MEDICAID MANAGED CARE ORGANIZATION (MCO)
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2019

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, 2018 to September 30, 2019. 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.

IMPORTANT NOTE: Adobe Acrobat Reader must be used to edit the survey. The MCO survey cannot be edited within a browser window.

MEDICAID MANAGED CARE ORGANIZATION (MCO)
DRUG UTILIZATION REVIEW ANNUAL REPORT FEDERAL
FISCAL YEAR 2019

I. DEMOGRAPHIC INFORMATION

State Abbreviation: NV

MCO Name: Health Plan of Nevada

Please note: Name above must match name entered in MDP DUR system.

Program Type: Other

If "Other," please specify.

Title XIX (Medicaid including Expansion) and Title XXI CHIP

Medicaid MCO Information

Identify the 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?

   254,615 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

   ○ Other organization

   If "Contractor" or "Other organization," please identify by name your pharmacy POS vendor.

   OptumRx

   *If "*Other*,"* please specify.

2. Identify ProDUR criteria source.

   ☐ First Databank

   ☒ Medi-Span

   ☐ MICROMEDEX

   ☐ Other, please specify.

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

- (•) Yes
- ( ) No

If "Yes," who reviews your new ProDUR criteria?

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

If "No," please explain.

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
   - ◉ Varies by alert type, please explain.

     The pharmacist at the point of sale using the NCPDP drug use evaluation codes may override most high dose edits, therapeutic duplication edits, and drug-drug interaction edits. As an example, the opioid MME dose maximum requires a prior authorization, and cannot be overridden by the pharmacist at the point of sale.

   - ○ Other, please explain.

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

- (●) Yes
- ( ) No

If "No," skip to question 6.

If "Yes," please continue.

a) How often?

- [ ] Monthly
- [x] Quarterly
- [ ] Annually
- [ ] Ad hoc (on request)
- [ ] Other, please explain.

b) If you receive reports, do you follow up with those providers who routinely override with interventions?

- ○ Yes
- ◉ No, please explain.

OptumRx is responsible for the audit activities for 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 5b is "No," skip to question 6.

If the answer to question 5b is "Yes," please continue.

By what method do you follow up?

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

6. **Early Refill**

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

Non-controlled drugs:

85 %

Schedule II controlled drugs:

90 %

Schedule III through V controlled drugs:

90 %

b) **For non-controlled drugs**

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

- (•) Yes
- ( ) No
- ( ) Dependent on the medication or situation

If the answer to question 6b is not "No" or "Dependent on medication or situation," who obtains authorization?

- ( ) Pharmacist
- (•) Prescriber
- ( ) Pharmacist or Prescriber

If the answer to question 6b 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 6c is "Yes," who obtains authorization?

- ( ) Pharmacist
- (●) Prescriber
- ( ) Pharmacist or Prescriber

If the answer to question 6c is "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 policy allow the pharmacist to override for situations such as:

a) Lost/stolen Rx

- ( ) Yes
- (●) No
- ( ) Overrides are only allowed by a pharmacist through a prior authorization

b) Vacation

- ( ) Yes
- (●) No
- ( ) Overrides are only allowed by a pharmacist through a prior authorization

c) Other, please explain.

8. 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

9. 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

10. 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, would your policy allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

    ○ Yes

    ◉ No

11. 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?

- (●) *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.

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

- (●) *If "Yes,"* what is the process?

  Health Plan of Nevada Medicaid allows for a 5 day emergency supply of medication be dispensed at the discretion of the point of sale pharmacist by entering the appropriate dynamic PA code. This will bypass any prior authorization requirements for the member for the emergency supply. This emergency supply is limited to one emergency supply override per drug per year.

- ( ) *If "No,"* please explain.

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

    Column 1 – Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level (*See Appendix for the list of Drug Names*.)

    Column 2 – Top 10 PA Requests by Drug Class (*See Appendix for Drug Class details*.)

    Column 3 – Top 5 Claim Denial Reasons (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, and Age Edits) (*See Appendix for the list of Denial Reasons*.)

    Column 4 – Top 10 Drug Names by Amount Paid (Generic Names), report at generic ingredient level (*See Appendix for the list of Drug Names*.)

    Column 5 – From Data in column 4, determine the Percentage of Total Drug Spend

    Column 6 – Top 10 Drug Names by Claim Count (Generic Names), report at generic ingredient level (*See Appendix for the list of Drug Names*.)

    Column 7 – From Data in Column 6, determine the Percentage of Total Claims

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

NOTE: If an entry is not included in the drop-down box list, please select 'Other' and enter a free form response in the box below. 'Other' is found at the bottom of the list.

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level (*See Appendix for the list of Drug Names*.)	Column 2 Top 10 Prior Authorization (PA) Requests by Drug Class (*See Appendix for Drug Class details*.)	Column 3 Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits) (*See Appendix for the list of Denial Reasons*.)	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level (*See Appendix for the list of Drug Names*.)	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, report at generic ingredient level (*See Appendix for the list of Drug Names*.)	Column 7 Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
dextroamphetamine/amphetamine	Other Dermatologicals	refill too soon	adalimumab	11.45 %	albuterol	3.42 %
aripiprazole	Other Analgesics (Opioids)	product/service not covered – plan/bene	insulin glargine	2.95 %	ibuprofen	3.26 %
hydrocodone /apap	Other Antidiabetic Agents	dur reject error	other GLECAPREVIR-PIBRENTASVIR	2.86 %	atorvastatin	2.48 %
diclofenac	Other ADHD/Anti-Narcolepsy	plan limitations exceeded	insulin lispro	2.83 %	lisinopril	2.06 %
morphine	Antipsychotics	prior authorization required	other DULAGLUTIDE	2.39 %	metformin	1.99 %
insulin lispro	Other Antiasthmatic/Bronchodilator Ag		other BICTEGRAVIR-EMTRICITABINE-TENC	2.29 %	amoxicillin	1.99 %
pregabalin	Anticonvulsants		etanercept	2.12 %	gabapentin	1.97 %
other Tretinoin	Antidepressants		albuterol	2.07 %	hydrocodone /apap	1.82 %
oxycodone	Other Antihyperlipidemics		elvitegravir/cobicistat/emtricitabine/tenof	1.75 %	fluticasone	1.68 %
varenicline	Other Analgesics (Anti-Inflammatory)		ustekinumab	1.56 %	montelukast	1.66 %

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.

   a) Please indicate how your program operates and oversees RetroDUR reviews. Is the RetroDUR program operated by the state or by the managed care plan? Does your state use a combination of state interventions as well as individual MCO interventions?

