

ABOUT THE SURVEY

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.

Note: Covered Outpatient Drugs (COD) are referenced throughout this survey and refers to participating labelers in the Medicaid Drug Rebate Program (MDRP).

This report covers the period October 1, 2019 to September 30, 2020 and is due for submission to CMS Central Office by no later than June 30, 2021. 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.

Pursuant to 42 C.F.R. Subpart A, Section § 438.3 (s), Medicaid managed care programs must submit to CMS an annual report on the operation of its DUR program activities for that Federal Fiscal Year (FFY). Beginning with FFY 2020 surveys, individual managed care plan's survey results will be published online and will be publicly available similar to the FFS surveys which have been published on Medicaid.gov since 2010. **Please confirm and acknowledge there is no proprietary or confidential information submitted in this report by checking the box below:**

I confirm I am aware this survey will be posted online. Confidential and proprietary information has been removed from this survey.

PRA DISCLOSURE STATEMENT (CMS-R-153)

This mandatory information collection (section 4401 of the Omnibus Budget Reconciliation Act of 1990 and section 1927(g) of the Social Security Act) is necessary to establish patient profiles in pharmacies, identify problems in prescribing and/or dispensing, determine each program's ability to meet minimum standards required for Federal financial participation, and ensure quality pharmaceutical care for Medicaid patients. State Medicaid agencies that have prescription drug programs are required to perform prospective and retrospective DUR in order to identify aberrations in prescribing, dispensing and/or patient behavior. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this information collection request is 0938-0659 (Expires: 11/30/2022). Public burden for all of the collection of information requirements under this control number is estimated at 64 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

I. **DEMOGRAPHIC INFORMATION**

State Abbreviation: _____

MCO Name: _____

Please note: Name above must match name entered in Medicaid Drug Programs (MDP) DUR system

Program Type: _____

(See Appendix A)

If “Other”, please specify.

Medicaid MCO Information

Identify the MCO person responsible for DUR Annual Report preparation.

First Name: _____

Last Name: _____

Email Address: _____

Area Code/Phone Number: _____

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

_____ Beneficiaries

II. **PROSPECTIVE DUR (ProDUR)**

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

State-operated

Contractor

Other organization

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

If “Other”, please specify.

2. Identify ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity. Check **all** that apply:

First Data Bank

Medi-Span

MICROMEDEX

Other, please specify.

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

Yes

Varies by Alert Type

No

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

Alerts can be overridden ahead of time

Alerts can be overridden with standard professional codes

Alerts need prior authorization (PA) to be overridden

Other, please explain.

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

Yes

- a) How often does your MCO receive reports? Check **all** that apply:

Monthly

Quarterly

Annually

Ad hoc (on request)

Other, please explain.

- b) Does your MCO follow up with those providers who routinely override with interventions?

Yes

- By what method does your MCO follow up? Check **all** that apply:

Contact Pharmacy

Refer to Program Integrity (PI) for Review

Other, please explain.

No

No, please explain.

5. Early Refill

a) At what percent threshold does your MCO set your system to edit?

i. Non-controlled drugs:

_____ %

ii. Schedule II controlled drugs:

_____ %

iii. Schedule III through V controlled drugs:

_____ %

b) For non-controlled drugs:

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

Yes

No

Dependent on the medication or situation

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

Pharmacist

Prescriber

Pharmacist or Prescriber

If “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 PA?

Yes

No

If "Yes", who obtains authorization?

Pharmacist

Prescriber

Pharmacist or Prescriber

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

Yes

No

6. 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 PA

b) Vacation

Yes

No

Overrides are only allowed by a pharmacist through a PA

c) Other, please explain.

7. 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”, does your MCO plan to implement this edit?

Yes

No

8. Does your 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

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

Yes

Check **all** that apply:

Automatic PA based on diagnosis codes or systematic review

Trial and failure of first or second line therapies

Pharmacist or technician reviews

Direct involvement with Pharmacy and/or Medical Director

Other, please explain.

No, please explain.

a) How does your MCO ensure PA criteria is no more restrictive than the FFS criteria and review? Please describe the process.

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

Yes

Check **all** that apply:

Real time automated process

Retrospective PA

Other process, please explain.

No, please explain.

