria will reject claims for opioids if the diagnosis of OUD is found. Also, the retro-DUR interventions on opioids will target prescribers writing opioid prescriptions for clients with OUD diagnosis.
Virginia	We review quarterly, members on chronic opioids and also with high risk activity which includes opioid use disorder and see if they are getting a claim for naloxone as well. We also have lettered prescribers on high risk for an opioid overdose and NO naloxone claims.

State	Explanation
Washington	Washington Apple Health (Medicaid) has developed a morphine milligram equivalent (MME) report that allows us to monitor enrollee's opioid MME and if they have a history of opioid use disorder (OUD) or are currently receiving medications used to treat OUD. The data in the MME report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	Reviewed monthly at RetroDUR meetings. It is limited to the Lock-in portion.
Wisconsin	Diagnosis information of opioid use disorder and opioid poisoning are utilized in retrospective profile reviews for lock-in and regular monthly DUR activities.

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

Figure 102 - 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

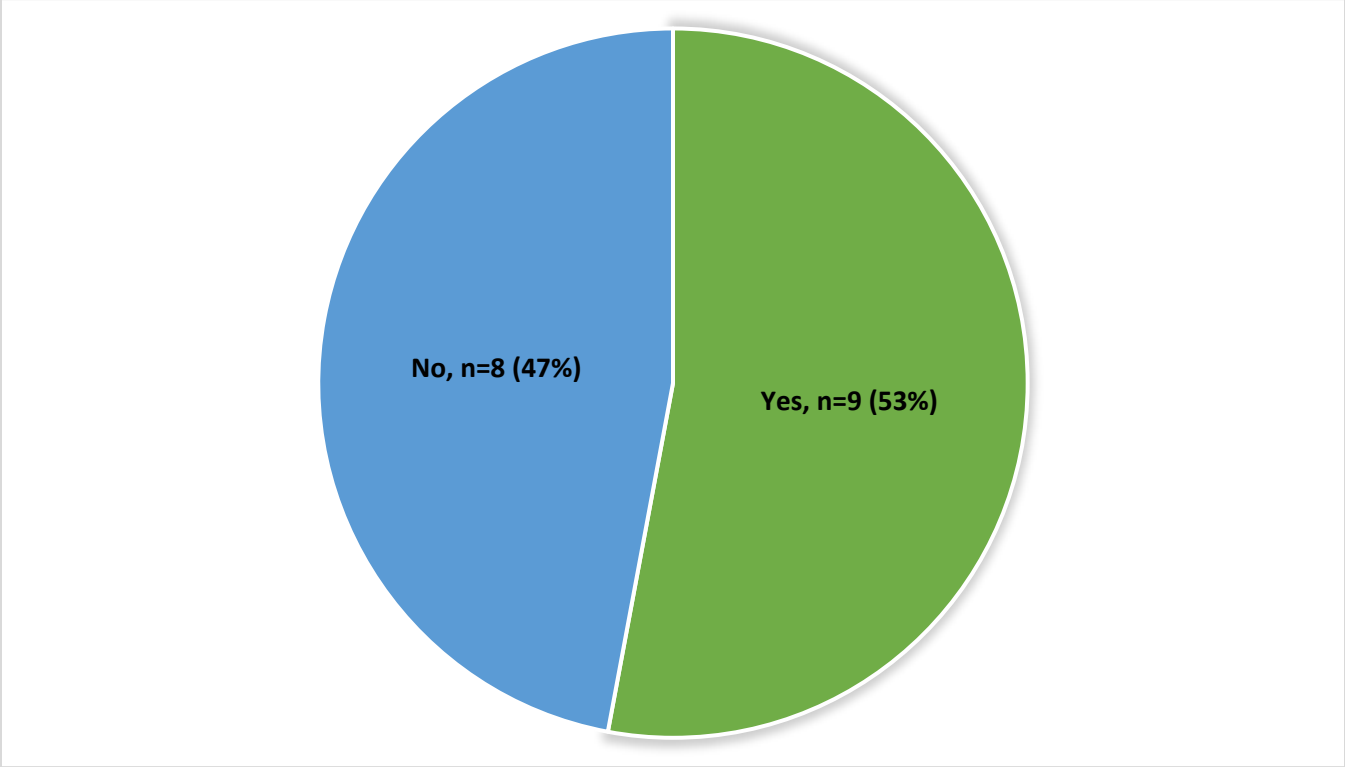

Table 168 - Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Response	States	Count	Percentage
Yes	Alaska, Delaware, Georgia, Illinois, Nevada, North Carolina, Oklahoma, Rhode Island, Utah	9	52.94%
No	Alabama, Hawaii, Indiana, Kentucky, Massachusetts, Nebraska, Vermont, Wyoming	8	47.06%
Total		17	100.00%

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

Table 169 - "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	Continuing collaboration between Division of Public Health (DPH) and Division of Substance Abuse and Mental Health (DSAMH) is ongoing to develop ways of data sharing to assist in identifying patients with a history of Opioid Use Disorder with the eventual goal of providing an outreach and intervention alert mechanism for referral to specialized care.

State	Explanation
Georgia	In the next year or so.
Illinois	During FFY21, the DUR Board noted that any history of OUD or opioid poisoning should be considered as a high risk for opioid overdose. System capabilities are being identified. Opioid reversal therapies and MAT therapies are available without restrictions.
Nevada	two to four years
North Carolina	NC is having ongoing discussions with our legal department to add a new claims edit to identify beneficiaries who have a history of OUD or opioid poisoning diagnosis. Implementation is pending.
Oklahoma	We have plans to further evaluate the implementation of point-of-sale (POS) safety edits, automated retrospective claim reviews, and/or provider education in regards to opioid use disorder (OUD).
Rhode Island	No date currently set.
Utah	2022/2023

If “No,” please explain.

Table 170 - “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
Alabama	There are no plans at this time.
Hawaii	Not needed for current population served. Department of Health provides.
Indiana	RetroDUR disclosures of this nature may violate substance abuse confidentiality regulations 42 CFR Part 2.
Kentucky	We consider diagnosis information when reviewing prior authorization criteria for opioids and/or buprenorphine products.
Massachusetts	Ad hoc retrospective reviews including direct outreach to prescribers bi-weekly for members who exceed clinical thresholds.
Nebraska	N/A
Vermont	No plans at the current time
Wyoming	Data has been reviewed with a small amount of utilization in this population. Data will be monitored regularly.

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

Figure 103 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

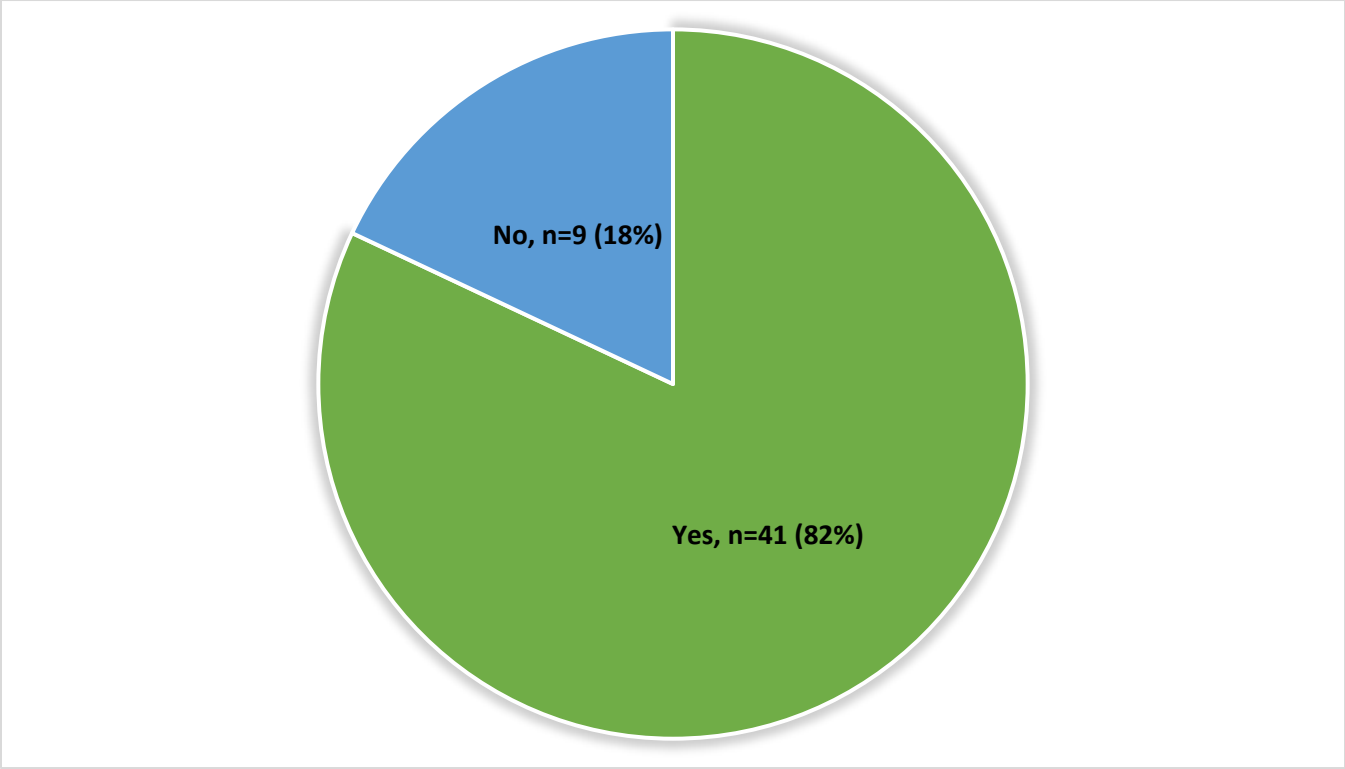

Table 171 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

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, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	41	82.00%
No	Louisiana, Maryland, Missouri, New Hampshire, North Dakota, Pennsylvania, South Dakota, Wisconsin, Wyoming	9	18.00%
Total		50	100.00%

If "Yes," please check all that apply.

Figure 104 - Pain Management / Opioid Prescribing Guidelines Provided

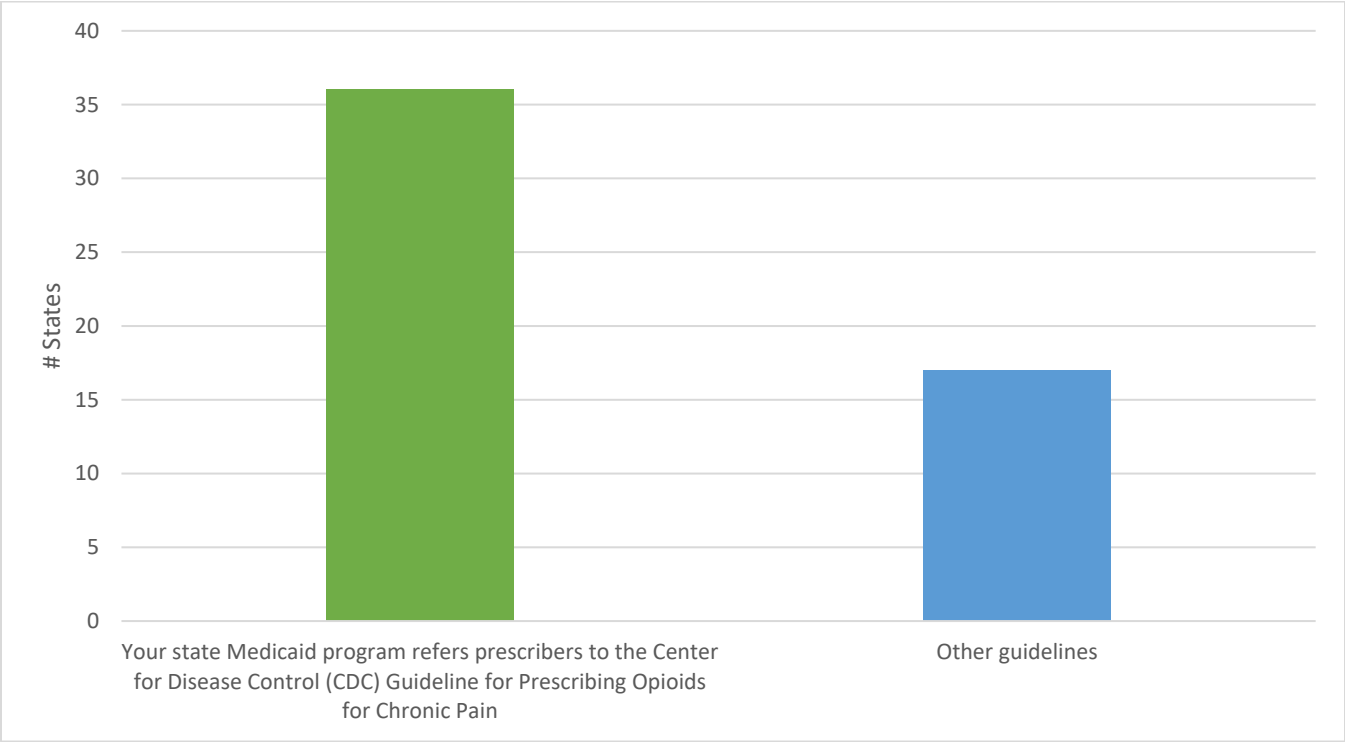

Table 172 - Pain Management / Opioid Prescribing Guidelines Provided

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, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Utah, Vermont, Washington, West Virginia	36	67.92%
Other guidelines	Alabama, Alaska, California, Colorado, Idaho, Illinois, Kansas, Minnesota, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Utah, Virginia, Washington, West Virginia	17	32.08%
Total		53	100.00%

If applicable, please identify the "other" guidelines.

Table 173 - "Other" Explanations of Pain Management / Opioid Prescribing Guidelines Provided

State	Explanation
Alabama	AL Medicaid provides the HHS Guidelines for Reduction and Discontinuation of Opioids on the Agency's website.
Alaska	Washington State AMDG guidelines
California	The Medical Board of California Guidelines for Prescribing Controlled Substances for Pain
Colorado	Colorado Department of Regulatory Agencies 2019 Revised Opioid Guidelines and the Washington State Agency Medical Directors' Group (AMDG) State developed policies for opioid use. The Department's Pain Management Resources and Opioid Use page (https://hcpf.colorado.gov/pain-management-resources-and-opioid-use) includes resources for providers such as information from the Colorado Consortium for Prescription Drug Abuse Prevention, information about the Colorado PDMP, guidance for tapering and discontinuing opioid therapy, and pain management guidance regarding the use of medications other than opioids.
Idaho	Appropriate use guidelines are provided on all opioid related PA forms and on the published preferred drug list.
Illinois	HFS uses criteria for opioid use for all long-acting narcotics and for the HFS Pain Management Program for medications that hit for the Four Prescription Policy. As applicable, the prescriber is referred to the DUR Board Education Web page for the following: CDC guideline for prescribing opioids for chronic pain, FDA warnings about concomitant benzodiazepines and narcotics, CDC/Surgeon General recommendations for naloxone use, Center for Opioid Research and Education Dental Opioid Guidelines for common dental procedures, or Methadone safety: a clinical practice guideline from the American Pain Society and College on problems of drug dependence, in collaboration with the Heart Rhythm Society.
Kansas	Our provider bulletins have CDC Guidelines website links as well as state specific opioid prescribing guidelines, based upon DUR Board approved criteria: https://www.kmap-stateks.us/Documents/Content/Bulletins/18027%2 0-%20General%20-%20Opioid_2.pdf https://www.kmap-stateks.us/Documents/Content/Bulletins/18101%2 0-%20General%20-%20Opioid_2.1.pdf https://ttps://www.kmap-stateks.us/Documents/Content/Bulletins/18112%2 0-%20General%20-%20Opioid_2.3.pdf Our Clinical PA has the following guidance for providers, in addition to the PA criteria: GENERAL CRITERIA FOR OPIOID MEDICATION USE: Prescriber must attest to reviewing K-TRACS prior to writing every new opioid prescription. Prescriber should calculate total MME per day for concurrent opioid medications. Initial use of immediate-release opioids is required before use of ER/LA opioids. Provider attests to limiting and avoiding where possible the concurrent use of CNS depressants, especially benzodiazepines, when prescribing opioids. Before starting & periodically, an evaluation of risk factors for opioid related harms should be done. Non-opioid ancillary treatments (e.g., NSAIDs, acetaminophen, antidepressants) and non-pharmacological treatments should be tried first unless contraindicated. Prescriber has screened patient for depression and substance use

State	Explanation
	disorder. Drug must not exceed maximum FDA approved dosage. Physician must consider use of opioids and Neonatal Opioid Withdrawal Syndrome if patient is pregnant.
Minnesota	Minnesota has their own guidelines which are similar to the CDC's Guidelines. https://mn.gov/dhs/opip/opioid-guidelines
North Carolina	The prescribing clinician shall review the North Carolina Medical Board statement on use of controlled substances for the treatment of pain (https://www.ncmedboard.org/resourcesinformation/professional-resources/laws-rules-positionstatements/ positionstatements/Policy_for_the_use_of_opiates_for_the_treatment_of_pain). Additionally, NC legislation implemented the STOP Act. The state's system edits are in compliance and supportive of this Act.
Ohio	Ohio Administrative Code Rule 4731-11-13 Prescribing of opiate analgesics for acute pain. Available at: For Prescribers - New Limits on Prescription Opioids for Acute Pain.pdf (ohio.gov). Ohio State Medical Board Overview: Regulations for Chronic and Subacute Opioid Prescriptions. Available at: https://med.ohio.gov/Overview-Regulations-for-Chronic-and-Subacute-Opioid-Prescriptions. Take Charge Ohio Healthcare professionals. Available at: http://www.takechargeohio.org/ Ohio Administrative Code Rule 4731-11-11 Standards and procedures for review of Ohio Automated Rx Reporting System. Available at: https://codes.ohio.gov/ohio-administrative-code/rule-4731-11-11 OARRS guidelines. Available at: https://www.ohiopmp.gov/ US Department of Health and Human Services. Available at: https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html
Oklahoma	Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting: The guidelines are available at http://poison.health.ok.gov.
Oregon	HERC Guidelines: https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Low-Back-Pain-Pharmacologic-Interventions-Final-11-13-14.pdf HHS Safe Opioid Prescribing: https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html Oregon Opioid Prescribing Guidelines: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/task-force.aspx
South Carolina	MAT Prior Authorization Guidelines SCDHHS, along with the managed care organizations (MCOs) in the South Carolina Medicaid market, provides coverage for all Food and Drug Administration-approved MAT options. MAT coverage criteria are available here. These criteria apply to the fee-for-service Medicaid benefit, as well as to each of the MCOs MBMB# 20-017 May 1, 2020 SCDHHS has engaged in an aggressive campaign of provider education to address the inappropriate use of opioids, named Timely Information for Providers in South Carolina (tipSC). Working with physicians, pharmacists and other experts from the Medical University of South Carolina (MUSC), tipSC develops and disseminates targeted, practical information to help prescribers make safe prescribing decisions. To encourage participation, these educational programs offer continuing

State	Explanation
	education credit for providers. These materials are available at https://msp.scdhhs.gov/tipsc/.
Utah	Utah Department of Health Medical Association. Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain 2018.
Virginia	We have sent out RetroDUR letters to prescribers in reference to members on several opioids and NO naloxone and referenced the opioid prescribing guidelines, alternatives to opioids, and the importance of prescribing naloxone with opioids.
Washington	Our program refers providers to the Center for Disease Control (CDC), the Washington State Agency's Medical Director's Group (AMDG), and the Bree Collaborative for safe and appropriate opioid prescribing and other best practices. Apple Health's fee-for-service and managed care programs have an Opioid Policy that incorporates the requirements of the SUPPORT Act and the CDC, AMDG, and Bree guidelines.
West Virginia	We have a SEMP (Safe and Effective Management of Pain) Program which offers guidance. More information about the program is below and can be found on the website www.semppguidelines.org "A geographically and professionally diverse expert panel of West Virginia professionals was formed with intention of creating guidelines for the safe and effective overall management of pain, which build upon the 2016 CDC Chronic Pain OPIOID Guidelines. These PAIN management guidelines intend to build upon the 2016 OPIOID guidelines of the CDC by providing a risk reduction strategy for the appropriate use of all pain treatments, and secondly, to provide pain management clinical treatment algorithms, similar to such for the treatment of hypertension, diabetes, and so on, in order to safely and effectively manage the pain of and improve the lives of West Virginians and beyond"

If “No,” please explain why no guidelines are offered.

Table 174 - 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	MO HealthNet refers prescribers to national guidelines.
New Hampshire	The Office of Professional Licensure and Certification (OPLC) has opioid prescribing guidelines for their licensees to follow.
North Dakota	ND Medicaid refers providers to existing national guidelines. While they aren't guidelines, our edits and limitations are explained in our online PDL for all providers to view.
Pennsylvania	The Pennsylvania Department of Health has developed opioid prescribing guidelines for prescribers in Pennsylvania.
South Dakota	Medicaid defers to the State Board of Medicine and the CDC.
Wisconsin	Wisconsin refers prescribers to the Wisconsin Medical Examining Board opioid guidelines.
Wyoming	The Wyoming Board of Medicine offers guidelines.

13. Does your state have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

Figure 105 - Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

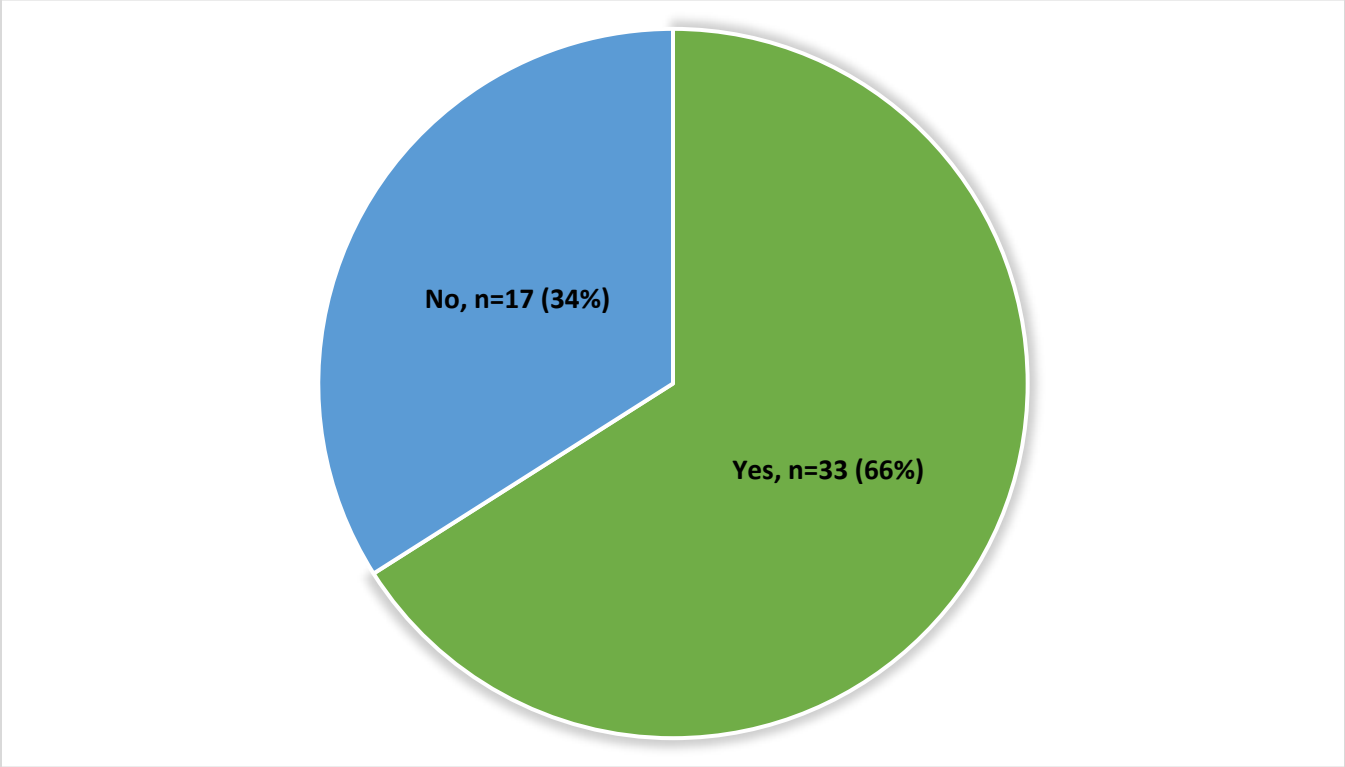

Table 175 - Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

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

If "Yes," please explain.

Table 176 - Explanation of Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

State	Explanation
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 List of Contract Drugs.
Connecticut	Abuse deterrent opioids are included on the PDL.
Delaware	Abuse deterrent medications do no require prior authorization if medications are prescribed with the FDA approved dosage limits. L select list of abuse deterrent medications are preferred in Delaware.
District of Columbia	All MAT medications are in preferred status on the Preferred Drug List in the District
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	Abuse deterrent opioid drugs on open formulary without restrictions.
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.
Indiana	Abuse deterrent opioids are available as preferred on the Preferred Drug List. Those agents with known high levels of abuse and no abuse deterrent are often placed as non-preferred.
Kansas	We have abuse deterrent opioids with preferred PDL status on our preferred drug list (PDL).
Louisiana	There are abuse deterrent opioid agents present on the preferred drug list.
Maine	Abuse deterrent formulations are available as preferred products on the MaineCare PDL.
Maryland	The FFS program has a preferred drug list with the opioid abuse deterrent products Embeda and Xtampza XR that were available as a preferred agent during the reporting period.
Michigan	MDHHS has a clinical prior authorization edit on the Opioid Abuse Deterrent agents to ensure appropriate prescribing. In addition, this class is on the PDL with a preferred abuse deterrent opioid agent.
Minnesota	Suboxone film and buprenorphine/naloxone sublingual tablets are preferred without prior authorization.
Mississippi	Medications Assisted Treatment (MAT) agents are available and included as preferred agents on our UPDL.
Missouri	MO HealthNet has an abuse deterrent opioid with preferred status on our PDL.
Nebraska	Butrans, OXYCONTIN (Oxycodone ER) listed on PDL as a preferred agents
Nevada	The preferred drug list contains a drug class specific to abuse deterrent opioids. Members do not have to try a non-abuse deterrent opioid prior to gaining access to abuse deterrent opioids.
New Hampshire	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.

State	Explanation
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	Yes this is listed as a separate section from non-abuse deterrent formulations on the PDL and one agent is always a preferred product.
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.
Pennsylvania	Xtampza ER Capsule is a preferred 'abuse-deterrent opioid' on the Statewide PDL.
Rhode Island	Abuse deterrent opioids are included as preferred on the Preferred Drug List.
South Carolina	Yes, prior to the manufacturers discontinuation of Embedda (morphine sulfate/naltrexone) 11/2019, the State PDL now inlcudes Butrans (buprenorphine transdermal) on the Preferred Drug List
Texas	Currently, the out-patient pharmacy formulary includes XTAMPZA ER (oxycodone) as a preferred agent.
Utah	Abuse deterrent formulations have preferred status on the PDL.
Vermont	Yes we have a preferred abuse deterrent opioid on the PDL Xtampza ER
Washington	WA Medicaid has multiple products as preferred on the AHPDL with lower MME equivalents. This includes abuse deterrent opioids and non- oral formulations.
West Virginia	We have attempted to provide preferred status to at least one abuse-deterrent product, however the majority of our products are not abuse-deterrent.
Wisconsin	Wisconsin has abuse deterrent opioid agents that are preferred products on the preferred drug list.

14. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?

Figure 106 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

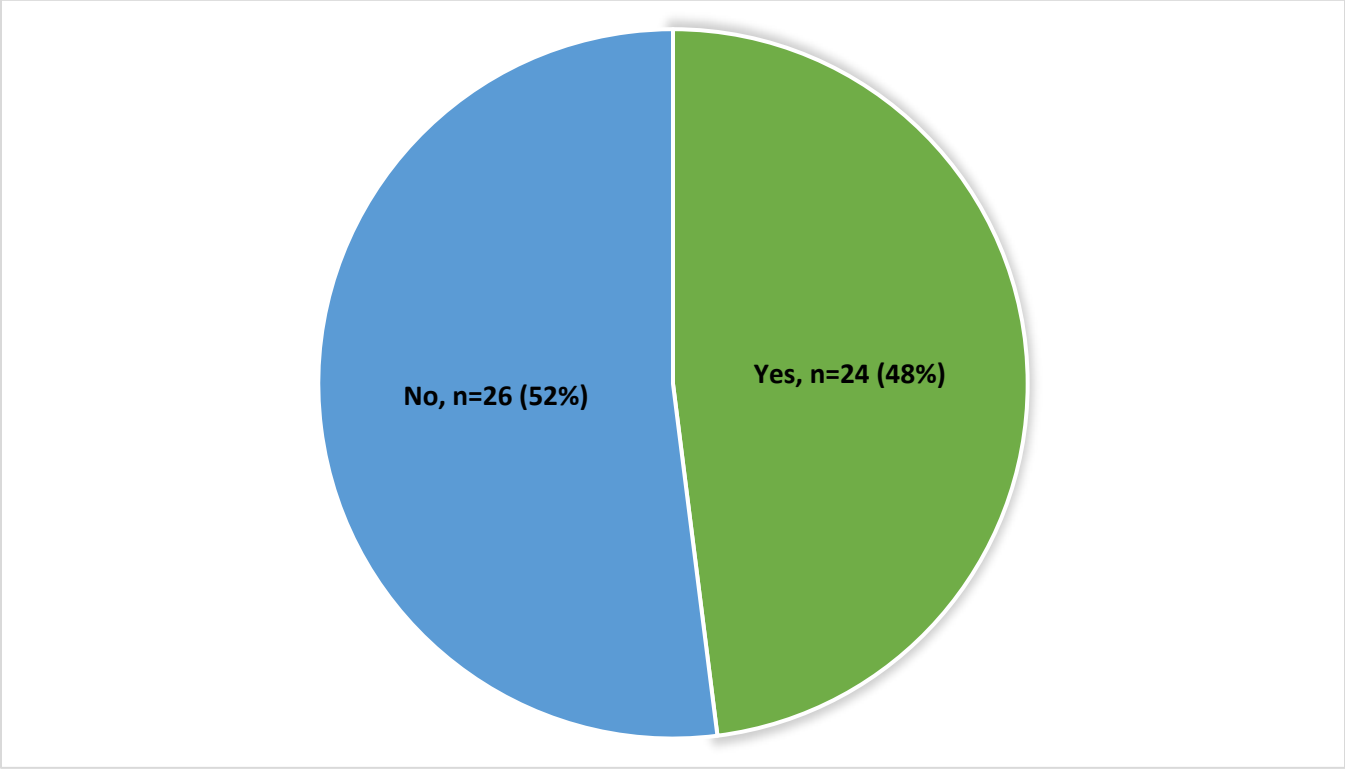

Table 177 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

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

If "Yes," please explain.

Table 178 - "Yes" Explanations for COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

State	Explanation
Alabama	MME phase down was placed on hold due to COVID-19.
Alaska	Refill tolerances were impacted due to transportation and patient access considerations.
Colorado	No edits on controlled substances related to the COVID-19 public health emergency were in effect during the reporting year. Retrospective DUR analyses were conducted in October 2020 and January 2021 (and also subsequent to the FFY2021 reporting period) to evaluate opioid utilization trends among beneficiaries during the course of the COVID-19 public health emergency.
Connecticut	During the public health emergency, early refill thresholds on controlled substances, including opioids, was relaxed from 93% to 80%.
District of Columbia	Some prior authorization requirements for mediactions including for controlled substances were relaxed aand or eliminated as a result of the declared public health emergency including quantity limits and days supply limits.
Georgia	We delayed further tapering our MME limit due to the pandemic.
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	The following was permitted at the Pharmacy level, at the discretion of the prescriber, so a member could obtain additional medication: Override for Early Refill or Temporary Days' Supply Allowance of up to a 90 days' supply for all medications.
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.
Maryland	Due to the COVID-19 public health emergency, a program was added to waive early refill edits. More information can be found at : https://health.maryland.gov/mmcp/pap/docs/ADVISORIES/Advisory%20206%20Waiving%20Early%20Refill%20Edits.pdf
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 prior approval overrides were increased 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.

State	Explanation
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 and extended some PAs
Pennsylvania	Early refill edits were turned off during the public health emergency.
Rhode Island	Some controlled substances required a PA. If there was an established prior authorization could be extended. Established prior authorizations for stimulants for children were extended. Opioids were reviewed case by case.
South Carolina	Due to COVID 19, along with the possible interruption of services and communications throughout South Carolina, SC DHEC Bureau of Drug Control hereby authorizes a ONE TIME early refill of Schedule III-V prescriptions for valid refills that are due within the next seven (7) days. Dispensers shall pull all original controlled substances prescriptions and document any early refill information in full detail; including, but not limited to, the date, time, reason for early refill, and the pharmacist signature associated with the transaction. Compliance with this Order supersedes any conflicting requirement of Regulation 61-4. https://llr.sc.gov/coronavirusbop/
South Dakota	Controlled substance edits were not impacted by the public health emergency. One RetroDUR review was not conducted due to Covid-19
Tennessee	The refill threshold for controlled substances was changed from 95% to 85% (the normal threshold for non-controlleds) during the COVID-19 public health emergency period.
Washington	Apple Health FFS and MCOs have removed refill to soon edits and are allowing up to a 90-day supply of all medications, including opioids during the public health emergency.
Wisconsin	Some controlled substance early refill prospective alerts were changed from a hard stop alert that required a call to the Drug Authorization and Policy Override Center to get an override (PA) to an alert the pharmacist can now override.

D. Morphine Milligram Equivalent (MME) Daily Dose

1. Have you set recommended maximum MME daily dose measures?

Figure 107 - State Recommended Maximum MME Daily Dose Measures

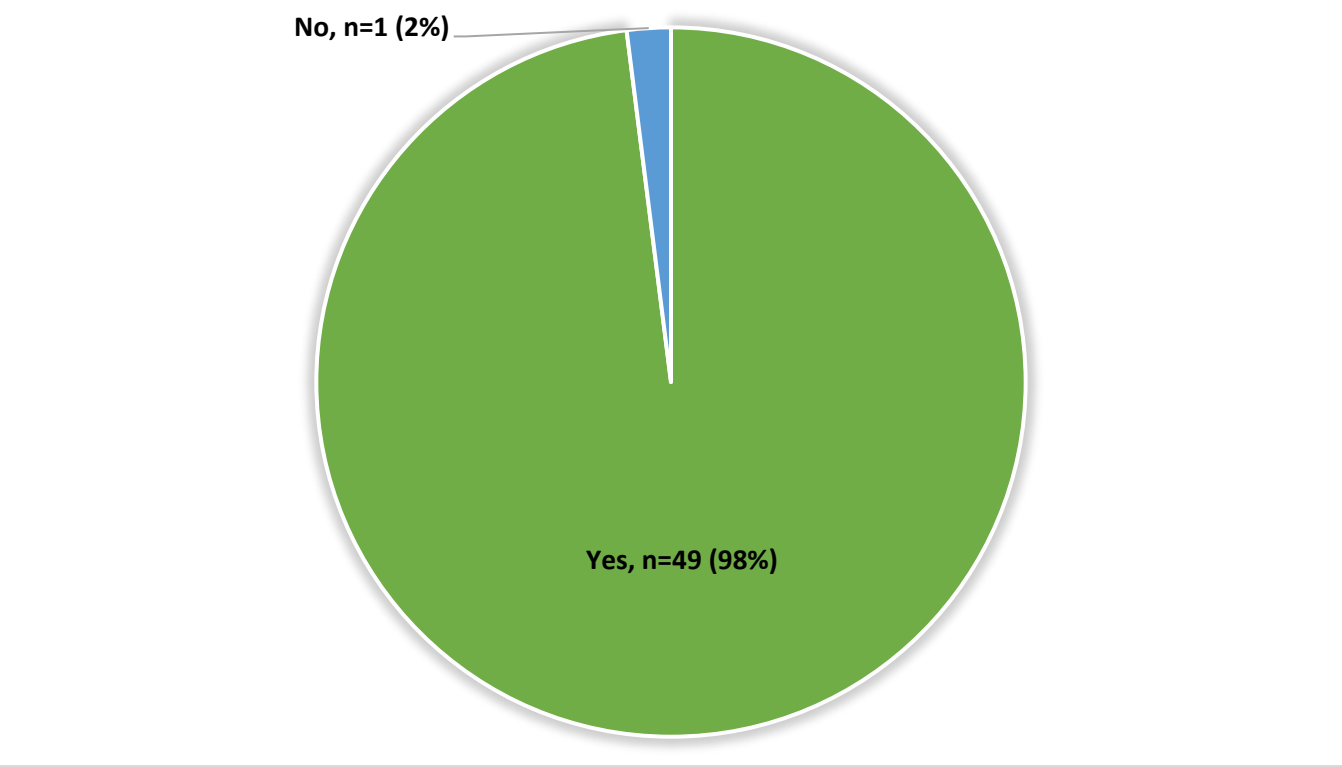

Table 179 - State Recommended Maximum MME Daily Dose Measures

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 Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	49	98.00%
No	Wisconsin	1	2.00%
Total		50	100.00%

a. If "Yes," what is your maximum morphine equivalent daily dose limit in milligrams?

Figure 108 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

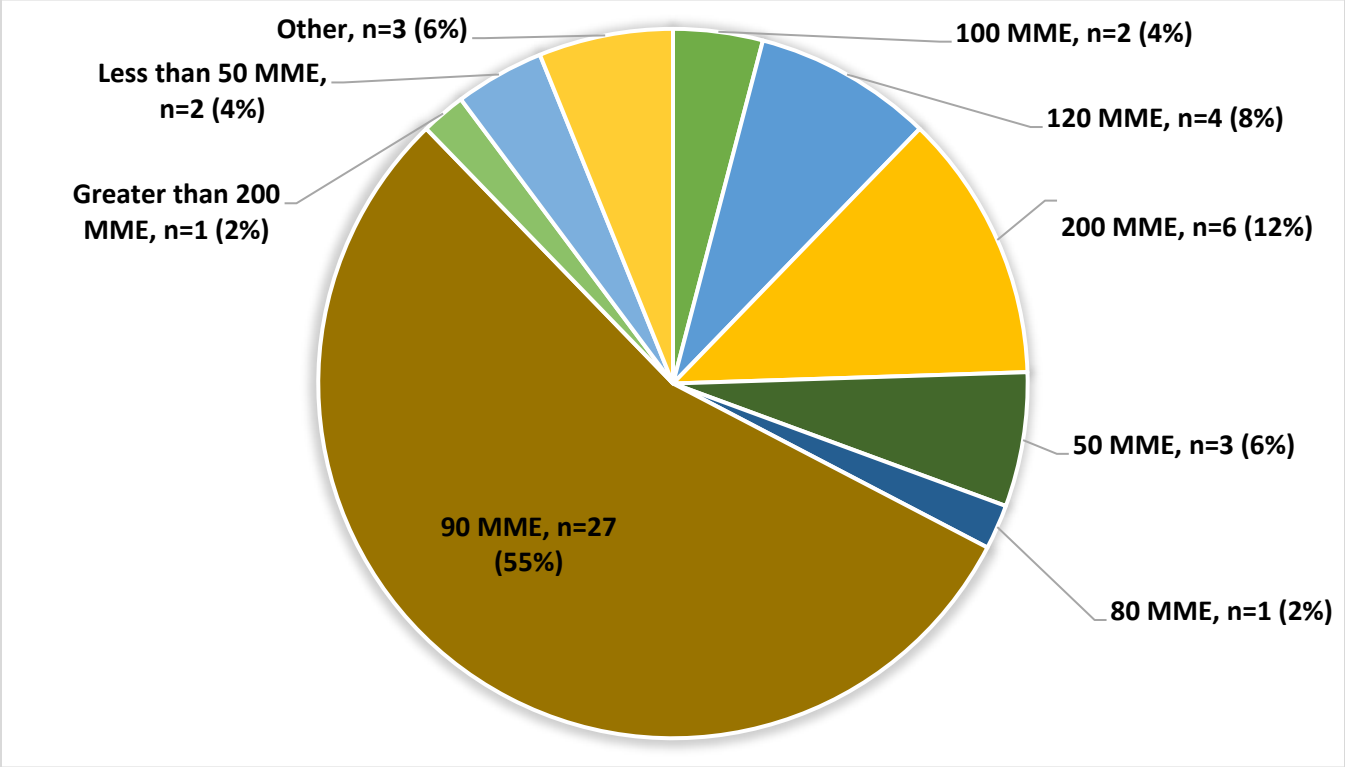

Table 180 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

Response	States	Count	Percentage
100 MME	Mississippi, New Hampshire	2	4.08%
120 MME	Hawaii, Kansas, Massachusetts, Wyoming	4	8.16%
200 MME	Alabama, Colorado, Kentucky, Missouri, Tennessee, Washington	6	12.24%
50 MME	Pennsylvania, Vermont, West Virginia	3	6.12%
80 MME	Georgia	1	2.04%
90 MME	Arkansas, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Louisiana, Maryland, Michigan, Minnesota, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia	27	55.10%
Greater than 200 MME	California	1	2.04%
Less than 50 MME	Maine, Ohio	2	4.08%
Other	Alaska, Indiana, Nevada	3	6.12%
Total		49	100.00%

If “Less than 50 MME”, please specify amount in mg per day.

Table 181 - 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 182 - 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 183 - “Other” Maximum Morphine Equivalent Daily Dose Limit

State	Other Limit
Alaska	150
Indiana	60
Nevada	60

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 184 - 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. Claims that exceed the cumulative daily MME limit of 150 MME/day will deny at the POS. The Agency will continue to phase down to a goal of 90 MME/day, but the phase down was placed on hold due to COVID-19.
Alaska	A target reduction of 50 MME every six months was employed to achieve current MME limit.
Arkansas	The maximum MME/day for opioid naive clients 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 patients is 90 MME with quantity limited to #93 in 31 days for short acting opioids. Clients with certain cancer diagnoses are exempt from the quantity edit. The MME edit is additive for all opioid drug claims with overlapping days' supply including long and short acting opioids. Clients 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 Treatment Authorization Request. This safety edit assists in identifying members at potentially-high clinical risk who may benefit from close monitoring and care coordination.
Colorado	Prior authorization involving a prescriber-to-prescriber consult is required for beneficiary claims for long-acting or short-acting opioids that exceed the cumulative MME limit. An

State	Explanation
	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 of cancer or sickle cell and their prescriber is in a hematology/oncology taxonomy. This limit applies to short acting opioid only. All long acting opioids require prior authorization with the exception of those prescribed by a hematology/oncology specialist.
Delaware	Delaware follows the most recent CDC recommendations . When the dose is above the current recommended dose, physicians receive retroactive written notification in order to reduce patient risk by encouraging reevaluation of the necessity of the higher dose. The 90 MME limit is also part of the clinical criteria for approval of PA and has been in place since July 1, 2018.
District of Columbia	MME limit applies to all opioids
Florida	For opioid treatment naive recipients, the limit is 90 MME. For treatment experienced recipients there is a soft edit at 50 MME.
Georgia	In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published guidelines for the use of opioids in chronic, non-cancer pain in 2016. In the Guidelines for Prescribing Opioids for Chronic Pain, the CDC recommends careful justification for titrating opioid doses above an average of 90 morphine milligram equivalents (MME) per day to avoid potential overdose. In an effort to reduce the risk of opioid-related harms while preserving access to appropriate pain treatment, Georgia Medicaid Fee-For-Service (FFS) implemented a prior authorization for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day. We are currently working on a further tapering plan that was delayed by the pandemic.
Hawaii	The limit applies to all opioids in the dental and transplant population. Dental should never reach 120MME. Only one patient was on opioids in the transplant population for 3 months.
Idaho	Edit implemented in July 2017. When a new prescription comes in the edit looks at the cumulative daily MME of currently received prescriptions plus the new prescription and will deny claim if all drugs and doses added together exceed the 90 MME at that point in time. A prior authorization is required for override to allow dispensing.
Illinois	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, staff will work with the prescriber to ensure prior approvals in place as needed to accommodate the planned taper schedule.
Indiana	Current limit applies to initial therapy. Indiana Medicaid is currently beginning a taper period to 90 MME. Current limit for long-term opioid utilizers is 1,000 MME. Indiana Medicaid will taper by 10% each quarter until reaching 90 MME.
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.
Kansas	All opioids for pain treatment have an MME limit unless the MME does not apply to that specific drug where an FDA maximum daily dose limit is set instead. Exceptions: patients

State	Explanation
	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 anyunderlying conditions; AND o Prescriber must submit clinical justification for exceeding 90 MME/day; AND o Prescriber attests that a naloxone prescription and associated counseling on its use was, or will be, offered to the member. Class Criteria for Approval of Very High MME Requests: Over 200 MME per Day. Additional criteria shall apply to ANY request where the cumulative opioid dose across all prescriptions is > 200 MME/day: o Note: Buprenorphine products (for opioid addiction treatment or pain) are not assigned an MME value and will not be included in the calculation. o Prescriber is, or has proof of consultation with, a Pain Management Specialist; AND o Prescriber submits clinical justification for exceeding 200 MME/day; AND o Prescriber submits documentation (e.g., progress notes) showing attempts and/or plans to taper below 200 MME/day as well as other non-opioid components (e.g., NSAIDs, physical therapy, etc.) of the treatment plan; AND o Prescriber attests that a naloxone prescription and associated counseling on its use, was or will be given to the member.
Louisiana	Each time an opioid prescription claim is submitted for a beneficiary, the MME per day for all active opioid prescriptions for that beneficiary is calculated and limited to a maximum of 90 MME per day. There are exemptions to the edits for maximum daily MME limits for opioids: cancer, palliative care, sickle cell crisis, and second and third degree burns. Authorization to increase the maximum prescribed MME limit for a recipient may be requested by the prescriber for approved by the PA unit prior to the initiation of the claim submission.
Maine	State of Maine has had 30 MME in place since 2013 and has successfully decreased overall opiate utilization per member drastically since the edit was initiated.
Maryland	Maryland Medicaid set the maximum morphine equivalent daily dose limit at 90MME in keeping with the published CDC guidelines in FFY 2018. Anyone exceeding a MEDD of 90mg is required to obtain a prior authorization. While patients with sickle cell anemia or patients in Hospice are excluded from the prior authorization process, the program recommends they be kept on the lowest effective dose for the shortest duration required to minimize the risk of harm. There was no requirement to taper patients off of opioids for the reporting period.

State	Explanation
Massachusetts	Prior Authorization for MME over 120mg/day requires a tapering schedule or pain specialist consultation to support the dose.
Michigan	MDHHS implemented an accumulated MEDD edit in September 2018 with the initial threshold set at 500 MEDD. 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. 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	For opioid naive patients, the initial prescription is limited to 50 MME on the initial fill of 7 days and 90 MME thereafter. Patients over 200 MME, claims are denied and require prior authorization and clinical review.
Montana	We started our opioid MME limits at 180 and have gradually lowered them to our final 90MME limit. This applies to opioid naive and non-opioid naive members. It does not apply to members with a cancer diagnosis. Providers with members already over our limits were given time (variable depending on how high the dose was to start) to taper. Providers who could not taper their patients successfully could request a prior authorization to remain at a dose over our limits. They are required to sign an attestation that they have exhausted other non-pharmacologic and non-opioid pharmacologic therapies, that they have reviewed the risks with the member and determined that the benefit exceeds the risk, that they have been assessed for 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/day by Dec 2020.
Nevada	The MME limit applies to all oral opioid products. The maximum MME daily dose limit is actually 60 MME, which is not an option above. The edit applies to all recipients. There is no tapering in process.
New Hampshire	NH Medicaid selected the daily MME at 100 to be consistent with the administrative prescribing rules published by the licensing boards (Medical, Nursing and Dental) that fall under the Office of Professional Licensure and Certification (OPLC). NH has a cumulative POS edit that will deny opioid claims for beneficiaries that exceed the 100mg MME unless there is a prior authorization in place.
New Jersey	For short-acting opioids (SAO), daily dosing is limited to 50 MME for an opioid naive patient or 90 MME for an opioid tolerant patient. Opioid naive patients are defined as those receiving no opioid therapy in the previous 90 days. For long-acting opioids (LAO), a patient must currently be on a short-acting opioid and daily dosing is limited to 90 MME. These limitations do not apply to cancer patients, sickle cell patients, or those on hospice, palliative or end of life care.
New Mexico	Limited to Opioids in State Therapeutic Class H3A-Analgesic Narcotics, H3N-Analgesics, Narcotic Agonist and NSIAD Combination, and H3U-Narcotic Analgesic and non-salicylate analgesic. No prior authorization requests received to assist with tapering patients to 90 MME.

State	Explanation
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.
North Dakota	Applies to all opioids and prior authorization is required to exceed. Limit is in place. Tapering patients that currently exceed this limit is addressed by one on one requests with clinical justification and provider directed tapering plans and timelines.
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	Edit applies to all opioid prescriptions via prior authorization. Patients are tapered via the prior authorization process.
Rhode Island	1. Support the states prescribing limitations of 20 doses/30 MME for opioid naive patients. 2. A 90 MME accumulator edit is in place.
South Carolina	Prescribers must limit the initial prescribing of opioid medications for the treatment of acute or post-operative pain to the lowest effective dose and for a quantity no more than necessary for the expected duration of pain. Providers must not exceed a five-day supply or 90 morphine milligram equivalents (MMEs) daily, except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care or medication-assisted treatment for substance use disorder. If, in a prescriber's clinical judgement, an initial supply of more than five days or 90 MMEs is medically necessary, the prescriber must document that need in the patient's medical record. The State continues to monitor for any next steps (outliers, education, alternate therapies, change in MME).
South Dakota	Prescriptions exceeding 90 MME require PA
Tennessee	Our limit for non-chronic users is 15 days per 180 days with no greater than 60 MME per day. Non-chronic use is defined as 90 days supply within the past 180 calendar days. The only exceptions to this limit are patients with sickle-cell disease, corrosive or other burns over a significant part of the body, and those in LTC facilities, and with these exceptions the limit is 45 days supply per 90 days at no greater than 60 MME per day. For chronic users, the limit is 200 MME per day.

State	Explanation
Texas	The 90 MME daily dose is cumulative and is applied to all opioids and is calculated for both for initial and subsequent therapies. For those who may require a tapering plan, provider may develop and manage patient-specific course of therapy. A 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, or hospice/palliative care are exempt.
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. A completed safety checklist (Prior Authorization) must be submitted for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opiates).
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 less than or equal to 20 years of age and 42 dosages per prescription for adults 21 years of age or older, 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.
Wyoming	The MME limit is applied to long-acting opioids. Patients over the limit have submitted a treatment plan outlining the prescribers plan to taper the opioid.

If "No," please explain the measure or program you utilize.

Table 185 - Explanations of the Measure or Program Utilized for Maximum Morphine Equivalent Daily Dose Limit

State	Explanation
Wisconsin	Wisconsin has a prospective DUR alert for claims with 90MME or greater. This alert notifies the pharmacy the claim is a high dose opioid and recommends the dispensing of naloxone. Wisconsin also monitors these drugs through edits, such as quantity limits, early refill and therapeutic duplication prospective DUR alerts. Wisconsin performs retrospective reviews of all opioids used at 250MME or greater and use of opioids at 50MME or greater with concomitant benzodiazepine. Prescribers identified during these processes receive a letter alerting them to a clinical concern.

2. Does your state have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

Figure 109 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded

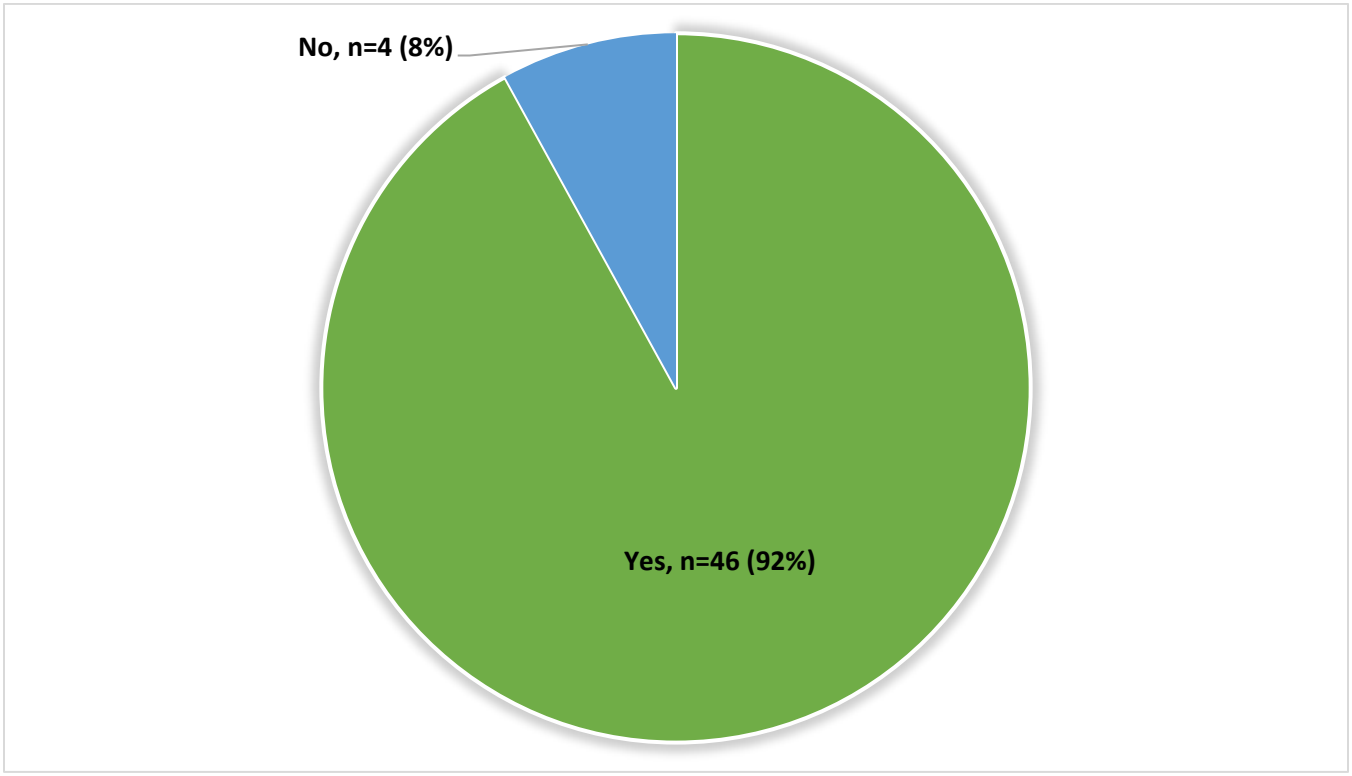

Table 186 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose Prescribed has been Exceeded

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

If "Yes," does your state require PA if the MME limit is exceeded?

Figure 110 - Prior Authorization Required if MME Limit is Exceeded

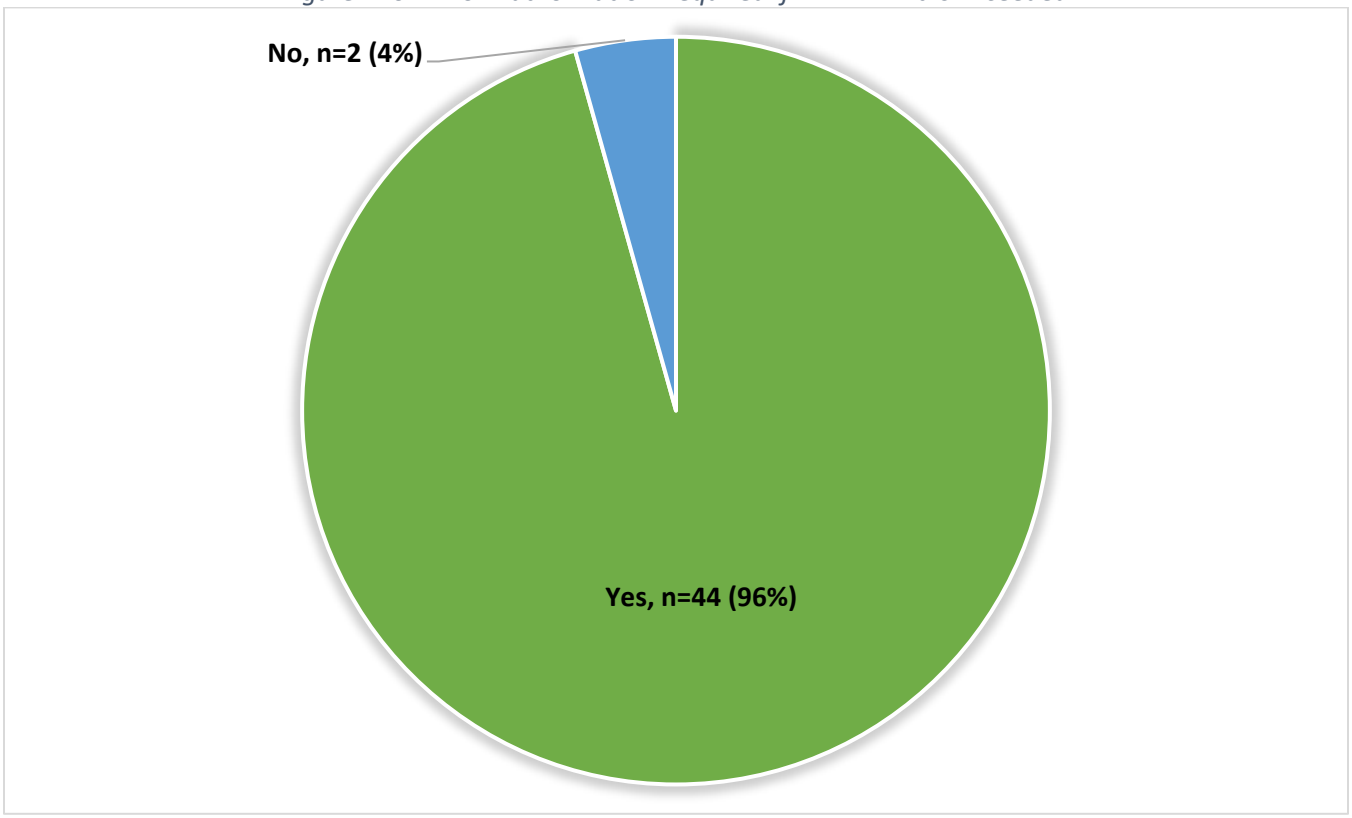

Table 187 - Prior Authorization Required if MME Limit is Exceeded

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	44	95.65%
No	Nevada, Wisconsin	2	4.35%
Total		46	100.00%

3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?

Figure 111 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

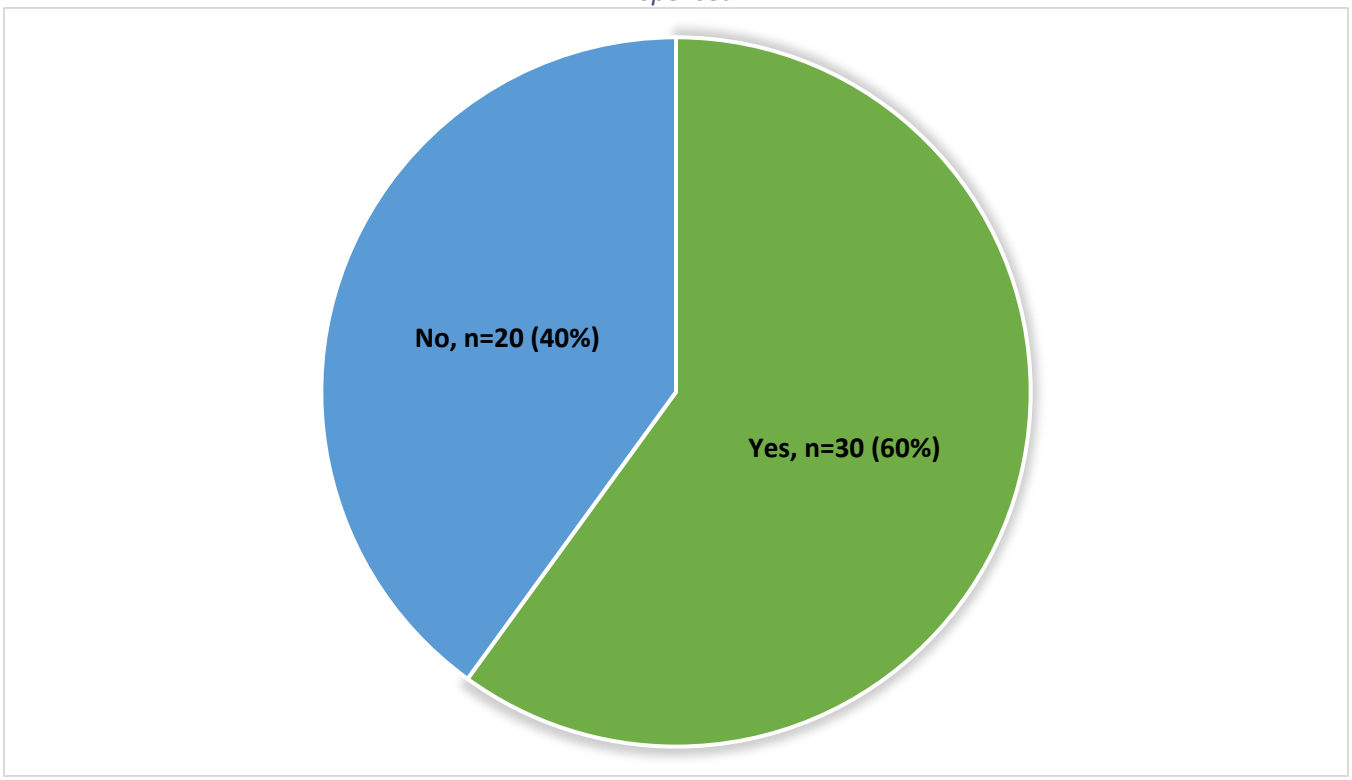

Table 188 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

Response	State	Count	Percentage
Yes	Alaska, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin	30	60.00%
No	Alabama, Arkansas, California, Georgia, Idaho, Kentucky, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, Rhode Island, Vermont, West Virginia, Wyoming	20	40.00%
Total		50	100.00%

Please explain.

Table 189 - Explanations for Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

State	Explanation
Alabama	AL Medicaid monitors prospective claims only.
Alaska	The opioid report includes the total MME daily dose and is reviewed by the state and DUR committee quarterly.
Arkansas	Our strict prospective edits prevent claims with >90 MME/day from processing at POS without a PA. So an automated process for retro review is not necessary. The RDUR program does monitor all requirements pertaining to Section 1004 of the SUPPORT Act including those exceeding our MME limits, but the reports are run manually.
California	We have completed several retrospective claim reviews to monitor total MME daily dose of opioid prescriptions dispensed, but they are not automated.
Colorado	Automated identification of beneficiary claims for short-acting and long-acting opioids are cumulatively included in the claims system MME calculation.
Connecticut	Retrospective MME criteria targets any patient receiving > 472.5 MME in 90 days.
Delaware	Providers are notified retroactively in cases where the high does alert is set on a claim.
District of Columbia	Quarterly claims review to monitor MME compliance including claims count over quantity limits, totatl opioids claims count, days supply and other edits.
Florida	The retrospective claim review to monitor total daily dose (MME) of opioid prescriptions is reviewed by the DUR Board.
Georgia	Not automated at this time.
Hawaii	Quarterly and annual reviews.
Idaho	We perform retrospective reviews to evaluate total MMEs, but it is not automated.
Illinois	During the second half of FFY21, Change Healthcare began to provide retrospective reports of participants who had opioid claims for a total daily MME greater than 50 MME and greater than 90 MME. Reports provide information regarding the past month or quarter. Besides claim level detail, percentage change in MME utilized by the participant is provided.
Indiana	Each month a report is provided to the DUR Board and quarterly to the Therapeutics Committee and Menta Health Quality Advisory Committee that displays current MME utilization, age ranges, new starts, and diagnosis(es) present.

State	Explanation
Iowa	A retrospective report is generated for review those exceeding the MME limit set. If issues are identified, it is referred to the DUR Commission for discussion and next steps, such as provider education.
Kansas	There is a hard edit and a PA is required for claims to pay, but an RDUR is done quarterly to monitor all opioid use outside of state set edits.
Kentucky	MME edits are prospective through the PA process.
Louisiana	Claims were reviewed retrospectively for MME exceeding 90 MME daily and 3 interventions were made during FFY21.
Maine	Reports have been developed to identify all members above 30MME
Maryland	During retrospective reviews, the RDUR program is able to identify patients who are receiving greater then 50MME as well as participants receiving over 90MME daily.
Massachusetts	We use claim edits to monitor daily MME, however no automated review. Reports are produced ad-hoc.
Michigan	Our comprehensive quarterly opioid trend report includes the accumulated MME of each member. The report provides claim and member detail if further investigation is required.
Minnesota	Prior authorization is required for any prescription where the opioid per day exceeds 90mg MME at the POS. Retrospective mailings occur two times a day. One of the criteria if exceeded a cumulative 90mg MME.
Mississippi	A monthly retrospective DUR mailing is sent to providers with beneficiaries above 50 MME opioid dosing. MME values are also included in the quarterly report on beneficiaries at high risk for opioid misuse or abuse.
Missouri	We do have an automated retrospective claims review process in place to monitor daily MME on opioid prescriptions. Our multi-faceted approach combines monthly MME reporting identifying individuals over the set limits, combined with our retrospective, population-based interventions targeting safe opioid utilization. Our retrospective intervention identifies members over the maximum cumulative daily MME, which was set at >/=200MME per day and educates providers on how to obtain prior approval for continued use, or how to safely taper the current opioid dose. The state uses the retrospective lettering process to communicate MME changes to providers and will continue this process as the target MME limit is reduced over time.
Montana	We do not have an automated retrospective review because we deny them prospectively and require prior authorization so any paid claims have already been reviewed and approved. However, we do Ad Hoc reviews to ensure providers whose members have been approved for a higher than 90MME dose have not further escalated the dose as per their attestation.
Nebraska	Automated PA edits/lookbacks are in place to monitor daily dose limits of 90 MMEs.
Nevada	The retrospective claim review is a manual review process through the retroDUR program and DUR meeting presentations.
New Hampshire	All claims of MME over 100 require a prior authorization.
New Jersey	Retrospective reviews to monitor MME are currently manually reviewed based on routine, quarterly ad hoc reporting.
New Mexico	A "hard stop" POS edit exists.
New York	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

State	Explanation
	regimen or substitution with non-opioid analgesics, discontinuation or opioid tapering may decrease risks and guidelines recommend tapering when risks outweigh benefits.
North Carolina	NC Tracks monitors the total MME of all opioid prescriptions concurrently dispensed. Prior approval is required for greater than 90 MME.
North Dakota	It is done prospectively. Claims will reject for prior authorization when MME is exceeded. If authorized, retrospective letters are still sent to providers and patients.
Ohio	We use automated retrospective claim reviews that monitor high quantity/day supply of opioids. We also monitor MME threshold through reporting monthly.
Oklahoma	The opioid MME edit calculates the cumulative MME based on the member's claims for active medications.
Oregon	The retoDUR Program for High-Risk Opioid Patients includes patients prescribed opioids in excess of state defined quantity limits of 90 MME per day. The full program is described elsewhere in the report, but includes patients with cumulative opioid dose >90 MME (for all opioid formulations) for >60 days (with <=7 day gap in therapy) in a 120 day lookback. Patients are reviewed quarterly and prescribers are notified as needed. Point of sale edits, including PA criteria and quantity limits address acute prescribing greater than 90 MME per day for new start patients.
Pennsylvania	The RetroDUR system is not able to calculate MME's.
Rhode Island	Currently no reviews in place.
South Carolina	There is not an "automated" claims review retrospectively for these claims, however, analytics and reporting are run periodically, at the States request. The MME limit is prospective for new starts, with exceptions noted in the above.
South Dakota	All claims are retrospectively reviewed on a monthly basis.
Tennessee	Our PBM vendor implemented a MME accumulation edit during FFY2021, however it was not in place for all of FFY2021. This implementation and new programming took over a year to implement by our PBM.
Texas	Prior to processing an incoming claim, the system checks cumulative daily MME levels of the existing claims and if the dose is above 90 MME per day, it will reject the incoming claim for prior authorization. System does not send messages to the prescriber in near real time.
Utah	This process is integrated into Prior Authorization work flow and monthly peer-to-peer opioid work.
Vermont	There is no automated claims review process in the Pharmacy Benefit. However this data is often looked at as a retrospective DUR analysis in collaboration with the DUR Board. The Vermont Department of Health also releases data summaries periodically with MME total MME dispensed data. https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Monthly_Opioid_Update.pdf The Department of Health also produces a VPMS quarterly report that includes Vermont Total MME Dispensed by Quarter. Interestingly, this report dated August 2021 (second quarter 2021) Since Quarter 1 of 2016, the Vermont total MME has decreased by over 48% https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP-VPMS-Q2-2021.pdf

State	Explanation
Virginia	We review members on chronic opioids and with high risk activity that includes being on high total daily doses for MME quarterly and present to each DUR Board meeting.
Washington	Washington Apple Health (Medicaid) has developed a morphine milligram equivalent (MME) report that allows us to monitor enrollee's opioid MME and if they have a history of opioid use disorder (OUD) or are currently receiving medications used to treat OUD. The data in the MME report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse.
West Virginia	We use MME to filter members for some Retrospective reviews. Members who receive an opioid equivalent to 50 MME or greater and also receive a benzodiazepine are flagged for review for higher risk of respiratory failure. High Average Daily Dose: 120 morphine milligram equivalents or more per day over the past 90 days (members with a cancer diagnosis are excluded) are flagged for review in the lock-in program.
Wisconsin	Wisconsin performs retrospective reviews of all opioids used at 250MME or greater and use of opioids at 50MME or greater with concomitant benzodiazepines. Prescribers identified during these processes receive a letter alerting them to a clinical concern. Outreach calls are conducted when the prescriber remains an outlier.
Wyoming	Each patient who is exceeding the MME limit has a prior authorization in place and is being monitored by the clinical team at the PA Help Desk.

4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere?

Figure 112 - Provide Information to Prescribers to Calculate MME Daily Dosage or Provide Calculator Elsewhere

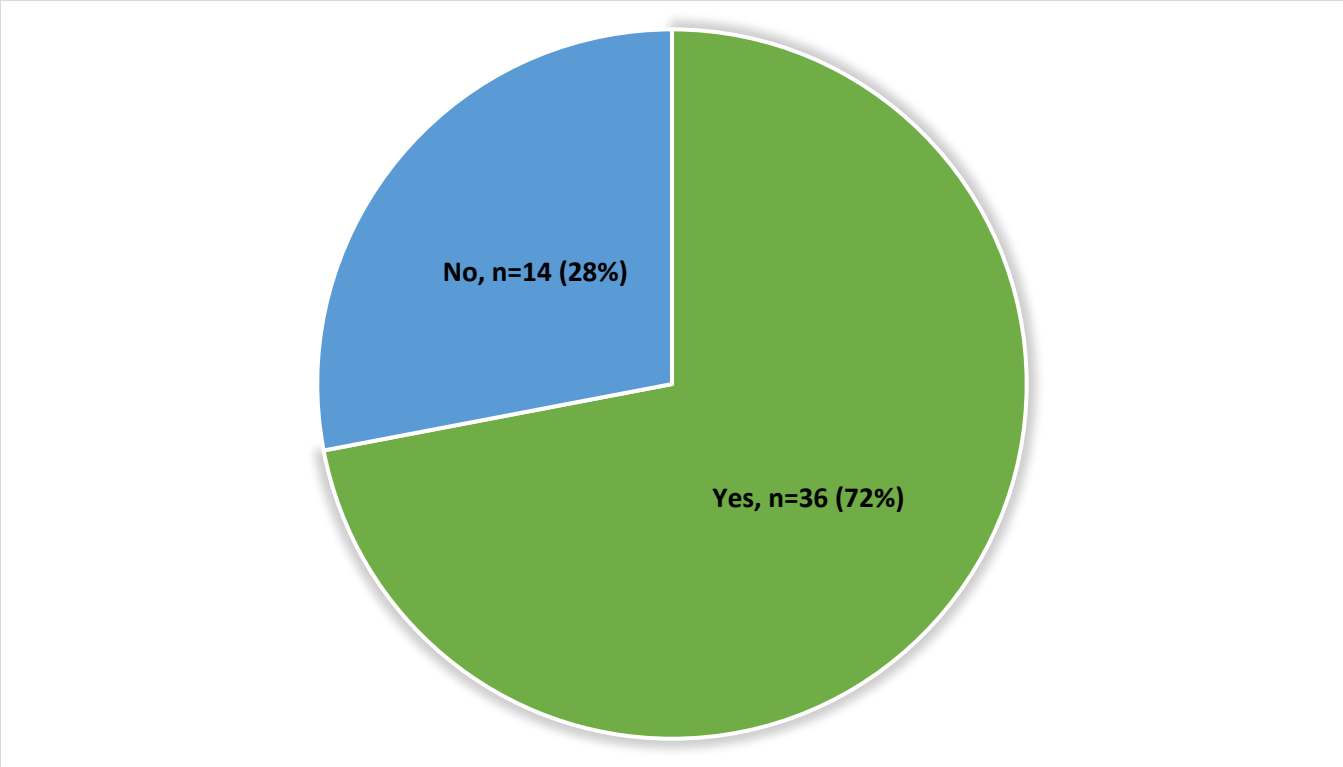

Table 190 - Provide Information to Prescribers to Calculate MME Daily Dosage or Provide Calculator Elsewhere

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	36	72.00%
No	Delaware, Georgia, Idaho, Kentucky, Louisiana, Minnesota, Missouri, Nevada, 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 113 - Developer of Calculator

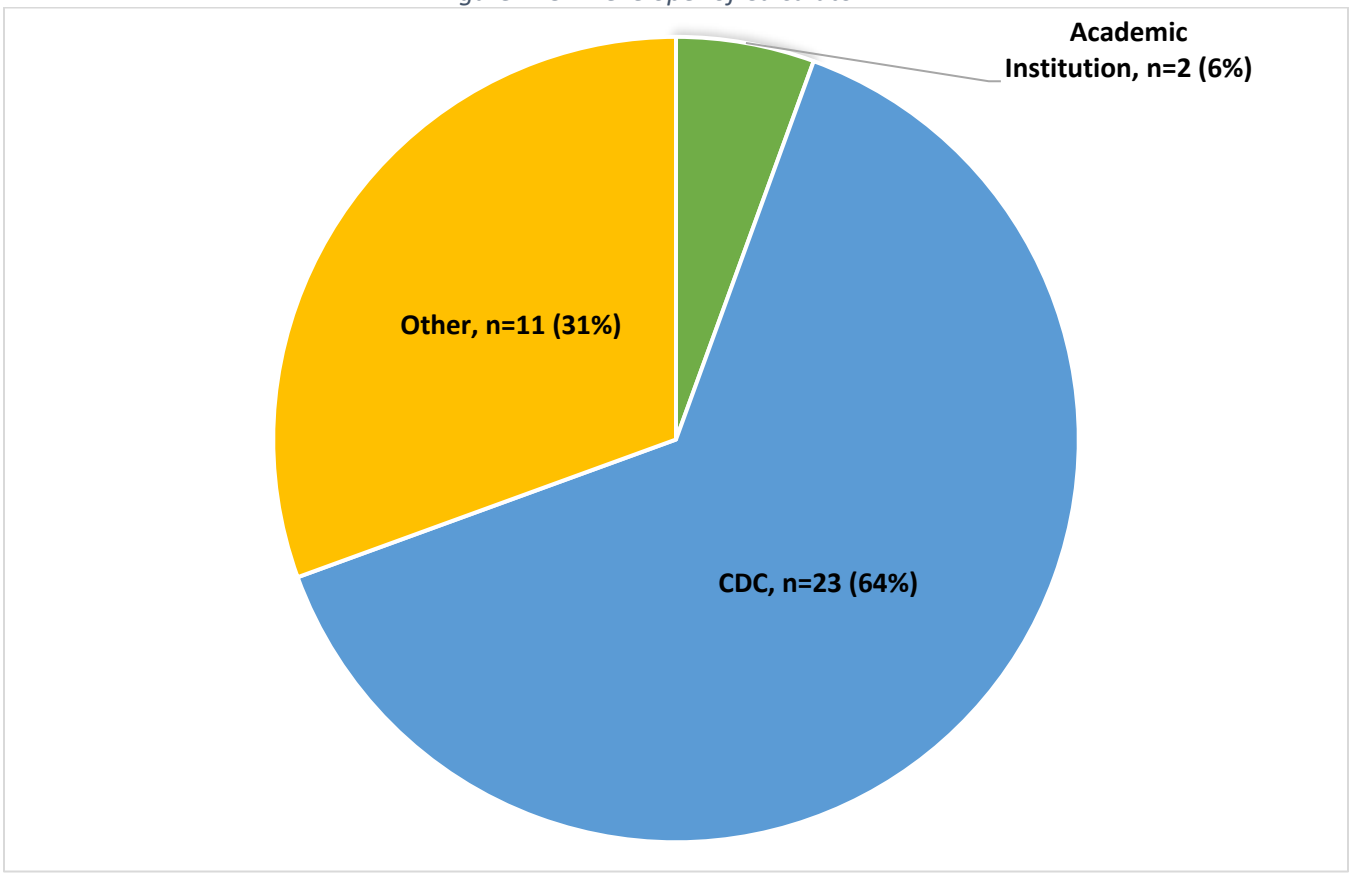

Table 191 - Developer of Calculator

Response	State	Count	Percentage
Academic Institution	North Dakota, Oregon	2	5.56%
CDC	Alabama, Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Maine, Maryland, Michigan, Mississippi, Montana, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, Utah, Vermont, West Virginia	23	63.89%
Other	Alaska, Colorado, Kansas, Massachusetts, Nebraska, New Hampshire, North Carolina, Ohio, South Carolina, Virginia, Washington	11	30.56%
Total		36	100.00%

If "Other," please specify.