      - ○ State operated interventions
      - ○ Managed Care executes its own RetroDUR activities
      - ◉ PBM performs RetroDUR activities
      - ○ Combination of MCO RetroDUR interventions and state interventions are performed
      - ○ Other, please explain.

b) Identify the entity, by name and type, that performed your RetroDUR activities during the time period covered by this report

- (●) Company

  Other

  If "Other," please identify by name and type.

  OptumRx

- ( ) Academic institution, please identify by name and type.

- ( ) Other, please identify by name and type

2. Who reviews and approves the RetroDUR criteria?

- ( ) State DUR Board
- ( ) MCO DUR Board
- ( ) PBM performs RetroDUR and has a RetroDUR Board
- ( ) PBM P&T Board also functions as a DUR Board
- ( ) State pharmacy director
- (●) Other, please explain.

  OptumRx performs RDUR activities with oversight from Health Plan of Nevada Medicaid. RDUR criteria is developed and maintained through OptumRx, the criteria utilized for their programs are created and approved through their own quality committee. Recommendations for additions or changes to the OptumRx RDUR program are made by both OptumRx and Health Plan of Nevada Medicaid and are presented to the DUR Board. OptumRx RDUR programs are reviewed by the Health Plan of Nevada Medicaid DUR Board annually and they

3. **Summary 1 – Retrospective DUR Educational Outreach Summary**

Summary 1 – Retrospective DUR Educational Outreach is a summary report on RetroDUR screening and educational interventions during the fiscal year reported. The summary should be limited to the most prominent **10** problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.

The Health Plan of Nevada Medicaid Retrospective DUR Educational Outreach report summarizes the RDUR interventions during the fiscal year reported. The following are the most prominent 10 problems with the largest number of interventions. The RDUR intervention activities and outcomes are included and detailed below. NOTE: Interventions are considered an eligible intervention for outcome evaluation if at the evaluation date the member is still an enrolled member and there are no enrollment gaps since the intervention.

1. Narcotic Drug Utilization Review Program-

This is a provider-targeted program designed to minimize the occurrence of drug abuse, diversion, and inappropriate use in members utilizing high-risk medications. The number of interventions during the federal fiscal year was 25,135 for this program. Outcomes are evaluated at 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 6,374. From those eligible interventions the number determined to be successful during the federal fiscal year was 1,545, yielding a success percentage of 24.24%.

2. Gaps in Care Asthma:

The purpose of this program is to optimize the use of long-term controller medications (LTCMs) as recommended by current guidelines and promote the appropriate use of short-acting beta-agonists (SABAs). The number of interventions during the federal fiscal year was 7,727 for this program. Outcomes are evaluated 180 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 6,752. From those eligible interventions the number determined to be successful during the federal fiscal year was 572, yielding a success percentage of 8.47%.

3. Gaps in Care Diabetes:

The purpose of this program is to optimize the management of diabetes by identifying and closing the gap for members with diabetes not on a statin and with diabetes and hypertension not on certain anti-hypertensive agents. The number of interventions during the federal fiscal year was 6,053 for this program. Outcomes are evaluated at 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 5,936. From those eligible interventions the number determined to be successful during the federal fiscal year was 761, yielding a success percentage of 12.82%.

4. Drug-Drug Interaction:

This is a provider-targeted program designed to minimize the occurrence of clinically significant, patient-specific drug-drug interactions. The number of interventions during the federal fiscal year was 5,163 for this program. Outcomes are evaluated at 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 4,424. From those eligible interventions the number determined to be successful during the federal fiscal year was 1,459, yielding a success percentage of 32.98%.

5. Duplicate Therapy:

This is a provider-targeted program designed to promote awareness of therapeutic duplication concerns. The number of interventions during the federal fiscal year was 3,547 for this program.

IV. DUR BOARD ACTIVITY

1. Summary 2 – DUR Board Activities Report

Summary 2 – DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported. Please provide a detailed summary below.

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
  a) For ProDUR, list problem type/drug combinations added or deleted.
  b) For RetroDUR, list therapeutic categories added or deleted.
- Describe Board policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens.
- Describe policies that establish whether and how results of RetroDUR screening are used to adjust ProDUR screens.
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.)
- Describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

1. DUR Board meetings held between 10/01/18 and 09/30/19
a. Health Plan of Nevada Medicaid DUR Board Meetings:
i. 03/21/19
ii. 09/19/19

2. Additions/deletions to DUR Board approved criteria.
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 Duplication: Statins, Beta Blockers, NSAIDs, Triptans, Chantix, and GLP-1 +DPP4 classes.
2. Cumulative High Dose (Therdose): Atomoxetine, Clonidine, Guanfacine, Modafanil, Armodafinil, and Citalopram.
3. Drug Interactions: Varenicline+Bupropion, Apomorphine+5-HT3 antagonists, and Amiodarone +Warfarin
ii. For retrospective DUR, list therapeutic categories added or deleted.
1. Gained approval to add the following programs to the RDUR program:
a. OptumRx Gaps in Care Sickle Cell
b. OptumRx Adherence Program if the health plan chooses to enroll
c. Health Plan of Nevada Medicaid Antipsychotic Monitoring in Pediatrics (AMP) program
2. Gained approval to ask OptumRx to evaluate adding therapeutic duplication triggers for anticoagulants and GLP-1 +DPP-4 to their program.
3. Gained approval to ask OptumRx to re-evaluate their current therapeutic duplication triggers for albulterol nebulizers + albuterol inhalers and modify triggers where a member is on 2 different strengths of a medication.

3. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens.
a. Health Plan of Nevada Medicaid evaluates the trends in the ongoing CDUR programs at the point of sale, and are completed by the DUR Team at minimum once yearly. Outlier medication related

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

- ○ Yes
- ◉ No

If "Yes," please continue with a) and b).

