

**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.

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.

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

I. DEMOGRAPHIC INFORMATION

State Abbreviation: _____

MCO Name: _____

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

Program Type:

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: _____

1. 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 it 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 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?

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.

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

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.

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:

_____ %

Schedule II controlled drugs:

_____ %

Schedule III through V controlled drugs:

_____ %

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?

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?

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)
				%		%
				%		%
				%		%
				%		%
				%		%
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				%		%
				%		%
				%		%
				%		%
				%		%

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

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

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.

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.

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).

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.

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

Yes

No

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

Require that a MedWatch Form be submitted.

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

Prior authorization is required.

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

Other, please explain.

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			

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: _____

Total Number of Claims: _____

Generic Utilization Percentage: _____

VII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW and RESTRICTION PROGRAMS

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

Yes

No

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

Deny claims and require prior authorization

Refer to Lock-In Program

Refer to Program Integrity Unit/Surveillance Utilization Review (SURs unit)

Refer to Office of Inspector General

Refer to legal authorities

Other, please explain.

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:

Number of controlled substances (CS)

Different prescribers of CS

Multiple pharmacies

Number days’ supply of CS

Exclusivity of short acting opioids

Multiple ER visits

PDMP data

Same FFS state criteria is applied

Other, please explain.

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

i) Prescriber only

Yes

No

ii) Pharmacy only

Yes

No

iii) Prescriber and pharmacy

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?

_____ %

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

Refer to Program Integrity Unit/Surveillance Utilization Review (SURs unit)

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.

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

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

No, 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.

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.

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.

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.

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.

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.

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.

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

Yes

No

Please explain.

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

Yes

No

Please explain.

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.

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

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

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.

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?

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.

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?).

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.

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.

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.

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.

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.

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).

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.

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) 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).

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).*

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.

APPENDIX

DRUG NAMES

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

clonazepam	efavirenz/emtricitabine/tenofovir disoproxil fumarate
clonidine	elbasvir/grazoprevir
clopidogrel bisulfate	elviteg/cob/emtri/tenofo disop
coagulation factors	elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide
contraceptives	emtricitabine/rilpivirine/tenofovir df
corticotropin	emtricitabine/tenofovir alafenamide
cyanocobalamin	enalapril maleate
cyclobenzaprine	enoxaparin sodium
cyclosporine	entecavir
darbepoetin alfa in polysorbat	epoetin alfa
darunavir ethanolate	ergocalciferol
darunavir/cobicistat	escitalopram
deferasirox	esomeprazole
deferoxamine	estradiol
deserasirox	etanercept
desogestrel/ ethinyl estradiol	estrogens
dexlansoprazole	everolimus
dexmethylphenidate	exenatide
dextroamphetamine/amphetamine	ezetimibe
diazepam	famotidine
diclofenac	fenofibrate
dicyclomine hydrochloride	fentanyl
digoxin	ferrous sulfate
diltiazem hydrochloride	filgrastim
dimethyl fumarate	finasteride
diphenhydramine	fingolimod
divalproex sodium	fluconazole
docusate	fluoxetine
dolutegravir	fluticasone
donepezil	fluticasone propionate/ salmeterol xinafoate
dornase	fluticasone/salmeterol
dorzolamide hydrochloride/timolol maleate	fluticasone/vilanterol
doxazosin mesylate	folic acid
doxycycline	furosemide
drospirenone/ ethinyl estradiol	gabapentin
duloxetine	gemfibrozil
eculizumab	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	trazodone
tamsulosin hydrochloride	treprostinil sodium
temazepam	triamcinolone
tenofovir disoproxil fumarate	ustekinumab
terazosin	valacyclovir
teriflunomide	valsartan
testosterone	varenicline
thyroid	vedolizumab
timolol	venlafaxine
tiotropium	verapamil
tizanidine	vitamins
topiramate	warfarin
tramadol	zolpidem
trastuzumab	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