Table 192 - Explanations for "Other"

State	Explanation
Alaska	Washington AMDG and the Alaska state PDMP website
Colorado	Washington State Agency Medical Directors' Group (AMDG)
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.
Nebraska	Nebraska Pain Management Guidance Document
New Hampshire	Washington State Agency Medical Directors' Group
North Carolina	NC has a table, not a calculator.
Ohio	Take Charge Ohio, OARRS guidelines.
South Carolina	Incorporated into PDMP and Magellan Call Center
Virginia	SA form states for prescriber to provide pts Daily MME from PMP (http://virginia.pmpaware.net/login)
Washington	A combination of CDC, AMDG, and HCA self created

b. If "Yes," how is the information disseminated (multiple responses allowed)?

Figure 114 - How Information is Disseminated

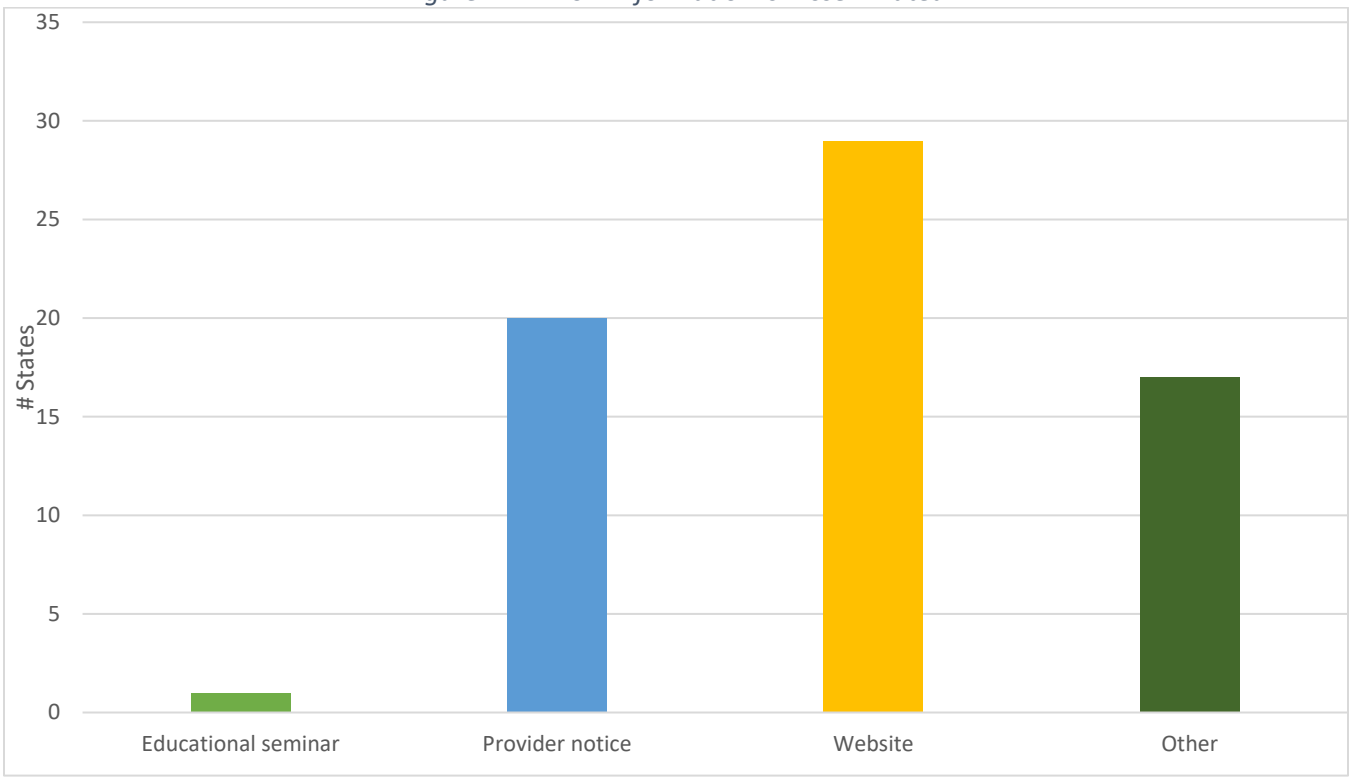

Table 193 - How Information is Disseminated

Information Type	State	Count	Percentage
Educational seminar	Washington	1	1.49%
Provider notice	Alabama, Arkansas, California, District of Columbia, Florida, Hawaii, Kansas, Maine, Massachusetts, Mississippi, Montana, Nebraska, New Jersey, Ohio, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia	20	29.85%
Website	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington	29	43.28%
Other	Alabama, Alaska, Arkansas, California, District of Columbia, Massachusetts, Michigan, Montana, New Mexico, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington	17	25.37%
Total		67	100.00%

If "Other," please explain.

Table 194 - 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.
California	In February 2019, the Medi-Cal DUR program published an educational bulletin entitled, Clinical Review Update: Morphine Equivalent Daily Dose to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service and remained on the Medi-Cal DUR website throughout FFY 2021.
District of Columbia	Quarterly Providers Forum presentations
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.
New Mexico	Provider outreach.
Oregon	Table of MME for individual agents is included on PA criteria: https://www.orpdl.org/durm/PA_Docs/opioids_long-acting.pdf https://www.orpdl.org/durm/PA_Docs/opioids_short-acting.pdf

State	Explanation
South Carolina	SC PDMP: A SCRIPTS report calculates MME per day for each patient prescription (Rx) using a common denominator, MME (Morphine Milligram Equivalents), so that the different Rxs can be added together (Active Daily MME) to help assess cumulative risk in addition to assessing the risk associated with a single opioid Rx. https://msp.scdhhs.gov/tipsc/sites/default/files/tipsc_mailer_Sept%202017_hot_links.pdf References/resources/web links are provided at following sites https://schealthviz.sc.edu/tipsc-topics and https://pharmacy.musc.edu/-/sm/pharmacy/f/selected-resources-insert.ashx?la=en
Tennessee	We list the MME calculations on our website and on all opioid Prior Authorization Forms.
Texas	A link to the CDC's calculation page is included on Opioid Policy Criteria guide document.
Utah	Quarterly Medicaid Information Bulletin and opioid peer to peer work.
Vermont	For example when relevant provider communications are sent the link to the CDC website and reference chart are included https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Cumulative%20MME%20Limits.pdf Sample language used in provider communications: The amount of daily morphine milligram equivalents (MMEs) is frequently used as a risk factor to evaluate potential opioid related harms . The MME conversion factor uses prescription data to calculate the daily MME. The strength per Unit x (Number of Units/Days' Supply) x MME conversion factor = MME/Day. DVHA uses the MME conversion factors provided by the Centers for Disease Control (CDC), and a chart has been provided for your reference (attached). More detailed information can be found on their website at https://www.cdc.gov/drugoverdose/prescribing/guideline.html
Virginia	A Medicaid Memo was posted to the state website with a blast email sent to those enrolled in the service. A patient specific letter was sent to those prescribers whose patients had received a prescription above the new limit.
Washington	We provide a link to the website and our calculator on our Opioid attestation form.

E. Opioid Use Disorder (OUD) Treatment

1. Does your state have utilization controls (i.e. 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 115 - State Has Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD

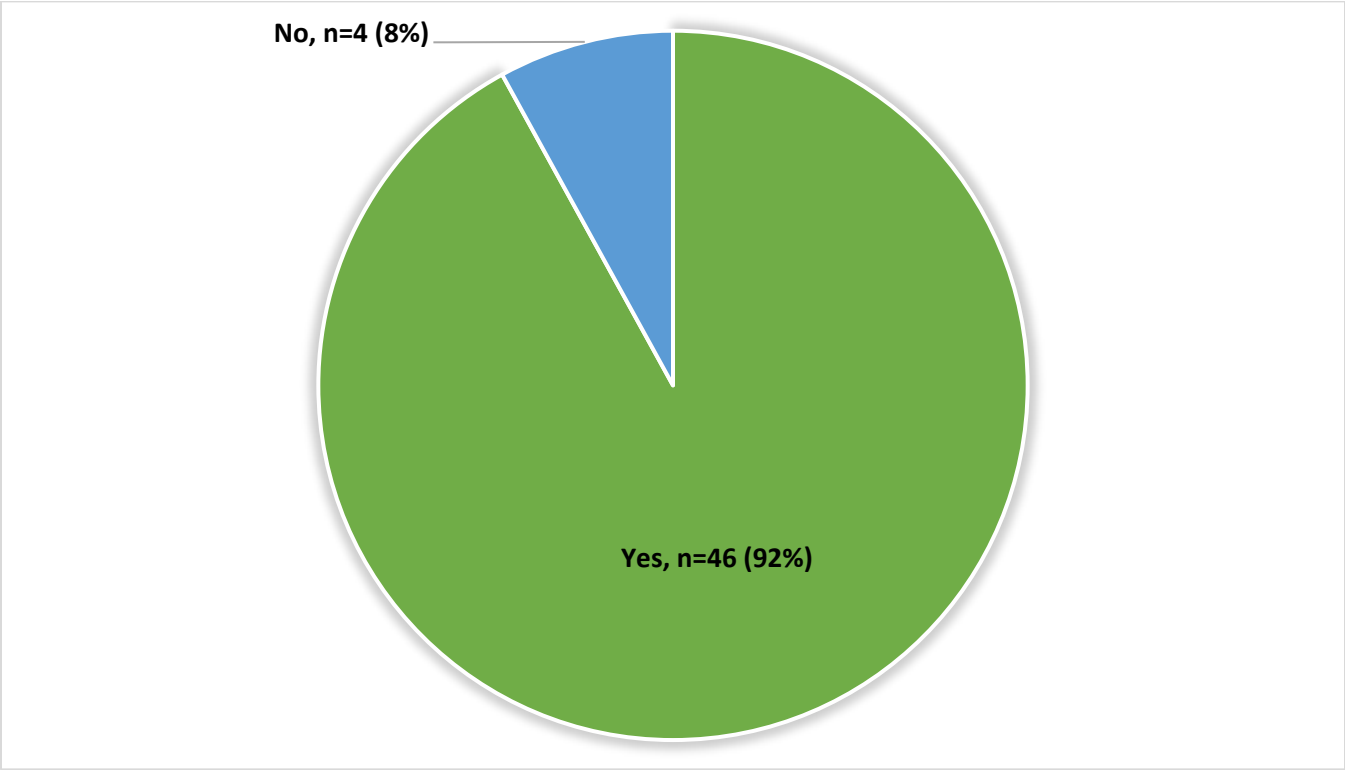

Table 195 - State Has Utilization Controls to Monitor or Manage Prescribing of MAT of Drugs for OUD

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, 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, Hawaii, Mississippi, South Dakota	4	8.00%
Total		50	100.00%

If "Yes," please explain.

Table 196 - Explanations of Utilization Controls to Monitor or Manage Prescribing of MAT Drugs for OUD

State	Explanation
Alabama	PA is required for buprenorphine products. Buprenorphine products are on the PDL and they also have quantity limits. AL Medicaid requires that an Informed Consent form is submitted along with the PA request form.
Alaska	PDL, PA, QL
Arkansas	The oral MAT class has 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, all oral buprenorphine-containing medications used to treat OUD required prior authorization verifying appropriate use, and a quantity limit was applied to these medications. Injectable formulations of medications used to treat OUD also required prior authorization for cases where eligible for billing under the pharmacy benefit. Following the reporting period, prior authorization requirements were removed for Suboxone (buprenorphine/naloxone) sublingual film.
Connecticut	Drugs that are grouped in the MAT class are subject to PDL requirements.
Delaware	Delaware maintains open access for OUD treatments in accordance with the SUPPORT Act.
District of Columbia	There are prior authorization and quantity limits requirements that have been disseminated to all providers through a Transmittal that specifies the maximum daily dosage for each MAT used 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	See below.
Idaho	We utilize max daily quantity limits, PA's for the products, and also do retrospective reviews on the medications.
Illinois	All MAT therapies are preferred.
Indiana	The state has preferred MAT agents on the PDL and quantity limits up to 24mg per day of buprenorphine.
Iowa	Preferred agents on PDL, quantity limits and age edit.
Kansas	Subutex and any non-rebate eligible MAT NDC requires a PA.
Kentucky	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.

State	Explanation
Louisiana	Buprenorphine/naloxone SL and naltrexone are on the PDL. Age limit, diagnosis requirement, and quantity limit for selected agents. Dose limit for buprenorphine containing agents POS edits for concurrent use of: Opioid, benzodiazepine and/or any buprenorphine-containing agent Buprenorphine containing agents or opioids 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 daily dose limit.
Minnesota	QL per FDA max dose. Nonpreferred drugs need a PA.
Missouri	MO HealthNet utilizes a PDL edit which includes clinical criteria and dosing limits.
Montana	We utilize PDL controls, max daily dose, 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	PDL, PA, and 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 exist on some MAT products.
New Mexico	Reports are generated by Conduent on the utilization of MAT drugs for state for review.
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 16 mg; limited to maximum of 24 mg.

State	Explanation
North Dakota	Quantity limits are in place for FDA and compendia max dosing recommendations. Therapeutic duplication edits are in place for dose consolidation. Prior authorization is required for single agent buprenorphine oral therapy with clinical criteria to either use combination with naloxone therapy or be pregnant or breast feeding.
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.
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, 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 available on the preferred drug list with no PA required.
South Carolina	Medication Assisted Treatment Guidelines were developed/implemented May 2020 Inconsistencies in the coverage of medication assisted treatment (MAT) among payers is

State	Explanation
	an often-cited barrier to the initiation and maintenance of MAT. To mitigate this barrier, SCDHHS is implementing standard coverage criteria across managed care organizations (MCOs). The coverage guidelines highlighted in this document were developed in concert with addiction treatment experts from across the state. The criteria contained within this document represent the minimum coverage requirements. The use of less restrictive parameters and the approval of therapy for a period longer than indicated in this document are permissible. https://www.scdhhs.gov/press-release/medicaid-coverage-treatment-opioid-use-disorder
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 prescriptions, approval is granted only if the client is pregnant or is intolerant to naloxone. All MAT therapy drugs are preferred 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 PDL has preferred agents with no PA required : Suboxone film, buprenorphine naloxone SL tabs, and naltrexone oral Maximum days supply for Suboxone Films, Buprenorphine/naloxone tablets is 30 days. Vivitrol is preferred after clinical criteria are met: documented trial of oral naltrexone to establish tolerability AND Patient should be opiate free for > 7 -10 days prior to initiation of Vivitrol. If the diagnosis is alcohol dependence, the patient should not be actively drinking at the time of initial Vivitrol administration.
Virginia	The following criteria must ALL be met for approval: * Patient is at least 16 years of age and older with a diagnosis of Opioid Use Disorder; AND * Prescriber has reviewed the Virginia Controlled Substance Database PMP before initiation of therapy. For maintenance therapy requests, prescriber must review PMP on the date of the request; AND *Requests for non-preferred medications will require submission of a completed FDA MedWatch form for adverse reactions to combination products; AND *Buprenorphine monotherapy (up to 16 mg/day) will be covered for pregnant women ONLY (maximum of 10 months) with documentation of positive pregnancy test submitted with the fax request form. Also document expected date of delivery (EDD). If criteria are met, may approve through EDD plus 30 days; PLUS *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

State	Explanation
	plan to achieve the lowest possible effective doses of these medications. Forward to pharmacist for review. *During maintenance the prescriber must check random urine drug screens as part of the treatment plan. - Checking for buprenorphine, norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates.
Washington	Washington Apple Health (Medicaid) has developed a morphine milligram equivalent (MME) report that allows us to monitor enrollee's opioid MME and if they have a history of opioid use disorder (OUD) or are currently receiving medications used to treat OUD. The data in the MME report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. For any enrollee or provider outliers one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - 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. In addition, clinical criteria is applied. A diagnosis of opioid use disorder or opioid abuse is required. Claims over 16 mg per day require a prior authorization.

2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

Figure 116 - Program Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

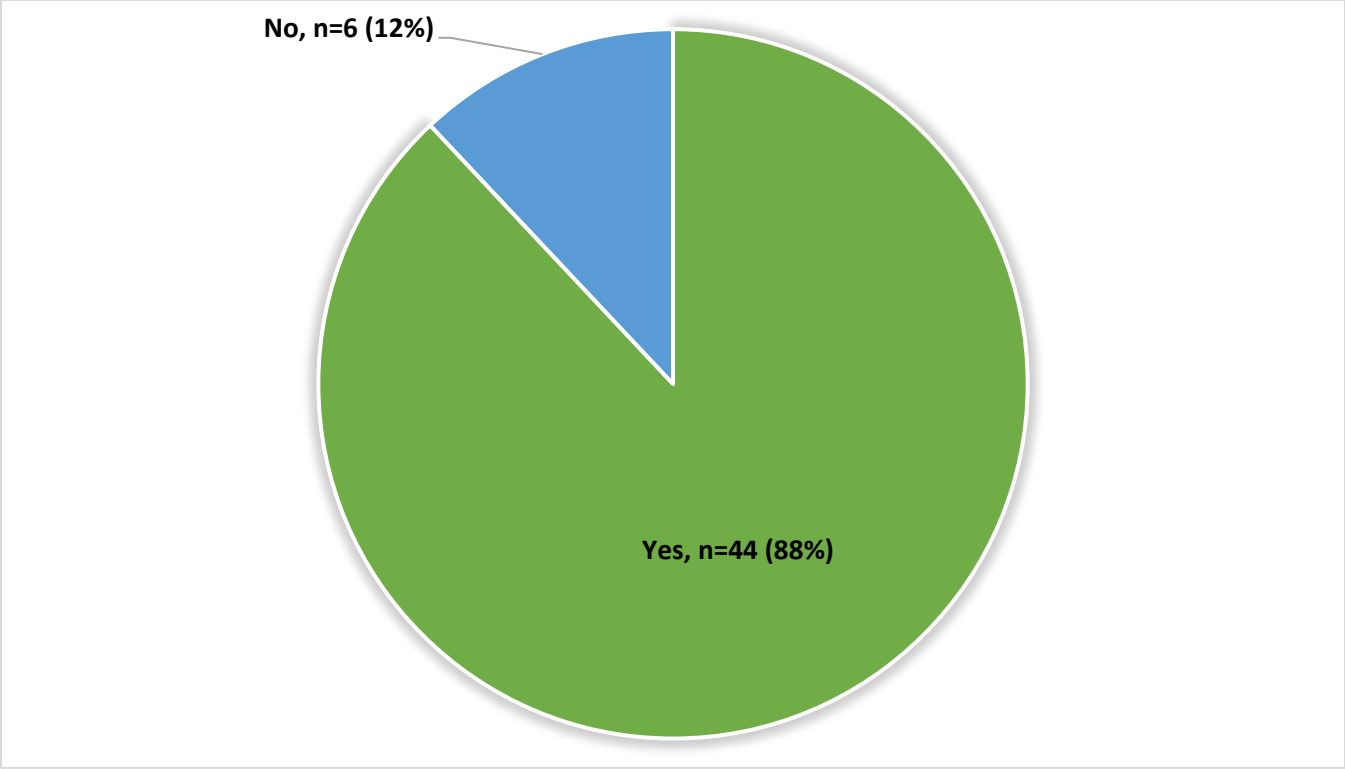

Table 197 - Program Sets Total Milligrams per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

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, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	44	88.00%
No	California, New Mexico, Rhode Island, South Dakota, Texas, Wisconsin	6	12.00%
Total		50	100.00%

If "Yes," please specify the total mg/day.

Figure 117 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

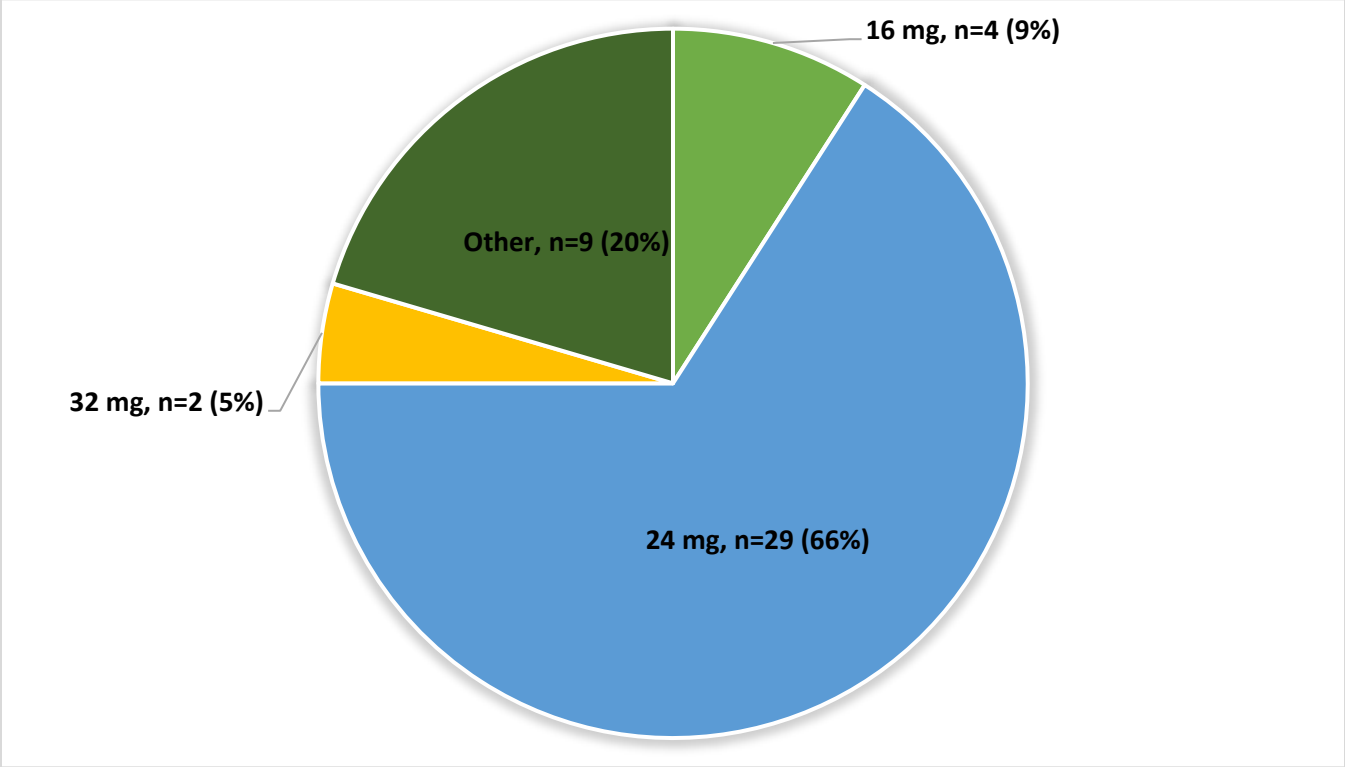

Table 198 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
16 mg	Maine, Oklahoma, Vermont, Wyoming	4	9.09%
24 mg	Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Oregon, South Carolina, Utah, Virginia, West Virginia	29	65.91%
32 mg	New Jersey, Washington	2	4.55%
Other	Alabama, Connecticut, Illinois, Kansas, Maryland, North Carolina, Ohio, Pennsylvania, Tennessee	9	20.45%
Total		44	100.00%

If “Other,” please explain.

Table 199 - “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 drugs at 24mg/day. Bunavail is not approved for >12.6mg/day and Zubsolv is not approved for >17.1mg/day.
Connecticut	An Informational alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
Illinois	Buprenorphine tablets total mg/day is 24mg. 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 and during FFY21 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.
Kansas	24mg for Subutex only. No daily limits for Non-rebate eligible NDCs.
Maryland	Maryland Medicaid employs varying quantity limits based on the drug and dosage form for buprenorphine and buprenorphine-naloxone combination products. Quantity limits are available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
North Carolina	Override is needed to exceed 16 mg; limited to maximum of 24 mg.
Ohio	After 90 days of 24 mg per day, members are required to taper to 16mg per day. A PA is required to exceed these limitations.
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 16mg per day, where enrollees who choose to continue to pay non-BESMART providers cash still have a 6-month limit of 16mg per day, and must reduce to 8mg/day thereafter with no limit on length of treatment at 8mg/day. Enrollees using BESMART providers are also eligible for up to 24mg/day with prior authorization and with medical necessity.

3. What are your limitations on the allowable length of this treatment?

Figure 118 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

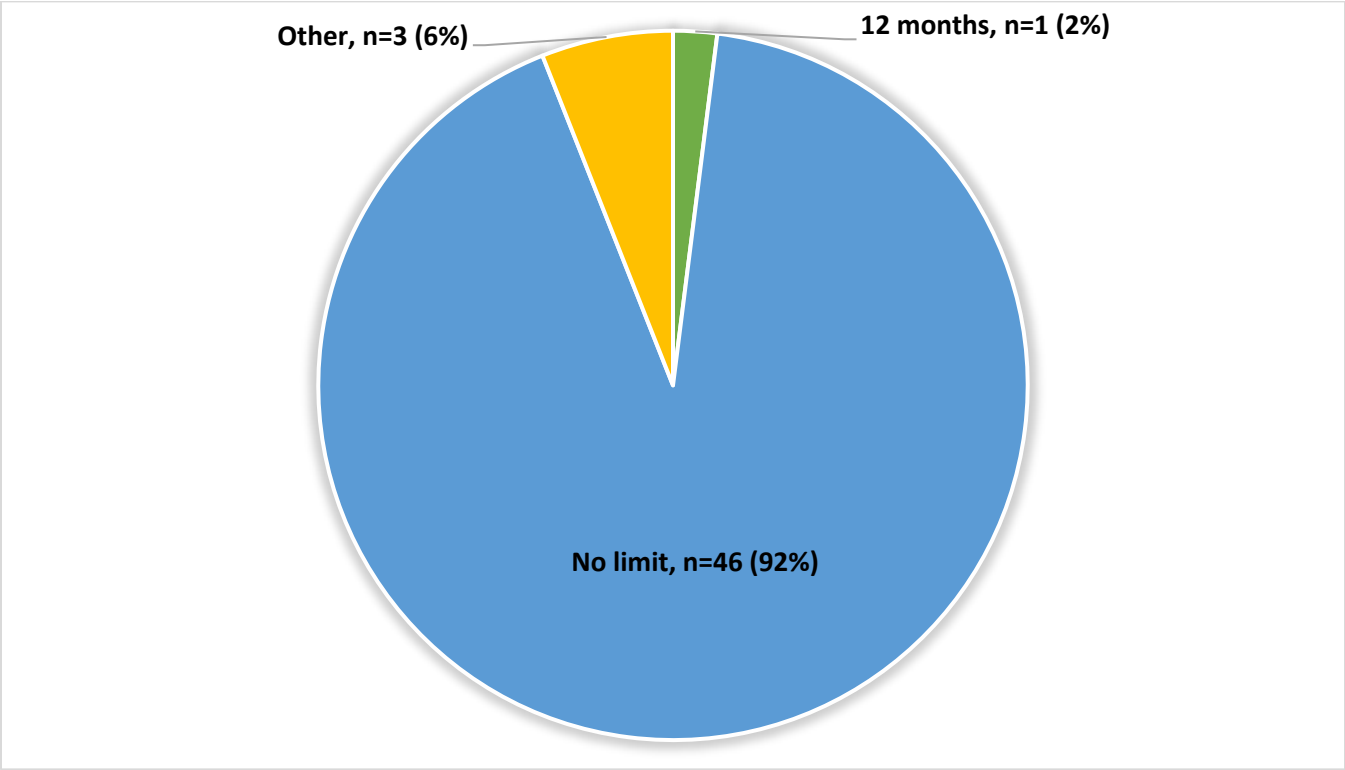

Table 200 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

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 201 - "Other" Explanations for Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

State	Explanation
Tennessee	See the prior answer. All depends on whether the enrollee is seeing a BESMART provider or not.
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 119 - Maximum Milligrams per Day Reduction After a Set Period of Time

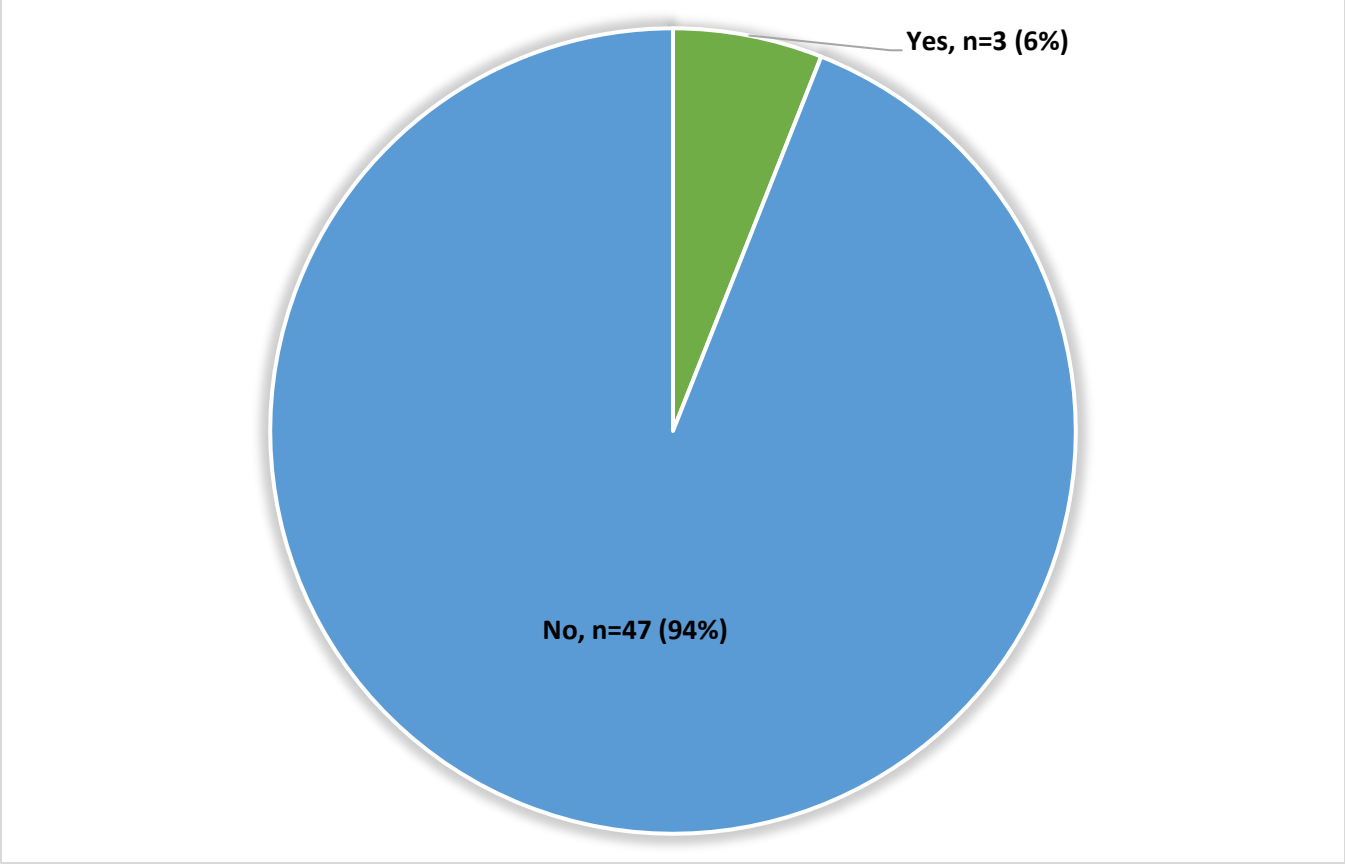

Table 202 - Maximum Milligrams per Day Reduction After a Set Period of Time

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

a. If "Yes," what is your reduced (maintenance) dosage?

Figure 120 - Reduced (Maintenance) Dosage

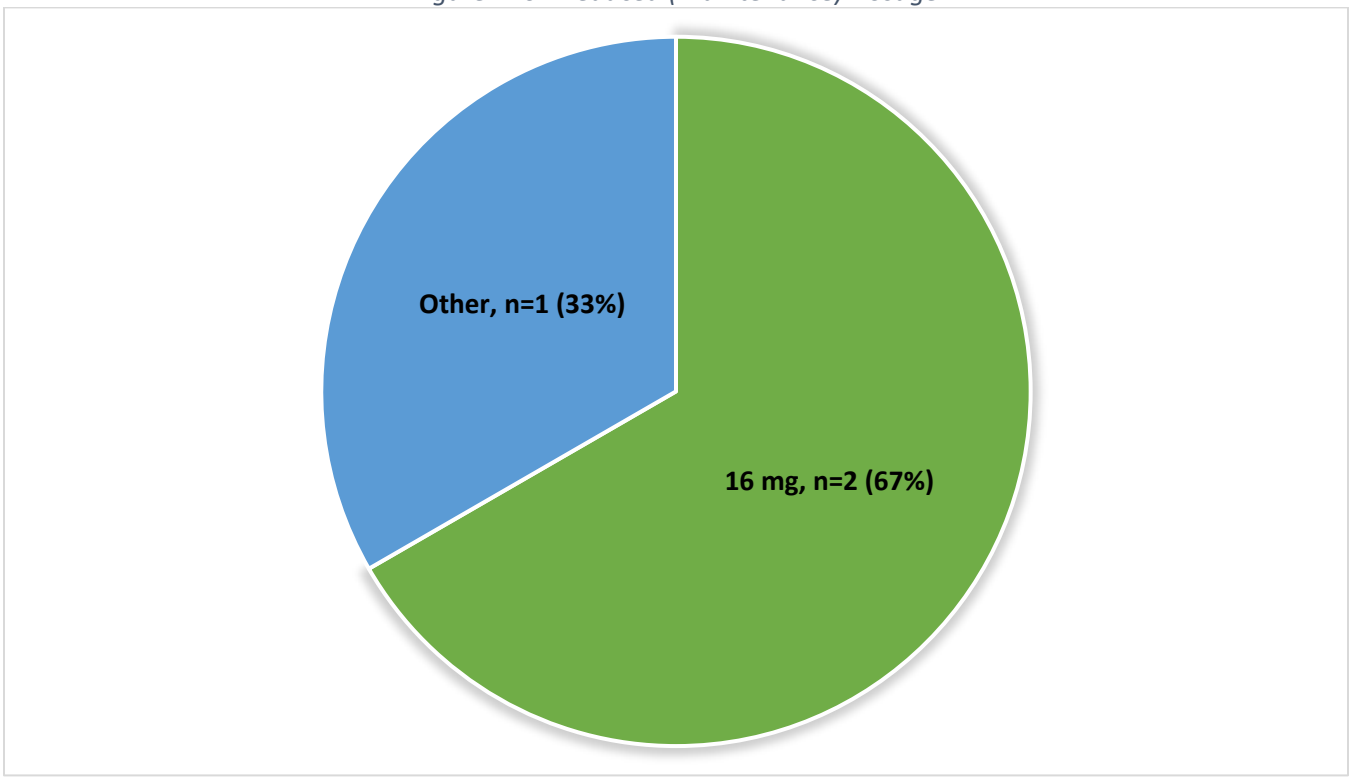

Table 203 - Reduced (Maintenance) Dosage

Response	States	Count	Percentage
16 mg	Maine, Ohio	2	66.67%
Other	West Virginia	1	33.33%
Total		3	100.00%

If "Other," please explain.

Table 204 - "Other" Explanations for Reduced (Maintenance) Dosage

State	Explanation
West Virginia	16 mg. However exceptions may be possible and are reviewed on a case-by-case basis by the medical director.

b. If "Yes," what are your limitations on the allowable length of the reduced dosage treatment?

Figure 121 - Limitations on the Allowable Length of the Reduced Dosage Treatment

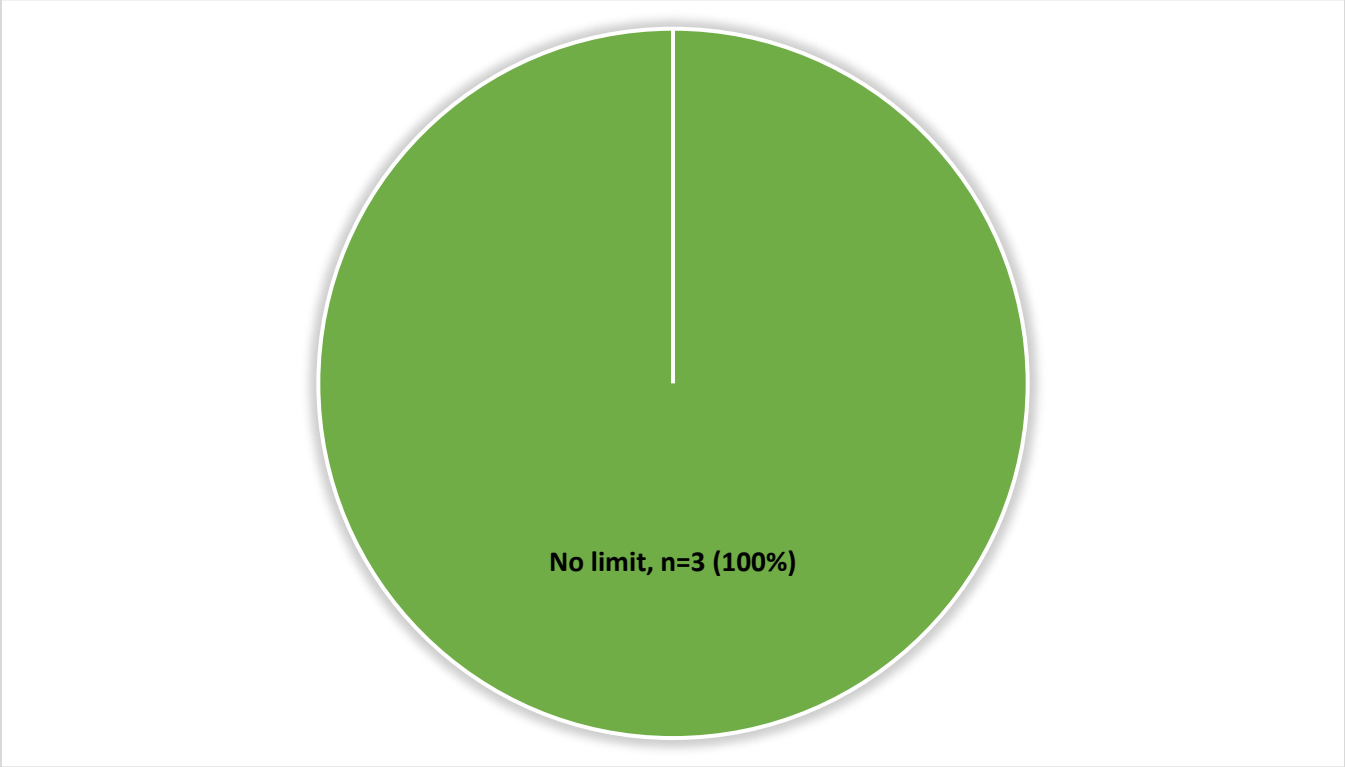

Table 205 - Limitations on the Allowable Length of the Reduced Dosage Treatment

Response	States	Count	Percentage
No limit	Maine, Ohio, West Virginia	3	100.00%
Total		3	100.00%

5. Does your state have at least one buprenorphine/naloxone combination product available without PA?

Figure 122 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

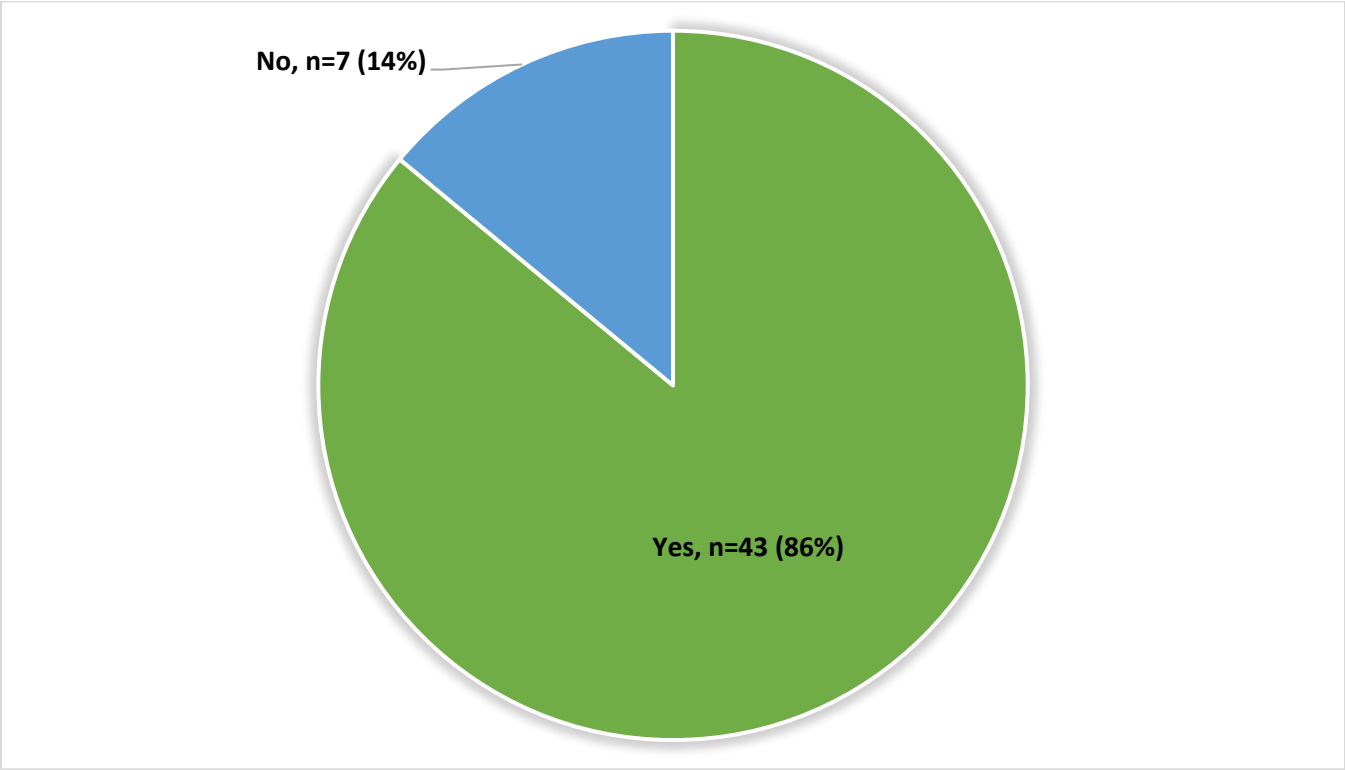

Table 206 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

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

6. Does your state currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

Figure 123 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

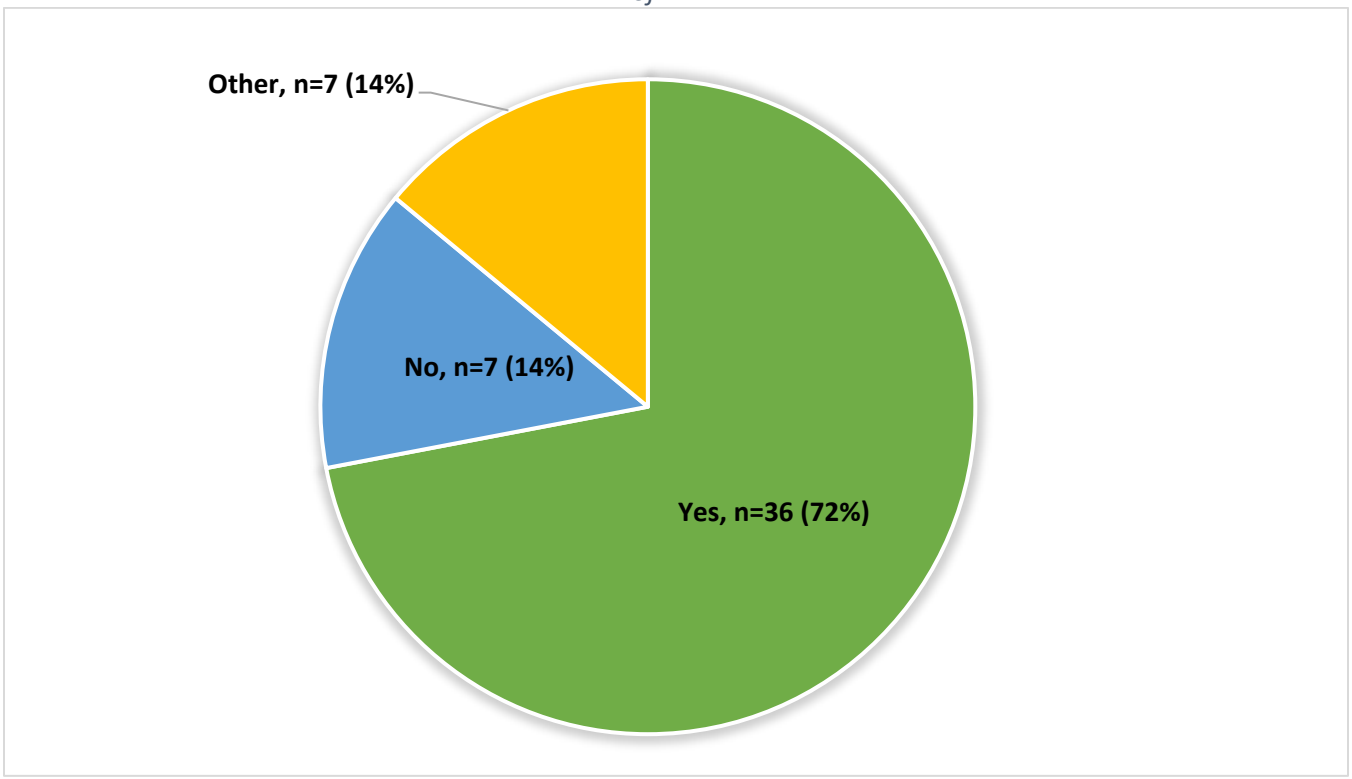

Table 207 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

Response	States	Count	Percentage
Yes	Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	36	72.00%
No	Alabama, California, Illinois, New Mexico, North Carolina, Oregon, South Dakota	7	14.00%
Other	Connecticut, Hawaii, Iowa, Kansas, Minnesota, Utah, Wisconsin	7	14.00%
Total		50	100.00%

If "Yes," can the POS pharmacist override the edit?

Figure 124 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

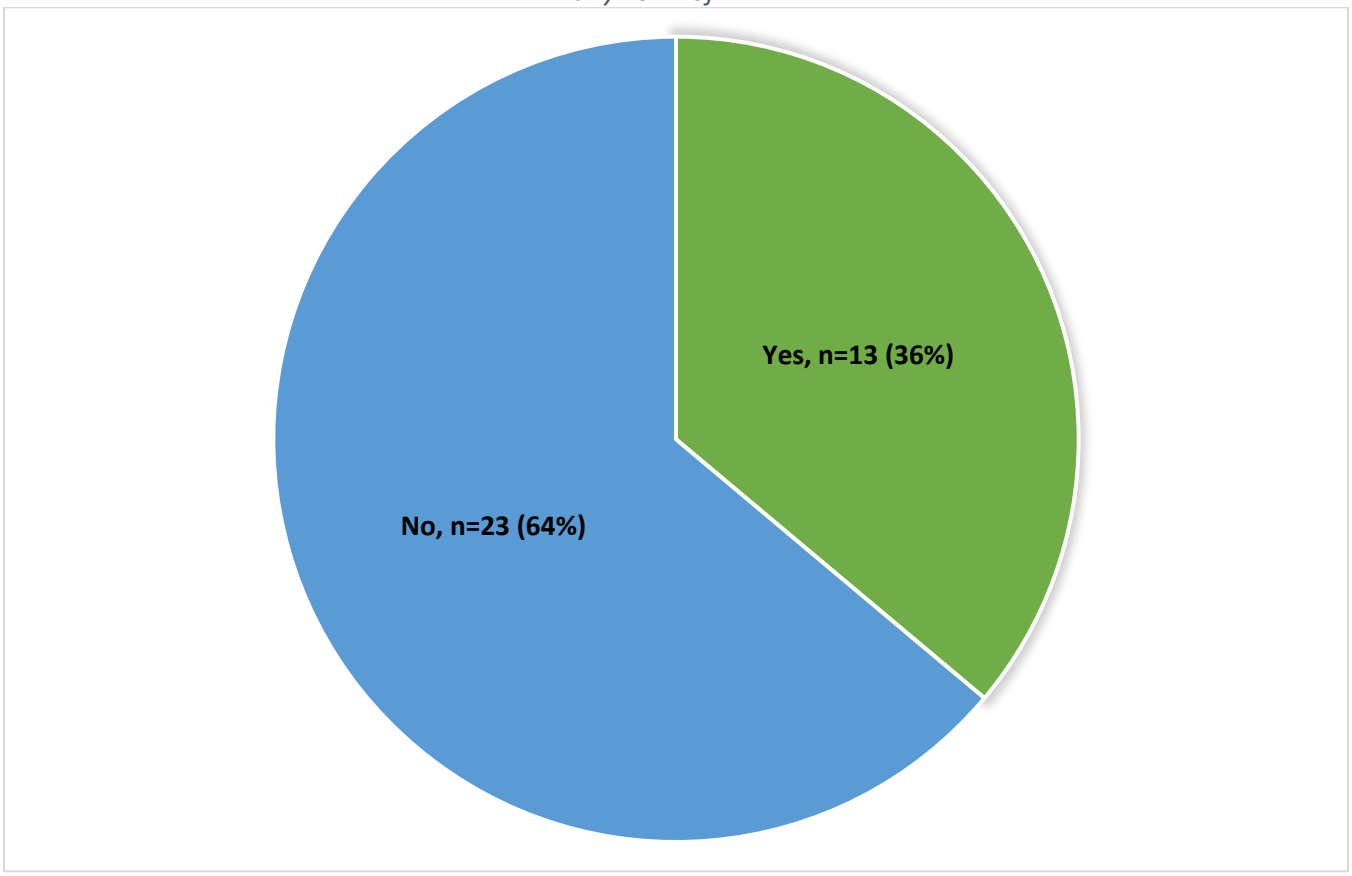

Table 208 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any Form of MAT

Response	States	Count	Percentage
Yes	Colorado, Delaware, Florida, Louisiana, Maryland, Nebraska, Nevada, Ohio, Rhode Island, South Carolina, Vermont, Virginia, Washington	13	36.11%
No	Alaska, Arkansas, District of Columbia, Georgia, Idaho, Indiana, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Pennsylvania, Tennessee, Texas, West Virginia, Wyoming	23	63.89%
Total		36	100.00%

If “Other,” please explain.

Table 209 - “Other” Explanations for 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	No OUD for current population due to nature of transplant program
Iowa	There is a soft edit in place for the pharmacist to review and consult the prescriber as needed.
Kansas	Only for Subutex, with the renewal PA edit.
Minnesota	This is part of the SUPPORT Act criteria for the RetroDUR mailings performed two times a year.
Utah	Begin January 1, 2021, Utah Medicaid limits the use of opioid medications in members who are also receiving MAT medications to treat opioid use disorder. When a claim for an opioid medication is processed through the pharmacy point of sale system, the system will look back to identify if a claim for MAT has been processed in the last 45 days. If the system recognizes that a claim for MAT has been processed in the last 45 days, the system will limit the opioid to a supply of 7 days or less, regardless of the prescribed quantity/duration. If the system does not identify a concurrent claim for MAT in the last 45 days, then the opioid will process without a 7-day limitation. All opioid policy limits still apply.
Wisconsin	Wisconsin monitors concurrent use of opioids and MAT treatment through retrospective claims review, including lock-in reviews.

7. Is there at least one formulation of naltrexone for OUD available without PA?

Figure 125 - Formulation of Naltrexone for OUD Available without Prior Authorization

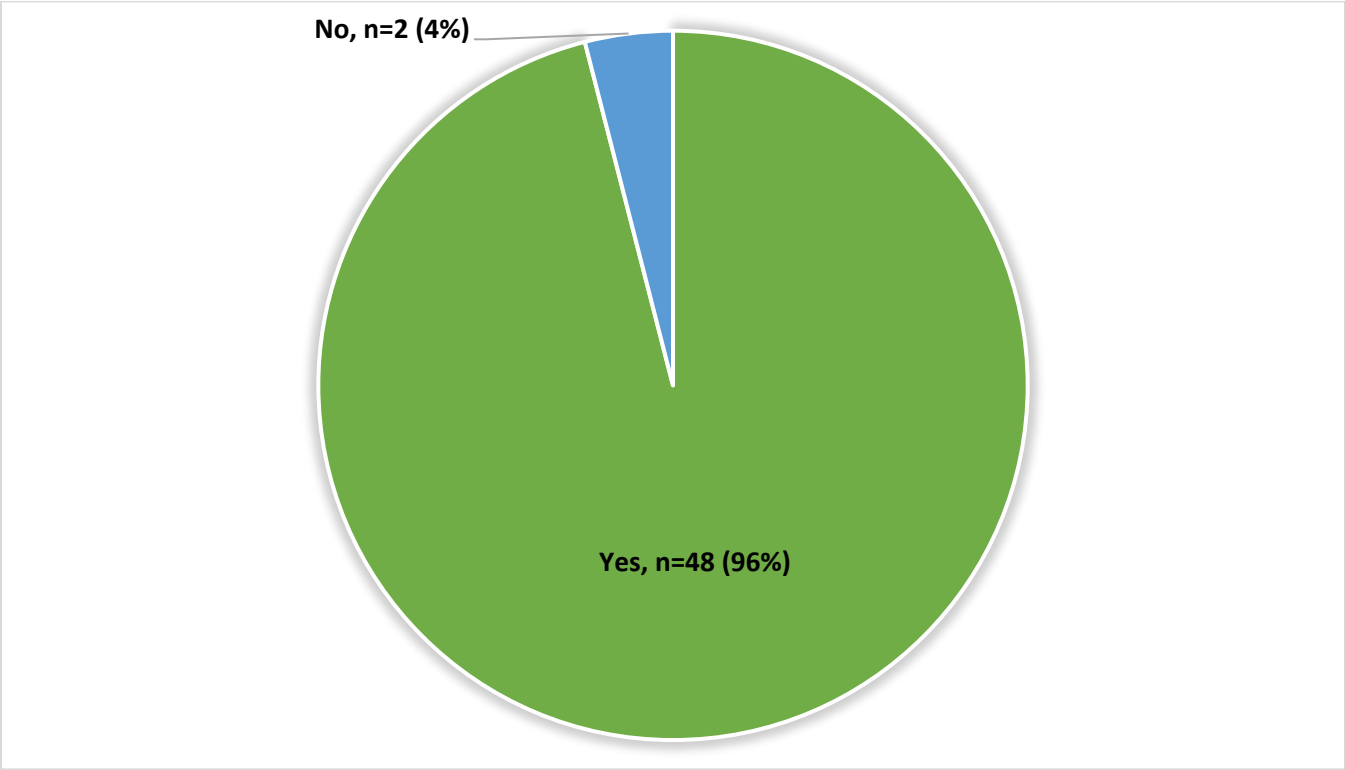

Table 210 - Formulation of Naltrexone for OUD Available without Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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	Idaho, Wyoming	2	4.00%
Total		50	100.00%

8. Does your state have at least one naloxone opioid overdose product available without PA?

Figure 126 -Naloxone Opioid Overdose Product Available without PA

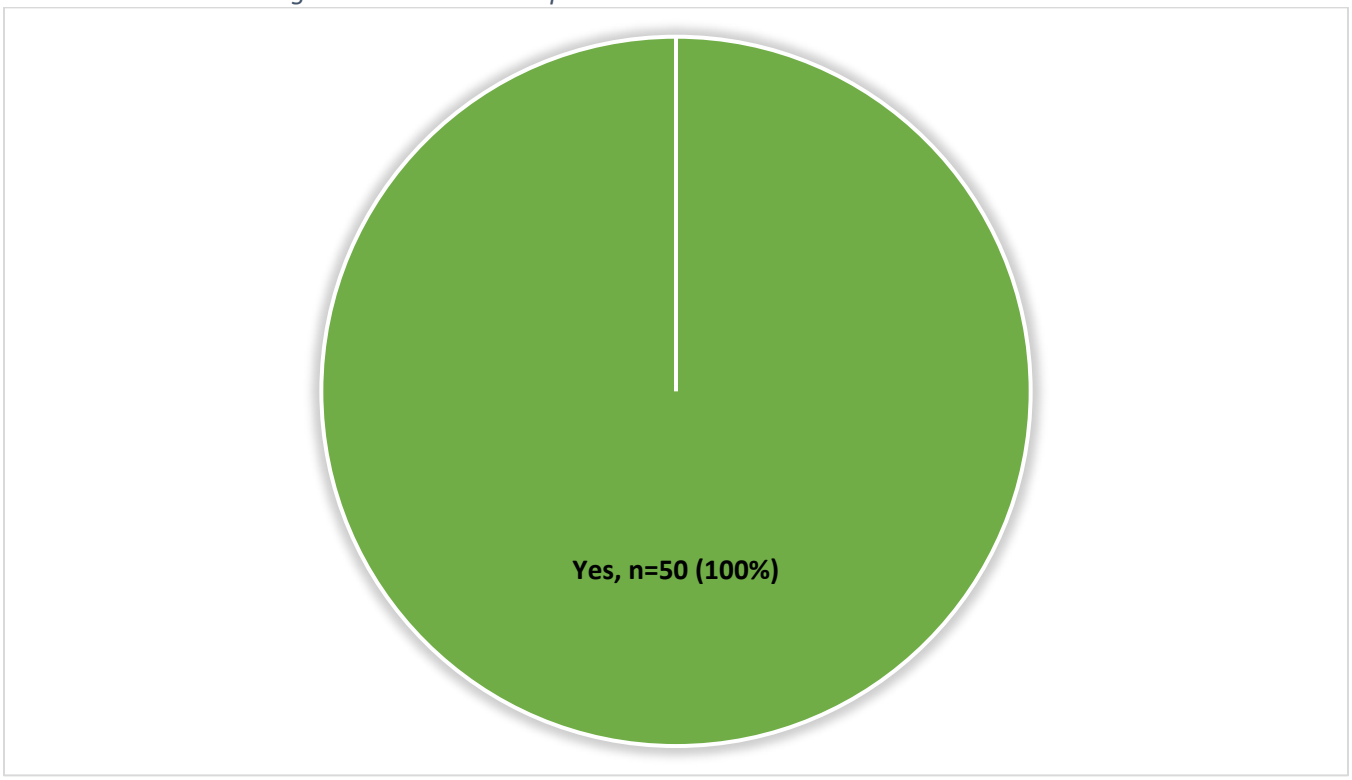

Table 211 - Naloxone Opioid Overdose Product Available without PA

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

9. Does your state retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 127 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

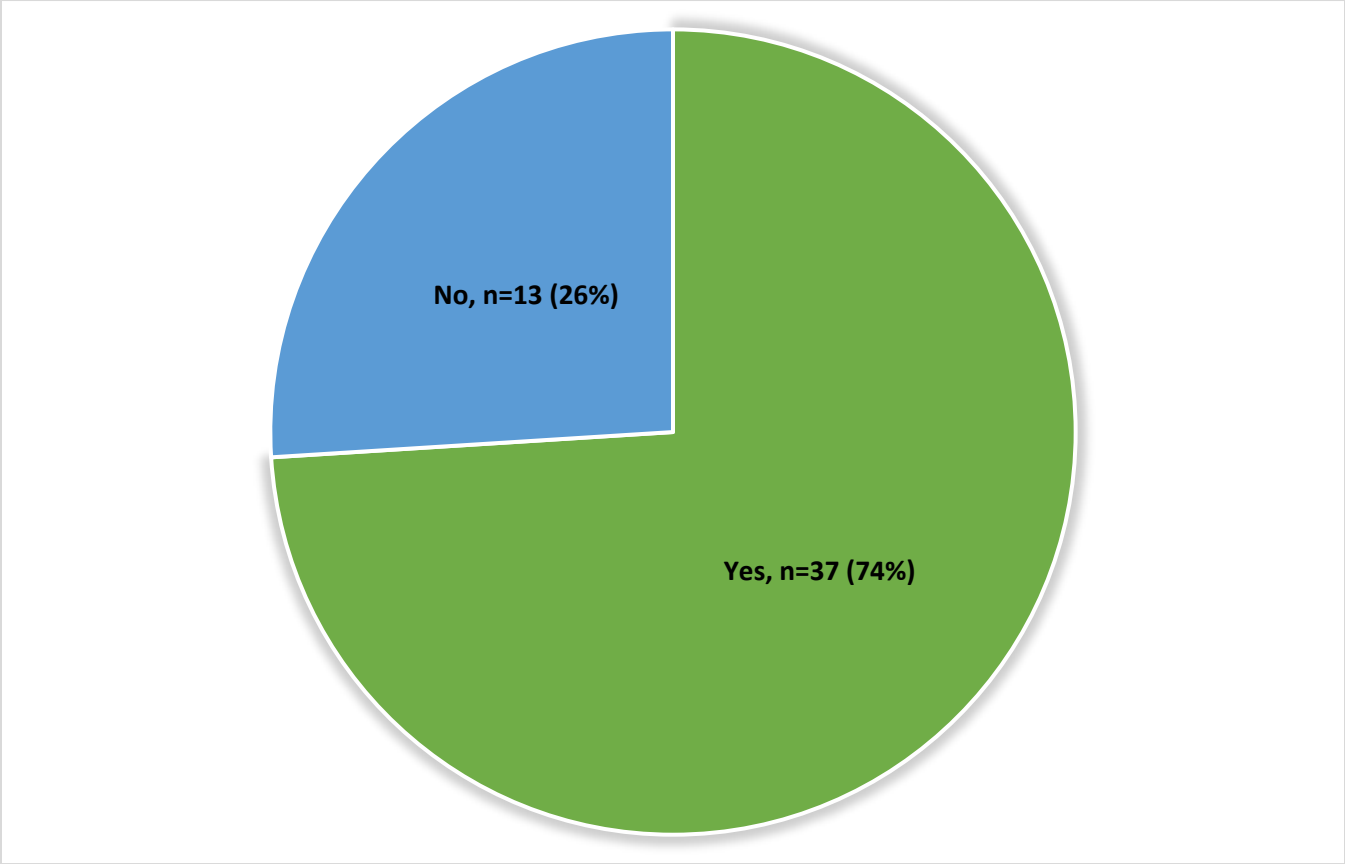

Table 212 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

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

If "No," please explain.

Table 213 - Explanations for Not Retrospectively Monitoring and Managing Appropriate Use of Naloxone to Persons at Risk of Overdose

State	Explanation
Arkansas	During FFY2021, the appropriate use of naloxone/opioids has been monitored with a prospective edit. When a second naloxone claim is billed to Medicaid within a 90 day period, the next opioid claim will deny and require a PA which can only be initiated by the prescriber. This ensures that the prescriber is aware of the potential opioid misuse by their patient. This edit excludes terminal cancer patients with a billed diagnosis in the last 365 days. Retrospective review of naloxone use will be performed during FFY2022.
Louisiana	Naloxone availability was addressed retrospectively in November 2021 (FFY22).
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.
Nebraska	At time of dispensing, patient counseling is offered.
New Hampshire	Prior authorizations for buprenorphine and opioid products require attestation by the prescriber that a prescription for naloxone is provided.
New Jersey	The New Jersey Division of Consumer Affairs requires that naloxone be co-prescribed with continued use of opioids.
New Mexico	A pro-DUR edit is in process for FFY22 or FFY23.
Ohio	Currently, we do not retrospectively monitor naloxone. However, in opioid RetroDUR interventions we do refer to the naloxone prescribing guidelines on appropriate usage.
Oklahoma	We encourage prescribers to follow guidelines when prescribing opioids. This includes the prescribing of naloxone with the opioid prescription. The utilization of naloxone is reviewed annually with the DUR Board.
Utah	Retrospective review and peer-to-peer education on high dose opioid and concurrent opioid/benzo monthly. Naloxone products don't require prior authorization.

State	Explanation
Vermont	Vermont rule Governing the prescribing of opioids for Chronic pain Naloxone should be co-prescribed if opioid dose exceeds 90 MME or if a benzodiazepine is co-prescribed. https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf Additionally, Vermont Law for Health Care Professionals (18 VSA 4240 (c)) This law allows health care professionals acting in good faith to prescribe, dispense and distribute an opioid antagonist to a person who is at risk of overdose - or to a family member, friend or other person in a position to help - so long as the recipient of the opioid antagonist has completed a prevention and treatment training program approved by the Vermont Department of Health. Unless acting recklessly, with gross negligence or intentional misconduct, a health professional who prescribes, dispenses or distributes an opioid antagonist under this section shall be immune from civil or criminal liability, regardless of whether the opioid antagonist was administered by or to the person for whom it was provided. https://legislature.vermont.gov/statutes/section/18/084/04240

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 128 - State Allows Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

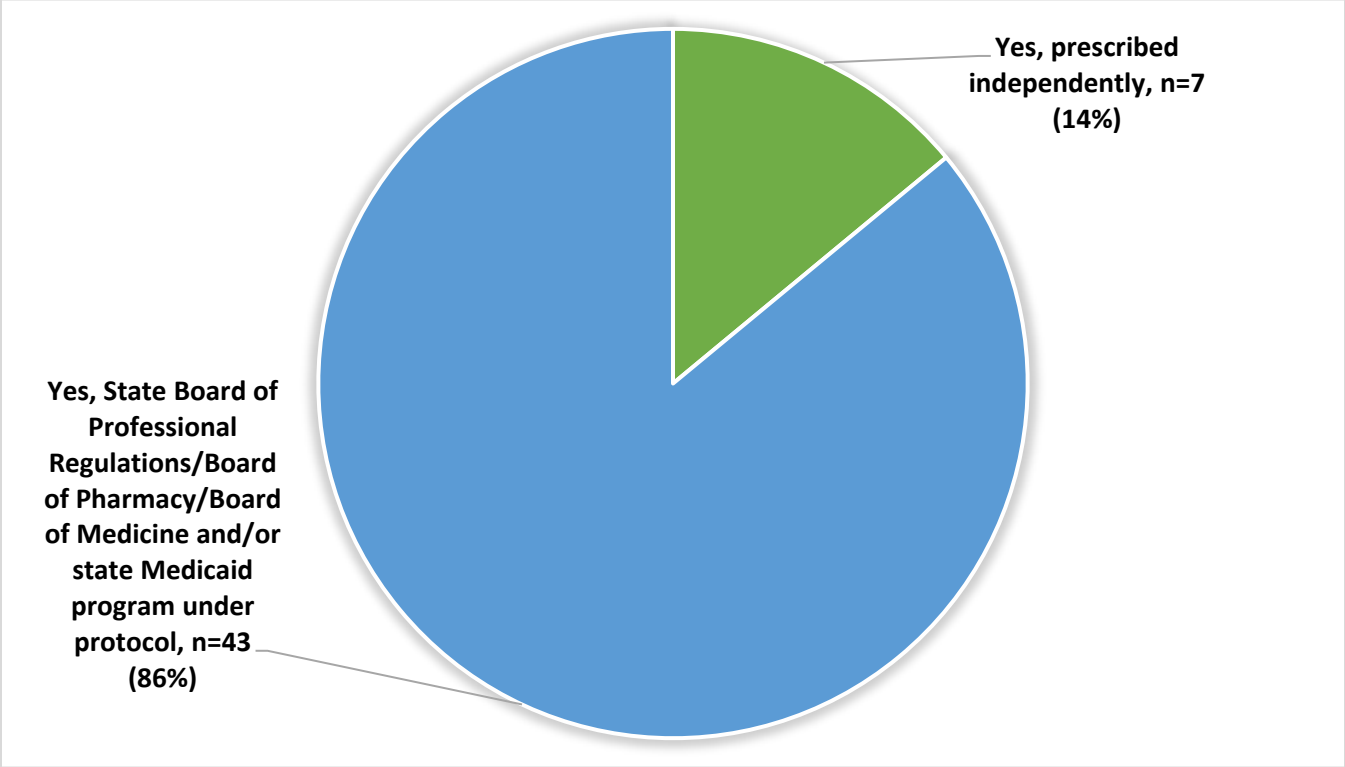

Table 214 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

Response	States	Count	Percentage
Yes, prescribed independently	Alaska, Connecticut, Idaho, New Mexico, North Dakota, Oregon, Wyoming	7	14.00%
Yes, State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program under protocol	Alabama, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	43	86.00%
Total		50	100.00%

F. Outpatient Treatment Programs (OTP)

1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services?

Figure 129 - State Covers OTPs that Provide BH and MAT services

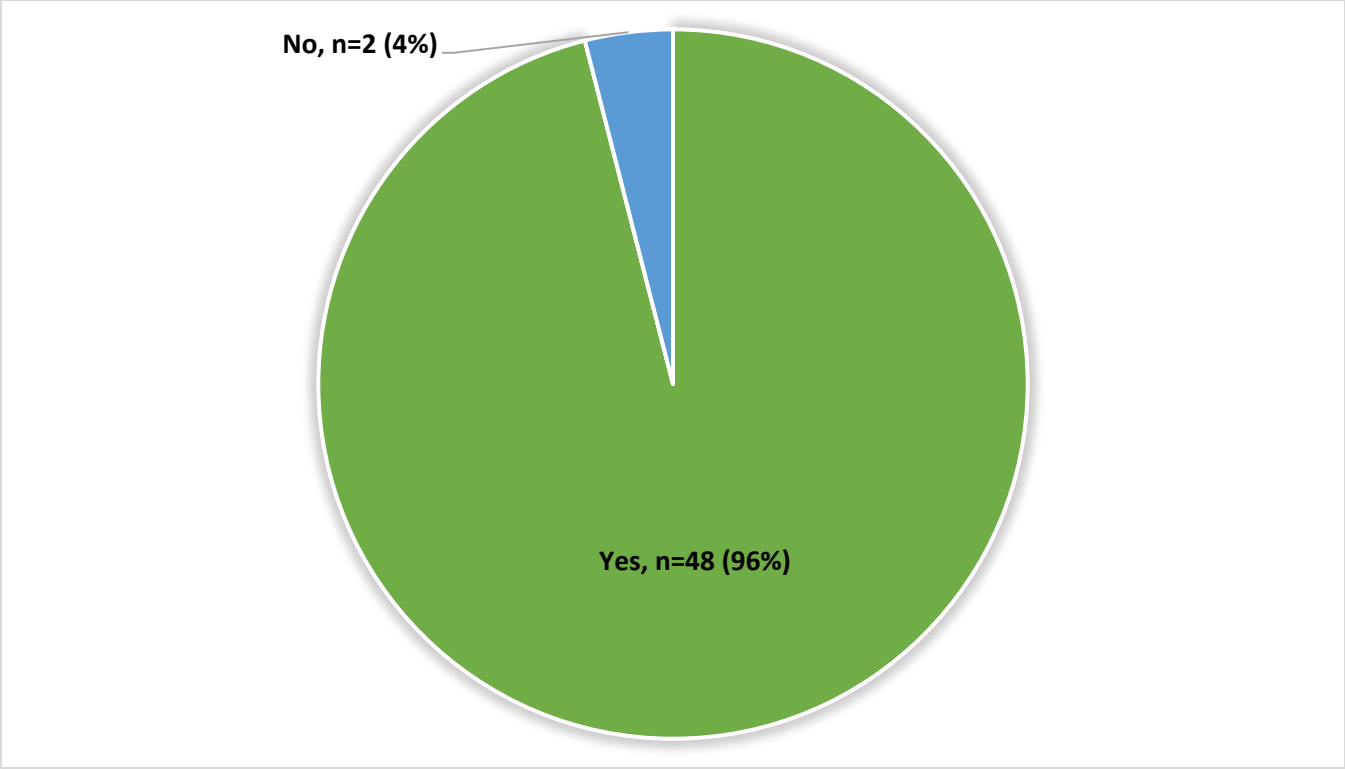

Table 215 - State Covers OTPs that Provide BH and MAT services

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 "Yes," is a referral needed for OUD treatment through OTPs?

