Nevada Medicaid

Annual DUR Survey
FFY 2018

Nevada Department of Health and Human Services
Helping People -- It's Who We Are And What We Do

Nevada Medicaid Annual DUR Survey

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Fee for Service
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ABOUT THE SURVEY

Section 1927 (g) (3) (D) of the Social Security Act (the 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.

This report covers the period October 1, 2017 to September 30, 2018 and is **due for submission to CMS Central Office by no later than June 30, 2019. Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory requirement.**

☒ I have read the information about this survey.

I. DEMOGRAPHIC INFORMATION

Medicaid Agency Information

Identify state person responsible for DUR Annual Report Preparation.

First Name: Holly

Last Name: Long

Email Address: hlong@dhcfp.nv.gov

Area Code/Phone Number: 775-684-3150

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

   179,119 beneficiaries

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

   509,453 beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy POS vendor.

   - ○ State-Operated
   - ◉ Contractor
   - ○ Other

   a. Vendor Name

      OptumRx

   b. Is the POS vendor also the MMIS fiscal agent?

      - ○ Yes
      - ◉ No

2. Identify prospective DUR criteria source.

- ☐ First Data Bank
- ☒ Medi-Span
- ☐ Other

Please specify.

3. Are new ProDUR criteria approved by the DUR Board?

- ○ Yes
- ◉ No

Please explain.

New ProDUR criteria is provided by Medispan.

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

- ◉ Yes
- ○ No
- ○ Partial

Please explain.

5. Do you receive and review follow-up periodic reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?

- ○ Yes
  - a. How often?
    - ○ Monthly
    - ○ Quarterly
    - ○ Annually
    - ○ Other
      Please explain.
  - b. If you receive reports, do you follow up with those providers who routinely override with interventions?
    - ○ Yes
      By what method do you follow up?
      - ○ Contact Pharmacy
      - ○ Refer to Program Integrity for Review
      - ○ Other
        Please explain.
    - ○ No
      Please explain.
- ◉ No
  Please explain.

Follow-up reports providing DUR alert override activity data have not been established at this time.

6. **Early Refill**

a. At what percent threshold do you set your system to edit?

i. Non-controlled drugs:

80 %

ii. Schedule II controlled drugs:

90 %

iii. Schedule III through V controlled drugs:

90 %

b. **For non-controlled drugs:**

When an early refill message occurs, does the state require prior authorization?

- (●) Yes
- ( ) No

If "Yes," who obtains authorization?

- ( ) Pharmacist
- ( ) Prescriber
- (●) Either

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

- ( ) Yes
- ( ) No

c. **For controlled drugs:**

When an early refill message occurs, does the state require prior authorization?

- (●) Yes
- ( ) No

If "Yes," who obtains authorization?

- ( ) Pharmacist
- ( ) Prescriber
- (●) Either

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

- ( ) Yes
- ( ) No

7. 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 (check all that apply):

- [ ] Lost/stolen Rx
- [ ] Vacation
- [x] Other

Please explain.

Pharmacist's are not currently allowed to override for these types of situations.

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

- ○ Yes
- ◉ No

If "Yes," please explain your edit.

If "No," do you plan to implement this edit?

- ○ Yes
- ◉ No

9. Does the state Medicaid agency or the state's Board of Pharmacy 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)?

- ○ Yes
- ◉ No

10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

- ○ Yes
- ◉ No

11. Please list the requested data in each category in Table 1 – Top Drug Claims Data Reviewed by the DUR Board below.

Table 1: Top Drug Claims Data Reviewed by the DUR Board

Column 1 **Top 10 Prior Authorization (PA) Requests by Drug Name**	Column 2 **Top 10 Prior Authorization (PA) Requests by Drug Class**	Column 3 **Top 5 Claim Denial Reasons Other Than Eligibility** (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)	Column 4 **Top 10 Drug Names by Amount Paid**	Column 5 **% of Total Spent for Drugs by Amount Paid** From data in Column 4, determine the % of total drug spend.	Column 6 **Top 10 Drug Names by Claim Count**	Column 7 **Drugs by Claim Count % of Total Claims** From data in Column 6, determine the % of total claims.
Hydrocodone/Acet	Analgesics-Opioid	Product or Service Not Covered	Advate	6 %	Hydrocodone/Acet	2 %
Oxycodone/Acetar	ADHD/Anti-narcolepsy/Anti-obesity/Anorexiant	Submit Bill to Other Processor	NovoSeven RT	3 %	Gabapentin	2 %
Oxycodone HCL	Hypnotics/Sedativ Disorder Agents	DUR Reject Error	Spinraza	2 %	Atorvastatin Calcium	2 %
Amphetamine/Dext Amphetamine	Ulcer Drugs/Antispasmo Anticholinergics	Filled After Coverage Term	Latuda	2 %	Proventil HFA	2 %
Vyvanse	Anti-asthmatic	Prior Authorization Required	Kogenate FS	2 %	Lisinopril	1 %
Zolpidem Tartrate	Dermatologicals		Epclusa	2 %	Alprazolam	1 %
Omeprazole	Antipsychotics/An Agents		Invega Sustenna	2 %	Levothryroxine Sodium	1 %
Methylphenidate HCL ER	Antidepressants		Proventil HFA	1 %	Oxycodone/Acetar	1 %
Morphine Sulfate ER	Anticonvulsants		Lyrica	1 %	Ibuprofen	1 %
Guanfacine ER	Gastrointestinal Agents - Misc.		Advair Diskus	1 %	Ondansetron HCL	1 %

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

- ☐ Medicaid agency
- ☒ State Board of Pharmacy
- ☐ Other

Please explain.

13. **Attachment 1 – Pharmacy Oral Counseling Compliance Report**
This attachment reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement. This attachment should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.

Does the state have Attachment 1 described above to upload?

- ◉ Yes
- ○ No

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Attachment 1: Pharmacy Oral Counseling Compliance Report

The State of Nevada Medicaid Program relies on the State Board of Pharmacy to audit pharmacist compliance with the oral counseling requirement. The Nevada State Board of Pharmacy includes adherence with counseling requirements as part of each annual pharmacy inspection. In addition, during any investigation of an incident or patient complaint, counseling records are checked by the inspector.

III. RETROSPECTIVE DUR (RetroDUR)

1. Identify, by name and type, the vendor that performed your RetroDUR activities during the time period covered by this report.

Organization Name

OptumRx

Organization Type

- (●) Company
- ( ) Academic Institution
- ( ) Other Institution

a. Is the RetroDUR vendor also the MMIS fiscal agent?

- ( ) Yes
- (●) No

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

- (●) Yes
- ( ) No

2. Who reviews and approves the RetroDUR criteria?

- ( ) State DUR board
- (●) Other

Please explain.

The DUR Board offers topics and reviews RetroDUR criteria but does not approve the letters and final initiatives. The contractor reviews and approves RetroDUR criteria.

3. **Attachment 2 – Retrospective DUR Educational Outreach Summary**
This is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary reports should be limited to the TOP 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included.

Does the state have Attachment 2 described above to upload?

- (●) Yes
- ( ) No

IV. DUR BOARD ACTIVITY

1. **Attachment 3 – Summary of DUR Board Activities**
This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
  a. For prospective DUR, list problem type/drug combinations added or deleted.
  b. For retrospective DUR, list therapeutic categories added or deleted.
- 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.
- 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).

Does the state have Attachment 3 described above to upload?

- (●) Yes
- ( ) No

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Attachment 2: Retrospective Educational Outreach Summary

The State of Nevada had three major Retrospective Education Outreach programs for the FFY 2018.

1. Members with admissions to emergency departments for uncontrolled asthma or COPD that were not receiving a long-term control medication we identified. Letters were mailed to primary care prescribers on file for the recipients. Current treatment guidelines were included for educational purposes. Fifteen letters were mailed, and zero responses were received.
2. Prescribers listed in the top ten count of claims for opioids were identified. Letters were mailed to these prescribers with information regarding their placement in the top 10. Ten letters were mailed and one response was received.
3. A search was completed looking for members receiving concurrent opioids and buprenorphine or buprenorphine/naloxone. Zero members were identified as receiving both an opioid and a buprenorphine product concomitantly.

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Attachment 3 – Summary of Drug Use Review Board Activities

The Nevada Medicaid Drug Use Review Board met four times in Federal Fiscal Year 2018. Every meeting included a discussion of the top opioid prescribers by claim count and the top members utilizing opioids. Other standard reports include the top ten therapeutic classes, prospective drug use review edits in the point of sale pharmacy system and retrospective drug use review initiatives.

October 18, 2018 DUR Board Meeting

The Board discussed several new medications for movement disorders including Austedo, Ingrezza, Xadago and Emflaza. The Board was fortunate to have input from a physician with experience treating children with neurological movement disorders. The Board also reviewed utilization for tramadol and codeine use in children under 18 years of age. Prior authorization criteria was added to restrict the use of codeine and tramadol to members 18 years of age or younger. Other prior authorization guidelines were discussed and updated according to current guidelines and recommendations.

DUR Board discussion:

- Anticonvulsant and psychotropic utilization in children and adolescents was presented to the board. The board agreed the previously implemented policy limiting children under 18 to one psychotropic from each class (antidepressant, antianxiety, antipsychotic and anticonvulsant) is effectively controlling the polypharmacy in children.
- A policy that requires maintenance medications be filled for 90 days at a time was implemented a month prior to this DUR meeting. The Board was briefed on current utilization and expected trends.
- The board discussed opioid utilization specifically looking at the top ten prescribers by claim count and the top members by claim count.

January 25, 2018 DUR Board Meeting

Discussion at this board meeting included adding and updating prior authorization criteria for Austedo, Bevyxxa and Benlysta. The board requested a simplified hepatitis C direct-acting antiviral criteria presented from the managed care organizations. The board was presented with options but decided to not take action until the following meeting.

DUR Board discussion:

- Drugs designated with an orphan disease status were discussed at length. The Board requested simplified criteria presented at a future meeting to address options to reduce off-label use of these medications.
- Opioid utilization in members under 18 was reviewed as well as the top opioid prescribers and members.

April 26, 2018 DUR Board Meeting

The Board's actions during this meeting included removing prior authorization criteria for Makena, updating GnRH analog criteria to include gender dysphoria treatment in youth and approval of a high-dollar prior authorization criteria on claims exceeding $10,000. The high-dollar claim criteria is intended to address the potential inappropriate utilization of medications indicated for the treatment of orphan diseases and the increase of FDA Fast Tracked drugs. Hepatitis C direct-acting antiviral criteria was presented to the Board again, but differences with managed care organization criteria and the Board's wishes left the topic without any action taken.

DUR Board Discussion:

- Acetaminophen utilization was presented and discussed. A policy of no more than 2,800 mg per day of acetaminophen was implemented several years prior. Utilization reports demonstrate this policy is still effective.
- Hospital admissions for members with a diagnosis of diabetes were reviewed. Due to the challenging nature of matching medical claims and pharmacy claims, it was difficult to draw any solid conclusions.
- Opioid utilization (specifically looking at members receiving more than four different opioids) was discussed in addition to the top prescribers and top members by claim count.

July 26, 2018 DUR Board Meeting

Antibiotic resistance patterns for Nevada were presented to the Board by a local pediatrician with expertise in antimicrobial stewardship. The presentation prompted the Board to adopt prior authorization criteria for fluoroquinolones, third-generation cephalosporins and oxazolidinones. Exceptions where allowed for emergency room physicians and physicians specializing in infectious disease. Hemophilia prior authorization criteria was also adopted to assure providers are appropriately following member's utilization. The Board voted to add prior authorization requirements for all compounded medications that exceed $200 per fill.

DUR Board Discussion:

- The Pharmacy Lock-In Program was discussed with current utilization and savings presented. Program comparisons between FFS and each MCO were discussed. The main differences found being the MCO's allow for a recipient to be removed from the Lock-In Program while FFS recipients remain in the program indefinitely and that the MCO's do not have access to the PDMP.
- A report from the State Medical Examiner's Office showing opioid overdose deaths was discussed. The Board was interested if an increase in illicit drug use and/or change in overdose deaths noted after the implementation of the opioid quantity limits implemented earlier in the year.
- Members with a diagnosis of asthma were reviewed for short-acting rescue inhaler use. The discussion prompted a request for prior authorization criteria to be presented at the next meeting for short-acting rescue inhalers.

2. Does your state have an approved CMS Medication Therapy Management Program?

- ○ Yes
- ◉ No

If the answer to question 2 is "Yes," please continue.

a. Have you performed an analysis of the program's effectiveness?

- ○ Yes

Please provide a brief summary of your findings.

- ○ No

b. Is your DUR Board involved with this program?

- ○ Yes
- ○ No

If the answer to question 2 is "No," are you planning to develop and implement a program?

- ◉ Yes
- ○ No

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MIMIS been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

   ○ Yes
   ◉ No

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

   ◉ Yes
   ○ No

2. RetroDUR?

   ◉ Yes
   ○ No

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

   ○ Yes
   ○ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. **Attachment 4 – Generic Drug Substitution Policies**
   Please report any factors that could affect your generic utilization percentage and include any relevant documentation.

   Does the state have Attachment 4 described above to upload?

   - (●) Yes
   - ( ) No

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?

   - (●) Yes
   - ( ) No

   If "Yes," check all that apply.

   - [ ] Require that a MedWatch Form be submitted
   - [x] Require the medical reason(s) for override accompany the prescription
   - [x] Prior authorization is required
   - [ ] Other
     Please explain.

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Attachment 4: Generic Drug Substitution Policies

The Nevada Statute NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand name; and d) is of the same generic type as the drug prescribed by brand name.

If the pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are available to him or her for substitution.

Before a pharmacist dispenses a drug in substitution for a drug prescribed by brand name, the pharmacist shall: a) advise the person who presents the prescription that the pharmacist intends to dispense a drug in substitution; and b) advise the person that he or she may refuse to accept the drug that the pharmacist intends to dispense in substitution, unless the pharmacist is being paid for the drug by a governmental agency.

If a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense the drug in substitution.

Complete Table 2 – Generic Drug Utilization Data and answer Questions 3 and 4 below.

Computation Instructions

KEY

> **Single Source (S)** – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.
>
> **Non-Innovator Multiple-Source (N)** – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market
>
> **Innovator Multiple-Source (I)** – Drugs which have an NDA and no longer have patent exclusivity.

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

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

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

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

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found at Medicaid.gov (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr 2018 Excel file).

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	213,078	1,610,435	142,618
Total Reimbursement Amount Less Co-Pay	243,970,702	34,677,025	24,805,848

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 – Generic Utilization Data.

Number of Generic Claims: 1,610,435

Total Number of Claims: 1,966,131

Generic Utilization Percentage: 81.91 %

4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 2 - Generic Drug Utilization Data.

Generic Dollars: $ 34,677,025

Total Dollars: $ 303,453,575

Generic Expenditure Percentage: 11.43 %

VII. PROGRAM EVALUATION / COST SAVINGS / COST AVOIDANCE

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

   - (●) Yes
   - ( ) No

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

   Institution Name

   OptumRx

   Institution Type

   - (●) Company
   - ( ) Academic Institution
   - ( ) Other Institution

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

	Data
ProDUR Total Estimated Avoided Costs	251,659,248
RetroDUR Total Estimated Avoided Costs	6,199.69
Other Cost Avoidance	243,189.08
Grand Total Estimated Avoided Costs	251,908,636.77

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 4, then multiplying this value by 100.

   Estimated Percent Impact: 83.01 %

4. **Attachment 5 – Cost Savings/Cost Avoidance Methodology**
Include copy of program evaluations/cost savings estimates prepared by state or contractor noting methodology used.

Does the state have Attachment 5 described above to upload?

- (●) Yes
- ( ) No

VIII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

- (●) Yes
- ( ) No

If "Yes," what actions does this process initiate? Check all that apply:

- [ ] Deny claims and require prior authorization
- [x] Refer to Lock-In Program
- [x] Refer to Program Integrity Unit
- [x] Other (i.e. SURS, Office of Inspector General)
Please explain.

The recipient information is provided to SURS for investigation.

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Attachment 5: Cost Savings/Cost Avoidance Methodology

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.

Summary by types of ProDUR edits:

ProDUR Edit	Sum of Total DUR Savings	
Drug Regimen Compliance	$	8,032,009.36
Drug-Drug Interaction Screening	$	61,702,548.31
Dosing/Duration Screening	$	41,639,153.08
Drug-Age Caution Screening	$	3,964.59
Drug-Sex Caution Screening	$	594.39
Duplicate Rx Screening	$	48,769,622.09
Duplicate Therapy Screening	$	77,496,658.65
Refill Too Soon	$	14,014,698.02
Grand Total	**$**	**251,659,248.49**

Description of Services:

Drug Regimen Compliance – Checks to make sure the patient is not underutilizing a drug. Prescription history is checked to determine if the member received the drug previously and if the member is receiving the new refill within a certain number of days since it was last filled.

Drug-Drug Interaction Screening – Checks the member's prescription history for interactions between two or more drugs.

Dosing/Duration Screening – Compares the dosage on the claim to the recommended dosage for the member's age group.

Drug-Age Caution Screening – Identifies contraindications for specified age groups.

Drug-Sex Caution Screening – Identified contraindications based on gender.

Duplicate Rx Screening – Checks for the exact same medication for a duplicate prescription.

Duplicate Therapy Screening – Checks for therapeutic usage duplications.

Refill Too Soon – Checks member's prescription history for a previously filled prescription for the same medication.

OptumRx calculates RetroDUR activities lead to a cost avoidance of $6,199.69 for FFY2018. Cost avoidance is a result of letters sent to the top 10 prescribers of opioids in Nevada. The quarter before the letters (7/1/18 – 9/30/18) and the quarter after (10/1/18 – 12/31/18) were compared. A reduction in pharmacy paid amount was observed from $218,450.54 to $212,250.85 leaving a cost avoidance of $6,199.69.

Initiatives to control the quantity of opioids dispensed resulted in a cost avoidance of $243,189.08. The pharmacy paid amount for the first quarter of FFY2018 (10/1/17 – 12/31/17) compared to the last (7/1/18 – 9/30/18) revealed the savings. The first quarter paid amount was $1,666,841.95 whereas the last was $1,423,652.87. Trend lines indicate this pattern will continue.

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

- (●) Yes
- ( ) No

If the answer to question 2 is "Yes," please continue.

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

- [x] Number of controlled substances (CS)
- [x] Different prescribers of CS
- [x] Multiple pharmacies
- [ ] Number days' supply of CS
- [ ] Exclusivity of short acting opioids
- [ ] Multiple ER visits
- [x] PDMP data
- [x] Other

Please explain.

Diagnosis related to substance abuse.

b. Do you have the capability to restrict the beneficiary to:

i) prescriber only

- (●) Yes
- ( ) No

ii) pharmacy only

- (●) Yes
- ( ) No

iii) prescriber and pharmacy only

- (●) Yes
- ( ) No

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

- ( ) 12 months
- ( ) 18 months
- ( ) 24 months
- (●) Other

Please explain.

There is no Lock-In time period. A recipient is locked-in indefinitely.

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

0.44 %

e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.

$ 1,307,604

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?

   ○ Yes
   ◉ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☐ Deny claims written by this prescriber
   ☐ Refer to Program Integrity Unit
   ☐ Refer to the appropriate Medical Board
   ☐ Other
   Please explain.

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?

   ○ Yes
   ◉ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☐ Deny claim
   ☐ Refer to Program Integrity Unit
   ☐ Refer to Board of Pharmacy
   ☐ Other
   Please explain.

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?

○ Yes

Please explain your program for fraud, waste, or abuse of non-controlled substances.

◉ No

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

◉ Yes

○ No

If the answer to question 1 is "Yes," please continue with a, b, and c.

a. Does your agency have the ability to query the state's PDMP database?

◉ Yes

○ No

If the answer to sub-question 1 a is "Yes," please continue.

i) Please explain how the state applies this information to control fraud and abuse.

A query may be used during a Lock-In evaluation of a recipient. It may also be used for evaluation of suspicious recipient activity.

ii) Do you also have access to border states' PDMP information?

◉ Yes

○ No

iii) Do you also have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?

- ○ Yes
- ◉ No

b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?

- ○ Yes
- ◉ No

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

- ◉ 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).

  Only one State staff is allowed access to the PDMP. Contractors (including PBM and MCO's) are not allowed access to the PDMP. By not allowing access to the MCO's, there is inconsistencies with Lock-In Program evaluation between FFS and the MCO's.

- ○ No

2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?

- ◉ Yes

  Please explain.

  In 2018, users were provided access to an advanced analytics and patient support tool called NarxCare. This enhancement provides aggregated and analyzed prescription information to providers and pharmacies. The analysis includes Narx Scores and Overdose Risks Scores.

- ○ No

C. PAIN MANAGEMENT CONTROLS

1. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

   ○ Yes

   ◉ No

   If the answer to question 1 is "Yes," please continue.

   a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

      ○ Yes

      ○ No

      If "Yes," please explain how information is applied.

      If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

      ○ Yes

      ○ No

   b. Do you apply this DEA file to your RetroDUR reviews?

      ○ Yes
      Please explain how it is applied.

      ○ No

2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

- ○ Yes
- ◉ No

Please explain why you do not have measures in place to either manage or monitor the prescribing of methadone for pain management.

Methadone is currently non-preferred on the FFS PDL. OptumRx is reviewing ways to support improved utilization.

D. OPIOIDS

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

- ◉ Yes, for all opioids
- ○ Yes, for some opioids
- ○ No, for all opioids

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

a. Is there more than one quantity limit for the various opioids?

- ○ Yes

Please explain.

- ◉ No

b. What is your maximum number of days allowed for an initial opioid prescription?

7 days

c. Does this day limit apply to all opioid prescriptions?

- (●) Yes
- ( ) No

Please explain.

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

- (●) Yes
- ( ) No

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

- ( ) 30 day supply
- ( ) 90 day supply
- (●) Other

Please explain.

Recipients are allowed to 13 seven-day supplies within a rolling twelve months without a prior authorization.

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?

- (●) Yes
- ( ) No

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

- ( ) 30 day supply
- ( ) 90 day supply
- (●) Other

Please explain.

Long-acting opioids have the same limit as short-acting opioids; Recipients are allowed to 13 seven-day supplies within a rolling twelve months without a prior authorization. If a recipient has an approved prior authorization on file, the maximum is 34 days supply per fill.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

- ◉ Yes
- ○ No

If "Yes," check all that apply:

- ☐ Pharmacist override
- ☐ Deny claim and require PA
- ☒ Intervention letters
- ☒ Morphine equivalent daily dose (MEDD) program
- ☐ Step therapy or clinical criteria
- ☒ Requirement that patient has a pain management contract or Patient-Provider agreement
- ☐ Requirement that prescriber has an opioid treatment plan for patients
- ☐ Require documentation of urine drug screening results
- ☒ Other

Please explain what additional opioid prescribing controls are in place.

If the recipient has chronic pain or requires extended opioid therapy and is under the supervision of a licensed prescriber, the pain cannot be controlled through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants, anti-seizure medications, physical therapy, etc.); the lowest effective dose is being requested and a pain contract is on file.

If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

- ○ Yes
  Please explain.
- ◉ No

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD), or opioid poisoning diagnosis?