10. 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 PA Requests by Drug Name, report at generic ingredient level ([See Appendix B for the list of Drug Names](#))

Column 2 – Top 10 PA Requests by Drug Class ([See Appendix C for Drug Class names](#))

Column 3 – Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE)) ([See Appendix D for the list of Denial Reasons](#))

Column 4 – Top 10 Drug Names by Amount Paid, report at generic ingredient level ([See Appendix B 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, report at generic ingredient level ([See Appendix B 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 PA Requests by Drug Name, report at generic ingredient level (See Appendix B for the list of Drug Names)	Column 2 Top 10 PA Requests by Drug Class (See Appendix C for Drug Class names)	Column 3 Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE)) (See Appendix D for the list of Denial Reasons)	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level (See Appendix B 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 B 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)
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%

III. **RETROSPECTIVE DUR (RetroDUR)**

1. Please indicate how your MCO operates and oversees RetroDUR reviews.

State-operated interventions

Managed Care executes its own RetroDUR activities

Pharmacy Benefit Manager (PBM) performs RetroDUR activities

Combination of MCO RetroDUR interventions and state interventions are performed

Other, please explain.

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

Company

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

Academic Institution, please identify by name and type.

Other Institution, please identify by name and type.

- a) Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?

Yes, please explain.

No, please explain.

- b) Does your MCO customize your RetroDUR vendor criteria?

Yes

No

Ad hoc based on state-specific needs

3. Who reviews and approves your MCO RetroDUR criteria?

State DUR Board

MCO DUR Board

PBM performs RetroDUR and has a RetroDUR Board

PBM Pharmacy and Therapeutics (P&T) Board also functions as a DUR Board

State Pharmacy Director

Other, please explain.

4. How often does your MCO perform retrospective practitioner-based education?

Monthly

Bi-monthly

Quarterly

Other, please specify: _____

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

Monthly

Bi-monthly

Quarterly

Other, please specify: _____

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

Mailed letters

Provider phone calls

Near real time fax

Near real time messaging

Other new technologies such as apps or Quick Response (QR) codes

Focused workshops, case management or WebEx training

Newsletters or other non-direct provider communications

Other, please specify:

5. Summary 1: RetroDUR Educational Outreach

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

IV. **DUR BOARD ACTIVITY**

1. Does your MCO utilize the same DUR Board as the state FFS Medicaid program 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. Summary 2: DUR Board Activities Summary

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

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
 - 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).

3. Does your MCO have a Medication Therapy Management (MTM) Program?

Yes

No

V. **PHYSICIAN ADMINISTERED DRUGS (PAD)**

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

1. ProDUR?

Yes

No

If “No”, does your MCO have a plan to include this information in your DUR criteria in the future?

Yes

No

2. RetroDUR?

Yes

No

If “No”, does your MCO 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 should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, PDL policies, educational initiatives, technology or promotional factors, or other state specific factors that affects your generic utilization rate.

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(s).

PA is required.

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.

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 Percentage of Total Drug 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](https://www.medicare.gov) (Click on the link “[National Drug Code and Drug Category file](#) [ZIP],” then open the Medicaid Drug Product File 4th Qtr. 2020 Excel file).

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drug
Total Number of Claims			
Total Reimbursement Amount Less Co-Pay			

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

Number of Generic Claims: _____

Total Number of Claims: _____

Generic Utilization Percentage: _____%

4. How many multi-source drugs have the innovator as the preferred drug product based on net pricing?

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

Generic Dollars: _____

Total Dollars: _____

Generic Expenditure Percentage: _____%

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

VII. FRAUD, WASTE, AND ABUSE DETECTION (FWA)

A. LOCK-IN OR PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by **beneficiaries**?

Yes

No

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

Deny claims

Require PA

Refer to Lock-In Program

Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation

Refer to Office of Inspector General (OIG)

Other, please explain.

2. Does your MCO have a Lock-In Program for beneficiaries with potential FWA 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:

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) Does your MCO 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 by the state/MCO 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?

_____ %

e) Please provide an estimate of the savings attributed to the Lock-In Program for the fiscal year under review.

_____ %

3. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by **prescribers**?

Yes

What actions does this process initiate? Check **all** that apply:

Deny claims written by this prescriber

Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation

Refer to the appropriate Medical Board

Other, please explain.

No, please explain.

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

Yes

What actions does this process initiate? Check **all** that apply:

Deny claims

Refer to Program Integrity Unit (PIU) and/ or Surveillance Utilization Review (SUR) Unit for audit/investigation

Refer to the Board of Pharmacy

Other, please explain.

No, please explain.

5. Does your MCO 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 FWA of non-controlled substances.

No, please explain.

B. **PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)**

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

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

Yes, receive PDMP data

Please indicate how often:

Daily

Weekly

Monthly

Other, please specify: _____

Yes, have access to the database

Check **all** that apply:

Can query by client

Can query by prescriber

Can query by dispensing entity

No, please explain.

If "Yes", please continue.

a) Please explain how your MCO program applies this information to control FWA of controlled substances.

b) Does your MCO have access to Border States' PDMP information?

Yes

No

c) Does your MCO also have PDMP data integrated into your POS edits?

Yes

No

2. Does your MCO or the professional board require prescribers (in your provider agreement) to access the PDMP patient history before prescribing controlled substances?