Figure 130 - Referral Needed for OUD Treatment Through OTPs

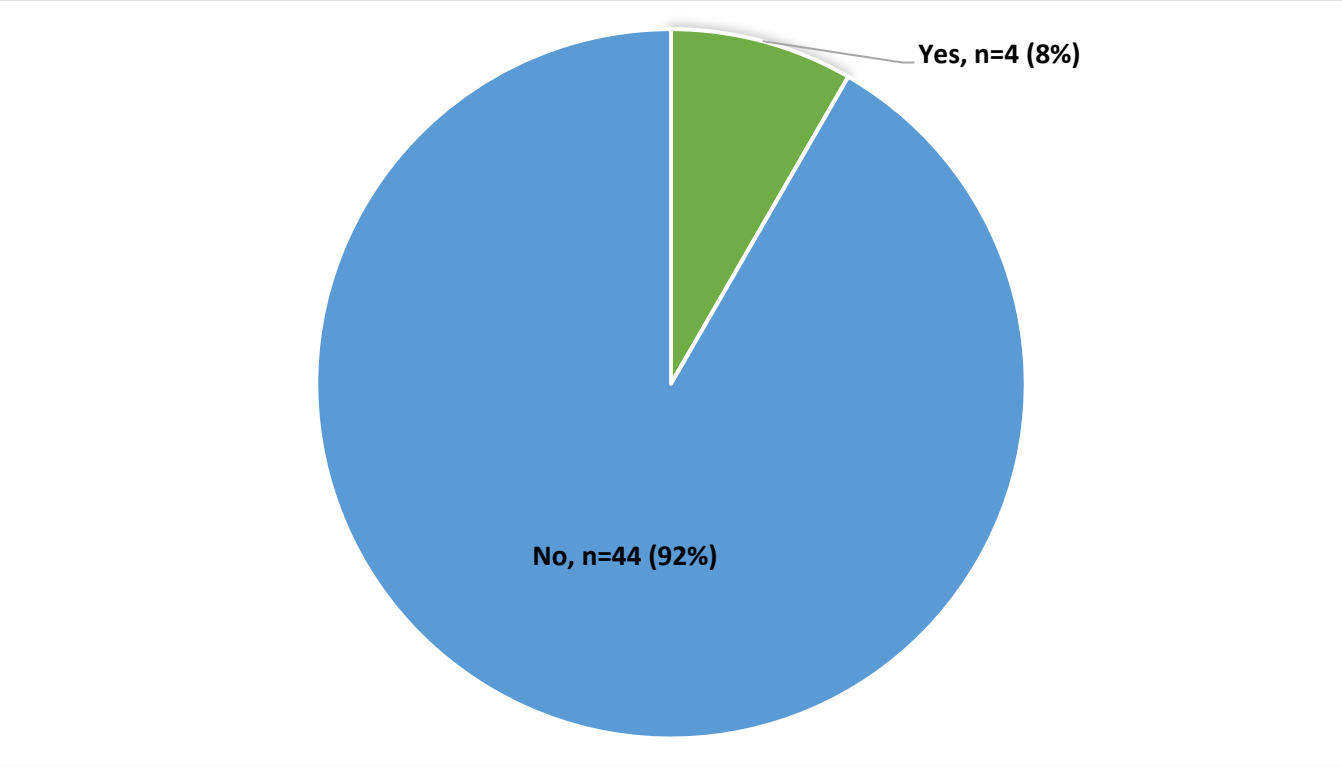

Table 216 - Referral Needed for OUD Treatment Through OTPs

Response	States	Count	Percentage
Yes	Colorado, Maine, Michigan, Texas	4	8.33%
No	Alabama, Alaska, Arkansas, California, 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, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	44	91.67%
Total		48	100.00%

Please explain.

Table 217 - 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.

State	Explanation
California	The state covers OUD treatment through OTPs and does not require a referral or prior authorization.
Colorado	Reimbursement for services is authorized by Regional Accountable Entities (RAEs) (regional agents administering the State's Medicaid SUD benefit) with submission of an OUD authorization form by a qualified provider.
Connecticut	A referral is not needed for OUD treatment through OTPs.
Delaware	No referral is needed.
District of Columbia	The DC Department of Behavioral Health does not require a referral for OUD treatment through its enrolled OTPs.
Florida	No referral is needed for OUD treatment through OTPs.
Georgia	n/a
Idaho	Answered all OTP questions for OTP program that went into effect 1/1/2021 so technically was not in place during federal fiscal year covered by this program. Specifically questions 1,2 and 4.
Illinois	State law mandates availability of medications for opioid use disorder. The American Society of Addiction Medicine (ASAM) assessment determines the level of care needed for treatment services, but no special referral is needed.
Indiana	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 drug-free treatment to be eligible for maintenance treatment. A one-week waiting period is required after such a detoxification attempt, however, before an attempt is repeated. The program physician shall document in the patient's record that the patient continues to be, or is again, physiologically dependent on narcotic drugs. h. Program staff shall ensure that a patient is voluntarily participating in the program, and the patient shall sign a Consent to Treatment Form. i. Pregnant patients may be admitted to opioid treatment in accordance with the following provisions: (1) Evidence of current physiological dependency is not needed if the program physician certifies the pregnancy and, in the physician's reasonable judgment, finds treatment to be justified. Documentation of all findings and justifications for admission shall be documented in the patient's record by the program physician prior to the administration of the initial dose of medication. (2) Pregnant patients shall be offered comprehensive prenatal care. If the program cannot provide prenatal services, the program shall assist the patient in obtaining such services and shall coordinate ongoing care with the collateral provider. (3) The program physician shall document that the patient has been informed of the possible risks to the unborn child from the use of medication and the risks of continued use of illicit substances. (4) Should a program have a waiting list for admission to the program, pregnant patients shall be given priority.
Kansas	The provider obtains the patient's medical history and does a physical examination before a dose of medication is given.
Kentucky	N/A
Louisiana	Referrals are not needed.
Maine	simple referral by the provider
Maryland	Maryland Medicaid does not require a referral for opioid use disorder treatment through outpatient treatment programs for participants.
Massachusetts	No referrals are required.
Michigan	Yes, a referral is required.
Minnesota	During the parallel process (a transfer of authorization methodology for SUD treatment in Minnesota), a client can choose the traditional Rule 25 process through a placing authority (County, Tribe or Managed Care Organization) and seek authorization and referral, or the client can go directly to the OTP for evaluation and possible admission. The parallel process

State	Explanation
	terminates on 1 July, 2022 when all client have the ability to directly access OTPs. Same is true for tribally licensed MAT programs.
Mississippi	No referral is required, but OTP services must be prior authorized.
Missouri	No referral is needed.
Montana	Medication Assisted Treatment dose not require a referral either through an OTP or OBOT
Nebraska	N/A
Nevada	OTPs are covered and referral is not needed for treatment.
New Hampshire	No referral is required.
New Jersey	Referrals for OUD treatment through OTPs is not required, but services may require authorization for payment.
New Mexico	No documented requirement at this time.
New York	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	Patients can self-refer.
Ohio	OTPs are regulated by the Ohio Department of Mental Health and Addiction Services, the Ohio Board of Pharmacy, and/or SAMHSA and prescribers are required to have DEA waiver.
Oklahoma	Outpatient treatment programs (OTPs) that provide behavioral health and MAT services are covered without a referral.
Oregon	No referral required, but providers have to enroll in State Medicaid program, and if applicable, the Coordinated Care Organization (Oregon's MCO).
Pennsylvania	Does OMHSAS require referrals?
Rhode Island	Currently no referral needed.
South Carolina	Effective on or after Jan. 1, 2019, SCDHHS will amend the South Carolina Title XIX State Plan to include covered services for OTPs. These services are intended to provide medically necessary treatment to eligible Medicaid beneficiaries with a confirmed diagnosis of opioid use disorder (OUD). These services must be provided in a clinic that is approved to render methadone maintenance therapy by the Drug Enforcement Agency (DEA) and accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA). OTP clinic services provided must be consistent with 42 CFR 8.12 https://www.scdhhs.gov/public-notice/public-notice-final-action-coverage-opioid-treatment-program-otp-services
South Dakota	A referral is not needed.
Tennessee	enrollees can self-refer, and a formal referral from a provider is not required.
Texas	Narcotic treatment centers (NTCs) are required to provide or offer referrals to patients for the following services: social and human services, mental health services, educational and vocational services, family counseling, and HIV/AIDS counseling/prevention/risk-reduction education. Texas residents of 18 years of age and older who have been diagnosed with moderate to severe opioid use disorder in the at least 12 months in a row are eligible for MAT services.

State	Explanation
	Financial eligibility is based on the patient's income and expenses, and some out-of-pocket expenses may apply. Eligible residents may receive medication-assisted treatment services by calling their local narcotic treatment center or call the outreach, screening, assessment and referral center for their region.
Utah	n/a
Vermont	Anyone can call or log on to Vt helplink to get help for Drug or Alcohol Addiction. https://vthelplink.org/
Virginia	A referral is not needed.
Washington	Clients are able to access benefits right away, there is no PA/referral needed for either prescribed OUD treatment in office-based settings, or in administered and dispensed medication opioid treatment program settings in WA.
West Virginia	A referral is not necessary but they can be accepted.
Wisconsin	Wisconsin does not require an referral for OUD treatment through OTPs.

If “No,” please explain.

Table 218 - Explanations for Not Covering OTPs that Provide BH and MAT services

State	Explanation
Hawaii	Current covered population of dental and transplant programs do not utilize.
Wyoming	Wyoming does not have any outpatient treatment programs.

2. Does your state Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

Figure 131 - Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

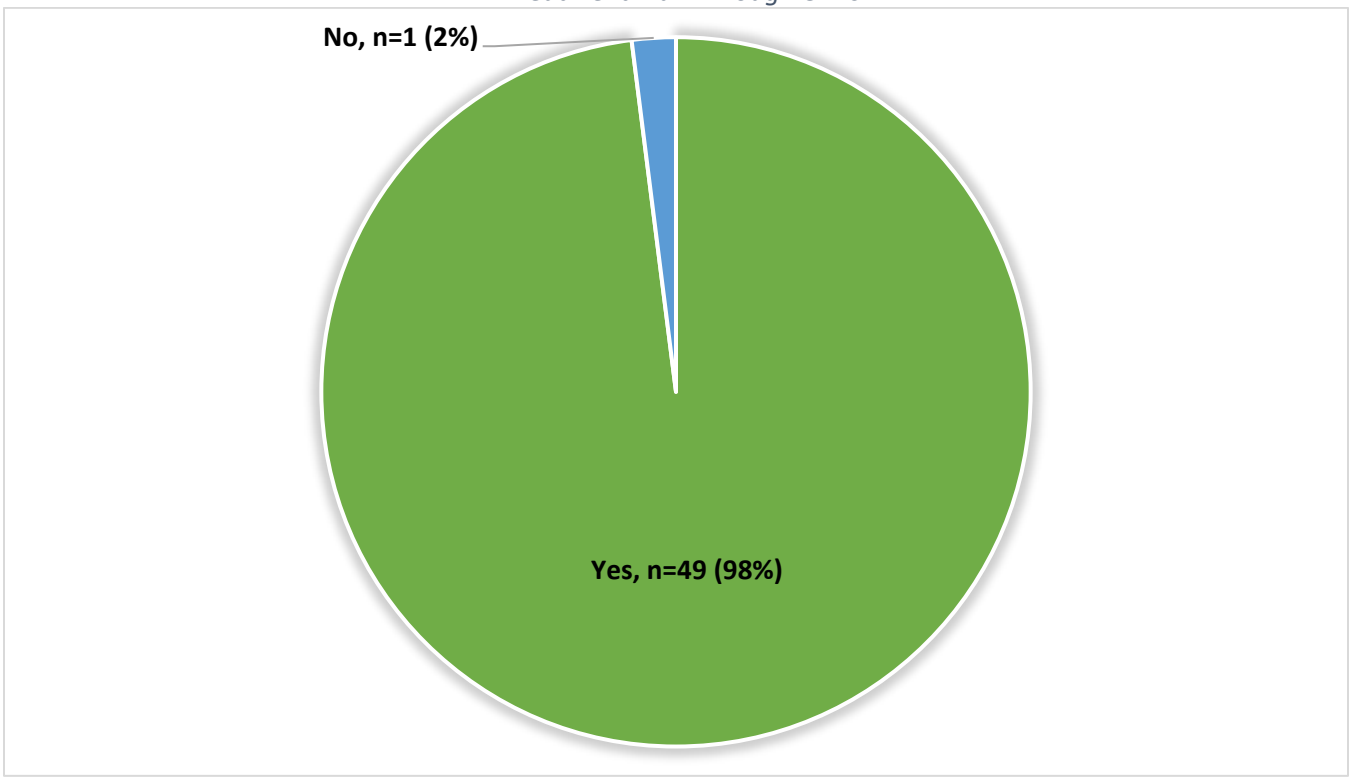

Table 219 - Cover Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

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 220 - 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 132 - Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

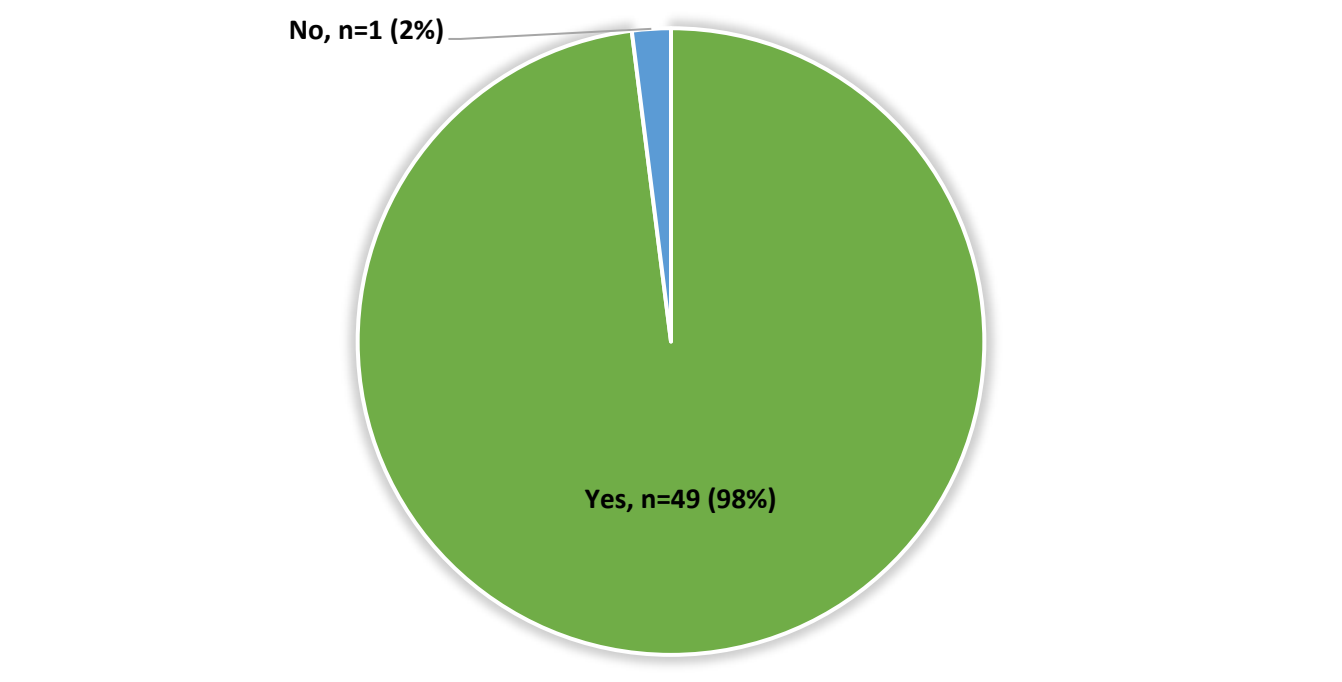

Table 221 - Cover Naltrexone for Diagnoses of OUD as Part of a Comprehensive MAT Treatment Plan Through OTPs

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 222 - 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 OTP setting.

4. Does your state Medicaid program cover Methadone for a substance use disorder (i.e. OTPs, Methadone Clinics)?

Figure 133 - State Program Covers Methadone for Substance Use Disorder

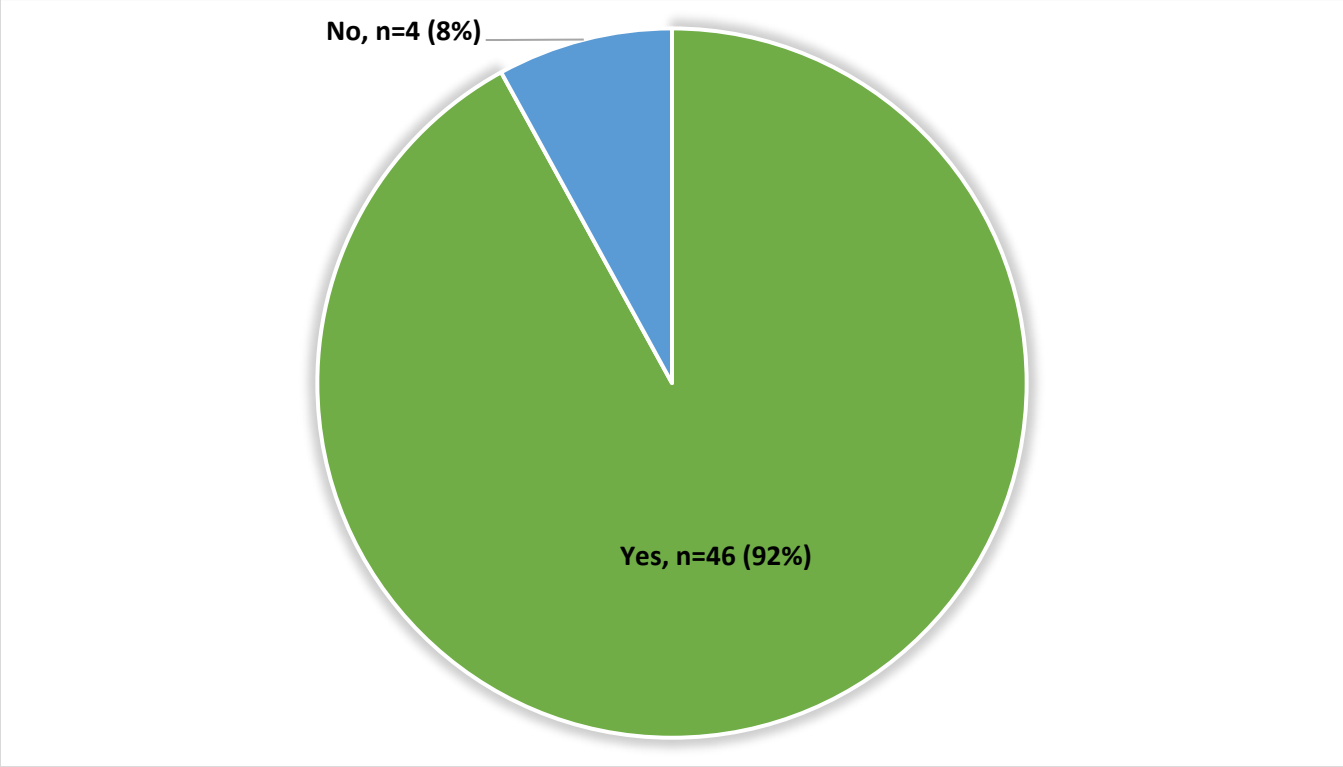

Table 223 - State Program Covers Methadone for Substance Use Disorder

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, 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, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	46	92.00%
No	District of Columbia, Kentucky, South Dakota, Wyoming	4	8.00%
Total		50	100.00%

G. Psychotropic Medication

Antipsychotics

1. Does your state currently have restrictions in place to limit the quantity of antipsychotic drugs?

Figure 134 - Restrictions to Limit Quantity of Antipsychotics

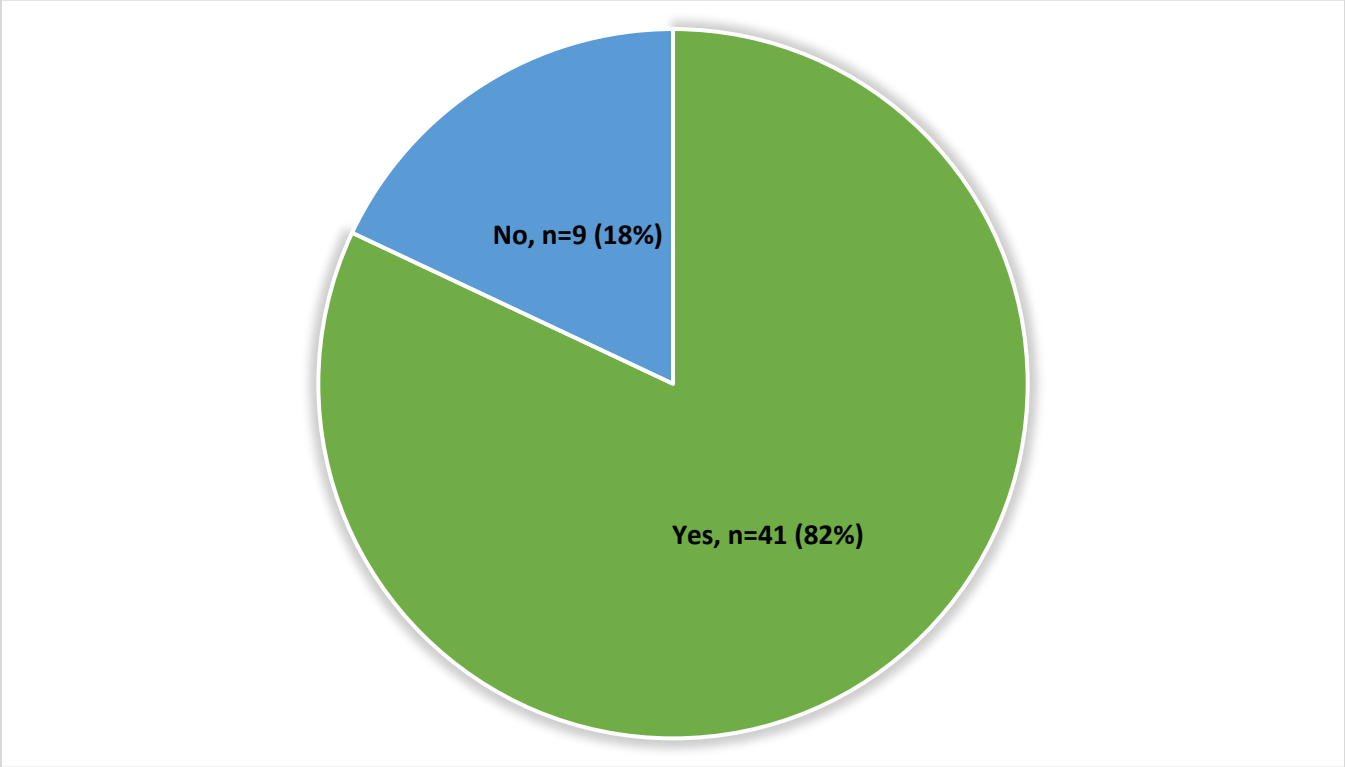

Table 224 - Restrictions to Limit Quantity of Antipsychotics

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

Please explain restrictions or N/A.

Table 225 - 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. 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 clients 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 client remains stable and compliant. Oral and injectable antipsychotics are on our PDL.
California	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 through 17 years of age. An approved Treatment Authorization Request is also required for beneficiaries residing in skilled nursing facilities (SNFs).
Colorado	Quantity limits are in place for select antipsychotic medications identified on the preferred drug list.
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 prescribed outside of FDA labeling. We also edit for therapeutic duplication and dose optimization.
District of Columbia	Injectable long acting antipsychotics are available through pharmacies participating in the POS Mental Health Network who deliver the medication directly to the prescriber's office or clinic for administration to the beneficiary. Some of these products mat require a clinical PA as well.
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	FDA
Idaho	Limit dose per day. Age limit per FDA approved labeling. Specifically do not allow for less than 6 years without a PA.
Illinois	Group accumulators on long-acting injectable antipsychotics and high dose override for some of the antipsychotics that overrides the Medispan programmed high dose. Also prior 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.

State	Explanation
Kentucky	There are quantity limits and dose accumulation limits on many of the secondgeneration and long-acting agents. Also, a PA is required for the member to receive more than 2 antipsychotics concurrently.
Louisiana	Selected antipsychotic agents have quantity limits. Additionally, safety edits are in place at POS and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for beneficiaries less than 7 years old.
Maine	Require prior authorization for use under age 5, for multiple anti-psychotic concurrently and routinely review metabolic monitoring during use.
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). These are the Peer Review Program (PRP) and the Tier 2 & Non Preferred (Tier 2 & NP) Antipsychotic Review Program. Non-preferred and Tier 2 clinical criteria. For additional information, please refer to https://mmcp.health.maryland.gov/pap/pages/Peer-Review-Program.aspx. The Program also employs clinical criteria and dose optimization requirements.
Massachusetts	Prior authorization is required for polypharmacy with two or more antipsychotics. PA criteria requires documentation of treatment-resistant diagnoses, complete treatment plan including dose, frequency and indication for each antipsychotic, psychiatrist involvement (either as the prescriber or consult notes from the past year) and additional rational for use (cross-taper planned that will result in only one antipsychotic, discharged on polypharmacy after a recent psychiatric hospitalization, or failed trail with two antipsychotics as monotherapy). Dosing is generally managed and monitored with only quantity limits.
Michigan	Current state law prohibits the Fee-For-Service (FFS) pharmacy program from prior authorizing, delaying, or denying coverage of psychotropic medications that are not controlled substances. All psychotropic medications are carved-out of MCO pharmacy benefit and paid through FFS.
Minnesota	FDA max dose.
Mississippi	Electronic PA age edits, quantity limits for all beneficiaries, multiple antipsychotic edit for children, and manual PA criteria for multiple antipsychotic continued use in children.
Missouri	Missouri utilizes a Dose Optimization Fiscal Edit to help reduce the utilization of drug therapies that comprise of multiple units of lower strength dosage forms, when single units of higher strength dosage forms deliver the same drug therapy, with lower cost to the program. Dosing that exceeds the set limitation requires prior authorization. Additionally there are clinical criteria surrounding atypical antipsychotics that must be met including dosing limits.
Montana	For children 7 and under we require prior authorization including documentation of metabolic labs and parental notification of potential side effects. Case management is performed on all foster children on psychotropic medications. Dosages and quantities are reviewed for appropriateness.
Nebraska	N/A
Nevada	OTPs are covered and referral is not needed for treatment.
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.

State	Explanation
New Jersey	Maximum daily dose edits are in place for antipsychotics. No more than two antipsychotics are to be taken concomitantly by a patient.
New Mexico	Only 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.
North Carolina	Antipsychotics have edits that require Prior Authorization, check for concomitant use, check for quantity limits, daily dose, and maximum quantity.
North Dakota	FDA and compendia max dose recommendations are followed for quantity limits.
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	Quantity limits are in place.
Rhode Island	N/A
South Carolina	Including, but not limited to: Prior authorization for indication and age, TD duplication edits, Overuse, etc.
South Dakota	Daily quantity limits
Tennessee	Tennessee has quantity limits for many psychotropic classes of drugs including anti-anxiety, antidepressants and atypical antipsychotics. The quantity limits for atypical antipsychotics are managed via a hard edit, and the limits may be surpassed via prior authorization. We would like to adhere strictly to quantity limits for APsy, however it would be extremely disruptive to the therapy of our enrollees, who are among the most vulnerable population served by our State. Many of our APsy are used for the worst of the worst cases, and doses have been necessarily and appropriately pushed higher than manufacturer's recommendations.
Texas	The POS criteria limits the number of antipsychotics prescribed concomitantly. The criteria allows for up to two different antipsychotics (that are not the same in chemical formulations). Combination of various strengths and dosage forms of the same drug is permitted.
Utah	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 in conjunction with the FDA maximum recommended dose This is listed on the PDL. For example ZIPRASIDONE (compare to Geodon) FDA maximum recommended dose = 160 mg/day
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization. Also there are quantity limits.

State	Explanation
Washington	For clients 17 years of age and younger WA Medicaid applies age/dose limits to second generation antipsychotics. These limits are set by the Pediatric Mental Health guidelines and all requests to exceed the established thresholds must have a Second Opinion (SON) Review by the Agency's contracted mental health specialist (Seattle Children's Hospital).
West Virginia	We use a therapeutic duplication edit to limit the use of multiple antipsychotics. Quantity limits are by FDA label.
Wisconsin	Wisconsin requires prior authorization for children less than nine years of age who are on antipsychotics.
Wyoming	Antipsychotics are limited to labeled maximum daily doses.

2. Does your state have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

Figure 135 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

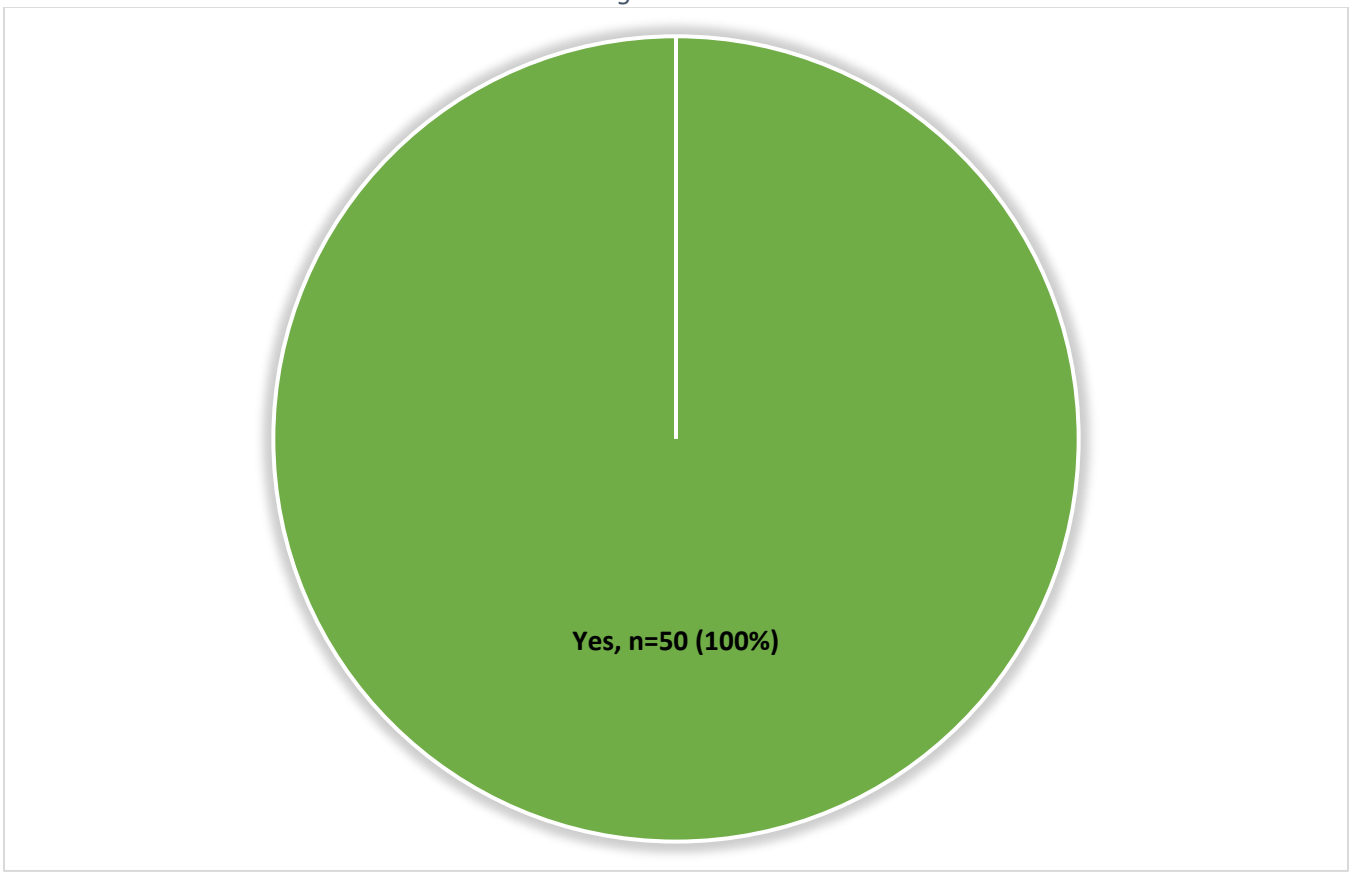

Table 226 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

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 136 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

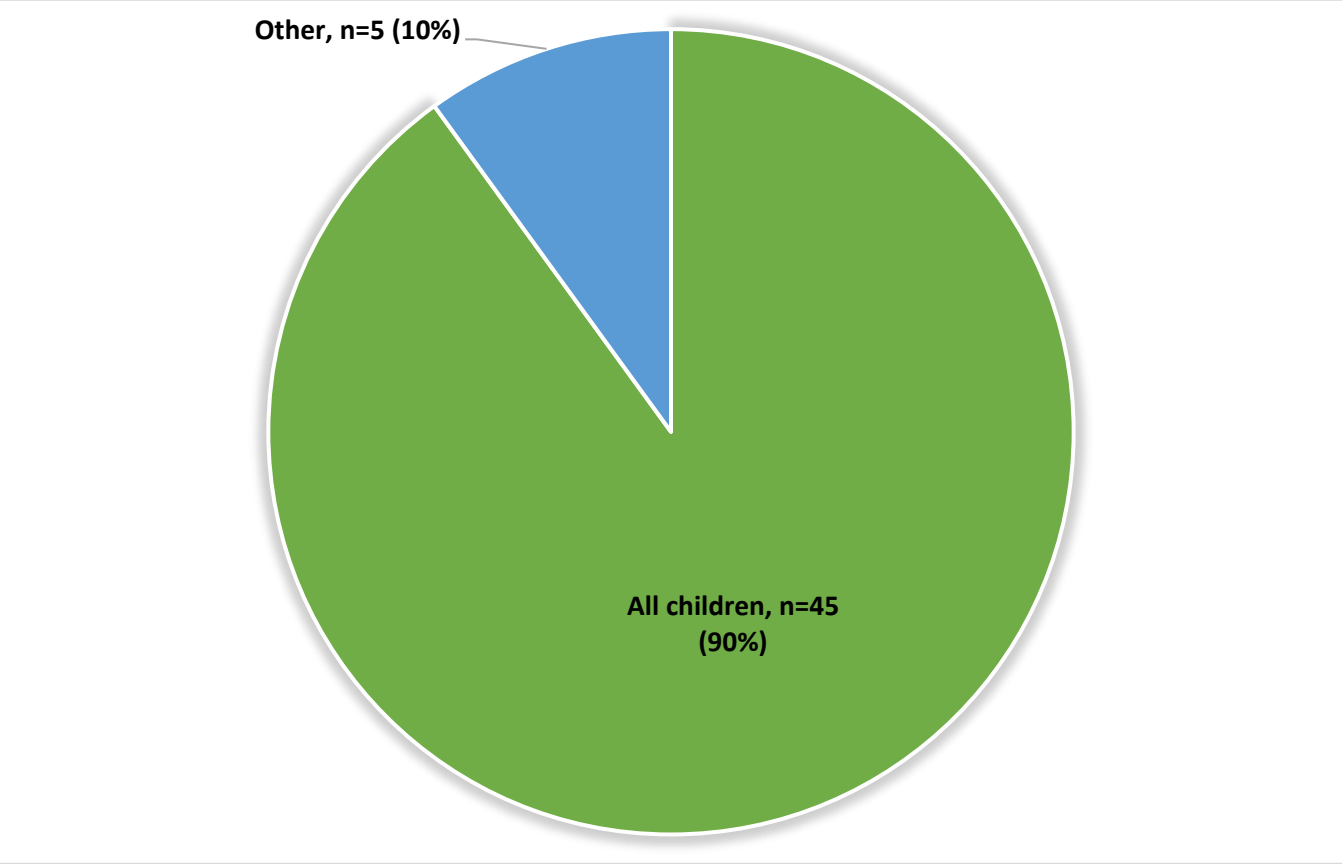

Table 227 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	States	Count	Percentage
All children	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 York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	45	90.00%
Other	Alabama, Illinois, New Mexico, Oregon, Wisconsin	5	10.00%
Total		50	100.00%

If "Other," please explain.

Table 228 - "Other" Explanations for Managing or Monitoring the Appropriate Use of Antipsychotic Drugs in Children

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.
Illinois	In FFS, prior authorization is required for all children under the Department of Child and Family Services (DCFS) Youth in Care; all children less than 8 years of age who are prescribed atypical antipsychotic medications (age edit); and all children prescribed long-acting atypical antipsychotics. Prior authorization is required for high-dose use and there is a group accumulator for long-acting injectable antipsychotics for all patients, including children. Doc Assist review and peer-to-peer consultation are also available.
New Mexico	Children prescribed antipsychotics from non-IHS prescribers are identified as requiring metabolic monitoring. The IHS prescribers are being notified by the State IHS liaison for follow-up.
Oregon	We monitor all foster care children yearly if prescribed an antipsychotic. For non-foster care children, higher risk children are identified for intervention based on a variety of prescribing characteristics. Specifically, in non-foster care, we're monitoring use in children less than 10 years of age prescribed long-term antipsychotics (>90 days) and we select the highest risk ones for intervention. Anyone who isn't in foster care and is over 10 years old isn't monitored.
Wisconsin	Wisconsin requires prior authorization for children less than nine years of age, including those children in foster care. Wisconsin monitors for multiple antipsychotic use for children under 19 years of age, including those children in foster care.

b. If "Yes," does your state have edits in place to monitor (multiple responses allowed):

Figure 137 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

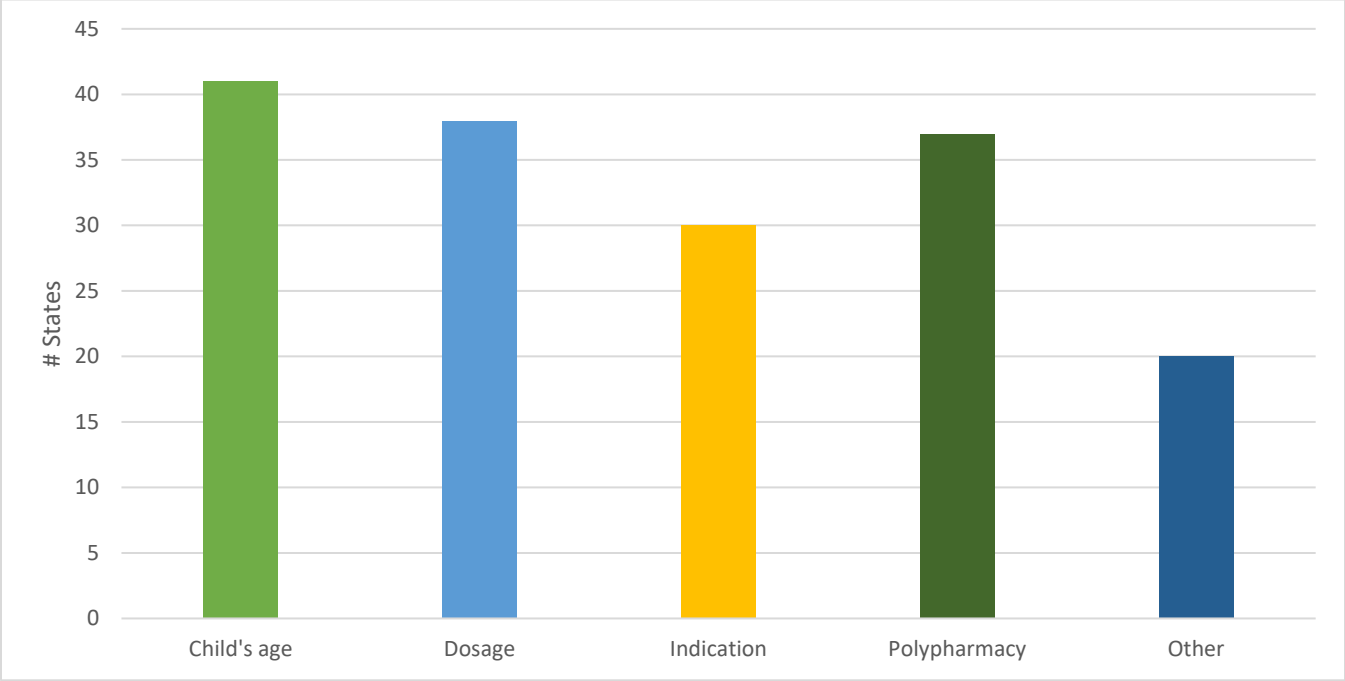

Table 229 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Child's age	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	24.70%
Dosage	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	38	22.89%
Indication	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington	30	18.07%

Response	States	Count	Percentage
Polypharmacy	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Washington, West Virginia, Wyoming	37	22.29%
Other	Alabama, Arkansas, Delaware, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Mississippi, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Texas, Vermont, Washington	20	12.05%
Total		166	100.00%

If “Child’s age,” please specify age limit in years.

Table 230 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

State	Age Limit in Years
Alabama	20
Alaska	5
Arkansas	17
California	17
Colorado	5
Connecticut	18
District of Columbia	18
Florida	6
Georgia	17
Hawaii	0
Idaho	6
Illinois	8
Indiana	18
Iowa	5
Kansas	17
Kentucky	18
Louisiana	6
Maine	5
Maryland	18
Massachusetts	6
Missouri	9
Montana	7
Nebraska	18
Nevada	18
New Hampshire	18
New York	5
North Carolina	17

State	Age Limit in Years
Oklahoma	4
Oregon	5
Pennsylvania	18
South Carolina	6
South Dakota	6
Tennessee	12
Texas	6
Utah	6
Vermont	17
Virginia	18
Washington	17
West Virginia	6
Wisconsin	9
Wyoming	5

If "Other," please explain.

Table 231 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

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.
Arkansas	Edits for clients <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 safety edits in place at POS for children, including age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Preauthorization is required for behavioral health agents for beneficiaries less than 7 years old. Antipsychotic agent utilization is reviewed retrospectively for adherence to therapy and for concurrent use with opioids.
Maine	metabolic monitoring is required and prior authorization if monitoring is not completed in the members medical claims data.
Massachusetts	Use of behavioral health medications in children 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.

State	Explanation
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 agent. Electronic PA age edits, quantity limits for all beneficiaries, multiple antipsychotic edit for children, and manual PA criteria for multiple antipsychotic continued use in children.
New Mexico	RetroDUR interventions 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
Rhode Island	Pro DUR edits such a therapeutic duplication.
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	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 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.
Vermont	All antipsychotic atypical & combinations require the following clinical criteria to be met for children under 18 years old Target symptoms or Diagnosis that will be accepted for approval: Target Symptoms - Grandiosity/euphoria/mania; Obsessions/compulsions; Psychotic symptoms; Tics (motor or vocal). Diagnosis- Autism with Aggression and/or irritability; Disruptive Mood Dysregulation Disorder; Bipolar Disorder; Intellectual Disability with Aggression and/or Irritability; Major Depressive Disorder with psychotic features; Obsessive Compulsive Disorder; Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome. 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 below. Note: all requests for patients < 5 years will be reviewed by the DVHA medical director.
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.

a. If "Yes," please briefly explain the specifics of your documented antipsychotic monitoring program(s).

Table 232 - 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 client's diagnosis and age, requested drug's indication, other concomitant therapy, and previous therapies tried when reviewing the PA requests. Oral antipsychotics have maximum dose edits for adults and children based on treatment guidelines and recommendations from the manufacturer's package insert for the specific drugs. Dose edits for children are further differentiated based on age. Clients <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 clients 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. Clients <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 client is prescribed 3 or more oral antipsychotics OR 2 oral antipsychotics along with a LAI. Patients with a denied claim for TD require a prior authorization request to be submitted by the prescriber. 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	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 through 17 years of age. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
Colorado	Edits are in place to identify doses exceeding maximum and appropriate use based on atypical antipsychotic indication and patient age, and prior authorization involving a provider-to-provider telephone consult with a child/adolescent psychiatrist may be

State	Explanation
	required. Retrospective DUR is conducted and letters are periodically sent to providers regarding pediatric members' use of multiple antipsychotic medications or members' use of multiple psychotropic medications (including antipsychotics).
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, utilizes targeted interventions in the foster care population. Ages on the atypical antipsychotic agents are set to the FDA approved indications. Synergy is achieved by partnering with the Department of Services for Children, Youth and their Families to address foster children.
District of Columbia	Monthly reports monitor opioid and antipsychotic use including for the pediatric population. Pharmacy POS DUE edits include concomitant use with opioids, phenothiazines and other drugs that may prolong QT intervals. Cases of concern are reviewed by a DUR Board member who is a child psychiatrist. She will contact the prescribing physician directly to discuss any issues of concern.
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	2 children in program and monitored annually for medical necessity, access, provider enrollment
Idaho	Targeted DUR interventions for all children less than 6 years old. Currently in process of implementing a specific PA form for that age group which will include an attestation that informed consent has occurred.
Illinois	- 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 (note age above does not allow for multiple entries of age), no metabolic monitoring claims 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

State	Explanation
	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 safety edits in place at POS for children, including age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Preauthorization is required for behavioral health agents for beneficiaries less than 7 years old. Antipsychotic agent utilization is reviewed retrospectively for adherence to therapy and for concurrent use with opioids.
Maine	This practice was suspended during the pandemic since the letters could not be generated and mailed from the work from home model. The DUR typically sent out over 1800 letters to providers in a FFY regarding the appropriate need for metabolic monitoring with the use of atypical antipsychotics. The communication included monitoring of weight and metabolic parameters including blood pressure, A1c, fasting glucose and fasting lipid profile in accordance with the ADA screening guidelines. The letters also described a process where baseline parameters would be obtained then at 12 weeks follow up labs would be required. Providers that were surveyed were given 20 weeks to obtain and submit the baseline and follow up numbers for review, if this information was not received than further antipsychotic use would require prior authorization to assure proper monitoring. In its review, 30% of members lack proper documentation of routine monitoring. The State continues to monitor antipsychotic monitoring even though individual provider mailings had been suspended.
Maryland	In October 2011 Maryland Medicaid established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non pharmacologic information for decision making and ensures the appropriate use while limiting adverse sequelae in the program's vulnerable pediatric population. The program initially addressed the use of antipsychotics in participants under the age of 5 years. During FFY 2013, the program was expanded to include all participants less than 10 years of age. As of January 2014, the program encompasses all participants less than 18 years of age.

State	Explanation
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 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. These reports show all psychotropic drugs received per child whether the child's psychotropic drugs hit on the RetroDUR criteria for not. The Children's Mental Health Division uses this information in many ways one of which is to do outreach to the provider community especially to those in foster care. Additionally, there are two RetroDUR mailings per year regarding criteria regarding psychotropic drug use in youth.
Mississippi	Our SmartPA criteria includes 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.

State	Explanation
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 requests outside of these limits.
Nevada	Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) without prior authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six years of age require prior authorization.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed an antipsychotic (or other psychotropic drug), a prior authorization is required. The criteria require that the patient is seen by a child psychiatrist, neurologist, or developmental pediatrician or that prescribing has been in consultation with one of these specialists. An additional consideration for use of an antipsychotic is for the diagnosis of Tourette's syndrome or tic disorder. For pediatric patients 6 years of age and older, a prior authorization is required if more than one antipsychotic is prescribed during a 60 day time frame. The criteria review that a patient has a DSM-V diagnosis and that the patient has received psychiatry, neurology, or care in consultation with a developmental pediatrician.
New Jersey	Maximum daily dose edits were updated to apply to antipsychotic drugs in children.
New Mexico	Require glucose and lipid monitoring for children on second generation antipsychotics.
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.

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 lettering is sent to providers and pharmacies when high doses are utilized that are not rejected with POS edits. Diagnosis submission is required for antipsychotics at the point of sale.
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 October 2020 directed at members taking multiple antipsychotics.
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

State	Explanation
	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	Reviewed by 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	PA is required for all children receiving an antipsychotic.
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; and A medication prescribed for a child five years old or younger. Flagged requests trigger a protocol in which the nurse consultants confer with psychiatric providers from Vanderbilt's Center of Excellence who specialize in child and adolescent prescribing practices. Consultation between the nurse consultants and psychiatric providers is reflective of evidence-based practices for use of psychotropic medications in children and adolescents. Potential risks and benefits of such medications are weighed before a recommendation regarding the proposed regimen is made. As the custodial body responsible for decision-making on the child's behalf, DCS uses this consultation in conjunction with the child's health history and other relevant factors to determine whether psychotropic medications are appropriate. Retrospective Programs for Monitoring and Managing Antipsychotic Medications for Children: The State's DUR Committee performs periodic retrospective reviews in conjunction with the Pharmacy Benefits Manager. Claims data is examined to determine whether prescriptions for antipsychotic medications are appropriate, medically necessary, and unlikely to result in adverse medical outcomes. The DUR Committee then has the option to notify the prescriber in writing of the potential drawbacks to use of the medication, as well as steps that can be taken to address those risks. In addition, if the DUR Committee's review of the claims data identifies wider trends that need to be addressed, then recommendations may be made to the State on more comprehensive actions to be taken. A second retrospective program used by the State to monitor the utilization of antipsychotic medications for children involves data obtained from the State's managed care organizations (MCOs) on three HEDIS measures: Metabolic Monitoring for Children and Adolescents on Antipsychotics, Use of Multiple Concurrent Antipsychotics in Children and Adolescents, and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Data collected within Tennessee on these three measures may be compared with data collected on a regional and national basis to help inform decision-making by the State.

State	Explanation
	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	Antipsychotic clinical prior authorization is an automated process. System approves children age 6 and older for diagnoses such as psychosis/ schizophrenia, bipolar disorder. For diagnoses such as depression for which antipsychotics are appropriate as adjunct therapy, the system automatically approves when evidence of antidepressant therapy is found. The system also approves up to two different antipsychotics.
Utah	Utah Medicaid implemented a new policy on October 1, 2019, to monitor and manage antipsychotic (AP) medications prescribed to members 19 years of age and younger. Pharmacies are required to enter the diagnosis code into the point of sale system when processing a claim for an antipsychotic. Prior Authorization is required for children who are taking high-dose antipsychotics, multiple antipsychotics, or under 6 years of age. Also, Retrospective Drug Utilization Review peer to peer educational interventions addresses the following: a. Use of other first-line services such as psychosocial counseling and safer medications. Dosing should follow the start low and go slow approach. Identification of higher than recommended doses. Careful and frequent monitoring of side effects such as metabolic screening, Body Mass Index, weight gain, movement disorders. Use of AP in children younger than 6 years old.
Vermont	In an effort of evaluating the PMQIC common measures, Change Healthcare conducted this study.To evaluate the PMQIC common measures, the study estimated them by using pharmacy claims for psychotropic medications paid by the Department of Vermont Health Access (DVHA) reported on a semi-annual basis. The study estimated and evaluated the following nine PMQIC common measures: 1) Percentage of children in foster care on any psychotropic medication, 2) Percentage of children in foster care on a specific class of medication, 3) Percentage of children in foster care on more than one psychotropic medication from the same class simultaneously for 90 days or more (defined above as co-pharmacy), 4) Percentage of children in foster care on 2 psychotropic medications; 3 psychotropic medications and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or

State	Explanation
	more, 5) Percentage of children in foster care < 6 years old on any psychotropic medication, 6) Percentage of children in foster care < 6 years on 2; 3 and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more, 7) Percentage of children in foster care < 6 years old on any antipsychotic medication, 8) Percentage of children in foster care on more than one antipsychotic simultaneously for 45 days or more, 9) Percentage of children in foster care who are continuously on an antipsychotic for more than 1 year. The study also estimated the above mentioned measures for non-foster care children as a comparison group. The study reviewed trends for both foster care and non-foster care groups of children over the mentioned timeframes. The study also estimated the common measures for different age and gender groups.
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization.
Washington	Washington Medicaid has developed reports that allows us to monitor children's prescription claims for psychotropic medications. The data in the report is updated weekly and can be accessed using a dashboard at any point. The Oversight Specialist monitors the reports on a quarterly basis and shares their analysis results with others in the pharmacy program. If there seems to be misuse or abuse one of the following actions may occur: - continue to monitor, - conduct provider education, - make a referral to the PRC program, - make a referral to the Quality Management Team, - collaborate with our managed care partners to conduct and oversight activity, - make a referral to Program Integrity to audit for fraud, waste, and abuse. This data is also reviewed for potential prospective and retrospective DUR activities.
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. Wisconsin monitors the use of multiple antipsychotic drugs in

State	Explanation
	children under 19 years of age, including those children in foster care. Child psychiatrists who are contracted with the State perform peer to peer outreach calls when 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 138 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

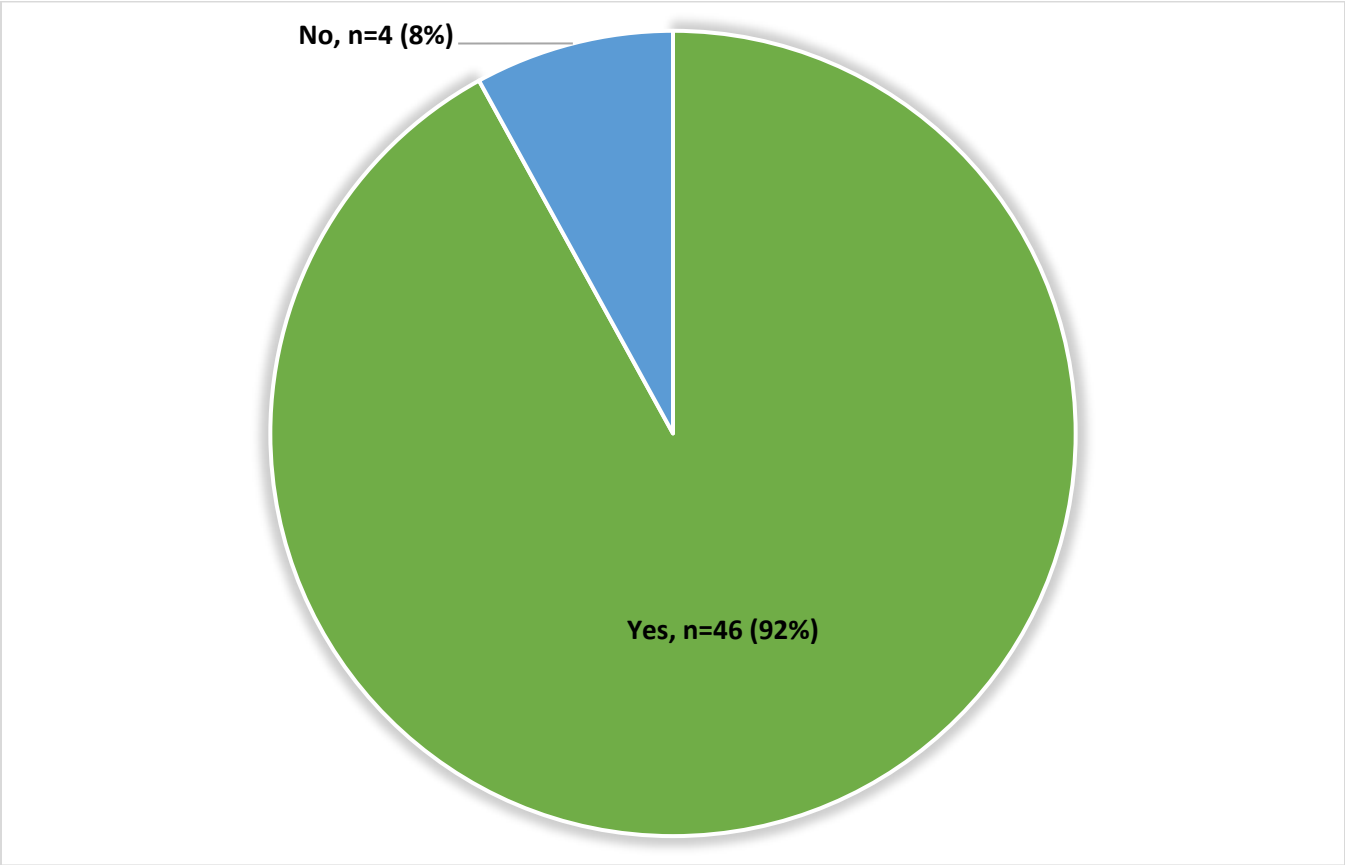

Table 233 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

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

4. Does your state have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

Figure 139 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

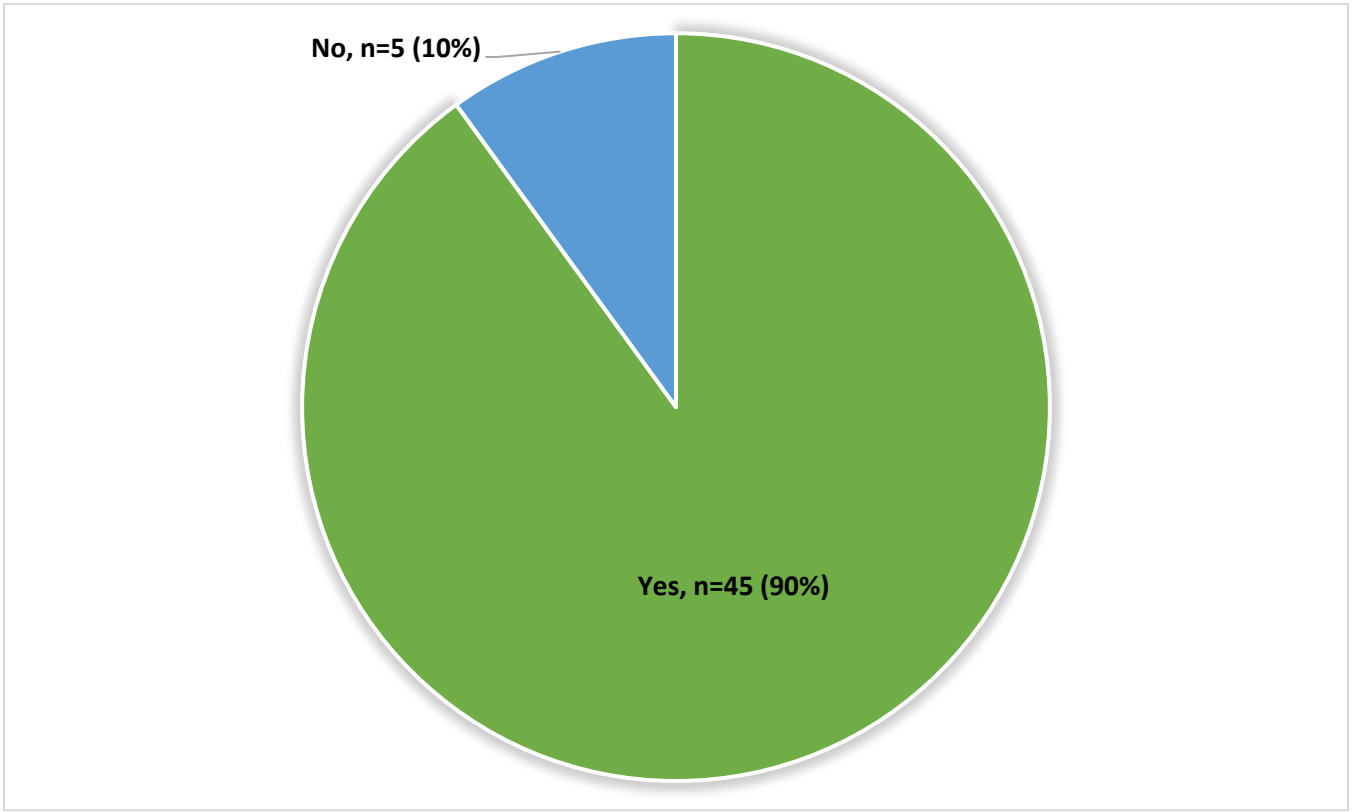

Table 234 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

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 York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	90.00%
No	Alaska, Maryland, New Jersey, New Mexico, South Dakota	5	10.00%
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 Stimulant Drugs

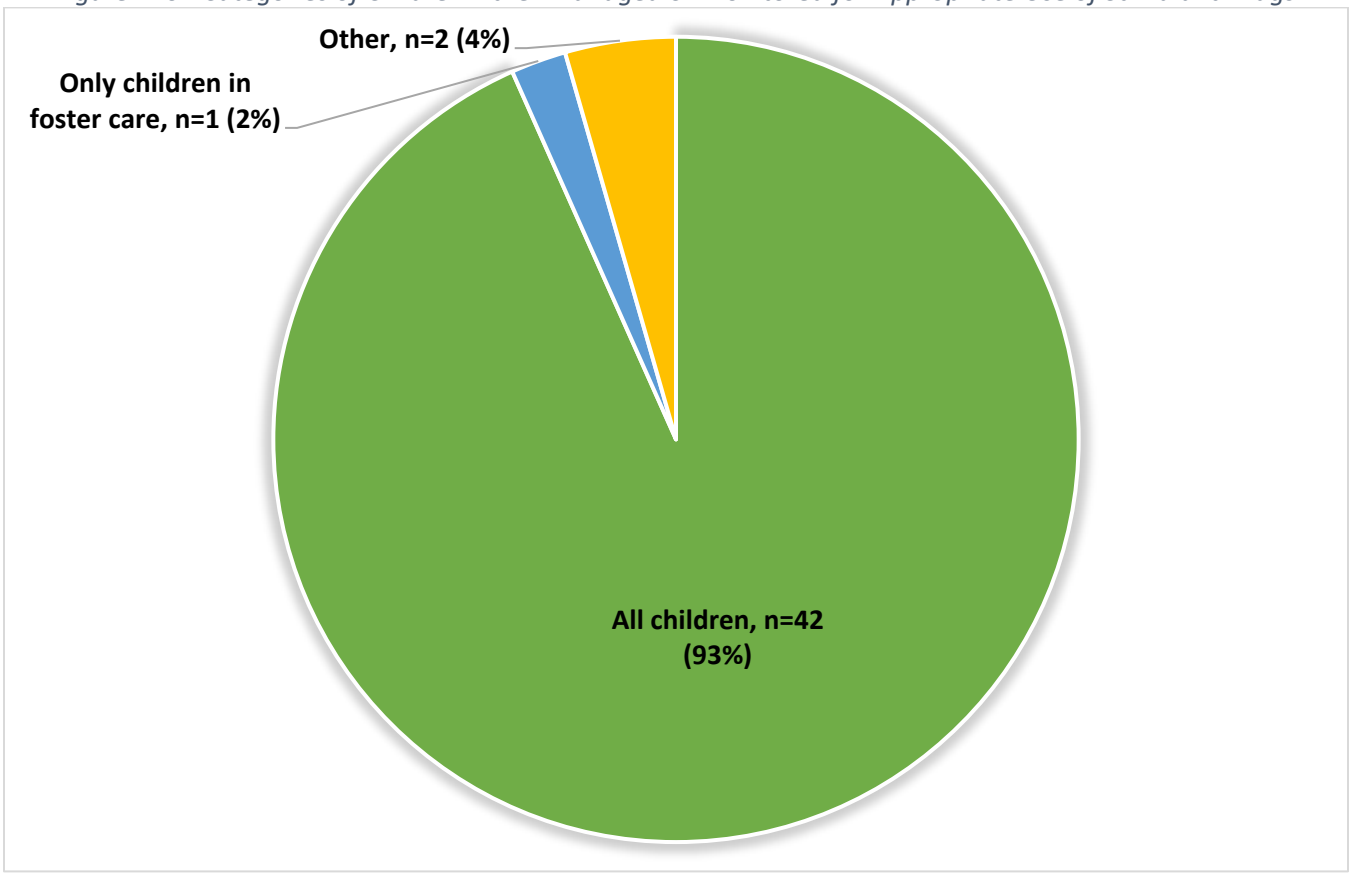

Table 235 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

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 York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	42	93.33%
Only children in foster care	Montana	1	2.22%
Other	Illinois, Wisconsin	2	4.44%
Total		45	100.00%

If “Other,” please explain.

Table 236 - “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 DCFS psychiatrist consent and prior authorization. - Stimulants require prior authorization for children less than 6 years of age.
Wisconsin	Wisconsin has quantity limits and diagnosis restrictions for all stimulants for both children and adults.

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 Stimulant Drugs in Children

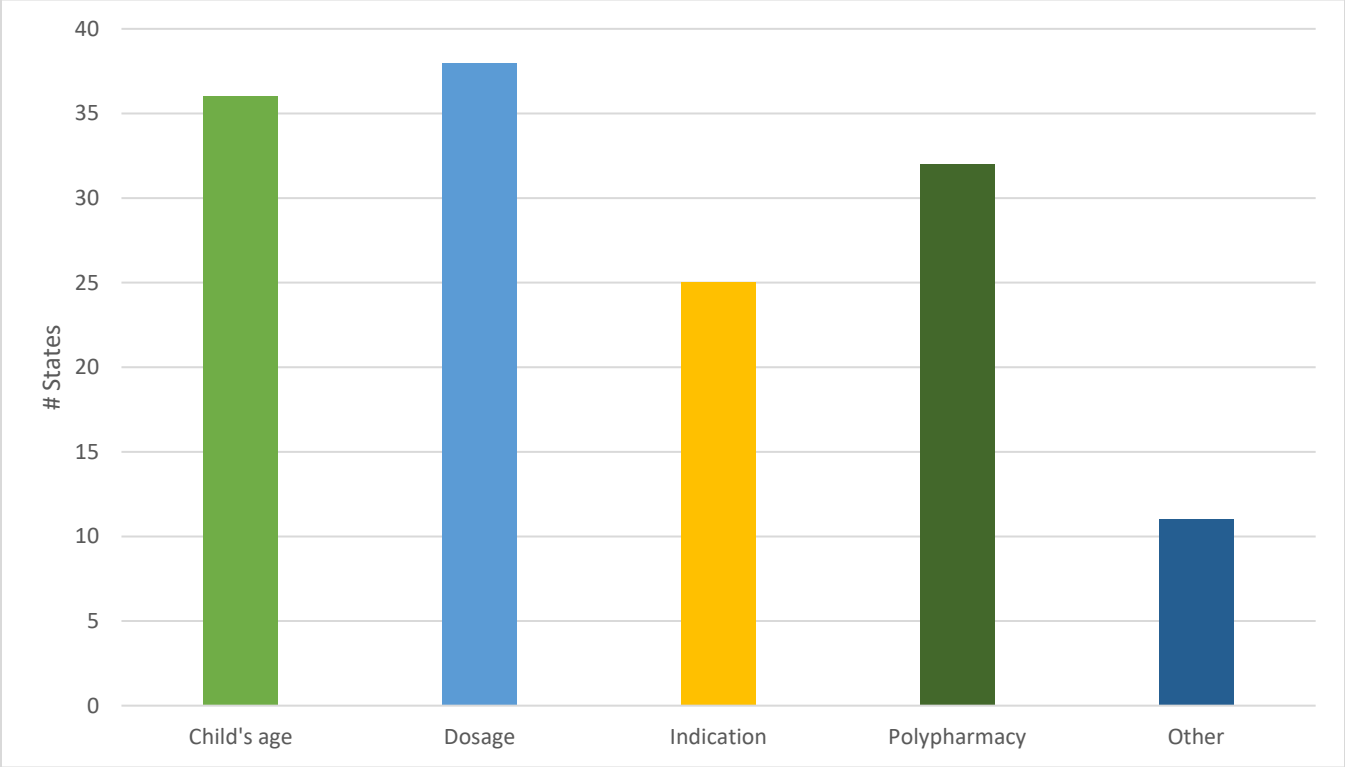

Table 237 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, California, 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, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, Wyoming	36	25.35%
Dosage	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wyoming	38	26.76%
Indication	California, Colorado, Connecticut, Florida, Hawaii, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Wisconsin	25	17.61%

Response	States	Count	Percentage
Polypharmacy	Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	32	22.54%
Other	Arkansas, Colorado, Delaware, Hawaii, Illinois, Kansas, Louisiana, Massachusetts, Ohio, Rhode Island, Utah	11	7.75%
Total		142	100.00%

If “Child’s age,” please specify age limit in years.

Table 238 - 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
California	17
Connecticut	18
District of Columbia	18
Florida	6
Georgia	17
Hawaii	0
Idaho	6
Illinois	6
Indiana	4
Iowa	3
Kansas	3
Kentucky	0
Louisiana	6
Maine	6
Massachusetts	3
Michigan	6
Missouri	6
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	3
North Carolina	17
North Dakota	3
Ohio	12
Oklahoma	4
Oregon	6
Pennsylvania	4
South Carolina	6

State	Age Limit in Years
Texas	3
Utah	6
Vermont	17
Virginia	18
West Virginia	18
Wyoming	4

If "Other," please explain.

Table 239 - "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. POS edits requiring a billed diagnosis consistent with stimulant use was approved by the DUR Board in FFY2021. After implementation, data indicated that most PA requests were due to lack of a billed diagnosis, and the PA requests were subsequently approved as there had been a delay in billing the diagnosis by the prescriber for the office visit. The extra burden on the clinical review team due to a significant increase in PA requests that were eventually approved prompted the removal of the POS edit.
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
Hawaii	icd-10 required
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 19 years of age. - Referral by prior authorization staff to address stimulant use in younger children to pediatric psychiatrists from DocAssist or the prescriber peer consultation for mental health medication use in children via University of Illinois Chicago, Clinical Services in Psychopharmacology Program.
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 old. POS edits for all ages include diagnosis requirement, therapeutic duplication of short acting ADHD agents, of long acting ADHD agents, and ADHD agents from different prescribers.
Massachusetts	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 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.

State	Explanation
Rhode Island	Some Pro-DUR edits such as therapeutic duplications.
Utah	Beginning July 2020, age edit limitations apply when a claim for an ADHD stimulant is processed through the pharmacy point of sale: 1) ADHD stimulant prescriptions for children under 4 years of age. 2) ADHD stimulant prescriptions for Adzenys ER suspension (susp.), Dyanavel XR, Desoxyn, Adhansia XR, Jornay PM, and Cotempla XR Orally Disintegrating Tablet (ODT) for children under 6 years of age.

c. If "Yes," please briefly explain the specifics of your documented stimulant monitoring program(s).

Table 240 - Explanations of Specifics of Documented Stimulant Monitoring Program(s)

State	Explanation
Alabama	All stimulants have quantity limits.
Arkansas	All stimulant requests for children <6 years of age require a manual review PA by the Medicaid Pharmacy Program psychiatrist and state clinical pharmacists. Clients <19 years of age with denied claims due to a POS edit will also require a PA. Reviewing a PA request requires review of the client's diagnosis, age, concomitant therapies, history of therapy, and psychosocial status. POS edits for stimulants include: 1) Therapeutic duplication edit--Criteria allows concurrent therapy for children <19 years of age with both a long-acting agent and a short-acting agent as a booster dose (one pill of short-acting per day). Atomoxetine is included in the therapeutic duplication edits with CII stimulants. If an incoming long-acting CII stimulant claim overlaps with a short-acting CII stimulant that was filled at a dose of at least 2 units per day, the long-acting product will require prior authorization. If an incoming short-acting CII stimulant claim overlaps with a long-acting CII stimulant, the short-acting product will only be approved for a dose of one unit per day. 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 2021 there were documented restrictions to use for all stimulants. These restrictions varied by drug, and may have included age limits, indication restrictions (for attention deficit disorder), and/or ProDUR edits for both high and low dosage. In addition, retrospective utilization of all psychotherapeutic medications in children younger than 18 years of age is reviewed on at least an annual basis.

State	Explanation
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 periodically sent to providers regarding pediatric members' use of multiple stimulant medications or pediatric members' use of multiple psychotropic medications (including stimulants).
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 ProDUR edits are in place to monitor for therapeutic duplication within the stimulant class of medications. Synergy is achieved by partnering with the Department of Services for Children, Youth and their Families to address foster children.
District of Columbia	Monthly DUR reports monitor the concomitant use of stimulants and opioids in children
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	ICD-10 required for claim to pay. Currently no patients and monitored annually for medical necessity, access, provider enrollment in case patient enters FFS.
Idaho	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.
Illinois	- Only one extended-release and one short-acting stimulant allowed at 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://www.illinois.gov/hfs/SiteCollectionDocuments/ADHDkids6122916HFSWEB007R416007.pdf - DocAssist referral by prior authorization staff to address stimulant use in younger children. - Prescriber peer consultation for mental health medication use in children via University of Illinois Chicago, Clinical Services in Psychopharmacology Program as needed.
Indiana	Stimulants require prior authorization when used in duplication or when drug-specific quantity and age limits have been exceeded (note, multiple age limits dependent on drug). Adults must have an FDA-approved or approved compendia diagnosis for use within medical profile; otherwise, medical necessity prior authorization review is required.
Iowa	ProDUR age edit on stimulants claim rejects for: amphetamines (excluding Adderall XR and Dexedrine ER) < 3 years of age; Dexmethylphenidate, methylphenidate, atomoxetine, Adderall XR and Dexedrine ER < 6 years of age. Dosage - Prior authorization is required for stimulants above the set quantity limit. Additionally, prescribers are required to check the Iowa PMP for any stimulant that requires PA.

