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: NV

MCO Name: Silver Summit Health Plan

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

Program Type: (*See Appendix A*)

Comprehensive MCO

If "Other", please specify.

Medicaid MCO Information

Identify the MCO person responsible for DUR Annual Report preparation.

First Name: THOMAS

Last Name: BERANEK

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

Area Code/Phone Number: 844-366-2880

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

59,993.00 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.

   CVS/Caremark

   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
- [x] 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.

Currently no pharmacies identified as outliers requiring outreach.

5. Early Refill

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

i. Non-controlled drugs:

80 %

ii. Schedule II controlled drugs:

90 %

iii. Schedule III through V controlled drugs:

90 %

b) For non-controlled drugs:

When an early refill message occurs, does 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.

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

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

   - (●) Yes
   - ( ) No

   If "Yes", please explain your edits.

   Edits are built into the adjudication system requiring that a total of 80percent of the days supplied must have elapsed before the prescription can be refilled. (90 percent for all controlled substances)

   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.

The provider may submit a request through covermymeds.com or by faxing a completed prior authorization form to Envolve Pharmacy Solutions (PBM).

○ 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.

Reviews are conducted quarterly of PA policies at both the state's quarterly DUR meeting and the plan's quarterly P&T meeting to ensure PA criteria is no more restrictive than FFS criteria.

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.

    All participating pharmacies are authorized to provide a 96-hour supply of medication whether or not the PA request is ultimately approved or denied.

- ○ 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)
hydrocodone/acetaminophen	analgesics, narcotic agents	plan limitations exceeded	bictegravir/emtricitabine/tenofovir	5.85%	ibuprofen	3.06%
oxycodone/acetaminophen	other dermatological	prior authorization required	adalimumab	3.90%	albuterol	3.05%
oxycodone	antipsychotic agents	NDC not covered	insulin glargine	2.59%	atorvastatin	2.96%
tramadol	antidepressant agents	refill too soon	lurasidone	2.37%	gabapentin	2.03%
morphine	attention deficit hyperactivity disorder age	other pharmacy not contracted with plan on date	dulaglutide	1.59%	lisinopril	1.69%
other glucose Blood	other anti-inflammatories		emtricitabine/tenofovir	1.58%	metformin	1.65%
pregabalin	anticonvulsant agents		cariprazine	1.51%	amoxicillin	1.57%
lisdexamfetamine	other gastrointestinal agents - misc		elvitegravir/cobicistat/emtricitabine/tenofov	1.49%	hydrocodone/acetaminophen	1.48%
quetiapine	skeletal muscle relaxant agents		buprenorphine/naloxone	1.49%	amlodipine	1.43%
duloxetine	diabetic testing blood glucose meters, tes		apixaban	1.46%	sertraline	1.37%

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

  Other

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

  Envolve Pharmacy Solutions

- ( ) 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.

  The MCO DUR Board reviews and approved DUR criteria.

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:

- [X] Monthly
- [ ] Bi-monthly
- [ ] Quarterly
- [ ] Other, please specify:

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

- [X] Mailed letters
- [X] Provider phone calls
- [X] 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.

SilverSummit Healthplan utilizes a comprehensive retrospective DUR program to positively impact the quality of care delivered to our members. The below describes our outreach to the provider community.
Provider Outreach Letters
SilverSummit Healthplan sends prescribers outreach letters notifying of multiple gaps in therapy, underutilization or concerns in treatment for members as outlined below:

1) Opioids and Antipsychotics – identify members who have overlapping fills of an opioid along with Antipsychotics. Identification rates in 2020 remained fairly consistent for members who had overlapping fills of an opioid along with an antipsychotic. Physician outreach was completed for these members to determine the medical necessity for combination therapy with these agents.

2) Morphine Equivalent Benchmark – identify members who are using opioids at doses greater than or equal to 90mg of morphine per day (cancer patients excluded). Identification rates in 2020 remained fairly consistent for members who used opioid analgesic medications with a total daily dose of 90 mg or more of morphine per day without having an inferred diagnosis of cancer. Outreach letters were sent to all prescribers on all members, subsequent letters were mailed to prescribers of members chronically using high dose opioids.