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 "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. Summary 3 – Generic Drug Substitution Policies

Summary 3 – Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details below.

The purpose of the Health Plan of Nevada Medicaid Generic Substitution Policy is to define the process of ensuring cost-effective generic drugs, or authorized brand alternatives (ABA) included in the preferred drug lists and covered by the pharmacy benefits of Health Plan of Nevada Medicaid. The Health Plan of Nevada Medicaid Pharmacy and Therapeutics committee determines which drugs are included in preferred drug lists and the PBM reviews the Medispan data base and generic pipeline report frequently to determine when generic drugs become available and if they are determined to be an authorized brand alternative (ABA) by the U.S. Food and Drug Administration.

The PBM programs the point-of-sale (POS) system to reject multi-source brand drugs as non-preferred when equivalent generic drugs become available. If the FDA identifies the equivalent generic drug as an ABA that does not lead to a corresponding multisource code (MSC) change, Health Plan of Nevada Medicaid will review the new product to identify if it provides an opportunity to manage towards a new lower cost alternative in the class. If identified as a lower cost opportunity, Health Plan of Nevada Medicaid will work with the PBM to adjust the coding to prefer national drug codes (NDC) of the ABA and reject the NDC of the brand name drugs as non-preferred. When adjudicated, the POS system reject claims for non-preferred multi-source brand drugs with a preferred ABA with a rejection message that indicates a generic substitution is required. If a prior authorization is in place for a non-preferred drug that has an ABA become available, Health Plan of Nevada Medicaid will work with the PBM to update those authorizations to allow the new ABA NDC to process and subsequently remove the NDC for the brand product leading to a POS reject for processed claims with a rejection message indicating generic substitution is required, unless prohibited by state regulation.

Health Plan of Nevada Medicaid reserves the right to implement a brand over generic strategy if, economically, the brand with a rebated discount is more cost effective than the generic equivalent. The PDL will define Brand over generic strategies and POS messaging will reflect this preference to direct pharmacy claims processing to the appropriate product.

The Prescriber can request coverage of a multi-source brand product by contacting the Pharmacy Prior Authorization Team via fax, telephone, or electronic prior authorization. The prescriber must provide documentation explaining the reason for the brand drug, and the Pharmacy Prior Authorization Team processes the request in accordance with coverage review guidelines for non-preferred drugs.

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.
   - [x] Prior authorization is required.
   - [ ] Prescriber must indicate "Brand Medically Necessary" on the prescription.
   - [ ] Other, please explain.

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:

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	172,149	2,126,921	116,797

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: 2,126,921

   Total Number of Claims: 2,415,867

   Generic Utilization Percentage: 88.04

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
   - [x] Refer to Lock-In Program
   - [x] Refer to Program Integrity Unit/Surveillance Utilization Review (SURs unit)
   - [x] Refer to Office of Inspector General
   - [x] Refer to legal authorities
   - [x] Other, 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 "No," skip to question 3.

If "Yes," please continue.

a) What criteria does your MCO 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
- [ ] PDMP data
- [ ] Same FFS state criteria is applied
- [x] 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

   - (•) Yes
   - ( ) No

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

- (•) 12 months
- ( ) 18 months
- ( ) 24 months
- ( ) As determined on a case by case basis
- ( ) Lock-In time period is based on number of offenses
- ( ) Other, please explain.

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

0.22 %

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

   - (•) Yes
   - ( ) No

   If "No," please explain.

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

   - [ ] Deny claims written by this prescriber
   - [x] Refer to Program Integrity Unit/Surveillance Utilization Review (SURs unit)
   - [x] Refer to the appropriate Medical Board
   - [ ] Refer to Peer Review Committee
   - [ ] 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 "No," please explain.

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

   - ☐ Deny claims
   - ☒ Refer to Program Integrity Unit/Surveillance Utilization Review (SURs unit)
   - ☒ Refer to the Board of Pharmacy
   - ☐ Refer to Peer Review Committee
   - ☒ Refer to legal authorities
   - ☒ 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.

   1. Health Plan of Nevada Medicaid targets medications with high abuse potential (muscle relaxers, sedating anxiolytics, gabapentin, etc.) in the criteria for lock-in in addition to all controlled substances. 2. The Optum Provider Behavior Operations - Drug Diversion team creates member cases for Health Plan of Nevada Medicaid. As part of their drug diversion leads non- controlled substances known to be potentiators of opioids or benzodiazepines are included

   ○ No, please explain.

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 your program applies this information to control fraud and abuse.

   ○ No, the state does not have a PDMP.

   ◉ No, please explain.

   Health Plan of Nevada Medicaid does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all state and federal laws which in the State of Nevada includes the checking of the PDMP before prescribing of controlled substances.

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

   - ○ Yes, we receive PDMP data
   - ○ Yes, we have access to the database
   - ◉ 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 "No," *skip to question 2*.

   If "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.

      Health Plan of Nevada Medicaid implements comprehensive edits to prevent adjudication of Medicaid claims with an inactive or invalid prescriber NPI and DEA. Validation will occur at the 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, please explain.

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

   ○ Yes, please explain how it is applied.

   ◉ No, please explain.

   The DEA Active Controlled Substance Registrant's File is not applied as part of RDUR program reviews. Since the PBM is able to leverage the use of the file at the point of sale this offsets the need for the downstream RDUR system to process the file again as part of the review.

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

Please explain.

Limitations on the quantity dispensed of an initial short-acting opioid prescription applies to new to therapy members (no opioid claims in the last 60 days).

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

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.

For short-acting opioid claims that meet the new to therapy requirements (no opioid claims in the last 60 days) a maximum of a 7 days supply (members 20 years of age and older) or 3 days supply (members less than 20 years of age) and a maximum of 50 MME is set for both age groups.

- ○ No

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

- ○ 3 days
- ◉ 7 days
- ○ 12 days
- ○ 30 days
- ○ Greater than 30 days
- ○ Other, please indicate # of days:

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

- ○ Yes
- ◉ Yes, some opioids
- ○ No

If the answer to question 1c is "Yes, some opioids" or "No," please explain.