State	Explanation
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 old. POS edits for all ages include diagnosis requirement, therapeutic duplication of short acting ADHD agents, of long acting ADHD agents, and ADHD agents from different prescribers.
Maine	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 concerns, a peer-to-peer discussion may be required between the member's prescriber and a psychiatrist associated with the initiative.
Michigan	State law allows for prior authorization and POS edits on controlled substances within the psychotropic medication drug class. Therefore, 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. In particular, the monitoring program reviews monthly reports of stimulants 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.

State	Explanation
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. These reports show all psychotropic drugs received per child whether the child's psychotropic drugs hit on the RetroDUR criteria for not. The Children's Mental Health Division uses this information in many ways one of which is to do outreach to the provider community especially to those in foster care. Additionally, there are two RetroDUR mailings per year regarding psychotropic drug use in youth.
Mississippi	Age 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. Edits are in place to prevent use of more than one stimulant and high doses in children.
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.
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.
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.
North Dakota	ND Medicaid requires diagnosis on amphetamine stimulants. Age limits and quantity limits apply to all stimulants according to FDA and compendia recommendations and to ensure dose consolidation. . Therapeutic duplication limits allow one type of stimulant at a time. Long and short acting stimulants of the same ingredient are allowed for some products. ND Medicaid proactively drives utilization to Vyvanse instead of other amphetamines with higher abuse potential. Retrospective DUR lettering is also sent to providers and pharmacies for high doses of stimulants that are not rejected with POS edits.
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. Adults older than 20 years of age require a prior authorization for any stimulant medications to ensure appropriate use. Quantity limits are in place based on FDA approved dosing.

State	Explanation
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	Reviewed by 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	A retrospective review of C-II stimulant use by children under age 21 was conducted in September 2020, based on claims during the period between June 1, 2020 and August 31, 2020. Enrollees chosen for this review review were based on the following criteria: Claims paid during the months of June through August of 2020 Chronic use- enrollees to have at least 90 count total units, 3 claims, and must have a claim in June, so it was possible to have claims in all 3 months. Selected those with at least 6 claims for C-II stimulants Selected those with at least 180 total unit count Selected those who had claims in June A total of 1926 enrollees fit the criteria above and were selected for the retrospective review. Of 1926 children chosen, 114 children under 21 used both amphetamine and methylphenidate products. 109 of 114 used both amphetamines and methylphenidate products concomitantly 5 of 114 discontinued either amphetamine or methylphenidate product and were switched to the other 114 were removed from the 1926 total enrollees to be looked at separately, however due to the combination, it was difficult to evaluate whether any individual doses were outliers. Amphetamine Claims Reviewed: Mean dose per day equaled 21.36mg with a Standard Deviation of 9.19mg. With 3 Standard Deviations over the mean being considered as an outlier, any dose higher than 48.91mg/day is an outlier. A total of only 6 enrollees were found to have an average daily dose over 48.91mg, with the highest daily dose equaling 65mg/day. Lisdexamfetamine has a 70mg dose available, and the highest average dose/day for children under 21 in this study did not reach the 70mg dosage form of Lisdexamfetamine. Methylphenidate products reviewed: Mean dose per day equaled 20.97mg with a Standard Deviation of 9.73mg. With 3 Standard Deviations over the mean being considered as an outlier, any dose higher than 50.16mg/day is an outlier. A total of 7 enrollees were found to have an average daily dose over 50.16mg, with the highest daily dose equaling 70.16mg/day. Methylphenidate has a 72mg dose available, and the highest average dose/day for children under 21 in this study did not reach the 70mg dosage form of Methylphenidate. Statistical outliers using greater than 50.16mg were still within the MAX dose of Methylphenidate at 60mg/day. Only 3 enrollees were found to use a dose higher than 60mg/day (70.16mg, 66mg, 63mg). In summarizing, doses of C-II stimulants for TennCare enrollees who are children under the age of 21 appeared to be within guidelines, with very few outliers. For children, prior authorization for C-II stimulants that are preferred products is not required. In the presenter's opinion, the data presented with this retrospective review supports TennCare in not requiring a prior authorization for these products, unless the product is non-preferred on TennCare's PDL.

State	Explanation
	This review was presented to TennCare's DUR Board during FFY2021
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). Combination of a IR and an ER stimulants, as well as, any combination of IR or ER stimulants with one or more non-stimulants are approved. For clients age 19 or older, a diagnosis of ADD/ADHD must be documented for approval after the initial approval for the first 90-days therapy.
Utah	Restriction on concomitant use of both methylphenidate class and amphetamine class, more than 2 stimulants, and quantity limit were implemented in 2022.
Vermont	Vermont gathers statistics based on previous participation in the Psychotropic Medications Quality Improvement Collaborative (PMQIC) with a goal of improving the use of psychotropic medication among children and youth in foster care. PMQIC common measures in Vermont Medicaid pharmacy Program includes ADHD medications /stimulants in the analysis..
Virginia	*All stimulants (preferred and non-preferred) require the submission of Clinical Service Authorization if prescribed for a child less than four or an adult eighteen years and older. Stimulants prescribed for children under the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician or in consultation with one of these specialists. The patient must have a diagnosis of ADHD. The prescriber must have reviewed the Virginia PMP on the date of the request. The prescriber has ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. (The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates). For maintenance: the practitioner must have checked the PMP at least every three months after the initiation of treatment. The practitioner has ordered and reviewed a random urine drug screen at least every six months. The practitioner has regularly evaluated the patient for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated.

State	Explanation
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 grandfathering until the end of the school year .
Wisconsin	Wisconsin has both documented restrictions and special programs to monitor, manage or control the use of stimulants for adults and children on stimulants. This includes diagnosis restrictions (allowable diagnoses are ADHD and narcolepsy), a prior authorization requirement for non-preferred stimulants on the preferred drug list. A Children's Mental Health workgroup focuses on behavioral health medications and the contracted child psychiatrist reviews high dose stimulant use and performs peer to peer outreach calls on an as needed basis. Wisconsin also has a quantity limit for all stimulant drugs.
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.

If "No," does your state plan on implementing a stimulant monitoring program in the future?

Figure 142 - Future Plans to Implement a Stimulant Monitoring Program

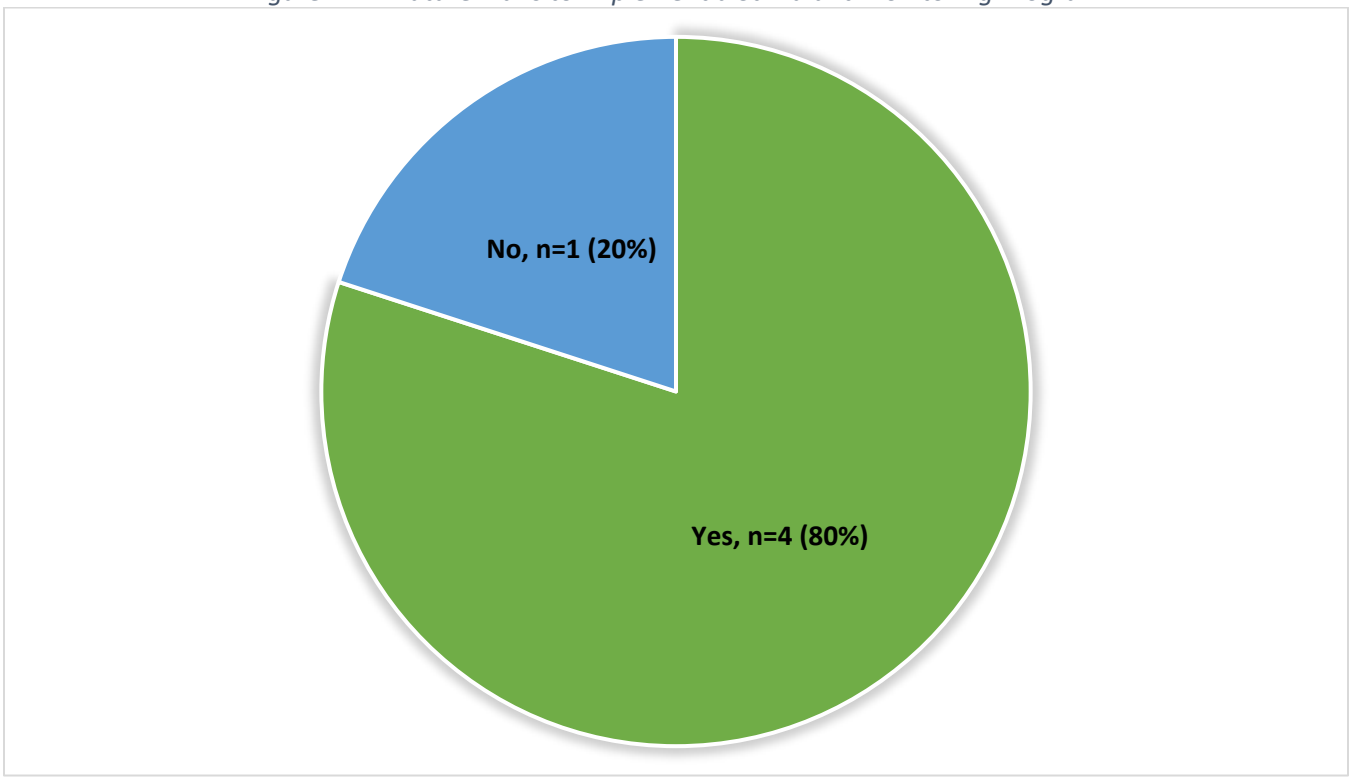

Table 241 - Future Plans to Implement a Stimulant Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, Maryland, New Jersey, South Dakota	4	80.00%
No	New Mexico	1	20.00%
Total		5	100.00%

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 242 - 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 Jersey	Effective 7/1/22, a retro review process will occur on quarterly basis.
South Dakota	State in conjunction with the P&T Committee plans to review stimulant utilization and implement appropriate edits.

If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 243 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanation
New Mexico	This will be part of the new MMIS replacement implementation in FFY23 or FFY24.

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 143 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children

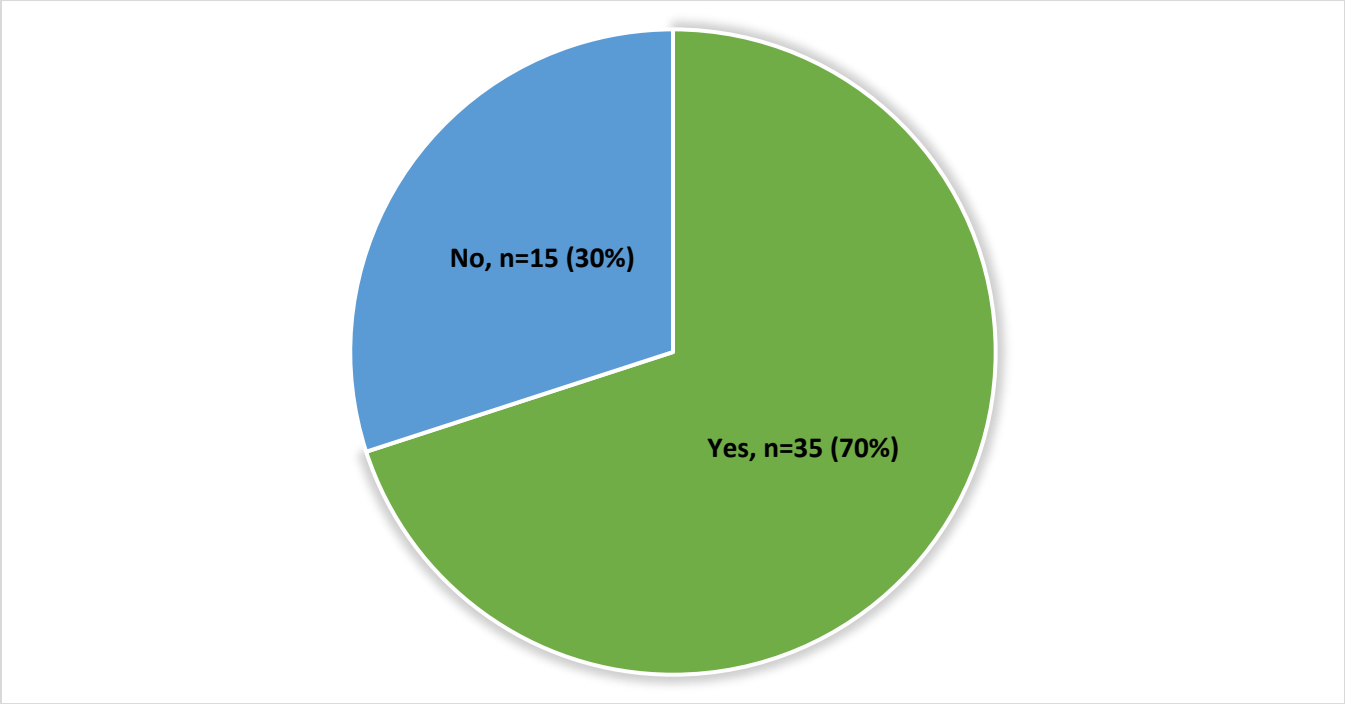

Table 244 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Washington, Wyoming	35	70.00%

Response	States	Count	Percentage
No	Alabama, Alaska, District of Columbia, Georgia, Iowa, Maryland, Minnesota, New Jersey, New Mexico, Rhode Island, South Dakota, Utah, Virginia, West Virginia, Wisconsin	15	30.00%
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 Antidepressant Drugs

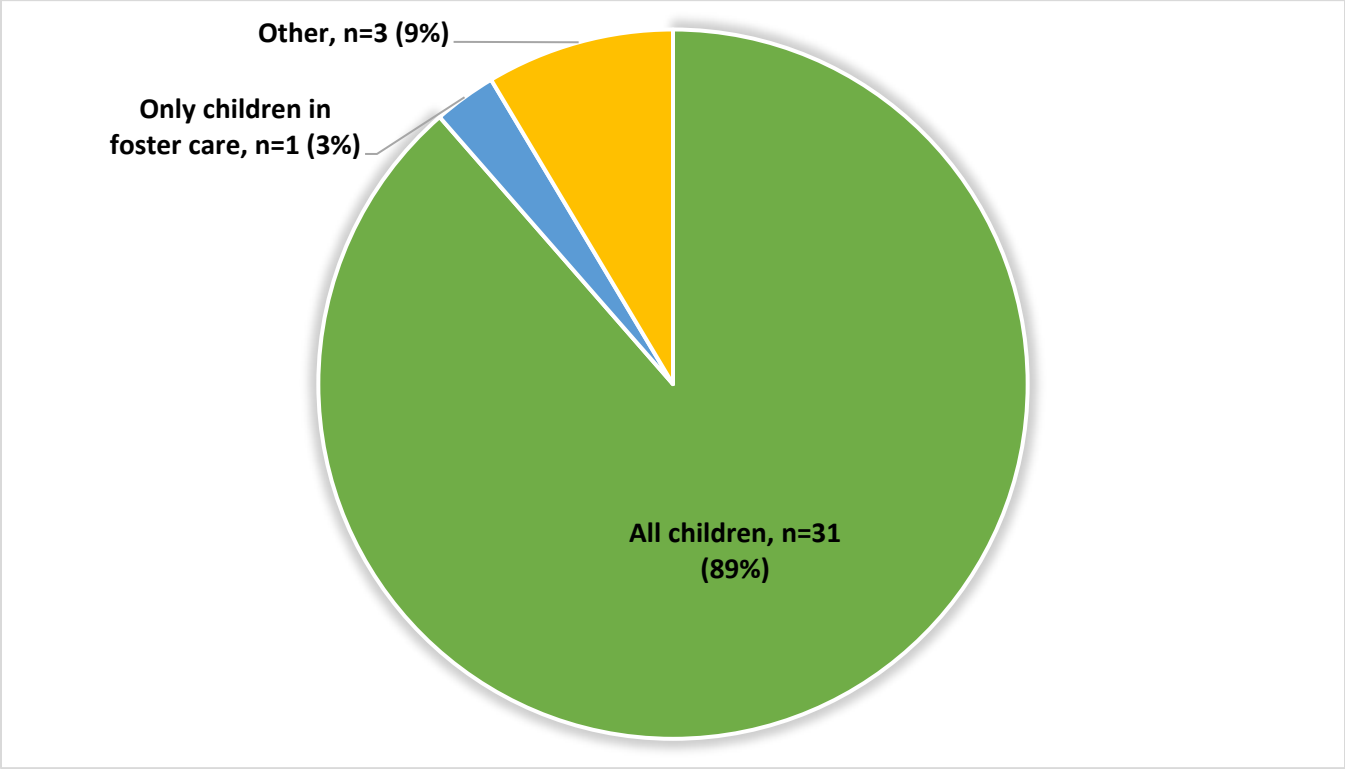

Table 245 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

Response	States	Count	Percentage
All children	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Vermont, Washington, Wyoming	31	88.57%
Only children in foster care	Montana	1	2.86%
Other	Illinois, New York, Texas	3	8.57%
Total		35	100.00%

If “Other,” please explain.

Table 246 - “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.
Texas	The antidepressant monitoring is done for all age groups through a retrospective DUR review and educational intervention.

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 Antidepressant Drugs in Children

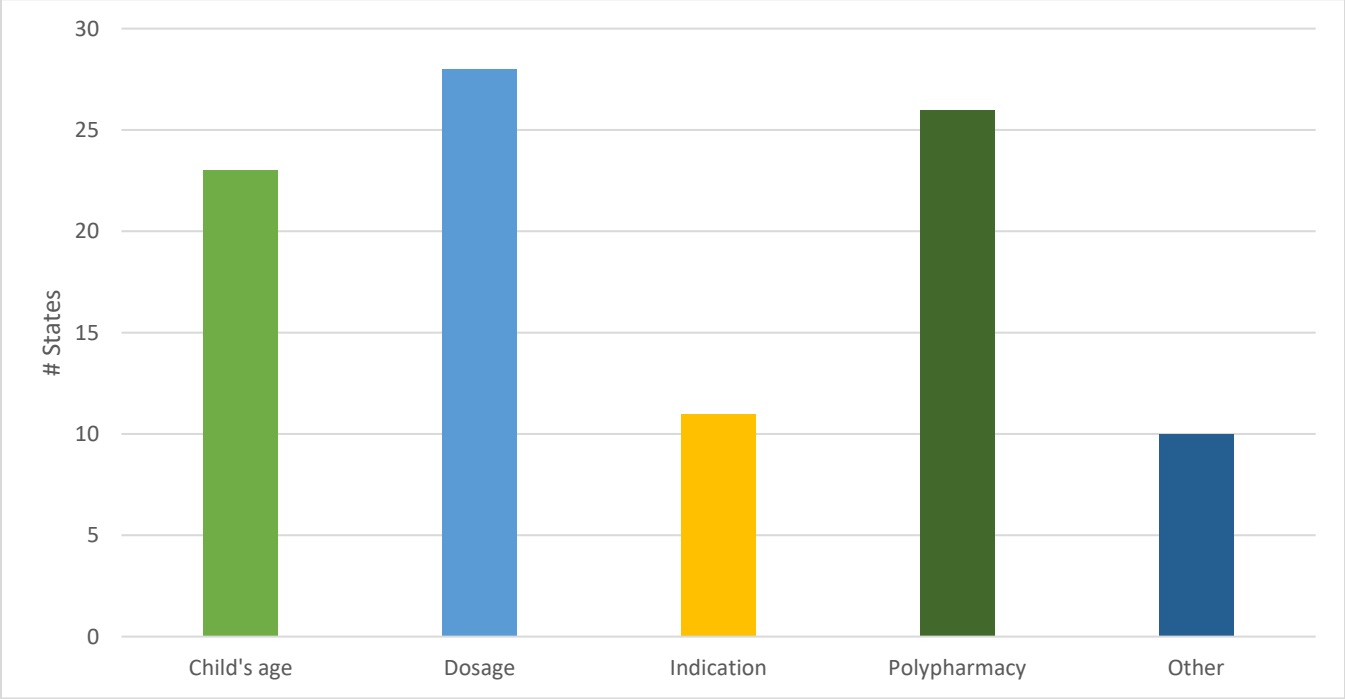

Table 247 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, California, Connecticut, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, Oklahoma, Oregon, Tennessee, Vermont, Wyoming	23	23.47%
Dosage	Arkansas, California, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Washington, Wyoming	28	28.57%

Response	States	Count	Percentage
Indication	Connecticut, Florida, Indiana, Massachusetts, Missouri, Montana, New York, North Carolina, South Carolina, Tennessee, Washington	11	11.22%
Polypharmacy	California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Vermont, Washington, Wyoming	26	26.53%
Other	Arkansas, Delaware, Illinois, Kansas, Louisiana, Massachusetts, Michigan, Ohio, Texas, Washington	10	10.20%
Total		98	100.00%

If "Child's age," please specify age limit in years.

Table 248 - 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
California	17
Connecticut	18
Florida	6
Hawaii	0
Idaho	6
Indiana	18
Kansas	17
Kentucky	18
Louisiana	6
Maine	18
Massachusetts	6
Missouri	5
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	0
Oklahoma	18
Oregon	12
Tennessee	18
Vermont	17
Wyoming	5

If "Other," please explain.

Table 249 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	Explanation
Arkansas	Clients <4 years of age require a prior authorization. Antidepressants are on the PDL. Therapeutic duplication edits are in place for multiple antidepressants.
Delaware	The age limit for children using antidepressants varies based on FDA approved indications.
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 old. SSRIs are subject to POS therapeutic duplication edits. Tricyclic antidepressants are 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 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.
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.
Ohio	We have additional edits in place which monitor any medication that has a drug interaction with an antidepressant.
Texas	There are no POS prospective edits or prior authorization in place for antidepressants to monitor for age, dose, indications, etc. However, in FFY 2021,there were multiple performance indicators which were selected for retrospective intervention which applied to clients of all ages with diagnosis of depression and/or who received antidepressants. Targeted prescribers received educational intervention letters.
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 250 - Explanations of Specifics of Documented Antidepressant Monitoring Program(s)

State	Explanation
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 clients 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

State	Explanation
	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 a PA. Maximum daily doses are in place based on treatment guidelines and the manufacturer's package insert recommendations. There is continuation criteria for non-preferred medications which ensures the prescriber is aware if their patient has a lack of adherence to prescription therapy. The client must have >90 days of therapy in the previous 120 days for the same drug, strength, and daily dose of the non-preferred agent.
California	The antidepressant monitoring program includes both ProDUR and RetroDUR components. During FFY 2021 there were documented restrictions to use for most antidepressant medications. These restrictions varied by drug, and may have included age limits 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	Interventional letters that contain patient-specific information identifying use of multiple psychotropic medications (including antidepressants) in children/adolescents are prepared and mailed to prescribers periodically. Ad hoc retrospective DUR analyses are also performed on an ongoing basis as part of monitoring utilization of psychotropic medications in all children.
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, 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	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 id 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	Currently no patients and monitored annually for medical necessity, access, provider enrollment in case patient enters FFS.
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	Note age limit applies to products that are not indicated in children. 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.

State	Explanation
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 old. SSRIs are subject to POS therapeutic duplication edits. Tricyclic antidepressants are 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 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). In particular, the monitoring program reviews monthly reports of antidepressants 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.
Mississippi	Age limits vary by agent as indicated. These limits are evaluated by a SmartPA criteria. For citalopram, the SmartPA 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.

State	Explanation
Nevada	Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) without prior authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six years of age require prior authorization.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed an 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 York	The RetroDUR process monitors for appropriate use of antidepressants. The criteria addresses drug-drug, drug-disease 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 and to ensure dose consolidation. Therapeutic duplication prevents more than one antidepressant in the same class to be utilized at the same time.
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 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.
South Carolina	Claims edits, Prior Authorizations may include: age, indication, dose and quantity. Periodic Retro DUR "runs" have been done regarding polypharmacy.
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.

State	Explanation
Texas	Major Depressive Disorder Management was one of the interventions performed in FFY 2021. The performance indicators selected for this intervention included: medication therapy that lasted less than 6 months. Medication therapy that lasted longer than 12 months for a single episode, Antidepressants for children and adolescents (excluding fluoxetine age 8-18 years and escitalopram for ages 12-17 years), Duplicative therapy, antidepressant adherence, and antidepressants dose consolidation (excluding pediatric patients)
Vermont	Also included in the PMQIC report.
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.

If "No," does your state plan on implementing an antidepressant monitoring program in the future?

Figure 146 - Future Plans to Implement an Antidepressant Monitoring Program

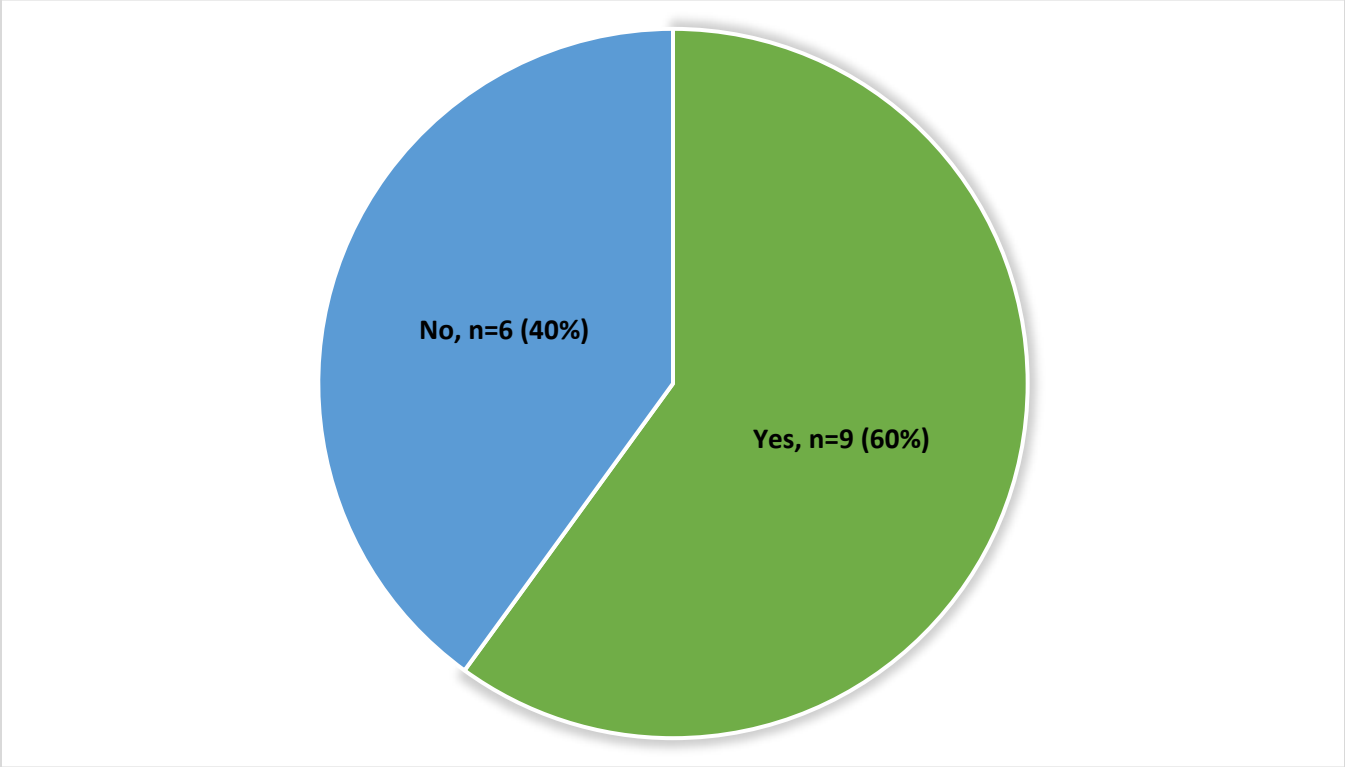

Table 251 - Future Plans to Implement an Antidepressant Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Georgia, Iowa, Maryland, New Jersey, New Mexico, South Dakota, Utah	9	60.00%
No	Alabama, Minnesota, Rhode Island, Virginia, West Virginia, Wisconsin	6	40.00%
Total		15	100.00%

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 252 - 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	Planning for implementation during the next fiscal year
Georgia	Not sure at this time
Iowa	Can look at as a future topic for the DUR Commission, date to be determined

State	Explanation
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 Jersey	Effective 7/1/22, a retro review process will occur on quarterly basis.
New Mexico	This will be part of the new MMIS replacement implementation in FFY23 or FFY24.
South Dakota	State in conjunction with the P&T Committee plan to review antidepressant utilization and implement appropriate edits if warranted.
Utah	2023

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 253 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	Explanation
Alabama	No plans at this time.
Minnesota	Antidepressants are part of the two times per year RetroDUR Intervention that includes criteria of three or greater psychotropic drugs in youth or psychotropic drug polypharmacy. Prescribers receive an alert letter about their patients meeting this criteria. This includes showing the drug profile of the patient. 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.
Rhode Island	Currently not an issue.
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.
Wisconsin	Wisconsin does not plan to implement monitoring of antidepressants at this time.

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 147 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

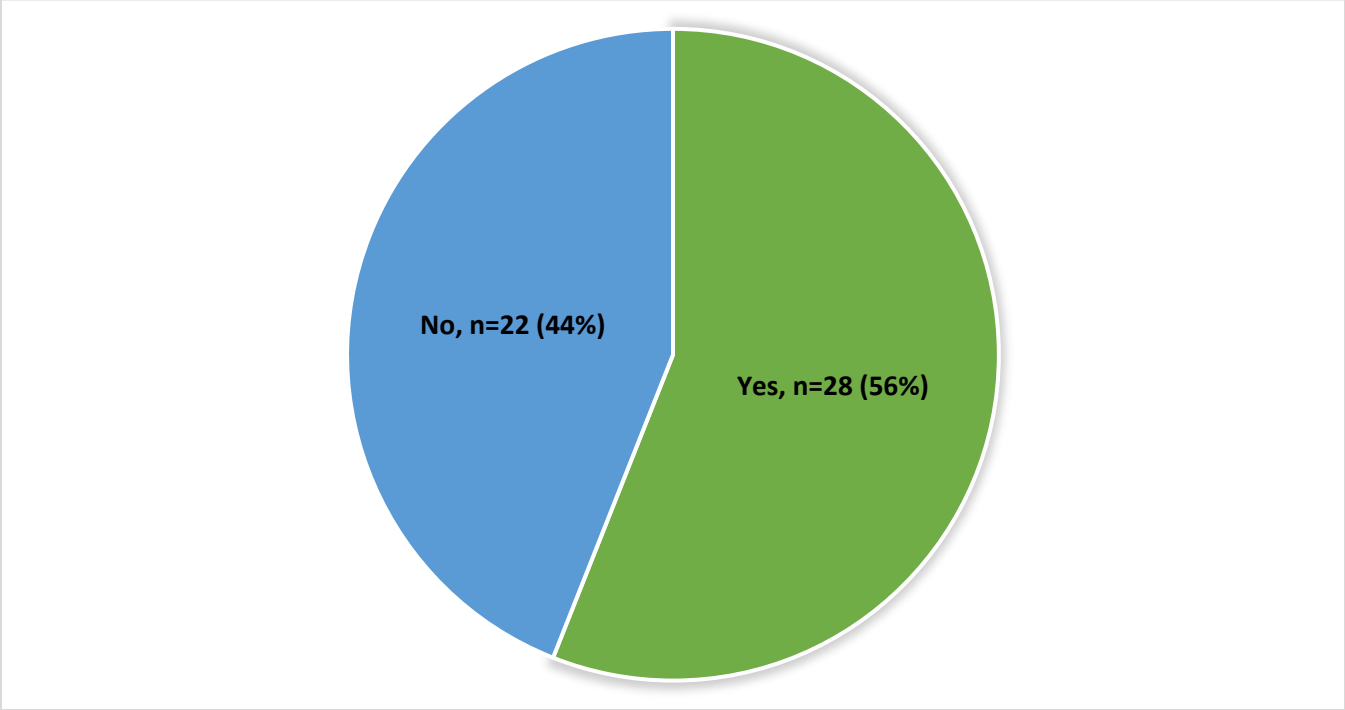

Table 254 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

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

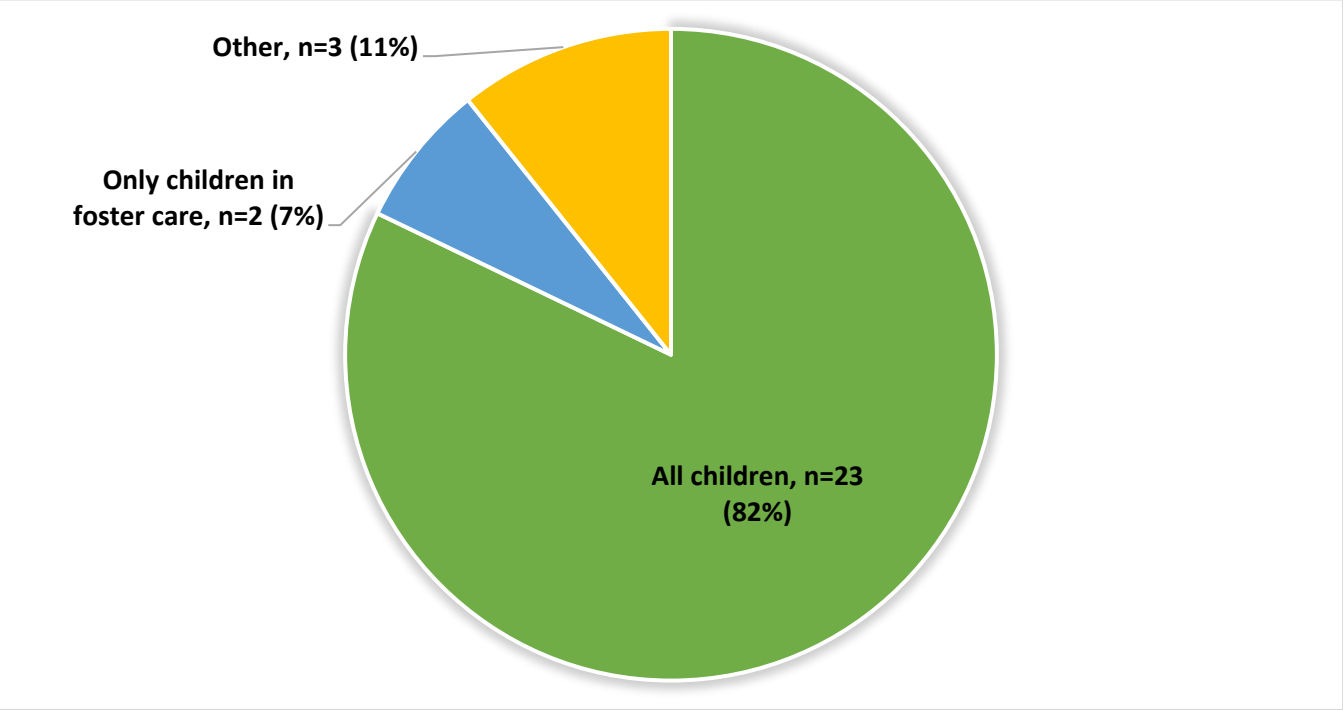

Table 255 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

Response	States	Count	Percentage
All children	California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Vermont, Washington, Wyoming	23	82.14%
Only children in foster care	Missouri, Montana	2	7.14%
Other	Illinois, New York, Texas	3	10.71%
Total		28	100.00%

If "Other," please explain.

Table 256 - "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.
Texas	Mood stabilizers are reviewed as a part of the retrospective intervention review criteria for topics such as Antipsychotic Drug Use Evaluation, or Bipolar Disease Management. The criteria are applied to all age groups.

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 Mood Stabilizing Drugs in Children

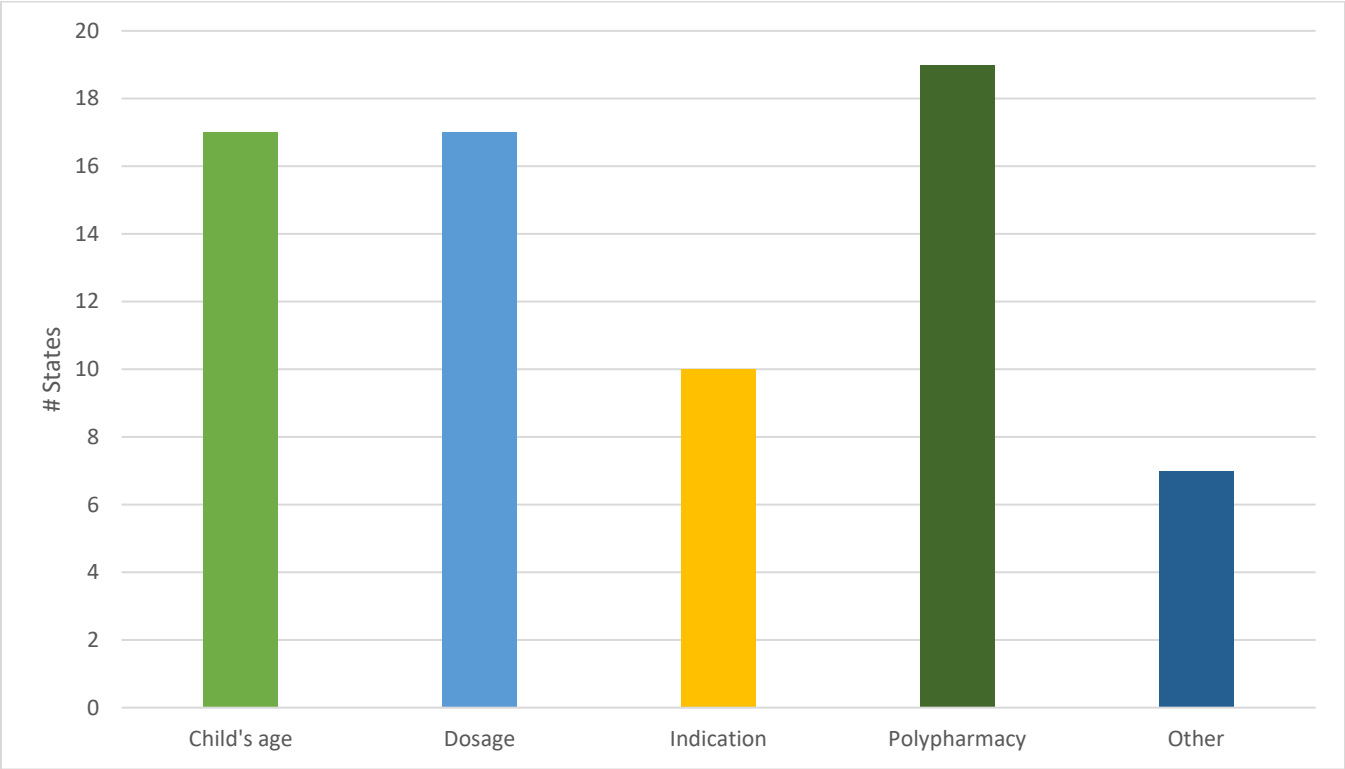

Table 257 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Response	States	Count	Percentage
Child's age	California, Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, Tennessee, Vermont	17	24.29%
Dosage	California, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Massachusetts, Montana, Nebraska, New York, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee	17	24.29%
Indication	Connecticut, Florida, Massachusetts, Missouri, Montana, Nevada, New York, South Carolina, Tennessee, Wyoming	10	14.29%
Polypharmacy	California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kentucky, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New York, Ohio, South Carolina, Vermont, Washington, Wyoming	19	27.14%
Other	Delaware, Illinois, Louisiana, Massachusetts, Michigan, Ohio, Texas	7	10.00%
Total		70	100.00%

If "Child's age," please specify age limit in years.

Table 258 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Age Limit in Years
California	12
Connecticut	18
Florida	6
Hawaii	0
Idaho	6
Indiana	18
Kentucky	18
Louisiana	6
Massachusetts	6
Missouri	21
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	0
Tennessee	18
Vermont	17

If "Other," please explain.

Table 259 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Explanation
Delaware	Age limit is based on FDA approved indications
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization.
Louisiana	Preauthorization is required for mood stabilizers for beneficiaries less than 7 years old.
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.
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.
Ohio	We have additional edits in place which monitor any medication that has a drug interaction with a mood stabilizer.
Texas	All the above options may be included for consideration for the retro-DUR criteria and interventions.

c. If "Yes," please briefly explain the specifics of your documented mood stabilizer monitoring program(s).

Table 260 - Explanations of Specifics of Documented Mood Stabilizer Monitoring Program(s)

State	Explanation
California	The mood stabilizer monitoring program includes both ProDUR and RetroDUR components. During FFY 2021 there were documented restrictions to use for mood stabilizer medications. These restrictions include age limits and/or ProDUR edits for both high and low dosage. In addition, retrospective utilization of all psychotherapeutic medications in children younger than 18 years of age is reviewed on at least an annual basis.
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. Ad hoc retrospective DUR analyses are also performed on an ongoing basis as part of monitoring utilization of psychotropic medications in all children.
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, 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	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 id 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	Currently no patients and monitored annually for medical necessity, access, provider enrollment in case patient enters FFS.
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. Please note age limit varies.
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 mood stabilizers for beneficiaries less than 7 years old.

State	Explanation
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. In particular, the monitoring program reviews monthly reports of mood stabilizers 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.
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	Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) without prior authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six years of age require prior authorization.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed 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.

State	Explanation
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 and 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.
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.
South Carolina	Claims edits, Prior Authorizations may include: age, indication, dose and quantity. Periodic Retro DUR "runs" have been done regarding polypharmacy.
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	Mood Stabilizers are also part of the data review included in the PMQIC report.
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.
Wyoming	Mood stabilizers are included in the overall review for polypharmacy in children.

If "No," does your state plan on implementing a mood stabilizer monitoring program in the future?

Figure 150 - Future Plans to Implement a Mood Stabilizer Monitoring Program

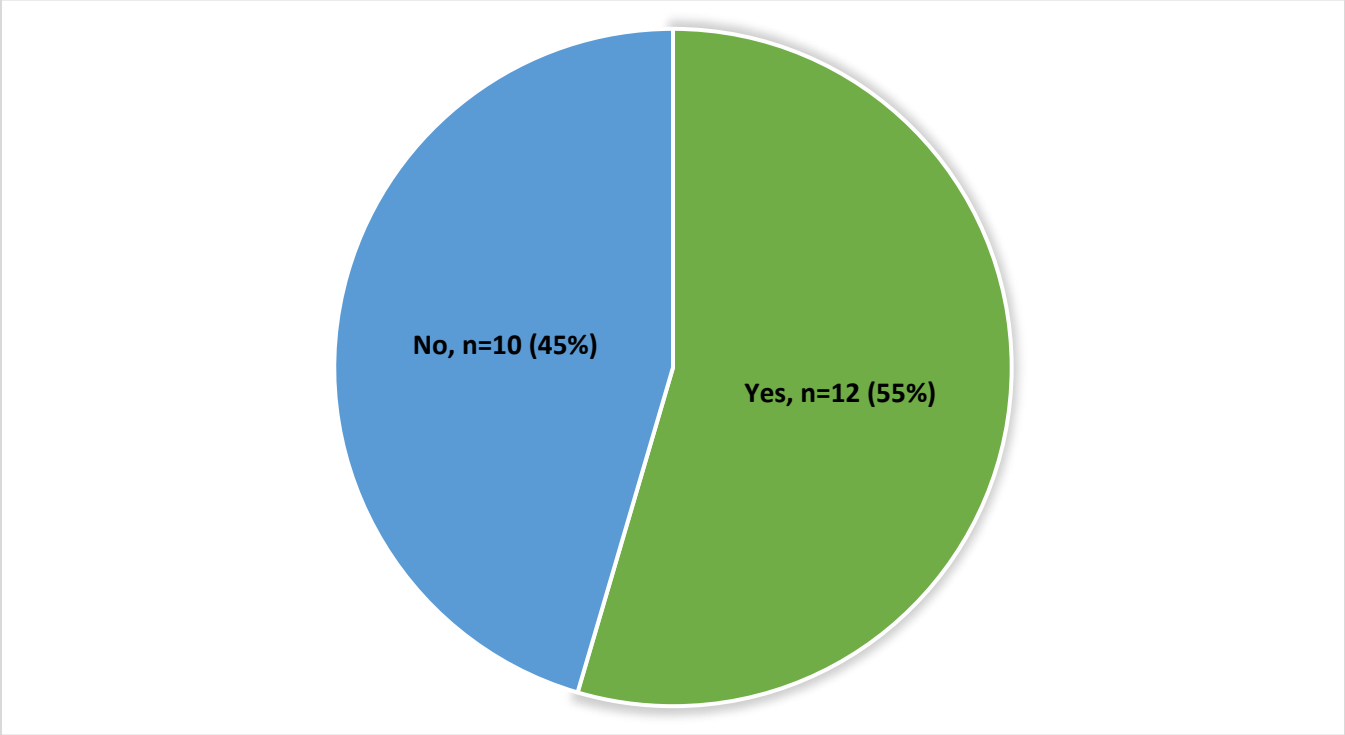

Table 261 - Future Plans to Implement a Mood Stabilizer Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, Arkansas, District of Columbia, Georgia, Iowa, Maine, Maryland, Mississippi, New Jersey, New Mexico, South Dakota, Utah	12	54.55%
No	Alabama, Kansas, Minnesota, North Carolina, Oregon, Pennsylvania, Rhode Island, Virginia, West Virginia, Wisconsin	10	45.45%
Total		22	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 262 - 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 stabilizers. We include lithium and divalproex on our monthly psychotropic report, but no action is taken with that information at this point.
District of Columbia	Planning for implementation during the next fiscal year

State	Explanation
Georgia	Not sure 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 the fall of 2022 for 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 work on this after implementation and stabilization of our new fiscal agent system later this year.
New Jersey	Effective 7/1/22, a retro review process will occur on quarterly basis.
New Mexico	This will be part of the new MMIS replacement implementation in FFY23 or FFY24.
South Dakota	State in conjunction with the P&T Committee plans to review mood stabilizer utilization and implement appropriate edits if warranted.
Utah	2023

If “No,” please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

Table 263 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	Explanation
Alabama	No plans at this time.
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.
Minnesota	Mood stabilizers are part of the two times per year RetroDUR Intervention that includes criteria of three or greater psychotropic drugs in youth. Prescribers receive an alert letter about their patients meeting this criteria. This includes showing the drug profile of the patient. 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.
North Carolina	The State does not have plans, within current operations timeline, to expand BH edits to include mood stabilizers.
Oregon	We are evaluating.
Pennsylvania	It is unclear how CMS is defining mood stabilizing drugs. Antidepressants, anticonvulsants, and antipsychotics are monitored.
Rhode Island	Currently not an issue.
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.
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 151 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

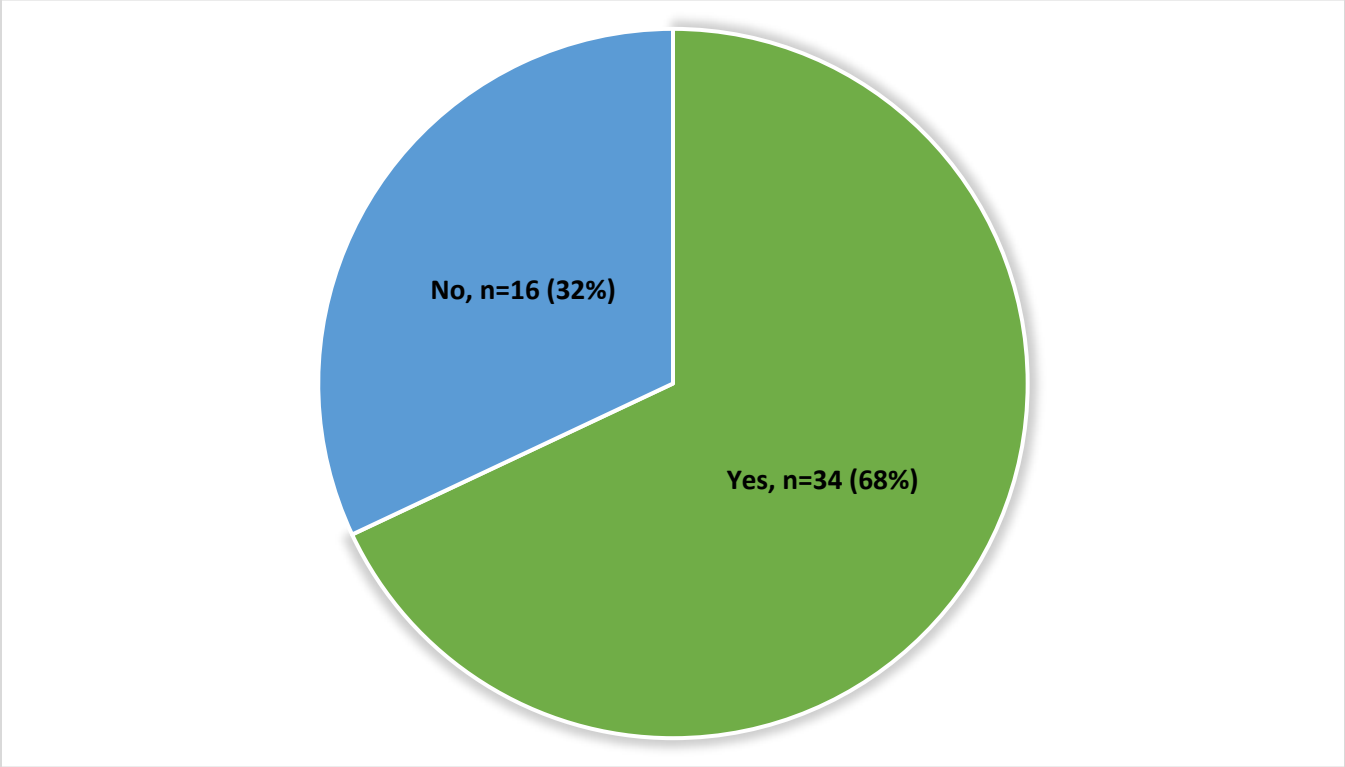

Table 264 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Washington, Wyoming	34	68.00%
No	Alabama, Alaska, District of Columbia, Georgia, Iowa, Maine, Maryland, Minnesota, New Jersey, New Mexico, Rhode Island, South Dakota, Utah, Virginia, 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 Antianxiety/Sedative Drugs

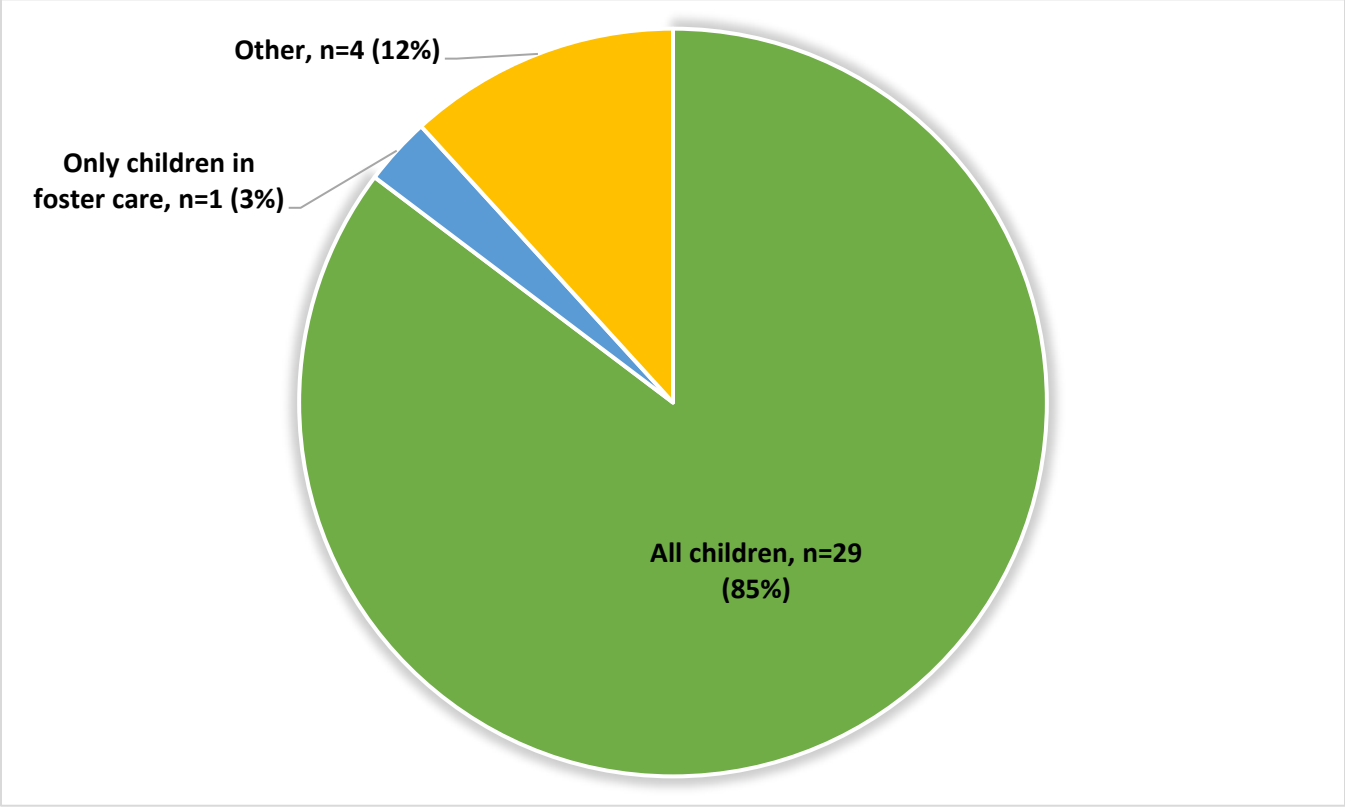

Table 265 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

Response	States	Count	Percentage
All children	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Vermont, Washington, Wyoming	29	85.29%
Only children in foster care	Montana	1	2.94%
Other	Illinois, Kansas, New York, Texas	4	11.76%
Total		34	100.00%

If "Other," please explain.

Table 266 - "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	claims for all age groups are subject to the anxiolytics/sedatives/hypnotics prior authorization and retrospective intervention criteria.

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 Antianxiety/Sedative Drugs in Children

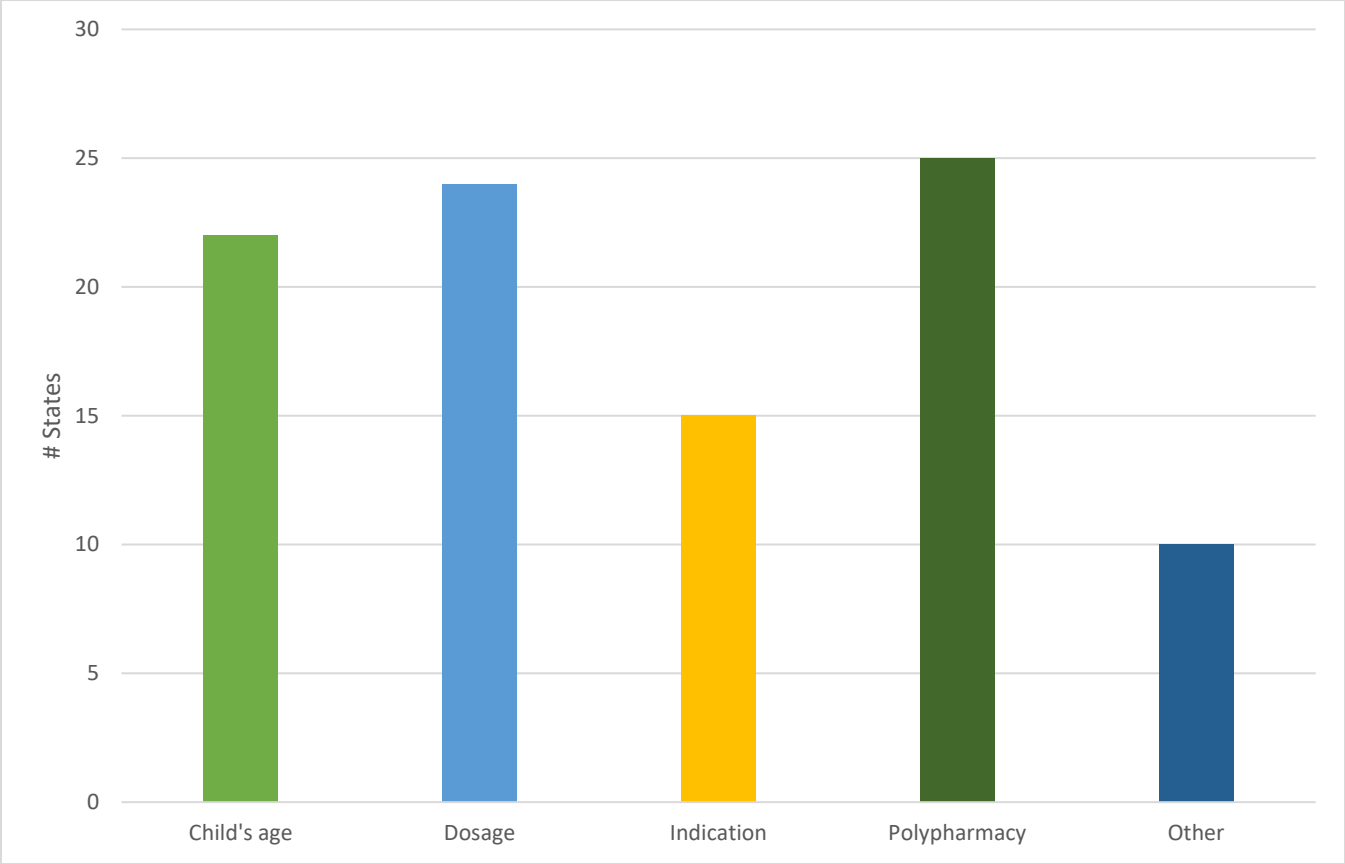

Table 267 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	States	Count	Percentage
Child's age	California, Colorado, Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, Oklahoma, Oregon, Pennsylvania, Tennessee, Vermont, Wyoming	22	22.92%
Dosage	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New York, North Dakota, Ohio, Pennsylvania, South Carolina, Tennessee, Wyoming	24	25.00%
Indication	California, Connecticut, Florida, Indiana, Massachusetts, Missouri, Montana, Nevada, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Tennessee, Washington	15	15.63%
Polypharmacy	California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Vermont, Washington, Wyoming	25	26.04%
Other	Arkansas, Delaware, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Missouri, Ohio, Texas	10	10.42%
Total		96	100.00%

If “Child’s age,” please specify age limit in years.

Table 268 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Age Limit in Years
California	18
Colorado	18
Connecticut	18
Florida	6
Hawaii	0
Idaho	6
Indiana	18
Kentucky	18
Louisiana	6
Massachusetts	6
Missouri	18
Montana	0
Nebraska	18
Nevada	18
New Hampshire	18
New York	0
Oklahoma	17

State	Age Limit in Years
Oregon	18
Pennsylvania	21
Tennessee	18
Vermont	17
Wyoming	18

If "Other," please explain.

Table 269 - "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	Age limit is based on FDA approved indications
Illinois	All DCFS Youth in Care require DCFS psychiatrist consent and prior authorization.
Indiana	Please note multiple age limits apply. Duration of therapy is restricted to 30 days in new starts. Diagnosis of seizure is excluded.
Louisiana	Anxiolytics: Preauthorization is required for anxiolytics (except meprobamate) for beneficiaries less than 7 years old. 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 palliative care-related diagnosis code. Selected agents for narcolepsy have POS therapeutic duplication edits. Sedatives: Preauthorization is required for doxepin for beneficiaries less than 7 years old. Sedatives 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.
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 selected controlled substances. All psychotropic medications are carved-out of MCO pharmacy benefit and paid through FFS.
Missouri	Edits are in place for minimum age, dosage, length of therapy, polypharmacy, and indication.

State	Explanation
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/sedatives/hypnotics.

c. If "Yes," please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).

Table 270 - Explanations of Specifics of Documented Antianxiety/Sedative Monitoring Program(s)

State	Explanation
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. During FFY2022, age edits will be added to non-benzodiazepine sedatives.
California	The antianxiety/sedative monitoring program includes both ProDUR and RetroDUR components. During FFY 2021 there were documented restrictions to use for most antianxiety/sedative medications. These restrictions include age limits, 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).
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, 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	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 id 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	Currently no patients and monitored annually for medical necessity, access, provider enrollment in case patient enters FFS.
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.

State	Explanation
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 old. 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 palliative care-related diagnosis code. Selected agents for narcolepsy have POS therapeutic duplication edits. Sedatives: Preauthorization is required for doxepin for beneficiaries less than 7 years old. Sedatives 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.

State	Explanation
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. In particular, the monitoring program reviews monthly reports of antianxiety/sedatives 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.
Mississippi	Our POS system has quantity limit edits for both standard and extended-release benzodiazepine.
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	Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant, or benzodiazepine) without prior authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six years of age require prior authorization.
New Hampshire	For pediatric patients 5 years of age and younger who are prescribed an 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 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.
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 consolidation. Therapeutic duplications allow use of one short acting benzodiazepine and one long acting benzodiazepine at a time. Long acting benzodiazepines are not allowed concurrently with sleeping medications. Benzodiazepines indicated for sleep indications only require prior authorization and age limits. Benzodiazepines require a diagnosis submission at point of sale.

State	Explanation
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.
South Carolina	Claims edits, Prior Authorizations may include: age, indication, dose and quantity. Periodic Retro DUR "runs" have been done regarding polypharmacy.
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	The clinical prior authorization criteria included are: age check, diagnosis check, and diagnosis of substance use disorder (SUD) safety check. The duration of PA is short termed to give the providers the opportunity to reevaluate continued therapy. The retrospective review also checks for chronic use and use in patients with a history of SUD, duplicative therapy, high dose, and use of controlled sedatives/hypnotics in youth.

State	Explanation
Vermont	Also included in the PMQIC measures.
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.
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.

If “No,” does your state plan on implementing an antianxiety/sedative monitoring program in the future?

Figure 154 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

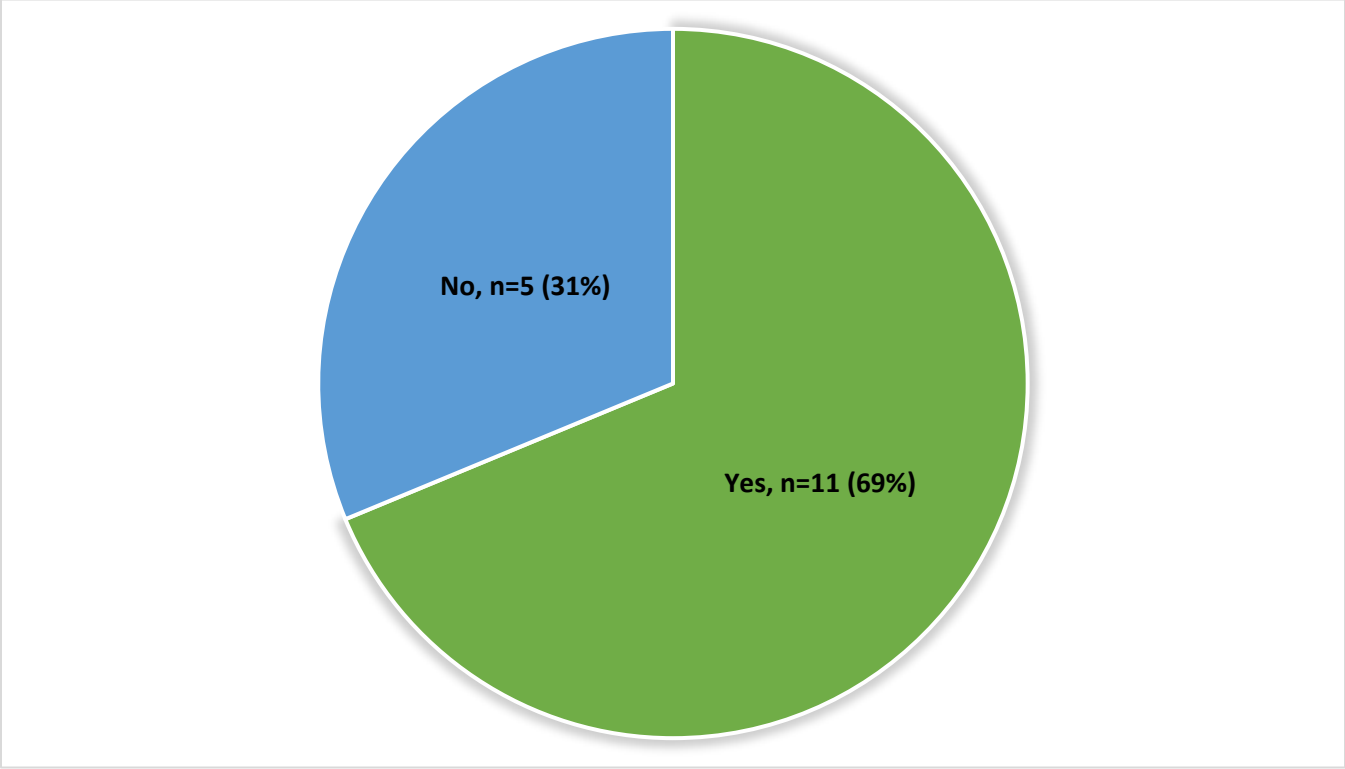

Table 271 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Georgia, Iowa, Maine, Maryland, New Jersey, New Mexico, South Dakota, Utah, Wisconsin	11	68.75%
No	Alabama, Minnesota, Rhode Island, Virginia, West Virginia	5	31.25%
Total		16	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 272 - 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	Planning for implementation during the next fiscal year
Georgia	Not sure 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 the fall of 2022 for 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 antianxiety/sedatives in the future.
New Jersey	Effective 7/1/22, a retro review process will occur on quarterly basis.
New Mexico	This will be part of the new MMIS replacement implementation in FFY23 or FFY24.
South Dakota	State in conjunction with the P&T Committee plans to review antianxiety/sedative utilization and implement appropriate edits if warranted.
Utah	2023/2024
Wisconsin	Wisconsin is currently developing a program to monitor polypharmacy of sedating medications in children. This is under the guidance of a child psychiatrist consultant. The program will include prescriber letters and outreach phone calls to prescribers by the psychiatrist.

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

Table 273 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	Explanation
Alabama	No plans at this time.
Minnesota	Antianxiety/sedative drugs are part of the two times per year RetroDUR Intervention that includes criteria of three or greater psychotropic drugs in youth. Prescribers receive an alert letter about their patients meeting this criteria. This includes showing the drug profile of the patient. Antianxiety/sedative drugs 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.
Rhode Island	Currently not an issue.
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 155 - 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

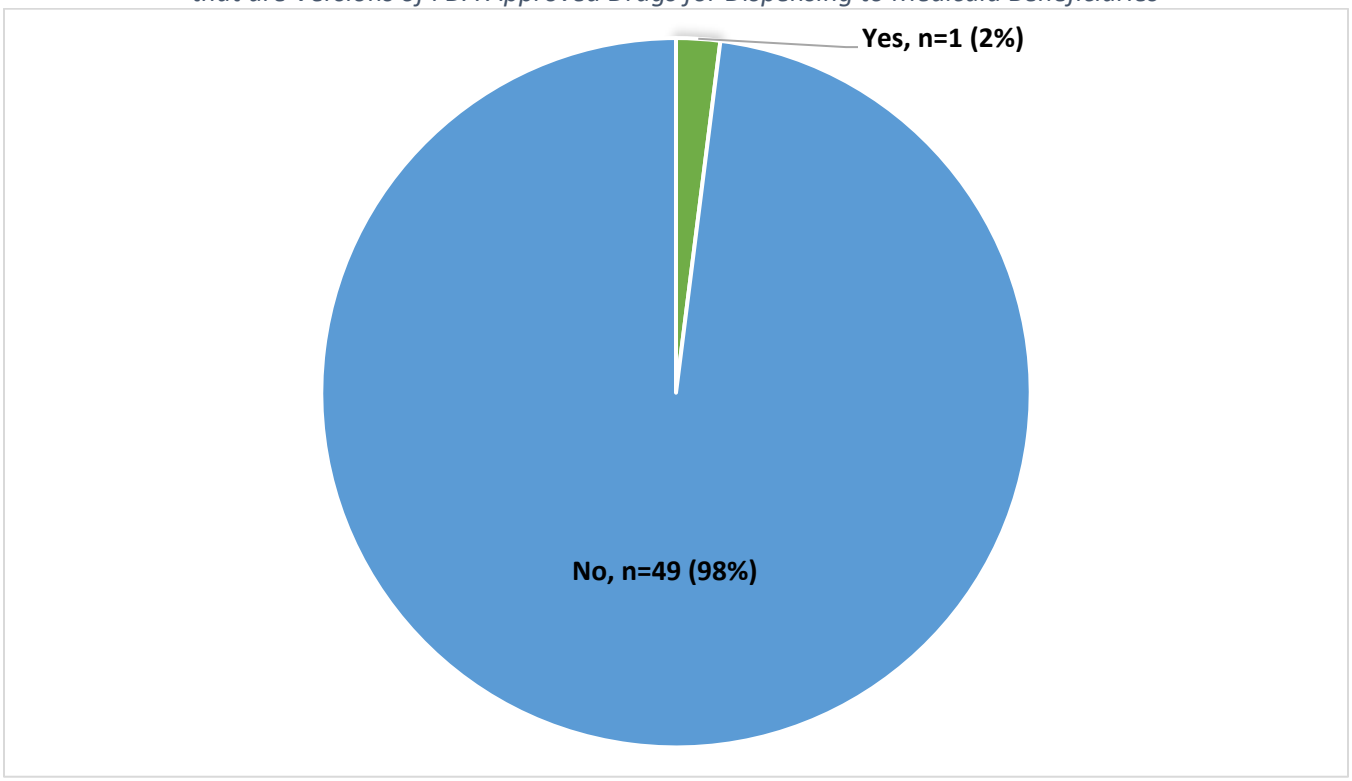

Table 274 - Demonstrations or Waivers to Allow Importation of Certain Drugs from Canada or Other Countries that are Versions of FDA Approved Drugs for Dispensing to Medicaid Beneficiaries

Response	States	Count	Percentage
Yes	Illinois	1	2.00%
No	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, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
Total		50	100.00%

If "Yes," please explain.

Table 275 - 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
Illinois	HFS allowed coverage of imported Apo-Varenicline from Canada. https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn210903b.aspx

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 276 - Innovative Practices Summary

State	Innovative Practices Summary
Alabama	The Alabama Medicaid Agency has several innovative practices that improve the administration of the Drug Utilization Review (DUR) program. In addition to a DUR program that consists of Prospective and Retrospective DUR, Academic Detailing and continuous education for providers, the following other practices were implemented during the FFY 2021. Require Colcrys to be billed with ad Dispense as Written (DAW) Code of 9. Update the default criteria for pharmacy reimbursement when no average acquisition cost (AAC) is available. Require Prior Authorization (PA) for dextroamphetamine/amphetamine ER. Brand Adderall XR will be added as preferred without PA and should be billed with a DAW-9 code. Include cyclosporine tablets and liquid in the mandatory three-month maintenance supply program. Allow COVID-19 vaccine administration fee reimbursement to Medicaid participating providers for federally-allocated COVID-19 vaccines. Require PA for pimecrolimus cream (generic Elidel cream). Brand Elidel cream will remain preferred and should be billed with a DAW-9 Code. Discontinue the COVID-19 universal PA number. Add pharmacy coverage for the shingles vaccine (Shingrix) for adults aged 50 and older. Remove PA for ritonavir (generic Norvir). Brand Norvir will covered with PA and will no longer be allowed to be billed with a DAW-9 code. 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.