Yes

No, please explain.

If "Yes", please continue.

a) Are there protocols involved in checking the PDMP?

Yes, please explain.

No

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

Yes

No

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

Yes

Does your MCO require the provider to submit, upon request, documentation to the MCO?

Yes

No, please explain.

No, please explain.

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

Yes

Are there protocols involved in checking the PDMP?

Yes, please explain.

No

No, please explain.

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

PDMP drug history

The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period

The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills

Other, please explain.

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 FWA?

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).

No

5. (Optional) Please specify below the following information for the 12-month reporting period for this survey. Note: Mandatory reporting will be required in FFY2023 under Section 1927(g)(3)(D) of the Act.

a) The percentage of covered providers who checked the prescription drug history of a beneficiary through a PDMP before prescribing a controlled substance to such an individual:

_____ %

b) Average daily MME prescribed for controlled substances per covered individuals who are receiving opioids:

_____ MMEs

c) Please complete Tables 3, 4, 5 and 6 below. Specify the controlled substances prescribed based on claim count (by generic ingredient(s)) and within each population during this FFY reporting period.

Table 3: Top Opioid Controlled Substances by Population

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving an Opioid Controlled Substance in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving an Opioid Controlled Substances in the 12 Month Reporting Period	Column 4 Top 3 Opioid Controlled Substances Received Within Each Age Group (<u>Generic Ingredient</u>) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Opioid Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Opioid Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.			%			%
19-29 yrs.			%			%
30-39 yrs.			%			%
40-49 yrs.			%			%
50-59 yrs.			%			%
60-69 yrs.			%			%
70-79 yrs.			%			%
80+ yrs.			%			%
Individuals with Disabilities Utilizing State Eligibility Categories			%			%

Table 4: Top Sedative/Benzodiazepines Controlled Substances by Population

When listing the controlled substances in different drug categories, for the purpose of Table 4 below, please consider long and short acting benzodiazepines to be in the same category.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving a Sedative/Benzodiazepine in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Sedative/Benzodiazepine in the 12 Month Reporting Period	Column 4 Top 3 Sedative/Benzodiazepine Received Within Each Age Group (<i>Generic Ingredient</i>) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Sedative/Benzodiazepine (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Sedative/Benzodiazepine (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.			%			%
						%
						%
19-29 yrs.			%			%
						%
						%
30-39 yrs.			%			%
						%
						%
40-49 yrs.			%			%
						%
						%
50-59 yrs.			%			%
						%
						%
60-69 yrs.			%			%
						%
						%
70-79 yrs.			%			%
						%
						%
80+ yrs.			%			%
						%
						%
Individuals with Disabilities Utilizing State Eligibility Categories			%			%
						%
						%

Table 5: Top Stimulant/ADHD Controlled Substances by Population

When listing the controlled substances in different drug categories, for the purpose of Table 5 below, please consider long and short acting ADHD medications to be in the same category.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD in the 12 Month Reporting Period	Column 4 Top 3 Stimulant/ADHD Received Within Each Age Group (<u>Generic Ingredient</u>) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Stimulant/ADHD (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Stimulant/ADHD (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.			%			%
						%
						%
19-29 yrs.			%			%
						%
						%
30-39 yrs.			%			%
						%
						%
40-49 yrs.			%			%
						%
						%
50-59 yrs.			%			%
						%
						%
60-69 yrs.			%			%
						%
						%
70-79 yrs.			%			%
						%
						%
80+ yrs.			%			%
						%
						%
Individuals with Disabilities Utilizing State Eligibility Categories			%			%
						%
						%

Table 6: Populations on 2 or more Controlled Substances in Different Drug Categories

When listing the controlled substances in different drug categories, for the purpose of Table 6 below, please consider long and short acting opioids to be in the same category. Please follow this approach for long and short acting ADHD medications and benzodiazepines in this table as well. Please note, Column 2 and Column 4 is requesting an average monthly value based on the 12 month reporting period.

Population	Column 1 Total Number of Beneficiaries within Each Age Group	Column 2 Number of Unique Beneficiaries in Each Age Group Receiving 2 or more Controlled Substances in Different Drug Categories per Month Averaged for the 12 Month Reporting Period	Column 3 Percentage of Age Group Receiving 2 or more Controlled Substances Averaged for the 12 Month Reporting Period	Column 4 Number of Unique Beneficiaries in Each Age Group Receiving 3 or more Controlled Substances in Different Drug Categories per Month Averaged for the 12 Month Reporting Period	Column 5 Percentage of Age Group Receiving 3 or more Controlled Substances Averaged for the 12 Month Reporting Period
0-18 yrs.			%		%
19-29 yrs.			%		%
30-39 yrs.			%		%
40-49 yrs.			%		%
50-59 yrs.			%		%
60-69 yrs.			%		%
70-79 yrs.			%		%
80+ yrs.			%		%
Individuals with Disabilities Utilizing State Eligibility Categories			%		%

i) If there is additional information you want to provide for the previous 12-month reporting period, please explain below, or N/A.

ii) If any of the information requested is not being reported above, please explain below, or N/A.