For short-acting opioid claims that meet the new to therapy requirements (no opioid claims in the last 60 days) a maximum of a 7 days supply (members 20 years of age and older) or 3 days supply (members less than 20 years of age) and a maximum of 50 MME is set. All initial supplies of long-acting opioid prescriptions require prior authorization before use with one requirement being that the patient is not opioid naive.

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
   - ( ) 34 day supply
   - ( ) 90 day supply
   - ( ) Other, please explain.

   If "No," 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
   - ( ) 34 day supply
   - ( ) 90 day supply
   - ( ) Other, please explain.

   If "No," 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, 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.

   If "Yes," please check **all** that apply:

   ☒ Pharmacist override
   ☒ Deny claim and require PA
   ☒ Intervention letters
   ☒ Morphine Milligram Equivalent (MME) daily dose 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
   ☒ Require diagnosis
   ☐ Require PDMP checks
   ☐ Workgroups to address opioids
   ☐ Other, please specify.

   Please provide details on these 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 monitoring for continuous opioid therapy. The attestation as an example requires the need for treatment goals, duration of treatment, and use of non-opioid/ non-pharmacological interventions to be clearly defined. 2. Long-acting opioid products require prior authorization before initial use with one criteria being adequate trial of short-acting opioid therapy (i.e.not opioid naïve) before initiating a

5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?

- (●) Yes
- ( ) No

Please explain.

Health Plan of Nevada Medicaid has a therapeutic duplication soft edit in place on short acting opioid + short acting opioid and long acting opioid + long acting opioid products. The dispensing pharmacist is required to enter the appropriate NCPDP codes to indicate an intervention was performed to override the reject and receive a paid claim. No prior authorization is required for this approach.

6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?

- (●) Yes
- ( ) No

Please explain.

Prescribers are required to obtain a prior authorization for members to receive a refill before the allowable refill threshold has been met.

7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?

- ( ) Yes, please explain in detail the scope and nature of these retrospective reviews.
- (●) No, please explain.

Health Plan of Nevada Medicaid is enrolled in an OptumRx RDUR program that notifies providers of chronic early refill of opioids, therapeutic duplication of short + short acting opioids and therapeutic duplication of long + long acting opioids, and high daily doses of opioids (over cumulative 90 MME). However, the inclusion criteria is not specific to the State of Nevada point of sale edits, but rather follows CDC guidance. In addition, prior authorization is required to exceed most opioid edits in place at the point of sale.

8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?

- [x] Yes, POS edits
- [ ] Yes, retrospective reviews
- [ ] No

If "Yes, POS edits" and/or "Yes, retrospective reviews," please explain in detail the scope and nature of reviews and/or edits in place.

1. POS edits: Health Plan of Nevada Medicaid has a Drug-Drug Interaction CDUR soft reject edit for Opioid+Benzodiazepine when the two medications are found to have overlapping days supply. The dispensing pharmacist is required to enter the appropriate NCPDP codes to override the reject and obtain a paid claim. No prior authorization is required for this approach.
2. Retrospective Review: Starting 10/1/2019, the OptumRx RDUR program implemented additional criteria that notifies prescribers via fax/mail when a member is receiving an opioid

If "No," please explain.

9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?

- [x] Yes, POS edits
- [ ] Yes, retrospective reviews
- [ ] No

If "Yes, POS edits" and/or "Yes, retrospective reviews," please explain in detail the scope and nature of reviews and/or edits in place.

Currently opioids and non-benzodiazepine sedative hypnotics are flagged with a message only strategy at the point of sale. This strategy does not stop the claim at the point of sale requiring NCPDP codes and does not require a prior authorization. The system identifies concurrent use of these products and displays the Medispan standard message along with the claim. On the agenda for the DUR Board meeting in September 2020 is the proposal to move opioids + sedative hypnotics to the soft message strategy requiring pharmacist use of appropriate

If "No," please explain.

10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?

- ☐ Yes, POS edits
- ☐ Yes, retrospective reviews
- ☒ No

If "Yes, POS edits" and/or "Yes, retrospective reviews," please explain in detail the scope and nature of reviews and/or edits in place.

If "No," please explain.

As part of an OptumRx RDUR program, a prescriber targeted notification for concurrent opioid + antipsychotic utilization was implemented on 10/01/2019.

11. Do you have POS safety edits or perform 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, POS edits
- ○ Yes, retrospective reviews and/or provider education
- ◉ No

If the answer to question 11 is "Yes, retrospective reviews and/or provider education," please continue with a) and b).

a) Please indicate how often:

- ○ Monthly
- ○ Quarterly
- ○ Semi-Annually
- ○ Annually
- ○ Ad hoc
- ○ Other, please specify.

b) Please explain the nature and scope of RetroDUR reviews and/or provider education reviews performed.

If the answer to question 11 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, when do you plan on implementing?

  OptumRx is currently in the process of building out RDUR rules as part of their Abused Meds program. This would notify prescribers of their patients with history of OUD and/or opioid poisoning that they have written opioid prescriptions. The addition of these rule sets to their program is anticipated for 2021.

- ( ) No, please explain.

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

    - (●) Yes
    - ( ) No

    If "Yes," please check:

    - ( ) Your prescribers are referred to the CDC's Guideline for Prescribing Opioids for Chronic Pain.
    - (●) Other guidelines, please identify.

      Health Plan of Nevada Medicaid has created a opioid resource section on the provider facing website. One page PDF resources range in topic from naloxone coverage, to opioid tapering, to treatment alternatives for common pain conditions. The website 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 Guideline for Prescribing Opioids

    - ( ) No guidelines are offered, please explain.

13. 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 MILLIGRAM EQUIVALENT (MME) DAILY DOSE**

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

- (●) Yes
- ( ) No, please explain.

If "Yes," please continue.

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

- ( ) Less than 50 MME
  Please specify. _____ mg per day
- ( ) 50 MME
- ( ) 70 MME
- ( ) 80 MME
- (●) 90 MME
- ( ) 100 MME
- ( ) 120 MME
- ( ) 200 MME
- ( ) Greater than 200 MME
  Please specify. _____ mg per day
- ( ) Other
  Please specify. _____ mg per day

b) Please explain nature and scope of dose limit (i.e. Who does the edit apply to? Does the limit apply to all opioids? Are you in the process of tapering patients to achieve this limit?).