- ○ Yes
- ◉ No

If "Yes," please indicate how often.

- ○ Monthly
- ○ Quarterly
- ○ Semi-Annually
- ○ Annually
- ○ Other
  Please explain.

If "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD, or opioid poisoning in the future?

- ◉ Yes
- ○ No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

- (●) Yes
- ( ) No

For either "Yes" or "No," please check all that apply:

- [x] Your state Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain.

  Please identify the "referred" guidelines.

  The Medicaid Services Manual (MSM) Chapter 1200, Prescribed Drugs, refers prescribers to the CDC Guideline for Prescribing Opioids for Chronic Pain link at http://www.cdc.gov/drugoverdose/prescribing/guideline.html, directly following the prior authorization guidelines for opioids.

- [ ] Other guidelines.

  Please identify the "other" guidelines.

- [ ] No guidelines are offered.

8. Do you 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)?

- (●) Yes

  Please explain.

  There are several abuse deterrent opioids that are available as preferred products on the preferred drug list. However, the same quantity limits apply as other opioids.

- ( ) No

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

- (●) Yes
- ( ) No

If "Yes," please continue.

a. What is your maximum morphine equivalent daily dose limit in milligrams?

60 mg per day

b. Please explain (i.e. are you in the process of tapering patients to achieve this limit?).

Initial fills are limited to 60 mg morphine equivalent daily dose.

If "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

   ○ Yes
   ◉ No

   If "Yes," please continue.

   a. Please name the developer of the calculator:

   b. How is the information disseminated? Check all that apply:

      ☐ Website
      ☐ Provider notice
      ☐ Educational seminar
      ☐ Other
      Please explain.

3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

   ◉ Yes
   ○ No

   If "Yes," do you require prior authorization if the MEDD limit is exceeded?

   ◉ Yes
   ○ No

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

- (●) Yes
- ( ) No

If "Yes," please specify the total mg/day:

- ( ) 12 mg
- ( ) 16 mg
- (●) 24 mg
- ( ) Other
  Please explain.

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

- ( ) 6 months
- ( ) 12 months
- (●) No limit
- ( ) Other
  Please explain.

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

- ○ Yes
- ◉ No

If "Yes," please continue.

a. What is your reduced (maintenance) dosage?

- ○ 8 mg
- ○ 12 mg
- ○ 16 mg
- ○ Other
  Please explain.

b. What are your limitations on the allowable length of the reduced dosage treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other
  Please explain.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

   - (●) Yes
   - ( ) No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

   - ( ) Yes
   - (●) No
   - ( ) Other

   Please explain.

   If "Yes," can the POS pharmacist override the edit?

   - ( ) Yes
   - ( ) No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

   - (●) Yes
   - ( ) No

7. Does your state board of pharmacy and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

   - (●) Yes
   - ( ) No

8. Does your state agency cover Methadone for a substance use disorder (i.e. Methadone Treatment Center)?

   - (●) Yes
   - ( ) No

G. ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics? Enter restrictions other than quantity limits in the text box below, or N/A.

   - (●) Yes
   - ( ) No

   Please explain.

   Recipients under 18 years old are limited to a single anti-psychotic without prior authorization.

2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

   - (●) Yes
   - ( ) No

   If "Yes," please continue.

   a. Do you either manage or monitor:

      - ( ) Only children in foster care
      - (●) All children
      - ( ) Other

        Please explain.

b. Do you have edits in place to monitor (check all that apply):

- [x] Child's Age
- [ ] Dosage
- [x] Polypharmacy
- [ ] Other

Please explain.

c. Please briefly explain the specifics of your antipsychotic monitoring program(s).

Children age 7 to 17 years old are allowed one drug from each class (antidepressant, anti-anxiety, anti-psychotic, anti-convulsant) without a prior authorization for up to three medications total.
The fourth medication would require a prior authorization.

If "No," do you plan on implementing a program in the future?

- ○ Yes
- ○ No

Please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?

- ◉ Yes
- ○ No

4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

- (●) Yes
- ( ) No

If "Yes," please continue.

a. Do you either manage or monitor:

- ( ) Only children in foster care
- (●) All children
- ( ) Other
  Please explain.

b. Do you have edits in place to monitor (check all that apply):

- [x] Child's Age
- [ ] Dosage
- [x] Polypharmacy

c. Please briefly explain the specifics of your documented stimulant monitoring program(s).

Prior authorization criteria for both children and adults are established and monitored by the DUR Board. The criteria applies to all stimulants. Only one long-acting stimulant (amphetamine and methylphenidate products) may be used at a time, a 30-day transitional overlap in therapy will be allowed and a diagnosis of ADD/ADHD or other FDA approved diagnosis is required. If

If "No," do you plan on implementing a program in the future?

- ( ) Yes
- ( ) No

Please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

IX. INNOVATIVE PRACTICES

1. **Attachment 6 – Innovative Practices Narrative**

   Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing)? Please describe in detailed narrative form 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 prior authorizations, continuing education programs).

   Does the state have Attachment 6 described above to upload?

   - (●) Yes
   - ( ) No

X. E-PRESCRIBING

1. Does your MMIS or pharmacy vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

   - (●) Yes
   - ( ) No

   If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

   - ( ) Yes

     Please explain the evaluation methodology in **Attachment 7 – E-Prescribing Activity Summary**. Describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

   - (●) No

   If "No," are you planning to develop this capability?

   - ( ) Yes
   - ( ) No

FFY 2018
Nevada Medicaid (FFS)

Attachment 6: Innovative Practices

The Nevada Medicaid Drug Use Review (DUR) Board continually evolves in order to meet the needs of the recipients and providers. We believe the following innovative practices have improved the administration of the Nevada Medicaid DUR Program.

Antibiotic resistance in Nevada was identified as an increasing area of concern. Many health care facilities maintain antibiotic stewardship programs. These programs are typically not carried forward when a patient is treated in the outpatient setting. An infectious disease specialist presented alarming antibiotic resistance patterns within Nevada. Based on this report, the Board has taken the action to add prior authorization requirements for third-generation cephalosporins, fluoroquinolones and oxazolidinones. Education for the provider community is critical to make these restrictions effective. The DHCFP website was updated to include the presentation information and provided other resources such as a policy newsletter and links to CDC guidelines. The approved prior authorization criteria will be implemented in FFY2019. Workshops and webinars will also be available to providers prior to implementation.

Medications to treat rare diseases or conditions are being approved at a rapid rate by the FDA. While these medications offer treatment options to a population with previously limited options, Nevada Medicaid struggled to make these medications available to the appropriate population. The Board voted to approve generic prior authorization criteria for claims that exceed $10,000 to capture these novel medications. Criteria includes meeting FDA approved indications and age limitations. This simplified criteria may take the place of individual criteria for other new medications approved for the treatment of rare diseases and conditions. These criteria will be implemented in FFY2019.

Opioid overuse and abuse has long been a focus of the DUR Board. Quantity limits including a max of 7-day supply, 60 mg morphine equivalents per day and a limit of 13 fills per rolling 12 months was implemented in FFY2017. The Board was concerned that illicit drug use obtained without a prescription would increase. The State collaborated with the State Medical Examiner's office to obtain the number of deaths associated with opioid overdoses for the period before and after the quantity limit was implemented. The report did not demonstrate a significant change between the two periods.

Medication assisted treatment for opioids is another area of focus. The State has updated educational material available on the web including an informational bulletin and lists of medications and services available to treat substance abuse disorder. The Board will continue to address initiatives to provide access to treatment of opioid abuse disorder in FFY2019.

Nevada Medicaid has three managed care organizations providing care to the State's residents. Incorporating their data for presentation to the DUR Board has been challenging and continues to evolve. Reporting has been standardized to ease report production and presentation during the

quarterly meetings. The Board can now compare utilization and trends across different programs.

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

- (●) Yes
- ( ) No

XI. MANAGED CARE ORGANIATIONS (MCOs)

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

3

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

- ( ) Yes
- (●) No
- ( ) Partial

Please specify the drug categories that are carved out.

3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)?

   ○ Yes
   ◉ No

   If "Yes," please continue.

   a. Please check all requirements that apply below:

      ☐ Formulary Reviews
      ☐ Same PDL
      ☐ Same ProDUR
      ☐ Same RetroDUR

   b. Please briefly explain your policy.

   If "No," do you plan to set standards in the future?

      ◉ Yes
      ○ No

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

   ◉ Yes
   ○ No
   Please explain why.

XII. EXECUTIVE SUMMARY

1. **Attachment 8 – Executive Summary**

FFY 2018
Nevada Medicaid (FFS)

Attachment 8: Executive Summary

The Drug Use Review Board (DUR) is a requirement of the Social Security Act, Section 1927 and operates in accordance with Nevada Medicaid Services Manual, Chapter 1200 – Prescribed Drugs and Nevada Medicaid Operations Manual Chapter 200. The mission of the Nevada DUR Board is to work with the agency to improve medication utilization in patients covered by Medicaid. The primary goal of drug utilization review is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use.

The DUR Board consists of no less than five members and no more than ten members appointed by the State Director of Health and Human Resources. Members must be licensed to practice in the State of Nevada and either an actively practicing physician or an actively practicing pharmacist.

During the Federal Fiscal Year 2018, the DUR Board was comprised of four physicians (one pain specialist, one psychiatrist, one neurologist and one family practice physician) and four pharmacists (two hospital pharmacists and two ambulatory care pharmacists) from various backgrounds and locations around the State of Nevada.

Other non-voting members who contribute to Board discussions include DHCFP staff members, a Deputy Attorney General and representatives from the contractors for MMIS and PBM services. The three managed care organizations attend, and each have non-voting representation on the Board.

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).

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.

Opioids and treating opioid addiction were areas of focus in 2018. Monitoring opioid use and looking at ways to curb over-utilization are top priorities for the DUR Board. The Board continues to address methods for limiting quantities and providing access to addiction treatment.

Board members are actively engaged in prescription drug take-back programs in Nevada. Resource material for Drug Take-Back days and locations are available on the State's DHCFP – Pharmacy Services website in addition to the information disseminated by the Board Members.

An Antibiotic Stewardship program discussion started in FFY2018 as a result of alarming resistance patterns identified. Education including an antibiotic newsletter were added to the State's DHCFP website. Follow-up on criteria added to control antibiotic prescribing will continue in future meetings.

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.

Annual DUR Survey

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities. 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.

This report covers the period October 1, 2017 to September 30, 2018. **Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory and regulatory requirements.**

If you have any questions regarding the DUR Annual Report, please contact your state's Medicaid Pharmacy Program.

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

I. DEMOGRAPHIC INFORMATION

MCO Name: Anthem

Medicaid MCO Information

Identify your MCO person responsible for DUR Annual Report Preparation.

First Name: Lisa

Last Name: Todd

Email Address: Lisa.Todd@Amerigroup.com

Area Code/Phone Number: 913-707-2451

1. On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

183,000 beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify it by name.

- ○ State-operated
- ○ Contractor, please identify by name.
- ◉ Other organization, please identify by name.

Express Scripts, Inc.

2. Identify prospective DUR criteria source.

- [x] First Data Bank
- [ ] Medi-Span
- [ ] Other, please specify.

3. Who reviews your new prospective-DUR criteria?

- [ ] MCO's DUR Board
- [ ] FFS agency DUR Board
- [x] Other, please explain.

Our DUR Board functions are handled by three committees which include Pharmacy Quality Programs(PQP), P&T, and Value Assessment (VAC) committees. PQP provides feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. P&T Committee reviews and approves policies so they are optionally available for each business unit to use (or not) according to their business needs. VAC decides to adopt a PA, and makes drug lis

4. Are new ProDUR criteria approved by the DUR Board?

- ○ Yes
- ◉ No, please explain.

Our DUR Board functions are handled by three committees which include Pharmacy Quality Programs(PQP), P&T, and Value Assessment (VAC) committees. PQP provides feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. P&T Committee reviews and approves policies so they are optionally available for each business unit to use (or not) according to their business needs. VAC decides to adopt a PA, and makes

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

- (●) Yes
- ( ) No
- ( ) Partial, please explain.

6. Do you receive and review follow-up periodic reports providing individual pharmacy provider override activity in summary and/or in detail?

   ○ Yes

   ◉ No, please explain.

   We receive a monthly denied claims report designated by denial reasons. Pro-DUR denial reasons are included.

If the answer to question 6 is "No," skip to question 7.

If the answer to question 6 is "Yes," please continue below.

a) How often do you receive reports?

   ○ Monthly

   ○ Quarterly

   ○ Annually

   ○ Other, please explain.

b) Do you follow up with those providers who routinely override with interventions?

- ○ Yes
- ○ No, please explain.

If the answer to question 6b is "No," skip to question 7.

If the answer to question 6b is "Yes," please continue below.

By what method do you follow up?

- ○ Contact Pharmacy
- ○ Refer to Program Integrity for Review
- ○ Other, please explain.

7. **Early Refill**

a) At what percent threshold do you set your system to edit?

Non-controlled drugs:

90.00 %

Schedule II controlled drugs:

90.00 %

Schedule III through V controlled drugs:

90.00 %

b) **For non-controlled drugs**

When an early refill message occurs, does your MCO require prior authorization?

- (●) Yes
- ( ) No

If the answer to question 7b is "Yes," who obtains authorization?

- ( ) Pharmacist
- ( ) Prescriber
- (●) Either

If the answer to question 7b is "No," can the pharmacist override at the point of service?

- ( ) Yes
- ( ) No

c) **For controlled drugs**

When an early refill message occurs, does your MCO require prior authorization?

- (●) Yes
- ( ) No

If the answer to question 7c is "Yes," who obtains authorization?

- ( ) Pharmacist
- (●) Prescriber
- ( ) Either

If the answer to question 7c is "No," can the pharmacist override at the point of service?

- ( ) Yes
- ( ) No

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

- [X] Lost/stolen Rx
- [X] Vacation
- [ ] Other, please explain.

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

- (●) Yes
- ( ) No

If "Yes," please explain your edits.

The refill thresholds are the following product
Retail Refill Too Soon: 90%
Mail Order Refill Too Soon: 75%
Paper Claim Refill Too Soon: 90%
Specialty Refill Too Soon: 75%
Ophthalmic Refill Too Soon: 70%

If "No," do you plan to implement this edit?

- ( ) Yes
- ( ) No

10. Does the MCO 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)?

- ( ) Yes
- (●) No

11. Does your MCO have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled chronic medication refills at the same time, your MCO would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

- (●) Yes
- ( ) No

12. For drugs not on your MCO's formulary, does your MCO have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

- (●) Yes
- ( ) No

If "Yes," what is the preauthorization process?

The claim denies at point of sale. Provider may request a PA to consider coverage based on medical necessity. The provider may need to submit clinical documentation to support the PA request. The PA reviewer uses the medical necessity criteria to evaluate the PA request.

If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

13. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

Table 1: Top Drug Claims Data Reviewed by the DUR Board

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name	**Column 2** Top 10 Prior Authorization (PA) Requests by Drug Class	**Column 3** Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)	**Column 4** Top 10 Drug Names by Amount Paid	**Column 5** % of Total Spent for Drugs by Amount Paid From data in Column 4, determine the % of total drug spend.	**Column 6** Top 10 Drug Names by Claim Count	**Column 7** Drugs by Claim Count % of Total Claims From data in Column 6, determine the % of total claims.
Hydrocodone/Acetaminophen	Opioid Combinations	Refill Too Soon	GENVOYA	3.64 %	VENTOLIN HFA	2.51 %
Buprenorphine Hydrochlori	Buprenorphine Hydrochlori Opioid Partial	DUR Reject Error	BASAGLAR KWIKPEN U-100	2.61 %	LORATADINE	1.31 %
Tramadol HCL	Opioid Agonists	Plan Limits Exceeded	ZEPATIER	2.04 %	IBUPROFEN	1.14 %
Hydrocodone/Acetaminophen	Opioid Combinations	Product Not on Formulary	VENTOLIN HFA	1.99 %	ALBUTEROL SULFATE	1.04 %
Oxycodone/Acetaminophen	Opioid Combinations	Days Supply Exceeds Plan Limitation	HUMIRA PEN	1.99 %	GABAPENTIN	1.01 %
Hydrocodone/Acetaminophen	Opioid Combinations		APIDRA SOLOSTAR	1.83 %	AMOXICILLIN	0.99 %
Morphine Sulfate ER	Opioid Agonists		TRIUMEQ	1.72 %	HYDROCODONE-ACETAMINOPHEN	0.95 %
Voltaren	Anti-Inflammatory Agents – TOP		TRUVADA	1.58 %	TRUE METRIX GLUCOSE TEST STRIPS	0.93 %
Assure Pro Test Strips	Diagnostic Tests		TIVICAY	1.48 %	IBUPROFEN	0.93 %
Assure Pro Test Strips	Assure Pro Test Strips Opioid		DESCOVY	1.18 %	ONDANSETRON ODT	0.89 %

III. RETROSPECTIVE DUR (RetroDUR)

1. Does your MCO utilize the same DUR Board as the state Fee-For-Service (FFS) agency or does your MCO have its own DUR Board?

   ○ Same DUR Board as FFS agency

   ○ MCO has its own DUR Board

   ◉ Other, please explain.

   Our DUR Board functions are handled by three committees which include Pharmacy Quality Programs(PQP), P&T, and Value Assessment (VAC) committees. PQP provides feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. P&T Committee reviews and approves policies so they are optionally available for each business unit to use (or not) according to their business needs. VAC decides to adopt a PA, and makes drug lis

2. Identify the entity, by name and type, that performed your RetroDUR activities during the time period covered by this report (company, academic institution, other organization, or indicate if your MCO executed its own RetroDUR activities).

   Anthem executed our own RetroDUR activities.

3. Who reviews and approves the RetroDUR criteria?

   ○ State DUR Board

   ○ MCO DUR Board

   ◉ Other, please explain.

   Our DUR Board functions are handled by three committees which include Pharmacy Quality Programs(PQP), P&T, and Value Assessment (VAC) committees. PQP provides feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. P&T Committee reviews and approves policies so they are optionally available for each business unit to use (or not) according to their business needs. VAC decides to adopt a PA, and makes drug lis

4. Has your MCO included **Attachment 1 – Retrospective DUR Educational Outreach Summary**, a year end summary of the Top 10 problem types for which educational interventions were taken?

   ◉ Yes

   ○ No

   See attachment naming instructions.

IV. DUR BOARD ACTIVITY

1. Has your MCO included a brief summary of DUR Board activities during the time period covered by this report as **Attachment 2 - Summary of DUR Board Activities**?

   ◉ Yes

   ○ No

Attachment 2 – Summary of DUR Board Activities

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
  a) For prospective DUR, list problem type/drug combinations added or deleted.
  b) For retrospective DUR, list therapeutic categories added or deleted.
- 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.
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

See attachment naming instructions.

ATT1-2018-NV-Anthem-REOS

State	Nevada	Anthem							
Date Range	October 1, 2017 - September 30, 2018								
Number	Top 10 Criteria based on # of Cases	Criteria Type	Criteria Description	Number of Members Identified	Members Eligible at end of Outcomes Period	Number of Prescriber Messages Generated & Sent	Number of Member Messages Generated & Sent	Positive Outcomes	Percent Positive Impact
1	2688	Adherence	Adherence - ACE/ARB	2910	1630	805	2534	570	34.97%
2	2429	Depression	Depression - New Start	2403	1272	0	2429	381	29.95%
3	1992	Adherence	Adherence - Statins	2305	1275	365	1935	419	32.86%
4	2076	Adherence	Adherence - Oral Diabetes	2264	1301	427	1992	384	29.52%
5	1622	Adherence	Adherence - Asthma Controller Adherence 75% MPR	1208	467	1638	0	82	17.56%
6	730	Adherence	Adherence - CCB	925	457	92	760	166	36.32%
7	908	Polypharmacy	Polypharmacy	908	186	8442	0	56	30.11%
8	444	Adherence	Adherence - Thiazides and Combos	551	273	38	458	86	31.50%
9	331	PPI Length of Therapy	PPI Length of Therapy - PPI Length of Therapy	331	168	331	0	64	38.10%
10	226	Adding Therapy	Adding Therapy - DM No Statin	252	75	243	0	15	20.00%

ATT2-2018-NV- Anthem-SDBA

RDUR programs are presented and approved by the Pharmacy Quality Programs Committee. One purpose of the committee is to provide feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request.

The committee is comprised of Medical Directors and Clinical pharmacy services representatives

The committee met on these dates during the timeframe of Oct 1 2017 to Sept 30, 2018

10/18/2017
12/20/2017
01/17/2018
6/20/2018
7/28/2018
8/15/2018
9/19/2018

RDUR interventions target members and providers, the outreach is done either by fax, letter or phone calls.

10/18/2017
PQP committee approved:
Polypharmacy and Multiple Prescribers and Multiple Psychotropic (expansion of current program).
Intervention: Provider fax and follow up call if necessary.
Goal: To improve the members quality of care through more clinically appropriate prescribing.
12/20/ 2017

PQP committee approved:
Sickle Cell: Hydroxyurea and Gap in Car. Increase the adherence to hydroxyurea in Sickle Cell patients and to recommend the addition of Hydroxyurea for members with a sickle cell diagnosis and no evidence of
Intervention: Provider adding therapy fax and member/provider adherence letter fax
Goal: To improve the adherence of hydroxyurea medication and to recommend to providers adding Hydroxyurea for members with a sickle cell diagnosis
Dementia: Improve member's quality of care through appropriate prescribing
Intervention: Educational Fax to providers
Goal: Improve member's quality of care through more clinically appropriate prescribing, intervene with prescribers to coordinate care.
1/17/2018 –

PQP approved programs:
Transplant medication: Increase adherence – Approve but has not started.
Intervention: Member and provider messaging via letter or fax
Goal: to increase the adherence to transplant medication
Expansion of Controlled Substances Utilization Management Program; approved started after reporting year
Interventions: Educational Member and Provider Messaging via fax or letter
Goal: Addition of various alerts to help providers in managing members controlled substance utilization

6/20/2018

PQP approved programs to move forward

Approval of member messages various CSUM alerts.

Intervention – Member messages via mail.

7/18/18

PQP approved programs to move forward

Intervention: Provider outreach

Goal: To ensure the appropriate use of antiretroviral medications for members without a diagnosis on file.

8/15/2018

PQP approved programs to move forward:

1st line treatment for COPD

Goal: identify and outreach to providers regarding members who are inappropriately utilizing ICS/LABA as 1st line therapy and improve management of patients with COPD.

9/15/2019

PQP approved the following with proposed messaging to be changed for each program

Reduce Long term use of Benzodiazepines:

Goal: Encourage providers to consider the risks associated with long term Benzodiazepine use and reduce duration of therapy.

Intervention – Message to providers

Inappropriate Use of Long-Acting Muscarinic Antagonists (LAMA) in Asthma

Goal: Encourage prescribing providers to consider asthma clinical guidelines recommendation and improve the management of patients with asthma.

Interventions:: Message to providers

2. Does your MCO have a Medication Therapy Management Program?

- ○ Yes
- ◉ No

If the answer to question 2 is "Yes," please continue with questions a) and b) below.

a) Have you performed an analysis of the program's effectiveness?