State	Innovative Practices Summary
Alaska	Innovative Practices for FFY 2021 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 2021. This supported COVID-19 efforts by allowing pharmacists to be reimbursed for professional services such as immunization administration, testing, and prescribing nasal naloxone. Alaska Medicaid enrolled pharmacists independently administered approximately 7,730 COVID-19 vaccines in FFY 2021 to Alaska Medicaid members. In FFY 2021 Alaska Medicaid developed the Alaska Pediatric Psychotropic Utilization and Quality Team, a collaboration between Medicaid and the Office of Children's Services to ensure appropriate utilization of psychotropic medications in children. Alaska currently utilizes pediatric psychiatric specialists to perform second level case reviews. Alaska solicited for a qualified clinical vendor to provide expanded services to achieve revised program outcome goals.
Arkansas	ARKANSAS INNOVATIVE PRACTICES FFY2021 UPDATED DUR BOARD COMPOSITION Pursuant to a new state law, the DUR Board composition was updated to include 2 rare disease physicians in addition to our current members which include a psychiatrist, OUD specialist, gerontologist, and pediatrician. With so many new rare disease medications in the pipeline, these members will be a great asset to our Board. To keep the required physician to pharmacist ratio, 2 new pharmacist positions were added as well. We are fortunate to have pharmacists with various practice backgrounds including retail, hospital, medication management, consultation, and education. PDL UPDATE Arkansas continues to review potential new drug classes for inclusion in the preferred drug list based on safety and efficacy. In addition to the 16 drug classes re-reviewed during FFY2021, the thrombopoiesis stimulating protein and PCSK9 inhibitors classes were added to the PDL. EARLY REFILL THRESHOLD The update to the early refill threshold was an important change for our program to help control fraud, waste and abuse of controlled substances. We increased the early refill threshold from 75% to 90%. 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

State	Innovative Practices Summary
	algorithms that utilize the client's medication history, billed medical diagnoses, billed procedure codes, and integrated lab values. During FFY2021, we added POS edits for Otezla, GI motility agents, Lyrica, and Symbicort/Dulera (based on new GINA guidelines). POLYPHARMACY SOFT EDITS Our program has been proactive with edits for opioids, benzodiazepines, and antipsychotics to help ensure proper prescribing and dispensing well before the federal SUPPORT Act requirements. To meet the SUPPORT Act requirements pertaining to monitoring of concomitant use of opioids with benzodiazepines or antipsychotics, our program has been reviewing utilization retrospectively. In an effort to add more oversight with these SUPPORT Act requirements, we have added polypharmacy soft edits prospectively at POS. These edits will require the dispensing pharmacist to review the concomitant use message and determine if the combination is medically necessary for the client. If the pharmacist approves the combination, a DUR override can be put in place allowing for a paid claim. Our program went a few steps beyond the requirements and not only included benzodiazepines and antipsychotics used with opioids, but the polypharmacy soft edits include the concomitant use of opioids with either muscle relaxers, sedative hypnotics, or gabapentin as well. We will be monitoring the impact of these edits, and we expect to see a decrease in concomitant utilization of these dangerous combinations. NEW-TO-MARKET POLICY Historically, our DUR Board has been utilized in clinical criteria development with input to RDUR and ProDUR to a lesser extent. To allow the DUR Board more time to review the RDUR and ProDUR programs, we developed a new-to-market policy that enables new medications to have PDL placement, clinical criteria based on similar medications. and addition of any label expansions without being presented to the DUR Board. Our policy can be accessed with this link. https://arkansas.magellanrx.com/client/docs/rxinfo/PDL_criteria_for_medications_new_to_market_or_label_expansion.pdf \
California	Much of FFY 2021 was dedicated to the transition of pharmacy services from the 26 managed care plans to Medi-Cal Fee-for-Service, which began on January 1, 2022. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system will be identified collectively as Medi-Cal Rx. The goals of this transition are as follows: 1. Standardize the Medi-Cal pharmacy benefit statewide, under one delivery system. 2. Improve access to pharmacy services with a network that includes approximately 94% of the state's pharmacies. 3. Apply statewide utilization management protocols to all outpatient drugs. 4. Strengthen California's ability to negotiate state supplemental drug rebates with pharmaceutical manufacturers. Medi-Cal Rx 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 will not include pharmacy services billed as a medical (professional) or institutional claim.

State	Innovative Practices Summary
	In addition, during FFY 2021 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 2021 included: COVID-19 Epidemiology Managed Care Plan Quality Improvement Projects COVID-19 Vaccines Medication Therapy Management Hormonal Contraception Medication Reconciliation Finally, Medication Therapy Management (MTM) was added as a new benefit during FFY 2021. The State Plan Amendment was submitted and subsequently approved by CMS on September 15, 2021.
Colorado	UNIVERSITY OF COLORADO CLINICAL MODULES As part of the State's contract with the CU Skaggs School of Pharmacy and Pharmaceutical Sciences, clinical module analyses are prepared every quarter to provide in-depth and more granular evaluations of medication related issues and policies pertinent to our members. The data in these modules are used to make policy changes as well as improve medication safety and quality of life for our members. Four module evaluations conducted during FFY 2021 are summarized below. CLINICAL MODULE 1: CHARACTERIZATION OF NEWER DIABETES AGENTS USE WITHIN COLORADO MEDICAID MEMBERS (Delivered December 2020) Objective 1: Identify and describe members using first- and second-generation diabetes agents. Outcomes: There were 48,333 members identified as having filled a prescription for a diabetes agent between July 1, 2018 and June 30, 2020. The majority of members were female (58.6%). While there were a small percentage (4.3%) of pediatric members, the majority of individuals were over the age of 35 (76.0%). Nearly 72% of members had at least one record of a T2DM diagnosis. First-generation diabetes agents were the most frequently utilized class of drugs, and of these, biguanide was the most commonly filled (75.2%) followed by insulin (40.8%), and metglitide (18.8%). Second-generation drugs were used by nearly 28% of members, with DPP-4 inhibitors being the most common second-generation drug (10.4%). Objective 2: Determine to what extent criteria are met for members to fill second-generation diabetes agents. Outcomes: For both DPP-4 inhibitors and GLP-1 agonists, a majority of member fills were for preferred agents and met prescribing criteria (88.9% and 85.6% respectively). Non-preferred agents were most frequently prescribed when criteria were not met for both DPP-4 inhibitor and GLP-1 agonist. Objective 3: Determine to what extent the American Diabetes Association guidelines for atherosclerotic cardiovascular disease (ASCVD) and heart failure with reduced ejection fraction (HFrEF) are followed

State	Innovative Practices Summary
	Outcomes: Among members with a T2DM diagnosis and HFrEF or ASCVD, use of second-generation diabetes agents, such as GLP-1 agonists and SGLT-2, were relatively uncommon. GLP-1 agonists were used by only 2.2% of members with HFrEF and T2DM and 2.8% of members with ASCVD, with Bydureon being the most frequently used GLP-1 agonist among these members. SGLT-2 agents were used by 2.7% of diabetic members with HFrEF and 3.4% of members with ASCVD, with Invokana being the most frequently used SGLT-2 inhibitors. Objective 4: Examine the safety of second-generation diabetes agents, as measured by health service utilization, contraindications, and side effects. Outcomes: There were 31,479 members eligible for inclusion in Objective 4, and of these members 8,200 had a fill for any second-generation diabetes agent. Among those members with second-generation use, the mean number of inpatient visits was 0.11 (median=0, range=0-10), the mean number of emergency visits was 0.62 (median=0, range=0-35), and the mean number of outpatient visits was 6.09 (median=2, range=0-180). Among those members without a history of second-generation diabetes agent use, the mean number of inpatient visits was 0.18 (median=0, range=0-17), the mean number of emergency visits was 0.7 (median=0, range=0-43), and the mean number of outpatient visits was 5.46 (median=2, range=0-180). Use of a second-generation diabetes agent was associated with a significant protective effect, or lower odds, of having an inpatient stay (OR: 0.59; 95% CI: 0.54, 0.65) or an emergency visit (OR: 0.92; 95% CI: 0.87, 0.97) when compared to those members without second-generation use. Additionally, use of a second-generation agent was associated with a significantly higher odds of outpatient visits (OR: 1.33; 95% CI: 1.25, 1.41). Among users of SGLT-2 inhibitors, renal failure was the most common contraindication observed in the year prior to initiation of the medication and occurred in nearly 10% of SGLT-2 users. Among DPP-4 inhibitor users, the only relevant contraindication observed in the year prior to initiation was HFrEF, which occurred in 5.5% of users. Contraindications for GLP-1 agonist were observed rarely, occurring in less than 1% of users. Among users of DPP-4 inhibitors, renal failure was the most commonly observed side effect in the year following initiation of the medication, followed by nasopharyngitis (11.2% and 6.6% respectively). Among GLP-1 users, UTI (8.8%), renal failure (8.5%), and nasopharyngitis (7.0%) were the most common side effects. Side effects were less often observed among SGLT-2 inhibitor users, with the most common side effect being UTI (5.4%). Discussion: When considering the entire population, we found that majority of Medicaid members were female (58.6%) over the age of 35 (76.0%) in which 72% had at least one record of a T2DM diagnosis. Not surprisingly, the most commonly prescribed diabetes agent were first-generation diabetes agents (metformin (75.2%) followed by insulin (40%)) with less than 10% being prescribed a second-generation agent. When evaluating if current PDL criteria were being adequately followed for the GLP-1 and DPP-4 classes, about 88% of patients met criteria; however, in the case of the GLP-1, 16.2% did not. This finding could be due to potential grandfathering of the second-generation agents. Unfortunately, the diffusion of recent ADA guidelines regarding the use of the second-generation agents (e.g., GLP-1 and SGLT-2) in the face of compelling cardiovascular indications (e.g., HFrEF and ASCVD) appears to be low. Less than 4% of eligible patients

State	Innovative Practices Summary
	with concomitant ASCVD and/or HFrEF and T2DM were prescribed a newer recommended second-generation agent with cardiovascular benefits. Compared to members receiving a first-generation agent, those taking a second-generation exhibited a significantly lower odds for both all-cause hospitalization and emergency room visits but a higher odds for outpatient physician visits. This finding may be due to the need for medication titration which is not unexpected. From a safety perspective, about 6% of patients taking DPP-4 inhibitors had a prior diagnosis of HFrEF and about 10% of those receiving an SGLT-2 inhibitor had a prior diagnosis of renal failure, which is concerning as these are either contraindications or precautions for use. In terms of safety, 11.2% of members taking a DPP-4 inhibitor and 8.5% of those receiving a GLP-1 agonist had new onset renal failure, which is a potential adverse signal As predicted, urinary tract infections in both men and women were high in those receiving an SGLT-2 inhibitor; however, these estimates are much lower than what is reported within clinical trials. Recommendations: Utilization of the second-generation diabetes agents is low particularly when considering the most recent ADA guidelines and the robust evidenced in the published literature. However, in members prescribed these agents, several had contraindications prior to receiving therapy. To this end, we recommend an educational intervention through the provider newsletter highlighting the most recent ADA guidelines, the newer indications for the SGLT-2 inhibitors in HFrEF as well as appropriate use of the second-generation agents. In light of published data and the ADA recommendations, consideration should be given to relaxing the PDL criteria for preferred GLP-1 agonists in patients with either HFrEF and/or ASCVD. This is currently in place for the SGLT-2 inhibitors. CLINICAL MODULE 2: CHARACTERIZATION OF NALOXONE USE WITHIN HEALTH FIRST COLORADO MEMBERS PRESCRIBED OPIOIDS (Delivered March 2021) Objective 1: Identify and describe members filling prescriptions for opioids. Outcomes: There were 46,173 members identified as having filled an opioid between July 1, 2020 and September 30, 2020. Of members with an opioid fill, 3,474 (7.5%) also had a naloxone fill within the lookback or study period. Members were more often female among both groups that filled (62.3%) and did not fill (63.5%) naloxone. The largest age group among opioid users that did not fill naloxone was age 18-35 years while opioid users that filled naloxone were older, with the largest age group being members age 51-65 years. The majority of members were white (45.9%) or of multiple race/ethnicities (38.3%). Naloxone fills most frequently occurred (74.8%) prior to member fill of an opioid. Nearly 22% of naloxone fills were identified as having been prescribed by a pharmacist. Among those members receiving naloxone, the majority (64.9%) had an opioid fill with an MME between 0 and 120. Within the highest MME group, or among those members with an MME greater than 200, naloxone was filled by 42.9% of members within the lookback period.

State	Innovative Practices Summary
	Objective 2: Describe naloxone utilization before and after the recent FDA Drug Safety Communication. Outcomes: A total of 1,269 unique naloxone fills were identified in the nine weeks before the announcement and 1,381 unique naloxone fills were identified in the nine weeks after the FDA Drug Safety Communication. Both prior to and following the safety communication, naloxone was more frequently prescribed by a provider other than a pharmacist. Objective 3: Identify and describe members at high risk for opioid overdose Outcomes: A total of 73,820 members were identified as being at high risk for an opioid overdose and of these members only 6.9% filled naloxone within the lookback or study period. 5,530 members were identified as being at high risk due to concomitant use of an opioid with either a benzodiazepine or a skeletal muscle relaxant; over 73% of these members had a least a 30 day overlap of fills with an opioid and a skeletal muscle relaxant. Among members with concomitant use of an opioid and other high-risk drugs, 41% of members with an MME greater than 200 filled naloxone within the lookback period. Opioid withdrawal therapy was identified among 5,456 members of which 23.4% also filled naloxone. High risk members were most frequently identified though substance misuse diagnoses at a medical encounter, with 69,689 high risk members identified. Members with an opioid or poisoning related substance misuse diagnosis filled naloxone more frequently (14.5% among members with opioid misuse and 14.1% among members with poisoning related misuse) than members with encounters for other forms of substance misuse (3.3% among members with alcohol misuse and 3.5% among members with cannabis misuse). Objective 4: Describe health service utilization by members with and without fills for a naloxone prescription. Outcomes: There were 46,173 members eligible for inclusion in Objective 4, and of these members 3,474 had a naloxone fill. Among those members with a naloxone fill, the mean number of all-cause inpatient visits was 0.74 (median=0, range=0-24), the mean number of substance misuse inpatient visits was 0.03 (median=0, range=0-7), the mean number of all-cause emergency visits was 3.31 (median=1, range=0-75), and the mean number of substance misuse emergency visits was 0.29 (median=0, range=0-56). Among those members without a naloxone fill, the mean number of all-cause inpatient visits was 0.34 (median=0, range=0-30), the mean number of substance misuse inpatient visits was 0.01 (median=0, range=0-11), the mean number of all-cause emergency visits was 1.94 (median=1, range=0-169), and the mean number of substance misuse emergency visits was 0.14 (median=0, range=0-87). A fill of naloxone was associated with significantly higher odds of having an all-cause inpatient stay (OR: 1.77; 95% CI: 1.64, 1.91) or a substance misuse inpatient stay (OR: 2.18; 95% CI: 1.67, 2.85) when compared to those members without a naloxone fill. Additionally, a naloxone fill was associated with a significantly higher odds of both all-cause emergency visits (OR: 1.55; 95% CI: 1.44, 1.67) and substance misuse emergency visits (OR: 2.32; 95% CI: 2.08, 2.60). There were 13,237 members identified as having an opioid fill with an MME </= 120, and of these members 2,254 had a naloxone fill. Among these members with an MME </= 120, a fill of naloxone was associated with significantly higher odds of having an all-cause inpatient stay (OR: 1.55; 95% CI: 1.40, 1.73) or a substance misuse inpatient stay (OR: 2.13; 95% CI: 1.39, 3.28) when compared to those members without a naloxone fill. Additionally, a naloxone fill was

State	Innovative Practices Summary
	associated with a significantly higher odds of both all-cause emergency visits (OR: 1.52; 95% CI: 1.38, 1.67) and substance misuse emergency visits (OR: 1.72; 95% CI: 1.44, 2.06). There were 1,066 members identified as having an opioid fill with an MME exceeding 120, and of these members 398 had a naloxone fill. Among these members with an MME > 120, a fill of naloxone was associated with significantly higher odds of having an all-cause inpatient stay (OR: 1.51; 95% CI: 1.15, 1.99) when compared to those members without a naloxone fill. A naloxone fill was also associated with a significantly higher odds of both all-cause emergency visits (OR: 1.60; 95% CI: 1.24, 2.07) and substance misuse emergency visits (OR: 1.64; 95% CI: 1.01, 2.67). There was no significant association between substance misuse inpatient stays and having filled naloxone among members with an MME > 120. Discussion: Based on our inclusion criteria, a total of 46,173 members were identified as having filled an opioid between July 1, 2020 and September 30, 2020. Of members with an opioid fill, 3,474 (7.5%) also had a naloxone fill within the lookback or study period. The majority of naloxone was not prescribed by a provider other than a pharmacist (78%), typically occurred prior to filling their opiate (75%), and in the setting of an MMEE of 0-120 mg (65%). The number of naloxone fills has increased since the FDA Drug Safety Communication Letter, the majority of which were filled by a provider other than a pharmacist. Based on our definition of high-risk members, a total of 73,820 members were identified as being at high risk for an opioid overdose and of these members only 6.9% filled naloxone within the lookback or study period. Opioid withdrawal therapy was identified among 5,456 members of which 23.4% also filled naloxone. Members with an opioid or poisoning related substance misuse diagnosis filled naloxone more frequently (14.5% among members with opioid misuse and 14.1% among members with poisoning related misuse) than members with encounters for other forms of substance misuse (3.3% among members with alcohol misuse and 3.5% among members with cannabis misuse). When addressing health service utilization, a fill of naloxone was associated with significantly higher odds of having an all-cause inpatient stay (OR: 1.77; 95% CI: 1.64, 1.91) or a substance misuse inpatient stay (OR: 2.18; 95% CI: 1.67, 2.85) when compared to those members without a naloxone fill. Additionally, a naloxone fill was associated with a significantly higher odds of both all-cause emergency visits (OR: 1.55; 95% CI: 1.44, 1.67) and substance misuse emergency visits (OR: 2.32; 95% CI: 2.08, 2.60). When stratified by MME, members with an MME > 120 and a fill of naloxone was associated with significantly higher odds of having an all-cause inpatient stay (OR: 1.51; 95% CI: 1.15, 1.99) when compared to those members without a naloxone fill. A naloxone fill was also associated with a significantly higher odds of both all-cause emergency visits (OR: 1.60; 95% CI: 1.24, 2.07) and substance misuse emergency visits (OR: 1.64; 95% CI: 1.01, 2.67).

State	Innovative Practices Summary
	Recommendations: While utilization of naloxone in members receiving opiates has increased, the percentage of members who truly warrant the drug (e.g., high risk for opiate high overdose or MME > 120 mg) remains low. To this end, we suggest a don't forget the naloxone campaign either through letters or the prescribers' newsletter highlighting the need for naloxone prescribing in high risk individuals. Additionally, naloxone prescribing was not initiated by a pharmacist. While pharmacists in the community are ideally situated to address naloxone utilization, many pharmacists may either not feel comfortable or are aware of current health policy surrounding prescribing. To address this issue, we suggest creation of a health policy newsletter to all pharmacies specifically detailing who and how to prescribe naloxone. CLNIICAL MODULE 3: OPIOID UTILIZATION AMONG HEALTH FIRST COLORADO MEMBERS WITH MIGRAINE OR EPISODIC CLUSTER HEADACHES (Delivered June 2021) Objective 1: Identify and describe members with migraine or episodic cluster headache diagnoses. Outcomes: There were 23,750 members identified as having at least one migraine diagnosis and 113 members with an ECH diagnosis between April 1, 2019 and March 31, 2021. Members with migraine or ECH diagnoses were more often female (78.1% and 50.4%, respectively). The largest age group among members with either migraine or ECH diagnoses was 18-35 years. Pediatric members (age < 18 years) were identified in both headache diagnosis groups, with 19.7% of the migraine group and 15.9% of the ECH group being under 18 years of age at the time of the member's index headache diagnosis. Nearly half of members with headache diagnoses were white (42.5-44.0%). Objective 2: Describe medication and health service utilization by members with and without opioid fills. Outcomes: There were 19,067 adult members with migraine diagnoses and 95 adult members with ECH diagnoses eligible for inclusion in Objective 2. Of these adult members, 2,778 migraine members and 12 ECH members had a naive opioid fill during the 180 days following their index headache diagnosis. There were 4,683 pediatric members with migraine diagnoses and 18 pediatric members with ECH diagnoses eligible for this objective. Among the pediatric members, 234 migraine members and no ECH members had a naive opioid fill following their headache diagnosis. Among adult members with a migraine diagnosis, an opioid fill was associated with significantly higher odds of having also filled prophylactic medications (fill before diagnosis - OR: 1.73; 95% CI: 1.59, 1.90; fill after diagnosis - OR: 1.78; 95% CI: 1.64, 1.93) and abortive medications (OR: 2.78; 95% CI: 2.56, 3.03) when compared to those members without an opioid fill. There were no significant associations among any medication utilization outcomes and having filled an opioid among adult members with an ECH diagnosis. Among adult members with a migraine diagnosis, an opioid fill was associated with significantly higher odds of having an all-cause inpatient stay before migraine diagnosis (OR: 1.25; 95% CI: 1.06, 1.48) or after diagnosis (OR: 3.06; 95% CI: 2.75, 3.41) when compared with those members without an opioid fill. Additionally, an opioid fill was associated with a significantly higher odds of an all-cause emergency department visit (before diagnosis - OR: 1.51; 95% CI: 1.39, 1.63; after

State	Innovative Practices Summary
	diagnosis - OR: 2.19; 95% CI: 2.02, 2.38) among adult migraine members. There was no significant association between having filled an opioid and having a migraine related ED visit. There were also no significant associations between any health service utilization outcome and having filled an opioid among adult members with an ECH diagnosis. Among pediatric members with a migraine diagnosis, an opioid fill was associated with significantly higher odds of having also filled an age inappropriate prophylactic medication at any time (OR: 4.06; 95% CI: 3.11, 5.30) or abortive medication at any time (OR: 1.92; 95% CI: 1.46, 2.52) compared with those members without an opioid fill. There were no opioids filled among pediatric ECH members, thus tests of association are unavailable for this age and headache group. Among pediatric members with a migraine diagnosis, an opioid fill was associated with significantly higher odds of having an all-cause inpatient stay both before migraine diagnosis (OR: 3.87; 95% CI: 2.00, 7.49) and after diagnosis (OR: 4.11; 95% CI: 2.49, 6.77) when compared with those members without an opioid fill. Additionally, an opioid fill was associated with a significantly higher odds of an all-cause emergency visit before migraine diagnosis (OR: 1.53; 95% CI: 1.17, 1.99) and after diagnosis (OR: 2.20; 95% CI: 1.69, 2.87) among pediatric migraine members. Objective 3: Describe opioid utilization among members with migraine or ECH diagnoses. Outcomes: For the 2,790 adult members with a headache diagnosis and at least one opioid fill, the mean number of opioid days covered per member was 11.74 (standard deviation = 20.5, median = 6). Among the 234 pediatric members with a headache diagnosis and at least one opioid fill, the mean number of opioid days covered per member was 5.36 (standard deviation = 2.67, median = 5). The average MME for adult members with at least 30-days supplied of an opioid was 35.46 (standard deviation=25.37, median = 31). No pediatric members with a headache diagnosis had at least 30 days supplied in order for MME to be calculated. Abortive medication use was more common (64.9%) than prophylactic use (30.5%). Mean opioid days covered were significantly higher for adult members taking a prophylactic medication compared to those not taking a prophylactic medication (p-value < 0.0001); there was no significant difference for abortive medication use. Mean days to opioid fill were significantly higher for members taking a prophylactic medication compared to those not taking prophylactic medications (p< 0.05), and for those taking an abortive medication compared to members not taking an abortive medication (p < 0.0001). There were no significant differences in average MME when comparing prophylactic medication users to non-users, or when comparing abortive medication users to non-users. Similar to among adults, abortive medication use was more common (73.1%) than prophylactic use (18.8%). Opioid days covered were significantly higher among pediatric members taking an abortive medication compared to those not taking an abortive medication (p < 0.05). There were no other significant differences in utilization measures. Note there were no pediatric members with at least 30 days supplied of an opioid so MME could not be calculated. Also note that no pediatric members had an ECH diagnosis and at least one opioid fill, so all 234 members included in this objective had a migraine diagnosis. NSAIDs and triptans were used by more than half of adult and pediatric members, with 73% of the pediatric group using NSAIDs and 59% of the adult members using NSAIDs. Antiemetics were used by approximately 20% of adult and pediatric members. Other abortive medications were rarely filled. Objective 4: Describe opioid utilization before and after emergence of SARS-CoV-2.

State	Innovative Practices Summary
	Outcomes: A total of 2,012 members with a migraine diagnosis and 6 members with an ECH diagnosis were identified as having filled an opioid in the 12 months before the emergence of SARS-CoV-2 (April 2020). In the 12 months following, 1,058 members with a migraine diagnosis and 7 members with an ECH diagnosis were identified as having filled an opioid. An interrupted time series analysis indicated that while the slope for the number of members filling in opioid was not statistically significant during the 12 months prior to April 2020, the slope significantly changed after April 2020, with the number of members with a migraine who were filling an opioid decreasing by 22.14 per month ($p < 0.05$). There was also a statistically significant change in the number of claims for an opioid among members with migraine. The number of opioid fills increased by 10 per month prior to April 2020 but decreased by 27 per month after April 2020 ($p < 0.01$). There were no significant time trends for members with ECH. Discussion: We identified 23,750 members with at least one migraine diagnosis and 113 members with an ECH diagnosis during the study period; we restricted this cohort to members with no opioid fills during the six months prior to their earliest headache diagnosis during the study period. The majority of members with a migraine diagnosis were between 18-35 years of age (38%), White (44%), and female (78%). Of members with migraine, 13% filled an opioid during the study period. In terms of ECH, the demographics were similar to that of members with migraines with the exception of gender, which was more evenly distributed (50% male/50% female); 11% filled an opioid during the study period. For pediatric patients, the majority of members were between 12-17 years of age for migraine (70%) and ECH (50%). Among both adult and pediatric members with a migraine diagnosis, an opioid fill was associated with significantly higher odds of having also filled a prophylactic migraine medication before and after migraine diagnosis, as well as abortive therapy when compared with those members without an opioid fill. Independent of when the member's migraine was diagnosed, an opioid fill was associated with a significantly higher odds of an all-cause emergency department visits and all-cause inpatient admissions for both adult and pediatric members when compared to members who did not fill an opioid. Opioid days covered and days to opioid fill were significantly larger for adult members with migraine/ECH who filled a prophylactic medication compared to those who had not, while only days to opioid fill was significantly larger for members who filled an abortive medication compared to those who had not. Opioid days covered was significantly larger for pediatric members with migraine who filled an abortive medication compared to those who had not; no other comparison for pediatric members with a migraine were statistically significant. There was a significant temporal trend in the number of members with a migraine diagnosis filling an opioid after the emergence of SARS-CoV-2 in which the slope significantly changed after April 2020, with the number of members with a migraine who

State	Innovative Practices Summary
	were filling an opioid decreasing by 22.14 per month ($p < 0.05$). There was also a statistically significant change in the number of claims for an opioid among members with migraine. Available evidence strongly suggests that opioids are not as effective as other medications for migraine, and they should not be used for the treatment of migraine. There is no evidence to support the use of opioids in children with migraine. Alternative acute and preventive agents should always be explored. Medications used to treat migraine should be selected to provide the best balance of efficacy, side effects and patient preference. Recommendations: Overall, compared to the estimates in the literature, the percentage of adult Health First Colorado members who filled an opioid at any time and had a migraine diagnosis was lower than the national average (28% vs 30%, respectively). However, we believe this estimate could be lower. With this in mind, additional prior authorization criteria be put in place to either deny opiate fills for migraine or significantly limit the number of opioid tablets a member can fill for abortive therapy. The number of pediatric patients utilizing opioids within this population is alarming, as well as the use of inappropriate abortive migraine therapy. First, we suggest discussing this issue with our pediatric and neurology providers on the DUR board to explore appropriateness. Second, based upon our findings, we can develop prior authorization criteria to limit or curtail use. Due to the stop measures put in place by the Department, overall utilization of opioids did not increase within the COVID time period. CLINICAL MODULE 4: HEMOPHILIA AND ASSOCIATED TREATMENT AMONG HEALTH FIRST COLORADO MEMBERS (Delivered September 2021) Objective 1: Identify and describe members with hemophilia (Type A, Type B, or both). Outcomes: There were 273 members with a hemophilia type A diagnosis, 57 members with a hemophilia type B diagnosis, and <30 members with both diagnoses during the study period (January 1, 2018 - March 31, 2021). The average age of members with hemophilia ranged from 24 years in the group with both type A and type B diagnoses during the study period to 33 years in the group with a type A diagnosis. Half of the members with both type A and type B hemophilia were age 0-17 years and 40% of the members with type B were age 0 - 17 years; age was more evenly distributed across ages 0 - 50 years among the members with type A hemophilia. Nearly all members (91%) with both a type A and type B diagnosis were male, while gender was more evenly distributed among members with only a type A or a type B diagnosis. The majority of members in each group reported White or multiple races. Objective 2: Describe hemophilia treatment utilization by hemophilia type. Outcomes: Among members with hemophilia type A, Advate was the most commonly filled Factor XIII product (19.4%), with 28.9% of members with hemophilia type A filling a Factor XIII product overall. Benefix was the most commonly filled Factor IX product among members with hemophilia type B (21.1%), with 33.3% of these members filling a Factor IX

State	Innovative Practices Summary
	product overall. Factor IX products were commonly filled by members with hemophilia type A and type B (68.2%). Hemlibra was filled by 11.7% of members with hemophilia type A, and by 13.6% of members with both hemophilia type A and type B. Amicar was more commonly filled by members with both hemophilia type A and type B (13.6%) than members with only type A (8.8%) or only type B (1.75%). The mean number of claims for a Factor XIII product among members with hemophilia type A was 4.9 (SD=24.9, median=0); for Advate specifically, the mean number of claims per member was 3.1 (SD=24.2, median=0). Factor IX products were filled more frequently by members with both hemophilia type A and type B (mean=11.9 (SD=16.5), median=2) than by members with only hemophilia type B (mean=2.3 (SD=5.6), median=0). Hemlibra was filled more frequently by members with both hemophilia type A and type B (mean=3.46 (SD=9.2), median=0) than by members with only hemophilia type A (mean=1.8 (SD=6.2), median=0). Among members with hemophilia type A, 74% of claims for all hemophilia treatments were filled through a pharmacy benefit rather than medical benefit, meaning they were self-administered. Among members with type B and with both type A and type B, nearly all claims for a hemophilia treatment were filled through a pharmacy benefit rather than medical benefit (98.5% and 98.7%, respectively). The mean number of claims for these treatments under a pharmacy benefit ranged from 2.3 claims (SD=5.5, median=0) for members with hemophilia type B to 16.9 claims (SD=18.1, median =7.5) for members with both type A and type B. There were fewer claims filled through a medical benefit across all types of hemophilia: the mean number of claims for these treatments under a medical benefit ranged from 0.04 claims (SD=0.26, median=0) for members with hemophilia type B to 1.81 claims (SD=23.7, median = 0) for members with hemophilia type A. Switching from one hemophilia treatment to another was most common among members with both hemophilia type A and type B: 36% of these members had at least one medication switch, while 17% of members with hemophilia type A had at least one switch and only 3% of members with hemophilia type B had at least one switch. The mean number of switches per-patient ranged from 0.04 (SD=0.19, median = 0) among members with hemophilia type B to 3.1 (SD=5.64, median = 0) among members with both hemophilia type A and type B. Objective 3: Describe health care utilization and clinical outcomes among members with hemophilia type A using Hemlibra and members not using Hemlibra. Outcomes: We identified 247 members with a hemophilia Type A diagnosis and at least six months of enrollment following their earliest hemophilia diagnosis. The majority (n=221; 89%) had not filled Hemlibra during the study period. Outpatient visits were common, with 81%-92% of members having at least one outpatient visit during the six-month follow-up. More than half (54%) of the members who had not filled Hemlibra had at least one ED visit (mean=0.34, SD=0.82, median=0), while 35% of members who had filled Hemlibra had at least one ED visit (mean=0.08, SD=0.39, median=0). Few members who filled Hemlibra had at least one inpatient stay (3.8%), though more frequent among members who had not filled Hemlibra (24%). Approximately 20% of the members filled a Factor VIII product and approximately 30% had a bleeding event during the six-month follow-up. Systematic embolism occurred among 20.36% of members without a Hemlibra fill (mean=1.00, SD=3.38, median=0) and was rarely observed among Hemlibra users (3.85%, mean=0.08, SD=0.39, median=0). In terms of outcomes pre and post Hemlibra approval in members with hemophilia type A diagnosis, type B diagnosis, or both during the study period (n=352), we saw a steady increase in outpatient visits following Hemlibra approval with a downward trend post-COVID. Prior to COVID and after Hemlibra approval, factor VIII fills,

State	Innovative Practices Summary
	inpatient visits, and ED admissions remained consistent over time. When considering just patients who had at least one Hemlibra fill (N=35), we saw a sharp increase in Hemlibra fills after its approval with a decreasing trend in Factor VIII fills, inpatient visits and ED admissions but an increase in outpatient visits prior to COVID. Discussion: Over the past thirty years, the evolution of pharmacotherapy for the treatment of hemophilia has significantly changed from administration of recombinant factor replacement, to bypass therapy with non-factor replacement, and in the very near future gene therapy. While the newer therapies (i.e., Hemlibra) have been shown to have lower bleeding and are more convenient, they do come at a very high cost to the state. Within our analysis, we identified 273 members with a hemophilia type A diagnosis, 57 members with a hemophilia type B diagnosis, and <30 members with both diagnoses during the study period (January 1, 2018 - March 31, 2021). The majority of patients with hemophilia type A were male (55%) ranging in age from 0-35 years (54%); for hemophilia type B, the majority were female (51%) with 40% being between the ages of 0-17 years; and for both hemophilia type A and B, the majority were male (90%) between the ages of 0-17 years (50%). Among members with hemophilia type A, Advate was the most commonly filled Factor XIII product (19.4%), with 28.9% of members with hemophilia type A filling a Factor XIII product overall. Benefix was the most commonly filled Factor IX product among members with hemophilia type B (21.1%), with 33.3% of these members filling a Factor IX product overall. Factor IX products were commonly filled by members with hemophilia type A and type B (68.2%). Hemlibra was filled by 11.7% of members with hemophilia type A, and by 13.6% of members with both hemophilia type A and type B. Amicar was more commonly filled by members with both hemophilia type A and type B (13.6%) than members with only type A (8.8%) or only type B (1.75%). Switching from one hemophilia treatment to another was most common among members with both hemophilia type A and type B: 36% of these members had at least one medication switch, while 17% of members with hemophilia type A had at least one switch and only 3% of members with hemophilia type B had at least one switch. Clinically, this is not uncommon as this may be reflective of specific factor availability and number of weight-based units needed. It is important to highlight that units will vary not only between but among brands name products. In terms of healthcare utilization, we identified 247 members with a Type A hemophilia diagnosis (with or without type B) and at least six months of follow-up after their earliest hemophilia diagnosis. Fewer members who filled Hemlibra had at least one inpatient stay (3.8%) compared to members who had not filled Hemlibra (24%). Approximately 20% of the members filled a Factor VIII product during the six-month follow-up. Hemlibra has been extensively studied through HAVEN trials with included pediatric and adult patients with hemophilia A with and without inhibitors. Across all of these studies, patients receiving Hemlibra had a significant reduction in annualized bleeding rates with minimal to no thrombotic events. In 2018, the Institute for Clinical and Economic Review

State	Innovative Practices Summary
	issued their final report evaluating Hemlibra for hemophilia A with inhibitors. Compared to no prophylaxis or bypassing prophylaxis, Hemlibra offered improved health outcomes and overall cost savings, both from a health system perspective considering only direct medical costs, and from a societal perspective considering broader benefits. In 2020 ICER released their final report for Hemlibra for hemophilia A without inhibitors. They recommended that payers should cover factor VIII prophylaxis at levels adequate to achieve higher troughs than the 1% level used in the past. In addition, considering the evidence of equivalent-to-improved comparative effectiveness, patient preference, and lower overall cost, payers should work with clinicians and patients to encourage the use of Hemlibra over factor VIII for prophylaxis, unless it is contraindicated. Based upon our preliminary findings, the overall clinical evidence, and the ICER reports, Hemlibra appears to offer a high value but at a high cost. Recommendations: As this module was a larger descriptive overview of our Health First members with hemophilia, we would suggest conducting a safety analysis to specifically evaluate if adverse bleeding events and their associated costs are lower for those who are currently utilizing Hemlibra for prophylaxis compared to other recombinant factor replacement. PAIN MANAGEMENT and CHILD/ADOLESCENT PSYCHOLOGY CONSULTATION SERVICES The Colorado DUR Program provides peer-to-peer telephone consultations with physicians in two different specialties: Child and Adolescent Psychiatry and Pain Management Enrolled providers for Health First Colorado are qualified to use these services. A consultation may occur if a member meets certain criteria established by the Department and an evaluation is triggered by the pharmacy benefits manager (PBM). Enrolled providers may also request a consultation through the PBM. 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. This letter, based in part on the July 2020 FDA Drug Safety Communication (https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone-all-patients-when-prescribing-opioid-pain), alerts prescribers to patients are taking opioids at a cumulative dose of MME > 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 has 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 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

State	Innovative Practices Summary
	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, Type 2 diabetes or asthma) plus at least 10 distinct prescription medication claims per quarter. 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, therapeutic drug monitoring requirements, etc.) and summary letters are mailed to both the 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 Approvals and Safety Reports at quarterly DUR Board meetings, prepare RetroDUR provider education letters for mailing each quarter, contribute articles to DUR Newsletters, and manage the technical aspects of virtual Board meetings.
Connecticut	Retrospective DUR Innovative Practices Pediatric Reviews There are approximately 950,000 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 2021 include; Patients who are diagnosed with poisoning or overdose and continue to receive controlled substance prescriptions, overutilization of zolpidem, triple antipsychotic therapy, overutilization of cyclobenzaprine, underutilization of lipid lowering agents, underutilization/nonadherence reviews (metformin, beta blockers, angiotensin receptor blockers, and calcium channel blockers), the use of atypical antipsychotics in the elderly, use of benzodiazepines in the elderly, underutilization of antidepressants, medication use in renal impairment, atypical antipsychotic use in diabetic patients, SUPPORT Act criteria concurrent opioids and benzodiazepines. Adult Reviews Adult drug utilization review has been the foundation of the RDUR program in Connecticut. Select topics of review during FFY 2021 for the adult population included; Pediatric

State	Innovative Practices Summary
	psychotropic medication monitoring for SSRIs, underutilization/nonadherence reviews (antidepressants, antipsychotics, anticonvulsants), inappropriate pediatric therapy, overutilization of stimulants and therapeutic duplication of long acting ADHD medications, review of antihistamine and steroid criteria, medications that cause additive sedation or respiratory depression, opioid use in the pediatric population (codeine and tramadol), stimulant use in patients with comorbid anxiety, risks associated with use of atypical antipsychotics in the pediatric population, therapeutic duplication of antidepressants. 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 2021 During December 2020, the DUR Board approved a newsletter covering migraine epidemiology, etiology, diagnosis, and treatments - old and new. In tandem with the newsletter targeted interventions were performed in the adult population for overutilization of acute migraine medication treatment. During January 2021, 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 918 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 446 of the 918 recipients intervened on continued to receive chronic opioid therapy without naloxone who were at risk for overdose, resulting in 51% of patients responding positively to the intervention. During March 2021, the DUR Board approved a newsletter focusing on the skeletal muscle relaxants. This newsletter was sent to all enrolled CT Medicaid providers, in tandem with a targeted intervention for the overutilization of cyclobenzaprine. During this intervention 911 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 442 of the 911 recipients intervened on continued to overutilize cyclobenzaprine, resulting in 51% of patients responding positively to the intervention. During February 2021, targeted RDUR interventions were performed on the pediatric population which reviewed underutilization of antidepressants, antipsychotics, and anticonvulsants. During this intervention 409 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 11 of the 409 recipients intervened on continued to be nonadherent, resulting in 97% positive response to the intervention. During June 2021, the DUR Board approved a newsletter covering new frontiers in treatment resistant depression. This newsletter was sent to all enrolled CT Medicaid

State	Innovative Practices Summary
	providers, in tandem with a targeted intervention for the underutilization of antidepressants. During this intervention 685 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 25 of the 685 recipients intervened on continued to underutilize their antidepressant, resulting in 96% of patients responding positively to the intervention. During July 2021, a targeted RDUR intervention was performed which reviewed opioid use in the pediatric population, specifically codeine and tramadol use. During this intervention 115 unique recipients were targeted, and their prescribers received intervention letters. We are currently awaiting the results of any potential changes in behavior based on our intervention, expected to be reported during February 2022. During September 2021, the DUR Board approved a newsletter covering schizophrenia and the second generation antipsychotics (SGAs). In tandem with the newsletter targeted interventions were performed in both the adult and pediatric populations reviewing appropriate use of SGAs. Prospective DUR Innovative Practices Established during FFY 2021 During FY2021, the Connecticut Medical Assistance Program (CMAP) established a diabetic supplies program under the pharmacy benefit. This new program established a preferred diabetic supplies product listing and enabled the CMAP program to contract with manufacturers of these diabetic supplies for supplemental rebates on products with preferred status. The categories of products included for implementation included blood glucose monitors, testing strips, lancets, blood glucose monitoring control solutions, syringes, and pen needles. Collecting these rebates on these products provides yet another cost savings method within the pharmacy benefit. Additionally, CMAP also implemented an enhancement on pharmacy claim denials for non-preferred products. Pharmacy point of sale (POS) claims that are denied due to the NDC on the claim being non-preferred now return in the denial message what preferred options are available. It is thought that the information contained in the denial could be leveraged by the pharmacy and that the information on what preferred alternatives available would be shared with the prescribing provider. Ultimately, the change was implemented to help with formulary compliance and cost savings by steering a provider to an alternative preferred agent if medically appropriate. CMAP continued to support the Public Health Emergency (PHE) by supporting coverage and administration reimbursement for COVID-19 vaccines administered via pharmacy. This included the necessary changes in reimbursement fees and modifications of pharmacy audits limiting the number of Covid-19 vaccinations a client could receive in a given time period to support new information and guidance with respect to additional/booster doses. Due to the expiration of State executive orders that had been made effective due to the PHE, many of the restrictions such as early refill percentage thresholds and maximum days supplies on prescription drugs were reverted to that of a pre-PHE status.

State	Innovative Practices Summary
Delaware	Delaware added continuous glucose monitors to the Preferred Drug List, without requiring a prior authorization, which will expand the monitoring options for diabetics and improve the quality of their care. In order to remove any financial barriers to Medication Assisted treatment of Opioid Use Disorder, Delaware has removed all co-pays for all drugs in this category. Reminders that naloxone is available at local pharmacies without co-pay have also been sent to providers to encourage dispensing these products to anyone at risk of opioid overdose. In compliance with the Support Act, Delaware monitors and manages the appropriate use of antipsychotic medications by children enrolled under the State plan, there is an on-going initiative to collaborate with the Department of Public Health (DPH) and Department of Services for Children, Youth, and their Families (DSCYF). A Clinical Pharmacist reviews patient medication protocols 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 had received the help they needed instead of assignment to a nonproductive punitive lock in period. Feedback from prescribers, pharmacists and beneficiaries has been mostly positive with the recognition of the extensive preliminary review and mitigation process that precedes a pharmacy lock-in decision. 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.

State	Innovative Practices Summary
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. 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	N/A

State	Innovative Practices Summary
Idaho	As background, Idaho Medicaid has a 100% fee-for-service pharmacy benefit and we manage our own on-site prior authorization pharmacy call center. In addition to point-of-sale (POS) pharmacy prior authorizations, our clinical staff also sets up criteria and performs prior authorizations on many physician-administered drugs covered through the medical benefit. Idaho implemented Medicaid Expansion in January 2020. As a result of Medicaid Expansion and the COVID-19 public health emergency maintenance of effort, Idaho Medicaid's population has grown by over 100,000 adult participants and is now well over 400,000. We have as a result seen an increase in drug utilization in general, and especially in the number of participants needing Hepatitis C drugs, HIV drugs, and opioids, which has challenged our small in-house staff. Although we have had little increase in staff to deal with expanded drug utilization, we have been able to collaborate with our Division of Public Health's Drug Overdose Prevention Program (DOPP) to hire two contract pharmacists using DOPP grant funding to focus opioids, benzodiazepines, and opioid use disorder treatments. This collaboration has not only freed up our in-house clinical staff pharmacists to focus on other significant drug problem utilization areas, but has really expanded our team's expertise in safe opioid prescribing. Our DOPP contract pharmacists have developed a standardized prior authorization form with prompts to guide best practice opioid prescribing. This form is educational and includes guidelines outlining the place of opioids in therapy and provides links to resources for safe opioid prescribing and tapering guidelines. This standardized form also prompts naloxone co-prescribing and includes a provider attestation form and signature field. The attestation form asks prescribers to confirm that the PDMP has been accessed, an opioid treatment agreement is in place, concurrent non-opioid and non-drug pain treatment is part of the treatment plan, and that urine drug screens are being done and evaluated. The form has also served as a starting point for our contract pharmacists to engage in one-on-one education with providers, similar to that provided through an academic detailing program. In addition to collaborating with the Division of Public Health's DOPP to hire two contract pharmacists to focus on safe opioid prescribing, the Idaho Medicaid's pharmacy program in Federal Fiscal Year 2021 laid the groundwork for a collaboration with the two Addiction Medicine Fellowships in town. Idaho Medicaid's Medical Director is Board-certified in Addiction Medicine and is on faculty with both Fellowships. She will host the fellows on a health systems rotation in Federal Fiscal Year 2022, that will include reviewing controlled substance prior authorizations as well as developing quality improvement projects related to safe opioid prescribing and increasing access to medications for opioid use disorder. Idaho Medicaid's innovative pharmacy program has facilitated significantly better pharmaceutical care for our participants as well as ensured the appropriate use of state financial resources.
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, clinically appropriate therapies. Illinois Medicaid routinely reviews processes to improve the care of Medicaid patients, maximize cost containment, and streamline operations.

State	Innovative Practices Summary
	Provider education is also a key part of facilitating appropriate therapeutic care. The following innovative practices are highlighted for FFY21. Illinois HFS opioid-related prospective edits based on SUPPORT for Patients and Communities Act (SUPPORT Act) were maintained during FFY21 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. In the second half of FFY21, the DUR Board initially reviewed naloxone utilization within HFS to identify extent of use via prescription or standing order. Change Healthcare's high opioid MME HFS report for the 4th quarter of 2020 and January 2021 was then used to identify one high-risk group that would benefit from naloxone availability. About a third of participants filling opioids at 50 MME or greater had filled a naloxone prescription ever. About 30% of the FFS and 40% of the MCO participants filling opioids 90 MME or greater had ever received naloxone. About a third of prescriptions overall were via a standing order from the Illinois Department of Public Health or the Walgreens Chief Medical Officer. The DUR Board determined need for prescriber outreach related to provision of naloxone for participants filling high MME opioids. Youth in the Care of the Department of Children and Family Services transitioned to the new managed care YouthCare program on September 1, 2020. Former Youth in Care participants had transitioned to YouthCare in February 2020. The YouthCare program provides active care coordination for behavioral health needs. During FFY21 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 medication use 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 prior authorization department continued monitoring adherence with hepatitis C, cystic fibrosis, and direct-acting anticoagulant therapies. During 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. During FFY21 HFS reinforced dispensing of 3-month supplies of allowed contraceptive drugs or supplies and reminded prescribers of emergency contraception pill (ECP) coverage as well as effective birth control counseling when ECP dispensed. Prescribers were reminded regarding coverage of blood pressure monitors. Due to the Chantix shortage, at the end of FFY21, HFS allowed coverage of imported apo-varenicline from Apotex for smoking cessation. At the end of FFY21, FFS and MCO prescribers were reminded regarding

State	Innovative Practices Summary
	timely access to covered treatment for mental, emotional, nervous, or substance use disorders or conditions. 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 report were maintained through FFY21 as the pandemic continued. During FFY21, HFS increased COVID-19 vaccine administration rates consistent with the Medicare vaccine administration rates and reimbursed pharmacies for administration of initial and booster doses based on electronic NCPDP claims for federally allocated COVID-19 vaccines. HFS also implemented the Uninsured COVID-19 Testing program. HFS reminded providers how vaccine administration should be billed if patients are uninsured. Transportation to receive vaccine administration was also a covered service. At the end of FFY21, prescribers were reminded that HFS does not cover off-label use of ivermectin for prevention or treatment of COVID-19 due to lack of FDA emergency authorization or approval for prevention or treatment of COVID-19. In the end of FFY21, HFS clarified that services rendered by Advanced Practice Nurses (APN) no longer needed to be billed under a collaborating physician's name and NPI, but rather should be billed with the APN name and NPI. Illinois ADVANCE (Academic Detailing Visits And New evidence CEnter) initiative. Illinois Public Act 101 0278 required establishment of an evidence- based, non-commercial education program for Medicaid prescribers consisting of web-based curriculum and academic educator outreach. This resulted in an HFS collaboration with the University of Illinois Chicago College of Pharmacy to provide academic detailing services in Illinois. During academic detailing clinical pharmacists meet one on one with prescribers for 15 to 20 minutes at their offices or via online video conferencing to provide unbiased, non-commercial, and current drug information while offering new tools, solutions, and support for Illinois Medicaid prescribers. The Illinois Advance Website provides continuing medical education (CME) 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 encourages appropriate prescribing also with their social media posts on LinkedIn, Facebook, and Twitter. During FFY21, FFS MRAD (Medication Review and Academic Detailing) and Prior Authorization clinical pharmacist staff continued virtual televisit academic detailing. Staff authored and edited materials used for prescriber education, authored frequently asked opioid- and diabetes-related questions for the website, and conducted outreach to inform state and county prescriber associations of Illinois ADVANCE services. During FFY21 Illinois ADVANCE launched Getting to the heart of Type 2 diabetes mellitus academic detailing that focuses on cardiorenal benefits of new anti-diabetic medication classes. Other academic detailing sessions continued to address the CDC Guideline for Prescribing Opioids for Chronic Pain, opioid alternatives, Illinois Prescription Monitoring Program's MyPMP feature, and opioid use disorder.

State	Innovative Practices Summary
	During FFY21, HFS began researching the 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.
Indiana	On November 1, 2009, the fee-for-service (FFS) pharmacy program implemented an automated prior authorization (PA) tool known as SmartPA. On May 24, 2013, OptumRx (previously known as Catamaran) became the pharmacy benefit manager and implemented SilentAuth. SilentAuth is an automated PA tool that executes real-time prior authorization decisions by utilizing highly sophisticated clinical PA edits supported by the member's medical profiles and pharmacy claims data. This results in quicker PA determinations for Medicaid members, with less intervention on the part of both the pharmacy and the prescribing provider. On May 24, 2013, OptumRx 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, three new interventions were implemented to address the utilization of hepatitis C agents and SVR rates, naloxone use in patients utilizing opioid therapy, and blood glucose monitoring in patients on insulin therapy. On July 1, 2021, the FFS pharmacy program in collaboration with the managed care organizations, implemented prior authorization criteria to address long-term benzodiazepine use in new starts. The criteria limit the utilization of benzodiazepine therapy and the dose of initiation. The criteria were added to the already existing criteria around duplicate therapy and concomitant use with opioid therapy. In response to low rates of metabolic monitoring in patients on antipsychotic therapy, the FFS pharmacy program implemented additional prior authorization criteria to include requirements for metabolic monitoring within the past year. On May 1, 2021, the criteria were automated to evaluate medical claims data to determine if a CPT code associated with metabolic monitoring had been processed within the past year. If present and other criteria are met, the claim processes at point-of-sale automatically.
Iowa	N/A
Kansas	We are continuing to work on improving our DUR program, but have no innovative practices that were implemented in FFY 2021.
Kentucky	During Federal Fiscal Year 2021, the Kentucky Medicaid Program made the following programmatic changes. 1. Expanded access to prenatal vitamins with an autoPA to include women of childbearing age (15-60 years old) in addition to pregnant or lactating females and patient's with chronic wasting or chronic malabsorption conditions. 2. Due to the spike in respiratory syncytial virus cases, the Kentucky Medicaid Program extended the 2021 Synagis season to start in August to allow for early access. 3. 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. 2. The P&T committee reviewed new drugs to market in various classes, such as Antiemetic/Antivertigo Agents, HIV/AIDS, Glucagon agents, Multiple Sclerosis agents, Bladder relaxants, Antifungals, and oral oncology, and DMS developed utilization management measures to ensure appropriate use.

State	Innovative Practices Summary
Louisiana	Louisiana did not initiate innovative practices in FFY 2021.
Maine	ATTACHMENT 6 - INNOVATIVE PRACTICES NARRATIVE 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. 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. COVID-19 Pandemic Initiative To ensure MaineCare members had access to the medications they needed, for the duration of the COVID-19 emergency, MaineCare in collaboration with the DUR committee instituted the following changes to provide access during a difficult and uncertain time. Waiving copays for prescriptions (excluding Maine Rx Plus and DEL programs). Early refill Currently, MaineCare members can get up to a 34-day supply of brand medications. Submission Clarification Code 13 (SCC 13): MaineCare is allowing pharmacies to use SCC 13, which is the Natural Disaster Emergency Override Code that pharmacies can use in the adjudication of pharmacy claims. Controlled Substances: Maine law (Chapter 488) limits the prescribing of controlled substances for chronic pain to 30 days; MaineCare recognizes those limits and has not made changes to Maine's existing controlled substance statues. Encouraging naloxone prescribing for opioid overdose rescue: MaineCare recognizes the potential risk for increases in drug overdose and overdose deaths during this high-stress time and continues to encourage providers and pharmacists to prescribe and dispense naloxone to all patients receiving prescriptions for opioid medications and/or buprenorphine for treatment of Opioid Use Disorder. Waiving initial PA requirements for asthma. MaineCare moved all acute albuterol inhalers to preferred on the PDL since these medications were needed for any rescue breathing related effects of the virus. Testing for COVID-19 by Medicaid Pharmacies: On July 10, 2020, MaineCare implement the guidelines from the Federal Health and Human Services Department to allow pharmacists to order and administer tests for COVID-19. the POS will be ready to process these claims. Administration of COVID-19 Vaccines by Medicaid Pharmacies: MaineCare implemented the guidelines from the Federal Health and Human Services Department to allow pharmacists to order and administer vaccines for COVID-19. These vaccines can be submitted through the pharmacy POS system.

State	Innovative Practices Summary
	Metabolic Monitoring This practice was suspended during the pandemic since the letters could not be generated and mailed from the work from home model. The DUR typically sent out over 1800 letters to providers in a FFY regarding the appropriate need for metabolic monitoring with the use of atypical antipsychotics. The communication included monitoring of weight and metabolic parameters including blood pressure, A1c, fasting glucose and fasting lipid profile in accordance with the ADA screening guidelines. The letters also described a process where baseline parameters would be obtained then at 12 weeks follow up labs would be required. Providers that were surveyed were given 20 weeks to obtain and submit the baseline and follow up numbers for review, if this information was not received than further antipsychotic use would require prior authorization to assure proper monitoring. In its review, 30% of members lack proper documentation of routine monitoring. 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 2021, enrolled an additional 1,105 members to total 5,797 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 2021, the PCM program included 1,652 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 856 follow-up reviews were completed on existing PCM patients. All follow-up reviews begin by researching all prescription fills and

State	Innovative Practices Summary
	prior authorization requests since the previous review to determine what, if any, contact and follow-up is needed with the patient and/or provider. Resultant of these reviews, MaineCare PCM contacted providers (prescribers and pharmacies) via telephone or fax a total of 236 times and contacted patients via telephone 50 times during the 4th quarter alone. Medication cost abatement readily occurs when a lower cost regimen is selected, a dose decrease occurs, or medication discontinuation ensues following a consult with our pharmacist. Treatment adherence is tracked in real time using established methods and also include assessment of medication possession ratio. We strive to achieve the highest treatment medication adherence to ensure maximal benefit from the treatment selected. Utilization information is continually monitored to assess the impact of the PCM program on all aspects of the patient's care including aggregate spend. This not only includes the direct cost of medications but other utilization measures such as emergency room visits, hospital stays, and laboratory services, amongst others. Hepatitis C Value-based Authorizations Hepatitis C is a serious illness that can lead to cirrhosis, liver cancer and death. It is the leading indication for liver transplants in the United States. Once again, further medication development and release occurred throughout Fiscal Year 2021 to further advance this field with the FDA approval of oral pellet formulations for several medications being one major milestone. Cures are possible with oral regimens that range from 8-24 weeks for most patients. However, the cost for treating this disease is staggering with hepatitis C drugs rising quickly to one of the top 5 categories in cost for almost every state Medicaid program. Despite the release now of multiple therapies and some relief in the form of cost competition and supplemental rebates, the cost remains high. Maine has taken a multi-pronged approach to managing these medications--balancing evidence-based science with cost to try to allow as many as possible to access this important category of medications. In addition to being expensive, the clinical care of Hepatitis C is complex. There are now over 25 regimens recommended by the AASLD/IDSA guidelines for the treatment of hepatitis C. The choice is based on the genotype of the virus as well as patient factors, such as prior treatments and the presence of cirrhosis. Given the continued high cost of treatment, it is critical that the correct therapy is chosen and that adherence be monitored. An incorrect choice of regimen or lack of adherence that results in an unsuccessful treatment course is not only costly, it makes the next attempt at cure potentially both less likely and more expensive. The most cost effective, clinically correct choice is to make sure the patient is cured with the first treatment course by ensuring that the correct treatment is chosen, the patient is ready for treatment and likely to be compliant and then monitoring for that compliance. Finally, it is critical that Maine ensures it pays the lowest net cost for the correct therapeutic regimen. The introduction of multiple new therapies has created options for treatment and options for price negotiation. In many circumstances, the guidelines offer as many as 4 clinically acceptable, equally efficacious regimens. Through its membership in the SSDC drug purchasing pool, Maine has been able to consider offers from all of the labelers of the major hepatitis C direct-acting antivirals. However, sorting through these offers and making sure the best overall value is obtained for this category has required complex modelling and consideration of the prevalence of the various genotypes and clinical scenarios to arrive at the most clinically effective as well as the most cost effective regimen for each of the various clinical circumstances. Using the AASLD/IDSA guidelines as

State	Innovative Practices Summary
	a source of evidence-based practice and considering the various offers available via complex clinical/fiscal models allowed determination of the best value for each unique clinical situation and helped to determine which agents would be placed in a preferred position on the preferred drug list and in which circumstance each was the best value (considering both efficacy and cost). The next hurdle was providing information to providers in an easy to use format so that they could see which choice of drug regimen in each unique clinical circumstance was the most cost effective. It is not as simple as choosing only preferred drugs. There are some complex situations where the use of a non-preferred drug is the most cost-effective choice for MaineCare as well as the right choice for the member. In this type of circumstance, the occasional use of a non-preferred drug to meet a specific clinical need is authorized. To meet this complex challenge, Maine worked with its DUR Board to develop a prior authorization form that helps lead the provider to the most clinically effective, cost-effective choice based on net pricing to the State of Maine. Considering the genotype, prior therapy and level of cirrhosis, a provider can work through the form to determine the clinically appropriate choice as well as the choice that represents the best value to the State. For cases that don't fall easily into the choices provided, MaineCare also offers expert oversight of the hepatitis therapies, when needed. This form was again updated during Fiscal Year 2021 to include the newest therapy options and changes to preferred regimens. Finally, the Pharmacy Care Management Program allows a pharmacist to interact with the member and provider on an ongoing basis to help ensure the medication is taken, monitored appropriately and to collect follow-up information on outcomes. The PCM program has continued to track adherence (at the end of Fiscal Year 2021, Hepatitis C adherence was measured at 96% based on a medication possession ratio of 0.8 or higher), as well as cure rates by receiving post-treatment viral loads from providers. During Fiscal Year 2021, cure rates based on Genotype and Fibrosis Level (degree of liver damage) ranged from 86% in the most diseased/difficult to treat members to 100% in the more common and less diseased groups. By synthesizing complex clinical and fiscal data into an easy to follow authorization form, Maine has made it easier for providers to choose the most cost-effective, clinically appropriate therapy the first time rather than asking for a therapy only to be told no and that another therapy is more cost-effective. By making the right choice easy to find, Maine is helping providers to navigate a complex therapeutic landscape to enable members access to these breakthrough therapies.
Maryland	Live Continuing Education Programs Annually, the Maryland Department of Health Office of Pharmacy Services (OPS) has sponsored a live continuing education program. In FFY 2021, OPS sponsored a live program for Maryland Medicaid healthcare providers. The program, “COVID-19: Prevention to Protection” was held in February 2021. Members of the DUR Board have actively participated as speakers at these events in past years, provided recommendations for potential speakers, and attended the presentations. Continuing education program details are available at www.mmppi.com/previous_seminars.htm. Response to the program was overwhelmingly positive. The Department plans to continue this service to the healthcare community.

State	Innovative Practices Summary
	Clinical Criteria Expansion In FFY 2021, OPS continued to update its website to include clinical criteria for additional medications. The clinical criteria are based on FDA approved indications and exist to ensure appropriate utilization of medications with limited indications. The list of medications for which prior authorization is required is updated regularly and can be found at: https://health.maryland.gov/mmcp/pap/pages/Clinical-Criteria.aspx. Dose Optimization and Quantity Limits Many drugs have flat pricing across dosage strengths; however, there are products with significant price disparities between dosage forms. In an effort to reduce waste and improve prescribing practices, dose optimization and quantity limits continue to be utilized. Medical necessity overrides are available with prior authorization. The most recent list of dose optimization quantity limits can be found at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf Online Formulary hosting for Maryland Medicaid and HealthChoice MCOs The OPS has maintained an electronic database with FFS and MCO formulary information since 2007. This program, which is free for providers and participants, provides updated information on the formulary status of medications. During FFY 2021, the use of Formulary Navigator allowed real time access to information for Maryland Medicaid providers for all nine MCO and FFS formulary information. This user-friendly platform allows searches by drug name (brand or generic), therapeutic class or alphabetical listing. Additionally, products are now displayed with drug strength/formulation, and multiple flags (prior authorization, quantity limits, criteria for use) are available to guide prescribing and facilitate access to medications for patients. Corrective Managed Care Program The Corrective Managed Care (CMC) Program has been instituted by the OPS to monitor and promote appropriate use of controlled substances. Through a monthly review, the state identifies Maryland Medicaid participants who appear to be on duplicate drug therapy, visit multiple prescribers writing for similar medications, and/or patronize multiple pharmacies. Intervention letters are mailed to prescribers and pharmacy providers in an effort to alert them to potential drug therapy concerns. If there continues to be overutilization of a substance by a participant after intervention letters are mailed, a participant can be locked-in to a single pharmacy. Under a Lock-In pharmacy agreement, the participant will be required to fill the related medications at one mutually agreed upon pharmacy. The CMC Program utilizes the Corrective Managed Care Advisory Committee, which is a sub-committee of the DUR Board, to assist with the review of individual participants and

State	Innovative Practices Summary
	help set policy regarding efforts to reduce the potential misuse of controlled substances. The Committee meets just prior to the regular quarterly DUR Board meeting and includes all members of the DUR Board. For those participants where contact with prescribers through means of intervention letters has not changed behavior, the CMC Advisory Committee reviews each participant's drug and diagnosis history profile. The Committee then advises the OPS on recommended corrective action, which may include “lock-in,” further provider education or continued follow-up. Specific criteria have been approved by the CMC Advisory Committee, which allow some participants to be automatically restricted to a single pharmacy without prior CMC review. Criteria are based on the number of claims for controlled substances in their recent history and the number of prescribers and pharmacies utilized. In addition, some criteria used to screen patients for potential misuse have been modified to allow for follow-up 3 months after initial letters are mailed to providers. In the past, follow-up was not performed until 6 months after letters were initially mailed to providers. On April 1, 2016 (FFY 2016), a Unified CMC program was initiated that expanded CMC lock-in participation to all Medicaid participants included in the MCO programs. The program was expanded to create a minimum standard for monitoring of controlled substances by participants. The pharmacy program and MCO programs provided input on the final criteria that will be utilized by all parties when reviewing participant prescription claims. In addition to providing optimal care for all Medicaid participants, the unified program prevents the enrollment into a program that may not provide this oversight and allow potential fraud or abuse of controlled substances to occur without any corrective actions. Under the new program, if a lock-in participant switches between any Medicaid program, the lock-in information is maintained for the full lock-in term of 24 months. The goal of the CMC program is to educate providers when patients appear to be over-utilizing controlled substances while ensuring that participants have access to appropriate medications they need and reducing adverse outcomes associated with over-utilizing controlled substances. Opioid Drug Utilization Review During FFY 2017, the Maryland Medicaid Pharmacy Program 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. These minimum standards continued to be utilized and monitoring of the program has shown improved prescribing of opioids without restricting access for Medicaid recipients.

State	Innovative Practices Summary
	Automated Prior Authorization System The Prospective DUR vendor, Conduent State Healthcare, LLC, utilizes an automated prior authorization program for selected medications which require prior authorizations. Pharmacy claims can be automatically authorized if specific criteria are met at the point of service. This eliminates the need for the provider to call for an authorization if the participant meets the criteria for approval. The Conduent automated prior authorization system is made up of two components known as SmartPA and SmartFusion. A brief description is below. SmartPA - A clinical rules-based system that allows flexibility when determining prior authorization acceptance or denial. It produces the prior authorization that can be saved within the system. It has help desk tracking, support, and reporting capabilities. SmartFusion - The call center solution for providing call center representatives access to the SmartPA rules engine via a window on certain claim processing screens. This system is used to determine pre-authorizations for rules based in SmartPA. Antipsychotic Review Programs The use of antipsychotic agents in children and adolescents has increased substantially over the past decade. There is increased public scrutiny, controversy and debate regarding the increasing use of the antipsychotic agents in children and the lack of data on long-term effects. The long-term efficacy and safety of these agents in the pediatric population has not been well-established for any given clinical indication. For these reasons, and in order to promote evidenced based, cost-effective prescribing of antipsychotic medications for all Medicaid participants, the OPS established two new programs, the first one is 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. During FFY 2013, all children under age 10 required prior authorization. As of January 2014 (FFY 2014), the program expanded to include all patients less than 18 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. The second program, implemented 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. Hepatitis C Peer Review Program

State	Innovative Practices Summary
	While coverage of Hepatitis C agents is provided by MCOs and the Medicaid FFS program, during FFY 2015, the OPS partnered with the MCOs in the State of Maryland to standardize treatment options for this disease state. Through a joint program, managed through the University of Maryland School of Pharmacy (UMSOP), clinical guidelines have been developed to address the growing use of Hepatitis C agents. These guidelines are updated as new information becomes available and serve as a guide for the FFS program and all nine MCOs. During FFY2019, the Department expanded coverage to include fibrosis scores of F1 (mild/portal or periportal fibrosis w/o septa) and greater; patients < 21 years were approved with a status F0; patients > 21 years old with a score of F0 was approved for treatment if they presented with a viral condition (e.g. HIV) which was known to accelerate hepatic disease progression. Additionally, drugs such as daclatasvir/sofosbuvir, Technivie and Viekira XR were removed from the criteria as they were discontinued due to low utilization. Full program details, including recommended treatment plans, medication guidelines and prior authorization forms, are available at: https://health.maryland.gov/mmcp/pap/pages/Hepatitis-C-Therapy.aspx Substance Use Disorder Carve-Out program Beginning January 1, 2015, the Maryland Department of Health initiated a carve-out program to provide all substance use disorder medications to Medicaid participants. Through this program, the OPS standardized coverage and criteria for use of medication assisted treatment, including buprenorphine-containing products, disulfiram, acamprosate, naltrexone (oral and injectable), varenicline, bupropion SR and nicotine replacement products. Effective October 1, 2018, Lucemyra (lofexidine) was added to the program. Criteria for use, quantity limits/dose optimization and copayment for participants were implemented with this program. Treatment guidelines are based off of the FDA-approved indications as well as CMS recommendations for comprehensive patient-care. In addition to medication assisted treatment for substance use disorders, the OPS also provided coverage of naloxone for opioid overdose/reversal for all Medicaid participants and community members who were certified to administer the medication. SUPPORT Act Effective October 1, 2019, the OPS implemented reporting and monitoring practices to be compliant with updated Federal regulations regarding the SUPPORT Act. These measures included prospective safety edits alerts and automated claims review processes that monitor when a participant is concurrently prescribed opioids and a benzodiazepine or an opioid and antipsychotic. Additionally, continued monitoring of those received medication assisted treatment for an opioid use disorder and also receiving an opioid, and monitoring of opioid claims. Because benzodiazepines and antipsychotics are carved out of the MCO benefit and paid FFS, the Department implemented these changes through the Coordinated drug utilization review program, while MCOs were encouraged to report on reporting and monitoring practices for opioid prescriptions, including initial and subsequent fills, quantity limits, therapeutic duplications, early refills and total morphine equivalent dosing.