Providers are not required to taper members to a dose below the cumulative MME threshold set at the point of sale. The prior authorization requirement is set at 90 MME to align with CDC guidelines indicating a threshold of risk the member is crossing by exceeding this dose. 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

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.

      ◉ CDC

      ○ Academic Institution

      ○ Other, please specify.

   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 MME limit is exceeded?

      ◉ Yes

      ○ No

4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?

   - (●) Yes
   - ( ) No

   Please explain.

   Health Plan of Nevada Medicaid has enrolled in an OptumRx RDUR program that notifies the prescribers of medication related issues including when individuals are receiving a high daily dose of opioids defined by the program as 90 MME.

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
   - ( ) 32 mg
   - ( ) Other, please explain.

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

- ○ 3 months or less
- ○ 6 months
- ○ 12 months
- ○ 24 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 or any form of MAT?

- ◉ 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. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

   - (•) Yes
   - ( ) No

   Please explain.

   OptumRx is currently working on Naloxone co-prescribing rules to include in their current RDUR Abused Meds program. They are also looking to integrate the language for naloxone co-prescribing in with the clinical rational provided to prescribers as part of the intervention notification. The addition of these triggers to their program is anticipated for 2021.

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

   - (•) Yes, please explain if a process is in place.

     The process for submitting a claim prescribed by a pharmacist or a collaborative practice agreement is the same as other claims- no specific process in place.

   - ( ) No

9. Does your program 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?

   - (●) Yes
   - ( ) No

   Enter restrictions other than quantity limits in the text box below, or N/A.

   Health Plan of Nevada Medicaid has the following restrictions in place in accordance with FDA labeling: 1) drug specific minimum age requirements - members less than the minimum age require a prior authorization 2) drug specific diagnosis requirements- diagnosis checks are done for preferred agents at the point of sale and off-label diagnosis require a prior authorization. 3) Prior authorization is required for all long-acting injectable products. 4) Health plan of Nevada Medicaid also has a therapeutic duplication soft reject edit at the point of sale on antipsychotics, and an FDA

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 "No," skip to d).

   If "Yes," please continue with a), b) and c).

   a) Do you either manage or monitor:

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

      Monitoring strategy of antipsychotics not only applies to all children, but all adult members as well. However, on 10/1/2019 a new program (Antipsychotic Monitoring of Pediatrics program) was implemented specifically for the entire pediatric population to provide additional clinical reviews of these members.

b) Do you have edits in place to monitor? Check **all** that apply:

- ☒ Child's Age
- ☒ Dosage
- ☒ Indication
- ☒ Polypharmacy
- ☐ Other, please explain.

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 , non-FDA approved diagnosis, or a dosage is above FDA approved maximums 2. CDUR therapeutic duplication soft edits and Cumulative High Dose soft edits are in place for antipsychotics 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 antipsychotic medications

If "No," please continue.

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

- ○ Yes, please specify when.
- ○ 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 "No," skip to d).

   If "Yes," please continue with a), b) and c).

   a) Do you either manage or monitor:

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

      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:

      - [X] Child's Age
      - [X] Dosage
      - [X] Indication
      - [X] Polypharmacy
      - [ ] Other, please explain.

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 programs send faxes to prescribers within 24 hours

If "No," please continue.

d) If you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

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

VIII. INNOVATIVE PRACTICES

1. Summary 4 – Innovative Practices

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MMEs, Value Based Purchasing)? Please describe in detailed narrative below any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e. disease management, academic detailing, automated prior authorizations, continuing education programs).

Concurrent Drug Utilization Review: Improving Effectiveness of Point of Sale Edits

Health Plan of Nevada Medicaid utilizes point-of-sale rejects to alert pharmacists when members are receiving medications that may have medication safety issues: therapeutic duplications, drug-drug interactions, or doses above the FDA maximum recommended dose. In order to ensure members have access to the medications they need, the pharmacist may override the reject at the point-of-sale by entering appropriate National Council for Prescription Drug Programs (NCPDP) codes. Health Plan of Nevada Medicaid continuously monitors the effectiveness of these point-of-sale edits to ensure they continue to be beneficial to our pharmacy partners in prioritizing our members' safety and care. Starting in the first quarter of 2019, monitoring of utilization of the override options began in order to take additional actions for our members' safety. This started by looking at claims that hit the therapeutic duplication edit in two therapeutic classes: respiratory medications and HIV products. Respiratory medication claims hit the point-of-sale edit if an individual attempts to fill a medication that contains an ingredient in the same therapeutic class as another medication on the member's profile; HIV medication claims hit the edit if an individual attempts to fill a medication that contains the same ingredient as another medication filled, or if the member attempts to fill a medication when the member has a complete HIV regimen on their profile.

What Are We Doing Differently
Health Plan of Nevada Medicaid analyzes the point-of-sale claims data on a quarterly basis to identify members who are receiving a large number of overrides. The Drug Utilization Review (DUR) Team then prioritizes the members with the most overrides and reviews the members' medication profiles to determine if a medication related issue exists. When Health Plan of Nevada Medicaid identifies an individual that has overrides multiple months in a row and the point-of-sale reject is not preventing a potential medication issue, the DUR Team recommends the member for follow-up with a clinical health plan pharmacist. The clinical pharmacist reviews the member's profile again and outreaches to the physician's office to discuss the potential medication-related issue. Two common scenarios have been identified through these interventions: 1) members who should have switched therapies, but the previous therapy was never discontinued and 2) members receiving two medications in the same therapeutic class from two different physicians. Health Plan of Nevada Medicaid has outreached to 80 members' physicians since beginning the initiative, with approximately ⅓ of the interventions leading to a change in therapy.

How Are We Ensuring Results
If the physician determines that no therapeutic change is necessary, the member can continue filling the medications as prescribed with no additional intervention required. However, if the physician determines therapeutic changes are necessary during the consultation, the DUR Team re-reviews the member's medication profile to ensure the therapeutic change has occurred and the intervention was successful. The DUR Team re-recommends the member for additional provider follow-up if the point-of-sale edits continue to be overridden after the intervention. This continues until the issue is resolved.