- ○ Yes, please provide a brief summary of your findings.

- ○ No

b) Is your DUR Board involved with this program?

- ○ Yes
- ○ No

If the answer to question 2 is "No," are you planning to develop and implement a program?

- ○ Yes
- ◉ No

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

   ○ Yes

   ◉ No

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

   ○ Yes
   ◉ No

2. RetroDUR?

   ○ Yes

   ◉ No

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

   ○ Yes
   ◉ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. Has your MCO included a brief description of policies that may impact generic utilization percentage as **Attachment 3 – Generic Drug Substitution Policies**?

   ◉ Yes

   ○ No

   See attachment naming instructions.

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 MCO have a more restrictive requirement?

   ◉ Yes

   ○ No

   If "Yes," check all that apply:

   ☐ Require that a MedWatch Form be submitted.

   ☒ Require the medical reason(s) for override accompany the prescription.

   ☒ Prior authorization is required.

   ☒ Prescriber must indicate "Brand Medically Necessary" on the prescription.

   ☐ Other, please explain.

ATT3-2018-NV-Anthem-GDSP Generic Drug Substitution policies

Our A08-Prior Authorization and A16-Health Plan Pharmacy Benefits policies address generic drug substitution. To promote prescribing of safe and cost effective medications, a PA is required for all non-formulary drugs, brand name medications with a generic equivalent, drugs excluded from the pharmacy benefit/plan design and any drug that exceeds plan limitations, for drugs requiring clinical criteria. The health plan requires the use of a preferred generic or therapeutic equivalent alternatives as medically necessary (where applicable) prior to approval of non-formulary/non-preferred drugs. When or if there has been a failure, contraindication, or intolerance to the specified alternatives providers must submit a PA request documenting the aforementioned events.

Complete Table 2 – Generic Drug Utilization Data using the following Computation Instructions.

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.

Generic Utilization Percentage

To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	129,045	1,291,234	68,944

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. This file will be made available from CMS to facilitate consistent reporting across states with this data request.

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in *Table 2 – Generic Utilization Data*.

Number of Generic Claims:	1,291,234
Total Number of Claims:	1,489,223
Generic Utilization Percentage:	86.71

VII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☐ Deny claims and require prior authorization

   ☒ Refer to Lock-In Program

   ☐ Refer to Program Integrity Unit

   ☐ Other (i.e. SURS, Office of Inspector General), please explain.

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

   ◉ Yes

   ○ No

   If the answer to question 2 is "No," skip to question 3.

   If the answer to question 2 is "Yes," please continue.

   a) What criteria does your MCO use to identify candidates for Lock-In? Check all that apply:

      ☒ Number of controlled substances (CS)

      ☒ Different prescribers of CS

      ☒ Multiple pharmacies

      ☐ Number days' supply of CS

      ☐ Exclusivity of short acting opioids

      ☐ Multiple ER visits

      ☐ PDMP data

      ☐ Same FFS state criteria is applied

      ☐ Other, please explain.

b) Do you have the capability to restrict the beneficiary to:

i) prescriber only

- (•) Yes
- ( ) No

ii) pharmacy only

- (•) Yes
- ( ) No

iii) prescriber and pharmacy only

- (•) Yes
- ( ) No

c) What is the usual Lock-In time period?

- (•) 12 months
- ( ) 18 months
- ( ) 24 months
- ( ) Other, please explain.

d) On average, what percentage of your Medicaid MCO population is in Lock-In status annually?

0.20 %

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☐ Deny claims written by this prescriber
   ☒ Refer to Program Integrity Unit
   ☐ Refer to the appropriate Medical Board
   ☐ Other, please explain.

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☐ Deny claims
   ☐ Refer to Program Integrity Unit
   ☐ Refer to Board of Pharmacy
   ☒ Other, please explain.

   Our PBM reviews pharmacy claims and conducts Fraud Waste and Abuse activities for pharmacy providers.

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?

   ◉ Yes, please explain your program for fraud, waste or abuse of non-controlled substances.

   Our Special Investigational Unit has a documented process to identify and prevent potential fraud or abuse of prescriptions. The SIU conducts systematic and manual review of claims data to address fraud, waste, and abuse.

   ○ No

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Do you require prescribers (in your provider agreement with your MCO) to access the PDMP patient history before prescribing controlled substances?

   ○ Yes, please explain how the MCO applies this information to control fraud and abuse.

   ◉ No

   ○ No, the state does not have a PDMP

2. Does your MCO have the ability to query the state's PDMP database?

   ○ Yes

   ◉ No

   If "Yes," are there barriers that hinder your MCO from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

   ○ Yes, please explain the barriers that exist.

   ○ No

3. Does your MCO have access to border states' PDMP information?

   ○ Yes

   ◉ No

C. PAIN MANAGEMENT CONTROLS

1. Does your MCO obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

   (●) Yes

   ( ) No

   If the answer to question 1 is "No," skip to question 2.

   If the answer to question 1 is "Yes," please continue.

   Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

   (●) Yes

   ( ) No

   If "Yes," please explain how information is applied.

   A valid DEA must be submitted on the pharmacy claim for a controlled substance.

   If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

   ( ) Yes

   ( ) No

2. Do you apply this DEA file to your RetroDUR reviews?

   ( ) Yes, please explain how it is applied.

   (●) No

3. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

   - (●) Yes
   - ( ) No, please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

D. OPIOIDS

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

   - (●) Yes, for all opioids
   - ( ) Yes, for some opioids
   - ( ) No, for all opioids

   If the answer to question 1 is "No," skip to question 2.

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

   a) Is there more than one quantity limit for the various opioids?

      - (●) Yes, please explain.

        Short-acting Opioids: For new prescriptions, there is a 7-day supply limit per fill and 14-day supply limit in a 30-day time frame. Prescriptions written for more than 7 days can be filled for 7-days with a refill if state dispensing rules allow it. Exceptions for: Members with certain documented conditions such as cancer-related pain, terminal condition, or Sickle Cell. Other conditions reviewed on a case by case basis.

      - ( ) No

b) What is your maximum number of days allowed for an initial opioid prescription?

7 days

c) Does the above initial day limit apply to all opioid prescriptions?

- ○ Yes
- ◉ No, please explain.

Exceptions for members with certain documented conditions such as cancer-related pain, terminal condition, or Sickle Cell.

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

   ◉ Yes

   ○ No

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

   ◉ 30 day supply

   ○ 90 day supply

   ○ Other, please explain.

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?

   ◉ Yes

   ○ No

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

   ◉ 30 day supply

   ○ 90 day supply

   ○ Other, please explain.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

   ◉ Yes

   ○ No

   If "Yes," please check all that apply:

   - ☐ Pharmacist override
   - ☐ Deny claim and require PA
   - ☐ Intervention letters
   - ☒ Morphine equivalent daily dose (MEDD) program
   - ☒ Step therapy or clinical criteria
   - ☒ Requirement that patient has a pain management contract or Patient-Provider agreement
   - ☒ Requirement that prescriber has an opioid treatment plan for patients
   - ☐ Require documentation of urine drug screening results
   - ☐ Other, please explain what additional opioid prescribing controls are in place.

   If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

   ◉ Yes, please explain.

   We have a concurrent DUR edit at the point of sale.

   ○ No

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis?

   ◉ Yes

   ○ No

   If the answer to question 6 is "Yes," please indicate how often:

   ◉ Monthly

   ○ Quarterly

   ○ Semi-Annually

   ○ Annually

   ○ Other, please explain.

   If the answer to question 6 is "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

   ○ Yes

   ○ No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

   ○ Yes

   ◉ No

   For either "Yes" or "No," please check all that apply:

   ☐ Your MCO refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain. Please identify the "referred" guidelines.

   ☐ Other guidelines, please identify.

   ☒ No guidelines are offered.

8. Do you 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)?

   ◉ Yes, please explain.

   Our preferred drug list and opioid policy steers treat-naive members to short-acting opioids for a 7 day supply. Long-acting opioids including abuse deterrent formulations may be obtained with a clinical prior authorization. We require prior authorization for all long acting opioids.

   ○ No

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

   ◉ Yes

   ○ No

   If the answer to question 1 is "Yes," please continue.

   a) What is your maximum morphine equivalent daily dose limit in milligrams?

   90 mg per day

   b) Please explain (i.e. are you in the process of tapering patients to achieve this limit?).

   Our MEDD limits have been implemented.

   If the answer to question 1 is "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

   ○ Yes

   ◉ No

   If the answer to question 2 is "No," skip to question 3.

   If the answer to question 2 is "Yes," please continue.

   a) Please name the developer of the calculator.

   b) How is the information disseminated? Check all that apply:

   ☐ Website

   ☐ Provider notice

   ☐ Educational seminar

   ☐ Other, please explain.

3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

   - (●) Yes
   - ( ) No

   If "Yes," do you require prior authorization if the MEDD limit is exceeded?

   - (●) Yes
   - ( ) No

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

1. Does your MCO set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

   - (●) Yes
   - ( ) No

   If "Yes," please specify the total mg/day:

   - ( ) 12 mg
   - ( ) 16 mg
   - (●) 24 mg
   - ( ) Other, please explain.

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

   ○ 6 months

   ◉ 12 months

   ○ No limit

   ○ Other, please explain.

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

   ○ Yes

   ◉ No

   If "Yes," please continue.

   a) What is your reduced (maintenance) dosage?

      ○ 8 mg

      ○ 12 mg

      ○ 16 mg

      ○ Other, please explain.

b) What are your limitations on the allowable length of the reduced dosage treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other, please explain.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

- ○ Yes
- ◉ No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

- ◉ Yes
- ○ No
- ○ Other, please explain.

If "Yes," can the POS pharmacist override the edit?

- ◉ Yes
- ○ No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

   - (●) Yes
   - ( ) No

7. Does your MCO allow pharmacists to dispense naloxone prescribed independently, or by collaborative practice agreements, or standing orders, or other predetermined protocols?

   - (●) Yes
   - ( ) No

8. Does your MCO cover methadone for OUD (i.e. Methadone Treatment Center)?

   - ( ) Yes
   - (●) No

G. ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

   - (●) Yes
   - ( ) No, please explain.

2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

   ◉ Yes

   ○ No

   If "Yes," please continue.

   a) Do you either manage or monitor:

      ○ Only children in foster care

      ◉ All children

      ○ Other, please explain.

   b) Do you have edits in place to monitor (check all that apply):

      ☒ Child's Age

      ☒ Dosage

      ☒ Polypharmacy

      ☐ Other

   c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

      We have Protocols to monitor the use of antipsychotic medications including: the oversight of the use of antispsychotics used in children under the age of six; Adults or children receiving more than one antipsychotic medication (polypharmacy); Program monitors for medication adherence of antipsychotic in those who have less than 80% PDC of their antipsychotic medications, as well monitoring for Gaps in care of those who are receiving antispsychotic medications but have not had a diabetes d

If you do not have an antipsychotic monitoring program in place, do you plan on implementing a program in the future?

- ○ Yes
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?
   - ◉ Yes
   - ○ No

4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?
   - ◉ Yes
   - ○ No

   If the answer to question 4 is "Yes," please continue.

   a) Do you either manage or monitor:
      - ○ Only children in foster care
      - ◉ All children
      - ○ Other, please explain.

b) Do you have edits in place to monitor (check all that apply):

- ☒ Child's Age
- ☒ Dosage
- ☒ Polypharmacy

c) Please briefly explain the specifics of your documented stimulant monitoring program(s).

We have Protocols that support a multimodal approach to ensure optimal ADHD medication management. Our protocols: Identifies members taking ADHD medications with no FDA approved diagnosis,
Education for Providers on the risk of cardiovascular events associated with use of stimulants in children with PMH of cardiac conditions;
Identify members that are taking multiple Stimulant, or ADHD medications prescribed

If the answer to question 4 is "No," that is you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

- ○ Yes
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

VIII. INNOVATIVE PRACTICES

Attachment 4 – Innovative Practices

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing)? Please describe in detailed narrative form 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 prior authorizations, continuing education programs).

*Please include **Attachment 4** described above when submitting this survey. (See naming instructions.)*

ATT4-2018-NV-Anthem-IPN

INNOVATION – Clinical Pharmacy-Quality: Oct 1, 2017 to Sept 30, 2018

During the past reporting period, we added new targeted alerts to our provider MedReview notes. These alerts are designed to help partner with our providers to close identified gaps in care and to encourage regular follow up with our members.

We enhanced our telephonic outreach to members through our Clinical Pharmacy Care Center. Our Asthma Medication Adherence and New Start calls aim to discuss medication concerns for members newly started on long acting controllers and to address barriers to adherence. The Diabetes Polypharmacy program was updated to include members with diabetes taking more than 10 medications. This program also includes a comprehensive medication review, addresses use of statin medications, elevated Hemoglobin A1C, and screening tests. The goals of the Asthma and Diabetes programs are to motivate our members to be in control of their chronic conditions and to improve their quality of life.

We implemented a Behavioral Health Polypharmacy program to address a growing problem of polypharmacy with the use of psychotropic medication, especially in our more vulnerable populations such as children and youth in foster care and in the elderly. Our program identifies members with multiple prescribers and multiple psychotropic medications in the same and across therapeutic drug class (Antidepressants, stimulants, antipsychotics, anxiolytics and sedative hypnotics). Once targeted members are identified a fax is generated to outreach to all of the prescribers of psychotropic medications for the member. The letters are followed up with telephonic outreach to the prescribers, during which a pharmacist coordinates care for the members. Pharmacy interventions also include referrals to plan case management for members whose care continues to go uncoordinated.

IX. E-PRESCRIBING

1. Does your pharmacy system or vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

   - (●) Yes
   - ( ) No

   If the answer to question *1 is "Yes,"* do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

   - (●) Yes, please explain the evaluation methodology in **Attachment 5 – E-Prescribing Activity Summary**. Describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

     *Please include **Attachment 5** described above when submitting this survey. (See naming instructions.)*

   - ( ) No

   If the answer *to question 1 is "No,"* are you planning to develop this capability?

   - ( ) Yes
   - (●) No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

   - ( ) Yes
   - (●) No

X. EXECUTIVE SUMMARY

Attachment 6 – Executive Summary

*Please include **Attachment 6** when submitting this survey. (See naming instructions.)*

ATT5-2018-NV-Anthem-EAS E-Prescribing Activity Summary

Prescribers have access to Anthem's formulary, clinical edits and safety alerts on most handheld devices and a desktop applications. Our formulary/PDL information is accessible via the web, enabling easy access to drug information. Providers can verify formulary/PDL status, copays (if applicable), view alternative and generic substitutions, check quantity limits, and look up prior authorization requirements when making prescribing decisions. We also work with our pharmacy partner to enable real time pharmacy benefit check within the e-prescribing process. When real-time benefit check is in place, prescribers will receive the most appropriate and cost-effective medication options based on patient-specific pharmacy benefits. This capability can be integrated into EMRs across the United States. Providers will also receive drug safety alerts. They can even request a PA electronically, and 46% of requests we receive for PA are submitted electronically.

ATT6-2018-NV-Anthem-ES

Drug Utilization Review Annual Report: FFY18
Attachment 6 – Executive Summary

Our DUR program activities and outcomes include Pro-DUR and Retro-DUR alerts and interventions to ensure safe and effective dosing while improving quality of care for our members.

I. Drug Utilization Review Program Overview

Anthem provides through our PBM electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (**POS**) and prospective drug utilization review (**Pro-DUR**) for the Anthem Nevada Medicaid Pharmacy 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.

Anthem also provides retrospective drug utilization review (**Retro-DUR**) for the Anthem Nevada Medicaid Pharmacy Program. The goal of this program is to promote appropriate medication prescribing by identifying patterns of potential inappropriate prescribing or medication use, alerting physicians and/or pharmacists to potential drug therapy problems, and recommending future corrective action.

II. Prospective Drug Utilization Review Program (ProDUR)

The primary focus of the POS/ProDUR program is to enhance the quality of patient care through appropriate drug therapy. Anthem's Concurrent DUR process follows the NCPDP Prospective DUR standard formats for conflict, intervention, and outcome. The program reviews all prescriptions, compares them to patient demographics, and checks for potential clinical conflicts that may result if the prescription is dispensed. These include drug-drug interactions, drug-allergy conflicts, drug-disease conflicts, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over-utilization, drug-age conflicts, drug-gender conflicts, and drug- pregnancy conflicts.

The Drug Interaction rule identifies potential problems with conflicting drug therapies. Comparing the incoming NDC to a table of interacting drug identifies this rule. If the incoming NDC is on the table, the point- of-sale claims processing system will identify other drugs that interact and will also review the patient profile for current interacting drugs. The table includes Level I, 2 and 3 interactions. Level 1 interactions are stopped at the point of sale and require the Pharmacist to intervene.

Through the use of a code, the Pharmacist can override Level 1 interactions after they have

intervened in order to continue filling the prescription if appropriate. Safety edits relating to drug/drug interactions are clinically classified at the following three levels:

- Level 3 is "No Response" and is of mild severity, probably resulting in little potential harm to the plan participant. In this situation, no message is given and a record is made for reporting purposes only.
- Level 2 is "Advisory" and alerts the pharmacist that there is potential for a serious drug/drug interaction.
- Level 1 is "Very Severe" which means there is a high risk of harm to the plan participant. This message rejects the claim. After clinical review, the dispensing pharmacist may override Level 1 interactions alert by entering a response code in order to proceed with dispensing, as appropriate.

The Drug-Allergy Conflicts rule identifies potential problems based on patient reported allergies. An incoming NDC will be compared to a drug-allergy combination table. If the drug is on the table, the point-of-sale claims processing system will identify allergies that are conflicting and will review the patient profile for a conflicting allergy.

The Cumulative Early Refill rule identifies a patient who has more than an adequate supply remaining for their prescription. An incoming NDC is matched to current drugs on the patient profile for the same therapy. If a cumulative remaining day's supply is greater than 25 percent of the maximum days' supply any previous claims, a reject for early refill will occur. Exceptions are made to standardize the minimum and maximum days' supply allowed. In mail service, if an order is received with approximately 30 days remaining before the criteria edit will pass, ESI's mail service pharmacy may hold the prescription until the system permits processing rather than return the prescription request to the member. The member receives notification of the hold and when it will process. If the days' supply remaining is longer than 30 days, the mail service pharmacy will place the prescription on the member's profile and notify the member via letter of the date on which the member may call to fill the prescription.

The Therapeutic Duplication rule identifies the dispensing of two or more drugs within the same therapeutic category for the same patient. An incoming NDC is matched to similar current therapy on the patient profile. If similar therapy exists, a therapy duplication message is sent. The point-of-sale claims processing system will exclude similar therapy where appropriate. When therapeutic duplication is identified, the claim is rejected. After performing a clinical review, which may include consultation with the prescriber, the dispensing pharmacist can enter response codes and may proceed with the dispensing process, as appropriate.

The Drug Exceeding Maximum Daily Dose rule identifies a prescription being filled for more than the recommended daily dose. The daily dose of the incoming claim is calculated by dividing quantity by days' supply. The result is compared to a recommended daily dose table. A warning message is returned if the calculated dose is greater than the maximum on the table.

The Drug-Age Conflict rule identifies drugs being inappropriately prescribed based on the patient's age. An incoming claim is matched to the Drug-Age Conflict table. The point-of-sale claims processing system identifies the target age and compares patient to target age. When

the patient's age is less than or greater than the target, a warning is sent.

The Drug-Gender Conflict rule identifies drugs being inappropriately prescribed based on patient gender. An incoming NDC is matched to the Drug-Gender table. The point-of-sale claims processing system pulls gender conflict and compares it to the patient gender. When the gender rule is violated, the point-of-sale claims processing system sends a warning message to the dispensing pharmacy.

The Drug-Pregnancy rule identifies drugs contraindicated for use by pregnant women. The incoming NDC is matched to a table with drug-pregnancy contraindications and the patient's profile is reviewed to determine the patient's age and sex. In addition, the patient's profile is reviewed if an inferred pregnancy diagnosis drug marker exists. If all criteria are met, a warning message is sent.

The Duration of Therapy rule identifies drugs being used beyond the manufacturer's recommendations for length of therapy. When a drug exceeds the limit, a warning message is sent or a prior authorization is required.

III. Retrospective Drug Utilization Review (Retro-DUR)

The goal of the Retro-DUR Program is to promote appropriate prescribing and medication use. RDUR analysis is performed through a review of administrative claims each day, week, and/or month. RDUR letters are faxed or mailed to targeted prescribers and members to encourage formulary compliance, identify gaps in care, discuss adherence and identify cases of potential under- and over-utilization and drug abuse or misuse. Some of these identified members are referred to the Lock-in program or to a Pharmacist for further evaluation or clinical intervention. In addition, the data is analyzed and used for RDUR provider education programs to support disease management programs. Plan-specific RDUR results are shared with the health plan leaders on an adhoc basis or at a minimum of quarterly on a scheduled basis. RDUR details are also presented during plan-specific Quality Management meetings and/or DUR Committee meetings.

Retrospective Safety Review

This program acts as a safety net for serious drug interactions that were not addressed at the point of sale. Our PBM runs a series of reports on claims filled the prior day. Pharmacists evaluate clinical safety opportunities within 72hours. If warranted, the clinical pharmacist will send a fax to the prescribing physician's office describing the drug- drug interaction and requesting a response through the accompanying prescriber response form. When the drug interaction will have a severe impact, however, pharmacists contact the pharmacy and/or prescriber by phone.

Prescribers have access to Anthem's formulary, clinical edits and safety alerts on most handheld devices and a desktop applications. Our formulary/PDL information is accessible via the web, enabling easy access to drug information. Providers can verify formulary/PDL status, copays (if applicable), view alternative and generic substitutions, check quantity limits, and look up prior authorization requirements when making prescribing decisions. We also work with our

pharmacy partner to enable real time pharmacy benefit check within the e-prescribing process. When real-time benefit check is in place, prescribers will receive the most appropriate and cost-effective medication options based on patient-specific pharmacy benefits. This capability can be integrated into EMRs across the United States. Providers will also receive drug safety alerts.

HEALTH PLAN OF NEVADA

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CMS ANNUAL DUR SURVEY

FFY 2018

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities. 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.

This report covers the period October 1, 2017 to September 30, 2018. **Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory and regulatory requirements.**

If you have any questions regarding the DUR Annual Report, please contact your state's Medicaid Pharmacy Program.

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

I. DEMOGRAPHIC INFORMATION

MCO Name: Health Plan of Nevada

Medicaid MCO Information

Identify your MCO person responsible for DUR Annual Report Preparation.

First Name: Leah

Last Name: Smith

Email Address: leah.smith@uhc.com

Area Code/Phone Number: 412-208-8933

1. On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

276,453 beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify it by name.

- ○ State-operated
- ◉ Contractor, please identify by name.

  OptumRx

- ○ Other organization, please identify by name.

2. Identify prospective DUR criteria source.

- ☐ First Data Bank
- ☒ Medi-Span
- ☐ Other, please specify.

3. Who reviews your new prospective-DUR criteria?

- ☒ MCO's DUR Board
- ☐ FFS agency DUR Board
- ☐ Other, please explain.