3) Antipsychotics Use in Children <18yrs old - identify members <18 yrs old who have filled an Antipsychotic. Identification rates in 2020 remained fairly consistent with some fluctuations for members younger than 18 years old who had fills of an antipsychotic. Careful monitoring in collaboration with a mental health provider was provided for these members to promote safe prescribing practices.

4) Under-Utilization of Maintenance Medications - identify members with a respiratory condition, which are over-utilizing their short acting beta agonist (rescue medications) Identified rates increased and decreased and remained fairly consistent toward the last quarter of 2020. The members were identified as over-utilizing their short-acting beta agonist. Outreach was made to prescribers through use of intervention letters.

5) Opioids, Benzodiazepines and Muscle Relaxants - identify members who have overlapping fills of an opioid along with a benzodiazepine and a skeletal muscle relaxant. Identification rates gradually decreased in 2020 for members who had overlapping fills of an opioid along with a benzodiazepine and a skeletal muscle relaxant. Physician outreach was performed for these members to determine the medical necessity for combination therapy with these agents.

6) Therapeutic Duplication - identify members concurrently using 2 or more proton pump inhibitors (ppi). Identified rates remained fairly consistent throughout 2020 for members who were identified for the simultaneous use of 2 or more proton pump inhibitors (ppi). The number of identified members gradually decreased after Q1. Intervention letters were sent to prescribers to remove unnecessary duplications for all members identified.

7) Diabetes: Under-Utilization of Preventative Medications - identify members who are at risk for diabetic nephropathy, but are not currently being treated with the recommended preventative

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).

The standard prospective and retrospective DUR programs are delegated to the designated pharmacy benefit manager (PBM), Envolve Pharmacy Solutions, utilizing the standards, criteria, protocols and procedures established by the mutual agreement of the Centene Corporate Pharmacy and Therapeutics Committee, Health Plan Pharmacy Departments, and Envolve Pharmacy Solutions, and in accordance with applicable state and federal requirements and NCQA standards. The DUR program is submitted for review and approval to the Centene Corporate and Health Plan Pharmacy and Therapeutics Committees annually. The DUR program is designed to alert prescribers and/or dispensing pharmacists by identifying overuse, underuse, inappropriate or medically unnecessary care, and to address safety concerns associated with specific drugs, including the potential for drug interactions. The DUR program also functions to identify opportunities to improve the quality of care for patients including adherence to prescribed therapy and improvements in the medication regimen consistent with the patient's diagnoses or conditions. The results of any retrospective DUR programs may also be used to initiate additional claims review and analysis at the health plans. In addition, follow-up studies may be performed to assess the impact and outcomes of retrospective DUR interventions.

Based on findings from quarterly retrospective DUR reviews, DUR pharmacists may recommend implementing changes to existing prospective/concurrent DUR edits to remedy apparent misuse/overuse. Recommendations may include but not limited to: formulary changes, quantity limits, prior authorization, hard blocks, and use of electronic step therapy.

The DUR Team produces quarterly provider educational material around areas of concern that is reviewed and approved by the DUR Board. Once approved by the DUR Board, this material is posted on a SharePoint site and made available to SilverSummit Healthplan (SSHP) for use and distribution.

SSHP pharmacists are notified by Envolve Pharmacy Solutions, of members identified as meeting the requirements for a potential DUR intervention. If deemed appropriate, communications are initiated to members via intervention letters. Providers are contacted by phone, fax or via intervention letters. Faxes and intervention letters may include patient prescription profiles for

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.

When generic drugs are available, the brand name drug will not be covered without SilverSummit Healthplan (SSHP) Prior Authorization(PA). Generic drugs have the same active ingredient and work the same as brand name drugs. If a physician/clinician provider feels a brand name drug is medically necessary, the physician/clinician can submit a PA.