Where Are We Going
Health Plan of Nevada Medicaid is committed to providing the highest quality care to all of our members. Through technological enhancements we will be able to add additional concurrent drug utilization review point-of-sale edits to the program for evaluation and analysis. This will allow an

IX. 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, please explain.

   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
   - ( ) No

   If "Yes," please explain the evaluation methodology in **Summary 5 – E-Prescribing Activity Summary**. Please 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 prescriber's e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

Health Plan of Nevada Medicaid has reporting metrics in place to monitor how often a preferred alternative is then used in e-Prescribing instead of the product the user initially started with. Logic is built out to determine which products should be preferred alternatives vs. other products in order to track which products would make the most impact to behavior change and switch rates. The following are some e-Prescribing accomplishments and plans for future developments.
Electronic Script Routing:
1. Electronic Script Routing on the first fill for last 12 months average (Retail, Home Delivery, Specialty): 70.8%.
2. OptumRx Mail Order (OptumRx Home Delivery and Optum Specialty Pharmacy) eScript Transaction for last 12 months averages at: 85.25%
3. OptumRx Home Delivery implemented script standards to new NCPDP script standards V2017071 and adopted new transaction types:
a. New Rx Received and Response
b. Cancel Rx Received and Response
c. Rx Renewal Received and Response
d. Rx Change Request/Response
e. RxRefill Request/Associated Response
4. Prescriber adaption rate for ePrescribing is at 59.8%
a. Prescriber ePrescribing adaption rate increased by 6% in last 12 months.
5. Please note: these are based on unique prescriber ePrescribed scripts counts on FIRST FILL / total unique prescriber counts on first fill paid.

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

- ○ Yes
- ○ No, please explain.

2. Does your system use the NCPDP Origin Code that indicates the prescription source?
   - ◉ Yes
   - ○ No

X. EXECUTIVE SUMMARY

1. **Summary 6 – Executive Summary**

   Please include a general overview and summary of program highlights from FFY 2019 as well as objectives, tools and outcomes of initiatives accomplished, as well as goals for FFY 2020. Include a summary of program oversight and initiatives.

The purpose of the Health Plan of Nevada Medicaid DUR Board is to provide clinical support for the development, maintenance, and clinical oversight of drug utilization review programs administered by Health Plan of Nevada Medicaid. 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 Health Plan of Nevada Medicaid's DUR Board also develops initiatives that support the medical management strategies for customers in pharmacy benefit plans issued or administered by Health Plan of Nevada Medicaid. The Health Plan of Nevada Medicaid DUR program and policy reviews are designed to assure that the clinical programs and related materials are consistent with published clinical evidence and Health Plan of Nevada Medicaid medical management policies and initiatives. The DUR program consists of four major components: retrospective DUR, prospective DUR, pharmacy lock-in programs, and formulary and utilization management strategies overseen by the P&T Committee.

Health Plan of Nevada Medicaid'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, OptumRx performs targeted retrospective DURs based on claims data spanning timeframes of one day to six months. DUR-identified physicians are sent a fax/letter the contains a description of the medication related problem or gaps in care and profiles of affected members. During the FFY 18-19 OptumRx ran 12 retrospective DUR programs in Nevada including: polypharmacy therapeutic duplication, narcotic drug utilization review, drug interaction alerts, age rx monitoring, average daily dose/dose

APPENDIX

DRUG NAMES

abacavir/dolutegravir/lamivudi
accolate
accupril
acetaminophen
acitretin
acyclovir
adalimumab
aflibercept
albuterol
albuterol sulfate/ipratropium bromide
alendronate sodium
allopurinol
alprazolam
ambrisentan
amiodarone hydrochloride
amitriptyline
amlodipine
amlodipine besylate/benazepril hydrochloride
amoxicillin
amoxicillin/potassium clav
amoxicillin; clavulanate potassium
amphetamine
androgens
antihemophilic factors
anti-inhibitor coagulant comp.
apixaban
apraclonidine
argatroban
aricept
aripiprazole
asenapine maleate
aspirin
atazanavir
atenolol
atomoxetine
atorvastatin
azithromycin
bacitracin/neomycin/ polymyxin b
baclofen
beclomethasone
benazepril hydrochloride
benzonatate
benztropine mesylate
bevacizumab
brexipiprazole
brimonidine tartrate
budesonide
budesonide/ formoterol
buprenorphine
buprenorphine hcl/naloxone hcl
bupropion
buspirone hydrochloride
canagliflozin
carbamazepine
carbidopa/ levodopa
carisoprodol
carvedilol
celecoxib
cephalexin
cetirizine
chlorthalidone
cholecalciferol
cinacalcet hcl
ciprofloxacin
citalopram
clindamycin
clobazam
clobetasol propionate

clonazepam
clonidine
clopidogrel bisulfate
coagulation factors
contraceptives
corticotropin
cyanocobalamin
cyclobenzaprine
cyclosporine
darbepoetin alfa in polysorbat
darunavir ethanolate
darunavir/cobicistat
deferasirox
deferoxamine
deserasirox
desogestrel/ ethinyl estradiol
dexlansoprazole
dexmethylphenidate
dextroamphetamine/amphetamine
diazepam
diclofenac
dicyclomine hydrochloride
digoxin
diltiazem hydrochloride
dimethyl fumarate
diphenhydramine
divalproex sodium
docusate
dolutegravir
donepezil
dornase
dorzolamide hydrochloride/timolol maleate
doxazosin mesylate
doxycycline
drospirenone/ ethinyl estradiol
duloxetine
eculizumab
efavirenz/emtricitabine/tenofovir disoproxil fumarate
elbasvir/grazoprevir
elviteg/cob/emtri/tenofo disop
elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide
emtricita/rilpivirine/tenof df
emtricitabine/tenofovir alafenamide
enalapril maleate
enoxaparin sodium
entecavir
epoetin alfa
ergocalciferol
escitalopram
esomeprazole
estradiol
etanercept
estrogens
everolimus
exenatide
ezetimibe
famotidine
fenofibrate
fentanyl
ferrous sulfate
filgrastim
finasteride
fingolimod
fluconazole
fluoxetine
fluticasone
fluticasone propionate/ salmeterol xinafoate
fluticasone/salmeterol
fluticasone/vilanterol
folic acid
furosemide
gabapentin
gemfibrozil
glatiramer