4. Are new ProDUR criteria approved by the DUR Board?

- ◉ Yes
- ○ No, please explain.

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

- (●) Yes
- ( ) No
- ( ) Partial, please explain.

6. Do you receive and review follow-up periodic reports providing individual pharmacy provider override activity in summary and/or in detail?

   ◉ Yes

   ○ No, please explain.

If the answer to question 6 is "No," skip to question 7.

If the answer to question 6 is "Yes," please continue below.

a) How often do you receive reports?

   ○ Monthly

   ◉ Quarterly

   ○ Annually

   ○ Other, please explain.

b) Do you follow up with those providers who routinely override with interventions?

- ○ Yes
- ◉ No, please explain.

  OptumRx is responsible for the audit activities for The Health Plan of Nevada Medicaid. They utilize their own set of algorithms to identify those pharmacies requiring outreach, which could include PDUR overrides.

If the answer to question 6b is "No," skip to question 7.

If the answer to question 6b is "Yes," please continue below.

By what method do you follow up?

- ○ Contact Pharmacy
- ○ Refer to Program Integrity for Review
- ○ Other, please explain.

7. **Early Refill**

a) At what percent threshold do you set your system to edit?

Non-controlled drugs:

85.00 %

Schedule II controlled drugs:

90.00 %

Schedule III through V controlled drugs:

90.00 %

b) **For non-controlled drugs**

When an early refill message occurs, does your MCO require prior authorization?

- (•) Yes
- ( ) No

If the answer to question 7b is "Yes," who obtains authorization?

- ( ) Pharmacist
- (•) Prescriber
- ( ) Either

If the answer to question 7b is "No," can the pharmacist override at the point of service?

- ( ) Yes
- ( ) No

c) **For controlled drugs**

When an early refill message occurs, does your MCO require prior authorization?

- (●) Yes
- ( ) No

If the answer to question 7c is "Yes," who obtains authorization?

- ( ) Pharmacist
- (●) Prescriber
- ( ) Either

If the answer to question 7c is "No," can the pharmacist override at the point of service?

- ( ) Yes
- ( ) No

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

- [ ] Lost/stolen Rx
- [ ] Vacation
- [x] Other, please explain.

None.

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

   ○ Yes

   ◉ No

   If "Yes," please explain your edits.

   If "No," do you plan to implement this edit?

   ○ Yes

   ◉ No

10. Does the MCO 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)?

    ○ Yes

    ◉ No

11. Does your MCO have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled chronic medication refills at the same time, your MCO would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

    ○ Yes

    ◉ No

12. For drugs not on your MCO's formulary, does your MCO have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

- (●) Yes
- ( ) No

If "Yes," what is the preauthorization process?

Authorization for non-preferred medications are reviewed and approvable when shown to be medically necessary. Medical necessity is established when the drugs offered on the preferred drug list are not appropriate to treat the member due to contraindications or intolerances. A formal prior authorization process is in place that validates the member's diagnosis to identify appropriate use, and asks for rationale why the preferred drugs are not appropriate.

If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

13. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

Table 1: Top Drug Claims Data Reviewed by the DUR Board

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name	**Column 2** Top 10 Prior Authorization (PA) Requests by Drug Class	**Column 3** Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)	**Column 4** Top 10 Drug Names by Amount Paid	**Column 5** % of Total Spent for Drugs by Amount Paid From data in Column 4, determine the % of total drug spend.	**Column 6** Top 10 Drug Names by Claim Count	**Column 7** Drugs by Claim Count % of Total Claims From data in Column 6, determine the % of total claims.
ADDERALL XR	ANALGESICS - OPIOID	DUR Reject Error	HUMIRA PEN	4.30 %	VENTOLIN HFA	2.50 %
MORPHINE SR	ANTIDIABETICS	Filled After Coverage Trm	ONETOUCH	2.37 %	HYDROCO/APAP	2.36 %
OXYCODONE IR	DERMATOLOGICALS	Prod/Service Not Covered	VENTOLIN HFA	2.32 %	AMOXICILLIN	2.18 %
ARIPIPRAZOLE	ANTIPSYCHOTICS/ ANTIMANIC	Refill Too Soon	GENVOYA	2.32 %	LISINOPRIL	2.14 %
SUBOXONE	ADHD/ ANTI-NARCOLEPSY/	Plan Limitations Exceeded	MAVYRET	2.18 %	ATORVASTATIN	2.13 %
ABILIFY	ANTIASTHMATIC AND		TOUJEO SOLO	2.03 %	ONETOUCH	2.02 %
LYRICA	ANTICONVULSANTS		TRIUMEQ	1.97 %	METFORMIN	2.00 %
DICLOFENAC	PSYCHOTHERAPEUTIC AND		ZEPATIER	1.86 %	GABAPENTIN	1.98 %
OXYCODONE/APAP	ANALGESICS - ANTIINFLAMM		HUMALOG KWIK	1.78 %	IBUPROFEN	1.75 %
HUMALOG	ANTIVIRALS		TRUVADA	1.66 %	FLUTICASONE	1.74 %

III. RETROSPECTIVE DUR (RetroDUR)

1. Does your MCO utilize the same DUR Board as the state Fee-For-Service (FFS) agency or does your MCO have its own DUR Board?

   ○ Same DUR Board as FFS agency

   ○ MCO has its own DUR Board

   ◉ Other, please explain.

   Health Plan of Nevada Medicaid utilizes the UHC DUR Board and also participates on the same DUR Board as the FFS agency.

2. Identify the entity, by name and type, that performed your RetroDUR activities during the time period covered by this report (company, academic institution, other organization, or indicate if your MCO executed its own RetroDUR activities).

   OptumRx

3. Who reviews and approves the RetroDUR criteria?

   ○ State DUR Board

   ○ MCO DUR Board

   ◉ Other, please explain.

   RDUR criteria is developed and maintained through OptumRx, the criteria utilized for their programs are created and approved through their own quality committee on an annual basis. The UHC DUR Board evaluates which RDUR programs to enroll in on an annual basis.

4. Has your MCO included **Attachment 1 – Retrospective DUR Educational Outreach Summary**, a year end summary of the Top 10 problem types for which educational interventions were taken?

   ◉ Yes

   ○ No

   See attachment naming instructions.

IV. DUR BOARD ACTIVITY

1. Has your MCO included a brief summary of DUR Board activities during the time period covered by this report as **Attachment 2 - Summary of DUR Board Activities**?

   ◉ Yes

   ○ No

Attachment 2 – Summary of DUR Board Activities

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
  a) For prospective DUR, list problem type/drug combinations added or deleted.
  b) For retrospective DUR, list therapeutic categories added or deleted.
- 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.
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

See attachment naming instructions.

Health Plan of Nevada

2018 Safety Management Activities – January through September

RetroDUR Activity Summary	Safety Management									
	January	February	March	April	May	June	July	August	September	YTD
Members Identified	**	**	3,565	1,602	793	785	929	700	1,254	9,024
Total Interventions	**	**	5,998	1,933	866	871	1,061	856	1,508	17,573
Average Daily Dose	**	**	0	0	0	0	0	0	0	0
Dose Per Day	**	**	1	0	0	0	2	1	4	14
Drug-Age Interaction	**	**	41	16	11	8	11	1	17	130
Drug-Disease Interaction	**	**	392	142	108	54	49	57	101	1,222
Drug-Drug Interaction	**	**	2,923	922	70	423	623	450	762	8,127
Duplicate Therapy	**	**	1,789	547	444	253	226	219	367	5,169
Overutilization_Days Supply	**	**	852	306	233	133	150	128	257	2,911
Average Interventions Per Member	**	**	1.7	1.2	1.1	1.1	1.1	1.2	1.2	1.9
Total Provider Outreaches	**	**	5,998	1,933	866	871	1,061	856	1,508	17,573
Unique Provider Outreaches	**	**	1,235	762	492	531	559	448	680	2,274

2018 Gaps in Care Activities – January through September

RetroDUR Activity Summary	Gaps in Care									
	January	February	March	April	May	June	July	August	September	YTD
Members Identified	**	**	2,381	794	636	365	293	264	624	5,645
Total Interventions	**	**	3,296	862	687	368	301	288	624	8,695
GIC Asthma	**	**	3,296	862	687	368	301	288	624	8,695
Average Interventions Per Member	**	**	1.4	1.1	1.1	1.0	1.0	1.1	1.0	1.5
Total Provider Outreaches	**	**	3,296	862	687	368	301	288	624	8,695
Unique Provider Outreaches	**	**	903	455	381	265	224	201	624	1,479

2018 RDUR Program Outcomes – January through September

RetroDUR Outcomes Summary		all YTD interventions eligible for outcomes	all YTD eligible interventions with a positive outcome	clinical impact %
Safety Management	Dose Per Day	1	1	100.00%
	Drug-Age Interaction	44	11	25.00%
	Drug-Disease Interaction	561	77	13.73%
	Drug-Drug Interaction	3,676	935	25.44%
	Duplicate Therapy	2,428	461	18.99%
	Overutilization_Days Supply	1,298	82	6.32%
Gaps In Care	GIC Asthma	3,689	336	9.11%
Total		**11,697**	**1,903**	**16.27%**

2018 Narcotic Drug Utilization Review Program – January through September

Program	Patients YTD	Prescribers Contacted YTD	Patient Alerts YTD	Alerts Analyzed YTD [b/]	Successes YTD [c/] [d/]	Success YTD (%)
Narcotic Drug Utilization Review Program Total	**1364**	**1214**	**1835**	**1255**	**752**	**59.92%**
Grand Total	**1364**	**1214**	**1835**	**1255**	**752**	**59.92%**

2017 RDUR Safety Management Results – October through December

Program Component	Patients	Prescribers Contacted	Patient Alerts	Alerts Analyzed	Successes	Successes %
Inappropriate Dose or Duration	4	4	4	4	3	75%
Inappropriate Age for Drug Use	16	11	16	16	9	56%
Drug Interaction Alert Program	753	514	899	294	163	55%
Potential Drug Misuse / Abuse	1372	1226	1479	1417	675	48%
Buprenorphine MAT +Opioid	3	4	3	3	2	67%
Sedatives + Stimulants	300	171	306	291	98	34%
Duplicate Therapy (DT)	363	265	381	371	219	59%
Grand Total	**2398**	**1570**	**2779**	**2102**	**1069**	**51%**

***Please see following pages for full program descriptions of the above programs. ***

2018 Retrospective Drug Utilization Review (rDUR)

Safety Management: Drug-Drug Interaction

Component	Description
Program Objective	This is a provider-targeted program designed to minimize the occurrence of clinically significant, patient-specific drug-drug interactions.
Program Timeline	▪ Provider intervention frequency: Daily
Member Inclusion Criteria	▪ Member possesses a pharmacy claims for two interacting medications with at least a day of overlap
Member Exclusion Criteria	▪ Exclusion Criteria (must satisfy any of the following criteria): Members previously targeted for the same issue that involves the combination of the same two times in the year ▪ Members with drug-drug interactions involving an HIV or psychiatric medication and two providers when the provider for the HIV or psychiatric medication is not contactable (only applies to select states that restrict the disclosure of sensitive medications to other prescribers who may also be prescribing medications for the same member).
Program Components	<u>Provider-Based Fax Intervention</u>* ▪ A provider letter introducing the program and reason for intervention ▪ A member-specific provider report that includes: o Potential clinical concern o Clinical rationale supporting the clinical concern o Prescription utilization details for the interacting medications
Outcomes	▪ Intervention activity statistics ▪ Clinical impact determined 120 days post prescriber outreach ▪ Accrued savings for prescription and estimated total health calculated up to 365 days after initial evaluation

Abbreviations: HIV, human immunodeficiency virus

2018 Retrospective Drug Utilization Review (rDUR)

Safety Management: Drug-Disease Interaction

Component	Description
Program Objective	This is a provider-targeted program designed to minimize the occurrence of clinically significant, patient-specific drug-disease interactions.
Program Timeline	▪ Provider intervention frequency: Daily
Member Inclusion Criteria	▪ Member possesses a disease condition identified by drug marker or medical claim and a pharmacy claim for a interacting medication within measurement period
Member Exclusion Criteria	▪ Exclusion Criteria (must satisfy any of the following criteria): Members previously targeted for the same issue within the previous 180 days
Program Components	Provider-Based Fax Intervention* ▪ A provider letter introducing the program and reason for intervention ▪ A member-specific provider report that includes: o Potential clinical concern o Clinical rationale supporting the clinical concern o Prescription utilization details for the medications involved in clinical concern
Outcomes	▪ Intervention activity statistics ▪ Clinical impact determined 120 days post prescriber outreach ▪ Accrued savings for prescription and estimated total health calculated up to 365 days after initial evaluation

2018 Retrospective Drug Utilization Review (rDUR)

Safety Management: Dose Per Day and Overutilization_Days Supply

Component	Description
Program Objective	This is a provider-targeted program designed to enhance provider awareness of appropriate medication dose and duration use based on approved prescribing information.
Program Timeline	▪ Provider intervention frequency: Daily
Member Inclusion Criteria	• Member possesses pharmacy claim(s) where the days supply of the identified medication exceeds the cumulative days supply threshold during the measurement period. • Member possesses pharmacy claim(s) where the dose per day of the identified medication exceeds the dose per day supply threshold during the measurement period.
Member Exclusion Criteria	Exclusion Criteria (must satisfy any of the following criteria): ▪ Members previously targeted for the same issue within the previous 180 days
Program Components	<u>Provider-Based Intervention</u>* ▪ A provider letter introducing the intervention ▪ A comprehensive member-specific provider report that includes: o Potential clinical concern(s) o Clinical rationale supporting the clinical concern o Prescription utilization details for the medications involved in clinical concern o Recommended action
Outcomes	▪ Intervention activity statistics ▪ Clinical impact determined 120 days post prescriber outreach ▪ Accrued savings for prescription and estimated total health calculated up to 365 days after initial evaluation

2018 Retrospective Drug Utilization Review (rDUR)

Safety Management: Drug – Age Interaction

Component	Description
Program Objective	This is a provider-targeted program designed to minimize the occurrence of potentially inappropriate medications (PIMs) in the geriatric (65 years and older) and pediatric (less than 18 years) population.
Program Timeline	▪ Provider intervention frequency: Daily
Member Inclusion Criteria	Geriatric ▪ Member must be at least 65 years of age or older ▪ Possess pharmacy claim(s) for a PIM meeting the minimum days supply threshold Pediatric ▪ Member must meet the age threshold (variable depending on the drug) on the last day of the identification period ▪ Possess pharmacy claim(s) for a PIM meeting the minimum days supply threshold
Member Exclusion Criteria	Previously targeted for the same intervention within the previous 180 days
Program Components	Provider-Based Intervention* ▪ A provider letter introducing the program and reason for intervention ▪ A member-specific provider report that includes: o Potential clinical concern o Clinical rationale supporting the concern o Recommended action
Outcomes	▪ Intervention activity statistics ▪ Clinical impact determined 120 days post prescriber outreach ▪ Accrued savings for prescription and estimated total health calculated up to 365 days after initial evaluation

2018 Retrospective Drug Utilization Review (rDUR)

Safety Management: Therapeutic Duplication

Component	Description
Program Objective	This is a provider-targeted program designed to promote awareness of Therapeutic duplication concerns.
Program Timeline	▪ Provider intervention frequency: Daily
Member Inclusion Criteria	Member possesses pharmacy claims for duplicate medications with an overlapping days supply that meets the minimum threshold.
Member Exclusion Criteria	Members previously targeted for the same intervention in the past 180 days
Program Components	Provider-Based Intervention* ▪ A provider letter introducing the intervention ▪ A comprehensive member-specific provider report that includes: o Potential clinical concern o Prescription utilization details for the medications involved o Recommended action
Outcomes	▪ Intervention activity statistics ▪ Clinical impact determined 120 days post prescriber outreach ▪ Accrued savings for prescription and estimated total health calculated up to 365 days after initial evaluation

2018 Retrospective Drug Utilization Review

(rDUR) Narcotic Drug Utilization Review Program

Component	
Program Objective	This is a provider-targeted program designed to minimize the occurrence of drug abuse, diversion, and inappropriate use in members utilizing high-risk medications.
Program Timeline	▪ Provider intervention frequency: Monthly
Member Inclusion Criteria	Must satisfy <u>any</u> of the following criteria: ▪ Total average acetaminophen dose exceeds 4 grams per day ▪ Multiple providers for any combination of opioid analgesics ▪ Multiple providers for any combination of benzodiazepines ▪ Multiple providers for any combination of muscle relaxants ▪ Multiple pharmacies for any combination of opioid analgesics ▪ Multiple pharmacies for any combination of benzodiazepines ▪ Multiple pharmacies for any combination of muscle relaxants ▪ Chronic early refills of the same oxycodone containing product ▪ Overlap of different extended-release (ER) or long-acting (LA) opioid analgesics ▪ High daily dose of opioids (Morphine equivalent dose) ▪ Large quantity of opioids ▪ Overlapping days of opioids and buprenorphines
Member Exclusion Criteria	Must satisfy <u>any</u> of the following criteria: ▪ Members previously targeted for the same issue within the past six months of the same calendar year (member can only be retargeted once in the same calendar year for same issue) ▪ Members with at least one pharmacy claim for an anti-cancer medication in the last 6 months *NOTE: The cancer exclusion only applies to select criteria*
Program Components	Provider-Based Intervention* ▪ A provider letter explaining the clinical concern and recommended action ▪ A comprehensive member-specific provider report that includes: o Clinical issue(s) of concern o Member evidence claims history from all prescribing physicians
Outcomes	▪ Intervention activity statistics ▪ Clinical outcomes determined 120 days post intervention ▪ Estimated cost savings

Gap In Care: Asthma Program

Component	Description
Program Objective	To optimize the use of long-term controller medications (LTCMs) as recommended by current guidelines, promote the appropriate use of short-acting beta-agonists (SABAs), and provide asthma management education to members and their providers.
Program Timeline	▪ Program frequency: Daily
Member Inclusion Criteria	▪ Ages 5 through 85 years at the start of the identification period ▪ Possess a medical and/or pharmacy claim representing asthma ▪ Possess pharmacy claims identifying SABA overutilization without the presence of a LTCM or possess a low controller ratio (greater than 0, but less than 0.5)
Member Exclusion Criteria	▪ Possess a medical and/or pharmacy claim for emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis, or acute respiratory failure ▪ Exclusion Criteria (must satisfy any of the following criteria): Members previously targeted for the same issue within the previous 180 days
Program Components	Provider Mailing ▪ Letter introducing the intervention and highlighting current recommendations ▪ Report identifying patients with potentially suboptimal asthma control who may benefit from a review of their asthma therapy and/or the addition of a LTCM
Provider Identification	▪ The most recent prescriber of any asthma medication
Outcomes	▪ Intervention activity statistics ▪ Clinical impact determined 120 days post prescriber outreach ▪ Accrued savings for prescription and estimated total health calculated up to 365 days after initial evaluation

Abbreviations: *SABA, short-acting* beta agonists; COPD, chronic obstructive pulmonary disease; LTCM, long-term controller medication; NIH, National Institutes of Health; GINA, Global Initiative for Asthma

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

1. DUR Board meetings held between 10/01/17 and 09/30/18
    a. 03/20/18
    b. 09/27/18
2. Additions/deletions to DUR Board approved criteria. (see complete DUR Board meeting minutes for the above dates attached)
    a. For prospective DUR, list problem type/drug combinations added or deleted.
        i. Approval to add Concurrent Drug Utilization Review (CDUR) soft edits at the point of sale for the following CDUR types and classes:
            1. Therapeutic Duplications: ACE Inhibitors, ARBs, ACE-I + ARBs, Anticoagulants, Antidepressants, Alpha Agonists, and Immunomodulators.
            2. Drug Interactions: Opioids + Carisoprodol, Linezolid + Serotonin Modulators, and Ciprofloxacine + Tizanidine.
            3. Cumulative High Dose (Theradose): PPIs, Sleep Aides, and Antipsychotics.
            4. Drug Inferred Health State: Opioids + Doxylamine-Pyridoxine (custom message only - no soft message)
        ii. NOTE: The above approved CDUR soft edits are only applied in states/contracts in which we have the autonomy to apply such edits.
    b. For retrospective DUR, list therapeutic categories added or deleted.
        i. Gained approval to add the following four Gaps-In-Care programs to the RDUR program for 1/1/2019:
            1. Gaps in Care Cardiovascular
            2. Gaps in Care Diabetes
            3. Gaps in Care COPD
            4. Gaps in Care HIV
        ii. Gained approval to ask OptumRx to reevaluate recommended ages and subsequent dose limitations of antipsychotics supported by the Prescribing Information and Clinical Literature to prevent lettering on appropriate and clinically supported therapies.
3. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens.
    a. Please see summary of UHC DUR Board Policies below.
4. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.
    a. Please see summary of UHC DUR Board Policies below.
5. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.).
    a. Please see summary of UHC DUR Board Policies below.
6. Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring).
    a. Please see summary of UHC DUR Board Policies below.

UnitedHealthcare®
COMMUNITY & STATE

UHCCS PHARMACY MANAGEMENT OPERATIONAL POLICY AND PROCEDURES		
Subject: Pharmaceutical Management Systems – Drug Utilization Review Board		
Policy Number: RX-039	**Issue Date:** October 4, 2011	**Last Review Date:** January 16, 2018
Approved By: James P. Hancovsky Vice President, Pharmacy Management	**Signature:**	
Revision Date: January 16, 2018	**NQOC Approval Date:** February 1, 2018	

POLICY STATEMENT:

The UnitedHealthcare Community & State Drug Utilization Review (DUR) Board is responsible for the development, maintenance, and medical oversight of drug utilization review programs used by Medicaid benefit plans issued or administered by UHC CS or its affiliates in accordance with the requirements of a DUR Board found in 1927(g) of the Social Security act relating to DUR activities.

SCOPE:

UnitedHealthcare Community & State Pharmacy Department, Pharmacy Benefit Administrator, UnitedHealthcare Community Plan, Medicaid and CHIP.

PURPOSE:

The purpose of the UnitedHealthcare Community & State DUR Board is to provide clinical support for the development, maintenance, and clinical oversight of drug utilization review programs used by Medicaid benefit plans issued or administered by UnitedHealthcare Community & State or its affiliates. The purpose of the clinical support provided is to ensure that the clinical pharmacy programs improve quality of patient care by promoting patient safety and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and health plan members. The UnitedHealthcare Community & State DUR Board also develops initiatives that support the medical management strategies for customers in pharmacy benefit plans issued or administered by UnitedHealthcare Community & State or its affiliates, the health plans managed by UnitedHealthcare Community & State, or other entities to which UnitedHealthcare Community & State provides pharmacy benefit administration services. The UnitedHealthcare Community & State DUR Board program and policy reviews are designed to assure that the clinical programs and related materials are consistent with published clinical evidence and UnitedHealthcare Community & State medical management policies and initiatives.

RESPONSIBILITIES/ACCOUNTABILITY:

The UnitedHealthcare Community & State DUR Co-Chairpersons ensure that the UnitedHealthcare Community & State DUR policy is accurately administered.