State	Innovative Practices Summary
	Carve in HIV Antiretrovirals for the treatment of HIV/AIDS were carved back in to the MCO benefit beginning January 1, 2020. This update and change in coverage included a thorough review of anticipated MCO coverage and clinical criteria for use, if appropriate. Additionally, a six-month soothing period was implemented to maintain coverage for all participants receiving these therapies. A late refill edit was also implemented to assist in improving compliance for this therapeutic class. COVID-19 initiatives Due to the novel Coronavirus pandemic, the Maryland Department of Health implemented multiple measures to facilitate the continued safe and appropriate use of medications for members. These measures included a waiver of early refills edits allowing a one time 30 day early refill supply and up to a 90 day supply on maintenance medications, a 14 day emergency supply of medications if a prescriber is unable to obtain a preauthorization, signature less deliveries of medications, and non-enforcement of certain preauthorization requirements. Additionally, pharmacies were authorized to collect specimens for COVID-19 testing. The Department has maintained a separate website with COVID-19 related information for public use to stay up to date on any changes and available resources. These initiatives are temporary and only in effect during the State of Emergency or designated timeframe.
Massachusetts	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. This strategy included developing accommodations to the claims processing system (e.g., early refill leniencies, 90 day supply allowances, select PA removal), proactively monitoring the COVID-19 treatment and vaccination pipeline and implementing proactive management strategies (where appropriate) and developing a messaging strategy to communicate virus response to stakeholders. We paid for delivery of medications and coordinated medication access to patients in COVID isolation and recovery sites. We expanded the DME products that will process at the POS. While PA leniencies and extensions were discontinued in FY20, 90 day supply allowances and other program changes continued throughout the public health emergency into FY21. In addition, monitoring of the COVID-19 treatment and vaccine pipeline continued. Finally, an assessment of the above accommodations on claims metrics was undertaken in FY21. Fully Unified Pharmacy Product List In July 2020, the unified pharmacy product list was expanded to a total of approximately 200 drugs for which PA status and approval criteria was coordinated amongst the Fee For Service/Primary Care Clinical/Accountable Care Organization type B plans were and coordinated with Managed Care Organization (MCO) plans. Efforts were also started to plan for full unification in 2023. Efforts were taken to evaluate impacts on plan members and differences between the benefits of plans. This was done as part of an evaluation of all

State	Innovative Practices Summary
	currently managed therapeutic classes. Efforts continued with regards to sharing clinical guidelines with MCO plans to facilitate this process. Estimated savings with the partial unified formulary was $120 million in calendar year 2021. Provider Outreach Programs The goal of this program is to identify high cost medications / disease states that are also associated with considerable nonadherence. The measure utilized within the programs will be the medication possession ration (MPR). Examples of such programs include the following: Synagis/RSV Prophylaxis and Hepatitis C Agents . Each individual program follows a similar model whereby a consultant pharmacist or pharmacy associate monitors medication claims/MPR for the select members. If a lapse or potential lapse in medication claims is identified, a consultant pharmacist conducts telephonic outreach to the prescriber. Prior Authorization determinations are adjusted on a case by case basis when indicated. These interactions are monitored, and outcomes of the interventions are reviewed periodically. 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. The monitoring program includes the following: CAR-T therapies, Vitrakvi (larotrectinib), Zolgensma (onasemnogene abeparvovecxioi), Luxturna (voretigene neparvovec-rzyl), Givlaari (givosiran) and Onpattro (patisiran). 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 of these meetings is to discuss and develop action plans for members on complex opioid regimes including high dose and duplicative therapies. Polypharmacy with other classes associated with abuse and diversion (e.g., benzodiazepines, stimulants) are considered in the evaluation. Opioid Dose Accumulator In 2019, point of sale coding was developed to identify and monitor members receiving multiple opioids and accumulate those different products into a cumulative daily dose. Monitoring of average opioid doses will guide further interventions included reassessing the morphine milligram equivalent (MME) limits for high dose opioid use. Concomitant Opioid Benzodiazepine initiatives In 2019, coding was developed to monitor members receiving opioids in combination with benzodiazepines. A claims edit was established in November 2019, which resulted in prior authorization applying to members receiving concomitant therapy starting in January 2020. The prior authorization process was aimed as identifying appropriate tapers of the benzodiazepine component of the regimen. An algorithm that evaluated concomitant polypharmacy classes with a risk of abuse and diversion and other medical conditions was created to triage highest risk members to case review at the complex Opioid therapeutic case management workgroup. Compounding Program and Monitoring

State	Innovative Practices Summary
	Periodic monitoring of high cost compounding ingredients is performed to ensure clinically appropriate and lowest cost ingredients are used. If an ingredient has been identified and determined not to be medically necessary, it may be subject to prior authorization. Hepatitis C Medications Following the Food and Drug Administration (FDA) -approval of Sovaldi (sofosbuvir) in late 2013, all prior authorization (PA) requests for hepatitis C regimens have been reviewed by Drug Utilization Review (DUR) to promote selection of the most cost -effective regimen. Several other products, Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Daklinza (daclatasvir), Epclusa (velpatasvir/sofosbuvir), Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir) , Vosevi (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier (elbasvir/grazoprevir) were also included in the prescriber outreach to discuss treatment alternatives following their FDA - approvals. At the time a PA request for one of the above products is received by the DUR, a DUR clinical pharmacist may contact the prescriber to discuss an alternative, more clinically appropriate and/or more cost - effective regimen. If the prescriber agrees to switch the member to the suggested regimen, prescriber may resubmit the PA request for that regimen and receive an approval. Pediatric Behavioral Health Medication Initiative / Therapeutic Case Management Workgroup A multidisciplinary Pediatric Behavioral Health Medication Initiative (PBHMI) Therapeutic Class Management (TCM) workgroup was created consisting of pharmacists, psychopharmacology consultant, child psychiatrists, and a social worker. Retrospective case review is conducted daily, and cases are discussed weekly among workgroup members to provide an increased level of clinical expertise and prescriber outreach as appropriate. Member cases reviewed by the workgroup include those with a recent psychiatric hospitalization, age less than three years, behavioral health regimens with six or more medications, and use of select high -risk agents in certain age groups (e.g., antipsychotics in children less eight years). Workgroup responsibilities include clinical discussions regarding treatment plans, prescriber outreach to encourage evidence - based prescribing practices, and referral of members to a behavioral health program that assists in integrating care and providing psychosocial interventions. Pharmaceutical Pipeline Monitoring and Budget Impact Forecasting Prospective monitoring of the pharmaceutical pipeline is essential to anticipate new medications and their impact on pharmacy programs from both a formulary perspective and a budgetary perspective. The pipeline pharmacist continuously tracks agents in development, reporting on the potential place in therapy, the anticipated FDA approval date, and potential impact to the plan membership. In 2019 this process evolved to consider pipeline agents within therapeutic classes to project the impact of competing products coming to market. In addition, the pipeline pharmacist uses available clinical and economic data to predict the cost of the new agent, adoption by providers and patients, and the potential budgetary impact to the plan. Based on this information, the program can successfully organize, prioritize, and determine appropriate management strategies for emerging therapies, as well as allocate budgetary resources appropriately. Accountable Care Organization Care Referrals In 2018, MassHealth enrolled most plan members into Accountable Care Organizations with the goal of providing coordinated high-quality care. To support the success of this model efforts were taken to identify at risk members for the ACO to facilitate intervention. Members referred to ACO case managers included those with diabetes (low adherence to medications and a recent emergency room visit or hospitalization), respiratory disorders

State	Innovative Practices Summary
	(patients using frequent as-needed bronchodilators without a controller medication) and pediatric members receiving psychiatric medications (those may be candidates for care coordination). Special Populations Extended Scope and Services Community Case Management (CCM) The special populations pharmacist maintains a direct means of expedited communication between MassHealth DUR and CCM. The CCM pharmacist tracks PA denials and approvals, reports trends and provide recommendations to MassHealth based on findings. Provider outreach involving medication related consultations, discharge consultations, and medication reconciliation ensure continuity of care among this at-risk population. A proactive outreach program was also created to help outreach to members with expiring prior authorizations to ensure continued adherence to medication in this population. Division of Children and Families (DCF) The special populations pharmacist maintains a direct means of expedited communication between MassHealth and DCF nurse case managers and social workers for medication related inquiries. The special populations pharmacist also facilitates procurement and appropriate utilization of medications through collaboration with DCF providers. Enhanced Coordination of Benefits (ECOB) The special populations pharmacist maintains a direct means of expedited communication between MassHealth DUR and ECOB health benefits coordinators to ensure appropriate use of third-party liability and pharmacy billing for members. Automated PA -Point of Sale (POS) Rules As the Drug Utilization Review (DUR) program reviews new medications, performs evidence -based medicine reviews and executes quality assurance analyses, updates to the PA process are required. These updates require the creation or update of a clinical guideline used for reviewing PA requests. Each clinical guideline that is created requires the development of a point of sale (POS) rule. These POS rules are decision algorithms designed to evaluate clinical criteria at the time the prescription is processed at the pharmacy level and bypassing the PA submission process. When a prescription is processed through the MassHealth Pharmacy Online Processing System (POPS), the software automatically searches medication history, diagnosis, or procedure codes from the MassHealth medical and pharmacy claims database. If all criteria are met, the medication will adjudicate at the pharmacy without a requirement for PA submission. Special Projects Does outreach improve hepatitis C treatment rates? This project has led to a better understanding of the impact of outreaching on members who received HCV viral genotyping but did not start HCV treatment. Implementation of Harm Reduction Strategies in High-Risk Opioid-Benzodiazepine Regimens. This project included an evaluation of the COBI initiative and strategies we could consider to improve care for members receiving these therapies. Evaluation of Compounding Trends in a State Medicaid Program. This project included an evaluation of the impact of a compounding management program. MassHealth Acute Hospital Carve-Out Drugs List This MassHealth Acute Hospital Carve-Out Drugs List section of the MassHealth Drug List (MHDL) applies to participating in-state MassHealth Acute Hospital providers, and as applicable to out-of-state MassHealth acute hospital providers pursuant to 130 CMR

State	Innovative Practices Summary
	450.233(D). 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 for purposes of Sections 5.B.8.b and 5.C.9 of the current MassHealth Acute Hospital Request for Applications for in-state acute hospitals (Acute Hospital RFA), and regulations at 130 CMR 450.233(D) for out-of-state acute hospitals. The hospital must obtain prior authorization (PA) from MassHealth for the APAD Carve Out Drugs and APEC Carve-Out Drugs on this list, and the associated treatment will be subject to monitoring, as indicated below. Other requirements also apply. This list, and the PA and other requirements, may be updated from time to time. APAD and APEC drugs include Car-T Therapies, Spinal Muscular Atrophy Gene Therapy, and FDA-Approved New to Market Drugs and Biologics that are not listed on the MassHealth Drug List are evaluated on a case by case basis. Direct Negotiations MassHealth has been working to lower drug costs to manage the program's spending while ensuring robust access for members at a time when rising drug prices have driven overall budget growth. With approval from the Legislature, in July 2019, MassHealth received the authority through the FY20 budget to directly and more effectively negotiate with drug manufacturers to come to supplemental and value-based rebate agreements. Since receiving authority to negotiate directly with drug manufacturers, MassHealth has signed supplemental rebate contracts on 45 drugs with 167 manufacturers (as of February 15, 2022), including 7 value-based agreements, with a total annual rebate value of approximately $201 million. Direct negotiations have not had any negative impact on consumer access.
Michigan	Throughout FFY 2021, Michigan Department of Health and Human Services (MDHHS) worked diligently to combat the opioid crisis; improve access to MAT and hepatitis C medications; and to manage spending through implementation of a single preferred drug list (sPDL) across Managed Medicaid in addition to Fee-For-Service Medicaid and outcomes-based contracting. MDHHS implemented the Medicaid Single Preferred Drug List (sPDL) to maximize drug manufacturer rebates (both Federal and PDL supplemental) to generate additional rebate 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 sPDL. The MCO Common Formulary workgroup will provide input and recommendations on sPDL coverage for P&T Workgroup consideration before each full P&T Committee meeting. Drugs not on the sPDL 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. It is leading a steering committee with stakeholders, clinicians and community leaders to develop a state plan that includes data and strategic planning, community-based interventions, and adult and pediatric interventions. They entitled this initiative We Treat Hep C. MDHHS and the Michigan Department of Corrections (MDOC) drafted a collaborative RFP to secure lower pricing on hepatitis C agents to treat as many Michiganders as possible. The goal was to select one hepatitis C medication as preferred on the sPDL. 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

State	Innovative Practices Summary
	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. 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. Outcomes-Based Contracts/Value-Based Purchasing agreements are encouraged by the Department of Health and Human Services to help address high drug costs and additional agreement opportunities are under Department review.
Minnesota	There are no innovative practices to report.
Mississippi	1. Since 2018, MS has had a standing order issue by the State Health Officer under which pharmacists may dispense naloxone without a prescription. After analyzing Medicaid claims data, DUR determined that there has been very little uptake of this practice. The DUR board recommended an education effort to spread the word to the medical and pharmacy communities. 2. Since being introduced to the marked in 2018, we observed a steady upward trend in prescription quantities on claims for Epidiolex. Believing this to be due to dosage creep, we performed an analysis of median dose per claim over time. Although the board did not elect to recommend any utilization management steps (dosage limits, etc.), we were felt that this was an important analysis with possible future use as a baseline benchmark. 3. In order to encourage appropriate utilization of growth hormones, we analyzed claims for all agents in the class and implemented diagnosis checks for children; such checks were already in place for adults.
Missouri	High Risk Combination Clinical Policy In April 2021, MO HealthNet implemented the High Risk Combination Clinical Edit requiring participants who received a combination of opioids and oral benzodiazepines to also have a rescue opioid reversal product in the previous two years. This policy was implemented ensure participants had access to a rescue agent when at a higher risk of death due to respiratory depression from the combination of opioids and benzodiazepines. In the 6 months prior to implementation 2,651 participants received a naloxone product from a retail pharmacy. In the 6 months post implementation 7,351 participants received a naloxone product from a retail pharmacy. This represents a 177% increase in participants with a rescue agent on hand in case there is an opioid overdose with respiratory depression. Project Hep Cure In July 2021, MO HealthNet and pharmaceutical manufacturer AbbVie launched an initiative, Project Hep Cure, to help eliminate hepatitis C by making prescription MAVYRET available to anyone enrolled in MO HealthNet at no cost. Since the launch, MO HealthNet has partnered with several other stakeholders to encourage broad screening, testing and treatment of hepatitis C by all prescribers. Partners include Project ECHO, Department of Health & Senior Services, and FQHCs. MO HealthNet also launched a website to track

State	Innovative Practices Summary
	progress of this important public health initiative, including state and county level data, at: https://dss.mo.gov/mhd/hepc/.
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 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

State	Innovative Practices Summary
	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 are currently working with stakeholders and providing educational presentations at various Montana conferences such as the Foster Resource Conference, Child Abuse and Neglect Conference, MSFAPA Conference, and the upcoming Youth Summit. The development of an educational brochure for CPS Workers, Foster Parents and children, and psychotropic medication education packet for foster parents has also been accomplished. Various successes have been realized; including increased laboratory monitoring and appropriate indication for atypical antipsychotic medication, medication dose decrease and/or discontinuation, and increased continuity of care between providers of care for the foster care population. Development of a Prior Authorization Required Process for Medications without prospective DUR edits In an effort to combat significant medication overuse/abuse and support patient safety, the pharmacy case management program worked with the department to develop and implement a process for a provider-driven PA required process managed through the point-of-sale system. This process is for medications normally not requiring prior authorization and members for this program are referred on a case-by-case basis. Implementation of a Drug Not Covered Status in the Medicaid POS system prevents a member from receiving a selected medication or complete therapeutic class of medications each time a claim is submitted, unless a prior authorization is granted per instructions developed by the provider and the case management pharmacist. Currently approximately 300 members are enrolled and managed through this program. This has been an effective means to provide a higher level of management for those members for who even the lock-in program cannot prevent overuse and misuse of medications. Case Management for Hepatitis C Medications The pharmacy case management program has been intimately responsible for managing the approval process for the new generation of medications to treat Hepatitis C. This has promoted the utilization of appropriate therapy through telephonic prescriber outreach by a clinical case management pharmacist and resulted in considerable cost savings to the Medicaid program. In coordination with the state, the criteria for treatment has changed and our staff has been able to help guide providers to better treatment outcomes for the increased population receiving antivirals treating/curing Hepatitis C. Case Management for Hereditary Angioedema (HAE) Medications Significant cost savings were found by working with patients and providers to increase use of attack logs, awareness of acute vs prophylactic medication need, and utilization management by the CM pharmacist that promoted better patient understanding of their disease. This effort reduced the anticipated amount of emergency department visits by coordinating care between the patient and their providers in addition to helping patients and their families understand the nature and progression of HAE.

State	Innovative Practices Summary
	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 to decrease the number of concomitant opioids, benzodiazepines, and tramadol medication use in Medicaid members receiving MAT therapy. This has also diminished the risk of overdose in this population by restricting their access to other opioid medications while receiving MAT therapy. The teams are also actively involved in both state and local taskforces working to help manage opioid use disorder and to be active within our communities as a resource to help manage patient care. Case Management of Pseudobulbar Affect (PBA) Diagnosis of this condition and its treatment can often be difficult, the medications are not highly effective, and patients are often left on therapy without evidence of success. Our CM team, using DUR Board approved protocols, evaluates diagnosis and patient need to start therapy and then follows up with providers to establish continued efficacy in relation to baseline metrics. This utilization effort not only sets up appropriate use but reduces costs in situations where the medication is not indicated or does not provide a benefit for a patient. Automated Prior Authorizations Our PA staff continues to work with the State and their contracted vendor to improve automatic prior authorizations where appropriate and the appropriate algorithms can be managed. Through weekly meetings and constant communication, any issues with these are resolved almost immediately, and without disruption to patient care.
Nebraska	Hepatitis C was made more accessible and treatment is now available for patients regardless of fibrosis score. Ongoing participation in TOP$ program to maximize savings based on utilization. Continuous Glucose Monitoring will be implemented shortly and this will allow us to track costs and review / obtain rebates.
Nevada	As of 12/21/2020, Nevada Medicaid implemented a new electronic prior authorization system that enables prescribers to submit pharmacy prior authorization request electronically.
New Hampshire	New Hampshire FFS Medicaid 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.

State	Innovative Practices Summary
	New Hampshire FFS Medicaid accessed MCO Align, a tool to review compliance with the single PDL and trending over time across the 3 managed care organizations in NH. This was designed to assist with oversight of MCOs in a dynamic reporting tool. New Hampshire FFS Medicaid program continuously monitors Hepatitis C medication guidelines and recommendations to allow coverage for additional Hepatitis C patients to be eligible for coverage. Specialty medications for oncology and HIV are covered without restriction but are monitored for potential cost saving initiatives. 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. Hospice, cancer, end-of-life and sickle cell patients are exempt from the prior authorization requirement. The prior authorization criteria require step therapy through non-opioid pain relievers, diagnosis information, justification for higher dosing, and multiple prescriber attestations targeting pain management contract, PDMP review, risk/benefit discussions with the patient, and naloxone prescribing. Continuous monitoring of members who exceed the MME limit is conducted and reviewed at each monthly meeting with the PBM. In response to New Hampshire law, drugs to treat ADD/ADHD and narcolepsy were added to the maintenance medication list to allow up to a 90-day supply per fill. 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 2021, 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 2021.
New Jersey	In FFY 21, 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 2019. In FFY 21, the Division adjusted its MME protocol to include a MME daily dosage not to exceed 50 MME for an opioid naive patient and a MME daily dosage not to exceed 90 MMEs for an opioid tolerant patient. Exclusions from the protocol continued to include patients diagnosed with cancer or sickle cell anemia, as well as hospice patients and those patients receiving palliative end of life care. The protocol also requires prior authorization for the concomitant use of opioids and benzodiazepines.

State	Innovative Practices Summary
	The Division adopted additional National Council for Prescription Drug Programs (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 response to the needs of the Public Health Emergency, the Division made available reimbursement for Pharmacist-Administered SARS-CoV-2 Vaccine Immunizations. In FFY21, DMAHS continued to perform retrospective DUR activities including: - Confirmation of a HIV compliance - Confirmation of diabetes compliance - Claims exceeding $4000 to monitor FWA/duplication of therapy - Concurrent utilization of opioids/benzodiazepines - Concurrent utilization of opioids/antipsychotics
New Mexico	No innovative practices were implemented to improve the administration of the DUR program, appropriateness of prescription drug uses, or to help control costs for FFY 2021.
New York	Development of an automated prospective physician administered drug (PAD) management program in an effort to align with management programs currently used within the pharmacy program. Pharmacy benefit for managed care members moving into the fee-for-service program (the scheduled implementation was 4/1/2021 and was moved to 4/1/2023). Drug Cap initiative which allows the negotiation for supplemental rebates across the fee-for-service and managed care populations for products identified as contributing to pharmacy spend above the projected expenditure threshold. 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. During the reporting period, there were twenty-two Drug Cap or High Cost Drug supplemental rebate contracts executed or renewed.
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.

State	Innovative Practices Summary
	November 2020 Pharmacy Newsletter- POS Pharmacy Claims with DAW 8 Dispense as Written (DAW) code 8 is defined as "Substitution not allowed - generic drug not available in marketplace." NC Medicaid acknowledges that shortages in the prescription drug marketplace sometimes necessitate that pharmacies utilize a brand name drug when its equivalent generic is not available from any source. However, utilizing DAW code 8 in any other circumstance is a violation of NC Medicaid policy. NC Medicaid utilizes an outside vendor to contact pharmacies regarding potential inappropriate utilization of the DAW code 8. If a participating pharmacy is contacted by the vendor about DAW code 8 utilization it is expected that the pharmacy provider will provide the vendor with any documentation available to show that the generic product was unavailable at the time the brand name product was dispensed January 2021 Pharmacy Newsletter Coverage of Over-the-Counter Emergency Contraception at Point-of-Sale As a reminder, North Carolina Medicaid covers Over-the Counter (OTC) emergency contraception products at the point-of-sale that are part of the Federal Medicaid Drug Rebate Program (MDRP) when the product is dispensed by a pharmacist pursuant to a lawful prescription. Pharmacists with concerns related to the lawful dispensing of these products can refer to the NC Board of Pharmacy's website for guidance. Special Medicaid Bulletin COVID-19 #152: Billing Guidance for COVID-19 Vaccines (PFIZER-BioNTech COVID-19 Vaccine HCPCS code 91300; Moderna COVID-19 Vaccine HCPCS code 91301) The following information is only for pharmacies administering vaccines outside of the CVS/Walgreens Long-Term Care program who have the means to handle the specific storage recommendations required of the COVID-19 vaccine and will be administering it. The COVID-19 vaccines are 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). Effective with date of service listed below, the Medicaid and NC Health Choice programs cover for use in the Physician Administered Drug Program (PADP): Dec. 12, 2020, Pfizer-BioNTech COVID-19 Vaccine: HCPCS code 91300 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use in individuals 16 years of age and older. Dec. 21, 2020, Moderna COVID-19 Vaccine (N/A): HCPCS code 91301 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use in individuals 18 years of age and older. Recommended Dose: The Pfizer-BioNTech COVID-19 Vaccine is administered intramuscularly as a series of two doses (0.3 mL each) three weeks apart. Individuals who have received one dose of Pfizer-BioNTech COVID-19 Vaccine should receive a second dose of Pfizer-BioNTech COVID-19 Vaccine to complete the vaccination series. The Moderna COVID-19 Vaccine is administered intramuscularly as a series of two doses (0.5 mL each) 1 month apart. Individuals who have received one dose of the Moderna

State	Innovative Practices Summary
	COVID-19 Vaccine should receive a second dose of the Moderna COVID-19 Vaccine to complete the vaccination series. The CDC has released Interim Guidance for Immunization Services During the COVID-19 Pandemic. This guidance is intended to help immunization providers in a variety of clinical and alternative settings with the safe administration of vaccines during the COVID-19 pandemic. If you have any questions about product-specific information, please contact the Immunization Branch help desk at (877) 873-6247 and press option 6. For Medicaid and NC Health Choice Billing The ICD-10-CM diagnosis code required for billing is: Z23 - Encounter for immunization Providers must bill with HCPCS code: o 91300 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use o 91301 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use One Medicaid unit of coverage is: o 0.3 mL for Pfizer vaccine o 0.5 mL for Moderna vaccine The maximum reimbursement rate per unit is: N/A (federally supplied) Providers must bill 11-digit NDCs: o Pfizer vaccine: 59267-1000-01, 59267-1000-02, 59267-1000-03 o Moderna vaccine: 80777-0273-10, 80777-0273-99 The NDC units should be reported as "UN1" The fee schedule for the PADP is available on NC Medicaid's PADP web page Important Claims Information: Medicaid and NC Health Choice will reimburse at the Medicare approved COVID-19 vaccination administration rate at 1st dose $16.94 and 2nd dose $28.39 Claims must have appropriate NDCs that correspond to the vaccine used for administration and corresponding CPT code Claims must contain both administration codes and vaccine codes to pay Vaccine codes should be reported as $0.00 Claims for 1st vaccine dose must be processed in NCTracks prior to submitting a claim for 2nd dose Medicaid and NC Health Choice do not allow copays to be charged for COVID-19 immunization or administrations COVID-19 vaccines are exempt from the Vaccines For Children (VFC) program Pharmacies may administer Pfizer COVID-19 Vaccine to any Medicaid and NC Health Choice beneficiary 16 years and older. Pharmacies may administer Moderna COVID19 Vaccines to any Medicaid and NC Health Choice beneficiary 18 years and older. All other vaccines (non-COVID-19 vaccines), that are approved by the NC Board of Pharmacy to be administered by a pharmacist, are only permissible to be administered at a pharmacy for Medicaid beneficiaries 19 years and older. TJ modifier should be appended to all NC Health Choice claims (age 16 through 18 years)

State	Innovative Practices Summary
	EP modifier should be appended to all non-NC Health Choice (only Medicaid beneficiaries) younger than 21 years of age CG modifier should be appended to ALL COVID-19 vaccine AND administration claims submitted by a pharmacy participating in the immunization program o EXCEPTION - CVS/Walgreens pharmacies participating in the Long-Term Care (LTC) immunization program for beneficiaries residing at the participating LTC February 2021 Pharmacy Newsletter Cost of Dispensing Survey NC Medicaid recently completed the Centers for Medicare and Medicaid Services (CMS) mandated cost of dispensing (COD) survey for North Carolina Medicaid enrolled pharmacies. Myers and Stauffer LC performed the survey of pharmacy COD, consistent with CMS guidelines, on behalf of NC Medicaid. North Carolina pharmacies, which were actively participating in the Medicaid program between Jan. 1, 2019, and April 30, 2020, were surveyed, with a 43.2% response rate. The findings of the survey were consistent with the 2015 survey; therefore, no changes will be made to the professional dispensing fee at this time. As a reminder, the five Medicaid Managed Care health plans have opted to pay a flat rate of $10.24 for all pharmacy claims billed through the managed care plans. This will occur with managed care claims effective July 1, 2021. All NC Medicaid Direct (traditional fee-for-service) claims will continue to be paid utilizing the tiered payment model, designed to incentivize dispensing of preferred generics and brands. The COVID-19 relief increase of 5% added to the dispensing fee per claim will remain in effect until notified by the Department. Transition to Medicaid Managed Care Standard Plans and the Eastern Band of Cherokee Indians (ECBI) Tribal Option are scheduled to go live July 1, 2021, while Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans are scheduled to launch July 1, 2022. Until that time, NC Medicaid will continue to operate under the current fee-for-service model administered by the Department. For the latest information, tools and other resources to help providers transition to Medicaid Managed Care, please visit the Provider Playbook. Visit the Provider Playbook often as resources will be added as they become available March 2021 Pharmacy Newsletter Oral Contraceptive Coverage Extension Effective May 1, 2021, Medicaid will allow coverage for up to a 365 days supply of oral contraceptives at a time. This will allow beneficiaries to receive up to a 12-month supply of birth control. The ability to receive a 12-month supply will help eliminate the need to return to a pharmacy every 30 or 90 days to refill prescriptions, reducing the possibility of temporarily not having access to contraception. Research has found that consistent, reliable access to birth control reduces the incidence of unintended pregnancies.

State	Innovative Practices Summary
	April 2021 Pharmacy Newsletter JANSSEN COVID-19 Vaccine (N/A) HCPCS code 91303: Billing Guidelines Janssen 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 18 years of age and older. Effective with date of service Feb 27, 2021, the Medicaid and NC Health Choice programs cover Janssen COVID-19 Vaccine (N/A) for use in the Physician Administered Drug Program (PADP) when billed with HCPCS code 91303 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x10^10 viral particles/0.5mL dosage, for intramuscular use. Janssen COVID-19 vaccine is a preservative-free suspension for injection in a multiple dose vial. It is administered intramuscularly as a single dose (0.5 mL). See full prescribing information for further detail. The CDC has released Interim Guidance for Immunization Services during the COVID-19 pandemic. This guidance is intended to help immunization providers in a variety of clinical and alternative settings with the safe administration of vaccines during the COVID-19 pandemic. If you have any questions about product-specific information, please contact the Immunization Branch help desk at 877-873-6247 and press option 6. For Medicaid and NC Health Choice Billing: The ICD-10-CM diagnosis code(s) required for billing is/are: Z23 - Encounter for immunization Providers must bill with HCPCS code: 91303 - Severe acute respiratory syndrome coronavirus2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x10^10 viral particles/0.5mL dosage, for intramuscular use One Medicaid and NC Health Choice unit of coverage is: 0.5 mL (1 dose) The maximum reimbursement rate per unit is: N/A (federally supplied) Providers must bill 11-digit NDCs and appropriate NDC units. The NDCs is/are: 59676-0580-05, 59676-0580-15 The NDC units should be reported as "UN1." The fee schedule for the PADP is available on NC Medicaid's PADP web page. Important Claims Information: Medicaid and NC Health Choice will reimburse at the Medicare approved COVID-19 vaccination administration rate at $28.39 for vaccine administered prior to March 15, 2021. The rate will April 2021 increase to the Centers for Medicare & Medicaid Services' (CMS) increased Medicare rate of $40 per dose for vaccine administered on and after March 15, 2021. Claims must have appropriate NDCs that correspond to the vaccine used for administration and corresponding CPT code Claims must contain both administration codes and vaccine codes to pay Vaccine codes should be reported as $0.00 Medicaid and NC Health Choice do not allow copays to be charged for COVID-19 immunization or administrations COVID-19 vaccines are exempt from the Vaccines For Children (VFC) program

State	Innovative Practices Summary
	Pharmacies may administer Janssen COVID-19 vaccines to any Medicaid and NC Health Choice beneficiary 18 years and older. All other vaccines (non-COVID-19 vaccines), that are approved by the NC Board of Pharmacy to be administered by a pharmacist, are only permissible to be administered at a pharmacy for Medicaid beneficiaries 19 years and older. TJ modifier should be appended to all NC Health Choice claims (through 18 years) EP modifier should be appended to all non-NC Health Choice (only Medicaid beneficiaries) younger than 21 years of age CG modifier should be appended to ALL COVID-19 vaccine AND administration claims submitted by a pharmacy participating in the immunization program Medicaid Rate Increases for COVID-19 Vaccine Administration Codes Effective March 15, 2021, NC Medicaid is aligning reimbursement for COVID-19 vaccine administration with the Centers for Medicare & Medicaid Services' (CMS) increased Medicare rate of $40 per dose. This higher payment rate will support important actions taken by providers, including pharmacies who vaccinate, that are designed to increase the number of vaccines they can furnish each day. At a time when vaccine supply is growing, NC Medicaid is supporting provider efforts to expand capacity and ensure that all NC Medicaid beneficiaries can be vaccinated against COVID-19 as soon as possible. NC Medicaid is increasing the reimbursement rate for administration of each dose of the following COVID-19 Vaccines: 91300 Pfizer-BioNTech COVID-19 Vaccine, 91301 Moderna COVID-19 Vaccine 91303 Janssen COVID-19 Vaccine This means that starting on March 15, 2021, for single dose COVID-19 vaccines, Medicaid will pay $40 for its administration, and for COVID-19 vaccines requiring multiple doses, Medicaid will pay $40 for each dose in the series. Medicaid and NC Health Choice claims submitted with dates of service prior to March 15, 2021 will continue to be reimbursed at the Medicare approved COVID-19 vaccination administration first dose rate of $16.94 and the second dose rate of $28.39. Please refer to previously released Special Medicaid Bulletins # 152 and # 160 at the following links for COVID-19 Vaccine billing guidance: (please note any references to rates has been replaced by this bulletin) https://medicaid.ncdhhs.gov/blog/2021/01/21/special-medicaid-bulletin-covid-19-152 billing-guidance-covid-19-vaccines https://medicaid.ncdhhs.gov/blog/2021/03/15/special-bulletin-covid-19-160 janssencovid-19-vaccine-hcpcs-code-91303-and-0031a Rebate Eligible Drug Coverage Guidelines The CMS Medicaid Prescription Drug Rebate Program was established to help offset the federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients. For prescription drugs, either through a medical claim or a point of sale pharmacy claim, to be covered by North Carolina Medicaid the specific national drug code (NDC) being submitted MUST be from a manufacturer that participates in the CMS Medicaid Drug Rebate Program. If a provider has a question of whether a manufacturer's NDC is a participating product, a provider has two options. A provider may contact the NCTracks Help Desk at 800-688-6696

State	Innovative Practices Summary
	or may look up the medication by name or NDC on the NCTracks website Drug Search lookup tool (https://www.nctracks.nc.gov/publicPortal/pub/druglookup/) May 2021 Pharmacy Newsletter NC Medicaid Managed Care Pharmacy Billing and Contracting Information Beginning July 1, 2021, approximately 1.6 million NC Medicaid and NC Health Choice beneficiaries will transition to having their health care benefits through Medicaid Managed Care Prepaid Health Plans (PHPs). This transition includes the pharmacy benefits of these beneficiaries as well. To be able to serve these beneficiaries that will be enrolled in a PHP after 7/1/2021 a pharmacy must be enrolled as an NC Medicaid provider, in addition to being enrolled with the beneficiary's PHP. Please see below for PHPs that will serve beneficiaries, their pharmacy processing information, and provider contracting information. Prepaid Health Plan PBM Processor BIN Number PCN Rx Group Number AmeriHealth Caritas PerformRx 019595 PRX00801 N/A Carolina Complete Health Envolve Rx (back end CVS Health) 004336 MCAIDADV RX5480 Healthy Blue (BCBS of NC) IngenioRx (back end CVS Health) 020107 NC 8473 United Healthcare Optum Rx 610494 4949 ACUNC WellCare of NC CVS Health 004336 MCAIDADV RX8904 For PHP provider contracting information for all 5 of the PHPs listed above, please visit the following page on the NC Medicaid website: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources June 2021 Pharmacy Newsletter Attention: All Providers American Rescue Plan Act The American Rescue Plan Act that was recently enacted includes several changes to COVID-19 Medicaid policy. North Carolina will now be covering all approved COVID-19 vaccines as of March 11, 2021, for the following limited benefit eligibility groups: COVID-19 testing limited benefit group, Family Planning, and women who qualify due to pregnancy. Vaccine providers may bill Medicaid if it is determined that the beneficiary is in one of these limited eligibility groups. In addition, internal Medicaid review of recently denied COVID-19 vaccine administration claims has led to modification of edits to allow many of these claims to process for payment. All providers are encouraged to resubmit previously denied claims for Covid-19 vaccine for possible payment. All rules for payment of the administration of COVID-19 vaccine continue to apply. The date of service will be used to determine payment amount. Claims are now reimbursable even if originally denied for: Vaccine CPT code and vaccine administration code were not both listed on the claim Charges were not added to the vaccine administration code Beneficiary received only Family Planning Waiver benefits (as of DOS 3/11/2021) Second dose of vaccine was billed before the first dose Claims are reimbursable for the following scenarios: o All eligible providers' taxonomies will be reimbursed for vaccine administration

State	Innovative Practices Summary
	o All approved places of service will be eligible for payment Please note claims may still not pay if the beneficiary has another insurance on file, provider is not enrolled in NC Medicaid, or the ordering provider is not listed on the claim. Please contact the NCTracks help desk for further assistance if needed. Attention: Pharmacy Providers Emergency Supply for the Beneficiary Management Lock-In Program-Override Reminder This is a reminder that the N.C. Medicaid Program will reimburse an enrolled Medicaid pharmacy for up to a four-day supply of a prescription dispensed to a beneficiary locked into a different pharmacy and/or prescriber in response to an emergent situation. The provider will be paid for the drug cost only and the beneficiary is responsible for the appropriate copayment. One emergency occurrence is reimbursed per beneficiary during each year of the two-year lock-in period. For beneficiaries covered in Medicaid Direct, the pharmacy can place a "3" in the Level of Service field (418-DI). For all other Medicaid members enrolled in one of the five Prepaid Health Plans, refer to that member's specific plan for instructions on how to obtain an override for an emergency supply. Medicaid Managed Care Transferring Prior Approvals Managed care begins for most North Carolina Medicaid beneficiaries on July 1, 2021. To ensure continuity of care for beneficiaries, The North Carolina Division of Health Benefits will be transferring all active approved medication prior approval files to the beneficiaries' health plans. This will allow the beneficiaries to continue to use their prior approvals with their new plans for June 2021 3 the remainder of the life of the prior approval. Going forward, active prior approvals will be transferred from plan to plan should the beneficiary decide to switch to a different plan. Attention: Pharmacy Providers New Practice Guidelines for Administration of Buprenorphine for Treating Opioid Use Disorder On January 14, 2021, the U.S. Department of Health and Human Services announced that it published Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder, which was designed to expand access to medication-assisted treatment (MAT) by exempting eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives, who are state licensed and registered by the DEA to prescribe controlled substances, an exemption from certain statutory certification requirements related to training, counseling and other ancillary services usually required to prescribe buprenorphine for opioid use disorder (OUD) treatment. The guidance took effect on April 28, 2021. For complete information on this guidance, see https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-theadministration-of-buprenorphine-for-treating-opioid-use-disorder August 2021 Pharmacy Newsletter Confirming Medicaid Coverage for Beneficiaries Providers and pharmacies should always use NCTracks to confirm eligibility NC Medicaid has received reports of confusion in the field by providers and pharmacies when members do not present an ID card or when presented with a Medicaid member ID card that differs from the data shown in the NCTracks system. To mitigate any confusion associated with newly issued Medicaid Managed Care member ID cards, providers and pharmacies should always use NCTracks Recipient Eligibility Verification/Response to confirm eligibility and not rely solely on the

State	Innovative Practices Summary
	information shown on a Member ID Card. Health plans are required to generate an identification card for each Member enrolled in their health plan that contains the Member's North Carolina Medicaid or NC Health Choice Identification number. Some health plans also include their health plan member ID as well. However, member ID cards are not required to provide service, and this includes pharmacies as well. Therefore, members should not be turned away due to the lack of a Member ID card in their possession. Follow these steps when an NC Medicaid or NC Health Choice member presents at your office: Verify eligibility, health plan and primary care provider enrollment using the NCTracks Recipient Eligibility Verification/Response or calling the NCTracks Call Center for more information: 800-688-6696 Confirm that your office participates with the member's assigned health plan and obtain the appropriate health plan member ID as needed to file claims. If you are not the assigned Primary Care Practice for the member but are in-network for the health plan, you can render and be paid for Primary Care Services. If the member would like to have you as their assigned Primary Care Practice, they should call their health plan to be reassigned to you. If you are a non-participating provider for the member's Medicaid health plan, you may still render services. Special protection is afforded to out-of-network providers. If a good-faith contracting effort has been made by the health plan and you declined to participate, then you are subject to receiving 90% of the Medicaid fee-for-service rate. If no good-faith contracting effort has occurred, or if it is in progress, then you are subject to receiving 100% of the Medicaid fee-for-service rate until the contracting effort has been resolved. Additionally, the health plan will honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for services covered by the health plan for the first 90 days after launch (until Sept. 29, 2021) or until the end of the authorization period, whichever occurs first. For the first 60 days after Launch (until Aug. 30, 2021), the health plan will pay claims and authorize services for Medicaid enrolled out-of-network providers equal to that of in-network providers until the end of the episode of care or for 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. % 58- 67-88(d), (e), (f), and (g).). August 2021 3 If a member transitions between health plans after July 1, 2021, a prior authorization authorized by their original health plan will be honored for the life of the authorization by their new health plan. Additional resources for providers can be found in the NC Medicaid Help Center, the Provider Playbook and on the Medicaid Transformation website. Additional resources for providers can be found in the NC Medicaid Help Center, the Provider Playbook and on the Medicaid Transformation website. For general provider inquiries and complaints regarding health plans, contact the Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or 866-304-7062. The Provider Ombudsman contact information is also published in each health plan's provider manual. For questions related to your NCTracks provider information, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into the NCTracks provider portal to verify your information and submit a Manage Change Request. For all other questions, please contact the NC Medicaid Contact Center at 888-245-0179.

State	Innovative Practices Summary
	September 2021 Pharmacy Newsletter Attention: Physicians, Nurse Practitioners, Physician Assistants, Pharmacists Third COVID-19 Vaccine Available for Immunocompromised Medicaid Beneficiaries On August 12, 2021, the FDA modified the Emergency Use Authorizations (EUAs) for Pfizer-BioNTech COVID-19 vaccine and Moderna COVID-19 vaccine to allow for administration of an additional dose (e.g., a third dose) of an mRNA COVID-19 vaccine after an initial two-dose primary mRNA COVID-19 vaccine series for certain immunocompromised people (e.g., people who have undergone solid organ transplantation or have been diagnosed with conditions that are considered to have an equivalent level of immunocompromise). The age groups authorized to receive the additional dose are unchanged from those authorized to receive the primary vaccination series: Pfizer-BioNTech: ages >=12 years Moderna: ages >=18 years The authorizations for these vaccines have been amended to allow for an additional, or third, dose to be administered at least 28 days following the two-dose regimen of the same vaccine to individuals who have undergone solid organ transplantation, or who are diagnosed with conditions that are considered to have an equivalent level of immunocompromise. More info can be found here. NC Medicaid vaccine providers may begin administering an additional dose of mRNA COVID-19 vaccine to people with moderate to severely compromised immune systems after an initial two-dose vaccine series. The additional mRNA COVID-19 vaccine dose should be the same vaccine product as the initial 2-dose mRNA COVID-19 primary vaccine series (Pfizer-BioNTech or Moderna). If the mRNA COVID-19 vaccine product given for the first two doses is not available, the other mRNA COVID-19 vaccine product may be administered. A person should not receive more than three mRNA COVID-19 vaccine doses. Conditions and treatments associated with moderate and severe immune compromise include but are not limited to: Active treatment for solid-tumor and hematologic malignancies Receipt of solid-organ transplant and taking immunosuppressive therapy Receipt of CAR-T-cell or hematopoietic stem cell transplant (within two years of transplantation or taking immunosuppression therapy) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome) Advanced or untreated HIV infection Active treatment with high-dose corticosteroids (i.e., >=20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers and other biologic agents that are immunosuppressive or immunomodulatory. Patient may self-attest to their medical condition. An updated Standing Order is forthcoming. According to an American Medical Association press release, the vaccine administration CPT code and long descriptor assigned to the third dose: Pfizer COVID-19 vaccine - 0003A - immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; third dose Moderna COVID -19 vaccine - 0013A - Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

State	Innovative Practices Summary
	(coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage; third dose NC Medicaid will pay for administering an additional dose of COVID-19 vaccine consistent with the FDA emergency use authorization (EUA). Payment amount will be equivalent as for other doses of the COVID-19 vaccine at $40 each. For Medicaid and NC Health Choice Billing The ICD-10-CM diagnosis code required for billing is: Z23 - Encounter for immunization. Providers must bill with HCPCS code: o 91300 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use o 91301 - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative-free, 100 mcg/0.5mL dosage, for intramuscular use The maximum reimbursement rate per unit is: N/A (only administration charge will be reimbursed). Claims must have appropriate NDCs, which correspond to the vaccine used for administration and corresponding CPT code. Claims must contain both administration codes and vaccine codes to pay Vaccine codes should be reported as $0.00. Medicaid and NC Health Choice do not allow copays to be charged for COVID-19 immunization or administrations. COVID-19 vaccines are exempt from the Vaccines for Children (VFC) program. TJ modifier should be used for NC Health Choice claims (age 6 through 18 years). EP modifier should be used for all non-NC Health Choice (only Medicaid beneficiaries) younger than 21 years of age. CG modifier should be used for claims submitted by a pharmacy participating in the immunization program for both the vaccine and administration codes. Currently, there are insufficient data to support the use of an additional mRNA COVID-19 vaccine dose after a single-dose Janssen COVID-19 vaccination series in immunocompromised people. FDA and CDC are actively working to provide guidance on this issue. Please see the updated Interim Clinical Considerations for use of COVID-19 Vaccines Currently Authorized in the United States for more details. Other resources and links: Pfizer EUA Pfizer Health Care Provider Fact Sheet Pfizer Fact Sheet for Recipients Moderna EUA Moderna Health Care Provider Fact Sheet Moderna Fact Sheet for Recipients Influenza Vaccine and Reimbursement Guidelines for 2021-2022 for NC Medicaid and NC Health Choice For 2021-2022, 100% of the projected vaccine supply produced will be quadrivalent (4-component) vaccines. There will not be any trivalent flu vaccine available. More

State	Innovative Practices Summary
	information about the upcoming influenza season can be found at the Centers for Disease Control. If you have any questions or need assistance about the influenza vaccine products, please contact the Immunization Branch Help Desk at 1-877-873-6247 and press option 6. If you have any questions about billing for influenza vaccines for Medicaid beneficiaries, please call the beneficiary assigned health plan or NCTracks call center at 1-800-688-6696 NC Medicaid will continue to keep the fees in place for the mailing of prescriptions or delivery of prescriptions that was instituted as a result of COVID-19 protocols to improve patient access to medications. There were many other innovative practices started prior to this FFY report as a result of COVID-19 that were maintained throughout the reporting period such as the ability to receive a 90 day supply of MAT drugs if the prescriber wrote the prescription in this manner and the allowance of a 14 day emergency supply in lieu of the 72 hour supply.
North Dakota	We worked with Hepatitis C practitioners to encourage Hepatitis C treatment during the time period in which members are experiencing frequent follow ups with the substance use practitioner, as well as encouraged practitioners to have conversations with members to enroll into a substance use treatment program for those that were not yet enrolled. We use our underutilization edit to identify large gaps in substance use treatment therapy. The purpose of this edit is to identify instances of relapse and to identify member's adherence barriers and treatment plan adjustment needs. An override is issued once the practitioner acknowledges these barriers and needs have been addressed by form. They must also attest to having checked the PDMP, providing the member access to Narcan, performing routine drug screens, as well has having a treatment contract with the member. This also provides an opportunity for the providers to counsel on overdose risk of relapsing during missed therapy, long acting buprenorphine options for non-compliance, and treatment readiness as the provider attests to on the form. We use our underutilization edit to identify injectable drugs (e.g. Victoza and Praluent) being billed with a 30 day supply every 60 days which results in subtherapeutic dosing. In the case of Victoza, the 2 pack is billed as a 30 day supply but the member is instructed to utilize 0.6mg daily to reduce gastrointestinal side effects which allows the 2 pack to last 60 days. The Victoza package insert specifically says that the 0.6mg is for initiation only and is not effective for glycemic control in adults. The underutilization edit identifies members that are using Victoza at this subtherapeutic dosing since the percentage of days covered is 50%, under the specified adherence threshold. For Praluent, the recommended starting dose is 75mg every 2 weeks (150mg for 30 supply). Praluent is billed as the expected 150mg with a 30 days supply but refilled only every 60 days, which is similarly identified by the underutilization edit as the percentage of days covered is 50% and under the specified adherence threshold. Providers are instructed to either use therapeutic dosing or submit for an alternative product due to an intolerance.
Ohio	Unified Preferred Drug List (UPDL) On January 1, 2020, ODM, in partnership with the Manage Care Plans (MCPs), moved toward a Unified Preferred Drug List (UPDL). All ODM MCPs prefer the same medications and use the same prior authorization criteria for drug categories. This was created to streamline access to the pharmacy benefit and reduce administrative burden for members, prescribers, and pharmacies. Adherence to the UPDL is monitored.

State	Innovative Practices Summary
	Several new therapeutic categories were added to the UPDL throughout 2021: Central Nervous System (CNS) Agents: Movement Disorders Central Nervous System (CNS) Agents: Narcolepsy Endocrine Agents: Diabetes Hypoglycemia Treatments Endocrine Agents: Endometriosis Endocrine Agents: Uterine Fibroids Ophthalmic Agents: Ophthalmic Steroids Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE (Self-Administered) Psychiatrist Exemption Providers who are registered with Ohio Medicaid as having a specialty in psychiatry are exempt from prior authorization of any non-preferred second-generation antipsychotic or step therapy of any preferred brand in the standard tablet/capsule or long-acting injectable dosage form. They are also exempt from prior authorization requirements for non-preferred or step therapy antidepressant medications. Neurology Exemption Providers who are registered with Ohio Medicaid as having the specialty of neurologist require the documentation of therapeutic failure to only one preferred product for 30 days for approval of a non-preferred standard tablet/capsule medication that is only used to treat seizures. Chronic Conditions Quality Improvement (QI) Project ODM worked to improve diabetes outcomes. SMART Aims included increasing the percentages of members with A1Cs of less than or equal to 9% and members who complete an annual A1C screening. Interventions included standardization of quantity limits for diabetic supplies (lancets, test strips, syringes) and removal of prior authorizations for CGM products to reduce administration burden, enhancing the role of practice-embedded pharmacists as a member of the care team, disseminating information on ODM's Diabetes Self-Management Education/Training (DSME/T) benefit, and utilizing in-home A1C testing. COVID-19 Vaccine ODM's pharmacy program additionally drove innovation by reimbursing Medicaid participating pharmacies an administration fee for administering first, second and third dose federally allocated COVID-19 vaccines, in accordance with guidance from CMS. Changes in DAW Codes ODM restructured their allowance of DAW codes submitted by pharmacies. ODM will reimburse participating pharmacies only when accepted DAW Codes are submitted. Dispense as Written (DAW) codes 0, 1, 4, 5, 7, 8, and 9 are the only accepted codes that should be submitted by pharmacy providers. DAW codes 2, 3, and 6 are no longer accepted values and will cause the claim to reject for inactive DAW code. To appropriately use DAW code 1, the pharmacy must submit the claim in compliance with Ohio Revised Codes 4729.38 and 4729.40.

State	Innovative Practices Summary
	Early Synagis Access In response to an increase in summer RSV activity, ODM began the 2021 Synagis season in July instead of November. Due to the prospect of a longer RSV season, ODM approved more than the standard five doses for the 2021-2022 season. Expanded Continuous Glucose Monitor Access To eliminate an administrative barrier and increase access to care, ODM removed all prior authorizations from CGM products in July 2021.
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 Attention-deficit/hyperactivity disorder (ADHD), use of atypical antipsychotic medications, antibiotic (ABX) usage and most recently, asthma. For members with a diagnosis of persistent asthma, current guidelines recommend treatment with rescue medication as needed and daily controller medication or single maintenance and reliever therapy (SMART). In Oklahoma, nearly two-thirds of pediatric asthma patients meet the diagnostic criteria for persistent asthma, and it is the 3rd leading cause of hospitalizations for patients aged 0 to 15 years. The College of Pharmacy analyzed Oklahoma SoonerCare claims during a one-year period to investigate asthma prescribing trends. Non-specialty providers were identified to receive AD if any of the following were true regarding their patients and/or paid claims: - Greater than or equal to 50% increase in the number of rescue inhaler claims from 2019 to 2020 - Greater than or equal to 50% increase in the number of claims for any asthma medication from 2019 to 2020 - Claims for any member with a diagnosis of status asthmaticus or greater than or equal to 12 asthma-focused office visits per year during 2020 - Greater than 10 petitions for prior authorization (PA) requests for asthma medications during 2020 - Greater than or equal to 3 members each using greater than or equal to 3 rescue inhalers during 2020 - Greater than 100 members in their practice with claims for any asthma medication

State	Innovative Practices Summary
	- Greater than or equal to 50% more rescue inhaler claims than their same specialty peers (e.g., general practitioner, physician assistant) - Greater than or equal to 50% more claims for any asthma medication than their same specialty peers (e.g., general practitioner, physician assistant) Academic Detailing Data Data is continuously compiled for review and educational opportunities for improvement. Collected data for FFY 2021 focused on changes in prescribing patterns, utilization, and use of specific therapeutic agents. During FFY 2021, nearly 200 providers received Asthma-AD visits and the program impacted 4,455 members. Specific educational focus was given to recent changes in both GINA (Global Initiative for Asthma) and NHLBI (National Heart Lung and Blood Institute) guidelines and focused updates considering their potential impact on prescribing for pediatric patients. Detailed providers improved their prescribing of controller medications for members with persistent asthma by 14% and their prescribing of rescue medications by 21%. AD providers had large-scale improvements in hospitalizations and emergency department (ED) visits in the year following an AD visit, compared to their own previous 5-year averages, representing a significant clinical improvement. Changes in Academic Detailing Outcomes Healthcare Utilization Pre-AD Post-AD Change % Change Hospitalization and ED visit costs $4,083,760 $2,496,148 -$1,587,612 -38.88% *negative indicates improvement 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 96% of providers describe the program as easily understood, clearly presented, and evidence-based. When asked 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	Prior authorization implementation for provider administered asthma biologics. Implemented streamlined RetroDUR mental health polypharmacy reviews. Added melatonin coverage for kids. Automated dose consolidation prescriber messaging program for high cost/high utilization agents. POS dose consolidation edits for high cost flat priced carveout medications. Prescriber messaging alerts for high-risk patients lacking appropriate therapy, duplicate therapy, or non-adherent to prescribed treatment (bi-polar disorder and other mental health conditions). Expanded case management referrals to FFS and HNA (tribal) patients with late prescription refills who have multiple comorbidities and high risk of acquiring COVID/complications. Developed tool to flag cost-saving formulation switch opportunities.

State	Innovative Practices Summary
	Expanded safety net program to include patients with denied claims due to antipsychotic dose consolidation.
Pennsylvania	FFS uses POS edits to deny claims for prior authorization in most drug classes when therapeutic duplication is found in the claims history. The RetroDUR program is used to identify therapeutic duplication in the MCO utilization. The Department required the MCOs to enforce therapeutic duplication at the POS. As a result, therapeutic duplication has decreased dramatically in the PA MA Program.
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	South Carolina continued to partner with the Medical University of South Carolina (tipSC) with efforts concentrated on opioids. The following were targeted by the tipSC group: An extensive US mailing served a dual purpose: the dissemination of updated versions of two provider tools that are favorites among providers visited and the promotion of virtual AD visits (and phone visits if necessary) in the personalized cover letter. The novel student pharmacist-led AD outreach to the pharmacy community continues as an ongoing experiential opportunity for students at the Medical University of South Carolina and Presbyterian College that impacts current and future pharmacists and is another example of a successful return on the investment of tipSC resources. The following are a few of the Academic Detailing interventions: Non-Drug Strategies for Non-Cancer Acute and Chronic Pain (February 2021), and Medications for Opioid Use Disorder Can Change a Life (July 2021). Ongoing/Adhoc reviews continue to supplement the tipSC activities, pending the restructuring of the DUR Board.
South Dakota	South Dakota is in the initial stages to join a drug purchasing consortium to obtain supplemental rebates.
Tennessee	Our PBM Vendor has yet to be able to implement a ProDUR edit for those enrollees who are using opioids and antipsychotics concomitantly, and in order to comply with the

State	Innovative Practices Summary
	SUPPORT Act, a decision was made to begin to assign one-half of the PBM Vendor's chart reviews per month (at least 400 of the 800 profile reviews per month) for these enrollees. To go a step further, a decision was made to present 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 that is reviewed with the DUR Board is blinded with respect to the identity of any of the enrollee, pharmacy, or provider. If the Board voted to proceed with a referral to the enrollee's MCO, it is convenient that three of our physician DUR Board members have private practices but are also on staff as Medical Directors with one of the three MCO's, the enrollee's profile have been reviewed with priority by the MCO Medical Director and by Case Management and Care Coordination associates with the MCO. We are still split on whether the MCO should report back to the DUR Board with results of their review, as that would not be considered actionable by the DUR Board; however we have received responses as to actions taken by the MCO, and results of any discussion or peer review with the prescribers. Thus far, we have seen some good results, we have had some very curious questions answered, and the practice of reviewing profiles with our DUR Board during DUR Board meetings has been a successful addition to our DUR Program in Tennessee.
Texas	In FFY 2021, Vendor Drug Program implemented many innovative practices. Below are some examples. 1. During the late spring and summer of 2021, VDP coordinated with the MCOs for reopening of the RSV season in all the state's health regions. Prior authorization for prophylactic therapy was not required for those whose approval was established and had received palivizumab during the 2020-2021 regular season. HHSC sent notifications to the prescribers and pharmacies. 2. On February 1, 2021, HHSC began using a browser-based submission portal for drug manufacturers or labelers to submit request for coverage of their drugs. 3. In November 2020, Texas Medicaid began to provide coverage of all drugs used to treat opioid use disorder (OUD) as per SEC. 1006.(b) of the SUPPORT Act. 4. On December 2020, HHSC began offering the COVID-19 vaccine as a pharmacy benefit in Medicaid (fee for service and managed care) and CHIP. 5. HHSC resumed quarterly Specialty Drug List (SDL) in July 2021. This legislatively required process was suspended due to concerns of drug shortage during COVID-19 public health emergency. 6. In July 2021, all Sickle Cell treatment agents were given preferred status. The DUR Board recommended preferring all medications after consideration for the medical complexity of the disease, the available treatment options, and public testimony.
Utah	In 2021, the Utah Medicaid Pharmacy Program launched a new Antidepressant Medication Management (AMM) program outreach to non-adherent members to address and improve medication adherence. In total, 828 initial and follow-up calls were made and 58 letters were sent from March to September 2021. The adherence rate increased from 54% at baseline to 56.3% for members who started antidepressants initially for the first 6 months

State	Innovative Practices Summary
	at the end of 2021. The adherence rate remained the same (33%) for members who have been on antidepressant medication for more than 6 months. In addition to this new AMM program the Utah Medicaid Pharmacy Program continued to deliver impactful results with the many peer-to-peer programs 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 4 in September 2021. The number of children on more than one antipsychotic declined from 16 to 2 children, and the number of children on high dose antipsychotics (including exceeding literature recommendations) reduced from 64 to 30 children in this same period. Regarding the metabolic screening, in all children (foster and non-foster) receiving antipsychotics from October 2019 to September 2021, the rate of metabolic screening increased from 22% to 27%, with higher rates of 33% in foster kids. A total of 33 peer-to-peer letters were sent to providers treating the pediatric members that fall into Medicaid's antipsychotic peer-to-peer program. Beginning in May 2021, the UT Medicaid Pharmacy Team contracted with the Utah Psychotropic Oversight Program (UPOP) to have UPOP 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. The Pharmacy Team continued the ADHD stimulant medication peer-to-peer intervention to manage stimulant use in children under 4 years of age (or under 6 years of age for some specific ADHD stimulant medications). This intervention helped reduce the number of children under 4 (6 years of age for selected ADHD stimulant medications) from 7 children in July 2020 to only 2 in September 2021. In April 2021, the Pharmacy Team started a new POS edit and peer-to-peer program restricting concurrent use of the amphetamine class and the methylphenidate stimulants class for children under 18 years of age. In addition, the program also restricts the use of three or more unique ADHD stimulant medications for both children and adult members. For a short period from April 2021 to September 2021, the number of members under 18 years of age receiving both cross-class amphetamine and methylphenidate stimulants were reduced from 19 to 0. No member received 3 or more unique stimulants in September 2021. In addition to the above peer-to-peer outreach interventions, the UT Medicaid Pharmacy Team also does patient outreaches to improve medication adherence: Continuing from April 1, 2020, the Hepatitis C Medication Adherence program demonstrated impactful results: by September 2021, with 329 members enrolled in the program the adherence rate increased from 80.9% at baseline to 90.2%.

State	Innovative Practices Summary
Vermont	Morphine Milligram Equivalent (MME) Pursuant to the Medicaid Drug Utilization (DUR) provisions that were included in Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment of Patients and Communities Act, also referred to as the SUPPORT Act, the Department of Vermont Health Access (DVHA) implemented prescription limits for opioids used in treating chronic pain. These standards are focused on preventing harm by minimizing opportunities for misuse, abuse, and diversion, and to optimize prevention of addition and overdose. The amount of daily morphine milligram equivalents (MMEs) is frequently used as a risk factor to evaluate potential opioid related harms. DVHA uses the MME conversion factors provided by the Centers for Disease Control (CDC). More detailed information can be found on their website at https://www.cdc.gov/drugoverdose/prescribing/guideline.html. Effective May 1, 2021, additional edits were applied that included any combination of short and long-acting opioids and members on chronic therapy for non-cancer pain. Members new to opioid therapy with a daily MME greater than 90 per day will require the completion of an opioid safety checklist as a prior authorization. Members with existing claims history in the past 90 days for opioids (not new to therapy) will require a safety checklist if the daily MME exceeds 120 per day. Using an opioid safety checklist as opposed to a Prior Authorization was the idea of the DUR Board. When the MME limit criteria was presented to the DUR Board the board requested removing all references to limits and instead wanted to see language referring to the need for completion of a safety checklist for members exceeding the MME threshold. Tobacco Cessation Per Act 178 of the 2020 legislative session pharmacists may prescribe both prescription and over-the-counter tobacco cessation products. Provision of this service must be done in accordance with a protocol approved by the Commissioner of Health after consultation with the Director of Professional Regulation and the Board of Pharmacy. The Vermont Medicaid program will reimburse pharmacists for providing tobacco cessation counseling. Pharmacists will be paid according to the Resource-Based Relative Value Scale (RBRVS) fee schedule. Coverage will continue to be limited to 16 visits per year for Medicaid members, which can be exceeded with prior authorization. This expansion to cover tobacco cessation services provided by pharmacists is expected to increase utilization of this benefit and improve the quit rate among Vermont Medicaid members. This change was implemented on July 1, 2021. Updates on the Hepatitis C Direct Acting Antivirals The changes incorporate American Association for the Study of Liver Diseases (AASLD) and Infectious Disease Society of America (IDSA) guidelines (https://www.hcvguidelines.org/treatment-naive/simplified-treatment) for simplified HCV treatment for treatment-naive adults without cirrhosis. To further improve access to DAA therapies, effective 07/09/2021, DVHA no longer required dispensing by an accredited specialty pharmacy. Prescriptions for the following medications can now be filled at any VT Medicaid enrolled pharmacy. Epclusa (sofosbuvir/velpatasvir) Harvoni (ledipasvir/sofosbuvir) Ledipasvir/sofosbuvir Mavyret (glecaprevir/pibrentasvir)* Sofosbuvir/velpatasvir* Sovaldi (sofosbuvir) Viekira PAK (ombitasvir, paritaprevir, ritonavir tablet with dasabuvir tablet) Vosevi (sofosbuvir/velpatasvir/voxilaprevir) Zepatier (elbasvir/grazoprevir) * Preferred on the PD

State	Innovative Practices Summary
Virginia	In order to align with the Virginia Board of Medicine Regulations governing prescribing of opioids, DMAS made the following changes effective July 1, 2017: Service Authorizations are required for all long acting opioids, service authorizations are required for all short acting opioids prescribed for greater than 7 days' supply or two prescriptions for a 7 day supply in a 60 day period. Virginia Board of Medicine requires limit of treatment for acute pain with opioids to a 7-day supply and all post-op pain to no more than a 14 days' supply. In addition, DMAS has further lowered the morphine milligram equivalents (MME) from 120 to 90 MME. Service authorizations are required for any cumulative opioid prescriptions exceeding 90 MME per day. Quantity limits apply to each drug. DMAS has implemented new edits and reports to meet the requirements for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act. The DUR Board reviews each quarter concurrent use of opioids and benzodiazepines, concurrent use of opioids and antipsychotics, and opioid use with high risk factors and no naloxone use or with naloxone use. DMAS also has ProDUR edits in place that sends the pharmacist a soft message in reference to the potential risk of concurrent opioids with benzodiazepines and concurrent opioids with antipsychotics. Moreover, DMAS has implemented an edit to notify the pharmacist when an opioid niave member is trying to fill an opioid prescription and sends a message back alerting of the potential risk and to offer naloxone. DMAS continued the CNS behavioral pharmacy program which the DUR Board began in 2007. In 2008 and 2009 the CNS contract was renewed for one additional year. In 2009, the DUR Board reviewed the percentage of all patients on behavioral health medications; children taking atypical antipsychotics; and, antipsychotic medication utilization in children ages 0 to 5. During FFY 2010, the DUR Board decided to monitor all children under age 6 who are new to atypical antipsychotic therapy on a quarterly basis, which was later changed to a monthly basis. During FFY 2011, the DUR Board decided to implement a Service Authorization (SA) requirement for the use of atypical antipsychotics in children under the age of six years of age based on the following criteria: a. The drug must be prescribed by a pediatric psychiatrist or pediatric neurologist or the prescriber must supply proof of a psychiatric consultation AND, b. The recipient must have an appropriate diagnosis AND, c. The recipient must be participating in a behavioral management program AND, d. Written, informed consent for the medication must be obtained from the parent or guardian. A pediatric psychiatrist was contracted to review service authorization requests for the antipsychotics in children under the age of six that do not meet the approved criteria and provide peer to peer consultations with the prescribing providers. For requests that do not meet the criteria, the SA contractor will authorize a SA for a period of 30 days so that the child will receive the medication while requests are reviewed. This program was implemented on December 1, 2011. In FFY 2014, the program was expanded to require prior authorization requests for children ages 0 to 12 years. The program continued in FFY 2020 to include all children ages 0 to 17 years and the board continues to monitor today. 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

State	Innovative Practices Summary
	physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. The DUR Board has been focused on compounded prescriptions in terms of safety, efficacy and effectiveness as well as cost. At the May 10, 2018 meeting the Board made the recommendation to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. In order for the service authorization to be approved, the prescriber would be required to submit peer review studies of the compounded products safety and effectiveness. Compound claims over these limits will be forwarded to the DMAS physicians for review and approval/denial. This change to the compounded prescription edit was implemented on November 26, 2018 and the DUR Board continues to monitor the results. The compound prescription edit has caused a significant decrease in the number of compounded claims and the total cost on compounded prescriptions per quarter. The DUR Board actively monitors new drugs to the market and evaluates the need for utilization management through Service Authorizations (SA). During FFY 2021, 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: • Bronchitol (mannitol) • Evrysdi (risdiplam) • Eysuvis (loteprednol etabonate) • Gavreto (pralsetinib) • Imcivree (setmelanotide) • Inqovi (decitabine and cedazuridine) • Lampit (nifurtimox) • Lupkynis (voclosporin) • Mycapssa (octreotide) • Onureg (azacitidine) • Orgovyx (relugolix) • Rukobia (fostemsavir) • Tepmetko (tepotinib) • Ukoniq (umbralisib) • Verquvo (vericiguat) • Zokinvy (lonafarnib)
Washington	Hepatitis C Elimination Strategy The Hepatitis C Free Washington public health effort is ongoing and the purchasing strategy Washington State has negotiated with Abbvie is still in effect. Mavyret is still the preferred product without any prior authorization restrictions and all antiretroviral Hepatitis C medications are carved out of MCO responsibility. The Hepatitis C elimination awareness bus traveled around Washington State for education campaigns and testing. The Elimination Awareness bus made stops in early 2020 in Spokane, Olympia, and Seattle however the Washington State Health Care Authority (HCA) put a hold on public gatherings as part of the COVID-19 response. Testing resumed in the summer of 2021 and the

State	Innovative Practices Summary
	Elimination Awareness Bus went out five times during FFY 2021. The bus made two stops in Spokane on August 11 2021 and August 14, 2021, one stop in Vancouver on September 6, 2021, one stop in Centralia on September 15, 2021, and one stop in Tacoma on September 17, 2021. MCOs also received data from HCA which identified patients diagnosed with Hepatitis C who have not been initiated on treatment. Once that data was received patients were connected to care by the MCO case managers. Creation of a Specialty Drug List Washington (Apple Health) created a specialty drug list which would be used to align coverage of specialty drugs for both Fee-For-Service (FFS) and the Managed Care Organizations (MCOs). The specialty drug list would include both provider-administered and outpatient drugs. Another purpose of the specialty drug list would be 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 the HCA spends on specialty drugs annually. The process and criteria were created in April 2021 and continues to be refined to help clinicians determine which covered drugs to add to the specialty drug list A covered drug may be added to the specialty drug list when the drug meets at least two of the following criteria and is estimated to have a monthly wholesale acquisition cost of greater than or equal to $670: 1. The drug is granted FDA approval with a biologics license application. 2. The drug is prescribed by a specialist to treat a complex disease state or rare disease. 3. The drug received a breakthrough, orphan drug or accelerated approval designation(s) as assigned by the FDA. 4. The drug requires drug-specific testing prior to being prescribed. 5. The drug is part of a limited distribution drug network as determined by the manufacturer and only available to a client through a specialty pharmacy. 6. The drug may be a part of a clinical management program for a complex disease that requires additional resources to better ensure appropriate use. 7. Or at the discretion of the clinical pharmacist. Drugs on the specialty drug list may not be limited to a specialty pharmacy when ONE of the following are met: 1. The drug is NOT a part of a limited distribution drug network. 2. The drug is used to treat the following medical categories: a. Human immunodeficiency virus (HIV) b. Acute infectious diseases (e.g. pneumonia, cellulitis) c. Long-acting antipsychotics d. Opioid use disorder e. Drugs to prevent preterm labor. The result of this work will not be implemented until FFY 2022. Quantity Limits for Apple Health Preferred Drug List The Apple Health Preferred Drug List (AHPDL) currently has quantity limits for selected products and has not gone through an extensive review for consideration of quantity limits. Similar to the specialty drug list, the purpose of quantity limits for the AHPDL is to align coverage for FFS and the MCOs. A process and criteria were created in September

State	Innovative Practices Summary
	2021 and continues to be refined to help clinicians determine eligibility of a covered drug to the specialty drug list. Covered drugs eligible to have quantity limits fall into one of the following buckets: 1. A drug class with high utilization has been identified via the internal drug utilization dashboard; OR 2. An AHPDL class is scheduled for an upcoming DUR Board review; OR 3. AHPDL drug class with quantity limits already established has been identified and needs to be re-reviewed. Once a drug class is identified, the clinician examines each product listed in the AHPDL class and determines if a quantity limit is appropriate taking into consideration the following: 1. FDA approved dosing listed on package insert OR drug compendia 2. Evidence-based clinical practice guidelines 3. Peer reviewed literature 4. Costs of medication (using cost sheets, utilization dashboard, state MAC rates, point-of-sale pricing) 5. Updates to already established quantity limits 6. Dose consolidation (ex: avg units/day) After taking all the above aspects into consideration, if appropriate, the clinician will propose a quantity limit for the drug. The result of this work will not be implemented until FFY 2022. Limitation of automatic refills Starting July 2021, 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 may submit a claim and fill 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.
West Virginia	COVID- set up billing to cover test kits at the pharmacy, reimbursing for COVID vaccinations for in home administration CGM- removed requirement of 90 days of 4x fingersticks prior to CGM approval, updated to include diagnosis of gestational diabetes. Hepatitis C- removed sobriety requirements, specialist requirement removed if patient is 18 years of age or older, treatment-naive, noncirrhotic, HBV-negative, HIV negative, and non-pregnant. Virtual Meetings- WV Medicaid has continued to conduct our large scale meetings (P&T and DUR Board) virtually. This has allowed us to gain new members who would have otherwise not been able to attend due to distance.

State	Innovative Practices Summary
	Tobacco Cessation Policy: Multiple quit attempts are permitted. Prior authorization for continuation of therapy beyond the initial 12-week approval requires a written letter from the prescriber briefly addressing the efficacy of the current therap New RetroDUR interventions: Morphine Milligram Equivalents (MME) greater than or equal to 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. Diagnosis of Hepatitis C without treatment. It is recommended that patients testing positive for Hepatitis C should be provided treatment. Significant changes in PDL placement: Sulocade moved to preferred status- PA to label Apretude- preferred without PA Clinical calls with PA Vendor: This past year we added clinical calls every other week with our PA vendor. While the PA vendor does sit in on our operational calls this meeting is to target questions that they specifically have and make sure the entire team is on the same page. Some topics we go over are: draft criteria for new drugs or drugs that do not have criteria created, limits, and any issues they are facing. D1 transactions: D1 transactions implemented so pharmacies can run test claims to see what their reimbursement would be rather than actual claims and reversals which cause them to go into a pay imbalance. This ends up having a significant impact on our independent pharmacies.
Wisconsin	Attachment 6 Innovative Practices CMS FFY 2021 Benzodiazepine Newsletter The Wisconsin Drug Utilization Review (DUR) Board developed a benzodiazepine newsletter to address increases in benzodiazepine prescribing and FDA labeling changes to benzodiazepines. The letter was written in coordination with a physician psychiatry consultant. Included in the newsletter were multiple guidelines for treating anxiety disorders, risk stratification for benzodiazepine use, challenges in the management of chronic benzodiazepine use, and considerations for deprescribing benzodiazepines. Multiple provider resources are also included in the newsletter. The letter was sent in December 2020 to all enrolled prescribers and pharmacies. Multiple Prospective DUR Alerts The Wisconsin DUR Board voted to implement a system enhancement to requiring pharmacies to respond to all unique prospective DUR alerts when multiple alerts are triggered on a single pharmacy claim. Previously providers only needed to respond to one unique alert type on a claim. The change became effective on March 1, 2021.

State	Innovative Practices Summary
	Pharmacist Prescriber Outreach Calls for Patients with High Daily MME For several years the Wisconsin DUR Board has sent intervention letters to address the prescribing of high daily morphine milligram equivalents of opioids. The intervention letter identifies members taking 250 or greater MMEs per day; letters are sent to the opioid prescriber. A post intervention analysis was conducted to identify members who continued to receive at least 250 MME and their associated prescribers. Starting in August 2020 and continuing quarterly, follow up phone calls from a pharmacy consultant were initiated targeting the prescribers identified in the post intervention analysis. Information collected during the phone calls included: the diagnosis to support opioid use, if the prescriber is planning to reduce the opioid dose, and whether naloxone has been prescribed. Data from the phone calls is being collected for further evaluation and presentation to the DUR Board. High Opioid Dose Prospective DUR Alert To address requirements in the Federal SUPPORT Act, the Wisconsin DUR Board implemented a new prospective DUR alert for high opioid prescribing. The alert triggers when a pharmacy claim has a daily MME that is greater than or equal to 90. The alert was initially implemented on June 1, 2020, as an informational alert, meaning the alert posted but the pharmacy was not required to respond. The alert has since been changed (FFY 2022) from an informational status to a standard prospective DUR alert on October 1, 2021. Pharmacies must now respond to the alert when it posts. Asthma Adherence Intervention The Wisconsin DUR Board approved a retrospective letter intervention to address adherence to inhaled asthma controller medications. The drugs included were fluticasone propionate HFA, budesonide/formoterol, and fluticasone propionate/salmeterol. Intervention criteria identified potential underutilization of the included drugs. A total of 318 letters were sent to prescribers. Analysis of prescriber responses indicated that many of the prescribers planned to take some action based on information in the letters. Some of the letter responses indicated providers were using these medications on an as needed basis which prompted discussion with the DUR board about newer updates to traditional asthma treatment guidelines. The National Heart, Lung, and Blood Institute (NHLBI) and the Global Initiative for Asthma (GINA) both support use of inhaled controller medications on an as needed basis. The Board agreed that newer guidelines may be a contributing factor to some of the noted underutilization found in this intervention. Ivacaftor Adherence Analysis A review of adherence to Ivacaftor containing products was presented to the Wisconsin DUR Board at the September 2021 quarterly Board meeting. Ivacaftor containing drugs are used for the treatment of cystic fibrosis and high-cost medications. Ivacaftor containing drugs should be taken daily for maximum effectiveness. There was a total of 139 members identified as taking Ivacaftor containing drugs. Overall adherence was good on ivacaftor containing products with only 13 members were identified as potentially non adherent. A clinical pharmacist review of the 13 members indicated only six were a medication adherence issues that may be of concern. The DUR Board decided further intervention was not necessary based on the low nonadherence rate.