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

Yes

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

No

C. **OPIOIDS**

1. Does your MCO 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 response above.

If “No”, [skip to question 1.b.](#)

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

Yes, please explain.

No

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

_____ # of days

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

Yes, for **all** opioids

Yes, for some opioids

No, for **all** opioids

Please explain response above.

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

Yes

What is your maximum days' supply per prescription limitation?

30-day supply

34-day supply

90-day supply

Other, please explain.

No, please explain.

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

Yes

What is your maximum days' supply per prescription limitation?

30-day supply

34-day supply

90-day supply

Other, please explain.

No, please explain.

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

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

Pharmacist override

Deny claim and require PA

Intervention letters

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.

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

Yes

No

Please explain above response.

6. Does your MCO have POS edits and an automated retrospective claims review process to monitor early refills of opioid prescriptions dispensed?

Yes, POS edits

Yes, automated retrospective claims review process

Yes, both POS edits and automated retrospective claims review process

No

If any response is “Yes”, please explain scope and nature of reviews and edits.

If “No”, please explain.

7. Does your MCO have a comprehensive automated retrospective claims review process to monitor opioid prescriptions exceeding state limitations?

Yes, please explain in detail the scope and nature of these retrospective reviews.

No, please explain.

8. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and benzodiazepines being used concurrently?

Yes, POS edits

Yes, automated retrospective claims review process

Yes, both POS edits and automated retrospective claims review process

Please explain the above response and detail the scope and nature of these reviews and/or edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the state justifies pain medications, i.e. Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e. quantity limits/practitioner education titration programs).

No, please explain.

9. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and sedatives being used concurrently?

Yes, POS edits

Yes, automated retrospective claims review process

Yes, both POS edits and automated retrospective claims review process

Please explain the above response and detail the scope and nature of these reviews and/or edits.

No, please explain.

10. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and antipsychotics being used concurrently?

Yes, POS edits

Yes, automated retrospective claims review process

Yes, both POS edits and automated retrospective claims review process

Please explain the above response and detail the scope and nature of these reviews and/or edits.

No, please explain.

11. Does your MCO have POS safety edits or perform automated retrospective claims review 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, automated retrospective claims review and/or provider education

Yes, both POS edits and automated retrospective claims review and/or provider education

No

If “No”, [skip to question 11.c.](#)

If “Yes, automated retrospective claims review and/or provider education”, please continue with questions 11.a and 11.b.

a) Please indicate how often:

Monthly

Quarterly

Semi-Annually

Annually

Ad hoc

Other, please specify.

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

If “No”, please continue.

- c) Does your MCO plan on implementing automated retrospective claims review and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

Yes, when does your MCO plan on implementing?

No, please explain.

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

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

Your prescribers are referred to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain

Other guidelines, please identify.

No, please explain why no guidelines are offered.

13. Does your MCO 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

D. **MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE**

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

Yes

No, please explain the measure or program you utilize.

If “Yes”, please continue.

a) What is your maximum MME 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

- 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?).

- 2. Does your MCO have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

Yes

No

If “Yes”, does your MCO require PA if the MME limit is exceeded?

Yes

No

- 3. Does your MCO have automated retrospective claims review to monitor the MME total daily dose of opioid prescriptions dispensed?

Yes, please explain.

No, please explain.

4. Does your MCO provide information to your prescribers on how to calculate the morphine equivalent daily dosage or does your MCO 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.

E. **OPIOID USE DISORDER (OUD) TREATMENT**

1. Does your MCO have utilization controls (i.e. PDL, PA, QL) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

Yes, please explain.

No

2. 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.

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

No limit

3 months or less

6 months

12 months

24 months

Other, please explain.

4. Does your MCO 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?

No limit

6 months

12 months

Other, please explain.

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

Yes

No

6. Does your MCO 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

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

Yes

No

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

Yes

No

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

Yes

No, please explain.

10. 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.

No

F. **OUTPATIENT TREATMENT PROGRAMS (OTP)**

1. Does your MCO cover OTPs that provide behavioral health (BH) and MAT through OTPs?

Yes

No, please explain.

If “Yes”, is a referral needed for OUD treatment through OTPs?

Yes, please explain.

No, please explain.

2. Does your MCO cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

Yes

No, please explain.

3. Does your MCO cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?

Yes

No, please explain.