PROCEDURES FOR POLICY COMPLIANCE:

UnitedHealthcare Community & State assures that all relevant aspects of the Drug Utilization Review clinical programs and related materials are consistent with published clinical evidence and UnitedHealthcare Community & State medical management policies and initiatives.

A. Composition

1. The membership of the UnitedHealthcare Community & State DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:
    a. The clinically appropriate prescribing of covered outpatient drugs.
    b. The clinically appropriate dispensing and monitoring of covered outpatient drugs.
    c. Drug use review, evaluation, and intervention.
    d. Medical quality assurance.

2. The membership of the DUR Board shall be made up at least 1/3 but no more than 51 percent licensed and actively practicing physicians and at least 1/3 licensed and actively practicing pharmacists. In addition, any state regulatory requirements for additional or specific types of membership will be included in the membership body.

B. Responsibilities and Duties of Committee Members

1. The DUR Board will have two Co-Chairpersons. The Co-Chairpersons shall be the Clinical Pharmacist for Drug Utilization Review programs (Chairperson and Clinical Pharmacy Operations for DUR programs) and the Director of Clinical Pharmacy Services (Chairperson and Clinical Pharmacy Operations). The responsibilities of these Chairs include:

    - Ensuring unbiased clinical perspective in areas such as prospective and retrospective utilization controls, protocols and interventions.

    - Reviewing and signing of the UnitedHealthcare Community & State DUR Board minutes, and of pertinent letters and documents relating to Board activity.

    - Representing the UnitedHealthcare Community & State DUR Board policies to the executive management of UnitedHealthcare Community & State and/or to UnitedHealthcare and its affiliates.

- Obtaining signed confidentiality and conflict of interest statements annually from UnitedHealthcare Community & State DUR Board.

2. The responsibilities of the UnitedHealthcare Community & State DUR Board members include:

   - Evaluating clinical programs for consistency with published clinical evidence;
   - Reviewing and approving clinical pharmacy programs and materials;
   - Reviewing materials pertinent to the meeting before the meeting, as well as reviewing other sources as needed to be knowledgeable about items on the agenda;
   - Providing support for clinical pharmacy programs;
   - Coordinating the communication of decisions made by the UnitedHealthcare Community & State DUR Board throughout UnitedHealthcare Community & State and its affiliates.
   - Volunteering and applying their knowledge of current medical and therapeutic practice during discussion.
   - Providing updates regarding any changes in conflict of interest status to the DUR Board Chairperson.

3. All members of the DUR Board will be required to complete a confidentiality and conflict of interest statement on an annual basis.

4. If a member has an interest that may affect or be perceived to affect the member's independence of judgement, the member must recuse himself/herself from the voting process. This recusal includes but is not limited to refraining from deliberation or debate, making recommendations, volunteering advice, and/or participating in the decision-making process in any way.

C. Activities of the DUR Board

1. Monitor and maintain Concurrent and Retrospective DUR programs as defined in RX-016 Drug Utilization Review.
2. The Board shall re-evaluate interventions to determine if active DUR programs have improved the quality of drug therapy, are successful interventions and make modifications as necessary.

D. Meetings

The UnitedHealthcare Community & State DUR Board shall meet at least semi- annually. The Board may elect to meet more often as necessary to review new program policies and/or to provide input to UnitedHealthcare Community & State or its affiliates regarding program issues. A quorum of 50% plus 1 of the UnitedHealthcare Community & State DUR Board members shall be necessary for the transaction of business. The Board shall

take action by the affirmative vote of a majority of DUR Board members present at a duly held meeting and any ties will be broken by one of the Co-Chairpersons. Meetings shall be scheduled at the beginning of each calendar year, and the dates shall be provided to members at that time. Changes to the meeting schedule are communicated to the Board members with adequate notice. Board members shall be expected to attend all meetings via teleconference. The agenda and meeting materials shall be provided to Board members in an adequate time frame to allow for proper review of the materials prior to the meeting as well as collegial consultation. Final minutes of the DUR Board shall be provided to and maintained by UnitedHealthcare Community & State Pharmacy Management.

DEFINITIONS:

RELATED POLICIES:

ATTACHMENTS/LINKS:

AUTHORITY/CITATIONS:

REFERENCES:

HISTORICAL CHANGE NOTES:

Date	Summary of Change	Reason for Change
October 4, 2011	New Policy	New policy to define the composition and responsibility of the Drug Utilization Review (DUR) Board.
September 18, 2012	Removed CMO approval signature	To be consistent across all Medical policies
December 2, 2013	Formatting change, Grammatical errors corrected	Annual review
August 12, 2014	Reviewed for accuracy. No changes made. New policy template. Added NQMOC date and last review date.	Annual review
August 5, 2015	Changes made to composition of committee. New Committee membership to comprise of Regional plan director plus 2 participants from each reason plus 2 chairpersons. Changed policy header to reflect the updated NQOC committee name	Align with committee recommendations made at DUR board meeting. Annual review

July 29, 2016	Reviewed for accuracy. Added CHIP to the Scope section	Annual review
January 11, 2017	Updated the Policy statement to include reference of the SSA. Updated the membership composition. Added the activities section. Updated all references to the DUR Committee to the DUR Board to match regulatory naming conventions.	Updated the policy to align with the requirements of the DUR Board found in 1927(g) of the Social Security Act.
January 16, 2018	Moved items related to conflict of interest forms and recusals from Section A. Composition to Section B. Responsibilities and Duties of a Committee Member. Deleted references to board members attending in person.	Annual review

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan DUR Board Committee Meeting Minutes

Meeting Date: March 20, 2018

Location: Via conference call/WebEx

Members	Title	Type	Status	Specialty
Denise Barker	Pharmacist	External	Voter	Retail Pharmacy
Tucker Freedy	Pharmacist	External	Voter	Clinical Pharmacy Specialist - Drug Information
Arethusa Kirk	Medical Doctor	Internal	Voter	Pediatric Practice
Rachel Cain	VA FFS DMAS Rep	External	Voter	Pharmacist
Lia Donato	Registered Nurse	External	Voter	Cardiology
Amanda Richardson	Registered Nurse	External	Voter	Emergency Room Practice
Leah Smtih	Clinical Pharmacist	Internal	Co-Chairperson	Clinical Pharmacy
Jason A Hackett	Director, Clin Pharmacy Op	Internal	Co - Chairperson	Clinical Pharmacy
James Hancovsky	Chief Pharmacy Officer for C&S	Internal	Non-Voter	Clinical Pharmacy
Hannah Kim	Clinical Pharmacist	Internal	Non-Voter	OptumRx
Kelsey Slanina	Clinical Pharmacist	Internal	Non-Voter	Clinical Pharmacy
Glenna Shutzberg	Clinical Pharmacist	Internal	Non-Voter	Clinical Pharmacy
Maddie Reisman	Clinical Pharmacist	Internal	Non-Voter	Clinical Pharmacy
Angela Molchan	Pharmacy Audit Analyst	Internal	Non-Voter	Pharmacy Lock-In
Kathy Neal	Pharmacy Audit Analyst	Internal	Non-Voter	Pharmacy Lock-In
Ashley Nichols	Pharmacy Audit Analyst	Internal	Non-Voter	Pharmacy Lock-In
Lorissa Bieranoski	Project Coordinator	Internal	Non-Voter	Clinical Pharmacy
Jeanne Cavanaugh	Regional Director, Pharmacy - Central	Internal	Non-Voter	Clinical Pharmacy
Mike Verba	Regional Director, Pharmacy - East	Internal	Non-Voter	Clinical Pharmacy
Ryan Bitton	Regional Director, Pharmacy - E&I Nevada market	Internal	Non-Voter	Clinical Pharmacy
Debra Schriber	Pharmacist Account Manager - HI	Internal	Non-Voter	Clinical Pharmacy
Nathan Musgrove	Pharmacist Account Manager - AZ	Internal	Non-Voter	Clinical Pharmacy
Kim Wong	Pharmacist Account Manager - RI	Internal	Non-Voter	Clinical Pharmacy
Rajeev Verma	Pharmacist Account Manager - VA	Internal	Non-Voter	Clinical Pharmacy
Bernadette Ueda	Pharmacist Account Manager - NE	Internal	Non-Voter	Clinical Pharmacy
Karrie Hansotia	Pharmacist Account Manager - IA	Internal	Non-Voter	Clinical Pharmacy
Matthew Samuel	Pharmacist Account Manager - NJ	Internal	Non-Voter	Clinical Pharmacy
Travis Ortiz	Pharmacist Account Manager - LA	Internal	Non-Voter	Clinical Pharmacy
Heather Odem	Pharmacist Account Manager - MS	Internal	Non-Voter	Clinical Pharmacy
Mona Kripalani	Pharmacist Account Manager - NY	Internal	Non-Voter	Clinical Pharmacy
Petra Eichelsdoerfer	Pharmacist Account Manager - WA, NM	Internal	Non-Voter	Clinical Pharmacy
Jennifer Murff	Pharmacist Account Manager - KS	Internal	Non-Voter	Clinical Pharmacy
Ankit Shah	Pharmacist Account Manager - CA	Internal	Non-Voter	Clinical Pharmacy
Tim Lew	Sr. Account Manager, Client Services	Internal	Non-Voter	OptumRx
Jomy Joseph	Sr. Account Manager, Client Services	Internal	Non-Voter	OptumRx
Toi Olden	Sr. Account Manager, Client Services	Internal	Non-Voter	OptumRx

Agenda Item	Speaker	Recommendation	Conclusions/Recommendations	Vote
Meeting called to order	L.Smith	Meeting called to order at 4:35PM EST		
A. Minutes of previous meetings	L.Smith	**Review of Minutes from August 15, 2017- Confirm review**	Yes/No	Yes
B. Retrospective Drug Utilization Review Programs	L.Smith	**National Results Quarter over Quarter of the 5 CORE RDUR programs**		
		Confirm review	Yes/No	Yes
	L.Smith	**State by State Results Quarter over Quarter of the 5 CORE RDUR programs- IN PACKET**		
		Confirm review	Yes/No	Yes
	L.Smith	**National Results Quarter over Quarter of the ASTHMA RDUR programs**		
		Confirm review	Yes/No	Yes
	L.Smith	**State by State Results Quarter over Quarter of the ASTHMA RDUR programs- IN PACKET**		
		Confirm review	Yes/No	Yes
	L.Smith	**National Results Quarter over Quarter of the POLY DRUG-DISEASE RDUR programs**		
		Confirm review	Yes/No	Yes
	L.Smith	**State by State Results Quarter over Quarter of the POLY DRUG-DISEASE RDUR programs- IN PACKET**		
		Confirm review	Yes/No	Yes
	L.Smith/H.Kim	**2018 OptumRx New Program Platform and Reporting Review**		
		Confirm review	Yes/No	Yes
	Comments:	**Leah Smith** will send out the RDUR prescriber fax template with the meeting minutes as we were not able to open the attachment during the meeting.		
C. Pharmacy Lock-In Program	L.Smith	**Overview of National UHC C&S Pharmacy lock-in program components**		
		Confirm review	Yes/No	Yes
	L.Smith	**Pharmacy Lock-in Statistics Quarter over Quarter**		
		Confirm review of lock-in enrollment, re-review, and release statistics	Yes/No	Yes
		Confirm review of lock-in program "first look" outcomes	Yes/No	Yes
D. Concurrent Drug Utilization Review Programs	L.Smith	**National Results Quarter over Quarter of the overall CDUR program**		
		Confirm review	Yes/No	Yes
	L.Smith	**Current State Overview of CDUR Soft Edit Program**		
		Confirm review	Yes/No	Yes
	L.Smith	**Additions to the Therapeutic Duplication Soft Edit Override CDUR Program**		
		Add the following classes fo the TD Soft edit program in the applicable markets: Angiotensin-converting enzyme inhibitors (ACE-I) and Angiotensin II receptor antagonists.	Motion made, seconded, and carried to accept recommendation	6:0
	L.Smith	**Additions to the Drug-Interaction Soft Edit Override CDUR Program**		
		Add the following classes fo the DDI Soft edit program in the applicable markets: Opioids + Carisoprodol, Linezolid + Serotonin Modulators, Ciprofloxacin + Tizanidine	Motion made, seconded, and carried to accept recommendation	6:0
	L.Smith	**Additions to the Theradose (High Dose) Soft Edit Override CDUR Program**		
		Add the following classes to the Theradose (High Dose) Soft edit program in the applicable markets: Proton Pump Inhibitors and Sleep Aides	Motion made, seconded, and carried to accept recommendation	6:0
E. Spotlight Focus: Opioid Statistics	L.Smith	**Review of UHC C&S Opioid Programs and Implementations**		
		Confirm Review	Yes/No	Yes
	L.Smith	**Review of Overall UHC Community Plan Opioid Prescribing Patterns**		
		Confirm Review	Yes/No	Yes
	L.Smith	**National Statistics Quarter over Quarter of the OptumRx Opioid Dashboard**		
		Confirm review	Yes/No	Yes

Agenda Item	Speaker	Recommendation	Conclusions/Recommendations	Vote
E. Spotlight Focus: Opioid Statistics	L.Smith	**State by State Statistics Quarter over Quarter of the OptumRx Opioid Dashboard- IN PACKET**		
		Confirm review	Yes/No	Yes
	L.Smith	**Opioid Educational Member Letters- New DUR Program Implementation**		
		Recommendation to enroll in the OptumRx Opioid Educational Mailing Program	Motion made, seconded, and carried to accept recommendation	6:0
	Comments:	**Denise Barker** asked if we have received feedback about letters and ensuring the language does not scare members. Maybe referencing emergenices regarding breathing problems. **Leah Smith** stated that there were some issues but the letters have been modified with OptumRx and our internal member review team.		
	L.Smith	**Update from August 2017 DUR Board Decisions**		
		Confirm Review: Educational DUR Newsletter – Opioid Community Partnership	Yes/No	Yes
		Confirm Review: Prescriber Outlier Letters – Health Plan Visits to Top Outlier Prescriber	Yes/No	Yes
Adjournment	L.Smith	Meeting concluded at 5:50PM EST		

Respectfully Submitted to the Committee,

James P. Hancovsky, M.S.I.A., R.Ph.
Chief Pharmacy Officer for C&S

<PLAN_PlanLogo1> <PLAN_PlanLogo2>

<RADR_ReturnAddressName>
<RADR_ReturnAddress1>
<RADR_ReturnAddress2>
Providerville, MN 12345

<TXHD_TransactionDate>

TO: <PROV_ProviderFormattedName>
FAX: <PROV_ProviderFax>
Pages: <Number of Pages>
Correspondence Number: <Correspondence ID>

<PROV_ProviderFormattedName><PROV_ProviderCredential>
<PROV_ProviderAddress1>
<PROV_ProviderAddress2>
<PROV_ProviderCity>, <PROV_ProviderState> <PROV_ProviderZip>

Re: Retrospective Drug Utilization Review Correspondence Number: <CPP_ID>

Dear. <PROV_ProviderFormattedName><PROV_ProviderCredential>

<PLAN_PBMName> administers the Retrospective Drug Utilization Review (RDUR) Program to promote the safe and appropriate use of medications for your patients who are <PLAN_PlanName1> members. The attached report identifies your patients with potential clinical concerns that require your attention.

This report does not take into account patient-specific variables that may factor into your prescribing decisions.

- If you have already identified the concern, please disregard this notice and continue to monitor your patient for potential issues.
- If you did not prescribe the identified medication(s), or if the patient is not under your care, please contact the dispensing pharmacy.
- If you like to make any therapy changes, please contact the dispensing pharmacy. This letter is not a valid prescription blank.

If you have questions about this report, please contact <PLAN_PBMName> at <CSPH_RDUR PhoneFaxTTY1>. Thank you.

Sincerely,

<PLAN_PlanSignature>
<PLAN_SignatureBlock1>
<PLAN_SignatureBlock2>
<PLAN_SignatureBlock3>

Enclosure

<PLAN_PlanLogo1> <PLAN_PlanLogo2>

Potential Clinical Concerns

Program Name	**<ProductName>**
Review Period	<IDTNn_IdentificationPerioidStartDate>-<IDTNn_IdentificationEndDate>
Provider:	<PROV_ProviderFormattedName> <PROV_ProviderUniqueID>
Case Number	<IDTNn_IdentificationID>
Patient Name:	<MEMDn_MemberFirstName> <MEMDn_MemberLastName>
Member ID:	<MEMDn_MemberID>
Date of Birth:	<MEMDn_MemberDOB>

Potential Clinical Concern(s)

<CLPRn_ClinicalRuleDescription>

<CLPRn_ClinicalRationale>

<CPRRn_ClinicalRationaleReference>

The following shows pharmacy claims related to the potential clinical concern identified above.

If you did not prescribe the identified medication(s), or if this is not your patient, please contact the dispensing pharmacy.

Drug Name	Fill Date	Quantity	Days Supply	Prescriber	Pharmacy
<CLTXn_ClaimDrugDisplayName>	<CLTXn_ClaimFilledDate>	<CLTXn_DrugQuantity>	<CLTXn_DaysSupply>	<CLTXn_ClaimProviderName> <CLTXn_ClaimPrescriberPhone>	<CLTXn_ClaimPharmacyName> < CLTXn_ClaimPharmacyPhone>
<CLTXn_ClaimDrugDisplayName >	<CLTXn_ClaimFilledDate>	<CLTXn_DrugQuantity>	<CLTXn_DaysSupply>	<CLTXn_ClaimProviderName> <CLTXn_ClaimPrescriberPhone>	< CLTXn_ClaimPharmacyName> < CLTXn_ClaimPharmacyPhone>

Note: The aggregate data used for this report may have limitations that could cause patients to be mistakenly identified [e.g., patient is deceased, no longer eligible for pharmacy benefits, already taking the recommended therapy, or not appropriate candidate for the recommended therapy]. If your patient has been mistakenly identified, please disregard this notice. You do not need to respond to this report. If you did not prescribe the identified medication(s), or if the patient is not under your care, please contact the dispensing pharmacy.

<PlanLogo1> <PlanLogo2>

Potential Clinical Concerns

Program Name	**<ProductName>**
Review Period	<IDTNn_IdentificationPerioidStartDate>-<IDTNn_IdentificationEndDate>
Provider:	<PROV_ProviderFormattedName> <PROV_ProviderUniqueID>
CaseNumber:	<IDTNn_IdentificationID>
Patient Name:	<MEMDn_MemberFirstName> <MEMDn_MemberLastName>
Member ID:	<MEMDn_MemberID>
Date of Birth:	<MEMDn_MemberDOB>

Potential Clinical Concern(s)

<CLPRn_ClinicalRuleDescription>

<CLPRn_ClinicalRationale>

<CPRRn_ClinicalRationaleReference>

Note: The aggregate data used for this report may have limitations that could cause patients to be mistakenly identified [e.g., patient is deceased, no longer eligible for pharmacy benefits, already taking the recommended therapy, or not appropriate candidate for the recommended therapy]. If your patient has been mistakenly identified, please disregard this notice. You do not need to respond to this report. If you did not prescribe the identified medication(s), or if the patient is not under your care, please contact the dispensing pharmacy.

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan DUR Board Committee Meeting Minutes

Meeting Date: September 27, 2018

Location: Via conference call/WebEx

Members	Type	Title	Status	Specialty
Denise Barker	External	Pharmacist	Voter	Retail Pharmacy
Tucker Freedy	External	Pharmacist	Voter	Clinical Pharmacy Specialist - Drug Information
Arethusa Kirk	Internal	Medical Doctor	Voter	Pediatric Practice
Rachel Cain	External	VA FFS DMAS Rep	Voter	Pharmacist
Lia Donato	External	Registered Nurse	Voter	Cardiology
Amanda Richardson	External	Registered Nurse	Voter	Emergency Room Practice
Leah Smtih	Internal	Clinical Pharmacist	Co-Chairperson	Clinical Pharmacy
Jason Hackett	Internal	Director, Clin Pharmacy Op	Co - Chairperson	Clinical Pharmacy
Jim Hancovsky	Internal	Chief Pharmacy Officer for C&S	Non-Voter	Clinical Pharmacy
Syd Mulder	Internal	Director, Clinical Pharmacy	Non-Voter	Clinical Pharmacy
Maria Theys	Internal	Clinical Pharmacist	Non-Voter	Clinical Pharmacy
Kelsey Slanina	Internal	Clinical Pharmacist	Non-Voter	Clinical Pharmacy
Glenna Shutzberg	Internal	Clinical Pharmacist	Non-Voter	Clinical Pharmacy
Maddie Reisman	Internal	Clinical Pharmacist	Non-Voter	Clinical Pharmacy
Steve Kramzer	Internal	Clinical Pharmacist	Non-Voter	Clinical Pharmacy
Kristi Fowler	Internal	Clinical Pharmacist	Non-Voter	Clinical Pharmacy
Jordan Collins	Internal	Business Process Analyst	Non-Voter	Clinical Pharmacy
Angela Molchan	Internal	Pharmacy Audit Analyst	Non-Voter	Pharmacy Lock-In
Kathy Neal	Internal	Pharmacy Audit Analyst	Non-Voter	Pharmacy Lock-In
Skylar Mcdowell	Internal	Pharmacy Audit Analyst	Non-Voter	Pharmacy Lock-In
Lorissa Bieranoski	Internal	Project Coordinator	Non-Voter	Clinical Pharmacy
Decinda Williams	Internal	Manager, Pharmacy	Non-Voter	Clinical Pharmacy
Jeanne Cavanaugh	Internal	Regional Director, Pharmacy - Central	Non-Voter	Clinical Pharmacy
Kelly Flannigan	Internal	Regional Director, Pharmacy - West	Non-Voter	Clinical Pharmacy
Michael Verba	Internal	Regional Director, Pharmacy - Northeast	Non-Voter	Clinical Pharmacy
Eileen Nolte	Internal	Pharmacist Account Manager - MD & PA	Non-Voter	Clinical Pharmacy
Debra Schriber	Internal	Pharmacist Account Manager - HI	Non-Voter	Clinical Pharmacy
Nathan Musgrove	Internal	Pharmacist Account Manager - AZ	Non-Voter	Clinical Pharmacy
Kim Wong	Internal	Pharmacist Account Manager - RI	Non-Voter	Clinical Pharmacy
Rajeev Verma	Internal	Pharmacist Account Manager - VA	Non-Voter	Clinical Pharmacy
Robert Schneider	Internal	Pharmacist Account Manager - MI	Non-Voter	Clinical Pharmacy
Karrie Hansotia	Internal	Pharmacist Account Manager - IA	Non-Voter	Clinical Pharmacy
Matthew Samuel	Internal	Pharmacist Account Manager - NJ	Non-Voter	Clinical Pharmacy
Mona Kripalani	Internal	Pharmacist Account Manager - NY	Non-Voter	Clinical Pharmacy
Petra Eichelsdoerfer	Internal	Pharmacist Account Manager - WA, NM	Non-Voter	Clinical Pharmacy
Ankit Shah	Internal	Pharmacist Account Manager - CA	Non-Voter	Clinical Pharmacy
Toi Olden	Internal	Sr. Account Manager, Client Services	Non-Voter	OptumRx