State	Innovative Practices Summary
	Naloxone Retrospective DUR Letters To address requirements in the Federal SUPPORT Act, the Wisconsin DUR Board implemented two new retrospective criteria identifying members at high risk of opioid overdose who may benefit from co-prescribing of naloxone. The new criteria were implemented in March 2021. One criterion identifies members who have 90 days of an opioid in 90 days with a diagnosis of substance abuse and no naloxone claims in the last 180 days. The other criteria identifies members who have 60 days of an opioid in the last 90 days with a diagnosis of opioid or benzodiazepine poisoning in the last 90 days and no naloxone claims in the last 180 days. Letters were sent to prescribers associated with the identified members starting in March 2021. In the first three months of this intervention, 119 letters were sent to prescribers. Initial analysis of prescriber responses indicated most planned to take some action based on the information in the letter. Naloxone utilization will continue to be monitored as part of the Support Act requirements. Multiple Sedative Hypnotic Intervention A focused intervention was conducted in June 2021 to address the use of multiple sedative hypnotic medications. Analysis was preformed to identify members who appeared to be taking multiple sedative hypnotic medications concurrently. In June 2021, 162 members were identified as meeting criteria and 115 letters were sent to their prescribers about the issue. A review of the prescriber responses were presented to the DUR Board. Most of the prescribers who responded indicated some positive action was going to be taken. The Board expressed interest in expanding the medication list used for this intervention to include other CNS depressants. This intervention has been continued with the expanded drug list.
Wyoming	Not applicable

Section X - Managed Care Organizations (MCOs)

1. How many MCOs are enrolled in your state Medicaid program?

Figure 156 - Number of MCOs Enrolled in State Medicaid Program

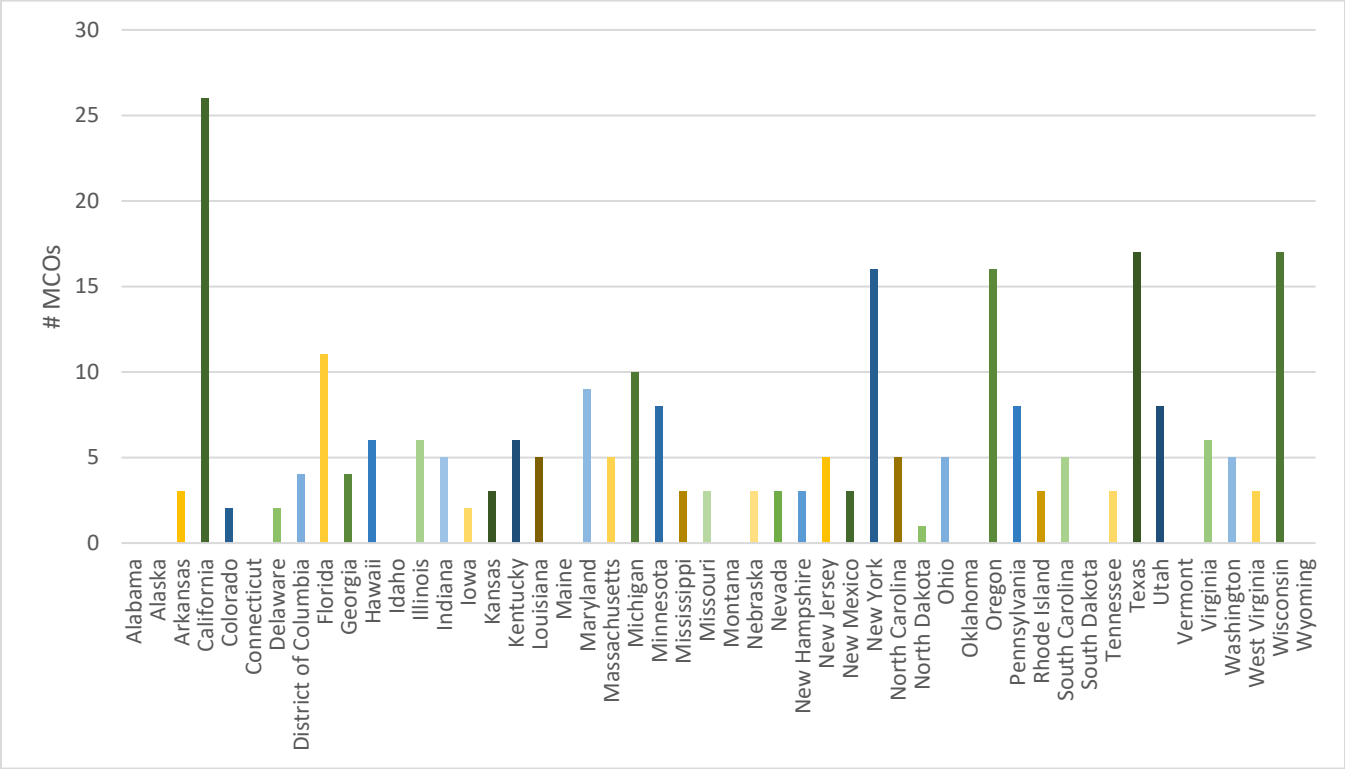

Table 277 - Number of MCOs Enrolled in State Medicaid Program

State	Number of MCOs
Alabama	0
Alaska	0
Arkansas	3
California	26
Colorado	2
Connecticut	0
Delaware	2
District of Columbia	4
Florida	11
Georgia	4
Hawaii	6
Idaho	0
Illinois	6
Indiana	5
Iowa	2
Kansas	3
Kentucky	6

State	Number of MCOs
Louisiana	5
Maine	0
Maryland	9
Massachusetts	5
Michigan	10
Minnesota	8
Mississippi	3
Missouri	3
Montana	0
Nebraska	3
Nevada	3
New Hampshire	3
New Jersey	5
New Mexico	3
New York	16
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	8
Vermont	0
Virginia	6
Washington	5
West Virginia	3
Wisconsin	17
Wyoming	0
Total	258

2. Is your pharmacy program included in the capitation rate (carved in)?

Figure 157 - Pharmacy Program Included in the Capitation Rate (Carved In)

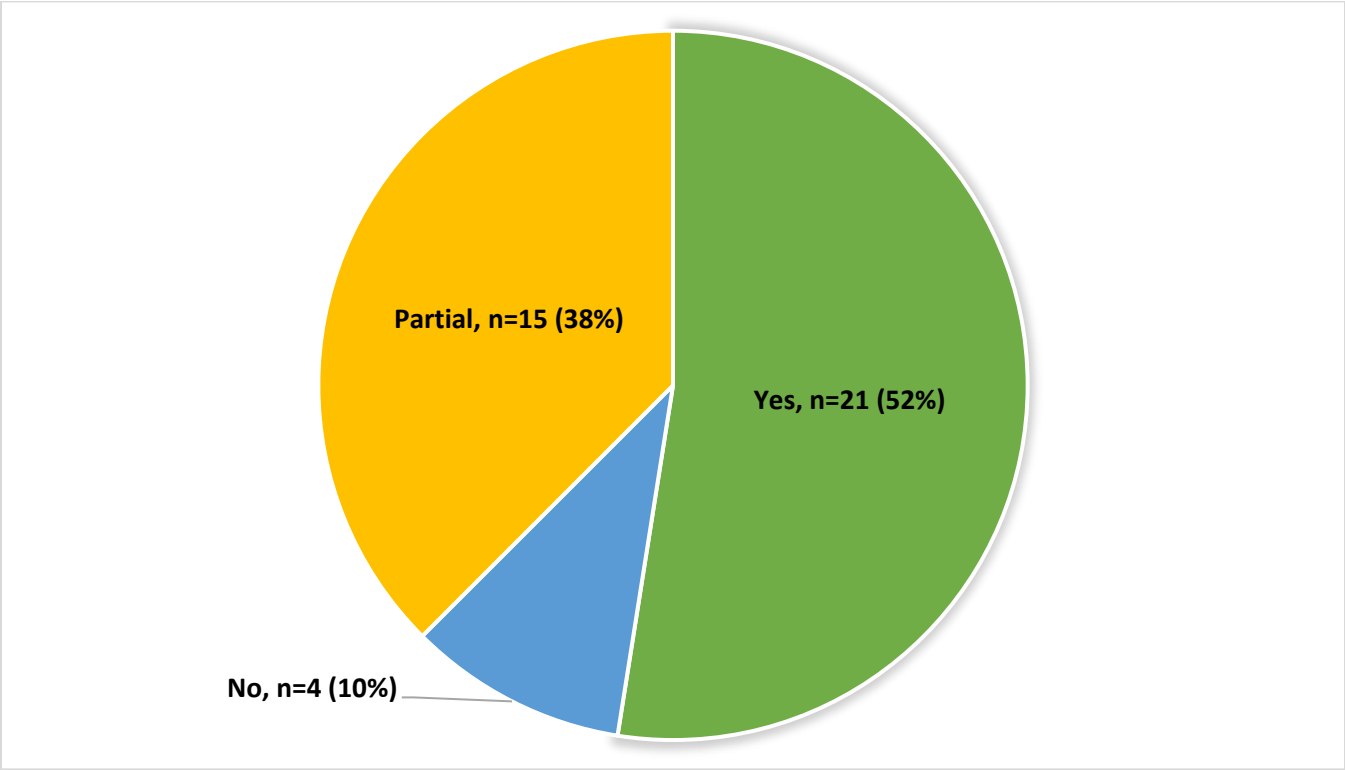

Table 278 - Pharmacy Program Included in the Capitation Rate (Carved In)

Response	States	Count	Percentage
Yes	Arkansas, Delaware, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Virginia, West Virginia	21	52.50%
No	Missouri, North Dakota, Tennessee, Wisconsin	4	10.00%
Partial	California, Colorado, District of Columbia, Florida, Indiana, Iowa, Maryland, Michigan, Mississippi, New Hampshire, Oregon, Rhode Island, Texas, Utah, Washington	15	37.50%
Total		40	100.00%

If "Partial," please specify the drug categories that are carved out.

Table 279 - Drug Categories that are Carved Out of the Capitation Rate

State	Drug Categories
California	1. Selected HIV/AIDS/Hepatitis B treatment drugs; 2. Selected alcohol and heroin detoxification and dependency treatment drugs; 3. Selected coagulation factors; and 4. Selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)
Colorado	Certain outpatient hospital specialty drugs are carved out from Enhanced Ambulatory Patient Group (EAPG) payment. These drugs include Brineura, Spinraza, Kymriah, Yescarta, Danyelza, and Zolgensma.
District of Columbia	HIV
Florida	Hemophilia
Indiana	Hepatitis C agents, cystic fibrosis agents, clotting factor agents, muscular dystrophy agents, non-hydroxyurea Sickle Cell agents, and spinal muscular atrophy agents are carved-out.
Iowa	Zolgensma
Maryland	During FFY2021, the following drug categories were carved out of the MCO benefit and paid FFS: mental health medications, substance use disorder products.
Michigan	Mental health drugs/psychotropics, substance abuse treatments, hemophilia clotting factors, HIV antivirals, Hepatitis C treatments and drugs used to treat rare conditions.
Mississippi	Beneficiaries diagnosed with hemophilia are carved out and enrolled in FFS. A member must be disenrolled from the contractor (MCO) and enrolled in FFS if the member is diagnosed with hemophilia. Hemophilia products are not included in the MCO capitation rate. Long-term care beneficiaries are also carved out and enrolled in FFS.
New Hampshire	Drugs to treat hemophilia when billed at point of service (POS), Carbaglu, Ravicti, Zolgensma and COVID vaccines,
Oregon	mental health drugs are caved out
Rhode Island	Stop gap arrangement for Hepatitis C medications.
Texas	There are some drugs that are considered as non-risk for the MCOs. These include: antihemophilic treatment agents, direct acting antivirals for treatment of hepatitis C, gene-based Duchene muscular dystrophy treatment, gene-based therapy for retinitis pigmentosa, immunotherapy for certain types of lymphoma
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

State	Drug Categories
Washington	ANTIHYPERLIPIDEMICS : ANGIOPOIETIN-LIKE PROTEIN INHIBITORS ENDOCRINE AND METABOLIC AGENTS : ADENOSINE DEAMINASE SCID TREATMENT AGENTS-INJECTABLE ENDOCRINE AND METABOLIC AGENTS : CORTISOL SYNTHESIS INHIBITORS ENDOCRINE AND METABOLIC AGENTS : MOLYBDENUM COFACTOR DEFICIENCY (MOCD) AGENTS ENDOCRINE AND METABOLIC AGENTS : NATRIURETIC PEPTIDES ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - INJECTABLE ENDOCRINE AND METABOLIC AGENTS : TRIPEPTIDYL PEPTIDASE 1 DEFICIENCY AGENTS ENDOCRINE AND METABOLIC AGENTS : X-LINKED HYPOPHOSPHATEMIA (XLH) AGENTS GASTROINTESTINAL AGENTS : ILEAL BILE ACID TRANSPORTER INHIBITORS GENITOURINARY AGENTS - MISC : HYPEROXALURIA AGENTS HEMATOPOIETIC AGENTS : ERYTHROID MATURATION AGENT HEMATOLOGICAL AGENTS - MISC : AMINOLEVULINATE SYNTHASE 1-DIRECTED SIRNA HEMATOPOIETIC AGENTS : SICKLE CELL ANEMIA - SELECTIN BLOCKER IMMUNOSUPPRESSIVE AGENTS : MONOCLONAL ANTIBODIES MISCELLANEOUS THERAPEUTIC CLASSES : PROGERIA TREATMENT AGENTS NEUROMUSCULAR AGENTS : ALS AGENTS - MISC NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY AGENTS - ANTISENSE OLIGONUCLEOTIDES NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY - GENE THERAPY AGENTS NUTRIENTS : LIPIDS ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T) ONCOLOGY AGENTS : RADIOPHARMACEUTICAL OPHTHALMIC AGENTS : GENE THERAPY

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 158 - Have States Updated Their MCOs' Contracts for Section 1004 Compliance

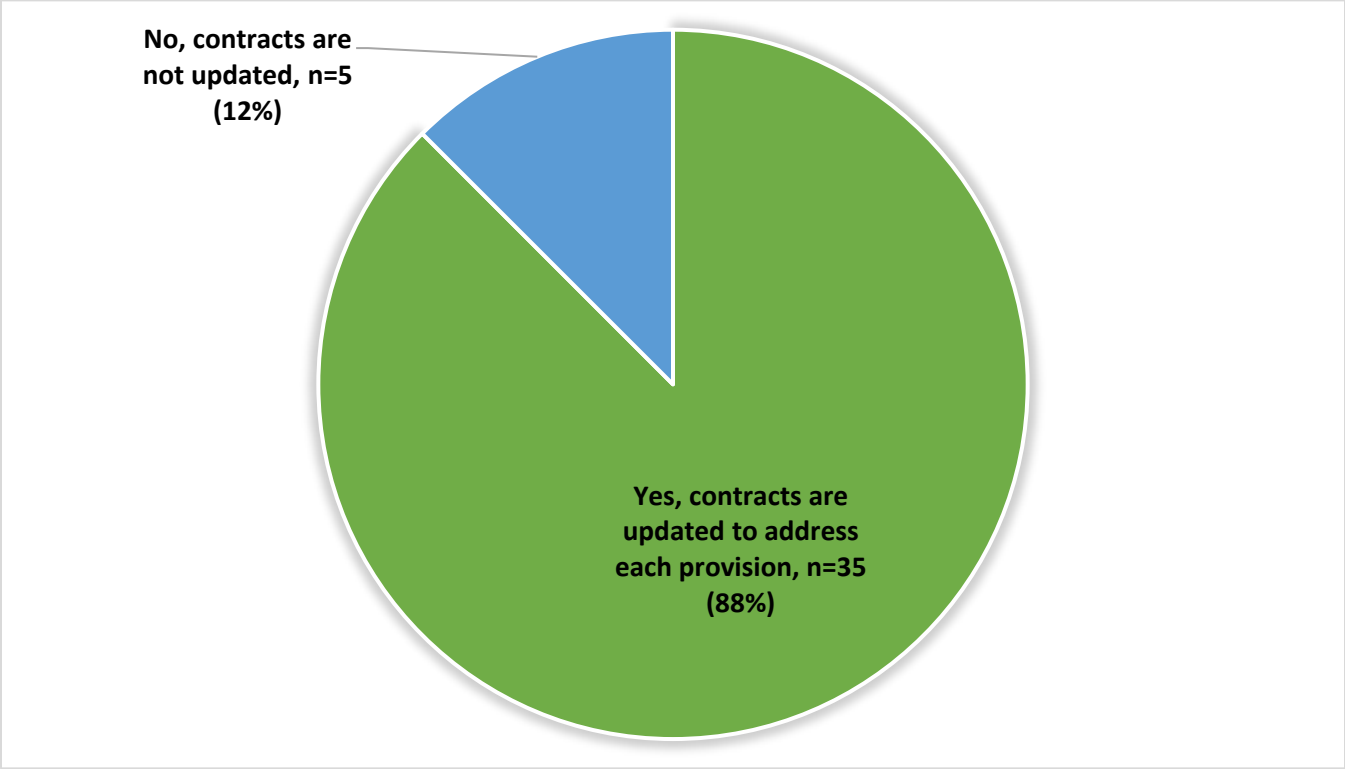

Table 280 - Have States Updated Their MCO's Contracts for Section 1004 Compliance

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, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia	35	87.50%
No, contracts are not updated	Mississippi, Missouri, New York, North Carolina, Wisconsin	5	12.50%
Total		40	100.00%

If "Yes," please specify effective date.

Table 281 - Effective Dates for Updating MCO Contracts for Section 1004 Compliance

State	Effective Date
Arkansas	09/19/2019
California	10/01/2019
Colorado	07/01/2021
Delaware	01/01/2019
District of Columbia	10/01/2020
Florida	10/01/2020
Georgia	10/01/2019
Hawaii	06/05/2020
Illinois	12/18/2019
Indiana	10/01/2019
Iowa	7/2/2020
Kansas	12/04/2020
Kentucky	01/01/2021
Louisiana	07/01/2019
Maryland	10/1/2019
Massachusetts	01/01/2020
Michigan	10/01/2020
Minnesota	01/01/2020
Nebraska	01/01/2017
Nevada	10/01/2020
New Hampshire	12/18/2019
New Jersey	10/01/2019
New Mexico	10/01/2018
North Dakota	01/01/2019
Ohio	7/1/2019
Oregon	01/01/2020
Pennsylvania	10/1/2019
Rhode Island	07/01/2021
South Carolina	07/01/2021
Tennessee	7/1/2020
Texas	08/14/2020
Utah	07/01/2019
Virginia	10/24/2018
Washington	07/01/2021
West Virginia	7/1/2020

If contracts are not updated, please explain.

Table 282 - Explanations for States That Have Not Updated MCO Contracts for Section 1004 Compliance

State	Explanation
Mississippi	An RFQ is in process now for MCOs. New contracts will be finalized later this year to reflect this provision.
Missouri	N/A
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 state has overarching language that requires the plans to comply with all state and federal requirements. Language will be added to future contract amendments to specify compliance with the SUPPORT Act.
Wisconsin	Covered outpatient drugs are carved-out of the managed care benefit packages and are covered fee-for-service. As a result, managed care entities do not process covered outpatient drug claims.

a. Is the state complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions?

Figure 159 - Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions

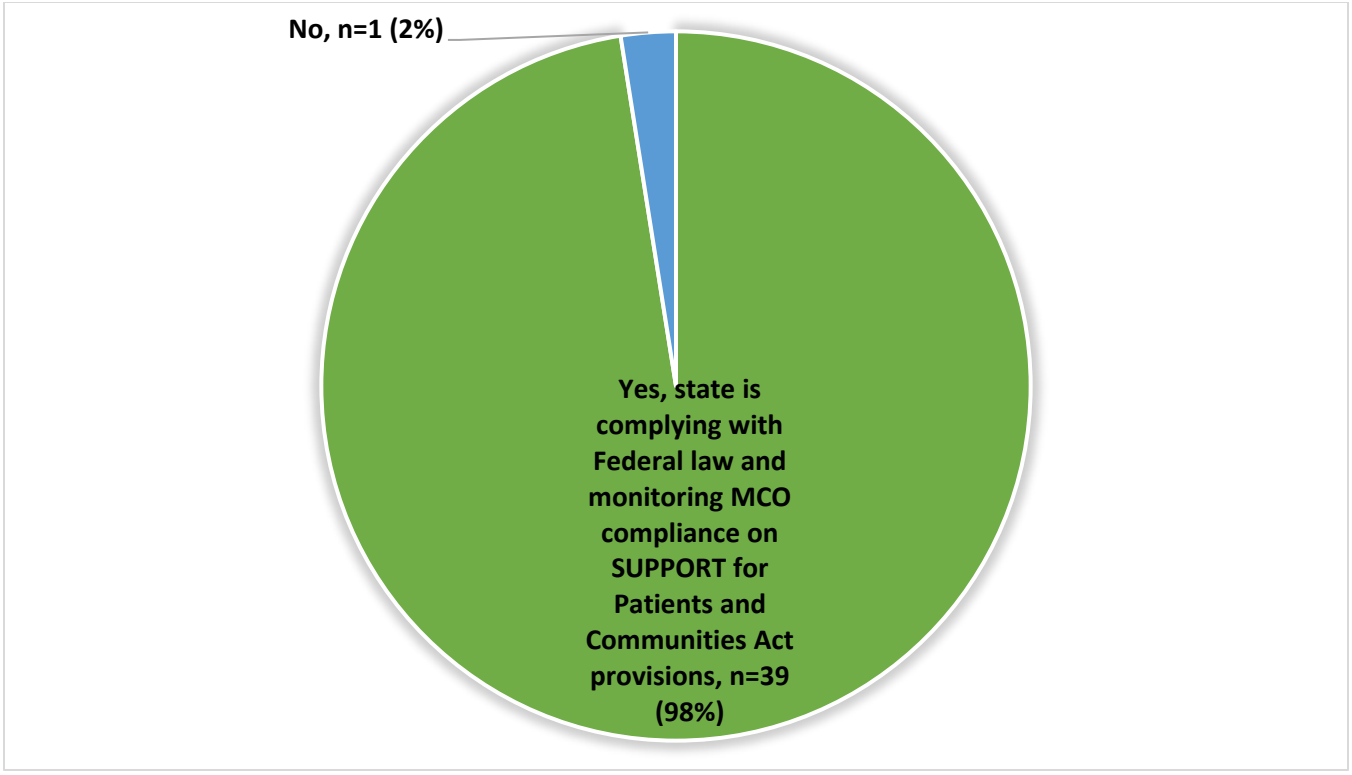

Table 283 - Monitoring MCO Compliance on SUPPORT for Patients and Communities Act Provisions

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 284 - 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 contract 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 for a claims review automated process for MME for treatment of chronic pain and for when the recipient exceeds maximum MME doses. 3. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. 4. Program to monitor and manage the appropriate us of antipsychotic medication by Medicaid children 5. Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies. The PASSEs are required to submit quarterly reports to the State for review. Ad hoc reports are often requested as well. Each PASSE is required to have a minimum of two DUR meetings per year, and the committee must include a voting representative from the State. This requirement allows for additional monitoring of ProDUR and RDUR processes which includes SUPPORT Act criteria.
California	Per All Plan Letter 19-012, all MCO policies and procedures addressing the requirements of the SUPPORT Act have been submitted by each MCO and reviewed for compliance.
Colorado	The State DUR Contact and other members of the State's Pharmacy Office team work directly with designated MCO DUR program pharmacist contacts (for each of the State's two MCOs) to coordinate DUR program activities and verify compliance with these provisions.

State	Explanation
Delaware	Delaware MCO oversight includes operational meetings with the MCOs, External Quality Review processes, and corrective actions plans with remediation activities. The SUPPORT Act compliance is incorporated into those operations. Delaware also added a Compliance Officer position in October 2019.
District of Columbia	DHCF conducts monthly oversight meetings with each MCO to review MCO drug utilization reports. MCOs attend quarterly FFS DUR Board meetings to present their monitoring and outcomes assessment of the MCO's drug utilization activities regarding opioid use, opioid/antipsychotic, opioid/benzodiazepines and opioid/antidepressant and the documented case management and medication management services that are offered to their members.
Florida	Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-49 sent on August 31, 2020 with the requirements of the Support Act: https://ahca.myflorida.com/medicaid/statewide_mc/mcp_plan_comunications_archive.shtml
Georgia	Antipsychotic use in children, walk-in programs, and use of PDMP, concurrent reviews, etc.
Hawaii	The FFS DUR Board discusses MCO program compliance. The State began meeting with MCO pharmacists monthly to discuss, implement, review and improve the MCO compliance. Quarterly reports are due with revised templates in FFY 2022.
Illinois	The MCOs must attest they are conducting DUR.
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.
Kentucky	Kentucky DMS monitors MCO compliance with the SUPPORT Act via quarterly reports from each of the MCOs.

State	Explanation
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 and rule both through the CMS annual report and quarterly reports with regards to prior authorizations that are responded to within the 24 hour requirement as part of the contracts.
Mississippi	SUPPORT Act requirements have been communicated to and discussed with the MCOs. The MCOs are reporting on the provisions.
Nebraska	Yes, it is. We are in constant contact with the MCO's and FFS and sharing SUPPORT Act data and as stated earlier, report out to the DUR Board at least every six months.
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.
New Jersey	The State confirms required coverage of OUD treatment medication in Medicaid, with some allowable exceptions, by requesting quarterly formulary submissions from each MCO. PA requirements for MAT services were removed effective April 1, 2019 for both the MCOs and FFS. Formulary submissions confirm no PA indicators exist on these products. Any changes to policies regarding the MCO outpatient DUR program, including prospective drug review, retrospective drug use review, and an educational programs, must be approved by the State prior to implementation.

State	Explanation
New Mexico	MCO Pharmacy Quarterly reports are submitted to the state that includes 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	The state has Point of Sale system edits to alert pharmacists to the combination of drugs listed in the SUPPORT Act. Additionally, a monthly report is generated to highlight beneficiaries receiving these combinations of drugs. All MAT drug are covered via Point of Sale, as is appropriate, with no PA requirements for Suboxone or Sublocade. During the period of the public health emergency, the state allowed a 90 day supply of MAT drugs via the Point of Sale system, if written in this manner by the prescriber. Additionally, the state allowed up to a 14 day emergency supply in lieu of the mandatory 72 hour in order to increase patient access to these meds during this unusual time. Part of the state's PA requirements for receiving opioids is a limit on the days supply for an initial fill in accordance with the state's STOP Act. Additionally, in order to receive an MME (cumulative for all meds) above 90, the prescriber must fill out a high dose PA request. The MCOs are required to follow our PA requirements and policies, thus helping to ensure the MCOs compliance to the SUPPORT Act.
North Dakota	We have been in communication with the MCO to ensure they are complying.
Ohio	ODM developed a minimum standards for SUPPORT Act compliance document and required all of the MCPs to submit to the state how they are currently meeting the standards and/or how they intend to meet the standards by no later than October 1, 2019. The document is available at: 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	o Section 2.12.03.02.01 Drug Utilization Review MCOis 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

State	Explanation
	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 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. o 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 o 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

State	Explanation
	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 2. at least 3 different pharmacies, and 3. at least 3 different emergency room prescribers. 2.30.6.8 The CONTRACTOR shall submit a quarterly Pharmacy Services Report on the prescribing of selected medications mutually agreed-upon by TENNCARE and the CONTRACTOR and includes a list of the providers who appear to be operating outside industry or peer norms as defined by TENNCARE or have been identified as non-compliant as it relates to adherence to accepted treatment guidelines for use of said medications and the steps the CONTRACTOR has taken to personally intervene with each one of the identified providers as well as the outcome of these personal contacts. 2.30.6.9 The CONTRACTOR shall submit a Pharmacy Services Report, On Request when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.
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.

State	Explanation
Washington	HCA has developed reports related to the SUPPORT Act for opioid MME, co-prescribing and psychotropic use in children. These reports will be used to conduct analysis and make recommendations for follow-up oversight activities to one of the following: HCA Program Integrity, HCA Quality Management Team, Managed Care Review and Analytics Team, Patient Review and Coordination Team, or to the Pharmacy Team for a DUR activity.
West Virginia	The MCO shall comply with Section 1004 of the SUPPORT for Patients and Communities Act and the Drug Utilization Review (DUR) regulations as described in section 1927(g) of the Act and 42 CFR part 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	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 opioids permitted in a calendar month, limiting the amount of short-acting and/or select long-acting opioids in a rolling calendar month, limiting early refills, limiting duplicate fills of select drug classes (i.e., opioids, benzodiazepines, etc.). Also conducting lock-in reviews, and reviewing concurrent utilization of opioids and benzodiazepines, opioids and antipsychotics, and monitoring of morphine milligram equivalents (MME). The state also monitors antipsychotic medications prescribed to children. The state also monitors potential 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 fee-for-service. As a result, managed care entities do not process covered outpatient drug claims and there are no managed care organization activities for the state to monitor in this regard. However, all Medicaid members are subject to the safety monitoring activities listed above.

If "No," please explain.

Table 285 - 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 (e.g. same preferred drug list, same ProDUR/RetroDUR)?

Figure 160 - State Mandating Requirements for the MCO's Pharmacy Benefit

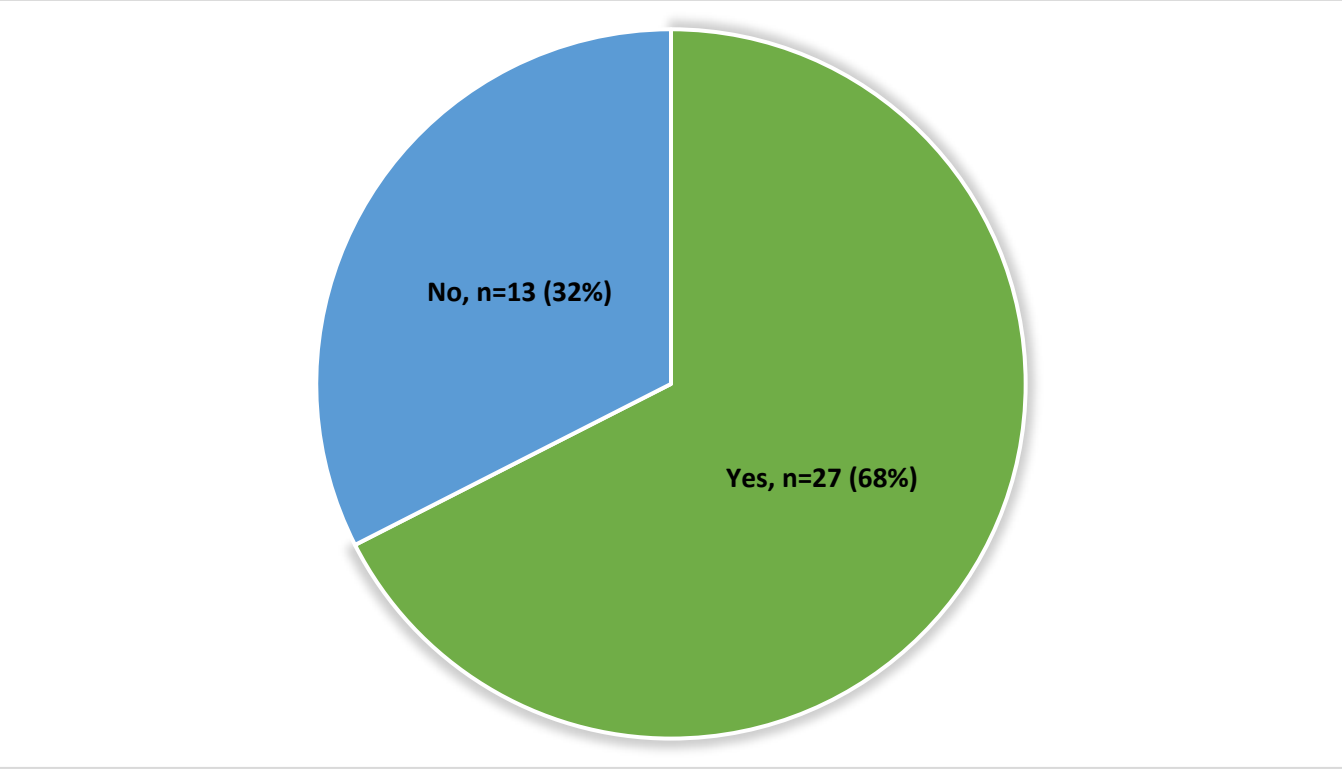

Table 286 - State Mandating Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia	27	67.50%
No	Georgia, Hawaii, Indiana, Missouri, Nevada, New Mexico, North Dakota, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin	13	32.50%
Total		40	100.00%

a. If "Yes," please check all that apply.

Figure 161 - State Requirements for the MCO's Pharmacy Benefit

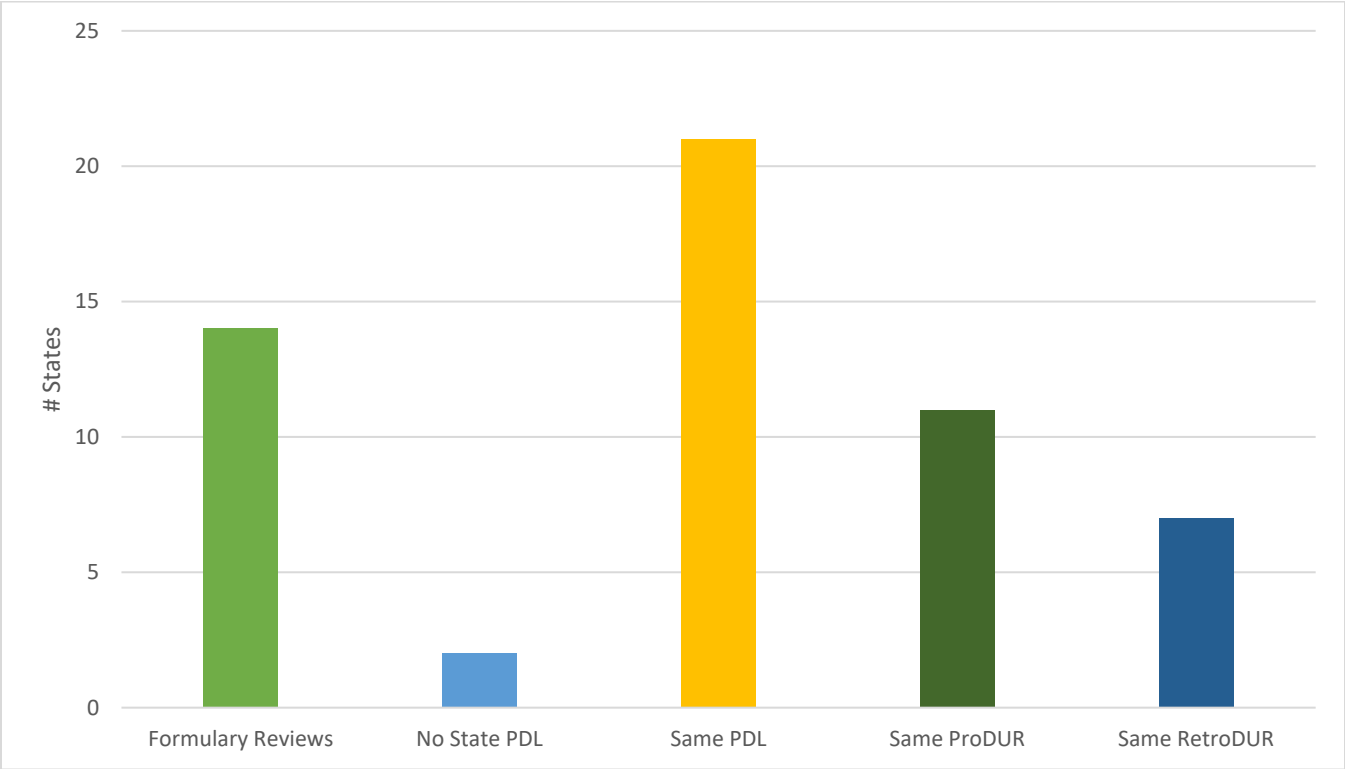

Table 287 - State Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Formulary Reviews	California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Washington	14	25.45%
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	Florida, Iowa, Kansas, Louisiana, Mississippi, Nebraska, New Jersey	7	12.73%
Total		55	100.00%

b. If "Yes," please briefly explain your policy.

Table 288 - 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-preferred status of each NDC. The PASSEs must update their pharmacy claims system within one business day of receipt of the Custom Drug File or for any off-cycle updates. The PASSEs are required to maintain a drug formulary that must be developed and reviewed at least annually by an appropriate P&T or DUR Committee. The reviewed formulary must be submitted to the State for input at least 30 days prior to implementation. Drugs on the PDL must be covered without prior authorization unless they are subject to clinical or utilization edits as defined by the State. For drugs not on the Arkansas PDL but that are covered outpatient drugs, the PASSEs may require prior authorization. Prior authorization criteria and PDL formulary cannot be more restrictive than the Arkansas Medicaid Fee For Service Program. The PASSEs are not authorized to negotiate rebates with manufacturers for products on the PDL, and the State collects all rebates for outpatient drugs dispensed to enrolled clients. Drug utilization encounter data must be provided by the PASSEs for all claims including paid, denied, voided, and rejected no later than 45 calendar days after the end of each quarterly rebate period. Also, the PASSEs must identify encounter claims administered under the 340B program.
California	Medi-Cal MCOs are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program and their preferred drug lists (PDLs) are required to be comparable to the Medi-Cal List of Contract Drugs. While all drugs included on the Medi-Cal List of Contract Drugs do not need to be included on the MCOs' PDLs, comparable means that the drugs on the PDLs must have the same mechanism of action sub-class within all major therapeutic categories of drugs included in the Medi-Cal List of Contract Drugs. Starting in FFY 2018, the DUR Board expanded to become the Global Medi-Cal DUR Board, with MCO representatives now included as Board members. MCOs utilize the Global Medi-Cal DUR Board and educational components of the Medi-Cal DUR program. However, MCOs maintain their current proprietary claims processing procedures and protocols and MCOs individually administer the systematic components related to the prospective and retrospective DUR processes. As is the case with the Fee-For-Service (FFS) program, MCOs are not required to implement all DUR Board recommended actions, nor are they required to mirror the Medi-Cal DUR activities.
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 to ensure consistency for providers and members. MCOs may adopt different clinical review requirements with approval from the State.
District of Columbia	Each MCO's formulary is reviewed and approved by DHCF upon contract initiation and with any quarterly updates or revisions. MCOs can not post changes to their formulary without notification to and approval of DHCF.
Florida	MCO plans criteria, edits, etc. cannot be more restrictive than the Agency.

State	Explanation
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-forservice (FFS) preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits.
Kansas	The MCOs are to have the same drug coverage and DUR program as FFS, with few exceptions. The MCOs can set different quantity or day supply limits, if there is not a limit already set in state policy. The state requires some specific 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 has been aligned over time. ProDUR: Each plan follows DUR Board directives for prospective criteria. However, safety edits such as quantity limits are allowed to be implemented by the MCO if they are in accordance with FDA guidelines. RetroDUR: FFS and MCOs adhere to an annual schedule of retrospective reviews. MCOs are allowed to implement additional retrospective reviews when approved by Medicaid pharmacy staff. Educational objectives are supported by the University of Louisiana at Monroe College of Pharmacy. MCOs are allowed to bring additional educational initiatives to the DUR Board and Medicaid pharmacy staff for consideration.
Maryland	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefit including P &T Committee management and procedures, formulary content/management, prior authorization procedures and criteria, generic substitution, drug utilization reviews and disease management programs. A review and assessment of each MCO Drug Use Management Program is conducted annually.
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.

State	Explanation
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 (sPDL) across both FFS and the MCOs was implemented.
Minnesota	DHS has developed a uniform nonpreferred PDL drug prior authorization used by both FFS and MCOs. If the MCO chooses, they can develop their own PA criteria but the criteria cannot disadvantage the preferred drug.
Mississippi	MCOs have been required to reimburse at the same amount as or higher than FFS on pharmacy claims. Since January 2015, MCOs have been required to use the UPDL and same clinical criteria.
Nebraska	Nebraska has a single PDL and manages their own RetroDUR program.
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	The plans are required to comply 100% with the state FFS pharmacy program for policy, PDL, PA, operations and reimbursement methodology. They are required to perform all ProDUR alerts as required by federal law, but may have slight variations on which drugs alert based on differing data base vendors. The plans are required to submit a ProDUR alert report each quarter in order to see which drugs are hitting the edits, which can be utilized as a tool to monitor the MCOs. We utilize a single PDL and the same PA requirements. Plans are not allowed to impose PA if the state FFS program does not have a PA. PA criteria is developed and approved by the state's P&T and PAG (Physician's Advisory Group). This information is then disseminated to the plans for implementation within 60 days of notice. The plans are held to a standard of 95% utilization of preferred drugs dispensed and are monitored each quarter. Plans not meeting this SLA are subject to liquidated damages.
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.

State	Explanation
Texas	The state sets some requirements for the MCOs pharmacy benefits: Single PDL Single Formulary POS clinical PA criteria must not be more astringent 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 13 closed classes for which only the drugs listed within the classes are covered. For the closed classes, the plans will NOT be able to add or delete any drugs to these classes. DMAS will collect supplemental drug rebates for the drugs in these closed classes. The primary focus of this is for the ease of the providers and the members. It will decrease the administrative burden for prescribers while ensuring continuity of care for the members.
Washington	In January 2018 Washington Medicaid began implementing a single Apple Health Preferred Drug List (AHPDL) to be used by the fee-for-service (FFS) program and all five contracted Managed Care plans (MCO). The AHPDL initially included approximately 25 drug classes with additional classes being added overtime (2018-2020). The AHPDL was fully implemented June 2020. The FFS and MCO programs are required to use the AHPDL drug statuses, prior authorization requirements, and drug policies. The MCOs may continue to apply their own quantity limits and corporate drug policies when a shared policy has not been developed. For all drugs paid through the pharmacy benefit and not included on the AHPDL, MCOs must have a wrap-around formulary and submit any requested changes to Washington Medicaid for review and approval.
West Virginia	All pharmacy is carved out. Previously the MCOs were required to use the same PDL.

If "No," does your state plan to set standards in the future?

Figure 162 - Future Plans to Set MCO Pharmacy Benefit Standards

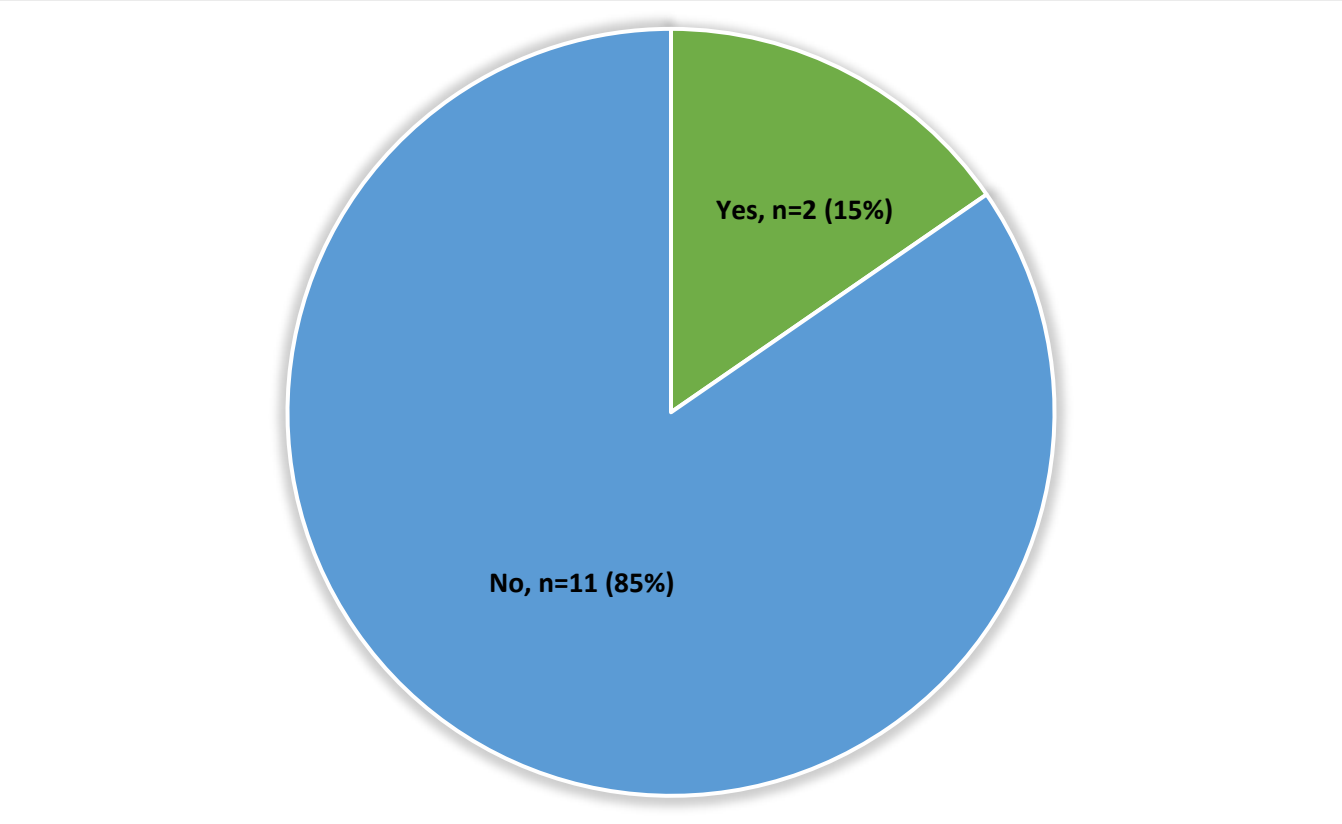

Table 289 - Future Plans to Set MCO Pharmacy Benefit Standards

Response	States	Count	Percentage
Yes	Nevada, South Carolina	2	15.38%
No	Georgia, Hawaii, Indiana, Missouri, New Mexico, North Dakota, Oregon, Rhode Island, Tennessee, Utah, Wisconsin	11	84.62%
Total		13	100.00%

If “No,” please explain.

Table 290 - Explanations for not Setting MCO Pharmacy Benefit Standards in the Future

State	Explanation
Georgia	Not planning on doing so in the future.
Hawaii	Currently ad hoc and selective legislated programs set the requirements for the MCO pharmacy benefit.
Indiana	Establishing requirements such as these would require substantial contract changes and negotiations.
Missouri	Pharmacy benefits are carved out of Managed Care.
New Mexico	Future considerations have been discussed for FFY23 or FFY24.
North Dakota	Pharmacy benefit 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	Currently no plan in place
Tennessee	Tennessee is a 100% managed care state, with pharmacy carved out, so the MCO's only manage and cover physician administered drugs from the office and outpatient settings. However, all members regardless of which MCO they are enrolled with, are under the same TennCare PDL, ProDUR, RetroDUR, and all products and categories are subject to formulary reviews by TennCare's PAC (Professional Advisory Committee), which is TennCare's P&T Committee.
Utah	Not planned at this time.
Wisconsin	The drug benefit is carved-out form 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 163 - RetroDUR Program Operated by State, MCO, or Combination of State and MCO

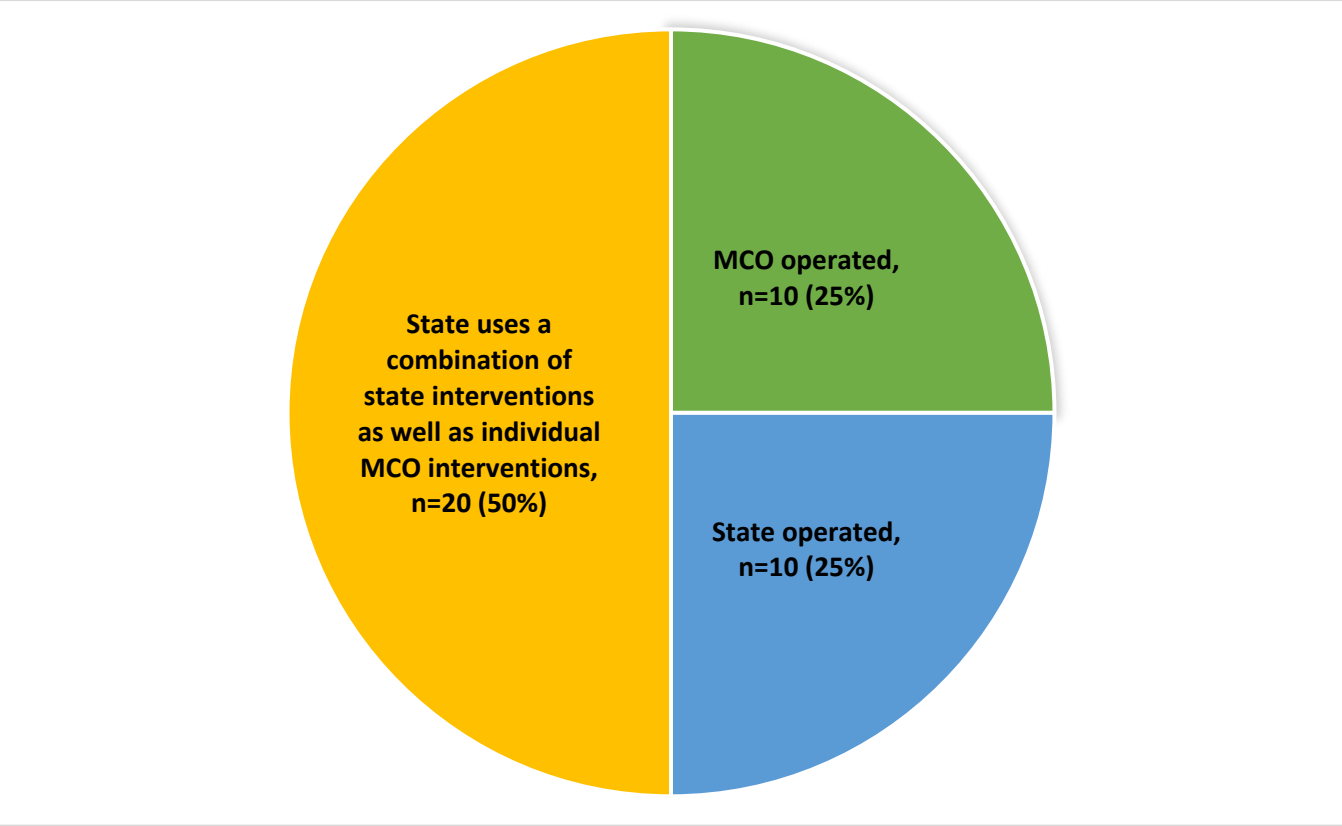

Table 291 - RetroDUR Program Operated by State, MCO, or Combination of State and MCO

Response	States	Count	Percentage
MCO operated	Arkansas, Hawaii, Illinois, Maryland, Michigan, Minnesota, Nevada, New Hampshire, Ohio, Rhode Island	10	25.00%
State operated	Florida, Georgia, Indiana, Iowa, Mississippi, Missouri, Nebraska, North Dakota, West Virginia, Wisconsin	10	25.00%
State uses a combination of state interventions as well as individual MCO interventions	California, Colorado, Delaware, District of Columbia, Kansas, Kentucky, Louisiana, Massachusetts, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington	20	50.00%
Total		40	100.00%

6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.

Table 292 - 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 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 FFS RetroDUR educational bulletins and alerts.
Colorado	The State's two MCOs each have designated DUR program pharmacist contacts that collaborate with the State DUR Contact and other members of the State's Pharmacy Office team regarding MCO RetroDUR program activities. MCO DUR contractual obligations are also managed through coordinated efforts involving the MCO contract management team within the State's Health Programs Office.
Delaware	Prospective and retrospective DUR alerts and edits for both MCOs and FFS require State approval. Educational programs and provider outreach also require approval by the State.
District of Columbia	MCO Pharmacy and Medical Directors attend quarterly FFS DUR Board meetings to present their individual MCO's monitoring and outcomes assessment of the MCO's drug utilization activities regarding opioid use, opioid/antipsychotic, opioid/benzodiazepines and opioid/antidepressant and the documented case management and medication management services that are offered to their members. Monthly Oversight meetings are held with individual MCO Pharmacy Directors to review and discuss questions or outlier claims found in the MCO monthly Drug Utilization and Prior Authorization reports.
Florida	The State oversees the DUR program which includes prospective and retrospective reviews. The State meets with the DUR Board quarterly to review drug utilization including pre and post impact analysis of edits, review of drug criteria, prior authorizations requirements, and pipeline drugs. The MCOs participate on the State DUR Board and also may operate their own internal DUR program. MCOs submit an annual report to Medicaid describing their DUR program activities.
Georgia	The State reviews each of the MCO's annual DUR report and approves prior to submission.

State	Explanation
Hawaii	State clinical staff attend and participate in all FFS DUR Board discussions for the FFS retrospective DUR program. Quarterly and annual MCO reports provide an example of the MCO retrospective DUR programs.
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.
Kentucky	The state is contracted with Magellan Medicaid Administration (MMA) for the FFS RetroDUR program. The state reviews and approves all RDUR criteria and interventions before they are sent. MMA provides the state with follow up stats on interventions and cost savings associated with interventions. Kentucky DMS utilizes quarterly reports to monitor the MCO's RetroDUR programs. Kentucky DMS monitors the following types of information: Retrospective drug utilization review activities and outcomes of initiatives performed during the calendar year, new or removed MCO RDUR initiatives for the calendar year, 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.

State	Explanation
Michigan	MDHHS and the DUR Board oversee the FFS RetroDUR activities and review the results and utilization patterns at each quarterly meeting. The MCO contract requires a DUR Board and the state's Health Plan Division oversees compliance with all MCO contract requirements via ad hoc inquiries, site visits and focus studies.
Minnesota	MCO compliance is monitored with the contract and rule both through the CMS annual report and quarterly reports with regards to prior authorizations that are responded to within the 24 hour requirement as part of the contracts.
Mississippi	The MCOs are contractually required to operate a DUR program that complies with the requirements described in section 1927(g) of the ACT and 42 C.F.R. Part 456, subpart K and to provide a detailed description of its drug utilization review program activities to DOM on an annual basis.
Missouri	The Retrospective DUR system applies to all MO HealthNet Division (MHD) participants and focuses on drug regimen reviews after the patient has received a prescription. It targets potential therapy problems that result after a period of time, possibly characterized by an exacerbated medical condition or the appearance of a drug side effect. The MHD has entered into an outside contract for the production of computerized patient reports or patient profiles. These patient profiles are generated by applying therapeutic criteria to paid MHD claims data. Therapeutic criteria are reviewed and approved by the DUR Board.
Nebraska	NE manages their own RetroDUR program.
Nevada	MCOs present quarterly at state DUR Board Meetings. Any changes due to their RetroDUR programs are to be shared at these meetings to ensure they align with the approved recommendations from the DUR Board. At least annually, the MCOs are required to present RetroDUR activities.
New Hampshire	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 Division for review and approval on an ongoing basis. The State approves the effective date for implementation of any DUR standards by the MCO and FFS.
New Mexico	The MCO health plans report their RetroDUR interventions in a quarterly pharmacy report. The state meets with the FFS vendor every other week to discuss the RetroDUR program and develop interventions. These interventions are presented at the quarterly DUR Board Meeting.
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.

State	Explanation
North Carolina	The state, along with its vendors and Board members, monitors utilization through the quarterly DUR Board meetings. The DUR Vendor for the state has access to MCO encounters and can report on this data when requested. Both the Board and the state define initiatives and interventions which are comprised of following utilization trends and new topics. Additionally, the state receives monthly reports to monitor requirements set forth in the SUPPORT Act, which are shared with the Board on a quarterly basis. MCOs are required to submit quarterly reports reflecting ProDUR alerts and retrospective utilization reports of the most commonly dispensed drugs by number of prescriptions, number of members and by cost. Additionally, the plans are required to submit a slide presenting the initiatives and interventions that took place during the previous quarter for the state's DUR Board and state staff review. The plans are required to have their own DUR Boards and meet at least quarterly. The state also has dashboards and metrics available via tableau to help monitor utilization. The state employs a dyad system whereby a clinical policy nurse and clinical pharmacist, from the state, are responsible for communication, troubleshooting and monitoring the plan. Initially, there were weekly 1:1 meetings and group meetings between the state and the MCOs. These meetings have now transitioned to every other week. The NC Medicaid Ombudsman and state staff use ServiceNow to create and track tickets which can be related to beneficiary or provider needs. These "help center tickets" are monitored for resolution via calls with the MCOs and the state three days a week. Tickets can only be closed by the state once the issue is satisfactorily resolved. These tickets provide insight into how the MCOs are complying with state and federal regulations and the state policy as well as their contracts and can highlight utilization issues as well as the showcase the plan's ability to intervene to ensure members have access to quality care and help improve member outcomes. These frequent meetings have been useful to ensure MCO compliance with programs, policies and regulations, as well as give insight into potential drug utilization issues that are shared in this environment.
North Dakota	State runs RetroDUR program for all (FFS and MCO) members. Claims data is shared with MCO.
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 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	For the FFS program the State sends a representative to the DUR Board meetings.
South Carolina	RetroDUR is a specific contract requirement, which is monitored by the State's Contract Monitoring Entity

State	Explanation
Tennessee	Regarding Oversight of the MCO RetroDUR program, TennCare's Office of Program Integrity (OPI) requires MCC oversite of prospective drug review, retrospective drug use review, data assessment of drug use against predetermined standards, outlier reviews, are appropriate and medically necessary, and requires educational outreach activities to ensure compliance with medical and pharmaceutical standards. Additionally, the MCCs Compliance Programs: 1. Have edits in place to alert them of any suspicious medical or pharmaceutical billing activities 2. Provide several venues to report suspicious activities or perceived violations of medical or drug usage 3. Several MCCs have specific triage procedures for prescription drug matters, for example prescription drug matters are sent directly to their Special Investigation Unit 4. Algorithms based on billing patterns and peer norms In addition, OPI monitors TennCare's MCCs oversight for medical, dental, and pharmaceutical suspicious claims activity through monthly and quarterly reports and meetings. All activities that require a closer inspection to determine if the billing is an administration error or possible fraud activities is monitored from the inception of the questionable billing to the determination of fraud or administrative error. Regarding FFS RetroDUR programs, listed are clauses in the PBM Vendor's Contract between TennCare and the PBM: A.45.a. TennCare Retrospective Drug Utilization Review (Retro-DUR) The Contractor shall provide to the State all necessary components of a TennCare Retro-DUR program as required in 42 CFR 456.709: for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. The Contractor's Retro-DUR system's intervention processes shall include, at a minimum, letter-based information to providers and a system for tracking provider response to the interventions. The Contractor shall prepare, for the State's approval, provider letters containing information related to the operation of the TennCare pharmacy program. The Contractor shall also implement a complete Retro-DUR program to be coordinated and maintained by the full-time DUR Clinical Pharmacist dedicated to TennCare and supported

	by the Provider Liaison Pharmacists who are Tennessee-licensed pharmacists, and additional clinical reviewers who are also Tennessee-licensed pharmacists. 1. Description of the Operation of the TennCare Retro-DUR Program -The Contractor shall provide to the State all necessary components of a Retro-DUR program and shall operationalize those as specified in 42 CFR 456.716: (b) Recruit, maintain, and reimburse a panel of clinical pharmacists sufficient to review member profiles as noted in subsection e. below. The clinical pharmacists shall recommend appropriate interventions related to each profile reviewed. (c) With input from the State and the DUR Board, the Contractor shall determine the focus of and generate data above for each of four (4) quarterly provider profile runs and each of twelve (12) monthly member profile runs. Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter. Monthly member profile reviews shall be completed and results/interventions distributed to prescribers within sixty (60) days of the end of the month. (d) After approval by the State of the focus of, and methodology to be used in, the member profile reviews, the Contractor shall produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per calendar quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken. Any summaries, correspondence or other documents produced as a result of the review process shall be approved by the State prior to their distribution. (e) After approval by the State of the focus of, and the methodology to be used in, the provider profile reviews, the Contractor shall produce two thousand four hundred (2,400) provider profiles per calendar quarter and determine appropriate interventions to address any potential problems identified during profile review. Unlike member profiling, provider profiles need not reviewed by clinical reviewers, as they simply detail members for whom a prescriber or pharmacy provider has prescribed or dispensed a medication under review for the calendar quarter. (f) Implement interventions designed to address problems identified during profile review. These interventions shall include, at a minimum, mailings sent to prescribers or pharmacy providers, but phone calls or visits may also be conducted if appropriate and/or upon the direction of the State. Mailings shall consist of an intervention letter to the prescriber or pharmacy provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included, along with a provider response form seeking input for the value of the intervention. Interventions regarding possible fraud and abuse shall be reported to the State. (g) Maintain a system that complies with all requirements of Section A.45.b below, capable of tracking all interventions, both letters and direct communication, and determining cost savings related to the specific interventions. This system shall also record input received from providers regarding the value of the intervention. A.45.b. TennCare Retro DUR Reporting System 1. The Contractor shall provide a reporting system that tracks the outcomes of the Retro DUR initiatives. TennCare's Retro DUR initiatives are mainly focused on improving care quality. The Contractor's system shall be able to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. The data elements tracked

State	Explanation
	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; (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. For 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.

State	Explanation
Washington	HCA requires several deliverables from our contracted MCOs that assist us with monitoring RetroDUR. These include: 1. Quarterly AHPDL Compliance report 2. Quarterly MCO drug rebate report 3. Quarterly MCO MAC List 4. Quarterly Network Pharmacy Reimbursement Reconciliation report 5. Quarterly Prescription Drug Authorization report 6. Annual List of drugs allowed through Specialty pharmacies 7. Quarterly Underpaid Pharmacy Claims The deliverables in combination with MCO encounter data are used to conduct retro-DUR analysis of drug spend, utilization, as well as overall program compliance. HCA uses the results of our analysis to inform us of potential pro-DUR opportunities, changes to drug status on our AHPDL, clinical policies development, and potential MCO contract changes. Examples of the retro-DUR activities conducted in FFY 2021 can be found in section III. HCA's Medicaid Compliance Review and Analytics team in collaboration with the Prescription Drug Program conducts annual reviews called TeamMonitor (42 CFR, part 438.66 State monitoring requirements) which included verification of the following for FFY 2021: 1. Evidence that shows appropriate procedures in place to identify psychotropic medication prescriptions that exceed the guidelines set by the pediatric mental health workgroup for HCA's Second Opinion Program, including when transition or continuation of therapy fills apply. 2. An explanation and claim example of how system configuration documents the reason for dispensing less than a 12-month supply for contraceptives. 3. Compliance of the single preferred drug list, Apple Health PDL (AHDPL), by providing examples of system coding and claims adjudication for 10 NDCs within 5 separate drug classes. 4. Proper AHPDL clinical policy implementation by providing decision processes for determining authorization requests, training materials and examples of an adverse benefit determination, approval and appeal for each of the following AHPDL policies: a. Growth Hormone Agents b. CGRP- (preventative) c. Atopic Dermatitis Agents: Dupilumab (Dupixent). HCA's Program Integrity team requires Program Integrity Activities (PIA) monthly deliverable from each managed care plan. For FFY 2021, the following number of Audits, Reviews, Investigations were reported by the managed care plans for the PIA deliverable: 1. Amerigroup: = 2 2. Coordinated Care of Washington: = 3 3. Community Health plan of Washington: = 1 4. Molina Healthcare of Washington: = 3 5. United Health plan of Washington: = 6

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 MCOs 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 CFR part 456, subpart K?

Table 293 - 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	MCOs are required to employ a prospective and retrospective DUR program, provide education to enrolled providers, and comply with DUR Board requirements.
District of Columbia	Compliance is required by contractual obligation in the current MCO contracts. Monthly reporting by the MCO on DUR activities decsribed in Section 1927(g) of the Act and 42 CFR part 456, subpart K is reviewed and concerns are discussed with each MCO on a monthly basis during monthly pharmacy program oversight meetings.

State	Explanation
Florida	MCO plans participate with the State DUR Board. The State complies with all provisions by having a DUR program that includes: Prospective drug review Retrospective drug review Education to providers on common drug therapy problems Claims reviews to identify medications trends, misuse, overutilization, underutilization, therapeutic or ingredient duplications, appropriateness, medical necessity, fraud, etc. The State conducts DUR Board meetings on a quarterly basis and applies all of the above aspects in its detailed analyses and documentation and on an annual basis reports to CMS on the details and compliance of the program. MCO plan data is reviewed during the DUR meeting along with fee-for-service data.
Georgia	The State monitors MCO's quarterly submissions of proDUR/rDUR reports.
Hawaii	MCO quarterly, ad hoc and annual reports are submitted for review. Input from providers on MCO compliance is received. New quarterly report templates are being refined for clinical quality. Drug rebate files are sampled for trends and ad hoc reports are then requested of the MCO for detail. Monthly meetings are held with the MCO pharmacists to introduce, implement, discuss and review DUR requirements.
Illinois	Evaluation of information reported in the DUR Annual report. 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.

State	Explanation
Kansas	In addition to our annual MCO oversight reviews, we have the following processes/supports in place. These requirements are included in a state policy, which also applies to the MCOs. Provider bulletins are used to notify the providers of program changes. Providers do make the state aware if they come across inconsistencies between the provider bulletin sent/posted by the state and provider experience. The state also reviews claims data, which assists in finding any potential non-compliance by the MCOs. The MCOs are required to have all provider education and marketing materials peer reviewed by the state before use.
Kentucky	As part of its DUR activities, the Contractor shall work collaboratively with the Department on related pharmacy initiatives such as the universal policy implementations, the pharmacy lock-in program, buprenorphine provider programs, and other initiatives as identified by DMS. The Contractor shall provide a detailed description of its drug utilization review program activities to the Department on an annual basis. The actual date shall be determined by the Department and in sufficient time to gather the information necessary to comply with and time submit the CMS Annual DUR report. The Contractor shall provide all data necessary for appropriate CMS Annual DUR Report submissions including, but not limited to, completing the Contractor's portion of the actual annual report template furnished by CMS and within the requested timeframe. At the request of DMS, quarterly written reports of DUR activities shall be provided to the Department. All Managed Care Organizations (MCOs) contracted with the Kentucky Department for Medicaid Services will have drug utilization review provisions as outlined in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. These provisions will include utilizing safety edits related to duplicate and early fills, quantity limits, dosage limits, and morphine milligram equivalents (MME). All MCOs will utilize safety edits for concurrent prescribing of opioids and benzodiazepines and opioids and antipsychotics. Additionally, all MCOs must have a program in place to monitor antipsychotic medications by children and document the appropriate actions taken based on the program.
Louisiana	The state reviews monthly MCO DUR reports.
Maryland	Maryland Medicaid has had a comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefit. A review of the Standards for drug use management programs occurs annually and Standards were updated to be in compliance with updated Federal regulations regarding DUR programs for both FFS and MCOs. These Standards are used for the internal annual review of the drug use management programs. This assessment occurs annually and is required under Maryland regulations for all who participate in the Medicaid program. Additionally, the Department has been proactive in providing guidance to MCOs regarding updated requirements for DUR programs.
Massachusetts	Contract managers ensure MCOs are meeting contract requirements including alignment with state's DUR program. in addition, the state meets monthly with representatives of the MCOs to address any changes and updates.
Michigan	MCO contracts were updated to require compliance with the DUR requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K. The state's Health Plan Division oversees compliance with all MCO contract requirements via ad hoc inquiries, site visits and focus studies. Additionally, the MCOs are required to provide reports to the State demonstrating compliance. Lastly, there is an established process for the state to investigate any reported compliance concerns.

State	Explanation
Minnesota	MCO compliance is monitored with the contract and rule both through the CMS annual report and quarterly reports with regards to prior authorizations that are responded to within the 24 hour requirement as part of the contracts.
Mississippi	DOM oversees one common 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.
Missouri	Pharmacy benefits are carved out of Managed Care.
Nebraska	NE manages their own RetroDUR program and shares updates with MCOs.
Nevada	MCOs must operate a drug utilization review program for covered outpatient drugs that includes prospective drug review, retrospective drug use review, application of standards and an education program in compliance with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR part 456, subpart K. Each MCO must provide a detailed description and information about its drug utilization review program activities by December 31 of each calendar year for the prior federal fiscal year.
New Hampshire	The 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, review the MCOs' utilization of these policies annually through encounter data to confirm DUR requirements are being managed efficiently and appropriately. Any changes to policies regarding the MCO outpatient DUR program, including prospective drug review, retrospective drug use review, and an educational programs, must be approved by the State prior to implementation. See responses above for additional information.
New Mexico	MCO compliance and DUR requirements are monitored through the quarterly pharmacy reporting 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	The state monitors paid and denied claims as well as approved and denied PAs. The state has thoroughly communicated to the plans that prescription rebate eligible drugs are covered drugs. The state also assists with ensuring the coverage of new to market drug as the plans are currently required to follow our policy 100% of the time. If non-rebate eligible drugs are discovered as paid claims, this is conveyed to the plans. They will in turn ensure that their PBM vendors are aware of how to handle these drugs and provide corrective actions.
North Dakota	The requirements are in the contract and the MCO is required to provide an annual report.

State	Explanation
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 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	The State has a liaison who has oversight responsibilities for 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

State	Explanation
Tennessee	First of all, when discussing ProDUR, since the MCO's provide only physician administered covered outpatient drugs, it isn't possible to have online, real-time ProDUR as in pharmacy claims via a PBM, where all ProDUR is instantaneous. However, we feel that the best two examples that we can offer would be: 1. diagnosis information that is provided by the MCO's are used as SmartPA in the PBM's system, allowing PA's to be approved when diagnosis is the primary criterion, and 2. The MCO's prospectively do approve many medications with pre-certification, similar to prior authorization with a PBM. During pre-certification the MCO determines that the product is safe, effective and medically necessary for the member. 3. Because the physician administered drugs are not reviewed by TennCare's P&T, known as PAC (Professional Advisory Committee), they are instead reviewed by each MCOs P&T, which reviews products and categories of drug to ensure safety, efficacy and pharmacoeconomic value. Regarding RetroDUR as found in Section 2(B) of the Act, and regarding identifications of patterns of fraud, abuse, gross overuse, etc., we noted in the previous answer number 6., that the MCO's are required under their contracts to have edits in place to alert them of suspicious behaviors, and to report found behaviors to their respective SIU's. Some details are available in the Abbreviated MCO reports attached to this submission. Regarding Section 3 of the Act, 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 a 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.

State	Explanation
Washington	HCA has developed the following to ensure MCO compliance of DUR requirements: 1. A utilization dashboard, including both FFS and MCO claims/encounters. This data is used to conduct retro-DUR analysis of drug spend, utilization, as well as overall program compliance. HCA uses the results of our analysis to inform us of potential pro-DUR, identify clinical policies development or other interventions. 2. Reports related to the SUPPORT Act for opioid MME, co-prescribing and psychotropic use in children. These reports will be used to conduct analysis and make recommendations for follow-up oversight activities to one of the following: HCA Program Integrity, HCA Quality Management Team, Managed Care Review and Analytics Team, Patient Review and Coordination Team, or to the Pharmacy Team for a DUR activity. 3. HCA's Prescription Drug Program, in collaboration with HCA's Medicaid Compliance Review and Analytics team, conducts annual reviews called TeamMonitor (42 CFR, part 438.66 State monitoring requirements). Part of this review is to ensure proper implementation and compliance of AHPDL and clinical policies approved by the Washington State DUR board.
West Virginia	WV is a pharmacy carve-out state. The MCO shall comply with Section 1004 of the SUPPORT for Patients and Communities Act and the Drug Utilization Review (DUR) regulations as described in section 1927(g) of the Act and 42 CFR part 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 form 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 164 - Managed Care Plans Submission of DUR Reports

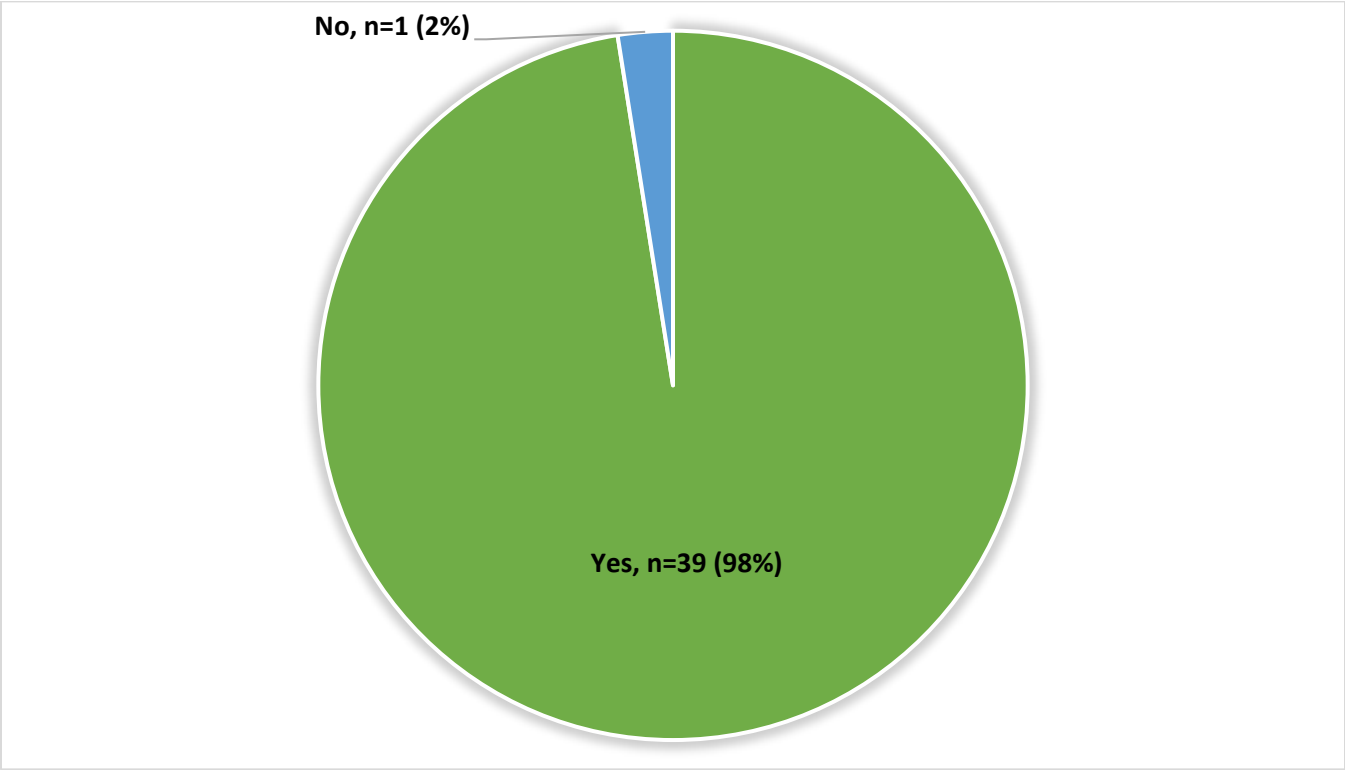

Table 294 - Managed Care Plans Submission of DUR Reports

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin	39	97.50%
No	North Carolina	1	2.50%
Total		40	100.00%

If "No," please explain.

Table 295 - Explanations for Managed Care Plans Not Submitting DUR Reports

State	Explanation
North Carolina	For the FFY2021, the MCOs have only been operational in NC for 3 months. Per the guidance, the plans were not required to submit DUR reports this year. Additionally, when we report the average number of beneficiaries enrolled in MCOs, this number is reported based on those three months, which results in slight under-reporting of the current enrollment in MCOs in NC.

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 296 - State Executive Summary

State	Executive Summary
Alabama	The AL Medicaid Drug Utilization Review (RDUR) report in its entirety serves as the summary for the RDUR Program for the AL Medicaid Agency covering Federal Year (FFY) 2021.
Alaska	Executive Summary for Annual DUR report for FFY 2021 The Alaska Medicaid Drug Utilization Review (DUR) committee met for four scheduled meetings in FFY 2021. 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 2021 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 2020 (82.96%) to FFY 2021 (84.4%) experienced a 1.44% increase, which contributes to a grand total of a 12% increase since FFY 2012. The generic expenditure for FFY 2020, as a percent of total costs, was 16.9%. In FFY 2021, this number decreased to 15.7%. 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 2021. 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 2021 relied primarily on the review of aggregate claims data. Various educational means were employed, including

State	Executive Summary
	sending informational letters to prescribers. The committee members are very passionate about sharing information within the medical community; communicating meaningful information can be a challenge when the reviews are limited to the Medicaid claims. The committee continues to explore other communication channels to provide meaningful education to prescribers and providers around the state. Conclusion In FFY 2021, in spite of pandemic challenges, 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 FFY2021 The purpose of the Drug Utilization Review (DUR) Board is to improve the quality of care for Arkansas Medicaid clients receiving prescription drug benefits by assuring that prescriptions are therapeutically and medically appropriate while conserving program funds. The Arkansas Medicaid DUR Board is governed by the Arkansas Department of Human Services and includes prospective drug utilization review, retrospective drug utilization review, and education for prescribers and pharmacists. 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 clients 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 three MCOs (Provider-Led Arkansas Shared Savings Entity (PASSE)) as of 9/30/2021 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. 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

State	Executive Summary
	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. FFY2021 HIGHLIGHTS EARLY REFILL THRESHOLD Prior to the early refill threshold update, our program required 75% utilization before a refill was allowed for scheduled II-V with the exceptions of 100% for sedative hypnotics and 90% for benzodiazepines. To better control potential fraud, waste, and abuse of controlled medications and to be more in-line with other Medicaid programs, the DUR Board voted to make all controlled substances require 90% utilization before a prescription refill will process. DUR BOARD ACTION The DUR Board created POS criteria edits for multiple medications to help decrease the burden on our clinical review team. Medications included Otezla, GI motility agents, asthma treatment with ICS-LABA, and Lyrica. The DUR Board reviewed and approved manual review criteria for 29 new medications, and the Board updated criteria and claim edits for 9 drugs/drug classes including asthma inhalers, Hetlioz, SGLT-2 inhibitors, antipsychotic informed consent form update for children, isotretinoin, GnRH receptor antagonists, thrombopoiesis stimulating proteins, immunomodulators for asthma, and Xpovio. The Board also voted to add polypharmacy soft POS edits and a new-to-market medication policy. The DUR Board reviews the quarterly FFS and MCO ProDUR reports and determines the RDUR intervention criteria for the next quarter. DRUG REVIEW COMMITTEE (DRC) The DRC reviews placement of drug classes on our preferred drug list (PDL) and meets quarterly in February, May, August, and November. The committee is comprised of 3 physicians and 4 pharmacists that are voting members with a representative from each PASSE as a non-voting member. The chairperson is a pharmacist from the Medicaid Pharmacy Program. The committee composition is varied in experience to ensure knowledge in many aspects of medicine. The Committee votes on placement of preferred and nonpreferred agents based on safety and efficacy data provided by a Magellan clinical pharmacist. Arkansas

State	Executive Summary
	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. Two new PDL classes were added in FFY2021 which included thrombopoiesis stimulating proteins and PCSK9 inhibitors. A total of 19 classes already on the PDL were re-reviewed during FFY2021 which included blood pressure medications, CAM antagonists, immunomodulators, ADHD medications, anticoagulants, antihyperuricemics, estrogen products, GI motility agents, hepatitis C agents, colony stimulating factors, statins, narcolepsy agents, phosphate binders, platelet aggregation inhibitors, Alzheimer's agents, BPH, hemorrhoid preps, oral opiate dependence agents, and muscle relaxers. FFY2022 GOALS FFY2022 goals include: 1. Develop a process to work with the Department of Health to share PDMP data. 2. Combine the DUR Board and DRC into one Board to allow us to discuss the PDL list while developing criteria for the class 3. Join a PDL pool 4. Execute value-based purchasing agreements
California	The purpose of Drug Utilization Review (DUR) is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. California's Medi-Cal DUR program is the responsibility of the Department of Health Care Services (DHCS), and includes prospective DUR reviews, retrospective DUR reviews, and educational interventions for providers and pharmacies. During federal fiscal year (FFY) 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, drug utilization reports, prospective and retrospective DUR reviews, and descriptions of educational bulletins and/or alerts. The Board is responsible for advising and making recommendations to DHCS for the Medi-Cal population. Over the course of FFY 2021 the Board reviewed prospective DUR criteria for 31 drugs. In addition, retrospective DUR criteria were reviewed for all psychotropic medications used in children and adolescents, opioid medications prescribed by dentists and oral surgeons, opioid medications prescribed in the emergency department and outpatient surgical settings, hepatitis C virus (HCV) medications, and all medications that became available on the Medi-Cal Contract Drugs List in FFY 2019. A total of seven educational bulletins and alerts were published on the Medi-Cal website in order to educate and inform Medi-Cal providers and beneficiaries on timely and relevant topics related to medication use. A total of four educational mailings were sent to selected prescribers to improve the quality of care for Medi-Cal beneficiaries. The Board continued to collaborate with key state agencies and national experts in FFY 2021, and actively worked to incorporate a variety of Medi-Cal MCO best practices across multiple plans into the Board meeting agenda. With input provided by the Board, Medication Therapy Management (MTM) was added as a new benefit during FFY 2021. This Annual Report was prepared through a collaborative effort between the California Department of Health Care Services, the Global Medi-Cal Drug Use Review Board, and the University of California, San Francisco.