4. Does your MCO cover Methadone for substance use disorder (i.e. OTPs, Methadone Clinics)?

Yes

No

G. **ANTIPSYCHOTICS /STIMULANTS**

ANTIPSYCHOTICS

1. Does your MCO currently have restrictions in place to limit the quantity of antipsychotics?

Yes

No

Please explain restrictions or N/A.

2. Does your MCO 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 question 2.d.](#)

If “Yes”, please continue with questions 2.a, 2.b and 2.c.

a) Does your MCO either manage or monitor:

Only children in foster care

All children

Other, please explain.

b) Does your MCO 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 documented antipsychotic monitoring program(s).

If "No," please continue.

d) Does your MCO plan on implementing a program in the future?

Yes, please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.

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

STIMULANTS

3. Does your MCO 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 question 4.d.](#)

If “Yes”, please continue with questions 4.a, 4.b and 4.c.

a) Does your MCO 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

Indication

Polypharmacy

Other, please explain.

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

If “No”, please continue.

- d) Does your MCO plan on implementing a program in the future?

Yes, please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.

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. Does your MCO participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid Beneficiaries?

Yes, please explain.

No

2. 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 PA, continuing education programs).

IX. EXECUTIVE SUMMARY

Summary 5: Executive Summary

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

APPENDIX A: MCO PROGRAM TYPES**DEFINITIONS OF MANAGED CARE PROGRAM TYPES**

A managed care program is defined by the set of benefits covered and the type of participating managed care plans (e.g., MCOs, PHPs, PACE, etc.) or providers (e.g., PCCM providers).

Managed Care Program Type	Definition
Comprehensive MCO	<p>Comprehensive Managed Care Organization: A program in which the State contracts with managed care plans to cover all acute and primary medical services; some also cover behavioral health, dental, transportation and long term care. Entities that qualify as MCOs include Health Maintenance Organizations (HMOs) and Health Insuring Organizations (HIOs in California).</p> <p>If the comprehensive MCO also covers long-term services and supports, the program type should be Comprehensive MCO + MLTSS.</p> <p>When certain benefits, such as behavioral health, dental, or transportation, are carved out of the comprehensive MCO program and covered through a limited benefit program (i.e. a Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan), enrollees in such limited benefit plans should be reported in separate programs of the appropriate type (e.g., BHO (PIHP and/or PAHP), Dental PAHP, or Non-Emergency Medical Transportation, or an MLTSS-only program when only LTSS and no other services are covered.</p> <p>Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS) as of the July 1 point in time.</p>
Comprehensive MCO + MLTSS	<p>Comprehensive Managed Care Organization + Managed Long-Term Services and Supports: A program in which plans cover comprehensive acute and outpatient benefits as defined above, where the same plan also covers long-term services and supports (LTSS).</p> <p>Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS).</p>
BHO Only (PIHP and/or PAHP)	<p>Behavior Health Organizations Only (Prepaid Inpatient Health Plan and/or Prepaid Ambulatory Health Plan): A program specializing in behavioral health (mental health and/or substance use disorder) services. Services are covered on a prepaid basis.</p>
Dental only (PAHP)	<p>A Prepaid Ambulatory Health Program (PAHP) that only provides dental services.</p>
MLTSS Only	<p>Managed Long Term Services and Supports Only: A program only covering long term services and supports.</p>
Other PHP	<p>Other Prepaid Health Plan: A program covering a limited set of services through PIHPs or PAHPs not otherwise included above. Examples include disease management and pharmacy benefits.</p>

Managed Care Program Type	Definition
PACE	<p>Programs of All-Inclusive Care for the Elderly: A program that provides prepaid, capitated comprehensive medical and social services in an adult day health center, supplemented by in-home and referral services according to a participant’s needs. To qualify, individuals must: (1) be 55 years of age or older, (2) meet a nursing home level of care, and (3) live in a PACE organization service area.</p>
PCCM	<p>Primary Care Case Management: A managed care arrangement in which primary care providers contract with the state to provide a core set of case management services to the enrollees assigned to them and to serve as the enrollees’ home for medical care, in exchange for a monthly case management fee. All other services are reimbursed on a FFS basis. Primary Care Providers (PCPs) can include primary care physicians, clinics, group practices and nurse practitioners, among others. In general, we would only expect case management and physician services to be covered under capitation for PCCM programs.</p>
PCCM entity	<p>Primary Care Case Management entity: In addition to providing primary care case management services for the State, a PCCM entity is an organization that provides any of the following functions: (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line; (2) Development of enrollee care plans; (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program; (4) Provision of payments to FFS providers on behalf of the State; (5) Provision of enrollee outreach and education activities; (6) Operation of a customer service call center; (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; (9) Coordination with behavioral health systems/providers; and/or (10) Coordination with long-term services and supports systems/ providers.</p>
Non-Emergency Medical Transportation (NEMT)	<p>A program that covers transportation to and from medically necessary health care services in which these services are paid for on a per capita basis (the state pays the transportation broker based on the number of people served, not the amount of service or trips that each individual receives). Do not report transportation programs in which individual trips are reimbursed on a FFS basis.</p>

MANAGED CARE PLAN CROSSWALK

The table below provides a crosswalk for plan types to program types.