Agenda Item	Speaker	Recommendation	Conclusions/ Recommendations	Vote
Meeting called to order	L.Smith	Meeting called to order at 4:35PM EST		
A. Minutes of previous meetings	L.Smith	**Review of Minutes from March 20, 2018 - Confirm review**	Yes/No	Yes
B. Retrospective Drug Utilization Review Programs	L.Smith	**National Results 2018 RDUR Activities and Outcomes**		
		Confirm review	Yes/No	Yes
	L.Smith	**RDUR Program Selections for 2019**		
		Continue with all Safety Management programs and the Asthma Gaps in Care for 2019 and in addition add the following Gaps in Care programs from OptumRx: Cardiovascular, Diabetes, COPD, and HIV	Motion made, seconded, and carried to accept recommendation	6:0
	L.Smith	**Update RX-016 DUR Programs and RX-039 DUR Board Policies**		
		Added language about compliance with 42 CFR subpart K to the policies	Motion made, seconded, and carried to accept recommendation	6:0
C. Pharmacy Lock-In Program	A. Molchan	**Pharmacy Lock-in Statistics Quarter over Quarter**		
		Confirm review of lock-in enrollment, re-review, and release statistics	Yes/No	Yes
	Comments:	• **Question:** Virginia's lock-in recommend number was 58 but only 44 were locked in. Why weren't all members chosen for lock-in? • **UHC Response:** 58 members met the criteria and after review some members were either no longer on the plan or their behavior had changed. Raj stated that he will check the PMP as he reviews the members as well.		
	A. Molchan	**Update UHC RX-020 High Prescription Utilization Policy**		
		Added re-review criteria language to the policy	Motion made, seconded, and carried to accept recommendation	6:0
	Comments:	• **Question:** If one of the criteria were met during re-review, is the time extended to another full year period? • **UHC Response:** Yes.		
D. Concurrent Drug Utilization Review Programs	M. Theys	**National Results Quarter over Quarter of the overall CDUR program**		
		Confirm review	Yes/No	Yes
	M. Theys	**State by State Results Quarter over Quarter of the overall CDUR program- IN PACKET**		
		Confirm review	Yes/No	Yes
	M. Theys	**Current State Overview of CDUR Soft Edit Program**		
		Confirm review	Yes/No	Yes
	Comments:	• **Question:**What is the definition of a soft edit? • **UHC Response:** The claim will stop at the point of sale but the pharmacy can override the edit to get a paid claim with NCPDP codes, unlike a hard edit. • **Question:** So what is a hard edit? • **UHC Response: F**or a hard edit the provider would have to submit a prior authorization request. • **Question:** For the opioid + prenatal vitamin edit, what is the goal here? Counseling? • **UHC Repsonse:** The pharmacy should first verify pregnancy (our message states to verify pregnancy at the POS). Some members take prenatals who are not pregnant. This is the reason for the custom message only. The goal would be that if they verify the member is pregnant they would then counsel, call the prescriber, etc • **Question:** Does this edit require the pharmacy to respond? • **UHC Response:** There is no POS entry of NCPDP codes that is required to be sent back to us for this messaging.		
	M. Theys	**Additions to the Therapeutic Duplication Soft Edit Override CDUR Program**		
		Add the following classes fo the TD Soft edit program in the applicable markets: Anticoagulants, Antidepressants, and Immunomodulators.	Motion made, seconded, and carried to accept recommendation	6:0
	M. Theys	**Additions to the Theradose (High Dose) Soft Edit Override CDUR Program**		

Agenda Item	Speaker	Recommendation	Conclusions/ Recommendations	Vote
		Add the following classes to the Theradose (High Dose) Soft edit program in the applicable markets: Antipsychotics	Motion made, seconded, and carried to accept recommendation	6:0
	M. Theys	**Additions to the Drug Inferred Health State Custom Message CDUR Program**		
		Add the following classes to the Drug Inferred Health State Custom Message Program: Opioids+Doxylamine-Pyridoxine.	Motion made, seconded, and carried to accept recommendation	6:0

Agenda Item	Speaker	Recommendation	Conclusions/ Recommendations	Vote
D. Concurrent Drug Utilization Review Programs	M. Theys	**National Results Quarter over Quarter of the overall CDUR program**		
		Confirm review	Yes/No	Yes
	M. Theys	**State by State Results Quarter over Quarter of the overall CDUR program- IN PACKET**		
		Confirm review	Yes/No	Yes
	M. Theys	**Current State Overview of CDUR Soft Edit Program**		
		Confirm review	Yes/No	Yes
	M. Theys	**Additions to the Therapeutic Duplication Soft Edit Override CDUR Program**		
		Add the following classes fo the TD Soft edit program in the applicable markets: Anticoagulants, Antidepressants, and Immunomodulators.	Motion made, seconded, and carried to accept recommendation	6:0
	M. Theys	**Additions to the Theradose (High Dose) Soft Edit Override CDUR Program**		
		Add the following classes to the Theradose (High Dose) Soft edit program in the applicable markets: Antipsychotics	Motion made, seconded, and carried to accept recommendation	6:0
	M. Theys	**Additions to the Drug Inferred Health State Custom Message CDUR Program**		
		Add the following classes to the Drug Inferred Health State Custom Message Program: Opioids+Doxylamine-Pyridoxine.	Motion made, seconded, and carried to accept recommendation	6:0
E. Spotlight Focus: Pediatric Behavioral Healh RDUR Review	M. Theys	**Review of UHC Summary of Pediatric Behavioral Health RDUR Triggers**		
		Confirm Review	Yes/No	Yes
	Comments:	• **Question:** Are all the states receiving the review? • **UHC Response:** All states were part of the review - what we have displayed is the top 5 states with the highest number of triggers. • **Question:** Can the Virginia data be sent out for review to Rachel Cain? • **UHC Response:** Yes. Will send along with the minutes to this meeting. • **Questions:** Is Optum using their own data to identify members and how are the providers being notified? • **UHC Response:** Yes, OptumRx is running the RD□R programs out of its own system so benefits that are carved out are not included. Providers are notified on the day of identification by fax or mail if fax is unknown.The behavioral health prescriber is the one that is generally notified. • **Questions:** Does the carve-out in MD hinder the RD□R program there? • **UHC Response:** Yes. Maryland members would not be identifed for these issues since they do not have the data in their system. • **Questions:** So this is an opportunity to try and carve in pharmacy benefits to □HC. • **UHC Response**: Yes. •**Question:** What type of communication is sent to the providers? • **UHC Response:** A standard letter is mailed listing the medications of concern for the last 3 months and the clinical concern of the identified issue. • **Questions:** Is there any way to specifically trigger for foster care homes? There has been political news around children in foster care having a higher chance of receiving too many behavioral health medications. • **UHC Response:** Current reporting does not identify which members may be foster children. However, we do recieve member level detail reports through these programs and could be used by the plans to bump up against any members they know are part of the foster care system. They could then use these reports to follow up on any members that may have not been successful in the initial outreach. We are also working with Optum on better reporting functions and looking into polypharmacy to address these types of issues in children.		
	M. Theys	**Educational DUR Prescriber Newsletter**		
		Recommendation: Address therapeutic duplication concerns initially focusing on alpha agonists and drug-drug interactions with antidepressants and alpha agonists and benzodiazepines + stimulants and provide education on the severity of the most common interactions involving behavioral health medications	Motion made, seconded, and carried to accept recommendation	6:0
	M. Theys	**Evaluation of the current Drug-Age Intervention for Antipsychotic Medication**		

Agenda Item	Speaker	Recommendation	Conclusions/ Recommendations	Vote
		Recommendation: Ask OptumRx to reevaluate recommended ages and subsequent dose limitations of antipsychotics supported by the Prescribing Information and Clinical Literature to prevent lettering on appropriate and clinically supported therapies.	Motion made, seconded, and carried to accept recommendation	6:0
	M. Theys	**Additions to the Therapeutic Duplication Soft Edit Override CDUR Program**		
		Add the following classes fo the TD Soft edit program in the applicable markets: Alpha Agonists	Motion made, seconded, and carried to accept recommendation	6:0
E. Spotlight Focus: Opioid Statistics	L.Smith	**National Statistics Quarter over Quarter of the OptumR Opioid Dashboard**		
		Confirm review	Yes/No	Yes
Ad ournment	L.Smith	Meeting concluded at 5:45PM EST		

Respectfully Submitted to the Committee,

ames P. Hancovsky, M.S.I.A., R.Ph.
Chief Pharmacy Officer for C S

2. Does your MCO have a Medication Therapy Management Program?

- (●) Yes
- ( ) No

If the answer to question 2 is "Yes," please continue with questions a) and b) below.

a) Have you performed an analysis of the program's effectiveness?

- ( ) Yes, please provide a brief summary of your findings.

- (●) No

b) Is your DUR Board involved with this program?

- ( ) Yes
- (●) No

If the answer to question 2 is "No," are you planning to develop and implement a program?

- ( ) Yes
- ( ) No

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

   ○ Yes

   ◉ No

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

   ○ Yes
   ◉ No

2. RetroDUR?

   ○ Yes

   ◉ No

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

   ○ Yes
   ◉ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. Has your MCO included a brief description of policies that may impact generic utilization percentage as **Attachment 3 – Generic Drug Substitution Policies**?

   ◉ Yes

   ○ No

   See attachment naming instructions.

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 MCO have a more restrictive requirement?

   ◉ Yes

   ○ No

   If "Yes," check all that apply:

   ☐ Require that a MedWatch Form be submitted.

   ☐ Require the medical reason(s) for override accompany the prescription.

   ☒ Prior authorization is required.

   ☐ Prescriber must indicate "Brand Medically Necessary" on the prescription.

   ☐ Other, please explain.

UHCCS PHARMAC MANA EMENT OPERATIONAL POLIC AND PROCEDURES		
Sub ect: Generic Substitution Policy		
Policy Number: RX-026	**Issue Date:** March 1, 2008	**Last Review Date:** July 12, 2018
Approved By: James P. Hancovsky Chief Pharmacy Officer, UHC C&S	**Signature:** 	
Revision Date: July 12, 2018	**NQOC Approval Date:** August 2, 2018	

POLIC STATEMENT:

UnitedHealthcare Community & State identifies cost-effective, bioequivalent generic drugs for inclusion in the preferred drug lists.

SCOPE:

Pharmacy, Pharmacy Benefit Administrator (PBA), UnitedHealthcare Community Plan, Medicaid and CHIP.

PURPOSE:

To define the process of ensuring cost-effective generic drugs are included in the preferred drug lists and covered by the pharmacy benefits of UnitedHealthcare Community & State.

RESPONSIBILITIES/ACCOUNTABILIT :

A. It is the responsibility of UnitedHealthcare Community & State pharmacy management to keep up-to-date with respect to the introduction of generic products and their rating for substitution.

B. It is the responsibility of the PBA to ensure that the POS system is programmed correctly for generic substitution, as defined by UnitedHealthcare Community & State.

PROCEDURES FOR POLIC COMPLIANCE:

A. The UnitedHealthcare Community & State Pharmacy and Therapeutics Committee (P & T) determines which drugs are included in the preferred drug lists or formularies.

B. The PBAs and the pharmacy project leader reviews Medispan data base updates weekly, and the generic pipeline report at least quarterly, to determine when generic drugs

become available and if they are rated as bioequivalent by the U.S. Food and Drug Administration.

C. The PBA programs the point-of-sale (POS) system to reject multi-source brand drugs as non-preferred when equivalent generic drugs become available.

D. When pharmacy claims are adjudicated, the POS system rejects claims for the non-preferred multi-source brand drugs with a rejection message indicating that generic substitution is required, unless otherwise prohibited by state regulation.

E. UnitedHealthcare Community and State reserves the right, in certain instances to implement a brand over generic strategy if, economically, the brand with a rebated discount is more cost effective than the generic equivalent. Brand over generic strategies will be clearly defined in the PDL and POS messaging will reflect this preference to direct pharmacy claims processing to the appropriate product.

F. The prescriber can request coverage of a multi-source brand drug by contacting the Pharmacy Prior Notification Service (PNS) via fax, telephone, or electronic prior authorization.
   1. The prescriber provides documentation explaining the reason for the brand drug.
   2. PNS processes the request in accordance with coverage review guidelines for non-preferred drugs.

   NOTE: Regulatory requirements in some markets require the use of DAW codes 1 or 2, which would eliminate the need for a PNS request for a brand drug.

DEFINITIONS:

Generic drug - means a drug product approved by the Food and Drug Administration (FDA) as equivalent to the brand name innovator product.

Generic substitution - means the dispensing of a generic product for the chemically equivalent brand name product.

Point-of-Sale (POS) system - the PBA system that adjudicates pharmacy claims submitted electronically by UnitedHealthcare Community & State network pharmacies.

Pharmacy Project Leader - the designated pharmacy director, pharmacy manager, or clinical pharmacist assigned the responsibilities related to this policy.

Medispan data base – The database used by the PBA as the source of truth for drug classification as single source brand, multisource brand or generic.

RELATED POLICIES:

ATTACHMENTS/LINKS:

AUTHORIT□/CITATIONS:

REFERENCES:

HISTORICAL CHAN□E NOTES:

Date	Summary of Change	Reason for Change
November 6, 2009	Updated approval signature lines	Annual review.
December 15, 2010	Updated branding, removed Medicare process as this now follows P&Ps related to the Common Medicare Infrastructure (CMI).	Annual review.
September 26, 2011	Updated procedure to reflect weekly review of Medispan updates. Added definition of Medispan.	Annual review.
October 9, 2012	Removed CMO approval signature	To be consistent across all Medical policies
September 9, 2013	Updated policy reference in header.	Annual review.
August 27, 2014	Removed reference that identifies NTIs as exceptions to mandatory generic substitution as the exception no longer applies. Added reference to allow for state exceptions to mandatory generic substitution. New policy template. Added NQMOC date and last review date.	Annual review and update

August 7, 2015	Added reference reserving the right to implement brand over generic strategies. Added note to indicate there are some markets that allow DAW codes to be used in lieu of a prior auth request for brands. Changed policy header to reflect the updated NQOC committee name	Annual review and update
July 28, 2016	Reviewed for accuracy. No content changes made.	Annual review
August 28, 2017	Reviewed for accuracy. No content changes made.	Annual review
July 12, 2018	Reviewed for accuracy. Under Procedures for Policy Compliance (F) added electronic prior authorization to list of ways provider can request a brand name drug.	Annual review and update

Complete Table 2 – Generic Drug Utilization Data using the following Computation Instructions.

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.

Generic Utilization Percentage

To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	210,120	2,237,786	99,734

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. This file will be made available from CMS to facilitate consistent reporting across states with this data request.

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in *Table 2 – Generic Utilization Data*.

Number of Generic Claims:	2,237,786
Total Number of Claims:	2,547,640
Generic Utilization Percentage:	87.84

VII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☐ Deny claims and require prior authorization

   ☒ Refer to Lock-In Program

   ☒ Refer to Program Integrity Unit

   ☒ Other (i.e. SURS, Office of Inspector General), please explain.

   Beneficiaries may be referred to the state medicaid agency or law enforcement if the program integrity unit case warrants the referral.

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

   ◉ Yes

   ○ No

   If the answer to question 2 is "No," skip to question 3.

   If the answer to question 2 is "Yes," please continue.

   a) What criteria does your MCO use to identify candidates for Lock-In? Check all that apply:

      ☒ Number of controlled substances (CS)

      ☒ Different prescribers of CS

      ☒ Multiple pharmacies

      ☐ Number days' supply of CS

      ☐ Exclusivity of short acting opioids

      ☐ Multiple ER visits

      ☐ PDMP data

      ☐ Same FFS state criteria is applied

      ☒ Other, please explain.

      In addition to controlled substances we target medications with high abuse potential (muscle relaxers, sedating anxiolytics, gabapentin, etc.)

b) Do you have the capability to restrict the beneficiary to:

i) prescriber only

- ○ Yes
- ◉ No

ii) pharmacy only

- ◉ Yes
- ○ No

iii) prescriber and pharmacy only

- ○ Yes
- ◉ No

c) What is the usual Lock-In time period?

- ◉ 12 months
- ○ 18 months
- ○ 24 months
- ○ Other, please explain.

d) On average, what percentage of your Medicaid MCO population is in Lock-In status annually?

0.13 %

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   - ☐ Deny claims written by this prescriber
   - ☒ Refer to Program Integrity Unit
   - ☒ Refer to the appropriate Medical Board
   - ☐ Other, please explain.

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   - ☐ Deny claims
   - ☒ Refer to Program Integrity Unit
   - ☒ Refer to Board of Pharmacy
   - ☒ Other, please explain.

     Referral to Medicare Drug Integrity Contractor (MEDIC), law enforcement, etc and internally to Network Administrative Action Committee or the Network Pharmacy Escalation Committee for consideration of corrective actions, including possible removal from the network.

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?

   ◉ Yes, please explain your program for fraud, waste or abuse of non-controlled substances.

   The targeted medication list for the pharmacy lock-in program includes select noncontrolled medications to help identify members for enrollment. Examples include gabapentin and cyclobenzaprine.

   ○ No

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Do you require prescribers (in your provider agreement with your MCO) to access the PDMP patient history before prescribing controlled substances?

   ○ Yes, please explain how the MCO applies this information to control fraud and abuse.

   ◉ No

   ○ No, the state does not have a PDMP

2. Does your MCO have the ability to query the state's PDMP database?

   ○ Yes

   ◉ No

   If "Yes," are there barriers that hinder your MCO from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

   ○ Yes, please explain the barriers that exist.

   ○ No

3. Does your MCO have access to border states' PDMP information?

   ○ Yes

   ◉ No

C. PAIN MANAGEMENT CONTROLS

1. Does your MCO obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

   (●) Yes

   ( ) No

   If the answer to question 1 is "No," skip to question 2.

   If the answer to question 1 is "Yes," please continue.

   Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

   (●) Yes

   ( ) No

   If "Yes," please explain how information is applied.

   The Health Plan of Nevada Medicaid implement comprehensive edits to prevent adjudication of Medicaid claims with an inactive or invalid prescriber NPI and DEA. Validation will occur at (POS) Point of Sale during prescription fulfillment. To be compliant with the Federal and State guidance, OptumRx will require prescribers' DEA numbers who have the authority to prescribe controlled substances. A claim submitted with a DEA number that does not have the right prescribing authority for

   If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

   ( ) Yes

   ( ) No

2. Do you apply this DEA file to your RetroDUR reviews?

   ( ) Yes, please explain how it is applied.

   (●) No

3. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

   - (●) Yes
   - ( ) No, please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

D. OPIOIDS

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

   - ( ) Yes, for all opioids
   - (●) Yes, for some opioids
   - ( ) No, for all opioids

   If the answer to question 1 is "No," skip to question 2.

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

   a) Is there more than one quantity limit for the various opioids?

      - (●) Yes, please explain.

        The following quantity limits are in place for opioid claims for The Health Plan of Nevada Medicaid:
        1. For short-acting opioid claims that meet the new to therapy requirements (no opioid claims in the last 60 days) a maximum of 7 days supply (for members 20 years of age or older) or 3 days supply (for members less than 20 years of age) and a maximum of less than 50 MME is set.

      - ( ) No

b) What is your maximum number of days allowed for an initial opioid prescription?

7 days

c) Does the above initial day limit apply to all opioid prescriptions?

- ○ Yes
- ◉ No, please explain.

The initial limits only apply to short-acting opioid products. Of note, long-acting opioid products require prior authorization before initial use with one criteria being adequate trial of short-acting opioid therapy before initiating a long-acting product.

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

   ◉ Yes

   ○ No

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

   ◉ 30 day supply

   ○ 90 day supply

   ○ Other, please explain.

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?

   ◉ Yes

   ○ No

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

   ◉ 30 day supply

   ○ 90 day supply

   ○ Other, please explain.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

   ◉ Yes

   ○ No

   If "Yes," please check all that apply:

   - ☒ Pharmacist override
   - ☒ Deny claim and require PA
   - ☒ Intervention letters
   - ☒ Morphine equivalent daily dose (MEDD) program
   - ☒ Step therapy or clinical criteria
   - ☐ Requirement that patient has a pain management contract or Patient-Provider agreement
   - ☐ Requirement that prescriber has an opioid treatment plan for patients
   - ☐ Require documentation of urine drug screening results
   - ☒ Other, please explain what additional opioid prescribing controls are in place.

     1. For opioids that require prior authorization before use or exceed the set limits, a prescriber attestation is required. The attestation aligns with appropriate prescribing monitoring for continuous opioid therapy. (i.e. Provider has screened for substance abuse/opioid dependence,treatment goals are defined, including duration of treatment, completed assessment for respiratory depression if co-morbid conditions or concurrent therapy are present , etc)

   If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

   ◉ Yes, please explain.

   The Health Plan of Nevada Medicaid has implemented a soft edit at the point of sale to flag opioid and benzodiazepine concurrent utilization claims. A soft edit at the point of sale means the pharmacist will need to address the clinical situation at the point of sale before entering appropriate NCPDP codes to receive a paid claim. No prior authorization is needed for this approach.

   ○ No

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis?

   ○ Yes

   ◉ No

   If the answer to question 6 is "Yes," please indicate how often:

   ○ Monthly

   ○ Quarterly

   ○ Semi-Annually

   ○ Annually

   ○ Other, please explain.

   If the answer to question 6 is "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

   ◉ Yes

   ○ No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

   ◉ Yes

   ○ No

   For either "Yes" or "No," please check all that apply:

   ☒ Your MCO refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain. Please identify the "referred" guidelines.

   The Health Plan of Nevada Medicaid has created a opioid resource section on our provider facing website. One page PDF resources range in topic from naloxone coverage to treatment alternatives for common pain conditions. UHC also provide links to external resources and guidelines including: 1. Agency for Healthcare Research and Quality (AHRQ) - Interagency Guideline on Prescribing Opioids for Pain. 2. Centers for Disease Control and Prevention - CDC Guidelines for

   ☐ Other guidelines, please identify.

   ☐ No guidelines are offered.

8. Do you 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)?

   ○ Yes, please explain.

   ◉ No

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

   ◉ Yes

   ○ No

   If the answer to question 1 is "Yes," please continue.

   a) What is your maximum morphine equivalent daily dose limit in milligrams?

   180 mg per day

   b) Please explain (i.e. are you in the process of tapering patients to achieve this limit?).

   Providers are not required to taper members to a dose below the cumulative MME threshold set at the point of sale but a prior authorization requirement is set at 180 MME. The prior authorization criteria for this edit ensures that the providers are properly monitoring and following up with members according to CDC recommended monitoring of chronic opioid therapy patients. In order to continue therapy on doses exceeding 180 MME providers are required to get subsequent prior authorizations

   If the answer to question 1 is "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

   ◉ Yes

   ○ No

   If the answer to question 2 is "No," skip to question 3.

   If the answer to question 2 is "Yes," please continue.

   a) Please name the developer of the calculator.

   Centers for Disease Control and Prevention

   b) How is the information disseminated? Check all that apply:

   ☒ Website

   ☒ Provider notice

   ☐ Educational seminar

   ☒ Other, please explain.

   One of the links on our provider website goes to the provider opioid resource center on the CDC website. On this site one of the CDC resources on the site focuses on calculating safe opioid doses. In addition, our provider notice for the contained the conversion factors for all opioids and encouraged providers to utilize the CDC Opioid Guideline App which contains their CDC calculator.