State	Executive Summary
Colorado	The Health First Colorado (Colorado Medicaid) DUR program is now in its ninth year of collaboration with the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Science (SSPPS). The DUR program continues to contract with a pain management specialist and a child and adolescent psychiatrist for teleconsultation services. In addition to the sub-contracted specialists, there are two clinical faculty members, an administrative faculty member, a biostatistician/analyst, a pharmacy outcomes researcher, and a pharmacy outcomes PhD student involved in conducting DUR-related analyses and performing other DUR program activities. One clinical faculty member serves as a contracted clinical consultant and SSPPS liaison to the State, working directly with the State DUR Contact and other members of the Department's Pharmacy Office team. During the time period of the reporting fiscal year, the Department Pharmacy Office managed implementation of the Health First Colorado Prescriber Tool, a multifunctional electronic platform accessible to prescribers through most electronic health record systems that provides patient-specific benefit and cost information to prescribers at the point of care. The Prescriber Tool functions to provide access to real-time benefits inquiry, e-prescribing capabilities, and the ability to submit electronic prior authorizations; in addition to providing access to the Department's opioid prescribing risk module, OpiSafe. The Prescriber Tool real-time benefits inquiry provides prescribers with rapid insight into preferred medications from the Health First Colorado Preferred Drug List (PDL) when prescribing medications to beneficiaries. 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 receiving multiple antipsychotic medications. DUR program policy-related medication management changes made during the reporting fiscal year included creation of a claims systems edit for concomitant use of opioids and buprenorphine-containing substance use disorder medications, loosening restrictions on prior authorization criteria for medications used to treat hepatitis C, expansion of vaccine coverage to include pharmacist-administered Covid-19 vaccines, and adding messaging to encourage consideration for COVID-19 vaccine administration on all submitted pharmacy claims for unvaccinated beneficiaries. The DUR program team also orchestrated a pharmacy intern project to evaluate opportunities for use of specific medical lab values as part of automated prior authorization for PDL drug classes. DUR Board meeting agendas continued to be very full as additional drug classes have been added to the State's FFS pharmacy PDL. New PDL classes added during FFY 2021 included inhaled antibiotics; methotrexate products; topical estrogen agents; topical antineoplastic agents; beta blockers; alpha blockers; calcium channel blockers; and anxiolytic benzodiazepine and non-benzodiazepine medications. The DUR Board continues to have high quality discussion leading to high quality recommendations made to the Department. DUR Board meetings continue to be held virtually, occurring at a quarterly frequency and lasting approximately 4-5 hours.

State	Executive Summary
Connecticut	Objectives for the operations of the Connecticut Medical Assistance Drug Utilization Review (DUR) Board during federal fiscal year 2021 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 10/01/2020 to 9/30/2021 the DUR Board was comprised of six pharmacists and three physicians. Four DUR Board meetings were held during FFY 2021. Twenty-four targeted retrospective analyses were reviewed and approved by the DUR Board and conducted during FFY 2021. 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 2021. The Pharmacy Lock-In Program is ongoing and Kepro is required to review 800 lock-in profiles monthly. 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 2021 from Kepro was $2,558,118. The reported cost savings for Prospective DUR during FFY 2021 was $105,000,531.

State	Executive Summary
Delaware	In Federal Fiscal year 2021, 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 maintained unified PDL. Claims editing on encounters mirrors that of FFS claims which helps keep both MCO and FFS drug programs aligned. This allows Medicaid beneficiaries to receive quality care with the least amount of disruption of treatment during any transition between FFS and MCO plans. As with last year, 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. 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. 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.

State	Executive Summary
District of Columbia	The Drug Utilization Review Board focused on several areas of clinical concern for the District during FY2021. The opioid epidemic in the District of Columbia has been fueled in part by prescribed opioid drug misuse and abuse. The recent implementation of a Prescription Drug Monitoring Program (PDMP) did not include a legislative mandate for prescribers to query the PDMP for previous or current opioid utilization before writing a prescription. The DUR Board members recognizing that some opioid prescribers may not have specialized training in pain management decided to address this presumed knowledge gap. Led by the efforts of a DHCF staff clinical pharmacist, the Board worked with community-based thought leaders and Medicaid providers to prepare a working document entitled Guidelines for Collaborative Management of Opioid Use which addressed the opioid epidemic in the District of Columbia. Discussion with these providers assisted the Board members in drafting recommendations for opioid treatment clinical criteria and best practices. The guideline was published and made available to stakeholders during FY21. Led by the DHCF MTM pharmacist, the DUR Board identified, vetted and approved a list of OTC and prescribed medications that could safely be excluded from the calculation of polypharmacy limits under the Pharmacy Lock-in Program. Working in collaboration with the managed care plans, a uniform exclusion list was developed that would be implemented across the FFS program and each MCO to assure parity in the beneficiary lock-in criteria. Excluded categories may include otic, vaginal, ophthalmic, rectal, nasal, and topical OTC and legend products. The Board actively incorporated involvement of the Pharmacy and Medical Directors of the MCOs into quarterly DHCF DUR Board meetings throughout FY21 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. 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 through the use of a provider newsletter and website postings. The Board recommended that several of the temporary pharmacy program enhancements made during the COVID-19 public health emergency PHE to promote maximal access to prescribed medications be 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. Board members continue their oversight of the four District Medicaid managed care plans by receiving quarterly presentations from the MCO Pharmacy Directors on specific topics such as: tracking opioid cash payment through the PDMP, clinical criteria for oral oncology medications and medication therapy management protocols and outcomes. 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.

State	Executive Summary
Florida	DUR Program Overview Magellan Medicaid Administration provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Florida Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients by reducing the potential for drug interactions as well as adverse drug reactions. Additional goals include conserving program funds and expenditures, as well as maintaining program integrity by controlling problems of fraud and benefit abuse. The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration (AHCA). The goal of the RetroDUR program is to promote appropriate medication prescribing by identifying patterns of potentially inappropriate prescribing or medication use. Once these patterns are reviewed and studied, potential interventions to address the issue are presented to the DUR Board for consideration. An analysis of the impact of planned interventions is created and agreed upon interventions are then communicated to physicians and/or pharmacists to improve prescribing and patient outcomes. Prospective Drug Utilization Review Program (ProDUR) ProDUR encompasses the detection, evaluation, and counseling components of predispensing 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: 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.

State	Executive Summary
	Insufficient Daily Dose (LD) Alert occurs when the calculated dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. Early Refill (ER) - Alert occurs when a prescription is refilled before 80 percent of the previously filled prescription's days' supply has elapsed. Therapeutic Duplication (TD) Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous six weeks. Drug-Drug Interactions (DD) Alert occurs when a drug that is to be dispensed may interact with a previously filled drug (within the previous six weeks) from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions. Ingredient Duplication (ID) Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy. Drug-Age Contraindication (PA) - 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 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. Underutilization (LR) - Underutilization alerts occur when patients have waited to refill their maintenance medications beyond the specified days' supply of the previous fill. ProDUR Cost Savings ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden. Retrospective Drug Utilization Review (RetroDUR) The goal of the Florida Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug therapy problems, identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems. The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration (AHCA). The RetroDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or 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

State	Executive Summary
	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 AHCA 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. 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 2021 demonstrated cost savings as documented below: The Eucrisa automated prior authorization yielded $81,018.76 savings The anticonvulsant multiple therapy soft edit yielded $777,762.84 savings per year. The asthma medication management soft edit produced a $281,618.12 savings. The Lyrica automated prior authorization produced a $8,937.44 savings. The long-acting opiate and benzodiazepine concomitant therapy soft edit produced a $53.36 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 2021 (FFY2021), 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

State	Executive Summary
	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 FFY2021, the DURB researched, reviewed and made PDL/PADL recommendations for the following drugs: Dayvigo Enspryng Evrysdi Fintepla Rukobia Uplizna Zeposia Kesimpta Ongentys Verquvo Viltepso Cabenuva/Vocabria Evkeeza Lupkynis Olinvyk Sevenfact Amondys 45 Cosela Gemtesa Ponvory

State	Executive Summary
	Qelbree In addition to the drug classes which the new drugs above belonged to, the 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	Virtual DUR Board meeting continue with COVID restrictions. FFS DUR Board monitoring of the MCO DUR programs is expanding. Statewide Hepatitis C remains stable with low utilization. Opioid use in Hawaii is lower than the rest of the country. Monthly meetings with the MCO pharmacists have begun. They are collaborative in nature and productive with the implementation of the SUPPORT Act. Refining and monitoring of the MCOs DUR programs are further developing. The dental population is slowly growing and SUPPORT Act changes to the dental formulary opioid criteria will better reflect the acute treatment program for adults. The transplant program remains small with patients in the program for 1-2 years before returning to a MCO. Use of ICD-10 at POS for Medication Assisted Treatment of Opioid Use Disorder started and will grow into other drug classes.
Idaho	During Federal Fiscal Year 2021, the activities of the Idaho Drug Utilization Review (DUR) Board were coordinated by Magellan Rx Management. Idaho Medicaid has developed and over the last decade continuously improved upon a successful DUR model that is different from that of many state Medicaid DUR programs. The model is a partnership between Magellan and the Idaho Medicaid program's clinical pharmacists. Medicaid's clinical pharmacists and the 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 by Medicaid clinical pharmacy staff. Both Magellan staff and Medicaid staff present their findings at our quarterly DUR meetings. The Division operates its own internal call center to manage the prior authorization (PA) program. Criteria are developed by our clinical 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. They also identify 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 evaluate 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, fourteen 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

State	Executive Summary
	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 86%. We prefer brand drugs over generics in many instances, which results in significant cost avoidance each quarter. Cost savings for Prospective DUR, based on claims reversed and not resubmitted was $ 41,402,858 and for Retrospective DUR was $ 10,000,000. Innovative practices by 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, and appropriate and fiscally responsible use of new and high-cost therapies, particularly biologics. 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 80 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 good health outcomes.
Illinois	Throughout FFY21, 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. The COVID-19 policy and edit changes enacted in third quarter FFY20 remained in place for FFY21. 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. 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 coverage. During FFY21, HFS increased COVID-19 vaccine administration rates and reimbursed pharmacies for administration of initial and booster doses. HFS implemented the Uninsured COVID-19 Testing program. Charges for personal protective equipment required to perform services were deemed part of the service billed rather than a separate participant charge. Transportation for vaccine administration was also a covered service. Off-label use of ivermectin for prevention or treatment of COVID-19 was not covered due to lack of FDA emergency authorization or approval for this indication. During FFY21, focus continued on reduction of overutilization of narcotic agents and benzodiazepines, medication adherence, as well as appropriate use of medications for mental health issues, specialty medications, immunosuppressant medications, antiviral medications, and biological products. Illinois HFS opioid-related prospective edits based on the SUPPORT for Patients and Communities Act (SUPPORT Act) were maintained during FFY21 with no changes due to the COVID-19 pandemic. Antipsychotic use in children 8 to 17 years of age, duration of dental opioid prescribing, extended-release alprazolam, opioid order standardization, and decreasing initial opioid days supply were reviewed topics. Prior

State	Executive Summary
	authorization requirements for topical lidocaine 5% patch were removed, providing another pain management option for participants. In the second half of FFY21, DUR Board review of naloxone utilization identified need for prescriber outreach and education regarding provision of naloxone for participants filling high MME opioid prescriptions. Youth in the Care of the Department of Children and Family Services transitioned to the new managed care YouthCare program on September 1, 2020. Former Youth in Care participants had transitioned to YouthCare in February 2020. The YouthCare program provides active care coordination for behavioral health needs. During FFY21 prescriber peer consultation for mental health medication use in children via University of Illinois Chicago, Clinical Services in Psychopharmacology Program continued as needed. During FFY21 HFS demonstrated greater responsiveness to participant and prescriber needs. During summer 2021 cooperation between pediatric hospitals serving Illinois children and HFS facilitated appropriate, timely care of pediatric participants based on national guidelines during a dynamically changing atypical RSV season. Due to the Chantix shortage, at the end of FFY21, HFS allowed coverage of imported apo-varenicline from Apotex for smoking cessation. In the end of FFY21, HFS clarified that services rendered by Advanced Practice Nurses (APN) should be billed with the APN name and NPI, rather than under the collaborating physician. 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. Illinois Public Act 101 0278 required establishment of an evidence- based, non-commercial education program for Medicaid prescribers consisting of a web-based curriculum and academic educator outreach. This resulted in the creation of Illinois ADVANCE, a HFS collaboration with the University of Illinois Chicago College of Pharmacy to provide academic detailing services in Illinois. During FFY21 virtual direct-one-on-one academic detailing of prescribers was launched regarding cardiorenal benefits of anti-diabetic medications for the treatment of Type 2 diabetes mellitus. Illinois ADVANCE academic detailing continued regarding opioid use for chronic pain, the Illinois Prescription Monitoring Program, opioid alternatives for pain management, and opioid use disorder. The Illinois ADVANCE Website provides continuing medical education (CME), frequently asked questions related to opioid and anti-diabetic medications, as well as opportunities to schedule an academic detailing appointment or have a drug information request answered. The academic detailing visits provide ACCME for prescribers. Illinois ADVANCE can be followed on LinkedIn, Facebook, and Twitter.

State	Executive Summary
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 2021, the total estimated savings for the Indiana Medicaid proDUR program was approximately $51.43 million. The retroDUR estimated savings were $61,873 in FFY 2021 with additional retroDUR savings to be demonstrated in the FFY 2022 report. The total savings was estimated at approximately $51.49 million. The cost to administer both programs is $0.30 million, which results in a net savings of approximately $51.19 million. In FFY 2013, the State of Indiana transferred the management of the pharmacy benefit to OptumRx (previously Catamaran). OptumRx manages both the proDUR and retroDUR programs, which were previously split between two contractors. OptumRx 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 2021. 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, COX II inhibitors and select non-steroidal anti-inflammatory agents (NSAIDs), antiseizure agents, SGLT2 inhibitors and combinations, antipsychotic agents, SSRI/SNRIs, pulmonary antihypertensives, proton pump inhibitors, 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 agents, antimigraine agents, pulmonary antihypertensive agents, PCSK9 inhibitors and select lipotropics, miscellaneous cardiac agents, miscellaneous step therapy, spinal muscular atrophy agents, Lucemyra®, compound criteria, bone formation stimulating agents, Reblozyl®, Dificid®, Sickle Cell agents, Cushing's Disease agents, Hetlioz®, growth hormone, ophthalmic anti-inflammatory agents/immunomodulator type, allergy specific immunotherapy, Cipro® suspension & Levaquin® solution, 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.

State	Executive Summary
Iowa	On April 1, 2016, Iowa Medicaid transitioned from 100 percent fee-for-service (FFS) to providing coverage through Managed Care Organizations (MCOs) for roughly 90 percent of its population. While this transition occurred over five years ago, the DUR program continues to evolve with the addition of Managed Care (MC). The MCOs are required to follow the FFS preferred drug list (PDL), prior authorization (PA) and utilization management (UM) edits. The state and MCOs work collaboratively to establish the DUR Board (Commission) meeting agendas and activities. Additionally, one MCO representative is a non-voting member of the DUR Commission, rotating every two years amongst the MCOs. The DUR Commission provides recommendations for new and revised PA criteria, utilization edits or prospective drug utilization review (ProDUR) edits, retrospective drug utilization review (retroDUR) initiatives and provider educational initiatives. The MCOs must enforce the Iowa Medicaid FFS ProDUR (hard and soft) edits through their pharmacy POS claims processing system. MCOs must also participate and collaborate in carrying out all aspects of retroDUR initiatives and provider educational program/interventions. The FFS program produced an estimated total cost savings of $5,774.76 versus an estimated total cost savings of $10,412.04 in FFYE 2020. While there was a slight decrease 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 $5,457.72 versus a savings of $10,173.48 in FFYE 2020. This decrease 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 2021 is $317.04 versus $238.56 in FFYE 2020. The slight increase in savings is due to the cost of the particular drug(s) involved in the intervention. The FFS program conducted several small problem-focused studies based on claims review and as recommended by the DUR Commission. The FFS and MCOs collaborated on multiple retroDUR initiatives during FFYE 2021. Topics include Concurrent Use of Gabapentin and Pregabalin, Concurrent use of an SSRI and SNRI, Duplicate Therapy: Opioids, Concurrent Opioids and Benzodiazepines, Duplicate Therapy: Benzodiazepines, Single Ingredient Buprenorphine, Duplicate Therapy: Muscle Relaxants, Concurrent Gabapentinoid and Opioid, and Montelukast without Asthma Diagnosis.
Kansas	Most of FFY 2021 has been spent working on process improvement and decreasing provider burden, in addition to implementing the SUPPORT Act and COVID-19 PHE requirements. The results of those changes became effective in calendar year 2022. We will report on those improvements in the FFY 2022 report.
Kentucky	This DUR program annual report encompasses the drug utilization review activities and outcomes that have occurred during FFY 2021. 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-forService (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients, to conserve program funds and expenditures, and to maintain program integrity by controlling problems of fraud and benefit abuse. On March 1, 2009 MMA began providing retrospective drug utilization review (RetroDUR) for the Commonwealth of Kentucky Medicaid FFS Pharmacy Program. The goal of this program is to promote appropriate medication prescribing by: Identifying patterns of potential inappropriate prescribing or medication use, alerting physicians and/or pharmacists to

State	Executive Summary
	potential drug therapy problems, and recommending future corrective actions to avoid identified problems. Prospective Drug Utilization Review Program (ProDUR) The POS/ProDUR system provides Kentucky Medicaid with the ability to meet an important objective: to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. The POS/ProDUR system provides the dispensing pharmacist with access to a comprehensive patient/drug incompatibility database. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations or additional drug therapy. ProDUR achieves this objective by: Reviewing all claims for therapeutic appropriateness before a medication is dispensed, Reviewing eight (8) weeks of the recipient's available drug claims and medical histories for incompatible or duplicative therapy, and Focusing on those recipients at the highest level of risk for harmful outcome. The primary focus of the Kentucky Medicaid FFS ProDUR program is to enhance the quality of patient care through appropriate drug therapy. The ProDUR system provides information that may have been previously unavailable, enabling the dispensing pharmacist to review comprehensive medical and drug histories. The system identifies potentially severe adverse consequences of drug therapy prior to dispensing. The dispensing pharmacist can use the therapeutic situations identified by the system to intervene via patient counseling and consultation with the prescribing physician. ProDUR messages are presented to the pharmacist as an informational tool that can enhance the pharmacist's ability to assure rational, effective and safe drug therapy. The ProDUR system was designed to function as an adjunct to the pharmacist's education and professional judgment and not to overwhelm the pharmacist with excessive alerts. Kentucky Medicaid's FFS ProDUR criteria are designed to be clear, concise, and clinically significant. Kentucky Medicaid's FFS ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing six drug therapy problem types in which potential medication problems may exist. The screening types identified by Kentucky Medicaid's FFS ProDUR criteria are: Excessive Drug-Dosage (HD) - Alert occurs when the calculated milligram dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific. This alert is also referred to as Min-Max Dose. Insufficient Daily Dose (LD) - Alert occurs when the calculated milligram dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. This alert is also referred to as Min-Max Dose. Early Refill (ER) - Alert occurs when a prescription is refilled before 90% of the previously filled prescription's days' supply has elapsed. Therapeutic Duplication (TD) - Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous eight weeks. Drug-Drug Interactions (DD) - Alert occurs when a drug that is to be dispensed may interact with a previously filled drug from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions. Ingredient Duplication (ID) - Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy. ProDUR Cost Savings ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden. Exact duplicate paid claims (DPC) are not included in ProDUR cost savings, because the Kentucky Medicaid FFS program denies these claims outside of the ProDUR environment. IV. Retrospective Drug Utilization Review (RetroDUR) The goal of the Kentucky Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR

State	Executive Summary
	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 indepth review. If, based on the professional judgment of the clinical reviewers or the MMA Kentucky Medicaid Clinical Manager, an aberrant pattern of prescribing and/or utilization is indeed present, an educational letter is sent to the prescribing physician and/or the dispensing pharmacist informing the provider of the suspected problem. MMA produces and mails provider letters documenting the therapeutic effects of the RetroDUR program and tracks provider responses and cost savings associated with the interventions. RetroDUR Cost Analysis The provision of high quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. MMA uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. Indirect effects arise when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a twelve (12) month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. Monthly cost savings may vary due to a variety of factors, including: the class selection and problem type chosen for review, intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system, the lag time before the next physician visit when changes in drug therapy may be made, and/or the incremental educational and familiarity impact on the prescriber after receiving intervention letters. Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve (12) consecutive months of review/tracking) vary with intensity of 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 2021 will not be known until the end of FFY 2022.

State	Executive Summary
Louisiana	This annual report represents a summary of the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program's drug utilization review (DUR) activities under the direction of the Louisiana Department of Health (LDH). A commitment to improving the quality of patient health care was demonstrated during the FFY21. 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 publishes a series of educational articles are published in the Provider Update newsletters (Appendix A). 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 $46,371,429 is attributed to the use of the prospective interventions during FFY21. 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 FFY21, LADUR interventions addressed issues in the following categories: opioid safety, sleep disorders, behavioral health, muscle relaxants, hypertension management, heart failure management, diabetes management, and asthma management. Pharmacy cost avoidance attributed to LADUR interventions during FFY21 projected to $424,644 in the targeted drug classes. - Drug expenditure reductions averaged 14 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.

State	Executive Summary
Maine	ATTACHMENT 8 EXECUTIVE SUMMARY 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 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 2021, the DUR reviewed 76 New Drugs, 1 revised clinical criteria, looked at 49 Therapeutic Class reviews, 1 Quantity Limits on new or established drugs, in determining placement of medications on the State's Preferred Drug List. Overall, 12 FDA safety alerts were reviewed and recommendations were made when appropriate. The DUR continued its review of narcotic utilization and co-prescribing, substance abuse prescribing, assessed the use of appropriate use of Chantix and compliance of utilization, the use of hydroxycholorquine pre and post COVID-19, patients, continuous use and adherence of long acting injectable Anti-Psychotics, influenza vaccination rates among MaineCare recipients to general CDC guidance, the DUR reviewed across a variety of PDL categories to reassess criteria and placement, The DUR did a variety of educational outreach to providers or review of prescriber activity with the Department in which the collected information provided multiple analysis for the DUR to review. As a result of the reviews mentioned above the DUR has recommended changes to PA requirements for these categories of drugs and in some cases has implemented new PA requirements. The DUR will continue to monitor these categories of drugs and provide recommendations to the Department to improve patient care and educate prescribers. The Department 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 2021 The objectives for the operation of the Maryland Medicaid Drug Utilization Review (DUR) Board during Federal Fiscal Year (FFY) 2021 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 2021, the DUR Board was comprised of six (6) pharmacists and five (5) physicians. Four (4) DUR Board meetings were held during FFY 2021. The meetings were held on the first Thursday of the months of March, June, September and December. Approximately 97% of Maryland Medicaid participants were enrolled in the managed care program known as HealthChoice during FFY 2021. There were nine (9) managed care organizations who participated in the HealthChoice Program during this timeframe. Mental health drugs, including many anticonvulsant agents, and substance use disorder medications are carved out of the managed care pharmacy benefits and are paid fee-for-service. As a result of this, the transition to managed care resulted in the need to integrate all prescription claims through a common source. The Department of Health (MDH) implemented and continues to maintain an electronic claims management pharmacy processing system which

State	Executive Summary
	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 2021, 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. Eleven (11) retrospective analyses were conducted during FFY 2021. All of these retrospective evaluations included the mailing of participant specific educational intervention letters to prescribers and pharmacy providers. Participant specific educational intervention letters highlight a drug therapy concern and are sent to prescribers and pharmacy providers with a complete participant drug and diagnosis history profile along with a response form. In the survey Section VI. Generic policy and utilization data, sub question 3, we have reported generic utilization percentage of 82%, however several brand drugs are preferred over their generic counterparts due to the availability of supplemental rebates and lower net cost. Taking into account the preferred brands, a generic use rate of 89% was calculated. There has been increased public scrutiny, controversy and debate regarding the increasing use of antipsychotic agents in children. As a response to this, OPS established a new program, The Peer Review Program for Mental Health Drugs. The program began in October 2011 and initially addressed the use of antipsychotics in Medicaid patients under five years of age. In partnership with the Behavioral Health Administration (BHA) and the University of Maryland (UMD) Division of Child and Adolescent Psychiatry and School of Pharmacy, the program's goal is to ensure that members of this vulnerable population receive optimal treatment in concert with appropriate non-pharmacologic measures in the safest manner possible. During FFY 2014, the program expanded to include all patients under 18 years of age. This program continues to benefit all covered participants. In 2013, the OPS, with the assistance of the University of Maryland, established the Antipsychotic Prescription Review Program (APRP) as another avenue to promote evidenced based, cost-effective prescribing. Through this program, the APRP retrospectively reviews paid antipsychotic claims and identifies outlying prescribing patterns. Subsequently, APRP contacts the prescribers associated with the above claims with the goal of improving their prescribing practices.

State	Executive Summary
	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. In the future, the DUR Board aims to accomplish the following: 1. Provide recommendations to OPS to improve drug therapy in the Maryland Medicaid population; 2. Analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service; 3. Recommend and review prescriber interventions and educational programs; and 4. Serve in an advisory role for OPS in the continued management of a Participant Corrective Managed Care (Pharmacy Lock-In) Program.

State	Executive Summary
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 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.

State	Executive Summary
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 2021 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 2021 with an average total enrollment of 2,887,714, an increase of 12% from FFY 2020. Approximately 74% of the Medicaid beneficiaries are enrolled in Managed Care Organizations (MCOs). The remaining 26% 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. FFY 2021 saw the continued expansion of hepatitis C virus (HCV) treatment coverage with the removal of the metavir scores for liver scarring requirement in October 2020 and the implementation of Michigan's HCV elimination program, called We Treat Hep C, in April 2021. This program removed barriers by eliminating the clinical prior authorization and prescriber specialty requirements. A great deal of time was devoted to the development of the single Medicaid PDL to maximize drug manufacturer rebates to generate savings. Coordination of the PDL PA criteria with the MCOs and FFS ensures consistency across the entire Medicaid population for the PDL drug classes. To further address the high cost of medications, MDHHS received CMS approval in October 2018 to pursue Outcomes-Based Contracts with drug manufacturers. In August 2020, the first contract was executed with Novartis Gene Therapies for the gene therapy medication, Zolgensma. The April 2021 contract with Abbvie for the HCV drug Mavyret was the second agreement. Outcomes-Based Contracts/Value-Based Agreements are encouraged and agreement opportunities are continuously reviewed by the Department of Health and Human Services to help address high drug costs.

State	Executive Summary
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 criteria for nonpreferred drugs cannot disadvantage preferred drugs. MCO may also use the same criteria as FFS Medicaid. Managed Care Organizations (MCO): This is the fourth federal fiscal year (FFY) where Minnesota Medicaid MCOs, BluePlus, HealthPartners, HennepinHealth, IMCare, Medica, PrimeWest, SouthCountry, and UCare will be included in the Medicaid State report to CMS. Oversight consists of pharmacy representatives from each MCO meet 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 where 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. 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 2021, there were a total of 8,307 provider letters mailed regarding 9,803 patients. These counts also include the two psychotropic drugs in children and the two SUPPORT Act mailings. Quarterly RetroDUR population-based mailings for FFY 2021 included Overuse of PPIs (3/2021), Respiratory Disease Management, (4/2021), Gabapentinoids (6/2021), and Management of Diabetes Mellitus (10/2021). Improvement in clinical indicators outcomes were Overuse of PPIs 40%, Respiratory Disease Management 43%, Gabapentinoids 43%, and Management of Diabetes Mellitus 77%. Psychotropic Drugs in Children: Two additional mailings during FFY 2021 were completed to address the use of psychotropic drugs in children (mailed 7/2021 and 10/2021). The criteria included (I) monitoring of second-generation antipsychotics (SGA) for changes in lipids and glucose, (II) multiple (2 or more) oral SGAs and (III) polypharmacy defined as three or greater psychotropic medications. The first mailing (7/2021) consisted of 1,354 prescriber letters regarding 3,349 patients. Improvement in clinical indicators for 7/2021 was 49%. The second mailing (10/2021) consisted of 962 prescriber letters regarding 1,151 patients. Improvement in clinical indicators for 10/2021 was 53%. Opioids: There were no new ProDUR edits. There were two SUPPORT Act RetroDUR mailings for FFY 2021: SUPPORT Act - opioid and SUPPORT Act -Medication Assisted Treatment (MAT). The

State	Executive Summary
	first mailing (06/2021) consisted of 557 provider letters regarding 362 patients after individual profile reviews. There was a 78.5% overall change in the five clinical indicators which included opioid and benzodiazepine current use, opioid and antipsychotic concurrent use, duplicative short-acting opioids, duplicative long-acting opioids, and exceeding a 90 mg cumulative maximum daily morphine milligram equivalent (MME). The second mailing (08/2021) was a special mailing which consisted of 576 provider letters regarding 535 patients. There was 49% overall change in the these two indicators regarding opioids for (1) OUD/MAT (opioid use disorder/medication assisted treatment) where there is no indication for opioids and (2) consider co-dispensing naloxone in high risk of opioid overdose cases. Starting next FFY, each SUPPORT Act mailing will include all the criteria above. Compiling results together resulted in a 52% successful change for the 897 adjusted patients in the post period periods.
Mississippi	As we have mentioned throughout, our agency is in the final days of implementing a new fiscal agent after about 20 years with our previous vendor. This project has consumed a lot of time and energy and touches every office and employee of the agency. One of the positive outcomes of the development and implementation of such a large system is the necessity and opportunity to examine every aspect of our program and consider different ways of doing things. As an example, we have identified several areas where automation can be employed to eliminate manual processes, which will free our staff to spend more time responding to the rapidly changing pharmaceutical landscape and the needs of our beneficiaries and providers. As our new system goes live in the coming months, we look forward to the implementation of several initiatives that we believe will improve our program further.

State	Executive Summary
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 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.

State	Executive Summary
Montana	Due to component's 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 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 are still in place.
Nebraska	The Nebraska Medicaid DUR Board is working very hard (post-COVID-19) to get back to 100% in-person meetings and can have 2 meetings virtually. We are saving those for bad weather events and when we need to have a quorum. Our meeting in March did not achieve a quorum, however we were able to complete the meeting but without any voting. The May meeting was fully attended except by 1 member. We ere able to review all the previous meeting's work and include May's new material also. As stated earlier, we have been able to establish a roadmap for this year and am excited about next year's offerings. Our review of the SUPPORT Act, naloxone use, Asthma and COPD therapies, Diabetes, and COVID-19 therapies have all been discussed and are being studied. The PDMP that is provided by CyncHealth and this relationship is providing us with a great data source and gives us the ability to run reports through their Health Information Exchange portal. This tool is showing results in its specificity and the many different categories where we can run data.
Nevada	The quarterly public DUR meetings are facilitated by a licensed clinical pharmacist from OptumRx, the Pharmacy Benefit Manager for Fee-for-Service Medicaid. The DUR Board meets to monitor drugs for therapeutic appropriateness, over or under-utilization, therapeutic duplications, drug-disease contraindications, and quality care. The DUR Board does this by establishing prior authorization and quantity limits to certain drugs/drug classes based on utilization data, experience, and testimony presented at the DUR Board meetings. This includes retrospective evaluation of interventions, and prospective drug review that is done electronically for each prescription filled at the Point of Sale (POS). During the Federal Fiscal Year 2021, the DUR Board was comprised of physicians and pharmacists from various backgrounds and locations around the State of Nevada. Other non-voting members who contribute to Board discussions include employees from the Division of Health Care Financing and Policy, a Deputy Attorney General, and representatives from the contractors for MMIS and PBM services. The three managed care organizations also participate, and each have non-voting representation on the Board. The public is welcome to provide testimony to the board before they vote on topics. Clinical reviews and proposed prior authorization criteria for the Board are supplied by OptumRx and the pharmacy directors from each managed care organization. Additional input is provided by pharmaceutical manufacturers, members of the public, and the DUR Boards unique experiences and research. All DUR Board meeting information is posted on the fiscal agent's website for the public before each meeting. This includes all clinical drug reviews, meeting materials and proposed criteria.

State	Executive Summary
New Hampshire	During FFY 2021 the New Hampshire Medicaid population was managed under 3 managed care organizations and the Fee-for-Service program. FFY 2021 focused on the response to the COVID pandemic to promote access to vaccines for the entire New Hampshire Medicaid population through the FFS program through POS to ensure timely and consistent access for single and multi-dose vaccines. Throughout the year, updates were made to ensure proper reimbursement with guidance changes, age limitations to assist with vaccine selection, and additional and booster dose allowance per FDA/CDC recommendations. Additionally, drugs used to treat the symptoms of COVID and drugs to treat COVID were updated with a $0 co-pay. Extensions to clinical prior authorizations and early refills were permitted if COVID was cited as the justification. The remaining effort was to provide continuous, exceptional care to New Hampshire Fee-for-Service recipients during the pandemic. The New Hampshire Medicaid FFS DUR board continued to have high quality discussion during the 2 virtual public meetings held in FFY 2021. In addition to updating 38 clinical criteria, 4 new criteria were approved, and 7 new PDL classes were added to the Medicaid PDL. These new PDL classes included: 1. self-administered glucagon agents 2. movement disorders 3. potassium binders 4. calcitonin gene-related peptide inhibitors for migraine treatment 5. idiopathic pulmonary fibrosis 6. ophthalmic anti-inflammatory immunomodulator agents 7. opiate dependence treatment expansion to include buprenorphine-containing injectables. In developing DUR programs for the Fee-for-Service program, the criteria is built on maintaining quality of care, effective provider outreach and upholding standards of care while managing cost. The development of therapeutic prior authorization criteria is based on evidence-based drug information. The ProDUR program is updated, as new medications are available, to monitor duplicate therapy, drug-drug, proper dosing and drug-disease initiatives to assist pharmacy providers in reducing negative patient outcomes. The RetroDUR program continues to develop clinically relevant programs to educate providers on the most up to date information. New Hampshire reviews all therapeutic classes, including non-control substance classes, for fraud and abuse. New Hampshire Medicaid's DUR program ensures appropriate access to medications while providing clinically sound interventions. 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 2021. This Summary details the activities and accomplishments of the New Jersey

State	Executive Summary
	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), with the exception of methadone prescribed for the treatment of substance use disorders. The DUR activities of the Board pertain to Fee-For-Service (FFS) pharmacy activities in FFY 21 for Medicaid/NJFC beneficiaries not transitioned to MLTSS and residing in long-term-care or receiving institutional care, those transitioning from FFS to managed care, and those transitioning between managed care organizations. The Medicaid/NJFC managed care contract requires that MCOs establish and maintain a DUR program that satisfies the minimum requirements for PDUR and RDUR described in Section 1927(g) of the SSA, as amended by OBRA 1990. The MCOs are required to submit to DMAHS an annual DUR report, similar to that required by CMS for the FFS program. The PDUR and RDUR standards established by the MCO are consistent with the standards established by the NJDURB for the FFS program. These standards include therapeutic duplication, drug-drug interactions, maximum daily dosage and therapy duration. In addition, the Board works to develop measures to ensure consistency in the drug protocols used by the MCOs when prior authorizing prescription drugs. The recommendations made by the Board pertaining to both FFS and MCO drug utilization managements are reviewed and approved by the State Commissioners of Health and Human Services. During FFY 2021, Gainwell Technologies paid 494,756 Medicaid/NJFC FFS pharmacy claims totaling $70,213,033 and 24,664,496 pharmacy encounter claims were reported by MCOs during this period totaling $1,646,998,866. Combined, 25,159,252 paid FFS and MCO encounter pharmacy claims were processed totaling $1,717,211,899. 90% of FFS claims or 9% of FFS pharmacy payments were for non-innovator drugs while 88% of reported encounter claims or 16% of MCO payments were for non-innovator drugs. Regardless of payer, 88% of paid claims or 16% of claim payments were for non-innovator drugs. The FFS Point-of-Sale (POS) system monitors PDUR conflicts including, but not limited to severe drug-drug interactions, therapeutic duplication, duration of therapy and maximum daily dosage. For FFY 2021, the FFS ProDUR savings totaled $2,993,371. Critical to our FFS PDUR program is the State's Medical Exception Process (MEP). The MEP is a prior authorization process which functions within the framework of DUR standards recommended by the NJDURB and approved by the New Jersey Departments of Health and Human Services. The MEP is a clinically based DUR process not influencing, in any way product selection by prescribers. Instead, the MEP prior authorizes certain FFS claims and is an effective tool for determining if drugs are being properly prescribed, providing cost savings by ensuring that prescriptions are clinically appropriate. The NJDURB is a 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/.

State	Executive Summary
	In FFY21, the NJDURB recommended the following DUR protocols: - Protocol for Vimizim (elosulfase alfa) - Protocol for Naglazyme (galsulfase) - Protocol for Mepsevii (vestronidase alfa-vjbk) - Protocol for Daraprim (pyrimethamine) - Protocol for Increlex (mecasermin) - Protocol for exclusion on Victoza (liraglutide) - Protocol for Korlym (mifepristone) - Protocol for Juxtapid (lomitapide) - Protocol for Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) products - Protocol for Cabenuva (cabotegravir/rilpivirine) injectable - Protocol for biologic response modifier products used in plaque psoriasis - Protocol for Lumizyme (alglucosidase alfa) - Protocol for Myalept (metreleptin) - Addendum for direct acting antiretrovirals (DAAs) for HCV protocol - Addendum for Dupixent (dupilumab) protocol - Addendum for Vyondys (golodirsen) protocol - Addendum for Epidiolex (cannabidiol) protocol - Addendum for Cablivi (caplacizumab) protocol Five (5) retrospective DUR activities were conducted in FFY21. These included: - Confirmation of a HIV compliance - Confirmation of diabetes compliance - Claims exceeding $4000 to monitor FWA/duplication of therapy - Concurrent utilization of opioids/benzodiazepines - Concurrent utilization of opioids/antipsychotics The State's Morphine Milligram Equivalents (MME) protocol includes a MME daily dosage not to exceed 50 MME for an opioid naive patient and a MME daily dosage not to exceed 90 MME for an opioid tolerant patient. Exclusions from the protocol continue to include patients diagnosed with cancer or sickle cell anemia, as well as hospice patients and those patients receiving palliative end of life care. The protocol also requires prior authorization for the concomitant use of opioids and benzodiazepines. During FFY 21, the Division expanded the scope of 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. Since April 2020 and continuing in FFY 21, the State has held quarterly virtual public meetings of the New Jersey Drug Utilization Review Board due to COVID 19 restrictions. Routine activities of the Board have been conducted successfully. The pandemic has, however, impacted opportunities for the Board to distribute educational materials to providers, outside of information shared individually with providers during the Medical Exception Process.

State	Executive Summary
New Mexico	EXECUTIVE SUMMARY The State of New Mexico is committed to operating a Medicaid DUR program that has a positive impact upon quality of care as well as upon pharmacy and medical expenditures. ProDUR and RetroDUR each serve a unique purpose in alerting practitioners and pharmacists with specific, focused, and comprehensive drug information. For FFY 2021, the total estimated new savings for ProDUR and RetroDUR programs for New Mexico was $3,640,420.22. The RetroDUR estimated savings were $19,233.22 while the ProDUR estimated savings were $3,621,187.00. The New Mexico DUR program remains beneficial to the State, provider community, and the population it served.
New York	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. 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 has proven to be an asset in the efforts of New York Medicaid to protect and improve the health of it's 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.

State	Executive Summary
North Carolina	In addition to DUR activities highlighted in this survey, NC began the transition to Managed Care July 1, 2021, moving from a 100% FFS model. At this time, beneficiaries who met program criteria were transitioned to one of the 5 MCOs, also referred to as Prepaid Health Plans or PHPs. Some of our efforts during the last FFY have been to develop partnerships with the contracted PHPs and to ensure a thorough understanding of NC's Medicaid Pharmacy Policy. Contractually, they are required to align with the state and there is a single PDL. The state employs a dyad model whereby a clinical policy nurse and pharmacist are assigned health plans to work as a team to monitor and provide guidance. Assuring compliance to contracts, state policy, and state and federal regulations is a top priority, as is ensuring the PHPs continue to do business in such a way that NC Medicaid beneficiaries continue to receive high quality healthcare. As per the guidance the state received from CMS, since the state only had PHPs in place for 3 months of the FFY under review, the state did not require the Plans to submit surveys to the state. Additionally, the number of beneficiaries in Managed Care is slightly underreported in the survey as a result of the direction to provide the average for FFS and MCO participation over the 12-month period. In December 2022, the state will add 6 more Tailored Plans. The pharmacy benefit will not go live until 4/1/2023. Until this date, the pharmacy benefit will continue to be managed by the state. This plan is an integrated health plan for individuals with significant behavioral health needs and intellectual/developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members, and be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians. The state began the efforts of this transition during FFY2021. NC Medicaid also put great effort into the process of developing an RFP for a PBM for the MMIS replacement project. This is a combined effort with other departments within Medicaid and DHHS. The state is currently in the silent period. Additionally, NC continued to put forth much effort in protecting NC's most vulnerable population during the COVID crisis by continuing to provide improved access to medications and enhancing services. Continued changes during the FFY2021 included: allowing up to 90 days' supply fills or refills of most non-controlled substances; allowing early refills of most non-controlled substances, subject to pharmacist and prescriber clinical judgement; allowing up to 14 days' supply of a medication waiting on prior authorization; allowing up to 14 days' supply of an emergency lock-in prescription (with limitations); suspending behavioral health edits to lessen administrative burdens on pharmacies and prescribers; allowing up to 90 days' supply of certain Schedule II stimulant medications; allowing up to 90 days' supply of certain medication assisted treatment (MAT) medications; adding a mailing fee of $1.50 (with restrictions) to retail pharmacy claims; adding a delivery fee of $3.00 (with restrictions) to retail pharmacy claims; and increasing traditional dispensing fees and diabetic supply rates by 5%. These were efforts to combat compliance issues due to the fear of being in public spaces, to address any transportation issues and decrease risk of disease transmission. The state also focused efforts on ensuring vaccine administration reimbursement was in place and that COVID at home testing was covered in our POS system. The state also updated the State Plan Amendment to include the option to use Value Based Contracting with manufacturers. NC has not yet entered into an agreement but is open to this as a supplemental rebate option if future opportunities present. The state collects and retains all rebates on behalf of the MCOs. The state plans on updating contractual language to reflect the requirement for MCOs to comply with the SUPPORT Act. Currently, contract language is overarching and requires plans to comply with all state and federal regulations. Compliance and patient outcomes continues to be a priority as we work with out PHP partners.

State	Executive Summary
North Dakota	The antipsychotic monitoring program is expanded to include POS edits for appropriate use of all antipsychotics using diagnosis codes and therapeutic duplication. Therapeutic duplication form requests are reviewed by pharmacists to monitor for guideline based therapy, including non-antipsychotic alternatives and dose optimization with one antipsychotic. Specific warnings and precautions letters are sent to prescribers: 9 prescribers have received the Makena letter regarding the FDA committee recommendation of withdrawal. 608 prescribers have received the montelukast letter regarding the black box warning of neuropsychiatric side effects. Patient identification notifications, electronic billing templates, and documentation templates are developed in vendor platforms to increase provider engagement in the Medication Therapy Management program.
Ohio	During FFY21, there were several enhancements made to the ODM pharmacy program including innovative initiatives (see Summary 5), improvements, and increased oversight of managed care partners. As an overview, ODM's Drug Utilization Review (DUR) Board is made up of four pharmacists and four physicians who meet on a quarterly basis. ODM also has a DUR Committee made up of eight pharmacists who meet monthly. The Committee reviews member profiles and makes recommendations to the DUR Board. In FFY21, the DUR Committee met eleven times and the DUR Board met four times. RetroDUR interventions were implemented pertaining to members taking multiple antipsychotics, members who had an adherence rate of less than 95% on their HIV medications, members taking proton pump inhibitors for greater than 6 months, members taking opioids greater than 80 MED, members taking triple antithrombotic therapy, children taking opioids, members taking chronic triptans, members taking multiple anticholinergic medications, members taking opioids and benzodiazepines, and pharmacy education requesting pharmacists to have their patients demonstrate their inhaler technique and reinforce correct inhaler use. In FFY21, DUR savings totaled approximately $32.5 million. Of note this year, there were several updates made to the DUR program due to the implementation of the Medicaid DUR provisions included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271). RetroDUR interventions were performed to address members taking opioids and benzodiazepines, multiple antipsychotics, opioids greater than 80 MED, and children taking opioids. 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 2021 and lists the most prominent problems with the largest number of exceptions. In FFY 2021, RetroDUR Educational Outreach activities included:

State	Executive Summary
	Quarterly SoonerPsych Antipsychotic Monitoring Program Mailings (4 separate mailings in October of 2020 and January, April, and July of 2021); Quarterly Chronic Medication Adherence Program Mailings (4 separate mailings in November of 2020 and February, May, and August of 2021); Pediatric Antipsychotic Monitoring Program Mailing in December 2020; Utilization of Glucagon-Like Peptide-1 (GLP-1) Agonists or Sodium-Glucose Co-Transporter-2 (SGLT-2) Inhibitors with Cardiovascular (CV) Benefit in Members with Type 2 Diabetes and High CV Risk or Established Atherosclerotic CV Disease Mailing in February 2021; Pediatric Antipsychotic Monitoring Program Mailing in July 2021; and Academic Detailing Program: Treatment of Persistent Asthma with analysis period beginning in January 2021. DUR Board Activities: During FFY 2021 the DUR Board met 11 times. Meetings were held in October, November, and December 2020, and in January, February, March, April, May, June, July, and September of 2021. In accordance with state legislative mandate, 18 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 26 additions to the CBPA program and 8 changes in FFY 2021. There were 70 additions to the PBPA program and 50 additional categories or products updated. RetroDUR activities included: Overview of U.S. Food and Drug Administration (FDA) Safety Alerts, Pediatric Antipsychotic Monitoring Program Update with second focused on foster care, Opioid MME Review, Montelukast RetroDUR, MTM Program Update, 2021 Spring Pipeline Report, SoonerPsych Program Update, Prenatal Vitamin Utilization RetroDUR, GLP-1 SGLT-2 with CV benefit in patients with High CV risk or ASCVD Mailing Update, Annual Review of the SoonerCare Pharmacy Benefit, Chronic Medication Adherence Program Update, and SFY MTM Review. Annual Reviews were presented or made available to the DUR Board for 52 CBPA categories or products and 38 PBPA categories. Cost Savings Estimates: Cost savings/cost avoidance are provided within the ProDUR and RetroDUR tables attached. Cost savings for FFY 2021 represented 14.7708% of the grand total. - State Maximum Allowable Cost Savings: $29,107,840.52 - Prior Authorization Program Savings: $11,534,634.53 - ProDUR Savings: $72,228,618.79 - RetroDUR Savings: $1,587,612 Total DUR Program Savings: $114,458,704 - O.U. College of Pharmacy: -$4,252,384.37 Annual Savings FFY 2021: $110,206,322 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, and most recently, asthma. For members with a diagnosis of persistent asthma, current guidelines recommend treatment with rescue medication as needed and daily controller medication or single maintenance and reliever therapy (SMART). In Oklahoma, nearly two-thirds of pediatric asthma patients meet the diagnostic criteria for persistent asthma, and it is the 3rd leading cause of hospitalizations for patients aged 0 to 15 years. The College of Pharmacy analyzed Oklahoma SoonerCare claims during a one-year period to

State	Executive Summary
	investigate asthma prescribing trends. Collected data for FFY 2021 focused on changes in prescribing patterns, utilization, and use of specific therapeutic agents. During FFY 2021, nearly 200 providers received Asthma-AD visits, and the program impacted 4,455 members. During FFY 2021, Asthma-AD resulted in total savings of $1,587,612. Data is continuously compiled to bring to the DUR Board for review and educational opportunities for improvement. Recommendations presented have included comprehensive communication with providers, pharmacy level communication if needed, and goals for future drug categories to explore. Interventions have shown a trend toward meaningful benchmarks in costs, prior authorizations, and program application. With the success of the program, further program material for additional drug categories will be created with more providers being reached.
Oregon	Oregon implemented prior authorization criteria in the fee-for-service (FFS) program to ensure medically appropriate use of Provider Administered Biologic agents and point of sale (POS) dose consolidation edits were implemented for high cost/high utilization medications. Drug Use Review (DUR) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program includes, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse. The DUR Board's priorities this reporting period focused on prior authorization criteria, drug use evaluations, and targeted strategies to identify high-risk patients lacking appropriate therapy, duplicate therapy, or non-adherent to prescribed treatments (bipolar disorder and other mental health conditions). Prescriber messaging alerts were developed and implemented, along with expanded case management referrals for FFS and tribal patients who have multiple comorbidities and high risk of acquiring COVID/complications when late prescription refills of chronic medications were identified. The safety net program was also expanded to include patients with denied claims due to antipsychotic dose consolidation. 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. CCO Pharmacy Directors and OHA continued regular meetings, with topics including health equity, the Vaccines for Children Program, influenza and COVID-19 vaccination planning (Operation Warp Speed), hepatitis C strategies for hard to reach populations and supporting HCV treatment for persons who inject, collaboration on smoking cessation - including pharmacist prescribing, revised minimum DUR standards, coverage of pre-exposure prophylaxis (PrEP) to prevent HIV, and coverage of Medication-Assisted Treatment (MAT).

State	Executive Summary
Pennsylvania	The emphasis of Pennsylvania's drug utilization review (DUR) program is to promote patient safety through an increased review and awareness of outpatient prescribed drugs to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. Pennsylvania employs a combination of prospective and retrospective DUR initiatives for a comprehensive approach to pharmacy utilization management. The prospective DUR component includes a combination of alerts transmitted to the dispensing pharmacist at the point of sale and clinical prior authorization required at the point of sale which is reviewed by the Pennsylvania clinical staff for medical necessity determination. The retrospective DUR component supports the overarching goal of patient health and safety by focusing on a retrospective review of patients' drug claims against specific criteria, identifying common drug therapy concerns such as inappropriate use of drugs, medically unnecessary care, and increased risk for drug interactions, and providing for educational interventions that promote effective prescribing practices in a factual and unobtrusive manner. Through the RetroDUR, the Department provides prescribing providers with a comprehensive drug history profile for their patient and specific recommendations which enable them to consider medically appropriate actions such as identifying and discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, or switching to safer drug therapies. Outcomes include enhanced therapy compliance and reductions in utilization of other medical services like emergency rooms and hospital stays, combined with reductions in drug abuse and diversions, all of which contribute to cost savings without compromising access or quality of care.

State	Executive Summary
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 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.

State	Executive Summary
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. The South Carolina Department of Health and Human Services (SCDHHS) has begun the transition to a new Medicaid Management Information System (MMIS). The project includes various system and services modules that will replace the current MMIS. The modules in the replacement MMIS (RMMIS) are the accounting and finance module, administrative services organization (ASO), business intelligence system (BIS), dental administrative services organization (DASO), electronic visit verification (EVV) module, pharmacy benefits administrator (PBA) and the third-party liability (TPL) module.
South Dakota	The aim of the South Dakota Drug Evaluation and Education Program's committee (South Dakota's retrospective DUR program) is to evaluate patient profiles on a monthly basis to identify areas of potentially problematic therapies. This report outlines the fiscal year of October 1st, 2020 through September 30th, 2021. Patient profiles are reviewed by a committee of six members (pharmacist/physician). These profiles are created through HID's Initial Criteria Exception Report that lists categories of exceptions to the clinical criteria appropriate for patient care. The patients reviewed are identified through this report and can be chosen by a total risk score assigned to individual patients or through specified criteria. The committee will then evaluate individual patient profiles to identify any areas of potentially problematic therapy. If any potentially problematic therapy is identified, the committee will send letters to the prescribing practitioners as well as the individual pharmacies involved highlighting the concern of the identified potentially inappropriate therapy. For the fiscal year stated above, the committee reviewed patient profiles and delivered letters during eleven of the twelve months. The DUR Review Committee had discussions concerning cases or criteria issues with each other by phone or email over the year. During a couple select months, the committee selected specific criteria for a focused review. These specific criteria included use of tramadol

State	Executive Summary
	in patients with renal insufficiency, underutilization of statin medications in diabetic patients, and patients receiving co-administration of opioids and benzodiazepines. Total number of letters sent out was 1,274 for the year with an approximate average of 116 letters per month when the committee reviewed patient profiles. Month Number of letters sent Specific criteria reviewed (if any) October 2020 115 New criteria reviewed/approved November 2020 86 Use of gabapentoids and respiratory depression Overuse of beta-agonists possibly signaling worsening asthma Life-threatening respiratory depression with gabapentoids New criteria reviewed/approved December 2020-- Committee did not review patient profiles January 2021 114 Transitioned to electronic review system February 2021 130 Use of statins in diabetic patients Use of tramadol in renal insufficiency March 2021 93 April 2021 129 May 2021 125 Co-administration of opioids and benzodiazepines New criteria reviewed/approved June 2021 93 July 2021 128 August 2021 142 Co-administration of opioids and benzodiazepines New criteria reviewed/approved September 2021 119 Use of statins in diabetic patients The committee has also decided to continue and expand on focusing on specific criteria on a monthly or every other month basis. Future targets will continue to focus on opioid use and concomitant opioid and benzodiazepine therapies in addition to other targeted reviews. The profile review was transitioned to a fully electronic review process during January 2021. This new system allows reviewers to access and evaluate patient profiles fully electronically. Some reviewers have continued to utilize paper reviews and the committee is expecting to fully transition to the electronic system.

Tennessee	Throughout FFY21, TennCare's DUR Board has finally solved our past issues with reaching quorum, and meetings have been successfully held, with excellent participation from our Board members. Our quorum has been an issue in the past because we could not retain physician members in order to achieve at least 33% physicians for our membership. This was remedied by TennCare requesting that each of the 3 MCO's provide a medical director to serve as a DUR Board member. Throughout FFY21, 2 of the three MCO's did provide a medical director (and in FFY22 all three MCO's have representation with medical directors). We feel that the role of the DUR Board and Tennessee's DUR program is to prospectively and retroactively review prescription claims, and upon seeing trends, make recommendations related to the safe and effective use of medications for our citizens to the Bureau. During FFY21, we also changed the number of members on the DUR Board, from 11-members to 8 members, comprised of 4 actively practicing pharmacists and 4 actively practicing physicians. As stated previously in last year's report, since the 3Q2020 meeting, the Board has met quarterly and has met quorum. The four actively practicing pharmacists include two independent pharmacists, one from middle Tennessee and one from a rural setting in East Tennessee, one hospital pharmacist at a large teaching hospital in Nashville working in a clinical setting, and one chain pharmacist working in a Managed Care setting for the drug chain. The four actively practicing physicians included 3 MCO medical directors and one physician who is an emergency room physician and has served the DUR Board for over 10 years. Tennessee's Pharmacy Benefits Manager is OptumRx, and their DUR Pharmacist Kimberly Barnes has responsibility for planning DUR Board meetings and for all enrollee profile reviews and provider education activities. Kimberly became the DUR Pharmacist with the prior person left in early 2021. The individual at TennCare with overall DUR responsibility was Ray McIntire, D.Ph., and Director of Pharmacy Operations. These two individuals worked collaboratively with Dr. Victor Wu, TennCare's Chief Medical Officer, Dr. David Collier, M.D., TennCare's Associate Medical Director, and Dr. Renee Williams-Clark, PharmD, TennCare's Chief Pharmacy Officer. As stated previously past yearly CMS report, the DUR Board has been involved in several aspects of fraud and abuse monitoring of TennCare enrollees and prescribers and are of great importance in assisting the TennCare Pharmacy team with our program integrity efforts. During FFY21, the DUR Board continued to review drug classes and make recommendations to our P&T, known in Tennessee as PAC (Pharmacy Advisory Committee), and these class reviews are retrospective reviews based on pharmacy claims data, merged with medical data and including data from the State of Tennessee's PDMP. During FFY21, we have already discussed in Innovative Practices, the sharing of the enrollee profiles who were concomitantly using opioids and antipsychotics, and the DUR Board also made a suggestion to the PAC Committee that tramadol's coverage should be updated to include a contraindication in pediatric patients younger than 12 years of age, and patients less than 18 years of age who are being treated for pain after tonsillectomy and adenoidectomy, and that coverage should be updated to warn against the use of tramadol in adolescent patients between the ages of 12 and 18 years old who are obese, or who have comorbid conditions such as obstructive

State	Executive Summary
	sleep apnea, or severe lung disease. The PAC Committee approved this recommendation during their next quarterly meeting. Board Meetings are held quarterly, follow parliamentary procedures and have a standing order of business, specifically: Call to Order Approval of Minutes TennCare Update presented by Dr. Collier TennCare Pharmacy Update presented by Dr. Williams-Clark Follow Up on Old Business Class Review (if presented) New Business Review of TennCare Population Trends Review of TennCare Drug Utilization Trends Review of Pharmacy Lock-In Review of DUR Activities Review of Provider Practice Activities Future Meeting Dates Adjournment The Bureau of TennCare continues to appreciate the time and efforts of the DUR Board members. The Bureau appreciates their support, and in our FY22 report next year, Tennessee will report with more DUR reviews, examples of how the DUR Board has been involved with reviewing profiles and providers in support of the SUPPORT Act, and we will be able to once again be successful in helping TennCare and our MCO's in ensuring cost-effective medically necessary health care and drug therapies for our beneficiaries. We expect to see much more success from their support and efforts in the years to come.

State	Executive Summary
Texas	Texas Medicaid conducts a robust and productive DUR program. Texas Medicaid implements a single formulary and PDL policy with all the contracted MCOs. In the FFY 2021, there were 17 MCOs contracted with Texas Medicaid. Vendor Drug Program (VDP) is responsible for managing the out-patient pharmacy formulary for members enrolled in Medicaid and CHIP as well as the state operated CHSCN program, Healthy Texas Women Program, and Kidney Health Program. In addition to the formulary and PDL, VDP is responsible for developing the prospective clinical prior authorization criteria proposals and the retrospective DUR intervention criteria proposals. These proposals are submitted to the DUR Board during the Board's regular meetings. The Board holds 4 quarterly meetings each year and makes recommendations on the proposals for PDL, prospective clinical PAs, retrospective drug use criteria, and retrospective interventions. HHSC implements the PDL decisions twice per calendar year, in January and in July. The PDL decisions from January and April DUR meetings are implemented in July. The PDL decisions from July and October meetings are implemented in January of the following year. In the FFY 2021, there were several significant additions to the PDL classes. In October 2020, the oral oncology drugs for treatment of prostate, breast, hematology, lung, prostate, renal, skin and other types of cancers were reviewed for the first time. All the reviewed drugs in these classes were given preferred status. Similarly, in the January 2021 Board meeting, anticonvulsants, HIV/AIDS, Antihemophilia, and multiple sclerosis drugs were reviewed for the first time and all were given preferred status. Finally, in response to the public and provider's request, HHSC granted preferred status to all sickle cell treatment agents. DUR Board also reviewed and voted on several new clinical prior authorization criteria proposals including Evrysdi, Orihann, Calcitonin gene-related peptide receptor (CGRP) antagonist for treatment of acute migraine, Wakix, Xyway in October 2021, Amantadine extended-release agents, Hemady, Dopamine agonists, Apokyn and Kynmobi, and Multiple Sclerosis agents (safety checks) in 2021. Of the several Board-approved retrospective DUR interventions proposals, Benzodiazepine Anxiolytics and Controlled Sedative Hypnotics Drug Use Evaluation, Comprehensive Opioid Management, and Psychotropic drugs in Youth worth mentioning. The total estimated cost savings/cost avoidance reported for the FFY 2021 is largely associated with the PDL and clinical PA implementations and the retro-DUR interventions. In FFY 2021, the total cost saving was $9,558,850. A small portion of this was from the state's FFS Lock-In program. VDP has several prospective and retrospective DUR policies and criteria in place for managing prescriptions for opioids and psychotropics (antipsychotics, antidepressants, anxiolytics, and simulants). through clinical edits, . These edits and interventions are intended to target overutilization, duplicative therapies, doctor/pharmacy shoppers, and medication treatment adherence. During the FFY 2021, HHSC implemented several innovative practices, including the reopening of intersessional RSV prophylaxis throughout all Texas Health regions, coverage of COVID-19 vaccines in out-patient pharmacy, and coverage of all OUD treatment drugs as per SEC. 1006.(b) of the SUPPORT Act.

State	Executive Summary
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 reducing inappropriate use of opioid medications, concurrent use of opioids and benzodiazepines, improper use of ADHD stimulants, and antipsychotic medication use in children and adolescents. Focus has also been on improving adherence to antidepressant medications, hepatitis C therapies, and positive clinical therapy alternatives on the Preferred Drug List. Peer-to-peer programs were launched and 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, 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 to have patient-focused discussions and educate them on Medicaid policies and procedures. Those conversations were followed by a prescriber letter summarizing the discussed points. Nearly all interactions were positive and well-received, and providers thanked us for the outreach. 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 by 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	EXECUTIVE SUMMARY The Department of Vermont Health Access (DVHA) assists individuals in accessing clinically appropriate health services, administers Vermont's public health insurance system efficiently and effectively, and collaborates with other health care system entities in bringing evidence-based practices to Vermont Medicaid members and providers . In support of goals of the Agency of Human Services and the Department, the Pharmacy program's goal is to ensure that members receive medically necessary medications in the most efficient and cost-effective manner. With ongoing fiscal challenges facing the state, at stake is preserving, to the greatest extent possible, the benefits that have evolved in Vermont's programs. The 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 related to administrative simplification of the Department and for providers. The primary role of the Pharmacy Unit is oversight of the contract with the Department's pharmacy benefits manager (PBM), Change Healthcare. Change Healthcare providers 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 in for making drug coverage determination 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, managing the Preferred Drug List (PDL) This is accomplished in part through activities of the Drug Utilization Drug Review Board (DURB), and operating a suite of software

State	Executive Summary
	programs that support all activities including clinical, operational and financial reporting suites. In addition to monitoring and oversight of 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. In SFY2021 total gross drug spend was $231.2 million and paid prescription claims totaled 2,045,702 for all programs. Specialty drugs represented approximately 29% of DVHA's overall drug spend and the average specialty drugs cost was approximately $7,100 per prescription. This Federal Fiscal Year (10/1/2020-9/30/2021) we continued to react swiftly to the COVID-19 Public Health Emergency by assuring that our members had continued access to prescriptions and pharmacies had the tools needed to continue to provide medications and provide Covid 19 vaccinations. Vermont Medicaid allowed pharmacists to enroll in the Medicaid program as licensed providers to provide Medicaid services in accordance with their scope of practice, and state and federal law. This includes ordering and administering COVID-19 diagnostic tests and COVID-19 vaccines during the public health emergency. Any pharmacist who administers or supervises administration of a COVID-19 vaccine must be enrolled with Vermont Medicaid for the pharmacy to be eligible for reimbursement for such vaccinations. In addition to multiple COVID accommodations, other areas of focus this FFY2021 included: Added coverage of Omnipod DASH products to the pharmacy benefit effective 04/01/21. The manufacturer is only making it available through the retail pharmacy channel, and not through DME. This allows claims to adjudicate in real time through the Pharmacy Point of Sale (POS) System which will allow for faster and easier access for patients. Removed the requirement that Direct Acting Antivirals (DAAs)to be dispensed by an accredited specialty pharmacy. This change was made to further improve access to DAA therapies effective 07/09/2021. Effective July 1, 2021, the Vermont Medicaid program allows reimbursement for pharmacists providing tobacco cessation counseling.
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 2021, the DUR Board approved clinical edits for Bronchitol, Evrysdi, Eysuvis, Gavreto, Imcivree, Inqovi, Lampit, Lupkynis, Mycapssa, Onureg, Orgovyx, Rukobia, Tepmetko, Ukoniq, Verquvo and Zokinvy.

State	Executive Summary
	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 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 naïve member is trying to fill an opioid prescription and sends a message back alerting of the potential risk and to offer naloxone. DMAS has further lowered the morphine milligram equivalents (MME) from 120 to 90 MME with quantity limits that apply to each opioid drug. DMAS also has several edits already in place to monitor and limit antipsychotic medication use in children. In addition, DMAS has sent out several RetroDUR letters to prescribers in reference to the SUPPORT Act. Virginia Medicaid has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. The DUR Board has been focused on compounded prescriptions in terms of safety, efficacy and effectiveness as well as cost. At the May 10, 2018 meeting the Board made the recommendation to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. In order for the service authorization to be approved, the prescriber would be required to submit peer review studies of the compounded products safety and effectiveness. Compound claims over these 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 $4,816,781 in FFY 2021. Virginia Medicaid also administers dose optimization and quantity limit programs that saved $721,990. The total cost avoidance, attributed to RetroDUR, during FFY 2021 was $131,480. Virginia Medicaid's overall DUR Program savings in FFY 2021 was $5,670,251.

State	Executive Summary
Washington	Pharmacy Services The Washington State Health Care Authority (HCA) is the designated state agency for administration of Medicaid in Washington State otherwise known as Washington Apple Health (Medicaid). The Pharmacy Services section at HCA manages the pharmacy benefit using a multi-component integrated system of utilization management and utilization review activities. Washington Apple Health (Medicaid) receives advisory support in prospective and retrospective drug utilization review through the P&T Committee and DUR Board. The P&T Committee provides advisory support for three state agencies regarding the administration of the Washington State Preferred Drug List (WA-PDL). The same members of the P&T Committee serve as the DUR Board for Medicaid and provide advisory support for administration of the Apple Health Preferred Drug List (AHPDL). The DUR board does not have set policies on what types of interventions need to be adopted however if identified they are determined on a topic-by-topic basis. Washington Apple Health (Medicaid) has completely shifted to a single Preferred Drug List called the AHPDL. 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 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 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 Managed Care Organizations (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. Opioid Monitoring Washington Apple Health (Medicaid) began efforts to address the opioid epidemic in April 2019 before passage of the SUPPORT Act. Quantity limits of 18 dosages per prescription for children less than 20 years of age and 42 dosages per prescription for adults 21 years of age or older were applied to FFS and MCOs. FFS and MCOs require an attestation form for anyone receiving chronic opioid therapy defined as opioids exceeding 42 calendar days within a rolling 90-day period. Measures that are in place to monitor or manage the prescribing of opioids includes PA, patient-provider agreements, requirement for prescriber to have an opioid treatment plan for patients, documentation of urine drug screening results, and PDMP checks. 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.

State	Executive Summary
	2. Encourages compliance where providers and managed care entities are able to self-disclose improper payments. 3. Holds MCOs 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 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 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 to allow pharmacists and pharmacy technicians to administered 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

State	Executive Summary
	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 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. MCO Contract Updates Washington Apple Health (Medicaid) updates contracts with the MCOs twice yearly in January and July. These managed care contracts identify the requirements and guidelines MCOs must follow when providing access to health care services. In January and July 2021, the following contract changes were updated and implemented: 1. Beginning March 1, 2021 and annually thereafter, the MCO shall provide HCA with nonredacted copies of all contracts between any retail pharmacy, mail pharmacy, specialty pharmacy, or pharmacy services administrative organization, and the MCO or PBM, to participate as a network provider in the MCO or PBMs Apple Health pharmacy network. 2. Products in the MCOs drug formulary are purchased from a participating rebate eligible manufacturer as defined in the Contract and show as rebate eligible on the weekly AHPDL file. A list of eligible manufacturers can be found at: https://www.hca.wa.gov/assets/billers-and-providers/rebate_customer_list.xls 3. The MCO is prohibited, and must prohibit their PBM, subcontracted PBM, and network pharmacies, from issuing automatic refills of prescriptions to their members. Automatic refill is any prescription refill the pharmacy initiates without the client/member requesting the prescription to be filled at that time. 4. The MCO must respond to a prior authorization request for a covered outpatient drug or over-the-counter drug by telephone or other telecommunication device within 24 hours of the request. Authorization Determinations for Covered Out Patient Drugs or Over-the-Counter Drugs: Consistent with Section 1927(d)(5) of the Social Security Act. The MCO must make a decision to approve, deny, or request additional information from the provider within five calendar days of the original receipt of the request. If additional information is required and requested, the MCO must give the provider five calendar days to submit the information. The MCO must approve or deny the request within four calendar days of the receipt of the additional information. If the provider does not respond to the MCO's request for additional information within five Business Days of the request the MCO must either approve based on the information at hand or issue a denial for no response.

State	Executive Summary
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 $588,818,132.67 in rebates in FFY2021, of which $63,444,862.71 were from negotiated supplemental rebates. An additional $ $10, 895,198 was saved through our SMAC program. PDL Compliance: The P&T Committee reviewed all available rebates and worked diligently to prefer drugs which possessed favorable therapeutic profiles at the lowest Guaranteed Net Unit Price (GNUP). In addition, the DUR Board developed prior authorization criteria that was meant to encourage clinically appropriate prescribing, and which resulted in an overall 95.28% compliance rate to the PDL.
Wisconsin	BACKGROUND The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that, effective January 1, 1993, each State establishes a Medicaid Drug Utilization Review (DUR) Program. The program must include both prospective and retrospective DUR to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. To accomplish this objective, the law requires Medicaid DUR programs to screen, based upon explicit criteria, for therapeutic problems specified in the law (for example, drug-drug interactions, incorrect dosage and duration of therapy, therapeutic duplication), to develop and implement interventions to change drug use behavior, and to assess the outcome of the intervention. Section 1927 (g) (3) (D) of the Social Security Act requires each State to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care as well as any cost savings generated by the program. HISTORY OF WISCONSIN DRUG UTILIZATION REVIEW PROGRAM The state agency in the Wisconsin Department of Health Services responsible for benefits administration is the Division of Medicaid Services (DMS), which established a Medicaid Evaluation and Decision Support Drug Utilization Review (DUR) Project. Since September 1996, the primary contractor for the DUR Project has been Gainwell Technologies (formerly, Hewlett Packard Enterprise (HPE)). From July 1, 2009, Gainwell Technologies administered the Wisconsin retrospective DUR activities through a subcontractor 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. Criteria are developed jointly by Kepro and DMS, then get reviewed and approved by the DUR Board for

State	Executive Summary
	implementation. If a potential drug problem is discovered, intervention letters are sent to all providers who prescribed a drug relevant to the identified problem. DUR BOARD ACTIVITIES The DUR Board meets quarterly. Meetings have been held virtually via a Zoom meeting since the Public Health Emergency. Materials are sent to Board members between meetings for review and action. Activities of the DUR Board include review and approval of DUR criteria, review and approval of educational material and interventions, and review of other recommendations to DMS on drug-related issues. COST SAVINGS A cost savings analysis of member's drug costs before and after a retrospective DUR letter intervention are reflected in Attachment 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 2021, the opioid SUPPORT Act requirements were an ongoing area of focus for Wisconsin's DUR activity.
Wyoming	In FFY2021, the Wyoming Drug Utilization Review (DUR) program conducted prospective and retrospective reviews resulting in a total estimated cost avoidance of more than $38 Million, an estimated impact of 65%. Generic medications accounted for 85% of claims and 33% of expenditures. Appropriate utilization of Suboxone and other treatments for pain along with new, expensive biologics were a major focus of discussion and education. In addition to ongoing education programs, comparative prescriber reports were completed detailing use of opioids in pediatrics, concurrent use of opioids, stimulants, and gabapentin, concurrent use of opioids and sedatives, and albuterol utilization.