Managed Care Plan Type	Managed Care Program Type
Comprehensive MCO	<ul style="list-style-type: none"> • Comprehensive MCO • Comprehensive MCO +MLTSS (if benefits include LTSS)
Traditional PCCM Provider	<ul style="list-style-type: none"> • PCCM
Enhanced PCCM Provider	<ul style="list-style-type: none"> • PCCM
HIO	<ul style="list-style-type: none"> • Comprehensive MCO
Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)	<ul style="list-style-type: none"> • Other PHP
Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)	<ul style="list-style-type: none"> • Other PHP
Long Term Care (LTC) PIHP	<ul style="list-style-type: none"> • MLTSS Only
Mental Health (MH) PIHP	<ul style="list-style-type: none"> • BHO (PIHP and/or PAHP)
Mental Health (MH) PAHP	<ul style="list-style-type: none"> • BHO (PIHP and/or PAHP)
Substance Use Disorders (SUD) PIHP	<ul style="list-style-type: none"> • BHO (PIHP and/or PAHP)
Substance Use Disorders (SUD) PAHP	<ul style="list-style-type: none"> • BHO (PIHP and/or PAHP)
Mental Health (MH) and Substance Use Disorders (SUD) PIHP	<ul style="list-style-type: none"> • BHO (PIHP and/or PAHP)
Mental Health (MH) and Substance Use Disorders (SUD) PAHP	<ul style="list-style-type: none"> • BHO (PIHP and/or PAHP)
Dental PAHP	<ul style="list-style-type: none"> • Dental
Transportation PAHP	<ul style="list-style-type: none"> • NEMT
Disease Management PAHP	<ul style="list-style-type: none"> • Other PHP
PACE	<ul style="list-style-type: none"> • PACE
Pharmacy PAHP	<ul style="list-style-type: none"> • Other PHP
Accountable Care Organization	<ul style="list-style-type: none"> • Comprehensive MCO • Other PHP • PCCM
Health/Medical Home	<ul style="list-style-type: none"> • PCCM

Managed Care Plan Type	Managed Care Program Type
Integrated Care For Dual Eligibles	<ul style="list-style-type: none"> • Comprehensive MCO + MLTSS, • MLTSS Only (if benefits cover LTSS)
Unknown – it is not yet known how PCCM entities will be reported in T-MSIS.	<ul style="list-style-type: none"> • PCCM entity

APPENDIX B: DRUG NAMES

0.9 % sodium chloride	atorvastatin
abacavir	azithromycin
abacavir/dolutegravir/lamivudine	aztreonam
abacavir/lamivudine	bacitracin
abacavir/lamivudine/zidovudine	bacitracin/polymyxin B
abatacept	baclofen
acetaminophen	beclomethasone
acetaminophen with codeine	belimumab
acyclovir	benzonatate
adalimumab	benztropine
adapalene	bevacizumab
adapalene/benzoyl peroxide	bictegravir/emtricitabine/tenofovir
aflibercept	brexpiprazole
albuterol	brompheniramine
alglucosidase alfa	brompheniramine/phenylpropanolamine
alogliptin	brompheniramine/pseudoephedrine
alogliptin/metformin	brompheniramine/pseudoephedrine/dextromethorpha n
alogliptin/pioglitazone	budesonide
alprazolam	budesonide/formoterol
ambrisentan	buprenorphine
amlodipine	buprenorphine/naloxone
amlodipine/atorvastatin	bupropion
amlodipine/benazepril	bupirone
amlodipine/olmesartan	cabergoline
amlodipine/valsartan	calcipotriene
amoxicillin	calcipotriene/betamethasone
amoxicillin/potassium clavulanate	calcitriol
amphetamine	cannabidiol (CBD)
apixaban	capsaicin
apremilast	carbetapentane/ephed/phenylephrine/chlorphenir
aripiprazole	cariprazine
armodafinil	carisoprodol
asenapine	carisoprodol/aspirin
aspirin	carisoprodol/aspirin/codeine
atezolizumab	carvedilol
atomoxetine	