3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

   - (●) Yes
   - ( ) No

   If "Yes," do you require prior authorization if the MEDD limit is exceeded?

   - (●) Yes
   - ( ) No

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

1. Does your MCO set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

   - (●) Yes
   - ( ) No

   If "Yes," please specify the total mg/day:

   - ( ) 12 mg
   - ( ) 16 mg
   - (●) 24 mg
   - ( ) Other, please explain.

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

   - ○ 6 months
   - ○ 12 months
   - ◉ No limit
   - ○ Other, please explain.

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

   - ○ Yes
   - ◉ No

   If "Yes," please continue.

   a) What is your reduced (maintenance) dosage?

      - ○ 8 mg
      - ○ 12 mg
      - ○ 16 mg
      - ○ Other, please explain.

b) What are your limitations on the allowable length of the reduced dosage treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other, please explain.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

- ◉ Yes
- ○ No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

- ◉ Yes
- ○ No
- ○ Other, please explain.

If "Yes," can the POS pharmacist override the edit?

- ◉ Yes
- ○ No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

   ◉ Yes

   ○ No

7. Does your MCO allow pharmacists to dispense naloxone prescribed independently, or by collaborative practice agreements, or standing orders, or other predetermined protocols?

   ◉ Yes

   ○ No

8. Does your MCO cover methadone for OUD (i.e. Methadone Treatment Center)?

   ◉ Yes

   ○ No

G. ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

   ◉ Yes

   ○ No, please explain.

2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

   ◉ Yes

   ○ No

   If "Yes," please continue.

   a) Do you either manage or monitor:

      ○ Only children in foster care

      ○ All children

      ◉ Other, please explain.

      The Health Plan of Nevada Medicaid's monitoring strategy of antipsychotics not only applies to all children, but all adult members as well.

   b) Do you have edits in place to monitor (check all that apply):

      ☒ Child's Age

      ☒ Dosage

      ☒ Polypharmacy

      ☐ Other

   c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

      1. Prior authorization is required when an antipsychotic is being utilized for a non-FDA approved age or a dosage is above FDA approved maximums 2. CDUR therapeutic duplication edits are in place for antipsychotics at the point of sale that can be overridden by a pharmacist. 3. Retrospective DUR programs - OptumRx runs multiple safety management RDUR programs that include antipsychotic medications. These RDUR programs send faxes to prescribers within 24 hours of the identified

If you do not have an antipsychotic monitoring program in place, do you plan on implementing a program in the future?

- ○ Yes
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?
   - ◉ Yes
   - ○ No

4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?
   - ◉ Yes
   - ○ No

   If the answer to question 4 is "Yes," please continue.

   a) Do you either manage or monitor:
      - ○ Only children in foster care
      - ○ All children
      - ◉ Other, please explain.

        The Health Plan of Nevada Medicaid's monitoring strategy of stimulants not only applies to all children, but all adult members as well.

b) Do you have edits in place to monitor (check all that apply):

☒ Child's Age

☒ Dosage

☒ Polypharmacy

c) Please briefly explain the specifics of your documented stimulant monitoring program(s).

1. Prior authorization is required when a stimulant is being utilized for a non-FDA approved age or if a dosage is above FDA approved maximums. 2. Therapeutic duplication and Cumulative High Dose edits are in place for stimulants at the point of sale that can be overridden by a pharmacist with appropriate NCPDP codes. 3. Retrospective DUR programs -OptumRx runs multiple safety management RDUR programs that include stimulant medications. These RDUR programssend faxes to

If the answer to question 4 is "No," that is you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

○ Yes

○ No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

VIII. INNOVATIVE PRACTICES

Attachment 4 – Innovative Practices

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing)? Please describe in detailed narrative form 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 prior authorizations, continuing education programs).

*Please include **Attachment 4** described above when submitting this survey. (See naming instructions.)*

Simplify the Way You Prescribe Medicine

Get patient-specific benefits data within your EMR at the time of care

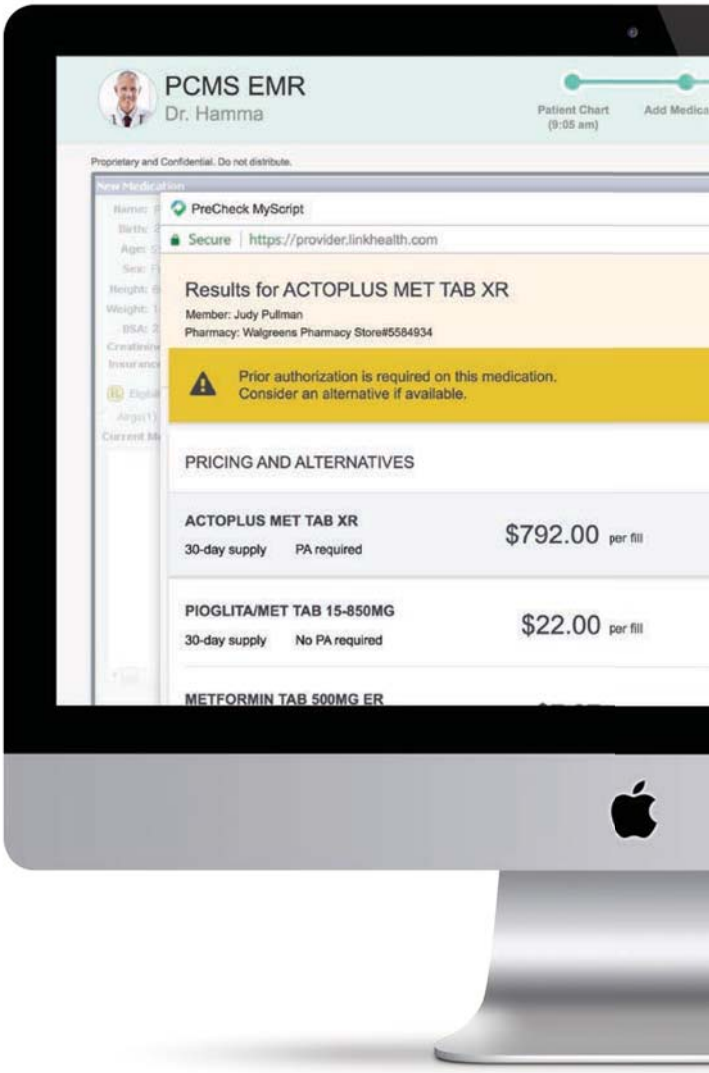
UnitedHealthcare is continually working with care providers to help increase member satisfaction and reduce frustration and delays. One way we're doing this is by making member benefit information — including drug costs — available at no cost within your electronic medical record (EMR) platform and as a standalone tool through OptumRx PreCheck My Script. You may already be using it within your EMR.

Patient-Specific Prescription Data

Unlike other benefit check solutions, PreCheck MyScript runs a trial claim from UnitedHealthcare's claims systems so your patient's benefit and medication information is accurate and up to date. With PreCheck MyScript, **you'll be able to tell your patient how much their medication will cost** based on their preferred pharmacy and benefit plan coverage. The price you see on the screen is what's in our pharmacy claim platform at that moment for that pharmacy and the member's benefit plan.

Helping Patients at the Point of Care

PreCheck MyScript can provide suggestions for lower-cost options, if available, or for medications that may not require prior authorization. This allows you to discuss costs and options with your patient while they're still in your office — before the prescription is sent to the pharmacy. See example on your right.

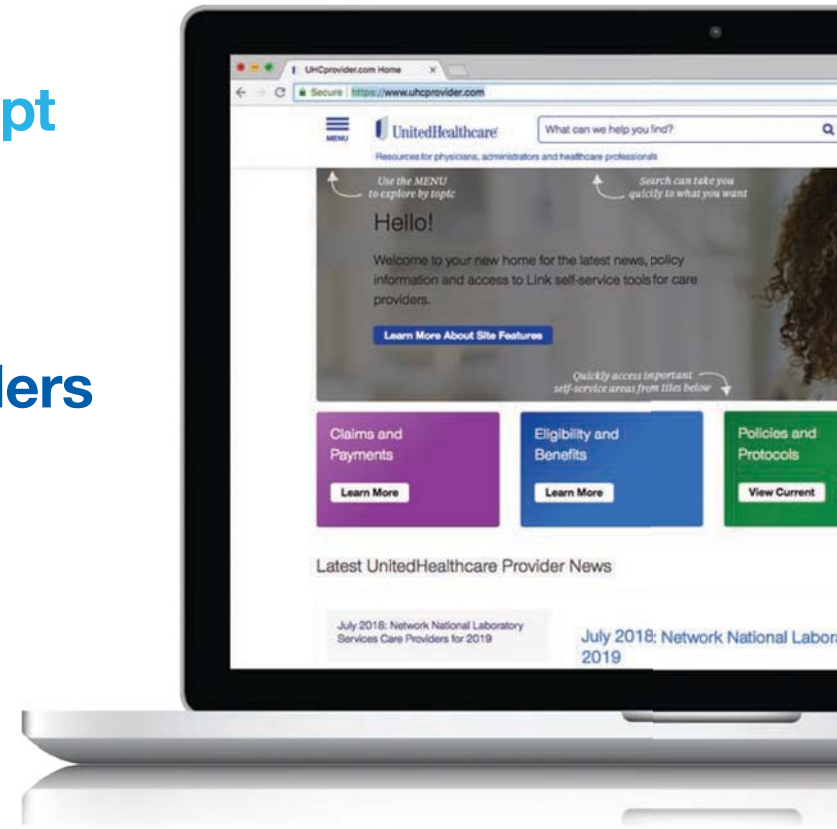


UnitedHealthcare®

It’s Easy to Request Prior Authorization

When you prescribe a medication that needs prior authorization, you’ll see an alert on your EMR screen. PreCheck MyScript makes it easy to submit your prior authorization request. The member’s plan-specific information is pre-populated, so you just need to answer some questions specific to that drug and submit the request electronically — often receiving approval within seconds. You can also see if a prescription isn’t covered, or is non-preferred.

Since PreCheck MyScript launched in July 2017, it’s helped reduce prior authorization requests and allowed care providers to discuss actual drug costs and options with their patients.



Addressing the Opioid Epidemic

PreCheck MyScript can help you manage a patient’s pain prescriptions and help prevent misuse by:

- Notifying you of alternative drug options
- Alerting you when prior authorization is required
- Advising when a patient has exceeded cumulative dosing limits

Use Within Your EMR or Online

PreCheck MyScript is currently available in three of the most common EMR platforms:

It's also called Real Time Benefit Check or myBenefit Check, depending on the EMR platform.

If you use a different EMR, you can still access PreCheck MyScript on Link through **UHCprovider.com/pcms**.

Get Started Today

For more information or to schedule a demonstration, contact your UnitedHealthcare Provider Advocate, or email **pcms_provider_information@uhc.com**.

UnitedHealthcare®

PreCheck MyScript□

□etter clinical decisions which leads to lower costs for patients, better adherence and health outcomes

Consumer

- □80 per script savings[1]
- □p to 4□ higher medication adherence[1]
- 80□ shift from tier 3 medications to lower tier[1]

Client

- □415 benefit plan savings per switch[1]
- Higher medication adherence may lead to lower Total Cost of Care

Pharmacist

- □1.□8 per script[1]
- 32□ pharmacist administrative cost savings with PCMS[1]

Physician

- 19□ decrease in cost[1]
- □24.49 savings per PA for physician/office staff[1]
- Within EMR work stream
- 80□ access in 2020[1]

2018 Performance[2]

110K+	Providers □tilizing
2.6M	Members Impacted
13.3M+	Transactions Generated
□2 sec	Application response time

□20□ of all transactions with an alternative resulted in a **drug change**[2]

□30□ of PreCheck MyScript prior authorizations were **initiated electronically or avoided**[2]

1. Third party analysis of OptumRx claims data. November, 2018. 2.OptumRx internal data, November 2018

IX. E-PRESCRIBING

1. Does your pharmacy system or vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

   ○ Yes

   ◉ No

   If the answer to question *1 is "Yes,"* do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

   ○ Yes, please explain the evaluation methodology in **Attachment 5 – E-Prescribing Activity Summary**. Describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

   *Please include **Attachment 5** described above when submitting this survey. (See naming instructions.)*

   ○ No

   If the answer *to question 1 is "No,"* are you planning to develop this capability?

   ◉ Yes

   ○ No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

   ◉ Yes

   ○ No

X. EXECUTIVE SUMMARY

Attachment 6 – Executive Summary

*Please include **Attachment 6** when submitting this survey. (See naming instructions.)*

Executive Summary

The objective of the Health Plan of Nevada's Drug Utilization Review (DUR) Program is ensuring that prescriptions are appropriate, medically necessary and not likely to result in adverse medical events. Our DUR program consists of four major components: retrospective DUR, prospective DUR, pharmacylock-in programs, and Pharmacy & Therapeutics (P&T) Committee.

The Health Plan of Nevada's retrospective DUR is carried out by OptumRx who reviews pharmacy claims data for our focused drug classification interventions or targeted DURs. As we identify potentially adverse patterns, we work with OptumRx to implement existing or new interventions that may yield improved outcomes and cost savings. On an ongoing basis, we perform targeted retrospective DURs based on claims data spanning timeframes of one day to six months. DUR-identified physicians are sent a letter describing the medications related problem and profiles of affected members. OptumRx continuously runs 8 retrospective DUR programs in Nevada including: polypharmacy therapeutic duplication, narcotic drug utilization review, drug interaction alerts, age rx monitoring, average daily dose/dose per day monitoring, overutilization days supply monitoring, polypharmacy drug disease interactions, and asthma therapy optimization programs.

The Health Plan of Nevada's prospective DUR is also carried out by OptumRx who utilizes their electronic claims system in conjunction with the Medispan database of identified drug therapy problems to define prospective/concurrent DUR edits. Any prescription that triggers one of our prospective DUR edits will be flagged. Based on the specific messaging or criteria programmed in the system, the real-time message sent to the dispensing pharmacist may indicate a hard reject of the prescription requiring prior authorization, a soft reject of the prescription requiring the pharmacist to enter appropriate NCPDP codes, or it may be a warning along with a paid claim that will prompt interaction and discussion with the member to determine the appropriateness of the medication being requested. The determination of which edits are flagged as hard, soft, or a message only warning are managed and maintained through the UnitedHealthcare DUR Board committee. All of these prospective utilization management tools adhere to contractual requirements.

The Health Plan of Nevada's Pharmacy lock-in program identifies and manages members that meet criteria indicative of potential misuse or abuse of prescription medications in specific therapeutic categories with the potential for high abuse, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances, etc) in order to minimize the occurrence of drug abuse and diversion of these medications. The program adheres to all criteria and program components that are contractually required.

The Health Plan of Nevada Pharmacy Services is charged with utilization review of specific medications to ensure that the use of these medications is consistent with clinical guidelines. In their review, the Health Plan of Nevada Pharmacy Services follows criteria established by UHC's P&T Committee that are consistent with FDA indications, medical literature and current medical practice. Medications targeted for utilization review include specialty products, second-line pharmaceuticals and branded therapeutic alternatives. The prior authorization process steers prescribers to high-quality cost-effective therapies, while still allowing the prescribing of non-preferred alternatives on a case-by-case basis as a member's care warrants. The prior authorization program adheres to all criteria and program components that are contractually required.

Annual DUR Survey

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities. 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.

This report covers the period October 1, 2017 to September 30, 2018. **Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory and regulatory requirements.**

If you have any questions regarding the DUR Annual Report, please contact your state's Medicaid Pharmacy Program.

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

I. DEMOGRAPHIC INFORMATION

MCO Name: SILVER SUMMIT HEALTH PLAN

Medicaid MCO Information

Identify your MCO person responsible for DUR Annual Report Preparation.

First Name: THOMAS

Last Name: BERANEK

Email Address: THOMAS.L.BERANEK@SILVERSUMMITHEALTHPLAN.COM

Area Code/Phone Number: 844-366-2880

1. On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

50,000 beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify it by name.

- ○ State-operated
- ◉ Contractor, please identify by name.

  ENVOLVE PHARMACY SOLUTIONS

- ○ Other organization, please identify by name.

2. Identify prospective DUR criteria source.

- ☐ First Data Bank
- ☒ Medi-Span
- ☐ Other, please specify.

3. Who reviews your new prospective-DUR criteria?

- ☐ MCO's DUR Board
- ☐ FFS agency DUR Board
- ☒ Other, please explain.

DUR is a function of the local P&T Committee.

4. Are new ProDUR criteria approved by the DUR Board?

- ◉ Yes
- ○ No, please explain.

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

- (●) Yes
- ( ) No
- ( ) Partial, please explain.

6. Do you receive and review follow-up periodic reports providing individual pharmacy provider override activity in summary and/or in detail?

   ◉ Yes

   ○ No, please explain.

If the answer to question 6 is "No," skip to question 7.

If the answer to question 6 is "Yes," please continue below.

a) How often do you receive reports?

   ◉ Monthly

   ○ Quarterly

   ○ Annually

   ○ Other, please explain.

b) Do you follow up with those providers who routinely override with interventions?

- ○ Yes
- ◉ No, please explain.

Currently no pharmacies identified as outliers requiring outreach.

If the answer to question 6b is "No," skip to question 7.

If the answer to question 6b is "Yes," please continue below.

By what method do you follow up?

- ○ Contact Pharmacy
- ○ Refer to Program Integrity for Review
- ○ Other, please explain.

7. **Early Refill**

a) At what percent threshold do you set your system to edit?

Non-controlled drugs:

80.00 %

Schedule II controlled drugs:

90.00 %

Schedule III through V controlled drugs:

90.00 %

b) **For non-controlled drugs**

When an early refill message occurs, does your MCO require prior authorization?

- ○ Yes
- ◉ No

If the answer to question 7b is "Yes," who obtains authorization?

- ○ Pharmacist
- ○ Prescriber
- ○ Either

If the answer to question 7b is "No," can the pharmacist override at the point of service?

- ○ Yes
- ◉ No

c) **For controlled drugs**

When an early refill message occurs, does your MCO require prior authorization?

- ○ Yes
- ◉ No

If the answer to question 7c is "Yes," who obtains authorization?

- ○ Pharmacist
- ○ Prescriber
- ○ Either

If the answer to question 7c is "No," can the pharmacist override at the point of service?

- ○ Yes
- ◉ No

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

- ☐ Lost/stolen Rx
- ☐ Vacation
- ☒ Other, please explain.

The pharmacist can't override at point of sale, but the Pharmacy Benefit Manager and/or pharmacy team member at SilverSummit Heatlhplan can enter overrides for Lost/Stolen, Vacation, Dose Increase/Change, and first fill of long acting injectable antipsychotics (Abilify Maintena, Aristada, Invega Sustenna, Invega Trinza, Risperdal) if they are rejecting for Specialty Pharmacy.

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

- ○ Yes
- ◉ No

If "Yes," please explain your edits.

If "No," do you plan to implement this edit?

- ◉ Yes
- ○ No

10. Does the MCO 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)?

- ○ Yes
- ◉ No

11. Does your MCO have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled chronic medication refills at the same time, your MCO would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

- ◉ Yes
- ○ No

12. For drugs not on your MCO's formulary, does your MCO have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

- (●) Yes
- ( ) No

If "Yes," what is the preauthorization process?

The provider may submit a request through covermymeds.com or by faxing a completed prior authorization form to the PBM.

If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

13. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

Table 1: Top Drug Claims Data Reviewed by the DUR Board

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name	**Column 2** Top 10 Prior Authorization (PA) Requests by Drug Class	**Column 3** Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)	**Column 4** Top 10 Drug Names by Amount Paid	**Column 5** % of Total Spent for Drugs by Amount Paid From data in Column 4, determine the % of total drug spend.	**Column 6** Top 10 Drug Names by Claim Count	**Column 7** Drugs by Claim Count % of Total Claims From data in Column 6, determine the % of total claims.
Hydroco/apap	Opioid Combinations	PLAN LIMITATIONS EXCEEDED	Genvoya	4.49 %	Ibuprofen	3.39 %
Oxycodone	Opioid Agonists	PRIOR AUTHORIZATION REQUIRED	Mavyret	3.59 %	Albuterol Sulfate	3.03 %
Oxycod/apap	Opioid Partial Agonists	NDC NOT COVERED	Truvada	2.61 %	Atorvastatin Calcium	2.11 %
Norco	Amphetamines	REFILL TOO SOON	Tivicay	2.38 %	Gabapentin	2.10 %
Tramadol Hcl	Anticonvulsants - Misc.	DUR REJECT ERROR	Triumeq	2.15 %	Hydrocodone-Acetaminophen	2.08 %
Suboxone	Selective Serotonin Reuptake Inhibitors		Suboxone	2.14 %	Amoxicillin	1.96 %
Percocet	Central Muscle Relaxants		Descovy	1.94 %	Lisinopril	1.95 %
Morphine Sul	Serotonin-Norepinephrine Reuptake Inhibitors		Latuda	1.90 %	Metformin HCl	1.66 %
Vyvanse	Dibenzapines		Epclusa	1.57 %	Sertraline HCl	1.32 %
Lyrica	Diagnostic Tests - BG Test Strips		Tecfidera	1.48 %	Amlodipine Besylate	1.28 %

III. RETROSPECTIVE DUR (RetroDUR)

1. Does your MCO utilize the same DUR Board as the state Fee-For-Service (FFS) agency or does your MCO have its own DUR Board?

   - (●) Same DUR Board as FFS agency
   - ( ) MCO has its own DUR Board
   - ( ) Other, please explain.

2. Identify the entity, by name and type, that performed your RetroDUR activities during the time period covered by this report (company, academic institution, other organization, or indicate if your MCO executed its own RetroDUR activities).

   Envolve People Solutions provides Retro DUR reports to SilverSummit Healthplan (SSHP). SSHP uses the provided data to determine which Retro DUR activities to execute. The pharmacy team sends out DUR letters to members and providers as warranted.

3. Who reviews and approves the RetroDUR criteria?

   - (●) State DUR Board
   - ( ) MCO DUR Board
   - ( ) Other, please explain.

4. Has your MCO included **Attachment 1 – Retrospective DUR Educational Outreach Summary**, a year end summary of the Top 10 problem types for which educational interventions were taken?

   ◉ Yes

   ○ No

   See attachment naming instructions.

IV. DUR BOARD ACTIVITY

1. Has your MCO included a brief summary of DUR Board activities during the time period covered by this report as **Attachment 2 - Summary of DUR Board Activities**?

   ◉ Yes

   ○ No

Attachment 2 – Summary of DUR Board Activities

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
  a) For prospective DUR, list problem type/drug combinations added or deleted.
  b) For retrospective DUR, list therapeutic categories added or deleted.
- 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.
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

See attachment naming instructions.

FFY 2018
Silver Summit Health Plan

Attachment 1 – Retrospective DUR Educational Outreach Summary FFY 2018

Silversummit Healthplan utilizes a comprehensive retrospective DUR program to positively impact the quality of care delivered to our members.