glimepiride
glipizide
glyburide
guanfacine
guanfacine hcl er
haloperidol
hctz
heparin
hydralazine hydrochloride
hydrochlorothiazide
hydrochlorothiazide/ lisinopril
hydrochlorothiazide/ losartan potassium
hydrochlorothiazide/ triamterene
hydrochlorothiazide/valsartan
hydrocodone
hydrocodone /apap
hydrocortisone
hydromorphone
hydroxychloroquine sulfate
hydroxyprogesterone
hydroxyzine
ibuprofen
imatinib mesylate
immune globulins
infliximab
insulin aspart
insulin detemir
insulin glargine
insulin human
insulin lispro
ipratropium
ipratropium/albuterol
irbesartan
isosorbide mononitrate
ketoconazole
lacosamide
lamotrigine
lansoprazole
latanoprost
ledipasvir/sofosbuvir
lenalidomide
leuprolide acetate
levalbuterol hcl
levetiracetam
levocetirizine dihydrochloride
levofloxacin
levothyroxine
lidocaine
linaclotide
linagliptin
lipase/protease/amylase
liraglutide
lisdexamfetamine
lisinopril
lithium
loratadine
lorazepam
losartan
lovastatin
lumacaftor/vacaftor
lurasidone
magnesium
meclizine hydrochloride
meloxicam
memantine hydrochloride
metformin
metformin hydrochloride/ sitagliptin phosphate
methocarbamol
methotrexate
methylcellulose (4000 mpa.s)
methylphenidate
methylprednisolone
metoprolol
metronidazole

mirtazapine
mometasone
mometasone/formoterol
montelukast
morphine
mupirocin
naloxone
naltrexone
naltrexone microspheres
naproxen
natalizumab
nebivolol hydrochloride
nicotine patch
nifedipine
nitrofurantoin
nitroglycerin
nivolumab
nortriptyline hydrochloride
olanzapine
olmesartan medoxomil
olopatadine
omalizumab
omega-3-acid ethyl esters
omeprazole
ondansetron
oseltamivir
oxybutynin
oxycodone
oxycodone/apap
palbociclib
paliperidone
palivizumab
pantoprazole sodium
paroxetine
pegfilgrastim
pioglitazone
polyethylene glycol 3350
potassium
pravastatin sodium
prednisolone
prednisone
pregabalin
progesterone
promethazine
promethazine hydrochloride
propranolol
quetiapine
raltegravir potassium
ramipril
ranitidine
ranitidine hcl
retinoids
rifaximin
risperidone
risperidone microspheres
ritonavir
rituximab
rivaroxaban
ropinirole hydrochloride
rosuvastatin
rufinamide
sertraline
sertraline hydrochloride
sevelamer hcl
simvastatin
sitagliptin
sitagliptin phos/metformin hcl
sodium chloride
sofosbuvir/velpatasvir
solifenacin succinate
somatropin
spironolactone
sulfamethoxazole/ trimethoprim
sumatriptan

tacrolimus
tamsulosin hydrochloride
temazepam
tenofovir disoproxil fumarate
terazosin
teriflunomide
testosterone
thyroid
timolol
tiotropium
tizanidine
topiramate
tramadol
trastuzumab
trazodone
treprostinil sodium
triamcinolone
ustekinumab
valacyclovir
valsartan
varenicline
vedolizumab
venlafaxine
verapamil
vitamins
warfarin
zolpidem
other

DRUG CLASSES

Analgesics: Drugs that relieve pain. There are two main types: non-narcotic analgesics for mild pain, and narcotic analgesics for severe pain.

Antacids: Drugs that relieve indigestion and heartburn by neutralizing stomach acid.

Antianxiety Drugs: Drugs that suppress anxiety and relax muscles (sometimes called anxiolytics, sedatives, or minor tranquilizers).

Antiarrhythmics: Drugs used to control irregularities of heartbeat.

Antibacterials: Drugs used to treat infections.

Antibiotics: Drugs made from naturally occurring and synthetic substances that combat bacterial infection. Some antibiotics are effective only against limited types of bacteria. Others, known as broad spectrum antibiotics, are effective against a wide range of bacteria.

Anticoagulants and Thrombolytics: Anticoagulants prevent blood from clotting. Thrombolytics help dissolve and disperse blood clots and may be prescribed for patients with recent arterial or venous thrombosis.

Anticonvulsants: Drugs that prevent epileptic seizures.

Antidepressants: There are three main groups of mood-lifting antidepressants: tricyclics, monoamine oxidase inhibitors, and selective serotonin reuptake inhibitors (SSRIs).

Antidiarrheals: Drugs used for the relief of diarrhea. Two main types of antidiarrheal preparations are simple adsorbent substances and drugs that slow down the contractions of the bowel muscles so that the contents are propelled more slowly.

Antiemetics: Drugs used to treat nausea and vomiting.

Antifungals: Drugs used to treat fungal infections, the most common of which affect the hair, skin, nails, or mucous membranes.

Antihistamines: Drugs used primarily to counteract the effects of histamine, one of the chemicals involved in allergic reactions.

Antihypertensives: Drugs that lower blood pressure. The types of antihypertensives currently marketed include diuretics, beta-blockers, calcium channel blocker, ACE (angiotensin-converting enzyme) inhibitors, centrally acting antihypertensives and sympatholytics.

Anti-Inflammatories: Drugs used to reduce inflammation - the redness, heat, swelling, and increased blood flow found in infections and in many chronic noninfective diseases such as rheumatoid arthritis and gout.

Antineoplastics: Drugs used to treat cancer.

Antipsychotics: Drugs used to treat symptoms of severe psychiatric disorders. These drugs are sometimes called major tranquilizers.

Antipyretics: Drugs that reduce fever.

Antivirals: Drugs used to treat viral infections or to provide temporary protection against infections such as influenza.

Barbiturates: See "sleeping drugs."

Beta-Blockers: Beta-adrenergic blocking agents, or beta-blockers for short, reduce the oxygen needs of the heart by reducing heartbeat rate.

Bronchodilators: Drugs that open up the bronchial tubes within the lungs when the tubes have become narrowed by muscle spasm. Bronchodilators ease breathing in diseases such as asthma.