SSHP will cover the brand name drug according to our clinical guidelines if there is a medical reason a member needs the particular brand name drug. If SSHP does not grant PA we will notify physician/clinician provider and provide information regarding the appeal process.

The Nevada Statute NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand name; and d) is of the same generic type as the drug prescribed by brand name. If the pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are available to him or her for substitution. Before a pharmacist dispenses a drug in substitution for a drug prescribed by brand name, the pharmacist shall: a) advise the person who presents the prescription that the pharmacist intends to dispense a drug in substitution; and b) advise the person that he or she may refuse to accept the drug that the pharmacist intends to dispense in substitution, unless the pharmacist is being paid for the drug by a governmental agency. If a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense the drug in substitution.

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* ÷ (*S* + *N* + *I*) × 100 = 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:

   ***$N* ÷ (*$S* + *$N* + *$I*) × 100 = Generic Expenditure Percentage**

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found at *Medicaid.gov* (Click on the link "*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	27,030	394,753	25,155
Total Reimbursement Amount Less Co-Pay	27,940,340.41	5,425,118.68	3,295,490.82

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: 394,753

   Total Number of Claims: 446,938

   Generic Utilization Percentage: 88.32 %

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

   9,999

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: 5,425,118.68

   Total Dollars: 36,660,949.91

   Generic Expenditure Percentage: 14.80 %

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

Yes. All biosimilar products require a prior authorization review before approval.

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
- [x] 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:

- [x] Number of controlled substances (CS)
- [x] Different prescribers of CS
- [x] Multiple pharmacies
- [x] Number days' supply of CS
- [ ] Exclusivity of short acting opioids
- [x] 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?

0.17 %

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

0.01 %

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.

   Early refill thresholds are set as a way of preventing prescriptions from being refilled too soon. For non-controlled drugs, the threshold is set at 80%

   ○ 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.

  The state of Nevada only allows prescribers and dispensers access to a patient's controlled substance prescription medication history.

  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.

Nevada Senate Bill 459requires the prescribing physicians obtain a patient utilization report from the prescription drug monitoring program (PDMP) before (1) initiation of a schedule II, III, or IV prescription drug for a new patient or (2) a course of treatment longer than 7 days that is part of a new course of treatment for an existing patient.

Nevada Assembly Bill 474 established an additional requirement to obtain a new report at least

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 dispending?

○ Yes

Are there protocols involved in checking the PDMP?

○ Yes, please explain.

○ No

◉ No, please explain.

There is no statute or requirement for pharmacists to check a patient's PDMP report before dispensing a prescription, but some pharmacy chains require their pharmacists to check the PDMP report before dispensing controlled substances.

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:

- [x] PDMP drug history
- [x] The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period
- [x] 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).

The state of Nevada doesn't allow MCO access, only prescribers and dispensers are allowed access to a patient's controlled substance prescription medication history.

- ( ) 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:

   46.99 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 (*Generic Ingredient*) 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.	20,727.00	191.00	0.92 %	hydrocodone/acetaminophen	130.00	0.63 %
				acetaminophen with codeine	25.00	0.12 %
				oxycodone/acetaminophen	19.00	0.09 %
19-29 yrs.	9,971.00	1,321.00	13.25 %	hydrocodone/acetaminophen	707.00	7.09 %
				buprenorphine/naloxone	99.00	0.99 %
				oxycodone/acetaminophen	306.00	3.07 %
30-39 yrs.	7,798.00	1,545.00	19.81 %	hydrocodone/acetaminophen	732.00	9.39 %
				buprenorphine/naloxone	173.00	2.22 %
				oxycodone/acetaminophen	365.00	4.68 %
40-49 yrs.	4,938.00	1,179.00	23.88 %	hydrocodone/acetaminophen	563.00	11.40 %
				oxycodone/acetaminophen	292.00	5.91 %
				oxycodone	142.00	2.88 %
50-59 yrs.	4,372.00	1,111.00	25.41 %	hydrocodone/acetaminophen	544.00	12.44 %
				oxycodone/acetaminophen	269.00	6.15 %
				oxycodone	136.00	3.11 %
60-69 yrs.	1,896.00	438.00	23.10 %	hydrocodone/acetaminophen	197.00	10.39 %
				oxycodone/acetaminophen	104.00	5.49 %
				oxycodone	56.00	2.95 %
70-79 yrs.	0.00	0.00	0.00 %	Top 1 Opioid	0.00	0.00 %
				Top 2 Opioid	0.00	0.00 %
				Top 3 Opioid	0.00	0.00 %
80+ yrs.	0.00	0.00	0.00 %	Top 1 Opioid	0.00	0.00 %
				Top 2 Opioid	0.00	0.00 %
				Top 3 Opioid	0.00	0.00 %
Individuals with Disabilities Utilizing State Eligibility Categories	0.00	0.00	0.00 %	Top 1 Opioid	0.00	0.00 %
				Top 2 Opioid	0.00	0.00 %
				Top 3 Opioid	0.00	0.00 %