Outreach Topic Criteria

SilverSummit Healthplan identifies multiple gaps in therapy, underutilization or concerns in treatment for members as outlined below:

1) Morphine Equivalent Benchmark– To identify members who are using opioids at doses greater than or equal to 90mg of morphine per day (cancer patients excluded).
2) Diabetes ACEI/ARB – To identify members who are at risk for diabetic nephropathy, but are not currently being treated with the recommended preventative medications.
3) Prescriber Profiling – Opioids - To identify physicians who are prescribing opioid analgesics to ≥ 75% of their patients/members (prescribers are excluded if they have prescribed to < 5 members during the report month).
4) Therapeutic Duplications - To identify members concurrently using 2 or more proton pump inhibitors (PPIs).
5) Respiratory Under Use – Identify members with a respiratory condition, who are over-utilizing their short acting beta agonist (rescue medications).
6) Multiple Opioid Prescribers – To identify members who are either being fraudulent or abusive with opioid analgesic medication.
7) Drug Disease Conflict - Dementia Beers Criteria High Risk Patient – To identify members who are 65 years of age and older, who are currently using a medication from the Beers Criteria list.
8) Respiratory: Inappropriate Utilization of Long Acting Beta Agonists (LABA) - To identify members who are using long-acting beta agonists (LABA) without concurrent use of an inhaled corticosteroid (despite black box warning).
9) Drug Age Conflict – BEERS - To identify members who are 65 years of age and older, who are currently using a medication from the Beers Criteria list (Strength of Recommendation – Strong & Recommendation – Avoid).
10) Acetaminophen Over-Utilization - To identify members using acetaminophen (APAP) containing product(s) with doses of APAP over 4000mg per day.

	Total Interventions				
Outreach Topic	**Q4 2017**	**Q1 2018**	**Q2 2018**	**Q3 2018**	**Total**
Morphine Equivalent Benchmark	318	364	218	232	1132
Diabetes ACEI/ARB	123	175	194	196	688
Prescriber Profiling - Opioids	33	46	53	50	182
Therapeutic Duplications	34	15	27	32	108
Respiratory Underuse	9	13	17	17	56
Multiple Opioid Prescribers	4	6	5	5	20
Drug Disease Conflict - Dementia	4	5	4	7	20
Respiratory: Inappropriate Utilization of Long Acting Beta Agonists (LABA)	2	7	3	4	16
Drug Age Conflict - BEERS	1	0	1	10	12
Acetaminophen Over-Utilization	0	3	0	6	9

FFY 2018
Silver Summit Health Plan

Attachment 2 – Summary of DUR Board Activities

The standard prospective (pDUR) and retrospective drug use review (rDUR) programs are delegated to the designated pharmacy benefit manager (PBM), Envolve Pharmacy Solutions, utilizing the standards, criteria, protocols and procedures established by the mutual agreement of the Centene Corporate Pharmacy and Therapeutics Committee, SilverSummit Healthplan, and Envolve Pharmacy Solutions, and in accordance with applicable state and federal requirements and NCQA standards. The DUR program is submitted for review and approval to the Centene Corporate and Health Plan Pharmacy and Therapeutics Committees annually. The DUR program is designed to alert prescribers and/or dispensing pharmacists by identifying overuse, underuse, inappropriate or medically unnecessary care, and to address safety concerns associated with specific drugs, including the potential for drug interactions. The DUR program also functions to identify opportunities to improve the quality of care for patients including adherence to prescribed therapy and improvements in the medication regimen consistent with the patient's diagnoses or conditions. The results of any rDUR programs may also be used to initiate additional claims review and analysis at the health plans. In addition, follow-up studies may be performed to assess the impact and outcomes of rDUR interventions.

Based on findings from quarterly rDUR reviews, DUR pharmacists may recommend implementing changes to existing prospective/concurrent DUR edits to remedy apparent misuse/overuse. Recommendations may include but are not limited to: formulary changes, quantity limits, prior authorization, hard blocks, and use of electronic step therapy.

The DUR Team produces quarterly provider educational material around areas of concern that is reviewed and approved by the DUR Board. Once approved by the DUR Board, this material is posted on a SharePoint site and made available to SilverSummit Healthplan (SSHP) for use and distribution.

SSHP pharmacists are notified by Envolve Pharmacy Solutions, of members identified as meeting the requirements for a potential DUR intervention. If deemed appropriate, communications are initiated to members via intervention letters. Providers are contacted by phone, fax or via intervention letters. Faxes and intervention letters may include patient prescription profiles for prescribers to review along with outcome checklists to monitor practitioner response. In most cases a brief but definitive provider communication is sent notifying prescribers of potential concerns or suggestions for improved therapy, while offering providers further detail upon request.

2. Does your MCO have a Medication Therapy Management Program?

- ○ Yes
- ◉ No

If the answer to question 2 is "Yes," please continue with questions a) and b) below.

a) Have you performed an analysis of the program's effectiveness?

- ○ Yes, please provide a brief summary of your findings.

- ○ No

b) Is your DUR Board involved with this program?

- ○ Yes
- ○ No

If the answer to question 2 is "No," are you planning to develop and implement a program?

- ◉ Yes
- ○ No

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

   ○ Yes

   ◉ No

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

   ◉ Yes
   ○ No

2. RetroDUR?

   ○ Yes

   ◉ No

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

   ◉ Yes
   ○ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. Has your MCO included a brief description of policies that may impact generic utilization percentage as **Attachment 3 – Generic Drug Substitution Policies**?

   ◉ Yes

   ○ No

   See attachment naming instructions.

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 MCO have a more restrictive requirement?

   ◉ Yes

   ○ No

   If "Yes," check all that apply:

   ☐ Require that a MedWatch Form be submitted.

   ☐ Require the medical reason(s) for override accompany the prescription.

   ☒ Prior authorization is required.

   ☐ Prescriber must indicate "Brand Medically Necessary" on the prescription.

   ☐ Other, please explain.

FFY 2018
Silver Summit Health Plan

Attachment 3 – Generic Drug Substitution Policies

The pharmacy benefit mandates use of the generic formulations of multi-source, AB-rated drugs. To obtain coverage for a brand name medication when a generic is available, criteria must be met for brand name override. When generic drugs are available, the brand name drug will not be covered without SilverSummit Healthplan (SSHP) prior authorization (PA). Generic drugs have the same active ingredient and work the same as brand name drugs. If a physician/clinician provider feels a brand name drug is medically necessary, the physician/clinician can ask for PA.

PROCEDURE:

1. The prescriber requests coverage for a specific, multi-source, brand name product by submitting a written or faxed request to the Envolve Pharmacy Solutions Prior Authorization department.
2. The prescriber must write DAW on the prescription. A pre-printed box or signature line is not accepted.
3. A registered clinical pharmacist at Envolve Pharmacy Solutions will review the request and respond to the prescriber within 24 hours. NOTE: If necessary, Envolve Pharmacy Solutions or NurseWise may enter a temporary override in the claims processing system to allow the patient to obtain the brand-name drug therapy while the request is being reviewed.
4. Coverage will be granted for all requests that are accompanied by recent, objective, measurable information showing that a patient is unable to take the generic version of a product.
5. Appeals of denials will be forwarded to the health plan for review and final determination will be made by the health plan pharmacist or medical director.

SSHP will cover the brand name drug according to our clinical guidelines if there is a medical reason a member needs the particular brand name drug. If SSHP does not grant PA, we will notify physician/clinician provider and provide information regarding the appeal process.

Complete Table 2 – Generic Drug Utilization Data using the following Computation Instructions.

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.

Generic Utilization Percentage

To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	43,010	314,934	1,578

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. This file will be made available from CMS to facilitate consistent reporting across states with this data request.

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in *Table 2 – Generic Utilization Data*.

Number of Generic Claims:	314,934
Total Number of Claims:	359,522
Generic Utilization Percentage:	87.60

VII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   ☒ Deny claims and require prior authorization

   ☒ Refer to Lock-In Program

   ☐ Refer to Program Integrity Unit

   ☐ Other (i.e. SURS, Office of Inspector General), please explain.

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

   ◉ Yes

   ○ No

   If the answer to question 2 is "No," skip to question 3.

   If the answer to question 2 is "Yes," please continue.

   a) What criteria does your MCO use to identify candidates for Lock-In? Check all that apply:

      ☒ Number of controlled substances (CS)

      ☒ Different prescribers of CS

      ☒ Multiple pharmacies

      ☒ Number days' supply of CS

      ☐ Exclusivity of short acting opioids

      ☒ Multiple ER visits

      ☐ PDMP data

      ☐ Same FFS state criteria is applied

      ☐ Other, please explain.

b) Do you have the capability to restrict the beneficiary to:

i) prescriber only

- (•) Yes
- ( ) No

ii) pharmacy only

- (•) Yes
- ( ) No

iii) prescriber and pharmacy only

- (•) Yes
- ( ) No

c) What is the usual Lock-In time period?

- (•) 12 months
- ( ) 18 months
- ( ) 24 months
- ( ) Other, please explain.

d) On average, what percentage of your Medicaid MCO population is in Lock-In status annually?

1.00 %

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   - ☐ Deny claims written by this prescriber
   - ☐ Refer to Program Integrity Unit
   - ☒ Refer to the appropriate Medical Board
   - ☐ Other, please explain.

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?

   ◉ Yes

   ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   - ☐ Deny claims
   - ☒ Refer to Program Integrity Unit
   - ☐ Refer to Board of Pharmacy
   - ☐ Other, please explain.

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?

   ◉ Yes, please explain your program for fraud, waste or abuse of non-controlled substances.

   Fraud, Waste and Abuse Plan
   Pharmacy Benefits Manager (PBM) – The Special Investigations Unit (SIU) and PBM work collaboratively to ensure pharmacy benefits are properly utilized. The PBM will conduct investigative audits of pharmacies within our network. The Centene-impacted ⊞

   ○ No

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Do you require prescribers (in your provider agreement with your MCO) to access the PDMP patient history before prescribing controlled substances?

   ○ Yes, please explain how the MCO applies this information to control fraud and abuse.

   ◉ No

   ○ No, the state does not have a PDMP

2. Does your MCO have the ability to query the state's PDMP database?

   ○ Yes

   ◉ No

   If "Yes," are there barriers that hinder your MCO from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

   ○ Yes, please explain the barriers that exist.

   ○ No

3. Does your MCO have access to border states' PDMP information?

   ○ Yes

   ◉ No

C. PAIN MANAGEMENT CONTROLS

1. Does your MCO obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

   (●) Yes

   ( ) No

   If the answer to question 1 is "No," skip to question 2.

   If the answer to question 1 is "Yes," please continue.

   Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

   (●) Yes

   ( ) No

   If "Yes," please explain how information is applied.

   Applicable at Point of Sale (POS) in real time. We utilize NCPDP's prescriber file which provides us DEA numbers as well as authorized schedules. For controlled substance prescribing, a prescriber must have an active DEA identifier in good standing and have the authority to prescribe a controlled substance in a given DEA drug class schedule (2,2N,3,3N,4,5).

   If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

   ( ) Yes

   ( ) No

2. Do you apply this DEA file to your RetroDUR reviews?

   ( ) Yes, please explain how it is applied.

   (●) No

3. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

   - (●) Yes
   - ( ) No, please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

D. OPIOIDS

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

   - (●) Yes, for all opioids
   - ( ) Yes, for some opioids
   - ( ) No, for all opioids

   If the answer to question 1 is "No," skip to question 2.

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

   a) Is there more than one quantity limit for the various opioids?

      - ( ) Yes, please explain.
      - (●) No

b) What is your maximum number of days allowed for an initial opioid prescription?

7 days

c) Does the above initial day limit apply to all opioid prescriptions?

- (•) Yes
- ( ) No, please explain.

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

   - (●) Yes
   - ( ) No

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

   - ( ) 30 day supply
   - ( ) 90 day supply
   - (●) Other, please explain.

     Maximum 30 day supply and must obtain a prior authorization for medical necessity.

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?

   - (●) Yes
   - ( ) No

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

   - ( ) 30 day supply
   - ( ) 90 day supply
   - (●) Other, please explain.

     Maximum 30 day supply and must obtain a prior authorization for medical necessity.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

   ◉ Yes

   ○ No

   If "Yes," please check all that apply:

   - ☐ Pharmacist override
   - ☒ Deny claim and require PA
   - ☐ Intervention letters
   - ☒ Morphine equivalent daily dose (MEDD) program
   - ☒ Step therapy or clinical criteria
   - ☐ Requirement that patient has a pain management contract or Patient-Provider agreement
   - ☐ Requirement that prescriber has an opioid treatment plan for patients
   - ☐ Require documentation of urine drug screening results
   - ☒ Other, please explain what additional opioid prescribing controls are in place.

     Documentation that the provider has reviewed the PDMP and that the Provider agrees to continuously assess the member's pain management regimen for possible discontinuation of opioid therapy.

   If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

   ○ Yes, please explain.

   ◉ No

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis?

   ◉ Yes

   ○ No

   If the answer to question 6 is "Yes," please indicate how often:

   ◉ Monthly

   ○ Quarterly

   ○ Semi-Annually

   ○ Annually

   ○ Other, please explain.

   If the answer to question 6 is "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

   ○ Yes

   ○ No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

   ◉ Yes

   ○ No

   For either "Yes" or "No," please check all that apply:

   ☒ Your MCO refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain. Please identify the "referred" guidelines.

   Tapering Opioids for Chronic Pain:
   https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

   2011 Centers for Disease Control and Prevention (CDC), Prescription Painkiller Overdoses in the US. Available at:
   https://www.cdc.gov/vitalsigns/painkilleroverdoses/index.html

   ☐ Other guidelines, please identify.

   ☐ No guidelines are offered.

8. Do you 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)?

   ◉ Yes, please explain.

   Our PDL does list which abuse deterrent opioids are formulary in the analgesic - opioid section.

   ○ No

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

   ◉ Yes

   ○ No

   If the answer to question 1 is "Yes," please continue.

   a) What is your maximum morphine equivalent daily dose limit in milligrams?

   90 mg per day

   b) Please explain (i.e. are you in the process of tapering patients to achieve this limit?).

   All orders over the maximum of 90 MME require a prior authorization for medical necessity and/or documentation that provider is tapering patient.

   If the answer to question 1 is "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

   ○ Yes

   ◉ No

   If the answer to question 2 is "No," skip to question 3.

   If the answer to question 2 is "Yes," please continue.

   a) Please name the developer of the calculator.

   b) How is the information disseminated? Check all that apply:

   ☐ Website

   ☐ Provider notice

   ☐ Educational seminar

   ☐ Other, please explain.

3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

   - (●) Yes
   - ( ) No

   If "Yes," do you require prior authorization if the MEDD limit is exceeded?

   - (●) Yes
   - ( ) No

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

1. Does your MCO set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

   - ( ) Yes
   - (●) No

   If "Yes," please specify the total mg/day:

   - ( ) 12 mg
   - ( ) 16 mg
   - ( ) 24 mg
   - ( ) Other, please explain.

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

   - ○ 6 months
   - ○ 12 months
   - ◉ No limit
   - ○ Other, please explain.

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

   - ○ Yes
   - ◉ No

   If "Yes," please continue.

   a) What is your reduced (maintenance) dosage?

      - ○ 8 mg
      - ○ 12 mg
      - ○ 16 mg
      - ○ Other, please explain.

b) What are your limitations on the allowable length of the reduced dosage treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other, please explain.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

- ◉ Yes
- ○ No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

- ◉ Yes
- ○ No
- ○ Other, please explain.

If "Yes," can the POS pharmacist override the edit?

- ○ Yes
- ◉ No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

   ◉ Yes

   ○ No

7. Does your MCO allow pharmacists to dispense naloxone prescribed independently, or by collaborative practice agreements, or standing orders, or other predetermined protocols?

   ◉ Yes

   ○ No

8. Does your MCO cover methadone for OUD (i.e. Methadone Treatment Center)?

   ◉ Yes

   ○ No

G. ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

   ◉ Yes

   ○ No, please explain.

2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

   ◉ Yes

   ○ No

   If "Yes," please continue.

   a) Do you either manage or monitor:

      ○ Only children in foster care

      ◉ All children

      ○ Other, please explain.

   b) Do you have edits in place to monitor (check all that apply):

      ☒ Child's Age

      ☒ Dosage

      ☒ Polypharmacy

      ☐ Other

   c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

      SilverSummit Healthplan utilizes a corporate Psychotropic Medication Utilization Review (PMUR) program that interfaces with a PMUR Coordinator (clinician) to manage and monitor the day to day activities.
      Triggers for review:
      1) Psychotropic medication prescribed without an identified psychiatric diagnosis.
      2) Prescribing of four (4) or more psychotropic medications concomitantly (side effec

If you do not have an antipsychotic monitoring program in place, do you plan on implementing a program in the future?

- ○ Yes
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?
   - ◉ Yes
   - ○ No

4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?
   - ◉ Yes
   - ○ No

   If the answer to question 4 is "Yes," please continue.

   a) Do you either manage or monitor:
      - ○ Only children in foster care
      - ◉ All children
      - ○ Other, please explain.

b) Do you have edits in place to monitor (check all that apply):

- [x] Child's Age
- [x] Dosage
- [x] Polypharmacy

c) Please briefly explain the specifics of your documented stimulant monitoring program(s).

Silversummit Healthplan utilizes a corporate Psychotropic Medication Utilization Review (PMUR) program that interfaces with a PMUR Coordinator (clinician) to manage and monitor the day to day activities.
Triggers for review:
1) Psychotropic medication prescribed without an identified psychiatric diagnosis.
2) Prescribing of four (4) or more psychotropic medications concomitantly (side effect

If the answer to question 4 is "No," that is you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

- ○ Yes
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

VIII. INNOVATIVE PRACTICES

Attachment 4 – Innovative Practices

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing)? Please describe in detailed narrative form 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 prior authorizations, continuing education programs).

*Please include **Attachment 4** described above when submitting this survey. (See naming instructions.)*

FFY 2018
Silver Summit Health Plan

Attachment 4 – Innovative Practices

In 2018, to address the HEDIS Follow-Up Care for Children Prescribed ADHD Medication (ADD) metric, the Drug Use Review (DUR) team partnered with the Prior Authorization (PA) department to send a message to prescribers of targeted ADHD medications of newly prescribed patients. This message reminded prescribers to schedule follow up visits with their patients.

SilverSummit Healthplan launched the On.Demand diabetes monitoring program which allows for cellular enabled readings of blood glucose levels. This provides real time numbers and results that can be intervened right away instead of waiting on claims data. The program includes the current education and coaching aspects of standard disease management for diabetics. If a member does not record a reading for 5 consecutive days a compliance call is made to the member. Barriers to testing are identified and the member is assisted in planning to eliminate hurdles. If the member has consecutive readings over 350 or under 70 OR 5 consecutive readings over 250 and/or under 70 the member is enrolled in a more intensive diabetes management coaching program, as necessary.

IX. E-PRESCRIBING

1. Does your pharmacy system or vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

   ◉ Yes

   ○ No

   If the answer to question *1 is "Yes,"* do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

   ◉ Yes, please explain the evaluation methodology in **Attachment 5 – E-Prescribing Activity Summary**. Describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

   *Please include **Attachment 5** described above when submitting this survey. (See naming instructions.)*

   ○ No

   If the answer *to question 1 is "No,"* are you planning to develop this capability?

   ◉ Yes

   ◉ No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

   ◉ Yes

   ○ No

X. EXECUTIVE SUMMARY

Attachment 6 – Executive Summary

*Please include **Attachment 6** when submitting this survey. (See naming instructions.)*

FFY 2018
Silver Summit Health Plan

Attachment 5 – E-Prescribing Activity Summary

There is no way to measure the exact details of the eRx event. Medication history enables the prescriber software clinical decision support logic to flag drug-drug interactions, duplicate therapy, etc. We don't have a way to measure if those alerts affected the prescriber's drug selection decision. We also don't have any way to show prescriber A, selected drug A, but changed to drug B based on the formulary and coverage information provided. Based on years of reviewing and evaluating post adjudicated claims (we use the Prescription Origin Code), comparing eRxs vs. non-eRxs, we know that on average, our pharmacy costs (amount we pay) is lower for eRxs vs. non-eRxs. This indicates the information must be influencing the prescriber's drug selection process.

FFY 2018

Silver Summit Health Plan

Attachment 6: Executive Summary

SilverSummit Healthplan (SSHP) is committed to providing appropriate, high quality, and cost effective medication therapy to all SSHP members. SSHP works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. SSHP covers prescription medications and certain over-the-counter (OTC) medications when ordered by a physician/clinician. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities.

SSHP monitors ongoing prescribing of medications for clinical appropriateness. SSHP reviews prescribing retrospectively to review for both safety and efficacy. SSHP contracts with Envolve Pharmacy Solutions to review for disease management, fraud and abuse (i.e. Coordinated Services Program), and prescriber profiling. Prescriber or member outreach may occur based on prescribing/dispensing patterns. SSHP routinely monitors for drug use review (DUR) opportunities and takes action as needed.

The standard prospective (pDUR) and retrospective Drug Use Review (rDUR) programs are delegated to the designated pharmacy benefit manager (PBM), Envolve Pharmacy Solutions, utilizing the standards, criteria, protocols and procedures established by the mutual agreement of the Centene Corporate Pharmacy and Therapeutics Committee, SilverSummit Healthplan, and Envolve Pharmacy Solutions, and in accordance with applicable state and federal requirements and NCQA standards. The DUR program is submitted for review and approval to the Centene Corporate and Health Plan Pharmacy and Therapeutics Committees annually. The DUR program is designed to alert prescribers and/or dispensing pharmacists by identifying overuse, underuse, inappropriate or medically unnecessary care, and to address safety concerns associated with specific drugs, including the potential for drug interactions. The DUR program also functions to identify opportunities to improve the quality of care for patients including adherence to prescribed therapy and improvements in the medication regimen consistent with the patient's diagnoses or conditions. The results of any rDUR programs may also be used to initiate additional claims review and analysis at the plan. In addition, follow-up studies may be performed to assess the impact and outcomes of rDUR interventions.

SSHP's prospective DUR program is administered by CVS utilizing the RxClaims electronic claims system. Our Point of Sale (POS) Safety Review utilizes a series of alerts designed to check the plan member's prescription history for possible drug conflicts and safety issues. When a claim is adjudicated, the CVS Caremark systems evaluate the complete patient drug history and send real time alerts to the dispensing pharmacist every time a safety issue is triggered.

SSHP's Pharmacy Program staff uses an evidence-based approach for developing proposals for the DUR Board to review and approve at the quarterly meetings, including clinical PA criteria algorithms and drug claim alerts (quantity, dose, cumulative quantity, age, or gender) that will support appropriate and safe prescription drug use.

SSHP's pharmacy lock-in program is in place to detect and prevent abuse of the pharmacy benefit, as defined by specific criteria designed to identify potential misuse or abuse of prescription medications in specific therapeutic categories with the potential for high abuse, by restricting members to one specific pharmacy and controlled substance provider (if one is chosen) for a defined period of time. SSHP's policy is to monitor and control suspected abuse of the pharmacy benefit by members, as identified and confirmed through analysis and audit by the pharmacy department.

SSHP's purpose is transforming the health of the community, one person at a time. Our mission is to ensure better health outcomes at lower costs.