cefdinir	dexmethylphenidate
ceftriaxone	dextroamphetamine
celecoxib	dextroamphetamine/amphetamine
cephalexin	dextromethorphan
certolizumab	dextrose
cetirizine	diazepam
chlorhexidine	diclofenac
chlorpromazine	dimethyl fumarate
cinacalcet	diphenhydramine
ciprofloxacin/dexamethasone	divalproex
citalopram	docusate
clarithromycin	dolutegravir
clindamycin	dornase alfa
clindamycin/benzoyl peroxide	doxercalciferol
clindamycin/tretinoin	doxycycline
clobazam	doxylamine
clobetasol	doxylamine/phenylephrine
clonazepam	doxylamine/pyridoxine
clonidine	dronabinol
clopidogrel	dulaglutide
coagulation factor VIIa (recombinant)	duloxetine
colchicine	dupilumab
corticotropin	eculizumab
crisaborole	efavirenz/emtricitabine/tenofovir
cyclobenzaprine	elexacaftor/tezacaftor/ivacaftor
cyclosporine	elvitegravir/cobicistat/emtricitabine/tenofovir
cyproheptadine	emicizumab
daptomycin	empagliflozin
daratumumab	emtricitabine
darunavir	emtricitabine/rilpivirine/tenofovir
eth/cobicistat/emtricitabine/tenofovir	emtricitabine/tenofovir
darunavir ethanolate	enoxaparin
darunavir ethanolate/cobicistat	epinephrine
dasatinib	epoetin alfa
deferasirox	erenumab
desvenlafaxine	ergocalciferol
dexamethasone	escitalopram
dexbrompheniramine/phenylephrine	esomeprazole

etanercept	heparin
eteplirsen	hyaluronate
etonogestrel	hydrochlorothiazide
everolimus	hydrocodone
exenatide	hydrocodone/acetaminophen
ezetimibe	hydrocodone/chlorpheniramine
ezetimibe/simvastatin	hydrocodone/homatropine
famotidine	hydrocodone/ibuprofen
fentanyl	hydrocortisone/lidocaine/aloe vera
fexofenadine	hydromorphone
fexofenadine/pseudoephedrine	hydroxyprogesterone
fingolimod	hydroxyzine
fluconazole	ibuprofen
fludeoxyglucose	ibuprofen/oxycodone
fluocinolone	icatibant
fluoride	imatinib
fluoride/iron/vitamins A,C,and D	immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL
fluoride/vitamins A,C,and D	immune globulin,gamma(IgG)/glycine/IgA average 46 mcg/mL
fluoxetine	infliximab
fluticasone	insulin aspart
fluticasone/salmeterol	insulin degludec
fluticasone/vilanterol	insulin detemir
folic acid	insulin glargine
folic acid/vitamin B complex and vitamin C	insulin lispro
gabapentin	interferon gamma-1b,recomb.
galcanezumab	ipratropium
glatiramer	ipratropium/albuterol
glecaprevir/pibrentasvir	isotretinoin
glipizide	ivacaftor
glucagon	ivermectin
glycerol phenylbutyrate	ixekizumab
glycopyrrolate	ketoconazole
guaifenesin	ketorolac
guaifenesin/hydrocodone	lacosamide
guaifenesin/phenylephrine	lamotrigine
guanfacine	lansoprazole
guselkumab	
haloperidol	

ledipasvir/sofosbuvir	methylprednisolone
lenalidomide	methyltestosterone
leuprolide	metoprolol
levabuterol	metronidazole
levetiracetam	mirtazapine
levocetirizine	modafinil
levonorgestrel	mometasone
levothyroxine	mometasone/formoterol
lidocaine	montelukast
lidocaine/aloe vera	morphine
lidocaine/epinephrine	multivitamin
lidocaine/hydrocortisone	multivitamin with iron
lidocaine/prilocaine	multivitamins with Fluoride
lifitegrast	multivitamins with Iron & Fluoride
linagliptin	mupirocin
linezolid	mycophenolate
lipase/protease/amylase	naloxone
liraglutide	naproxen
lisdexamfetamine	natalizumab
lisinopril	neomycin/bacitracin/polymyxin B/lidocaine
lithium	neomycin/polymyxin B/lidocaine
lopinavir/ritonavir	nicotine
loratadine	nilotinib
lorazepam	nitrofurantoin
losartan	nivolumab
lumacaftor/ivacaftor	norelgestromin/ethinyl estradiol
lurasidone	norepinephrine
macitentan	norgestimate-ethinyl estradiol
medroxyprogesterone	nusinersen
megestrol	nystatin
meloxicam	nystatin/triamcinolone
mercaptopurine	ocrelizumab
mesalamine	olanzapine
metformin	olanzapine/fluoxetine
methadone	olopatadine
methamphetamine	omalizumab
methotrexate	omeprazole
methylphenidate	onabotulinumtoxinA