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 (*Generic Ingredient*) 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.	20,727.00	36.00	0.17 %	diazepam	11.00	0.05 %
				alprazolam	4.00	0.02 %
				lorazepam	8.00	0.04 %
19-29 yrs.	9,971.00	375.00	3.76 %	alprazolam	199.00	2.00 %
				lorazepam	73.00	0.73 %
				zolpidem	49.00	0.49 %
30-39 yrs.	7,798.00	591.00	7.58 %	alprazolam	302.00	3.87 %
				zolpidem	107.00	1.37 %
				diazepam	95.00	1.22 %
40-49 yrs.	4,938.00	491.00	9.94 %	alprazolam	252.00	5.10 %
				zolpidem	119.00	2.41 %
				lorazepam	64.00	1.30 %
50-59 yrs.	4,372.00	500.00	11.44 %	alprazolam	239.00	5.47 %
				zolpidem	137.00	3.13 %
				diazepam	78.00	1.78 %
60-69 yrs.	1,896.00	210.00	11.08 %	alprazolam	95.00	5.01 %
				zolpidem	57.00	3.01 %
				diazepam	29.00	1.53 %
70-79 yrs.	0.00	0.00	0.00 %	Top 1 Sedative/Benzodiazepine	0.00	0.00 %
				Top 2 Sedative/Benzodiazepine	0.00	0.00 %
				Top 3 Sedative/Benzodiazepine	0.00	0.00 %
80+ yrs.	0.00	0.00	0.00 %	Top 1 Sedative/Benzodiazepine	0.00	0.00 %
				Top 2 Sedative/Benzodiazepine	0.00	0.00 %
				Top 3 Sedative/Benzodiazepine	0.00	0.00 %
Individuals with Disabilities Utilizing State Eligibility Categories	0.00	0.00	0.00 %	Top 1 Sedative/Benzodiazepine	0.00	0.00 %
				Top 2 Sedative/Benzodiazepine	0.00	0.00 %
				Top 3 Sedative/Benzodiazepine	0.00	0.00 %

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 (*Generic Ingredient*) 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.	20,727.00	439.00	2.12%	methylphenidate	196.00	0.95%
				dextroamphetamine/amphetami	206.00	0.99%
				lisdexamfetamine	52.00	0.25%
19-29 yrs.	9,971.00	295.00	2.96%	dextroamphetamine/amphetami	244.00	2.45%
				lisdexamfetamine	34.00	0.34%
				methylphenidate	29.00	0.29%
30-39 yrs.	7,798.00	288.00	3.69%	dextroamphetamine/amphetami	250.00	3.21%
				lisdexamfetamine	25.00	0.32%
				methylphenidate	20.00	0.26%
40-49 yrs.	4,938.00	141.00	2.86%	dextroamphetamine/amphetami	121.00	2.45%
				lisdexamfetamine	9.00	0.18%
				methylphenidate	10.00	0.20%
50-59 yrs.	4,372.00	81.00	1.85%	dextroamphetamine/amphetami	62.00	1.42%
				methylphenidate	10.00	0.23%
				dextroamphetamine	2.00	0.05%
60-69 yrs.	1,896.00	16.00	0.84%	dextroamphetamine/amphetami	11.00	0.58%
				methylphenidate	2.00	0.11%
				lisdexamfetamine	2.00	0.11%
70-79 yrs.	0.00	0.00	0.00%	Top 1 Stimulant/ADHD	0.00	0.00%
				Top 2 Stimulant/ADHD	0.00	0.00%
				Top 3 Stimulant/ADHD	0.00	0.00%
80+ yrs.	0.00	0.00	0.00%	Top 1 Stimulant/ADHD	0.00	0.00%
				Top 2 Stimulant/ADHD	0.00	0.00%
				Top 3 Stimulant/ADHD	0.00	0.00%
Individuals with Disabilities Utilizing State Eligibility Categories	0.00	0.00	0.00%	Top 1 Stimulant/ADHD	0.00	0.00%
				Top 2 Stimulant/ADHD	0.00	0.00%
				Top 3 Stimulant/ADHD	0.00	0.00%