Cold Cures: Although there is no drug that can cure a cold, the aches, pains, and fever that accompany a cold can be relieved by aspirin or acetaminophen often accompanied by a decongestant, antihistamine, and sometimes caffeine.

Corticosteroids: These hormonal preparations are used primarily as anti-inflammatories in arthritis or asthma or as immunosuppressives, but they are also useful for treating some malignancies or compensating for a deficiency of natural hormones in disorders such as Addison's disease.

Cough Suppressants: Simple cough medicines, which contain substances such as honey, glycerine, or menthol, soothe throat irritation but do not actually suppress coughing. They are most soothing when taken as lozenges and dissolved in the mouth. As liquids they are probably swallowed too quickly to be effective. A few drugs are actually cough suppressants. There are two groups of cough suppressants: those that alter the consistency or production of phlegm such as mucolytics and expectorants; and those that suppress the coughing reflex such as codeine (narcotic cough suppressants), antihistamines, dextromethorphan and isoproterenol (non-narcotic cough suppressants).

Cytotoxics: Drugs that kill or damage cells. Cytotoxics are used as antineoplastics (drugs used to treat cancer) and also as immunosuppressives.

Decongestants: Drugs that reduce swelling of the mucous membranes that line the nose by constricting blood vessels, thus relieving nasal stuffiness.

Diuretics: Drugs that increase the quantity of urine produced by the kidneys and passed out of the body, thus ridding the body of excess fluid. Diuretics reduce water logging of the tissues caused by fluid retention in disorders of the heart, kidneys, and liver. They are useful in treating mild cases of high blood pressure.

Expectorant: A drug that stimulates the flow of saliva and promotes coughing to eliminate phlegm from the respiratory tract.

Hormones: Chemicals produced naturally by the endocrine glands (thyroid, adrenal, ovary, testis, pancreas, parathyroid). In some disorders, for example, diabetes mellitus, in which too little of a particular hormone is produced, synthetic equivalents or natural hormone extracts are prescribed to restore the deficiency. Such treatment is known as hormone replacement therapy.

Hypoglycemics (Oral): Drugs that lower the level of glucose in the blood. Oral hypoglycemic drugs are used in diabetes mellitus if it cannot be controlled by diet alone, but does require treatment with injections of insulin.

Immunosuppressives: Drugs that prevent or reduce the body's normal reaction to invasion by disease or by foreign tissues. Immunosuppressives are used to treat autoimmune diseases (in which the body's defenses work abnormally and attack its own tissues) and to help prevent rejection of organ transplants.

Laxatives: Drugs that increase the frequency and ease of bowel movements, either by stimulating the bowel wall (stimulant laxative), by increasing the bulk of bowel contents (bulk laxative), or by lubricating them (stool-softeners, or bowel movement-softeners). Laxatives may be taken by mouth or directly into the lower bowel as suppositories or enemas. If laxatives are taken regularly, the bowels may ultimately become unable to work properly without them.

Muscle Relaxants: Drugs that relieve muscle spasm in disorders such as backache. Antianxiety drugs (minor tranquilizers) that also have a muscle-relaxant action are used most commonly.

Sedatives: Same as Antianxiety drugs.

Sex Hormones (Female): There are two groups of these hormones (estrogens and progesterone), which are responsible for development of female secondary sexual characteristics. Small quantities are also produced in males. As drugs, female sex hormones are used to treat menstrual and menopausal disorders and are also used as oral contraceptives. Estrogens may be used to treat cancer of the breast or prostate, progestins (synthetic progesterone to treat endometriosis).

Sex Hormones (Male): Androgenic hormones, of which the most powerful is testosterone, are responsible for development of male secondary sexual characteristics. Small quantities are also produced in females. As drugs, male sex hormones are given to compensate for hormonal deficiency in hypopituitarism or disorders of the testes. They may be used to treat breast cancer in women, but either synthetic derivatives called anabolic steroids, which have less marked side-effects, or specific anti-estrogens are often preferred. Anabolic steroids also have a "body building" effect that has led to their (usually nonsanctioned) use in competitive sports, for both men and women.

Sleeping Drugs: The two main groups of drugs that are used to induce sleep are benzodiazepines and barbiturates. All such drugs have a sedative effect in low doses and are effective sleeping medications in higher doses. Benzodiazepines drugs are used more widely than barbiturates because they are safer, the side-effects are less marked, and there is less risk of eventual physical dependence.

Tranquilizer: This is a term commonly used to describe any drug that has a calming or sedative effect. However, the drugs that are sometimes called minor tranquilizers should be called antianxiety drugs, and the drugs that are sometimes called major tranquilizers should be called antipsychotics.

Vitamins: Chemicals essential in small quantities for good health. Some vitamins are not manufactured by the body, but adequate quantities are present in a normal diet. People whose diets are inadequate or who have digestive tract or liver disorders may need to take supplementary vitamins.

Other: Please specify.

DENIAL REASONS

accumulation refill too soon

age

brand request

claim requires an approved treatment authorization request (tar)

claim submitted does not match pa

compliance monitoring/early or late refill

cumulative early refill

daily dose exceeded

days supply

drug covered by medicare part D

drug list initiative threshold

drug-disease reported precaution

drug-drug interaction

duplicate claim

dur reject error

early refill: overuse precaution

eligibility

exceeds allowable plan days supply

filled after coverage terminated

high dose alert

m/i days supply

m/i diagnosis code

m/i other coverage code
m/i prescriber
md must call for a prior authorization
member enrolled in managed care
members benefits package does not include this medication
ndc not consistent with any billed diagnosis
ndc not covered
ndc vs diagnosis restriction
no rebate
non-covered and non-rebate products
non-matched prescriber id
non-preferred drug
over utilization precaution
patient is not covered
PDL
pharmacy maintenance supply required for drug
plan limitations exceeded
prescriber is not covered
prior authorization required
product/service not covered – plan/benefit exclusion
produr alert
provider not enrolled in benefit plan
bill medicare
quantity dispensed exceeds maximum allowed
refill exceeds max. allowable refills
refill too soon
reported disease
service not covered
submit bill to other processor or primary payor
tamper proof pad reqd
therapeutic duplication
under utilization precaution
other