ondansetron	quetiapine
oseltamivir	racepinephrine
osimertinib	ranibizumab
oxcarbazepine	ranitidine
oxycodone	ranolazine
oxycodone/acetaminophen	rifaximin
oxycodone/aspirin	risperidone
oxycodone/oxycodone terephthalate/aspirin	ritonavir
oxymorphone	rituximab
palbociclib	rivaroxaban
paliperidone	rizatriptan
palivizumab	ropinirole
pantoprazole	rosuvastatin
pediatric multivitamin	rufinamide
pegfilgrastim	sacubitril/valsartan
pembrolizumab	secukinumab
penicillin G potassium	semaglutide
penicillin G procaine	sertraline
penicillin G sodium	sevelamer
penicillin V potassium	sildenafil
pentazocine/naloxone	simvastatin
permethrin	sitagliptin
pertuzumab	sitagliptin/metformin
phentermine	sodium fluoride/potassium nitrate
phenylephrine	sodium oxybate
phenylephrine/hydrocodone/chlorpheniramine	sofosbuvir/velpatasvir
phenylephrine/promethazine	somatropin
phenylephrine/pyrilamine	spinosad
phenylpropanolamine/hydrocodone	sucalfate
polyethylene glycol 3350	sulfamethoxazole/trimethoprim
posaconazole	sumatriptan
prazosin	sumatriptan succinate/naproxen sodium
prednisolone	tacrolimus
prednisone	tamsulosin
pregabalin	teduglutide
probenecid/colchicine	telmisartan/amlodipine
propofol	tenofovir
pyridoxine	teriflunomide

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testosterone	umeclidinium
tetrabenazine	ustekinumab
tezacaftor/ivacaftor	valacyclovir
ticagrelor	valbenazine
tiotropium	valganciclovir
tizanidine	valsartan
tobramycin	valsartan/hydrochlorothiazide
tobramycin/dexamethasone	vancomycin
tobramycin/nebulizer	varenicline
tofacitinib	vedolizumab
topiramate	venlafaxine
tramadol	vigabatrin
trastuzumab	vortioxetine
trazodone	warfarin
treprostinil	zaleplon
tretinoin	ziprasidone
triamcinolone	zolpidem
triprolidine	other
triprolidine/pseudoephedrine	

APPENDIX C: DRUG CLASSES

acne agents	bile salt agents
alzheimer agents	bladder relaxant agents
analgesics, narcotic agents	bone resorption suppression and related agents
androgenic agents	bronchodilator agents
anesthetics agents	calcium channel blocker agents
angiotensin modulator agents	cephalosporin agents
angiotensin modulator/calcium channel blocker combination agents	chronic obstructive pulmonary disease agents
antibiotics, gi agents	colony stimulating factor agents
antibiotics, inhaled agents	constipation agents
antibiotics, otic agents	contraceptive agents
antibiotics, topical agents	cough and cold agents
antibiotics, vaginal agents	cytokine and cam antagonist agents
anticoagulant agents	diabetic testing blood glucose meters, test strips, lancets
anticonvulsant agents	diuretic agents
antidepressant agents	epineprine agents
antiemetic agents	erythropoiesis stimulating protein agents
antifungal agents	fluoroquinolone agents
antihemophilic factor ix agents	glucocorticoid agents
antihemophilic factor viii/vwf agents	growth hormone agents
antihistamine agents	hereditary angioedema agents
antihypertensives, sympatholytic agents	histamine ii receptor blocker agents
antihyperuricemic agents	hypoglycemic agents
antimigraine agents	immunomodulators
antiparasitic agents	intranasal rhinitis agents
antiparkinson's agents	leukotriene receptor antagonist agents
antipsoriatic agents	lincosamides/oxazolidinones/streptogramin agents
antipsychotic agents	lipotropic agents
antiviral agents	macrolide agents
antivirals, antiretroviral agents	mood stabilizer agents
antivirals, hepatitis c agents	movement disorder agents
antivirals, other agents	multiple sclerosis agents
anxiolytic agents	neuropathic pain agents
attention deficit hyperactivity disorder agents	nsaid agents
benign prostatic hyperplasia agents	oncology agents
beta blocker agents	ophthalmic agents

opiate dependence agents	skeletal muscle relaxant agents
opiate overdose agents	steroid agents
pancreatic enzyme agents	stimulants and related agents
penicillin agents	tetracycline agents
phosphate binder agents	thyroid hormone agents
pituitary suppressants, central precocious puberty (cpp) agents	ulcerative colitis agents
platelet aggregation inhibitor agents	urinary anti-infective agents
progestational agents	vasodilator agents
proton pump inhibitor agents	vitamin agents
pulmonary arterial hypertensive agents	other
sedative hypnotic agents	

APPENDIX D: DENIAL CODES

accumulation refill too soon
age
bill Medicare
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 not on formulary

product/service not covered - plan/benefit exclusion

produr alert

provider not enrolled in benefit plan

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