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.	20,727.00	47.00	0.23 %	4.00	0.02 %
19-29 yrs.	9,971.00	122.00	1.22 %	16.00	0.16 %
30-39 yrs.	7,798.00	201.00	2.58 %	28.00	0.36 %
40-49 yrs.	4,938.00	160.00	3.24 %	29.00	0.59 %
50-59 yrs.	4,372.00	157.00	3.59 %	20.00	0.46 %
60-69 yrs.	1,896.00	54.00	2.85 %	10.00	0.53 %
70-79 yrs.	0.00	0.00	0.00 %	0.00	0.00 %
80+ yrs.	0.00	0.00	0.00 %	0.00	0.00 %
Individuals with Disabilities Utilizing State Eligibility Categories	0.00	0.00	0.00 %	0.00	0.00 %

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

N/A

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

Aged, Blind and Disabled are an exclusion from the MCOs and are only covered by Fee For Service Medicaid.

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.

There is a POS edit to limit the initial fill of an opioid prescription to 7 days.

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?

7 # 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.

For Short Term Therapy our policy allows 7 days supply or less for initial fill of an opioid prescription.

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.

    Maximum 30 day supply and must obtain a prior authorization for medical necessity.

- ( ) 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.

    Maximum 30 day supply and must obtain a prior authorization for medical necessity.

- ( ) 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.

Documentation that the provider has reviewed the PDMP and that the Provider agrees to continuously assess the member's pain management regimen for possible discontinuation of opioid therapy.

Please provide details on these opioid prescribing controls are in place.

Claim will deny and require a PA if no diagnosis code has been submitted or if the prescription exceeds 90 MME per day. Failure of at least 2 non-opioid ancillary treatments (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], acetaminophen, anticonvulsants, antidepressants) unless contraindicated or clinically significant adverse effect are experienced. PA form requires acknowledgment of PDMP review and agreement for continuous assessment

○ 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.

   Restrictions on claims are implemented to prevent members from receiving excessive medication regimens within the same, or similar, medication classes.

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.

Edits are built into the adjudication system requiring that a total of 90 percent of the opioid prescription days supplied must have elapsed before the prescription can be refilled.

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.

Claims are reviewed monthly and those claims identified as exceeding state limitations prompt MME benchmark letters being sent to the physician providers on the claims.

- ○ 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).

Monthly retrospective claims review by a pharmacist identifies providers that warrant a patient safety letter. The letter educates the provider on concurrent use of opioids and benzodiazepines and offers titration process options.

- ○ 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.

POS edits are in place to notify retail pharmacists when opioids and sedatives are dispensed concurrently.

- ( ) 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.

Opioid/antipsychotics have soft edits rejects at POS and the DUR team generates monthly reports for plan to review.

- ○ No, please explain.

11. Does your MCO have POS safety edits or perform automated respective 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.

  Our PDL does list which abuse deterrent opioids are preferred formulary in the analgesic - opioid section.

- ( ) 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?).

All orders over the maximum of 90 MME require a prior authorization for medical necessity and/or documentation that provider is tapering patient.

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.

The DUR team generates and sends the plan a monthly claims review of opioid prescriptions dispensed with a daily MME of 90 and higher.

- ( ) 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.

   Our PDL does list which abuse deterrent opioids are preferred formulary in the analgesic - opioid section with appropriate PA and QL controls.

   ○ 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.

    NV Senate Bill 459 Authorizes a registered pharmacist to furnish an opioid antagonist, without a RX, in accordance with standardized procedures OR protocols developed by the state board of Pharmacy (NRS 453C.010 – 453C.150)

    ○ 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.

   Referral is not required as long as the member utilizes as in network provider.

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.

   Restrictions on age implemented to prevent children from utilizing medications below FDA recommended age limits. Restrictions on claims implemented to prevent members from receiving excessive medication regimens within the same, or similar, medication class.

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):

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

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

SilverSummit Healthplan utilizes a corporate Psychotropic Medication Utilization Review (PMUR) program that interfaces with a PMUR Coordinator (clinician) to manage and monitor the day to day activities.

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).

SilverSummit Healthplan utilizes a corporate Psychotropic Medication Utilization Review (PMUR) program that interfaces with a PMUR Coordinator (clinician) to manage and monitor the day to day activities.

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).

In 2020 SilverSummit made an agreement with a non-affiliated subcontractor, to provide Medication Management Services. Utilizing a high-touch chronic care pharmacy-at-home model coupled with proprietary technology and automation, this vendor provides comprehensive complex medication management and adherence support program. The goal of these services is to drive improved medication adherence and better overall health for Client's Members.
This agreement provides our members:
o A monthly medication review on all prescribed medications,
o Medications in multidose adherence packaging,
o Free home delivery service of medications
o Ongoing refill management services which includes, proactively working with prescribers to coordinate and synchronize medication refills to ensure no interruption in the medication regimen
o Personal support, such as counseling, changes in therapy, prior authorizations, and new drug regimens, provided to the Members from the Vendor's team of licensed pharmacists

Project ECHO Provider Pain Management Training. In 2020, SilverSummit identified a large volume of referrals for pain management specialists and of pain medication prescriptions across the network. In partnership with the University of Nevada-Reno and Project ECHO, we developed a unique training program to educate Providers on treating patients with chronic pain using non-pharmacological multi-modal treatment plans. Of the Providers who participated, 94% strongly agreed/agreed that they would make changes in their prescribing practices as a result of the training.

SilverSummit Healthplan also continues the On.Demand diabetes monitoring program which allows for cellular enabled readings of blood glucose levels. This provides real time numbers and results that can be intervened right away instead of waiting on claims data. The program includes the current education and coaching aspects of standard disease management for diabetics. If a member does not record a reading for 5 consecutive days a compliance call is made to the

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.

SilverSummit Healthplan (SSHP) is committed to providing appropriate, high quality, and cost effective medication therapy to all SSHP members. SSHP works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. SSHP covers prescription medications and certain over-the-counter (OTC) medications when ordered by a physician/clinician. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities.

SSHP monitors ongoing prescribing of medications for clinical appropriateness. SSHP reviews prescribing retrospectively to review for both safety and efficacy. SSHP contracts with Envolve Pharmacy Solutions to review for disease management, fraud and abuse (i.e. Coordinated Services Program), and prescriber profiling. Prescriber or member outreach may occur based on prescribing/dispensing patterns. SSHP routinely monitors for drug use review (DUR) opportunities and takes action as needed.

The standard prospective (pDUR) and retrospective Drug Use Review (rDUR) programs are delegated to the designated pharmacy benefit manager (PBM), Envolve Pharmacy Solutions, utilizing the standards, criteria, protocols and procedures established by the mutual agreement of the Centene Corporate Pharmacy and Therapeutics Committee, SilverSummit Healthplan, and Envolve Pharmacy Solutions, and in accordance with applicable state and federal requirements and NCQA standards. The DUR program is submitted for review and approval to the Centene Corporate and Health Plan Pharmacy and Therapeutics Committees annually. The DUR program is designed to alert prescribers and/or dispensing pharmacists by identifying overuse, underuse, inappropriate or medically unnecessary care, and to address safety concerns associated with specific drugs, including the potential for drug interactions. The DUR program also functions to identify opportunities to improve the quality of care for patients including adherence to prescribed therapy and improvements in the medication regimen consistent with the patient's diagnoses or conditions. The results of any rDUR programs may also be used to initiate additional claims review and analysis at the plan. In addition, follow-up studies may be performed to assess the impact and outcomes of rDUR interventions.

SSHP's prospective DUR program is administered by CVS utilizing the RxClaims electronic claims system. Our Point of Sale (POS) Safety Review utilizes a series of alerts designed to check the plan member's prescription history for possible drug conflicts and safety issues. When a claim is adjudicated, the CVS Caremark systems evaluate the complete patient drug history and send real time alerts to the dispensing pharmacist every time a safety issue is triggered.SSHP's Pharmacy Program staff uses an evidence-based approach for developing proposals for the DUR Board to review and approve at the quarterly meetings, including clinical PA criteria algorithms and drug claim alerts (quantity, dose, cumulative quantity, age, or gender) that will support appropriate and safe prescription drug use.

SSHP's pharmacy lock-in program is in place to detect and prevent abuse of the pharmacy benefit, as defined by specific criteria designed to identify potential misuse or abuse of prescription medications in specific therapeutic categories with the potential for high abuse, by restricting members to one specific pharmacy and controlled substance provider (if one is chosen) for a defined period of time. SSHP's policy is to monitor and control suspected abuse of the pharmacy benefit by members, as identified and confirmed through analysis and audit by the

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	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). If the comprehensive MCO also covers long-term services and supports, the program type should be Comprehensive MCO + MLTSS. 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. 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.
Comprehensive MCO + MLTSS	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). Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS).
BHO Only (PIHP and/or PAHP)	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.
Dental only (PAHP)	A Prepaid Ambulatory Health Program (PAHP) that only provides dental services.
MLTSS Only	Managed Long Term Services and Supports Only: A program only covering long term services and supports.
Other PHP	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.

Managed Care Program Type	Definition
PACE	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.
PCCM	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.
PCCM entity	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.
Non-Emergency Medical Transportation (NEMT)	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.

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	• Comprehensive MCO • Comprehensive MCO +MLTSS (if benefits include LTSS)
Traditional PCCM Provider	• PCCM
Enhanced PCCM Provider	• PCCM
HIO	• Comprehensive MCO
Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)	• Other PHP
Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)	• Other PHP
Long Term Care (LTC) PIHP	• MLTSS Only
Mental Health (MH) PIHP	• BHO (PIHP and/or PAHP)
Mental Health (MH) PAHP	• BHO (PIHP and/or PAHP)
Substance Use Disorders (SUD) PIHP	• BHO (PIHP and/or PAHP)
Substance Use Disorders (SUD) PAHP	• BHO (PIHP and/or PAHP)
Mental Health (MH) and Substance Use Disorders (SUD) PIHP	• BHO (PIHP and/or PAHP)
Mental Health (MH) and Substance Use Disorders (SUD) PAHP	• BHO (PIHP and/or PAHP)
Dental PAHP	• Dental
Transportation PAHP	• NEMT
Disease Management PAHP	• Other PHP
PACE	• PACE
Pharmacy PAHP	• Other PHP
Accountable Care Organization	• Comprehensive MCO • Other PHP • PCCM
Health/Medical Home	• PCCM

Managed Care Plan Type	Managed Care Program Type
Integrated Care For Dual Eligibles	• Comprehensive MCO + MLTSS, • MLTSS Only (if benefits cover LTSS)
Unknown – it is not yet known how PCCM entities will be reported in T-MSIS.	• PCCM entity

APPENDIX B: DRUG NAMES

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

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

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

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

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

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

APPENDIX C: DRUG CLASSES

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

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

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